Kaweah Delta Health Care District
Board of Directors Meeting

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

Kaweah Health
MORE THAN MEDICINE. LIFE.

DATE POSTED: March 20, 2026

NOTICE

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

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

SCHEDULE:

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

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

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

PUBLIC RECORDS:
Disclosable public records related to this agenda are available for public inspection at:
Kaweah Health Medical Center – Acequia Wing, Executive Offices (1st Floor)
400 West Mineral King Avenue, Visalia, CA 93291
You may also request records by contacting the Board Clerk at (559) 624-2330 or **kedavis@kaweahhealth.org**, or by visiting the District's website at **www.kaweahhealth.org**.

KAWEAH DELTA HEALTH CARE DISTRICT
David Francis, Secretary/Treasurer

Prepared by:

Kelsie K. Davis
Board Clerk / Executive Assistant to the CEO

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

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

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS MEETING

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

Wednesday March 25, 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. **CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION AND RISK MANAGEMENT –** Discussion with legal counsel regarding ongoing litigation matters involving risk management, patient safety, or related claims. (Pursuant to Government Code 54956.9(d)(1))

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

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

   Possible reportable action

4. **MEDICAL STAFF CREDENTIALING AND PRIVILEGING** - Medical Executive Committee (MEC) requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the MEC be reviewed for approval pursuant to Government Code 54957.

   Possible reportable action

5. **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.

6. **APPROVAL OF THE CLOSED MEETING MINUTES** – February 2026.
   Possible reportable action

7. **ADJOURN CLOSED SESSION**

Kaweah Delta Health Care District
Board of Directors Meeting

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

Kaweah Health
MORE THAN MEDICINE. LIFE.

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. **RECOGNITIONS**
   - **6.1.** Presentation of Resolution 2283 to Karen Hydeman in recognition as the Kaweah Health World Class Employee of the month – March 2026.
   - **6.2.** World Class Team of the Month – 2 North Team
7. **INTRODUCTIONS**
   - **7.1.** Thomas (Tom) Boggs, Chief Ambulatory Officer
8. **CHIEF OF STAFF REPORT**
   Report relative to current Medical Staff events and issues.
9. **CONSENT CALENDAR**
   All items listed under the Consent Calendar are considered routine and non-controversial by District staff and will be approved by one motion, unless a Board member, staff, or member of the public requests that an items be removed for separate discussion and action.

   Public Participation

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

   Action Requested – Approval of all items on the March 25, 2026, Consent Calendar.
   [Consent Calendar Items 9.1 – 9.5 as presented]

Section	Item	Description	Type
9.1. REPORTS	1	Physician Recruitment	Receive and File
	2	Overall Strategic Plan	Receive and File
	3	Environment of Care Annual Evaluation 2025	Receive and File
	4	Cardiovascular Services	Receive and File
9.2. MINUTES	1	Marketing & Community Relations- February 4, 2026	Approve Minutes
	2	Finance Property Services Acquisition Committee- February 18, 2026	Approve Minutes
	3	Quality Council Committee – February 19, 2026	Approve Minutes
	4	Special Open Board Meeting- February 10 & 12, 2026	Approve Minutes
	5	Regular Open Board Meeting – February 25, 2026	Approve Minutes
9.3. POLICIES	**A**	**Administrative Policies**	
	1	AP 180 Weapons Brought Into the District	Approve Revisions
9.4. MEC	1	MS 52 Use of External Proctors	Approve Revisions
	2	MS 53 Temporary Privileges	Approve Revisions
	3	MS 25 Rescinded or Lapsed Membership and/or Privileges Policy	Approve Revisions
	4	MS 33 Reporting Guidelines	Approve Revisions
	5	MS 101 Red Rules	Approve Revisions
	6	MS 02 Medical Staff Well-Being Committee	Reviewed and File
	7	MS 51 Medical Staff and Advanced Practice Professional Notifications	Approve Revisions
	8	MS 16 Medical Staff Organization Financial Assistance for Fit-For-Duty Evaluations	Reviewed and File
	9	MS 57 Guidelines for Privacy Violations	Approve Revisions
	10	MS 56 Medical Staff & Advanced Practice Professional Education Policy	Approve Revisions
	11	MS 03 Medical Staff Fees	Approve Revisions
	12	MS 44 Ongoing Professional Practice Evaluation (OPPE)/ Focused Professional Practice Evaluation (FPPE)	Approve Revisions
	13	NPPA Privilege Form	Approve Revisions
9.5. DISTRICT	1	Graduate Medical Education Graduates 2026	Approve and File

10. QUALITY INCENTIVE POOL REPORT

Presentation of high-level overview of program objectives, performance metrics, and current status updates related to quality improve initiatives. The presentation is intended to provide

transparency into ongoing efforts to enhance patient care, outcomes, and compliance with applicable regulatory and program requirements.

11. **STRATEGIC PLANNING INITAITIVE – PHYSICIAN ALIGNMENT**
Presentation and discussion regarding the strategic growth and innovation initiative, including strategic objectives, implementation framework and anticipated outcomes.

12. **PATIENT EXPERIENCE AND SATISFACTION UPDATE**
Staff presentation and discussion regarding aggregated and de-identified patient experience data, including trends, themes, and opportunities for improvement. No individual patient information will be disclosed.

13. **MENTAL HEALTH EXPANSION**
Overview of expansion, status, outcomes, and emerging priorities
Possible reportable action

14. **FINANCIALS**
Presentation and discussion of current financial statements, budget performance, revenue, and expense trends, and year-to-date comparisons for the District.

15. **REPORTS**
15.1. Chief Executive Officer Report - Report on current events and issues.

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

CLOSED SESSION – IMMEDIATELY FOLLOWING OPEN SESSION

1. **CALL TO ORDER**

2. **CEO EVALUATION** – Discussion with the Board and the Chief Executive Officer relative to the evaluation of the Chief Executive Officer pursuant to Government Code 54957(b)(1).

3. **ADJOURN**

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Agenda Posting and Public Records
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Agenda item intentionally omitted

Resolution 2283

RESOLUTION 2283

Board Resolution Honoring
Karen Hydeman as World Class Employee of the Month of March

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

WHEREAS, Karen Hydeman, of the Medical Business Office, 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 March 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, Karen'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 Karen as **World Class Employee of the Month** for March 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 Karen Hydeman as a token of recognition and gratitude.

PASSED AND ADOPTED this 25th of March, 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

Physician Recruitment Board Report - Physician Group Targets
March 2026

Key Medical Associates
Gastroenterology x1
Pediatrics x1
Pulmonology x1
Rheumatology x1

Orthopaedics Associates
Orthopedic Surgery (General) x1

Sequoia Cardiology
EP Cardiology x1

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

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

Valley ENT
Audiology x1
Otolaryngology x1

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

March Board Report Narrative:

During the month of March, The Physician Recruitment Team continued to advacnce recruitment efforts across several priority specialties, with multiple candidates progressing through the offer and contracting phases.

Signed letters of intent have been received from a Gastroenterologist and an Otolaryngologist (ENT), both of whom plan to join estiblished local practices. Additionally, a signed letter of intent has been received from an Adult Hospitalist who will support inpatient care needs. These additions are expected to help strengthen specialty access and inpatient coverage for the community.

Offers have recently been extended to physicians in several key specialties, including OBGYN, Cardiothoracic Surgery, Electrophysiology Cardiology, Family Medicine, Physical Medicine & Rehabilitation, Neurology, and multiple Urologists. Venice Hills Medical Associates is now operational, and several recruitment discussions and offers are being coordinated in support of physicians who may join the community through that model as well.

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

Board Report - Physician Recruitment - Mar 2026

	Specialty	Group	Phase	Expected Start Date
1	EP Cardiology	TBD	Site Visit	
2	General Surgery	TBD	Site Visit	
3	Interventional Radiology	Mineral King Radiology	Site Visit	
4	Ped Hospitalist	Valley Childrens	Site Visit	
5	OBGYN	TBD	Screening	
6	Pediatrician	TBD	Screening	
7	Family Medicine	TBD	Screening	
8	Pulmonology	TBD	Screening	
9	Rheumatology	TBD	Screening	
10	Family Medicine	TBD	Screening	
11	Internal Medicine	TBD	Screening	
12	OBGYN	TBD	Screening	
13	Gastroenterology	TBD	Screening	
14	Psychiatry	TBD	Screening	
15	Pulmonology	TBD	Screening	
16	Radiology	TBD	Screening	
17	Family Medicine	TBD	Screening	
18	Family Medicine	TBD	Screening	
19	Orth Surgeon (Hand)	Orthopedic Assoc	Screening	
20	Orth Surgeon (Hand)	Orthopedic Assoc	Screening	
21	Cardiac Anesthesia	Oak Creek	Screening	
22	Cardiothoracic Surgery	TBD	Offer Extended	
23	EP Cardiology	TBD	Offer Extended	
24	Family Medicine	TBD	Offer Extended	
25	PM&R	TBD	Offer Extended	
26	OBGYN	TBD	Offer Extended	
27	Urology	1099 - KH Direct	Offer Extended	
28	Urology	1099 - KH Direct	Offer Extended	
29	Neurology	Venice Hills Medical Associates	Offer Extended	
30	General Surgery	SAMGI	Offer Extended	
31	Internal Medicine	TBD	Offer Accepted	
32	Gastroenterology	TBD	Offer Accepted	
33	Family Medicine	TBD	Offer Accepted	
34	Family Medicine	TBD	Offer Accepted	
35	Cardiothoracic Surgery	TBD	Offer Accepted	04/01/26
36	Family Medicine	1099 - KH Direct	Offer Accepted	
37	Endocrinology	1099 - KH Direct	Offer Accepted	TBD
38	Neurology	1099 - KH Direct	Offer Accepted	TBD
39	Ortho - Spine	1099 - KH Direct	Offer Accepted	
40	ENT	Valley ENT	Offer Accepted	
41	General Surgery	SAMGI	Offer Accepted	04/01/26
42	General Surgery	SAMGI	Offer Accepted	02/27/26
43	General Surgery	SAMGI	Offer Accepted	08/03/26
44	Adult Hospitalist	Valley Hospitalist Group	Offer Accepted	
45	Family Medicine	TBD	Leadership Call	
46	Family Medicine	TBD	Leadership Call	
47	Neurology	TBD	Leadership Call	
48	Cardiology (EP)	TBD	Leadership Call	

	Specialty	Group	Phase	Expected Start Date
49	General Surgery	TBD	Leadership Call	
50	Psychiatry	Oak Stone Medical Group	Leadership Call	
51	Orth Surgeon (Hand)	Orthopedic Assoc	Applied	
52	Gastroenterology	TBD	Applied	
53	Neurology	TBD	Applied	
54	Neurology	TBD	Applied	
55	Family Medicine	TBD	Applied	
56	Family Medicine	TBD	Applied	
57	Hospitalist	TBD	Applied	
58	Uro/Gyn	TBD	Applied	

Separator Page

Overall Strategic Plan

FY 2026 Strategic Plan

Monthly Performance Report
March 25, 2026

Kaweah Health Strategic Plan: Fiscal Year 2026

Our Mission

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

Our Vision

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

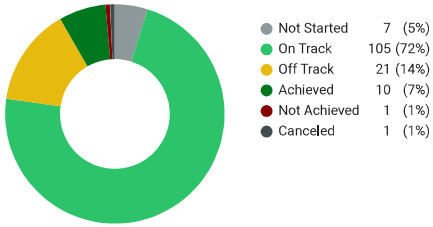
Our Pillars

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

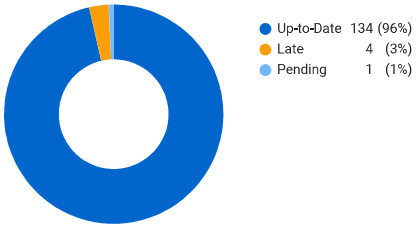
Our Five Strategic Plan Initiatives

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

Kaweah Health Strategic Plan FY2026 Overview: Status



Kaweah Health Strategic Plan FY2026 Overview: Updates



Ideal Environment

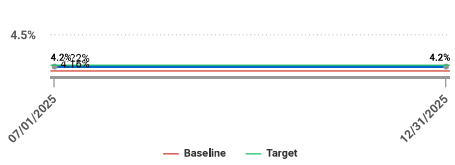
Champions: Dianne Cox and Hannah Mitchell

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

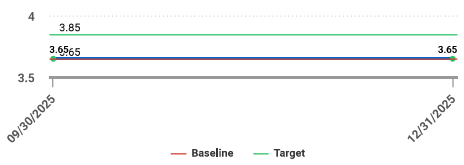
FY2026 Strategic Plan - Ideal Environment Strategies

#	Name	Description	Status	Assigned To	Last Comment
1.1	Integrate Kaweah Care Culture	Integrate Kaweah Care culture into the various aspects of the organization.	On Track	Hannah Mitchell	The Executive Team and Directors of Organizational Development, Patient and Community Experience, Marketing, Medical Staff and GME meet on a monthly basis to further projects and initiatives surrounding the culture. Details are presented at the Board sub-committees for Patient Experience and Human Resources. The outcome will be measured by the performance of our employee engagement survey in June 2026 and the physician portion of the safety survey in spring 2027.
1.2	Ideal Practice Environment	Ensure a practice environment that is friendly and engaging for providers, free of practice barriers.	On Track	Teresa Boyce	Pending medical staff review and approval of proposed KPIs. Anticipated approval date: 3/17/26.
1.3	Growth in Nursing School Partnerships	Increase the pool of local RN candidates with the local schools to increase RN cohort seats and increase growth and development opportunities for Kaweah Health Employees	On Track	Kelly Pierce	Working with Carrington for Advanced Placement for LVN's and other staff that have nursing pre-req's completed. We have 27 Employees graduating from Unitek on April 10th.

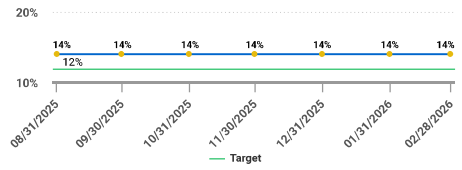
Employee Engagement Survey Score Greater Than 4.22%



Physician and APP Engagement Survey Score Greater Than 3.85%



Decrease Overall Turnover Rate



Strategic Growth and Innovation

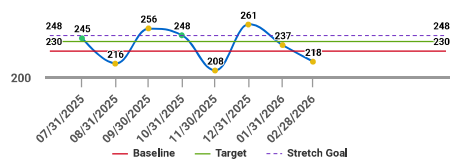
Champions: Marc Mertz and Kevin Bartel

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

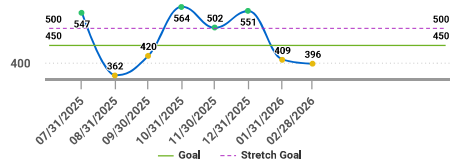
FY2026 Strategic Plan - Strategic Growth and Innovation Strategies

#	Name	Description	Status	Assigned To	Last Comment
2.1	Grow Targeted Service Line Volumes	Grow volumes in key service lines, including Orthopedics, Endoscopy, Urology and Cardio Thoracic services.	Off Track	Kevin Bartel	Volume for CTS Impella procedures has exceeded FY26 target goal. February volumes for orthopedics and Endoscopy were below target.
2.2	Enhance Medical Center Capacity and Efficiency	Enhance existing spaces to grow capacity for additional and expanded services and focus on operational efficiency within the surgery areas.	On Track	Kevin Morrison	Still progressing toward adding additional outpatient procedure spaces.
2.3	Expand access for patients though Clinic Network Development	Strategically expand and enhance the existing ambulatory network to increase access at convenient locations for the community.	On Track	Ivan Jara	Outpatient clinic access continues to grow through the development of new locations, new specialties, and the expansion of current services. Current efforts include physician recruitment (Primary and Specialty Care), advanced practice provider recruitment, new clinic locations (Specialty, Rural, and Commercial), and federal/state programs and grants.
2.4	Innovation	Implement and optimize new tools and applications to improve the patient experience, communication, and outcomes.	On Track	Kevin Bartel	Ambulatory rollout of Oracle's clinical AI application is now successfully supporting 30 providers, with consideration now being assessed for this tool to support in the ED as well. Full utilization of call center platform is in place to support a broader scope of service lines/departments. WellApp (platform supporting enhancement for patient scheduling, registration and billing) is fully implemented throughout the clinics, with additional AI scheduling platforms being explored to improve the overall patient experience.
2.5	Enhance Health Plan Programs	Improve relationships with health plans and community partners and participate in local/state/federal programs and funding opportunities to improve overall outcomes for the community.	On Track	Sonia Duran-Aguilar	No changes to status or work.

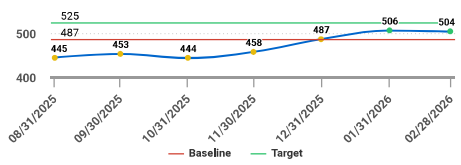
Perform 241 Orthopedic Surgery Cases Per Month



Perform 450 Endoscopy Cases Per Month



Increase Enrollment to 640 Lives in Enhanced Care Management



Outstanding Health Outcomes

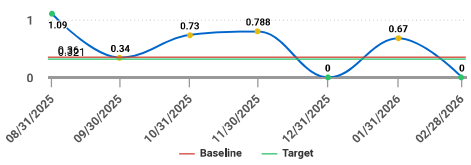
Champions: Dr. Paul Stefanacci

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

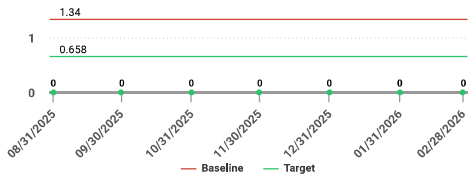
FY2026 Strategic Plan - Outstanding Health Outcomes Strategies

#	Name	Description	Status	Assigned To	Last Comment
3.1	Safety Program Enhancement	Improve the Patient Safety Program through enhanced proactive evidence based strategies.	On Track	Cindy Vander Schuur	Data currently calculated and reported monthly. Monthly Serious Safety Event Rate (SSER) data will need to be collected for 9-12 months in order to establish a reliable and accurate baseline calculation to support the Patient Safety Program. No barriers.
3.2	Reduce Hospital Acquired Infections (HAI)	Reduce the Hospital Acquired Infections (HAIs) to the selected national percentile in FY26 as reported by the Centers for Medicare and Medicaid Services.	Off Track	Shawn Elkin	While we are achieving goals with CAUTI and MRSA BSI event reduction, CLABSI events have increased greatly over the past couple of months. We have interventions planned to help put us back on track. The newly formed CAUTI/CLABSI Committee is meeting on 3/10/2026 to discuss these interventions with the interest in initiating them immediately.
3.3	Reduce Surgical Complications	Reduce the Patient Safety Indicator (PSI) 90 composite rate to the selected national percentile in FY26 as reported by the Centers for Medicare and Medicaid Services.	On Track	Chris Patty	Date range represented November 1, 2025 - January 31, 2026; score is 0.979. Goal is Midas national 50th percentile of 1.33; lower scores are better.

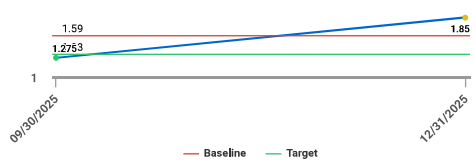
Decrease Standardized Infection Ratio (SIR) CAUTI to less than or equal to .321



SIR MRSA FYTD </=.0658



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



Patient Experience and Community Engagement

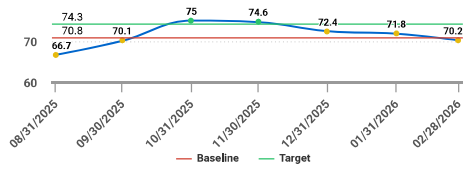
Champions: Marc Mertz and Deborah Volosin

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

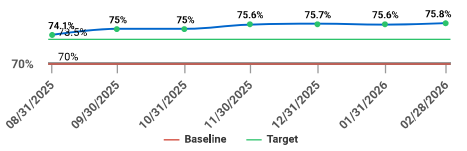
FY2026 Strategic Plan - Patient Experience and Community Engagement Strategies

#	Name	Description	Status	Assigned To	Last Comment
4.1	Empowering Leaders to Enhance Patient Experience	To improve patient experience, it is essential to cultivate a leadership culture that prioritizes patient-centered care. This strategy focuses on equipping leaders at all levels with the necessary skills, tools, and authority to drive meaningful improvements in patient interactions, service delivery, and overall satisfaction.	On Track	Deborah Volosin	PX department sends monthly reports to all clinical leaders. This report summarizes their scores, priorities, and includes patient feedback (positive and negative)
4.2	Fostering a Culture of Empathy and Human Understanding	Creating a culture of empathy and human-centered care is essential for enhancing patient experience and community trust.	On Track	Deborah Volosin	WMTY is now on 2N, 2S, 3N, 3S, 4T, 4N
4.3	Transforming the Patient Environment for a Better Experience	A well-designed and patient-friendly physical environment plays a critical role in patient experience and overall well-being. This strategy focuses on improving the hospital's physical spaces to promote comfort, accessibility, and a sense of healing	On Track	Deborah Volosin	Facilities, EVS, and PX rounding to ensure our environments are warm and welcoming.
4.4	Strengthening Community Engagement	Building strong relationships with the community is essential for fostering trust, improving health outcomes, and increasing access to care. This strategy focuses on actively engaging with community members through outreach programs, partnerships, and educational initiatives.	On Track	Deborah Volosin	Service Club participation, VEDC and Industrial Roundtable monthly attendance, chamber ambassadors, CAC meetings.
4.5	Adopting a Patient-Centered Approach to the Entire Healthcare Experience		On Track	Deborah Volosin	Met with 4N and 4T teams to roll out WMTY and talk about importance of the patient's voice being at the center of everything we do.

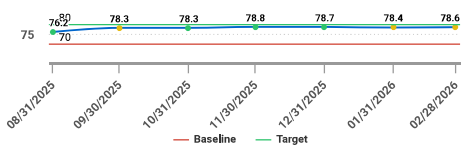
Achieve a score of 74.3 in HCAHPS Overall Rating



Achieve an Organizational-wide score of 73.5 in Human Understanding



Achieve a score of 80 in "Cleanliness of Clinic"



Physician Alignment

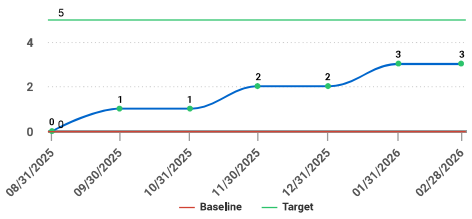
Champions: Marc Mertz and JC Palermo

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

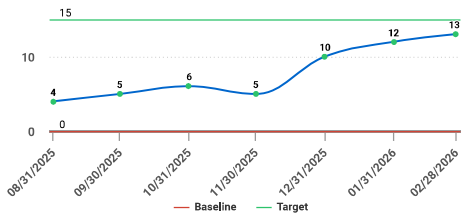
FY2026 Strategic Plan -Physician Alignment - Strategies

#	Name	Description	Status	Assigned To	Last Comment
5.1	Recruit Physicians and Advanced Practice Providers	Refine and execute recruitment strategy and employment options for physicians and advanced practice providers that will assist with recruitment of providers to support community needs and Kaweah Health's growth.	On Track	JC Palermo	The Recruitment Policy has been revised, and new recruitment guardrails have been put in place. These changes will provide more flexibility in offer creativity when drafting offers for physician candidates.
5.2	Develop and Provide Practice Support for Physicians	Continue to develop services and opportunities that improve alignment with and support for contracted and affiliated physician practices.	On Track	Jag Batth	We continue to see increasing volumes of EBUS and ION cases with our pulmonologists. We're in the process of designing new space in the old OB suites on the 2nd floor to help accommodate this growth. The MitraClip program is tentatively targeted to launch in the April/May timeframe. We're also continuing to evaluate utilization of robotic surgery cases. Our new cardiothoracic surgeon will be using the robot downstairs, and we'll assess the potential need for a second robot over the next year or so. In addition, we're closely reviewing block utilization and overall OR efficiency. We've launched a new monthly meeting with providers and the Surgery Director to strengthen alignment around incentives and improve overall OR practices.
5.3	Physician Alignment through Integrated Delivery Network (i.e. Sequoia Integrated Health)	With our physician community partners, continue to develop and strengthen relationships with health plans through Sequoia Integrated Health.	On Track	Marc Mertz	Kaweah is working with SIH on potential new payor arrangements, the possibility of a Healing at Home program, and seeking new ways to improve performance under current Medicare Advantage plans.

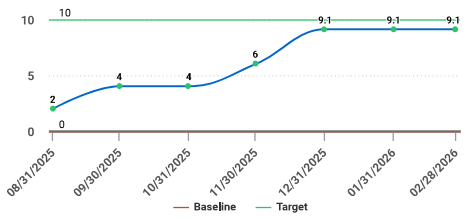
Recruit 5 Primary Care Physicians



Recruit 15 Specialty Providers

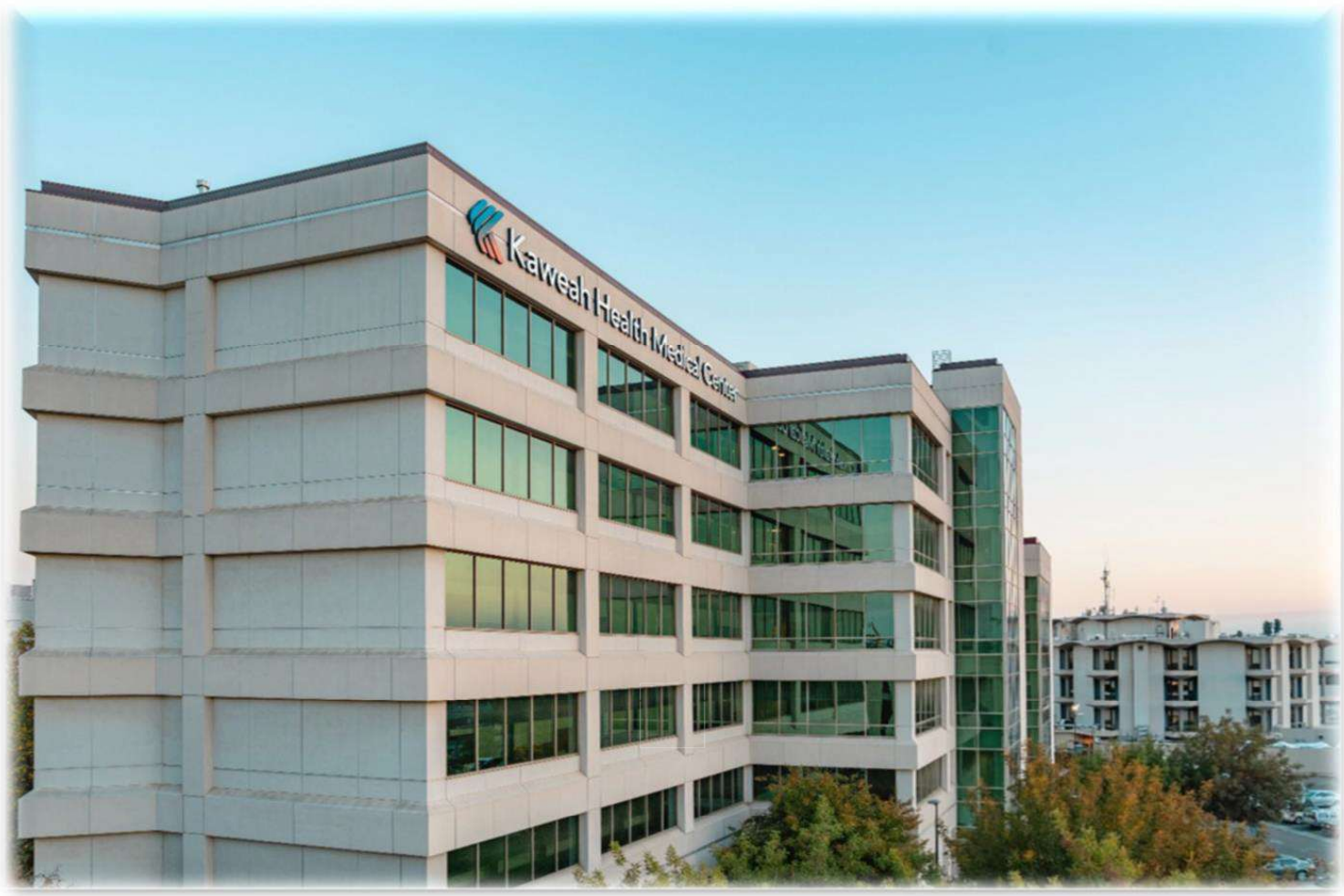


Recruit 10 Advanced Practice Providers



Environment of Care Annual Evaluation 2025

Annual Evaluation of the Environment of Care 2025



Prepared by

Environment of Care Committee
Maribel Aguilar, Assistant Director of Environment of Care/Safety Officer

Please contact Maribel Aguilar with any questions (559) 624-2381
March 2026

Annual Evaluation of the Environment of Care 2025

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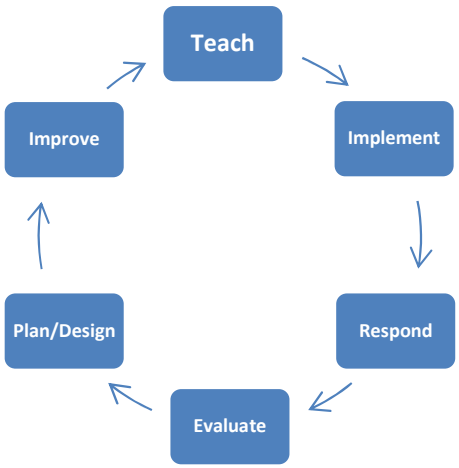
Evaluation of the *Objectives* of the Environment of Care Management Plans and the Emergency Operations Plan 2025

Introduction

The goal at Kaweah Health is to provide a safe *Environment of Care* for our patients, staff, physicians and visitors, so that quality is preserved and risks are minimized. The *Environment of Care* filters through every aspect of our Organization, from the first patient contact (i.e., clean hospital, comfortable place to sit, privacy), through the assessment, treatment, discharge and continuing care. It is an integral component of patient safety as risks could negatively impact their patient experience, such as a medical equipment failure due to a power outage, a breach in infant or child security, or the untoward effects of a hazardous materials exposure.

Other important functions, such as Infection Prevention (when pre-construction risk assessments are made or Infection Prevention permits are issued), overlap with the E*nvironment of Care*. There is also integration with Human Resources with respect to educational needs and competency assessments for our staff. To determine if elements of the *Environment of Care* and Emergency Operations are effective, there is linkage to Performance Improvement (i.e., in the establishment of performance standards to monitor if we are meeting established thresholds of performance.) The objectives of the various *Environment of Care* Management plans and the Emergency Operations Plan have been to manage risk so that our patient occupants and visitors can safely receive care and our patient care providers can provide treatment in a safe environment. We continue to view the following dynamic processes as tools and constructs to support change and improvements within the *Environment of Care* and Emergency Operations within the Organization.

Teach: *Educating staff regarding their roles*



Improve*: Making decisions about our findings*

Implement*: Implementing design*

Plan/Design: *Strategic and ongoing master planning by the organizational leadership*

Respond: *Measuring standards that we have set for the environment of care and emergency management*

Evaluate*: Gathering information about our outcomes*

Our *Environment of Care* Management plans address six elements, and one chapter (Emergency Management) which provides the framework for disaster planning and emergency operations. The six elements include Safety, Security, Hazardous Materials and Waste, Fire Prevention, Clinical Equipment and Utilities Management. There is much diversity in *Environment of Care* and Emergency Operations planning, however each have parallels with planning, teaching, implementing, responding, monitoring and improving. Our focus with the *Environment of Care* is to ensure ongoing diminishment of risk (e.g., possible loss or injury) within our Organization. The Safety Officer and *Environment of Care* Committee members provide the leadership foundation for the management of risks, promoting a teamwork approach, and ongoing attention to programs, plans, and related activities that point toward risk reduction. Whenever possible, *Environment of Care* and Emergency Management is integrated with regulatory requirements from Federal, State and local agencies having jurisdiction, enforcing standards that encourage continued improvement in the workplace.

Evaluation of Objectives – Safety Management Plan

Various risks are inherent in the environment because of the types of care provided and the types of equipment that may be used during patient care or office activities. The Safety Management plan is designed to provide a physical environment wherein risks may be proactively identified.

Evaluation of Objectives – Safety Management Plan, Continued

Risks are managed proactively from multiple areas—environmental surveillance, insurer surveys, regulatory and or accreditation surveys, and sometimes in response to an incident or injury that has occurred. It is the responsibility of the Safety Officer and *Environment of Care* Committee members to coordinate and manage these risk assessment and reduction activities. Safety and Infection Prevention policies and procedures, staff training and continuing education provide structure and direction for our staff so that their attention to tasks at hand can be focused on doing the right thing and/or implementing the safest method involved in their day-to-day work activities. Taken together, these programs and activities have contributed to effective injury management and support the objective of the Safety Management plan to reduce risk. The objectives of the Safety Management Plan have been met.

Evaluation of the Objectives of the Hazardous Materials and Waste Management Plan

The objective of the Hazardous Materials and Waste Management plan is to minimize the risks associated with hazardous chemicals, radioactive materials, hazardous energy sources, hazardous medications and hazardous gases/vapors for all those who enter the Organization, as well as the surrounding community. Equally important is our effort to reduce waste and to use non-hazardous products whenever feasible. Our educational programs, completion of annual chemical inventories and monitoring of spills and radiation/laser issues in the Organization demonstrate our commitment to minimize the risks associated with the use and disposal of hazardous materials. The objectives of the Hazardous Materials and Waste Management Plan have been met.

Evaluation of Objectives – Security Management Plan

The Security Management Plan is designed to support the mission of the Security Services Department: *"To ensure everyone in our facility feels protected, valued, and treated with dignity while receiving or delivering care."* Through ongoing security risk assessments and program evaluations, we continually seek opportunities to enhance security systems and reduce risk. The growing prevalence of workplace violence underscores the importance of robust training and collaboration with local law enforcement partners. Security staff receive training in the Healthcare Defensive Tactics System, as well as Crisis Prevention Institute (CPI) Basic and Advanced programs. Additionally, Emergency Department staff, Mental Health staff, and other personnel in high-risk areas also complete CPI training to reduce risk. Physical security measures, including access control systems and video surveillance, are in place and regularly evaluated for improvements to strengthen effectiveness. All security incidents are documented and analyzed to identify trends, enabling the development of strategies to address any patterns. The organization maintains a zero-tolerance stance on violence, and these processes directly support the Security Management Plan's objective to minimize risk within the premises. Based on current evaluations, the objectives of the Security Management Plan have been successfully met.

Evaluation of the Objectives of the *Emergency Operations Plan*

The objective of the *Emergency Operations Plan* is to minimize risks related to potential emergencies that fall on a continuum from disruptive to disastrous, and to ensure an effective staff response to disasters and emergent events that may affect our organization's ability to provide care. This plan is intended to identify risks and balance these risks against preparedness and mitigation strategies in place as well as to use information relating to these risks in the design of our disaster drills. Our *Emergency Operations Plan* addresses four phases of emergency management, which includes: mitigation, preparedness, response and recovery, and includes the testing of our plan through drill activities that require a practiced response from staff. Our staff effectively exercised a system failure exercise in June 2025. The incident included Southern Edison Gas reporting they have a compressor system failure in their main gas pipeline system that supplies the southern portion of the San Joaquin Valley. The exercise tested our ability to manage multiple systems that are affected by the loss of natural gas and the ability to continue cooking hot food, running hot water, Co Gen, laundry service, and steam for sterile processing. The exercise also tested our 96-hour process. In December 2025, we conducted an exercise that involved power outage in our facility and evacuated some patients (volunteers) utilizing evacuation Medsleds. Both the exercises included Hospital Incident Command System (HICS) activation, Emergency Department staffing (accessing additional physicians, residents and staff available), labor pool activation, alternate care sites identified and prepared, etc. The use of the HICS, a standardized approach to disaster management, allows our management and staff to respond with an all-hazard approach to disasters. We have continued to actively partner with our community partners including The County of Tulare Office of Emergency Services, Tulare County Public Health Emergency Preparedness Program, Visalia Police Department, Visalia Fire Department and various local ambulance agencies .

Evaluation of the Objectives of the *Emergency Operations Plan*, *continued*

We have continued to train staff for in emergency response including decontamination and workplace violence prevention, and we have a very active Emergency Management Subcommittee that has addressed multiple issues throughout the year, including, but not limited to, refining and augmenting our inventory of organizational assets and resources, planning for drills, and completing the hazard vulnerability analysis. The Organization has succeeded in meeting the objectives of the Emergency Operations Plan and have continued to strengthen our partnerships with other organizations, and agencies having jurisdiction (e.g., local law enforcement, fire departments, and the Tulare County Department of Health Services). The objectives of the Emergency Management Plan have been met.

Evaluation of the Objectives of the Life Safety / Fire Prevention Management Plan

We recognize that the risk of fire carries with it the most significant single threat to the environment of care as our patients are often unable to move safely by themselves. Staff must continually practice their fire response skills to extend protection to our patients in the event of a fire or the products of fire. The objective of the Fire Prevention Management Plan is to minimize the risk of fire, potential injury from fire and limit property damage. Our expectation and duty is to comply with the *Life Safety Code©* through a fire equipment testing and maintenance program as well as through ongoing fire drills, which test correct staff fire response. Through scheduled hazard surveillance, fire drills, a viable *Statement of Conditions*, fire equipment testing, inspection, maintenance and staff education, the objective of the Fire Prevention plan has been successfully met.

Evaluation of the Objectives of the Clinical Engineering Management Plan

The objective of the Clinical Engineering Management Plan includes the assurance that our medical equipment is operationally reliable, with the risk of a medical equipment failure minimized. In order to meet this objective multiple programs are in place which include but are not limited to: (1) risk assessment of all incoming medical equipment, (2) preventive and corrective maintenance programs, (3) corrective maintenance program for equipment that needs repair, and (4) training for the users and maintainers to minimize human error. We monitor our preventive maintenance for Non-high-risk life safety and High-risk life including life support medical equipment to ensure we are meeting established thresholds, which promotes sound operational reliability for medical equipment used on our patients. We ensure that any type of medical equipment that enters the Organization is checked by Clinical Engineering staff before it is used on our patients. These programs and safeguards have been effective in allowing us to meet the objectives stated in our Clinical Engineering Management Plan.

Evaluation of the Objectives of the Utilities Management Plan

The objective of the Utilities Management Plan is to minimize the risks relating to utility disruptions and to ensure our utility equipment remains operationally reliable. Meeting these two objectives promotes a safe, controlled and comfortable environment for our patients, staff, visitors and physicians. To meet this objective, programs must be in place that include, but are not limited to, risk assessment of utility equipment, preventive and corrective maintenance programs, timely and efficient response to utility failures, and ongoing education for those who use and maintain utility equipment. The Environment of Care committee monitors preventive maintenance of utility equipment and utility failures to ensure established thresholds of performance are met. These efforts are for the purpose of promoting the highest level of operational reliability for utility equipment that supports our built environments. These programs are in place in all facilities within the Organization with ongoing monitoring and assessment demonstrating that our objectives for the Utility Management plan have been met.

Evaluation of the *SCOPE* of the Environment of Care Management Plans 2025

Evaluation of the Scope: Our management plans identify the scope of each plan which applies to all Organization staff and physicians. The scope of the management plans are intended to be broad-based to allow for a multitude of accomplishments to occur. Each contributes to overall risk reduction in the Organization. The activities that are identified below support a multi-faceted approach to reducing risks that may occur from different sources, internal and external, to the Organization. The scope, based upon these activities, is evaluated to be supportive of a safe physical environment within which we proactively risk-assess and take appropriate actions. The following key activities support a breadth and depth of the scope *of the Environment of Care (EOC) activities* and Emergency Management at Kaweah Health.

Safety Management:

- Environmental surveillance completed, with action items identified, and corrections made.
- Safety Education for employees include online learning modules.
- Sharp exposures, with an increase in sharp injuries. Syringe safety education provided.
- Employee injuries monitored, with 33% decrease in OSHA reportable injuries (Without Covid+ claims) in 2025. Worker's Compensation Administrator continues to implement the Risk Improvement Action Plan.
- Safe Patient Handling training complete for patient care staff.
- Infection Prevention monitored hand hygiene compliance.
- Environment of Care training modules distributed.
- Dialysis water testing monitored.
- Product recalls monitored.
- *Environment of Care* Committee meetings regularly scheduled, reviewing Organization-wide issues, trends, reflecting a solid EOC program.
- Reviewed/revised Safety Management Plan with approval from Board of Directors.

Security Management:

- All security incidents are documented and analyzed to identify trends, enabling the development of strategies to address any patterns related to violence.
- CPI- Nonviolent Crisis Intervention training conducted for employees working in Mental Health, Security, Emergency Department, Float Pool, Rehab and South Campus. Additionally, Licensed Patient Family Services staff, Maintenance staff, Leadership staff, Unit Charge staff, 4South staff and Nursing Supervision staff also received CPI training.
- CPI with advanced physical skills training conducted for employees working in Mental Health and Security and other ancillary staff stationed at Mental Health.
- Code Silver mini drills added to unit education.
- Department procedures and policies have been thoroughly reviewed and revised to enhance efficiency and better support operations.
- Annual Security Risk Assessments completed in conjunction with weekly hazard surveillance rounds.
- Reviewed/revised Security Management Plan with approval from Board of Directors.

Hazardous Materials and Waste Management:

- Annual hazardous materials inventory complete. Annual chemical specific and safety data sheet training for all district employees.
- Radiation Safety Committee monitored radiation issues (i.e., badge reading, apron safety, license requirements, annual update of radiation safety plan, etc.).
- USP 800 Education rolled out to all district employees.
- Hazardous gas monitoring and testing completed.
- Reviewed/revised Hazardous Materials Plan with approval from Board of Directors.
- Hazardous Materials Business Plan updated-submitted to Tulare County.
- Participated in Radiological Event tabletop exercises with County of Tulare and partners.

Evaluation of Scope, *continued*

Emergency Operations:

- The Emergency Management Subcommittee involved with planning/design relating to: Inventory of organizational assets, equipment purchases, drill design, implementation and follow-up relating to drills and actual events, and integrating community partnerships into planning activities.
- The Hazardous Vulnerability Analysis reviewed/revised with top risks identified, and mitigation, preparedness, response, recovery identified.
- Training was completed for the following: Decontamination, Emergency Preparedness, Evacusled Evacuation-Safe Handling, and new hire orientation.
- The Emergency Operations Plan reviewed/revised based on the evaluations of the emergency exercises with approval from Board of Directors.
- Reviewed/revised unit specific fire, safety and emergency plans.
- Participated in Tulare County disaster planning activities.

