KAWEAH DELTA HEALTH CARE DISTRICT
SPECIAL BOARD OF DIRECTORS MEETING

Kaweah Health Support Services Building – Graduate Medical Education Classrooms (5th Floor)
520 W. Mineral King Avenue, Visalia, CA

Monday June 1, 2026 {Special Meeting}

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

OPEN MEETING AGENDA {5:30PM}

1. **CALL TO ORDER**
2. **PUBLIC PARTICIPATION –** Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdiction of the Board are requested to identify themselves at this time.
3. **BOARD GOVERNANCE**- Summary of discussions and key observations from the Governance Institute with identified opportunities.
4. **ADJOURNED**

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obtained by contacting the Board Clerk at 400 W. Mineral King Avenue, Visalia, CA, or by email at kedavis@kaweahhealth.org, or on the District website.

Strategic Themes from The Governance Institute

June 2026

1. Financial Resilience
2. Governance Agility
3. AI & Technology
4. Aging & Feminization
5. Population Health

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Why We're Here

Our mandates as Kaweah leaders

1. **We've quantified our revenue and expense challenges.**

   Finance has modeled the multi-year impact of HR1. We also have major expense pressures (Ex: SWB and IT). We know the gap and need to figure out how to fill it and then build beyond it.

2. **Treading water is unsustainable.**

   We need a plan that compensates for lost revenue while building a stronger bottom line through efficiency and growth. The working name is Project 2030.

3. **A multi-year plan needs to be developed.**

   The themes and priorities surfaced today will directly inform that multi-year plan to achieve financial stability and remain a forever organization for our employees and patients.

4. **It's critical to begin implementing solutions now.**

   Some of these themes have already been incorporated in the FY27 strategic plan. These themes should drive our focus throughout the fiscal year.

How we'll use the next 2 hours

- **0:00** **Framing**
  Where Kaweah stands today
- **0:15** **Theme 1: Financial Resilience**
  Preparing for the Medicaid gap
- **0:35** **Theme 2: Governance Agility**
  Lead or react?
- **0:55** **Theme 3: AI & Technology**
  Workforce multiplier
- **1:15** **Theme 4: Aging & Feminization**
  The demographic wave
- **1:35** **Theme 5: Population Health**
  Strategy vs. programs
- **1:55** **Near-term follow-ups**
  FY27 + next 90 days

From This Session to Action

Three outputs we need to leave with today

1

FY27 Focus Areas

Which themes do we need to focus on most in our FY27 Strategic Plan?
Which themes are not adequately addressed?
What are we committing to do differently in the next 90 days?

(Capture during discussion)

2

Future planning priorities

Which themes need the deepest work in a future planning session?
What are the biggest open questions that need to be resolved to develop a multi-year plan?

(Capture during discussion)

3

Framing Project 2030

What's the right name and approach for the multi-year plan?
What does success look like in 2030 for Kaweah Health?

(Capture during discussion)

Where Kaweah Stands: Current State Assessment

This session is about better understanding the challenges we face and refining our strategic responses.

THE CHALLENGE

Revenue is under structural pressure

- HR1 creates a multi-year Medi-Cal revenue hole. Finance has already projected the impact
- Expense growth outpaces Medicare reimbursement every year and the margin squeeze is compounding
- Central Valley Medi-Cal dependency is above the CA average and our exposure is asymmetric (~62% Medi-Cal)
- The cuts begin in 2026 and 2027 and only increase through 2031-2034

THE OPPORTUNITY

Kaweah has strategic leverage & options

- Independent community systems that act now keep their options. The longer we wait the less options we have
- CalAIM creates near-term payment opportunities for population health infrastructure
- AI scribes and back-office automation are proven tools for margin improvement today
- The Central Valley's demographics create genuine growth opportunity as we attract young families and keep elective care in Visalia

THE PATH

Project 2030 is what we're building toward

- Compensate for the Medi-Cal revenue gap while building a stronger bottom line
- Drive efficiency and cost reduction with immediate initiatives, before the revenue peak pressures hit in two to three years
- Build the growth infrastructure that makes Kaweah the region's destination for complex care
- A facilitated planning process will develop the full multi-year financial and strategic plan to achieve our objectives

Question for consideration: Which themes from TGI are most urgent for Kaweah? And what must be focused on in the FY27 plan vs. what needs deeper work in a future planning session?

