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.

August 22, 2025

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in the City of Visalia City Council Chambers {707 W. Acequia, Visalia, CA} on Wednesday, August 27, 2025:

- 4:00PM Open meeting to approve the closed agenda.
- 4:01PM Closed meeting pursuant to Government Code 54956.8, Government Code 54956.9(d)(1), Government Code 54956.9(d)(2), Health and Safety Code 1461 and 32155.
- 4:15PM Open meeting.

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.

All Kaweah Delta Health Care District regular board meeting and committee meeting notices and agendas are posted 72 hours prior to meetings (special meetings are posted 24 hours prior to meetings) in the Kaweah Health Medical Center, Mineral King Wing near the Mineral King entrance.

The disclosable public records related to agendas can be obtained by contacting the Board Clerk at Kaweah Health Medical Center – Acequia Wing, Executive Offices (Administration Department/Executive Offices) {1st floor}, 400 West Mineral King Avenue, Visalia, CA via phone 559-624-2330 or email: kedavis@kaweahhealth.org, or on the Kaweah Delta Health Care District web page http://www.kaweahhealth.org.

KAWEAH DELTA HEALTH CARE DISTRICT
David Francis, Secretary/Treasurer

Kelsie Davis
Board Clerk / Executive Assistant to CEO

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

KAWEAH DELTA HEALTH CARE DISTRICT
BOARD OF DIRECTORS MEETING

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

Wednesday August 27, 2025 {Regular Meeting}

OPEN MEETING AGENDA {4:00PM}

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

CLOSED MEETING AGENDA {4:01PM}

1. **CALL TO ORDER**

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

A. BURNS-NUNEZ V KDHCD	J. RAMIREZ V KDHCD
B. ONEY V KDHCD	K. BURGER V KDHCD
C. PARNELL V KAWEAH HEALTH	L. ANDRADE V KDHCD
D. M. VASQUEZ V KDHCD	M. MARTINEZ-LUNA V KDHCD
E. RHODES V KDHCD	N. VIZCAINO V KDHCD
F. NEGRETE V KDHCD	O. MEDINA V KDHCD
G. LARUMBE-TORRES V KDHCD	P. MORENO V KDHCD
H. SMITHSON V KDHCD	Q. ISQUIERDO 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); Evidence code 1157. 1 case.

   Action Requested

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 and Evidence Code 1157.

   Action Requested

5. **MEDICAL STAFF QUALITY ASSURANCE** 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 and Evidence Code 1157.

6. **APPROVAL OF THE CLOSED MEETING MINUTES** – July 1, 2025, and July 23, 2025, closed meeting minutes.
   Action Requested

7. **ADJOURN**

OPEN MEETING AGENDA {4:15PM}

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 minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdiction of the Board are requested to identify themselves at this time.
5. **CLOSED SESSION ACTION TAKEN** – Report on action(s) taken in closed session.

6. RECOGNITIONS

6.1. Presentation of Resolution 2268 to Benny Alva in recognition as the Kaweah Health World Class Employee of the month – August 2025.

6.2. Presentation of Resolution 2269 to Angelina Banks in recognition for years of service and retirement after 30 years.

6.3. Team of the Month – Home Health

7. INTRODUCTION – New Directors

7.1. Ayham Zoreikat, Director of Cardiovascular Service Line and Operations

7.2. Shannon Vinson, Director of Medical Staff Services

7.3. Adam Chavez, Interim Director of Procurement and Logistics

8. CHIEF OF STAFF REPORT – Report relative to current Medical Staff events and issues.

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

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

Action Requested – Approval of all items on the August 27, 2025, Consent Calendar.

Section	Item	Description	Type
9.1. REPORTS	A	Physician Recruitment	Receive and File
	B	Monthly Throughput Report	Receive and File
	C	Renal Services	Receive and File
9.2. MINUTES	A	Patient Experience Committee – July 9, 2025	Approve Minutes
	B	Finance Property Services & Acquisition Committee – July 21, 2025	Approve Minutes
	C	Quality Council Committee – July 17, 2025	Approve Minutes
	D	Special Open Board Meeting – July 1, 2025	Approve Minutes
	E	Regular Open Board Meeting – July 23, 2025	Approve Minutes
9.3. POLICIES	**A**	**Administrative Policies**	

1	AP 08 Patient Complaint and Grievance Management	Approve Revisions
2	AP 14 Department Visits by Vendor Representatives	Approve Revisions
3	AP 18 Foreign Language Forms, Signs, etc.	Approve Revisions
4	AP 19 Travel Per Diem and Other Employee Reimbursement	Approve Revisions
5	AP 39 Catering Guidelines	Delete
6	AP 53 Patients' Rights and Responsibilities	Approve Revisions
7	AP 60 Technology Assessment Process	Reviewed
8	AP 67 District Fleet Vehicles and Management	Approve Revisions
9	AP 88 Grievance Procedure – Section 504 of the Rehabilitation Act of 1973	Approve Revisions
10	AP 103 Public Release of Patient Information	Approve Revisions
11	AP 122 Interpreter Services	Approve Revisions
12	AP 123 Financial Assistance Program Full Charity and Partial Discount Programs	Reviewed
13	AP 161 Workplace Violence Prevention Program	Approve Revisions
14	AP158 Solicitation, Fundraising and Distribution of Materials	Reviewed
B	**Human Resources**	
1	HR 04 Special Pay Practices	Approve Revisions
2	HR 61 Status Classification of Employees/Concurrent Jobs	Approve Revisions
3	HR 70 Meal Periods, Rest Breaks and Breast feeding, and/or Lactation Accommodation	Approve Revisions
4	HR 78 Salary Administration Program	Approve Revisions
5	HR 183 Identification Badges	Approve Revisions
6	HR 200 Drug Free Place and Drug/Alcohol Testing	Approve Revisions
7	HR 213 Performance Management and Competency Assessment Program	Approve Revisions
8	HR 234 PTO, EIB, and Health Workplace, Healthy Families Act of 2014	Approve Revisions
9	HR 246 Team Member COVID-19 Symptomatic Testing	Delete
10	EHS 04 Infectious Disease Guidelines for Employees	Approve Revisions
11	EHS 11 Immunization Requirements for Health Care Workers	Approve Revisions
12	EHS 01 Infection Prevention Guidelines for Pregnant Healthcare Workers	Delete
13	HR 246 Team Member COVID-19 Symptomatic Testing	Delete
C	**Environment of Care**	
1	EOC 1001 Safety Management Plan	Approve Revisions

	2	EOC 2000 Emergency Operations Plan	Approve Revisions
	3	EOC 4003 District Pest Control Policy	New Policy
	4	DM 2205 Code Pink Infant Abduction	Approve Revisions
	5	DM 2228 Continuity of Operations and Recovery	Approve Revisions
9.4. MEC	1	Request for a One Time Exception to the Use of Outside Proctors Policy	Approve Revisions
9.5. DISTRICT	1	Semi Annual Investment Report – June 30, 2025	Approve and File

10. **INCIDENT MANAGEMENT**– Presentation and discussion regarding the new Kaweah Health Incident Management process, including procedures for Root Cause Analysis, and Midas event scoring.

11. **KAWEAH HEALTH PHYSICIAN RECRUITMENT REPORT** – Presentation and discussion of current Kaweah Health physician recruitment efforts, including recent hires, open positions, and strategies to address identified staffing needs and retention.

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

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

14. **REPORTS**

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

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

CLOSED MEETING AGENDA
IMMEDIATELY FOLLOWING THE OPEN SESSION

1. **CALL TO ORDER**

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

3. ADJOURN

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Agenda item intentionally omitted

Resolution 2268

RESOLUTION 2268

Board Resolution Honoring
Benny Alva as Employee of the Month of August

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

WHEREAS, Benny Alva, of the Maintenance Department, has consistently demonstrated exceptional commitment to their responsibilities, a strong work ethic, and a positive attitude that uplifts their team;

WHEREAS, He has made significant contributions during the month of August 2025, including but not limited to providing seamless support and maintaining unshakable professionalism while juggling the chaos that only an exemplary employee can make;

WHEREAS, Benny's professionalism, integrity, and enthusiasm embody the core values of Kaweah Health, setting a high standard for colleagues and exemplifying what it means to go above and beyond in the workplace;

NOW, THEREFORE, BE IT RESOLVED, that the Board of Directors formally recognizes and congratulates Benny Alva as **Employee of the Month** for August 2025, and expresses its sincere appreciation for his outstanding contributions;

BE IT FURTHER RESOLVED, that this resolution be entered into the official records of Kaweah Health and that a copy be presented to Benny Alva as a token of recognition and gratitude.

PASSED AND ADOPTED this 27th of August, 2025, by the Board of Directors of Kaweah Health.

Mike Olmos
President
Kaweah Health Board of Directors

David Francis
Secretary/Treasurer
Kaweah Health Board of Directors

Resolution 2269

RESOLUTION 2269

RESOLUTION HONORING ANGELINA BANKS ON THE OCCASION OF THEIR YEARS OF SERVICE AND RETIREMENT

WHEREAS, Angelina Banks has faithfully and diligently served Kaweah Health for 30 years; and

WHEREAS, throughout their tenure, Angelina has demonstrated exceptional dedication, professionalism, and leadership in their role as Food Coordinator; and

WHEREAS, she has made significant contributions to Kaweah Kids; and

WHEREAS, Angelina has earned the respect, admiration, and gratitude of colleagues, staff, and the community through their commitment to excellence and their positive influence on workplace culture; and

WHEREAS, the Board of Directors of Kaweah Health recognizes the lasting legacy and enduring impact Angelina Banks leaves behind;

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

PASSED AND ADOPTED this 27th of August 2025, by the Board of Directors of Kaweah Health.

Mike Olmos
President
Kaweah Health Board of Directors

David Francis
Secretary/Treasurer
Kaweah Health Board of Directors

Physician Recruitment

Physician Recruitment Board Report - Physician Group Targets
August 2025

Key Medical Associates
Gastroenterology x1 Pediatrics x1 Pulmonology x1 Rheumatology x1

Orthopaedics Associates
Orthopedic Surgery (General) x1 Orthopedic Surgery (Hand) x1

Sequoia Cardiology
EP Cardiology x1

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

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

Valley ENT
Audiology x1 Otolaryngology x1

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

August Board Report Narrative:

The Kaweah Health Recruitment Team has begun working with our new DIO, Angel Smith. We are coordinating a refreshed approach to meet with our residents and help them prepare for life after residency and ensure they understand the opporunities available at Kaweah Health and in our community.

Offers Extended:
1) Cardiac Anesthesiologist
2) Occupational Medicine Physician
3) Cardiac Surgeon
4) Outpatient Pulmonology Physician

Upcoming Site Visits:
1) Orthopedic Hand Surgeon x 2
2) Gastroenterologist
3) OB/GYN x 2
4) Outpatient Family Practice
5) Otolaryngologist

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

Board Report - Physician Recruitment - August 2025

	Specialty	Group	Phase	Expected Start Date
1	Gastroenterology	TBD	Site Visit	
2	Orth Surgeon (Hand)	Orthopedic Assoc	Site Visit	
3	OBGYN	TBD	Site Visit	
4	Internal Medicine	CFC	Site Visit	
5	OBGYN	TBD	Site Visit	
6	Orth Surgeon (Hand)	Orthopedic Assoc	Site Visit	
7	Family Medicine	TBD	Site Visit	
8	ENT	Valley ENT	Site Visit	
9	General Surgery	TBD	Screening	
10	General Surgery	TBD	Screening	
11	Radiology	TBD	Screening	
12	Gastroenterology	TBD	Screening	
13	Neurology	TBD	Screening	
14	Neurology	TBD	Screening	
15	Psychiatry	TBD	Screening	
16	Psychiatry	TBD	Screening	
17	Psychiatry	TBD	Screening	
18	Anesthesia (Cardiac)	Oak Creek	Screening	
19	Family Medicine	TBD	Screening	
20	Family Medicine	TBD	Screening	
21	Family Medicine	TBD	Screening	
22	Family Medicine	TBD	Screening	
23	Internal Medicine	1099 - KH Direct	Screening	
24	EP	TBD	Screening	
25	Neurology	TBD	Offer Extended	
26	Anesthesia (Cardiac)	Oak Creek	Offer Extended	
27	Occ Med	TBD	Offer Extended	
28	Cardiothoracic Surgery	TBD	Offer Extended	
29	Pulmonology	TBD	Offer Extended	
30	Neonatology	Valley Childrens	Offer Accepted	11/03/25
31	Anesthesia (Regional)	Oak Creek	Offer Accepted	08/01/25
32	Family Medicine	KH Faculty MG	Offer Accepted	TBD
33	Family Medicine	Key Medical Associates	Offer Accepted	TBD
34	General Surgery	Dr. Potts	Offer Accepted	10/20/25
35	General Surgery	1099 - KH Direct	Offer Accepted	08/01/25
36	Intensivist	Sound	Offer Accepted	TBD
37	OBGYN	1099 - KH Direct	Offer Accepted	TBD
38	Urology	1099 - KH Direct	Offer Accepted	03/01/25
39	Endocrinology	1099 - KH Direct	Offer Accepted	TBD
40	Neonatology	Valley Childrens	Offer Accepted	07/28/25
41	Neurology	1099 - KH Direct	Offer Accepted	TBD
42	OBGYN	TBD	Leadership Call	
43	Cardiology (EP)	TBD	Leadership Call	
44	Psychiatry	TBD	Leadership Call	
45	PM&R	TBD	Leadership Call	
46	Rheumatology	TBD	Leadership Call	
47	Gastroenterology	TBD	Leadership Call	
48	General Surgery	TBD	Applied	

	Specialty	Group	Phase	Expected Start Date
49	Urogynecology	TBD	Applied	
50	Anesthesia Program Director	TBD	Applied	
51	Family Medicine	TBD	Applied	
52	Urogynecology	TBD	Applied	

Separator Page

Monthly Throughput Report

Update	Next Steps
ED Flow • The redesign of the Emergency Department Front End Throughput process has yielded significant improvements in key performance indicators, demonstrating enhanced efficiency and patient care. • Notably, the median door-to-discharge time has shown a consistent downward trend, reaching 257 minutes in the current period, a substantial improvement from 271 minutes in February, 295 minutes in January, and a marked decrease from prior comparable high-volume periods where times exceeded 300 minutes. • This achievement underscores the team's effectiveness in rapidly registering, triaging, and evaluating patients. This expedited initial assessment facilitates the swift initiation of diagnostic workups and treatments, leading to more timely interventions and, consequently, reduced lengths of stay. • Left Without Being Seen (LWBS) rate has been sustained at an exceptionally low 0.8% for the entire month, indicating a significant success in ensuring patients are seen and evaluated, thereby enhancing patient satisfaction and safety.	Next Steps: • Sustained Reduction in LOS for Discharged Patients: Achieving and maintaining a significant reduction in the median Length of Stay (LOS) for discharged patients • Improvement in Bed Utilization: Demonstrable improvement in the efficient utilization of ED beds. • Reduction in EMS Wall Times: Decrease the median EMS offload time to below 45 minutes. *(Measure: Median EMS offload time consistently below 45 minutes)*
ED to Inpatient Admission Process: Dr TU educating on process for "Request to Admit" will only be put in after contact initiated with admitting Doc. This will ensure the start time is consistent on each pt admit. UR work group continuing work for utilization of MRI in ED and Inpt, delaying pt progression. Social Admit new process, decision to pull upstairs <24 hours	ED to Inpatient Admission Process: • ED CM taking on the role of Gatekeeper. Keeping soft admissions from making it to floor/process DC from ED. Pushing Social Admits up when not able to U-turn. Assuring admissions are viable and ready to transition earlier in day. • EVS to turn over clean rooms more timely • Transport to move patients more timely.
Observations Observation Dashboard ready for use 10/2023. September power plan useage 47.45% (highest since go-live 12/2023) PCP follow up process and resources finalized. Medical observation Powerplan updates went live 11/28/23: educated to providers sent 11/27, Emma presented at Valley Hospitalist meeting 11/21, attended Department of Critical Care, Pulmonary Medicine & Adult Hospitalist meeting 12/18 to educate as well.	Observation **Next Steps:** • Re-evaluate next steps and needs for observation program. Need a reset of priorities and where we want to focus efforts.

Renal Services

REPORT TO THE BOARD OF DIRECTORS

Renal Services – FY25

Amy Baker, MSN, RN
Director of Specialty Clinics
(559) 624-3033
August 15, 2025

Summary Issue/Service Considered

- **Census Growth**- Prioritize building the overall census, with specific attention to increasing the Peritoneal Dialysis (PD) program through outreach, patient education and physician collaboration.

- **Process Optimization**- Improve internal workflows to expedite care in the clinic setting. Optimize patient treatment scheduling and employee shift planning to enhance efficiency, improve resource utilization and decrease cost per treatment.

- **Quality Monitoring and Improvement**- Actively track all CMS and internal quality measures. Focus on achieving targets for treatment adequacy, fistula utilization rates and reduction of blood stream infections.

- **Patient Experience and Safety**- Maintain nursing's focus on patient satisfaction and safety initiatives, ensuring a culture of compassionate, high-quality care.

- **Cost Management-** Implement strategies to reduce cost per treatment while maintaining high standards of care.

- **Financial Collaboration and Compliance-** Partner with the Finance Department to ensure accurate and optimal reimbursement and confirm precise charge capture.

Quality/Performance Improvement Data

Patient Satisfaction Scores:

Question Table Client Name: Kaweah Health

Time Period: Fall 2024

Question Text	Benchmark	Kaweah Health Dialysis Center	
		Positive Score	n-size
Center was clean	78.1%	93.8%	16
Connected to machine within 15 min	48.9%	62.5%	16
Doctors cared	67.4%	75.0%	16
Doctors explained things understandably	65.3%	68.8%	16
Doctors listened carefully	65.5%	68.8%	16
Doctors showed respect	73.7%	87.5%	16
Doctors spent enough time	55.6%	68.8%	16
Doctors up to date about care from other doctors	90.0%	86.7%	15
Doctors/staff talked about peritoneal dialysis	64.9%	56.3%	16
Doctors/staff talked about what treatment was right	87.4%	87.5%	16
Felt comfortable asking about dialysis care	94.9%	100.0%	16
Involved as much as wanted in choosing treatment	88.8%	87.5%	16
Know how to take care of dialysis connection method	93.7%	93.8%	16
Rate center	79.4%	87.5%	16
Rate kidney doctors	67.4%	75.0%	16
Rate staff	75.3%	81.3%	16
Staff behaved professionally	77.1%	87.5%	16
Staff cared	72.2%	68.8%	16
Staff checked on patient as closely as wanted	66.6%	68.8%	16
Staff discussed diet	91.6%	100.0%	16
Staff explained blood test results understandably	66.8%	75.0%	16
Staff explained things understandably	67.8%	68.8%	16
Staff explained what to do if problems at home	87.2%	87.5%	16
Staff gave written info re: patient rights	90.5%	93.8%	16
Staff inserted needles painlessly as possible	49.7%	90.9%	11
Staff kept patient information private	93.9%	100.0%	16
Staff listened carefully	70.7%	68.8%	16
Staff made patient comfortable	75.1%	81.3%	16
Staff reviewed rights as patient	84.1%	93.3%	15
Staff showed respect	73.1%	75.0%	16
Staff spent enough time	67.0%	68.8%	16
Staff told you how to disconnect from machine	90.6%	93.8%	16

*Reporting has been produced by NRC Health for quality improvement purposes and does not represent official CMS Results.

Significance Color Code
- No Significance
- Score statistically significantly greater than benchmark

CMS gave a 5 star rating for Patient Satisfaction Scores for 2024. This was a big accomplishment for the Dialysis Clinic. For 2025, we received 4 star rating. NRC Health completed our fall patient satisfaction survey. We had sixteen patients complete the survey. Kaweah Health Dialysis Clinic scored statistically significantly greater than

benchmark in the area of “Staff insterted needles painlessly as possible”. Out of the thirty two questions twenty eight were higher than the benchmark. Scores below benchmark are discussed during our unit based council meetings. Unit Based Council (UBC) members include unit leadership, Registered Nurses and Certifed Hemodialysis Techicians. Plans were developed and implemented to address any low scores. Ideas for improving patient satisfacation that come from front line staff are very successful. Plans to address our schedule have been reviewed to address the low score for “Connected to machine within 15 minutes”. Education has been developed to give patients information about arrival time versus chair time.

KT/V Scores:

	Goal 2022	Actual 2022	Goal 2023	Actual 2023	Goal 2024	Actual 2024	Goal 2025	Actual 2025
%KT/V>1.2	≥97.61%	96.43%	≥97.61%	97.66%	≥97.61%	96.4%	≥97.61%	92.85%

A KT over V score measures how well a patient is being dialyzed. It measures the adequacy of the treatment or how well the treatment is cleaning the patients blood. Our dialysis team continues to monitor patients labs and work closely with nephrologists to adjust treatments to ensure treatments are adequate. An interdisciplinary care team meets weekly to discuss patients who do not meet there KT/V goal. The interdisciplinary care team includes dieticians, registered nurses and a social worker to ensure the best care is delivered to our patients. The nephrologists are notified and changes to the treatment are requsted. Changes include longer dialysis treatments or more days per week to come for treatment. Some patients refuse nephrologist recommendation which makes it harder to achieve goal. There has been an noticeable increase in patients either not attending scheulded treatments or discontinuing care before the full course of treatment is completed. Targeted education has been provided to the 7 patients whom are not meeting KT/V.

Fistula and Catheter Rates:

	Goal 2022	Actual 2022	Goal 2023	Actual 2023	Goal 2024	Actual 2024	Goal 2025	Actual 2025
Fistula Rate	≥62%	54.48%	≥62%	56.49%	≥62%	50%	≥62%	46.28%
Long term Catheter Rate (Greater than 90 days)	≤17%	23.83%	≤17%	22.32%	≤17%	25.30%	≤17%	32.10%

We continue to promote “Fistula First” to prevent complications associated with catheters. This is the industry standard. We have consolidated roles amongst back office staff and continue to provide a lot of patient education about fistula’s. All participants of the interdisciplinary care team assist with stressing the importance of a fistula to the patient. Barriers to fistulas include patient preferences for a catheter and access to vascular surgeons to create the fistulas. When patients have fistulas, the fistulas get accessed with needles. Some patients prefer the catheters due to not getting poked by a needle each treatment. The Kaweah Health team continues to educate patients on the effectiveness

of the fistula. Surgery team and surgeons are increasing operating room access to perform fistula procedures.

Bloodstream Infection Rates (BSI):

	Goal 2022	Actual 2022	Goal 2023	Actual 2023	Goal 2024	Actual 2024	Goal 2025	Actual 2025
BSI Ratio Standard Infection Ratio (SIR)	0	2.340	0	1.334	0	0.836	0	2.015

Bloodstream infections can occur when bacteria or fungus enter the blood stream. With patients receiving hemodialysis three times a week the chances of obtaining a blood stream infection is higher than the general population. At the Dialysis Clinic, we take every precaution to prevent blood stream infections. The number of actual infections divided by the number of expected infections gives us a standard infection ratio (SIR). To ensure best practice we have implemented employee audits by our Nurse Manager. These audits include observations of hand hygiene compliance, medication preparation and administration, and central venous access exit site care. We have provided education to our patients about the importance of washing their hands and fistula sites prior to initiating dialysis and the importance of using chlorhexidine. We review each bloodstream infection with our infection prevention registered nurse liaison. Learning opportunities are discussed at the monthly Quality Assessment and Performance Improvement (QAPI) meeting.

Policy, Strategic or Tactical Issues

- Each month, all quality data is reviewed during the Quality Assessment and Performance Improvement committee (QAPI) meeting to ensure that established goals are being met. If any goal is not achieved, then a further evaluation is conducted to identify the causes and determine corrective actions. During these meetings, approximately 90 different quality data indicators related to hemodialysis and 50 quality data indicators related to peritoneal dialysis are discussed in detail.
- This year, focused efforts were made to grow our Peritoneal Dialysis program. A dedicated *Peritoneal Dialysis Review Meeting* was established to routinely evaluate patient growth and identify barriers. During these meetings, all current hemodialysis patients are reviewed to assess potential candidacy for peritoneal dialysis. If a patient is identified as a potential candidate, the peritoneal dialysis nurses engage with them directly using educational tools to assess interest and provide information about the modality. If the patient expresses interest, the nephrologist is contacted for an order to initiate the modality change. In addition, we have begun rounding on new dialysis initiates on the inpatient renal unit 4 North, with the goal of identifying and targeting patients who are just beginning dialysis and may be good candidates for peritoneal dialysis.
- *Clarity*, the electronic medical record the dialysis clinic utilizes, does not interface well with Soarian Financials. Each month, Clarity should send charges to Soarian

Financials for each patient to generate the claim to submit to insurance. This has not been working correctly. Charges are being missed or charged incorrectly causing manual audits to ensure accuracy. Clarity is not sending all the information needed to submit claims appropriately. This is specific to missing drug coding and modifiers. Manual audits and manual charge entry into Soarian Financials is occurring to confirm accuracy. A work group with dialysis clinic, revenue cycle and finance team members has been established to collaborate and improve upon fallout opportunities.

Recommendations/Next Steps

- **Staff Retention and Education:** Efforts continue to educate and retain Registered Nurses and Certified Hemodialysis Technicians in order to reduce staff turnover and minimize burnout. Ongoing training and support are key components of this strategy.

- **Employee Engagement:** Focus has been placed on addressing top opportunities identified in the most recent Employee Engagement Pulse Survey. These efforts aim to improve job satisfaction, communication, and overall team morale.

- **Communication and Safety Initiatives:** Weekly employee update emails are distributed to ensure transparent and consistent communication from leadership to staff. Additionally, a daily Employee Safety Huddle is held at 10:30 a.m. to discuss safety concerns for both staff and patients. This initiative has successfully helped resolve several clinic issues and has positively impacted overall morale.

- **Supply Optimization:** The clinic is working to improve supply utilization by reviewing and removing unnecessary items from the supply list, resulting in greater efficiency and cost savings.

- **Medication Management:** Close collaboration with the pharmacy continues to monitor medication trends and evaluate the cost-effectiveness of therapies, ensuring the best outcomes for patients while managing expenses responsibly

- **Equipment and Infrastructure Monitoring:** Assess and monitor aging dialysis machines and the reverse osmosis (RO) water room to ensure equipment reliability, patient safety, and compliance with regulatory standards. Planning for upgrades or replacements is ongoing as part of proactive maintenance efforts.

Approvals/Conclusions

- Strive for high-quality clinical outcomes by setting measurable goals and continuously seeking opportunities for improvement

- Increase both peritoneal dialysis and hemodialysis patient volumes to strengthen the clinic's financial performance and sustainability

- Monitor patient-to-nurse assignments to ensure optimal staffing ratios are maintained, promoting both quality care and financial efficiency.

- Evaluate and propose the implementation of a new EMR system for the dialysis clinic, including integrated third-party billing, to eliminate the need for interfacing with Soarian Financials and improve operational efficiency

- Evaluate current hemodialysis standards of care to make informed pharmaceutical decisions that balance clinical effectiveness with cost-conscious practices for both patients and the clinic.

- Develop a long-term plan to replace aging dialysis machines and upgrade the reverse osmosis (RO) water room. This project will require significant financial investment and careful coordination, as it is expected to be both costly and time-intensive

Kaweah Health
Report to the Board of Directors

Innovative Renal Care Kaweah Dialysis Center
July 2025

Summary Issue/Service Considered

Innovative Renal Care Kaweah Dialysis Center is a dialysis clinic located in Visalia, California at 3446 South Mooney Boulevard. It opened in June of 2021 with seventeen stations to perform hemodialysis. In August of 2024 they expanded to 21 stations. They offer both in center hemodialysis and at home peritoneal dialysis. They currently serve approximately 90 patients with a max capacity to serve 180 patients. There peritoneal dialysis patient volume is 20.

Kaweah Health signed an operating agreement of Visalia Kidney Center, limited liability company (LLC) in August of 2018. The first amendment to the operating agreement was completed in May 2020 establishing percentage of membership of each party. Kaweah Health entered a joint venture with American Renal Associates, LLC and Tariq Javed, Nephrologist. Kaweah Health's percentage of membership interest is ten percent. In 2021, Innovative Renal Care and American Renal Associates merged to become Innovative Renal Care family of companies. They are the third largest provider of dialysis services in the United States.

The managing committee of Visalia Kidney Center, LLC meets quarterly to discuss clinical and operational updates, financial and managed care reviews, and progress on strategic items.

Financial/Statistical Information

Fiscal Year	KH Contribution to JV	Income (loss) Allocation - 10%	KH Distribution from JV	Kaweah Investment Balance
2020	$ 49,101	$ -	$ -	$ 49,101
2021	-	-	-	49,101
2022	34,500	(109,064)	-	(25,463)
2023	133,800	(75,720)	-	32,617
2024	-	43,087	(9,000)	66,703
2025	-	120,589	(108,000)	79,292
Total	$ 217,401	$ (21,109)	$(117,000)	$ 79,292

Quality/Performance Improvement Data

Innovative Renal Care Kaweah Dialysis Center tracks several quality metrics for in center hemodialysis and home peritoneal dialysis. Some of the top performing measures are medication reconciliation at 100% complete for all patients for the last ten months and zero

blood stream infections for the last ten months. One quality measure that is no meeting goal is the long term catheter percentage of patients. The last ten month average was 35.37%.

Policy, Strategic or Tactical Issues

1. Innovative Renal Care Kaweah Center's primary competition includes Kaweah Health Dialysis Clinic and three DaVita Dialysis Clinics in Visalia.

2. Working with Nephrology USA to recruit additional nephrologist to support clinic operations and meet growing patient demand.

3. A marketing strategy is being developed to support clinic specific materials and digital advertising efforts. This includes creation of tailored marketing for clinic and launch of digital ad campaigns targeting relevant patient populations. A new Facebook page has been created to share patient education content and information about Innovative Renal Care, helping increase visibility and community engagement.

4. Opportunity to open an additional clinic on the northwest side of town. They are inquiring whether Kaweah Health would be open to pursing another joint venture to establish and operate this new clinic.

Recommendations/ Next Steps/ Approvals/ Conclusions

The presence of competing dialysis clinics in Visalia, such as DaVita and others, is inevitable due to market demand. However, Innovative Renal Care and Dr. Javed extended an opportunity for Kaweah Health to participate as a small partner allowing us to maintain a presence in this space and contribute to patient care rather than be completely excluded.

Patient Experience Committee

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 July 9, 2025
Kaweah Health Medical Center – Executive Office Conference Room

Present: Director: Mike Olmos (Chair) & Armando Murrieta; Gary Herbst, Chief Executive Officer; Marc Mertz, Chief Strategy Officer; Deborah Volosin, Director of Patient & Community Experience; Sintayehu Yirgu, Patient Experience Advocate; Teresa Bobadilla, Patient Experience Data Analyst; and Lisette Mariscal, Recording

CALL TO ORDER – This meeting was called to order at 4:02 PM by Mike Olmos.

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

PATIENT EXPERIENCE –

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

1.2. Teresa Bobadilla presented the latest data from HCAHPS survey and reviewed the Patient Experience dashboard. (see Attachment 1.2 of the agenda)

1.3. Sintayehu Yirgu reported on patient rounding metrics for the month of June. (see Attachment 1.3 of the agenda)

1.4 – 1.7. Discussion on agenda items 1.4 through 1.7 were deferred.

Adjourned at 5:17 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.

Finance Property Services & Acquisition Committee

Kaweah Delta Health Care District
Board of Directors Committee
Meeting Minutes

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

Finance, Property, Services, and Acquisition Committee – OPEN MEETING
Monday July 21, 2025
Kaweah Health Medical Center – Executive Office Conference Room

Present: Directors: David Francis & Dean Levitan, M.D.; Gary Herbst, CEO; Malinda Tupper, Chief Financial Officer; Marc Mertz, Chief Strategy Officer; Jennifer Stockton, Director of Finance; Jag Batth, Chief Operating Officer; R. Gates, Chief Ambulatory Officer; K. Davis, Board Clerk Recording

Called to order at 1:00PM

Public Participation- None.

MINUTES- Minutes were reviewed from June 18, 2025.

The committee recommends the minutes be forwarded to the Board for approval.

SEQUOIA INTEGRATED HEALTH AND SEQUOIA HEALTH PLAN- A review of the most recent plan financials was presented by Gary Herbst. (A copy is attached to the original of these minutes and is considered a part thereof.)

The Committee recommends to the Board that Kaweah Delta Health Care District continue its contract with Sequoia Health Plan (Humana Medicare Advantage) for the remainder of calendar year 2025 and all of calendar year 2026. It further recommends that the Board continues to actively evaluate the Plan's financial performance over the contract period and that it will make a decision prior to the expiration of the current agreement as to its intention to renew the contract beyond December 31, 2026.

FINANCIALS – Review of the most current fiscal year financial results and a progress review of projections relative to the Kaweah Health initiatives to decrease costs and improve cost efficiencies (copy attached to the original of these minutes and considered a part thereof) - *Malinda Tupper – Chief Financial Officer*

Kaweah Delta Health Care District
Board of Directors Committee
Meeting Minutes

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

Adjourned at 2:30 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.

Quality Council Committee

OPEN Quality Council Committee
Thursday, July 17, 2025
The Lifestyle Center Conference Room

Attending: Board Members: Mike Olmos (Chair) & Dr. Dean Levitan, Board Member; Gary Herbst, CEO; Sandy Volchko, Director of Quality & Patient Safety; Schlene Peet, Interim Chief Nursing Officer; Mark Mertz, Chief Strategy Officer; Ryan Gates, Chief Ambulatory Officer; Dr. Lamar Mack, Medical Director of Quality & Patient Safety; Amy Baker, Director of Specialty Clinics; Connie Green, Nurse Manager; Cody Ericson, RN-Advanced Practice Nurse; Shawn Elkin, Infection Prevention Manager; Erika Pineda, Quality Improvement Manager; Kyndra Licon – Recording.

Mike Olmos called to order at 7:30 AM.

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

Mike Olmos adjourned the meeting at 7:31 AM.

Public Participation – None.
Mike Olmos called to order at 8:00 AM.

3. **Review of June Quality Council Open Session Minutes –** Mike Olmos, Committee Chair; Dr. Dean Levitan, Board Member.
    - Reviewed and acknowledged the June Quality Council Open Session Minutes by Dr. Dean Levitan and Mike Olmos. No further actions.

4. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives: **–** Reports reviewed and attached to minutes. No action taken.
    4.1 Best Practice Teams
    4.2 Diabetes Committee Quality Report

5. **Kaweah Health Dialysis Report –** A review of key performances indicators and actions associate with care of dialysis patient population. – Reports reviewed and attached to minutes. No action taken. Trend on volume and not percentage.

6. **Clinical Quality Goals Update**- A review of current performance and actions focused on the clinical quality goals for Healthcare Acquired Infections and Sepsis. – Reports reviewed and attached to minutes. No action taken.

Adjourn Open Meeting – *Mike Olmos, Committee Chair*

Mike Olmos adjourned the meeting at 9:09 AM.

Special Open Board Meeting

SPEICAL MINUTES OF THE OPEN SPECIAL MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD TUESDAY JULY 1, 2025, AT 2:30PM IN THE 4T OWER CLASSROOM 4TH FLOOR ACEQUIA WING – 605 W ACQUIA AVENUE, VISALIA, CA.

PRESENT: Directors Havard Mirviss, Murrieta, Francis & Levitan; G. Herbst, CEO; and K. Davis, recording

The meeting was called to order at 2:30 PM by Director Havard Mirviss.

ROLL CALL- Director Havard Mirviss, Francis, Murrieta and Levitan were all present.

PUBLIC PARTICIPATION – None.

ADJOURN - Meeting was adjourned at 230PM

Lynn Havard Mirivss, Vice President
Kaweah Delta Health Care District and the Board of Directors

ATTEST:

David Francis, Secretary/Treasurer
Kaweah Delta Health Care District Board of Directors

SPEICAL MINUTES OF THE OPEN SPECIAL MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD TUESDAY JULY 1, 2025, AT 2:44PM IN THE 4T OWER CLASSROOM 4TH FLOOR ACEQUIA WING – 305 W ACQUIA AVENUE, VISALIA, CA.

PRESENT: Directors Havard Mirviss, Murrieta, Francis & Levitan; G. Herbst, CEO; and K. Davis, recording

The meeting was called to order at 2:24 PM by Director Mirviss.

REPORT OUT OF CLOSED SESSION- *The board voted 4-1 to appoint Schlene Peet as Chief Nursing Officer, Effective July 1, 2025. Directors Francis, Murrieta, Havard Mirviss and Levitan voted in favor. Absent- Olmos.*

ADJOURN - Meeting was adjourned at 245PM

Lynn Havard Mirviss, Vice President
Kaweah Delta Health Care District and the Board of Directors

ATTEST:

David Francis, Secretary/Treasurer
Kaweah Delta Health Care District Board of Directors

Regular Open Board Meeting

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD WEDNESDAY JULY 23, 2025, AT 4:00PM IN THE CITY OF VISALIA CITY COUNCIL CHAMBERS – 707 W. ACEQUIA, VISALIA, CA.

PRESENT: Directors Olmos, Francis, Levitan & Murrieta; G. Herbst, CEO; D. Hightower, Chief of Staff; M. Tupper, CFO; B. Cripps, Chief Compliance Officer; D. Cox, Chief Human Resource Officer; R. Gates; Chief Ambulatory Officer; M. Mertz, Chief Strategy Officer; S. Peet, CNO; D. Leeper, Chief Information Officer; P. Stefanacci, Chief Medical Officer; R. Berglund, Legal Counsel; and K. Davis, recording

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

PUBLIC PARTICIPATION –None.

ADJOURN - Meeting was adjourned at 4:00PM

Mike Olmos, President
Kaweah Delta Health Care District and the Board of Directors

ATTEST:

David Francis, 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 JULY 23, 2025, AT 4:30PM IN THE CITY OF VISALIA CITY COUNCIL CHAMBERS – 707 W. ACEQUIA, VISALIA, CA.

PRESENT: Directors Olmos, Francis, Murrieta & Levitan; G. Herbst, CEO; D. Hightower, Chief of Staff; M. Tupper, CFO; B. Cripps, Chief Compliance Officer; D. Cox, Chief Human Resource Officer; R. Gates; Chief Ambulatory Officer; M. Mertz, Chief Strategy Officer; S. Peet, CNO; D. Leeper, Chief Information Officer; P. Stefanacci, Chief Medical Officer; R. Berglund, Legal Counsel; and K. Davis, recording

The meeting was called to order at 4:36 PM by Director Olmos.

ROLL CALL- Director Olmos, Francis, Levitan and Murrieta were all present.

FLAG SALUTE- Director Olmos lead the flag salute.

Director Olmos has announced that an items has come to the attention of the board regarding

PUBLIC PARTICIPATION – None.

CLOSED SESSION ACTION TAKEN: In closed session the board approved the Credentialing recommendations of the MEC and the Closed June board minutes from June 25, 2025.

RECOGNITIONS- Resolution 2265 and 2266.

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

- No report.

CONSENT CALENDAR – Director Olmos entertained a motion to approve the July 23, 2025, consent calendar without the following items Section 9.2.A, B, and C.

PUBLIC PARTICIPATION – None.

MMSC (Francis/Levitan) to approve the July 23, 2025, consent calendar except 9.2.A, B, and C. This was supported unanimously by those present. Vote: Yes – Olmos, Levitan, Murrieta and Francis.

STRATEGIC OPPORTUNTIES RELATED TO LENGTH OF STAY – A board discussion of operational and clinical strategies to improve patient throughput and optimize average length of stay based on current performance, metrics, and benchmarks. Copy attached to the original of the minutes and to be considered a part thereof.

KAWEAH HEALTH CHRONIC DIALYSIS QUALITY REPORT – A presentation and discussion of quality performance indicators for chronic dialysis services. Copy attached to the original of the minutes and to be considered a part thereof.

PATIENT EXPERIENCE AND SATISFACTION UDPATE – A staff presentation and discussion of regarding aggregated and de-identified patient experience data, including trends, themes, and opportunities for improvement. Copy attached to the original of the minutes and to be considered a part thereof.

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

REPORTS

Chief Executive Officer Report – Mr. Herbst gave an update on the hospital census. – *Gary Herbst, CEO*

Board President- None. – *Mike Olmos, Board President*

ADJOURN - Meeting was adjourned at 7:25PM

Mike Olmos, President
Kaweah Delta Health Care District and the Board of Directors

ATTEST:

David Francis, Secretary/Treasurer
Kaweah Delta Health Care District Board of Directors

AP 08

Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

Policy Number: AP08	**Date Created: No Date Set**
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration)	

Patient Complaint & Grievance Management

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

POLICY: Kaweah Delta Health Care District (KDHCD), herein referred to as Kaweah Health, is committed to the timely resolution of any complaint and/or grievance raised by the patient or their representative. The patient or their representative have the right to file a written complaint with the California Department of Public Health (CDPH), The Joint Commission (TJC), or other appropriate agencies regardless of whether they choose to use Kaweah Health's complaint or grievance process. The District Board of Directors approves this policy, and delegates oversight responsibility of the complaint and grievance process to the Director of Risk Management and to the Grievance Committee.

Kaweah Health is committed to actively seeking, listening, and responding to the needs, preferences, concerns, complaints, and grievances of our patients and their families. It is the policy of this organization to encourage the patient or their representative to express their complaints in order to identify opportunities to improve the quality of patient care services. At no time shall a complaint or grievance be used as a reason to retaliate against or deny a patient current or future access to Kaweah Health services. All staff members are responsible for identifying and responding to complaints from patients, their representatives or family.

Data collected regarding patient grievances, as well as other complaints not defined as grievances, will be incorporated into Kaweah Health's Quality Assessment and Performance Improvement Plan (QAPI).

DEFINITIONS:

Complaint- verbal communication the the hospital by a patient, or the patient's representative, regarding the patient's care or non-care issue that can be resolved immediately by the staff present.

Grievance- a written or verbal complaint by a patient, or the patient's representative regarding the patient's care, abuse or neglect, issues related to the hospital's compliance with the Centers for Medicare and Medicaid Services (CMS) Hospital

Conditions of Participation (COP), or a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR §489.

- A verbal complaint is a grievance if it cannot be resolved at the time of the complaint by staff present, is postponed for later resolution, is referred to other staff for later resolution, requires investigation, and/or requires further actions for resolution, then the complaint is a grievance for the purposes of these requirements.

Staff Present- any hospital staff present at the time of the complaint, or who can quickly be at the patient's location (supervisor, manager, house supervisor, administration, etc.) to resolve the patient's complaint.

Grievance Committee –The internal committee given authority and oversight for the resolution of grievances within Kaweah Health. The Director of Risk Management is the chair and membership includes, but is not limited to:

- The Chief Operating Officer (COO),
- The Chief Nursing Officer (CNO),
- The Chief Medical Officer (CMO),.

PROCEDURE

I. Problems, questions or complaints should be handled by the staff present and in the simplest and most direct way that is appropriate to the situation. Depending on the nature of the complaint expressed by the patient or by their representative, the Manager or Director of that department will be notified and will be accountable for the initial response to the complainant and for attempting to provide an acceptable resolution.

a. II. Complaints unable to be resolved by the staff present and to the satisfaction of the complainant will become a grievance and documented by completing an occurrence report in accordance with AP 10. The Department of Risk Management will forward the complaint as indicated in Attachment A. Telephone and written grievances (including emails or faxes) will be processed by the Risk Management Department.

b. Complaints pertaining to Social media ~~-related concerns~~ will be facilitated by the Media Relations department and referred to the appropriate department leaders for issue resolution.

~~Social media-related concerns will be facilitated by the Media Relations department and referred to the appropriate department leaders for issue resolution.~~

c. ~~Any~~ C~~c~~omplaints or grievances pertaining to legal, abuse, violence, injury, or death will be forwarded to the Risk Management Department.

d. ~~d.~~ Complaints ~~specifically related to~~pertaining to breaches of patient privacy or misuse of Protected Health Information will be forwarded to the Compliance Department.

e. Complaints pertaining to discrimination on the basis of economic status, educational background, race, color, religion, ancestry, national origin, sex, gender, sexual orientation, gender identity/expression, disability, medical condition, marital status, age, registered domestic partner status, genetic information, citizenship, primary language, immigration status (except as required by federal law) or the source of payment for care will be forwarded to the ~~Compliance~~ Risk Management Department (Civil Rights Coordinator).

III. MEDICAL STAFF GRIEVANCES:

a. Grievances concerning members of the medical staff will be forwarded to the Medical Staff organization for investigation and for resolution through the occurrence reporting system.

b. If the complaint is in writing, the complainant will be informed of the following and given the address and toll-free number of the applicable state board:

i. The Medical Board of California is responsible for processing consumer complaints about physicians and surgeons;

ii. The Board of Podiatry Medicine is responsible for consumer complaints about podiatrists.

c. There is no requirement that the preceding steps be taken in response to a verbal complaint.

RESOLUTION*:*

I. The complaint or grievance is considered closed when the patient is satisfied with the actions taken on their behalf *unless* reasonable and appropriate actions have been taken on the patient's behalf in order to resolve the patient's grievance and the patient or their representative remains unsatisfied with the hospital's actions. Documentation of efforts and compliance with CMS requirements must be maintained.

II. All grievances will be responded to in writing within 7 days acknowledging receipt of grievance if resolution is unable to be achieved during this timeframe.

a. Written notice/response of the hospital's determination regarding the grievance must be communicated to the patient or to their representative in a language and manner the patient or their representative understands.

b. The written response will be provided by the Risk Management department.

III. The written notice/response MUST contain:

a. The name of the hospital contact person; (the Director of Risk Management or designee)

b. The steps taken on behalf of the patient to investigate the grievance

c. The results of the grievance process

d. The date of completion

I) IV. Complaints and Grievances may be responded to in person or via telephone when appropriate or when more information is required to fully investigate. This does not replace a written notice/response.

V. Every attempt will be made to resolve the grievance within 30 days. KDHCD will inform the patient or patient's representative if there will be a delay and, the timeframe within which they may expect our written response.

VI. If a Medicare beneficiary submits a grievance regarding quality of care or early discharge issues, the complainant will be provided information regarding their rights to contact the designated Quality Improvement Organization (QIO) for Medicare.VII. The Hospital Governing Board is responsible for the effective operation of the grievance process. The Board may delegate the responsibility for review and resolution of grievances to a Grievance Committee.

GRIEVANCE EXCEPTIONS

I. Billing issues are not usually considered a grievance except Medicare beneficiary billing complaints related to rights and limitations provided in 42 CFR 489. Examples provided below:
   a. Example: a complaint that the bill is incorrectly calculated **is <u>not</u>** a grievance
   b. A complaint that the patient was billed more because they were of a particular ethnic or racial group **<u>is</u>** a grievance.

PATIENT NOTIFICATION OF COMPLAINT PROCESS

A. Patients and their representatives will be notified of their rights to file a complaint or grievance with Kaweah Health, CDPH, and/or The Joint Commission via:
   a. Signage posted in the Kaweah Health main visitor lobbies, emergency room lobby, Health Information Management department, and the patient registration office.
   b. The Kaweah Health patient information guide (The Guide),
   c. The Kaweah Health website.

II. If, due to a patient's illness, injury, mental state, or due to an emergency situation, the patient's rights and/or grievance process cannot be communicated to the patient, those rights and the grievance process may be communicated to the patient's representative in a language and manner easily understood by the recipient.

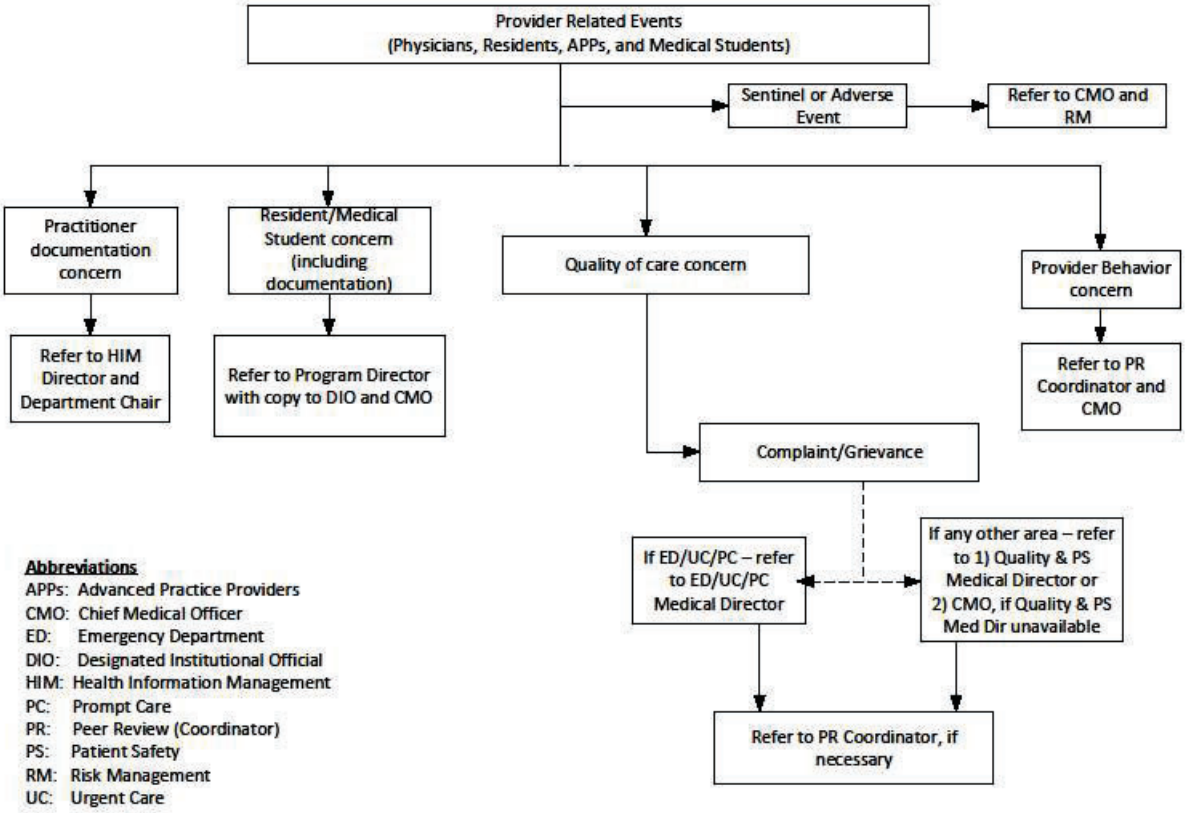
<u>CONFIDENTIALITY</u>

All information obtained through the Complaint and Grievance process will be maintained with the strictest confidentiality and security at all times. The accessibility of this information will be limited to those individuals authorized by the requirements of Peer Review Privilege and HIPAA.

Reference:
AP10 – Occurrence Reporting Process

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

ATTACHMENT A



Abbreviations
APPs: Advanced Practice Providers
CMO: Chief Medical Officer
ED: Emergency Department
DIO: Designated Institutional Official
HIM: Health Information Management
PC: Prompt Care
PR: Peer Review (Coordinator)
PS: Patient Safety
RM: Risk Management
UC: Urgent Care

AP 14

Policy Number: AP14	Date Created: No Date Set
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Department Visits by Vendor Representatives	

Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

Policy Number: AP14	Date Created: No Date Set
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Department Visits by Vendor Representatives	

POLICY: Kaweah Delta Health Care District is required by the Health Insurance Portability and Accountability Act (HIPAA) and State of California Privacy regulations to safeguard our patients' rights to privacy and confidentiality. In addition, ~~the District~~Kaweah ~~Delta~~Health is required to preserve the integrity of the patient care environment for our employees and medical staff. This policy shall define the procedure by which vendors, ~~and~~as well as manufacturer representatives, ~~Vendor~~ will be provided access to clinical, technical and administrative departments of Kaweah Delta for the purposes of conducting business with Kaweah Delta personnel, and will apply in all areas owned or operated by Kaweah ~~Delta~~Health.~~Therefore, it is required that the District defines and enforces appropriate and reasonable guidelines for sales representatives who access District employees and facilities to conduct business~~

~~Sales~~Vendor representatives are defined as individuals who represent products used by ~~the District~~Kaweah ~~Delta~~Health, including those individuals who mak~~inge~~ themselves available in the clinical setting to answer questions about or give guidance concerning the use of these products. ~~Sales~~Vendor representatives are also defined as individuals who provide general services, such as landscaping, courier or janitorial services, to the District. A ~~sales~~vendor representative **is not** any person who provides direct patient care (registry staff, perfusionists, etc.), any person who comes in direct physical contact with any patient, or any person who performs duties normally performed by an employee (such as temporary staff, interns, students, etc.) under the direction of a ~~District~~Kaweah ~~Delta~~Health supervisor, manager or

Director. These individuals are not governed by this policy, and ~~should~~ shall be referred to Human Resources for appropriate processing.
~~This policy shall define the procedure by which vendor and manufacturer representatives (sales representatives) will be provided access to clinical, technical and administrative departments of the District for the purposes of conducting business with District personnel, and will apply in all areas owned or operated by the District.~~

PROCEDURE:

I. Responsibilities of ~~Sales~~Vendor Representatives

A. ~~Sales~~Vendor representatives will acknowledge that their ability to conduct business with Kaweah ~~Delta~~Health ~~Health Care District~~, its personnel, and within its facilities, is a privilege and not a right. As such, all ~~sales~~vendor representatives will be required to respect and comply with all ~~District~~Kaweah ~~Delta~~Health policies and procedures at all times.