Life Safety Management:

- All fire drills were held per schedule, with no trends noted.
- Visalia Fire Department conducted annual Life Safety Inspection.
- The Statement of Conditions monitored routinely and updated throughout 2025.
- Fire testing equipment completed per schedule.
- Reviewed/revised Life Safety Management Plan with approval from Board of Directors.

Clinical Engineering Management:

- Preventive maintenance for Non-High Risk medical equipment completed, with thresholds of performance met.
- Preventive maintenance for High-Risk including Life Support medical equipment completed, with thresholds of performance met.
- Reviewed/revised Clinical Equipment Management Plan with approval from Board of Directors.

Utility Equipment Management:

- Preventive maintenance and utility reports reviewed quarterly, including utility failures, and actions taken.
- Indoor air quality monitored and issues identified with resolutions completed.
- Reviewed/revised Utility Management Plan with approval from Board of Directors.

EVALUATION of *PERFORMANCE STANDARDS*

OVERVIEW. Information to follow represents the evaluation of established performance standards. Performance Standards were chosen based upon the following criteria:

1. The performance standard represents a measurable area of one of the EOC components.
2. The performance standard indicates a key reflection of the scope of the component.
3. The performance standard represents a high-volume activity, or low volume but high-risk consequences.
4. The performance standard reflects actual or potential risk to the organization.

2025 PERFORMANCE STANDARDS – Kaweah Health

SAFETY

Objective is to reduce OSHA reportable work-related injuries/illness in the year 2025.

Goal: Reduce OSHA reportable injuries by 10% and stay below National benchmark.

Outcome: Goal met.

Patient death or serious disability associated with a *fall will be monitored.*

Goal: No patient death or serious disability while on the premises of a KH facility.

Outcome: Goal not met.

Reduction of non-patient safety related events.

Goal: Decrease of preventable Non-patient safety related injuries by 2 events.

Outcome: Goal met.

Infection Prevention - Presence of medical supplies, device or medication within 3ft of sink.

Goal: 100% compliance.

Outcome: *Goal not met. Environmental hazard rounds to continue 2026.*

Infection Prevention- Compliance with biohazard instrument transport containers.

Goal: 100% compliance.

Outcome: *Goal not met. Environmental hazard rounds to continue 2026.*

During hazardous surveillance, rounding expired sanitizer will be monitored.

Goal: 100% compliance.

Outcome: *Goal not met. Environmental hazard rounds to continue 2026.*

During hazardous surveillance, rounding cleanliness of soiled utility rooms & EVS closets will be monitored.

Goal: 100% compliance

Outcome: *Goal not met. Environmental hazard rounds to continue 2026.*

During hazardous surveillance, rounding cleanliness of vents will be monitored.

Goal: 100% compliance

Outcome: *Goal not met. Environmental hazard rounds to continue 2026.*

UTILITIES MANAGEMENT

Correction of causation within 30 days of work order being placed for ceiling tiles that are damaged/stained .

Goal: 100% compliance.

Outcome: Goal met. However environmental hazard rounds to continue 2026.

Inspections will be performed to confirm that electrical panels are locked.

Goal: 100% compliance.

Outcome: Goal not met. Environmental hazard rounds to continue 2026.

SECURITY

During hazardous surveillance rounding, units will be evaluated for authorized personnel doors/exit only door accessibility to the public.

Goal: 100% Compliance

Outcome: Goal not met.

FIRE PREVENTION

Sprinkler heads will be monitored for damage, corrosion, foreign material, and paint.

Goal: 100% Compliance.

Outcome: *Goal not met. Environmental hazard rounds to continue 2026.*

CLINICAL EQUIPMENT

Maintain a 100% compliance rate on non-high risk and high-risk Medical Equipment.

Goal: 100% Compliance.

Outcome: *Goal met*

Maintain a 100% compliance rate for High-Risk including Life Support medical equipment.

Goal: 100% Compliance.

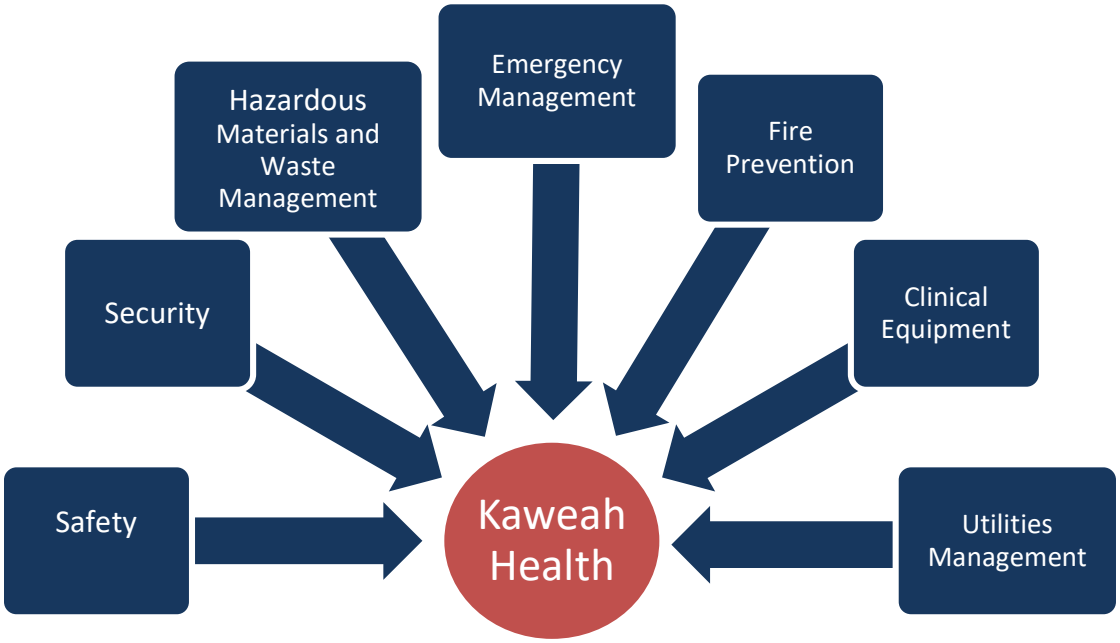
Outcome: *Goal met*

Performance Improvement Goal for 2025:

High-Risk including Life Support medical equipment Missing for Preventative Maintenance will be identified and documented monthly for up to six months until found and PM is received or retired.

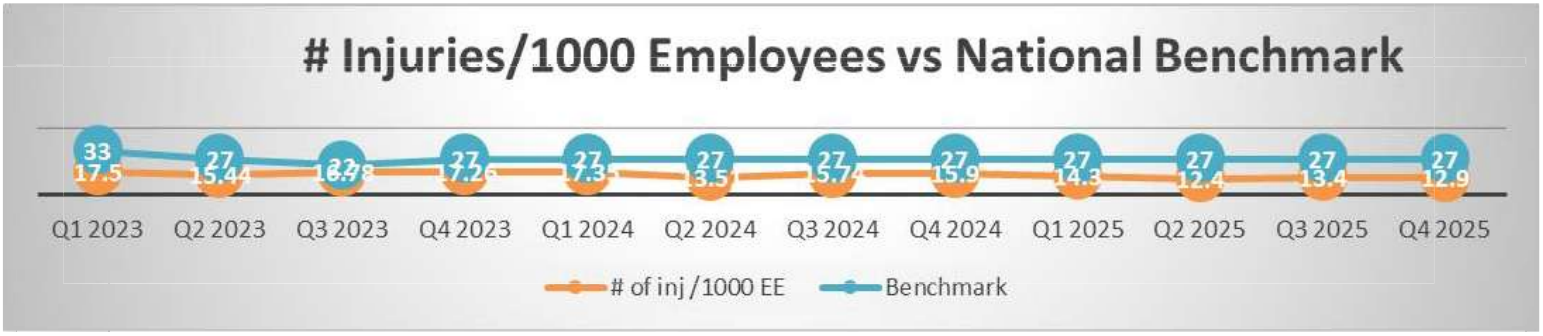
Goal: 100% Compliance.

Outcome: *Goal met*



Kaweah Health
Performance Monitoring 2025

Performance Standard: Our goal for 2025 is to maintain a safety record that is better than the national benchmark for workplace injuries and illnesses. To achieve this, we are planning to implement new processes that focus on reducing workplace injuries, keeping track of injury trends by department and type, and improving awareness of potential risks. Our Workers Compensation Program will be providing educational opportunities that align with the most common types of injuries in each department.



Evaluation Q4:

- 55 OSHA Recordable
- 21 COVID-19 employees
- Provided 14 + Tele sitter Department Ergonomic Evaluations
- 26 Sharps Exposure

Type of Injury	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Totals '25	Totals '24
Total Incidents	144	128	141	135	548	623
COVID 19 +	32	20	104	21	177	622
OSHA Recordable	45	38	41	55	179	216
Lost time cases	18	23	19	29	89	139
Strain/Sprain	39	38	24	33	134	166
Sharps Exp.	20	12	18	25	75	68
# of Employees (EE) end of QTR	5215	5210	5254	5271		

Plan for Improvement:

We have devised a set of processes to ensure safety and prevent accidents at our workplace. These measures include:

- Providing Managers and Directors with quarterly notifications of Work Injury Reports (WIR), which will contain up-to-date year-to-date information.
- Offering education through quick reference guides that can be posted in break rooms, Mandatory Annual Training (MAT) and/or education provided by clinical education or ancillary departments.
- Conducting follow-ups with managers to identify prevention opportunities and/or process changes and policy reviews. The investigation and follow-up may include photos, videos, and interviews of witnesses and managers.
- Increasing Sharps education in General Orientation by Infection Prevention and Manager Orientation by EHS. Demonstrating the correct sharps activation in new hire physicals with all employees handling sharps.
- Utilizing Physical Therapist Aide in Employee Health for Ergo evaluations. Evaluating for proper body mechanics to prevent injury, stretching exercises, and equipment recommendations to ensure safety with our jobs.
- Working with Infection Prevention to track exposures and outbreaks amongst Health Care Workers in 2025.

OSHA recordable injuries and Illnesses are as follows:

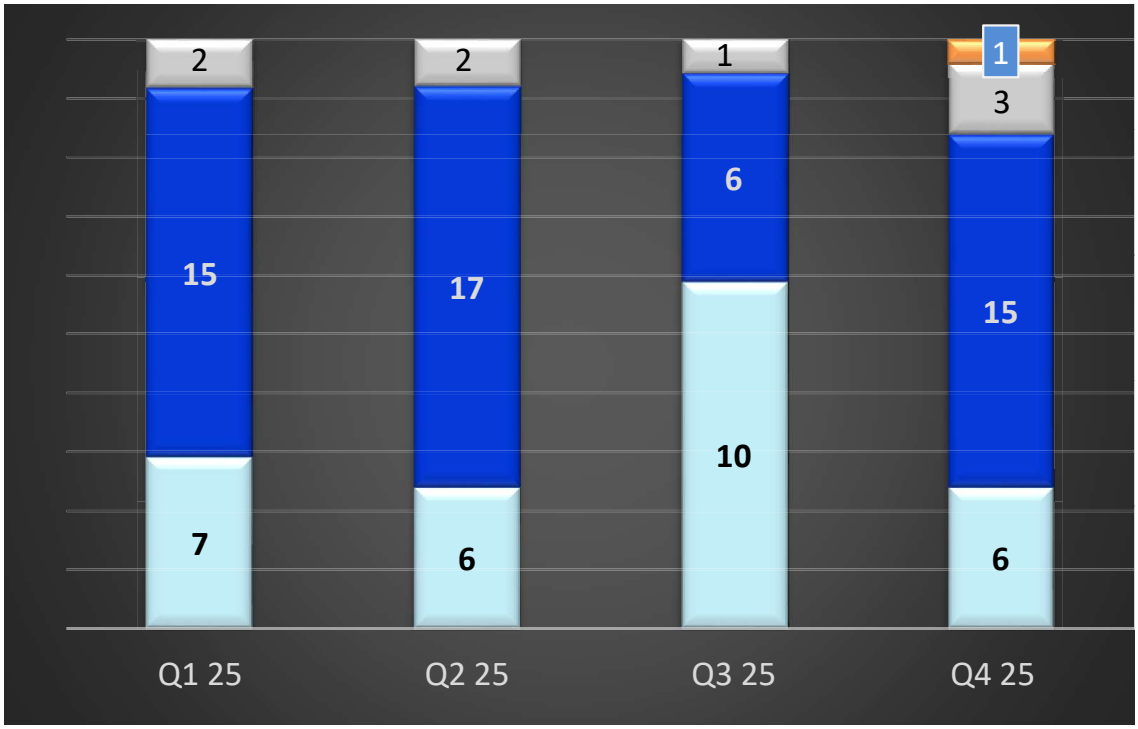
- Fatalities (reportable)
- Hospitalizations (reportable)
- Claim with lost workday, or modified work with restrictions (recordable)
- Medical treatment other than First Aid (recordable)

Total Incidents include First Aid and Report Only

EOC Component: **SAFETY**
RISK MANAGEMENT

<u>Goal #1: Annual Performance Standard</u>: Zero patient death or serious disability associated with a fall while being cared for in a KDHCD facility.
Goal: Met

<u>Goal #2: Annual Performance Standard</u>: Reports of <u>preventable</u> non-patient safety events will decrease by two (2) events or more.
Goal: Not Met



*Injury is defined as physical or mental impairment that requires additional medical treatment or intervention.

Q4 25 Lifestyle Center – Six (6) Non-Preventable Events
Q4 25 Kaweah Health – Fifteen (15) Non-Preventable Events
Q4 25 Kaweah Health – Three (3) Preventable Events
One (1) Preventable Event

Evaluation:
Events tracked by the Risk Management department via Midas occurrence reports. Investigations and opportunities for improvement were documented for each event, preventable and non-preventable. Each event and corrective actions were reported to the Environment of Care Committee. In 2025, a trend was identified with slips and falls wherein existing meal tray carts were found to have leaks causing puddles of liquid in hallways. An EOC Sub-Committee developed a plan of action to repair meal tray carts. Since these repairs, there have been zero (0) slip and fall events related to leaking carts.

Infection Prevention Component: **INFECTION PREVENTION COMPREHENSIVE ROUNDS**

Performance Standard: **Comprehensive Rounds 2025 Infection Prevention Goal:**
Will audit for 3 specific observations related to rigid biohazard instrument transport containers:
(1) the rigid biohazard instrument transport container is secured "locked" when in use. **Met**
(2) enzymatic/wetting solution is present along all surfaces of used instrumentation/scopes, and that enzymatic/wetting solution has not dried out. **Not Met**
(3) used instrumentation/scopes are placed in a rigid biohazard instrument transport container. **Met**
Goal: 100% compliance (no fallouts).
Minimum Performance Level: 95% overall compliance.

Evaluation:
100% compliance achieved for audit metrics one and three.

90.3% compliance achieved for audit metric two.

Audit	Compliance Rate				
	2025 Q1	2025 Q2	2025 Q3	2025 Q4	2025 Total
The rigid biohazard instrument transport container is secured "locked" when in use. (HZ)	100.0%	100.0%	100.0%	100.0%	100.0%
Used instruments/scopes have enzymatic/wetting solution present on all surfaces and has not dried. (HZ)	100.0%	100.0%	83.3%	77.8%	90.3%
Used instrumentation/scopes are placed in a rigid biohazard instrument transport container. (HZ)	100.0%	100.0%	100.0%	100.0%	100.0%

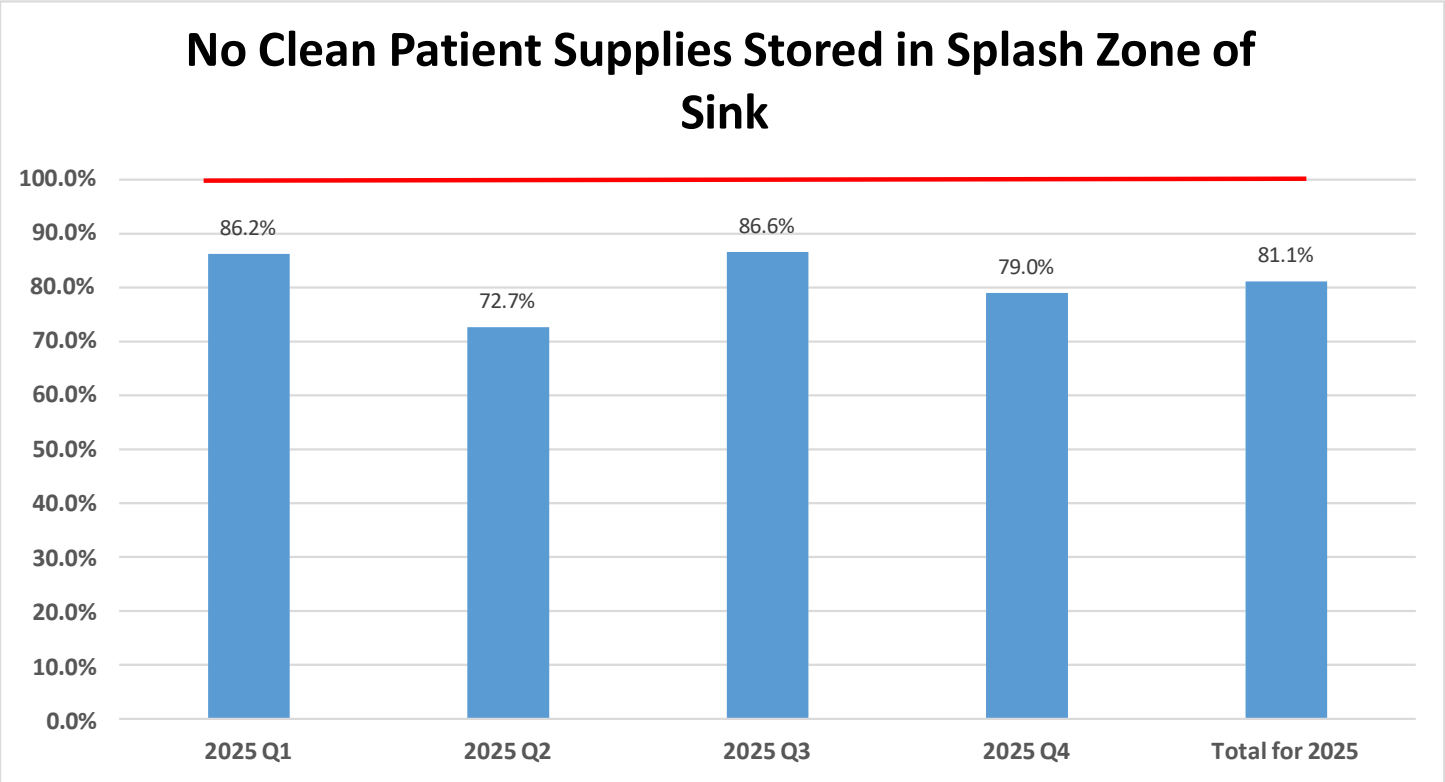
Plan for Improvement:
Methods to mitigate these events from occurring:

1. Appropriate use of rigid biohazard instrument transport container by staff in department observed.
2. Unit leaders notified in RLDatix and in real time during rounds when fallouts are identified.
3. Continue monitoring and educating staff about proper use of enzymatic/wetting solution.

Infection Prevention Component:	**INFECTION PREVENTION HAZARD ROUNDS**
Performance Standard:	**Weekly EOC Hazard Rounds 2025 Infection Prevention Goal:** During EOC rounds, as applicable, the following is evaluated: presence of medical supplies, devices and/or medication within 3 feet on either side of sinks present in patient care areas, including outpatient care clinical settings.

Goal: 95% - 100% compliance
Minimum Performance Level: 95% overall compliance.

Evaluation:
2025 Annual Summary: **81.1% Compliance.** Goal not met.



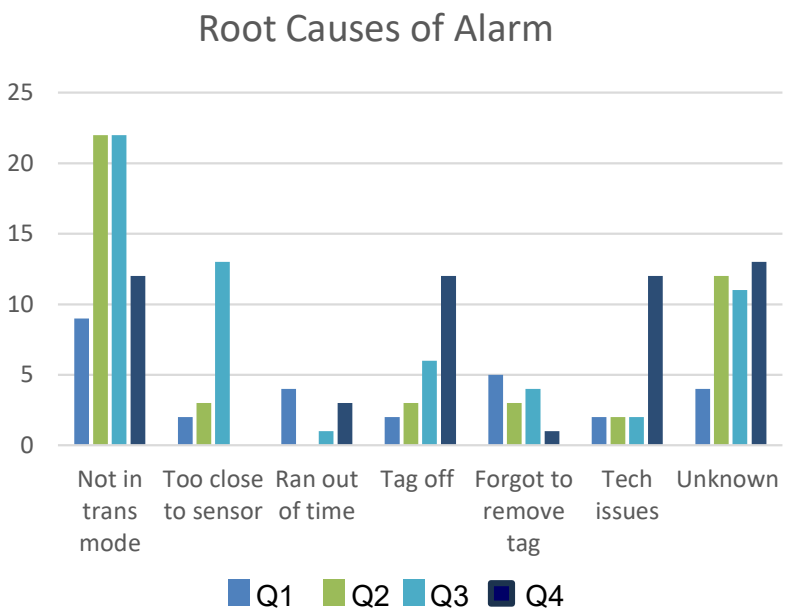
Plan for Improvement:
Methods to mitigate these events from occurring:
1. Eliminate clutter/storage of supplies, devices, medication within 3 feet on either side of a patient care sink.
2. Install an approved hard plastic barrier that prevents water exposure to medical supplies, devices and/or medication that are present within 3 feet on either side of patient care sinks.
3. Educational material distributed to unit leaders in advance of audits and each time fallout observed.
4. Infection Prevention increased rounding in 2025 on all inpatient units and continues to notify leaders of fallouts and recommendations.

EOC Component: **SECURITY**

Performance Standard: **False Code Pink Activations–** False Code Pink alarms, intended to prevent alarm fatigue and ensure rapid response, have surged dramatically. After improving from 48 in 2020 to 21 in 2023, incidents spiked to 138 in 2024 (557% increase) and rose further to 185 in 2025—168% above the annual goal of fewer than 69. This trend underscores the need for stricter compliance with established unit protocols

Evaluation:
In 2025, there were 185 Code Pink false alarms, peaking in Q3 before a slight improvement in Q4. The top three causes—failure to activate transport mode, unknown reasons, and tag removal—accounted for nearly 70% of incidents. Additional issues included technical failures in Q4 due to wet tags and procedural lapses during discharge

Plan for Improvement:
- Enforce Transport Mode Compliance: Implement accountability measures; target 40% reduction.
- Resolve Technical Issues: Vendor to ensure waterproof tags; maintain ≤3 incidents per quarter.
- Strengthen Tag Removal Protocols: Standardize discharge process; reduce by 50%.
- Optimize Transport Time Windows: Review and adjust to minimize missed steps.

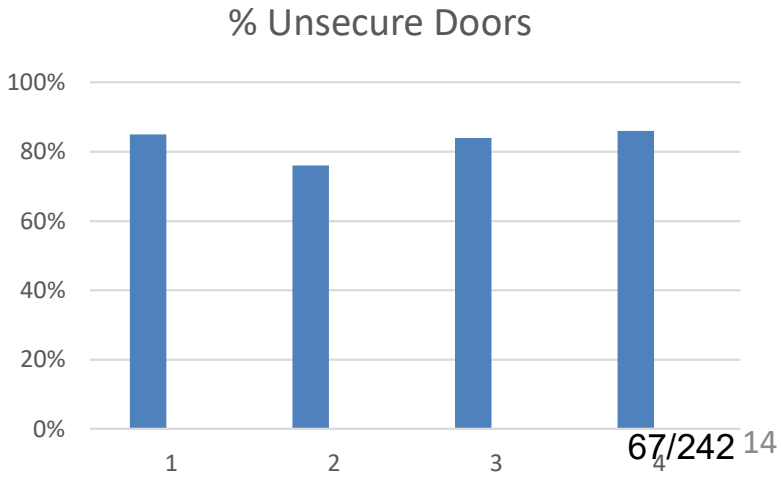


EOC Component: **SECURITY**

Performance Standard: During hazardous surveillance rounding, units will be evaluated for authorized personnel doors/exit only door accessibility to the public. Goal 100% compliance with doors not accessible to the public.

Evaluation:
Security evaluated units for compliance with door security standards, specifically ensuring that authorized personnel doors and exit-only doors were not accessible to the public. The goal was 100% compliance, meaning all such doors should remain closed and secured. Findings indicate that this goal was not met. The percentage of doors found unsecured during quarterly inspections were:

Plan for Improvement:
- Focus on improving compliance and security through quarterly audits
- Staff accountability measures, refresher training with visible signage, a clear escalation process for persistent issues
- Potential technology upgrades such as door alarms or enhanced access controls in those areas



UTILITIES MANAGEMENT

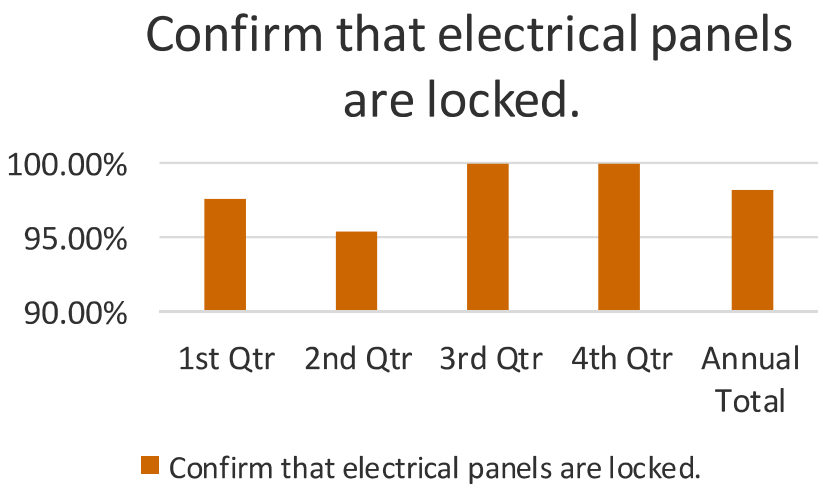
FOURTH QUARTER AND ANNUAL EVALUATION 2025

Performance Standard: Inspections will be performed during EOC rounds to confirm that electrical panels are locked.

Goal: 100% Compliance
Status: **Not** Met

Evaluation:
169 Departments or buildings were surveyed in the 2025. 3 electrical panels were found unlocked, this resulted in 98.24% compliance rate.

Minimum Performance Level not met during through the Year



We are searching for a universal surface mount panel lock that is keyless and self latching.
98.24% Compliance for 2025
This performance measure will continue for 2026

UTILITIES MANAGEMENT

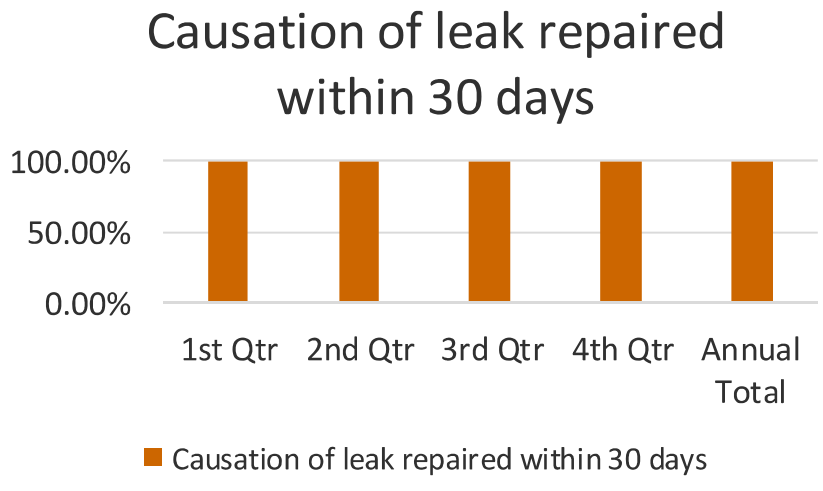
FOURTH QUARTER AND ANNUAL EVALUATION 2025

Performance Standard: Inspections will be performed during EOC rounds to identify any ceiling tiles that are damaged/stained. The expectation is staff that work in the area have placed a Facilities Maintenance work order and the Goal is to correction of causation within 30 days of work order being placed.

Goal: 100% Compliance
Status: **Met**

Evaluation:
169 Departments or buildings were surveyed in 2025. 63 Stained ceiling tiles were documented. The correction of the causation of 63 were repaired within 30 days of work order being placed. This resulted in 100% compliance rate.

Minimum Performance Level was met during this quarter.



Detailed Plan for Improvement:
100% Compliance for 2025
This performance measure will continue for 2026

SAFETY

Fourth Quarter 2025 and Annual Evaluation

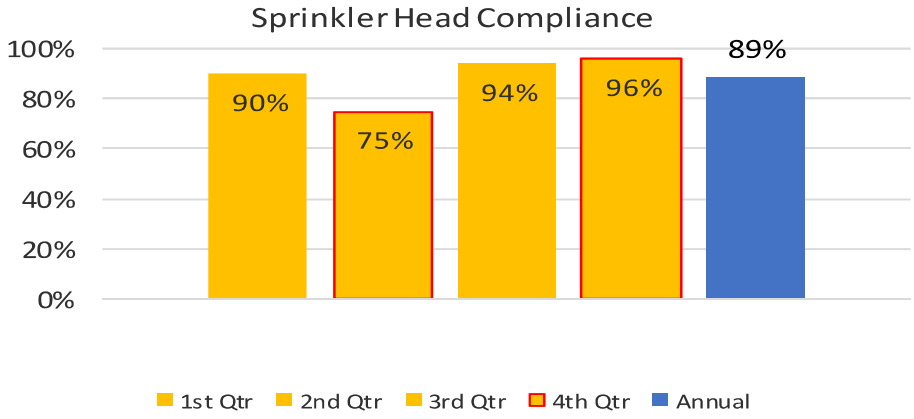
Performance Standard: During hazardous surveillance rounding, sprinkler heads will be monitored for damage, corrosion, foreign material, and paint.

Goal 100% compliance

Evaluation:

For 2025 there were a total of 200 sprinkler head observations. Of those observations, 20 were found to have foreign material, which resulted in an 90% compliance rate for the year.

Goal not met for 2025



Detailed Plan for Improvement:
Findings were sent to EVS leaders at the time of survey. Meeting conducted with EVS leadership to outline process for cleaning sprinkler heads. Schedule will be created for cleaning locations. Findings for corrosion or damage will be sent to Facilities for review. We will continue to monitor during rounds on a weekly basis and report findings to leaders of non-compliant areas.

Environmental Services (EVS) 4th Quarter

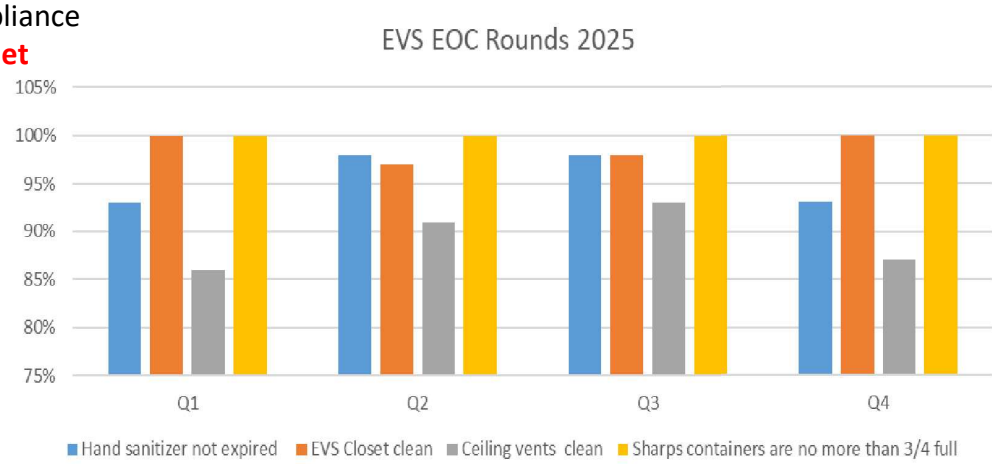
Performance Standard: During EOC rounds, as applicable, the following is evaluated: hand sanitizer not expired; EVS closets are clean; ceiling vents are clean and Sharps containers are no more than ¾ full.

Goal: 95% -100% Compliance

Status: **2 Met and 2 unmet**

Evaluation:

1. **Hand Sanitizer not expired: = 93% (Not Met)**
2. **EVS Closets clean: = 100% (Met)**
3. **Ceiling vents clean: = 87% (Not Met)**
4. **Sharps containers are no more than ¾ full = 100% (Met)**



Detailed Plan for Improvement:
Sharps containers no more than ¾ full are compliant for the year and quarter. Hand sanitizer not expired is at 93%.Ceiling vents are at 87% . EVS Closets Clean are 100%. Two out of our four goals are not met but our numbers are improving. We will continue to closely monitor through:

- EVS Leadership continue to proactively monitor areas routinely while completing departmental rounds (ongoing) including off site buildings which is where some of our findings were. Leaders will also help to do quality checks in areas and patient rooms.
- Purchasing cordless backpack vacuums for offsite and OR areas.
- EVS Stock Room Clerks are helping to rotate sanitizer to move to areas that they will be used more frequently.
- We have also removed sanitizer from areas that it is not being utilized or easily accessible for example we found one behind a wire rack in a Storage room.

WORKPLACE VIOLENCE

FORTH QUARTER AND EVALUATION 2025

Workplace Violence Events-2025

Year/Qtr	2 North	2 South	2 West-ICU	3 North	3 South	3 Tower-CV ICU	3 West	4 Center	4 North	4 South	4 Tower	5 Tower	ASC	Acequia Lobby	Cafeteria	CSU	CT	ED
2024, Q1	1	5	1	0	6	0	1	0	9	3	3	0	0	0	0		0	28
2024, Q2	1	1	0	4	5	0	0	0	2	10	4	1	0	0	0		0	20
2024, Q3	6	3	3	2	5	0	5	0	1	6	4	0	0	0	1		0	28
2024, Q4	4	3	0	5	6	1	0	0	9	7	0	1	0	0	0		0	34
Total 2024	**12**	**12**	**4**	**11**	**22**	**1**	**6**	**0**	**21**	**26**	**11**	**2**	**0**	**0**	**1**	**0**	**0**	**110**
2025, Q1	0	3	1	3	3	0	0	0	7	15	1	0	0	0	0		0	66
2025, Q2	5	1	0	7	2	0	2	0	5	5	2	2	0	0	0		0	58
2025, Q3	2	6	2	10	4	0	4	1	3	9	1	1	0	0	0		0	56
2025, Q4	3	1	0	5	25	0	6	0	27	15	8	5	0	1	0	5	0	74
Total 2025	**10**	**11**	**3**	**25**	**34**	**0**	**12**	**1**	**42**	**44**	**12**	**8**	**0**	**1**	**0**	**5**	**0**	**254**

MK Lobby	Mother-baby	MRI	PACU	PBX-Operator	Parking Lot	Peds	Public Area	Rehab Hospital	Respitory	SSB	Specialty Clinic	Sub-Acute, S. Campus	TLC	UCC, S. Court	Visalia Dialysis	Visalia SRCC	West Campus	X-Ray	Total
0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	103
0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	76
0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	95
0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	127
0	**1**	**0**	**0**	**0**	**3**	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**401**
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	136
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	137
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	128
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	201
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	602

Evaluation: Workplace violence(WPV) reporting on MIDAS is continuing to improve. In 2025 WPV was up from 401 in 2024 to 602 in 2025. We did see a decrease of events in the Mental Health facility. Some areas of concern were inpatient units for 3North, 3South, 3West, 4North and 4South.

Detailed Plan for Improvement (2025):

1. 4South has continued to train staff focusing on dementia patients.
2. Leaders will continue to encourage staff to enter incident reports for workplace violence on Midas.
3. Traveler nurses will receive a CPI physical skills training upon hire. Those travel nurses will also receive a de-escalation tutorial and access to our code grey and code green information sheets.
4. WPV cases will be reviewed by the WPV case review team, and results to those case studies will be sent out to leadership to review for their units.
5. Safety specialists will assist mental health leadership in conducting WPV case reviews at the MH facility monthly.
6. MH will conduct a code grey drill monthly.
7. CPI training will include use of the new 3rd edition from the Crisis Prevention Institute. Refresher courses will focus on the latest in CPI instruction.
8. We have added another CPI instructor in December 2025 from our Mental Health staff.

EMERGENCY MANAGEMENT/EMERGENCY OPERATIONS PLAN
Evaluation of Performance - 2025

The KH Emergency Preparedness Committee, a subcommittee of the Environment of Care Committee, met regularly throughout 2025 to address the preparedness needs within the Organization. Members from the Subcommittee ensured that leadership throughout the Organization were assigned positions in the *Hospital Incident Command System* (HICS), and that the organizational chart was kept current. The KH Emergency Operations Plan was reviewed/revised during 2025.

Community Partners: Participated with Tulare County Public Health Emergency Preparedness Advisory Committee, Tulare County Office of Emergency Services, Central California Emergency Medical Services Agency (CCEMSA), County of Tulare Evacuation Planning, and Visalia Fire Department and other agencies throughout Tulare County.

Hazard Vulnerability Analysis: The Hazard Vulnerability Analysis (HVA) was re-evaluated and approved by the Environment of Care Committee. Input regarding the HVA was solicited from our executive team, medical staff and community partners. KH also worked with CCEMSA hospitals in Fresno, Kings, Madera, and Tulare Counties to review the communitywide HVA.

Offsite Facilities: During 2025, the Emergency Planning Committee focused on the offsite facilities to ensure the specific risks of each facility were addressed during emergency exercises.

Disaster Exercises: On June 25, 2025, Kaweah Health activated the Hospital Incident Command System (HICS) in response to a system failure exercise. The incident Southern Edison Gas reporting that they have a compressor system failure in their main gas pipeline system that supplies the southern portion of the San Joaquin Valley. The exercise also tested our ability to manage multiple systems that are affected by the loss of natural gas and the ability to continue cooking hot food, running hot water, Co Gen, laundry service, and steam for sterile processing. The exercise included testing the districts plan for the next 96-hour while protecting and maintain normal functions for our patients.

On December 11, 2025, Kaweah Health activated the Hospital Incident Command System (HICS) in response to an exercise that involved power outage in our facility and test our staff's ability to vertically evacuate some patients (volunteers) by utilizing evacuation Medsleds. This also involved the coordination with emergency medical services to get patients to other near by local hospitals.

Both the exercises included Hospital Incident Command System (HICS) activation, Emergency Department staffing (accessing additional physicians, residents and staff available), labor pool activation, alternate care sites identified and prepared, etc. The use of the HICS, a standardized approach to disaster management, allows our management and staff to respond with an all-hazard approach to disasters. We have continued to actively partner with our community partners including The County of Tulare Office of Emergency Services, Tulare County Public Health Emergency Preparedness Program, Visalia Police Department, Visalia Fire Department and various local ambulance agencies .

Six critical elements were identified during the exercise, with staff performance exceeding the established threshold. The exercises/incidents were critiqued through a multidisciplinary process which included administration, clinical and support staff, and medical staff. After action improvement items were identified and will be presented to the Emergency Management Sub commitment. Objectives were evaluated relating to six critical areas: communications, resources and assets, safety and security of the patient, staff roles and responsibilities, the management of utilities and patient clinical and support activities.

EVALUATION – OVERALL *EFFECTIVENESS*
ENVIRONMENT OF CARE AND EMERGENCY OPERATIONS

Safety: Based upon the objectives, scope and performance standards, the risks within our Safety Management plan have been managed effectively. The Safety Education program for the Organization is highly effective; departments completed the Safety Training Modules. The Infection Prevention Department monitored infection control practices. Risk Management continued to monitor visitor injuries, with no trends identified. Based on the high level of commitment to education, surveillance and ongoing activities, the Management Plan for Safety is highly effective in promoting safety standards for the organization and in guiding the direction of safety-related activities. In 2025, we will improve safety outcomes by continuing with our monitoring activities and current programs, knowing they are effective in promoting safety standards for the organization and in guiding us towards continued risk reduction.

Security: The Management Plan for Security and the security program is effective at Kaweah Health has proven by the objectives to minimize security risks being met in 2025. The Workplace Violence Committee worked to monitor the Workplace Violence Program, implementing recommendations and responding to actual threats. Workplace violence awareness and crisis intervention training is provided to employees working in high-risk areas and for support staff who also support patient care in those high-risk patient care areas. Code Silver (active shooter) education is available for staff. Security risk assessments were completed in conjunction with weekly hazard surveillance rounding. Any identified deficiencies are reported and tracked until correction/improvement is made.

Hazardous Materials: We continue to minimize risks related to hazardous materials and wastes by monitoring spill activity and completing hazardous gas monitoring in areas with known chemical contaminants. An annual chemical inventory was completed, and all employees were required to complete Hazardous Materials and chemical specific training. Other activities that support the effectiveness of our program include assessing the level of knowledge staff have relating to the Hazardous Materials program, specifically their role during a spill event. Our Radiation Safety Committee monitors radiation issues, such as badge readings, apron safety, annual review of the Radiation Safety Plan, and license amendments. Based upon the objectives, scope and performance standards, the Hazardous Materials Plan and program is rated to be highly effective.

Emergency Management: Based upon the objectives, scope and performance standards, the Emergency Operations Plan is effective in providing the framework for disaster response for our staff. The Emergency Management Subcommittee continued to meet to review and plan for multiple preparedness activities including, but not limited to, drill design and follow-up activities. Training was completed for Decontamination Processes, Emergency Preparedness, patient evacuation and new hire orientation. The Hazard Vulnerability Analysis was reviewed and found to be an effective tool in prioritizing critical events and assessing the prioritization against the Organization's preparedness. KH is actively involved with community-wide preparedness activities which strengthening ties with agencies having jurisdiction and the California Department of Health Services.

Fire Prevention Management: Based upon the objectives, scope and performance standards, the Fire Prevention Management plan is effective. Fire drills were completed for the Organization, with staff performing according to a pre-established checklist. Fire equipment inspection, maintenance and testing was completed, with ongoing monitoring of the *Statement of Conditions* in effect. Infection Prevention assessment continued to be integrated into construction activities along with any Interim Life Safety Measures assessments that were needed

Clinical Equipment Management: Based upon the objectives, scope and performance standards, the Clinical Equipment Plan and program are effective. Preventive Maintenance was monitored quarterly for high-risk including life support and non-high-risk medical equipment, with the thresholds of performance met. The separation of our inventory (i.e., high risk including life support medical equipment from non-high-risk medical equipment) places a higher focus on the safety of our patients and keeps the *Environment of Care* closely integrated with Patient Safety standards. The Clinical Equipment Plan and program are effective in promoting safe equipment usage for our patients.

