

Kaweah Delta Health Care District Board of Directors Meeting

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



DATE POSTED: July 17, 2026

NOTICE

Date: Wednesday, July 22, 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](tel:+16467493122)

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).

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Board Member

Jonna Schengel • Zone 2
Board Member

Dean Levitan, MD • Zone 3
Secretary/Treasurer

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Kaweah Delta Health Care District

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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

Dean Levitan, M.D, Secretary/Treasurer

Prepared by:

A handwritten signature in blue ink, appearing to read "Kelsie K. Davis", is written over a light blue horizontal line.

Kelsie K. Davis

Board Clerk / Executive Assistant to the CEO

DISTRIBUTION:

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

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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 July 22, 2026 {Regular Meeting}

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

- 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

- 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. CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION AND RISK MANAGEMENT** – Discussion with legal counsel regarding ongoing litigation matters involving risk

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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. ISQUIERDO V KDHCD	K. ALVARADO V KDHCD
D. LARUMBLE-TORRES V KDHCD	L. MORENO V KDHCD
E. SMITHSON V KDHCD	M. RICHARDSON V KDHCD
F. VELASEQUEZ V KDHCD	N. TINOCO V KDHCD
G. MEDINA V KDHCD	O. MACKEY V KDHCD
H. JOHNSON 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); Two potential 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.

Action Requested – Approval of Medical Staff Credentialing and Privileging

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** – [June 2, 2026](#), and [June 24, 2026](#).

Action Requested – Approval of all Closed Meeting Minutes from June.

8. **ADJOURN CLOSED SESSION**

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

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. BOARD MEMBER REPORT OUTS

7. RECOGNITIONS

7.1. Presentation of [Resolution 2296](#) to Edith Alvarez in recognition as the Kaweah Health World Class Employee of the month – July 2026.

7.2. Team of the Month – July Mental Health

8. CONSENT CALENDAR

All items listed under the Consent Calendar are considered routine and non-controversial by District staff and will be approved by one motion, unless a Board member, staff, or member of the public requests that an items be removed for separate discussion and action.

Public Participation

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

Action Requested – Approval of all items on the July 22, 2026, Consent Calendar.

[Consent Calendar Items 8.1 – 8.5 as presented]

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Section	Item	Description	Type
8.1. REPORTS	A	Physician Recruitment	Receive and File
	B	Length of Stay	Receive and File
	C	Respiratory Services	Receive and File
	D	The Lifestyles Center	Receive and File
8.2. MINUTES	A	Finance Property Services Acquisition Committee- June 17, 2026	Approve Minutes
	B	Quality Council Committee – June 18, 2026	Approve Minutes
	C	Marketing and Community Relations Board Committee- June 10, 2026	Approve Minutes
	D	Special Board Meetings- June 1, 2026 & June 2, 2026	Approve Minutes
	E	Regular Open Board Meeting – June 24, 2026	Approve Minutes
8.3.1 POLICIES		Board Policies	
	A	BOD1 Orientation of New Board Member	Reviewed
	B	BOD2 CEO Transition	Reviewed
	C	BOD3 CEO Criteria	Reviewed
	D	BOD4 Executive Compensation	Reviewed
	E	BOD5 Conflict of Interest	Approve Revisions
	F	BOD6 Board Travel and Expense Reimbursement	Reviewed
	G	BOD7 Presentation of Claims	Reviewed
	H	BOD8 Promulgation of Board Governance Policies	Reviewed
	I	BOD9 Board Compensation	Reviewed
	J	BOD10 CEO Employment Agreement	Reviewed
	K	BOD11 CEO Severance and Compensation	Approve Revisions
	L	BOD12 CEO Performance Evaluation	Reviewed
	M	BOD13 Board Oversight and Accountability	Reviewed
	N	BOD14 Public Transparency and Disclosure Policy	Reviewed
	O	BOD15 Closed Session and Labor Negotiations Policy	Reviewed
	P	BOD16 Board Meeting Transparency and Remote Access Policy	Reviewed
	Q	BOD17 Language Access for Public Meeting Notice and Agenda Policy	Reviewed
	R	BOD18 Legal Counsel	Approve New
	S	BOD19 Board Self-Evaluation	Approve New
	T	BOD20 Board Education & Continuing Education	Approve New
8.3.2 POLICIES		Administrative Policies	
	A	AP41 Quality Improvement Plan	Approve Revisions
	B	AP180 Weapons Brought into the District	Approve Revisions

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Section	Item	Description	Type
8.3.3 POLICIES		Environment of Care Policies	
	A	DM2104 Emergency Impact Assessment	Reviewed
	B	DM2112 Elevator Use During Emergency Situations	Reviewed
	C	DM2201 Code Triage- Activation Plan	Approve Revisions
	D	DM2203 Code Gray- Activation Plan	Reviewed
	E	DM 2207 Code Red- Activation Plan	Approve Revisions
	F	DM2209 Code Shelter-in-Place	Reviewed
	G	DM2216 Water Systems Failure/Disruption	Reviewed
	H	DM2225 Lockdown-Security of Entry Doors	Approve Revisions
	I	DM 2107 Media Plan	Approve Revisions
	J	DM 2204 Code Silver Activation	Approve Revisions
	K	DM 2212 Earthquake Response	Approve Revisions
	L	DM 2226 Surge Tent Use	Reviewed
8.4. MEC	A	MS42 Quality Review of Medical Staff, Resident Physician, and Advanced Practice Professional Medical Record Documentation	Approve Revisions
	B	MS50 Late Career	Approve Revisions
	C	MS54 Covid Testing Guidelines	Approve Revisions
	D	APP-NP/PA Privilege Form	Approve Revisions
	E	Family Medicine Privilege Form	Approve Revisions
	F	MS40 Impaired Practitioner Policy	Approve Revisions
	G	MS45 Focused Professional Practice Evaluation Guidelines for Initial Proctoring	Approve Revisions
	H	MS49 Practitioner Health Policy	Approve Revisions
8.5. DISTRICT	A	First Addendum to CEO Agreement	Approve Addendum
	B	Annual Tualre County Property Tax Rate Resolution 2295	Approve Resolution
	C	2026 Board Bylaws	Approve Revisions
	D	Board Education Plan	Approve New Plan

9. **ANNUAL INSTITUTIONAL REVIEW BOARD (IRB) REVIEW REPORT – GRADUATE MEDICAL EDUCATION** - Receive and discuss the annual Institutional Review Board (IRB) report for the Graduate Medical Education Department, including an overview of research oversight activities, resident and fellow scholarly projects, compliance with applicable research requirements, and continued alignment with Graduate Medical Education accreditation standards.

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Action Requested – Approval of the Institutional Statement of Commitment to Graduate Medical Education.

- 10. ORTHOPEDIC SERVICE LINE QUALITY REPORT** - Receive an annual quality update from the Orthopedic Service Line highlighting key quality and patient safety outcomes, clinical performance metrics, improvement initiatives, patient experience measures, and ongoing efforts to advance high-quality orthopedic care.

- 11. 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.

- 12. FINANCIAL STEWARDSHIP**
Financial Stewardship report and discussion regarding the financial status of the District, including budget performance, revenue and expense trends, financial sustainability initiatives, capital planning, operational efficiencies, compliance considerations, and fiscal oversight responsibilities of the Board. The Board may provide direction to staff regarding financial priorities and oversight activities.

Action Requested – Approval of Monthly Financials

- 13. FUTURE GOVERNANCE TOPICS**
Discussion regarding future governance topics, Board education opportunities, governance priorities, committee work planning, policy development, regulatory updates, and potential future agenda items to support effective governance and Board oversight responsibilities. The Board may provide direction to staff regarding future governance planning and educational priorities.

REPORTS

13.1. Chief of Staff Report- Report relating to current medical staff events and issues.

13.2. Chief Executive Officer Report - Report on current events and issues.

13.3. Board President - Report on current events and issues.

14. ADJOURNMENT

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Agenda item intentionally omitted

Resolution 2296



RESOLUTION 2296

Board Resolution Honoring Edith Alvarez as World Class Employee of the Month of July

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

WHEREAS, Edith Alvarez, 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 July 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, Edith'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 Edith as **World Class Employee of the Month** for July 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 Edith Alvarez as a token of recognition and gratitude.

PASSED AND ADOPTED this 22nd of July 2026, by the Board of Directors of Kaweah Health.

David Francis
President
Kaweah Health Board of Directors

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

Physician Recruitment

56 ACTIVE CANDIDATES	28 FY26 COMMITMENTS	6 CURRENT OFFERS EXTENDED	4 PENDING SITE VISITS	10 CURRENTLY IN SCREENING
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PHYSICIAN GROUP TARGETS

Key Medical Associates • Pulmonology x1 • Psychiatry x1	Oak Creek Anesthesia • Anesthesia - Cardiac x1 • Anesthesia - General x1 • Anesthesia - Regional x1 • Anesthesia - GME Program Dir x1	Valley Children's • Maternal Fetal Medicine x2 • Neonatology x1 • Pediatric Cardiology x1 • Pediatric Hospitalist x1
Orthopaedics Associates • Ortho Joint x1 • Ortho Trauma / General x1 • Ortho Surgery (General) x1	Other Recruitment / Group TBD • Adult / Child Psychiatry x1 • Cardiology General / HF x1 • Cardiology Interventional x1 • CT Surgery x1 • Family Medicine x5 • Gastroenterology x2 • Infectious Disease x1 • Neurology IP/OP x1 • OB/GYN x4 • Pulmonology OP x1 • Radiation Oncology x1 • Rheumatology x1 • Urology x2 • Vascular Surgery x1	

FY26 YEAR-END SUMMARY

130 CANDIDATES PURSUED	22% CONVERSION RATE 28 of 130 committed	21 SPECIALISTS COMMITTED	7 PRIMARY CARE COMMITTED
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BOARD NARRATIVE | JUNE 2026

During the month of June, the Physician Recruitment Team continued to advance active recruitment efforts across multiple priority specialties while closing out a strong fiscal year.

Signed letters of intent were received in June for two Family Medicine physicians, one joining the Akers Clinic and one joining the Ben Maddox Clinic, as well as two Electrophysiology Cardiologists. These additions reflect continued progress across both primary and specialty care as FY27 begins.

Conference participation at the American Urological Association and American College of Obstetricians and Gynecologists annual meetings continued to build pipeline in two top-priority specialties. Active screening volume in Radiation Oncology represents a near-term pipeline highlight entering the new fiscal year.

The Recruitment team is beginning to work closely with the Medical Staff Office to strengthen alignment across the recruitment and onboarding continuum. Recent efforts include earlier Medical Staff engagement in the recruitment process, participation in physician site visits, and collaborative work to identify opportunities to expedite credentialing and onboarding for incoming physicians.

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

Active Physician Pipeline

July 2026



Phase Key:	Site Visit	Screening	Offer Extended	Offer Accepted	Leadership Call	Applied
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#	Specialty	Group	Phase	Start Date
1	Nephrology	Dr. Javed's Group	Site Visit	
2	Ped Hospitalist	Valley Children's	Site Visit	
3	Rad Oncology	Sequoia Regional Cancer Center	Site Visit	
4	Vascular Surgery	TBD	Site Visit	
5	Anesthesia (Regional)	TBD	Screening	
6	Cardiology (Interventional)	TBD	Screening	
7	Cardiothoracic Surgery	TBD	Screening	
8	Family Medicine	TBD	Screening	
9	OB/GYN	TBD	Screening	
10	Radiation Oncology	Sequoia Regional Cancer Center	Screening	
11	Radiation Oncology	SRCC	Screening	
12	Rheumatology	TBD	Screening	
13	Vascular Surgery	TBD	Screening	
14	Vascular Surgery	TBD	Screening	
15	Family Medicine	TBD	Offer Extended	
16	General Surgery	TBD	Offer Extended	
17	Heart Failure	TBD	Offer Extended	
18	Nephrology	Dr. Javed's Group	Offer Extended	
19	Nephrology	Dr. Javed's Group	Offer Extended	
20	Urology	1099 - KH Direct	Offer Extended	
21	Adult Hospitalist	VHMG	Offer Accepted	09/01/26
22	Cardiology (EP)	1099 - KH Direct	Offer Accepted	
23	Cardiology (EP)	1099 - KH Direct	Offer Accepted	08/01/26
24	ENT	Valley ENT	Offer Accepted	09/01/27
25	Endocrinology	1099 - KH Direct	Offer Accepted	TBD
26	Family Medicine	TBD	Offer Accepted	11/16/26
27	Family Medicine	TBD	Offer Accepted	08/01/26
28	Family Medicine	TBD	Offer Accepted	09/01/26
29	Family Medicine	1099 - KH Direct	Offer Accepted	11/01/26
30	General Surgery	SAMGI	Offer Accepted	02/27/26
31	Internal Medicine	TBD	Offer Accepted	09/01/26
32	Neurology	1099 - KH Direct	Offer Accepted	TBD
33	Orth Surgeon (Hand)	Orthopedic Assoc	Offer Accepted	12/01/26
34	Ortho - Spine	1099 - KH Direct	Offer Accepted	08/01/26
35	PM&R;	TBD	Offer Accepted	05/01/27
36	Pediatrics	1099 - KH Direct	Offer Accepted	
37	Pediatrics	TBD	Offer Accepted	11/16/26

#	Specialty	Group	Phase	Start Date
38	Psychiatry	Oak Stone Psychiatry	Offer Accepted	07/01/27
39	Urology	1099 - KH Direct	Offer Accepted	
40	Family Medicine	Woodlake	Leadership Call	
41	Family Medicine	TBD	Leadership Call	
42	Infectious Disease	TBD	Leadership Call	
43	Neurology	TBD	Leadership Call	
44	OB/GYN	TBD	Leadership Call	
45	Pediatrics	TBD	Leadership Call	
46	Pulmonology	TBD	Leadership Call	
47	Urology	TBD	Leadership Call	
48	Gastroenterology	TBD	Applied	
49	Hospitalist	TBD	Applied	
50	Internal Medicine/Outpatient	TBD	Applied	
51	Ped Hospitalist	TBD	Applied	
52	Pediatrics	TBD	Applied	
53	Pediatrics	TBD	Applied	
54	Radiation Oncology	Sequoia Regional Cancer Center	Applied	
55	Uro/Gyn	TBD	Applied	
56	Urology	TBD	Applied	

Length of Stay

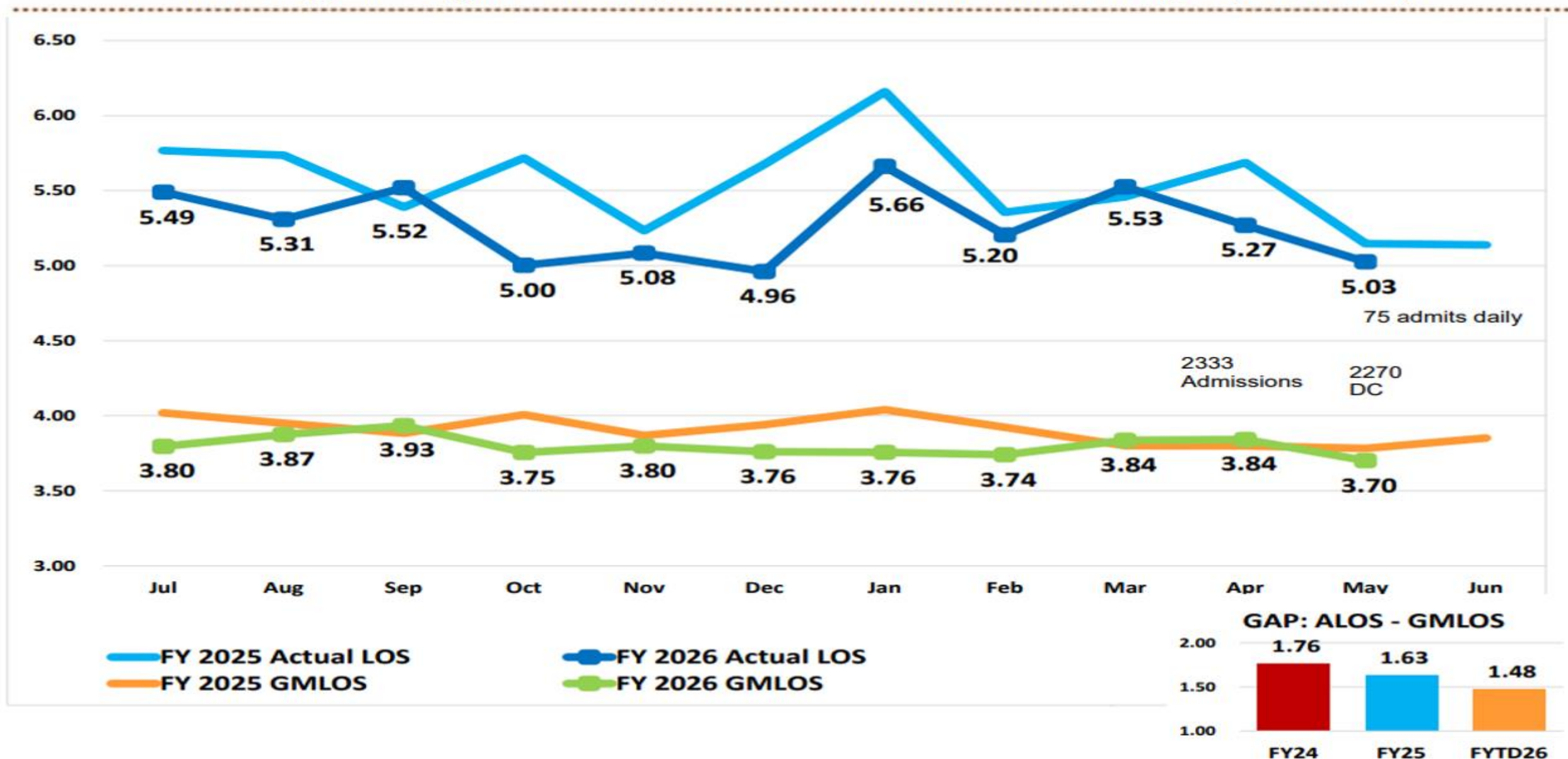
Patient Throughput Committee

June 25, 2026



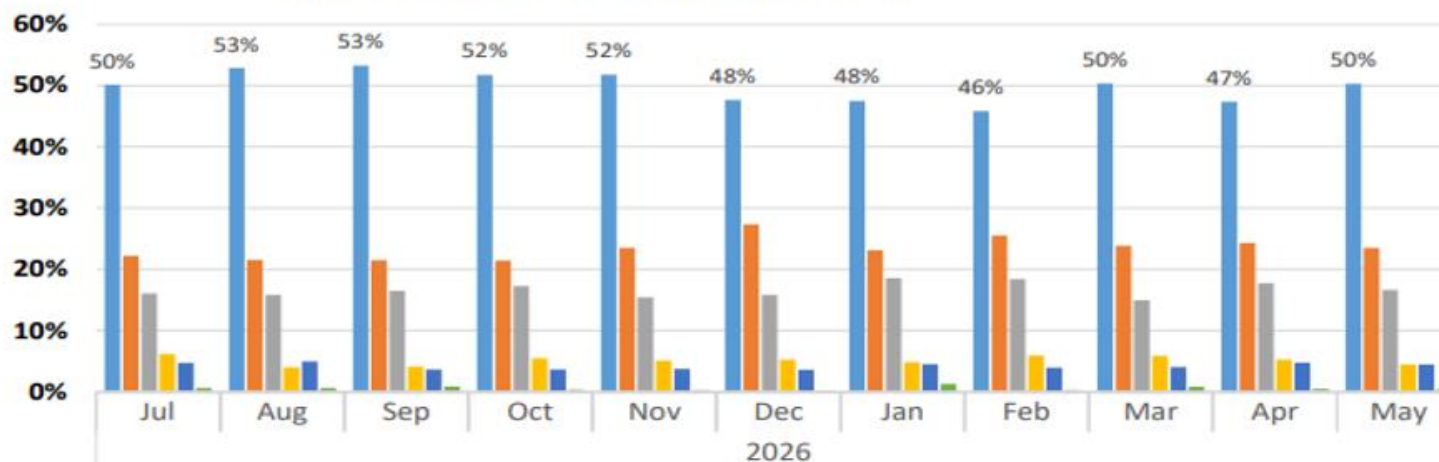
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Average Length of Stay versus National Average (GMLOS)



Average Length of Stay Distribution

FY26 Overall LOS Distribution



748	■ at GMLOS or Better	50%	53%	53%	52%	52%	48%	48%	46%	50%	47%	50%
350	■ 1-2 days over GMLOS	22%	22%	21%	21%	24%	27%	23%	26%	24%	24%	24%
248	■ 2-6 days over GMLOS	16%	16%	17%	17%	15%	16%	19%	18%	15%	18%	17%
67	■ 6-10 days over GMLOS	6%	4%	4%	6%	5%	5%	5%	6%	6%	5%	5%
67	■ 10-30 days over GMLOS	5%	5%	4%	4%	4%	4%	5%	4%	4%	5%	5%
7	■ 30+ days over GMLOS	0.6%	0.6%	0.9%	0.4%	0.3%	0.3%	1.3%	0.3%	0.9%	0.5%	0.5%

Goal 78%
Current 74%

Key Medical CM-Lorraine Simms

- Daily complex huddles with Key leadership & Key Medical Director
- New routine leadership meetings with Key, Kaweah CM & PFS leadership
- Valley Hospitalists providing support through the KMG hospitalist staffing changes.

Recommendations

- Key to have designated patient review time at Kaweah's GMLOS/long LOS meeting, Lorraine to attend.
- Meet with Valley Hospitalists leadership to create best communication with Key CM.
- Improve ED/registration alerts.
 - Kaweah CM Leadership is reviewing with registration.

Emergency to Inpt-Dr KhoaTu

- Establish a formal protocol where all House Supervisors send a standardized text notification to admitting leadership whenever the ED hits a specific admission hold threshold.
- Implement a formal "pending admission" sign-out process for admitting teams so that cases requiring additional testing are handed off directly to oncoming colleagues as a priority follow-up to cut down on re-page from ED.
- Formalize the expectation that the admitting provider bears the final responsibility for the admission order and level of care designation, as they are the clinicians managing the patient's inpatient course.
- Clarify that while the ED may do the primary workup, the rest of the workup can be continued on the inpatient side and it is acceptable to have RRT's and upgrades to the level of care after admission if this is part of the progression of disease.
- We also had several days where MRI scans are significantly impacted with deep queues. ED physicians need to encourage their inpatient counterparts to take patients upstairs before MRI are resultd, to keep patients from sitting in the ED 24-36 extra hours.

2-South-Observation-Bre Mercer

The unit is facing recurring delays from Interventional Radiology (IR), Nuclear Medicine, and Surgical services that are pushing patients well beyond the observation window:

- **IR/Fistulagrams:** Patients requiring fistulagrams on Friday afternoons end up with a **48-hour delay** due to no weekend IR coverage over the weekend, and then a backlog of patients waiting for these procedures.
- **Nuclear Medicine:** Staffing shortages and multiple occasions of low doses of radiopharmaceutical vials have resulted in diagnostic delays pushing patients into the **48–72 hour** range.
- **Surgical Backlog:** High volumes of emergent cases have caused routine procedures, specifically Laparoscopic Cholecystectomies, to be delayed by **24–48 hours**.

Recommendations:

- **Continued work with other dept:** we need weekend coverage for IR for fistulograms, thoracentesis and paracentesis
- **Echo Reading:** Physicians unaware of being slated to read that day. Need shorter TAT for echo reads.
- **Leadership tracking:** cont. tracking extended LOS pts in IDT Rounds daily

Future Standing Reports

Patient Transportation-Cameron-July
Non-CM driven discharge processes-TBD

ED to Inpatient-Cameron Beatty-April
Physician Rounding Per Diem-Dr Said
EVS Per Diem-Denice and/or Rebecca Ceballos-April

Avoidable Delays -Amandeep Kaur
SAMG LOS—Dr Collins-April

Open Heart Project-Lynne Perkins

Project to recover open heart surgery and provide post operative care to discharge in one unit. The project is called “The Universal Bed Project”.

There are 2 phases to the project – Phase 1 is the recovery phase. We are currently in this phase. Phase 2 is the post operative phase. It is interdisciplinary with interdisciplinary rounds. The patient is the center of care and has their own interactive activity board to help progress them to discharge.

Our goal is LOS < 5 days. We were at 7.9 (7.58 Rev Cycle) LOS. We are 2.5 weeks into the project and have a LOS with our first 4 patient at 5. 67 LOS currently in June.

Cardiothoracic Surgery-Ayham Z

Current: For the past two months, multidisciplinary LOS/throughput meetings have been conducted every Monday and Wednesday with billing and coding , Case Management, the Thoracic Surgery team, and the Cardiology team. During these meetings, all cardiovascular service patients are reviewed to identify barriers to discharge, coordinate care plans, and expedite safe discharges.

Recommendations: Continue the twice-weekly multidisciplinary LOS review meetings and consider expanding the process with real-time escalation of discharge barriers, physician accountability metrics, and daily unit huddles to sustain improvements and further reduce LOS.

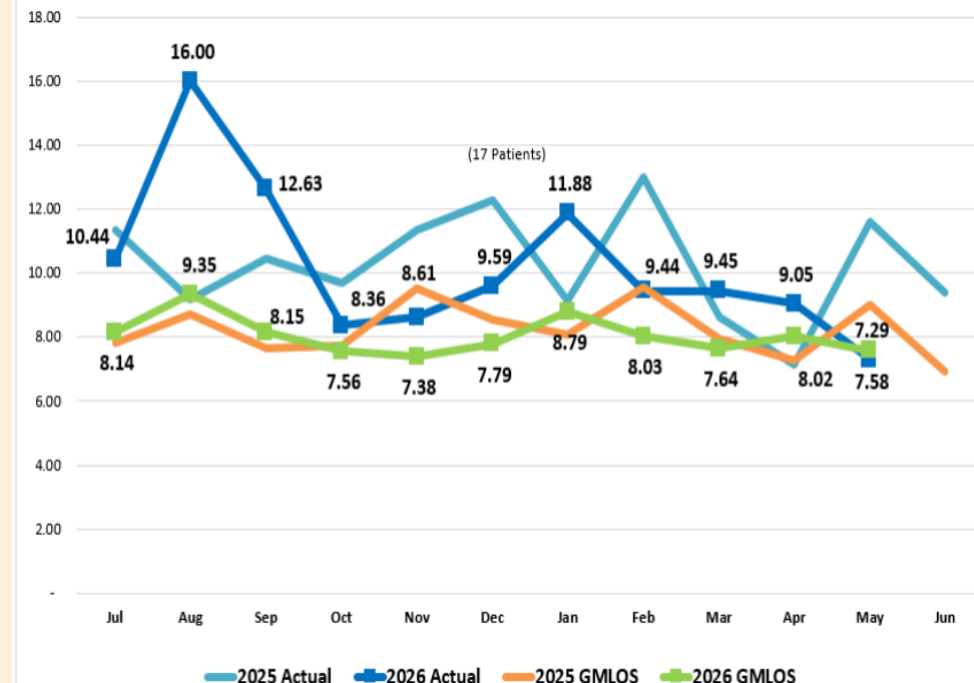
Interdisciplinary Rounds

Daily M-F exception of Holidays @ 10 on Med-Surg floors
Dietary & Therapies attend as needed.
Ran by Case Management
Managers or ANMs or Charge Nurses attend
Focus:

DC date is being identified **May have had some drift from this.**
AM-PAC is being identified **Remains a struggle for some nurses to have this information**
Discussions on DC Plan and who has action items for it to come to fruition.

- Challenges:
 - Physicians wanting to report on only their pts first-**Working to make this uniform on each floor**
 - Each floor has a slightly different process-**Identified needs for non-uniform processes, however, are working toward leaning processes across the board.**

Open Heart Average Length of Stay



FY27 Focus-DC Order to DC Time

- Most Delays will fall into these 5 categories (focuses we will implement going forward, create throughput workgroups)

<u>Delay Category</u>	<u>Typical Cause</u>	<u>Improvement Opportunity</u>
Physician workflow	Orders written late in day	Early discharge planning (med rec day prior, etc) Dr Said/Patel
Case management	Disposition not finalized	Predictive discharge process Amandeep/Dee/Kim
Pharmacy	Medication reconciliation delays	Meds-to-beds program Rebekah
Nursing	Discharge education completed after order	Pre-discharge education Bekah/Doss
Transportation	Family pickup delays	Advance transportation planning CM and Bedside

Metric

Target

Average order-to-discharge time

<120 min

Median order-to-discharge time

<90 min

% **discharge orders before noon**

>50%

% **discharged before 2pm**

>60%

Med-to-bed utilization

>80% eligible patients

Predicted vs actual discharges

>85% accuracy

Respiratory Services

SERVICE LINE BOARD REPORT

RESPIRATORY SERVICES
WENDY JONES
559-624-2329



Executive Summary

Top Wins

- New pulmonologist joining us as our medical director
- Outpatient pulmonary function visits at a all time high of nearly 1,300

Top Risks

- Sleep lab staffing challenges
- Financial improvement dependent on the increased government funding provided to help cover the cost of taking care of our Medi-Cal and Medi-Cal Managed Care patients

Goal for the next year

- Increase in home sleep testing using Ensodata AI-powered sleep diagnosis
- American Board of Sleep Medicine re-accreditation for the Sleep Center

Financials

Respiratory Services

- Respiratory Services contribution margin is anticipated to be \$9.7 million for FY 2026, with \$5.6 million provided by supplemental government funding.
- Contribution Margin increased 29% over prior year due to increases in net revenue and additional reimbursement while direct costs remain stable.
- Financial results are driven by the inpatient side, with contribution margin at the highest in the last four years.
- Sleep lab financial results are consistent over the years, improving in current year with increased visits and contribution margin. Total visits were 2378 and contribution margin \$495K.
- Outpatient pulmonary function visits at nearly 1,300 in FY 2026, with contribution margin at a 4 year high of \$417k.

Quality

Report Timeliness:

- Pulmonary function-Sleep lab-98% of the studies reach the standard from test date to dictation.
- standard is report to provider within 7days currently 4.5 days

Adequacy of Positive Airway Pressure (PAP) Titration:

- 99% of our titrations reach optimal PAP ranges to correct obstructive sleep apnea.

Average Ventilator Days Per Patient

- Current ventilator days 4.09 down from 4.68 over the prior year
- We continue to support and champion decreased ventilator days to:
- Improving patient safety by rapid weaning and extubation
- Reduction in hospital acquired infections
- Reducing overall Hospital Length of Stay



Employees

Respiratory had a 2% turnover rate in the previous year.

- Recruitment for Respiratory primarily comes for our local college. We have 3 PRN positions that will be filled soon with the new class that is graduating.
- Recruitment for sleep lab has greatly improved after a needed market adjustment. We currently have 1 PRN
- Sleep Center NRC engagement score is 86.67% which is extremely high engagement. The crosswalk from Press Ganey to NRC engagement score is 4.53 with the organization goal of 4.11.
- Respiratory Therapy NRC engagement is 51.72% which is high engagement. The crosswalk from Press Ganey to NRC engagement score is 4.07 with the organization goal of 4.11.



Growth & Access

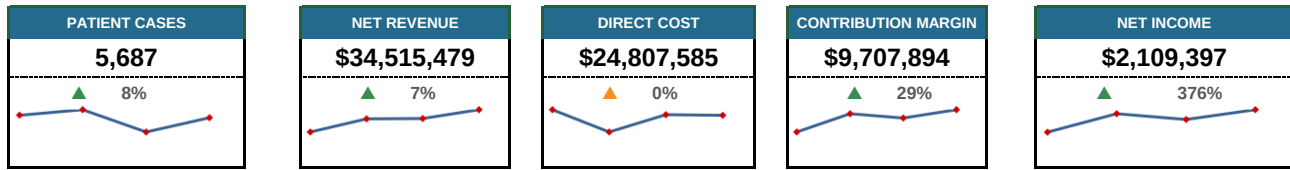
- We have increased the Pulmonary function lab hours of operation to 10 hour a day to accommodate an increase in volume projected to be nearly 20%.
- We are expanding sleep lab capacity by onboarding and training new staff, allowing us to add an additional night of testing each week. Current wait times are approximately 4 months for in-lab studies and 6 weeks for home studies. Once the additional night is operational, our goal is to reduce in-lab wait times to 2-3 months. While this is an improvement, wait times of several months remain the standard for sleep labs throughout the Valley.
- Respiratory staff and equipment have been added to support the expansion of our sub acute unit enabling us to care for an additional 22 patients by the end of the year.
- Respiratory Therapy will be moving to a new space in the Acequia Tower. The new location will enhance our team's efficiency, organization, and ability to deliver timely, high-quality patient care.

The pursuit of healthiness



ANNUALIZED FY 2026 ELEVEN MONTHS ENDED MAY 31, 2026

KEY METRICS - FY 2026



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

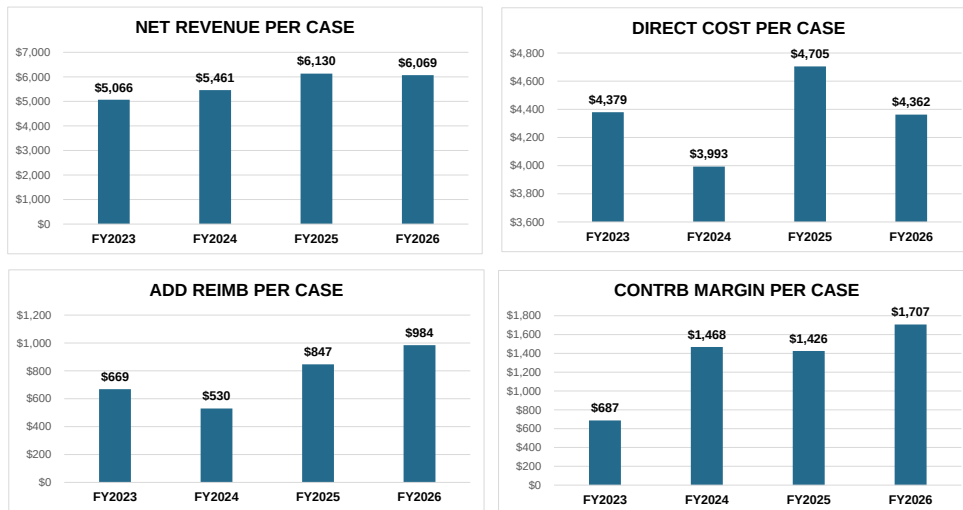
METRICS BY SERVICE LINE - FY 2026

SERVICE LINE	PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
PULMONARY INPATIENT	1,867	\$32,083,021	\$23,313,001	\$8,770,020	\$1,672,180
SLEEP DISORDERS CENTER OUTPATIENT	2,378	\$1,790,127	\$1,294,633	\$495,494	\$95,230
PULMONARY FUNCTION OUTPATIENT	1,296	\$591,857	\$175,067	\$416,791	\$324,991
OUTPATIENT EEG	146	\$50,474	\$24,884	\$25,590	\$16,997
RESPIRATORY SERVICES TOTAL	5,687	\$34,515,479	\$24,807,585	\$9,707,894	\$2,109,397

METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
PATIENT CASES	5,757	5,914	5,283	5,687	▲ 8%	
NET REVENUE	\$29,167,127	\$32,298,115	\$32,386,880	\$34,515,479	▲ 7%	
ADDITIONAL REIMB	\$3,849,483	\$3,135,750	\$4,472,351	\$5,598,025	▲ 25%	
DIRECT COST	\$25,212,390	\$23,616,270	\$24,854,716	\$24,807,585	▲ 0%	
CONTRIBUTION MARGIN	\$3,954,736	\$8,681,846	\$7,532,164	\$9,707,894	▲ 29%	
INDIRECT COST	\$8,402,173	\$7,733,232	\$8,297,258	\$7,598,497	▼ -8%	
NET INCOME	(\$4,447,437)	\$948,614	(\$765,094)	\$2,109,397	▲ 376%	
NET REVENUE PER CASE	\$5,066	\$5,461	\$6,130	\$6,069	▼ -1%	
ADD REIMB PER CASE	\$669	\$530	\$847	\$984	▲ 16%	
DIRECT COST PER CASE	\$4,379	\$3,993	\$4,705	\$4,362	▼ -7%	
CONTRB MARGIN PER CASE	\$687	\$1,468	\$1,426	\$1,707	▲ 20%	
CM w/o ADD REIMB PER CASE	\$18	\$938	\$579	\$723	▲ 25%	
NR w/o Add Reimb PER CASE	\$4,398	\$4,931	\$5,284	\$5,085	▼ -4%	

GRAPHS



Report Notes:

Selection Criteria: Kaweah Health Medical Center Inpatient Pulmonary Service Line and Outpatient Service Line 1 Respiratory Services.

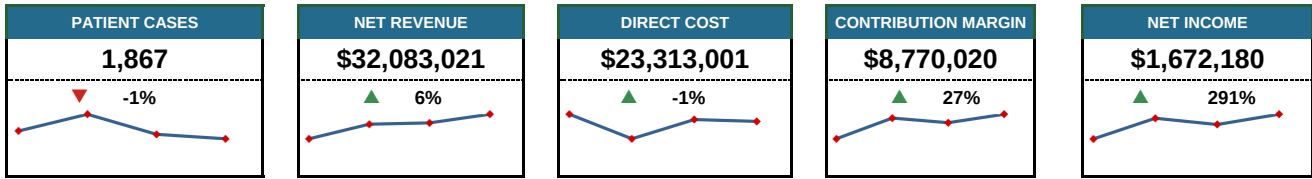
KAWEAH HEALTH ANNUAL BOARD REPORT

Respiratory Services - *Pulmonary Inpatient*

FY2026

ANNUALIZED FY 2026 ELEVEN MONTHS ENDED MAY 31, 2026

KEY METRICS - FY 2026

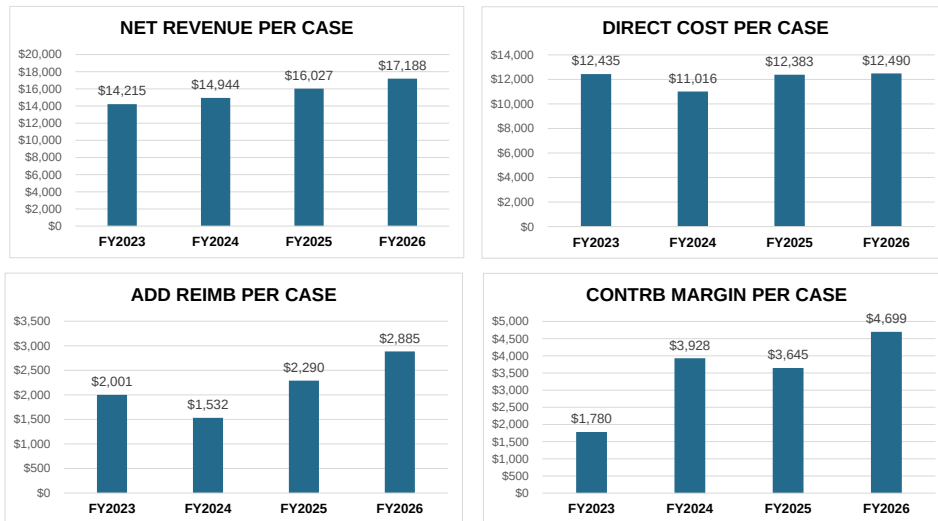


*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS SUMMARY - 4 YEAR TREND

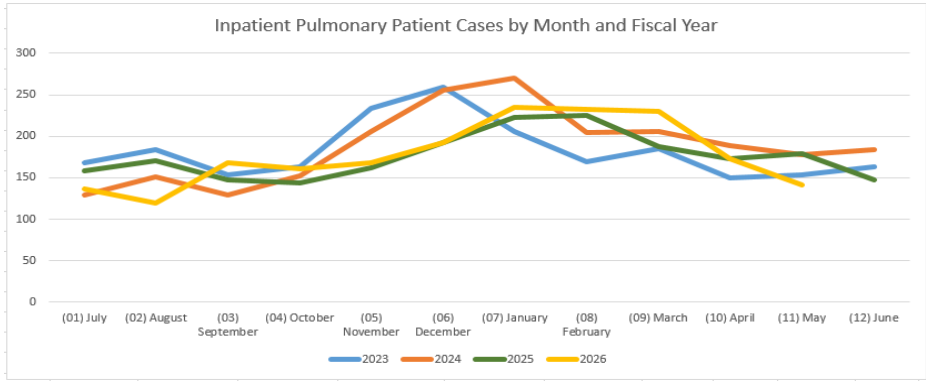
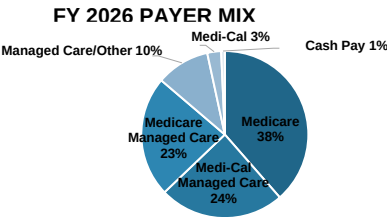
METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
PATIENT CASES	1,913	2,013	1,893	1,867	-1%	
PATIENT DAYS	10,556	10,168	9,533	8,809	-8%	
ALOS	5.52	5.05	5.04	4.72	-6%	
GM LOS	3.92	3.76	3.70	3.53	-5%	
OPPORTUNITY LOS	1.60	1.29	1.34	1.19	-11%	
NET REVENUE	\$27,193,434	\$30,082,028	\$30,339,956	\$32,083,021	6%	
ADDITIONAL REIMB	\$3,827,041	\$3,084,344	\$4,334,607	\$5,384,807	24%	
DIRECT COST	\$23,789,026	\$22,174,334	\$23,440,409	\$23,313,001	-1%	
CONTRIBUTION MARGIN	\$3,404,408	\$7,907,694	\$6,899,547	\$8,770,020	27%	
INDIRECT COST	\$7,851,240	\$7,245,390	\$7,772,947	\$7,097,840	-9%	
NET INCOME	(\$4,446,832)	\$662,304	(\$873,401)	\$1,672,180	291%	
NET REVENUE PER CASE	\$14,215	\$14,944	\$16,027	\$17,188	7%	
ADD REIMB PER CASE	\$2,001	\$1,532	\$2,290	\$2,885	26%	
DIRECT COST PER CASE	\$12,435	\$11,016	\$12,383	\$12,490	1%	
CONTRB MARGIN PER CASE	\$1,780	\$3,928	\$3,645	\$4,699	29%	
CM w/o ADD REIMB PER CASE	(\$221)	\$2,396	\$1,355	\$1,814	34%	
NR w/o Add Reimb PER CASE	\$12,215	\$13,412	\$13,738	\$14,304	4%	

PER CASE TRENDED GRAPHS



ANNUALIZED FY 2026 ELEVEN MONTHS ENDED MAY 31, 2026

PAYER MIX - 4 YEAR TREND (GROSS REVENUE)				
*Annualized				
PAYER	FY2023	FY2024	FY2025	FY2026
Medicare	44%	42%	39%	38%
Medi-Cal Managed Care	21%	21%	22%	24%
Medicare Managed Care	20%	21%	24%	23%
Managed Care/Other	10%	12%	11%	10%
Medi-Cal	5%	3%	2%	3%
Cash Pay	1%	1%	0%	1%



Report Notes:
Source: KHMC, Inpatient Service Line Report
Selection Criteria: Service Line 1 = Pulmonary

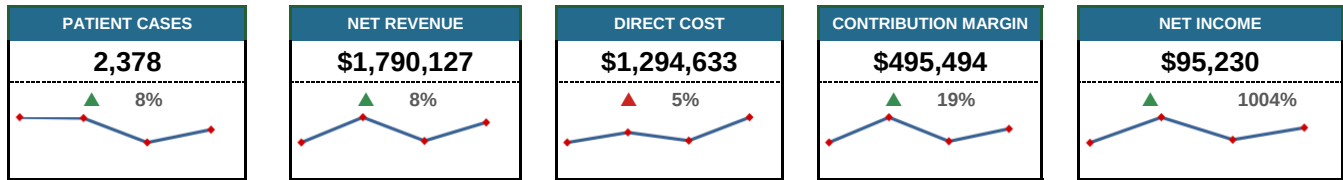
KAWEAH HEALTH ANNUAL BOARD REPORT

Respiratory Services - *Sleep Disorders Center*

FY2026

ANNUALIZED FY 2026 ELEVEN MONTHS ENDED MAY 31, 2026

KEY METRICS - FY 2026

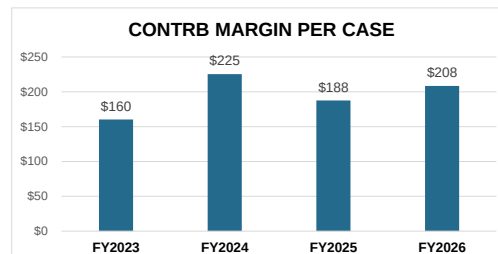
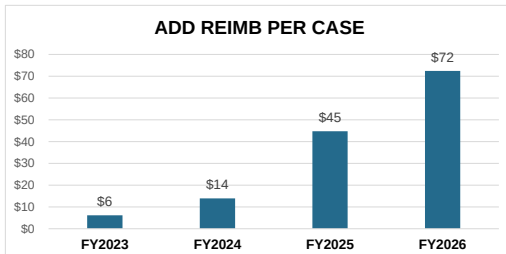
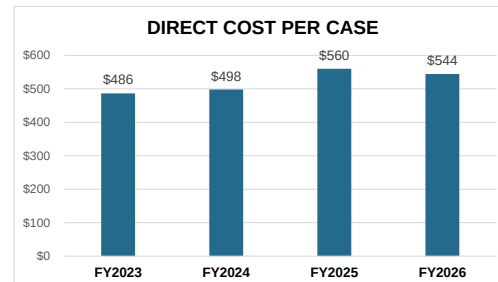
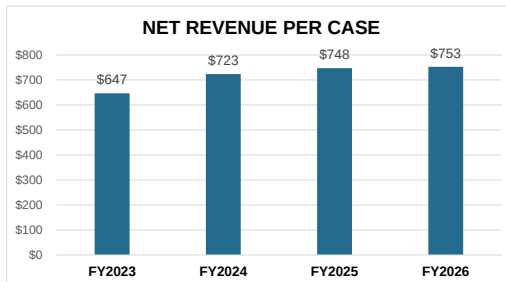


*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
PATIENT CASES	2,538	2,527	2,212	2,378	▲ 8%	
NET REVENUE	\$1,641,132	\$1,828,147	\$1,653,474	\$1,790,127	▲ 8%	
ADDITIONAL REIMB	\$15,684	\$35,211	\$98,988	\$172,206	▲ 74%	
DIRECT COST	\$1,234,303	\$1,258,553	\$1,238,719	\$1,294,633	▲ 5%	
CONTRIBUTION MARGIN	\$406,830	\$569,594	\$414,756	\$495,494	▲ 19%	
INDIRECT COST	\$444,476	\$382,081	\$425,285	\$400,265	▼ -6%	
NET INCOME	(\$37,647)	\$187,512	(\$10,529)	\$95,230	▲ 1004%	
NET REVENUE PER CASE	\$647	\$723	\$748	\$753	▲ 1%	
ADD REIMB PER CASE	\$6	\$14	\$45	\$72	▲ 62%	
DIRECT COST PER CASE	\$486	\$498	\$560	\$544	▼ -3%	
CONTRB MARGIN PER CASE	\$160	\$225	\$188	\$208	▲ 11%	
CM w/o ADD REIMB PER CASI	\$154	\$211	\$143	\$136	▼ -5%	

PER CASE TRENDING GRAPHS



KAWEAH HEALTH ANNUAL BOARD REPORT

Respiratory Services - *Sleep Disorders Center*

FY2026

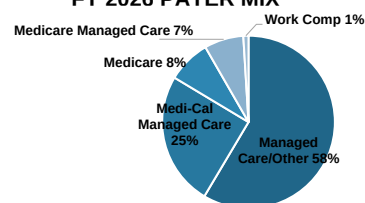
ANNUALIZED FY 2026 ELEVEN MONTHS ENDED MAY 31, 2026

PAYER MIX - 4 YEAR TREND (Cases)

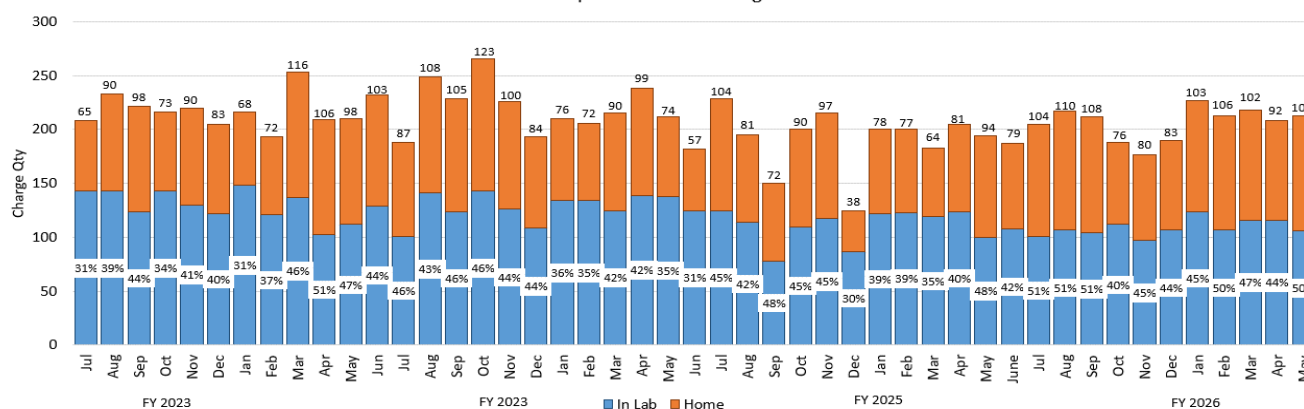
*Annualized

PAYER	FY2023	FY2024	FY2025	FY2026
Managed Care/Other	59%	59%	60%	58%
Medi-Cal Managed Care	23%	24%	25%	25%
Medicare	11%	9%	9%	8%
Medicare Managed Care	6%	6%	5%	7%
Work Comp	1%	1%	1%	1%

FY 2026 PAYER MIX



Sleep Lab Trended Charges



Note: □
Source: Outpatient Service Line Report
Selection Criteria: Service Line 1 = Respiratory Services and Service Line 2 = Sleep Disorders Center
Chart is based on charges

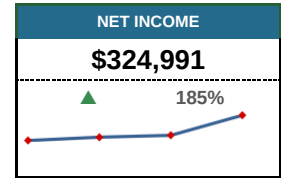
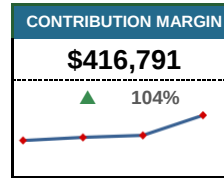
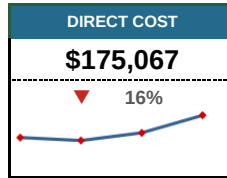
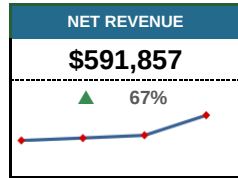
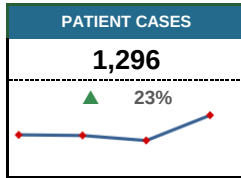
KAWEAH HEALTH ANNUAL BOARD REPORT

Respiratory Services - *PULMONARY FUNCTION OUTPATIENT*

FY2026

ANNUALIZED FY 2026 ELEVEN MONTHS ENDED MAY 31, 2026

KEY METRICS - FY 2026



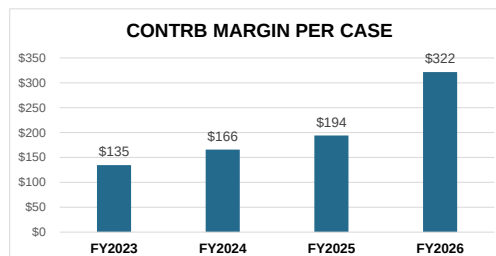
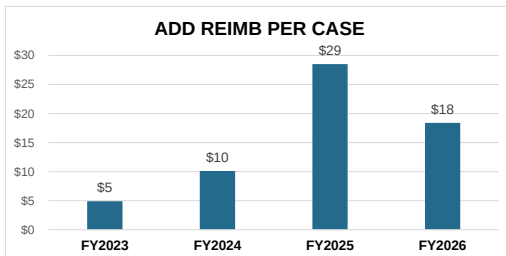
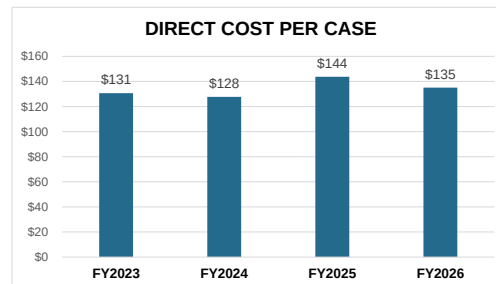
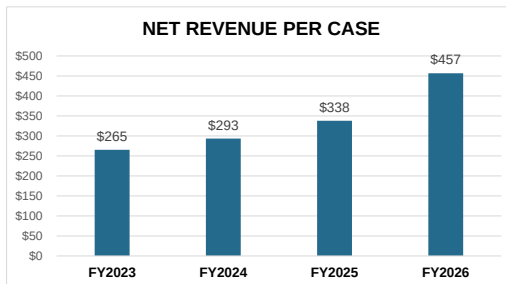
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS SUMMARY - 4 YEAR TREND

*Annualized

METRIC	FY2023	FY2024	FY2025	FY2026		%CHANGE FROM PRIOR YR	4 YR TREND
PATIENT CASES	1,106	1,100	1,051	1,296	▲	23%	
NET REVENUE	\$293,496	\$322,805	\$355,124	\$591,857	▲	67%	
ADDITIONAL REIMB	\$5,415	\$11,119	\$29,965	\$23,834	▼	-20%	
DIRECT COST	\$144,533	\$140,499	\$151,056	\$175,067	▲	16%	
CONTRIBUTION MARGIN	\$148,963	\$182,306	\$204,068	\$416,791	▲	104%	
INDIRECT COST	\$90,541	\$88,763	\$90,229	\$91,800	▲	2%	
NET INCOME	\$58,422	\$93,543	\$113,839	\$324,991	▲	185%	
NET REVENUE PER CASE	\$265	\$293	\$338	\$457	▲	35%	
ADD REIMB PER CASE	\$5	\$10	\$29	\$18	▼	-35%	
DIRECT COST PER CASE	\$131	\$128	\$144	\$135	▼	-6%	
CONTRB MARGIN PER CASE	\$135	\$166	\$194	\$322	▲	66%	
CM w/o ADD REIMB PER CASE	\$130	\$156	\$166	\$303	▲	83%	

PER CASE TRENDING GRAPHS

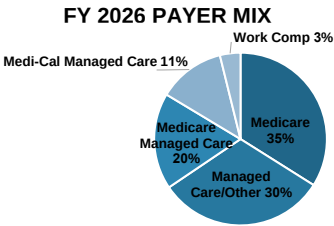


FY 2026 ELEVEN MONTHS ENDED MAY 31, 2026

PAYER MIX - 4 YEAR TREND (Cases)

*Annualized

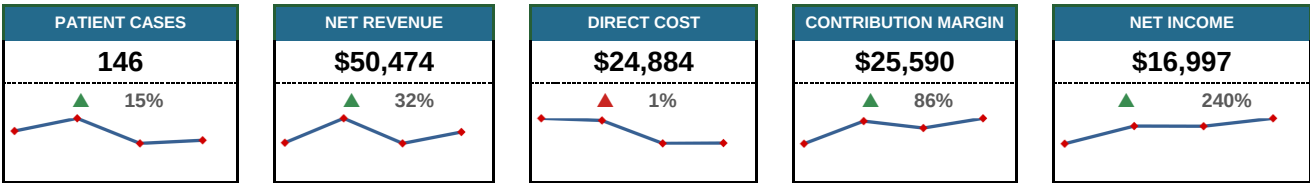
PAYER	FY2023	FY2024	FY2025	FY2026
Medicare	31%	30%	32%	35%
Managed Care/Other	33%	33%	31%	30%
Medicare Managed Care	16%	18%	18%	20%
Medi-Cal Managed Care	19%	16%	17%	11%
Work Comp	1%	2%	1%	3%



Note: □
Source: Outpatient Service Line Report
Selection Criteria: Service Line 1 = Respiratory Services and Service Line 2 = Pulmonary Function
Second Chart is based off of Pulmonary Charges

ANNUALIZED FY 2026 ELEVEN MONTHS ENDED MAY 31, 2026

KEY METRICS - FY 2026

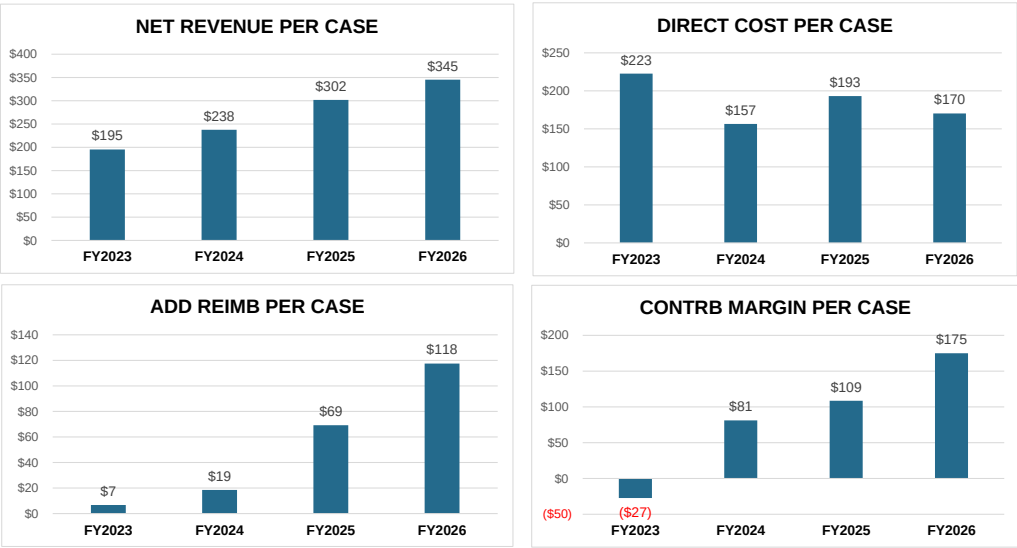


*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS SUMMARY - 4 YEAR TREND

*Annualized						
METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
PATIENT CASES	200	274	127	146	▲ 15%	
NET REVENUE	\$39,064	\$65,136	\$38,325	\$50,474	▲ 32%	
ADDITIONAL REIMB	\$1,343	\$5,077	\$8,791	\$17,178	▲ 95%	
DIRECT COST	\$44,529	\$42,884	\$24,532	\$24,884	▲ 1%	
CONTRIBUTION MARGIN	(\$5,465)	\$22,252	\$13,793	\$25,590	▲ 86%	
INDIRECT COST	\$15,916	\$16,997	\$8,797	\$8,593	▼ -2%	
NET INCOME	(\$21,381)	\$5,255	\$4,996	\$16,997	▲ 240%	
NET REVENUE PER CASE	\$195	\$238	\$302	\$345	▲ 14%	
ADD REIMB PER CASE	\$7	\$19	\$69	\$118	▲ 70%	
DIRECT COST PER CASE	\$223	\$157	\$193	\$170	▼ -12%	
CONTRB MARGIN PER CASE	(\$27)	\$81	\$109	\$175	▲ 61%	
CM w/o ADD REIMB PER CASE	(\$34)	\$63	\$39	\$58	▲ 46%	

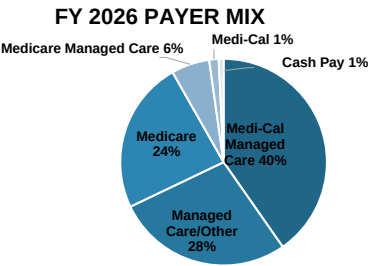
PER CASE TRENDED GRAPHS



ANNUALIZED FY 2026 ELEVEN MONTHS ENDED MAY 31, 2026

PAYER MIX - 4 YEAR TREND (Cases) *Annualized

PAYER	FY2023	FY2024	FY2025	FY2026
Medi-Cal Managed Care	37%	32%	34%	40%
Managed Care/Other	34%	25%	24%	28%
Medicare	23%	28%	35%	24%
Medicare Managed Care	3%	13%	4%	6%
Medi-Cal	3%	1%	2%	1%
Cash Pay	1%	0%	0%	1%



Note: □
Source: Outpatient Service Line Report
Selection Criteria: Service Line 1 = Respiratory Services and Service Line 2 = EEG
Chart is based off of EEG Charges

The Lifestyles Center

SERVICE LINE BOARD REPORT

LIFESTYLE FITNESS CENTER
PATRICK TAZIO
(559) 624-3407



Executive Summary

Executive narrative

Top Three Wins

1. Continued Membership Growth
2. Continued Financial Growth
3. Member Retention

Top Three Risks

1. Increased Competition
2. Loss of Members
3. Increased Utility Cost

Goal for the next year

\$1,000,000 Financial Contribution

Financials

Lifestyle Fitness Center

- Operating Margin \$895,000
- Units of Service (Members) +1%
- Net Revenue +2%
- Direct Cost +1%
- Contribution Margin +9%
- Indirect Cost +1%
- Net Income +20%

Dashboard

Service Line Metrics

Memberships

Single - 2,321
Couple - 1,242
Family - 2,130

Senior - Single -723
Couple -567

Silver Sneakers -1,852

Student - 207

Kaweah Health Employees

Single -428
Couple -702
Family -1,007

Total Members – 11,179



Employees

- The Lifestyle Fitness Center NRC engagement score is 62.22% which is extremely high engagement. The crosswalk from Press Ganey to NRC engagement score is 4.44 with the organization goal of 4.11.
- The Lifestyle Fitness Center NRC Response Rate was 78.95% which is high engagement.
- The Lifestyle Fitness Center NRC Survey average is 4.47 with the organization average of 4.25.



Growth & Access

FY 2026 –Year End

Revenue - \$4,409,254

Members Served (UOS) - 131,722

Member Visits – 468,229

Guest Visits – 4,869

FY2027 - Projection

Revenue – \$4,615,000

Members Served (UOS) - 132,540

Member Visits – 472,910

Guest Visits – 7,887

The pursuit of healthiness

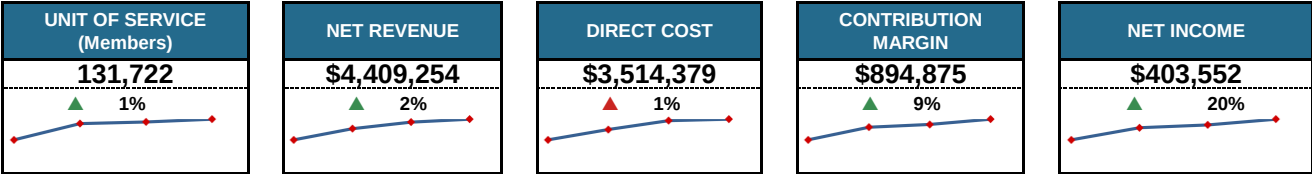


KAWEAH HEALTH ANNUAL BOARD REPORT
Kaweah Health Lifestyle Fitness Center

FY2026

*FY2026 Annualized: ELEVEN MONTHS ENDED MAY 31, 2026

KEY METRICS - FY 2026 ANNUALIZED

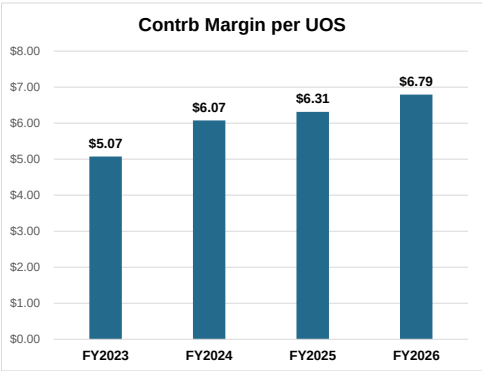
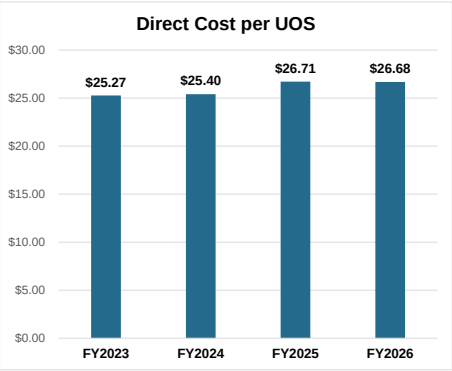
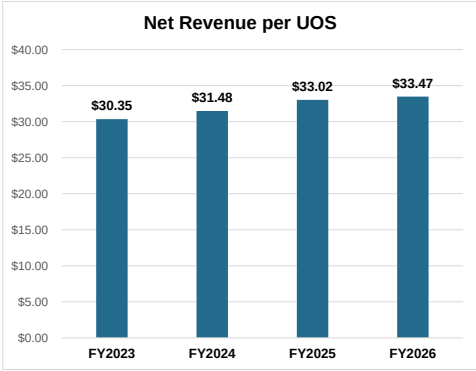


*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS SUMMARY - 4 YEAR TREND

* Annualized						
METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Unit of Service (Members)	121,429	129,507	130,340	131,722	▲ 1%	
Net Revenue	\$3,684,873	\$4,076,654	\$4,304,280	\$4,409,254	▲ 2%	
Direct Cost	\$3,068,663	\$3,289,918	\$3,481,473	\$3,514,379	▲ 1%	
Contribution Margin	\$616,210	\$786,736	\$822,807	\$894,875	▲ 9%	
Indirect Cost	\$452,930	\$483,061	\$486,168	\$491,323	▲ 1%	
Net Income	\$163,280	\$303,675	\$336,639	\$403,552	▲ 20%	
Net Revenue per UOS	\$30.35	\$31.48	\$33.02	\$33.47	▲ 1%	
Direct Cost per UOS	\$25.27	\$25.40	\$26.71	\$26.68	▲ 0%	
Contrb Margin per UOS	\$5.07	\$6.07	\$6.31	\$6.79	▲ 8%	

PER CASE TRENDING GRAPHS



Notes:

Source: Non-Cerner Service Line Report, Lifestyle Fitness Center

June 17, 2026

Kaweah Delta Health Care District

Board of Directors Committee Meeting

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



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 June 17, 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; Kevin Morrison, VP Support Services; Max Heckhausen, VP Strategy; Tom Boggs, Chief Ambulatory Officer; Kelsie Davis, Board Clerk Recording

OPEN MEETING – Called to order at 10:01 AM

PUBLIC PARTICIPATION –None

MINUTES- Reviewed and forward to the Board for approval.

SEQUOIA INTEGRATED HEALTH AND SEQUOIA HEALTH PLAN- the presentation was reviewed and attached hereto the minutes.

FINANCIALS- Review of the most current fiscal year financial results and proposed FY27 budget. Rehab services and wound care was highlighted. The presentation is attached hereto the minutes.

ADJOURN – 11:43am *David Francis, President*

Mike Olmos • Zone 1
Board Member

Jonna Schengel • Zone 2
Board Member

Dean Levitan, MD • Zone 3
Secretary/Treasurer

David Francis • Zone 4
President

Armando Murrieta • Zone 5
Vice President

June 10, 2026

Kaweah Delta Health Care District

Board of Directors Committee

Meeting Minutes

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

Marketing & Community Relations Committee – OPEN MEETING

Wednesday June 10, 2026

Kaweah Health Medical Center – Executive Office Conference Room

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

CALL TO ORDER – This meeting was called to order at 4:00 PM by Chair David Francis.

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

MINUTES- The open meeting minutes from April 1, 2026, were reviewed.

COMMUNITY EXPERIENCE –

4.1. Deborah Volosin provided a verbal update regarding community events and sponsorships, reporting a total of 587 community touches in the second quarter.

MARKETING & MEDIA RELATIONS –

5.1.1. Amee Longbottom provided a verbal update on the materials being developed for the new commercial.

5.1.2. The committee received an update on the organization’s website, which has now been live for one year. It was reported that the website has received more than 100,000 visits since April. (see Attachment 5.1.2 of the agenda)

5.1.3. The team reported 1100 projects came in from July 2025 – June 2026. (see Attachment 5.1.3 of the agenda)

5.1.4. It was reported that 784 patient visits resulted from recipients of the latest Vital Signs issue.

5.1.5. Discussion ensued regarding patient retention.

5.1.6. Jaclyn Bunting gave a verbal update on leads generated through the EDGE campaign.

Kaweah Delta Health Care District

Board of Directors Committee

Meeting Minutes

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

5.1.7. The team reported 18 service lines were featured this past quarter in the eNewsletter.

5.1.8. The Primary Care Campaign ran from August 2025 – April 2026. It was reported that there was strong engagement with the digital ad.

5.2. – A report on recent marketing performance and engagement metrics was shared. (see attachment 5.2. of the agenda.

Adjourned at 4:54 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.

June 1, 2026

MINUTES OF THE SPECIAL OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD MONDAY JUNE 1, 2026, AT 5:30PM IN KAWEAH HEALTH SUPPORT SERVICES BUILDING, GRADUATE MEDICAL EDUCATION CLASSROOMS – 520 W MINERAL KING AVENUE, VISALIA CA 93230.

PRESENT: Directors Olmos, Francis, Levitan, Schengel & Murrieta; M. Mertz, CEO; J. Randolph, Chief of Staff; M. Tupper, CFO; D. Cox, Chief Human Resource Officer; D. Leeper, CIO; P. Stefanacci, CMO; B. Cripps, CCO; J. Batth, COO; K. Morrison, VP Support Services; S. Baker, CNO; R. Berglund, Legal Counsel; and K. Davis, recording

The meeting was called to order at 5:30 PM by Director Francis.

PUBLIC PARTICIPATION –None.

BOARD GOVERNANCE - The Board of Directors met with management on summary of discussions and key observations from the Governance Institute with identified opportunities.

ADJOURN - Meeting was adjourned at 7:37PM

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

June 2, 2026

MINUTES OF THE SPECIAL OEPN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD TUESDAY JUNE 2, 2026, AT 2:31PM IN THE KAWAEAH HEALTH MEDICAL CENTER, 4 TOWER MULTIPURPOSE CONFERENCE ROOM – 305 W. ACEQUIA, VISALIA, CA.

PRESENT: Directors Olmos, Francis, Levitan, Schengel & Murrieta; M. Mertz, CEO; the full executive team and K. Davis, recording

The meeting was called to order at 2:32 PM by Director Francis.

PUBLIC PARTICIPATION– None.

CLOSED SESSION REPORT OUT- The board met in closed session and approved the Interim CFO of Steve Forney and new VP, Information Systems to Luke Schneider.

BOARD REVIEW OF NEW FISCAL YEAR 2027 BUDGET – Malinda and team met to review and discuss the proposed fiscal year 2027 operating and capital budget including key financial assumptions, strategic priorities, revenue and expense projections, workforce planning, capital investments and financial sustainability considerations.

ADJOURNED TO CLOSED MEETING - Meeting was adjourned at 3:52PM

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

June 24, 2026

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD WEDNESDAY JUNE 24, 2026, AT 4:00PM IN THE CITY OF VISALIA CITY COUNCIL CHAMBERS – 707 W. ACEQUIA, VISALIA, CA.

PRESENT: Directors Olmos, Francis, Levitan, Schengel & Murrieta; M. Mertz, CEO; M. Tedaldi, Vice Chief of Staff; M. Tupper, CFO; D. Cox, Chief Human Resource Officer; D. Leeper, CIO; P. Stefanacci, CMO; B. Cripps, CCO; J. Batth, COO; K. Morrison, VP Support Services; S. Baker, CNO; 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 JUNE 24, 2026, AT 5:00PM IN THE CITY OF VISALIA CITY COUNCIL CHAMBERS – 707 W. ACEQUIA, VISALIA, CA.

PRESENT: Directors Olmos, Francis, Levitan, Schengel & Murrieta; M. Mertz, CEO; J. Randolph, Chief of Staff; M. Tupper, CFO; D. Cox, Chief Human Resource Officer; D. Leeper, CIO; P. Stefanacci, CMO; B. Cripps, CCO; J. Batth, COO; K. Morrison, VP Support Services; S. Baker, CNO; R. Berglund, Legal Counsel; and K. Davis, recording

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

ROLL CALL- Directors Olmos, Levitan, Francis, Schengel and Murrieta were present.

FLAG SALUTE- Director Levitan 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 June 2026. The board approved the closed meeting minutes of June 24, 2026, and the Board also approved settlement funds in the matter of Larumbe-Torres v. Kaweah Health Care District. The Boards final action was to reject two claims on its merits.

BOARD MEMBER REPORT OUTS- Discussion ensued.

RECOGNITIONS- Resolution 2292 and 2294

CONSENT CALENDAR – Director Francis entertained a motion to approve the June 24, 2026, consent calendar without 9.1.C, D, and E for further discussion.

PUBLIC PARTICIPATION – None.

MMSC (Olmos/Murrieta) to approve the June 24, 2026, consent calendar without 9.1.C,D, and E. This was supported unanimously by those present. Vote: Yes – Olmos, Levitan, Murrieta, Schengel, and Francis.

Discussion ensued on the reports pulled.

CONSENT CALENDAR – Director Francis entertained a motion to approve the pulled consent calendar items 9.1.C, D, and E.

PUBLIC PARTICIPATION – None.

MMSC (Schengel/Murrieta) to approve the consent calendar items 9.1.C, D, and E. This was supported unanimously by those present. Vote: Yes – Olmos, Levitan, Murrieta, Schengel, and Francis.

ROBOTIC SURGERY PROGRAM UPDATE – Dr. Bansal presented an overview on Kaweah’s first robotic lung cancer surgery procedure.

MEDICAL SUPPLY UPDATE- Malinda presented an update on medical supplies as a result of the Medline fire.

STRATEGIC OVERSIGHT (MONTHLY REPORT) – OUTSTANDING HEALTH OUTCOMES – Both Paul Stefanacci provided his strategic oversight discussion regarding organizational priorities, long-term planning initiatives, strategic objectives, operational alignment, community health needs, workforce considerations, and progress toward Board-approved strategic goals.

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.

FINANCIAL STEWARDSHIP – 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.

MMSC (Levitan/Olmos) to approve May's Financials. This was supported unanimously by those present. Vote: Yes – Olmos, Levitan, Murrieta, Schengel, and Francis.

REPORTS

Chief Executive Officer Report –Report relative to current CEO activities. – *Marc Mertz, CEO*
Board President- None. – *David Francis, Board President*

Chief of Staff Report – Report relative to current Medical Staff events and issues – *Julianne Randolph, DO, Chief of Staff.*

ADJOURN - Meeting was adjourned at 7:28PM

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

BOD1 Orientation of New Board Member

Policy Number: BOD1	Date Created: 09/08/2004
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: 06/27/2025
Approvers: Board of Directors (Administration)	
Orientation of a New Board Member	

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

PURPOSE: To acquaint newly-elected or appointed directors with Board policies and procedures and the fundamental organizational, physical, and operational aspects of the District.

POLICY: The Board of Directors, the Chief Executive Officer, and Kaweah Delta Health Care District dba Kaweah Health staff shall assist each new member-electee or appointee to understand the Board's functions, policies, and procedures upon taking office.

PROCEDURE:

- I. The Board member shall be given and will review the following materials with the Board President related to carrying out the duties of a Kaweah Delta Health Care District Board of Directors member including the following:
 - A. Board of Directors Bylaws
 - B. Board of Directors Policies
 - C. Board of Directors member listing including terms of office
 - D. Board Committee Structure
 - E. Board minutes for the past year
 - F. District Conflict of Interest Policy including Statement of Economic Interest (Form 700) to be completed upon taking office.
 - G. Brown Act Guidelines
- II. The Chief Executive Officer shall assist each new Board member in the review of the following materials relevant to District orientation.
 - A. Vision, Mission, and Pillars
 - B. District Goals
 - C. Strategic Plan and Initiatives
 - D. Projects and Priorities
 - E. District's Organization Chart

- F. Budget for current fiscal year, immediate prior fiscal year and current financial statement. This will be reviewed with the Board member in an education session on the Districts financial statements.
- G. Continuum of Care
- H. Kaweah Health Medical Staff Executive Committee member listing
- III. The Chief Executive Office will coordinate a personal introduction of the new Board member to the Kaweah Health Medical Executive Committee members.
- IV. The Chief Executive Officer will coordinate a tour of all of the District's facilities for the new Board member and meetings with the District's Executive Team members.
- V. Incoming Board members shall be invited to attend Board meetings prior to taking office to become familiar with Board discussions and meeting protocol.
- VI. New Board members will be invited to attend a Governance Institute (GI) Conferences where they will receive materials relative to Board member duties in conjunction with their training at these sessions.
- VII. New Board members will attend the "Kaweah Health – A Great Organization" session of General Employee Orientation meeting at which attendance is required of all new Kaweah Health employees at the start of their employment.
- VIII. After elected, a new Board member will be assigned another Board member to serve as a mentor.

"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."

BOD2 CEO Transition

Policy Number: BOD2	Date Created: 09/01/2004
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: 06/27/2025
Approvers: Board of Directors (Administration)	
Chief Executive Officer (CEO) Transition	

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

PURPOSE: It is the belief of the Board of Directors of Kaweah Delta Health Care District dba Kaweah Health that the continued proper functioning of the District, the maintenance of the highest quality of patient care and the preservation of the District's financial integrity require that the District have a pre-established and orderly process for replacement of the CEO, in the event of the CEO's death, disability or termination of his/her employment relationship with the District.

Accordingly the Board adopts the following policy.

POLICY:

- I. **Temporary Succession of CEO when unable to perform duties.** In the event the CEO becomes unable to perform his/her duties as the result of death or the sudden onset of disability, or in the event the Board decides to immediately terminate the District's employment relationship with the CEO, the Chief Operating Officer shall immediately assume those responsibilities pending further action of the Board Of Directors. In the event the Chief Operating Officer is unable to immediately assume those responsibilities because of death, disability or vacancy in the position of Chief Operating Officer, then the Chief Nursing Officer shall immediately assume those responsibilities pending further action of the Board of Directors.

In the event the CEO is temporarily unable to perform his/her duties due to vacation; out-of-town meetings, out-of-town conferences, short-term illness, etc., the Administrator on call (an Executive Team Member) shall serve as the acting CEO while the CEO is away. The Board President shall be informed of CEO absences and the assignment of an acting CEO by the Board Clerk.

- II. **Death of the CEO** - In the event of the CEO's death, the Board shall immediately commence the process for hiring a new CEO.
- III. **Temporary Disability of the CEO** - If the disability of the CEO is temporary, as determined by Board in the reasonable exercise of its discretion, after reviewing appropriate medical information, the CEO shall again assume the duties of CEO as soon as he/she is able.
- IV. **Permanent Disability of the CEO** - If the disability of the CEO is permanent (i.e. will extend for 6 months or more) and prevents the CEO from performing his/her duties, as determined

by the Board in the reasonable exercise of its discretion, after reviewing appropriate medical information, the Board may terminate the CEO's contract, in accordance with the contract provisions, and commence the process for hiring a new CEO.

- V. **Voluntary termination of the CEO's employment contract** - If the CEO advises the Board of his/her intention to voluntarily end his/her employment relationship with the District, or if the Board makes a decision to terminate the CEO's contract or a decision not to renew the CEO's contract at the expiration of its term, the Board shall commence the process for hiring a new CEO expeditiously so as to minimize, or avoid if possible, the time during which there would be no CEO under contract with the District.

VI. **Involuntary Termination of the CEO**

- A. During the term of his/her contract, the CEO's employment may be terminated by the Board if the CEO fails to properly carry out the responsibilities of the CEO, if the CEO engages in conduct which reflects poorly on the District, if the CEO engages in conduct which is criminal or which involves moral turpitude, or if, for any other reason, the Board loses confidence in the CEO's ability to properly discharge the duties of CEO.
- B. The Board shall meet in closed session (Gov. Code 54957) to discuss the CEO's departure and consider options, including appointing an interim CEO and initiating recruitment for a permanent successor.

VII. **Hiring of a new CEO**

- A. Recruitment and Search. When it becomes necessary for the Board to replace the CEO, the District will look internally as well as advertising the position widely and/or engage a consultant to assist in the search, in a manner which the Board determines at that time will be effective for attracting qualified candidates. If, however, in the Board's opinion, a qualified candidate (or candidates) are already employed by the District, the Board, at its discretion, may waive the foregoing requirements. The Board may consult with the District's Chief Human Resources Officer to acquire information on processes available for advertising the position or for engaging a consultant to assist in the search for a new CEO. At the time of the search, the Board will establish criteria for selecting its new CEO. All actions regarding recruitment authorization shall occur in open session.
- B. Interviews of Prospective CEO Candidates. Interviews of prospective CEO candidates will be done by the entire Board. The Board will determine in the exercise of its discretion if individuals other than elected Board members will participate in the actual CEO candidate interviews. Candidate review and interviews shall occur in closed session pursuant to Government Code 54957. Final appointment and contract approval shall occur in open session.
- C. CEO Contract. The CEO shall be employed for a definite period of time pursuant to a written contract which sets forth the specific terms of the CEO's employment, including the compensation and other consideration to be paid, the term of the agreement, a detailed description of the duties of the CEO, the specific criteria to be used by the Board to evaluate the CEO's performance, and the bases upon which the contract can be terminated by either the Board or the CEO. The contract shall require the CEO to

provide at least six (6) months' notice of the CEO's voluntary termination of the contract.

It is the policy of the District to compensate the CEO in a manner that is appropriately competitive in the marketplace, taking into consideration, among other things, the compensation paid to CEOs of similar sized California and U.S. hospitals. Accordingly, the Board will review surveys of salaries paid to CEOs of California and U.S. hospitals as part of the process of setting the CEO's compensation. The Board may consult with the District's Chief Human Resources Officer to acquire information on available survey information.

VIII. Public Communication

- A. All public announcements regarding CEO transitions shall be coordinated through the Board President and the Districts Director of Marketing.
- B. Media statements must be consistent, factual, and protect confidentiality where appropriate.

IX. CEO Departure

- A. The outgoing CEO shall ensure all district records, passwords, contracts, and pending matters are transitioned to the Interim or new CEO.
- B. A formal written handoff memo is encouraged to promote continuity.

This policy shall be administered in compliance with the California Brown Act, Government Code 54950 et seq., the Public Records Act, and relevant employment laws.

This policy shall be reviewed as part of the Board's governance policies every three years or upon significant changes in leadership structure.

"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."

BOD3 CEO Criteria

Policy Number: BOD3	Date Created: 11/02/1999
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: 06/27/2025
Approvers: Board of Directors (Administration)	
Chief Executive Officer (CEO) Criteria	

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

The Board has determined to establish clear and consistent criteria for the selection, appointment, and evaluation of the Chief Executive Officer (CEO) of Kaweah Health in accordance with the District's mission, strategic goals, and fiduciary responsibilities.

The Board of Directors shall appoint a CEO who meets the qualifications and performance expectations set forth in this policy. The Board shall conduct periodic evaluations and provide oversight to ensure effective executive leadership.

The CEO shall possess, at a minimum, the following:

I. Education

- A. A graduate degree in healthcare management is required. Such degree could be from a variety of graduate schools such as a business school, a school of public health, school of public administration or a school with an interdisciplinary program. An equivalency to a graduate degree in health administration will be considered if the candidate has bachelor's and a minimum of ten years' experience in an executive leadership position in a hospital or healthcare system. (Master's degree is preferred.)
- B. The prospective candidate should be a Fellow in the American College of Healthcare Executives (ACHE) or a member committed to advancement in this professional organization. If the prospective candidate is ineligible to be a Fellow due to the lack of graduate degree, the prospective candidate should be an active member in the ACHE.
- C. The candidate should possess business ability and financial acumen that has been demonstrated in past executive management or leadership positions. The candidate in this regard should be familiar with business proformas, budgets, financial statements, and decision-making tools.
- D. The candidate should demonstrate a social conscience in terms of specific activities, which relates to development or implementation of services related to the improvement of health or the quality of life in the population being served.
- E. The candidate should have knowledge of applicable California laws, regulations, and public agency governance standards.

II. Spirit of Service

- A. The candidate should have values that are patient centered and compatible with the values of the District.

- B. The candidate should demonstrate skills and competency in the requirements of leadership and organizational development.
 - C. The candidate should possess imagination and creativity and should show results which demonstrate this characteristic.
 - D. The candidate should have initiative and be able to work independently and without supervision to carry out the policies of the Board and the strategic plan of the District.
 - E. The candidate must possess executive ability, which involves maintaining a sound organization that has both human and fiscal resources necessary to carry out the Mission of the District.
- III. The candidate should have a track record of diplomacy and effectiveness in dealing with a wide variety of constituents and a record of being successful in handling difficult and complex situations.
- Selection Process
- A. The Board may appoint a recruitment committee or engage a third-party search firm.
 - B. The selection process shall be transparent and based on objective criteria.
 - C. All candidates shall undergo background and reference checks.
 - D. Final selection must be approved by a majority vote of the Board of Directors.
- IV. Terms of Employment
- A. The Board shall approve the CEO's employment agreement, which includes compensation, benefits, term length, and termination provisions, consistent with public agency guidelines.
 - B. The agreement shall be reviewed by legal counsel before execution.
- V. CEO Evaluation
- A. The Board shall conduct a formal CEO evaluation at least annually.
 - B. Evaluation criteria shall be based on:
 - a. Achievement of strategic and operational goals.
 - b. Financial performance and budget adherence.
 - c. Quality of Care and Regulatory compliance.
 - d. Staff engagement and leadership effectiveness.
 - e. Community relations and public trust.
 - f. Patient Satisfaction
- Evaluation results shall be documented in closed session minutes and may inform contract renewal, compensation adjustments, or corrective actions.
- VI. Succession Planning
- A. The Board shall ensure that an emergency and long-term CEO succession plan is in place, reviewed annually, and updated as necessary.

This policy shall be reviewed every three years or as needed due to regulatory changes.

"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."

BOD4 Executive Compensation

Policy Number: BOD4	Date Created: 06/01/2008
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: 06/27/2025
Approvers: Board of Directors (Administration)	
Executive Compensation	

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

PURPOSE: This Executive Compensation Policy of Kaweah Delta Health Care District dba Kaweah Health is intended to set forth the rationale and the processes to be utilized by the Board of Directors (“Board”) with respect to the compensation of the Chief Executive Officer (“CEO”), and to set forth the rationale and the processes to be utilized by the CEO with respect to the compensation of the other members of the Executive Team.

Currently, competition for quality executives in the healthcare industry is very high while the years of continuous employment of healthcare executives at a specific institution is surprisingly low. Unnecessary turnover in executives, especially the CEO, can cause major disruptions at healthcare institutions, potentially adversely impacting employee relations, Medical Staff relations, strategic planning, organizational development, implementation of programs and services, physician and patient satisfaction and ultimately the quality of care.

It is the position of the Board, in order to maintain appropriate continuity in the Executive Team, while at the same time continuing as good stewards of Kaweah Health’s funds, that the CEO and the members of the Executive Team should receive total compensation that is at or near the median for executives in functionally comparable positions at comparable institutions. Comparable institutions will be included, consistent with industry standards, on the basis of number of licensed beds, patient volumes, total operating revenues, nonprofit status, number of full-time employees, and geographic location, among other factors.

It is also the position of the Board, after years of working with an independent consulting firm with expertise in healthcare executive compensation, that incentive compensation for healthcare executives is a common, expected and valuable part of a total compensation package. Accordingly, it will continue to be the policy of Kaweah Health to provide for appropriate incentive compensation for members of the Executive Team as part of their total compensation.

POLICY:**I. Chief Executive Officer**

- A. **CEO Contract.** Employment of the CEO at Kaweah Health is pursuant to written contract between Kaweah Health and the CEO. California law permits each contract with the CEO to be up to four (4) years in duration. The Board shall evaluate the CEO's performance annually. Any Discussion or negotiation of salary, benefits, or contract terms must be noticed under Gov. Code 54957.6. When negotiating a new or renewed contract with the CEO, the Board President shall be the chief negotiator for the Board and shall work closely with legal counsel for Kaweah Health with respect to the negotiation and completion of the written agreement. The Board President may utilize the assistance of the Board Secretary/Treasurer in conducting and evaluating CEO negotiations. Final decisions on executive compensation, contracts, bonuses, or amendments must be approved in open session by the Board of Directors. The full agreement or summary of terms must be available to the public at the time of approval.
- B. **CEO Base Salary.** The appropriateness of the CEO's Base Salary will be confirmed on an annual basis through the use of an outside and independent consulting firm with nationwide expertise in healthcare executive compensation. Automatic annual adjustment of the CEO's base salary, consistent with adjustments in the base salaries of CEO's in comparable institutions, may be provided for in the written agreement with the CEO. Confirmation of any compensation adjustment pursuant to a written contract provision will be made by the full Board.
- C. **Potential CEO Incentive Compensation.** Part of the CEO's annual compensation will be on an incentive basis, i.e., based on the successful completion of specific, objectively definable and measurable goals for that contract year. The goals, the potential incentive compensation amount, and the percentage of the total incentive compensation amount attributable to the successful completion of each of the goals must be set in advance, must be in writing, and must be agreed to by the CEO and the Board. The successful completion of each of the goals must be capable of determination on an objective basis. Potential incentive compensation amounts for the CEO for each contract year shall be within the range set forth in the last data received from the healthcare executive compensation consultant, and shall be consistent with the Board's general approach to maintaining the combination of base CEO salary and potential incentive compensation amounts at or near the median for comparable institutions. The Board President and the CEO will confer at the end of the contract year with respect to the CEO's successful completion of the incentive goals, and together they will report their determinations to the full Board. Any incentive compensation amount to be paid to the CEO as the result of

successful completion of goals must be approved in advance by the full Board.

- D. **Overall Consideration.** As an employee of Kaweah Health, the CEO will be entitled to health and retirement benefits as offered to other employees of Kaweah Health. In evaluating and setting base salaries, incentive compensation, and overall consideration, the Board shall take into consideration and may make adjustments for the overall consideration (which may include health, life and disability benefits, deferred compensation or other retirement benefits, and other perquisites common in the industry) provided to CEO's in comparable institutions, with a view toward having the total overall consideration provided to Kaweah Health's CEO be at or near the median of the total overall consideration provided to CEO's at comparable institutions.

Executive Team Compensation Other Than the CEO. A. **Base Salaries.** The appropriateness of the base salaries of Executive Team members other than the CEO will be confirmed on at least a biennial basis through use of an outside and independent consulting firm with expertise in healthcare executive compensation. The CEO and the Board President will confer on an annual basis with respect to the most recent information received from the consultant and the consistency of existing executive compensation ranges with that information. The CEO retains authority to set base salary amounts consistent with the information received from the consultant and consistent with the Board's general approach to maintaining executive base salaries at or near the median for comparable institutions.

B. **Potential Incentive Compensation.** On an annual basis, Kaweah Health will include in its budget a specific amount for potential incentive compensation for members of the Executive Team. The CEO and the Board President will work together, with counsel for Kaweah Health if necessary, to establish specific, objectively definable goals for each of the members of the Executive Team for that fiscal year. The goals, the potential incentive compensation amounts, and the percentage of the total incentive compensation amount for that executive attributable to the successful completion of each goal must be set in advance, must be in writing, and must be agreed to by the Executive Team member in question in advance as indicated by his/her signature on the written goals. The successful completion of each of the goals must be capable of determination on an objective basis. Potential incentive compensation amounts for each of the members of the Executive Team shall be within the ranges set forth in the last data received from the healthcare executive compensation consultant for that position, and shall be consistent with the Board's general approach to maintaining the combination of base executive salaries and potential incentive compensation amounts at or near the median for comparable institutions.

- E. **Overall Consideration.** As employees of Kaweah Health, the other members of the Executive Team will be entitled to health and retirement benefits as offered to other employees of Kaweah Health. In evaluating base salaries and incentive compensation, the CEO may take into consideration the overall consideration (which may include health, life and disability benefits, deferred compensation or

other retirement benefits, and other perquisites common in the industry) provided to executives in functionally comparable positions at comparable institutions, with a view toward having the total consideration provided to members of Kaweah Health's Executive Team be at or near the median of the total consideration provided to executives in functionally comparable positions at comparable institutions. If the CEO believes that any member of the Executive Team should, on the basis of such information, have his/her salary or incentive compensation re-set above the median for executives in functionally comparable positions at comparable institutions, the CEO shall obtain the prior approval of the Board.

- F. This policy shall be reviewed by the Board every three years or upon change in applicable law.

"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."

BOD5 Conflict of Interest

Policy Number: BOD5	Date Created: 11/01/2011
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: 06/27/2025
Approvers: Board of Directors (Administration)	
Conflict of Interest	

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

POLICY: Government Code Section 87300 requires each state and local government agency to adopt and promulgate a Conflict of Interest Code. The Fair Political Practices Commission has adopted Section 18730 of Title 2 of the California Code of Regulations, which contains the terms of a model conflict of interest code (hereinafter "Standard Code") which may be adopted by reference by any state or local agency which desires to do so.

For the purpose of providing a conflict of interest code for Kaweah Delta Health Care District dba Kaweah Health {Kaweah Health}, its Board of Directors, and its employees, the terms of the Standard Code and any amendments to it duly adopted by the Fair Political Practices Commission are hereby incorporated by reference and made a part hereof as if set forth herein at length, and, along with Exhibits A and B attached hereto, in which officials and employees are designated and disclosure categories are set forth, such Standard Code shall constitute the Conflict of Interest Code for Kaweah Delta Health Care District Kaweah Health, its Board of Directors, and its employees.

The Chief Executive Officer shall ensure that a current copy of the Standard Code is kept on file in the Kaweah Health administrative office with this Conflict of Interest Code. A copy of the current version of the Standard Code is attached hereto as "Exhibit C" for information purposes only.

Pursuant to Section 4 of the Standard Code, designated employees shall file statements of economic interests with the Chief Executive Officer of Kaweah Health. Upon receipt of the statements filed by the designated employees of the department, the Chief Executive Officer shall make and retain the original and forward a copy of these statements to the code reviewing body, which in this case is the Tulare County Board of Supervisors.

Adopted by the Board of Directors of Kaweah Delta Health Care District effective June 25, 2025.

PROCEDURE:**I. Members, Board of Directors and Chief Executive Officer**

All members of the Kaweah Health Board of Directors and the individual occupying the position of Chief Executive Officer must complete and file Statements of Economic Interest with the Office of the Chief Executive Officer. Disclosure must include items listed in Exhibit "B".

II. Other Affected Positions

Individuals occupying positions as noted in Exhibit "A" are also required to complete and file, with the office of the Chief Executive Officer of Kaweah Health, Statements of Economic Interest. The types of interest to be disclosed are identified on "Exhibit B" per position held with Kaweah Health.

III. Filing Deadlines

Individuals required to complete and file Statements of Economic Interest must do so with the appropriate office:

- A. within thirty (30) days after the effective date of the adoption of the Conflict of Interest Code;
- B. within thirty (30) days after assuming a position requiring filing such Statement;
- C. within thirty (30) days after leaving a position requiring filing of such Statement; and,
- D. annually, during the month of January, no later than April 1, for each year in which the individual occupies a position requiring a Statement.

IV. Training

- A. All Board members and designated employees must complete ethics training (AB1234) every two years and retain proof of completion.

This policy shall be reviewed every two years or when required by law. Kaweah Health Care District shall amend its Conflict-of-Interest Code in coordination with the Tulare County Board of Supervisors, consistent with Government Code 87306.5

EXHIBIT "A"

**KAWEAH DELTA HEALTH CARE DISTRICT
DBA KAWEAH HEALTH**

CONFLICT OF INTEREST CODE**Disclosure Categories**

<u>Designated Positions</u>	<u>Category of Interests Required to be Disclosed</u>
Members of the Board of Directors	1
Employees	
Chief Executive Officer	1
Chief Financial Officer	1
Chief Operating Officer	1
Chief Medical & Quality Officer	1
Chief Nursing Officer	1
Chief Information & Cybersecurity Officer	1
Chief Human Resources Officer	1
Chief Strategy Officer	1
Chief Ambulatory Officer	1
Chief Medical Education Officer	1
Chief Compliance & Risk Officer	1
Director of Consulting & Project Management	1
Director of Procurement and Logistics Material Management	1
Director of Risk Management	1
Director of Facilities 1	
All Directors of Kaweah Delta Health Care District dba Kaweah Health	4B
Consultants	
Legal Counsel to the Board of Directors	1

["Consultants may be designated employees who must disclose financial interests as determined on a case-by-case basis. The District must make a written determination whether a consultant must disclose financial interests. The determination shall include a description of the consultant's duties and a statement of the extent of the disclosure requirements, if any, based upon that description. All such determinations are public records and shall be retained for public inspection with this conflict of interest code.

["Consultants can be deemed to participate in making a governmental decision when the consultant, acting within the authority of his or her position:

- (1) Negotiates, without significant substantive review, with a governmental entity or private person regarding certain governmental decisions; or*
- (2) Advises or makes recommendations to the decision-maker either directly or without significant intervening substantive review, by:*

- a. *Conducting research or making an investigation, which requires the exercise of judgment on the part of the person and the purpose of which is to influence a governmental decision; or*
- b. *Preparing or presenting a report, analysis, or opinion, orally or in writing, which requires the exercise of judgment on the part of the person and the purpose of which is to influence the decision."*

(From the Tulare County Counsel)

{A consultant is also subject to the disclosure requirements if he/she acts in a staff capacity (i.e., performs the same or substantially all the same duties that would otherwise be performed by an individual holding a position specified in the Code).}

EXHIBIT "B"**KAWEAH DELTA HEALTH CARE DISTRICT
DBA KAWEAH HEALTH****CONFLICT OF INTEREST CODE****Disclosure Categories****1. Full Disclosure:**

Designated persons in this category must report:

All interests in real property located entirely or partly within this District's jurisdiction or boundaries, or within two miles of this District's jurisdiction or boundaries or of any land owned or used by this District. Such interests include any leasehold, ownership interest or option to acquire such interest in real property.

All investments, business positions, ownership and sources of income, including gifts, loans and travel payments.

2. Full Disclosure (excluding interests in real property):

All investments, business positions, ownership and sources of income, including gifts, loans and travel payments.

3. Interests in Real Property (only):

All interests in real property located entirely or partly within this District's jurisdiction or boundaries, or within two miles of this District's jurisdiction or boundaries or of any land owned or used by this District. Such interests include any leasehold, ownership interest or option to acquire such interest in real property.

4. General Contracting (two options):

A. All investments, business positions, ownership and sources of income, including gifts, loans and travel payments, from sources that provide, or have provided in the last two years, leased facilities, goods, supplies, materials, equipment, vehicles, machinery, services, or the like, including training or consulting services, of the type utilized by the District.

[Intended for employees whose duties and decisions involve contracting and purchasing for the entire District.]

B. All investments, business positions, ownership and sources of income, including gifts, loans and travel payments, from sources that provide, or have provided in the last two years, leased facilities, goods, supplies, materials, equipment, vehicles, machinery, services, or the like, including training or consulting services, of the type utilized by the employee's department or division.

[Intended for employees whose duties and decisions involve contracting and purchasing for a specific department or division of the District.]

5. Regulatory, Permit or Licensing Duties:

All investments, business positions, ownership and sources of income, including gifts, loans and travel payments, from sources that are subject to the regulatory, permit or licensing authority of, or have an application for a license or permit pending before, the employee's department or division, or the District.

6. **Grant/Service Providers/Departments that Oversee Programs:**

A. All investments, business positions, ownership and sources of income, including gifts, loans and travel payments, or income from a nonprofit organization, if the source is of the type to receive grants or other monies from or through a specific department or division of the District.

[Intended for employees whose duties and decision involve awards of monies or grants to organizations or individuals.]

EXHIBIT "C"
KAWEAH DELTA HEALTH CARE DISTRICT
DBA KAWEAH HEALTH

CONFLICT OF INTEREST CODE

Standard Code

§ 18730. Provisions of Conflict of Interest Codes.

(a) Incorporation by reference of the terms of this regulation along with the designation of employees and the formulation of disclosure categories in the Appendix referred to below constitute the adoption and promulgation of a conflict of interest code within the meaning of Government Code section 87300 or the amendment of a conflict of interest code within the meaning of Government Code section 87306 if the terms of this regulation are substituted for terms of a conflict of interest code already in effect. A code so amended or adopted and promulgated requires the reporting of reportable items in a manner substantially equivalent to the requirements of article 2 of chapter 7 of the Political Reform Act, Government Code sections 81000, *et seq.* The requirements of a conflict of interest code are in addition to other requirements of the Political Reform Act, such as the general prohibition against conflicts of interest contained in Government Code section 87100, and to other state or local laws pertaining to conflicts of interest.

(b) The terms of a conflict of interest code amended or adopted and promulgated pursuant to this regulation are as follows:

(1) Section 1. Definitions.

The definitions contained in the Political Reform Act of 1974, regulations of the Fair Political Practices Commission (2 Cal. Code of Regs. sections 18100, *et seq.*), and any amendments to the Act or regulations, are incorporated by reference into this conflict of interest code.

(2) Section 2. Designated Employees.

The persons holding positions listed in the Appendix are designated employees. It has been determined that these persons make or participate in the making of decisions which may foreseeably have a material effect on economic interests.

(3) Section 3. Disclosure Categories.

This code does not establish any disclosure obligation for those designated employees who are also specified in Government Code section 87200 if they are designated in this code in that same capacity or if the geographical jurisdiction of this agency is the same as or is wholly included within the jurisdiction in which those persons must report their economic interests pursuant to article 2 of chapter 7 of the Political Reform Act, Government Code sections 87200, *et seq.*

In addition, this code does not establish any disclosure obligation for any designated employees who are designated in a conflict of interest code for another agency, if all of the following apply:

(A) The geographical jurisdiction of this agency is the same as or is wholly included within the jurisdiction of the other agency;

(B) The disclosure assigned in the code of the other agency is the same as that required under article 2 of chapter 7 of the Political Reform Act, Government Code section 87200; and

(C) The filing officer is the same for both agencies. ¹

Such persons are covered by this code for disqualification purposes only. With respect to all other designated employees, the disclosure categories set forth in the Appendix specify which kinds of economic interests are reportable. Such a designated employee shall disclose in his or her statement of economic interests those economic interests he or she has which are of the kind described in the disclosure categories to which he or she is assigned in the Appendix. It has been determined that the economic interests set forth in a designated employee's disclosure categories are the kinds of economic interests which he or she foreseeably can affect materially through the conduct of his or her office.

(4) Section 4. Statements of Economic Interests: Place of Filing.

The code reviewing body shall instruct all designated employees within its code to file statements of economic interests with the agency or with the code reviewing body, as provided by the code reviewing body in the agency's conflict of interest code. (5) Section 5. Statements of Economic Interests: Time of Filing.

(A) Initial Statements. All designated employees employed by the agency on the effective date of this code, as originally adopted, promulgated and approved by the code reviewing body, shall file statements within 30 days after the effective date of this code. Thereafter, each person already in a position when it is designated by an amendment to this code shall file an initial statement within 30 days after the effective date of the amendment.

(B) Assuming Office Statements. All persons assuming designated positions after the effective date of this code shall file statements within 30 days after assuming the designated positions, or if subject to State Senate confirmation, 30 days after being nominated or appointed.

(C) Annual Statements. All designated employees shall file statements no later than April 1.

(D) Leaving Office Statements. All persons who leave designated positions shall file statements within 30 days after leaving office.

(5.5) Section 5.5. Statements for Persons Who Resign Prior to Assuming Office.

Any person who resigns within 12 months of initial appointment, or within 30 days of the date of notice provided by the filing officer to file an assuming office statement, is not deemed to have assumed office or left office, provided he or she did not make or participate in the making of, or use his or her position to influence any decision and did not receive or become entitled to receive any form of payment as a result of his or her appointment. Such persons shall not file either an assuming or leaving office statement.

(A) Any person who resigns a position within 30 days of the date of a notice from the filing officer shall do both of the following:

(1) File a written resignation with the appointing power; and

(2) File a written statement with the filing officer declaring under penalty of perjury that during the period between appointment and resignation he or she did not make, participate in the making, or use the position to influence any decision of the agency or receive, or become entitled to receive, any form of payment by virtue of being appointed to the position.

(6) Section 6. Contents of and Period Covered by Statements of Economic Interests.

(A) Contents of Initial Statements.

Initial statements shall disclose any reportable investments, interests in real property and business positions held on the effective date of the code and income received during the 12 months prior to the effective date of the code.

(B) Contents of Assuming Office Statements.

Assuming office statements shall disclose any reportable investments, interests in real property and business

positions held on the date of assuming office or, if subject to State Senate confirmation or appointment, on the date of nomination, and income received during the 12 months prior to the date of assuming office or the date of being appointed or nominated, respectively.

(C) Contents of Annual Statements. Annual statements shall disclose any reportable investments, interests in real property, income and business positions held or received during the previous calendar year provided, however, that the period covered by an employee's first annual statement shall begin on the effective date of the code or the date of assuming office whichever is later, or for a board or commission member subject to Government Code section 87302.6, the day after the closing date of the most recent statement filed by the member pursuant to 2 Cal. Code Regs. section 18754.

(D) Contents of Leaving Office Statements.

Leaving office statements shall disclose reportable investments, interests in real property, income and business positions held or received during the period between the closing date of the last statement filed and the date of leaving office.

(7) Section 7. Manner of Reporting.

Statements of economic interests shall be made on forms prescribed by the Fair Political Practices Commission and supplied by the agency, and shall contain the following information:

(A) Investments and Real Property Disclosure.

When an investment or an interest in real property³ is required to be reported,⁴ the statement shall contain the following:

1. A statement of the nature of the investment or interest;
2. The name of the business entity in which each investment is held, and a general description of the business activity in which the business entity is engaged;
3. The address or other precise location of the real property;
4. A statement whether the fair market value of the investment or interest in real property equals or exceeds two thousand dollars (\$2,000), exceeds ten thousand dollars (\$10,000), exceeds one hundred thousand dollars (\$100,000), or exceeds one million dollars (\$1,000,000).

(B) Personal Income Disclosure. When personal income is required to be reported,⁵ the statement shall contain:

1. The name and address of each source of income aggregating five hundred dollars (\$500) or more in value, or fifty dollars (\$50) or more in value if the income was a gift, and a general description of the business activity, if any, of each source;
2. A statement whether the aggregate value of income from each source, or in the case of a loan, the highest amount owed to each source, was one thousand dollars (\$1,000) or less, greater than one thousand dollars (\$1,000), greater than ten thousand dollars (\$10,000), or greater than one hundred thousand dollars (\$100,000);
3. A description of the consideration, if any, for which the income was received;
4. In the case of a gift, the name, address and business activity of the donor and any intermediary through which the gift was made; a description of the gift; the amount or value of the gift; and the date on which the gift was received;
5. In the case of a loan, the annual interest rate and the security, if any, given for the loan and the term of the

loan.

(C) Business Entity Income Disclosure. When income of a business entity, including income of a sole proprietorship, is required to be reported,⁶ the statement shall contain:

1. The name, address, and a general description of the business activity of the business entity;
2. The name of every person from whom the business entity received payments if the filer's pro rata share of gross receipts from such person was equal to or greater than ten thousand dollars (\$10,000).

(D) Business Position Disclosure. When business positions are required to be reported, a designated employee shall list the name and address of each business entity in which he or she is a director, officer, partner, trustee, employee, or in which he or she holds any position of management, a description of the business activity in which the business entity is engaged, and the designated employee's position with the business entity.

(E) Acquisition or Disposal During Reporting Period. In the case of an annual or leaving office statement, if an investment or an interest in real property was partially or wholly acquired or disposed of during the period covered by the statement, the statement shall contain the date of acquisition or disposal.

(8) Section 8. Prohibition on Receipt of Honoraria.

(A) No member of a state board or commission, and no designated employee of a state or local government agency, shall accept any honorarium from any source, if the member or employee would be required to report the receipt of income or gifts from that source on his or her statement of economic interests. This section shall not apply to any part time member of the governing board of any public institution of higher education, unless the member is also an elected official.

Subdivisions (a), (b), and (c) of Government Code section 89501 shall apply to the prohibitions in this section.

This section shall not limit or prohibit payments, advances, or reimbursements for travel and related lodging and subsistence authorized by Government Code section 89506.

(8.1) Section 8.1 Prohibition on Receipt of Gifts in Excess of \$390.

(A) No member of a state board or commission, and no designated employee of a state or local government agency, shall accept gifts with a total value of more than \$390 in a calendar year from any single source, if the member or employee would be required to report the receipt of income or gifts from that source on his or her statement of economic interests. This section shall not apply to any part time member of the governing board of any public institution of higher education, unless the member is also an elected official.

Subdivisions (e), (f), and (g) of Government Code section 89503 shall apply to the prohibitions in this section.

(8.2) Section 8.2. Loans to Public Officials.

(A) No elected officer of a state or local government agency shall, from the date of his or her election to office through the date that he or she vacates office, receive a personal loan from any officer, employee, member, or consultant of the state or local government agency in which the elected officer holds office or over which the elected officer's agency has direction and control.

(B) No public official who is exempt from the state civil service system pursuant to subdivisions (c), (d), (e), (f), and (g) of Section 4 of Article VII of the Constitution shall, while he or she holds office, receive a personal loan from any officer, employee, member, or consultant of the state or local government agency in which the public official holds office or over which the public official's agency has direction and control. This subdivision shall not apply to loans made to a public official whose duties are solely secretarial, clerical, or manual.

(C) No elected officer of a state or local government agency shall, from the date of his or her election to office through the date that he or she vacates office, receive a personal loan from any person who has a contract with the state or local government agency to which that elected officer has been elected or over which that

elected officer's agency has direction and control. This subdivision shall not apply to loans made by banks or other financial institutions or to any indebtedness created as part of a retail installment or credit card transaction, if the loan is made or the indebtedness created in the lender's regular course of business on terms available to members of the public without regard to the elected officer's official status.

(D) No public official who is exempt from the state civil service system pursuant to subdivisions (c), (d), (e), (f), and (g) of Section 4 of Article VII of the Constitution shall, while he or she holds office, receive a personal loan from any person who has a contract with the state or local government agency to which that elected officer has been elected or over which that elected officer's agency has direction and control. This subdivision shall not apply to loans made by banks or other financial institutions or to any indebtedness created as part of a retail installment or credit card transaction, if the loan is made or the indebtedness created in the lender's regular course of business on terms available to members of the public without regard to the elected officer's official status. This subdivision shall not apply to loans made to a public official whose duties are solely secretarial, clerical, or manual.

(E) This section shall not apply to the following:

1. Loans made to the campaign committee of an elected officer or candidate for elective office.
2. Loans made by a public official's spouse, child, parent, grandparent, grandchild, brother, sister, parent-in-law, brother-in-law, sister-in-law, nephew, niece, aunt, uncle, or first cousin, or the spouse of any such persons, provided that the person making the loan is not acting as an agent or intermediary for any person not otherwise exempted under this section.
3. Loans from a person which, in the aggregate, do not exceed five hundred dollars (\$500) at any given time.
4. Loans made, or offered in writing, before January 1, 1998.

(8.3) Section 8.3. Loan Terms.

(A) Except as set forth in subdivision (B), no elected officer of a state or local government agency shall, from the date of his or her election to office through the date he or she vacates office, receive a personal loan of five hundred dollars (\$500) or more, except when the loan is in writing and clearly states the terms of the loan, including the parties to the loan agreement, date of the loan, amount of the loan, term of the loan, date or dates when payments shall be due on the loan and the amount of the payments, and the rate of interest paid on the loan.

(B) This section shall not apply to the following types of loans:

1. Loans made to the campaign committee of the elected officer.
2. Loans made to the elected officer by his or her spouse, child, parent, grandparent, grandchild, brother, sister, parent-in-law, brother-in-law, sister-in-law, nephew, niece, aunt, uncle, or first cousin, or the spouse of any such person, provided that the person making the loan is not acting as an agent or intermediary for any person not otherwise exempted under this section.
3. Loans made, or offered in writing, before January 1, 1998.

(C) Nothing in this section shall exempt any person from any other provision of Title 9 of the Government Code.

(8.4) Section 8.4. Personal Loans.

(A) Except as set forth in subdivision (B), a personal loan received by any designated employee shall become a gift to the designated employee for the purposes of this section in the following circumstances:

1. If the loan has a defined date or dates for repayment, when the statute of limitations for filing an action for default has expired.

2. If the loan has no defined date or dates for repayment, when one year has elapsed from the later of the following:

- a. The date the loan was made.
- b. The date the last payment of one hundred dollars (\$100) or more was made on the loan.
- c. The date upon which the debtor has made payments on the loan aggregating to less than two hundred fifty dollars (\$250) during the previous 12 months.

(B) This section shall not apply to the following types of loans:

- 1. A loan made to the campaign committee of an elected officer or a candidate for elective office.
- 2. A loan that would otherwise not be a gift as defined in this title.
- 3. A loan that would otherwise be a gift as set forth under subdivision (A), but on which the creditor has taken reasonable action to collect the balance due.
- 4. A loan that would otherwise be a gift as set forth under subdivision (A), but on which the creditor, based on reasonable business considerations, has not undertaken collection action. Except in a criminal action, a creditor who claims that a loan is not a gift on the basis of this paragraph has the burden of proving that the decision for not taking collection action was based on reasonable business considerations.
- 5. A loan made to a debtor who has filed for bankruptcy and the loan is ultimately discharged in bankruptcy.

(C) Nothing in this section shall exempt any person from any other provisions of Title 9 of the Government Code.

(9) Section 9. Disqualification.

No designated employee shall make, participate in making, or in any way attempt to use his or her official position to influence the making of any governmental decision which he or she knows or has reason to know will have a reasonably foreseeable material financial effect, distinguishable from its effect on the public generally, on the official or a member of his or her immediate family or on:

(A) Any business entity in which the designated employee has a direct or indirect investment worth two thousand dollars (\$2,000) or more;

(B) Any real property in which the designated employee has a direct or indirect interest worth two thousand dollars (\$2,000) or more;

(C) Any source of income, other than gifts and other than loans by a commercial lending institution in the regular course of business on terms available to the public without regard to official status, aggregating five hundred dollars (\$500) or more in value provided to, received by or promised to the designated employee within 12 months prior to the time when the decision is made;

(D) Any business entity in which the designated employee is a director, officer, partner, trustee, employee, or holds any position of management; or

(E) Any donor of, or any intermediary or agent for a donor of, a gift or gifts aggregating \$390 or more provided to, received by, or promised to the designated employee within 12 months prior to the time when the decision is made.

(9.3) Section 9.3. Legally Required Participation.

No designated employee shall be prevented from making or participating in the making of any decision to the extent his or her participation is legally required for the decision to be made. The fact that the vote of a designated employee who is on a voting body is needed to break a tie does not make his or her participation

legally required for purposes of this section.

(9.5) Section 9.5. Disqualification of State Officers and Employees.

In addition to the general disqualification provisions of section 9, no state administrative official shall make, participate in making, or use his or her official position to influence any governmental decision directly relating to any contract where the state administrative official knows or has reason to know that any party to the contract is a person with whom the state administrative official, or any member of his or her immediate family has, within 12 months prior to the time when the official action is to be taken:

(A) Engaged in a business transaction or transactions on terms not available to members of the public, regarding any investment or interest in real property; or

(B) Engaged in a business transaction or transactions on terms not available to members of the public regarding the rendering of goods or services totaling in value one thousand dollars (\$1,000) or more.

(10) Section 10. Disclosure of Disqualifying Interest.

When a designated employee determines that he or she should not make a governmental decision because he or she has a disqualifying interest in it, the determination not to act may be accompanied by disclosure of the disqualifying interest.

(11) Section 11. Assistance of the Commission and Counsel.

Any designated employee who is unsure of his or her duties under this code may request assistance from the Fair Political Practices Commission pursuant to Government Code section 83114 and 2 Cal. Code Regs. sections 18329 and 18329.5 or from the attorney for his or her agency, provided that nothing in this section requires the attorney for the agency to issue any formal or informal opinion.

(12) Section 12. Violations.

This code has the force and effect of law. Designated employees violating any provision of this code are subject to the administrative, criminal and civil sanctions provided in the Political Reform Act, Government Code sections 81000 – 91014. In addition, a decision in relation to which a violation of the disqualification provisions of this code or of Government Code section 87100 or 87450 has occurred may be set aside as void pursuant to Government Code section 91003.

NOTE: Authority cited: Section 83112, Government Code.

Reference: Sections 87103(e), 87300-87302, 89501, 89502 and 89503, Government Code.

¹ Designated employees who are required to file statements of economic interests under any other agency's conflict of interest code, or under article 2 for a different jurisdiction, may expand their statement of economic interests to cover reportable interests in both jurisdictions, and file copies of this expanded statement with both entities in lieu of filing separate and distinct statements, provided that each copy of such expanded statement filed in place of an original is signed and verified by the designated employee as if it were an original. See Government Code section 81004.

²See Government Code section 81010 and 2 Cal. Code of Regs. section 18115 for the duties of filing officers and persons in agencies who make and retain copies of statements and forward the originals to the filing officer.

³For the purpose of disclosure only (not disqualification), an interest in real property does not include the principal residence of the filer.

⁴Investments and interests in real property which have a fair market value of less than \$2,000 are not investments and interests in real property within the meaning of the Political Reform Act. However, investments or interests in real property of an individual include those held by the individual's spouse and

dependent children as well as a pro rata share of any investment or interest in real property of any business entity or trust in which the individual, spouse and dependent children own, in the aggregate, a direct, indirect or beneficial interest of 10 percent or greater.

⁵A designated employee's income includes his or her community property interest in the income of his or her spouse but does not include salary or reimbursement for expenses received from a state, local or federal government agency.

⁶Income of a business entity is reportable if the direct, indirect or beneficial interest of the filer and the filer's spouse in the business entity aggregates a 10 percent or greater interest. In addition, the disclosure of persons who are clients or customers of a business entity is required only if the clients or customers are within one of the disclosure categories of the filer.

BOD6 Board Travel and Expense Reimbursement

Policy Number: BOD6	Date Created: 03/27/2013
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: 06/27/2025
Approvers: Board of Directors (Administration)	
Board Reimbursement for Travel and Service Clubs	

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

- PURPOSE:** To provide reimbursement to members of the Kaweah Delta Health Care District dba Kaweah Health Board of Directors, consistent with legislative regulations, for the performance of the duties of their office.
- POLICY:** Each member of the Board of Directors shall be allowed his/her actual necessary traveling and incidental expenses including service organization dues incurred in the performance of official business of Kaweah Health.
- PROCEDURE:** Travel and incidental expenses including service organization dues will be reimbursed to Board members that are paid with personal credit cards or cash upon the submittal of itemized receipts to the Board Clerk.

I. Travel

- A. Meals will be reimbursed with the submittal of an itemized meal receipt.
- B. Air Fare for board member for the cost of coach fares and standard luggage fees. If the traveler chooses to travel in a premium class such as business or first, the difference in cost between coach travel rates and the premium travel rates must be paid by the traveler.
- C. Parking, taxi, or rental car fees and other transportation expenses will be reimbursed.
- D. If driving, mileage will be reimbursed at current IRS guidelines.
- E. Hotel room will be covered in full for Board Member. Lodging costs shall not exceed the maximum group rate published by the conference or activity sponsor as long as the group rate is available to the Board member at the time of booking. Any additional nights beyond or prior to the conference shall be incurred by the Board member.
- F. Conference registration for Board Members will be paid in full.

II. Service Club District Reimbursed Memberships

Kaweah Health recognizes the value of professional and service club memberships for its members of the Board of Directors. All Board members are encouraged to participate in such activities to benefit health care education and community

involvement. As such Board members may have dues for these memberships paid for by the District. Members of the Board of Directors are eligible for membership in a community organization. Kaweah Health will not reimburse for meals, fines, or other assessments at regular meetings.

"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."

BOD7 Presentation of Claims

Policy Number: BOD7	Date Created: 10/30/2013
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: 06/27/2025
Approvers: Board of Directors (Administration)	
Presentation of Claims and Service Process Act	

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

POLICY: This policy sets forth the procedures for presenting, receiving, and processing claims against the District, in compliance with: the California Government Claims Act (Gov. Code 900 et seq.), and the Brown Act (Gov. Code 54950 et seq.), suits for money or damages filed against a public entity such as Kaweah Delta Health Care District dba Kaweah Health are regulated by statutes contained in division 3.6 of the California Government Code, commonly referred to as the Government Claims Act. Government Code § 905 requires the presentation of all claims for money or damages against local public entities such as Kaweah Health, subject to certain exceptions. Claims for personal injury and property damages must be presented within six (6) months after accrual; all other claims must be presented within one (1) year.

Presentation of a claim is generally governed by Government Code § 915 which provides that a claim, any amendment thereto, or an application for leave to present a late claim shall be presented to Kaweah Health by either delivering it to the clerk, secretary or auditor thereof, or by mailing it to the clerk, secretary, auditor, or to the governing body at its principal office.

Service of process on a public entity such as Kaweah Health is generally governed by Code of Civil Procedure § 416.50 which provides that a summons may be served by delivering a copy of the summons and complaint to the clerk, secretary, president, presiding officer or other head of its governing body.

This policy is intended to precisely identify those individuals who may receive claims on behalf of Kaweah Health and those individuals who may receive a summons and complaint on behalf of Kaweah Health.

PROCEDURE:

- I. **Presentation of a Government Claim:** the formal filing of a claim with the District Clerk or Secretary under Government Code 910:
 - A. Claims must be submitted in writing to the District Clerk at the District's main office: 400 W. Mineral Avenue, Visalia, California 93291. Electronic submission is not accepted unless authorized by District resolution.
 - B. Claim Form Requirements must include:
 - a. Name and address of the claimant

- b. Date, location, and facts of the incident
 - c. Description of injury or damages
 - d. Amount claimed (if known)
 - e. Signature of claimant or representative
- C. Authorized Recipient of Claims for a Special District. Per Government code 9145(a) if the District has not adopted a specific resolution, claims must be delivered or mailed to the Board Clerk, Secretary or Auditor of the District, or if no such officer exists, the governing body (Board) of the District. The Board of Directors reserves the right to adopt a resolution designating another official or designee as the authorized agent to receive claims.
- D. Personal Delivery. Only the Board Clerk, Secretary, or Auditor of the District are authorized to receive a personal delivery of a Government Claim on behalf of Kaweah Health. No other individual is authorized to receive delivery of a Government Claim on behalf of Kaweah Health.
- E. Mailing. Only the Board Clerk, the Board Secretary, or the Auditor are authorized to receive mailing of a Government Claim on behalf of Kaweah Health. No other individual is authorized to receive mailing of a Government Claim on behalf of Kaweah Health, unless the claim is addressed to the Board of Directors and mailed to the Board of Directors of Kaweah Health at 400 West Mineral King Avenue, Visalia, CA, 93291, the principal office of the Board of Directors.
- F. Processing a Presented Claim. If a claim is (1) delivered to the Board Clerk, the Board Secretary, or the Auditor. is authorized to receive personal delivery of a government claim on behalf of the District; or (2) received in the mail addressed to the Board Clerk, the Board Secretary, or the Auditor; or (3) received in the mail addressed to the Board of Directors of Kaweah Health at 400 West Mineral King Avenue, Visalia, CA, 93291, the claim shall be immediately provided to the Board Clerk shall date, time and manner of delivery/ mailing can be recorded in a log to be maintained in the Board Clerk's office. The Board Clerk shall then make prompt arrangements to have a copy of the claim, as well as the log information for the claim, provided to the Kaweah Health Risk Management Department and to the legal counsel for Kaweah Health who will be representing Kaweah Health with respect to the claim. In the event that a claim is accepted by the Auditor, in the absence of the Board Clerk, the claim shall be marked with the date/time and manner of delivery/ mailing recorded. The claim shall be immediately forwarded to the Risk Management Department copying the Board Clerk to be processed as noted above and logged in the official log.

If delivery of a claim is attempted on any individual other than the Board Clerk, the Board Secretary, or the Auditor, then the person attempting delivery shall be advised by the individual on whom delivery of a claim is being attempted that he/she is not authorized to receive delivery of a claim on behalf of Kaweah Health and he/she shall decline to accept delivery. If a claim is delivered to any individual other than the Board Clerk, the Board Secretary, or the Auditor, then the claim shall be promptly forwarded directly to Kaweah Health's general counsel for possible return to the sender. The general counsel shall advise the District's Risk Management Department of the handling of the improperly presented claim.

If a claim is received in the mail that is not addressed to the Board Clerk, the Board Secretary, or the Auditor and is not addressed to the Board of Directors of the District at 400 West Mineral King Avenue, Visalia, CA, 93291, then the claim shall be promptly forwarded directly to Kaweah Delta's general counsel for possible return to the sender. Kaweah Delta's general counsel shall advise the Risk Management Department of the handling of the improperly presented claim.

G. Service of Summons and Complaint.

a. Personal Delivery. Only the Board Clerk, the Board Secretary or the Board President is authorized to accept delivery of a summons and complaint on behalf of Kaweah Delta. In the absence of the Board Clerk, the Board Secretary, or the Board President, In the absence of the Board Clerk, Board Secretary, Board President the Executive Office staff will contact Kaweah Delta's general counsel who will advise how to proceed with the service of the summons and complaint. No other individual, and no other manner of service, is authorized in the absence of a court order or a specific authorization from the Board President, who is granted limited authority as described in this policy.

b. Processing a Delivered Summons and Complaint. If a summons and complaint are delivered to the Board Clerk, the Board Secretary or the Board President, they shall be immediately provided to the Board Clerk so the date, time and manner of delivery can be recorded by the Board Clerk in a log to be maintained in the Board Clerk's office. In the absence of the Board Clerk, the Board Secretary, or the Board President, the Executive Office staff will contact Kaweah Delta's general counsel who will advise how to proceed with the service of the summons or complaint. No other individual is authorized to receive personal delivery of a Summons and Complaint on behalf of the District. The Board Clerk shall then make prompt arrangements to have a copy of the summons and complaint, as well as the log information for the summons and complaint, provided to the Risk Management Department and to the legal counsel for Kaweah Health who will be representing Kaweah Health with respect to the litigation.

If service of a summons and complaint is attempted on any individual other than the Board Clerk, the Board Secretary or the Board President, then the person attempting delivery shall be advised by the individual on whom delivery is being attempted that he/she is not authorized to accept service of a summons and complaint on behalf of Kaweah Health and he/she shall decline to accept service.

An exception to the forgoing may be made only in circumstances where legal counsel for Kaweah Health receives prior authorization from the Board President to accept service of a summons and complaint on behalf of Kaweah Health.

If a summons and complaint is received under circumstances other than by delivery to the Board Clerk, the Board Secretary or the Board President, or through receipt by legal counsel with prior authorization from the Board President to accept service on behalf of Kaweah Health, then the summons and complaint shall be promptly forwarded directly to Kaweah Health's general counsel for possible return to the party who attempted service. Kaweah Health's general counsel shall advise the

Risk Management Department of the handling of the improperly served summons and complaint.

"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."

BOD8 Promulgation of Board Governance Policies

Policy Number: BOD8	Date Created: 06/12/2025
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: 06/25/2025
Approvers: Board of Directors (Administration), Kelsie Davis (Board Clerk/Executive Assistant to CEO)	
Promulgation of Kaweah Delta Health Care District Procedures	

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

Purpose: This policy serves to document the official approval, issuance, and dissemination of the above-named policy by the authority of the Board of Directors or Chief Executive Officer of Kaweah Health, a Special Health Care District governed under California Law. The purpose is to provide guidelines to clarify and standardize the process for the Chief Executive Officer and each member of the Executive Management team (collectively, “Executive Team”) to develop and independently promulgate departmental policies and procedures for the proper operation and administration of the Kaweah Delta Health Care District’s (“Kaweah Health”) affairs.

This Policy is issued pursuant to: California Health & Safety Code 32000, et seq., Government Code 61000, et. seq., Brown Act Compliance (Gov. Code 54950-54936), and all applicable accreditation or regulatory standards (e.g. CDPH, CMS, Joint Commission).

Definitions:

- I. “Organizational **Policy**” means a Board-approved document that provides broad strategic direction, delegates authority, fulfills a non-delegable duty of the Board or sets out rules for the Board’s operations. {See AP.38}
- II. “Departmental Policy and **Procedure**” means a document describing a standard of care, practice and/or steps for performing an agreed course of action.
- III. “**Publication**” means the reduction of an Organizational Policy or Departmental Policy and Procedure to writing and its subsequent distribution, by the promulgating Authorized Signer, via the Policy Tech document management system.

Standard of Practice:

- I. Executive Team members shall have the authority to develop and approve Departmental Policies and Procedures, as appropriate to their respective areas of administrative responsibility. In no event shall any Executive Team member attempt to promulgate a Departmental Policy and Procedure that is inconsistent with an Organizational Policy. Executive Team members may

- delegate the above-described development and approval authority to an appropriate departmental director, service line director, or manager (as appropriate).
- II. The Chief Executive Officer shall have authority and responsibility to establish a structure for development and maintenance of Departmental Policies and Procedures.
 - III. Departmental Policies and Procedures that directly affect the professional services of a Kaweah Health Medical Staff physician or advanced practice professional must be reviewed and approved by the appropriate department of the Medical Staff and other reviewing/approving Kaweah Health or Medical Staff Committees, as appropriate and necessary.
 - IV. A Departmental Policy and Procedure developed pursuant to this Organizational Policy shall become effective and binding immediately upon its approval and publication in Policy Tech by the promulgating Executive Team signer.
 - V. The authorized Executive Team signer responsible for promulgating a Departmental Policy and Procedure pursuant to this Organizational Policy shall be primarily responsible for supervising implementation of such Departmental Policy and Procedure and compliance therewith by Kaweah Health.
 - VI. Each authorized Executive Team signer shall be responsible for reviewing all Departmental Policies and Procedures within his or her jurisdiction at least once every three (3) years or earlier when required by law, accreditation standards or warranted based on changes in the law, state of the art, current knowledge, technology or other factors.
 - VII. All Kaweah Health Organizational Policies and Departmental Policies and Procedures promulgated prior to the effective date of this Policy are hereby ratified to the extent they are not inconsistent with this Organizational Policy or each other and notwithstanding the manner in which they were promulgated.
 - VIII. This policy shall be posted to the District's official intranet and/or policy repository. Distributed to relevant department heads and staff, included in new employee orientation, and ongoing compliance and education.
 - IX. This Organizational Policy will be reviewed and updated as required by law or internal audit or at least every three (3) years.

"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."

BOD9 Board Compensation

Policy Number: BOD 9	Date Created: No Original Creation Date Set
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: 06/27/2025
Approvers: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	
Board Compensation	

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

PURPOSE: To comply with California Health and Safety Code Section 32103, this Policy documents the Board's justification for compensating members for more than five meetings per calendar month.

POLICY: The Board of Directors of Kaweah Health finds, based on substantial evidence, that the effective operation of the District requires Board members to participate in more than five compensated meetings in some months.

Factors supporting this finding include:

- Oversight of complex healthcare operations
- Legal and regulatory compliance demands
- Community engagement and advisory participation
- Strategic planning and financial oversight
- Coordination with local, regional, and state partners

This policy shall be reviewed and readopted annually by the Board of Directors.

"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."

BOD10 CEO Employment Agreement

Policy Number: BOD 10	Date Created: No Original Creation Date Set
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: 01/29/2026
Approvers: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	
Executive Employment Agreement Policy	

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

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

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

Requirements

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

Implementation and Review

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

BOD11 CEO Severance and Compensation

Policy Number: BOD11	Date Created: 01/01/2026
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: 01/28/2026
Approvers: Board of Directors (Administration)	
Severance and Compensation Limitation Policy	

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

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

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

Severance Restrictions

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

Compensation Changes

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

Implementation and Review

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

BOD12 CEO Performance Evaluation

Policy Number: BOD 12	Date Created: 01/01/2026
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: 1/28/202601/30/2026
Approvers: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	
CEO Performance Evaluation Policy	

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

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

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

1. In alignment with **Article VI, Section 5** of the Board Bylaws, the Board shall meet annually in executive session to monitor and evaluate the performance of the Chief Executive Officer.
2. The evaluation shall:
 - Be conducted annually
 - Be based on goals and objectives agreed upon at the beginning of the evaluation cycle, consistent with **Board performance responsibilities outlined in Article II**
 - Include both qualitative and quantitative performance measures
3. Conclusions and recommendations from the evaluation shall be documented and transmitted to the CEO by the Board President, consistent with **Article III duties of the President**.
4. Results of the evaluation shall inform compensation decisions, which must be approved in open session.

Implementation and Review

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

BOD13 Board Oversight and Accountability

Policy Number: BOD 13	Date Created: 01/01/2026
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: 01/29/2026
Approvers: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	
Board Oversight and Accountability Policy	

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

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

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

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

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

Implementation and Review

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

BOD14 Public Transparency and Disclosure Policy

Policy Number: BOD14	Date Created: 01/01/2026
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: 01/28/2026
Approvers: Board of Directors (Administration)	
Public Transparency and Disclosure Policy	

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

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

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

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

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

Implementation and Review

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

BOD15 Closed Session and Labor Negotiations Policy

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

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

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

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

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

Implementation and Review

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

BOD16 Board Meeting Transparency and Remote Access Policy

Policy Number: BOD16	Date Created: 01/01/2026
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: 1/28/2026
Approvers: Board of Directors (Administration)	
Board Meeting Transparency and Remote Access Policy	

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

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

General Transparency Requirements

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

Remote Public Access

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

Board Member Participation

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

Meeting Disruptions

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

Responsibility

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

Implementation and Review

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

BOD17 Language Access for Public Meeting Notice and Agenda Policy

Policy Number: BOD17	Date Created: 01/01/2026
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: 1/28/2026
Approvers: Board of Directors (Administration)	
Language Access for Public Meeting Notices and Agendas Policy	

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

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

Language Posting Requirements

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

Standard District Practice

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

Interpretation Services

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

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

Responsibility

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

Implementation and Review

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

BOD18 Legal Counsel

Policy Number: BOD18	Date Created: 06/30/2026
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: TBD
Approvers: Board of Directors (Administration)	
Legal Counsel	

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

PURPOSE: To establish the authority, responsibilities, and governance principles governing the Board of Directors' relationship with legal counsel and ensure the District receives independent, timely, and effective legal advice.

POLICY: The Board recognizes that competent legal counsel is essential to lawful and effective governance. Legal counsel serves the District as a public entity. Administrative procedures are governed by AP.57 – Access to Legal Counsel.

The Board may retain, appoint, replace, or terminate legal counsel; approve special counsel; receive confidential legal advice in closed session as authorized by law; and direct legal counsel on matters authorized by Board action.

- A. Legal counsel represents the District acting through its duly authorized Governing Body and does not represent individual Directors or employees unless authorized by law or the Board.
- B. Provide legal advice on governance, healthcare law, employment, contracts, litigation, public agency law, regulatory compliance, and other legal matters; advise on fiduciary duties; review governance documents as requested.
- C. Requests for legal services shall follow AP.57. Individual Directors shall not independently direct or retain counsel on behalf of the District unless authorized by the Board.
- D. Privileged communications shall remain confidential to the fullest extent permitted by law.
- E. Legal advice shall be based upon applicable law and independent professional judgment.

The Board shall periodically evaluate the performance, responsiveness, expertise, communication, and value of legal counsel.

Implementation and Review

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

BOD19 Board Self-Evaluation

Policy Number: BOD19	Date Created: 06/30/2026
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: TBD
Approvers: Board of Directors (Administration)	
Board Self Evaluation	

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

PURPOSE: To establish a formal process for evaluating the effectiveness of the Board of Directors in fulfilling its governance responsibilities and promoting continuous improvement.

POLICY: The Board of Directors shall conduct a comprehensive self-evaluation at least once every two years, or more frequently if determined appropriate by the Board.

- A. The evaluation shall assess:
 - Governance effectiveness
 - Fiduciary oversight
 - Strategic leadership
 - Committee effectiveness
 - Board meeting effectiveness
 - Director participation
 - Board culture
 - Relationship with the CEO
 - Compliance with Board policies and bylaws
 - Overall governance performance
- B. The Governance Board Committee shall:
 - recommend the evaluation process;
 - decide who will administer the evaluation; compile results; and present findings to the Board;
 - recommend governance improvements.
- C. Confidentiality
 - Individual responses shall remain confidential.
- D. Improvement Plan
 - Following each evaluation, the Board shall identify opportunities for improvement and incorporate appropriate actions into its annual governance work plan.

REFERENCE:

- Board Bylaws
- BOD13 Board Oversight & Accountability

Implementation and Review

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

BOD20 Board Education & Continuing Education

Policy Number: BOD20	Date Created: 06/30/2026
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: TBD
Approvers: Board of Directors (Administration)	
Board Education & Continuing Education	

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

PURPOSE: To ensure members of the Board maintain the knowledge, skills, and competencies necessary to effectively govern the District.

POLICY: Every Director shall participate in orientation and continuing governance education.

Education should include:

- A. Brown Act
- B. Political Reform Act
- C. Ethics (AB 1234)
- D. SB 827 training
- E. Cybersecurity awareness
- F. Healthcare finance
- G. Quality oversight
- H. Patient safety
- I. District governance
- J. Fiduciary responsibilities
- K. Strategic planning
- L. CEO oversight
- M. Healthcare reimbursement
- N. Compliance
- O. Public Records Act

ORIENTATION: New Directors shall complete orientation within six months of assuming office.

Orientation should include:

- District history
- Mission, Vision, and Values
- Strategic Plan
- Bylaws
- Board Governance Policies
- Medical Staff Bylaws
- Organizational structure
- Budget overview
- Quality program

- Compliance program
- Tour of District facilities

CONTINUING EDUCATION: Each Director should complete ongoing education each year through:

- Association of California Healthcare Districts (ACHD)
- Association of Governing Boards (AGB)
- California Hospital Association (CHA)
- Educational conferences
- Governance workshops
- Board retreats
- Webinars
- District educational sessions

DOCUMENTATION: The Board Clerk shall maintain records of all required governance education, certifications, and statutory training.

GOVERNANCE COMMITTEE: The Governance Committee shall annually review:

- Board educational needs
- Orientation materials
- Annual education calendar
- Compliance with statutory education requirements

REFERENCE:

- Board Bylaws
- BOD13 Board Oversight & Accountability

Implementation and Review

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

AP41

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	

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

I. Purpose

The purpose of Kaweah Health's Quality Improvement Plan is to have an effective, data-driven Quality Assessment Performance 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 service areas fall within the scope of the quality improvement plan requirements.

III. Structure and Accountability

Board of Directors

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

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

Quality Council

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

activities for identifying and evaluating opportunities to improve patient care and services throughout the organization. The effectiveness of the quality improvement and patient safety activities will be evaluated and reported to the Quality Council.

Quality Committee (“QComm”)

In accordance with currently approved medical staff bylaws, shall be accountable for the quality of patient care. The Board delegates’ authority and responsibility for the monitoring, evaluation and improvement of medical care to the Quality Committee “QComm”, chaired by the Vice Chief of Staff and co-chaired by the CMO/CQO (or designee). The Chief of Staff delegates accountability for monitoring individual performance to the Clinical Department Chiefs. QComm shall receive reports from and assure the appropriate functioning of the Medical Staff committees. QComm 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 to assure that they are focused on high- risk, high-volume, or problem- prone areas. It shall focus on issues of known frequency, prevalence or severity and shall give

precedence to issues that affect health

approval

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 identify opportunities 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 on the projects.

Medical Executive Committee

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

IV. Graduate Medical Education

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

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

V. Methodologies:

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

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

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

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

- **Plan:**

- Objective and statistically valid performance measures are identified for monitoring and assessing processes and outcomes of care including those affecting a large percentage of patients, and/or place patients at serious risk if not performed well, or performed when not indicated, or not performed when indicated; and/or have been or likely to be problem prone.
- Performance measures are based on current knowledge and clinical experience and are structured to represent cross-departmental, interdisciplinary processes, as appropriate.

- **Do:**

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

- **Check:**

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

- **Act:**
 - Take actions to correct identified problem areas or improve performance
 - Evaluate the effectiveness of the actions taken and document the improvement in care
 - Communicate the results of the monitoring, assessment and evaluation process to relevant individuals, departments or services
3. **DMAIC (Lean Six Sigma):** DMAIC is an acronym that stands for Define, Measure, Analyze, Improve, and Control. It represents the five phases that make up the road map for Lean Six Sigma QI initiatives.
- **Define** the problem, improvement activity, opportunity for improvement, the project goals, and customer (internal and external) requirements. QI tools that may be used in this step include:
 - Project charter to define the focus, scope, direction, and motivation for the improvement team
 - Process mapping to provide an overview of an entire process, starting and finishing at the customer, and analyzing what is required to meet customer needs
 - **Measure** process performance.
 - Run/trend charts, histograms, control charts
 - Pareto chart to analyze the frequency of problems or causes
 - **Analyze** the process to determine root causes of variation and poor performance (defects).
 - Root cause analysis (RCA) to uncover causes
 - Failure mode and effects analysis (FMEA) for identifying possible product, service, and process failures
 - **Improve** process performance by addressing and eliminating the root causes.
 - Pilot improvements and small tests of change to solve problems from complex processes or systems where there are many factors influencing the outcome
 - Kaizen event to introduce rapid change by focusing on a narrow project and using the ideas and motivation of the people who do the work
 - **Control** the improved process and future process performance.
 - Quality control plan to document what is needed to keep an improved process at its current level. Statistical process control (SPC) for monitoring process behavior
 - Mistake proofing (poka-yoke) to make errors impossible or immediately detectable

VI. Confidentiality

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

§1157.

VII. Annual Evaluation

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

VIII. Attachments (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 Structure
Attachment 2: Kaweah Health Reporting Documents
Attachment 3: Quality and Patient Safety Priorities, Outstanding Health Outcomes Strategic Plan

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approval

approval

AP180

Policy Number: AP180	Date Created: 12/01/2009
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Weapons Brought Into The District	

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

PURPOSE:

Kaweah Health is committed to the safety and wellbeing of our employees, physician staff, volunteers, patients, and visitors.

DEFINITION:

A weapon is any object, device, or substance that is designed, intended, or reasonably capable of causing death or serious physical harm, or that may present a safety or security risk to patients, staff, visitors, or the organization when introduced into the healthcare environment.

Weapons include items that are inherently dangerous or items that, based on their size, construction, modification, or manner of use, could reasonably be used to inflict harm or threaten safety.

Examples of weapons include, but are not limited to:

- Firearms, loaded or unloaded
- Any edged weapon with a blade length greater than three (3) inches
- Striking instruments, such as batons, clubs, or similar devices
- Chemical agents, including pepper spray, mace, or other chemical irritants
- Projectile or missile weapons, including slingshots, bows, and arrows
- Explosive or incendiary devices

Any other object that is not required for patient care or authorized activity and that, through intentional misuse or reasonably foreseeable use, could cause injury, harm, or disruption to the safe operation of the facility.

A weapon is defined as any firearm, knife, chemical spray, or device that can cause bodily harm or injury.

Examples of weapons include, but are not limited to:

FirearmsEdged weapons (Swords, Knives)

Generally pocket knives and multi-tools are not considered weapons; however, extreme caution should be taken in their presence. Any edged weapon with a blade length of over 3 inches will be considered a weapon and will be stored in the safe. (Generally pocket knives and multi-tools are not considered weapons (except in Zone 4 of the ED and in the Mental Health Hospital); however, extreme caution should be taken in their presence.)

Striking implements (Batons, Clubs)Missile throwing objects (slingshots, bow/arrows)ExplosivesIncendiary devices

Any other object deemed to be inherently dangerous to Sentara patients, staff, visitors, contractors, or vendors.

POLICY:

- I. Weapons are ~~never not permitted~~ prohibited on Kaweah Health ~~Health Care District property~~ properties.

II. Restricted Items in High-Risk Areas

Due to the increased risk to patients, staff, and visitors, additional items are restricted within the Emergency Department, Mental Health Hospital, and Youth Crisis Stabilization Unit, regardless of otherwise permissible status elsewhere in the district.

The following items are prohibited in these areas:

- Any edged weapon, regardless of blade length, including razor blades
- Ignition sources, including lighters and matches

- III. A notice stating that weapon screening is required upon entry, and that no person shall be refused medical care, will be posted at all entry points where weapon screening is conducted.

Weapons discovered after arrival must either be secured in the owner's vehicle or surrendered to Security for safekeeping. Local law enforcement agency will be contacted for any illegal weapon discovered.

A patient requiring treatment who refuses weapon screening shall still receive necessary emergency medical care. Security personnel will escort the patient and

remain present during the encounter. The treating clinical team and charge nurse shall be notified immediately. The patient's belongings may be secured separately pending screening.

Weapons discovered after arrival must either be secured in the owner's vehicle or surrendered to Security for safekeeping.

IV. Law Enforcement / Off-Duty Peace Officer Exception

It is not uncommon for the Medical Center, Urgent Care Centers, or off-site clinics to receive visits from uniformed peace officers as well as off-duty (plain-clothes) officers. These individuals are sworn peace officers with the State of California and their respective agencies and are authorized to carry their department-issued or off-duty firearm.