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Government reimbursement gaps are growing quickly and heavily impacted by HR1

Federal and state policy changes create an asymmetric financial threat for Kaweah and other high Medicaid systems

>$1T
Federal Medicaid cuts
2025–2034 (HR1)

~17M+
Newly uninsured
by 2034 (HR1 and ACA Changes)

15%
Avg Medicaid cut
across states

CA
Considering
hospital price caps

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Source(s): Kaufman Hall National Hospital Flash Report 2025; Congressional Budget Office (CBO); KFF – Key Facts About Medicaid's Share of National Health Spending

Expense Growth Is Structural and Outpacing Revenues

Hospital expenses grew 17.5% (2019–2022); Medicare reimbursement grew just 7.5%

Labor — 11%

Contract labor usage, workforce shortages, wage increases

Drugs — 30%

New high-priced specialty drugs, price inflation, shortages

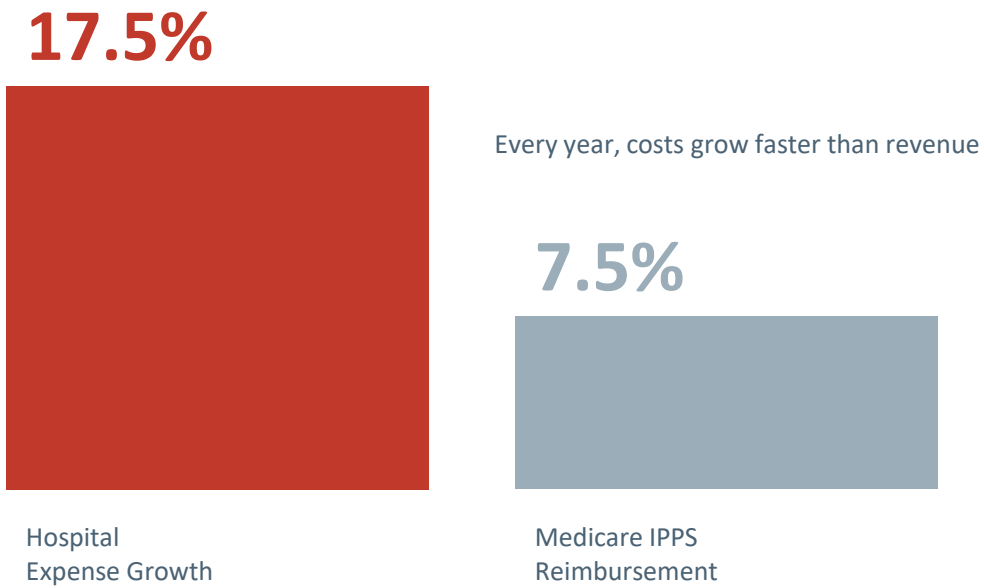
Supplies — 27%

Supply chain disruptions, rising patient acuity

Purchased Services — 21%

Economy-wide wage increases and inflation

Cumulative growth (2019–2022):



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Source(s): Kaufman Hall National Hospital Flash Report Sept 2025; AHA Cost of Caring 2023
Holloran et al., Fitch Ratings Oct 2023; Gist Weekly at Kaufman Hall

The Medi-Cal Cuts are in Motion

$971.4B

total Medicaid spend in 2025, the program's annual cost

$1.02T

in projected cuts over 10 years, equates to more than one full year of the program

>1 in 3

Californians on Medi-Cal;
Kaweah's exposure is above the CA norm at ~62%

The Medicaid cuts are scheduled and ramp up quickly

2025 **HR1 enacted** 10-year, $1.02T reduction framework triggered. Federal matching rate reductions begin.

2026 **First real impacts** Work requirements + eligibility redeterminations take effect. 5–10M Americans begin losing coverage.

2027 **FMAP reductions** California's enhanced federal matching rate drops forcing higher state share or benefit cuts.

2028+ **Full exposure builds** ~17M newly uninsured by 2034 (HR1 and ACA changes). Peak uncompensated care. Independent systems with high Medi-Cal mix face structural margin pressure.

