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: November 13, 2026

NOTICE

Date: Wednesday, November 18, 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:

- **3:30 PM** – Open Session
- **4:00 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)
- **4:15 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).

Mike Olmos • Zone 1 Board Member
Jonna Schengel • Zone 2 Board Member
Dean Levitan, MD • Zone 3 Secretary/Treasurer
David Francis • Zone 4 President
Armando Murrieta • Zone 5 Vice President

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

KAWEAH DELTA HEALTH CARE DISTRICT
Dean Levitan, M.D, Secretary/Treasurer

Prepared by:

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

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

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his 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 November 18, 2026 {Regular Meeting}

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OPEN SESSION – 3:30 PM

1. **CALL TO ORDER**
2. **PUBLIC COMMENT –** Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdiction of the Board are requested to identify themselves at this time.
3. **BOARD EDUCATIONAL STUDY SESSION** - The Board of Directors will receive an educational presentation regarding Quality and safety are core fiduciary responsibilities of the board. This session will examine how well we are positioned, drawing on three Governance Institute resources covering leadership and culture, accountability structures, emerging risks such as AI, cybersecurity, and new CMS expectations, and practical oversight tools like PFACs and leader rounding.
4. **ADJOURN TO CLOSED SESSION**

CLOSED SESSION – 4:00 PM

Mike Olmos • Zone 1 Board Member
Jonna Schengel • Zone 2 Board Member
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1. **CALL TO ORDER**

2. **CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION AND RISK MANAGEMENT** – Conference with legal counsel regarding potential exposure to litigation pursuant to Government Code 54956.9(d)(2); Matters involve compliance, risk management review, and related quality assurance issues.

A. BURNS-NUNEZ V KDHCD	G. MARTINEZ-LUNA V. KDHCD
B. M. VASQUEZ V. KDHCD	H. MORENO V KDHCD
C. OLVERA V KDHCD	I. TINOCO V KDHCD
D. LARUMBLE-TORRES V KDHCD	J. MACKEY V KDHCD
E. SMITHSON V KDHCD	K. MEDINA V KDHCD
F. VELASEQUEZ V KDHCD	L. JOHNSON 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); Three potential 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.

   Action Requested – Approval of Medical Staff Credentialing and Privileging

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** – October 28, 2026.

Mike Olmos • Zone 1 Board Member
Jonna Schengel • Zone 2 Board Member
Dean Levitan, MD • Zone 3 Secretary/Treasurer
David Francis • Zone 4 President
Armando Murrieta • Zone 5 Vice President

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

7. ADJOURN CLOSED SESSION

OPEN SESSION – 4:15 PM (OR IMMEDIATELY FOLLOWING CLOSED SESSION)

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1. CALL TO ORDER
2. ROLL CALL
3. FLAG SALUTE
4. PUBLIC PARTICIPATION
Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five (5) minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdiction of the Board are requested to identify themselves at this time.

5. CLOSED SESSION ACTION TAKEN
Report on action(s) taken in closed session.

6. BOARD MEMBER REPORT OUTS
Board members may provide brief reports on attendance at conferences, educational programs, meetings with external organizations, community events, or other activities related to District business. No action will be taken on matters not otherwise listed on the agenda. Matters requiring further discussion or Board action may be referred to staff for follow-up or placed on a future agenda in accordance with applicable open meeting laws.

7. RECOGNITIONS
7.1 Senator Shannon Grove - for her contributions to healthcare and the Central Valley
7.2 Team of the Month – Broderick Pavilion

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

Public Participation

Mike Olmos • Zone 1 Board Member
Jonna Schengel • Zone 2 Board Member
Dean Levitan, MD • Zone 3 Secretary/Treasurer
David Francis • Zone 4 President
Armando Murrieta • Zone 5 Vice President

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 November 18, 2026, Consent Calendar.
[Consent Calendar Items 8.1 – 8.4 as presented]

Section	Item	Description	Type
8.1. REPORTS	A	Medical Staff Recruitment	Receive and File
	B	Overall Strategic Plan	Receive and File
	C	Rad, CT, Ultrasounds	Receive and File
	D	Quarterly Compliance Report	Receive and File
8.2. MINUTES			
	A	Patient Experience Committee – September 9, 2026	Approve Minutes
	B	Finance Property Services Acquisition Committee - October 21, 2026	Approve Minutes
	C	Quality Council Committee – October 15, 2026	Approve Minutes
	D	Population Health Committee – September 21, 2026	Approve Minutes
	E	Regular Open Board Meeting – October 28, 2026	Approve Minutes
	F	Special Board Meeting – October 26, 2026	Approve Minutes
8.3. POLICIES			
		Administrative Policies	
	A	AP134 Expenses reimbursable by Foundation restricted funds	Approve Revisions
	B	AP170 Use of Medical/Allied Health Staff Personal Information	New Policy
		Disaster Manual	
	C	DM 2205 Code Pink Infant Abduction	Revised
	D	DM 2230 Radioactive Disaster Management	Revised
	E	DM 2810 Total Evacuation Plan	Revised
		EOC Policies	
	F	EOC 1018 Monitoring Refrigerator and Freezer Temperatures	Revised
	G	EOC 1039 Failure of Air Conditioner	Reviewed
	H	EOC 1071 Ergonomics	Revised
	I	EOC 4010 RCRA Disposal of Hazardous Waste	Reviewed
	J	EOC 5003 Fire Watch	Reviewed

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Section	Item	Description	Type
	K	EOC 7305 Utilities Management Inventory	Reviewed
	L	EOC 7403 Emergency Generator Testing and Fuel Levels	Reviewed
8.4. MEC			
	A	Privilege Form – Certified Nurse Midwife	Revised
	B	MS 24 Trauma Peer Review and Trauma Performance Improvement (TPTIP)	Reviewed
	C	MS 57 Guidelines for Privacy Violations	Revised

9. 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.

10. STRATEGIC OVERSIGHT (MONTHLY REPORT) – PHYSICAN ALIGNMENT

Physician Alignment discussion on initiatives, physician alignment priorities, physician engagement, and opportunities to strength collaboration between physicians and organizational leadership, and progress toward Board-approved strategic goals. The Board may provide direction to staff regarding strategic priorities and future planning efforts.

11. QUALITY REPORT (MONTHLY REPORT)– VALUE BASED PURCHASING

Staff presentation and discussion regarding completed and planned initiatives to identify and address Value Based Purchasing.

12. BOD16- MEETING TRANSPARENCY AND REMOTE ACCESS POLICY

The Board will consider amendments to Policy BOD16 to adopt procedures for recessing and reconvening Board Meetings when a disruption of telephonic or internet-based service prevents remote public access or participation, as required by Senate Bill 707 and to update remote public access provisions.

Action Requested – Approve the amendments to Policy BOD16 as presented.

13. FINANCIAL STEWARDSHIP

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

Action Requested – Approval October's Financials.

Mike Olmos • Zone 1 Board Member
Jonna Schengel • Zone 2 Board Member
Dean Levitan, MD • Zone 3 Secretary/Treasurer
David Francis • Zone 4 President
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14. FUTURE GOVERNANCE TOPICS

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

15. REPORTS

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

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

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

16. ADJOURNMENT

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BOARD EDUCATIONAL STUDY SESSION

Board Education
Intentional Governance
Quality Oversight

Paul Stefanacci, MD, FACS, MBA
Chief Medical Officer - Chief Quality Officer

Farid Sheikh, Pharm.D., BCPS, CPHQ, CIC
Director of Quality and Patient Safety

November 2026

Kaweah Health

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Board Quality Oversight



Priorities and Goals

What the organization is committed to accomplishing this year, in clear goals and objectives, and who is accountable for each.



Action Plans

How management turns goals into action, and what the board should expect to see in a credible plan.



Performance

How to read performance against benchmarks and goals, and how to judge whether the plans are working.



Discuss: What would help each of you explain our top-quality priorities and goals clearly?

Governance Approves Strategic Priorities

Management owns the work

The Board: governance

- Approves strategy and goals
- Asks for measures that matter
- Seeks assurance that progress is real
- Holds the executive team accountable for results

Management and medical staff

- Leads the improvement work
- Chooses interventions
- Directs implementation
- Reports results with context
- Escalates risks early

Discuss: What does a strong partnership between the board and management look like to you?

Setting Priorities

LEVEL	WHAT IT IS	OWNER
Priority	The direction: what matters most to patients and the community	Board
Goal	A measurable target, set against a benchmark, with a date	Board
Objective	A specific, time-bound step that moves the goal	Management
Initiative	The work itself: who does what, by when	Management

Discuss: Which of these levels do we do best?

Setting Goals: The S.M.A.R.T. Standard

S

Specific

Names one clear outcome.

M

Measurable

Has a defined measure and a starting baseline.

A

Achievable

Ambitious but realistic, with the target set against a recognized benchmark.

R

Relevant

Tied to a strategic priority and to patient outcomes.

T

Time-bound

States the date by which it will be achieved.

Discuss: Which of these five elements is hardest to confirm?

Quality Review: Three Components

1 AIM

What are we trying to accomplish?

BOARD

Approves priorities and goals, in plain terms.

MANAGEMENT

Turns goals into objectives, owners and timelines.

2 MEASURE

How will we know a change is an improvement?

BOARD

Confirms the measures are relevant and benchmarked.

MANAGEMENT

Defines, collects and reports data with context.

3 CHANGE

What changes will result in improvement?

BOARD

Reviews the action plan for credibility, then watches results.

MANAGEMENT

Designs, runs and adjusts the improvement work.



Discuss: Do we present all three components adequately?

Developing Action Plans

1

Understand the gap

MANAGEMENT DOES

Compares current results with the goal and identifies the root causes.

BOARD ASKS

How big is the gap, and why?

2

Choose changes

MANAGEMENT DOES

Selects changes with evidence behind them.

BOARD ASKS

What evidence supports these changes?

3

Assign owners and resources

MANAGEMENT DOES

Designates initiative owner, sets dates, and identifies support and resources.

BOARD ASKS

What do you need from the board?

4

Set measures and checkpoints

MANAGEMENT DOES

Selects process and outcome measures and schedules review dates.

BOARD ASKS

How will we know it is working, and when?

Evaluating Performance: Report Review

Measure

WHAT IT TELLS YOU

Is this the right measure, what does it count, and what is it telling us

ASK

Is this the right measure for the aim?

Baseline

WHAT IT TELLS YOU

Where we started, over a defined period.

ASK

What period does the baseline cover?

Current

WHAT IT TELLS YOU

The latest result, often rolling 12 months or fiscal year to date.

ASK

How many cases sit behind it?

Goal

WHAT IT TELLS YOU

The target for the year, set from a benchmark.

ASK

How was the goal chosen?

Benchmark

WHAT IT TELLS YOU

Peer performance, such as a percentile, or a best practice standard.

ASK

Which peer group and which year?

Status and trend

WHAT IT TELLS YOU

At goal, improving or off track, and direction over time.

ASK

What is the trend, not just this month?

Discuss: Which of these six elements is missing from the reports you see?

Evaluating Performance: Action Plan Review

CHECK	WHAT GOOD LOOKS LIKE	RED FLAG
Linked to the goal	Every action traces to a measure and a target.	Activities with no link to a measure
Specific actions	States what will be done, not general intentions.	General intentions instead of concrete steps
Named owner and dates	One accountable leader and a timeline for each step.	No owner or timeline
Early indicators	Process measures show the work is taking hold before outcomes move.	Only outcome data, no early indicators
Resources and barriers	Names the staffing, tools and decisions needed, and what could get in the way.	No frontline input; barriers left unnamed
A review point	A date when management reports back and adjusts the plan.	Updates report effort, not results; goals shift when results lag

Discuss: Which of these six areas do we present well? Where do we have opportunities to improve?

Ten success drivers

Board sets or reviews **Leadership and staff deliver**

1. Unequivocal board commitment and executive focus
2. Excellence, with patients at the center
3. Clear quality and safety goals approved by the board
4. Patient safety as a leadership priority and value
5. Quality aligned with mission and strategy
6. Systematic review of performance against targets
7. Measurement, data, and transparency system-wide
8. Engaged physicians, clinicians, and frontline staff
9. Investment in improvement capacity and methods
10. Celebrating success

Discuss: Which of these drivers are our strengths, and which need more attention?

Source: Improving Quality in Health Systems: How Do They Do It? (The Governance Institute, Fall 2021).

Intentional work, measurable results

Leapfrog Hospital Safety Grade: Spring 2023 to Fall 2026



Source: The Leapfrog Group, Hospital Safety Grade

Intentional

Every priority has a goal, a benchmark, a champion and a plan.

Expert

Quality and performance improvement specialists work with clinical staff.

Leading

We bring the data, plan and progress; the board sets direction.

Key takeaways: how we lead

KEY TAKEAWAY	HOW THE QUALITY TEAM WILL LEAD
1 **The board sets the aim and seeks assurance; management owns the how and the who**	We lead the work and bring you clear answers and candid updates.
2 **Priorities become goals that are measurable, benchmarked and owned**	A S.M.A.R.T. goal and a named champion for every priority.
3 **Read numbers against the right target, and judge the trend, not one month**	One consistent scorecard: baseline, current, goal, benchmark and trend.
4 **A credible plan links actions to measures, with owners, dates and a review point**	Plans with early indicators, owners and dates, reported back on schedule.
5 **Intentional work is what achieves results**	We keep leading it, with your oversight: priorities, plans and results.

Agenda item intentionally omitted

Medical Staff Recruitment

Physician Recruitment Board Report

November 2026

81	12	4	12	16
ACTIVE CANDIDATES	FY27 COMMITMENTS	CURRENT OFFERS EXTENDED	PENDING SITE VISITS	CURRENTLY IN SCREENING

PHYSICIAN GROUP TARGETS

Key Medical Associates

- Pulmonology x1
- Psychiatry x1

Oak Creek Anesthesia

- Anesthesia - Cardiac x1
- Anesthesia - General x2
- Anesthesia - Regional x1

Valley Children's

- Maternal Fetal Medicine x2
- Neonatology x1
- Pediatric Cardiology x1
- Pediatric Hospitalist x1

Orthopaedics Associates

- Ortho Joint x1
- Ortho Trauma / General x1
- Ortho Surgery (General) x1

Other Recruitment / Group TBD

- Cardiology General / HF x1
- Cardiology Interventional x1
- CT Surgery x1
- Family Medicine x3
- Gastroenterology x2
- Infectious Disease x1
- OB/GYN x4
- Radiation Oncology x1
- Rheumatology x1
- Urology x2
- Vascular Surgery x1

FY27 YEAR-TO-DATE SUMMARY

90	12	13%
FY27 CANDIDATES PURSUED	FY27 COMMITMENTS July - November 2026	FY27 CONVERSION RATE 12 of 90 committed

BOARD NARRATIVE | OCTOBER 2026

During the month of October, the Physician Recruitment Team secured two new commitments and significantly expanded the candidate pipeline, adding 19 candidates across priority specialties.

Signed letters of intent were received from a Pulmonologist with a September 2027 start date and a Family Medicine physician with a March 2027 start date. Following an October site visit, an offer has also been extended to a second Pulmonology candidate.

Site visits were completed in Physical Medicine and Rehabilitation and Pulmonology, with additional visits scheduled in Vascular Surgery and Family Medicine through December.

Pipeline growth was strongest in Family Medicine. The Physician Recruitment Team will continue national outreach in November at physician career fairs in Chicago and New York.

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

Active Physician Pipeline

November 2026

Kaweah Health

Phase Key:	Site Visit	Screening	Offer Extended	Offer Accepted	Leadership Call	Applied

#	Specialty	Group	Phase	Start Date
1	Colorectal Surgery	TBD	Site Visit	
2	Family Medicine	1099 - KH Direct	Site Visit	
3	Family Medicine	1099 - KH Direct	Site Visit	
4	Family Medicine	TBD	Site Visit	
5	OB/GYN	Key Medical Associates	Site Visit	08/01/27
6	OB/GYN	TBD	Site Visit	
7	Orth Surgeon (General)	Orthopedic Assoc	Site Visit	01/04/27
8	PM&R	TBD	Site Visit	
9	Ped Hospitalist	Valley Children's	Site Visit	
10	Vascular Neurology	TBD	Site Visit	
11	Vascular Surgery	TBD	Site Visit	
12	Vascular Surgery	TBD	Site Visit	02/01/27
13	Anesthesia	Oak Creek	Screening	
14	Anesthesia	Oak Creek	Screening	
15	Anesthesia (Cardiac)	Oak Creek	Screening	
16	Cardiology (EP)	TBD	Screening	
17	Cardiothoracic Surgery	TBD	Screening	
18	Colorectal Surgery	TBD	Screening	
19	Diagnostic Radiology	Mineral King Radiology	Screening	
20	Family Medicine	TBD	Screening	
21	Internal Medicine (Outpatient)	TBD	Screening	
22	OB/GYN	TBD	Screening	
23	OB/GYN	TBD	Screening	
24	Radiation Oncology	SRCC	Screening	
25	Radiation Oncology	Sequoia Regional Cancer Center	Screening	
26	Vascular Surgery	TBD	Screening	
27	Vascular Surgery	TBD	Screening	
28	Vascular Surgery	TBD	Screening	
29	Heart Failure	1099 - KH Direct	Offer Extended	08/01/27
30	OB/GYN	TBD	Offer Extended	08/01/27
31	Pulmonology	TBD	Offer Extended	09/01/27
32	Rad Oncology	Sequoia Radiation Oncology	Offer Extended	08/01/27
33	Cardiology (EP)	1099 - KH Direct	Offer Accepted	11/01/26
34	ENT	Valley ENT	Offer Accepted	09/01/27
35	Endocrinology	1099 - KH Direct	Offer Accepted	11/01/26
36	Family Medicine	1099 - KH Direct	Offer Accepted	01/01/27
37	Family Medicine	1099 - KH Direct	Offer Accepted	03/01/27
38	Family Medicine	Venice Hills Medical Associates	Offer Accepted	11/01/26
39	Nephrology	Dr. Javed's Group	Offer Accepted	09/01/27

#	Specialty	Group	Phase	Start Date
40	Neurology	1099 - KH Direct	Offer Accepted	01/01/27
41	Neurology	1099 - KH Direct	Offer Accepted	09/01/27
42	Neurology	1099 - KH Direct	Offer Accepted	11/04/26
43	Nurse Practitioner	Mineral King Radiology	Offer Accepted	07/06/26
44	Nurse Practitioner	Oak Stone Medical Group	Offer Accepted	09/30/26
45	Orth Surgeon (Hand)	Orthopedic Assoc	Offer Accepted	12/01/26
46	PM&R	Dr. Sorenson's Practice	Offer Accepted	05/01/27
47	Pediatrics	1099 - KH Direct	Offer Accepted	01/01/27
48	Pediatrics	Venice Hills Medical Associates	Offer Accepted	11/01/26
49	Psychiatry	Oak Stone Psychiatry	Offer Accepted	07/01/27
50	Pulmonology	1099 - KH Direct	Offer Accepted	09/01/27
51	Urology	1099 - KH Direct	Offer Accepted	05/01/27
52	Cardiology (Interventional)	KH Sequoia Cardiology	Leadership Call	
53	Colorectal Surgery	TBD	Leadership Call	
54	Infectious Disease	TBD	Leadership Call	08/01/27
55	Pulmonology	TBD	Leadership Call	
56	Pulmonology	TBD	Leadership Call	08/01/27
57	Vascular Surgery	TBD	Leadership Call	
58	Anesthesia	Oak Creek	Applied	
59	Anesthesia (Cardiac)	Oak Creek	Applied	
60	Colorectal Surgery	TBD	Applied	
61	Colorectal Surgery	TBD	Applied	
62	Colorectal Surgery	TBD	Applied	
63	Colorectal Surgery	TBD	Applied	
64	Colorectal Surgery	TBD	Applied	
65	Family Medicine	TBD	Applied	
66	Family Medicine	TBD	Applied	
67	Family Medicine	TBD	Applied	
68	Family Medicine	TBD	Applied	
69	Family Medicine	TBD	Applied	
70	Gastroenterology	TBD	Applied	
71	Gastroenterology	TBD	Applied	
72	Gastroenterology	TBD	Applied	
73	Internal Medicine/Outpatient	TBD	Applied	
74	Interventional Radiology	Mineral King Radiology	Applied	
75	OB/GYN	TBD	Applied	
76	Orth Surgeon (General)	Orthopedic Assoc	Applied	
77	PM&R (Interventional Pain)	TBD	Applied	
78	Ped Hospitalist	TBD	Applied	
79	Podiatry	TBD	Applied	
80	Tele-Endocrinology	TBD	Applied	
81	Urology	TBD	Applied	

Overall Strategic Plan

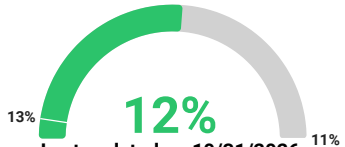
FY2027 Strategic Plan
Monthly Performance

Board of Directors
November 18, 2026



Kaweah Health
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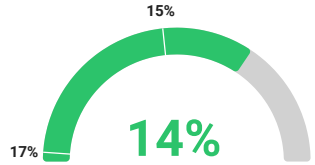
Decrease Overall Turnover Rate to less than equal to 11% (FYE-26)



Last updated on 10/31/2026

Move from baseline of 13% to target of 11%

Decrease New Hire Turnover Rate (leaving within 6 months) to less than or equal to 15% (FYE-26)



Last updated on 10/31/2026

Move from baseline of 17% to target of 15%

Decrease RN New Hire Turnover Rate (leaving within 6 months) to less than or equal to 8% (FYE-26)



Last updated on 10/31/2026

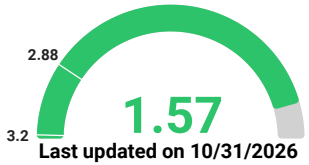
Move from baseline of 10% to target of 8%

Strategy Summary - Ideal Environment

Name	Status	Start Date	Due Date	Assigned To	Last Comment
Employee Engagement and Retention	On Track	07/01/2026	06/30/2027	Hannah Mitchell	Current Month *Annual NRC business review and key takeaways across products with the Executive Team and key departments. *NRC Employee Engagement Survey results presented to the Board of Directors. *Kickoff of leadership employee engagement action plan presentations to the Executive Team if over low scoring and/or response rate workgroups. *New Hire Turnover Project presented at the October Leadership Team Meeting, and new interview guides launched. *Market adjustments under way for selected positions to remain competitive with local pay rates. *TeamSTEPPs draft rollout plan shared with the Executive Team. *HealthStream launched with new CPR model and plans to expand in the future. *New training launched including Mandatory AI Training, Positive Employee Relations Knowledge Check, HealthStream overview, and a KHU Scholars Program. *Inaugural Avante Nursing Leadership Meeting to bring nursing leaders together to learn, grow, share best practices, and align priorities. Next Steps *Present action plan roadmap to the Executive Team and finalize tactics in the November Kaweah Care Steering Committee Meeting. *Continue with leadership employee engagement action plan presentations through December. *Meet with leaders over high turnover areas to better understand challenges and discuss ideas. *Continue to expand educational offerings. *TeamSTEPPS multidisciplinary taskforce to continue working on rollout plan. *Avante will continue as a monthly meeting.
School Partnerships and Volunteer Programs	On Track	07/01/2026	06/30/2027	Jaime Morales	Current Month *RN New Grad Recruitment: In October, hired 4 external RN New Grads and facilitated 15 internal RN New Grad transfers, bringing a total of 19 New Grad RNs into Kaweah Health. *Employee Educational Sponsorship Program Selections: Selected 25 employees for the January 2027 Unitek cohort, with tenure ranging from 3 months to 24 years and an average tenure of approximately 4.5–5 years. *Educational Sponsorship Interviews: Ongoing interviews for the COS LVN>RN, Carrington Spring 2027 ADN, and Carrington Rad Tech Spring 2027 cohorts. *Hosted an Education Assistance booth at the October 23 Benefits Fair. *Hosted Unitek nursing program information sessions. *Volunteer Services: In October, 205 individuals volunteered more than 2,850 hours. *School Outreach: *Attended 8 offsite high school career events to promote volunteer opportunities and careers at Kaweah Health. *Participated in 3 college health career advisory events * Provided 4 hospital tours to student groups Next Steps *Conduct a Kaweah Health employee survey to determine how many employees qualify for the COS RN program with completion of all required pre-requisite courses. The goal is to better prepare qualified employees for the TEAS exam and applications to the Summer 2027 Year-Round Program. *Continue recruitment and hiring of RN New Grads, with a focus on candidates interested in building a long-term career with Kaweah Health and who are familiar with our organization, culture, and patient population. *Development of an internal employee webpage dedicated to Career Pathways and educational and sponsorship opportunities.

Resident Engagement and Retention	On Track	07/01/2026	06/30/2027	Angel Smith	Current Month Scheduling ongoing monthly touchpoints with each program beginning 10/29/2026; purpose is to answer residents' questions about program/department operations, upcoming changes, and keep them updated on how Kaweah is working to improve their training experience and clinical learning environment.
Physician and Provider Engagement	On Track	07/01/2026	06/30/2027	Teresa Boyce	Current Month Governing documents under continual review. CME Coordinator working with CMO to provide leadership education. Engagement of Greeley for support.

Reduce Serious Safety Event Occurrences by 10% to 2.88 (FYTD-27)



Last updated on 10/31/2026

Move from baseline of 3.2 to target of 2.88

CMS thirty-day death rate among surgical inpatients with complications less than or equal to 46.20 (CMS 50th percentile) (FYTD-27)



Last updated on 10/31/2026

Move from baseline of 81.76 to target of 46.2

Hospital Acquired Pressure Injuries, Stage 2 and above, <0.46 (World Health Organization pooled incidence rate) (FYTD-27)



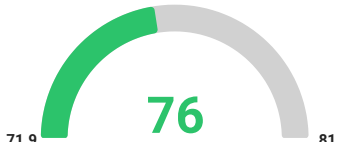
Last updated on 10/31/2026

Move from baseline of 0.51 to target of 0.45

Strategy Summary - Outstanding Health Outcomes

Name	Status	Start Date	Due Date	Assigned To	Last Comment
Safety Program Optimization	On Track	07/01/2026	06/30/2027	Cindy Vander Schuur	YTD Update: *Current process for handoff and escalation reviewed/mapped with process improvement engineer and clinical directors *Finalized draft of standard safety rounding board *Reported OHO updates to both QCOMM and Quality Council Next Steps: *Unit Quality & Safety Rounding board will be presented to the Executive Team at QSOC on 11.11.26 for final approval *Once Rounding board is approved will work with the Executive Team on specifics of the rounding structure *Reach out to Cleveland Clinic, Stanford CNS, and Chartis for their best practices/example policies for Chain of Command/Escalation of Patient Condition (pending Chief approval) *Update wording on Chain of Command policy *Protocol & Order Set optimization *Feedback from PCM regarding the Handoff Process and Timing *Feedback from PPC/UBC regarding both Handoff and real-time Escalation of Patient Condition (escalation to resolution)
Reduce Hospital Acquired Infections (HAI)	On Track	07/01/2026	06/30/2027	Shawn Elkin	YTD Update: * Plans for several interventions to reduce CLABSI and C. difficile infections are being initiated during the month of November. * The rates for Healthcare Associated Infections remain unchanged from September's values.
Surgical Safety Program	Off Track	07/01/2026	06/30/2027	Chris Patty	YTD Update: *September PSI-90 events = 3; September rate = 1.62 (goal is 1.01). Meeting with Dr. Jeffcoach November 4. Next Steps: *Discuss PSI-9 (postop hemorrhage) and PSI-15 (accidental puncture) cases at November 12 SQIP meeting.
Safety in Nursing Practice	On Track	07/01/2026	06/30/2027	Mara Lawson	YTD Update: * HAPI rates decreased after the action plan was implemented. We continue to have patient falls, but are meeting our goal. *Next steps: * HAPI dashboard being built to track unit level data. * Evidence-Based, standardized post fall debrief tool licensed from Johns Hopkins to align with risk assessment and mobility project.

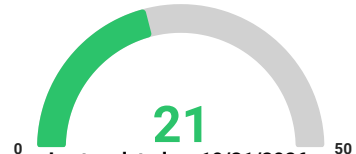
HCAHPS "Would Recommend Hospital" is 72.3 (FY2027)



Last updated on 10/31/2026

Move from baseline of 71.9 to target of 81

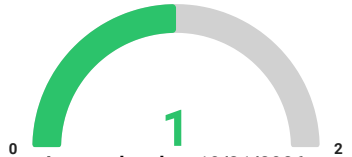
50 community outreach events FYTD-27



Last updated on 10/31/2026

Move from baseline of 0 to target of 50

Two or more Cuadrilla events in FYTD-27



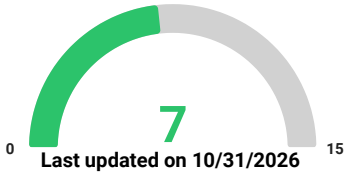
Last updated on 10/31/2026

Stay between baseline of 0 and target of 2

Strategy Summary - Patient and Community Experience

Name	Status	Start Date	Due Date	Assigned To	Last Comment
Promote a Patient-Centric Culture	On Track	07/01/2026	06/30/2027	Deborah Volosin	Continued with Compassionate Communication Trainings, Quality Rounding Training for clinical directors.
Improve the hospital's physical spaces.	On Track	07/01/2026	06/30/2027	Deborah Volosin	Facilities has 20+ projects targeted for completion in FY27.
Strengthen Community Engagement	On Track	07/01/2026	06/30/2027	Deborah Volosin	In October, CE met with CAC groups and hosted a stroke award event.

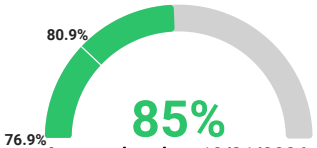
Recruit 15 Specialty Providers



Last updated on 10/31/2026

Move from baseline of 0 to target of 15

NPS "Likelihood to Recommend: Medical Practices" at 80.9 or greater



Last updated on 10/31/2026

Move from baseline of 76.9% to target of 80.9%

Perform on Seven or more QIP measures for calendar year 2026



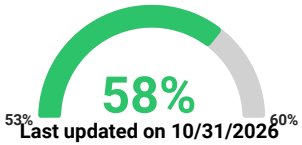
Last updated on 10/31/2026

Stay above baseline of 0

Strategy Summary - Physician Alignment

Name	Status	Start Date	Due Date	Assigned To	Last Comment
Recruit Physicians and Advanced Practice Providers	On Track	07/01/2026	06/30/2027	JC Palermo	YTD Update: *Attended the UCSF Fresno career fair and held the FM coordinator meeting; discussions continue with promising residency candidates. *An LOI was delivered to an OB/GYN candidate through visa sponsorship discussions with Key Medical Group; acquisition conversations with two local physicians are progressing. *Recruited to date: 7 of 15 Specialty Providers, 3 of 5 Primary Care Physicians, 5.0 of 10 APP FTEs. *Review of the recruitment and onboarding process continues with internal stakeholders. Next Steps: *Follow up with career fair candidates, schedule a presentation to UCSF residents, and pursue additional coordinator introductions and Dignity Health face time. *Continue active searches, including Family Medicine and Radiation Oncology, and support the Key Medical Group and Sunmed Health searches. *Advance the OB/GYN LOI and the acquisition conversations.
Mature Value Based Care Capabilities to position Kaweah Health as the Must Have Network	On Track	07/01/2026	06/30/2027	Tom Boggs	YTD Update: * Workgroups on Annual Wellness Visits and Quality (Gaps in Care / Stars) execution., with performance beating prior year *Executed contract for Implementation of Oracle tools to support accurate documentation, patient orchestration Next Steps: *Develop Annual Quality Workplan for Pop Health Committee Approval *Execute 4th Quarter push tactics
Journey to Top Decile Ambulatory Clinic Performance	On Track	07/01/2026	06/30/2027	Tom Boggs	YTD Update: *Initial focus on Patient Experience due to gap - RECORD-HIGH for NPS Likelihood to Recommend at 86.7 *Access to Care: substantial improvements in Third Next Available Appt. *Quality: Focus on Annual Well Visit (AWV) ramp-up; developing Annual Quality Workplan & resource requirements Next Steps: *Execute 4th Quarter Quality Push *Complete Physician Productivity Benchmarks *Continue Access and sustain Patient Sat results

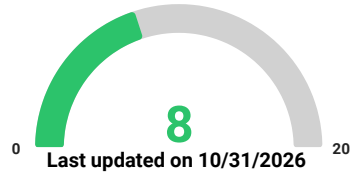
Through the work of the OR Optimization Committee, increase overall block usage to 60% in FY2027 (12% increase)



Last updated on 10/31/2026

Move from baseline of 53% to target of 60%

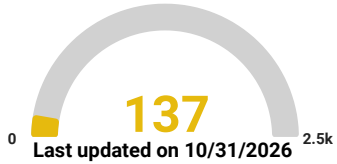
Complete 20 Mitra Clip Procedures in FY2027



Last updated on 10/31/2026

Stay between baseline of 0 and target of 20

2,500 new patient PCP visits for FY2027 (39% increase)



Last updated on 10/31/2026

Move from baseline of 0 to target of 2.5k

Strategy Summary - Strategic Growth and Innovation

Name	Status	Start Date	Due Date	Assigned To	Last Comment
Grow Targeted Service Line Volumes	On Track	07/01/2026	06/30/2027	Kevin Bartel	YTD Update: *Volume goals met in many areas -- TAVR, mitral clip & EP procedures, endoscopy, Urology *Volume goals not met in orthopedics and general surgery, but initiatives in place to promote growth *9 beds opened in SNF, with phase 2 & 3 in planning Next Steps: *Physician liaison support enlisted with identified elective practices to promote more known referral patter pipelines with local providers to drive clinic volume, including Ortho as volumes were below budget *Recruitment of EP cardiologist with identified candidate, potential start date may fall into early FY28
Enhance Medical Center Capacity and Efficiency	On Track	07/01/2026	06/30/2027	Kevin Bartel	YTD Update: *Continue OR Optimization committee -- slightly below targeted utilization at 58% for the month -- KH leaders are in dept during first case starts to encourage staff and MDs to be accountable *Expansion of CV PACU and construction of two OP procedure rooms on track to be completed in FY2027 Next Steps: *Focus of OR Optimization committee will be on addressing first case start times and OR turnaround time, as not all metrics did not meet established goals in September *While construction of two OR procedure rooms is on track for completion in FY27, licensing delays may ultimately push clinical use of this space into FY28
Expand access for patients though Clinic Network Development	On Track	07/01/2026	06/30/2027	Ivan Jara	YTD Update: * 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 for Primary and Specialty Care and advanced practice providers * Continued efforts to identify new clinic locations (Specialty, Rural, and Commercial) * Ongoing review and application for federal/state programs and grants
Innovation	On Track	07/01/2026	06/30/2027	Kevin Bartel	YTD Update: *Hospitalist pilot of AI ambient listening is complete, with 128 providers using the platform in October *Workday demo for HR, Finance, Supply Chain & Payroll *Care at Home program -- Straw Model developed for workflows, etc Next Steps: *Clinical AI agent nursing pilot scheduled for Q2 2027 *Internal meetings to decide whether to move forward with AI agents in Workday *TMaH -- meetings with partner health plans along with non-binding application of interest *Scoping of $ risk exposure in Ambulatory Medical Specialty (ASM) Model *Care at Home program -- Review with clinic Medical Director Leadership for feedback
Enhance Health Plan Programs	On Track	07/01/2026	06/30/2027	Sonia Duran-Aguilar	* Evaluate CHW Medi-Cal Benefit application and submit to MCPs for CHW reimbursement contracting for ED implementation. Work underway to complete certification application with both Anthem BC and HealthNet.

Rad, CT, Ultrasounds

Imaging Services

FY2026 Annual Board Report

Renee Lauck

Outpatient imaging results, quality, and plans

Fiscal year July 1, 2025 to June 30, 2026

Report date November 10, 2026



FY2026 at a glance

54,959
Patient visits
up 7% from FY25

$22.6M
Net revenue
up 21% from FY25

$12.8M
Contribution margin
up 16% from FY25

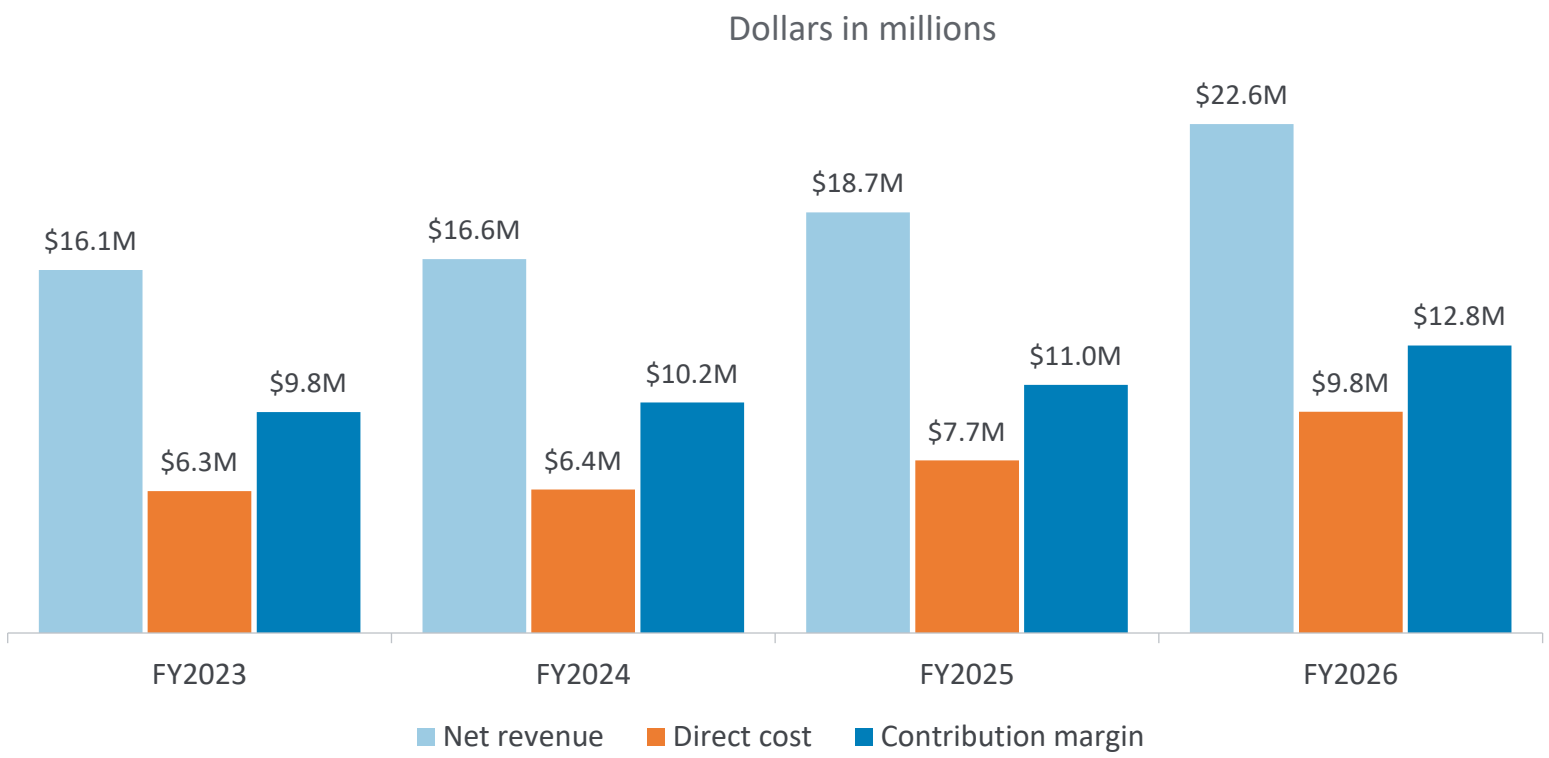
$9.8M
Net income
up 26% from FY25

$411
Net revenue per visit
up 13% from FY25

$9.8M
Direct cost
up 28% from FY25

Total for 13 outpatient imaging Services. Combined, compared with FY2025

Margin up every year since FY23



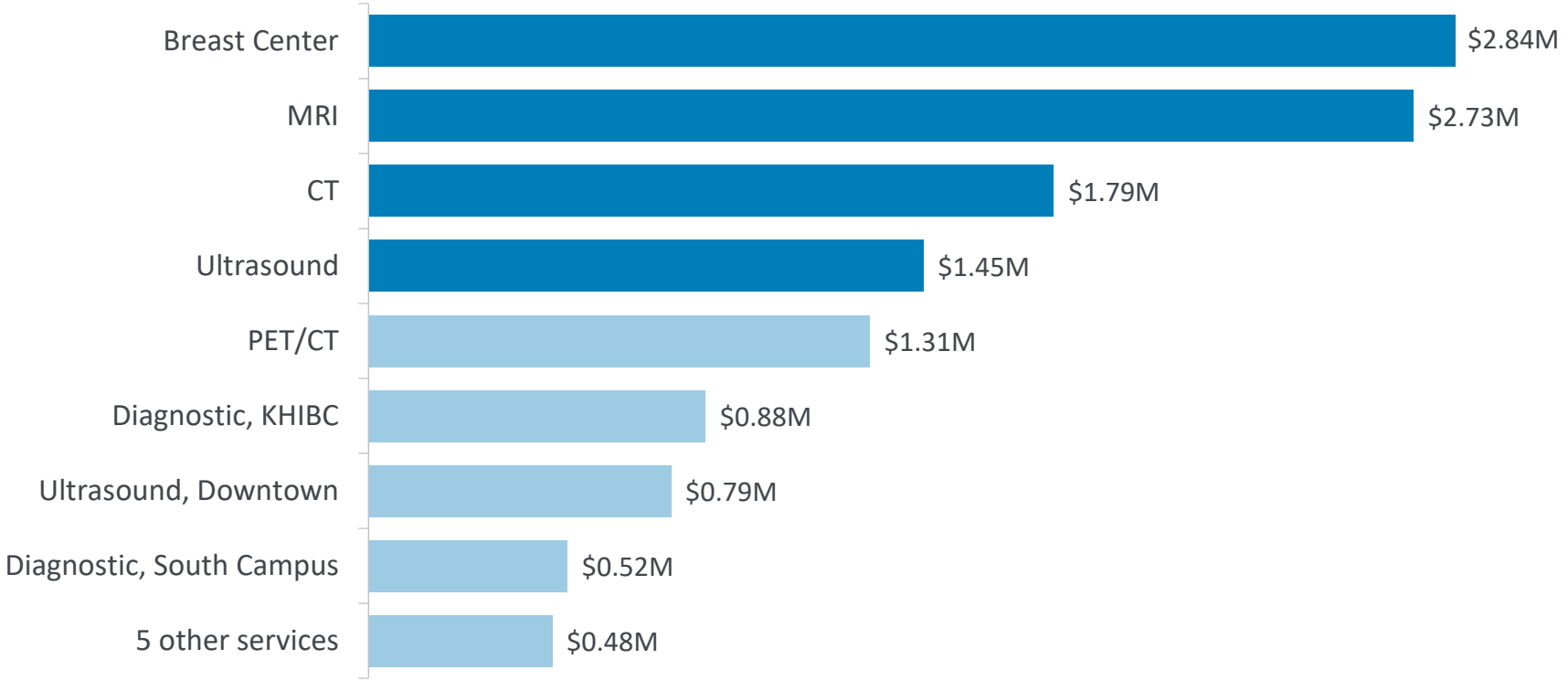
+14%

visits since FY2023

+40%

net revenue since FY2023

Four services drive 69% of margin



$8.8M

69% of total margin

comes from Breast Center, MRI, CT and Ultrasound at the Kaweah Health Imaging & Breast Center (dark bars).