B. ~~Sales~~Vendor representatives shall, prior to entering any ~~District~~Kaweah ~~Delta~~Health location ~~premises~~, be registered with Vendormate and use a Vendormate kiosk to check in and obtain the appropriate vendor identification badge. Vendor identification badges must be worn at all times while on ~~District~~ premises at Kaweah ~~Delta~~Health. Vendor identification badges will be displayed above the waist on the upper chest so as to be fully visible to ~~District~~Kaweah ~~Delta~~Health personnel and Security staff.

~~Sales~~Vendor representatives visiting patient care areas for the purposes of providing support during invasive procedures will be subject to additional restrictions and requirements specific to those departments (for example, OR, Cath Lab, Endoscopy, etc.). Department specific policies and requirements of these areas will be provided to the ~~sales~~vendor representative through Vendormate and must be acknowledged upon initial registration within the Vendormate system, and annually thereafter. Department specific policies will require the same level of respect and compliance as ~~District~~Kaweah ~~Delta~~Health level policies, and must be complied with at all times.

~~Sales~~Vendor representatives visiting patient care areas for purposes of providing clinical in-service education must coordinate the in-service with the Clinical Education Department in advance.

C. All visits by ~~sales~~Vendor representatives will be by appointment only, scheduled **prior** to arriving at the facility. Appointment hours are between 8:00 a.m. and 4:30 p.m., Monday through Friday. Exceptions to these hours must be approved by the department Director. ~~Sales~~Vendor representatives who have not made prior arrangements with the ~~d~~Departments, or whose appointments can not be confirmed

upon their arrival, will not be allowed to enter ~~District~~Kaweah ~~Delta~~Health facilities ~~premises~~.

D. ~~Sales~~Vendor representatives who have appropriately checked in through Vendormate, and have had their appointment(s) confirmed, will report directly to the area of his/her appointment(s). Under no circumstance will ~~sales~~vendor representatives be allowed to visit unscheduled areas of Kaweah ~~Delta~~Health facilities~~the hospital~~. This policy will be strictly enforced.

E. ~~Sales~~Vendor representatives found to be in violation of this policy or any other ~~District~~Kaweah ~~Delta~~Health policies, may immediately lose any and all visiting privileges within ~~the District~~Kaweah ~~Delta~~Health facilities. In the event of loss of visiting privileges, the minimum period of restriction will be 30 days. Depending upon the nature and severity of the violation, this period may be extended as ~~the District~~Kaweah ~~Delta~~Health deems appropriate, up to and including the permanent loss of all visiting privileges at Kaweah ~~Delta~~ Health ~~Health Care District~~. ~~Sales~~Vendor representatives found to be in violation of this policy, or any ~~District~~Kaweah ~~Delta~~Health policy, are subject to immediate removal by the ~~District~~Kaweah ~~Delta's~~Health's Security staff. Repeated violations of this policy or any other ~~District~~Kaweah ~~Delta~~Health policies will result in the immediate and permanent ban of the sales representative from all ~~District~~Kaweah ~~Delta~~Health facilities.

F. ~~Sales~~Vendor representatives will be required to sign a Declaration of Confidentiality on an annual basis, and prior to entering any ~~District~~Kaweah ~~Delta~~Health facility for the first time. (See Exhibit A) ~~-~~In addition, prior to entering any ~~District~~Kaweah ~~Delta~~Health facility for the first time, ~~sales~~Vendor representatives will be provided through Vendormate, and acknowledge receipt of, copies of pertinent Kaweah Delta Health Care District policies including, but not limited to, Administrative Policy #14 – Departmental Visits by ~~Sales~~Vendor Representatives, and Human Resources Policy #13 – Sexual or Unlawful Harassment. Strict compliance of ~~sales~~vendor representatives with these policies, and all ~~District~~Kaweah ~~Delta~~Health policies, will be required at all times.

G. ~~Sales~~Vendor representatives are strictly prohibited from conducting business with physicians on ~~District~~Kaweah ~~Delta~~Health premises. Vendor appointments with physicians must be made directly with the physician's office, and be held outside of ~~District~~Kaweah ~~Delta~~Health facilities. Under no circumstance will a ~~sales~~vendor representative be allowed access to any physician lounge.

H. ~~Sales~~Vendor representatives are expected to respect the need of patients, patient family members, and physicians to have ready access to ~~District~~Kaweah ~~Delta~~Health parking. ~~Sales~~Vendor representatives will not be allowed to park, even for short periods of time for

loading/unloading, in any ~~District~~Kaweah ~~Delta~~Health parking space that has been designated for physician or patient use. ~~Sales~~Vendor representatives will also not park in designated staff parking areas. ~~Sales~~Vendor representatives will utilize only general public parking areas made available by the City of Visalia in the areas surrounding ~~District~~Kaweah ~~Delta~~Health premises, or the vendor designated parking in the lot just east of Kaweah Kids Center.

I. ~~Sales~~Vendor gifts and gratuities shall be governed and managed by AP.40 Vendor Relationships and Conflict of Interest.

~~representatives are prohibited from providing meals to District staff members unless the meal is provided as part of a vendor sponsored educational seminar or conference. Other token gifts (such as vendor promotional items like pens, notepads, etc.) will be allowed only at the discretion of the department Director or manager, and only when provided to the entire department. Gifts greater than $50 must be made to the Kaweah Delta Hospital Foundation.~~

J. Any ~~sales~~Vendor representative that requires access to Sterile Processing or the Operating Room must have permission from the Director of Surgical Services, the Operating Room Supervisor, or their designee before entering any surgical suite. All ~~sales~~Vendor representatives requiring such access must provide proof of training in sterile procedure and operating room techniques on an annual basis via the Vendormate credentialing process. In addition, proof of a negative TB skin test ~~–~~and other appropriate vaccinations must be provided on an annual basis, again through the Vendormate credentialing process. ~~Sales~~Vendor representatives exhibiting any sign of illness will not be allowed into the surgical suite.

Appropriate scrub attire is required by ~~District~~Kaweah ~~Delta~~Health Operating Room policy for those ~~sales~~Vendor representatives entering any surgical suite. ~~Sales~~Vendor representatives must wear ~~District~~Kaweah ~~Delta~~Health ~~-owned~~ scrubs while in the surgical suite as well as ~~District~~Kaweah ~~Delta~~Health provided red bonnets which clearly identify them as vendor personnel. Under no circumstance will sales representatives be allowed to wear scrubs provided by anyone other than the ~~District~~Kaweah ~~Delta~~Health. Upon completion of their business in the Operating Room, the sales representative must change into their personal or company-provided clothing and return the ~~District~~Kaweah ~~Delta~~Health ~~-owned~~ scrubs to the appropriate collection area. ~~Sales~~Vendor representatives are not to remove ~~District~~Kaweah ~~Delta~~Health scrubs from the premises, or leave ~~District~~Kaweah ~~Delta~~Health premises while wearing ~~District~~Kaweah ~~Delta~~Health ~~-owned~~ scrubs, for any reason.

Other than for purposes of entering the OR staff locker room to change scrubs, or to conduct an in-service education previously approved by the ~~District~~Kaweah ~~Delta~~Health's Clinical Education Department and the Director of Surgical Services, ~~sales~~vendor representatives are to remain outside of the OR staff lounge at all times. The OR staff lounge

is provided for the safety and comfort of Kaweah ~~Delta~~Health OR staff only. The cafeteria or other public waiting areas should be used by vendors that are between cases.

K. Vendor representatives providing instruments or equipment for special surgical cases must deliver the necessary instruments or equipment to ~~the District~~Kaweah ~~Delta~~Health no later than 24 hours prior to the scheduled case to allow adequate time for sterilization. ~~The District~~Kaweah ~~Delta~~Health is not responsible for instruments or equipment loaned to us by vendors, other than compensation for damages occurring due to negligence during normal use, storage or cleaning. ~~Sales~~Vendor representatives are responsible for lost or stolen equipment.

II. ~~District~~ Kaweah ~~Delta~~Health Staff Member Responsibility

It is the responsibility of all ~~District~~Kaweah ~~Delta~~Health staff members to understand and enforce the contents of this policy. All ~~District~~Kaweah ~~Delta~~Health employees will interact with sales representatives in a fair, honest and courteous manner. ~~District~~Kaweah ~~Delta~~Health employees will not accept gifts from ~~sales~~Vendor representatives beyond what is permitted in AP.40 Vendor Relationships and Conflict of Interest. ~~that which is allowed by this policy.~~ Department Managers/Supervisors and/or staff members contacted by ~~sales~~Vendor representatives shall inquire whether the representative has followed the protocol for registering with Vendormate. In cases where protocol was not followed, the representative will be instructed that they will not be allowed to visit the ~~District~~Kaweah ~~Delta~~Health until they have enrolled within the Vendormate credentialing system.

~~I.~~III. Purchasing Commitments

Only designated Materials Management Department staff are authorized to make purchase commitments on behalf of the ~~District~~Kaweah ~~Delta~~Health, except as noted below. ~~Sales~~Vendor representatives are cautioned not to expect payment for product brought into the ~~District~~Kaweah ~~Delta~~Health without a purchase order issued by the Materials Management Department. Except in cases where a consignment agreement exists between ~~the District~~Kaweah ~~Delta~~Health and a vendor, product should not be left in the facility with the expectation that the ~~District~~Kaweah ~~Delta~~Health will purchase the product at a later date. Product left in the facility without a consignment agreement, or brought into the facility without a properly issued purchase order, will be considered a donation to ~~the District~~Kaweah ~~Delta~~Health.

Exception: Director of Pharmacy and Director of Food Services, or their designees, may make purchase commitments for pharmaceuticals and foods stuffs, respectively.

IV. Evaluation Only Products and/or New Products

~~The District~~Kaweah ~~Delta~~Health ~~–~~follows a standardized, employee-driven evaluation process for the introduction of new products or equipment to our facilities on either a temporary evaluation or permanent basis. ~~Sales~~Vendor representatives will understand and respect this process. New equipment and/or products may not be put into service within the ~~District~~Kaweah ~~Delta~~Health without the knowledge and approval of the Materials Management Department. As noted above, any product or equipment brought into the facility for use, in disregard of this process, will be considered a donation. Kaweah ~~Delta~~Health ~~Health Care District~~ also follows strict policy concerning the use of equipment brought into the facility for evaluations. Any equipment brought to any ~~District~~Kaweah ~~Delta~~Health facility for evaluation purposes must, prior to its use by any staff member or on any patient, be reviewed and cleared through the appropriate ~~District~~Kaweah ~~Delta~~Health Department's including, but not limited to, Materials Management and Clinical Engineering.

"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."

EXHIBIT A

Declaration of Confidentiality

I, the undersigned, as a business associate/vendor representative to Kaweah Delta Health Care District, promise that I will observe the greatest confidentiality in all matters pertaining to ~~the District~~Kaweah ~~Delta~~Health's business.

Without limiting the completeness and generality of the above statement, I will continually keep in mind that any and all matters pertaining to:

- the care and treatment of all individuals dealing with ~~the District~~Kaweah ~~Delta~~Health;
- all activities of ~~the District~~Kaweah ~~Delta~~Health, of whatever description, with its patients, doctors, or with any other entities or person;
- the medical or personal history of all persons regarding which I may acquire information through the business of ~~the District~~Kaweah ~~Delta~~Health;

must be kept in complete and absolute confidence, and further, I will observe this confidence on all matters whenever my association with ~~the District~~Kaweah ~~Delta~~Health ends.

I understand that access or review of information, through verbal, written or electronic means, on a patient or client is allowed only to effectively carry out my assigned duties.

I will not use any ~~District~~Kaweah ~~Delta~~Health computer system to access patient information.

I further acknowledge that a breach of the foregoing statements by me will (without limiting any other rights of ~~the District~~Kaweah ~~Delta~~Health or others) justify ~~the District~~Kaweah ~~Delta~~Health in terminating my relationship with ~~the District~~Kaweah ~~Delta~~Health.

_____ _____
Printed Name Date

_____
Signature

_____
Company Name

~~(Date) (Signature)~~

AP 18

Policy Number: AP18	Date Created: 06/01/1998
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Foreign Language Forms, Signs, Etc.	

Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

Policy Number: AP18	Date Created: 06/01/1998
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Foreign Language Forms, Signs, Etc.	

POLICY: To ensure quality of translation, all forms, signs, pamphlets, brochures, etc., produced for display on or distribution by Kaweah Delta Health Care District, in a language other than English, will be coordinated through the Marketing and Interpreter Services Departments. ~~to provide proper content and structure meeting District standards.~~

"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."

AP 19

Kaweah Health
MORE THAN MEDICINE. LIFE.

Administrative Manual

Policy Number: AP19	Date Created: No Date Set
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Travel, Per Diem and Other Employee Reimbursement	

Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

Policy Number: AP19	Date Created: No Date Set
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Travel, Per Diem and Other Employee Reimbursements	

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

POLICY: Kaweah Health will reimburse employees for travel-related expenses and approved business costs, that are reasonably incurred during official Kaweah Health business activities.

GENERAL GUIDELINES:

- **Per Diem:** Employees traveling on Kaweah Health business will receive standard per diem to cover meals and incidental expenses.
- **Receipts:** All reimbursable expenses not covered by the per diem must be supported by original receipts. Expenses without a receipt will not be reimbursed unless approved by an Executive Team member.
- **Travel Outside of the Contiguous U.S.:** Travel beyond the lower 48 states is not permitted unless approved by an Executive Team member. (Contiguous US excludes Alaska and Hawaii)

REFERENCES:

AP46 Procurement Card
AP84 Mileage Reimbursements
AP105 Professional and Service Club District Reimbursed Memberships
AP156 Standard Procurement Practices

AUTHORIZATION: Authorization for expenses will be obtained as follows:

- Pre-Approval: For conference related travel, the employee must submit a spend authorization in Workday to obtain approval from their immediate supervisor and Cost Center Manager (Director) prior to the travel taking

place. A Spend Authorization includes all out of pocket expenses that the employee anticipates incurring as a result of the travel.

- Goods and services purchased for the benefit of employees and staff appreciation accounted for under any HR program (such as Job Well Done) must have Executive and HR approval before the purchase is made to confirm that the department has sufficient budgeted funds available to secure the purchase.

METHODS OF PAYMENT: Method of payments of approved travel expense is as follows:

- Payment by a Kaweah Health issued credit card – Approved business expenses paid for by using a Kaweah Health issued credit card must follow policies as set forth in AP46 (Commercial Card Expense Reporting (CCER))
- Prepayment by Accounts Payable – Travel expenses which are being paid for directly by Kaweah Health to a third party vendor must be submitted to Accounts Payable on a Accounts Payable Payment Request form before payment will be processed.
- Payment by the Employee (out of pocket expenses) – Approved business expenses may be paid by the employee and reimbursed based on employee reimbursement procedures as outlined herein.

PROCEDURE:

Travel, Per Diem, and other Employee Reimbursements:

I. No matter what mode of travel is being used, travel costs paid for by Kaweah Health for travel subsequently cancelled must immediately be refunded to the Kaweah Health unless such cancellation is for the business benefit or convenience of Kaweah Health and has been approved by a member of the Executive Team. The approver authorizing the travel is responsible to ensure that the refund is received by the Kaweah Health timely and the appropriate cost center properly credited for the refund. Non-reimbursable travel and non-travel expenses include, but may not be limited to:

A. charge card fees
B. meals in excess of the per diem rate, unless approved by the Executive Team
C. airline hospitality fees
D. frequent user program fees
E. personal services and sundries
F. personal gas or oil if a mileage allowance is received
G. baby-sitting/child care fees
H. traffic or parking violation citations
I. laundry and valet services
J. pet care
K. Extra luggage fees
L. replacement of lost luggage

M. personal gifts

N. alcoholic beverages except as permitted under section V and approved by a member of the Executive Team or Board of Directors.

II. Employees must submit an expense report and linked to the approved spend authorization.

III. Air Travel and Lodging

A. The lowest appropriate airfare will be obtained at all times unless alternative is specifically approved by the Director or a member of the Executive Team as applicable. Employees will only be reimbursed for the cost of coach fares and standard luggage fees.

B. Hotels offering special or corporate rates should be used whenever possible. When attending a conference, employees may stay at the hotel where the event is held to take advantage of the conference "host" discount.

C. Employees may participate, to their own personal benefit, in frequent user bonus programs. Kaweah Health will not reimburse any employee for costs associated with participation in frequent user bonus programs. Employees may not seek reimbursement when using rewards points for payment on airfare or lodging.

IV. Ground Transportation - Employees requiring ground transportation shall determine and utilize the most cost-effective means available.

A. Personal Vehicle - When it is necessary for an employee to utilize their personal vehicle to conduct Kaweah Health business, expenses will be reimbursed in accordance with AP84 (Mileage Reimbursement).

B. Taxi, Hotel or Airport Shuttle, Convenience Vans, etc. - Employees requiring transportation to or from a commercial carrier port such as an airport shall employ the most cost-effective alternative in arriving at their destination. Reimbursement will be made available to employees based upon actual costs incurred, supported by a detailed receipt. The use of alternate transportation shall only be used if more cost effective than the use of the employee's personal vehicle. Rental Cars - When adequate transportation at lower cost is not available (i.e., personal car, hotel or airport shuttle, taxi, etc.), cars (up to mid-sized) may be rented from a local vendor. Employees will not be reimbursed for charges associated with the rental company fee for waiver for collision/loss damage or liability.

V. Meals and Incidentals – Other than specific identified exceptions, meals and incidentals will not be reimbursed based on the cost of the meal or item of purchase. Instead, employees shall receive a standard travel per diem rate to cover all meals and incidentals while traveling (See Per Diem Section below). Exception to the per diem rate for which meals can be reimbursed based on original receipt include:

A. Reimbursing an Executive Team member, Director, or Board member for the cost of a group meal incurred while meeting with a business group consisting of employee(s), physician(s), supplier(s), employee or physician recruitment or any group meeting on Kaweah Health business.

B. Reimbursing an employee for the cost of a meal incurred while entertaining a visitor or other non-Kaweah Health employee on Kaweah Health business with the approval of the Executive Team or Board member.

Commented [VJ1]: Would this fall under the procedure section?

Commented [VJ2]: May need to be reworded

Commented [VJ3]: Does this belong here?

C. Reimbursing an employee for the cost of a meal incurred while entertaining a prospective physician candidate with the approval of the Executive Team member.

In the circumstances described above in items A, B, and C, alcoholic beverages may be consumed in connection with the meal and shall be considered a reimbursable business expense. Such purchases shall be reasonable and reflective of appropriate judgement/prudence.

Commented [VJ4]: Should this be "D" or a standard paragraph?

VI. Per Diem - Employees will receive a standard travel per diem rate to cover all expenses incurred by the employee on behalf of Kaweah Health during travel (aside from air fares, standard luggage fees, hotel registrations, mileage, transportation, and registration fees which are paid for by the Kaweah Health or directly reimbursed to the employee). A travel day includes the day immediately before and after the business event or if traveling on the same day as the business event, the travel day includes the official work day that is more than 12 hours but less than 24 hours as allowable by the U.S. General Service Administration located at *www.gsa.gov/**perdiem***.

A. To receive a per diem payment prior to travel, the employee must submit a Spend Authorization and an Expense report in Workday at least one week prior to travel along with the required documentation described below in Section VII. If travel is canceled for any reason, the employee must immediately refund Kaweah Health the per diem payment received for days not traveled unless otherwise approved by the Executive Team.

B. To receive the per diem payment after travel has been completed the employee must submit an Expense report within 30 days after travel has been along with the required documentation described below in Section VII.

VII. Entertainment – All requests for reimbursement of entertainment expenses must be approved by an Executive Team member.

VIII. Other Reimbursable Expenses:

A. Allowable Expenses

1. When obtaining goods, supplies or services through the normal purchasing procedure outlined in AP156 (Standard Procurement Practices) is not appropriate or practical for the given situation, or travel.
2. Purchases made must be for expenses associated with official Kaweah Health business.
3. Dues and memberships expenses must be in compliance with AP105 (Professional and Service Club District Reimbursed Memberships)

B. Prohibited Expenses

1. Capital expenditures, unless prior approval is obtained by the CEO and obtaining the capital item through the normal purchasing procedure via Materials Management is not appropriate or practical.
2. Goods, supplies or services normally purchased through materials management in accordance with Kaweah Health's Standard Procurement Practices (District Administrative Policy AP156)
3. Leases/rental agreements
4. Maintenance/Service Agreements
5. Software Licensing Agreements
6. Supplier Invoices of any kind

7. Office supplies in order to circumvent the normal ordering process)
8. Amazon purchases from a personal account (must be procured through Materials Management)
9. Services of sole proprietorships, individuals, non incorporated businesses, or physician payments (these are 1099 reportable and generally covered by a Kaweah Health contractual agreement)
10. Payment of any type of penalty or fines

IX. Required Documentation for Travel:

A. A Spend Authorization must be completed in Workday and and must include the Per Diem Calculation form along with the allowable per diem rate for location of travel as provided by the U.S. General Service Administration located at *www.gsa.gov/**perdiem*** and included on Kaweah Compass and (ii) evidence of the number of days traveling and location.

B. No receipts need to be submitted for expenses incurred that will be covered by the per diem rate. For expenses not covered by the per diem rate, itemized receipts **MUST** be uploaded when creating an expense report for reimbursement.

C. In the rare and unique occurrence that a receipt cannot be located, an Executive Team member must sign a Statement of No Receipt in order to be reimbursed. The Executive Team member can deny the reimbursement request.

D. If the business purpose of the transaction is not evident upon review of the receipt, further documentation of the business purpose is required.

Guidelines for Travel Time to determine hours to be paid.

1. Seminars, conferences, institutes or workshops inside or outside Kaweah Health's setting that directly impact or contribute to the employee's current job responsibilities may be compensated. If these meetings or courses are deemed "mandatory," there are specific wage and hour laws pertaining to compensation and for compensation for travel time for non-exempt personnel.

2. Time spent by employees attending training programs, lectures and meetings are not counted as hours worked if the attendance is voluntary on the part of the employee and all of the following criteria are met:

   a. Attendance is outside of regular working hours;
   b. Attendance is voluntary and employment will not be affected by nonattendance;
   c. The course, lecture, or meeting is not prescribed by Kaweah Health;
   d. The employee does not perform any productive work during such attendance.

Overnight Travel Out of Town:

1. If an non-exempt employee is required to travel on an overnight, mandatory out-of-town assignment, the employee will be paid for all hours from the time the employee leaves his/her home until the time that he/she reaches his/her destination. However, if the employee leaves directly from home to begin his or her travel, the employee's normal commute time shall be subtracted from the compensable travel time at the beginning and end of travel day.

2. If an employee is required to report to his or her worksite first and then leaves for the out-of-town travel assignment, all travel time is compensable, but the employee's normal commute will be subtracted at the end of the day.

3. Time that the employee spends sleeping and time when the employee is free to engage in purely personal pursuits in not compensable.

Meal and Rest Period Policy:

- Regardless of the type of travel, if being paid productive hours, employees are required to comply with the meal and rest period policies on any travel date.

Applies to mandatory seminars, conferences, institutes or workshops inside or outside the District setting that directly impact or contribute to the employee's current job responsibilities.

"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."

~~**POLICY:** Kaweah Delta Health Care District will reimburse employees for certain travel, travel time, and acceptable business expenses which are reasonably incurred in the course of District Kaweah Delta business. For travel costs relating to the cost of meals and incidentals while on travel to conduct Kaweah Delta business, the employee will receive a per diem rate to cover such costs.~~

~~All expenses submitted for reimbursement will require original receipts when not covered by the per diem rate. All receipts must include a detail of all items purchased. A summary credit card receipt will not be sufficient for reimbursement. Unless otherwise approved by an Executive Team Member "ET", expenses submitted without original detailed receipts will not be reimbursed by the DistrictKaweah Delta.~~

~~Travel or attendance at conferences outside the Contiguous US are generally prohibited. (Contiguous United States consists of the lower 48 states. This excludes Alaska and Hawaii.) Any exception requires the prior approval of the appropriate Director and Executive Team member.~~

~~**REFERENCES:**~~
~~AP46 Commercial Card Expense Reporting Program (CCER)~~
~~AP84 Mileage Reimbursements~~
~~AP105 Professional and Service Club District Reimbursed Memberships~~
~~AP156 Standard Procurement Practices~~

~~**AUTHORIZATION:** Authorization for expenses will be obtained as follows:~~

Pre-Approval: For conference travel, the employee must obtain written approval from their immediate supervisor (immediate supervisor refers to department Department Director or a member of the Executive Team) prior to the travel taking place (email approval is acceptable). Travel expenses not receiving prior approval will not be reimbursed by the DistrictKaweah Delta unless later approved by an ETExecutive Team member.

After travel: Employee expenses must be approved by the employee's authorized signer (generally a director or ETExecutive Team member). The approver must be an authorized signer with a completed Purchase Authorization Sheet on file with Materials Management (See District Policy AP156) having purchase limits and authority to approve travel expenses.

Department Manager/Supervisor expenses must be approved by their Director or , Vice President or Sr. Vice President.

Vice Presidents may sign for expenses to the limit of the authority provided them through the budgeting process. Vice President / Sr. Vice President's travel expenses must be approved by the Chief Executive Officer.

Goods and services purchased for the benefit of employees and staff appreciation accounted for under any HR program (such as Job Well Done) must have VP and HR approval before the purchase is made to confirm that the department has sufficient budgeted funds available to secure the purchase.

METHODS OF PAYMENT: Method of payments of approved travel expense is as follows:

Payment by a District Kaweah Delta issued credit card – Approved business expenses paid for by using a DistrictKaweah Delta issued credit card must follow policies as set forth in AP46 (Commercial Card Expense Reporting (CCER))

Prepayment by Accounts Payable – Travel expenses which are being paid for directly by the DistrictKaweah Delta to a third party vendor must be submitted on the attached Travel Reimbursement Form or nonstock before payment will be processed.

Payment by the Employee (out of pocket expenses) – Approved business expenses may be paid by the employee and reimbursed based on employee reimbursement procedures as outlined herein.

PROCEDURE:

Travel, Per Diem, and other Employee Reimbursements not related to travel:

No matter what mode of travel is being used, travel costs paid for by the DistrictKaweah Delta for travel subsequently cancelled must immediately be refunded to the DistrictKaweah Delta unless such cancellation is for the business benefit or convenience of the DistrictKaweah Delta and has been approved by a member of the ETExecutive Team. The approver authorizing the travel is responsible to ensure that the refund is received by the DistrictKaweah Delta timely and the appropriate cost center properly credited for the refund. Non-reimbursable travel and non-travel expenses include, but may not be limited to:

charge card fees
meals in excess of the per diem rate, unless approved by the Executive Team
airline hospitality fees
frequent user program fees
personal services and sundries

personal gas or oil if a mileage allowance is received
baby-sitting/child care fees
traffic or parking violation citations
laundry and valet services
pet care
replacement of lost luggage
personal gifts
alcoholic beverages except as permitted under section IV and approved by a member of the ET Executive Team or Board of Directors.

Air Travel and Lodging

The lowest appropriate airfare will be obtained at all times unless alternative is specifically approved by the Employee's employee's supervisor (supervisor refers to department Department Director or a member of the Executive Team) as applicable. Employees will only be reimbursed for the cost of coach fares and standard luggage fees.

Hotels offering special or corporate rates should be used whenever possible. When attending a conference, employees may stay at the hotel where the event is held to take advantage of the conference "host" discount.

Employees may participate, to their own personal benefit, in frequent user bonus programs. KDHCD Kaweah Delta will not reimburse any employee for costs associated with participation in frequent user bonus programs.

Ground Transportation - Employees requiring ground transportation shall determine and utilize the most cost-effective means available.

Personal Vehicle - When it is necessary for an employee to utilize their personal vehicle to conduct DistrictKaweah Delta business, expenses will be reimbursed in accordance with AP84 (Mileage Reimbursement).

Taxi, Hotel or Airport Shuttle, Convenience Vans, etc. - Employees requiring transportation to or from a commercial carrier port such as an airport shall employ the most cost-effective alternative in arriving at their destination. Reimbursement will be made available to employees based upon actual costs incurred, supported by a detailed receipt. The use of alternate transportation shall only be used if more cost effective than the use of the employee's personal vehicle. Any exceptions must be approved by the employee's supervisor.

Rental Cars - When adequate transportation at lower cost is not available (i.e., personal car, hotel or airport shuttle, taxi, etc.), cars (up to mid-sized) may be rented from a local vendor. Employees will not be reimbursed for charges associated with the rental company fee for waiver for collision/loss damage or liability.

Private Limousine - Limousine costs will be reimbursed only when other reasonable transportation (i.e., shuttle, rental car, taxi cab, etc.) is not available.

Meals and incidentals Incidentals – Other than specific identified exceptions, meals and incidentals will not be reimbursed based on the cost of the meal or item of purchase. Instead, employees shall receive a standard travel per diem rate to cover all meals and incidentals while traveling (See Per Diem Section below). Exception to the per diem rate for which meals can be reimbursed based on original receipt include:

Reimbursing an ET Executive Team member, Director, or Board member for the cost of a group meal incurred while meeting with a business group consisting of employee(s), physician(s),

vendor(s), employee or physician recruitment or any group meeting on DistrictKaweah Delta business.

Reimbursing an employee for the cost of a meal incurred while entertaining a visitor or other non-DistrictKaweah Delta employee on DistrictKaweah Delta business with the approval of the ETExecutive Team or Board member.

Reimbursing an employee for the cost of a meal incurred while entertaining a prospective physician candidate with the approval of the Vice President.

In the circumstances described above in items A, B, and C, alcoholic beverages may be consumed in connection with the meal and shall be considered a reimbursable business expense. Such purchases shall be reasonable and reflective of appropriate judgement/prudence.

Per Diem – Employees will receive a standard travel per diem rate to cover all expenses incurred by the employee on behalf of DistrictKaweah Delta during travel (aside from air fares, standard luggage fees, hotel registrations, mileage, transportation, and registration fees which are paid for by the DistrictKaweah Delta or directly reimbursed to the employee). A travel day includes the day immediately before and after the business event or if traveling on the same day as the business event, the travel day includes the official work day that is more than 12 hours but less than 24 hours as allowable by the U.S. General Service Administration located at *www.gsa.gov/**perdiem***.

To receive a per diem payment prior to travel, the employee must submit to Finance at least one week prior to travel an approved Travel Reimbursement Form (see attached form) requesting a per diem payment along with the required documentation described below in Section VII. If travel is canceled, and not approved by an Executive Team member, the employee must immediately refund DistrictKaweah Delta the per diem payment received for days not traveled.

To receive the per diem payment after travel has been completed the employee must submit to Finance within 60 days after travel has been completed an approved Travel Reimbursement Form (see attached form) requesting per diem pay along with the required documentation described below in Section VII.

Entertainment – All requests for reimbursement of entertainment expenses must be approved by an Executive Team member.

Required Documentation for all All tTravel:

Instead of completing a nonstock form, the employee must complete the Travel Reimbursement Form (see attached form) and must include (i) appropriate approval for travel as discussed above under "Authorization", (ii) the allowable per diem rate for location of travel as provided by the U.S. General Service Administration located at *www.gsa.gov/**perdiem*** and included on KD Central and (iii) evidence of the number of days traveling and location. The Travel Reimbursement Form is to be completed for each request for payment.

No receipts need to be submitted for expenses incurred that will be covered by the per diem rate. For expenses not covered by the per diem rate, original receipts **MUST** be submitted to the approver and attached to the Travel Reimbursement Form in order to be submitted to Finance for reimbursement.

For vendor purchases, a receipt including the vendor name, transaction amount, date, and detail of the item(s) purchased.

For Internet purchases, a screen print or order confirmation email

All receipts and/or invoices less than 8 ½ by 5 ½ inches must be taped to a plain white sheet of paper. Multiple receipts may be included on the same sheet of paper, but they may not overlap.

In the rare and unique occurrence that a receipt cannot be located, an Executive Team member must sign the Travel Reimbursement Form approving the missing receipt. The executive team member can deny the reimbursement request.

If the business purpose of the transaction is not evident upon review of the receipt, further documentation of the business purpose is required.

Guidelines for Travel Time to determine hours to be paid.

Seminars, conferences, institutes or workshops inside or outside the District setting that directly impact or contribute to the employee's current job responsibilities may be compensated. If these meetings or courses are deemed "mandatory," there are specific wage and hour laws pertaining to compensation and for compensation for travel time for non-exempt personnel.

Time spent by employees attending training programs, lectures and meetings are not counted as hours worked if the attendance is voluntary on the part of the employee and all of the following criteria are met:

Attendance is outside of regular working hours;
Attendance is voluntary and employment will not be affected by nonattendance;
The course, lecture, or meeting is not prescribed by Kaweah Delta;
The employee does not perform any productive work during such attendance.

Overnight Travel Out of Town:

If an non-exempt employee is required to travel on an overnight, mandatory out-of-town assignment, the employee will be paid for all hours from the time the employee leaves his/her home until the time that he/she reaches his/her destination. However, if the employee leaves directly from home to begin his or her travel, the employee's normal commute time shall be subtracted from the compensable travel time at the beginning and end of travel day.

If an employee is required to report to his or her worksite first and then leaves for the out-of-town travel assignment, all travel time is compensable, but the employee's normal commute will be subtracted at the end of the day.

Time that the employee spends sleeping and time when the employee is free to engage in purely personal pursuits in not compensable.

Meal and Rest Period Policy:

Regardless of the type of travel, if being paid productive hours, employees are required to comply with the meal and rest period policies on any travel date. Time that employees spend taking uninterrupted meal breaks of at least 30 minutes is not considered compensable "hours worked."

Procedures:

If the employee is eligible for compensation for attendance at any such meetings, classes or seminars, the time must be noted on the timekeeping record as such. Each employee is to complete a timesheet for each day of travel, recording hours worked. The timesheet should indicate the start and stop time of each travel and work period, as well as the start and stop time of each meal period. Pay will be generated from the employee's own accurate account of their time spent working and traveling. Each employee's time sheet must be signed by the employee and is subject to audit. The employee will receive his/her current hourly rate for all hours, exclusive of any differentials, but within wage and hour laws pertaining to overtime.

Refer to AP84: Mileage Reimbursement

Applies to mandatory seminars, conferences, institutes or workshops inside or outside the District setting that directly impact or contribute to the employee's current job responsibilities.

"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."

Kaweah Delta Health Care District

400 W. Mineral King Visalia, CA 93291-6263 (559) 624-2000 **Travel Approval and Reimbursement Form**

This form must be completed to submit request for conference and travel approval and for payment of per diem or reimbursement of travel expenses Submit completed form with supporting documentation and/or receipts to your Department Manager / Supervisor or Vice President / Sr. Vice President / CEO as applicable.

Name: Department # Date:

Title of Seminar / Conference:

Location (City, State) of Seminar / Conference:
Dates of Conference From: To:

TRIP DETAIL	**Estimated Expense**	**Actual**	**Method of Payment**	**Supporting Documentation for payment request? If "no" explain why.**
Registration Fees (608700)			KD Wells Fargo Personal Card Cash	
Mileage rate when using own car: Total miles _____ x $____ per mile Rate is determined by IRS.gov rate				
Public Transportation: Air, Bus, Train, Cab, etc.			KD Wells Fargo Personal Card Cash	
Lodging(See AP19-"Air Travel and Lodging" Paragraph: Total days ____ x $___ per day*			KD Wells Fargo Personal Card Cash	
Per Diem(See AP19 -"Per Diem" Section III)Working days ____ x $__ per day*Travel days ___ x $__ per day x 75%*				
Meals(See AP19-"Meals" Section III)			KD Wells Fargo Personal Card Cash	
Misc. Expenses (please specify) Parking / Car Rental, etc.			KD Wells Fargo Personal Card Cash	
TRAVEL COSTS TO BE CHARGED TO (608800)				

*** Amounts exceeding the per-day allowances must be approved by an Executive Team member prior to travel.**
Approval (Must include an Authorized Signor for the department being charged)

Conference Approval Expense/Reimbursement Approval

Employee Signature Employee Signature

~~Authorizing Supervisor (Director level or above)~~ ~~Authorizing Supervisor Director level or above~~

AP 53

Policy Number: AP53	Date Created: No Date Set
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Patients' Rights and Responsibilities, and Non-Discrimination	

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

PURPOSE: To support the expression of patients' values and beliefs within the limits of the organization's mission and philosophy, to allow patients to exercise cultural and spiritual beliefs and sexual orientation and gender identity that do not interfere with the well-being of others or the planned course of medical therapy for the patient and to ensure appropriate use and disclosure of patient information. To outline patient rights to access, amend, use, and request restrictions on the use and disclosure of Protected Health Information (PHI) and provide the framework for patient complaints regarding the access, use and disclosure of PHI so as to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and more specifically the Privacy Rule. To comply with applicable State and Federal civil rights laws regarding non-discrimination on the basis of economic status, educational background, race, color, religion, ancestry, national origin, sex, gender, sexual orientation, gender identity/expression, disability, medical condition, marital status, age, registered domestic partner status, genetic information, citizenship, primary language, immigration status (except as required by federal law) or the source of payment for care.~~race, color, national origin, age, disability or sex.~~

DEFINITIONS:

"**Closed Medical Records**" describes a completed record after discharge or after services have been provided.

"**Open Medical Records**" indicates the patient is not yet discharged from the facility.

"Designated Record Set" refers to a group of records that include protected health information ("PHI") that is maintained, collected, used or disseminated by, or for, Kaweah ~~Delta~~ Health for each individual that receives care from Kaweah ~~Delta~~ Health or another entity that Kaweah ~~Delta~~ Health's clinicians include in the individual's records.

The designated record set includes the following:

- Medical records and billing records about individuals maintained by or for a covered health care provider or one of its business associates.
- Enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan.
- Information used, in part or in whole, to make decisions about individuals. (Information from third parties should not be included)

Any research activities that create PHI should be maintained as a part of the designated record set and are accessible to research participants unless a HIPAA Privacy Rule exception exists.

"**Protected Health Information (PHI)"** Individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. May also be referred to as electronic protected health information (ePHI).

-or-

Any information in any form or medium that is created or received by Kaweah ~~Delta~~ Health that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

-or-

Information (i) that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse about a patient and (ii) including demographic information that may identify a patient that relates to the patient's past, present, or future physical or mental health or condition, related health care services, or payment for health care services.

POLICY:

In accordance with requirements of Section 70707 of the California Code of Regulations, Title 22, Medicare Conditions of Participation, Section 1557 of the Patient Protection and Affordable Care Act (42 USC 18116), Section 504 of the Rehabilitation Act of 1973, the Health Insurance Portability and Accountability Act (HIPAA) and The Joint Commission on Accreditation of Healthcare Organizations (The Joint Commission), Kaweah Health ~~Delta~~ has adopted the patients' rights and responsibilities detailed below.

I. Patient Rights

A. A patient shall have the right to exercise these rights without regard to economic status, educational background, race, color, religion, ancestry, national origin, sex, gender, sexual orientation, gender identity/expression, disability, medical condition, marital status, age, registered domestic partner status, genetic information, citizenship, primary language, immigration status (except as required by federal law) or the source of payment for care:~~sex, age, disability, economic status, educational background, race, color, religion, ancestry, national~~

~~origin, sexual orientation, gender identity or marital status or the source of payment of care:~~

1. Considerate and respectful care and to be made comfortable. The patient has the right to receive respect for their cultural, psychosocial, spiritual, and personal values, beliefs and preferences.

2. Have a family member (or other representative of their choosing) and their own physician notified promptly of their admission to the hospital.

3. Know the name of the licensed health care practitioner acting within the scope of his or her professional licensure who has primary responsibility for coordinating their care and the names and professional relationships of other physicians and non-physicians involved in their care.

4. Receive information about their health status, diagnosis, prognosis, course of treatment, prospect for recovery and outcomes of care (including unanticipated outcomes) in terms the patient can understand. The patient has the right to effective communication and to participate in the development and implementation of their plan of care. The patient has the right to participate in ethical questions that arise in the course of their care, including issues of conflict resolution, withholding resuscitative services, and foregoing or withdrawing life-sustaining treatment.

5. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedure as they may need in order to give informed consent or to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.

6. Request or refuse treatment, to the extent permitted by law. However, the patient does not have the right to demand inappropriate or medically unnecessary treatment or services. The patient has the right to leave the hospital against the advice of physicians, to the extent permitted by law.

7. Be advised if the hospital/licensed health care practitioner proposes to engage in or perform human experimentation affecting their care or treatment. The patient has the right to refuse to participate in such research projects.

8. Reasonable responses to any reasonable requests made for service.

9. Appropriate assessment and management of their pain, information about pain, pain relief measures and to participate in pain management decisions. The patient may request or reject the use of any or all modalities to relieve pain, including opiate medication, if they suffer from severe chronic intractable pain. The physician may refuse to prescribe the opiate medication, but if so, the physician must inform the patient that there are physicians who specialize in the treatment of severe chronic pain with methods that include the use of opiates.

10. Formulate advance directives. This includes designating a decision maker if the patient becomes incapable of understanding a proposed treatment or become unable to communicate their wishes regarding care. Hospital staff and practitioners who provide care in the hospital shall comply with these directives. All patients' rights apply to the person who has legal responsibility to make decisions regarding medical care on the patient's behalf.

11. Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be told the reason for the presence of any individual. The patient has the right to have visitors leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms.

12. Confidential treatment of all communications and records pertaining to their care and stay in the hospital. The patient will receive a separate "Notice of Privacy Practices" that explains their privacy rights in detail and how we may use and disclose your protected health information.

13. Receive care in a safe setting, free from mental, physical, sexual or verbal abuse and neglect, exploitation or harassment. The patient has the right to access protective and advocacy services including notifying government agencies of neglect or abuse.

14. Be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience, or retaliation by staff.

15. Reasonable continuity of care and to know in advance, the time and location of appointments as well as the identity of the person providing the care.

16. Be informed by the physician, or a delegate of the physician, of continuing health care requirements following discharge from the hospital. The patient has the right to be involved in the development and implementation of your discharge plan. Upon their request, a friend, domestic partner or family member may be provided this information also.

17. Know which hospital rules and policies apply to patient conduct while a patient.

18. Designate visitors of their choosing, if the patient has decision-making capacity, whether or not the visitor is related by blood or marriage, or registered domestic partner status, unless:

    - No visitors are allowed.
    - The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility.
    - The patient has told the health facility staff that they no longer want a particular person to visit.

    However, a health facility may establish reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors. The health facility must inform the patient (or the support person, where appropriate) of the visitation rights, including any clinical restrictions or limitations. The health facility is not permitted to restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

19. To have their wishes considered, if they lack decision-making capacity, for the purposes of determining who may visit. The method of that consideration will comply with federal law and be disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any persons living in your household and any support person pursuant to federal law.

20. Examine and receive an explanation of the hospital's bill regardless of the source of payment.

21. Exercise these rights without regard to, and be free of discrimination on the basis of economic status, educational background, race, color, religion, ancestry, national origin, sex, gender, sexual orientation, gender identity/expression, disability, medical condition, marital status, age, registered domestic partner status, genetic

information, citizenship, primary language, immigration status (except as required by federal law) or the source of payment for care. If you feel these rights have been violated, you can contact:

The Kaweah Health Risk Management Department
(Civil Rights Coordinator)
520 W Mineral King Ave, Visalia, CA 93291
21. Telephone (559)624-2340 ~~Exercise these rights without regard to sex, race, color, religion, ancestry, national origin, age, disability, medical condition, marital status, sexual orientation, educational background, economic status, or the source of payment for care.~~

22. File an internal grievance. The patient or their representative may do so by writing or calling:

~~Patient Relations Department~~Risk Management Department
Kaweah ~~Delta~~ Health
400 West Mineral King Avenue
Visalia, CA 93291
PHONE (559) 624-6665
FAX (559) 635-4064

Commented [AV1]: Is this phone number accurate?

The ~~Patient Relations~~Risk Management Department will review each grievance and provide the patient with a written response. The written response will contain the name of a person to contact at the hospital, the steps taken to investigate the grievance, the results of the grievance process, and the date of completion of the grievance process. Concerns regarding quality of care or premature discharge will also be referred to the appropriate Medicare Utilization and Quality Control Peer Review Organization (PRO).

23. File an external complaint with California Department of Public Health and/or The Joint Commission regardless of whether they use the hospital's internal grievance process.

California Department of Public Health
1200 Discovery Plaza, Suite 120
Bakersfield, CA 93309
PHONE (661) 336-0543
FAX (661) 336-0529

The Joint Commission
Division of Accreditation Operations
Office of Quality Monitoring
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
PHONE (800) 994-6610

FAX (630) 792-5636
www.complaint@jcaho.org

B. Patient Rights shall be posted at appropriate places throughout Kaweah HealthDelta. Patients of Kaweah DeltaHealth, upon admission or shortly thereafter, will be given a copy of Patient Rights and will have this policy explained by Patient Access staff.

II. Patient Privacy Rights/Notice of Privacy Practices (NOPP)

Patients, and other interested persons, will be provided with a defined opportunity to receive adequate notice of (1) the uses and disclosures of protected health information (PHI) that may be made by Kaweah DeltaHealth, (2) patient rights concerning PHI, and (3) Kaweah Delta's Health's legal duties pertaining to PHI.

A. Reasonable effort shall be made to provide patients or their legally authorized representative the current NOPP on the date of the first service deliver, except where the first service delivery involves emergency medical treatment; in such cases, the NOPP shall be provided as soon as it is reasonably practicable to do so.

B. Except in emergencies, reasonable effort shall be made to obtain a signed acknowledgement of receipt of the current NOPP from the patient or the legally authorized representative.

C. Document reasonable attempts to provide the current NOPP by filing the signed acknowledgement of receipt in the medical record. Refusals to sign the acknowledgement, or refusals to accept the NOPP, shall also be documented.

D. A current NOPP will be posted in a prominent location where it is reasonable to expect that patients will see and have an opportunity to read it. In addition, the current NOPP must be prominently posted and made electronically available on Kaweah Delta's Health's website. At any time, a patient or the patient's legally authorized representative may request and receive a copy of the current NOPP.

E. The NOPP shall provide a description of actual privacy practices, policies and procedures; a description of all uses and disclosures of PHI that Kaweah Delta Health may make without written authorization; a description of the types of uses and disclosures that require written authorization; and a statement that uses and disclosures not described in the NOPP also require written authorization.

F. The NOPP shall be revised and distributed promptly to reflect material changes to the uses or disclosures of PHI, patients' rights, Kaweah Delta's Health's legal duties, or the privacy practices stated in the notice. Subsequent to any revision, a copy of the 'old' NOPP shall be retained for 6 years from the date it was last effective.

G. Any person, not only a patient, who has questions about the NOPP or privacy/confidentiality practices shall be directed to the Compliance and Privacy Official for further information, if necessary.

H. Any member of the general public (who is not a patient or a patient's legally authorized representative) requesting the NOPP shall be provided the current NOPP as promptly as circumstances permit. The documentation requirements do not apply.

III. Patient responsibilities.

A. All patients have a responsibility to:

1. Provide, to the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters related to his/her health.

2. Report unexpected changes in his/her condition to the responsible practitioner.

3. Report whether he/she clearly comprehends a contemplated course of action and what is expected of him/her.

4. Follow the treatment plan recommended by the practitioner primarily responsible for his/her care. This may include following the instructions of nurses and allied health personnel as they carry out the coordinated plan of care, implement the responsible practitioner's orders, and enforce the applicable Kaweah ~~Delta~~ Health rules and responsibilities.

5. Keep appointments and, when unable to do so for any reason, notify the responsible practitioner or hospital.

6. Assure that the financial obligations associated with his/her health care are fulfilled as promptly as possible.

7. Follow the hospital rules and regulations affecting patient care and conduct.

8. Be considerate of the rights of other patients and Kaweah Health ~~Delta~~ staff members and for assisting in the control of noise, smoking, and the number of visitors.

9. Be respectful of the property of other persons and of Kaweah ~~Delta~~Health.

10. Be accountable for his/her actions if treatment is refused or if he/she does not follow the practitioner's instructions.

IV. Non-Discrimination

Kaweah ~~Delt~~He~~a~~lth complies with applicable Federal civil rights laws and does not discriminate on the basis of economic status, educational background, race, color, religion, ancestry, national origin, sex, gender, sexual orientation, gender identity/expression, disability, medical condition, marital status, age, registered domestic partner status, genetic information, citizenship, primary language, immigration status (except as required by federal law) or the source of payment for care.~~race, color, national origin, age, disability, or sex. Kaweah Delta Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.~~

Kaweah ~~Delta~~Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters;
- Written information in other formats (large print, audio, accessible electronic formats, other formats);
- Provides free language services to people whose primary language is not English, such as: q~~Q~~ualified interpreters;
- Information written in other languages.

If a person needs any of these services, contact the Interpreter Services Department at (559) 624-5902.

If a person believes that Kaweah Health~~Delta~~ has failed to provide these services or discriminated in another way on the basis of economic status, educational background, race, color, religion, ancestry, national origin, sex, gender, sexual orientation, gender identity/expression, disability, medical condition, marital status, age, registered domestic partner status, genetic information, citizenship, primary language, immigration status (except as required by federal law) or the source of payment for care:~~race, color, national origin, age, disability, or sex,~~ one can file a grievance in accordance with the procedure outlined above. (See I.A(22) and I.A(23) above and AP.08 Patient Complaint & Grievance Management)

The Kaweah Health Risk Management Department
(Civil Rights Coordinator)
520 W Mineral King Ave, Visalia, CA 93291
Telephone (559)624-2340

A person can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html.

Complaints regarding privacy concerns may be filed with the Chief Compliance and Risk ~~Privacy~~ Officer,
400 W. Mineral King Avenue,
Visalia, CA, 93291,
559-624-21545006, Fax 559-635-4064.,
~~email~~ ~~www.kdhcd.org~~www.kaweahhealth.org.

If assistance is needed, the Compliance and Privacy Officer, or their designee, is available.

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

Attachment A
(Forms available online at:
https://www.kaweahdelta.org/Patients-Visitors/For-Patients/Request-Medical-Records.aspx)

Kaweah Delta Health Care District
400 W. Mineral King - Visalia, CA 93291 - 559.624.2218 - Fax: 559.741.4888

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. **Failure to provide all information requested may invalidate this Authorization.**

USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: (___) _____ Alternate Phone: (___) _____
DOB: _____ SSN: _____

I hereby authorize _____ (Name of physician, hospital or health care provider) to disclose to:
Name of Requestor: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: (___) _____ Fax: (___) _____
Purpose of requested disclosure:
[ ] Medical Care [ ] Personal [ ] Other: _____
Date of Service: _____

This authorization applies to the following information:

[ ] History and Physical [ ] Dialysis Records [ ] Operative Report
[ ] Discharge Summary [ ] Labs/X-Rays/HIV Results
[ ] Mental Health Treatment Info [ ] Alcohol/Drug Treatment

Method of Release:
[ ] Pick up by Patient
[ ] Mail to: _____
[ ] Fax to: _____
[ ] Pick up by other than patient:
Name: _____

EXPIRATION

This authorization expires (insert date): _____

Kaweah Health

400 W. Mineral King – Visalia, CA 93291–6362 – 559.624.2000

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. **Failure to provide all information requested may invalidate this Authorization.**

USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name _____

Address _____

City _____ State _____ Zip Code _____

Phone (____)_____ Alternate Phone (____)_____

DOB _____ Last 4 Digits of SSN _____

I hereby authorize _____(Name of physician, hospital or health care provider) to disclose to:

Name of Requestor: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (____)_____ Fax:(____)_____

Purpose of requested disclosure:

❑Medical Care ❑Personal ❑Other: _____

Date of Service: _____

This authorization applies to the following information:

❑History and Physical
❑Discharge Summary
❑Mental Health Treatment Info
❑Operative Report
❑Office/Clinic Note
❑Immunization Record
❑Wellness Check (Physical)
❑Dialysis Records
❑Labs/X-Rays
❑HIV Treatment
❑Alcohol/Drug Treatment
❑Emergency Department Report
❑Genetic Information
❑Other: _____

Method of Release:

❑CD ❑Flashdrive ❑Paper ❑Mailed ❑Email

If emailed to patient, email address: _____

❑Pick up by patient

❑Pick up by other than patient:
Name: _____

EXPIRATION

This authorization expires (one year from today's date): _____

Kaweah Health
400 W. Mineral King – Visalia, CA 93291–6362 – 559.624.2000

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

NOTICE OF RIGHTS AND OTHER INFORMATION

I may refuse to sign this authorization. I have the right to receive a copy of this authorization.

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address:

Kaweah Health
Health Information Management
400 W. Mineral King Avenue
Visalia, CA 93291

My revocation will be effective upon receipt, but will be limited to the extent that the requestor or others may have responded to this authorization.

Neither treatment, payment, or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

Information disclosed pursuant to this authorization could be re–disclosed by the recipient and might no longer be protected by federal confidentiality law(HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or
unless such disclosure is specifically required or permitted by law.

I may inspect or obtain a copy of the health information that I am being asked to authorize use or disclosure.

I understand that this may include ALL medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my condition, including psychological or psychiatric impairment, drug abuse and/or alcoholism, and HIV results.