Key Consideration: Cost transformation must happen before the revenue decline peaks and not in response to it. 2026 and 2027 milestones are critical to develop.

Source(s): KFF Medicaid National Health Spending 2025; Health Management Associates / CBO FFY 2024; CA LAO Publication 4838

What We Heard at TGI

Restructure and reimagine health systems for the future

- Leaner cost structure
- Embedding AI
- Reshaping the business model around affordability
- Incremental improvement is not enough

Cost growth compounds faster than revenue growth

- Expense growth outpaces Medicare reimbursement every year
- The window to transform costs ahead of HR1 impact is 2026-2027

Payor mix is a major constraint

- 69% of revenue is non-negotiable (governmental), leaving only 31% commercial
- Volume alone cannot protect margins
- There is a structural revenue ceiling

Diversify revenue to mitigate cost pressure

- Opportunities to diversify include:
  - CIN/ACO participation
  - Value-based contracting
  - Employer partnerships
- Reduce fee-for-service exposure before Medicaid cuts force the issue

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Source(s): Kaufman Hall / Donohue / Silverstein, TGI April 2026

Discussion

Does Kaweah have a financial resilience plan that is honest about the HR1 timeline?

To get us started:

1. What are our reimbursement gaps in 2027-2031? What % of our population will be uninsured by 2031?
2. Is our cost transformation moving fast enough to fill these gaps?
3. Are we growing revenue fast enough to account for the gaps? Are we diversifying revenue streams to mitigate cuts?

KAWEAH IMPLICATIONS

(Capture during discussion)

Governance Agility will determine whether Kaweah leads or reacts

The pace of transformation is set by board quality and not market conditions

WHY

Purpose &
Priorities

WHAT

Structure &
Process

WHO

Composition &
Succession

HOW

Relationships
& Culture

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Source(s): WittKieffer Governance Survey 2025; Kaufman Hall; Dr. Tam, TGI April 2026

What We Heard at TGI

Leading vs. Reacting requires deliberate choices

- Proactively move toward strategic growth, revenue diversification, and value-based care to protect independence, or wait for margin pressure and loss of control
- Independent systems that act now keep options and avoid acquisition and compromising their mission

The trajectory will not change on its own, Board decisions drive trajectory

Levers boards control through deliberate decisions are:

- Capital allocation
- Demand management
- Governance mechanics

50%+ of board time should be strategic and focused dialogue

- Boards spending most time on operational reports cannot drive transformation at the pace the environment demands
- Dashboards replace deep-dives

Board expertise should align with the community and system's needs

Skills/Knowledge needed now:

- Financial restructuring
- AI/technology
- Value-based contracting
- California health policy

Source(s): WittKieffer / Kaufman Hall / Dr. Tam, TGI April 2026

Discussion

Is this Board structured and operating in a way that drives transformation at the pace the environment requires?

To get us started:

1. What % of our meeting time is in strategic deliberation vs. operational reports?
2. What % of our time is spent on transformative topics like AI, value-based contracting, and CA health policy?
3. What transformative milestones or metrics are we driving toward as a system? How do we measure our success?

KAWEAH IMPLICATIONS

(Capture during discussion)

AI Is a Workforce Multiplier that requires careful adoption, especially in the clinical setting

Tools that reduce clinician burnout and protect revenue are available today. Governance is a potential bottleneck.

NOW

Scribes, billing,
prior auth automation

NEXT

Care coordination,
risk stratification

FUTURE

Agentic AI,
learning health systems

CONSIDER

AI for clinical use cases needs careful evidence-based implementation

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Source(s): Wachter / UCSF, TGI April 2026; AMA Physician AI Sentiment Report 2026; Doximity 2026

What We Heard at TGI

At UCSF and many leading systems, AI is embedded in the care continuum

- Every clinician has AI scribe access
- Ambient documentation, prior auth, billing, and chart summarization are must-haves to compete vs. these systems
- Patients and providers appreciate the additional face to face interaction time and efficiency increases

Patients are actively using AI in hospitals and clinics

- 36% of U.S. adults use AI chatbots for health info
- Patients fact-check physicians in real time
- Complaint letters are regularly AI-drafted