Breast Center up 33%, MRI steady

Breast Center

11,131 visits, up 15%

$2.84M contribution margin, up 33%

$395 net revenue per visit, up 15%

After 3 long-term mammography specialists retired, 3 staff were hired and trained to full licensure, which expanded appointment times.

MRI

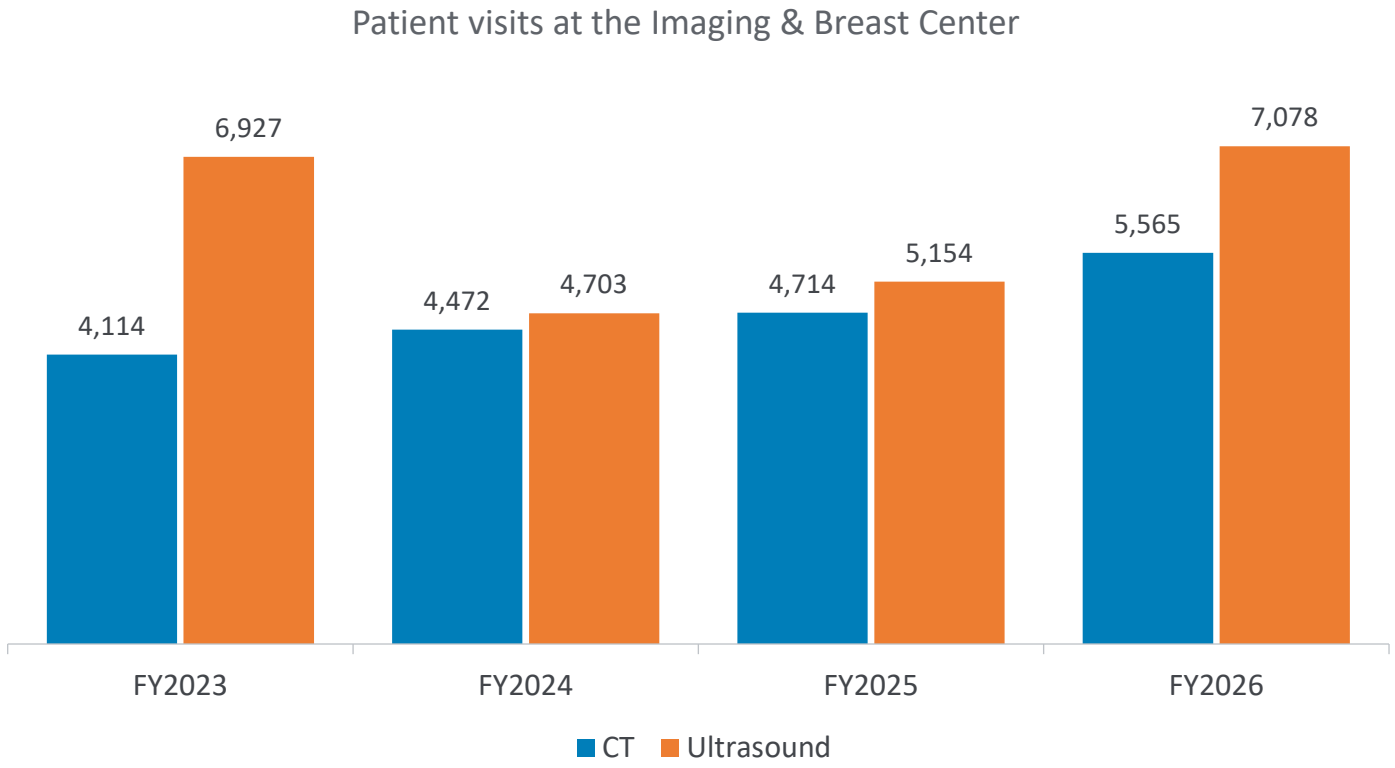
4,626 visits, up 3%

$2.73M contribution margin, up 1% (4-year high)

$792 net revenue per visit, up 6%

Direct costs rose 40% with added staffing to meet community need and higher equipment service costs.

CT and Ultrasound expand access



CT: visits up 18%

5,565 visits. Margin up 21% to $1.79M and net income at a 4-year high. Saturday appointments added.

Ultrasound: visits up 37%

7,078 visits. A third room and 10-hour shifts lifted margin 60% to $1.45M.

Where we are watching closely

PET/CT

-7%

change in margin. Visits grew 13%, but direct cost rose 25% and margin per visit fell to $784 from $960.

Direct cost growth

+28%

growth in direct cost, versus visits up 7%. Cost per visit rose 20% to $179.

Added reimbursement

$2.2M

in added reimbursement, up 59%. It drove about half of the margin gain; without it, margin per visit rose 3%.

Volume softness

-30%

drop in Downtown ultrasound visits. South Campus diagnostic imaging visits fell 13%.

Added reimbursement is included in net revenue. FY2026 compared with FY2025.

Quality and safety standards in place

ACR accreditation in place

- CT (KHIBC and KHMC)
- MRI (KHIBC and KHMC)
- Breast MRI (KHIBC)
- Mammography (KHIBC)
- Breast ultrasound (KHIBC)
- Stereotactic breast biopsy
- Ultrasound (KHMC)
- Ultrasound (KHIBC)

What we monitor

Required measures: radiation misadministration, mammography recall rates, repeat and rejected images. Also tracked: MRI safety incidents and burns, critical findings, and fluoroscopy and lead apron QA, with yearly physics testing and on-schedule maintenance on every unit.

ED turnaround focus

ED goals were met 11 of 12 months in FY2025. Tougher goals were set for FY2026 amid record CT orders and new graduate technologists. Daily CT and ultrasound huddles are helping.

Equipment projects and operations

1

KHMC CT replacement

Faster, higher-technology scanners that can perform cardiac CT

2

KHMC radiography and fluoroscopy

New Fuji unit replaces our oldest, end-of-life equipment

3

KHIBC 3.0T MRI, mid-December

Adds prostate MRI for the cancer program and advanced neuro studies

Operations to resolve

Isotope supply: late Cardinal deliveries have caused reschedules. We are vetting another supplier, which needs licensing and pharmacy review.

Hiring: new Nuclear Medicine and CT manager in place; one tech posted, one traveler to backfill.

People: engagement up in most areas; two new managers still growing into the role.

Priorities for FY2027

1 See patients within 7 to 10 days

Keep expanded hours and Saturday appointments in nearly every service line.

2 Replace equipment early

Act before parts are unavailable or delays reach patient care.

3 Stay current and competitive

Keep technology relevant for referring providers and patients.

4 Match services to need

Review volumes, revenue and priorities for Visalia and surrounding counties.

5 Pursue a women's center

Bring together breast center, OB ultrasound and other services for women.

6 Replace the MRI before a second

The current hospital MRI needs replacing to meet ED and inpatient demand.

The pursuit of healthiness



Kaweah Health
MORE THAN MEDICINE. LIFE.

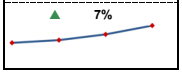
KAWEAH HEALTH ANNUAL BOARD REPORT

Outpatient Imaging Services - Summary

FY2026

KEY METRICS - FY 2026 BASED ON THE TWELVE MONTHS ENDED JUNE 30, 2026

PATIENT VISITS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
54,959	$22,613,231	$9,830,786	$12,782,445	$9,796,349
▲ 7%	▲ 21%	▲ 28%	▲ 16%	▲ 26%



METRICS BY SERVICE LINE - FY 2026

SERVICE LINE	Patient Visits	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME	CONTRB MARGIN per VISIT
Breast Center Kaweah Health Img Ctr	11,131	$4,401,416	$1,560,822	$2,840,594	$2,367,656	$255
MRI Kaweah Health Img Ctr	4,626	$3,664,811	$937,345	$2,727,466	$2,263,121	$590
CT Scan Kaweah Health Img Ctr	5,565	$2,667,032	$875,335	$1,791,697	$1,355,377	$322
Ultrasound Kaweah Health Img Ctr	7,078	$2,121,908	$675,071	$1,446,837	$1,251,793	$204
PET Scan Kaweah Health Img Ctr	1,673	$3,561,858	$2,250,286	$1,311,572	$984,326	$784
Diag Imaging Kaweah Health Img Ctr	12,625	$2,201,567	$1,324,565	$877,002	$366,808	$69
Ultrasound Downtown Campus	2,582	$1,232,772	$440,601	$792,171	$693,231	$307
Diag Imaging South Campus	7,763	$1,027,726	$512,232	$515,494	$339,832	$66
CT Scan Downtown Campus	309	$658,561	$470,246	$188,315	$127,913	$609
Nuclear Medicine Downtown Campus	795	$672,587	$529,094	$143,493	($30,761)	$180
Diagnostic Imaging Downtown Campus	309	$256,989	$191,537	$65,452	$20,172	$212
MRI Downtown Campus	124	$102,089	$38,176	$63,913	$46,101	$515
Diag Img UCC Demaree Walk-in	379	$43,915	$25,476	$18,439	$10,780	$49
Outpatient Imaging Services Total	54,959	$22,613,231	$9,830,786	$12,782,445	$9,796,349	$233

METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Visits	48,056	49,211	51,490	54,959	▲ 7%	
Net Revenue	$16,127,755	$16,624,746	$18,695,265	$22,613,231	▲ 21%	
Direct Cost	$6,308,464	$6,379,654	$7,666,433	$9,830,786	▲ 28%	
Additional Reimb	$419,553	$517,997	$1,404,107	$2,236,751	▲ 59%	
Contribution Margin	$9,819,291	$10,245,092	$11,028,831	$12,782,445	▲ 16%	
Indirect Cost	$2,999,885	$2,889,807	$3,231,114	$2,986,096	▼ -8%	
Net Income	$6,819,406	$7,355,285	$7,797,717	$9,796,349	▲ 26%	
Net Revenue per Visit	$336	$338	$363	$411	▲ 13%	
Net Rev w/o Add Reimb per Visit	$327	$327	$336	$371	▲ 10%	
Add Reimb per visit	$9	$11	$27	$41	▲ 49%	
Direct Cost per Visit	$131	$130	$149	$179	▲ 20%	
Contrb Margin per Visit	$204	$208	$214	$233	▲ 9%	
CM w/o Add Reimb per Visit	$196	$198	$187	$192	▲ 3%	
% of Add Reimb per visit/CM per visit	4%	5%	13%	17%	▲ 37%	

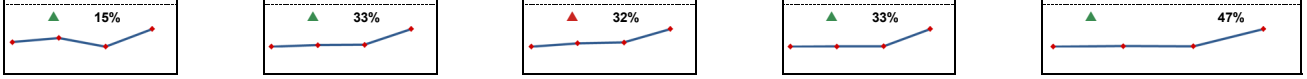
KAWEAH HEALTH ANNUAL BOARD REPORT

FY2026

Outpatient Imaging Services - Breast Center Kaweah Health Imaging Center

KEY METRICS - FY 2026 BASED ON THE TWELVE MONTHS ENDED JUNE 30, 2026

PATIENT VISITS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
11,131	$4,401,416	$1,560,822	$2,840,594	$2,367,656
▲ 15%	▲ 33%	▲ 32%	▲ 33%	▲ 47%



METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Visits	10,054	10,393	9,681	11,131	▲ 15%	
Net Revenue	$3,183,972	$3,288,325	$3,318,462	$4,401,416	▲ 33%	
Direct Cost	$1,064,635	$1,161,050	$1,180,418	$1,560,822	▲ 32%	
Additional Reimb	$69,575	$100,505	$210,971	$342,100	▲ 62%	
Contribution Margin	$2,119,337	$2,127,275	$2,138,044	$2,840,594	▲ 33%	
Indirect Cost	$533,449	$513,490	$531,044	$472,938	▼ -11%	
Net Income	$1,585,888	$1,613,785	$1,607,000	$2,367,656	▲ 47%	
Net Revenue per Visit	$317	$316	$343	$395	▲ 15%	
Net Rev w/o Add Reimb per Visit	$310	$307	$321	$365	▲ 14%	
Direct Cost per Visit	$106	$112	$122	$140	▲ 15%	
Add Reimb per Visit	$7	$10	$22	$31	▲ 41%	
Contrb Margin per Visit	$211	$205	$221	$255	▲ 16%	
CM w/o Add Reimb per Visit	$204	$195	$199	$224	▲ 13%	
% of Add Reimb per visit/CM per vis	3%	5%	10%	12%	▲ 22%	

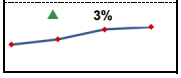
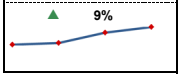
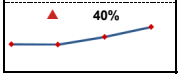
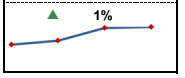
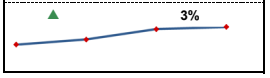
KAWEAH HEALTH ANNUAL BOARD REPORT

Outpatient Imaging Services - MRI Kaweah Health IMG CTR

FY2026

KEY METRICS - FY 2026 BASED ON THE TWELVE MONTHS ENDED JUNE 30, 2026

PATIENT VISITS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
4,626	$3,664,811	$937,345	$2,727,466	$2,263,121
▲ 3%	▲ 9%	▲ 40%	▲ 1%	▲ 3%

METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Visits	3,786	4,039	4,503	4,626	▲ 3%	
Net Revenue	$2,740,503	$2,834,091	$3,369,012	$3,664,811	▲ 9%	
Direct Cost	$477,385	$466,301	$670,185	$937,345	▲ 40%	
Additional Reimb	$47,914	$40,351	$94,611	$179,377	▲ 90%	
Contribution Margin	$2,263,118	$2,367,790	$2,698,827	$2,727,466	▲ 1%	
Indirect Cost	$455,223	$426,611	$492,868	$464,345	▼ -6%	
Net Income	$1,807,895	$1,941,179	$2,205,959	$2,263,121	▲ 3%	
Net Revenue per Visit	$724	$702	$748	$792	▲ 6%	
Net Rev w/o Add Reimb per Visit	$711	$692	$727	$753	▲ 4%	
Add Reimb per Visit	$13	$10	$21	$39	▲ 85%	
Direct Cost per Visit	$126	$115	$149	$203	▲ 36%	
Contrb Margin per Visit	$598	$586	$599	$590	▼ -2%	
CM w/o Add Reimb per Visit	$585	$576	$578	$551	▼ -5%	
% of Add Reimb per visit/CM per vis	2%	2%	4%	7%	▲ 88%	

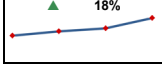
KAWEAH HEALTH ANNUAL BOARD REPORT

Outpatient Imaging Services - CT Scan Kaweah Health Imaging Center

FY2026

KEY METRICS - FY 2026 BASED ON THE TWELVE MONTHS ENDED JUNE 30, 2026

PATIENT VISITS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
5,565	$2,667,032	$875,335	$1,791,697	$1,355,377
▲ 18%	▲ 21%	▲ 21%	▲ 21%	▲ 38%



METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Visits	4,114	4,472	4,714	5,565	▲ 18%	
Net Revenue	$1,918,348	$2,080,359	$2,197,648	$2,667,032	▲ 21%	
Direct Cost	$597,057	$576,397	$722,269	$875,335	▲ 21%	
Additional Reimb	$22,686	$28,356	$80,656	$142,967	▲ 77%	
Contribution Margin	$1,321,291	$1,503,962	$1,475,379	$1,791,697	▲ 21%	
Indirect Cost	$438,406	$414,178	$495,895	$436,320	▼ -12%	
Net Income	$882,885	$1,089,784	$979,484	$1,355,377	▲ 38%	
Net Revenue per Visit	$466	$465	$466	$479	▲ 3%	
Net Rev w/o Add Reimb per visit	$461	$459	$449	$454	▲ 1%	
Direct Cost per Visit	$145	$129	$153	$157	▲ 3%	
Add Reimb per Visit	$6	$6	$17	$26	▲ 50%	
Contrb Margin per Visit	$321	$336	$313	$322	▲ 3%	
CM w/o Add Reimb per Visit	$316	$330	$296	$296	▶ 0%	
% of Add Reimb per visit/CM per visit	2%	2%	5%	8%	▲ 46%	

ote: All visits with a primary service of Radiology and secondary service of Dig Img UCC Demaree. This excludes visits with Outpatient Imaging services performed as a part of another outpatient service line (eg. Urgent Care, Emergency epartment).

KAWEAH HEALTH ANNUAL BOARD REPORT

FY2026

Outpatient Imaging Services - Ultrasound Kaweah Health Imaging Center

KEY METRICS - FY 2026 BASED ON THE TWELVE MONTHS ENDED JUNE 30, 2026

PATIENT VISITS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
7,078	$2,121,908	$675,071	$1,446,837	$1,251,793
▲ 37%	▲ 66%	▲ 83%	▲ 60%	▲ 67%

METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Visits	6,927	4,703	5,154	7,078	▲ 37%	
Net Revenue	$1,298,445	$1,026,104	$1,275,244	$2,121,908	▲ 66%	
Direct Cost	$394,883	$298,734	$368,238	$675,071	▲ 83%	
Additional Reimb	$75,283	$65,366	$186,413	$409,449	▲ 120%	
Contribution Margin	$903,562	$727,370	$907,006	$1,446,837	▲ 60%	
Indirect Cost	$207,249	$162,262	$156,864	$195,044	▲ 24%	
Net Income	$696,313	$565,108	$750,142	$1,251,793	▲ 67%	
Net Revenue per Visit	$187	$218	$247	$300	▲ 21%	
Net Rev w/o Add Reimb per Visit	$177	$204	$211	$242	▲ 15%	
Add Reimb per Visit	$11	$14	$36	$58	▲ 60%	
Direct Cost per Visit	$57	$64	$71	$95	▲ 33%	
Contrb Margin per Visit	$130	$155	$176	$204	▲ 16%	
CM w/o Add Reimb per Visit	$120	$141	$140	$147	▲ 5%	
% of Add Reimb per visit/CM per visit	8%	9%	21%	28%	▲ 38%	

KAWEAH HEALTH ANNUAL BOARD REPORT

FY2026

Outpatient Imaging Services - PET Scan Kaweah Health Imaging Center

KEY METRICS - FY 2026 BASED ON THE TWELVE MONTHS ENDED JUNE 30, 2026

PATIENT VISITS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
1,673	$3,561,858	$2,250,286	$1,311,572	$984,326
▲ 13%	▲ 10%	▲ 25%	▼ -7%	▼ -11%

METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Visits	1,248	1,505	1,476	1,673	▲ 13%	
Net Revenue	$2,946,830	$2,913,936	$3,224,315	$3,561,858	▲ 10%	
Direct Cost	$1,213,289	$1,624,732	$1,806,841	$2,250,286	▲ 25%	
Additional Reimb	$69,076	$29,590	$40,519	$52,702	▲ 30%	
Contribution Margin	$1,733,541	$1,289,204	$1,417,474	$1,311,572	▼ -7%	
Indirect Cost	$232,879	$223,558	$307,404	$327,246	▲ 6%	
Net Income	$1,500,662	$1,065,646	$1,110,070	$984,326	▼ -11%	
Net Revenue per Visit	$2,361	$1,936	$2,184	$2,129	▼ -3%	
Net Rev w/o Add Reimb per Visit	$2,306	$1,917	$2,157	$2,098	▼ -3%	
Add Reimb per Visit	$55	$20	$27	$32	▲ 15%	
Direct Cost per Visit	$972	$1,080	$1,224	$1,345	▲ 10%	
Contrb Margin per Visit	$1,389	$857	$960	$784	▼ -18%	
CM w/o Add Reimb per Visit	$1,334	$837	$933	$752	▼ -19%	
% of Add Reimb per visit/CM per visit	4%	2%	3%	4%	▲ 41%	

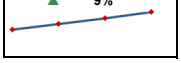
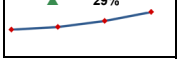
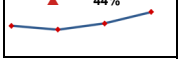
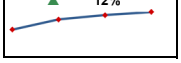
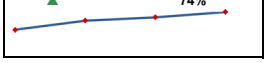
KAWEAH HEALTH ANNUAL BOARD REPORT

FY2026

Outpatient Imaging Services - Diagnostic Imaging Kaweah Health Imaging Center

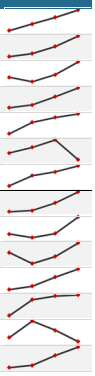
KEY METRICS - FY 2026 BASED ON THE TWELVE MONTHS ENDED JUNE 30, 2026

PATIENT VISITS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
12,625	$2,201,567	$1,324,565	$877,002	$366,808
▲ 9%	▲ 29%	▲ 44%	▲ 12%	▲ 74%

METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Visits	9,704	10,631	11,569	12,625	▲ 9%	
Net Revenue	$1,224,850	$1,370,673	$1,707,724	$2,201,567	▲ 29%	
Direct Cost	$843,445	$706,129	$921,644	$1,324,565	▲ 44%	
Additional Reimb	$40,458	$103,496	$290,906	$487,772	▲ 68%	
Contribution Margin	$381,405	$664,544	$786,079	$877,002	▲ 12%	
Indirect Cost	$531,958	$550,501	$575,227	$510,194	▼ -11%	
Net Income	($150,553)	$114,043	$210,852	$366,808	▲ 74%	
Net Revenue per Visit	$126	$129	$148	$174	▲ 18%	
Net Rev w/o Add Reimb per visit	$122	$119	$122	$136	▲ 11%	
Direct Cost per Visit	$87	$66	$80	$105	▲ 32%	
Add Reimb per Visit	$4	$10	$25	$39	▲ 54%	
Contrb Margin per Visit	$39	$63	$68	$69	▲ 2%	
CM w/o Add Reimb per Visit	$35	$53	$43	$31	▼ -28%	
% of Add Reimb per visit/CM per visit	11%	16%	37%	56%	▲ 50%	



KAWEAH HEALTH ANNUAL BOARD REPORT

FY2026

Outpatient Imaging Services - Ultrasound Downtown Campus

KEY METRICS - FY 2026 BASED ON THE TWELVE MONTHS ENDED JUNE 30, 2026

PATIENT VISITS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN
2,582	$1,232,772	$440,601	$792,171
▼ -30%	▲ 3%	▲ 10%	▼ -1%

METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2023	FY2024	FY2025	4 YR TREND
Patient Visits	824	2,136	3,693	
Net Revenue	$506,080	$821,707	$1,200,924	
Direct Cost	$157,912	$226,472	$402,156	
Additional Reimb	$5,873	$63,451	$268,757	
Contribution Margin	$348,168	$595,235	$798,768	
Indirect Cost	$56,162	$84,651	$139,983	
Net Income	$292,006	$510,584	$658,785	
Net Revenue per Visit	$614	$385	$325	
Net Rev w/o Add Reimb per Visit	$607	$355	$252	
Direct Cost per Visit	$192	$106	$109	
Add Reimb per Visit	$7	$30	$73	
Contrb Margin per Visit	$423	$279	$216	
CM w/o Add Reimb per Visit	$415	$249	$144	
% Of Add Reimb per visit/CM per vis	2%	11%	34%	

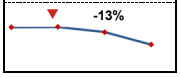
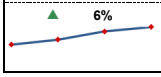
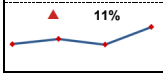
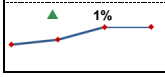
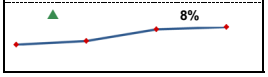
KAWEAH HEALTH ANNUAL BOARD REPORT

Outpatient Imaging Services - Diag Imaging South Campus

FY2026

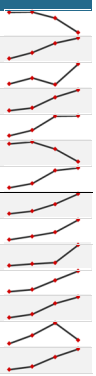
KEY METRICS - FY 2026 BASED ON THE TWELVE MONTHS ENDED JUNE 30, 2026

PATIENT VISITS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
7,763	$1,027,726	$512,232	$515,494	$339,832
▼ -13%	▲ 6%	▲ 11%	▲ 1%	▲ 8%

METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Visits	9,441	9,475	8,966	7,763	▼ -13%	
Net Revenue	$815,132	$875,526	$973,479	$1,027,726	▲ 6%	
Direct Cost	$462,513	$477,317	$460,628	$512,232	▲ 11%	
Additional Reimb	$43,056	$70,895	$179,670	$254,946	▲ 42%	
Contribution Margin	$352,619	$398,209	$512,851	$515,494	▲ 1%	
Indirect Cost	$208,625	$212,272	$198,898	$175,662	▼ -12%	
Net Income	$143,994	$185,937	$313,953	$339,832	▲ 8%	
Net Revenue per Visit	$86	$92	$109	$132	▲ 22%	
Net Rev w/o Add Reimb per Visit	$82	$85	$89	$100	▲ 12%	
Direct Cost per Visit	$49	$50	$51	$66	▲ 28%	
Add Reimb per Visit	$5	$7	$20	$33	▲ 64%	
Contrb Margin per Visit	$37	$42	$57	$66	▲ 16%	
CM w/o Add Reimb per Visit	$33	$35	$37	$34	▼ -10%	
% of Add Reimb per visit/CM per vis	12%	18%	35%	49%	▲ 41%	



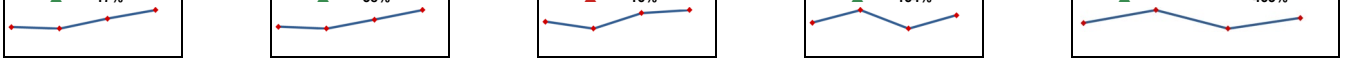
KAWEAH HEALTH ANNUAL BOARD REPORT

FY2026

Outpatient Imaging Services - CT Scan Downtown Campus

KEY METRICS - FY 2026 BASED ON THE TWELVE MONTHS ENDED JUNE 30, 2026

PATIENT VISITS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
309	$658,561	$470,246	$188,315	$127,913
▲ 17%	▲ 38%	▲ 16%	▲ 154%	▲ 463%



METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Visits	221	213	264	309	▲ 17%	
Net Revenue	$348,732	$312,693	$478,764	$658,561	▲ 38%	
Direct Cost	$223,487	$79,107	$404,712	$470,246	▲ 16%	
Additional Reimb	$2,148	$1,310	$9,950	$16,134	▲ 62%	
Contribution Margin	$125,245	$233,586	$74,052	$188,315	▲ 154%	
Indirect Cost	$46,598	$27,283	$51,342	$60,402	▲ 18%	
Net Income	$78,647	$206,303	$22,710	$127,913	▲ 463%	
Net Revenue per Visit	$1,578	$1,468	$1,814	$2,131	▲ 18%	
Net Rev w/o Add Reimb per Visit	$1,568	$1,462	$1,776	$2,079	▲ 17%	
Direct Cost per Visit	$1,011	$371	$1,533	$1,522	▼ -1%	
Add Reimb per Visit	$10	$6	$38	$52	▲ 39%	
Contrb Margin per Visit	$567	$1,097	$281	$609	▲ 117%	
CM w/o Add Reimb per Visit	$557	$1,090	$243	$557	▲ 129%	
% of Add Reimb per visit/CM per visi	2%	1%	13%	9%	▼ -36%	

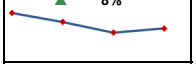
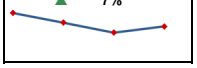
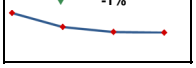
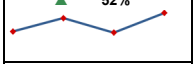
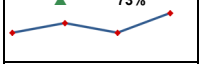
KAWEAH HEALTH ANNUAL BOARD REPORT

FY2026

Outpatient Imaging Services - Nuclear Medicine Downtown Campus

KEY METRICS - FY 2026 BASED ON THE TWELVE MONTHS ENDED JUNE 30, 2026

PATIENT VISITS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
795	$672,587	$529,094	$143,493	($30,761)
▲ 8%	▲ 7%	▼ -1%	▲ 52%	▲ 73%

METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Visits	998	880	739	795	▲ 8%	
Net Revenue	$768,476	$700,237	$628,757	$672,587	▲ 7%	
Direct Cost	$670,936	$569,615	$534,319	$529,094	▼ -1%	
Additional Reimb	$5,978	$7,429	$19,478	$29,241	▲ 50%	
Contribution Margin	$97,540	$130,622	$94,438	$143,493	▲ 52%	
Indirect Cost	$210,805	$203,517	$207,746	$174,254	▼ -16%	
Net Income	($113,265)	($72,895)	($113,308)	($30,761)	▲ 73%	
Net Revenue per Visit	$770	$796	$851	$846	▼ -1%	
Net Rev w/o Add Reimb per visit	$764	$787	$824	$809	▼ -2%	
Direct Cost per Visit	$672	$647	$723	$666	▼ -8%	
Add Reimb per Visit	$6	$8	$26	$37	▲ 40%	
Contrb Margin per Visit	$98	$148	$128	$180	▲ 41%	
CM w/o Add Reimb per Visit	$92	$140	$101	$144	▲ 42%	
% of Add Reimb per visit/CM per visit	6%	6%	21%	20%	▼ -1%	

Note: All visits with a primary service of Radiology and secondary service of NM Downtown Campus. This excludes visits with Outpatient Imaging services performed as a part of another outpatient service line (eg. Urgent Care, Emergency Department).

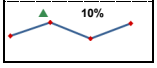
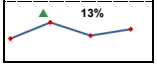
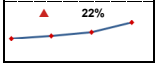
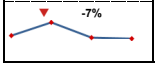
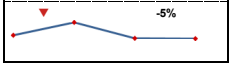
KAWEAH HEALTH ANNUAL BOARD REPORT

Outpatient Imaging Services - Diagnostic Imaging Downtown Campus

FY2026

KEY METRICS - FY 2026 BASED ON THE TWELVE MONTHS ENDED JUNE 30, 2026

PATIENT VISITS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
309	$256,989	$191,537	$65,452	$20,172
▲ 10%	▲ 13%	▲ 22%	▼ -7%	▼ -5%

METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Visits	286	311	281	309	▲ 10%	
Net Revenue	$214,964	$288,548	$227,698	$256,989	▲ 13%	
Direct Cost	$134,619	$143,226	$157,319	$191,537	▲ 22%	
Additional Reimb	$965	$1,178	$7,528	$11,500	▲ 53%	
Contribution Margin	$80,345	$145,322	$70,379	$65,452	▼ -7%	
Indirect Cost	$43,549	$44,244	$49,238	$45,280	▼ -8%	
Net Income	$36,796	$101,078	$21,141	$20,172	▼ -5%	
Net Revenue per Visit	$752	$928	$810	$832	▲ 3%	
Net Rev w/o Add Reimb per Visit	$748	$924	$784	$794	▲ 1%	
Direct Cost per Visit	$471	$461	$560	$620	▲ 11%	
Add Reimb per Visit	$3	$4	$27	$37	▲ 39%	
Contrb Margin per Visit	$281	$467	$250	$212	▼ -15%	
CM w/o Add Reimb per Visit	$278	$463	$224	$175	▼ -22%	
% of Add Reimb per visit/CM per vis	1%	1%	11%	18%	▲ 64%	

Note: All visits with a primary service of Radiology and secondary service of Diag Img DT Campus. This excludes visits with Outpatient Imaging services performed as a part of another outpatient service line (eg. Urgent Care, Emergency Department).

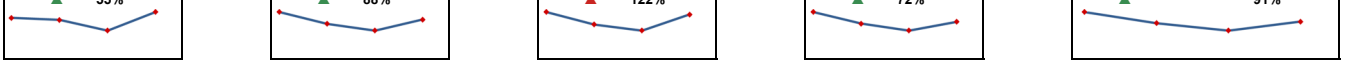
KAWEAH HEALTH ANNUAL BOARD REPORT

Outpatient Imaging Services - MRI Downtown Campus

FY2026

KEY METRICS - FY 2026 BASED ON THE TWELVE MONTHS ENDED JUNE 30, 2026

PATIENT VISITS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
124	$102,089	$38,176	$63,913	$46,101
▲ 55%	▲ 88%	▲ 122%	▲ 72%	▲ 91%



METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Visits	110	105	80	124	▲ 55%	
Net Revenue	$134,838	$83,457	$54,403	$102,089	▲ 88%	
Direct Cost	$41,501	$25,197	$17,192	$38,176	▲ 122%	
Additional Reimb	$34,546	$1,561	$1,703	$6,003	▲ 252%	
Contribution Margin	$93,337	$58,260	$37,211	$63,913	▲ 72%	
Indirect Cost	$23,635	$15,897	$13,049	$17,812	▲ 37%	
Net Income	$69,702	$42,363	$24,162	$46,101	▲ 91%	
Net Revenue per Visit	$1,226	$795	$680	$823	▲ 21%	
Net Rev w/o Add Reimb per Visit	$912	$780	$659	$775	▲ 18%	
Direct Cost per Visit	$377	$240	$215	$308	▲ 43%	
Add Reimb per Visit	$314	$15	$21	$48	▲ 127%	
Contrb Margin per Visit	$849	$555	$465	$515	▲ 11%	
CM w/o Add Reimb per Visit	$534	$540	$444	$467	▲ 5%	
% of Add Reimb per Visit/CM per visit	37%	3%	5%	9%	▲ 105%	

Note: All visits with a primary service of Radiology and secondary service line of MRI Downtown Campus. This excludes visits with Outpatient Imaging services performed as a part of another outpatient service line (eg. Urgent Care, Emergency Department).

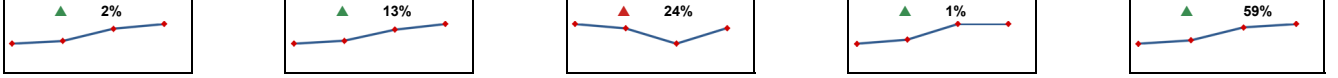
KAWEAH HEALTH ANNUAL BOARD REPORT

FY2026

Outpatient Imaging Services - Diagnostic Imaging UCC Demaree (Walk-in Radiology)

KEY METRICS - FY 2026 BASED ON THE TWELVE MONTHS ENDED JUNE 30, 2026

PATIENT VISITS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
379	$43,915	$25,476	$18,439	$10,780
▲ 2%	▲ 13%	▲ 24%	▲ 1%	▲ 59%



METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2023	FY2024	FY2025	FY2026	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Visits	343	348	370	379	▲ 2%	
Net Revenue	$26,585	$29,090	$38,835	$43,915	▲ 13%	
Direct Cost	$26,802	$25,376	$20,512	$25,476	▲ 24%	
Additional Reimb	$1,995	$4,509	$12,945	$15,640	▲ 21%	
Contribution Margin	($217)	$3,714	$18,323	$18,439	▲ 1%	
Indirect Cost	$11,347	$11,343	$11,557	$7,659	▼ -34%	
Net Income	($11,564)	($7,629)	$6,766	$10,780	▲ 59%	
Net Revenue per Visit	$78	$84	$105	$116	▲ 10%	
Net Rev w/o Add Reimb per Visit	$72	$71	$70	$75	▲ 7%	
Direct Cost per Visit	$78	$73	$55	$67	▲ 21%	
Add Reimb per Visit	$6	$13	$35	$41	▲ 18%	
Contrb Margin per Visit	($1)	$11	$50	$49	▼ -2%	
CM w/o Add Reimb per Visit	($6)	($2)	$15	$7	▼ -49%	
% of Add Reimb per visit/CM per visit	-919%	121%	71%	85%	▲ 20%	

Note: All visits with a primary service of Radiology and secondary service of Dig Img UCC Demaree. This excludes visits with Outpatient Imaging services performed as a part of another outpatient service line (eg. Urgent Care, Emergency Department).

Quarterly Compliance Report

Compliance Program Activity Report – Open Session

July 2026 through September 2026



Ben Cripps, Chief Compliance & Risk Officer

Education

Live Presentations

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

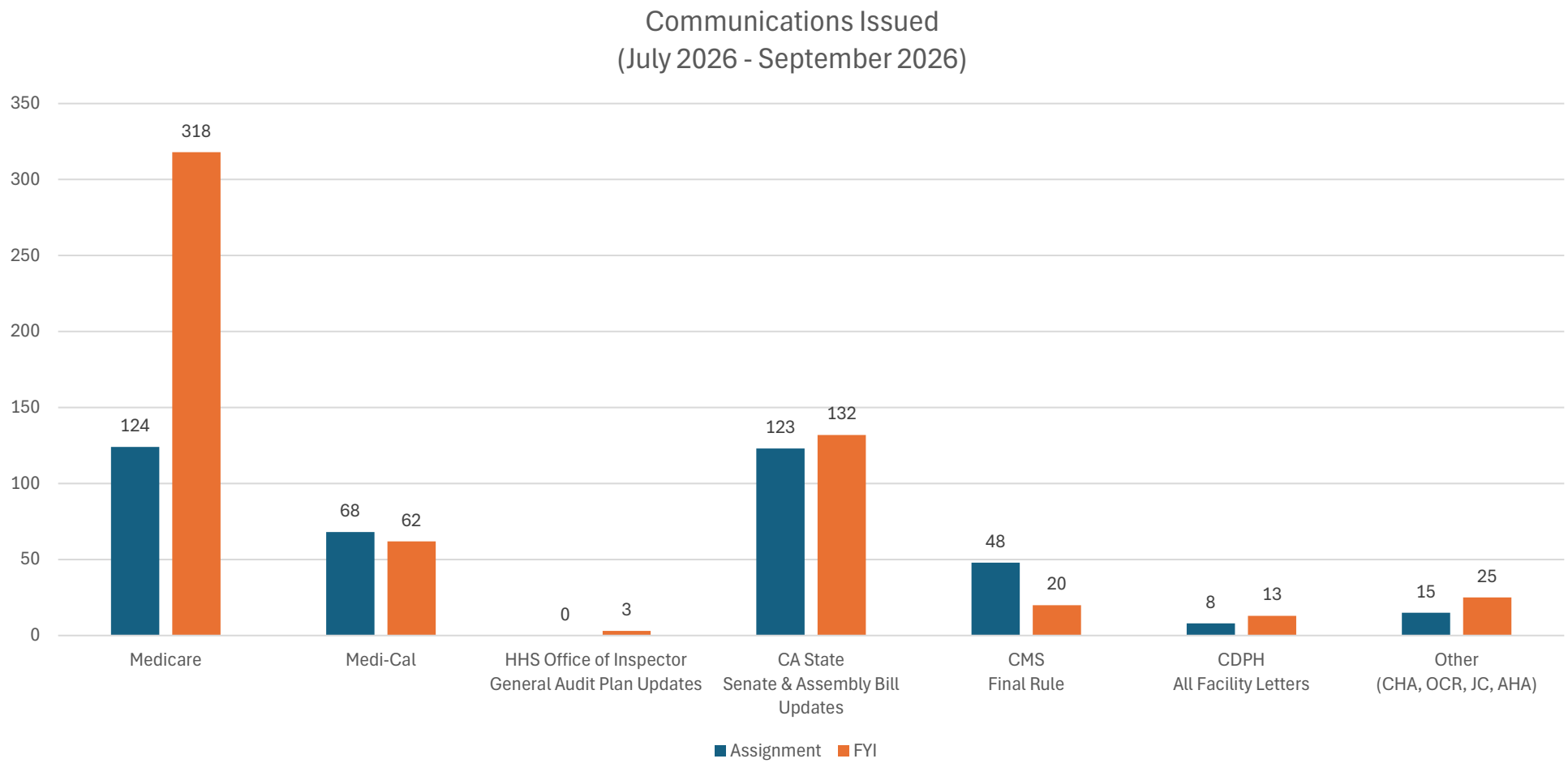
Written Communications – Bulletin Board / Area Compliance Experts (ACE) / All Staff

- Compliance Matters – FairWarning
- Compliance Matters – Think Before You Act

Prevention & Detection

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

Prevention & Detection - Issuance



Total Issued: 962
Assignments: 387
FYIs: 575

Oversight

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

- Electronic Medical Record (EMR) User Access Privacy Audits – Monitoring of EMR user access through the use of FairWarning electronic monitoring technology which analyzes user and patient data to detect potential privacy violations.
  - An average of one hundred and one-hundred forty (140) daily alerts were received between July 1, 2026 – September 30, 2026.
    - 90% were automatically closed by FairWarning analysis tools.
    - 10% required further review/investigation by Compliance Department staff.
  - Types of Alerts Received:
    - Same Last Name: 76.42%
    - Co-Worker: 21.94%
    - VIP: 1.44%
    - Self-Access: 0.08%
    - Same Household: 0.12%

Recovery Audit Contractor Activity

- Medicare Recovery Audit Contractor (RAC) Activity – Requests reviewed, records prepared and submitted, appeal timelines tracked, and results reported. The following RAC Audit Activity took place between July 2026 – September 2026:
  - New RAC Requests:
    - Two-hundred fifty (250) new RAC record requests were received.
  - Open/Ongoing RAC Requests:
    - Sixty-seven (67) were reviewed and closed by the RAC with no recovery after submission of documentation.
      - (1) won on discussion by Case Management.
    - Thirteen (13) were denied by the RAC and closed, no further appeal will be made.
      - Eight (8) unbundling cases for outpatient therapy and SNF.
      - Eighteen (18) are pending Level 1 decisions after appeal by Case Management.
      - Six (6) are pending discussion period response.
      - Thirty-nine (39) are pending demand letters and are pending review for appeals.
        - Coding – a variety of Ambulatory Payment Classification Coding Validations ex: bone marrow biopsy, Epidural Steroid Injection, insertion of tunneled central venous device, & DRG.
        - Case Management – Percutaneous Vertebral Augmentation, Kyphoplasty.
        - Skilled Nursing.
    - Two-hundred twenty-seven (227) are still pending documentation review and decision by the RAC.
  - Dollar amount involved in quarterly activity:
    - Billed amount $6,415,743.
    - Payment Amount $1,729,600.
    - Recouped Amount $850.

Auditing and Monitoring

- Office of Inspector General (OIG) Exclusion Report Verification – Quarterly monitoring of OIG exclusion reports and attestations.
  - Medical Staff and Advanced Practice Providers – Review of reports and certification by Medical Staff Office of screening completion and no Excluded Individuals or Entities were identified between July 2026 – September 2026.
  - Suppliers – Review of reports and certification by Finance Department of screening completion and no Excluded Individuals or Entities were identified between July 2026 – September 2026.
  - Medicare Opt-Out List:
    - Ten (10) non-credentialed providers were identified on the Medicare Opt-Out list between July 2026 – September 2026. Findings were tracked and logged into the system. No additional action was required as providers were only referring and not treating.

Licensing and Facility Enrollment

- Licensing Applications -- Forms preparation and submission of licensing applications to the California Department of Public Health (CDPH):
  - Eight (8) applications related to facility licensure were submitted.

- Medicare/Medi-Cal Facility Enrollment – Forms preparation and submission of facility enrollment applications for Medicare and Medi-Cal. Ongoing communications and follow-up regarding status of pending applications. Research and guidance provided to:
  - Three (3) applications for government payor enrollment and/or information changes were submitted.

The pursuit of healthiness



Kaweah Health
MORE THAN MEDICINE. LIFE.

Patient Experience Committee – September 9, 2026

Kaweah Delta Health Care District
Board of Directors Committee
Meeting Minutes

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

Patient Experience Committee – OPEN MEETING
Wednesday, September 9, 2026
Kaweah Health Medical Center – Executive Office Conference Room

Present: Director: Armando Murrieta (Chair), Mike Olmos; Marc Mertz, Chief Executive Officer; Jewel Calub, Chief Nursing Officer; Tom Boggs, Chief Ambulatory Officer; Cameron Beatty, Director of Emergency and Trauma Services; Deborah Volosin, Director of Patient & Community Experience; Sintayehu Yirgu, Patient Experience Advocate; Teresa Bobadilla, Patient Experience Data Analyst; Marlo Montejano, Patient Experience Liaison; and Lisette Mariscal, Recording

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

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

MINUTES – The minutes from the July 8, 2026 meeting were reviewed.