If this box ❑is checked, the requestor will receive compensation for the use or disclosure of my information.

SIGNATURE

Patient: _____ Signature: _____ Date/Time: _____

☐ Signed by other due to patient's condition at time of service

Other's Signature: _____ Date/Time: _____ Relationship: _____

Attending must authorize release of Psychiatric and Chemical Dependency records:

Please check one: ❑Authorize Release ❑Deny Release

_____	_____	_____	_____ am / pm
Physician	Signature	Physician #	Date/Time

Kaweah Delta Health Care District
400 W. Mineral King - Visalia, CA 93291 - 559.624.2218 - Fax: 559.741-4888

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

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Kaweah Delta Health Care District
Health Information Management
400 W. Mineral King Avenue
Visalia, CA 93291

My revocation will be effective upon receipt, but will be limited to the extent that the requestor or others may have responded to this authorization.

Neither treatment, payment, or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

I may inspect or obtain a copy of the health information that I am being asked to authorize use or disclosure.

I understand that this may include ALL medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my condition, including *psychological or psychiatric impairment, drug abuse and/or alcoholism, and HIV results.*

If this box [ ] is checked, the requestor will receive compensation for the use or disclosure of my information.

SIGNATURE

Date: _____ Time: _____ am/pm

Signature: _____
(Patient/representative/spouse/financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient:

_____

Attending must authorize release of Psychiatric and Chemical Dependency records:
Please check one: [ ] Authorize Release [ ] Deny Release

Signature: _____ Date: _____
(Attending Practitioner Signature)

Kaweah Delta Health Care District
400 W. Mineral King - Visalia, CA 93291 - 559.624.2000

AUTORIZACIÓN PARA EL USO O LA DIVULGACIÓN DE INFORMACIÓN MÉDICA

Completar este documento autoriza la divulgación y / o uso de información médica personal que podría identificarlo, según se explica a seguir, de conformidad con la ley Federal y de California pertinente a la privacidad de dicha información.
No proporcionar toda la información solicitada puede invalidar esta autorización.

USO O DIVULGACIÓN DE INFORMACIÓN MÉDICA

Nombre del paciente: _____

Dirección: _____

Ciudad: _____ Estado: _____ Código Postal: _____

Teléfono: (___) _____ Teléfono alternativo: (___) _____

Fecha de nacimiento: _____ Número de seguro social: _____

Por medio del presente Yo autorizo a _____
(Nombre del médico, hospital or proveedor de cuidado de salud,
para que intercambie información con:

Nombre del Solicitante: _____

Dirección: _____

Ciudad: _____ Estado: _____ Código Postal: _____

Teléfono: (___) _____ FAX: (___) _____

Propósito de la divulgación solicitada: [ ] Atención médica [ ] Personal
[ ] Otro: _____

Fecha del servicio: _____

Esta autorización aplica a la siguiente información:

[ ] Historial Médico y Examen Físico
[ ] Resumen al dársele de alta
[ ] Informe Operativo
[ ] Info. de Tratamiento de Salud Mental
[ ] Registro de Diálisis
[ ] Laboratorio / Rayos X / Resultados VIH
[ ] Info. de Tratamiento por Abuso de Alcohol / Drogas

Método de divulgación: [ ] Enviado por Fax a: _____
[ ] Recogido por el paciente [ ] Enviado por correo a: _____
[ ] Recogido por otra persona que no es el paciente
Nombre: _____

Kaweah Health

400 W. Mineral King - Visalia, CA 93291-6362 - 559.624.2000

AUTORIZACIÓN PARA EL USO Y DIVULGACION DE DATOS MEDICOS

Al completar este documento usted autoriza la divulgación y/o uso de datos médicos individuales que lo identifican, como se describe a continuación, de acuerdo a la ley Federal y de California sobre la privacidad de tal información. **El no suministrar toda la información solicitada pudiera causar que ésta autorización no sea válida.**

USO O DIVULGACIÓN DE DATOS MÉDICOS

Nombre del paciente: _____

Domicilio: _____

Ciudad: _____ Estado: _____ Código Postal: _____

Teléfono: (___) _____ Teléfono alternativo: (___) _____

Fecha de nacimiento: _____ Últimos 4 números de su seguro social: _____

De esta manera autorizo a _____

(Nombre del médico, hospital o profesional de atención médica)

para divulgar a:

Nombre del Solicitante: _____

Domicilio: _____

Ciudad: _____ Estado: _____ Código Postal: _____

Teléfono: (___) _____ Fax: (___) _____

Motivo por el cual se solicita la divulgación:

❑Atención médica ❑Personal ❑Otro: _____

Fecha en que se dieron los servicios: _____

Esta autorización aplica a lo siguiente:

❑Historial Médico y Examen Físico
❑Resumen al dársele de alta
❑Informe Operativo
❑Información de Tratamiento de Salud Mental
❑Nota de oficina/clinica
❑Registro de vacunas
❑Examen fisico (wellness)
❑Registro de Diálisis
❑Laboratorio / Radiografías
❑Tratamiento de VIH
❑Tratamiento por Abuso de Alcohol / Drogas
❑Informe de Sala de Emergencias
❑Información genética
❑Otro: _____

Método de divulgación

❑Recogido por el paciente: ❑Papel ❑CD ❑Unidad flash ❑Correo ❑Correo electronico
Si se manda por correo electrónico al paciente, indique el correo electrónico: _____

❑Recogido por otra persona que no es el paciente
Nombre: _____

VENCIMIENTO

Esta Autorización se vencerá (un año a partir de la fecha de hoy): _____

Kaweah Delta Health Care District
400 W. Mineral King - Visalia, CA 93291 - 559.624.2000

AUTORIZACION PARA EL USO O LA DIVULGACION DE INFORMACION MÉDICA

VENCIMIENTO

Esta Autorización vence: Fecha: _____

NOTIFICACIÓN DE DERECHOS Y OTRA INFORMACIÓN

Yo puedo negarme a firmar esta autorización. Tengo derecho a recibir a una copia de esta autorización. Puedo revocar esta autorización en cualquier momento. Mi revocación debe ser realizada por escrito, firmada personalmente por mí o por una persona que firme en mi nombre, y debe ser enviada a la siguiente dirección:

Kaweah Delta Health Care District, Health Information Management
400 W. Mineral King Avenue Visalia, CA 93291

Mi revocación entrará en efecto desde el momento en que sea recibida, pero no tendrá efecto referente a los actos que el Solicitante u otras personas hayan realizado basándose en esta autorización.

Mi decisión de dar o de negarme a dar esta autorización no condicionará el tratamiento, pago o mi elegibilidad para beneficios.

La información divulgada de conformidad con esta autorización podría a su vez ser divulgada por el receptor y podría dejar de estar protegida por la ley federal de confidencialidad (HIPAA, por su siglas en inglés). Sin embargo, las leyes de California prohíben a la persona que recibe mi información médica divulgarla a los otras personas, a menos que se obtenga otra autorización para esta divulgación de mi parte o que tal divulgación sea específicamente requerida o permitida por ley.

~~Puedo examinar u obtener una copia de la información médica que me están pidiendo~~ autorizar para usar o divulgar.Yo entiendo que lo anterior puede incluir TODOS los registros médicos, u otra información relacionada con mi tratamiento, hospitalización, y/o atención médica como paciente externo para mi condición, incluyendo *impedimento psicológico o psiquiátrico, abuso de drogas y/o alcoholismo y resultados de exámenes para detectar el VIH.*

Si este casillero está marcado [ ], el Solicitante recibirá compensación por el uso o divulgación de mi información.

FIRMA

Fecha: _____ Hora: _____am/pm

Firma: _____
(Paciente/representante/esposo/esposa/persona económicamente responsable)

Si firma otra persona que no sea el paciente, indique la relación legal a el paciente:

_____

El profesional que atiende debe autorizar la divulgación de los registros Psiquiátricos y de Dependencia Química:

Por favor, marque una: [ ] Autorizo la divulgación [ ] No autorizo la divulgación

Firma: _____ _____
(Firma del Profesional que atiende al paciente) *(Fecha)*

Kaweah Health
400 W. Mineral King – Visalia, CA 93291–6362 – 559.624.2000

AUTORIZACIÓN PARA EL USO Y DIVULGACIÓN DE DATOS MÉDICOS

NOTIFICACIÓN DE DERECHOS Y OTRA INFORMACIÓN

Yo puedo negarme a firmar esta autorización. Tengo derecho a recibir una copia de esta autorización. Puedo revocar esta autorización en cualquier momento. Mi revocación debe ser realizada por escrito, firmada personalmente por mí o por una persona que firme en mi nombre, y debe ser enviada a la siguiente dirección:

Kaweah Health
Health Information Management
400 W. Mineral King Avenue
Visalia, CA 93291

Mi revocación entrará en efecto desde el momento en que sea recibida, pero no tendrá efecto referente a los actos que el Solicitante u otras personas hayan realizado basándose en esta autorización.

Mi decisión de dar o de negarme a dar esta autorización no condicionará el tratamiento, pago o mi elegibilidad para beneficios.

La información divulgada de conformidad con esta autorización podría a su vez ser divulgada por el receptor y podría dejar de estar protegida por la ley federal de confidencialidad (HIPAA, por sus siglas en inglés). Sin embargo, las leyes de California prohíben a la persona que recibe mi información médica divulgarla a los a otras personas, a menos que se obtenga otra autorización para esta divulgación de mi parte o que tal divulgación sea específicamente requerida o permitida por ley.

Puedo examinar u obtener una copia de la información médica que me están pidiendo autorizar para usar o divulgar. Yo entiendo que lo anterior puede incluir TODOS los registros médicos, u otra información relacionada con mi tratamiento, hospitalización, y/o atención médica como paciente externo para mi condición, incluyendo *impedimento psicológico o psiquiátrico, abuso de drogas y/o alcoholismo y resultados de exámenes para detectar el VIH.*

Si este casillero está marcado ❑, el Solicitante recibirá compensación por el uso o divulgación de mi información.

FIRMA

Paciente _____ Firma _____ Fecha/Hora _____

☐ Firmado por otra persona debido a la condición del paciente al momento de los servicios

Firma de la otra persona _____ Fecha/Hora _____ Relación: _____

El profesional que atiende debe autorizar la divulgación de los registros Psiquiátricos y de Dependencia Química:

Por favor, marque una: ❑Autorizo la divulgación ❑No autorizo la divulgación

				am / pm
Physician	Signature	Physician #	Date/Time	

AP 67

Policy Number: AP67	Date Created: 03/01/2007
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	

District Fleet Vehicles and Management

POLICY: Kaweah Delta Health Care District dba Kaweah Health owns, leases, operates, and provides vehicles which may be used for authorized staff only when engaged in the performance of Kaweah Health business.

PROCEDURES:

I. Drivers License and Fines

Staff members whose job description require the operation of a Kaweah Health owned or leased vehicle while engaged in Kaweah Health business are required to possess a valid California Drivers ~~License. This~~License. This will be verified as part of the hiring process. In addition, a DMV check will be completed on all new employees hired into a position that requires driving.

Any and all fines incurred as a result of driving and/or parking violations are the exclusive responsibility of the driver.

II. Motor Vehicle Records will be examined periodically via the DMV's Employer Pull notice program to determine if employees have unsafe or poor driving records. District drivers may be removed from a driving position if the driver has evidence of the violations below:

a. Conviction for an alcohol and/or drug related driving offense
b. Serious moving violation, such as reckless driving
c. Any combination of (3) or more moving violations such as "At fault accidents the last 3 years"
d. Suspension, Revocation of driver's license
e. Leaving the scene of an accident as defined by state laws
f. At fault in a fatal accident
g. Felony committed involving a vehicle

~~II.~~III. ~~Kaweah Health Van~~

~~III. Kaweah Health maintains a van to be used on a reservation basis only for drivers approved through the Risk Management Department assuming it is available. To reserve a Kaweah Health Van the following must be completed:~~

~~A. Approval must be obtained from the employee's manager or director.~~

~~B. Request to reserve the van must be made at least five business days before it is to be used. This allows adequate time for authorization, issuance of fuel card PIN numbers and DMV checks.~~

~~C. The Kaweah Health Driver Attestation Form (Attachment 1) will be completed and a copy of the employee's driver license will be submitted to Risk Management at the time the van is requested (at least five days before it is to be used). The information must be faxed to 635-4064. Ensure that all drivers who might be driving the van during the period checked out complete the required documentation.~~

~~D.~~A. ~~The van will be picked up in PBX on the day it is needed and returned when the employee returns to town. The van should always be returned with the full tank of gas~~.

IV. Hours Worked

Time spent by a staff member driving a Kaweah Health vehicle while on Kaweah Health business during normal working hours will be considered hours worked for pay purposes.

V. Gasoline

Each Kaweah Health Vehicle will have a WEX Fuel Card included in the glove box for use. To use the WEX card, an assigned driver must be issued a PIN from the Risk Management Department. ~~Fleet Card Coordinator in Finance~~. Those assigned a WEX Pin number must do the following:

A. Complete the WEX PIN Authorization Form (Attachment 2)
B. Use the WEX card exclusively when fueling District vehicles
C. Enter the exact current mileage at the time of the purchase at the pump
D. Use self service pumps and fuel of the type and grade specified by the manufacturer
E. If a problem is encountered at the time of fueling, contact WEX immediately using the 800 number on the back of the card.
F. Report a lost, damaged or stolen card to the Fleet Card Coordinator immediately upon discovery.

VI. Vehicle Maintenance and/or Maintenance Issues

Each vehicle will have an Enterprise Maintenance Card included in the glove box, along with authorized locations where maintenance can be performed. It is the responsibility of the Department using the vehicle to ensure that appropriate maintenance is completed on the fleet vehicle, including oil changes, tire rotations and other routine maintenance items. Questions regarding non routine maintenance or services must be director to the Director of Facilities.

VII. Traffic Accidents

In the event that a staff member is involved in a traffic accident while in a Kaweah Health vehicle, regardless of the extent of damage or the lack of injuries, the staff member will report the accident immediately to their Supervisor, Risk Management and the Director of Facilities.

In the event of a traffic accident, staff members are expected to cooperate fully with the authorities and reply to questions of investigating officers. However, staff members should make no voluntary statements or make any admissions of liability.

VI. Monthly Safety Inspection and Annual Training

A monthly safety inspection will be completed each month for each vehicle that is part of the Kaweah Health Fleet. The monthly safety inspection will be completed to ensure that basic safety features of each vehicle are working effectively. It is the responsibility of the Director to which the vehicle is assigned that all vehicle safety issues are remediated in a timely manner using an approved vendor, as outlined in Section IV of this policy.

In addition, a driving safety training course will be required annually for all employees in a driving job code. Driving safety training may also be assigned to employees specific to post accident investigations as needed. ~~This training course will be provided through Net Learning~~.

Drivers of vehicles that transport children will be trained in child seat safety.

VI. Monthly Reporting

Each month an email will be sent from the Facilities and Maintenance Department to each Director who is assigned a Kaweah Health vehicle or vehicles. This email will include reports regarding vehicle usage, maintenance costs, oil changes that are due to be completed, and fueling reports. It is the responsibility of each director to review this information for appropriateness and to ensure that indicated maintenance is completed.

ATTACHMENT 1

KAWEAH DELTA HEALTH CARE DISTRICT dba KAWEAH HEALTH DRIVER ATTESTATION FORM

1. I am 21 years old or older.

2. My date of birth is _____.

3. My California Driver's license is current – expiration date: _____.

4. My California Driver's license number is _____.

5. My California Driver's license is not suspended.

6. I have had 2 years experience as a licensed driver in the United States.

7. I have not had more than TWO major violations in the past three years.

8. I have not had more than TWO chargeable accidents in the past three years

9. I have never had a driving under the influence, narcotic, drug or felony conviction.

10. I hereby authorize Kaweah Health to procure Motor Vehicle Records and additional reports about me from time to time, as it deems appropriate, to evaluate my insurability or for other permissible purposes

_____
Date

_____ _____
Employee's Signature PRINT Employee's Name

_____ _____
Manager's/Director's Signature PRINT Manager/Director Name

ATTACHMENT 2

WEX Personal Identification Number (PIN) Authorization Form
Kaweah Delta Healthcare District dba Kaweah Health

Last Name _____ First Name _____

Job Title _____ Employee ID _____

Dept Name _____ Dept # _____

Business Phone _____

Manager/Director Approval Signature_____

Date _____

Employees authorized to fuel company vehicles are issued a (4) digit **Driver ID** to be used with a Kaweah Health (KDH) WEX Fuel Card. This document is to verify that you understand your responsibilities and the company's policies regarding the use of your Personal Identification Number (PIN).

Employee Acceptance Statements

1. I have been issued a Driver ID, which authorizes me to fuel company vehicles only, using the WEX Fuel Card.

2. I understand that my PIN identifies me by name on a fuel report and that I am accountable for all transactions made using my PIN. Therefore, I will not share my PIN with anyone. If I believe someone else knows my PIN, I will immediately notify the Fleet Card Coordinator. .

3. I understand that each time I use a WEX Fuel Card I am required to completely fill the vehicle's fuel tank and enter an accurate odometer reading. This will allow the monitoring of fuel usage and track required maintenance intervals. My failure to do this may result in disciplinary action.

4. I understand that each WEX Fuel Card is assigned to an individual Kaweah Health vehicle or specific fueling purpose (example; off road equipment fuel card). I understand that it is against District policy to swap or share cards between vehicles or to use any card for other than the intended purpose, including personal vehicles or non-business purposes. . Using the WEX Fuel Card for any purpose other than official business use will be considered theft of Kaweah Health property

Evidenced by my signature below, I understand and agree to the above statements. I acknowledge I have read and been given an opportunity to discuss the Kaweah Health Fleet

Vehicles Policy I understand that violations of this policy can result in administrative, disciplinary and/or criminal action by Kaweah Health up to and including termination.

Employee Name_____

Employee Signature_____ Date _____

"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."

AP 88

Kaweah Delta Health Care District

Kaweah Health
MORE THAN MEDICINE. LIFE.

Administrative Manual:~~Subcategories of Department Manuals not selected.~~

Policy Number: AP88	**Date Created: No Date Set**
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration)	

Grievance Procedure - Section 504 of the Rehabilitation Act of 1973

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

PURPOSE: The purpose of this policy is to establish a process for the receipt and processing of complaints for persons with disabilities.

POLICY: Kaweah Delta Health Care District, herein referred to as Kaweah Health, has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by the U.S. Department of Health and Human Services regulations (45 C.F.R. Part 84), implementing Section 504 of the Rehabilitation Act of 1973 as amended (29 U.S.C. 794). Section 504 states, in part, that "no otherwise qualified disabled individual…shall solely by reason of his/her disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance…" The law and regulation may be examined in the office of the Chief Compliance and Risk~~Privacy~~ Officer, Kaweah ~~Delta~~ Health ~~Care District~~, ~~520 West~~400 W. Mineral King, Visalia, CA 93291, (559) 624-5006, who has been designated as the Section 1557 Civil Rights ~~Section 504~~ Coordinator to coordinate the efforts of Kaweah ~~Delta~~ Health ~~Care District~~ to comply with the regulations. The purpose of this procedure is to ensure full compliance with this regulation and to provide the means for promptly addressing complaints or concerns that may arise.

PROCEDURE:

I. Grievances must be submitted to the Section 1557 Coordinator (The Risk Management Department) within (60 days) of the date the person filing the grievance becomes aware of the alleged discriminatory action.

II. A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.

III. The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of [Name of Covered Entity] relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.

IV. The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.

V. The person filing the grievance may appeal the decision of the Section 1557 Coordinator by writing to the (Administrator/Chief Executive Officer/Board of Directors/etc.) within 15 days of receiving the Section 1557 Coordinator's decision. The (Administrator/Chief Executive Officer/Board of Directors/etc.) shall issue a written decision in response to the appeal no later than 30 days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex (including pregnancy, sexual orientation, and gender identity), age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

Complaint forms are available at: https://www.hhs.gov/ocr/complaints/index.html. Such complaints must be filed within 180 days of the date of the alleged discrimination.

Kaweah Health will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

~~I. A complaint should be in writing, contain the name and address of the person filing it, and briefly describe the discriminatory act.~~

~~II. A complaint should be filed in the office of the Section 504 Coordinator within a reasonable time after the person filing the complaint becomes aware of the alleged discriminatory act.~~

~~III. The Section 504 Coordinator, or designee, will investigate the complaint. The investigation will be informal but thorough, affording all interested persons and their representatives an opportunity to submit evidence relevant to the complaint.~~

~~IV. The Section 504 Coordinator shall issue a written decision determining the validity of the complaint no later than 30 days after its filing.~~

~~V. The Section 504 coordinator shall maintain the files and records relating to all complaints filed. The Section 504 coordinator may assist persons with the preparation and filing of complaints, participate in the investigation of complaints, and make recommendations concerning their resolution.~~

~~VI. An individual who files a complaint may pursue other remedies. This includes filing a complaint with the:~~

~~U.S. Department of Health & Human Services~~
~~Office of the Civil Rights, Region IX~~
~~90 7th Street, Suite 4-100~~
~~San Francisco, CA 94103~~
~~Phone (415) 437-8310~~
~~FAX (415) 437-8329~~
~~TDD (415) 437-8311~~

~~OR~~

~~U.S. Department of Health and Human Services~~

~~Office for Civil Rights~~
~~200 Independence Avenue, S.W.~~
~~Room 509F HHH Bldg~~
~~Washington, D.C. 20201~~
~~OCRMail@hhs.gov (E-mail)~~

"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."

AP 103

Policy Number: AP103	Date Created: No Date Set
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Public Release of Patient Information	

Administrative Manual:

Policy Number: AP103	Date Created: No Date Set
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Public Release of Patient Information	

PURPOSE: To provide guidelines for communication of specific patient information upon inquiry from the media or a member of the public.

POLICY: Basic patient information, as detailed below, may be released upon an inquiry concerning a specific patient, unless the patient specifically requests that such information be withheld. (Reference: Civil Code Section 56.16 and CHA Consent Manual and California Health Information Privacy Manual). However, there are special situations and circumstances that are described in more detail below and where applicable, should be followed.

Media requests for information should be forwarded to the Marketing and Media ~~Public~~ Relations Department during business hours and to the Nursing Supervisor at all other times. If necessary, the nurse in charge of any unit may provide the information requested.

Marketing, the Nursing Supervisor, or the nurse in charge of the unit may handle requests for information from the general public where the patient is receiving care. Information is limited as detailed below.

PROCEDURE:

I. Basic Information Which May Be Publicly Released

The only information which may be released to the public is confirmation of the patient's presence in the hospital and the general condition of the patient. Information about the condition and location of a patient may be released only if the

inquiry specifically contains the patient's name. No information can be given out if a request does not include the patient's name.

Other patient information cannot be released unless the patient specifically authorizes the release through a written authorization form.

A. General Conditions

In describing a patient's condition, employees should limit their comments to the following one-word descriptions:

1. **Undetermined.** Patient is awaiting physician assessment.
2. **Good.** Vital signs are stable and within normal limits. Patient is conscious and comfortable. Indicators are excellent.
3. **Fair.** Vital signs are stable and within normal limits. Patient is conscious but may be uncomfortable. Indicators are favorable.
4. **Serious.** Vital signs may be unstable and not within normal limits. Patient is acutely ill. Indicators are questionable.
5. **Critical.** Vital signs are unstable and not within normal limits. Patient may be unconscious. Indicators are unfavorable.
6. **Treated and Released.** Received treatment but not admitted.
7. **Treated and Transferred.** Received treatment. Transferred to a different facility.

"Stable" is not an accurate description of a patient's condition. This term should be avoided.

No statement may be made that there was a suicide or attempted suicide.

No statement may be made that a child's injuries appear to be the result of child abuse.

No statement may be made as to whether the patient is intoxicated or whether the ingested material is alcohol or other drugs regardless of whether the patient records are subject to state and federal regulation of drug or alcohol abuse patient records. Federal regulations and California law strictly prohibit the giving of any information about mental health or drug and alcohol abuse patients, including information as to whether or not they are in the hospital. While reporters may have information from the police concerning persons who subsequently become psychiatric or drug and alcohol abuse patients, all such inquiries should be answered, "We cannot, under federal regulations and/or California law, comment on the matter."

B. Location of a Patient

Disclosure of information concerning the patient's location to persons who inquire about the patient by name is permitted. However, caution should be exercised in disclosing this information over the phone. Release of such information is intended to facilitate visits by family and friends, as well as the delivery of gifts or flowers. Location should not be released to media. If such a request is made, contact the House Supervisor to handle the situation.

II. Special Situations

A. Death of a Patient

Privacy protections continue to apply to a patient's medical information even after the patient's death. The death of a patient is a "patient condition" and may be disclosed using the one-word "deceased." However, a patient's death may not be routinely announced by Kaweah ~~Delta~~ Health ~~Care District (Kaweah Delta)~~, but rather by the patient's physician or the coroner. Care should be taken to make sure that the patient's family has been notified and does not object to disclosure prior to making any announcement of a patient's death.

B. Public Figures

1. Public figures are entitled to the same considerations for privacy as all other members of the public.
2. The hospital should work with the public figure or his or her designee to answer these questions with minimum disruption for all concerned and to provide the appropriate cooperation with the media.

C. Patient or Patient's Family Contacts Media

The laws regarding the release of patient information apply even when the patient or the patient's family contacts the media. Other than cooperating to the extent described above, refer issues to Kaweah ~~Delta's~~ Health's Chief Compliance and ~~Privacy~~ Risk Officer, Director of Risk Management, Media Relations Department, Marketing Department, Administration, or House Supervisor.

D. Community Disasters

Marketing Department staff will coordinate media communications in the event of a disaster.

E. Identity of Physician

The attending physician's name should not be given to the news media without the permission of the physician and written authorization of the patient.

F. Release of Patient Information for Minors

Release of information for a minor requires that written consent be obtained prior to releasing information from either:

1. The minor, if he/she consented to the treatment; or
2. The parent or legal guardian, if it was necessary for the hospital to obtain his/her consent for treatment of the minor.

Once consent has been given, the general rules regarding release of patient information will apply.

G. Inquiries must contain the patient's name, unless the inquiry comes from clergy

Information about the condition and location of an inpatient, outpatient or emergency department patient may be released only if the inquiry specifically contains the patient's name. No information is to be given if a request does not include a specific patient's name. This includes inquiries from the press.

Inquiries from the clergy are an exception. Federal and State privacy regulations expressly permit hospitals to release the patient's name, location in the hospital, general condition and religion, so long as the patient has not refused release of the information. Clergy do not need to ask for the individual by name. Clergy may access the census via their assigned user ID and their own password.

H. Media Visits

When a member of the media needs to be on Kaweah Health ~~Delta~~ property for business purposes, they must arrange their visit through the ~~Marketing and Public~~Media Relations Department or Administration. An appropriate Kaweah Health ~~Delta~~ staff member or security must accompany reporters and photographers at all times. Media access to departments or areas within Kaweah ~~Delta~~ Health facilities may be restricted for safety and confidentiality reasons at any time.

"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."

AP 122

Policy Number: AP122	**Date Created: No Date Set**
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration)	
Interpreter Services	

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

PURPOSE:

A. To define the communication system that is used for patients who are Limited English Proficient (LEP) or who are deaf or hard of hearing (hearing impaired). Such a system will include appropriate "auxiliary aids" and/or language interpretation services to ensure effective communication between patients and staff during critical health services or treatment situations.

B. To provide guidelines for coordinating timely response to meeting the assessed special language needs of individual patients, their designated representative, guardian or next of kin.

C. To comply with the Americans with Disabilities Act (ADA), Title VI of the Civil Rights Act of 1964 and Health and Safety Code of California

Health and Safety Code of California requires licensed general acute care hospitals to provide language assistance services to patients with language or communication barriers.

Title VI of the Civil Rights Act of 1964 requires federal fund recipients to ensure the eligible Limited English Proficiency (LEP) persons have "meaningful access" to health services.

ADA Title II requires that public accommodations provide "auxiliary" aids when necessary to enable a person with disabilities to benefit from their services.

POLICY: It is the policy of Kaweah Delta Health Care District (KDHCD), herein referred to as Kaweah Health, to provide, to the extent possible, the use of qualified interpreters or assistive devices whenever a language or communication barrier exists. For patients that are minors or incapacitated, the preferred language of the patient's parent(s) guardian, or surrogate decision-maker will also be determined. The Bill of Rights for People with Limited English Skills will be provided orally or in a written format. The patient will be informed of the availability of free ~~interpretive~~ interpreter services. If the patient still chooses to use a family member or

friend who volunteers to interpret this will be documented in the electronic medical record., ~~then a Waiver of Interpreter Services will be initiated and entered into the patient file~~medical record.

A. ~~KDHCD~~ Kaweah Health recognizes that individuals and Health Care Providers must be able to communicate effectively. When language barriers exist between providers and patients, the quality of information is diminished and the outcome of the patient encounter may be unsatisfactory. This may lead to decreased patient compliance and increased potential for medical errors and misdiagnosis.

In emergency situations, treatment will be provided in accordance with standard medical practice. Interpreters will be sought promptly; but treatment will not be delayed pending the arrival of an interpreter.

B. It is the policy of ~~KDHCD~~KAWEAH HEALTH to provide equal access to and equal participation in healthcare activities for persons who are visually impaired, deaf or hard-of-hearing as well as for persons with Limited English Proficiency (LEP). ~~KDHCD~~KAWEAH HEALTH provides communication aids and services at no cost to the patient during their course of care. It is the policy of ~~KDHCD~~KAWEAH HEALTH to use qualified interpreters (certified, certificated or trained ~~or certificated~~) during critical health services or treatment situations. Qualified Sign Language interpreters are also available.

C. Effective communication is important in every area of hospital communication, but ~~KDHCD~~KAWEAH HEALTH prioritizes the most careful attention to effective communication in the provision of medical, nursing and ancillary services, where patient safety, medical error, and ability to understand treatment options are affected. The following types of encounters and procedures which are performed by providers who do not speak the primary language spoken by the patient/surrogate decision-maker, and which require the use of healthcare interpreter services, including, but not limited to:

a. Providing clinic and emergency medical services;
b. Obtaining medical histories;
c. Explaining any diagnosis and plan for medical treatment;
d. Discussing any mental health issues or concerns;
e. Explaining any change in regimen or condition;
f. Explaining any medical procedures, tests or surgical interventions;
g. Explaining patient rights and responsibilities;
h. Explaining the use of seclusion or restraints;
i. Obtaining informed consent;
j. Providing medication instructions and explanation of potential side effects;
k. Explaining discharge plans;

l. Discussing issues at patient and family care conferences and/or health education sessions;
m. Discussing Advanced Directives;
n. Discussing end of life decisions; and,
o. Obtaining financial and insurance information.

D. Interpreter Services are available 24 hours a day, 7 days a week and are free of charge to the patient. Interpreter Services can be made available in a variety of ways, depending on the specific needs of the patient. (See "Procedure" for additional information.)

E. All employees shall be instructed about interpretation services during their orientation program and on an ongoing basis as appropriate.

F. The patient's preferred language is to be noted in the patient's medical record ~~and plan of care~~. This will be determined by asking, "In what language do you prefer to discuss your health care?" This is regardless of whether the patient speaks English fluently or uses another language to communicate.

G. The policy of ~~KDHCD~~KAWEAH HEALTH shall be to provide all patients and surrogate decision-makers requiring language assistance with medical care information in their preferred language. LEP patients/surrogate decision-makers shall be advised of their right to have interpreter services provided within a reasonable time, at no charge to them.

~~H.~~ A patient is not required or expected to use friends or family members as interpreters because the use of such individuals may result in breach of confidentiality and reluctance from the patient to reveal personal information critical to the services to be provided. Should an LEP patient/patient representative insist upon the use of a friend or family member to be her/his interpreter, ~~KDHCD~~KAWEAH HEALTH needs to first ensure that the patient understands that interpreter services are legally guaranteed and free of charge. The Office of Civil Rights (OCR) Policy Guidance states that the hospital may proceed, provided that the use of such a person does not compromise the effectiveness or confidentiality of the patient, and provided that the offer and the patient's wishes are documented in the patient's file. ~~KDHCD~~KAWEAH HEALTH ~~personnel shall ensure that the patient signs the "Waiver of Interpreter Services" showing they have refused a hospital-provided interpreter (see attached form).~~

H.

I. Patient/families are to be made aware of the bilingual resources available in the following ways:

a. Signage/postings
i. Multilingual notices are to be placed in conspicuous locations informing patients of available bilingual services and how to access them. These notices ~~shall also~~ contain the telephone number where patients can file complaints about interpretation

services.
Each notice shall also include a TTY number for the hearing impaired. (See attached notices in English/Spanish.)

ii. Notices shall be posted in conspicuous areas around the facility including, but not limited to, the emergency room and major entrances, admitting areas and lobbies.

iii. Educational and vital documents and materials shall also be translated to Spanish and be made available to Spanish only speaking patients, as this population comprises at least 5% of ~~KDHCD~~KAWEAH HEALTH patient population.

J. It will be the policy of ~~KDHCD~~KAWEAH HEALTH to translate and make available all Vital Documents in Threshold Languages. The translation of other hospital written materials in Frequently Encountered or other languages shall be at the discretion of the issuing staff. Vital Documents that are not produced in a written translation shall be verbally translated to the patient or surrogate decision-maker. The provision of oral translation of all Vital Documents to patients shall be documented and documentation shall become a part of the medical record.

a. Prior to the assignment of work to a translator, the Interpreter Services Department will provide a Materials Review process for all materials that are to be translated into Spanish to ensure:
   i. Appropriate reading level for the target population;
   ii. Plain language will be used. The language is simple and clear;
   iii. Messages and illustrations are culturally appropriate;
   iv. Document prints clearly in black and white if it will be posted on the internet for public download

b. The ~~KDHCD~~KAWEAH HEALTH Interpreter Services Department will translate all Spanish translations, unless they are unable to meet indicated timelines. All requests for translations in any language will be routed through the Interpreter Services Department. Approved agencies may be used by the Interpreter Services Department to provide translation of patient information or education.

c. The Interpreter Services Department will review all translations returned by approved translation agencies before translations are returned to the department for duplication and/or distribution.

d. The Interpreter Services Department will assist the Marketing Department with the Spanish translation of forms, signs, pamphlets, etc. for display or distribution by ~~KDHCD~~KAWEAH HEALTH. (See Policy #: AP.18)

PROCEDURE

I. Notification of Interpreter Services

a. Notices in the form of Language ID Posters ~~and Language Easels~~ are

posted in the main hallway of each facility, Emergency Dept. and outpatient areas advising patients and their families about the availability of free interpretation services, a list of available languages, and how to access an interpreter.

II. Patient Identification
   a. The first access point in which a patient acquires services (emergency room registration, admissions, etc.) shall incorporate the determination of language needs into intake procedure.
      i. Do you speak a language other than English at home?
      ii. In what language do you prefer to receive your medical services?
   b. If the patient does not understand, use the Language Determination Cards/Posters to help patients identify their language.
   c. If the patient is unable to use the Language Determination Card, and hospital staff cannot determine the appropriate language, dial 8989 for assistance with the identification of their language.
   d. Note the patient's preferred language in the Patient's medical record, on their face sheet and the Assessment Data Base Record.

III. Inform Patients of their Right to Have Interpreter Services
   a. If the patient speaks a language other than English at home, the statement informing patients of their rights to interpreter services will also be provided to patients in written form in their primary language.
   b. This statement will be translated into all Threshold Languages.

IV. Patient Wristbands
   a. The wristband is light blue with the message: i. DIAL EXT. 8989 FOR INTERPRETER…
   b. In order to ensure that the preferred communication preferences follow the patient from department/facility to department/facility, a light blue wristband will be placed on the patient's wrist (dominant arm) and secured in order to identify and visually communicate to all staff that the patient has requested interpreter service be provided during his/her stay.
   c. If the patient's condition prohibits the application of the wristband to the wrist, then the ankle may be used.
   d. This procedure is applicable to all staff that initially register/admit the patient, as well as staff who provide patient care.

V. The Health Care Interpreter Network (HCIN)
   a. Simply dial 8989.
   b. Available 24 hours a day to assist with video and phone Interpretation via any ~~KDHCD~~KAWEAH HEALTH telephone, mobile phone or video phone.
   ~~c. Procedures are outlined on KDCentral under Department/Interpreter Services/Health Care Interpreter Network.~~

~~d.~~c. ~~If you are asked for your Access Code, it is 841263~~.

VI. Requesting an Interpreter
   a. Staff must utilize the appropriate interpreter for explanations of tests/procedures, surgery, to obtain informed consent, and to give critical instructions.
   b. If the staff person determines that an "in person" interpreter is required, he/she may contact the Interpreter Services Department at Ext. 2501, 5981, 5902);
   c. A Language Resource Assistant (LRA) may also be called and is listed under KDNet/Directories/Interpreter Directory.
   d. Necessary emergency care will not be withheld pending the arrival of interpreter services.
   e. All necessary contact numbers ~~and access codes~~ for ~~the direct contact of~~ contracted interpreter services shall be available to Emergency Room staff and in KDCentral.

VII. Hearing Impaired Patients
   a. American Sign Language Services are available by using the HCIN video phones located throughout the hospital and outlying facilities.
   b. Call the Interpreter Services Department at Ext. 5981, 5902, or 2501 for assistance.
   c. TTY Machines are available through PBX or the Information Desk as well as facilities throughout the District. Please follow the operating instructions.
      i. Plug the AC adapter into the nearest electrical outlet, connect to phone line and turn the power on.
      ii. Pick up the headset of the telephone and dial 1-800-735-2929 or 9-711.
      iii. Place the headset onto the TTY machine
      iv. Patient may begin using the keyboard.

VIII. Documentation:
   ~~a. The Staff person utilizing the qualified provider of healthcare interpreting or device will document the encounter in the patient's medical record.~~

      ~~1. Method (Face-to-face, Telephone, Video)~~
      ~~2. Date and time~~

   a. Documentation will be maintained in the Interpreter Services Department for:

      i. All interpretation encounters performed by ~~KDHCD~~KAWEAH HEALTH Interpreter Services Staff.

      ii. All services provided by contracted language interpretation services, including telephonic and videophone services.

IX. ~~Waiver of Interpreter Services~~

~~a. If after a patient has been informed of their right to receive free interpreter services, the patient insists upon the use of a friend of family member, then the Waiver of Interpreter Services will be completed and signed by the patient.~~

X. Qualified Providers of Healthcare Interpreting

a. Certified Medical Interpreters:

i. These English/Spanish speaking interpreters are obtained from the ~~KDHCD~~KAWEAH HEALTH Interpreter Services Department. These interpreters have achieved either a CHI credential from the Certification Commission for Healthcare Interpreters or a CMI credential from the National Board of Certification for Medical Interpreters.

~~a.~~b. Certificated Medical Interpreters:

i. These English/Spanish speaking interpreters are obtained from the ~~KDHCD~~KAWEAH HEALTH Interpreter Services Department and have been trained as interpreters.

~~b.~~c. Language Resource Assistants:

i. A list of staff is available on the KDNet service system under Directories/ Interpreter Directory.

ii. These bilingual staff members have indicated a willingness to interpret and have been tested and qualified for their ability to do so at the general or clinical/advanced level. (See Policy # HR.17).

~~iii. Currently, only English/Spanish and English/Lahu bilingual staff is listed. They are classified at the general or clinical level. (See Policy # HR.17).~~

c. Contracted Interpreter Services

XI. VIDATAK EZ Board

a. Available through the Interpreter Services Department as well as Patient Family Services and House Supervisor.

b. Initially designed for mechanically ventilated patients, they also work well for patients who display communication barriers but read in their own language and need to communicate basic needs and pain levels to their care providers from their bedside.

c. They are available in English and pictures as well as:

Spanish	Chinese	Vietnamese	Korean	Indonesian
Russian	Tagalog	Hindi	Japanese	Arabic
Polish	French	German	Portuguese	Italian
Farsi				

Definition of Terms

Non-English or Limited English Proficiency (LEP)
Those individuals whose native language is other than English and who cannot speak, read, write, or understand the English language at a level that permits them to interact effectively with healthcare providers.

Communication Barrier
Applies to a person who is deaf/hearing impaired, intubated or has neurological deficits or speaks another language hindering communication.

Deaf
This term is generally used to describe individuals with a severe to profound hearing loss, with little or no residual hearing. Some deaf people use sign language, such as America Sign Language (ASL) or Langue des Signes Quebecoise (LSQ) to communicate using their residual hearing and hearing aids, technical devices or cochlear implants, and/or speech reading.

Hard of Hearing “person with hearing loss”, Hearing Impaired
This term is generally used to describe individuals who use spoken language (their residual hearing and speech) to communicate. Most hard of hearing people can understand some speech sounds with or without hearing aids and often supplement their residual hearing with speech reading, hearing aids and technical devices.

Qualified Sign Language (ASL – American Sign Language) Interpreter:
A person who is fluent in sign language and is trained and proficient in the skill and ethics of interpreting and who is knowledgeable about the specialized terms and concepts that need to be interpreted for purposes of ensuring effective communication.

Healthcare Interpreter
One who has been trained in healthcare interpreting, adheres to the professional code of ethics and protocols of healthcare interpreters, is knowledgeable about medical terminology, and can accurately and completely render communication from one language to another.

Bilingual staff may provide patient instructions only if they had their competency tested and qualified to do so.

Translator
One who converts written text into a written text in a second language corresponding to and equivalent in meaning to the text in the first language.

Language Resource Assistant (LRA)
Kaweah Delta Health Care District staff member who is bilingual and who is willing to provide language interpretation. This person's language competency has been tested and is classified as general or clinical/advanced. They are identified by either an Orange LRA pin for General or a Dark Blue LRA pin for Clinical/Advanced that must be worn on their badge. Based on the designated level of language competency, the LRA will receive additional compensation to their current salary:

General - $ 2.~~50~~ 00 (~~fifty cents~~two dollars) for each 15 minute increment Clinical/Advanced - $~~1~~4.00 (~~one dollar~~four dollars) for each 15 minute increment

Compensation will be provided only for actual time of interpretation if such staff member is pulled outside of their line of work or work area. If being bilingual was an initial requirement of the job or staff member interprets within the course of their own work, additional compensation will not be awarded. A log of encounters will be submitted to the Interpreter Services Department on a bi-weekly basis. LRA compensation does not apply to the ~~KDHCD~~KAWEAH HEALTH Residency program.

Auxiliary Aids
Dual handset telephone for foreign language interpretation; qualified interpreters; telephones with volume control, Vidatak boards, patient needs communication cards; exchange of written notes.

Contracted Services
A designated service that provides 24-hour foreign language interpretation services either in-person or via telephone through which ~~KDHCD~~KAWEAH HEALTH has contractual agreements that define expectations and response time.

Attachments:
~~Waiver of Interpreter Services~~
Availability of Interpreter/Para Obtener un Intérprete
Available Languages from contracted services

See Administrative Policy AP.18

Kaweah Delta Health Care District

400 W. Mineral King • Visalia, CA 93277-6263 • 559 624 2000 **WAIVER OF INTERPRETER SERVICES**

I, _____ (Patient's name) have been informed of my right to receive free interpreter services from Kaweah Delta Health Care District. I understand that I am entitled to these services at no cost to me or my family.

I am choosing to provide my own interpreter at this time. To the best of my knowledge, this person is 18 years old or over. This person will act as my interpreter from __/__/__ to __/__/__. The name of my interpreter is:

NAME:
_____
_

ADDRESS:
_____

PHONE:
_____

RELATIONSHIP TO PATIENT:
_____

I understand I can withdraw this waiver at any time and request the services of an interpreter at no cost.

I also understand that this waiver does not give permission for any interpreter to act as my Authorized Representative.

This form was translated to me orally in _____ and I understand it.

Yo, _____(nombre del paciente) he sido informado de mi derecho a recibir los servicios gratuitos de tener interprete de Kaweah Delta Health Care District. Entiendo que tengo derecho a que se presten servicios gratuitos de interpretación para mí o mis familiares.

He decidido proveer mi propio intérprete en este momento. A mi mejor saber y entender, esta persona es mayor de 18 años. Esta persona me brindará servicios desde el _____ (fecha inicial) hasta el _____ (fecha final). El nombre de mi intérprete es:

NOMBRE:
_____

DOMICILIO:
_____

TELÉFONO:
_____

RELACIÓN AL PACIENTE:
_____

Entiendo que podré revocar esta renuncia en cualquier momento y solicitar los servicios de un intérprete sin cargo alguno.
También entiendo que esta renuncia no autoriza a ningún intérprete a actuar como mi representante autorizado.

Este formulario fue traducido para mí y entiendo su contenido.

Signature / Firma del paciente	Date / Fecha
Signature of Interpreter / Firma del intérprete	Date / Fecha
Signature of Staff Person / Firma del proveedor de servicios	Date / Fecha

Label

WAIVER OF INTERPRETER SERVICES

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Kaweah Delta Health Care District

400 W. Mineral King • Visalia, CA 93277-6263 • 559 624 2000 **WAIVER OF INTERPRETER SERVICES**

Bill of Rights for People with Limited English Skills

Even if you do not speak English well, you have the right:

- To get help from an interpreter who can translate English into your language. This service is free to you and your family;
- To be treated with courtesy and respect;
- To be treated in a way that is sensitive to your ethnic and cultural needs;
- To obtain services without facing discrimination, abuse or harassment;
- To get information about health care services in your language;
- To be part of the process of assessing your health and putting together a plan for your health services;
- To be told in your language what could happen if you accept services or refuse them;
- To raise concerns you have about the services you receive;
- To be told in your language about how to make a complaint about healthcare providers; To be told in your language about your rights and responsibilities when using services;
- To be told in your language about laws and policies a health-care provider must follow;
- To have your health care records kept confidential.

Declaración de derechos para personas con conocimiento limitado del idioma inglés

Aunque no hable bien el idioma inglés, usted tiene derecho a:

- Recibir ayuda de un intérprete que pueda traducir del inglés a su idioma. Este servicio es gratuito para usted y su familia;
- Ser tratado con cortesía y respeto;
- Ser tratado de manera sensible a sus necesidades étnicas y culturales;
- Recibir servicios sin enfrentar discriminación, abuso ni hostigamiento;
- Recibir información sobre servicios de atención de la salud en su idioma;

- ~~Participar en el proceso de evaluación de su salud y en el desarrollo de un plan para sus servicios de salud;~~
- ~~Recibir información, en su idioma, sobre lo que podría pasar si usted acepta servicios o los rechaza;~~
- ~~Expresar sus preocupaciones sobre los servicios que recibe;~~
- ~~Recibir información, en su idioma, sobre la forma de presentar quejas sobre proveedores de atención de la salud;~~
- ~~Recibir información, en su idioma, sobre sus derechos y responsabilidades al utilizar servicios;~~
- ~~Recibir información, en su idioma, sobre las leyes y normas que deben respetar los proveedores de atención de la salud;~~
- ~~Que sus registros de atención de la salud se mantengan en privado.~~

~~Label~~

~~WAIVER OF INTERPRETER SERVICES~~

~~Page 2 of 2~~

~~CVBF #934 Rev. 11/07~~

AVAILABILITY OF INTERPRETERS

Patients/surrogate decision-makers of Kaweah Delta Health Care District, who are Limited English Proficient (LEP), shall have services provided to them in their primary language or have interpreter services provided to them during the delivery of all significant healthcare services. Interpreter services shall be available within a reasonable time, at no cost to patients.

Commented [AV1]: Is this document updated? Should reflect "Kaweah Health"

This establishment subscribes to 24 hour interpretation services provided by:
The Health Care Interpreter Network

To obtain an interpreter for further assistance, please notify:
Interpreter Services Department
624-5902 or 624-5981

TTY phones for Deaf & Hearing Impaired patients will be provided when needed or requested. Please contact the Operator. A qualified American Sign Language (ASL) Interpreter may be called by contacting the Interpreter

Services Department. Service provided by:
The Health Care Interpreter Network

To file a complaint with the District regarding interpreter services provided, contact the District's Interpreter Services Manager at (559) 624-5902 or the:

Office of Civil Rights
US Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310: (415) 437-8311 TDD
Fax (415) 437-8329

You will not be penalized for filing a complaint.

DISPONIBILIDAD DEL SERVICIO DE INTÉRPRETES

Los pacientes o personas que toman decisiones al estar bajo la atención del Kaweah Delta Health Care District, quienes cuentan con un Dominio Limitado del Inglés (LEP, por sus siglas en Inglés), recibirán servicios en su propio idioma o tendrán los servicios provistos por un intérprete al estar recibiendo atención de salud clínicamente relevante. Los servicios del Departamento de Intérpretes se proporcionarán dentro de un espacio de tiempo razonable, sin costo alguno para el paciente.

Éste centro está suscrito al servicio de interpretación las 24 horas del día, y será provisto por:

The Health Care Interpreter Network

Para más ayuda y conseguir un intérprete, por favor llame a: Interpreter Services Department
624-5981 ó 624-5902

Los Teléfonos TTY para los pacientes Sordos e Impedidos de la Audición serán provistos cuando se necesiten o se soliciten. Por favor, comuníquese con la Operadora. Un intérprete capacitado en Lenguaje en Señas Americano (ASL, por sus siglas en Inglés) podrá ser llamado al comunicarse con el Interpreter Services Department. Dicho servicio será provistos por:

The Health Care Interpreter Network

Para presentar una queja frente al Distrito respecto a los servicios de interpretación provistos, comuníquese con la Gerencia del Interpreter Services Department al (559) 624-5902 ó a:

Office of Civil Rights (Oficina de Derechos Civiles)
US Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437 – 8310, (415) 437- 8311 TDD
Fax (415) 437-8329

No se le penalizará por presentar una queja.