- On-duty law-enforcement officers

If, during the course of treating an on-duty law enforcement officer, they are unable to maintain control or security of their weapon (i.e. treatment/exam would require the weapon to be out of their immediate control, administration of medications that may impair judgement, etc.) the law enforcement agency is to be contacted, and they will provide another officer to take control of the weapon.

- Off-duty law-enforcement officers

If, during the course of treating an off-duty law enforcement officer, they are unable to maintain control or security of their weapon... (i.e. treatment/exam would require the weapon to be out of their immediate control, administration of medications that may impair judgement, etc.)

- Have the patient secure their weapon in their home or vehicle
- Have the patient return for service when they are unarmed
- Send the patient to the emergency department where hospital security can help with gun storage needs

Armed off-duty peace officers (plain clothes) visiting suicide risk patients in the Emergency Department, including visiting patients who are being seen in an area of the ED or the Mental Health Hospital, where suicide risk patients are being cared for, are not permitted to carry a firearm.

V. Employee Exception

Understanding that our employee workforce is our greatest resource and that we have a shared value to keep our employees safe, Kaweah Health will permit employees to carry mace/pepper spray and stun gun/taser electroshock self-defense devices tools when coming to and leaving work.

Employees who choose to carry approved personal self-defense tools while coming to and going from work may bring such items on-site. However, it is a violation of company policy to openly display, carry, or inappropriately refer to possession in a threatening or disruptive manner while performing work responsibilities or interacting with co-workers or customers.

- Storage

- Employees are responsible for ensuring that self-defense tools are stored properly where patients and the public cannot access the property.
- Department employees and support staff assigned to work in the Emergency Department and the Mental Health Hospital are prohibited to enter the patient care areas/units with these self-defense tools. Property must be secured before stepping onto the patient care area.

- Disclaimer

- Employees are liable for the cost of property damage, cleanup, or injuries resulting from an accidental discharge, negligent use, or willful use of personal self-defense tools while on duty.

- Aerosol Warning

- Pepper spray is a chemical compound that irritates the eyes to cause tears, pain, and temporary blindness (inflammatory effects cause eye to close). An accidental discharge of pepper spray inside our facilities can travel through the HVAC (heating, ventilation and air conditioning) system and contaminate the environment.

LAW ENFORCEMENT/ OFF-DUTY PEACE OFFICER EXCEPTION:

It is not uncommon for the Medical Center, Urgent Care Centers, or off-site clinics to receive visits from uniformed peace officers as well as off-duty (plain clothes) officers. These members of our community are sworn peace officers with the State of California and their respective agencies, and are authorized to carry their department issued or off-duty firearm.

PEACE OFFICERS SEEKING TREATMENT AT UCC/ OFF-SITE CLINICS:

On-duty law enforcement officers

If, during the course of treating an on-duty law enforcement officer, they are unable to maintain control or security of their weapon (i.e. treatment/exam would require the weapon to be out of their immediate control, administration of medications that may impair judgement, etc.) the law enforcement department is to be contacted, and they will provide another officer to take control of the weapon.

Off-duty law-enforcement officers

If, during the course of treating an OFFoff-duty law enforcement officer, they are unable to maintain control or security of their weapon... (i.e. treatment/exam would require the weapon to be out of their immediate control, administration of medications that may impair judgement, etc.):

- Have the patient secure their weapon in their home or vehicle
- Have the patient return for service when they are unarmed
- Send the patient to the emergency department where hospital security can help with gun storage needs

OFF-DUTY PEACE OFFICER FIREARMS RESTRICTIONS – SUICIDE RISK PATIENTS

Armed OFFoff-duty peace officers (plain clothes) visiting suicide risk patients in the Emergency Department, including visiting patients who are being seen in an area of the ED or the Mental Health Hospital, where suicide risk patients are being cared for, are not permitted to carry a firearm.

EMPLOYEE EXCEPTION:

Understanding that our employee workforce is our greatest resource and that we have a shared value to keep our employees safe, Kaweah Health will permit employees to carry mace/pepper spray and stun gun/taser electroshock self-defense devices tools when coming to and leaving work.

Employees who choose to carry approved personal self-defense tools while coming to and going from work may bring such items on-site. However, it is a violation of company policy, to openly display, carry, or inappropriately refer to possession in a threatening or disruptive manner while performing work responsibilities or interacting with co-workers or customers.

STORAGE:

Employees are responsible for ensuring that self-defense tools are stored properly where patients and the public cannot access the property.

Department employees and support staff assigned to work in the Emergency Department and the Mental Health Hospital are ~~not permitted~~prohibited to enter the patient care areas/units with these self-defense tools. Property must be secured before stepping onto the patient care area.

DISCLAIMER:

Employees are liable for the cost of property damage, cleanup, or injuries resulting from an accidental discharge, negligent use, or willful use of personal self-defense tools while on duty.

AEROSOL WARNING:

Pepper spray is a chemical compound that irritates the eyes to cause tears, pain, and temporary blindness (inflammatory effects cause eye to close). An accidental discharge of pepper spray inside our facilities can travel through the HVAC (heating, ventilation and air conditioning) system and contaminate the environment.

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DM2104 Emergency Impact Assessment

Policy Number: DM 2104	Date Created: 07/01/2011
Document Owner: Maribel Aguilar (Director of Physical Environment)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	
Emergency Impact Assessment	

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

Policy

Kaweah Delta Health Care District's herein after referred to Kaweah Health (KH) Emergency Management Plan is flexible so that it can be quickly adapted to meet any situation. Defining the location, type and likely impact of an emergency at the time of the incident helps clarify the type and level of response required. The Hospital Command Center (HCC) gathers data from various sources including departments (status reports), Emergency Department (incoming victims), Public Information Officer (news media reports), Liaison Officer (response agency intelligence) and will assess the likely scope and impact of the incident based on critical analysis of these reports.

Procedure

- A. Location of emergency and its impact on hospital response

Emergency Location	Definition	Hospital Response
Internal emergency	Emergencies within the hospital (fire, explosions, chemical spill, etc.)	Relocation of patients and staff from threatened or affected areas, as necessary. Confinement of situation to provide for prevention of injuries and for as little disruption of services as possible.
External emergency, within county	Community emergency, from minor (involving a relatively small number of casualties) to major (involving large number of casualties)	Expansion of treatment and patient areas to care for casualties and discharge of inpatients as possible. May require call in of hospital personnel for treatment of casualties. Send personnel and supplies upon request.
External emergency, outside county	Emergencies occurring in other communities	Expansion to receive casualties and inpatients transferred from stricken community. May require call in of hospital personnel for treatment of casualties. Send personnel and supplies upon request.

Emergency Location	Definition	Hospital Response
Emergency threats	To either the hospital or community (fire adjacent to hospital, bomb threats, civil disorders, etc.)	Precautionary evacuation either partial or total when indicated. "Alert" notification to staff and outside cooperating agencies.

B. Emergency Impact Assessment

1. Emergency impact assessment is an ongoing process for the HCC team, initially driven by the Incident Commander and Planning Chief. The HCC Team gathers facts about the emergency situation and response resources. The Planning Chief compiles scenario/resource projections from all Section Chiefs to effect long-range planning. The Planning Chief confirms facts collected and, following analysis, distributes critical information.

As part of its fact-finding and analysis, the HCC also considers the following factors to assess the impact of each emergency:

Type of Emergency

- Is this a known or suspected terrorist event?
- If yes, lock down facility and consider potential for secondary attack. Should security sweep be provided?
- Is this an emergency that requires relocation or evacuation?
- Is the emergency contained (limited to known number of casualties) or is impact unknown, or likely to be greater than what is currently known?
- What are the expected mid and longer-term repercussions of this emergency? (A fire in single location has different repercussions than radiological incident with potential for large numbers of casualties over time. A bioterrorism attack with the release of a biological agent may affect just a few people or hundreds.)
- Will anticipated response go beyond 24 hours?

Patients

- How many casualties are expected?
- What is the seriousness of injuries, illness or exposure?
- Will rapid discharge be required?

Engineering

- Will the emergency allow the hospital to carry on business as usual?
- Will additional acute care sites or field hospitals be required?
- To what extent and for how long will hospital resources be taxed beyond normal levels?
- What hospital resources are likely to be taxed beyond normal levels? (Emergency Department, surgical units, burn unit, respiratory therapy, dealing with hysterical illness, etc.)
- Are there impacts on Ambulatory Services sites and Acute Psych Services?

Personnel

- Will personnel beyond normal staffing levels be required?
- Is there a need to expand or change shift lengths?
- Will augmentation of personnel through volunteers or non-employees be required?
- Will personnel have injuries, illness, or exposures in the same proportion as the public?
- Will staff require education, such as with the release of a little known chemical or biological agent?
- What types and frequency of staff updates are needed?

2. The Incident Commander determines the appropriate emergency response level.

Based on its assessment of the likely impact of emergency on the hospital, the HCC team determines whether an emergency is Minor, Moderate or Catastrophic.

C. Color Code Emergency Response Classification

Kaweah Health also uses specific color codes to plan for and announce specific types of emergencies, such as fire (Code Red), bomb threat (Code Yellow), and child abduction (Code Purple).

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DM2112 Elevator Use During Emergency Situations

Policy Number: DM 2112	Date Created: 07/01/2011
Document Owner: Maribel Aguilar (Director of Physical Environment)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	
Elevator Use During Emergency Situations	

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

I. Policy

This procedure outlines the safe and appropriate use and securing of elevators at Kaweah Delta Health Care District herein referred to as Kaweah Health (KH) during emergency situations.

II. Procedure

- A. Emergencies affecting Kaweah Health Medical Center – no elevator use in affected building
 1. During situations such as fire, explosion, toxic cloud or earthquake that effect the hospital facility directly, elevators in the affected buildings must **not** be used by anyone until authorized to do so by the fire department and maintenance staff.
 - a. Structural damage from an earthquake, including aftershocks, fire or explosion may cause the elevator to cease functioning, causing entrapment, injury or death.
 - b. When a toxic cloud in the vicinity necessitates a Code Shelter-in-Place, the use of elevators may draw toxic air in from the outside.
 - 1) Once Maintenance can seal off the venting system at the top and bottom of the shaft, one elevator can then be operated for emergency use.
 - 2) An operator will be designated to run the single elevator and allow it to travel only one floor at a time, opening and closing at each floor to minimize the “piston effect” of the elevator in a closed system.
 2. In emergencies affecting the entire hospital facility (and during drills concerning these situations), Maintenance staff will bring the elevators down by manual operation (priority key) to the first floor and secure them.
 - a. When elevators are secured in *affected* areas, the Incident Commander may assign a Labor Pool designee to operate the elevators at each of the elevator banks in other *unaffected* areas.
 - b. Staff member assigned to elevator bank in unaffected buildings shall ensure priority use of elevators for patient flow and transport for duration of emergency.

B. Emergencies Not Affecting the Hospital Facility – Elevators May Be Used

1. If the hospital has not suffered damage or is not in danger of fire, i.e., an emergency occurring in the community not involving the hospital structure, elevators may be used.
2. Elevators should be used primarily for patient and supply transport during any emergency situation.

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DM2201 Code Triage- Activation Plan

Policy Number: DM 2201	Date Created: 03/14/2008
Document Owner: Maribel Aguilar (Director of Physical Environment)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	
Code Triage- Activation Plan	

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

I. Policy

In the event of an emergency incident that has the potential to overwhelm day-to-day operations, Kaweah Delta Health Care District herein after referred as Kaweah Health (KD) will activate the Emergency Operations Plan. The decision to activate the plan will be made by the Incident Commander CEO, Administrator on Duty (until the CEO arrives), or Nursing Supervisor (until the CEO or Administrator on Duty arrives). The decision to terminate shall be made by the Incident Commander in coordination with the authority having jurisdiction and other civil or military authorities involved. The Emergency Operations Plan is flexible and can be customized to the needs of an emergency per the Hospital Incident Command System (HICS) model. The Incident Commander has ultimate responsibility and authority for decision making during Emergency Operations Plan activation.

Emergencies affecting the hospital may be:

A. Internal – Any occurrence within the District such as fire, explosion, bomb threat, hazardous materials spill/release, etc., which significantly impact normal practices and procedures and/or which overwhelm available resources. This could include injured patients and/or employees, loss of critical systems or services needed for patient care that would require partial or complete evacuation. Also, a large external disaster could overtax District resources to the point that it also becomes an internal disaster.

B. External – A major fire, flood, earthquake, explosion, air or ground vehicular accidents, hazardous materials spill/release, or any other major emergency outside of District facilities that produces multiple victims requiring timely treatment of mass casualties.

II. Procedures

A. Determining Need for Emergency Operations Plan Activation

1. Upon direction of the Incident Commander, the PBX Operator notifies the HICS team via paging system “Code Triage, Alert” (3x).

- a. When an emergency or unusual event impacts the District, the primary leaders for the Hospital Command Center (HCC) report to the HCC for an early stage Code Triage.
- b. Staff who report to the HCC include those who fill the following key roles in the **HICS model**:

1. Incident Commander:
2. Safety/Security Officer
3. Liaison Officer
4. Public Information Officer (PIO)
5. Logistics Chief
6. Planning Chief
7. Operations Chief
8. Finance Chief
9. Facility Unit Leader

10. Medical Staff Director

2. The HICS team will analyze the situation and determine the level of response.

B. Code Triage – Emergency Operations Plan Activation

1. The Incident Commander authorizes the PBX Operator to announce the Code Triage and implements HICS to the extent required.

2. Hospital-Wide Announcement

- a. Incident Commander/Administrator On Call/Director On Call/CEO will determine if Code Triage needs to be activated.
- b. Approved list from (A.) will contact the PBX Operator x44 to make the overhead announcement: "Code Triage" (3x).
- c. Approved list from (A.) will contact the ISS Help Desk x2280 to activate the Cisco phone digital display (Berbee) on all district phones and to notify leadership staff via xMatters alert system.

Example of verbiage for Cisco Phone Display (Berbee): Code Triage: ED still experiencing high volumes. Inpatient and Mental Health also with high volumes. Capacity is improved, will continue to work to move patients. Possible staffing needs tonight. More information to follow.

Example of verbiage for xMatters: Code Triage: ED still experiencing high volumes. Inpatient and Mental Health also with high volumes. Capacity is improved, will continue to work to move patients. Possible staffing needs tonight. More information to follow.

C. Response Procedure

See attached Plan Activation Checklist and flowchart (Appendix B & C).

D. Functional Areas

See attached table, "Functional Areas during Activation of the Emergency Operations Plan." (Appendix D)

E. Emergency Supplies, Disaster Kits and MOUs

Kaweah Health will maintain a minimum stockpile of emergency supplies and ensure immediate access to critical materials including pharmaceuticals, medical supplies, food, linen, industrial and potable (drinking) waters as needed. The hospital will maintain Memos of Understanding (MOUs) with vendors to receive priority shipment of critical supplies in the event of an emergency.

See attached table, "Emergency Supplies." (Appendix E)

F. Termination of Code Triage

1. The decision to terminate the Code Triage will be made by the Incident Commander, in coordination with the authority having jurisdiction and other involved civil or military authorities.
2. When the Code Triage is terminated, the Incident Commander notifies the PBX Operator, who makes the overhead announcement, "Code Triage, All Clear" (3x).

Note: See Appendix for form:

Department Emergency Status Report

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CODE TRIAGE – PLAN ACTIVATION

INCIDENT COMMANDER CHECK LIST- House Supervisor, AOC or Designee

- ☐ Establish HCC.(Temp at MSC Auditorium or as specified by IC)
 - ☐ Assess situation and activate HICS to the extent necessary to manage the incident.
 - ☐ Direct PBX Operator for all overhead emergency announcements.
 - ☐ Brief managers and medical staff on anticipated impact and update them on the event's status.
 - ☐ Provide leadership for HICS Command Team (see Incident Commander Job Action Sheet).
 - ☐ Determine when the incident has been stabilized to the point where normal hospital operations may be resumed and deactivate HICS. Authorize PBX Operator to announce "All Clear."
 - ☐ Conduct an incident debriefing as soon as possible following the deactivation of Code Triage.
- Note:** The Incident Commander has ultimate responsibility and authority for decision-making during Emergency Operations Plan activation.

PBX OPERATOR / HELP DESK ANALYST CHECKLIST

- ☐ As directed by Incident Commander/Administrator On Call/Director On Call/CEO. PBX Operator implements "Code Triage, Alert" to summon key HICS staff to the HCC.
- ☐ PBX Operator announces: "Code Triage" (3x)
- ☐ Help Desk will send Cisco phone message (Berbee) to all digital hospital phones.
- ☐ Help Desk will send xMatters to all Leadership staff.
- ☐ Help Desk will send xMatters to all staff, if requested by Incident Commander/Administrator On Call/Director On Call/CEO.

DEPARTMENT MANAGERS CHECKLIST

- ☐ Implement hospital and department disaster-specific plan.
 - ☐ Inventory personnel, supplies, equipment, victims and injuries on your *Emergency/Disaster Status Report* and send to HCC via runner.
 - ☐ Report all needs and concerns via HICS Chain-of-Command.
- At Code Triage:
- ☐ Complete Department Status Form and fax to Incident Command Center #713-2332.
 - ☐ Send surplus staff to Labor Pool.
 - ☐ Activate staff call backlists to summon off-duty staff if requested.
 - ☐ Report to Incident Command Center for assignment.
 - ☐ Update HCC on department status as needed or requested. Stand by for further instructions from HCC.
 - ☐ Participate in incident debriefing as requested.

STAFF RESPONSE CHECKLIST

If Off-Duty:

- ☐ Secure home and family (and pets), then
- ☐ If you have a pre-assigned emergency duty through HICS, report for work automatically and do not wait for contact from Kaweah Health.
- ☐ If you do not have a pre-assigned emergency duty, stay tuned to television news broadcasts or the following radio stations: KMJ 580.
- ☐ Be prepared to report for an emergency assignment.
- ☐ If the broadcast message indicates, or if you do not hear a broadcast message within two hours after a major event, call the Employee Emergency Phone Line: 559-624-2008 .
- ☐ The message will specify where and when to report.
- ☐ Leave a message on the phone line giving your status and the time you will be able to arrive at the assigned work location.
- ☐ If summoned, wear ID badge and bring appropriate license.

If On-Duty:

- ☐ ~~Follow instructions in the Emergency Management Manual.~~
- ☐ All unassigned or available hospital staff must report to the Labor Pool.
- ☐ Remain at hospital and perform duties as assigned. Wear your ID badge at all times.
- ☐ If you are evacuated from a building, check in at your assigned Evacuation Assembly Area.

EMERGENCY DEPARTMENT CHECKLIST

- ☐ The ED Team Leader will report all incident-related messages from StatusNet Communications system or EMS Agency Duty Officer to the Incident Commander at HCC.
- ☐ When the emergency incident/disaster involves the potential for large numbers of victims arriving to the ED, the Operations Chief will appoint a HICS Medical Care Director/Treatment Areas Supervisor to direct the activation, emergency operations and assignment of HICS Unit Leaders for functional treatment areas required during activation of the Emergency Operations Plan. The HICS Unit Leader positions will be assigned on the basis of staff availability and experience.
- ☐ Call Central Logistic to request the ED Disaster Carts.
- ☐ ED Team Leader to refer to ED specific "Disaster Cheat Sheet" for more detailed actions.
- ☐ Directions for activation (HICS Job Action Sheets) of treatment areas will be distributed to the HICS Unit Leaders by the HICS Medical Care Director/Treatment Areas Supervisor.
- ☐ Supplies for the Triage and Treatment areas are located in the ED supply room and in pre-positioned MCI Supply trailers. ED Charge Nurse/Nursing Shift Supervisor has keys.
- ☐ Treatment Areas Unit Leaders communicate staff overload issues during a Code Triage to the Treatment Areas Supervisor, who will discuss with the Medical Care Director/Operations Chief.

ALL CLEAR

At the conclusion of a disaster, the Incident Commander will notify the PBX Operator to overhead page, "Code Triage, All Clear" (3x) and notify other medical facilities and government agencies as appropriate. Return to your normal work duties, unless otherwise directed.

Note: Following the emergency incident, the Department Manager(s) of the affected area(s) shall fax an *Emergency Occurrence/Drill Critique* to the Safety Office within 24 hours: 559-713-2204.

Functional Areas during Activation of the Emergency Management Plan

Appendix D

Functional Area	Location		Essential Activity	Responsible Person
	Primary	Secondary		
Clinical Admitting	Admitting	TBD	Complete admission paperwork and locate bed assignment	Bed Control in collaboration with the Nursing Unit Leader
Decontamination Area	Emergency Department Decon Shower	N/A	For chemical and radioactive decontamination	Decon Unit Leader
Delayed Treatment Area			Care of dying and those who may be treated when time and staff permit	Delayed Treatment Unit Leader
Dependent Care Area	Kaweah Kids		Care for staff dependents who have no alternative care arrangements	Dependent Care Unit Leader
Discharged Patients Holding Area	Acequia Wing Lobby		Hold discharged patients until transportation is available	Discharge Unit Leader
Employee/ Physician Entrance	Admin Entrance	Lobby Entrance	Controlled access to hospital	Medical Staff Labor Pool and Labor Pool Unit Leaders
Holding Area for Patients Waiting to be Admitted	Main Lobby		Waiting area for patients awaiting inpatient beds	Immediate Treatment Unit Leader
Hospital Command Center (HCC) (GSH)	MSC Auditorium	Admin Conf Room	Command area	Incident Commander
Satellite HCC at West Campus	Rehab Charting Room		Command area	West Campus Incident Commander
Satellite HCC at South Campus	Subacute Station A			South Campus Incident Commander
Immediate Treatment Area	Emergency Department		Treatment of critical and serious patients	Immediate Treatment Unit Leader
Labor Pool – Main Campus	Cafeteria	MCS Auditorium	Organize and assign personnel	Labor Pool Unit Leader
Labor Pool – South Campus	Cafeteria	TBD	Organize and assign personnel	Labor Pool Unit Leader
Labor Pool – West Campus	Rehab Cafeteria	TBD	Organize and assign personnel	Labor Pool Unit Leader

Functional Area	Location		Essential Activity	Responsible Person
	Primary	Secondary		
Logistics Command Post	Blue Room	Maintenance Upstairs	Manage the provision of material/supply resources, nutritional resources and the safe environment	Logistics Chief
Media Area	Acequia Wing Lobby	SSB Emerald Room	Provide information to news media, coordinate all internal and external communication	Public Information Officer
Medical Staff Pool	Medical Staff Offices		Organize and assign medical staff	Medical Staff Unit Leader
Minor Treatment Area and Non-emergent First Aid	Emergency Dept Zone 6		Walking wounded and stable patients treated	Minor Treatment Unit Leader
Morgue	Morgue	Medical Waste Storage Area	Deceased victims	Morgue Unit Leader
Operations Command Post	MSC Auditorium		Manage the medical mission of the hospital, including all nursing units and supportive and ancillary units	Operations Chief
Patient Information Area	Surgery Center Waiting Room		Victims' families receive information	Patient Information Officer
Relative Waiting Area	Surgery Center Waiting Room		Victims' families receive information	Patient Information Officer
Security Command Post	Security Offices	VP Operations' Office	Monitor security cameras, assign Security Officers, answer calls	Safety/Security Officer
Staff Rest/ Nutrition Area	4th Floor Conference Room	Cafeteria	Provision of a staff rest area, food and drink, information updates and psychological support	Staff Support Unit Leader
Triage Area	Outside Emergency Department		Patients triaged	Triage Unit Leader
Visitor/Relative's Entrance	AW Lobby Entrance	Main Entrance	Controlled access to hospital	Safety & Security Officer

Code Triage- Activation Plan			
1.	Communication equipment: • 800 MHz handheld radios • Emergency Cell phones • Laptops, Cellular Hot Spots	PBX / ISS	
2.	Decontamination Equipment, including • Personal protective equipment (PPE) • Plastic tarps, tents, frames • Shower curtains • Privacy screens • Showers • Liquid soaps and towelettes • Water supply • Fan • Trash/laundry receptacles and bags	t Emergency Trailer located in Physician Lot and Decontamination shower outside of Emergency Department	N/A
3.	Decontamination Unit (Portable)	Emergency Trailer	N/A
4.	Disaster Kits (recommended supplies) • Heavy work gloves • Crowbar • Flashlight and batteries • Waterless soap • Duct tape • Blue tape (for sealing windows) • Super Bar (to open jammed doors or cabinets, etc.)	Onsite Maintenance	N/A
5.	Evacuation Equipment • Stryker Evac Chairs • Evacusleds	Mineral King Floors 3 rd and 4 th floor. Mineral King Wing beds	N/A
6.	Evacuation Maps	Onsite	N/A
7.	First Aid Supplies	Onsite	N/A
8.	Food Supplies	Kitchen/Creekside	N/A
9.	HICS vests	Hospital Command Center (HCC)	N/A
10.	Lighting • Portable emergency lighting • Extension cords • Flashlights	Plant Operations Emergency Trailer Departments	N/A
11.	Linen	Laundry	MOU
	• 1 Box 20 gauge IV Catheters • 1 Box 18 gauge IV Catheters • 1 Box 16 gauge IV Catheters • 10 boxes Exam Gloves small • 10 boxes Exam Gloves medium • 10 boxes Exam Gloves large • 2 boxes Exam Gloves extra large	Units	
12.	Pharmaceuticals • Standard emergency medications • Other specific drugs as indicated by the incident	Contact Pharmacy Director or Emergency Management Coordinator for	N/A

14.	Incident Command Cart	Hospital Command Center (HCC)	N/A
	Code Triage- Activation Plan		8
		location of cache.	
15.	Medical Supply Disaster Carts: Water (potable). Supplemental in-tank and bottled water (24 oz bottles) 5 Adult Ambu-Bags (Bag-Valve Mask Device) 5 Pediatric Ambu-Bags (Bag-Valve Mask Device) 5 Anesthesia Bags (To provide ventilation to an infant or newborn) 10 Pediatric O2 Masks 10 Adult Non-Rebreather O2 Masks 20 Hand Held Nebulizers (for breathing treatments). Possibly stocked in Respiratory. 2 Box disposable tongue depressors. 2 IV Pumps 20 Secondary IV Set (To hang IV Piggybacks) 5 boxes alcohol preps 5 Yankauer Suction Catheters 5 Suction catheters 8 French 5 Suction catheters 10 French 5 Suction catheters 14 French 5 Suction catheters 18 French 5 Suction Connection Tubings 5 Suction Canisters 5 Stethoscopes 5 Manual BP Cuffs Adult Size (Not the disposable cuffs that are designed for use on a machine) 5 Manual BP Cuffs Pediatric Size 40 bags IV Normal Saline 1000 mL 10 bags IV Normal Saline 250 mL 10 bags IV D5W/0.25% Normal Saline 1 Box 24 gauge IV Catheters 1 Box 22 gauge IV Catheters	Central Logistics – the three Disaster Carts would be delivered to the ED	In Progress

DM2203 Code Gray- Activation Plan

Policy Number: DM 2203	Date Created: 07/01/2011
Document Owner: Maribel Aguilar (Director of Physical Environment)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	
Code Gray- Activation Plan	

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

POLICY

Code Gray is designed to show a coordinated team response to protect our employees and others from any potential aggressor. The hospital has “zero tolerance” for violence.

In situations where hospital staff, physicians, or visitors are not comfortable due to persons becoming aggressive, abusive, or threatening in any manner, a CODE GRAY may be called. This will initiate help, first from any personnel in the immediate area, and secondly from a follow-up team as described below. The intent of declaring a CODE GRAY will be to immediately have additional personnel show up, not necessarily to intervene directly, but to demonstrate a presence of other people in the area. The person calling the CODE GRAY will have the opportunity to request additional help or to dismiss staff responding.

Extremely violent situations will require a different approach. This area should be considered OFF LIMITS by initiating a Code Silver (See Policy #2204 Code Silver). Calling additional staff members to the scene puts additional people at risk. Calling an area OFF LIMITS will signal a STAT page to security and the Nursing Supervisor. The Visalia Police Department would be notified immediately when any person reports that an individual is threatening violence with a weapon.

Procedure

A. Response

See attached checklist and flowchart.

B. Supporting Information

1. Combative or abusive behavior can be displayed by anyone; a patient, a patient’s family member, staff, staff family members, or acquaintances of employees and patients. Combative or abusive behavior can escalate into a more violent episode. A comprehensive workplace violence prevention policy should include procedures and responsibilities to be taken in the event of a violent incident in the workplace.
2. Recognize early warning signs. The following are examples of warning signs but are not all inclusive.
 - a. Direct or verbal threats of harm.

- b. Intimidation of others by words and or actions.
- c. Refusing to follow policies.
- d. Hypersensitivity or extreme suspiciousness.
- e. Extreme moral righteousness.
- f. Inability to take criticism of job performance.
- g. Holding a grudge, especially against supervisor.
- h. Often verbalizing hope for something to happen to the other person against whom the individual has the grudge.
- i. Expression of extreme desperation over recent problems.
- j. Intentional disregard for the safety of others.
- k. Destruction of property.

Emergency Management Manual

CODE GRAY – ABUSIVE/ASSAULTIVE BEHAVIOR

Purpose: To provide a safe and secure healthcare environment for patients, visitors, volunteers, physicians and employees. Also, to assist employees in managing and/or de-escalating the situation by a show of support, to gain the cooperation of the abusive or assaultive person, or to subdue and restrain the individual if necessary.

Note: If the situation involves a weapon, immediately notify PBX of “Code Silver and location.”

The Hospital Incident Command System (HICS) is not activated for a Code Gray unless the incident disrupts day-to-day hospital operations.

STAFF RESPONSE CHECKLIST

In the event a situation with an angry, belligerent or threatening person has escalated or has the potential to escalate; or, in the event of imminent danger where there is a potential for a violent or criminal act to occur; or, when a violent or criminal act is in progress:

- ☐ Dial the District operator at Ext. 44. Provide the operator with the following:
- ☐ Where you are and where the incident is occurring
- ☐ Description and number of person(s) involved. Do not hang up until the operator has all your information.

Verbal Abuse:

- ☐ Use a calm voice and attempt to verbally de-escalate the situation.
- ☐ If verbal abuse continues, call a second person to assist you.
- ☐ Move patients away from the hostile person, if safe to do so.
- ☐ Step back from person and try to get a barrier between you and the person.
- ☐ Direct others away from the area.

Physical Battery:

- ☐ Protect yourself and others from blows, attempt to get away from the person/area and defend yourself as necessary for personal safety.
- ☐ Put distance and/or barrier between the parties involved – only when safe to do so. Do not attempt to confront the person(s).
- ☐ Remove patients, staff and visitors from the immediate area. Remain calm and reassure those around you.
- ☐ Provide assistance and medical help for all injured persons when safe to do so.

Documentation to Complete:

- ☐ Per normal procedures, if employee is injured:
- ☐ Employee completes Incident Report and submits to supervisor, who completes, signs and forwards report to Risk Management

If you hear a “Code Gray” announcement:

- ☐ Trained available personnel respond to the Code and take direction from Nursing Supervisor, charge staff or Security Officer.
- ☐ Stand by for further instructions.
- ☐ Provide assistance as requested.

If you are at an off campus site: In the event a situation has escalated and a violent or criminal act occurs call 911.

PBX CHECKLIST

- ☐ When notified of a violent or potentially violent situation, immediately overhead page "Code Gray and location" (2x).
- ☐ Notify Security via radio.

CHECKLIST-SOUTH CAMPUS

When notified of a violent or potentially violent situation, immediately overhead page to South Campus "Code Gray and location" (2x).

Send out a Berbee page and Berbee message to South Campus.

Notify Security via radio.

Notify Nursing Supervisor. (And notify police if instructed to do so by Nursing Supervisor by dialing 911.)

SECURITY CHECKLIST**Upon notification of the potential for or actual occurrence of a violent or criminal act:**

Dispatch Security personnel to the location as appropriate.

☐ When responding to the scene and approach with caution. When using force, Security will use only the minimum amount of physical force necessary to restrain or protect the individual from self-injury and/or from injuring others.

If situation has potential to disrupt hospital operations:

☐ Notify Nursing Supervisor.

☐ Direct PBX to announce by overhead page "Code Gray, location."

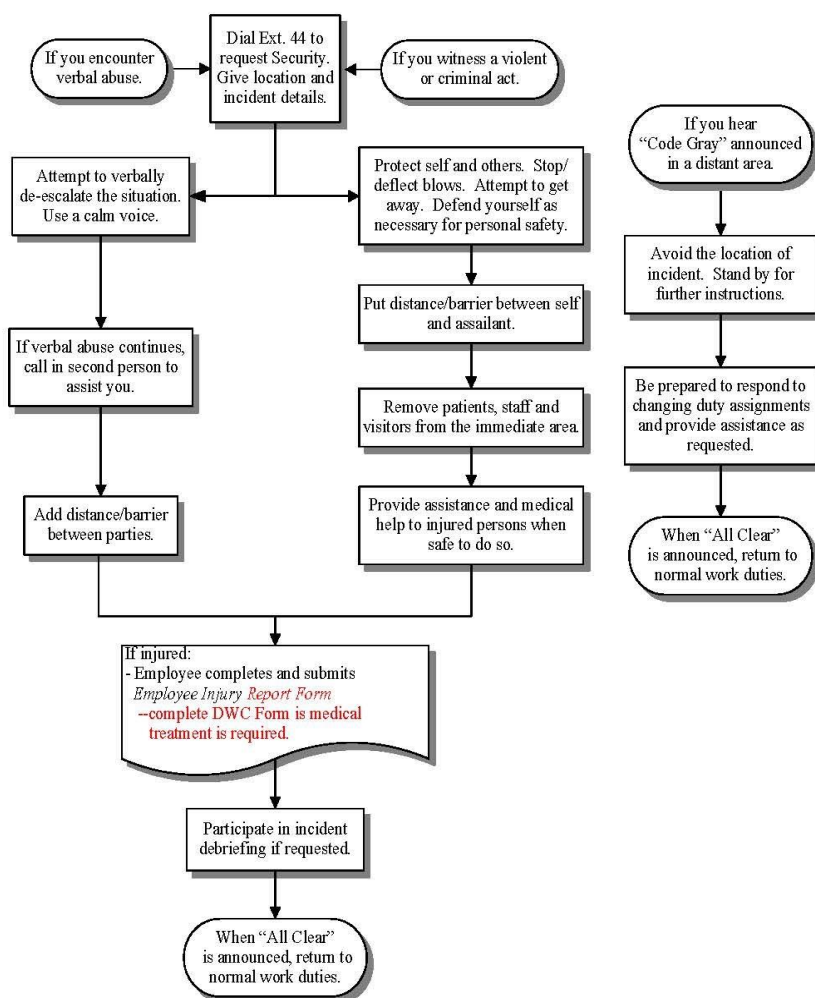
☐ Monitor and coordinate incident per department procedures. Control crowds and provide direction at the scene.

☐ Request help from the police department if necessary or call in extra Security staff for long-term incidents.

☐ If warranted, the Security Officer will file an Incident Report. Officers will determine if a report should be filed with law enforcement.



**Emergency Management Manual
Code Gray - Abusive/Assaultive Behavior**



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DM 2207 Code Red- Activation Plan

Policy Number: DM2107	Date Created: 07/01/2011
Document Owner: Maribel Aguilar (Director of Physical Environment)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	
Media Plan	

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

Policy

During a major emergency or disaster, the Kaweah Health (KH) may need to communicate with employees and physicians who are not on campus at the time of an emergency regarding emergency staffing requirements or other staff instructions. The media may provide an efficient and effective means of communication between Kaweah Delta Health Care District herein referred to as Kaweah Health (KH) and off-campus employees.

In order to fulfill its obligation to inform the general public about the scope of the emergency, the media will seek casualty and other disaster-related information from the hospital. KH will cooperate with this community mission to the best of its ability in a manner that will not interfere with patient care or hospital operations.

The Public Information Officer (PIO) is responsible for coordination and release of appropriate and relevant information to the media during an emergency incident or disaster.

II. Procedure

A. Media Releases

The PIO, working as an integral component of the KH Hospital Incident Command System (HICS) Team, will obtain approval from the Incident Commander for media releases during an emergency incident or disaster.

B. Media Relations

The PIO will serve as principal liaison with individual members of the media and will direct media representatives to the designated Media Area, which may be located in the Support Services Building. The PIO will confirm that media representatives have appropriate access to hospital facilities in a manner that will not interfere with patient care or hospital operations as follows:

1. News media persons will be taken to the designated Media Area during activation of the Emergency Management Plan.
2. Media personnel WILL NOT be allowed in Intensive Care, Emergency Department (ED), Operating Room (OR), Morgue Area, Decontamination Areas, any Triage site or the Hospital Command Center (HCC) under any circumstances.
3. Security officers will be assigned to keep the media away from unauthorized areas, as needed.

C. Employee Communications

The PIO will coordinate and assist in preparation of written communication releases to on-duty staff with the Support Branch Director.

The PIO will work directly with news outlets to provide status information to physicians and employees on such issues as contingent staffing needs.

1. Staffing Requests to Off-Campus Employees – The PIO will coordinate with the Labor Pool and Credentialing Unit Leader the release of staffing requests for KH employees off-campus by providing announcements to designated broadcasters for dissemination.
2. On-Campus Employees – The PIO will coordinate with the Situation Unit Leader for dissemination of incident-related information to KH employees on campus.

D. Casualty Interviews

Interviews with casualties admitted to the hospital may be granted only by the Incident Commander following consultation with the attending physician. Any interview may be terminated at the discretion of the physician attending the patient.

E. Media Lists

Media lists, kept current by KH's Marketing Department, will be maintained as Attachments to the PIO Job Action Sheet.

F. Communications Group

The PIO will work with the following HICS positions to coordinate information collection and release: PIO, Situation Unit Leader, Patient Tracking Manager and Support Branch Director.

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DM2209 Code Shelter-in-Place

Policy Number: DM 2209	Date Created: 07/01/2011
Document Owner: Maribel Aguilar (Director of Physical Environment)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	
Code Shelter-In-Place	

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

I. Policy

Upon notification of a potentially hazardous airborne chemical/radiation cloud, smoke or other pollutants in the atmosphere surrounding a facility in the Kaweah Delta Health Care District herein referred to as Kaweah Health (KH), will activate its Toxic Cloud (Code Shelter-in-Place) procedure to protect the health of patients, employees and visitors.

“Shelter-in-Place” is a nationally accepted emergency code indicating the need to stay inside of a shelter or facility during periods of potential exposure to airborne hazards. County Communications may divert ambulance traffic to other facilities during a Shelter-in-Place incident.

II. Procedure

A. Plan Activation

Authority for activation of the Shelter-in-Place rests with Administration/Administrator On Duty/Nursing Supervisor following an alert from Tulare County Communications, as received in the Emergency Department via the ER communications system.

The Emergency Department staff receiving the alert will notify Emergency Department Manager or, after hours, the Nursing Supervisor who will then notify Administration. Administration will direct PBX to overhead page “Code Shelter-in-Place.”

If the incident has potential to overwhelm normal hospital operations, Code Triage will also be activated. The Incident Commander will assume responsibility for emergency operations.

B. Notification of Staff

1. Activation – When advised to do so by the Incident Commander, PBX announces “Code Shelter-in-Place” (2x) and contacts the ISS Help Desk to activate xMatters messaging system, CISCO phone display messaging..
2. Termination – When the incident is over, only the Incident Commander has the authority to terminate the Code Shelter-in-Place, and direct PBX to announce “Code Shelter-in-Place, All Clear” via overhead page, xMatters messaging system. Areas not served by overhead page will be notified by a pre-established telephone tree initiated by PBX.

C. Code Shelter-in-Place Response

Please see attached Shelter in Place checklist and flowchart for detailed response guidelines.

CODE SHELTER-IN-PLACE

Purpose: To protect the health of all occupants within the facility in the event of potentially hazardous atmospheric contamination from chemicals, smoke, radiation or other pollutants.

Background:

- ☐ “Shelter-in-Place” is a nationally accepted term indicating the need to stay inside of a shelter or facility during periods of potential exposure to an airborne chemical, smoke, radiation or other contaminants. It is a process of “sheltering” individuals from these hazards by using prearranged measures including, but not limited to, entrance and exit limitations, securing outside air sources, communicating the danger of its occupants, and at the same time trying to maintain a normal business function. Upon notification from County Communications, EMS and/or the fire department, the Incident Commander will have PBX page “Code Shelter-in-Place” (2x). All outside persons wishing to enter the facility will be directed to the Main entrance. Engineering and Security will help secure the building.
- ☐ County Communications may divert ambulance traffic during a Shelter-in-Place incident.

INCIDENT COMMANDER CHECKLIST

- ☐ Notify, even if off-site, the Administrator on Call, Emergency Management Coordinator, and Public Information Officer.
- ☐ Notify PBX and request that they call Security and the Engineer On Duty.
- ☐ Order a facility lock down.
- ☐ Notify PBX, when appropriate, to request overhead page of “Code Shelter-in-Place.”
- ☐ Document all communications.

STAFF RESPONSE CHECKLIST

Upon hearing Code Shelter-in-Place:

- ☐ Stay inside and notify visitors to also remain inside the hospital.
- ☐ Ensure all external windows and doors are closed and locked until the “All Clear” is announced.
- ☐ Use plastic sheeting and blue tape to seal any doors and windows with obvious air leaks.
- ☐ Discontinue using any devices that require an exhaust hood, and/or the replenishment of air from outside the hospital (i.e., lab or pharmacy equipment, dietary gas ovens and cook tops).
- ☐ Provide assistance as requested.
- ☐ County Communications will divert ambulance traffic during a Shelter-in-Place incident.

PBX CHECKLIST

- ☐ Upon direction from the Incident Commander, announce “Code Shelter-in-Place” (2x).
- ☐ Contact ISS Help Desk to send out Berbee message to all phones “Code Shelter in Place”
- ☐ Contact ISS Help Desk to send out an xMatters message to all employees “Code Shelter in Place”
- ☐ Upon direction from the Incident Commander, announce “Code Shelter-in-Place, All Clear” (2x).

EMERGENCY MANAGEMENT COORDINATOR CHECKLIST

- ☐ Assist the Incident Commander in managing the incident.
- ☐ Request status on toxic cloud from County Communications.
- ☐ Direct and inform staff based on information received from agencies managing the incident (FD, HazMat).

ENGINEERING CHECKLIST

Upon hearing the page, “Code Shelter-in-Place,” Engineering will:

- ☐ Shut Down HVAC
- ☐ Bring elevator down by manual operation to the first floor and secure them.
- ☐ Lock down the Central Plant (doors are supposed to be locked at all times).

- ☐ Lock Down Facility
- ☐ Proceed to perform the Facility Lock Down.
 - ☐ Ensure all external windows and doors are closed (to minimize any outside air seeping into the hospital).
 - ☐ Notify Security Officer via mobile radio that the lock down has been completed.
 - ☐ Update the HCC when each of the preceding procedures has been completed.

If Main entrance is to be used, set up fans between the sets of double doors to blow air outside.

SECURITY CHECKLIST

Upon hearing the page, "Code Shelter-in-Place," Security will:

- ☐ Post signs on exterior doors directing people to authorized main entrance.
- ☐ Assist with crowd control.
- ☐ Post a monitor from the Labor Pool to redirect exiting people to remain in the Lobby until "All Clear" is announced.
- ☐ Immediately lock all entrances and the cafeteria patio door.
- ☐ Confirm that the ED and other entrances are locked. If not locked, proceed with "Facility Lock Down."
- ☐ Ensure the ED Ambulance door is in locked position.
- ☐ Notify Engineer on duty via radio that Facility Lock Down has been completed.
- ☐ Notify Director of Plant Operations and Security supervisor.
- ☐ Limit foot traffic into and out of the facility by alerting and discouraging anyone from leaving the facility during the Shelter-in-Place and funneling patients into a pre-assigned location/entrance thus keeping the outside air from entering the facility.
- ☐ Maintain radio contact with the HCC, ED, PBX and Engineering.
- ☐ Do not leave post unless instructed to do so by the Incident Commander, Director of Plant Operations or by the Security supervisor.

EMERGENCY DEPARTMENT STAFF CHECKLIST

Upon hearing the page, "Code Shelter-in-Place," Emergency Department Team Lead or designee will:

- ☐ Act as the communications liaison between the County and the ED Leadership or the Nursing Supervisor and the HCC.
- ☐ Notify the ED Director or the Nursing Supervisor of the alert, giving known details of the type and extent of the crisis.
- ☐ Notify visitors in the waiting room of the alert and explain that the doors will remain closed until after the "All Clear."
- ☐ Communicate regularly with the HCC.
- ☐ Notify the HCC of any updates from government agencies.
- ☐ Document all communications.

ALL CLEAR

When "Code Shelter-in-Place, All Clear" is announced, return to your normal work duties unless otherwise directed.

- ☐ When the danger has passed, Engineering will turn on supply fans first to pressurize building with filtered air and then turn on exhaust fans.
- ☐ Security will open doors, remove signs, and assist with crowd control.

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DM2216 Water Systems Failure/Disruption

Policy Number: DM 2216	Date Created: 07/01/2011
Document Owner: Maribel Aguilar (Director of Physical Environment)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	
Water Systems Failure/Disruption	

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

I. Policy

In the event of a water systems failure, Kaweah Delta Health Care District (KDHCD) herein after referred to as Kaweah Health (KH) will activate its Water Systems Failure/Disruption procedure. There is built-in redundancy.

II. Procedure

- A. The following equipment may be disrupted due to a water systems failure in the affected building:

Equipment	Disrupted
Air Conditioning and Heating	✓
Dialysis	✓
Diesel Generators	—
Dietary Dishwasher	✓
Food & Nutrition Services Steam Operated Equipment	✓
Fire Sprinklers	✓
Laundry Equipment	✓
Hand Washing (sinks)	✓
Linear Accelerator/CT/MRI	✓
Medical Air	—
Medical Vacuum	—
Other High-Tech Heat-Generating Equipment	✓
Radiology Film Developer	—
Sanitary Waste Disposal	✓
Some Refrigerators/Freezers	✓
Steam Sterilizers	✓

Toilets	✓
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✓ = probable equipment disruption
 — = not applicable

- B. In the event that the water service is interrupted for reasons other than a shut down for repairs, the following steps will be taken.

The Maintenance Department will immediately be notified. Each department will be notified to limit the use of water.

CALL: CALIFORNIA WATER SERVICE

559-624-1600

Ask for an estimate of the time that service will be interrupted.

C. IF WATER IS CUT OFF TO THE HOSPITAL:

1. Pressure will drop until water is exhausted.
2. Boilers will be turned off. There will be no heat or sterilization.
3. Food Services will utilize single service dishes and utensils instead of china. Meal preparation will be adjusted to utilize cold food preparation techniques.
4. Laundry Department will implement downtime procedure (Send all Soiled Linen to Mission Linen – Fresno Plant)
5. Hemodialysis will be terminated due to no water.

- D. During a water outage everyone should take precautions to conserve as much as possible. Patient baths, toilet flushing, and washing procedures should be kept to a minimum.

Maintenance is responsible for the distribution of emergency water supplies. Food services will distribute water for hydration via patient meal trays.

III. Emergency Water Supplies:

Main Campus:

In the event of an emergency, water supplies would be needed for approximately 1,000 people for 96 hours. One gallon per person per day totals 4,000 gallons.

Potable water contained in hot water tanks:

3,000 gallon tank located in Mineral King Wing building
 5,000 gallon tank located in Mineral King building serving ED Zone 5
 4,000 gallons tank located in two 2,000 gallon tanks in Acequia Wing building
 6537 gallons of water for hydration and rehydration of Meals For All.

Total: 18,537gallons potable water available at main campus.

In addition, there are 5 pallets of bottled water located at the downtown campus. There is a total of 1,673 gallons of bottled water available for all campuses.

South Campus:

In the event of an emergency, water supplies would be needed for approximately 200 people for 96 hours. One gallon per person per day would total 800 gallons.

55 gallons of water in kitchen ice machines

65 gallons of water in hot water tank outside kitchen

1,000 gallons of water in hot water tank

112 gallons of water from bottled water

Total: 1,232 gallons of potable water available at South Campus

West Campus

In the event of an emergency, water supplies would be needed for approximately 300 people for 96 hours. One gallon per person per day would total 1,200 gallons of water.

650 gallons of water in the Rehab hot water tank

600 gallons of water in the Lifestyles hot water tank

440 gallons of water in the Mental Health hot water tank

150 gallons of water in the SRCC hot water tank

600 gallons of water in the Dialysis hot water tank

44 gallons of water in kitchen ice machines

80 gallons of water in bottles available & kept in storage

Total: 2,564 gallons of potable water available at West Campus

In case of a county disaster that disrupts the Kaweah Health water system, the Tulare County Office of Emergency Planning will be handling certain aspects of supplying services and can be called upon for service. (559-686-3461)

OTHER SOURCES OF WATER AND TRANSPORTATION OF WATER IN CASES OF EMERGENCY ARE:

Kraft Foods-Tulare (Knudsen Dairy)	559-685-0790
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California National Guard	559-733-3062
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Major-Sysco	1-800-877-4194
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Pepsi-Cola	1-800-932-0966
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	559-485-5050
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Alhambra -Sierra Springs	1-800-453-0293
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Culligan / Lindsay-office	559-562-6361
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Culligan Personnel to contact:

Cary Miller	559-359-8650
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Alex Blackwell	559-361-3686
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Sepp Becker	559-359-5320
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Nancy Becker	559-359-3287
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Emergency Management Manual

WATER SYSTEMS FAILURE/DISRUPTION

Purpose: In the event of a partial or total disruption of the water supply, the hospital will provide specific procedures for staff to follow.

Note: A large-scale incident may develop into a Code Triage.

STAFF RESPONSE CHECKLIST

- ☐ Notify Maintenance by calling PBX at Ext. 44.
- ☐ **Immediately cease use of water** and check with Department Manager or designee for department procedures.
- ☐ To wash hands, use hand gel sanitizer. Soap and water should be used as sparingly as needed if hands are visibly soiled. .
- ☐ To use “dry toilets” tape a red plastic bag over the 2 red bags already taped to the toilet. Remove the single bag after use, tie the bag, and dispose in a covered large, double-lined, leak-proof container.
- ☐ Steam and water required sterilization devices will not function. Use alternate cold sterilizing methods.

If given advance notice, take the following steps:

- ☐ Fill all available sinks, basins, etc., with water.
- ☐ Have patients bathed prior to shut down.
- ☐ Obtain waterless hand washing product from storeroom for hand washing. (Should be on all units.)
- ☐ In surgery and Emergency Department (ED), obtain bottled water for surgical scrubs.
- ☐ Line toilets with red bags.
- ☐ Maintenance to obtain water tanker for on site.
- ☐ Ensure public toilets are closed.

DEPARTMENT CHECKLIST

Implement Water Systems Failure/Disruption procedures in the department.

- ☐ Establish adequate inventory of hand gel sanitizer in department. Direct that the use of bathing facilities be immediately discontinued.
- ☐ Obtain water supply for hand hygiene when sanitizer is not appropriate.
- ☐ If loss of services is for an extended period of time, as determined by the Incident Commander, consider dismissal of non-patient-related employees.
- ☐ Have employees report to Labor Pool for assistance in patient care areas if needed.
- ☐ Do not dispose of any waste in drains during utility failure until service has been restored.
- ☐ Identify procedures which require water that can be delayed or canceled.
- ☐ Assess and report department status to the Incident Commander on the *Emergency/Disaster Status Report* regarding the following items:
- ☐ Calculate the amount of water needed by determining the number of patients and staff on duty in the department. (A minimum of 1 gallon of water per person per 24-hour period is needed.)
- ☐ Determine other patient fluid requirements or special department needs for the next 24 hours.
- ☐ Inventory available potable water and non-potable water in the department (i.e., potable drinking water, canned drinks, IV fluids, distilled water, non-potable water in tubs, mop buckets, etc.).
- ☐ Identify critical areas of impact within the department. (Refer to the grid on page 1 of this policy.)

ENVIRONMENTAL SERVICES CHECKLIST

- ☐ Ensure that water for cleaning is restricted to whatever non-potable water is available.
- ☐ Determine the number and location of “dry toilets” and which toilets may be locked (in consultation with Maintenance).
- ☐ Check germicidal wipe availability in patient care areas.
- ☐ Restrict use of toilets and sinks and post “Do Not Use” signs.
- ☐ Provide red plastic bags and large double-lined leak-proof containers to designated bathrooms that remain in use.
- ☐ Assist in waste collection.
- ☐ Make necessary cleaning adjustments to conserve water use.
- ☐ Schedule additional rounds for picking up waste from nursing units.
- ☐ Obtain extra containers for waste and deliver to floors.
- ☐ Do not dispose of any waste in drains during utility failure until service has been restored.

MAINTENANCE CHECKLIST

- ☐ Maintenance will assess the water disruption and inform Administration and affected departments of the expected duration.
- ☐ Based on assessment, Engineering will activate the “Water Systems Failure/Disruption” procedure.
- ☐ Implement Engineering Department water disruption/failure plan.
- ☐ Institute Fire Watch as necessary.
- ☐ Order portable toilets with hand washing facility for each hospital entrance.
- ☐ Complete *Utility Failure Report* detailing the circumstances surrounding the utility loss and corrective action taken.

FOOD SERVICES CHECKLIST

- ☐ Go to disposable service and implement other water-saving measures.
- ☐ Use foods that do not require use of water for preparation. Use non-steam-operated equipment.
- ☐ Close cafeteria and have food catered, if necessary.
- ☐ Do not dispose of any waste in drains during utility failure until service has been restored.

SURGERY CHECKLIST

- ☐ Cancel all elective procedures, if necessary.
- ☐ Use bottled water already in the department (sterile and distilled).
- ☐ Use instruments sterilized prior to water outage. Borrow instruments from another facility, if necessary.
- ☐ Use waterless hand washing product for hand washing supplied on each unit and from the storeroom.
- ☐ Line hoppers with red bags.
- ☐ Do not dispose of any waste in drains during utility failure until services has been restored.
- ☐ Steam and water required sterilization equipment will not function.

NURSING AREAS CHECKLIST

- ☐ Do not use disposable wipes for cleaning patients, only use product designed for skin cleaning.
- ☐ Use hand sanitizer for hand washing supplied on each unit and from the storeroom.
- ☐ Line toilets with red bags.
- ☐ Discharge as many patients as possible (if needed).
- ☐ Use bedside commodes/bedpans and dispose of waste in red “hazardous waste” bags.
- ☐ Do not dispose of any waste in drains during utility failure until service has been restored.

DIALYSIS AREAS CHECKLIST

- ☐ Notify Nephrologists of Water disruption
- ☐ Notify patients of water disruption and not come to scheduled appointments

LABORATORY CHECKLIST

- ☐ Drain liquid instrument waste into spill-proof, leak-proof, hazardous waste containers supplied by Environmental Services.
- ☐ Do not dispose of any waste in drains during utility failure until service has been restored.

SECURITY CHECKLIST

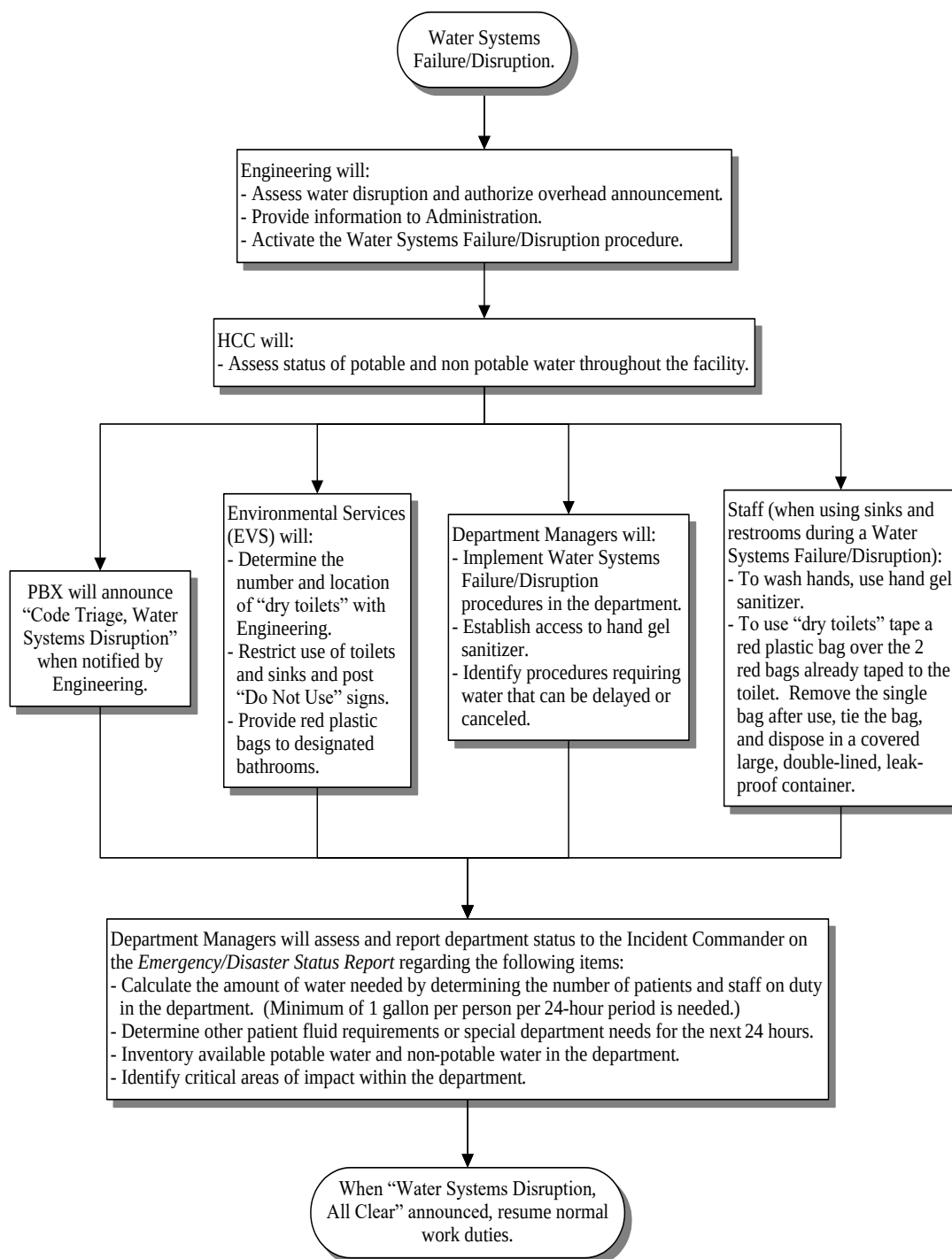
- ☐ Conduct fire watch throughout the hospital, if directed.
- ☐ Assist in ensuring public toilets are not used by putting up signs and tape on doors.
- ☐ Do not dispose of any waste in drains during utility failure until service has been restored.

ALL CLEAR

When "Water Systems Disruption, All Clear" is announced, return to your normal work duties unless otherwise directed.



Emergency Management Manual Water Systems Failure/Disruption



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DM2225 Lockdown-Security of Entry Doors

Policy Number: DM 2225	Date Created: 09/01/2011
Document Owner: Maribel Aguilar (Director of Physical Environment)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	
Lockdown-Security of Entry Doors	

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

POLICY:

A facility lockdown will be authorized as indicated for each facility by the Incident Commander. In the event an emergency situation requiring the need for facility lockdown, all entry doors to the facilities will be secured and monitored to isolate the hospital or any Kaweah Health facility from the outside public due to an emergency, either internal or external.

Staff from the labor pool will be assigned to each entry door in order to monitor entries and exits through those doors.

PROCEDURE:

Door Monitor Procedures:

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

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

Persons may exit, but no one is allowed to enter.

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

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

may be endangered, special consideration should be made to ensure the securing of all access points into and out of the Emergency Department. The MSE can be performed in appropriate sites other than the physical plant of the Emergency Department as directed by the Hospital Incident Commander should the Emergency Department facility become uninhabitable.

The lockdown will remain in effect until the Incident Commander through PBX announces "all clear".

RESPONSIBLE PARTY

Executive Officer or designee,
Incident Commander
Safety Officer, Security
Officer, Nursing Administration
Security Staff
Staff Labor Pool

ACTION

1. Order Lockdown procedures
2. Execute lockdown procedures
3. Door monitoring assignments are made, employees report to assigned doors and monitor door access.

Door Numbers: (See attached map)

Downtown Campus

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

South Campus:

- 1) Urgent Care main entrance 1633 South Court
- 2) Urgent Care south door
- 3) Urgent Care ambulance Bay
- 4) Urgent Care glass door
- 5) KATS Main Entrance sliding door
- 6) KATS employee entrance south door

- 7) TCU and Subacute visitor entrance TCU ambulance bay
- 8) Subacute north east door
- 9) Subacute north door
- 10) Storage entrance south door
- 11) Dietary south door

West Campus Door Numbers:**Mental Health:**

- 1) West exterior (4 exit route) doors
- 2) North entrance Ambulance port doors
- 3) Food Services Dining Room (2) exterior doors
- 4) Dietary Patio (gate) door
- 5) Front (Patient Family Services) entrance door
- 6) Main entrance/Lobby door
- 7) South exterior (Distribution/Loading zone) door
- 8) East exterior(Exit route) door
- 9) North exterior (Gate) door

Kaweah Dialysis Center

- 1) Main entrance/Lobby Automatic Doors
- 2) East exterior (Patio/Lounge) door
- 3) West entrance (Ambulance) door
- 4) North entrance (Employee) door
- 5) North Biohazard Door
- 6) North Supply Room Door

Rehabilitation Center:

- 1) South entrance (Ambulance port) door
- 2) Southeast exterior (exit route) double doors
- 3) East exterior (Exit route) door
- 4) Front entrance (Cousteau's Grill) double doors
- 5) East side exterior (Cousteau's Grill) single door
- 6) North entrance (Loading Zone door
- 7) North exterior (Employee) door
- 8) North Exterior (Exit route) door
- 9) Front entrance (Outpatient) automatic double doors
- 10) Main entrance/Lobby automatic double doors

Lifestyle Fitness Center

- 1) South exterior (Gymnasium) door
- 2) West entrance (2nd floor) door
- 3) West Entrance (1st floor) Outpatient Rehab doors
- 4) Main entrance/Lobby automatic double doors
- 5) East Entrance (Employee) door
- 6) East entrance (2nd floor) door
- 7) South exterior (Lap Pool) door
- 8) North Exterior (Hand Center) door
- 9) East (Lap Pool) door
- 10) East Entrance (Gym)

Kaweah Health Imaging and Breast Center

- 1) West exterior (Lab Draw) door
- 2) West entrance (Employee) door
- 3) South end exterior (exit route) door
- 4) Two South exterior (Exit routes) doors (back courtyard area)

- 5) Front Entrance/Main Lobby automatic double doors
- 6) North Door exterior (Employee) door Breast Center

Sequoia Regional Cancer Center

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

Exeter Rural Health Clinic

Family Medicine

- 1) North entrance door
- 2) East exterior (lobby) door
- 3) West exterior (lobby) door
- 4) East exterior suite 1 and 2 (Employee) door
- 5) West exterior suite 6- side a (Employee) door
- 6) West exterior suite 6- side b (Employee) door
- 7) South Exterior suite 3 (Employee) door
- 8) South Exterior suite 4 (Employee) door
- 9) South Exterior suite 5 (Employee) door

Pediatrics

- 1) West entrance door
- 2) East exterior (Employee) door

Women's Health

- 1) West entrance door
- 2) East exterior (Employee) door

Behavioral Health

- 1) North entrance door
- 2) South exit hallway A (Employee) door
- 3) South exit hallway B (Employee) door

Administration building

- 1) West entrance (Employee) door
- 2) North entrance door (Employee) door

Tulare Rural Health Clinic

- 1) North entrance door
- 2) North exterior (employee) door
- 3) North exit door
- 4) East exit (employee) door

Lindsay Rural Health Clinic

Family Medicine

- 1) West entrance door
- 2) South exit (employee) door
- 3) North exit (employee) door

Child and Adolescent Behavioral Health

- 1) South entrance door
- 2) East exit (employee) door

Adult Behavioral Health

- 1) South entrance door
- 2) East exit hallway 2 (Employee) door
- 3) East exit hallway 1 (Employee) door
- 4) North exit (Employee) door

Dinuba Rural Health Clinic

- 1) North main entrance door
- 2) North hallway exit (Employee) door
- 3) South exit Hallway 1 (Employee) door
- 4) South exit Hallway 2 (Employee) door

Woodlake Antelope Rural Health Clinic

- 1) South entrance door
- 2) South exit (Employee) door
- 3) North exit Hallway 1 (Employee) door
- 4) North exit Hallway 2 (Employee) door

Valencia Rural Health Clinic

- 1) West entrance door
- 2) South exit door

North

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DM 2107 Media Plan



Policy Number: DM 2207	Date Created: 07/01/2011
Document Owner: Maribel Aguilar (Director of Physical Environment)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	
Code Red-Activation	

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

Policy

In the event of smoke or a fire, Kaweah Delta Health Care District hereinafter referred to as Kaweah Health (KH) will activate its Code Red procedure (See KH Facility Fire Response Policy #EOC 5001). The Hospital Incident Commander (Nursing Supervisor or Administrator on Call) will assume responsibility for emergency operations and activate the HICS Code Red Team.

Procedure

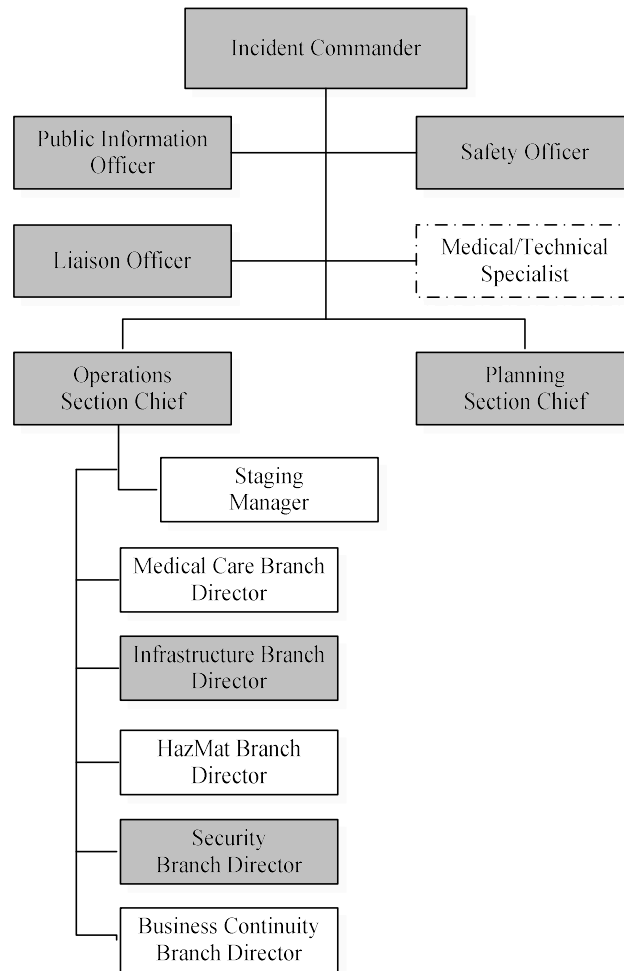
A. The person discovering the fire must immediately:

RACE

1. **Rescue** - REMOVE any persons in immediate danger.
2. **Alarm** - Communicate the presence of fire by immediately activating the nearest fire alarm pull station.
Call, or designate someone to call the operator by dialing Ext. 44 or 9-911 if no alarm is available to report the exact location and type of fire. If possible, have someone stay by the pull station to direct the Code Red responders to the site.
3. **Contain** – Close Doors
4. **Extinguish** - The fire should be extinguished if it is small and easily controllable by use of the fire extinguishers; however, all personnel in the fire area must evacuate the area as instructed in their fire response.

B. The following organizational chart represents the minimum level of HICS activation for a fire incident that requires relocation and/or has potential victims.

Fire Incident Management Team Chart - Immediate



B. Code Red Fire Alarm Response Team

1. Fire Alarm Response member roles and responsibilities:

Fire Alarm Response members are not intended to serve the role of firefighter. They are to provide assistance as required at the site of the alarm as directed by the person in charge of the scene.

General duties include:

- Respond to the site of the fire alarm.
- Use the fire extinguisher only if not directly in danger and trained in fire extinguisher use.
- Assist staff with closing doors and windows.
- Assist staff with clearing hallways of all obstructions.
- Assist with traffic control in the immediate fire area.
- Assist with removing equipment, if applicable.
- Assist in relocating patients if instructed to do so.

2. Fire Alarm Response staff members:

- Engineers
- Environmental Services
- Nursing Supervisor
- Transport Aides
- Security Officers

CODE RED – FIRE RESPONSE (ALL STAFF)

- Purpose:** To respond safely and effectively to the threat of smoke or fire (or burning odor) within KH or on its grounds.
- Emergency Operations:** The Hospital Incident Commander (Nursing Supervisor or Administrator on Call) will assume responsibility for emergency operations and activate the Hospital Incident Command System (HICS) Code Red Team. The Fire Department will respond, assume responsibility for emergency operations and authorize any evacuation. The Hospital Incident Commander will authorize "All Clear."
- Note:** A large-scale incident may develop into a Code Triage.

INCIDENT COMMANDER CHECKLIST (AOD/NURSING SUPERVISOR)

- ☐ Establish Hospital Command Center (HCC).
- ☐ Determine evacuation route (especially exit stairwell) in consultation with Fire Department/Maintenance.

STAFF RESPONSE CHECKLIST

Immediately upon discovering smoke or fire: ~~RA~~ (RACE)

- ☐ **Rescue** people in danger. (Close door when all occupants have been evacuated. Mark the door with a 10-inch "X" in the center of the door using tape or writing implement.)
- ☐ Remove all patients from corridors.
- ☐ Move all equipment to one (same) side of corridor.
- ☐ **Activate** the alarm and dial Ext. 44.
- ☐ **Contain** fire – close all doors and windows to prevent spread of smoke and flames.
- ☐ **Extinguish** fire if safe to do so. If the fire is small and you know you can put it out **quickly**, do so using available sources (fire extinguisher). Otherwise, do not attempt to extinguish the fire.
 - ☐ Clothing on fire: instruct person to drop and roll to extinguish flames.
 - ☐ Bed on fire: ~~smother~~; smother flames with blanket, remove patient and extinguish, if possible.
 - ☐ Unplug any electrical equipment in area of fire, if possible. Turn off wall oxygen in area, if possible.
 - ☐ Evacuate if area becomes unsafe to occupy.

Note: Do not use elevators in the affected building during a "Code Red."

To extinguish a small fire: (PASS)

- ☐ Pull the pin on the extinguisher.
- ☐ Aim the nozzle/hose at the base of the fire.
- ☐ Squeeze the handle.
- ☐ Sweep from side to side.

To extinguish fire on surgical patient:

- ☐ Smother small flames with saline.
- ☐ Aim water mist nozzle at flames.
- ☐ Cover wound with saline dressing.

Stand at least 10 feet back while using the fire extinguisher.

Immediately upon hearing "Code Red" overhead page:

If you are in the area specified by "Code Red":

- ☐ At the direction of the Person in Charge, relocate patients outside the fire zone, beyond the fire/smoke barrier doors per the evacuation direction diagram posted in each department. Close windows/doors and clear corridors, etc.
- ☐ Once unit is secured, make rapid rounds, checking on and reassuring patients.

If you are in an area away from the "Code Red":

- ☐ Secure unit by placing patients into rooms, closing windows/doors, clearing corridors, etc.
- ☐ Once unit is secured, make rapid rounds, checking on and reassuring patients.
- ☐ If the affected area evacuates to your unit, direct staff to prepare to receive patients. Position one staff member at unit entrance to direct staff arriving with evacuated patients to appropriate areas of receiving unit.
- ☐ Ensure initial care of patients who have been evacuated to your area, if applicable.

PBX CHECKLIST FOR WEST CAMPUS ONLY

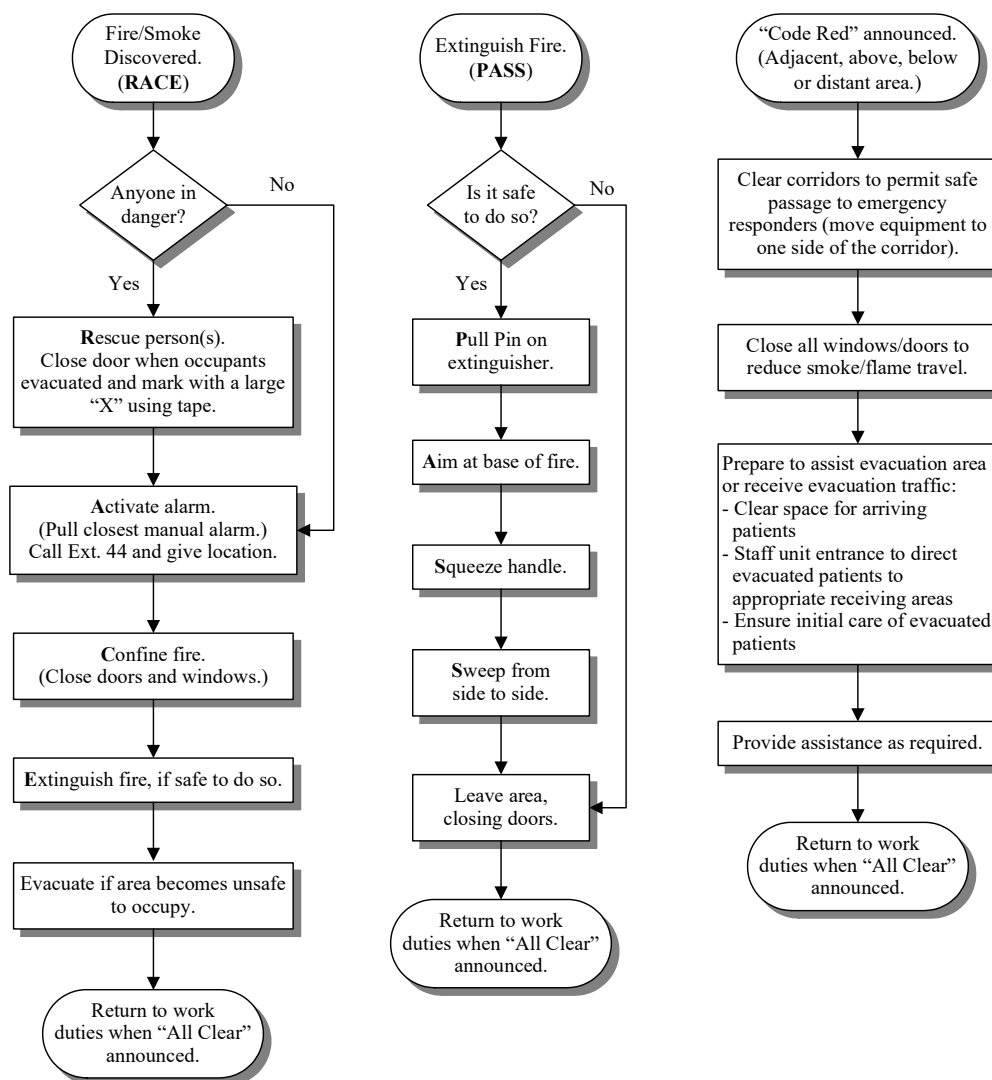
- ☐ Announce "Code Red" and state the location over the PA system at West Campus ONLY

- ☐ [Follow the same process by notifying Security of the Code at West Campus via handheld radio](#)
- ☐ [When being notified by the West Campus to clear Code Red, follow the same process by announcing the ALL-CLEAR via Cisco phone and state the location over PA system at the West Campus *ONLY*](#)
- ☐ [Dial 911 first and then dial Ext. 44 to notify you of code and indicate at West Campus](#)
- ☐ [Continue to follow policy and procedures](#)

ALL CLEAR

When "Code Red, All Clear" is announced, return to your normal work duties unless otherwise directed. Maintenance, Security and the Department Person in Charge will complete an *Incident Report*.

Emergency Management Manual Code Red - Fire Response



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DM 2204 Code Silver Activation

Policy Number: DM2204	Date Created: 03/01/2008
Document Owner: Maribel Aguilar (Director of Physical Environment)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	
Code Silver-Activation Plan	

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

I. Policy

To establish guidelines to be followed in the event that an individual is brandishing or using a weapon, or there is a hostage situation.

II. Procedure

~~When an employee believes an event is occurring in the hospital, with an individual brandishing or using a weapon or a hostage situation, they must notify Security, the Nursing Supervisor and Administration immediately by dialing Ext. 44 and giving the nature of the incident, the exact location and if possible, the number of suspects, and the names of the hostages to the PBX Operator. Outside facilities will dial 911 followed by Ext. 44.~~ In the event an employee believes an incident is occurring within the hospital involving an individual brandishing or using a weapon, or a potential hostage situation, the employee must immediately notify Security, the Nursing Supervisor, and Administration. To initiate the response, dial Ext. 44 and provide the PBX Operator with the following information: Nature of the incident Exact location Number of suspects (if known) Names of any hostages (if known)

For outside facilities: Dial 911 first, then call Ext. 44 to report the situation internally.

A. The following steps should be taken without delay:

1. PBX Operator will dial 911 and report the situation (i.e. person with a weapon and type of weapon, active shooter, hostage) to the Visalia Police Department.
2. PBX will overhead page "Code Silver and Location". PBX will notify the ISS Help Desk and they will announce through Berbee message on all Cisco Phones."
3. PBX Operator will notify Security by two-way radio giving the location and nature of the incident.
4. PBX Operator will notify the Administrator on Call and the Manager of Security.
5. If after hours, the Administrator on Call will be notified by PBX Operator and immediately report to the location of the incident.
6. Staff will follow Staff Response Checklist: evacuate when possible and shelter in place, close all doors and reassure patients and visitors.

7. Security Officers will respond to confirm the event, secure the perimeter and ensure no one enters the area. When possible, Security will rope off with yellow caution tape or secure doors.
8. The Administrator on Call and/or Nursing Supervisor and Security Officer will obtain any information from witnesses, i.e., number of suspects, weapons involved, and number of hostages to be given to the appropriate authority, i.e., Visalia Police Department.
9. The House Supervisor or the Administrator on Call will establish the Hospital Command Center (HCC) in the executive conference room or other designated area and initiate the Hospital Incident Command System (HICS) to the degree necessary.
10. In the event of a hostage situation, at no time will any demands or requests from the assailant be met prior to the arrival of law enforcement agencies.
11. The following members of the management staff will be called by Administrator on call or House Super and meet in the established HCC of the specified location:
 - a. Administrator on Call
 - b. Director on Call
 - c. House Supervisor
 - d. Security Manager or designee
 - e. Director of Risk Management or designee
 - f. Director of Facilities or designee
 - g. Safety Officer or designee
 - h. Director of Marketing or designee
 - i. Director of Chaplain Services or designee
12. Upon the arrival of law enforcement, the Officer in Charge will act as the negotiator with the suspect(s).
13. The hospital's Public Information Officer (PIO) will be assigned a designated area for the gathering of the news media.
14. Hostages' relatives arriving at the hospital will be placed in a secure location away from the news media and the hostage containment area.
 - a. Patient Family Services staff will be assigned to assist the hostage's relatives and the Psychological Support Unit Leader will man the area.
15. Hostages' relatives will be kept informed by a member of the administrative team or by a law enforcement representative.
16. No information will be released to the news media without the approval of the Hospital Incident Commander, Public Information Officer (PIO) and law enforcement.
17. Law enforcement, in conjunction with the Hospital Incident Commander, is in charge of the hostage negotiations and the possible need to evacuate and/or halt activities surrounding the hostage area.

CODE SILVER – PERSON WITH A WEAPON AND/OR HOSTAGE SITUATION
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- Purpose:** To provide assistance to anyone who is confronted by a person brandishing a weapon or who has been taken hostage on District property. Weapons include firearms and all other potentially deadly weapons such as knives, bats, batons, etc.
- Procedure:** In the event someone brandishes a weapon, Kaweah Delta Health Care District hereinafter referred to as Kaweah Health (KH) will activate the following Code Silver procedure to warn personnel and summon the Visalia Police Department.

INCIDENT COMMANDER CHECKLIST

If the scope of the incident requires HICS activation, the hospital Incident Commander assumes overall responsibility for hospital emergency operations, in collaboration with law enforcement.

If the incident has potential to disrupt hospital operations:

- ☐ Activate HICS.
- ☐ Direct PBX regarding all Code Silver-related overhead pages, in collaboration with law enforcement.
- ☐ Direct PIO to contact the families of identified hostages and serve as liaison with media. (Ensure that all official statements are coordinated with the police before being released.)
- ☐ As soon as the incident is cleared, direct PBX to announce by overhead page “Code Silver, All Clear.”

STAFF RESPONSE CHECKLIST

If you encounter a person brandishing a weapon:

- ☐ Seek cover/protection and warn others; evacuate if possible.
- ☐ Dial the operator at Ext. 44 and Security will respond. Provide PBX with the following:
 - ☐ Where you are and where incident is occurring.
 - ☐ Description and number of suspects.
 - ☐ Number and location of hostages.
 - ☐ Number and type of weapons involved.
- ☐ Come to the aid of others when safe to do so, removing patients, staff and visitors from immediate area.
- ☐ **Do not** attempt to confront the individual(s). Remain calm; reassure patients, staff and visitors.
- ☐ Attempt to keep others out of the area.

Note: If Code Blue team is needed, call PBX to overhead page “Code Blue” assistance to the scene *when the scene is secure*. **Do not** put Code Blue team at risk.

If you hear “Code Silver”:

- ☐ **Stay away from the area specified in “Code Silver.”** This is an extremely dangerous and sensitive situation that should only be handled by trained authorities.

Employees in the affected or immediate area of on the same floor adjacent to the “Code Silver” location:

- ☐ Close and barricade doors to patient areas or rooms to “shelter-in-place”.
- ☐ Where feasible and safe, evacuation may be initiated by using fire evacuation routes and fire stairwells at the direction of the area Manager or designee. Extreme caution shall be exercised in determining whether or not an evacuation will be initiated.

Employees in all other locations shall initiate a shelter-in-place response and remain at the location until an “all clear” announcement is made:

- ☐ Close/secure all patient and unit exit doors. Close and barricade doors leading in the department to “shelter in place”. Do not allow visitors or patients to leave the safety of the unit.
- ☐ Remain calm and quiet reassuring patients and visitors the situation is being managed.
- ☐ Refrain from calling the operator or Security Department to inquire about updates. The “all clear” announcement will be made when the incident is stabilized and under control.

- ☐ Do not discuss situation; refer media inquiries to the Public Information Officer (PIO).
- If you are taken as a hostage:**
- ☐ **Do everything the hostage-taker says to do.**
- ☐ Be especially careful during the first 5 minutes, as the captor is probably as desperate and nervous as the victim.
- ☐ Speak only when spoken to, do not make wisecracks.
- ☐ Try not to show emotions openly, captors play off emotions and take advantage of emotional weaknesses.
- ☐ Sit down if possible to appear less aggressive.
- ☐ Act relaxed as this may relax the hostage-taker.
- ☐ Weigh carefully any chance to escape to be sure that escape is certain and no one else is endangered.
- ☐ Be patient, help is coming. Have faith in negotiators.
- ☐ Do not make suggestions to the hostage-taker. If they go wrong, the captor will think you were trying to trick him or create problems.

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PBX CHECKLIST

- ☐ Upon notification or recognition of a situation involving a person with a weapon, active shooter, or hostage taking, announce by overhead page, "Code Silver" with the location of incident; immediately notify:
 - ☐ Visalia Police Department and provide details of situation:

☐ Location	☐ Entrance location to area
☐ Number of assailants	☐ Weapons(s)
☐ Description of assailants	☐ Number of hostages
- ☐ Maintain a phone connection between the reporting party and Security or responding law enforcement officers to keep officers updated about the situation.
- ☐ Refer staff inquiries regarding incident to the Incident Commander.
Note: DO NOT dispatch the Code Blue Team to Code Silver area until the police deem it safe to do so.
- ☐ Upon direction from the Incident Commander, announce by overhead page "Code Silver, All Clear."

SECURITY CHECKLIST

- ☐ When notified of a person on campus with a weapon or a hostage situation, immediately notify the Visalia Police Department (if not already done by PBX).
- ☐ Security will respond to the affected area to ascertain the threat status
- ☐ Security will lockdown the hospital building to prevent the public from entering into a hostile environment, or to keep an outside threat from entering into the facility
 - ☐ Secure area perimeter – keep others from danger. Clear bystanders from the area.
- ☐ When feasible, Security will monitor the closed circuit television to gather suspect information
- ☐ Security will meet with responding law enforcement personnel to:
 - ☐ Describe the specific area and surrounding area.
 - ☐ Number and description of suspects.
 - ☐ Number and description of hostages.
 - ☐ Number and description of weapons, if known.
 - ☐ Names of suspects and hostages, if known.
 - ☐ Preliminary demands or intentions of suspects.
 - ☐ Diagram of the area in question.

- ☐ Monitor and coordinate the incident with the Incident Commander/law enforcement per Security's policies and procedures.
 - ☐ If the HCC is not activated, assist the Incident Commander and law enforcement by establishing a command post for communications and negotiations.
 - ☐ Provide law enforcement with facility layout indicating rooms, exits, windows, utility access and phone numbers.
 - ☐ Provide logistical and manpower support.

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MAINTENANCE CHECKLIST

- ☐ Gather maps of the affected area and report to Visalia Police Officers in area.

ALL CLEAR – STAFF RESPONSE

- ☐ When it is safe to do so, get medical help to victims if needed.
- ☐ When you hear PBX announce "Code Silver, All Clear," return to your normal work duties, unless otherwise directed.
- ☐ If any employee is involved in a weapons incident, Human Resources must be notified immediately.
- ☐ Participate in incident debriefing as requested. Incident Commander, Security and the Department Person in Charge will complete an *occurrence report*.

Note: Following the emergency incident, the Department Manager(s) of the affected area(s) shall submit an occurrence report.

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DM 2212 Earthquake Response

Policy Number: DM2212	Date Created: No Original Creation Date Set
Document Owner: Maribel Aguilar (Director of Physical Environment)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	
Earthquake Response	

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

Policy

In the event of an earthquake that is of sufficient magnitude or duration to cause injury to individuals or damage to the facility, Kaweah Delta Health Care District, hereinafter referred to as Kaweah Health (KH) will activate its earthquake response procedure.

Procedure

A. See attached procedure and flowchart.

B. Training

All employees receive training on emergency preparedness plans and codes at new employee orientation and annually thereafter. All employees are required to complete safety training modules and participate in semiannual Emergency Exercises.

C. Hazard Mitigation

The Hazard Surveillance Team inspects all departments in the hospital for hazards semiannually. This team evaluates equipment bracing, general safety and life safety deficiencies. A report of identified hazards is sent to each department manager and Maintenance for correction. A report of correction is sent to the Safety Department.

A major earthquake in the Central Valley Area could require activation of any one or a combination of the following KH emergency plans for:

- Fire
- Evacuation
- System failures
- HICS/Mass Casualty Incident (MCI)

Attachments:

- Attachment A, "Earthquake Damage Assessment Sheet"
- Attachment B, "Bed Availability & Discharge Form"

Attachment A

Earthquake Damage Assessment sheet

Note: Complete this sheet and be prepared to report the information herein to the Damage Assessment and Control Officer and/or the HCC.

A. DEPARTMENT DATA

Name of Department/Area: _____ Floor: _____ Ext. _____
 Person Completing This Form: _____ Floor: _____ Ext. _____

B. STRUCTURAL INTEGRITY

	Collapsed			Collapsed			Collapsed	
	Yes	No		Yes	No		Yes	No
Walls, Exterior	☐	☐	Windows	☐	☐	Shelves	☐	☐
Walls, Interior	☐	☐	Hallways	☐	☐	Bookcases	☐	☐
Ceiling	☐	☐	Exits	☐	☐	Cabinets	☐	☐
Stairs	☐	☐	Doors	☐	☐	Equipment	☐	☐

C. UTILITIES

	Functioning			Functioning			Functioning	
	Yes	No		Yes	No		Yes	No
Electricity	☐	☐	Telephone	☐	☐	Sewer	☐	☐
Water	☐	☐	Plumbing	☐	☐	Gas	☐	☐
Medical Gas	☐	☐	Oxygen	☐	☐	Suction	☐	☐

D. HAZARDOUS MATERIALS SPILL

Yes ☐ No ☐

Name of Products/Chemicals spilled: _____

E. Special Department Problems (type of equipment not functioning)

G. General Status of Department/Area: Functional ☐ Partially Func. ☐ Non-Func. ☐

Total No. of Casualties _____ **Types:** Delayed ☐ Minor ☐ Deceased ☐ Immediate ☐

Location: _____

Attachment B Bed Availability & Discharge Form

Department: _____ Time: _____ Date: _____ Person Completing Form: _____ Ext.: _____

Empty Room & Bed No.	Name of Patient Who Can be Discharged	Room & Bed No.	Doctor	Patient's Special Needs	Equipment Needed

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EARTHQUAKE

Purpose: To protect yourself from injury during an earthquake and then provide assistance to others at Kaweah Health.

Background: Recovery from a major, nearby earthquake can take days, weeks, or months, depending on its magnitude.

- All staff who have pre-assigned HICS positions at the Hospital Command Center (HCC) should report to the hospital as quickly as possible without waiting to be called and without waiting to “get in uniform.” Be prepared to show your approved hospital identification.
- If you do not have pre-assigned duty, call the KH Disaster Update Line 559-624-2008 for information on facility staffing needs or listen to radio/TV and be prepared to report to the hospital.
- Respond in accordance with this procedure and those developed by your department. A large-scale incident may develop into a Code Triage.(See Code Triage Plan)

STAFF RESPONSE CHECKLIST

Immediately upon sensing a significant earthquake:

- ☐ Remain in the building. Move away from windows, shelving or other furnishings/equipment that may topple or fall on you. Watch for falling objects such as ceiling tiles or light fixtures. Have patients cover their faces with bed linens for protection from falling glass. DO NOT: run for exits, stand in doorways or use elevators.
- ☐ Protect your head from falling debris. Find shelter under a sturdy desk/table or against an inside wall. **Duck, cover and hold till shaking stops.**
- ☐ If you are outside, get into open space away from buildings or power lines.
- ☐ Triage your immediate area. Identify major potential hazards such as fire, hazardous materials spill/release, flooding, electrical/trip hazards, and injuries to others nearby.
 - ☐ Report significant findings to your supervisor.
 - ☐ Minimize hazards to reduce further damage or injury. Turn off damaged equipment, and clear away debris for safe pathways. Prepare to extinguish a fire, avoid a hazardous materials spill/release, flooding, and evacuate the area as necessary, taking medical records. (See Relocation and Evacuation).
- ☐ Prepare for aftershocks. Move items that are likely to fall or move during an aftershock to a safer location (on the floor out of the path, etc.).
- ☐ Units that have medical gases should be prepared to use emergency shutoff valves if necessary.
- ☐ *Do not* use hospital telephone system to call home or other family members as these lines will most likely be overloaded and urgently needed for hospital business.

- ☐ Be prepared to respond to changing work hours and duty assignments when directed. The hospital reserves the right to cancel vacations and days off, if necessary, in order to maintain critical hospital services.

DEPARTMENTS CHECKLIST

- ☐ Supervisors are to report damages/injuries to HCC on the *Department Status Report* (Fax to 713-2332 or email to hics@kdhcd.org or via runner).
- ☐ If instructed by the HCC, follow evacuation procedures.
- ☐ Do not immediately clean up damage from earthquake until photos have been taken to document damage, except for debris blocking exit hallways or evacuation routes.

ENGINEERING CHECKLIST

- ☐ Assess damage and report the status of all critical utilities (HVAC, electrical, water, sewer, medical air and vacuum systems) to the HCC on the *Facility System Status Report*.

NURSING CHECKLIST

- ☐ Institute emergency life saving procedures and medical attention to personnel and patients on the unit.
- ☐ Be prepared to relocate or evacuate personnel and patients from unit, taking records and medications if possible.
- ☐ Move patients to interior walls, away from windows and glass; pull curtains; lock patient bed wheels (except newborn isolettes or infant cribs, which are prone to tip); place side rails up.
- ☐ Clean up any spilled medication, drugs or other hazardous materials. (See Code Orange.)
- ☐ Ensure that ambulatory patients wear shoes to protect their feet from broken glass or sharp objects.
- ☐ Nursing and surgery personnel evaluate the medical gas and vacuum system in their area and report status to the HCC. It may be necessary to use portable oxygen and back-up anesthesia sources.

ALL CLEAR

Return to your normal work duties, unless otherwise directed. Dial Ext. 44 for all emergencies in hospital. Dial 911 at other locations.

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DM 2226 Surge Tent Use

Policy Number: DM2226	Date Created: 09/01/2011
Document Owner: Maribel Aguilar (Director of Physical Environment)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	
Surge Tent Use	

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

Policy

In the event of an influx of patients the Emergency Department may determine the need to activate the Surge Tents as an Alternate Care Site. The decision to activate the Surge Tent Plan will be made by the Incident Commander, Administrator on Call, CEO or Nursing Supervisor and they will activate the Emergency Operations Plan.

In the absence of any specific suspension of statute or regulation by Governor's Executive Order, tents will be approved for use only as waiting rooms, to conduct triage and Medical Screening Exams, to provide basic first-aid, and outpatient treatment that meets all applicable rules and regulations. To insure compliance with Surge Tent requirements approval from the Safety Officer or the Director of Facilities or designee must be obtained prior to patients being cared for in the tents.

Tent Use/Space Conversion Approval:

Approval to set up a tent is required by California Code of Regulations Title 22 (22 CCR), §70805, which states that, "Spaces approved for specific uses at the time of licensure shall not be converted to other uses without the written approval of the Department." Use of hospital property for tents constitutes a conversion of space. This means that hospitals must obtain CDPH's written approval for tent use. Approval of tents will not be provided unless the hospital has obtained written approval from the local fire authority for tent use.

To receive approval for tent use, hospitals must contact their L&C District Office (DO), explain their situation, justify their use of tents, and obtain tent use approval. (see Attachment CDPH Form for Approval) The form to use in submitting requests for L&C approvals, as referenced above, can also be accessed at <https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph5000a.pdf>
See Surge Tent Checklist.

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SURGE TENT USE - ALTERNATE CARE SITE

Purpose:

In the event of an influx of patients, the Emergency Department may determine the need to activate the Surge Tents as an Alternate Care Site. The decision to activate the Surge Tent Plan will be made by the Incident Commander, Administrator on Call, CEO or Nursing Supervisor and they will activate the Emergency Operations Plan.

In the absence of any specific suspension of statute or regulation by Governor's Executive Order, tents will be approved for use only as waiting rooms, to conduct triage and Medical Screening Exams, to provide basic first-aid, and outpatient treatment that meets all applicable rules and regulations. To receive approval for tent use, hospitals must contact their L&C District Office (DO), explain their situation, justify their use of tents, and obtain tent use approval.

To insure compliance with Surge Tent requirements approval from the Safety Officer or the Director of Facilities must be obtained prior to patients being cared for in the tents.

INCIDENT COMMANDER DIRECTOR CHECKLIST
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- ☐ Establish HCC.
- ☐ Assess situation and activate HICS to the extent necessary to manage the incident.
- ☐ Direct PBX Operator for all overhead emergency announcements.
- ☐ Brief managers and medical staff on anticipated impact and update them on the event's status.
- ☐ Provide leadership for HICS Command Team (see Incident Commander Job Action Sheet).
- ☐ Determine when the incident has been stabilized to the point where normal hospital operations may be resumed and deactivate HICS. Authorize PBX Operator to announce "All Clear."
- ☐ Conduct an incident debriefing as soon as possible following the deactivation of Code Triage.

HOUSE SUPERVISOR OR CNO CHECKLIST
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- ☐ To receive approval for tent use, hospitals must contact their L&C District Office (DO), explain their situation, justify their use of tents, and obtain tent use approval. The form to use in submitting requests for L&C approvals, as referenced above, can also be accessed at.

<https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph5000a.pdf>

PBX CHECKLIST

- ☐ As directed, PBX Operator implements "Code Triage, Alert" to summon key HICS staff to the HCC.
- ☐ If directed by the Incident Commander, the PBX Operator announces: "Code Triage" (3x). PBX Operator will notify areas not receiving overhead page via pre-established telephone tree.
- ☐ Notify the Safety Officer and Director of Facilities.

ENGINEERING CHECKLIST

Upon being notified that the Surge Tents need to be set up:

- ☐ Notify the Director or Manager of Facilities

- ☐ Arrange for the Disaster Trailers that contain the tent equipment to be transported from the Warehouse to the Emergency Department parking lot.

Engineering shall insure the following:

- ☐ Fire apparatus access roads shall be provided to all sides of the tent in accordance with Section 503 of the Fire Code.
- ☐ Tents may not be located within 20 feet of lot lines, buildings, other tents, canopies or membrane structures, parked vehicles or internal combustion engines. For the purpose of determining required distances, support ropes and guy wires shall be considered as part of the tent.
- ☐ An unobstructed fire break passageway or fire road not less than 12 feet wide and free from guy ropes or other obstructions shall be maintained on all sides of all tents, canopies and membrane structures unless otherwise approved by the fire department.
- ☐ Tents and their appurtenances shall be adequately roped, braced and anchored to withstand the elements of weather and prevent against collapsing. Documentation of structural stability shall be furnished to the fire department on request.
- ☐ Exit openings from tents shall remain open unless covered by a flame-resistant curtain. Curtains shall be free sliding on a metal support. The support shall be a minimum of 80 inches above the floor level at the exit. The curtains shall be so arranged that, when open, no part of the curtain obstructs the exit. Unless approved otherwise by the fire department, curtains shall be of a color or colors that contrast with the color of the tent.
- ☐ Smooth-surfaced, unobstructed aisles having a minimum width of not less than 44 inches shall be provided from exits to all portions of the interior of the tent. The arrangement of aisles shall be subject to approval by the fire department and shall be maintained clear at all times during occupancy.
- ☐ Exits shall be clearly marked, Exit signs shall be installed at required exit doorways and where otherwise necessary to indicate clearly the direction of egress when the exit serves an occupant load of 50 or more. Exit signs shall be of an approved self-luminous type or shall be provided with an internal back-up battery capable of illuminating the sign for a minimum of 90 minutes after power has failed.
- ☐ The means of egress shall be illuminated with light having an intensity of not less than 1 foot-candle at floor level while the structure is occupied. Fixtures required for means of egress illumination shall be supplied from a separate emergency power circuit or from an internal battery.
- ☐ The areas within and adjacent to the tent shall be maintained clear of all combustible materials or vegetation that could create a fire hazard within 30 feet of the structure. Combustible trash shall be removed at least once a day from the tent during the period the structure is occupied.
- ☐ Smoking shall not be permitted in tents. Approved "No Smoking" signs shall be conspicuously posted.
- ☐ Open flame or other devices emitting flame, fire or heat or any flammable or combustible liquids, gas, charcoal or other cooking device or any other unapproved devices shall not be permitted inside or located within 20 feet of the tent, canopy or membrane structures while open to the public unless approved by the fire code official.
- ☐ Portable fire extinguishers shall be provided as required by the fire department.
- ☐ Heating equipment, tanks, piping, hoses, fittings, valves, tubing and other related components shall be installed as specified in the California Mechanical Code and shall be approved by the fire department. Gas, liquid and solid fuel-burning equipment designed to be vented shall be vented to the outside air as specified in the California Mechanical Code. Such vents shall be equipped with approved spark arresters when required. Where vents or flues are used, all portions of the tent, canopy or membrane structure shall be not less than 12 inches from the flue or vent. Heating equipment shall not be located within 10 feet of exits or combustible materials. Electrical heating equipment shall comply with the California Electrical Code.
- ☐ LP-gas equipment such as tanks, piping, hose, fittings, valves, tubing and other related components shall be approved and in accordance with Chapter 38 of the Fire Code and the California Mechanical Code. LP-gas containers shall be located

outside and safety release valves shall be pointed away from the tent. Portable LP-gas containers with a capacity of 500 gallons or less shall have a minimum separation between the container and structure not less than 10 feet. Portable LP-gas containers, piping, valves and fittings which are located outside and are being used to fuel equipment inside a tent shall be adequately protected to prevent tampering, damage by vehicles or other hazards and shall be located in an approved location. Portable LP-gas containers shall be securely fastened in place to prevent unauthorized movement.

- ☐ Generators and other internal combustion power sources shall be separated from tents, canopies or membrane structures by a minimum of 20 feet and shall be isolated from contact with the public by fencing, enclosure or other approved means.
- ☐ Tents shall not obstruct the acquired means of egress from the hospital or obstruct fire department access, or access to fire protection equipment including fire hydrants, sprinkler control valves and fire department hose connections unless expressly permitted by the fire department.

SAFETY OFFICER CHECKLIST

Upon being notified of the Surge Tent activation, Safety Officer (or designee) will:

- ☐ Immediately notify Visalia Fire Department that the tents have been erected.
- ☐ Approve tent set up prior to patients being treated in the tents

EMERGENCY DEPARTMENT CHECKLIST

Emergency Department Charge Nurse will arrange the following:

- ☐ Arrange for the following equipment and supplies for the Surge Tent:
 - Portable blood pressure machine with disposable cuffs
 - Thermometers
 - Pulse Oximeter
 - One computer
 - One phone
 - One hand held radio
 - Two desks
 - Twelve chairs
 - Partitions for privacy
 - Lighting
 - Extra Electrical Cords
 - Admitting Supplies – armbands, dashew plates, clipboards
 - Emesis Basins
 - Thermometer probes & covers (temporal and Oral)
 - Nelcore Pulse Ox (disposable)
 - Sanitizer Wipes
 - Portable upright hand sanitizer
 - PPE – masks, gloves (small, med, large, xl)
 - Linen cart
 - 2 Doffit-Kits
 - Hand washing station/hand sanitizer station
- ☐ Staff Roles
 - Triage Tent Nurse
 - ILI Runner
 - Tent RN
 - Physician/PA
 - Team Leader
 - Admitting Clerk
 - Main Triage Reception RN

- Triage Reception EDT
- WO RN
- WO EDT
- WO Admitting
- Dispo RN
- MICN
- Customer Service Rep
- Social Worker
- Respiratory Tech

☐ Patient Care

- Triage algorithm
- Screening tool for ILI
- Registration Process

MS42



Medical Staff Manual

Policy Number: MS 42	Date Created: 09/19/2025
Document Owner: Ody DaSilva (Medical Staff Coordinator)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration); Medical Executive Committee; Boyce, Teresa; DaSilva, Ody; Davis, Kelsie	
Process for Quality Review of Medical Staff, Resident Physician, and Advanced Practice Professional Medical Record Documentation	

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

PURPOSE

To define the process by which the quality of medical record documentation is reviewed, monitored and reported; identify opportunities for documentation improvement and take appropriate action when necessary.

POLICY

The Health Information Management Committee will conduct routine medical record reviews to assure the documentation accurately reflects and documents medical events occurring during either hospitalization or clinic visits to ensure they meet The Joint Commission requirements for content. Members of the committee will review medical records to assure each represents an accurate description of the patient's condition and progress while either hospitalized or seen in a clinic, including adverse or unexpected occurrences and identification of responsibility for patient care rendered during hospitalization or clinic visits. Results of the reviews are utilized to assess a practitioner's professional performance as part of the credentialing, privileging and corrective action processes. All information is privileged and confidential in accordance with medical staff bylaws, rules and regulations, state laws, and other regulations pertaining to confidentiality and non-discoverability.

MEMBERSHIP

The documentation review team will be comprised of the HIM Health Information Analysts.

MEETINGS

The documentation review team will meet as often as needed to review records. .

The documentation review team will also attend the monthly HIM Committee business meeting to provide the findings. The Findings are verified by the HIM Committee.

PROCEDURE

1. Category I: Documentation Referrals
 - a. Clinicians, nurses, case managers, clinical documentation specialists, coders, etc. identify documentation discrepancies.
 - b. Complete Midas event form to request review.
 - c. Request will be forwarded to documentation team.
 - d. Documentation review team will review record documentation for appropriateness, completes Quality Review Documentation form and sends to HIM Department.
 - e. HIM Department will compile data and report to HIM Committee.
2. Category II: Reappointment
 - a. Medical Staff Office will provide a list of practitioners up for reappointment:
 - i. 250 – 300 practitioners/year

- ii. 20 – 25 practitioners/month
 - b. Documentation review team will review 3 – 5 records of each practitioner up for reappointment for Ongoing Professional Practice Evaluation (OPPE):
 - i. 60 – 125 records /month
 - c. Documents to be reviewed: Emergency Department Notes, History and Physicals, Consultation Notes, Progress Notes, Operative/Procedure Notes, Discharge Summaries, Office Clinic Notes, etc.
 - d. Documentation review team will review record documentation for appropriateness, completes Quality Review Documentation form and sends to HIM Department.
 - e. HIM Department will compile data and report to HIM Committee.
3. Category III: Ongoing Record Review
- a. Documentation review team will perform their ongoing record review audits
 - b. Documents to be reviewed: Behavioral Health History and Physical's and psych evals, Main Op and post op report, VOTO's, pre/post anesthesia, History and Physical's at TC South, TC West, Rehab and Cardio, op and post op report cardio, discharge summary at TC South, TC West and Sub-Acute. Also any document that seem appropriate to be added.
 - c. HIM Department will compile data and report to HIM Committee
 - d. All fallouts will be presented and HIM Committee will determine what is entered into the Physician Tracking System

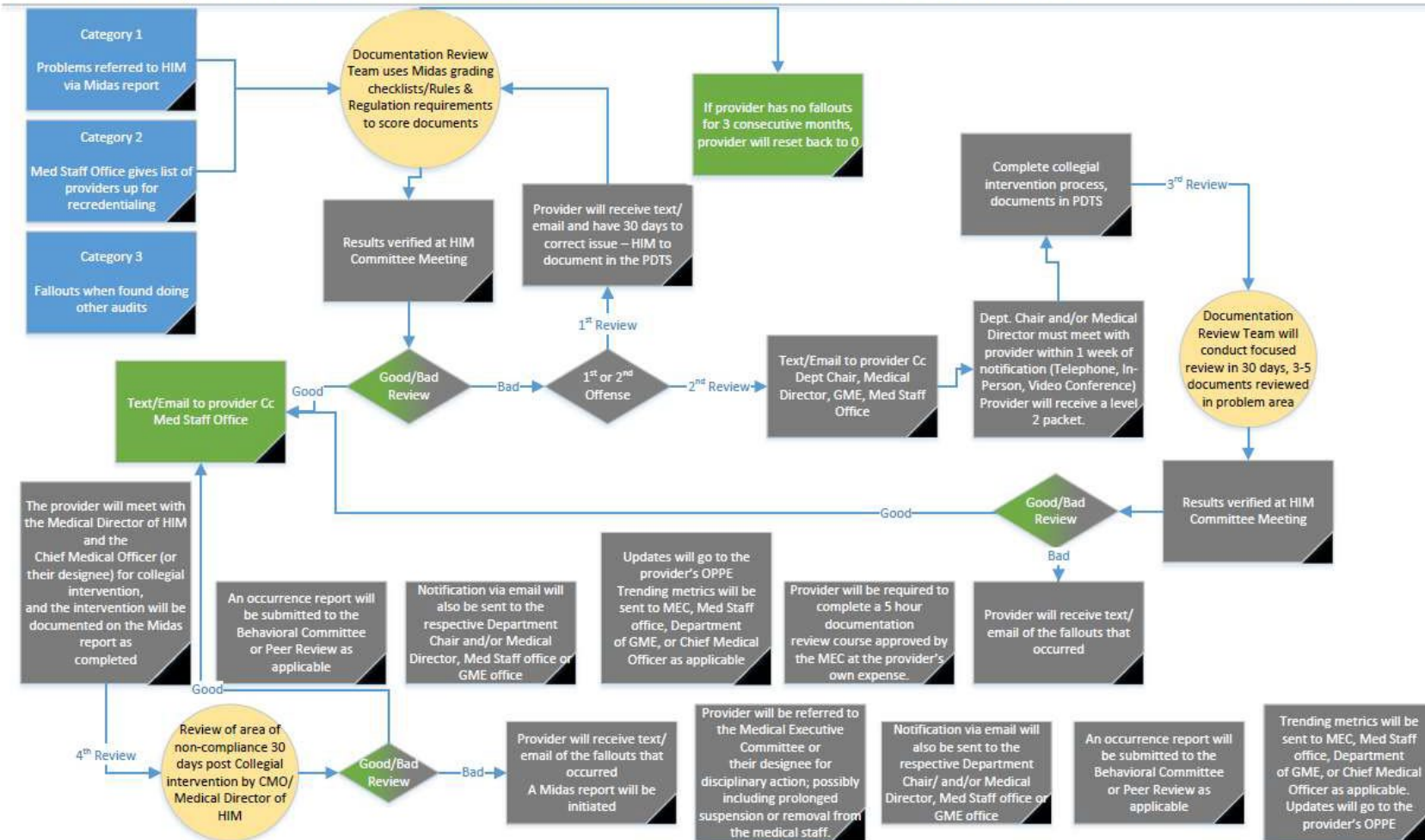
FINDINGS AND REPORTING

1. Satisfactory Finding
 - a. Text/email to provider with a copy to the Medical Staff Office
2. Unsatisfactory Finding
 - a. First Occurrence: Provider will receive text/email and have 30 days to correct issue. HIM to document in Midas Physician Tracking System. Focus review on 3 -5 charts in area that was deficient in the initial review.
 - b. Second Occurrence: Text/Email to provider with copy to Dept. Chair, Medical Director, GME, Med Staff Office (as applicable). Dept. Chair and/or Medical Director must meet with provider within 1 week of notification (Telephone/In-Person/Video Conference) and complete collegial intervention process, document in Midas. Focus review in 30 days on 3-5 charts in area that was deficient.
 - c. Third Occurrence: Notification to provider via email with a copy to Dept. Chair/ Medical Director/GME/ Med Staff Office (as applicable). Medical Director of HIM, Chief Medical Officer or their designee will perform collegial intervention. Occurrence report written and sent to the Professionalism Committee/Peer Review Committee. Updates to Ongoing Professional Practice Evaluation (OPPE). Trending metrics sent to MEC, Med Staff Office, VP for contract if applicable
 - d. Fourth Occurrence: The provider will be referred to the Medical Executive Committee or their designee for disciplinary action possibly including prolonged suspension or removal from the medical staff. An occurrence report will be submitted to the Behavioral Committee / Peer Review. Trending metrics will be sent to MEC, Med Staff office, Department of GME, or Chief Medical Officer. Updates will go to the provider's OPPE.
3. Results will be reviewed at monthly HIM Committee meeting. Trending metrics will be reported monthly to the Medical Staff Office and Medical Executive Committee.
4. All adverse determinations will be reviewed by a physician prior to action being taken.

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HIM Physician Documentation Review Workflow

2/10/25





Medical Staff Services

Policy Number: MS 50	Date Created: 09/19/2025
Document Owner: Ody DaSilva (Medical Staff Coordinator)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Medical Executive Committee, Kelsie Davis (Board Clerk/Executive Assistant to CEO), Ody DaSilva (Medical Staff Coordinator), Teresa Boyce (Director of Medical Staff Services)	
Late Career Policy	

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

Policy:

The purpose of this policy is to

- ensure patients receive safe, high quality medical care
- identify issues that may be pertinent to the health and clinical practice of medical staff members
- support members of the medical staff; and
- apply Medical Staff evaluation criteria objectively, equitably, respectfully, and confidentially

Any practitioner age 75 or older during the month of their appointment or reappointment to the Medical Staff will obtain as part of the application process, documentation of their health status from a primary care provider (PCP), approved by the Medical Staff Officers. If the Department Chair, Credentials Committee or Medical Executive Committee deems appropriate, they may request that any practitioner, regardless of age, provide similar documentation at the time of appointment or reappointment.

Procedure:

I. Notification of the practitioner

- With initial or reappointment notification, the practitioner will be provided with a copy of this policy and informed that
 - The applicant must return the "Release of Information" form (Attachment C) with the completed application/reapplication to the Medical Staff Office.
 - Upon receipt of the Release of Information form from the applicant, the Medical Staff Office will provide
 - The applicant with contact information of the PCP available to perform a health screening exam.
 - The PCP with a cover letter, blank questionnaire (Attachments A & B), the signed release of information form, and a copy of the applicants requested privileges.
 - The applicant will be responsible for making an appointment with the approved PCP.
 - the application will be deemed incomplete without receipt of the completed questionnaire from the PCP.

If, due to inaction by the applicant, the assessment from the PCP is delayed such that an application for reappointment remains incomplete and cannot be considered by the Department Chair, Well Being Committee, Credentials

Committee, Medical Executive Committee, and Board of Directors before the end of the member's current term, the application will be deemed withdrawn and the practitioner's appointment and/or privileges will lapse at the end of the current term without any procedural rights under Article 9 of the Medical Staff Bylaws.

II. Processing the Assessment from the Primary Care Provider

- a. After completion of the applicant's health screening the PCP will return a completed questionnaire to the Medical Staff Office. This information will be kept confidential and forwarded to the Well Being Committee for evaluation.
 - i. If the health document identifies health conditions that may interfere with the practitioner's ability to safely and competently exercise the privileges requested, the Well Being Committee will meet with the provider to discuss concerns and possible options. At this time the practitioner may choose to modify the privileges requested and re-submit to the Medical Staff Office (this would not require a report to the NPDB or an 805 report).
 - ii. If additional evaluation is warranted the Well Being Committee will assist the practitioner in obtaining the appropriate evaluation(s).
 1. A Fit for Duty exam will be automatically required if cognitive deficiency or physical deficiency related to the specific practice of the practitioner is identified in the health screening exam. The cost of the Fit for Duty exam will be the responsibility of the applicant

III. Outcomes of Review sent to the Credentials Committee:

- a. No known concerns: If the findings do not identify potential patient care concerns, the results will be filed in a confidential file maintained by the Medical Staff Services Department, and the Credentials File will only reflect that the assessment process has been completed with no significant concerns identified. The appointment process will proceed as specified in the Medical Staff Bylaws.
- b. Concerns: If the findings identify potential patient care concerns and the practitioner, after meeting with the Well Being Committee, elects not to modify the privileges requested, the Department Chair and the Credentials Committee will, on a confidential basis, evaluate the Well Being Committee's recommendation in addition to the entire contents of the (re)application file. A representative of the committee, the Department Chair or Chief of Staff, will meet with the practitioner to discuss alternative practice patterns or modification of requested privileges. *The goal of such discussion is to be supportive and respectful of the practitioner and to suggest resources to assist the practitioner.*
- c. Practitioner Rights: If the Credentials Committee recommends denial of some or all privileges requested, or that certain conditions or restrictions be placed on privileges, and if that recommendation is approved by the MEC, the practitioner will be entitled to the procedural rights in Article 9 of the Medical Staff Bylaws.

- IV. Throughout this process the intent of each step is to enhance quality healthcare, protect patient safety and provide support to the practitioner by assisting in any resulting changes in practice patterns or transitions.

References:

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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 A

Primary Care Physician Questionnaire (to be completed by your Primary Care Physician)

Patient Name: _____ DOB: _____

I attest that I have performed a comprehensive history and physical examination on this practitioner, and that I have reviewed the clinical privileges requested by this practitioner.

- In the history and physical examination the practitioner has no apparent findings that would necessarily preclude the practitioner from performing the privileges requested.
 - o Agree: _____ Disagree: _____ If disagree, please elaborate below: _____
- In tests and studies performed on the practitioner, the practitioner has no apparent findings that would necessarily preclude the practitioner from performing the privileges requested.
 - o Agree: _____ Disagree: _____ If disagree, please elaborate below: _____
- Do you have any recommendation for further study or evaluation?
 - o No: _____ Yes: _____
If yes, please elaborate below: _____
- Additional Comments:
 - o _____

ATTACHMENT B

Sample cover letter to PCP

CONFIDENTIAL PEER REVIEW INFORMATION
Protected by California Evidence Code §1157

[DATE]

RE: History and Physical Examination

Dear Dr. _____,

The Medical Staff of Kaweah Health, as part of its efforts to protect both patients and practitioners, requires a comprehensive history and physical examination of practitioners applying or reapplying for clinical privileges beyond the age of seventy-five (75). Important components of this assessment include a review of systems that addresses functional status, and comprehensive sensory examination including tests of hearing, visual acuity with eye chart and exam, and a thorough neurological examination including a mini mental status examination. The elements of the examination should be modified as appropriate to address the age, clinical condition, medical problems and the clinical privileges requested by the practitioner. Included is a copy of the clinical privileges requested by the practitioner.

Please review the practitioner's clinical privileges before conducting your examination.

To respect the confidentiality of the practitioner's medical information, please submit only the form that is enclosed. The form is to be returned to the Kaweah Health Medical Staff Services Department (see enclosed envelope).

As noted on the form, the Medical Staff is interested only in, and should only receive a detailed report on, those aspects of the practitioner's health, if any, that have the potential to adversely affect the practitioner's ability to safely perform the requested privileges or that document the practitioner's ability to perform the privileges. You may supply additional information that you feel would be beneficial to the Medical Staff in this assessment, such as if you feel additional studies or further evaluation is indicated. The report is confidential and will be provided to the Medical Staff Wellness Committee.

ATTACHMENT C

Sample Release

CONFIDENTIAL PEER REVIEW INFORMATION
Protected by California Evidence Code §1157

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize _____ to release information of my health evaluation, and to provide information regarding my present medical condition and fitness to perform the duties identified on the enclosed privilege form to Gurtej S. Dhillon, M.D., Chair of the Well-Being Committee.

Print Name

Signature

Date

Reports are to be mailed to

Kaweah Health
Medical Staff Services

400 Mineral King Ave
Visalia, CA 93291



Medical Staff Services
COVID Manual

Policy Number: MS 54	Date Created: 11/07/2025
Document Owner: Ody DaSilva (Medical Staff Coordinator)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Medical Executive Committee, Kelsie Davis (Board Clerk/Executive Assistant to CEO), Ody DaSilva (Medical Staff Coordinator), Teresa Boyce (Director of Medical Staff Services)	
COVID-19 Testing Guidelines <u>and Isolation</u>	

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

These guidelines are for practitioners ordering repeat tests for patients suspected to be or infected with the COVID-19 virus. Tests may be processed through Kaweah Health Medical Center Lab, the Tulare county Public Health Lab (TCPHL), or a Commercial lab. Supplies of testing kits will be continuously monitored.

Repeat testing parameters:

- Allowed for symptomatic patients **only** IF the first test is negative
- If a patient's first test is negative but there is strong suspicion of COVID-19 based on clinical presentation or recent exposure, the patient should be placed in appropriate precautions and re-tested as close to the first test as possible. Recommend retesting with a non-rapid molecular test (example: PCR).
 - PCR test results will supersede any ID-Now results.
- If a second COVID test is negative, subsequent diagnostic testing should be done at least 3 ~~and to~~ 5 days after the first ~~negative test(s)~~symptoms. Patient to remain in isolation if there continues to be a strong suspicion of COVID-19 until ruled out.

Follow up Testing on Prior Positive Persons:

- If a patient does not have a COVID-19 positive test on file and is here receiving COVID-19 care or in quarantine for COVID-19, they should be retested.
 - If a patient is not here for COVID-19 care and is post quarantine but within 390 days of their last positive test, they do not need to be retested.
- Repeat testing to determine release from quarantine is not approved except for patients being discharged to or at the Kaweah Health Mental Health Hospital (KHHM)
 - If a patient is requiring admission to the KHHM, is asymptomatic for COVID-19 and 7 days post their COVID-19 positive date, they may be retested for COVID-19 on an antigen platform. If the test is negative, be removed from quarantine.

- In all other circumstances, no additional COVID-19 testing is required for 390 days post-infection. Instead, use Time-Based or Symptom-Based strategies to determine resolution of infection (see attached flowcharts)

Practitioners and Employees:

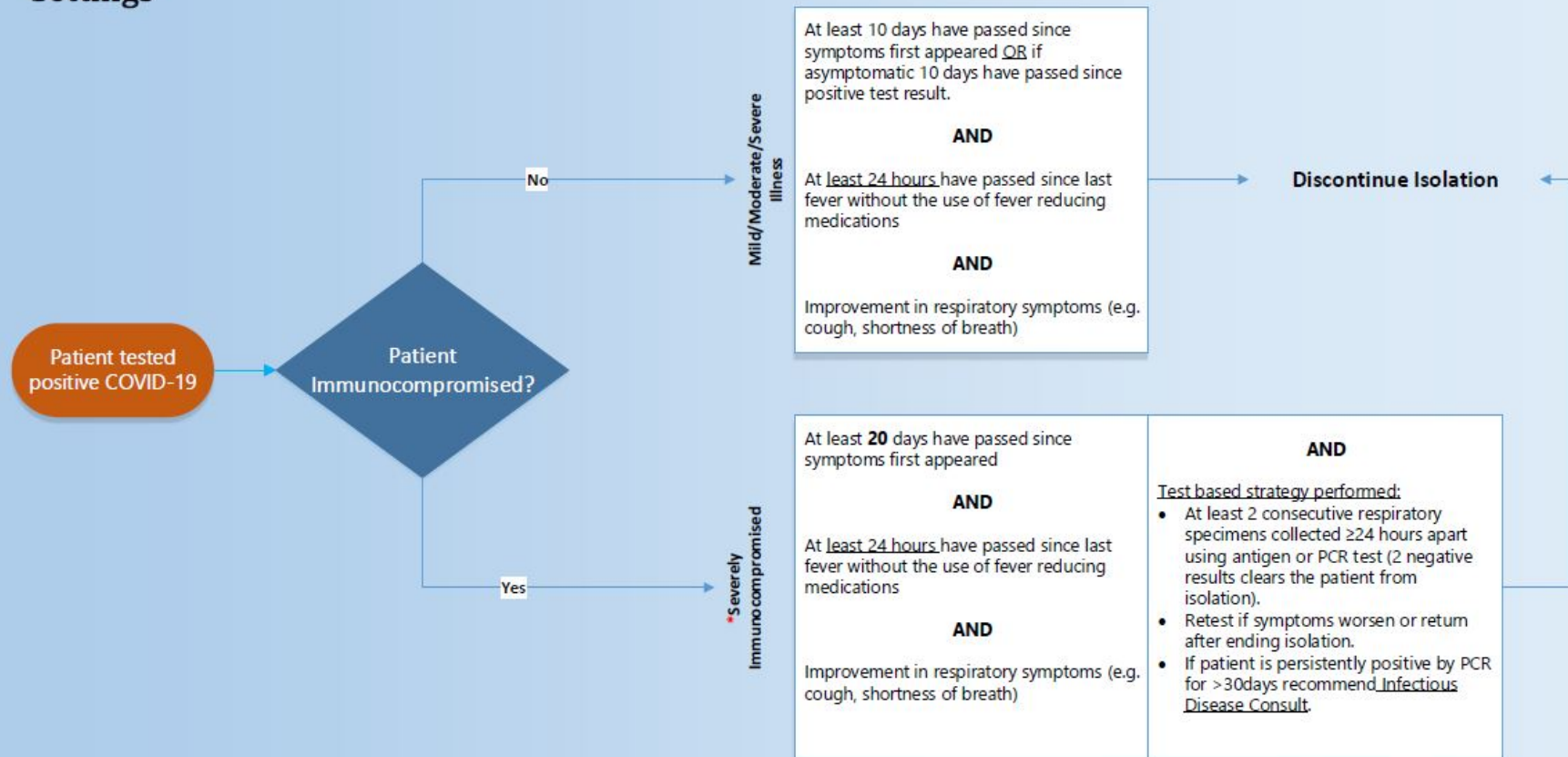
Employee Health will use the Centers for Disease Control (CDC) recommended non-test based strategies for return to work clearance: Time-Based for asymptomatic and Symptom-Based for symptomatic COVID-19 positive healthcare personnel.

References:

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html>
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html>

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Discontinuation of Transmission-Based Precautions and Disposition of Patient with COVID-19 in Healthcare Settings

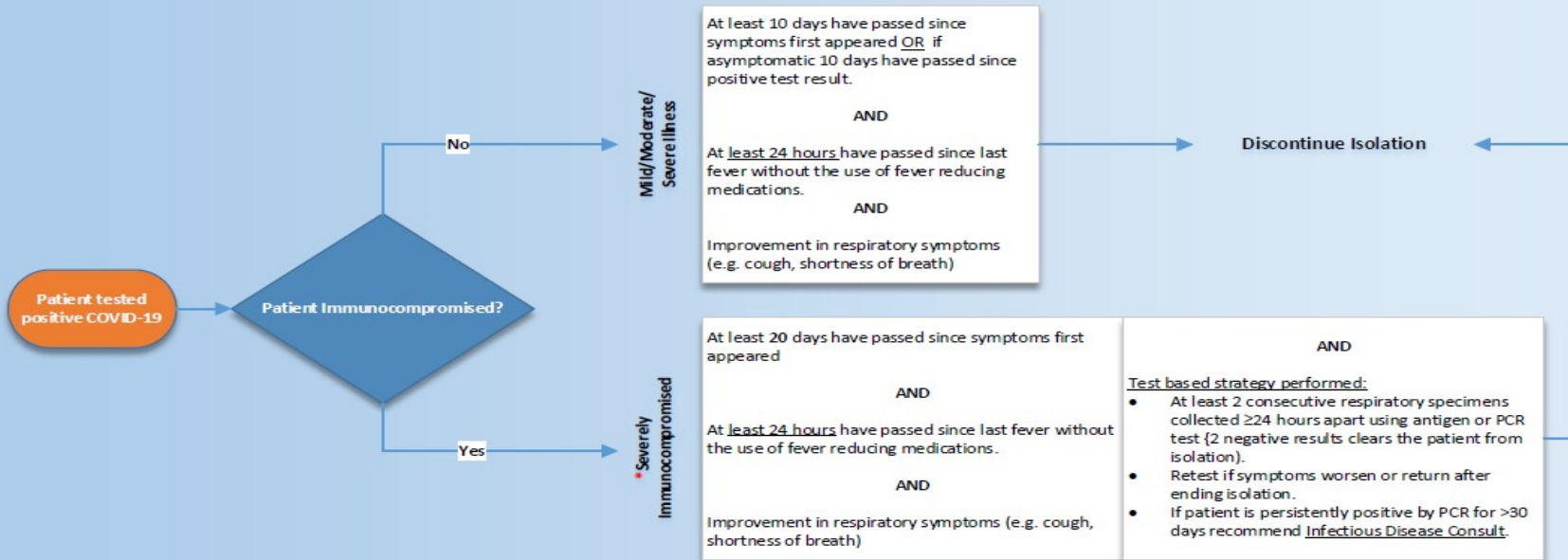


*Severely Immunocompromised conditions include:

- Active treatment for solid tumor and hematologic malignancies, solid organ transplant and taking immunosuppressive therapy
- CAR-T cell therapy or hematopoietic cell transplant (HCT) within 2 years of transplantation or taking immunosuppression therapy
- Moderate to severe primary immunodeficiency, and active treatment with high-dose corticosteroids (i.e. ≥20mg prednisone or equivalent per day administered for ≥2 weeks)
- Alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, chemotherapeutic agent classified as severely immunosuppressive, other biologic agents that immunosuppressive or immunomodulatory.

Note: Criteria depicted above is not required for discharge to home.

Discontinuation of Transmission-Based Precautions and Disposition of Patient with COVID-19 in Healthcare Settings



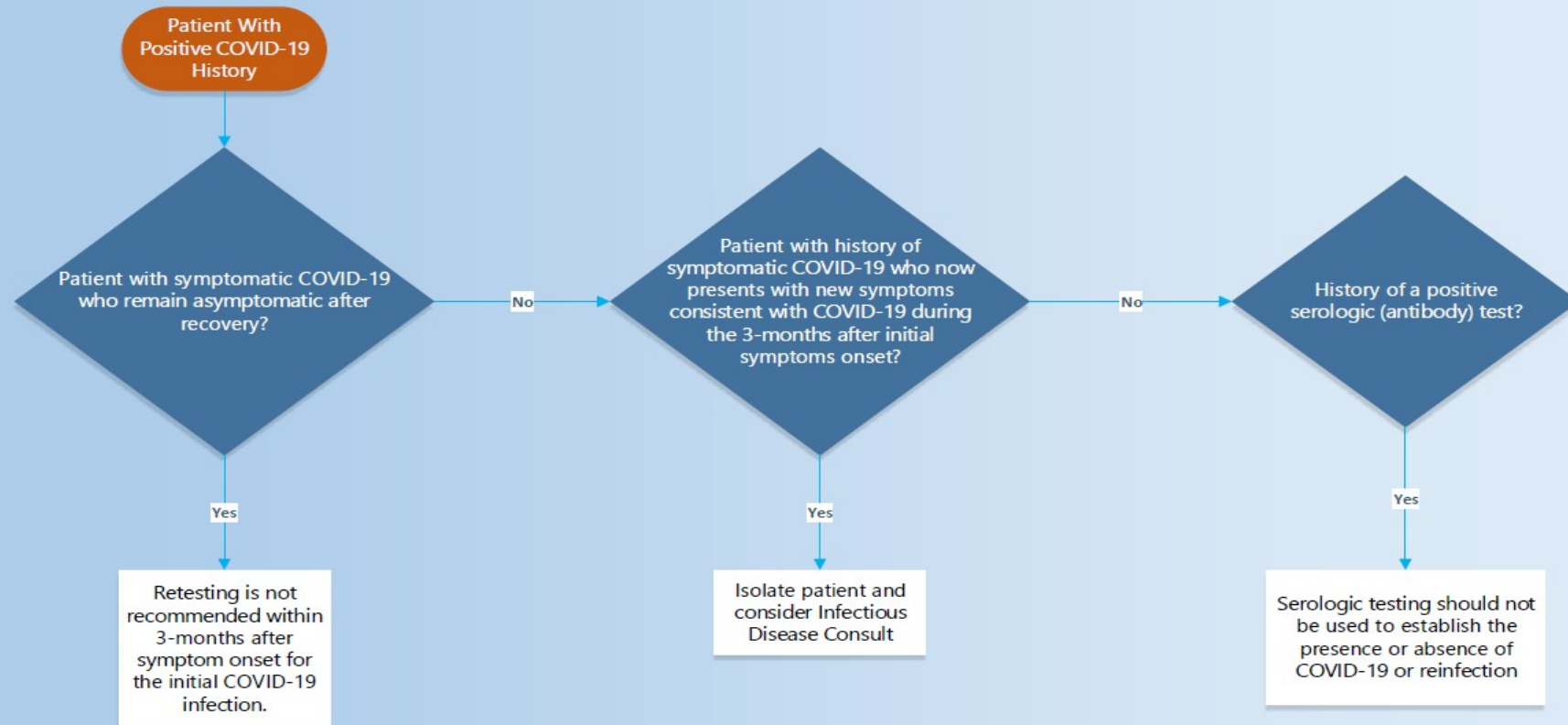
***Severely Immunocompromised conditions include:**

- Active treatment for solid tumor and hematologic malignancies.
- Hematologic malignancies associated with poor response to COVID-19 vaccines regardless of current treatment (e.g. chronic lymphocytic leukemia, non-Hodgkin lymphoma, multiple myeloma, acute leukemia).
- Receipt of solid-organ transplant or an islet transplant and taking immunosuppressive therapy.
- Receipt of chimeric antigen receptor (CAR)-T cell therapy or hematopoietic cell transplant (HCT) (within 2 years of transplantation or taking immunosuppressive therapy).
- Moderate or severe primary immunodeficiency (e.g., common variable immunodeficiency disease, severe combined immunodeficiency, DiGeorge syndrome, Wiskott-Aldrich syndrome).
- Advanced HIV infection (people with HIV and CD4 cell counts less than 200/mm³, history of an AIDS-defining illness without immune reconstitution, or clinical manifestations of symptomatic HIV) or untreated HIV infection.
- Active treatment with high-dose corticosteroids (i.e., 20mg or more of prednisone or equivalent per day when administered for 2 or more weeks), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, other biologic agents that are immunosuppressive or immunomodulatory (e.g., B-cell depleting agents).

Note: Criteria depicted above is not required for discharge home.

Version-5
11/3/2023

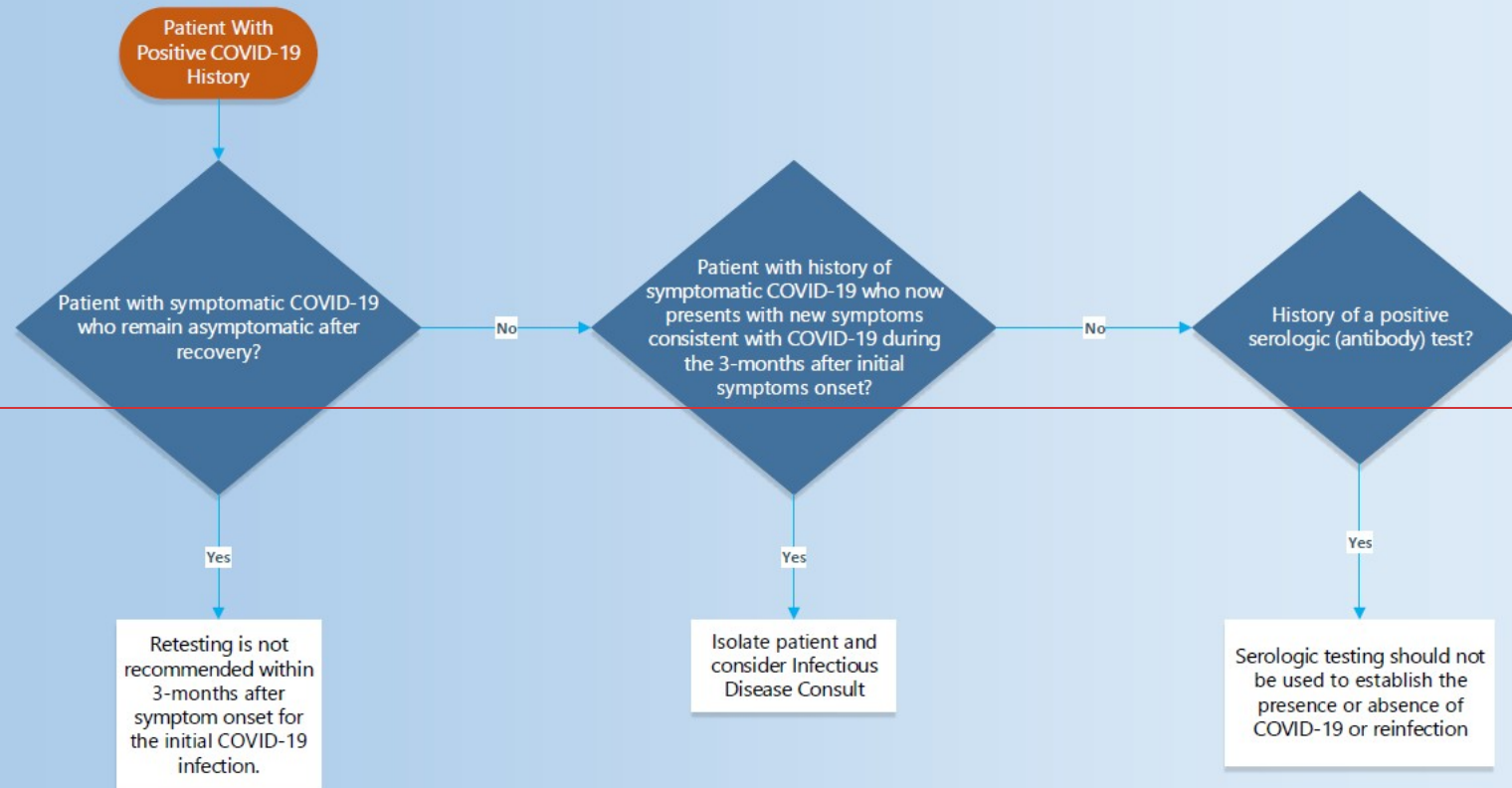
Role of Testing after Discontinuation of Isolation Precautions and Role of Serologic Testing



The algorithm above will be regularly revised to stay in line with professional and regulatory guidance.

Version-1
8/13/2020

Role of Testing after Discontinuation of Isolation Precautions and Role of Serologic Testing



The algorithm above will be regularly revised to stay in line with professional and regulatory guidance.

Version-1
8/13/2020

APP-NP/PA Privilege Form

Provider Name: _____ Date: _____

Please Print

NURSE PRACTITIONER / PHYSICIAN ASSISTANT

Initial Criteria				
Physician Assistant: Completion of an ARC-PA approved program; Current certification by the NCCPA (<i>Obtain certification within one year of completion of PA program or granting of privileges</i>); Current licensure to practice as a PA by the California Physician Assistant Board; OR Nurse Practitioner: Completion of an advanced nursing program accredited by the Commission of Collegiate of Nursing Education (CCNE) or National League for Nursing Accrediting Commission (NLNAC) with emphasis on the NP's specialty area; current certification by the ANCC or AANP (<i>Obtain certification within one year of completion of Masters/Doctorate program</i>); AND Certifications: BLS or ACLS and full schedule California DEA; Emergency Medicine: ACLS & PALS (Must obtain within 12 months of hire) Current Clinical Experience: Documentation of patient care for 100 patients in the past two years OR completion of NP/PA training program within the last 12 months. AND for Emergency Medicine and/or OB: Completion of Kaweah Health Post Partum Hemorrhage & Hypertensive Disorder in Pregnancy Education Modules within 30 days of privilege granted AND Completion of an Implicit Bias Training prior to or within 30 days of privilege granted Renewal Criteria: Documentation of patient care for 100 patients in the past 24 months AND maintenance of current certification by NCCPA, ANCC, or AANP (For PA's granted privileges prior to March 2016 that are not certified by the NCCPA: Must provide 100 CMEs within the last 2 year period, 50 of which must be category I, as defined by the NCCPA for Certification); AND full schedule DEA license; AND Urgent Care: BLS OR ACLS; Emergency Medicine: ACLS & PALS AND Completion of Kaweah Health Post Partum Hemorrhage & Hypertensive Disorder in Pregnancy Education Modules within the last 24 months AND Completion of an Implicit Bias Training within the last 24 months AND Completion of Environment of Care/Workplace Violence Education Module within the last 24 months. FPPE: A minimum of 5 cases by Direct Observation and Retrospective Chart Review at the supervising physician's discretion.				
Request	GENERAL CORE PRIVILEGES			Approve
	Includes procedures on the following list and such other procedures that are extensions of the same techniques and skills (may include telehealth):			
☐	- Application of traction; simple and/or superficial foreign body removal - Apply, remove, and change dressings and bandages; Perform debridement and general care for superficial wounds and minor superficial surgical procedures - Apply/remove cast; diagnosis/treatment and strapping of sprains; splinting and reduction of fractures and dislocations; - Assess, work up and perform differential diagnosis by means of H&P, medical decision making, laboratory and/or other studies, ECG's and diagnostic imaging - Counsel and instruct patients, families, and caregivers as appropriate - Direct care as specified by medical staff-approved protocols; Make daily rounds on hospitalized patients, as appropriate; Initiate appropriate referrals;	- Implement palliative care and end-of-life care through evaluation, modification, and documentation according to the patient's response to therapy, changes in condition, and to therapeutic interventions - Implement therapeutic intervention for specific conditions when appropriate - Insert and remove nasogastric tube; provide tracheostomy care - Order and initial interpretation of diagnostic testing and therapeutic modalities; - Pelvic examinations, including pap smears, and IUD removal - Perform field infiltrations of anesthetic solutions; incision and drainage of superficial abscesses; insertion of packing - Perform History & Physical/ MSE; - Perform other emergency treatment	- Prescribe & Administer medications per formulary of designated certifying board - Record progress notes; - Removal of drains, sutures, staples, & packing - Remove arterial catheters, central venous catheters, chest tubes; - Short-term and indwelling urinary bladder catheterization; venous punctures for blood sampling, cultures, and IV catheterization; superficial surgical procedures - Laceration repair (not requiring plastics intervention); nasal packing; excision of simple skin lesion; removal of impacted cerumen; nail trephination & removal; excision of thrombosed hemorrhoids; - Tonometry / Wood's & Slit Lamp exam of the eye - Write Discharge Summaries and Instructions, as appropriate	☐
POPULATION:				
☐	Adult: Patients >18 years of age			☐
☐	Pediatric: Well newborn up to 18 years of age			☐
SETTING:				
☐	Acute Care Services for Inpatients at a Kaweah Health facility			☐
☐	Emergency Medicine Additional Core Privileges: - Direct care per Emergency Medicine protocol (i.e. Tintinalli's edition) - Point of Care Ultrasound - Replacement of PEG tubes - Insert and remove orogastric tube - Intraosseous Line insertion with EZ-10 - Perform other emergency treatment per protocol (i.e. Tintinalli's edition)			☐
☐	Outpatient Services at a Kaweah Health Clinic identified below. Privileges include performance of core privileges/procedures as appropriate to an outpatient setting and may include telehealth: ___Dinuba ___Exeter ___Lindsay ___Tulare ___Valencia ___Woodlake ___KHMC – Akers ___KHMC – Willow Specialty 202 ___KHMC – Willow 502 ___KHMC – Willow Specialty 305 ___Dialysis Clinic ___Hospice ___Specialty Clinic ___Wound Care Center ___Cardiology Center ___Cardiothoracic Surgery Clinic ___Neuroscience Center ___KHMC – Ben Maddox ___KHMC – Plaza ___Urgent Care – Court Street ___Urgent Care – Demaree ___SRCC Visalia ___SRCC Hanford ___Tulare Cardiology Clinic ___Youth Crisis Stabilization Unit			☐

Advanced Practice Provider – Nurse Practitioner/ Physician Assistant (General)

1

Approved 04.22.26

Provider Name: _____ Date: _____

Please Print

ADVANCED PRIVILEGES					
Initial FPPE is deemed to have been satisfied based on successful completion of a preceptorship at Kaweah Health within 6 months prior to the grant of clinical privileges					
Request	Procedure	Initial Criteria	Renewal Criteria	FPPE	Approve
☐	Arthrocentesis & Joint Aspiration	2 in the last 2 years.	2 in the last 2 years.	A minimum of 1 concurrent	☐
☐	Biopsy of the cervix	Documentation of training and 10 procedures in the last 2 years	2 in the last 2 years.	A minimum of 1 concurrent	☐
☐	Bone Marrow Aspiration & Biopsy	Documentation of training of a minimum of 2 procedures AND direct observation of 1 procedure performed in the last 2 years	2 procedures in the last 2 years.	A minimum of 2 concurrent	☐
☐	Bronchoscopy	20 procedures in the last 2 years	10 procedures in the last 2 years	Minimum of 5 concurrent	☐
☐	Cardiothoracic Advanced Privileges includes sternal closure under supervision, performing minimally invasive radial artery harvesting and/or open technique and performing minimally invasive vein harvesting and/or open technique	Documentation of a Vein Harvesting Certification Course or 20 procedures in the last 2 years	10 procedures in the last 2 years	Minimum of 10 concurrent cases	☐
☐	Cerebral Spinal Fluid (CSF Shunt Tap)	2 in the last 2 years	1 in the last 2 years	2 concurrent	☐
☐	Colposcopy	Documentation of training and 10 procedures in the last 2 years.	10 procedures in the last 2 years.	A minimum of 1 concurrent	☐
☐	Complex Wound Care (Wound debridement, application of skin substitutes, complicated management and wound biopsy) (Wound Care Center Only)	20 procedures in the last 2 years	20 procedures in the last 2 years	First 2 concurrent cases	☐
☐	Endometrial Biopsy	Documentation of training and 10 procedures in the last 2 years	2 in the last 2 years.	A minimum of 1 concurrent	☐
☐	Endotracheal Intubation	10 in the last 2 years	8 in the last 2 years	Minimum of 3 concurrent	☐
☐	Hospice: Rounding on home-bound patients enrolled in KDHC Hospice Services	Initial Criteria for Core Privileges	20 patient contacts in the last 2 years.	2 concurrent or retrospective chart reviews.	☐
☐	Hyperbaric Oxygen Therapy Pre-requisite: Hyperbaric Course approved by the Undersea and Hyperbaric Medical Society (UHMS) or the American College of Hyperbaric Medicine (ACHM) (Wound Care Center Only)	Completion of 40 hour Hyperbaric Course and documentation of 20 cases in the last 2 years.	20 procedures AND documentation of 10 CME in wound care/hyperbaric medicine in the last 2 years	2 direct observation & 2 retrospective chart reviews	☐
☐	Insertion of Arterial Lines	5 in the last 2 years	5 in the last 2 years	2 concurrent	☐
☐	Insertion of central venous access or dialysis catheters	5 in the last 2 years	5 in the last 2 years	Minimum of 2 -any site concurrent	☐
☐	Insertion of Chest Tubes	5 in the last 2 years	5 in the last 2 years	Minimum of 3 concurrent	☐
☐	Joint Injection	Documentation of training and 5 procedures in the last 2 years (Use of Sim Lab acceptable for up to 2)	2 procedures in the last 2 years (Sim Lab procedures not accepted)	A minimum of 1 concurrent	☐
☐	Laceration Repair – Complex and Layered	3 in the last 2 years	3 in the last 2 years	3 concurrent	☐
☐	Lumbar Puncture	3 in the last 2 years	3 in the last 2 years	2 concurrent	☐
☐	Myelogram	3 in the last 2 years	3 in the last 2 years	2 concurrent	☐



Provider Name: _____ Date: _____

Please Print

ADVANCED PRIVILEGES - CONTINUED

FPPE requirement waived if provider has successfully completed training (preceptorship) at Kaweah Health within the last 6 months

Request	Procedure	Initial Criteria	Renewal Criteria	FPPE	Appr
☐	Nephrology: Changing dry weight, checking declots (Dialysis Centers Only)	Initial Criteria for Core Privileges	20 nephrology patient contacts in the last 2 years	2 concurrent or retrospective chart reviews.	☐
☐	Nexplanon insertion and removal	Documentation of training and 10 procedures in the last 2 years	2 in the last 2 years.	A minimum of 1 concurrent	☐
☐	OB Care: Prenatal and post-partum care	Documentation of training and 20 prenatal/ post-partum cases in the last 2 years. AND Completion of Kaweah Health Post Partum Hemorrhage & Hypertensive Disorder in Pregnancy Education Modules within 30 days of privilege granted AND Completion of an Implicit Bias Training prior to or within 30 days of privilege granted	20 prenatal/ post-partum cases in the last 2 years. AND Completion of Kaweah Health Post Partum Hemorrhage & Hypertensive Disorder in Pregnancy Education Modules within the last 24 months AND Completion of an Implicit Bias Training within the last 24 months	2 concurrent or retrospective chart reviews.	☐
☐	OB ultrasonography: Evaluation of fetal presentation, number, confirmation of cardiac activity, position and placental placement	Completion of Basic Obstetric Ultrasound course in limited U/S and 10 in the last 2 years.	10 in the last 2 years.	3 concurrent and/or retrospective chart reviews	☐
☐	Orthopedic Advanced Privileges to include Open fracture superficial closure – loose approximation of open fracture closure under direct supervision (prior to definitive surgical closure by the surgeon in the OR) and the following procedures: ___ Joint Injection & Arthrocentesis	5 Joint Injections or Arthrocentesis in the last 2 years	15 procedures in the last 2 years	A minimum of 1 concurrent	☐
☐	Paracentesis (may or may not include the use of ultrasound guidance)	5 in the last 2 years	5 in the last 2 years	5 concurrent	☐
☐	Paragard and Mirena IUD insertion	Documentation of training and 10 procedures in the last 2 years	2 in the last 2 years.	A minimum of 1 concurrent	☐
☐	Perform pharmacological and non-pharmacological stress tests	10 in the last 2 years	10 in the last 2 years	2 concurrent	☐
☐	Placement of External Ventricular Drainage Device	3 in the last 2 years	3 the last 2 years	2 concurrent	☐
☐	Placement of Intracranial Monitoring Devices	3 in the last 2 years	3 in the last 2 years	2 concurrent	☐
☐	<u>Punch Biopsy</u>	<u>Documentation of training within the last 24 months and/or a minimum of 6 procedures in the last 2 years</u>	<u>A minimum of 6 procedures in the last 2 years</u>	<u>A minimum of (1) one by direct observation.</u>	☐
☐	Radiation Oncology: Assist with simulations; high dose rate brachytherapy, intravenous radioactive therapy, oral radioactive administration and atrontium beta-irradiation application	A minimum of 3-month training period with a radiation oncologist OR previous experience.	10 in the last 2 years	A minimum of 10 (including Core) concurrent	☐
☐	Radiologic procedures to include CT, Fluoroscopy, and Ultrasound of deep & superficial organs and organ systems (including aspirations, biopsies, drainages, or injections)	25 in the last 2 years	25 in the last 2 years	5 concurrent	☐

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Provider Name: _____ Date: _____

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ADVANCED PRIVILEGES - CONTINUED

FPPE requirement waived if provider has successfully completed training (preceptorship) at Kaweah Health within the last 6 months

Request	Procedure	Initial Criteria	Renewal Criteria	FPPE	Approve
☐	Removal of Intra-Aortic Balloon Pump	5 in the last 2 years	2 in the last 2 years	5 concurrent	☐
☐	Removal of Intra-cardiac lines or temporary Epicardial Pacer Wires	2 in the last 2 years	1 in the last 2 years	2 concurrent	☐

ADVANCED PRIVILEGES — CONTINUED

FPPE requirement waived if provider has successfully completed training (preceptorship) at Kaweah Health within the last 6 months

Request	Procedure	Initial Criteria	Renewal Criteria	FPPE	Approve
☐	Replacement of tracheostomy tubes >1 month since time of tracheostomy	5 in the last 2 years	5 in the last 2 years	5 concurrent	☐
☐	Surgical Assistant (<i>may not perform opening and/or closing surgical procedures at or below the fascia on a patient under anesthesia without the personal presence of a supervising physician and surgeon</i>).	10 in the last 2 years	10 in the last 2 years	2 concurrent	☐
☐	Thoracentesis	5 in the last 2 years	5 in the last 2 years	Minimum of 2 concurrent	☐
☐	Tilt Table	5 in the last 2 years	5 in the last 2 years	2 concurrent	☐
☐	Uncomplicated Ventilator Management	5 in the last 2 years	5 in the last 2 years	2 concurrent	☐
☐	Urology Advanced Privileges to include: — Urodynamics — PTNS (percutaneous tibial nerve stimulation) — Cystoscopy — Cystoscopy with stent removal	10 Urodynamics cases in the last 2 years AND 10 PTNS cases in the last 2 years AND 5 Cystoscopy cases in the last 2 years AND 6 Cystoscopy cases with stent removal in the last 2 years	10 in the last 2 years	A minimum of 1 concurrent	☐

ADDITIONAL PRIVILEGES

Request	Procedure	Initial Criteria	Renewal Criteria	FPPE	Approve
☐	Use of fluoroscopy equipment (or supervision of other staff using the equipment)	Current and valid CA Fluoroscopy supervisor and Operator Permit or a CA Radiology Supervisor and Operator Permit	Current and valid CA Fluoroscopy supervisor and Operator Permit or a CA Radiology Supervisor and Operator Permit	None	☐
☐	Image-guided techniques as an adjunct to privileged procedures	Documentation of training and 10 procedures in the last 2 years.	10 procedures in the last 2 years.	None	☐
☐	Administration of Moderate Sedation	Successful completion of Kaweah Health sedation exam	Successful completion of Kaweah Health sedation exam	None	☐

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Provider Name: _____ Date: _____

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Acknowledgment of Practitioner:

I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise and; I understand that:

- (a) In exercising any clinical privileges granted, I am constrained by any Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.
- (b) I may participate in the Kaweah Health Street Medicine Program, as determined by Hospital policy and Volunteer Services guidelines. As a volunteer of the program, Medical Mal Practice Insurance coverage is my responsibility.
- (c) **Emergency Privileges** – In case of an emergency, any member of the medical staff, to the degree permitted by his/her license and regardless of department, staff status, or privileges, shall be permitted to do everything reasonably possible to save the life of a patient from serious harm.