Utility Equipment Management: Based upon our objective, to provide a comfortable, safe, environment for our patients and our staff, are programs are effective. Performance monitoring focused on the completion of critical life support utility equipment . A skilled facilities staff, strong leadership, and the management of the automated preventive maintenance program has helped us in improving the objective to minimize the risks associated with utility failures.

Cardiovascular Services

REPORT TO THE BOARD OF DIRECTORS

Cardiovascular Services -Summary

Ayham Zoreikat RN, MBA
Director of Cardiovascular Service Line & Operations

March 2026

Summary Issue/Service Considered

- Contribution margin is expected to end FY 2026 at $30.5 million, a $6.9 million increase over prior year as well as a four-year high.
- The increase is mostly due to two components:
    - Supplemental government funding provided $20.9 million or 68.5% of contribution margin.
    - Contribution margin w/o Addition Reimbursement represented 29% of the contribution margin, a result of stronger volumes.
- Contribution margin w/o Additional Reimbursement per Case increased to $187 per case in FY 2026 from $155 per case in FY 2025. This represents an additional $2 million in contribution margin w/o Additional Reimbursement.
- Inpatient cases increased 3% and outpatient increased 6%; resulting in a total patient case increase of 6%. Both settings provide substantial contribution margin, with and without additional government funding. Contribution margin w/o Additional Reimbursement Per Case increased 33% over prior year for inpatient and 21% over prior year for outpatient.
- Cardiovascular services are primarily a Medicare and Medicare Managed Care business, representing approximately 60-66% of the payer mix, depending on the service. Medi-Cal Managed Care and Medi-Cal represent approximately 25%, bringing in substantial government supplemental funding.

Quality/Performance Improvement Date

Continued participation in the Society of Thoracic Surgeons national registry for adult cardiac surgery with the following results:

- Two-star overall rating for Coronary Artery Bypass Graft (CABG)
- Two-star overall rating for Aortic Valve Replacement (AVR)

Participation in this registry offers near real-time data, enabling swift adaptation to improvement opportunities, the implementation of evidence-based care, and ultimately, better patient outcomes.

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

Invested in quality improvement in Thoracic Surgeries by securing three heart and lung pumps as well as two advanced-imaging Echo machines to support structure heart program.

Policy, Strategic or Tactical Issues

- Decrease Average Length of Stay (ALOS)
- Increase program services: MitralClip, Leadless pacemaker, Renal Denervation and MitraClip.

Recommendations/Next Steps

Continuous strategic planning will remain pivotal in navigating the evolving landscape of healthcare delivery.

Approvals/Conclusions

Over the past year, cardiovascular services have begun to trend in a positive direction in both financially and in quality.

REPORT TO THE BOARD OF DIRECTORS

Inpatient Cardiology Services

Ayham Zoreikat RN, MBA
Director of Cardiovascular Service Line & Operations
624-2409

March 2026

Summary Issue/Service Considered

- Contribution margin annualized at $19.8 million, a $2.4 million (14%) increase over prior year. 45.9% of this increase is a $1.1 million increase in government supplemental funding and 54.1% of the increase is due to a stronger contribution margin w/o additional funding, a result of stronger volumes.
- Volumes increased 4% over prior year.
- ALOS decreased 7% from 4.54 days in FY 2025 to 4.20 days in FY 2026.
- Net Revenue per case continues to steadily increase since FY 2023; currently trending at $22,810 per case, a 5% increase over prior year.
- 66.7%, or $13.2 million, of the annualized contribution margin is from Cath Lab procedures. The Cath Lab contribution margin continues to increase each year.
- Services include: PTCAs, Cardiac Caths, Cardiac Defibrillator implants, pacemakers, TAVRs and Impellas
- Payer mix consist of: Medicare (39%), Medicare Managed Care (26%), Medica-Cal Managed Care (18%), Managed Care/Other (14%) and Medi-Cal (2%).

Quality/Performance Improvement Date

- Goal #1: Reduce ST Elevated Myocardial Infarction (STEMI) Mortality from 2.1% to <1.86% (goal met)
- Goal #2: Reduce Acute Kidney Injury (AKI) from 6.3% to <5.5% (Goal met)
- Goal #3: Reduce Bleeding Events from 2.19% to <1.31% (goal met)

Policy, Strategic or Tactical Issues

- Realignment of nurse practitioners to be designated to provide full coverage for cardiology patients only in order to facilitate a lower LOS and ensure compliance with regulatory documentation requirements.
- Expanding cardiology services.
- Optimize block access utilization and CVOR.
- Increased staff ratio in Cath Lab to decrease turnaround time in order to improve surgeon and patient satisfaction.
- Established structural heart pre-case multidisciplinary team meeting.

Recommendations/Next Steps

Continue to work on growth strategies and improve quality of the program.

Approvals/Conclusions

Over the past year, we focused on lowering our LOS while at the same time increasing volumes and program services that contributed to a solid increase to our contribution margin.

REPORT TO THE BOARD OF DIRECTORS

Inpatient Cardiothoracic Surgeries (CTS)

Ayham Zoreikat RN, MBA
Director of Cardiovascular Service Line & Operations

March 2026

Summary Issue/Service Considered

- Inpatient Cardiothoracic Surgeries contribution loss annualized at -$518,875, a $1.7 million (77%) improvement from prior year. 21.6% of this increase is a $370,603 increase in government supplemental funding and 78.4% of the increase is due to a stronger contribution margin w/o additional funding, a result of lower Direct Cost.
- Direct Cost decreased $1.3 million (-6%) from prior year a result of lower physician fee.
- ALOS decreased 8% from 11.26 days in FY 2025 to 10.38 days in FY 2026. GM LOS is 8.65 days.
- Net Revenue per case continues to steadily increase since FY 2023; currently trending at $84,995 per case, a 9% increase over prior year.
- Open Heart contributes 70% of the procedures.
- Services include: Cardiac valves, Coronary Bypass (CABG) and Impella 5.5, a new service that began Quarter 1 of FY 2026 and reimbursed at the highest level (DRG 1).
- Payer mix consists of: Medicare Managed Care (34%), Medicare (25%), Medi-Cal Managed Care (20%), Managed Care/Other (17%) and Medi-Cal (3%).

Quality/Performance Improvement Date

- Continued participation in the Society of Thoracic Surgeons national registry for adult cardiac surgery with the following results:
  - Two-star overall rating for Coronary Artery Bypass Graft (CABG)
  - Two-star overall rating for Aortic Valve Replacement (AVR)

- Operative Mortality Reduction: Decrease STS Operative Mortality to </=2.5% (goal met)

Policy, Strategic or Tactical Issues

- Established weekly LOS status meeting with case managers and thoracic coordinator to review all inpatients in order to discharge timely in accordance with CMS guidelines.
- Replaced all end-of-life cardiac heart and lung pumps with advanced technology equipment to support an advanced program.
- Replacing end-of-life Echo machines with current technology to provide better imaging.
- New Cardiothoracic surgeon starts in April 2026 and focused on robotic surgeries.
- Increase coverage hours from eight hours to twelve hours to support expanded growth of the structure heart program.
- Expanded services to include the Impella 5.5 procedure (a DRG 1 procedure)

Recommendations/Next Steps

Continuous strategic planning will remain pivotal in navigating the evolving landscape of healthcare delivery. Our CTS program will focus on increasing volume, decreasing length-of-stay (LOS) and growing our elective thoracic surgery program. Continue to utilize our affiliation with Cleveland Clinic to improve quality and CVOR efficiencies. This collaboration has resulted in improved patient outcomes and educational opportunities for our CTS Team.

Approvals/Conclusions

Over the past year, we focused on lowering our LOS as well as bringing equipment to current standards to improve the quality of the overall program.

REPORT TO THE BOARD OF DIRECTORS

OP Cardiac Cath Lab (7570)

Ayham Zoreikat RN, MBA
Director of Cardiovascular Service Line & Operations

March 2026

Summary Issue/Service Considered

- Contribution margin annualized at $11.3, a $1.6 million (16%) increase over prior year. 97.3% of this increase is due to a stronger contribution margin w/o additional funding, a result of better reimbursement and increased volumes.
    - Volumes increased 5% over prior year while Contribution Margin per case increased 10% over prior year.
- Net Revenue per case continues to steadily increase since FY 2023; currently trending at $9,026 per case, a 9% increase over prior year.
- Services include: Cardiac Caths, PCI w/ stent and Pacemakers.
- Payer mix consists of: Medicare (44%), Managed Care/Other (23%), Medicare Managed Care (22%) and Medi-Cal Managed Care (10%). Payer mix stays consistent year over year.

Quality/Performance Improvement Date

- Continued participation in the NCDR CathPCI national registry for percutaneous coronary intervention (PCI) procedures with the following results:
    - Radial usage continues to be the preferred method of access
    - Reduction in acute kidney injury and post procedure bleeding
    - Same-day discharge continues to be above national goal, including same-day discharge post Watchman procedure
- Realign staff to patient ratio to improve on-time starts and ensure an assigned dedicated sedation nurse to each procedure.

Policy, Strategic or Tactical Issues

Our outpatient Cath Lab continues to grow, offering a wide range of procedures with an exceptionally knowledgeable, trained and experienced team of interventional cardiologists and clinicians.

Structural Heart Program growth

- Expansion of program – added interventional cardiologist who performs structural heart procedures
- Watchman program launched in September 2023 and continues to grow
- TAVR program continues to grow
- MitraClip program will launch April 2026

- Leadless Pacemaker program will launch April 2026
- Renal Denervation program will launch April 2026
- CarioMEMS program will launch April 2026

Recommendations/Next Steps

Continue to utilize our affiliation with Cleveland Clinic to improve efficiency and quality in the Cath Lab. This collaboration has resulted in improved patient outcomes, educational opportunities for physicians and staff, and added novel procedures to our cardiovascular service line. Continued focus on growth of our structural heart program.

Approvals/Conclusions

Our Cardiac Cath Lab remains financially strong. The addition of an interventional cardiologist, combined with a highly experienced Cath Lab team and improved processes, will enhance efficiency and lead to excellent patient outcomes.

REPORT TO THE BOARD OF DIRECTORS

Outpatient Cardiology Clinic – Visalia (7088), Non-invasive Cardiology (7560) and Diagnostic Center (7561/7652) ,

Ayham Zoreikat RN, MBA
Director of Cardiovascular Service Line & Operations

March 2026

Summary Issue/Service Considered

- Contribution margin annualized at $1.2 million, a $1.19 million increase over prior year. 53.6% of this increase is a $637,108 increase in government supplemental funding and 46.4% of the increase is due to a stronger contribution margin w/o additional funding, a result of lower Direct Costs.
- Net Revenue per case continues to steadily increase since FY 2023; currently trending at $290 per case, a 4% increase over prior year.
- Direct Costs decreased $798,197 (-8%) from prior year, reducing direct cost per case from $280 in FY 2025 to $255 in FY 2026.
- Payer mix consists of: Medicare (37%), Managed Care/Other (25%), Medicare Managed Care (22%), Medi-Cal Managed Care (14%), Workers Comp (1%) and Medi-Cal (1%) Payer mix stays consistent year over year.

Quality/Performance Improvement Data

- Access and Throughput Metrics: Decrease no-show and cancellation rates.
- Operational Efficiency and Documentation: Decrease documentation lag time
- Revenue cycle & Financial health: Improve first-pass resolution rate (FPRR)
- Management & Governance: Improve meeting attendance & committee participation

Policy, Strategic or Tactical Issues

- Designated a nurse practitioner to support Vascular surgeon (Dr. LaMar Mack) inpatient and outpatient services.

- Implemented IronRod, a remote monitoring service, that will improve patient follow-up and one-time patient monitoring reporting.

- Our focus remains on growing our market share for cardiology services. This includes cardiology physician services, noninvasive testing (ie. stress testing, echocardiograms) and vascular studies (ie. ultrasound). Also continued focus on growing our nuclear medicine program (SPECT and cardiac PET).

Recommendations/Next Steps

- Increase productivity by reducing check-in time
- Increase patient satisfaction – patients now receiving automated call requesting completion of an over-the-telephone survey regarding their last visit; data breakdown providing insight where attention should be which has resulted in increased patient satisfaction scores; patient experience online portal also provides close to "real time" ability to follow-up on any negative patient experience feedback
- Decrease errors in information collected at front desk during check-in (results in clean claims)
- Increase upfront cash collections for all services
- Decrease no-show rates for all areas

Approvals/Conclusions

The Cardiology Center, Diagnostic Center, Diagnostic Center Nuclear Medicine, and Noninvasive Cardiology (inpatient/hospital) provide needed cardiology and vascular services to our community. We continue to assess innovative methods to deliver high quality and cost-effective care. This multi-service clinic continues offering world-class cardiovascular services in one location and remains committed to the delivery of the highest quality of care with service excellence at the core of what we do.

REPORT TO THE BOARD OF DIRECTORS

Cardiothoracic Surgery Clinic (7424)

Ayham Zoreikat RN, MBA
Director of Cardiovascular Service Line & Operations

March 2026

Summary Issue/Service Considered

The Cardiothoracic Surgery (CTS) Clinic was open in FY 2024 to provide services to patients needing open heart, valve and thoracic surgery procedures. This clinic serves as a base for elective consults for this surgical service line and for post-operative visits.

- Contribution loss annualized at -$259,921, a $88,276 improvement over prior year, a result of Direct Cost decreasing $83,988 from prior year.
- Net Revenue per case has remained fairly flat since inception of this clinic in FY 2024.
- Direct Cost per case decreased from $819 in FY 2025 to $581 in FY 2026, a -29% decrease.
- Payer mix consists of: Medicare (36%), Medicare Managed Care (27%), Managed Care/Other (20%), Medi-Cal Managed Care (15%) and Medi-Cal (2%). Payer mix has shifted slightly from Medicare to Medicare Managed Care.

Quality/Performance Improvement Date

- The clinic team prides itself on focusing on quality and customer service. Referrals received are promptly scheduled within 7-10 days for a new referral. (goal met).
- Data from the Society of Thoracic Surgeons is shared and discussed.

Policy, Strategic or Tactical Issues

- New CT surgeon starts April 2026, with a focus on robotic surgery.
- In collaboration with Dr. Bansal, a strategic plan was completed; marketing activities focus on program growth to meet community needs.
- Increase outpatient referral from the private cardiologist offices to Kaweah's Cardiothoracic surgeon.
- Continue to focus on Inpatient CTS NPs to provide clinic coverage by FY26; this will improve clinic throughput so surgeons can focus on expedited consults and NPs will focus on post-operative visits

Recommendations/Next Steps

As this service line grows as a KH entity, we can quickly pivot to ensure the above focus/metrics are routinely met, even exceeded. Starting robotic thoracic surgery will be key to increasing volumes and revenue, including Pulmonology Lung nodule program (ION).

Approvals/Conclusions

The CT Surgery service line has experienced a change in CT surgeons. Quality of care and outcomes have remained unchanged despite these changes. Our focus remains on providing world class care to our CT surgery patients, a personal touch in the clinic for consultative, preoperative and postoperative care.

REPORT TO THE BOARD OF DIRECTORS

Cardiology Center – Tulare (7025)

Ayham Zoreikat RN, MBA
Director of Cardiovascular Service Line & Operations

March 2026

Summary Issue/Service Considered

The Cardiology Center in Tulare was opened in May 2023. FY 2024 was the first full year of operation.

- Contribution loss annualized at -$997,717, a $66,250 improvement over prior year.
- Volumes increased from 7,876 in FY2025 to 10,203 in FY 2026, a 305 increase over prior year.
    - A significant portion of the contribution loss is because 100% of the surgeons' professional fee payment is charged to this facility while revenues are earned in other Kaweah facilities.
- Net Revenue per case increased from $109 in FY 2025 to $119 in FY 2026, a 9% increase over prior year.
- Direct Cost per case decreased from $227 in FY 2025 to $216 in FY 2026, a -5% decrease.
- Payer mix consists of: Medicare (40%), Medicare Managed Care (29%), Managed Care/Other (24%) and Medi-Cal Managed Care (5%)

Quality/Performance Improvement Date

- Obtain accreditation for Nuclear stress test, which will improve revenue and collection and eliminate denied claims.
- Access and Throughput Metrics: No-show and cancellation rates.
- Operational Efficiency and Documentation: Decrease documentation lag time
- Revenue cycle & Financial health: First-pass resolution rate (FPRR)
- Management & Governance: Meeting attendance & committee participation, people/staff turnover rate

Policy, Strategic or Tactical Issues

- Added additional cardiologist and nurse practitioner to improve clinic growth and increase referrals for inpatient surgeries.

- Implemented IronRod, a remote monitoring service, that will improve patient follow-up and one-time patient monitoring reporting.

- Our focus remains on growing our market share for cardiology services. This includes cardiology physician services. Also continued focus on growing our nuclear medicine program (SPECT and cardiac PET).

Recommendations/Next Steps

Maximize clinic schedule with efficient and creative scheduling. Continue assessing volume produced from this clinic as it relates to the overall Cardiovascular Service Line. Staffing level continually assessed as volume increases. Once on NRC platform to measure patient experience data, use this data to drive strategic initiatives to ensure an excellent patient experience at this KH clinic.

Approvals/Conclusions

This clinic has quickly grown since May 2023. The team at this location is small despite the upward trajectory of growth. This team prioritizes high-touch customer service with each patient receiving individual attention, which is reflected in the positive comments verbalized to the staff and physician.

KAWEAH HEALTH ANNUAL BOARD REPORT

Cardiovascular Services - Summary

FY2026 Annualized

KEY METRICS - FY 2026 Seven Months Ended January 31, 2026 Annualized

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
51,118	$128,181,032	$97,682,813	$30,498,219	$8,284,902
▲ 6%	▲ 9%	▲ 4%	▲ 29%	▲ 726%

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

METRICS BY SERVICE LINE - FY 2026

*Annualized

SERVICE LINE	PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
Inpatient Cardiology	2,902	$66,201,776	$46,427,077	$19,774,699	$6,684,820
Outpatient Cardiac Cath Lab	3,194	$28,827,943	$17,524,066	$11,303,877	$7,287,765
Outpt. Cardiology Clinic & Non-Inv. Cardi	34,006	$9,877,517	$8,681,362	$1,196,155	($475,762)
Cardiothoracic Surgery Clinic	554	$61,514	$321,434	($259,921)	($301,895)
Inpatient Cardiothoracic Surgeries	259	$22,001,454	$22,520,328	($518,875)	($3,696,249)
Cardiology Clinic Tulare	10,203	$1,210,829	$2,208,546	($997,717)	($1,213,777)
Cardiovascular Services Totals	51,118	$128,181,032	$97,682,813	$30,498,219	$8,284,902

METRICS SUMMARY - 4 YEAR TREND

*Annualized

METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	36,772	44,617	48,327	51,118	▲ 6%	
Net Revenue	$97,199,581	$111,283,016	$117,873,681	$128,181,032	▲ 9%	
Direct Cost	$83,492,200	$85,789,531	$94,233,841	$97,682,813	▲ 4%	
Additional Reimb	$5,944,858	$18,389,995	$16,162,336	$20,932,438	▲ 30%	
Contribution Margin	$13,707,382	$25,493,485	$23,639,840	$30,498,219	▲ 29%	
Indirect Cost	$20,282,780	$19,142,134	$22,636,758	$22,213,316	▼ -2%	
Net Income	($6,575,398)	$6,351,351	$1,003,081	$8,284,902	▲ 726%	
Net Revenue Per Case	$2,643	$2,494	$2,439	$2,508	▲ 3%	
Direct Cost Per Case	$2,271	$1,923	$1,950	$1,911	▼ -2%	
Add Reimb Per Case	$162	$412	$334	$409	▲ 22%	
Contrb Margin Per Case	$373	$571	$489	$597	▲ 22%	
CM w/o Add Reimb Per Case	$211	$159	$155	$187	▲ 21%	

GRAPHS

Source: Inpatient and Outpatient Service Line Reports
Criteria: Inpatient Cardiothoracic Surgeries and Cardiology Service Line
Criteria: Outpatient Service Line (Cardiac Cath Lab, Cardiology Clinic and Non-Invasive Cardiology, Cardiology Clinic Tulare and CTS Clinic)

KAWEAH HEALTH ANNUAL BOARD REPORT

FY2026 Annualized

Cardiovascular Services - Inpatient Summary

KEY METRICS - FY 2026 Seven Months Ended January 31, 2026 Annualized

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
3,161	$88,203,230	$68,947,405	$19,255,825	$2,988,571
▲ 3%	▲ 7%	▲ 3%	▲ 27%	▲ 233%

*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
Inpatient Cardiology	2,902	$66,201,776	$46,427,077	$19,774,699	$6,684,820
Inpatient Cardiothoracic Surgeries	259	$22,001,454	$22,520,328	($518,875)	($3,696,249)
Inpatient Cardiovascular Services Total	3,161	$88,203,230	$68,947,405	$19,255,825	$2,988,571

METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2023	FY2024	FY2025	*Annualized FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	2,926	3,002	3,074	3,161	▲ 3%	
Patient Days	15,618	15,976	15,813	14,889	▼ -6%	
ALOS	5.34	5.32	5.14	4.71	▼ -8%	
Net Revenue	$68,330,493	$80,167,117	$82,366,435	$88,203,230	▲ 7%	
Direct Cost	$62,758,450	$62,202,707	$67,198,810	$68,947,405	▲ 3%	
Additional Reimb	$6,787,325	$8,453,958	$8,015,620	$9,475,909	▲ 18%	
Contribution Margin	$5,572,043	$17,964,410	$15,167,625	$19,255,825	▲ 27%	
Indirect Cost	$15,683,421	$14,756,440	$17,418,706	$16,267,254	▼ -7%	
Net Income	($10,111,378)	$3,207,970	($2,251,081)	$2,988,571	▲ 233%	
Net Revenue Per Case	$23,353	$26,705	$26,795	$27,902	▲ 4%	
Direct Cost Per Case	$21,449	$20,720	$21,860	$21,811	▶ 0%	
Add Reimb Per Case	$2,320	$2,816	$2,608	$2,998	▲ 15%	
Contrb Margin Per Case	$1,904	$5,984	$4,934	$6,091	▲ 23%	
CM w/o Add Reimb Per Case	($415)	$3,168	$2,327	$3,094	▲ 33%	

GRAPHS

Source: Inpatient Service Line Reports
Criteria: Inpatient Cardiothoracic Surgeries and Cardiology Service Line

KAWEAH HEALTH ANNUAL BOARD REPORT

Cardiovascular Services - Outpatient Summary

FY2026 Annualized

KEY METRICS - FY 2026 Seven Months Ended January 31, 2026 Annualized

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
47,957	$39,977,802	$28,735,408	$11,242,394	$5,296,331
▲ 6%	▲ 13%	▲ 6%	▲ 33%	▲ 63%

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

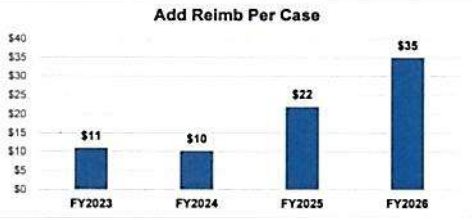
METRICS BY SERVICE LINE - FY 2026

SERVICE LINE	PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
Outpatient Cardiac Cath Lab	3,194	$28,827,943	$17,524,066	$11,303,877	$7,287,765
Outpt. Cardiology Clinic & Non-Inv. Card	34,006	$9,877,517	$8,681,362	$1,196,155	($475,762)
Cardiothoracic Surgery Clinic	554	$61,514	$321,434	($259,921)	($301,895)
Cardiology Clinic Tulare	10,203	$1,210,829	$2,208,546	($997,717)	($1,213,777)
Outpatient Cardiovascular Services Tota	47,957	$39,977,802	$28,735,408	$11,242,394	$5,296,331

METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2023	FY2024	FY2025	*Annualized FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	33,846	41,615	45,253	47,957	▲ 6%	
Net Revenue	$28,869,089	$31,115,899	$35,507,246	$39,977,802	▲ 13%	
Direct Cost	$20,733,750	$23,586,823	$27,035,031	$28,735,408	▲ 6%	
Additional Reimb	$372,815	$425,585	$994,711	$1,676,613	▲ 69%	
Contribution Margin	$8,135,339	$7,529,075	$8,472,215	$11,242,394	▲ 33%	
Indirect Cost	$4,599,359	$4,385,694	$5,218,052	$5,946,063	▲ 14%	
Net Income	$3,535,980	$3,143,381	$3,254,162	$5,296,331	▲ 63%	
Net Revenue Per Case	$853	$748	$785	$834	▲ 6%	
Direct Cost Per Case	$613	$567	$597	$599	▶ 0%	
Add Reimb Per Case	$11	$10	$22	$35	▲ 59%	
Contrb Margin Per Case	$240	$181	$187	$234	▲ 25%	
CM w/o Add Reimb Per Case	$229	$171	$165	$199	▲ 21%	

GRAPHS



Source: Outpatient Service Line Reports
Criteria: Outpatient Service Line (Cardiac Cath Lab, Cardiology Clinic and Non-Invasive Cardiology)

KAWEAH HEALTH ANNUAL BOARD REPORT

Cardiovascular Services - Inpatient Cardiology Service Line

FY2026 Annualized

KEY METRICS - FY 2026 Seven Months Ended January 31, 2026 Annualized

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
2,902	$66,201,776	$46,427,077	$19,774,699	$6,684,820
▲ 4%	▲ 9%	▲ 7%	▲ 14%	▲ 23%

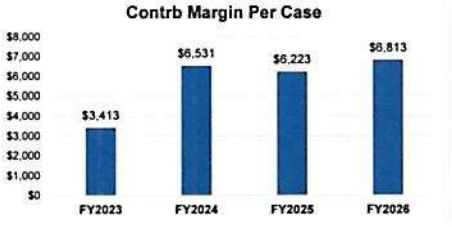
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS SUMMARY - 4 YEAR TREND

*Annualized

METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	2,610	2,692	2,796	2,902	▲ 4%	
Patient Days	12,162	12,527	12,684	12,201	▼ -4%	
ALOS	4.66	4.65	4.54	4.20	▼ -7%	
GM LOS	3.38	3.34	3.28	3.22	▼ -2%	
Opportunity Days	1.28	1.31	1.26	0.99	▼ -22%	
Net Revenue	$47,297,379	$56,362,105	$60,700,296	$66,201,776	▲ 9%	
Direct Cost	$38,390,751	$38,780,199	$43,301,715	$46,427,077	▲ 7%	
Additional Reimb	$4,647,969	$5,604,111	$6,066,295	$7,155,981	▲ 18%	
Contribution Margin	$8,906,627	$17,581,907	$17,398,581	$19,774,699	▲ 14%	
Indirect Cost	$10,455,931	$10,167,171	$11,946,247	$13,089,879	▲ 10%	
Net Income	($1,549,304)	$7,414,735	$5,452,334	$6,684,820	▲ 23%	
Net Revenue Per Case	$18,122	$20,937	$21,710	$22,810	▲ 5%	
Direct Cost Per Case	$14,709	$14,406	$15,487	$15,997	▲ 3%	
Add Reimb Per Case	$1,781	$2,082	$2,170	$2,466	▲ 14%	
Contrb Margin Per Case	$3,413	$6,531	$6,223	$6,813	▲ 9%	
CM w/o Add Reimb Per Case	$1,632	$4,449	$4,053	$4,348	▲ 7%	

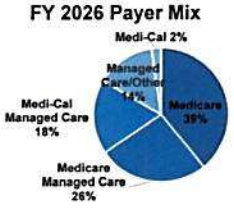
PER CASE TRENDED GRAPHS



PAYER MIX - 4 YEAR TREND (GROSS REVENUE)

*Annualized

PAYER	FY2023	FY2024	FY2025	FY2026
Medicare	42%	38%	38%	39%
Medicare Managed Care	22%	25%	27%	26%
Medi-Cal Managed Care	19%	19%	18%	18%
Managed Care/Other	13%	13%	13%	14%
Medi-Cal	3%	4%	2%	2%



KAWEAH HEALTH ANNUAL BOARD REPORT

Cardiovascular Services - Inpatient Cardiothoracic Surgeries

FY2026 Annualized

KEY METRICS - FY 2026 Seven Months Ended January 31, 2026 Annualized

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
259	$22,001,454	$22,520,328	($518,875)	($3,696,249)
▼ -7%	▲ 2%	▼ -6%	▲ 77%	▲ 52%

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

METRICS SUMMARY - 4 YEAR TREND

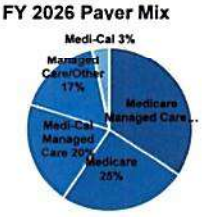
METRIC	FY2023	FY2024	FY2025	FY2026 *Annualized	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	316	310	278	259 ▼	-7%	
Patient Days	3,456	3,449	3,129	2,688 ▼	-14%	
ALOS	10.94	11.13	11.26	10.38 ▼	-8%	
GM LOS	8.37	8.06	8.45	8.65 ▲	2%	
Opportunity Days	2.56	3.07	2.81	1.73 ▼	-38%	
Net Revenue	$21,033,114	$23,805,012	$21,666,139	$22,001,454 ▲	2%	
Direct Cost	$24,367,698	$23,422,508	$23,897,095	$22,520,328 ▼	-6%	
Additional Reimb	$2,139,356	$2,849,847	$1,949,325	$2,319,928 ▲	19%	
Contribution Margin	($3,334,584)	$382,503	($2,230,956)	($518,875) ▲	77%	
Indirect Cost	$5,227,490	$4,589,269	$5,472,459	$3,177,374 ▼	-42%	
Net Income	($8,562,074)	($4,206,766)	($7,703,415)	($3,696,249) ▲	52%	
Net Revenue Per Case	$66,560	$76,790	$77,936	$84,995 ▲	9%	
Direct Cost Per Case	$77,113	$75,556	$85,961	$86,999 ▲	1%	
Add Reimb Per Case	$6,770	$9,193	$7,012	$8,962 ▲	28%	
Contrb Margin Per Case	($10,552)	$1,234	($8,025)	($2,004) ▲	75%	
CM w/o Add Reimb Per Case	($17,323)	($7,959)	($15,037)	($10,967) ▲	27%	

PER CASE TRENDED GRAPHS

PAYER MIX - 4 YEAR TREND (GROSS REVENUE)

*Annualized

PAYER	FY2023	FY2024	FY2025	FY2026
Medicare Managed Care	21%	25%	27%	34%
Medicare	38%	28%	34%	25%
Medi-Cal Managed Care	12%	25%	17%	20%
Managed Care/Other	24%	19%	18%	17%
Medi-Cal	5%	3%	4%	3%



KAWEAH HEALTH ANNUAL BOARD REPORT

Cardiovascular Services - OP Cardiac Cath Lab

FY2026 Annualized

KEY METRICS - FY 2026 Seven Months Ended January 31, 2026 Annualized

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
3,194	$28,827,943	$17,524,066	$11,303,877	$7,287,765
▲ 5%	▲ 15%	▲ 14%	▲ 16%	▲ 14%

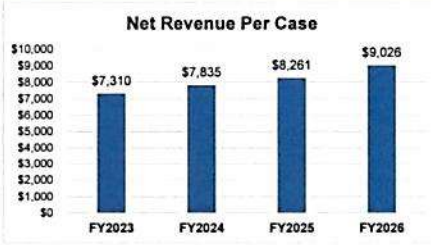
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS SUMMARY - 4 YEAR TREND

*Annualized

METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	2,695	2,765	3,039	3,194 ▲	5%	
Net Revenue	$19,701,129	$21,662,523	$25,104,291	$28,827,943 ▲	15%	
Direct Cost	$13,913,326	$14,250,292	$15,359,998	$17,524,066 ▲	14%	
Additional Reimb	$43,501	$30,230	$75,064	$116,452 ▲	55%	
Contribution Margin	$5,787,803	$7,412,231	$9,744,293	$11,303,877 ▲	16%	
Indirect Cost	$3,182,357	$2,950,246	$3,376,427	$4,016,112 ▲	19%	
Net Income	$2,605,446	$4,461,984	$6,367,866	$7,287,765 ▲	14%	
Net Revenue Per Case	$7,310	$7,835	$8,261	$9,026 ▲	9%	
Direct Cost Per Case	$5,163	$5,154	$5,054	$5,487 ▲	9%	
Add Reimb Per Case	$16	$11	$25	$36 ▲	48%	
Contrb Margin Per Case	$2,148	$2,681	$3,206	$3,539 ▲	10%	
CM w/o Add Reimb Per Case	$2,131	$2,670	$3,182	$3,503 ▲	10%	

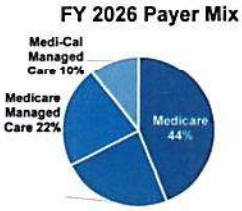
PER CASE TRENDED GRAPHS



PAYER MIX - 4 YEAR TREND (Patient Visits)

*Annualized

PAYER	FY2023	FY2024	FY2025	FY2026
Medicare	44%	44%	44%	44%
Managed Care/Other	22%	21%	23%	23%
Medicare Managed Care	19%	23%	20%	22%
Medi-Cal Managed Care	13%	11%	12%	10%



KAWEAH HEALTH ANNUAL BOARD REPORT

FY2026 Annualized

Cardiovascular Services - Outpatient Cardiology Clinic & Non-Invasive Cardiology

KEY METRICS - FY 2026 Seven Months Ended January 31, 2026 Annualized

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
34,006	$9,877,517	$8,681,362	$1,196,155	($475,762)
▶ 0%	▲ 4%	▼ -8%	▲ 15668%	▲ 70%

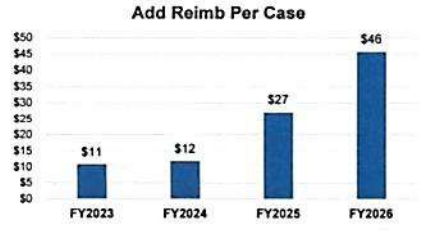
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS SUMMARY - 4 YEAR TREND

*Annualized

METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	30,323	33,247	33,843	34,006	▶ 0%	
Net Revenue	$9,078,315	$8,758,785	$9,487,146	$9,877,517	▲ 4%	
Direct Cost	$6,616,723	$7,478,864	$9,479,559	$8,681,362	▼ -8%	
Additional Reimb	$329,314	$395,355	$919,066	$1,556,174	▲ 69%	
Contribution Margin	$2,461,592	$1,279,921	$7,586	$1,196,155	▲ 15668%	
Indirect Cost	$1,416,989	$1,273,344	$1,612,613	$1,671,917	▲ 4%	
Net Income	$1,044,603	$6,577	($1,605,027)	($475,762)	▲ 70%	
Net Revenue Per Case	$299	$263	$280	$290	▲ 4%	
Direct Cost Per Case	$218	$225	$280	$255	▼ -9%	
Add Reimb Per Case	$11	$12	$27	$46	▲ 69%	
Contrb Margin Per Case	$81	$38	$0	$35	▲ 15592%	
CM w/o Add Reimb Per Case	$70	$27	($27)	($11)	▲ 61%	

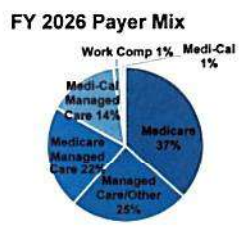
PER CASE TRENDED GRAPHS



PAYER MIX - 4 YEAR TREND (Patient Visits)

*Annualized

PAYER	FY2023	FY2024	FY2025	FY2026
Medicare	38%	38%	37%	37%
Managed Care/Other	25%	25%	24%	25%
Medicare Managed Care	17%	21%	21%	22%
Medi-Cal Managed Care	17%	13%	14%	14%
Work Comp	1%	1%	1%	1%
Medi-Cal	2%	1%	1%	1%



KAWEAH HEALTH ANNUAL BOARD REPORT

Cardiovascular Services - Outpatient Kaweah Health Cardiothoracic

FY2026 Annualized

KEY METRICS - FY 2026 Seven Months Ended January 31, 2026 Annualized

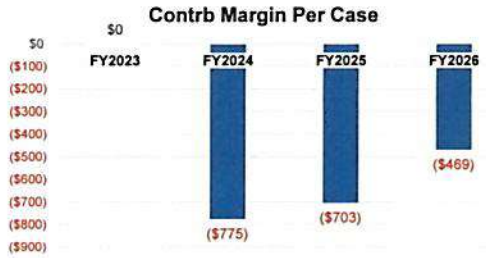
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
554	$61,514	$321,434	($259,921)	($301,895)
▲ 12%	▲ 7%	▼ -21%	▲ 25%	▲ 22%

*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	0	363	495	554	▲ 12%	
Net Revenue	$0	$49,572	$57,225	$61,514	▲ 7%	
Direct Cost	$0	$331,059	$405,422	$321,434	▼ -21%	
Contribution Margin	$0	($281,486)	($348,197)	($259,921)	▲ 25%	
Indirect Cost	$0	$0	$37,092	$41,974	▲ 13%	
Net Income	$0	($281,486)	($385,289)	($301,895)	▲ 22%	
Net Revenue Per Case	$0	$137	$116	$111	▼ -4%	
Direct Cost Per Case	$0	$912	$819	$581	▼ -29%	
Contrb Margin Per Case	$0	($775)	($703)	($469)	▲ 33%	

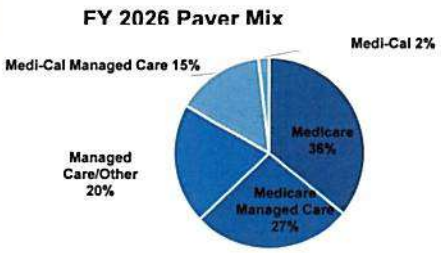
PER CASE TRENDED GRAPHS



PAYER MIX - 4 YEAR TREND (Patient Visits)

*Annualized

PAYER	FY2023	FY2024	FY2025	FY2026
Medicare	0%	44%	38%	36%
Medicare Managed Care	0%	22%	28%	27%
Managed Care/Other	0%	22%	21%	20%
Medi-Cal Managed Care	0%	10%	12%	15%
Medi-Cal	0%	1%	1%	2%



KAWEAH HEALTH ANNUAL BOARD REPORT

FY2026 Annualized

Cardiovascular Services - Outpatient Kaweah Health Cardiology Clinic Tulare

KEY METRICS - FY 2026 Seven Months Ended January 31, 2026 Annualized

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
10,203	$1,210,829	$2,208,546	($997,717)	($1,213,777)
▲ 30%	▲ 41%	▲ 23%	▼ -7%	▼ -8%

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

METRICS SUMMARY - 4 YEAR TREND

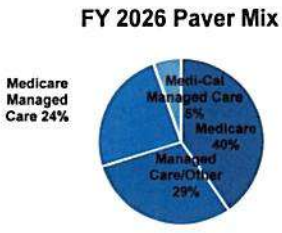
METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	828	5,240	7,876	10,203	▲ 30%	
Net Revenue	$89,644	$645,019	$858,585	$1,210,829	▲ 41%	
Direct Cost	$203,701	$1,526,609	$1,790,052	$2,208,546	▲ 23%	
Contribution Margin	($114,057)	($881,590)	($931,467)	($997,717)	▼ -7%	
Indirect Cost	$13	$162,104	$191,921	$216,059	▲ 13%	
Net Income	($114,069)	($1,043,694)	($1,123,388)	($1,213,777)	▼ -8%	
Net Revenue Per Case	$108	$123	$109	$119	▲ 9%	
Direct Cost Per Case	$246	$291	$227	$216	▼ -5%	
Contrb Margin Per Case	($138)	($168)	($118)	($98)	▲ 17%	

PER CASE TRENDED GRAPHS

PAYER MIX - 4 YEAR TREND (Patient Visits)

*Annualized

PAYER	FY2023	FY2024	FY2025	FY2026
Medicare	39%	40%	41%	40%
Managed Care/Other	38%	37%	30%	29%
Medicare Managed Care	22%	22%	24%	24%
Medi-Cal Managed Care	0%	1%	4%	5%



February 4, 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 February 4, 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; Nou Her, Sr. Social Media Specialist; 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 December 3, 2025, were reviewed.

COMMUNITY EXPERIENCE –

2.1. Discussion on agenda item deferred.
2.2. Deborah provided a quarterly report regarding community activities and current trends. (see Attachment 2.2. of the agenda)

MARKETING & MEDIA RELATIONS –

3.1.1. – Amee presented the results of the Private Home Care Mailer Campaign. (see attachment 3.1.1 of the agenda.)
3.1.2. – A verbal update was provided regarding the February issue of Vital Signs. (see attachment 3.1.2 of the agenda)
3.1.3. – Kaweah Health will have new signage at Visalia Rawhide. (see attachment 3.1.3 of the agenda)
3.1.4. – Two new TV commercial drafts were presented for review.
3.1.5. – Discussion on agenda item deferred.
3.1.6. – An update was provided regarding the Medscape campaign. (see attachment 3.1.6 of the agenda)

Kaweah Delta Health Care District
Board of Directors Committee
Meeting Minutes

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

3.1.7. – An update was presented on the ongoing Primary Care campaign. (see attachment 3.1.7 of the agenda)
3.1.8. – Discussion on agenda item deferred.
3.1.9. – Upcoming February initiatives were announced. (see attachment 3.1.9 of the agenda)
3.2. – A report on recent marketing performance and engagement metrics was shared. (see attachment 3.2. of the agenda.

Adjourned at 4:51 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.

February 18, 2026

Kaweah Delta Health Care District
Board of Directors Committee Meeting

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

Kaweah Health
MORE THAN MEDICINE. LIFE.

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 February 18, 2025

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

OPEN MEETING – Called to order at 10:07AM

PUBLIC PARTICIPATION –None

MINUTES- Reviewed and forward to the Board for approval.

SEMI ANNUAL INVESTMENTS REPORT- Review of report ending December 31, 2026. This was recommended to forward to the Board for approval on consent calendar.

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

ADJOURN – 11:12am *David Francis, Board Secretary/Treasurer*

February 19, 2026

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

Attending: Board Members: Dr. Dean Levitan, Chair; Jonna Schengel, Board Member; Jag Batth, Chief Operation Officer; Dr. Paul Stefanacci, Chief Medical Officer; Scott Baker, Interim Chief Nursing Officer; Malinda Tupper, Chief Financial Officer; Evelyn McEntire, Director of Risk Management; Shawn Elkin, Infection Prevention Manager; Chris Patty, Clinical Practice Guidelines Program Manager; Ayham Zoreikat, Director of Cardiovascular Services; Megan Stuart, RN Clinical Care QA (Recording); Martha Cardenas, RN Clinical Care QA;

Dr. Dean Levitan called to order at 8:03 AM.

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

Dr. Dean Levitan adjourned the meeting at 8:33 AM.

Public Participation – None.
Dr. Dean Levitan called to order at 8:35 AM.