Supported Languages and Dialects by Language

Acholi – *Uganda, Sudan*
Afrikaans – *South Africa, Namibia*
Akan – *Ghana, Ivory Coast*
Akateko – *Guatemala*
Albanian – *Albania*
Algerian Arabic – *Algeria*
Amharic – *Ethiopia*
Arabic – *Widely Distributed*
Armenian – *Armenia*
Ashanti (Asante Twi) – *Ghana*
Assyrian – *Iraq*
Azerbaijani – *Azerbaijan*
Azorean Portuguese – *Azores Islands*
Bahnar – *Vietnam*
Bahasa Indonesia (Indonesian) – *Indonesia*
Bambara – *Mali*
Belarusan – *Belarus*
Bengali – *Bangladesh, India*
Bosnian – *Bosnia & Herzegovina*
Brazilian Portuguese – *Brazil*
Bulgarian – *Bulgaria*
Burmese – *Myanmar (former Burma)*
Cambodian (Khmer) – *Cambodia*
Cantonese – *China*
Cape Verdean (Portuguese Creole) – *Cape Verde*
Catalan – *Andorra, Spain*
Cebuano – *Philippines*
Chaldean – *Iraq*
Chamorro – *Guam*
Chaozhou (Teochew) – *China*
Chin – *Myanmar (former Burma)*
Chinese (var. languages/dialects) – *China*
Chuukese (Trukese) – *Micronesia*
Croatian – *Croatia*
Czech – *Czech Republic*
Danish – *Denmark*
Dari (Afgan Farsi) – *Afghanistan*
Dene – *Canada*
Dewoin – *Liberia*
Dinka – *Sudan*
Duala – *Cameroon*
Dutch – *Netherlands*
Egyptian Arabic – *Egypt*
Estonian – *Estonia*
Ewe – *Ghana*
Fante – *Ghana*
Farsi (Persian) – *Afghanistan, Iran, Iraq, Pakistan*
Fijian – *Fiji*
Filipino (Tagalog) – *Philippines*
Finnish – *Finland*
Flemish – *Belgium*
French – *Africa, Canada, France, Tunisia, et al.*
French Creole – *Caribbean*
Fukienese – *China*
Fulani (Fulfulde, Fula) – *Cameroon, Niger, Nigeria, Senegal*
Fuzhou – *China*
Ga – *Ghana*
Gen (Mina) – *Togo, Benin*
German – *Germany*
Gokana (Khana) – *Nigeria*
Greek – *Greece*
Gujarati – *India*
Haitian Creole – *Haiti*
Haka Burmese – *Myanmar (former Burma)*
Hakka – *China*
Hausa – *Niger, Nigeria*
Hebrew – *Israel*
Hindi – *India*
Hmong – *China, Vietnam, Laos*
Hungarian – *Hungary*
Ibo (Igbo) – *Nigeria*
Ilocano – *Philippines*
Indonesian (Bahasa Indonesia) – *Indonesia*
Iraqi Arabic – *Iraq*
Italian – *Italy*
Japanese – *Japan*
Jarai – *Vietnam*
Javanese – *Indonesia*
Jordanian Arabic – *Jordan*
Juba Arabic – *Sudan*
Kanjobal (Q'anjob'al) – *Guatemala*
Kannada – *India*
Kapampangan – *Philippines*
Karen (Pa'o, S'gaw) – *Myanmar (former Burma)*
Kayah – *Myanmar (former Burma)*
Khmer (Cambodian) – *Cambodia*
Kinyarwanda – *Rwanda*
Kirundi – *Burundi*
Koho – *Vietnam*
Korean – *Korea*
Kpele – *Guinea, Liberia*
Krahn – *Liberia, Ivory Coast*
Krio – *Sierra Leone*
Kunama – *Eritrea*
Kurdish [Kurmanji, Sorani] – *Iraq, Turkey, Iran*
Kurmanji (Northern Kurdish) – *Turkey*
Kuawaiti Arabic – *Kuwait*
Lao – *Laos*
Latvian – *Latvia*
Lebanese Arabic – *Lebanon*
Lingala – *Congo, Republic of the*
Lithuanian – *Lithuania*
Luganda – *Uganda*
Luo – *Kenya*
Maay (Af Maay, Rahanween, Bantu) – *Somalia*
Macedonian – *Macedonia*
Malay – *Malaysia*
Malayalam – *India*
Malinke – *Senegal*
Mam – *Guatemala*
Mandarin – *China*
Mandinka (Mandingo) – *Senegal*
Marathi – *India*
Marshallese – *Marshall Islands*
Mayan [Akateko, Kanjobal] – *Guatemala, Mexico*
Mien – *China, Laos, Thailand*
Mina (Gen) – *Togo, Benin*
Minangkabau – *Indonesia*
Mixteco Alto – *Mexico*
Mixteco Bajo – *Mexico*
Mnong – *Vietnam*
Mongolian – *Mongolia*
Moroccan Arabic – *Morocco*
Nahuatl – *Mexico*
Navajo – *U.S.A.(Southwest)*
Nepalese – *Nepal, India*
Nuer – *Sudan*
Oromo – *Ethiopia*
Palestinian Arabic – *Israel, Jordan*
Pangasinan – *Philippines*
Papiamento – *Netherlands Antilles*
Pashto (Pushto) – *Pakistan, Afghanistan*
Persian (Farsi) – *Afghanistan, Iran, Iraq, Pakistan*
Polish – *Poland*
Portuguese – *Portugal, Brazil, et al.*
Portuguese Creole (Cape Verdean) – *Cape Verde*
Pulaar – *Senegal*
Punjabi (Panjabi) – *Pakistan, India*
Quechua – *Argentina, Bolivia, Colombia, Ecuador, Peru*
Quiche (K'iche) – *Guatemala*
Rade – *Vietnam*
Romanian – *Romania*
Russian – *Russia*
Samoan – *Samoa*
San Miguel – *Mexico*
Santa Eulalia – *Guatemala*
Saraiki – *Pakistan, India*
Serbian – *Serbia, Montenegro*
Serbo-Croatian – *Balkans*
Shanghainese – *China*
Sichuan (Szechuan) – *China*
Sinhalese – *Sri Lanka*
Slovak – *Slovakia*
Somali – *Somalia*
Soninke (Serahule) – *Mali*
Sorani (Central Kurdish) – *Iraq*
Spanish – *Spain, Latin America, et al.*
Sudanese Arabic – *Sudan*
Susu – *Guinea*
Swahili – *Kenya, Somalia, Tanzania, et al.*
Swedish – *Sweden*
Syrian Arabic – *Syria*
Tagalog (Filippino) – *Philippines*
Tai Dam – *Vietnam*
Taiwanese – *Taiwan*
Tamil – *India*
Telugu – *India*
Teochew (Chaozhou) – *China*
Thai – *Thailand*
Tibetan – *China*
Tigrigna (Tigrinya) – *Ethiopia, Eritrea*
Toishanese – *China*
Tongan – *Tonga*
Trukese (Chuukese) – *Micronesia*
Tunisian Arabic – *Tunisia*
Turkish – *Turkey*
Twi – *Ghana*
Tzotzil – *Mexico*
Ukrainian – *Ukraine*
Urdu – *Pakistan, India*
Vietnamese – *Vietnam*
Wolof – *Senegal*
Xhosa – *South Africa*
Yemeni Arabic – *Yemen*
Yiddish – *Israel*
Yoruba – *Nigeria*
Yup'ik – *U.S.A (Alaska)*
Zulu – *South Africa*
Zarma – *Niger*

Afghani	Croatian	Hmong	Maltese	Shona
Afrikaans	Czech	Hokkien	Mandarin	Sicilian
Akan	Danish	Huizhou	Mandingo	Sindhi
Albanian	Dari	Hungarian	Marathi	Sinhala
Amharic	Dene	Icelandic	Mien	Slovakian
Arabic	Dinka	Igbo/Ibo	Micif	Slovenian
Aramaic	Dogrib	Ilocano	Min Nan	Somali
Armenian	Dutch	Indonesian	Moldavian	South Slavey
Assyrian	Eritrean	Inuinaktun	Mongolian	Spanish
Azarbajiani	Estonian	Inuktitut	Ndebele	Susu
Azari/Azeri	Fante	Italian	Nepali	Swahili
Belorussian	Farsi	Japanese	North Slavey	Swedish
Bengali	Fijian	Kakwa	Norwegian	Tagalog
Berber	Finnish	Karen	Nuer	Taiwanese
Bosnian	Flemish	Khmer/Cambodian	Nyanja	Tamil
Bulgarian	Formosan	Kinyarwanda	Nzema	Telegu
Burmese	French	Kirundi	Ojibway	Thai
Cantonese	French-Canadian	Kiswahili	Ojicree	Tibetan
Cebuano	Frisian	Korean	Oromo	Tigrinya
Chaldean	Fuchownese	Kurdish	Polish	Toisan
Chao Chow	Fur	Kutchi	Portuguese	Tongan
Chilcotin	Ga	Lao	Punjabi	Turkish
Chipewyan	German	Latin	Pushto	Turkmen
Cree	Greek	Lingala	Romanian	Twi/Asante
Cree-James Bay	Gujarati	Lithuanian	Russian	Ukrainian
Cree-Plains	Gwichin	Low German	Salish	Urdu
Cree-Swampy Cree	Hakka	Lugbara	Sanskrit	Uyghur
Cree-Swampy	Hausa	Ma Di	Saulteaux	Veneto
Cree-Woodlands	Harari	Macedonian	Serbian	Vietnamese
Creole	Hebrew	Malay	Serbo-Croatian	Yiddish
Creole-Haitian	Hindi	Malayalam	Shanghainese	Zulu

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AP 161

Policy Number: AP161	Date Created: No Date Set
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	

Workplace Violence Prevention Program

PURPOSE:

1. To provide guidance on appropriate responses to all violence or threats of violence that may affect Kaweah Health (KH) workplace in any significant way. This policy and procedures applies, but is not limited to, employees, physicians, residents, patients, visitors, contract and temporary workers, vendors and other individuals, who are either on KH property or otherwise involved with KH operations in any way.
2. To heighten the safety of every individual in the workplace and to recognize that everyone must share in the responsibility of preventing and responding to threats of violence and actual workplace violence. Cooperation, adherence to and support of this policy and procedure by everyone, both management and non-management, are essential.
3. To recognize that a safe environment is fundamental to a productive and positive workplace, and that both physical and psychological safety are integral factors in providing patients with the quality health treatment and services to which KH has been entrusted.

POLICY: KH strictly forbids any behavior or threat of behavior which is inconsistent with the purpose of this policy, or which may constitute a violation of law or public policy. Once the potential for violent behavior has been established, KH will act immediately to minimize and diffuse such behavior. All employees bear a responsibility to report any potentially violent situation or individual to his/her manager, the Risk Management Department, Human Resources, Security and/or when applicable, the Police Department (or other appropriate law enforcement agency). The District will strictly abide by applicable statutes, laws and regulations regarding work place safety and security.

DEFINITIONS:

"Environment of Care" (EOC):
The physical and social environment within which services are provided for patients within the District and off site areas.

Workplace:
Any location, either temporary or permanent, where an employee performs

any work-related duty. This includes, but is not limited to, the buildings and surrounding perimeters, including the parking lots, field locations, alternate work locations, and travel to and from work assignments.

Workplace Violence:
Workplace violence means any act of violence or threat of violence that occurs at the work site. The term workplace violence does not include lawful acts of self-defense or defense of others.

(A) The threat or use of physical force against an employee that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury;

(B) An incident involving the threat or use of a firearm or other dangerous weapon, including the use of common objects as weapons, regardless of whether the employee sustains an injury;

(C) Four workplace violence types:

1. *"Type 1 violence" means workplace violence committed by a person who has no legitimate business at the work site, and includes violent acts by anyone who enters the workplace with the intent to commit a crime.*
2. *"Type 2 violence" means workplace violence directed at employees by customers, clients, patients, students, inmates, or any others for whom an organization provides services.*
3. *"Type 3 violence" means workplace violence against an employee by a present or former employee, supervisor, or manager.*
4. *"Type 4 violence" means workplace violence committed in the workplace by someone who does not work there, but has or is known to have had a personal relationship with an employee.*

Imminent/Actual:
Any act or speech threatening or committing assaultive behavior including, but not limited to, any physical contact or menacing behavior which would lead a reasonable person to believe that he/she is in danger of violence and or harm.

Potential Violence:
A potentially violent situation or individual includes but is not limited to:

- verbal harassment or threats perceived by a reasonable person occur as a prelude to assaultive behavior;
- a domestic dispute spills over into the work place;
- a restraining order has been obtained by an employee against another person;
- an employee is the victim of a stalker;
- an altercation occurs between persons on the premises;
- when gang activity spills over into the work place;
- when an assaultive or potentially assaultive patient is admitted.

Assault:
An unlawful attempt, coupled with a present ability, to commit a violent injury on the person of another.

Battery:
Any willful and unlawful use of force or violence upon the person of another.

COMPLIANCE

Implement procedures to obtain the active engagement of employees in developing, implementing, and reviewing the Workplace Violence Prevention Plan, including their participation in identifying, evaluating, and correcting workplace violence hazards, designing, and implementing training, and reporting and investigating workplace violence incidents. A copy of the plan is available to any employee at any time on KH's Policy Tech System.

PROCEDURES: See Workplace Violence Checklists on Pages 10-12.

RESPONSIBLITIES: Responsibilities for employees include, but are not limited to:

I. Employees:

To immediately report concerns or observed incidents of violence to his/her supervisor or in the absence of such supervisor, to Security, the Risk Management Department, Human Resources or any manager, and when applicable, to the Police Department (or other appropriate law enforcement agency). Patient Family Services can be reached by dialing Ext. 5633 for information on referral so. Follow Administrative Policy .10, Occurrence Reporting Process to complete the Occurrence Reporting form and submit to Risk Management for investigation. The Occurrence Report must be submitted before end of shift.

A. Employees who have reason to believe they, or others, may be victimized by a violent act sometime in the future, at the workplace or as a direct result of their employment with the Kaweah Health, are to inform their supervisor immediately. The supervisor will immediately inform the Risk Management Department, Security Department, Human Resources and his or her Director or Chief. The manager will work with the employee to complete a Workplace Violence Incident Report and, if indicated, contact local law enforcement officials. The Employee cannot be retaliated against for seeking assistance and intervention from emergency services or law enforcement when a violent incident occurs.

B. Employees who have signed and filed a restraining order, temporary or permanent, against an individual due to a potential act of violence, who would be in violation of the order by coming near them at work, will immediately supply a copy of the signed order to their supervisor. The supervisor will provide copies to Human Resources. Human Resources or designee will contact Security, local law enforcement officials, and others as appropriate.

II. Management

To immediately take action to prevent violence by reporting any potential violence to Security, Human Resources, or Risk Management, and when applicable, to the Police Department (or other appropriate law enforcement agency). Patient Family Services can be reached by dialing Ext. 5633 for information on referral sources.

III. Security Department

To assess any immediate or imminently violent situation and respond as appropriate based upon that a follow-up written investigation will be part of all assessments, and this report will be routed to Risk Management and, to Human Resources. If Security cannot diffuse the situation, or perceives the situation escalating, the Police Department (or other appropriate law enforcement agency) must be notified immediately. Other responsibilities include:

A. Keeping records of all violent acts, including location, time of day and actions taken; identifying trends, and using the information collected to develop action plans that may be needed;
B. Reporting findings to the *Environment of Care* Committee on a quarterly basis;
C. Ensuring at least annually, a security risk assessment is completed that identifies workplace security factors that have been shown to contribute to the risk of violence in the workplace. The risk assessment should include the review of access points, barrier placement between patients and providers, escape routes, location of panic alarms, security staffing ratios, security operational practices, the need for escort services or "buddy systems" when walking at night, camera surveillance and use of protective equipment by Security;
D. Reporting data to Human Resources;
E. Knowing when and how to implement access control to the organization;
F. Ensuring the *Security Management Plan*, EOC 3000 is current and addresses measures taken to protect personnel, patients and visitors from aggressive or violent behavior.

IV. Human Resources

A. Work in collaboration with Security and management to ensure communication linkages remain open;
B. Ensure a written *Illness and Injury Prevention Program* is in effect that addresses the following:
    a. Safe and healthy work practices, which includes non-engagement with threats and physical actions that create a security hazard to others;
    b. A system of communication with employees that includes a method employees can use to inform the employer of security hazards at the worksite;
    c. Periodic inspections that includes identification of security hazards;
    d. Procedures for investigating occupational injuries and/ or exposures;
    e. Procedures for communicating to employees the outcome of the investigation and any action plan to be taken;
    f. Procedures for correcting unsafe conditions, work practices, work procedures including workplace security hazards with attention to procedures for protecting employees from physical retaliation for reporting threats;
    g. Ensuring no retaliation of any kind will be taken against anyone who reports acts or threats of violence, or who participates in any action or investigation related to such complaints;

h. Training and instruction regarding how to recognize workplace security hazards, how to recognize "triggers" for violence, measures to prevent workplace assaults and what to do when an assault occurs, including emergency actions and post emergency procedures, and actions to take to diffuse a situation.

C. Provision of Emergency Department and Security staff with continuing education relating to security;
D. Provision of post-event trauma counseling to employees who are the victim of violence in order to reduce the short and long term physical and emotional effects of the incident;
E. Ensuring reductions in force, terminations and disciplinary actions such as suspensions are carried out in a manner that is designed to minimize a violent eruption;
F. Ensuring policies and procedures are consistently and fairly applied;
G. Ensuring any fatalities, illnesses and injuries that result from violence are reported to the Occupational Safety and Health Administration (OSHA) immediately and recorded on the OSHA log, and completing the required supplementary forms.

WORKPLACE VIOLENCE PREVENTION TEAM: The Workplace Violence Prevention team is designated to assess the vulnerability to workplace violence and reach agreement on preventive action to be taken. The team reports through the Environment of Care Committee and is responsible for:

- Implementing the Workplace Violence Plan;
- Assessing the vulnerability of workplace violence at KH and reaching agreement on preventive actions to be taken;
- Recommending/implementing employee training programs on workplace violence;
- Implementing plans for responding to acts of violence;
- Communicating internally with employees.

The WVP Team is composed of the following members:

- ✓ *Employee Health Manager*
- ✓ *Employee Relations Coordinator*
- ✓ *Human Resources Directors*
- ✓ *Organization Development Director*
- ✓ *Security Manager*
- ✓ *Facilities/Physical Plant Director*
- ✓ *Nursing Supervision Director*
- ✓ *Emergency Department Director*
- ✓ *Behavioral Health Director*
- ✓ *Outpatient Clinics Director*
- ✓ *Home Health Director*
- ✓ *Diagnostic Imaging Director*
- ✓ *Pharmacy Director*
- ✓ *Medical Staff Director*
- ✓ *Contracting Officer*
- ✓ *Vendor Management*

- ✓ *Marketing/Communications Director*
- ✓ *Compliance Officer*
- ✓ *Risk Management Director*
- ✓ *Environmental Services Director*
- ✓ *Safety Officer*
- ✓ *Executive Liaison (Nursing)*

ACTIVE ENGAGEMENT OF EMPLOYEES IN DEVELOPING, IMPLEMENTING AND EVALUATING THE WVP PLAN

At a minimum one employee from each high risk department and will actively participate in developing, implementing and reviewing the WVP plan.

LAW ENFORCEMENT INVOLVEMENT

The Security Manager and/or the Director of Risk Management will maintain collaborative involvement and partnership with local police department.

Proactive business relationships are maintained with Visalia Police District 1 and District 2 Commanders through quarterly meetings, formal committee meetings attendance (with invitation) or requests for incident review.

TRAINING AND INSTRUCTION:

Kaweah Health shall be responsible for ensuring that all employees, including managers, supervisors and contractors are provided training and instruction on general workplace safety practices. Department Directors shall be responsible for ensuring that all employees, including managers and supervisors, are provided training and instructions on job specific workplace security practices.

General workplace violence and security training and instruction include, but are not limited to, the following:

- Explanation of the Workplace Violence Prevention Program including measures for reporting any violent acts or threats of violence;
- Recognition of workplace security hazards including the risk factors associated with the four types of violence;
- Measures to prevent workplace violence, including procedures for reporting workplace security hazards or threats;
- Ways to defuse hostile or threatening situations;
- Measures to summon others for assistance;
- Employee routes of escape;
- Notification to law enforcement when a criminal act may have occurred;
- Emergency medical care provided in the event of any violent act upon an employee;
- Post-event trauma counseling for those employees desiring such assistance.

Training and instruction is conducted at minimum at new hire orientation, annually or when laws or procedures change.

Workplace security training and instruction includes, but is not limited to, the following:

- Techniques for recognizing the potential for violence;
- Preventive measures to reduce the threat of workplace violence, including procedures for reporting workplace security hazards;
- In addition, specific instructions shall be provided to all employees regarding workplace security hazards unique to their job assignment;
- Non-Violent Crisis Intervention training is required within 60 days of hire for employees in high-risk areas and those whose assignment is to respond to alarms or other notifications of violent incidents or whose assignments involve confronting or controlling persons exhibiting aggressive or violent behavior. Refresher classes are also required, every 12 months;
- How employees will document and communicate to other employees (including between shifts and units) information regarding conditions that may increase the potential for workplace violence incidents.

Managers and Supervisors shall be trained to:

- Ensure that employees are not placed in assignments that compromise safety and in methods and procedures which will reduce the security hazards.
- Respond compassionately towards co-workers when an incident does occur.
- Ensure that employees follow safe work practices and receive appropriate training to enable them to do this.
- Reinforce the Work Place Violence Prevention Program, promote safety and security, and ensure employees receive additional training as the need arises.

Workplace Violence Response Team

Employees whose job duties include responding to alarms or other notifications of violent incidents will receive additional, interactive training that is specific to confronting or controlling persons exhibiting aggressive or violent behaviors.

These team members will receive the highest level of Crisis Intervention Training.

1. All Department Managers/Asst. Managers
2. Acute Psych and Behavioral Health
3. Certified Nursing Assistant
4. Chaplain Services
5. Charge Staff
6. Clinical Engineering
7. Facilities/Maintenance Department
8. Nursing Supervision
9. PFS/Case Management
10. Security Department
11. ~~11.~~ 4 South staff
12. Home Care Services

PROCEDURES FOR IDENTIFYING POTENTIAL TYPE 2 VIOLENCE

- Behavior Dysfunction

- Developmentally Delayed
- Domestic Violence
- Forensic Patient (Jail/Corrections/in-Custody Prisoner)
- Gang Affiliation
- Intoxication (drugs or alcohol)
- Mental Illness with Aggressive Tendencies

Procedures to Identify and evaluate patient-specific risk factors
We have a process in place to evaluate patient-specific risk factors which can include:

1. Patient mental status and conditions that may cause the patient to be non-responsive to instruction or behave unpredictably, disruptively, uncooperatively, or aggressively;
2. A patient's treatment and medication status, type, and dosage, as is known to the health care facility and employees;
3. A patient's history of violence, as is known to the health facility and employees;
4. Any disruptive or threatening behavior displayed by patient.

Violence Risk Screening

Violence is a complex social interaction, characterized by an inability to cooperate and negative emotions, that may include nonverbal, verbal, and physical behavior that is threatening or harmful to others or property.

Using a standardized evidence-based tool which assists in the prediction of violent behavior, screening will be used for all children aged 10 and over and all adult patients at the point of entry to Kaweah Health, inpatient/ outpatient services, Kaweah Health Rehabilitation Hospital, Sub-acute and Transitional Care Services, and Urgent Cares.

On admission to inpatient units or at the beginning of outpatient services and as needed for behavioral changes:

1. Patients will be observed for potential risk to harm others by licensed nursing staff using the Broset violence checklist.
2. If the licensed nursing staff determines the patient is at risk for harm to others, an indicator will be activated to alert staff of potential risk.
3. Follow violence interventions as appropriate (See attached toolkit).

Incidents That Must be Reported

1. An incident involving the use of a firearm or other dangerous weapon, regardless of whether the employee sustained an injury. For the purpose of this reporting requirement, a "dangerous weapon" means an instrument capable of inflicting death or serious bodily injury.

2. The use of physical force against an employee by a patient or a person accompanying a patient that results in, or has a high likelihood of resulting in

injury, psychological trauma, or stress, regardless of whether the employee sustains an injury. For the purpose of determining whether an incident must be reported, "injury" means an incident which results in one or more of the following:

a. Death- Any occupational injury that results in death, regardless of the time between injury and death. (Title 8,California Code of Regulations, Section 14300.46);
b. One or more days away from work (which includes the day the injury occurred);
c. Restricted work or transfer to another job. Restricted work occurs when, as a result of the work related injury, the employer keeps the employee from performing on or more of the routine functions of the job, or from working the full workday that he or she would otherwise have been scheduled to work; or a licensed health care professional recommends the employee not perform one or more of the routine functions of the job, or not work the full workday. A "routine function" is a work activity that the employee regularly performs at least once a week. [Title 8, California Code of Regulations, Section 14300.7(b)(4)];
d. Medical treatment beyond first aid. "Medical treatment" means the management and care of a patient to combat disease or disorder. For the purpose of the law, medical treatment does not include:
    - Visits to a licensed health care professional solely for observatory or counseling;
    - The conduct of diagnostic procedures, such as x-rays and blood tests, including the administration of prescription medications used solely for diagnostic purposes (e.g., eye drops to dilate pupils); or
    - First aid
e. Loss of consciousness, regardless of the length of time the employee remains unconscious.
f. A significant injury diagnosed by a licensed health care professional. In the context of workplace violence, this could be a fractured or cracked toe or rib, or a punctured eardrum. Most significant injuries that must be reported will involve one of the categories above (death, days away from work, medical treatment beyond first aid, or loss of consciousness)

[Title 8, California Code of Regulations, Section 14300.7] If the employee reports psychological trauma or stress as a result of the use of physical force by a patient, visitor, employee or other individual at the worksite, the incident must be reported, even if there is no physical injury.

References:

Title 8; California Code of Regulations (CCR) §3203
Health and Safety Code 1257.7
Assembly Bill 508
http://www.dir.ca.gov/dosh/dosh_publications/worksecurity.html
The Joint Commission – *Environment of Care* Standards,

WORKPLACE VIOLENCE CHECKLIST

Purpose: *To provide a safe and secure healthcare environment for patients, visitors, volunteers, physicians and employees. Also, to assist employees in managing and/or de-escalating the situation.*

Note: *If the situation involves a weapon, immediately notify PBX and announce "Code Silver and Location".*

STAFF RESPONSE

In a violent or imminently violent situation:

- ☐ *Call Security at Ext 44*
- ☐ *Provide the District operator with the following information:*
  - ☐ *Code Gray or Code Silver;*
  - ☐ *State your name, where you are and where the incident is occurring and if weapons are involved..*

(Code Silver)

- ☐ *Description and number of suspects;*
- ☐ *Number and location of hostages;*
- ☐ *Number and type of weapons involved;*
- ☐ *Within the limits of personal safety, clear the area and limit access to area and to patient as much as possible;*
- ☐ *Immediately notify your manager or immediate supervisor and the House Supervisor;*
- ☐ *Seek shelter, protecting patients as able;*
- ☐ *Complete an occurrence report and send to Risk Management.*

In a potentially violent situation:

- ☐ *Call Security, Ext 44;*
- ☐ *Clear the area as able;*
- ☐ *Complete an occurrence report and send to Risk Management.*

MANAGER

In a violent or imminently violent situation:

- ☐ *Call Security at Ext 44;*
- ☐ *Provide the District operator with the following information:*
  - ☐ *Code Gray or Code Silver;*
  - ☐ *State your name, where you are and where incident is occurring and if weapons are involved.*

(Code Silver)

- ☐ *Description and number of suspects;*
- ☐ *Number and location of hostages;*
- ☐ *Number and type of weapons involved;*
- ☐ *Clear the area and limit access to area and to patient as much as possible;*
- ☐ *Complete an occurrence report and send to Risk Management.*

In a potentially violent situation:

- ☐ *Call Security, Ext 44;*
- ☐ *Notify Human Resources if an employee is involved;*
- ☐ *Complete and occurrence report and send to Risk Management.*

SECURITY

In a violent or imminently violent situation:

- ☐ *Respond to reported situation and assess for (1) type of violence. (2) Threat of physical danger and the need for police assistance.*
- ☐ *Manage the incident in accordance with Security Department policy and procedures.*
- ☐ *Follow-up with investigation and written security incident report.*

In a potentially violent situation:

- ☐ *If the situation permits, consult with Supervisor/Lead Office in Security to determine the appropriate action to take*
- ☐ *Follow up with investigation, provide written incident report.*

Reporting Responsibilities:

- ☐ *Any act of assault or battery that results in injury or involves the use of a firearm or other dangerous weapon against any on-duty personnel SHALL be reported to the local police department within 72 hours of the incident.*
- ☐ *Any other act of assault or battery against any on-duty personnel MAY be reported to the local police department within 72 hours of the incident.*

SECURITY SERVICES MANAGER

Violent or imminently violent situation:

- ☐ *Once a reported incident is stabilized, follow up with Risk Management, Human Resources and the manager of the department affected by the incident.*

Potentially violent situation:

- ☐ *If the situation permits, conduct meeting with Risk Management, Human Resources and appropriate management to determine the proper action to take.*

Note: *When notified by the Security Officer on the scene that a "Code Gray" is in progress, Security will send back up support as needed.*

HUMAN RESOURCES

In a violent or imminently situation:

- ☐ *If the situation permits, verify with Security or appropriate management, the assessment of the injury or threat to the employee;*
- ☐ *Jointly with Security and Department Manager, assess the need to remove and/or reassign the employee to a more secure work area.*

In a potentially violent situation:

- ☐ *Consult with Risk Management, Security and Department Manager to determine the appropriate action to take;*
- ☐ *Maintain documentation of all actions taken, and maintain in Human Resources.*

RISK MANAGEMENT

In a violent or imminently, or potentially violent situation:

- ☐ *Follow routine risk management process for all imminently violent events.*

REPORTING RESPONSIBILITES- EMPLOYEE VICTIM

Employee Health

- ☐ *If an employee reports to Employee Health with an injury related to an incident of violence, after treatment has been rendered, the Employee Health personnel has a duty to report the incident to the local police department (verify with Security to determine if the incident has been reported).*

Emergency Department

- ☐ *When you hear PBX announce "Code Silver, All Clear," or "Code Grey" All Clear", return to your normal work duties, unless otherwise directed;*
- ☐ *In the event Employee Health is closed, the Emergency Department has the same duty to report to the police department any injury to an employee which was sustained due to an incident of violence. Verify with security to determine if the incident has been reported.*

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HR 04

Policy Number: HR.04	Date Created:12/19/2019
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: 10/23/24
Approvers: Board of Directors (Human Resources)	
Special Pay Practices	

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

Designated departments may have special pay practices that provide for competitive compensation and/or incentives for employees to work varying shifts or additional shifts. All special pay practices are approved by the Hospital and are subject to change at any time. In all cases, Wage and Hour Law will apply.

Pay Practices:

Other Hours- Base rate of pay for additional hours or shifts worked for certain exempt positions approved by HR.

MICN: and TNCC$1.50 for each active certification(s). when primary cost center is 7010 – Emergency Department. ~~The differential will also apply if transferring hours to cost center 6179-M/S Overflow – ED 1E.~~ Effective upon pay period following submission/validation of certification to Human Resources.

- RN-Emergency-ED: 2217/2247
- Charge Nurse-Emergency-ED: 2277
- Assistant Nurse Manager-Emergency-ED: 2187
- ~~ED Supervisor: 2352~~

Donning and Doffing Sterile Scrubs
Employees who work in surgical services or sterile procedural areas are entitled to up to 10 minutes to change into provided sterile scrubs before and after their shift.

Sleep Pay
Hourly rate paid to Surgery and Cath Lab employees for those who require an 8-hour gap between the current shift worked and the next scheduled shift. The employee will be paid at the start of the next scheduled shift but is not expected to work until the 9th hour after finishing prior shift

Private Home Care Holiday
Rate is based on where the employee travels. Holiday differential is received for Kaweah Health observed holidays, in addition to Mother's Day and Easter.

Private Home Care On-Call

Eligible Job Codes:

- PHC Staffing Coordinator: 0123 (Base rate of pay for a minimum of 1- hour for on-call)

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HR 61

Policy Number: HR.61	**Date Created: 06/01/2007**
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	**Date Approved: 12/22/2022**
Approvers: Board of Directors (Administration), Board of Directors (Human Resources), Dianne Cox (Chief Human Resources Officer)	

Status Classification of Employees/Concurrent Jobs

POLICY: Each Kaweah Health employee has a current status designation that is used to determine compensation, benefits, and status. It is Kaweah Health's policy to comply with the Fair Labor Standards Act (FLSA).

PROCEDURE:

I. Exempt/Non-Exempt Status

Each position (not individual) will be designated as either exempt or non-exempt under the FLSA for overtime purposes. The Human Resources Department will conduct a job evaluation to determine whether the position has exempt or non- exempt status.

A. Exempt Status

1. Full-time employees occupying positions designated as exempt under the FLSA are exempt from overtime payments under federal law.

~~2.~~ To qualify for an exemption from overtime, employees must be paid on a salary basis. For further information, refer to policy (HR.62) Exempt Employee Pay/Salary Basis Safe Harbor Provision. ~~EXEMPT EMPLOYEE PAY/SALARY BASIS SAFE HARBOR PROVISION.~~

~~3.~~2. Employees categorized as exempt are expected to work hours necessary to accomplish their job duties. Compensatory time off will not be authorized.

B. Non-Exempt Status

Employees occupying positions designated as non-exempt under the FLSA are eligible for compensation of overtime for hours ~~worked in excess of~~exceeding 40 regular hours per week under federal law. Compensatory time off will not be authorized.

II. Employment Status

Individuals will be designated as full-time, part-time or per diem.

A. Full-time Status- Benefits Eligible

Employees occupying positions designated as full-time are normally and regularly scheduled to work 36 to 40 hours per week.

Weekly Hours	Bi-Weekly Hours	Classification
36-40	72-80	Full Time - Benefits Eligible

B. Part-time Status - Benefits Eligible

Employees occupying positions designated as part-time are normally and regularly scheduled to work 24-35 hours per week.

Weekly Hours	Bi-Weekly Hours	Classification
24-35	48-71	Part Time - Benefits Eligible

C. Part Time - No Benefits

Employees occupying positions designated as part-time are normally and regularly scheduled to work less than 24 hours per week. Employees who work less than 24 hours per week are not eligible to participate in employee-sponsored benefit programs, unless eligible for medical insurance in compliance with the ACA.

Weekly Hours	Bi-Weekly Hours	Classification
0-23	0-47	Part Time - No Benefits

D. Per Diem Employees

Per Diem Employees who work as needed are not eligible to participate in employee-sponsored benefit programs, unless eligible for medical insurance in compliance with the ACA. Active Per Diem job codes are determined by Human Resources.

Note: Regardless of status, all employees are eligible to participate in the Retirement Plans 401(k) and 457(b).

III. Employee Acknowledgement

Upon initial hire and/or change in employment status of an existing employee from full or part time to Per Diem, the employee will sign a Per Diem Agreement form indicating that they have read and acknowledged the requirements and commitments they make in order to remain a Per Diem employee.

IV. Performance Management Program

Per Diem employee will be evaluated annually to assure performance standards are being met.

V. Paid Time Off (PTO)

In the event a full or part time employee changes to Part-Time less than 24 hours per week or Per Diem status, all accrued PTO Time in their bank at the time of status change will be paid out to the employee at the hourly rate prior to the change. Any accrued EIB Time will be held in abeyance in the event the employee returns to regular full or part time benefit eligible status.

VI. Concurrent Jobs

Employees may, with permission from department leaders, work ~~at~~ in more than one Kaweah ~~Delta~~ Health job or department. Additional jobs are referred to as concurrent jobs. Employees apply for concurrent jobs by following the same process used for transfer requests. Refer to HR.31 Transfer Policy.

~~(HR.31) Transfer Policy.~~

One department leader must agree to be the primary manager of the employee. This leader confirms the employee's payroll.

For ~~Timekeeper~~timekeeping, the employee clocks in for all hours worked ~~using the transfer function~~ in ~~HR Timekeeper~~Workday or on the wall clock, adjusting their ~~job code or~~ department as appropriate using the department transfer process.

- If an employee's primary and concurrent jobs are both non-exempt, overtime will be paid for combined hours worked in excess of 40 hours in a week.
- If an employee has one job that is exempt and one job that is non-exempt, all hours worked over 40 will be paid at overtime any week in which the non-exempt duties exceed 50% of the hours

worked in that week.

- If an employee's primary job and concurrent job are classified as exempt, no overtime will be paid for hours exceeding 40 hours in a week.

The department that schedules the concurrent hours is responsible for paying any overtime. ~~overtime unless an alternate agreement has been reached between the primary and concurrent managers~~. The primary manager confirms all hours to be paid after verifying with the appropriate manager(s) the hours worked in the concurrent department(s).

Changes in Employment Status

Changes in employment status (e.g., from full-time to part-time and back to full-time) may be made as warranted and will be effective on the first day of a pay period. Changes in employment status which result in the employee becoming eligible or ineligible for benefit coverage (e.g., from non-benefits eligible to benefits-eligible,) will be as follows:

A. Non-benefits eligible employees who change status to benefits-eligible may apply for insurance coverage for themselves and their eligible dependents within thirty (30) days of that eligibility. Coverage will be effective on the first day of the following month.

B. Benefits-eligible employees who change status to become non-benefits eligible lose their eligibility for insurance benefit coverage unless eligible under the Affordable Care Act for medical insurance. Coverage terminates the end of the month in which the status occurred. Accrual rates

for PTO/EIB adjust according to status and eligibility. Coverage for some benefits may be continued by eligible employees under COBRA. For more information, see HR.128 Employee Benefits Overview.

"*Responsibility for the review and revision of this Policy is assigned to the Chief Human Resources Officer. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases. Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Health Policies and Procedures.*"

HR 70

Kaweah Health
MORE THAN MEDICINE. LIFE.

Human Resources

Policy Number: HR.70	**Date Created: 06/01/2007**
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	**Date Approved: 12/18/2024**
Approvers: Board of Directors (Administration), Kelsie Davis (Board Clerk/Executive Assistant to CEO)	

Meal Periods, Rest Breaks and Breastfeeding, and/or Lactation Accommodation

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

PURPOSE:

It is important that Kaweah Health employees receive their meal periods and rest breaks. These assist staff in attending to personal matters as well as downtime. Kaweah Health will facilitate meal periods and rest breaks by relieving employees of duties for specified amounts of time. In addition, Kaweah Health will provide rest and recovery periods related to heat illness for occupations that may be affected ~~by same~~ (i.e. Maintenance employees who work outdoors). Kaweah Health supports new mothers who desire to express milk for their infants while at work. Kaweah Health will provide the use of a room, or other location to the nursing mothers work area for expressing milk.

MEAL PERIOD POLICY AND PROCEDURE:

For non-exempt employees working more than five hours per day, including 8-, 9-, or 10-hour shift employees, Kaweah Health will provide, and employees are expected to take a 30-minute duty-free meal period. The meal period will be scheduled to start within the first five hours of each shift, i.e. the meal period must start before the end of the fifth hour in the shift. An employee who works ~~routinely~~ five to six hours ~~or less~~ per day may voluntarily choose to waive the meal period in writing.

For non-exempt employees working more than ten hours per day, including 12-hour shift employees, Kaweah Health will provide, and employees are expected to take a second 30-minute duty-free meal period; this meal period must start before the end of the tenth hour of the shift. Employees working more than ten hours, but less than twelve hours may choose to waive, in writing, one of the two meal periods provided. If one of the two meal periods is waived, the single meal period will be scheduled approximately in the middle of the ~~workday~~ shift as practicable. An employee working more than 12 hours is authorized and expected to take a third 30-minute meal period. The third meal period cannot be waived.

Commented [TB1]: Should this be removed?

Meal periods will be made available and provided by Kaweah Health Leaders; it is each employee's responsibility to ensure that they are taking appropriate meal periods as set forth in the policy. ~~30~~ 30-minute uninterrupted meal periods are to be scheduled. ~~On rare occasions, an employee may request to delay their meal period. If an employee voluntarily~~

~~delays a meal period that is permitted.~~ Kaweah Health retains the right to set work schedules, including meal periods and rest break schedules.

Meal periods will be unpaid ~~only if the employee is relieved of all duty for at least 30 minutes and the employee is not interrupted during the meal period with work-related requests~~. Non- exempt employees may leave the organization premises during meal periods~~, but are to notify their supervisor if they do leave, and inform them when they return~~.

Employees who are not provided a 30- minute meal period of uninterrupted time in a timely manner as described are entitled to one hour of pay at their regular rate of pay (pay code MPRB1hour). An employee who is not provided with a meal period according to policy must, complete a time adjustment sheet by the end of the current pay period and notify their leader. The leader will authorize payment of premium pay in the timekeeping system. Note that if the employee voluntarily delays their meal period, ~~no~~ additional pay of one hour at their regular rate will not be paid.

In particular circumstances and based solely on the nature of the work, and with the approval of Human Resources, a revocable On-Duty Meal Period Agreement can be completed by the employee and Kaweah Health. This typically applies when there are few employees in a department or night shift is limited.

The beginning and end of each meal period must be accurately recorded on the time card or timekeeping system.

MEAL PERIOD WAIVER
Employee or Kaweah Health may revoke a signed "Meal Period Waiver" at any time providing at least one day's advance notice in writing to Human Resources and their manager. ~~Otherwise~~Otherwise, the waiver will remain in effect until revoked.

REST BREAK POLICY AND PROCEDURE:
By way of this policy, non-exempt employees are also authorized, permitted, and expected to take a 10-minute rest break for every four hours of work or major fraction thereof. Employees must work at least 3.5 hours to be entitled to a rest break. Rest breaks should be taken in the middle of each 4- hour period ~~in so~~as ~~far as it is~~ practicable. These rest breaks are authorized by Kaweah Health; but it is each employee's responsibility to ensure that they are taking appropriate rest breaks.

Rest breaks are considered paid ~~time,~~time and employees do not clock out and clock in for taking such breaks. Leaving the organization premises is ~~not~~ permitted ~~during a rest break~~as long as you are able to return within 10-minutes.

If for some reason, an employee's rest break is not authorized or permitted, the employee will be entitled to one hour of pay at their regular rate of pay. An employee who is not authorized or permitted to take a rest break according to policy must complete a time adjustment sheet by the end of the current pay period and notify their leader. Only one premium payment per day will be paid for missing one or more rest breaks.

ADDITIONAL INFORMATION:

Commented [TB2]: Penalty pay is addressed in next paragraph.

Commented [TB3]: Leave or remove? Technically they can claim late, but maybe this is okay as long as we allow it?

An employee may be entitled to no more than two hours of premium pay per day (one for a meal period that was not provided and one for one or more rest breaks that were not authorized or permitted). Employees are required to submit time adjustment sheets by the end of the current pay period for the missed or interrupted meal ~~break~~ period or unauthorized rest break listing the reason or reasons for a missed or shortened meal period or a missed rest break.

Employees may not shorten the normal workday by not taking or combining breaks, nor may employees combine rest breaks and meal periods for an extended break or meal period.

Non-Exempt employees are entitled to rest breaks as follows:

- Less Than 3.5 Hours: An employee who works less than three-and-a-half is not entitled to a rest break.
- 3.5 Hours or More: An employee who works three-and-a-half hours or more is entitled to one ten-minute rest period.
- More than 6 Hours: An employee who works more than six hours is entitled to two ten- minute rest periods, for a total of 20 minutes of resting time during their shift.
- More than 10 Hours: An employee who works more than ten hours is entitled to three ten-minute rest periods, for a total of 30 minutes of resting time during their shift.
- An employee is entitled to another ten-minute rest period every time they pass another four-hour, or major fraction thereof, milestone.

How Many Meal ~~Breaks~~ Periods Must be Taken:

- 5 Hours or Less: An employee who works five hours or less is not entitled to a meal ~~break~~period.
- More than 5 Hours: An employee who works more than five hours is entitled to one 30- minute meal break.
- More than 10 Hours: An employee who works more than ten hours is entitled to a second 30-minute meal break.
- More than 12 Hours: An employee who works more than twelve hours is entitlesd to a third 30-minute meal break.

BREASTFEEDING AND/OR LACTATION ACCOMMODATION

Kaweah Health is compliant with the Pregnant Workers Fairness Act (PWFA) requirements and the Providing Urgent Maternal Protections for Nursing Mothers Act (PUMP Act). Kaweah Health will provide a reasonable amount of break time to allow an employee to express breast milk for that employee's infant child. The break time will run concurrently, if possible, with any rest break or meal period time already provided to the nursing mother. If it is not possible for the break time that is already provided to the employee, the break time shall be unpaid.

Kaweah Health will make reasonable efforts to provide the nursing mother with the use of a room or other location in close proximity to their work area for the nursing mother to

express milk in private. If a refrigerator cannot be provided, Kaweah Health may provide another cooling device suitable for storing milk, such as a lunch cooler.

There are several designated lactation rooms that may be found throughout Kaweah Health. Their locations are the following:

a) Mineral King Wing, 1st Floor MK lobby by Lab Station
b) Mineral King Wing, 2nd Floor on the left heading to ICU
c) Mineral King Wing, 3rd Floor on the left just past the stairwell
d) Acequia Wing, Mother/Baby Department
e) Support Services Building, 3rd Floor, (Computer available)
f) South Campus, next to Urgent Care Lobby
g) Imaging Center/Breast Center Office (Computer available)
h) Mental Health Hospital, Breakroom Suite
i) Visalia Dialysis, Conference Room, (Computer available)
j) Exeter Health Clinic, Family Practice Department, (Computer available)
k) Woodlake Health Clinic, (Computer available)
l) Dinuba Health Clinic, (Computer available)
m) Lindsay Health Clinic, (Computer available)
n) Rehabilitation Hospital, next to Outpatient Speech Therapy Office

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HR 78

Human Resources ~~Subcategories of Department Manuals not selected.~~

Policy Number: HR.78	**Date Created: 06/01/2007**
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	**Date Approved: 12/22/2022**
Approvers: Board of Directors (Administration)	
Salary Administration Program	

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

POLICY:

Kaweah Health has established and maintains a compensation program to govern the fair and competitive administration of wages and salaries. This program was implemented to provide salary consistency and internal equity throughout all Kaweah Health departments and jobs. This program will be reviewed annually and updated as necessary. We strive to have, wages and salaries that are:

1. Internally Equitable: Fairly reflecting the scope and complexity of each position in relation to all other positions in the organization; ensuring fair and e~~0~~quitable wages between individuals with the same job class.

2. Externally Competitive: Enabling Kaweah Health to attract, retain and motivate qualified employees through compensation and benefits that are positioned fairly within the competitive labor market as defined by Human Resources. Exceptions to this philosophy may be made in cases where there are significant imbalances in the demand and supply for staff. Kaweah Health participates in and/ or purchases results of salary surveys. The results of these surveys are used in the job evaluation process used to assign salary grades to each job. In no case should managers or employees participate in or initiate salary surveys. Any requests for established salary grades for any position are to be forwarded to Human Resources. Kaweah Health's policy prohibits formal or informal sharing or receipt of salary grade information outside the context of salary surveys conducted by third parties.

3. Cost Effective: Consistent with Kaweah Health's needs, financial goals and ability to pay.

4. ~~Effetive~~Effective January 1, 2023, ranges of pay will be included on job ~~descriptions~~ postings on the Kaweah Health Careers website in accordance with California State Law.

Job Evaluation Process used for assigning salary grades:
Human Resources uses input from department leaders as needed to assure market competitiveness when evaluating the appropriate salary grade for a job. Human Resources uses a market based system and the results of salary surveys to evaluate the market value of a job and to assign a

salary grade. Using the market based system, each job is either a "benchmark job" or a "linkage job". A "benchmark job" is one typically found in published surveys. Jobs that are not "benchmark jobs" are linked to a benchmark job with similar levels of duties and responsibilities within a similar job family. These jobs are called "linkage" jobs.

This linkage process helps ensure internal equity while at the same time acknowledging the salaries paid for the same or similar positions with the local job market.

Salary survey data is reviewed initially when a job is established and then at least annually. Jobs are assigned to a salary grade based on the survey results. When an employee's job is assigned to a different grade, the hourly rate may be adjusted to preserve internal equity. Pay adjustments may be given based on the survey data results and annual budget considerations.

DEFINITIONS:
Minimum Wage:
The minimum wage complies with Federal and California minimum wage guidelines.

Equal Pay:
The equal pay standard requires that male and female workers receive equal pay for work requiring equal skill, effort, and responsibility and performed under similar working conditions.

Child Labor:
“Minor” means any person under 18 years of age. Only minors under age 18 who have graduated from high school or who have been awarded a certificate of proficiency may be employed.

Discrimination:

Kaweah Health is an “Equal Opportunity Employer” and is committed to a policy which establishes individual qualifications and merit as the only conditions for employment. Refer to HR.12 ~~(~~Equal Employment Opportunity~~).~~

Job Code:
A code which identifies an employee’s position title, pay grade, salary range, and associated pay practices.

Pay Grade:
Job codes reflecting jobs with requirements, duties and responsibilities of similar complexity are grouped by pay grade. The pay grade is a code which identifies a salary range.

Salary Range:
The range of pay between the minimum and maximum of a salary grade.

Minimum Rate:
The minimum hourly rate of pay within the salary range.

Midpoint:
The pay rate that is midway between the minimum and maximum of the salary range.

Maximum Rate:
The maximum hourly rate of pay within the salary range.

Base Rate:
The employee’s current hourly rate, which is based on relevant experience, excluding differentials. The employee’s education and/or performance may be considered as well.

Performance Evaluation/Competence Assessment:
The process from date of hire through employment used for formal evaluation by the department head or supervisor for appraising an employee’s job performance. This process includes performance evaluations, skills checklists and competency assessments. Refer to HR.213 Performance Management and Competency Assessment Program.

Merit Review Date:
~~This normally corresponds with the date of hire with exceptions made for unsatisfactory performance, leaves of absence, promotions, demotions, or transfers, and/or failure to comply with job requirements.~~ Merit increases will be effective the first day of the second pay period in October for all eligible employees. Merits are

contingent on budget approval each fiscal year. Refer to HR.213 Performance Management and Competency Assessment Program.

Merit Increase:
An increase based on the employee's current rate and determined by the overall performance evaluation.

Promotional Increase:
A change in position to one that is at least one grade higher than the current grade.

Downgrade/Demotion:
A downgrade/demotion is considered to be a change in position to one that is at least one grade lower than the current grade.

a. Demotion - Generally an involuntary action taken by Kaweah Health, based on unacceptable performance by an employee. Refer to HR.221 Employee Reduction in Force - or- Reassignment Resulting in Demotion

b. Downgrade - Generally a voluntary action taken by an employee, or taken Kaweah Health due to a restructure.

Exempt:
An exempt employee is paid on a "salary" basis, which means that ~~he/she~~they will receive a pre-determined amount each pay period constituting all or part of his/her compensation, and the amount will not be subject to reduction because of variations in the number of hours worked in the work day or week, except in accordance with "Leave of Absence" Policy or Paid Time Off (PTO) Policy. Refer to HR.62 Exempt Employees Pay/Salary Basis Safe Harbor Provision and HR.234 Paid Time Off (PTO), Extended Illness Bank (EIB) and Healthy Workplace, Healthy Families Act of 2014.

Non-exempt:
Employees in this classification are paid on an hourly basis and are subject to overtime under Federal Labor Standards Act (FLSA).

Productive Hours Worked:
Includes all regular, overtime, call back, ~~and~~ orientation and workshop hours.

Non-Productive Hours Paid:
Any time for which the employee is paid while not at work (i.e., Paid Time Off (PTO), Bereavement Leave, Jury Duty, Employee Illness Bank (EIB), or Leave of Absence).

Overtime Hours:

Productive hours worked in excess 40 hours per week; applies only to non-exempt employees.

Overtime Pay:

The overtime rate times the overtime hours, applied with Fair Labor Standards Act calculations. Employees classified as non-exempt by the Fair Labor Standards Act will receive overtime after 40 hours in a 7-day work week at one and one-half times the employee's regular rate.

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HR 183

Human Resources

Policy Number: HR.183	**Date Created: 06/01/2007**
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	**Date Approved: 10/25/2023**
Approvers: Board of Directors (Administration)	

Identification Badges

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

POLICY:

Employees and contract staff are required to wear the official Kaweah Health Identification (ID) badge at all times while on duty. Students, sales and service representatives, temporary help, contractors and construction workers, and volunteers will wear ~~identification~~ ID badges as a condition of being on Kaweah Health property. The badge is to be worn chest high or above, with the name and picture clearly visible to patients, visitors, co-workers, physicians, and volunteers. No other badges, buttons or insignias, other than the official ~~I.D.~~ ID Badge may be worn while on duty. Unauthorized stickers or pins cannot be placed on the ID Badge. In the event of a disaster, the official Kaweah Health ~~identification~~ ID badge must be worn to gain admittance to the property.

Some badges issued by Human Resources include access control. These badges are programmed for each employee to have access to certain locations of Kaweah Health. Employees who do not have access via their badge may not enter these protected areas without specific permission from a member of management. Employees with specific access may not provide access to anyone else.

~~A $10.00 replacement charge will occur if an employee requests an ID badge due to it being lost or forgotten. The $10.00 charge is the actual cost of the badge, including the attachments that must also be replaced.~~ There is no charge to replace a lost, damaged, or worn badge. Human Resources tracks requests to reprint badges, including reason. Requests to reprint lost or forgotten badge may result in disciplinary action.

PROCEDURE:

1. Human Resources will prepare ID badges indicating the name and title.

2. Employees can make purchases using their ID Badge in the Gift Shop, Kaweah Korner, Pharmacy, and Cafeteria. All amounts will be paid via payroll deduction, including a final check if leaving employment.

3. If an individual loses his/her badge or the badge is damaged or worn, he/she must report to Human Resources immediately to have a new badge prepared.

~~3. Individuals will be held financially responsible for purchases made with their ID Badge, even if the badge is lost or stolen. A $10.00~~

4. Badge photos must be current (within 10 years). Contact Human Resources to coordinate time to have a new photo taken and badge printed.

~~replacement charge will occur if an employee requests an ID badge due to it being lost or forgotten. The $10.00 charge is the actual cost of the badge, including the attachments that must also be replaced. There is no cost to replace a damaged or worn badge.~~

~~4.~~5. A new badge will be issued when an employee has a name change or title change. A name change will only be issued upon presentation of a Social Security Card with the new name, and required licensure is verifiable with the new name.

~~5.~~6. The Purchasing Department, via a Vendormate kiosk, will issue temporary badges to all sales representatives.

~~6.~~7. Upon termination of employment or if work or service will no longer be provided to Kaweah Health, the ID badge must be turned in to the department. All ID badges must be returned to Human Resources.

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R 200

Policy Number: HR.200	**Date Created: 06/01/2007**
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	**Date Approved:~~2/28/2024~~**
Approvers: Board of Directors (Administration)	

Drug Free Work Place and Drug/Alcohol Testing

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

POLICY:

As a part of our commitment to safeguard the health of our employees and volunteers and provide a safe work environment, Kaweah Health has established this policy on the use or abuse of alcohol and illegal drugs or other controlled substances by employees, contract staff or volunteers (all three categories are referred to as employee in this policy for reference only). At work or otherwise, substance abuse seriously endangers the safety of the work environment, as well as our patients and the general public.

As a condition of employment all employees are required to abide by this policy. Kaweah Health has established this policy to detect users and remove abusers of drugs and alcohol and to prevent the use and/or presence of these substances in the workplace. Confirmed incidents of drug diversion will be reported to the appropriate licensing, regulatory, and/or law enforcement agencies. See policy AP110 Reporting requirements for drug diversion illegal substance abuse or controlled substance abuse. Confirmed incidents of potential violations of the Definitions below will be reported to any applicable agency. If an individual quits or leaves their assignment prior to a drug test or investigation, they will be reported to any applicable agency.

A violation of this policy by an employee or job applicant may subject the employee or applicant to Disciplinary Action up to and including termination of employment or rescission of the job offer. Kaweah Health may suspend employees without pay under this policy pending the results of a drug test or investigation.

Whenever a District employee observes evidence of possible impairment or diversion of drugs by a Provider/Practitioner while on hospital premises, the staff member must immediately inform his or her supervisor who shall inform the CEO or Designee. The CEO or Designee shall immediately inform the Chief of Staff/Designee.

DEFINITIONS:

The definitions of words and terms as set forth in this policy are as follows:

1. “Illegal drugs or other controlled substances” means any drug or substance that
   a) is not legally obtainable; or
   b) is legally obtainable but has not been legally obtained; or
   c) has been legally obtained but is being sold or distributed unlawfully.

2. “Legal drugs” means any drug, including prescription drugs and over-the-counter drugs, that has been legally obtained and that is not unlawfully sold or distributed.

3. Marijuana or marijuana-related products are prohibited while on Kaweah Health premises, or while conducting / performing district business.