Annual Committee Evaluation – The committee completed the Annual Board Committee Evaluation.

PATIENT EXPERIENCE –
5.1 Teresa Bobadilla reviewed the August 2026 Patient Experience Dashboard. (see Attachment 5.1. of the agenda)
5.2 – 5.5. Discussion on agenda item deferred.
5.6. Sintayehu and Marlo reviewed data related to rounding and patient feedback. (see Attachment 5.6 of the agenda)
5.7. – 5.9. Discussion of this agenda item deferred.

Adjourned at 5:04 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.

Mike Olmos • Zone 1 Board Member | **Jonna Schengel • Zone 2** Board Member | **Dean Levitan, MD • Zone 3** Secretary/Treasurer | **David Francis • Zone 4** President | **Armando Murrieta • Zone 5** Vice President

Finance Property Services Acquisition Committee - October 21, 2026

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 October 21, 2025

Present: Directors: David Francis (Chair) & Dean Levitan; Marc Mertz, Chief Executive Officer. Malinda Tupper, Chief Financial Officer; Jennifer Stockton, Director of Finance; Jag Batth, Chief Operating Officer; Kevin Morrison, VP Support Services; Max Heckhausen, VP Strategy; Tom Boggs, Chief Ambulatory Officer; Kelsie Davis, Board Clerk Recording

OPEN MEETING – Called to order at 10:04 AM

PUBLIC PARTICIPATION –None
MINUTES- Reviewed and forward to the Board for approval.
SENIOR LIVING/RETIREMENT COMMUNITY ENTITIES- Received a report regarding NW Senior Housing, LLC; Quail Park Retirement Village, LLC; and Laurel Court at Quail Park, that included an update on current operations, organizational status, and other matters of relevance to the District.
FINANCIALS- Discussion ensued on the most current fiscal year financial results and proposed FY27 budget. The presentation is attached hereto the minutes.

ADJOURN – 11:03am *David Francis, President*

Mike Olmos • Zone 1 Board Member
Jonna Schengel • Zone 2 Board Member
Dean Levitan, MD • Zone 3 Secretary/Treasurer
David Francis • Zone 4 President
Armando Murrieta • Zone 5 Vice President

Quality Council Committee – October 15, 2026

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

Attending: Board Members: Dr. Dean Levitan, Chair; Dave Francis, Board Member; Marc Mertz, CEO; Kevin Morrison, VP of Support Services; Jag Batth, Chief Operation Officer; Ben Cripps, Chief of Compliance; Max Heckhausen, VP of Strategy; Jewel Crisan Calub, Chief Nursing Officer; Dr. Paul Stefanacci, CMO/CQO; Farid Sheikh, Director of Quality and Patient Safety; Luke Schneider, VP of Information Systems and Services; Christina Noel, Quality Data Abstractor I; Cheryl Smit, Stroke Manager; Amy Baker, Director of Specialty Clinics; Connie Green, Nurse Manager; Rhonda Quinones, Director of Maternal Child Health; Stephanie Genetti, Nurse Manager; Felicia Vaughn, Nurse Manager; Mara Lawson, Director of Nursing Practice Professional Development; Kyndra Licon, Quality Project Manager

Closed Session:

Dr. Dean Levitan called to order at 8:00 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 8:20 AM.

Open Session:

Public Participation – None.

Dr. Dean Levitan called to order at 8:30 AM.

4. **Review of September Quality Council Open Session Minutes –** Dr. Dean Levitan, Chair Board Member
    - Reviewed and acknowledged the September Quality Council Open Session Minutes by Dr. Dean Levitan.
5. **Maternal Child Health**
   A review of current performance and actions focused on the care of maternal child health patient population. Rhonda Quinones*, Director of Maternal Child Health; Stephanie Genetti, Nurse Manager; Daniel Castaneda, Nurse Manager; Felicia Vaughn, Nurse Manager.* Dr. Levitan has requested to discuss more on the Braden Score Criteria at next month meeting.
6. **Renal Service Quality Report**
   A review of key performance indicators and action associate with care of dialysis patient population. *Amy Baker, MSN, RN, Director of Specialty Clinics; Connie Green, Nurse Manager, Chronic Dialysis.* No actions taken.
7. **Clinical Quality Goals Update**
   A review of outstanding health outcomes initiatives for Safety in Nursing Practice and Safety Program Optimization. Mara Lawson, Director of Nursing Practice Professional Development. Cindy Vander Schuur, Patient Safety Manager. No actions taken.

Adjourn Open Meeting – *Dr. Dean Levitan*
Dean Levitan adjourned the meeting at 9:30 AM.

Regular Open Board Meeting – October 28, 2026

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD WEDNESDAY OCTOBER 28, 2026, AT 3:30PM IN THE CITY OF VISALIA CITY COUNCIL CHAMBERS – 707 W. ACEQUIA, VISALIA, CA.

PRESENT: Directors Olmos, Francis, Levitan, Schengel & Murrieta; M. Mertz, CEO; R. Berglund, Legal Counsel; T. Boggs, CAO; K. Ferguson, Director Reimbursement; and K. Davis, recording

The meeting was called to order at 3:30 PM by Director Francis.

PUBLIC PARTICIPATION –None.

BOARD EDUCATIONAL STUDY SESSION- The board received an educational presentation regarding national and local Medicare and Medicare Advantage enrollment trends.

ADJOURN - Meeting was adjourned at 4:15PM

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

ATTEST:

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

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD WEDNESDAY OCTOBER 28, 2026, AT 5:15PM 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; D. Cox, Chief Human Resource Officer; J. Batth, COO; K. Morrison, VP Support Services; J. Calub, CNO; L. Schnieder, VP Digital ISS; T. Boggs, CAO; R. Berglund, Legal Counsel; and K. Davis, recording

The meeting was called to order at 5:22 PM by Director Francis.

ROLL CALL- All Directors were present and there was a quorum.

FLAG SALUTE- Director Francis lead the flag salute.

PUBLIC PARTICIPATION – Roy Kendall requested a meeting with the Board President.

CLOSED SESSION ACTION TAKEN: In closed session the board approved the Medical Executive Committee's credentialing recommendations for October 2026 and denied one waiver. The board approved settlement funds, approved the closed meeting minutes of September 23, 2026, and the Board also rejected three claims.

BOARD MEMBER REPORT OUTS- Discussion ensued.

RECOGNITIONS- Resolution 2300

CONSENT CALENDAR – Director Francis entertained a motion to approve the October 28, 2026, consent calendar.

PUBLIC PARTICIPATION – None.

MMSC (Schengel/Levitan) to approve the October 28, 2026, consent calendar. This was supported unanimously by those present. Vote: Yes – Olmos, Levitan, Murrieta, Schengel and Francis.

ANNUAL AUDITED FINANCIAL STATEMENT – FISCAL YEAR 2026 – Baker Tilly presented an exit overview on their financial 2026 auditing. Copy of presentation attached to the original of the minutes and to be considered a part thereof.

MMSC (Levitan/Murrieta) to approve the 2026 Audited Financial Statements. This was supported unanimously by those present. Vote: Yes – Olmos, Levitan, Murrieta, Schengel and Francis.

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

EMPLOYEE ENGAGEMENT SURVEY - Dianne presented the results of the employee engagement survey. Copy attached hereto the original of the minutes.

PATIENT EXPERIENCE AND SATISFACTION UPDATE- Deborah presented October's overview of patient experience. Copy attached hereto the original of the minutes.

FINANCIAL STEWARDSHIP – A presentation and discussion of current financial statements, budget performance, revenue, and expense trends, and year-to-date comparisons for the

District. Presented by Jennifer Stockton. Copy attached to the original of the minutes and to be considered a part thereof.

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

FUTURE GOVERNANCE TOPICS – The board requested that the ED leaders come and talk to the board about the challenges they're facing.

REPORTS

Chief Executive Officer Report –Report relative to current CEO activities. – *Marc Mertz, CEO*
Board President- None. – *David Francis, Board President*
Chief of Staff Report – Report relative to current Medical Staff events and issues – Julianne Randolph, DO, *Chief of Staff.*

ADJOURN - Meeting was adjourned at 7:04PM

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

Special Board Meeting – October 26, 2026

MINUTES OF THE SPECIAL OEPN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD MONDAY OCTOBER 26, 2026, AT 1:00PM IN THE KAWAEAH HEALTH MEDICAL CENTER, EXECUTIVE OFFICE CONFERNCE ROOM – 305 W. ACEQUIA, VISALIA, CA.

PRESENT: Directors Olmos, Francis, Levitan, & Schengel; D. Cox; Fernando Garcia, Esq., and K. Davis, recording

The meeting was called to order at 1:00 PM by Director Francis.

PUBLIC PARTICIPATION– None.
ADJOURNED TO CLOSED MEETING - Meeting was adjourned at 1:00PM

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

AP170 Use of Medical/Allied Health Staff Personal Information

Kaweah Health
MORE THAN MEDICINE. LIFE.

Administrative Manual

Policy Number: AP170	**Date Created: No Original Creation Date Set**
Document Owner: Jenn Cooper (Assistant Board Clerk/Executive Assistant to COO)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration)	

Use of Medical/Allied Health Staff Personal Information

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

POLICY: The information on the Kaweah Health Physician Directory (online or Cisco phone) is intended for internal patient care and business use by Kaweah Health staff and medical/advanced practice providers only. Any personal medical/advanced practice provider contact information such as cell phone number, pager number, etc., is NOT to be given out or provided to any outside parties, including patients and families. Only exception: unless explicitly directed to do so by the medical/advanced practice provider member.

"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."

DM 2205 Code Pink Infant Abduction

Policy Number: DM2205	Date Created: No Original Creation Date Set
Document Owner: Maribel Aguilar (Director of Physical Environment)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Code Pink- Infant Abduction

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Policy

This policy is designed to provide a coordinated and effective response by a trained team of professionals to an infant abduction.

II. Procedure

A. Background

In the event an infant is removed from Kaweah Health Medical Center by unauthorized persons, Kaweah Health Medical Center will activate its Code Pink procedure. Assigned staff must respond immediately to their assigned exits of the medical center. Other medical center staff should remain in their areas, stay alert and report any suspicious persons to the PBX Operator at Ext. 44.

B. Response

See attached checklist and flowchart and map.

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CODE PINK – INFANT ABDUCTION

Purpose: To protect infants from removal by unauthorized persons and to identify the typical physical description and actions demonstrated by someone attempting to kidnap an infant from a healthcare facility. Additionally, to define healthcare facility response to an infant abduction.

Kidnapper Profile: The typical abductor:

- Usually a female of childbearing age who appears pregnant.
- Most likely compulsive; most often relies on manipulation, lying and deception.
- Frequently indicates they have lost a baby or are incapable of having one.
- Often married or cohabitating; companion's desire for a baby or the abductor's desire to provide their companion with a baby may be the motivation for the abduction.
- Usually lives in the community where the abduction takes place.
- Frequently, initially visits nursery and maternity units at more than one health care facility prior to the abduction; asks detailed questions about procedures and the maternity floor layout; frequently uses a fire exit stairwell for her escape; and may also try to abduct from the home setting.
- Usually plans the abduction, but does not necessarily target a specific infant; frequently seizes any opportunity present to abduct a baby.
- Frequently impersonates a nurse or other allied health care personnel.
- Often becomes familiar with health care staff members, staff member work routines and victim's parents.
- Often demonstrates a capability to provide care to the baby once the abduction occurs, within her emotional and physical abilities.

Abductor would be:

- Carrying an infant
- Carrying a bag large enough to hold an infant
- Covering the infant with a coat and/orbaby blanket
- Dressed in other medical attire and carrying an infant

Infants are discharged from the medical center in the arms of theirparent/guardian, who is transported via wheelchair and accompanied by a staff member or medical center volunteer. An infant who is being transported between departments will be moved in a crib and accompanied by a staff member.

STAFF RESPONSE CHECKLIST

☐ Medical Center staff must respond immediately to the exits of the medical Center as follows:

Name of Exit or Area	Department To Respond
First Floor Doors:	
1. Mineral King Main Lobby	Patient Access after 2100 hr Emergency Department
2. Ambrosia Exit	Food Services
3. Nurse Supervisor /Bed Coordinator Office	Bed Coordinator
4. Endoscopy Hallway	Respiratory
5. Surgery Center Exit	Surgery Waiting Patient Access after 1700 Pharmacy
6. Acequia West Staircase Exit	Patient Access after 2100 hr CVICU
7. Acequia West Employee Entrance/Exit by Visitor Elevators	Patient Access after 2100 hr CVICU
8. Acequia Wing Lobby	Patient Access after 2100 hr 4-Tower
9. Acequia East Employee Entrance/Exit	EVS
10. ED Zone 2	Security
Acequia Zone A - Outside by Ambulance Bay with clear view of East Stairwell exit, EMS Door, Ambulance Door, and Emergency Department Stairwell exit.	Emergency Department
Acequia Zone B – East Stairwell Exit	Emergency Department
Acequia Zone C – Northeast Employee Entrance/ Exit	Patient Access after 1700 hr CV
Acequia Zone D – Acequia Main Stairwell & Exit Door – northeast side	Patient Access after 1700 hr 4Tower
Acequia Zone E – Acequia Main Entrance	Patient Access after 1700 hr Emergency Department.
Acequia Zone F – Northwest exit & stairwell	Environmental Services
Acequia Zone G - Acequia Southwest Exit with clear view of west stairwell, , recessed exit,	Environmental Services
Mineral King Zone H – Surgery Center Pre-Op West Exit door with view of courtyard walkway, back surgery door.	Laundry Department
Mineral King Zone I – Surgery Center Main Entrance	Surgery Patient Access after 1700 hr Pharmacy
Mineral King Zone J – Loading Dock	Shipping and Receiving after 1500 hr Maintenance
Mineral King Zone K – Dietary Exit Door	Food Services
Mineral King Zone L – Ambrosia Exit	Ambrosia Staff after 2000 hr Security
Mineral King Zone M – Mineral King Main Entrance	Patient Access after 2100 hr Security
Mineral King Zone N – Emergency Department Main Entrance	Security
Second Floor Doors:	
ICU patio exit and back stairwell to their unit	ICU
2 North stairwell	2 North

Name of Exit or Area	Department To Respond
2 North stairwell next to nurse manager's office	2 North
Third Floor Doors:	
3 West Patio exit and back stairwell to their unit	3 West
3 North back stairwell	3 North
3 North central stairwell	3 North
3 South back stairwell	3 South
3 South visitor and utility elevators & patio	3 South
Fourth Floor Doors:	
4 North back stairwell	4 North
4 North central stairwell, employee elevators	4 North
4 South back stairwell	4 South
4 South Visitor and utility elevators	4 South
***After 1700** an outside perimeter will be established by Maintenance/Security with Maintenance covering the outside south side exits. Security will cover outside the ambulance bay and the main entrance and the exit at the Ambrosia Café.	

- ☐ Other medical center staff, not specifically assigned to respond, should remain in their areas, stay alert, and report any suspicious persons to the PBX Operator at Ext. 44.
- ☐ Redirect all **exiting** visitors to Main Lobby exit without impeding entry to facility. (Script, "I'm sorry, you'll have to exit through the Main Lobby, thank you.")
- ☐ Identify an object that could conceal an infant (i.e., purse, backpack, gym bag, grocery bag) and report to Security.
- ☐ If a person runs, do not attempt to apprehend them. Without losing the person, ask for someone to call Security. Take special note of their appearance, what they are wearing (style, color, etc.), how they leave the medical center grounds, and note their car's make, color and license plate number.
- ☐ Immediately report above information to Security.
- ☐ Should the person abandon the infant and escape, keep the infant with you and report above information to Security.
- ☐ Do not leave exit until you hear "All Clear."

AFFECTED AREA CHECKLIST

- ☐ Dial 44 and instruct the operator to initiate "Code Pink" and give PBX Operator the description, age and gender of missing infant.
- ☐ Instruct available staff to start a room-to-room search of the floor areas.

Charge Nurse will:

- ☐ Initiate a search on Mother Baby Unit, 2 East Labor and Delivery, Pediatrics, and Neonatal Intensive Care. Notify medical center operator and Hospital Command Center (HCC) of results.
- ☐ The search includes areas not limited to: Patient rooms, Corridors, Nourishment Center, Waiting Room/Classrooms, Conference Rooms, Elevator/Stairways, Storage Rooms, Restrooms, Housekeeping/Utility closets, dietary/housekeeping carts, Offices, OBOR, and cabinets.

- ☐ Relocate the mother to another area leaving all items in the mother's room untouched. Obtain any information regarding the description of the abductor and call this information into the HCC.
- ☐ Contact the attending physician to relay information regarding the incident and request that they respond to the medical center. (Contact the mother's physician and the infant or child's physician.)
- ☐ Protect the area where the abduction occurred; close the door to the room. DO NOT TOUCH OR MOVE ANYTHING.
- ☐ Assign a staff member and social worker to the mother/parent/caregiver and who will accompany the family at all times for immediate crisis assistance, obtain an interpreter if required, and collaborate with patient to determine the best location for her and her family to wait. (It is best to remove the patient from the area the abduction took place as soon as possible).
- ☐ Place cord blood on hold. Place lab work on hold, locate and secure infant's/child's medical record. Locate and secure photographs where available.
- ☐ Arrange for additional staffing on the unit if necessary.
- ☐ Gather all relevant information in preparation for the arrival of the police department.
- ☐ Complete an *Incident Report* at the conclusion of the event and submit to Risk Management.

PBX/ISS HELP DESK CHECKLIST

- ☐ Notify the following

If the Infant Security System Alarms:

- Security
- Immediately overhead page "Code Pink and location

In the event of an alarm, Unit Staff or Security can authorize a "Code Pink, All Clear"

Confirmed Infant Abduction-Call:

- Visalia Police Department (911)
- Call House Supervisor
- Risk Management

- ☐ Initiate a "No Information" status for this patient.
- ☐ In the event of an infant abduction, only Security or Visalia Police Department will have the authority to call a "Code Pink, All Clear".

SECURITY CHECKLIST

- ☐ Immediately respond to the location of the possible abduction. Secure the scene by stopping the flow of traffic out of the unit.
- ☐ Assign Security Officer to Front Entrance.
- ☐ Attempt to get information on possible description of suspected abductor.
- ☐ Greet police with description and any known information.
- ☐ Escort police to location of incident.
- ☐ The police will assume leadership in an internal search of the medical center with assistance of Maintenance and/or Nursing Supervisor.
- ☐ Following the "All Clear," notify other local hospitals of any attempted infant abduction.

ADMITTING STAFF CHECKLIST

Admitting staff stationed at Main Lobby:

- ☐ Screen all exiting visitors for kidnap profile.

- ☐ Request permission to search large bags. If individual does not wish to cooperate, immediately report their description to the HCC. Get description of vehicle and license plate number.
- ☐ **DO NOT PROVIDE ANY INFORMATION REGARDING A POSSIBLE ABDUCTION.**

INCIDENT COMMANDER CHECKLIST

- ☐ Maintain radio contact with Security and PBX at all times.
- ☐ Serve as liaison with the police department personnel.
- ☐ Provide decision-making authority and commit resources as appropriate in support of the plan response activities and needs.
- ☐ Request that police set up a traffic stop at the entrance/exit.
- ☐ As soon as possible, dispatch additional personnel to assist Security with control of the medical center's perimeter.

MARKETING/MEDIA RELATIONS

- ☐ Arrange for a communication center and supply the media with regular briefings. Information released to the media will only be done by the Nursing Supervisor, Administration Representative, or Marketing Director.

ALL CLEAR

Only the AOD (Incident Commander), Security or VPD can authorize PBX to page "Code Pink, All Clear" when operations may return to normal.

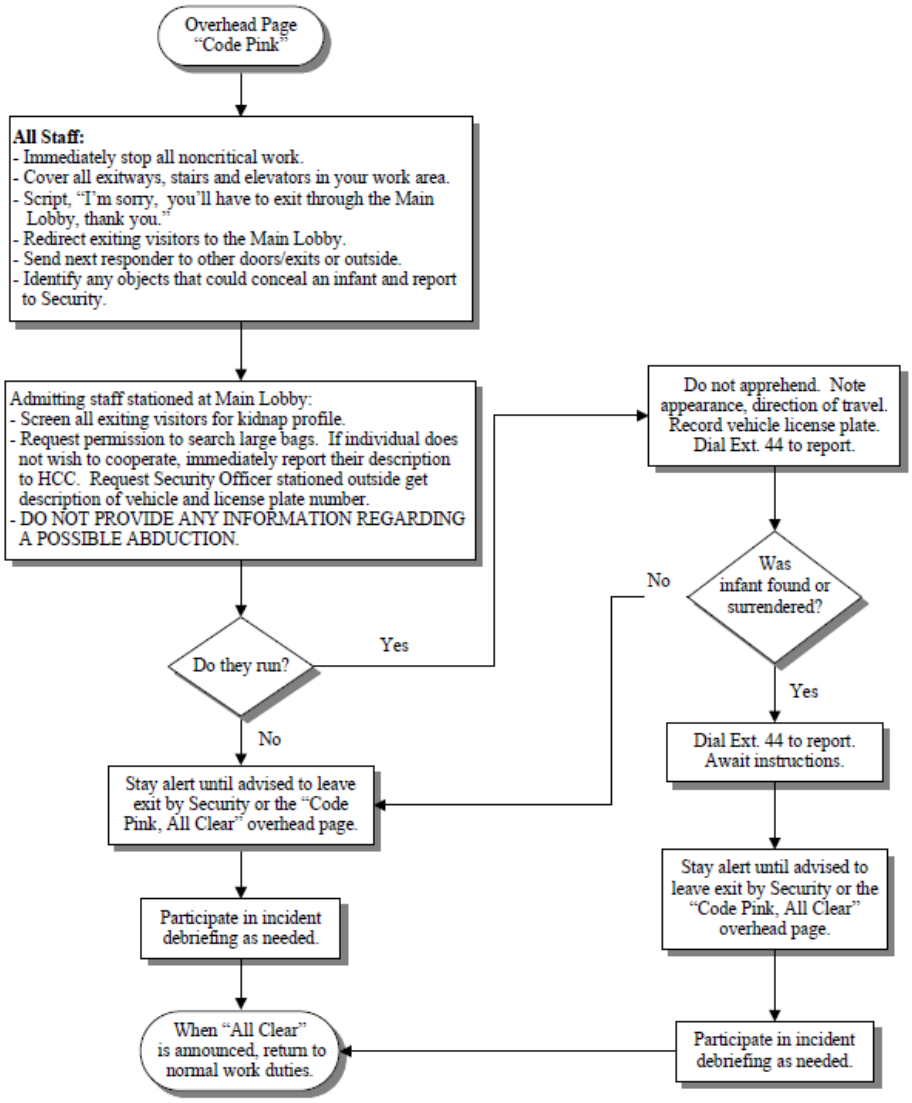
Note: Following the emergency incident, the Department Manager(s) of the affected area(s) shall complete an Incident Report and submit to Risk Management.

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Kaweah Health

Emergency Management Manual

Code Pink - Infant Abduction



DM 2230 Radioactive Disaster Management

Policy Number: DM2230	Date Created: 09/01/2007
Document Owner: Maribel Aguilar (Director of Physical Environment)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Radioactive Disaster Management

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GENERAL INFORMATION ON CLINICAL MANAGEMENT OF RADIATION ACCIDENT

PATIENTS

1. ONLY when a patient has been contaminated with radioactive material does the medical care of that patient differ from any other type of injury as seen by the Emergency Department.

2. Types of radiation injuries to be covered range from internal radiation from ingested or inhaled radioactivity; to surface radioactivity contamination by liquids and dust, both with and without surface wounds. This will include the immediate care (what to do first) and special care needed that is unique to this type accident. The definition of lethal dose and description of the acute radiation syndrome, care of the same will be described.

PRINCIPALS OF CARE

1. The medical needs of the victim always take precedence over the control of radioactive contamination.

2. Three basic principles help you to limit the radiation exposure to attending personnel and victims:
   - TIME - Minimize the amount of time any person is near the site of active contamination.
   - DISTANCE - Maximize the distance from the site of active contamination for any time period a person is required to be in that area.
   - SHIELDING - Use any available heavy object or lead/concrete walls to minimize exposure to personnel in the vicinity.

STANDARDS AND OBJECTIVES

1. Definition: Decontamination of patients refers to those techniques used to remove radioactive materials from the surface of or in the body of a patient.

2. The level of radioactive contamination that is acceptable on patients ideally is zero or "no radiation level above background." However, in an emergency situation it may be necessary to postpone any or complete decontamination in order to perform functions that are lifesaving.

3. It may be that decontamination of skin surfaces will become ineffective at radiation levels two or three times background. In these cases, rather than risk skin injury by

continuing active decontamination, wait 24 hours and resurvey. Usually the radiation level will have dropped to background levels.

GENERAL CONSIDERATION

1. Evaluation of extent and degree of contamination must be done initially and recurrently in order to guide personnel in decontamination procedures. This is even more important where there is possibility of internal deposition of radionuclide within the body of the patient.

2. Adequate records of contamination and decontamination must be kept.

1. All patients who are contaminated shall have their urine collected for a number of successive 24-hour periods for determination of internally deposited radioactive nuclides.

2. Major efforts shall be made to prevent body absorption of radioactive materials. The prime barrier minimizing body absorption of radioactive material is the skin. Do not injure the skin.

3. Skin breaks, abrasions, lacerations etc. shall be kept free of radioactive materials. If already contaminated, skin breaks shall receive priority decontamination.

4. In decontamination, with the exception of contaminated skin breaks start to decontaminate the areas where higher levels of contamination are present.

5. Contaminated areas shall be localized with drapes and tape to prevent the spread of radioactive nuclides to "clear" areas or areas of lesser contamination. Cover and protect areas not being immediately decontaminated..

6. Repeatedly check level of contamination of those reagents and equipment used in decontamination. You cannot clean up a "low level" area with a highly contaminated brush or detergent.

7. PATIENTS CAN BE CATEGORIZED IN THE FOLLOWING WAY:

No Contamination: A patient involved in a radiation incident that does not become contaminated but is transported to a hospital as a precautionary measure.

External Radiation Exposure Only: An individual who has received whole- or partial-body external radiation exposure, regardless of dose, is not a contamination hazard to hospital personnel, other patients, or the environment. The management of this patient depends on the absorbed radiation dose and may be similar to the management of a patient receiving radiation therapy or chemotherapy.

External Radiation Exposure Only: The individual who has received whole or partial body external radiation exposure, regardless of dose is no contamination hazard to hospital personnel, other patients, or the environment. The management of this patient depends upon the absorbed dose of radiation and could be similar to the management of a radiation therapy or chemotherapy patient.

Internal Contamination: Such contamination results from inhalation or ingestion of radioactive material. (Inhalation and ingestion almost always occur together). This patient is usually no hazard to personnel, other patients or the environment. Following

cleansing of minor amounts of contaminated material deposited on the body from an exposure to airborne radioactivity, this person could be handled similar to a case involving exposure to a chemical poison such as lead. The patient's body wastes must be collected and saved in order that measurements of the amount of radioactive materials present can be made to assist in determining the total radiation dose received and the appropriate therapy.

External Contamination: External contamination of the body surface and/or clothing by radioactive material presents problems similar to cases of vermin infestation. Surgical isolation and decontamination techniques, to protect other patients and the Kaweah Delta Health Care District environment, must be employed in order to confine and control any potential hazard.

10. If probable external contamination is indicated, save all clothing and bedding from ambulance, blood, urine, stool, vomitus and all metal objects (i.e., jewelry, belt buckle, dental plates, etc.). Label with name, body location, time and date. Save each in appropriate containers marked clearly ... "RADIOACTIVE ... DO NOT DISCARD."

11. Careful removal of patient's clothing will remove most of the external contamination. If clothing is grossly contaminated, it might be a good idea to moisten the clothing before removal or clothing may be cut off to minimize spread of contamination during normal removal.

EMERGENCY DEPARTMENT MANAGEMENT OF RADIATION ACCIDENT VICTIM(S)

When a known or suspected patient with radioactive material contamination exposure is brought into the Emergency Department:

1. The Emergency Department's Charge Nurse notifies the Director of Radiology (Administrative Director) and the Radiation Safety Officer (a qualified medical radiation physicist) and/or Nuclear Medicine Technologist. (If it is after hours, PBX or Radiology personnel, will call the radiologist on call and a nuclear medicine or radiology technologist, using the disaster call list for radiology).

2. Emergency telephone assistance can be obtained from the Radiologic Health Branch, State Of California at 800-852-7550 (24 hours/day) or 916-445-0931 during normal business hours. These numbers may be updated periodically.

3. Additionally, NCRP Report #65 titled “Management of Persons Accidentally Contaminated with Radionuclides” is located on site for consultation.

4. While they are in route to the hospital, the Nuclear Medicine or Radiology Technologist, or biomed obtains the Geiger Counters (CVD 700) and the Dosimeters (CVD 715) from the Nuclear Medicine Department and takes them to the Triage Area; Emergency Department staff obtain the Decontamination Packs from the Emergency Department Storage Area. NOTE: Be sure to cover the probe of the Geiger Counter with a plastic/rubber glove before use to prevent contamination of the probe, rendering it useless.

5. The Emergency Department Charge Nurse/Delegate notifies the following of the potential radiation incident: Chief Executive Officer/Designee, Nursing Supervisor, Environmental Services, Security Services, and Maintenance Department.

6. NOTE: If a disaster has occurred in conjunction with the radiation accident, the Chief Executive Officer or designee declares it is a disaster and has the Operator "page" an "INTERNAL TRIAGE"; and appropriate personnel are contacted.

7. While awaiting the aforementioned individuals, the Emergency Department nurse requests the ambulance personnel to remove and "bag" the clothing the patient is wearing and place him/her in two (2) clean sheets or blankets. (This can reduce the radioactive contamination by 70%). This is especially important if the incident is called in from the scene that this be done right away.

EMERGENCY DEPARTMENT PREPARATIONS:

1. Evacuation of Emergency Department. A clear path must be created from the ambulance entrance to the decontamination room by moving patients and any other persons as necessary from the area. Patients with non-critical problems will be moved to waiting rooms or other suitable areas.

2. Preparation for arrival of victims: Floors of rooms will be prepared by placing tape on the floor separating the decontamination side from the non-contaminated side.

3. Route from ambulance entrance to decontamination room will be covered with a roll of plastic, paper, or with sheets. Covering will be secured to floor with tape. Above route will be marked off with ropes, if necessary, and marked radioactive until cleared by Radiation Safety Officer.

4. Decontamination rooms will be prepared within the Emergency Department. Rooms shall have separate ventilation systems. If they do not, have the hospital Engineering Department personnel turn off the ventilation system.

5. Floor will be covered smoothly with plastic, paper floor covering, or sheets and secured to the floor with tape. Nonessential equipment will be removed from the room or covered with plastic. Light switches and handles on cabinets and doors will be covered with tape.

6. The Charge Nurse will designate an individual to stand outside and receive supplies for medical and decontamination teams.

7. A trough will be made on the decontamination table with plastic sheeting. Large plastic or metal containers with plastic bags shall be provided to receive discarded contaminated clothes, gauze, supplies, etc.

8. Environmental Services Role: They, along with the Emergency Department's staff, will begin setting up either or both of the Decontamination Areas.

9. Additional help can be obtained by contacting the Nursing House Supervisor. Depending on the information received prior to the arrival of the victim(s), have necessary life-support equipment on hand if necessary.

10. Security's Role: They shall clear the area outside around the Decontamination Areas, and plan for alternate placement of cars and traffic.

11. Maintenance Department's Role: They will obtain supplies, such as rope, etc., and assist with the set-up and security as determined by other priorities and needs at the time.

12. Decontamination Packs: The packs are kept in the Emergency Department Storage Area. They are clearly marked with the contents on the outside of the box. They shall be brought to the area where the decontamination process will be conducted, and the equipment can be set up.

13. The staff who will be monitoring/decontaminating the patient shall begin to gown and glove up. (This is usually performed by the Radiologist, Radiation Oncologist, Radiation Safety Officer (RSO), and Radiation Medical Physicist for Radiation Oncology Services and/or the Nuclear Medicine Technologist.)

14. Physician, nurse, radiology personnel and/or monitors shall wear the following: gown, gloves, mask, hat, plastic boots with tape around the ankles and wrists. They will proceed to the Decontamination Triage Area to evaluate the degree of physical injury and the level of radioactivity of the arriving victims. Check the ABC's: Airway, Breathing, and Circulation and if necessary, stabilize the patient first. NOTE: If emergency lifesaving equipment/procedures are required, delay the radiation monitoring; place the patient on a clean, covered gurney, and proceed into the Decontamination Room where emergency equipment will be available.

15. If the patient is stable, but injured, place him/her on a covered gurney and monitor him/her behind the "hot line" at the entrance. If the patient is uninjured and able to stand; have him/her stand on the "hot pad."

MONITORING THE PATIENT:

1. Begin with the hands; then work from the head down; front of the patient, then the back, having the patient turn around. Perform the assessment as quickly as possible, passing the probe 1-inch above the skin (cover the probe with a plastic glove to prevent skin contamination of the probe rendering it useless). List the levels of radiation obtained over the various parts of the patient's body.

2. After the initial monitoring of any uninjured patient(s), transport them to the adjacent decontamination room located within the Emergency Department. If the patient is not radioactive, he/she may be taken to any other regular ED room.

3. Once the patient has been stabilized (if necessary) and evaluated, the personnel involved in the transportation of the victims shall be monitored for contamination, and shall not leave the area until this is done and they are released. The vehicle/ambulance and its contents shall be thoroughly monitored and decontaminated if required.

4. The personnel who will be involved in the monitoring of the victims or the actual decontamination process shall be dressed as follows:
    - Gown
    - Pairs of light gloves
    - Taped with masking tape at the wrist
    - Plastic cap
    - Waterproof shoe covers taped at the ankles with masking tape
    - An x-ray film badge or a dosimeter.

5. Patient Transfer. If hospital admission is required, place the patient on a clean gurney. Transfer him/her through the buffer zone during which he/she is resurveyed. Have a "clean" staff person receive the patient outside the buffer zone and transport to his/her room.

6. Waste Disposal: contaminated water will be flushed into the ordinary drains. Faucets will be left open to ensure adequate dilution. Contaminated disposable supplies will be put into plastic bags for disposition. Contaminated equipment will remain in the control area until decontaminated.

7. Personnel Disposition: All persons entering the control area will be dressed and equipped. All persons in the control area will shower and change clothing before leaving the control area. All persons upon leaving the control area will present themselves at the control point for pre-exit survey.

8. In case showering facilities outside of the radiation control area are utilized, these secondary showers will be considered a control area. If secondary showering facilities are utilized, persons in the radiation control area will still change clothes and present themselves for survey at the control point in the Emergency Department. They will then be escorted singly or in-groups to the secondary showering facility.

9. All personnel when dressed in their street clothes will again report to a control point for a final survey, which will be recorded. All personnel will be requested to collect three successive 24-hour urine specimens for analysis of radioactivity.

ROLE OF DIAGNOSTIC RADIOLOGY DEPARTMENT IN DECONTAMINATION

1. When the Diagnostic Radiology Department is notified of the arrival of a radioactive material contaminated victim, the Nuclear Medicine Technologist is to be contacted. If the Nuclear Medicine Technologist is not in the hospital, the Radiology Technologist on staff obtains the available Geiger counters and dosimeters from the Nuclear Medicine Department and proceeds to the Triage Area for evaluation of the arriving victims.
2. If more than one technologist is available, he/she will go to the Decontamination Area and assist with setting up the equipment and dressing for the decontamination. Due to the interfacing of the roles of the Diagnostic Radiology Department and Emergency Department; Together, all personnel are to become familiar with the role for each Department.

ROLE OF NURSING SUPERVISOR IN DECONTAMINATION

1. Upon being notified of a contamination event by the E.D. Charge Nurse, the Nursing Supervisor evaluates the situation, and if necessary, announces "Code II Mobilize." He/she begins to notify the Chief Executive Officer and Department Director/ Manager, or delegates this to a responsible person. The Nursing Supervisor works with Housekeeping Services to obtain the stored supplies and kits for the necessary decontamination room and halls to be set up and used.

2. Uninjured victims: first left rooms upon entrance. Injured Victims: first right rooms upon entrance. Additional Rooms: right rooms as needed. Halls: entrance to Emergency Department from Willow St.
NOTE: The RED TAPE is used to designate the Hot Lines and the Buffer Zones. Depending on the degree of the disaster, the Supervisor and the E.D. Charge Nurse determine the type/amount of extra staff needed.

SECURITY'S ROLE IN RADIATION DISASTER

1. Upon being notified by the Emergency Department Charge Nurse of the arrival of contaminated victims, assigned Security personnel proceed to the side of the hospital and clears the area near the entrance to the Emergency Department (Triage Area), of cars and people.

2. A security officer will await the arrival of the ambulance and directs it to the Triage Area and later on the ED entrance.

3. Charge Nurse or designee will coordinate staging area for Injured-Uninjured Victims and appropriate entrance to the Emergency Department.

4. The Security Officer restricts access to the area and to the possibly contaminated ambulance.

5. Assigned Security personnel will be available to be utilized as directed by the individual in charge.

HOUSEKEEPING SERVICES ROLE IN RADIATION DISASTER

1. The person in charge of Housekeeping Services assigns Housekeeping personnel to begin preparing the areas to be used:

2. Emergency Department entrance and hallway going into Emergency Department. Remember to cover the air vents so contaminant does not travel through the air system.

3. The "Controlled Areas" will be roped off.

4. If possible, other Housekeeping personnel will be stationed at the entrance to the "Control Areas," to monitor those who enter and/or leave, and keep visitors out of the area.
KEEP UNNECESSARY PEOPLE OUT OF THE CONTROL AREA!

5. The Nursing Supervisor, if able, will assist Housekeeping Services in organizing and setting up equipment.

6. After the decontamination process is completed, Housekeeping Services under the guidance of the Radiologic Health Branch personnel and/or Maintenance Department will decontaminate the area and handle the waste disposal as required.

WASTE DISPOSAL

1. Contaminated waste will be flushed into the ordinary drains. Faucets will be left open to ensure adequate dilution. Contaminated disposable supplies will be put into plastic bags and labeled "Radioactive Material" for disposition. Contaminated equipment will remain in the Control Area until decontaminated.

2. Personnel in Control Area: All persons in the Control Area will shower and change clothing before leaving the Control Area. All persons upon leaving the Control Area will present themselves at the Control Point for a pre-exit survey.

ROLE OF MAINTENANCE DEPARTMENT IN DECONTAMINATION

1. When the Maintenance Department is notified of the arrival of a contaminated victim, the engineer on duty will:

   Contact the Department Supervisor and advice of the situation. If possible, supervise and/or assist Security in traffic control. If trained in the use of radioactive detection equipment/material (Geiger counter): Assist at the Triage Area with evaluation of patients. Evaluate persons leaving Control Area. Assist and guide Housekeeping Services with waste disposal. Assist VFD HAZMAT TEAM with waste disposal.

CONTAMINATED CORPSES:

1. Contaminated corpses must be wrapped in plastic and put on ice in a large container.

LIMITS OF PERSONNEL EXTERNAL RADIATION EXPOSURE

1. All practical efforts will be made to reduce personnel exposure to less than 300 mrem. In those instances when the situation demands the allowance of greater personnel exposures, hospital personnel will be considered in the same category as occupationally exposed workers and the quarterly radiation limit set by the California Radiation Control Regulations of 1250 mrem will pertain.

LETHAL DOSE

1. May occur in-Patient who has received full or partial body external radiation exposure.

2. L.D. 50 in man approximately 400 REM.

3. L.D. 100 in man approximately 800 REM.

4. Definition of L.D. 50 - dose which will produce an acute illness (A.R.S.) followed by death in 30 - 60 days in 50% of the people thus exposed.

5. Triage will be necessary if widespread accident such as in a major nuclear disaster or war attack to segregate Patients and keep those exposed to an L.D. 100 comfortable but save supplies and manpower for persons in which there is some hope for recovery. Also emergency assistance from the state and federal government is available and required. Contact the California State Department of Health Services Radiologic Health Branch at 865-576-1005 and the Reactor Emergency Action Center (REAC-TC) at 916-558-1784.

6. Lower doses (L.D. 30, L.D. 10)

7. Effect of lower dose is proportionately less. At 100 REM only 15% of people develop any symptoms.

8. At 25 - 50 REM no clinical findings are present and the syndrome is only diagnosable by laboratory tests (blood count changes).

ACUTE RADIATION SYNDROME:

1. Assume a dose of 400 REM (L.D. 50). This dose almost invariably would be from external radiation.

2. Smaller doses would show an attenuated A.R.S. both in time and severity of symptoms.

3. Early Phase: (1 hour to 2 days). Nausea plus or minus vomiting. Malaise plus or minus hyperexcitability of reflexes.

4. Asymptomatic Phase: (2 hours to 2 days). Patient feels well but tissue damage is progressing. WBC drops during first day, first lymphocytes then granulocytes to the range of 1000 cells per cc. This is followed by a drop in RBC's and platelets. Internal bleeding. G.I. Skin.

5. Height of Disease (2 to 3 weeks). Elevated temperature in the range of 103 to 104 degrees. Exhaustion Weight loss Reddened skin Loss of hair. Hemorrhages in skin. Ulcerated mucous membrane. G.I. hemorrhages. Infection, may be ultimate cause of death. Fluid imbalance.

6. Delayed effects in survivors: Hair loss Cataracts Anemia Leukopenia may go on to Leukemia. Impaired spermatogenesis premature aging shortened life span.

7. Internal contamination: The total body dose will be lower. No acute radiation syndrome is ordinarily seen. The disease tends to be a chronic matter with toxicity and damage from the agent. Bone seekers Thyroid seekers, etc. Treatment is mainly directed to eliminate the isotope from the body as quickly as possible and particularly in bone seekers to use the well-known treatments for heavy metal poisoning.

"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."

DM 2810 Total Evacuation Plan

Subcategories of Department Manuals not selected.

Policy Number: DM 2810	Date Created: 09/11/2011
Document Owner: Maribel Aguilar (Director of Physical Environment)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	
Total Evacuation Plan	

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

TOTAL EVACUATION PLAN

I. Policy:

The Total Evacuation Plan is activated only as a last resort and upon the order of the Hospital Incident Commander or designee and/or the responding Incident Commander from Visalia Fire Department. In the event of a total facility evacuation, a Joint Incident Command (Kaweah Health/Visalia Fire Department) would be used. The Fire Chief would assume the role of primary Incident Commander in the event of a fire.

II. Scope:

This is an organization-wide plan that incorporates all services and sites of care provided by Kaweah Delta Health Care District herein after referred to as Kaweah Health (KH) (in patient offsite areas listed below). This plan applies to staff, , contract workers, and volunteers.

The following is a list of KH in-patient off site areas:

o Kaweah Health Mental Health, 1100 South Akers, Visalia, CA.
o Kaweah Health Rehab Hospital, 840 South Akers, Visalia, CA.
o Kaweah Health Skilled Nursing, 1633 South Court Street, Visalia, CA.

Each off site area is required to have a unit-specific Fire Safety plan that addresses the unique considerations of each area in the case of evacuation.

III. Procedure Response Plan

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I. ACTIVATION/NOTIFICATION

A. Evacuation Criteria

1. The decision to evacuate is the responsibility of the Hospital Command Center (HCC) staff, led by the Incident Commander and in consultation with local authority having jurisdiction (e.g., Visalia Fire, Visalia Police, Central California EMS Agency).