4. **Review of January Quality Council Open Session Minutes –** Dr. Dean Levitan, Board Member
    - Reviewed and acknowledged the December Quality Council Open Session Minutes by Dr. Dean Levitan. No further actions.

5. **Written Quality Reports –** a review of key quality metrics and actions associated with the following improvement initiatives: Reports reviewed, accepted, and attached in minutes. No action taken.
    a. **Annual Review of Quality and Patient Safety Plans**

6. **Cardiac Surgery Service Line –** A review of key process and outcomes measures related to cardiac surgery service line. Ayham Zoreikat, Director of Cardiovascular Services. Report reviewed and attached in minutes. Committee requested to bring back report to revisit when the next scheduled reporting calendar.

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

Adjourn Open Meeting – *Dr. Dean Levitan*
Mike Olmos adjourned the meeting at 9:12 AM.

10

MINUTES OF THE SPECIAL OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD TUESDAY FEBRUARY 10, 2026, AT 10:00AM IN THE EXECUTIVE OFFICE CONFERENCE ROOM – 305 W. ACEQUIA, VISALIA, CA.

PRESENT: Directors Olmos, Francis, Levitan, & Murrieta; Marc Mertz, CEO; and K. Davis, recording

The meeting was called to order at 10:00 AM by Director Francis.

PUBLIC PARTICIPATION –None.

KAWEAH DELTA HEALTH CARE DISTRICT BAORD OF DIRECTORS- ZONE II- The board met to review the applications for Zone II vacancy and proceeded with interviewing 2 out of the six applicants. Jonna Schengel and Steven Koobatian.

ADJOURN - Meeting was adjourned at 10:57AM

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

12,

MINUTES OF THE SPECIAL OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD TUESDAY FEBRUARY 12, 2026, AT 2:00PM IN THE EXECUTIVE OFFICE CONFERENCE ROOM – 305 W. ACEQUIA, VISALIA, CA.

PRESENT: Directors Olmos, Francis, and Levitan; Marc Mertz, CEO; and K. Davis, recording

The meeting was called to order at 2:00 PM by Director Francis.

PUBLIC PARTICIPATION –None.

KAWEAH DELTA HEALTH CARE DISTRICT BAORD OF DIRECTORS- ZONE II- The board met to interview 2 out of the six applicants. Jonna Schengel and Steven Koobatian.

Dave asked for a motion to approve Jonna Schengel as Kaweah Health's Zone II Board Appointment until the term is up in November.

MMSC (Olmos/Levitan) to approve the appointment of Jonna Schengel as Kaweah Health's Zone II Board Member.

This was supported unanimously by those present. Vote: 3 Yes – Olmos, and Francis. 1- Murrieta was absent.

ADJOURN - Meeting was adjourned at 3:45PM

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

February

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD WEDNESDAY FEBRUARY 25, 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; 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 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

25, 2026

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD WEDNESDAY FEBRUARY 25, 2026, AT 4:45PM 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 5:08 PM by Director Francis.

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

FLAG SALUTE- Director Francis lead the flag salute.

PUBLIC PARTICIPATION – None.

CLOSED SESSION ACTION TAKEN: In closed session the board approved the Medical Executive Committee's credentialing recommendations for February 2026. There was also action taken by the Board to reject two claims on its merits pursuant to Government Code Section 54956.9. And finally the board approved the closed meeting minutes from January 2026.

RECOGNITIONS- Resolution 2281, 2282.

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

- Doctors Day Celebration is in March.

CONSENT CALENDAR – Director Francis entertained a motion to approve the February 25, 2026, consent calendar.

PUBLIC PARTICIPATION – None.

MMSC (Murrieta/Levitan) to approve the February 25, 2026, consent calendar.. This was supported unanimously by those present. Vote: Yes – Olmos, Levitan, Murrieta, Schengel, and Francis.

CARDIAC SERVICE LINE REPORT–Overview of initiatives, outcomes and emerging priorities related to cardiac surgery service line and inclusive practices. – (attached hereto the minutes is the presentation presented by Ayham and Dr. Bansal.

STRATEGIC PLANNIGN INITIATIVE – PATIENT AND COMMUNITY EXPERIENCE – Presented by Deborah Volosin regarding the strategic growth and innovation initiative, including strategic objectives, implementation framework and anticipated outcomes. – (Attached hereto the minutes is the presentation presented by Deborah Volosin.)

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

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

REPORTS
Chief Executive Officer Report – Updates on Joint Commission and Moonshine Soiree. – *Marc Mertz, CEO*
Board President- None. – *David Francis, Board President*

ADJOURN - Meeting was adjourned at 6:13PM

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

ATTEST:

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

AP 180 Weapons Brought Into the District

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	

Administrative Manual

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	

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:~~

- ~~Firearms~~
- ~~Edged 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)~~
- ~~Explosives~~
- ~~Incendiary 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. Weapons that are discovered after arrival should be returned to the owner's vehicle or turned in to Security for safekeeping.~~

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

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 o~~O~~n~~N~~-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 ~~departmen~~agency~~t~~ 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~~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.):

1) Have the patient secure their weapon in their home or vehicle
2) Have the patient return for service when they are unarmed
3) 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 ~~OFF~~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.

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.

"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."

MS 52 Use of External Proctors

Policy Number: MS 52	Date Created: 08/19/2025
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)	

Use of External Proctors

Purpose: To provide guidelines for the application and assessment ~~to~~of outside proctors.~~.~~

Policy: Whenever a new procedure, non-procedural skill or technology has been approved and an outside proctor is required, the outside proctor will be evaluated using the procedure outlined below.

Outside Proctors, whether vendor sponsored or identified by other means will be allowed to function on an observational level and will not be involved in the procedure, non-procedure skill or technology with any hands-on participation and at any level that would constitute the practice of medicine, including the participation in a clinical intervention with a patient. Outside Proctors shall not be members of the Medical Staff of Kaweah Health and shall not have access to any of the rights or prerogatives of membership and shall abide by all applicable hospital and Medical Staff Bylaws, Rules and Regulations and other governance documents.

~~based upon current licensure (U.S.) and current membership of the Active medical staff at a Joint Commission accredited acute care hospital where he/she currently holds privileges for the procedure he/she is proctoring. Documentation of the applicant's current clinical activity performing the noted procedure is required and will be requested from the current hospital(s). The outside proctor is expected only to proctor (observe and report) and not to assist with patient care.~~

Procedure:

I. Outside Proctor Request

Individuals or vendors on their behalf requesting to be an outside proctor ~~or companies requesting an outside proctor to come in~~ will be provided an ~~application (~~Outside Proctor Application~~)~~ which must be completed by the applicant and returned to the Credentialing Services office at least ten (10) working days prior to the date of procedure with a minimum of the following:

1. Completed Application ~~(all information provided including fax numbers~~ and signed Consent and Release~~)~~

2. Current Curriculum Vitae (CV)
3. ~~Current~~ Valid ~~Photo~~ Government Issued ID in ~~(must be~~ in color~~)~~
~~3.~~
4. Copy of current PPD result (must be within the last 12 months)
5. If positive reactor to PPD, completion of TB Screening Affidavit Form is required which notes the date and result of most recent chest x-ray result
6. Copy of current Flu vaccination (if during influenza season) or Completion of declination form
~~6.~~7. Copy of most recent COVID Booster or Completion of declination form

II. Processing the Application

When the application is returned, a review for completeness is performed by the Credentialing Services office. If the application is incomplete, it will be returned to the applicant.

If the application is complete, the Credentialing Services office will process as follows:

1. Current U.S. state medical license will be verified (license must be current and unrestricted)
2. Medicare/Medicaid Sanction verification (OIG)
3. Written or verbal verification from current hospital affiliation(s) where applicant is on the Active staff and holds privileges for the procedure to be proctored will be requested.
4. A clinical activity report will be requested from the institution ~~to verify that~~ where the applicant is currently performing the procedure to be proctored. ~~here.~~ The ~~R~~report shall span a twenty-four (24) month ~~will be requested for the last two (2) year~~ period showing the Outside Proctor meets the minimum ~~.~~number as required by Kaweah Health. The documentation must attest to their experience and satisfactory outcomes in the technology, procedure or non-procedural skill to be proctored.

~~4.~~ Additionally, the proctor shall be approved by the Chair of the Department.

5.

6. Information gathered on the application will be verified by the primary source. 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.

III. Approval Process

1. Once all verifications and clinical activity report are received, the application and supportive documentation are made available to the Chief of Staff for review and approval.
2. If approved, the Chief of Staff will appoint the outside proctor as an ex-officio department member.
3. The Medical Staff Services ~~Credentialing Services~~ office will email notification of approval to the applicant and appropriate hospital personnel.
4. On the day of procedure(s), outside proctor is required to pick up Proctor badge and blank proctor forms from Medical Staff Services Office.

IV. Outside Proctor Responsibilities

The Outside Proctor's duties and responsibilities are limited to the following:

~~IV.~~

1. Providing instruction and training to the Kaweah Health member of the medical staff or Advanced Practice Professional in order that they become proficient in the procedure, non-procedural skill or technology, to include both the utilization of technical and cognitive skills;

2. Serving as a guide and resource to the Kaweah Health member of the medical staff or Advanced Practice Professional during procedures;
1. Serving as a guide and resource to the Kaweah Health member of the medical staff or Advanced Practice Professional for pre-procedural preparation;
2. Providing post-procedural feedback to the Kaweah Health member of the medical staff or Advanced Practice Professional;
3. Providing additional training to the Kaweah Health member of the medical staff or Advanced Practice Professional, as needed;
4. Participating in the evaluation of Kaweah Health member of the medical staff or Advanced Practice Professional with respect to whether proficiency has been attained in the procedure or non-procedure; and
5. Providing written or oral updates and reports on the Kaweah Health member of the medical staff or Advanced Practice Professional's activities when and as requested.

~~1. The outside proctor is expected only to proctor (observe and report) and is not authorized to assist with patient care.~~
~~2. The outside proctor will directly observe and evaluate the procedure being performed via the proctor form.~~
~~3. It is the outside proctor's responsibility to report any poor or significantly substandard performances.~~
~~4. After procedure has been performed, a proctor form is completed by the outside proctor immediately following the procedure.~~
~~5. Prior to leaving the facility, the completed proctor form is returned to the Credentialing Services office at the time the Proctor badge is returned.~~

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable ~~approach, but~~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."

MS 53 Temporary Privileges

Policy Number: MS 53	Date Created: 09/19/2025
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)	

Temporary Privileges

Policy:

Temporary privileges may be considered if eligibility requirements are met as outlined in the Medical Staff Bylaws section 5.B. Additionally, all required documentation has been received, all items requiring verification have been verified, and there are no significant concerns, e.g., discrepancies in information, gaps, unfavorable recommendations, or negative responses concerning the applicant's qualifications for privileges. All applications for temporary privileges will be evaluated based upon current licensure, education, training or experience, current competence and ability to perform the clinical privileges requested.

Procedure (See Attachment A for flow chart of application process):

I. **New Applicants (pending final approval of application by Board of Directors)**

Perform the steps below for individuals requesting temporary privileges if their application is pending review by the MEC and the Board following a favorable recommendation by the Credentials Committee after considering the evaluation of the department chair (after completion of the New Applicant process; see the Credentialing and Privileging of Medical Staff & Advanced Practice Providers -Policy MS 48):

A. Online verifications of the following (in addition to verifications already completed for initial application process)
   1. CA Medical or Professional License
   2. CA Furnishing License (if applicable)
   3. OIG
   4. NPDB

B. Temporary Privileges Approval Form
   1. Follow steps under "Temporary Privileges Approval Form" in Temporary Privileges Process/Follow-Up Procedure

C. Approval
   1. The application, temporary privileges approval form, privilege request form and supportive documentation are made available to the following signatories for reviews and signatures:

a. Department Chair (or designee)
b. Chief of Staff (or designee)
c. Chief Medical Officer (or designee, if applicable)
d. Chief Executive Officer (or designee)

D. Follow-Up Procedure
1. Follow steps starting under “Soarian Financials” in Temporary Privileges Process/Follow-Up Procedure

II. Locum Tenens

Individuals requesting temporary privileges as a locum tenens covering for a member of the medical staff or an advanced practice provider who is ill, on vacation, attending an educational seminar or when necessary to prevent a lack or lapse of services in a needed specialty area will be provided a link to the Online Application on the MD Staff website. Content of the website will include:

A. Application including licensure information on any active or inactive licenses, DEA registration, Education History, Work History, Insurance History and complete information for Peer References
B. Attestation Questionnaire
C. Authorization to Release Information Form
D. Professional Liability Questionnaire
E. Claims Status Form, to be completed for each Open and Closed claim in the last five (5) years
F. Health Screening Requirements (PPD, Influenza Vaccination)
G. Background Release Form
H. Continuing Education Attestation Form
I. Confidentiality and Conflict of Interest Statement of Compliance
J. Medicare Acknowledgment Statement
K. Code of Conduct and Professional Behavior
L. Privilege Forms
M. Medical Staff Bylaws, Rules & Regulations
N. A copy of a current government-issued photo ID
O. 2x2 recent color photo required to be uploaded on the online application
P. Current Curriculum Vitae (CV) documented in months and years
Q. Signature Attestation
R. Online verifications of the following:
1. CA Medical or Professional License
2. CA Furnishing License (if applicable)
3. OIG
4. NPDB
S. Temporary Privileges Approval Form
1. 1. Follow steps under “Temporary Privileges Approval Form” in Temporary Privileges Process/Follow-Up Procedure
T. Approval
1. The application, temporary privileges approval form, privilege request form and supportive documentation are made available to the following signatories for reviews and signatures:
a. Department Chair (or designee)
b. Chief of Staff (or designee)

c. Chief Medical Officer (or designee, if applicable)
d. Chief Executive Officer (or designee)

U. Follow-Up Procedure
1. Follow steps starting under "Soarian Financials" in Temporary Privileges Process/Follow-Up Procedure

III. Visiting

Individuals requesting temporary privileges when there is an important patient care, treatment or service need such as: a) the care of a specific patient; or b) when a proctoring or consulting physician is needed, but is otherwise unavailable will be provided a link to the Online Application on the MD Staff website. Content of the website will include:

A. Application including licensure information on any active or inactive licenses, DEA registration, Education History, Work History, Insurance History and complete information for Peer References
B. Attestation Questionnaire
C. Authorization to Release Information Form
D. Professional Liability Questionnaire
E. Claims Status Form, to be completed for each Open and Closed claim in the last five (5) years
F. Health Screening Requirements (PPD, Influenza Vaccination)
G. Background Release Form
H. Continuing Education Attestation Form
I. Confidentiality and Conflict of Interest Statement of Compliance
J. Medicare Acknowledgment Statement
K. Code of Conduct and Professional Behavior
L. Privilege Forms
M. Medical Staff Bylaws, Rules & Regulations
N. A copy of a current government-issued photo ID
O. 2x2 recent color photo required to be uploaded on the online application
P. Current Curriculum Vitae (CV) documented in months and years
Q. Signature Attestation
R. Online verifications of the following:
1. CA Medical or Professional License
2. CA Furnishing License (if applicable)
3. OIG
4. NPDB
S. Temporary Privileges Approval Form
1. Follow steps under "Temporary Privileges Approval Form" in Temporary Privileges Process/Follow-Up Procedure
T. Approval
1. The application, temporary privileges approval form, privilege request form and supportive documentation are made available to the following signatories for reviews and signatures:
a. Department Chair (or designee)
b. Chief of Staff (or designee)
c. Chief Medical Officer (or designee, if applicable)
d. Chief Executive Officer (or designee)
U. Follow-Up Procedure

1. Follow steps starting under “Soarian Financials” in Temporary Privileges Process/Follow-Up Procedure

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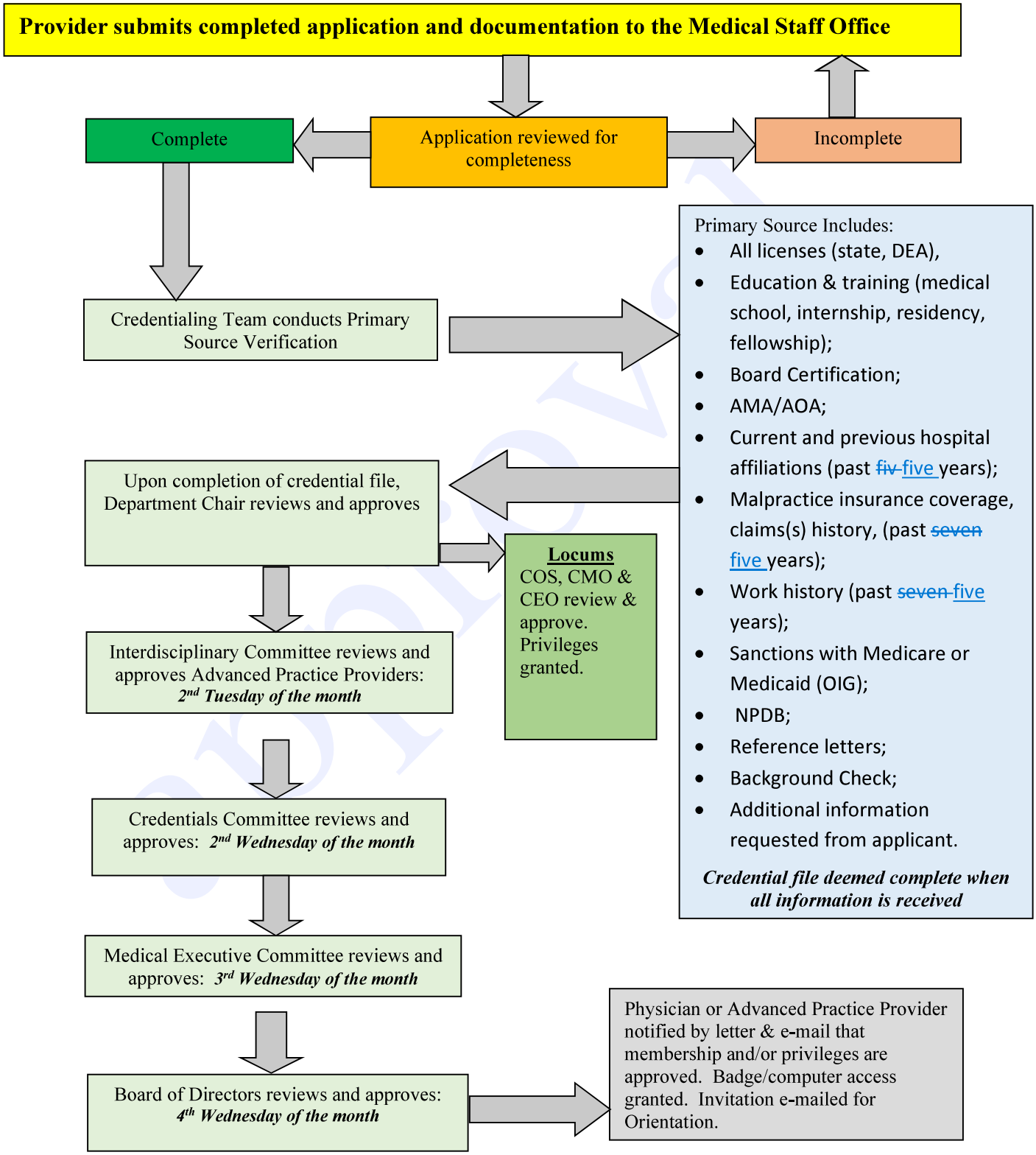
ATTACHMENT A

Kaweah Health
Medical Staff Credentialing Process



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."

MS 25 Rescinded or Lapsed Membership and/or Privileges Policy

Policy Number: MS 25	Date Created: 11/01/2001
Document Owner: Ody DaSilva (Medical Staff Manager)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Medical Executive Committee, Shannon Vinson (Director of Medical Staff Services)	

Rescinded or Lapsed Membership and/or Privileges Policy

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

POLICY:

It shall be the policy of the medical staff to consider an individual's request to rescind their resignation and/or reestablish medical staff and/or ~~/a~~Advanced ~~p~~Practice ~~p~~Professional (APP)~~vider staff~~ membership and/or privileges if the:

- Resignation or voluntary lapse in membership and/or privileges occurred within the previous 12 months.
- Individual resigned or voluntarily allowed their membership and/or privileges to lapse while in good standing.
- Individual not currently the subject of discipline or investigation by a licensing authority, governmental or regulatory body or other health care entity.

PROCEDURE:

The individual shall have the burden of proof in providing or complying with each of the following:

- A completed reappointment application accompanied by other documents required for reappraisal purposes, as defined in the medical staff bylaws.
- A signed statement regarding interval activity from date of resignation to present.
- Payment of Medical Staff fees, as appropriate.
- Appearance at a professional ~~interview,~~interview should it be determined necessary.
- The Department Chair will review and recommend reinstatement through the end of the practitioner's original term of appointment. Approval process will follow the process defined in the Medical Staff Bylaws.

- If the relinquishment and/or resignation was due to an administrative error, the Department Chair may recommend temporary privileges until the reinstatement is approved through the process defined in the Medical Staff Bylaws.

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MS 33 Reporting Guidelines

Policy Number: MS 33	Date Created: 06/01/2011
Document Owner: Ody DaSilva (Medical Staff Manager)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Medical Executive Committee, Shannon Vinson (Director of Medical Staff Services)	

Reporting Guidelines

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

I. Policy

State and Federal Governments require specific disciplinary actions against Practitioners to be reported. This purpose of this policy is to provide guidance what must be reported and required timelines.

II. Procedure

State Reporting

California Business and Professional Code Section 805 ~~requires that~~ mandates that peer review bodies and healthcare facilities report specific disciplinary actions against licensed healthcare professionals to the relevant state licensing agency. These reports, known as "805 reports," are required within 15 days of the effective date of actions like suspension or restriction of clinical privileges and must detail the reasons for the action, which must relate to a "medical disciplinary cause or reason" detrimental to patient safety or care. ~~disciplinary actions against physicians be reported to the California Medical Board and the California Osteopathic Medical Board.~~

Kaweah Health Medical Staff Office follows established guidelines for Section 805 reporting found at the following Board sites:

- Physicians
  - Medical Board of California
  - Osteopathic Medical Board of California
- Dentists
  - Dental Board of California
- Podiatrists
  - Podiatric Medical Board of California
- Nurse Practitioners, Certified Nurse Midwives & Certified Registered Nurse Anesthetists
  - California Board of Registered Nursing
- Physician Assistants
  - California Physician Assistant Board

~~https://www.mbc.ca.gov/Forms/Health_Facility_Reporting_FAQ.aspx~~
~~https://www.ombc.ca.gov/forms_pubs/~~

Federal Reporting

Reports for specific disciplinary actions against practitioners must be filed with the National Practitioner Data Base (NPDB). Kaweah Health Medical Staff Office follows established guidelines for reporting to the NPDB found at the following site: https://www.npdb.hrsa.gov/

~~https://www.npdb.hrsa.gov/hcorg/whatYouMustReportToTheDataBank.jsp~~

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MS 101 Red Rules

Policy Number: MS.101	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)	

Red Rules

Policy: ~~To detail practices included by approved Red Rules for staff members and responsibilities of staff members to implement and comply with Red Rules.~~The Red Rules policy provides guidance and focuses attention on actions or processes that are critical to the safety of our patients and employees. Red Rules must be followed exactly as specified except in rare or urgent situations.

Policy:

I. There are certain practices that are maintained by this facility. These practices include the following:

   a. Strong research evidence that the "Red Rules" will improve patient outcomes;
   b. Evidence from other ~~high risk~~high-risk industries that the "Red Rules" will improve patient safety;
   c. Regulatory and / or
   d. Ethical imperatives.

II. A "Red Rule" has written policy to support it and includes a simple (noncomplex) process that can be done.

III. Communication is given to the appropriate personnel for whom the "Red Rule" applies.

IV. Approval of a "Red Rule" is required by the Medical Executive Committee and by the ~~KDHCD~~ Kaweah Health Board of Directors.

Red Rules

I. Approved Red Rules include the following:

1. Time Outs: The "time-out" is a physician/proceduralist led safety strategy to ensure the correct procedure is performed on the correct patient on the correct side. A time-out consists of a deliberate pause by the healthcare team immediately prior to beginning a surgery or invasive procedure. All team members must suspend all activities until the time-out has been completed. This includes procedures performed in the Emergency Department, Catholicization Laboratory, Gastroenterology Laboratory, Radiology, at the bedside, or elsewhere.

~~1.~~

- ~~Physician / proceduralist led~~

Responsibilities / Implementation

I. Responsibility for implementing Red Rules is shared by members of the healthcare team, individually and collectively. This includes physicians, nursing staff, and other clinical and non-clinical staff members.

II. Medical Staff leadership is expected to bear responsibility for the physician's role in leading this process.

III. Staff is supported when reporting the violation of a "Red Rule."

IV. Management of initial non-compliance is addressed by the department chair. Subsequent violations are addressed by the Chief Medical Officer, Chief of the Medical Staff, and Department Chair.

V. Hospital staff members are addressed by Human Resources (HR) policies.

VI. Red Rules are implemented and reassessed as needed.

References:

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MS 02 Medical Staff Well-Being Committee

Policy Number: MS 02	Date Created: 02/01/2007
Document Owner: Ody DaSilva (Medical Staff Manager)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Medical Executive Committee, Shannon Vinson (Director of Medical Staff Services)	

MEDICAL STAFF WELL-BEING COMMITTEE

PURPOSE:

In order to maintain and improve the quality of care and assist staff members in the maintenance of appropriate standards of personal performance, the medical staff Well-Being Committee (WBC) is responsible to take note of and to evaluate issues related to the health, well-being or impairment of medical staff/allied health members.

DEFINITION:

1. Impaired practitioner: one who is unable to practice medicine with reasonable skill and safety to patients because of physical or mental illness, including deterioration through the aging process or loss of motor skill, or abuse or excessive use of drugs, including alcohol.

   Recognition of impairment of practitioners:
   a. Irritability: mood swings; negative attitude; argumentative; inappropriate anger; overreaction of criticism; altercations with staff, peers and patients; “personality change”
   b. Inaccessibility: frequent tardiness; frequent absence; “MIA” missing in action (frequent trips to bathroom, parking lot); prolonged lunch breaks; unavailable when on call; frequent beeper failure; frequent illness
   c. Cognitive impairment: lack of concentration; confusion; forgetfulness; difficulty thinking/speaking
   d. Physical impairment (resulting in the inability to provide optimal patient care): loss of motor skills; problems with balance; poor coordination and clumsiness
   e. Mental impairment: disruption in thinking, feeling, moods, and ability to relate to others
   f. Incidentals: disheveled appearance; tremors; “green tongue” from mints; bruises; needle tracks; heaving drinking at staff or social functions; off-duty intoxication; runny nose; raspy voice; alcohol on breath; red, yellow or black and blue eyes; dilated or constricted pupils; staff, patient or peer complaints; slurred speech; black outs; subject of hospital gossip (marital problems, DUI, financial problems, “party” reputation, etc.)

COMPOSITION:

A minimum of five (5) active members of the medical staff shall be appointed by the chief of staff, a majority of whom, including the chair, shall be physicians. The membership shall include a psychiatrist and up to 5 immediate Past Chiefs of Staff who no longer serve on MEC. Except for initial appointments, each shall serve a term of two (2) years, and the terms shall be staggered. Insofar as possible, members of the committee shall not serve as active participants on other peer review or quality improvement committees while serving on this committee.

Individuals who are not members of the medical staff may be appointed when such appointment will materially increase the effectiveness of the work of the committee.

Involvement of the following qualified physicians is desirable:

1. Physician recovering from alcoholism and/or other chemical dependence;
2. Psychiatrist or physician with mental health and/or addiction medicine training

RESPONSIBILITIES:

The role of the Well-Being Committee is advisory in nature, and not a substitute for a personal physician or a disciplinary body. The Committee's focus should be the needs of the physician in question. It will report only to MEC and to the physician in question.

The Committee:

1. Will be the identified point within the District where information and concerns about the health of an individual medical/allied health member can be delivered for consideration and evaluation.

2. May receive and assess reports related to the health, well-being or impairment of medical/allied health staff members; seek corroboration and additional information.

3. The referring source will be advised that follow-up action was taken.

4. Provide advice, recommendations and assistance to the Practitioner in question; provide recommendations for treatment and/or education; provide assistance in obtaining what is recommended.

5. Monitor Practitioner for compliance with the terms of a monitoring agreement.

6. Assist Practitioner with reinstatement issues.

7. Educate Practitioners and other organization staff about physician health, well-being and impairment; about appropriate responses to different levels and kinds of distress and impairment; about treatment, recovery and monitoring; about the responsibilities of the medical staff in response to concerns about a

Practitioner's health; and about appropriate resources for prevention, treatment, rehabilitation, monitoring and reinstatement.

8. When the medical staff receives a notification that a physician has entered a substance abuse recovery program, this communication should trigger the development of a monitoring agreement between the Well-Being Committee and the physician in diversion.

   a. Once practitioner has completed a program, the Well-Being Committee will establish a post-monitoring agreement whereby the practitioner agrees to provide an attestation at the time of reappointment. Attestation will address continued compliance regarding their particular issue.

9. Maintenance of confidentiality of the licensed independent practitioner seeking referral or referred for assistance is maintained by the Well-Being Committee, except as limited by applicable law, ethical obligation, or when the health and safety of a patient is threatened."

10. In the event information received by the committee clearly demonstrates that the health or known impairment of a medical/allied health member poses an unreasonable risk of harm to patients or others in the hospital, that information shall be conveyed to the Chief of Staff for assuring that appropriate follow-up action is taken.

REFERRALS TO THE COMMITTEE:

1. Practitioners who develop a physical/mental impairment are required to "self-report" to the chief of staff/designee. The practitioner agrees to notify the chief of staff/designee immediately in writing upon learning that he/she has developed substance abuse, mental or physical illness, or sustained any injury which could have an effect on the exercise of his/her clinical privileges.

2. Any person, practitioner or employee, suspecting a practitioner of being impaired must initiate a report to the Well-Being Committee. The individual making the report does not have to have proof of the impairment, but must state the facts leading to the suspicions, including dates, times, locations. The report will be forwarded to the chief of staff, via the medical staff office.

3. A charge of, or arrest for, driving while intoxicated/under the influence will automatically trigger a referral to the Well Being Committee.

4. If a practitioner enters a health, treatment, or monitoring program without involvement of the WBC and the organization receives notification of entry into the program, the communication will trigger the development of a specific monitoring agreement between the WBC and the practitioner.

TREATMENT AND MONITORING OF THE IMPAIRED PRACTITIONER

The WBC, acting on behalf of the Medical Executive Committee, is responsible for assessing the situation and identifying the most appropriate treatment and monitoring requirements for the practitioner. Examples include participation in initial and ongoing treatment and maintenance of abstinence from alcohol and any drugs or non-prescribed medications. The practitioner is required to comply, and the WBC monitors the practitioner for compliance with those requirements for a specific length of time.
The purpose of monitoring is to assure the Medical Executive Committee and the Governing Board that the physician is in recovery, continues in recovery and is participating in an appropriate recovery program.

The WBC may engage the services of a third party monitoring service to carry out the necessary elements of a monitoring agreement and report to the WBC. The WBC receives and evaluates reports from those services and reports up to the Chief of Staff compliance/non-compliance of the practitioner under the monitoring agreement. The Chief of Staff will report up to the Medical Executive Committee and the Governing Board. If the practitioner withdraws or terminates participation in the agreed upon monitoring program, the WBC will notify the Chief of Staff for appropriate action by the Medical Executive Committee.

MONITORING PLAN

A monitoring plan will be specific to the physician and includes the following elements:

- Evaluation
- Completion of initial treatment;
- On-going treatment/counseling;
- Facilitated monitoring groups;
- Drug testing;
- Regular face to face contact with a knowledgeable and approve observer;
- Reports made to the coordinator of monitoring;
- Regular conferences.

The monitoring plan should be reviewed periodically, e.g., every six months, by the WBC or its designee to keep it tailored to current circumstances while the monitoring period progresses.

At the recommendation of the WBC and Chief of Staff there may be concurrent peer review and regular record review for all monitored physicians, for a period of time to be determined in each case.

Lapse or relapse is not uncommon for those recovering from substance use disorder. The response to the lapse/relapse will be the same as the handling of the initial complaint. A lapse or relapse alone should not be considered cause for termination of privileges. The WBC will consider intensifying the treatment and/or monitoring program, and may require the physician to take a leave from patient care for a period of time.

REPORTING

Reports from the following entities will be regularly and consistently gathered and reviewed by the WBC:

- From the hospital or other practitioner work place;
- From a workplace monitor;
- From results of testing for drug/alcohol use;
- From an aftercare coordinator;
- From treating physicians and/or other treatment providers.

Per California Code of Regulations, Title 22 70703(d), reports of activities and recommendations relating to the assistance provided to impaired practitioners are to be made to the Medical Executive Committee and the governing body, at least quarterly.

CONFIDENTIALITY

Physician information obtained by the WBC is confidential and should be disclosed outside the WBC only to another Medical Staff committee in order to assist that committee with its physician evaluation activities, at the written request of the individual involved, or to any other entity upon advice from Medical Staff Legal Counsel.

The physician's identity and information about the situation needs to be known only to the signers of the monitoring agreement, the monitors and the medical staff committee responsible for the monitoring.

RECORD KEEPING

Records for each case being monitored must include a copy of the signed monitoring agreement, copies of all signed forms authorizing disclosure of information to the committee, and adequate information to assess the physician's status in recovery and compliance with the elements in the agreement.

Records must be retained indefinitely, or as long as the physician practices - plus five years. Records must be kept in strict confidence and in a secured storage area.

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MS 51 Medical Staff and Advanced Practice Professional Notifications

Policy Number: MS 51	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)	

Medical Staff and Advanced Practice Professional Notifications

Policy:

To establish guidelines for notifications to members of the Medical Staff and Advanced Practice ~~Provider~~ Professional Staff (Collectively, "Practitioner").

Procedure:

I. Notifications of upcoming expirations
- A. License, Certificates, and Insurance
  - i. Upcoming expiration notices are sent 45, 30, and 10 days prior to expiration.
  - ii. Once suspended (day of expiration) the Practitioner is notified via certified mail.
- B. Health Requirements (PPD, TB affidavit)
  - i. Upcoming expiration notices are sent 45, 30, and 10 days prior to the end of the month in which the Practitioners current health status expires.
  - ii. The first business day of the month after the Practitioner's health status has expired a final notice granting a two week extension is sent from the Chief of Staff.
  - iii. Once suspended (day after extension expires) the Practitioner is notified via certified mail.
- C. Proctoring
  - i. 1st notice is sent when privileges are granted
  - ii. Additional notices are sent 4-6 weeks and 3 months after the initial notification
  - iii. Notification of the Board has granted request for extension or privileges have expired is sent.
- D. Reappointments
  - i. Application (1st notice) is sent 4 months prior to expiration.
  - ii. Notices are sent 3 ½ months, 3 months, and 2 ½ months prior to expiration
  - iii. Final Notice: Practitioner is notified privileges will expire via certified mail, email, and text 2 months prior to expiration.

II. Notifications of Mandatory Education
    A. Notices are sent after initial/temporary appointment and 4 months prior to reappointment expiration.

III. Processing Application
    A. Once an initial application is received and accepted in the Medical Staff Services Office the Practitioner applying for privileges is notified of the status of their application every 10 days until the 4th and Final notice is sent.

IV. The Medical Staff Services office uses the following methods of communication:
    A. E-mail
    B. Fax
    C. Text
    D. Phone Calls
    E. Postal Mail (includes various products offered by the United States Postal Service & FedEx)
    ~~F. Certified Mail~~

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MS 16 Medical Staff Organization Financial Assistance for Fit-For-Duty Evaluations

Policy Number: MS 16	Date Created: 10/01/2008
Document Owner: Ody DaSilva (Medical Staff Manager)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Medical Executive Committee, Shannon Vinson (Director of Medical Staff Services)	

Medical Staff Organization Financial Assistance for Fit-For-Duty Evaluations Fit-For-Duty Evaluations

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

PURPOSE - This policy is intended to define under what circumstances the medical staff organization will provide financial assistance for fit-for-duty evaluations.

Policy:
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.

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MS 57 Guidelines for Privacy Violations

Policy Number: MS 57	Date Created: 06/29/2022
Document Owner: Ody DaSilva (Medical Staff Manager)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Medical Executive Committee, Shannon Vinson (Director of Medical Staff Services)	
Guidelines for Privacy Violations	

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

PURPOSE: The Medical Staff of Kaweah ~~Delta~~ Health ~~Care District (KDHCD)~~ seeks to establish standards for the security of confidential patient health information and guidelines for appropriate disciplinary action for privacy breaches. These guidelines provide a consistent framework for the Medical Staff to identify and evaluate the seriousness of violations of state and federal privacy laws, and of privacy and security provisions set forth in the Medical Staff Bylaws, the Medical Staff Rules, and Hospital and Medical Staff policies ("~~KDHCD~~ Privacy Policies").

BACKGROUND: The Medical Staff is committed to ensuring compliance with all applicable privacy and security laws, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH"), the California Confidentiality of Medical Information Act, the Fair Credit Reporting Act, and the regulations promulgated under these laws, and ~~the KDHCD~~ Privacy Policies.

All Medical Staff members are required to comply with these privacy and security laws and the ~~KDHCD~~ Privacy Policies and to immediately report suspected or known violations to ~~KDHCD's~~ VP & Chief Compliance and Risk Officer or designee. Neither the Hospital nor the Medical Staff will intimidate or retaliate against any individual who reports acts or practices by Medical Staff members or Advanced Practice Providers that are unlawful and/or violate ~~the KDHCD~~ Privacy Policies, provided the member believes in good faith that the practice was unlawful and/or a violation of the ~~KDHCD~~ Privacy Policies.

I. Definitions

a. "Protected Health Information (PHI)" means individually identifiable health information, including demographic information, in any form or media, whether electronic, paper, or oral, that is created or held by a health care provider, health plan, employer, or health care clearinghouse or its business associate, that relates to the past, present, or future physical or mental health or condition of an individual in his or her status as a patient, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. Examples of PHI include

name, address, birth date, Social Security Number, contact information, diagnosis, medical test results, treatment information, prescription information, and medical record numbers.

b. "Access" means to view, manipulate, utilize or examine PHI.

c. "Disclosure" means the release, transfer, provision of access to, or the divulging in any manner PHI to any individual within or outside of Hospital who does not have a legitimate need to access the information or who has not been authorized in writing to access or disclose the PHI by the individual whose PHI is at issue, or the individual's representative.

d. "Hospital" means Kaweah ~~Delta~~ Health ~~Care District~~ dba Kaweah Health Medical Center and all its affiliations.

II. Types of Violations

The type of the breach of patient confidentiality, privacy, or security (hereinafter collectively referred to as "privacy breach") will be determined according to several factors: (1) the intrusiveness of the privacy breach and the extent of information accessed or disclosed; (2) whether the privacy breach was the result of human error; and (3) whether the privacy breach was an isolated incident or evidences a pattern of improper access to or disclosure of PHI. The degree of discipline warranted by the privacy breach ranges from coaching and re-education to termination of the membership and/or clinical privileges of the Medical Staff member or Advanced Practice Provider, as determined by Medical Executive Committee (and ~~KDHCD~~ Board of Directors, when applicable) based on the results of an investigation.

There are four general types of privacy breaches identified below as Categories 1 – 4 based on the seriousness of the privacy breach. Sanctions, set forth in Attachment A may be modified based on mitigating factors, in the discretion of the Medical Executive Committee.

Category 1: Theft or loss of device containing encrypted PHI.

Category 2: Accidental or inadvertent access or disclosure. This is an unintentional privacy breach that may be caused by carelessness or other human error.

Category 3: Unauthorized access or disclosure. This is a privacy breach resulting from unauthorized or unlawful access of/to PHI. "Unauthorized" means the inappropriate accessing of medical information without a direct need for that information for a lawful use. This includes accessing or disclosing PHI for which the individual or the recipient has no legitimate business need. This breach is often motivated by curiosity or a desire to gain information for personal use.

Category 4: Malicious violation . This is a privacy breach that involves the access or disclosure of PHI to third parties motivated by financial, personal, or commercial gain and an intent to harm patients and/or the Hospital.

Examples of each category of privacy breach and the recommended sanctions are set forth in Attachment A.

III. PROCEDURE

Hospital uses FairWarning, an analytics and insider threat detection platform, to detect suspicious activity and policy violations, including privileged user access to patient healthcare information. Any individual who is aware of or suspects that a member of the Medical Staff or an Advanced Practice Provider has violated the ~~KDHCD~~ Privacy Policies must immediately report the occurrence to ~~KDHCD's~~ the VP & Chief Compliance and Risk Officer or designee. The ~~KDHCD~~ VP & Chief Compliance and Risk Officer or designee will notify the Chief of Staff upon receipt of the report and will conduct a timely investigation. At a minimum, the investigation will include an interview of the provider who is alleged to have violated ~~the KDHCD~~ Privacy Policies. Following completion of the investigation, ~~KDHCD's~~ VP & Chief Compliance and Risk Officer or designee will submit a report setting forth the findings of the investigation, including the category of the privacy breach, if any, to the Chief of Staff.

When the investigation concludes a privacy breach occurred, a copy of the report and its findings will be provided to the Medical Executive Committee. At its next regularly scheduled meeting, the Medical Executive Committee will make a recommendation as to the sanction for the privacy breach. The sanction recommended by the Medical Executive Committee is separate and apart from any civil or criminal penalties that may result from the privacy breach.

If the sanction does not involve a restriction or suspension of clinical privileges, the Medical Executive Committee will issue a notice to the provider of the sanction and its terms. The notice will inform the provider of the opportunity to submit a written response, which will be maintained in the provider's confidential file.

If the Medical Executive Committee's recommended sanction involves a restriction on or suspension of clinical privileges, the subject provider will be sent notice of the recommendation and the basis therefore and an opportunity to request to meet with the Medical Executive Committee to discuss the matter. Following that meeting, or if the provider does not timely request such a meeting, the Medical Executive Committee will render its final recommendation. If the final recommendation constitutes grounds for a hearing under the Medical Staff Bylaws, the procedures set forth in Article 9 of the Medical Staff Bylaws will be followed. If the final recommendation does not constitute grounds for a hearing but involves a restriction on or suspension of clinical privileges, the Medical Executive Committee's recommendation will be forwarded to the Board of Directors for consideration and approval before implementation.