Advanced Practice Provider Signature *Date*

Supervising/Collaborating Physician Signature *Date*

DEPARTMENT CHAIR SIGNATURE(S) :

Department of Cardiovascular Services *Date*

Department of Critical Care, Pulmonary & Adult Hospitalist *Date*

Department of Emergency Medicine *Date*

Department of Family Medicine *Date*

Department of Internal Medicine *Date*

Department of OB/GYN *Date*

Department of Pediatrics *Date*

Department of Psychiatry & Neurosciences *Date*

Department of Radiology *Date*

Department of Surgery *Date*

Family Medicine Privilege Form

Name: _____ Date: _____
Please Print

FAMILY MEDICINE PRIVILEGES					
Education: M.D. or D.O. and successful completion of an ACGME or AOA accredited residency/fellowship in Family Medicine AND current certification or active participation in the examination process leading to Board Certification in Family Medicine by the ABFM or AOBFM,. Board certification must be obtained within the timeframe determined by the certifying board. Initial Criteria: Documentation of a minimum of 50 adult, pediatric, and/or GYN patient contacts within the last 2 years, depending on privileges requested or completion of residency or clinical fellowship within the past 12 months. Renewal Criteria: Maintain current certification or active participation in the examination process leading to certification in Family Medicine by the American Board of Family Medicine or the American Osteopathic Board of Family Medicine and documentation of a minimum of 24 adult and/or pediatric, patient contacts within the last 2 years, depending on privileges requested. FPPE: Minimum 5 admissions with 3 different diagnoses from the following: GI/ ; Abdominal; Cardiac; Pulmonary; Neurology; Endocrinology Outpatient Only - Chart review of 5 diverse diagnoses					
Request	FAMILY MEDICINE CORE PRIVILEGES	Approve			
☐	Core Privileges include: the ability to perform H&P, evaluate diagnose, treat and provide consultation (may include telehealth) to patients of all ages (including the care of the normal newborn as well as the uncomplicated premature infant born at or after 37 weeks of gestation), with a wide variety of illnesses, diseases, injuries, and functional disorders of organ systems; AND the following procedures and other procedures that are extensions of the same techniques and skills: <table border="1"> <tbody> <tr> <td> - Arthrocentesis and joint injection - Breast cyst aspiration - Cervical biopsy and polypectomy - Culdcentesis Cryosurgery/cautery for benign disease - Endometrial biopsy excision/biopsy of vulvar lesions - Management of burns, superficial and partial thickness - Excision of cutaneous and subcutaneous lesions, tumors, and nodules </td> <td> - Incision and drainage of abscesses and Bartholin duct cyst or marsupialization - Injection bursa or trigger point - Insertion and removal of intrauterine devices - Management of uncomplicated, minor, closed fractures and uncomplicated dislocations - Nail Trephination - Performance of local anesthetic techniques </td> <td> - Performance of needle biopsies - Performance of simple skin biopsies - Peripheral nerve blocks - Placement of anterior and posterior nasal hemostatic packing - Preliminary reading of diagnostic tests - Removal of foreign bodies from the vagina - Removal of a nonpenetrating foreign body from the eye, nose or ear - Suturing of uncomplicated lacerations </td> </tr> </tbody> </table>	- Arthrocentesis and joint injection - Breast cyst aspiration - Cervical biopsy and polypectomy - Culdcentesis Cryosurgery/cautery for benign disease - Endometrial biopsy excision/biopsy of vulvar lesions - Management of burns, superficial and partial thickness - Excision of cutaneous and subcutaneous lesions, tumors, and nodules	- Incision and drainage of abscesses and Bartholin duct cyst or marsupialization - Injection bursa or trigger point - Insertion and removal of intrauterine devices - Management of uncomplicated, minor, closed fractures and uncomplicated dislocations - Nail Trephination - Performance of local anesthetic techniques	- Performance of needle biopsies - Performance of simple skin biopsies - Peripheral nerve blocks - Placement of anterior and posterior nasal hemostatic packing - Preliminary reading of diagnostic tests - Removal of foreign bodies from the vagina - Removal of a nonpenetrating foreign body from the eye, nose or ear - Suturing of uncomplicated lacerations	☐
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☐	Privileges to Admit patients to Kaweah Health Acute Care Facilities	☐			
☐	Outpatient Services at a Kaweah Health facility to include Medical exam, evaluate, diagnose and treat patients of all ages; pre & post-natal care; and core procedures as appropriate to the outpatient setting and may include telehealth. Prerequisite: Contract for Outpatient Clinical services with Kaweah Delta Health Care District. Please identify location: Dinuba __ Exeter __ Lindsay __ Tulare __ Valencia __ Woodlake __ KHMC – Akers __ KHMC – Willow Specialty 202 __ KHMC – Willow 502 __ Specialty Clinic __ Dialysis Clinic __ Urgent Care – Court __ Urgent Care – Demaree __ KHMC - Ben Maddox __ KHMC – Plaza __ Tulare Cardiology Clinic	☐			
FAMILY MEDICINE—INPATIENT ACUTE REHABILITATION CORE PRIVILEGES					
Initial Criteria: Documentation of having served as attending rehabilitation physician for at least 24 patients in the last 2 years Renewal Criteria: Admission or management of 24 acute rehabilitation patients in the last 2 years and a Minimum of 10 hrs of physical medicine and rehabilitation CME and documentation of compliance to all IRF regulations validated by Medical Director FPPE: 3 Retrospective chart reviews					
Request	FAMILY MEDICINE INPATIENT ACUTE REHABILITATION CORE PRIVILEGES	Approve			
☐	Inpatient Acute Rehabilitation Core Privileges include: complete required post-admission physician evaluation and overall plan of care within required time frames; Face to face visits with each patient at least three days per week to assess patient medically and functionally as well as to modify the course of treatment as needed; Facilitate weekly team conferences and family conferences; <i>*Applicant is familiar with and agrees to abide by all CMS Inpatient Rehabilitation Facility (IRF) regulations and to collaborate with contracted rehabilitation services physician group in regards to admission criteria, after hours and weekend coverage, and specialist consultation as needed.</i>	☐			
FAMILY MEDICINE - OBSTETRICS PRIVILEGES					
Initial Criteria: Documentation of two months of obstetrical rotation during family medicine residency, with 40 patients delivered; AND Current neonatal resuscitation program certification AND Documentation of the performance of at least 20 deliveries in the past 24 months OR completion of training in the past 12 months. AND Completion of Kaweah Health Post Partum Hemorrhage & Hypertensive Disorder in Pregnancy Education Modules within 30 days of privilege granted AND Completion of an Implicit Bias Training prior to or within 30 days of privilege granted Renewal Criteria: Documentation of the performance of at least 20 deliveries in the past 24 months AND Completion of Kaweah Health Post Partum Hemorrhage & Hypertensive Disorder in Pregnancy Education Modules within the last 24 months AND Completion of an Implicit Bias Training within the last 24 months FPPE: 3 vaginal deliveries, to include operative deliveries (included but not limited to vacuum) and 3 degree repairs. Invasive procedures require direct observation.					

Name: _____ Date: _____

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Request	FAMILY MEDICINE- OBSTETRICS CORE PRIVILEGES			Approve								
☐	Inpatient Obstetric privileges for family physicians include the ability to perform an H&P, evaluate (may include telehealth), and manage female patients with normal-term pregnancy with an expectation of non-complicated vaginal delivery, management of labor and delivery, and procedures related to normal delivery, including medical diseases that are complicating factors in pregnancy (with consultation) and other procedures that are extensions of the same techniques and skills: <table border="1"> <tr> <td> - Amniotomy; - Augmentation of labor - Dilation and curettage, including suction and postpartum; - Excision of vulvar lesions at delivery; - External and internal fetal monitoring; - Induction of labor with consultation and pitocin management; </td> <td> - Initial management of postpartum hemorrhage; - Manual removal of placenta, post delivery - Normal spontaneous vaginal delivery of a full-term vertex presentation, including ante- and postpartum care; </td> <td> - Oxytocin challenge testing; - Postpartum endometritis; Pudendal anesthesia; - Repair of episiotomy, including; lacerations/extensions; - Repair of vaginal and cervical lacerations; - Vacuum-assisted delivery </td> </tr> </table> The Family Medicine physician must document in the electronic medical record consultation with a back-up Obstetrician for admitted patients for the following required consultations. The record of the consult being discussed with the OB should be placed in the chart by the FM provider. The OB provider will document the consult at their discretion. <table border="1"> <tr> <td> - Pregnancy > 42 weeks and not in labor. - Chronic hypertension, gestational hypertension, pre-eclampsia or eclampsia. - Any gravely ill patient. - First stage of labor longer than 24 hours. - Pre-term admission (less than 36 weeks) with obstetrical complications. - Failure to progress (one of the following): - Secondary arrest of dilatation on latent phase (cervix <4cm; 8 hr labor without appreciable progress). - Secondary arrest of dilatation in active phase (cervix >4cm and no dilatation for 4 hr). - Secondary arrest of descent. </td> <td> - Second stage of labor > 2 hr, >3 hr with epidural - Significant postpartum hemorrhage. 2 nd or 3 rd trimester non-cervicitis antepartum bleeding. - Persistent, significant variable or late decelerations not remedied by oxygen or position change. - All inductions of labor <40 weeks. - Premature rupture of the membranes greater than 24 hours or with fever > 100.4F - Retained placenta requiring general anesthetic. - IUGR or macrosomia. - Polyhydramnios/oligohydramnios </td> <td> - Suspected chorioamnionitis or documented fever complicating labor of 100.4F or greater without an obvious source. - Postpartum fever 100.4F or persisting over 48 hours after delivery. - Non-reassuring fetal heart rate tracing. - Instrumented delivery, other than outlet. - Rh Isoimmunization. - Hyperthyroidism. Active hepatitis. - Epilepsy. - Severe anemia (hct <25). - Gynecologic cancers </td> </tr> </table> The Family Medicine physician shall obtain formal consultation, and the consultant will decide whether the pregnancy management will be by joint management or a physician with OB/GYN privileges: <table border="1"> <tr> <td> A. Initial Prenatal Factors: - Anticipated Trial of Labor after Cesarean - Multiple pregnancy - Insulin dependent diabetes - Chronic hypertension requiring medication during pregnancy - Renal failure - Heart disease, Class 2 or greater - Hyperthyroidism, poorly controlled - Rh Isoimmunization with prior preterm delivery, significant neonatal jaundice or neonatal transfusion - Isoimmune thrombocytopenia - Active lupus or other collagen vascular disease </td> <td> B. Subsequent Prenatal and Intrapartum Factors - Hospital admission for preterm labor - Preterm pre-eclampsia or severe pre-eclampsia at any gestational age - Significant malformation excluding anencephaly - Fetal demise beyond 14 weeks - Breech or other abnormal presentation of labor. - Significant malformation of the fetus. - Prolapsed cord. </td> </tr> </table>			- Amniotomy; - Augmentation of labor - Dilation and curettage, including suction and postpartum; - Excision of vulvar lesions at delivery; - External and internal fetal monitoring; - Induction of labor with consultation and pitocin management;	- Initial management of postpartum hemorrhage; - Manual removal of placenta, post delivery - Normal spontaneous vaginal delivery of a full-term vertex presentation, including ante- and postpartum care;	- Oxytocin challenge testing; - Postpartum endometritis; Pudendal anesthesia; - Repair of episiotomy, including; lacerations/extensions; - Repair of vaginal and cervical lacerations; - Vacuum-assisted delivery	- Pregnancy > 42 weeks and not in labor. - Chronic hypertension, gestational hypertension, pre-eclampsia or eclampsia. - Any gravely ill patient. - First stage of labor longer than 24 hours. - Pre-term admission (less than 36 weeks) with obstetrical complications. - Failure to progress (one of the following): - Secondary arrest of dilatation on latent phase (cervix <4cm; 8 hr labor without appreciable progress). - Secondary arrest of dilatation in active phase (cervix >4cm and no dilatation for 4 hr). - Secondary arrest of descent.	- Second stage of labor > 2 hr, >3 hr with epidural - Significant postpartum hemorrhage. 2 nd or 3 rd trimester non-cervicitis antepartum bleeding. - Persistent, significant variable or late decelerations not remedied by oxygen or position change. - All inductions of labor <40 weeks. - Premature rupture of the membranes greater than 24 hours or with fever > 100.4F - Retained placenta requiring general anesthetic. - IUGR or macrosomia. - Polyhydramnios/oligohydramnios	- Suspected chorioamnionitis or documented fever complicating labor of 100.4F or greater without an obvious source. - Postpartum fever 100.4F or persisting over 48 hours after delivery. - Non-reassuring fetal heart rate tracing. - Instrumented delivery, other than outlet. - Rh Isoimmunization. - Hyperthyroidism. 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ADVANCED FAMILY MEDICINE-OBSTETRICS PRIVILEGES												
Request	Procedure	Initial Criteria	Renewal Criteria	FPPE	Approve							
☐	C-Section (Advanced Privilege) – for - scheduled repeat term pregnancy; - failed vaginal birth after cesarean section; breech or transverse presentation > 34 weeks; - nonreassuring fetal heart tracings; - failure to progress (outside criteria) Must have arrangements for Back-up with an Active member of the Department of OB/GYN.	Completion of 1 year additional focused fellowship training in OB within previous 2 years OR training and current experience similar in scope and depth AND 25 c-sections in the last 2 years	Documentation of 10 c-sections in the last 2 years	A minimum of 2 procedures under direct observation	☐							
☐	Forceps Delivery	Documentation of 10 procedures in the last 2 years	Documentation of 5 procedures in the last 2 years	Minimum of 5 concurrent	☐							

Name: _____ Date: _____

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☐	Dilation and curettage, incomplete abortion	Documentation of 5 procedures in the last 2 years	3 procedures in the last 2 years	1 concurrent	☐
☐	OB Ultrasound: Evaluation of fetal presentation, number, confirmation of cardiac activity, position and placental location.	Training in residency or documentation of 10 procedures in the last 2 years. AND Completion of Kaweah Health Post Partum Hemorrhage & Hypertensive Disorder in Pregnancy Education Modules within 30 days of privilege granted AND Completion of an Implicit Bias Training prior to or within 30 days of privilege granted	Documentation of 10 procedures in the last 2 years. AND Completion of Kaweah Health Post Partum Hemorrhage & Hypertensive Disorder in Pregnancy Education Modules within the last 24 months AND Completion of an Implicit Bias Training within the last 24 months	3 concurrent and/or retrospective	☐
☐	Tubal Ligation	Documentation of 10 procedures in the last 2 years	5 procedures in the last 2 years	1 concurrent	☐
ADVANCED FAMILY MEDICINE PRIVILEGES					
Request	Procedure	Initial Criteria	Renewal Criteria	FPPE	Approve
☐	Abdominal Paracentesis	Documentation of 5 procedures in the last 2 years	Documentation of 5 procedures in the last 2 years	5 concurrent	☐
☐	Arterial Line Placement	Documentation of 5 procedures in the last 2 years	5 procedures in the last 2 years	3 under direct observation	☐
☐	Chest Tube Placement	Documentation of 5 procedures in the last 2 years	Documentation of 5 procedures in the last 2 years	Minimum of 3	☐
☐	Colonoscopy	Documentation of 10 procedures in the last 2 years	Minimum of 10 procedures in the last 2 years.	Minimum of 1 concurrent	☐
☐	Colposcopy	Documentation of 10 procedures in the last 2 years	Documentation of 5 procedures in the last 2 years	Minimum of 1 concurrent	☐
☐	Circumcision	Documentation of 5 procedures in the last 2 years OR co-management of a minimum of 5 patients with a physician possessing the privilege. (Use of Sim lab acceptable)	5 procedures in the last 2 years. (Use of Sim Lab acceptable)	1 concurrent	☐
☐	Diagnostic Ultrasound: ☐ Aorta ☐ Ocular ☐ Biliary ☐ Soft Tissue ☐ Cardiac ☐ Urinary Tract ☐ DVT ☐ Pulmonary ☐ Musculoskeletal	Documentation of a minimum of 25 point of care ultrasound (POCUS) exams for each application in the last 2 years. (Use of Sim lab acceptable for up to 15)	Documentation of a minimum of 25 POCUS exams for each application in the last 2 years. (Use of Sim lab acceptable for up to 15)	2 exams per each application	☐
☐	Endotracheal Tube placement - Adult	Documentation of 10 procedures in the last 2 years and current ACLS	Documentation of 8 procedures in the last 2 years and current ACLS (Use of Sim lab acceptable)	Minimum of 3 concurrent	☐
☐	Endotracheal Tube placement – Pediatric (does not include neonatal)	Documentation of 10 procedures in the last 2 years and current PALS	Documentation of 8 procedures in the last 2 year and current PALS (Use of Sim lab acceptable)	Minimum of 3	☐
☐	4 th degree laceration repair	Documentation of 5 procedures in the last 2 years (Use of Sim lab acceptable)	2 procedures in the last 2 years (Use of Sim lab acceptable)	None	☐
☐	Lumbar Puncture	Documentation of 3 procedures in the last 2 years	Documentation of 3 procedures in the last 2 years	2 concurrent	☐

Name: _____ Date: _____

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☐	Sigmoidoscopy	Documentation of 60 procedures in the last 2 years	60 procedures in the last 2 years.	Minimum of 1 concurrent	☐
☐	Thoracentesis	Documentation of 5 procedures in the last 2 years	Documentation of 5 procedures in the last 2 years	Minimum of 2 concurrent	☐
☐	Uncomplicated Ventilator Management	Documentation of 5 procedures in the last 2 years or current ACLS.	Documentation of 5 procedures in the last 2 years or current ACLS	1 concurrent	☐
☐	Vasectomy	Documentation of 5 procedures in the last 2 years OR co-management of a minimum of 5 patients with a physician possessing the privilege (Use of Sim lab acceptable)	3 procedures in the last 2 years	1 under direct observation	☐
☐	Venous Central Line Placement	Documentation of 5 procedures in the last 2 years	5 procedures in the last 2 years	2 under direct observation	☐
ADDITIONAL PRIVILEGES					
Request	Procedure	Initial Criteria	Renewal Criteria	FPPE	Approve
☐	Supervision of a technologist using fluoroscopy equipment	Current and valid CA Fluoroscopy supervisor and Operator Permit or a CA Radiology Supervisor and Operator Permit	Current and valid CA Fluoroscopy supervisor and Operator Permit or a CA Radiology Supervisor and Operator Permit	None	☐
☐	Administration of Moderate Sedation	Successful completion of Kaweah Health sedation exam	Successful completion of Kaweah Health sedation exam	None	☐

Acknowledgment of Practitioner:

I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise and I understand that

- In exercising any clinical privileges granted, I am constrained by any Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.
- I may participate in the Kaweah Health Street Medicine Program, as determined by Hospital policy and Volunteer Services guidelines. As a volunteer of the program, Medical Mal Practice Insurance coverage is my responsibility.
- Emergency Privileges** – In case of an emergency, any member of the medical staff, to the degree permitted by his/her license and regardless of department, staff status, or privileges, shall be permitted to do everything reasonably possible to save the life of a patient from serious harm.

Signature: _____ *Applicant* _____ *Date*

Signature: _____ *Department of Family Medicine Chair* _____ *Date*

MS40



Policy Number: MS 40	Date Created: 09/19/2025
Document Owner: Ody DaSilva (Medical Staff Manager)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration); Medical Executive Committee; DaSilva, Ody; Davis, Kelsie; Vinson, Shannon	
Impaired Practitioner Policy	

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

- I. **Purpose:** Substance abuse can adversely impact patient care and workplace safety. Use and abuse of alcohol or controlled substances may impair the ability of a medical staff member and advanced practice provider (collectively, Practitioner) to provide services and may endanger the individual, his or her co-workers, patients and the public. This policy is developed to provide for patient safety and to help eliminate the problem of workplace substance abuse.
- II. **Policy:** It is the Medical Staff's policy to continuously strive toward preventing Practitioners from providing patient care services while impaired and toward maintaining a work environment free from illegal drug use and abuse of other substances. It is also the Medical Staff's policy that the integrity, well-being, confidentiality, and professional activity and personal privacy of the Practitioner under review be protected to the extent permitted by law.
- III. **Applicability of Policy:** This policy applies to all Practitioners holding membership or privileges at Kaweah Health.
- IV. **Definitions:**
 - A. Controlled substance – Any and all chemical substances or drugs listed in any controlled substances acts or regulations applicable under any federal, state or local laws.
 - B. Illegal drug – Any controlled substance the possession of which is illegal under any federal, state or local laws. Where these laws are conflicting (e.g.: medical marijuana) legal counsel will determine the legality of such substances.
 - C. Substance Use Disorder (SUD) – A disease that affects a person's brain and behavior and leads to an inability to control the use of a legal or illegal drug medication. Substances such as alcohol, marijuana, and nicotine also are considered drugs.
 - D. Opioid Use Disorder (OUD) – A chronic lifelong disorder, with serious potential consequences including disability, relapses or death. OUD, also known as opioid addiction, is defined as a problematic pattern of opioid use leading to clinically significant impairment or distress.
 - E. Alcohol Use Disorder (AUD) – A drinking problem that becomes severe. AUD is a chronic relapsing brain disorder characterized by an impaired ability to stop or control alcohol use despite adverse social, occupational, or health consequences.
 - F. Drug or alcohol test – Any test administered to determine the presence or absence of a chemical or drug in a person's urine or blood. Testing should be done by a reputable laboratory with a definitive testing modality and NOT a screening test, which may be unreliable. When warranted by the circumstances, a Practitioner may be required to submit hair or nail samples for drug or alcohol testing.
 - G. Under the influence – A condition that impairs or may impair a Practitioner's ability to provide medical services in a safe and productive manner and/or may adversely affect

his or her safety or that of patients or other Practitioners. This must be shown to be reasonably present at the time of occurrence.

- H. At High Risk of Impairment – As used in this policy, a Practitioner is at high risk of impairment in the performance of patient care duties when the Practitioner has or is suspected to have a Substance Abuse Disorder, Opioid Use Disorder, and/or Alcohol Use Disorder.
- I. Screening Physical Exam – An immediate thorough exam that includes, as appropriate, bedside point-of-care (POC) testing [blood glucose, ethanol breathalyzer, EKG, etc] mini-mental status exam, neurological exam, GCS, and/or toxidrome evaluations. This exam will be documented.
- J. Chief of Staff Designee– Any Officer of the Medical Staff: Vice Chief of Staff, Past Chief of Staff or Secretary/Treasurer; The Chief Medical Officer may be asked on a case by case basis to act as a Chief of Staff Designee in the absence of all Officers of the Medical Staff.

V. Prohibited Actions:

The following are prohibited while engaging in activities related to patient care at any Kaweah Health facility:

1. Possessing, consuming, or being under the influence of alcohol or illegal drugs.
2. Exhibiting physical or mental impairment likely to adversely affect patient care or workplace safety.
3. Distribution, sale, or purchase of controlled substances or illegal drugs while on Kaweah Health property, even if the illegal drug itself is not actually possessed on Kaweah Health premises.
4. Use or being under the influence of any substances that cause an altered psycho physiological state, where there is any possibility such use may impair the Practitioner's ability to safely provide medical services to patients or may adversely affect their safety or patient safety and care or the safety of other individuals.
5. Diversion or stealing any medications, including controlled substances, from Kaweah Health.

VI. Circumstances Requiring Recusal From Follow Up Actions

A member of the Medical Staff must recuse himself or herself from the follow-up actions described in Sections VII, VIII, and IX of this policy whenever an absolute conflict of interest, as described, below arises.

Members of the Medical Staff may recuse himself or herself from the follow –up actions described in Sections VII, VIII, IX of this policy should a potential conflict of interest, as described below, arise. If the member with a potential conflict of interest does not voluntarily recuse himself or herself, he or she must promptly notify a Medical Staff Officer of the potential conflict. The Medical Staff Officer(s) must then decide whether the member's continuing involvement in the matter is appropriate.

An Officer or other member of the Medical Staff without an absolute or potential conflict of interest should serve in lieu of the recused member.

1. Absolute conflicts arise when the member of the Medical Staff is:
 - a. the Practitioner under review,

- b. a first degree relative by consanguinity or affinity¹, or
 - c. a current or former spouse or intimate partner by marriage, civil union, or domestic partnership.
2. Potential conflicts of interest arise if the member of the Medical Staff is or was:
- a. directly involved in the patient's care but not related to the issues under review,
 - b. a direct competitor, partner or key referral source of the Practitioner under review,
 - c. involved in a perceived personal conflict with the practitioner under review or
 - d. a relative other than those defined as having an absolute conflict.

VII. REPORTING OF SUSPECTED IMPAIRMENT

Evidence of possible impairment or policy violation includes altered mental state, slurred speech, impaired balance, smell of alcohol, unsteady gait, lack of focus, shaking hands, vision impairment, problems communicating, observed possession use, or diversion of alcohol, controlled substances or illegal drugs, or failure to comply with protocols for documenting use of controlled substances or other drugs.

Whenever a hospital staff member observes evidence of possible impairment by a Practitioner while on hospital premises, the staff member must immediately inform his or her supervisor who shall inform the Kaweah Health Chief Executive Officer ("CEO") or Designee. The CEO or Designee must immediately inform the Chief of Staff /Designee. The completion of an incident report in Kaweah Health's incident-reporting system (e.g., MIDAS) fulfills this obligation.

Whenever a Practitioner observes evidence of possible impairment of another Practitioner, he or she must immediately inform the Chief of Staff or Designee, who will, in turn, immediately inform Kaweah Health's CEO. The CEO will ensure that the issue is entered into the Kaweah Health's incident-reporting system.

VIII. FOLLOW UP ON REPORT OF SUSPECTED IMPAIRMENT OR POLICY VIOLATION

Kaweah Health's event screening process (e.g. the MIDAS Events Triage and Ranking Committee and Quality Oversight Committee) shall ensure that the Pharmacy Department investigates any possible diversion of controlled substances. The results of such investigation shall be reported to the CEO and Chief of Staff. If the results of such investigation confirm that the Practitioner was diverting controlled substances or other medications (e.g., propofol) from the Hospital, the Chief of Staff or Designee and/or the CEO will immediately inform the Medical Executive Committee. The CEO will promptly inform the Hospital's Governing Board of the diversion and the actions being taken. The Director of Pharmacy, in coordination with the Director of Risk Management, shall notify the local police department, the State Board of Pharmacy, the Drug Enforcement Administration and the California Department of Public Health of the diversion facts and circumstances.

Whenever the Chief of Staff or Designee receives a report of possible impairment or policy violation, he or she must promptly conduct or supervise the administration of a Screening Physical Exam of the Practitioner. The purpose of the preliminary evaluation is to determine whether there is a reasonable suspicion that the Practitioner is under the influence such that drug or alcohol testing is warranted. When possible, the Screening Physical Exam should be witnessed by an addiction specialist physician, a member of the Medical Staff Services Department or a representative of Employee Health, if the Practitioner is a hospital employee.

If any follow up inquiry or investigation by the Chief of Staff/Designee or Hospital administration identifies facts suggesting or establishing that a Practitioner has violated this policy, that information must be reported to the Medical Executive Committee for consideration of initiating a formal investigation and/or imposing disciplinary action, if warranted. If it is determined that the violation of this policy involves diversion of a controlled substance, the MEC will immediately initiate an investigation under the Medical Staff Bylaws; the investigating committee appointed by the MEC to conduct the investigation must coordinate with the Hospital's Director of Pharmacy, Director of Risk

¹ A blood relative who is a parent, sibling or child, a non-blood relative who is a stepparent, step sibling, or step child, or a spouse's parent, sibling or child.

Management, and other members of Hospital leadership, as appropriate, to conduct a thorough investigation.

The Medical Executive Committee, in consultation with legal counsel, will determine whether any mandatory reports to applicable licensing boards (e.g. Medical Board of California) under Business and Professions Code sections 805 and 805.01 are triggered by any events and follow-up inquiries conducted under this policy and will comply with such reporting requirements. The Chief of Staff and/or CEO will file an 805 report when a Practitioner's membership and/or clinical privileges are summarily suspended for more than 14 days or when required by Business and Professions Code section 805(b) or (c). The Chief of Staff and/or CEO will file an 805.01 report if the Medical Executive Committee takes or recommends disciplinary action as to a Practitioner, following an investigation that determines a Practitioner may have: (1) used, prescribed or administered to himself or herself, any controlled substance, any dangerous drug, or alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to himself or herself, any other person, or the public, or to the extent that such use impairs his or her ability to practice safely; or (2) engaged in repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefor.

If mandatory reports are not required, the Chief of Staff and/or Medical Executive Committee may consider whether to submit a voluntary report to the applicable licensing board about the possible or confirmed impairment of a Practitioner. However, in the situation where diversion of controlled substances by a Practitioner is confirmed and a mandatory 805 and/or 805.01 report is not triggered, the Chief of Staff, Medical Executive Committee, and/or CEO shall submit a voluntary report to the applicable licensing board about the diversion.

IX. SUBSTANCE ABUSE TESTING FOR REASONABLE CAUSE

- A. Situations When Drug or Alcohol Testing is Required. A Practitioner is required to submit to drug or alcohol testing under any of the following circumstances:
 1. When there is a reasonable suspicion that the Practitioner is under the influence of alcohol, a controlled substance or illegal drugs while engaging in activities related to patient care at a Kaweah Health facility. "Reasonable suspicion" includes but is not limited to incidents in which the Practitioner:
 - a. Is observed using alcohol, controlled substances, or illegal drugs while engaging in activities related to patient care at a Kaweah Health facilities;
 - b. Is in an apparent state of physical impairment as determined by an immediate Screening Physical Exam.
 - c. Is in an impaired mental state, as determined by the immediate Screening Physical Exam.
 - d. Exhibits marked changes in behavior that are not otherwise explainable, as determined by an immediate Screening Physical Exam.
 - e. Is involved in one or more incidents raising serious concerns about his or her work performance or delivery of patient care that is not explained by the immediate Screening Physical Exam.
 - f. Any suspected or actual violation of this policy. Examples include MIDAS event reports; concerns from colleagues or staff regarding usage or diversion; medication and/or narcotic documentation discrepancy trends.
 2. When a Practitioner is suspected to be in possession of alcohol, a controlled substance or an illegal drug in violation of this policy, or when alcoholic beverages, controlled substances or illegal drugs are found on Kaweah Health premises under the control of the Practitioner (e.g., locker or desk);

3. When a Practitioner has suspicious patterns or discrepancies in any medication and/or narcotic documentation; and
 4. As required by Well-Being Committee contract with the Practitioner.
- B. If testing for reasonable cause is indicated:
1. Both the person reporting the event and Chief of Staff/Designee will complete an Occurrence Report.
 2. If deemed warranted by the Screening Physical Exam, the Chief of Staff or Designee will escort the Practitioner to the Medical Staff conference room to submit to a POC test. In this situation, the Practitioner must submit to the POC test within two (2) hours.
 3. The Chief of Staff or Designee will obtain from the Practitioner the Consent for Drug and/or Alcohol Testing (Attachment A), including an authorization for release of medical information. Refusal to submit to drug or alcohol testing or to execute the Consent form will be cause for summary suspension of clinical privileges.
 4. The Chief of Staff or Designee shall ask the Practitioner if he or she is taking any medication prescribed or recommended by a health care professional and will note on the Consent form any prescribed medication so specified. If the test reveals the presence of a medication prescribed for the Practitioner, he or she will not be subject to discipline unless the levels of the medication show abuse. Even if the Practitioner is not abusing a prescribed medication, the medication may make the individual unfit to attend to patients as determined by the Screening Physical Exam. If so, the Practitioner will not be disciplined, but may be required to refrain from attending to patients while under the influence of the medication.
 5. The Chief of Staff or Designee will contact the Director of Medical Staff Services or the Kaweah Health house supervisor to obtain the phone number for Adventist Health Toxicology mobile services, after which he or she will contact the service to come to a location designated by the Chief of Staff or Designee, where a urine or blood sample will be obtained to test for the suspected substance following the chain of custody for specimens. The Chief of Staff or Designee will directly observe the collection of all samples.
 6. A confidential number, as assigned by the Medical Staff Services Director/designee, will be used for all samples and for reporting the results.
 7. The Practitioner submitting the specimen will validate the chain of custody process through signature on the chain of custody form (Attachment B) and initials on the sealed specimen.
 8. The same specimen will then be transported by Adventist Health phlebotomist to the Adventist Health Toxicology Lab in Tulare, CA for testing, with the chain of custody being followed.
 9. The Medical Staff Services Director shall maintain the confidential documentation of the incident for the Chief of Staff or Designee and CEO or Designee to review.
 10. The original test results will be forwarded to the Medical Staff Services Director for review by the Chief of Staff or Designee, the CEO or Designee, and the Well-Being Committee.
- E. If the POC testing for substance use and/or the Screening Physical Exam indicate impairment at the time of providing care to patients, the Practitioner's privileges will be summarily suspended pursuant to the Medical Staff Bylaws, pending the test results from Adventist Health Toxicology. The responsibility for care of the Practitioner's hospitalized

patients will be assigned to another Practitioner with appropriate clinical privileges. The wishes of the patient will be considered in the selection of a covering Practitioner.

- F. Arrangements for safe transportation home will be made for the Practitioner.
- G. If the test results are negative, the Practitioner will be advised through the Well-Being Committee of the need for further evaluation of other medical or mental health issues.
- H. A positive alcohol and/or drug test result, including a result indicating abuse of a prescribed medication may result in the continuation of a summary suspension. The Medical Executive Committee will meet to consider continuing the summary suspension within the timelines specified in the Medical Staff bylaws. The Practitioner will be referred to the Well-Being Committee.

ATTACHMENT A

**CONSENT TO DRUG AND/OR ALCOHOL TESTING AND
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I voluntarily agree to submit to a comprehensive drug and alcohol testing and analysis to be administered by an outside, independent laboratory.

I understand that the testing is voluntary on my part, that I may refuse to submit to testing , and that such refusal may be grounds for disciplinary action, including summary suspension of my clinical privileges.

I hereby authorize the testing facility to disclose the results of the evaluation and tests, including any related analyses and/or reports of testing to the Kaweah Health Chief of Staff via the Medical Staff Services Director for use in connection with the consideration of whether I am fit to practice and my continued qualification for Medical Staff membership and clinical privileges by the Chief of Staff and Medical Executive Committee. I authorize the Chief of Staff to release this information to Kaweah Health's Chief Executive Officer, the Medical Executive Committee and any Ad Hoc Committee that may be formed in connection with this purpose. I also authorize the Chief of Staff to release this information to the Chair of the Kaweah Health Medical Staff Well-Being Committee.

I understand that the information obtained will be maintained confidentially and will not be released to anyone else or used for any other purpose unless required by law, governmental agencies, or subpoena.

My consent and authorization shall expire one year from the date of this consent and authorization.

I have signed this consent and authorization voluntarily, and I understand that I have a right to receive a copy upon my request.

Signature

Date

Printed Name



Medical Staff Services

Policy Number: MS 45	Date Created: 05/18/2023
Document Owner: Ody DaSilva (Medical Staff Manager)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Credentials Committee, Medical Executive Committee, Debbie Roeben (Medical Staff Coordinator), Kelsie Davis (Board Clerk/Executive Assistant to CEO), Ody DaSilva (Medical Staff Manager), Shannon Vinson (Director of Medical Staff Services)	
Focused Professional Practice Evaluation Guidelines for Initial Proctoring	

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

Scope:

1. Newly appointed Physicians and Advanced Practice Providers
2. Practitioners who request additional clinical privileges

Policy: The Medical Staff is responsible for overseeing the quality of care provided by Physicians and Advanced Practice Providers (hitherto referred to as practitioners). In order to ensure competency, all new practitioners will be required to participate in Focused Professional Practice Evaluation (FPPE) which may include proctoring, as specified by their Departments. Proctoring is an objective evaluation of a physician's clinical competence by a proctor who represents, and is responsible to the medical staff. Prospective, retrospective and concurrent proctoring and/or chart review may be used to confirm clinical competence according to each department's guidelines.

PROCEDURE:**I. New Staff Member – Initial Appointment Responsibilities**

A practitioner's FPPE begins when privileges are granted by the Board, either for new applicants or current members requesting new/additional privileges.

1. A primary proctor will be assigned by the Department Chair. Any medical staff practitioner with like, unrestricted privileges may proctor.
2. The new practitioner will review privileges granted and proctoring requirements as delineated on their delineation of privileges (DOP) form.
3. The new practitioner will accept the responsibility to schedule his/her cases at a time when an eligible proctor has agreed to be available.
4. The new practitioner must be proctored for the minimum number of procedures indicated on the DOP or until the practitioner demonstrates competency to the satisfaction of the proctor.
5. For all invasive procedures, FPPE shall include direct observation by the proctor and concurrent chart review.
6. The practitioner must request an extension if he/she is unable to complete proctoring within the timeframe allowed.

II. Temporary Physicians & Advanced Practice Providers

1. Physicians who are on site for a specific patient or to proctor another physician are not subject to the proctoring requirements of this policy.
2. Locum Tenens covering for a specific practitioner are not subject to proctoring requirements as established in this policy.
3. Long term temporary practitioners (more than 30 days) will be subject to complete proctoring requirements as established in this policy. The proctoring will be based on activity from their first patient contact and procedures performed.

III. Requirements and Responsibilities of the Proctor

1. The proctor must be a member in good standing of the Medical Staff of Kaweah Health and must have similar, unrestricted privileges, which are to be proctored.
2. It is the responsibility of all members of the Medical Staff within a specific Department to participate as proctor when assigned to do so.
3. The proctor shall have no pecuniary interest in the procedure and/or patient. The proctor shall not be remunerated for proctoring.
4. A proctor will timely complete and sign a confidential proctoring form for each case proctored and return this form to the MSO.
5. The proctor's role is to observe and record the performance of the practitioner being proctored. The proctor is not mandated to intervene when he/she observes what could be construed as deficient performance on the part of the practitioner being proctored.
6. It is the proctor's responsibility to report any poor or significantly substandard performances of the proctoree immediately to the clinical department chair.
7. In an emergency situation, the proctor may intervene; even though he/she has no legal obligation to do so, and in such a circumstance, the proctor is acting in good faith and should be qualified as a Good Samaritan within the "Good Samaritan" laws of the State of California.
8. The activities of the proctor constitute an integral part of the peer review system of the Medical Staff, and as such, any and all information and records regarding the proctorship shall be subject to all confidentiality requirements within the bylaws and proctors are subject to all immunities accorded Medical Staff peer review activities and any applicable regulations, statutes or legal decisions.

IV. Department Responsibilities

1. The Department Chair will assign proctor(s)
2. Members of the Department will participate in proctoring when assigned by the Department Chair.
3. The Department Chair may consider an extension or automatic expiration of privileges for practitioners who have failed to complete proctoring within the assigned timeframe. This recommendation will be forwarded to the Credentials Committee to approve the extension or allow the privileges to automatically expire, per the Medical Staff Bylaws.
4. The Department Chair will evaluate proctoring results and make a recommendation to the Credentials Committee.

V. Options

1. Kaweah Health may accept up to 80% of proctoring from other institutions to supplement actual observation on the premises if the following conditions are present:
 - a. Preapproval of the Department Chair and Credentials Chair.
 - b. The range and level of privileges requested are similar at both institutions.
 - c. Proctor reports, or a summary of proctored cases (volume/procedures), have been signed and dated within the last 15 months.

VI. Medical Staff Office (MSO) Responsibilities

1. The MSO will provide each new staff member at initial appointment with blank proctoring forms, a copy of clinical privileges granted, and proctoring requirements. This information will be sent to the practitioner by email and with the Governing Board letter.
2. The MSO will send two courtesy reminders on behalf of the Chief of Staff via email and/or text. A final notification on behalf of the Chief of Staff will be sent via email and/or text at the 6-month deadline informing practitioners of a 30-day extension to complete proctoring unless an extension has been requested or already granted.
3. MSO will notify Department Chair when a practitioner fails to complete proctoring within 6 months or at the end of a granted extension period. Department Chair will recommend to Credentials Committee – extension of time frame or automatic relinquishment.
4. At the recommendation of the Credentials Committee the practitioner's privileges will be automatically relinquished, or an extension will be granted. If privileges are automatically relinquished, per Medical Staff Bylaws 4.B.3., the practitioner may not reapply for one (1) year. MSO will resign practitioner from databases and send out notification.
5. The MSO will submit a proctoring summary to the Credentials Committee. The summary will identify the successful completion of the proctoring requirements and any outstanding privileges that require an extension of time for completion of proctoring.

VII. Completion of proctoring

1. Successful Completion – Proctoring shall be deemed successfully completed when the practitioner satisfactorily completes the required number of proctored cases within the time frame established and the practitioners performance in the cases meet the standard of care of the Medical Center.
2. Failure to Complete Necessary Volume – Refer to Medical Staff Bylaws 4.B.3.
3. Failure to Complete Proctoring Satisfactorily – Refer to Medical Staff Bylaws 4.B.3.

VIII. Confidentiality

1. **Strict adherence to the code of confidentiality is required.**
2. **The original FPPE form shall be filed in the individual's confidential credential file in the Medical Staff Services office.**

Resources

- Medical Staff Bylaws
- MS 44 Ongoing Professional Practice Evaluation (OPPE) / Focused Professional Practice Evaluation (FPPE)

"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."



Medical Staff Services

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Approvers: Board of Directors (Administration), Credentials Committee, Medical Executive Committee, Debbie Roeben (Medical Staff Coordinator), Kelsie Davis (Board Clerk/Executive Assistant to CEO), Ody DaSilva (Medical Staff Manager), Shannon Vinson (Director of Medical Staff Services)	
Credentialing and Privileging of Medical Staff & Advanced Practice Providers	

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

Policy:

All applications for appointment, reappointment and requests for clinical privileges for physicians (MD, DO, DPM, DDS, DMD and PhD) and Advanced Practice Providers (CRNA, CNM, NP, PA, and PharmD), will be evaluated based on current licensure, education, training or experience, current competence and ability to perform the clinical privileges requested. For Temporary Privilege see [Temporary Privileges](#) policy.

Procedures (See Attachment A for flow chart of application process)

I. New Applicants

Individuals requesting to be credentialed and privileged will be provided a link to the Online Application on the MD Staff website.

The practitioner shall be required to submit/review:

1. Complete application including licensure information on any active or inactive licenses, DEA registration, Education History, Work History, Insurance, Peer References and Board Certification/Eligibility
2. Attestation Questionnaire
3. Consent and Release Form
4. Professional Liability Questionnaire, that includes claim status for each open or closed claim in the last five years.
5. Health Screening Requirements (PPD, Influenza Vaccination; Most Recent COVID Booster); (fitness for duty as required)
6. Background Release Form
7. Continuing Education Attestation form
8. Confidentiality and Conflict of Interest Statement of compliance
9. Medicare Acknowledgement Statement
10. Code of Conduct and Professional Behavior
11. Signed Organized Health Care Arrangement Agreement
12. Privilege Form
13. Medical Staff Bylaws, Rules & Regulations
14. A Copy of a current, government issued photo ID
15. 2x2 recent color photo
16. Current Curriculum Vitae (CV) documented in months and years
17. Life Support Certification (BLS, ACLS, etc.) as defined on privilege form.

18. Non U.S. Citizens: Copy of current Employment Authorization Card or H1B Visa for employment to provide services at Kaweah Health.

II. Reappointments

Reappointment to the Medical Staff and Advanced Practice Provider Staff and requesting of clinical privileges shall occur no less often than biennially.

A link to the on line application shall be sent to providers five(5) months prior to their appointment expiration date and are expected to be completed and returned within 30 days.

The practitioner shall be required to submit/review:

1. Complete application including licensure information on any active or inactive licenses, DEA registration, Education History, Work History, Insurance, Peer References and Board Certification/Eligibility
2. Attestation Questionnaire
3. Consent and Release Form
4. Professional Liability Questionnaire, that includes claim status for each open or closed claim in the last two years or since last reappointment if less than two years.
5. Health Screening Requirements (PPD, Influenza Vaccination); (, fitness for duty as required)
6. Continuing Education Attestation form
7. Confidentiality and Conflict of Interest Statement of Compliance
8. Medicare Acknowledgement Statement
9. Code of Conduct and Professional Behavior
10. Privilege Form
11. Medical Staff Bylaws, Rules & Regulations
12. Life Support Certification (BLS, ACLS, etc.) as defined on privilege form.

If the provider fails to submit a completed online application, they shall be deemed to have voluntarily resigned their Medical Staff membership. The procedural rights set forth in the Medical Staff Bylaws shall not apply to a voluntary resignation.

III. Timeliness of Information

Any of the following information found to be beyond 180 days at the time the file is presented to the Credentials Committee or Interdisciplinary Practice Committee (IPC) will be re-verified prior to review by that committee:

- All on line verifications
 - CA Medical or Professional License
 - CA Furnishing License, if applicable
 - DEA
 - NPDB
 - OIG
- Answers to attestation questions

- Signature and date on consent form

IV. Approval

1. The application, privilege request form and supportive documentation are made available to the appropriate Department Chair for review and recommendation to the IPC and/or Credentials Committee. Any documents of concern will be printed and flagged. The Department Chair will complete the recommendation form and note the length of appointment and any concerns which will be forwarded to the Credentials Committee.

V. Requests for Additional Privileges

Any provider may request additional privileges at any time. These requests are processed as follows.

1. The provider must complete the appropriate privilege form and supply supporting documentation regarding training or experience, as required.
2. The following must be verified by the Medical Staff Office:
 - CA Medical or Professional License
 - CA Furnishing license, if applicable
 - DEA, if applicable
 - OIG
 - NPDB
3. The evaluation and approval for additional privilege(s) is forwarded to the IPC and/or Credentials Committee upon recommendation of the Department Chair, with final review and recommendation by the MEC and Governing Board.

VI. Provider rights to amend application and to receive updates

Providers have the right to correct erroneous information obtained throughout the credentialing process. If any submitted items differ substantially from documentation disclosed through the verification process, the provider will be asked via written request (email or certified letter) to resolve this discrepancy and will be expected to do so within 10 business days of the request. Any and all corrections should be submitted in writing to the Medical Staff Office for adequate review of current documentation. Any instance of the provision of information containing misrepresentations or omissions is forwarded to the Credentials Committee for review and action. Providers are allowed access to their credential files, with the exception of Peer Evaluations or verifications.

Providers have the right to receive updates on their application for appointment or reappointment. All such requests will be responded to within a reasonable period of time, not to exceed four business days.

VII. Processing the application

When the application for appointment or reappointment is returned, a review for completeness is performed by the Medical Staff office. If additional information is required, or if questions are left blank, the application will be returned back to the applicant for completion. Failure to submit the requested information within 30 days shall be considered a voluntary withdrawal of the application.

Information gathered on the application will be verified by the primary source, as required by The Joint Commission. Primary source may include verbal verifications, which require a dated, signed note in the credentialing file, including the name of individual providing the information, date and time of verification. After three failed attempts to gather information from a primary source, a secondary source may be used, i.e., another hospital where the practitioner is currently credentialed.

In addition, queries will be made to the NPDB and the the appropriate CA state licensing Board if any verification received has adverse actions, the practitioner will be asked to provide a written explanation of the issue. Sources used for verification include:

1. California Professional License / Professional Licenses from other States

2. DEA Certification

An online NTIS query is required for primary source verification. All providers must have a valid DEA certificate, including all schedules (2, 2N, 3, 3N, 4 and 5), with a California address. A practitioner with an out of state address on their DEA may be credentialed pending the change of address, if proof of request has been received by the Medical Staff Office.

Radiologic Health Branch Certificate/Permit Required for all practitioners as specified by privileges (i.e., Fluoroscopy, Radiography or Radiology).

3. Verification of Hospital Affiliations and Work History

Written verification of five (5) years of clinical work history from hospitals or other health care organizations affiliations is required for initial appointments (2 years for reappointment). Affiliation verifications within the last five (5) years will be required for new appointments (2 years for reappointment). A minimum of five (5) affiliation verifications will be required if an applicant has more than five (5) affiliations. A request of the practitioner's quality and performance profile/data may be accepted in lieu of a "good standing" letter.

Any gaps in the past five (5) years of work history of three months or more will require written clarification from the practitioner.

Failure to obtain verification of an affiliation after three attempts with the applicant's assistance shall be documented in the practitioners' file for the Department Chair. The file may then move through the evaluation process without this documentation.

4. Verification of Medical/Professional School and Completion of Post Graduate Programs

Verification of education and completion of post graduate training may be obtained from the institution(s) where the training was completed, and/or an agency that is deemed primary source verification (AMA/AOA) or Background Check for Advance Practice Providers hired by HR. If unable to obtain verification from any of the above resources after three attempts, information

will be obtained from a reliable secondary source such as another hospital that has a documented primary source verification of the credential. A letter of completion of residency or fellowship program will be obtained for all new graduates.

Verification for International Medical Graduates must present certification by the Education Commission for Foreign Medical Graduates (ECFMG), or successful completion of a fifth pathway (excluding Canada).

5. Board Certification

Board Certification or active pursuit of board certification is a requirement for membership and privileges for individuals appointed after March 2016. Medical Staff Members appointed prior to March 2016 are grandfathered and governed by any board certification requirements at the time of their appointment. Verification of certification is obtained through the ABMS online database or a letter directly from the certification board. Board certification is verified at the time of initial appointment and each reappointment. In exceptional circumstances, initial applicants who are not board certified and existing Medical Staff members seeking recertification may request additional time to obtain certification or recertification for one additional period, not to exceed two years. In order to be eligible to request an extension in these situations, an individual must satisfy criteria set forth in the Medical Staff Bylaws 2.A.1.

All Advanced Practice Practitioners are required to have National Certification at the time of hire or obtain certification within one year of completion of professional training and maintain certification by any of the following bodies:

- American Academy of Nurse Practitioner AANP
- American Nurses Association Credentialing Center – ANCC
- Pediatric Nursing Certification Board – PNCB
- National Certification Corp. for the Obstetric, Gynecologic and Neonatal Nursing Specialties – NCC
- American Association of Critical Care Nurses – AACN
- National Commission on Certification of Physician Assistants – NCCPA
- National Board of Certification & Recertification for Nurse Anesthetists - NBCRNA

6. Current, Adequate Professional Liability Insurance

The Certificate of Insurance must meet the requirements determined by the Kaweah Health Board of Directors. See Attachment B.

7. Professional Liability Claims History

Verification of claims history for the immediately preceding five (5) years for new appointments and two (2) years for reappointments will be obtained from the National Practitioner Data Bank (NPDB). Verification of current malpractice and claims history will be obtained directly from the Insurance Company.

Failure to obtain verification of a current claims history after three attempts with the applicant's assistance shall be verified by the NPDB.

8. Background Checks

Background checks shall be performed at the time of initial appointment. Results will be stored electronically in the credentials file. Adverse information will be evaluated by the Department Chair and appropriate review committees.

9. Privileging Criteria – Current Clinical Competency

Each applicant must meet the criteria related to the privileges they are requesting on the privilege form. Clinical activity from all facilities at which the physician has been privileged to practice within the reappointment timeframe, will be included for specific privileges requested and volume requirements. At reappointment, if the practitioner does not have an adequate volume required by the department, a letter of reference may be required from a colleague who has observed the practitioner and can attest to their competency. Volumes from facilities other than Kaweah Health do not count towards membership category assignments.

10. National Practitioner Data Bank

The NPDB must be queried for all new and reappointments and when additional privileges are requested. Continuous Query is utilized for all privileged members. Adverse information will be evaluated by the department chair.

11. Medicare/Medicaid Sanctions

Medicare and Medicaid Sanction verifications will be processed by obtaining a Sanctions Exclusions Report published by the OIG for each credentialed provider. In addition, ongoing monitoring for sanctions will be done on a monthly basis for all credentialed practitioners.

12. Professional References

Three professional references are requested for new applicants and two are required for application packets to be considered complete. Peer references are required at reappointment for providers who do not have adequate volume to evaluate competency. Advanced Practice Provider's supervising physician evaluation may be utilized in lieu of a peer reference letter. The references must be from individuals who have recently worked with the applicant, have directly observed their professional performance and can provide reliable information regarding clinical ability, health status, ethical character and the ability to work with others. If the applicant has completed a residency or fellowship in the past two years, a reference from the program director shall be requested. Adverse comments or reluctance to recommend will be flagged for review. Peer references will be asked to identify the picture of the applicant is the person they are providing a reference for which will be used by the hospital to verify the practitioner requesting approval is the same practitioner identified in the credentialing documents.

Failure to obtain a peer reference after three attempts the applicant will be asked to provide contact information for additional peer reference(s).

13. Continuing Education

An attestation must be signed for appointment or reappointment indicating that the practitioner has met their applicable continuing professional education requirements for licensure.

14. Ongoing Professional Practice Evaluation (OPPE)

Quality Data for each practitioner is evaluated by the Department Chair every eight months. A two year composite of the data is provided to the chair for a comprehensive review at reappointment.

15. Training Modules

All applicants shall be informed of any assigned educational requirements at the time of appointment or reappointment.

16. Health Screening

All practitioners are required to comply with annual PPD and Influenza Vaccination requirements. Failure to do so will result in an administrative suspension until appropriate documentation is provided to the Medical Staff Services Department.

17. The credentialing data for all practitioners credentialed by Medical Staff Office are entered into the Medical Staff Office credentialing database (MD STAFF). Medical Staff Office utilizes this system to maintain current credentialing and privileging information, and to monitor proctoring, license, DEA, insurance renewals and reappointment activities. All information contained in the database is confidential and has restricted access. Medical Staff Office is responsible for ensuring that the information contained in the database is accurate and current. The Managed Care department has access to information in the Medical Staff Office database that specifically pertains to information needed for credentialing with the health plans.

18. All practitioners are required to pay dues and application fees; Fees are determined by the MEC and are non-refundable.

VIII. Category Assessment

During the processing of each reappointment, practitioner activity reports will be evaluated to confirm if they are assigned to the appropriate membership category. The following guidelines shall be used:

1. A physician currently on the Active Medical Staff but has had less than 24 patient contacts in the last 2 years at a Kaweah Health facility the practitioner will be reassigned to a category that appropriately reflects their activity, in accordance with the Medical Staff Bylaws.
2. A physician currently on the Active or Courtesy staff, who has had no patient contacts at a Kaweah Health Facility during the previous two years, shall be

reassigned to the Community Affiliate Category (membership only, no clinical privileges).

3. A Physician currently on the Consulting staff who has activity from other hospitals and office practice shall not be reassigned unless requested by the practitioner.

If applicable criteria indicate a membership category reassignment may be appropriate, the credentialing staff will send a letter, email, text or fax to the practitioner outlining any changes being recommended for their feedback. The complete credential file is forwarded to the Department Chair along with any additional information submitted by the provider for review and final recommendation.

IX. Expirables

The following items will be monitored as Expirables. An expired certificate or license shall result in an administrative suspension of membership/privileges, or a suspension of the privilege tied to that certificate.

- CA State license
- Furnishing License
- DEA
- Professional Liability Insurance
- Radiologic Health Branch Certificate/Permit, as specified by privileges (i.e., Fluoroscopy)
- ACLS, ATLS, BLS, NRP, PALS (as specified by privileges)
- Delinquent Health Records

Failure to provide updated documents within 60 days will result in voluntary withdrawal of membership/privileges or a voluntary withdrawal of the privilege tied to that certificate.

Practitioners will be notified by email or text approximately 45 days, 30 days, and 15 days prior to license or certificate expiration.

X. Delegated Credentialing for Telehealth Providers

Delegated Credentialing is accepted for telehealth providers under the following conditions:

1. The Distant Site is accredited by the Joint Commission
2. A contract for related services has been executed between Kaweah Health and the Distant Site
3. Distant site provides proof of accreditation as a Medicare Provider
4. Procedure – Initial Application
 - a. Distant Site Provides the following:
 - i. Medical Staff Fees
 - ii. Current list of privileges granted to practitioner by Distant Site.
 - iii. Most recent Board approval letter to practitioner by Distant Site.
 - iv. Current Certificate of Professional Liability
 - v. Completed Delegated Credentialing Attestation by the Distant Site (provided by Kaweah Health)

Credentialing and Privileging of Medical Staff & Advanced Practice Providers

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- vi. 2" X 2" recent color photo
 - vii. Current Government-Issued Photo ID
 - viii. Completed Kaweah Health Consent Form
 - ix. Signed Organized Health Care Arrangement Agreement
 - x. Completed Kaweah Health Privilege Request Form
 - xi. Completed Kaweah Health Online TeleHealth Application
 - xii. An updated list of providers (addendum to the contract) to Kaweah Health Medical Staff Office upon any change of providers (additions and/or resignations).
 - b. Originating Site performs the following verifications:
 - i. NPDB, OIG, Licensure (including LVS for MDs only), and NPI.
 - ii. Information forwarded for approval through the process defined in the Medical Staff Bylaws.
5. Procedure – Reappointment Application
- a. Distant Site provides the following:
 - i. Medical Staff Fees
 - ii. Current list of privileges granted to practitioner by Distant Site.
 - iii. Completed Delegated Credentialing Attestation by the Distant Site (provided by Kaweah Health)
 - iv. Completed Kaweah Health Consent Form
 - v. Completed Kaweah Health Privilege Request Form
 - vi. Completed Kaweah Health Online TeleHealth Reappointment Application
 - b. Originating Site performs the following verifications:
 - i. NPDB, OIG, and Licensure (including LVS for MDs only)
 Information forwarded for approval through the process defined in the Medical Staff Bylaws.
6. Procedure – Expirables
- a. Medical Staff Office keeps track of the following Expirables
 - i. CA Licensure
 - ii. Professional Liability

Related Documents:

Kaweah Health Medical Staff Bylaws, Rules and Regulations

References:

- TJC Standards
- Title 22 Regulations

"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

Credentialing and Privileging of Medical Staff & Advanced Practice Providers

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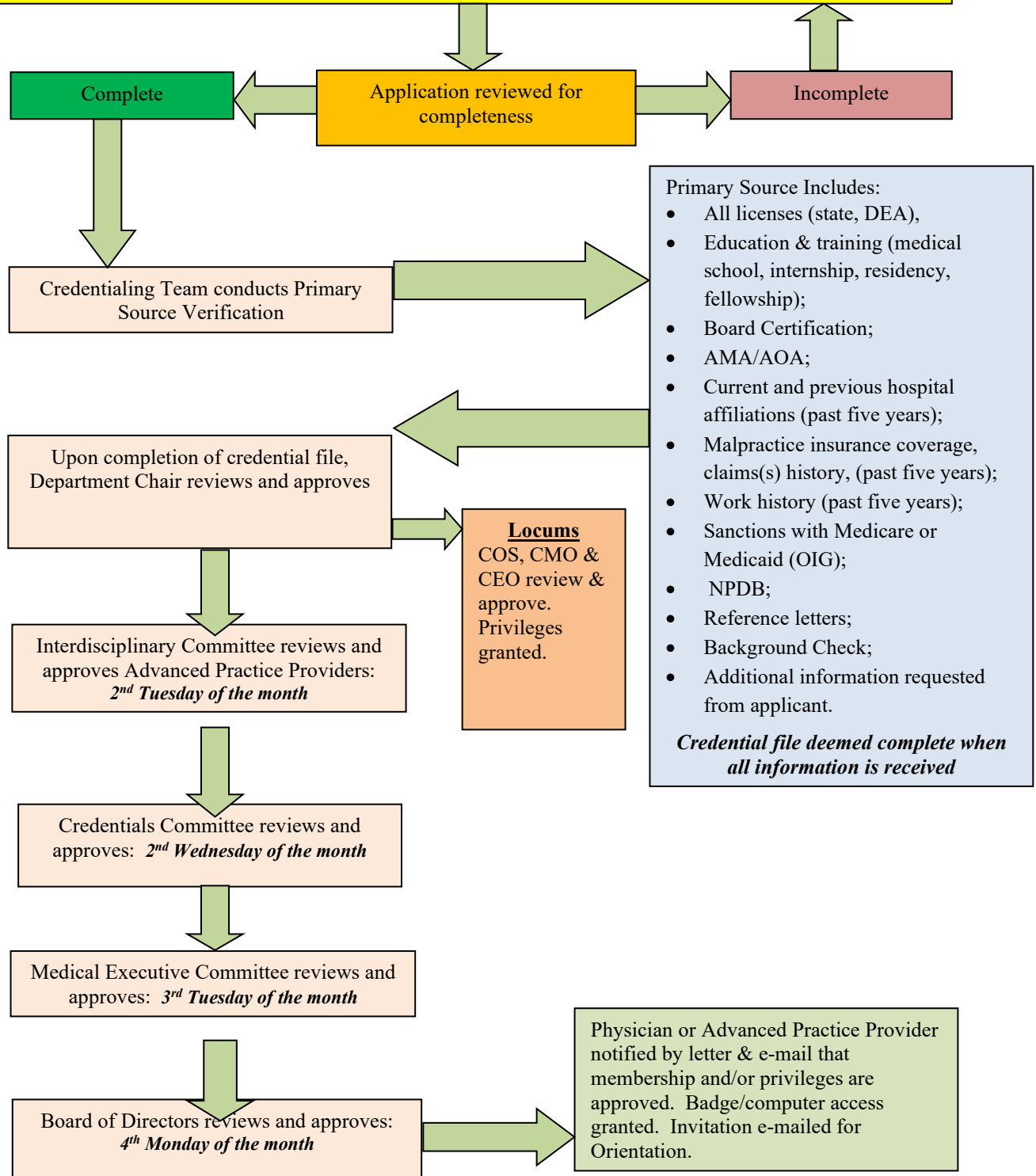
research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

Credentialing and Privileging of Medical Staff & Advanced Practice Providers

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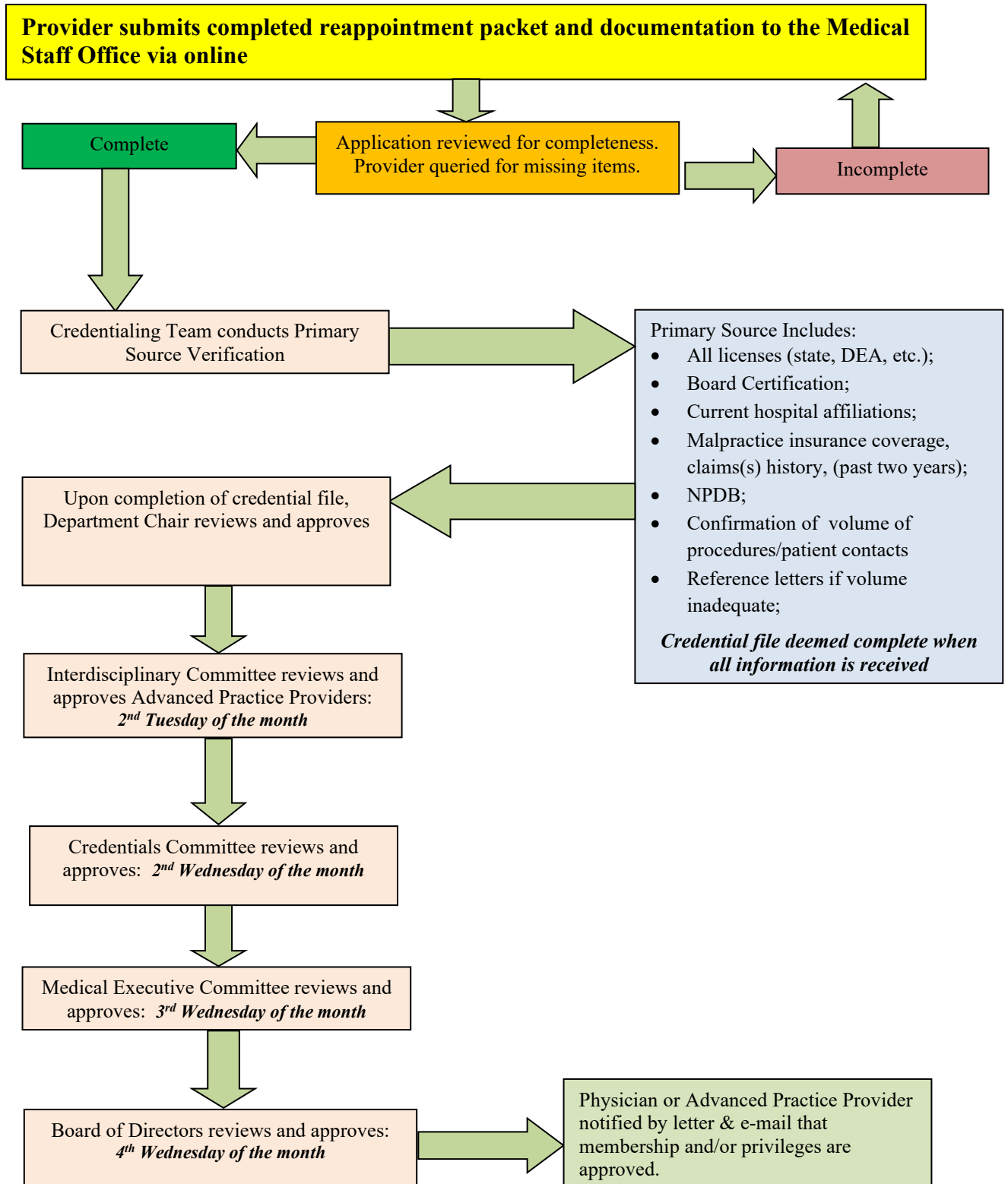
ATTACHMENT A INITIAL APPLICATION PROCESS

Provider submits completed application and documentation to the Medical Staff Office via online



Additional information can be requested at any time during the process, sending it back to the previous step.
Medical Staff Bylaws 4.A.8 "Once an application is **deemed complete**, it is expected to be processed within 120 days, unless it becomes incomplete."

REAPPOINTMENT PROCESS



ATTACHEMENT B

**Kaweah Health Malpractice Insurance Guidelines
Per Kaweah Health Board of Directors' Resolution adopted 11/16/2023**

All members of the Medical Staff of Kaweah Health, as a condition of appointment or reappointment and to maintain admitting and clinical privileges, and all members of the Advanced Practice Provider Staff, as a condition of appointment or reappointment and to maintain clinical privileges, are required to obtain and maintain at all times, continuous coverage the meets or exceeds the standards set forth below:

1. **Coverage Limits:** At least \$1 million per claim and at least \$3 million annual aggregate, with a deductible or self-insured retention of not more than \$100,000; **and**
2. **Rating and Financial Strength:** Maintains an A.M. Best Rating of at least A, and a Financial Strength Category ("FSC") of at least VII (\$50 million to \$100 million); **and**
3. **Admitted Carriers:** An insurance company on the List of Admitted Insurers published by the California Department of Insurance, which can be accessed here:
https://interactive.web.insurance.ca.gov/apex_extprd/f?p=144:10:11467228532262::NO::; Type of Insurance=Medical Malpractice; Sort by=Alphabetical **or**
4. **Non-Admitted/Surplus Line Insurers:** An insurance company that meets the criteria identified in paragraphs 1 and 2, and is on the List of Approved Surplus Line Insurers ("LASLI") published by the California Department of Insurance, which can be accessed here: <https://www.insurance.ca.gov/01-consumers/120-company/07-lasli/lasli.cfm> **or**
5. **Federal Tort Claims Act:** An insurance fund that meets the criteria identified in paragraph 1 and 2, and is administered under the Federal Tort Claims Act for federal employees, when the Kaweah Health Medical Staff member or Advanced Practice Provider Staff is so covered (for example, as a result of their employment with Family Health Care Network).



Policy Number: MS 49	Date Created: 09/19/2025
Document Owner: Ody DaSilva (Medical Staff Manager)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Medical Executive Committee, Kelsie Davis (Board Clerk/Executive Assistant to CEO), Ody DaSilva (Medical Staff Manager), Shannon Vinson (Director of Medical Staff Services)	
Practitioner Health Policy	

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

Policy:

In order to provide safe, high-quality care at Kaweah Health facilities, all Medical Staff and Advanced Practice Providers ("Practitioners") granted privileges and/or membership by the Kaweah Health Board of Directors are required to adhere to the health requirements listed below.

Procedure:

- I. Tuberculosis Screening
 - A. Medical Staff and Advanced Practice Providers must submit evidence of a tuberculosis screening test during the initial application process and annually thereafter to the Medical Staff Services Department. Acceptable documentation:
 1. PPD Skin Test that includes date administered, date read, lot # expiration date, and results of test. PPD Skin Tests can be administered by Employee Health, free of charge. The practitioner is responsible for providing the Medical Staff Services Department with the results after the test is read.
 2. Quantiferon Gold-TB Blood Test
 3. Positive reactors will complete the TB Affidavit form and attach a copy of their most recent chest x-ray report. A new chest x-ray is only required upon the development of TB symptoms.
 - B. Any Medical Staff or Advanced Practice Provider exposed to a patient with TB will be contacted by the Employee Health Department for a baseline TB Test ten (10) weeks after the exposure.
- II. Influenza Prevention and Immunization
 - A. Practitioners must comply with annual influenza vaccinations. Employee Health will offer the seasonal influenza vaccination at no cost. . Practitioners applying for initial privileges during influenza season will be required to submit proof of vaccination with their application. Employee Health will not provide influenza vaccinations for initial applicants.

- B. All Vaccinated Health Care Professionals will be provided and wear a designation on their badge, indicating they have received a current influenza vaccination.
- C. The scheduled annual influenza timeframe is determined by the Infection Prevention Team and/or Public Health Officer.
- D. In Limited Circumstances, a seasonal vaccination exemption will be permitted for either medical contraindication or religious/philosophical beliefs.
 - 1. Documentation of influenza vaccination declination must be submitted to the Medical Staff Services Department Annually.
 - 2. If Medical Staff or Advanced Practice Provider declines the influenza vaccination they will be required to wear a mask during the defined influenza timeframe.

III. Well Being Committee

- A. The Medical Staff has established a Well Being Committee to provide support for providers dealing with behavioral, health, aging, and/or substance abuse issues. (See [MEDICAL STAFF WELL-BEING COMMITTEE](#) for details).
- B. Financial Assistance
The Medical Staff Organization will provide up to \$5,000 life-time financial assistance for fit-for-duty evaluations for a medical staff member, as required/requested by MEC or the Medical Staff Well-Being committee.

References:

Medical Staff Bylaws

"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."

First Addendum to CEO Agreement

FIRST ADDENDUM TO CHIEF EXECUTIVE OFFICER AGREEMENT

This is an addendum to the Chief Executive Officer Agreement, which became effective December 22, 2025 (“Agreement”), between Kaweah Delta Health Care District (“KDHCD”) and Marc Mertz (“Mr. Mertz”).

WHEREAS, the Agreement provides at Section 4.a. and 4.b, in pertinent part:

4. Total Compensation. As compensation for performing the duties of CEO, during the term of this Agreement, Kaweah Health shall pay Mr. Mertz the total compensation described below.

a. Base Salary. During the first contract year, Mr. Mertz shall be paid an annual base salary of One Million Nine Thousand Six Hundred Dollars and Zero Cents (\$1,009,600.00). Kaweah Health shall pay Mr. Mertz his base salary in equal biweekly installments, except for the amount, if any, Mr. Mertz wants contributed to a deferred income program.

b. Incentive Compensation. In addition to the base salary referenced above, during the First Contract Year, Mr. Mertz shall be eligible for annual incentive compensation of up to Two Hundred Fifty-Two Thousand Four Hundred Dollars and Zero Cents (\$252,400.00). Mr. Mertz’s eligibility for the incentive compensation each year shall be based upon objectively measurable goals, to be agreed upon by the Board and Mr. Mertz, and to be completed by Mr. Mertz within the contract year. A list of the goals and incentive amounts attached to the successful completion of the respective goals for the first contract year shall be set and included as Exhibit “C” and is incorporated by reference.

WHEREAS, as stated in section D of the Agreement, the market for healthcare CEOs is national and highly competitive with significant demand for qualified candidates. Compensation of Mr. Mertz at competitive and equitable rates based on national rates is therefore necessary.

WHEREAS, to assist the Board in this process, it engaged the Human Resources & Compensation consulting practice of national consulting firm Arthur J. Gallagher & Company (“Gallagher”). Gallagher possesses one of the nation’s largest and most complete healthcare compensation databases. Its proprietary database contains current total compensation data on more than 550 health systems and over 3,000 hospitals. They have drawn upon this data to create a custom peer group used to evaluate total compensation for KDHCD’s CEO.

WHEREAS, the Board, after reviewing the information from Gallagher, determined at an open meeting on July 22, 2026 that an increase in Mr. Mertz’s base salary to \$1,223,640.00 for the second contract year of the Agreement was warranted by the Gallagher data; and

WHEREAS, the Board, after reviewing the information from Gallagher, and considering the past percentages of incentive compensation awards actually paid to the KDHCD CEO

compared to the amounts potentially capable of being earned, determined at an open meeting on July 22, 2026 that an increase in Mr. Mertz's potential incentive compensation to \$305,910.00 for the second contract year of the Agreement was warranted by the Gallagher data; and

WHEREAS, the KDHCD Board of Directors by action on July 22, 2026 authorized the Agreement to be modified as set forth below,

THEREFORE, KDHCD and Mr. Mertz agree that the Agreement is hereby amended as follows:

1. Mr. Mertz's base salary for the second contract year (July 1, 2026 through June 30, 2027) is \$1,223,640.00. KDHCD personnel are authorized to take the necessary steps to pay this salary amount prospectively and to make the necessary retroactive salary payment based on the difference between the amount actually paid to the CEO in the second contract year and the new salary amount reflected in this Addendum.
2. Mr. Mertz's potential incentive compensation for the second contract year (July 1, 2026 through June 30, 2027) is \$305,910.

WHEREAS, the KDHCD Board and Mr. Mertz have agreed upon the incentive goals and incentive amounts for the second contract year of the Agreement;

THEREFORE, KDHCD and Mr. Mertz agree that the Agreement is hereby amended as follows:

The incentive compensation goals and the corresponding incentive amounts for the second contract year (2026-2027) shall be established and approved by the Board and will be incorporated to this Addendum as Exhibit "A."

The remaining terms and conditions of the Agreement shall remain the same.

KAWEAH DELTA HEALTH CARE DISTRICT

By _____
David Francis, Board President

By _____
Marc Mertz, CEO

Annual Tualre County Property Tax Rate Resolution 2295

KAWEAH HEALTH
FINANCE DIVISION MEMORANDUM

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

FROM: Stephen Forney, Interim Chief Financial Officer
Jennifer Stockton, Director of Finance

DATE: July 15, 2026

SUBJECT: General Obligation Tax Resolution

On July 22, 2026, the Kaweah Health Board of Directors (the “**Board**”) will be asked to approve Resolution No. 2295 directing the County of Tulare to levy and collect, for the fiscal year July 1, 2026 to June 30, 2027, a tax sufficient to pay the principal and interest of the 2014 bonds (debt service schedule attached to the resolution).

History of the Bonds: In November of 2003, the residents of the Kaweah Delta Health Care District voted to approve the issuance of \$51 million of general obligation bonds. General Obligation (“GO”) bonds can be issued by governmental entities and are secured by property taxes of the residents that live within the boundaries of the entity. These taxes are in addition to the normal operating taxes collected by the County. The related GO bonds were issued by Kaweah Health in 2004 and the funds were used to construct improvements to the Kaweah Health facility that are currently referred to as the “Acequia Wing”. In 2014, the 2004 bonds were advance refunded in order to take advantage of favorable interest rates. With an advance refunding we are allowed to issue new bonds with new lower rates, and then pay off the old bonds that had higher rates.

Each year in July, Kaweah Health Finance representatives work with representatives of the County of Tulare to calculate the amount of tax to levy. The tax rate per \$100 is determined by utilizing the annual debt service on the bonds, the internal bond reserve funds, unsecured tax revenues and unitary revenues estimated by the County, and the total Kaweah Delta Health Care District secured property values as determined by the County.

A trend of the values utilized to determine the annual tax rate is attached.

For any questions regarding the documents, please contact Jennifer Stockton at 624-5536.

Kaweah Delta Health Care District
Tax Rate Resolution - for submission to County of Tulare
Debt Service of 2004 (2014 refi) General Obligation Bonds

Fiscal Year	26-27	25-26	24-25	23-24	22-23
Internal Reserve	\$ 2,289,417	\$ 1,930,980	\$ 1,952,555	\$ 1,635,832	\$ 1,785,239
Balance to be raised	\$ 3,843,022	\$ 3,262,939	\$ 3,681,520	\$ 3,594,816	\$ 3,514,268
Unsecured Value	\$ 1,475,689,311	\$ 1,502,885,029	\$ 1,498,385,757	\$ 1,286,828,333	\$ 1,096,631,965
Delinquency Rate	93%	95%	95%	92%	96%
Unsecured Revenue	\$ 168,142	\$ 210,071	\$ 229,294	\$ 190,964	\$ 189,748
Unitary Revenue	\$ 663,357	\$ 720,101	\$ 786,023	\$ 725,151	\$ 782,522
Secured Value	\$ 20,713,126,482	\$ 19,558,074,906	\$ 18,536,667,144	\$ 17,054,838,914	\$ 16,016,117,073
Delinquency Rate	97%	97%	97%	97%	98%
Secured Amount to Raise	\$ 3,011,524	\$ 2,332,767	\$ 2,666,201	\$ 2,678,701	\$ 2,541,998
Tax Rate - per \$100 of value	\$ 0.014918	\$ 0.012212	\$ 0.014729	\$ 0.016044	\$ 0.016057
Increase in Secured Values	\$ 1,155,051,576	\$ 1,021,407,762	\$ 1,481,828,230	\$ 1,038,721,841	\$ 1,134,208,147
	5.9%	5.5%	8.7%	6.5%	7.6%

**BOARD OF DIRECTORS
KAWEAH DELTA HEALTH CARE DISTRICT**

RESOLUTION 2295

**A RESOLUTION DIRECTING TULARE COUNTY, CALIFORNIA, TO
LEVY A TAX TO PAY THE PRINCIPAL OF AND INTEREST ON
GENERAL OBLIGATION BONDS OF THE DISTRICT.**

WHEREAS, by Resolution No. 1312 (the "*Ballot Resolution*") adopted by the Board of Directors of Kaweah Delta Health Care District (the "*Board*") on July 22, 2003, the Board determined and declared that public interest and necessity demanded the acquisition, construction and/or reconstruction, improvement and equipping of additional health care facilities to expand Kaweah Delta Hospital of Kaweah Delta Health Care District (the "*District*"); and

WHEREAS, by the Ballot Resolution, the Board duly called an election to be held on November 4, 2003, for the purpose of submitting to the electors of the District a proposition to incur bonded indebtedness to finance all works, property, parking and structures necessary or convenient for the acquisition, improvement, construction and/or reconstruction of an expansion to Kaweah Delta Hospital, as more fully defined herein (the "*Project*"); and

WHEREAS, an election was held in the District on November 4, 2003, for the purpose of submitting to the qualified voters of the District a proposition for incurring bonded indebtedness of the District in the aggregate principal amount not to exceed \$51,000,000 to finance the Project; and

WHEREAS, the Registrar of Voters of Tulare County, California, duly canvassed the return of said election and, as the result of such canvass, certified to the Board that more than two-thirds of the votes cast on said proposition favored the incurring of such bonded indebtedness; and

WHEREAS, in 2004, the District issued its General Obligation Bonds, Election of 2003, Series 2004 (the "*2004 Bonds*") in the aggregate principal amount of \$51,000,000 for the purposes authorized and on the conditions set forth in Ordinance No. 04-02 (the "*Ordinance*"); and

WHEREAS, on January 6, 2014, the Board adopted Resolution No. 1795 authorizing the issuance of its General Obligation Refunding Bonds, Series 2014 (the "*2014 Bonds*") in an amount sufficient to provide for the advance refunding and redemption, on August 1, 2014, of the 2004 Bonds maturing on or after August 1, 2015; and

WHEREAS, on January 30, 2014, the Board issued its 2014 Bonds in the aggregate principal amount of \$48,906,000 pursuant to Chapter 4, Division 23 (Sections

32300 *et seq.*) of the California Health & Safety Code (the “*Authorizing Law*”), Chapter 3, Part 1, Division 2, Title 5 of the California Government Code and Resolution No. 1795;

WHEREAS, pursuant to the Authorizing Law, the District is authorized to direct Tulare County, California, in which jurisdiction the District is located (the “*County*”), to levy an *ad valorem* tax on all property within the District for the purpose of paying the principal and interest coming due on the 2014 Bonds,

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF DIRECTORS OF KAWEAH DELTA HEALTH CARE DISTRICT AS FOLLOWS:

Section 1. Recitals. All of the recitals herein are true and correct. To the extent that the Recitals relate to findings and determinations of the Board, the Board declares such findings or determinations to be made hereby.

Section 2. Tax Levy. For the purpose of paying the principal of and interest on the 2014 Bonds, and subject to the provisions below, the Board hereby directs the County to levy and collect, in each successive fiscal year, commencing with the District's fiscal year beginning July 1, 2026, and ending June 30, 2027 a tax sufficient to pay the annual interest on the 2014 Bonds as the same becomes due and also such part of the principal thereof as becomes due before the proceeds of a tax levied at the time for making the next general tax levy can be made available for the payment of such interest or principal. Attached to this Resolution as Exhibit A is the annual debt service schedule for the 2014 Bonds. Attached to this Resolution as Exhibit B is the property tax rate set by the Board for the fiscal year ending June 30, 2027.

The levy of taxes for the 2014 Bonds takes into account amounts on deposit in the General Obligation Refunding Bond Fund of the District established pursuant to Resolution No. 1795 of the District to pay debt service on the 2014 Bonds during such year as estimated by the Chief Financial Officer.

Said tax shall be in addition to all other taxes levied for District purposes, shall be levied and collected by the County at the same time and in the same manner as other taxes of the District are levied and collected, and shall be used only for the payment of the 2014 Bonds, and the interest thereon.

Pursuant to Sections 32127 and 32204 of the California Health & Safety Code, all taxes collected by the County pursuant to this Section 2 shall be paid into the treasury of the District and deposited forthwith in a special account of the District as set forth in Resolution No. 1795 of the District.

Section 3. Request for Necessary County Actions. The Board of Supervisors, the Treasurer, the Tax Collector, the Auditor and other officials of the County are hereby requested to take and authorize such actions as may be necessary pursuant to law to provide for the levy and collection of a property tax on all taxable property within the District sufficient to provide for the payment of all principal of, redemption premium (if any), and interest on the 2014 Bonds, as the same shall become due and payable, and

to transfer the tax receipts from such levy to the District for deposit into the District's General Obligation Refunding Bond Fund. The Chief Financial Officer is hereby authorized and directed to deliver certified copies of this Resolution to the clerk of the Board of Supervisors of the County, and the Treasurer, Tax Collector and Auditor of the County.

Section 4. Ratification. All actions heretofore taken by officials, employees and agents of the District with respect to the request and direction for the tax levy described herein are hereby approved, confirmed and ratified.

Section 5. General Authority. The President of the Board, the Secretary/Treasurer, the Chief Executive Officer and the Chief Financial Officer, and their respective designees, are each hereby authorized, empowered and directed in the name and on behalf of the District to take any and all steps, which they or any of them might deem necessary or appropriate in order to ensure that the County levies and collects the property taxes as described herein and otherwise to give effect to this Resolution.

Section 6. This Resolution shall take effect immediately upon enactment.

THE FOREGOING RESOLUTION WAS PASSED AND ADOPTED by the Board of Directors of Kaweah Delta Health Care District on July 22, 2026 by the following vote:

AYES: _____

NOES: _____

ABSENT: _____

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

Attest:

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

EXHIBIT A

BOND DEBT SERVICE

Kaweah Delta Health Care District of Tulare County, California
General Obligation Refunding Bonds, Series 2014
(Refunds Series 2004 G.O. Bonds)
FINAL

Period Ending	Principal	Coupon	Interest	Debt Service	Annual Debt Service
08/01/2014			956,281.17	956,281.17	956,281.17
02/01/2015			950,997.85	950,997.85	
08/01/2015	1,089,000	** %	950,997.85	2,039,997.85	2,990,995.70
02/01/2016			930,734.35	930,734.35	
08/01/2016	1,193,000	** %	930,734.35	2,123,734.35	3,054,468.70
02/01/2017			908,535.15	908,535.15	
08/01/2017	1,301,000	** %	908,535.15	2,209,535.15	3,118,070.30
02/01/2018			884,325.80	884,325.80	
08/01/2018	1,412,000	** %	884,325.80	2,296,325.80	3,180,651.60
02/01/2019			858,044.95	858,044.95	
08/01/2019	1,530,000	** %	858,044.95	2,388,044.95	3,246,089.90
02/01/2020			829,571.50	829,571.50	
08/01/2020	1,651,000	** %	829,571.50	2,480,571.50	3,310,143.00
02/01/2021			798,844.10	798,844.10	
08/01/2021	1,779,000	** %	798,844.10	2,577,844.10	3,376,688.20
02/01/2022			765,734.30	765,734.30	
08/01/2022	1,913,000	** %	765,734.30	2,678,734.30	3,444,468.60
02/01/2023			730,134.10	730,134.10	
08/01/2023	2,054,000	** %	730,134.10	2,784,134.10	3,514,268.20
02/01/2024			691,907.70	691,907.70	
08/01/2024	2,211,000	** %	691,907.70	2,902,907.70	3,594,815.40
02/01/2025			650,759.75	650,759.75	
08/01/2025	2,380,000	** %	650,759.75	3,030,759.75	3,681,519.50
02/01/2026			606,469.35	606,469.35	
08/01/2026	2,550,000	** %	606,469.35	3,156,469.35	3,762,938.70
02/01/2027			559,011.15	559,011.15	
08/01/2027	2,725,000	** %	559,011.15	3,284,011.15	3,843,022.30
02/01/2028			508,297.60	508,297.60	
08/01/2028	2,917,000	** %	508,297.60	3,425,297.60	3,933,595.20
02/01/2029			454,010.45	454,010.45	
08/01/2029	3,113,000	4.090%	454,010.45	3,567,010.45	4,021,020.90
02/01/2030			390,349.60	390,349.60	
08/01/2030	3,328,000	4.090%	390,349.60	3,718,349.60	4,108,699.20
02/01/2031			322,292.00	322,292.00	
08/01/2031	3,547,000	4.090%	322,292.00	3,869,292.00	4,191,584.00
02/01/2032			249,755.85	249,755.85	
08/01/2032	3,803,000	4.090%	249,755.85	4,052,755.85	4,302,511.70
02/01/2033			171,984.50	171,984.50	
08/01/2033	4,066,000	4.090%	171,984.50	4,237,984.50	4,409,969.00
02/01/2034			88,834.80	88,834.80	
08/01/2034	4,344,000	4.090%	88,834.80	4,432,834.80	4,521,669.60
	48,906,000		25,657,470.87	74,563,470.87	74,563,470.87

EXHIBIT B

TAX RATE FOR FISCAL YEAR 2026-2027

\$.014918 per \$100 of assessed value

2026 Board Bylaws

Kaweah Delta Health Care District Bylaws

Article I The District and Its Mission

- Section 1** 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. {California Health and Safety Code – Division 23 – Sections 32000-32499.4} The purpose of the District is to provide quality health care within defined areas of expertise. It is the intent of the District that no person shall be denied emergency admission or emergency treatment based upon ability to pay. It is further the intent of the District that no person shall be denied admission or treatment based upon race, color, national origin, ethnic, economic, religious or age status or on the basis of gender or sexual preference. The medical welfare of the community and its particular health needs will be fulfilled to the capacity of the District's financial limitations.
- Section 2** Kaweah Delta Health Care District operates under the authority of California Health and Safety Code for a health care district. As such, Kaweah Delta Health Care District is publicly owned and operates as a public entity.
- Section 3** As permitted by law, the District may, by resolution of the Board, conduct any election by all-mailed ballots pursuant to Division 4 (commencing with Section 4000) of the California Elections Code.
- Section 4** The Mission of Kaweah Delta Health Care District is: Health is our passion. Excellence is our focus. Compassion is our promise.
- Section 5** The Vision of Kaweah Delta Health Care District is: To be your world-class healthcare choice, for life.
- Section 6** The Pillars of Kaweah Delta Health Care District are:
1. Achieve outstanding community health
 2. Deliver excellent service
 3. Provide an ideal work environment
 4. Empower through education
 5. Maintain financial strength
- Section 7** The mission, vision, and pillars of the District support the safety and quality of care, treatment, and service. {Joint Commission Standard LD.02.01.01}
- Section 8** The Code of Conduct of Kaweah Delta Health Care District is a commitment to ethical and legal business practices, integrity, accountability, and excellence. The Code of Conduct is a founding document of the Compliance Program, developed to express Kaweah Health's understanding and obligation to comply with all applicable laws and regulations. {Joint Commission Standard LD.04.01.01}

Article II The Governing Body

- Section 1** The Governing Body of the Kaweah Delta Health Care District is a Board of Directors constituted by the five (5) publicly elected directors, who are elected by zone, each for four (4) year terms, with two (2) being elected on staggered terms and three (3) being elected two (2) years later on staggered terms. {California Health and Safety Code 32100} The election of the directors is to conform with the applicable California Code. Notwithstanding any other provision of law, a vacancy in any elective office on the governing board of a special district shall be filled as provided in Government Code 1780. This publicly elected Governing Body is responsible for the safety and quality of care, treatment, and services, establishes policy, promotes performance improvement, and provides for organizational management and planning {Joint Commission Standard LD.1.10}.
- Section 2** The Governing Body, every ten years, using new census data, shall redraw their district lines to reflect how local populations have changed. The Governing Body is required to engage the community in the redistricting process by holding public hearings and/or workshops and doing public outreach, including to non-English speaking communities {AB 849 - The Fair and Inclusive Redistricting for Municipalities and Political Subdivisions (FAIR MAPS) Act}.
- Section 3** The Governing Body adopts the Bylaws of the organization. {California Health and Safety Code 32125}
- Section 4** The Governing Body shall establish, adopt, amend, and rescind Board Governance Policies governing the operation and oversight of the Governing Body. Administrative Policies governing District operations shall be promulgated in accordance with Board Policy BOD8 – Promulgation of Kaweah Health Policies.
- Section 5** The principal office of Kaweah Delta Health Care District is located at Kaweah Health Medical Center - Acequia Wing, Executive Offices, 400 West Mineral King Avenue, Visalia, CA 93291. Correspondence to the Board should be addressed to the Board of Directors at this address. Kaweah Health also maintains a Web site at www.kaweahhealth.org. All noticed meeting agendas and supporting materials for Board meetings and Board committee meetings can be obtained at www.kaweahhealth.org/About-Us/Board-of-Directors.
- Section 6** Duties and the Responsibilities of the Governing Body. As boards of directors have basic collective responsibilities, Board members are also entrusted with individual responsibilities as a part of Board membership. The obligations of Board service are considerable; they extend well beyond any basic expectations of attending meetings. Board members as individuals have no special privileges, prerogatives, or authority; they must meet in formal session to negotiate and make District decisions. The specific responsibilities of the Board are clustered into four areas: setting the direction for the District; establishing and supporting the structure of the District; holding the District accountable on behalf of the community; and serving as community leaders.

Considering the complexities of Board membership, a clear statement of individual Board member responsibilities adapted to the organization's needs and circumstances can serve many purposes including clarifying expectations before candidates file for a seat that is up for election on the Kaweah Delta Health Care District Board of Directors.

PRIMARY RESPONSIBILITY - This Board's primary responsibility is to develop and follow the organization's mission statement, which leads to the development of specific policies in the four key areas of:

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

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

- 1) Establish policy guidelines and criteria for implementation of the mission. The Board also reviews the mission statements of any subsidiary units to ensure that they are consistent with the overall mission.
- 2) Evaluate proposals brought to the Board to ensure that they are consistent with the mission statement. Monitor programs and activities of the hospital and subsidiaries to ensure mission consistency.
- 3) Periodically review, discuss, and if necessary, amend the mission statement to ensure its relevance.

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

- 1) Understand and accept responsibility for the actions of all physicians, nurses, and other individuals who perform their duties in the organization's facilities.
- 2) Review and carefully discuss quality reports that provide comparative statistical data about services and set measurable policy targets to ensure continual improvement in quality performance.
- 3) Carefully review recommendations of the Medical Staff regarding new physicians who wish to practice in the organization and be familiar with the termination and fair hearing policies.
- 4) Reappoint individuals to the Medical Staff using comparative outcome data to evaluate how they have performed since their last appointment.
- 5) Appoint physicians to governing body committees and seek physician participation in the governance process to assist the Board in its patient quality-assessment responsibilities.

- 6) Fully understand the Board's responsibilities and relationships with the Medical Staff and maintain effective mechanisms for communicating with them.
 - 7) Regularly receive and discuss malpractice data reflecting the organization's experience and the experience of individual physicians who have been appointed to the Medical Staff.
 - 8) Adopt a Performance Improvement Plan and Risk Management Plan for the District and provide for resources and support systems to ensure that the plans can be carried out.
 - 9) Regularly receive and discuss data about the Medical Staff to ensure that future staffing will be adequate in terms of ages, numbers, specialties, and other demographic characteristics.
 - 10) Ensure that management reviews and assesses the attitudes and opinions of those who work in the organization to identify strengths, weaknesses, and opportunities for improvement.
 - 11) Monitor programs and services to ensure that they comply with policies and standards relating to quality.
 - 12) Take corrective action when appropriate and necessary to improve quality performance.
- B. FINANCIAL PERFORMANCE RESPONSIBILITIES - This Board has the ultimate responsibility for the financial soundness of the organization. To accomplish this the Board must:
- 1) Annually review and approve the overall financial plans, budgets {Joint Commission Standard LD.04.01.03}, and policies for implementation of those plans and budgets on a short and long-term basis. The plan must include and identify in detail the objective of, and the anticipated sources of financing for each anticipated capital expenditure:
 - 2) Approve an annual audited financial statement prepared by a major accounting firm and presented directly to the Board of Directors. {Government Code Section 6061 & Health and Safety Code 32133}
 - 3) Approve any specific capital expenditure in excess of \$75,000, which is not included in the annual budget.
 - 4) Authorize the Chief Executive Officer to settle a claim against Kaweah Delta Health Care District not to exceed \$75,000. Authorize the Chief Compliance & Risk Officer to settle a claim against Kaweah Delta Health Care District not to exceed \$25,000.
 - 5) Approve financial policies, plans, programs, and standards to ensure preservation and enhancement of the organization's assets and resources.
 - 6) Exercising prudence with the Board in the control and transfer of funds.
 - 7) Faithfully reading and understanding the organization's financial statements and otherwise helping the Board fulfill its fiduciary responsibility.
 - 8) Monitor actual performance against budget projections and review and adopt ethical financial policies and guidelines.

- 9) Review major capital plans proposed for the organization and its subsidiaries.
- C. PLANNING PERFORMANCE RESPONSIBILITIES - The Board has the final responsibility for determining the future directions that the organization will take to meet the community's health needs. To fulfill this responsibility, the Board must:
- 1) Review and approve a comprehensive strategic plan and supportive policy statements.
 - 2) Develop long-term capital expenditure plans as a part of its long-range strategic planning.
 - 3) Determine whether or not the strategic plan is consistent with the mission statement.
 - 4) Assess the extent to which plans meet the strategic goals and objectives that have been previously approved.
 - 5) Periodically review, discuss, and amend the strategic plan to ensure its relevance for the community.
 - 6) Regularly review progress towards meeting goals in the plan to assess the degree to which the organization is meeting its mission.
 - 7) Annually meet with the leaders of the Medical Staff to review and analyze the health care services provided by Kaweah Health and to discuss long range planning for Kaweah Health.
- D. MANAGEMENT PERFORMANCE RESPONSIBILITIES - The Board is the final authority regarding oversight of management performance by our Chief Executive Officer (CEO). To exercise this authority, the Board must:
- 1) Oversee the recruitment, employment, and regular evaluations of the performance of the CEO.
 - 2) Evaluate the performance of the CEO annually using goals and objectives agreed upon with the CEO at the beginning of the evaluation cycle.
 - 3) Communicate regularly with the CEO regarding goals, expectations, and concerns.
 - 4) Periodically survey CEO at comparable organizations to assure the reasonableness and competitiveness of our compensation package (BOD4).
 - 5) Periodically review management succession plans to ensure leadership continuity.
 - 6) Ensure the establishment of specific performance policies, which provide the CEO with a clear understanding of what the Board expects and ensure the update of these policies based on changing conditions.
- E. The Board is also responsible for managing its own governance affairs in an efficient and successful way. To fulfill this responsibility, the Board should:

- 1) Maintain written conflict-of-interest policies that include guidelines for the resolution of existing or apparent conflicts of interest. {Board of Directors policy BOD.05 – Conflict of Interest}
- 2) Members of the governing body are required to complete ethics training every two years, with the requirement that they take their first training no later than a year after they start their first day of service with the district. {AB 1234}
- 3) Members of the governing body are elected by the public and, accordingly, are judged on their individual performance by the electorate.
- 4) Participate both as a Board and individually in orientation programs and continuing education programs both within the organization and externally. As such, the District shall reimburse reasonable expenses for both in-state and out-of-state travel for such educational purposes. {Board Of Directors policy BOD.06 – Board Reimbursement for Travel and Service Clubs} {California Health and Safety Code 32103}
- 5) Periodically review Board structure to assess appropriateness of size, diversity, committees, tenure, and turnover of officers and chairpersons.
- 6) Assure that each Board member understands and agrees to maintain confidentiality with regard to information discussed by the Board and its committees.
- 7) Assure that each Board member understands and agrees to adhere to the Brown Act ensuring that Board actions be taken openly, as required, and that deliberations be conducted openly, as required.
- 8) Adopt, amend, and, if necessary, repeal the articles and bylaws of the organization.
- 9) Maintain an up-to-date Board policy manual, which includes specific policies covering oversight responsibilities in the area of quality performance, financial performance, strategic planning performance, and management performance.

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

Section 7 General Expectations of the Kaweah Health Board. Adhere to the duties and responsibilities of the Governing Body as outlined in Article II the Governing Body, Section 5 of the Kaweah Delta Health Care District Bylaws.

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

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

Serving in leadership positions and undertaking special assignments willingly and enthusiastically.

Avoiding prejudiced judgments on the basis of information received from individuals and urging those with grievances to follow established policies and procedures through their supervisors. (All matters of potential significance should be called to the attention of the executive and the Board's elected leader as appropriate.)

Section 8 **Relationship with Staff.** Counseling the chief executive as appropriate and supporting them through often difficult relationships with groups or individuals.

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

Section 9 **Avoiding Conflicts.** Serving the organization as a whole rather than any special interest group or constituency. Regardless of whether or not the Board member was invited to fill a vacancy reserved for a certain constituency or organization, their first obligation is to avoid any preconception that they "represent" anything but the organization's best interests.

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

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

Never accepting (or offering) favors or gifts from (or to) anyone who does business with the organization.

The Board shall assess the adequacy of its conflict-of-interest/confidentiality policies and procedures at least every two years. {Political Reform Act (Government Code 8100 et seq.)}

Section 10 **Meetings.** Preparing for and participating in Board and committee meetings, including appropriate organizational activities.

Asking timely and substantive questions at Board and committee meetings consistent with the Board member's conscience and convictions, while at the same time supporting the majority decision on issues decided by the Board.

Maintaining confidentiality of the Board's executive sessions and speaking for the Board or organization only when authorized to do so.

The Board of Directors of the Kaweah Delta Health Care District shall hold regular meetings at a meeting place within the jurisdiction of the Kaweah Delta Health Care District on the fourth Wednesday of each month, as determined by the Board of Directors each month. In the months of November and December, regular meetings shall be held on the third Wednesday of the month to accommodate holiday schedules. {California Health and Safety Code 32104}

The Board of Directors of the Kaweah Delta Health Care District may hold a special meeting of the Board of Directors as called by the President of the Board or in their absence the Vice President. In the absence of these officers of the Board a special meeting may be called by a majority of the members of the Board. A special meeting requires 24-hour notice before the time of the meeting. {Government Code 54956}

Meetings of the Board of Directors shall be noticed and held in compliance with the applicable California Code for Health Care Districts. {The Ralph M. Brown Act - Government Code 54950} Sections 32100.2 and 32106 of the California Health and Safety Code, as amended, indicate the attendance and quorum requirements for members of the Board of Directors of any health care district in the State of California. For general business the Board may operate under the rules of a small committee, however, upon the request of any member of the Governing Body immediate implementation of the Standard Code of Parliamentary Procedure (Roberts Rules of Order) shall be adopted for the procedure of that meeting. The Board of Directors is committed to conducting its business openly and transparently. Public access to board information, meeting materials, governance records, and public disclosures shall be governed by Board Policy BOD14 – Public Transparency and Disclosure, together with applicable provisions of the Ralph M. Brown Act, the California Public Records Act, and other applicable laws.

The President of the Board of Directors shall appoint the committees of the Board and shall appoint the Chairperson and designate the term of office in a consistent and systematic approach. All committees of the Governing Body shall have no more than two (2) members of the Governing Body upon the committee and both Board members shall be present prior to the Board committee meeting being called to order. All committees of the Governing Body shall serve as extensions of the Governing Body and report back to the Governing Body for action.

The President of the Board of Directors may appoint, with concurrence of the Board of Directors, any special committees needed to perform special tasks and functions for the District.

Any special committee shall limit its activities to the task for which it was appointed, and shall have no power to act, except as specifically conferred by action of the Board of Directors.

Closed sessions of the Board of Directors shall be conducted only as authorized by applicable law. Procedures governing closed sessions, confidentiality, labor negotiations, and reporting of closed session actions shall be administered in accordance with BOD15 – Closed Session and Labor Negotiations.

The Chief of Staff shall be notified and shall facilitate Medical Staff participation in any Governing Board Committee that deliberates the discharge of Medical Staff responsibility.

The Board shall provide public access to its meetings consistent with applicable law. Procedures governing meeting technology, remote participation, public

observation, accessibility, and electronic meeting practices shall be administered in accordance with Board Policy BOD16 – Board Meeting Transparency and Remote Access.

The standing committees of the Governing Body are:

A. Academic Development

The members of this committee shall consist of two (2) Board members, Chief Executive Officer (CEO), Chief Medical & Quality Officer, Designated Institutional Officer, Director of Graduate Medical Education, Director of Pharmacy, and any other members designated by the Board President.

This committee will provide Board direction and leadership for the Graduate Medical Education Program, the Pharmacy Residency Program, and achievement of Kaweah Health's foundational Pillar "Empower through Education."

B. Audit and Compliance

The members of this committee shall consist of two (2) Board members (Board President or Secretary/Treasurer shall be a standing member of this committee), CEO, Chief Financial Officer (CFO), Chief Compliance & Risk Officer, Compliance Manager, legal counsel, and any other members designated by the Board President. The Committee will engage an outside auditor, meet with them pre audit and post audit, and review the audit log of the Chief Compliance & Risk Officer. The Committee will examine and report on the manner in which management ensures and monitors the adequacy of the nature, extent and effectiveness of compliance, accounting and internal control systems. The Committee shall oversee the work of those involved in the financial reporting process including the outside auditors, to endorse the processes and safeguards employed by each. The Committee will encourage procedures and practices that promote accountability among management, ensuring that it properly develops and adheres to a compliant and sound system of internal controls, that the Chief Compliance & Risk Officer objectively assess management's accounting practices and internal controls, and that the outside auditors, through their own review, assess management and the Chief Compliance & Risk Officer's practices. This committee shall supervise all of the compliance activities of the District, ensuring that the Compliance department effectively facilitates the prevention, detection and correction of violations of law, regulations, and/or District policies. The Chief Compliance & Risk Officer will review and forward to the full Board a written Quarterly Compliance Report.

This Committee, on behalf of the Board of Directors, shall be responsible for overseeing the recruitment, employment, evaluation and dismissal of the Chief Compliance & Risk Officer. These responsibilities shall be performed primarily by the CEO and/or the CEO's designees, but final decisions on such matters shall rest with this Committee, acting on behalf of the full Board.

C. Finance / Property, Services & Acquisitions

The members of this committee shall consist of two (2) Board members, (Board President or Secretary/Treasurer will be a standing member of this committee), CEO, CFO, VP Strategy, VP Support Services, Director of Facilities, and any other members designated by the Board President.

This committee will oversee the financial health of the District through careful planning, allocation and management of the District's financial resources and performance. To oversee the construction, improvement, and maintenance of District property as well as the acquisition and sale of property which is essential for the Health Care District to carry out its mission of providing high-quality, customer-oriented, and financially strong healthcare services.

D. Governance Committee

The members of this committee shall consist of two (2) Board members, the CEO, the Board Clerk and any other members designated by the Board President.

The Governance Committee shall assist the Board of Directors in promoting effective governance through oversight of Board governance practices, bylaws, governance policies, Board education and development, committee structure, Board self-assessment, and compliance with applicable governance requirements.

The Committee serves in an advisory capacity and shall make recommendations to the Board regarding governance matters, Board effectiveness, and policy improvements.

E. Governance & Legislative Affairs

The members of this committee shall consist of two (2) Board members {Board President or the Board Secretary/Treasurer}, CEO and any other members designated by the Board President. Committee activities will include: reviewing Board committee structure, calendar, bylaws and, planning the bi-annual Board self-evaluation, and monitor conflict of interest. Legislative activities will include: establishing the legislative program scope & direction for the District, annually review appropriation request to be submitted by the District, effectively communicating and maintaining collegial relationships with local, state, and nationally elected officials.

F. Human Resources

The members of this committee shall consist of two (2) Board members, CEO, Chief Human Resources Officer, Chief Nursing Officer (CNO) and any other members designated by the Board President. This committee shall review and approve all personnel policies. This committee shall annually review and recommend changes to the Salary and Benefits Program, the Safety Program and the Workers' Compensation Program. This

committee will annually review the workers' compensation report, competency report & organizational development report.

G. Information Systems

The members of this committee shall consist of two (2) Board members, CEO, CFO, CNO, VP Digital and Information Systems, Medical Director of Informatics, and any other members designated by the Board President. This committee shall supervise the Information Systems projects of the District.

H. Marketing and Community Relations

The members of this committee shall consist of two (2) Board members and CEO, VP Strategy, Marketing Director, and any other members designated by the Board President.

This committee shall oversee marketing and community relations activities in the District in order to increase the community's awareness of available services and to improve engagement with the population we serve. Additionally, create a brand that builds preference for Kaweah Health in the minds of consumers and creates a public image that instills trust, confidence, and is emblematic of Kaweah Health's mission and our vision to become "world-class." Further develops and fosters a positive perception that will attract the highest caliber of employees and medical staff.

I. Patient Experience

The members of this committee shall consist of two (2) Board members and the CEO, CNO, Director of Patient & Community Experience and any other members designated by the Board President.

This committee will work with the patient experience team and leadership to develop a patient experience strategy to ensure that patient experiences are meeting the Mission and Vision of Kaweah Health and its foundational Pillar "Deliver excellent service".

J. Population Health & Community Committee

The members of this committee shall consist of two (2) Board members and the CEO, Chief Ambulatory Officer, Director of Population Health, Community Members and Medical Staff. Population Health & Community Committee shall assist the Board of Directors in providing oversight of the District's population health strategy, community health improvement initiatives, community benefit activities, health equity efforts, and partnerships that advance the health and well-being of the communities served by the District.

The Committee serves in an advisory capacity and shall make recommendations to the Board regarding community health priorities, population health initiatives, and related policies and strategic objectives.

K. Quality Council

The members of this Committee shall consist of two (2) Board members, CEO or designate, CNO, Chief Medical and Quality Officer (CMQO), Chief of Staff of the Medical Staff, chair of the Professional Staff Quality Committee (Prostaff), Medical Directors of Quality and Patient Safety, Director of Quality and Patient Safety, Director of Risk Management, and members of the Medical Staff as designated by the Board.

This Committee shall review and recommend approval of the annual Quality Improvement (QI) plan and Patient Safety plans to the Board of Directors, determine priorities for improvement, monitor key outcomes related to Quality Focus Team activities, evaluate clinical quality, patient safety, and patient satisfaction, monitor and review risk management activities and outcomes, evaluate the effectiveness of the performance improvement program, foster commitment and collaboration between the District and Medical Staff for continuous improvement, and review all relevant matters related to Quality within the institution, including Performance Improvement, Peer Review, Credentialing/Privileging and Risk Management.

L. Strategic Planning

The members of this Committee shall consist of two (2) Board members, CEO, VP Strategy, all Executive Team members, Medical Staff Officers, Immediate past Chief of Staff along with other members of the Medical Staff as designated by the Board and the CEO.

This Committee shall review the budget plan, review the strategic plan and organize objectives, review changes or additions to service lines.

The Strategic Planning Committee will provide oversight and forward to the full Board the following reports:

1. Review of the Strategic Plan Annually
2. Strategic Plan initiatives progress and follow-up bi-monthly to full Board.

M. Independent Committees

The following independent committees may have Board member participation:

1. Cypress Company, LLC
2. Graduate Medical Education Committee (GMEC)
3. Joint Conference
4. Kaweah Health Hospital Foundation
5. Quail Park {All entities}
6. Retirement Plans' Investment Committee
7. Sequoia Integrated Health, LLC
8. Sequoia Surgery Center, LLC
9. Sequoia Regional Cancer Center – Medical & Radiation, LLC
10. (TKC Development, LLC

- The Board President shall serve as General Manager for TKC Development, LLC.

11. Central Valley Health Care Alliance - JPA

N. Medical Affairs

- 1) A member of the Board, as appointed by the President, shall also serve on the following Medical Staff Committees:
 - a) Joint Conference Committee - This committee shall regularly meet to discuss current issues/concerns with Medical Staff, Board, and Administration.
 - b) Credentials Committee - The Board shall participate in this committee to observe the Medical Staff process.

Section 11 Compensation



Pursuant to California Health and Safety Code Section 32103, members of the Board of Directors shall serve without compensation except as expressly authorized by the Governing Body.

The the Board of Directors may, by resolution adopted by a majority vote of the members of the Board, authorize compensation not to exceed the amounts the amounts permitted by law, including but not limited to:

- A. Not to exceed two hundred dollars (\$200) per regular or special Board meeting;
- B. Not to exceed one hundred dollars (\$100) per each Board Committee meeting;
- C. Not to exceed fifty dollars (\$50) per Community Advisory Committee meeting;
- D. Not to exceed seven (7) meetings a calendar month for purposes of compensation to each member of the Board of Directors.

Commencing July 1, 2025, if the District compensates its members for more than five ((5)) meetings in a calendar month, the Board of Directors shall annually adopt a written policy describing, based on a finding supported by substantial evidence, why more than five meetings per month are necessary for the effective operation of the District.

All compensation and expense reimbursement for members of the Board of Directors shall be administered in accordance with the Board of Directors Policy BOD9. (Board Compensation and Expense Reimbursement Policy), as may be amended from time to time. In the event of any inconsistency between this Section and BOD9, the provisions of applicable law and duly adopted Board resolution shall control.

Each member of the Board of Directors shall be entitled to his or her or their actual necessary travel and incidental expenses incurred in the performance of official business of the District as approved by the Board. For purposes of this section, the determination of whether a Director's activities on any specific day are compensable shall be made pursuant to Article 2.3 (commencing with

Section 53232) of Chapter 2 of Part 1 of Division 2 of Title 5 of the Government Code. Reimbursement for these expenses is subject to Sections 53232.2 and 53232.3 of the Government Code.

The Board Clerk shall maintain official records of Board-approved compensation, attendance documentation, meeting verification, reimbursement requests, and supporting records required for compliance with BOD9, audit standards, and applicable law.

Section 12 The Governing Body Bylaws:

The Governing Body Bylaws and any changes thereto may be adopted at any regular or special meetings by a legally constituted quorum of the Governing Body. All portions of Governing Body Bylaws must be in compliance with applicable California Code, which is the ruling authority.

Any member of the Governing Body may request a review for possible revision of the Bylaws of the organization.

The Governance Board Committee and the Governing Body shall review the Bylaws and recommend appropriate changes annually.

Section 13 Members of the Governing Body shall exercise oversight responsibilities consistent with Board Policy, (Board Policy BOD13- Board Oversight and Accountability) and annually sign the Board Bylaws, which outline the duties and responsibilities of the Governing Body members including but not limited to adherence to the Board policies and the Brown Act.

Section 14 Members of the Governing Body are publicly elected. The members of the Governing Body are expected to participate actively in the functions of the Governing Body and its committees and to serve the constituency who elected them. Notwithstanding any other provision of law, the term of any member of the board of directors shall expire if he or she is absent from three consecutive regular meetings, or from three of any five consecutive meetings of the board and the board by resolution declares that a vacancy exists on the board. {California Health and Safety Code 32100.2}

Section 15 The Board of Directors shall maintain policies governing Director orientation, continuing education, governance development, and Board self-evaluation. Such activities shall be administered in accordance with Board Policies BOD1 (Orientation of New Board Member), BOD 19 (Board Self-Evaluation), and BOD 20 (Board Education and Continuing Education). All members of the Board of Directors shall be provided with current copies of the District Bylaws and the Medical Staff Bylaws and any revisions of these Bylaws.

Article III Officers of the Board

Section 1 The offices of President, Vice President, and Secretary/Treasurer shall be selected at the first regular meeting in December of a non-election year of the District. To hold the office of President, Vice President, or Secretary/Treasurer, a Board member must have at least one year of service on the Board of Directors.

These officers shall hold office for a period of two (2) years or until the successors have been duly selected (or in the case of an unfulfilled term, appointed) and qualified. The officer positions shall be by election of the Board itself.

Section 2 The duties and responsibilities of the Governing Body President are:

- A. Adhere to the duties and responsibilities of the Governing Body as outlined in Article II - The Governing Body of the Kaweah Delta Health Care District Bylaws.
- B. Keep the mission of the organization at the forefront and articulate it as the basis for all Board action.
- C. Understand and communicate the roles and functions of the Board, committees, Medical Staff, and management.
- D. Understand and communicate individual Board member, Board leader, and committee chair responsibilities and accountability.
- E. Act as a liaison between the Board, management, and Medical Staff.
- F. Plan agendas.
- G. Preside over the meetings of the Board.
- H. Preside over or attend other Board, Medical Staff, and other organization meetings.
- I. Enforce Board and hospital bylaws, rules, and regulations (such as conflict of interest and confidentiality policies).
- J. Appoint Board committee chairs and members in a consistent and systematic approach.
- K. Act as a liaison between and among other Boards in the healthcare system.
- L. Direct the committees of the Board, ensuring that the committee work plans flow from and support the hospital and Board goals, objectives, and work plans.
- M. Provide orientation for new Board members and arrange continuing education for the Board.
- N. Ensure effective Board self-evaluation.
- O. Build cohesion among the leadership team of the Board President, CEO, and Medical Staff leaders.
- P. Lead the CEO performance objective and evaluation process.

Section 3 The duties and responsibilities of the Governing Body Vice President are:

- A. Adhere to the duties and responsibilities of the Governing Body as outlined in Article II - The Governing Body of the Kaweah Delta Health Care District Bylaws.

- B. The Vice President shall act as President in the absence of the President or the Secretary/Treasurer in the absence of the Secretary/Treasurer, and so acting shall have all the responsibility and authority of that position.

Section 4 The Secretary/Treasurer shall act as the Secretary for the Board of Directors of Kaweah Delta Health Care District and in so doing shall:

- A. Adhere to the duties and responsibilities of the Governing Body as outlined in Article II the Governing Body of the Kaweah Delta Health Care District Bylaws.
- B. Maintain minutes of all meetings of the Board of Directors;
- C. Be responsible for the custody of all records and for maintaining records of the meetings;
- D. Be assured that an agenda is prepared for all meetings.
- E. Will be custodian of all funds of Kaweah Delta Health Care District as well as the health care facilities operated by the District.
- F. Will assure that administration is using proper accounting systems; that this is a true and accurate accounting of the transactions of the District; that these transactions are recorded and accurate reports are regularly reported to the Board of Directors.
- G. In conjunction with the Board Audit and Compliance Committee shall see that a major accounting firm provides ongoing overview and scrutiny of the fiscal assets of the District and shall further assure that an annual audit is prepared by a major accounting firm and presented directly to the Board of Directors.

Article IV The Medical Staff

Section 1 The Governing Body shall appoint the Medical Staff composed of licensed physicians, surgeons, dentists, podiatrists, clinical psychologists, and all Allied Health Practitioners (including Physician Assistants, Nurse Practitioners and Nurse Midwives) duly licensed by the State of California. {California Health and Safety Code of the State of California, Section 32128} The Governing Body, upon consideration of the recommendations of the Medical Staff coming from the Medical Executive Committee, through the Credentials Committee, affirms or denies appointment and privileges to the Medical Staff of Kaweah Delta Health Care District in accordance with the procedure for appointment and reappointment of the medical staff as provided by the standards of the Joint Commission on Accreditation of Healthcare Organizations. {Joint Commission Standard MS.01.01.01} The Board of Directors shall reappoint members to the Medical Staff every two (2) years, as set forth in the Medical Staff Bylaws. The Governing Body requires that an organized Medical Staff is established within the District and that the Medical Staff submits their Bylaws, Rules and Regulations and any changes thereto, to the Governing Body for approval.

- Section 2** Members of the Medical Staff are eligible to run in the public election for membership on the Governing Body in the same manner as other individuals.
- Section 3** The Chief of Staff of Kaweah Delta Health Care District shall be notified and invited to each regular monthly meeting of the Governing Body and the Chief of Staff's input shall be solicited with respect to matters affecting the Medical Staff.
- Section 4** The Chief of Staff of Kaweah Delta Health Care District shall be invited to all meetings of the Governing Body at which credentialing decisions are made concerning any member of the Medical Staff of Kaweah Health Medical Center or at which quality assurance reports are given concerning the provision of patient care at Kaweah Health Medical Center. Quality assurance reports shall be made to the Board periodically. Credentialing decisions shall be scheduled on an as-needed basis. The Chief of Staff shall be encouraged to advise the Board on the content and the quality of the presentations, and to make recommendations concerning policies and procedures, the improvement of patient care and/or the provision of new services by the District.
- Section 5** The District has an organized Medical Staff that is accountable to the Governing Body. {Joint Commission Standard LD.01.05.01} The organized Medical Staff Executive Committee shall make recommendations directly to the Governing Body for its approval. Such recommendations shall pertain to the following:
- A. the structure of the Medical Staff;
 - B. the mechanism used to review credentials and delineate clinical privileges;
 - C. individual Medical Staff membership;
 - D. specific clinical privileges for each eligible individual;
 - E. the organization of the performance improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate, and revise such activities;
 - F. the mechanism by which membership on the Medical Staff may be terminated;
 - G. the mechanism for fair hearing procedures.
- Section 6** The Governing Body shall act upon recommendations concerning Medical Staff appointments, re-appointments, termination of appointments, and the granting or revision of clinical privileges within 120 days following the regular monthly meeting of the Governing Body at which the recommendations are presented through the Executive Committee of the organized Medical Staff. The Secretary of the Board of Directors or the Chief Executive Officer shall mail notice of the action or decision to the affected applicant or medical staff member with the time specified in the applicable bylaw or rule (California Health & Safety Code 32151}.
- Section 7** The Governing Body requires that only a member of the organized Medical Staff with admitting privileges at Kaweah Health Medical Center may admit a patient to Kaweah Health Medical Center and that such individuals may practice only within the scope of the privileges granted by the Governing Body and that each

patient's general medical condition is the responsibility of a qualified physician of the Medical Staff.

Section 8

The Governing Body requires, as outlined in Resolution 2207, that members of the organized Medical Staff, as a condition of appointment or reappointment and to maintain admitting and clinical privileges, and all Advanced Practice Providers, as a condition of appointment or reappointment and to maintain clinical privileges, to obtain and maintain at all times, continuous coverage that meets or exceeds the standards set forth below:

Coverage Limits: At least \$1 million per claim and at least \$3 million annual aggregate, with a deductible or self-insured retention of not more than \$100,000; and

Rating and Financial Strength: Maintains an A.M. Best Rating of at least A, and a Financial Strength Category ("FSC") of at least VII (\$50 million to \$100 million); and;

Admitted Carriers: An insurance company on the List of Admitted Insurers published by the California Department of Insurance, which can be accessed here:

https://interactive.web.insurance.ca.gov/apex_extprd/f?p=144:10:11467228532262::NO::; or

Non-Admitted/Surplus Line Insurers: An insurance company that meets the criteria identified in paragraphs 1 and 2, and is on the List of Approved Surplus Line Insurers ("LASLI") published by the California Department of Insurance, which can be accessed here: <https://www.insurance.ca.gov/01-consumers/120-company/07-lasli/lasli.cfm#MP>; or

Federal Tort Claims Act: An insurance fund that meets the criteria identified in paragraph 1 and 2 and is administered under the Federal Tort Claims Act for federal employees, when the Kaweah Health Medical Staff member or Advanced Practice Provider Staff is so covered (for example, as a result of their employment with Family Health Care Network).

Section 9

The Governing Body holds the Medical Staff responsible for the development, adoption, and annual review of its own Medical Staff Bylaws, Rules and Regulations that are consistent with Kaweah Health policy, applicable codes, and other regulatory requirements. Neither the Medical Staff nor The Governing Body may make unilateral amendments to the Medical Staff Bylaws or the Medical Staff Rules and Regulations.

The Medical Staff Bylaws and the Rules and Regulations adopted by the Medical Staff, and any amendments thereto, are subject to, and effective upon, approval of the Governing Body, such approval not to be unreasonably withheld.

Section 10

The Medical Staff is responsible for establishing the mechanism for the selection of the Medical Staff Officers, Medical Staff Department Chairpersons, and Medical Staff Committee Chairpersons.

This mechanism will be included in the Medical Staff Bylaws.

- Section 11** The Governing Body requires the Medical Staff and the Management to review and revise all department policies and procedures as often as needed. Such policies and procedures must be reviewed at least every three (3) years.
- In adherence with Title 22 {70203}, Policies relative to medical service {those preventative, diagnostic and therapeutic measures performed by or at the request of members of the organized medical staff} shall be approved by the governing body as recommended by the Medical Staff.
- In adherence with Title 22 {70213}, Nursing Service Policies for patient care shall be developed, maintained and implemented by nursing services; policies which involve the Medical Staff shall be reviewed and approved by the Medical Staff prior to implementation.
- Section 12** Individuals who provide patient care services (other than District staff members), but who are not subject to the Medical Staff privilege delineation process, shall submit their credentials to the Interdisciplinary Practice Committee of the Medical Staff which shall, via the Executive Committee, transmit its recommendations to the Governing Body for approval or disapproval.
- Section 13** The quality of patient care services provided by individuals who are not subject to Medical Staff privilege delineation process, shall be included as a portion of the District's Performance Improvement program.
- Section 14** The Governing Body specifies that under the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA), the Medical Staff and the District are in an Organized Health Care Arrangement (OHCA). The OHCA is a clinically integrated care setting in which individuals receive health care from more than one provider and the providers hold themselves out to the public as participating in a joint arrangement. The Medical Staff is in an OHCA with the District for care provided at District facilities. This joint arrangement is disclosed to the patients in the Notice of Privacy Practices given to patients when they access care at any of the District's facilities. Nothing in the OHCA or otherwise, is intended to, and does not alter the independent relationship between the District and health care providers who have privileges with District.

Article V Joint Committees

- Section 1** The President of the Governing Body or a member of the Board appointed by the President shall participate, along with the CEO, in the Joint Conference Committee, which is a committee of the Medical Staff. This committee shall serve as a systematic mechanism for communication between members of the Governing Body, Administration, and members of the Medical Staff. Specifically, issues which relate to quality of patient care shall be regularly addressed. Additionally, other matters of communication which are of importance to maintaining a sound working relationship between the Governing Body and the Medical Staff shall be discussed. The minutes, if any, shall be kept by the organized Medical Staff under the direction of its President. The proceedings and records of this committee are protected by Section 1157 of the evidence Code.

Article VI Chief Executive Officer

- Section 1** The Governing Body shall be solely responsible for appointment or dismissal of the Chief Executive Officer. {Board of Directors policy – BOD2 – Chief Executive Officer (CEO) Transition}. The terms and conditions of employment of the Chief Executive Officer shall be established through an Employment Agreement approved by the Board of Directors in accordance with Board Policy BOD10— Executive Employment Agreement. Any severance benefits or post-employment compensation shall be governed by Board Policy BOD11- CEO Severance and Compensation.
- Section 2** The Governing Body shall assure that the Chief Executive Officer is qualified for their responsibilities through education and/or experience. {Board of Directors policy – BOD3 – Chief Executive Officer (CEO) Criteria}
- Section 3** The Chief Executive Officer shall act on behalf of the Governing Body in the overall management of the District.
- Section 4** In the absence of the Chief Executive Officer, an Executive Team member designated by the Chief Executive Officer or by the President of the Governing Body shall assume the responsibilities of this position. The Governing Body retains final authority to name the person to act during the absence or incapacity of the Chief Executive Officer.
- Section 5** Annually the Governing Body shall meet in Executive session to monitor the performance of the Chief Executive Officer. The conclusions and recommendations from this performance evaluation will be transmitted to the Chief Executive Officer by the Governing Body. The evaluation process shall be conducted in accordance with Board Policy BOD12 – Chief Executive Officer Performance Evaluation.
- Section 6** Compensation of the Chief Executive Officer shall be determined by the Board of Directors in accordance with Board Policy BOD4 – Executive Compensation, applicable law, and all regulatory requirements.
- Section 7** The Chief Executive Officer shall have the authority to appoint, employ, supervise, and discharge all District employees. The appointment and removal of the Chief Compliance Officer and the Board Clerk shall be subject to approval by the Board of Directors upon the recommendation of the Chief Executive Officer. Employment of all other personnel shall be within the authority of the Chief Executive Officer and subject to budget authorization granted by the Board of Directors.
- Section 8** The Chief Executive Officer shall organize, and have the authority to reorganize the administrative structure of the District, below the level of CEO, subject to the limitations set forth in Section 6 above. The District’s organizational chart shall reflect that the Chief Compliance & Risk Officer and Board Clerk having direct, solid-line reporting relationships to the Board (functional) and to the CEO (administrative).

- Section 9** The Chief Executive Officer shall report to the Board at regular and special meetings all significant items of business of Kaweah Delta Health Care District and make recommendations concerning the disposition thereof.
- Section 10** The Chief Executive Officer shall submit regularly, in cooperation with the appropriate Committee of the Board, periodic reports as required by the Board.
- Section 11** The Chief Executive Officer shall attend all meetings of the Board when possible and shall attend meetings of the various Committees of the Board when so requested by the Committee chairperson.
- Section 12** The Chief Executive Officer shall serve as a liaison between the Board and the Medical Staff. The Chief Executive Officer shall cooperate with the Medical Staff and secure like cooperation on the part of all concerned with rendering professional service to the end that patients may receive the best possible care.
- Section 13** The Chief Executive Officer shall make recommendations concerning the purchase of equipment and supplies and the provision of services by the District, considering the existing and developing needs of the community and the availability of financial and medical resources.
- Section 14** The Chief Executive Officer shall keep abreast and be informed of new developments in the medical and administrative areas of hospital administration.
- Section 15** The Chief Executive Officer shall oversee the physical plants and ground and keep them in a good state of repair, conferring with the appropriate Committee of the Board in major matters, but carrying out routine repairs and maintenance without such consultation.
- Section 16** The Chief Executive Officer shall supervise all business affairs such as the records of financial transactions, collections of accounts and purchase and issuance of supplies, and be certain that all funds are collected and expended to the best possible advantage.
- Section 17** The Chief Executive Officer shall supervise the preservation of the permanent medical records of the District and act as overall custodian of these records.
- Section 18** The Chief Executive Officer shall keep abreast of changes in applicable laws and regulations and shall insure that a District compliance program, appropriate educational programs, and organizational memberships are in place to carry out this responsibility.
- Section 19** The Chief Executive Officer shall be responsible for assuring the organization's compliance with applicable licensure requirements, laws, rules, and regulations, and for promptly acting upon any reports and/or recommendations from authorized agencies, as applicable.
- Section 20** The Chief Executive Officer will ensure that the business of the District is conducted openly and transparently, as required by law.
- Section 21** The Chief Executive Officer will oversee the activities of the District's Community Relations Committees to ensure meaningful participation of community members and communication of the input and recommendation from the committee to the Board and to organization's management.

Section 22 The Chief Executive Officer shall perform any special duties assigned or delegated to them by the Board.

Article VII Chief Compliance Officer

Section 1 The Chief Compliance Officer shall have the authority to:

- A. Communicate directly with the Board Chair, the Board of Directors or any committee of the Board concerning matters within the scope of the Compliance Program;
- B. Schedule an executive session with the Board when the Chief Compliance Officer determines a matter requires confidential discussion;
- C. Attend all Board meetings during consideration of compliance matters unless otherwise directed by the Board; and
- D. Escalate compliance concerns directly to the Board when necessary to fulfill the responsibilities of the office.

Section 2 The Chief Compliance Officer shall support the Audit and Compliance Committee in fulfilling its compliance responsibilities.

Section 3 The Chief Compliance Officer shall have a dual reporting relationship. The Chief Compliance Officer shall report directly to the Board of Directors for monitoring and auditing to evaluate risks, ensure controls and working and prevent non-compliance. One purpose of this direct reporting relationship is to ensure objective internal investigations and autonomy in decision-making. The Chief Compliance Officer shall report directly to the Chief Executive Officer for day-to-day administrative matters and strategic alignment.

Article VIII Board Administration

Section 1 The Board of Directors shall have a Board Clerk who shall serve as the official clerk of the Board and custodian of the Board's official records. The Board Clerk shall support the Board of Directors in fulfilling its governance responsibilities and shall perform the duties prescribed by these Bylaws, applicable law, and Board policy.

Section 2 The Board Clerk shall report administratively to the Chief Executive Officer or the Chief Executive Officer's designee for matters relating to employment, compensation, and day-to-day administration.

For matters relating to Board governance, official Board records, meeting administration, and compliance with applicable laws governing meetings of the Board, the Board Clerk shall function under the direction of the Board of Directors through the Board Chair.

Nothing in this Article shall be construed to diminish the authority of the Chief Executive Officer over District operations except as expressly provided herein.

Section 3 The Board Clerk shall:

A. Maintain records demonstrating compliance with all required Board member education and training, including ethics training required by Government Code Section 53235 (AB 1234), Senate Bill 827, Brown Act education, cybersecurity awareness, and other governance education required by law or Board policy.

B. Maintain records of Board members' Statements of Economic Interests (Form 700), Conflict of Interest disclosures, oaths of office, committee assignments, and terms of office.

C. Coordinate compliance with the District's Conflict of Interest Code and governance disclosure requirements applicable to the Governing Body.

D. Coordinate Board elections, appointments, vacancies, oaths of office, seating of newly elected Directors, and related governance activities in accordance with applicable law.

E. Coordinate candidate orientation and provide governance information to newly elected Directors following certification of election results.

F. Maintain the official governance calendar, including Board meetings, committee meetings, Board education, policy reviews, Board evaluations, election cycles, and governance filing deadlines.

G. Coordinate required Board reporting, notices, and filings with governmental agencies as required by law.

H. Coordinate compliance with Board Policies and applicable laws relating to language accessibility for public meeting notices, agendas, and related governance documents, in accordance with Board Policy BOD17 -Language Access for Public Meeting Notices and Agendas. To ensure Board meeting notices, agendas, and postings comply with the Ralph M. Brown Act and other applicable open meeting laws.

I. Coordinate attendance and registration for governance conferences, educational programs, and Board development activities, and maintain records of Director participation.

J. Maintain records of Board member acknowledgments of the Bylaws, Board Policies, Code of Conduct, confidentiality requirements, and other governance documents.

K. Serve as the official custodian of the Board's governance records, including Bylaws, Board Policies, Board directives, resolutions, committee charters, governance manuals, and historical governance documents.

L. Certify official Board records and actions when required by law or Board action.

M. Perform such other governance-related duties as may be assigned by the Governing Body or required by law.

N. Monitor changes in federal and state laws, regulations, and governance best practices affecting the Governing Body and coordinate updates to the Board Chair, Chief Executive Officer, legal counsel, and Board Policies or Bylaws as appropriate.

O. Serve as the official custodian and designated recipient for all claims submitted against the District under the California Government Claims Act (Government Code Section 900 et seq.), ensuring timely date-stamping, logging, and transmission of claims to appropriate District departments and legal counsel in accordance with law and District policy (BOD7).

P. Serve as the official custodian of Board records and the designated intake point for Public Records Act (Government Code Section 7920.000 et seq.) ensuring timely logging, tracking, and coordination with the Chief Executive Officer, Legal Counsel, and other responsible departments for response in accordance with law and District policy AP116.

Section 4 The Board Clerk shall have direct access to the Board Chair regarding matters involving Board governance, meeting administration, maintenance of official Board records, and compliance with Board procedures.

The Board Clerk may communicate directly with the Board of Directors regarding procedural or governance matters when necessary to fulfill the responsibilities of the office.

Section 5 In carrying out responsibilities relating to the official records and proceedings of the Board, the Board Clerk shall exercise professional judgment consistent with applicable law, these Bylaws, and Board policy.

The Board Clerk shall maintain the integrity of the official records of the Board and shall not alter, withhold, or destroy official Board records except as authorized by law or by formal action of the Board of Directors.

Section 6 In the temporary absence or incapacity of the Board Clerk, the Chief Executive Officer may designate an Acting Board Clerk to perform the duties of the office until the Board Clerk returns or a successor is confirmed by the Board.

Article IX Legal Counsel

Section 1 The Board of Directors shall retain legal counsel to provide legal advice and representation to the District and the Board of Directors in accordance with applicable law. The Board's governance responsibilities regarding the appointment, oversight, independence, evaluation, and use of legal counsel shall be governed by Board Policy BOD18 – Legal Counsel, as may be amended from time to time.

Section 2 The Board of Directors recognizes that timely access to legal counsel is essential to fulfilling its fiduciary, governance, and oversight responsibilities.

Access to and communications with legal counsel shall be conducted in accordance with the District's Administrative Policy AP.57 – Access to Legal Counsel, as amended from time to time. The Board expects all Directors, officers, and employees to adhere to the requirements and procedures established in AP.57.

Section 3 Communications between legal counsel and the Board of Directors shall be afforded the protections of the attorney-client privilege and attorney work-product doctrine to the fullest extent permitted by law.

Article X The Health Care District Guild

Section 1 The Governing Body recognizes the Kaweah Delta Health Care District Guild, a separate non-profit organization, in support of the staff and patients of the District.

Section 2 The Chief Executive Officer is charged with effecting proper integration of the Guild within the framework of the District.

Article XI Performance Improvement (PI)

Section 1 The Governing Body requires that the Medical Staff and the Health Care District staff implement and report on the activities and mechanisms for monitoring and evaluating the quality of patient care, for identifying and resolving problems, and for identifying opportunities to improve patient care within the District.

Section 2 The Governing Body, through the Chief Executive Officer, shall support these activities and mechanisms.

Section 3 The Governing Body shall adopt a Performance Improvement Plan and Risk Management Plan for the District and shall provide for resources and support systems to ensure that the plans can be carried out.

Section 4 The Governing Body requires that a complete and accurate medical record shall be prepared and maintained for each patient; that the medical record of the patient shall be the basis for the review and analysis of quality of care. The Governing Body holds the organized Medical Staff responsible for self-governance with respect to the professional work performed in the hospital and for periodic meetings of the Medical Staff to review and analyze at regular intervals their clinical experience. Results of such a review will be reported to the Governing body at specific intervals defined by the Board.

Section 5 The quality assurance mechanisms within any of the District's facilities shall provide for monitoring of patient care processes to assure that patients with the same health problem are receiving the same level of care within the District.

Article XII Conflict of Interest

Section 1 The Administration Policy Manual of Kaweah Delta Health Care District and the Board of Directors Policy Manual contain written Conflict of Interest Policies {Administrative Policy AP23 and Board of Directors Policy BOD5}. These policies require the completion and filing of Economic Interests disclosing financial interests that may be materially affected by official actions and require designated officials and staff members to disqualify themselves from participating in decisions when required to avoid a conflict of interest.

The requirements of these policies are in addition to the provisions of the California Political Reform Act (Government Code section 87100 et. seq.), Government Code Sections 87300-87313, and other applicable federal and state laws pertaining to conflict of interest; and nothing herein is intended to modify or abridge the provisions of the policies of Kaweah Delta Health Care District which apply to:

- A. members of the Governing Body,
- B. Executive leadership,
- C. employees who occupy designated positions identified in Exhibit "A" of the District Conflict of Interest Code.

Section 2 Each member of the Governing Body, designated executives, and designated employees must timely file Statement of Economic Interests (Form 700) in accordance with the California Political Reform Act, Government Code Sections 87300-87313, and the District's Conflict of Interest Code.

Section 3 Members of the Governing Body shall complete all ethics education and training required by applicable California Law, including Government Code Section 53235 and any successor statutes, including the requirements established by Senate Bill 827, within the prescribed timeframes. The District shall maintain records demonstrating compliance with these training requirements.

Section 4 The Board shall assess the adequacy of its Conflict of Interest Policy (BOD 5), Administrative Policy AP23 (Conflict of Interest), and the Districts Conflict of Interest Code at least every even-numbered year, or more frequently as required by law, to ensure continued compliance with the California Political Reform Act, regulations of the Fair Political Practices Commission (FPPC), and other applicable state laws. c

Section 5 In carrying out their fiduciary responsibilities, members of the Governing body shall avoid not only actual conflicts of interest and, whenever reasonably possible, avoid circumstances that could create the appearance of impropriety or diminish the public's confidence in the integrity of the District's governance.