2. The factors upon which a decision to evacuate include but are not limited to:
   a. Structural integrity of the building.

   b. Emergency (life threatening) conditions such as fire and chemical spills.

   c. Impending disaster, which is expected to compromise the hospital (i.e., imminent flood).

B. Activation It is anticipated that the event resulting in the need for total facility evacuation will have resulted in activation of Code Triage and use of the Hospital Incident Command System (HICS). The HCC will be established to coordinate and direct the emergency response.

C. Notification – Internal In the event of a major emergency triggering facility-wide evacuation response, PBX will announce “Code Triage” (2x). Upon instruction from Administrator on Call /Incident Commander, PBX will announce “Code Triage, Evacuate the Building.”

If main hospital patients will need to be transported offsite for continuation of care the Emergency Department Team Leader will be immediately notified of possible evacuation. If evacuating patients from offsite campuses, Hospital Command Center will ensure 911has been called for EMS Disaster response.

D. Notification – External

The Incident Commander will instruct the Liaison Officer to notify:
1. California Department of Public Health (DHS) at 408-277-1784
(Monday–Friday, 8 a.m.–5 p.m.) or OES (Office of Emergency Services) at 916-845-8911 (after hours/weekends).
2. Tulare County Department of Public Health
Public Health Officer – Dr. Thomas Overton
559-624-7499 ext 4 or 559-471-7092 after hours
3. Complete the Hospital Status Report Form (see Appendix) and send to the Tulare County Department of Emergency Operations Center (DEOC). If the DEOC is not activated, send the Hospital Status Report Form by fax to the Operational Area EOC.

E. Total Evacuation Procedure – All Staff Checklist

EVACUATION, TOTAL

Purpose: To safely remove <u>all individuals</u> from all floors of the hospital to designated outside areas.

Background: Total evacuation means removing all individuals from the dangerous structure to an area outside the structure which offers safety and is free from danger. **Evacuation is done only as a last resort and only upon the order of the Incident Commander (IC) or local authority having jurisdiction (fire department).**

Note: Elevators will be used for evacuation only when authorized and supervised by Fire Department or Maintenance Department staff.

ED TEAM LEADER OR MICN DESIGNEE CHECKLIST

- ☐ Notify TCCAD (Tulare County Consolidated Ambulance Dispatch) of possible hospital evacuation and request disaster response.
- ☐ Notify CCEMSA (Central California EMS Agency) Coordinator On-Call of possible hospital evacuation and request them to respond.
- ☐ Notify area hospitals of possible evacuation. Initial notifications will be to all CCEMSA EMS Base Hospital MICN Hotlines. Secondary notifications will be to all other area hospitals.
- ☐ Have EMS Medical Group Supervisor and CCEMSA Coordinator report to the ED Team Leader (or designee) for briefing with the Hospital Command Center.
- ☐ Work with Security and Visalia Police Department to establish ambulance staging area & patient staging areas.
- ☐ Hospital Evacuation Coordinator (or designee) will work EMS Medical Group Supervisor and EMS Transportation Officer to assign ambulance transport destinations for evacuated patients.
- ☐ Request Closed Status Ambulance Diversion from CCEMSA if main hospital is to be evacuated. Refer to KH Policy CP85.

STAFF RESPONSE CHECKLIST

Immediately upon receiving orders to evacuate:

- ☐ Evacuate to the evacuation assembly area in this order:
  (**Note:** If 48-hour advance planning time, reverse this order.)
  - ☐ **Ambulatory patients** closest to danger (if visibility is reduced, form chain by holding hands and lead to safety). Travel down nearest stairwell according to posted Evacuation Maps or direction from the IC.
  - ☐ **Wheelchair patients** by elevator, if cleared for use, or down nearest stairwell using evacuation equipment.
  - ☐ **Non-ambulatory patients** in their beds by elevator (if operational), or down nearest stairwell using evacuation equipment. (Nursing will determine whether patient care equipment and/or traction can be discontinued and assign sufficient number of staff to move patients.) If wheelchair is needed for further evacuation, remove patient from wheelchair and make comfortable. Take wheelchair to remove additional patients.
  - ☐ **Critical Care/Ventilator-Dependent Patients** are the last to be moved. Move entire bed if necessary.
- ☐ Evacuation Monitor will make a final room check to determine the area is completely empty, doors are closed and marked with a large “X” to signify that the room has been checked and is empty.
- ☐ Take patient’s hard chart or paper record charts medications and associate staffing assignment sheet when relocating. Ensure patients being removed from Respiratory Precautions wear a mask. (See page 8, Checklist – Nursing Care Guidelines for Special Situations.)
- ☐ During total hospital evacuation, charge personnel will direct patients, visitors and staff to the department-specific evacuation route and convene in the appropriate evacuation assembly area, outside the building.
- ☐ Once evacuated to the evacuation assembly areas, charge personnel will:
  - ☐ Conduct a patient/staff headcount and assessment for injuries and report this information to the Hospital Command Center (HCC).
  - ☐ Keep medical records, medications, assistive devices and personal belongings with patient.
  - ☐ Continue to observe patients. Report any problems or injuries, or staff injuries to charge personnel.
  - ☐ Stand by for specific instructions and prepare to assist, as instructed by charge personnel.

  Note: Patients may need to be transferred to other facilities for continued care or may be evaluated by a physician for immediate discharge home.

  Note: See Evacuation Assembly Areas identified on site map

MAINTENANCE CHECKLIST

- ☐ Clear roadways.
- ☐ Man the elevators (or cordon off if not authorized for use).
- ☐ Secure building mechanical/electrical systems, begin shutdown procedures. (See Maintenance Department Manual.)
- ☐ Relocate evacuation equipment to priority areas.
- ☐ Rotate and change radio batteries.
- ☐ Help Clinical Engineering load any medical equipment onto trucks.
- ☐ Provide extension cords to evacuation assembly/staging areas for medical equipment.
- ☐ Provide lighting at evacuation assembly/staging areas.

SECURITY CHECKLIST

- ☐ Secure area to prevent persons from entering evacuated area (including staff, patients, visitors, and possible intruders/vandals). Direct vehicular traffic to and around three staging areas. Stage/prioritize vehicles.

ALL CLEAR

Do not return to the building until cleared by fire department and Incident Commander and instructed by the Floor Monitor. When “All Clear” is announced, return to your normal work duties, unless otherwise directed.

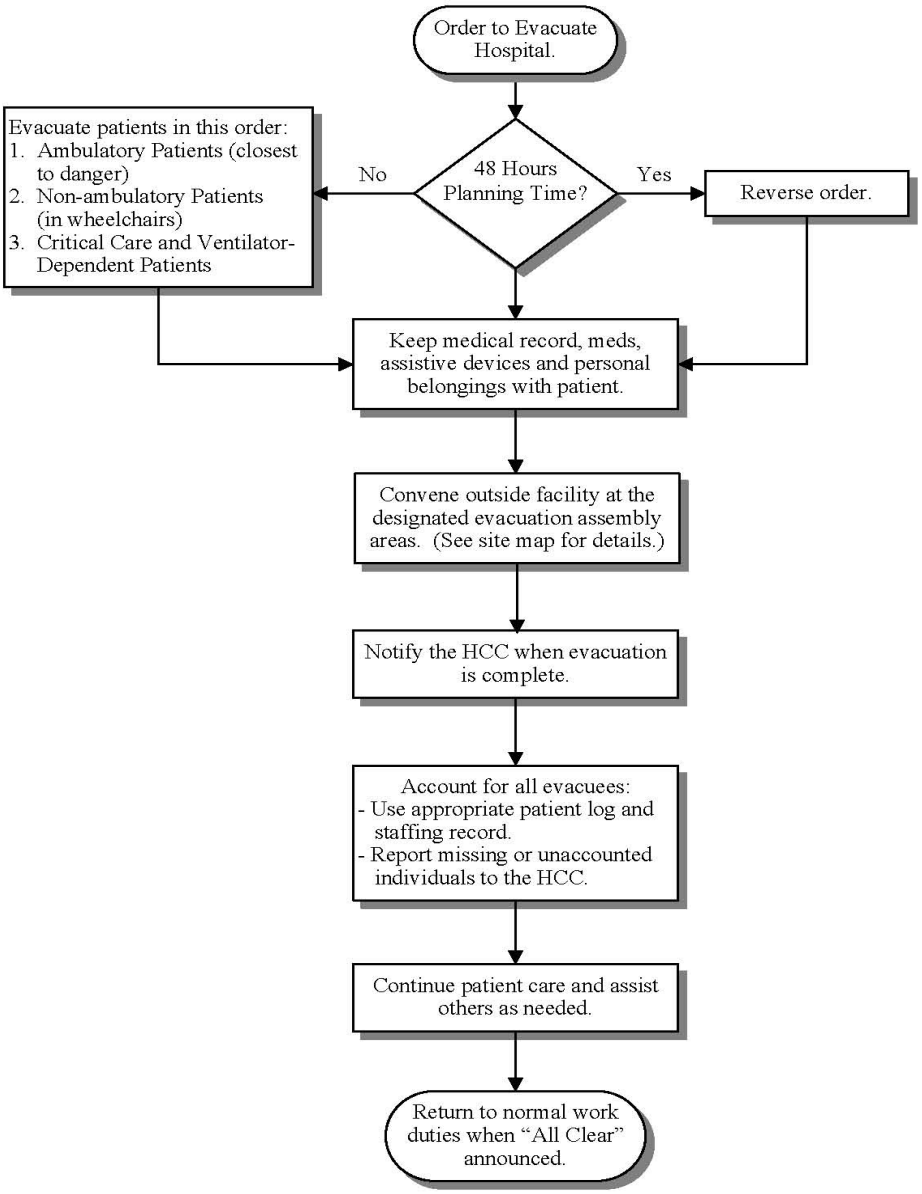
TOTAL EVACUATION PLAN

Equipment/ Carry Type	Staff Needed	Instructions
1. One-Person Assist (semi-ambulatory)	1	If patient can walk, accompany patient to area of refuge. If patient requires assistance to walk: 1. Stand next to patient and place his/her nearest arm around your waist. 2. Reach behind and around patient’s waist and grasp his/her other arm. 3. “Hug from behind” and walk side by side in step – grasping your wrist. 4. When items 1, 2 and 3 have been accomplished, in order, walk the patient to the area of refuge. (If elevators are not functional, use evacuation equipment as needed to transport the patient down the stairs.)
2. Stryker Evacuation Chair	2	1. Unfold chair, place on floor. Set up following the instructions on back of seat. 2. Transport patient to chair. 3. Place restraints (for lap, chest and ankles) according to guidelines on chair. Fit should be firm but comfortable. 4. Transporters face forward in the direction of carry. The strongest person(s) should always be on the down side when ascending or descending stairs. 5. Evacuation chairs should be rolled, not carried, on all even surfaces.

Equipment/ Carry Type	Staff Needed	Instructions
3. Evacusled	2	1. Clear evacuation route, angle bed, lower bed and lock bed brakes when deploying Evacusled from bed deck. 2. Reassure patient, cocoon patient with bed linen and put IV/charts etc. in with patient. Note: Deployment can also be directly from floor position. 3. At head end of bed pull the orange cord straight up with a quick tug, over patient's head, ease white cords around mattress corners. Repeat at foot end. Velcro together. 4. Pull down to tighten cords at 4 self-locking cleats, secure patient and mattress. Tighten toggles. 5. With palms up grasp 2 carry handles below cleats. Shift your body weight to pull foot end of mattress to floor at a 45 degree angle, then guide head end gently to the floor. 6. Go to foot end of the mattress and pull out orange towing cord. Pull/roll feet first. Roll down hallway with foot end raised so sled is rolling on wheels. Make wide turns. 7. At stairwell, double check that cleats are secure. Walk down a few steps until underside wheels begin to roll downstairs. Always keep at least 2 steps between yourself and the foot end of sled. Wheels and gravity are doing the work as you guide the Evacusled down the stairs. 8. Speed of Evacusled is easily controlled with simple braking system on underside. Simply lower foot end of sled against stairs and /or press hand into sled at foot end. Pass off to next rescuer and return to get next patient.
4. Litter/Stretcher • Cervical Traction Board • Back Board		1. Place patient on stretcher. 2. Transporters should walk out of step (person in front should walk, start walking with left foot while person in back should walk right foot first). 3. Patient should be carried feet first if possible.
5. Blanket Drag		To be used as a last resort. 1. Unfold blanket. 2. Place patient face up diagonally on blanket. 3. Lift corner of blanket nearest to patient's head. 4. Drag patient, head first, to place of safety. 5. Mattress may be used in stairwells to assist with patients' evacuation.
6. Swing Method		1. Place patient in sitting position. 2. With a nurse on each side, both nurses pass one arm under the patient's arm and cross the patient's back. Each nurse should secure a firm grip on each other's shoulders. 3. The nurse's free arm is then passed under the patient's knees. One nurse keeps her palm up and the other nurse keeps her palm down, grasping each other's wrist. 4. Lift patient with arms and shoulders and remove to safety.

Total Evacuation Plan

All Staff Flowchart



Checklist – Nursing Care Guidelines for Special Situations

Mode of Hospitalized Patient Transportation	
Patient Type	**Mode of Transportation to Stairwell**
Ambulatory	Walking
Sitting patients or patients who get out of bed easily	Wheelchair
Bedridden patients	Bed or Gurney
Babies	In Arms, Cribs, or Aprons
Toddlers	In Arms or Cribs

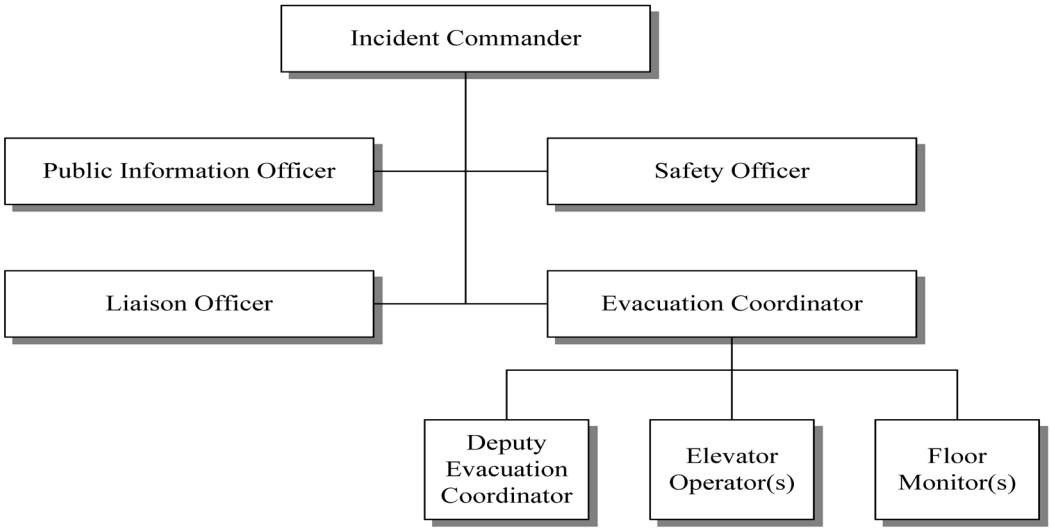
Protocol to Follow When the Hospitalized Patient is Attached to Special Equipment		
Equipment	**Procedure**	**Mode of Transportation***
Traction	Stabilize limbs – gently place weights on bed	In Bed
Stryker Bed	Transfer patient to gurney	Gurney
Central Venous Lines	All central lines must be maintained	Wheelchair or Gurney
Oxygen	Continue use with portable tank. If not available, then stop oxygen; shut off and remove flowmeter from wall, restart as soon as possible.	Walking, Wheelchair, Gurney or Bed
Precaution/Isolation Patients	Continue precautionary measures	Wheelchair or Gurney
Monitors/Telemetry	Disconnect and re-establish as soon as possible.	Wheelchair, Gurney or Bed
Ventilator Patients	Use Transport Ventilator. If not available then disconnect ventilators; connect manual resuscitator; manually ventilate patient	Gurney or Bed
Note: A nurse or respiratory therapist or physician must ventilate during transport, unless a transport ventilator is being utilized.		
Arterial Lines Central Venous Lines	Disconnect from monitor and maintain continuous flush pressure system/ all central lines must be maintained	Gurney or Bed
Intra-Aortic Balloon Pump	• If elevators approved for use: maintain IABP using internal battery If elevators are not usable: Disconnect IAB from pump. Maintain Artline as noted above. Hand inflate the balloon every 5 minutes with half its total volume. Clamp off drain during egress from unit and unclamp as soon as possible	Gurney or Bed
Hemodialysis Patients on Dialysis	• Emergently return blood to patient. • Flush lines • Clamp and disconnect	Gurney or Bed

Vasoactive medications	• Continue via battery powered pump if possible	Gurney or Bed
Swan-Ganz Catheter	• Continue monitoring & infusions with portable monitor and battery powered pumps if possible. • Consult with physician to see if patient is a candidate to have Swan-Ganz Catheter removed.	Gurney or Bed
Special handling for patients who have received Radiopharmaceuticals (Muga Scan, Bone Scan, Brain Scan): Ambulatory Patients – flush toilet two times after voiding. Bedridden Patients (with Foley catheters) – wrap catheter in linen while in transport. Incontinent Patients – wrap patients in linen. **Note:** Follow decision of the HCC depending on results of assessment of situation.		Continue via battery powered pump if possible

Total Evacuation Plan

II. HICS – EVACUATION INCIDENT MANAGEMENT TEAM

A. Organization Chart



EVACUATION COORDINATOR

Mission:

Coordinate evacuation with Floor Monitors and keep Incident Commander updated on efforts. Work with Deputy Evacuation Coordinator to confirm arrival of evacuees at Evacuation Assembly Area.

Assigned to:	(your name)	(date and time)
You report to:	(Incident Commander)	(phone/pager)
Key contacts:	(Basement)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)

CHECKLIST OF DUTIES

Immediate:

- ☐ 1. Receive appointment from the Incident Commander (IC).
- ☐ 2. Obtain Clipboard with Job Action Sheet, Identification Vest, megaphone and forms.
- ☐ 3. Read this entire Job Action Sheet and review the organizational chart on the clipboard.
- ☐ 4. Obtain handheld radio from the Safety Officer/HCC.
- ☐ 5. Obtain a situation briefing from the Incident Commander.
- ☐ 6. Activate Deputy Evacuation Coordinator (station at Evacuation Assembly Area).
- ☐ 7. Serve as a liaison with emergency responders (e.g., fire department, police department, etc.).
- ☐ 8. Meet responders upon their arrival and convey specific information about hazards in the building, access, locations of persons with special needs, etc.
- ☐ 9. Maintain communication with Floor Monitors regarding the status of the evacuation their floor.

Intermediate:

- ☐ 10. Keep Floor Monitors updated on incident status as necessary. Relay pertinent information from Floor Monitors to the HCC.
- ☐ 11. Document activities on the HICS Activity Log.
- ☐ 12. Obtain progress reports from Floor Monitors as appropriate.
- ☐ 13. Assist Public Information Officer in preparing information updates for hospital staff as needed.

Note: Report to the HCC for battery replacement for handheld radio as needed.

Forward completed Job Action Sheet to Incident Commander after the All Clear.

DEPUTY EVACUATION COORDINATOR

Mission:

Coordinate evacuation with Floor Monitors and keep Evacuation Coordinator updated on efforts. Work with Evacuation Coordinator to confirm arrival of evacuees at Evacuation Assembly Area.

Assigned to:	(your name)	(date and time)
You report to:	(Incident Commander)	(phone/pager)
Key contacts:	(Basement)	(phone/pager)
	(Floor Monitor/Building –	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)
	(Floor Monitor/Building	(phone/pager)
	(Floor Monitor/Building	(phone/pager)
	(Floor Monitor/Building	(phone/pager)
	(Floor Monitor/Building	(phone/pager)
	(Floor Monitor/Building – Roof)	(phone/pager)

CHECKLIST OF DUTIES

Immediate:

- ☐ 1. Receive appointment from the Evacuation Coordinator.
- ☐ 2. Obtain Clipboard with Job Action Sheet, Identification Vest, megaphone and forms.
- ☐ 3. Read this entire Job Action Sheet and review the organizational chart on the clipboard.
- ☐ 4. Obtain handheld radio from the Safety Officer/HCC.
- ☐ 5. Obtain a situation briefing from the Evacuation Coordinator.
- ☐ 6. Report to Evacuation Assembly Area.
- ☐ 7. Maintain communication with Floor Monitors regarding the status of the evacuation on their floor.

Intermediate:

- ☐ 8. Keep Evacuation Coordinator updated on status as necessary. Relay pertinent information from Evacuation Assembly Area to the HCC.
- ☐ 9. Document activities on the HICS Activity Log.
- ☐ 10. Obtain progress reports from Floor Monitors as appropriate.
- ☐ 11. Assist HICS Human Services Director (see JAS in Chapter 9) in preparing information updates for hospital staff as needed.

Note: Report to the HCC for battery replacement for handheld radio as needed.

Forward completed Job Action Sheet to Incident Commander after the All Clear.

ELEVATOR OPERATOR

Mission:

Operate designated elevator, if authorized, during an evacuation.
[Note: Elevators will be used for evacuation only when authorized and supervised by Fire Department or Engineering Department staff.]

Assigned to:	(your name)	(date and time)
You report to:	(Incident Commander)	(phone/pager)
Key contacts:	(Basement)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)

CHECKLIST OF DUTIES

Immediate:

- ☐ 1. Receive appointment from the Evacuation Coordinator.
- ☐ 2. Obtain Clipboard with Job Action Sheet, Identification Vest and forms.
- ☐ 3. Read this entire Job Action Sheet and review the organizational chart on the clipboard.
- ☐ 4. Use handheld radio for communication with Evacuation Coordinator.
- ☐ 5. Obtain a situation briefing from the Evacuation Coordinator.
- ☐ 6. Use elevator override key to efficiently transport non-ambulatory patients.
- ☐ 7. Evacuate patients in the order directed by the Evacuation Coordinator.

Note: Report to Engineering Department for battery replacement for handheld radio as needed.

Forward completed Job Action Sheet to Incident Commander after the All Clear.

FLOOR MONITOR

Mission:
Coordinate evacuation of floor to external Evacuation Assembly Area.

Assigned to: _____ (your name) _____ (date and time)

You report to: _____ (Evacuation Coordinator) _____ (phone/pager)

Key contacts: _____ (Deputy Evacuation Coordinator) _____ (phone/pager)

CHECKLIST OF DUTIES

Immediate:

- ☐ 1. Receive appointment from the Evacuation Coordinator.
- ☐ 2. Obtain Clipboard with Job Action Sheet, Identification Vest and forms.
- ☐ 3. Read this entire Job Action Sheet and review the organizational chart on the clipboard.
- ☐ 4. Obtain handheld radio from the Safety Officer/HCC.
- ☐ 5. Obtain a situation briefing from the Evacuation Coordinator.
- ☐ 6. Ensure that all floor occupants are aware of the emergency and the need to evacuate. (Use megaphone.)
- ☐ 7. Be aware of patients/staff with special needs who may need assistance during an evacuation (e.g., hearing- or sight-impaired, on crutches, in a wheelchair, etc.).
- ☐ 8. Rank order patients to be moved. Prioritize. Write order on *Patient Evacuation Log*. (Contains name plus list of items accompanying patient.)
- ☐ 9. Assign designee to get equipment to evacuate/transport patients.
- ☐ 10. Assign trained staff to do various types of transport.
- ☐ 11. Assign runner if communications down.
- ☐ 12. Send information/status sheet to the HCC on available evacuation equipment/supplies.
- ☐ 13. Call Ext. 44 whenever a situation could pose immediate danger to people, property, or processes in the building.
- ☐ 14. Direct staff, patients and visitors to appropriate Evacuation Assembly Area.
- ☐ 15. Verify arrival of evacuees at Evacuation Assembly Area and note on *Patient Evacuation Log*.

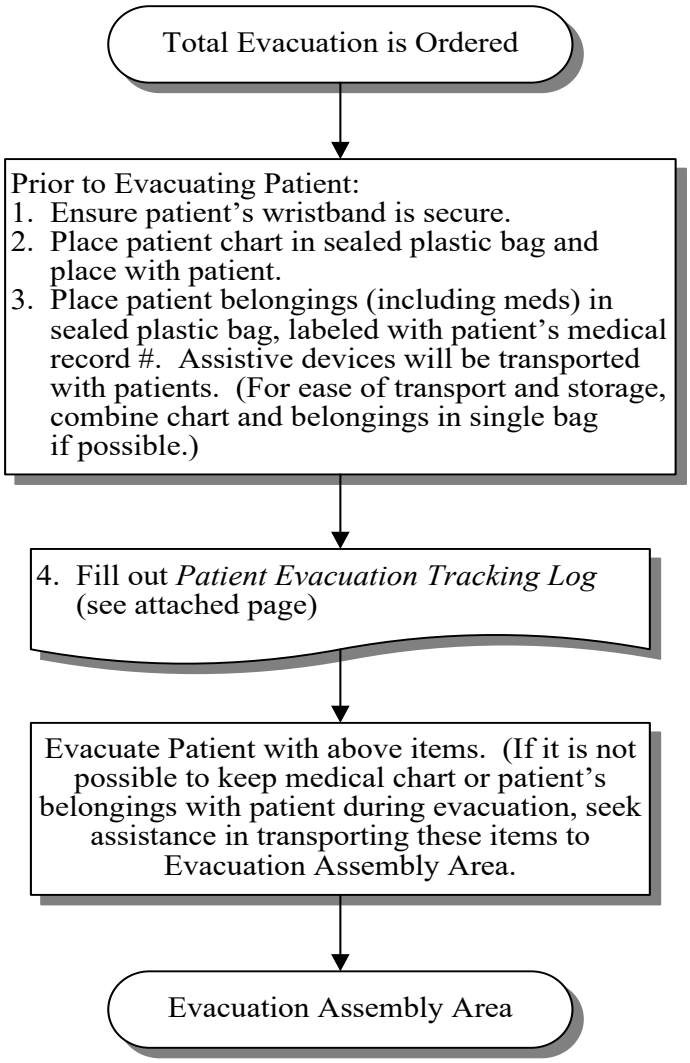
Note: Report to the HCC for battery replacement for handheld radio as needed.

Forward completed Job Action Sheet to Incident Commander after the All Clear.

III. PATIENT TRACKING METHOD

A. Patient Tracking Process

In the event of total facility evacuation, Kaweah Health may implement its disaster patient tracking process. This tracking system will ensure that all patients may be readily located at all times. The Patient Tracking Officer will receive all information about patient movement and be the resource for patient location. Patients will be documented as described in the following procedural steps:



IV. EVACUATION ASSEMBLY AREAS

Once occupants are out of the building, they must be directed to a safe area away from the building. The following site map highlights evacuation assembly areas for each floor. These areas are where head counts will be completed. Employees should gather in these areas so that additional information can be provided easily.

Employees must be accounted for after an evacuation so that we can determine if people are missing. Floor monitors confirm that all patients and staff are out of the building or identify who is missing. This information is provided to the Hospital Command Center and local authorities when they arrive.

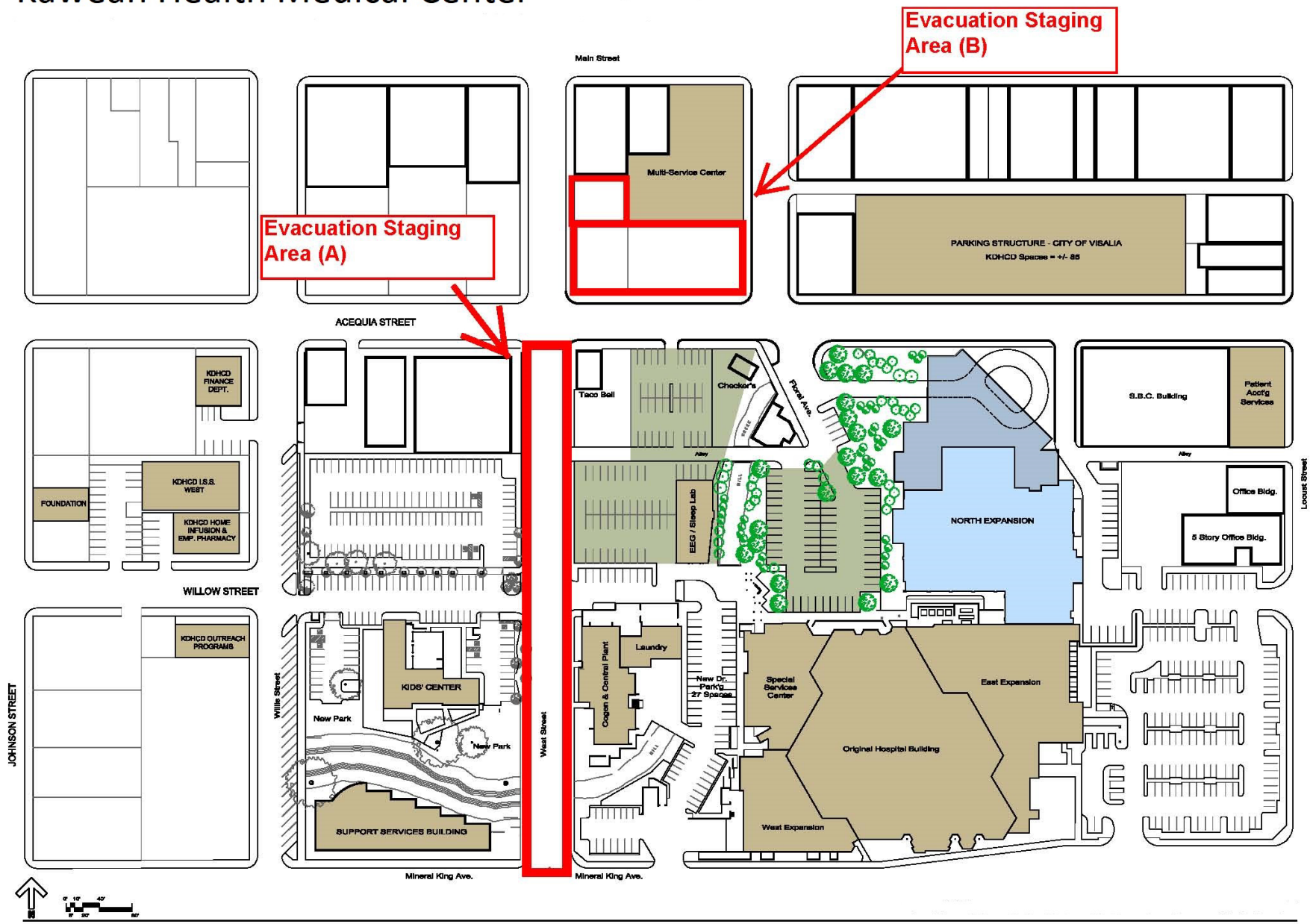
A. Designated Evacuation Assembly Areas:

• Go to nearest Evacuation Assembly Point (see attached Evacuation Assembly Site Map).

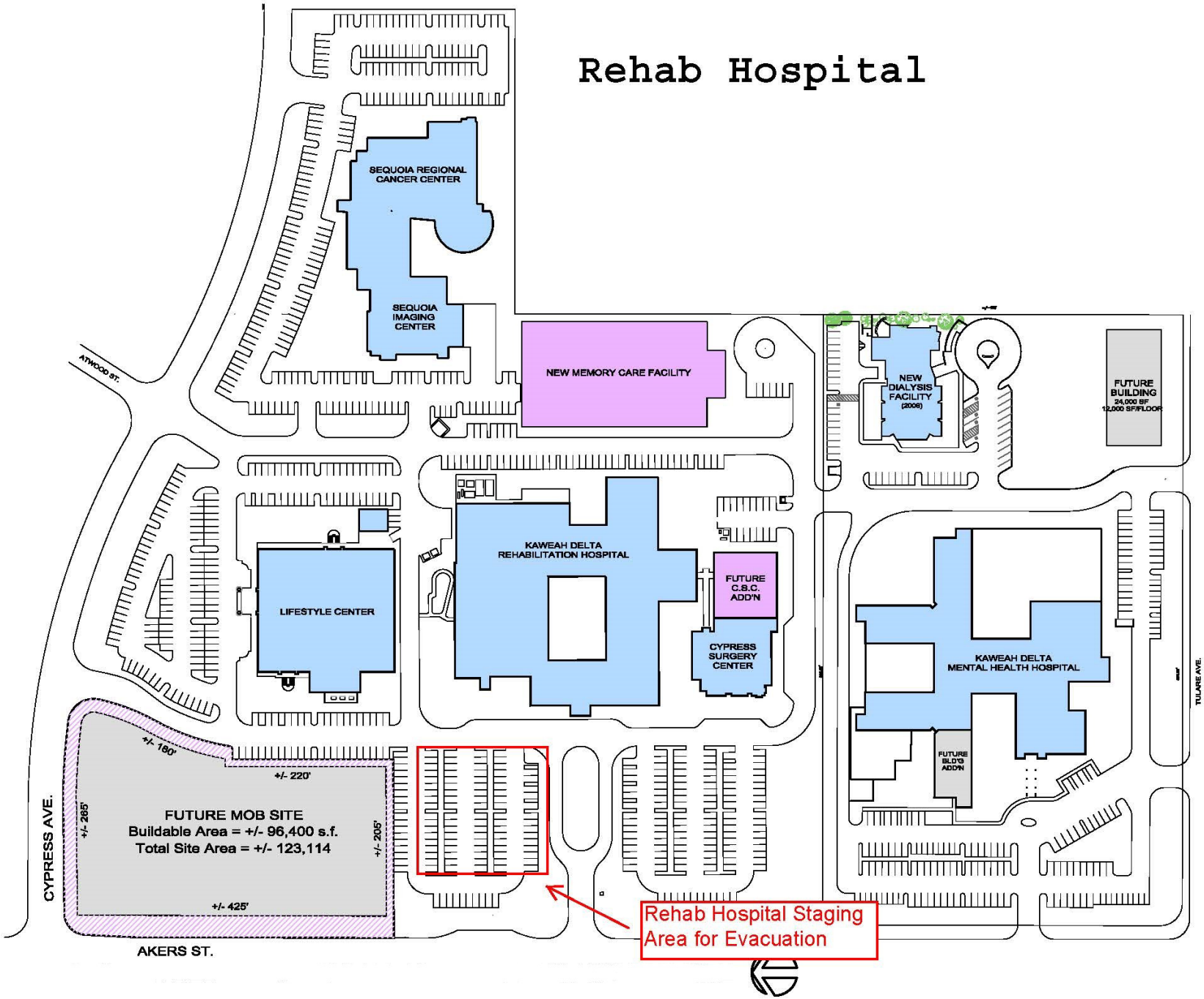
B. Location of Exterior Assembly Points
1. Kaweah Health Medical Center
• Primary: West Street between Acequia & Mineral King
• Secondary: Multiservice Center parking lot.
2. Kaweah Health Mental Health
• Primary: Main parking lot west of hospital
• Secondary: Rehab Hospital Main Lot
3. Kaweah Health Rehab Hospital
• Primary: Main parking lot west of hospital
• Secondary: Mental Health Hospital Main Lot
4. Kaweah Health – South Campus
• Primary: Main parking lot south of hospital
Secondary: North Paradise House area

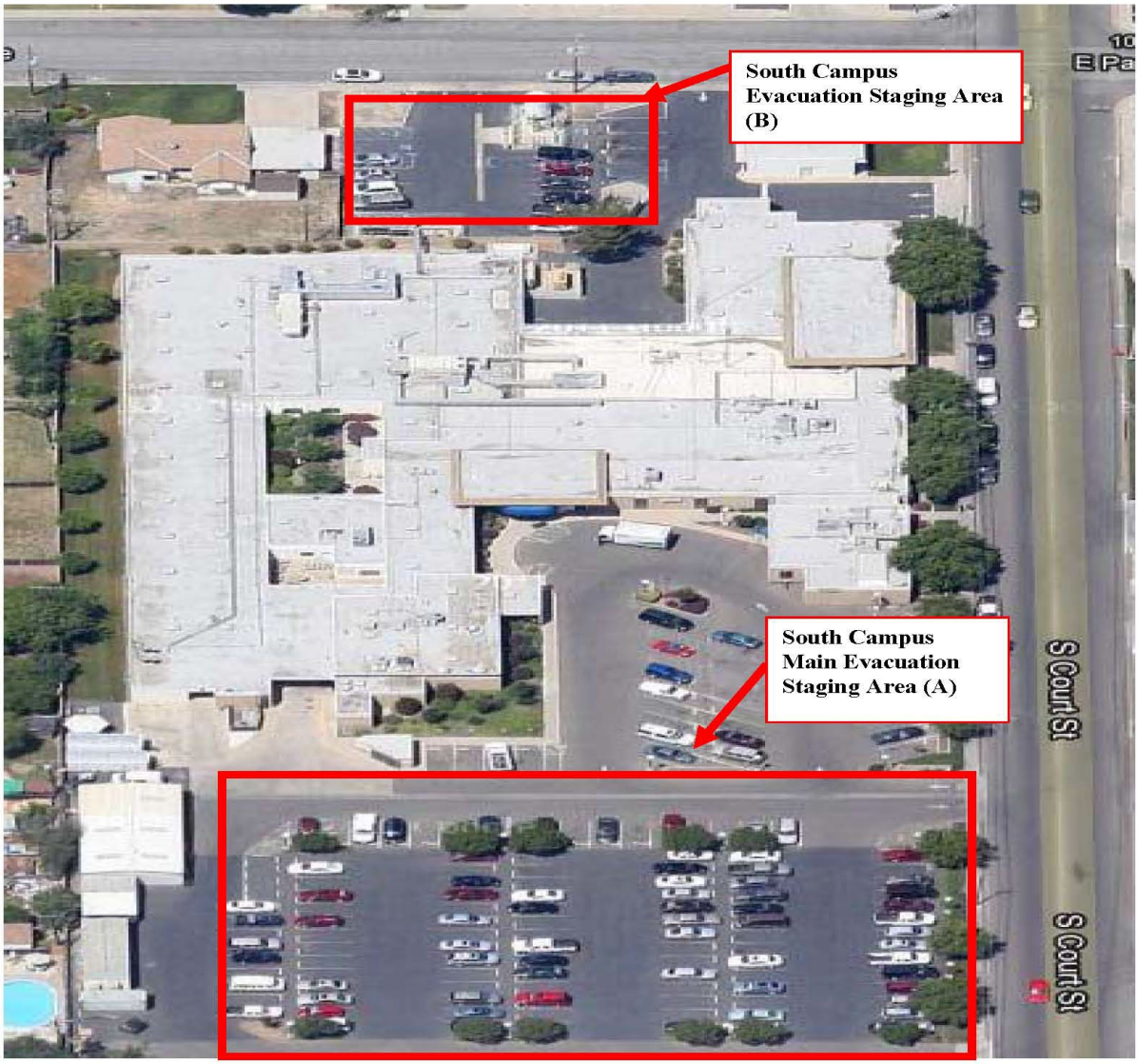
NOTE: If designating alternate evacuation assembly areas, these assembly areas should be far enough from the building to ensure the safety of personnel and should not block access for emergency responders. Plans should include an alternate assembly area in case the primary area is affected by the emergency. Include visitors, outside contractors and vendors, and employees from other sites. A system should be in place to monitor the arrival and departure of all people in the facility.

Kaweah Health Medical Center



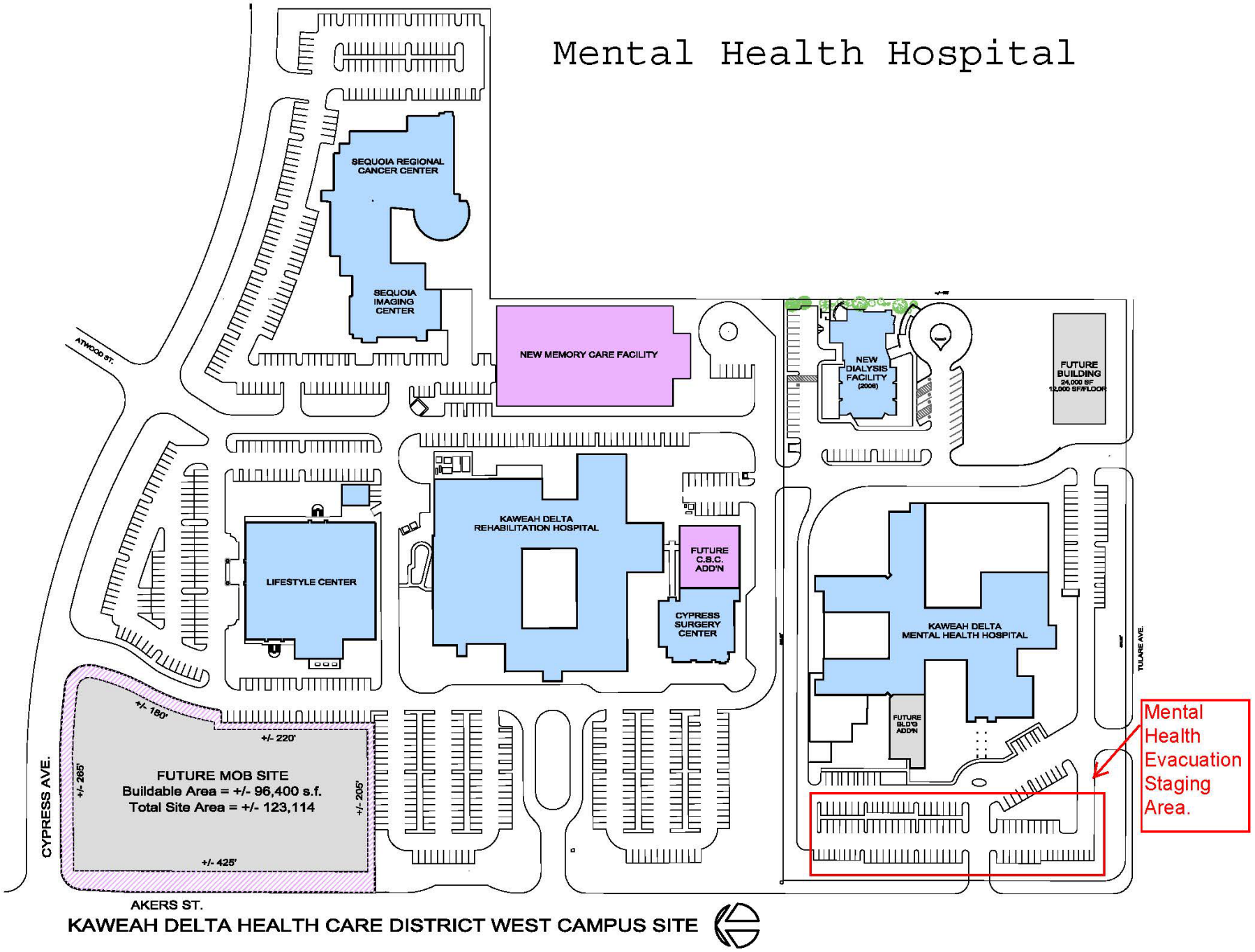
Rehab Hospital





South Campus Facility

Mental Health Hospital



KAWEAH DELTA HEALTH CARE DISTRICT WEST CAMPUS SITE

ALTERNATE TREATMENT LOCATIONS

A. Overview

Kaweah Health will transfer patients and arriving casualties to identified alternate care sites when the hospital environment cannot support adequate patient care. The Alternate Care Site(s) Plan is a tool that establishes a process for managing patients during emergencies including activation/notifications, modification or discontinuation of services, control of patient information and patient transportation. It is anticipated that the event resulting in the need for alternate care site(s) will have resulted in an activation of Code Triage and the use of the Hospital Incident Command System (HICS).