ATTACHMENT A

Incident	Sanction
Category 1: Theft or loss of device containing encrypted PHI	**Coaching and Re-Education**
Possible Scenarios: Work or personal device, not password protected and containing non-encrypted PHI, is lost or stolen.	Provider will receive coaching by Medical Staff leadership and undergo re-education and training by the ~~KDHCD's~~ VP & Chief Compliance and/or Risk Officer. Further violations will lead to progressive disciplinary action.
Category 2: Accidental or inadvertent disclosure	**Letter of Reprimand and Re-Education**
Possible Scenarios: • Directing PHI via mail, email, fax or other method to a wrong party; or • Failing to safeguard portable device from loss or theft; or • Leaving detailed PHI on an answering machine without patient authorization; or • Transmitting PHI using an unsecured method; or • Improperly disposing of PHI; or • Failing to properly sign off from or lock computer when leaving a work-station.	Provider will be sent letter of reprimand. Mandatory re-education and training will be required. Further violation will lead to progressive disciplinary action.
Category 3: Unauthorized access or disclosure	**Suspension and Re-Education**
Possible Scenarios: • Accessing or using PHI without a legitimate need to do so, such as checking the results of a hospital employee's pregnancy test or the medical records of a relative without prior written authorization; or • Disclosing PHI to someone who has no legitimate business need to have the PHI.	Provider's clinical privileges will be suspended for a minimum of 29 days. Mandatory re-education and training will be required. Further violation will result in a recommendation to terminate Medical Staff membership and/or clinical privileges.
Category 4: Malicious violation	**Termination of Medical Staff membership and/or privileges**
Possible Scenarios: • Disclosing PHI to an unauthorized individual or entity for illegal purposes (i.e., identity theft); or • Posting PHI to social media websites; or • Selling PHI to entities for personal or financial gain; or • Disclosing an individual's PHI to the media.	Medical Executive Committee will recommend termination of Medical Staff membership and/or privileges.

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MS 56 Medical Staff & Advanced Practice Professional Education Policy

Subcategories of District Manuals not selected.

Policy Number: MS 56	Date Created: 12/22/2025
Document Owner: Ody DaSilva (Medical Staff Manager)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Medical Executive Committee, Shannon Vinson (Director of Medical Staff Services)	

Medical Staff & Advanced Practice Professional Education Policy

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

Policy: Kaweah Health is committed to providing education to credentialed staff as outlined below. As noted, specific education is mandatory per the Medical Executive Committee, Kaweah Health, federal or ~~State~~local Laws, regulatory, or accreditation agencies.~~.~~

1. Education provided at Orientation for Active Staff, Courtesy Staff, Consulting Staff, Advanced Practice Providers, and Temporary Practitioners:
    a. Time Out & Informed Consent
    b. ~~Provider Restraint~~Restraints & Seclusion
    c. Workplace Violence Prevention
    d. Environment of Care Standards
    e. Pain Management
    f. Antimicrobial Stewardship at Kaweah Health: An Overview
    g. Stroke Awareness and Prevention
    (Applicable to the following departments:
        - Anesthesiology
        - Cardiovascular Services
        - Critical Care, Pulmonology & Adult Hospitalist Medicine
        - Family Medicine
        - Internal Medicine
        - Obstetrics & Gynecology
        - Psychiatry & Neurosciences
        - Radiology
        - Surgery

    h. Suicide Risk Assessment
    i. Interfacility transfer Notes & Medication Reconciliation
    ~~f.~~j. Decision-Making Capacity & Informed Consent

2. Mandatory Anti-Harassment Education Module to be completed at initial appointment and at reappointment for the following Practitioners:
    a. Active Staff
    b. Courtesy Staff
    c. Consulting Staff
    d. Advanced Practice Providers

e. Temporary Practitioners covering more than 6 months

3. Mandatory Glucommander Education Module to be completed at initial appointment for the following departments:
   a. Cardiovascular Services
   b. Critical Care, Pulmonary, and Adult Hospitalist~~s~~ Medicine
   c. Family Medicine (Inpatient Practitioners Only)
   d. Internal Medicine (Admitting Practitioners Only)

4. Mandatory Implicit Bias Training Education Module to be completed at initial appointment and at reappointment for all practitioners that provide perinatal care:
   a. Department of OB/GYN OB Practitioners
   b. Department of Family Medicine Practitioners with OB privileges
   c. Department of Emergency Medicine Practitioners

The required anti-harassment education and implicit bias course is offered at Kaweah Health but can be met if proof of completion at another facility within the last year is provided at initial and reappointment.

Note: The courses listed in this document are not all-inclusive. The Medical Staff and Kaweah Health reserve the right to add, modify, or remove course requirements as necessary to comply with applicable policies, regulatory standards, local and federal laws, and other governance requirements.~~Additional education provided as needed.~~

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MS 03 Medical Staff Fees

Policy Number: MS03	Date Created: 07/24/2014
Document Owner: Ody DaSilva (Medical Staff Manager)	Date Approved: Not Approved Yet
Approvers: Medical Executive Committee, Board of Directors	

Medical Staff Fees

Policy: Medical Staff membership and/or privileging fees shall be determined by the Medical Executive Committee (MEC) and may vary by category or privilege status. Fees shall be payable upon request. Failure to pay fees shall result in ineligibility to apply for Medical or Advanced Practice Staff reappointment or renewal of privileges.

Procedure:

A. **Initial Application Fees:** A non-refundable Initial Application ~~p~~Processing fee of $400.00 plus the applicable Practitioner fee (See Section B ~~payable~~) payable to "Kaweah Health Medical Staff" must be submitted at the time of application. Payment may be made online or by check. The application will not be processed until the fee is received in the Medical Staff Office. Initial Application Processing fees are for the benefit of Kaweah Health and shall ~~be deposited~~ allocated to the Medical Staff Services Department ~~account~~ cost center #8710 ~~($400.00)~~.

B. ~~**Medical Staff**~~**Practitioner Fees**~~: Medical~~: Practitioner ~~Staff~~ fees are payable upon submission of ~~the~~ initial and~~/or~~ reappointment applications. Payment may be made online or by check. ~~The~~ Applications will not be processed until ~~the~~ all applicable fees are~~is~~ received in the Medical Staff Office. ~~Medical Staff~~Practitioner fees are deposited in the Medical Staff General Fund account~~Bank~~ to be ~~and~~ utilized for the benefit of the Medical Staff of Kaweah Health~~purposes~~.

~~I.~~ Exemptions:

~~1.~~ ~~1.~~ Honorary/Retired/Administrative Staff

1.

2. Physicians who are donating services without remuneration for said service (i.e., contract or billing of services) may request a waiver for fees. Upon consideration of the request, on a case-by-case basis, the MEC may grant the waiver.

~~2. Physicians who are donating services without remuneration for said service (i.e.,~~

~~contract or billing of services) may request a waiver for fees. The Medical~~

~~Executive Committee will grant the waiver on a case by case basis.~~

3. All fees are waived for current Kaweah Health residents who apply to moonlight for the ~~District~~Hospital. ~~*~~If they choose to remain at Kaweah Health after completion of their residency, they will be required to pay applicable ~~the initial application~~ fees as noted in II.1 and II.2 below.

~~II.~~ **~~Initial processing Fee and Medical Staff Fee schedule~~Fees Schedule**:

1. Initial Application Processing fee $400.00

~~1.~~2. Practitioner Fees

~~2.~~a. ~~Physicians~~Medical Staff ~~_____~~
$450.00

b. Advanced Practice Pro~~viders~~fessional ~~_____~~ $350.00

~~3.~~c. Rush Applications/Temporary Privileges $500.00

~~a)~~ ~~Advanced Practice Providers are responsible for payment of Medical Staff fees, as determined by the Medical Executive Committee. Applications will not be processed without payment. Kaweah Health employed~~ Advanced Practitioners employed by Kaweah Health will be reimbursed by the hospital for applicable fees by submitting ~~am~~ an Accounts Payable (AP) Request form and all required documentation ~~attached invoice~~ to their hospital department manager.

~~C.~~3. ~~Use of~~ **Credit Card Processing Fees:** ~~for payment:~~ ~~Practitioners~~Practitioners will be ~~charged~~ assessed a ~~3.5%~~ service charge when paying fees by credit card.

~~D.~~4. **Replacement Fees:** Replacement fees ($10.00) will be assessed for replacement of parking permits or ID badges.

References:

A. ***Kaweah Health Medical Staff Bylaws***

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Graduate Medical Education Graduates 2026

Anesthesiology	Name
	Cody Brazeal, D.O.
	Oliver Marigold, M.D.
	Katherine Baohoa Nguyen, D.O.
	Michael Dewitt Prentice, M.D.
Emergency Medicine	**Name**
	Abimbola Yemi Bankole, M.D.
	John Remington Betz, D.O.
	Shadi Kiaei, D.O.
	Tyler Kelly Kirkland, M.D.
	Joshua Osayuwamen Obamedo, M.D.
	Iman Conner Shull, D.O.
	Shenaya Thomas, M.D.
Family Medicine	**Name**
	Martin Larry Granados, D.O.
	Manpreet Kaur, M.D
	Cristina Francisca Lee, M.D.
	Rina Patel, M.D.
	Kimberly Lyn Rivera, M.D.
	Ulysses Sanchez, M.D.
	Brandy Leah Truong, M.D.
Psychiatry	**Name**
	Monica Khokhar, M.D.
	Long Ly Nguyen, D.O.
	Rubani Sidhu, M.D.
	Jesse Godfrey, D.O.
	Synthia Lay, M.D.
	Anup Misra, M.D.
Surgery	**Name**
	Rachel Handelsman, M.D.
	Emily Ann McNabb, M.D.
	Alex Benjamin Petrak, M.D.
	Jasmine Martha Siao Santos, M.D.
	Evan Sheh, M.D.
Transitional Year	**Name**

	Yasaman Arabi, D.O.
	Ethel Kate Briones, D.O.
	Malie Collins, M.D.
	Bryce Granata, M.D.
	Jennifer Huang, M.D.
	Christopher Luan, M.D.
	Spencer Moulton, D.O.
	Bibhash Neupane, D.O.
	Vikas Ravi, D.O.
	Seerat Sekhon, D.O.
	Huy Truong, D.O.
	Brandon Wong, M.D.
CAP	**Name**
	Richa Gautami, M.D.
	Christopher Carlos Jaime, D.O.
	Tracy Johnson, M.D.

Separator Page

QUALITY INCENTIVE POOL REPORT

QIP QCOMM Report

March 19, 2026

Kaweah Health

QIP Program Updates

Quality Incentive Pool (QIP) Program

What: CMS 1115 Waiver program through the Department of Health Care Services (DHCS)

Why - Goals of QIP:

- Promote access to care
- Increase organization's investment value-based payment arrangements
- Encourages collaboration with Medi-Cal managed care plans and Hospitals

How: Funding is tied to quality outcomes as defined by DHCS annually

When:

- Kaweah Health reports QIP performance annually to DHCS for prior Calendar Year (CY)
- Funding is only earned if DHCS targets are achieved.
- Funding changes year after year along with targets.

QIP Reporting Highlights

CY 2025 Report Underway due 6/15/2026

Currently in CY 2026 Performance Period (1/1/2026-12/31/2026)

- Plan to report on 7 Quality Measures and perform on 7 Quality Measures ~ $12.7M ($1.8M/quality measure)

Funding Model Updated to 60% Medi-Cal Reimbursement/40% Quality Measures

Priority vs. Elective Quality Measures-Funding implications

- Pushes ***continuous quality improvement*** (preventing switching measures annually)
- 50% of total measures need to be Priority Measures
- 30% of total measures need to be reported year prior

Kaweah Health has strategically selected quality measures for QI and reporting that align with Primary and Preventive care to ensure high likelihood of performance.

RHC workflows impact performance for 100% of quality measures selected.

Quality Measures Cozeva Performance Year 2025	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26			Trends
	Aggregate Performance August	Aggregate Performance September	Aggregate Performance October	Aggregate Performance November	Aggregate Performance December	Aggregate Performance January	Target	Delta	
Q-CBP Controlling High BP	52.72%	62.90%	66.25%	66.70%	68.99%	71.67%	67.36%	-4.31%	
Q-GSD Diabetes|Glycemic Status Assessment for Patients With Diabetes (Glycemic Status <=9.0%)	42.04%	48.82%	56.04%	56.30%	61.84%	58.51%	72.99%	14.48%	
Q-CMS130 Colorectal Cancer Screening (1) (Trending Break PY5, new Population 45-75)	35.55%	35.71%	36.66%	38.34%	39.17%	40.79%	42.44%	1.65%	
Q-W30: Well-Child Visits in the First 15 Months	48.93%	50.21%	51.06%	54.35%	55.90%	56.44%	69.67%	13.23%	
Q-W30: Well-Child Visits in the First 30 Months of Life 15-30 Months	66.58%	68.21%	69.21%	70.34%	69.15%	69.36%	76.49%	7.13%	
Q-WCC Prevention and Screening|Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile	78.54%	89.99%	91.79%	89.70%	91.04%	91.27%	83.28%	-7.99%	
Q-WCC Prevention and Screening|Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	49.68%	55.09%	61.02%	67.29%	69.60%	70.92%	72.33%	1.41%	
Q-WCC Prevention and Screening|Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	52.73%	57.70%	63.01%	69.12%	71.19%	72.24%	72.56%	0.32%	
Q-IMA: Immunizations for Adolescents		21.51%	25.59%	25.78%	25.12%	25.12%	31.36%	6.24%	
Q-CIS10-Immunizations|Childhood Immunization Status COMBO-10		6.43%	6.19%	6.61%	6.76%	6.61%	22.87%	16.26%	
Q-LSC- Lead Screening in Children	77.03%	77.55%	78.53%	79.04%	78.89%	78.44%	79.51%	1.07%	
Q-PPC-PRE Prenatal Care	86.36%	89.04%	89.98%	88.52%	89.25%	88.97%	87.66%	-1.31%	
Q-PPC-PST Post Natal Care	76.36%	72.05%	82.15%	88.52%	89.49%	89.44%	78.41%	-11.03%	
Q-BCS Breast Cancer Screening	52.17%	52.70%	53.97%	55.68%	56.68%	56.65%	57.29%	0.64%	
Q-CCS Cervical Cancer Screening	58.24%	59.06%	59.20%	61.01%	62.18%	62.45%	56.98%	-5.47%	
Q-CHL Chlamydia Screening	47.13%	48.11%	37.75%	55.48%	57.05%	58.44%	49.65%	-8.79%	
Q-WCV: Child and Adolescent Well-Care	33.64%	34.17%	38.85%	45.34%	47.73%	49.40%	46.57%	-2.83%	

QIP Proxy Performance

Meeting 6.3 QM
Target 8 QM

Caveat-claims data

Kaweah Health

DHCS QIP Reporting Updates

"Better of MCP or QIP Entity Rate"

Limitation on use of Local Mapping to clinical events to reflect performance

RISK- If the claims or documentation to the health plans do not include the proper coding (quality codes, CPTII, LOINC) performance will be negatively impacted

Work to improve code capture remains underway

No Local Mapping to clinical events will be allowed.

Claims submission along with coding of diagnosis codes and Quality Codes will be *key to meeting performance*.

Kaweah Health

QIP Performance Year 9 (2026)

Kaweah Health

QIP PY9 2026 Quality Measure Focus

1. Controlling High BP - *Q-CBP* **(Priority)**
2. Glycemic Status Assessment for patients with Diabetes - *Q-GSD* **(Priority)**
3. Colorectal Cancer Screening - *Q-CMS130* **(Elective)**
4. Lead Screening in Children - *Q-LSC-* **(Elective)**
5. HIV Screening - *Q-CMS349* **(Elective)**
6. Cervical Cancer Screening - *Q-CCS* **(Priority)**
7. Breast Cancer Screening - *Q-BCS* **(Priority)**

Strategy to monitor more than 7 measures.

Funding available ~$12.7M

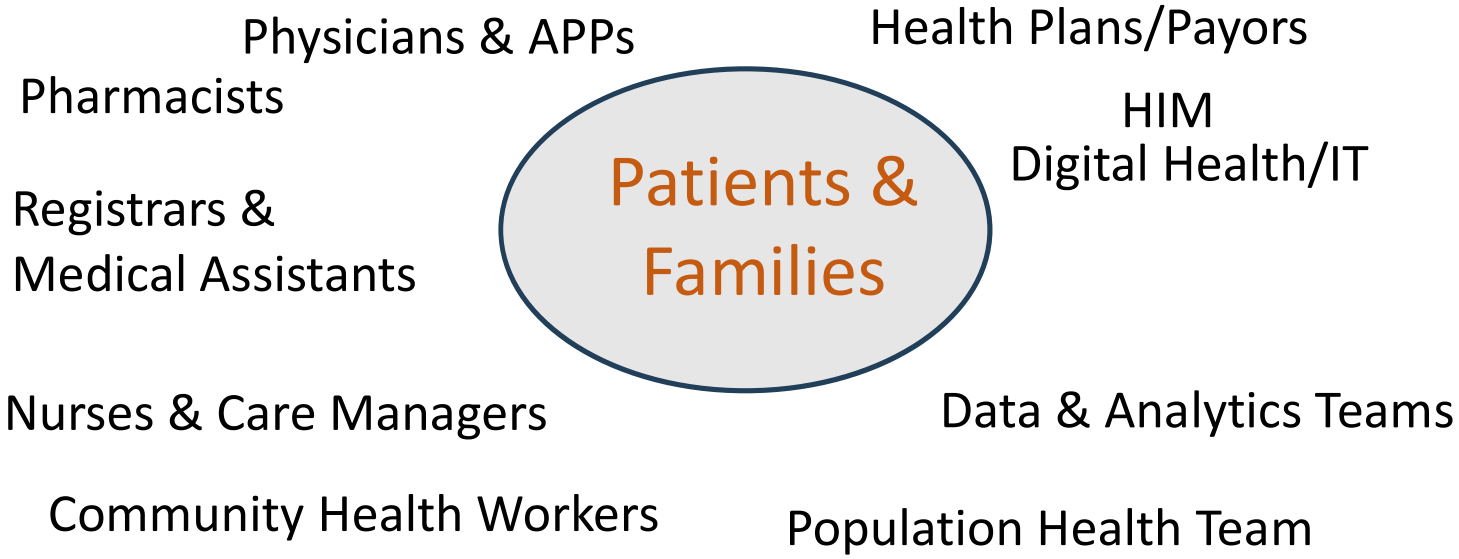
Contingency Plan

1. Prenatal Care - *Q-PPC-PRE* **(Priority)**
2. Post Natal Care - *Q-PPC-PST* **(Priority)**
3. Chlamydia Screening - *Q-CHL* **(Priority)**
4. Preventative Care and Screening: Tobacco Use-Screening and Cessation Intervention Rate 1, Rate 2, & Rate 3 - *Q-CMS138* **(Priority)**

Informational

1. Number of Members enrolled in Enhanced Care Management (ECM) - *Q-ECM*
2. Number of and Percentage of Eligible Members Receiving Community Supports (COMS) and Number of Unique COMS received by members - *Q-COMS*
3. Percentage of Acute Hospital Stay Discharges Which Had Follow-Up Ambulatory Visits W/in 7 days Post Hospital Discharge- *Q-FUAH*

Quality is a Team Sport



Quality Improvement Initiatives

1. **Supplemental Data Uploads:** Ongoing by Gaps in Care (GIC) team & Pop Health in Cozeva from Cerner MILN (18 measures)
2. **Supplemental Flat File Submission:** Captures values not submitted on claims; sent monthly by ISS Business Development
3. **CPTII Data Coding:** Population Health Data Team & Partnering with HIM (3 measures)
4. **External Document Scanning:** QA external document type scans project HIM & Population Health (3 measures)
5. **Cologuard HL7 Interface with Cerner:** go live August 2025
6. **Targeted QI Efforts**
   a. **Community Outreach Events:** Immunizations, Colorectal CA Screening, Diabetes Management, Medi-Cal Enrollment
   b. **Colorectal Cancer Screening:** Kits shipped to patients' home w/ Well App text messaging & phone reminders

Quality Improvement Initiatives

7. Communication Strategies

Sharing performance & targeted QI efforts Monthly Population Health Steering Committee, Clinic lead, RHC Manager, Medical Director & Provider Meetings; Quarterly Population Health Quality Meeting

8. IT Build Pending

a. Diabetic QuickVisits

b. Real Time QM Performance Dashboard (5 QM)

1. Controlling High Blood Pressure
2. Tobacco Screening and Cessation
3. Glycemic Status Assessments for Patients with Diabetes (GSD) A1c <9%
4. Influenza
5. HIV

c. Patient Advisories (Long Term)

Monthly Quality Meetings: Managed Care Plans (Anthem BC and HealthNet)

The pursuit of healthiness

Separator Page

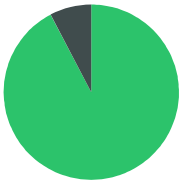
STRATEGIC PLANNING INITAITIVE – PHYSICIAN ALIGNMENT

FY 2026 Strategic Plan

Physician Alignment
March 25, 2026

Physician Alignment - Marc Mertz and JC Palermo

All Items



On Track 12 (92%)
Canceled 1 (8%)

Spotlight Items

Name	Aligns To	Status	Spotlight Comment
Continue efforts of the Physician Recruitment and Retention Strategy Committee to understand and refine physician recruitment needs, fair market value and physician and APP retention strategies	Recruit Physicians and Advanced Practice Providers	On Track	Established Venice Hills Medical Group to provide W-2 employment options for physician recruitment.
Recruit 5 Primary Care Physicians	Recruit Physicians and Advanced Practice Providers	On Track	Added three Family Medicine physicians to the community pipeline through local recruitment and residency retention.
Recruit 15 Specialty Providers	Recruit Physicians and Advanced Practice Providers	On Track	Recruited thirteen Specialty Physicians and secured letters of intent for three additional specialties.

Recruit and Retain Physicians and Advanced Practice Providers Champions: JC Palermo

Description: *Refine and execute strategies for recruitment and retention of physicians and Advanced Practice Providers.*

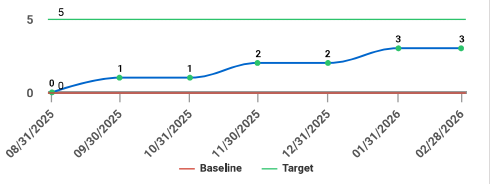
Work Plan (Tactics)

#	Name	Start Date	Due Date	Assigned To	Status	Last Comment
5.1.1	Beginning early in their residencies, educate and build partnerships with Central Valley medical residents related to practice opportunities and recruitment packages	07/01/2025	06/30/2026	JC Palermo	On Track	Working with Kaweah Health GME leadership, the physician recruitment team has scheduled an internal meeting to strategize internal efforts related to Kaweah Health resident outreach. We continue sending emails to nationwide GME programs with specialties we are recruiting.
5.1.2	Continue to work directly with Key Medical Group, local physicians and other medical groups to assist in recruitment and placement of new physicians and APPs and explore strategies for long-term practice sustainability and growth	07/01/2025	06/30/2026	JC Palermo	On Track	We are in discussions with multiple local practices to assist with the recruitment of additional physicians.
5.1.3	Continue efforts of the Physician Recruitment and Retention Strategy Committee to understand and refine physician recruitment needs, fair market value and	07/01/2025	06/30/2026	JC Palermo	On Track	The committee meets monthly to discuss recruitment strategy and how we can best utilize our available resources to support the community. We also regularly discuss our processes and procedures to ensure they are sound and position the committee to make objective and fair decisions.

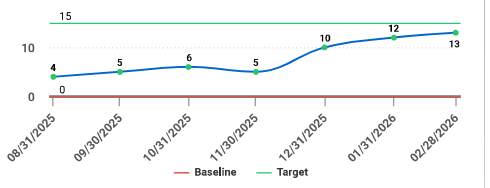
Performance Measure (Outcomes)

#	Name	Start Date	Due Date	Assigned To	Status	Last Comment
5.1.4	Recruit 5 Primary Care Physicians	07/01/2025	06/30/2026	JC Palermo	On Track	We have recruited 1 Family Practice Physician to work in part-time capacity, and we have signed a former Kaweah Health Family Resident physician to return and work with the Faculty Medical Group, along with a 2026 Kaweah Health graduating resident to join the Faculty Medical Group.
5.1.5	Recruit 15 Specialty Providers	07/01/2025	06/30/2026	JC Palermo	On Track	This fiscal year we have recruited: 1 Intensivist, 1 Anesthesiologist, 1 Neonatologist, 1 Cardiothoracic Surgeon, 1 Orthopedic Spine Surgeon, 1 Adult Hospitalist, 1 Gastroenterologist, and 6 General Surgeons
5.1.6	Recruit 10 Advanced Practice Providers	07/01/2025	06/30/2026	JC Palermo	On Track	Recruitment includes APPs for the following locations: 4.3 for Urgent Care/Exeter/Wound, 1.6 for Willow/Exeter, 3 for Akers, and .2 for Woodlake. Several other candidates have accepted offers and are pending medical staff/payer credentialing.

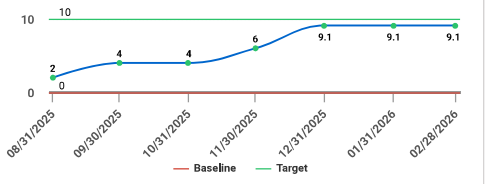
Recruit 5 Primary Care Physicians



Recruit 15 Specialty Providers



Recruit 10 Advanced Practice Providers



Develop Practice Support for Physicians Champions: JC Palermo

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

Work Plan (Tactics)

#	Name	Start Date	Due Date	Assigned To	Status	Last Comment
5.2.1	Support physicians and their respective medical groups by offering management services organization (MSO) services to alleviate the administrative burden and enable them to focus on patient care activities	07/01/2025	06/30/2026	JC Palermo	Canceled	Kaweah will not pursue establishment of management services this fiscal year.
5.2.2	Promote Kaweah Health services and the physicians that support them	07/01/2025	06/30/2026	JC Palermo	On Track	CT Surgery commercial released in early January, MEDSCAPE digital campaign for CT Surgery in our primary service area and extending into Fresno/Clovis, and Digital EDGE campaigns through WebMD supporting multiple service lines and specialties coming in February.

Physician Alignment through Integrated Delivery Network Champions: Marc Mertz

Description: *With our physician community partners, continue to develop and strengthen relationships with health plans and providers through Sequoia Integrated Health.*

Work Plan (Tactics)

#	Name	Start Date	Due Date	Assigned To	Status	Last Comment
5.3.1	Continue physician alignment efforts through our joint venture with Key Medical Group, Tulare-Kings Foundation for Medical Care and Sierra View Local Healthcare District (i.e. Sequoia Integrated Health) to contract with payers to become the provider network of choice	07/01/2025	06/30/2026	Marc Mertz	On Track	Kaweah regularly meetings with SIH to discuss quality improvement initiatives. We are also evaluating new payer contracts.
5.3.2	Work with providers to design and implement care models and invest in resources that improve quality outcomes, patient experience and decrease cost	07/01/2025	06/30/2026	Marc Mertz	On Track	We continue our internal efforts, but are also engaged in discussions with SIH regarding strategies to increase our Medicare stars scores for the Humana population.
5.3.3	Invest in resources and infrastructure that supports physician practices and the management of their attributed, capitated or empaneled patients	07/01/2025	06/30/2026	Marc Mertz	On Track	Our population health and clinic leadership continue to drive improvement for our patients. We are also working with SIH to identify additional ways to improve outcomes.

Separator Page

PATIENT EXPERIENCE AND SATISFACTION UPDATE

Patient & Community Experience

March 2026

kaweahhealth.org

Kaweah Health
MORE THAN MEDICINE. LIFE.

Patient Experience Matters

Opportunities and insights to increase patient satisfaction.

Kaweah Health
February 2026

Fiscal Year Data
July 2025 – January 2026

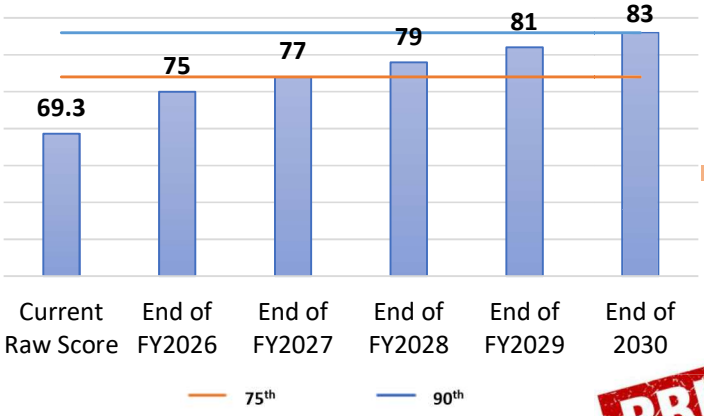
Survey Scores

HCAHPS: 69.3
45th Percentile

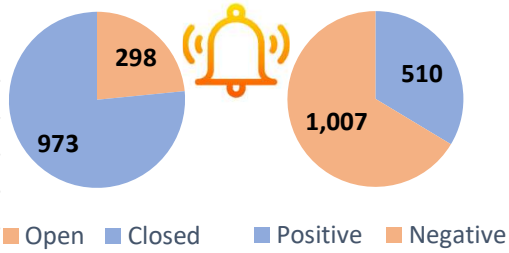
Inpatient NPS: 60.2
30th Percentile

Medical Practice NPS: 78.0
12th Percentile

5 Year HCAHPS Goal



Service Alerts



Human Understanding – 75.8
12th Percentile

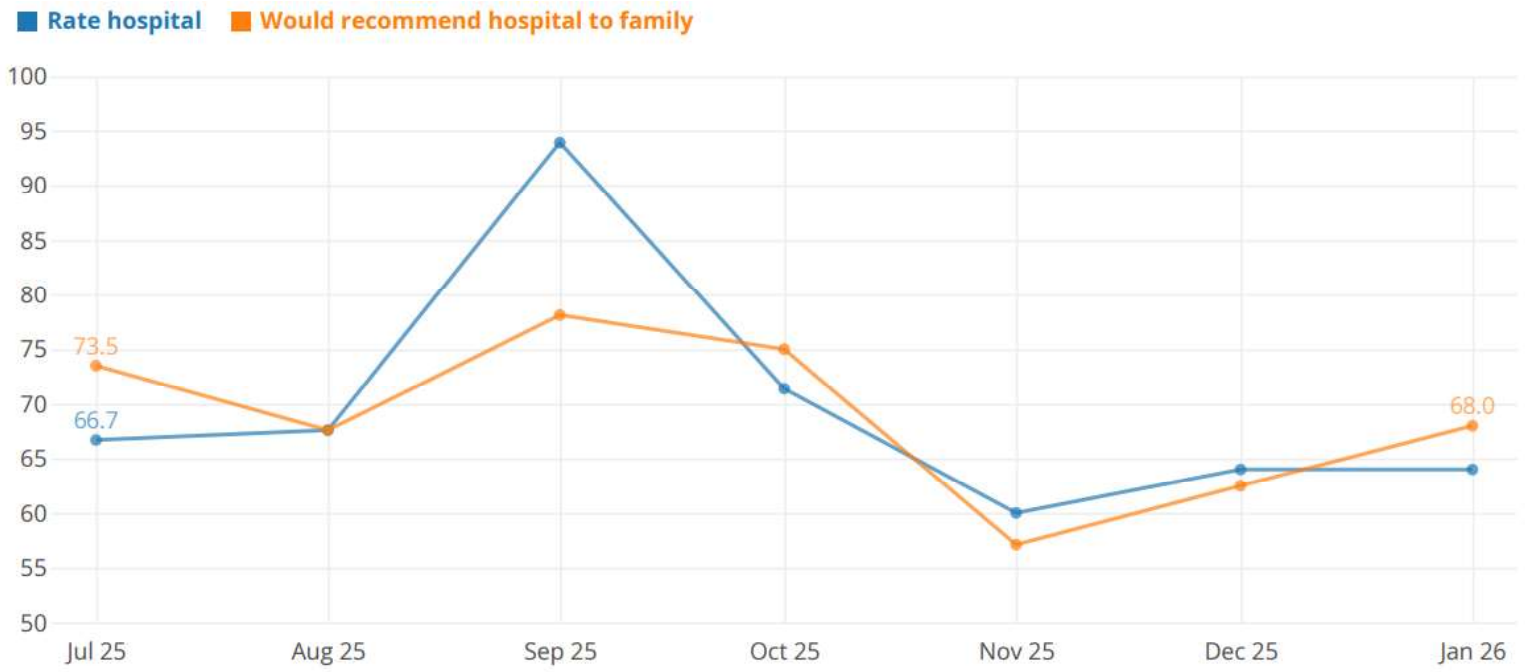
February 2026

- **Rounding** 306
- **MIDAS** 74 Opened
- **ED Rounding** 246

PRIORITY

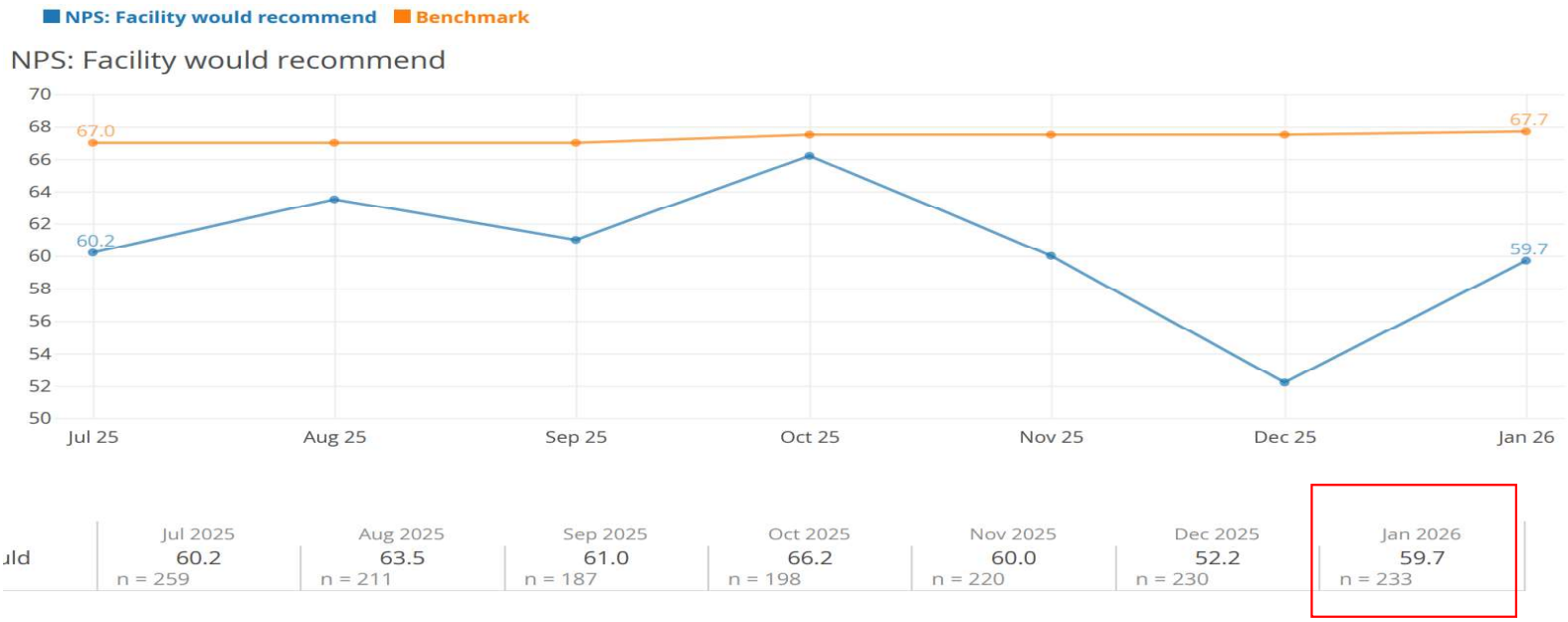
- **Trusting providers with care**
- **Spending enough time with patient**
- **Safety**
- **Providers explaining things understandably**
- **Nurses explaining things understandably**

HCAHPS Trend July 2025 – December 2025



Question	Benchmark	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26
Rate hospital	71.4	66.7 n = 33	67.6 n = 34	93.9 n = 33	71.4 n = 28	60.0 n = 30	64.0 n = 25	64.0 n = 25
Would recommend hospital to family	72.8	73.5 n = 34	67.6 n = 34	78.1 n = 32	75.0 n = 28	57.1 n = 28	62.5 n = 24	68.0 n = 25

Inpatient (FY-1/31/2026)



uld	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026
	60.2	63.5	61.0	66.2	60.0	52.2	59.7
	n = 259	n = 211	n = 187	n = 198	n = 220	n = 230	n = 233

Med Practice (FY-1/31/2026)

nrc HEALTH | Human understanding **Trend**

Respondents 4,531

	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026
Provider would recommend	78.1 n = 770	77.3 n = 688	78.6 n = 695	75.6 n = 620	80.3 n = 529	78.8 n = 556	80.7 n = 673

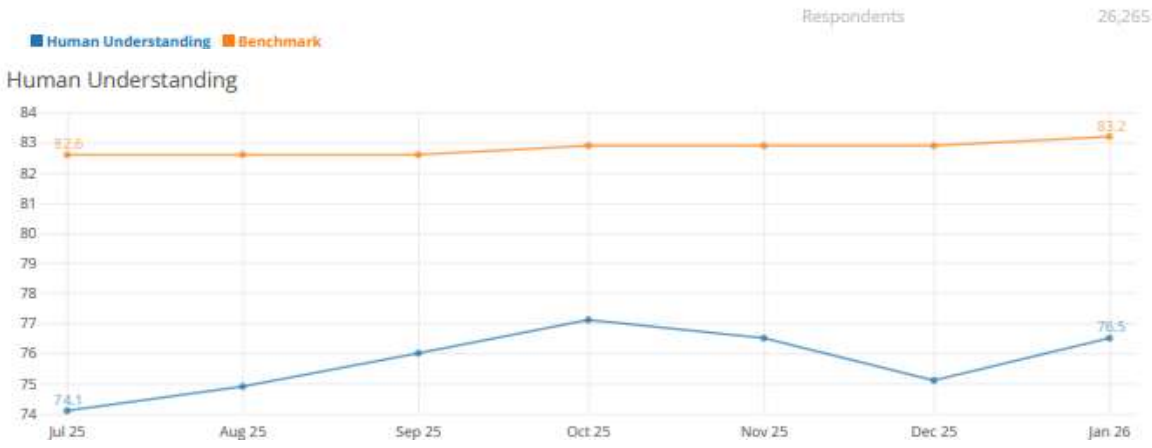
Emergency Department (FY-1/31/26)

nrc HEALTH | Human understanding **Trend**

	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026
NPS: Facility would recommend	39.5 n = 845	42.4 n = 821	39.2 n = 793	43.5 n = 710	43.0 n = 698	35.6 n = 758	36.0 n = 801

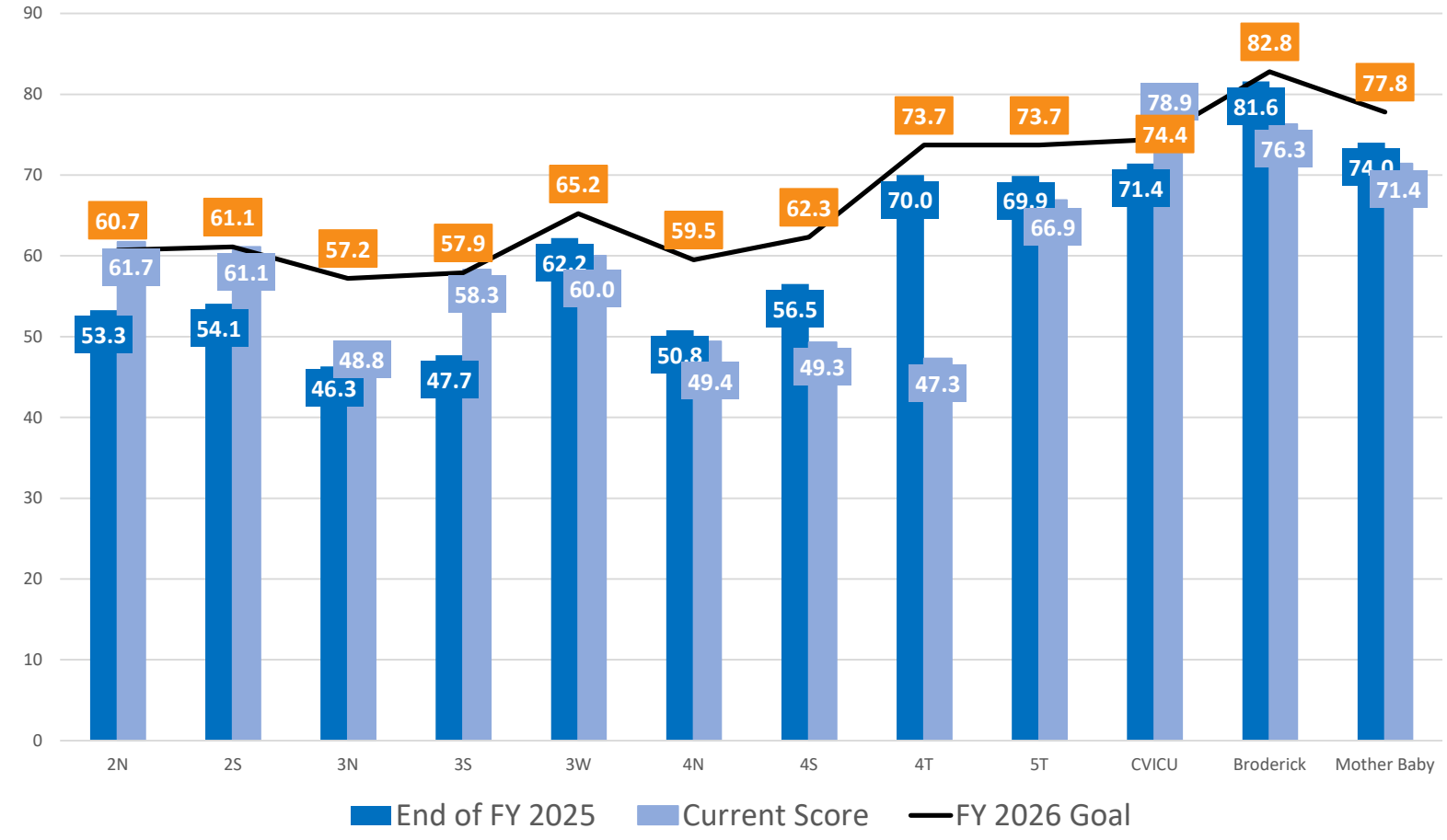
Human Understanding (FY-1/31/2026)

nrc HEALTH | Human understanding **Trend**



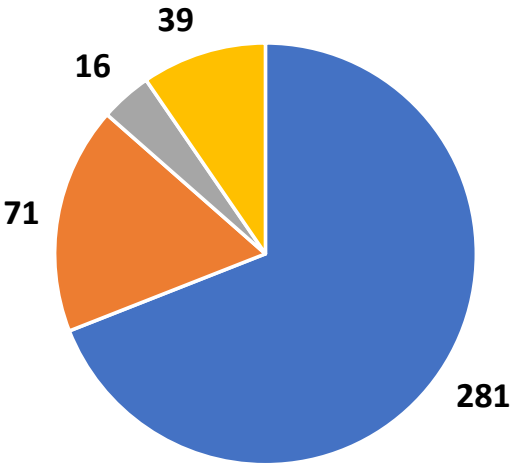
	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026
Human Understanding	74.1 n = 3,593	74.9 n = 3,510	76.0 n = 3,836	77.1 n = 3,949	76.5 n = 3,380	75.1 n = 3,813	76.5 n = 4,184