Safe vs. dangerous AI Utilization, critical to know the line

- AI excels at rote, high-volume tasks
- It can be dangerous if used for clinical diagnosis (Ex: fabricates references) and should not give direct patient advice

Governance must lead adoption

- Judgment and sensemaking belong to humans
- Boards must establish AI governance policy and adoption strategy before clinical AI is widely deployed
- Not having a clear AI policy and strategy leads to variance and risks in AI utilization
- It is unrealistic to expect providers to wait for a policy to roll out to begin using AI tools

Source(s): Wachter / Koulopoulos / Dhaliwal / Baron, TGI April 2026

More Patients are Using AI to Find and Manage their Care

Consumers are utilizing AI more often to understand and "self-diagnose" their medical symptoms, fact check physicians in real time, or draft complaints and grievances.

36%

of U.S. adults have used AI chatbots for health-related information

85%

find AI chatbots helpful for health information

65%

engage with AI health tools monthly or more

Usage by generation highlights that younger adults lead, but all cohorts show meaningful engagement:

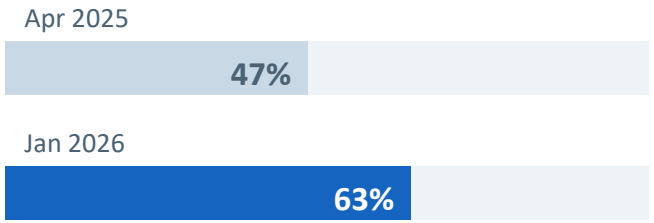
Gen Z	Millennials	Gen X	Boomers	Silent
51%	48%	37%	21%	17%

Question for Consideration: Are we prepared for patients to fact check our clinicians in real time? How can we better support and educate our teams to prepare them?

Source(s): Doximity 2026 AI in Medicine Report (Mar 2026); NRC Health Market Insights Explore Trends Report, Nov 2025

Physician AI Adoption is Accelerating Fast and Governed Slowly

Adoption accelerating



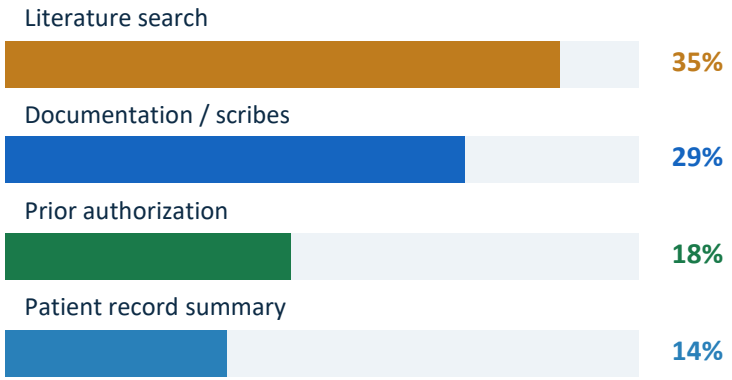
- Adoption increased 16% in less than a year
- Physician AI awareness hit 81% in 2026, more than double the 2023 rate

Once adopted, daily use becomes routine

74%
use AI daily

98%
at least weekly

Top physician use cases



Impact on care and burnout

75%
Reduced admin burden and improved job satisfaction

69%
Improved patient care and outcomes

90%
Potential to eliminate "pajama time"

The hesitation governance hasn't kept up

71%
Cite accuracy/reliability as top concern

~50%
Find hospital AI policies confusing or evolving

85%
Want a voice in AI adoption decisions

Question for Consideration: How can we better support our physicians in safely adopting AI to improve patient experience and efficiency?

Source(s): Doximity 2026 AI in Medicine Report (Mar 2026); AMA Physician AI Sentiment Report 2026; eMarketer; HIT Consultant

Discussion

Is AI on the board agenda as a governance matter? What is our AI Strategy today?

To get us started:

1. Do we have an AI governance policy with clear human judgment boundaries? Is it adequately socialized?
2. Have we assessed how patients in our community are using AI health tools? What about physicians?
3. What is the potential ROI for AI scribes and revenue cycle automation?