B. Activation/Notification

1. Tulare Department of Public Health- Department Emergency Operations Center (DEOC) – Incident Commander, or designee, will notify the DEOC of the need to evacuate patients and provide information as to the number of patients and types of specialty care required.
2. California Department of Public Health (CDPH) – Incident Commander, or designee will notify DHS of the need to utilize alternate care site(s) for patient care.

C. Emergency Transfer of Patients

1. Discharge or transfer procedures in an emergency situation:
   a. Discharge
      The Medical Staff Director, as requested by the Incident Commander, will initiate the Emergency Rapid Discharge Plan. (See Section I.)
   b. Transfers

      The Kaweah Health Incident Commander will request that Public Health activate the DEOC, via County Communications. The DEOC will survey hospitals in the county for their bed status to determine their ability to receive transferred patients. The DEOC will instruct Kaweah Delta Health Care District as to the number of patients to be transferred to each facility. Arrangements with receiving facilities will be coordinated through the Nursing Unit Leader and Medical Staff Director. Staff will ensure that medical records and personal belongings accompany each patient. The Nursing Unit Leader will maintain a record of patient transfers and destination.

   c. Transportation

      Arrangements will be made to transport patients from the hospital by the Transportation Unit Leader in collaboration with the Nursing Unit Leader and the Tulare County Emergency Medical Services (EMS

2. Alternate Care Site(s) – Acute Care Facilities
   Acute care hospitals in the CCMSA five county MOU plan. Counties may be able to accept Kaweah Health patients, depending upon the circumstances of the disaster. The Tulare County DEOC assists in locating hospitals with beds appropriate for placement of patients at alternate care sites.

If necessary, a request for National Disaster Medical System (NDMS) assistance would be made through the DEOC to the Governor. The NDMS is a federally coordinated system that augments the nation's emergency medical response capability to ensure resources are available to provide medical services following a disaster that overwhelms the local health care resources.

3. Interim Alternate Care Site(s)

In the event that evacuated patients and incoming casualties cannot be transferred to other acute care facilities, they will be routed to interim alternate care sites. These non-sterile, "hostile" environments may need to be maintained for hours or days, depending upon the circumstances of the disaster. Therefore, the HCC will:

a. Select buildings on the hospital campus to be used and/or utilize tents for staff and patients and set up in the hospital parking lot.

b. Coordinate available staff, equipment and supplies, water, power/lighting, shelter, Food & Water resources, security, recordkeeping, and other needs to support interim care sites.

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EOC 1018 Monitoring Refrigerator and Freezer Temperatures

Kaweah Health

Subcategories of Department Manuals not selected.

Policy Number: EOC 1018	**Date Created: 03/01/2008**
Document Owner: Maribel Aguilar (Director of Physical Environment)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Monitoring Refrigerator and Freezer Temperatures

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

POLICY: All refrigerators and freezers containing food and medications for patient use will have temperature ranges monitored in compliance with all laws and regulations.

PROCEDURE:

1. Refrigerator and freezer temperatures will be monitored daily and documented on the appropriate temperature chart. Exception: refrigerators/freezers containing vaccine are checked at minimum twice a day The managers of the respective units are accountable for ensuring that all appropriate refrigerators are checked at the required frequency.
2. Normal temperature ranges are:
   a. Refrigerators
      1. Food Temperature: 0 degrees C (32 degrees F) and 4 degrees C (40 degrees F).
      2. Medication Temperature 2 degrees C (36 degrees F) and 8 degrees C (46 degrees F).
   b. Freezers:
      1. Food Temperature: -18 degrees C (0 degrees F) or lower.
      2. Medication Temperature: Shall be stored at less than or equal to minus (-) 20 degrees C (minus (-) 4 degrees F) Note: This definition differs from CCR section 1735.1, alternate range permitted if otherwise specified by pharmaceutical manufactures(s) for the product
3. If the temperature is not within normal range:
   a. Record the temperature on the “Temperature Chart”
   b. Adjust the temperature control.
   c. Contact Maintenance.
   d. Contact Food & Nutrition Services (FNS) to remove and dispose of all food items from the refrigerator. If Time/Temperature Control for Safety (TCS) have a recorded temperature of >41 degrees Fahrenheit and it has been for more than 2 hours they are to be discarded. If unsure of the time food is to be discarded.
   e. A repeat temperature will be taken within 2 hours and recorded.
      1. If at the 2 hour check the temperature is IN range, nothing further needs to be done except to document the in-range temperature in the column labeled “temperature 2 hours later”.
      2. If at the 2 hour check the temperature is OUT of range, document the temperature in the column labeled “temperature 2 hours later” contact maintenance for expedited service.
   f. Contact Pharmacy to discuss alternate medication storage to be used until repairs are completed or unit is replaced and to consider disposal.

4. Document ALL corrective actions taken (e.g. adjusted temperature dial, perishable items discarded, refrigerator taken out of service, etc.) and your signature in the designated area of the form

5. Departments that are not staffed 7 days per week or that do not have a method to check daily will be equipped with a thermometer that records maximum High and Low temperatures on the days the area is closed and will otherwise follow this policy and procedure. The unit manager or designee will document the "recorded" temperatures the next business day as described below :

a. Record the current temperature on the temperature chart in the area that corresponds with the current day of the month.
b. Record the Minimum (MIN) temperature on the temperature chart on the date(s) that correspond with the date(s) the area was closed.
c. Record the Maximum (MAX) temperature on the temperature chart on the date(s) that correspond with the date(s) the area was closed.
d. Reset the thermometer by pressing the "memory clear" button located on the front of the thermometer
e. If the min/max temperatures for medication storage were not in the desired range on the days the unit was closed, the effected medications will be segregated, a pharmacist will be contacted, and the medications will not be used until determined by the pharmacist that they are suitable for use

6. All refrigerators in patient care areas will be cleaned as needed and at least once a week by Environmental Services.

7. If the refrigerator thermometer is broken or missing, contact the Food & Nutrition Services Department for replacement. Traceable thermometers used in medication-containing refrigerators/freezers are distributed by the Pharmacy Department.

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EOC 1039 Failure of Air Conditioner

Policy Number: EOC 1039	Date Created: 04/01/2010
Document Owner: Maribel Aguilar (Director of Physical Environment)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Failure of Air Conditioner

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

POLICY:

The Engineering Department, will take the necessary steps to correct any failures of essential equipment or major utilities

PROCEDURE:

Notify **a qualified vendor** when repair of the air conditioning system is beyond the scope of engineering staff. Consider utilizing fans or portable HVAC units to assist in cooling until repairs can be completed.

Notify the house supervisor and all departments that are affected. Tell them approximately how long repairs will take.

Follow unit specific procedures.

The Nursing Supervisor shall decide if Code Triage or Code Triage Alert needs to be called, if patients and/or building occupants need to be relocated.

Notify affected departments upon restoration of service.

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EOC 1071 Ergonomics

Policy Number: EOC 1071	Date Created: 04/01/2010
Document Owner: Maribel Aguilar (Director of Physical Environment)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Ergonomics

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

POLICY: Kaweah Delta Health Care District herein after referred to as Kaweah Health (KH) has adopted this ergonomics program to minimize repetitive motion injuries (RMI's) through (A) Worksite Evaluations, (B) adoption of control measures and (C) training of employees in a manner consistent with Title 8 CCR 5110.

DEFINITIONS:

1. "RMI's" are musculoskeletal injuries resulting from a job, process, or operation of identical work activity which have been the predominant cause of objectively identified and diagnosed musculoskeletal RMI's to more than one employee reported within a twelve-month period. The identification and diagnosis of a RMI must be performed by a licensed physician.
2. "Identical Work Activity" means the employees were performing the same repetitive motion tasks, such as, but not limited to, word processing.
3. "Potentially Exposed Employee" is an employee working a job, process or operation of identical work activities in which more than one RMI has been reported within a twelve-month period.
4. "Predominant cause" means that 50% or more of the injury was caused by a repetitive job, process or operation of identical work activity.

PROCEDURE:

A. Worksite Evaluations:

1. Where more than one RMI is reported as defined below, a representative number of the applicable job, process, or operation of identical work activity will be evaluated.
2. Employee Health Services will maintain a list of all jobs, processes and operations, which have been evaluated.
3. The evaluation identifies potential exposures and suggests the methods Kaweah Health can use to control or minimize these exposures.
4. Potentially exposed employees will be informed of the potential exposures and trained in Kaweah Health's control measures.

B. Control of Exposures Which Have Caused RMI's.

1. It is Kaweah Health's policy to timely correct exposures that have caused RMI's or if the exposure is not capable of being corrected, it is Kaweah Health's policy to minimize the exposure to the extent feasible.
2. It is Kaweah Health's policy to consider the following engineering and administrative controls in determining how to correct or minimize exposures:

Engineering Controls	*Administrative Control*
- workstation redesign	- job rotation
- adjustable fixtures	- work pacing
- tool redesign	- alternative work breaks

Kaweah Health may also consider other reasonable, cost effective engineering or administrative controls.

3. If engineering and administrative controls cannot reasonably correct or minimize exposures to the extent feasible, Kaweah Health will consider minimizing exposure through the use of personal protective equipment.

C. Training.

1. *Scope of Training.* Employees (including managers and supervisors are provided with training that includes an explanation of:
   a. The ergonomics program.
   b. Exposures, which have been associated with RMI's.
   c. The symptoms and consequences of injuries caused by repetitive motion.
   d. The importance of reporting symptoms and injuries to the employer.
   e. The methods used by the District to minimize RMI's.

2. *Timing and frequency of training.* Training is provided to potentially affected employees as follows:
   a. Initial training is provided as part of the establishment of the ergonomics program.
   b. Upon completion of a worksite evaluation which identifies exposures which may have caused RMI's.
   c. To all new potentially exposed employees.
   d. To all potentially exposed employees given new job assignments for which training has not previously been received.
   e. Annually for potentially exposed employees.
   In addition, general ergonomics awareness training is provided to all employees upon hire and annually.

D. *Employee Reporting Obligations.* All employees are required to report to manager/supervisor and Employee Health Service. All RMI's which have been objectively identified and diagnosed by a licensed physician which are suspected of being 50% or more caused by a job, process or operation within Kaweah Health will then be handled as above in A, B, C.

All employees are encouraged to report all suspected RMI's or RMI symptoms or

ergonomic concerns in a timely manner in Orientation and in Department meetings.

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EOC 4010 RCRA Disposal of Hazardous Waste

Kaweah Health

Subcategories of Department Manuals not selected.

Policy Number: EOC 4010	**Date Created: 09/01/2014**
Document Owner: Maribel Aguilar (Director of Physical Environment)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

RCRA Disposal of Hazardous Waste

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

RCRA Disposal of Hazardous Waste and Soft Trace Chemotherapy PPE Waste Resource Conservation and Recovery Act

I. General

1. Purpose

   To ensure that Pharmaceutical Wastes, classified as hazardous waste under the federal Resource Conservation and Recovery Act (RCRA), including chemotherapy/biotherapy wastes, are stored, handled, packaged, transported and disposed of in accordance with all federal, state and local government regulations.

2. Responsibilities:

   A. Staff: Personnel, providers and volunteers participate in training and adhere to all defined roles and responsibilities as outlined in this policy and procedure.

   B. Safety Committee: Responsible for the review and approval of this policy and procedure.

   C. Department Managers and Supervisors: Responsible for ensuring that all staff are knowledgeable and adhere to their roles and responsibilities as defined in this policy and procedure.

II. Policy

1. General

   A. All items which come in contact with hazardous drugs during preparation or administration should be treated as hazardous waste and be discarded in a DESIGNATED container.

   B. The items include needles, syringes, empty drug vials/ampoules, IV tubing, IV bags and bottles, IV connecting devices, alcohol wipes, Chemotherapy PPE (gowns, gloves, masks) and leak proof drapes and /or pads.

   C. Barium contrast not used for its intended purpose must be discarded as RCRA waste. Barium removed from a patient is considered bio-hazardous waste and should not be placed in the RCRA container.

III. Definitions

1. Hazardous Drugs (HD): Drugs that are capable of causing toxicity to personnel and others who come in contact with them. Hazardous drugs pose a potential health risk to personnel who prepare, handle, administer and dispose of these drugs.

2. Drugs may be classified as hazardous when they possess any one of the following characteristics.
    A. Genotoxicity
    B. Carcinogenicity
    C. Teratogenicity
    D. Reproductive toxicity
    E. Organ toxicity at low doses
    F. Structure and toxicity profiles of new drugs mimic existing drugs determined to be hazardous by the above criteria.
3. Potential exposure routes to hazardous drugs may occur through inhalation, skin contact, skin absorption, ingestion or injection.
4. National Institute for Occupational Safety and health (NIOSH) Alert, Centers for Disease Control and Prevention:
    A. NIOSH alert was revised in 2004. The purpose of the document is to increase awareness among health care workers and their employers about the health risks posed by working with hazardous drugs and to provide them with measure for protecting their health.
5. RCRA hazardous Waste:
    A. Resource Conservation and Recovery Act. California regulations are more stringent than federal regulations and impact pharmaceutical waste management.
    All pharmaceutical waste that meets the definition of federal hazardous waste (RCRA) must be managed as such and is under the jurisdiction of Cal/EPA Department of Toxic Substances Control (DTSC). A pharmaceutical waste that is federally non-hazardous but meets the expanded definition of a hazardous waste in California is considered a “California only hazardous waste” and must be managed under the Medical Waste Management Act.
6. Regulatory bodies that oversee pharmaceutical waste management are:
    A. Environmental Protection Agency (EPA)
    B. Department of Transportation (DOT)
    C. Drug Enforcement Agency)DEA)
    D. Occupational Safety and Health Administration (OSHA)
    E. California Department of Public Health (CDPH)
    F. California State Pharmacy Boards
    G. Local Publically Owned Treatment Works (POTW)
    H. Department of Toxic Substance Control (DTSC)
7. RCRA hazardous waste is divided into the following categories:
    A. Listed waste
    P – Listed chemicals (acutely hazardous)
    U – Listed chemicals (toxic)
    B. Characteristic waste:
    Ignitability
    Corrosivity
    Reactivity
    Toxicity
    C. D-Listed (Characteristics toxicity)

IV. Procedure

1. The following medications must be discarded in black RCRA containers:
    A. Hexachlorophene (Phisohex)
    B. Insulin (E.g. insulin pens and vials)
    C. Nicotine (e.g. patches, gum, lozenges)
    D. Nitroglycerin 50 mg/ml INJ ONLY
    E. Phenol (e.g. Choraseptic spray)
    F. Phentermine
    G. Physostigmine
    H. Warfarin
    I. Aerosol Propellants (pressurized containers)
    J. Alcohol-containing products .=24% (Dehydrated alcohol injection, Ethyl alcohol for compounding, Benzoin compound, Isopropyl alcohol, Avagard hand sanitizer, green soap, Guaic(Hemocult developer (75%), any other product containing .=24%.
    K. ALL Chemotherapy Drugs and biotherapy drugs and their immediate containers, vial, bag, bottle, medicine cup full, partially empty or empty and associated PPE and spill kit contents.
    L. Selenium-containing products
    M. Silver-containing products (Silver nitrate sticks, Silver Sulfadiazine)
    N. Trace elements/minerals (cadmium, chromium, selenium found in multi-vitamins and with minerals and multi-trace 4).
    O. Health metals (Barium Sulfate used in Radiology).
2. RCRA containers will be placed in all departments that utilize pharmaceuticals considered hazardous under the Resource Conservation and Recovery Act (RCRA). The size of the RCRA container will depend on the anticipated amount of waste.
3. Write the start date and the name of the department, using a Sharpie, on the lid of the RCRA container. This ensures that the RCRA container will be disposed of within the 120 day limit.
4. RCRA hazardous waste should be placed in the black RCRA containers located in the designated areas. The lid to the container should be kept closed except when placing an item into the container. The largest section of the lid should be in the locked position. Listen for the clicks that indicate it is locked.
5. Chemotherapy and biotherapy: Bags/bottles with attached IV tubing and connection, IV piggyback bags with attached tubing and connections should be placed in chemotherapy zip lock bags before disposal into the RCRA containers.
6. Chemotherapy and Biotherapy pill containers, medicine cups, pack again and all other items that come into contact with the hazardous drugs such as gauze, alcohol wipes, paper drapes and pads should be placed in chemotherapy zip lock bags and placed in the black RCRA containers.
7. Other RCRA waste can be placed directly into the RCRA container.
8. Spills will be handled according to the KDHCD Hazardous Material Policy and procedure. Chemotherapy spill items-items that have become contaminated by chemotherapy/biotherapy such as PPE, linens, patient gowns, mop heads, used for spill clean-up should be placed in the RCRA container after being placed in a yellow chemotherapy waste bag.

9. When RCRA container is ¾ full, lock it down and notify Housekeeping to schedule it to be transported to the designated hazardous waste holding area. Housekeeping staff will remove locked containers from the department and place in a storage area designated for hazardous waste.
10. A Hazardous Materials Management Company will pick up and properly dispose of RCRA waste as needed from the designated hazardous waste holding area.

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EOC 5003 Fire Watch

Kaweah Health

Subcategories of Department Manuals not selected.

Policy Number: EOC 5003	**Date Created: 10/09/2026**
Document Owner: Maribel Aguilar (Director of Physical Environment)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration); Board of Directors (EOC/Emergency Preparedness); Aguilar, Maribel; Davis, Kelsie	

Fire Watch

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

PURPOSE:

To provide emergency measures for monitoring any fire alarm and/or fire sprinkled building in the Kaweah Delta Health Care District hereinafter referred to as Kaweah Health (KH) in the event of an impaired fire alarm or fire sprinkler system.

DEFINITIONS:

Fire Watch: A temporary measure that provides surveillance rounding to the area(s) of the building where the fire alarm and/or fire sprinkler are not currently in full functioning capacity. Fire Watch allows buildings to be temporarily occupied when the fire suppression systems or the fire alarms are out of service.

Fire Watcher: A dedicated, trained person(s), whose sole responsibility is to, either, look for fires within an appointed area or watch the fire alarm panel for the duration of the unsafe condition. The fire watcher is required to patrol the affected area(s), initiate Code Red, prevent a fire from occurring and extinguish small fires, if safe to do so.

System Bypass: When the fire alarm and/or fire sprinkler reporting system has been bypassed so that it will not remotely report a fire or trouble alarm to the off-site monitoring company. These systems will still alarm to the fire alarm panel itself.

System Down: When the fire alarm has been completely taken off line and will not ring at the panel, if needed, or report out to the off-site monitoring company. Fire Watch rounds are to be implemented immediately when this occurs.

System down also applies when the fire sprinklers have to be drained for repair work to be completed. Fire Watch rounds will also be implemented immediately when this occurs.

POLICY:

Fire Watch is required to be implemented when any of the following takes place:

1. The fire alarm and/or sprinkler system is temporarily shut down or taken off-line for more than four (4) hours in a twenty-four (24) hour period (does not need to be consecutive). Fire Watch will begin, immediately, at the end of the four (4) hour window.

2. A system failure of the fire alarm control panel or monitoring capabilities occurs. In this instance, Fire Watch will start immediately.

3. The fire watch log (Attachment A) must be completed by facilities lead/manage/on-call or construction manager/designee.

Conducting Fire Watch Rounds:

1. Only Fire Watch trained personnel, who are familiar with the building(s) and evacuation plan(s), shall conduct Fire Watch rounds.

2. Fire Watchers shall have knowledge of: preventing, identifying and controlling fire hazards.

3. In the event that Security or Maintenance is not available for Fire Watch, staff will be trained by condensed orientation and literature review.

   Documentation of completed training, See "*Attachment B*," shall be kept by the Safety Department or designee; a copy will also be kept in the employee file.

4. Fire Watchers will be familiar with fire extinguisher locations.

5. When on Fire Watch, Fire Watcher will be solely dedicated to this task. They will not be pulled off for other duties (without being replaced) or asked to do any other tasks while on Fire Watch rounds.

Discontinuing Fire Watch Rounds:

1. Fire Watch shall not be discontinued without approval from the Maintenance Department.

PROCEDURE:

1. <u>Routine maintenance, testing and inspection:</u>

   A. When routine maintenance is performed and the fire alarm and/or fire sprinkler system is put into bypass, a timer shall be started or resumed from original timing (if previous Fire Watch was started during the previous twenty-four (24) hours). Attachment "A" shall be filled out during business hours with 24 hour notice.

B. When the timer reaches a combined total of four (4) hours, the Fire Watcher will immediately notify Maintenance and PBX that a Fire Watch is now being implemented.

C. Rounds will commence immediately and be conducted within every 60 minutes.

D. Rounds will be tracked on the Fire Watch Log *"Attachment A,"* see attached.

E. During the 60 minute rounds of the Fire Watcher, rooms that will be checked include: storage areas, hazardous areas, restrooms, break rooms, offices, exit corridors, and exit stairwells.

F. After the system(s) have been repaired and tested, Maintenance will notify Security and PBX that Fire Watch is no longer necessary.

G. Security will then send the Fire Watch Log(s) to Maintenance via EFAX and give the originals to the Security Department Manager.

2. Emergency Deactivation of System(s):

A. When an emergency occurs and the fire alarm and/or fire sprinkler system is inoperable, the facility shall immediately be put into Fire Watch and rounds will be conducted accordingly.

B. Rounds will be tracked on the Fire Watch Log *"Attachment A,"* see attached.

C. During the 60 minute rounds of the Fire Watcher, rooms that will be checked include: storage areas, hazardous areas, restrooms, break rooms, offices, exit corridors, and exit stairwells.

D. After the system(s) have been repaired and tested, Maintenance will notify Security and PBX that Fire Watch is no longer necessary.

E. Security will then send the Fire Watch Log(s) to Maintenance via EFAX and give the originals to the Security Department Manager.

RESPONSIBILITIES:

1. Maintenance/Construction:

A. When putting the system in bypass (non-emergency):

I. Notify: Maintenance Lead, Maintenance Manager, or the On-Call Maintenance individual (Swing/Night Shift) of the need for Fire Watch. Document the need and time for Fire Watch in the pass down log, fire watch log (attachment A) and the fire watch control log (attachment C).

II. Call the Fire Alarm monitoring company and let them know how long the system will be in bypass.

III. Call the Visalia Fire Department Dispatch Center at: 559-734-8117 and let them know how long we will be in bypass and at which building/campus.

IV. Call the Security Department Lead on duty and notify them of the condition of the system. If you cannot reach the Lead directly, call PBX and have them contact the Lead to call you back. It is very important to speak with Security directly.

V. When repairs, tests, inspections or emergencies have been completed and the system is back in normal condition, call each of the above places to notify them that we are no longer on Fire Watch. Document the need and time for Fire Watch in the pass down log.

B. When putting the system in bypass (emergency):

I. Notify: Maintenance Lead, Maintenance Manager, Facilities Director, House Supervisor and the On-Call Maintenance individual (Swing/Night Shift) of the need for Fire Watch. Document the need and time for Fire Watch in the pass down log, on the fire watch log and the fire watch control log.

II. Call the Fire Alarm monitoring company and let them know how long the system will be in bypass.

III. Call the Visalia Fire Department Dispatch Center at: 559-734-8117 and let them know how long we will be in bypass and at which building/campus.

IV. Call the Security Department Lead on duty and notify them of the condition of the system. If you cannot reach the Lead directly, call PBX and have them contact the Lead to call you back. It is very important to speak with Security directly.

V. When repairs, tests, inspections or emergencies have been completed and the system is back in normal condition, call each of the above places to notify them that we are no longer on Fire Watch. Document the need and time for Fire Watch in the pass down log.

2. Security:

A. System(s) in bypass:

I. Upon receiving notification from Maintenance that the fire alarm and/or fire sprinkler systems are in bypass for testing, inspection or repair, Security will check the Fire Watch clipboard, located in PBX, to

notate the Fire Watch Control Log (Attachment "C") and check the last time that a bypass was requested.

II. Check the guidelines below and start the timer:

a. If the system was last in bypass during the last 24 hours, the timer will **CONTINUE** from the last point it stopped.

b. If the system was last in bypass more than 24 hours ago, the timer will **RESTART** for the 4 hour countdown.

III. If/when the timer runs out and the system has been on bypass for 4 hours (total) in a 24 hour period, Fire Watch will begin immediately. Contact Maintenance to inform them that Fire Watch rounds have begun.

B. System(s) down:

I. Upon receiving notification from Maintenance that the fire alarm and/or fire sprinkler system(s) are completely down, due to repair or an emergency, Security will begin Fire Watch rounds immediately.

3. Safety, Facilities Director and/or Designee:

Upon notification that the facility is in Fire Watch, the designated person will complete the following:

A. Contact the District's Director of Risk Management or Designee to inform them that a building (specify) is on Fire Watch.

B. Contact the Fire Marshal (Authority Having Jurisdiction) to notify which building (give the address and location) is in Fire Watch. Be as specific as possible with dates and times.

C. When fire watch rounds are complete and the system is back on line:

I. Call Risk Management to notify that rounds are complete and that the system is back on line.

II. Call the Fire Marshal to notify that rounds are complete and that the system is back on line.

4. Risk Management:

A. After the initial 4 hour grace period, notify the California Department of Public Health (CDPH) by fax at: 661.336.0529 to notify them that we are on fire watch and the estimated time when we will be back to normal function.

B. When fire watch rounds are complete and the system is back on line, fax the completed fire watch rounding sheets to CDPH along with a memo

stating that the rounds have been completed. If there was a repair to be made, note that the repair was made and attach the service record from the vendor.

5. Unable to perform Fire Watch:

   A. If Security is unable to perform Fire Watch duties, the task will be performed by the Maintenance and/or Construction Department.

   B. If Maintenance is unable to perform Fire Watch duties, they will call their immediate Supervisor.

TRAINING:

Upon new hire, training shall be held for Security and Maintenance personnel to teach best practices in order to conduct Fire Watch.

REGULATIONS AND STANDARDS:

2016 California Fire Code, Title 24, Part 9, Chapter 9, Section 901.7

NFPA 101:2012 Life Safety Code, §9.6.1.8

The Joint Commission

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Attachment "A"
FIRE WATCH LOG

ASSIGNED BUILDING/AREA: _____ DATE: _____
TIME NOTIFIED: _____ TIME FIRE WATCH TO START: _____

WHY IS THE FIRE WATCH IN EFFECT? _____

1. ** To be filled out by facilities manager/lead/designee or construction manager/designee. Copy to be kept in PBX during fire watch.
2. A. Who is completing form: _____
   B. Who is performing work: _____
   C. Contact name: _____
   D. Contact phone number: _____

Circle One

	A. System Working	**1**
	A. System bypassed for scheduled repairs or maintenance and testing *while being monitored by vendor at annunciator and can verbally communicate alarms to PBX operator*.	**1**
	A. System bypassed for scheduled repairs or maintenance and testing *while **NOT** being monitored by vendor at annunciator* **and** **B.** Has the system been disabled for 4 or more hours in the last 24 hours?	**3**
	A. System bypassed for scheduled repairs or maintenance and testing *while **NOT** being monitored by vendor at annunciator* **and** **B.** Has the system been disabled between 0 to 4 hours in the last 24 hrs?	**2**
	A. Has the system broke down or malfunctioned	**3**

1=No fire watch, **2***=Start fire watch after a total of 4 hours in the last 24 hours, **3***=Start fire watch NOW
***** Only the area(s) effected by the Malfunctioned/Repair/Testing need to be under Fire Watch

FIRE-WATCHER: _____ INITIALS:____
FIRE-WATCHER: _____ INITIALS:____
FIRE-WATCHER: _____ INITIALS:____
(May add additional names and initials on the back of this form)

Fire watch personnel must perform continuous, un-interrupted tours such that rooms in their assigned area are **checked at no less than 60 minute intervals**. Times must be recorded using the 24-hour clock and initialed. Any problems found during the fire watch must be documented (along with the time found and initialed) and reported immediately, at the time of discovery, to the maintenance lead, manager and/or designee for immediate correction.

I certify (by my initials below) that I completed a tour of my entire assigned area at the following times:									
Time Tour Completed	Initials		Time Tour Completed	Initials		Time Tour Completed	Initials		Time Tour Completed	Initials
00__			06__			12__			18__	
01__			07__			13__			19__	
02__			08__			14__			20__	
03__			09__			15__			21__	

04__			10__			16__			22__	
05__			11__			17__			23__	

Problems noted during fire watch (also note who you reported the problems to):

By signing this form you agree that you have verified the accuracy of this Fire Watch Log: Security Lead Signature: _____ Date: _____

Attachment "A" continued

KAWEAH HEALTH

FIRE WATCH IMPLEMENTATION CHECKLIST

Your primary role, as the Fire Watcher, is to serve as a "human smoke/heat/fire detector" and to notify the Switchboard at x44 at the first sign of smoke, excessive heat or fire.

Conduct a continuous patrol of the entire area(s), including but not limited to: storage areas, hazardous areas, restrooms, break rooms, offices, exit corridors, and exit stairwells. Remain alert to signs of smoke, excessive heat and fire.

To be a human smoke/heat/fire detector:

- ✓ Remain attentive. Patrol your designated area, at least, every 60 minutes
- ✓ Listen for in-room smoke detectors sounding
- ✓ Look for observable signs of smoke and/or fire
- ✓ Enter all stairwells – open doors and look into each stairwell

At the first sign of smoke and/or fire:

- ✓ Call PBX at x44 and initiate a *Code Red* (off-site facilities also dial 9-911)
- ✓ If possible and safe, use a nearby fire extinguisher to extinguish the flames (P.A.S.S.)
- ✓ If the fire is too big to extinguish or too dangerous, initiate R.A.C.E.

Attachment "B"

KAWEAH HEALTH
FIRE WATCH ACKNOWLEDGEMENT OF TRAINING

I understand that, during Fire Watch, I will be responsible for all of the items listed below:

1. Rounds must be conducted, at a minimum, of every 60 minutes for the area where I am assigned.

2. Be aware of your surroundings. Use your nose, eyes and ears to detect fire and/or smoke. In addition, listen to your intuition, if something does not seem right find out why.

3. During the 60 minute rounds rooms that will be checked include: storage areas, hazardous areas, restrooms, break rooms, patient rooms, offices, exit corridors, and exit stairwells.

4. Corridors and Exits must be kept free and clear of all obstructions.

5. Check to ensure that exit and fire doors are not blocked by anything that could keep them from closing.

By signing below, I agree that I have been made aware of the expectations placed upon me during a Fire Watch at Kaweah Health .

I agree to conduct Fire Watch Rounds within 60 minutes for my designated area.

I agree that I have been informed that Fire Watch Rounds are to be completed by me and that I am not to conduct any other business during this time period. I will be solely dedicated to the task of Fire Watch Rounds.

If, at any time, I feel that I cannot conduct these Fire Watch Rounds (for various reasons), I agree to contact my Supervisor immediately.

Print Name: _____Date: _____

Signature: _____

Attachment "C"

KAWEAH HEALTH

FIRE WATCH CONTROL LOG (To be kept updated in PBX)

Building	Date	Time notified by Maintenance to Start	Time notified by Maintenance to Stop	Time Fire Watch Rounds will Start (within 24 hours)	Total Time that the System was off (within 24 hours)

EOC 7305 Utilities Management Inventory

Subcategories of Department Manuals not selected.

Policy Number: EOC 7305	**Date Created: 04/01/2010**
Document Owner: Maribel Aguilar (Director of Physical Environment)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Utilities Management Inventory

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

POLICY:

A maintained and current equipment inventory shall be available for all District facilities equipment at the Maintenance and Engineering office. This inventory shall be kept current with-in 30 days at all times by the administrative assistant to the Facility Director.

The equipment inventory must be kept separate from other equipment information and must be produced as a separate entity. The inventory must include all equipment in the Computerized Maintenance Management Program.

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

EOC 7403 Emergency Generator Testing and Fuel Levels

Kaweah Health

Subcategories of Department Manuals not selected.

Policy Number: EOC 7403	**Date Created: 04/01/2010**
Document Owner: Maribel Aguilar (Director of Physical Environment)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Emergency Generator Testing and Fuel Levels

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

POLICY:

Kaweah Delta Health Care District herein after referred to as Kaweah Health (KH) maintains and tests emergency power generators at: KaweahHealth Medical Center, Kaweah Health Skilled Nursing Services, Kaweah Health Rehabilitation Hospital and Kaweah Health Mental Health Hospital.

PURPOSE:

To ensure adequate operational capability and fuel in the event of a utility power failure.

PROCEDURE:

All emergency diesel generator sets will be inspected weekly and exercised under load conditions for a minimum of 30 continuous minutes, once a month, as per the requirements set forth by *NFPA 110, Standard for Emergency & Stand by Power Systems*.

Each generator will also be tested, annually, using supplemental loads to achieve the requirements set forth by *NFPA 110, Standard for Emergency & Stand by Power Systems*.

Every 36 months, the emergency generators will each be tested for a minimum of 4 continuous hours, using supplemental loads to achieve the requirements set forth by *NFPA 110, Standard for Emergency & Stand by Power Systems*.

In the event an emergency power test is unable to be completed by Patient Care Priorities, such as an operation, the Nursing Supervisor will be consulted for an acceptable re-schedule time that falls within the guidelines set forth by NFPA.

FUEL TANKS:

Each fuel tank will be checked, weekly, for fuel levels. All tanks will maintain, at least, 65% of their fuel capacity. This ensures that each tank will run for a 96 hour minimum.

"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."

Privilege Form – Certified Nurse Midwife

Provider Name: _____ Date: _____

Please Print

Advanced Practice Provider – Certified Nurse Midwife

CERTIFIED NURSE MIDWIFE **Initial Criteria**
Education & Training: Completion of a nurse-midwife educational training program accredited by the ACNM; Current certification by the AMCB; Current licensure to practice as a CNM by the California board of Nursing; Evidence of adequate professional liability insurance; Employment by, or agreement with a physician currently appointed to Kaweah Health's medical staff to collaborate with or supervise CNM practice in the hospital.
Inpatient Clinical Experience: Completion of Education & Training within the last 12 months **OR d**ocumentation of management of patient care for 30 deliveries in the past two years. **AND** Completion of Kaweah Health Post Partum Hemorrhage & Hypertensive Disorder in Pregnancy Education Modules within 30 days of privilege granted **AND** Completion of an Implicit Bias Training prior to or within 30 days of privilege granted
Outpatient Clinical Experience: Completion of Education & Training within the last 12 months OR documentation 30 women's health outpatient contacts in the past two years AND Completion of Kaweah Health Post Partum Hemorrhage & Hypertensive Disorder in Pregnancy Education Modules within 30 days of privilege granted AND Completion of an Implicit Bias Training prior to or within 30 days of privilege granted
Inpatient Renewal Criteria: -Documentation of management of patient care for -30 deliveries in the past 24 months **AND** Maintenance of current certification by ACNM **AND** Completion of Kaweah Health Post Partum Hemorrhage & Hypertensive Disorder in Pregnancy Education Modules within the last 24 months **AND** Completion of an Implicit Bias Training within the last 24 months
Outpatient Renewal Criteria: Documentation of 30 women's health outpatient contacts in the past 24 months **AND** Maintenance of current certification by ACNM **AND** Completion of Kaweah Health Post Partum Hemorrhage & Hypertensive Disorder in Pregnancy Education Modules within the last 24 months **AND** Completion of an Implicit Bias Training within the last 24 months
Inpatient FPPE: 5 deliveries- by Direct Observation (must include 2 perineal laceration repairs)
Outpatient FPPE: Minimum of 5 chart reviews

CERTIFIED NURSE MIDWIFE CORE PRIVILEGES			
Request	**CORE** Includes procedures on the following list and such other procedures that are extensions of the same techniques and skills:	***CONDITIONS REQUIRING PHYSICIAN CONSULTATION** ****HIGH RISK CONDITIONS REQUIRING PHYSICIAN ATTENDANCE**	**Approve**
☐	Evaluate, Diagnose, and consult (may include telehealth) for patients through antepartum, intrapartum, and postpartum care in collaboration with or under the supervision of a physician who holds privileges at the hospital in this specialty area. Privileges include but are not limited to, the following: • Taking histories and performing physical examinations • Ordering laboratory, radiological, sonographical, and other diagnostic examinations • Collecting specimens for pathological examination • Initiating management of obstetrical emergencies with immediate physician consultation • Performing the following procedures: ➢ Fetal surveillance ➢ Amniotomies ➢ Midline/mediolateral episiotomies ➢ Repair of midline/mediolateral episiotomies ➢ Exploration of the uterus and manual removal of placenta fragments • Providing care to mothers and their infants in the postpartum period • Providing well-woman gynecological care as a member of a healthcare team that provides a full range of women's healthcare services	* Providing care for women who are attempting trial of labor after cesarean Pre-eclampsia *Post-maturity, greater than 42 weeks *Prolonged labor *Thick meconium staining *Non-reassuring fetal heart rate *Significant vaginal bleeding *Temperature greater than 38°C. repeated x2 **Malpresentation **Prematurity, less than 35 weeks	☐

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Provider Name: _____ Date: _____

Please Print

SPECIAL NON-CORE PRIVILEGES Effective 5.23.19 Initial FPPE is deemed to have been satisfied based on a sucessful completion of a preceptorship at Kaweah Health within 6 months prior to the grant of clinical privileges					
Request	**Procedure**	**Initial Criteria**	**Renewal Criteria**	**FPPE Requirements**	**Approve**
☐	Serving as first assistant during cesarean section	Documentation of training and experience and 10 cases performed in the past two years	10 cases performed in the past two years	First 3 cases	☐
☐	OB ultrasonography: Evaluation of fetal presentation, number, confirmation of cardiac activity, position and placental placement	Completion of a Basic Obstetric Ultrasound course in limited U/S and 10 procedures in the last 2 years .	10 procedures in the last 2 years.	3 concurrent and/or retro-spective chart reviews	☐
☐	Biopsy of the cervix	Documentation of training and 10 procedures in the last 2 years	2 in the last 2 years.	A minimum of 1 concurrent	☐
☐	Colposcopy	Documentation of training and 10 procedures in the last 2 years.	10 procedures in the last 2 years.	A minimum of 1 concurrent	☐
☐	Outpatient Services at a Kaweah Health Clinic identified below. Privileges include performance of core privileges/procedures as appropriate to an outpatient setting and may include telehealth: **__Dinuba __Exeter __Lindsay __Tulare __Valencia __Woodlake __KHMC- Akers __KHMC – Willow Specialty 202 __KHMC – Willow 502 __Specialty Clinic __Dialysis Clinic __Tulare Cardiology Clinic**	Initial Core Criteria **AND** Contract for Outpatient Clinical services with Kaweah Delta Health Care District.	Maintain initial criteria	None	☐

Acknowledgment of Practitioner:

I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise and; I understand that:

(a) In exercising any clinical privileges granted, I am constrained by any Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

(b) I may participate in the Kaweah Health Street Medicine Program, as determined by Hospital policy and Volunteer Services guidelines. As a volunteer of the program, Medical Mal Practice Insurance coverage is my responsibility.

(c) **Emergency Privileges –** In case of an emergency, any member of the medical staff, to the degree permitted by his/her license and regardless of department, staff status, or privileges, shall be permitted to do everything reasonably possible to save the life of a patient from serious harm.

_____ _____

Advanced Practice Provider Signature *Date*

_____ _____

Collaborating/Supervising Physician Signature *Date*

_____ _____

Department of OB/GYN Chair Signature *Date*

MS 24 Trauma Peer Review and Trauma Performance Improvement (TPTIP)

Kaweah Health
MORE THAN MEDICINE. LIFE.

Medical Staff Services

Policy Number: MS 24	Date Created: 02/14/2011
Document Owner: Teresa Boyce (Director of Medical Staff Services)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Medical Executive Committee, Teresa Boyce (Director of Medical Staff Services)	

Trauma Peer Review and Trauma Performance Improvement (TPTIP)

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

I. Purpose

The purpose of the Trauma Committee's Trauma Performance Improvement Plan (TPIP or Master Plan) is to measure, evaluate, and improve the process and effectiveness of care rendered to the injured patient including the performance of base hospital medical control with pre-hospital providers, resuscitation, inpatient care and inter-facility transfer. This includes a multidisciplinary effort to monitor, assess, and improve both the processes and outcomes of care of the injured. The process is based on outcome, has a refined method for analyzing errors useful to for trauma performance improvement. The long-term goal is to decrease death and disability by reducing inappropriate variation in care through progressive cycles of performance review.

The activities defined in the Master Plan are medical staff committee functions. All documentation and information referenced in the Plan will be kept and used in accordance with the Medical Staff's policies and procedures related to confidential peer review information so as to preserve their protection under California Evidence Code, section 1157.

II. Identification of Trauma Patient Population

Criteria for determining which patients undergo monitoring and evaluation of care is correlated with the American College of Surgeon's and hospital-specific indicators. A review of care using these pre-established indicators is conducted for patients meeting the following criteria:

1. Patients who meet California state or Central California Regional Trauma Audit Committee (CCRTAC) criteria.
2. All trauma related hospital admissions > 24 hours
3. Any trauma related deaths (DOA/ Death in the Emergency Department/ Death in the hospital)
4. Any trauma transfer either into or out of the hospital
5. Any Trauma Team activation (Level I or II)
6. Patients who are discharged from the hospital with an ICD-9-CM diagnosis 800.0-959.9
7. Trauma patients as defined by the Surgical Admission Decision Tree.
8. Excludes the following patient categories:
    a. Diagnostic codes within the following ranges: 905-909.0 (late effects of injury)
    b. Diagnostic codes within the following ranges: 910-924.9 (superficial injuries including blisters, contusions, abrasions and insect bites)

c. Diagnostic codes within the following ranges: 930- 939.9 (foreign bodies)
d. “Slip and fall” patients who have only minor injuries such as bruises, scratches and small lacerations. If the patient has suffered sufficient trauma that they need to be admitted for care of their traumatic injuries they should be admitted to a trauma service.
e. Patients with hip fractures who are over 65 years of age or where the hip fracture is related to osteoporosis.

III. Structure

Trauma Performance Improvement at Kaweah Delta Health Care District consists of internal and external monitoring and evaluation of care provided by medical, nursing, and ancillary personnel, as well as hospital departments, services and programs. Such monitoring is performed under the direction of the Trauma Committee. Monitoring is ongoing and systematic; opportunities to reduce inappropriate variations in care are sought, and strategies to improve care are documented in an action plan. The effectiveness of the action plan is evaluated through continuous reassessment and monitoring utilizing an ongoing performance improvement process.

IV. Responsibilities/Authority

The Trauma Medical Director and the Trauma Program Manager address performance issues that involve multiple services and departments. The Trauma Medical Director leads the PI process through weekly case reviews, participation in Trauma Rounds and review of variances, indicators, complications and complaints. The Trauma Medical Director will conduct initial evaluation of professional care and develop the action plans to be taken in response to concerns. Exceptions will be those issues that are either deemed appropriate for Trauma Peer Review Committee evaluation (in which case judgment will be made by Trauma Peer Review Committee vote) or for which the Trauma Peer Review Committee has deferred judgment to the Medical Staff Peer Review Committee. The Trauma Peer Review Committee is a subcommittee of the Trauma Committee.

The Trauma Registrar abstracts data from the patient’s chart, identifies and reports complications, variances in care, complaints and opportunities for improvement as they are identified.