Inpatient Unit's Goal vs Current Score: July 2025 – January 2026



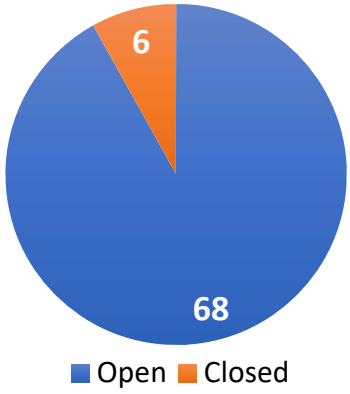
Rounding: February

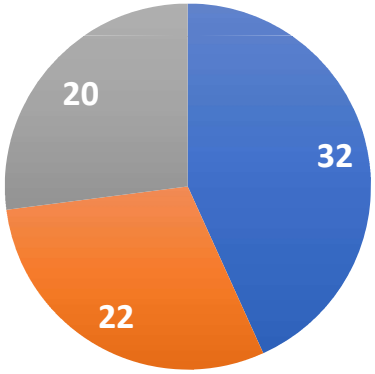
306 Rounds



MIDAS: February

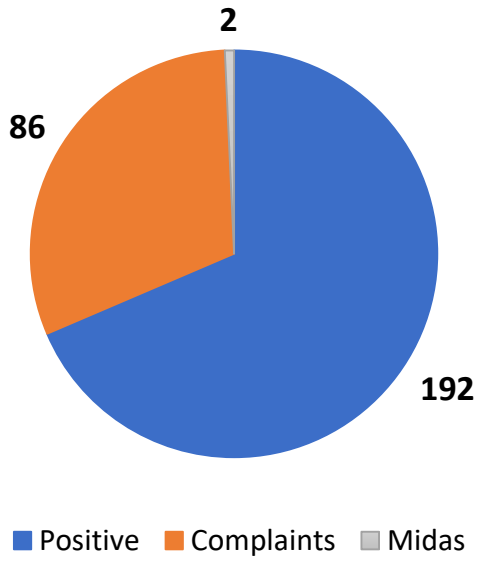
74 Opened





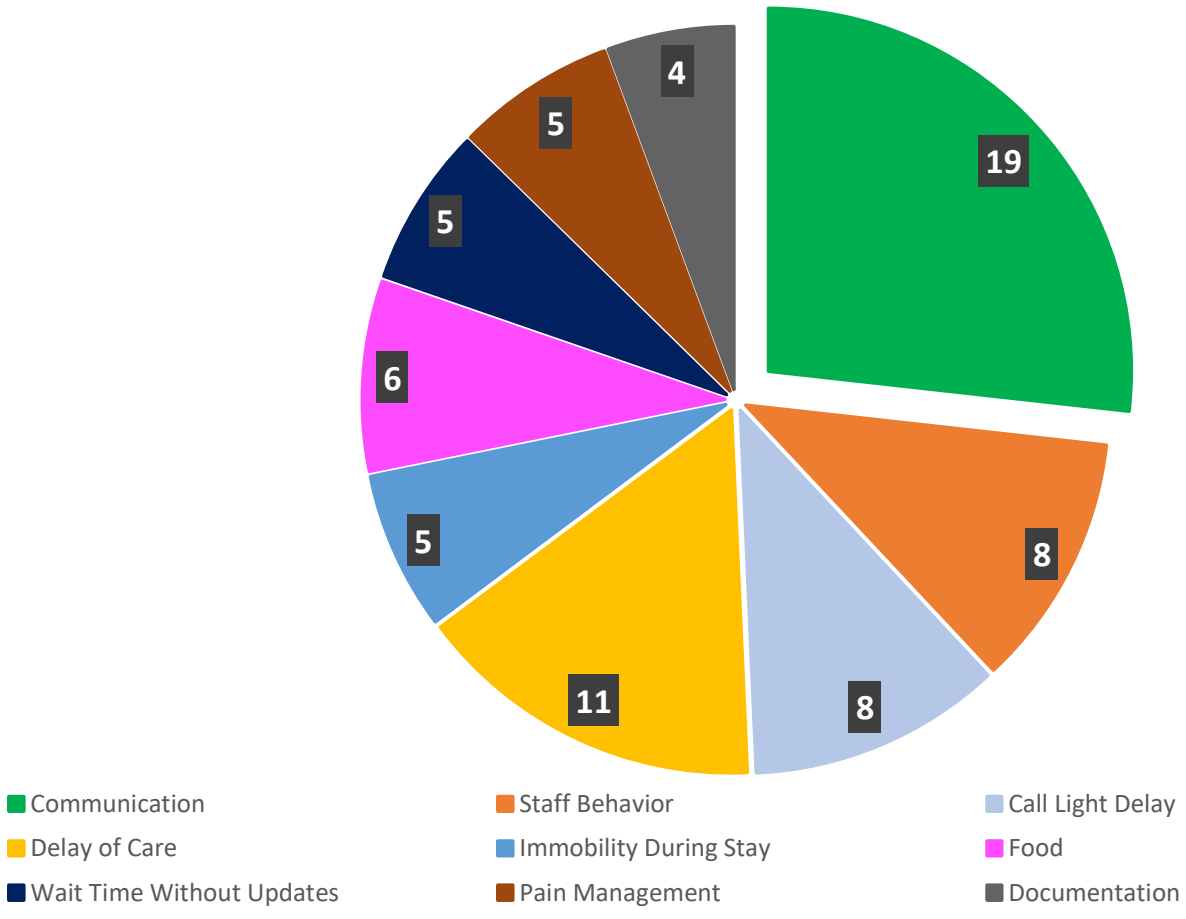
ED Rounding: February

246 Rounds



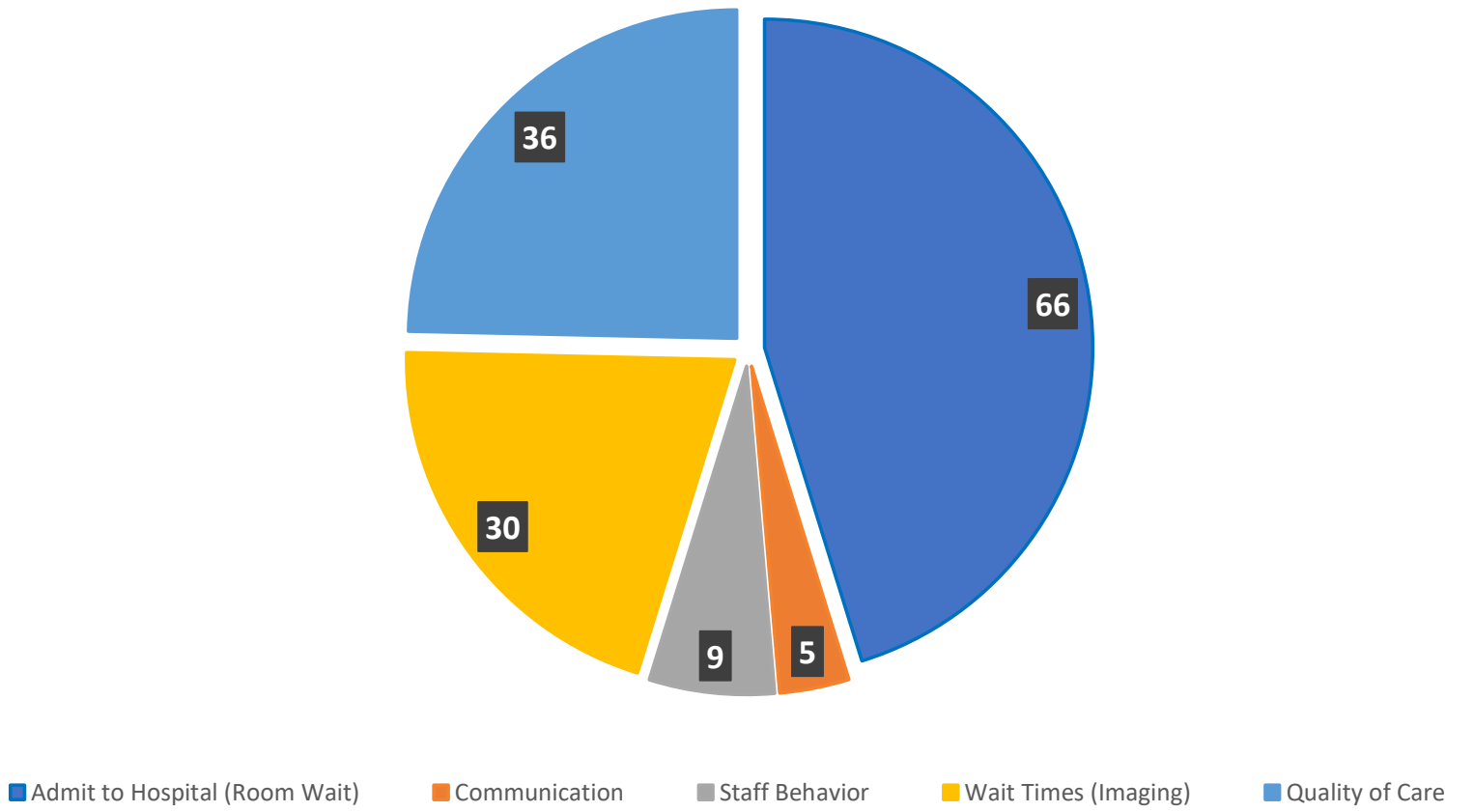
Patient Rounding Complaints Breakdown: February

71 complaints

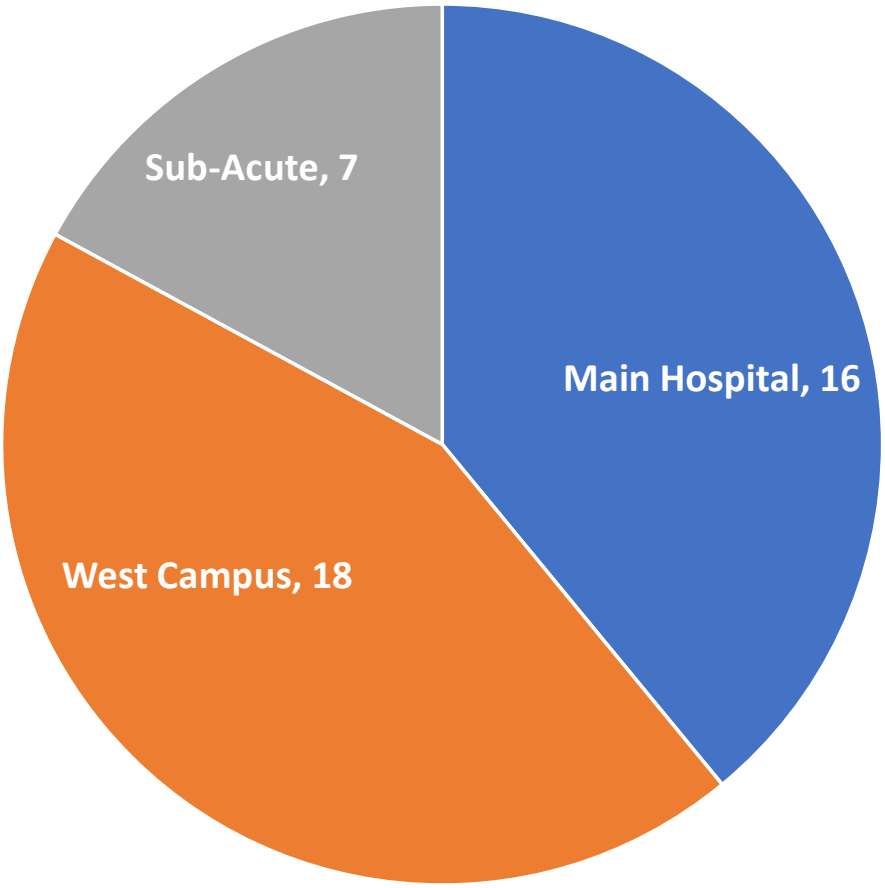


ED Patient Rounding Complaints Breakdown: February

86 Complaints

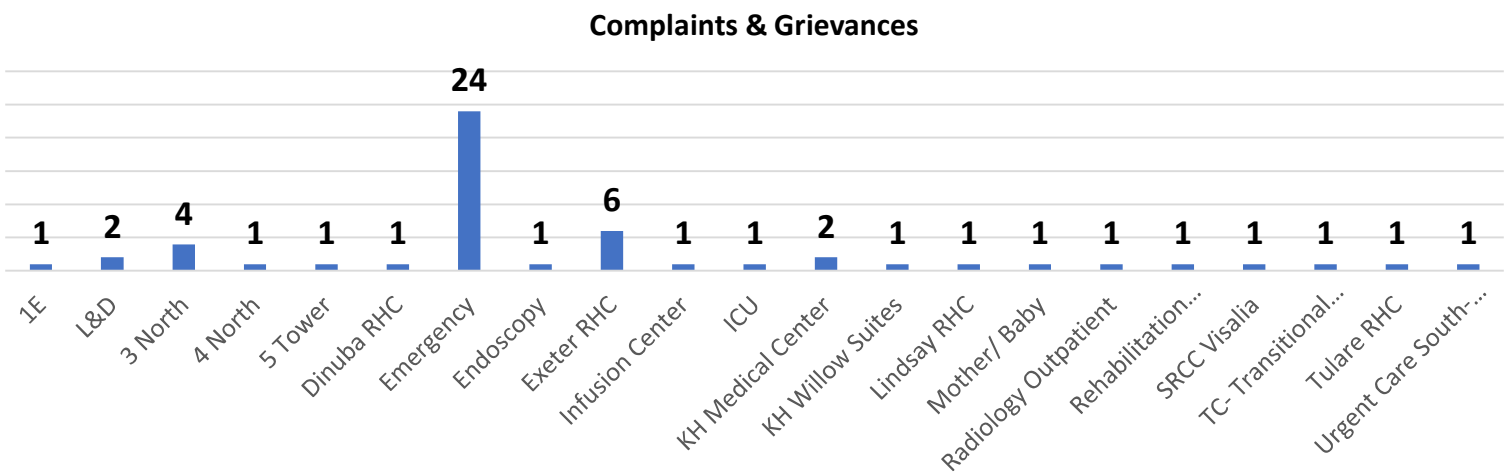


Leader Rounds: February

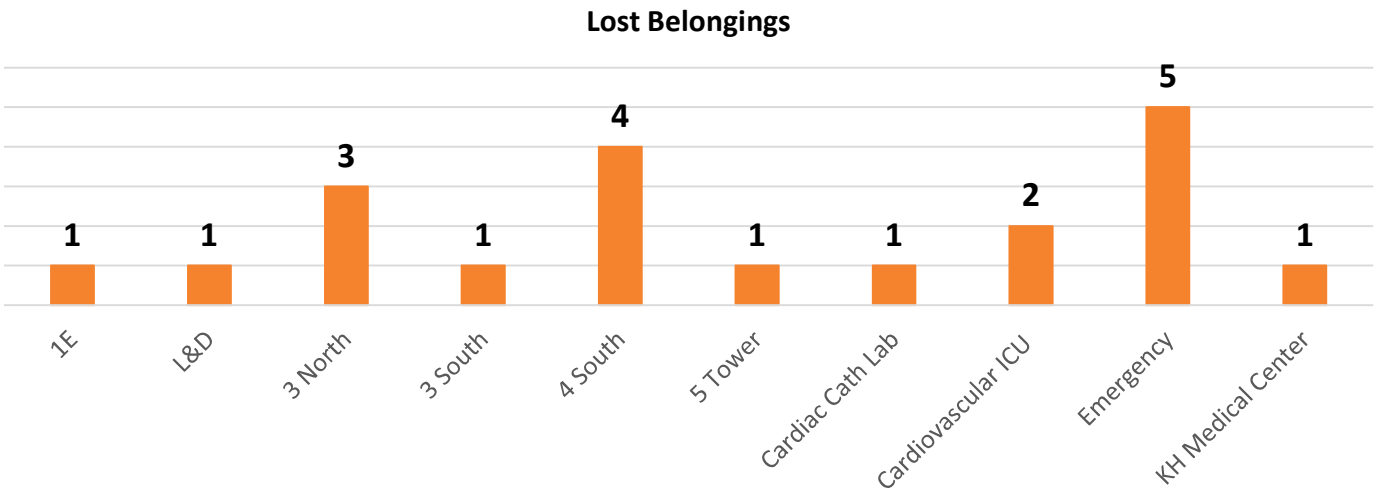


MIDAS: February

74 Opened



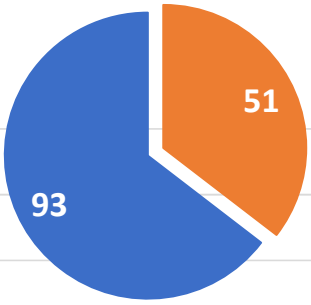
Lost Belongings: February



Lost Belongings

FY to Date: 144

7/1/25 - 2/28/26



ROUNDING

February Executive Team Rounds = 4 executive rounds, 1 BOD round

Executive	November	December	January	February
CEO/Marc Mertz.	11/4, 11/20	12/3, 12/23	1/12	
Jag B.	11/12	12/10	1/13	
Malinda T.	11/17	12/22	1/6	
Dianne C.	11/11	12/15	1/8	2/4
Scott B.	11/24		1/27	2/12
Ben C.	11/24	12/18	1/22	
Paul S.		12/2	1/28	2/18
Doug L.			1/19	2/11
Board of Directors				2/9 (MO)

Separator Page

FINANCIALS

CFO Financial Report

Month Ending February 2026

Kaweah Health
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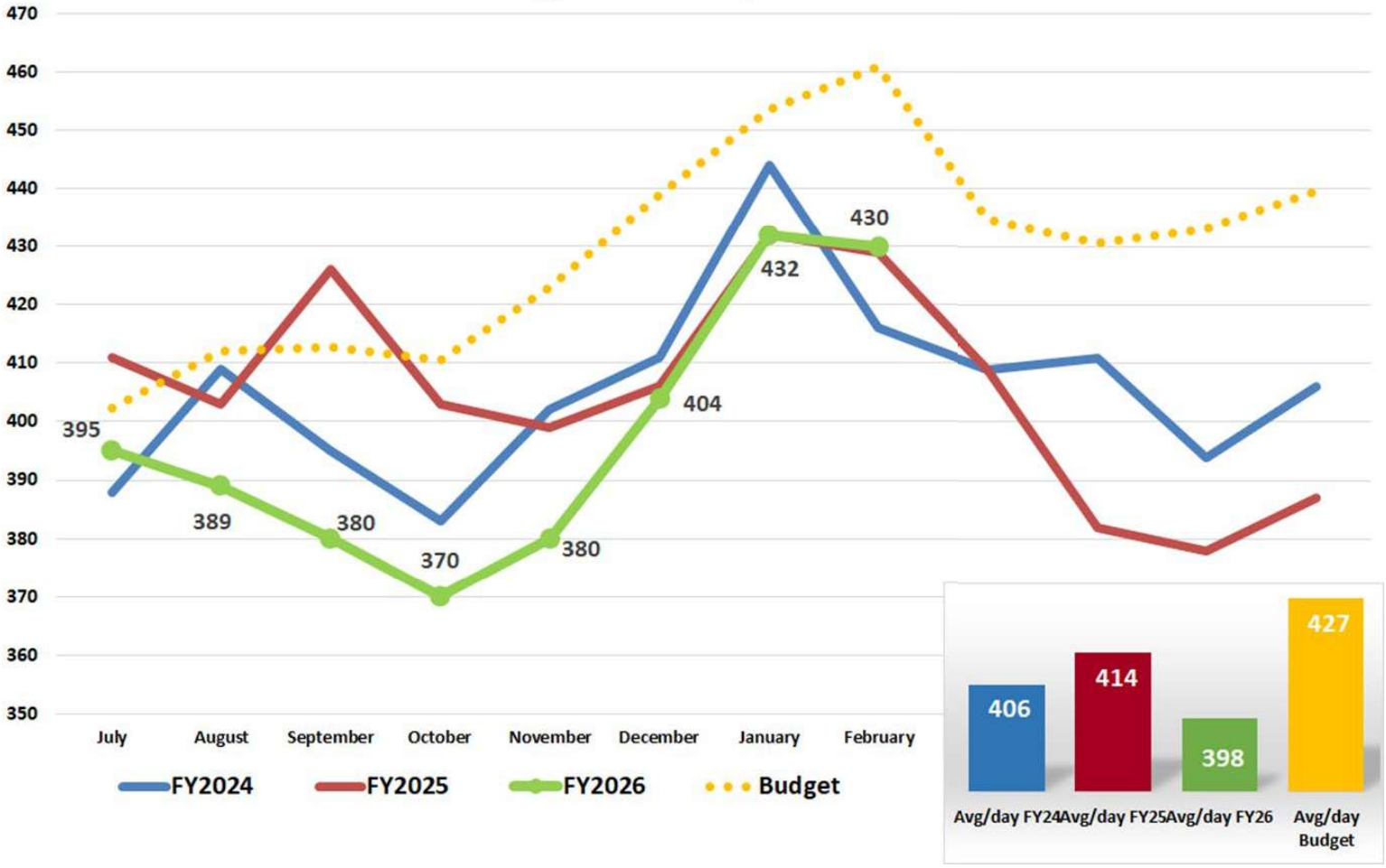
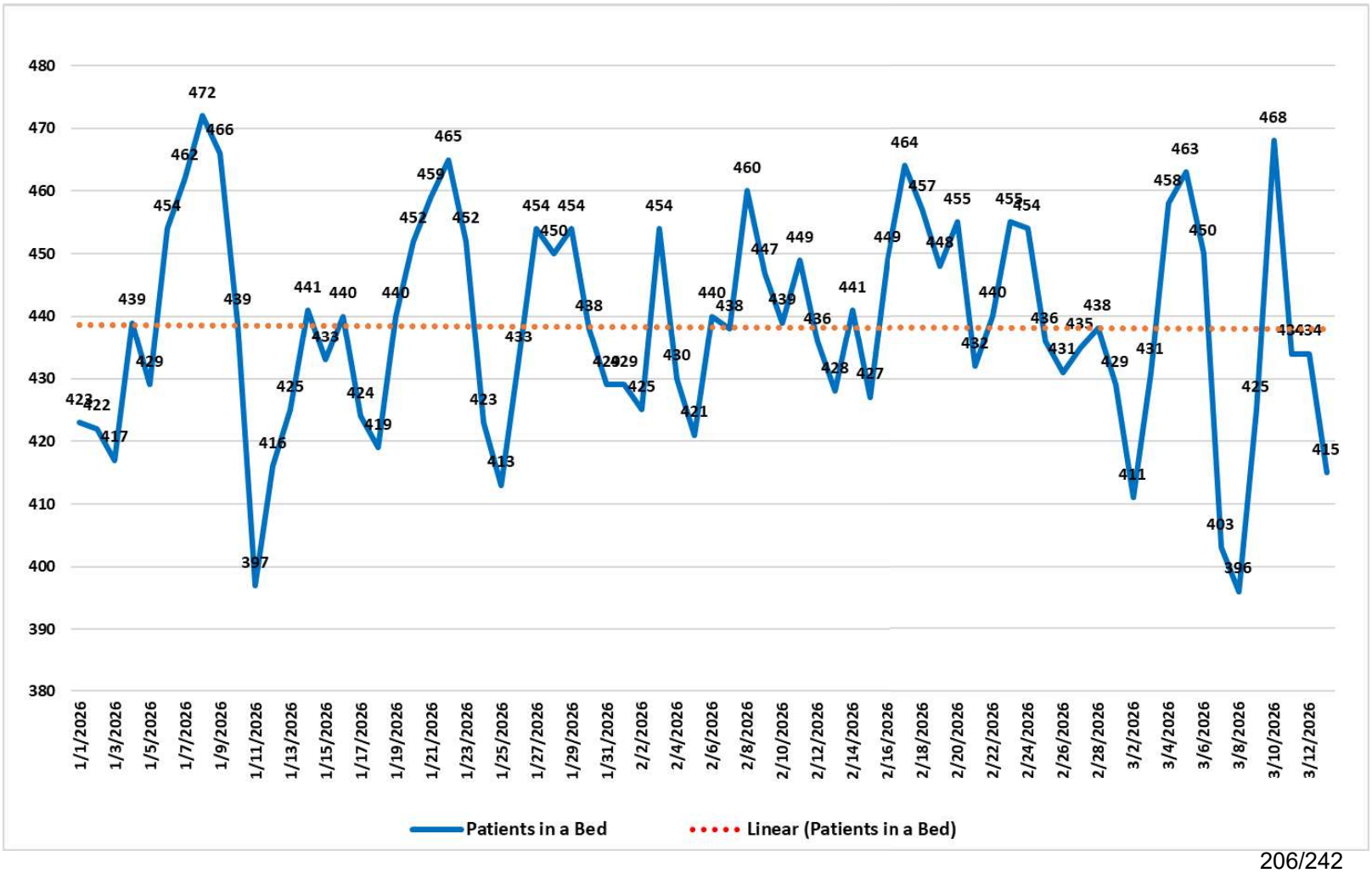
Fiscal Year 2027 Budget Calendar

Wednesday	**March 11, 2026**	Finance Department starts preparing cost center operating budgets using 8-month FYTD actual results and guiding principles adopted by Executive Team
Friday	**March 20, 2026**	Operating budgets with statistics distributed to cost center Directors Capital budgets distributed to cost center directors
Friday	**April 17, 2026**	Completed VP reviewed and approved cost center **Operating Budgets AND Capital Budgets** submitted to Finance Department
Monday	**April 20 – May 8**	First round of Budget meeting sessions will begin with Executives, Directors, & Managers
Monday	**May 18, 2026**	First draft of budget presented to Executive Team
Monday	**May 18, 2026**	Leadership/Finance Team submits final vetted capital equipment budget
Wednesday	**May 20, 2026**	Present to Board of Directors of preliminary budget concepts and guidelines
Wednesday	**June 10, 2026**	Budget finalized in preparation for Board Meeting
Friday	**June 12, 2026**	Complete presentation for Finance Board Meeting due
Wednesday	**June 17, 2026**	Present to Finance Board
Friday	**June 19, 2026**	Complete presentation for Board Meeting due
Wednesday	**June 24, 2026**	Final budget presented to Board of Directors for approval

Average Daily Census



Patients in a Bed YTD 2026

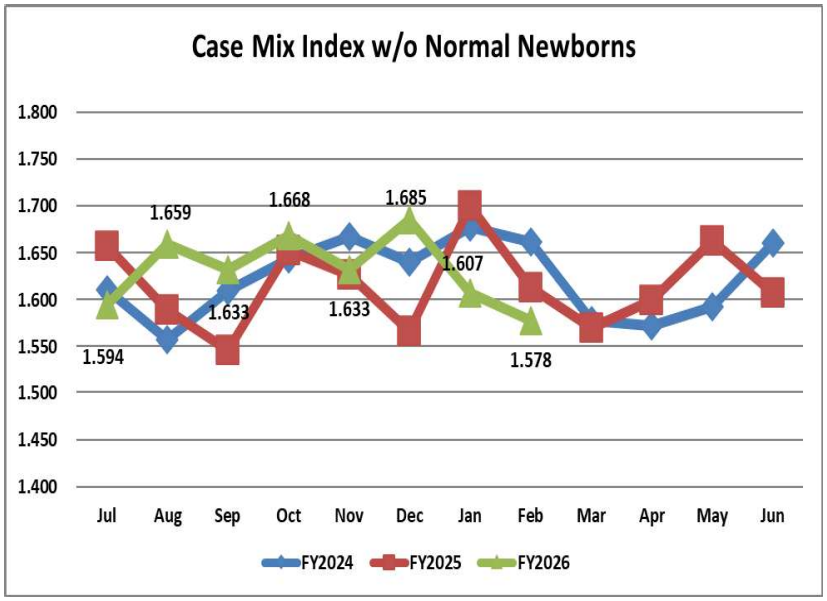


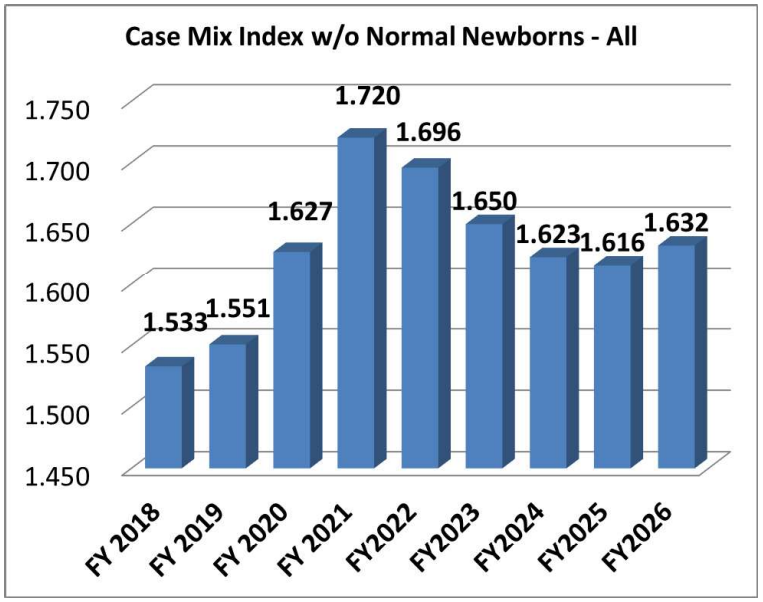
Statistical Results – Fiscal Year Comparison (Feb)

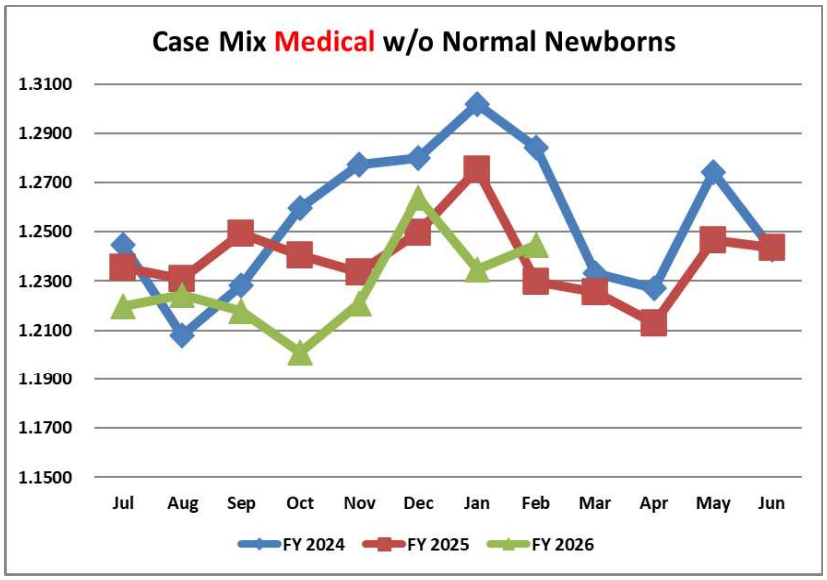
	Actual Results			Budget	Budget Variance	
	Feb 2025	Feb 2026	% Change	Feb 2026	Change	% Change
Average Daily Census	**429**	**430**	**0.2%**	**461**	**(31)**	**(6.7%)**
KDHCD Patient Days:						
Medical Center	8,287	7,937	(4.2%)	8,628	(691)	(8.0%)
Acute I/P Psych	981	1,306	33.1%	1,484	(178)	(12.0%)
Sub-Acute	853	880	3.2%	851	29	3.4%
Rehab	664	773	16.4%	652	121	18.6%
TCS-Ortho	375	364	(2.9%)	378	(14)	(3.7%)
NICU	335	414	23.6%	389	25	6.4%
Nursery	512	363	(29.1%)	520	(157)	(30.2%)
Total KDHCD Patient Days	**12,007**	**12,037**	**0.2%**	**12,902**	**(865)**	**(6.7%)**
Total Outpatient Volume	**58,156**	**58,800**	**1.1%**	**63,898**	**(5,098)**	**(8.0%)**

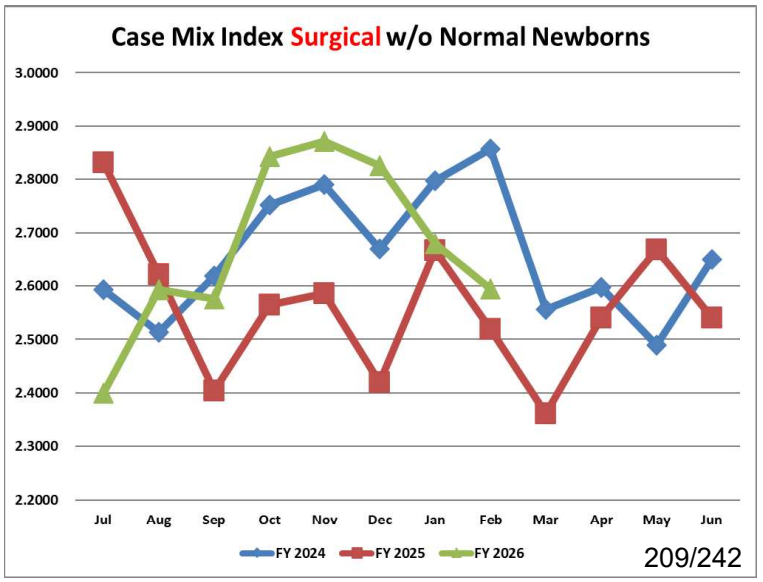
Statistical Results – Fiscal Year Comparison (Jul-Feb)

	Actual Results			Budget	Budget Variance	
	FYTD 2025	FYTD 2026	% Change	FYTD 2025	Change	% Change
Average Daily Census	**413**	**397**	**(3.8%)**	**426**	**(29)**	**(6.9%)**
KDHCD Patient Days:						
Medical Center	69,127	63,494	(8.1%)	69,268	(5,774)	(8.3%)
Acute I/P Psych	8,780	10,796	23.0%	11,988	(1,192)	(9.9%)
Sub-Acute	7,319	7,085	(3.2%)	7,294	(209)	(2.9%)
Rehab	4,857	5,346	10.1%	5,119	227	4.4%
TCS-Ortho	2,906	3,358	15.6%	3,092	266	8.6%
NICU	3,291	3,005	(8.7%)	3,062	(57)	(1.9%)
Nursery	4,179	3,420	(18.2%)	3,790	(370)	(9.8%)
Total KDHCD Patient Days	**100,459**	**96,504**	**(3.9%)**	**103,613**	**(7,109)**	**(6.9%)**
Total Outpatient Volume	**478,663**	**497,446**	**3.9%**	**554,542**	**(57,096)**	**(10.3%)**

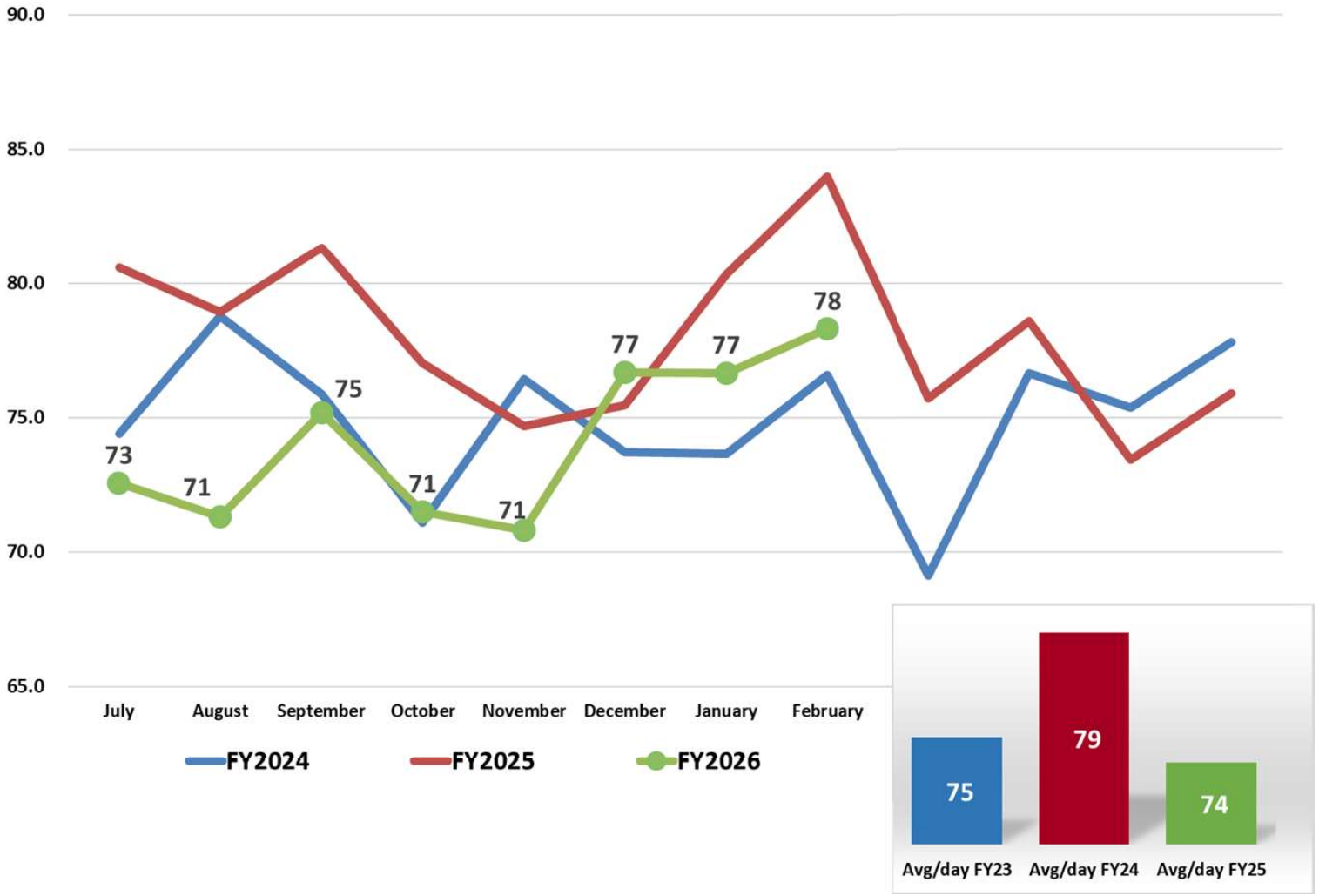

Case Mix Index w/o Normal Newborns
1.800
1.750
1.700
1.650
1.600
1.550
1.500
1.450
1.400
1.659
1.668
1.685
1.607
1.633
1.633
1.594
1.578
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY2024
FY2025
FY2026


Case Mix Index w/o Normal Newborns - All
1.750
1.700
1.650
1.600
1.550
1.500
1.450
1.533
1.551
1.627
1.720
1.696
1.650
1.623
1.616
1.632
FY 2018
FY 2019
FY 2020
FY 2021
FY2022
FY2023
FY2024
FY2025
FY2026

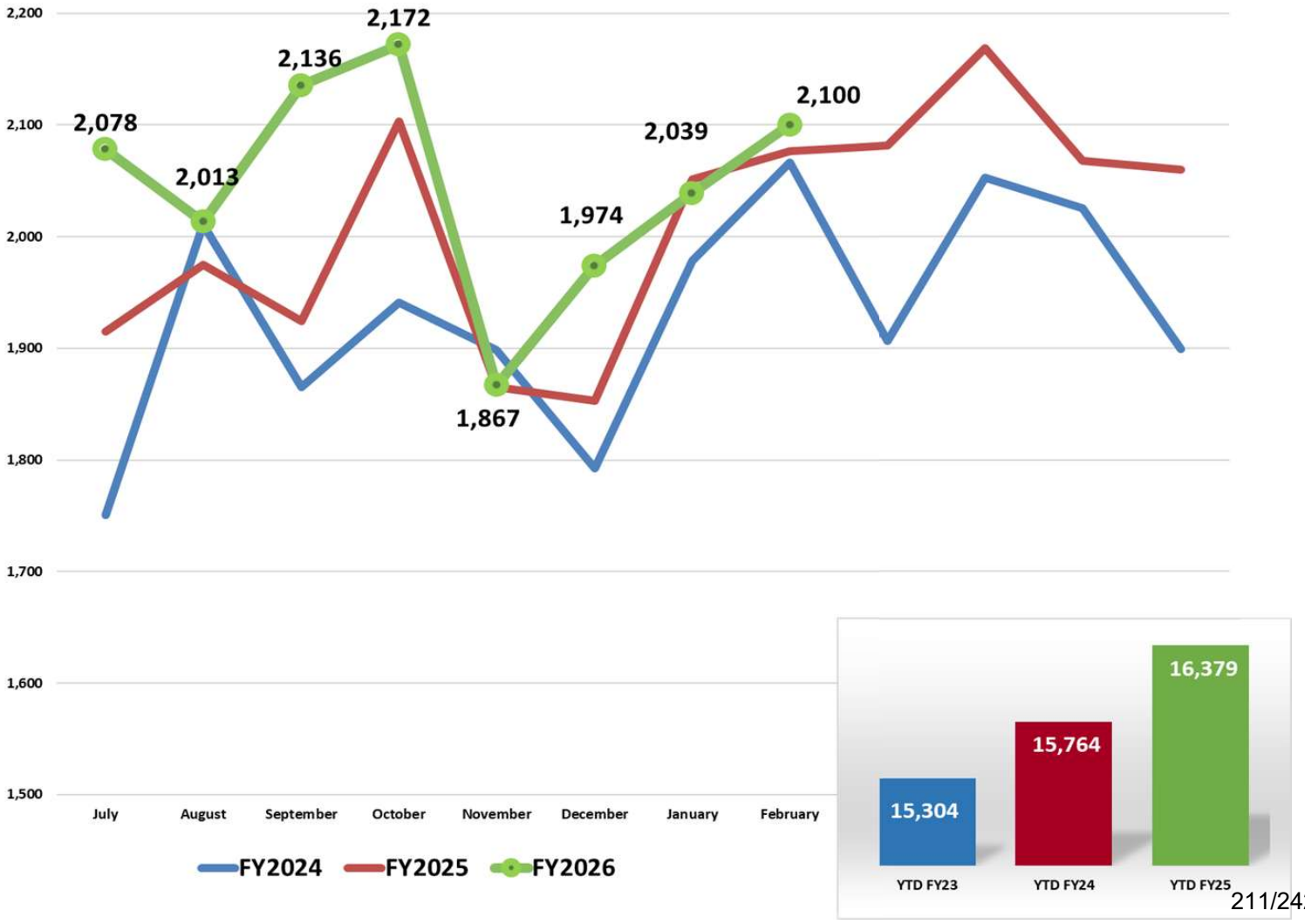

Case Mix Medical w/o Normal Newborns
1.3100
1.2900
1.2700
1.2500
1.2300
1.2100
1.1900
1.1700
1.1500
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY 2024
FY 2025
FY 2026