KAWEAH IMPLICATIONS

(Capture during discussion)

Our population is aging and becoming more female driven

Two structural demographic shifts are reshaping Kaweah's workforce and demand realities, and we need to actively address them

1/3
Hospital discharges are 65+ today

95M
Americans 65+ by 2060

1/3
Physicians over 60 many hesitant to retire

>50%
Med school grads now women

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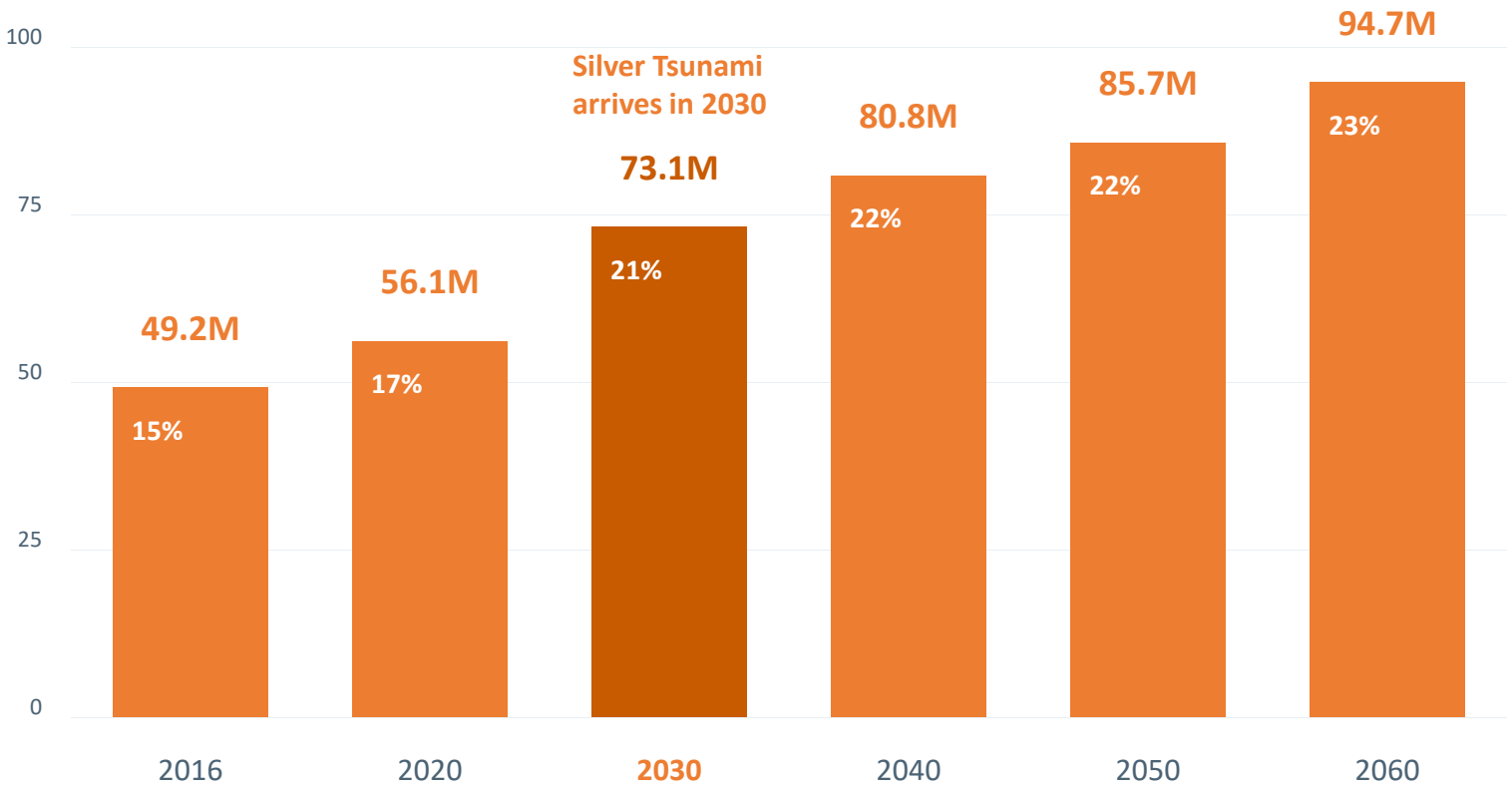
Source(s): Sagin / The Rising Storm, TGI April 2026
U.S. Census Bureau 2017 Population Projections; AMA Physician AI Sentiment Report 2026