The Trauma Program Manager (TPM) facilitates the function of the Trauma Peer Review Committee, the Trauma Committee and Trauma multidisciplinary educational conferences. The TPM also coordinates action planning and documentation between the trauma program and the hospital-wide PI program. Issues relating to the provision of trauma care, whether institutional, systems related or provider related, are relayed to the Trauma Medical Director for evaluation and action. The Trauma Program Manager is also responsible for data processing, analyzing, and reporting variances to the Trauma Medical Director or designee. The Trauma Medical Director has the responsibility for the Trauma Performance Improvement Program. The authority for the trauma peer review program comes from existing quality and peer review structures within the hospital. The trauma program is an official Medical Staff function and interacts with at least equal authority

with other departments. Adequate administrative support, as well as defined lines of authority, must be in place to guarantee the comprehensive evaluation of all aspects of trauma care The Trauma Medical Director is empowered to address issues that involve multiple departments, so that program development and performance improvement can occur expeditiously. In addition, subject to the Corrective Action provisions in the Medial Staff bylaws and to the fair procedure requirements of California law, the Trauma Medical Director has the authority to correct deficiencies or recommend remedial action in trauma care and to exclude or recommend exclusion from the trauma call panel any member that does not meet the criteria outlined below:

1. General surgeons who fail to be present for Level I and Level II Trauma Alerts within 30 minutes of notification at least 80% of the time.
2. Failure of core general surgeons to have been ATLS certified at some time (documentation required) or who have not recertified when requested to do so by the Trauma Medical Director. The Trauma Medical Director must maintain current ALTS certification.
3. Failure of any member of the general surgery core group of surgeons to attend at least 50% of the Trauma Peer Review meetings.
4. Failure of non-general surgeons and non-core general surgeons to attend at least 50% of the Trauma Peer Review meeting during which they have been notified in writing that a case that their case will be discussed.
5. Emergency Medicine physicians who are not either board certified or who have currently ATLS (documentation required).
6. The Trauma Medical Director has determined that the trauma related care being delivered by a panel member is not appropriate and that the situation has not been remedied after one-on-one counseling by the Trauma Director and after a written warning has been given to the provider that they are at risk for being removed from the trauma call panel. Any such action shall be taken in accordance with the Medical Staff bylaws and applicable California law.
7. Sub-specialty surgeons on the Trauma Panel do not respond promptly to the needs of trauma patients when requested to do so.
8. Trauma Panel surgeons do not remain knowledgeable in trauma care principles whether treating the patient locally or transferring the patient to a facility with more resources. If the provider wishes to appeal the Trauma Medical Directors decision this must be requested in writing within 30 days. The Trauma Peer Review Committee will then review the request for reconsideration. The Trauma Medical Director will recuse himself/herself from these discussions and from the vote. Any final action under this section shall be taken in accordance with the Medical Staff bylaws and applicable California law.
9. The Trauma Medical Director determines that the trauma care rendered by a provider on the Panel is below the standard of care. If the provider wishes to appeal the Trauma Medical Directors decision this must be requested in writing within 30 days. The Trauma Peer Review Committee will then review the request for reconsideration. The Trauma Medical Director will recuse himself/herself from these discussions and from the vote. Any final action under this section shall be taken in accordance with the Medical Staff bylaws and applicable California law.

10. The Trauma Medical Director may recommend suspension of the ability of a provider to participate in the Trauma Panel pending further review if there has been a sentinel event, an egregious error or when patient safety may be at risk. Any such suspension shall be subject to the summary suspension provision of the Medical Staff bylaws. In such situations the matter will then be referred to the Medical Staff structure for evaluation by normal Medial Staff procedures.

Note that removal of a provider from the Trauma Call Panel does not affect the affected provider's clinical privileges granted by the Medical Staff for that provider to practice in the Kaweah Health Care District.

V. Data Collection and Information Sources

Data is collected during hospitalization and retrospectively after discharge. At a minimum 80% of cases must be entered in the Trauma Registry within 60 days of discharge. The data is abstracted from the patient's medical record and other sources as listed below. The following information sources may be utilized to evaluate the effectiveness of care and for monitoring the hospital's trauma program and the Trauma Performance Improvement Program.

- Pre-hospital care reports
- Hospital medical records
- Emergency Department registry
- Daily Emergency Department Admit Log
- Trauma Alert flow sheets
- Inter-hospital transfer records (if applicable)
- Autopsy findings
- Hospital Trauma registry data
- External benchmarking data (i.e. NTDB, Lancet Trauma One and California and/or Central California Regional Trauma system databases.
- Referral from facilities to which patients were transferred for a higher level of care.
- Kaweah Delta Health Care District's Performance Improvement Committee
- Complaints from all sources
- Trauma Program Manager
- Trauma Medical Director
- Daily rounds by the Trauma Service Specialists
- Rounds by the Trauma Medical Director
- Referrals from staff involved in the care of trauma patients
- Referrals from physicians involved in care of trauma patients
- E-mail communications
- Referrals from Risk Management
- Referrals from other hospitals

Kaweah Delta Health Care District's Performance Improvement Department communicates information related to Trauma care from other hospital sources (such as other departments, divisions and care providers) to the Trauma Program. Trauma case review findings, case referrals and action plans from the Trauma PI

Program are communicated to the Medical Staff Peer Review Committee (PRC) and the Medical Care Review Committee (MCRC).

Steps in the Review Process:

1. Identify the injury/trauma patient (see Identification of Trauma Patient Population)
2. Data is collected by the Trauma Registrar on ALL patients meeting the following criteria:
3. Patients discharged from the hospital with an ICD-9-CM diagnosis 800.0-959.9
4. Excludes the following patient categories:
    a. Diagnostic codes within the following ranges: 905-909.0 (late effects of injury)
    b. Diagnostic codes within the following ranges: 910-924.9 (superficial injuries including blisters, contusions, abrasions and insect bites)
    c. Diagnostic codes within the following ranges: 930- 939.9 (foreign bodies)
5. Issues/problems revolving around the care of the patient from pre-hospital through the discharge process are identified.
6. The Trauma Program Manager reviews the issue/problem/complaint and attempts to resolve the issue if appropriate. The Trauma Medical Director is kept apprised of issues. Issues that are trends, cross departments, personnel/staffing issues or systems issues need to be addressed in the multidisciplinary Trauma Committee.
7. Problems/issues that are identified as trends in system issues will be reviewed by the Trauma Program manager and referred for discussion and resolution by the multidisciplinary Trauma Committee, or other hospital committees or medical or administrative staff as appropriate
8. Any problem/issue that is identified as a sentinel event must be referred to Risk Management for evaluation as per hospital policy.
9. Problems/issues that are identified as credentialed provider-related are referred to the Trauma Peer Review Committee for resolution with documentation of closure. If the Trauma Peer Review committee refers the issue to the Medical Staff Peer Review Committee, or to other departments or committees must clear written documentation must be sent back to the Trauma Medical Director documenting resolution/closure of the issue.
10. All admitted trauma patients go through some level of review which may be as brief as the data collection and brief case review by the Trauma Program Manager, Trauma Registrar or extensive as a full Trauma Peer Review Committee evaluation or referral to the Medical; Staff Peer Review Committee (PRC), or other aspects of the Performance Improvement process.
9. Complications as identified by review of the Trauma Registry, can be monitored through trend analysis if they are deemed to meet the definitions of Standards or Practice, Rating 1 or 2, or of a Complication Grading Scale, Grade 1, as defined by Trauma Peer Review Morbidity and Mortality Determinations (Appendix A). When an individual provider is identified as a potential outlier during trend analysis they will be notified by mail of the specific complication being trended. If it is noted that a certain complication

is occurring more frequently than expected then an audit and full review are warranted.

10. Complications that have been followed by trend analysis and found to exceed expected thresholds will be referred to the medical staff Peer Review Committee:
    a. Failure of a single provider to call > 5 Trauma Alerts in any single 12 month period.
    b. Complications that fall outside of the expected norm as determined by National Trauma Data Bank statistics.
11. Events rated by Trauma Peer Review as Standards of Practice Ratings 3 and/or Complications that are determined to be grade 3 or 4 (except for non-preventable deaths declared as Dead on Arrival (DOA) will be referred to the hospital Peer Review Committee for review (*Appendix A*).
12. The appropriateness of Trauma Alert Criteria will be evaluated using the Cribari Matrix/Method *(Appendix B).*

Levels of Review:

First Level Review: The Trauma Registrar reviews each case as it is entered into the Trauma Program Data Base. Cases may also be referred directly to the Trauma Program manager or the Trauma Medical Director and initially reviewed by them.

Second Level Review: The Trauma Registrar, or other sources as defined in Data Collection and Information Sources, may refer cases to the Trauma Program Manager or the Trauma Medical Director. In situations where the Trauma Medical Director's delivery of care is being reviewed the TMD will recuse himself or herself and the Vice Chair of the Trauma Committee will substitute for the Trauma Medical Director. Those cases in which a second level review is completed and clinical care is clearly appropriate and no provider or system issues have been identified will be closed at the secondary level and are not required to have a tertiary review. Examples of cases that meet criteria for closure at this level include:

1. Admission to a non-trauma service of a patient with no trauma related injuries or issues.
2. Admission to a non-trauma service for a simple "slip and fall" in patients who have only minor injuries such as bruises, scratches and small lacerations.
3. Admission to a non-trauma service for an isolated hip fracture occurring in a patient over 65 years of age.
4. Admission to a non-trauma service for an isolated hip fracture occurring in a patient with documented osteoporosis.
5. System issues previously identified as "for tracking only" unless tracking has identified a specific issue that needs to be brought forward to the Trauma Peer Review committee or the Trauma Committee regarding performance issues or for referral to the appropriate hospital committee, division or department. Those issues that are identified as needing further review will be identified for third level review.

Third Level Review: The Trauma Program Director and the Trauma Medical Director review cases together. In situations where the Trauma Medical Director's delivery of care is being reviewed he or she will recuse themselves and the Vice Chair of the Trauma Committee will substitute for the TMD. Cases in which a third level review is required are when issues in clinical care, provider or systems issues may be evident

or in question and the Trauma Medical Director's medical expertise and/or judgment are required. These cases may, or may not, be closed at this level depending upon the TMD's discretion. If there is disagreement between the Trauma Program Manager and the Trauma Program Director the case will be sent forward for quaternary review.

Fourth Level Review: This level of review occurs at the weekly Trauma Working Group meeting- including the Trauma Program Manager, the Trauma Medical Director and the Vice-Chair of the Trauma Committee. The Chairs of the Emergency Medicine Department and the Department of Surgery may also attend. Cases in which a fourth level review is required are when issues in clinical care, provider or systems issues may be evident or in question and the Trauma Working Group's medical expertise and/or judgment are required. These cases may, or may not, be closed at this level depending upon the discretion and agreement of the working group. If there is disagreement between the members of the Trauma Working Group the case will be sent forward for formal Trauma Peer Review Committee (fifth level) review.

Fifth Level Review: Cases that are referred for fifth level review will be tracked by utilizing the Case Review Tracking Forms and the Morbidity and Mortality Case Review Form (*Appendix E*). The Trauma Peer Review Committee reviews all cases that meet the following criteria:

1. Cases that have been forwarded to the Trauma Peer Review Committee by the Trauma Working Group.
2. All trauma related patient deaths. Every death will also be reviewed utilizing the Mortality Case Review form (*Appendix D*).
3. Major complications.
4. Audit filter fallouts requiring review and input from the Trauma Peer Review Committee (*Appendix E*).
5. Any trauma case as deemed appropriate for Trauma Peer Review Committee review as determined by the Trauma Program Manager, the Trauma Medical Director, The Trauma Working Group or any case review requested by a member of either the Trauma Peer Review Committee or Trauma Committee.

Sixth Level Review: Cases that have been designated by vote of the Trauma Peer Review Committee for referral to the Medical Staff Peer Review committee. The issues of concern to the Trauma committee will be recorded on the Trauma Peer Review Committee referral form (*Appendix F*) for the Medial Staff Peer Review Committee to review.

Additional criteria for referral to the Medical Staff Peer Review Committee include:

1. A single egregious case as determined by the Trauma Peer Review Committee, The Trauma Medical Director or the Vice-Chair of the Trauma Committee.
2. Within any twelve-month period of time, if any one of the following criteria are met: (1) three cases rated as Preventable or (2) five cases rated as Potentially Preventable.

For those cases that have been referred to the Medical Staff Peer Review committee a record of the final determinations and corrective actions (if appropriate) of the PRC will be attached to the referral form and returned to the Trauma Medical Director for loop closure. Should the judgment of the Peer Review Committee or Medial Executive Committee be disciplinary action, referral to the Physician Well Being

Committee or suspension of privileges this action may be recorded on the referral form as "*appropriate action taken*" to ensure strict confidentiality regarding any possible peer review issues.

External Peer Review:
Circumstances requiring external peer review will be managed as per the Medical Staff policy "Request for Outside Peer Review. Either hard copies or CD-ROM disks of any available radiology studies relating to trauma patients must be sent with the medical records to the outside reviewer. The outside reviewer must also agree to review and comment upon the actual hard copies or CD-ROM disks of the radiology studies that have been provided to them.

Re-opening of a Case:
If a physician, trauma provider or Trauma Peer Review Committee member requests reopening of a case, that individual must state in writing the reasons for the appeal within sixty days of the date of final determination. Indicators that favor consideration are likely to include but are not limited to: new findings of fact or persuasive expert opinion not previously considered. Indicators that do not favor consideration include but are not limited to: failure to attend the Trauma Peer Review Committee when invited to a review of that provider's case and when they did not request deferral of peer review for valid reasons (as determined by the Trauma Medical Director). The Trauma Peer Review Committee will then consider the document for reconsideration of the referenced case. Deferral of discussion of a trauma provider's case may not be requested more than once except under exceptional circumstances (as determined by the Trauma Medical Director).

Requests for re-opening of cases that were referred by the Trauma Peer Review Committee to the medical staff Peer Review Committee must be directed to the medical staff PRC as per the Performance Improvement Department Manual in the Medical Staff Office Manual entitled Peer Review Process.

Aspects of Review & Key Activities
American College of Surgeons (ACS), State of California, Central California Regional Trauma Audit Committee (CCTAC) and medical staff Peer Review Committee indicators are used for identifying audit criteria, trending incidents, benchmarking performance, identifying issues for Trauma Peer Review Committee evaluation.

Injured patient who meet criteria for review are screened using the pre-established list of quality indicators and reviewed for variances, morbidity and mortality. Any provider related mortality or case referred for fifth level review is presented at the Trauma Peer Review Committee. Physicians and Allied Health Professionals (AHP's) Care Providers are invited for educational purposes and to facilitate loop closure during individual case reviews or at the time of case presentation at Trauma Peer Review Committee. Allied Health Professionals are non-voting members of the Trauma Peer Review Committee.

Members of the Trauma Panel

Providers who have been credentialed by the Medical staff, and who provide trauma care for injured patients as a part of their normal professional practice are eligible to be on the Trauma Panel with the following exceptions:

1. The specialty services provided are subject to an exclusive contract and the provider is not a member of the contracted group.
2. The provider has been removed from the Trauma Panel in accordance with this plan.
3. The provider has been removed from the Trauma Panel in accordance with this Plan and the remedial action plan for re-instatement that was developed by the provider, the Trauma Medical Director and approved by the Trauma Peer Review Committee has not been fulfilled.
4.

Requirements for Trauma Panel Providers

Trauma panel physicians must meet Medical Staff Credentialing criteria, Central California Emergency Medical Services Agency (CCEMSA) credentialing requirements and be certified by the Trauma Medical director to be included on the trauma call panel. Trauma call paneling will be in accordance with CCEMSA Trauma Center Credentialing Standards and California Code of Regulations, Title 22, Chapter 7.

Trauma panel General Surgeons must be capable of evaluating and treating adult and pediatric trauma patients. When on-call they must be promptly available (within thirty minutes) at all times. If the primary on-call General Surgeon is not available (e.g., already in the OR) the designated Back-up surgeon must be available within thirty minutes.

Trauma panel Orthopedic Surgeons must be board certified or qualified by Section 100242, Title 22. The designated on-call Orthopedic Surgeon must be dedicated to one hospital or have a designated back-up Orthopedic Surgeon on-call

Medical staff and Allied Health Professional credentialing occurs through Kaweah Delta Health Care District's established medical staff and allied health mechanisms. Nurses are evaluated through the hospitals Human Resources Department processes or by the Interdisciplinary Practice Committee. Coordinating the verification of physician, physician assistants and nursing credentialing is a collaborative effort of the Trauma Medical Director and the Trauma Program Manager, in conjunction with the Medical Staff office and Human Resources.

Volume Trending

The trauma population at Kaweah Delta Medical Center is identified on a daily basis by screening the daily Emergency Department Admit Log, the daily Emergency Department Admission Log and the Trauma and Acute Care Surgical Service census. The trauma patients serve as the denominator for enabling the trauma program to monitor resource and service utilization, morbidity and mortality rates, and other significant factors. The incidence of complications is used to establish the need to develop practice guidelines, enhance staff education, and identify facility and resource needs and to address systems issues.

Process Measures
Process indicators are used to measure, evaluate, and improve system performance (e.g., Lab turn around times, OR availability, CT availability, etc.). Process expectations are developed from committee consensus, hospital policies, medical staff policies, practice guidelines and protocols. The Trauma Program is focused on timeliness and availability of Trauma Providers, radiology services, operating room availability, ICU bed availability, appropriateness of triage, documentation, etc.

Outcome Measures
The Trauma Service measures the outcome of trauma care including morbidity, mortality, and length of hospital and intensive care unit stay, cost and patient satisfaction. Complications and injury related deaths are identified and evaluated for preventability and appropriateness of care. Complications and deaths will be determined utilizing pre-defined definitions.

The Trauma Peer Review committee reviews all provider and system related deaths and complications. The Trauma Service will prepare a bi-annual report for the Medical Care Review Committee (MCRC), Quarterly reports for the Medical Executive Committee (MEC) and annual reports for the Quality Council of the Board documenting the service's performance, including outcome rates. Deaths and complications will be presented with a defined denominator.

Evaluation
Morbidities and mortalities are evaluated as to whether their occurrence is disease, provider or system related. A disease related morbidity or death is an anticipated sequela of disease, medical illness or injury. A provider associated complication results from delays and errors in treatment provided by EMTs, nurses, allied health providers or physicians. The case review categorizes errors in technique, judgment, treatment, etc. and is evaluated to determine preventability.

Action Plan
When variations in care, opportunities to trauma improve care, or problems relating to trauma care are identified an Action Plan will be developed. Action plan strategies may be carried out using any or all of the following mechanisms: modification of policies, procedures, guidelines, protocols, professional education for staff, counseling of involved personnel, revision of trauma provider paneling and tracking or trending. Action plans may also include referral of issues to the medical staff Peer Review Committee or other appropriate committees or departments. The Trauma Peer Review committee, The Trauma Committee, the Trauma Program Manager or the Trauma Medical Director will develop an action plan that includes:

1. Who or what is going to change.
2. Who is assigned responsibility for problem resolution.
3. What action will be undertaken.
4. When action will occur
5. Who is responsible for action and when it will occur

Remonitoring

Continuous evaluation provides a method for assuring the effectiveness of corrective action plans. Action plans, follow-up and evaluation are reflected in the Trauma Committee and Trauma Peer Review Committee minutes.

Documentation & Control of Confidential Information
The comprehensive Trauma PI program includes accurate and confidential documentation of ongoing monitoring, corrective action, progress, and re-evaluation. Information is handled in a strictly confidential manner. The essential aspects of control of patient and provider related information include the following measures:

1. Provisions of the Health Information and Portability Act will be strictly adhered to.
2. Use of locked files and offices for all provider related information. Only the Trauma Registrar, the Trauma Program Manager and the Trauma Medical Director will have access to these cabinets.
3. Provision of a confidentiality statement/agreement for all participants in PI activities.
4. All participants in the Trauma Performance Improvement Process will abide by the Confidentiality Procedure for Performance Review (*Appendix G*).
5. Sanctions for any breaches of confidentiality.
6. Shredding of all copies of PI documentation and personal health information when it is no longer needed for the PI process (except original copy stored in the shadow chart in a locked cabinet in the Trauma Services Office).
7. Collection and shredding of all case review documents after each medical meeting.
8. Computer generated PI or Peer Review documentation may only be accessed via user ID and password.
9. Use of security procedures when mailing or transmitting PI documentation through a facsimile or modem is adhered to by;
    a. Addressing all correspondence to an assigned person rather than an agency.
    b. Clearly marking all letters “confidential”.
    c. Removing all patient identifiers, dates, and location of scenes from information, particularly when used for education.

Performance Improvement Minutes and Reports
Reports are prepared in summary format and include a written summary of problem identification and resolution. Performance Improvement Expectations as outlined in will be reviewed periodically. Summary reports are submitted to the Trauma Peer Review Committee, the Trauma Committee, the Medical Staff Peer Review Committee and other hospital committees as deemed necessary. Such documents are maintained as confidential, peer review documents protected by Evidence Code Section 1157.
Issues are delegated to the appropriate medical service or hospital representative for management of issues and to promote positive change. Confidentiality is maintained via a confidential letter or direct communication with providers involved.

References:

- Resources for Optimal Care of the Injured Patient, 2006.
- CCEMSA Trauma Center Standards, Summary of California Code of Regulations, Title 22, chapter 7.
- CCRTAC audit indicators.
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- Trauma Center Associations of America website: accessed 10/11/10.
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- Performance Improvement for Local, Regional, and State Trauma Systems: Oregon Model, January 2001.
- Deaconess Medical Center Trauma Services Practice Guideline: July 1, 2005.
- Performance Improvement Guidelines for North Carolina Trauma Centers. North Carolina Committee on Trauma Performance Improvement Sub-committee of the American College of Surgeons. April 1, 2002.
- Trauma Performance Improvement Reference Manual. Performance Improvement Subcommittee of the ACS. January 2002.
- Trauma Outcomes and Performance (TOPIC) Manual. Society of Trauma Nurses. 2003.
- Surgical Care Improvement Process (SCIP)

Original: March 2009
Revised: June 2009
Revised: October 25, 2010
Revised: November 16, 2010
Revised: November 30, 2010
Revised: December 8, 2010

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Appendix I: Definitions

Appendix E: Audit Filters

1. Delay in diagnosis/impression: Injury related diagnosis not discovered until greater than 48 hours after admission and resulting in minimum morbidity.
2. Error in diagnosis/ impression: Injury missed because of misinterpretation or inadequacy of physical examination (or diagnostic) procedure.
3. Error in judgment: Therapeutic or diagnostic decision made contrary to available data.
4. Error in technique: Technical error occurring during the performance of a diagnostic or therapeutic procedure.
5. Mechanical error: Failure of equipment or inability to adapt equipment to circumstance.

6. Error in supply: Usual equipment for patient care not available when needed.
7. Error in vigilance: Lack of general attention to detail.
8. Failure to call Trauma Alert when appropriate.
9. Surgeon response > 20 minutes to Level I Trauma Alert or Level II Trauma Alert once consulted.
10. Anesthesiologist not available in operating room to meet patient within 30 minutes of being called.
11. Delay in start time of surgical procedure in patient with systolic BP< 90 mm Hg due to OR personnel not being available within 30 minutes of being called.
12. Delay to CT scanner (> 40 minutes)
13. Delay to operating room > 60 minutes after arrival in hypotensive patient (SBP<90).
14. Delay to operating room for patient with systolic BP<90 mm Hg due to diagnostic imaging studies.
15. Delay to operating room > 4 hours in stable patient.
16. Failure to record VS as per protocol.
17. Failure to intubate patient with GCS< 9.
18. Admission of a defined trauma patient to a non-trauma service.
19. Failure to transfer a patient within six hours of injury to, or from, the hospital for a higher level of care.
20. Failure to transfer a head injured patient to a higher level of care within one hour of arrival to the Emergency Department.
21. Failure to follow ATLS recommendations for management of airway, breathing and circulation priorities of patient management.
22. Esophageal intubation (pre-hospital and in-hospital)
23. Failure to decompress the chest by needle decompression for obvious pneumothorax or hemothorax with hemodynamic and respiratory compromise unless chest tube thoracostomy can be immediately placed.
24. No chest tube placed for hemothorax or symptomatic pneumothorax within 15 minutes of diagnosis or inappropriate size chest tube used.
25. Persistent over or under ventilation within the first 12 hours (pCO_2 < 32 or > 50) in patients with airway management.
26. Inability to obtain vascular access in a patient with unstable vital signs.
27. Failure to adhere to Mass Transfusion Protocol when indicated.
28. Failure to control external bleeding.
29. Failure to maintain systolic BP> 90 and/or pCO_2 <35 or >40 in head injured patients with a GCS<9.
30. Base deficit >8 after initial resuscitation.
31. Prolonged hypothermia without adequate re-warming measures.
32. Inappropriate pediatric fluid administration: Infusion of > 50 ml/kg crystalloid solution during the first two hours in a pediatric patient with normal vital signs.
33. Patient with systolic BP<70 mm Hg greater than two hours after hospital arrival with no definitive surgical intervention.
34. No spinal precautions initiated in the field or spinal precautions not maintained until adequately cleared.
35. Cervical spine cleared by CT scan or cervical x-rays in-patient with altered level of consciousness.
36. AP chest and pelvis films not completed following ATLS protocol for blunt trauma victims.

37. No application of traction or splinting for long bone fractures.
38. Failure to attempt reduction of obvious extremity fractures or dislocations with lack of pulses.
39. Failure to attempt reduction of hip dislocation within 6 hours of hospital arrival.
40. Failure to administer IV antibiotics for open fractures or extensive breakdown in skin integrity.
41. Failure to administer prophylactic peri-operative antibiotics.
42. Failure to administer prophylactic appropriate peri-operative antibiotics as per SCIP recommendations.
43. Failure to discontinue prophylactic peri-operative antibiotics within 24 hours as per Surgical Care Improvement Program.
44. Patient did not receive appropriate venous thromboembolism prophylaxis.
45. No rectal exam documented prior to placement of Foley catheter in a male patient.
46. For patients with ISS>15 or ICU admission NO nutritional support started within 48 hours of admission.
47. Failure to diagnose major vascular injury within 6 hours of hospital arrival.
48. Unplanned or unexpected repair of an organ during operative procedure including laceration, puncture, tear or perforation.
49. Surgical site infection.
50. Unplanned readmission within 30 days of discharge related to initial traumatic injuries or associated treatment.
51. Surgical/ Procedural complications identified by ICD-9 996.0- 999.9 (complications of medial or surgical care not elsewhere classified) and 557.0 (acute vascular insufficiency of the intestine).
52. Unanticipated return to surgery for removal of hematoma or hemorrhage.
53. Unanticipated return to surgery for removal of foreign body.
54. Unexpected surgical mortality
55. Major peri-operative complications: Death in OR/PACU or within 24 hours of anesthesia. Peri-operative cardiac arrest, acute MI, unexpected neurological deficit.
56. Perforation due to devices used for administration of anesthesia.
57. Re-intubation in PACU after post-procedure extubation.
58. Re-intubation within 48 hours of extubation.
59. Emergency Department trauma patients who return for trauma related injuries and are admitted.
60. Radiology over reads that do not match teleradiology reading.
61. Disagreement between emergency physician or surgeon reading of radiology studies and radiologist’s reading.
62. Failed non-operative management of solid organ injury

Appendix I: Definitions

Action Plan: A structured effort to improve performance that has been identified through the Performance Improvement process to be sub optimal.

Allied Health Personnel: Physicians Assistants, Registered Nurse Practitioners and Family Nurse Practitioners.

Brief Review: A brief review of patient care/ record must include, at a minimum, collection of data and input into the registry, and review of that information by either the Trauma Registrar (TR), the Trauma Program Manager (TPM) and/or the Trauma Medical Director (TMD). Patients that may need only brief review include those who are admitted to trauma and non-trauma services that have no delays in care, no unexpected complications, no errors in care and who do not die. Patients for whom their transfer occurred within six hours of injury and/or patients admitted for 24 hours or less and who are discharged alive.

CCEMSA: Central California Emergency Services Agency.

Closing the Loop: The process or outcome has been measured after completion of Peer Review and/or after implementation of the Action Plan and outcomes and/or improvements have been documented.

Complication: An event that deviates from an anticipated uneventful recovery from illness or surgery. The Trauma Program maintains a standard list of complications that are routinely collected and reviewed.

Credentialing: A Medical Staff process for approval of privileges to provide patient care within the Kaweah Health Care District.

Cribari Matrix: A tool created to help trauma programs evaluate their over- and under-triage rates.

CCRTAC: Central California Regional Trauma Audit Committee.

Dead on Arrival (DOA): Patient who arrived in the Emergency Department without signs of life (absence of pulse, spontaneous movement, respiratory effort or effective cardiac activity or who have cardiac standstill as seen on ultrasonographic examination).

- Additional criteria include the following:
    - Adults who are victims of blunt trauma and have been under pre-hospital CPR for greater than five minutes.
    - Adults who are victims of penetrating trauma to the abdomen, head, neck or groin who have been under pre-hospital CPR for greater than five minutes.
    - Adults who are victims of penetrating trauma to the chest and have been under pre-hospital CPR for more than fifteen minutes.
    - Children (age <13 years) who are victims of blunt or penetrating trauma and who have been under pre-hospital CPR (open or closed) for more than fifteen minutes.

Disease Related: An event or complication that is an expected seqeula of a disease, injury or illness.

Filters: Audit criteria that may be used to evaluate trauma programs and/or patient care issues related to the provision of trauma care.

Full Review: A full review of a patient record/ care includes evaluation of care provided from the pre-hospital period at least through patient discharge. The review must include any complications (either expected or unexpected), delays in care and patient outcomes. If the patient dies a determination must be made as to whether the death was preventable, possibly-preventable or non-preventable. This review must be documented in writing and submitted to the Trauma Medical Director for final evaluation. All patients that die must have a full review. If the patient has been cared for exclusively by a non-trauma service physician or group, that death review may be conducted by the hospital Peer Review Committee to include the same death judgment and appropriateness of care. Patients who must also undergo a full review include the following:

- Those that are transferred to/ or from the hospital greater than six hours after injury.
- Patients that are re-admitted for the same injury or a missed injury.
- All patients who die.
- Patients with an unexpected outcome.

Medical Care Review Committee (MCRC): A multidisciplinary committee of the medical staff that reviews the delivery of patient care within the Kaweah Health Care District.

Medical Staff Peer Review Committee (PRC): A multidisciplinary committee of the medical staff as defined in the Performance Improvement Department Manual of the Kaweah Health Care District.

Morbidity: Any deviation from normal health that may be a result of a complication or injury, or may be due to a pre-existing illness or injury.

Non-Preventable: An event or complication that is an expected or unexpected sequel of a procedure, disease, illness or injury for which reasonable and appropriate steps for prevention have been taken.

NTRACS: National Trauma Registry of the American College of Surgeons (ACS). A commercial software package for collection, storage, analysis and reporting of trauma patient information on an individual hospital level. Some “blinded” information may be shared with state and national registries. NTRACS publishes an aggregate report of the data collected from Trauma Centers annually.

Peer Review Process: A standardized process by which trauma providers are confidentially reviewed by a multidisciplinary. It is part of the overall Trauma Performance Improvement Process.

Potentially Preventable: An event or complication that is an expected or unexpected sequela of a procedure, disease, illness or injury that has the potential to have been prevented or substantially ameliorated.
Preventable: An event or complication that is an expected or unexpected sequela of a procedure, disease, illness or injury that could have been prevented or substantially ameliorated.

SCIP: Surgical Care Improvement Process.

TPIP: Trauma Performance Improvement Plan.

TPRC: Trauma Peer Review Committee.

Trauma Alert Criteria: A predefined set of criteria for activation of the Trauma Team.

Trauma Committee: Primarily directed towards systems and operational issues. It is primarily process related. The Trauma Committee is a multidisciplinary committee composed of:

- Trauma Medical Director
- Trauma Program Director (non-voting)
- Trauma Registrar (non-voting)
- Orthopedic Surgery Trauma Liaison
- Anesthesiology Trauma Liaison

- Core Trauma Surgeons
- Emergency Medicine Trauma Liaison
- Neurosurgery Trauma Liaison
- Radiologist Trauma Liaison
- Allied Health Providers who are designated Trauma Team Providers
- Pediatric Liaison (ad hoc)
- Critical Care Liaison (ad hoc)
- Liaison alternates may also attend the Trauma Peer Review Committee.
- Invited Physician and Allied Health Providers involved in the delivery of care for the cases being presented for evaluation. (Invited Physicians and Allied Health Care Providers will be notified by confidential letter their case will be presented at least two weeks prior to the scheduled Trauma Peer Review Committee Meeting. They will also be notified via e-mail, when possible, that they should expect a notification letter in the mail.)

Trauma Performance Improvement Process: A process to measure, evaluate, and improve the quality and effectiveness of care rendered to the injured patient

Trauma Provider Certification: Approval of a physician or Allied Health Provider (AHP) as a member of the group of Trauma Providers based upon a review of the providers training and experience by the Trauma Medical Director. Physicians and Allied Health Personnel must also be credentialed through the hospital Medical Staff and are subject to Trauma Peer Review.

Trauma Service: the general surgery service assigned to take trauma call (TACSS), orthopedic surgery and hand surgeons (orthopedic or general surgeons who sub-specialize in hand surgery).

Trauma Team: A pre-determined group of care providers scheduled to be available for the emergency treatment and evaluation of critically injured patients. Members of the Trauma Team include the following members who are activated in a graded response based on pre-determined Trauma Alert Criteria:

- Emergency Department physician.
- General surgeon on call for trauma (or second call general surgeon).
- Orthopedic Surgeon on-call (when appropriate)
- Anesthesiologist on-call (when appropriate)
- Trauma Team Registered Nurse Lead
- Emergency Department Registered Nurses and Technicians.
- Radiology Technician.
- Phlebotomist.
- Pharmacist.
- R. N. House Supervisor
- Social Worker
- Chaplain

Trauma Working Group: Meets weekly or as needed to address current issues and functions at the fourth level of Trauma Peer Review. The Working Group is comprised of the Trauma Registrar, the Trauma Program Manager, the Trauma

Medical Director and the Vice-Chair of the Trauma Committee. The Chairs of the Emergency Medicine Department and the Department of Surgery may also attend.

Appendix F

Case Referral: Trauma Peer Review Committee to Medical Staff Peer Review Committee
Date of Referral: _____ Date of TPRC Review: _____
The Trauma Peer Review Committee has voted to refer the following case to you for review.
Medical Record # _____ Account # _____

Provider # _____ Date of Admission or incident: _____

Brief Summary of Case:

Concerns of the Trauma Peer Review Committee:
1.

2.
3.
4.
5.

Once the review of the PRC has been completed and the case closed please provide a written summary to the Trauma Medical Director for loop closure. Should the judgment of the Peer Review Committee or Medial Executive Committee be disciplinary action, referral to the Physician Well Being Committee or suspension of privileges this action may be recorded on the referral form as “appropriate action taken” to ensure strict confidentiality regarding any possible peer review issues.
Thank you for your evaluation of this case.
Sincerely,

Rebecca Zulim, M.D.
Trauma Medical Director

Trauma Peer Review and Trauma Performance Improvement (TPTIP)
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"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 57 Guidelines for Privacy Violations

Kaweah Health
MORE THAN MEDICINE. LIFE.

Medical Staff Services

Policy Number: MS 57	Date Created: 06/29/2022
Document Owner: Teresa Boyce (Director of Medical Staff Services)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Medical Executive Committee, Teresa Boyce (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 Health 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 ("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 Privacy Policies.

All Medical Staff members are required to comply with these privacy and security laws and the Privacy Policies and to immediately report suspected or known violations to 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 Privacy Policies, provided the member believes in good faith that the practice was unlawful and/or a violation of the 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 Health 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 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 Privacy Policies must immediately report the occurrence to the VP & Chief Compliance and Risk Officer or designee. The 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 Privacy Policies. Following completion of the investigation, 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 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.

"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."

PATIENT EXPERIENCE AND SATISFACTION UPDATE

Patient & Community Experience

Board of Directors
November 2026



kaweahhealth.org

Kaweah Health
MORE THAN MEDICINE. LIFE.

PX Patient Experience Matters

Opportunities and insights to increase patient satisfaction.

Kaweah Health

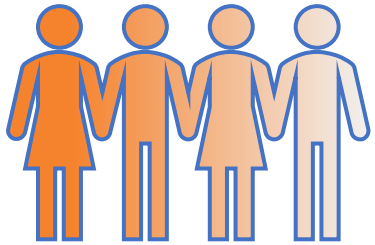
October 2026

Fiscal Year Data	NRC survey results reflect July – September 2026	Operational data (Midas, Rounding) reflect October 2026

Survey Scores



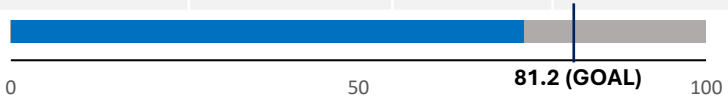
HCAHPS:
Would Recommend Hospital
76.0
66th Percentile



Overall Organization NPS:
Would Recommend Facility
73.7
17th Percentile

FY27 Organizational Goal Status

Goal Measure	Current Score (Percentile)	FY27 Goal	Status
NPS: Would Recommend	73.7 (17th Percentile)	81.2	↓ 7.5 points below goal



October 2026 Operational Data

Midas Opened	PX Inpatient Rounds	PX ED Rounds	Leader Rounds
78	200	349	2,138

Service Alerts

Closed	Open
185	339

Human Understanding

76.3
12th Percentile

Priority

Received Consistent Information

Keep patients on the same page. Communicate changes in care plans with the team and make sure patients receive clear, consistent information throughout their visit.

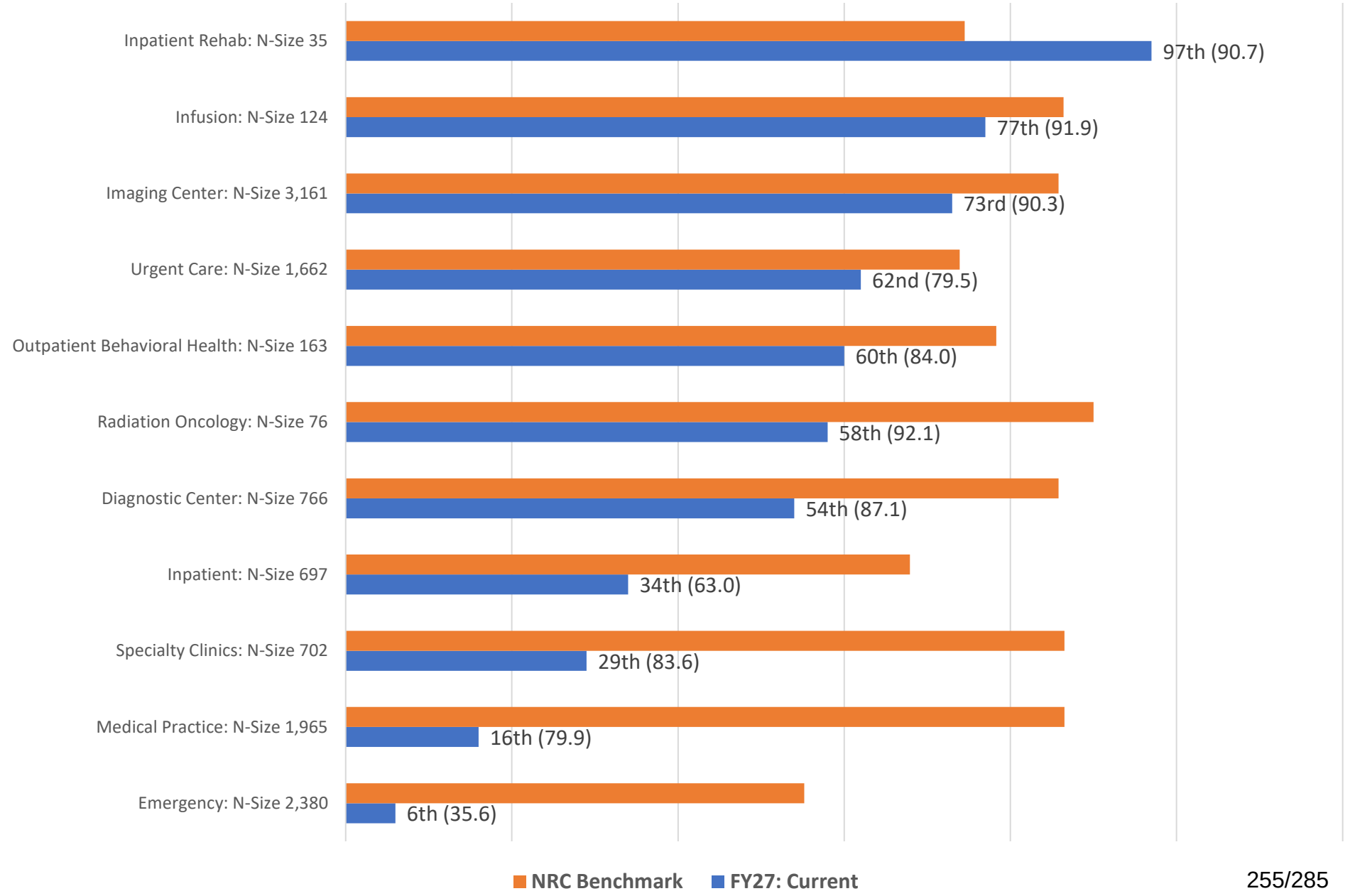
Informed of Delays

Don't leave patients wondering. Provide updates when delays occur, explain what is causing the wait when possible, and let patients know what to expect next.