Article XIII Indemnification of Directors, Officers, and Employees

Section 1 Actions other than by the District. The District shall have the power to indemnify any person who was or is a party, or is threatened to be made a party, to any proceeding (other than an action by or in the right of the District to procure a judgment in its favor) by reason of the fact that such person is or was a director,

officer or employee of the District, against expenses, judgments, fines, settlements, and other amounts actually and reasonably incurred in connection with such proceeding if that person acted in good faith and in a manner that the person reasonably believed to be in the best interest of the District and, in the case of a criminal proceeding, had no reasonable cause to believe the conduct of that person was unlawful. The termination by any proceeding by judgment, order, settlement, conviction or upon a plea of nolo contendere or its equivalent, shall not, of itself, create a presumption that the person did not act in good faith and in the manner that the person reasonably believed to be in the best interests of the District person's conduct was unlawful.

Section 2 Actions by the District. The District shall have the power to indemnify any person who was or is a party, or is threatened to be made a party, to any threatened, pending, or completed action by or in the right of the District to procure a judgment in its favor by reason of the fact that such person is or was a director, officer, or employee of the District, against expenses actually and reasonably incurred by such person in connection with the defense or settlement of that action, if such person acted in good faith, in a manner such person believed to be in the best interest of the District and with such care, including reasonable inquiry, as an ordinarily prudent person in a like position would use under a similar circumstance.

No indemnification shall be made under this Section:

- A. with respect to any claim, issue or matter as to which such person has been adjudged to be liable to the District in their performance of such person's duty to the District, unless and only to the extent that the court in which that proceeding is or was pending shall determine upon application that, in view of all the circumstances of the case, such person is fairly and reasonably entitled to indemnity for the expenses which the court shall determine;
- B. of amounts paid in settling or otherwise disposing of a threatened or pending action, with or without court approval;
- C. of expenses incurred in defending a threatened or pending action that is settled or otherwise disposed of without court approval.

Section 3 Successful defense by director, officer, or employee. To the extent that a director, officer or employee of the District has been successful on the merits in defense of any proceeding referred to in Section 1 or Section 2 of this Article X, or in defense of any claim, issue or matter therein, the director, officer or employee shall be indemnified as against expenses actually and reasonably incurred by that person in connection therewith.

Section 4 Required approval. Except as provided in Section 3 of this Article, any indemnification under this Article shall be made by the District only if authorized in the specific case, upon a determination that indemnification of the officer, director or employee is proper in the circumstances because the person has met the applicable standard of conduct set forth in Sections 2 and 3 of this Article X, by one of the following:

- A. a majority vote of a quorum consisting of directors who are not parties to the proceeding; or
- B. the court in which the proceeding is or was pending, on application made by the District or the officer, director or employee, or the attorney or other person rendering services in connection with the defense, whether or not such other person is opposed by the District.

Section 5 Advance of expenses. Expenses incurred in defending any proceeding may be advanced by the District before the final disposition of the proceeding upon receipt of an undertaking by or on behalf of the officer, director or employee to repay the amount of the advance unless it shall be determined ultimately that the officer, director or employee is entitled to be indemnified as authorized in this Article.

Section 6 Other contractual rights. Nothing contained in this Article shall affect any right to indemnification to which persons other than directors and officers of this District may be entitled by contract or otherwise.

Section 7 Limitations. No indemnification or advance shall be made under this Article except as provided in Section 3 or Section 4, in any circumstance where it appears:

- A. that it would be inconsistent with the provision of the Articles, a resolution of the Board, or an agreement in effect at the time of accrual of the alleged cause of action asserted in the proceeding in which the expenses were incurred, or other amounts were paid, which prohibits or otherwise limits indemnification; or
- B. that it would be inconsistent with any condition expressly imposed by a court in approving a settlement.

Section 8 Insurance. If so desired by the Board of Directors, the District may purchase and maintain insurance on behalf of any officer, director, employee or agent of the corporation, insuring against any liability asserted against or incurred by the director, officer, employee or agent in that capacity or arising out of the person's status as such, whether or not the District would have the power to indemnify the person against that liability under the provisions of this Article.

If any article, section, sub-section, paragraph, sentence, clause or phrase of these Bylaws is for any reason held to be in conflict with the provisions of the Health and Safety Code of the State of California, such conflict shall not affect the validity of the remaining portion of these Bylaws.

These Bylaws for Kaweah Delta Health Care District are adopted, as amended, this 22nd day of July 2026.

President

Secretary/Treasurer

July 22, 2026

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Kaweah Delta Health Care District

Kaweah Delta Health Care District

Vice President
Kaweah Delta Health Care District

Board Member
Kaweah Delta Health Care District

Board Member
Kaweah Delta Health Care District

Board Education Plan

Board of Directors Annual Education Plan

Fiscal Year 2027



Purpose

- Provide structured, ongoing education for the Board of Directors
- Ensure knowledgeable, ethical, and effective governance
- Align with Governance Institute, ACHD best practices, and Brown Act requirements

Education Goals

- Understand district mission, strategy, and governance duties
- Maintain compliance with legal and fiduciary responsibilities
- Stay current on healthcare trends impacting the District
- Engage in quality, finance, and strategic planning oversight
- Achieve ongoing certification and professional development

2027-2028 Calendar Overview

	August	September	October
	Fiduciary Responsibility Management vs. Governance*	Legal & Regulatory Compliance	Medicare vs. Medicare Advantage
November	December	January	February
Quality Oversight*	Artificial Intelligence	Workforce Challenges	Strategic Pillar & Mission Review*
March	April	May	June
Changing what we Can – MediCal	Cybersecurity	Enterprise Risk Management*	Site of Care Shifts

*Intentional Governance Topics – These are topics that we recommend reviewing each year as governance best practice.

August – Fiduciary Responsibility Management vs. Governance (Intentional Governance)

Suggested Pre-Work:

E-Learning: Management vs. Governance

Additional Resources:

[Elements of Governance: Distinction between Management & Governance A strong Board-Executive Partnership can Achieve Bolder Goals](#)

[An Intentional Approach to Board Decision Making](#)

Suggested Discussion Questions:

1. Is the board able to define the role of the board vs. the role of management?
2. Are board meetings spent primarily in strategic discussion or is there large portion of time spent discussing operational matters?
3. Is the board and executive team's culture and risk preferences aligned and congruent with the overall strategic aspirations?

September – Legal & Regulatory Compliance

Suggested Pre-Work:

CMS Physician Self-Referral (Stark Law) Overview

Additional Resources:

[American Hospital Association \(AHA\) Trustee services- Physician Relationships and Board Oversight](#)

[American Health Law Association \(AHLA\) – Stark Law Basics](#)

[National Rural Health Association \(NRHA\) Compliance Education for District Hospitals](#)

Suggested Discussion Questions:

1. How does understanding Stark Law support our Duty of Care?
2. What is the Boards role versus managements role in physician contracting?
3. How can physician partnerships be structured to remain compliant while supporting strategic growth?
4. How does Stark Law impact recruitment and retention?
5. What are the recent enforcement trends and how does Kaweah Health maintain compliance?

October –Medicare vs. Medicare Advantage

Suggested Pre-Work:

Healthcare Policy

Additional Resources:

[Shifting Profit Pools: Reconsidering the \\$1T Medicare Advantage Opportunity \(June 2024 BoardRoom Press, p4\)](#)

Suggested Discussion Questions:

1. How do we balance short-term profits with long-term financial sustainability with the rapid rise of Medicare Advantage?
2. What are the major factors in entrenching health systems in a fee-for-service business model versus value-based models?

November –Quality Oversight (Intentional Governance)

Suggested Pre-Work:

The Definitive Quality Dashboard

E-Learning: The Board's Role in Quality

Additional Resources:

[Elements of Governance: The Boards Role in Quality - The Board's Role in Quality | The Governance Institute \(TGI\)](#)

[Key Governance Questions \(May 1, 2025\): Redesigning for Patient Safety](#)

[Improving Quality in Health Systems: How Do They Do It?](#)

Suggested Discussion Questions:

1. What are we trying to accomplish? (The aim)
2. How will we know that a change is an improvement? (The measurers or indicators)
3. What changes can we make that will result in improvement? (The action plan)
4. Is there a process in place so the board can assure itself that the outcomes and processes being measured for quality are the most relevant ones?
5. Can management and the medical staff adequately articulate the outcome and process improvement goals they are setting for themselves – and how these will be measured?
6. Is there a process in place so the board can determine over time whether the medical staff and management team are accomplishing their goals?

December - AI

Suggested Pre-Work:

Pre-reads, E-Learning courses, & additional materials

Additional Resources:

[TGI AI Resource Center](#)

[AI Governance: Bringing Light to Shadows](#)

[AI Governance: Strategy Alignment: Empowering Effective Decision-Making](#)

Suggested Discussion Questions:

1. How are we currently using AI in our organization, and are these tools predictive or generative? Are we using them according to “best practice” protocols used widely in other healthcare organizations?
2. What new uses of AI have we deployed or may be considering deploying and why?
3. What regulatory and ethical considerations should we be discussing?

January –Workforce Challenges

Suggested Pre-Work:

E-Learning: The Board's Role in Addressing Healthcare Workforce Challenges

Webinar: Strategies for Strengthening your Clinical Workforce

Additional Resources:

E-Briefings May 2025: An interview with Dr. G: Building Scalable Trust with Consumers and Physicians Hospital Focus (Nov 2024): Creating the Workforce of the Future

Webinar: Reconnecting to Purpose: New Strategies to Elevate Physician Well-Being A New Approach to the Healthcare Workforce Challenges in Rural America

In 2023, Human Capital Is Your Strategy

Healthcare Workforce Scarcities: The Governance Role

Suggested Discussion Questions:

1. What is our management's approach to workforce development? Is there a plan in place?
2. What is our organization doing to attract new employees?
3. What is our organization doing to promote employee retention?
4. What are the implications of workforce shortages to our organization's short- & long-term financial plans?

February –Strategic Pillar & Mission Review (Intentional Governance)

Suggested Pre-Work:

E-Learning: The Board's Role in Strategic Planning

Additional Resources:

[Board Culture –An intentional Governance Guide](#)

Suggested Discussion Questions:

1. Why does our organization exist?
2. If we did not exist, why would someone establish us?
3. What do we expect to be the greatest changes in our market– and when?
4. How could we add value and to whom would these benefits accrue?

March – Changing What We Can

Suggested Pre-Work:

Key Governance Questions (March 6, 2025): Changing What We Can

Additional Resources:

[E-Learning: Short Course –Advocacy: The Board Member’s Role](#)

[Key Governance Questions \(April 3, 2025\): Restructuring of the US DHHS](#)

[Webinar: Tax Exemption Under a Microscope: Understanding Board’s Duties During This Time of Scrutiny](#)

Suggested Discussion Questions:

1. What can we do to support our employed physicians to minimize payment gaps between private insurers and Medicaid? How can this help with our overall access and equity efforts?
2. How can we expand our community health worker model as well as scopes of practice for CHWs and social workers as part of our workforce strategy so they can become key providers?
3. What community-based initiatives could help us realize more direct cost savings or revenue?
4. What are we doing to ensure a strong primary care network for our communities? How can we integrate behavioral health and what is the value equation for doing that?
5. What more can we be doing on the advocacy front to influence local and state policy makers to make changes that will help us continue providing quality care and improving the health of our communities?

April – Cybersecurity

Suggested Pre-Work:

E-Learning: Short Course –Cybersecurity

Webinar– Guiding the Future: A Board Member’s Framework for Managing AI Risks

Additional Resources:

[Preparing for and Responding to Cybersecurity Threats](#)

[Key Governance Questions \(March 21, 2024\) –Cybersecurity \(Again\)](#)

Suggested Discussion Questions:

1. Whoa re our third-party IT vendors, and what do we know about their security risk management protocols? Do they align with our standards as well as the national NIST/ISO standards?
2. How much do our vendors invest in Cybersecurity? How are they showing us, in a meaningful way that cybersecurity is top priority?
3. Do we have language in our vendor contracts specifically stating that enforcing security protections is critical?
4. If we don’t have the internal expertise we need to ensure secure relations with IT vendors, what resources or partners can help us with this issue?

May – Enterprise Risk Management (Intentional Governance)

Suggested Pre-Work:

E-Learning: Short Course –Enterprise Risk Management

Additional Resources:

[Enterprise Cyber Risk Management: A Toolbook for Healthcare Boards and Executives](#)

[Effective Enterprise Risk Management: Double Clicking on IT and Cybersecurity \(*BoardRoom Press, Apr 2025, pp6-10*\)](#)

Suggested Discussion Questions:

1. How much do we, as a board, understand about Enterprise Cyber Risk Management (ECRM)?
2. Where is our organization in relationship to legal requirements, best practices and standards related to Enterprise Cyber Risk Management (ECRM)?
3. How does our organization conduct ECRM? (Understanding of this should be at the strategic, enterprise level, not at the tactical level).

June – Site of Care Shifts

Suggested Pre-Work:

A Shifting Business Model: Becoming the Nexus of Care in your Community

Additional Resources:

[E-Learning: Innovation: The Board's Opportunity to Shape the Future](#)

[Reflections on Governance Oversight of Ambulatory and Outpatient Quality and Safety](#)

Suggested Discussion Questions:

1. What is the volume and types of care delivered in our ambulatory space?
2. What processes do we have in place to collect and monitor outpatient quality and safety measures?
3. How are we meeting our patients/consumers where they are?

Ongoing Learning Options

- Conferences & Webinars (ACHD, CHA, CSDA, GI)
 - Governance Institute in person Conference (Every even year starting 2026)
 - Board Strategic Retreat (every odd year starting 2027)
- Board Education Library (On-demand modules, reading materials)
 - TGI online - <https://www.governanceinstitute.com/login.aspx>

Evaluation & Reporting

- Biennial Board Self-Evaluation
- Education Participation Tracking (attendance, completion)
- Annual Report summarizing activities and outcomes

Board Commitment

- Participate in monthly board education discussions
- Complete all required Brown Act and AB 1234 Ethics training
- Attend orientation (new board members)
- Complete a minimum of 4 hours (or 4 activities) of formal governance education annually through conferences, webinars, Governance Institute courses, ACHD, CHA, CSDA, retreats, or other approved governance education

Conclusion

- Bottom line: adopting this plan positions the board to document compliance in every governance focus area



The pursuit of healthiness

ANNUAL INSTITUTIONAL REVIEW BOARD (IRB) REVIEW REPORT – GRADUATE MEDICAL EDUCATION

Annual Institutional Review AY2025-26

Designated Institutional Official Report to
the Kaweah Health Executive Team

July 13, 2026

Angel Smith, JD – DIO



kaweahhealth.org



ACGME Institutional Requirement

1.14. The GMEC must demonstrate effective oversight of the Sponsoring Institution's accreditation through an Annual Institutional Review (AIR).

1.14.a. The GMEC must identify institutional performance indicators for the AIR, to include, at a minimum: **1.14.a.1.** the most recent ACGME institutional letter of notification; **1.14.a.2.** results of ACGME surveys of residents/fellows and core faculty members; and, **1.14.a.3.** each of its ACGME-accredited programs' ACGME accreditation information, including accreditation and recognition statuses and citations.

Areas of Focus

- Institutional Overview
 - ACGME Accreditation Status
 - ACGME Survey Results
- Program Overview
 - ACGME Program Accreditation Status
 - ACGME Resident/Fellow Survey Results
 - ACGME Faculty Survey Results
 - Resident/Fellow Performance
- Institutional & Program Opportunities

Institutional Overview



7 Programs

- Six residencies
- One fellowship



139 Residents/Fellows



No Citations



ACGME Survey Results are at or above National Compliance % except:

- Safety & Health Conditions
- Comfort calling supervisor w/ questions
- Fear of intimidation/retaliation
- Faculty Teaching & Supervision
- Four or more days free in 28-day period

Accreditation Council for
Graduate Medical
Education

401 North Michigan Avenue
Suite 2000
Chicago, IL 60611

Phone 312.755.5000
Fax 312.755.7498
www.acgme.org

1/16/2026



Angel Smith, JD
Designated Institutional Official & Chief Medical Education Officer
400 Mineral King Ave.
GME, 5th Floor
Visalia, CA 93291

Dear Ms. Smith,

The Institutional Review Committee (IRC), functioning in accordance with the policies and procedures of the Accreditation Council for Graduate Medical Education (ACGME), has reviewed the information submitted regarding the following institution:

Kaweah Delta Health Care District (KDHCD)
Visalia, CA

Institution: 8000500018

Based on the information available at its recent meeting, the Review Committee accredited the institution as follows:

Status: Continued Accreditation
Effective Date: 01/12/2026

The Review Committee determined that the institution is in substantial compliance with the Institutional Requirements and did not issue any new citations.

The Review Committee must be notified of any major changes in the organization of the institution. When corresponding with this office, please identify the institution by number and name as indicated above.

Sincerely,

Kenneth Brown
Associate Executive Director, IRC
Institutional Review Committee

Institutional Resources & Infrastructure

Requirement	Requirement Met/At-Risk	Action Plan
Administrative Staffing	Met: Additional PC for EM starts July 20, 2026	N/A
Access to Food	Met	N/A
Educational Space	Met	N/A
Resident Lounge Space	Met	Resident Lounge being renovated; Resource Library adding workstations
IT & Simulation Support	Met	N/A
Call Rooms	Met	N/A

Medical School Affiliations & Visiting Learners

Total	What?	Who?
64	Medical School Affiliations	(Most frequent rotators) • CHSU-Fresno – 43 • ATSU (Santa Maria) – 26 • UC Davis – 23 • Kansas City University – 15 • Western Univ. – 9
248	Student Rotations	190 Medical Students (# per specialty) ANES (28) EM Sub-I (45) EM Core (37) Psych Sub-I (18) Psych Core (17) Neurology (4) Gen Surg Sub-I (4) Gen Surg Core (6) Ultrasound (8) Peds (5) 44 PA students 14 SRNA students
13	Clinical Experiences	(# per specialty) ANES (28) EM Sub-I (45) EM Core (37) Psych Sub-I (18) Psych Core (17) Neurology (4) Gen Surg Sub-I (4) Gen Surg Core (6) Ultrasound (8) Peds (5)

Match Results

Program/Positions	% Filled in Match	Of Note
ANES / 6	100	<i>TBD</i>
EM / 13	100	<i>TBD</i>
FM / 7	100	<i>TBD</i>
GS / 3 + 2 prelims	100 categorical / Prelims in SOAP	Categorical positions were filled in top five of rank list – all women
PSYCH / 7	100	<i>TBD</i>
CAP / 3	100	<i>TBD</i>
TY / 12	100	<i>TBD</i>

Program Overview

- ACGME Program Accreditation Status
- ACGME Resident/Fellow Survey Results
- ACGME Faculty Survey Results
- Resident/Fellow Performance



Anesthesiology



6-6-4-4 = 20



Faculty Survey:

- 100% Very Positive
- Low Scoring areas
 - Process to transition care when resident fatigued
 - Residents instructed in cost-effectiveness



No citations



ACGME Res/Fel Survey Results

- At or above Specialty Compliance %
 - Except: increased clin resp granted
- Overall Res Eval went from 65% to 80%



ITEs: 50th%

Step 3: 1 awaiting results

Board Pass: 75% (not aggregate)



Opportunities:

- Faculty Recruitment
- Grad Retention

Accreditation Council for
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Chicago, IL 60611
Phone 312.755.5000
Fax 312.755.7498
www.acgme.org

2/9/2026



Anne Shapiro, DO, MAS
Interim Residency Program Director, Core Faculty, Obstetric Anesthesiology
Kaweah Health
400 W. Mineral King Avenue
Visalia, CA 93291-6263

Dear Dr. Shapiro,

The Review Committee for Anesthesiology, functioning in accordance with the policies and procedures of the ACGME, has reviewed the information submitted regarding the following program:

Anesthesiology

Kaweah Delta Health Care District (KDHCD) Program
Kaweah Delta Health Care District (KDHCD)
Visalia, CA

Program 0400500028

Based on the information available to it at its recent meeting, the Review Committee accredited the program as follows:

Status: Continued Accreditation
Effective Date: 12/15/2025
Total Approved Resident Positions: 24
Complement Breakdown by Level: 6 - 6 - 6 - 6

The Review Committee determined that the program is in substantial compliance with the Program Requirements and did not issue any new citations.

The Review Committee must be notified of any major changes in the organization of the program. When corresponding with this office, please identify the program by number and name as indicated above.

Sincerely,

Cheryl Gross, MA
Executive Director

Family Medicine



7-7-7 = 21



Faculty Survey:

- 100% Completion



One citation for
insufficient faculty



Opportunities:

- Recruitment/Retention
- Faculty Scholarly Activity



ACGME Res/Fel Survey Results

- At or above Specialty Compliance %
 - Except: increased clin resp granted
- Overall Res Eval went from 70% to 75%



ITEs: 65% scored at/above means

Step 3: 1 has not passed, 3 not taken

Board Pass: 100%

Accreditation Council for
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2/25/2025

ACGME

Mario Martinez, MD
Family Medicine Residency Program Director
Kaweah Delta Health Care District (KDHCD)
400 West Mineral King Avenue
Visalia, CA 93291

Dear Dr. Martinez,

The Review Committee for Family Medicine, functioning in accordance with the policies and procedures of the ACGME, has reviewed the information submitted regarding the following program:

Family medicine

Kaweah Delta Health Care District (KDHCD) Program
Kaweah Delta Health Care District (KDHCD)
Visalia, CA

Program 1200500714

Based on the information available to it at its recent meeting, the Review Committee accredited the program as follows:

Status: Continued Accreditation
Effective Date: 01/22/2025
Total Approved Resident Positions: 21

The Review Committee determined that the program is in substantial compliance with the Program Requirements and did not issue any new citations.

AREAS FOR IMPROVEMENT / CONCERNING TRENDS

The Review Committee identified the following areas for program improvement and/or concerning trends:

Evaluations

The Committee encourages the program to review results from the Resident Survey, as there were concerns expressed across three domains. The Committee reminds the program that Resident Survey results are reviewed annually to assist with the determination of substantial compliance with the requirements.

Faculty Scholarly Activity

The Committee noted that program-level faculty scholarship will be monitored annually for improvement and evidence of substantial compliance. Over 50% of the program faculty reported zero scholarly productivity.

Psychiatry



7-7-9-3 = 26



Faculty Survey:

- 100% Very Positive

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Chicago, IL 60611
Phone 312.755.5000
Fax 312.755.7498
www.acgme.org

3/4/2026



Mandeep S Bagga, MD
Program Director
Kaweah Health
400 West Mineral King Avenue
GME Office
Visalia, CA 93291

Dear Dr. Bagga,

The Review Committee for Psychiatry, functioning in accordance with the policies and procedures of the ACGME, has reviewed the information submitted regarding the following program:

Psychiatry

Kaweah Delta Health Care District (KDHCD) Program
Kaweah Delta Health Care District (KDHCD)
Visalia, CA

Program 4000500313

Based on the information available to it at its recent meeting, the Review Committee accredited the program as follows:

Status: Continued Accreditation
Effective Date: 02/12/2026
Total Approved Resident Positions: 28

The Review Committee determined that the program is in substantial compliance with the Program Requirements and did not issue any new citations.

Subspecialty Programs

The following is a list of subspecialty programs associated with your program. Subspecialty programs with ** preceding the program number were not reviewed at the most recent RC meeting.

4050540001- Child and adolescent psychiatry
Continued Accreditation - Effective: 02/12/2026

The Review Committee must be notified of any major changes in the organization of the program. When corresponding with this office, please identify the program by number and name as indicated above.



No citations



Opportunities:

- Faculty Recruitment

ACGME Res/Fel Survey Results

- At or above Specialty Compliance % Except:
 - Safety and health conditions
 - Increased clin resp granted
 - Witnessed abuse, harassment
- Overall Res Eval went from 76% to 56%



ITEs: $\geq 75\%$ scored at or above 80th%

Step 3: 1 awaiting results

Board Pass: 100%



Child & Adolescent Psychiatry



3-3 = 6



Faculty Survey:

- 100% Very Positive
- Areas for Improvement
 - Info not lost during handoff
 - Residents instructed in cost-effectiveness



No citations

ACGME Res/Fel Survey Results

- At or above Specialty Compliance % Except:
 - Participate in safety event invest/analysis
 - Appropriate level of supervision
 - Evaluation
- Overall Res Eval went from 100% to 83%



ITEs: 50th%

Board Pass: 100% (not aggregate)



Opportunities:

- C&A Unit MHH
- Grad Retention

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3/4/2026

Cory D Jaques, MD
Program Director
Kaweah Delta Health Care District (KDHCD) Program
400 W Mineral King Ave
Visalia, CA 93291

Dear Dr. Jaques,

The Review Committee for Psychiatry, functioning in accordance with the policies and procedures of the ACGME, has reviewed the information submitted regarding the following program:

Child and adolescent psychiatry

Kaweah Delta Health Care District (KDHCD) Program
Kaweah Delta Health Care District (KDHCD)
Visalia, CA

Program 4050540001

Based on the information available to it at its recent meeting, the Review Committee accredited the program as follows:

Status: Continued Accreditation
Effective Date: 02/12/2026
Total Approved Fellow Positions: 6

The Review Committee determined that the program is in substantial compliance with the Program Requirements and did not issue any new citations.

The Review Committee must be notified of any major changes in the organization of the program. When corresponding with this office, please identify the program by number and name as indicated above.

Sincerely,



Transitional Year



12 per year

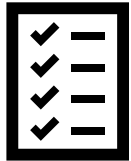


Faculty Survey:

- 100% Very Positive
- Low Scoring areas
 - Process to transition care when resident fatigued
 - Residents instructed in cost-effectiveness



No citations



ACGME Res/Fel Survey Results

- At or above Specialty Compliance % Except:
 - Time to interact with patients
 - Increased clin resp granted
 - 80-hour week / Four or more days free in 28
- Overall Res Eval went from 100% to 92%



Step 3: 4 awaiting results



Opportunities:

- Better leveraging of TY residents in QI
- Recruitment of former grads

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Chicago, IL 60611
Phone 312.755.5000
Fax 312.755.7498
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2/6/2026



Michael Stanley, DO
Transitional Year Residency Program Director
Kaweah Delta Health Care District (KDHCD) Program
400 West Mineral King Avenue
Visalia, CA 93291

Dear Dr. Stanley,

The Review Committee for Transitional Year, functioning in accordance with the policies and procedures of the ACGME, has reviewed the information submitted regarding the following program:

Transitional year

Kaweah Delta Health Care District (KDHCD) Program
Kaweah Delta Health Care District (KDHCD)
Visalia, CA

Program 9990500244

Based on the information available to it at its recent meeting, the Review Committee accredited the program as follows:

Status: Continued Accreditation
Effective Date: 12/04/2025
Total Approved Resident Positions: 12

The Review Committee determined that the program is in substantial compliance with the Program Requirements and did not issue any new citations.

The Review Committee must be notified of any major changes in the organization of the program. When corresponding with this office, please identify the program by number and name as indicated above.

Sincerely,

Cheryl Gross, MA
Executive Director
Review Committee for Transitional Year



13-14-11 = 38



No citations



Faculty Survey:

- 90% Very Positive
- Low Scoring area
 - Faculty act unprofessionally

ACGME Res/Fel Survey Results

- Focus Areas Below Specialty Compliance %
 - Balance btw educ and pt care
 - Safety and Health conditions
 - Able to raise concerns/process for dealing confidentially w/ probs and concerns
 - Appropriate amt of teaching
 - Satisfied w/ feedback
- Overall Res Eval went from 79% to 71%



ITEs: < 50% at benchmarks

Step 3: 10 awaiting results, 3 did not pass

Board Pass: 100%



Opportunities:

- ITE scores
- Difficult interactions
- Special Review

Emergency Medicine

Accreditation Council for
Graduate Medical
Education

401 North Michigan Avenue
Suite 2000
Chicago, IL 60611

Phone 312.755.5000
Fax 312.755.7498
www.acgme.org

3/6/2026



Sean H Oldroyd, DO
Emergency Medicine Residency Program Director
Kaweah Delta Health Care District (KDHCD)
400 West Mineral King Avenue
Visalia, CA 93291-6263

Dear Dr. Oldroyd,

The Review Committee for Emergency Medicine, functioning in accordance with the policies and procedures of the ACGME, has reviewed the information submitted regarding the following program:

Emergency medicine

Kaweah Delta Health Care District (KDHCD) Program
Kaweah Delta Health Care District (KDHCD)
Visalia, CA

Program 1100500213

Based on the information available to it at its recent meeting, the Review Committee accredited the program as follows:

Status: Continued Accreditation
Effective Date: 01/14/2026
Total Approved Resident Positions: 42

The Review Committee determined that the program is in substantial compliance with the Program Requirements and did not issue any new citations.

The Review Committee must be notified of any major changes in the organization of the program. When corresponding with this office, please identify the program by number and name as indicated above.

Sincerely,

Jenny Campbell, MA
Associate Executive Director
Review Committee for Emergency Medicine
312.755.5026
jcampbell@acgme.org



5-3-3-3-3 = 17



No citations



Faculty Survey:

- 75% Positive
- Low Scoring areas
 - Satisfied w/ Prof Dev and Educ
 - Process to transition care when resident fatigued
 - Evaluation
 - Instruction on cost-effectiveness



ACGME Res/Fel Survey Results

- Focus Areas Below Specialty Compliance %
 - Resources
 - Professionalism
 - Fac Teaching and Supervision
 - Interprofessional Teamwork skills modelled/taught
 - Satisfied w/ feedback
- Overall Res Eval went from 100% to 18%



ITEs: at or above benchmarks

Step 3:

Board Pass: 83% (not aggregate)



Opportunities:

- Faculty Engagement
- Expanding Rotations
- Special Review

Surgery

Accreditation Council for
Graduate Medical
Education

401 North Michigan Avenue
Suite 2000
Chicago, IL 60611

Phone 312.755.5000
Fax 312.755.7498
www.acgme.org

3/11/2026



John J Hong, MD
Program Director
400 West Mineral King Avenue
GME Office, SSB Building, Fifth Floor
Visalia, CA 93291

Dear Dr. Hong,

The Review Committee for Surgery, functioning in accordance with the policies and procedures of the ACGME, has reviewed the information submitted regarding the following program:

Surgery

Kaweah Delta Health Care District (KDHCD) Program
Kaweah Delta Health Care District (KDHCD)
Visalia, CA

Program 4400500428

Based on the information available to it at its recent meeting, the Review Committee accredited the program as follows:

Status: Continued Accreditation
Effective Date: 01/15/2026
Total Approved Resident Positions: 17
Complement Breakdown by Level:

4 - 4 - 3 - 3 - 3
C = 3-3-3-3-3
P = 1-1

The Review Committee determined that the program is in substantial compliance with the Program Requirements and did not issue any new citations.

RESOLVED CITATIONS

The Review Committee determined that the following citations have been resolved:

Performance on Board Exams | Since: 01/04/2024 | Status: Resolved
[Program Requirement V.C.3.a)] For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)

Fellowship Matches

Program	Resident	Fellowship
Anesthesiology	Dr. Katherine Nguyen	Children's Hospital of Los Angeles – Pediatric Anesthesiology
Emergency Medicine	Dr. Abimbola Bankole Dr. Shadi Kiaei Dr. Tyler Kirkland Dr. Iman Shull	SUNY Update Med University NY Medical – Toxicology Rutgers New Jersey Medical School – Medical Toxicology Stanford Health – Addiction Medicine Vituity / Kaweah Health - Medical Education
Psychiatry	Dr. Sheena Ghalla Dr. Nicole Haggerty Dr. Liz Jahng Dr. Monica Khokhar Dr. Rahul Maini	Kaiser Permanente Fontana – Child and Adolescent Psychiatry UC San Diego – Child and Adolescent Psychiatry Kaweah Health– Child and Adolescent Psychiatry UCLA Medical Center – Addiction Psychiatry Fontana – Child and Adolescent Psychiatry
Surgery	Dr. Handelsman Dr. McNabb Dr. Petrak	Melanoma Fellowship – (International – Australia) Baylor University Med Center – Surgical Critical Care Hackensack NJ - Minimally Invasive Surgery

Resident Retention

Academic Year 25-26

Priority: Retain Kaweah Health Residents

Program	Graduates (June 2026)	# Signed with KH	# Signed in Central Valley	% Retained Overall	Notes
Anesthesiology	4	2	1 (Dr. Marigold – St. Agnes)	75%	One resident (Dr. Prentice) signed a two-year contract and the other (Dr. Brazeal) signed for one year
Emergency Medicine	11	2		18%	Dr. Eduardo Amaya and Dr. Iman Shull (Shull – Education Fellowship for one year)
Family Medicine	7	3	2 (Dr. Sanchez – United Dr. Granados - Bakersfield)	71%	Drs. Truong (Tulare Clinic/Inpt), Patel (Akers and Women's Hlth), and Rivera (Plaza and Ben Maddox)
Psychiatry	4	0		0%	
Surgery	3	0		0%	All grads went to fellowships
Child & Adol Psychiatry	3	0		0%	*Overall retention = 31% *KH retention = 22%

AY2025-26 Successes

Area	Institution	Programs
Accreditation	Continued Accreditation With No Citations (Jan. 16, 2026)	All – Continued Accreditation
Resident Match	N/A	All Categorical Positions 100% Filled
Resolved Citations/AFIs	N/A	ANES – Evaluations & Fac Tchg Superv FM – Educ Environ SURG – Board Pass Rate
Scholarly Activity	N/A	Residents had six publications Faculty had 12 publications
Expansion	CSU Opening C&A Unit MHH Ground-breaking	CAP and Psychiatry
Grants	Applied for cap slots via Section 126 (CMS) March 2026; app under review (May 2026)	ANES

AY2025-26 Risks

Area	Concern(s)	Action Plan
Faculty attrition	Loss of EM faculty (APD), change in surgery faculty group, adequate FM faculty	Partner with provider groups to recruit; better grad retention
Finances	Legislation passed affecting Medicare/Medicaid reimbursement rates	Optimizing clinical documentation; grant funding opportunities
Case volumes	Loss of elective case volume for surgery program	Expanding surgery clinic to support elective cases; elective surgery rotations (St. Agnes)
Faculty Teaching & Supervision	Faculty interested in teaching; Environment of Inquiry; Appropriate amount of teaching in clinical and didactic activities; Increasing clinical responsibility granted	Work with program leadership to assess faculty role/responsibilities and implement targeted faculty development; create “Junior Faculty” leadership training path for retained grads; clear delineation and regular (monthly) monitoring of faculty responsibilities and outcomes (accountability measures)
Safety/Health Conditions	Disruptive/unsafe patients; Walking to car when dark	Exec Team approved two FT security guards for Lindsay and Exeter BH clinics; reported through GMEC that a security guard is available to escort residents to cars
Program Data	Inability to obtain program-specific data as required by ACGME (EM, FM, Psych)	Follow-up with BI team about creating a dashboard template with needed data points that PDs can access and run as needed.

GME Strategic Growth Opportunities

Area	Opportunity	Implementation
Resources	Community pipeline development – more exposure to community physicians for succession planning, practice models, additional faculty	One to two years – requires changes to resident schedules/rotations to accommodate
Program Expansion	New program/fellowship feasibility (FM/OB fellowship through BCFMO) Internal Medicine (SV partnership) Rural training track/HOS reclass Alignment with hospital service line growth	Two to three years – requires feasibility study, resource procurement and allocation
Medical School Alignment	Sole clinical site for MS3 and MS4 rotations Evaluating/expanding medical school affiliations	One to two years – requires programs to assess recruitment and retention strategies/goals, and align with schools that meet goals



Questions?



[kaweahhealth.org](https://www.kaweahhealth.org)



ORTHOPEDIC SERVICE LINE QUALITY REPORT-

Orthopedic Service Line

Quality Report
July 2026

Kevin Bartel,
Director of Surgical Service Lines



Orthopedic Service Line

Scope of Services

Trauma/Emergent call coverage & surgical services

- 24/7 call coverage

- Dedicated orthopedic traumatologist to support cases staying local

Elective orthopedic surgical services

- Team of orthopedic NPs dedicated to support patient throughput & outcomes

- MAKO robot for hip & knee surgical support

- Blue Distinction + designation for Total Joint, Spine

Orthopedic Service Line

Key Initiatives & Process Improvement

Increase orthopedic surgical volume – 2,846 cases in FY26 (↑ 4.5%)

- Reducing outbound transfers
- Improving OR efficiencies with block utilization, 1st case on-time starts
- Recruitment of additional specialties – spine, hand

Reduction in orthopedic surgical patient Length of Stay (LOS)

- Monthly review of LOS trends, by surgeon
- FYTD Elective LOS (1.87 days) vs. GMLOS (2.75 days)
- FYTD Emergent/Trauma LOS (5.84 days) vs. GMLOS (4.17 days)
 - Monthly case review, trend recognition, interdepartmental collaboration

Orthopedic Service Line

Key Initiatives & Process Improvement (cont.)

Timely fixation of fractures per ACS guidelines (within 24 hours)

- Monthly outlier review, trend analysis, surgeon discussion

2025	Benchmark	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Average
Femur Fixation <24 hr (avg)	24 hr.	29:01:00	9:36:00	16:31:00	12:37:00	24:56:00	9:42:00	20:41:00	20:04:00	16:06:00	14:51:00	26:18:00	33:08:00	19:27:35
Hip Fx < 24 hr	24 hr.	26:02:00	23:20:00	20:58:00	36:00:00	22:38:00	23:33:00	18:26:00	23:38:00	31:14:00	23:49:00	23:50:00	21:04:00	24:32:40
Open tib/fib <24 hr	24 hr.	15:46:00	27:38:00	11:49:00	21:08:00	n/a	11:35:00	23:51:00	75:34:00	16:24:00	15:34:00	21:03:00	11:10:00	22:52:00

Surgical quality compliance with ERAS initiatives

Kaweah Health.		Surgical Quality Dashboard												
		Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Total
ERAS Ortho (n=)	ISCR Benchmark	11	11	10	9	10	8	10	10	10	10	11	9	119
	Perioperative Antibiotics	100% 11/11	100% 11/11	100% 10/10	100% 9/9	100% 10/10	100% 8/8	100% 10/10	100% 10/10	100% 10/10	100% 10/10	100% 11/11	100% 9/9	100% 119/119
	Multi-modal Pain Management	90.90%												
	Postop VTE Chemoprophylaxis	90.91% 10/11	100% 11/11	100% 10/10	100% 9/9	100% 10/10	100% 8/8	100% 10/10	100% 10/10	100% 10/10	100% 9/10	100% 11/11	100% 9/9	98.32% 117/119
	Postop Mobilization	88.80% 11/11	100% 11/11	100% 10/10	100% 9/9	100% 10/10	100% 8/8	100% 10/10	100% 10/10	100% 10/10	100% 10/10	100% 10/10	100% 9/9	100% 118/118
	Postop Intake of Liquids	100% 11/11	100% 11/11	100% 10/10	100% 8/9	100% 10/10	100% 8/8	100% 10/10	100% 10/10	100% 10/10	100% 10/10	100% 11/11	100% 9/9	99.16% 118/119
	Foley Removal	91.70% N/C	N/C	100% 1/1	N/C	N/C	100% 1/1	N/C	N/C	100% 1/1	100% 1/1	N/C	100% 2/2	100% 6/6

Surgical Site Infection January 1 – December 31, 2025 (12 months)

Type of SSI	Total # of Procedures	Actual # of infections	Predicted # of Infections	Kaweah Health Standardized Infection Ratio	National benchmark* (lower is better)
KPRO (TKA)	171	0	1.324	0	5th percentile
HPRO (THA)	191	1	2.88	0.347	17th percentile
FUSN (Spinal fusion)	354	9	5.562	1.618	72 nd percentile
FX (hip fracture)	392	1	1.324	0.266	N/A
Total	1,108	11	11.09	0.992	

*CDC NHSN 2024 data

Goal: measure the standardized infection ratio (SIR) of these orthopedic procedure types for patients who experienced a surgical site infection within 90 days after surgery – Kaweah goal is at or below 30th percentile

Review/Analysis

- 10 of 11 patients with SSI were elective procedures, one was a critical trauma
- 9 of 11 patients with SSI received post-acute care (HH, SNF or Rehab)
- Pre-op comorbidities known (obesity, DM and/or decreased mobility) in 7 of 9 elective SSI cases that may have impacted wound and overall healing
- 200% increase in Spinal Fusion SSI cases from prior reporting period – surgeon commonality in 8 of 9 FUSN cases

Surgical Site Infection

January 1 – December 31, 2025 (12 months)

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS/UPDATES
Timely SSI review- Review of identified SSIs in a timely manner by Director and Orthopedic Nurse Practitioners that support the service to identify trends in care provision/education that can be discussed both at SQIP and directly with the surgeon and surgery teams at the monthly orthopedic co-management meetings as appropriate.	Ongoing	Delays in receiving timely SSI incidence from IP for internal review, impacting timely review and discussion with surgeon and committees as appropriate
SPD processes and workflows – Through audit of SPD workflows (initiated Nov 2025) there was a determination that opportunity existed to address gaps in our SPD workflows and processes to reduce incidence of incomplete and non-sterile trays. New SPD leadership effective January 2026 to support this effort.	Ongoing	Surgery and SPD leadership implementing improvements to workflows and processes, and collaborating directly with surgeons as issues arise to address underlying trends

Complication Rate

January 1 – December 31, 2025 (12 months)

KAWEAH DELTA MEDICAL CENTER
CMS CJR Hip/Knee Arthroplasty - Complication Rate, Same Facility
Compared with 400+ beds

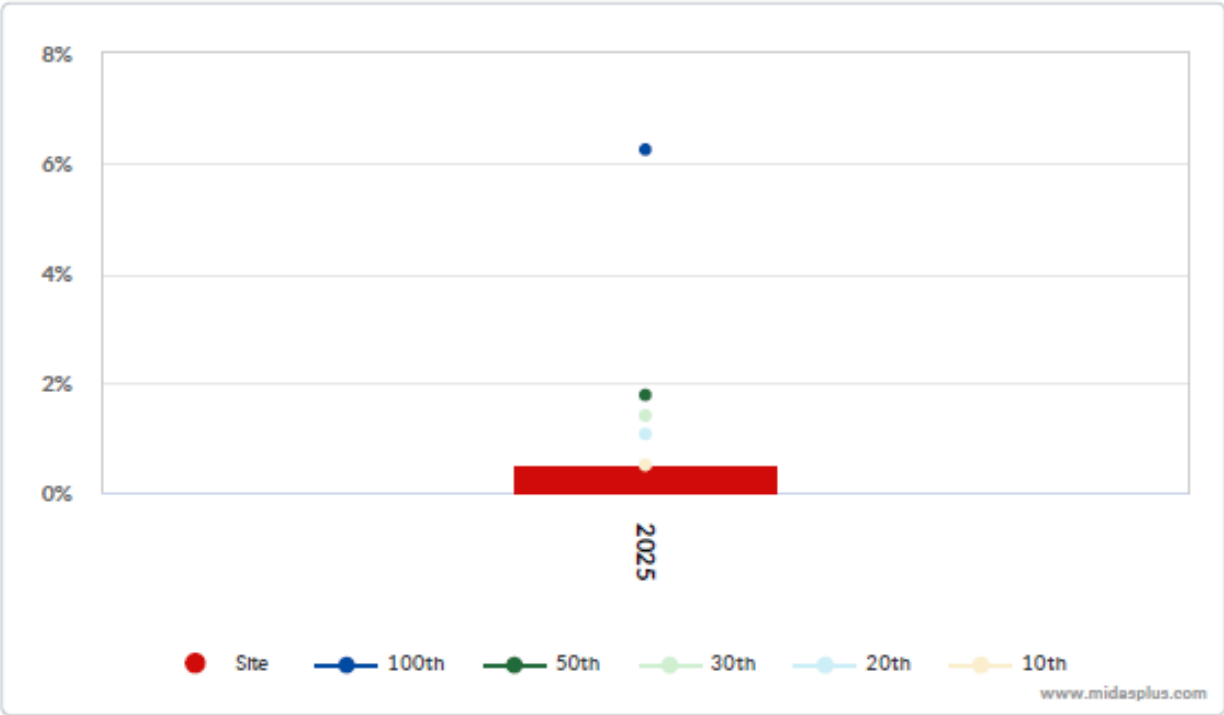
All Payers

Overall complication rate:
0.52% (3 complications from
573 total cases)

Percentile: 9th percentile
(lower is better)

Kaweah goal: 20th percentile
(1.07% complication rate)

GOAL MET



Period	Site Value	Site Percentile	Num	Den	Category	10th	20th	30th	50th	100th	# Sites
2025	0.52%	9th	3	573	400+ beds	0.52	1.07	1.43	1.79	6.25	80

Complication Rate

January 1 – December 31, 2025 (12 months)

KAWEAH DELTA MEDICAL CENTER
CMS CJR Hip/Knee Arthroplasty - Complication Rate, Same Facility, Medicare
Compared with 400+ beds

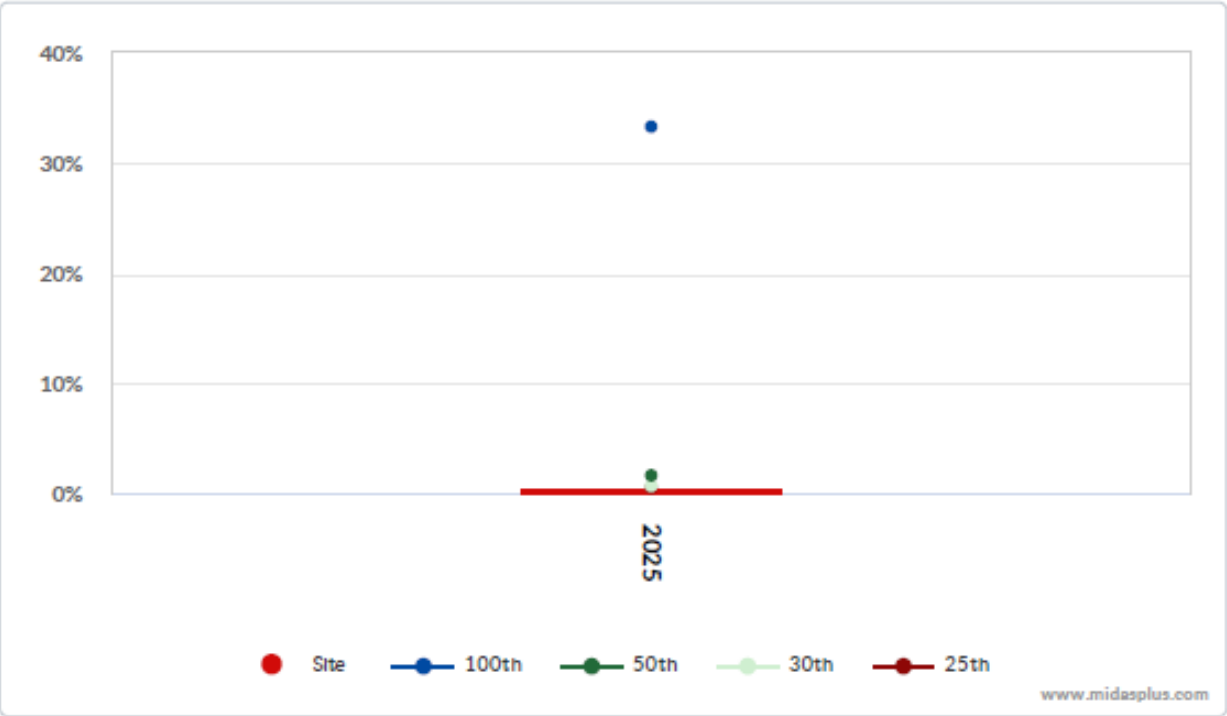
Medicare only

Overall complication rate:
0.60% (1 complication from
166 total cases)

Percentile: 25th percentile
(lower is better)

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

GOAL MET



Period	Site Value	Site Percentile	Num	Den	Category	25th	30th	50th	100th	# Sites
2025	0.60%	25th	1	166	400+ beds	0.58	0.78	1.65	33.33	79

Complication Rate

January 1 – December 31, 2025 (12 months)

	Primary Proc Type	Primary Proc Date	Complication Type
Q1 2025			
Q2 2025	THA	5/15/2025	death within 30 days
Q3 2025			
Q4 2025	TKA	10/9/2025	sepsis within 7 days
	TKA	10/31/2025	pneumonia within 7 days

Medicare

Complication inclusion criteria

1. Mechanical complication within 90 days
2. Wound infection or periprosthetic joint infection within 90 days
3. Surgical site bleeding within 30 days
4. Pulmonary embolism within 30 days
5. Death within 30 days
6. Acute myocardial infarction within 7 days
7. Pneumonia within 7 days
8. Sepsis, septicemia or shock within 7 days

Complication Rate

January 1 – December 31, 2025 (12 months)

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS/UPDATES
Joint surgery patient education - Providing consistent and standardized education for our joint surgery patients is critical to optimize expectations and outcomes. KH Joint Surgery books are provided to local offices to disburse to patients pre-operatively, a joint surgery educational video on the KH website is promoted to scheduled surgery patients, and information from patients is gathered pre-operatively (functional and social status) by our orthopedic NPs to consider optimal discharge disposition in advance.	Ongoing	Relying on various local orthopedic offices to disperse joint surgery educational books and promote educational video is challenging, as their workflows vary.
Coordinated therapy pre/post op With majority of total joint surgeries resulting in discharge to home with surgeon follow up approximately 2 weeks post-operatively, there may be benefit with scheduling these patients with a session of physical therapy pre-operatively, and/or coordinating therapy to begin within a week of surgery, so that a licensed PT can play a role in wound inspection, inflammation reduction modalities, patient education on healing, and guiding light exercises.	9/30/26	Refine this workflow consideration with Dr. Kim in collaboration with therapy leadership
Optimize patient discharge disposition: Coordinated communication between our KH orthopedic NPs and KH case managers/post-acute liaisons to spotlight priority patients coordinate appropriate level of rehab/therapy indicated for their condition (i.e. transfer to inpatient rehab, short stay, SNF, home health as appropriate) in order to optimize patient access to recovery and education.	Ongoing	We continue to experience scenarios where patients have been told by their surgeon that they can go to rehab after their surgery, which isn't always allowed (per payer guidelines).

Thank you

Live with passion.

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



PATIENT EXPERIENCE AND SATISFACTION UPDATE

Patient & Community Experience

Board of Directors
July 2026



kaweahhealth.org





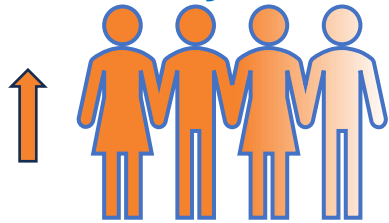
Patient Experience Matters



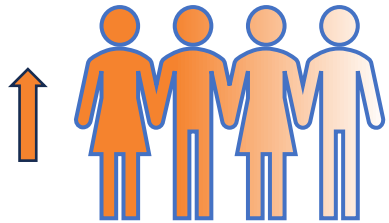
Opportunities and insights to increase patient satisfaction.

Kaweah Health June 2026

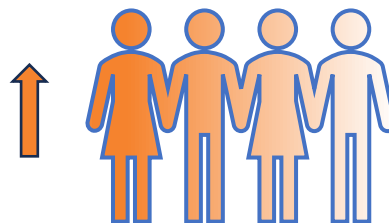
Survey Scores



HCAHPS: 71.9
51st Percentile



Inpatient NPS: 61.4
31st Percentile

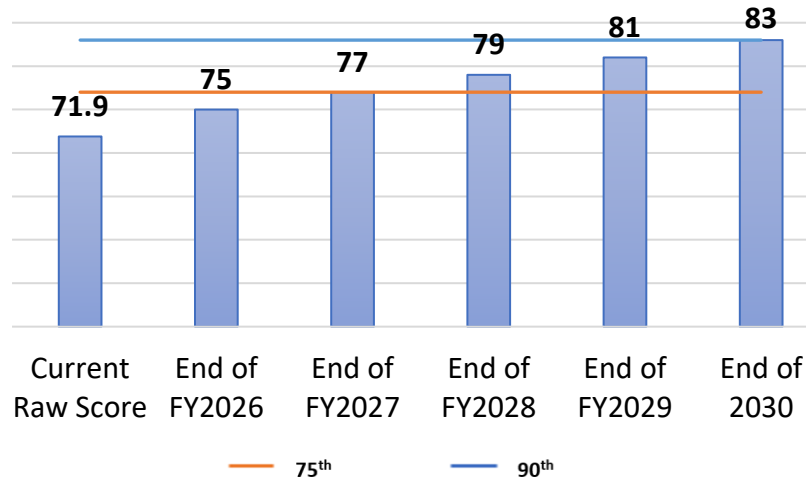


Medical Practice NPS: 79.3
12th Percentile

Fiscal Year Data

July 2025 – May 2026

5 Year HCAHPS Goal



June 2026

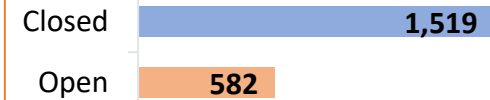
MIDAS
59
Opened

PX
Rounding
225

ED
Rounding
307

Leader
Rounding
1,193

Service Alerts



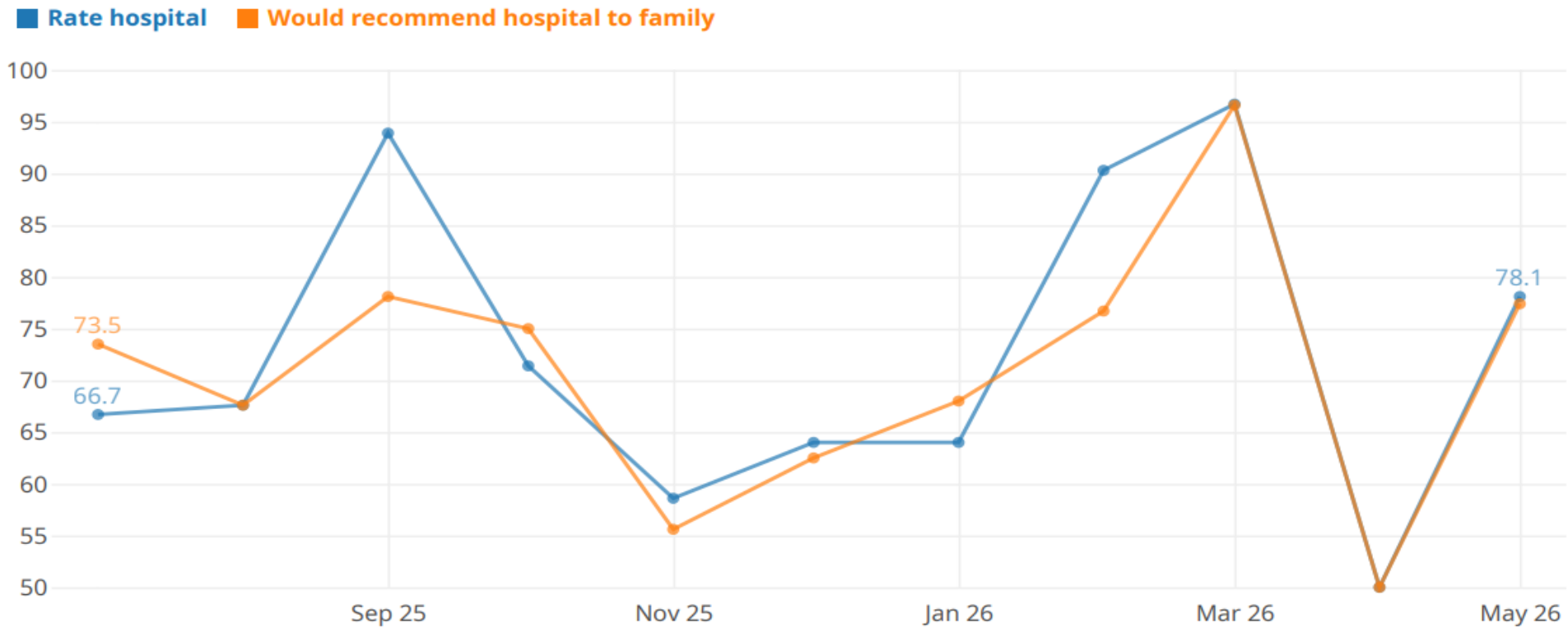
Human Understanding – 75.6
11th Percentile

PRIORITY

- **Received Consistent Information:**
 - Before entering the room, review the patient's plan of care to ensure consistent communication across the care team.
- **Nurses Explained Things Understandably:**
 - Explain medications, treatments, and next steps in clear, everyday language, then ask if the patient has any questions.
- **Quiet Rooms At Night:**
 - Help create a restful environment by keeping voices low, minimizing hallway noise, and closing doors quietly whenever possible.

HCAHPS Trend July 2025 – May 2026

3



Question	Benchmark	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26
Rate hospital	71.7	66.7 n = 33	67.6 n = 34	93.9 n = 33	71.4 n = 28	58.6 n = 29	64.0 n = 25	64.0 n = 25	90.3 n = 31	96.7 n = 30	50.0 n = 24	78.1 n = 32
Would recommend hospital to family	73.2	73.5 n = 34	67.6 n = 34	78.1 n = 32	75.0 n = 28	55.6 n = 27	62.5 n = 24	68.0 n = 25	76.7 n = 30	96.6 n = 29	50.0 n = 24	77.4 n = 31

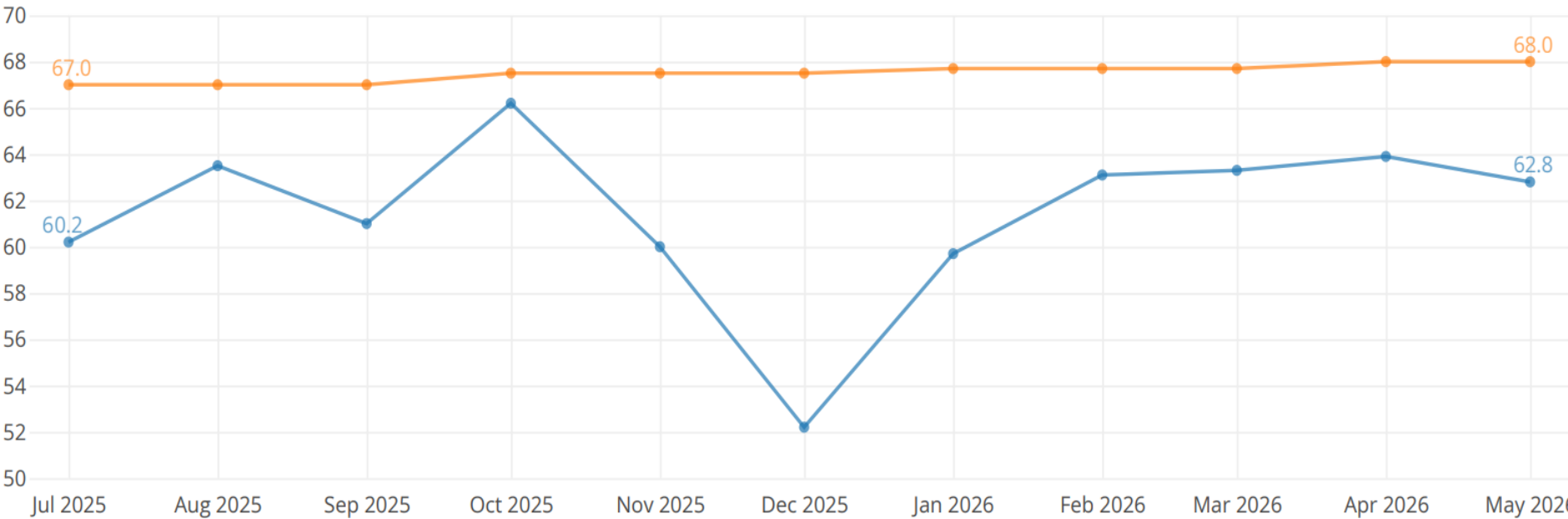
476/645

Inpatient

July 2025-May 2026

■ NPS: Facility would recommend ■ Benchmark

NPS: Facility would recommend



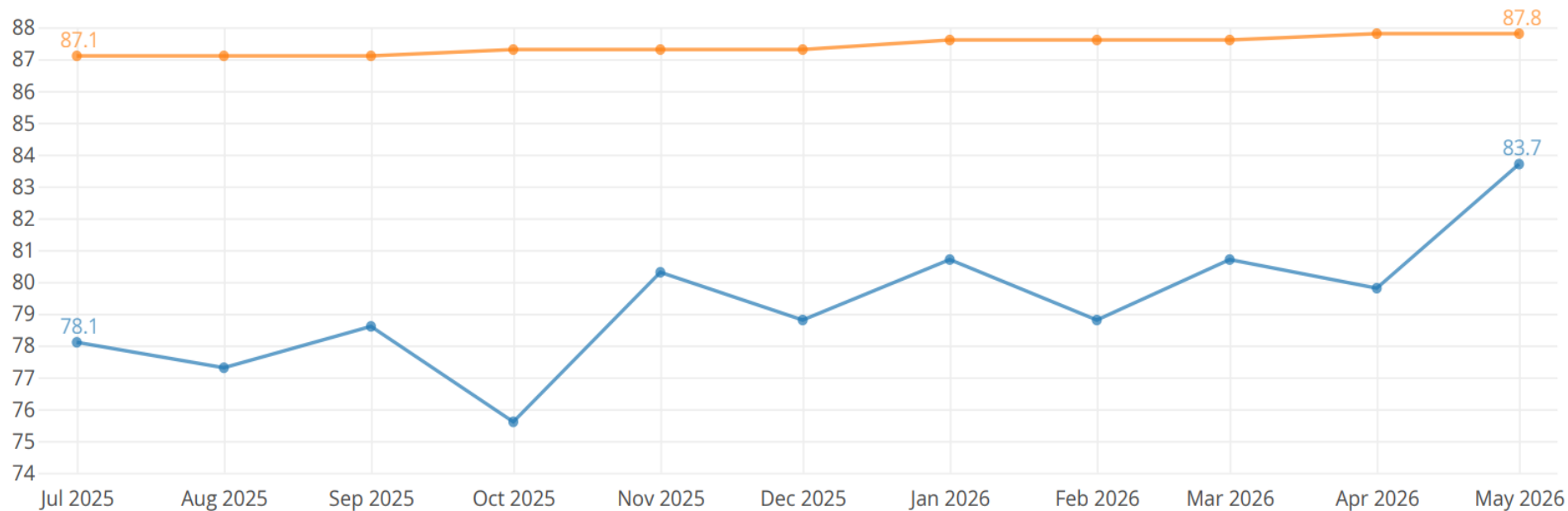
	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026
uld	60.2	63.5	61.0	66.2	60.0	52.2	59.7	63.1	63.3	63.9	62.8
	n = 259	n = 211	n = 187	n = 198	n = 220	n = 230	n = 233	n = 198	n = 221	n = 219	n = 242

Medical Practice

July 2025-May 2026

■ Provider would recommend ■ Benchmark

Provider would recommend



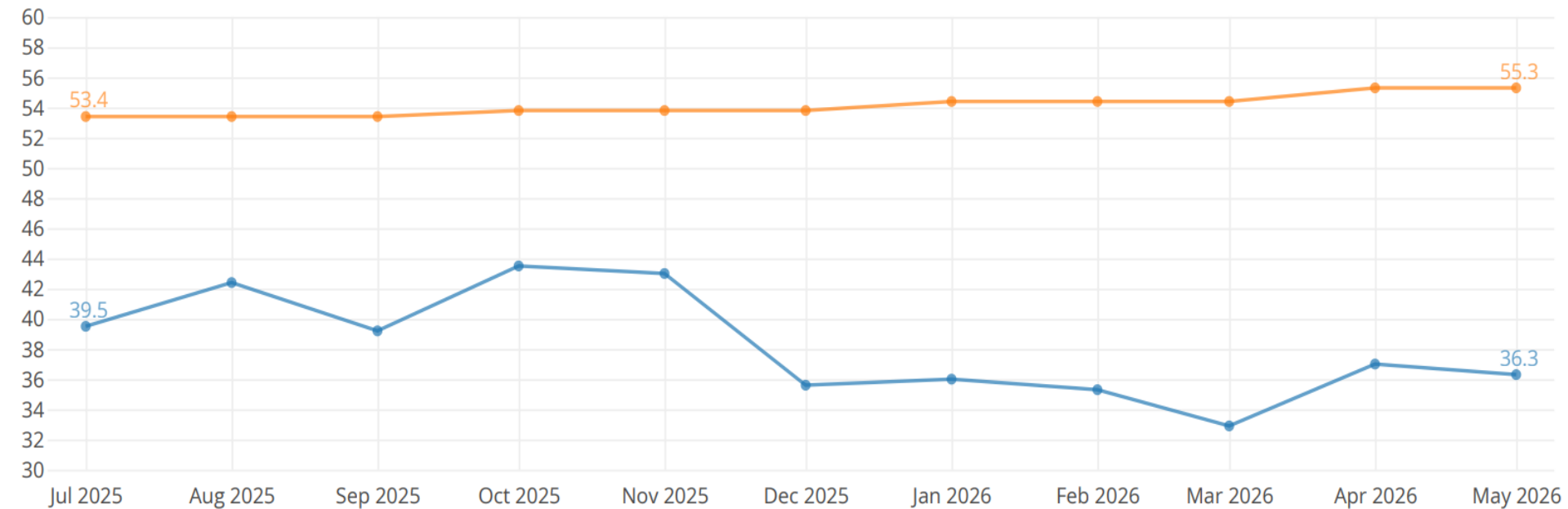
Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026
78.1	77.3	78.6	75.6	80.3	78.8	80.7	78.8	80.7	79.8	83.7
n = 770	n = 688	n = 695	n = 620	n = 529	n = 556	n = 673	n = 609	n = 596	n = 664	n = 645

Emergency Department

July 2025-May 2026

■ NPS: Facility would recommend ■ Benchmark

NPS: Facility would recommend



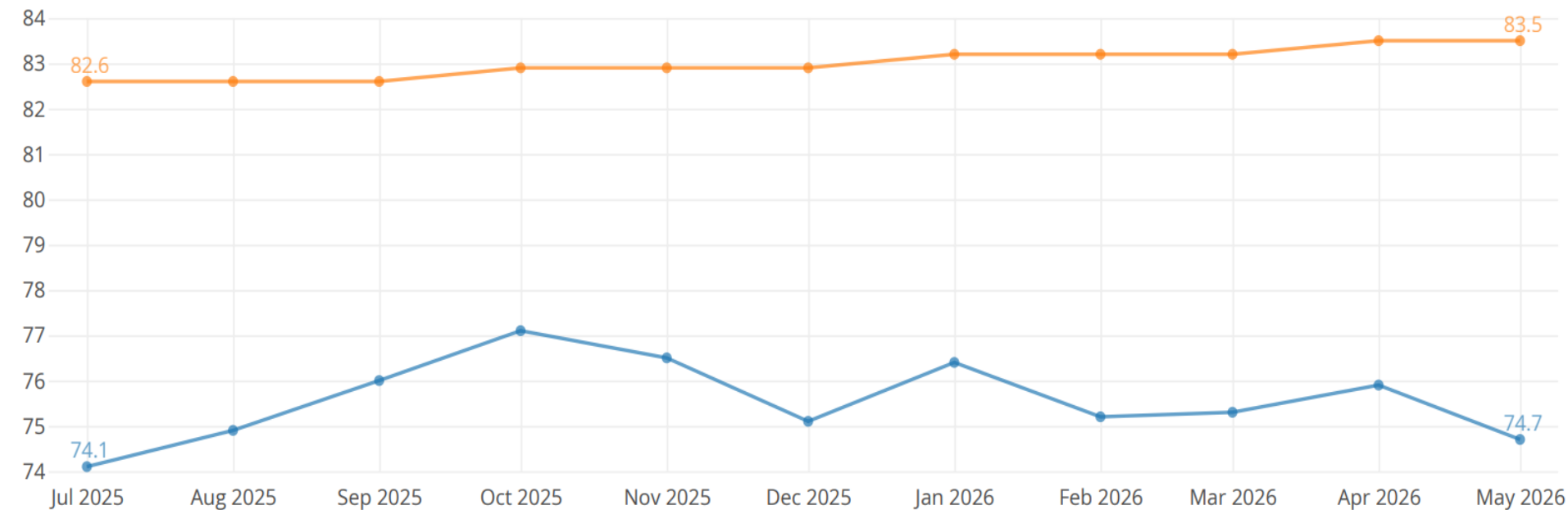
	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026
ld	39.5	42.4	39.2	43.5	43.0	35.6	36.0	35.3	32.9	37.0	36.3
	n = 845	n = 821	n = 793	n = 710	n = 698	n = 758	n = 801	n = 750	n = 832	n = 789	n = 805

Human Understanding: Organization

July 2025-May 2026

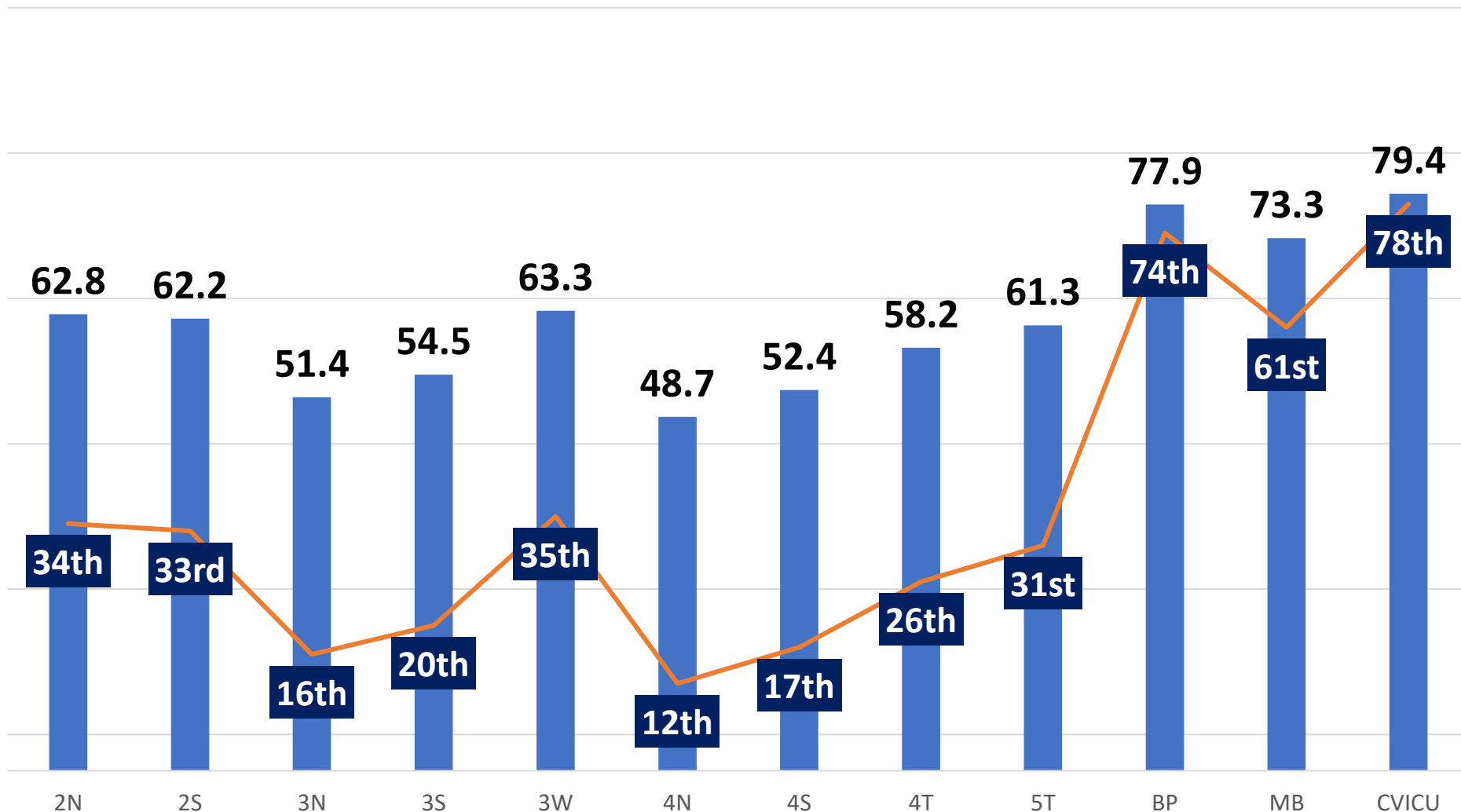
■ Human Understanding ■ Benchmark

Human Understanding

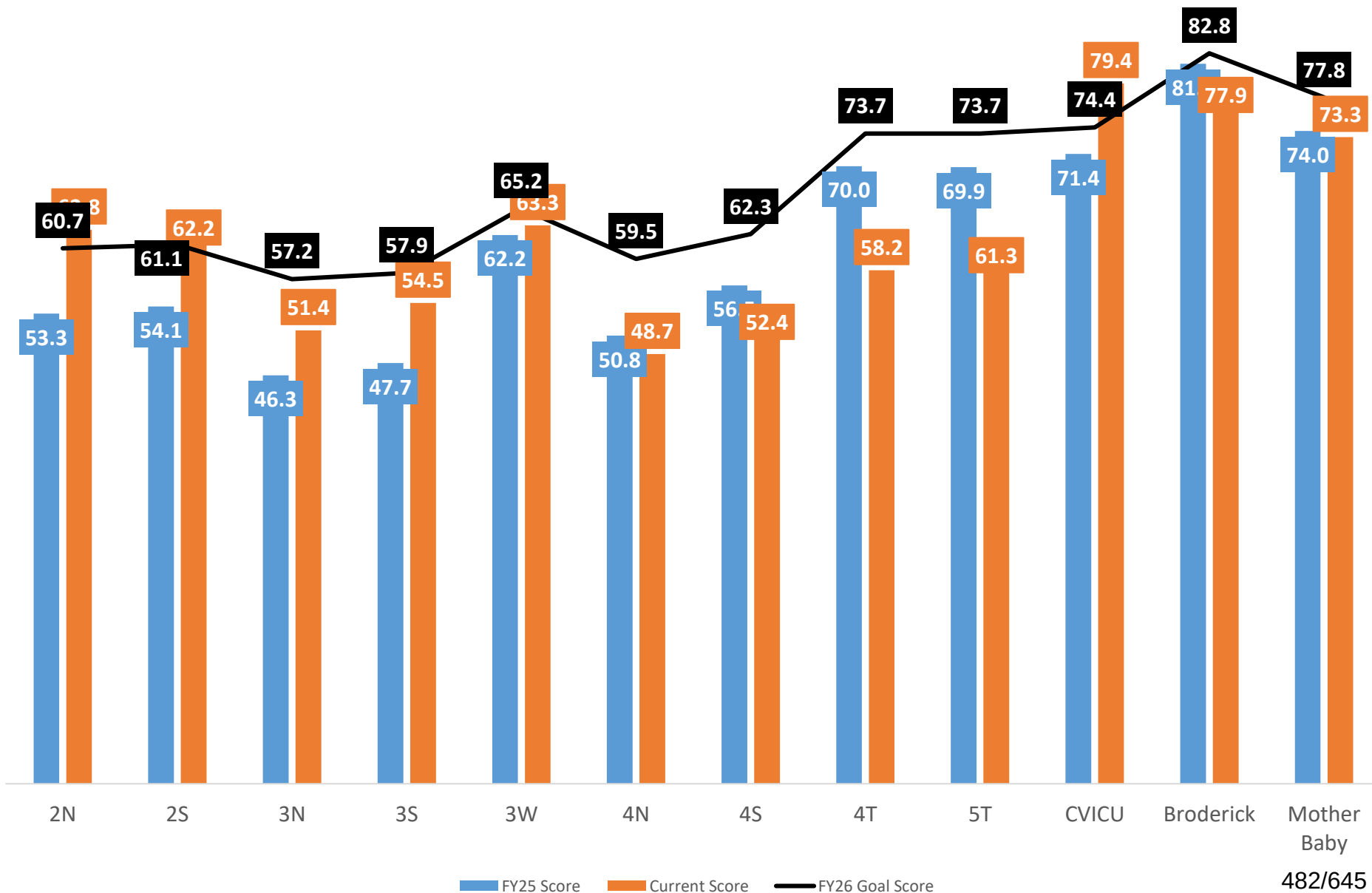


	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026
Understanding	74.1	74.9	76.0	77.1	76.5	75.1	76.4	75.2	75.3	75.9	74.7
	n = 3,593	n = 3,510	n = 3,836	n = 3,949	n = 3,380	n = 3,813	n = 4,188	n = 3,854	n = 4,208	n = 4,081	n = 4,010

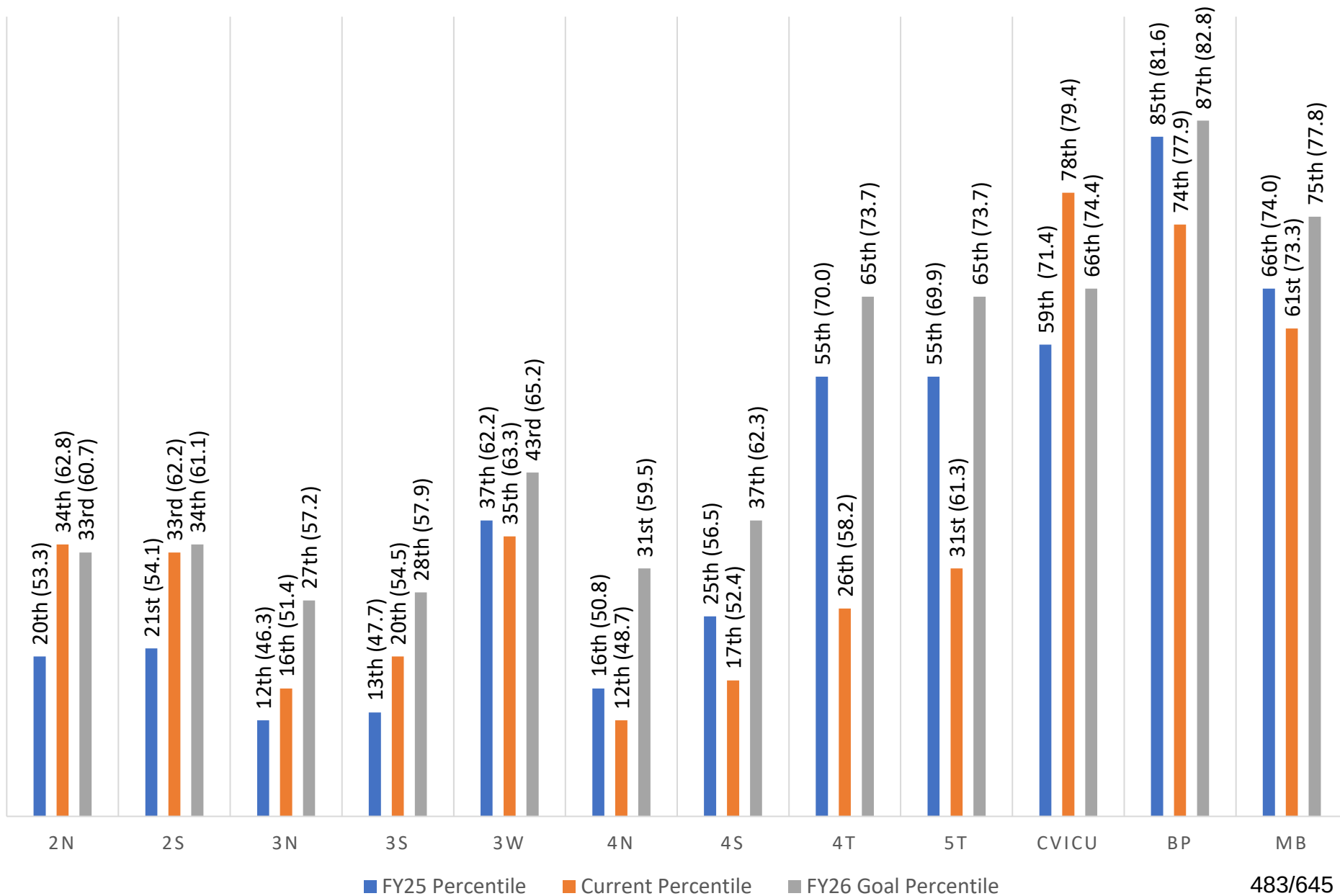
Inpatient Unit's NPS Score: July 2025 – May 2026



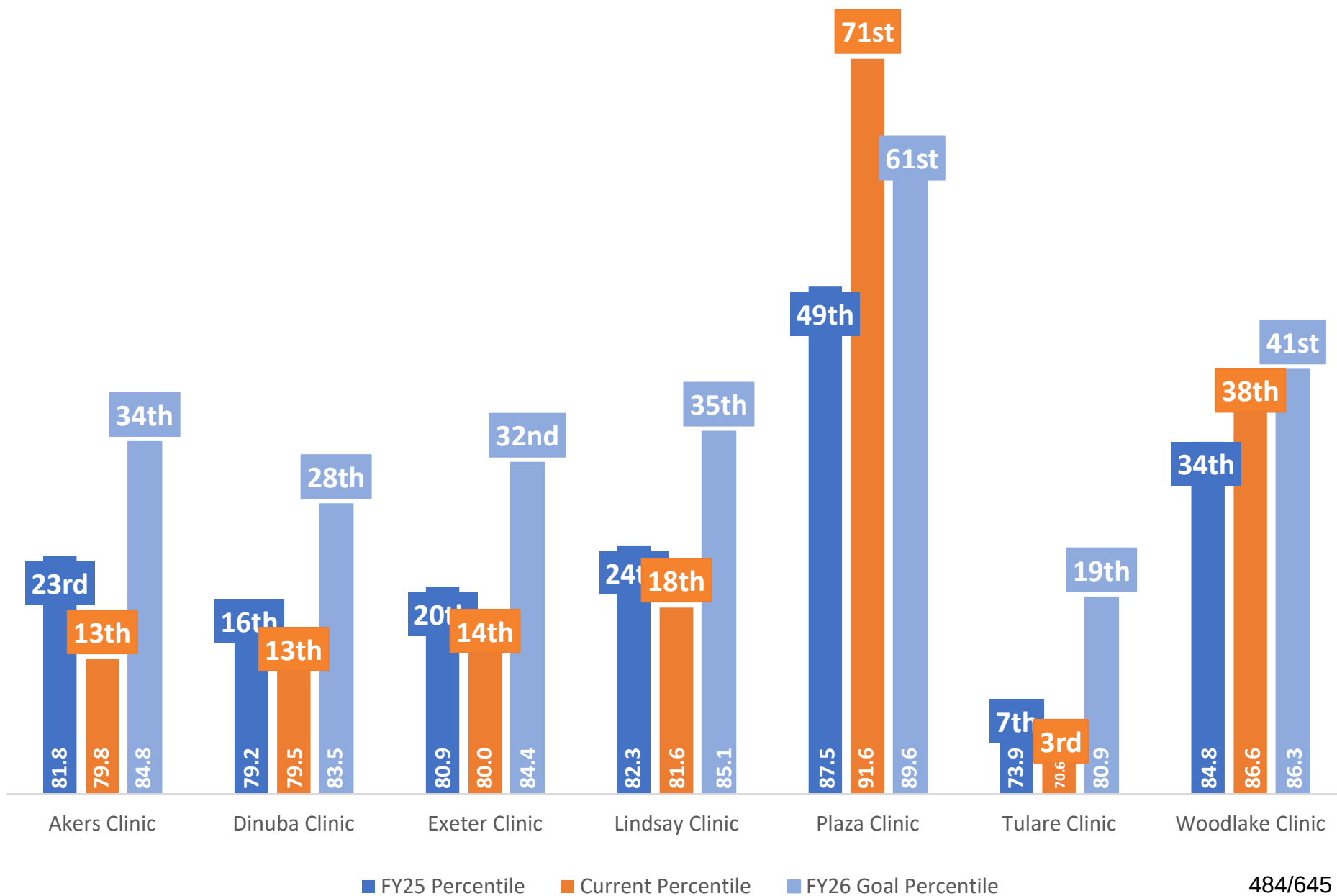
Inpatient Unit's Goal vs Current Score: July 2025 – May 2026



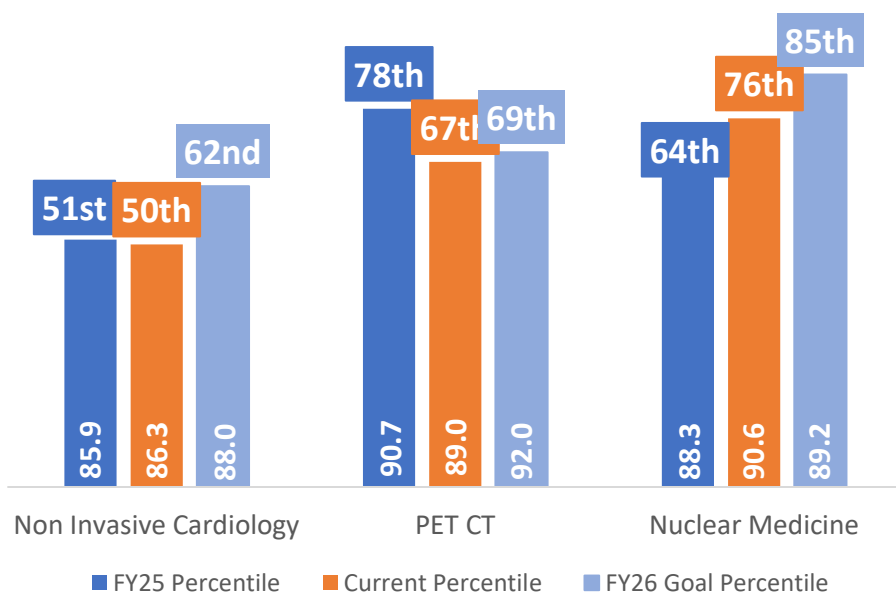
Inpatient Unit's Goal vs Current Score: July 2025 – May 2026



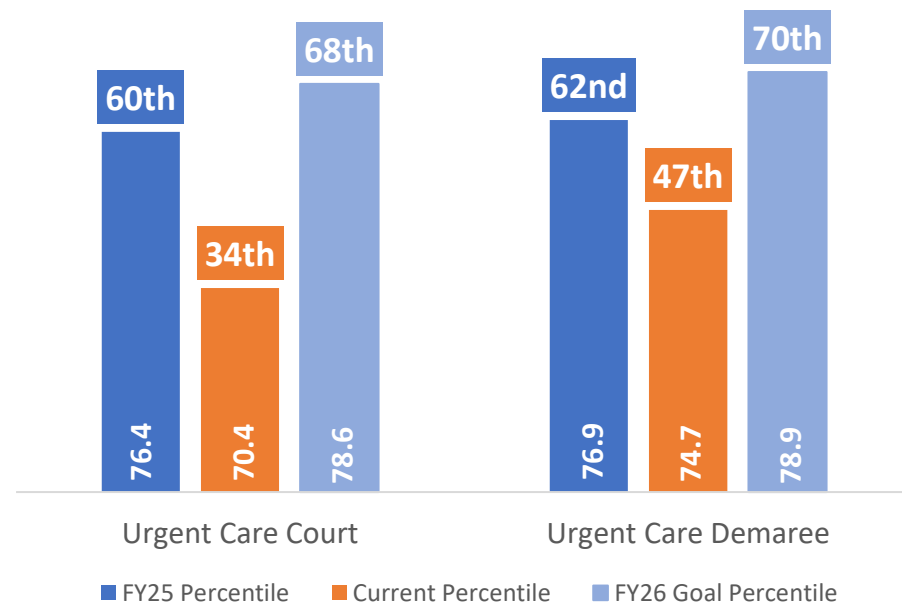
RHC Goal vs Current Score: July 2025 – May 2026



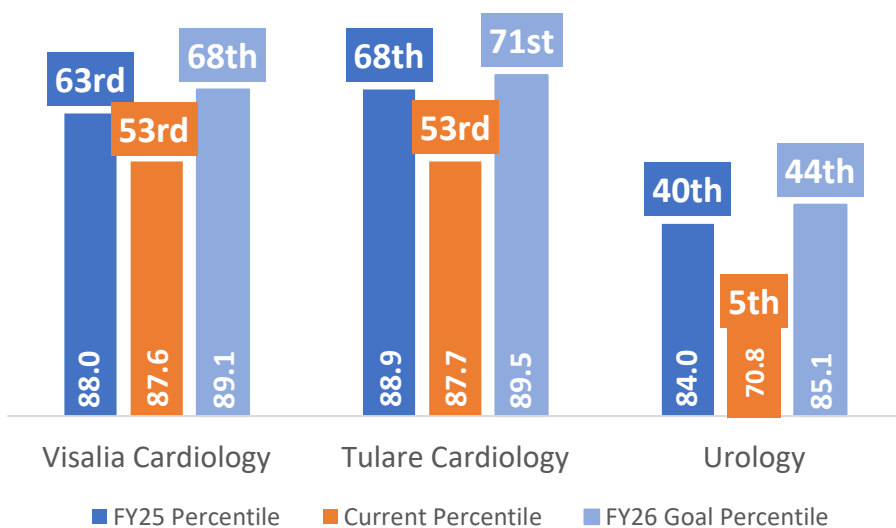
Diagnostic Center



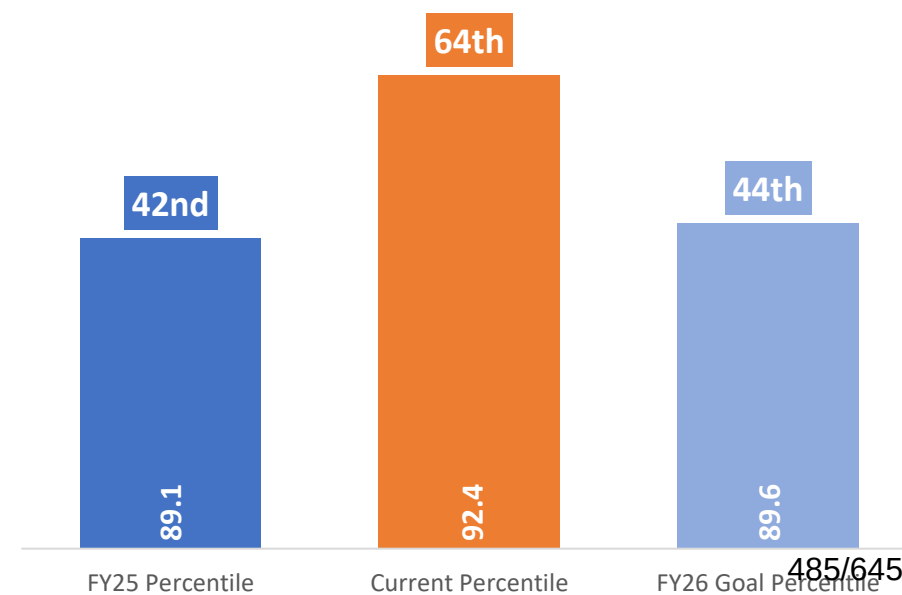
Urgent Care



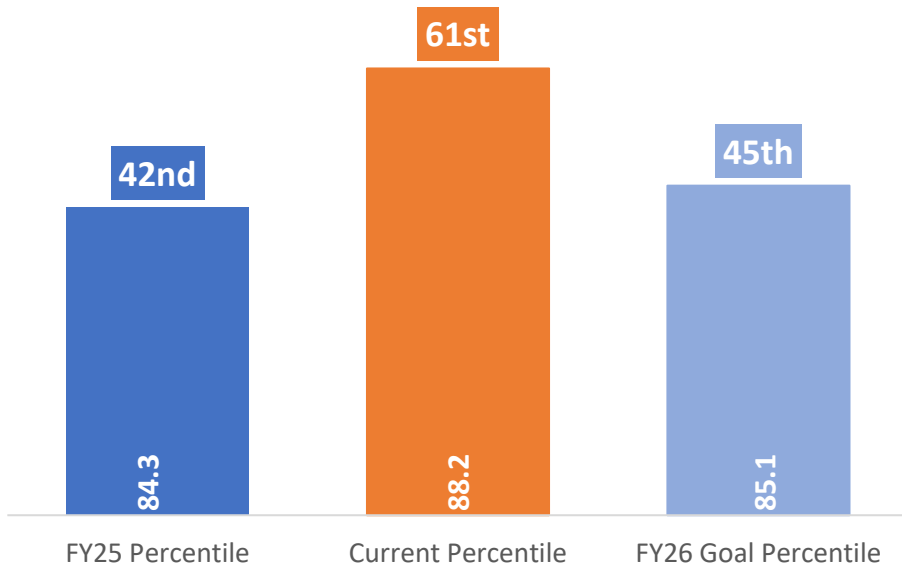
Specialty Clinics



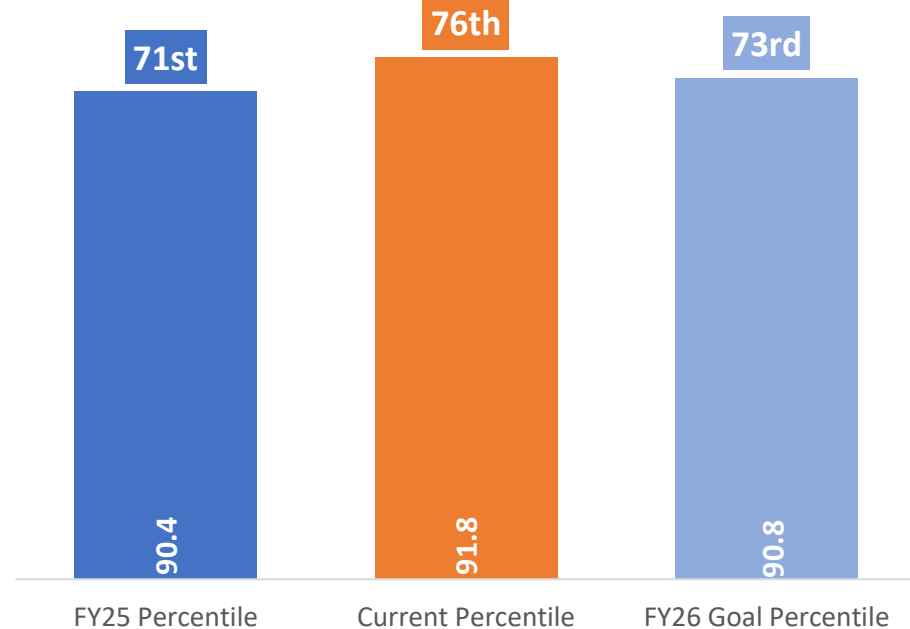
Radiation Oncology



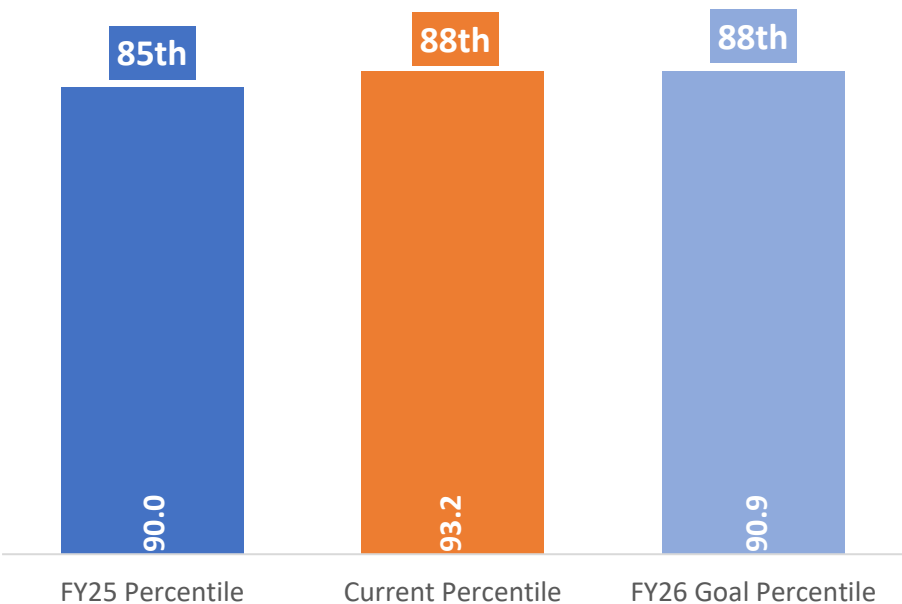
Imaging Center



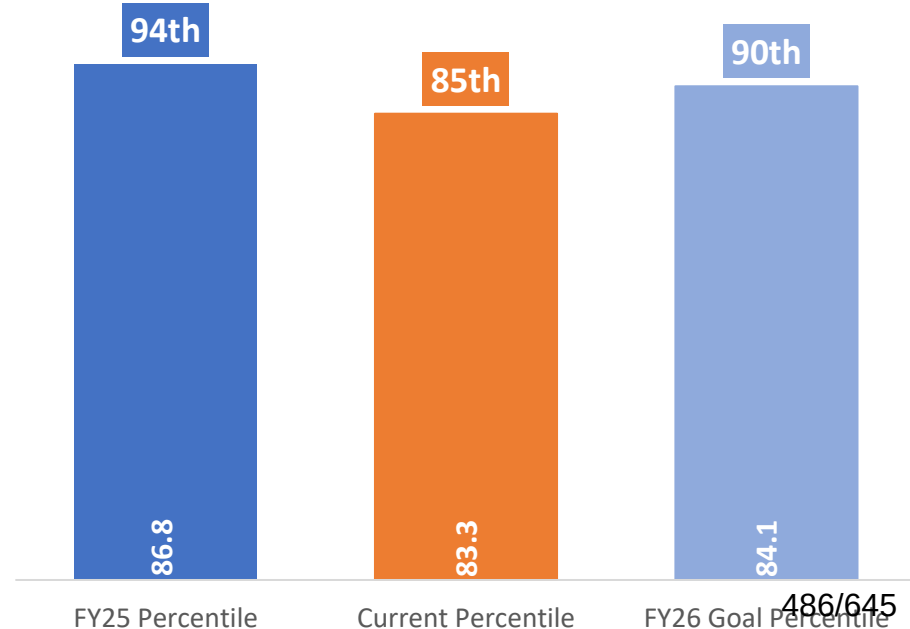
Outpatient Infusion



Center for Mental Wellness

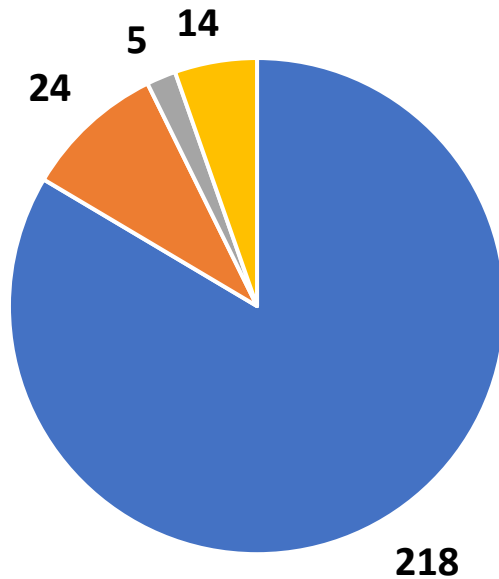


Inpatient Rehab



PX Rounding: June

225 Rounds

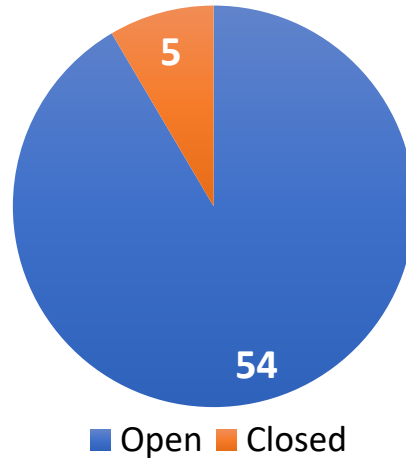


- Positive
- Complaints
- Midas
- Real Time Service Recovery

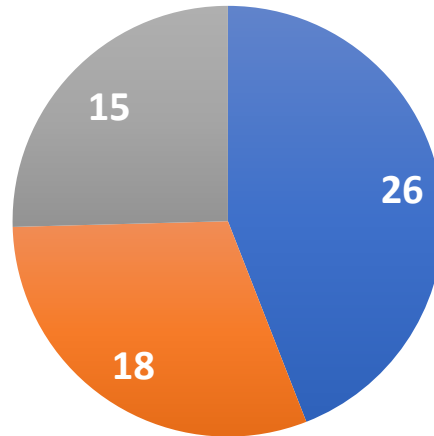


MIDAS: June

59 Opened



- Open
- Closed

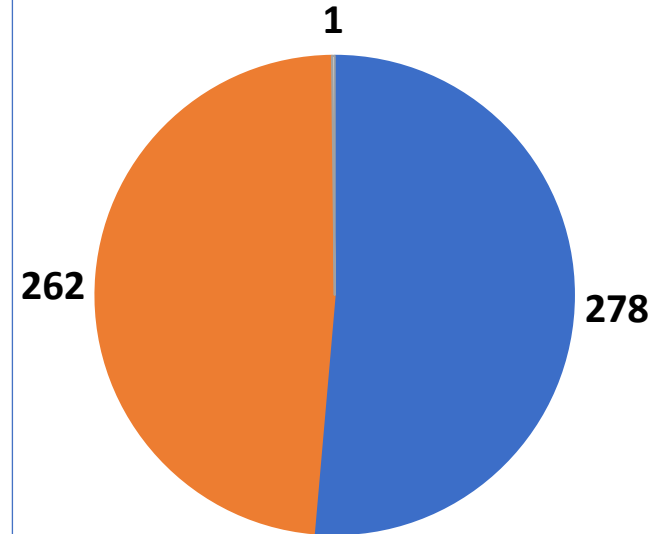


- Complaint
- Grievance
- Lost



ED Rounding: June

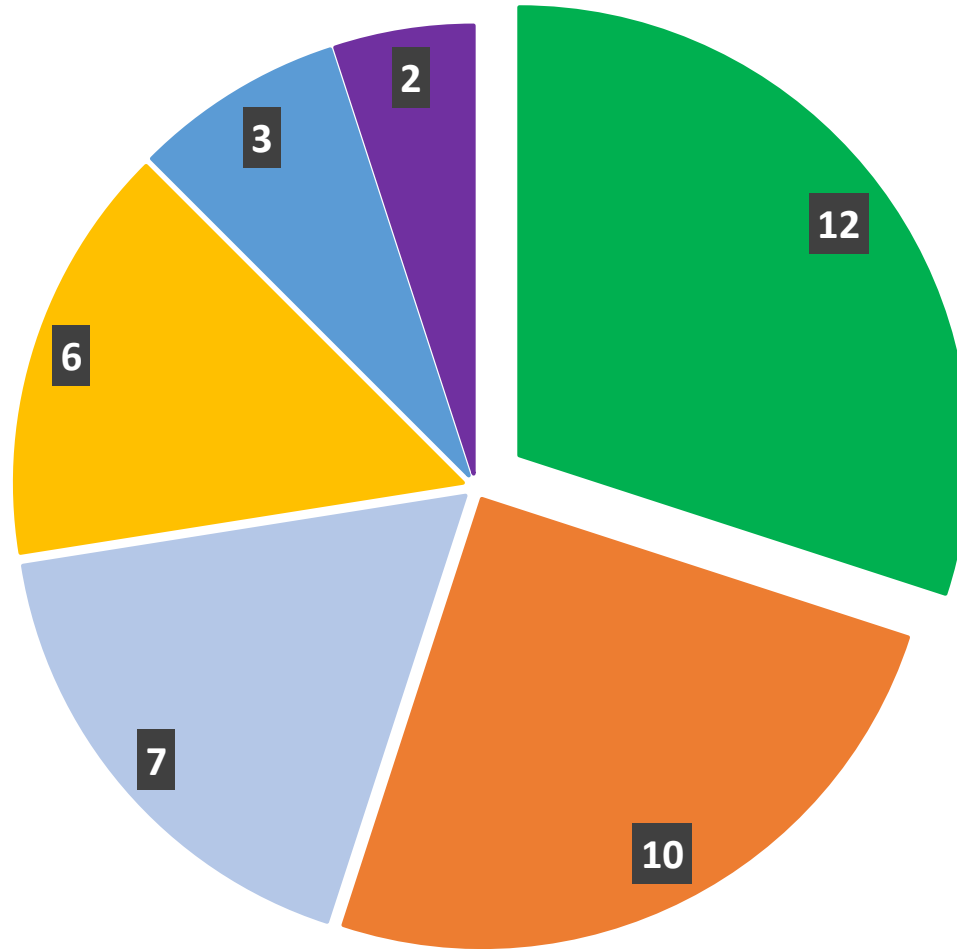
307 Rounds



- Positive
- Complaints
- Midas

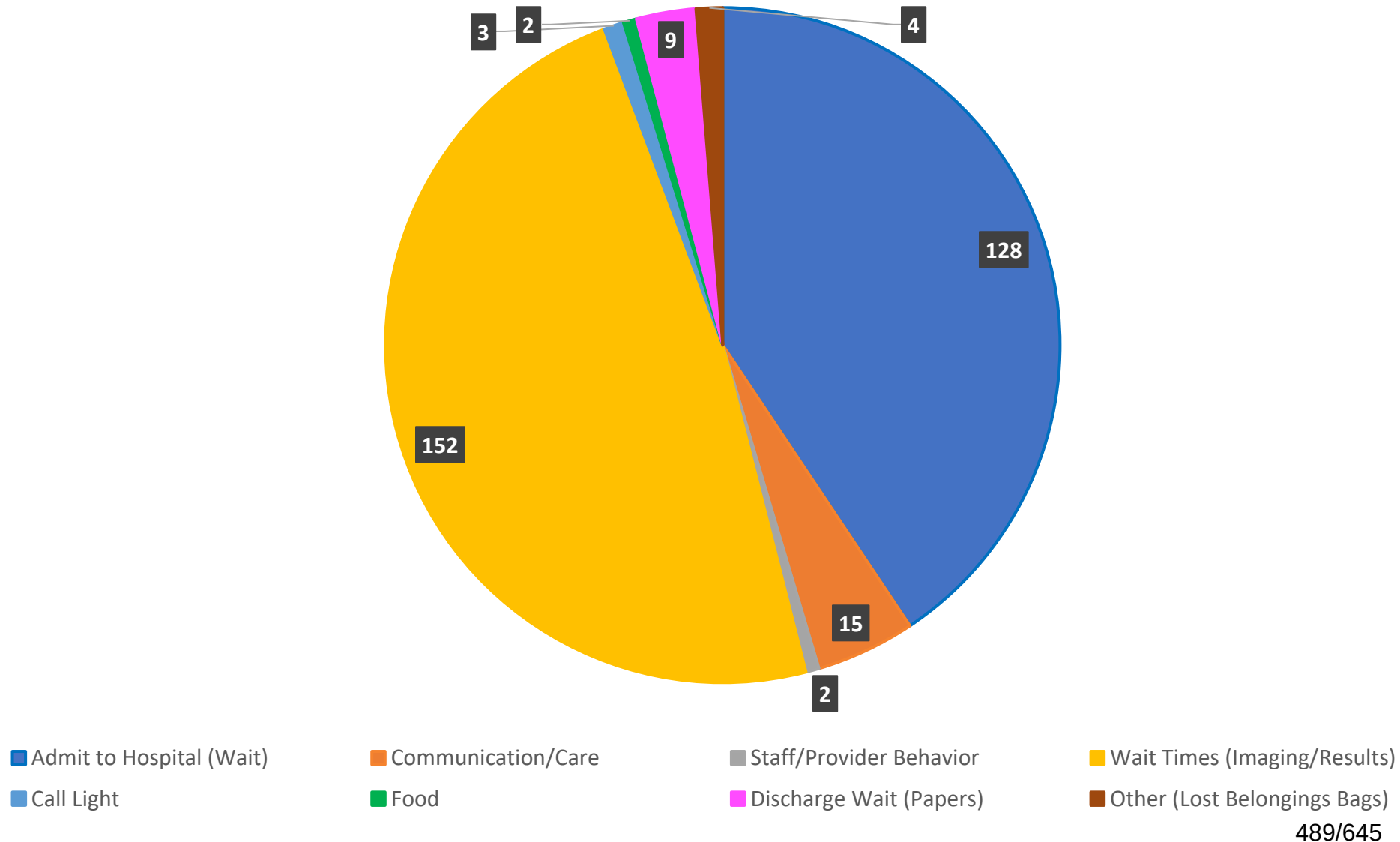


PX Patient Rounding Complaints Breakdown: June 2026

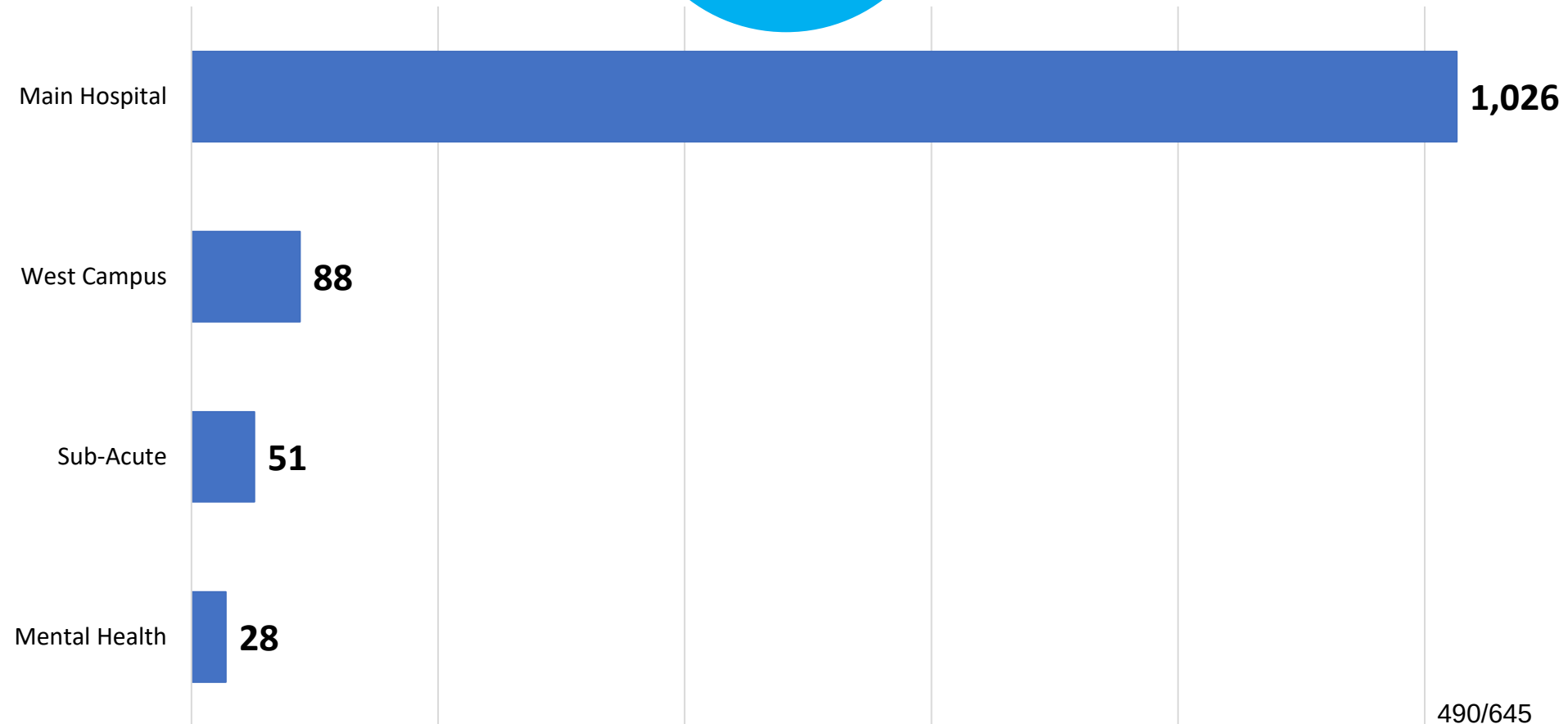
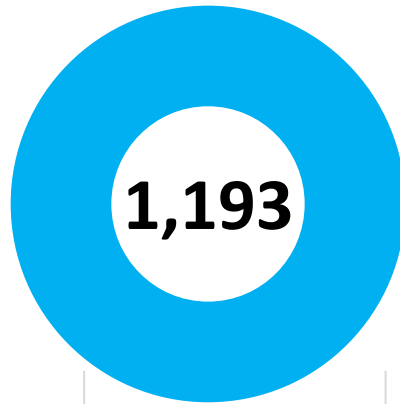


■ Communication ■ Delay of Care ■ Quality of Care ■ Food ■ Staff Behavior ■ Provider Issue

ED Patient Rounding Complaints Breakdown: June 2026



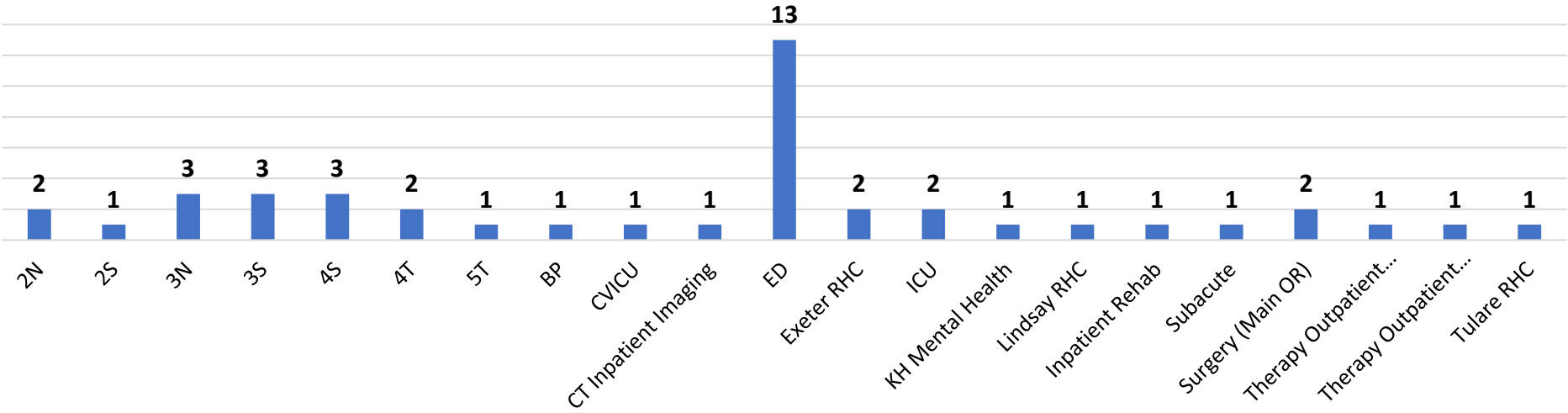
Leader Rounds: June 2026



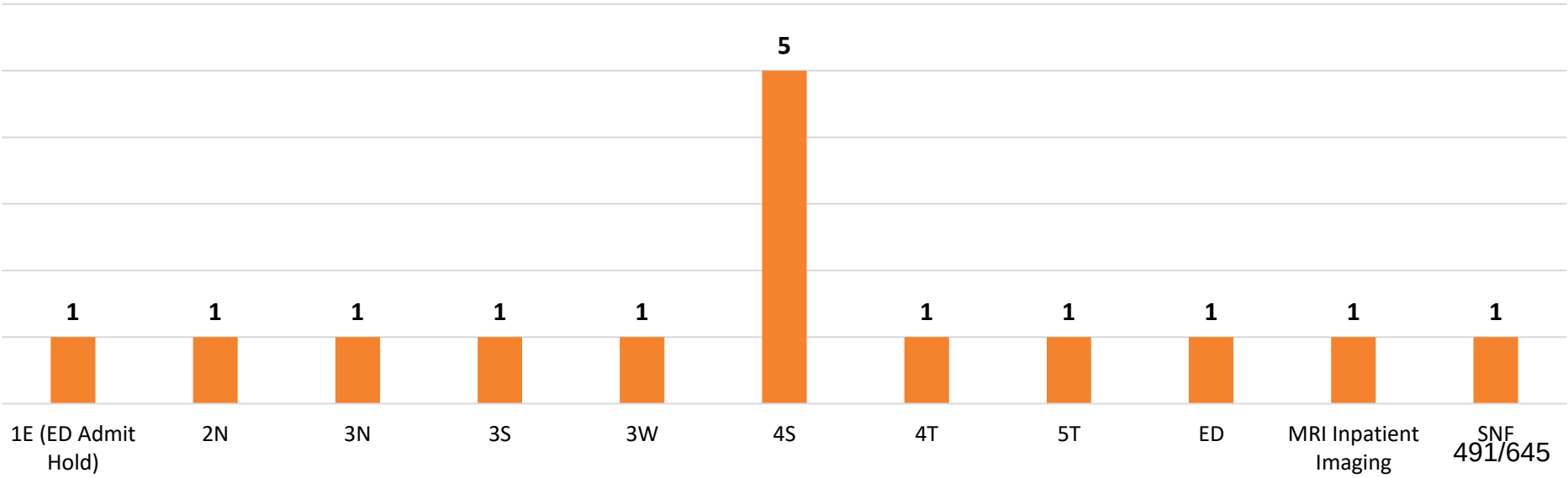
MIDAS: June 2026

59 Opened

Complaints & Grievances



Lost Belongings



Lost Belongings

FY26: July 2025 – May 2026

Total Reported in Midas: 199

199

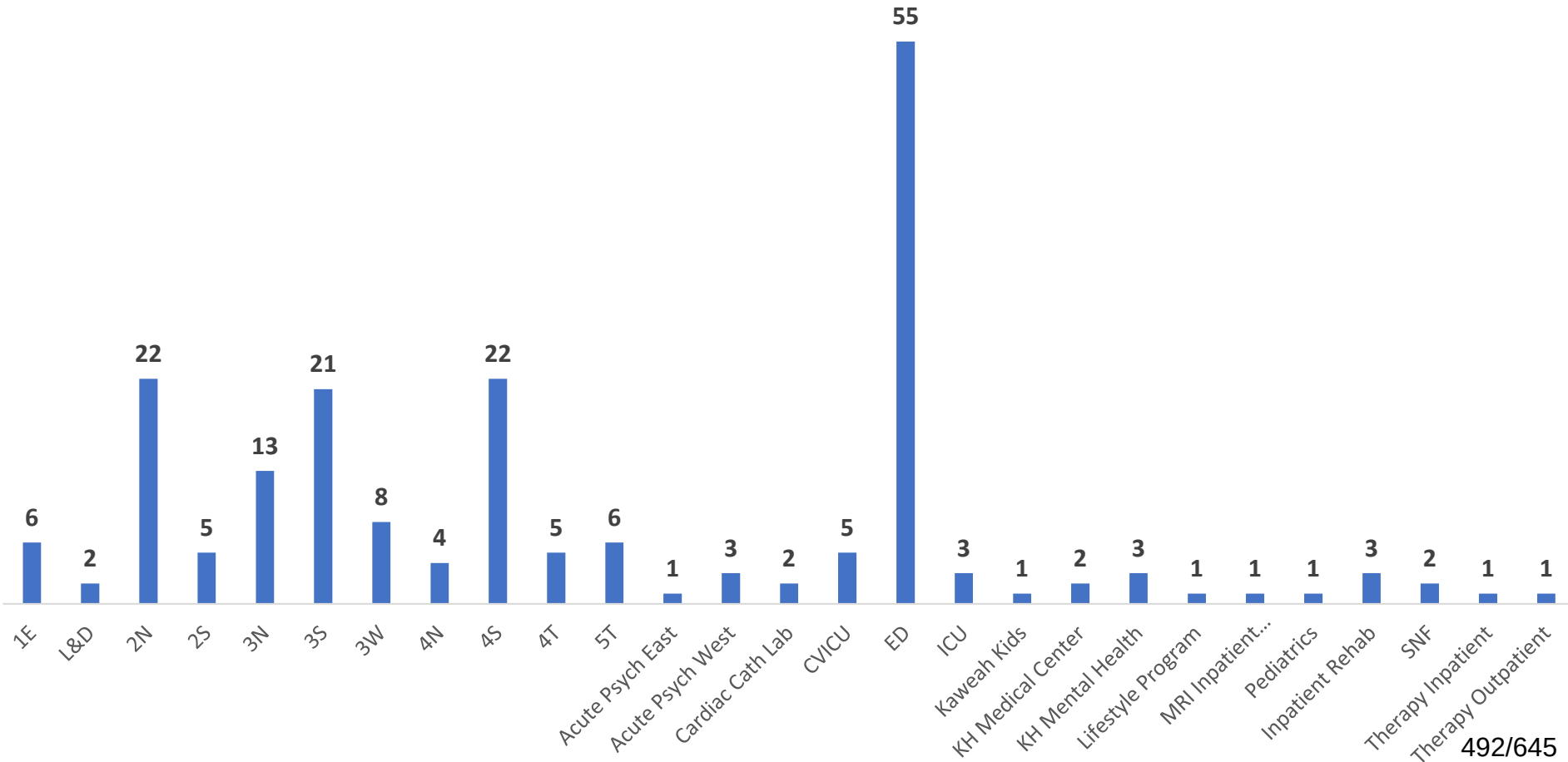
Total Cases

167

Closed (84%)

32

Open (16%)



Executive Rounding - June

Executive Team Rounds = 10 executive rounds, 1 BOD round

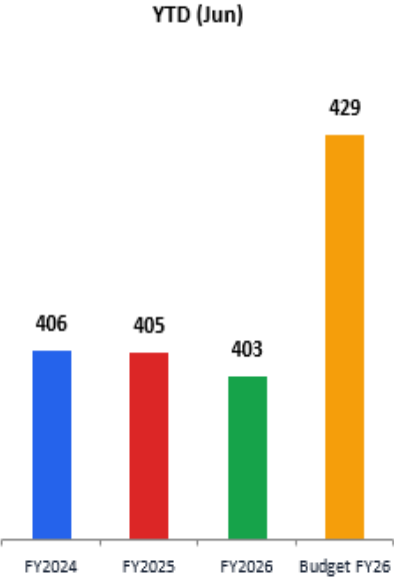
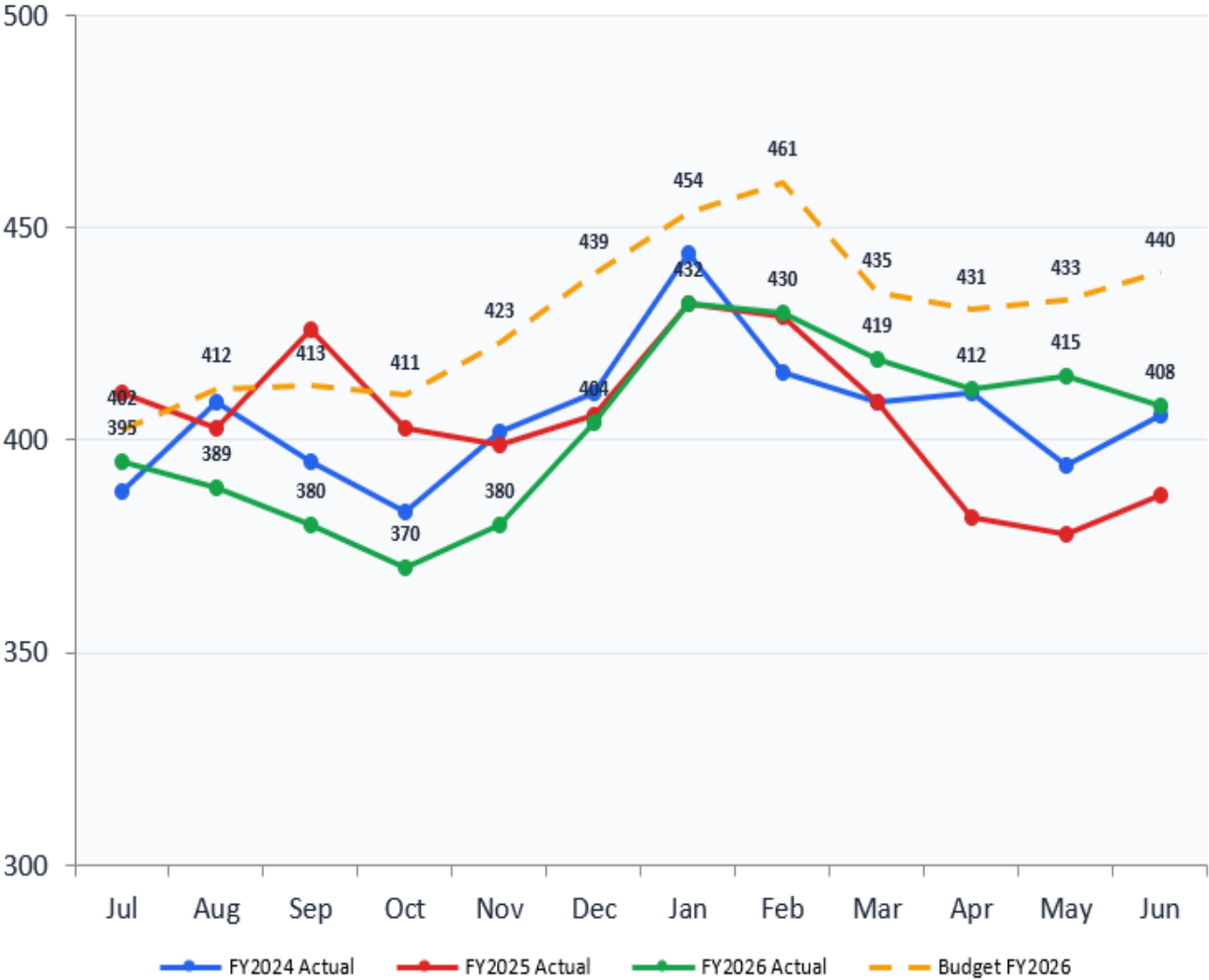
Executive	November	December	January	February	March	April	May	June
CEO/Marc Mertz.	11/4, 11/20	12/3, 12/23	1/12	Cancelled JC	3/25	4/23	5/11	6/23
Jag B.	11/12	12/10	1/13	Cancelled JC	3/19	4/8	5/7	Cancelled
Malinda T.	11/17	12/22	1/6	Cancelled JC	3/31	4/20	5/18	6/30
Dianne C.	11/11	12/15	1/8	2/4	3/5	4/22	5/28	6/25
Scott B.	11/24		1/27	2/12	3/24	4/14	5/12	6/26
Ben C.	11/24	12/18	1/22	Cancelled JC	Cancelled by PX	4/22	5/21	6/16
Paul S.		12/2	1/28	18-Feb	3-Mar	4/15	5/19	6/11
Doug Leeper			1/19	11-Feb	30-Mar	4/21		
Kevin Morrison						4/30	5/29	6/15
Board of Directors				2/9 (MO)	3/2 (AM)	4/16 (DF)	5/11 (MO)	6/4 (DL)
Luke Schneider							5/4	6/24
Max Heckhausen							5/5	6/2
Tom Boggs							5/20	6/29

FINANCIAL STEWARDSHIP

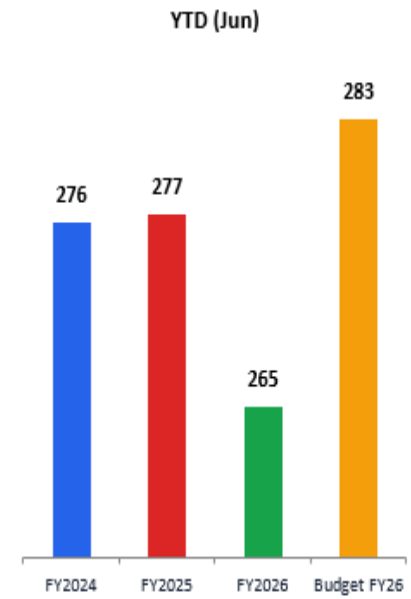
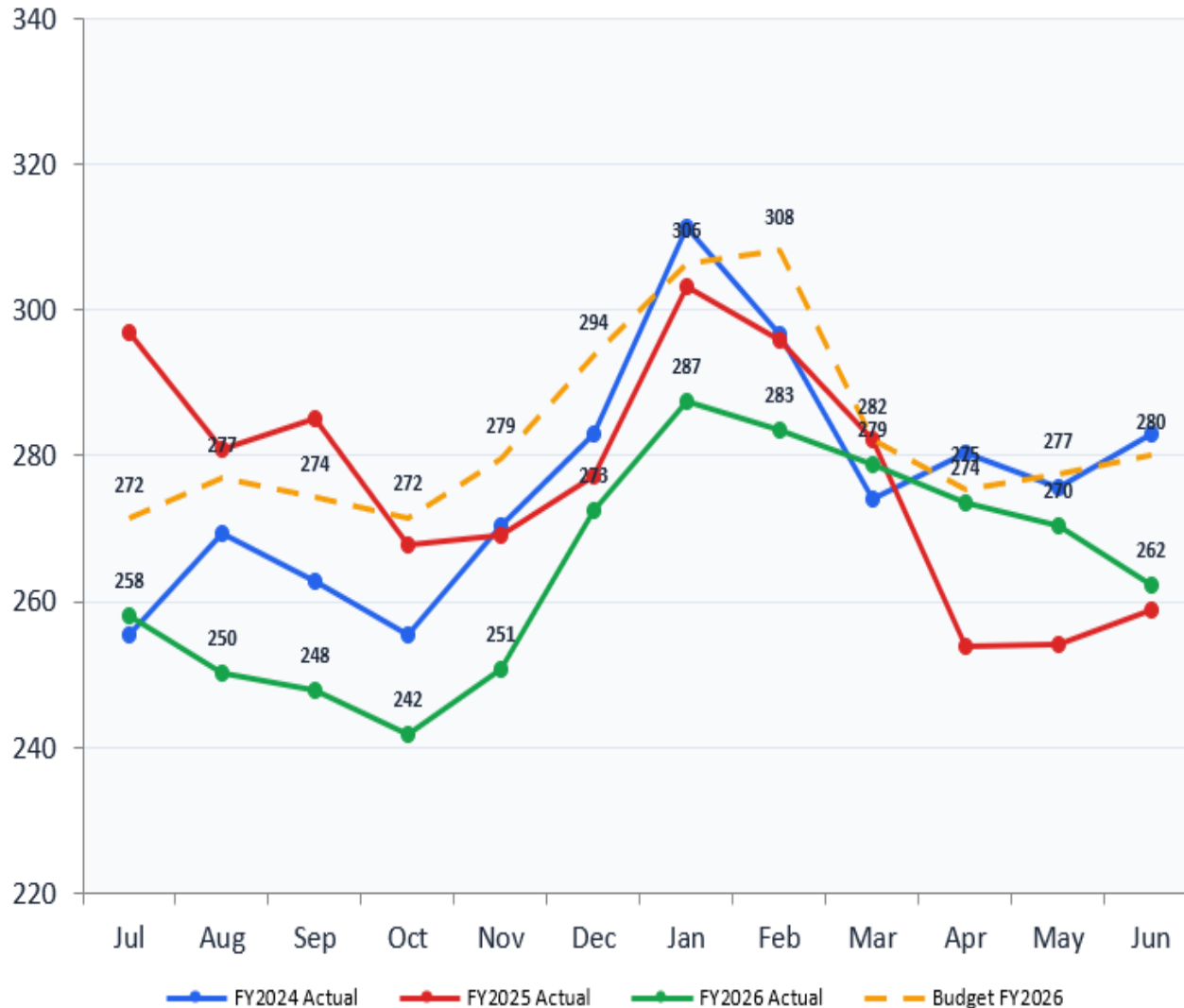
CFO Financial Report

Month Ending June 2026

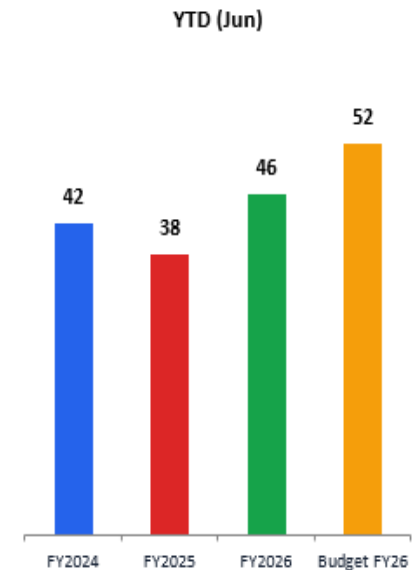
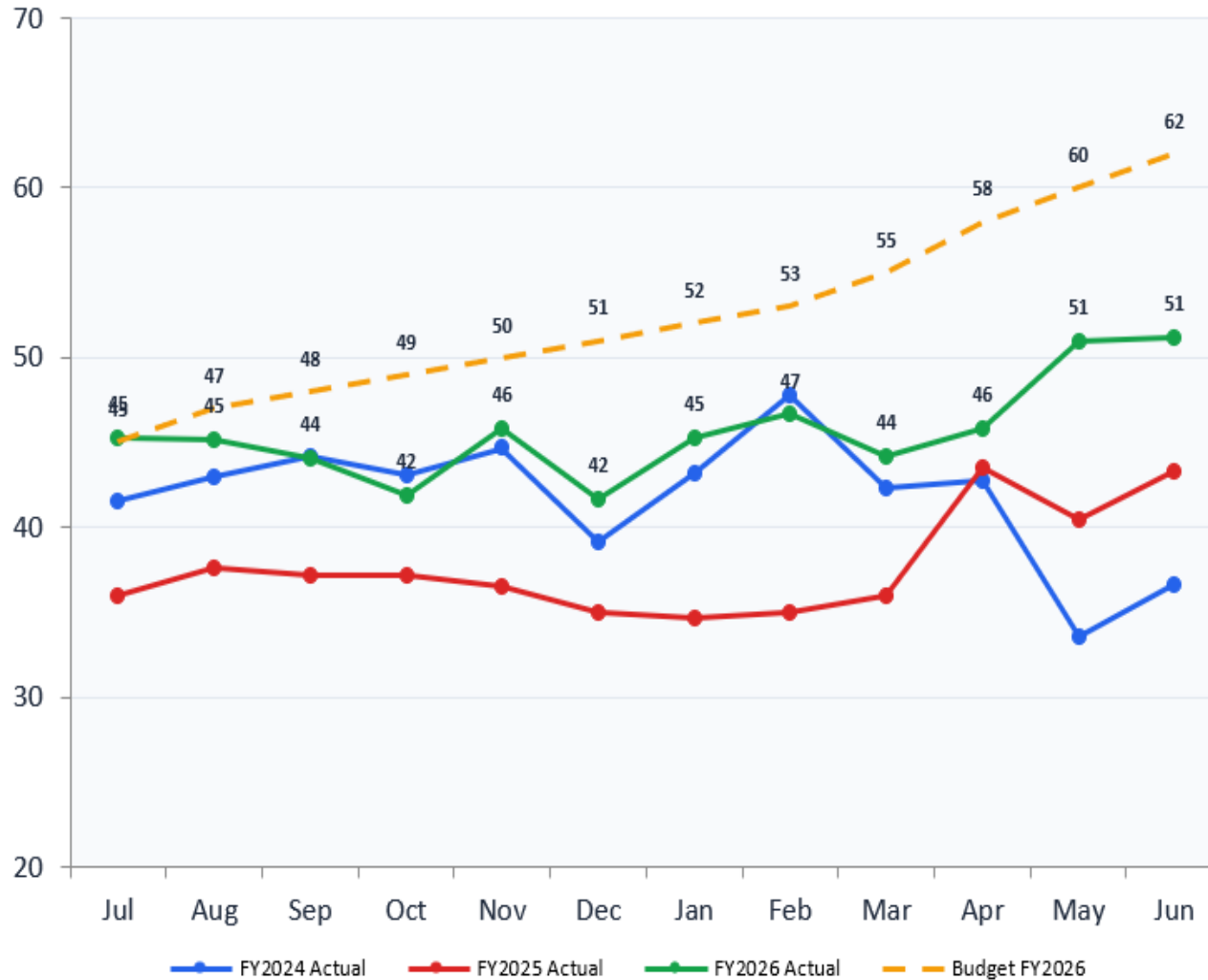
Average Daily Census



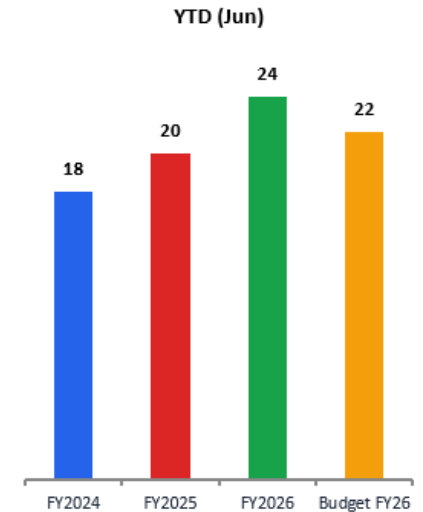
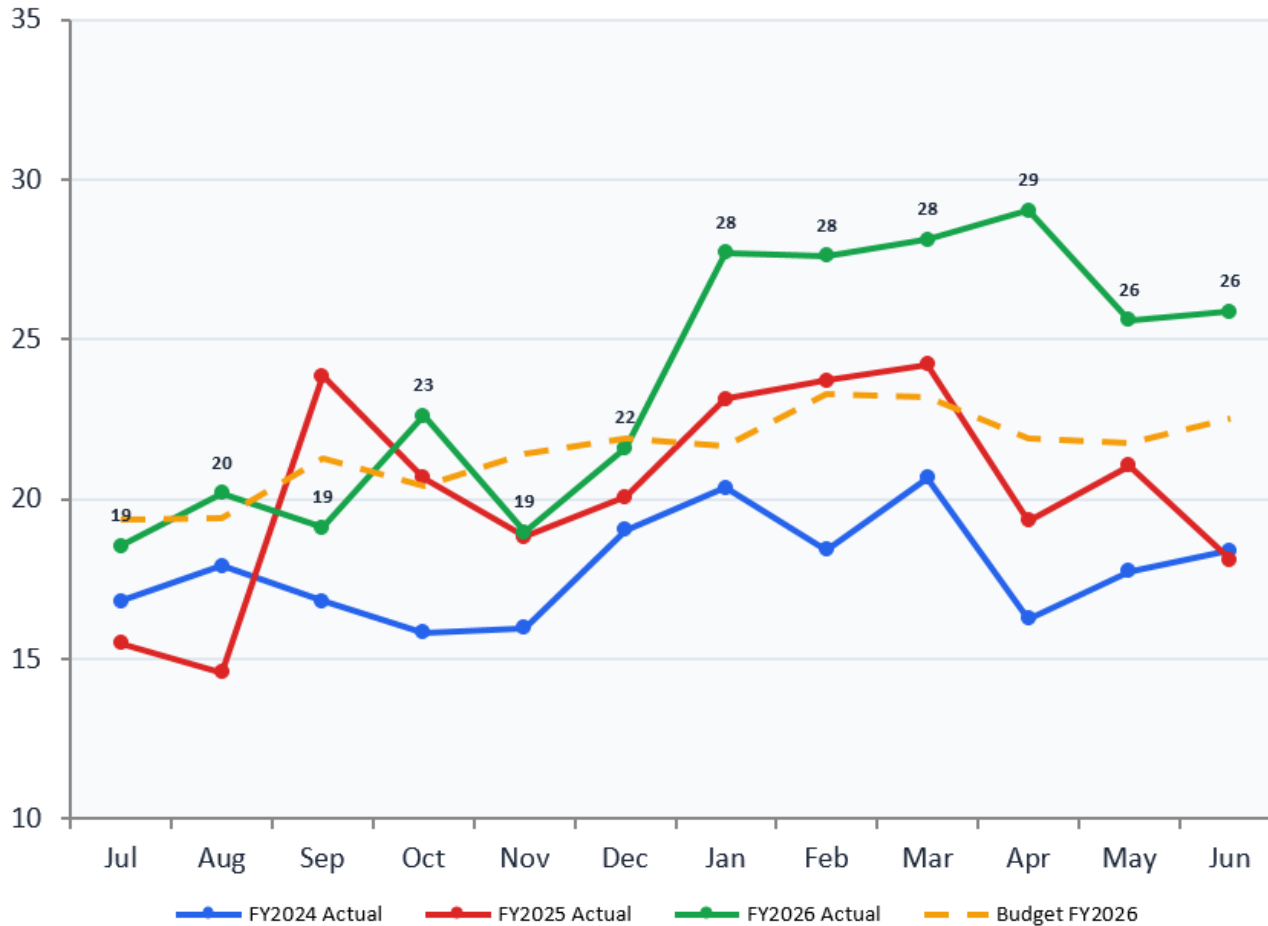
Medical Center (Avg Patients Per Day)



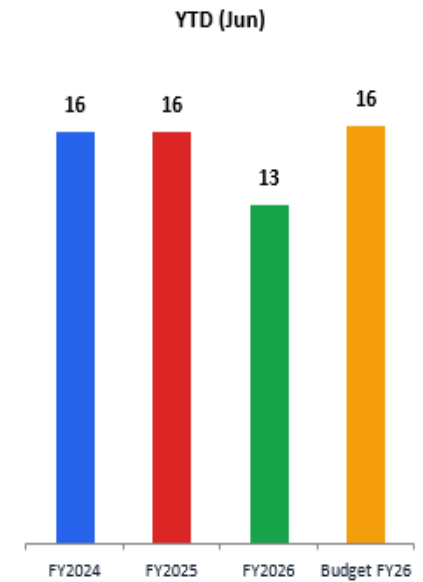
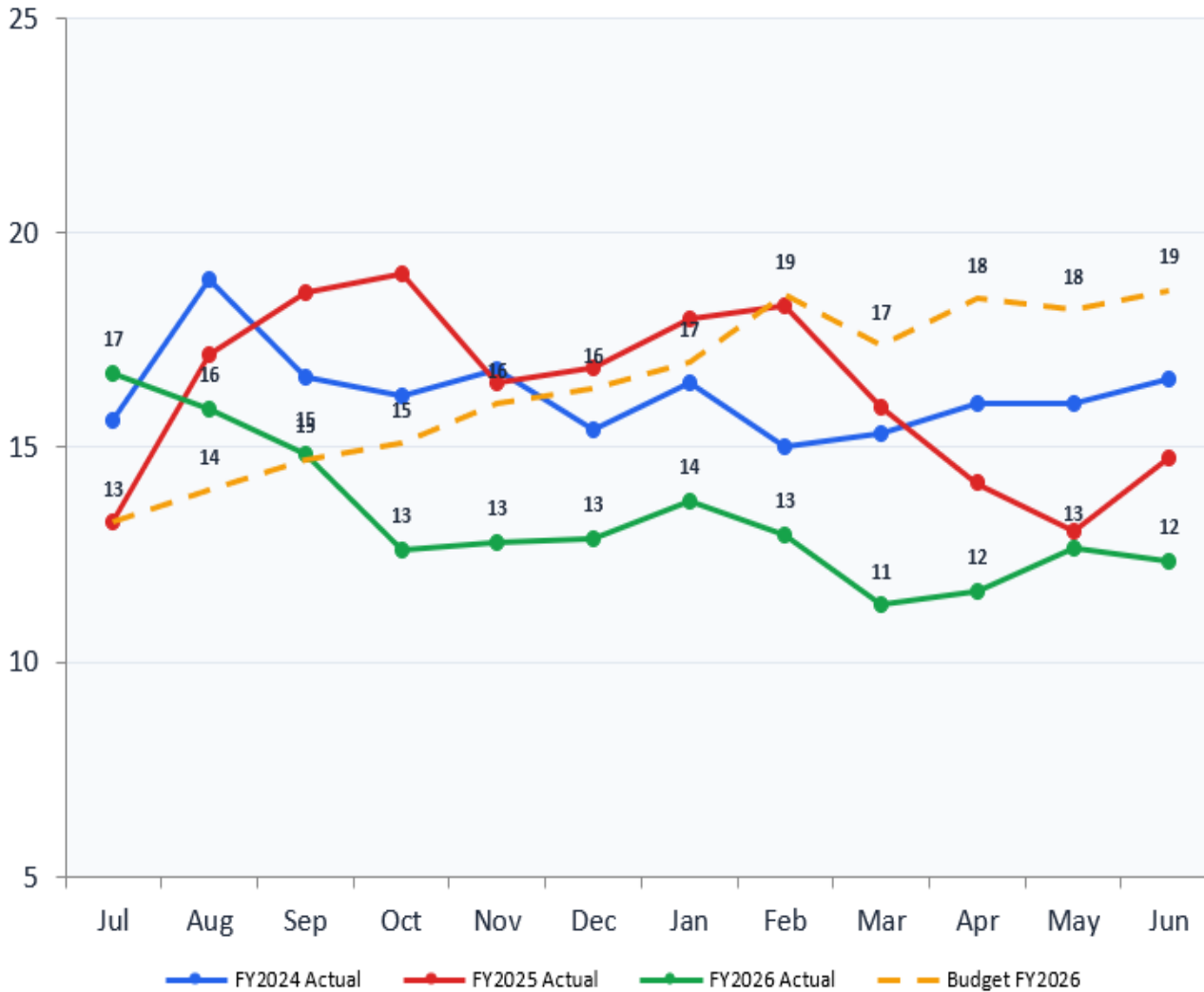
Acute I/P Psych (Avg Patients Per Day)



Rehabilitation Hospital (Avg Patients Per Day)



Nursery (Avg Patients Per Day)