Case Mix Index Surgical w/o Normal Newborns
3.0000
2.9000
2.8000
2.7000
2.6000
2.5000
2.4000
2.3000
2.2000
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY 2024
FY 2025
FY 2026

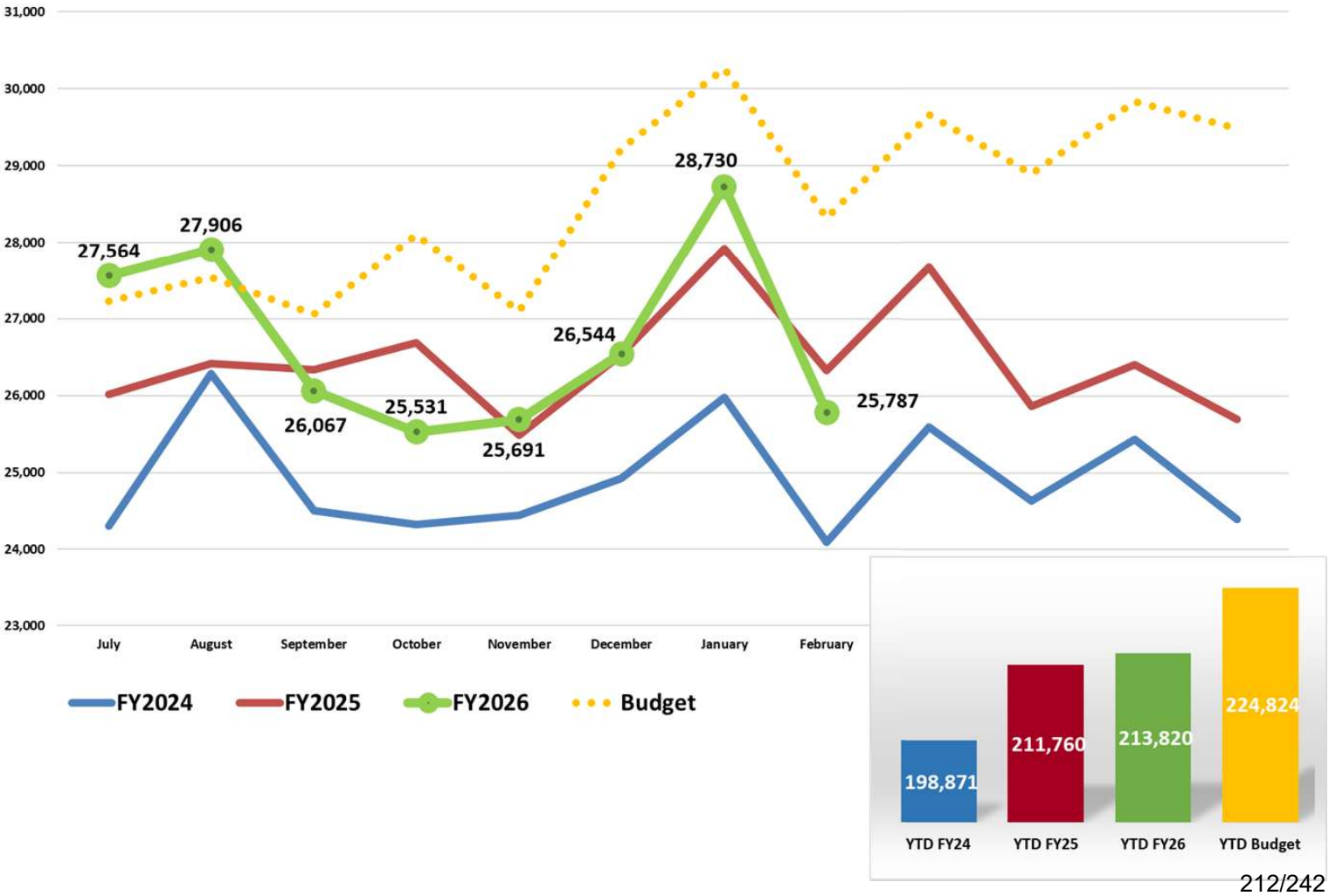
Average Discharges per Day



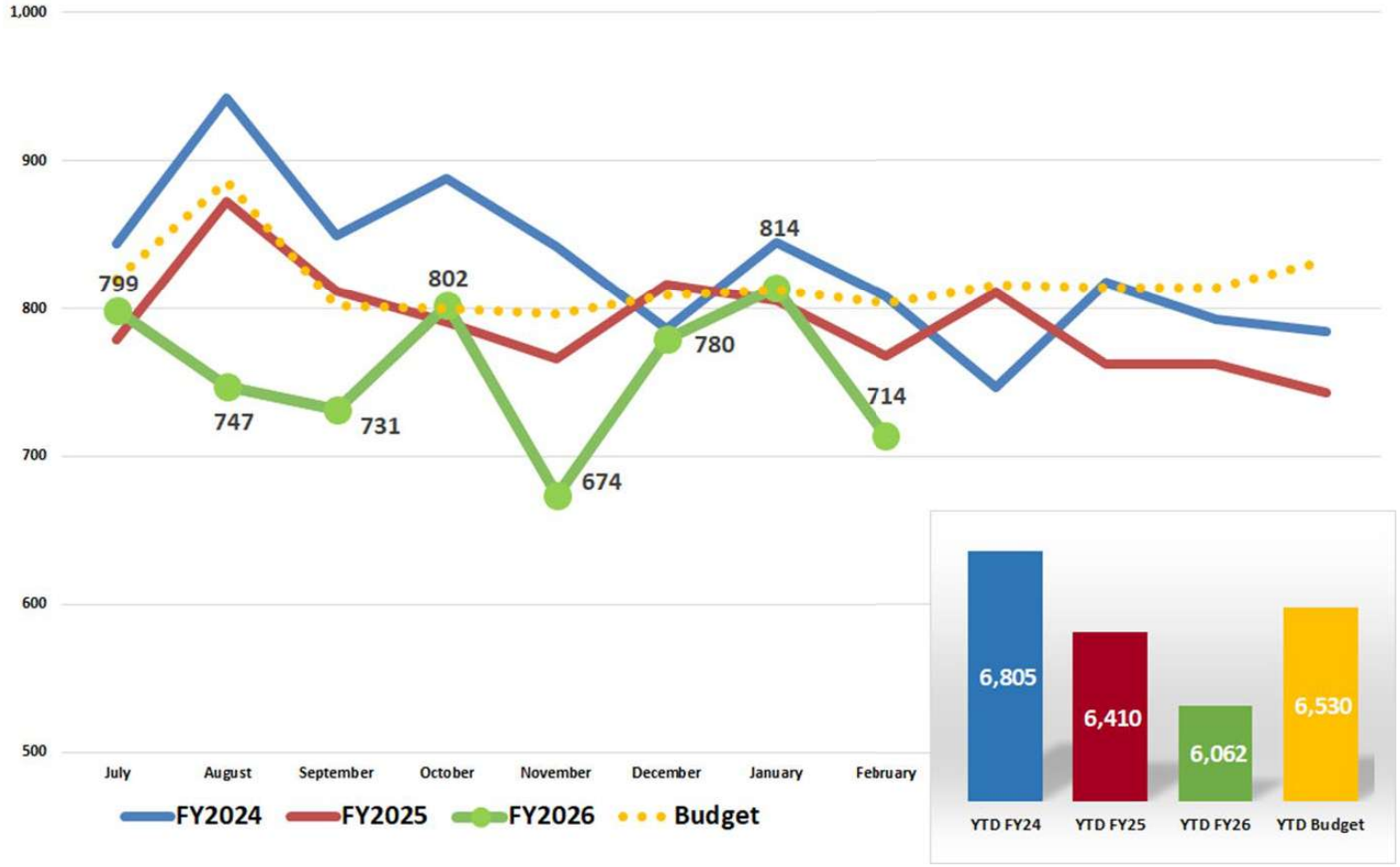
Outpatient Registrations Per Day



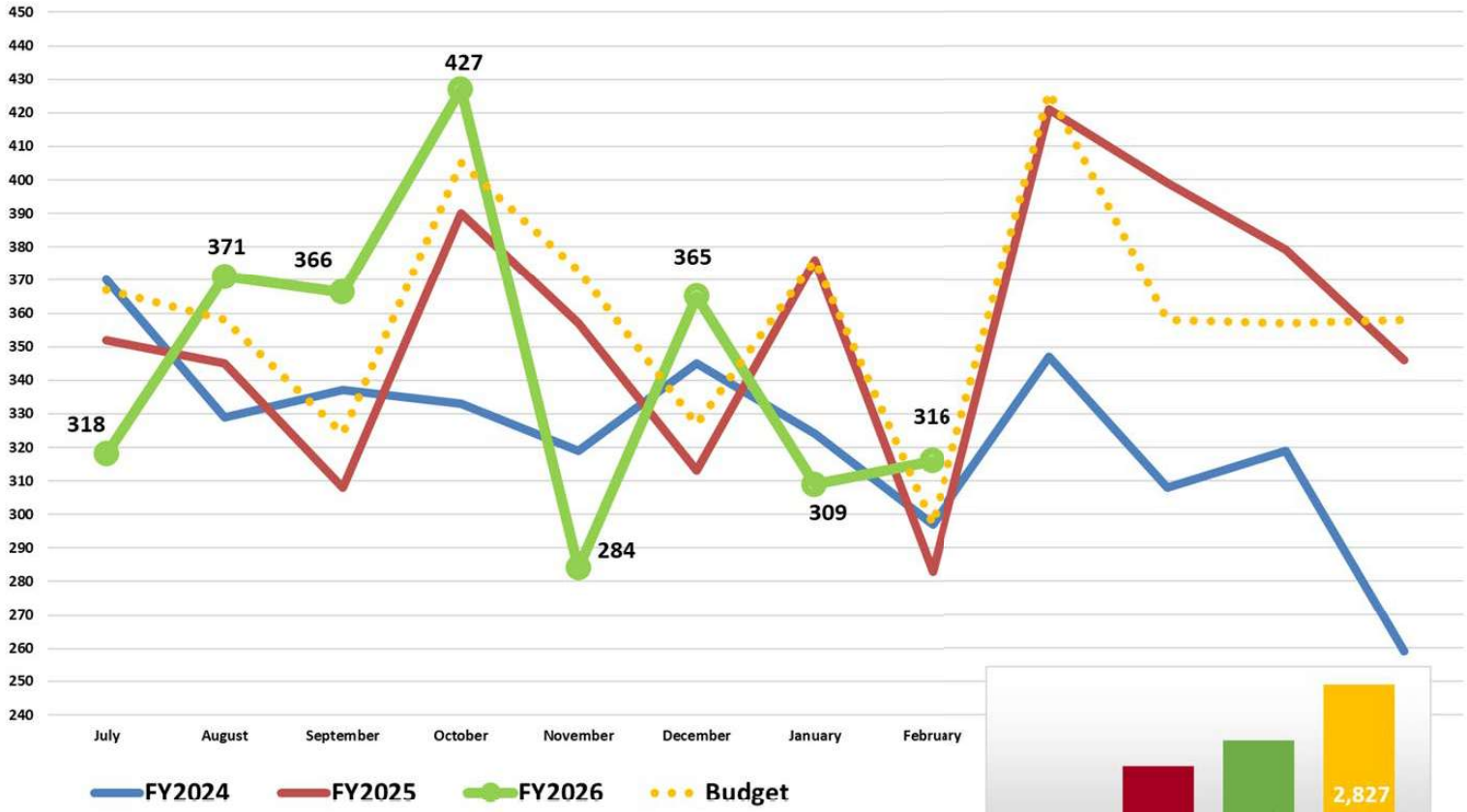
Adjusted Patient Days

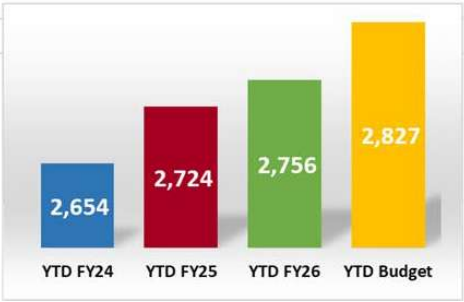


Surgery (IP & OP) – 100 Min Units



Cath Lab (IP & OP) – 100 Min Units





Other Statistical Results – Prior Year/Budget Comparison (Feb)

	Actual Results				Budget	Budget Variance	
	Feb 25	Feb 26	Change	% Change	Feb 26	Change	% Change
ED - Avg Treated Per Day	276	283	7	2.6%	293	(10)	(3.6%)
Surgery (IP & OP) – 100 Min Units	768	714	(54)	(7.0%)	804	(90)	(11.2%)
Endoscopy Procedures	619	400	(219)	(35.4%)	452	(52)	(11.5%)
Cath Lab (IP & OP) - 100 Min Units	283	316	33	11.7%	297	19	6.4%
Cardiac Surgery Cases	21	29	8	38.1%	29	(0)	(0.6%)
Deliveries	395	286	(109)	(27.6%)	418	(132)	(31.6%)
Clinical Lab	252,687	266,437	13,750	5.4%	277,956	(11,519)	(4.1%)
Reference Lab	7,327	6,170	(1,157)	(15.8%)	6,417	(247)	(3.9%)
Dialysis Center - Visalia Visits	1,407	1,199	(208)	(14.8%)	1,404	(205)	(14.6%)
Infusion Center - Units of Service	367	527	160	43.6%	661	(134)	(20.3%)
Hospice Days	3,239	3,524	285	8.8%	3,840	(316)	(8.2%)
Home Health Visits	3,116	2,579	(537)	(17.2%)	2,939	(360)	(12.2%)
Home Infusion Days	20,608	20,991	383	1.9%	20,600	391	1.9%

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

	YTD Actual Results				Budget	Budget Variance	
	YTD Feb 25	YTD Feb 26	Change	% Change	YTD Feb 26	Change	% Change
ED - Avg Treated Per Day	260	274	14	5.2%	278	(4)	(1.6%)
Surgery (IP & OP) – 100 Min Units	6,410	6,062	(349)	(5.4%)	6,530	(468)	(7.2%)
Endoscopy Procedures	4,911	3,862	(1,049)	(21.4%)	4,201	(339)	(8.1%)
Cath Lab (IP & OP) - 100 Min Units	2,724	2,756	32	1.2%	2,827	(71)	(2.5%)
Cardiac Surgery Cases	213	221	8	3.8%	265	(44)	(16.7%)
Deliveries	3,327	2,602	(725)	(21.8%)	2,983	(381)	(12.8%)
Clinical Lab	1,988,650	2,093,216	104,566	5.3%	2,187,515	(94,300)	(4.3%)
Reference Lab	54,985	56,311	1,326	2.4%	54,214	2,097	3.9%
Dialysis Center - Visalia Visits	11,924	11,303	(621)	(5.2%)	12,046	(743)	(6.2%)
Infusion Center - Units of Service	3,383	4,775	1,392	41.1%	5,079	(304)	(6.0%)
Hospice Days	27,876	32,661	4,785	17.2%	32,433	228	0.7%
Home Health Visits	23,005	22,739	(266)	(1.2%)	24,114	(1,375)	(5.7%)
Home Infusion Days	174,072	189,977	15,905	9.1%	175,102	14,875	8.5%

Other Statistical Results – Prior Year/Budget Comparison (Feb)

	Actual Results				Budget	Budget Variance	
	Feb 25	Feb 26	Change	% Change	Feb 26	Change	% Change
All O/P Rehab Svcs Across District	19,001	17,938	(1,063)	(5.6%)	19,633	(1,695)	(8.6%)
Physical & Other Therapy Units (I/P & O/P)	18,188	19,669	1,481	8.1%	18,904	765	4.0%
Radiology - CT - All Areas	4,423	5,032	609	13.8%	4,303	729	16.9%
Radiology - MRI - All Areas	807	842	35	4.3%	822	20	2.4%
Radiology - Ultrasound - All Areas	2,867	2,941	74	2.6%	2,857	84	2.9%
Radiology - Diagnostic Radiology	9,497	9,404	(93)	(1.0%)	9,674	(270)	(2.8%)
Radiology – Main Campus	14,893	14,955	62	0.4%	14,847	108	0.7%
Radiology - Ultrasound - Main Campus	2,253	1,968	(285)	(12.6%)	2,034	(66)	(3.2%)
West Campus - Diagnostic Radiology	1,222	1,277	55	4.5%	1,141	136	11.9%
West Campus - CT Scan	473	623	150	31.7%	452	171	37.9%
West Campus - MRI	392	391	(1)	(0.3%)	393	(2)	(0.6%)
West Campus - Ultrasound	614	973	359	58.5%	823	150	18.2%
West Campus - Breast Center	1,409	1,770	361	25.6%	1,409	361	25.6%

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

	YTD Actual Results				Budget	Budget Variance	
	YTD Feb 25	YTD Feb 26	Change	% Change	YTD Feb 26	Change	% Change
All O/P Rehab Svcs Across District	162,902	158,266	(4,636)	(2.8%)	166,511	(8,245)	(5.0%)
Physical & Other Therapy Units (I/P & O/P)	147,614	150,779	3,165	2.1%	157,718	(6,939)	(4.4%)
Radiology - CT - All Areas	36,700	41,070	4,370	11.9%	36,296	4,774	13.2%
Radiology - MRI - All Areas	6,945	7,294	349	5.0%	6,945	349	5.0%
Radiology - Ultrasound - All Areas	24,053	24,134	81	0.3%	23,949	185	0.8%
Radiology - Diagnostic Radiology	76,744	76,108	(636)	(0.8%)	78,064	(1,956)	(2.5%)
Radiology – Main Campus	122,615	123,948	1,333	1.1%	122,078	1,870	1.5%
Radiology - Ultrasound - Main Campus	18,789	17,622	(1,167)	(6.2%)	17,118	504	2.9%
West Campus - Diagnostic Radiology	9,310	10,353	1,043	11.2%	9,160	1,193	13.0%
West Campus - CT Scan	3,937	4,491	554	14.1%	3,829	662	17.3%
West Campus - MRI	3,316	3,302	(14)	(0.4%)	3,356	(54)	(1.6%)
West Campus - Ultrasound	5,264	6,512	1,248	23.7%	6,831	(319)	(4.7%)
West Campus - Breast Center	13,173	13,370	197	1.5%	13,174	196	1.5%
Med Onc Visalia Treatments	8,475	9,206	731	8.6%	8,881	325	3.7%
Rad Onc Visalia Treatments	11,264	13,387	2,123	18.8%	11,581	1,806	15.6%
Rad Onc Hanford Treatments	1,906	1,955	49	2.6%	1,942	13	0.7%

Other Statistical Results – Prior Year/Budget Comparison (Feb)

	Actual Results				Budget	Budget Variance	
	Feb 25	Feb 26	Change	% Change	Feb 26	Change	% Change
Rural Health Clinics Registrations	12,807	10,931	(1,876)	(14.6%)	13,414	(2,483)	(18.5%)
RHC Exeter - Registrations	6,076	5,073	(1,003)	(16.5%)	6,522	(1,449)	(22.2%)
RHC Lindsay - Registrations	1,756	1,640	(116)	(6.6%)	2,080	(440)	(21.2%)
RHC Woodlake - Registrations	1,334	596	(738)	(55.3%)	637	(41)	(6.4%)
RHC Woodlake Valencia - Registrations	0	556	556	0.0%	1,200	(644)	(53.7%)
RHC Dinuba - Registrations	1,506	1,215	(291)	(19.3%)	1,700	(485)	(28.5%)
RHC Tulare - Registrations	2,135	1,851	(284)	(13.3%)	2,475	(624)	(25.2%)
Urgent Care – Court Total Visits	2,639	2,579	(60)	(2.3%)	3,000	(421)	(14.0%)
Urgent Care – Demaree Total Visits	1,632	2,270	638	39.1%	2,150	120	5.6%
KH Medical Clinic - Ben Maddox Visits	895	920	25	2.8%	-	920	0.0%
KH Medical Clinic - Plaza Visits	243	206	(37)	(15.2%)	271	(65)	(24.0%)
KH Willow Specialty Clinic	0	363	363	0.0%	509	(146)	(28.6%)
KH Cardiology Center Visalia Registrations	1,368	1,176	(192)	(14.0%)	1,582	(406)	(25.7%)
KH Mental Wellness Clinic Visits	234	316	82	35.0%	350	(34)	(9.7%)
Urology Clinic Visits	305	316	11	3.6%	821	(505)	(61.5%)
Therapy-Wound Care Svcs Encounters	235	291	56	23.8%	324	(33)	(10.2%)

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

	YTD Actual Results				Budget	Budget Variance	
	YTD Feb 25	YTD Feb 26	Change	% Change	YTD Feb 26	Change	% Change
Rural Health Clinics Registrations	107,438	96,812	(10,626)	(9.9%)	110,126	(13,314)	(12.1%)
RHC Exeter - Registrations	51,200	46,596	(4,604)	(9.0%)	53,705	(7,109)	(13.2%)
RHC Lindsay - Registrations	14,784	13,607	(1,177)	(8.0%)	16,490	(2,883)	(17.5%)
RHC Woodlake - Registrations	10,537	4,436	(6,101)	(57.9%)	5,468	(1,032)	(18.9%)
RHC Woodlake Valencia - Registrations	0	4,900	4,900	0.0%	6,698	(1,798)	(26.8%)
RHC Dinuba - Registrations	12,133	10,474	(1,659)	(13.7%)	13,875	(3,401)	(24.5%)
RHC Tulare - Registrations	18,784	16,799	(1,985)	(10.6%)	20,588	(3,789)	(18.4%)
Urgent Care – Court Total Visits	19,691	20,446	755	3.8%	23,500	(3,054)	(13.0%)
Urgent Care – Demaree Total Visits	12,155	15,570	3,415	28.1%	16,250	(680)	(4.2%)
KH Medical Clinic - Ben Maddox Visits	6,408	7,777	1,369	21.4%	5,500	2,277	41.4%
KH Medical Clinic - Plaza Visits	2,154	1,817	(337)	(15.6%)	2,232	(415)	(18.6%)
KH Willow Specialty Clinic	0	2,842	2,842	0.0%	3,685	(843)	(22.9%)
KH Cardiology Center Visalia Registrations	12,216	11,273	(943)	(7.7%)	12,927	(1,654)	(12.8%)
KH Mental Wellness Clinic Visits	2,299	2,381	82	3.6%	3,020	(639)	(21.2%)
Urology Clinic Visits	2,412	1,474	(938)	(38.9%)	3,201	(1,727)	(54.0%)
Therapy-Wound Care Svcs Encounters	1,514	2,653	1,139	75.2%	2,813	(160)	(5.7%)

February Financial Summary (000's) Budget Comparison

	Comparison to Budget - Month of February			
	Budget Feb-2026	Actual Feb-2026	$ Change	% Change
Operating Revenue				
Net Patient Service Revenue	$54,746	$54,599	($147)	-0.3%
Other Operating Revenue	$22,072	$21,119	($953)	-4.5%
Total Operating Revenue	**$76,818**	**$75,718**	**($1,100)**	**-1.5%**
Operating Expenses				
Employment Expenses	$40,719	$40,711	($8)	0.0%
Other Expenses	$35,992	$35,074	($918)	-2.6%
Total Operating Expenses	**$76,711**	**$75,785**	**($926)**	**-1.2%**
Operating Margin	**$107**	**($67)**	**($174)**	
Stimulus/FEMA	$0	$0	$0	
Operating Margin after Stimulus/FEMA	**$107**	**($67)**	**($174)**	
Nonoperating Revenue (Loss)	$870	$1,178	$308	
Excess Margin	**$977**	**$1,111**	**$134**	

February Financial Summary (000's) Prior Year Comparison

	Comparison to Prior Year - Month of February			
	Actual Feb-2025	Actual Feb-2026	$ Change	% Change
Operating Revenue				
Net Patient Service Revenue	$53,731	$54,599	$868	1.6%
Other Operating Revenue	$18,979	$21,119	$2,140	10.1%
Total Operating Revenue	**$72,710**	**$75,718**	**$3,008**	**4.0%**
Operating Expenses				
Employment Expenses	$38,637	$40,711	$2,074	5.1%
Other Expenses	$33,796	$35,074	$1,278	3.6%
Total Operating Expenses	**$72,433**	**$75,785**	**$3,352**	**4.4%**
Operating Margin	**$277**	**($67)**	**($344)**	
Stimulus/FEMA	$0	$0	$0	
Operating Margin after Stimulus/FEMA	**$277**	**($67)**	**($344)**	
Nonoperating Revenue (Loss)	$1,166	$1,178	$12	
Excess Margin	**$1,443**	**$1,111**	**($332)**	

Year to Date Financial Summary (000's)

	Comparison to Budget - YTD February			
	Budget YTD Feb-2026	Actual YTD Feb-2026	$ Change	% Change
Operating Revenue				
Net Patient Service Revenue	$457,356	$455,339	($2,017)	-0.4%
Other Operating Revenue	$174,716	$180,529	$5,812	3.2%
Total Operating Revenue	**$632,072**	**$635,868**	**$3,795**	**0.6%**
Operating Expenses				
Employment Expenses	$340,147	$345,311	$5,164	1.5%
Other Expenses	$296,881	$296,040	($841)	-0.3%
Total Operating Expenses	**$637,028**	**$641,351**	**$4,323**	**0.7%**
Operating Margin	**($4,956)**	**($5,483)**	**($527)**	
Nonoperating Revenue (Loss)	$7,026	$10,441	$3,415	
Excess Margin	**$2,070**	**$4,958**	**$2,888**	

February Financial Comparison (000's)

	Comparison to Budget - Month of Febuary				Comparison to Prior Year - Month of Febuary			
	Budget Feb-2026	Actual Feb-2026	$ Change	% Change	Actual Feb-2025	Actual Feb-2026	$ Change	% Change
Operating Revenue								
Net Patient Service Revenue	**$54,746**	**$54,599**	**($147)**	**-0.3%**	**$53,731**	**$54,599**	**$868**	**1.6%**
Supplemental Gov't Programs	$9,727	$8,772	($954)	-10.9%	$7,650	$8,772	$1,122	12.8%
Prime Program	$631	$631	($0)	0.0%	$792	$631	($161)	-25.6%
Premium Revenue	$7,415	$7,224	($192)	-2.7%	$6,367	$7,224	$856	11.9%
Other Revenue	$4,300	$4,493	$193	4.3%	$4,170	$4,493	$323	7.2%
Other Operating Revenue	$22,072	$21,119	($953)	-4.5%	$18,979	$21,119	$2,140	10.1%
Total Operating Revenue	**$76,818**	**$75,718**	**($1,100)**	**-1.5%**	**$72,710**	**$75,718**	**$3,008**	**4.0%**
Operating Expenses								
Salaries & Wages	$32,414	$32,267	($147)	-0.5%	$30,528	$32,267	$1,739	5.4%
Contract Labor	$1,454	$574	($880)	-153.4%	$1,948	$574	($1,374)	-239.5%
Employee Benefits	$6,851	$7,870	$1,020	13.0%	$6,161	$7,870	$1,709	21.7%
Total Employment Expenses	**$40,719**	**$40,711**	**($8)**	**0.0%**	**$38,637**	**$40,711**	**$2,074**	**5.1%**
Medical & Other Supplies	$13,622	$14,144	$522	3.7%	$12,648	$14,144	$1,497	10.6%
Physician Fees	$7,584	$7,201	($383)	-5.3%	$7,412	$7,201	($211)	-2.9%
Purchased Services	$1,786	$1,975	$189	9.6%	$1,447	$1,975	$528	26.7%
Repairs & Maintenance	$2,298	$2,227	($71)	-3.2%	$2,355	$2,227	($129)	-5.8%
Utilities	$1,005	$835	($170)	-20.4%	$909	$835	($74)	-8.9%
Rents & Leases	$133	$124	($9)	-7.5%	$155	$124	($31)	-25.4%
Depreciation & Amortization	$3,497	$3,365	($132)	-3.9%	$3,221	$3,365	$145	4.3%
Interest Expense	$517	$596	$79	13.2%	$555	$596	$41	6.9%
Other Expense	$2,144	$1,859	($285)	-15.3%	$2,032	$1,859	($173)	-9.3%
Humana Cap Plan Expenses	$3,406	$2,749	($657)	-23.9%	$3,063	$2,749	($314)	-11.4%
Total Other Expenses	**$35,992**	**$35,074**	**($918)**	**-2.6%**	**$33,796**	**$35,074**	**$1,278**	**3.6%**
Total Operating Expenses	**$76,711**	**$75,785**	**($926)**	**-1.2%**	**$72,433**	**$75,785**	**$3,352**	**4.4%**
Operating Margin	**$107**	**($67)**	**($174)**		**$277**	**($67)**	**($344)**	
Nonoperating Revenue (Loss)	$870	$1,178	$308		$1,166	$1,178	$12	
Excess Margin	**$977**	**$1,111**	**$134**		**$1,443**	**$1,111**	**($332)**	

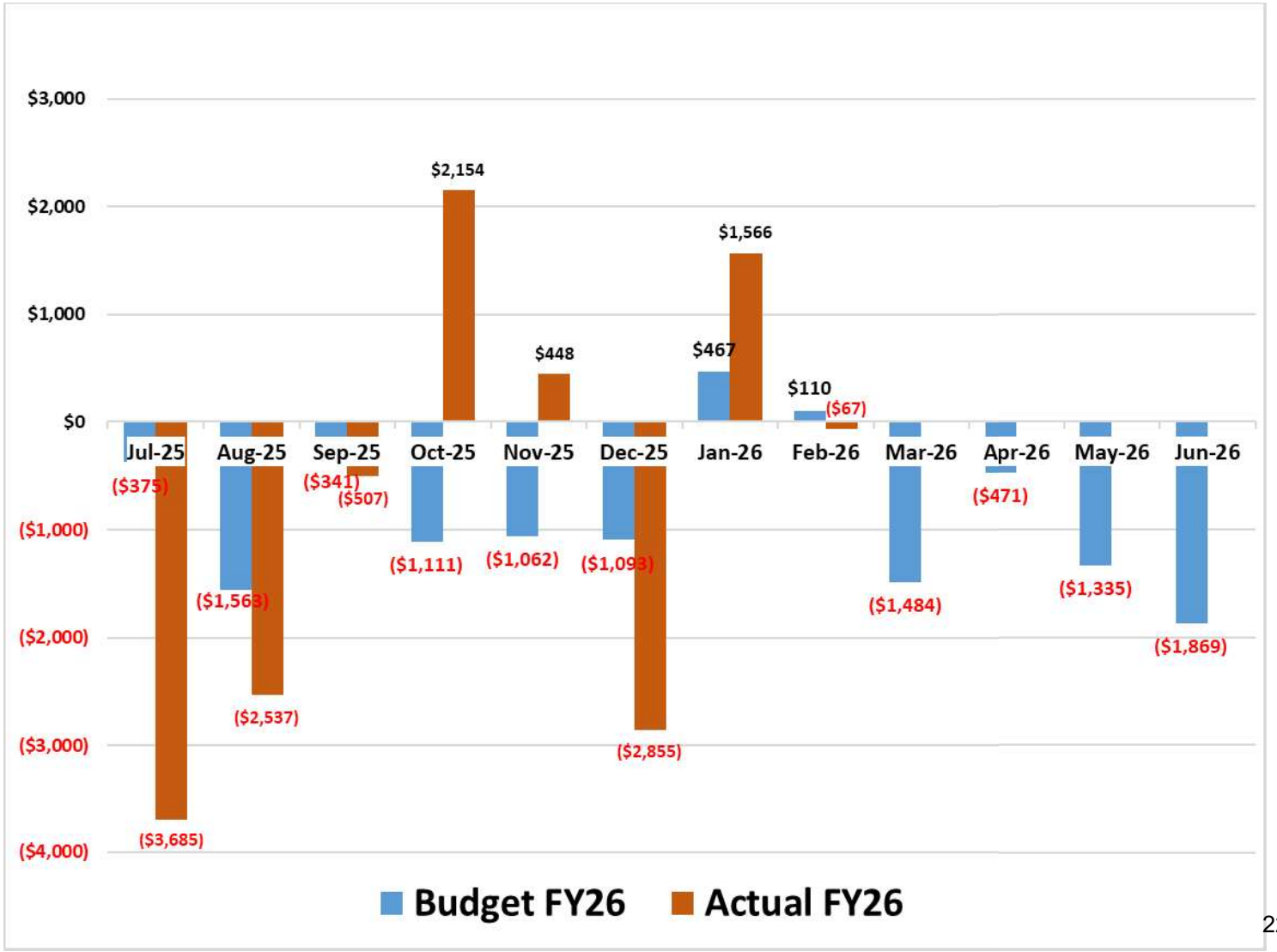
Year to Date: July through February Financial Comparison (000's)

	Comparison to Budget - YTD February				Comparison to Prior Year - YTD February			
	Budget YTD Feb-2026	Actual YTD Feb-2026	$ Change	% Change	Actual YTD Feb-2025	Actual YTD Feb-2026	$ Change	% Change
Operating Revenue								
Net Patient Service Revenue	**$457,356**	**$455,339**	**($2,017)**	**-0.4%**	**$435,269**	**$455,339**	**$20,070**	**4.4%**
Supplemental Gov't Programs	$77,812	$77,639	($173)	-0.2%	$56,222	$77,639	$21,417	27.6%
Prime Program	$5,045	$5,045	($0)	0.0%	$11,094	$5,045	($6,049)	-119.9%
Premium Revenue	$57,202	$58,299	$1,098	1.9%	$55,388	$58,299	$2,911	5.0%
Other Revenue	$34,657	$39,545	$4,888	12.4%	$32,857	$39,545	$6,688	16.9%
Other Operating Revenue	$174,716	$180,529	$5,812	3.2%	$155,561	$180,529	$24,967	13.8%
Total Operating Revenue	**$632,072**	**$635,868**	**$3,795**	**0.6%**	**$590,831**	**$635,868**	**$45,037**	**7.1%**
Operating Expenses								
Salaries & Wages	$266,522	$268,503	$1,981	0.7%	$254,382	$268,503	$14,121	5.3%
Contract Labor	$16,032	$15,691	($341)	-2.2%	$13,146	$15,691	$2,545	16.2%
Employee Benefits	$57,593	$61,117	$3,523	5.8%	$51,725	$61,117	$9,391	15.4%
Total Employment Expenses	**$340,147**	**$345,311**	**$5,164**	**1.5%**	**$319,253**	**$345,311**	**$26,058**	**7.5%**
Medical & Other Supplies	$112,200	$116,407	$4,206	3.6%	$110,395	$116,407	$6,011	5.2%
Physician Fees	$60,282	$62,393	$2,112	3.4%	$57,788	$62,393	$4,605	7.4%
Purchased Services	$15,189	$15,740	$551	3.5%	$13,190	$15,740	$2,549	16.2%
Repairs & Maintenance	$19,936	$17,545	($2,392)	-13.6%	$17,269	$17,545	$276	1.6%
Utilities	$7,774	$7,119	($655)	-9.2%	$7,670	$7,119	($551)	-7.7%
Rents & Leases	$1,124	$1,221	$96	7.9%	$1,126	$1,221	$94	7.7%
Depreciation & Amortization	$28,027	$26,581	($1,446)	-5.4%	$25,435	$26,581	$1,147	4.3%
Interest Expense	$4,486	$4,651	$165	3.5%	$4,742	$4,651	($91)	-2.0%
Other Expense	$18,301	$16,728	($1,573)	-9.4%	$16,429	$16,728	$300	1.8%
Humana Cap Plan Expenses	$29,561	$27,655	($1,906)	-6.9%	$33,613	$27,655	($5,958)	-21.5%
Total Other Expenses	**$296,881**	**$296,040**	**($841)**	**-0.3%**	**$287,657**	**$296,040**	**$8,383**	**2.8%**
Total Operating Expenses	**$637,028**	**$641,351**	**$4,323**	**0.7%**	**$606,910**	**$641,351**	**$34,441**	**5.4%**
Operating Margin	**($4,956)**	**($5,483)**	**($527)**		**($16,080)**	**($5,483)**	**$10,596**	
Stimulus/FEMA	**$0**	**($0)**	**($0)**		**$47,722**	**($0)**	**($47,722)**	
Operating Margin after Stimulus/FEMA	**($4,956)**	**($5,483)**	**($527)**		**$31,642**	**($5,483)**	**($37,126)**	
Nonoperating Revenue (Loss)	$7,026	$10,441	$3,415		$10,992	$10,441	($551)	
Excess Margin	**$2,070**	**$4,958**	**$2,888**		**$42,634**	**$4,958**	**($37,676)**	

Month of February - Budget Variances

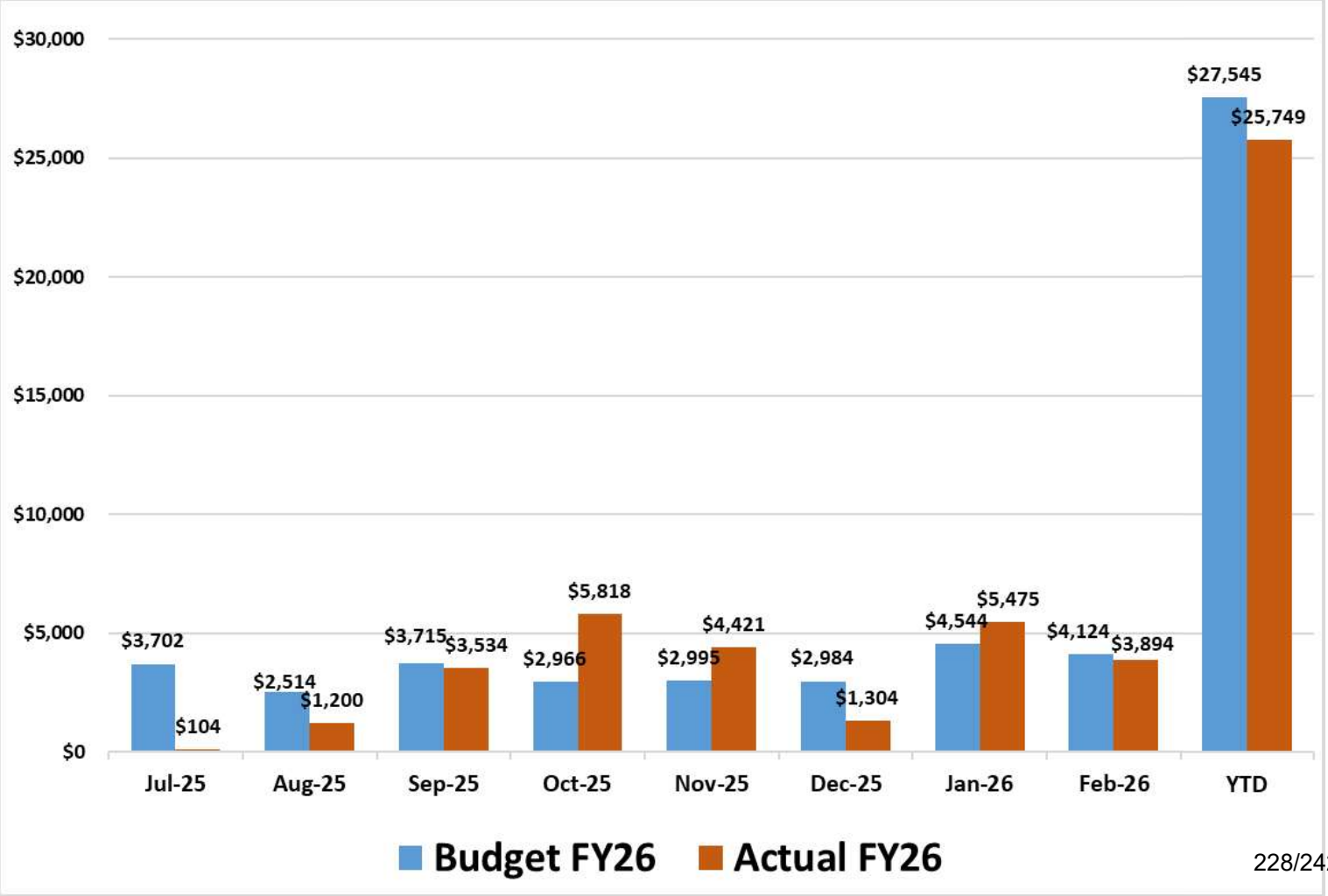
- **Supplemental Gov't Programs:** The unfavorable budget variance of $954K is primarily due to unanticipated HQAF State legislation – a decrease of 40% which we will experience through the end of the fiscal year.
- **Contract Labor:** The positive variance of $880k in February is the result of timing, as January was over accrued by approximately $1M – overstating January's and understating February's expense. Fiscal year-to-date there is a favorable variance of $341K (2.2%) under budget.
- **Employee Benefits:** The unfavorable budget variance of $1M in February is due to employee health insurance, specifically the cost of pharmaceuticals.
- **Medical Supplies:** Pharmaceutical cost for medical oncology and retail pharmacy was the main cause of the $522K unfavorable budget variance in February.
- **Humana Cap Plan Expenses:** The $657K favorable variance is due to lower than expected experience for third party health care costs of those covered by our Medicare Managed Care capitated contract.