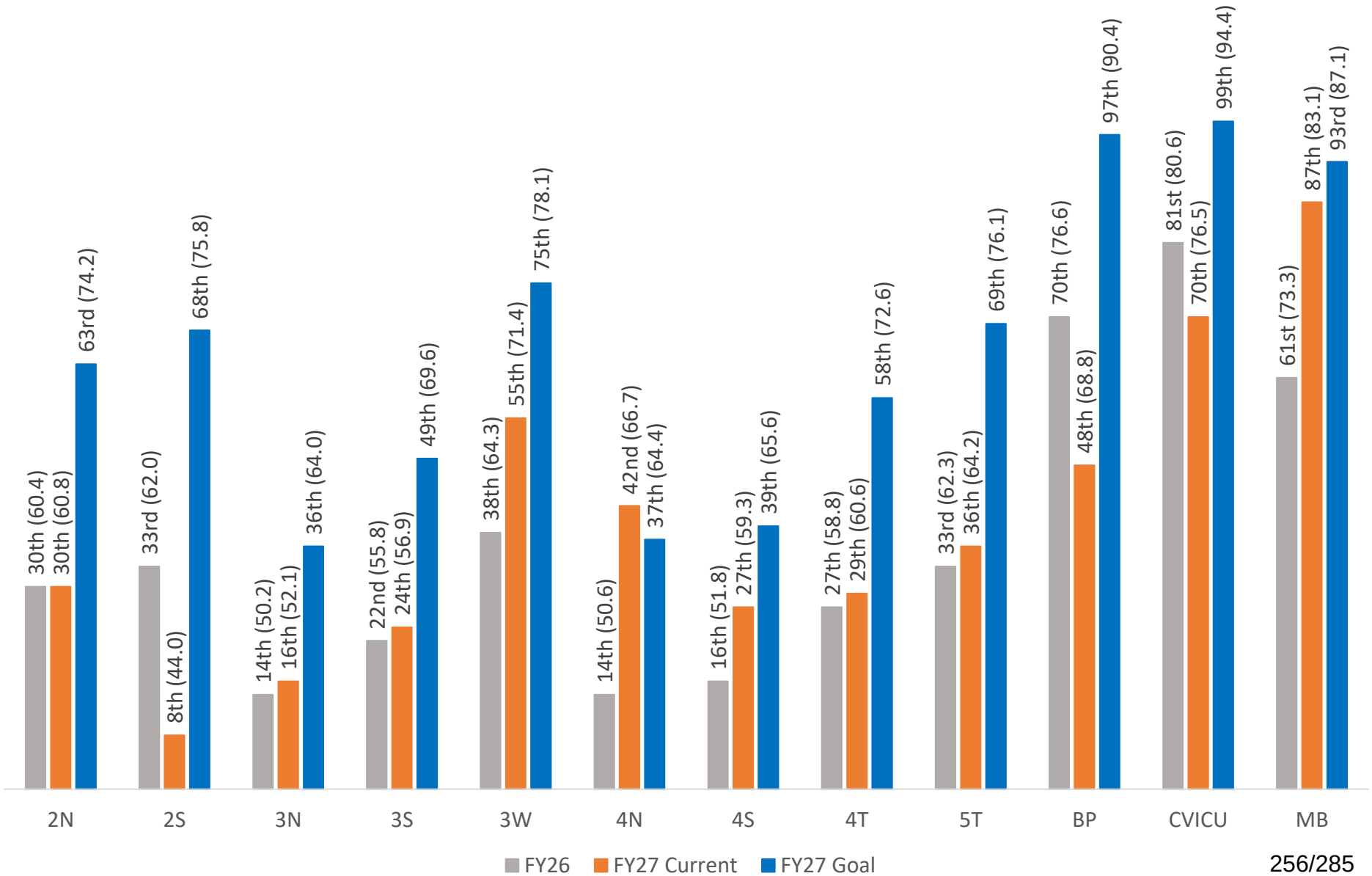
Safety Was a Priority

Show patients that safety comes first. Explain safety measures before providing care, encourage patients to speak up about concerns, and address those concerns promptly.

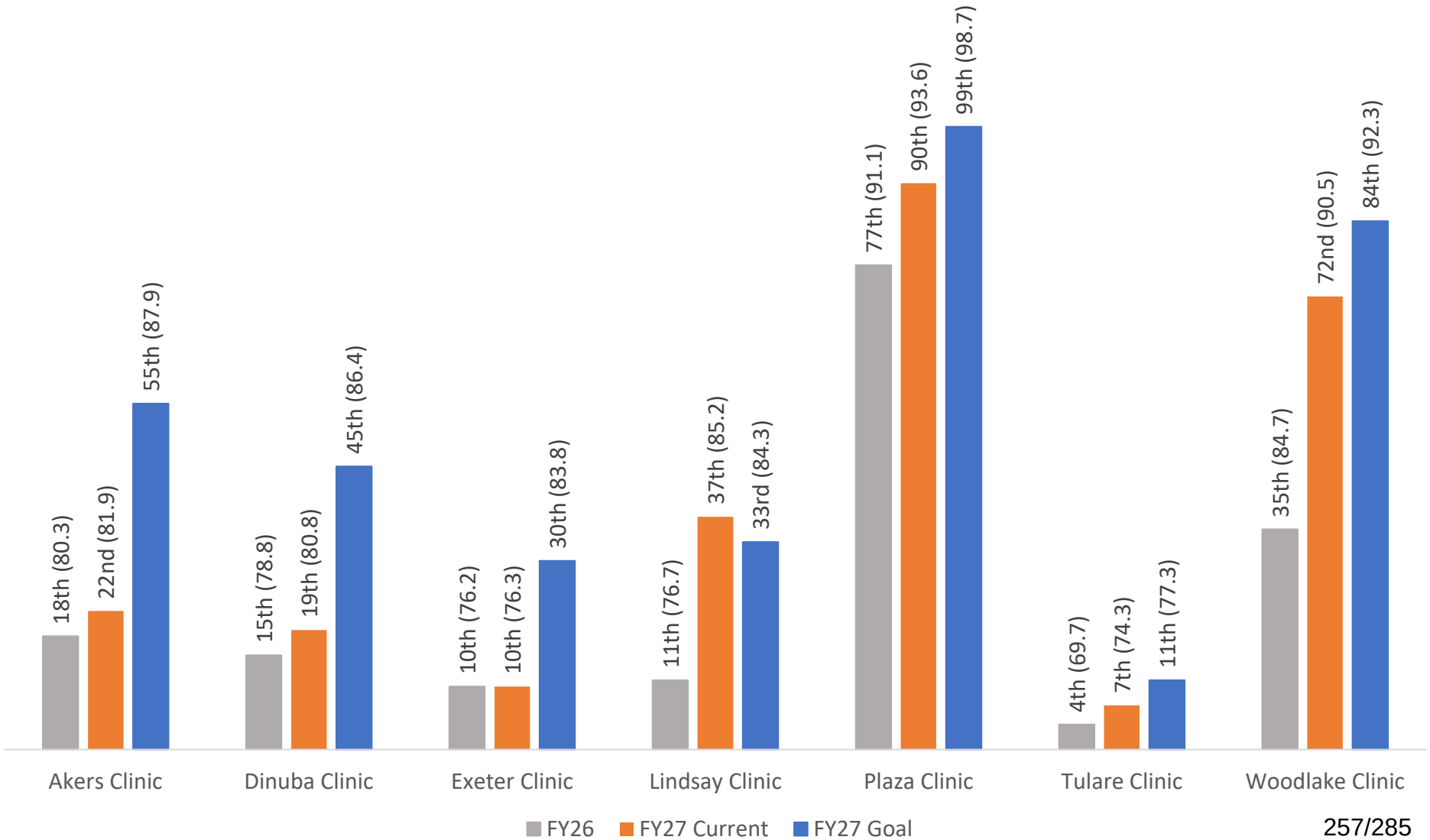
NPS By Service Line: July – September 2026



Inpatient Unit's Current Score: July - September 2026

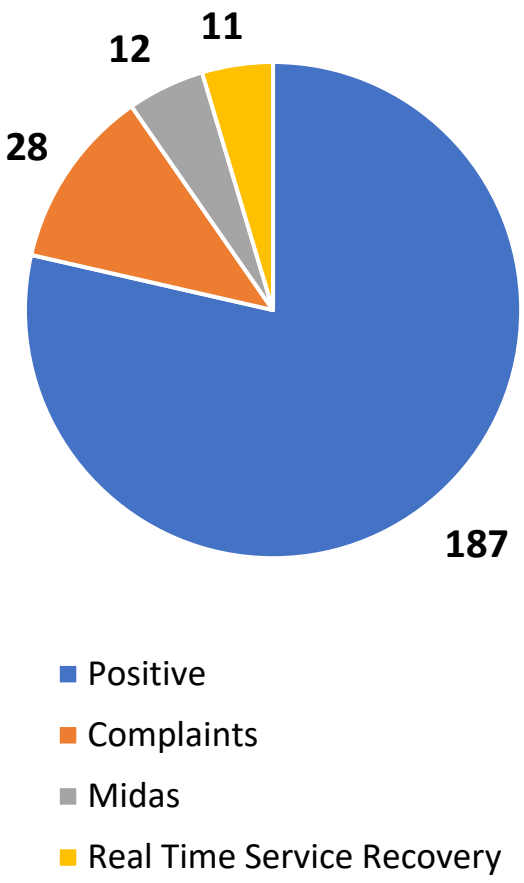


Outpatient Medical Practice Current Score: July - September 2026



PX Rounding: October

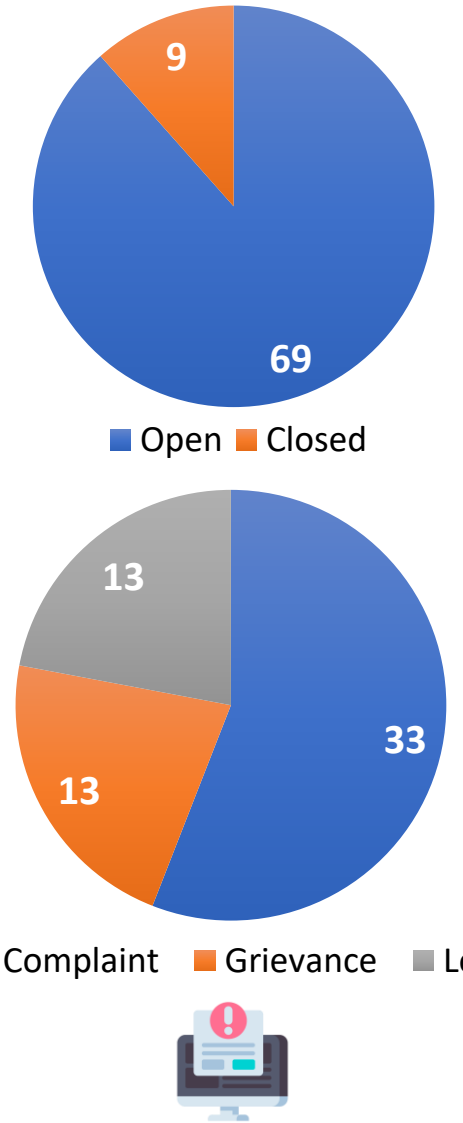
200 Rounds





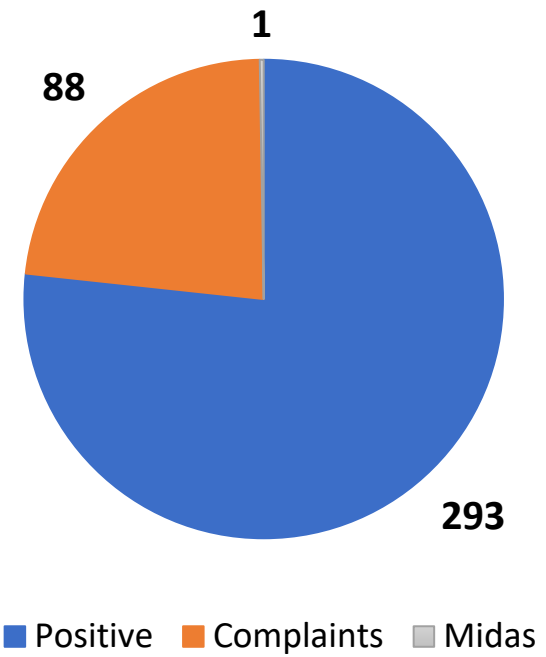
MIDAS: October

78 Opened



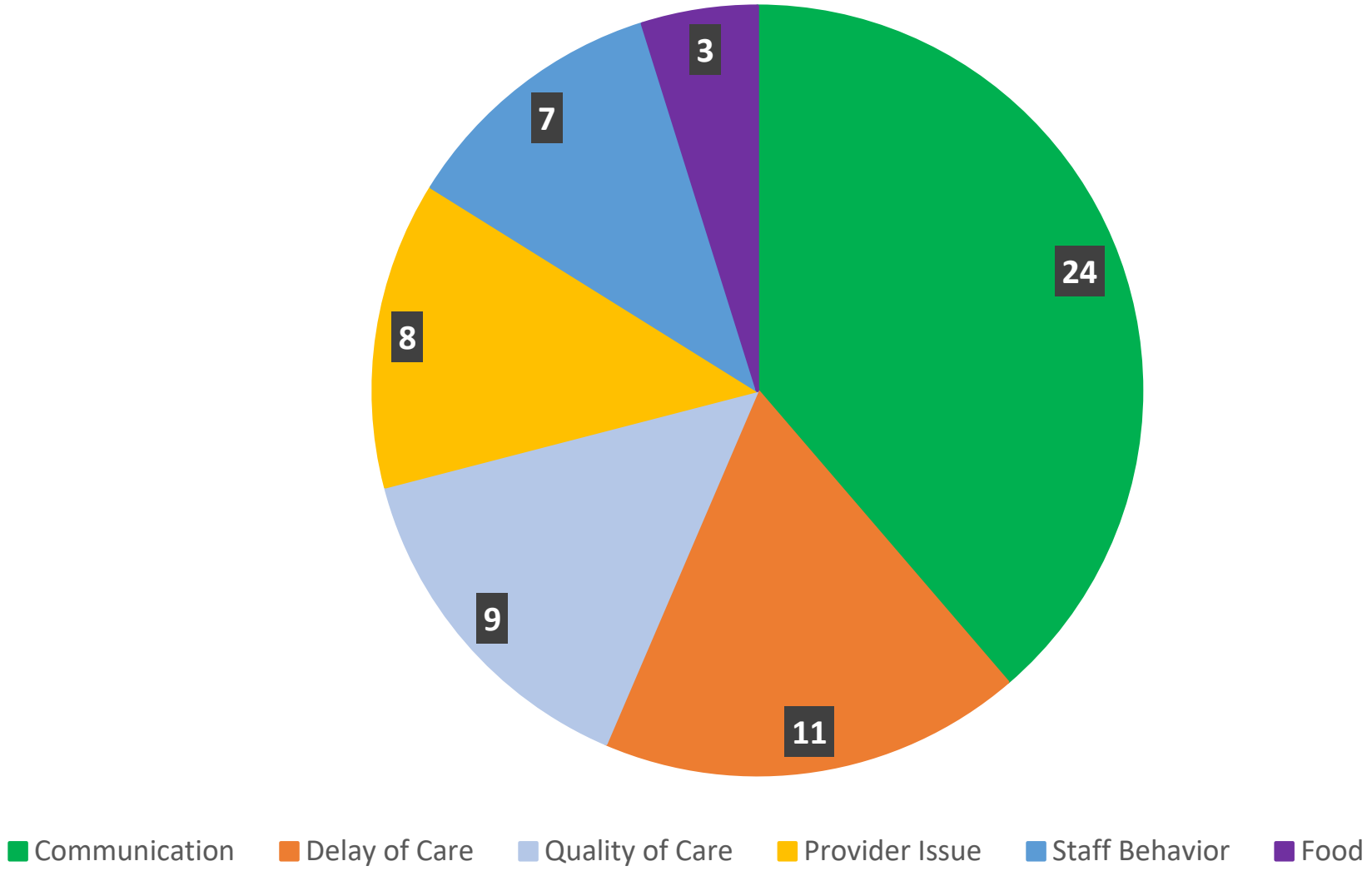
ED Rounding: October

349 Rounds

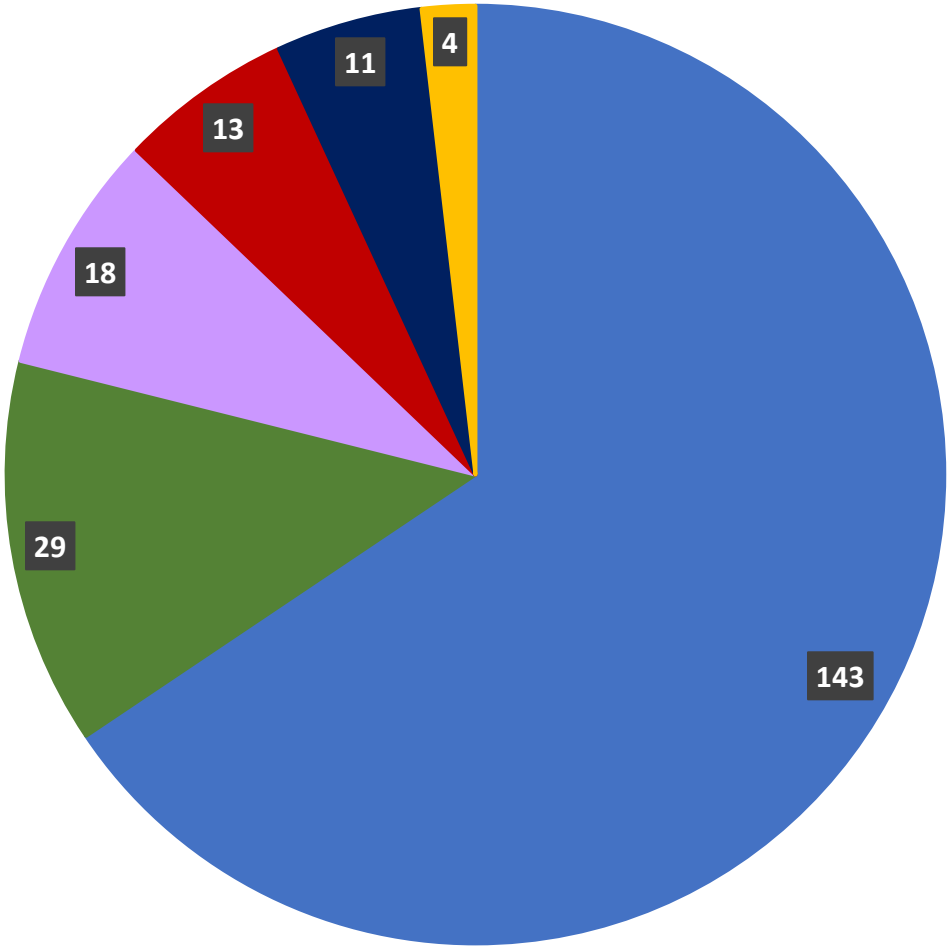




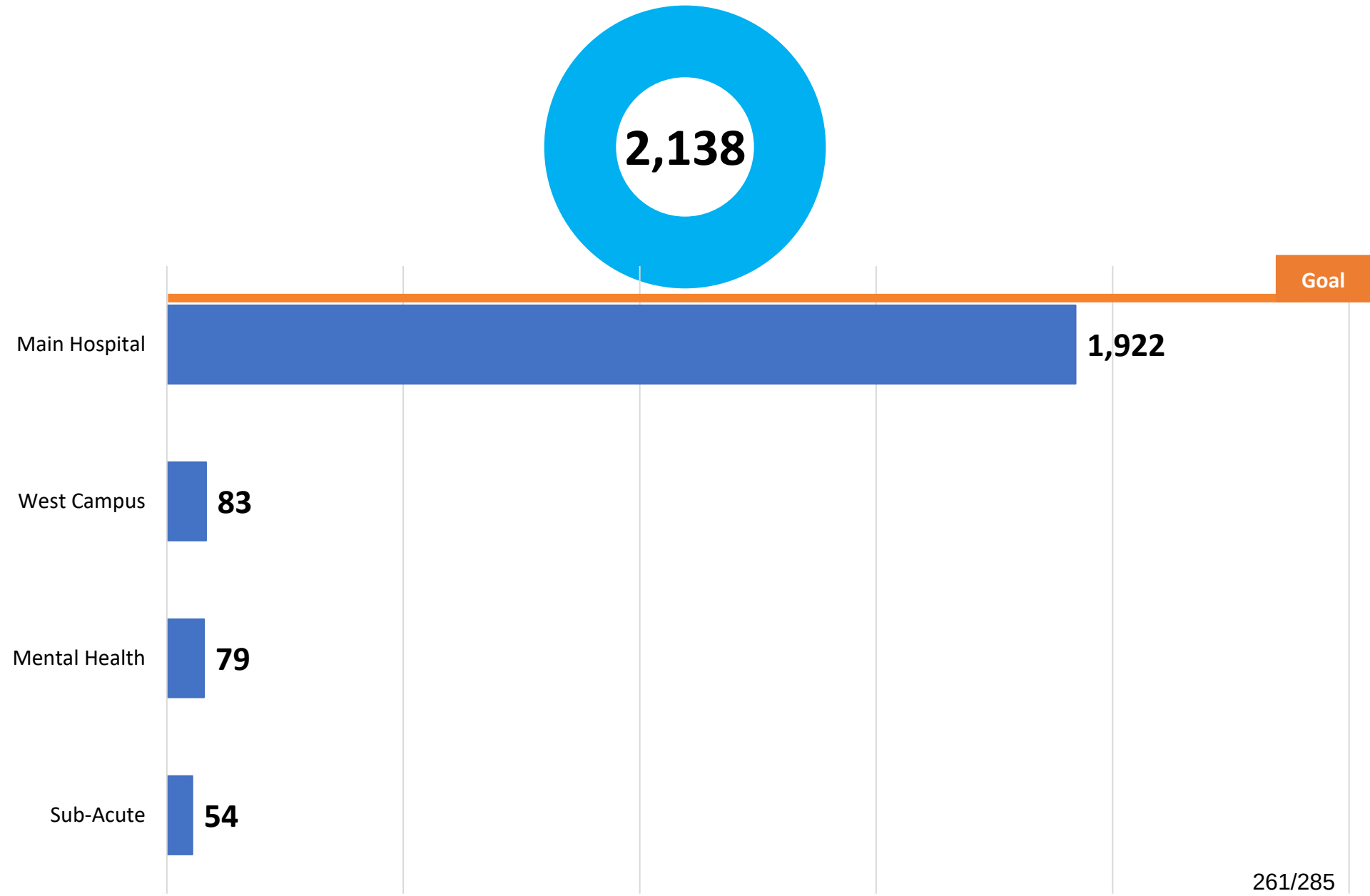
PX Patient Rounding Complaints Breakdown: October 2026



ED Patient Rounding Complaints Breakdown: October 2026



Leader Rounds: October 2026



Executive Rounding - October

Executive Team Rounds = 10 executive rounds

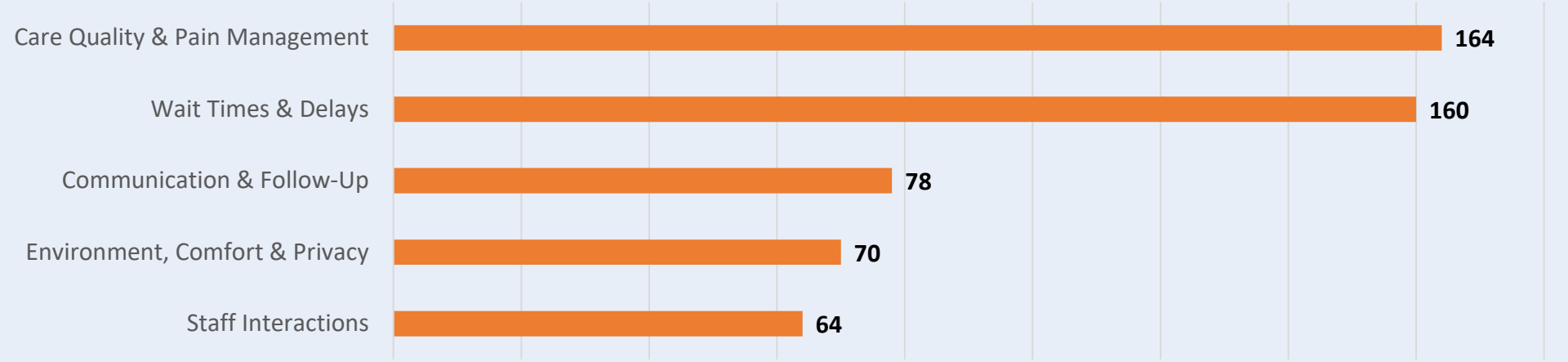
Executive	NOV	DEC	JAN	FEB	MAR	APR	May	June	July	AUG	SEP	OCT
CEO/Marc Mertz.	11/4, 11/20	12/3, 12/23	1/12	Cancelled JC	3/25	4/23	5/11	6/23	7/28	8/27	9/10, 9/30	10/8, 10/20
Jag B.	11/12	12/10	1/13	Cancelled JC	3/19	4/8	5/7	Cancelled	7/14	8/28	9/22	10/28
Dianne C.	11/11	12/15	1/8	2/4	3/5	4/22	5/28	6/25		8/26	9/29	10/30
Jewel C.										8/25		10/23
Ben C.	11/24	12/18	1/22	Cancelled JC	Cancelled by PX	4/22	5/21	6/16	7/23	8/11	9/24	10/22
Paul S.		12/2	1/28	18-Feb	3-Mar	4/15	5/19	6/11	7/22	8/17	9/3	10/7
Kevin Morrison						4/30	5/29	6/15	7/1	8/4	9/15	10/29
Board of Directors				2/9 (MO)	3/2 (AM)	4/16 (DF)	5/11 (MO)	6/4 (DL)	N/A	N/A	9/21 (AM)	
Luke Schneider							5/4	6/24	7/15	8/12	9/9	10/14
Max Heckhausen							5/5	6/2	7/8	8/19	9/23	10/13
Tom Boggs							5/20	6/29		8/18	9/17	

What Patients Are Telling Us

Feedback Management Data Analysis

September 2026

Top Reported Concerns



What Stands Out

ED wait times and uncertainty about next steps and recurring patient frustrations.	Patients want clearer communication about their care, results, and delays.	Courtesy, respect, and compassionate care continue to be recognized.

Opportunities for Improvement

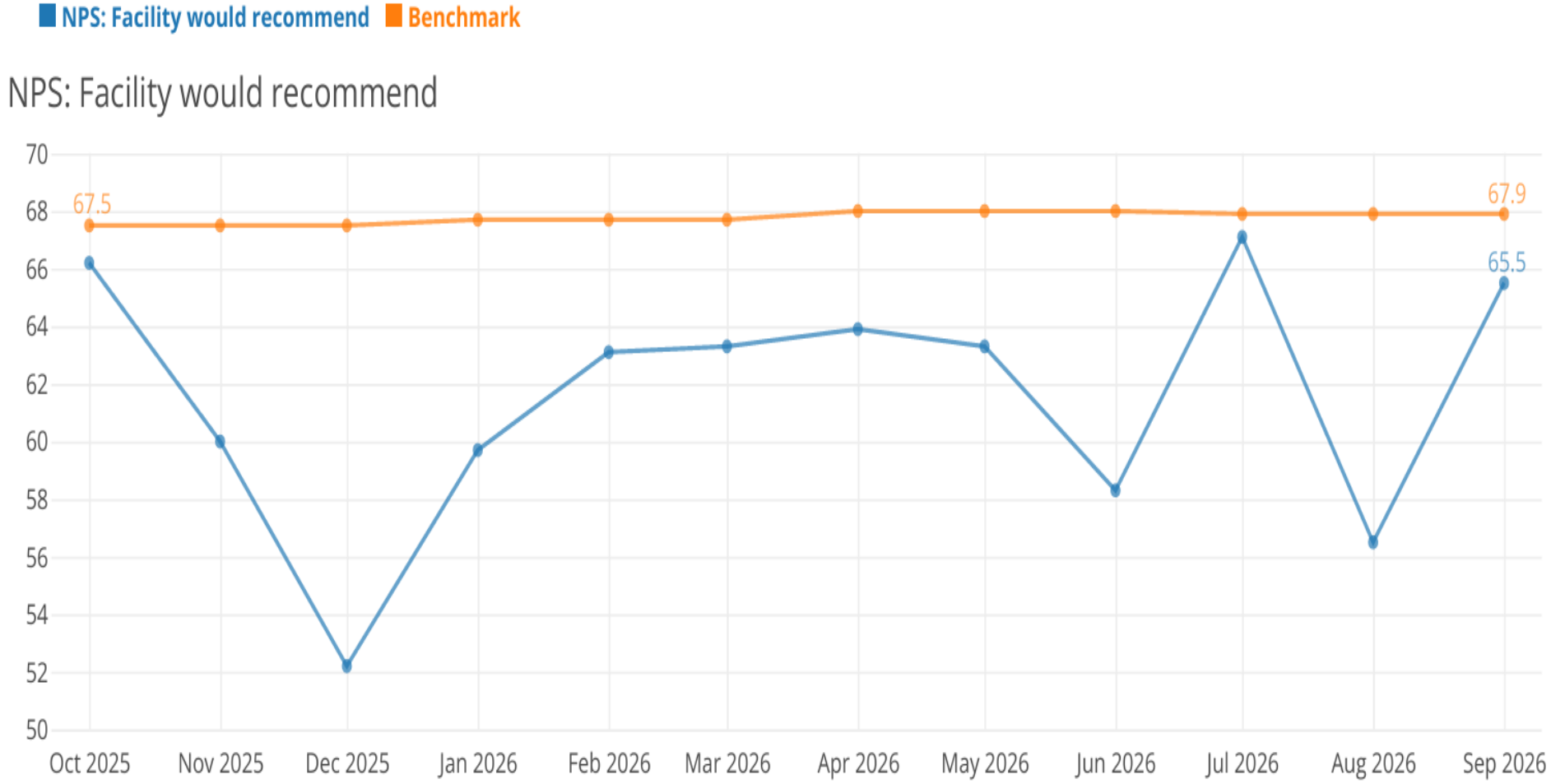
Proactive updates during delays | Clear explanations of next steps | Consistent acknowledgement of patient concerns

Appendix: Supporting Materials

- Trend Lines
  - Appendix A: Inpatient NPS
  - Appendix B: Medical Practice
  - Appendix C: Emergency Department
  - Appendix D: Human Understanding
- Scores
  - Outpatient Services
    - Appendix E: Center for Mental Wellness, Urgent Care, Specialty Outpatient Infusion
    - Appendix F: Imaging Center, Radiation Oncology, Diagnostic Center, Inpatient Rehab
- Appendix G: Midas / Lost Belongings
- Appendix H: Lost Belongings FY27 Totals

Appendix A

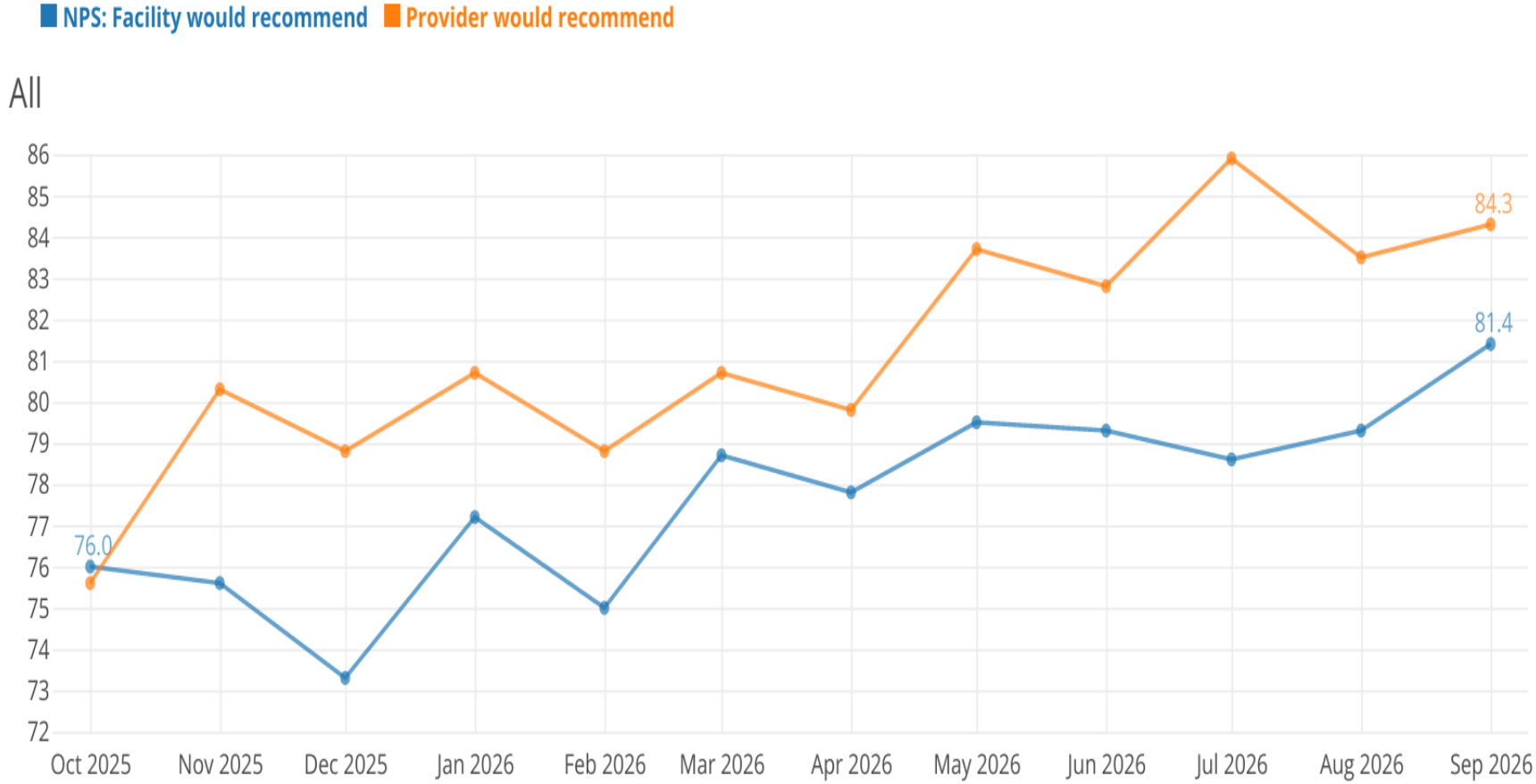
Inpatient: Last 12 Months



	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026	Jul 2026	Aug 2026	Sep 2026
uld	66.2	60.0	52.2	59.7	63.1	63.3	63.9	63.3	58.3	67.1	56.5	65.5
	n = 198	n = 220	n = 230	n = 233	n = 198	n = 221	n = 219	n = 245	n = 218	n = 237	n = 237	n = 223

Appendix B

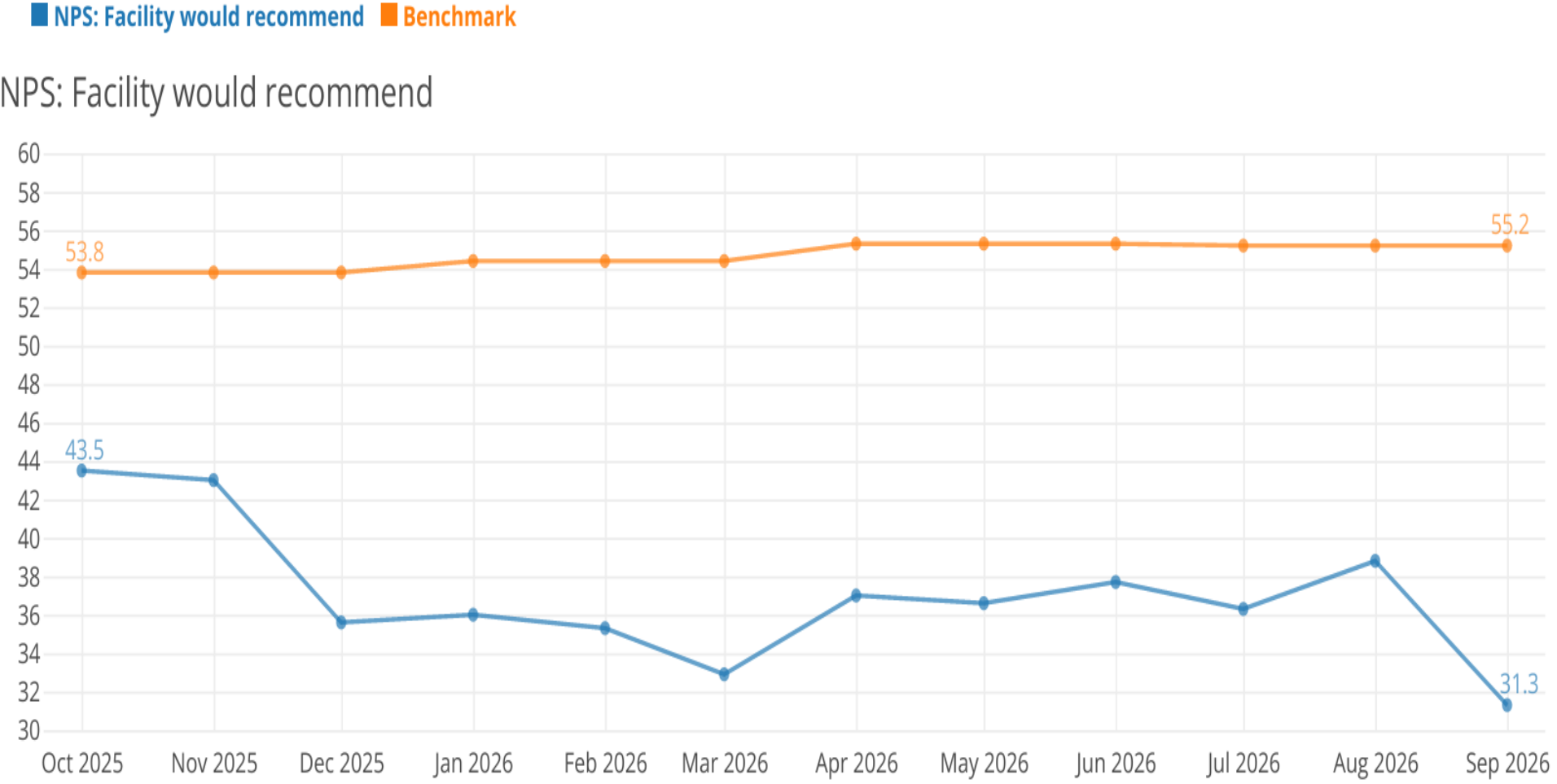
Outpatient Medical Practice: Last 12 Months



	Benchmark	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026	Jul 2026	Aug 2026	Sep 2026
NPS: Facility would recommend	86.5	76.0 n = 637	75.6 n = 537	73.3 n = 565	77.2 n = 689	75.0 n = 627	78.7 n = 609	77.8 n = 686	79.5 n = 657	79.3 n = 656	78.6 n = 524	79.3 n = 695	81.4 n = 746
Provider would recommend	88.1	75.6 n = 620	80.3 n = 529	78.8 n = 556	80.7 n = 673	78.8 n = 609	80.7 n = 596	79.8 n = 664	83.7 n = 645	82.8 n = 639	85.9 n = 510	83.5 n = 680	84.3 n = 725

Appendix C

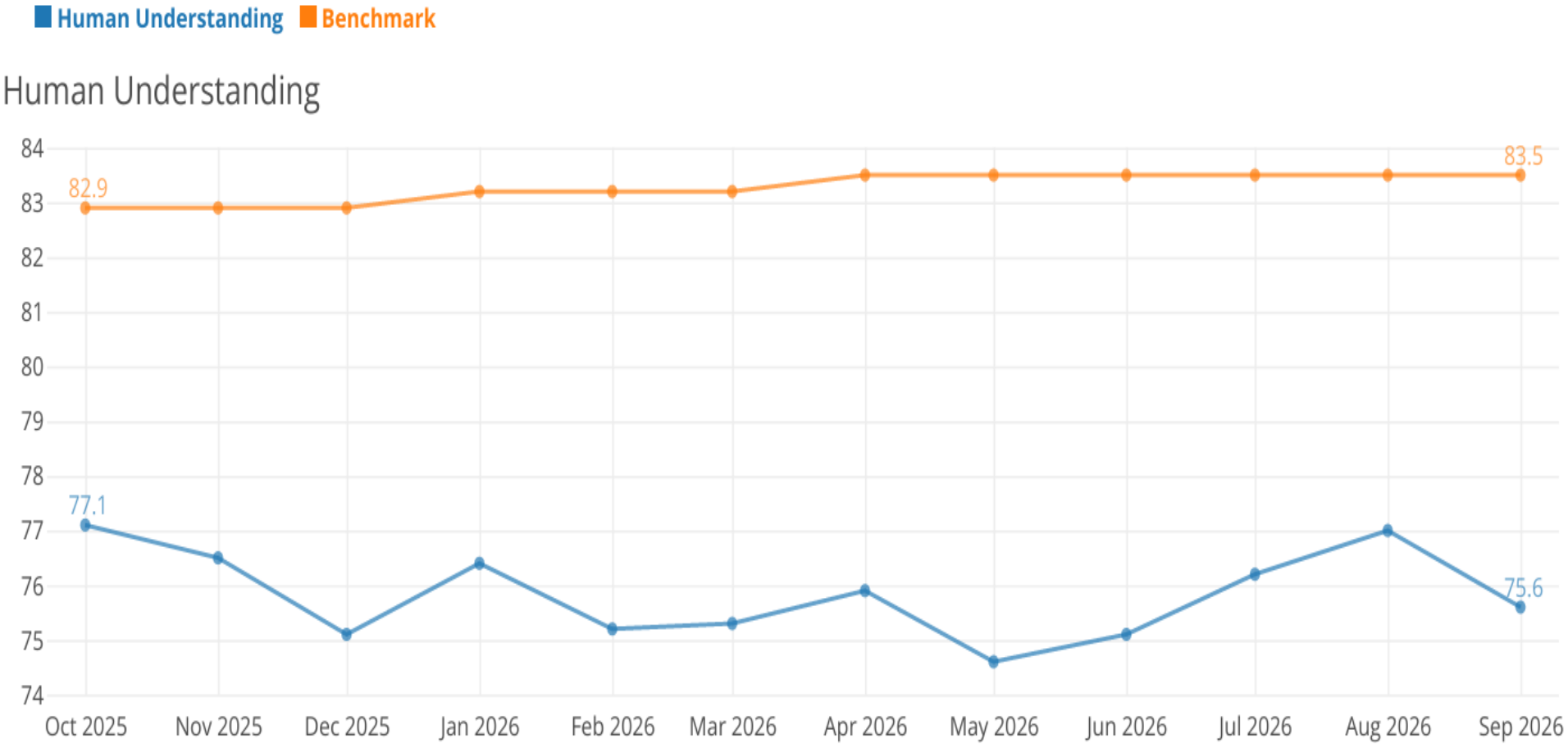
Emergency Department: Last 12 Months



	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026	Jul 2026	Aug 2026	Sep 2026
ld	43.5	43.0	35.6	36.0	35.3	32.9	37.0	36.6	37.7	36.3	38.8	31.3
	n = 710	n = 698	n = 758	n = 801	n = 750	n = 832	n = 789	n = 837	n = 803	n = 742	n = 882	n = 756