Statistical Results – Fiscal Year Comparison (Jun)

Actual Results			Budget	Budget Variance	
Jun 2025	Jun 2026	% Change	Jun 2026	Change	% Change

Average Daily Census	387	408	5.4%	440	(32)	(7.3%)
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KDHCD Patient Days:

Medical Center	7,765	7,870	1.4%	8,417	(547)	(6.5%)
Acute I/P Psych	1,299	1,534	18.1%	1,860	(326)	(17.5%)
Sub-Acute	836	937	12.1%	893	44	4.9%
Rehab	543	776	42.9%	676	100	14.8%
TCS-Ortho (Short Stay Rehab)	393	345	(12.2%)	370	(25)	(6.8%)
NICU	323	405	25.4%	423	(18)	(4.3%)
Nursery	443	371	(16.3%)	560	(189)	(33.8%)

Total KDHCD Patient Days	11,602	12,238	5.5%	13,199	(961)	(7.3%)
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Total Outpatient Volume	61,800	64,410	4.2%	68,462	(4,052)	(5.9%)
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Statistical Results – Fiscal Year Comparison (Jul-Jun)

Actual Results			Budget	Budget Variance	
FYTD 2025	FYTD 2026	% Change	FYTD 2026	Change	% Change

Average Daily Census	405	403	(0.6%)	429	(27)	(6.2%)
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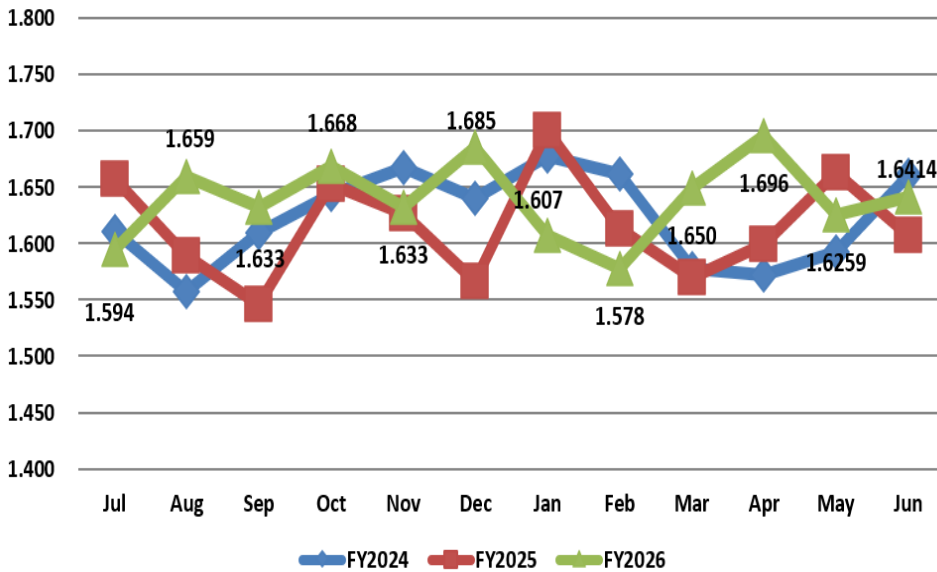
KDHCD Patient Days:

Medical Center	101,129	96,597	(4.5%)	103,361	(6,764)	(6.5%)
Acute I/P Psych	13,754	16,655	21.1%	19,153	(2,498)	(13.0%)
Sub-Acute	10,719	10,867	1.4%	10,949	(82)	(0.7%)
Rehab	7,384	8,659	17.3%	7,846	813	10.4%
TCS-Ortho (Short Stay Rehab)	4,333	4,845	11.8%	4,602	243	5.3%
NICU	4,643	4,480	(3.5%)	4,782	(302)	(6.3%)
Nursery	5,945	4,884	(17.8%)	6,008	(1,124)	(18.7%)

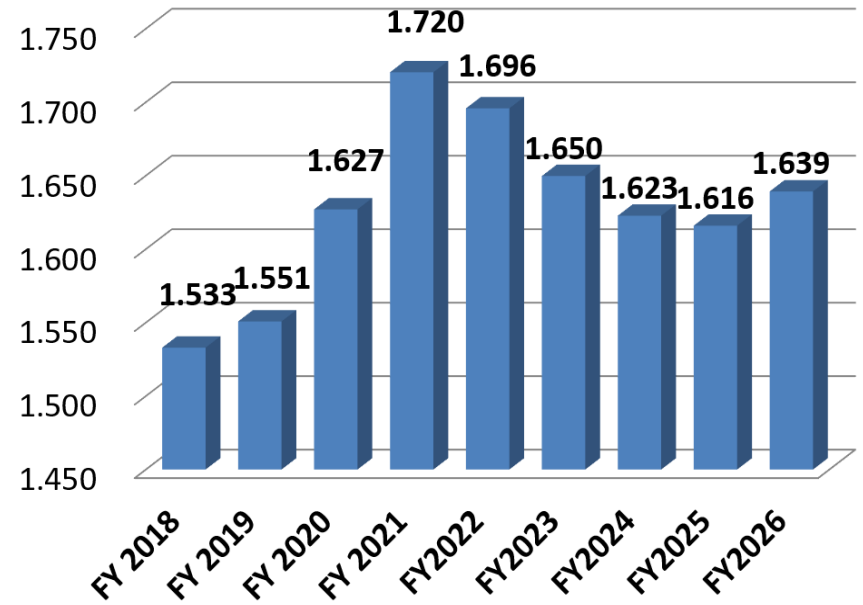
Total KDHCD Patient Days	147,907	146,987	(0.6%)	156,701	(9,714)	(6.2%)
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Total Outpatient Volume	734,152	758,599	3.3%	832,954	(74,355)	(8.9%)
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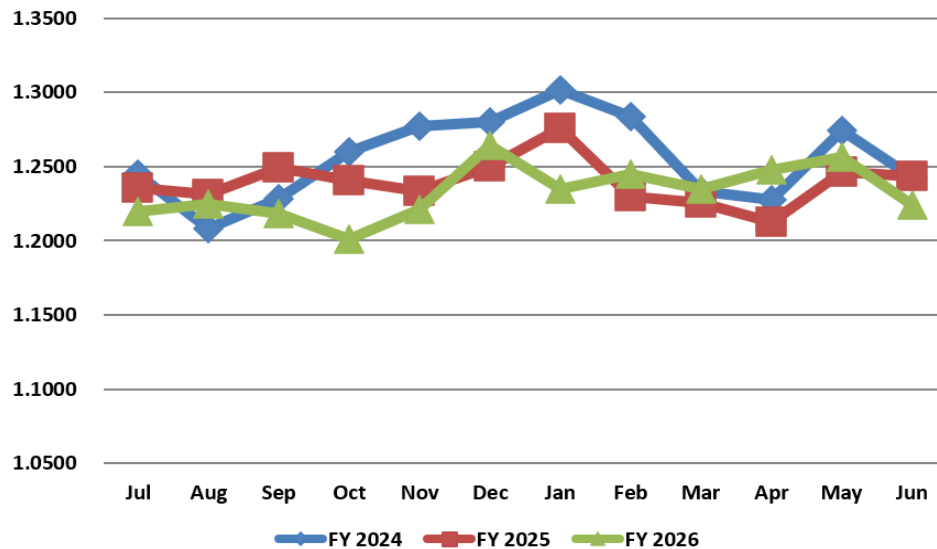
Case Mix Index w/o Normal Newborns



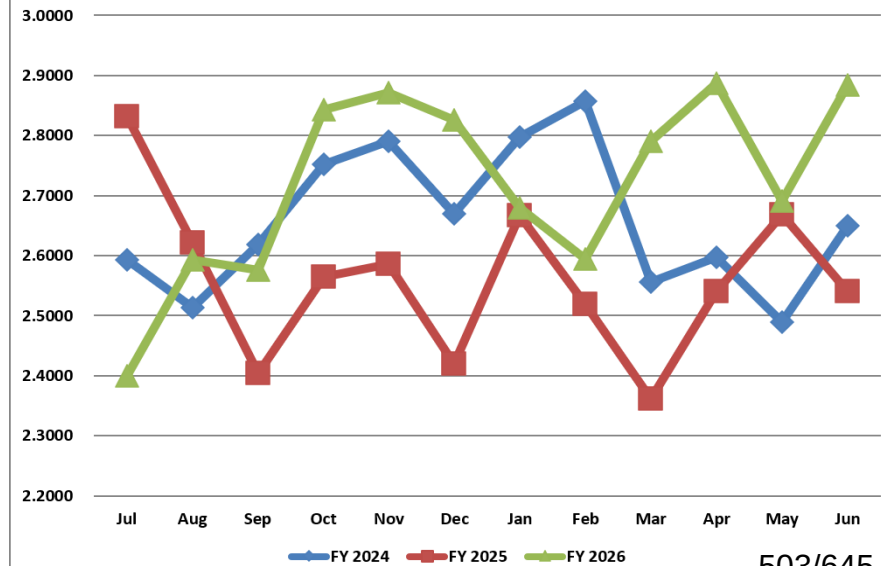
Case Mix Index w/o Normal Newborns - All



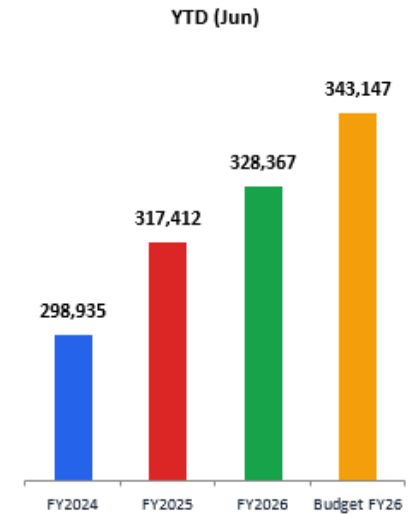
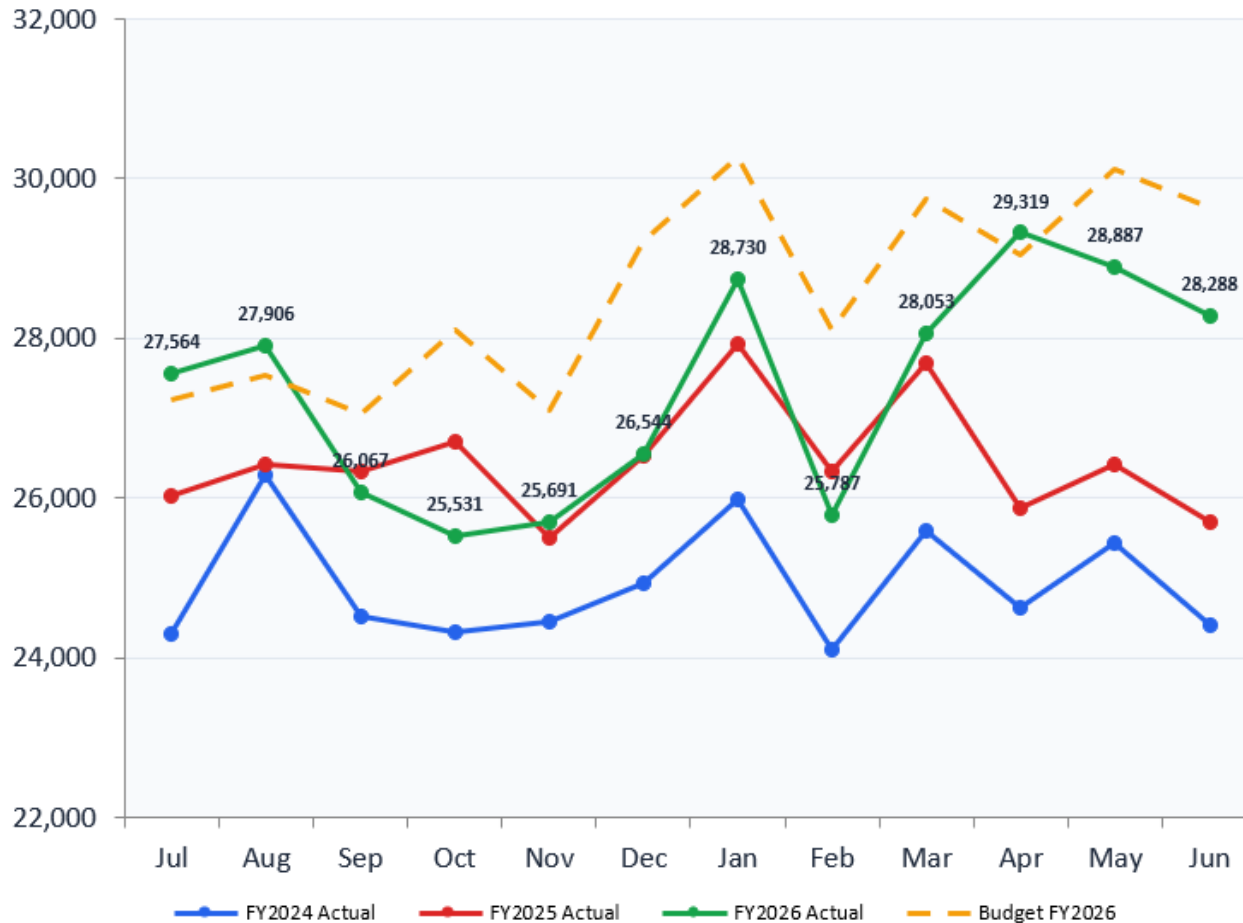
Case Mix **Medical** w/o Normal Newborns



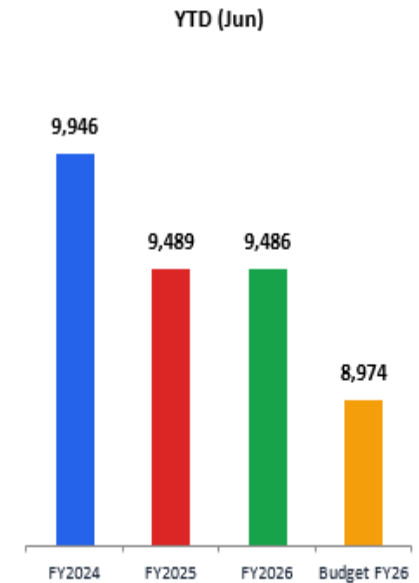
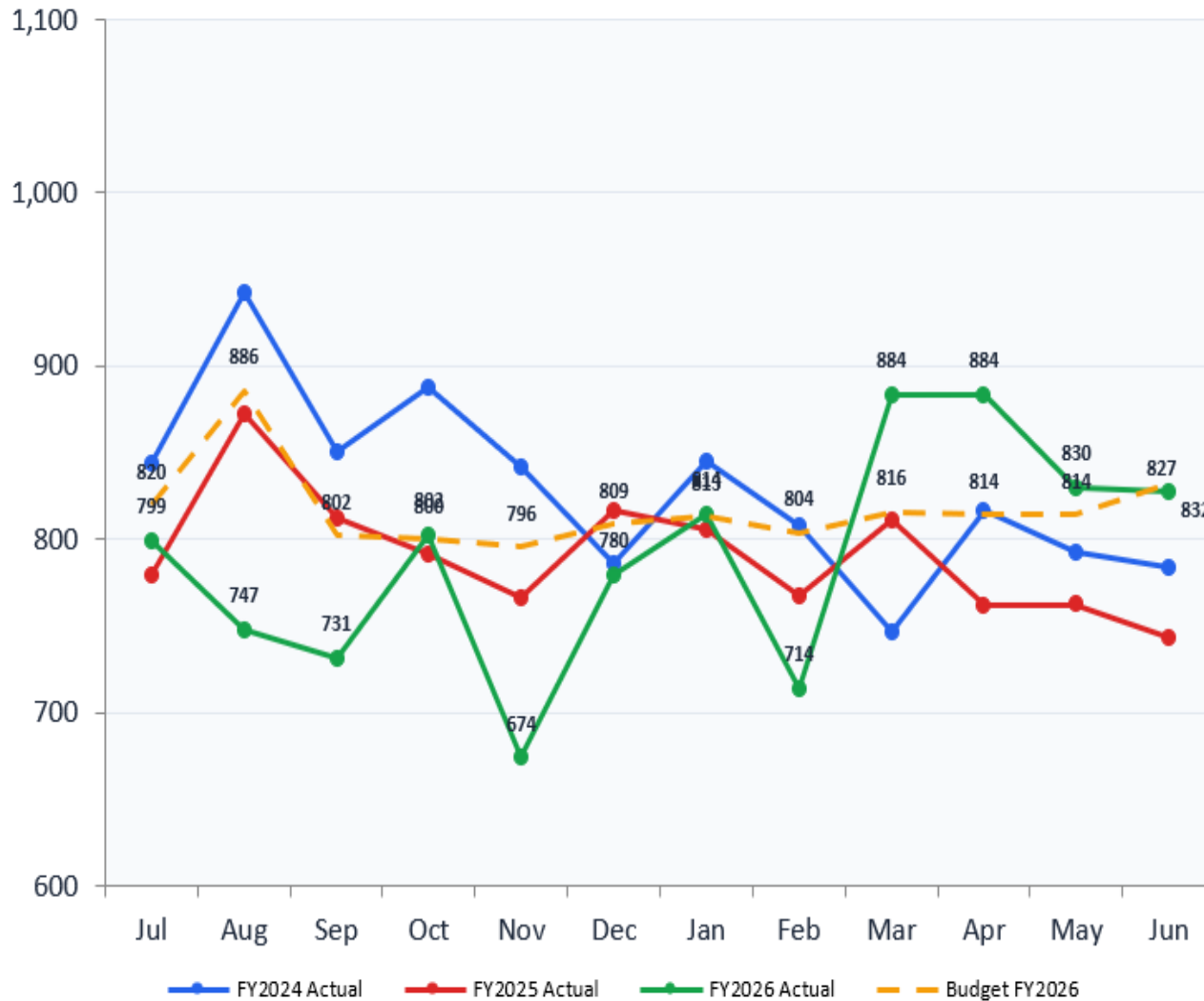
Case Mix Index **Surgical** w/o Normal Newborns



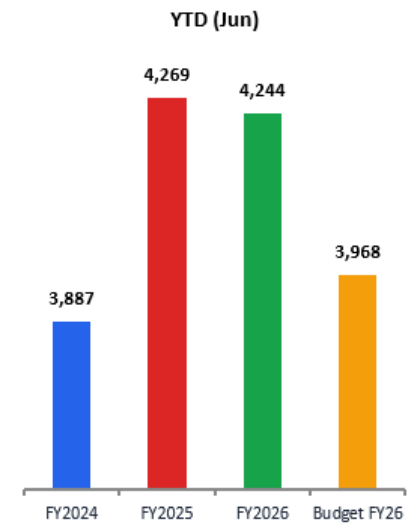
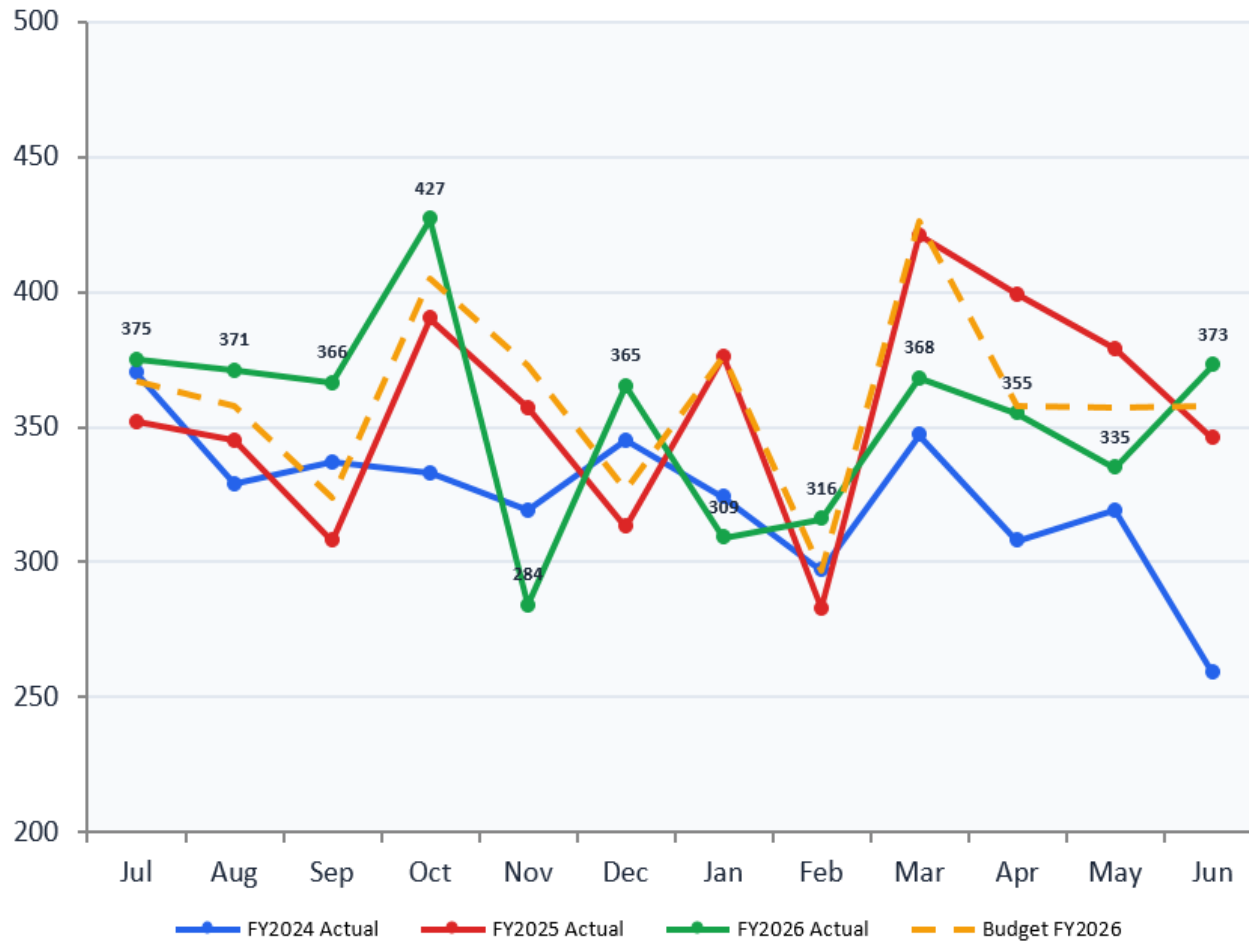
Adjusted Patient Days



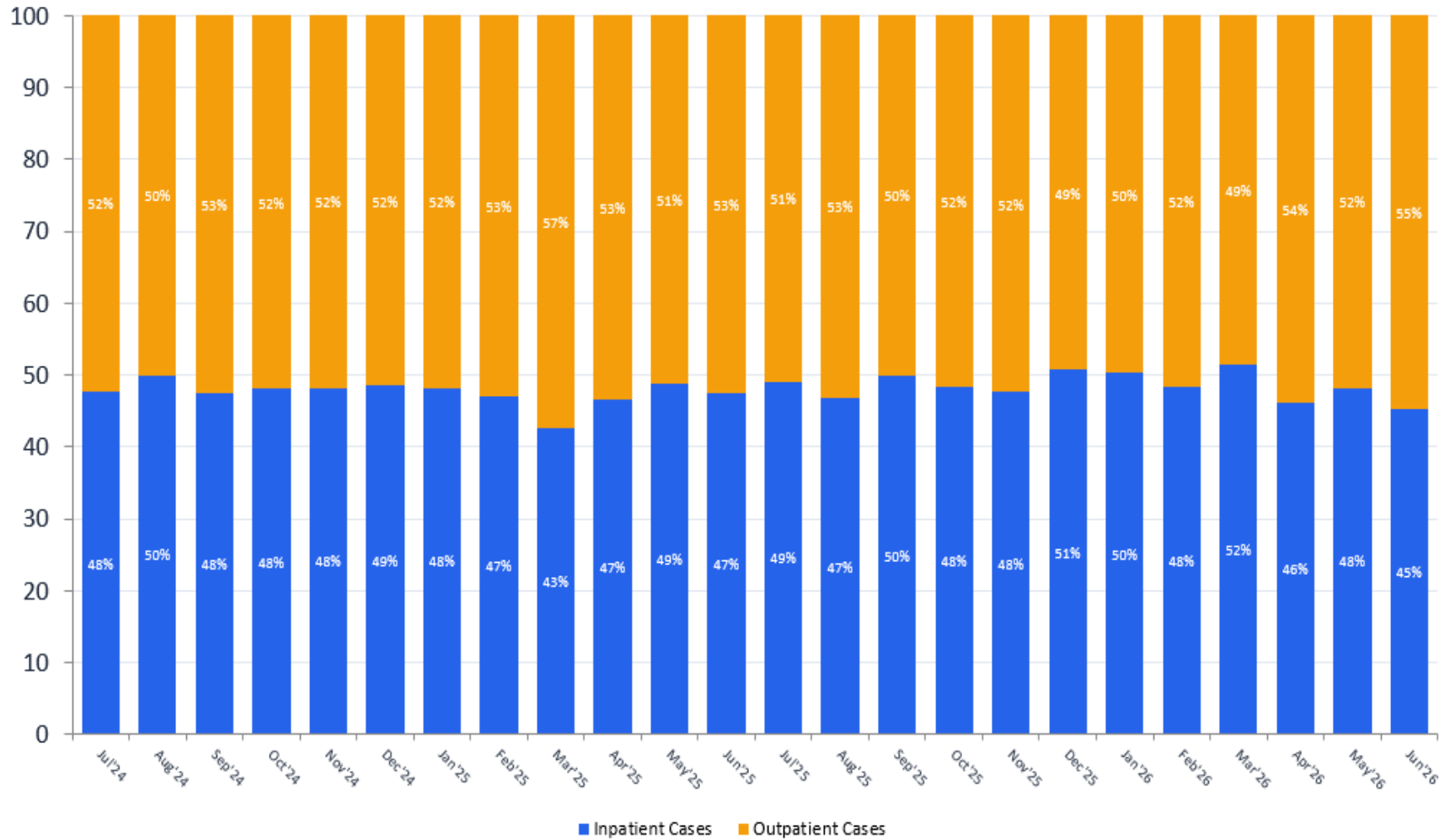
Surgery (IP & OP) – 100 Min Units



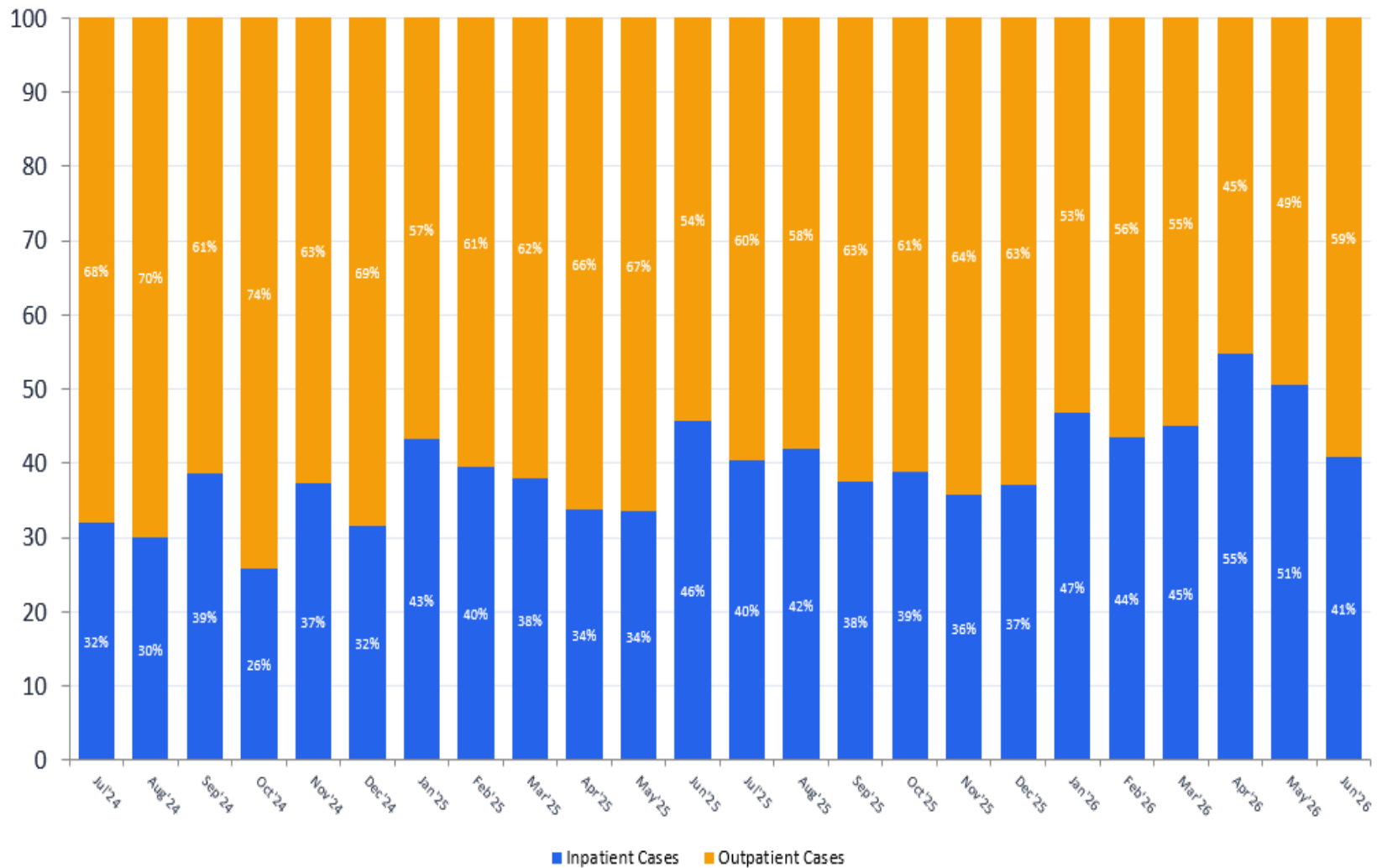
Cath Lab (IP & OP) – 100 Min Units



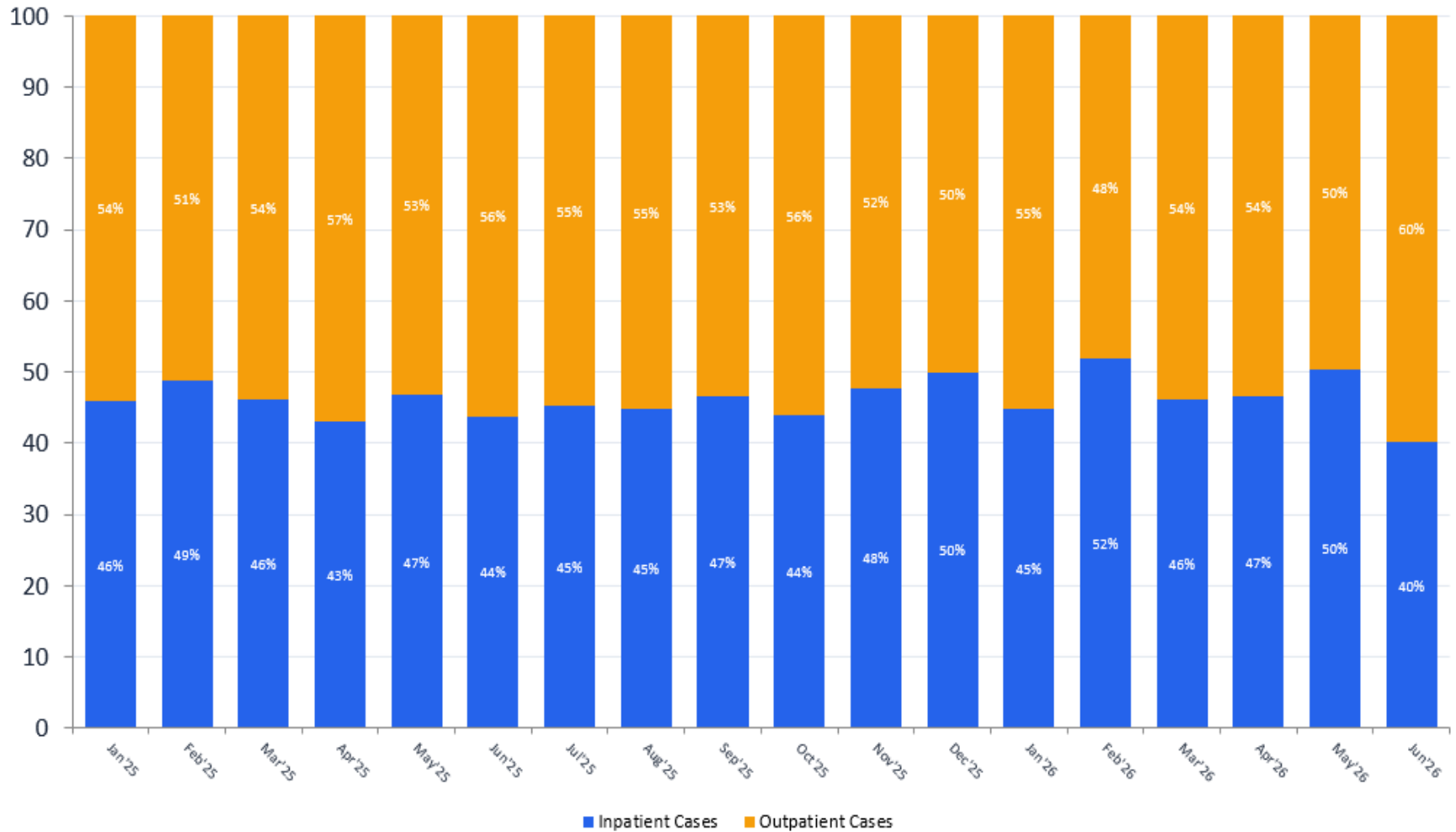
Surgery Cases (IP & OP)



Endo Cases (Suites A & B and OR)



Cath Lab Patients (IP & OP)



Other Statistical Results – Prior Year/Budget Comparison (June)

	Actual Results				Budget	Budget Variance	
	Jun25	Jun26	Change	% Change	Jun26	Change	% Change
All O/P Rehab Svcs Across District	20,711	20,094	(617)	(3.0%)	22,041	(1,947)	(8.8%)
Physical & Other Therapy Units (I/P & O/P)	17,449	20,136	2,687	15.4%	19,669	467	2.4%
Radiology - CT - All Areas	5,109	5,833	724	14.2%	4,783	1,050	22.0%
Radiology - MRI - All Areas	1,128	1,026	(102)	(9.0%)	879	147	16.8%
Radiology - Ultrasound - All Areas	3,153	3,340	187	5.9%	3,217	123	3.8%
Radiology - Diagnostic Radiology	9,677	10,377	700	7.2%	9,535	842	8.8%
Radiology – Main Campus	16,052	16,827	775	4.8%	15,412	1,415	9.2%
Radiology - Ultrasound - Main Campus	2,439	2,271	(168)	(6.9%)	2,330	(59)	(2.6%)
West Campus - Diagnostic Radiology	1,310	1,522	212	16.2%	1,178	344	29.2%
West Campus - CT Scan	523	667	144	27.5%	515	152	29.5%
West Campus - MRI	468	491	23	4.9%	422	69	16.2%
West Campus - Ultrasound	714	1,069	355	49.7%	887	182	20.5%
West Campus - Breast Center	1,635	2,225	590	36.1%	1,721	504	29.3%
Med Onc Visalia Treatments	1,100	1,036	(64)	(5.8%)	1,198	(162)	(13.5%)
Rad Onc Visalia Treatments	1,675	1,654	(21)	(1.3%)	1,513	141	9.4%
Rad Onc Hanford Treatments	391	146	(245)	(62.7%)	232	(86)	(37.0%)

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

	YTD Actual Results				Budget	Budget Variance	
	YTD Jun 25	YTD Jun 26	Change	% Change	YTD Jun 26	Change	% Change
All O/P Rehab Svcs Across District	248,488	243,141	(5,347)	(2.2%)	253,319	(10,178)	(4.0%)
Physical & Other Therapy Units (I/P & O/P)	220,355	231,667	11,312	5.1%	238,004	(6,337)	(2.7%)
Radiology - CT - All Areas	57,086	63,669	6,583	11.5%	55,292	8,378	15.2%
Radiology - MRI - All Areas	10,766	11,214	448	4.2%	10,520	694	6.6%
Radiology - Ultrasound - All Areas	36,707	37,168	461	1.3%	36,579	590	1.6%
Radiology - Diagnostic Radiology	116,224	116,992	768	0.7%	116,994	(2)	(0.0%)
Radiology – Main Campus	186,875	189,810	2,935	1.6%	184,048	5,762	3.1%
Radiology - Ultrasound - Main Campus	28,658	26,474	(2,184)	(7.6%)	26,191	283	1.1%
West Campus - Diagnostic Radiology	14,716	16,309	1,593	10.8%	13,965	2,344	16.8%
West Campus - CT Scan	6,061	7,052	991	16.4%	5,907	1,145	19.4%
West Campus - MRI	5,082	5,178	96	1.9%	5,076	102	2.0%
West Campus - Ultrasound	8,049	10,694	2,645	32.9%	10,388	306	2.9%
West Campus - Breast Center	19,258	22,182	2,924	15.2%	19,827	2,355	11.9%
Med Onc Visalia Treatments	12,972	13,491	519	4.0%	13,792	(301)	(2.2%)
Rad Onc Visalia Treatments	16,943	17,774	831	4.9%	17,573	201	1.1%
Rad Onc Hanford Treatments	2,925	2,695	(230)	(7.9%)	2,859	(164)	(5.7%)

Other Statistical Results – Prior Year/Budget Comparison (Jun)

	Actual Results				Budget	Budget Variance	
	Jun25	Jun26	Change	% Change	Jun26	Change	% Change
Rural Health Clinics Registrations	13,574	11,763	(1,811)	(13.3%)	13,250	(1,487)	(11.2%)
RHC Exeter - Registrations	6,490	5,444	(1,046)	(16.1%)	6,471	(1,027)	(15.9%)
RHC Lindsay - Registrations	1,868	1,642	(226)	(12.1%)	1,970	(328)	(16.6%)
RHC Woodlake - Registrations	1,302	488	(814)	(62.5%)	637	(149)	(23.4%)
RHC Woodlake Valencia - Registrations	0	761	761	0.0%	1,300	(539)	(41.5%)
RHC Dinuba - Registrations	1,257	1,193	(64)	(5.1%)	1,750	(557)	(31.8%)
RHC Tulare - Registrations	2,657	2,235	(422)	(15.9%)	2,422	(187)	(7.7%)
Urgent Care – Court Total Visits	2,473	2,280	(193)	(7.8%)	2,700	(420)	(15.6%)
Urgent Care – Demaree Total Visits	1,568	1,927	359	22.9%	1,850	77	4.2%
KH Medical Clinic - Ben Maddox Visits	837	0	(837)	(100.0%)	-	0	0.0%
KH Medical Clinic - Plaza Visits	254	365	111	43.7%	365	0	0.0%
KH Willow Specialty Clinic	248	371	123	49.6%	509	(138)	(27.1%)
KH Cardiology Center Visalia Registrations	1,396	2,267	871	62.4%	1,690	577	34.1%
KH Mental Wellness Clinic Visits	270	298	28	10.4%	390	(92)	(23.6%)
Urology Clinic Visits	243	243	0	0.0%	913	(670)	(73.4%)
Therapy-Wound Care Svcs Encounters	322	303	(19)	(5.9%)	347	(44)	(12.7%)

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

	YTD Actual Results				Budget	Budget Variance	
	YTD Jun 25	YTD Jun 26	Change	% Change	YTD Jun 26	Change	% Change
Rural Health Clinics Registrations	164,323	146,605	(17,718)	(10.8%)	164,641	(18,036)	(11.0%)
RHC Exeter - Registrations	78,302	69,572	(8,730)	(11.1%)	80,150	(10,578)	(13.2%)
RHC Lindsay - Registrations	22,470	20,383	(2,087)	(9.3%)	25,050	(4,667)	(18.6%)
RHC Woodlake - Registrations	15,980	6,932	(9,048)	(56.6%)	8,016	(1,084)	(13.5%)
RHC Woodlake Valencia - Registrations	0	7,628	7,628	0.0%	11,898	(4,270)	(35.9%)
RHC Dinuba - Registrations	18,242	16,725	(1,517)	(8.3%)	20,675	(3,950)	(19.1%)
RHC Tulare - Registrations	29,329	25,365	(3,964)	(13.5%)	30,750	(5,385)	(17.5%)
Urgent Care – Court Total Visits	30,487	30,217	(270)	(0.9%)	35,300	(5,083)	(14.4%)
Urgent Care – Demaree Total Visits	18,797	24,078	5,281	28.1%	24,050	28	0.1%
KH Medical Clinic - Ben Maddox Visits	9,985	9,235	(750)	(7.5%)	5,500	3,735	67.9%
KH Medical Clinic - Plaza Visits	3,151	3,094	(57)	(1.8%)	3,632	(538)	(14.8%)
KH Willow Specialty Clinic	422	4,249	3,827	906.9%	5,720	(1,471)	(25.7%)
KH Cardiology Center Visalia Registrations	18,285	20,007	1,722	9.4%	19,577	430	2.2%
KH Mental Wellness Clinic Visits	3,598	3,676	78	2.2%	4,560	(884)	(19.4%)
Urology Clinic Visits	3,551	2,687	(864)	(24.3%)	6,826	(4,139)	(60.6%)
Therapy-Wound Care Svcs Encounters	2,649	3,919	1,270	47.9%	4,225	(306)	(7.2%)

Other Statistical Results – Prior Year/Budget Comparison (Jun)

	Actual Results				Budget	Budget Variance	
	Jun25	Jun26	Change	% Change	Jun26	Change	% Change
ED - Avg Treated Per Day	280	284	4	1.4%	282	2	0.8%
Surgery (IP & OP) – 100 Min Units	743	827	84	11.3%	832	(5)	(0.6%)
Endoscopy Procedures	606	589	(17)	(2.8%)	504	85	16.8%
Cath Lab (IP & OP) - 100 Min Units	346	373	27	7.8%	358	15	4.2%
Cardiac Surgery Cases	30	33	3	10.0%	26	7	26.1%
Deliveries	331	289	(42)	(12.7%)	434	(145)	(33.4%)
Clinical Lab	256,686	271,347	14,660	5.7%	273,440	(2,094)	(0.8%)
Reference Lab	7,108	7,417	309	4.3%	6,712	705	10.5%
Dialysis Center - Visalia Visits	1,457	1,288	(169)	(11.6%)	1,565	(277)	(17.7%)
Infusion Center - Units of Service	487	562	75	15.4%	829	(267)	(32.2%)
Hospice Days	4,112	3,919	(193)	(4.7%)	4,176	(257)	(6.2%)
Home Health Visits	2,789	2,736	(53)	(1.9%)	2,990	(254)	(8.5%)
Home Infusion Days	24,374	22,163	(2,211)	(9.1%)	22,660	(497)	(2.2%)

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

	YTD Actual Results				Budget	Budget Variance	
	YTD Jun 25	YTD Jun 26	Change	% Change	YTD Jun 26	Change	% Change
ED - Avg Treated Per Day	265	277	12	4.4%	278	(1)	(0.3%)
Surgery (IP & OP) – 100 Min Units	9,489	9,486	(3)	(0.0%)	9,806	(320)	(3.3%)
Endoscopy Procedures	7,438	5,978	(1,460)	(19.6%)	6,224	(246)	(3.9%)
Cath Lab (IP & OP) - 100 Min Units	4,269	4,244	(25)	(0.6%)	4,326	(82)	(1.9%)
Cardiac Surgery Cases	344	350	6	1.7%	372	(22)	(5.9%)
Deliveries	4,677	3,748	(929)	(19.9%)	4,733	(985)	(20.8%)
Clinical Lab	3,020,527	3,153,163	132,637	4.4%	3,281,275	(128,112)	(3.9%)
Reference Lab	84,410	86,912	2,502	3.0%	82,478	4,435	5.4%
Dialysis Center - Visalia Visits	17,884	16,520	(1,364)	(7.6%)	18,251	(1,731)	(9.5%)
Infusion Center - Units of Service	5,193	6,989	1,796	34.6%	8,256	(1,267)	(15.3%)
Hospice Days	43,419	47,788	4,369	10.1%	49,005	(1,217)	(2.5%)
Home Health Visits	34,533	33,607	(926)	(2.7%)	36,638	(3,031)	(8.3%)
Home Infusion Days	268,810	281,490	12,680	4.7%	264,713	16,777	6.3%

June **Prelim** Financial Summary (000's) **Budget Comparison**

Operating Revenue

Net Patient Service Revenue

Other Operating Revenue

Total Operating Revenue

Operating Expenses

Employment Expenses

Other Expenses

Total Operating Expenses

Operating Margin

Stimulus/FEMA

Operating Margin after Stimulus/FEMA

Nonoperating Revenue (Loss)

Excess Margin

Comparison to Budget - Month of June			
Budget June-2026	Actual June-2026	\$ Change	% Change
\$57,561	\$62,791	\$5,229	8.3%
\$22,085	\$23,709	\$1,624	6.8%
\$79,647	\$86,500	\$6,853	7.9%
\$43,180	\$44,269	\$1,089	2.5%
\$38,340	\$41,912	\$3,572	8.5%
\$81,520	\$86,181	\$4,661	5.4%
(\$1,873)	\$319	\$2,192	
\$0	\$0	\$0	
(\$1,873)	\$319	\$2,192	
\$863	\$2,290	\$1,426	
(\$1,010)	\$2,608	\$3,618	

June **Prelim** Financial Summary (000's) **Prior Year Comparison**

Comparison to Prior Year - Month of June			
Actual June-2025	Actual June-2026	\$ Change	% Change
Operating Revenue			
Net Patient Service Revenue	\$44,473	\$62,791	\$18,317 29.2%
Other Operating Revenue	\$29,489	\$23,709	(\$5,780) -24.4%
Total Operating Revenue	\$73,962	\$86,500	\$12,537 14.5%
Operating Expenses			
Employment Expenses	\$40,488	\$44,269	\$3,781 8.5%
Other Expenses	\$44,194	\$41,912	(\$2,282) -5.4%
Total Operating Expenses	\$84,682	\$86,181	\$1,498 1.7%
Operating Margin	(\$10,720)	\$319	\$11,039
Stimulus/FEMA	\$0	\$0	\$0
Operating Margin after Stimulus/FEMA	(\$10,720)	\$319	\$11,039
Nonoperating Revenue (Loss)	\$2,603	\$2,290	(\$313)
Excess Margin	(\$8,117)	\$2,608	\$10,726

Year to Date **Prelim** Financial Summary (000's)

Comparison to Budget - YTD June				
	Budget YTD June-2026	Actual YTD June-2026	\$ Change	% Change
Operating Revenue				
Net Patient Service Revenue	\$689,140	\$706,831	\$17,691	2.5%
Other Operating Revenue	\$263,030	\$272,572	\$9,542	3.5%
Total Operating Revenue	\$952,170	\$979,403	\$27,233	2.8%
Operating Expenses				
Employment Expenses	\$513,409	\$523,619	\$10,210	1.9%
Other Expenses	\$448,889	\$461,453	\$12,564	2.7%
Total Operating Expenses	\$962,298	\$985,072	\$22,774	2.3%
Operating Margin	(\$10,128)	(\$5,669)	\$4,459	
Stimulus/FEMA	\$0	(\$0)	(\$0)	
Operating Margin after Stimulus/FEMA	(\$10,128)	(\$5,669)	\$4,459	
Nonoperating Revenue (Loss)	\$10,472	\$14,731	\$4,259	
Excess Margin	\$345	\$9,063	\$8,718	

June Prelim Financial Comparison (000's)

Comparison to Budget - Month of June			
Budget June-2026	Actual June-2026	\$ Change	% Change

Comparison to Prior Year - Month of June			
Actual June-2025	Actual June-2026	\$ Change	% Change

Operating Revenue

Net Patient Service Revenue	\$57,561	\$62,791	\$5,229	8.3%	\$44,473	\$62,791	\$18,317	29.2%
Supplemental Gov't Programs	\$9,727	\$8,113	(\$1,614)	-19.9%	\$16,632	\$8,113	(\$8,520)	-105.0%
Prime Program	\$631	\$2,757	\$2,126	77.1%	\$524	\$2,757	\$2,233	81.0%
Premium Revenue	\$7,415	\$7,669	\$254	3.3%	\$7,191	\$7,669	\$478	6.2%
Other Revenue	\$4,313	\$5,170	\$857	16.6%	\$5,143	\$5,170	\$28	0.5%
Other Operating Revenue	\$22,085	\$23,709	\$1,624	6.8%	\$29,489	\$23,709	(\$5,780)	-24.4%
Total Operating Revenue	\$79,647	\$86,500	\$6,853	7.9%	\$73,962	\$86,500	\$12,537	14.5%

Operating Expenses

Salaries & Wages	\$35,068	\$35,215	\$147	0.4%	\$32,473	\$35,215	\$2,743	7.8%
Contract Labor	\$929	\$1,662	\$733	44.1%	\$3,699	\$1,662	(\$2,036)	-122.5%
Employee Benefits	\$7,182	\$7,391	\$208	2.8%	\$4,316	\$7,391	\$3,074	41.6%
Total Employment Expenses	\$43,180	\$44,269	\$1,089	2.5%	\$40,488	\$44,269	\$3,781	8.5%

Medical & Other Supplies	\$15,353	\$16,355	\$1,002	6.1%	\$13,191	\$16,355	\$3,164	19.3%
Physician Fees	\$7,584	\$9,870	\$2,286	23.2%	\$7,459	\$9,870	\$2,411	24.4%
Purchased Services	\$1,909	\$2,264	\$355	15.7%	\$2,545	\$2,264	(\$281)	-12.4%
Repairs & Maintenance	\$2,462	\$2,259	(\$203)	-9.0%	\$1,738	\$2,259	\$522	23.1%
Utilities	\$925	\$783	(\$142)	-18.1%	\$267	\$783	\$516	65.9%
Rents & Leases	\$133	\$211	\$78	36.9%	\$121	\$211	\$90	42.8%
Depreciation & Amortization	\$3,502	\$3,480	(\$22)	-0.6%	\$3,795	\$3,480	(\$315)	-9.1%
Interest Expense	\$554	\$502	(\$52)	-10.4%	\$694	\$502	(\$192)	-38.3%
Other Expense	\$2,267	\$2,505	\$238	9.5%	\$9,199	\$2,505	(\$6,694)	-267.2%
Humana Cap Plan Expenses	\$3,650	\$3,682	\$33	0.9%	\$5,185	\$3,682	(\$1,502)	-40.8%
Total Other Expenses	\$38,340	\$41,912	\$3,572	8.5%	\$44,194	\$41,912	(\$2,282)	-5.4%
Total Operating Expenses	\$81,520	\$86,181	\$4,661	5.4%	\$84,682	\$86,181	\$1,498	1.7%
Operating Margin	(\$1,873)	\$319	\$2,192		(\$10,720)	\$319	\$11,039	
Stimulus/FEMA	\$0	\$0	\$0		\$0	\$0	\$0	
Operating Margin after Stimulus/FEMA	(\$1,873)	\$319	\$2,192		(\$10,720)	\$319	\$11,039	
Nonoperating Revenue (Loss)	\$863	\$2,290	\$1,426		\$2,603	\$2,290	(\$313)	
Excess Margin	(\$1,010)	\$2,608	\$3,618		(\$8,117)	\$2,608	\$10,726	

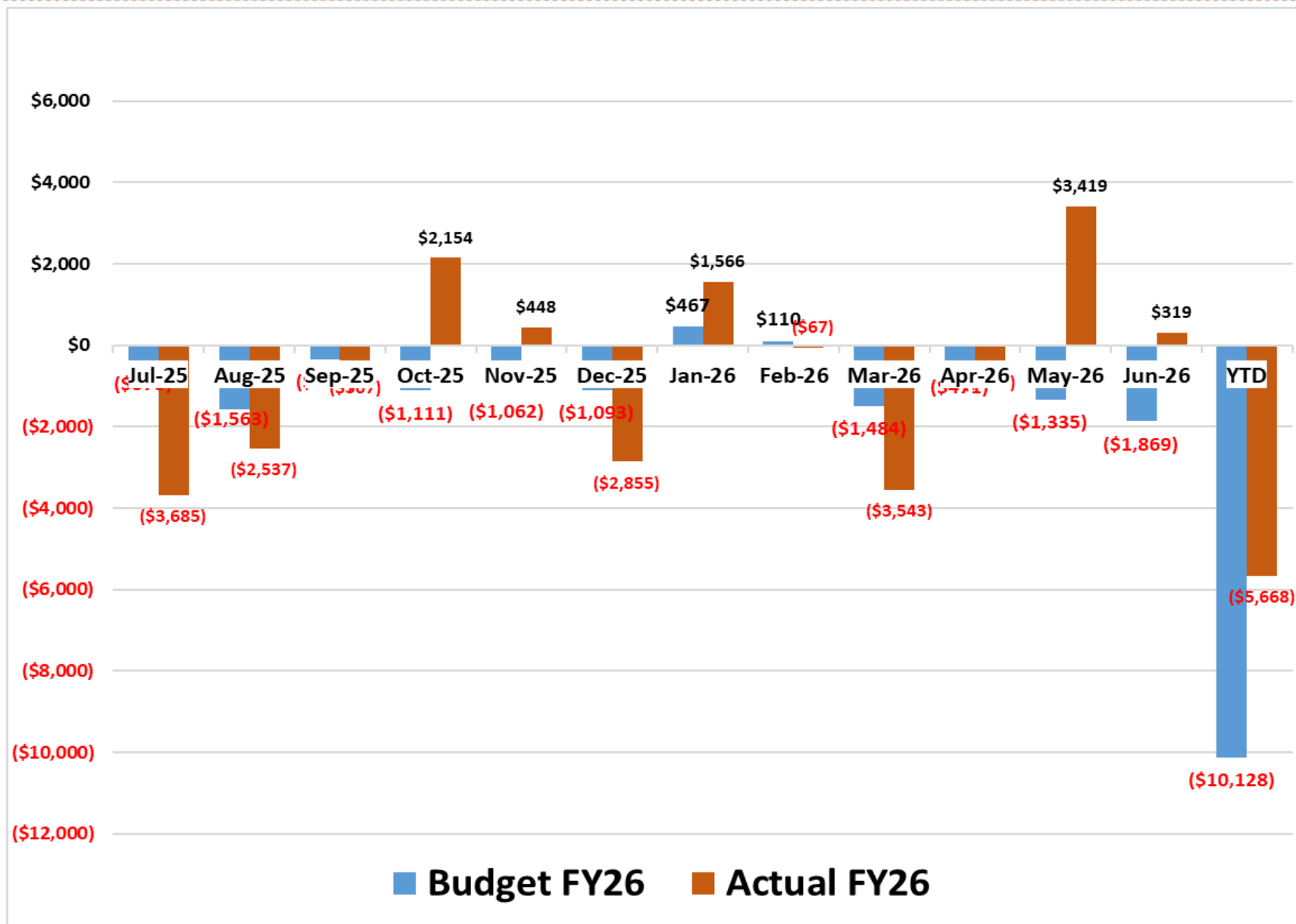
Year to Date: July through June **Prelim** Financial Comparison (000's)

	Comparison to Budget - YTD June				Comparison to Prior Year - YTD June			
	Budget YTD June-2026	Actual YTD June-2026	\$ Change	% Change	Actual YTD June-2025	Actual YTD June-2026	\$ Change	% Change
Operating Revenue								
Net Patient Service Revenue	\$689,140	\$706,831	\$17,691	2.5%	\$648,904	\$706,831	\$57,927	8.2%
Supplemental Gov't Programs	\$116,718	\$111,400	(\$5,318)	-4.8%	\$94,965	\$111,400	\$16,436	14.8%
Prime Program	\$7,568	\$12,576	\$5,008	39.8%	\$13,994	\$12,576	(\$1,418)	-11.3%
Premium Revenue	\$86,863	\$89,451	\$2,589	2.9%	\$85,931	\$89,451	\$3,521	3.9%
Other Revenue	\$51,881	\$59,144	\$7,263	12.3%	\$51,793	\$59,144	\$7,352	12.4%
Other Operating Revenue	\$263,030	\$272,572	\$9,542	3.5%	\$246,682	\$272,572	\$25,890	9.5%
Total Operating Revenue	\$952,170	\$979,403	\$27,233	2.8%	\$895,585	\$979,403	\$83,818	8.6%
Operating Expenses								
Salaries & Wages	\$405,883	\$409,054	\$3,171	0.8%	\$386,997	\$409,054	\$22,057	5.4%
Contract Labor	\$20,577	\$23,273	\$2,696	11.6%	\$25,550	\$23,273	(\$2,277)	-9.8%
Employee Benefits	\$86,949	\$91,292	\$4,343	4.8%	\$79,249	\$91,292	\$12,043	13.2%
Total Employment Expenses	\$513,409	\$523,619	\$10,210	1.9%	\$491,796	\$523,619	\$31,823	6.1%
Medical & Other Supplies	\$171,447	\$179,931	\$8,483	4.7%	\$165,851	\$179,931	\$14,079	7.8%
Physician Fees	\$90,619	\$98,148	\$7,530	7.7%	\$88,396	\$98,148	\$9,752	9.9%
Purchased Services	\$22,954	\$24,456	\$1,501	6.1%	\$21,412	\$24,456	\$3,044	12.4%
Repairs & Maintenance	\$29,949	\$26,687	(\$3,262)	-12.2%	\$25,463	\$26,687	\$1,224	4.6%
Utilities	\$11,593	\$10,406	(\$1,187)	-11.4%	\$10,556	\$10,406	(\$150)	-1.4%
Rents & Leases	\$1,656	\$1,982	\$325	16.4%	\$1,706	\$1,982	\$275	13.9%
Depreciation & Amortization	\$42,042	\$40,310	(\$1,732)	-4.3%	\$39,870	\$40,310	\$440	1.1%
Interest Expense	\$6,739	\$6,905	\$167	2.4%	\$7,229	\$6,905	(\$323)	-4.7%
Other Expense	\$27,487	\$27,598	\$111	0.4%	\$32,950	\$27,598	(\$5,352)	-19.4%
Humana Cap Plan Expenses	\$44,403	\$45,031	\$628	1.4%	\$48,086	\$45,031	(\$3,055)	-6.8%
Total Other Expenses	\$448,889	\$461,453	\$12,564	2.7%	\$441,519	\$461,453	\$19,934	4.3%
Total Operating Expenses	\$962,298	\$985,072	\$22,774	2.3%	\$933,315	\$985,072	\$51,757	5.3%
Operating Margin	(\$10,128)	(\$5,669)	\$4,459		(\$37,730)	(\$5,669)	\$32,061	
Stimulus/FEMA	\$0	(\$0)	(\$0)		\$48,412	(\$0)	(\$48,412)	
Operating Margin after Stimulus/FEMA	(\$10,128)	(\$5,669)	\$4,459		\$10,682	(\$5,669)	(\$16,351)	
Nonoperating Revenue (Loss)	\$10,472	\$14,731	\$4,259		\$16,977	\$14,731	(\$2,245)	
Excess Margin	\$345	\$9,063	\$8,718		\$27,658	\$9,063	(\$18,596)	

Month of June - Budget Variances

- **Net Patient Service Revenue:** The favorable budget variance of \$5.2M is primarily due stronger patient volume and mix.
- **Supplemental Gov't Programs:** The unfavorable budget variance of \$1.6M is primarily due to unanticipated HQAF State legislation – a decrease of 40%.
- **QIP (Prime) Program:** The QIP program performed better than anticipated with actual CY24 payments exceeding budget and CY26 estimates anticipating higher than expected results. We recognized a \$2.9M positive adjustment in May and \$2.1M in June.
- **Contract Labor:** The unfavorable variance of \$733K in June is primarily due to staffing needs in the Emergency Department.
- **Medical and Other Supplies:** The unfavorable variance of \$1M is due to the increase in surgical and cardiac catheterization lab volumes in June.
- **Physician Fees:** The overage in physician fees is due to volume increases and the change in the radiology contract, which is now partially offset in net patient revenue.
- **Investment Income:** The \$1.5M favorable variance is due to the quarterly adjustment to reflect the current market value of the District's and the Foundation's investment portfolios.

Budget and Actual Fiscal Year 2026: Trended Operating Margin (000's)



Budget and Actual Fiscal Year 2026: Trended Operating Margin (000's)

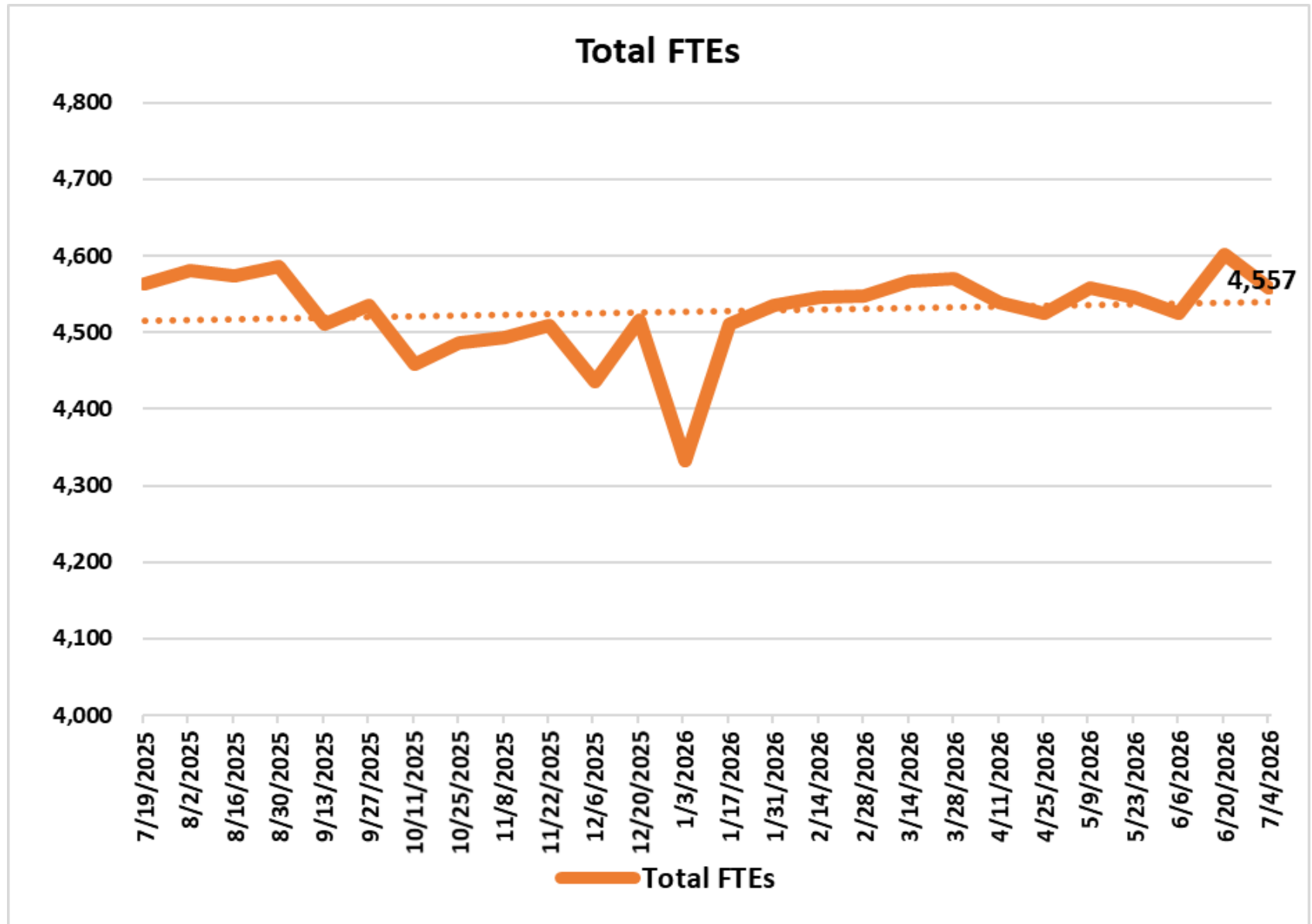
	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	FY 2026
Patient Service Revenue	\$55,676	\$60,513	\$54,599	\$57,753	\$66,284	\$64,663	\$62,791	\$706,831
Other Revenue	\$22,751	\$21,414	\$21,119	\$22,212	\$21,531	\$24,591	\$23,709	\$272,572
Total Operating Revenue	\$78,427	\$81,928	\$75,718	\$79,966	\$87,815	\$89,254	\$86,500	\$979,403
Employee Expense	\$44,400	\$43,089	\$40,711	\$45,084	\$43,166	\$45,789	\$44,269	\$523,619
Other Operating Expense	\$36,883	\$37,272	\$35,074	\$38,424	\$45,030	\$40,046	\$41,912	\$461,453
Total Operating Expenses	\$81,282	\$80,361	\$75,785	\$83,509	\$88,196	\$85,836	\$86,181	\$985,072
Net Operating Margin	(\$2,855)	\$1,566	(\$67)	(\$3,543)	(\$380)	\$3,419	\$319	(\$5,669)
NonOperating Income	\$1,608	\$1,168	\$1,178	(\$468)	\$1,170	\$1,299	\$2,290	\$14,731
Excess Margin	(\$1,248)	\$2,734	\$1,111	(\$4,011)	\$790	\$4,717	\$2,608	\$9,062

Profitability								
Operating Margin %	(3.6%)	1.9%	(0.1%)	(4.4%)	(0.4%)	3.8%	0.4%	(0.6%)
Operating Margin %excl. Int	(2.9%)	2.6%	0.7%	(3.7%)	0.2%	4.5%	0.9%	0.1%
Operating EBIDA	\$1,304	\$5,475	\$3,894	\$445	\$3,405	\$7,646	\$4,301	\$41,547
Operating EBIDA Margin	1.7%	6.7%	5.1%	0.6%	3.9%	8.6%	5.0%	4.2%

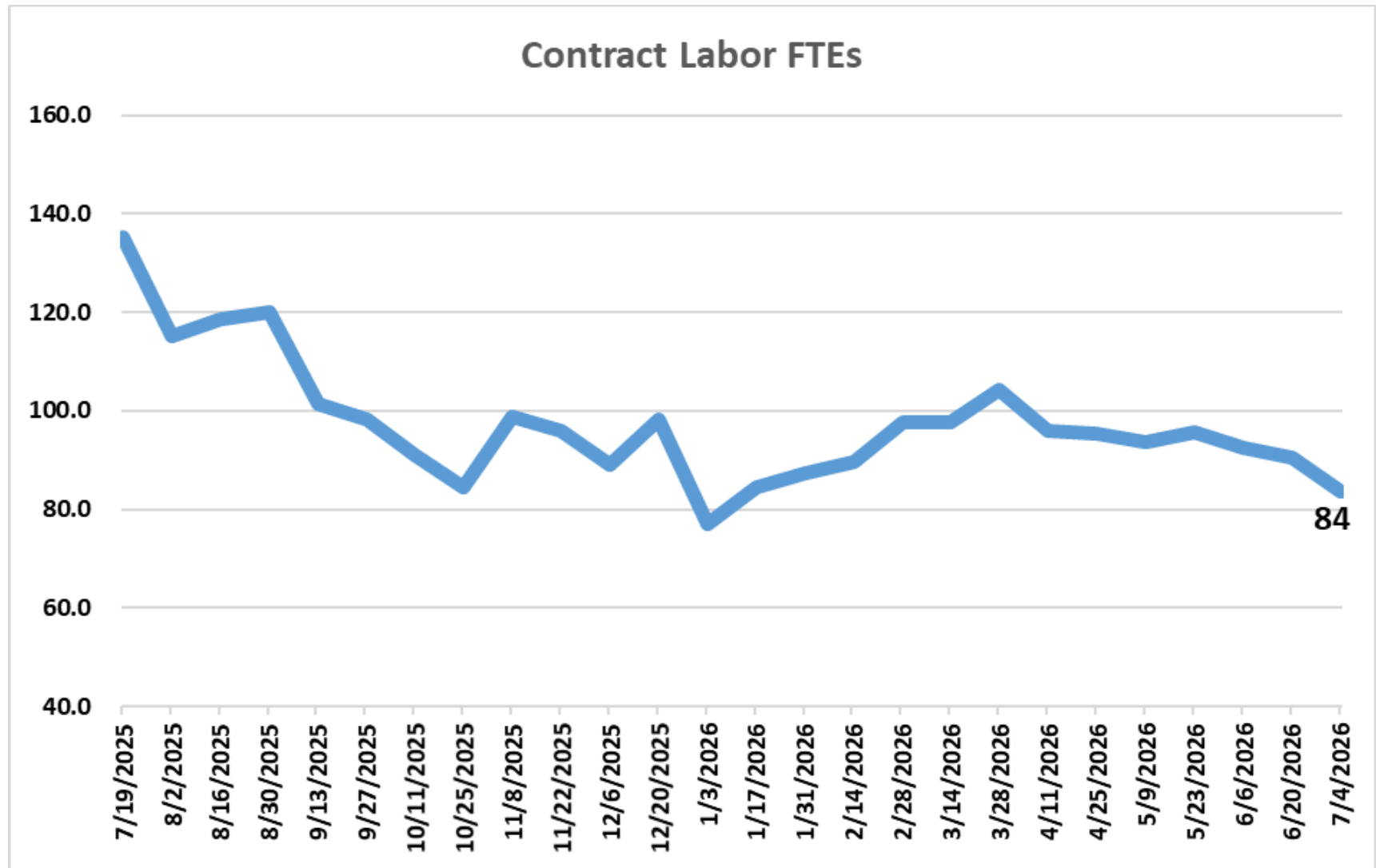
Liquidity Indicators								
Day's Cash on Hand	97.1	105.6	113.3	115.1	117.3	112.1	114.6	114.6
Day's in Accounts Rec.	68.3	73.6	72.5	68.3	68.0	70.7	69.5	69.5

Debt & Other Indicators								
Debt Service Coverage (MADS)	1.72	1.91	1.97	1.70	1.70	2.00	2.10	2.10
Discharges (Monthly)	2,377	2,376	2,192	2,185	2,325	2,270	2,262	2,253
Adj Discharges (Case mix adj)	8,489	8,195	7,410	7,778	9,345	8,282	8,582	8,245
Adjusted patient Days (Mo.)	26,544	28,730	25,787	28,053	29,319	28,887	28,288	27,364
Cost/Adj Discharge	\$9.6	\$9.8	\$10.2	\$10.7	\$9.4	\$10.4	\$10.0	\$ 10.0
Compensation Ratio	80%	71%	75%	78%	65%	71%	71%	74%

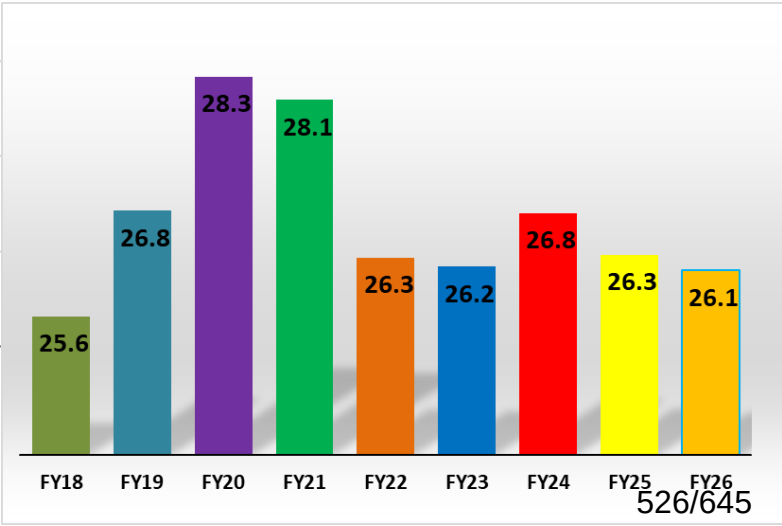
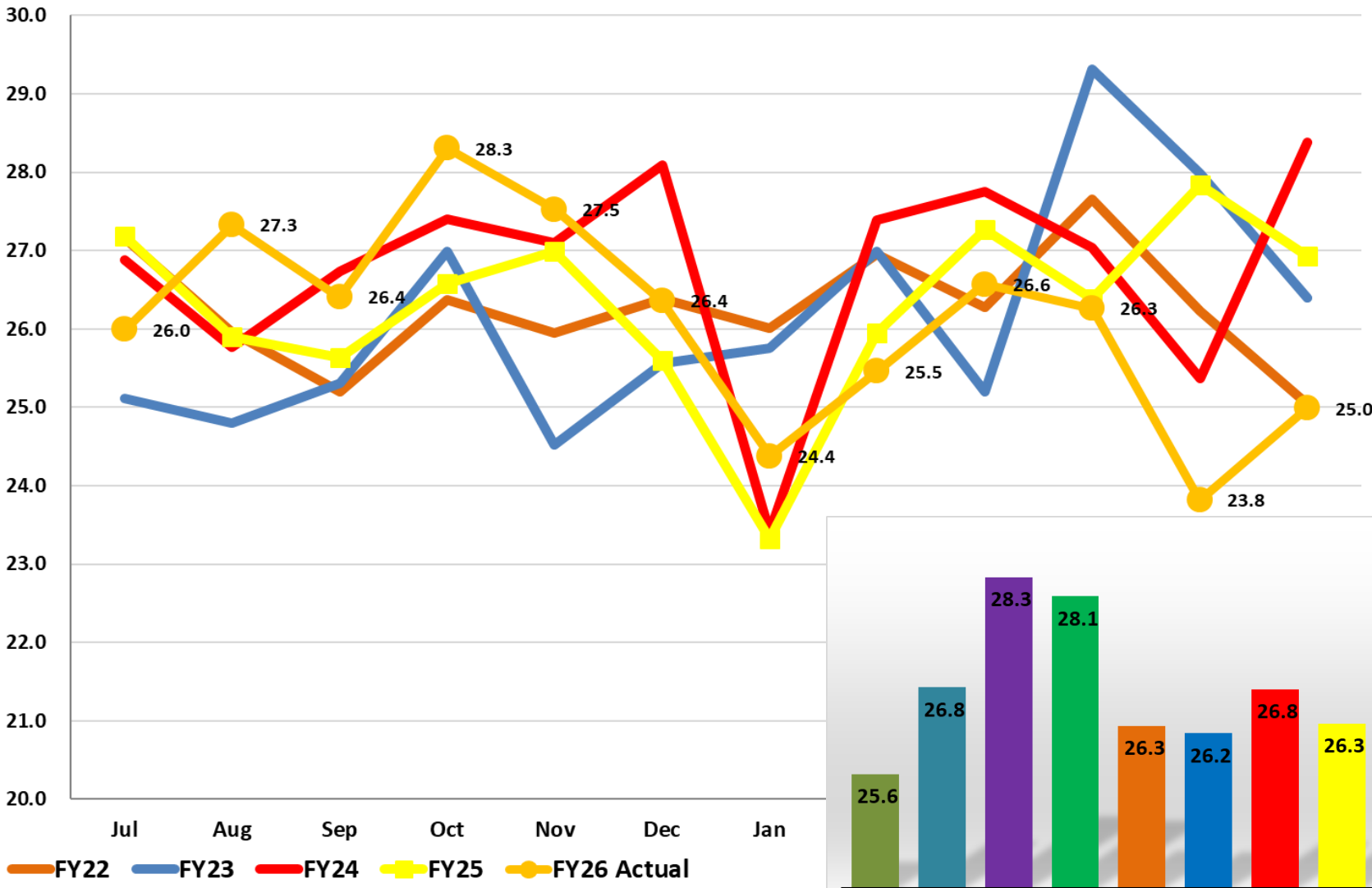
Total FTEs (includes Contract Labor)



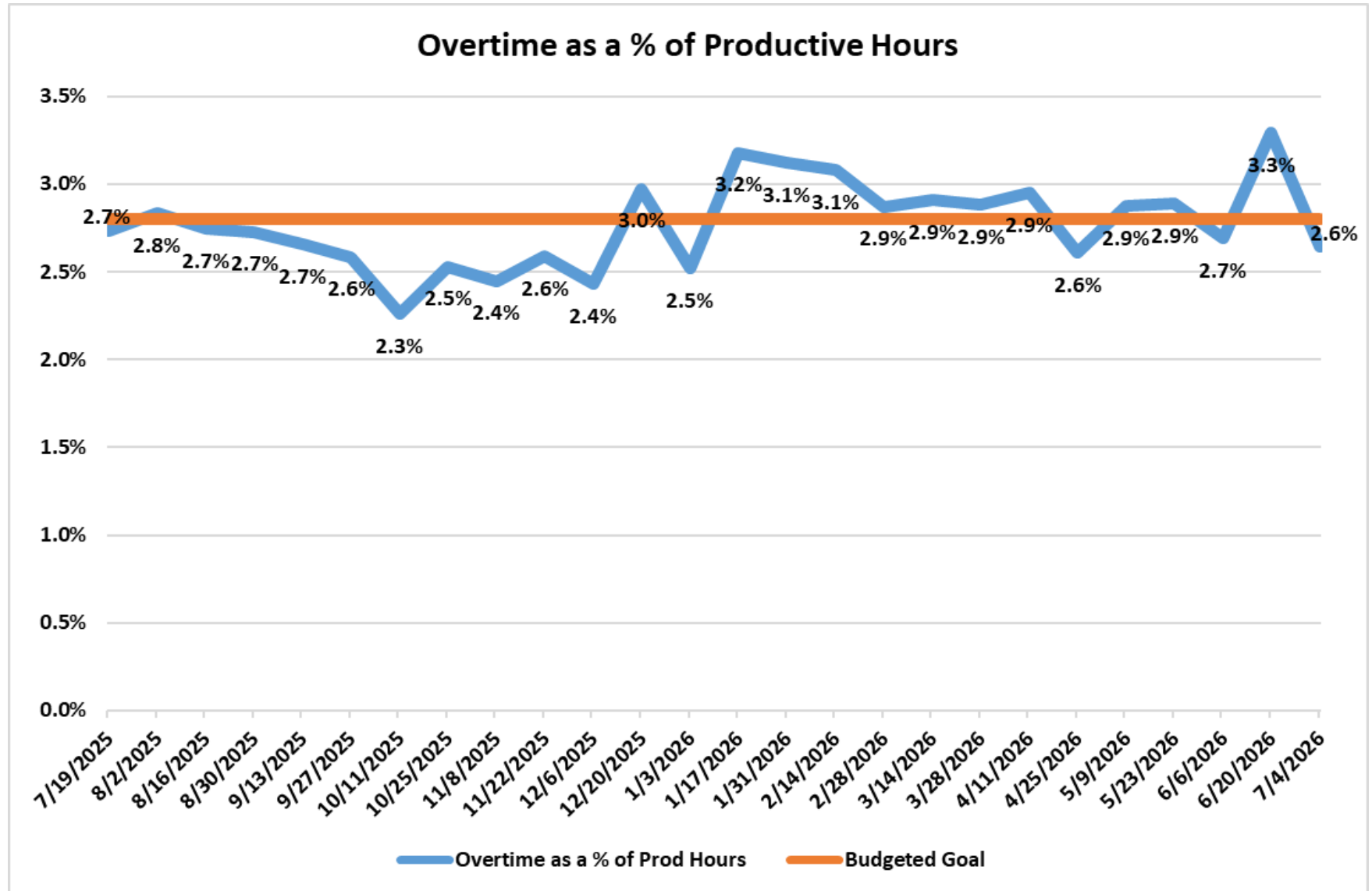
Contract Labor Full Time Equivalents (FTEs)



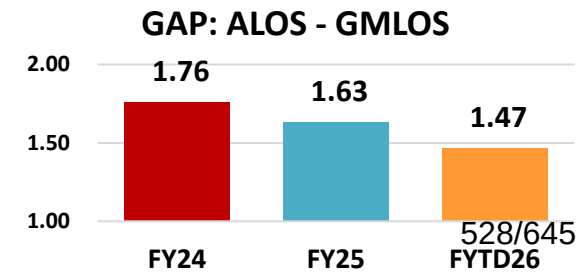
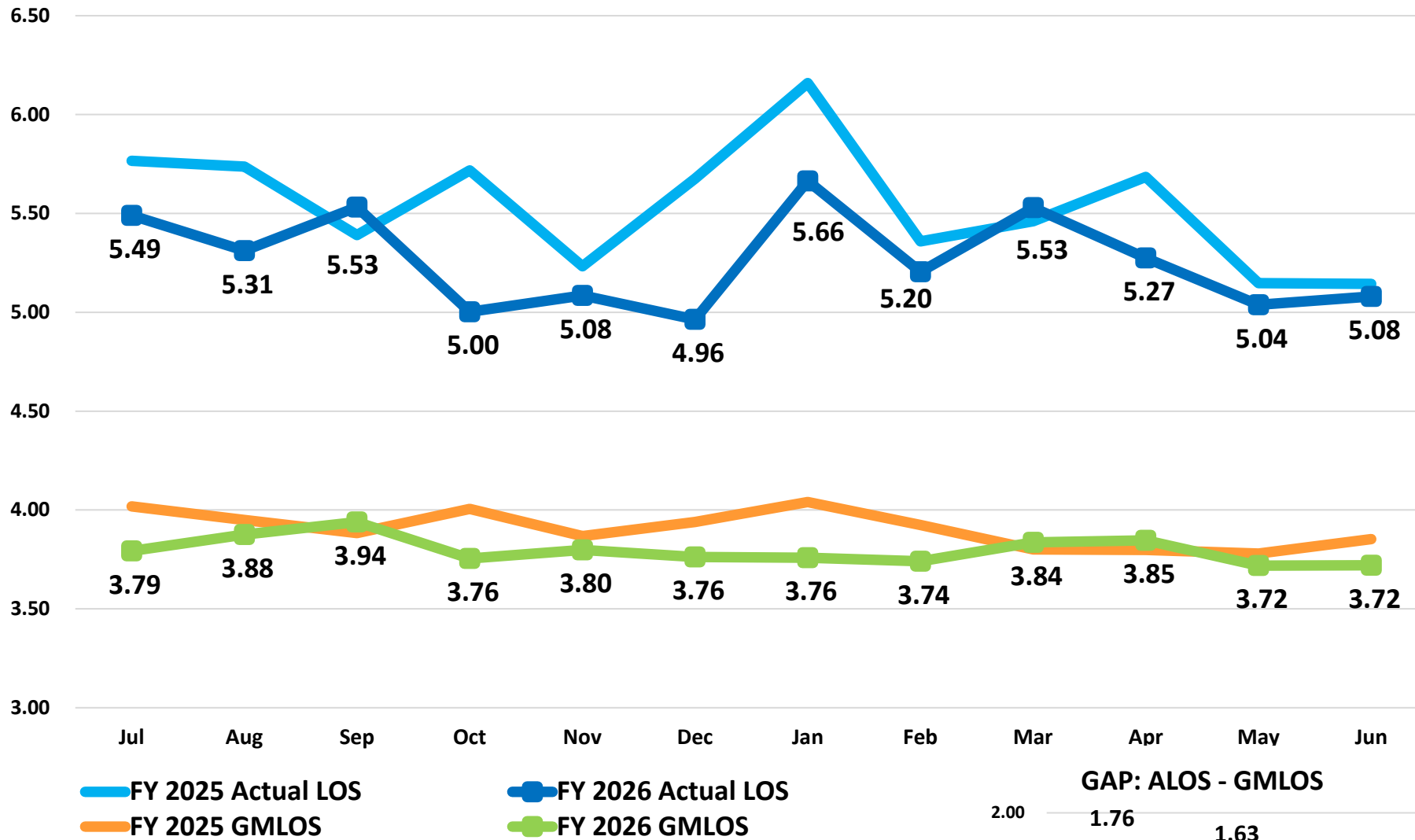
Productivity Measure : Worked Hours/ Adj. Patient Days



Overtime as a % of Productive Hours



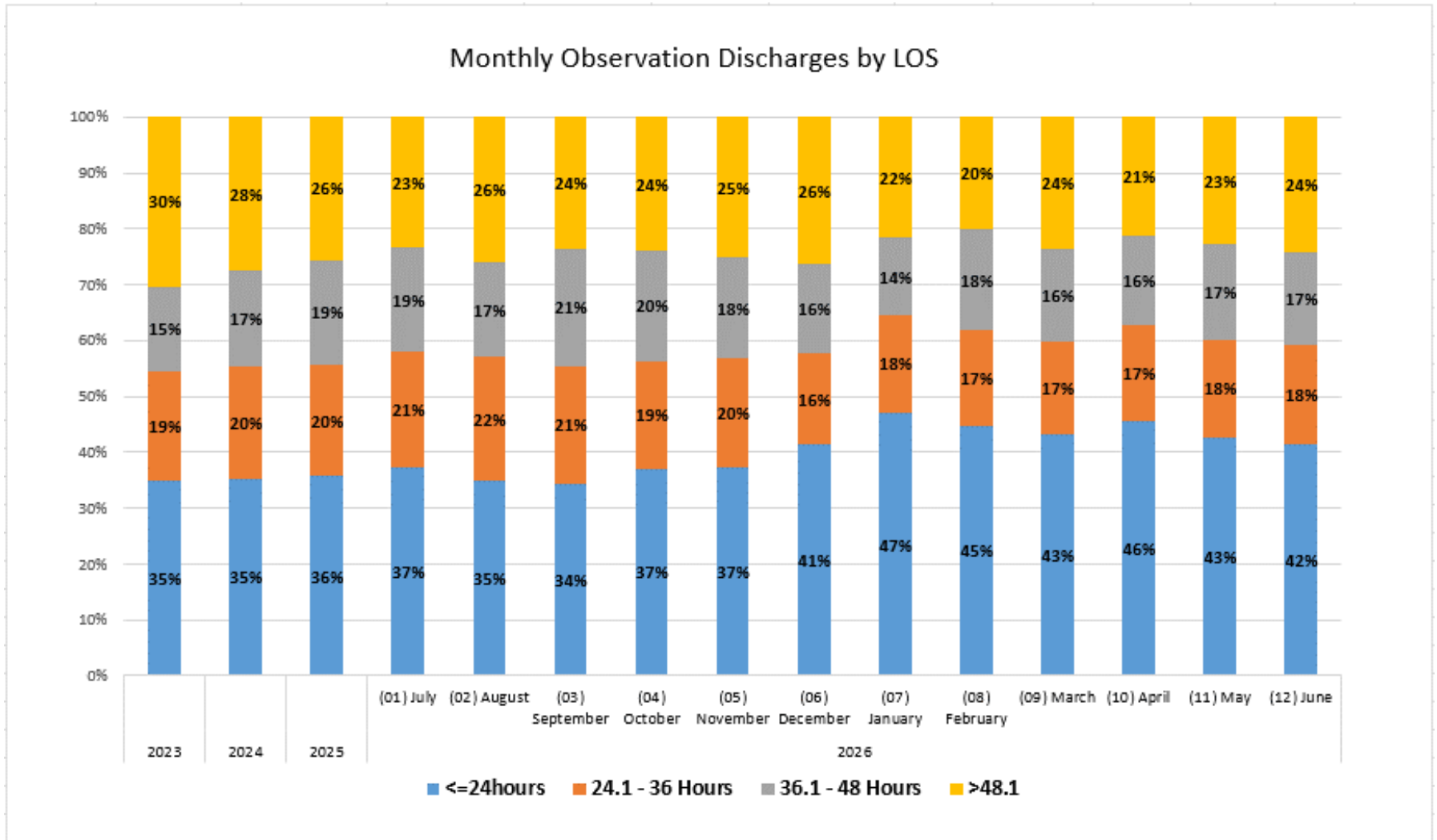
Average Length of Stay versus National Average (GMLOS)



Average Length of Stay versus National Average (GMLOS)

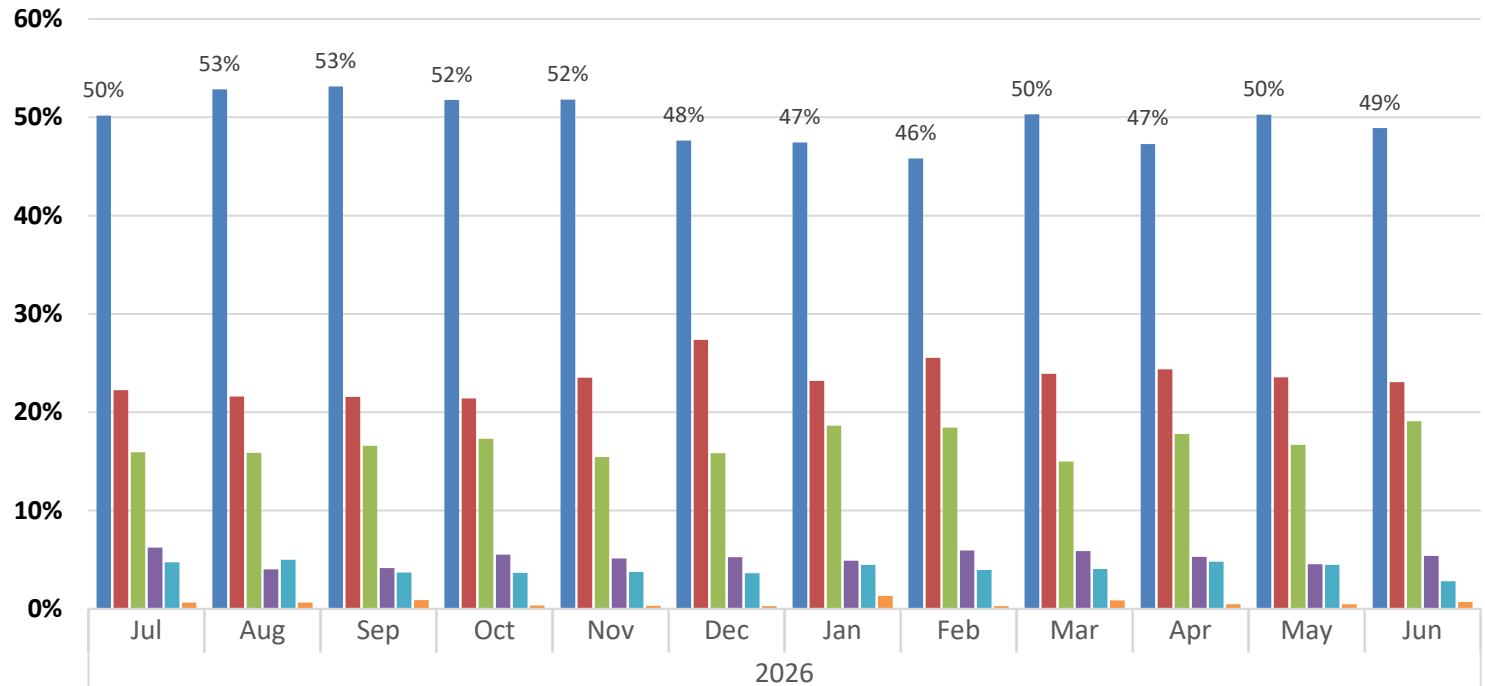
	ALOS	GMLOS	GAP
Jul-24	5.77	4.02	1.75
Aug-24	5.74	3.95	1.79
Sep-24	5.39	3.88	1.51
Oct-24	5.72	4.01	1.71
Nov-24	5.23	3.87	1.36
Dec-24	5.68	3.94	1.74
Jan-25	6.16	4.04	2.12
Feb-25	5.36	3.92	1.43
Mar-25	5.46	3.80	1.66
Apr-25	5.68	3.80	1.89
May-25	5.15	3.78	1.37
Jun-25	5.14	3.85	1.29
Jul-25	5.49	3.79	1.70
Aug-25	5.31	3.88	1.44
Sep-25	5.53	3.94	1.59
Oct-25	5.00	3.76	1.25
Nov-25	5.08	3.80	1.29
Dec-25	4.96	3.76	1.20
Jan-26	5.66	3.76	1.91
Feb-26	5.20	3.74	1.46
Mar-26	5.53	3.84	1.69
Apr-26	5.27	3.85	1.43
May-26	5.04	3.72	1.32
Jun-26	5.08	3.72	1.36

Trended % of Observation by Length of Stay



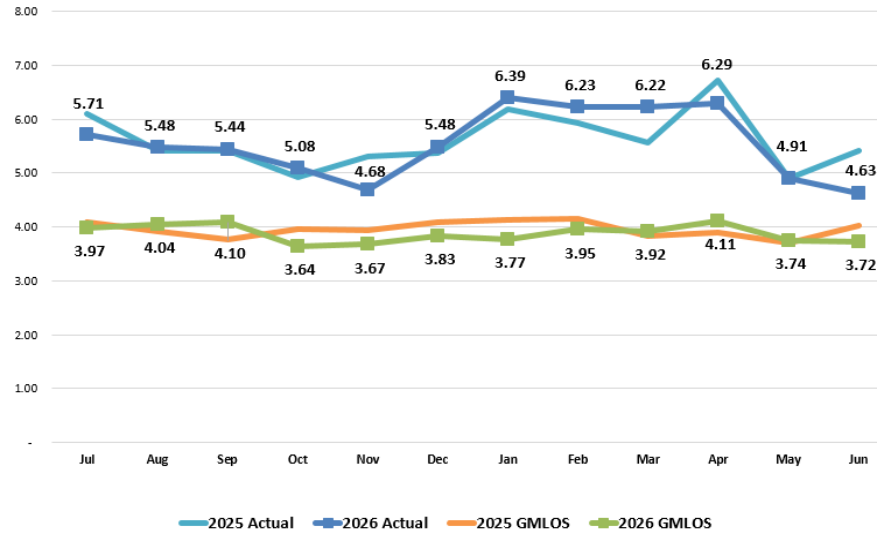
Average Length of Stay Distribution

FY26 Overall LOS Distribution

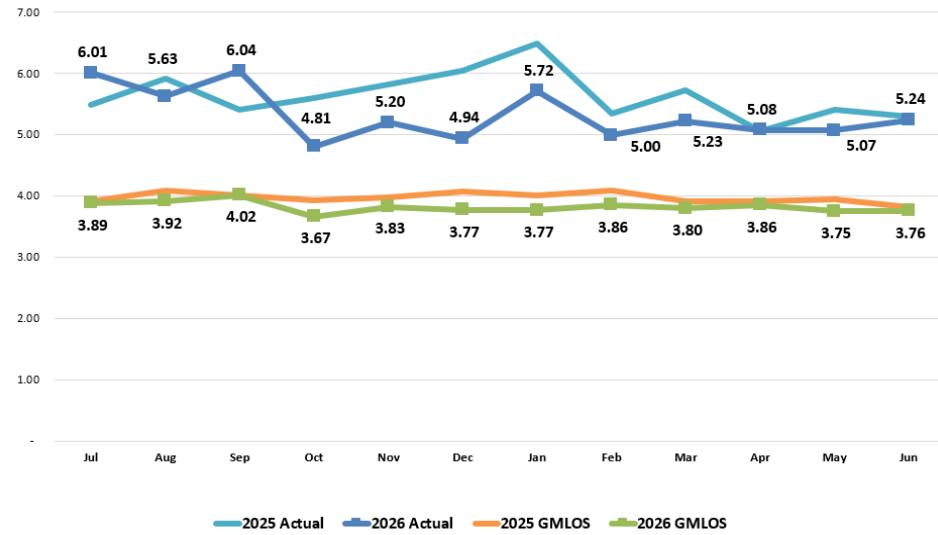


■ at GMLOS or Better	50%	53%	53%	52%	52%	48%	47%	46%	50%	47%	50%	49%
■ 1-2 days over GMLOS	22%	22%	22%	21%	24%	27%	23%	26%	24%	24%	24%	23%
■ 2-6 days over GMLOS	16%	16%	17%	17%	15%	16%	19%	18%	15%	18%	17%	19%
■ 6-10 days over GMLOS	6%	4%	4%	6%	5%	5%	5%	6%	6%	5%	5%	5%
■ 10-30 days over GMLOS	5%	5%	4%	4%	4%	4%	4%	4%	4%	5%	4%	3%
■ 30+ days over GMLOS	0.6%	0.6%	0.9%	0.4%	0.3%	0.3%	1.3%	0.3%	0.9%	0.5%	0.5%	0.7%

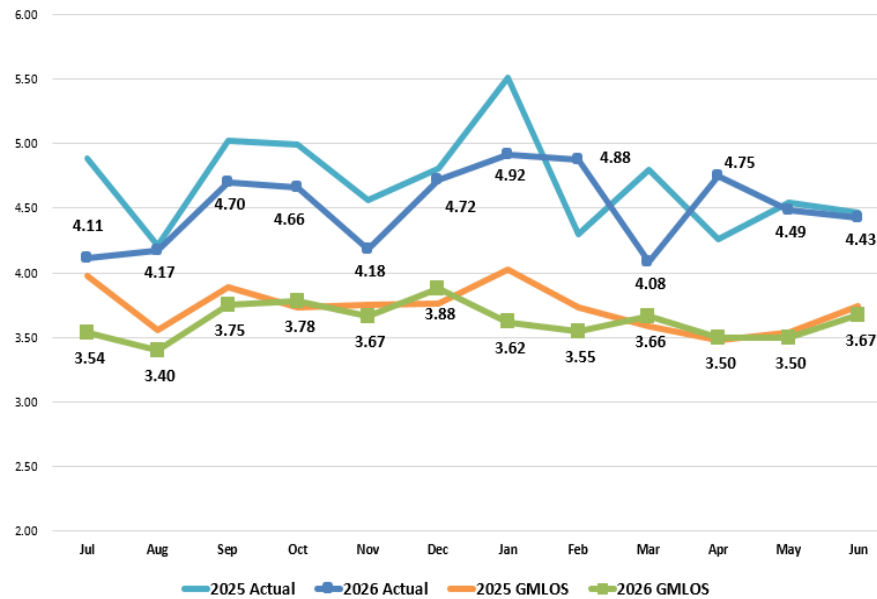
Medicare Managed Average Length of Stay



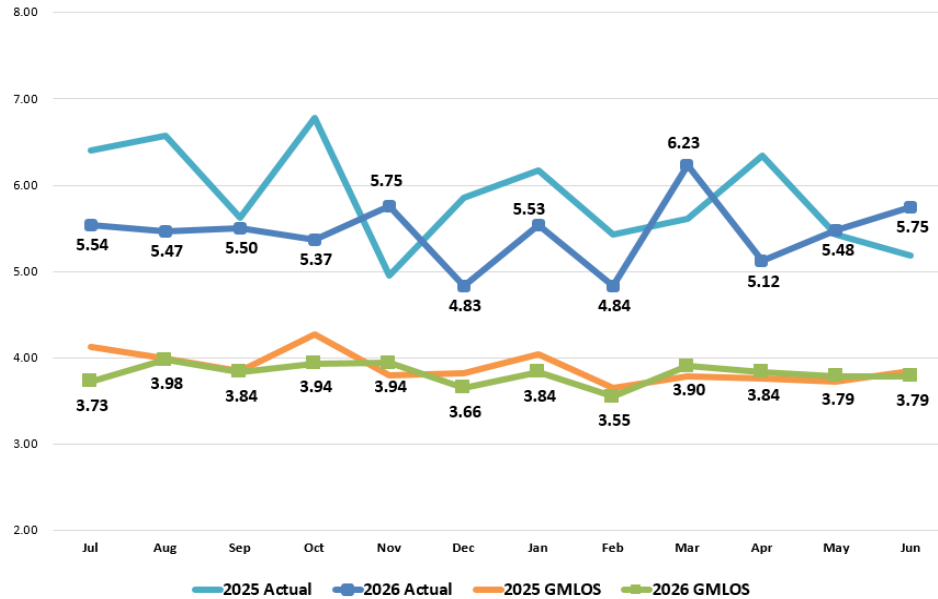
Medicare Average Length of Stay



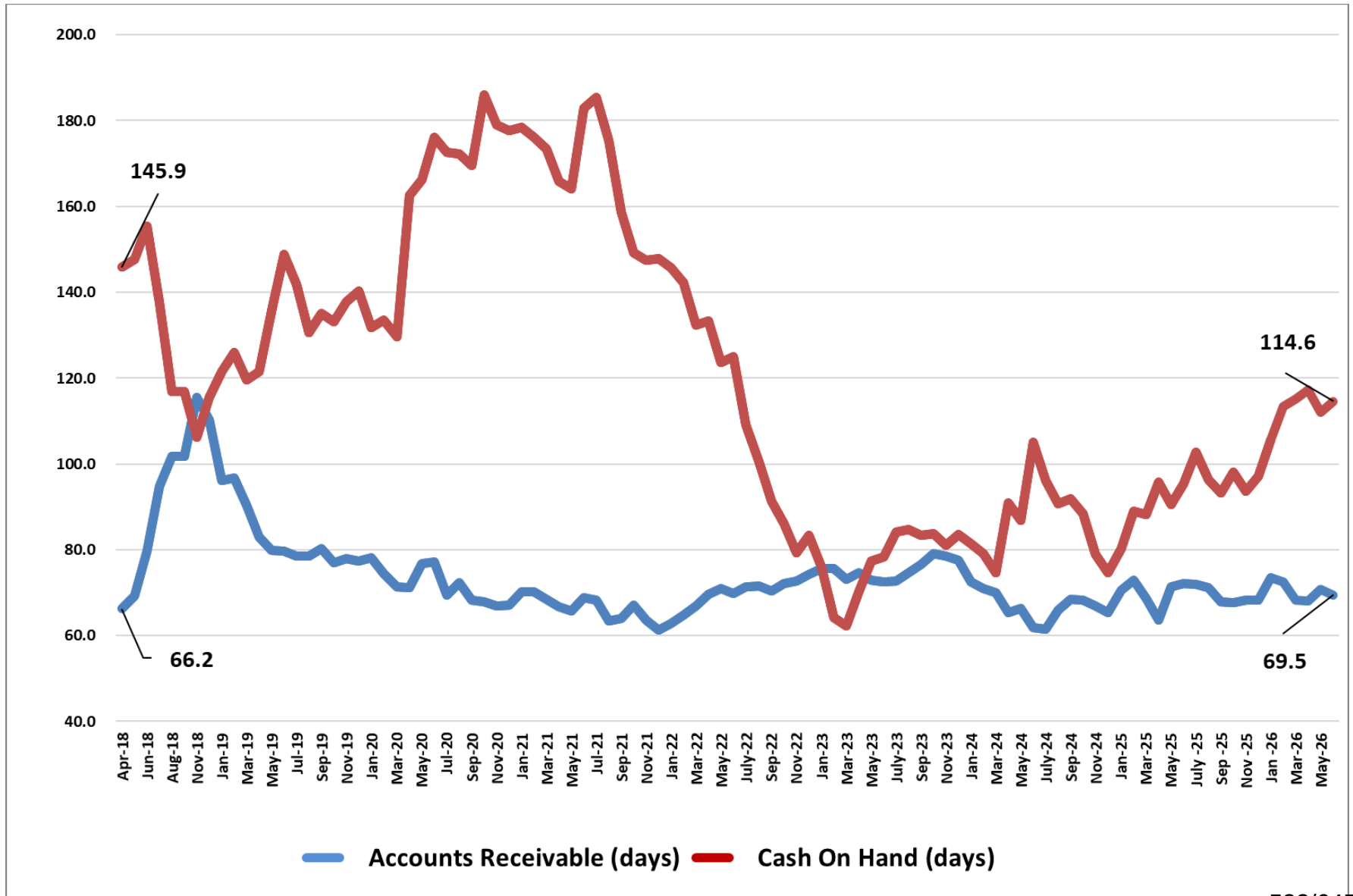
Commercial Average Length of Stay



Medi-Cal and Medi-Cal Mged Average Length of Stay



Trended Liquidity Ratios



Ratio Analysis Report

JUNE 30, 2026

	Current Month Value	Prior Month Value	June 30, 2025 Audited Value	2024 Moody's Median Benchmark		
				Aa	A	Baa
LIQUIDITY RATIOS						
Current Ratio (x)	2.3	2.4	2.5	1.6	1.9	1.7
Accounts Receivable (days)	69.5	70.7	72.1	48.7	46.7	48.6
Cash On Hand (days)	114.6	112.1	95.3	282	194.6	122.9
Cushion Ratio (x)	13.5	13.1	10.9	46.1	26.8	15.5
Average Payment Period (days)	52.1	50.8	55.1	75.8	61.9	62.3
CAPITAL STRUCTURE RATIOS						
Cash-to-Debt	150.5%	139.7%	114.9%	297.1%	188.1%	111.0%
Debt-To-Capitalization	29.4%	30.9%	31.3%	20.8%	28.7%	35.5%
Debt-to-Cash Flow (x)	3.6	4.0	2.8	2.2	3.1	5.0
Debt Service Coverage	2.6	2.5	3.8	7.9	5.3	3.3
Maximum Annual Debt Service Coverage (x)	2.1	2.0	3.0	7.2	4.8	2.7
Age Of Plant (years)	14.0	14.0	13.6	11.1	13.3	14.8
PROFITABILITY RATIOS						
Operating Margin	(.6%)	(.7%)	(4.2%)	2.9%	1.6%	(.5%)
Excess Margin	0.9%	0.7%	2.9%	6.7%	4.3%	1.3%
Operating Cash Flow Margin	4.2%	4.2%	1.0%	7.9%	6.6%	4.2%
Return on Assets	1.0%	0.8%	3.1%	4.5%	3.8%	1.7%

Consolidated Statements of Net Position (000's)

	Jun-26	Jun-25
	(Audited)	
ASSETS AND DEFERRED OUTFLOWS		
CURRENT ASSETS		
Cash and cash equivalents	\$ 13,819	\$ 6,595
Current Portion of Board designated and trusted assets	16,043	17,533
Accounts receivable:		-
Net patient accounts	167,205	154,634
Other receivables	22,312	70,335
	189,517	224,969
Inventories	13,508	13,871
Medicare and Medi-Cal settlements	68,662	62,463
Prepaid expenses	9,124	8,234
Total current assets	310,674	333,666
NON-CURRENT CASH AND INVESTMENTS -		
less current portion		
Board designated cash and assets	274,306	218,025
Revenue bond assets held in trust	-	22,950
Assets in self-insurance trust fund	275	626
Total non-current cash and investments	274,581	241,602
INTANGIBLE RIGHT TO USE LEASE,	18,175	15,613
net of accumulated amortization		
INTANGIBLE RIGHT TO USE SBITA,	10,459	8,062
net of accumulated amortization		
CAPITAL ASSETS		
Land	20,544	17,542
Buildings and improvements	447,823	437,184
Equipment	348,824	340,593
Construction in progress	16,481	18,729
	833,672	814,048
Less accumulated depreciation	564,737	541,607
	268,935	272,441
OTHER ASSETS		
Property not used in operations	2,113	5,155
Health-related investments	1,778	2,147
Other	22,251	20,922
Total other assets	26,142	28,224
Total assets	908,966	899,608
DEFERRED OUTFLOWS	11,819	13,133
Total assets and deferred outflows	\$ 920,786	\$ 912,741

Consolidated Statements of Net Position (000's)

	Jun-26	Jun-25
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accounts payable and accrued expenses	\$ 33,916	\$ 43,963
Accrued payroll and related liabilities	74,089	71,620
SBITA liability, current portion	3,314	3,031
Lease liability, current portion	3,954	3,204
Bonds payable, current portion	15,293	13,014
Notes payable, current portion	3,843	-
Financing Lease Liability, current portion	499	-
Total current liabilities	134,908	134,831
LEASE LIABILITY, net of current portion	14,921	12,850
SBITA LIABILITY, net of current portion	4,821	3,941
LONG-TERM DEBT, less current portion		
Financing Lease payable	2,614	-
Notes payable	16,907	20,750
Total long-term debt	207,606	222,369
NET PENSION LIABILITY	19,224	16,169
OTHER LONG-TERM LIABILITIES	55,624	50,472
Total liabilities	437,105	440,632
NET ASSETS		
Invested in capital assets, net of related debt	53,863	60,147
Restricted	41,002	58,980
Unrestricted	388,815	352,983
Total net position	483,681	472,110
Total liabilities and net position	<u>\$ 920,786</u>	<u>\$ 912,741</u>



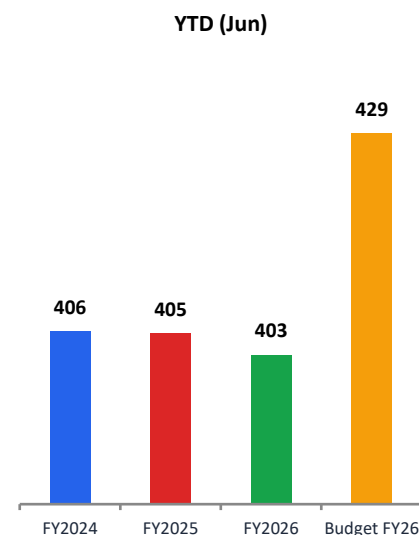
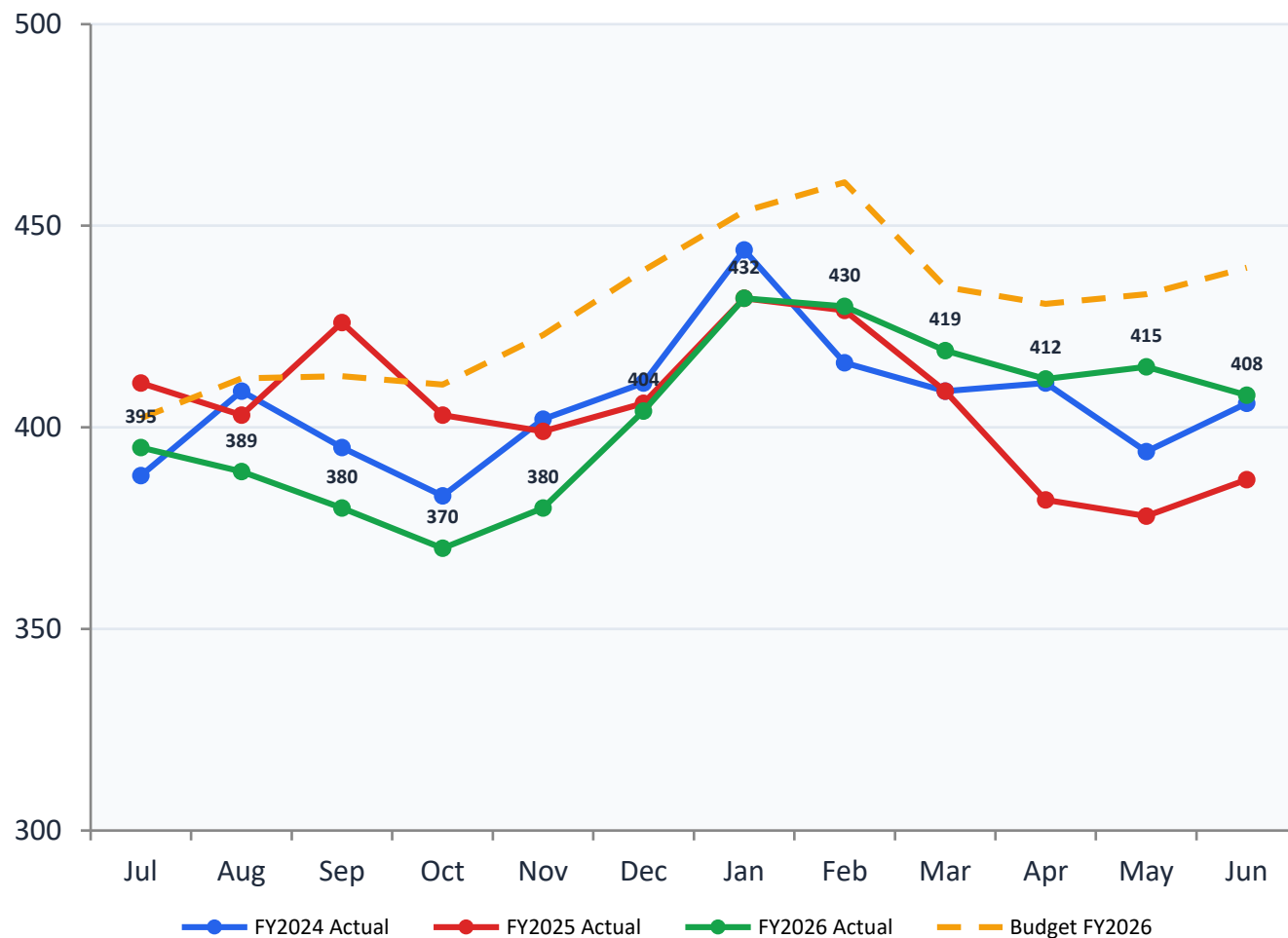
Monthly Statistics Report

FY2024 – June FY2026 Actuals | Budget FY2026

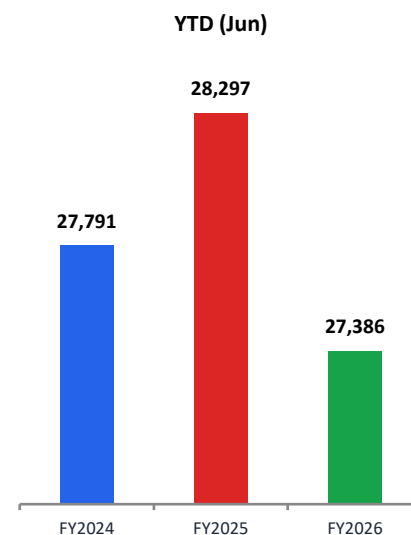
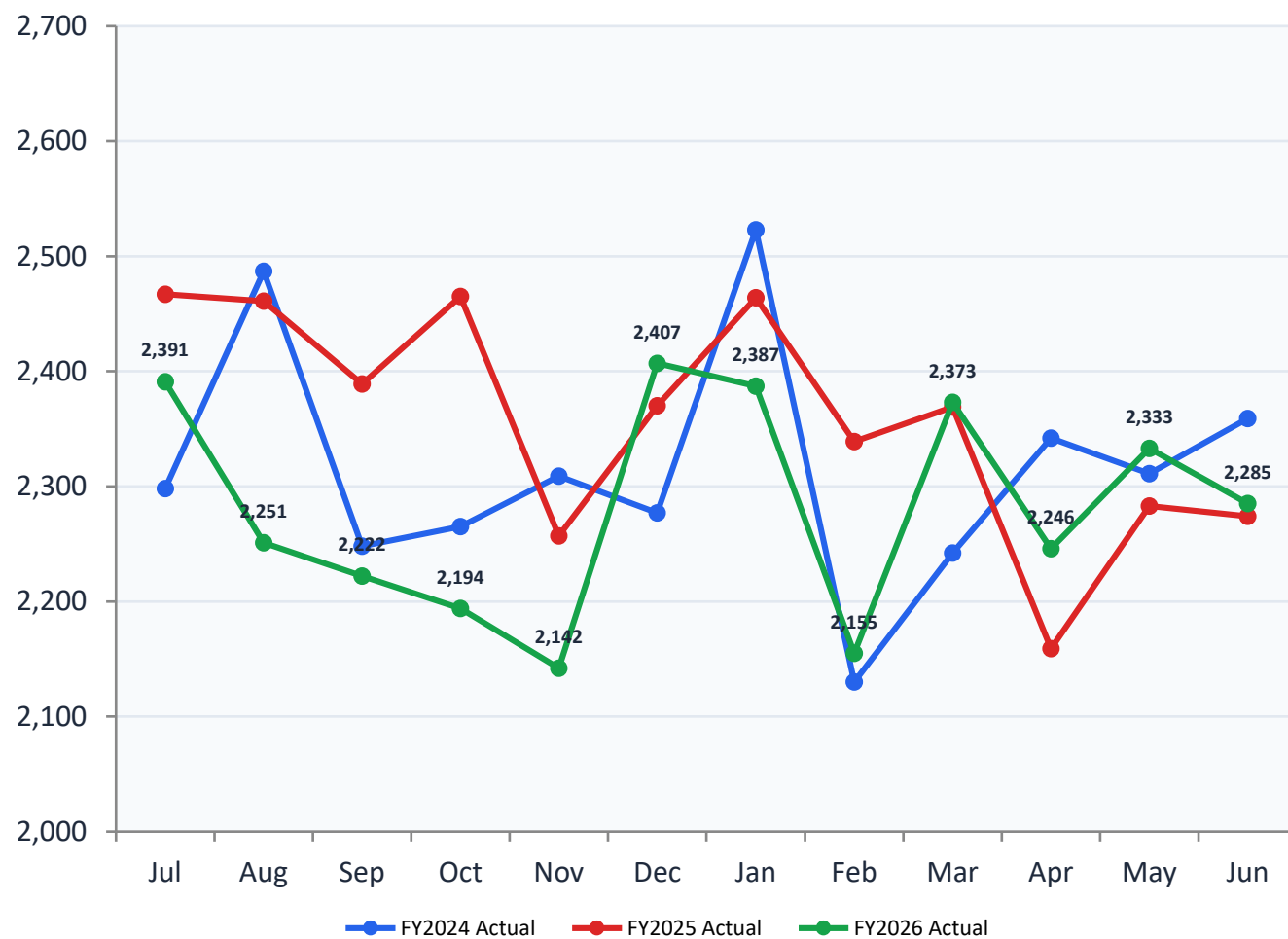
Kaweah Health

June 2026

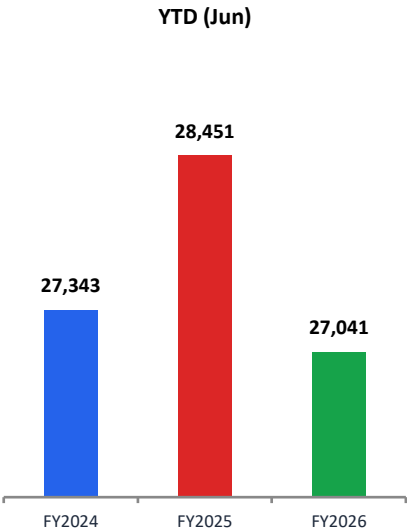
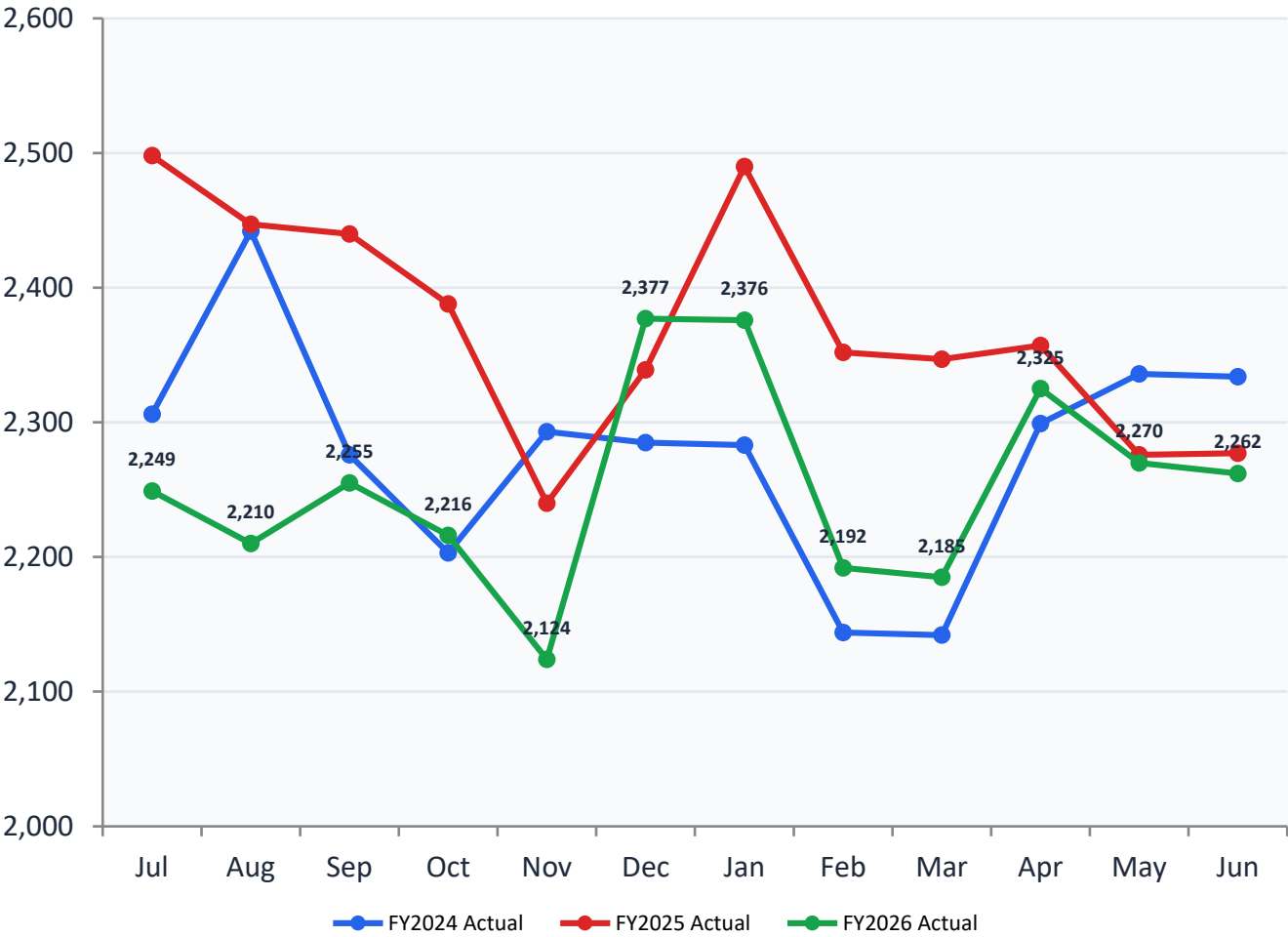
Average Daily Census



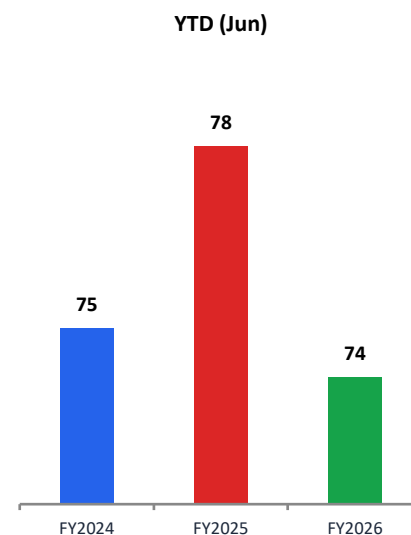
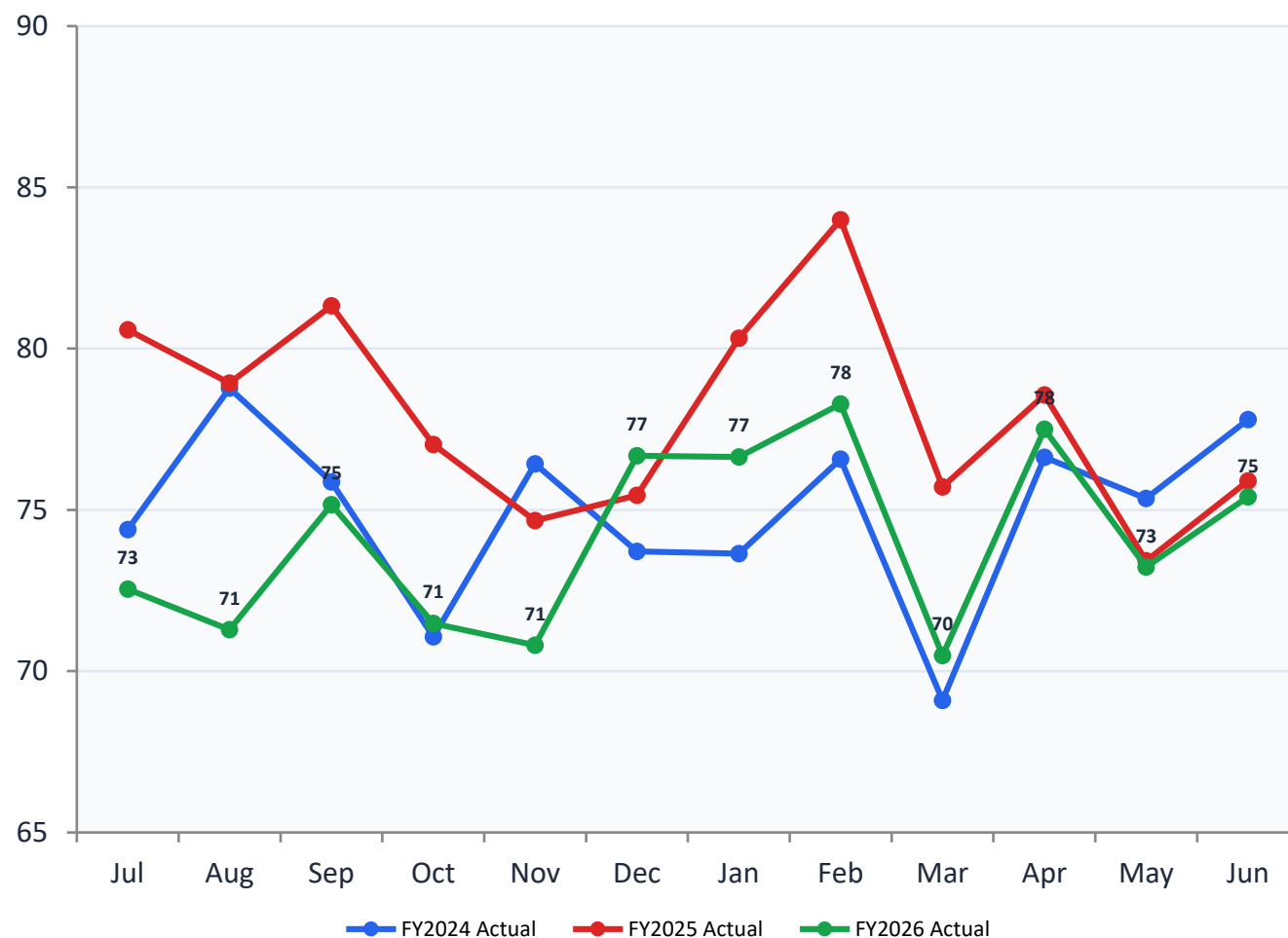
Admissions



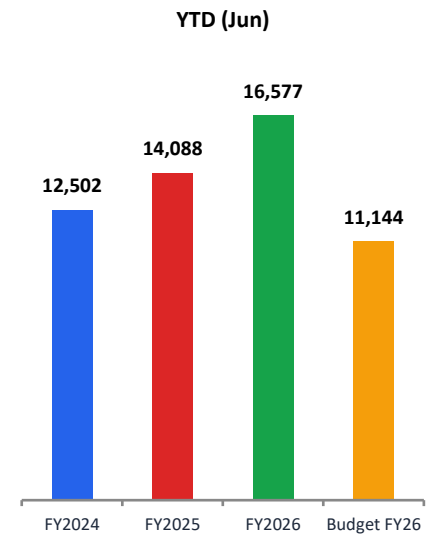
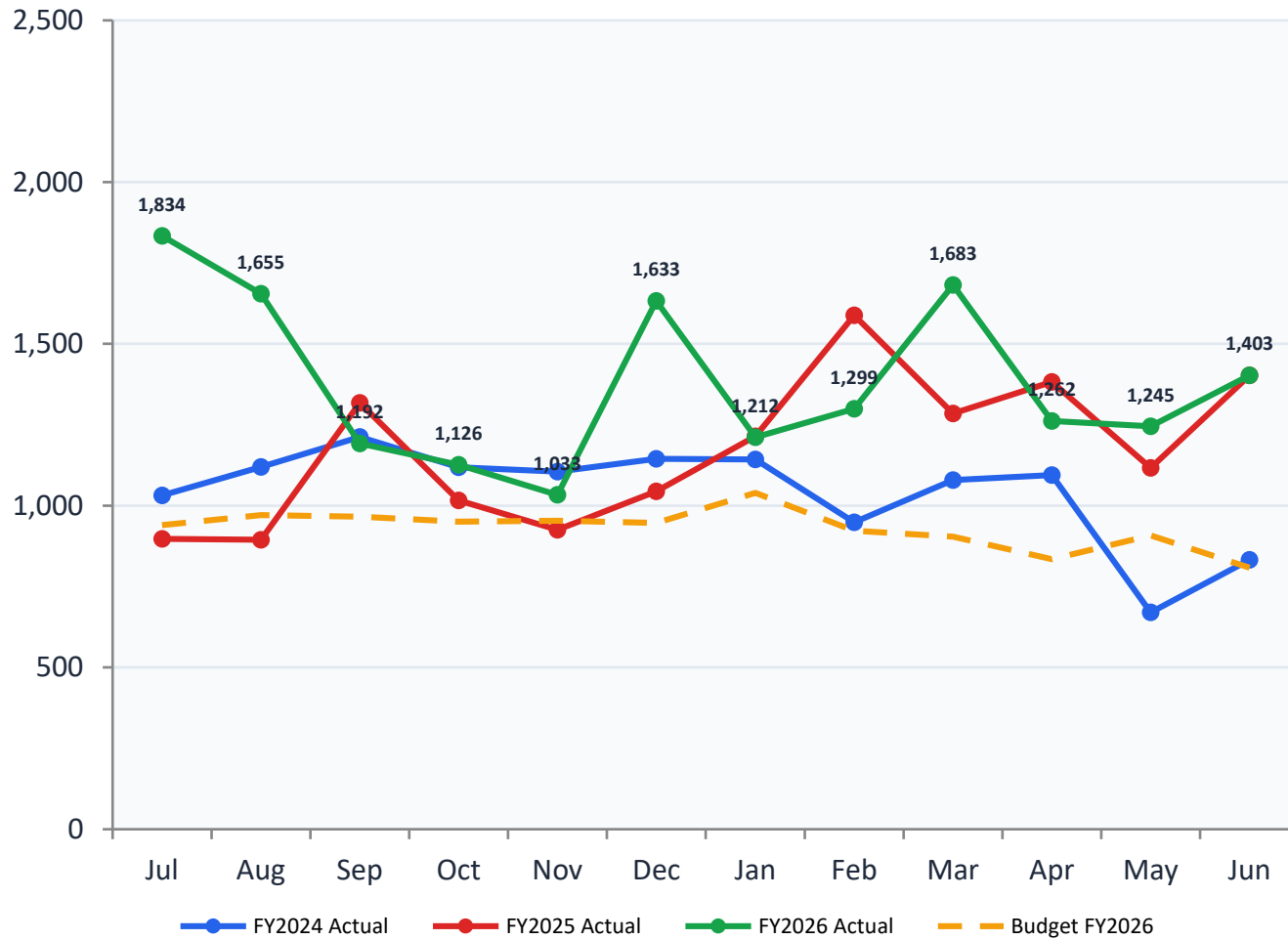
Discharges



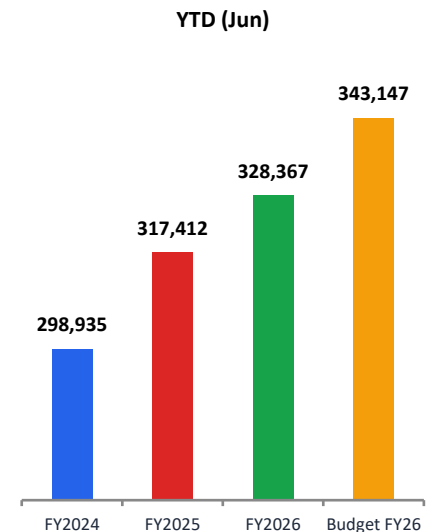
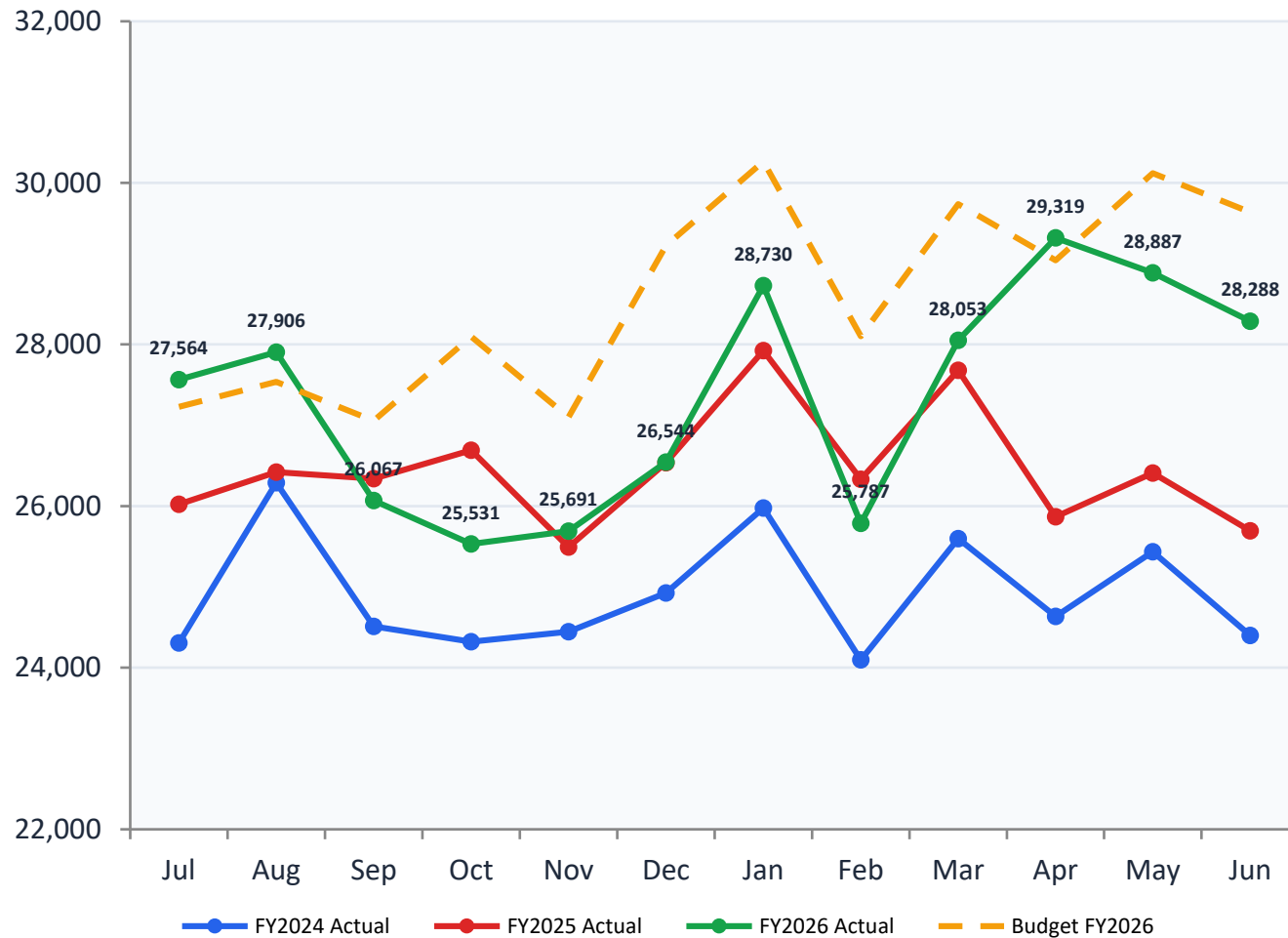
Avg Discharges per day



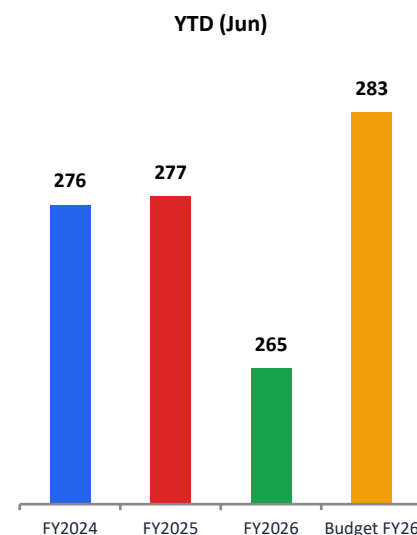
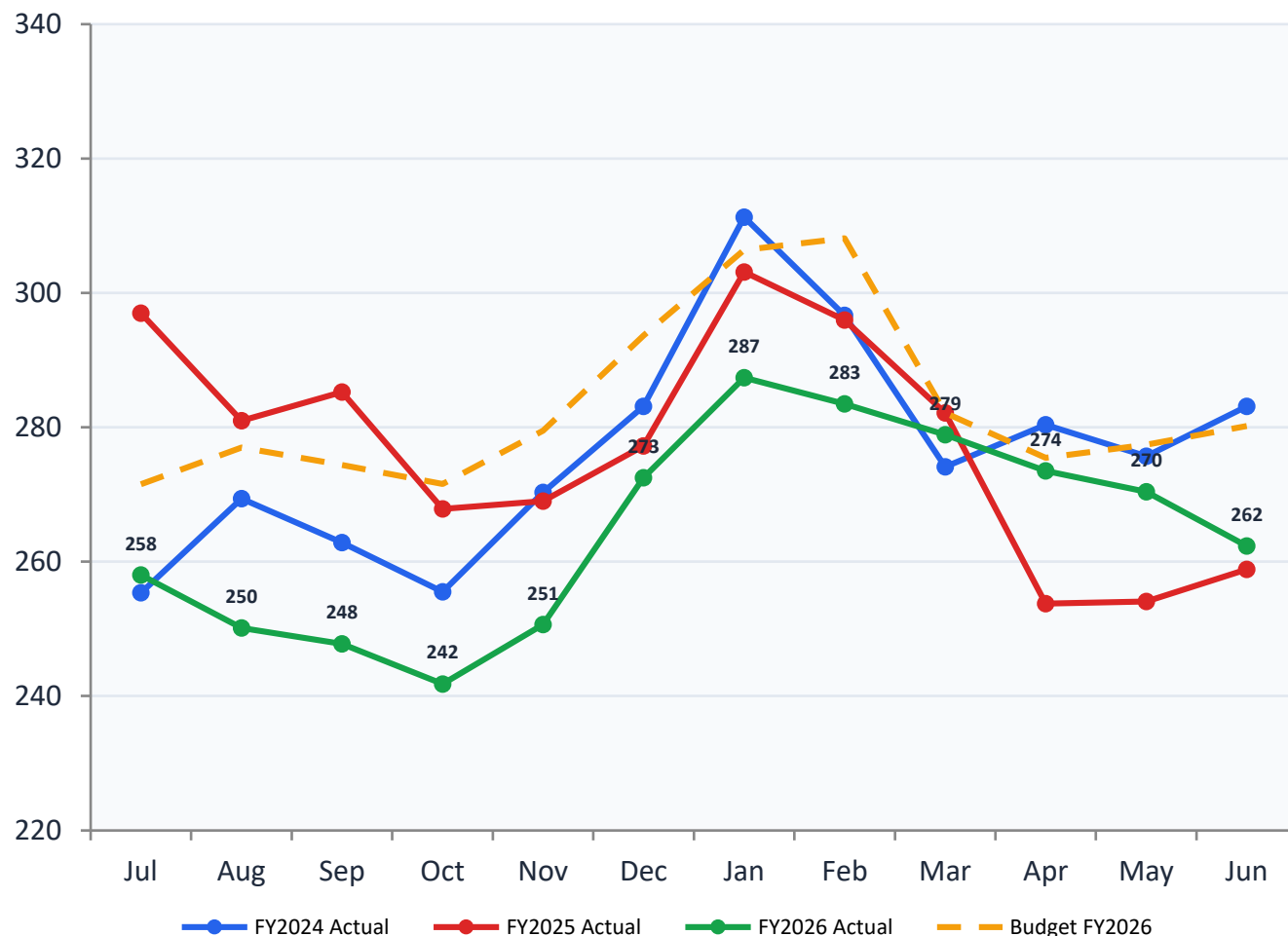
Observation Days



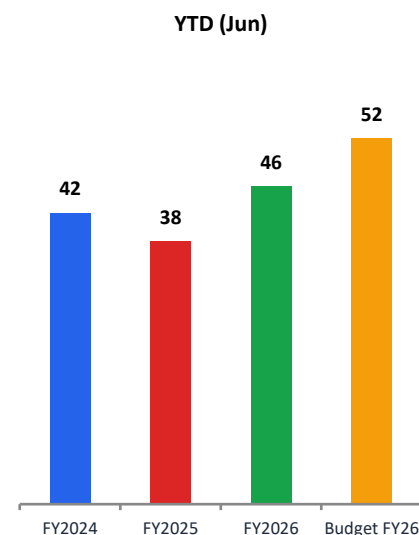
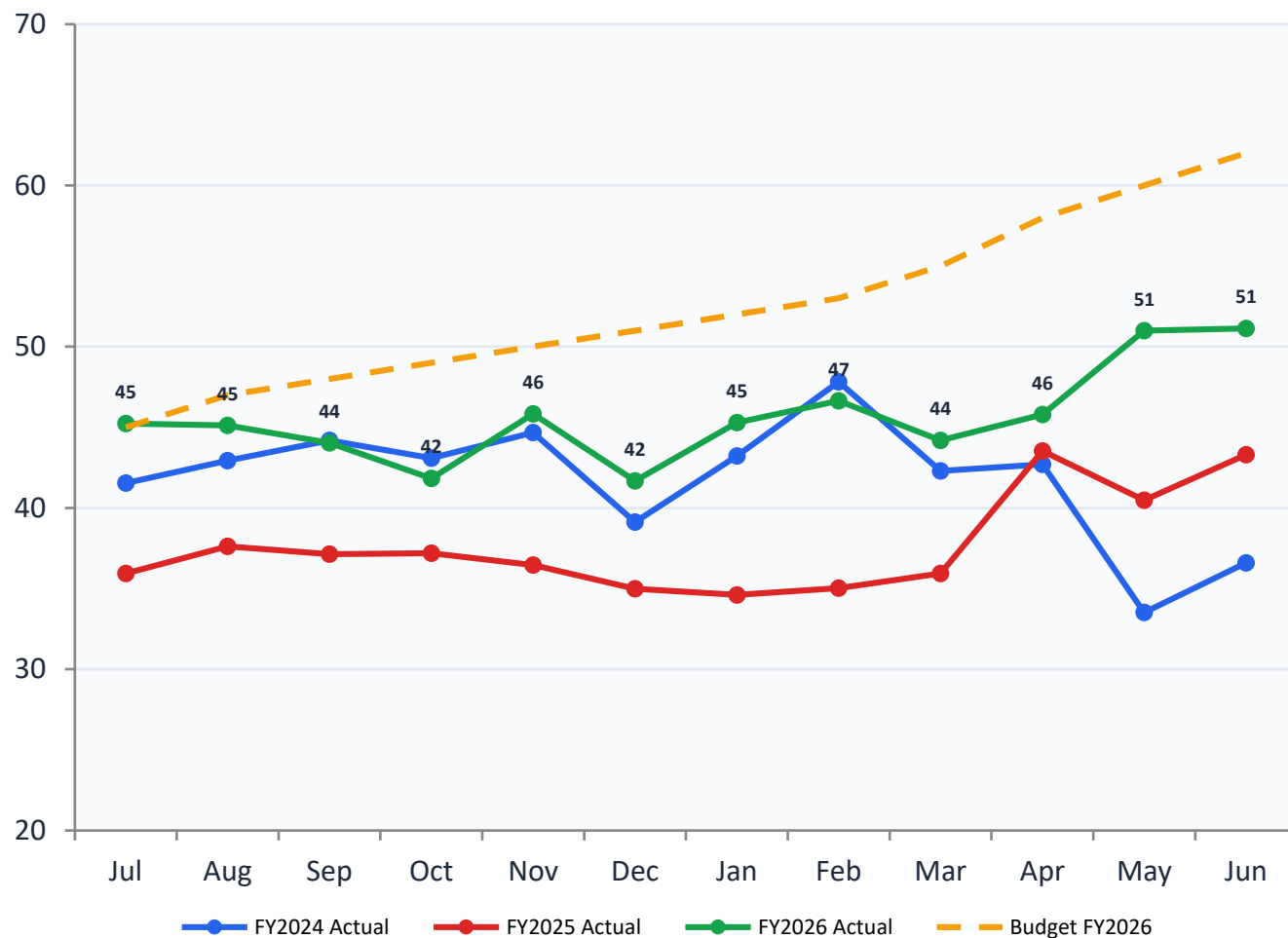
Adjusted Patient Days