4. “Abuse of any legal drug” means the use of any legal drug:
    a) for any purpose other than the purpose for which it was prescribed or manufactured;
    b) in a quantity, frequency, or manner that is contrary to the instructions or recommendations of the prescribing physician or manufacturer.

5. “Reasonable suspicion” includes suspicion that is based on specific personal observations such as an employee’s manner, disposition, muscular movement, appearance, behavior, speech, or breath odor; information provided to management by an employee, by law enforcement officials, or by other persons believed to be reliable; or suspicion that is based on other surrounding circumstances, including but not limited to, protracted poor job performance, continued unexplained absences, chronic tardiness, and/or audit findings or charting issues.

6. “Possession” means that an employee has the substance on his or her person or otherwise under his or her control.

7. “Drug diversion” means to obtain, possess, prescribe or use any controlled substance or drug in violation of state or federal law.

ALCOHOL USE PROHIBITIONS:

It is against policy to report to work or to work if an employee’s ability to work safely or efficiently may be impaired because the employee is under the influence of alcohol.

1. For the purpose of this policy, an employee is presumed to be under the influence of alcohol if a blood test shows forensically acceptable positive proof.

2. Any employee who is perceived to be under the influence of alcohol will be removed immediately from their work for evaluation of impairment and possible testing. Kaweah Health may take further action (i.e., reporting to a licensing agency and/or Disciplinary Action) based on medical information, work history and other relevant factors. The determination of what action is appropriate in each case rests solely with Kaweah Health.

3. Refusal to submit to, efforts to tamper with, or failure to pass an alcohol test may result in Disciplinary Action, up to and including termination of employment.

Violation of any of the following will result in reporting the employee to a licensing board or agency, and/or Disciplinary Action, up to and including termination of employment:

1. The consumption of alcohol on Kaweah Health property or while on duty is prohibited. There may be occasions, removed from the usual work setting, at which it is permissible to consume alcohol in moderation, on Kaweah Health property or at Kaweah Health sanctioned events authorized by the Chief Executive Officer or designee.

2. Off-duty abuse of alcohol which adversely affects an employee's job performance or adversely affects or threatens to adversely affect other interests of Kaweah Health is prohibited.

3. The personal possession (i.e., on the person, or in a desk, or locker) of alcohol on Kaweah Health property or on duty is prohibited.

4. The possession of alcohol in a personal vehicle while on duty or a Kaweah Health-assigned vehicle is prohibited.

5. Employees arrested for an alcohol-related incident must immediately notify their department management and Human Resources of the arrest if the incident occurs in any of the following circumstances:

    a) During scheduled working hours; or
    b) While operating a Kaweah Health vehicle on Kaweah Health or personal business, or
    c) While operating a personal vehicle on Kaweah Health business.

DRUG USE PROHIBITIONS:

Violation of any of the following will result in reporting the employee or individual to certain agencies as appropriate, and/or Disciplinary Action, up to and including termination of employment. This applies if the employee or individual quits or leaves their assignment. The Director of Pharmacy or designee will determine the necessity of reporting to Drug Enforcement Agencies, the California Board of Pharmacy and police. Human Resources will report to the employee's licensing or certifying Board as necessary. The Risk Management department will report to the California Department of Public Health or law enforcement as appropriate.

1. The unlawful use, sale, purchase, possession, manufacture, distribution, or dispensation of any drug or un-prescribed controlled substance on property or during work time is against policy.

2. It is also against policy to report to work or work if a prescription or non-prescription medication may adversely affect the employee's ability to perform his/her normal job duties.

3. Prescription drugs or non-prescription drugs may also affect the safety of the

employee or fellow employees or members of the public. Therefore, any employee who is taking any prescription or, non-prescription drug which might impair safety, performance, or any motor, cognitive functions must advise his/her supervisor or department head before reporting to work under such medication. Employees will not be required to identify such medications or the underlying illnesses. If Kaweah Health determines that such use does not pose a safety risk, the employee will be permitted to work.

TESTING:

1. Testing of Applicants

   a. All applicants considered final candidates for a position will be tested for the presence of illegal or un-prescribed drugs as a part of the application process;

   b. Any job applicant who refuses to submit to drug or alcohol testing, refuses to sign the consent form, fails to appear for testing, tampers with the test, or fails to pass the post-offer employment drug test will be ineligible for hire and any job offer will be rescinded.

2. Testing of Current Employees

   a. Employees must submit to a drug test if reasonable suspicion exists to indicate that their ability to perform work safely or effectively may be impaired. Reasonable suspicion testing means drug testing based on a belief that an employee is using or has used drugs in violation of Kaweah Health policy. Among other things, such facts and inferences may be based upon:

      1) Direct observation of drug use or physical symptoms or manifestations of being under the influence of a drug.
      2) Abnormal conduct or erratic behavior while at work or a significant deterioration in work performance.
      3) A report of drug use, provided by a reliable and credible source.
      4) Evidence that an individual has tampered with a drug test during his/her employment with Kaweah Health.
      5) Information that an employee has caused or contributed to, or been involved in an accident while at work.
      6) Evidence that an employee has used, possessed, sold, solicited, or transferred drugs while working or while on Kaweah Health's premises or while operating Kaweah Health's vehicles, machinery or equipment.
      7) Audit findings or charting issues.
      ~~7)~~8) Suspicion of Drug Diversion (See AP110).

3. Actions to be taken by Management

   There may be instances where supervisors/managers have reasonable cause to believe that an employee has consumed drugs on Kaweah Health's premises or reported to work under the influence of one or both. In these instances,

management may request a drug test from the employee. If management has reason to consider requiring a drug or alcohol test, use the following process:

a. Escort the employee personally to your office or other private area. Have another supervisor/ manager present as a witness.

b. Discuss with the employee your reasons for suspecting drug and/or alcohol policy violations, including audit findings and charting issues if applicable. From your conversation with the employee, determine whether or not you believe the employee has either consumed drugs or alcohol on Kaweah Health's premises or during work duty or is under the influence of either, or is diverting drugs.

c. If you conclude the employee does not appear to be under the influence of alcohol or drugs, including controlled substances and prescription drugs, and the employee is able to perform regular work duties, have him/her return to the work unit and resume work. Please document incident and notify Human Resources.

d. If you believe that the employee is under the influence of or has consumed drugs and/or alcohol on Kaweah Health's premises or during work duty, report this to Human Resources or the House Supervisor. The employee will be advised that the policy may have been violated and that he/she is being requested to provide blood sample for testing. Provide a copy of this Policy and the Consent to Submit to Drug and Alcohol testing.

e. Upon signing the Consent Form (attached), if the employee is able, the employee is to be escorted to ~~Employee Health Services~~House Supervisor's office to provide a sample. If the employee refuses to sign the consent or provide a sample, he/she will be subject to Disciplinary Action up to and including termination of employment.

f. If you believe the employee is impaired, make arrangements to have the employee taken home or contact a cab company, which will be paid for by Kaweah Health. Do not permit him/her to leave the premises or to drive alone. If the employee refuses any assistance, make sure the witnessing supervisor can verify that the employee refused such assistance.

g. If the employee cannot control his/her actions and departs without assistance, call the local police or law enforcement agency immediately to inform them of the employee's condition and refusal of assistance. Tell the law enforcement agency the employee's name, and a description of the vehicle, including the license number.

DRUG-FREE CONTRACT AND FOLLOW-UP TESTING:

As a condition of employment and/or continued employment, participants in a rehabilitation program for drug and/or alcohol abuse must consent in writing via a Kaweah Health Drug-Free Contract to periodic unannounced testing for a period of up to two (2) years after returning to work. An employee who has a positive,

confirmed test is subject to Disciplinary Action, up to and including termination of employment.

1. Additional Testing
   Additional testing may also be conducted as required by applicable State or Federal laws, rules, or regulations or as deemed necessary by Kaweah Health, such as post-accident or injury testing.

2. Refusal to Test
   Employees who refuse to submit to a drug and/or alcohol test are subject to Disciplinary Action, up to and including termination from employment.

TESTING PROCEDURE:

1. Job applicants and all employees will be provided with the Drug Free Work Place and Drug Testing Policy and must sign both the Employee Acknowledgment of Receipt and Understanding and Consent to Submit to Drug and/or Alcohol Testing.

2. Urine and/or blood samples will be used for the initial test and confirmation for all drugs and alcohol. Samples will be analyzed by a qualified laboratory selected by Kaweah Health.

3. A specimen for a drug test will be taken or collected by:

4. Testing Laboratory

   a. The laboratory used to analyze initial or confirmation drug specimens will be licensed to perform such tests.

   b. All laboratory security, chain of custody, transporting and receiving of specimens, specimen processing, retesting, storage or specimens, instrument calibration and reporting of results will be in accordance with State and Federal laws.

   c. The laboratory will provide technical assistance to the employee or job applicant or Medical Review Office (“MRO”) for the purpose of interpreting any positive confirmed test results.

5. Applicants and employees will be given an opportunity via the testing laboratory and a Medical Review Office (MRO) prior to and after testing to provide any information they consider relevant to the test including listing all drugs they have taken recently, including prescribed drugs, to explain the circumstances of the use of those drugs in writing or other relevant medical information.

6. An employee injured at the workplace and required to be tested will be taken for immediate treatment of injury. If the employee is not at a designated collection site, the employee will be transported to one as soon as it is medically feasible and specimens will be obtained. If it is not medically feasible to move the injured

employee, specimens will be obtained at the treating facility under the procedures set forth in this policy.

7. Kaweah Health will pay the cost of initial and confirmation drug tests required of employees and job applicants. An employee or job applicant will pay the cost of any additional drug tests not required by Kaweah Health.

TEST RESULTS:

1. Reporting Results

   a. The laboratory will report positive test results to the Medical Review Officer (MRO) results will be reported to the Employee Health Nurse. The MRO may request the laboratory to provide quantification of test results.

   b. The laboratory will report as negative all specimens which are negative on the initial test or negative on the confirmation test; results will be reported to the Employee Health Nurse.

   c. The laboratory will transmit results in a manner designed to ensure confidentiality of the information. The laboratory and MRO will ensure the security of the data transmission and restrict access to any data transmission, storage and retrieval system.

2. Medical Review Officer (MRO)

   a. Prior to the transmittal of the positive test results to Kaweah Health, the test results shall be reviewed and verified by a MRO. The MRO shall be a licensed physician, under contract with Kaweah Health, with knowledge of substance abuse disorders, medical use of prescription drugs and pharmacology and toxicology of illicit drugs.

   b. The MRO shall follow all of the requirements set forth in applicable State and Federal regulations. The MRO shall evaluate the drug test result(s), verify the chain of custody forms and ensure that the donor's identification number on the laboratory report and the chain of custody form accurately identifies the individual.

   c. The MRO shall notify the employee or the job applicant of a confirmed positive test result within three (3) days of receipt of the test result from the laboratory and inquire as to whether prescriptive or over-the-counter medications could have caused the positive test result. Within five (5) days of notification to the donor of the positive test result, the MRO shall provide an opportunity for the employee or job applicant to discuss the positive test result and to submit documentation of any prescriptions relative to the positive test result.

   d. The MRO shall properly identify the employee or job applicant, inform them that the MRO is an agent of Kaweah Health whose responsibility is to make a

determination on test results and report them to Kaweah Health, inform them that medical information revealed during the MRO's inquiry will be kept confidential, unless the MRO believes the employee or job applicant is in a safety sensitive or special risk position with Kaweah Health.

e. Additionally, the MRO shall outline the rights and procedures for a retest of the original specimen and process any employee or job applicant requests for retest of the original specimen within one hundred, eighty (180) days of notice of the positive test result in another licensed laboratory selected by the employee or job applicant. The employee or job applicant requesting the additional test shall be required to pay for the cost of the retest, including handling and shipping expense. The MRO shall contact the original testing laboratory to initiate the retest.

f. Upon receipt of information and/or documentation from the employee or job applicant, the MRO shall review any medical records provided, authorized and/or released by the individual's physician, to determine if the positive test result was caused by a legally prescribed medication. The MRO shall inquire about over-the-counter medications which could have caused the positive test result. The donor shall be responsible for providing all necessary documentation (i.e., a doctor's report, signed prescription, etc.) within the five (5) day period after notification of the positive test result.

g. If the MRO determines that there is a legitimate medical explanation for the positive test result, the MRO shall report a negative test result to Kaweah Health.

h. If the MRO has any questions as to the accuracy or validity of a test result or has a concern regarding the scientific reliability of the sample, the MRO may request the individual to provide another sample. Once an MRO verifies a positive test result, the MRO may change verification of the result if the employee or job applicant presents information which documents that a serious illness, injury, or other circumstance unavoidably prevented them from contacting the MRO within the specified time frame and if they present information concerning a legitimate explanation for the positive test result.

i. If the MRO is unable to contact a positively tested donor within three (3) days of receipt of the test results from the laboratory, the MRO shall contact Kaweah Health and request that Kaweah Health direct the employee to contact the MRO as soon as possible. If the MRO has not been contacted by the employee or job applicant within two (2) days from the request of Kaweah Health, the MRO shall verify the report as positive.

j. If the employee or job applicant refuses to talk with the MRO regarding a positive test result, the MRO shall validate the result as a positive and annotate such refusal in the remarks section. If the employee or job applicant voluntarily admits to the use of the drug in question without proper prescription, the MRO shall advise them that a verified positive test result will be sent to Kaweah Health.

k. The MRO shall notify Kaweah Health in writing of the verified test result, negative, positive, or unsatisfactory and appropriately file chain of custody forms to Kaweah Health.

3. Kaweah Health Notification of Test Results

a. Within five (5) working days after receipt of a positive confirmed test result, Kaweah Health will attempt to inform the employee or job applicant in writing of such positive test results, the consequences of such results, and the options available to the employee or job applicant.

b. Kaweah Health will provide to the employee or job applicant a copy of the test results upon request.

c. For all tests based on reasonable suspicion, Kaweah Health will detail in writing the circumstances which formed the basis of the determination that reasonable suspicion existed to warrant the testing. A copy of the report will be given to the employee upon request. The original report will be kept confidential and retained by Kaweah Health.

4. Challenges to Test Results

Within 5 (five) working days after receiving notice of a positive confirmed test result, the employee or job applicant may submit information to Kaweah Health explaining or contesting the test results. The employee or job applicant will be notified in writing if the explanation or challenge is unsatisfactory to Kaweah Health. The written notice will be given to the employee or job applicant, and will include why the employee's or job applicant's explanation is unsatisfactory, along with the report of positive confirmed test results. All such documentation will be kept confidential and will be retained by Kaweah Health.

5. Employee and Job Applicant Protection

a. During the one hundred eighty (180) day period after written notification of a positive test result, the employee or job applicant will be permitted by Kaweah Health to have a portion of the specimen retested at the employee's or job applicant's expense. The retesting must be done at another State licensed laboratory. The second laboratory must test at equal or greater sensitivity for the drug in questions as the first laboratory. The first laboratory which performed the test for Kaweah Health will be responsible for the transfer of the portion of the specimen to be retested, and for the integrity of the chain of custody for such transfer.

b. Kaweah Health will not request or receive from the testing facility any information concerning the personal health, habit or condition of the employee or job applicant.

c. Kaweah Health will not discharge, discipline, refuse to hire, discriminate

against, or request or require rehabilitation of an employee or job applicant on the sole basis of a positive test result that has not been verified by a confirmation test.

d. Kaweah Health will not discharge, discipline, or discriminate against an employee solely upon the employee's voluntarily seeking treatment, while under the employment of Kaweah Health.

INVESTIGATION:

1. To ensure that illegal drugs and alcohol do not enter or affect the workplace, Kaweah Health reserves the right to search all vehicles, containers, lockers, or other items on Kaweah Health property in furtherance of the policy. Individuals may be requested to display personal property for visual inspection upon Kaweah Health request. Searches will be conducted only where Kaweah Health has reason to believe that the employee has violated Kaweah Health's policy.

2. Failure to consent to a search or display of personal property for visual inspection will be grounds for Disciplinary Action up to and including termination of employment or denial of access to Kaweah Health property.

3. Searches of an employee's personal property (purses, pockets, etc.) will take place only in the employee's presence, to the extent possible. All searches under this policy will occur with the utmost discretion and consideration for the employee involved.

4. In the course of the investigation, the patient care or work the employee or individual was assigned to will be reviewed and audited, including patient record audits if applicable. In addition, the Pharmacy will conduct a review of patient drug utilization trends if applicable to the position of the employee or individual.

5. Because the primary concern is the safety of its employees and their working environment, Kaweah Health will not normally prosecute in matters involving illegal substances. However, Kaweah Health may turn over all confiscated drugs to the proper law enforcement authorities. Further, Kaweah Health reserves the right to cooperate with or enlist the services of proper law enforcement authorities in the course of any investigation subject to the confidentiality requirements in the statutes and regulations.

6. An Employee may be placed on Administrative Leave pending the results of the investigation.

ARREST OR CONVICTION FOR DRUG-RELATED CRIME:

1. If an employee is arrested for or convicted of a drug-related crime, Kaweah Health will investigate all of the circumstances, and Kaweah Health may utilize the drug-testing procedure if cause is established by the investigation. In most cases, an arrest for a drug-related crime constitutes reasonable suspicion of drug use under this policy. The following procedure will apply:

a. During investigation, an employee may be placed on leave. When the investigation is complete, the leave may be converted to a suspension or the employee may be reinstated depending upon the facts and circumstances.

b. If convicted of a drug-related crime, an employee will be terminated.

c. Because of the seriousness of such situations, Kaweah Health reserves the right to alter or change its policy or decisions on a given situation depending upon its investigation and the totality of the circumstances.

2. As a condition of employment, an employee will notify Human Resources in writing of any criminal drug conviction, including manufacturing, distributing, dispensing, possessing, or using controlled substances. The employee must give notice to Kaweah Health within five (5) calendar days of the conviction.

CONFIDENTIALITY:

All information, interview, reports, statement memoranda and drug test results, written or otherwise, received by Kaweah Health as part of this drug testing program are confidential communications. Unless authorized by State laws, rules or regulations, Kaweah Health will not release such information.

"Responsibility for the review and revision of this Policy is assigned to the Chief of Human Resources Officer. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Health Policies and Procedures."

Kaweah Health
MORE THAN MEDICINE. LIFE.

CONSENT TO SUBMIT TO DRUG AND/OR ALCOHOL TESTING

- I acknowledge that Kaweah Health is concerned about my ability to perform my job and that I have been requested to submit to drug and/or alcohol testing per policy HR.200 Drug Free Workplace and Drug/Alcohol Testing. I further acknowledge that I have been informed of the testing policy.

- I understand that the test results will be released to Kaweah Health, and that the results may be used as grounds for discipline up to and including termination.

- Because the presence of certain prescribed and/or over the counter medication may cause a positive test, Kaweah Health has the right to ask to see your prescriptions if the test results are positive.

- I have read this form and agree to submit to drug and/or alcohol testing. I understand that the testing is voluntary on my part, that I may refuse to submit, and that such refusal may be grounds for discipline up to and including termination.

- I understand that I will be placed on Paid Administration Leave pending the results. When the results become available, there will be a meeting in Human Resources to review the results of the test and next steps will be discussed.

Employee Name Employee Signature Date

Supervisor/Manager Name Supervisor/Manager Signature Date

Witness Name Witness Signature Date

HR 213

Kaweah Health
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Human Resources

Policy Number: HR.213	**Date Created: 06/01/2007**
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	**Date Approved: 08/23/2023**
Approvers: Board of Directors (Administration)	
Performance Management and Competency Assessment Program	

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

POLICY:

It is the policy of Kaweah Health to assess, maintain, develop and improve employee performance and competence on an ongoing basis. Performance is formally evaluated on an annual basis through an employee self-evaluation, peer evaluations as appropriate, and a manager evaluation. Competency is the demonstrated ability to integrate the knowledge, skills, and attitudes required in a designated role or setting. Competency is verified through utilization of techniques such as demonstration, review of policy/procedure, verbalization, and/or written testing.

The performance evaluation and competency assessment process ensures that the requirements of the position are met, that each individual is provided opportunities for professional development, and allows for merit increase opportunities consistent with the compensation program in place at the time of the performance evaluation. The performance evaluation process for all eligible employees will start in July of each year. Employees with a hire date on or before June 30 will included in the evaluation cycle.

Kaweah Health requires annual mandatory training in compliance with regulatory agency requirements as well as Kaweah Health policy. Documentation of completion is recorded in the HR systems and written documentation may be maintained in Human Resources or department employee's files. Management is responsible for ensuring employees complete the requirements and for obtaining and maintaining documentation of completion. However, employees are ultimately responsible for meeting job requirements and mandatory training by established due dates. Failure to complete requirements and mandatory training may result in suspension and Disciplinary Action up to and including termination of employment.

PROCEDURE:

Annual Performance Evaluations:

1. The annual Performance Evaluation is a tool utilized by both management and the employee to identify and communicate the performance of the employee and the future annual expectations of the position, and to determine ways to improve performance or to gain advanced knowledge, including development opportunities. The Performance Evaluation is to be discussed with the employee ~~in a face-to-face meeting~~. The employee is encouraged to provide additional feedback, written comments, and share development interests.

2. The Performance Evaluation includes an assessment of overall job performance, attendance, and behavioral standards of performance. It also includes comments, goals to be used for training and development, and to describe actions which will be used to develop skills and improve the employee's performance, such as additional training or work assignments.

3. Employees are required to complete an honest and timely self-evaluation of their performance. Management may also request peer evaluation for feedback of the employee's performance in their role and alignment of behaviors to the vision, mission and behavioral standards.

4. The final review will be electronically ~~signed~~ acknowledged by both the employee and individual completing the evaluation. The evaluation must include feedback on clinical duties by a person who has the expertise at least equal to the individual being observed or tested.

5. At the completion of the annual evaluation, the overall performance rating will be consistent with the definitions noted on the performance evaluation tool. Failure to successfully meet expectations of performance may result in the employee ~~being placed on~~ receiving Disciplinary Action, up to and including termination of employment.

Review Date and Applicable Merit Increases:

1. Self-evaluations for all employees are sent out by HR in July and are due no later than July 31. The manager evaluation and employee electronic acknowledgement is due by September 30. It is the responsibility of employees to complete a timely and thoughtful self-evaluation. After July 31, the ~~selfevaluation~~self-evaluation will no longer be available for the employee to complete. It is expected that department management will complete evaluations on time to ensure merit increases are not delayed for eligible employees.

Commented [TB1]: Remove? We do have quite a few remote employees now and the meeting may not always be face to face.

2. At the time the employee is hired or changes to a different position, he/she will be provided with a copy of the Job Description that will be used to evaluate ~~his/her~~their performance. The employee completes an electronic acknowledgment of receipt. ~~For~~ Employees who have job changes/transfers that are considered a promotion and effective July 1 through the merit effective date, ~~the merit increase will be pushed out to October of the following year.~~are not eligible for a merit increase.

3. Completion of the annual review is defined as the employee's electronic signature in the Human Resources system. Human Resources will process any associated merit increase. Merit increases are effective the first day of the second pay period in October for all eligible employees.

4. Merit increases are based on the salary range and merit increase percentages in effect on the due date of the evaluation, not the day the evaluation is presented to Human Resources. The merit increase will be paid retroactively if the evaluation is completed late.

5. Per Diem Employees on a Critical Flat will receive a performance evaluation, but will not be eligible for annual performance merit adjustment.

6. Per Diem Employees on the Range will receive a performance evaluation, and will be eligible for annual performance merit adjustments.

~~7.~~ Employees who are close to or at the maximum of their pay range receive their merit up to the pay range maximum. ~~Merit increases that place an employee's rate at the maximum of the range will result in the application of a Merit Lump Sum amount, equivalent to the employee's productive and non-productive hours (excluding standby, overtime, double time or callback hours) multiplied by the hourly rate in place for the employee prior to the evaluation. An employee may receive a partial merit increase to the maximum of salary range and a partial Merit Lump Sum.~~

Competence Assessment:

1. During the first of 48 hours of employment, all employees will complete the 48hour checklist for departmental orientation.

2. Competency is the demonstrated ability to integrate the knowledge, skills, and attitudes required for performance in a designated role or setting. Competency is verified through utilization of techniques such as demonstration, review of policy/procedure, verbalization, written testing, etc. For the initial competency evaluation at the time of hire or transfer, a face-to face discussion will occur to assess and document the initial competency of an employee who provides patient care. Initial competency documentation is maintained in the department files or Human Resources as determined by the department. All items must be

reviewed, checked and signed for competency by a person who has the expertise at least equal to the individual being observed or tested. An employee must be deemed competent to perform a skill prior to them performing the skill independently.

3. Patient care and related employees will complete an annual clinical competency assessment for their position as applicable. All items must be reviewed, documented and signed for competency by a person who has the expertise at least equal to the individual being observed or tested.

4. In addition, employees must be deemed competent when new procedures or equipment is introduced into the clinical setting, and this information will be maintained in the Human Resources or department file.

Remediation:

1. If an employee falls below expected levels of performance or is not deemed competent of a requirement or skill, the employee will be provided with opportunities for improvement.

2. The remediation plan may be included in a Disciplinary Action/Performance Notice, or a separate remediation plan may be developed. Time frames for follow up and requirements will be noted as applicable, and may include meetings, testing, review of policies, and other appropriate actions to ensure performance and competency. Failure to comply with or successfully complete the plan may result in further Disciplinary Action up to and including termination of employment.

"Responsibility for the review and revision of this Policy is assigned to the Chief of Human Resources Officer. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Health Policies and Procedures."

HR 234

Policy Number: HR.234	Date Created: 06/01/2007
Document Owner: Dianne Cox (Chief Human Resources Officer)	Date Approved: 6/25/2025
Approvers: Board of Directors (Administration)	

Paid Time Off (PTO), Extended Illness Bank (EIB) and Healthy Workplace, Healthy Families Act of 2014

POLICY:

Paid Time Off (PTO), Extended Illness Bank (EIB) and Healthy Workplace, Healthy Families Workplace Act of 2014 – Paid Sick Leave (PSL) benefits are offered to all employees as defined in this policy. PTO is offered to full-time and part-time benefit eligible employees for leisure, celebration of holidays, short-term illness and other personal needs. EIB is offered to full-time and part-time benefit eligible employees for extended illness and Kin Care. Private Home Care staff, temporary staff/interims and Per Diem staff are not eligible for PTO or EIB but are eligible for Paid Sick Leave (PSL) as defined in this policy. Excessive occurrences of unapproved time off may result in disciplinary action. See Policy HR.184 Attendance and Punctuality.

This policy does not apply to Graduate Medical Education

PROCEDURE:

Eligibility and Accrual for PTO and EIB

Full-time and part-time benefited employees are eligible to receive PTO and EIB as of the first pay period of eligibility (date of hire or transfer). If an eligible employee is changed to a non-eligible status, the PTO and EIB time accrual will cease. The employee will receive a lump-sum payment for all accrued PTO paid at 100% of their hourly rate of pay prior to the status change. During the non-eligible status, the employee will accrue PSL.

If a non-eligible employee is changed to an eligible status, the employee begins accruing PTO and EIB as of the first pay period in which the status change became effective; PSL accrual will cease. At no time will an employee accrue PTO and EIB as well as PSL. An employee accrues either PTO and EIB or PSL.

EIB accrual will be reinstated for employees who leave Kaweah Health and are rehired as follows:

a. If left as non-benefited and rehired as a non-benefited, we will reinstate the ending available EIB balance into a reserve bucket. These hours are available for use.

b. If terminated as a benefited and rehired as benefited, we will reinstate the ending EIB balance.

c. If terminated as non-benefited and rehired as benefited, we will reinstate the ending available EIB balance from the reserved EIB balance (if any).

d. If terminated as a benefited and rehired as non-benefited, we will reinstate the ending available EIB balance up to the 80-hour maximum, placing the excess EIB balance into a reserve bucket. These hours are not available for use.

The rate of PTO and EIB accrual received is based on years of service. Employees receive accruals on up to 80 eligible hours, per pay period. The bi-weekly pay period starts at 12 AM on a Sunday, and ends at 11:59 PM on the last Saturday of the pay period. Qualified service hours which count towards a year of service for the accrual rate include the following: regular hours worked (non-overtime), Flex Time Off, PTO FMLA, PTO unscheduled, PTO/PSL, PTO Sick/Pregnancy, PTO/Workers Compensation, Sitter Pay, Sleep Pay, PTO hours, bereavement hours, jury duty hours, training/workshop hours, orientation hours, and mandatory dock hours. Neither EIB nor PTO accruals will be earned while employees are being paid EIB hours.

All Other Employees					Directors					Chiefs				
Beg Years	End Years	PTO Max Hrly Accrual Rate (Up to 80 elg hrs)	Max Hours accrued per pay period	PTO Days per year	Beg Years	End Years	PTO Max Hrly Accrual Rate (Up to 80 elg hrs)	Max Hours accrued per pay period	PTO Days per year	Beg Years	End Years	PTO Max Hrly Accrual Rate (Up to 80 elg hrs)	Max Hours Accrued per pay period	PTO Days per year
0.0	4.9	0.084625	6.77	22	0.0	4.9	0.103875	8.3	27	0.0	1.0	0.103875	8.3	27
5.0	9.9	0.103875	8.31	27	5.0	9.9	0.123000	9.8	32	1.1	4.0	0.123000	9.8	32
10.0	14.9	0.123000	9.84	32	10.0	14.9	0.142250	11.4	37	4.1	9.0	0.142250	11.4	37
15	19.9	0.126875	10.15	33	15	19.9	0.146125	11.7	38	9.1	13.5	0.146125	11.7	38
20	24.9	0.130750	10.46	34	20	24.9	0.150000	12.0	39	13.6	18.0	0.150000	12.0	39
25	26.9	0.134625	10.77	35	25	26.9	0.153875	12.3	40	18.1	22.5	0.153875	12.3	40
27	28.9	0.138500	11.08	36	27	28.9	0.157750	12.6	41	22.6	27.0	0.157750	12.6	41
29+		0.142375	11.39	37	29+		0.161625	12.9	42	27.1		0.161625	12.9	42

Eligibility and Accrual for PSL

PSL eligible employees include Per-Diem, Private Home Care, and Part-Time non- benefit eligible employees. PSL eligible employees will accrue at the rate of one hour per every 30 hours worked (.033333 per hour); accrual begins as of the first pay period. To qualify for sick leave (PSL), an employee must:

- Must be employed for 30-days;
- May use beginning at 90-days of employment;
- Will be paid to the extent of an employee's accrued hours only.

Employees are limited to use up to 40 hours or five (5) days whichever is greater of accrued time in each calendar year. PSL will carry over to the following calendar year not to exceed 60 hours of accrual in any calendar year.

Maximum Accruals

The maximum PTO accrual allowed for exempt and non-exempt staff is 4~~4500~~ hours. The maximum PTO accrual allowed for Directors and Chiefs is 505 hour. The accrual will cease once the maximum accrual is reached until PTO hours are used or cashed out. The maximum EIB accrual is 2000 hours; the maximum PSL accrual is 120 hours in a calendar year. No payment is made for accrued EIB or PSL time when employment with Kaweah Health ends for any reason.

Requesting, Scheduling, and Access to PTO, EIB and PSL

Employees are required to use accrued PTO for time off for illness or unexpected absence occurrences.

Routine unpaid time off is not allowed. Any requests for unpaid time should be considered only on a case-by-case basis taking into consideration the need for additional staffing to replace the employee and other departmental impacts. It is the responsibility of management to monitor compliance. Employees should be aware that unpaid time off could potentially affect their eligibility for benefits.

Any planned request for PTO time, whether for traditional holiday, for vacation time or otherwise must be approved in advance by management. Management will consider the employee's request as well as the needs of the department. In unusual circumstances, management may need to change the PTO requests of employees based upon the business and operational needs of Kaweah Health. In such situations, Kaweah Health is not responsible for costs employees may incur as a result of a change in their scheduled PTO time.

AB 1522 Healthy Workplace Healthy Families Act of 2014

An employee may utilize up to five (5) days or 40 hours 40 hours, whichever is greater, of PTO or PSL in a calendar year (January-December). For example: ○ For employees who work 12-hour shifts, the employee will be entitled to use up to 60 hours of paid sick leave (5 days x 12 hours). ○ An employee who works 10-hour shifts will be entitled to use up to 50 hours (5 days x 10 hours).

○ An employee who works 8-hour shifts will be entitled to use up to 40 hours (5 days x 8 hours). ○ Alternatively, if an employee works only 6 hours a day and takes five days of paid sick leave, for a total of 30 hours, the employee will still have 10 hours remaining.

Employee may use PTO or PSL for the following purposes:

a) Diagnosis, care, or treatment of an existing health condition, or preventative care for an employee or an employee's designated person, family member, as defined as employee's parent, child, spouse, registered domestic partner, grandparent, grandchild, and siblings.

b) "Family Member" means any of the following:

i. A child, which for purposes of this policy means a biological, adopted or foster child, stepchild, legal ward, or a child to whom the employee stands in loco parentis; this definition of child is applicable regardless of age or dependency status. ii. A biological, adoptive, or foster parent, stepparent, or legal guardian of an employee or the employee's spouse or registered domestic partner, or a person who stood in loco parentis when the employee was a minor child. iii. Spouse
iv. Registered domestic partner
v. Grandparent vi. Grandchild
vii. Sibling

c) Designated Person means the following:
   i. Under the California Family Rights Act (CFRA) and California Healthy Workplaces Health Families Act (HWHFA) an employee will be able to identify a designated person for whom they want to use leave when they request unpaid CFRA or paid HWHFA.

d) For an employee who is a victim of domestic violence, sexual assault or stalking, as specified.

There is no cash out provision for the PSL accrual, including upon termination of employment or with a status change to a benefit eligible position. However, if an employee separates from Kaweah Health and is rehired within one year, previously accrued and unused PSL will be reinstated.

PSL and PTO time shall be utilized at a minimum of 1-hour increments and no more than the length of the employee's shift.

PTO and PSL time taken under this section is not subject to the Progressive Discipline Policy HR.216.

Time Off Due To Extended Illness

Employees who are absent due to illness for more than three (3) consecutive work days should notify their manager and contact the Human Resources Department to determine if they are eligible for a leave of absence. Accrued EIB can be utilized for an approved continuous leave of absence beyond three (3) days and if admitted to a hospital or have a medical procedure under anesthesia. However, in instances when an employee has been issued Disciplinary Action and directed to provide a doctor's note for all sick days, then an employee may need to submit a doctor's note. If applying for a continuous leave of absence, accrued PTO may be applied for the first twenty four (24) hours at the employee's regular shift length, if leave is for your own medical condition.

Employees who are absent due to illness for more than seven (7) consecutive days should file a claim for California State Disability Insurance. Claim forms are available in Human Resources. State Disability payments will be supplemented with any accrued EIB time by the Payroll Department and PTO at the employee's request.

Employees who are absent due to a Worker's Compensation injury for less than 14 days, there is a three (3) day waiting period before TTD (Total Temporary Disability)

will begin. The first three (3) days is paid using accrued EIB hours. If the employee is off work more than 14 days, TTD begins on day one (1).

Employees who are absent with an Intermittent Leave under FMLA/CFRA are required to use accrued PTO for their absences, at no less than one hour and no more than the regular length of the shift.

Time Off Due to Kin Care

Kin Care allows eligible employees to use up to one-half (1/2) of the Extended Illness Bank (EIB) that they accrue annually in a calendar year to take time off to care for a sick family member. Only employees who accrue EIB are eligible for Kin Care. No more than one-half of an employee's EIB accrual in a calendar year period can be counted as Kin Care. An employee who has exhausted their EIB and then is absent to care for a sick family member cannot claim that absence under Kin Care.

Kin Care can be used to care for a sick family member, to include a spouse or registered domestic partner, child of an employee, "child" means a biological, foster, or adopted child, a stepchild, a legal ward, a child of a domestic partner, or a child or a person standing in loco parentis, parents, parents- in-law, siblings, grandchildren and grandparents.

EIB time taken under this section to care for an immediate family member is not subject to the Progressive Discipline Policy HR.216.

Holidays

Kaweah Health observes 72 holiday hours each year. Eligible employees may be scheduled a day off and will be paid provided adequate accrual exists within their PTO bank account for each observed holiday. Time off for the observance of holidays will always be in accordance Kaweah Health needs.

1. New Year's Day (January 1st)
2. President's Day (Third Monday in February)
3. Memorial Day (Last Monday in May)
4. Independence Day (July 4th)
5. Labor Day (First Monday in September)
6. Thanksgiving Day (Fourth Thursday in November)
7. Day after Thanksgiving Day (Friday following Thanksgiving)
8. Christmas Day (December 25th)
9. Personal Day

Business departments and/or non-patient care areas will typically be closed in observance of the noted holidays. Where this is the case, employees assigned to and working in these departments will be scheduled for a day off on the day the department is closed. Employees affected by department closures for holidays should maintain an adequate number of hours within their PTO banks to ensure that time off is with pay.

In business departments and/or non-patient care areas, holidays, which fall on Saturday, will typically be observed on the Friday preceding the actual holiday and holidays, which fall on Sunday, will be observed on the Monday following the actual holiday.

Employees who work hours on some of these holidays may be eligible for holiday differential. For more information of eligibility, see policy HR.75 Differential Pay- Shift, Holiday, and Weekend.

"Responsibility for the review and revision of this Policy is assigned to the Chief of Human Resources. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases. Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the staff member's responsibility to review and understand all Kaweah Health Policies and Procedures."

EHS 04

Policy Number: EHS 04	Date Created: 06/01/2007
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: Not Approved Yet
Approvers: Dianne Cox (Chief Human Resources Officer), Gaby Robles (Administrative Clerk)	

Infectious Disease Guidelines for Employees

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

PURPOSE:

These Infectious Disease guidelines will direct the care of ~~employees~~ healthcare personnel (HCP) who are ill. ~~Employees~~ HCP will be relieved from patient contact and/or all work duties according to the specific disease or exposure status of the employee, as noted in the table below. When ~~employees~~ HCP of the d~~D~~istrict are exposed to a highly contagious disease or industrial hazard requiring immediate therapy, prophylactic or otherwise, the following procedure will be implemented.

POLICY/GUIDELINE:

Summary of suggested work restrictions for healthcare personnel exposed to or infected with infectious diseases of importance in healthcare settings, in the absence of state and local regulations (modified from ACIP recommendations)

Disease/Problem	***Work Restriction***	***Duration***
Conjunctivitis	Restrict from patient contact and contact with the patient's environment	Until discharge ceases
Cytomegalovirus		
Active	No restriction	
Postexposure	No restriction	
Diarrheal diseases:		
Acute stage (diarrhea with other symptoms)	Restrict from patient contact, contact with the patient's environment, or food handling	Until symptoms resolve (no diarrhea episodes for 24 hours)
Convalescent stage, Salmonella spp.	Restrict from care of high-risk patients	Until symptoms resolve (no diarrhea episodes for 24 hours); consult with local and state health authorities regarding

Disease/Problem	Work Restriction	Duration
		need for negative stool cultures
Diphtheria Respiratory	Exclude from work	Until antibiotic and antitoxin (if needed) therapy are completed AND at least 24 hours after completion of antibiotic therapy, two consecutive pairs of nasal AND pharyngeal cultures, obtained at least 24 hours apart, are negative for toxin-producing C. diphtheriae
Cutaneous or other diphtheria infection manifestations	Exclude from work	Consult with federal, state, and local public health authorities to determine duration
Postexposure (regardless of vaccination status)	Exclude from work and obtain nasal and pharyngeal swabs for diphtheria culture. Administer postexposure prophylaxis in accordance with CDC recommendations. Implement daily monitoring for the development of signs and symptoms of diphtheria for 7 days after last exposure.	If nasal AND pharyngeal cultures are negative for toxin-producing C. diphtheriae, healthcare personnel may return to work while completing postexposure antibiotic therapy If nasal OR pharyngeal cultures are positive for toxin-producing C. diphtheriae complete postexposure antibiotic therapy. Healthcare personnel may return to work when postexposure antibiotic therapy is completed AND at least 24 hours after completion of postexposure antibiotic therapy, two consecutive pairs of nasal AND pharyngeal cultures, obtained at least 24 hours apart, are negative for toxin-producing C. diphtheriae.
Enteroviral infections	Restrict from care of infants, neonates, and immunocompromised patients and their environments.	Until symptoms resolve (no fever >100.4 for 24 hours)
Head Lice (Pediculosis)	Exclude from work	Until treatment done and no active lice present after 2 days. Second treatment may be necessary
Hepatitis A	Restrict from patient contact, contact with patient's environment, and food handling. Occupational Exposure: Employee Health Services (EHS) will notify Infection Prevention (IP) and consult with the Medical Director and/or	Until 7 days after onset of jaundice

Disease/Problem	Work Restriction	Duration
	Infectious Disease Doctor to determine if prophylaxis is needed. Non-Occupational Exposure: Personnel should contact EHS as soon as possible. EHS will notify IP and EHS will refer employee to their physician and/or Tulare County Public Health Department as needed for possible prophylaxis or treatment.	
Hepatitis B Personnel with acute or chronic hepatitis B surface antigemia who do not perform exposure-prone procedures	No restriction (unless epidemiologically linked to transmission of infection), refer to state regulations; standard precautions should always be observed	
Personnel with acute or chronic hepatitis B e antigenemia who perform exposure-prone procedures	Do not perform exposure-prone invasive procedures until counsel from an expert review panel has been sought; panel should review and recommend procedures the worker can perform, taking into account specific procedure as well as skill and technique of worker; refer to state regulations	Until hepatitis B e antigen is negative
Hepatitis C	No restriction. Use Standard Precautions	
Herpes Simplex Genital	No restriction	
Hands (herpetic whitlow)	Restrict from patient contact and contact with the patient's environment	Until lesions heal
Orofacial	Evaluate for need to restrict from care of high-risk patients	Until lesions heal

Disease/Problem	***Work Restriction***	***Duration***
Human immunodeficiency virus	Do not perform exposure-prone invasive procedures until counsel from an expert review panel has been sought; panel should review and recommend procedures the worker can perform, taking into account specific procedure as well as skill and technique of the worker; standard precautions should always be observed; refer to state regulations	
Measles		
Active (known or suspected)	Exclude from work	For 4 days after the rash appears. For immunocompromised HCP exclude from work for the duration of their illness.
Postexposure (asymptomatic HCP ***with*** presumptive evidence* of immunity to measles)	Not necessary Postexposure prophylaxis is not necessary Implement daily monitoring for signs and symptoms of measles from the 5th day after their first exposure through the 21st day after their last exposure	
Postexposure (asymptomatic HCP ***without*** presumptive evidence* of immunity to measles)	Exclude from work Administer postexposure prophylaxis in accordance with CDC and ACIP recommendations: https://www.cdc.gov/acip-recs/hcp/vaccine-specific/mmr.html Work restrictions are not necessary for HCP who received the first dose of MMR vaccine prior to exposure: They should receive their second dose of MMR vaccine as soon as possible (at least 28 days after their first dose). Implement daily monitoring for signs and symptoms of measles from the 5th day after their first exposure through the 21st day after their last exposure	From 5th day after their first exposure through 21st day after last exposure regardless of receipt of postexposure prophylaxis.
Outbreak	Administer measles vaccine to HCP in accordance with CDC and ACIP recommendations	

Disease/Problem	Work Restriction	Duration
	https://www.cdc.gov/acip-recs/hcp/vaccine-specific/mmr.html	
Meningococcal Disease		
Active (HCP with invasive N. meningitidis disease	Exclude from work	Until 24 hours after the start of effective antimicrobial therapy
Carrier state (HCP who only have nasopharyngeal carriage of N. meningitidis)	Not necessary	
Postexposure to N. meningitidis (regardless of vaccination status)	Administer antimicrobial prophylaxis	
Mumps		
Active (known or suspected)	Exclude from work	For 5 days after the onset of parotitis. If HCP does not have parotitis, exclude for 5 days after onset of their first symptom.
Postexposure (asymptomatic HCP ***with*** presumptive evidence* of immunity to mumps)	Not necessary Implement daily monitoring for signs and symptoms of mumps from the 10th day after their first exposure through the 25th day after their last exposure	
Postexposure (asymptomatic HCP ***without*** presumptive evidence* of immunity to mumps)	Exclude from work Work restrictions are not necessary for HCP who received the first dose of MMR vaccine prior to exposure: They should receive their second dose of MMR vaccine as soon as possible (at least 28 days after their first dose). Implement daily monitoring for signs and symptoms of mumps infection from the 10th day after their first exposure through the 25th day after their last exposure	From the 10th day after their first exposure through the 25th day after their last exposure.
Outbreak	Administer mumps vaccine to HCP in accordance with CDC and ACIP recommendations	

Disease/Problem	Work Restriction	Duration
	https://www.cdc.gov/acip-recs/hcp/vaccine-specific/mmrv.html	
Pertussis		
Active (symptomatic HCP known or suspected)	Exclude from work	For 21 days from onset of cough, or until 5 days after the start of effective antimicrobial therapy
Postexposure (asymptomatic HCP, regardless of vaccination status, who are likely to interact with persons at increased risk for severe pertussis)	Administer postexposure prophylaxis Work restrictions are not necessary if received postexposure prophylaxis, regardless of their risk for interaction with persons at increased risk for severe pertussis. If not receiving postexposure prophylaxis restrict from contact (e.g., furlough, duty restriction, or reassignment) with patients and other persons at increased risk for severe pertussis	For 21 days after the last exposure
Postexposure (asymptomatic HCP, regardless of vaccination status, who are NOT likely to interact with persons at increased risk for severe pertussis)	Administer postexposure prophylaxis OR implement daily monitoring 21 days after the last exposure for development of signs and symptoms of pertussis.	
Postexposure (asymptomatic HCP, regardless of vaccination status, who have preexisting health conditions that may be exacerbated by a pertussis infection)	Administer postexposure prophylaxis	
Rabies		
Active infection (suspected or confirmed)	Exclude from work	Consult federal, state, and local public health authorities for duration
Postexposure (asymptomatic HCP)	Not necessary Administer postexposure prophylaxis in accordance with CDC and ACIP recommendations and in consultation	

Disease/Problem	Work Restriction	Duration
	with federal, state, and local public health authorities	
Rubella		
Active (known or suspected)	Exclude from work	For 7 days after the rash appears
Postexposure (asymptomatic HCP ***with*** presumptive evidence* of immunity to rubella)	Not necessary Implement daily monitoring for signs and symptoms of rubella from the 7th day after their first exposure through the 23rd day after their last exposure	
Postexposure (asymptomatic HCP ***without*** presumptive evidence* of immunity to rubella)	Exclude from work	From the 7th day after their first exposure through the 23rd day after their last exposure.
Scabies	Restrict from patient contact	Until cleared by medical evaluation
Staphylococcus aureus infection		
Active, draining skin lesions	Restrict from contact with patients and patient's environment, or food handling	Until lesions have resolved
Carrier State	No restriction, unless personnel are epidemically linked to transmission of the organism	
Streptococcus, Group A		
Active infection (known or suspected)	Exclude from work (if possible, obtain a sample from infected site)	Until Group A Streptococcus infection is ruled out, or until 24 hours after the start of effective antimicrobial therapy, provided that any draining skin lesions can be adequately contained and covered. For draining skin lesions that cannot be adequately contained or covered (e.g., on the face, neck, hands, wrists), exclude from work until the lesions are no longer draining.
Postexposure	Not necessary Postexposure prophylaxis is not necessary	

Disease/Problem	Work Restriction	Duration
Colonization, (known or suspected if personnel are not linked to transmission of the organism in the healthcare setting, if they are see below)	Not necessary	
Colonization, (personnel who are epidemiologically linked to transmission of the organism in the healthcare setting)	Exclude from work	Until 24 hours after the start of effective antimicrobial therapy AND administer chemoprophylaxis in accordance with CDC recommendations AND obtain a sample from the affected site for group A Streptococcus testing 7 to 10 days after completion of chemoprophylaxis; if positive, repeat administration of chemoprophylaxis and again exclude from work until 24 hours after the start of effective antimicrobial therapy.
Tuberculosis		
Active disease	Exclude from work	Until proved noninfectious. Staff who have current TB at a site other than the lung shall be allowed to work as recommended by their personal physician until sputum is free of acid-fast bacillus on 3 consecutive smears obtained on separate days or until sputum cultures show no growth.
PPD Converter	No restriction	
Varicella (chickenpox)		
Active	Exclude from work	Until all lesions have dried and crusted; or, for those who only have non-vesicular lesions that do not crust, exclude from work until no new lesions appear within a 24-hour period.
Postexposure (asymptomatic HCP ***with*** evidence of immunity to varicella)	Not necessary Postexposure prophylaxis is not necessary Implement daily monitoring for signs and symptoms of varicella from the 8th day after the first exposure through the 21st day after the last exposure	

Disease/Problem	***Work Restriction***	***Duration***
Postexposure (asymptomatic HCP ***without*** evidence of immunity to varicella)	Exclude from work Administer postexposure prophylaxis in accordance with CDC and ACIP recommendations: https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6228a4.htm https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5604a1.htm Work restrictions are not necessary for HCP who received one dose of the varicella vaccine prior to exposure if they receive the second dose of vaccine within 5 days after exposure Implement daily monitoring for signs and symptoms of varicella from the 8th day after the first exposure through the 21st day after the last exposure	From the 8th day after first exposure through 21st day after last exposure; if varicella-zoster immune globulin is administered as postexposure prophylaxis, exclude from the 8th day after first exposure through the 28th day after the last exposure
Viral Respiratory Infections, Acute (suspected or confirmed)	Exclude from work Consider temporary reassignment or exclusion of HCP from care of patients at highest risk of severe disease, including those with moderate or severe immunocompromising conditions, for 7-10 days after symptom onset or until symptom resolution, whichever is longer. HCP with respiratory viral infections who are moderately or severely immunocompromised may shed virus for prolonged periods. Consider consultation with EHS to determine when these HCP may return to work and discontinue masking. EHS may consider consulting with an infectious disease specialist or other expert in making this determination. Wear a facemask for source control in all patient care and common area of the facility (ex: breakrooms) for at least 10 days after symptom onset or positive test (if asymptomatic), if not already wearing a facemask as part of universal source control masking. Perform frequent hand hygiene, especially before and after each patient encounter or contact with respiratory secretions.	For at least 3 days from symptom onset (first day of symptoms is day 0, making the first possible day of return to work on day 4) and at least 24 hours have passed with no fever (without using fever-reducing medicines), symptoms are improving, and they feel well enough to return to work. If testing is performed that renders a positive result, but the individual is asymptomatic throughout their infection, HCP should not return to work until at least 3 days have passed since their first positive test.