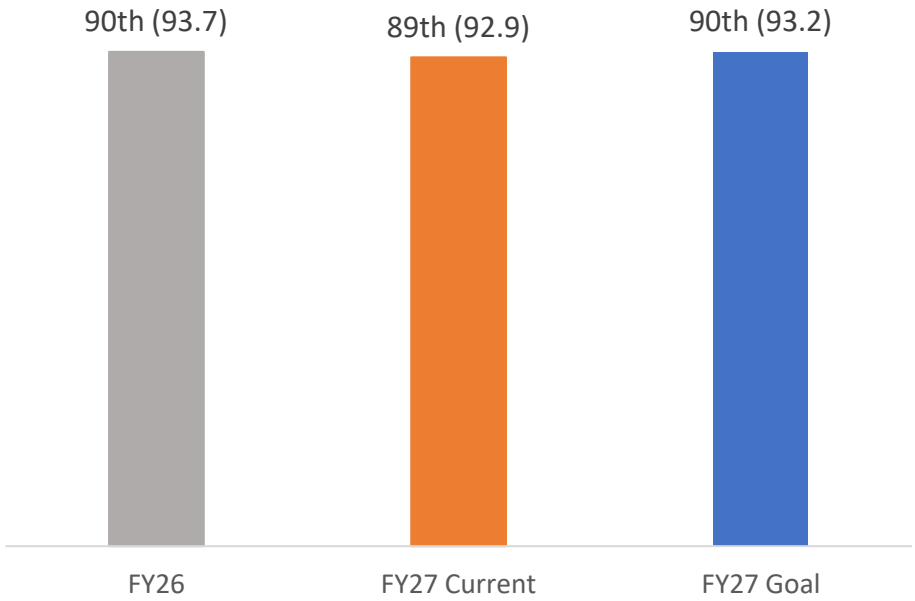
Appendix D

Human Understanding: Organization
Last 12 Months

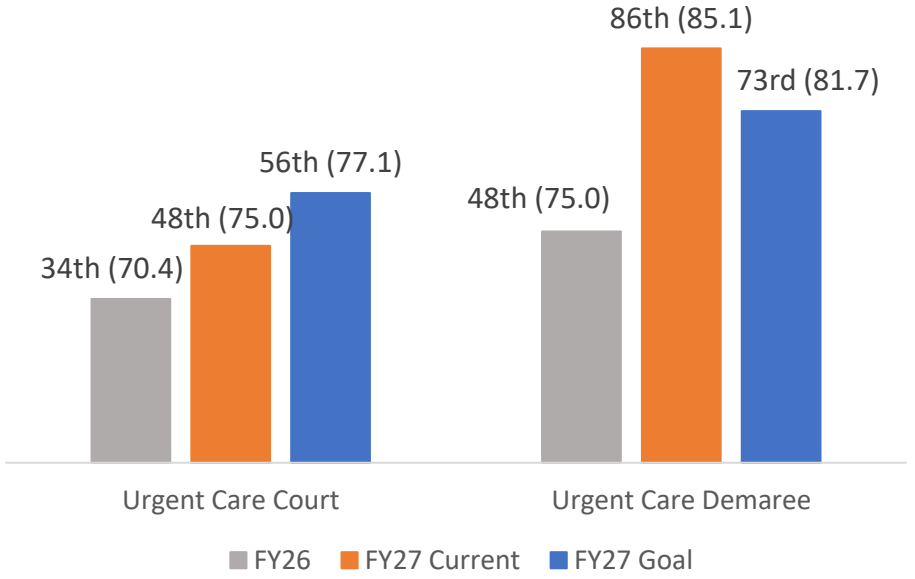


anding	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026	Jul 2026	Aug 2026	Sep 2026
	77.1	76.5	75.1	76.4	75.2	75.3	75.9	74.6	75.1	76.2	77.0	75.6
	n = 3,949	n = 3,380	n = 3,813	n = 4,188	n = 3,854	n = 4,208	n = 4,081	n = 4,066	n = 4,008	n = 3,948	n = 4,041	n =

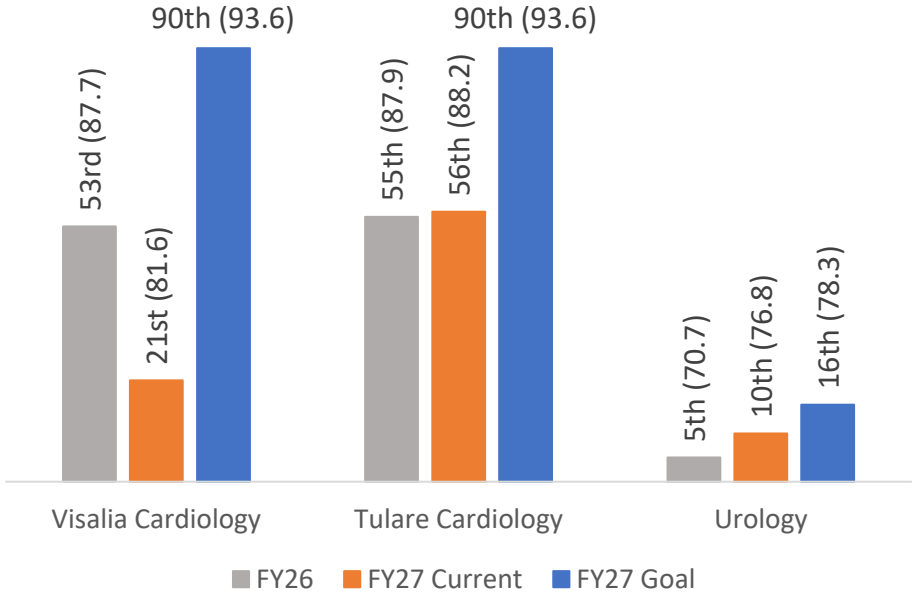
Appendix E Center for Mental Wellness



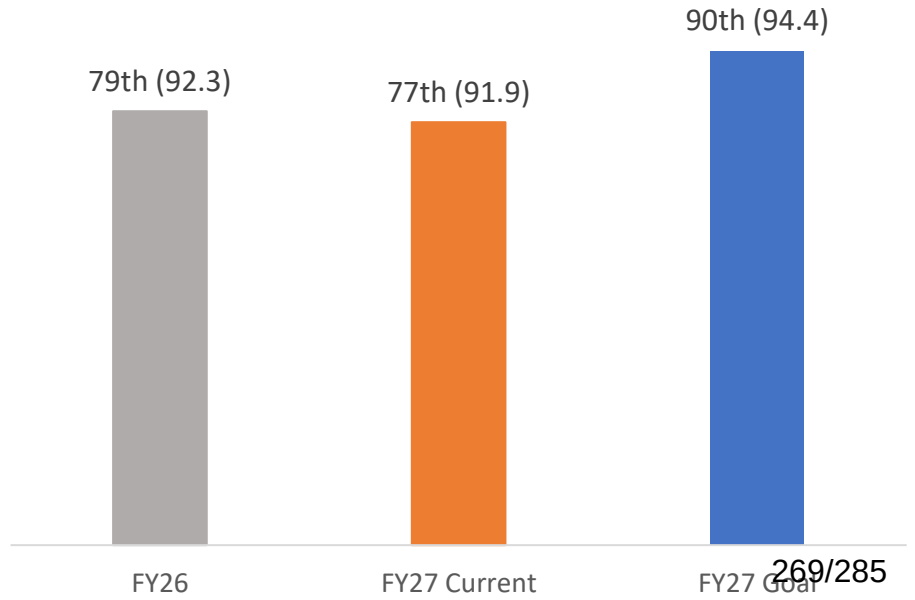
Urgent Care



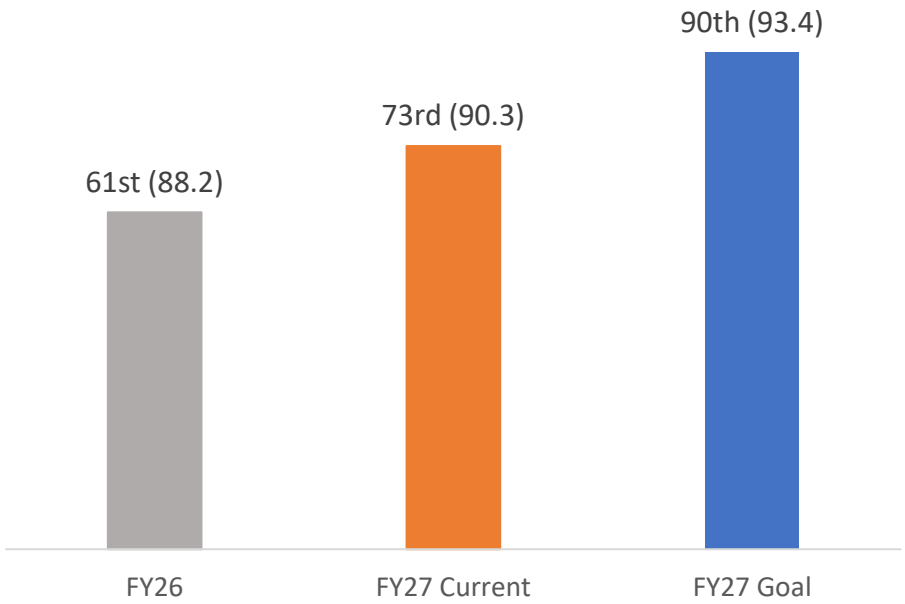
Specialty Clinics



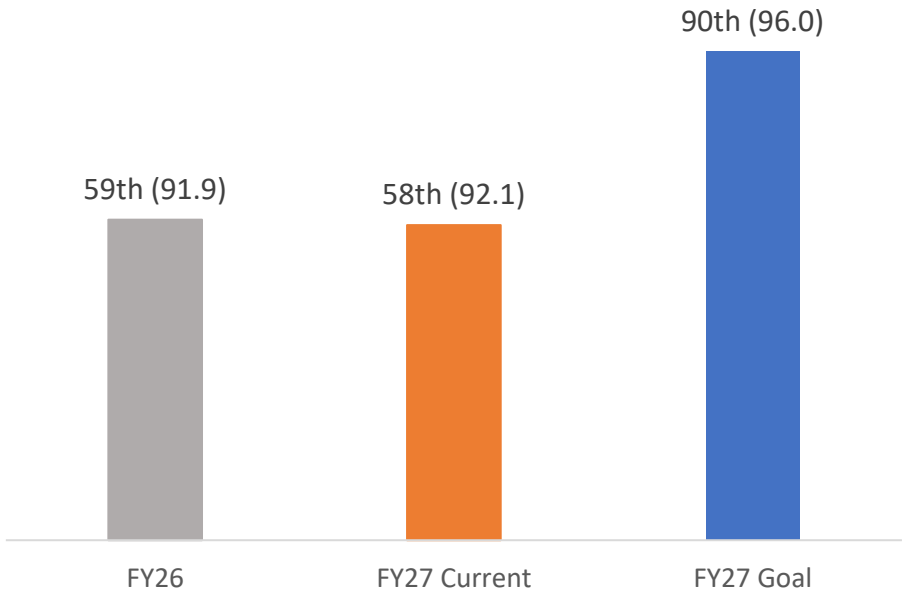
Outpatient Infusion



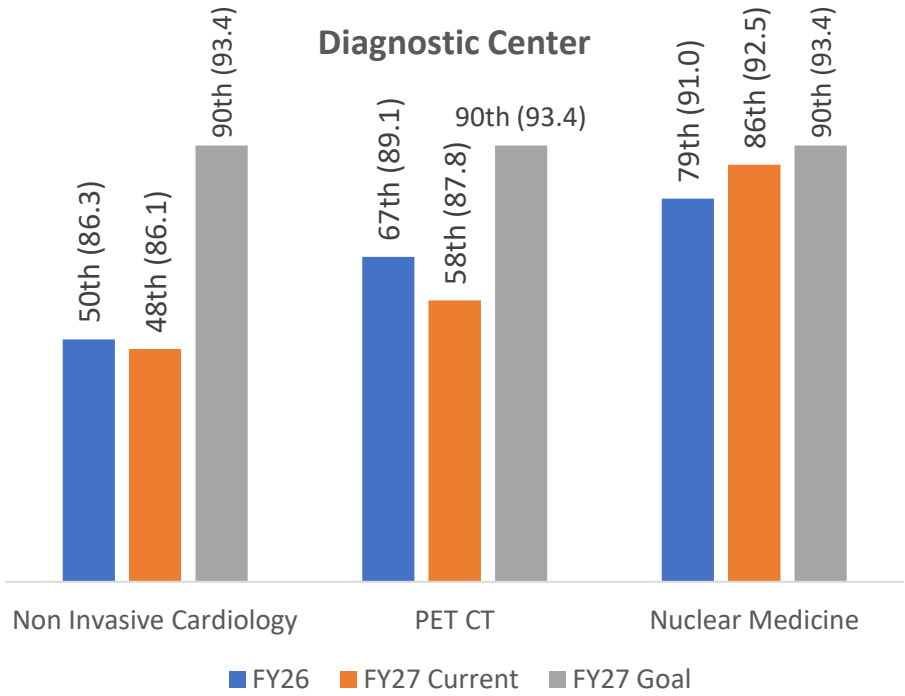
Imaging Center



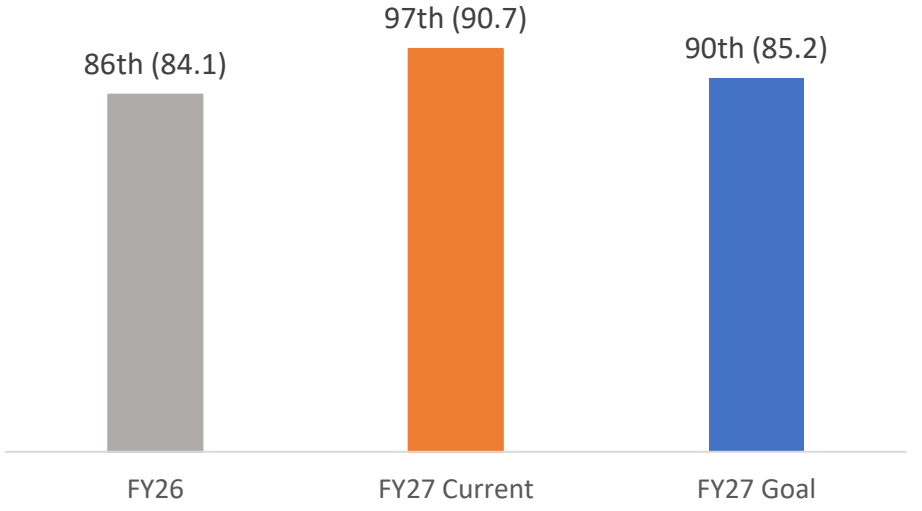
Radiation Oncology



Diagnostic Center



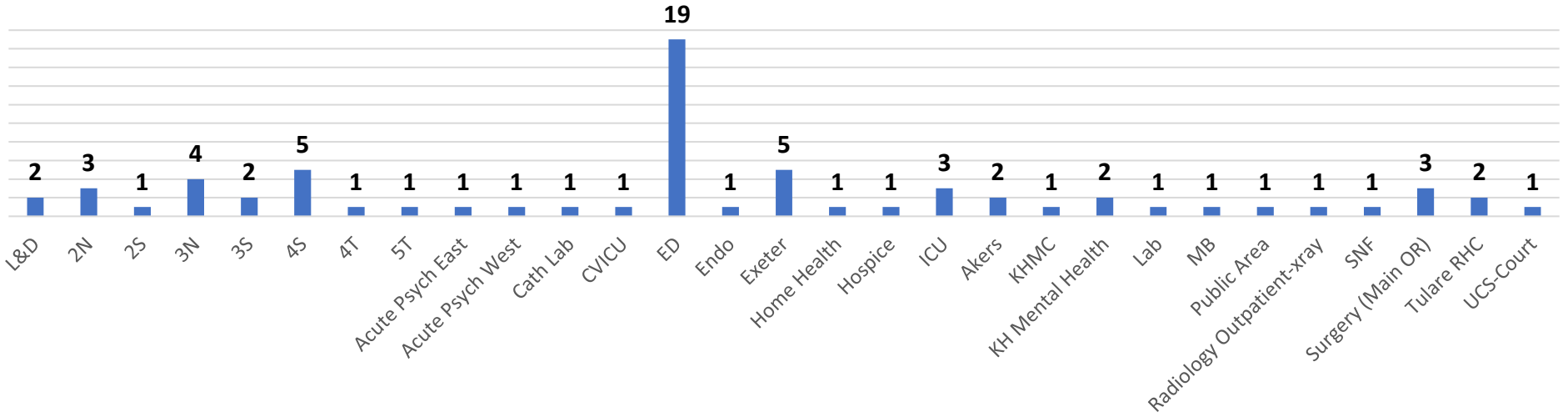
Inpatient Rehab



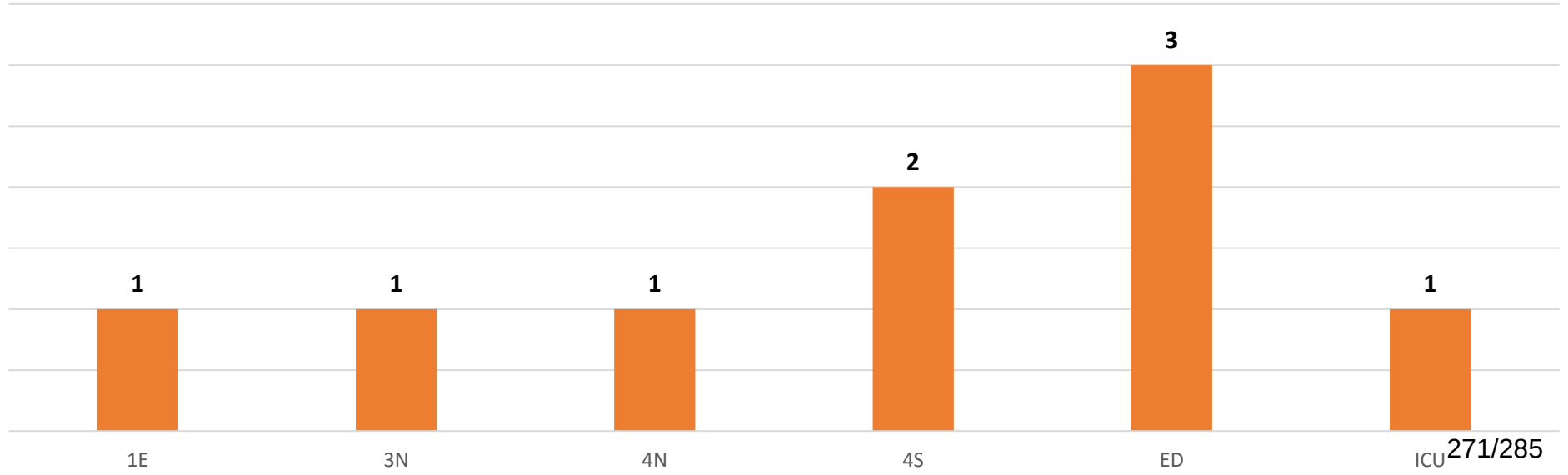
MIDAS: October 2026

78 Opened

Complaints & Grievances



Lost Belongings



Lost Belongings

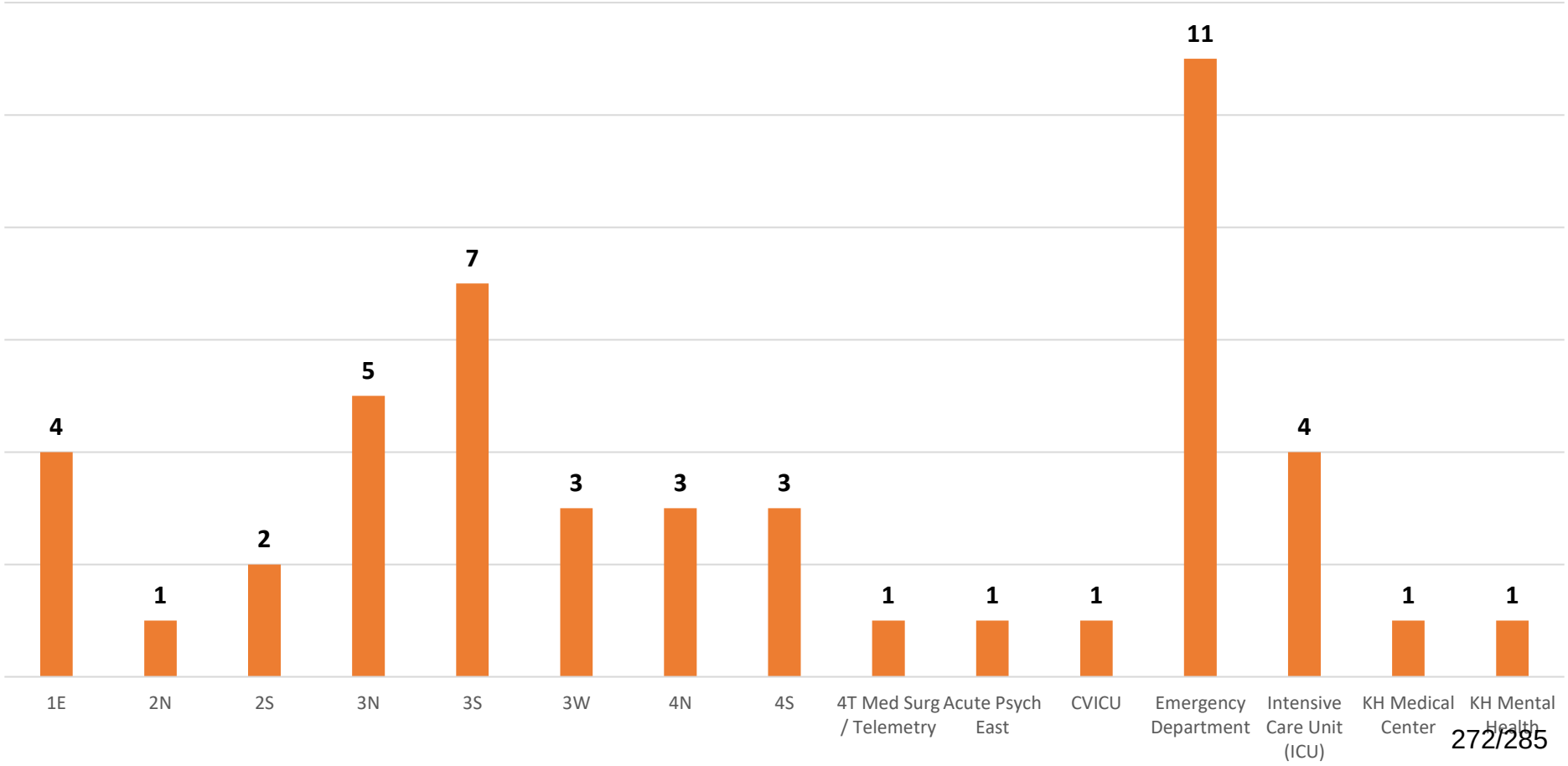
FY27: 7/1/2026 – 9/30/2026

Total Reported in Midas: 48

48
Total Cases

31
Closed

17
Remain Open



STRATEGIC OVERSIGHT (MONTHLY REPORT) – PHYSICAN ALIGNMENT

Physician Alignment

Board of Directors Meeting
November 18, 2026



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Strategy: Recruit Physicians and Advanced Practice Providers

Initiative: Physician Alignment

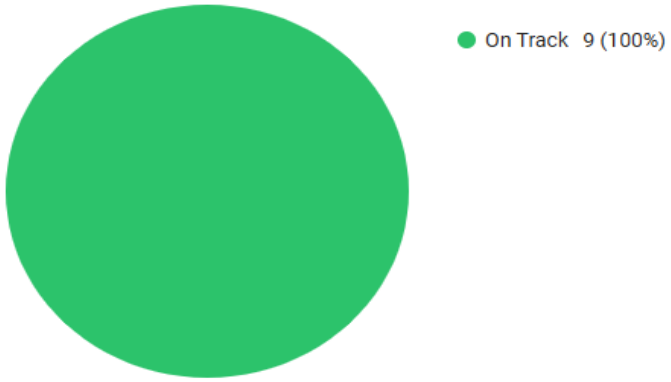
Strategy Owner: JC Palermo, Director of Physician Recruitment and Relations

Executive Sponsor: Tom Boggs, Chief Ambulatory Officer

November 2026

METRICS & OUTCOMES	ON TRACK	UPDATES	ON TRACK

Recruit Physicians and Advanced Practice Providers



Strategy Summary

Status	Last Update's Comment
On Track	**YTD Update** *Attended the UCSF Fresno career fair and held the FM coordinator meeting; discussions continue with promising residency candidates. *An LOI was delivered to an OB/GYN candidate through visa sponsorship discussions with Key Medical Group; acquisition conversations with two local physicians are progressing. *Recruited to date: 7 of 15 Specialty Providers, 3 of 5 Primary Care Physicians, 5.0 of 10 APP FTEs. *Review of the recruitment and onboarding process continues with internal stakeholders. **Next Steps** *Follow up with career fair candidates, schedule a presentation to UCSF residents, and pursue additional coordinator introductions and Dignity Health face time. *Continue active searches, including Family Medicine and Radiation Oncology, and support the Key Medical Group and Sunmed Health searches. *Advance the OB/GYN LOI and the acquisition conversations.

Recruit 15 Specialty Providers ...



Last updated on 10/31/2026

Move from baseline of 0 to target of 15

Recruit 10 Advanced Practice Providers ...



Last updated on 10/31/2026

Move from baseline of 0 to target of 10

Recruit 5 Primary Care Physicians ...



Last updated on 10/31/2026

Move from baseline of 0 to target of 5

Strategy: Value Based Care - Kaweah Health is Must Have Network

Initiative: Physician Alignment

Strategy Owner: Tom Boggs, Chief Ambulatory Officer

Executive Sponsor: Tom Boggs, Chief Ambulatory Officer

November 2026

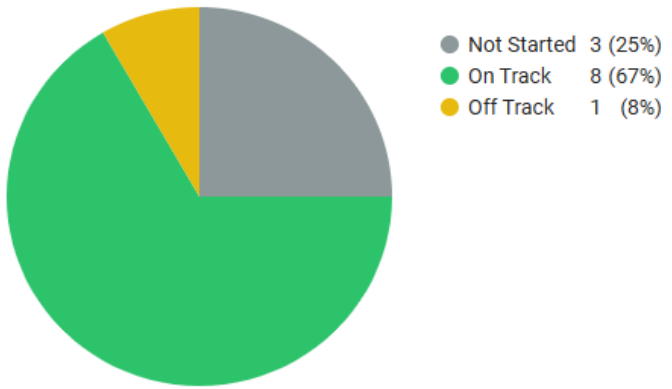
METRICS & OUTCOMES

ON TRACK

UPDATES

ON TRACK

Mature Value Based Care Capabilities to position Kaweah Health as the Must Have Network



Strategy Summary

Status	Last Update's Comment
On Track	**YTD Update (NOTE Data is lagged due to claims-based measures.)** * QIP (Medi-Cal) tracking to earn 100% full achievement. * Dedicated teams formed to focus on Annual Wellness Visits (AWVs) and Quality (Gaps in Care / Stars) execution, with performance beating prior year. * Contract for Oracle tools to support accurate documentation & patient orchestration. **Next Steps** * Develop Annual Quality Workplan for Pop Health Committee Approval * Execute 4th Quarter Quality Push for Year-End Quality Gap Closure * Tactics to improve Care Continuity in partnership with Key & Kaweah

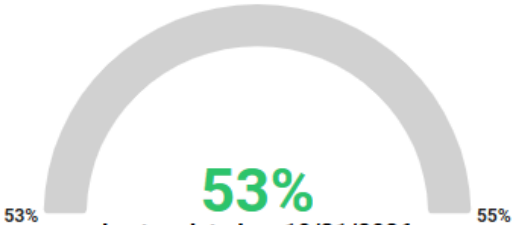
Perform on Seven or more QIP measures for calendar year 2026



Last updated on 10/31/2026

Stay above baseline of 0

Increase domestic spend (Sequoia Health Plan Capitation) to 55% (2% increase)



Last updated on 10/31/2026

Move from baseline of 53% to target of 55%

Strategy: Journey to Top Decile Ambulatory Clinic Performance

Initiative: Physician Alignment

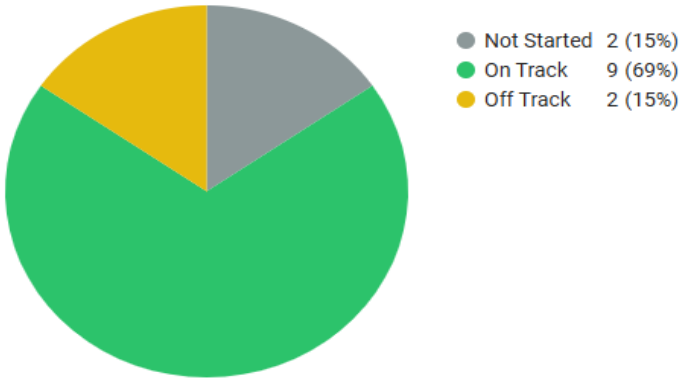
Strategy Owner: Tom Boggs, Chief Ambulatory Officer

Executive Sponsor: Tom Boggs, Chief Ambulatory Officer

November 2026

METRICS & OUTCOMES	ON TRACK	UPDATES	ON TRACK

Journey to Top Decile Ambulatory Clinic Performa...



Strategy Summary

Status	Last Update's Comment
On Track	**YTD Update** * Patient Experience: RECORD-HIGH NPS LIkelihood to Recommend at 86.7 in Oct * Access to Care: Substantial YoY improvements driven by provider recruitment, template standardization, call center abandonment rate 3% & 400K+ “patient touches” * Level 3 (the highest) Patient Centered Medical Home (PCMH) awarded by NCQA **Next Steps** * Sustain Patient Satisfaction and Access improvements * Complete Physician Productivity Benchmarks

"Likelihood to Recommend"at or above the median for NPS



Last updated on 10/31/2026

Move from baseline of 76.9% to target of 80.9%

Third next available PCP appointment within 7 business days



Last updated on 10/31/2026

Move from baseline of 29 to target of 7

Align staff FTEs per 10,000 WRVUs to MGMA standards

Not Started

Start Date: 1/1/2027

QUALITY REPORT (MONTHLY REPORT)– VALUE BASED PURCHASING

Value Based Purchasing

QComm Report
November 2026



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CMS Hospital Value-Based Purchasing (VBP) Estimated Financial Impact – Kaweah Health

FY 2025 and FY 2026 Compared to Estimated FY 2027 Performance

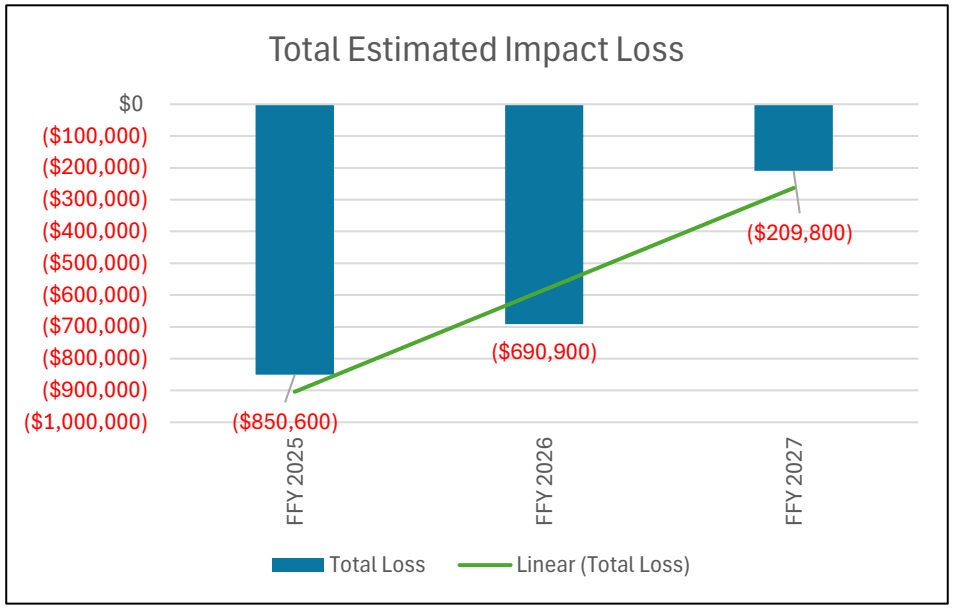
Domain (25% weight each)	FY 2025 Impact	FY 2026 Impact	FY 2027 Estimated Impact
Person & Community Engagement HCAHPS and communication measures	($185,700)	($169,200)	($140,500)
Clinical Outcomes Mortality, complications, readmissions	($221,600)	($197,400)	($146,700)
Safety HAIs, CAUTI, CDI, CLABSI, MRSA, SSI	($42,100)	$84,600	$199,400
Efficiency Medicare spending per beneficiary (MSPB)	($401,200)	($408,900)	($122,000)
Total Estimated Impact	($850,600)	($690,900)	($209,800)

This analysis is intended to provide hospitals with a preview of the potential impact of the FFY 2027 Medicare inpatient hospital VBP program based on currently available quality data and program rules established by CMS.

kaweahhealth.org

Where we have been: FY 2025 to FY 2027 (estimated)

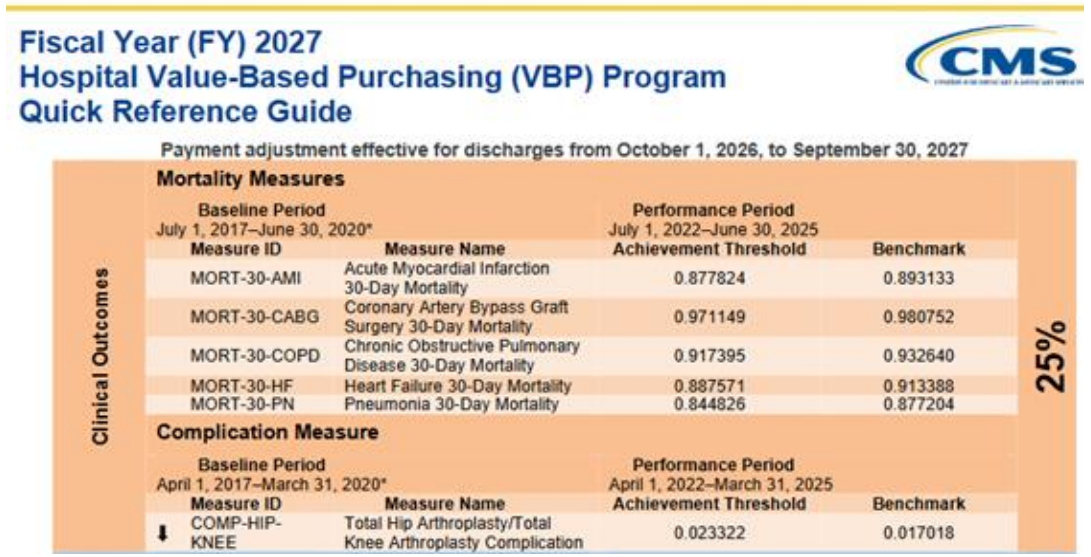
- Estimated net loss down about 75%, from $850,600 to $209,800
- Safety moved from a loss to a gain; Engagement and Clinical Outcomes are now the largest remaining losses
- **These scored periods are closed.** Today's performance drives FY 2028 and beyond (next slide).



Federal Fiscal Year 2027: Oct. 1, 2026 to Sept. 30, 2027
Federal Fiscal Year 2026: Oct. 1, 2025 to Sept. 30, 2026
Federal Fiscal Year 2025: Oct. 1, 2024 to Sept. 30, 2025

Kaweah Health
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Clinical Outcomes



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Clinical Outcomes — 25%

Mortality Measures

Baseline Period July 1, 2017–June 30, 2020*		Performance Period July 1, 2022–June 30, 2025	
Measure ID	Measure Name	Achievement Threshold	Benchmark
MORT-30-AMI	Acute Myocardial Infarction 30-Day Mortality	0.877824	0.893133
MORT-30-CABG	Coronary Artery Bypass Graft Surgery 30-Day Mortality	0.971149	0.980752
MORT-30-COPD	Chronic Obstructive Pulmonary Disease 30-Day Mortality	0.917395	0.932640
MORT-30-HF	Heart Failure 30-Day Mortality	0.887571	0.913388
MORT-30-PN	Pneumonia 30-Day Mortality	0.844826	0.877204

Complication Measure

Baseline Period April 1, 2017–March 31, 2020*		Performance Period April 1, 2022–March 31, 2025	
Measure ID	Measure Name	Achievement Threshold	Benchmark
⬇ COMP-HIP-KNEE	Total Hip Arthroplasty/Total Knee Arthroplasty Complication	0.023322	0.017018

Measure	Current Performance	VBP FY 2027: Scored Period
Clinical Outcomes: 30-day mortality O/E (lower is better)	**Jan 26 to Oct 26 (CYTD)**	**April 22 to March 26**
AMI	0.582	0.881
CABG	0.261	0.986
COPD	0.745	0.896
Heart failure	0.249	0.852
Pneumonia	0.478	0.814
THA/TKA complication rate	0.909	0.0291

Initiatives

Cardiology Mortality and Morbidity Committee (MORT-30-AMI, HF, CABG)

- Medical Directors review cases; the physician involved presents the case to the committee.
- Committee identifies opportunities for improvement and evaluates process changes to improve care and outcomes.
- Committee partners with service lines to implement improvements and standardize best practices.

Sepsis care (MORT-30-PN)

- The pneumonia mortality cohort includes patients with a principal diagnosis of sepsis (not severe sepsis) and pneumonia present on admission; ED Code Sepsis work (see Safety) supports this measure.

Person and Community Engagement

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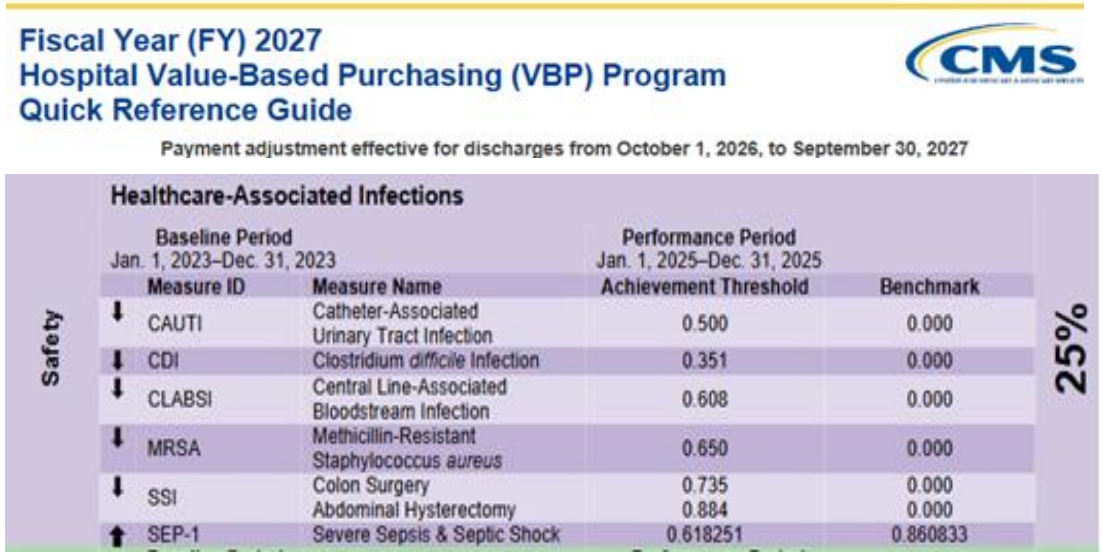
Person and Community Engagement	Baseline Period Jan. 1, 2023–Dec. 31, 2023		Performance Period Jan. 1, 2025–Dec. 31, 2025		25%
	HCAHPS Survey Dimensions*	Floor (%)	Achievement Threshold (%)	Benchmark (%)	
	Communication with Nurses	51.40	77.32	86.30	
	Communication with Doctors	51.59	77.53	86.29	
	Responsiveness of Hospital Staff	X	X	X	
	Communication about Medicines	35.92	58.08	70.11	
	Hospital Cleanliness and Quietness	38.41	63.37	77.73	
	Discharge Information	64.47	86.02	91.48	
	Care Transition	X	X	X	
	Overall Rating of Hospital	34.52	68.79	83.97	

Measure	Current Performance	VBP FY 2027: Scored Period
Person and Community Engagement: HCAHPS (higher is better)	**Jan 26 to Sept 26 (CYTD)**	**CY 2025**
Cleanliness	76.8%	54.1%*
Restfulness of hospital environment	66.5%	54.1%*
Communication about medicines	71.1%	58.1%
Communication with doctors	81.4%	75.6%
Communication with nurses	84.4%	73.1%
Discharge information	91.3%	85.9%
Overall rating of hospital	75.8%	65.2%

Initiatives

- Leaders are trained to access and interpret NRC feedback to support service recovery, identify trends, and drive improvement.
- Patient Experience partners with leaders to strengthen inpatient rounding: guidance on effective practices, quality of each round, and validation and reporting to administration.
- Education on Consistent Compassionate Communication using AIDET and HEARD.
- Five Community Engagement groups meet monthly, bringing community members and hospital leaders together to co-design care and services.

Safety



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Healthcare-Associated Infections

Safety — 25%

	Measure ID	Measure Name	Baseline Period Jan. 1, 2023–Dec. 31, 2023 Achievement Threshold	Performance Period Jan. 1, 2025–Dec. 31, 2025 Benchmark
⬇	CAUTI	Catheter-Associated Urinary Tract Infection	0.500	0.000
⬇	CDI	Clostridium difficile Infection	0.351	0.000
⬇	CLABSI	Central Line-Associated Bloodstream Infection	0.608	0.000
⬇	MRSA	Methicillin-Resistant Staphylococcus aureus	0.650	0.000
⬇	SSI	Colon Surgery Abdominal Hysterectomy	0.735 0.884	0.000 0.000
⬆	SEP-1	Severe Sepsis & Septic Shock	0.618251	0.860833

Measure	Current Performance	Scored Period (FY 2027)
Safety	**Jan 26 to Oct 26 (CYTD)**	**CY 2025**
SEP-1 sepsis bundle compliance (higher is better)	76.2%	76.8%
CAUTI - Catheter-Associated Urinary Tract Infection (lower is better)	1.087	0.631
CDIF - Clostridium *Difficile* Infection (lower is better)	1.316	0.423
CLABSI - Central Line-Associated Bloodstream Infection (lower is better)	1.781	0.805
MRSA - Methicillin-Resistant Staphylococcus *aureus* (lower is better)	0	0.875
SSI – Colon Surgery (lower is better)	0.578	0.414
SSI – Abdominal Hysterectomy (lower is better)	2.56	N/A**

Initiatives

Sepsis (SEP-1)
- Completed ED Code Sepsis Project with a dedicated two-bed sepsis room (ED Zone 5, Room 45).
- Physician leadership for sepsis oversight established with Dr. Tu and the ED Chief Resident.

CAUTI
- Nurse-driven protocol and bladder management policies updated to narrow indwelling catheter indications.
- Daily review of indwelling urinary catheters on inpatient units, with a goal of prompt removal.

CLABSI
- ICU/CVICU pilot of a central line insertion bundle: direct observation of insertion and completion of the CLIP document.
- IV Safety Team (launched November): evidence-based insertion, management, and removal of vascular devices.

CDI (hospital-onset: hospital day 4 and beyond)
- Pursuing a required Infectious Disease consult for all C. difficile testing on hospital day 4 and beyond.
- Moving testing from the GDH/EIA-NAAT algorithm to NAAT followed by toxin EIA, to better separate colonization from active infection.

SSI (colon and abdominal hysterectomy)
- Ensuring prophylactic antimicrobials are administered timely before incision.
- Auditing sterilization and high-level disinfection so surgical instruments and equipment are safely reprocessed.

Efficiency and Cost Reduction

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Efficiency and Cost Reduction	Baseline Period Jan. 1, 2023–Dec. 31, 2023		Performance Period Jan. 1, 2025–Dec. 31, 2025		25%
	Measure ID	Measure Name	Achievement Threshold	Benchmark	
	⬇ MSPB	Medicare Spending per Beneficiary	Median MSPB ratio across all hospitals during the performance period	Mean of lowest decile of MSPB ratios across all hospitals during the performance period	

Medicare Spending per Beneficiary (MSPB-1) Episode:
3 days before admission through 30 days after discharge

Main Spending Components

Component	What drives cost
Skilled nursing facility	How many patients go, how long they stay, which facilities
Inpatient Rehab / LTACH	High per-case cost; a few patients move the average
Readmissions	A readmission adds a full DRG payment to the episode
Home health	Less costly than SNF, but visit volume varies by agency
Hospice	Timing of appropriate referral

Initiatives: Evidence is strongest for structured transition models and for moving appropriate patients to lower-intensity settings.

- **Discharge destination:** Largest lever. Risk stratification, early discharge planning, patient and caregiver education, home health when safe; strict criteria-based placement into rehab or SNF.
- **Referral patterns:** Preferred SNF network selected on length of stay, readmission rate, and cost per episode, with active hospital-SNF coordination.
- **Transitions of care:** Transition coach support and continued patient contact after discharge.
- **Follow-up access:** Follow-up appointment scheduled before discharge (within 7 days for high-risk patients, 14 days otherwise); missed appointments trigger same-day outreach.

Questions?