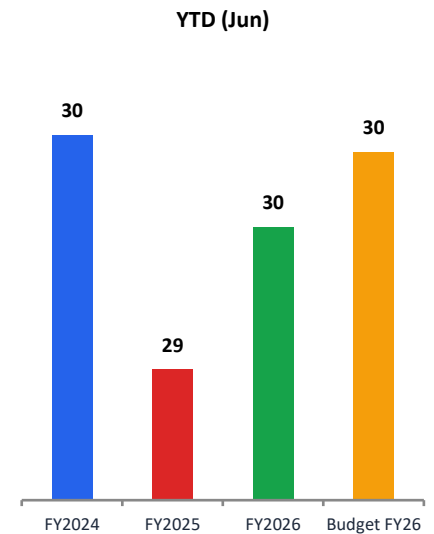
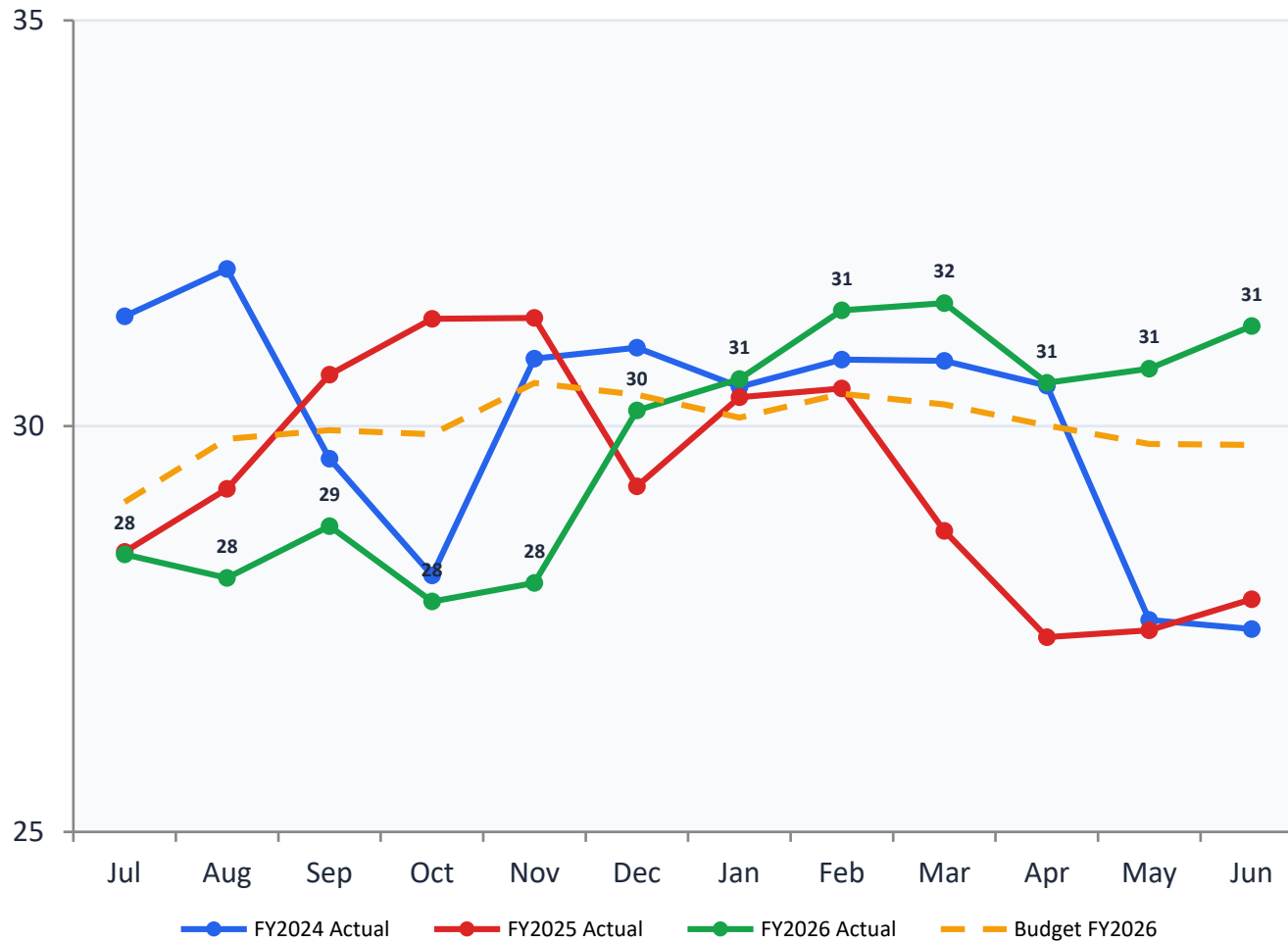
Medical Center (Avg Patients Per Day)



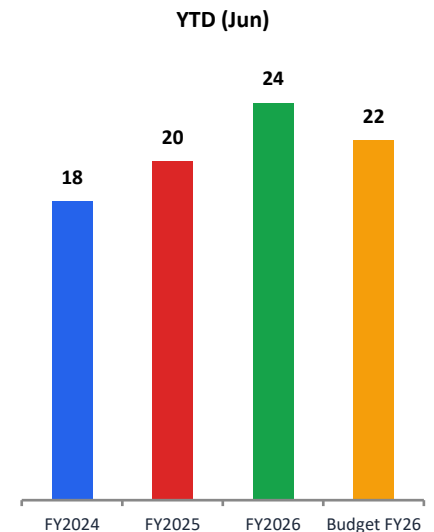
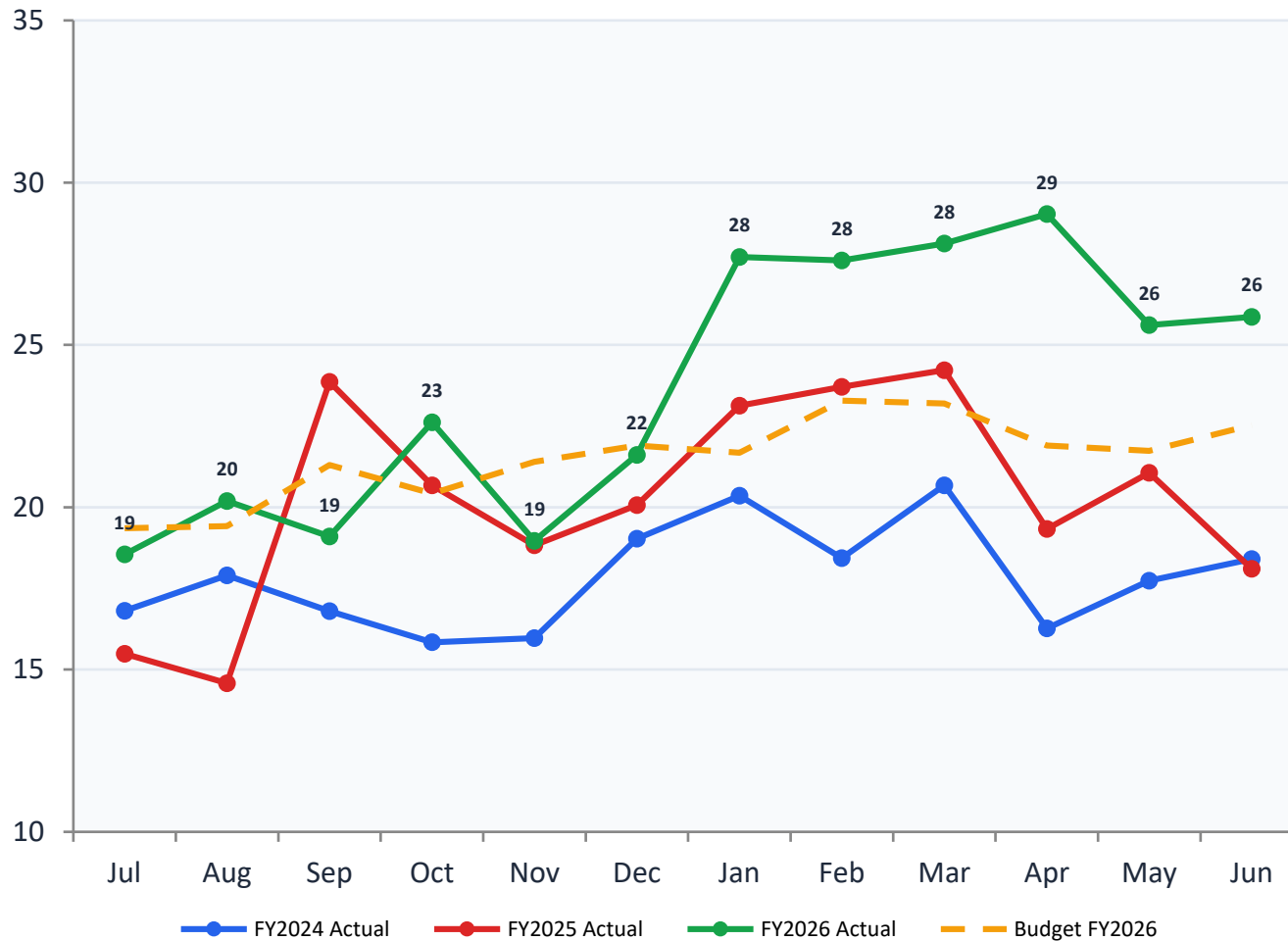
Acute I/P Psych (Avg Patients Per Day)



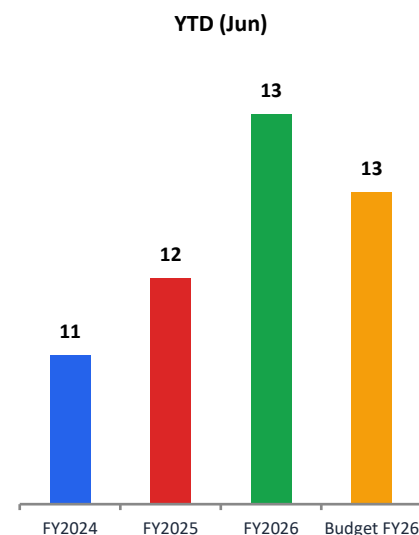
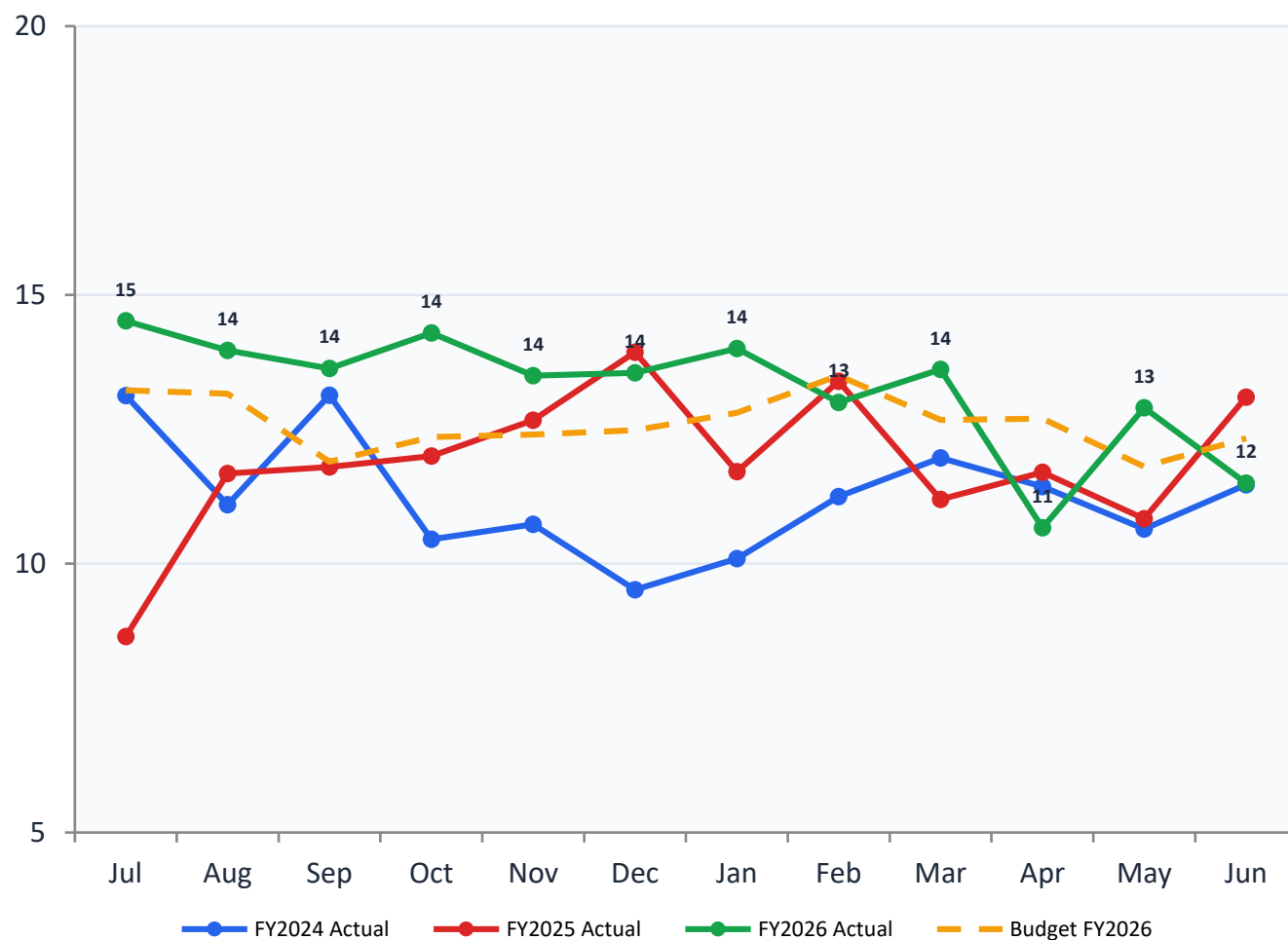
Sub-Acute - Avg Patients Per Day



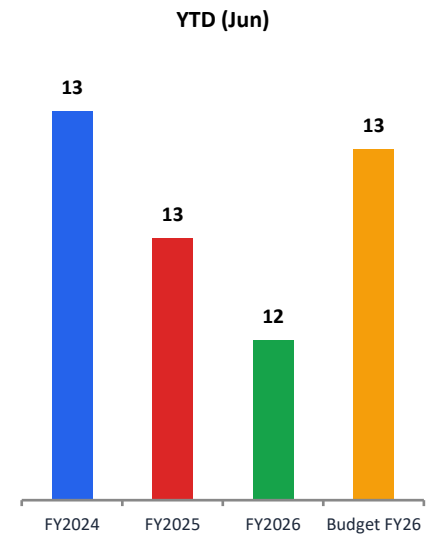
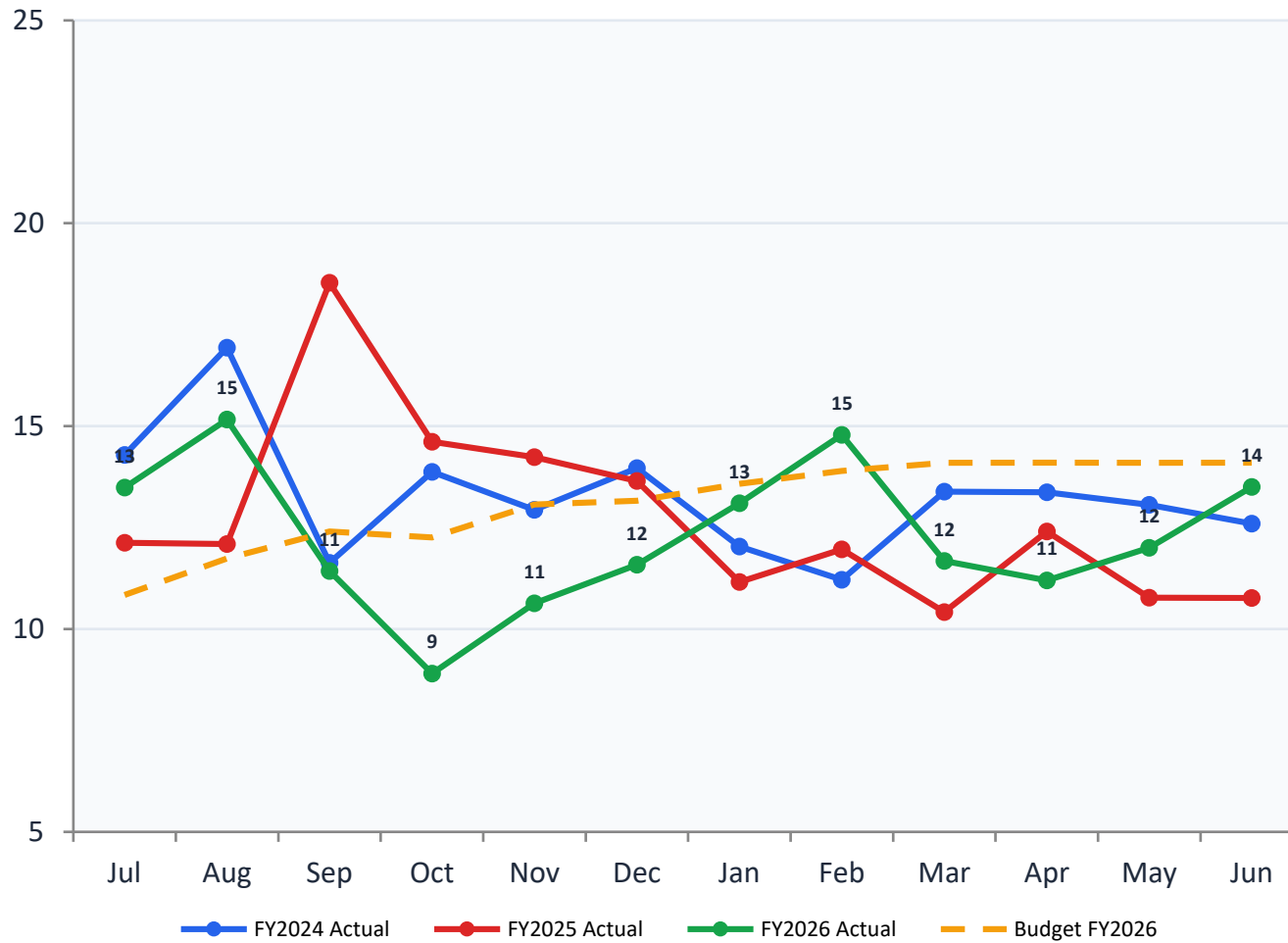
Rehabilitation Hospital - Avg Patients Per Day



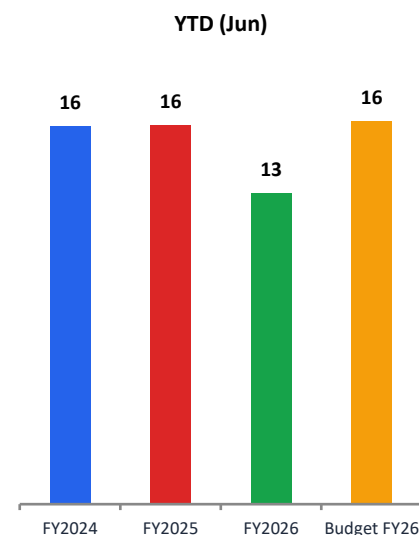
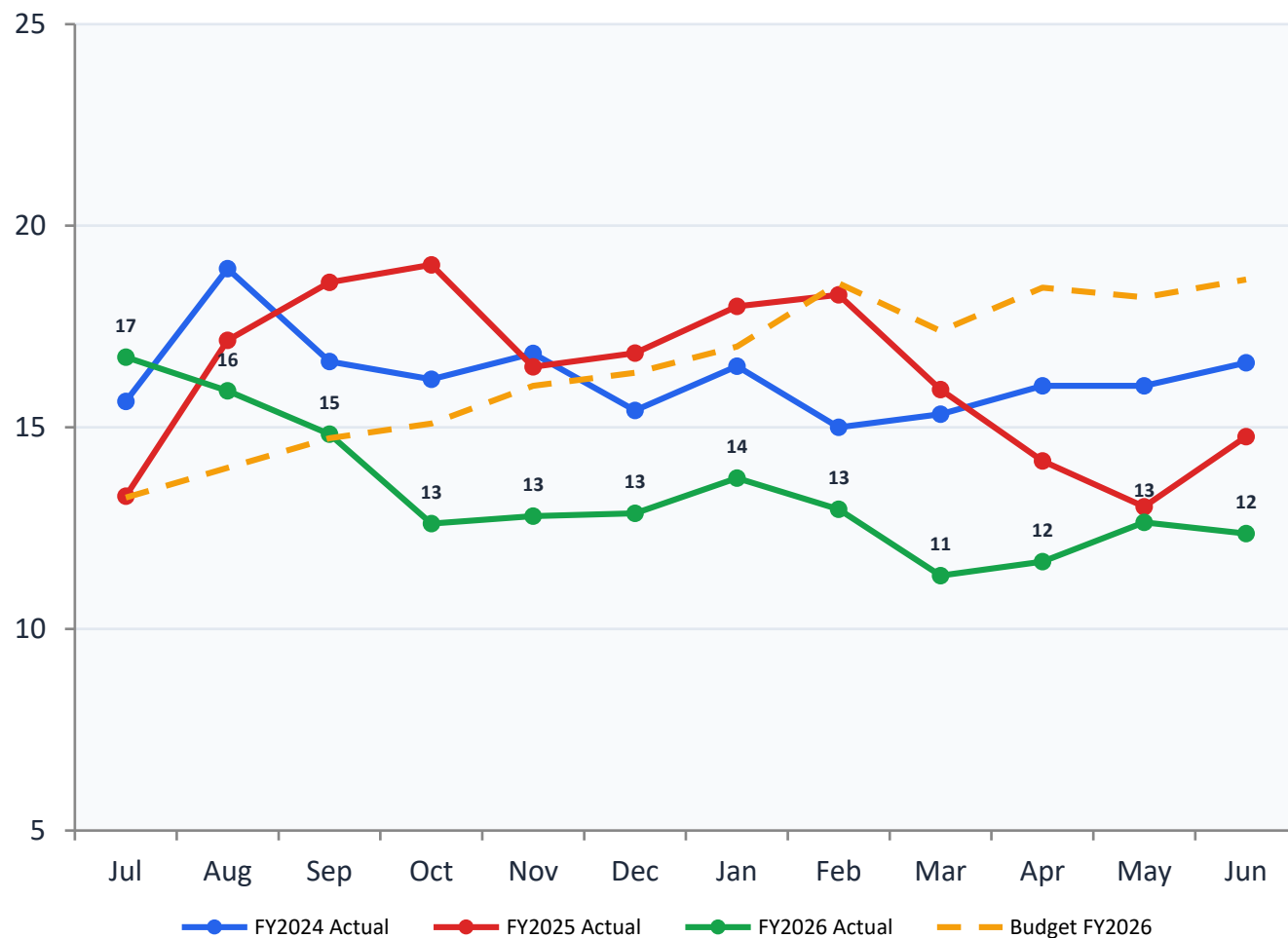
TCS Ortho - Avg Patients Per Day



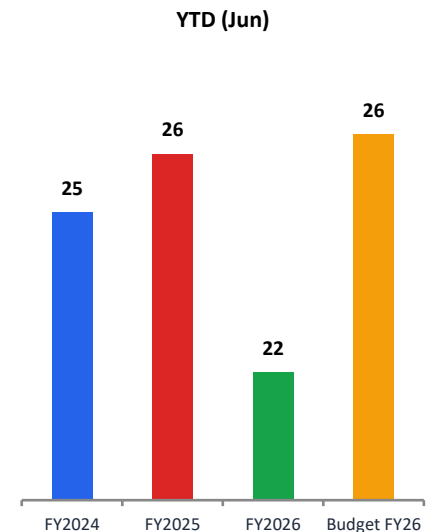
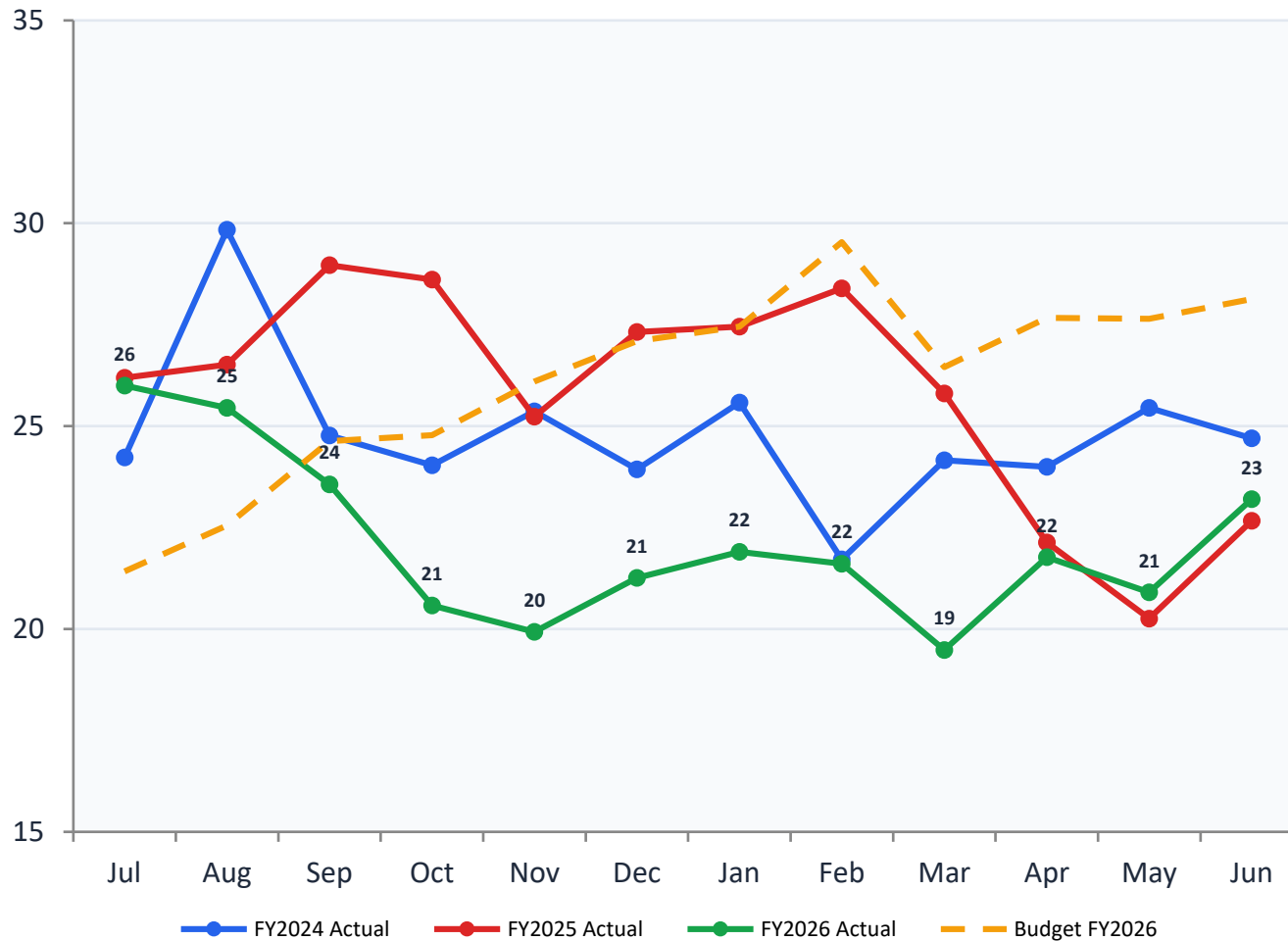
NICU - Avg Patients Per Day



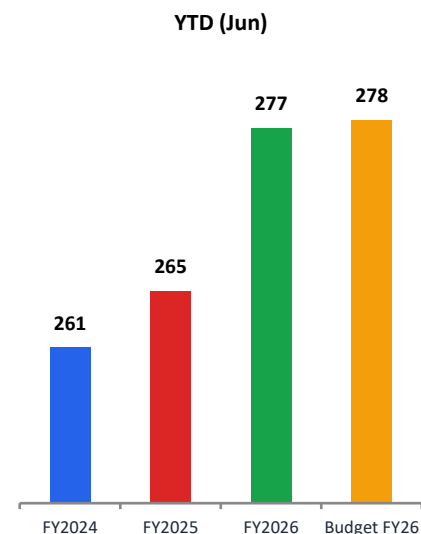
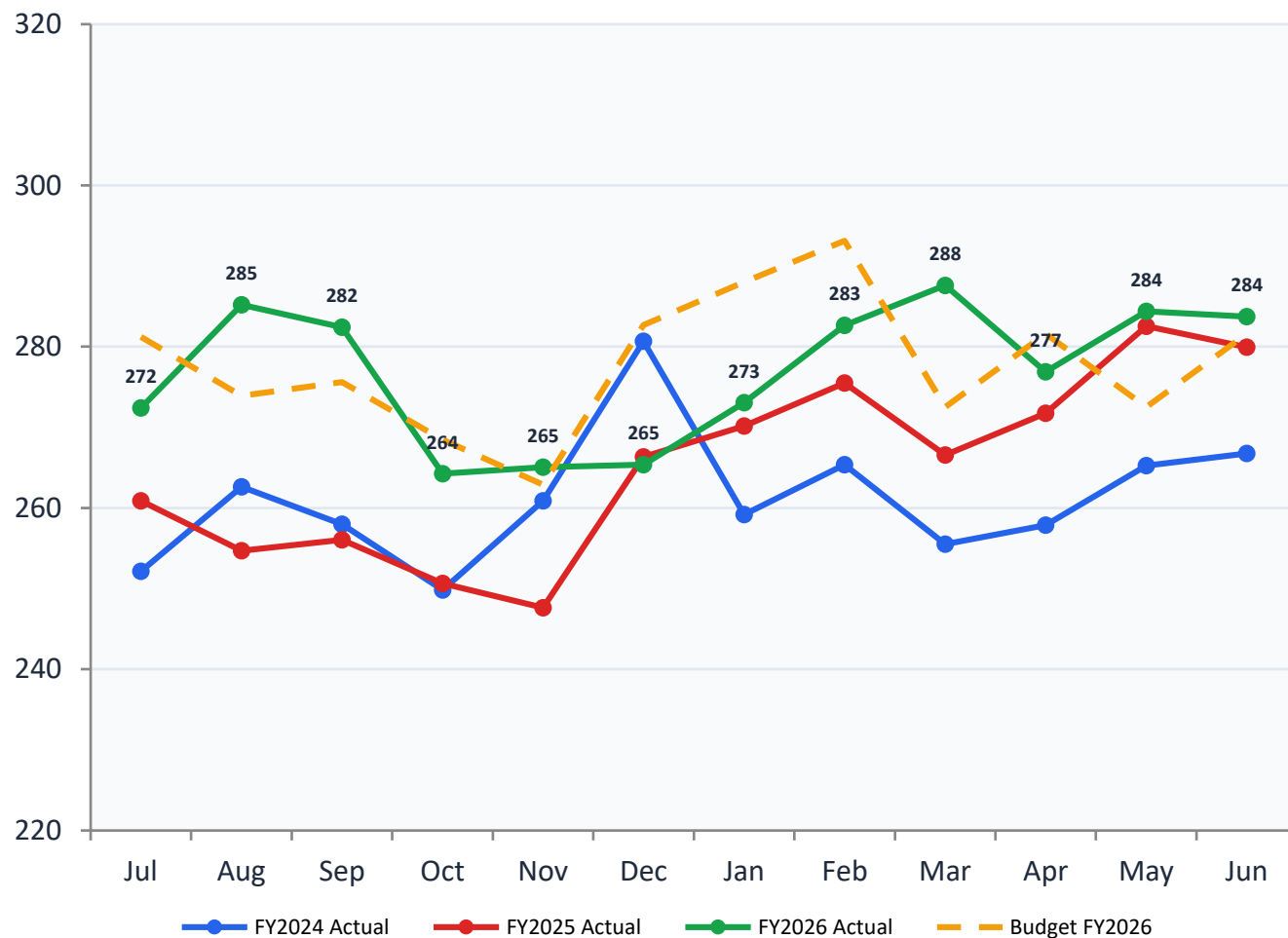
Nursery - Avg Patients Per Day



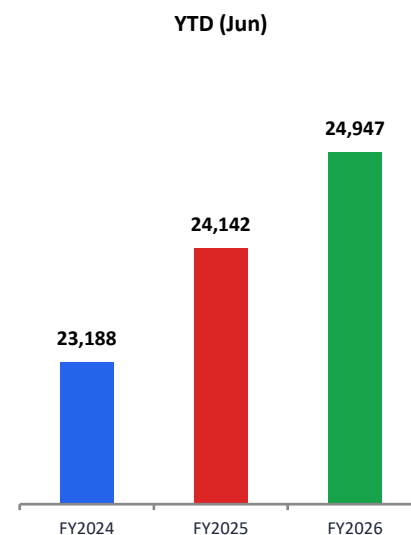
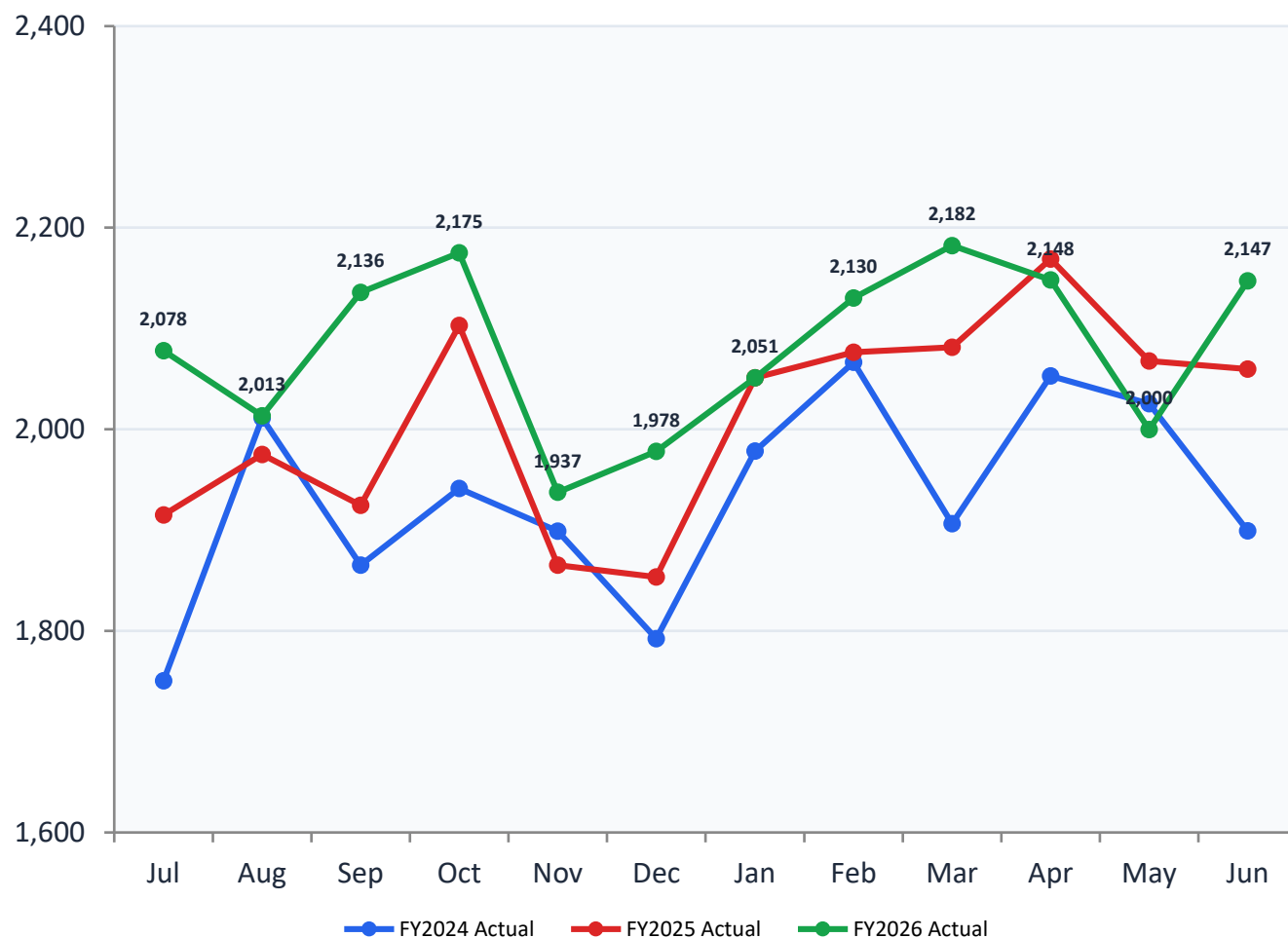
Obstetrics - Avg Patients Per Day



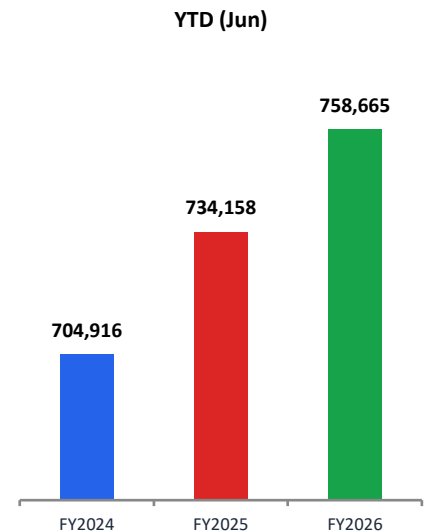
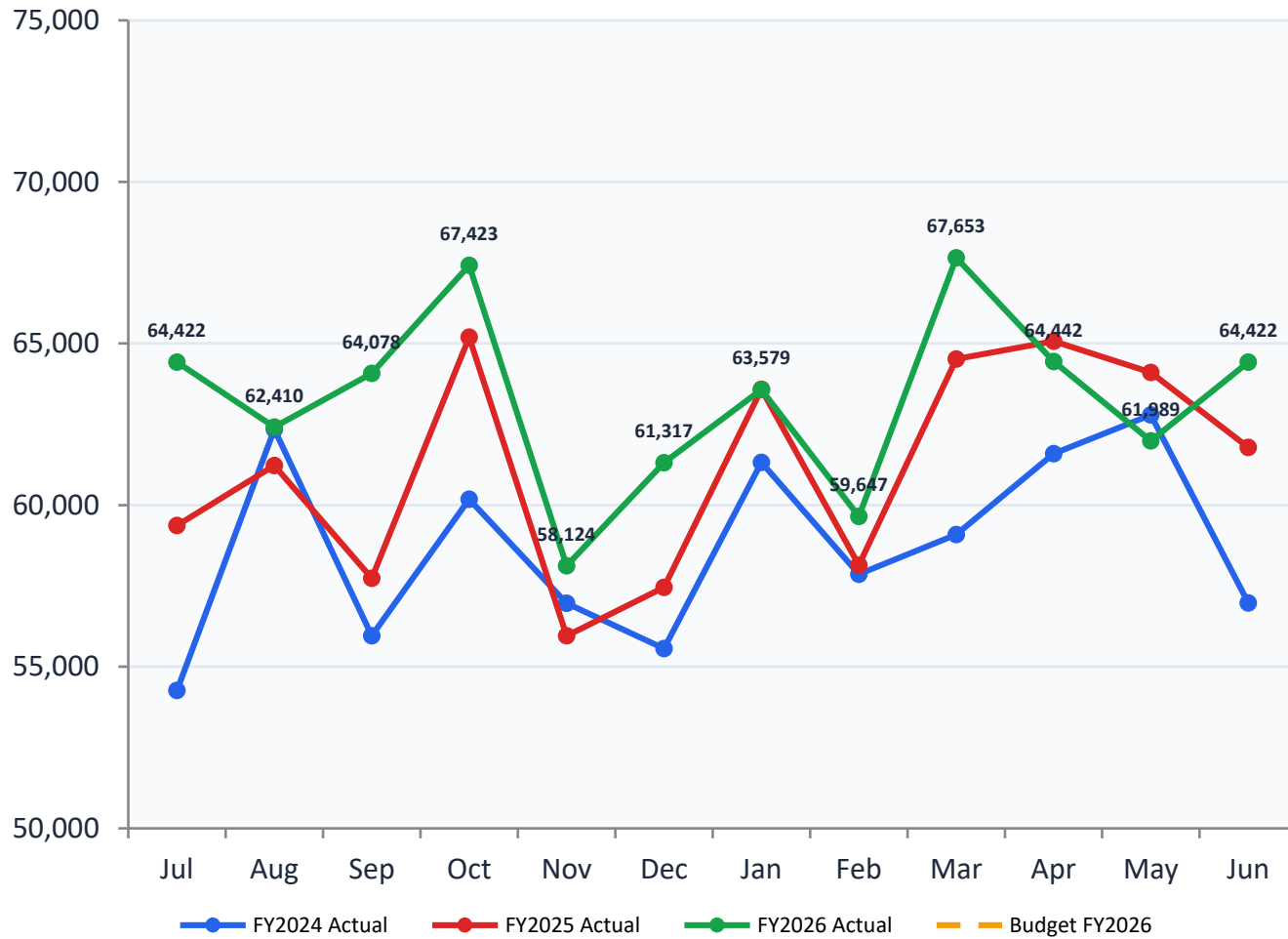
ED - Avg Treated Per Day



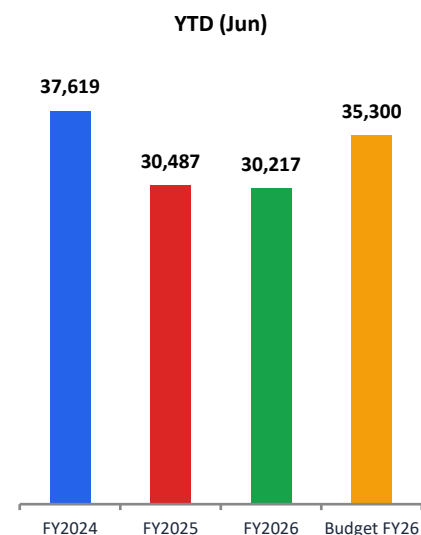
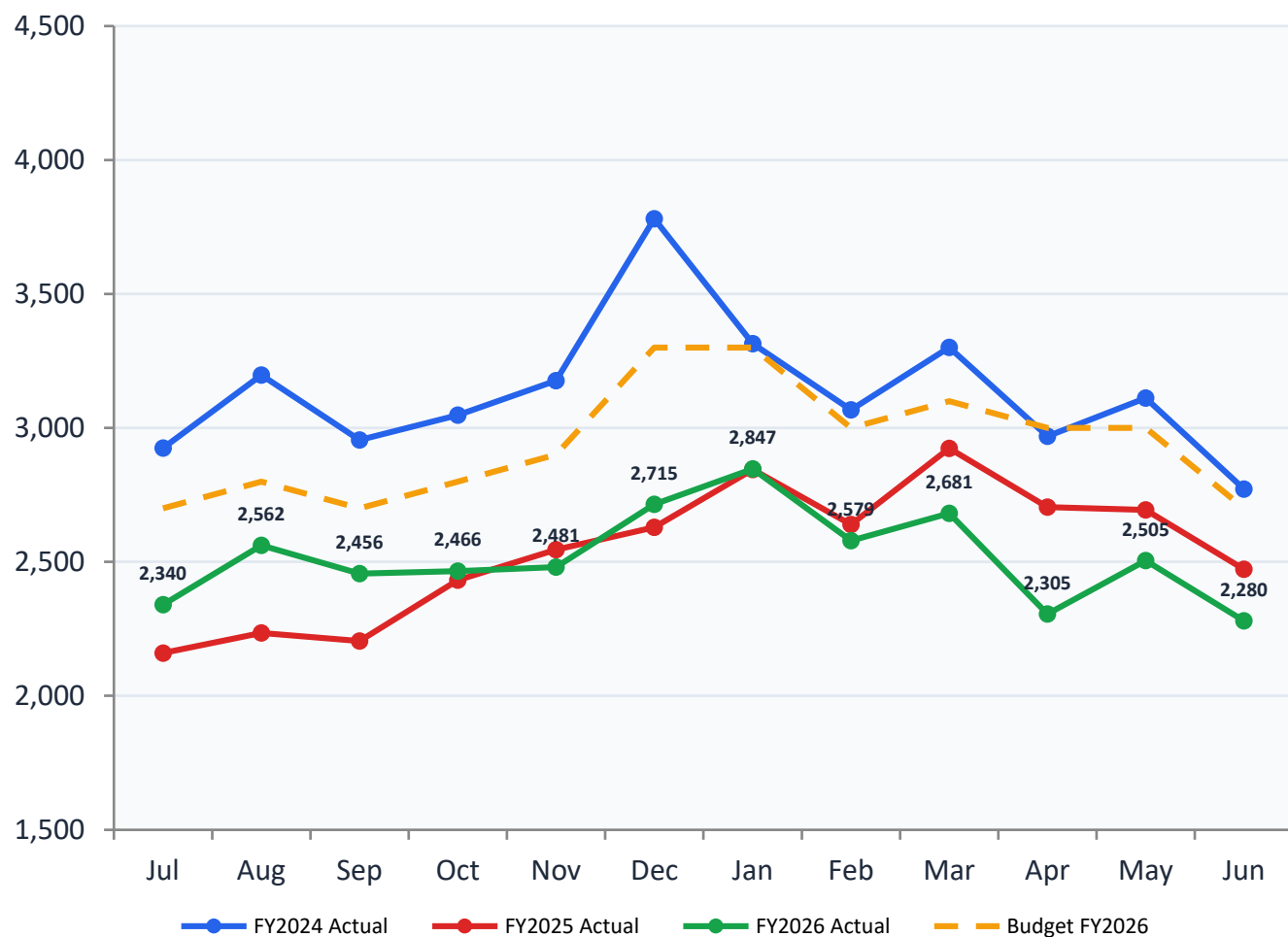
Outpatient Registrations Per Day



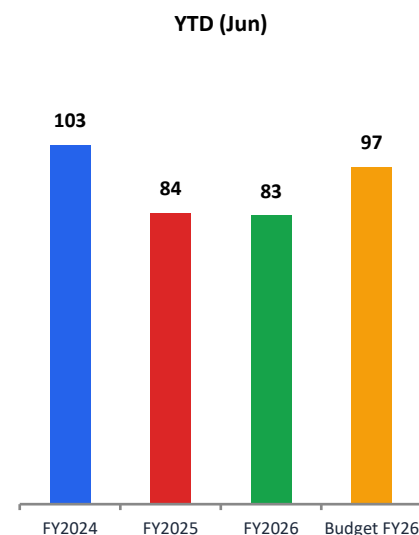
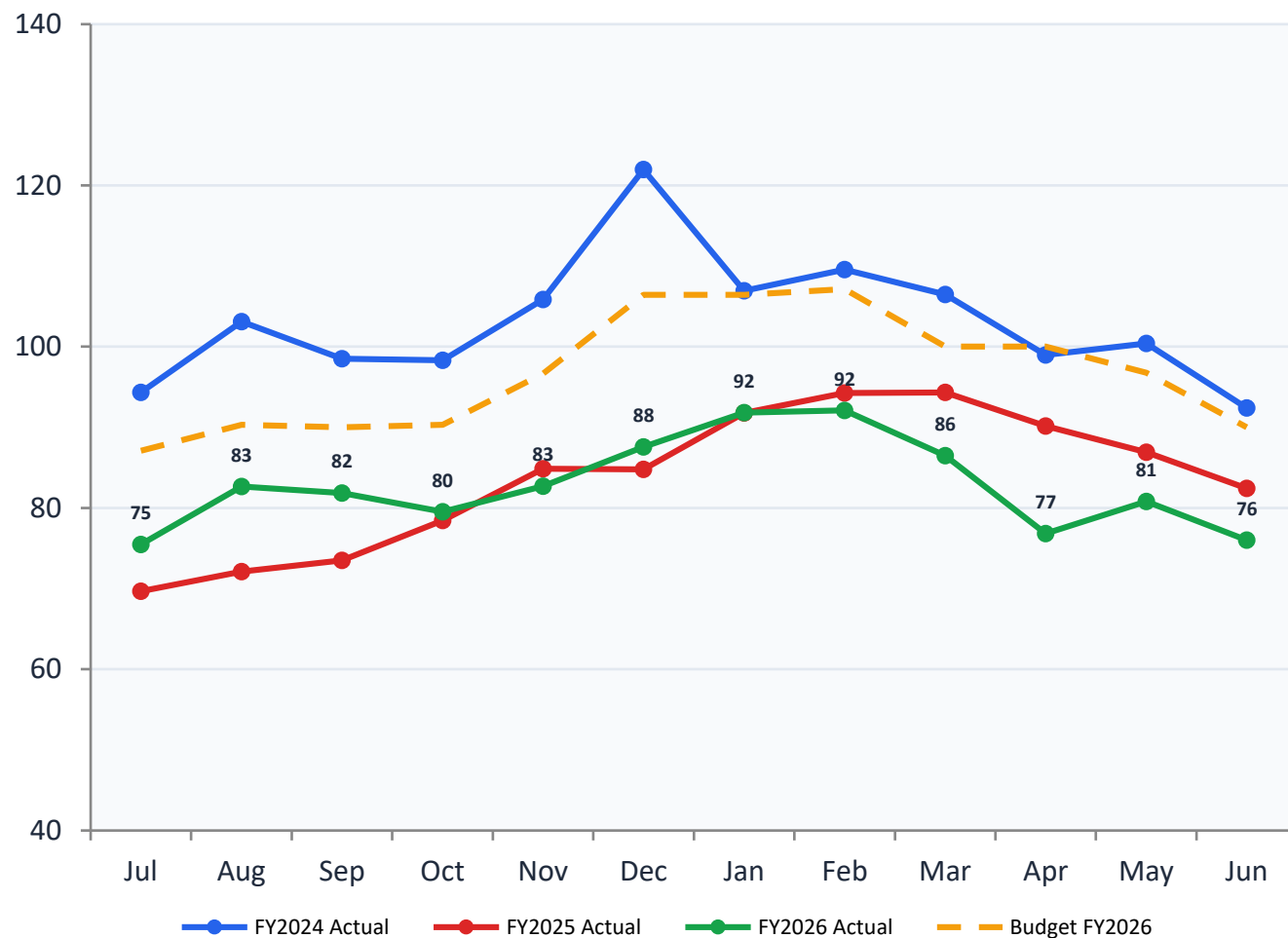
Outpatient Registrations



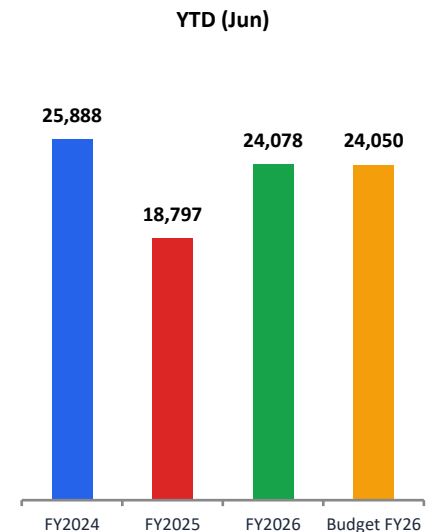
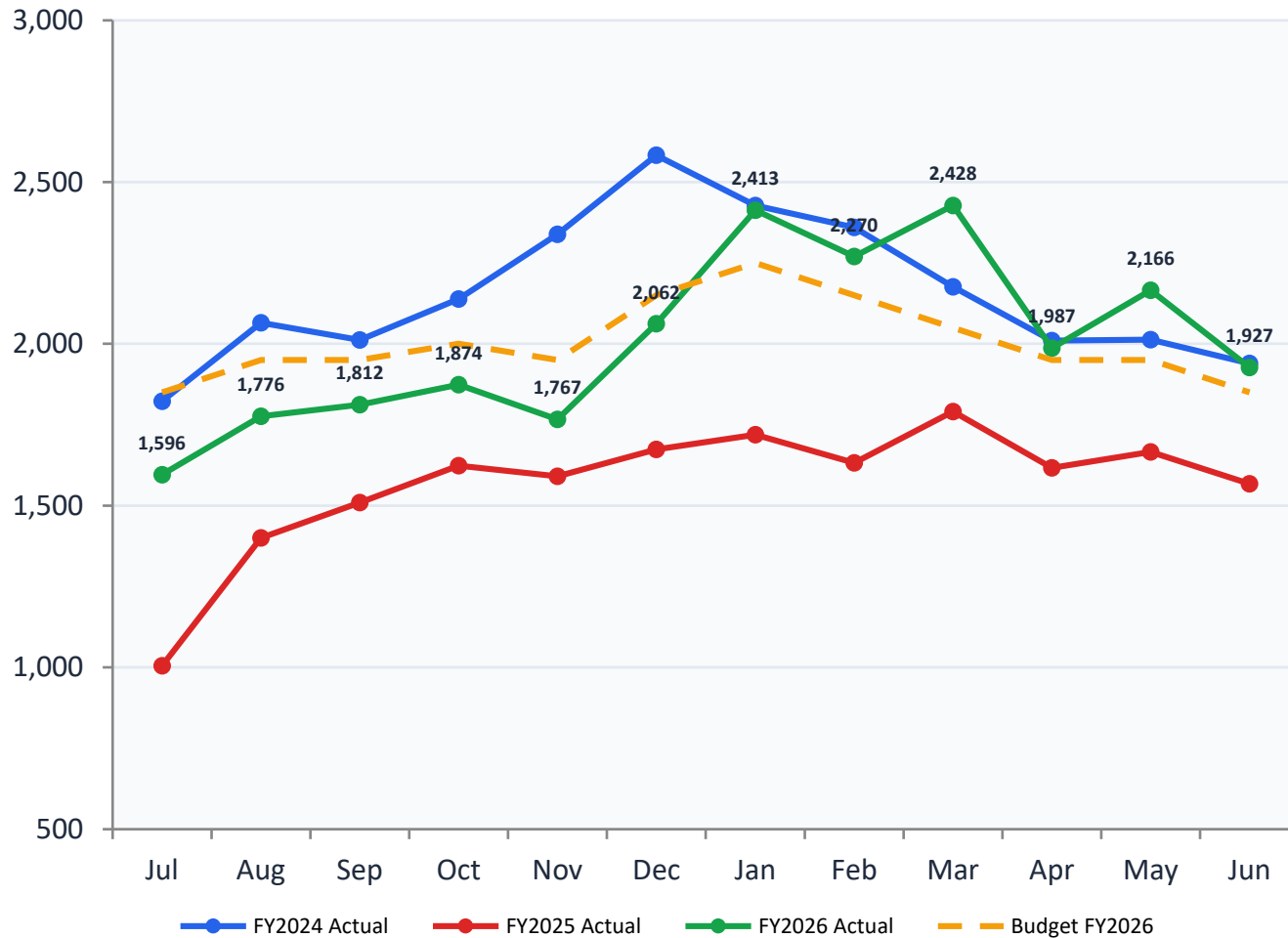
Urgent Care – Court Total Visits



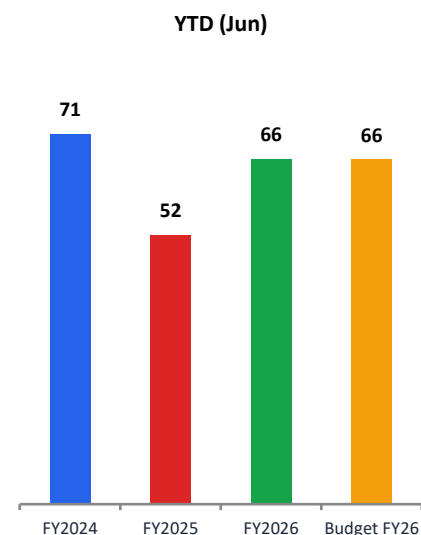
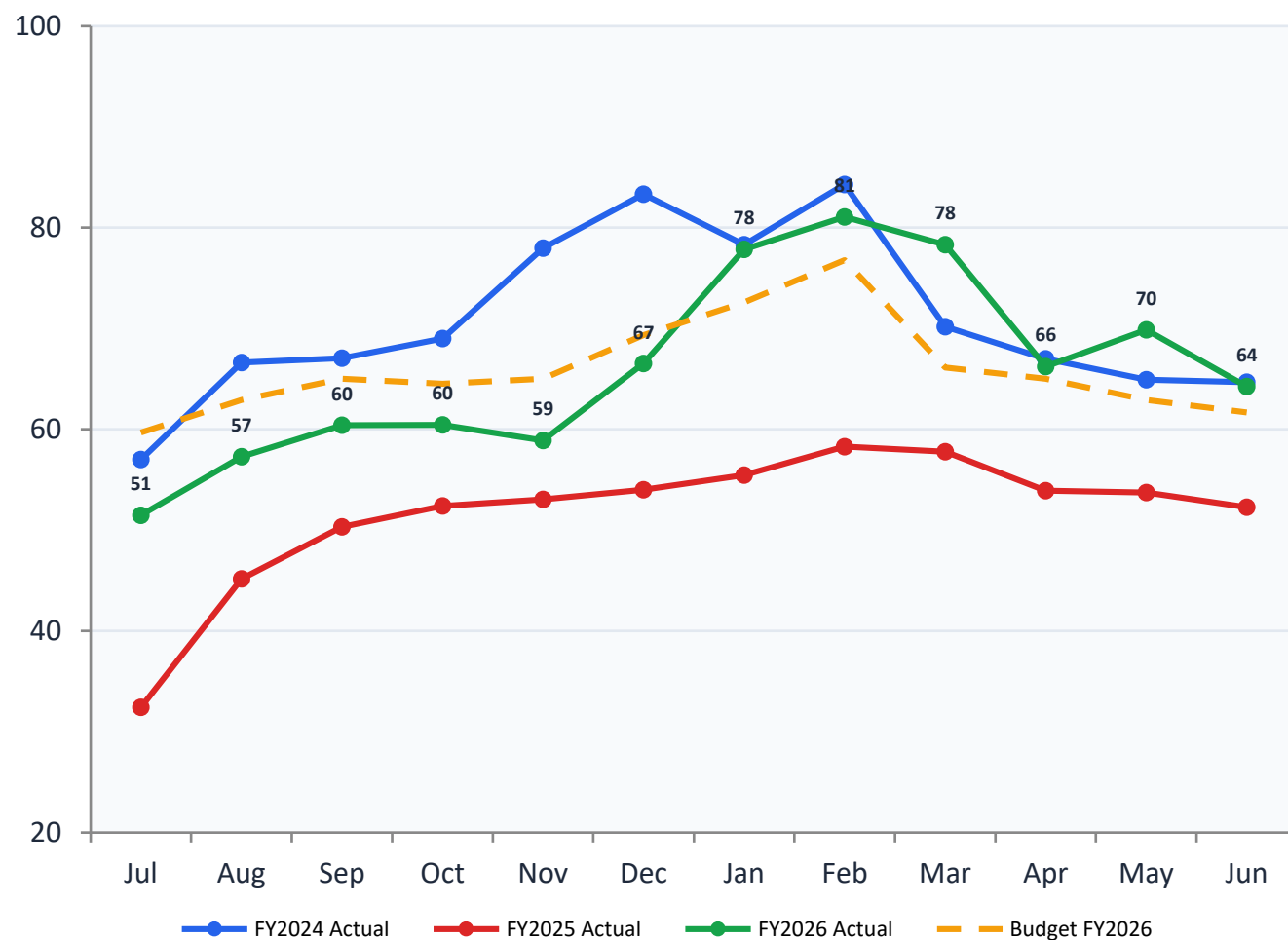
Urgent Care – Court Avg Visits Per Day



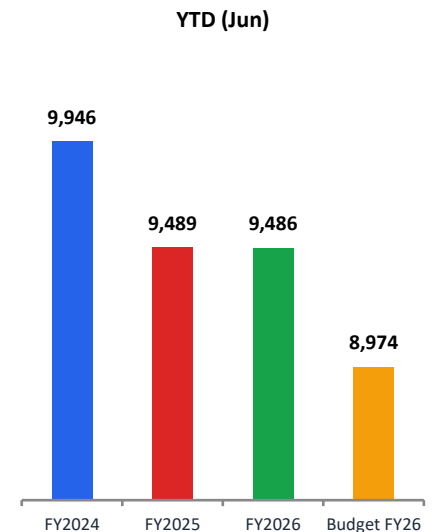
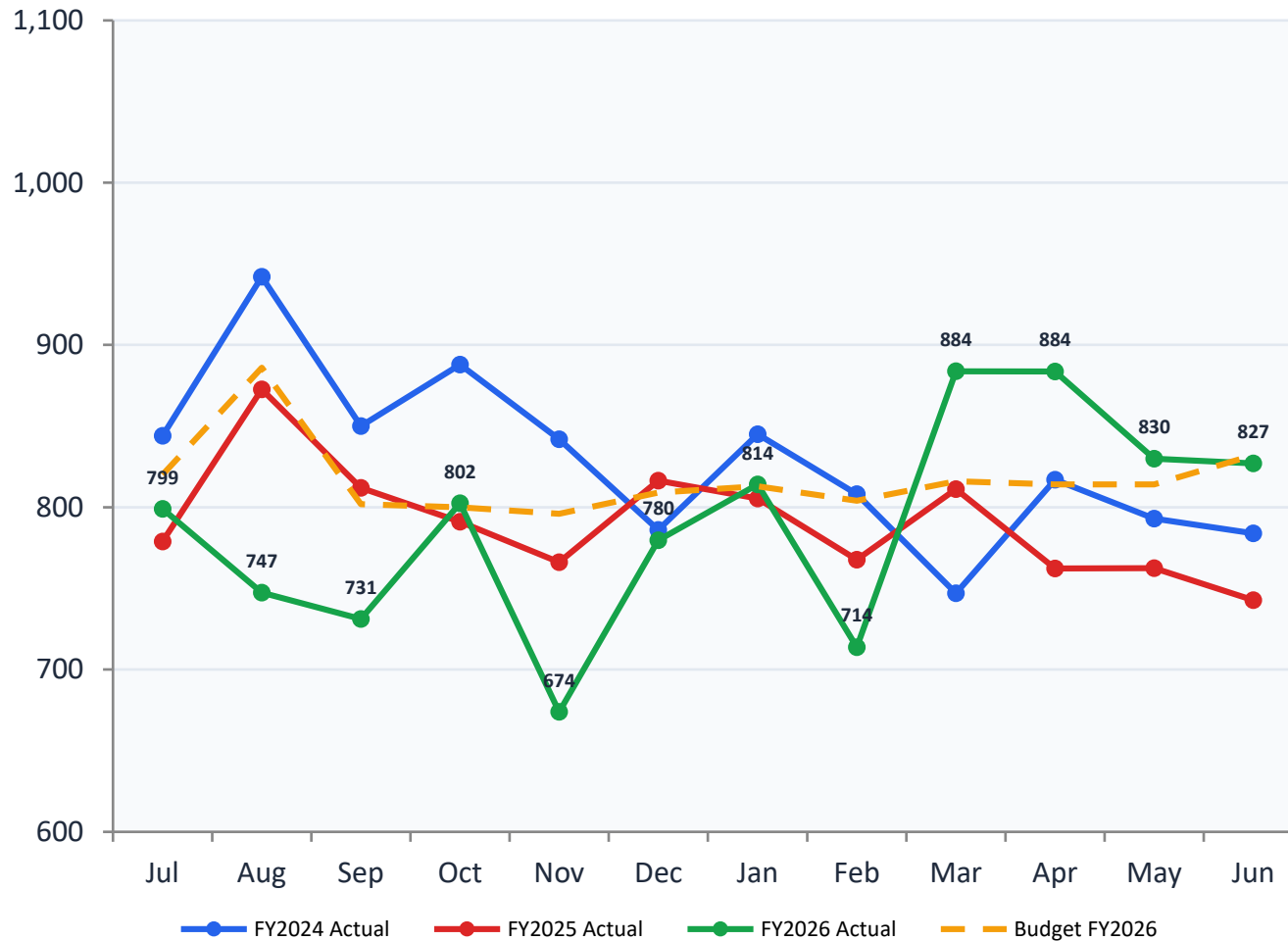
Urgent Care – Demaree Total Visits



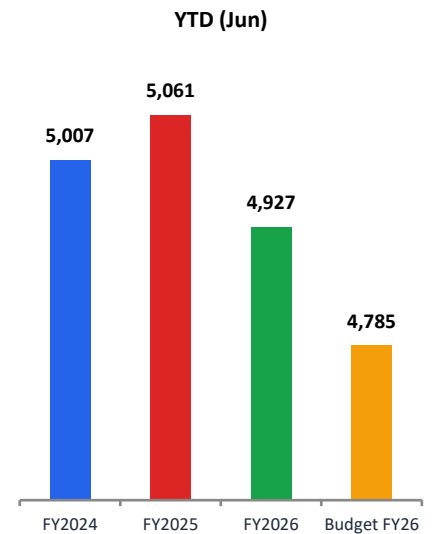
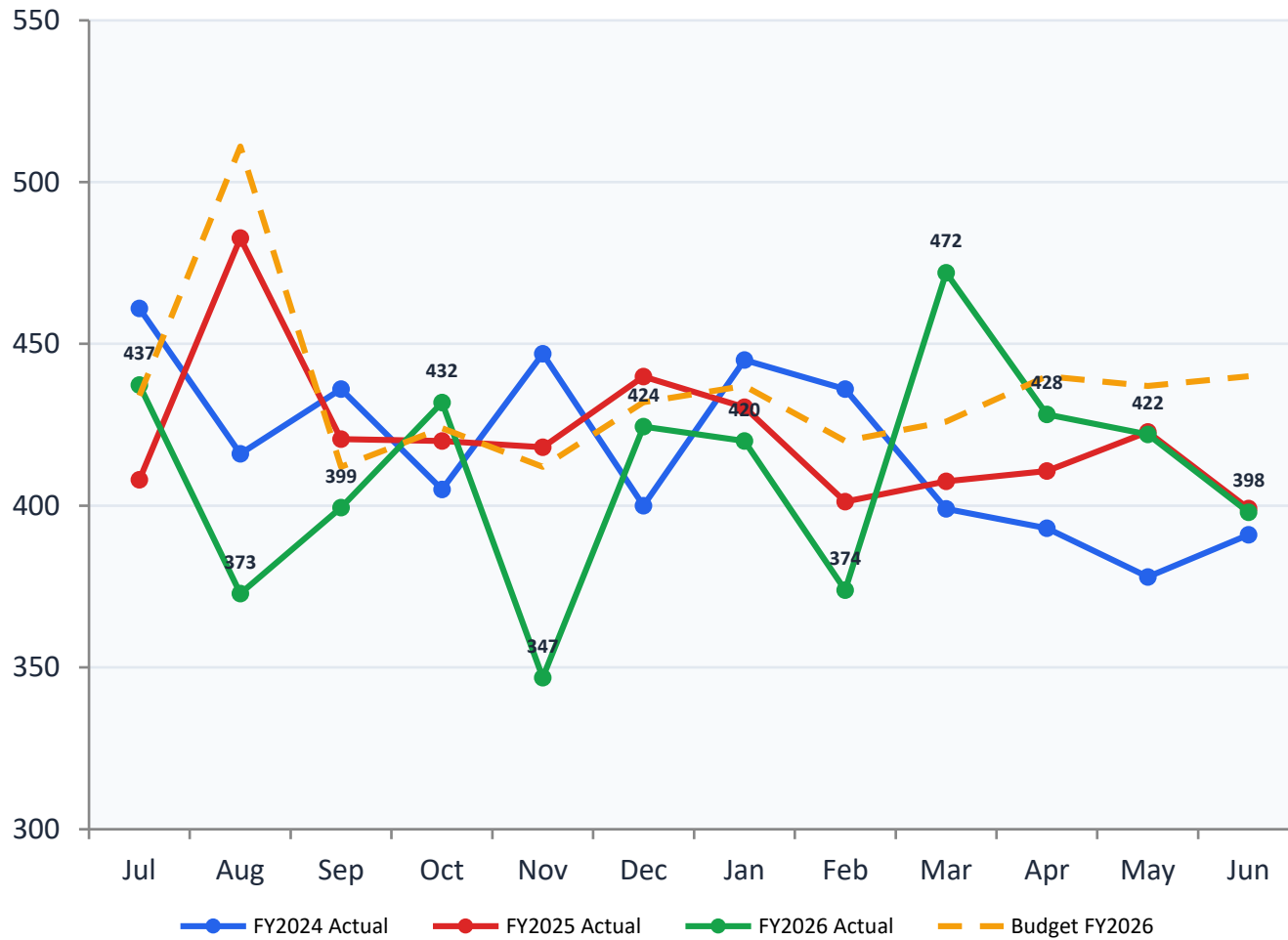
Urgent Care – Demaree Avg Visits Per Day



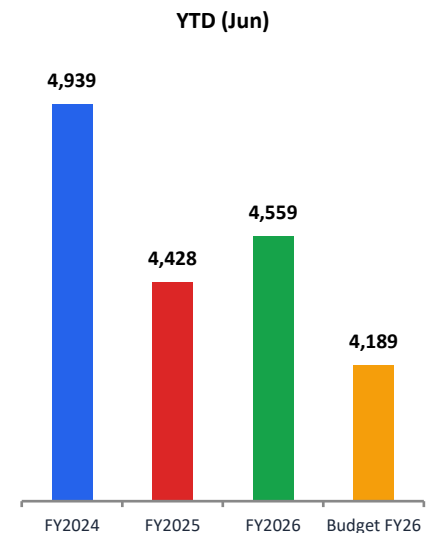
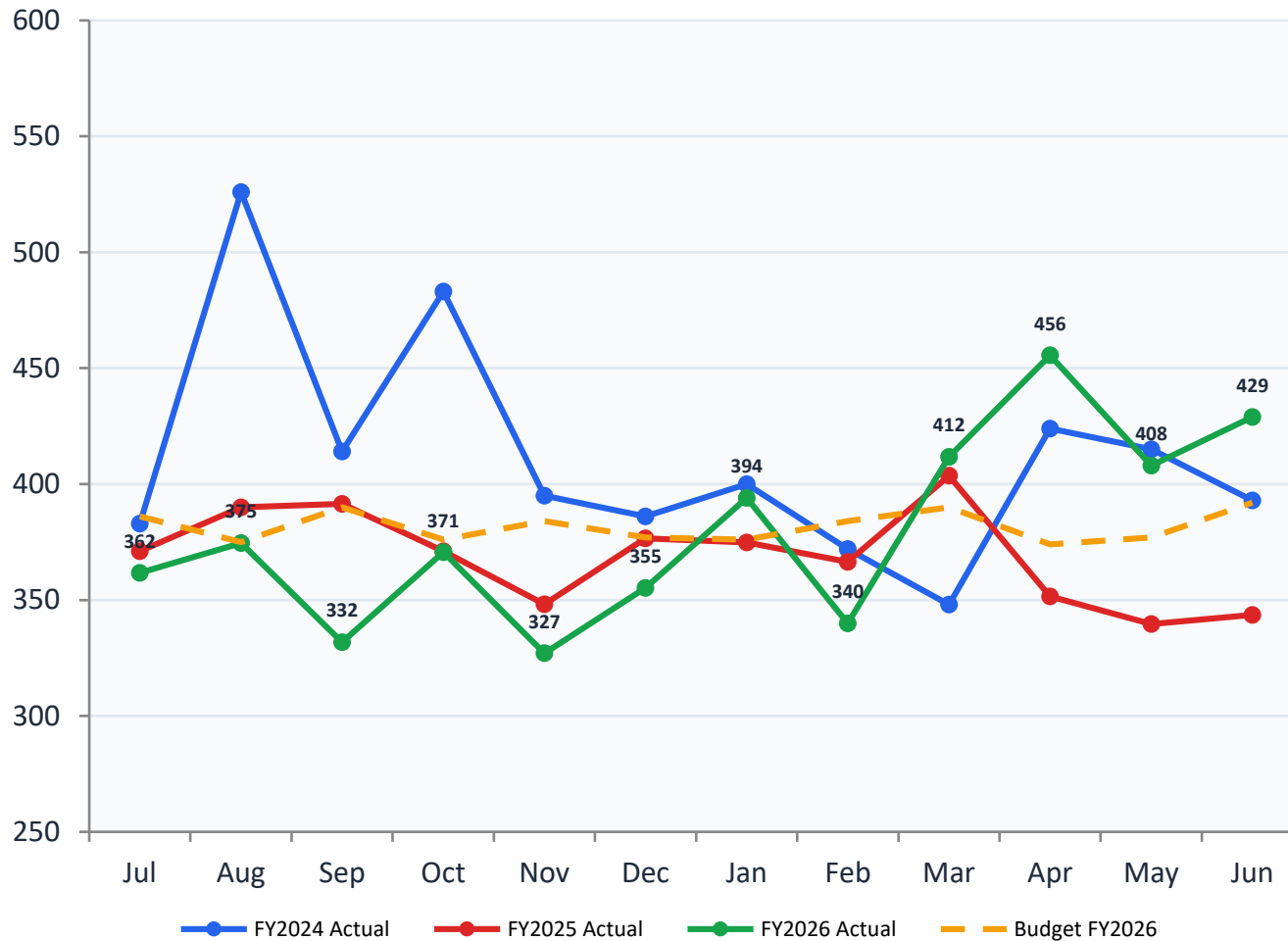
Surgery (IP & OP) – 100 Min Units



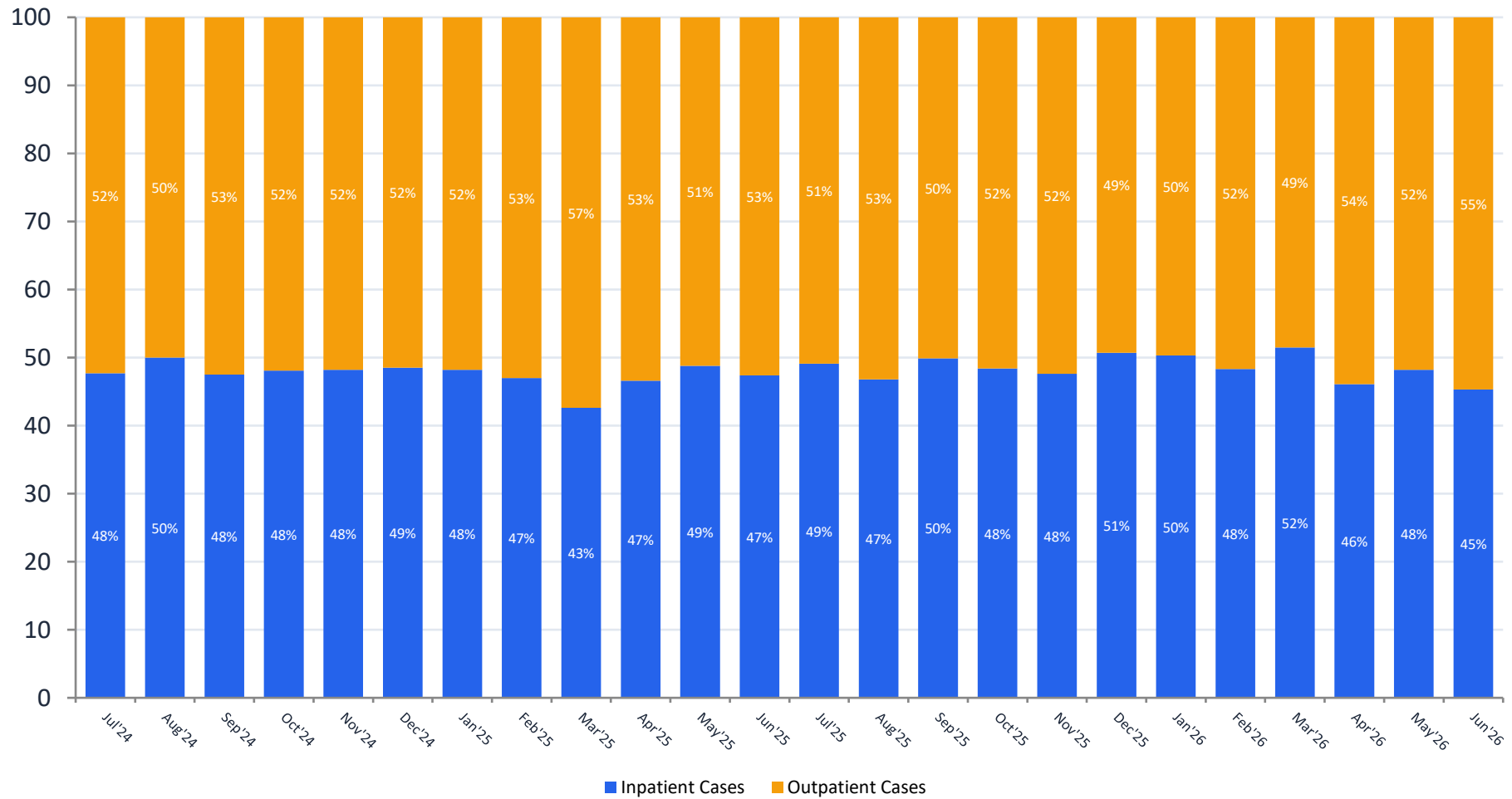
Surgery (IP Only) - 100 Min Unit



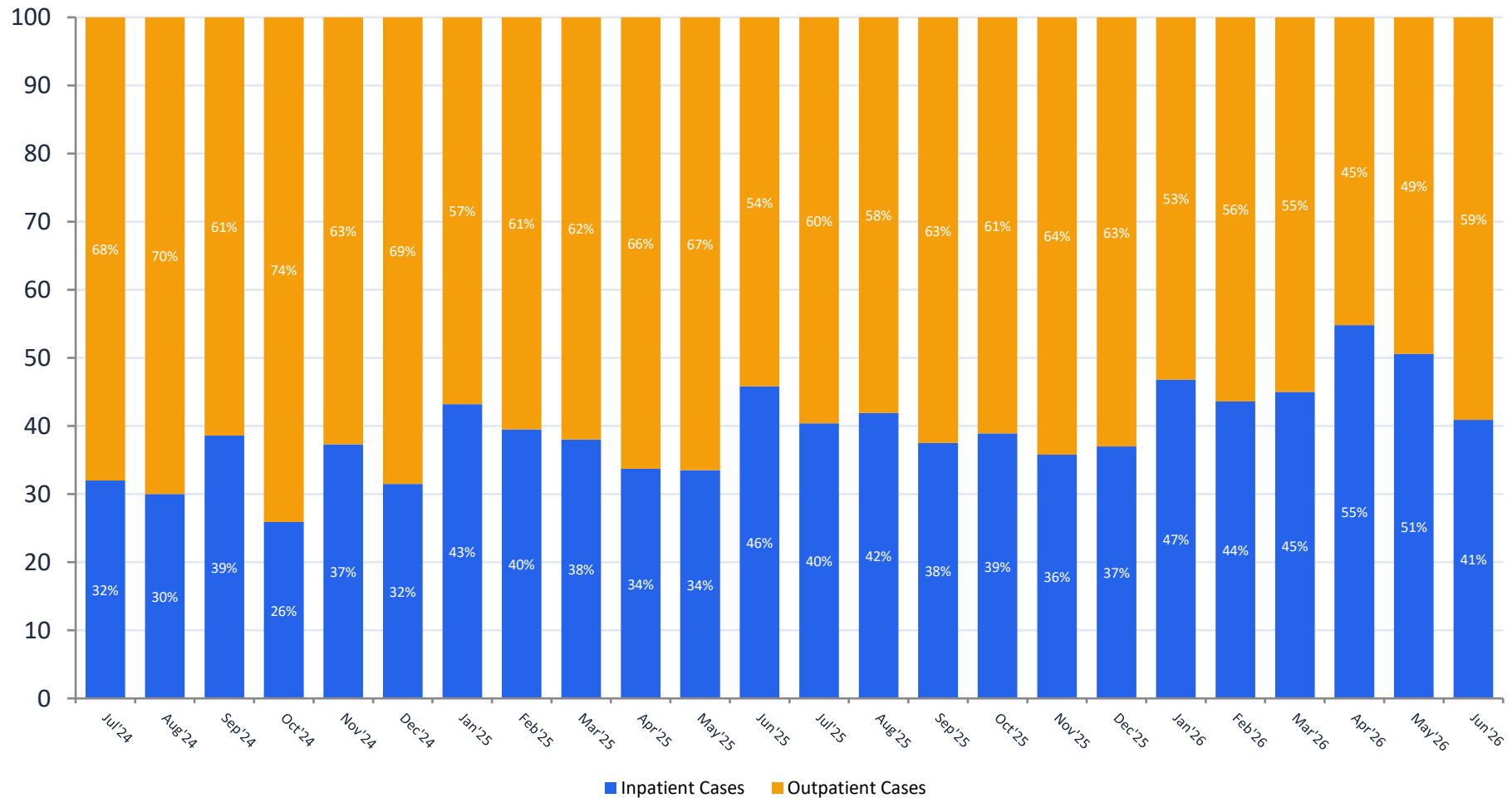
Surgery (OP Only) - 100 Min Units



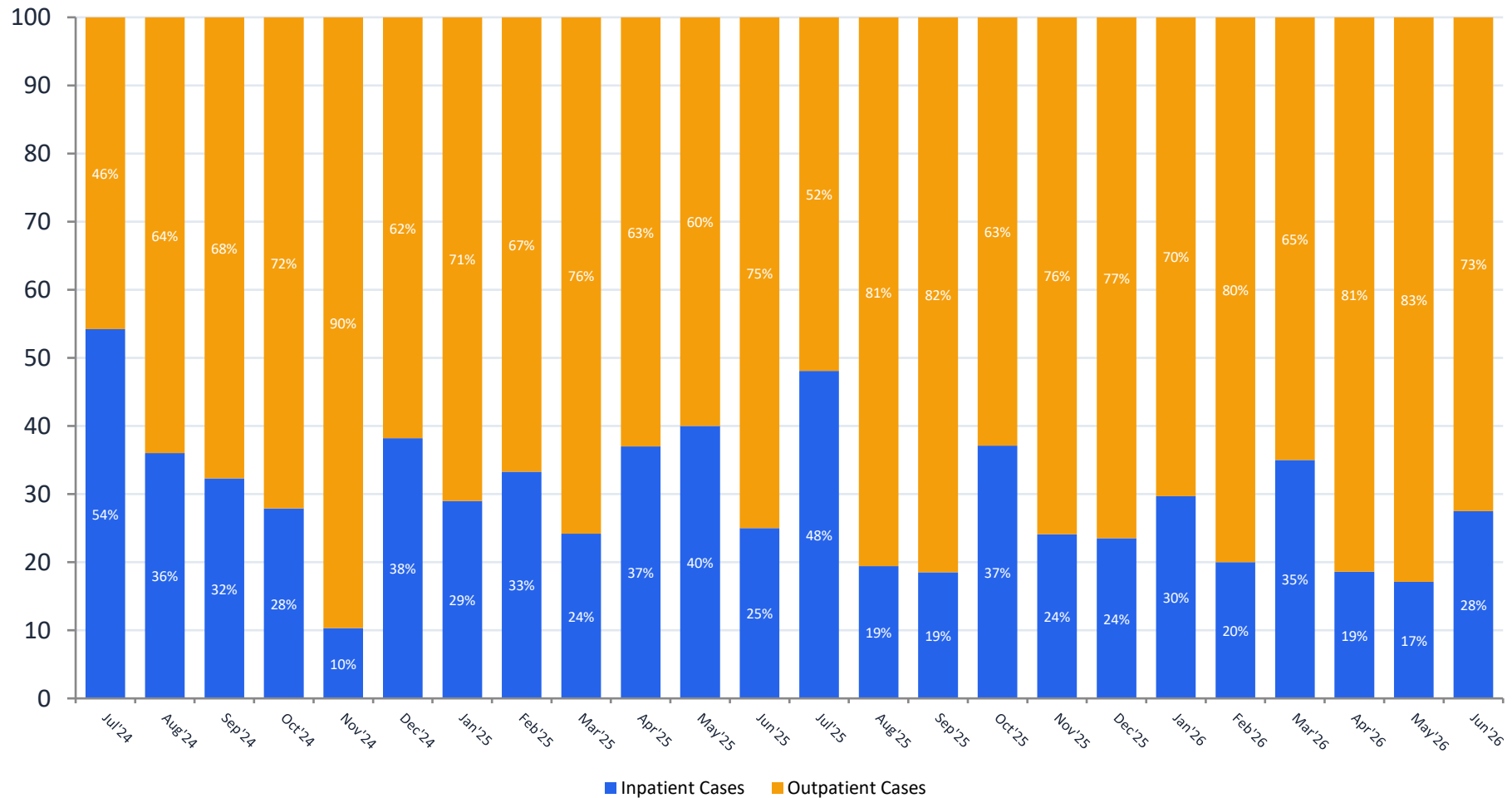
Surgery Cases (IP & OP)



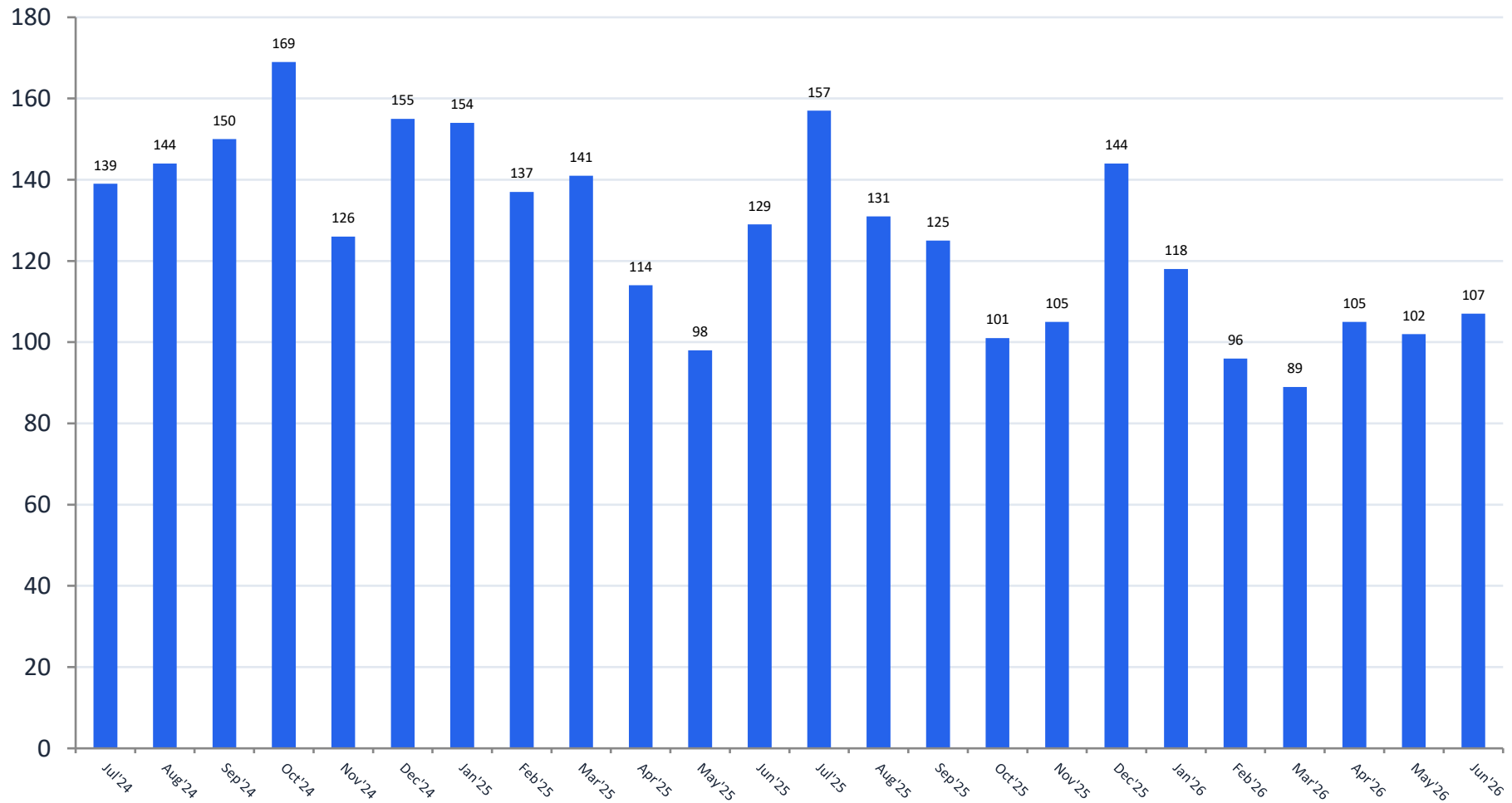
Endo Cases (Suites A & B and OR)



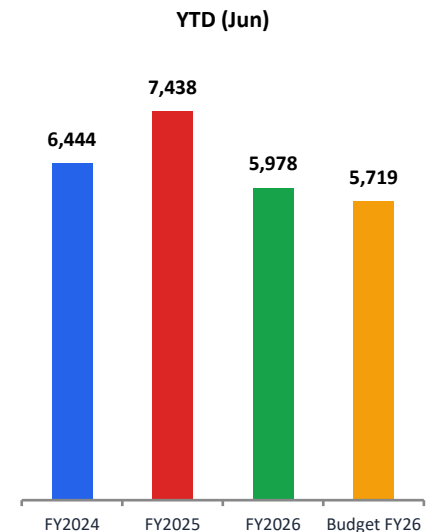
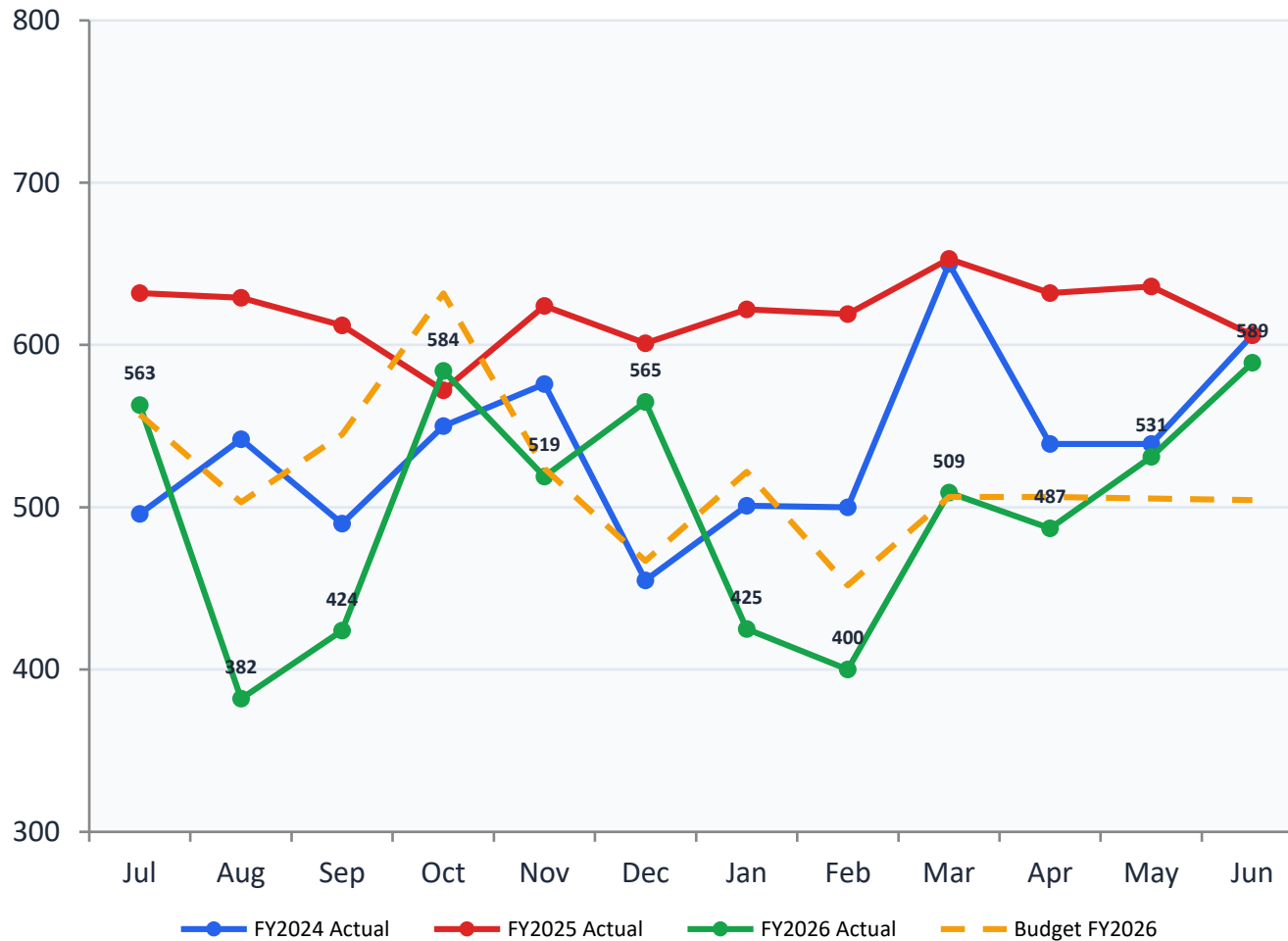
Robotic Cases (IP & OP)



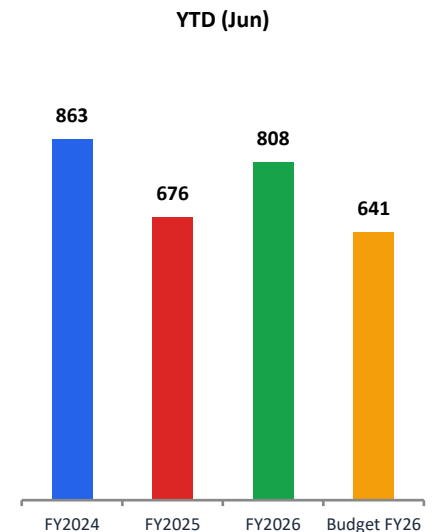
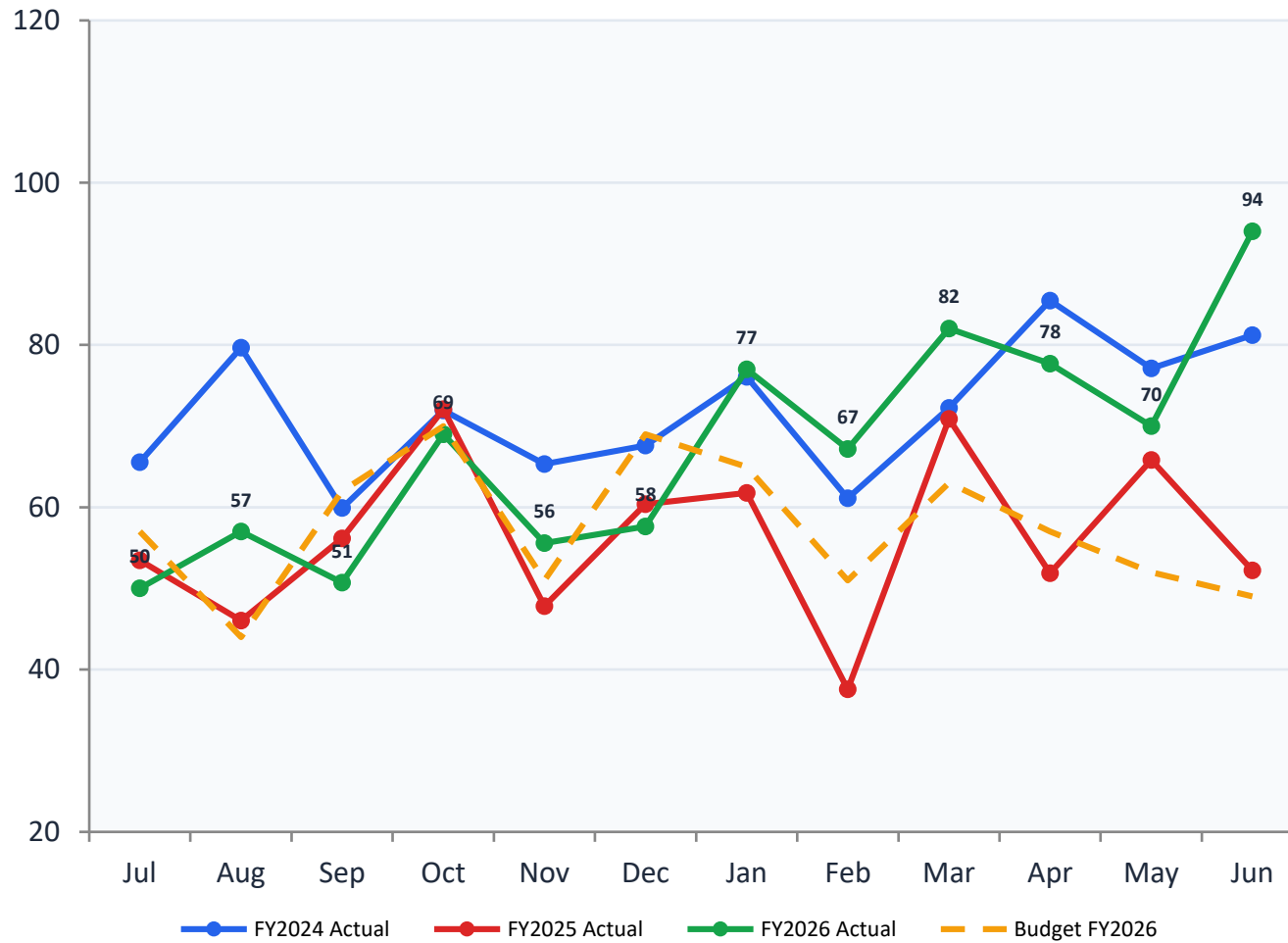
OB Cases



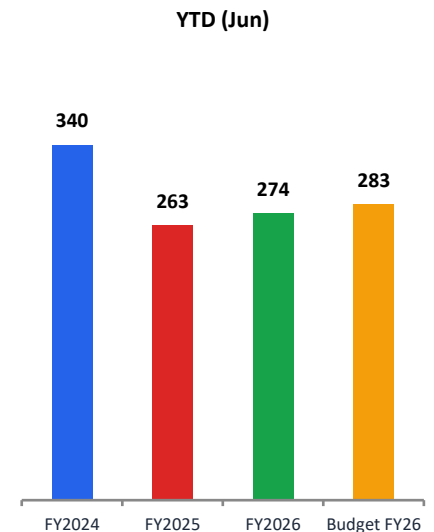
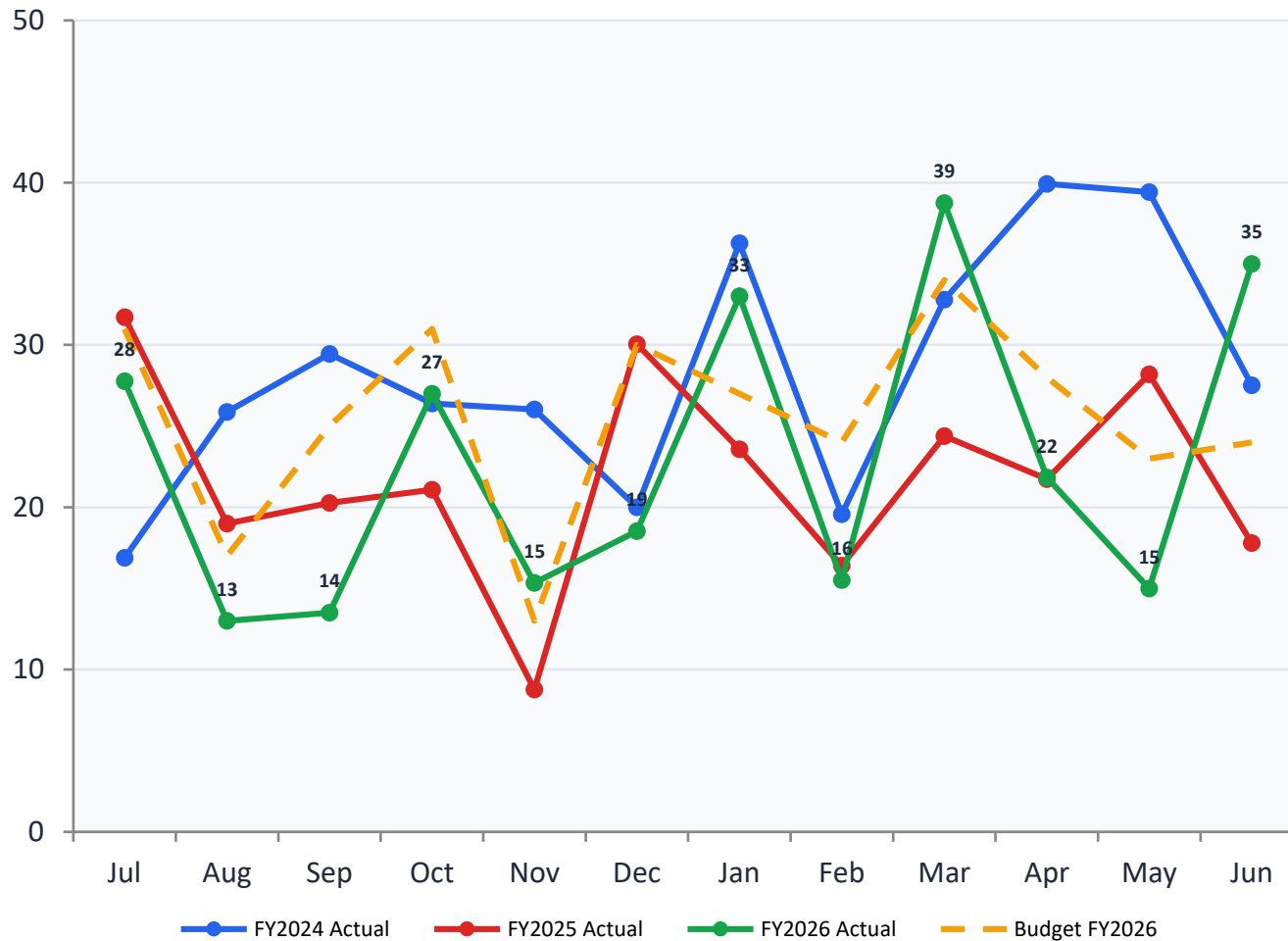
Endoscopy Procedures



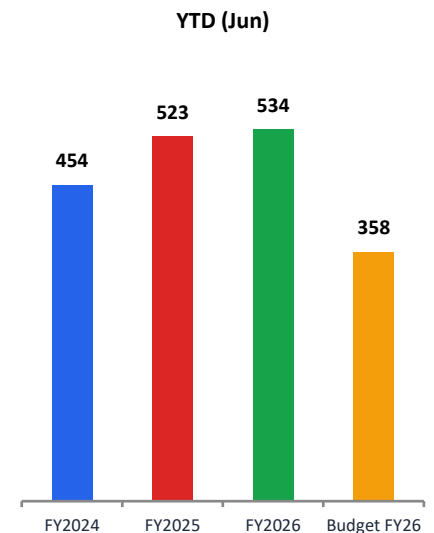
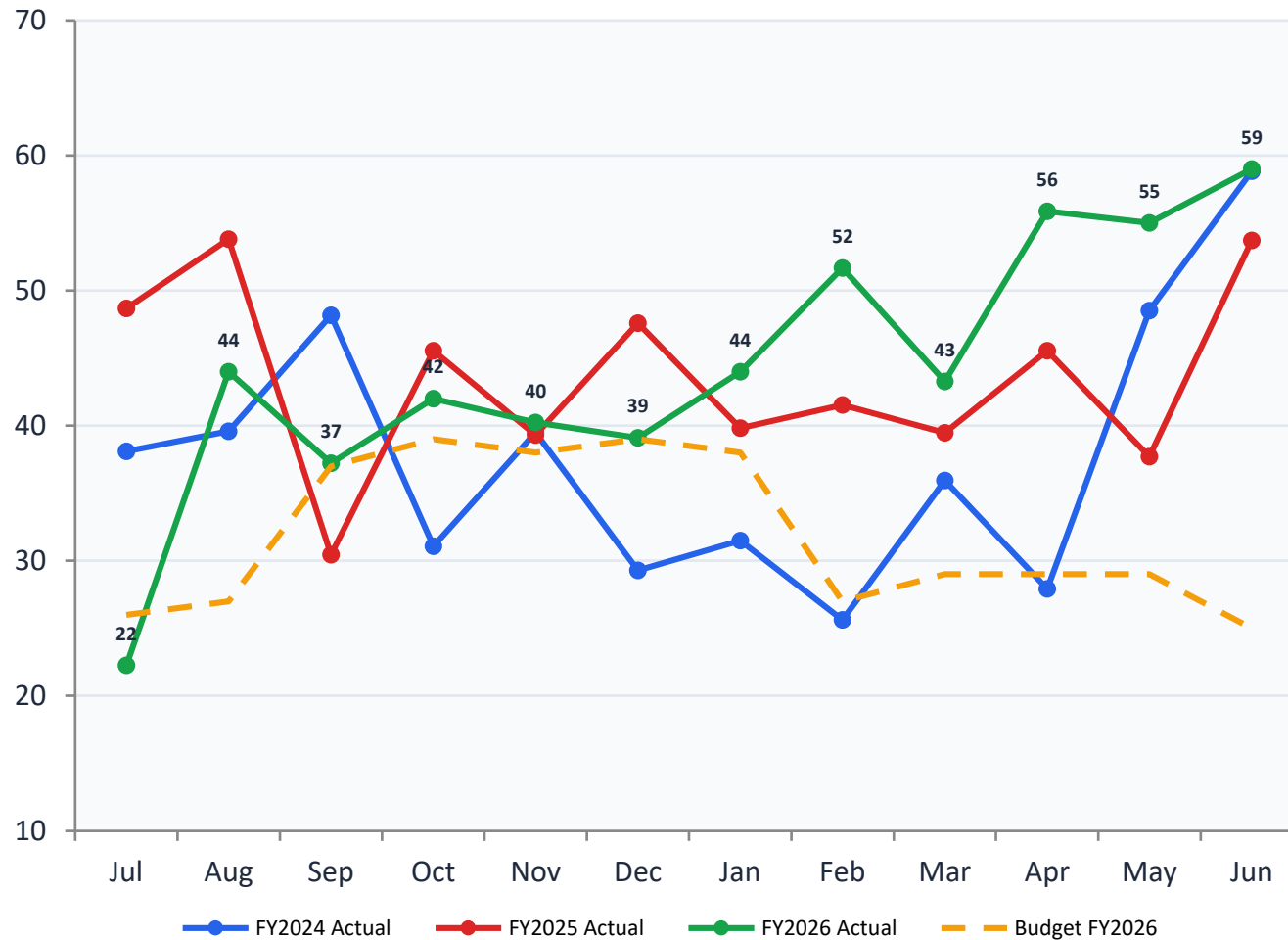
Robotic Surgery (IP & OP) - 100 Min Units



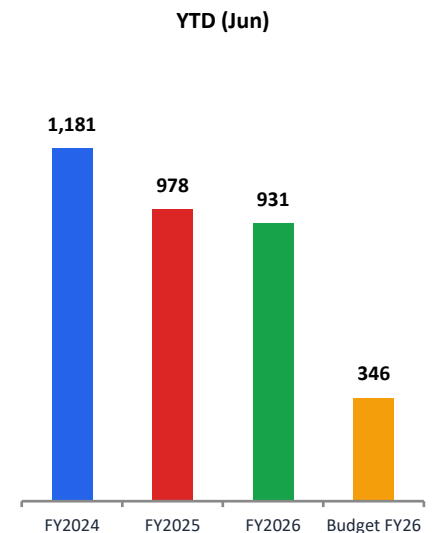
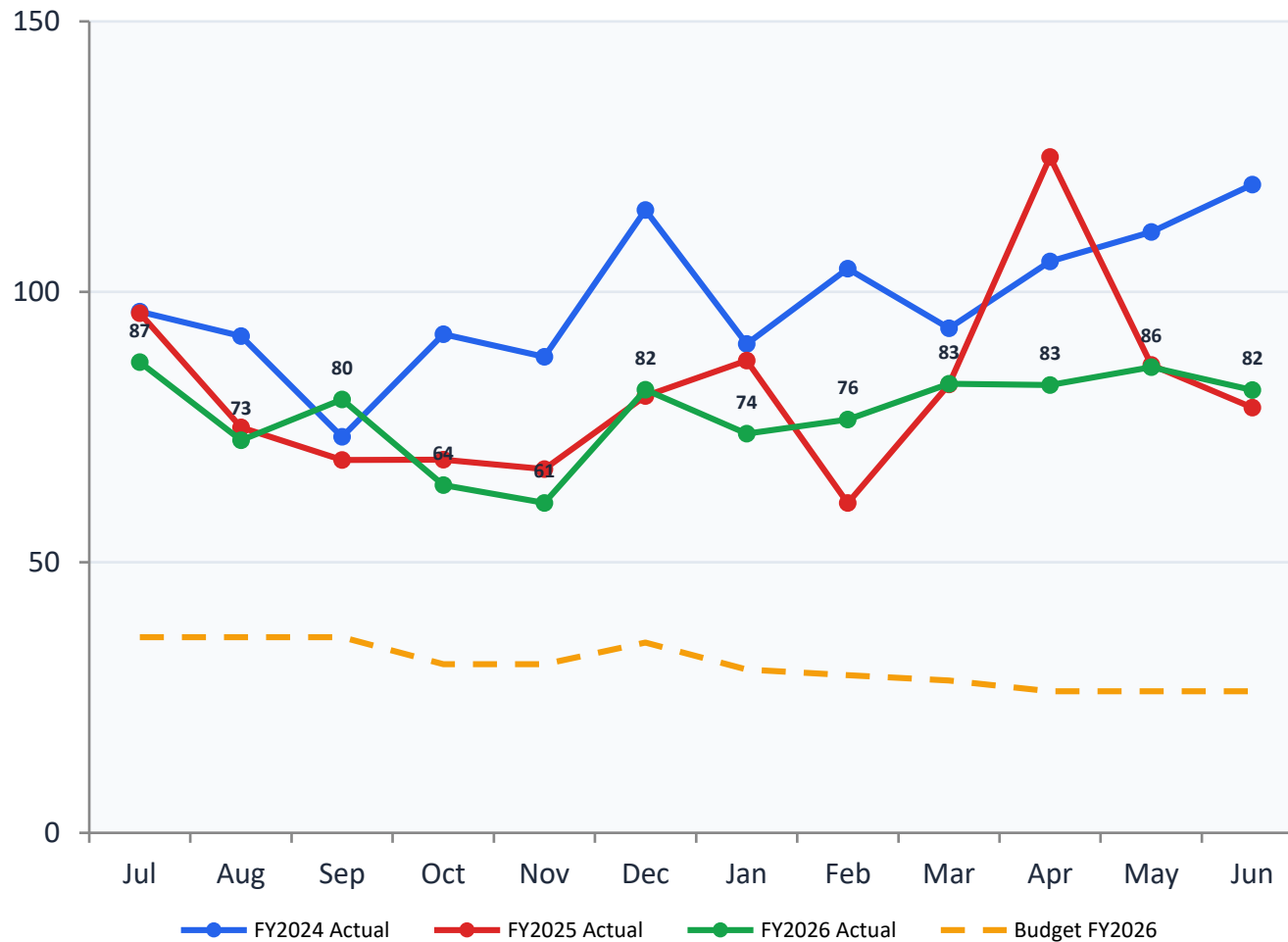
Robotic Surgery Minutes (IP Only)



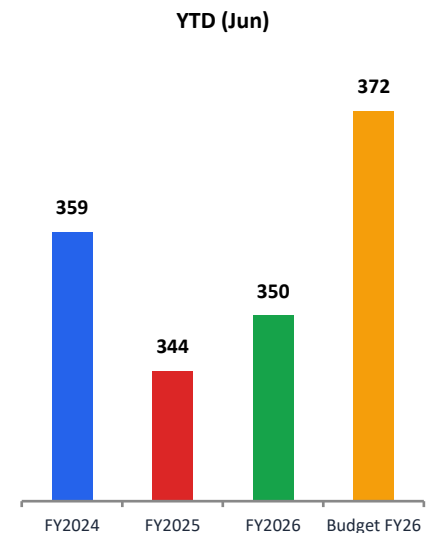
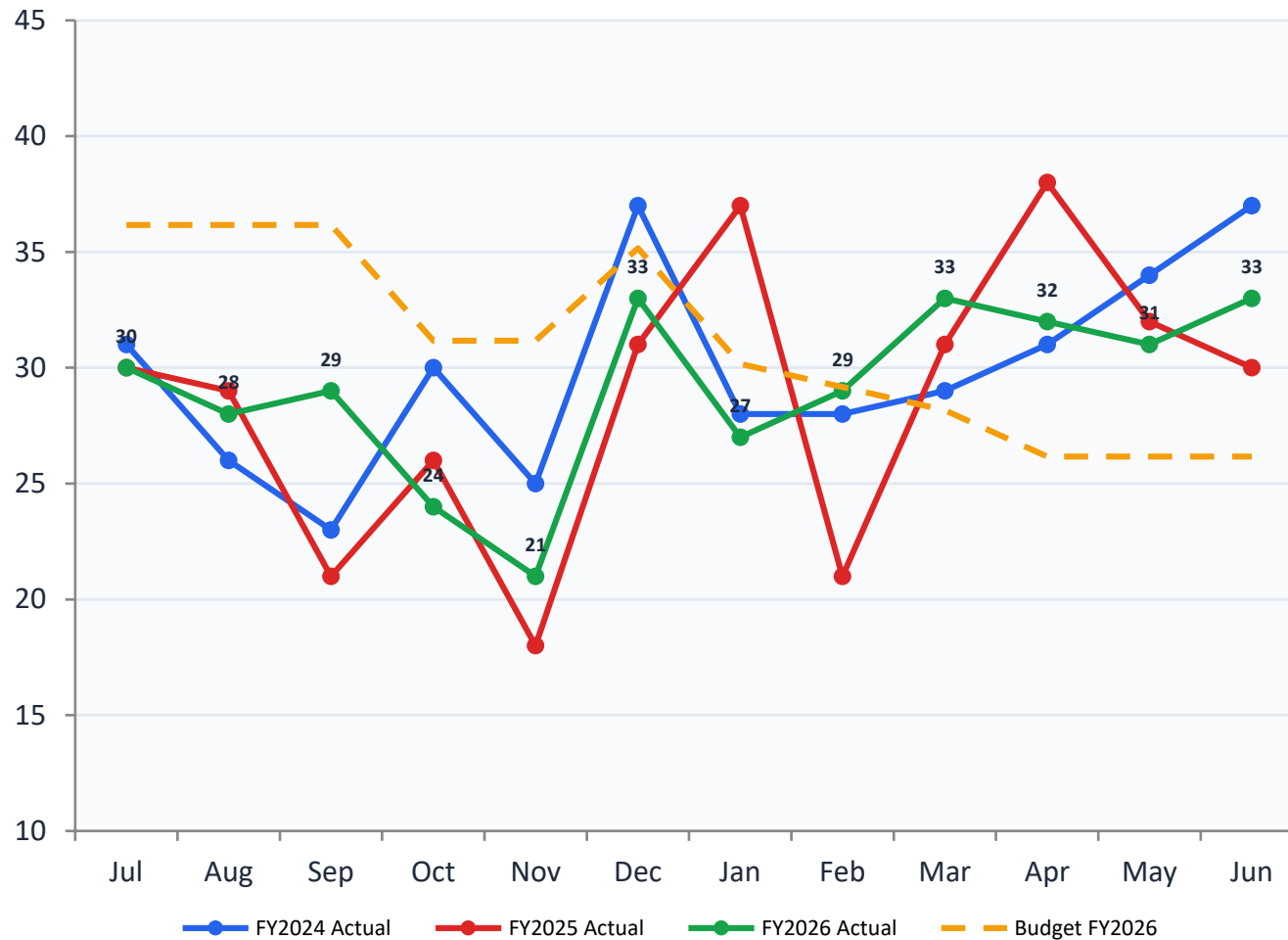
Robotic Surgery Minutes (OP Only)



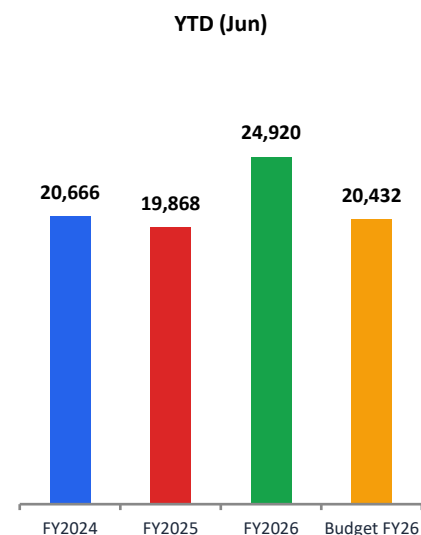
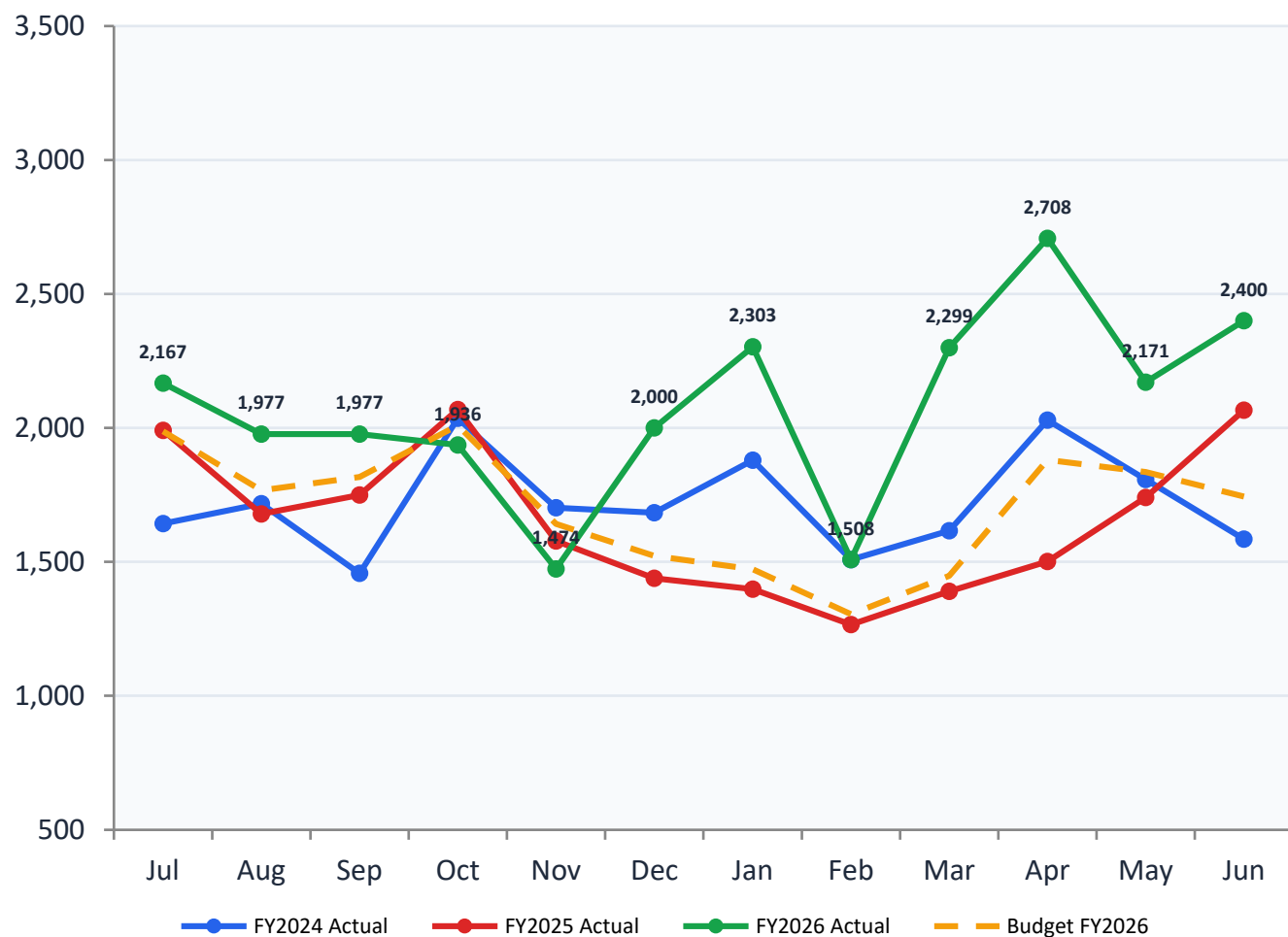
Cardiac Surgery - 100 Min Units



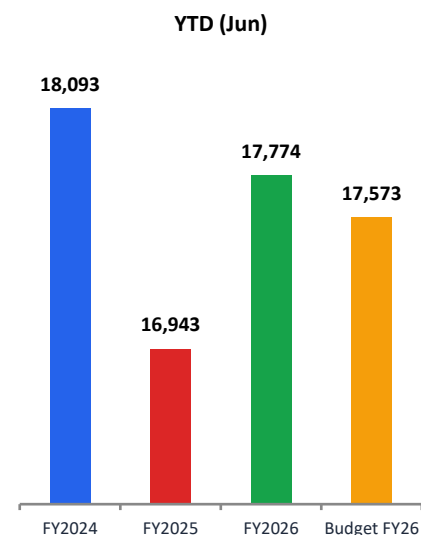
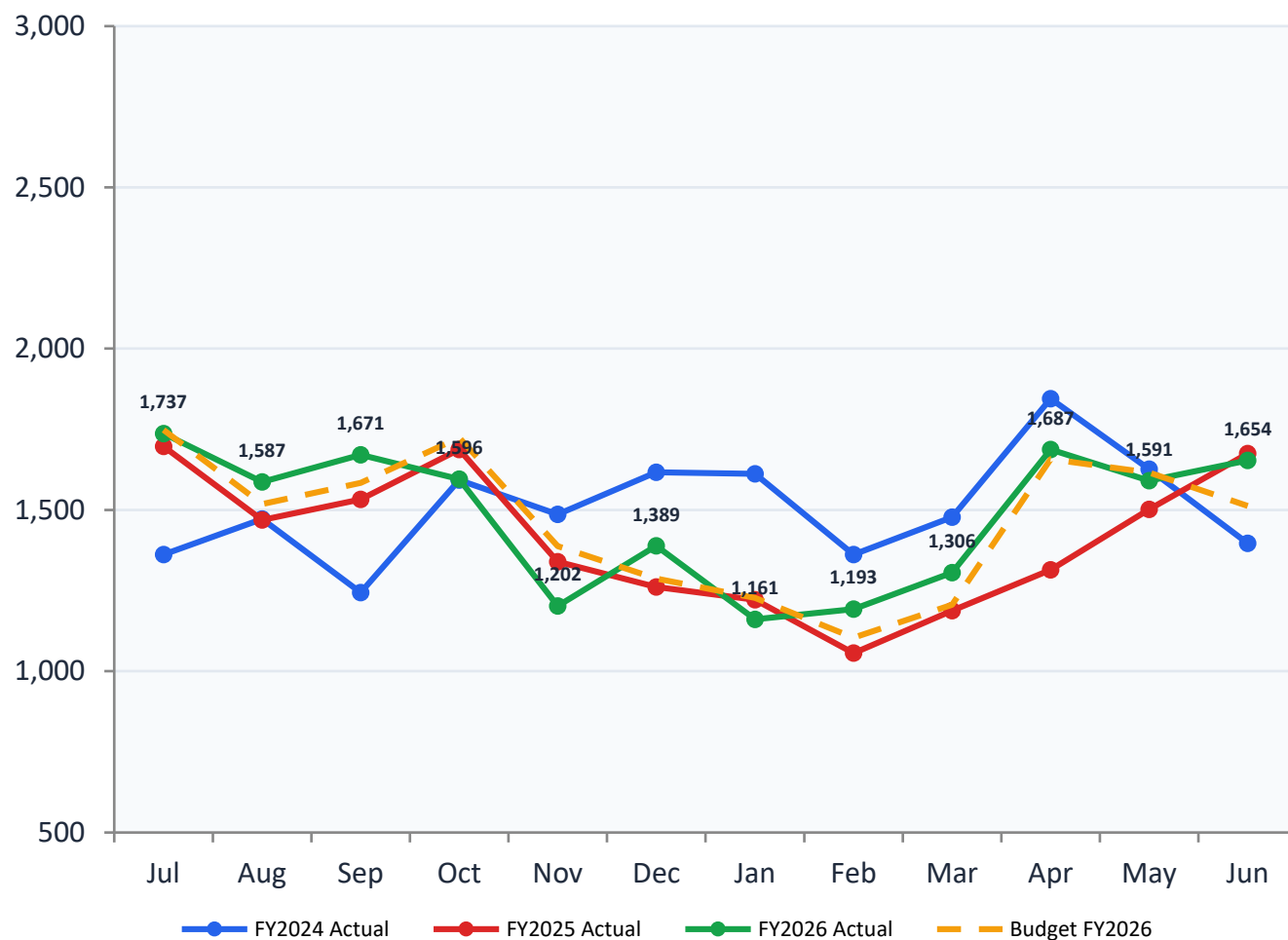
Cardiac Surgery Cases



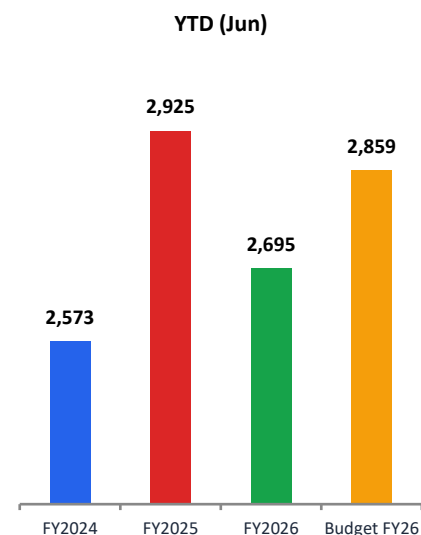
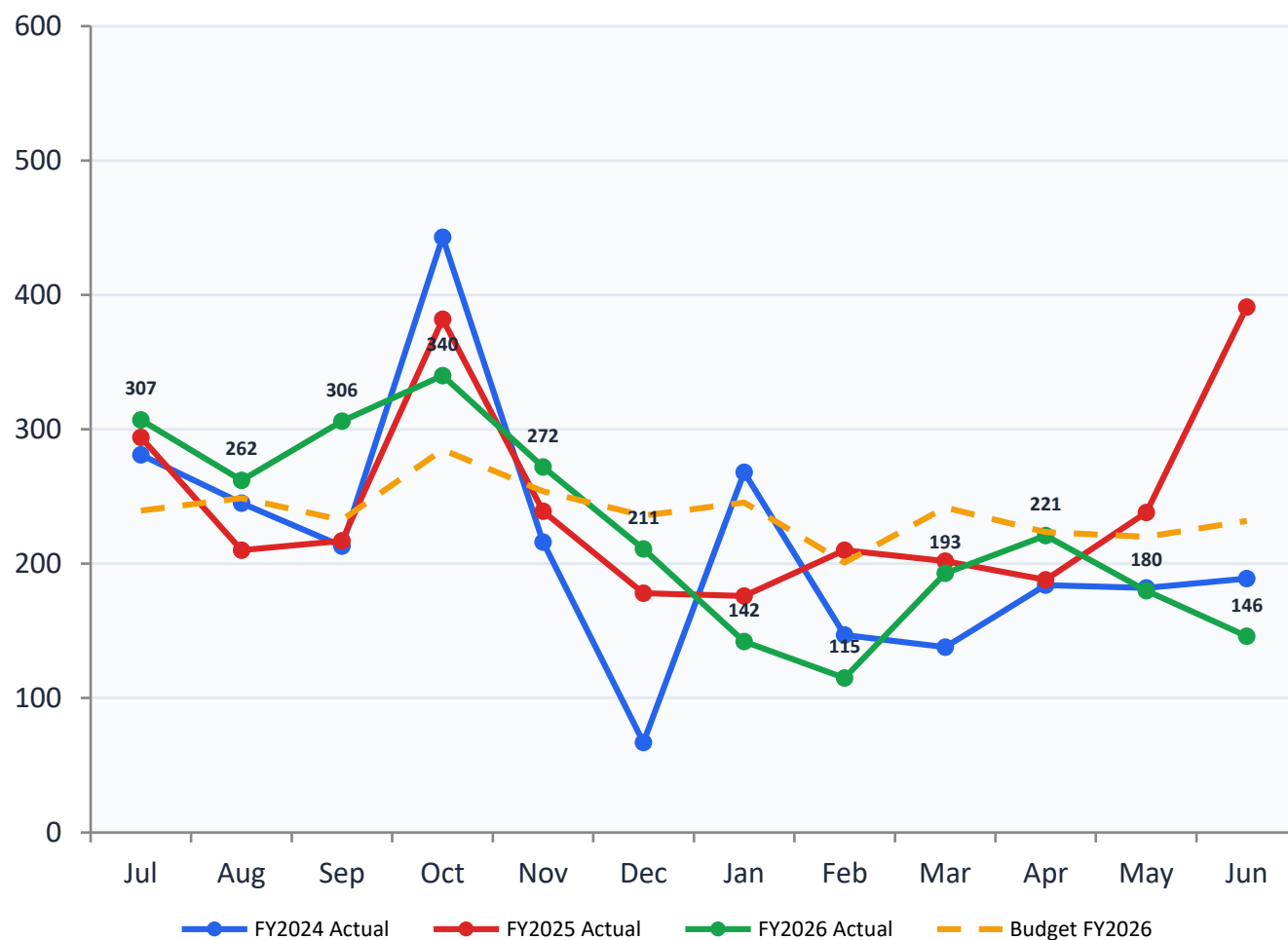
Rad Onc Treatments (Vis. & Hanf.)