Silver Tsunami: 65+ Population Will Nearly Double by 2060

Millions of Americans 65 and older and their share of total population



What this means for Kaweah:

1/3 of all hospital discharges are 65+ today

40-45% of adults 75-84 are hospitalized each year

50-60% of adults 85+ are hospitalized each year

+7M net new consumers vs +3M producers (2024-34)

Question for Consideration: How would our care model need to evolve to see twice as many seniors at Kaweah as we do today?

Source(s): U.S. Census Bureau 2017 Population Projections; Bureau of Labor Statistics; Sagin / The Rising Storm, TGI April 2026

What We Heard at TGI

Silver Tsunami arrives in 2030

- 65+ population hits 21% of the U.S. by 2030
- Patients 75-84 hospitalized at 40-45% annually
- Patients 85+ hospitalized at 50-60% annually

The physician workforce is aging out

- 120,000 physicians over 70
- Fatigue is the #1 driver of late-career exits
- Studies show drop-offs in knowledge adherence with age

Feminization changes the healthcare workforce and demand

- Women are earning the increasing majority of bachelors degrees (58%) and medical school degrees (55%)
- This shift highlights the opportunity to provide targeted recruitment incentives (caregiving and family support, etc.)
- Women disproportionately choose PT schedules reducing effective supply of physicians even as headcount grows
- Women make 80% of healthcare decisions

Geriatrics infrastructure is a board investment decision

Investments to reduce 65+ harm and free beds include:

- ACE units
- Mobile geriatrics consult teams
- PACE programs
- Delirium prevention
- Care at Home

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Source(s): Sagin / The Rising Storm / Koulopoulos, TGI April 2026; The National Center for Education Statistics; US Department of Labor

Discussion

How can we optimize our care models to accommodate our growing number of geriatric patients?

To get us started:

1. What are our delirium, fall, and readmission rates for 75+ patients? How do we improve our performance in this growing cohort?
2. What is our physician retirement risk in the next 5 years by specialty? How are we recruiting to mitigate that risk?
3. Are our practice models designed to recruit and retain early-career female physicians? How do we become the physician practice location of choice?
4. Are we the go-to option for women in our community who make 80% of healthcare decisions? Why or why not?

KAWEAH IMPLICATIONS

(Capture during discussion)

Improving Population Health enables long-term community health and financial sustainability

The nation's health and socioeconomic trends are burdens that hospital-centric models cannot address. These burdens are even greater in the Central Valley.

60%
Americans with chronic disease

80%
Health outcomes driven outside the clinic

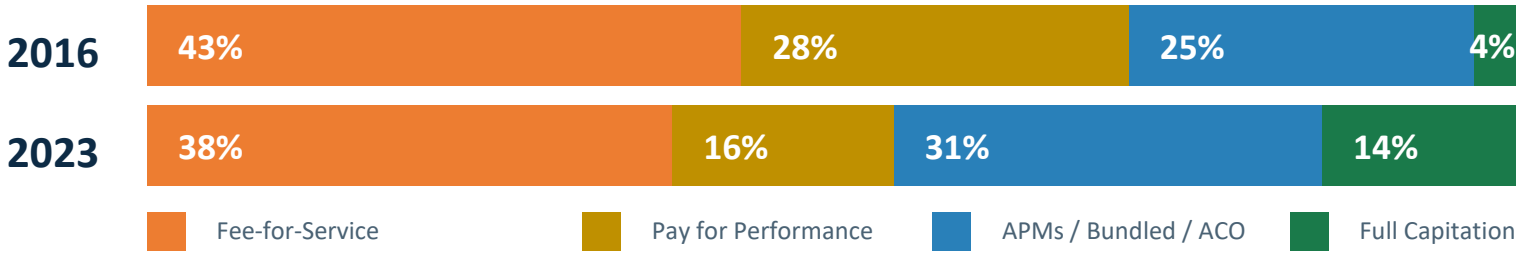
50%
Outcomes linked to zip code

3-5yr
Infrastructure build time before ROI on many population health solutions

Source(s): Silverstein, TGI April 2026; CMMI; Institute for Clinical Systems Improvement