Budget and Actual Fiscal Year 2026: Trended Operating Margin (000's)



Budget and Actual Fiscal Year 2026: "Cash Flow"

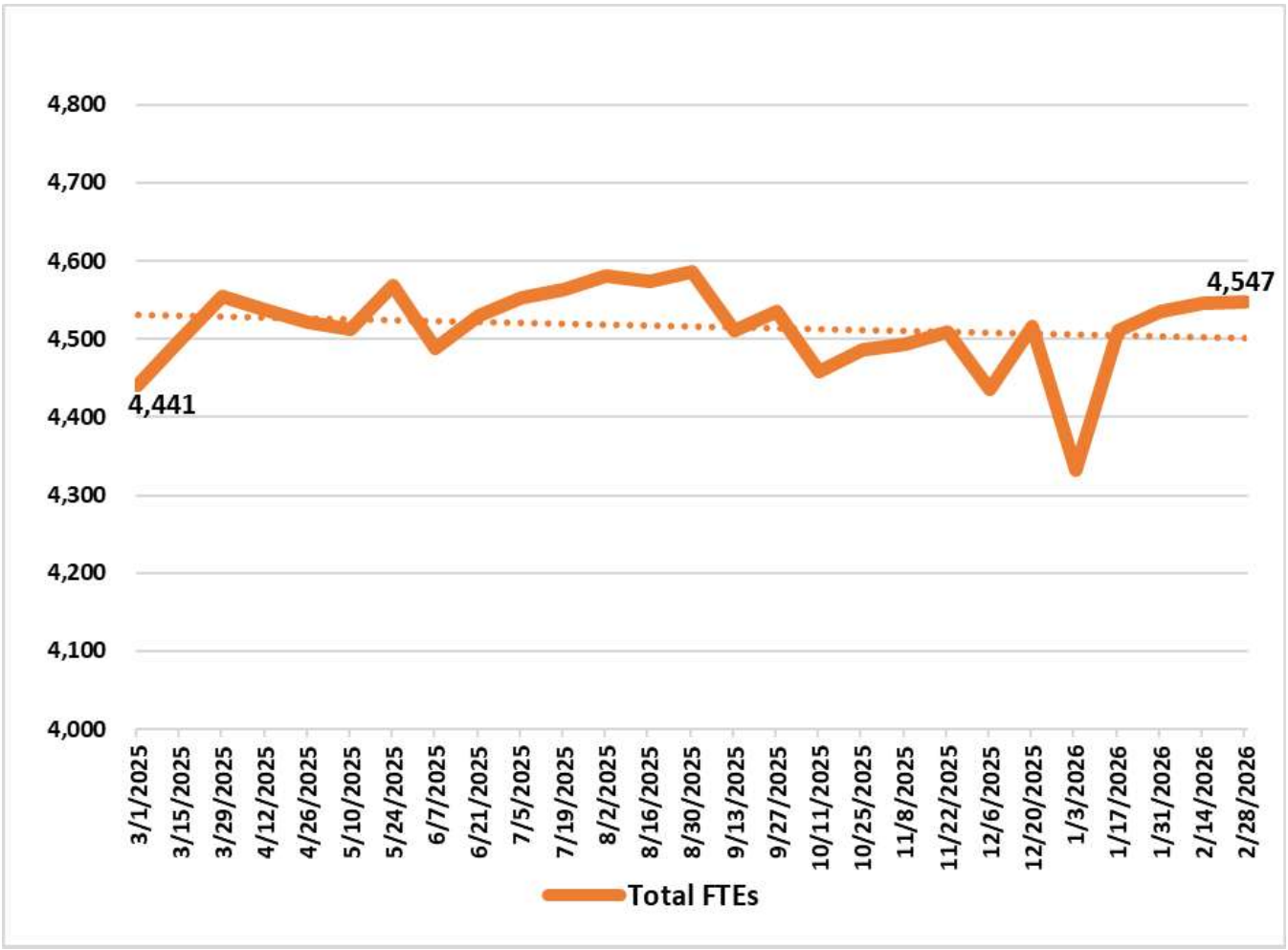
Net Earnings before Depreciation and Interest (000's)



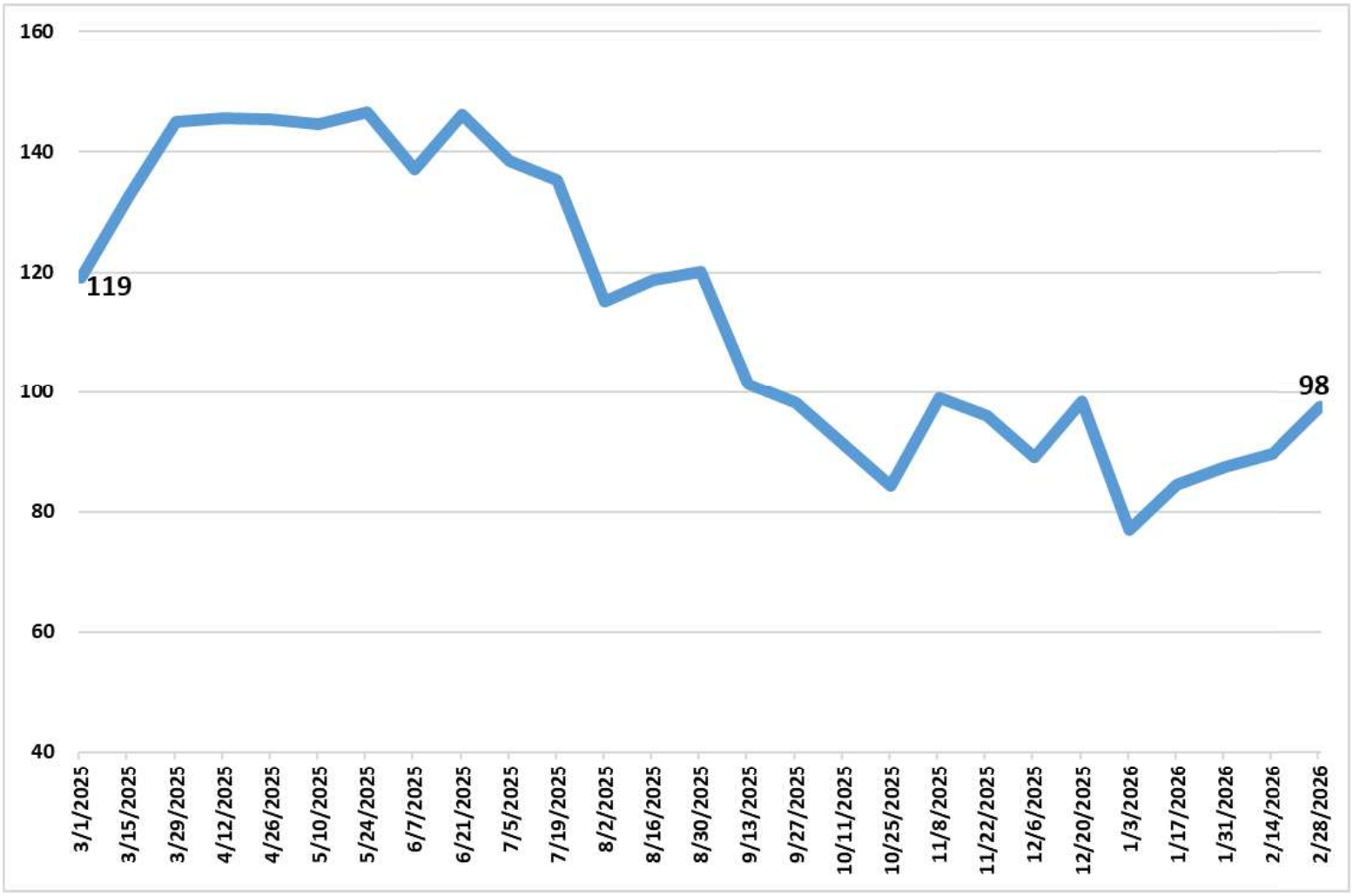
Budget and Actual Fiscal Year 2026: Trended Operating Margin (000's)

	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	FY 2026
Patient Service Revenue	$56,501	$53,289	$56,822	$61,063	$56,876	$55,676	$60,513	$54,599	$455,339
Other Revenue	$21,848	$23,904	$22,899	$24,620	$21,974	$22,751	$21,414	$21,119	$180,529
Total Operating Revenue	$78,349	$77,193	$79,720	$85,682	$78,850	$78,427	$81,928	$75,718	$635,868
Employee Expense	$43,550	$42,743	$42,190	$44,735	$43,893	$44,400	$43,089	$40,711	$345,311
Other Operating Expense	$38,484	$36,987	$38,038	$38,793	$34,509	$36,883	$37,272	$35,074	$296,040
Total Operating Expenses	$82,034	$79,730	$80,228	$83,528	$78,402	$81,282	$80,361	$75,785	$641,351
Net Operating Margin	($3,685)	($2,537)	($507)	$2,154	$448	($2,855)	$1,566	($67)	($5,483)
NonOperating Income	$1,059	$1,243	$1,968	$850	$1,368	$1,608	$1,168	$1,178	$10,441
Excess Margin	($2,625)	($1,295)	$1,461	$3,004	$1,816	($1,248)	$2,734	$1,111	$4,958
Profitability									
Operating Margin %	(4.7%)	(3.3%)	(0.6%)	2.5%	0.6%	(3.6%)	1.9%	(0.1%)	(0.9%)
Operating Margin %excl. Int	(4.0%)	(2.6%)	0.1%	3.2%	1.3%	(2.9%)	2.6%	0.7%	(0.1%)
Operating EBIDA	$104	$1,200	$3,534	$5,818	$4,421	$1,304	$5,475	$3,894	$25,749
Operating EBIDA Margin	0.1%	1.6%	4.4%	6.8%	5.6%	1.7%	6.7%	5.1%	4.0%
Liquidity Indicators									
Day's Cash on Hand	102.7	96.4	93.2	98.0	93.7	97.1	105.6	113.3	113.3
Day's in Accounts Rec.	72.0	71.2	67.9	67.8	68.2	68.3	73.6	72.5	72.5
Debt & Other Indicators									
Debt Service Coverage (MADS)	0.16	0.53	1.22	1.68	1.88	1.72	1.91	1.97	1.97
Discharges (Monthly)	2,249	2,210	2,255	2,216	2,124	2,377	2,376	2,192	2,250
Adj Discharges (Case mix adj)	8,071	8,493	8,430	8,462	7,409	8,489	8,195	7,410	8,120
Adjusted patient Days (Mo.)	27,564	27,906	26,067	25,531	25,691	26,544	28,730	25,787	26,728
Cost/Adj Discharge	$10.2	$9.4	$9.5	$9.9	$10.6	$9.6	$9.8	$10.2	$ 9.9
Compensation Ratio	77%	80%	74%	73%	77%	80%	71%	75%	76%

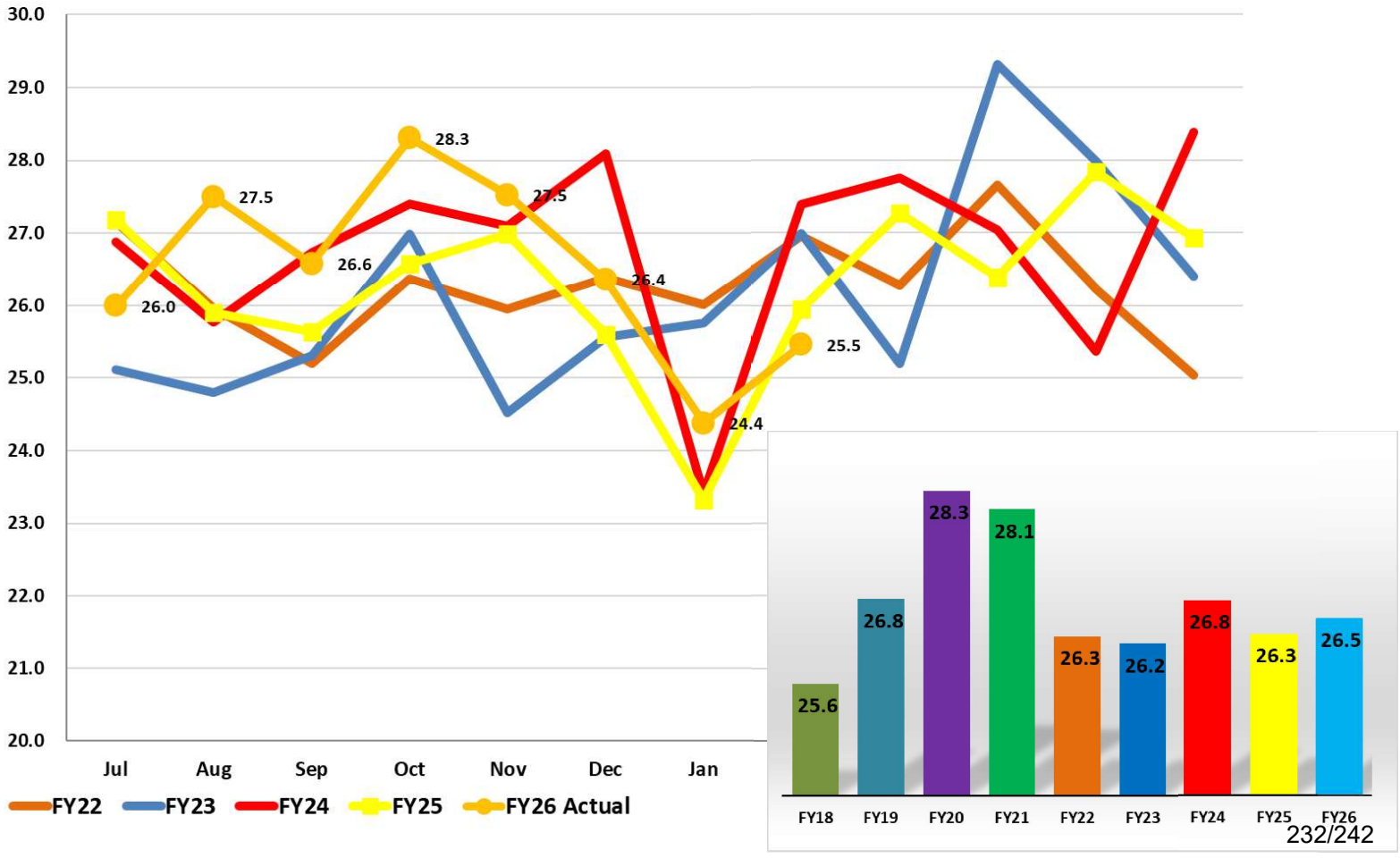
Total FTEs (includes Contract Labor)



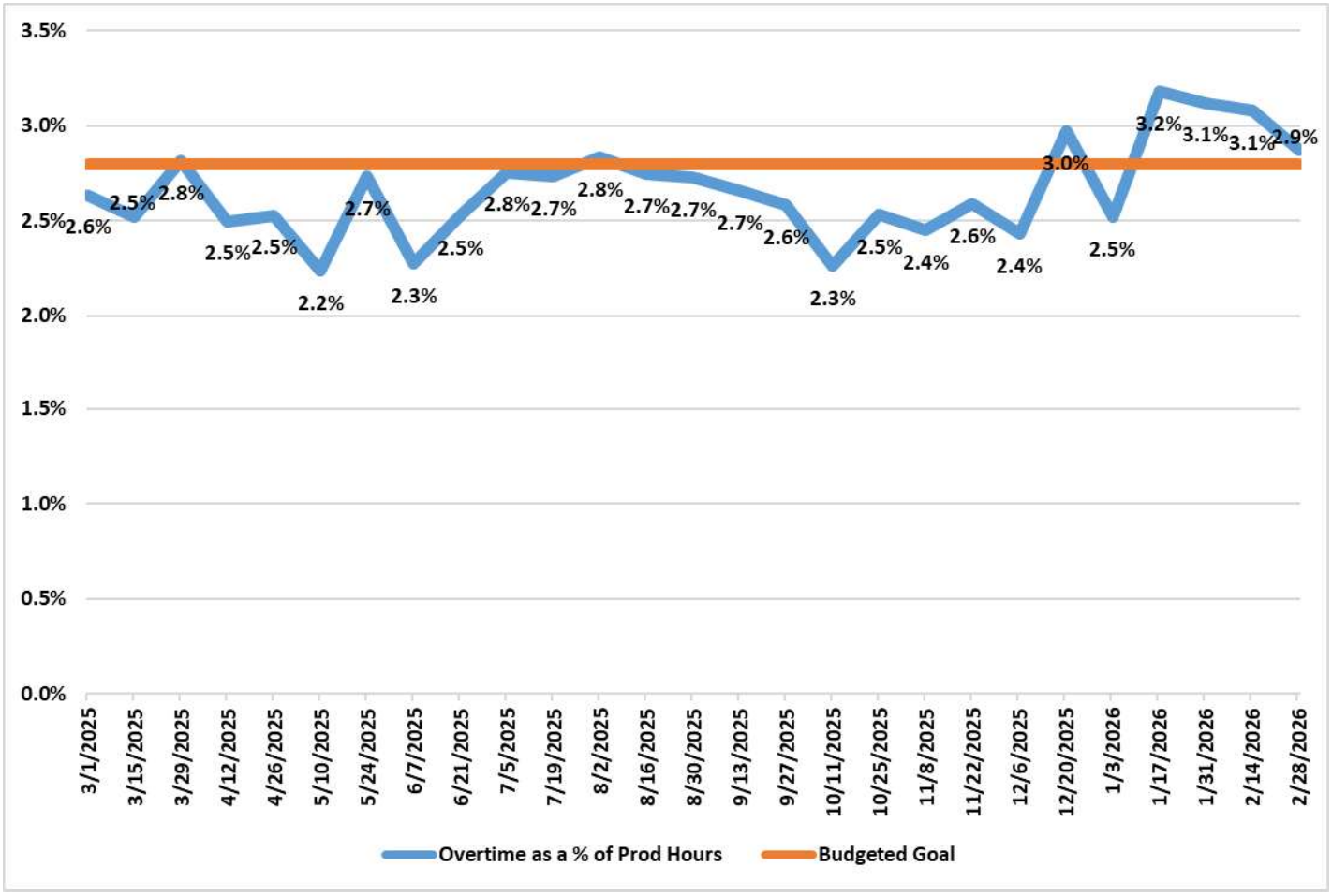
Contract Labor Full Time Equivalents (FTEs)



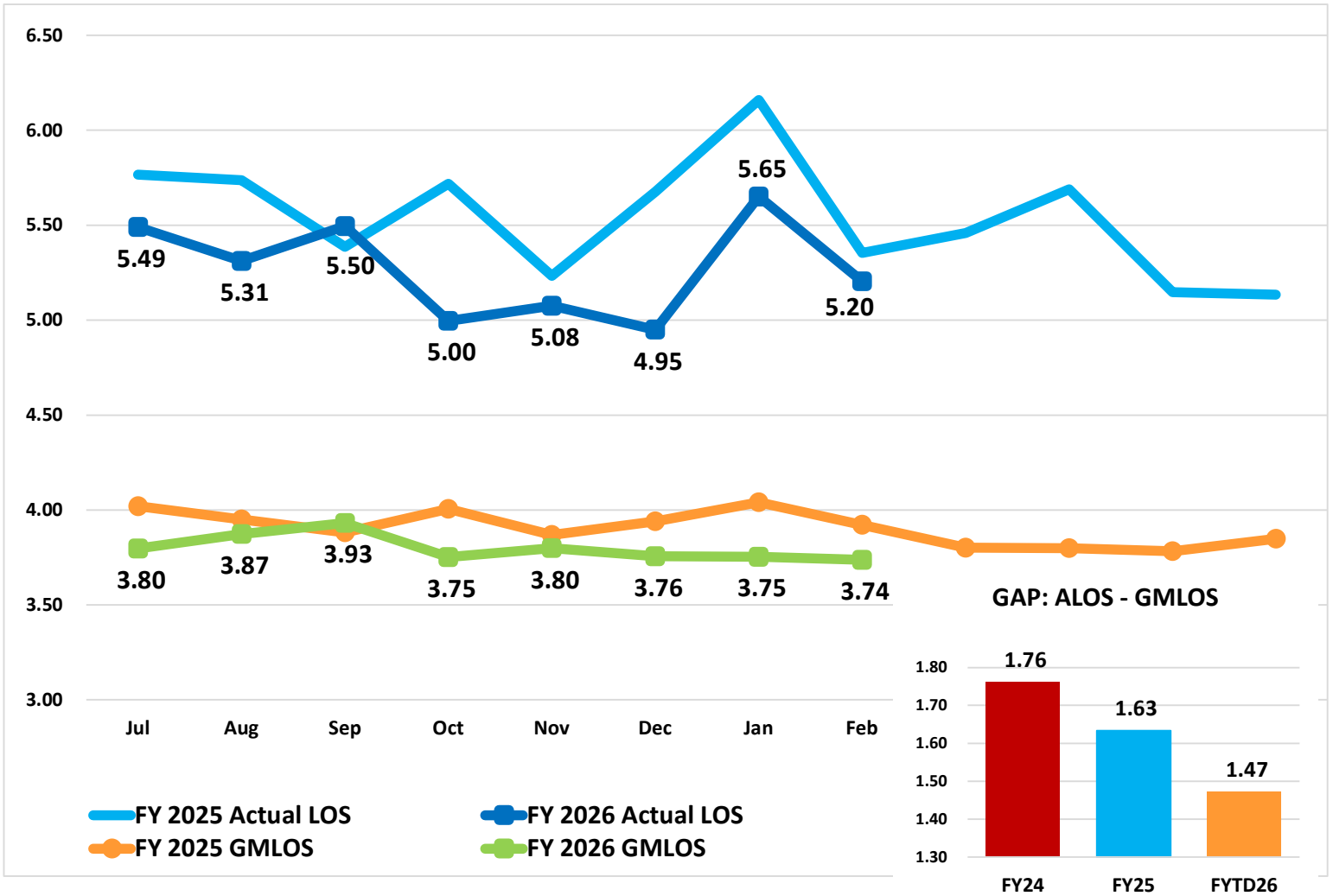
Productivity Measure : Worked Hours/ Adj. Patient Days



Overtime as a % of Productive Hours

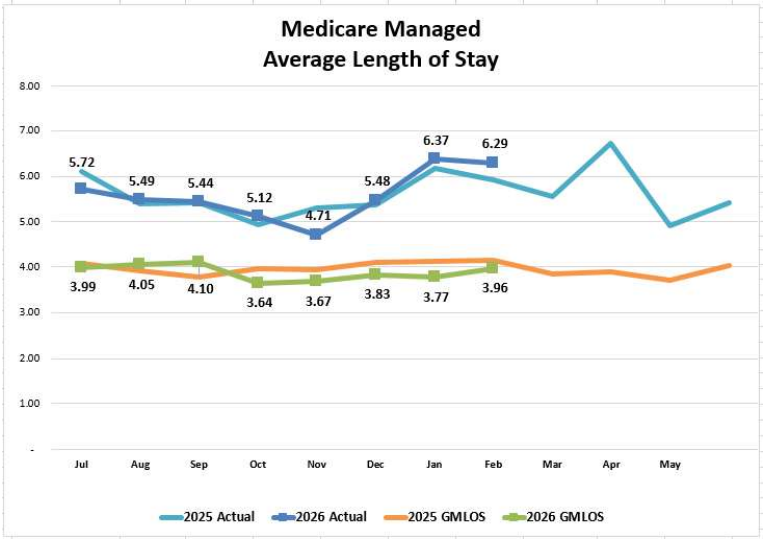


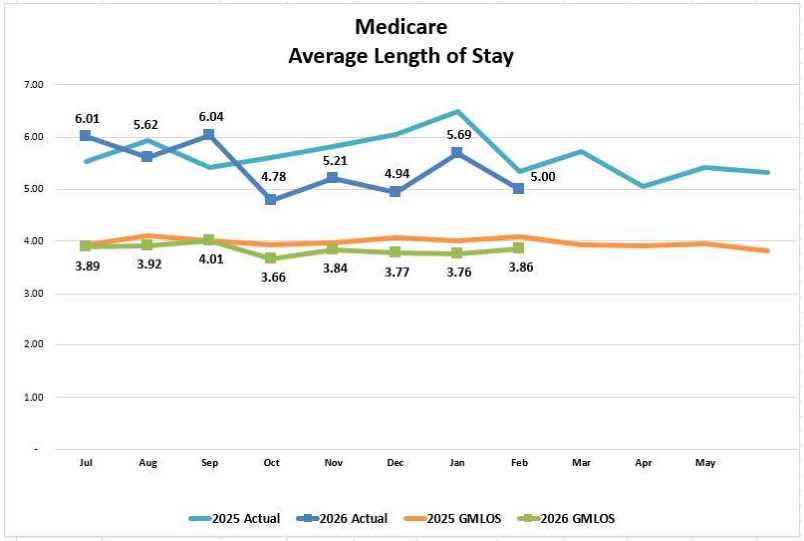
Average Length of Stay versus National Average (GMLOS)

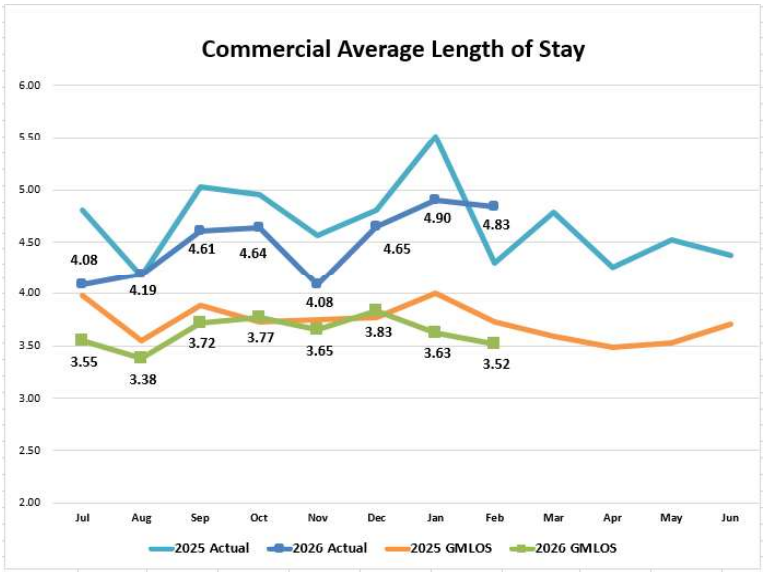


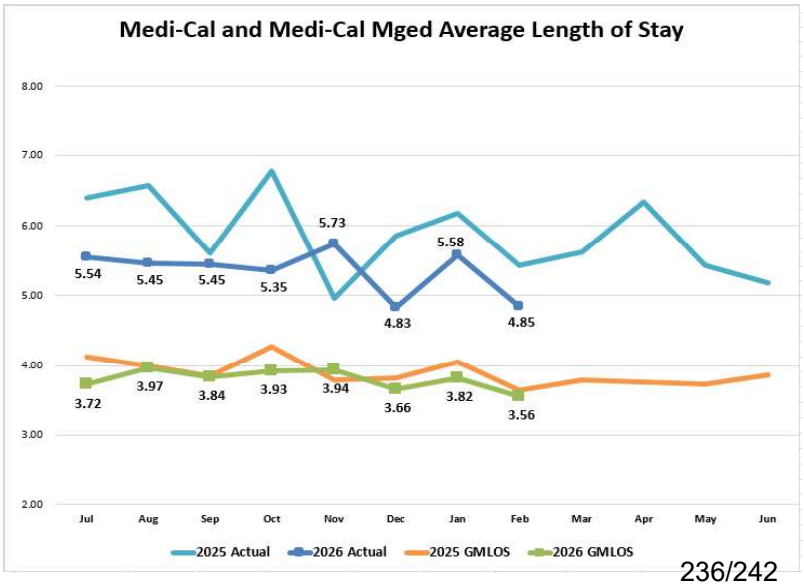
Average Length of Stay versus National Average (GMLOS)

	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	5.35	3.92	1.43
Mar-25	5.46	3.80	1.66
Apr-25	5.69	3.80	1.89
May-25	5.15	3.78	1.36
Jun-25	5.13	3.85	1.29
Jul-25	5.49	3.80	1.69
Aug-25	5.31	3.87	1.44
Sep-25	5.50	3.93	1.56
Oct-25	5.00	3.75	1.24
Nov-25	5.08	3.80	1.28
Dec-25	4.95	3.76	1.19
Jan-26	5.65	3.75	1.90
Feb-26	5.20	3.74	1.47

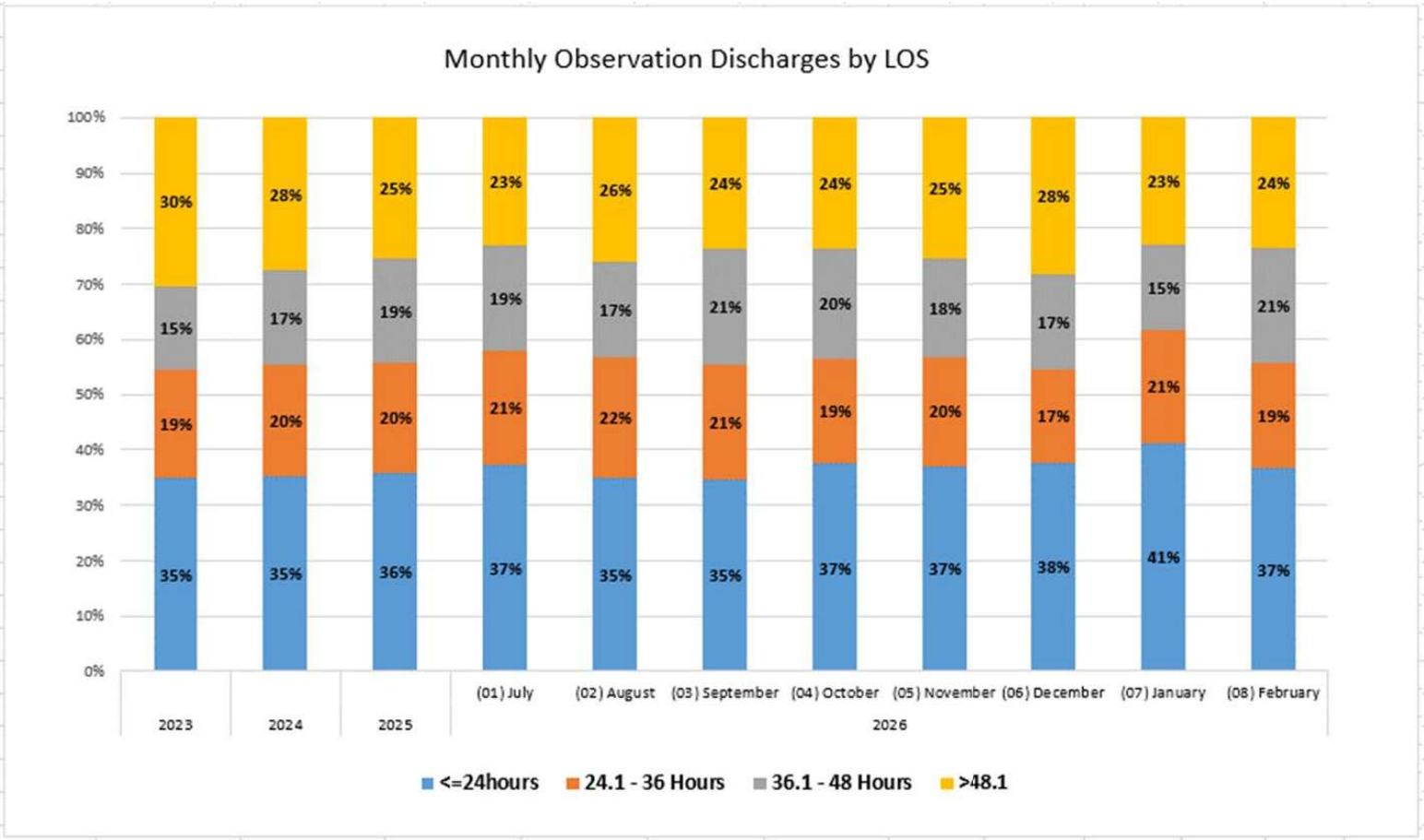

Medicare Managed
Average Length of Stay
8.00
7.00
6.00
5.00
4.00
3.00
2.00
1.00
-
5.72
5.49
5.44
5.12
4.71
5.48
6.37
6.29
3.99
4.05
4.10
3.64
3.67
3.83
3.77
3.96
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
2025 Actual
2026 Actual
2025 GMLOS
2026 GMLOS


Medicare
Average Length of Stay
7.00
6.00
5.00
4.00
3.00
2.00
1.00
-
6.01
5.62
6.04
4.78
5.21
4.94
5.69
5.00
3.89
3.92
4.01
3.66
3.84
3.77
3.76
3.86
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
2025 Actual
2026 Actual
2025 GMLOS
2026 GMLOS

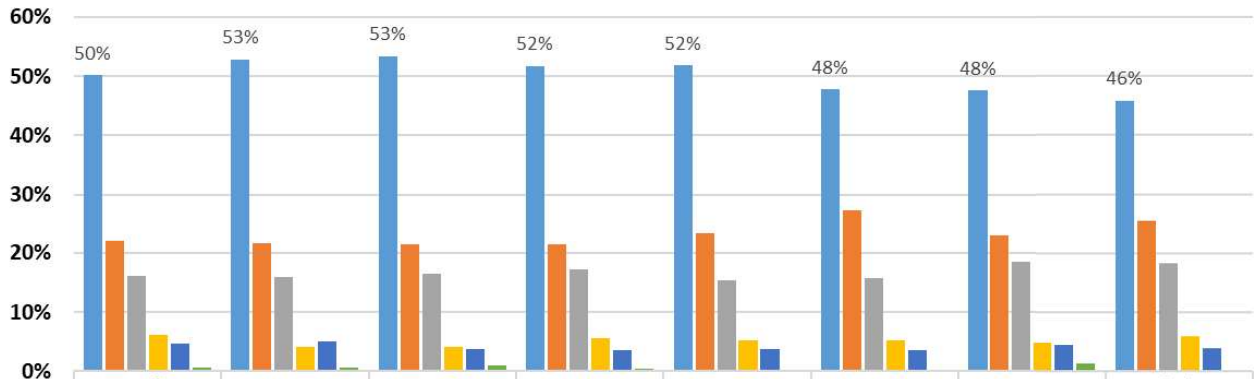

Commercial Average Length of Stay
6.00
5.50
5.00
4.50
4.00
3.50
3.00
2.50
2.00
4.08
4.19
4.61
4.64
4.08
4.65
4.90
4.83
3.55
3.38
3.72
3.77
3.65
3.83
3.63
3.52
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
2025 Actual
2026 Actual
2025 GMLOS
2026 GMLOS


Medi-Cal and Medi-Cal Mged Average Length of Stay
8.00
7.00
6.00
5.00
4.00
3.00
2.00
5.54
5.45
5.45
5.35
5.73
4.83
5.58
4.85
3.72
3.97
3.84
3.93
3.94
3.66
3.82
3.56
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
2025 Actual
2026 Actual
2025 GMLOS
2026 GMLOS

Trended % of Observation by Length of Stay

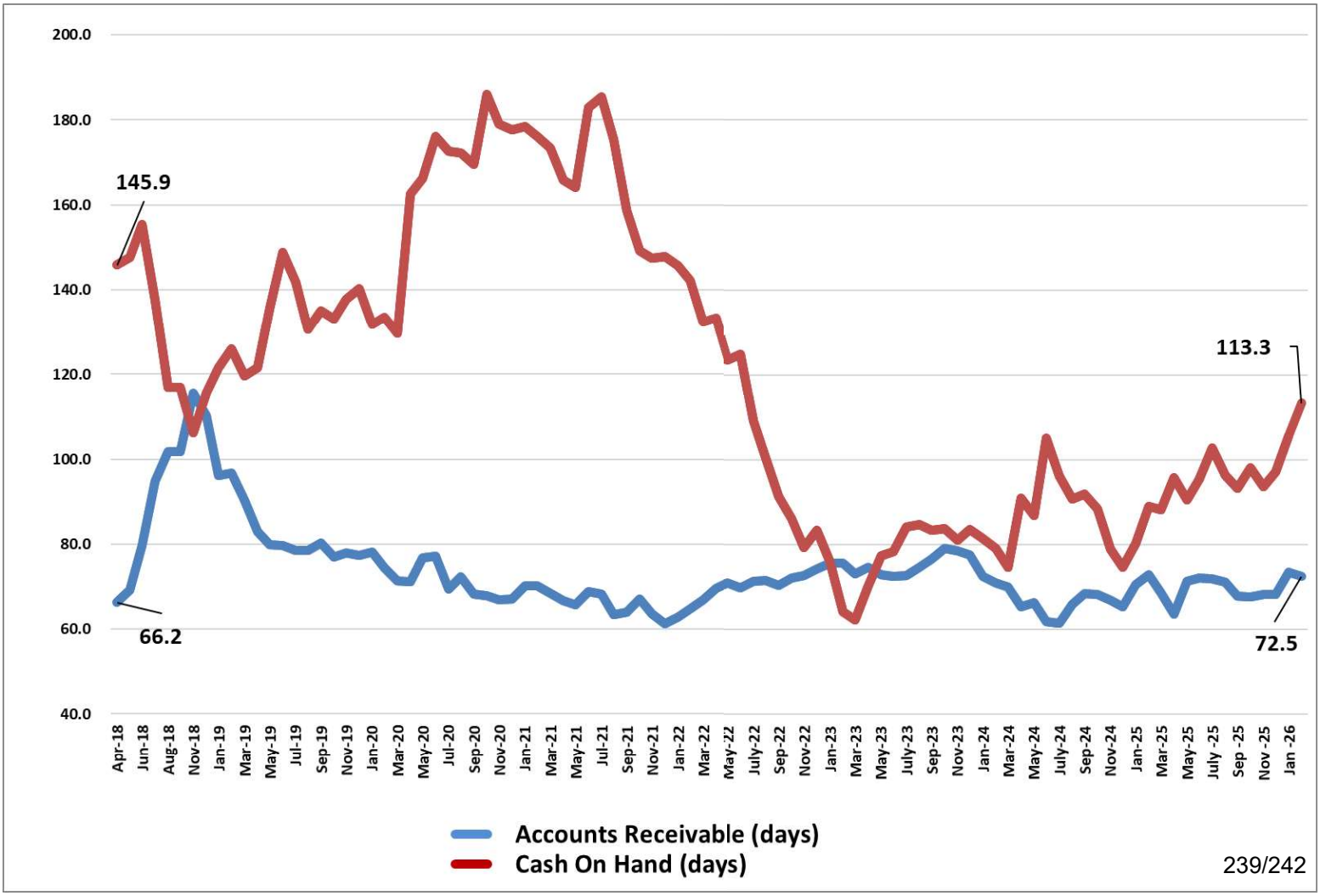


Average Length of Stay Distribution



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
at GMLOS or Better	50%	53%	53%	52%	52%	48%	48%	46%
1-2 days over GMLOS	22%	22%	21%	21%	23%	27%	23%	26%
2-6 days over GMLOS	16%	16%	16%	17%	15%	16%	19%	18%
6-10 days over GMLOS	6%	4%	4%	6%	5%	5%	5%	6%
10-30 days over GMLOS	5%	5%	4%	4%	4%	4%	5%	4%
30+ days over GMLOS	0.6%	0.6%	0.9%	0.4%	0.3%	0.3%	1.3%	0.3%

Trended Liquidity Ratios



Ratio Analysis Report

	February 2026 Value	January 2026 Value	June 30, 2025 Audited Value	2024 Moody's Median Benchmark Aa	A	Baa
LIQUIDITY RATIOS						
Current Ratio (x)	2.4	2.5	2.5	1.6	**1.9**	1.7
Accounts Receivable (days)	72.5	73.6	72.1	48.7	**46.7**	48.6
Cash On Hand (days)	113.3	105.6	95.3	282	**194.6**	122.9
Cushion Ratio (x)	13.1	12.1	10.9	46.1	**26.8**	15.5
Average Payment Period (days)	50.4	50.2	55.1	75.8	**61.9**	62.3
CAPITAL STRUCTURE RATIOS						
Cash-to-Debt	138.7%	128.9%	114.9%	297.1%	**188.1%**	111.0%
Debt-To-Capitalization	30.9%	30.9%	31.3%	20.8%	**28.7%**	35.5%
Debt-to-Cash Flow (x)	4.0	4.1	2.8	2.2	**3.1**	5.0
Debt Service Coverage	2.5	2.4	3.8	7.9	**5.3**	3.3
Maximum Annual Debt Service Coverage (x)	2.0	1.9	3.0	7.2	**4.8**	2.7
Age Of Plant (years)	13.9	14.0	13.6	11.1	**13.3**	14.8
PROFITABILITY RATIOS						
Operating Margin	(.9%)	(1.0%)	(4.2%)	2.9%	**1.6%**	(.5%)
Excess Margin	0.8%	0.7%	2.9%	6.7%	**4.3%**	1.3%
Operating Cash Flow Margin	4.0%	3.9%	1.0%	7.9%	**6.6%**	4.2%
Return on Assets	0.8%	0.7%	3.1%	4.5%	**3.8%**	1.7%

Consolidated Statements of Net Position (000's)

	Feb-26	Jun-25 (Audited)
ASSETS AND DEFERRED OUTFLOWS		
CURRENT ASSETS		
Cash and cash equivalents	$ 4,426	$ 6,595
Current Portion of Board designated and trusted assets	25,829	17,533
Accounts receivable:		-
Net patient accounts	159,585	154,634
Other receivables	28,469	70,335
	188,055	224,969
Inventories	14,276	13,871
Medicare and Medi-Cal settlements	61,138	62,463
Prepaid expenses	12,007	8,234
Total current assets	305,730	333,666
NON-CURRENT CASH AND INVESTMENTS - less current portion		
Board designated cash and assets	273,596	218,025
Revenue bond assets held in trust	-	22,950
Assets in self-insurance trust fund	278	626
Total non-current cash and investments	273,874	241,602
INTANGIBLE RIGHT TO USE LEASE, net of accumulated amortization	19,144	15,613
INTANGIBLE RIGHT TO USE SBITA, net of accumulated amortization	10,226	8,062
CAPITAL ASSETS		
Land	20,544	17,542
Buildings and improvements	445,730	437,184
Equipment	346,416	340,593
Construction in progress	16,344	18,729
	829,034	814,048
Less accumulated depreciation	554,721	541,607
	274,313	272,441
OTHER ASSETS		
Property not used in operations	2,126	5,155
Health-related investments	1,804	2,147
Other	22,168	20,922
Total other assets	26,098	28,224
Total assets	909,385	899,608
DEFERRED OUTFLOWS	12,250	13,133
Total assets and deferred outflows	**$ 921,635**	**$ 912,741**

Consolidated Statements of Net Position (000's)

	Feb-26	Jun-25
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accounts payable and accrued expenses	$ 30,869	$ 43,963
Accrued payroll and related liabilities	73,569	71,620
SBITA liability, current portion	3,429	3,031
Lease liabiilty, current portion	3,561	3,204
Bonds payable, current portion	13,184	13,014
Notes payable, current portion	2,306	-
Financing Lease Liability, current portion	554	-
Total current liabilities	127,472	134,831
LEASE LIABILITY, net of current portion	16,185	12,850
SBITA LIABILITY, net of current portion	4,679	3,941
LONG-TERM DEBT, less current portion		
Financing Lease payable	3,192	-
Notes payable	18,444	20,750
Total long-term debt	220,665	222,369
NET PENSION LIABILITY	21,045	16,169
OTHER LONG-TERM LIABILITIES	53,650	50,472
Total liabilities	443,697	440,632
NET ASSETS		
Invested in capital assets, net of related debt	64,191	60,147
Restricted	47,111	58,980
Unrestricted	366,636	352,983
Total net position	477,938	472,110
Total liabilities and net position	**$ 921,635**	**$ 912,741**