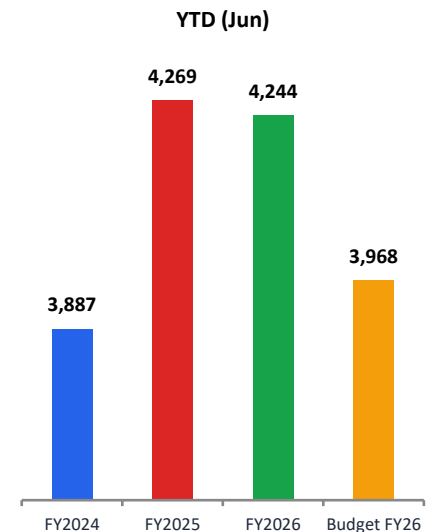
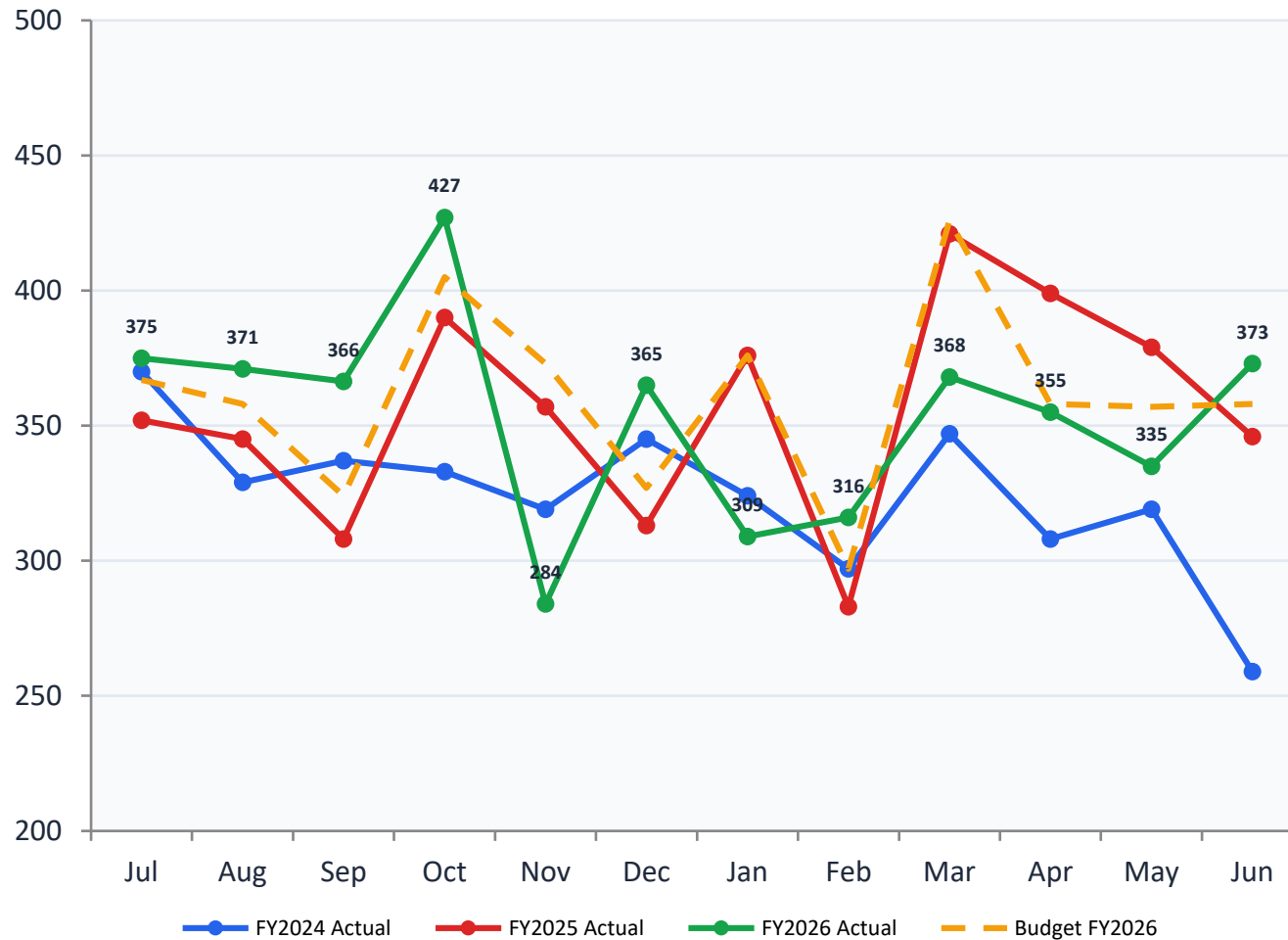
Rad Onc Visalia



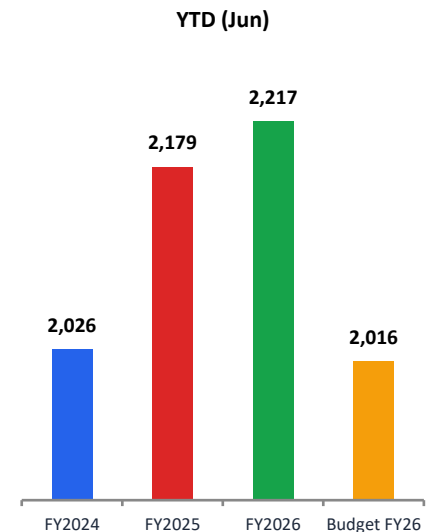
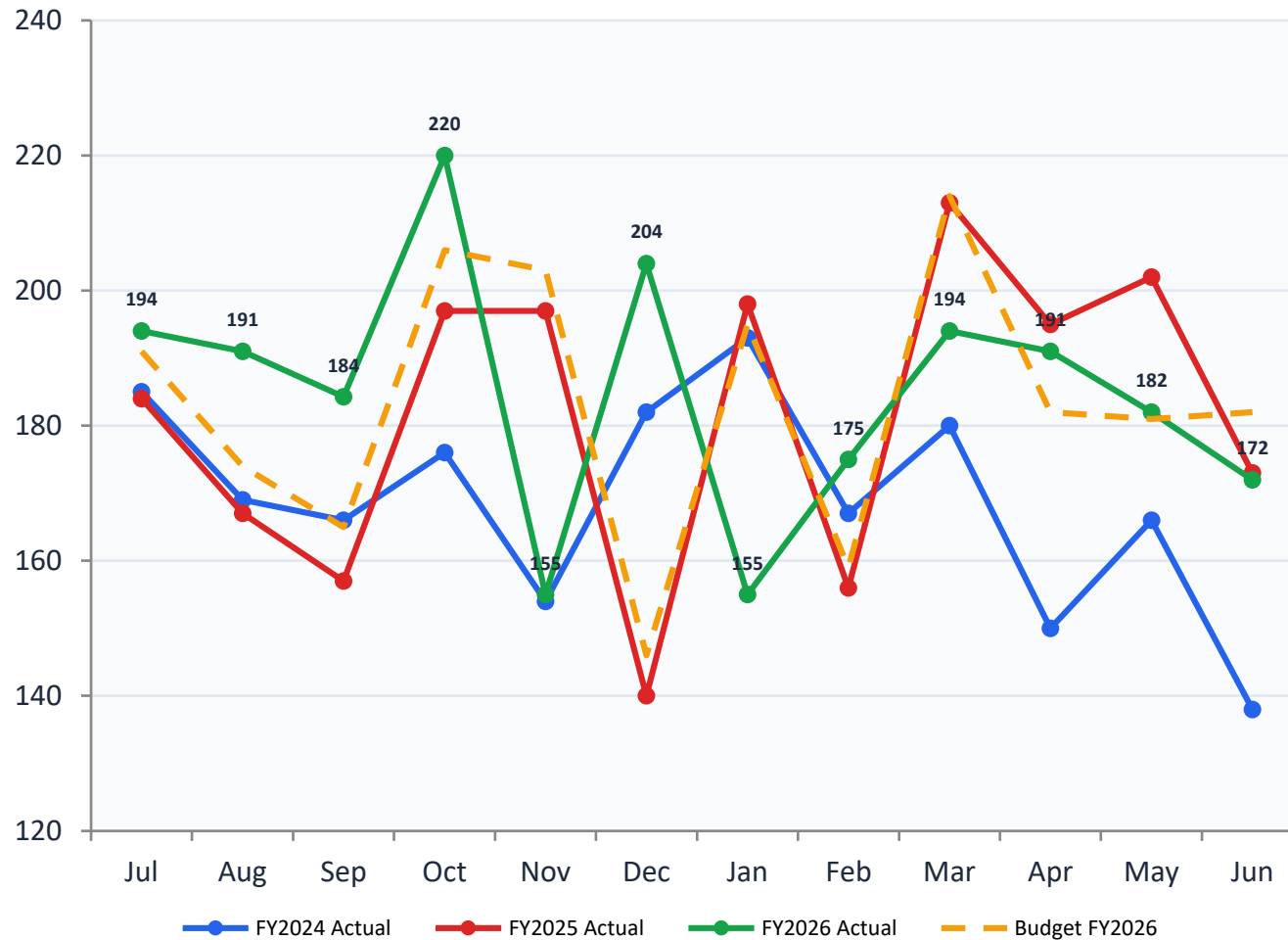
Rad Onc Hanford



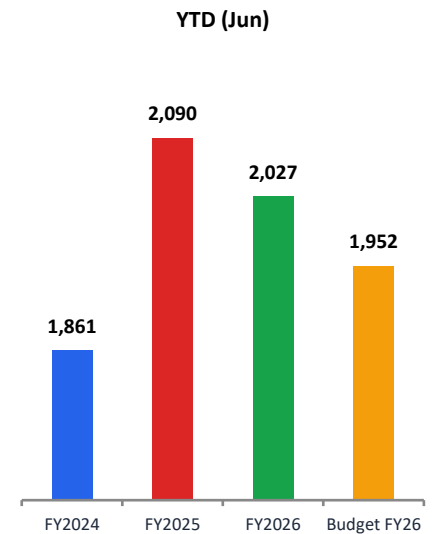
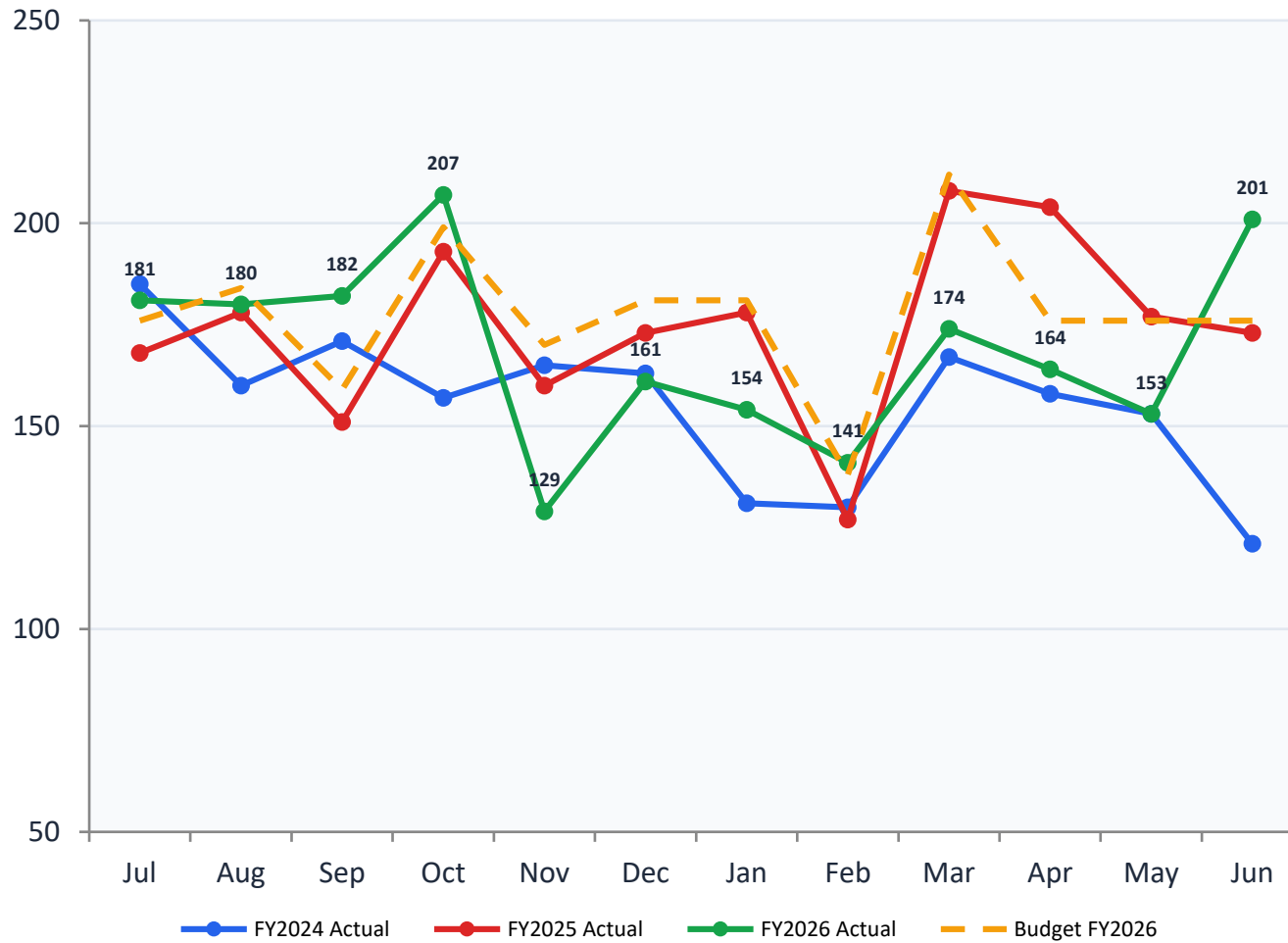
Cath Lab (IP & OP) - 100 Min Units



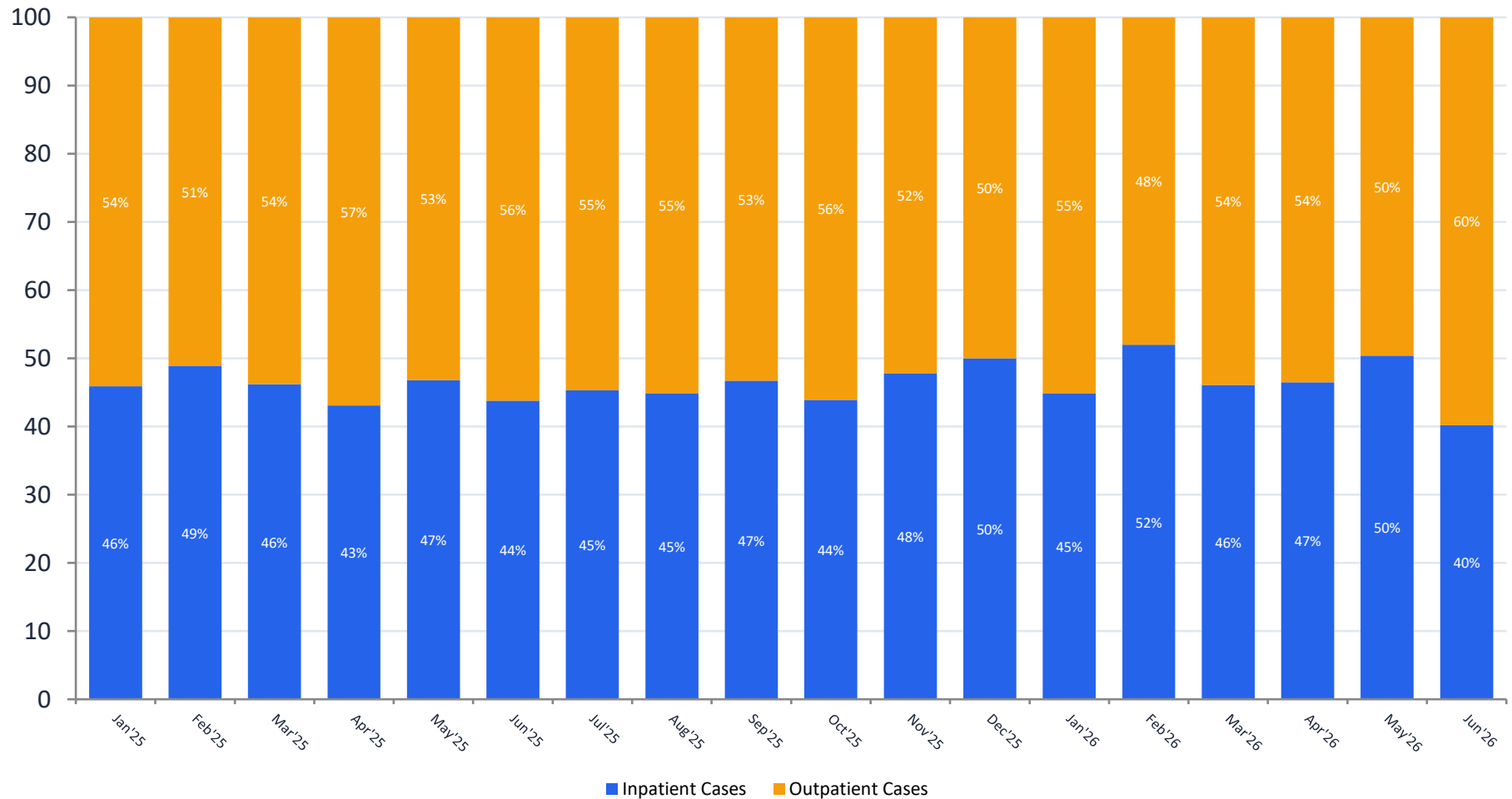
Cath Lab (IP Only) – 100 Min Units



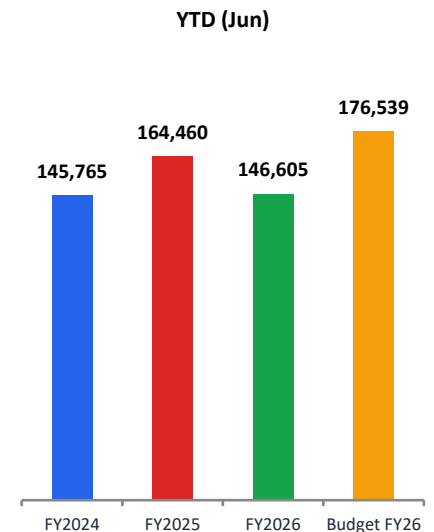
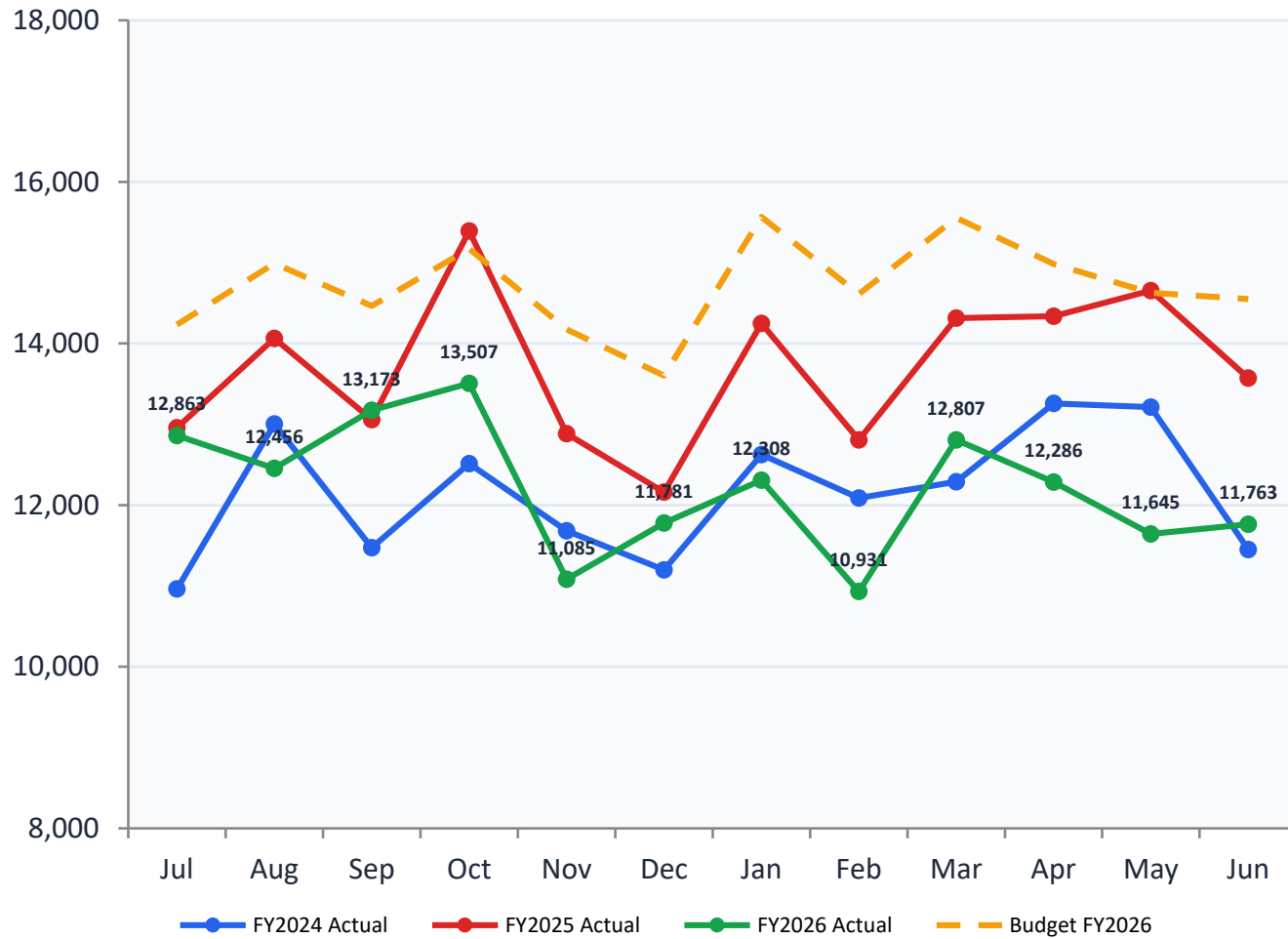
Cath Lab (OP Only) – 100 Min Units



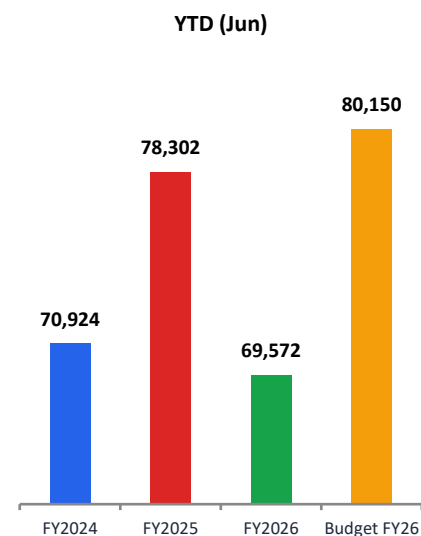
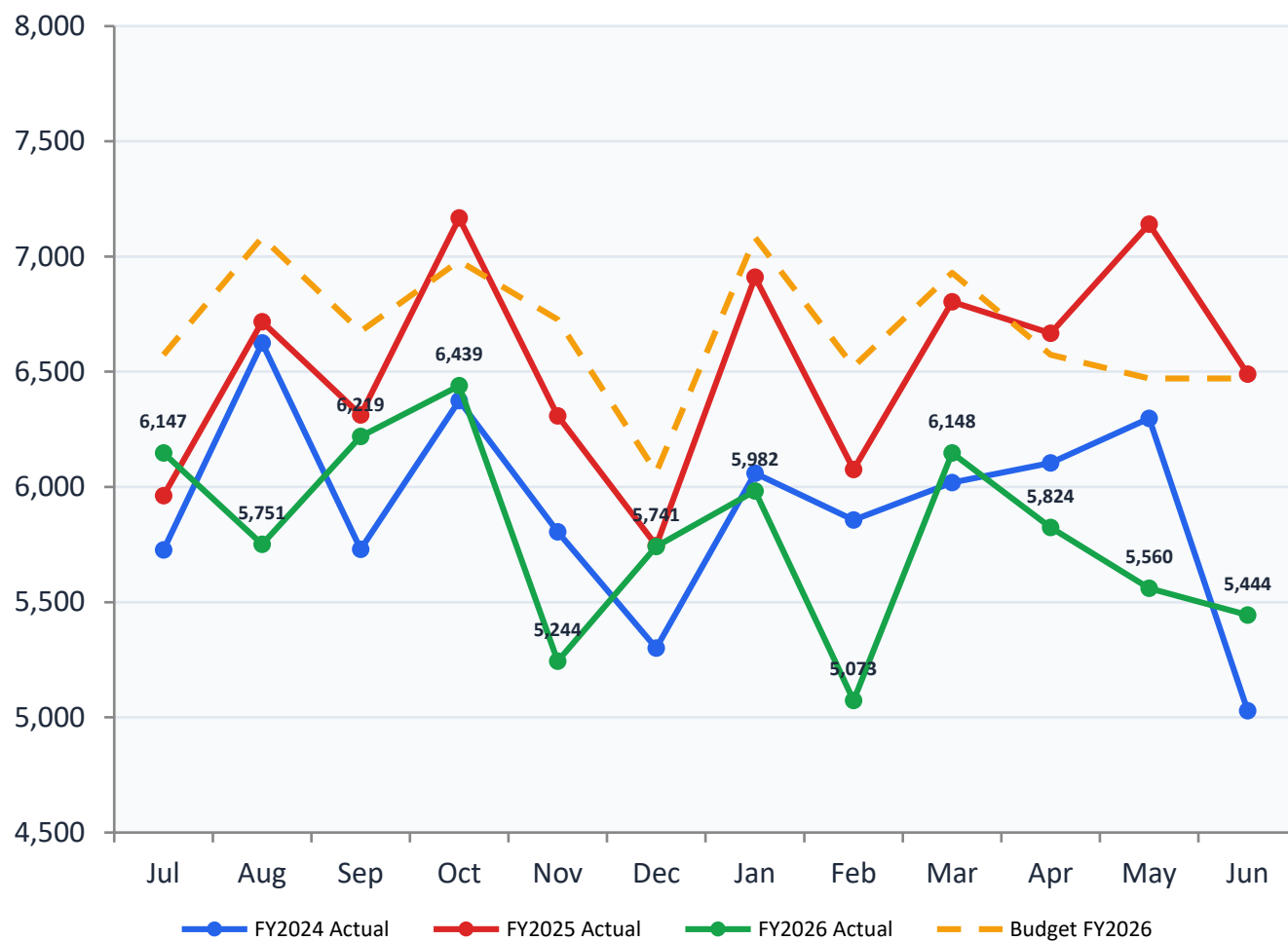
Cath Lab Patients (IP & OP)



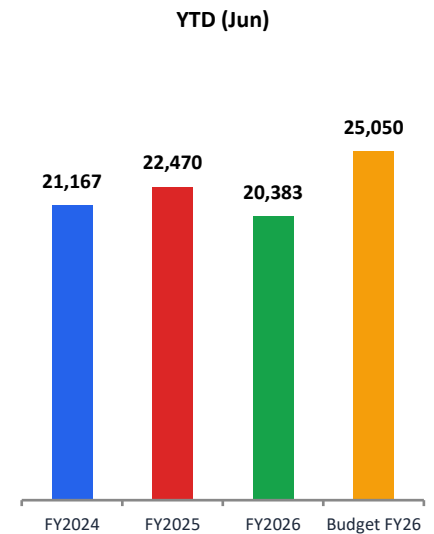
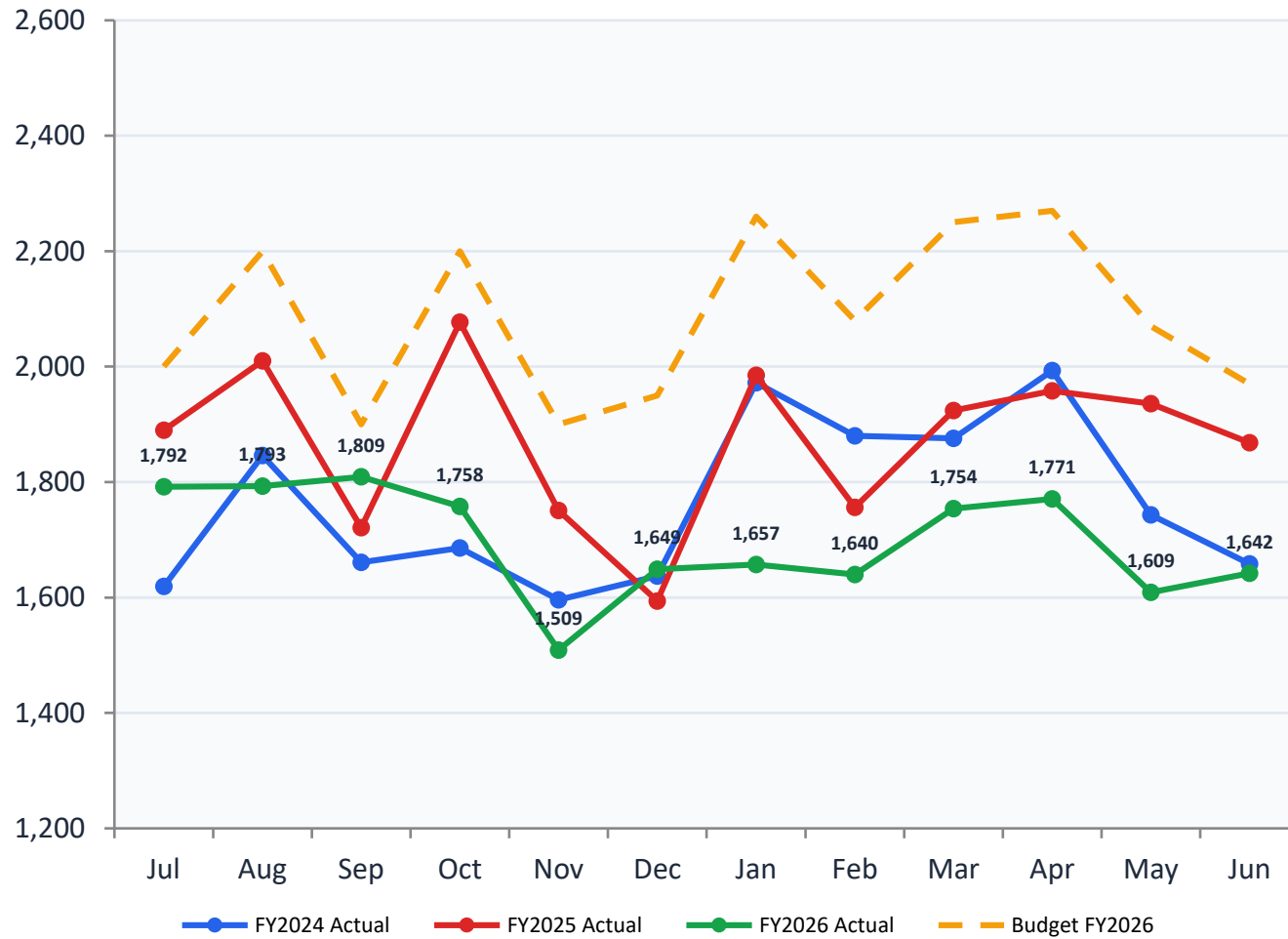
Rural Health Clinics Registrations



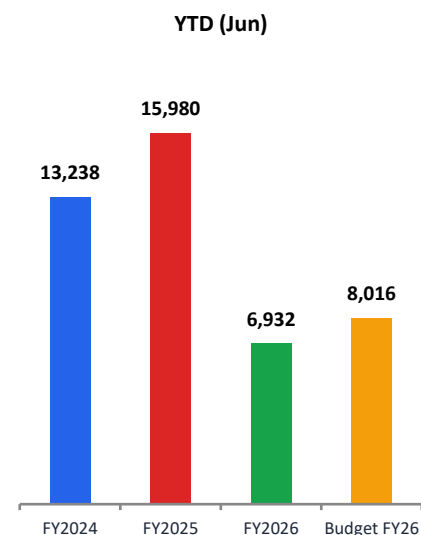
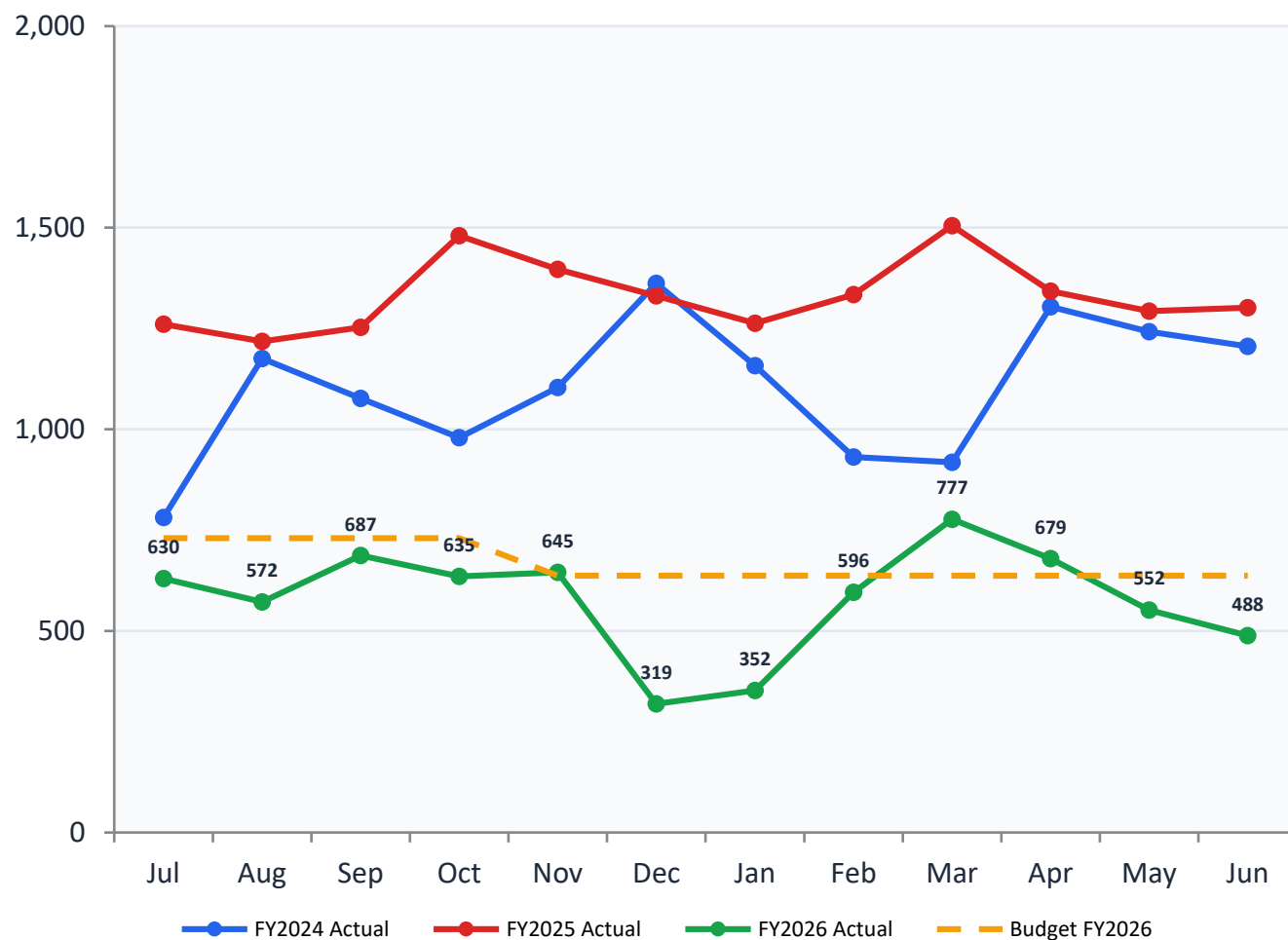
RHC Exeter - Registrations



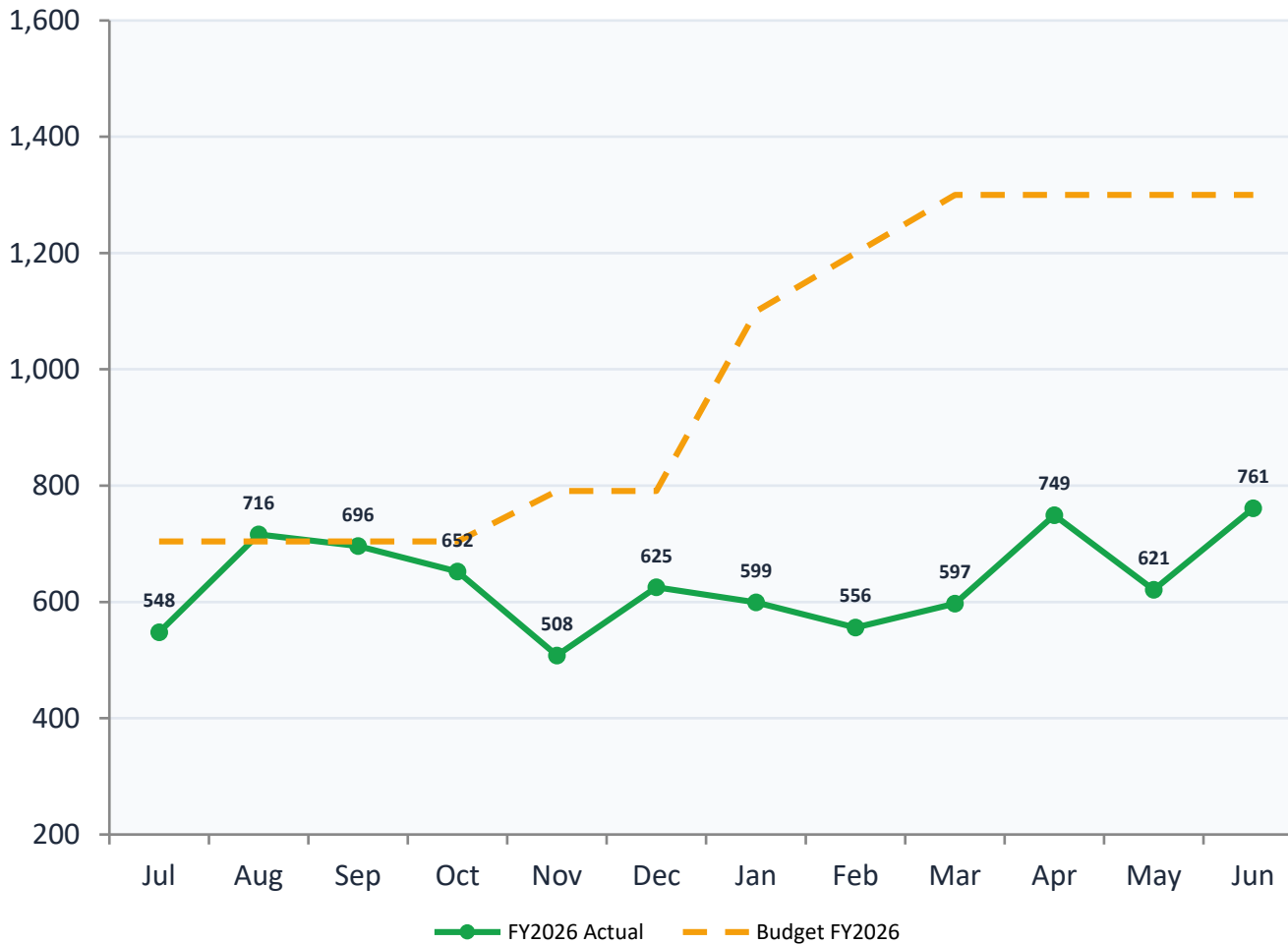
RHC Lindsay - Registrations



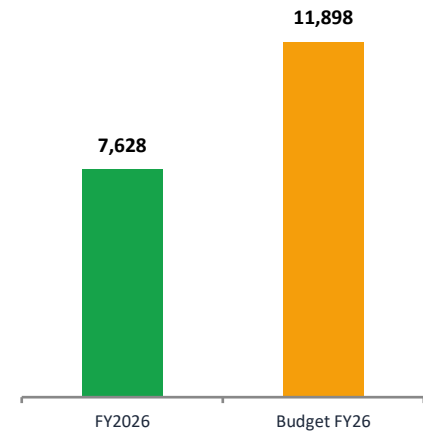
RHC Woodlake - Registrations



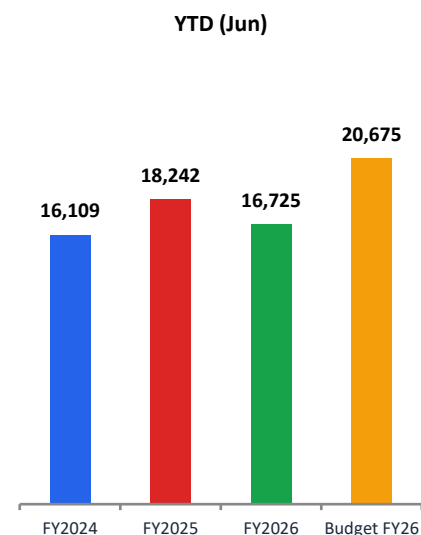
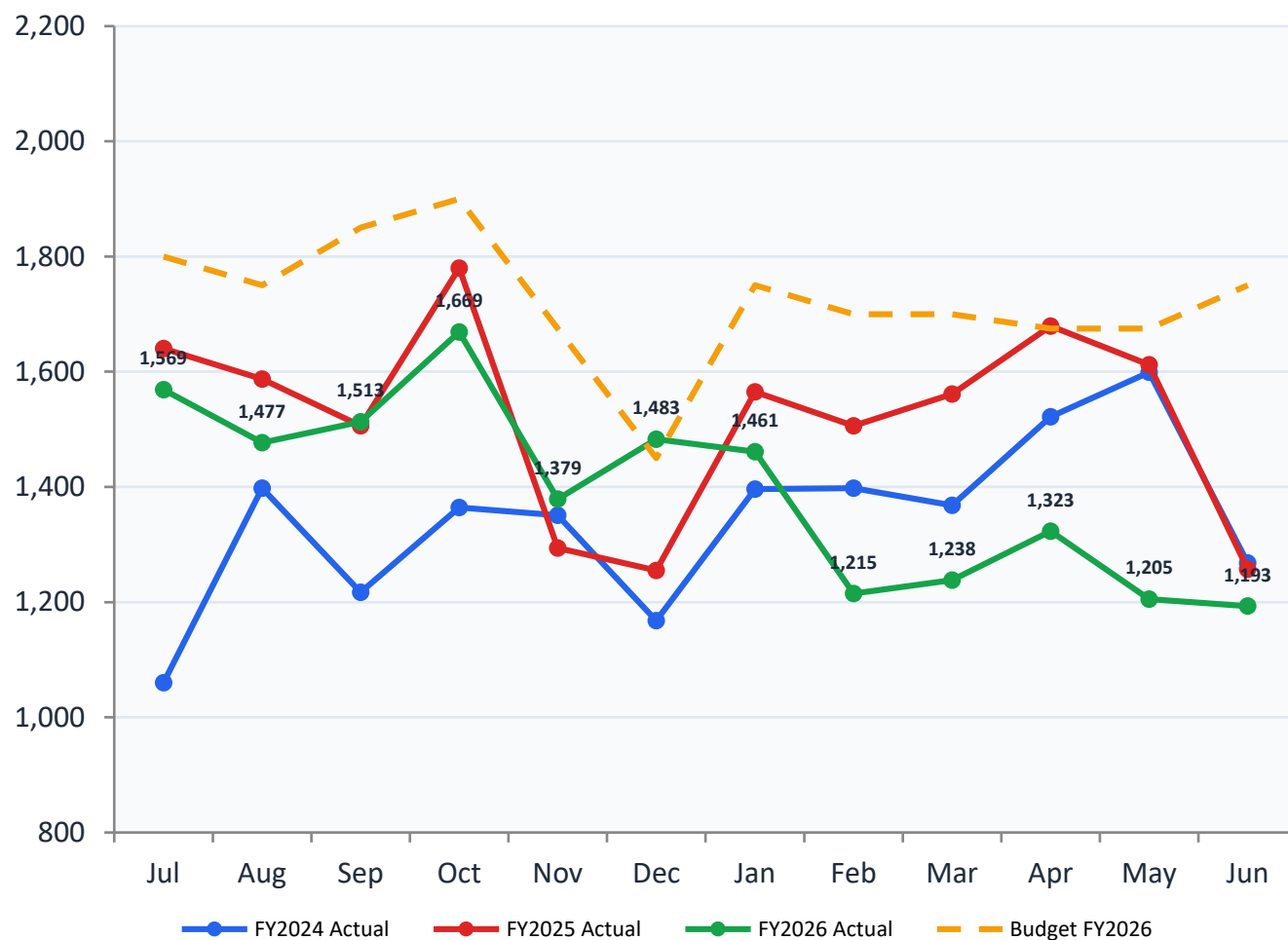
RHC Woodlake Valencia - Registrations



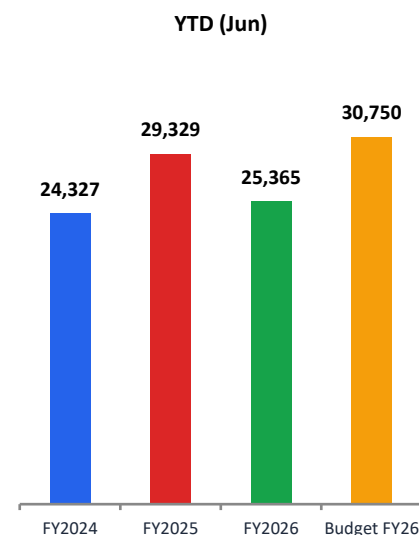
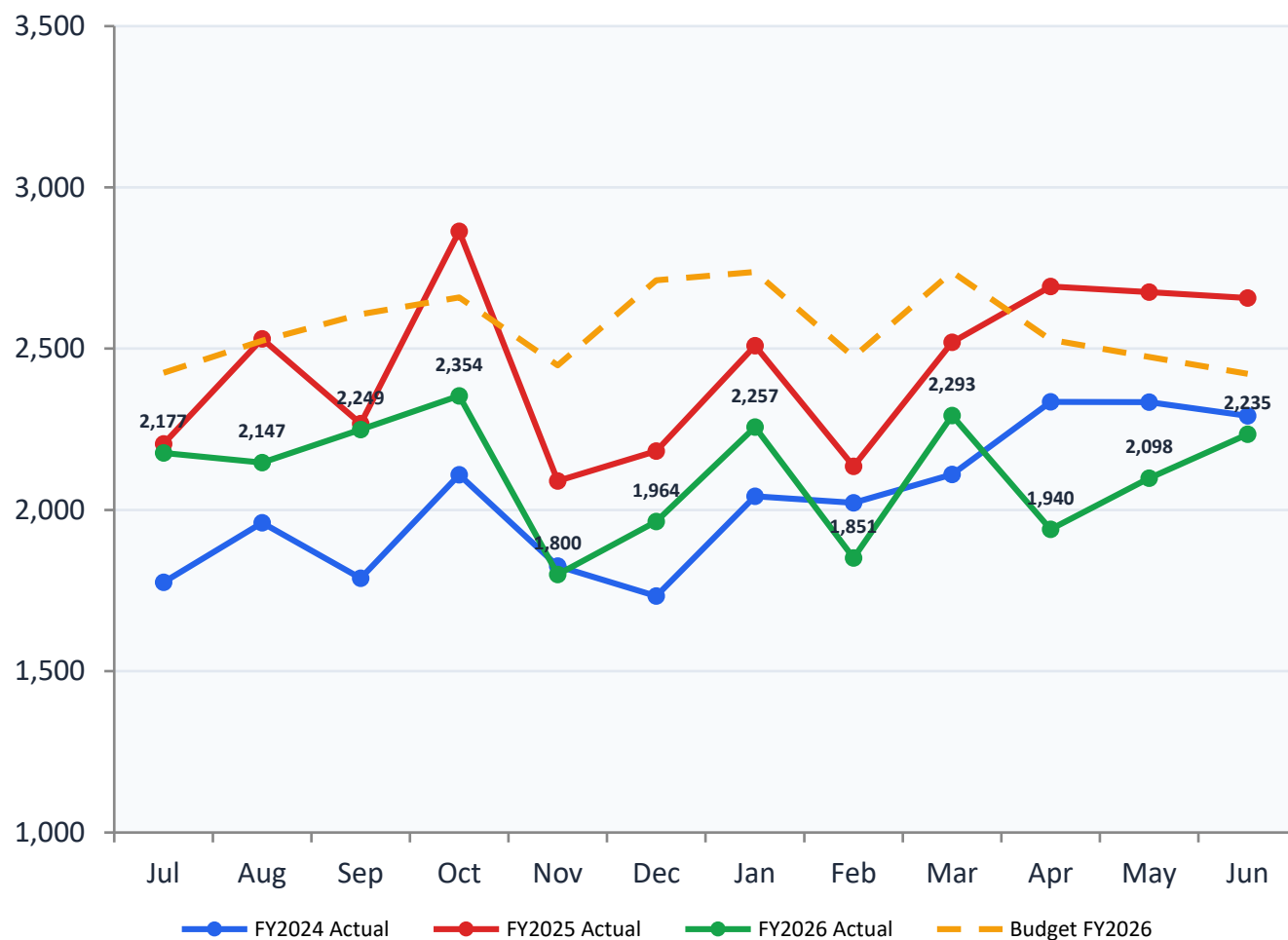
YTD (Jun)



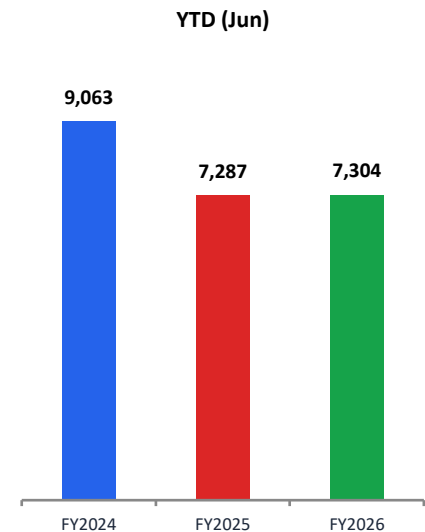
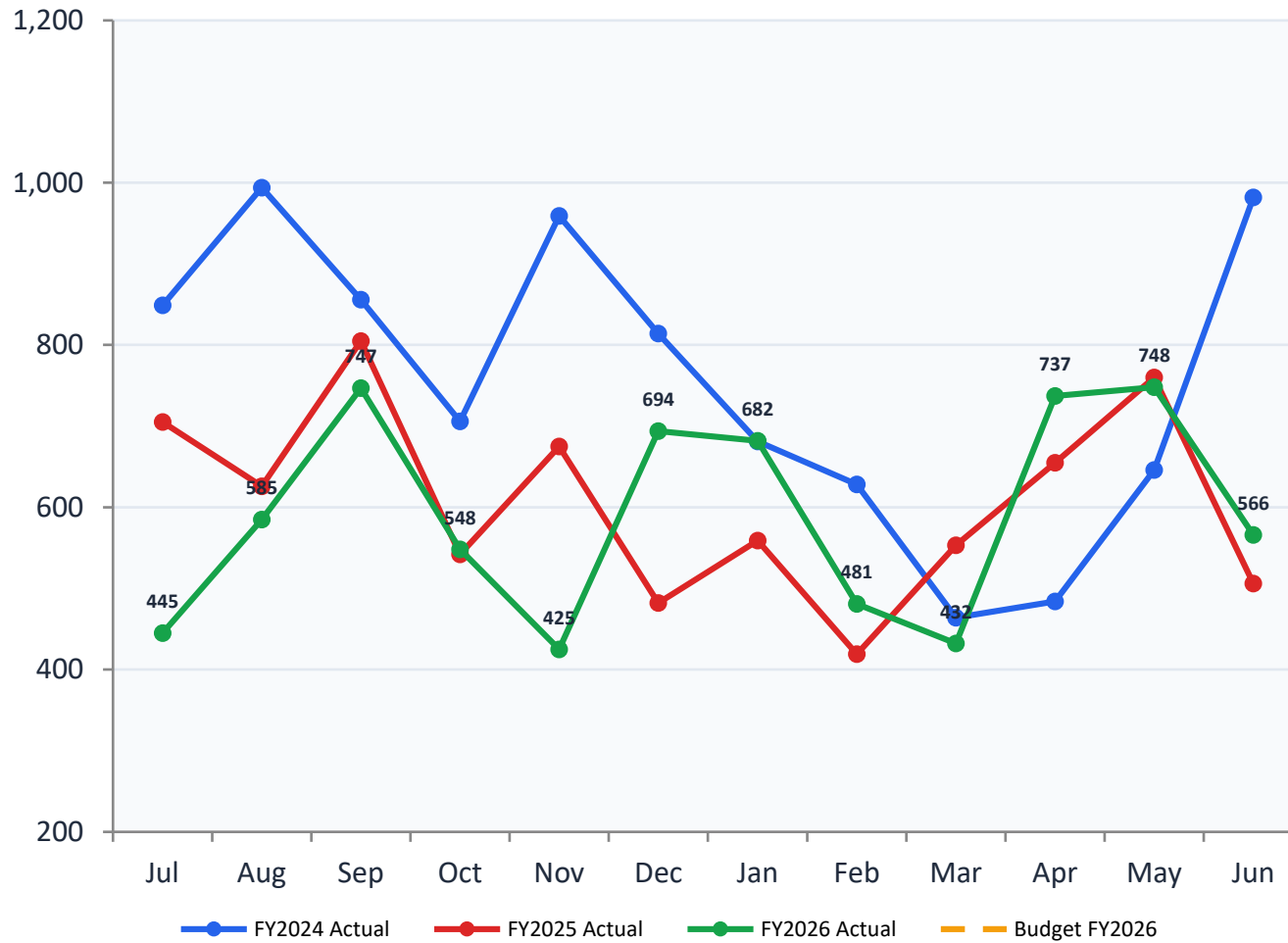
RHC Dinuba - Registrations



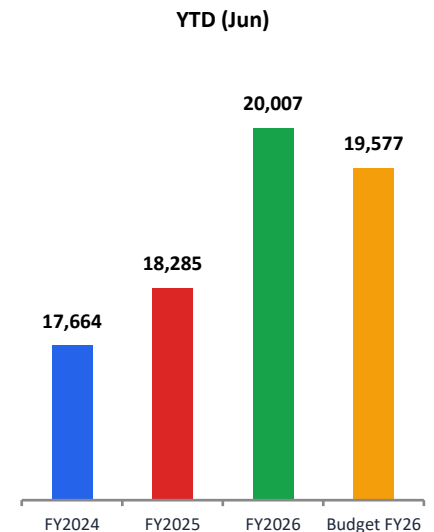
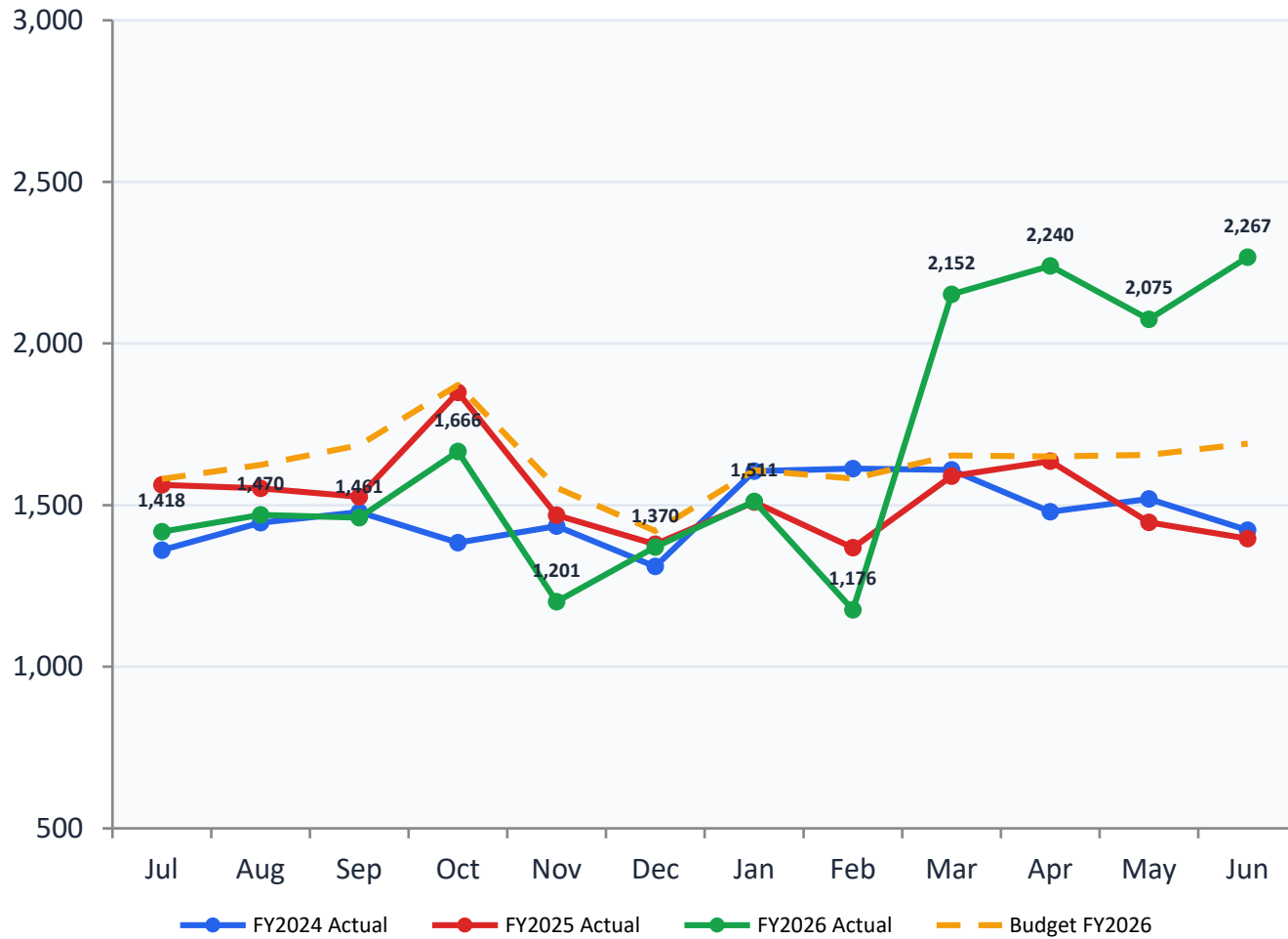
RHC Tulare - Registrations



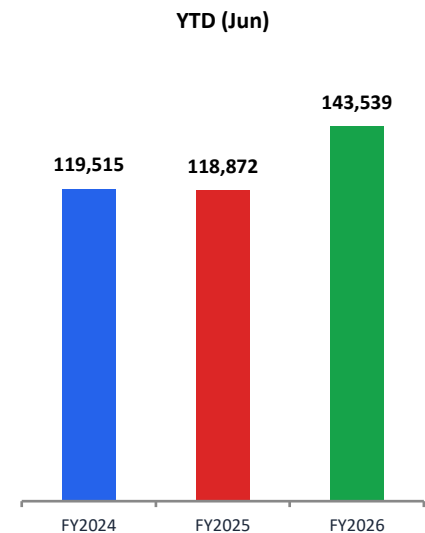
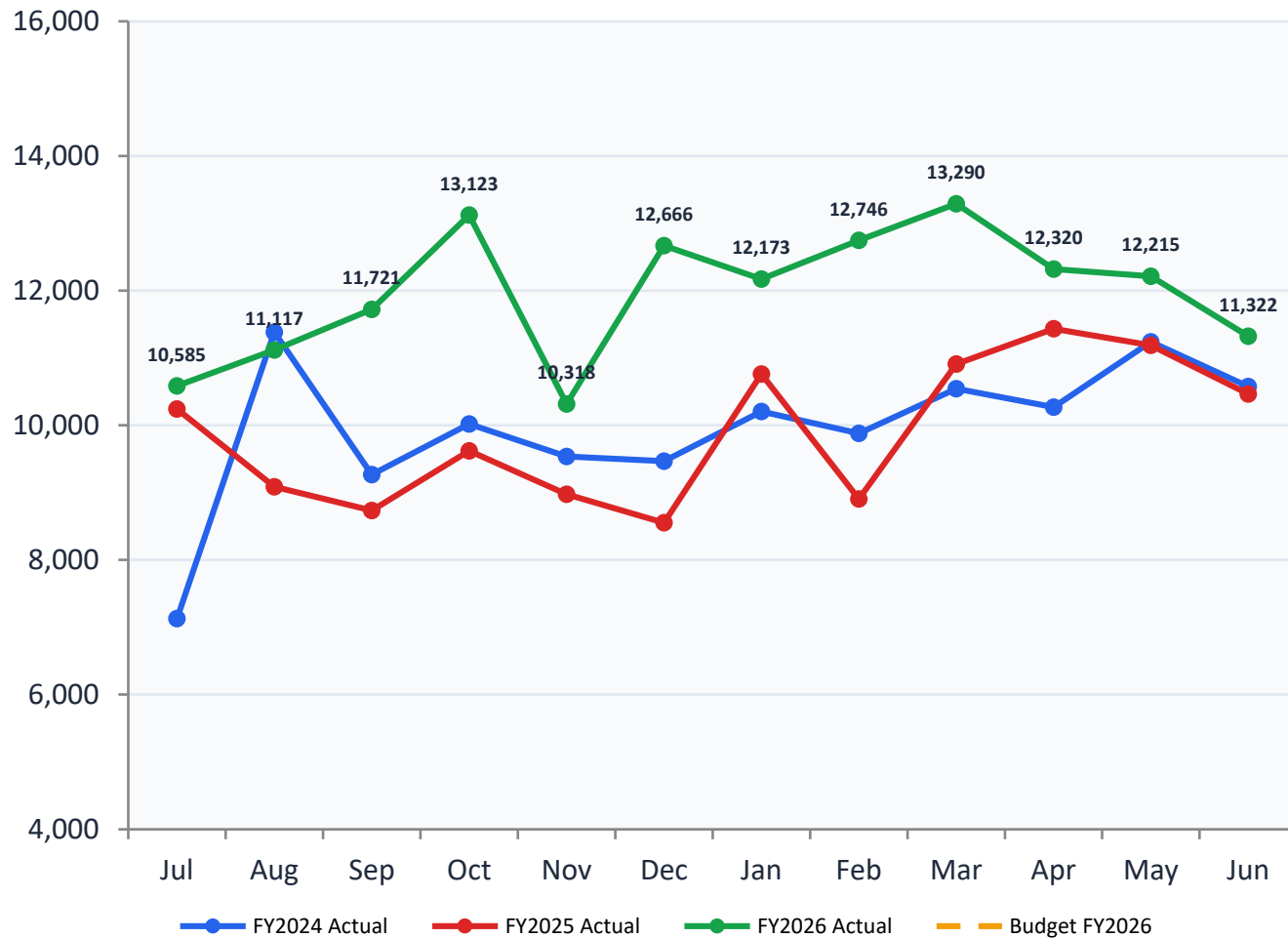
Neurosurgery Clinic - wRVU's



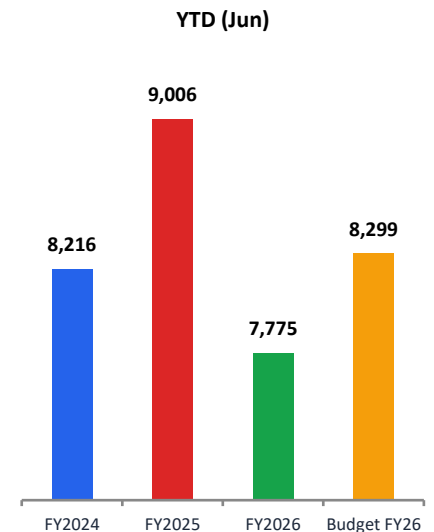
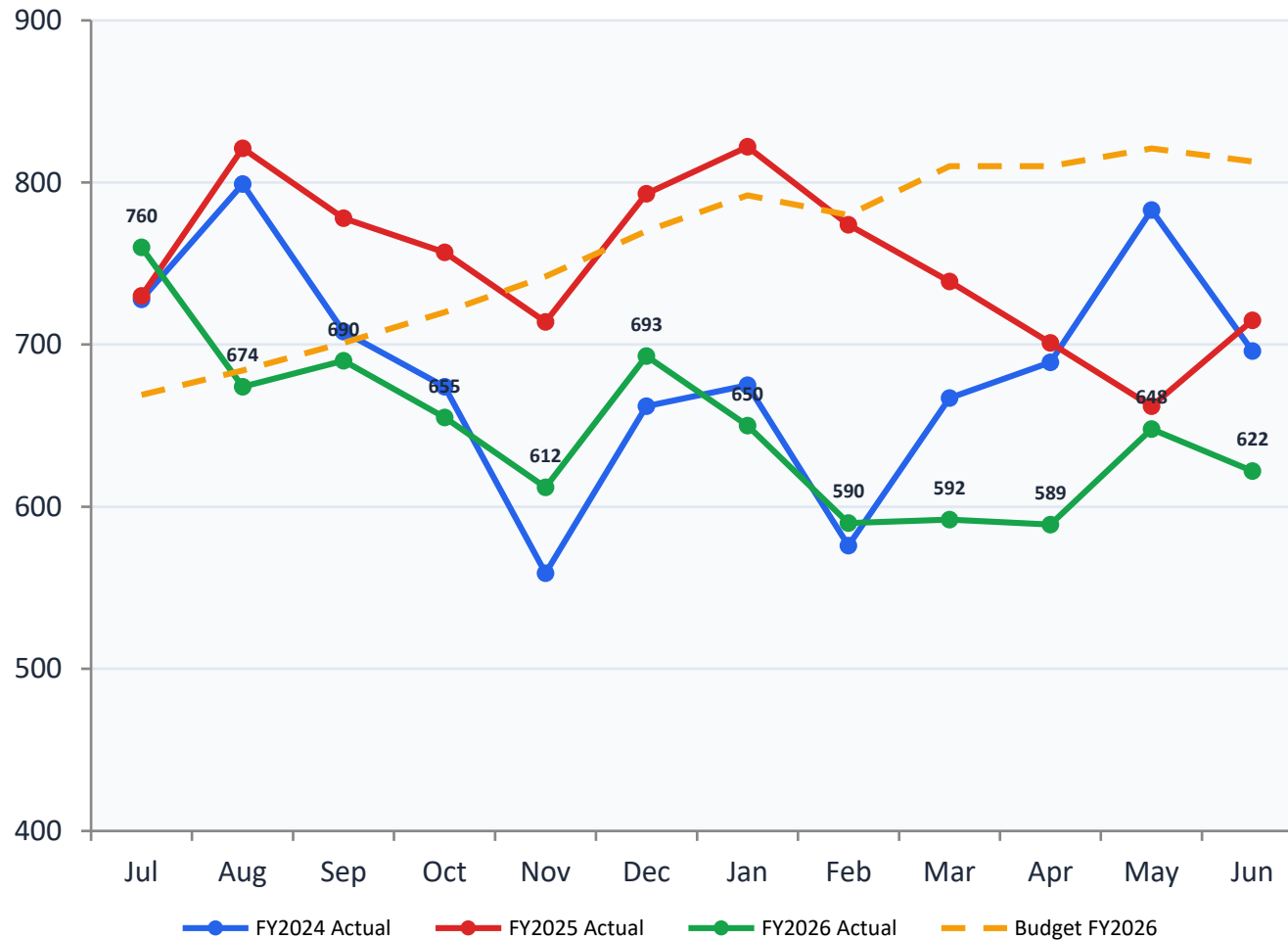
KH Cardiology Center Registrations



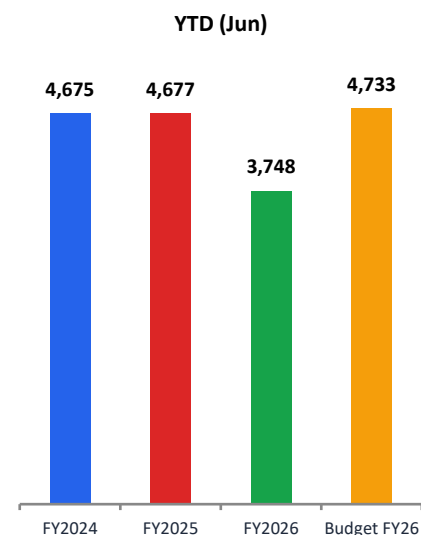
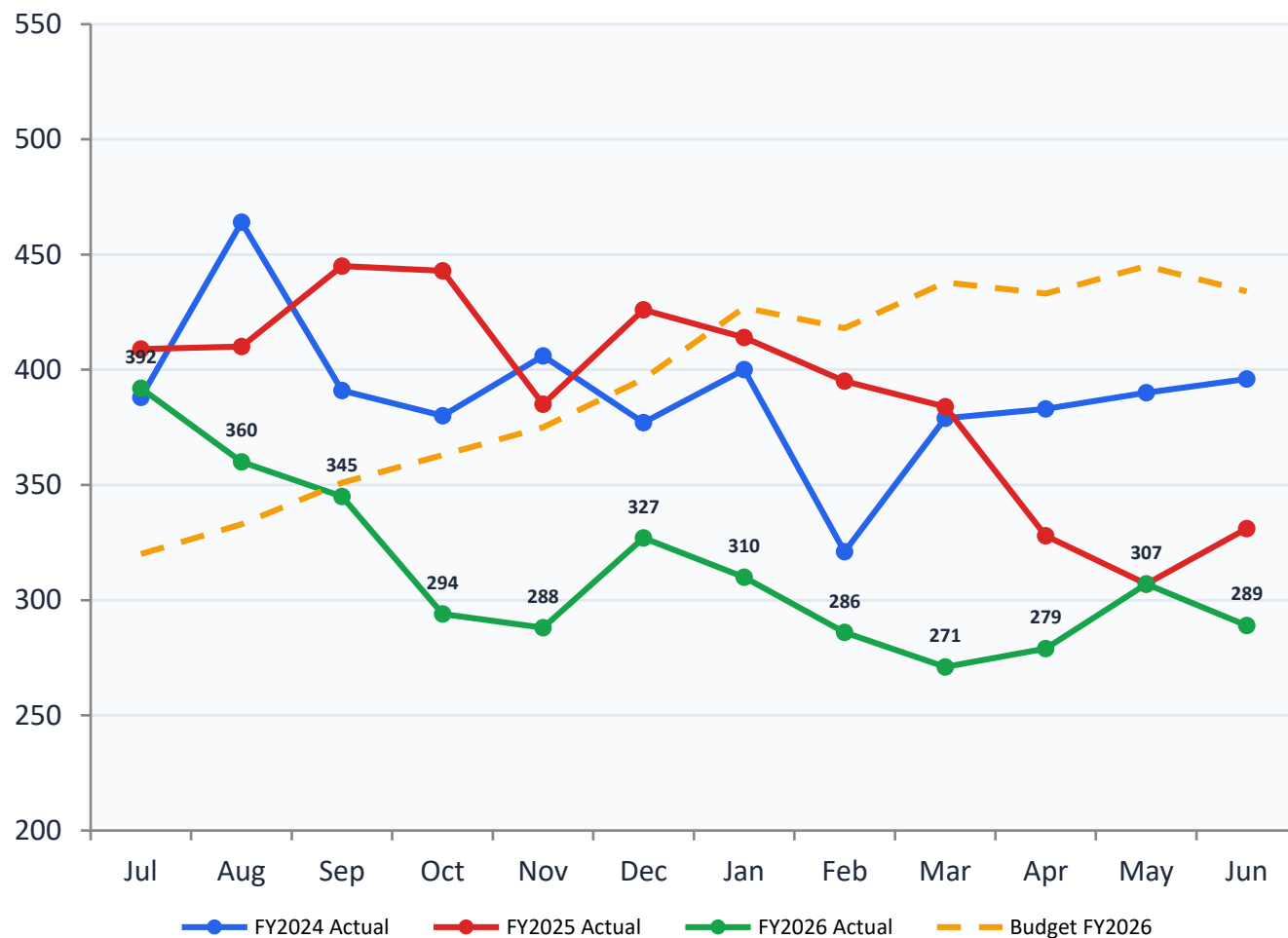
KH Cardiology Center - wRVU's



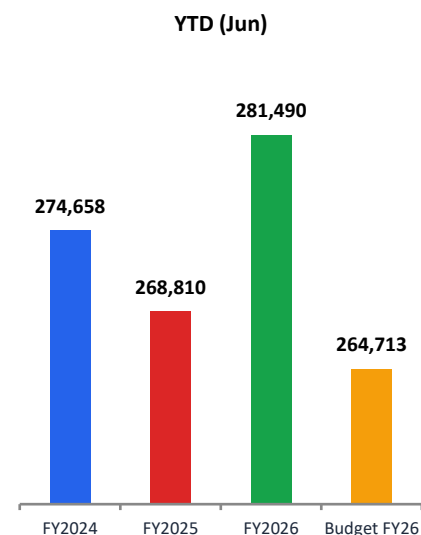
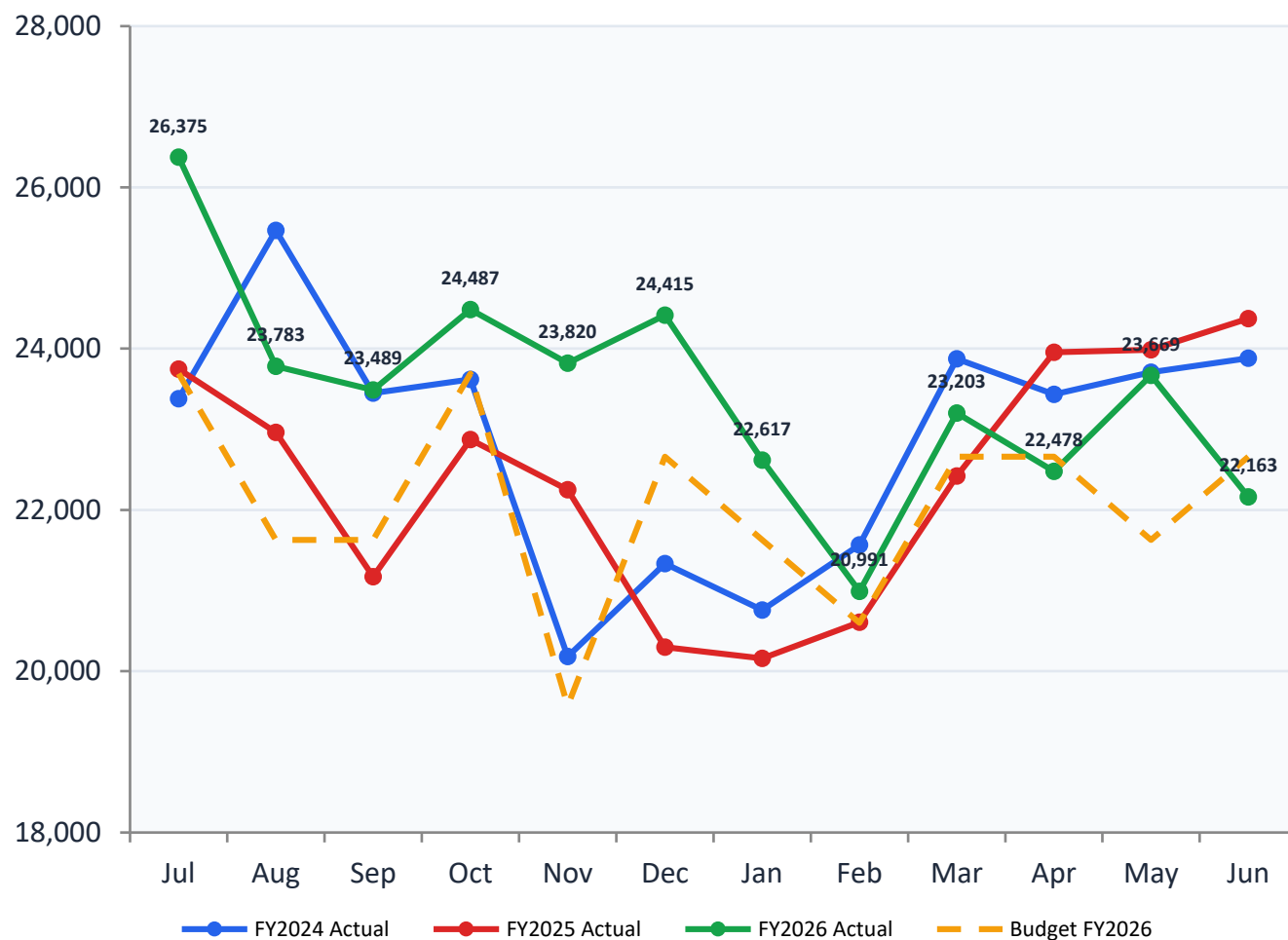
Labor Triage Registrations



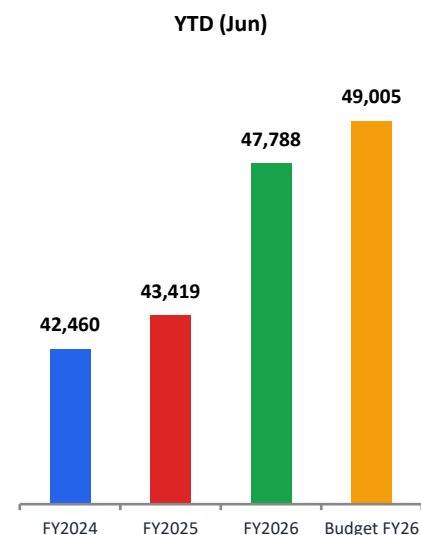
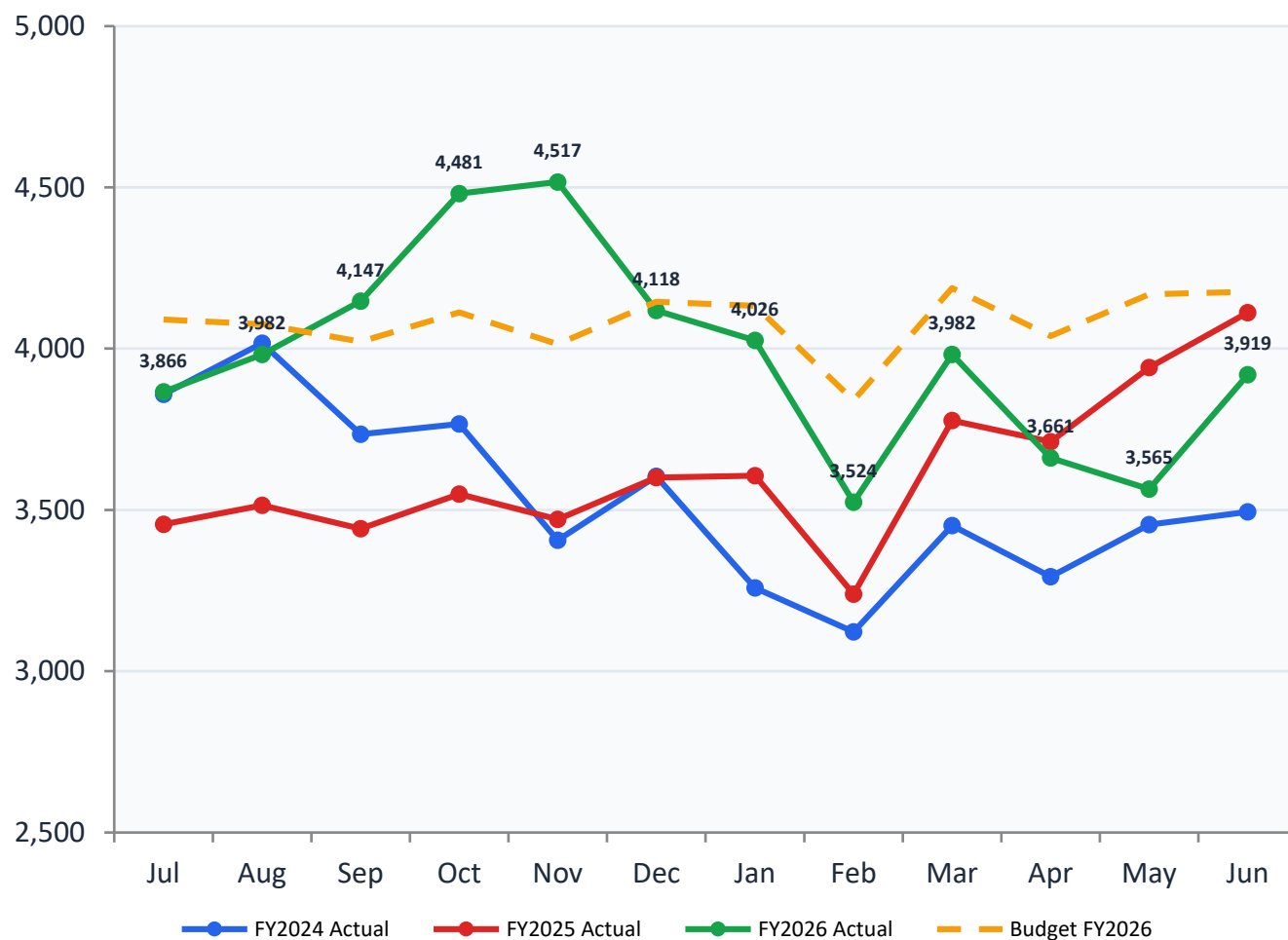
Deliveries



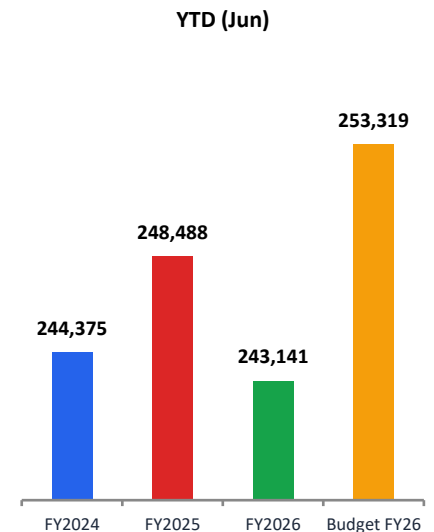
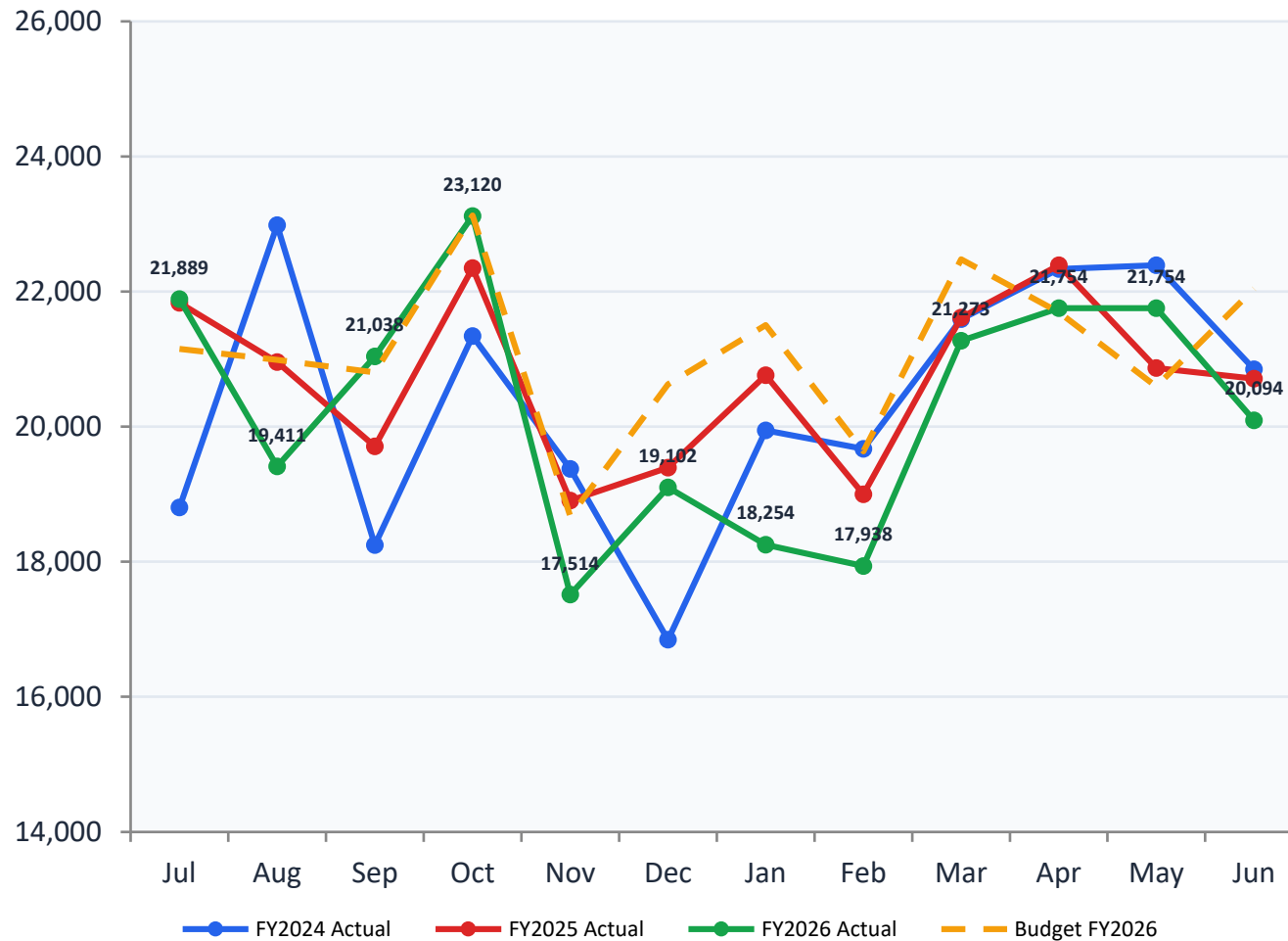
Home Infusion Days



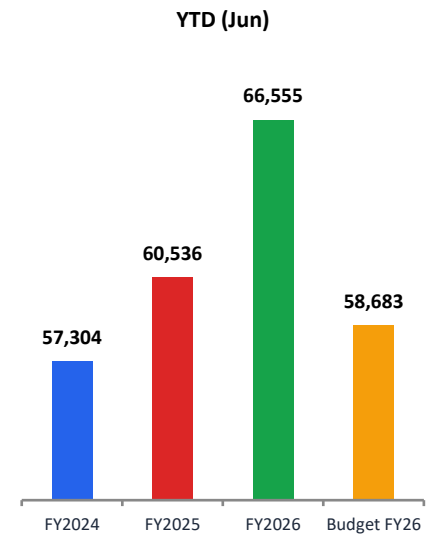
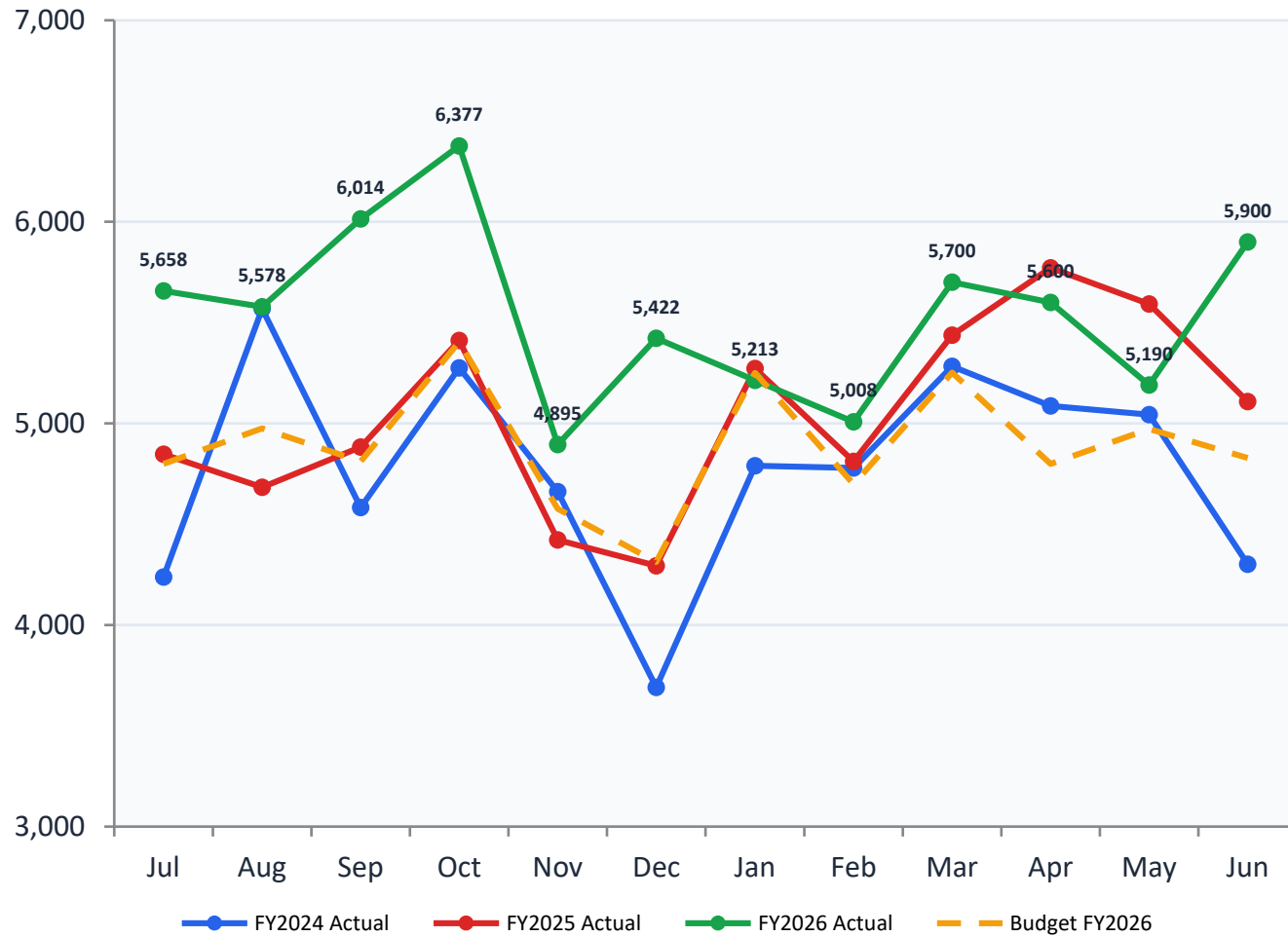
Hospice Days



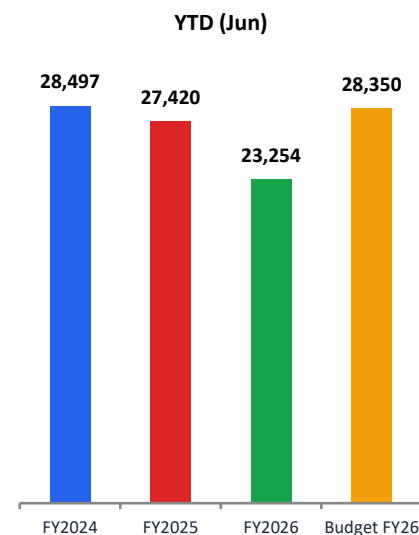
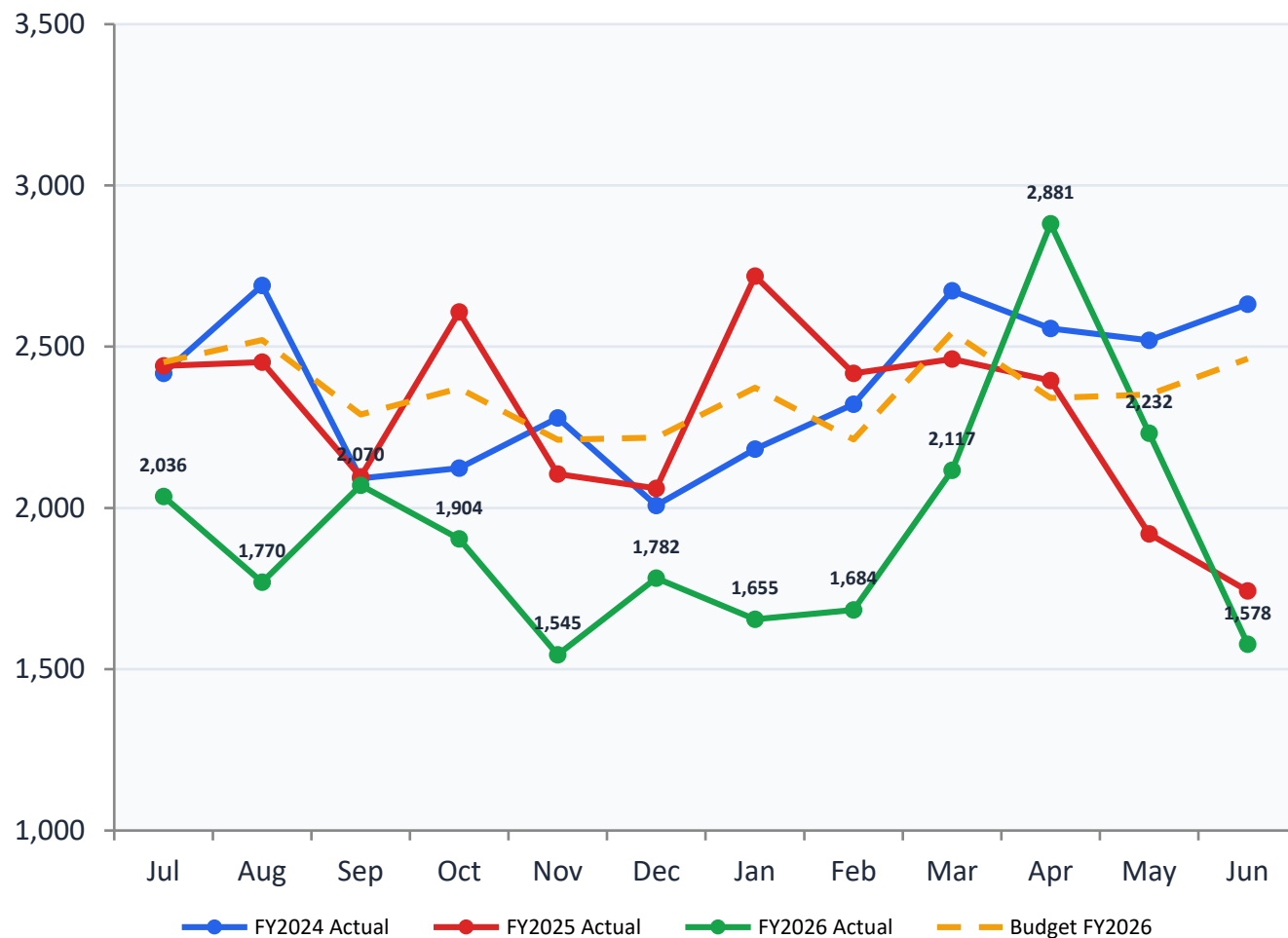
All O/P Rehab Svcs Across District



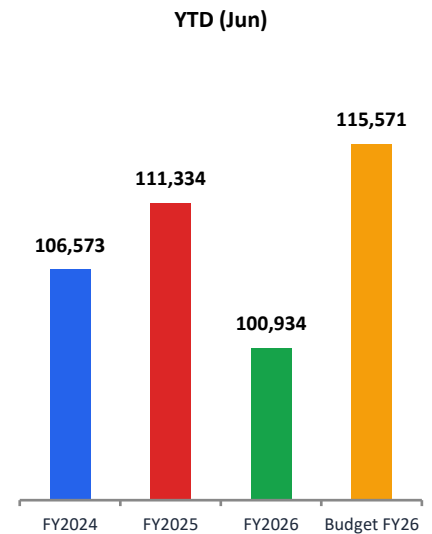
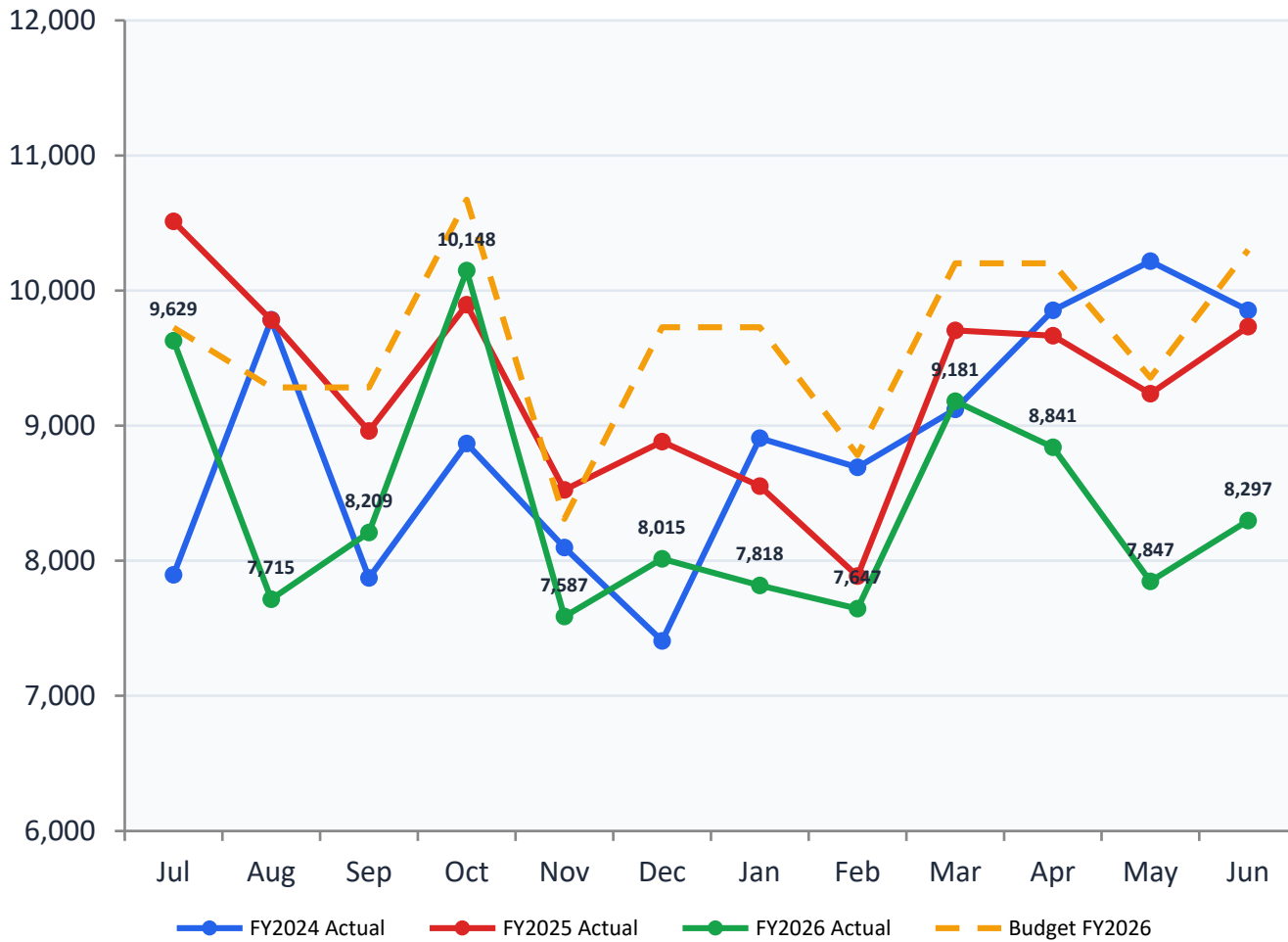
O/P Rehab Services



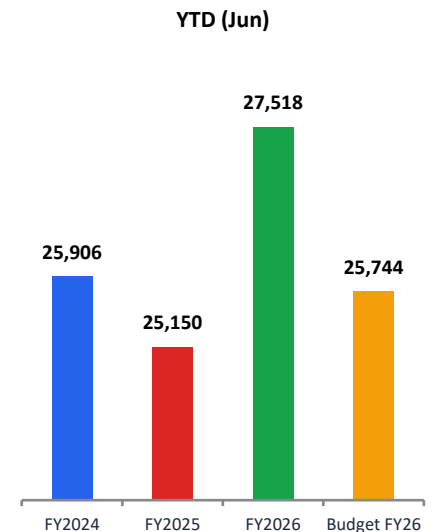
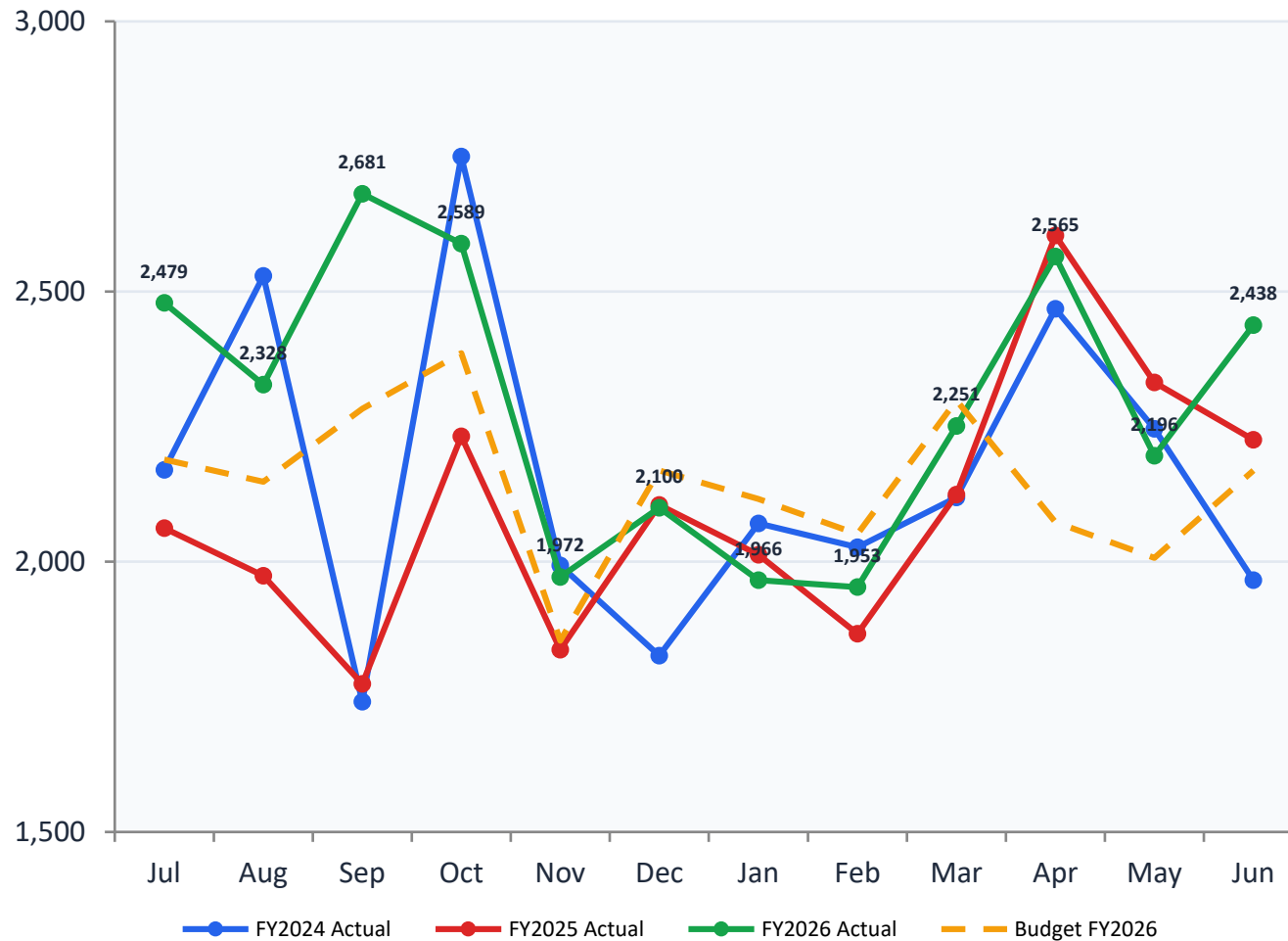
O/P Rehab - Exeter



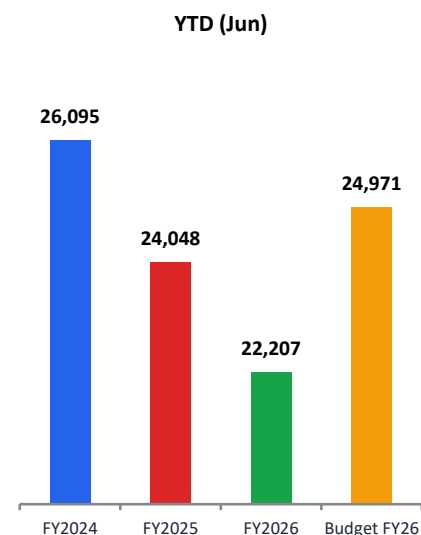
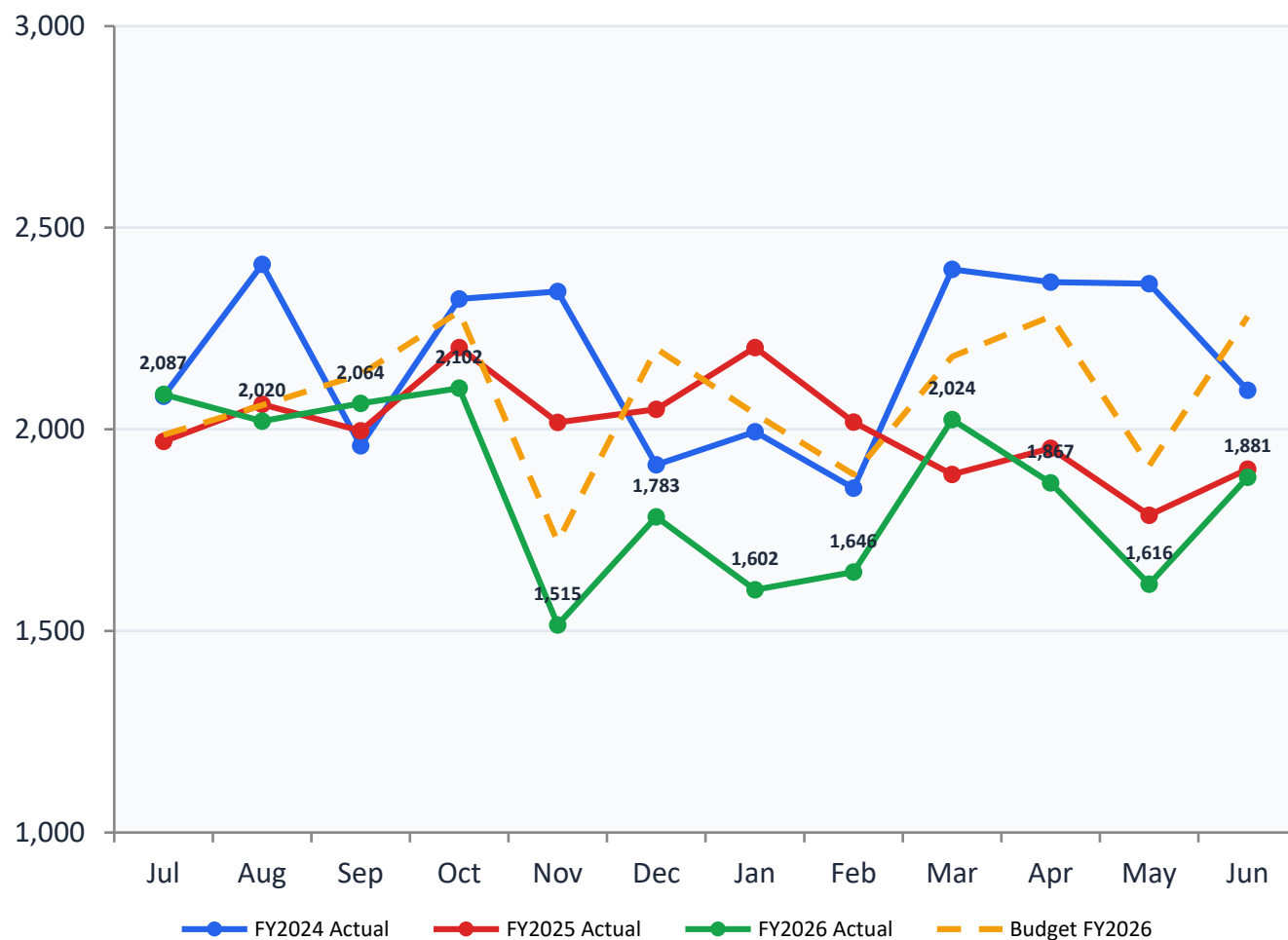
O/P Rehab - Akers



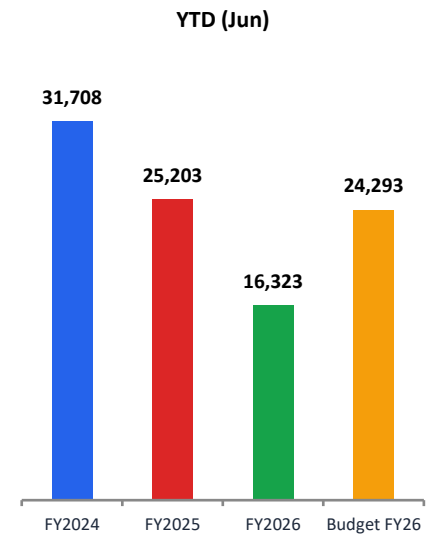
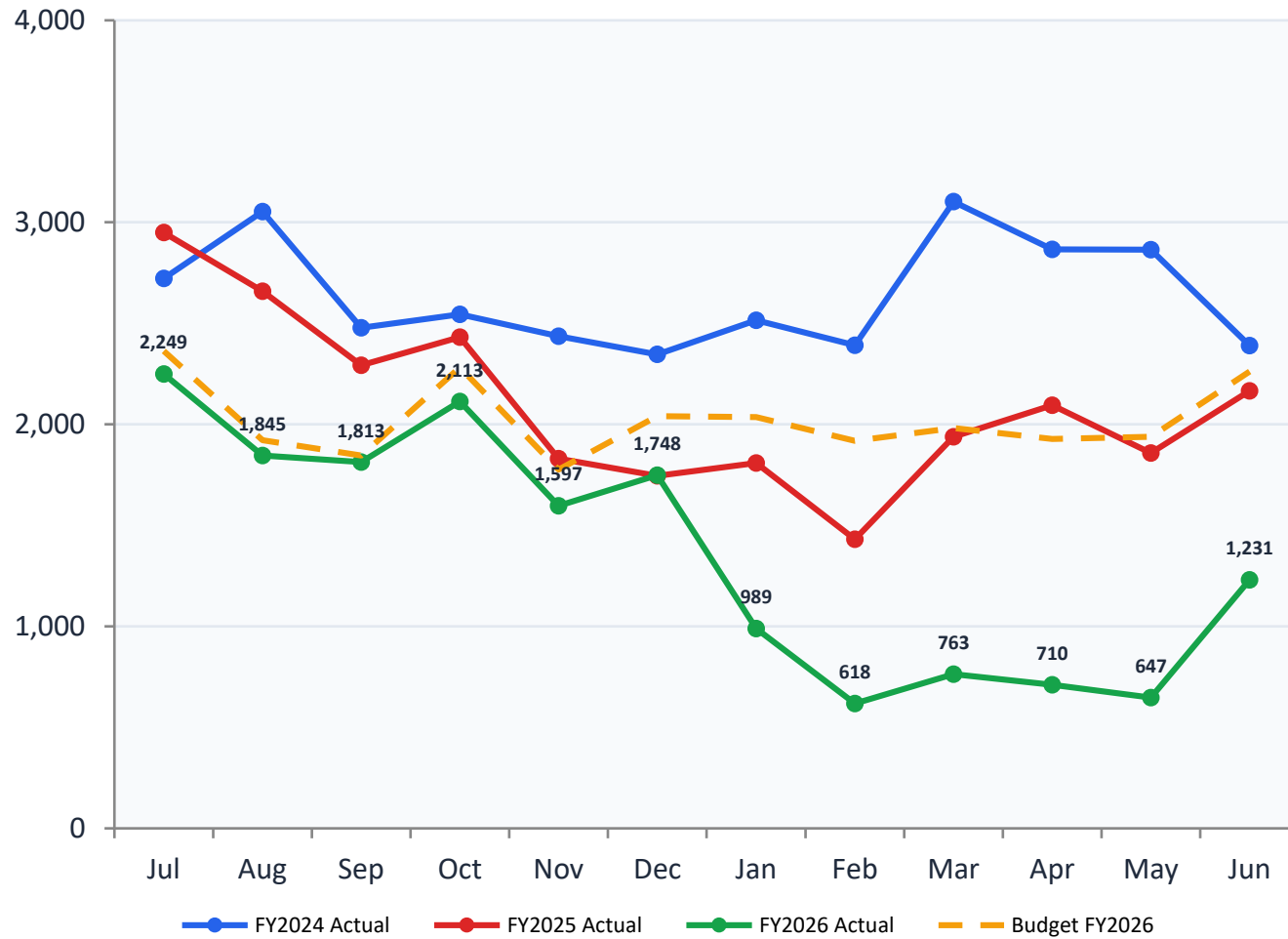
O/P Rehab - LLOPT



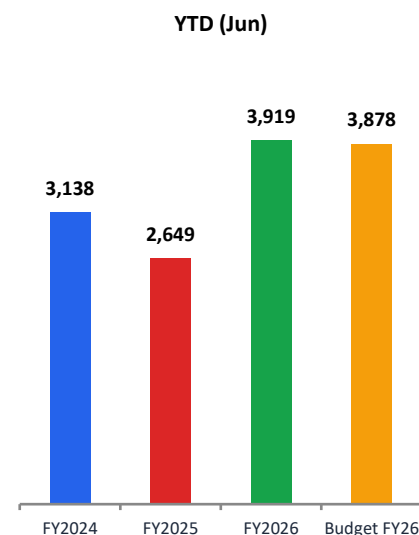
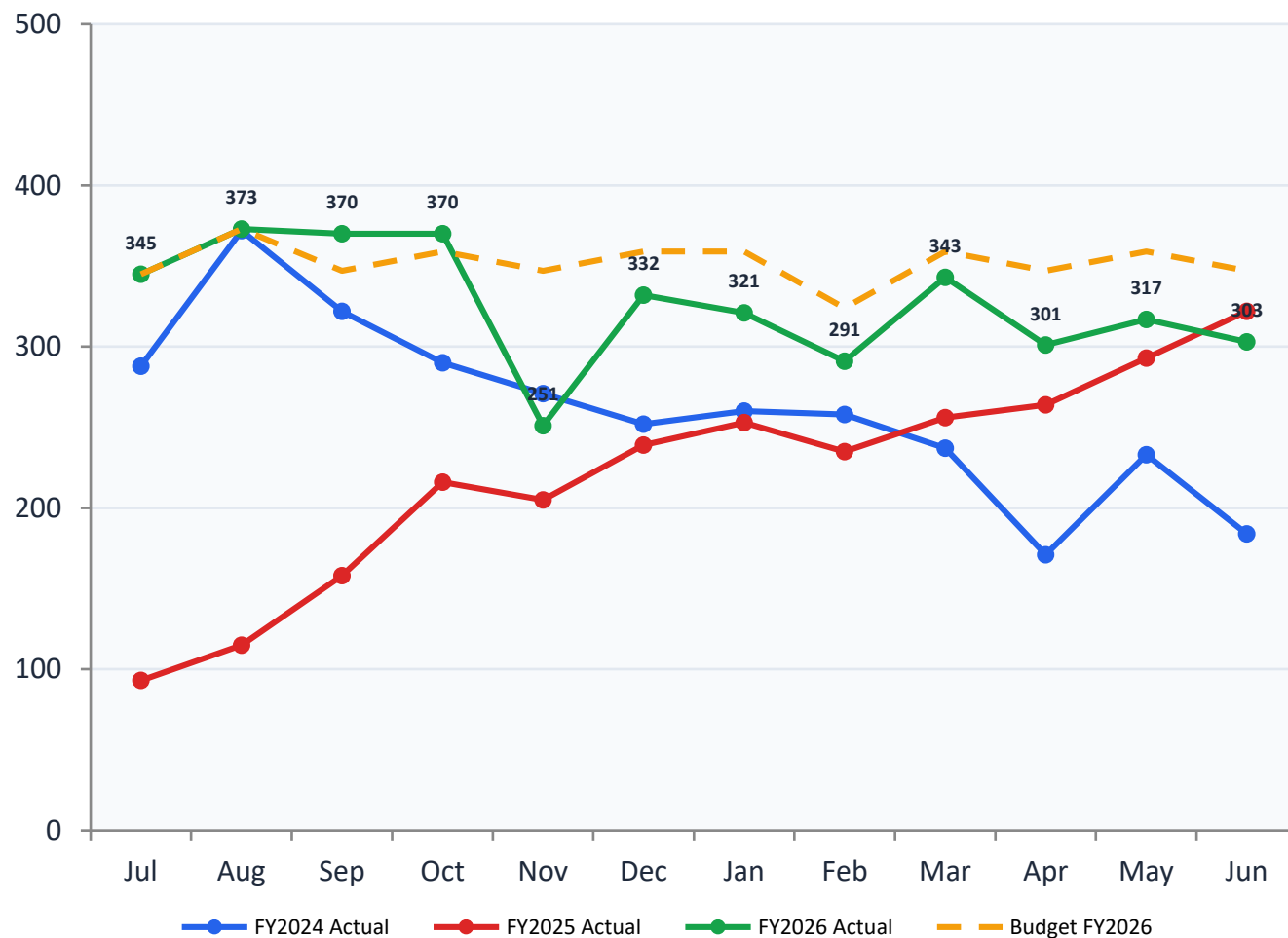
O/P Rehab - Dinuba



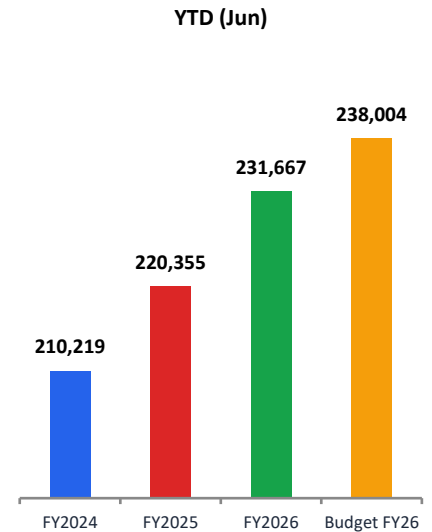
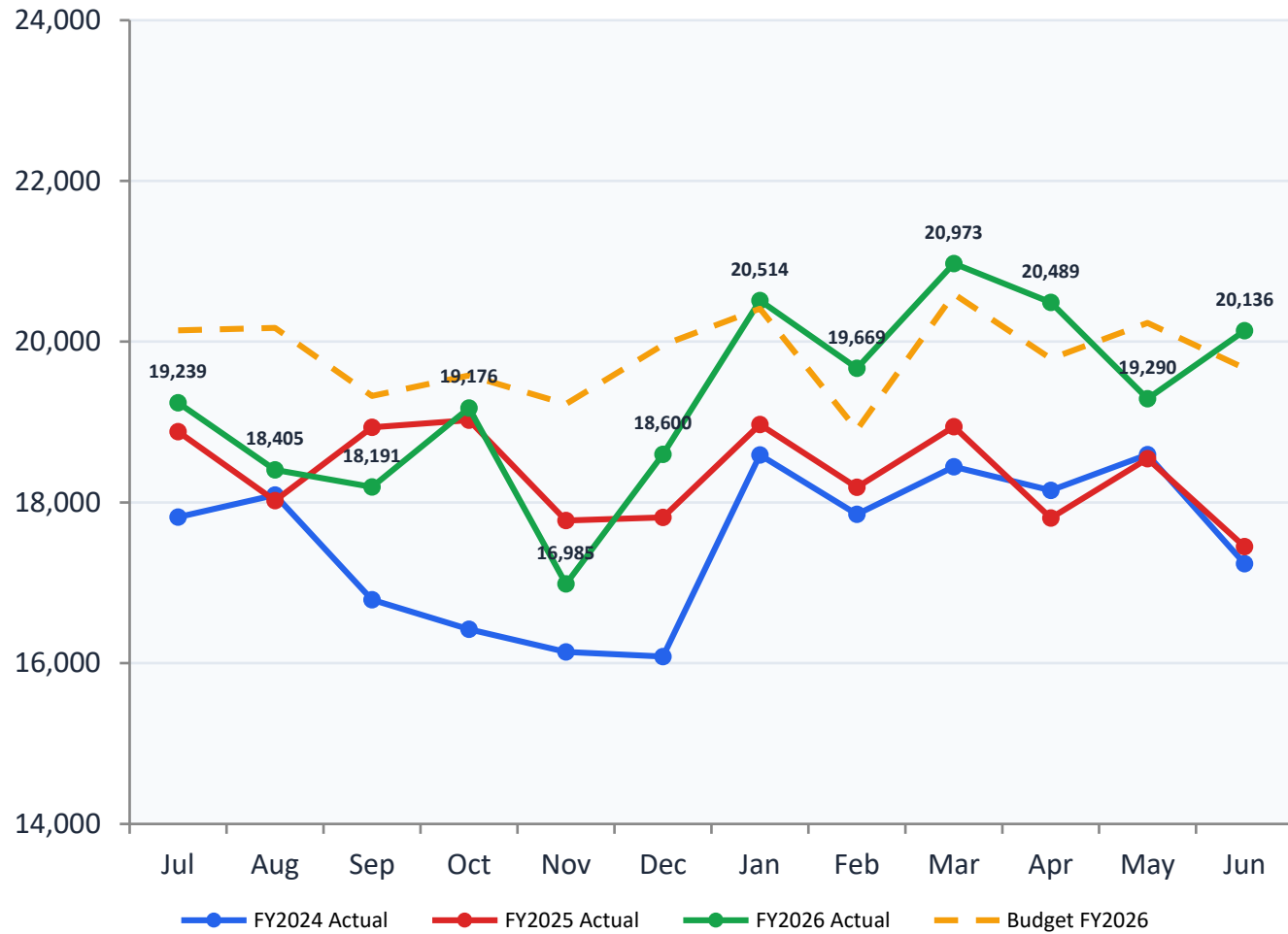
Therapy - Cypress Hand Center



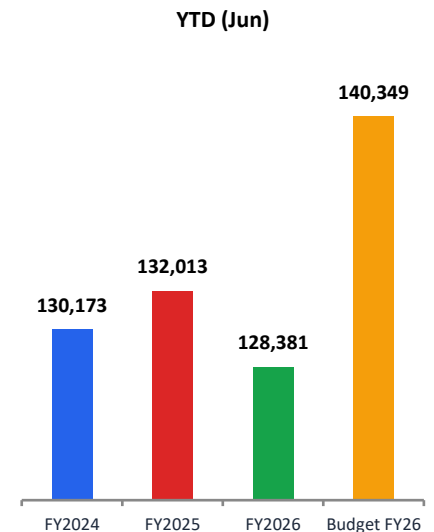
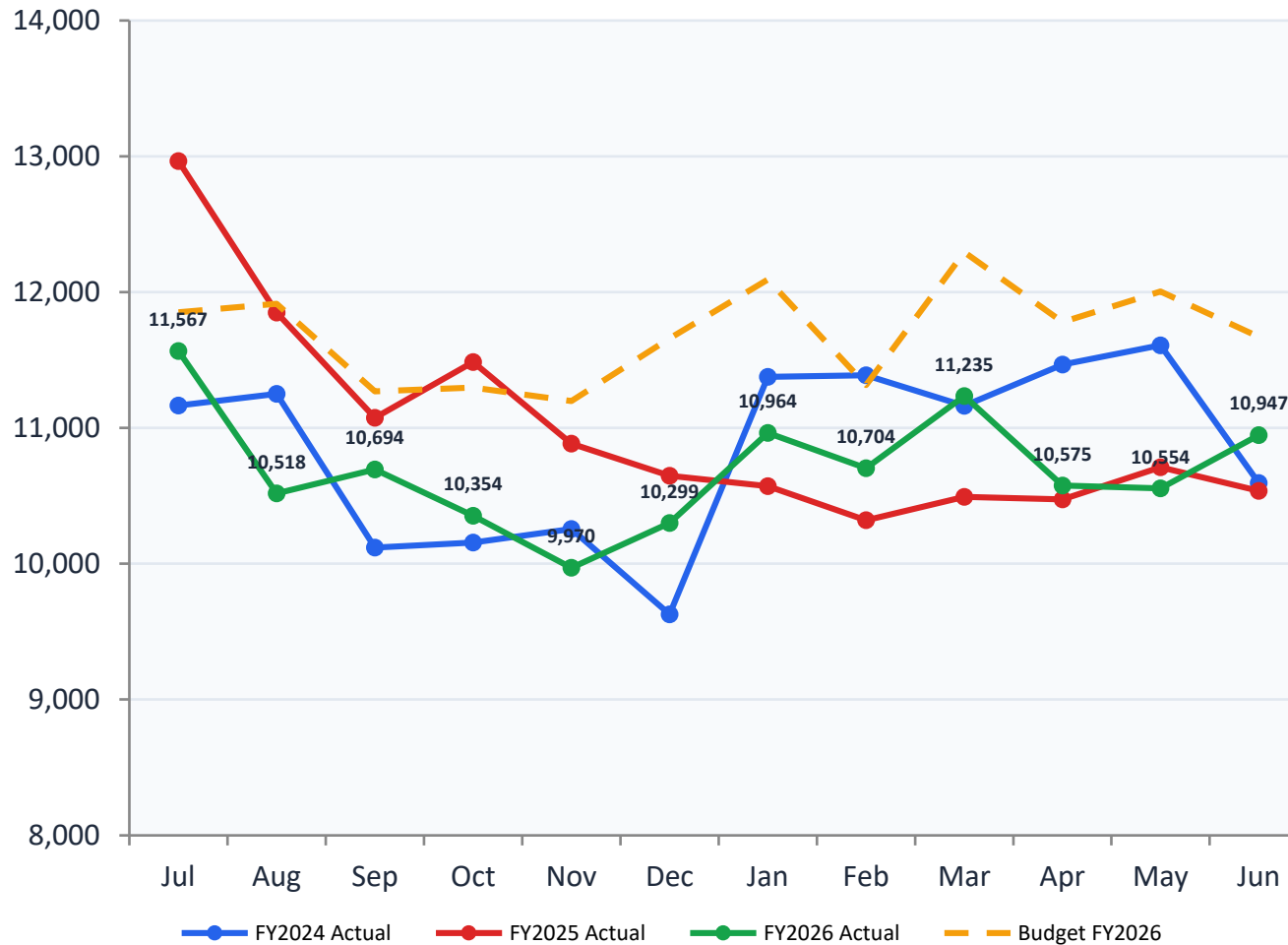
Therapy-Wound Care Svcs Encounters



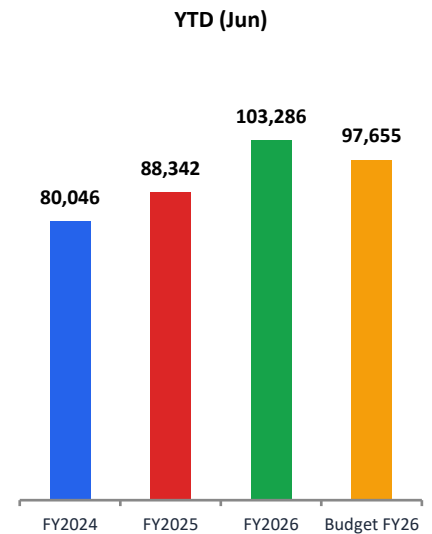
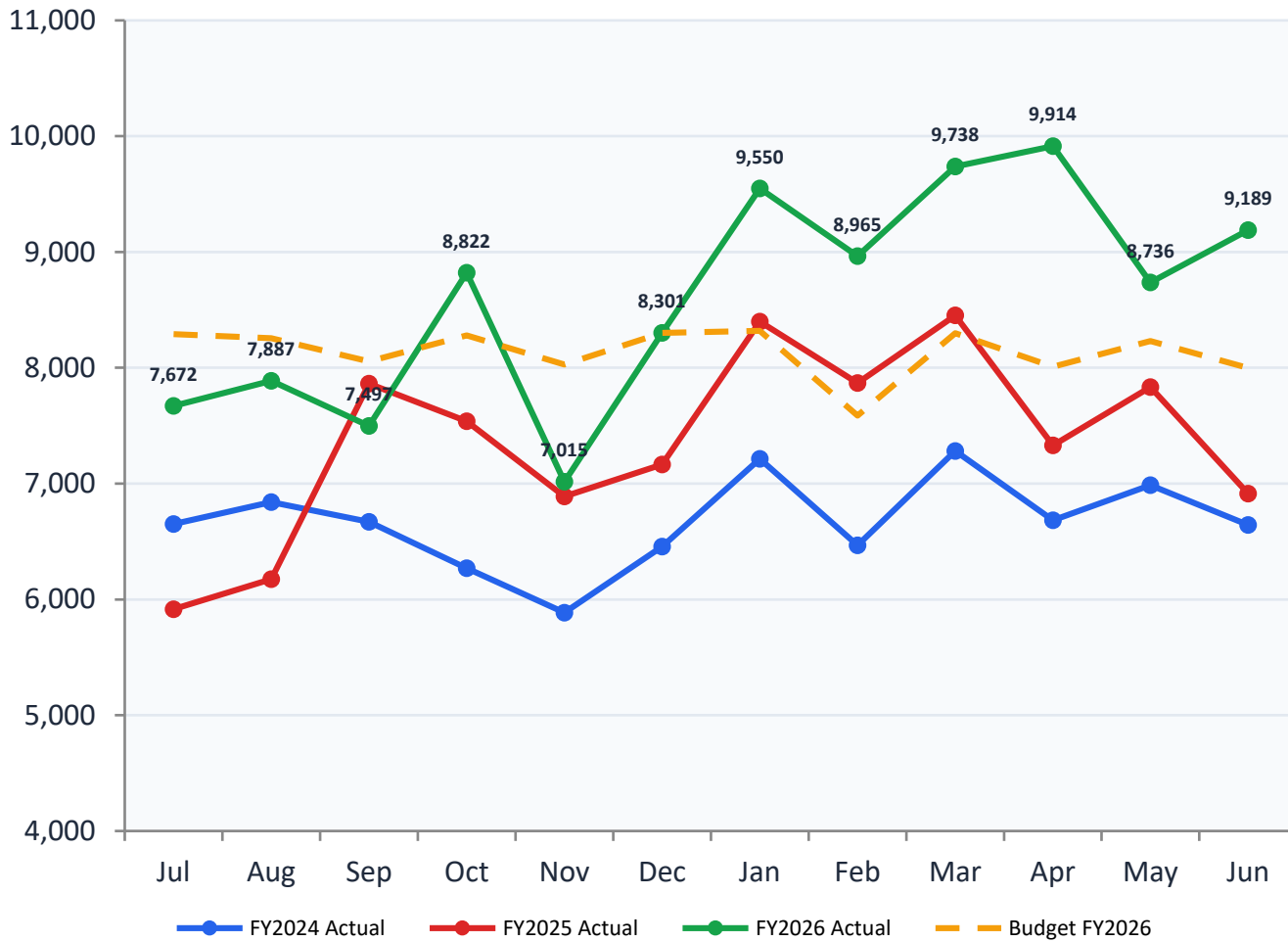
Physical & Other Therapy Units (I/P & O/P)



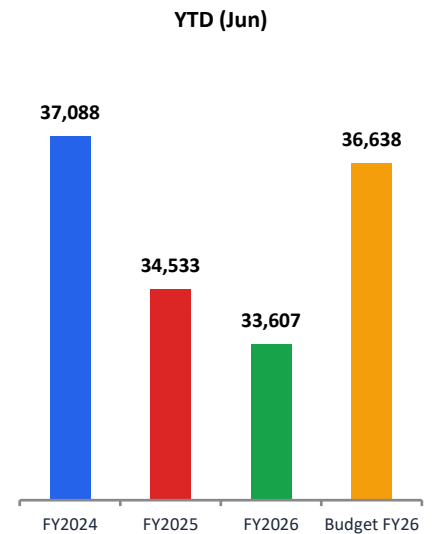
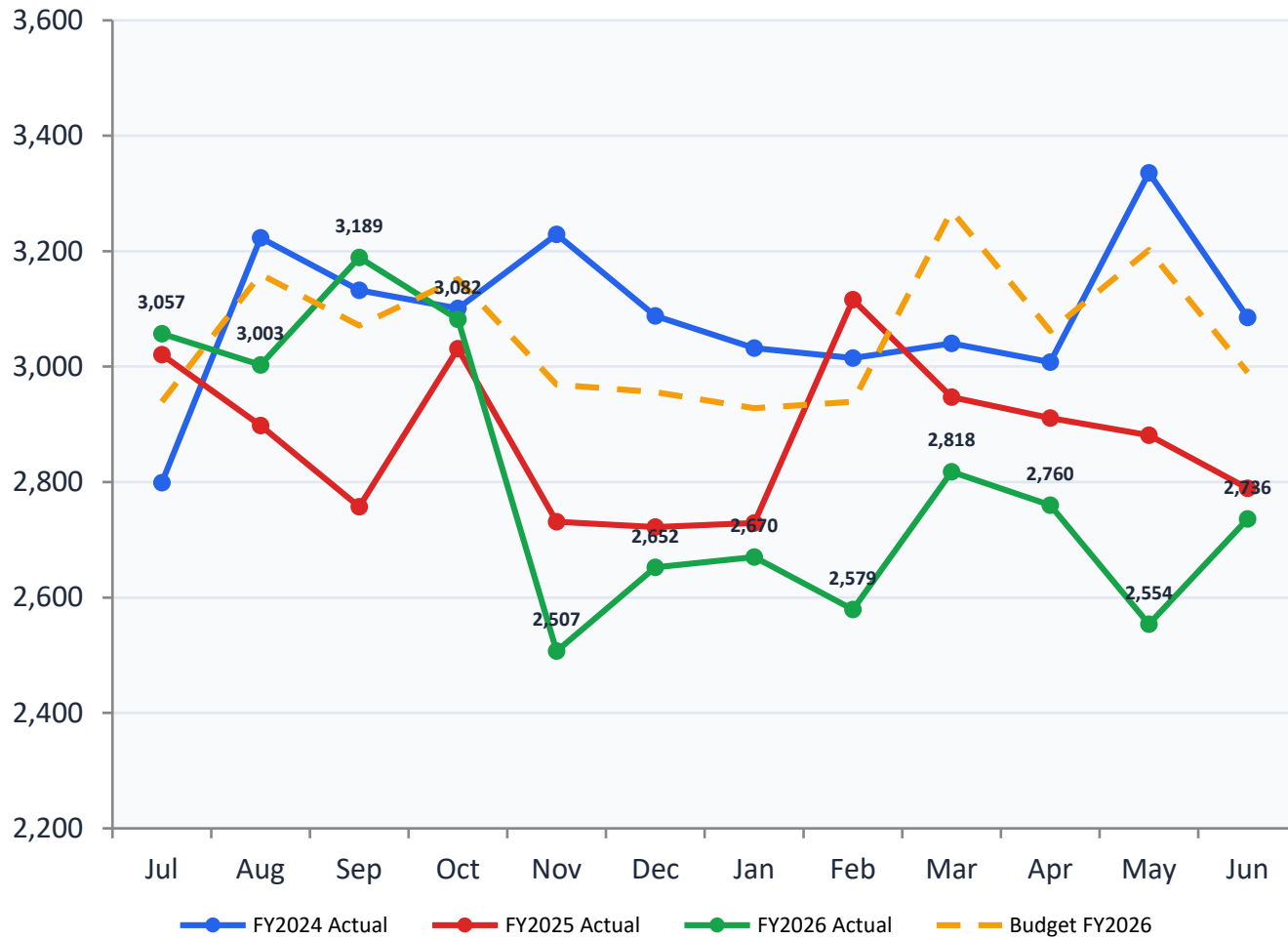
Physical & Other Therapy Units (I/P & O/P)-Main Campus



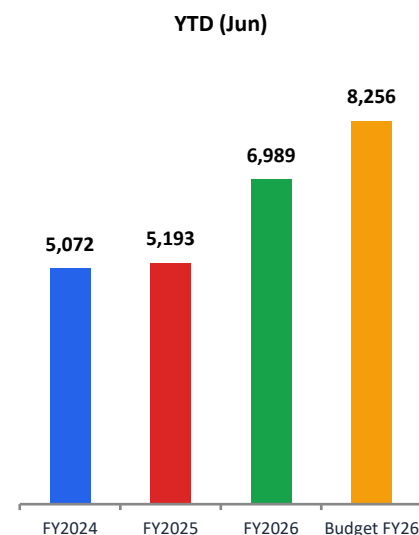
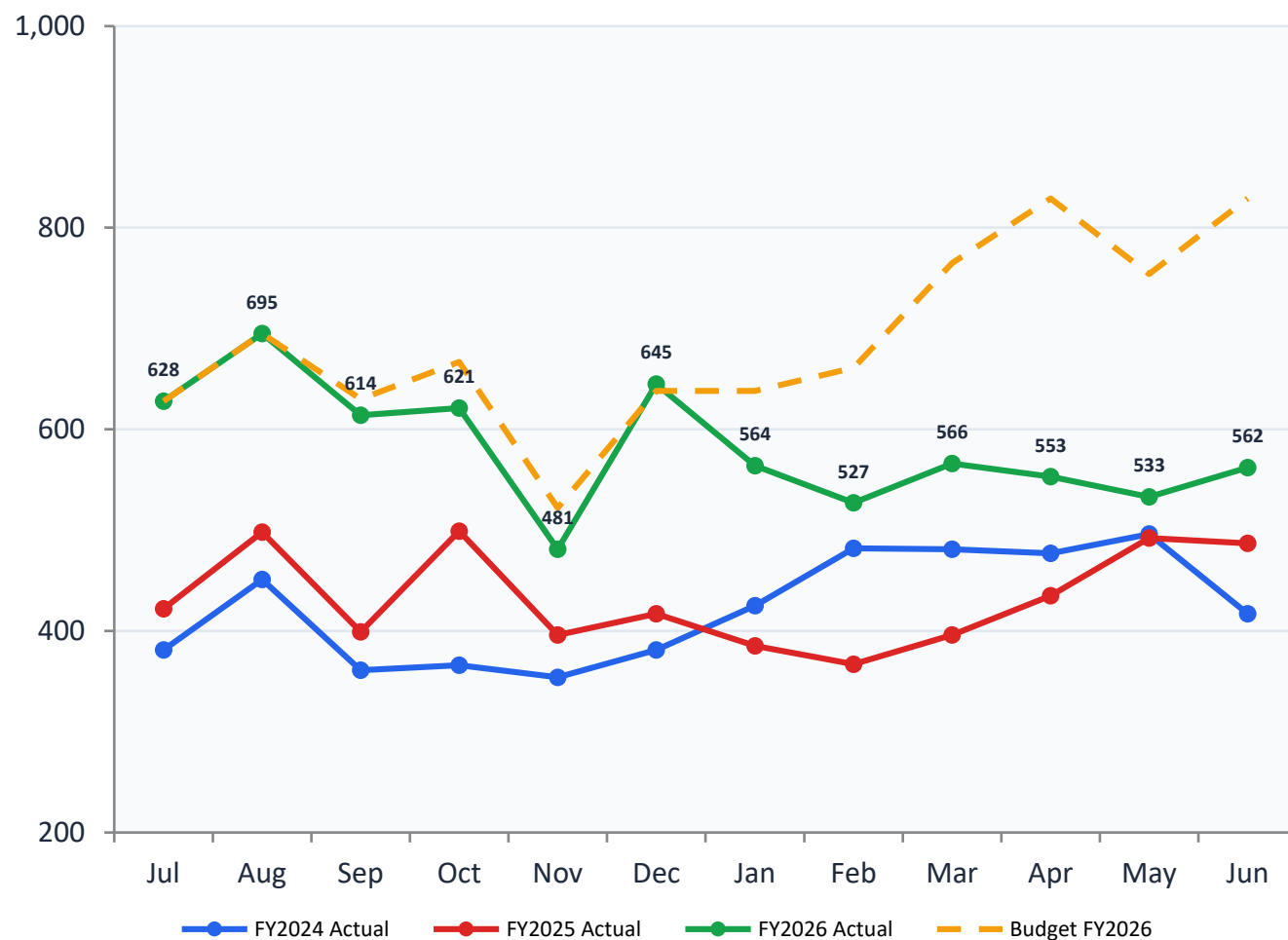
Physical & Other Therapy Units (I/P & O/P)-KDRH & South Campus



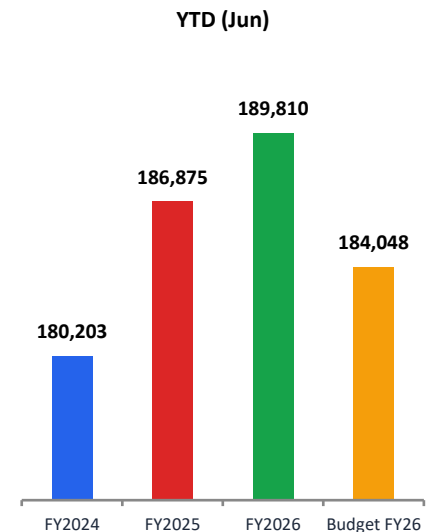
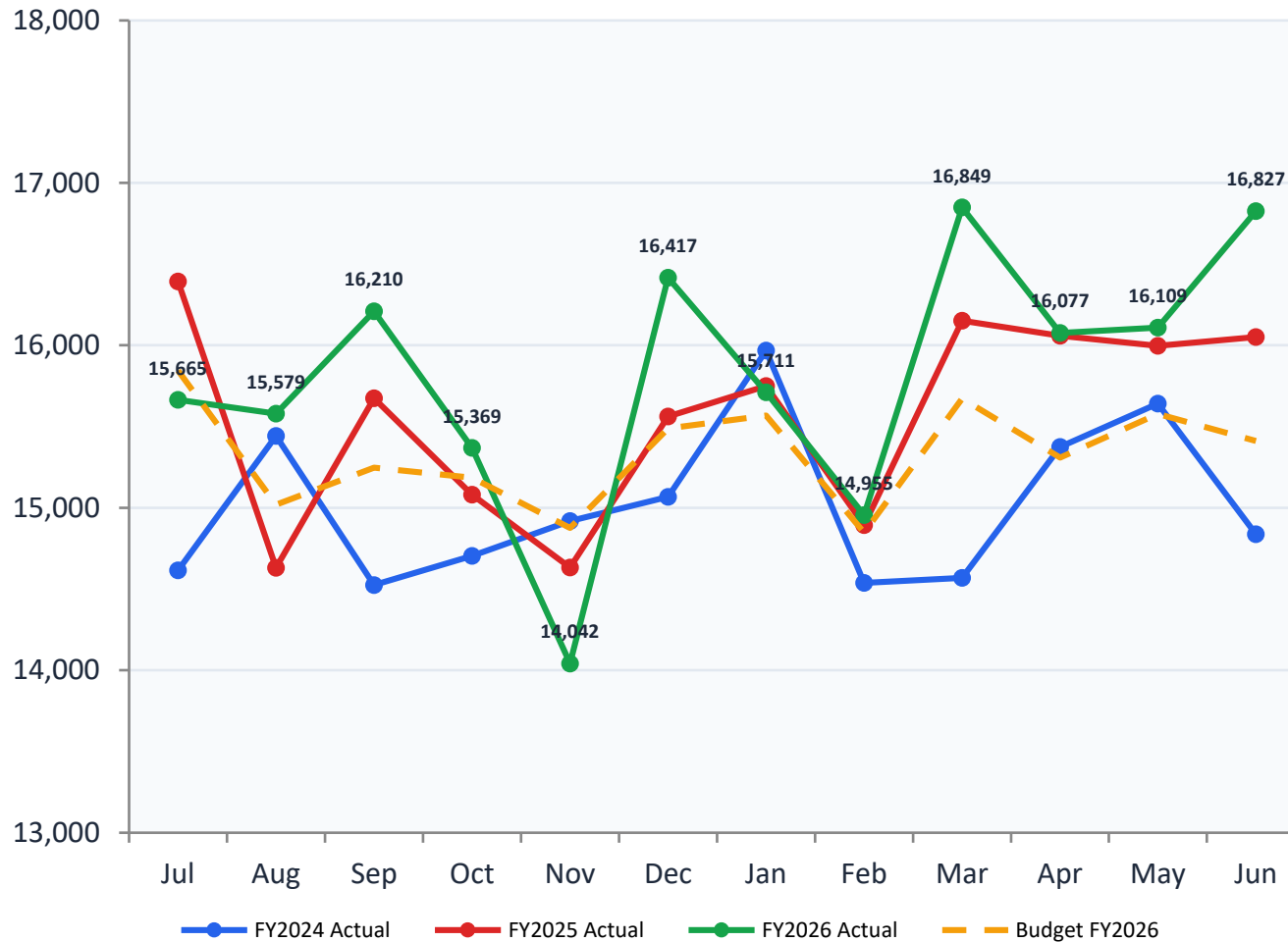
Home Health Visits



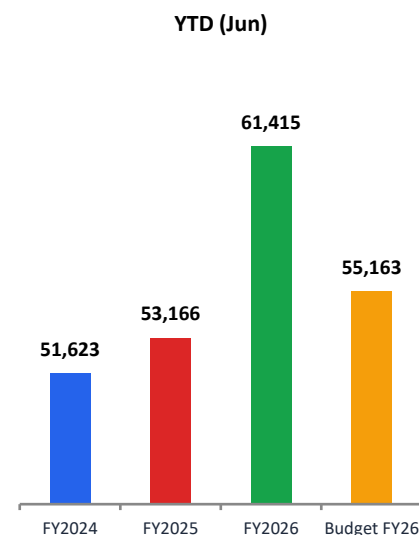
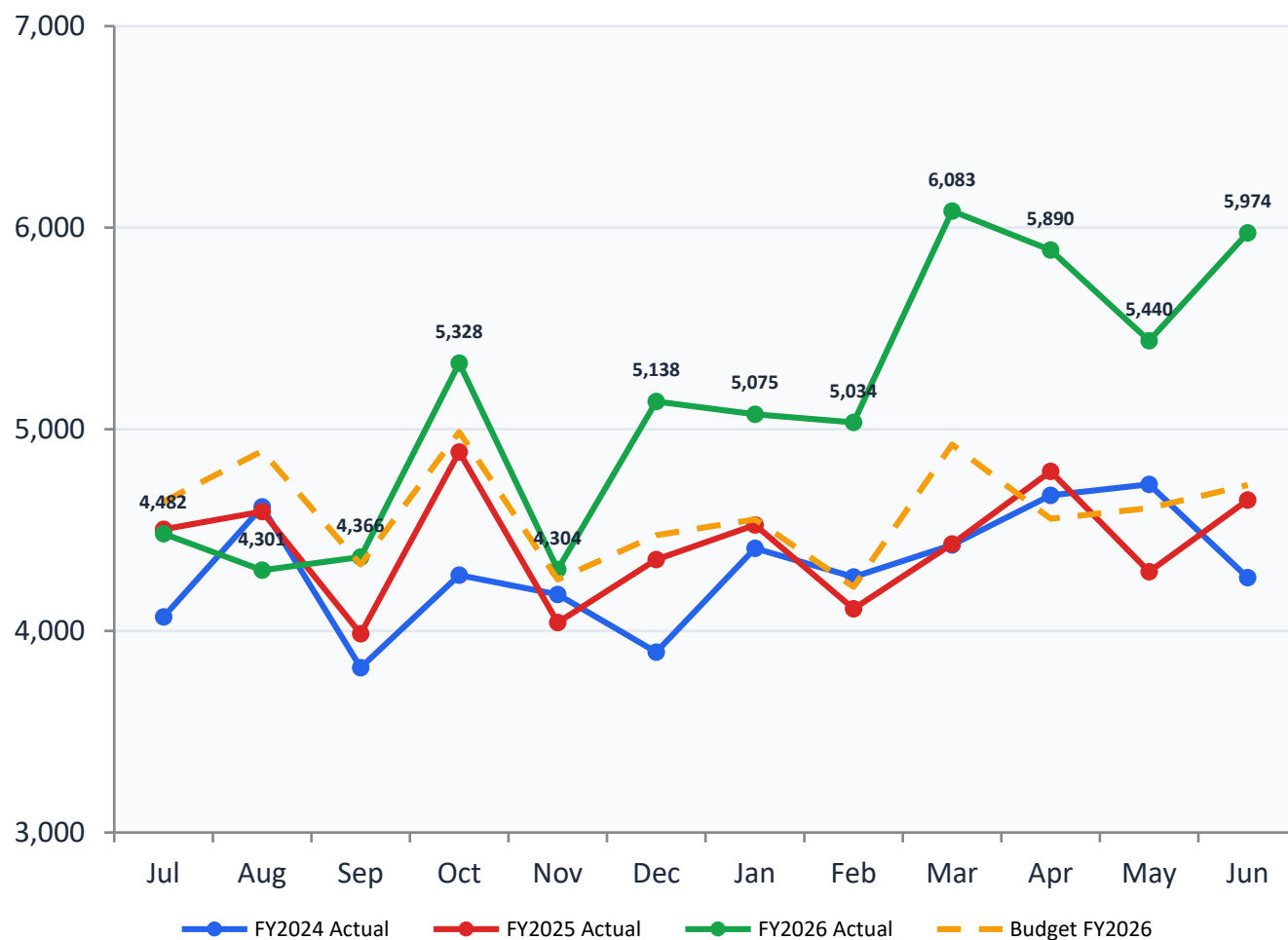
Infusion Center - Units of Service



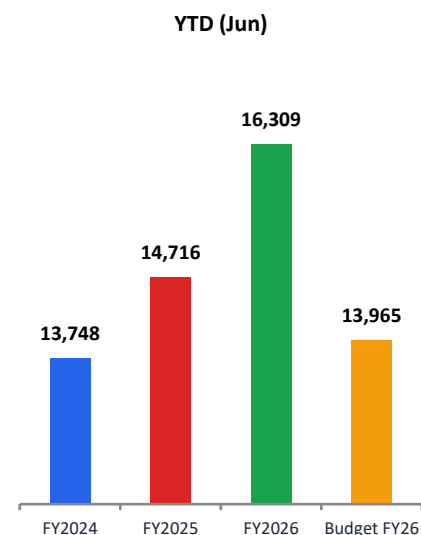
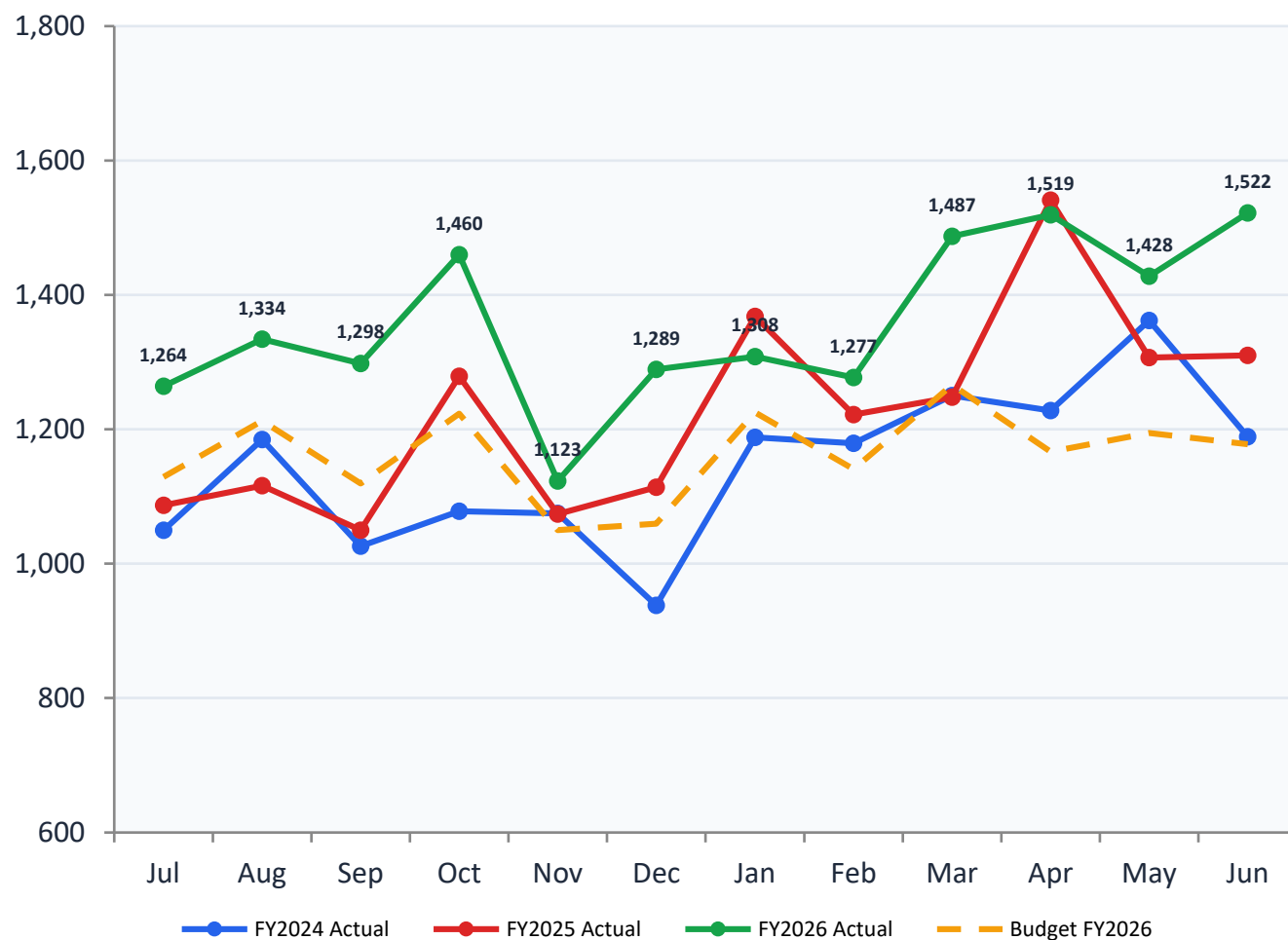
Radiology – Main Campus



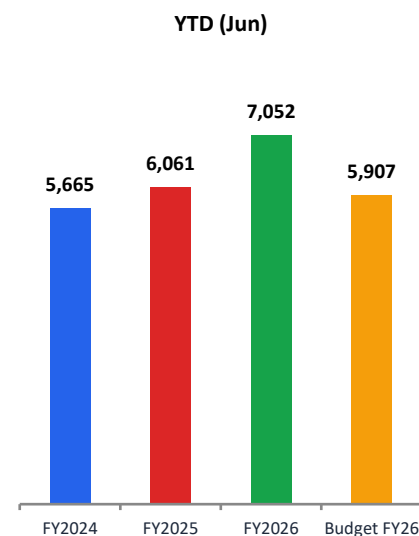
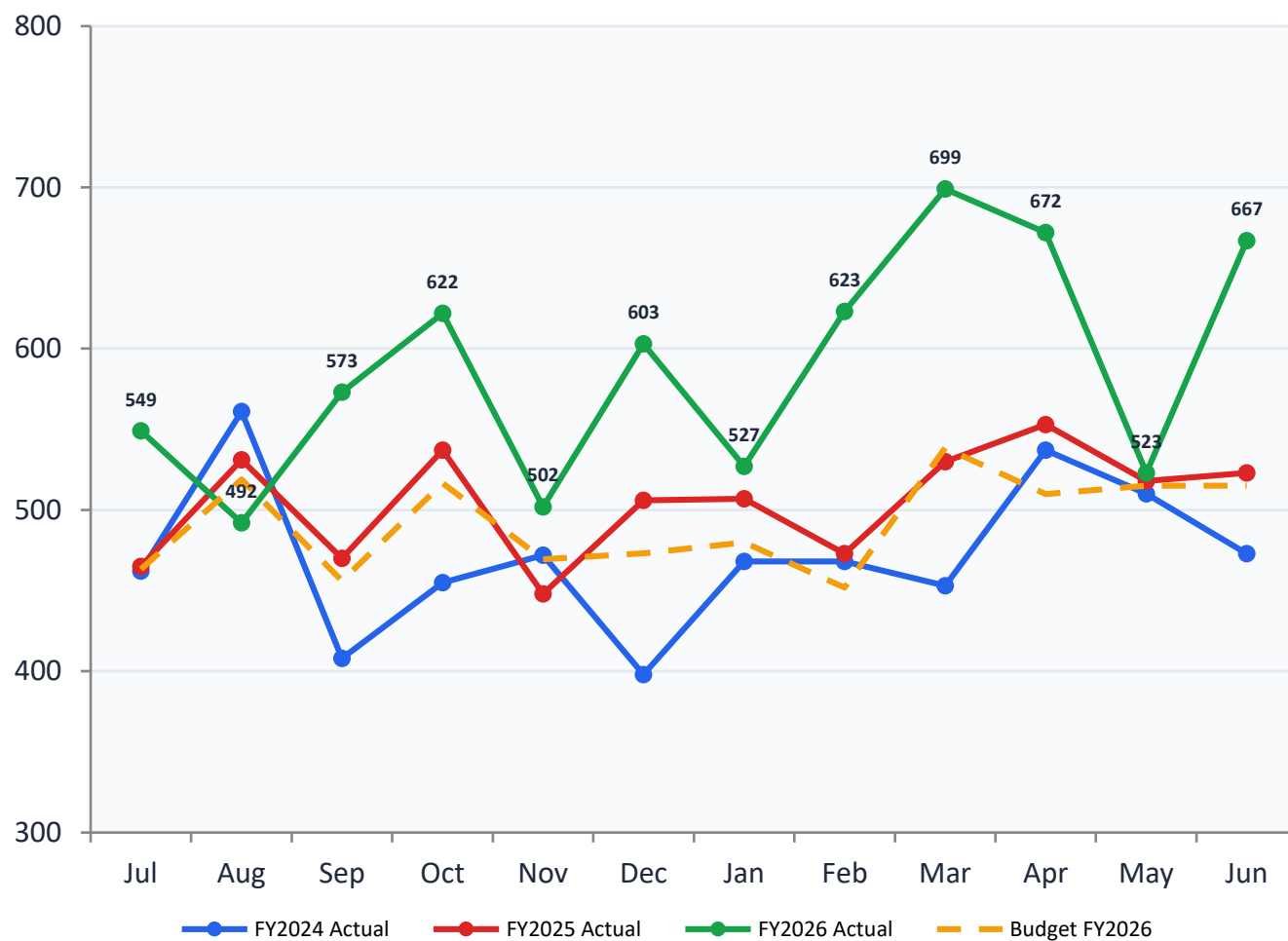
Radiology - West Campus Imaging



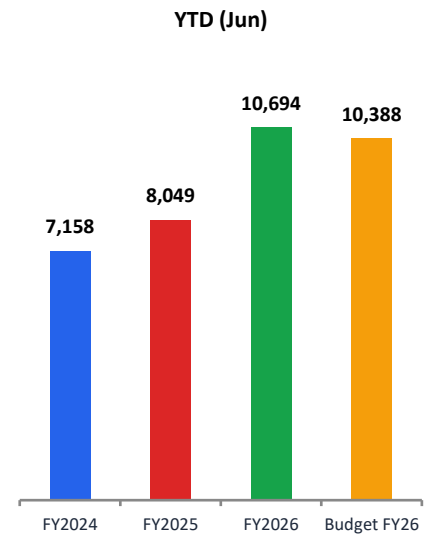
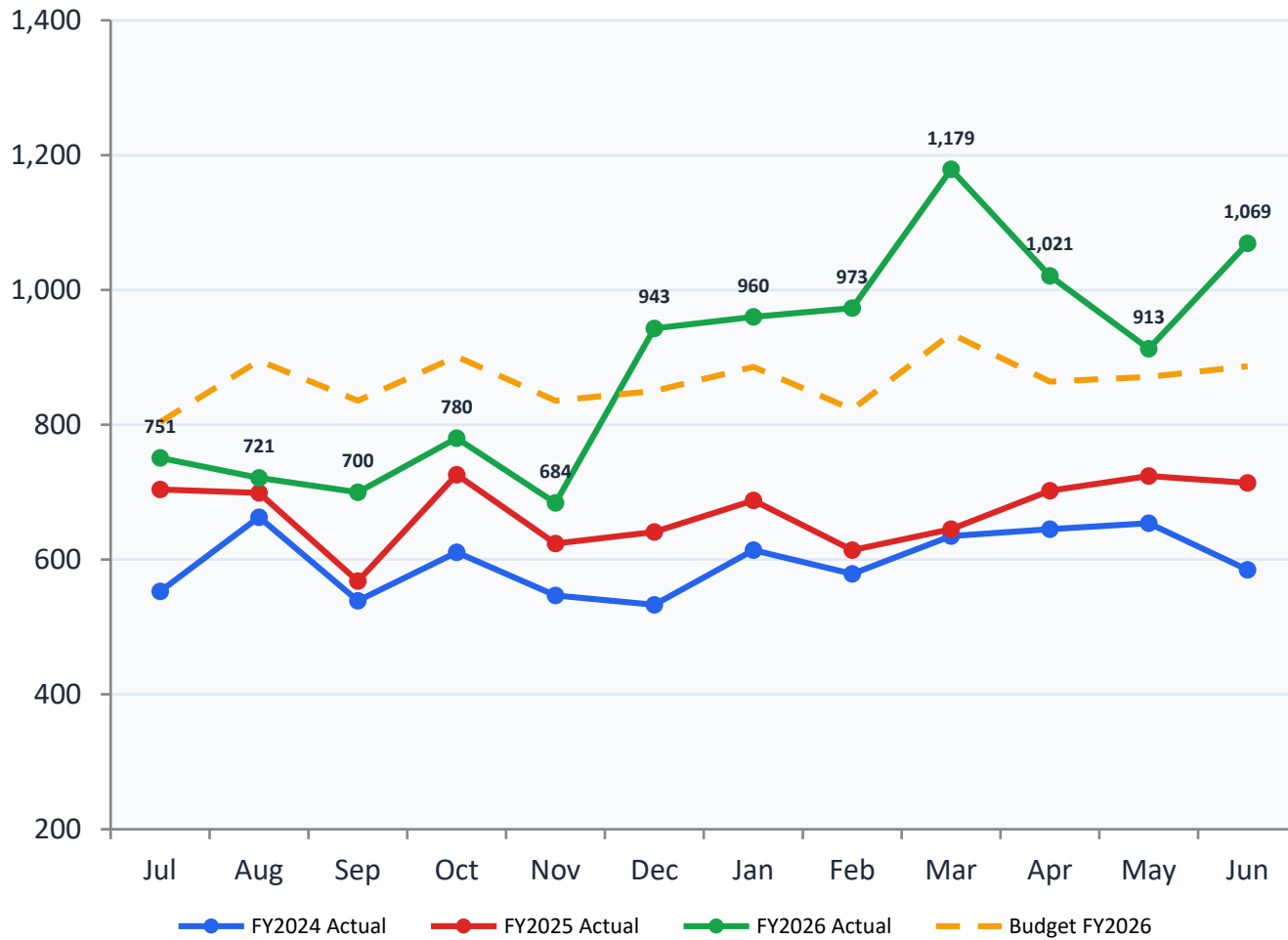
West Campus - Diagnostic Radiology