The Business Model is Continuing to Migrate Away from FFS

Share of Medicare Payments by Category, 2016 vs 2023 and Overview of Models Driving Shift:



Any VBP participation by all Physicians :

37% 2019
↓
58% 2022

New CMMI models launching 2026–2036 will accelerate the shift. Kaweah needs to be strongly positioned before entry is forced

Model	Core Focus	Payment Mechanism	Timeline
LEAD	ACO Evolution	Capitation / Shared Savings	2027–2036
ACCESS	Tech-Enabled Chronic Care	Outcome-Aligned Payments	2026–2036
WISeR	Waste Reduction	Performance-Based Savings	2026–2031
AHEAD	State TCOC	Global Budgets / TCOC	Through 2035

Source(s): HCP-LAN; Silverstein TGI April 2026; Health Affairs Scholar Aug 2024 (Winberg et al.); CMMI

What We Heard at TGI

Population health is a different operating model

- Populations Health solutions include:
  - Proactive/preventive care
  - Care coordination
  - Data-driven interventions
- Look beyond individual programs and fundamentally redesign how the system works

CalAIM creates a near-term revenue opportunity

- California's Medi-Cal reform pays for enhanced care management and social determinant interventions
- Limited to systems with population health infrastructure and data management in place

Critical to focus on the sickest patients as they drive the most healthcare costs

- 3% of patients drive 29% of costs
- Patients with advanced illness and multiple chronic conditions dominate spend
- Targeted interventions in these bands move margin faster than broad programs

Value-based contracts require years of preparation to effectively capture

- Risk based reimbursements require:
  - Registries
  - Strong care management pathways
  - Advanced analytics
- Systems that wait too long will be forced into these payment models unprepared and end up under-funded.

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Source(s): Silverstein / CMMI / Institute for Clinical Systems Improvement, TGI April 2026

Discussion

Do we have an integrated population health strategy, or just a collection of population health programs?

To get us started:

1. Do we have a board-approved population health roadmap with investment commitments and milestones?
2. How effectively are we capturing CalAIM enhanced care management payments today?
3. What is our thesis on value-based contracting and taking on risk and what's the timeline?

KAWEAH IMPLICATIONS

(Capture during discussion)

Inputs for Project 2030

What must move now and what needs deeper work in a future planning session?

Theme	FY27 Focus Areas	Future planning input	Owner
1. Financial Resilience	HR1 scenario modeling; integration in financial and strategic plans	Multi-year revenue/cost model; Project 2030 financial architecture	CEO & CFO
2. Governance Agility	Board skills matrix; Board onboarding/education overview	Governance model design for a transforming organization	CEO & Board
3. AI & Technology	AI governance policy and strategy development/roll out; AI roadmap development for pilot authorizations	AI ROI framework; long-range clinical and efficiency opportunity assessments	VP of Strategy, VP of ISS & CCO
4. Aging & Feminization	Physician workforce and recruitment analysis; geriatric patient volume and outcomes data	Geriatrics strategy; women in medicine recruitment model	VP of Strategy, CMO &CNO
5. Population Health	CalAIM readiness assessment; identification of infrastructure gaps	Population health investment thesis; VBC contract strategy	CAO & CFO

Question for Consideration: How do we build and hardwire processes to ensure engagement/participation from our Medical Staff leaders in our strategic initiatives?

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Three outputs we need to leave with today

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Which themes do we need to focus on most in our FY27 Strategic Plan?
Which themes are not adequately addressed?
What are we committing to do differently in the next 90 days?

(Capture during discussion)

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Future planning priorities

Which themes need the deepest work in a future planning session?
What are the biggest open questions that need to be resolved to develop a multi-year plan?

(Capture during discussion)

3

Framing Project 2030

What's the right name and approach for the multi-year plan?
What does success look like in 2030 for Kaweah Health?

(Capture during discussion)

The pursuit of healthiness

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