Disease/Problem	***Work Restriction***	***Duration***
Viral Respiratory Infections, Acute Exposure	No work restriction Recommended to wear a facemask for 10 days from exposure date Monitor for symptoms. If symptoms begin, contact leader and employee health services.	
Zoster (Shingles) Active (disseminated herpes zoster or for immunocompromised HCP with localized herpes zoster until disseminated disease has been ruled out)	Exclude from work	Until all lesions have dried and crusted
Active (immunocompetent HCP who have localized herpes zoster and for immunocompetent HCP who have localized herpes zoster and have had disseminated disease ruled out)	Cover all lesions and when feasible, exclude from direct care of patients at high risk for severe varicella If lesions cannot be covered (ex: hands/face), exclude from work	Until all lesions are dried and crusted Until all lesions have dried and crusted
Postexposure to disseminated or localized herpes zoster (asymptomatic HCP ***with*** evidence of immunity to varicella)	Not necessary Postexposure prophylaxis not necessary Implement daily monitoring for signs and symptoms of varicella from the 8th day after the first exposure through the 21st day after the last exposure	
Postexposure to disseminated or localized herpes zoster (asymptomatic HCP ***without*** evidence of immunity to varicella)	Exclude from work Administer postexposure prophylaxis in accordance with CDC and ACIP recommendations: https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6228a4.htm https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5604a1.htm Work restrictions are not necessary for	From the 8th day after first exposure through 21st day after last exposure; if varicella-zoster immune globulin is administered as postexposure prophylaxis, exclude from the 8th day after first exposure through the 28th day after the last exposure

Disease/Problem	Work Restriction	Duration
	HCP who received one dose of the varicella vaccine prior to exposure if they receive the second dose of vaccine within 5 days after exposure Implement daily monitoring for signs and symptoms of varicella from the 8th day after the first exposure through the 21st day after the last exposure	

~~POLICY/GUIDELINE~~

~~Summary of suggested work restrictions for health care personnel exposed to or infected with infectious diseases of importance in health care settings, in the absence of state and local regulations (modified from ACIP recommendations).~~		
~~Hepatitis B~~		
~~Personnel with acute or chronic hepatitis B surface antigemia who do not perform exposure-prone procedures~~	~~No restriction (unless epidemiologically linked to transmission of infection), refer to state regulations; standard precautions should always be observed~~	
~~Personnel with acute or chronic hepatitis B e antigenemia who perform exposure-prone procedures~~	~~Do not perform exposure-prone invasive procedures until counsel from an expert review panel has been sought; panel should review and recommend procedures the worker can perform, taking into account specific procedure as well as skill and technique of worker; refer to state regulations~~	~~Until hepatitis B e antigen is negative~~
~~Hepatitis C~~	~~No restriction. Use Standard Precautions~~	
~~Herpes Simplex~~		
~~Genital~~	~~No restriction~~	
~~Hands (herpetic whitlow)~~	~~Restrict from patient contact and contact with the patient's environment~~	~~Until lesions heal~~
~~Orofacial~~	~~Evaluate for need to restrict from care~~	~~Until lesions heal~~

	of high-risk patients	
Human immunodeficiency virus	Do not perform exposure-prone invasive procedures until counsel from an expert review panel has been sought; panel should review and recommend procedures the worker can perform, taking into account specific procedure as well as skill and technique of the worker; standard precautions should always be observed; refer to state regulations	
Measles Active *Postexposure (susceptible personnel)	 Exclude from work Exclude from work	 Until 7 days after the rash appears From 5th day after 1st exposure through 21st day after last exposure and/or 4 days after rash appears
Meningococcal Disease Active (personnel with invasive N. meningitidis disease Carrier state (personnel who only have nasopharyngeal carriage of N. meningitides) Postexposure (regardless of vaccination status)	 Exclude from work Not necessary Administer antimicrobial prophylaxis and exclude potentially infectious personnel from work	 Until 24 hours after the start of effective antimicrobial therapy Consult with local and state health authorities for guidance
Mumps Active Postexposure (susceptible personnel)	 Exclude from work Exclude from work	 Until 9 days after onset of parotitis From the 12th day after 1st exposure through 26th day after last exposure or until 9 days after onset of parotitis
Pertussis Active (symptomatic personnel known or suspected) Postexposure asymptomatic	 Exclude from work Administer postexposure prophylaxis	 For 21 days from onset of cough, or until 5 days after the start of effective antimicrobial therapy

personnel who are likely to interact with persons at increased risk for severe pertussis (regardless of vaccination status)	and work restrictions are not necessary regardless of their risk for interaction with persons at increased risk for severe pertussis. If not receiving postexposure prophylaxis restrict from contact (e.g., furlough, duty restriction, or reassignment) with patients and other persons at increased risk for severe pertussis	For 21 days after the last exposure
Postexposure asymptomatic personnel who are NOT likely to interact with persons at increased risk for severe pertussis (regardless of vaccination Status)	Administer postexposure prophylaxis OR implement daily monitoring 21 days after the last exposure for development of signs and symptoms of pertussis. No work restrictions	
Postexposure asymptomatic personnel who have preexisting health conditions that may be exacerbated by a pertussis infection (regardless of vaccination status)	Administer postexposure prophylaxis and work restrictions are not necessary regardless of their risk for interaction with persons at increased risk for severe pertussis	
Rabies Active infection (suspected or confirmed) Postexposure asymptomatic Personnel	Exclude from work Not necessary	Consult federal, state, and local public health authorities for duration Administer postexposure prophylaxis in accordance with CDC and APIC recommendations and in consultation with federal, state, and local public health authorities
Scabies	Restrict from patient contact	Until cleared by medical evaluation
Staphylococcus aureus infection Active, draining skin lesions Carrier State	Restrict from contact with patients and patient's environment, or food handling No restriction, unless personnel are epidemically linked to transmission of the organism	Until lesions have resolved
Streptococcus, Group A		

Active infection (known or suspected)	Exclude from work (if possible obtain a sample from infected site)	Until group A Streptococcus infection is ruled out, or until 24 hours after the start of effective antimicrobial therapy, provided that any draining skin lesions can be adequately contained and covered. For draining skin lesions that cannot be adequately contained or covered (e.g., on the face, neck, hands, wrists), exclude from work until the lesions are no longer draining.
Streptococcus, Group A postexposure	Not necessary	
Streptococcus Group A Colonization, (known or suspected if personnel are not linked to transmission of the organism in the healthcare setting, if they are see below)	Not necessary	
Streptococcus Group A Colonization, (personnel who are epidemiologically linked to transmission of the organism in the healthcare setting)	Exclude from work	Until 24 hours after the start of effective antimicrobial therapy AND administer chemoprophylaxis in accordance with CDC recommendations AND obtain a sample from the affected site for group A Streptococcus testing 7 to 10 days after completion of chemoprophylaxis; if positive, repeat administration of chemoprophylaxis and again exclude from work until 24 hours after the start of effective antimicrobial therapy.
Tuberculosis		
Active disease	Exclude from work	Until proved noninfectious. Staff who have current TB at a site other than the lung shall be allowed to work as recommended by their personal physician until sputum is free of acid-fast bacillus on 3 consecutive smears obtained on separate days or until sputum cultures show no growth.
PPD Converter	No restriction	
Varicella		
Active	Exclude from work	Until all lesions dry and crust
Postexposure (susceptible personnel)	Exclude from work	From 10th day after 1st exposure through 21st day (28th day if VZIG given) after last

		exposure
Zoster Localized, in healthy person	Cover lesions; restrict from care of high-risk patients (neonates and immunocompromised persons at any age)	Until all lesions dry and crust
Generalized or localized in immunosuppressed person	Restrict from patient contact	Until all lesions dry and crust
Postexposure (susceptible personnel)	Restrict from patient contact	From 10th day after 1st exposure through 21st day (28th day if VZIG given) after last exposure or, if varicella occurs, until lesions dry and crust
Viral respiratory infections, acute febrile	Consider excluding from the care of high-risk patients (for complications of influenza) or contact with their environment during community outbreak of RSV and influenza	Until acute symptoms resolve (no fever >100.4 for 24 hours)

*presumptive evidence: https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6204a1.htm#Tab3

Special Populations: Pregnant Healthcare Personnel

Recommendations: Do not routinely exclude HCP only on the basis of their pregnancy or intent to be pregnant from the care of patients with infections that have potential to harm the fetus (ex: Cytomegalovirus (CMV), Human Immunodeficiency Virus (HIV), viral hepatitis, herpes simplex, parovirus, rubella, varicella). For additional information, refer to the Pregnant HCP section Special Populations: Pregnant Healthcare Personnel | Infection Control | CDC

PROCEDURE:

All employees with contagious/communicable diseases and conditions must be reported to Employee Health Services for determination of work status, exposure follow-up and reporting to the local health department, if applicable. Infection Control may be notified for all contagious/communicable illnesses.

The Supervisor of the department will collaborate with Human Resources, Employee Health Services, and Infection Control (if necessary) to determine if the employee's condition interferes with their normal course of work, the work of others, or the safety of patients and visitors. The employee may be asked to see their private physician. The employee will be responsible for any financial obligation for non-work related

contagious/communicable illnesses. Any costs of lab tests required to determine the nature of the illness will be the responsibility of the employee unless it is job related.

Return-to-work documentation must be provided to Employee Health. Return-to-work documentation may be provided by the Employee Health Nurse, a physician, or the local health department when applicable.

Examples of employee illnesses that must be reported immediately are:

a. Fever over 100.4 degrees with cough
b. Vomiting
c. Diarrhea (unknown origin)
d. Respiratory infections (Group A Strep, Pneumonia, active TB, Influenza, Covid 19)
e. Chicken Pox and Shingles
f. Hepatitis A
g. Open draining wounds
h. Measles, Mumps, Rubella, or any other infectious or contagious communicable disease.

The House Supervisor will handle illnesses occurring during night or weekend work hours until Infection Control and/or Employee Health is available.

"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."

References:

Bolyard, E., Deitchman, S., Pearson, M., et al. (June 1998). *Guideline for infection control in health care personnel.* Hospital Infection Control Practices Advisory Committee. American journal of infection control; v. 23, no. 3, p. 289-354 and Infection control and hospital epidemiology; v. 19, no. 6, p. 407-63. https://stacks.cdc.gov/view/cdc/11563
~~*1.* Title : Infection control in healthcare personnel : infrastructure and routine practices for occupational infection prevention and control services~~

Centers for Disease Control and Prevention. *Summary of Recommendations from the Infection Control in Healthcare Personnel: Epidemiology and Control of Selected Infections Transmitted Among Healthcare Personnel and Patients (2024) guideline*. Summary of Recommendations | Infection Control | CDC

Driscoll, Chelsea, CDPH. “Interim Work Exclusion Guidance for Healthcare Personnel with COVID-19, Influenza, and Other Acute Respiratory Viral Infections.” AFL 25-01. January 10, 2025. https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-25-01.aspx

Personal Author(s) : Kuhar, D.avid T, .;BabcockCarrico, HR.uth M, .;Brown, V.Cox, K, et al. (Updated October 22, 2024)endra;de Perio, Marie A.;Irwin, Kathleen L.;Lundstrom,. *Infection control in Healthcare Personnel: Epidemiology and Control of Selected Infections Transmitted Among Healthcare Personnel and Patients: Cytomegalovirus, Diphtheria, Group A Streptococcus, Measles, Meningococcal Disease, Mumps, Pertussis, Rabies, Rubella, Varicella, and Special Populations: Pregnant Healthcare Personnel.* Tammy;Overholt, Amanda D.;Roberts, Kristin Tansil;Russi, Mark;Steed, Connie;Sen, Srila;Talbot, Thomas R.;Weber, David J.;Babcock, Hilary M.;

Corporate Authors(s) : Hospital Infection Control Practices Advisory Committee (U.S.);National Center for Emerging and Zoonotic Infectious Diseases (U.S.). Division of Healthcare Quality Promotion.;National Institute of Occupational Safety and HealthCenters for Disease Control and Prevention, National Center for Emerging and Zoonotic Infectious Diseases, Division of Healthcare Quality Promotion.. Infection Control in Healthcare Personnel: Epidemiology and Control of Selected Infections Transmitted Among Healthcare Personnel and Patients;

Published Date : October 2019

URL : https://stacks.cdc.gov/view/cdc/82043

2.Title : Guideline for infection control in health care personnel, 1998

Personal Author(s) : Bolyard, Elizabeth A.;Deitchman, Scott;Pearson, Michele L.;Shapiro, Craig N.;Tablan, Ofelia C.;Williams, Walter W.;

Corporate Authors(s) : Hospital Infection Control Practices Advisory Committee (U.S.);National Center for Infectious Diseases (U.S.);National Immunization Program (Centers for Disease Control and Prevention);National Institute for Occupational Safety and Health.;

Published Date : June 1998

Series : American journal of infection control ; v. 23, no. 3, p. 289-354;Infection control and hospital epidemiology ; v. 19, no. 6, p. 407-63;

URL :P

EHS 11

Policy Number: EHS 11	Date Created: Not Set
Document Owner: ~~Ellason Schales~~Stephanie Hauge ~~(RN-Employee Health Nurse)~~	Date Approved: 05/28/2024
Approvers: Dianne Cox (Chief Human Resources Officer)	

Immunization Requirements for Health Care Workers

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

Policy:

Healthcare Personnel (HCPs) are at risk for exposure to and possible transmission of vaccinepreventable diseases because of their contact with patients or infective material from patients. The Centers for Disease Control (CDC) and Advisory Committee on Immunization Practices (ACIP) recommend the following requirements for all Healthcare Personnel Immunizations.

Procedure:

Hepatitis B Vaccine:

- Documented evidence of complete hepatitis B series and a positive hepatitis B surface antibody titer (HBSAB titer) or positive HBSAB titer alone for all healthcare personnel who have an occupational risk for exposure to blood and/or other body fluids.
- Vaccination for hepatitis B can be either a 3-dose series of Recombivax HB or Engerix-B or a 2-dose series of Heplisav-B. Doses will be provided at intervals recommended per current CDC guidelines.
- If the HCP has had the complete series already but does not have evidence of a positive/reactive HBSAB titer, draw an HBSAB titer. If the HBSAB is nonreactive, meaning no or low immunity to the hepatitis B virus, give one hepatitis B booster, then recheck HBSAB in 4-8 weeks. If the healthcare personnel's HBSAB remains nonreactive, complete the full series of hepatitis B vaccine. Retest HBSAB 4-8 weeks following the competed series.
- HCP who are non-responders should be considered susceptible to HBV and are counseled regarding precautions to prevent HBV infection.
- HCP who are exposed to Hepatitis B antigen in the workplace, EHS 02 Employee Exposure to Bloodborne Pathogens Policy will be followed.
- Administration of more than two complete hepatitis B series is generally not recommended, expect for people on hemodialysis.

Influenza Vaccine:

- One dose of influenza vaccine annually. See Policy EHS 05: Influenza Prevention.

Measles, Mumps, Rubella Vaccine (MMR):

- Proof of two documented doses of measles-and mumps-containing vaccine and 1 documented dose of rubella-containing vaccine or proof of positive titers.

- If no evidence of vaccination or positive titer, draw titer.
- For healthcare personnel who do not have serologic evidence of immunity or prior vaccination, give 2 doses of MMR (4 weeks apart). No follow up titer necessary.

- If the healthcare personnel provides proof of two documented measles-and mumpscontaining vaccinations and also has a negative or equivocal titer(s) result for measles or mumps, it is not recommended that they receive an additional dose of MMR vaccine. Such people should be considered to have acceptable evidence of measles or mumps immunity; retesting is not necessary.
- If healthcare personnel (except for women of childbearing age) who have 1 documented dose of rubella-containing vaccine are tested serologically and have a negative or equivocal titer result for rubella, it is not recommended that they receive an additional dose of MMR vaccine. Such people should be considered to have acceptable evidence of rubella immunity, retesting not necessary.

Varicella Vaccine (Chicken Pox):

- Proof of two documented doses of varicella vaccine or a positive titer.
- If no evidence of vaccination or positive titer, draw titer.
- For healthcare personnel who do not have serologic evidence of immunity or prior vaccination, give 2 doses of varicella (4 weeks apart). No follow up titer necessary.
- If the healthcare personnel provides proof of two documented varicella vaccinations and has a negative or equivocal titer result for varicella, it is not recommended that they receive an additional dose of varicella vaccine (commercial assays are not sensitive enough to always detect antibodies after vaccination).

Tetanus, Diphtheria, and Pertussis Vaccine (Tdap):

- One time dose of Tdap for high risk areas. See Policy EHS 07: Tdap Policy for Healthcare Personnel.

Covid 19 vaccine:

- Two dose series or approved one dose vaccine plus one booster.

Tuberculosis testing (TB):

- A two-step TB skin test is required for all new hire healthcare personnel, or one Quantiferon Gold (QFG), and then ~~an annual~~ a TB test will be required every four years thereafter.
- A TB test will be administered as frequent as once a year to employees who request to have TB skin test performed more frequently than every four years.
- High-risk areas will continue to require annual TB testing (i.e. Acute Psych and Skilled Nursing Facilities).
- Upon hire, HCP will complete TB risk assessment and TB symptom questionnaire.
- If the healthcare personnel provides documentation of a TB skin test within the last year, it will be counted as #1 of the ~~two step~~two-step TB skin test. If documentation is provided of a second TB skin test that was placed and read within the last 3 months prior to hire date, it will be accepted as #2 TB skin test. Otherwise the healthcare personnel will need a

current TB skin test(s) placed and read to begin orientation.

- If the HCP has had a previous documented positive TB test, they will need a chest x-ray performed (proof of chest x-ray within the last year is acceptable) and ~~annual~~ TB symptom questionnaire completed upon hire and every four years thereafter.
- HCP with untreated latent TB will complete annual TB symptom questionnaire.
- TB education will be provided annually to HCP.

Declinations of Vaccines:

- HCP's who require a vaccination will be provided the CDC Vaccine information sheets.
- If a HCP declines the MMR, Varicella, or Hepatitis B vaccines after receiving information of the benefits, they will be provided a declination form to sign for each of the vaccines they are declining. This information will be recorded in their Employee Health record.
  For HCP's declining influenza vaccine refer to policy EHS 05: Influenza Prevention for process to decline influenza vaccine
- For HCP's declining Tdap vaccine refer to EHS 07: Tdap Policy for Healthcare Personnel for process to decline Tdap vaccine

- For HCP's declining Covid vaccination refer to Covid 36: Team Member Covid-19 Vaccination Policy for process to decline Covid vaccine

References:

Immunization of Health Care Personnel: Recommendations of the Advisory Committee in Immunization Practices (ACIP) November 25, 2011 / 60(RR07); 1-45 (https://www.cdc.gov/mmwr/pdf/rr/rr6007.pdf)

Centers for Disease Control and Prevention Website: Recommended Vaccines for Healthcare Workers. Last Reviewed May 2, 2016. (https://www.cdc.gov/vaccines/adults/rec-vac/hcw.html)

"Responsibility for the review and revision of this Policy is assigned to the Chief of Human Resources Officer. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Health Policies and Procedures."

EOC 1001

Kaweah Health
MORE THAN MEDICINE. LIFE.

Subcategories of Department Manuals not selected.

Policy Number: EOC 1001	**Date Created: 06/01/2009**
Document Owner: Maribel Aguilar (Assistant Director of Environment of Care/Safety Officer)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Safety Management Plan

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

I. OBJECTIVES

The objectives of the Management Plan for Safety at Kaweah Delta Health Care District herein referred to as Kaweah Health (KH) is to provide a built-environment wherein patient care can be optimized, and to create an environment that minimizes physical harm and hazards for the patient-care population, staff, volunteers, physicians, contracted workers and visitors. It is an accreditation/standards-based and regulatory driven program, which is assessed for effectiveness during the annual evaluation process.

II. SCOPE

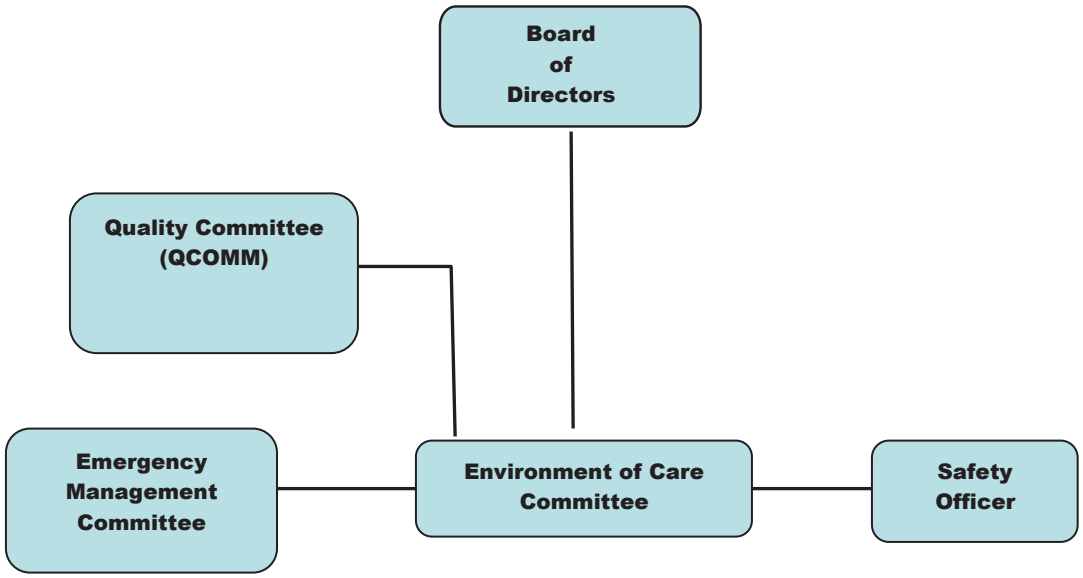
The scope of this management plan applies to KH and any off site area as per KH license. Off-site areas are monitored for compliance with this plan during routine surveillance by Environment of Care (EOC) committee members. Each off site area is required to have a unit-specific safety plan that addresses the unique considerations of the building environment. It is the responsibility of the Safety Officer to assess and document compliance with the Safety Management Plan. Safety-related issues may be brought to the attention of the EOC Committee. The scope of the plan and program includes, but is not limited to the following safety-related activities: surveillance activities, applicable safety policies and procedures, educational and performance improvement activities.

III. AUTHORITY

The authority for the Management Plan for Safety is EC. 01.01.01 and EC. 04.01.01. The authority for overseeing and monitoring the safety management plan and program lies in the EOC Committee, for the purpose of ensuring that safety management activities are identified, monitored and evaluated, and for ensuring that regulatory activities are monitored and enforced as necessary. Whenever possible, regulatory requirements are integrated with accreditation standards to avoid duplication of efforts and to assist in meeting or exceeding the requirements or the accreditation standards. The Chief Executive Officer and Board of Trustees have given the Safety Officer the authority to intervene whenever a hazard exists that poses a threat to life or property at a KH facility.

IV. ORGANIZATION

The following represents the organization of safety management at KH:



V. RESPONSIBILITIES

Leadership within KH has varying levels of responsibility and work together in the management of risk and in the coordination of risk reduction activities in the physical environment as follows:

Board of Directors: The Board of Directors supports the Safety Management Plan by:

- Review and feedback if applicable of the quarterly and annual *Environment of Care* reports
- Endorsing budget support as applicable, which is needed to implement a safe and healthy environment, identified through the activities of the Safety Management Program.

Quality Committee: Reviews annual *Environment of Care* report from the EOC Committee, providing feedback if applicable.

Administrative Staff: Administrative staff provides active representation on the EOC Committee meetings and sets an expectation of accountability for compliance with the Safety Management Program

Environment of Care Committee: EOC Committee members review and approve the quarterly *Environment of Care* reports, which contain a Safety Management component. Members also monitor and evaluate the Safety Management program **(EC .04.01.01-1)** and afford a multidisciplinary process for resolving EOC issues. Committee members represent clinical, administrative and support services when applicable. The committee addresses *EOC* issues in a timely manner, and makes recommendations as appropriate for approval. *EOC* issues are communicated to the KH's leaders through quarterly and annual evaluation reports. At least annually, one Process Improvement activity may be selected by EOC Committee members, based upon risk to the organization. EOC issues are communicated to those responsible for managing the patient safety program as applicable.

Directors and Department Managers: These individuals support the Safety Management Program by:

- Reviewing and correcting deficiencies identified through the hazard surveillance process.
- Communicating recommendations from the EOC Committee to affected staff in a timely manner.
- Developing education programs within each department that insure compliance with the policies of the Safety Management Program including, but not limited to department-specific safety training for new hires, students, volunteers, contracted workers, annual safety reorientation and unit-specific hazard training applicable to their areas.

- Supporting all required employee safety education and training by monitoring employee participation and setting clear expectations for employee participation to include a disciplinary policy for employees who fail to meet the expectations.
- Serving as a resource for staff on matters of health and safety.
- Ensuring employees are knowledgeable on how to access EOC Policies on Policy Tech.
- Ensuring that the procedure for work-related injuries is followed, and that accident investigation is completed immediately post injury or exposure, and documented on the appropriate form.

Employees. Employees of KH are required to participate in the Safety Management program by:

- Completing required safety education.
- Using the appropriate personal protective equipment when applicable. Practicing safe work habits and reporting any observed or suspected unsafe conditions to his or her department manager as soon as possible after identification.

Medical Staff: Medical Staff will support the Safety Management Program by practicing safe work practices while performing procedures at KH, and assisting in the care of employees who receive a work-related injury.

SAFETY OFFICER AUTHORITY

Safety Officer. A qualified individual, is appointed by executive leadership to assume the safety officer role, and oversees the development, implementation and monitoring of safety management at KH. The Safety Officer is responsible for responding to system or process failures that may have an impact on employee, patient or building safety.

MANAGEMENT OF SAFETY RISKS

(KH) identifies safety risks associated with the environment of care. Risks are identified from internal sources such as ongoing monitoring of the environment, results of root-cause analysis, results of annual proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts. If a risk is identified, a risk/benefit analysis process is used to determine if actions and monitoring activities are required. This information is documented and presented to the EOC committee.

Risk Assessment: The management of risks within KH **is multi-focal, and consists of the following processes:**

1. **Policy/Plan/Program Development**. Inherent in risk assessment are the development of safety policies (e.g., Safety Manual or unit-specific), management plans, and program development for safety through the structure of the EOC Committee. Regulations, accreditation or industry standards (e.g., TJC, Title 8 – Employee Illness and Injury Prevention Program, Title 22-licensing requirements for acute care facilities, Title 17-Radiation Safety, OSHA 29 CFR 1910-Chemical Hygiene Officer and Plan) provide the basis and authority for policy/plan and program development.
2. **Environmental Surveillance, Results of Root-Cause Analysis, Pro-active Risk Assessment of high-risk processes.** Included in risk assessment are findings during environmental surveillance that reflect risk identification, and findings from root-cause analysis that require follow-up and improvement actions. During the annual evaluation process, risk identification may occur from a retrospective analysis of performance monitoring of high-risk processes, which will require a plan for improvement to minimize unfavorable outcomes from the possibility of consequential risks. Accountability for assessment and improvement activities are with the EOC committee.
3. **External Sources:** *Sentinel Event Alerts*, Regulatory and Insurer inspections, Audits, and Consultants. Risk assessment may occur as a result of findings or recommendations generated from external sources, such as *Sentinel Event Alerts,* Regulatory and/or Insurer surveys, or audits conducted by recruited consultants. Accountability for assessment and improvement activities is with the EOC committee.

4. **Education:** Education is implemented to provide information, and thereby mitigate risk and includes, but is not limited to:
    - New hire
    - Annual Reorientation
    - Department Specific Education
    - Education for patients, staff, physicians, volunteers, students
    - Education based upon a needs assessment for any specific population.
    - Education based upon risk assessment or the results of surveys, inspections or Audits
5. **Drills – Planned Exercises:** Conducting drills such as fire, disaster, and infant security constitute activities designed to inform, educate and thereby mitigate risk when areas of risk are identified during the debriefing and or evaluation process.
6. **Interim Life Safety Risk Assessment.** The *Interim Life Safety Risk Assessment* process is used to identify potential risks associated with construction, with the intent to develop interim life safety measures to mitigate the risks associated with construction projects. Concurrent building safety guidelines/processes are used to mitigate the risks associated with new construction (e.g., permits, Life Safety Code compliance, current *Statement of Conditions, Guidelines for Design and Construction of Hospitals and Health Care Facilities).*
7. **Reporting and Investigation of Incidents:** Complementary to risk assessment is proper reporting and investigation of incidents. There are multiple processes within KH wherein reporting and investigating elements contribute to risk assessment. Internal processes and activities that support risk assessment include reporting and investigation mechanisms which may identify the opportunity to mitigate risk, such as:
    - Security investigation of property damage, thefts, vandalism, burglary, assault, battery and any workplace violence incidents.
    - Risk Management investigations of patient and visitor incidents, including incidents on the grounds and premises.
    - Employee Health investigations that addresses employee incidents and injuries within Kaweah Health and on the grounds and premises.
    - Infection Control investigations and or surveillance that pro-actively identify practices that provide the opportunity to mitigate risks
    - Material Distribution recalls for products that may pose risk and the opportunity to proactively mitigate the potential for adverse outcomes
    - Pharmaceutical recalls, medication errors or near-misses that may provide the opportunity to proactively mitigate risk

ACTIONS TO MINIMIZE OR ELIMINATE IDENTIFIED SAFETY RISKS

KH **takes action to minimize or eliminate identified safety risks.**

When risks are identified from the above processes, the EOC Committee uses the risks identified to select and implement procedures and controls to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people coming to KH. Moreover, the identified risks may serve as the basis for the selection of performance standards, with the criteria identified as follows:

- The performance standard represents a high-volume activity, thereby representing risk by virtue of ongoing occurrences.
- The performance standard could represent a sentinel event activity (e.g., infant abduction). These types of activities, though rare in occurrence, represent risk due to their seriousness.
- The performance standard represents an activity or finding that needs improvement due to the possibility of adverse outcomes

Risk Reduction Strategies-Proactive

The following strategies are in place at KH to proactively minimize or eliminate safety risks:

1. **Worker Safety Program with Safety Officer Role**. The *Environment of Care* Committee outlines the broad objectives of the safety program for (KH), and implements various activities to ensure the program is viable, as well as defines, through the Safety Management Plan, how the overall plan and program will be evaluated for effectiveness. The Safety Officer has the authority to intervene whenever a hazard exists that poses a risk to the safety of the patients and or building. Alternate individuals are identified in the

absence of the Safety Officer. A Chemical Hygiene Officer role is in place within the Laboratory that oversees policies and procedures relating to lab safety for employees. An Infection Control Nurse oversees surveillance and infection control programs to minimize exposure risks.

2. **Committees.** The EOC Committee is the structure through which safety-related problems and issues can be identified and resolved. It should be noted that the EOC Committee is closely integrated with patient safety functions. The purpose of the EOC Committee with respect to the Patient Safety standards is to remain aware of sentinel event alert information from the Joint Commission and to assess organizational practices against current information relating to patient safety. Additionally, when recommendations are made for hospitals, each recommendation is critically reviewed, with a plan of action established. If sentinel events occur within the District setting that reflect *environment of care* issues, the EOC Committee will participate in improving outcomes relating to patient safety.

   The Radiation Safety Committee impacts worker safety as it oversees the radiation safety program and issues relating to the safety of the worker and radiation exposures. The Emergency Management Subcommittee convenes for the purpose of minimizing risks associated with unforeseen emergent situations that have the potential for consequential or adverse events.

3 **Reporting and Investigation Mechanisms:** Multiple sources of reporting and investigating mechanisms are in place (as identified above) that have the potential to identify risk and thereby implement action as needed to mitigate or minimize the identified risks.

4 **Policies/Procedures.** Safety policies and procedures are in place to assist the employee in the performance of safe-related activities related to the nature of their job tasks or their work areas. Policies and procedures are reviewed at least every three years.

5. **Education** – for Newly-hired Staff and Ongoing

   New hire education. Education relating to general safety processes is given during new hire orientation, and covers such topics as introductory information, an employee ‘s role with respect to general safety processes, types of safety materials and resources available for the employee on his/her unit, preliminary introduction to the concepts of “RACE” and compartmentalization”, emergency management, and introductory information relating to “Employee Right to Know”. This education is documented. Licensed Independent practitioners (LIP’s) receive *Environment of Care* education through the re-credentialing process, which identifies how LIP’s can eliminate or minimize physical risks in the environment of care, actions to take in the event of an incident, and how to report risks.

   a) **Area Specific Safety**. Area specific safety is covered for new employees and contracted workers on each department within (KH) and is the responsibility of the department manager and is documented. Information may include, but not be limited to location of the department’s fire alarms, fire extinguishers, exits, evacuation plans; and location of unit- specific policies and procedures.

   b) **Specific Job-Related Hazards**. Education relating to specific job-related hazards may be part of the new employee’s competencies, and part of the competency reorientation process. Examples of this may include job-related hazards related to the use of chemotherapy for nurses, “lock-out-tag out” for engineering staff, or use of certain cutting materials in the kitchen. Education for specific job-related hazards is the responsibility of the department manager and is documented.

Educational sources

Various types of experience at (KH) provide sources from which educational material is developed. These include, but will not necessarily be limited~~,~~ to, the following:

a) **Environmental surveillance trends**. Through trending of surveillance results, it may be determined that staff need additional education. The survey process itself may be an educational tool for staff. For example, when staff are asked specific questions relating to fire or disaster roles, or location of SDS, or relating to their responsibilities with respect to defective equipment.

b) **Fire and Disaster drills**. When staff performance is evaluated during fire and disaster drills, educational topics may be developed if a knowledge deficit exists or if staff performance was not at the expected level.
c) **Changes in Operational Practices**. Whenever changes occur within (KH) that requires additional safety education, the education will be determined by the EOC committee.
d) **Needs Assessment**. Another source of education is determined from periodic needs assessment tools. These can be gathered from educational evaluations wherein the staff may be asked, "What other types of educational topics would you like to see?" Or it may be done at the unit level, for example, with the use of medical equipment when user errors occur.
e) **Illness and Injury Trends**. When illness and injury trends demonstrate an increase, the increase may be the catalyst for further education. Increasing back or needle stick injuries, or falls are examples of using injury trends to substantiate the need for additional education.
f) **Consequential Events or Risk of Consequential Events**. An incident may occur that results in an adverse patient, visitor or employee injury. This will warrant investigation, and the possibility of additional education.
g) ***Environment of Care* Committee**. The EOC Committee may impose education upon staff due to various regulatory and/or accreditation agencies that require updating.
h) **Risk Assessment Activities**. When risks have been identified, the risks will serve as a source of education for staff, based upon the severity and type of risk assessed.

Risk Reduction Strategies – When Risks Have Been Identified
When proactive risks have been assessed, risk reduction strategies will be the responsibility of the EOC Committee, unless the risk poses the potential for serious consequential events (i.e., death, serious injury or building threat). In this instance, the individual who has assessed the risk will notify the Safety Officer and Risk Management leadership who will then assume responsibility for reduction of the risk threat. Risk reduction strategies for the possibility of non-serious or non-imminent consequential events may be addressed through the *Sentinel Event Review* or EOC Committee, based upon the severity and type of risk identified. Risk reduction strategies include, but are not limited to the following:

1. Policies and Procedures. Policies and procedures may require development or revision, with applicable training completed for affected staff.
2. Education. New or reinforced education may be implemented to minimize the potential for future risk.
3. Equipment. The purchase of new equipment or the use of current equipment may require evaluation.
4. Administrative Controls. Administrative controls such as changes in staffing, or changes in staffing patterns may require evaluation and implementation.
5. Equipment Training. Training on equipment may be implemented or re-enforced.
6. Repairs/ Upgrades on Equipment. Repairs and or upgrades on medical, utility, or building equipment may be required.
7. Elimination of the Risk. Elimination of the risk through removal of a hazard may occur.
8. Product or Equipment Change-out or Recall. Faulty or defective products or equipment may be recalled and replaced.

MAINTENANCE OF GROUNDS AND EQUIPMENT
(KH) manages risks associated with the grounds and equipment in order to minimize consequential events or adverse outcomes related to accidents.
Environmental surveys are done routinely by EOC Committee personnel. Additionally, routine and varied security patrols are conducted wherein any safety hazards are brought to the attention of the EOC Committee. Routine building/grounds surveys with a contractor's representative are conducted when construction activities are occurring. Special investigations by the Safety Officer and other designated staff, when requested, are conducted. Additionally, Risk Management reviews data from reported incidents that may identify patterns, trends and opportunities for improvements. The data involves all patient and visitor incidents related to accidents or other unusual events which are not

consistent with routine patient care and treatment. Incidents that involve patients or visitors, wherein some aspect of the building/grounds plays a consequential role, the Safety Officer will be notified so the hazard may be investigated and corrected as necessary. All of these activities contribute to an overall monitoring plan for the grounds and safety-related equipment.

Equipment - Imaging Risk Reduction:
The hospital provides MRI services, and manages safety risks associated with MRI for the following circumstances:

- Patients who may experience claustrophobia, anxiety or emotional distress: Medication may be provided by the physician to help the patient relax or to decrease his/her anxiety or emotional distress. The RN or MRI technologist may provide psycho-social support as necessary. .
- Patients who may require urgent or emergency medical care: for these patients, a crash cart is available if needed, with transfer to the Emergency Room or Critical Care an option when necessary.
- Patients with medical implants, devices or imbedded foreign objects (such as shrapnel): All patients receive a pre-screening questionnaire to determine if he/she has any imbedded implants, devices or foreign object that will require a clinical judgment to proceed or terminate the MRI. Implants are reviewed by MRI technologist to check for MRI conditional status and review parameters necessary, prior to MRI.
- Ferromagnetic objects entering the MRI environment: MRI staff have been trained to decrease/eliminate any ferromagnetic objects from entering the MRI environment.
- Acoustic noise: The noise made by the MRI can be bothersome to some patients. Patients are informed of this possibility, and that the MRI may be stopped if the noise becomes unbearable. Headphones, where available, and/or earplugs are provided to reduce MRI noise.
- Restricting access to everyone not trained in MRI safety or screened by MRI-trained staff from the scanner room and the area that immediately precedes the entrance to the MRI scanner room: Signage is in place that prohibits unauthorized personnel from entering the MRI area. Door is secure with key pad which effectively restricts entrance to only those who have been safety trained in MRI safety and individually screened using MRI screening questions.
- Making sure that these restricted areas are controlled by and under the direct supervisor of MRI-trained staff: Controlled areas to the MRI are under the direct supervision of MRI-trained staff.
- Posting signage at the entrance to the MRI scanner room that conveys the potentially dangerous magnetic fields that are present in the room. Signage should also indicate that the magnet is always on. Signage is posted at the entrance to the MRI stating that the MRI scanner room has potentially dangerous magnetic fields present, and no one is allowed except authorized personnel. All personnel review annual MRI safety during annual training via our online learning platform.

Performance evaluation of Imaging Equipment.
To reduce the potential of risks relating to the operation and function relating to imaging equipment, the following activities and processes are in place:
For Diagnostic Radiology Equipment:

- A least annually a diagnostic medical physicist conducts a performance evaluation of all Diagnostic Imaging equipment that produce ionizing radiation. The evaluation, along with any recommendations and corrections, are documented. The evaluation utilizes phantoms to measure accuracy of dosages; alignment of beam, light, and collimators; and any functional process involved in acquiring images. Image quality of Computerized Radiography Reading units, Digital Detector Plates, workstations and monitors throughout the Imaging are also evaluated annually for image quality and accuracy, to include high and low contrast resolution, and artifact evaluation

For MRI Equipment:

- A least annually a diagnostic medical physicist or MRI scientist conducts a performance evaluation of all MRI imaging equipment. The evaluation, along with any recommendations, are documented. The evaluation includes the use of phantoms to assess the following: image uniformity for all radiofrequency coils used clinically, slice

position accuracy, alignment light accuracy, high and low contrast resolution, geometric or distance accuracy, magnetic field homogeneity, and artifact evaluation.

FOR CT Equipment:

- Quality control and maintenance is in effect to maintain the clarity/quality of diagnostic images produced. Biomedical leadership identifies the frequency of maintenance activities for Imaging from a risk-based standpoint, and or manufacturer's recommendations.
- Annually, a medical physicist completes the following: measures the radiation dose (in the form of volume computed tomography dose index [CTDIvol] for the adult brain, adult abdomen, pediatric brain and pediatric abdomen.
- Verifies that the radiation dose in the form of the CTDIvol that is displayed by the CT imaging system for each tested protocol is within 20% of the CTDIvol displayed on the CT console. The dates, results and verifications of these measurements are documented (Note: this is only applicable for systems capable of calculating and displaying radiation doses in the form of CTDIvol.
- Annually a medical physicist conducts a performance evaluation of all CT Imaging equipment, with the evaluation, along with recommendations for correcting any problems, documented. The evaluation includes the use of phantoms to assess the following: image uniformity, slice thickness accuracy, slice position accuracy (when prescribed from a scout image), alignment light accuracy, table travel accuracy, radiation beam width, high contrast resolution, low contrast resolution, geometric or distance accuracy, CT number accuracy and uniformity, artifact evaluation.
- All CT protocols on CT units are password protected and reviewed by CT technologist, radiologist and radiation safety officer (RSO).

FOR Nuclear Medicine Equipment:

- At least annually, a diagnostic medical physicist conducts a performance evaluation of all Nuclear Medicine imaging equipment. The evaluation, along with recommendations for correcting any problems identified, are documented.
- The evaluations are conducted for all the image types produced clinically by each type of Nuclear Medicine scanner (e.g., planar and or tomographic) and include the use of phantoms to assess the following imaging metrics: image uniformity/system uniformity, high contrast resolution/system spatial resolution, low contrast resolution or detectability (not applicable for planar), sensitivity, energy resolution, count rate performance and artifact evaluation.

FOR PET Imaging:

- At least annually, a diagnostic medical physicist conducts a performance evaluation of all PET Imaging equipment. The evaluation results, along with recommendations for corrections, are documented. The evaluations are conducted for all of the image types produced clinically by each PET scanner (for example, planar and or tomographic), and include the use of phantoms to assess the following imaging metrics: image uniformity/system uniformity, high contrast resolution/system spatial resolution, low-contrast resolution or detectability (not applicable for planar acquisitions), and artifact evaluation. Note: the following tests are recommended, though not required for PET: sensitivity, energy resolution and count-rate performance; this is at the discretion of the Imaging leadership.

FOR Diagnostic X-Ray, MRI, CT, NM, PET Equipment: the annual performance evaluation conducted by the medical physicist includes testing of image acquisition display monitors for maximum and minimum luminance, luminance uniformity, resolution and spatial accuracy.

Product Notices and Recalls

Product Notices and Recalls. Product safety recall reports are presented to the EOC Committee with follow-up and outcome(s) on a quarterly basis. Noted are whether or not there were any adverse actions for the patient, the type of the product and the disposition of the product. Affected managers are notified when the product is identified within our inventory.

Pharmacy Safety: In support of safe and sterile conditions within the Pharmacy during compounding or admixing, sterility of packaging is present with "event shelf life" or dated products. Infection Control

performs periodic surveillance to observe for practices and/or environmental requirements critical to contamination control within the sterile compounding environment. Pharmacy implements quality control by visually inspecting prior to use all components to be used for the compounding of sterile preparations to ensure there is no container breakage, looseness of cap or closure, or deviation from expected appearance, aroma or texture of the contents that might have occurred during storage. Before opening, the packaging of sterile container closures (e.g., luer lock tip caps) is inspected and before use the container closure is inspected to ensure free from defects that could compromise sterility. (KH) licensed pharmacy compounding facilities are constructed to allow for clean, uncluttered and functionally separate areas for product preparation, and pharmacy staff is trained to use clean or sterile techniques. During preparation of pharmaceutical drugs and solutions, pharmacy staff is trained to visually inspect the medications for particulates, discoloration or other loss of integrity, and if found to be unsuitable for use are not used to prepare the compounded sterile preparation and any other lots from that vendor are examined to determine whether other lots have the same defect. Defective lots are removed from active inventory and the manufacturer is notified. To support pharmaceutical safety, (KH) licensed pharmacy compounding facilities have a laminar airflow hood for the preparation of intravenous admixtures or any other sterile drug preparations. The laminar airflow hood receives preventive maintenance in accordance with the manufacturer's recommendations.

Prohibition of Smoking
A nonsmoking policy is in place at (KH) and is enforced and monitored throughout all buildings by management, employees and Security staff. The purpose of the policy is to restrict smoking at KH and to reduce risks to patients who have a history of smoking, including possible adverse effects on treatment, and to reduce the risks to others of passive smoking and fire. The smoking policy prohibits smoking anywhere on District property. The smoking policy is addressed with all new employees upon hire and new patients upon admission. Security personnel are the primary monitoring personnel for enforcement. If breaches of policy are noted, the EOC Committee will develop strategies in conjunction with Security as enforcement, to eliminate the incidence of policy violations.

Information Collection System to monitor conditions in the Environment
1. (KH) establishes a process(es) for continually monitoring, internally reporting, and investigating the following:
    - Injuries to patients or others within the District's facilities
    - Occupational illnesses and injuries to staff
    - Incidents of damage to its property or the property of others
    - Security incidents involving patients, staff or others within its facilities, including those related to workplace violence
    - Hazardous materials and waste spills and exposures
    - Fire safety management problems, deficiencies and failures
    - Medical or laboratory equipment management problems, failures and use errors
    - Utility systems management problems, failures or use errors

Through the EOC Committee structure, each of the above elements are reported and investigated on a routine basis by managerial or administrative staff, with oversight by the committee. Minutes and agendas are kept for each *Environment of Care* meeting.

Environmental Tours
(KH) conducts environmental tours to identify deficiencies, hazards and unsafe practices**.**

Department environmental tours are conducted throughout the District, including offsite locations by EOC Committee members for both the patient care and non-patient care areas. Environmental tours are conducted in the patient care areas, and in the non-patient care areas, with deficiencies, hazards and unsafe practices identified and corrected, or with a plan implemented.

Annual Evaluation of the Safety Management
On an annual basis EOC Committee members evaluate the Management Plan for Safety, as part of a risk assessment process. Validation of the management plan occurs to ensure contents of each plan support ongoing activities within KH. Based upon findings, goals and objectives will be determined for the subsequent year. A report will be written and forwarded to the Governing Board. The annual evaluation will include a review of the following:

- The objectives: The objective of the Safety Management plan will be evaluated to determine continued relevance for Kaweah Health (i.e., the following questions will be asked; was the

objective completed? Did activities support the objective of the plan? If not, why not? What is the continuing plan? Will this objective be included in the following year? Will new objective(s) be identified? Will specific goals be developed to support the identified objective?).

- The scope. The following indicator will be used to evaluate the effectiveness of the scope of the safety management plan: the targeted population for the management plan will be evaluated (e.g., did the scope of the plan reach employee populations in the off-site areas, and throughout KH?)
- Performance Standards. Specific performance standards for the Safety Management plan will be evaluated, with plans for improvement identified. Performance standards will be monitored for achievement. Thresholds will be set for the performance standard identified. If a threshold is not met an analysis will occur to determine the reasons, and actions will be identified to reach the identified threshold in the subsequent quarter.
- Effectiveness. The overall effectiveness of the objectives, scope and performance standards will be evaluated with recommendations made to continue monitoring, add new indicators if applicable or take specific actions for ongoing review.

(KH) analyzes identified Environment of Care Issues
Environment of care issues are identified and analyzed through the EOC Committee with recommendations made for resolution. It is the responsibility of the EOC Committee chairperson to establish an agenda, set the meetings, coordinate the meeting and ensure follow-up occurs where indicated. Quarterly *Environment of Care* reports are communicated to Performance Improvement, the Medical Executive Committee and the Governing Board.

Priority Improvement Project
At least annually, one or more priority Improvement activities may be selected by Environment of Care Committee members. The priority improvement activity is based upon ongoing performance monitoring and identified risk within the environment.

KH improves its Environment of Care
Performance standards are identified monitored and evaluated that measure effective outcomes in the area of safety management. Performance standards are also identified for Security, Hazardous Materials, Emergency Management, Fire Prevention, Medical Equipment management and Utilities management. The standards are approved and monitored by the EOC Committee with appropriate actions and recommendations made. Whenever possible, the *environment of care* is changed in a positive direction by the ongoing monitoring, and changes in actions that promote an improved performance.

Patient Safety
Periodically there may be an *Environment of Care* issue that has impact on the safety of our patients. This may be determined from *Sentinel Event* surveillance, environmental surveillance, patient safety standards or consequential actions identified through the risk management process. When a patient-safety issue emerges it is the responsibility of the Safety Officer or designee to bring forth the issue through the patient safety process.

"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 2000

Kaweah Health
MORE THAN MEDICINE. LIFE.

Emergency Operations Plan

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Purpose
Kaweah Delta Health Care District herein after referred to as Kaweah Health (KH) is committed to providing a healthy and safe environment for our patients, visitors and employees. This plan describes a comprehensive, organization-wide Emergency Management system that addresses KH's emergency management program and ensures an effective response to a variety of disasters.

The purpose of the **Emergency Operations Plan** is to define the program that Kaweah Health to respond effectively to events that pose an immediate danger to the health and safety of patients, staff, and visitors. The Emergency Operations Plan consists of a number of procedures designed to respond to those situations most likely to disrupt the normal operations of the hospital. Each response is designed to assure availability of resources for the continuation of patient care during an emergency. *An emergency is an unexpected or sudden event that significantly disrupts the organization's ability to provide care, or the environment of care itself, or that results in a sudden, significantly changed or increased demand for KH's services.* The emergency may be natural, such as an earthquake, or human-made, or a combination of both.

Inherent in the Emergency Operations Plan, whenever possible, is the intent to collaborate with partnerships within the community, and with agencies having jurisdiction, such as the local fire, police, Department of Homeland Security, and County of Tulare.

This Emergency Operations Plan (EOP) has been developed so that Kaweah Health can effectively plan for, and respond to, emergencies in six critical areas:

• Communications

• Resources and Assets

• Safety and Security

• Staff Responsibilities

• Utilities Management

• Patient Clinical and Support Activities

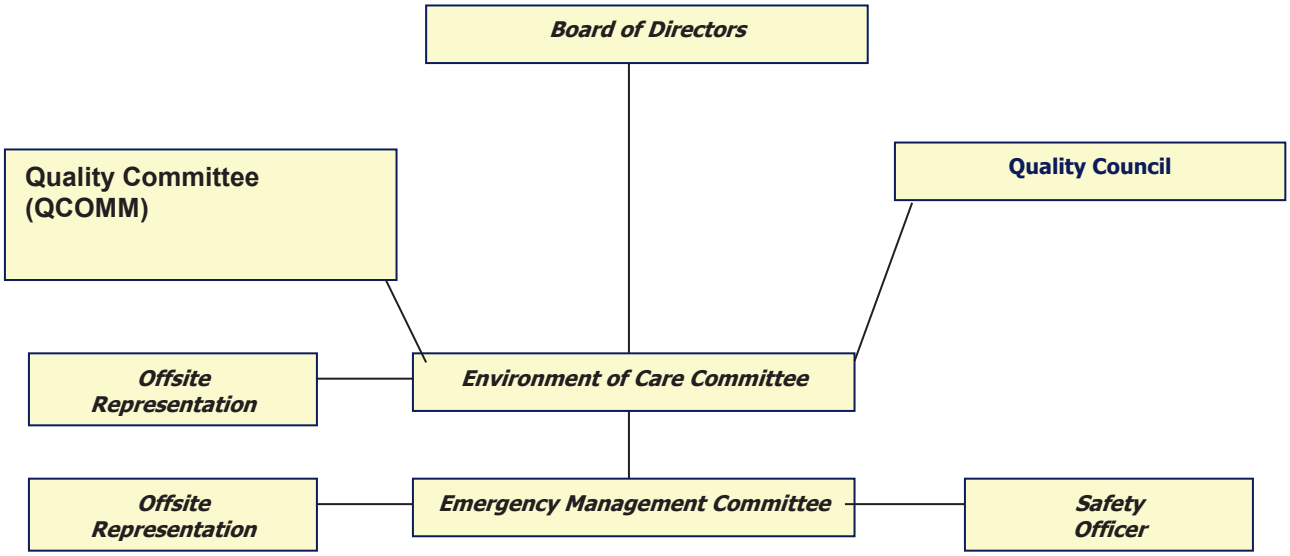
II. AUTHORITY

The authority for the establishment of an Emergency Operations Plan is with TJC EM.01.01.01. The authority for overseeing and monitoring the Emergency Operations Plan is with the Environment of Care Committee, and Emergency Management Subcommittee, Title 22, California Code of Regulations, additionally requires a written disaster plan. The Emergency Operations plan is developed at the Emergency Management Subcommittee level, and approved at the *Environment of Care* Committee. The plan is a multi-disciplinary effort of leadership within the District, including medical staff review and input.

III. ORGANIZATION

Reporting Structure: following represents how the Emergency Management program's reporting structure is organized:

Organization – Emergency Management Reporting
Kaweah Health



Responsibilities

1. **The Board of Directors.** The Board of Directors receives regular reports of the activities of the Emergency Operations Plan and program from the Environment of Care Committee in the form of a quarterly report. The Board of Directors also provides support to facilitate the ongoing activities of the Emergency Operations Plan.
2. **Quality Committee (QCOMM).** This Council **r**eceives an annual report from the Environment of Care Committee, which includes information relating to the Emergency Operations Plan, and provides assistance as needed in the development of quality indicators.

3. **Quality Council:** Reviews annually reports of Emergency Preparedness, which are a part of the Environment of Care Committee report. Medical Staff serves on the Emergency Management Committee.

4. **Environment of Care Committee and Emergency Management Committee**. The Environment of Care Committee works in collaboration with the Emergency Management Committee for managing all aspects of the Emergency Operations Plan and Program.
5. **Management.** Managers are responsible for orienting new personnel to the procedures of the department and, as appropriate, to job and task specific responsibilities for emergency management.
6. **Staff.** Individual personnel are responsible for learning and following job and task specific procedures for emergency response and for participation in emergency activities as appropriate to their jobs.

IV. Objectives

The primary goal and objective of the Emergency Operations Plan is to mitigate harm to life and property due to unforeseen circumstances. The plan is intended to identify risks to the organization and balance these risks against preparedness and mitigation strategies in place and to use information relating to this risk analysis in design, planning, implementation and evaluation of the overall plan. The Emergency Operations Plan comprehensively describes the District's approach to responding to

emergencies within the organization or in its community that would suddenly and significantly affect the need for the District's services, or its ability to provide those services. The plan addresses four phases of emergency management: mitigation, preparedness, response and recovery as they relate to the above six critical areas.

Broad objectives of the Emergency Operations plan include:

• Identifying and assessing vulnerabilities and hazards, which may impact on the District.
• Strategic planning for emergency response
• Effectively managing disaster supplies and resources
• Exercising critical program elements
• Providing training and assessing staff knowledge

V. Scope

The scope of this management plan applies to Kaweah Health, and any off site areas per KH license.

Each off site area is required to have a unit specific emergency plan that addresses the unique considerations of each area, including, but not limited to, initial emergency response. Offsite areas are monitored for compliance with this plan by Environment of Care committee members.

The hospital's leaders, including leaders of the medical staff, participate in planning activities *prior* **to developing an Emergency Operations Plan.**
The District's leaders participate in planning activities at the Emergency Management Subcommittee. It is at this committee level that the *Hazard Vulnerability Analysis* is conducted, drill exercises are designed and planned, education relating to drill implementation is prepared, the inventory of organizational assets is developed and monitored, and activities relating KH's Hospital Incident Command Center are developed.

All activities that emanate from the Emergency Management Subcommittee are integrated into the Emergency Operations plan, and are brought forth to the *Environment of Care* Committee.

The hospital conducts a hazard vulnerability analysis (HVA) to identify potential emergencies that could affect demand for the hospital's services or its ability to provide those services, the likelihood of those events occurring, and the consequences of those events. The findings of this analysis are documented.