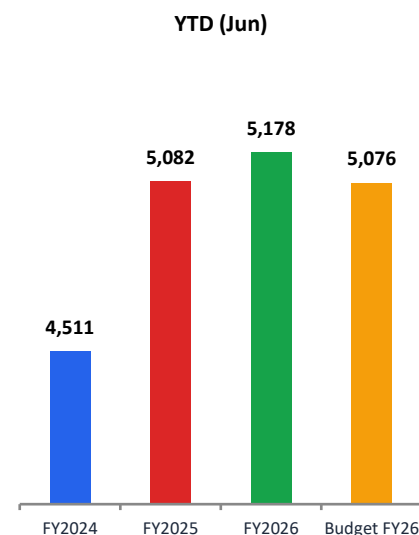
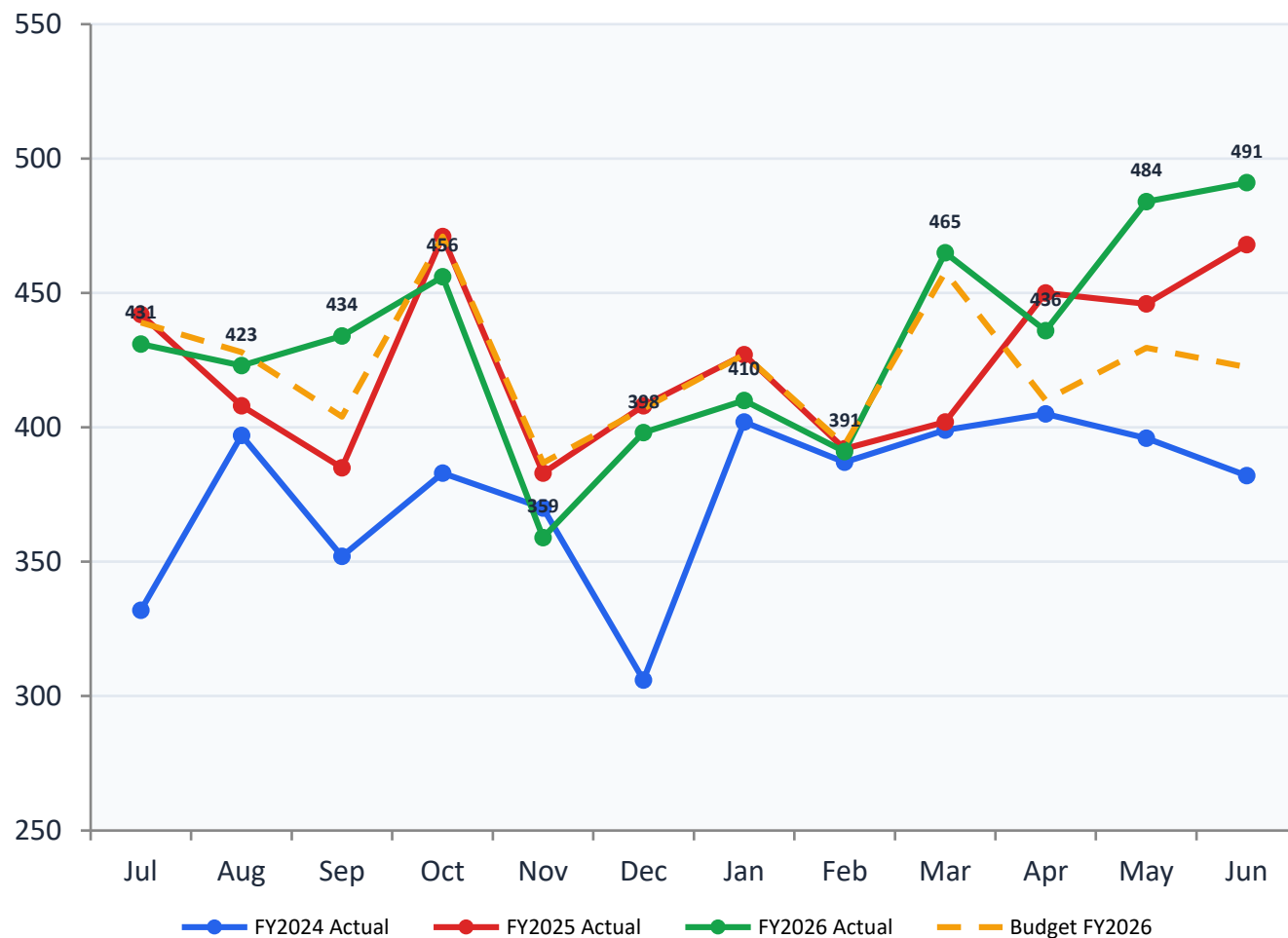
West Campus - CT Scan



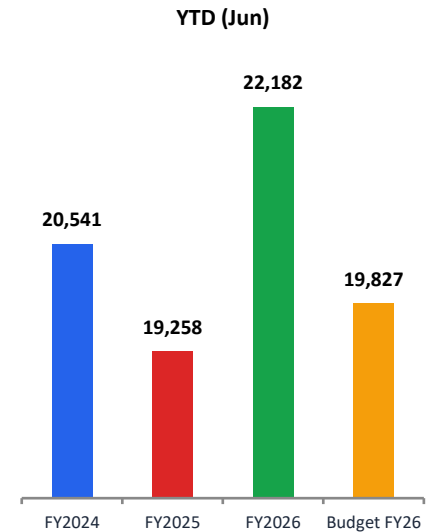
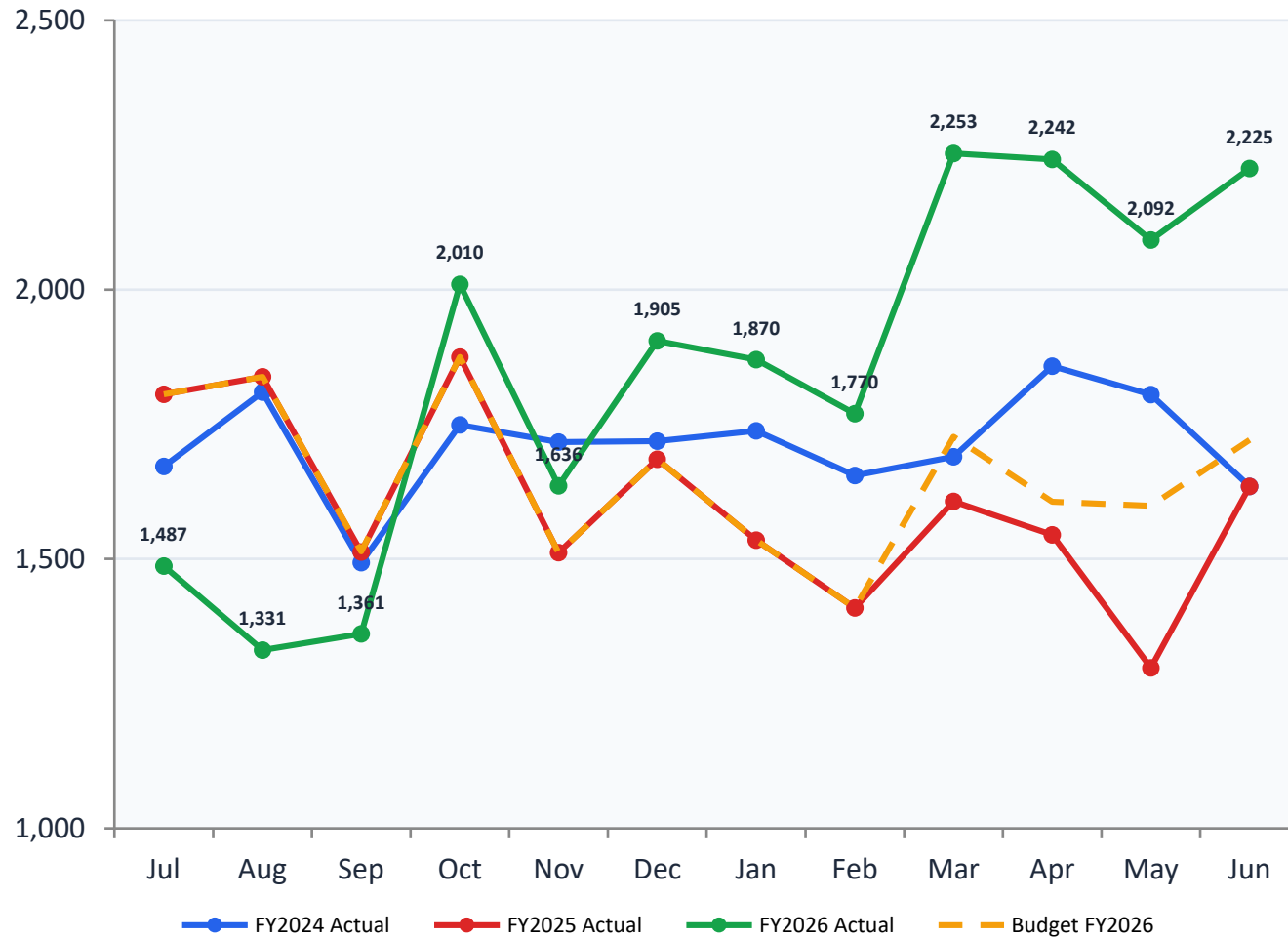
West Campus - Ultrasound



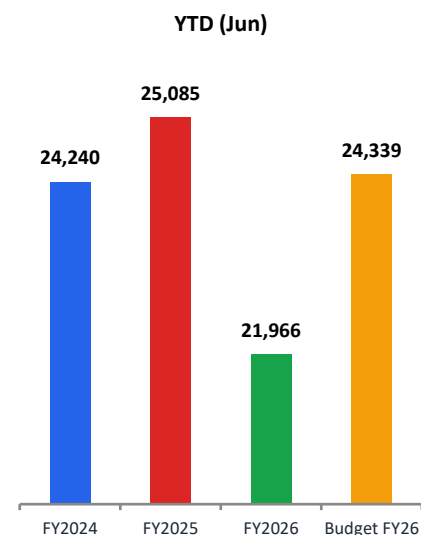
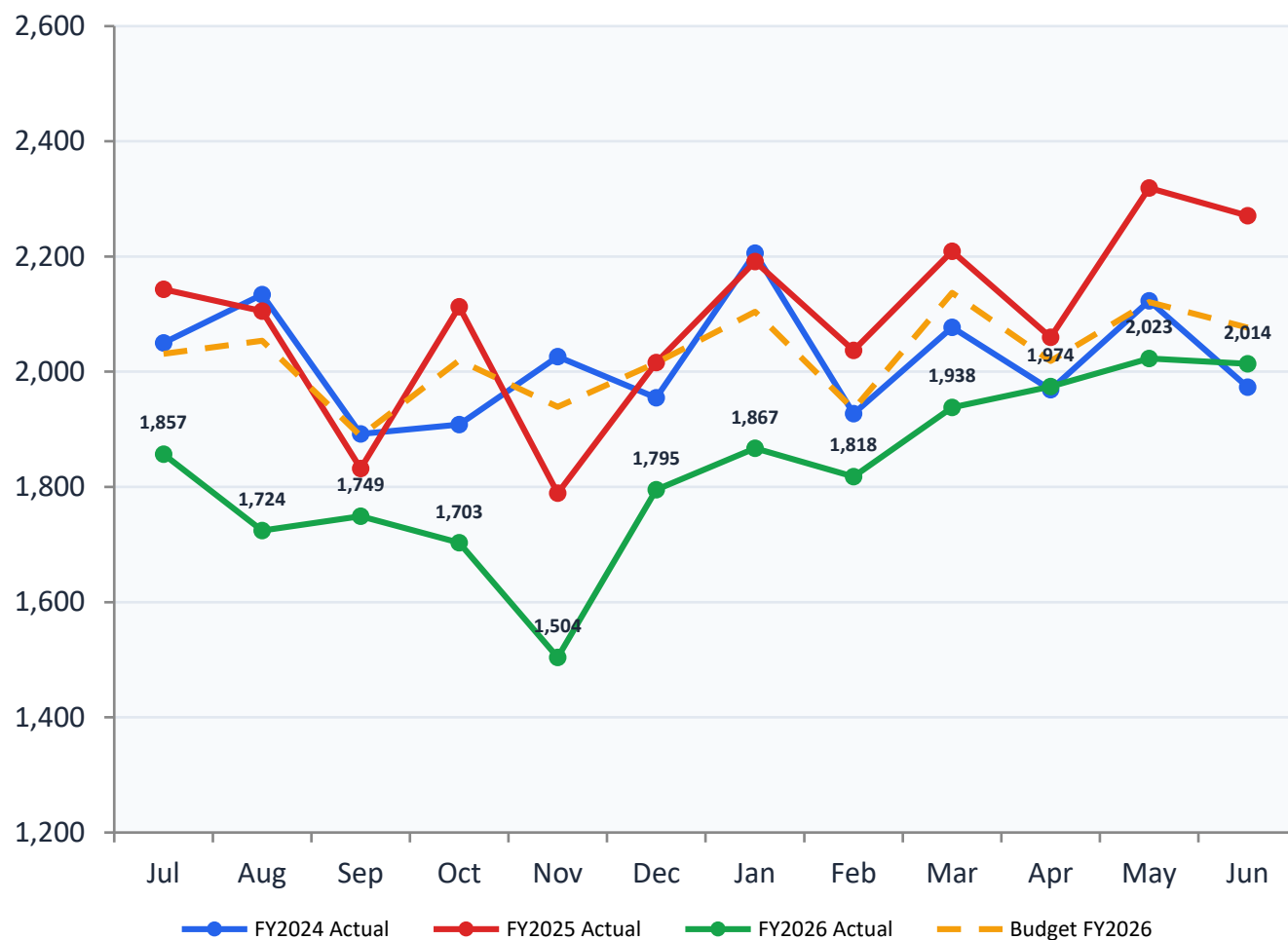
West Campus - MRI



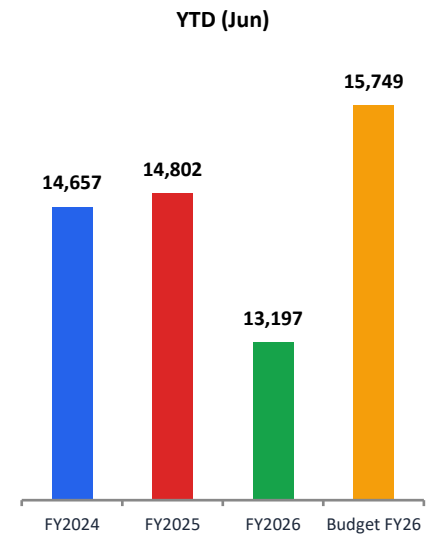
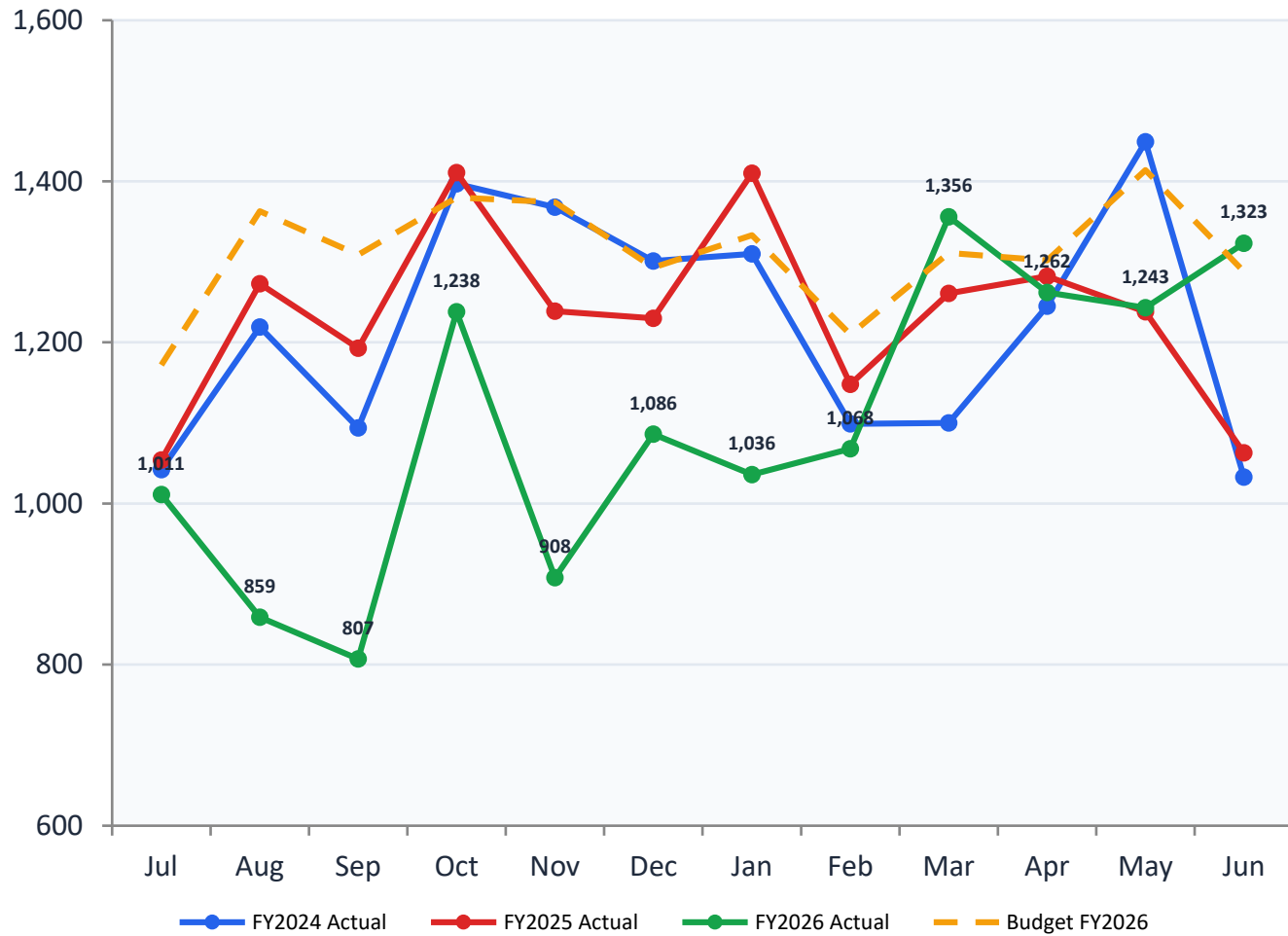
West Campus - Breast Center



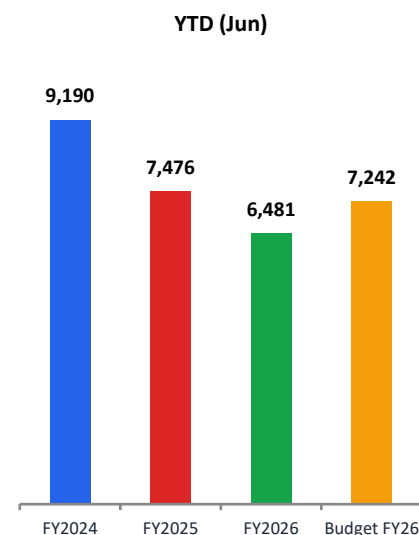
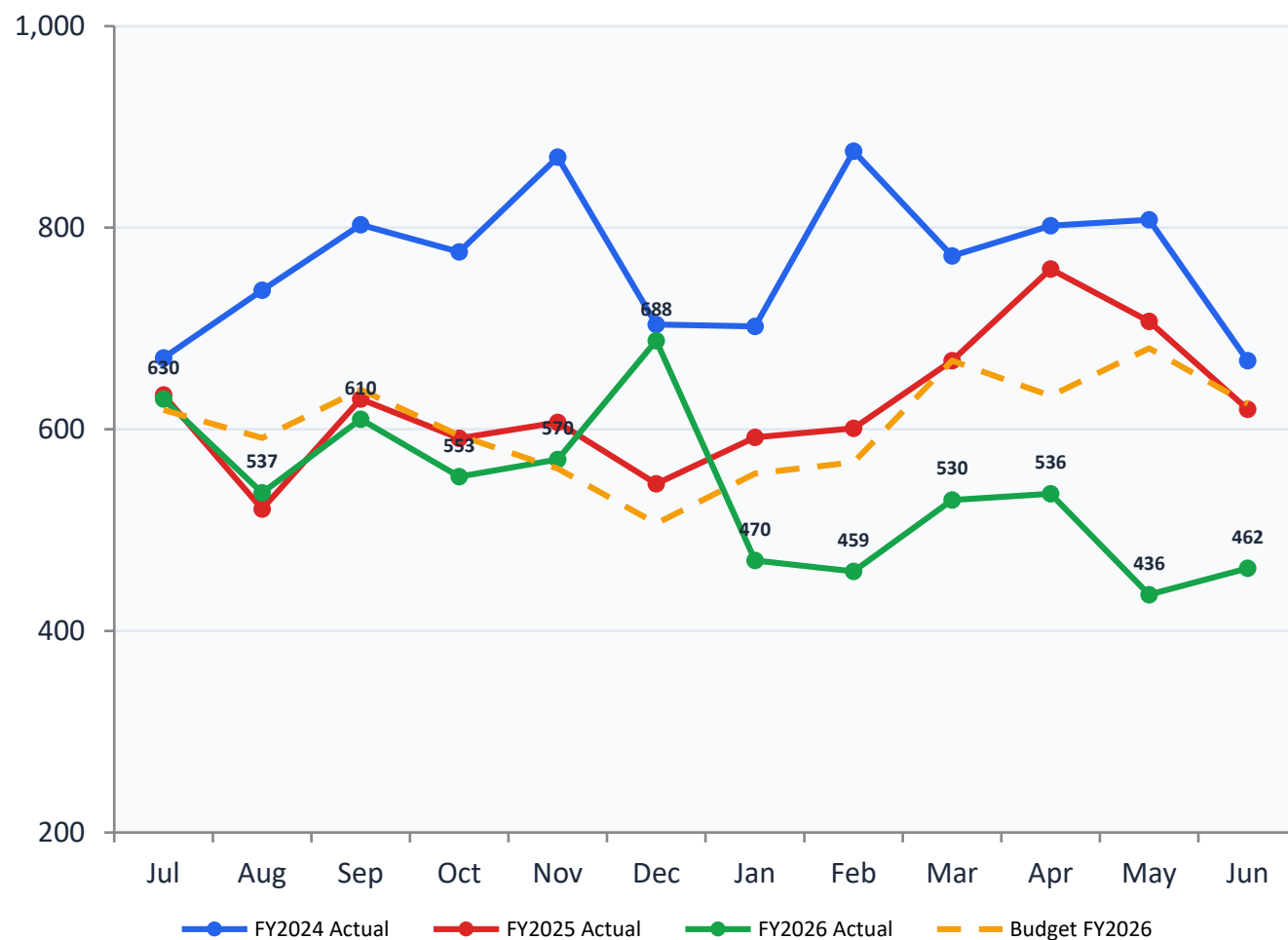
Noninvasive Cardiology-KHMC



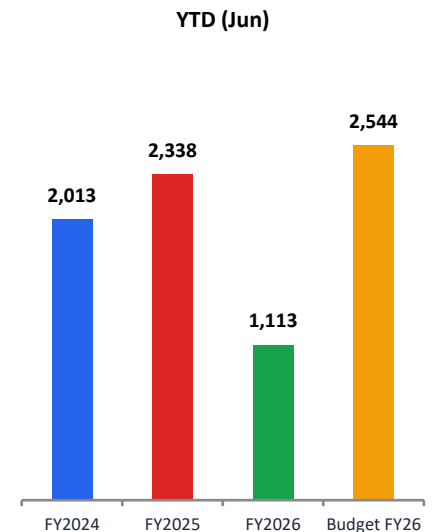
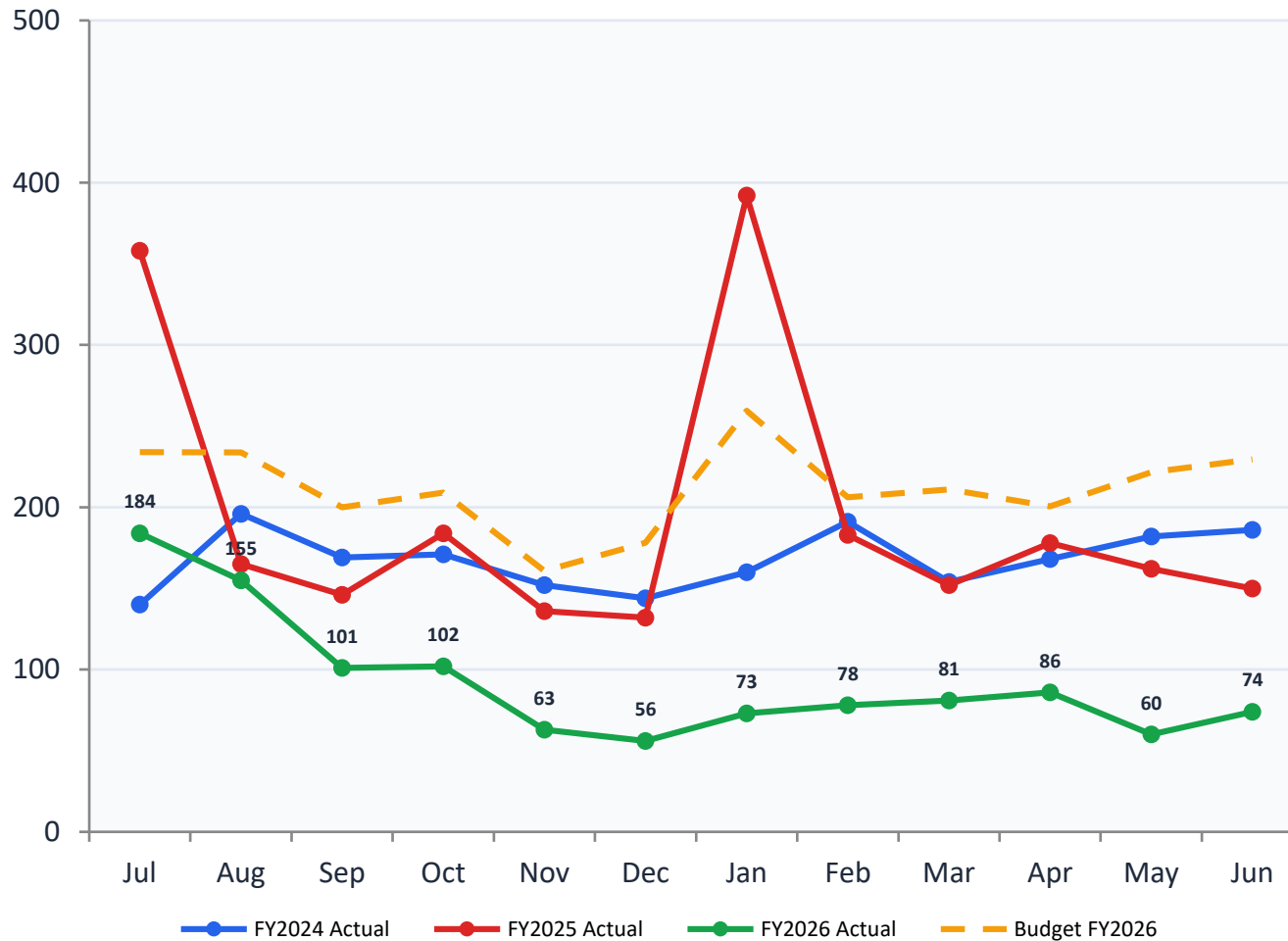
Noninvasive Cardiology-KHDC



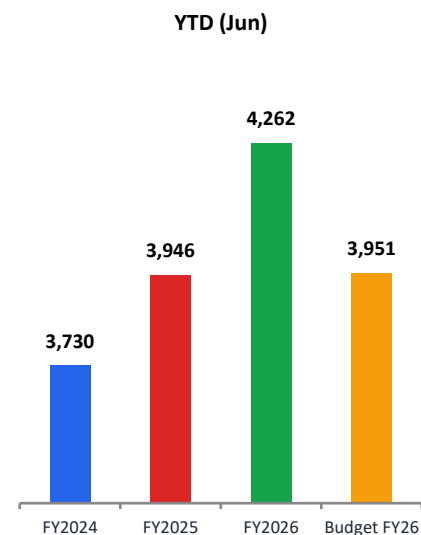
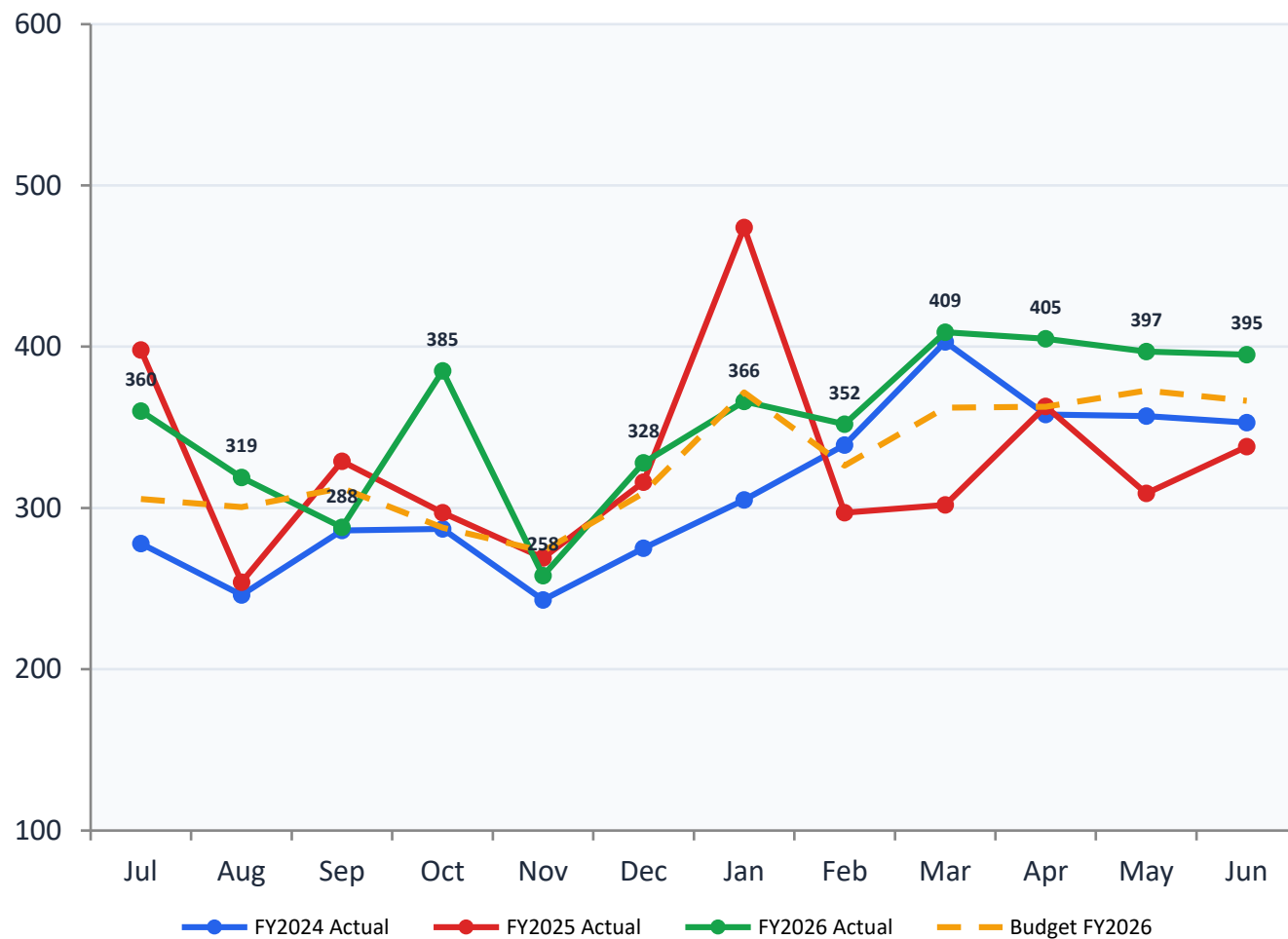
Nuclear Medicine-KHMC



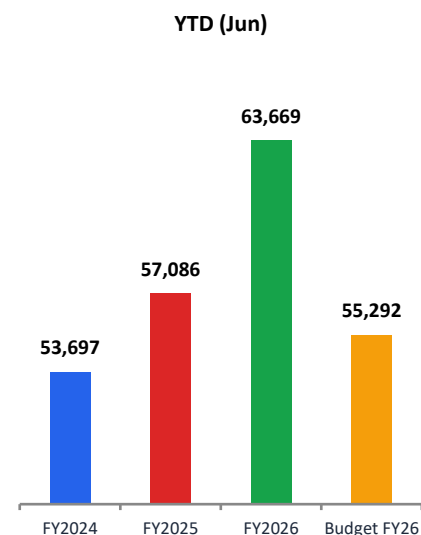
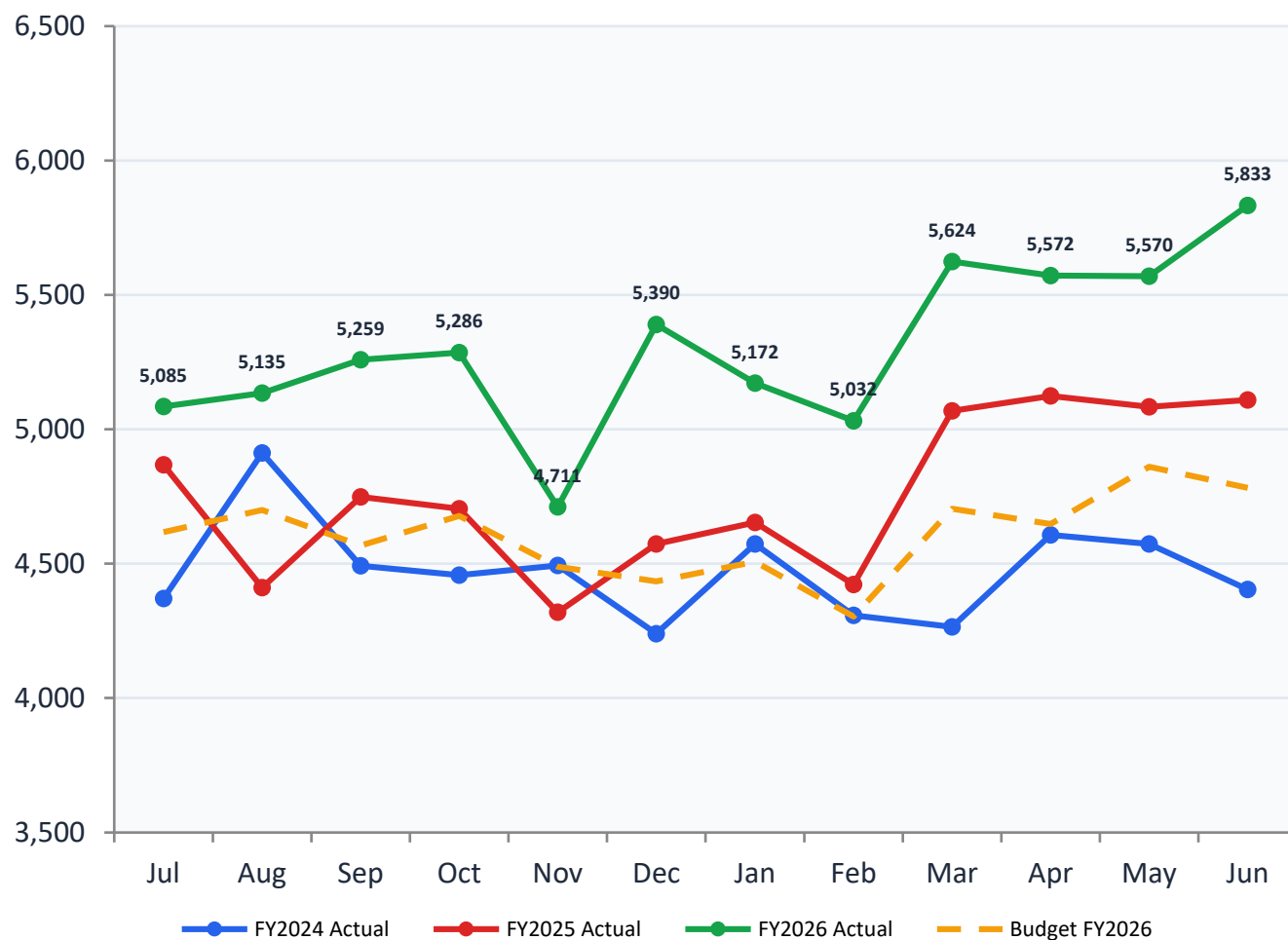
Nuclear Medicine-KHDC



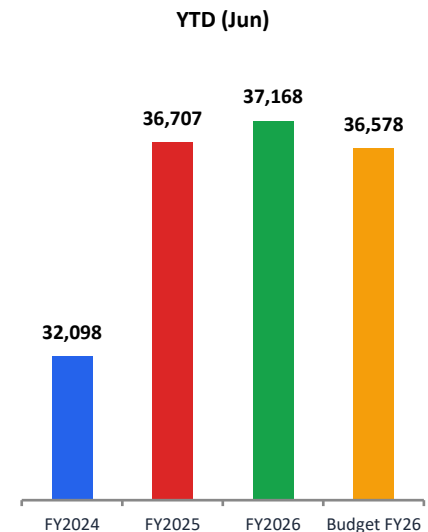
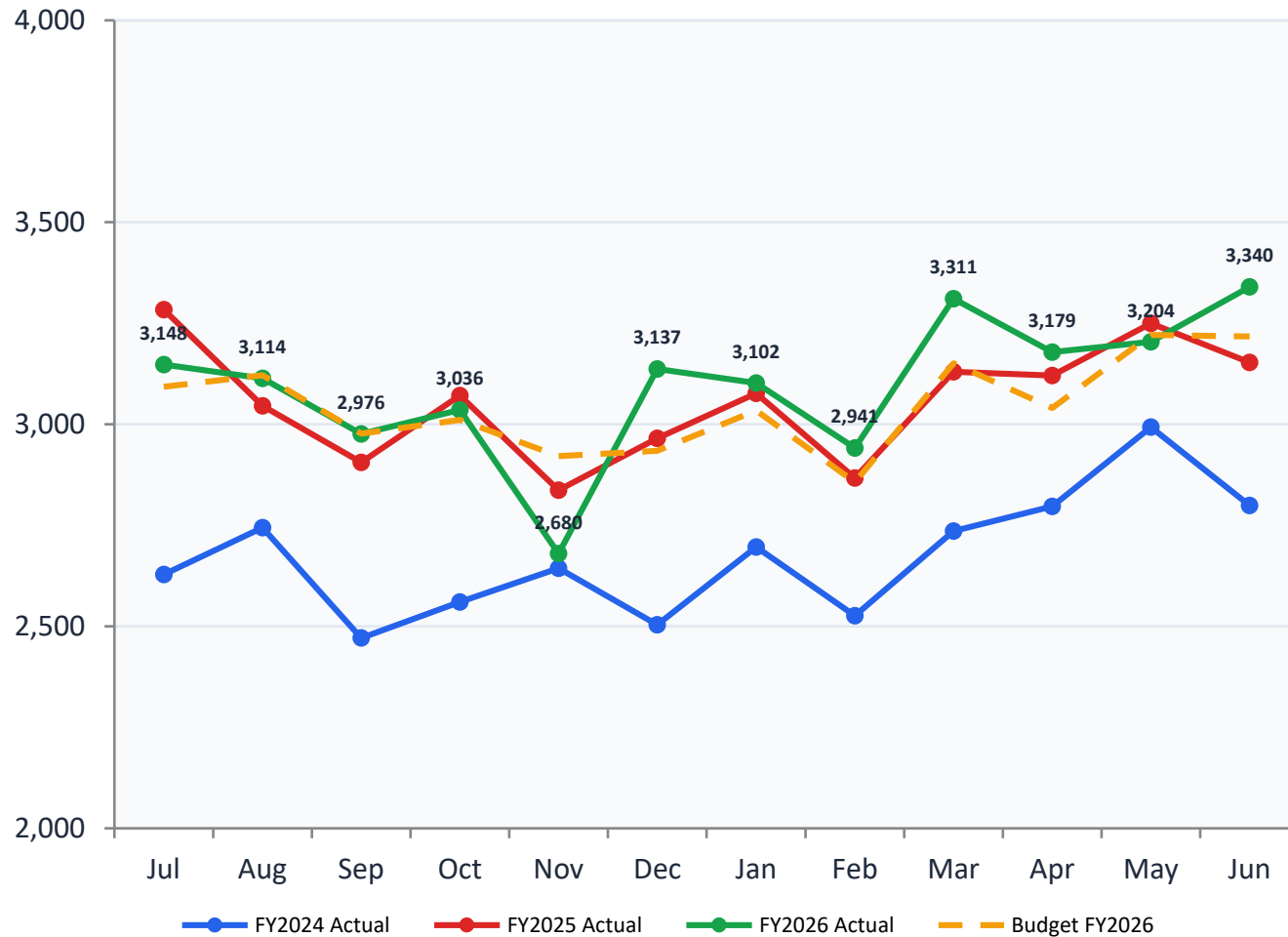
PET/CT-KHDC



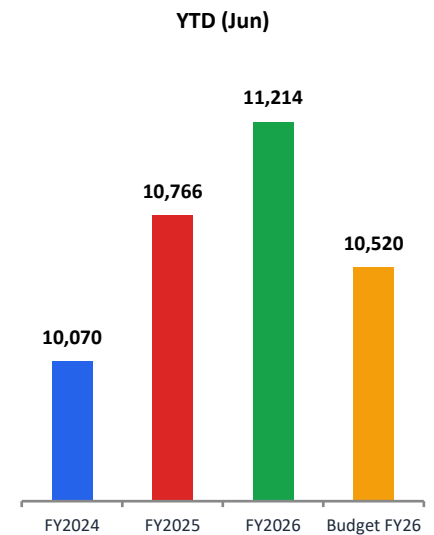
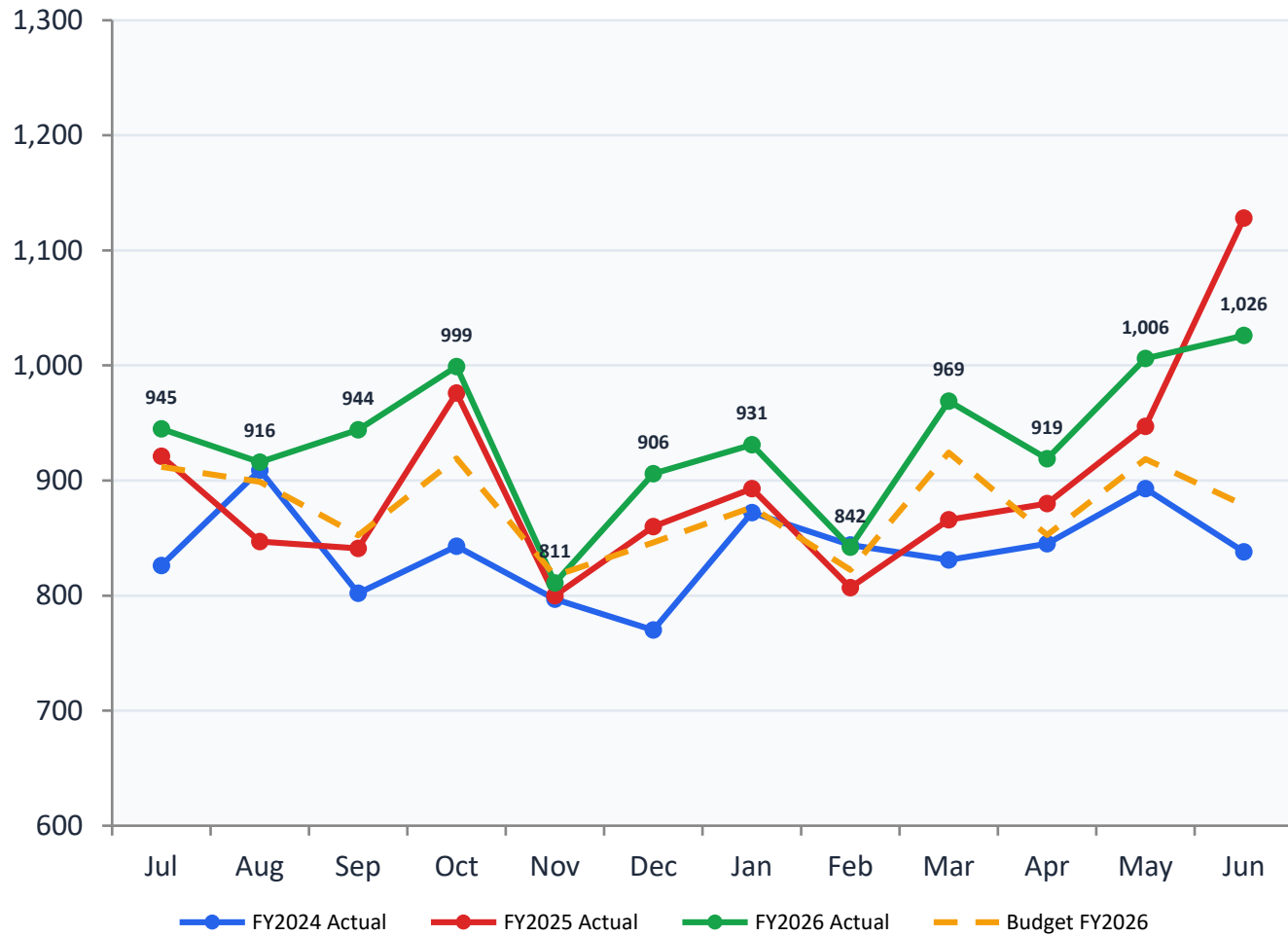
Radiology - CT - All Areas



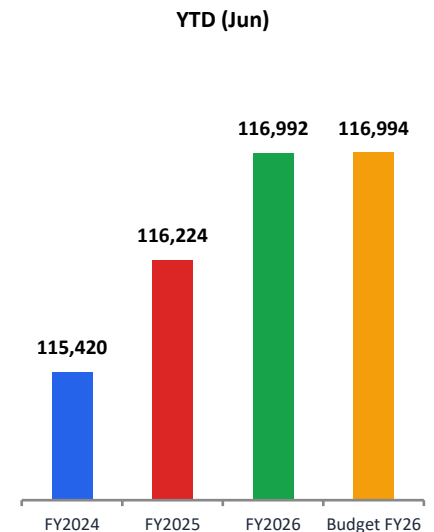
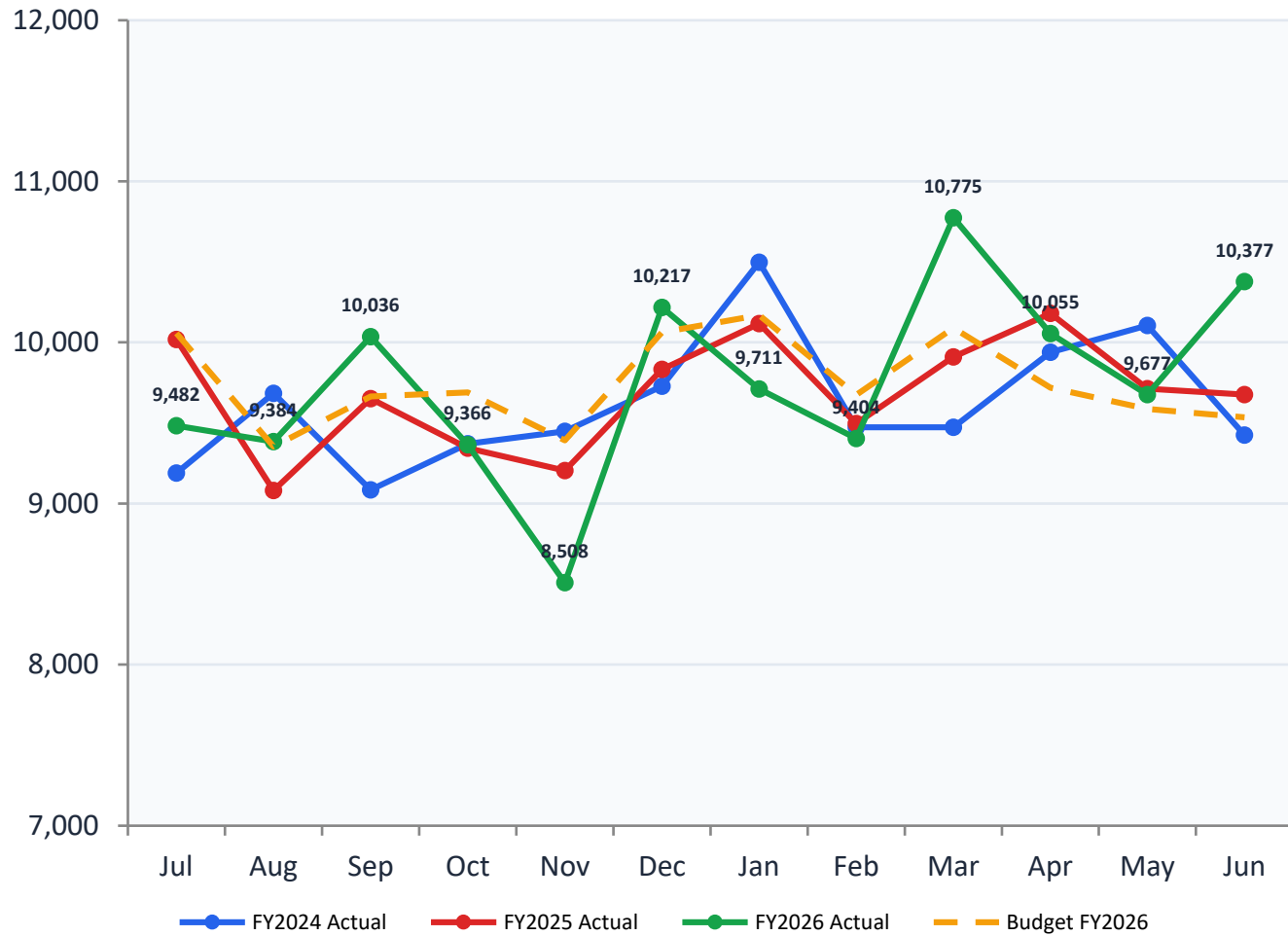
Radiology - Ultrasound - All Areas



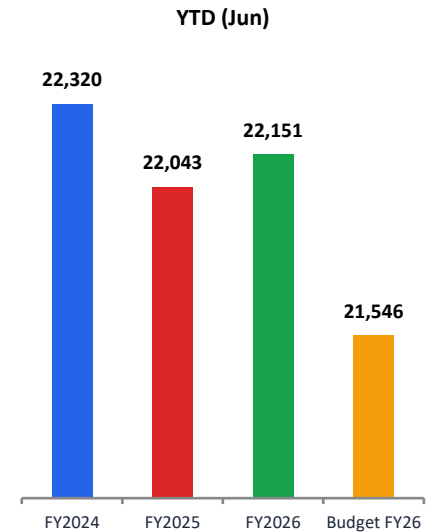
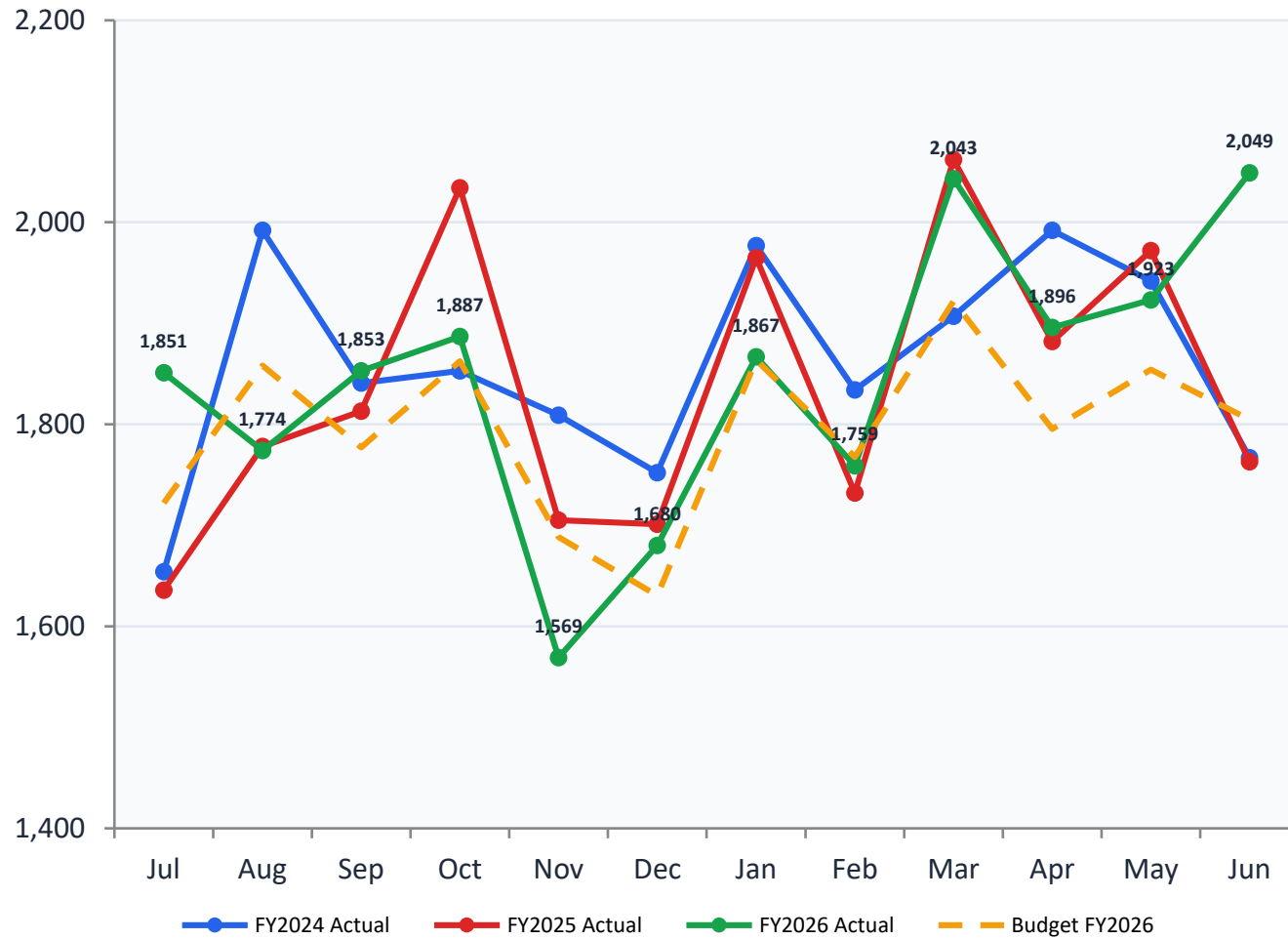
Radiology - MRI - All Areas



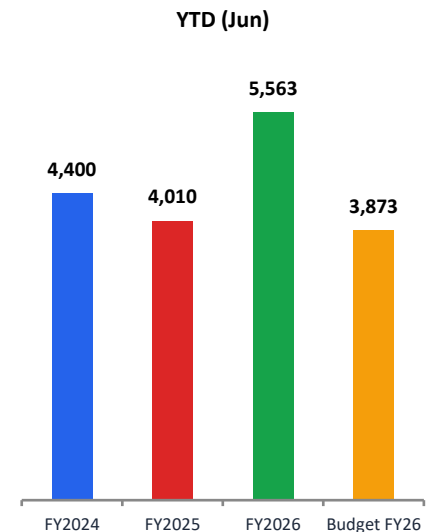
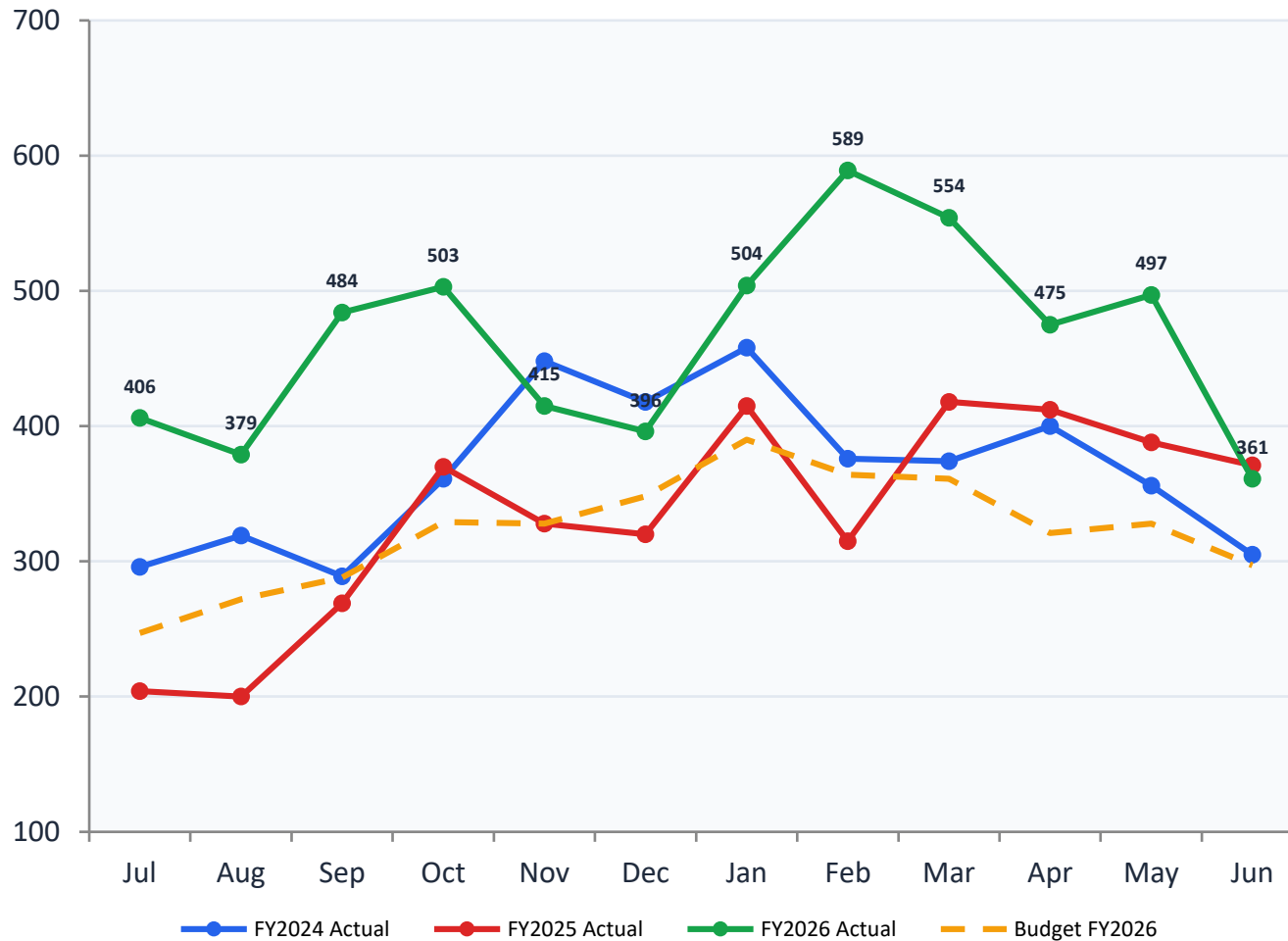
Radiology Modality - Diagnostic Radiology



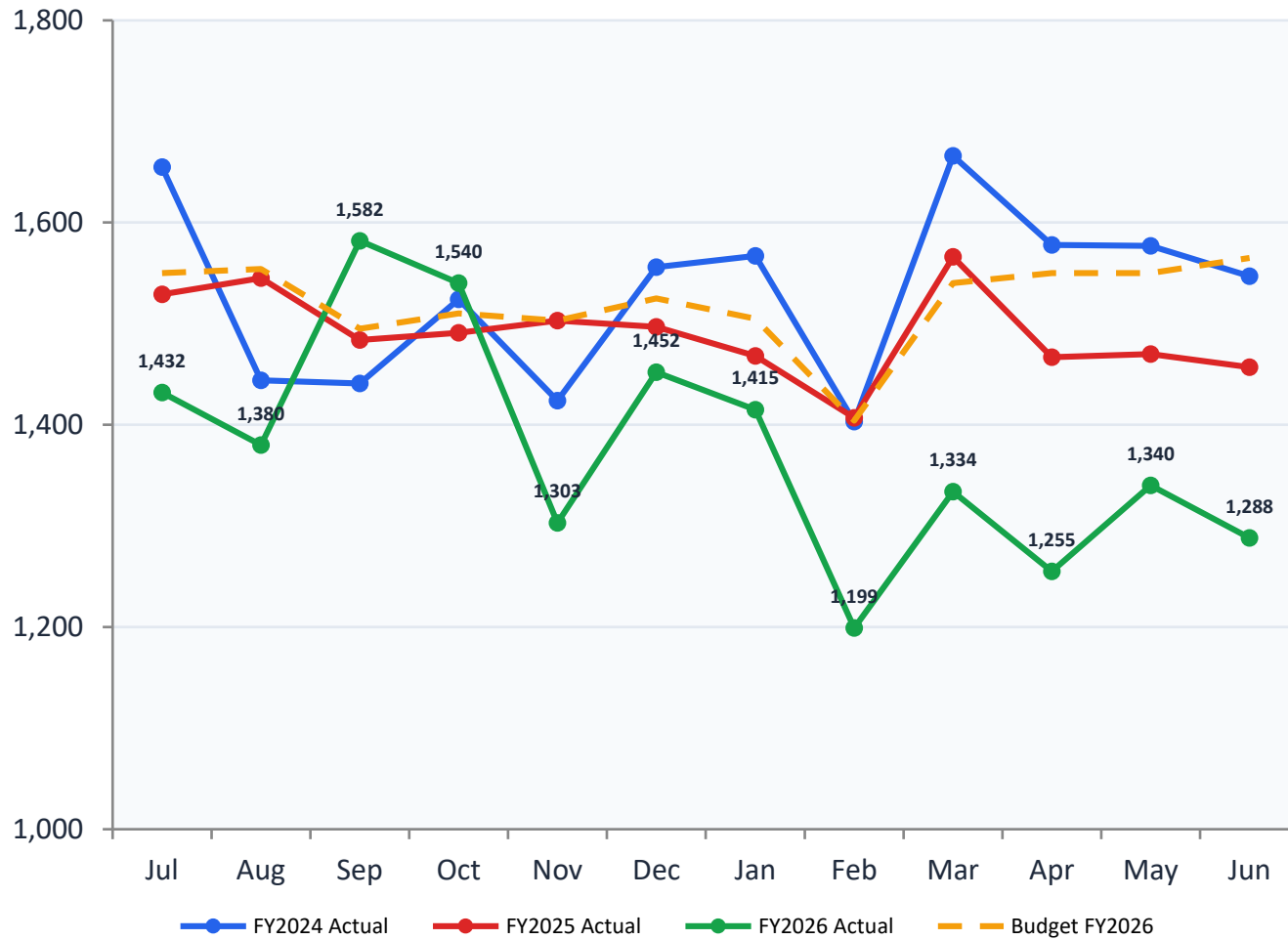
Radiology - UC Court/South Campus



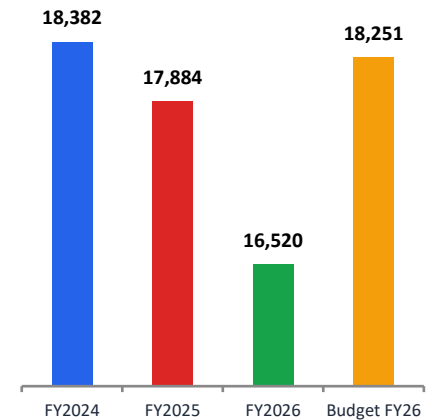
Radiology - UC Demaree/North Campus



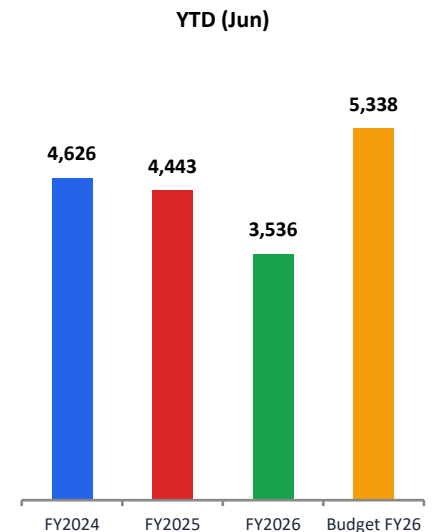
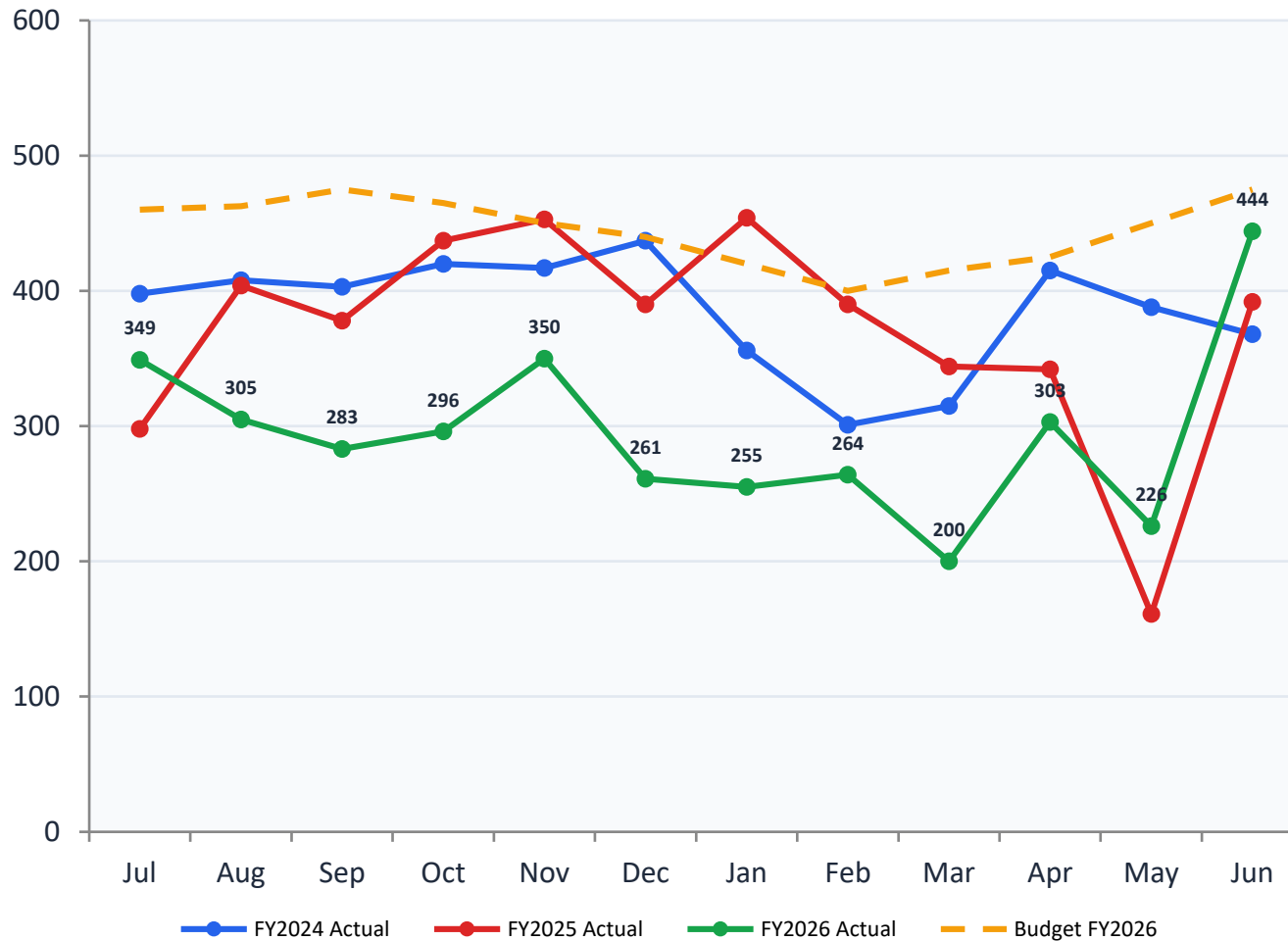
Chronic Dialysis - Visalia



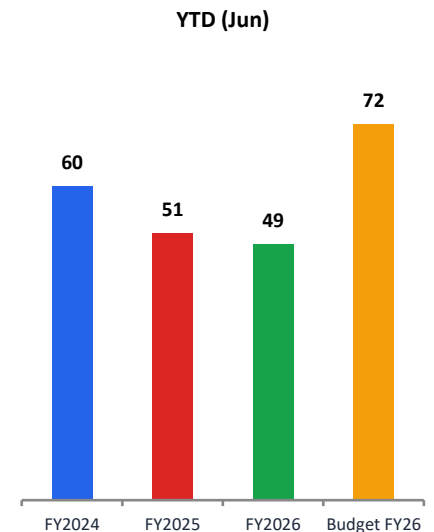
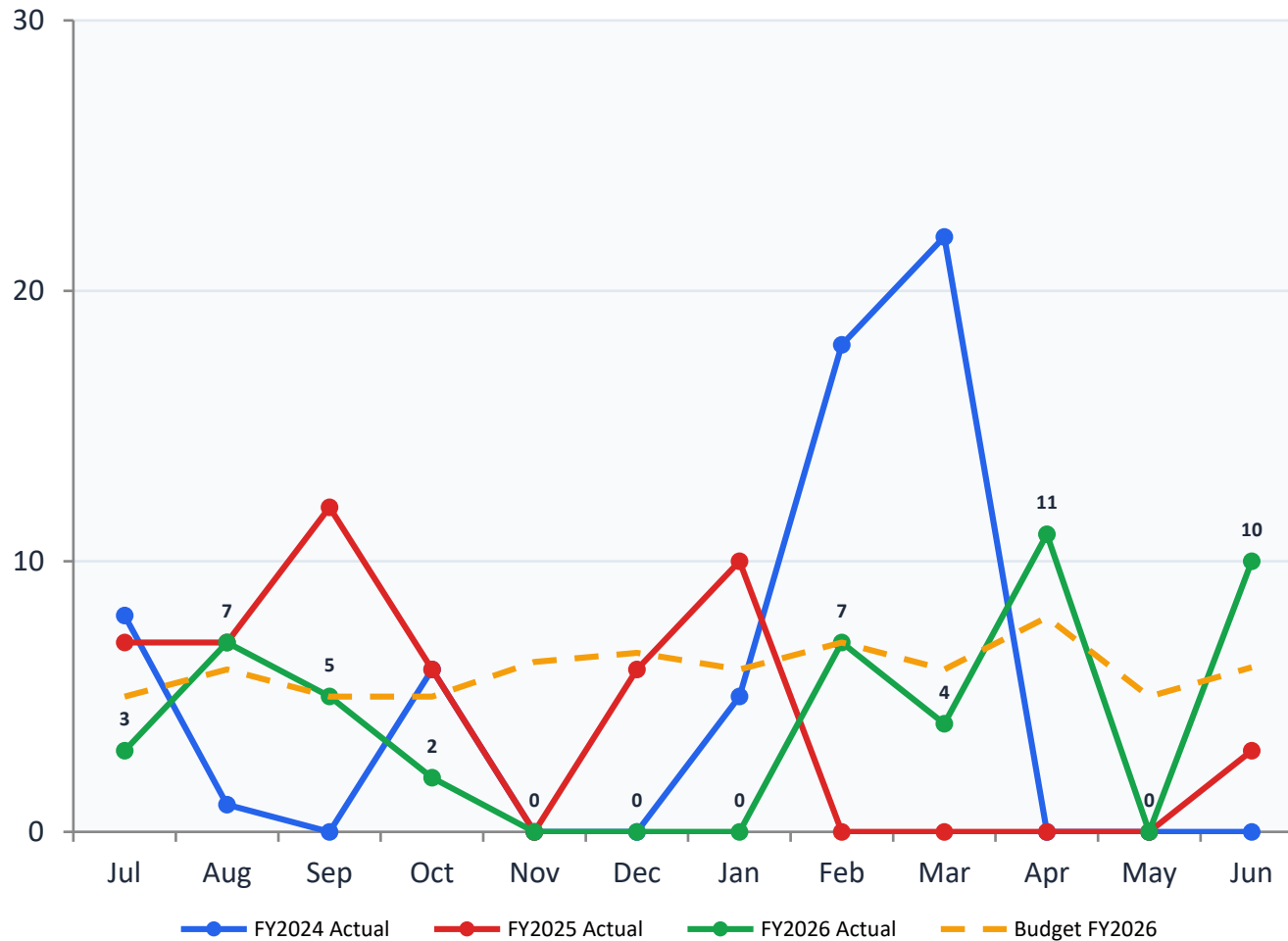
YTD (Jun)



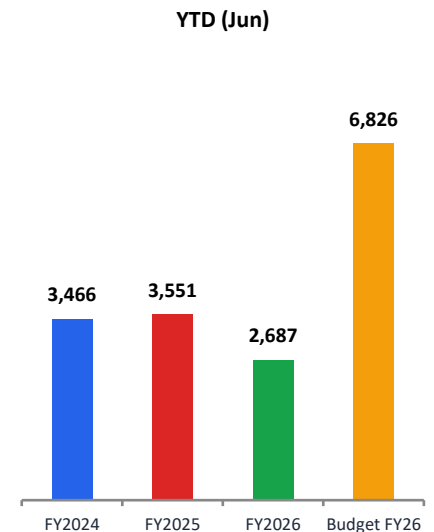
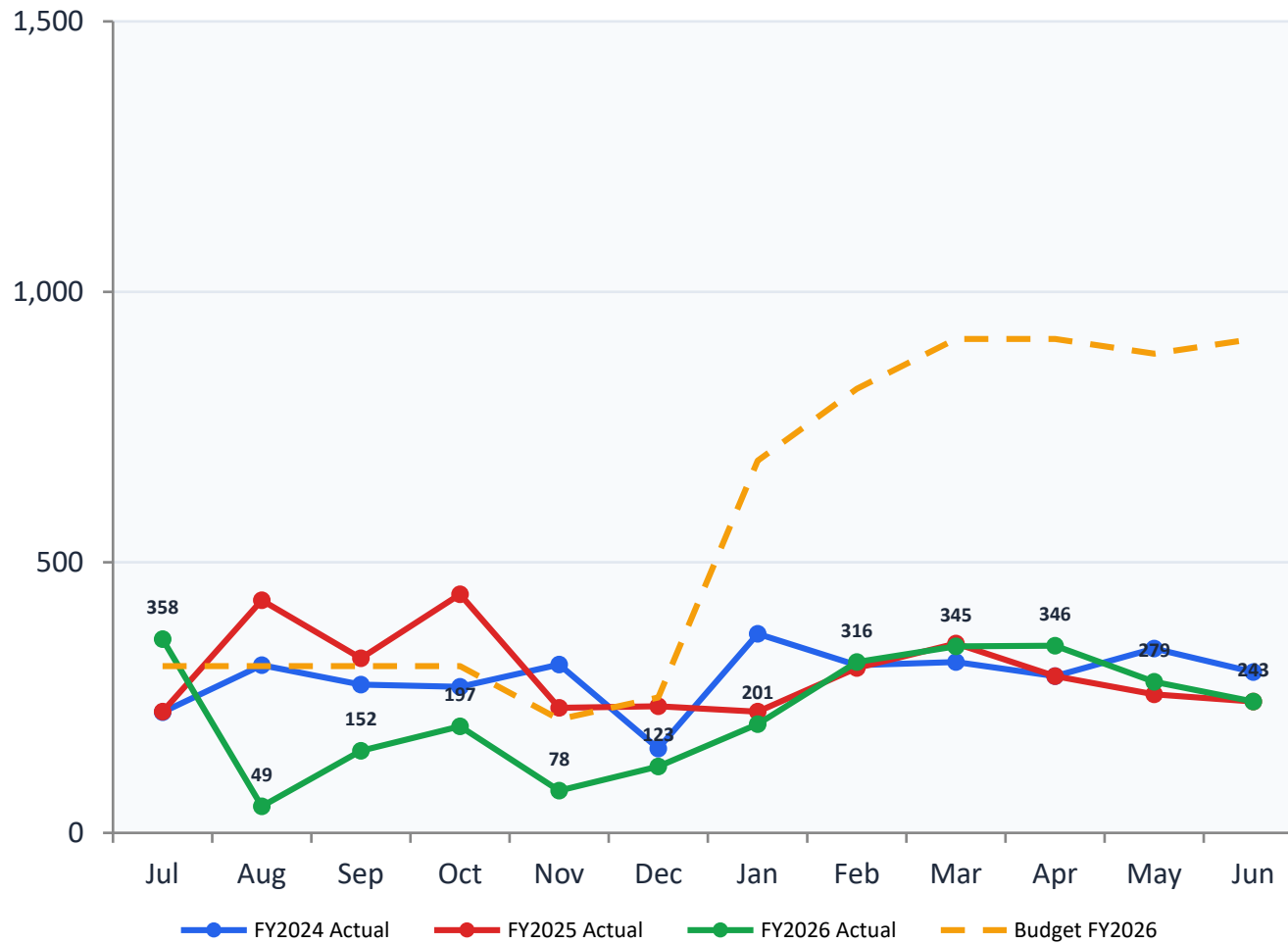
CAPD/CCPD - Maintenance Sessions



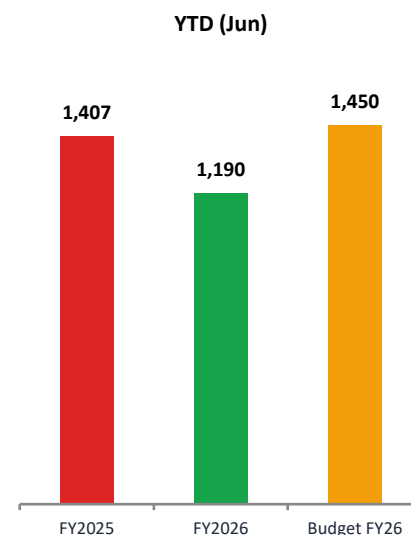
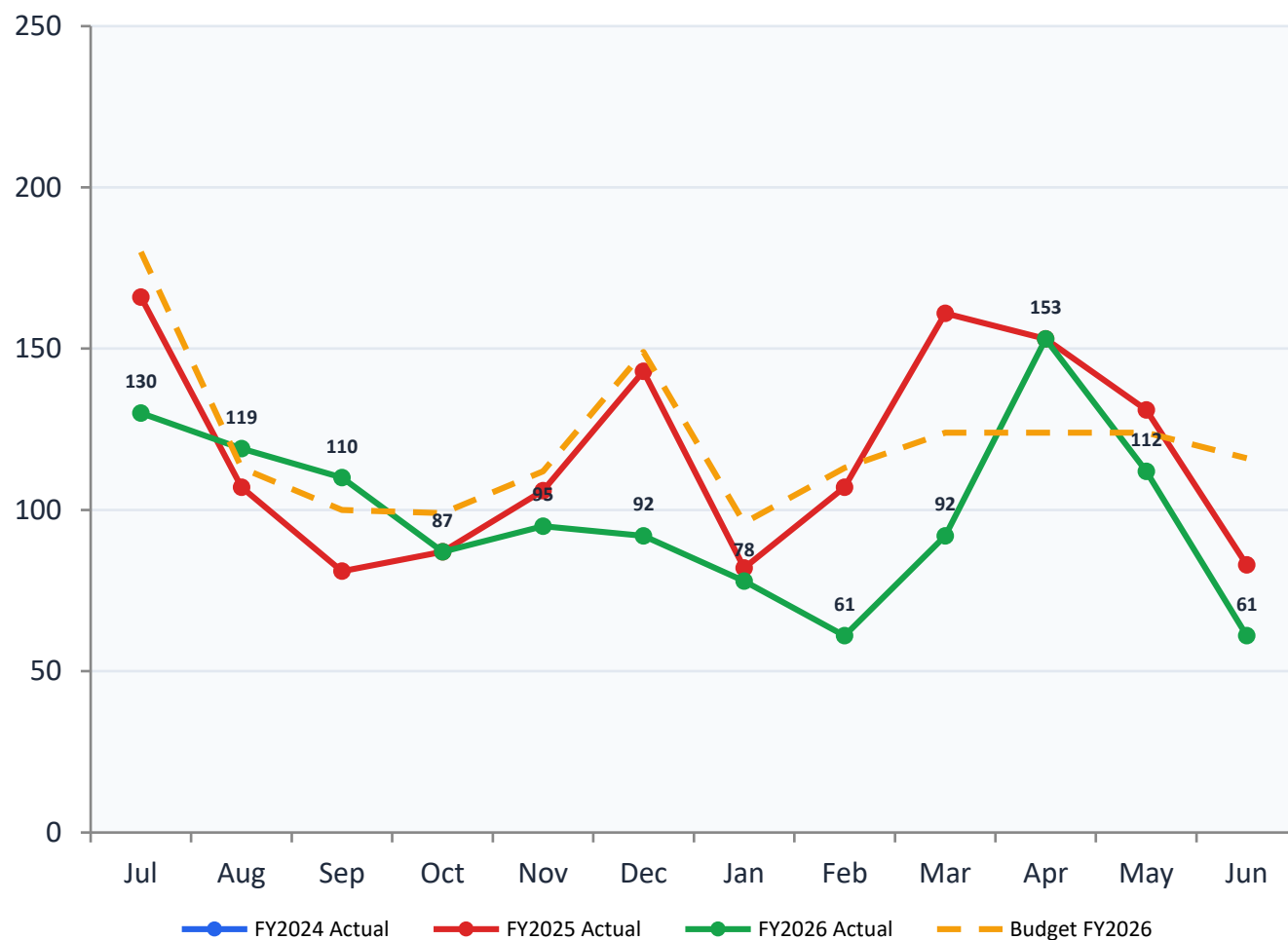
CAPD/CCPD - Training Sessions



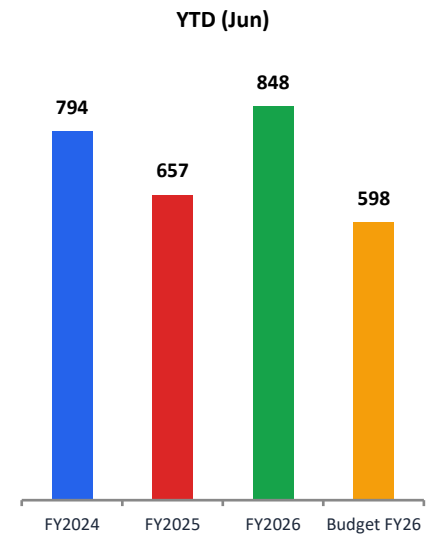
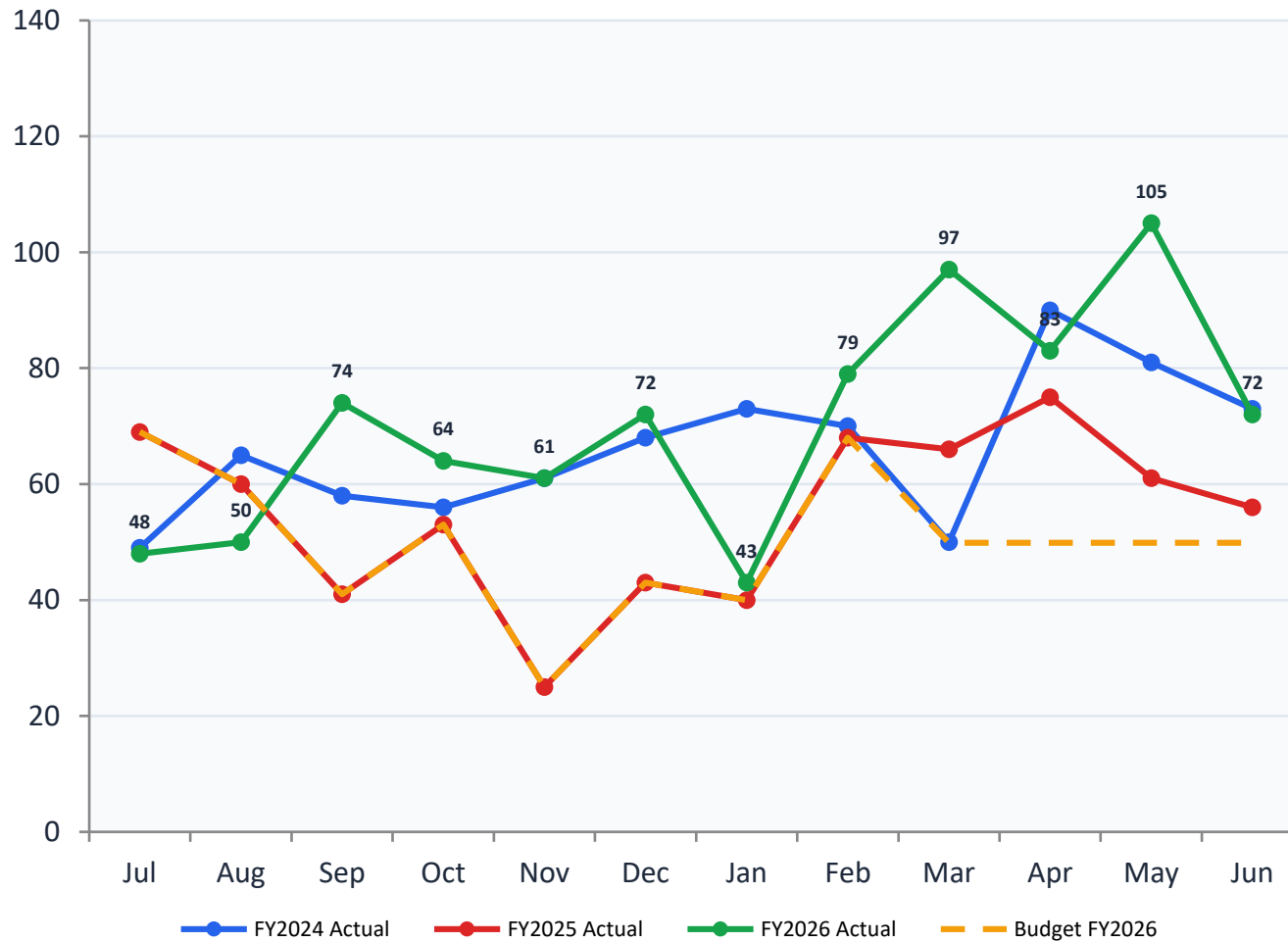
Urology Clinic Visits



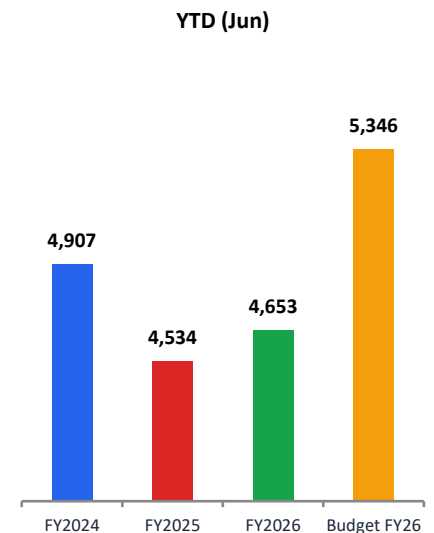
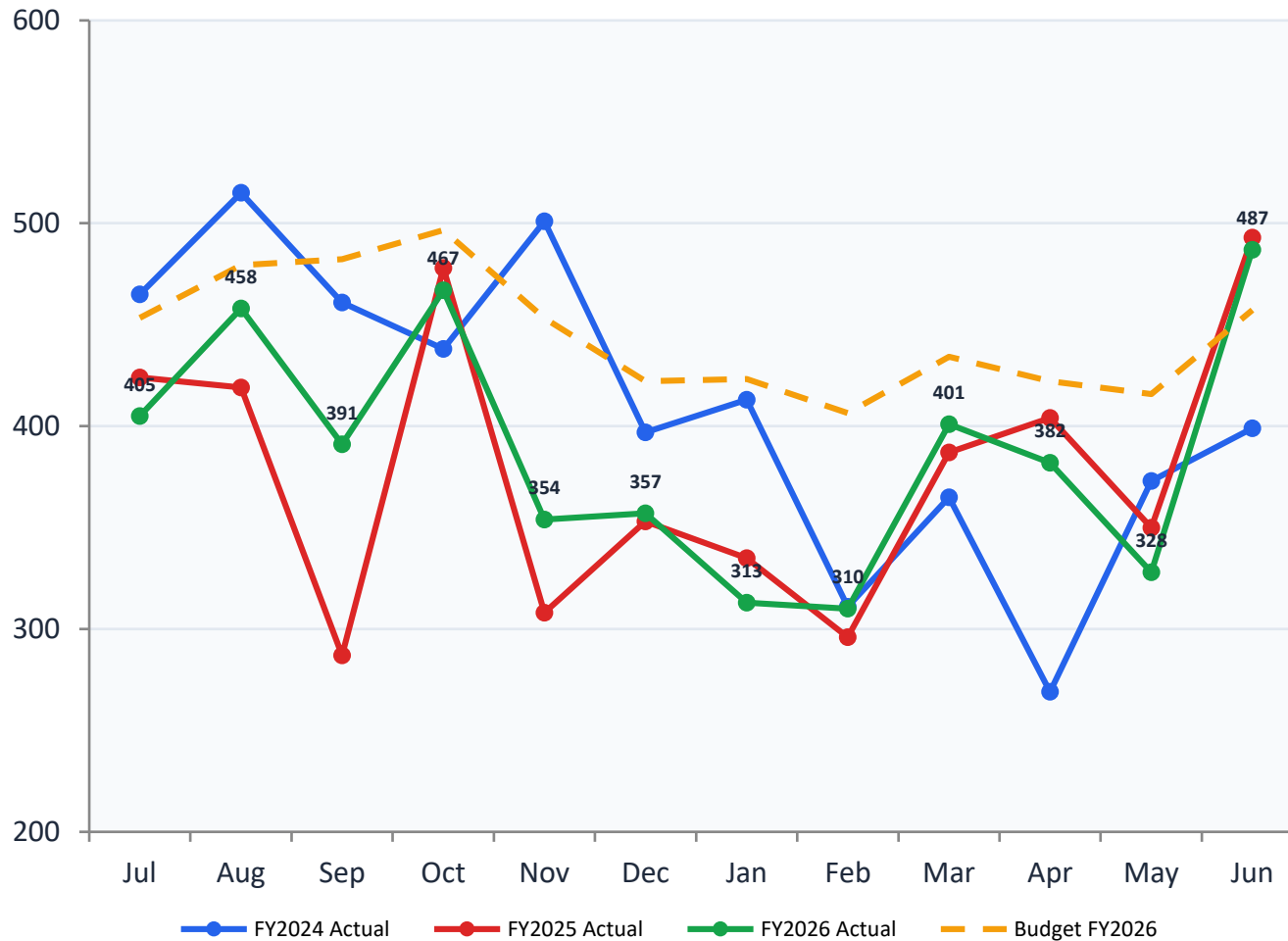
Open Arms House - Patient Days



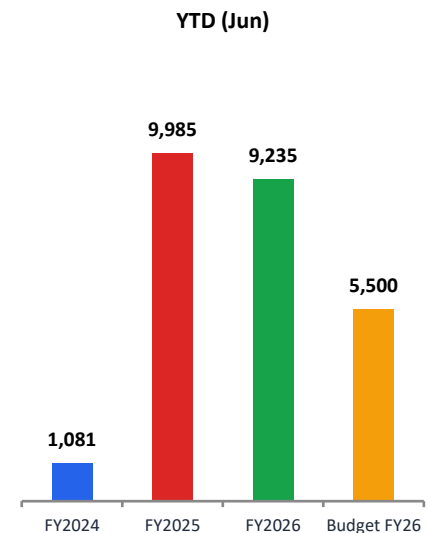
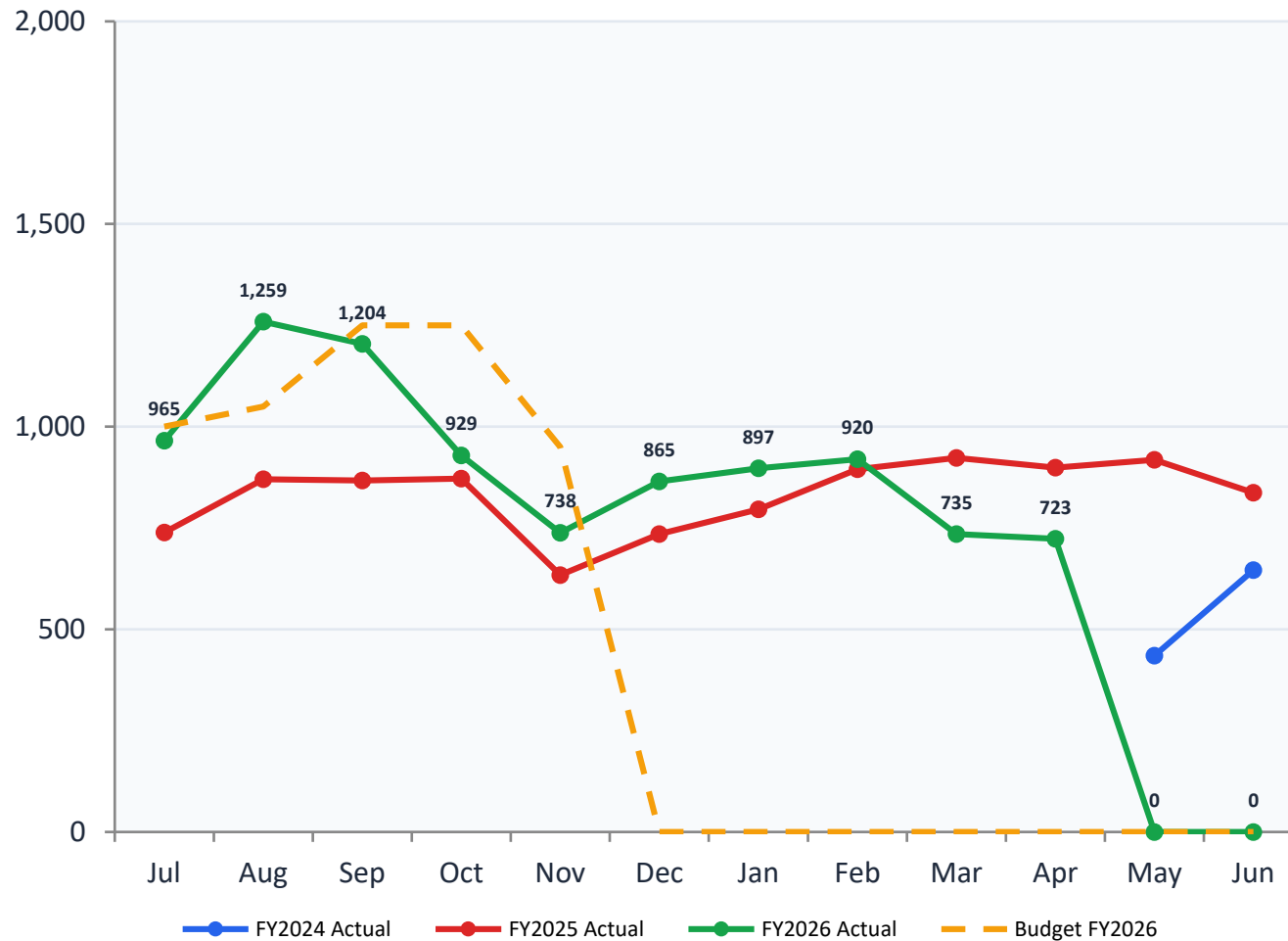
Cardiothoracic Surgery Clinic - Visits



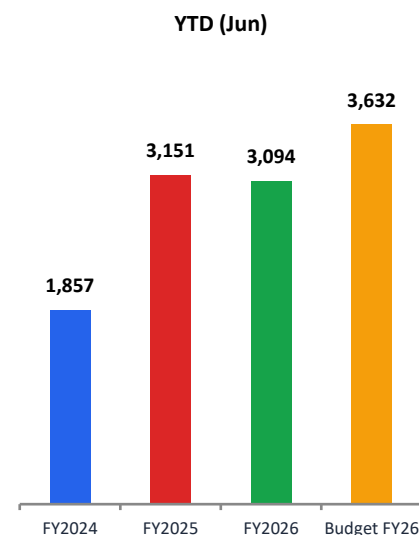
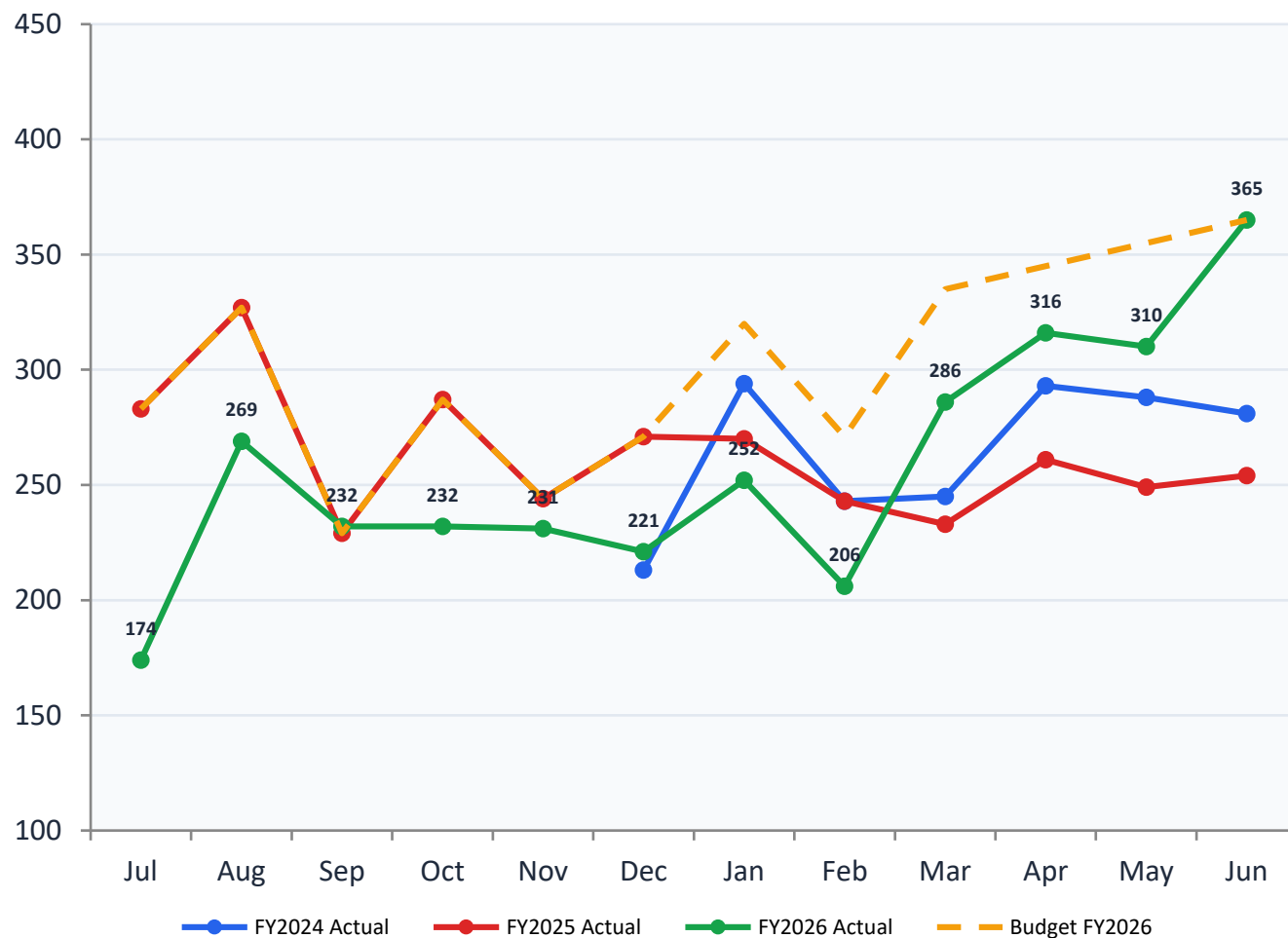
Cardiac Rehabilitation



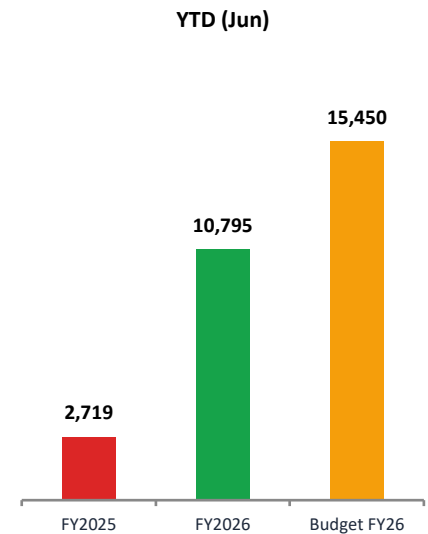
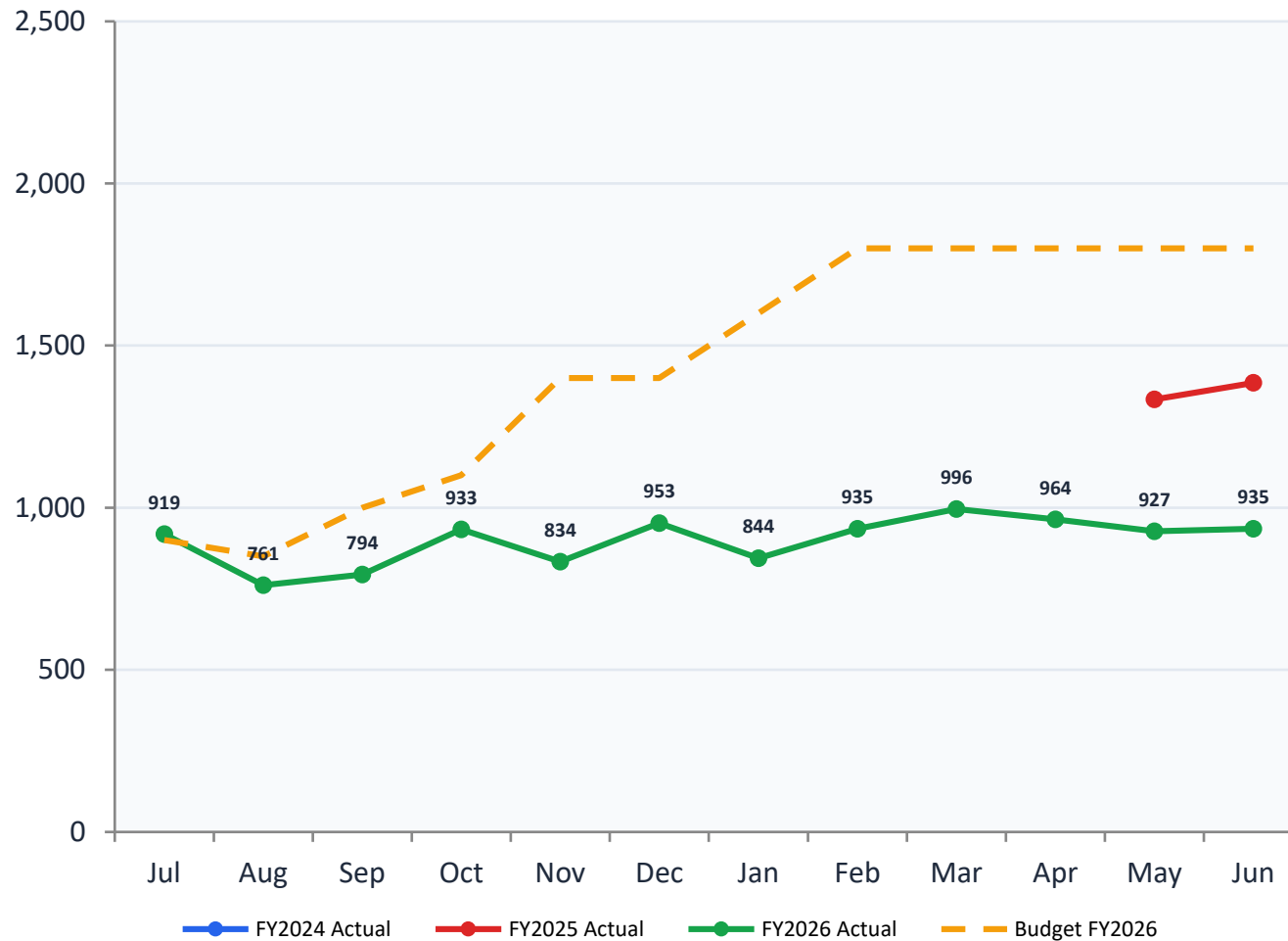
KH Medical Clinic - Ben Maddox



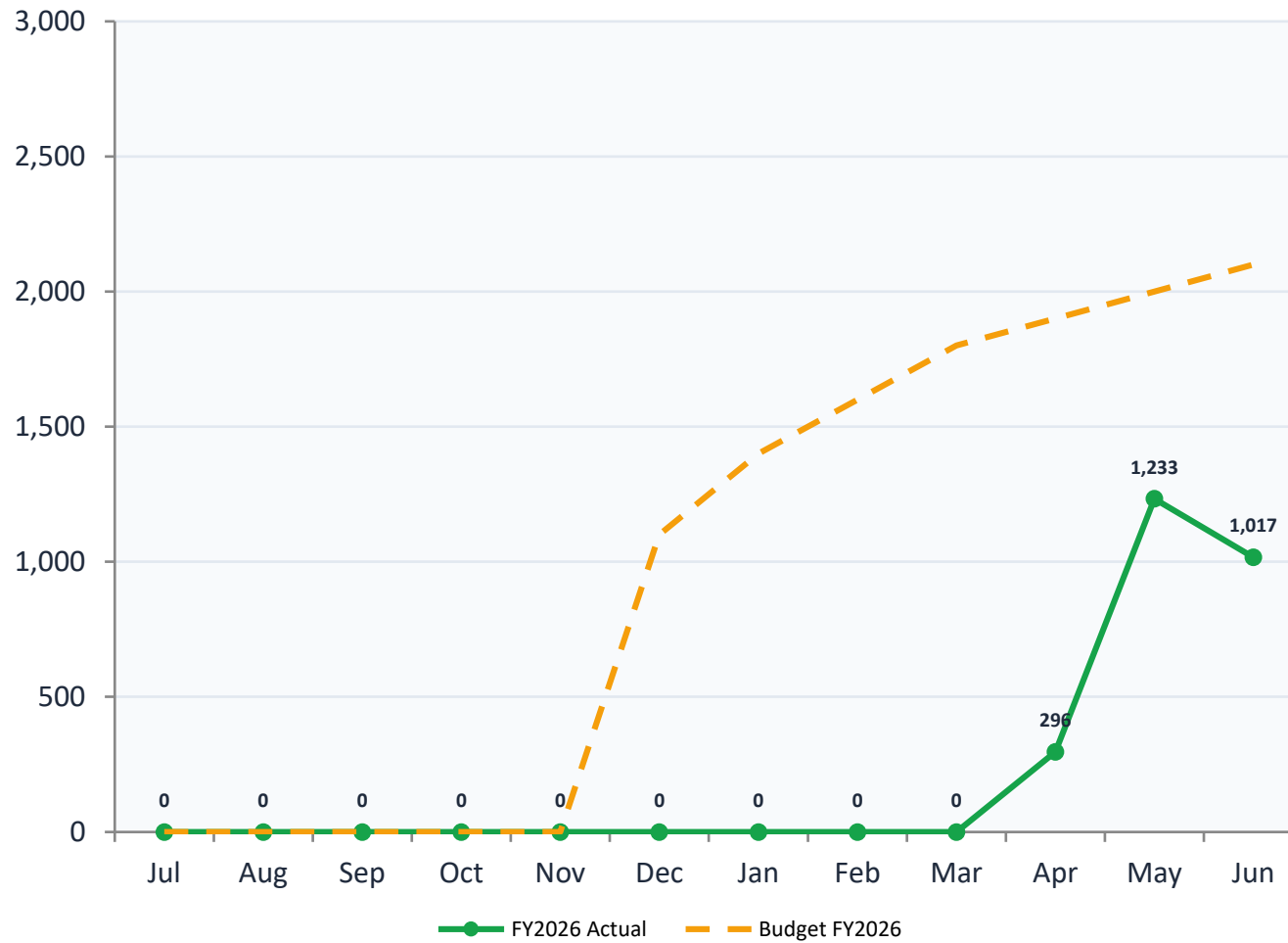
KH Medical Clinic - Plaza



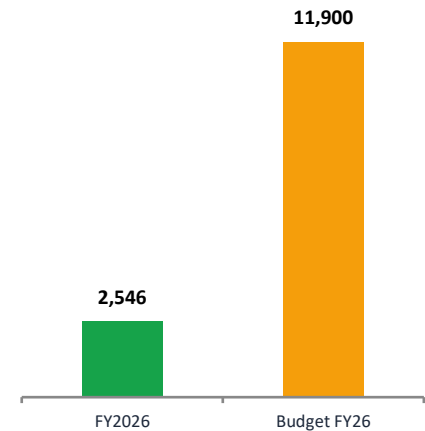
KH Willow Clinic-Women's Health



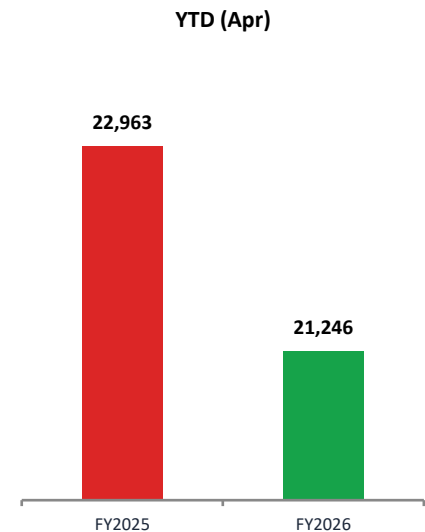
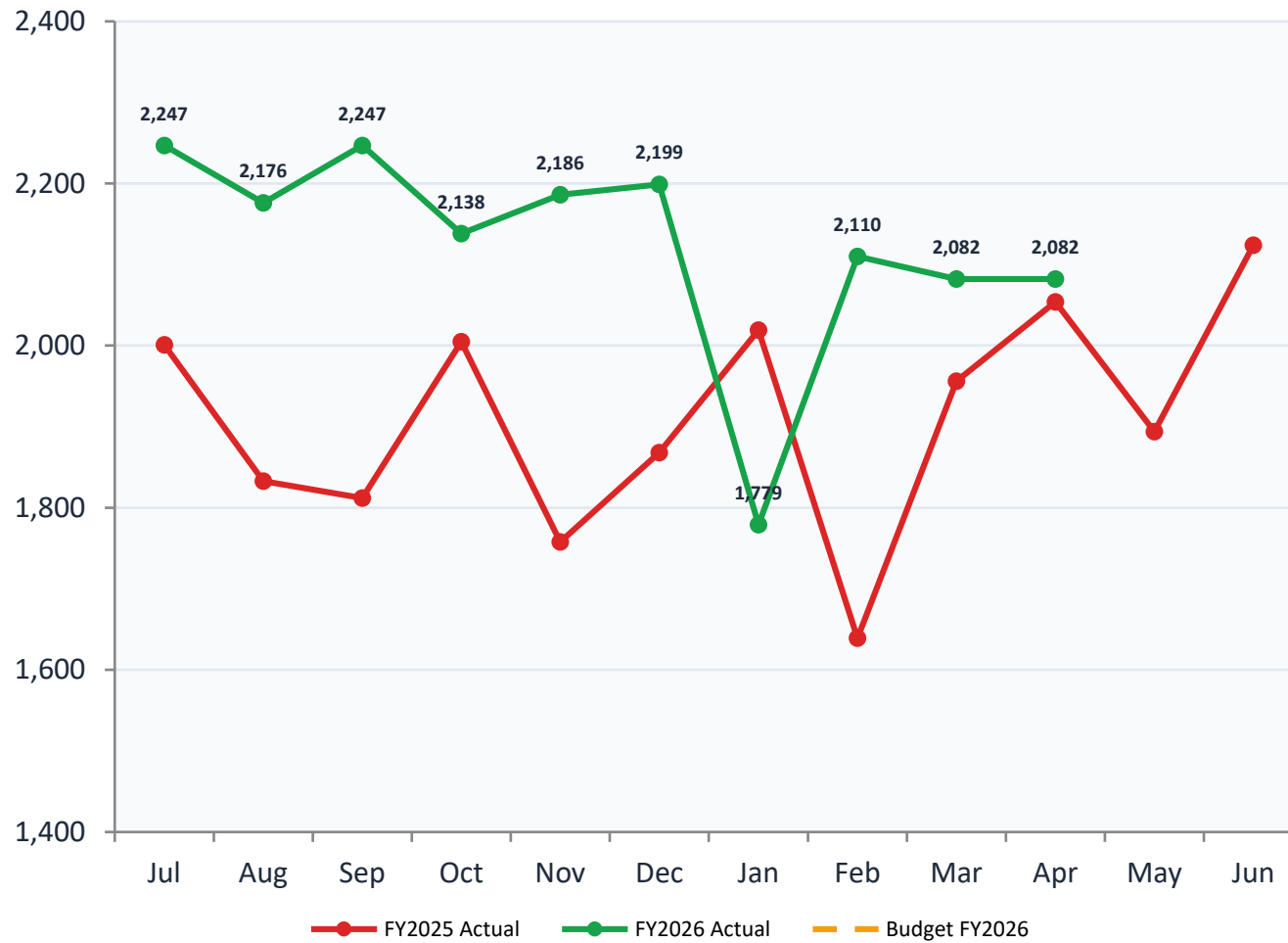
KH Medical Clinic - Akers



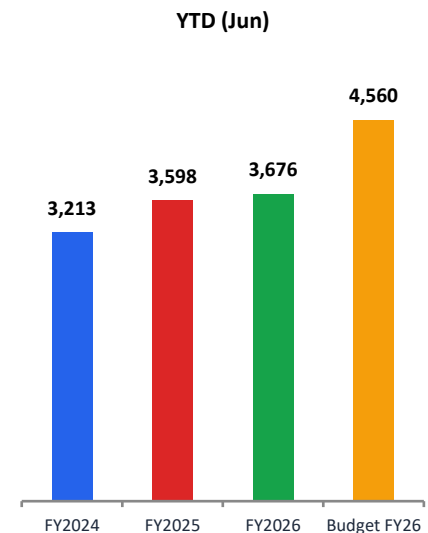
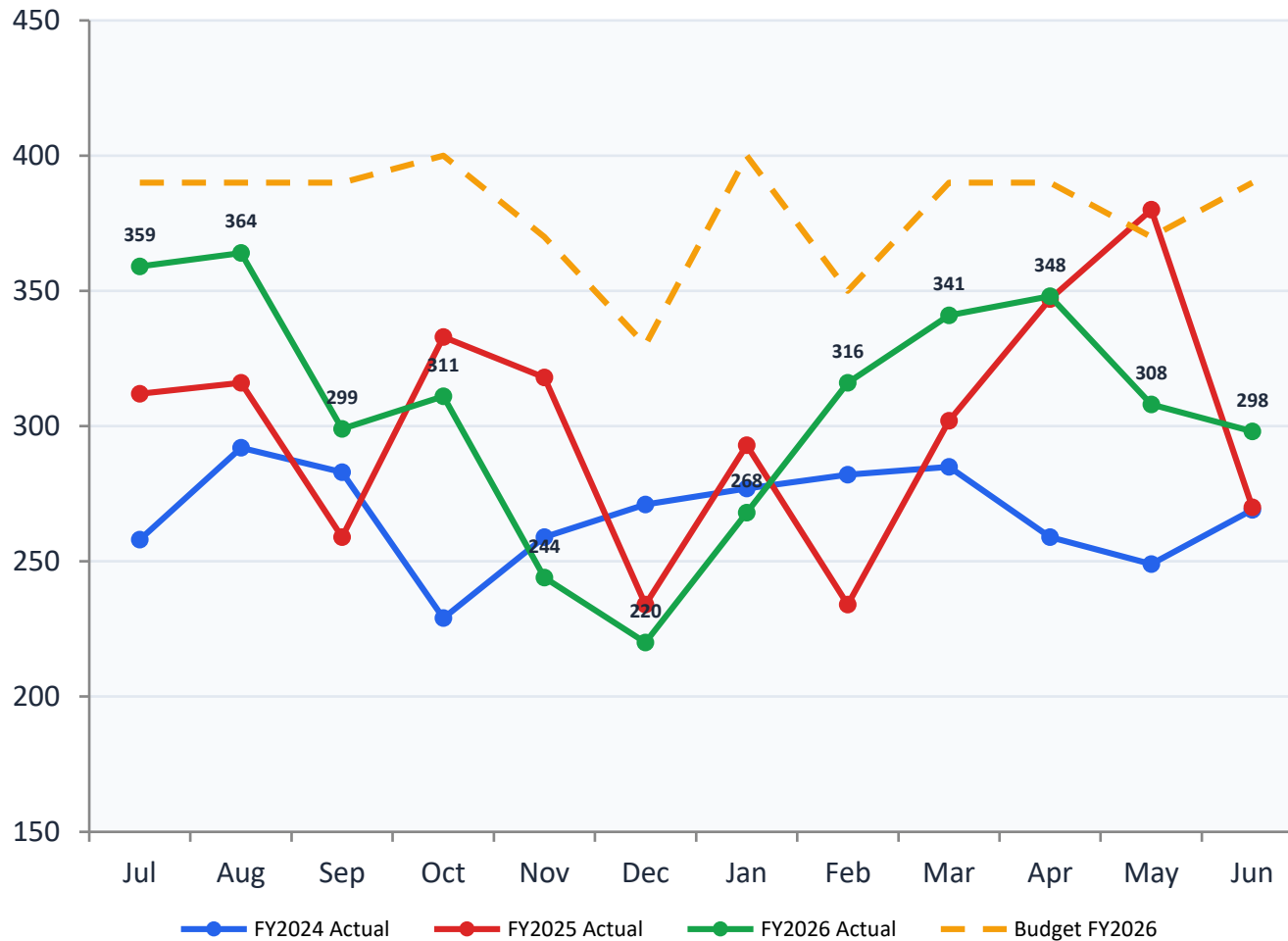
YTD (Jun)



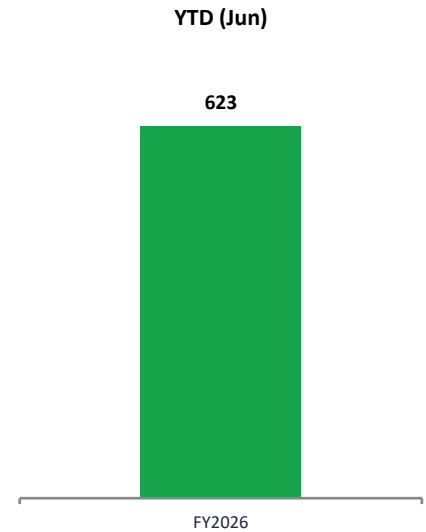
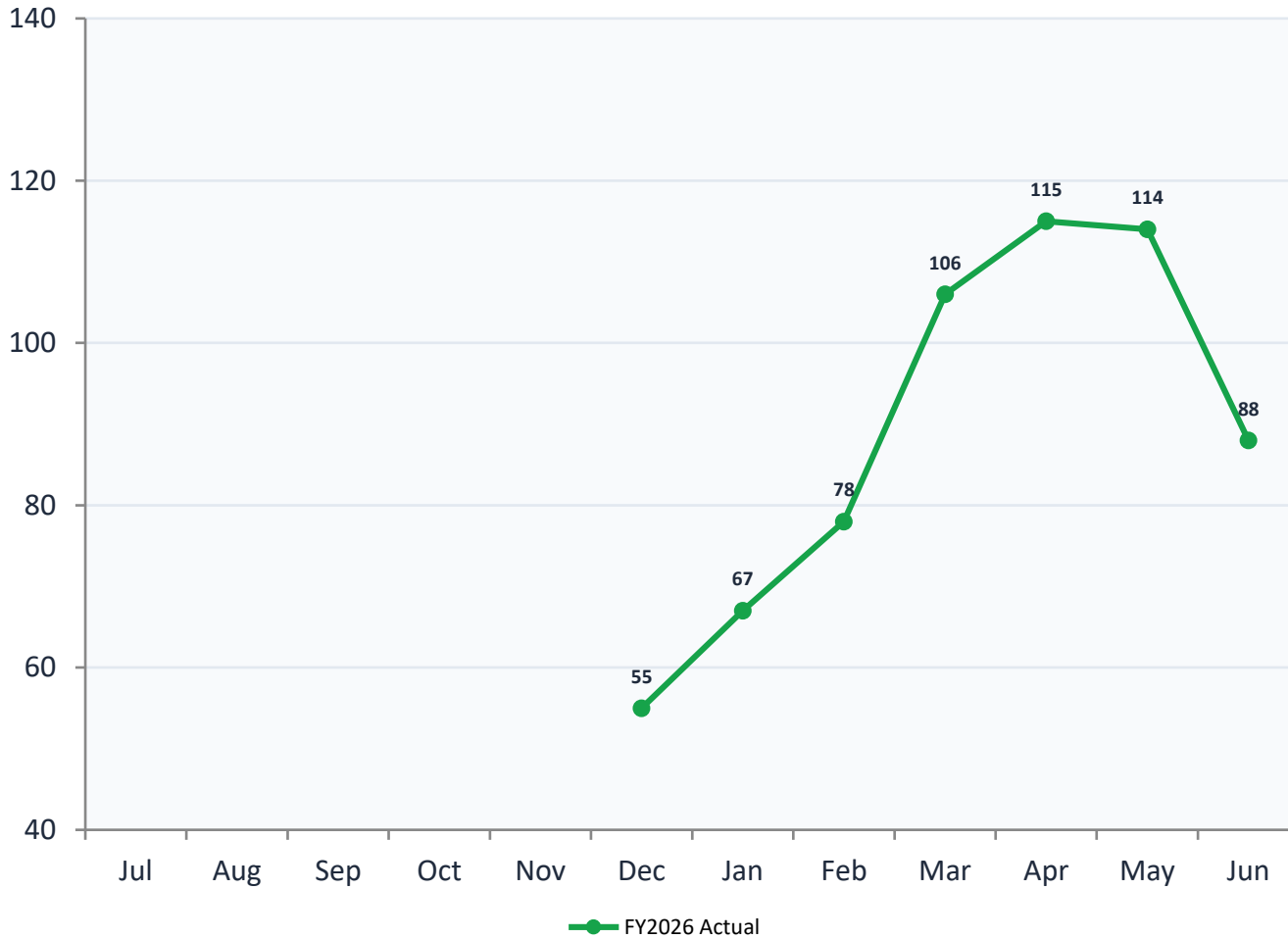
Med Onc Visits



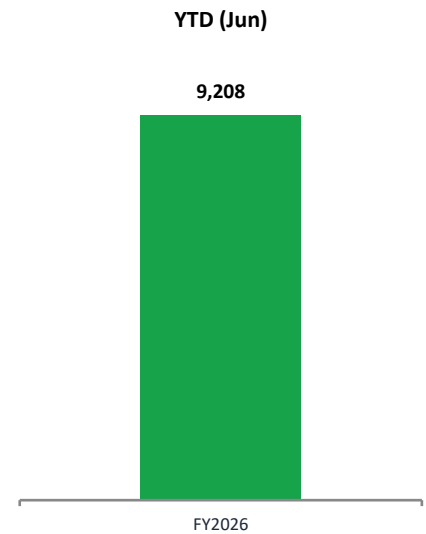
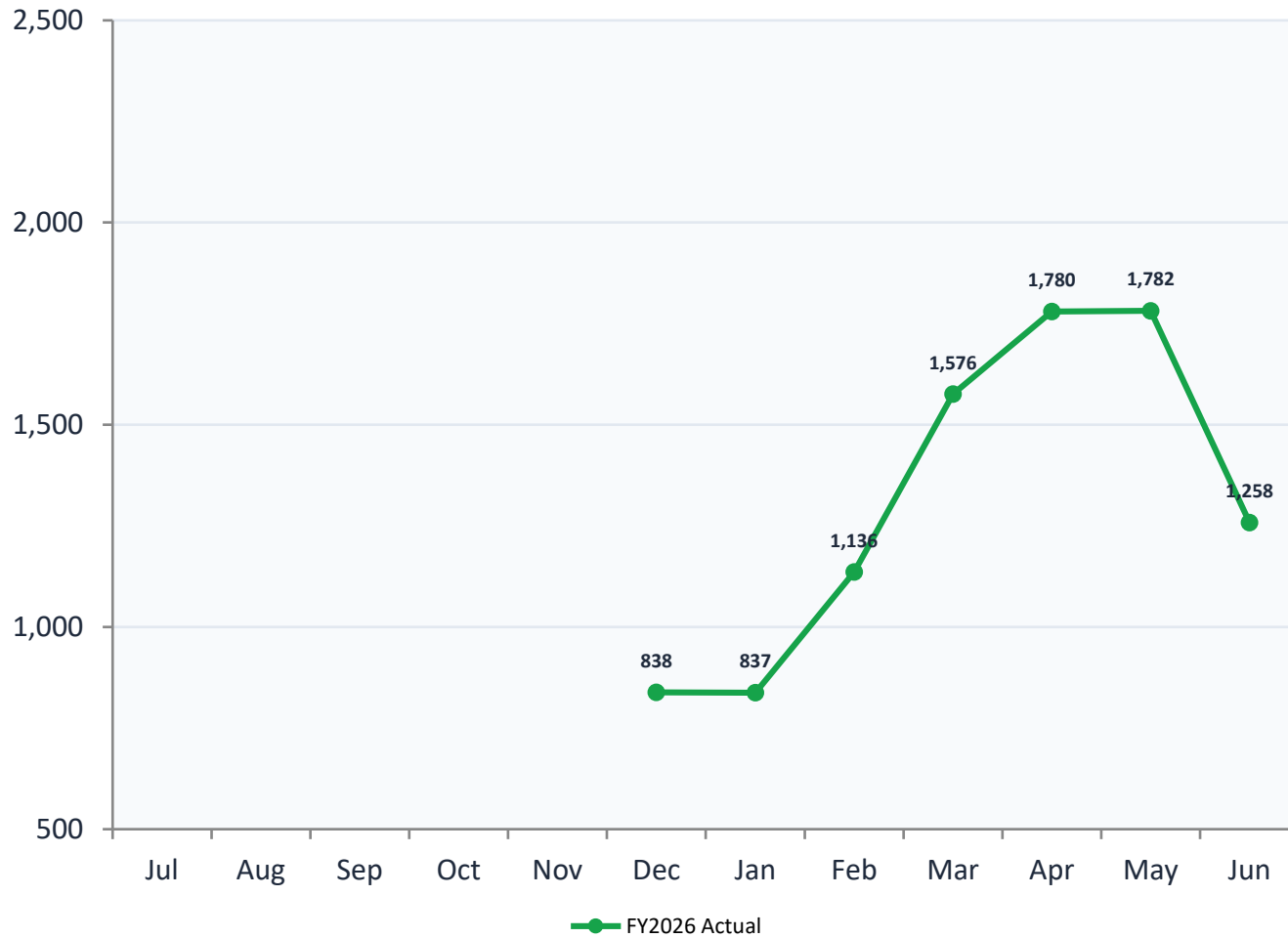
Mental Wellness Clinic - Visits



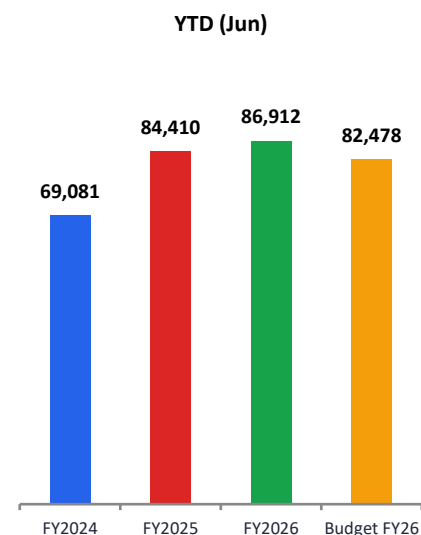
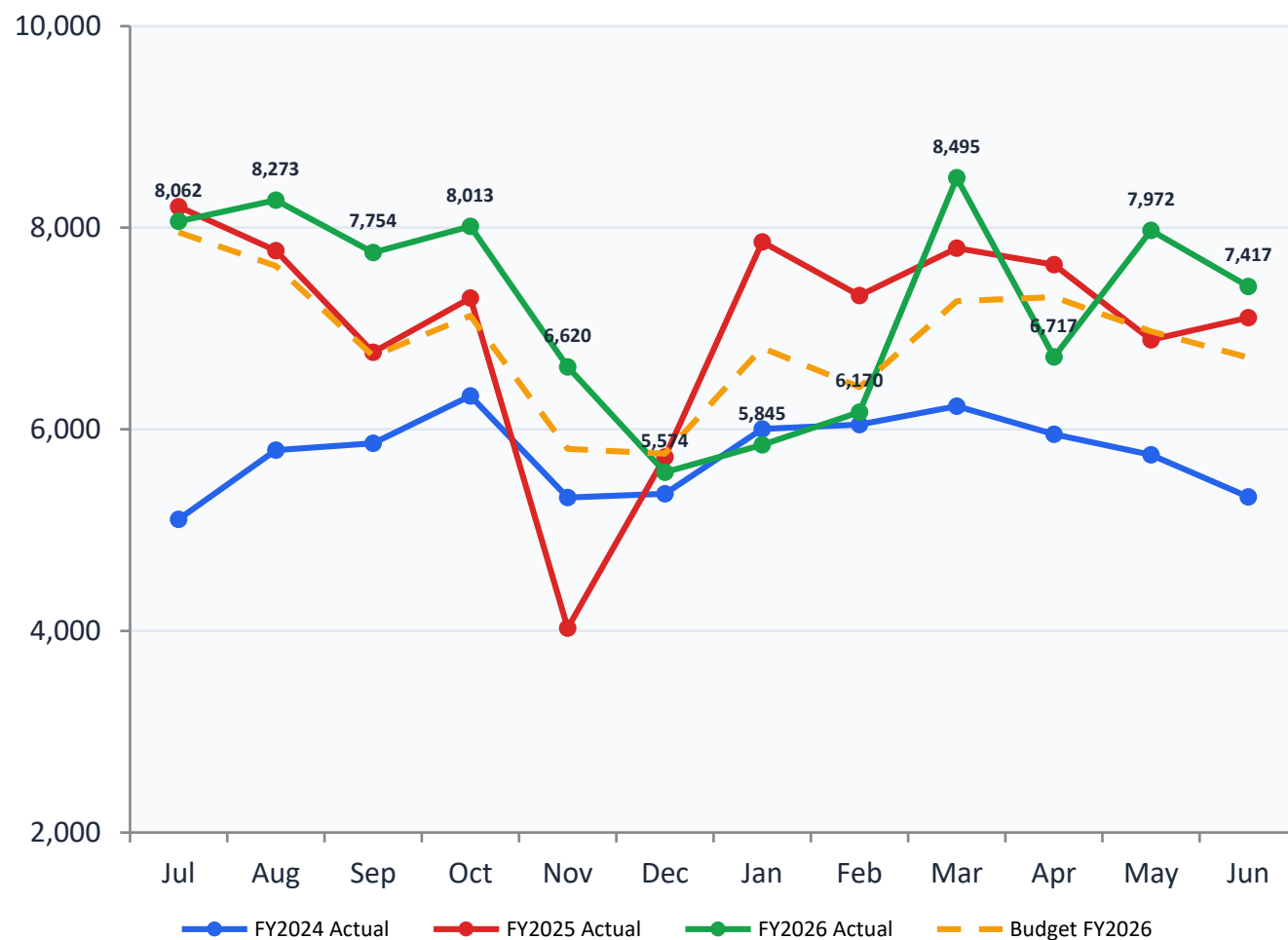
Crisis Stabilization Unit Visits



Crisis Stabilization Unit - Hours



Reference Lab



Other Statistical Results – Prior Year/Budget Comparison (June)

	Actual Results				Budget	Budget Variance	
	Jun25	Jun26	Change	% Change	Jun26	Change	% Change
ED - Avg Treated Per Day	280	284	4	1.4%	282	2	0.8%
Surgery (IP & OP) – 100 Min Units	743	827	84	11.3%	832	(5)	(0.6%)
Endoscopy Procedures	606	589	(17)	(2.8%)	504	85	16.8%
Cath Lab (IP & OP) - 100 Min Units	346	373	27	7.8%	358	15	4.2%
Cardiac Surgery Cases	30	33	3	10.0%	26	7	26.1%
Deliveries	331	289	(42)	(12.7%)	434	(145)	(33.4%)
Clinical Lab	256,686	271,347	14,660	5.7%	273,440	(2,094)	(0.8%)
Reference Lab	7,108	7,417	309	4.3%	6,712	705	10.5%
Dialysis Center - Visalia Visits	1,457	1,288	(169)	(11.6%)	1,565	(277)	(17.7%)
Infusion Center - Units of Service	487	562	75	15.4%	829	(267)	(32.2%)
Hospice Days	4,112	3,919	(193)	(4.7%)	4,176	(257)	(6.2%)
Home Health Visits	2,789	2,736	(53)	(1.9%)	2,990	(254)	(8.5%)
Home Infusion Days	24,374	22,163	(2,211)	(9.1%)	22,660	(497)	(2.2%)

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

	YTD Actual Results				Budget	Budget Variance	
	YTD Jun 25	YTD Jun 26	Change	% Change	YTD Jun 26	Change	% Change
ED - Avg Treated Per Day	265	277	12	4.4%	278	(1)	(0.3%)
Surgery (IP & OP) – 100 Min Units	9,489	9,486	(3)	(0.0%)	9,806	(320)	(3.3%)
Endoscopy Procedures	7,438	5,978	(1,460)	(19.6%)	6,224	(246)	(3.9%)
Cath Lab (IP & OP) - 100 Min Units	4,269	4,244	(25)	(0.6%)	4,326	(82)	(1.9%)
Cardiac Surgery Cases	344	350	6	1.7%	372	(22)	(5.9%)
Deliveries	4,677	3,748	(929)	(19.9%)	4,733	(985)	(20.8%)
Clinical Lab	3,020,527	3,153,163	132,637	4.4%	3,281,275	(128,112)	(3.9%)
Reference Lab	84,410	86,912	2,502	3.0%	82,478	4,435	5.4%
Dialysis Center - Visalia Visits	17,884	16,520	(1,364)	(7.6%)	18,251	(1,731)	(9.5%)
Infusion Center - Units of Service	5,193	6,989	1,796	34.6%	8,256	(1,267)	(15.3%)
Hospice Days	43,419	47,788	4,369	10.1%	49,005	(1,217)	(2.5%)
Home Health Visits	34,533	33,607	(926)	(2.7%)	36,638	(3,031)	(8.3%)
Home Infusion Days	268,810	281,490	12,680	4.7%	264,713	16,777	6.3%

Other Statistical Results – Prior Year/Budget Comparison (June)

	Actual Results				Budget	Budget Variance	
	Jun25	Jun26	Change	% Change	Jun26	Change	% Change
All O/P Rehab Svcs Across District	20,711	20,094	(617)	(3.0%)	22,041	(1,947)	(8.8%)
Physical & Other Therapy Units (I/P & O/P)	17,449	20,136	2,687	15.4%	19,669	467	2.4%

Radiology - CT - All Areas	5,109	5,833	724	14.2%	4,783	1,050	22.0%
Radiology - MRI - All Areas	1,128	1,026	(102)	(9.0%)	879	147	16.8%
Radiology - Ultrasound - All Areas	3,153	3,340	187	5.9%	3,217	123	3.8%
Radiology - Diagnostic Radiology	9,677	10,377	700	7.2%	9,535	842	8.8%
Radiology – Main Campus	16,052	16,827	775	4.8%	15,412	1,415	9.2%
Radiology - Ultrasound - Main Campus	2,439	2,271	(168)	(6.9%)	2,330	(59)	(2.6%)

West Campus - Diagnostic Radiology	1,310	1,522	212	16.2%	1,178	344	29.2%
West Campus - CT Scan	523	667	144	27.5%	515	152	29.5%
West Campus - MRI	468	491	23	4.9%	422	69	16.2%
West Campus - Ultrasound	714	1,069	355	49.7%	887	182	20.5%
West Campus - Breast Center	1,635	2,225	590	36.1%	1,721	504	29.3%

Med Onc Visalia Treatments	1,100	1,036	(64)	(5.8%)	1,198	(162)	(13.5%)
Rad Onc Visalia Treatments	1,675	1,654	(21)	(1.3%)	1,513	141	9.4%
Rad Onc Hanford Treatments	391	146	(245)	(62.7%)	232	(86)	(37.0%)

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

	YTD Actual Results				Budget	Budget Variance	
	YTD Jun 25	YTD Jun 26	Change	% Change	YTD Jun 26	Change	% Change
All O/P Rehab Svcs Across District	248,488	243,141	(5,347)	(2.2%)	253,319	(10,178)	(4.0%)
Physical & Other Therapy Units (I/P & O/P)	220,355	231,667	11,312	5.1%	238,004	(6,337)	(2.7%)
Radiology - CT - All Areas	57,086	63,669	6,583	11.5%	55,292	8,378	15.2%
Radiology - MRI - All Areas	10,766	11,214	448	4.2%	10,520	694	6.6%
Radiology - Ultrasound - All Areas	36,707	37,168	461	1.3%	36,579	590	1.6%
Radiology - Diagnostic Radiology	116,224	116,992	768	0.7%	116,994	(2)	(0.0%)
Radiology – Main Campus	186,875	189,810	2,935	1.6%	184,048	5,762	3.1%
Radiology - Ultrasound - Main Campus	28,658	26,474	(2,184)	(7.6%)	26,191	283	1.1%
West Campus - Diagnostic Radiology	14,716	16,309	1,593	10.8%	13,965	2,344	16.8%
West Campus - CT Scan	6,061	7,052	991	16.4%	5,907	1,145	19.4%
West Campus - MRI	5,082	5,178	96	1.9%	5,076	102	2.0%
West Campus - Ultrasound	8,049	10,694	2,645	32.9%	10,388	306	2.9%
West Campus - Breast Center	19,258	22,182	2,924	15.2%	19,827	2,355	11.9%
Med Onc Visalia Treatments	12,972	13,491	519	4.0%	13,792	(301)	(2.2%)
Rad Onc Visalia Treatments	16,943	17,774	831	4.9%	17,573	201	1.1%
Rad Onc Hanford Treatments	2,925	2,695	(230)	(7.9%)	2,859	(164)	(5.7%)

Other Statistical Results – Prior Year/Budget Comparison (June)

	Actual Results				Budget	Budget Variance	
	Jun25	Jun26	Change	% Change	Jun26	Change	% Change
Rural Health Clinics Registrations	13,574	11,763	(1,811)	(13.3%)	13,250	(1,487)	(11.2%)
RHC Exeter - Registrations	6,490	5,444	(1,046)	(16.1%)	6,471	(1,027)	(15.9%)
RHC Lindsay - Registrations	1,868	1,642	(226)	(12.1%)	1,970	(328)	(16.6%)
RHC Woodlake - Registrations	1,302	488	(814)	(62.5%)	637	(149)	(23.4%)
RHC Woodlake Valencia - Registrations	0	761	761	0.0%	1,300	(539)	(41.5%)
RHC Dinuba - Registrations	1,257	1,193	(64)	(5.1%)	1,750	(557)	(31.8%)
RHC Tulare - Registrations	2,657	2,235	(422)	(15.9%)	2,422	(187)	(7.7%)
Urgent Care – Court Total Visits	2,473	2,280	(193)	(7.8%)	2,700	(420)	(15.6%)
Urgent Care – Demaree Total Visits	1,568	1,927	359	22.9%	1,850	77	4.2%
KH Medical Clinic - Ben Maddox Visits	837	0	(837)	(100.0%)	-	0	0.0%
KH Medical Clinic - Plaza Visits	254	365	111	43.7%	365	0	0.0%
KH Willow Specialty Clinic	248	371	123	49.6%	509	(138)	(27.1%)
KH Cardiology Center Visalia Registrations	1,396	2,267	871	62.4%	1,690	577	34.1%
KH Mental Wellness Clinic Visits	270	298	28	10.4%	390	(92)	(23.6%)
Urology Clinic Visits	243	243	0	0.0%	913	(670)	(73.4%)
Therapy-Wound Care Svcs Encounters	322	303	(19)	(5.9%)	347	(44)	(12.7%)

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

	YTD Actual Results				Budget	Budget Variance	
	YTD Jun 25	YTD Jun 26	Change	% Change	YTD Jun 26	Change	% Change
Rural Health Clinics Registrations	164,323	146,605	(17,718)	(10.8%)	164,641	(18,036)	(11.0%)
RHC Exeter - Registrations	78,302	69,572	(8,730)	(11.1%)	80,150	(10,578)	(13.2%)
RHC Lindsay - Registrations	22,470	20,383	(2,087)	(9.3%)	25,050	(4,667)	(18.6%)
RHC Woodlake - Registrations	15,980	6,932	(9,048)	(56.6%)	8,016	(1,084)	(13.5%)
RHC Woodlake Valencia - Registrations	0	7,628	7,628	0.0%	11,898	(4,270)	(35.9%)
RHC Dinuba - Registrations	18,242	16,725	(1,517)	(8.3%)	20,675	(3,950)	(19.1%)
RHC Tulare - Registrations	29,329	25,365	(3,964)	(13.5%)	30,750	(5,385)	(17.5%)

Urgent Care – Court Total Visits	30,487	30,217	(270)	(0.9%)	35,300	(5,083)	(14.4%)
Urgent Care – Demaree Total Visits	18,797	24,078	5,281	28.1%	24,050	28	0.1%

KH Medical Clinic - Ben Maddox Visits	9,985	9,235	(750)	(7.5%)	5,500	3,735	67.9%
KH Medical Clinic - Plaza Visits	3,151	3,094	(57)	(1.8%)	3,632	(538)	(14.8%)
KH Willow Specialty Clinic	422	4,249	3,827	906.9%	5,720	(1,471)	(25.7%)
KH Cardiology Center Visalia Registrations	18,285	20,007	1,722	9.4%	19,577	430	2.2%
KH Mental Wellness Clinic Visits	3,598	3,676	78	2.2%	4,560	(884)	(19.4%)
Urology Clinic Visits	3,551	2,687	(864)	(24.3%)	6,826	(4,139)	(60.6%)
Therapy-Wound Care Svcs Encounters	2,649	3,919	1,270	47.9%	4,225	(306)	(7.2%)