At the Emergency Management Subcommittee, in a multidisciplinary forum that includes medical staff involvement, the HVA is analyzed at least on an annual basis, or whenever experiences warrant additional review. Historical experience, geographical location, weather and climate conditions, local hazards, political conditions and populations served are factored into the analysis, and balanced against the District's mitigation strategies and preparedness activities. When the HVA is completed, collaboration with the local fire department, and other governmental or municipal agencies as applicable, occur to assist in defining priorities within the HVA and to ascertain capacities to support the needs of unexpected events. The HVA process is documented, and kept on file in the Emergency Management Subcommittee and *Environment of Care* minutes. The HVA is part of the routine agenda of the Emergency Management Subcommittee to keep members apprised of the current status, and to be easily accessible in the event changes are required. The HVA is kept current for each emergency management subcommittee meeting in order to determine how changing mitigation strategies may impact identified risks.

The hospital uses its hazard vulnerability analysis as a basis for defining mitigation activities (that is,
activities designed to reduce the risk of and potential damage from an emergency).
During the HVA process, mitigation strategies are defined that reduce the risk of potential damages that might occur from an emergency situation. See **ATTACHMENT A - HAZARD VULNERABILITY ANALYSIS (detailed analysis). The top five hazards have been identified as follows:**

HVA - 2025– Top 6 Risks

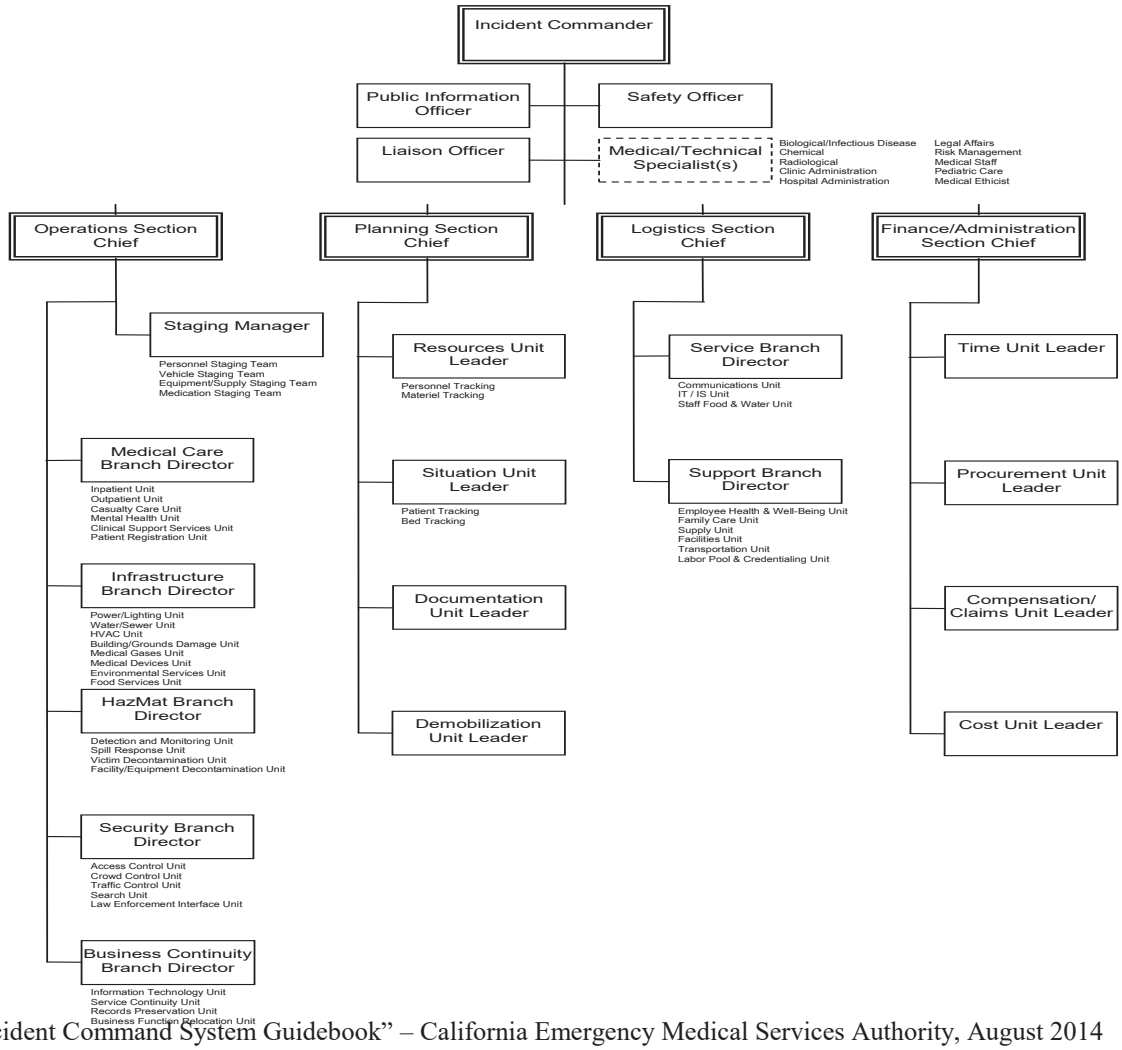
Event	Rationale
Epidemic/Emerging Infectious Disease 67%	An especially severe influenza pandemic could lead to high levels of illness, death, social disruption, and economic loss.
Sewer Failure 61%	**Due to the age of our building greater possibility of failure.**
Chemical Exposure 56%	Pesticides are widely used in our agriculture areas.
Fog 56%	Central Valley fog is very heavy and there is a history of multi-vehicle (100+) accidents on local highways.
Mass Casualty (Hazmat) 56%	Pesticides are widely used in our agriculture areas.
Patient Surge 67%	Crisis across our state has increased the last year. Patient volume continues to increase not solely related to Covid 19.

The hospital uses its hazard vulnerability analysis as a basis for defining the preparedness activities that will organize and mobilize essential resources.
The HVA is used as a planning tool in defining preparedness activities that will organize and mobilize essential resources. It is also used to determine what assets may be needed to augment emergency preparedness at KH, and what community partnerships may be invoked to strengthen response and or mitigation.

The hospital's incident command structure is integrated into and consistent with its community's command structure.

Kaweah Health uses the Hospital Incident Command System (HICS) as a scalable response to different types of emergencies. The District has adopted NIMS (National Incident Management System), and has integrated NIMS into pre-planning for disasters. Key personnel with the District are expected to respond to the Hospital Command Center if activated, and to assume functional responsibilities within the HICS command structure. HICS and NIMS training are required for staff that assumes leadership roles in the management of emergencies. HICS is compatible with an "all hazards approach" for the management of disasters, and is consistent with our local agencies having jurisdiction, such as the fire and police. HICS appointees are selected at the Emergency Management Subcommittee based upon parallel functions within their day-to-day job activities, and anticipated HICS response for a variety of scenarios. However, it is possible that a multiple number of employees can equally assume a HICS role due to the nature of standardized responses. For example, any member of the administrative team could be expected to assume the Incident Commander Role in the event pre-identified HICS appointees are unable to assume the Incident Commander role due to injury during a disaster or because he/she are not on site during the event. HICS education will apply to those individuals who could at any time assume a HICS role. At least annually HICS participants receive education/training relative to their role and anticipated responses during a drill or actual event. The education for HICS staff may be given "pre-drill", with "anticipated actions" identified for the planned scenario. It should be noted that not all HICS appointees may be activated during a disaster due to the "scalability" of the command response, i.e., only those HICS positions that are essentially needed for the planned scenario or actual event should be activated. The chart below identifies how HICS is organized at Kaweah Health:

Hospital Incident Command Structure* Kaweah Health



* "Hospital Incident Command System Guidebook" – California Emergency Medical Services Authority, August 2014

The hospital keeps a documented inventory of the resources and assets it has on site that may be needed during an emergency, including, but not limited to, personal protective equipment, water, fuel, and medical, surgical and medication-related resources and assets. Kaweah Health maintains an inventory of assets and resources that are maintained on-site that could be used in the event of an emergency. The inventory includes, at a minimum, but is not necessarily limited to, the following:

- Two trailers with supplies and equipment
- Personal protective equipment
- Water
- Fuel
- Medical supplies
- Pharmaceuticals
- Food supplies

The inventory is assessed by the Emergency Management Committee on an ongoing basis. During an emergency, KH will monitor the quantities of assets and resources by using the inventory as a planning tool. The inventory will be updated daily by Materials Management, or "stakeholders" of information relating to supplies/equipment/services for the duration of the emergency, and the

updated inventory communicated to the Hospital Command Center. See **ATTACHMENT B: INVENTORY OF ASSETS AND RESOURCES**.

The hospital's leaders, including leaders of the medical staff, participate in the development of the Emergency Operations Plan.
The Emergency Operations Plan is developed as an outcome of pre-planning meetings at the Emergency Management Subcommittee. As members of the Emergency Management Subcommittee medical staff leadership participate in the development of the Emergency Operations Plan. Leadership within the Hospital Command Center will make decisions in an emergency. The EOP requires the Hospital Command Center to determine what specific response procedures are needed during an emergency, including the decision to continue operations if inventory supplies are used, and it is not imminent that re-stocking will occur. Response options may include minimizing operations or closure of operations. Relocation of patients and staff to an alternate care site may be another option. The Hospital Command Center may initiate collaboration with countywide Emergency Operations as needed when planning involves a loss or diminishing supplies, or when patients may need to be moved to an alternate care site. Other response options that will be determined at the Hospital Command Center may include staged or total evacuation.

The Emergency Operations Plan identifies the hospital's capabilities and establishes response procedures for when the hospital cannot be support by the local community in the hospital's efforts to provide communications, resources and assets, security and safety, staff, utilities or patient care for at least 96 hours.

In the event of a disaster and it is known that KH cannot be supported by the local community, an immediate assessment of the six critical areas will be initiated by the Hospital Command Center (communications, resources and assets such as food, fuel, water, linen, supplies and pharmaceuticals, staff security and utilities). The safety and security of patients will be assessed by managers and or lead personnel on every unit, and the security of the buildings will be assessed by the Security Branch Director and his appointed officers. The Infrastructure Branch Director will assess utilities, including power, HVAC, potable water and fuel. Patient clinical and support activities will be assessed when the District's infrastructure and resources are taxed. All managers will conduct bed availability and staffing needs for current patients, as well as for expected incoming patients if known. Hospital Command personnel will use the *Inventory of Organizational Assets* as a planning guide in determining resource needs and allocation, and whether or not conservation strategies will be initiated.

The hospital develops and maintains a written Emergency Operations Plan that describes the recovery strategies and actions designed to help restore the systems that are critical to providing care, treatment, and services after an emergency.

Kaweah Health has developed recovery strategies that will assist management in resumption of normal operations (**see Attachment C – "Manager's Recovery Guidelines**"). Within HICS are scenarios for various types of emergencies that include recovery guidelines, including which HICS participants are responsible for implementation.

The Emergency Operations Plan describes the processes for initiating and terminating the hospital's response and recovery phases of the emergency, including under what circumstances these phases are activated.

The individual who assumes the Incident Commander role at KH has the authority to initiate and terminate the District's response and recovery phases of the emergency. The Emergency Operations Plan is activated when an unexpected or sudden event significantly disrupts KH's ability to provide care, or that results in a sudden and increased demand for services.

The Emergency Operations Plan identifies alternative care sites for care, treatment and services that meet the needs of its patients during emergencies.

Alternate care sites have been identified as follows:
A. Alternate Care Site #1: Emergency Department Parking Lot (Tents)

B. Alternate Care Site #2: Kaweah Health Rehab Hospital
Phone number: 559-624-3700
C. Alternate Care Site #3: Kaweah Health Mental Health
Phone: 559-624-3322
D. Alternate Care Site #4: Kaweah Health South Campus
Phone: 559-624-6204

If the hospital experiences an actual emergency, the hospital implements its response procedures related to care, treatment and services for its patients.

In the event of an actual emergency, Kaweah Health is prepared to respond using HICS to manage the event, which includes oversight of activities relating to the care, treatment and services for our patients. Activities relating to emergency management may include the establishment of a triage and/or decontamination area, deployment of staff, allocation of resources and equipment, monitoring of supplies and actions taken, and documentation of the event, if possible. Through the hazard vulnerability process, the KH is poised to respond to emergencies, fully activating HICS, which is scalable to the event.

Crisis standards of care guidelines can be used for disaster situations when district healthcare resources are overwhelmed during a declared Code Triage. The decision to initiate Crisis Standards of Care will only be implemented on the order of the Incident Commander. When Crisis Standards of Care are initiated; district policies may be temporarily suspended in order to provide the best possible care for the greatest number of patients when district resources are overwhelmed during disaster situations.

HICS Incident Response Guides, HICS Incident Planning Guides and HICS Job Action sheets identifies comprehensive potential actions or strategies the hospital may use during a disaster. There references are kept with our HICS Supplies and can be accessed from: https://emsa.ca.gov/disaster-medical-services-division-hospital-incident-command-system

As part of its Emergency Operations Plan, the organization prepares for how it will communicate during emergencies.

Communications
How staff will be notified that emergency response procedures have been initiated.

When the Emergency Operations Plan is activated, the Command Center will establish mechanisms for initial and ongoing communication with staff. The type of emergency will determine the specific modes of communication. Various types of communications available are: District telephone systems, Cisco phones, two-way radios, cellular phones, electronic mail, fax, and runners.
Key members of the Hospital Command Center, who have assumed a HICS role, will be notified upon activation of the Emergency Operations Plan. KH leadership will be notified via the Xmatters web based messaging system. HICS staff ordinarily reports to the Hospital Command Center (HCC) for an initial briefing regarding the nature of the emergent event. At this time the scope of the event and its anticipated impact on the organization is determined, as well as the need for the activation of other HICS personnel.

Notification of staff in various departments will be managed by the following: overhead page (main hospital, telephone (Digital Display on all Cisco phones), e-mail and runner. Off site areas: Telephone Display on all Cisco phones, areas without Cisco phones will be notified by call tree, two way radios, email, and fax.

Staff not on duty at the time of the emergency are notified (if necessary) through activation of department / unit call- back procedures. Other ways to notify staff are as follows:
1. The Communications Unit Leader will set up a message phone for incoming employee calls and broadcast this through local radio and television networks.

2. Staff should monitor the Emergency Alert System/Network. Notice to return to work may be announced over this radio service. It is the responsibility of the Communications Unit Leader to notify the Emergency Alert System of any facility needs and information.

3. Local Radio stations: the local radio stations have agreed to broadcast hospital information for employees. The Public Information Officer will take responsibility for notifying the radio stations and compiling the information to be broadcast. Employees and physicians can monitor the following station:

Emergency Alert System (EAS) Network: KMJ – 580

The Hospital Command Center, throughout the duration of the emergency, will keep key response leaders apprised regarding the status of the emergency, the status of the organization, and any anticipated needs during the upcoming twenty-four hour period. Information will be provided to staff, from the Hospital Command Center, through various venues: by overhead page, e-mail, and through communication with managers and supervisors. Fax may be used for physicians.

How the hospital will communicate information and instruction and instruction to its staff and licensed in depended practitioners during and emergency.
Staff in various departments and care areas on duty at the time of the emergency will be notified as follows, depending upon capability:
• By overhead page
• By telephone and or FAX if operating
• By email
• By runner
• By hand-held radios
• By combination of the above
Licensed Independent Practitioners who are within KH premises will be notified as above.
Licensed Independent Practitioners who may be in their private offices will be notified by telephone, by fax (if operating), by runners if they are located in close proximity to KH. The Public Information Officer will also be making announcement for Licensed Independent Practitioners through radio and television media.

Staff not on duty at the time of the emergency are notified (if necessary) through activation of department /unit call- back procedures. If phone service is disrupted, the following will be considered:

• Notify staff through public service announcements on local television and radio (e.g., KMJ through the Public Information Officer)
• Notify staff through announcements placed on the District's website and social media sites.

How the hospital will notify external authorities that the emergency response measures have been initiated.
Communication with various external authorities may occur as follows:
Government Notification
The Hospital Incident Commander will confirm with the declaring authority whether the hospital is on ACTIVATION status. The Medical Health Operational Area Coordinator (MHOAC) will be notified by the Liaison Officer the status of the District.

Tulare County Public Health Emergency Preparedness (PHEP) Disaster and Mass Casualty Notification
The District will activate communication with the County PHEP Duty Officer by way of telephone (624-7499), Email, and message services.
Notifications may be activated for the following reasons:

1) Provide situation reports to PHEP regarding our operational status.
2) Requests for any additional resources needed to support operations. This would include (but not limited to) supplies, medications, equipment, and appropriately trained care providers. Incident Commander (or designee)

will contact the Tulare County Public Health Emergency Preparedness Duty Officer to initiate a request.

How the hospital will communicate with external authorities during and emergency.

The District will activate communication with the external authorities by way of telephone, Emergency Department EMS Radio system, message services and Status-Net. If Status-Net is utilized, communications will be handled by a Mobile Intensive Care Nurse (MICN) A MICN is an Emergency Department RN that is certified by the Central California Emergency Medical Services Agency. They receive specialized training in emergency communications including use of the StatusNet911 system.

How the hospital will communicate with patients and their families, including how it will notify families when patients are relocated to alternate care sites
Patient Care providers will communicate with patients using routine methods, such as verbal, and though call light response. The PIO will establish processes to communicate pertinent information to patients and their families – including when patients are relocated to an alternative care site. Consistent with law and regulation and surrounding confidentiality of patient information, families may be apprised of the following:

• Verification that the patient is at the organization
• The general condition of the patient
• If the patient is going to be moved to an alternate care site, then the name, address, and specific care area of that site, as well as the anticipated timeframe for relocation.

How the hospital will communicate with the community or the media during an emergency

The Command Center will establish a Public Information Center for providing timely and accurate information to the public during a crisis or emergency situation. During an event, the Pubic Information Officer (PIO) will handle:
- Media and public inquiries;
- Emergency public information and
- Rumor monitoring and response;
- Media monitoring; and

Other functions required for coordinating, clearing with appropriate authorities, and disseminating accurate and timely information related to the incident, particularly regarding information on public health, safety and protection, and patient care and management issues. All media and community inquiries will be managed through the PIO. The effective use of the media to convey information during and following an incident is critical. The information provided to the public must include direction on what actions should and should not be taken, along with appropriate details about the incident and the actions being taken by the District. The PIO will work closely with the PIO at other community response agencies so that any contradictory or confusing messages coming from different sources can be avoided.

How the hospital will communicate with purveyors of essential supplies, services and equipment during and emergency.

The Logistics Section Chief and Operations Section Chief of the HICS Command Center will work collaboratively to assure that there is appropriate communication with vendors that may provide essential supplies, services, and equipment once emergency measures are initiated. Memorandums of understanding (MOU) may be invoked with key vendors to assure priority delivery and service to the organization during an emergency. For each vendor, the District has defined:

- Vendor contact information
- The type of critical supplies, equipment, and/or service that will be provided during an emergency

See Vendor List Page 12

How the hospital will communicate with other healthcare organizations in its contiguous geographic area regarding the essential elements of their respective command structures, including the names and roles of individuals in their command structure and their command structure telephone numbers.

The Hospital Command Center will use normal methods of communication, e.g., phones (landlines and cellular), and email to communicate with other healthcare organizations, providing these services have not been interrupted. If communications have been interrupted, the Hospital Command Center will communicate to other healthcare facilities in our geographic area by Status Net through the County. At a minimum the following may be communicated to and from these healthcare organizations:

- Essential elements of the command structures and control centers for emergency responses
- Names and roles of individual(s) in their command structures and the telephone number of their command center.
- Resources and assets that could potentially be shared in an emergency response.
- If requested, and if in accordance with law and regulation, the names of patients and deceased individuals brought to the organization.

Names and individuals in other Hospital Command Centers are as follows:

Name of Hospital	Name of Emergency Coordinator	Number and email of Emergency Coordinator	Number of Hospital Command Center
Sierra View Medical Center	David Wittington	559-788-6008 dwhittington@sierra-view.com	559-791-3730
St. Agnes Medical Center, Fresno	Brian Minor	(559-450-3721 brian.minor@samc.com	559-450-2475
Veterans Administration Hospital - Fresno	Fred Rodarte	559-225-6100 x5331 fred.rodarte@va.gov	
Kaiser Permanente Fresno Medical Center	Victoria Urritia	victoria.d.urrutia@kp.org	559-448-2257
-Valley Children's Hospital	Ashely Ave	559-353-6227 aave@valleychildrens.org	559-353-8680
Community Regional Medical Center-Fresno	Aaron Dwoskin	559-231-7717	559-353-8680
Fresno Surgical Hospital	Julie Gresham	559-447-7316	559-431-8000
Adventist Health Tulare Adventist Health Hanford	Rick Durr	DurrJR@ah.org	559-240-2706

How the hospital will communicate with other healthcare organizations in its contiguous geographic area regarding the sources and assets that could be shared in an emergency response. Kaweah Health will communicate with the above healthcare organizations through landline, and or email with respect to the sharing of resources and assets; however, if communications have failed, the Liaison Officer will communicate through Emergency cell phones or satellite phone, using the County to facilitate communications between hospitals. Runners may be used as a last resort, if they are able to use their vehicles.

How the hospital will communicate the names of patients and the deceased with other healthcare organizations in its contiguous geographic area. Kaweah Health will communicate the names of the patients and the deceased with other healthcare organizations in its contiguous geographic area through normal communication channels if operational, only with an individual designated to be the Public Information Officer (PIO). If normal communications are not operating, the Liaison Officer, in coordination with the PIO, will transfer information to the County through emergency cell phones, or satellite phone (including agencies having jurisdiction, such as the police and fire).

How and under what circumstances, the hospital will communicate information about patients to third parties (such as other healthcare organizations, the state health department, police and the FBI) The Public Information Officer will establish a plan to communicate pertinent patient information to third parties – including when patients are relocated to an alternative care site. Every attempt will be made to remain consistent with law and regulation surrounding patient confidentiality. The Public Information plan to communicate patient information will include minimally the following:

- Verification that the patient is at the medical center.
- The general condition of the patient
- If the patient is going to be moved to an alternate care site, including the name, address, and specific care area of that site, as well as the anticipated timeframe for relocation.

The emergency operations plan describes the following: How the hospital will communicate with identified alternate care sites.

Depending on the nature, scope, and duration of the emergency, the Hospital Command Center will establish periodic communication with designated alternate care sites. The first choice of communication will be landline, cellular phone and e-mail. If these forms of communication are disrupted, runners will be dispatched from the Labor Pool to send and retrieve information if it is safe to do so. The purpose of communication will be to:

- Apprise alternate care sites as to the status of the organization, its operational capability, and the anticipated need for assistance.
- Determine the status of the alternate care site(s), their operational capability, and their ability to receive patients should it become necessary.

The hospital establishers backup systems and technologies for the communication activities
Kaweah Health has established the following as back-up communications in the event normal lines of communication are inoperable:

- Hand-held radios are available for internal communication between the Command Center and key patient care and other areas throughout the District.
- Runners can be dispatched from the Labor Pool to transmit information
- Cellular phones can be used for communication with external agencies.
- Radio communication between the Emergency Department and the EMS agency through the Emergency Department EMS Radio system
- Email and Internet capability is available in all sites of care.

The hospital implements the components of its emergency operations plan that require advance preparation to support communications during and emergency..
Through various activities, KH participates in advance preparation to support communications during an emergency. These include, but are not limited to:

- Maintenance of communication equipment (e.g., hand-held radios)
- Practice with alternate communications during drill exercises (e.g., hand-held radios, HAM radio, activation of runners)
- Practice with downtime procedures relative to email and internet capabilities (e.g., during routine service repairs and or equipment maintenance, electrical shut-downs)

AS PART OF ITS COMMUNICATION PLAN, KH MAINTAINS THE NAMES AND CONTACT INFORMATON OF THE FOLLOWING

Staff, physicians and other licensed practitioners, other hospitals and critical assess hospital volunteers, entities providing services under arrangement, relevant federal, state, tribal, regional, and local emergency preparedness staff, other sources of assistance. The district, in the Incident Command Center, hold a listing pertinent phone numbers for disaster events.

The hospital operations plan describes the following: Process for communicating information about the general condition and location of patients under the organizations care to public and private entities assisting with disaster

Kaweah Health will activate communication with external authorities by way of telephone and via fax if required. If systems are compromised runners will be assigned to assist in such communication.

Process in the event of an evacuation to release patient information to family, patient representative, or others responsible for the care of the patient.

The PIO will establish a process to communicate pertinent information to patients and their families. During evacuation, the hospital command center will appoint an individual from each floor to gather patient information and have available for family or patient representative.
The hospital maintains documentation of completed and attempted contact with the local, state, tribal, regional, and federal emergency preparedness officials in its service area.

Kaweah Health participated on a quarterly basis in planning meetings with Tulare County Public Health Emergency Preparedness program and with Central California Healthcare Coalition.

The Emergency Operations Plan included a continuity of operations strategy that covers: A succession plan that lists who replaces key leaders during an emergency.

KH follows an administration chain of command structure. The house supervisor is the first point of contact for all district emergencies. They are supported by the Director on call and administrator on call. See policy DM 2228 Continuity of Operations and Recovery.

The hospital has procedures for requesting an 1135 waiver for care and treatment at an alternate care site.
When the district has initiated their Incident Command Center and the President declares a disaster or emergency under the Stafford Act or National Emergencies Act and the HHS Secretary declares a public health emergency the liaison officer will submit a request to operate under a 1135 waiver for care and treatment at an alternate care site. See policy DM 2227 Request to Operate under CMS 1135 Waiver.

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The Emergency Operations Plan describes a means to shelter patients, staff and volunteers on site who remain in the facility.
The district will utilize all available office space to accommodate patient, staff and volunteers on site who remain in the facility. This includes all district properties in the surrounding areas.

As part of its Emergency Operations Plan, the [organization] prepares for how it will manage resources and assets during emergencies.
Resources and Assets

The emergency operations plan describes how the hospital will obtain and replenish medications, medical supplies, and non-medical related supplies that will be required throughout the response and recovery phases of an emergency, including access to and distribution of medication caches that may be stockpiled by the hospital, its affiliates, or local, state or federal resources. The Operations Chief and Staging Manager will coordinate with Pharmacy and Materials Management the initial delivery of supplies, equipment and pharmaceuticals upon activation of a CODE TRIAGE ACTIVATION. Prioritization will be given to those areas either immediately impacted by the emergency, or are likely to be so.

Carts containing pre-positioned pharmaceuticals, supplies, and equipment, will be sent to designated staging areas. The contents of the carts will be rotated out on a regular basis to assure that inventory does not expire. Equipment designated for pre-positioning is included in the organization's medical equipment inventory and is maintained in accordance with pre-established preventive maintenance requirements.

Ongoing replenishment of supplies, equipment and pharmaceuticals.
For the duration of the emergency – including response and recovery phases – the Operations Section Chief and Staging Manager are responsible for monitoring the inventory of supplies (including personal protective equipment), equipment, and pharmaceuticals in the various care areas. Replenishment from storage areas (Central Supply, Storeroom, etc) will occur on an as needed basis.

A general inventory of supplies (including personal protective equipment), equipment and pharmaceuticals will be taken in their respective storage areas on at least a daily basis (or more frequently if necessary) for the duration of the emergency. Remaining inventory shall be measured against the rate of consumption that is occurring as a result of the emergency. When existing inventory of critical supplies (including personal protective equipment), equipment, and/or pharmaceuticals are in danger of reaching insufficient levels, then contingency plans with outside vendors will be implemented. See Vendor List below:

Type of Service	Name of Vendor	Telephone Number
AIR/GAS	Airgas- Act# 3441851	800-336-4004
BOILER	California Boiler	559-625-5151
	R.F Mcdonald	559-498-6949
BOTTLED WATER	Pepsi Cola US Food Service	559-485-5050 1-800-682-1228
HVAC	American Air	559-651-1776
	Grants A/C	559-734-7361
	Brott Mechanical, Inc	559-688-7571
GENERATORS	Quinn Engine System	559-896-4040
HAZARDOUS MATERIALS	Atlas Enviornmental Healthwise Services	559-860-8871 559-834-3333
FUEL	Valley Pacific	559-732-8381
PNEUMATIC CONTROLS/ENGERGY MANAGEMENT	Trane Summit Siemens Bldg Systems	559-271-4625 559-276-2600
PNEUMATIC TUBE SYSTEM 4" AND 6"	Swisslog/Translogic	800-525-1841
ELECTRICIANS	American	559-651-1776
EQUIPMENT SUPPLY	Grainger	559-635-2524
	Fastenal	559-651-0696
	McMaster Carr	562-692-5911
FIRE ALARMS	Siemens Inc Central Cal Electronics	559-276-2600 559-485-1254
MEDICAL SUPPLIES	Cardinal Healthcare	909-605-0900
NURSE CALL SYSTEM	Central Cal Electronics	559-485-1254
PHARMACIES	AmeriSource Bergen	800-635-4907
PLUMBERS	Robert Marks	559-625-8038
	American Air	559-651-1176
	Parker & Parker	559-625-4020
SECURITY	AAA Security	559-594-5600
RESPIRATORY CARE SERVICES	Certified Medical Testing	1-800-243-5427
MEDICAL GASES	AirgasVisalia Branch Direct Line: After hours: Tim Solis (Medical Specialist): (916) 870-3380 Airgas Visalia 525 N. Burke St. Visalia, CA 93292 Account #3441851	559-733-3443

If emergency replenishment from outside vendors is not feasible, the community-wide EOC should be contacted to facilitate access to, and distribution of, stockpiled supplies, equipment, and pharmaceuticals. Other healthcare organizations in the immediate geographical location should also be contacted to see if necessary supplies, equipment, and pharmaceuticals could be made available.

Ongoing replenishment of non-medical supplies
For the duration of the emergency – including response and recovery phases –
Logistics Section Chief and the Infrastructure Branch Director in coordination with Materials Management are responsible for monitoring the non-medical supply inventory. These supplies include, but are not necessarily limited to:

- Food
- Water
- Linen
- Fuel for Emergency Power Generators
- Fuel for Vehicles

A general inventory of non-medical supplies will be taken in their respective storage areas on at least a daily basis (or more frequently if necessary) for the duration of the emergency. Remaining inventory shall be measured against the rate of consumption that is occurring as a result of the emergency. When existing inventory of critical non-medical supplies are in danger of reaching insufficient levels, and then contingency plans with outside vendors will be implemented.

Sustainability of operations without external support
It is possible that the nature, scope, and duration of the emergency may preclude outside agencies, vendors, authorities, or other vital entities from assisting the organization in a timely manner. Outside assistance may not be available for up to 96 hours following initiation of the Emergency Operations Plan.

Kaweah Health has designed its operations so that it can be self-sufficient for a designated time frame depending on resources and assets being affected. The table below summarizes the organization's ability to be self-sufficient in key areas. Hours of self-sufficiency is based on the following:

- The average amount of resource or asset within the organization at any given time.
- The estimated consumption of the resource or asset based on maximum capacity of patients and staff.

Resource or Asset	Hours Self Sufficient
1. Potable Water	168 with water conservation plan*
2. Food	168 with food rationing and dry food plan**
3. Fuel for Emergency Generators	96+
4. Pharmaceuticals – Analgesics / Narcotics	96+ with Cache supplies from local EOC
5. Pharmaceuticals – Broad Spectrum Antibiotics	96+ with Cache supplies from local EOC

Surgeries	Emergency Only Sterilization sent off site
Dialysis Patients	Diverted to other facilities (Clinic Patients)
In Patients	Sponge bath with "wipettes" Hand washing with alcohol gel
All Staff	Hand washing with alcohol gel
All Staff/Patients	Consume bottled drinks-try to limit to no more than 2 quarts per day; ration plan is implemented by Food/Nutritional Care Services

Toilets	If able to flush, flush after 3rd usage. If unable to flush, insert plastic bags into toilets, and seal when finished; EVS to remove to terminal waste collection area
Generators	Can run for approximately 7 days depending upon load usage.
HVAC System	Heating and air circulation on E-Power, cooling- bring in fans as needed.

***Food Supply – Patients Employees/MD/s, Other**	4 day supply for 1,000 total people per day, which includes patients, employees, physicians, & visitors Disaster menu established for 7 days	Meets 168-Hour sustainability: if food supplies begin to diminish, food-rationing plan will go into effect (e.g., 2 meals per day with snacks). **We will use food from cold sources first (refrigerator and freezers), then change to dry supplies.**

Food and Nutrition Services Disaster Plan

1. Food and Nutrition Services Director or designee will communicate with the Command Center regarding staffing, supplies, kitchen conditions and any expected deliveries that may require security clearance.
2. Emergency call lists will be activated.
3. Temporary off-site kitchen when needed
    a. South Campus = 1633 S. Court Avenue
    b. West Campus (Rehab Hospital) = 840 S. Akers St. Visalia, CA
4. The 96- hours disaster food and supplies are stored at Creekside. The key is labeled #1.
5. When food items for the same day are prepared, use when possible. If not, use the cold disaster menus located in the Chef's office.
6. Utilize the 2-day Cold Disaster Menu first then the Meals for All for 5 days.
7. There is a supply of perishable and non-perishable foods in the department refrigerators, freezers and storeroom. This food should be used first and utilized to feed staff.
8. An inventory of available foods should be completed as soon as possible. If utilities are down:
    a. Use perishable foods (refrigerated and frozen) first, then fresh food, then canned food.
        i. Please note:
            1. Utilize dry stores with shortest shelf life i.e bread, rolls
            2. A full freezer will hold temperature for 48 hours if the door remains closed.
            3. A refrigerator will hold temperature safely for about 4 hours if the door remains closed.
    b. Per Engineering, no equipment is attached to the emergency power.
    c. Three (3) emergency electrical sockets are available. Location: by the gas shut off valve, behind the supplement storage area and dry storage area.
    d. Lighting is limited. Use lanterns located in the Chef's office. Battery is in Chef's office.
9. Using the most current diet sheets identify patients and their diets. This information can be used to plan the amount and type of foods to be sent to the nursing units and to write meal identifier tickets

10. Meals for patients will be assembled in the kitchen using supplies from kitchen (dry and cold storage areas) using the disaster menu. Meals will be placed in paper bags for delivery to the nursing units.
11. Additional personnel will be required to assemble and deliver meals. Use 3 people to deliver meals and remove garbage. In addition, 4 -5 people will be required to assemble meals for patients and staff. 2 – 3 cooks will be needed to prepare the foods.
12. When the dish machine is not functional, the "3 sink method" method of cleaning and sanitizing is required. The first sink shall contain a dish/pot detergent solution for removing food debris. The second sink shall contain clean water for rinsing. The third sink shall contain a sanitizing solution of Quaternary Ammonium Sanitizer (Oasis 146) and water after soaking in sanitizing solution for 1 minute, remove items and allow to air dry.

If critical assets and resources have neared depletion levels, and there is no anticipated assistance from external sources in the near future, then the Command Center will need to make a determination as to whether or not operational capability can be sustained. Possible actions include:

- Continuing current operational capability based on anticipated assistance from external sources
- Curtailing or modifying selected operational capability
- Closing and evacuating the facility(s)

Decisions involving curtailment, modification, or halting of operational capability will be made by the highest-ranking administrator in conjunction with the County of Tulare.

The emergency operations plan describes how the hospital will share resources and assets with other health care organizations within the community, and outside for the community if necessary. Kaweah Health will share assets and resources with other local hospitals if needed. Within community, assets and resources will likely be shared with:

Name of Hospital	Name of Emergency Coordinator	Number and email of Emergency Coordinator	Number of Hospital Command Center
Valley Children's Hospital	Ashley Ave	559-353-9227 Aave@valleychildrens.org	559-353-8680
Sierra View Medical Center	David Whittington	dwhittington@sierra-view.com	559-799-6008
St. Agnes Hospital, Fresno	Joseph Lopez	(559) 450-3721	559-450-2475
Kaiser Permanente Fresno Medical Center	Jamie E. Sutton	5593206230	559-448-2257
Veterans Administration Hospital – Fresno	Fred Rodarte	559-225-6100 x 5331 Fred.rodarte@va.gov	
Community Regional Medical Center- Fresno	Aaron Dwoskin	559-231-7717	559-353-8680
Fresno Surgical Hospital	Julie Gresham	559-447-7316	559-431-8000
Adventist Health Tulare Adventist Health Hanford	Rick Durr	durrjr@ah.org	559-240-2706

The emergency operations plan will describe how the hospital will monitor quantities of its resources and assets during and Pharmacy, Food/Nutritional Services, and Materials Management, at the onset of any

emergency, will determine the current quantities of medications, food/water, supplies, and linens. Daily usage will be measured against the current available quantities. If it is determined that the rate of usage/consumption is greater than expected replenishment, local resources will be accessed. If necessary, conservation measures will go into effect as stated above. If it is determined KH can no longer support the care, treatment and services for the patients, a decision will be made by the Incident Commander to transfer and or evacuate patients.

The emergency operations plan will describe arrangements for transporting some or all patients, their medications, supplies, equipment and staff to an alternate care site when the environment cannot support care, treatment. Also included are the arrangements for transferring pertinent information, including essential clinical and medication-related information with patients moving to alternate care sites. The Planning Section Chief, Security Branch Director, and the Patient Tracking Manager are responsible for coordinating the transfer and transporting of patients to alternate care sites should KH need to be evacuated. An EMS Strike Team(s) would be requested through the Central California EMS Agency Duty Officer. This would include transporting the patient's medication, necessary equipment and supplies, as well as pertinent clinical and medication-related information.

A tracking system will be implemented that notes at least the following:

- The patient's name
- The patient's medical record or other identification number
- The disposition of the patient (where the patient was sent to)
- Whether or not family was notified (attempts should be made to notify family prior to transfer)
- Whether or not the patient's medical record was sent. At least copies of the H&P, operative reports, current medications (including last dose given), and most recent care records should be sent.
- When the patient was transferred
- When the patient arrived at the receiving facility and where the patient was placed
- When report was given on the patient to the receiving facility, and to whom the report on the patient was given.

Patients will be assessed to determine if they need to be transported by BLS or ALS as appropriate to their clinical condition. If necessary, qualified hospital staff will accompany the patient.

The hospital implements the components of its emergency operations plan that require advance preparation to provide for resources and assets during emergencies. One function of the Emergency Management Subcommittee is to plan in advance, and in an ongoing fashion, an inventory of organizational assets and resources relating to emergency preparedness. This effort is a multi-disciplinary process, with monthly meetings that are driven by a standard agenda. The inventory is modified as new assets and resources are accumulated, and revised as quantities may be used during drills and or actual events.

As part of its Emergency Operations Plan, the medical center prepares for how it will manage security and safety during an emergency

Security and Safety

Description for internal security and safety

Upon initiation of Code Triage Activation, the Hospital Command Center will determine the need to activate the Security Branch Director position of HICS. This decision is based on the nature, scope, anticipated duration, and likely impact of the emergency on the safety of persons and the security of the facility. The *Job Action Sheet* for the Security Branch Director provides guidelines for the individual who assumes the role. Access control and hospital shutdown will be of primary importance.

Coordination of security activities with community agencies.
It may become necessary to supplement internal security efforts with assistance from external law enforcement agencies, based upon the nature of the incident. The decision to request assistance from such agencies will be made by the Incident Commander based on incoming information, and the scope of the event. The Security Branch Director will work in coordination with the Operations Section Chief when coordinating with outside community agencies.

Once a decision is made to integrate with external law enforcement agencies, the Security Branch Manager will coordinate with a designated lead officer(s) of the agency having jurisdiction, and agree on the following issues:

- Incident Command
- Integration of Law Enforcement into Organization Operations
- Decision Making
- Rules of Engagement for Crowd Control
- Chain of Custody

Law enforcement will prevail, with consideration given to specific Kaweah Health concerns that may arise.

Management of hazardous material and waste
During emergencies, when the structural integrity of the building may be impacted, for example, due to an earthquake or internal flood, the Safety Officer, in conjunction with Facilities staff, will assess all areas that contain hazardous materials to determine if there are any spillages as follows:

- Above ground diesel storage tank located at ISS
- Above ground diesel storage tank located at Facilities Plant
- Above ground diesel storage tank located in Acequia Wing Basement
- Laboratory located in Mineral King Basement
- Hazardous Materials Waste Storage Area located North of the Ambulance Bay (in dumpster enclosure)
- Surgery Soiled Utility Room
- OB Surgery Soiled Utility Room
- Environmental Services Chemical Storage Room located in West Basement
- Kitchen, 1st floor Mineral King Wing
- Laundry Area

If any spillages are determined, the area will be cordoned, with staff evacuated. The SDS for the spilled material will be obtained. If a spill kit can be safely used, this will be the procedural response. If the nature of the spilled material poses risk to the employee or the building, an outside hazardous materials response team will be called. In the interim, the areas will be cordoned, with staff evacuated. Any staff member that has experienced signs and symptoms relating to an exposure will be escorted to the Emergency Department for treatment. The Safety Officer will work in coordination with the outside hazardous materials response team.

Radioactive, biological and chemical isolation/decontamination
Kaweah Health has staff that is trained for decontamination response, including decontamination equipment. The Emergency Department follows district policies and has procedures for decontamination, which includes the care of the patient while minimizing risk to employees. Primary goals for emergency department personnel in handling a contaminated patient include termination of exposure to the patient, patient stabilization, and patient treatment, while not jeopardizing the safety of district emergency facilities and personnel. Termination of exposure can best be accomplished by removing the patient from the area of exposure and by removing contaminants from the patient.

Personnel must first address life-threatening issues and then decontamination and supportive measures if a radioactive exposure occurs. Priority is given to the ABC with simultaneous contamination reduction. Once life-threatening matters have been addressed, emergency department personnel can then direct attention to thorough decontamination, secondary patient assessment, and identification of materials involved. If a chemical exposure has occurred, decontamination occurs first, and then emergency management of the patient.

Personal Protective Equipment. Any staff member providing patient care to a contaminated patient must wear the appropriate personal protective wear. Decontamination must occur outside of the Emergency Department by staff that are trained specifically for decontamination response within KH. Should large-scale decontamination be required, HICS will be activated, with specific response guidelines implemented by staff that assumes HICS positions.

Control of entrance into and out of the medical center during and emergency

It is likely that access to the organization's facility(s), and movement within the facility(s), will need to be monitored and controlled for the duration of the emergency. Upon activation of the Code Triage Activation, the following may occur:

1) Entrances to the Hospital will be staffed by Security or designated personnel through the Labor Pool. Visitors and other non-hospital personnel will be instructed to proceed to designated areas (DM 2225 Security Lockdown of Entry Doors). If necessary, entrances and exits will be locked down to prevent ingress or egress as warranted.
2) Movement by visitors and other non-hospital personnel will be restricted to a minimum. If visitors need to move beyond designated areas, they will be identified and their intended location within the facility will be ascertained.
3) Appropriate staff will be assigned to monitor vehicular access to the facility(s) and assure that access to the Emergency Department and other designated staging areas in unimpeded.

The Operations Section Chief and/or Security Branch Manager will assume responsibility for managing the aforementioned activities.

Control of movement of individuals with the health care facility during an emergency, including control of vehicular access.
It is likely that access to the facilities in Kaweah Health, and movement within the facility, will need to be monitored and controlled for the duration of the emergency. Upon activation of the Code Triage, the following may occur, and will be under the responsibility of the Security Branch Director:

- Entrances to the facilities in Kaweah Health will be staffed by Security or designated personnel through the Labor Pool. Visitors and other non-hospital personnel will be instructed to proceed to designated areas. If necessary, entrances and exits will be locked down to prevent ingress or egress as warranted.
- Movement by visitors and other non-hospital personnel will be restricted to a minimum. If visitors need to move beyond designated areas, they will be identified and their intended location within the facility will be determined.
- Vehicular access to the facilities in Kaweah Health will be monitored by Security, including access to the Emergency Department and other designated staging areas is unimpeded.

Advance preparation for security and safety during and emergency
Security and safety issues are regularly addressed at the Emergency Management Subcommittee, and various aspects are periodically rehearsed during pre-planned drills, which are designed and implemented through the Emergency Management Subcommittee.

The medical center p**repares for the management of staff during an emergency.**
Roles and responsibilities for staff during emergencies
Roles and Responsibilities of staff for communications, resources and assets, safety and security, utilities and patient management begin at the Emergency Management Subcommittee through the HICS structure appointments, through the careful monitoring of the KH's inventory of organizational assets, and through ongoing assessment of risk and mitigation strategies when assessing hazard vulnerabilities. Drills are designed with specific objectives relating to functional responsibilities of staff during exercises based upon risk to the District. Integrated into drill planning are resource and asset allocation and utilization. These activities are preplanned during ongoing Emergency Management Subcommittee meetings. These activities additionally support ongoing training for staff that may include other types of learning, such as new hire orientation, annual re-training, and pre-drill training.
Staff roles and responsibilities in an emergency are largely determined by the priority emergencies identified as a result of the HVA, as well as the reporting relationships in the command and control operations of the organization.

Depending on the nature, scope, and durations of the emergency, staff may be asked to assume specific duties and responsibilities other than those normally noted in their position description. This most likely will involve assuming a HICS job function. In this case, the Job Action Sheet for that specific job function defines the staff person's role and responsibilities. Staff roles and responsibilities are identified in at least the following key areas with respect to the Job Action Sheet:

- Communications
- Resources and Assets
- Safety and Security
- Utilities
- Clinical Activities

In addition, staff roles and responsibilities may be further identified as it relates to unit-specific planning, policies and procedures and specific competencies.

All staff' have – at a minimum – the following responsibilities relative to the above mentioned areas:

- To communicate situational needs, observations, operational status, and issues in a clear, concise, and timely manner to the appropriate individual(s) or entity(s).
- To conserve resources and assets and utilize said resources and assets appropriately
- To be aware of, and maintain, the safety and security of themselves, their patients and the environment in which care, treatment, and service are rendered.
- To appropriately utilize and conserve utilities, and to report disruption or failure of utilities to the appropriate individual(s) or entity(s) in a timely manner.
- To assure that clinical activities are carried out in accordance with accepted standards of care, and in a safe and efficacious manner.

Staff are minimally trained relative to the codes for activation of the Emergency Operations Plan, and where to report for assignment. In addition, specific training is required for staff in accordance with the National Incident Command System (NIMS) as follows:

Staff Role	NIMS Based Training
• Personnel likely to be involved as initial responders	• ICS-100: Introduction to ICS or equivalent • FEMA IS-700: NIMS, An Introduction
• Personnel likely to function as Unit / Care Area Supervisors or Specialists in HICS	• ICS-100: Introduction to ICS or equivalent • ICS-200: Basic ICS or equivalent • FEMA IS-700: NIMS, An Introduction
• Personnel likely to function as Managers, Unit Leaders, and Branch Directors in HICS	• ICS-100: Introduction to ICS or equivalent • ICS-200: Basic ICS or equivalent • FEMA IS-700: NIMS, An Introduction
• Personnel likely to function as the Incident Commander, PIO, Safety Officer, Liaison Officer or Section Chief in HICS	• ICS-100: Introduction to ICS or equivalent • ICS-200: Basic ICS or equivalent • FEMA IS-700: NIMS, An Introduction • FEMA IS-800.A: National Response Plan (NRP), An Introduction* * NOTE: Personnel whose primary responsibility is emergency management must complete this training.

Managing staff support activities during and emergency
Depending on the nature, scope, and duration of the emergency, the Hospital Command Center will establish mechanisms to meet the needs of staff. Such mechanisms include, but are not necessarily limited to:

- Housing

- Transportation
- Communication
- Food and Water
- Stress Debriefing
- Child/Elder Care

If possible, unoccupied inpatient care areas of the facility will be converted into sleep rooms for staff and their children, including elder care. If unoccupied patient care areas are not available, unoccupied general areas may be converted into dormitory style housing with cots, blankets, etc.

It may be necessary to transport staff to the facility from a remote location. If so, a collection point will be determined, and staff reporting to the facilities in Kaweah Health will be instructed to meet there. Coordination with local transportation companies (bus, taxis, etc) will be used to transport staff to the facilities in Kaweah Health as needed. Chaplains and Social Workers shall be made available to staff on an as needed basis to cope with the stress of the emergency. The Logistics Section Chief and the Support Branch Director are responsible for implementing processes necessary to meet the needs of staff as noted above.
The Service Branch Director will coordinate with the Infrastructure Director to assure that adequate amounts of food and water are supplied to staff. Communications will include landlines, cell phones, E-mail, or runners and bull horn if normal communications are not operating.

Depending on the nature, scope, and duration of the emergency, it may be possible to share resources and assets with other healthcare organizations both within and outside the community. These assets and resources include, but are not necessarily limited to:

- Personnel
- Beds
- Transportation
- Linen
- Fuel
- Personal Protective Equipment
- Medical Equipment and Supplies

All licensed staff coming to work at the District will need competencies assessed by Human Resources and Nursing. If personnel from the District are going to be shared with another facility, staff will be apprised of the following information:

- The location and type of facility that they are being sent to
- The type of care, treatment, and service they are being asked to provide
- The expected duration of the assignment
- The contact information at the receiving organization.

Staff will be instructed to wear their identification badges. If possible, copies of pertinent documents such as licensure, competencies, etc. will be made and given to staff to take with them. An accurate record will be maintained of who went where and how long they stayed.

For equipment and supplies, an accurate inventory will be maintained of what was sent to other facilities and when, so that appropriate reimbursement can occur.

If resources and assets are to be shared outside of the organization's geographic service area, then the Liaison Officer will coordinate efforts from Kaweah Delta Health Care District with the County Emergency Operations Center.

The identification of licensed independent practitioners, staff, authorized volunteers The role of licensed independent practitioners (LIP') as well as designated allied health practitioners (AHP') is to render medical evaluation and care during the emergency within the scope of their competence and privileges granted unto them by the medical staff. LIP's and AHP's are responsible for reporting to the Physician Labor Pool. Staff and physicians are responsible for wearing their name badges during the emergency period. In addition, staff assigned to specific roles and responsibilities during the emergency (e.g. HICS positions) will be identified with color-coded vests.

Initial and ongoing training relevant to their emergency response role is provide to all staff, volunteers, and individual providing on-site services. Staff demonstrate knowledge in drills and exercises and critique activity.

Preparation /Management of Utilities during an Emergency
EP 2-9
Alternate means of provision of electricity, water for consumption and essential care activities, equipment/sanitary purposes, fuel, medical gas,/vacuum systems, and essential utilities (vertical/horizontal transport, heating and cooling systems, steam for sterilization)
Complementing the efforts to meet the medical care needs of the patients and protecting the staff will be the maintenance of overall facility operations. This responsibility primarily rests with the Infrastructure Branch in the Operations Section. The responsibilities include maintaining the normal operational capability of the facility including power and lighting, water, HVAC, medical gases, and building/grounds, increasing capacities when patient surge requirements dictate; and identifying and fixing utility service-delivery failures. The acquisition of equipment parts or outside contractors will be coordinated with the Support Branch.

The Infrastructure Branch Director is also responsible for assuring that there is an alternate means of meeting essential utilities when normal supply mechanisms are compromised or disrupted. At a minimum, this means identifying alternate providers both within and outside the local community, and invoking memoranda of understanding for priority delivery and supply during an emergency. A summary of the key utility and alternate means / providers is as follows:

Essential Utility	Alternate Means of Provision
• Electricity-power and lighting	Self-Generation
• Water for Consumption and Essential care Activities	**Arrowhead – Memorandum of Understanding on file for priority delivery.** Water Conservation Plan will be implemented (page 12) if quantities begin to diminish before water deliveries can occur. See Disaster Policy 2216, Water Systems Failure/Disruption.
• Water Needed for Equipment & Sanitary Purposes	Water for Equipment: If water supplies diminish and equipment is no longer able to be supported, a decision will be made by the Incident Commander to divert patients, evacuate patients and close operations. Water for Sanitary Purposes: If water supplies diminish before replenishment can occur, water conservation will be implemented (page 13).
• Medical Gases/Air	3000 Gallon bulk oxygen storage is available, which will provide oxygen for 7-10 days, depending upon usage; plus, we have a 500-gallon back-up tank, which will provide approximately one day of usage.(Downtown Campus).
• Heating, Ventilation & Air Conditioning	Loss of HVAC will be dependent upon seasonal requirements. Windows will be opened if we are experiencing high heat, with cooling measures instituted (extra water consumption, cold trays, no blankets). If it is winter, extra blankets will be obtained, warm tray menu will go into effect. In both cases, if the HVAC loss

	is sustained for greater than four hours, patients will go on divert until the HVAC issue is resolved. If the HVAC loss results in adverse effects for patient and staff, a decision to close operations and evacuate patients will be made by the Incident Commander.
• Steam for Sterilization	If there is no water for steam sterilization, instruments will be sent to an outside vendor for sterilization, and or an adjacent hospital with whom we have made arrangements.
• Fuel required for building operations, generators and essential transport that the hospital would typically provide.	Conservation plan will be put in place and memorandum of understandings will be invoked for fuel.

Management of Patients during Emergencies

Patient scheduling, triage, assessment, management of clinical

When the Emergency Operations Plan is initiated, and for the duration of the emergency event, the Hospital Command Center will implement processes relating to the following:

- Triage of Patients
- Scheduling of Patients
- Assessment and Treatment of Patients
- Admission, Transfer, Discharge, and, if necessary, evacuation of patients

Within HICS, there are job action sheets that outline the specific duties and responsibilities of the Section Chiefs, Branch Directors and Unit Leaders relative to the above. In addition, the following general guidelines will apply:

Triage of Patients Done by Emergency Department *MICN or Emergency Medicine Attending Physician. May also be delegated to an Emergency Medicine Resident as designated by the Emergency Medicine Attending Physician*

If disaster involves Trauma Patients, then Triage of trauma patients may be delegated to a Trauma Surgeon Attending Physician (or Surgical Resident designated by the Surgical Attending Physician)

During an emergency, victims of an internal or external disaster will be triaged to determine their necessary level of care, including subspeciality needs, and any needs for secondary procedures.

Patients will be assigned to one of the following triage categories utilizing the START and Jump START triage system:

- Immediate Treatment area
- Delayed Treatment area
- Minor Treatment area
- Deceased or Expectant area

Patients whose clinical needs fall outside of the scope of services or ability of KH to care for them will be promptly identified and transferred to a healthcare facility equipped to provide appropriate care.

Scheduling of Patients

Depending on the nature, scope, and duration of the emergency, non-urgent tests, procedures, diagnostic studies, and care appointments may need to be delayed or canceled. When possible, patients will be notified of any delay or cancellation and when routine service is expected to resume. A record will be maintained of any cancellations so that patients can be contacted at the conclusion of the emergency to have their medical care needs met.

Admitting Patients

Admissions during an emergency will be limited to the following:

- Emergency Department Patients
- Disaster Victims

- Pregnant Patients in Labor
- Critically Ill Persons

Non-disaster and/or emergency admissions will be screened to determine their necessity for admission. Routine admissions may be resumed if authorized by the Command Center. Patient admissions will follow normal procedure as much as possible.

Potential Discharge & Transfer of Patients

Patients housed on the various care units will be evaluated for possible transfer or discharge in the event that it becomes necessary to release selected existing patients in order to make room for more seriously injured patients. Patients will be classified for transfer or discharge as follows:

- Patients that can be safely discharged to the care of relatives or friends.
- Patients that can be safely transferred to another medical care facility. (NOTE: Critical Care Units will identify patients who can be transferred to a nursing floor)

Evacuation of Patients

If the nature, scope, and/or duration of the emergency is such that KH can no longer support care, treatment, or service, then it may become necessary to evacuate part or all of the facility(s).
The decision to evacuate shall be made by the Incident Commander in collaboration with the Section Chiefs within the Command Center. If necessary, communication will also occur with the County Emergency Operations Center, Central California Emergency Medical Services Agency, and the Department of Health Services.
The order to evacuate a given area is based on the safety of remaining in that area as compared to the risk of moving the patient population in question. Familiarity with several types of evacuation is necessary for all hospital personnel. Specific plans must be worked out within individual departments. Evacuation must take into consideration the number and types of patients, as well as alternative means of life support and cessation of invasive procedures when possible and considering the available resources at the disposal of the staff at the time the evacuation is to take place. There are generally four types of evacuation. Each may be a separate and complete operation or all may have to be used in successive stages if circumstances dictate. (KH DM2810)

Partial Evacuation. Partial evacuation is removing the patient(s) and staff from a dangerous area to one of safety within the Hospital. The area being vacated will be marked as *unsafe* by Security. Once the area has been cleared of patients and staff, the area will remain off limits until repaired or cleared of the danger by the local agency having jurisdiction.

Horizontal Evacuation. Horizontal evacuation is the removal of all patients laterally by bed, wheelchair, stretcher or other type of transport, to an adjacent protected area. The patients in immediate danger are removed first, including those that might be separated from safety if fire or other danger enters the corridor. Ambulatory patients are moved next. Contrary to some opinions, panic is never caused by helpless people. Ambulatory patients are to be instructed to line up outside of their rooms forming a chain by holding hands and following the lead staff member. All rooms are to be carefully checked for stragglers, looking particularly in all closets, under the bed and in the bathrooms. Each room door, after it is checked, is to be sealed with tape in such a manner that each room door cannot be opened without breaking the seal. Once in the evacuation area, patients must be rechecked to see that no one is missing.

Total Evacuation. In the hospital, patients will be evacuated to the nearest evacuation collection point outside of the hospital, with the goal to transfer to either: an alternate care site near the premises, or Kaweah Health. Patients requiring ventilator support will need special assistance during evacuation and must be moved with caution. In the event of total failure, electrical systems and building integrity, ventilator dependent patients will be maintained with manual support using a bag valve tube or mask. The order to evacuate is made by the person in the highest authority at the time of the disaster. Coordination with the Central California EMS Agency will be necessary to request an EMS Strike Team(s) & EMS Disaster Medical Support Units.

Clinical services for vulnerable populations

Special consideration will be given to vulnerable patient populations, including but not necessarily limited to, the following:

- Pediatric Patients

- Geriatric Patients
- Disabled Patients
- Patients with a Serious Chronic Medical Condition
- Patients with Addictions
- Bariatric Patients
- Mental Health Patients

Staff, within their scope of practice, in the various care areas will be required to identify vulnerable patients and their specific care needs. These will be noted in their plan of care and communicated to other care providers as warranted by the patient's condition and circumstances. Each patient identified will be escorted by a patient care provider.

Patient hygiene and sanitation needs

Technical specialist experts (e.g., Infection Control) will be appointed by the Incident Commander to be responsible for assuring that patent and staff hygiene and sanitation needs are met during the emergency. The following will be considered:

- All non-essential environmental cleaning services will be discontinued and resources reallocated to patient care and treatment areas, as well as staff mobilization areas.
- Central Supply will re-supply personal hygiene articles such as toothbrushes, toothpaste, shaving articles, feminine hygiene articles, soap, and alcohol based hand gel or foam.
- If necessary, arrangements will be made to bring in additional portable restrooms to handle increases in-patient, visitor, and staff volumes.
- Waterless bath packets can be procured to allow for personal hygiene in a waterless environment.

Patient mental health needs

The mental and emotional needs of patients will be monitored by chaplains and social workers within the District. If it is feasible during the event, psychiatrists and clinical psychologists will be requested to assist as needed. Nurses will be requested to provide psycho-social support as needed, within their scope of practice, to patients exhibiting emotional or mental duress during the emergency.

Mortuary services

If morgue services become unable to accommodate increasing fatalities, the following actions will be taken:

- The County Emergency Operations and Public Health Department will be contacted to provide temporary morgue services such as an environmentally controlled trailer.
- Local mortuaries will additionally be contacted to arrange for direct transport of deceased individuals to the mortuary.
- If the County local mortuaries are not available, body bags will be used to protect each expired patient, and stacked until other arrangements can be made.

Documentation and tracking of patients clinical information

Documentation will occur per normal protocol throughout the emergency. Each patient is provided with a unique clinical record identifier (i.e., a medical record number or account number). All clinical information about the patient will be noted on forms or other documentation tools with the patient's name and assigned number. In addition, the location of the receiving facility or alternate site shall be documented. If normal documentation procedures have been disrupted because of the emergency, then downtime or designated alternate procedures will be used.

During disasters, the medial center may grant disaster privileges to volunteer licensed independent practitioners.
The granting of disaster privileges
Definitions. Volunteer practitioners include:

- Licensed independent practitioner: physicians (M.D, or D.O.), podiatrist (DPM), dentist or oral maxillofacial surgeon (DDS, DMD), Psychologist.
- Physician Assistants and Advanced practice registered nurses (NP and PA)

Authority for granting privileges. During disaster(s) in which the emergency management plan has been activated and the hospital is unable to meet immediate patient needs, the chief executive officer/designee and/or chief of staff/designee has the option to grant privileges during a disaster. The responsible individual is not required to grant privileges to any individual and is expected to make such decisions on a case-by-case basis in accordance with the needs of the hospital and its patients, and on the qualifications of its volunteer practitioners. The medical staff oversees the professional performance of volunteer licensed independent practitioners, either by direct observation, mentoring or clinical record review.

Once the immediate disaster situation is under control, the privileges are terminated. Additionally, privileges granted during a disaster may be terminated at any time without any reason or cause. Termination of privileges granted in a disaster does not entitle the individual to a hearing or other due process.

The procedure for granting disaster privileges include the following processes:

1. The individual being given privileges during a disaster (applicant) must:

   A. Complete the privilege form: This form includes the applicant's statement that he/she is licensed, the license number, the state issuing the license and his/her area of specialty.

   B. Present a valid government issued photo identification issued by a state or federal agency, e.g., driver's license or passport, and at least one of the following:

      - A current picture hospital ID card that clearly identifies professional designation
      - A current license to practice
      - Primary source verification of the license
      - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organizations or groups
      - Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances **(**such authority having been granted by a federal, state or municipal entity)
      - Identification by current hospital or medical staff member(s) who possesses personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster

2. The CEO/designee and/or the chief of staff/designee may grant privileges during a disaster.

3. Medical staff coordination is accomplished by the chief of staff/designee who will assign physicians to appropriate areas.

4. The privilege form shall be forwarded as soon as possible to the medical staff office to immediately verify as much information as possible, including verification of licensure, hospital affiliation, National Practitioner Data Bank and OIG query. A record of this information will be retained by the medical staff office. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. In the extraordinary circumstances that primary source verification cannot be completed in 72 hours (for example, no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster privileges.

5. The CEO/designee, in consultation with the chief of staff/designee, makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted.

6. To ensure oversight of the professional performance of volunteer licensed independent practitioners:

    a. If medical staff members are available, concurrent mentoring will occur; the volunteer will be paired with a current member of the medical staff. Should medical staff members not be available due to the extent of the disaster, practitioner-specific outcome data will be collected when conducting record reviews after the disaster situation is resolved.
    b. Staff and patient satisfaction surveys will be conducted to assess care provided by volunteer practitioners.

    1. Any information gathered that is not consistent with that provided by the individual must be referred to the chief of staff/designee immediately, who will determine any additional necessary action. A physician's privileges approved during a disaster will be immediately terminated in the event that any information received through the verification process indicates any adverse information or suggests the person is not capable of rendering services in an emergency.

    2. Each physician will be required to wear a hospital badge signifying that the volunteer is authorized.

***Disaster Clinical/Privilege/Practice Prerogative Approval* Form.** A *Disaster Clinical Privilege /Practice Prerogative Approval* form will be completed for each volunteer, which includes unique identifying information about the volunteer, such as specialty, office address, phone number license/certification/registration number and expiration date, driver's license or passport number, date of birth, social security number, name of professional liability insurance carrier and limits of liability, etc.

Primary Source Verification. Kaweah Health personnel involved in the credentialing process will use the appropriate licensing/certification/registration on-line and print verification if possible:

- Medical Board of California: www.medbd.ca.gov (for MDs, DPMs and PAs)
- California Osteopathic Medical Board: www.ombc.ca.gov (for D.O.s)
- California Board of Registered Nursing: www.rn.ca.gov (for RNs, NPs)
- Board of Behavioral Sciences: www.bbs.ca.gov (for MFCC's, and LCSWs)
- California Psychology Board: www.psychboard.ca.gov (for clinical psychologists)

If computer access is not available, a copy of the practitioner's license/certification/registration and driver's license or other identification will be made and attached to the *Disaster Privilege/Prerogative Approval* form. If a copier is not available, the hospital representative will perform a visual verification of the above documents, and document such verification. If primary source verification cannot be accomplished at the time of initial credentialing, it must be performed as soon as the immediate situation is under control, and completed no later than 72 hours from the time the volunteer presented to the hospital. In extraordinary circumstances when primary source verification cannot be completed, the following must be documented:

- Why primary source verification could not be performed in the required timeframe
- Evidence of a demonstrated ability to continue to provide adequate care, treatment and services, and
- An attempt to rectify the situation as soon as possible.

Medical Staff Services shall query the National Practitioner Data Bank and other sources as needed per *Temporary Privilege* policy for purposes of an important patient care need as soon as the emergency situation has been contained. Primary source verification is not required if the volunteer has not provided care, treatment and services under the disaster privileges.

Identification. Practitioners granted disaster privileges shall be issued a temporary badge or sticker to allow staff to readily identify these individuals. Badges should contain the volunteer's name, specialty or AHP category, and a notation stating, "practicing with disaster privileges".

Oversight. If possible, the practitioner should be paired with a medical staff member and should act only under the direct supervision of a medical staff, AHP, or hospital employee, as appropriate, to observe or mentor the volunteer. If partnering is not possible, oversight will be conducted by medical record review. Based on the oversight, the Chief Executive Officer or Chief of Staff or their designees have the authority to determine if the granted disaster privileges should continue. Disaster privileges may be terminated at any time without any stated reason or cause. The declaration by the CEO or designee, which the emergency is over will automatically terminate all emergency privileges. Termination of disaster privileges shall not afford hearing rights under the Medical Staff Bylaws or any other authority.

The medical center may assign disaster responsibilities to volunteer practitioners who are not licensed independent practitioners, but who are required by law and regulation to have a license, certification or registration.

Granting Privileges. When the disaster plan has been implemented, and the immediate needs of the patients cannot be met, KH may implement a modified credentialing and privileging process for eligible volunteer practitioners and or allied health practitioners. A process is in place, which provides safeguards to assure volunteer practitioners are competent to provide safe and adequate care, treatment and services. This section applies to individuals that are not licensed independent practitioners (i.e., individuals who are required by law and regulation to have a license, certificate or registration to practice their profession, such as registered nurses, licensed vocational nurses, MFCC's, LCSWs and Clinical Psychologists).

Assignment of Disaster Privileges. The Chief Executive Officer or Chief of Staff or their designees have the authority to grant disaster privileges. Designees for the CEO include the COO and CNO. Designees for the Chief of Staff include the Vice Chief of Staff, Secretary-Treasurer, or any Department Chairperson. The responsible individual is not required to grant privileges to any individual and is expected to make decisions on a case-by-case basis. The procedure for granting disaster privileges include the following processes:

- Current picture hospital ID card
- Current license to practice
- Primary source verification of the license
- Identification that the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRC, ESAR-VHP, or other recognized state or federal organization or group
- Identification indicating that the individual has been granted authority to render patient care treatment and services in disaster circumstances, such authority having been granted by a federal, state or municipal entity
- Identification by current hospital or medical staff member(s) who possess personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster

Primary Source Verification. Kaweah Health personnel involved in the credentialing process will use the appropriate licensing/certification/registration on-line and print verification if possible:

- California Board of Registered Nursing: www.rn.ca.gov (for RNs, NPs)
- Board of Behavioral Sciences: www.bbs.ca.gov (for MFCC's, and LCSWs)
- California Psychology Board: www.psychboard.ca.gov (for clinical psychologists)

If computer access is not available, a copy of the practitioner's license/certification/registration and driver's license or other identification will be made and attached to the *Disaster Privilege/Prerogative Approval* form. If a copier is not available, the hospital representative will perform a visual verification of the above documents, and document such verification. If primary source verification cannot be accomplished at the time of initial credentialing, it must be performed as soon as the immediate situation is under control, and completed no later than 72 hours from the time the volunteer presented to the hospital. In extraordinary circumstances when primary source verification cannot be completed, the following must be documented:

- Why primary source verification could not be performed in the required timeframe
- Evidence of a demonstrated ability to continue to provide adequate care, treatment and services, and
- An attempt to rectify the situation as soon as possible.

Primary source verification is not required if the volunteer has not provided care, treatment and services under the disaster privileges.

Identification. Volunteer practitioners granted disaster privileges shall be issued a temporary badge or sticker to allow staff to readily identify these individuals. Badges should contain the volunteer's name, specialty or AHP category, and a notation stating, "practicing with disaster privileges".

Oversight. If possible, the voluntary practitioners should be paired with a staff member who is similar licensed, and should act only under their direct supervision as appropriate, who will observe or mentor the volunteer. If partnering is not possible, oversight will be conducted by medical record review. Based on the oversight, the Chief Executive Officer or Chief of Staff or their designees have the authority to determine if the granted disaster privileges should continue. Disaster privileges may be terminated at any time without any stated reason or cause. The declaration by the CEO or designee, which the emergency is over will automatically terminate all emergency privileges.

Evaluation of the effectiveness of emergency management planning activities

On an annual basis, at the Environment of Care Committee, KH will conduct an annual review of the effectiveness of emergency management planning activities. This review will be forwarded to senior leadership for review. The annual review will include the following processes:

- The Objectives of the Emergency Operations Plan will be evaluated as follows: The intent of the objectives will be reviewed to determine if still relevant and applicable, and if change or modification is required.
- The Scope of the Emergency Operations Plan will be evaluated as follows: Planning activities will be reviewed to determine if modifications are required due to changes within the District, its structure, the patient population served, community planning partners or other factors that may have an impact on disaster response to emergencies.
- The *Hazard Vulnerability Analysis* will be reviewed to determine if risks, preparedness and mitigation strategies have changed or altered to lower or increase overall probability of defined risks.
- The *Inventory of Organizational Assets* will be reviewed to determine if resources and assets relating to emergency preparedness have been changed, or require change.

Evaluation of the effectiveness of the Emergency Operations Plan

Kaweah Health conducts exercises to assess the effectiveness of the Emergency Operations Plan at least twice a year, stressing the limits of the plan to support assessment of preparedness and performance. The design of exercises will reflect likely disasters, and will test the District's ability to respond to emergencies, and to provide care, treatment and services under stressed situations. Off-site areas classified as business occupancy (as defined by the *Life Safety Code*) will conduct one such drill a year.

Influx of patients, escalating event and community participation. At least one drill a year conducted by the District will include an influx of simulated patients, and one drill will simulate an escalating event in which the surrounding community is unable to support the hospital. This portion of the drill may be conducted separately or in conjunction with a community wide drill, or tabletop exercise. One exercise will be conducted in participation with the County and or State of California.

Evaluation of drills: Exercises will incorporate likely scenarios as identified on Kaweah Health's *Hazard Vulnerability Analysis*, with an evaluation tool used that monitors and assesses staff response to handling of communications, resources and assets, security, staff, utilities and patients. An individual(s) will be selected whose sole responsibility during exercises is to monitor performance.

Opportunities for improvement will be addressed during debriefing by a multidisciplinary process, which includes independent practitioners, and documented, with a final evaluation completed at the Emergency Management Subcommittee. It will be the responsibility of the Emergency Management Subcommittee members to follow-through with documented deficiencies, with information provided to the Environment of Care Committee. Identified deficiencies are expected to be resolved prior to the next planned exercise, with interim measures put in place until final modifications are made. Subsequent exercises reflect modifications made and or interim measures identified.

-Description	Quantities/Descriptions	96 Hour Sustainability and Critical Asset	Individual Responsible Phone
Accommodations – Employees/Families	Kaweah Health Kids Child Care Center will accommodate childcare during a disaster. The rationale was to offer support/care to employees during a disaster, letting them know that their children could remain close by if no other accommodations could be made for them. Individuals to oversee setting up the accommodations, assuming childcare responsibility would be appointed from the Hospital Command Center.		Kaweah Kids Director 624-2471
Alternate Care Site	Alternate Care Site #1: Emergency Department Parking Lot (Tents) Surge Tent Policy #DM 2226 Alternate Care Site #2: Kaweah Health Rehab Hospital Phone: 559-624-3700 Alternate Care Site #3: Kaweah Health Mental Health Phone: 559-624-3322 Alternate Care Site #4: KH South Campus Phone: 559-624-6204 Emergency Room Triage Area- Acequia Wing Conference Room		Safety Dept. 624-2381
Bulk Oxygen Storage	3000 Gallon bulk oxygen storage, which will provide oxygen for 7-10 days, depending upon usage; plus, we have a 500 gallon back-up tank, which will provide approximately one day of usage	3000 gallon will provide oxygen for 7-10 days. 500 gallon will provide approximately 1 day use.	Maintenance Director 624-2327
***Communications – Alternate types**	**Districtwide** • HT 1250 Radios, charger, battery and clips. • Xmatter messaging available for Leadership and employees • Emergency cell phones available at each campus • Text Messaging • Landlines throughout the medical center • Runners • **Emergency Department** • StatusNet911: Multi-Agency Emergency Communication System capable of communicating with all area regional hospitals & EMS Dispatch Centers • Kenwood TK-2140 hand portable radio capable of communicating with all area regional hospitals & EMS Dispatch Centers. •All regional hospitals & EMS dispatch centers radio channels along with 3 dedicated EMS Phone lines. We use the CAREpoint III communications system along with the eBridege 12 Lead EKG Transmission system. Our CAREpoint III system uses a combination of a Motorola MIP 5000/SLR 8000 radio along with three Kenwood NX820 radios. We also have a backup Motorola XRP 4550. • Dedicated MICN Laptop & Cellular Broadband Card. This laptop is equipped with the StatusNet & Hospital Paging systems. Dedicated EMS Communications Cellular Phone.	**-Hand-held radios available at each campus** **-Emergency cell phones available at each campus** **-Runners available via Labor Pool.** **-PBX (on emergency power) will extend to 96 hour sustainability if not damaged.**	Communications Manager 624-2280
Cots	20 sleeping cots are available in Disaster trailers		Safety Dept. 624-2381

Decontamination Shower	Emergency Department – 1 built in shower with 500 gallon waste water containment tank. 1 Portable decon shower + 2 portable decon shower stored in decon trailer.		Safety Dept. 624-2381
Education Plan – Decontamination	Employees trained on 10.2021		Safety Dept. 624-2381
Emergency Operations Plan	Revised approved by BOD 2020		Safety Dept. 624-2381
Emergency Equipment Inventory and Location	See Attached Emergency Equipment Inventory Equipment located in Lab Basement Cage, Trailers at CHC, Trailer at Warehouse and 515 W. Willow.		Safety Dept. 624-2381
Food Plan - Disaster	We will utilize food from cold sources first (refrigerators & freezers), then change to dry supplies	We will utilize food from cold sources first (refrigerators & freezers), then change to dry supplies	Director Nutritional Services 624-5081
Food Supply – Patients, Employees/MDs, other	In the event of a disaster existing food inventories will be utilized to feed patients, staff, others. Menus will be adjusted to utilize (on-hand at the time) food supplies. Typically enough food is on site to feed 800-1,000 people per day for 3 – 4 days.	If food supplies begin to diminish, "Memos of Understanding" (M.O.U.s) are in place with Costco & Smart & Final to procure supplies as needed. Emergency plans have also been set up with US Foods & Sysco.	Director Nutritional Services 624-5081
***Fuel**	4000 gallon tank located on premises; however, usually the tank has approximately 3600 gallons of diesel fuel available		Maintenance Director 624-2327
Generator-portable	3 available		Maintenance Director 624-2327
HEPA Filters	5 available		Maintenance Director 624-2327
Letters of Agreement • Cardinal Health • Professional Hospital Supply • Medline • Sysco (Food)	LOA for Cardinal Health – priority delivery agreement LOA LOA for PHS – priority delivery agreement LOA LOA for Medline – priority delivery agreement Agreements with local vendors	Cardinal has agreed to deliver from alternate sites. If Cardinal cannot deliver we have agreements with secondary suppliers. If those suppliers cannot deliver we have agreements with local vendors	624-2596

<table>
<tr>
<td>Water – For All</td>
<td>Cal-Water Management Team has placed a back-up engine tied to a water pump that supplies water to the main campus. So in the event of a major power failure they will be able to provide water to our main campus.

Secondary Plan:
Nutritional Services has Emergency Water Plans for KH, West Campus and South Campus to provide water for 4 days. Emergency Water is stored in Nutritional Services Storage Areas.
Water Conservation Strategies
<table>
<tr><td>Surgeries</td><td>Emergency only Sterilization sent off site</td></tr>
<tr><td>Dialysis Patients</td><td>Diverted to other facilities</td></tr>
<tr><td>In Patients</td><td>Sponge bath with “wipettes”
Hand washing with alcohol gel</td></tr>
<tr><td>All Staff</td><td>Hand washing with alcohol gel</td></tr>
<tr><td>All Staff/Patients</td><td>Consume bottled drinks-try to limit to no more
than 2 quarter per day; ration plan is implemented by Nutrition Services</td></tr>
<tr><td>Toilets</td><td>If able to flush, flush after 3rd usage. If unable
to flush, insert plastic bags into toilets, and seal when finished. EVS to remove to terminal waste collection area</td></tr>
<tr><td>Sinks</td><td>Affix signs: “Do Not Use”</td></tr>
<tr><td>Chillers</td><td>This is only affected if boilers can no longer run.</td></tr>
<tr><td>Boilers</td><td>Season will determine heating and or chilling needs.</td></tr>
<tr><td>Generators</td><td>Can run for approximately 7 days depending upon load usage.</td></tr>
<tr><td>HVAC</td><td>Heating and air circulation on E-Power, cooling- bring in fans as needed.</td></tr>
</table></td>
<td>168 hours sustainability with
water conservation measures if needed

Meets 96 hour sustainability with power by cogeneration plant.</td>
<td>Maintenance Director
624-2327</td>
</tr>
<tr>
<td>Linens</td>
<td>24-hour supply on hand

Daily deliveries
Linen Conservation Plan will need to go into effect if there is interference with deliveries:
○ Bed Bath every 3rd day
○ Change linen every 3rd day if not soiled; clean chux daily
○ Use alcohol gel or wipes for hand washing
○ Whenever possible use wipes instead of wash cloths
○ Change hospital gowns every 3rd day unless soiled; encourage use of personal sleeping attire if at the hospital
○ Agreement in place with Mission Linen</td>
<td>Agreement in place with Mission Linen a local firm</td>
<td>EVS Director
624-2380</td>
</tr>
</table>

Hazard Vulnerability Completed – Top Five Hazards	2025 HVA- Top 6 Risk Epidemic/Emerging Infectious Disease 67% — An especially severe influenza pandemic could lead to high levels of illness, death, social disruption, and economic loss. Sewer Failure 61% — **Due to the age of our building greater possibility of failure.** Chemical Exposure 56% — Pesticides are widely used in our agriculture areas. Fog 56% — Central Valley fog is very heavy and there is a history of multi-vehicle (100+) accidents on local highways. Mass Casualty (Hazmat) 56% — Pesticides are widely used in our agriculture areas. Patient Surge 67% — Crisis across our state has increased the last year. Patient volume continues to increase not solely related to Covid 19. Epidemic/Emerging Infectious Disease 78% — An especially severe influenza pandemic could lead to high levels of illness, death, social disruption, and economic loss. Chemical Exposure 56% — Pesticides are widely used in our agriculture areas. Fog 56% — Central Valley fog is very heavy and there is a history of multi-vehicle (100+) accidents on local highways. Mass Casualty (HazMat) 56% — Pesticides are widely used in our area. Patient Surge 56% — Crisis across our state has increased the last year. Patient volume continues to increase not solely related to Covid 19. Event Rational		Safety 624-2381
Isolation Rooms – Negative Pressure	Total Number of Isolation Rooms: 17		Director – House Supervision 624-2642
Licensed Beds	270 Unspecified General Acute Care 89 Perinatal Services 41 Intensive Care 23 Intensive Care Newborn Nursery 12 Pediatric Services 45 Rehabilitation Center at KHRH		Director – House Supervision 624-2642
Personal Protective Equipment	Mask – respirator TB – 14 cases (210 masks per case) in Materials 85 cases (210 masks per case) in Emergency Supplies		
***Pharmacy Meds on Supply**	Pharmacy Cache from the State: two chem. Packs (1) for approximately 450 (1) for hospital, servicing 1000 employees Can request syringes from Tenet Cache and/or obtain from local sister hospital	Can reach 96-hour sustainability with access to Tenet Cache and from other Tenet hospitals.	Pharmacy Director 624-2470

<table>
<tr>
<td>Pharmacy Chem Pack contents

Emergency Operations Plan</td>
<td>Emergency Medical Services: Treatment Capacity 454 Patients
EMS Chempack Contents*
<table>
<tr><th>Drug/Dosage Form/Device</th><th>NDC/Product #</th><th>Number of units/box</th></tr>
<tr><td>Antidote Treatment-Nerve Agent Auto-Injector (ATNAA)</td><td>11704-777-01</td><td>200</td></tr>
<tr><td>Atropine Sulfate 0.4 mg/ml 20 ml vial</td><td>63323-234-20</td><td>100</td></tr>
<tr><td>Pralidoxime 1 gm 20 ml vial</td><td>60977-141-01</td><td>276</td></tr>
<tr><td>Diazepam 5 mg/ml Auto Injector</td><td>6505-01-274-0951</td><td>150</td></tr>
<tr><td>Diazepam 5 mg/ml 10 ml vial</td><td>0409-3213-02</td><td>25</td></tr>
<tr><td>Sterile H2O Inj 20 ml</td><td>0409-4887-20</td><td>100</td></tr>
<tr><td>Atropen 0.5 mg*</td><td>11704-104-01</td><td>144</td></tr>
<tr><td>Atropen 1 mg*</td><td>11704-105-01</td><td>144</td></tr>
</table>
*KH has 2 Chempacks on the Medical Center premises; each Chempak is designed to treat 454 patients.</td>
<td>Can reach 96-hour sustainability with Pharmacy Chem Pack contents</td>
<td></td>
</tr>
<tr>
<td>Pharmacy Supplies</td>
<td>Our hospital pharmacies disaster drug procurement plan is outlined in Pharmacy Manual 6.25.0. We have an established plan that was developed in conjunction with our primary drug distributor (AmeriSourceBergen). We have a list of medications that would be available for use in the event of a disaster. In the event of a disaster, we would notify the distributor of such an event and processes put in place to assure drug procurement based on the pre-developed drug list is executed. Per our Disaster Recovery Plan with our distributor, they will obtain assistance from local Emergency Services companies, the CA Office of Emergency Services, local law enforcement agencies, private contractors, the media, and military organizations. These agencies will be used to transport product overland or via helicopter if necessary.</td>
<td>Can reach 96-hour sustainability with our Disaster Recovery Plan</td>
<td>Pharmacy Director
624-2470</td>
</tr>
<tr>
<td>Surge Capacity Plan</td>
<td>Surge Capacity Plan in place; key issues addressed:
o Census Saturation Plan AP. 114 in place
o Identification of Isolation Rooms with Negative Pressure Availability of Infection Control Nurses x24 hours/7 days week
o Bio-Safety Level 2 rating for Microbiology Laboratory, and is capable of testing for: influenza A&B antigens, RSV antigen, C. diffile toxin, E coli 0157, VRE and MRSA, routine cultures and anti-microbial susceptibilities, fungus and yeast isolation/identification. The Clinical Lab is equipped to rule out bio-terrorism organisms and rare and unusual organisms. The lab is able to refer specimens to reference labs and Tulare County Public Health Department.</td>
<td></td>
<td>Director – House Supervision
624-2642
Safety
624-2381</td>
</tr>
</table>

<table>
<tr><td></td><td>o (3) month supply of small regular size Tecnol N-95 respirators; high risk departments have designated fit-testers who can fit test employees if needed; N-95 respirators may be able to be accessed from Tulare County cache
o Pharmacy – Disaster Drug Procurement Plan in conjunction with our primary drug distributor based on pre-developed drug list.
o Employee/family accommodations will be made available as needed</td><td></td><td>Safety
624-2381</td></tr>
<tr><td>Tents</td><td>Have two tents available for use</td><td></td><td>Director
624-2327</td></tr>
<tr><td>*Security – Ways to Increase</td><td>Security Staff is in-house. We have a current contract with Triple A Security for additional security staff if needed in an emergency.</td><td>Can reach 96 hours sustainability with In- house staff and contract with Triple A Security.</td><td>Security Manager
624-5591</td></tr>
<tr><td>*Staffing hours – Ways to increase</td><td><table><tr><th>Priority</th><th>Strategy</th></tr><tr><td>One</td><td>Adapt staffing ratios to need. Each of the designated patient care levels (critical, complex/ critical, basic, and supportive) will require different staffing ratios.</td></tr><tr><td>Two</td><td>8-hour shifts may be changed to 12-hour shifts.</td></tr><tr><td>Three</td><td>Prioritize tasks so only essential patient care tasks are provided by staff.</td></tr><tr><td>Four</td><td>• Use media to contact volunteer healthcare workers. • Acquire staff through established MOUs and partnerships with other sister facilities. • Consider alternate labor sources such as MRCs, Community Emergency Response Teams (CERTs), etc., through County</td></tr><tr><td>Five</td><td>Consider flexing scope of practice of staff to provide necessary care with available staff (when authorized by the Governor during a declared state of emergency to allow flexed scope of practice).</td></tr></table></td><td>Can reach 96-hour sustainability with our Staffing Strategies.</td><td>House Supervisor
624-2642</td></tr>
<tr><td>Staffing – Physicians & Resident Physicians</td><td>Must report to the Physician Labor Pool</td><td></td><td>Medical Staff Director
624-2358</td></tr>
<tr><td>Ventilators</td><td>33 total ventilators plus 3 in storage which will be on preventive maintenance inventory and kept maintained for emergencies</td><td></td><td>Director Respiratory Services
624-2417</td></tr>
</table>

Decontamination Shower	Emergency Department Ambulance Bay – Built in Hazmat Decontamination shower & wand with temperature controlled water flow & 500 gallon waste water containment tank	
	Emergency Department Ambulance Bay – Built in Hazmat Decontamination shower & wand with temperature controlled water flow & 500 gallon waste water containment tank.	
	FSI Portable Decon Shower (Model 1010S)	1
	FSI Portable Decon Shower Sump Pump	1
	Waste Water Containment Pool (748 Gallon)	1
	ILC Dover CBRN PAPR (D Cell Battery Powered)	12
	D Cell Battery (10 per Box)	12
	Dedicated Temperature controlled faucets for portable Decon showers in ambulance bay.	3
	ILC Dover CBRN Filter Cartridges (3 per pack)	24 Packs
	Level C HazMat PPE Ensemble Kit Each kit contains: Chemical Resistant Steel Toe Boots, Chemical Resistant Gloves, Chemical Resistant Tape. Tychem 4000 Suit.	6 Kits of various sizes
	150 foot hose line on reel	1
	Pop-Up Canopy	1
	HazMat & Decon References	
	Decon Team Monitoring Forms Decon Team Monitoring Supplies: BP Cuffs/Thermometers/Stethoscopes	
	pH Test Paper	1 Roll

	Sponges Brushes & Soap/Shampoo Bottles	
	Garden Hose for Decon Shower	2
	Tool Box (Wrenches, Screwdrivers, Pliers, etc.)	1
	TVI Corporation Elevation Grate	3
	Equipment for decontamination of non-ambulatory patients.	
	Extension Cords for Sump Pump	2
	Don-It Personal Privacy Kit (Adult)	
Equipment – Bioterrorism – in the County provided trailer #2. Located in Physician Parking Lot.		
	TVI Corporation 3 Line Decontamination Shower with sump pump.	1
	TVI Corporation High Volume Water Heater	1
	FSI Portable Decon Shower (Model 1010S)	2
	TVI Corporation Elevation Grate	3
	Honda 3000 Generator with Telescoping Light Kit	2
	Extension Cords for Sump Pump	4
	FSI Portable Decon Shower Sump Pump	2
	4'X100' Safety Fence	3
	55 Gal. Containment Drums w/ dollies	2
	Don-It Post Decon Personal Privacy Kits – Adult – 20 per case	7 cs
	Boxes Nitril Gloves (LG)	1
	Boxes Nitril Gloves (MD)	1
	Boxes Nitril Gloves (SM)	1
	Container 2 buckets, brush and sponges	1

	Quick Shade Instant Canopy (10'X10')	2
	Caution Tape and Hazard Tape *(tub)*	1
	Don-It Personal Privacy Kit (Adult)	16
	Don-It Personal Privacy Kit (Youth)	8
	Don-It Post Decon Personal Privacy Kits – Child – 20 per case	4 cs
	Chemical Tape	12 Rolls
	Spinal Immobilization Board	1
	Bedside Commode	2
	Garden hoses for portable decontamination showers	3
	Caution Tape and Hazard Tape *(tub)*	1
	Traffic Delineators	6
	Bull Horn	1
	Infant Car Seat without liner for decon of infants	1
	Steel Toe Boots (Size 11 Orange)	3
2 Equipment – Bioterrorism – located in of the County provided trailer (at South Campus) 1633 S. Court St. Visalia, Ca 93292		
	Model Pelair 24,000 Portable air conditioner	2
	On Scene Bio Protective Kit (XL)	100
	Honda 10,000 Generator	1
	On Scene Bio-Tec Kit (2XL)	100
	On Scene Bio-Tech Kit (2XL)	100
	Cooling Vests	23
	Rubbermaid 5 Drawer Tool Box	1
	Wrench Set	1

	Rubbermaid Cart (grey)	1
	Spinal Immobilization Board	11
	Disaster Cots	20
	Extraction Litters	4

Equipment – Warehouse 240 South Dunsworth, Visalia Ca	Clean Air RX Air 3000 Air Purifier	1
	Western Shelter GateKeeper Disaster Tents	2
	Western Shelter High-Capacity Generator	1
	Western Shelter Power Distribution Kit	
	Generator Cord	1
	Mintie 1000V Hepa	2
	Mintie ECU 2 Bundle	1
	OmniAire 1000 V (Hepa Air Units)	2
	Poly Pad	1
	Pressure Kit	1
	Star Heater	1
	Clean Air RX Air 3000 Air Purifier	1
Equipment- Safety Office/MSC PLN Room	3M 10 Unit battery Charger (PAPR)	2
	ILC Dover CBRN PAPR (Nickel-Metal Hydride Battery)	12
	CBRN PAPR Cartridges of filters (3 each per pack)	12 packs
	HEPA PAPR Cartridges of filters (3 each per pack)	12 packs
	Tychem 4000 Decon Suits (XL) 6 suits per case	2 cases
	Tychem 4000 Decon Suits (2X) 6 suits per case	2 cases
	Tychem 4000 Decon Suits (3X) 6 suits per case	1 case
	Tychem 4000 Decon Suits (Large) 6 suits per case	1 case
	ILC Dover CBRN PAPR (Nickel-Metal Hydride Battery)	12

	CBRN PAPR Cartridges of filters (3 each per pack)	12 packs
	HEPA PAPR Cartridges of filters (3 each per pack)	12 packs
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	Tychem 4000 Decon Suits (2X) 6 suits per case	2 cases
	Tychem 4000 Decon Suits (3X) 6 suits per case	1 case

	Tychem 4000 Decon Suits (Large) 6 suits per case	1 case
Equipment- 515 Building		
	Phillips Heart Start Defibrillators	2
	Portable Suction Units	2
	EPV 200 Ventilator	3
	EPV 200 Ventilator Circuits	1 case
	Radiation Detector	1
	Radio Chest Packs	10
	Scissors	20
	Stereoscopes	10
	Bull Horn	1
	Phillips Heart Start Defibrillators	2
	Portable Suction Units	2
	EPV 200 Ventilator	3
	EPV 200 Ventilator Circuits	1 case
	Radiation Detector	1
	Radio Chest Packs	10
	Scissors	20
	Stereoscopes	10
	Bull Horn	1
	Phillips Heart Start Defibrillators	2
	Portable Suction Units	2
	EPV 200 Ventilator	3
	EPV 200 Ventilator Circuits	1 case
	Radiation Detector	1

Equipment – Evacuation	• Stryker evacuation chair at staff elevator landings on the 3rd and 4th floors. • Med Sled NICU Evacuation Basket Med and Rack System. • Infant Evacuation Vest. • Cache of Evacusled™ ESA evacuation sleds.	

ATTACHMENT C

Manager's Recovery Guidelines (Recovery Checklist Post Disaster)

Manager's Recovery Guidelines

Damage Assessment	Staff Requirements	Equipment Requirements	Document Requirements	Other
Assess patient safety post incident.	Assess current capacity of staff and possible overtime hours.	Assess equipment for operational status	**Document requirements are critical to financial recovery.**	Data safety: whenever possible, data in your computer(s) should be on back up files
Assess employee safety post incident	Determine if staffing needs were met, and if additional staff was utilized, or overtime was used.	Identify what alternates to current equipment can be used.	Document hours worked by staff during the incident, and post incident and until the incident is declared resolved.	
Assess area safety to determine where it is safe to move	Ensure staff hours worked during the incident are disaster-coded properly to the disaster cost center.	Notify Biomed for equipment needs.	Photograph damages to building and equipment. Contact photography or departments with digital cameras , videos (Engineering)	
Complete Damage Assessment in your area. If damage has occurred, obtain photographs of the area—preferably by camera or digital camera. Keep as part of records; originals to the Cost Officer with date, time, location, contact person.		Document all rental usage. Try to rent as opposed to purchase as rental fees are more easily recoverable, than purchase fees.	Maintain files for P.O's relating to rental of equipment needs, or purchase of supplies relating to the incident. If in doubt, write "PO-Emergency Incident", and the P.O.'s will be evaluated at a later date. Originals to Cost Officer	
Make copy of completed *Damage Assessment form* and maintain in your records		Photograph damaged equipment. Originals to Cost Officer: date, time, location, contact person.	All food/nutrition/supply need to be documented as distributed during the disaster to determine cost of nutritional deliveries for patients, staff, visitors.	
Bring *Damage Assessment form* to the Command Post				
Be on the alert for other damages that may occur (eg., noticeable structural or non-structural damages from after shocks post earthquake).				**NOTE:** Ensure all disaster worked hours, purchased or rented services or equipment or supplies are coded to the Disaster Cost Center—obtained from Payroll or Purchasing.
Document any new damages on a second *Damage Assessment form* and bring to the Command Post.				

DESCRIPTION	YES	NO

A. Damage Assessment Form 1. Area assessed for visual damages using *Damage Assessment Form.* If an earthquake occurred, and there are "aftershocks", area must be re-assessed using the same form, and resent to the Command Post.	**If Yes, describe major damages: (use separate pages if necessary)**	
B. Staff Requirements 1, Were staff requirements assessed?	**If Yes, describe how many staff personnel were required and what job codes:**	
2, Are hours worked by staff being charged to the Disaster Cost Center?	**Cost Center being used on timecard is:**	
C. Equipment Requirements 1. **Identify what type of equipment is being purchased or rented for the disaster. Rent whenever possible.**	**If Yes, identify type of equipment, quantity, duration of rental and cost per unit. Copies of all P.O.'s to the Cost Officer.**	
D. Document Requirements		
1. **Have you photographed the area?**	**If Yes, ensure photograph and copies are maintained; original to Cost Officer. If "No", request immediate Photography Services.**	
2 Have you maintained copies of all P.O's related to the Disaster?	**If Yes, copies of all P.O's to the Cost Officer. If you are unsure if the P.O. is related to the disaster, note your concerns on a separate piece of paper attached to the P.O.**	
3 If involved with Food Services, have you itemized all food services related to the care of victims, families, staff, etc., during the time of the disaster?	**If Yes, copies of all P.O's to the Cost Officer. If you are unsure if the P.O. is related to the disaster, note your concerns on a separate piece of paper attached to the P.O**	
4. Have you itemized all P.O's during the disaster.	**If Yes, copies of all P. O's to the Cost Officer. If you are unsure if the P.O. is related to the disaster, note your concerns on a separate piece of paper attached to the P.O.**	
E. Other Any other itemizations should be stated on a separate page, and attached.	**If Yes, state all itemizations on a separate page and attach. If more space is required, categorize each entry with letters and numbers on this page (EG. A1, D2, etc.)**	
F. Consequential Events. Were there any consequential events as a result of this disaster?	**If yes, describe on a separate page, using an UOR, and attach.**	
Business Loss. Were services closed as a result of this incident?	**If yes, state what services were closed, with best estimate of loss of revenue. Identify in detail on a separate piece of paper, with heading entitled "Business Loss", and bundle with other information, sending to Cost Officer. Identify your name, department and phone number.**	

Appendix A

Procedures for specific areas of high risk as determined by hazard vulnerability analysis:

Epidemic/Highly Infectious Disease

Procedure:

a. Determine how many patients have been infected. Ensure implementation of surge plan, proper triage and infection precautions

b. Anticipate an increased need for medical supplies, antivirals, IV fluids and pharmaceuticals, oxygen, ventilators, suction equipment, respiratory protection/PPE, and respiratory therapists, transporters and other personnel

c. Conduct disease surveillance, including number of affected patients/personnel

d. Continue isolation activities as needed

e. Consult with infection control for disinfection requirements for equipment and facility

f. Continue patient management activities, including patient cohorting, patient/staff/visitor medical care issues.

Chemical Exposure, External

In the event of a chemical incident where patients are being brought into the facility the following measures will be taken:

a. Notify Administration, House Supervisor, Hospital Safety Officer, Security and Emergency Department Nurse Manager.

b. Determine area of decontamination and staging.

c. See DM 2211 Decontamination plan for more detailed information

d. Consider HICS activation

Fog

In times where fog is too dense and staff are unable to report to work the following steps shall be taken.

a. Notify Administration, House Supervisor, Hospital Safety Officer, and Security

b. Gather information regarding staff shortage

c. Begin call back procedures

d. Consider cancelling elective procedures

e. Begin discharging patients as appropriate

Mass Casualty (Haz Mat)

In the event we experience a large scale haz mat incident and we experience high number of casualties.

a. Notify Administration, House Supervisor, Hospital Safety Officer, Security and Emergency Department Nurse Manager.

b. Security to secure a perimeter around the area to keep people out of the area.
c. Notify Visalia Haz Mat Team to assist. .
d. Consider activating HICS.

Patient Surge (See Census Saturation Plan AP114)

a) Notify Administration, House Supervisor, Hospital Safety Officer, Security and Emergency Department Nurse Manager.
b) A census saturation meeting will be held at the discretion of the House Supervisor, and will include the Directors who have leadership responsibility for the nursing units with the greatest census/acuity impact. This meeting will occur at 11:00 a.m. and can be canceled as determined by the House Supervisor.
c) Bed status may be reassessed and communicated every 2-4 hours by the House Supervisor or their designee as needed.
d) If it is determined that the Census Crisis is to persist past 12 hours, the CNO or Chief Operating Officer(COO) may be asked to attend the bed meeting.
e) Nursing Directors, Chief Medical Officer (CMO), Chief of Staff or Medical staff designee or any other stakeholders determined to be appropriate for the event may be included. The purpose will be to review the inpatient activity and to assist in decision making to provide relief for the ED and/or surgery, cath lab services.
    a. Chief of Staff or Medical Staff designee determines need to cancel procedures.
    b. If procedures cancellation is required, affected medical staff members are contracted by the Chief of Staff and/or the CMO along with the patients effected.
f) The House Supervisor and/or Nursing Director on call will open an identified patient Discharge Lounge as needed to house discharged adult patients while they wait for their private transportation home.

Sewer Failure (EOC 1037)

a. Maintenance will notify affected departments and the Nursing Supervisor of the failure and the expected downtime.

b. Should sewage stoppage or disruption of service be unable to be repaired in a reasonable amount of time, maintenance will order portable toilets for patient, visitor and staff use.

c. 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, and if cases need to be cancelled/rescheduled.

d. It may be necessary to shut off all water at the campus to keep sewage waste to a minimum. This decision will be made by Administration and the Director of Facility Operations or designee. See Policy #DM2216 for “Water Systems Failure/Disruption.”

EOC 4003

Policy Number: EOC 4003	Date Created: 03/31/2025
Document Owner: Maribel Aguilar (Assistant Director of Environment of Care/Safety Officer)	Date Approved: Not Approved Yet
Approvers: Board of Directors (EOC/Emergency Preparedness), Maribel Aguilar (Assistant Director of Environment of Care/Safety Officer)	

District Pest Control Policy

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

Summary:
The policy establishes the requirement that all staff report pest sightings immediately, enabling a swift intervention and preventing potential pest issues from escalating. This document works with a separate comprehensive Integrated Pest Management (IPM) program intended to safeguard District healthcare facilities through systematic monitoring, prompt reporting, and rapid response upon the detection of pest activity. The Integrated Pest Management (IPM) Program will be managed by the IPM Team with oversight by the Environment of Care Committee**.**

Policy:
Every employee must report any sighting of pests as soon as they occur. The process for reporting is to use the Facilities work order system, housed on Kaweah Compass. Please include in your report: what you saw, where you saw and approximate time in your report and/or directly contact the Facilities department. This immediacy is crucial because a delay in reporting can result in a rapid increase in pest populations, which in turn can compromise both patient safety and operational efficiency. Rapid reporting is seen as the first line of defense, ensuring that the pest management team can act before minor issues develop into significant issues. Immediate reporting allows the IPM Team to assess the situation quickly, identifying the pest species involved and determining the severity of the issue. This timely communication is not only about mitigating current risks but also plays a preventive role. By addressing issues early, the risk to public health and potential structural or aesthetic damage to the facility is minimized. This document stresses that every minute counts when a pest is observed, underlining the idea that rapid identification and response are essential components of an effective pest control program.

Procedure:

Roles and Responsibilities:
A well-defined division of responsibilities ensures that every member of the organization is accountable for pest management. The policy outlines the roles as follows:

- **Executive Leadership**: Responsible for endorsing the policy and allocating necessary resources. Their commitment signals the importance of pest control as a priority within all District facilities.

- **IPM Team/Environment of Care Committee**: Tasked with the direct oversight of the IPM program. Their duties include managing pest control activities, reviewing ongoing procedures, and approving both the use of pesticide products and the specific applications of such products. Their role is pivotal in turning reported pest sightings into actionable responses.
- **Department Leaders:** They serve as the link between the IPM Team and general staff. Leaders are responsible for ensuring that employees understand their roles in the reporting process, adhering to preventive measures, and participating in necessary training sessions when applicable.
- **All Staff:** The policy makes it abundantly clear that every employee is a frontline defender against pest issues. Regardless of their specific role, all staff members are expected to report any pest sightings immediately. This collective responsibility ensures that no incident goes unnoticed, and it supports a culture of vigilance.
- **Pest Management Professionals**: Licensed and certified experts are employed to execute the pest control measures. They operate under the direction of the IPM Team, ensuring that every intervention is both scientifically valid and compliant with regulatory requirements. Their expertise is critical in formulating appropriate responses and in documenting the process.

References:

EPA – Integrated Pest Management In Health Care Facilities Implementing an IPM Program July 2021
https://www.epa.gov/system/files/documents/2021-07/integrated-pest-management-toolkit-2021.pdf

DM 2205

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

Code Pink- Infant Abduction

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.

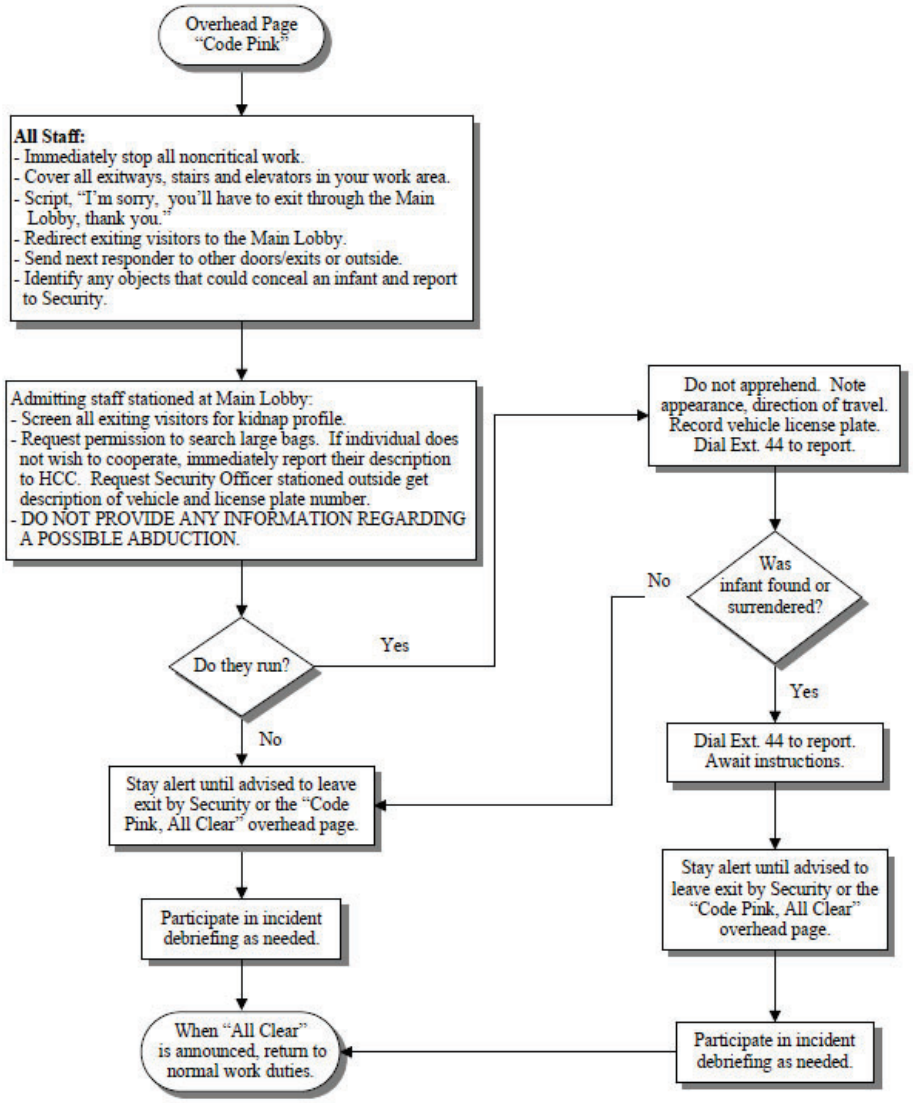
ALL CLEAR

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.

Kaweah Health

Emergency Management Manual
Code Pink - Infant Abduction



DM 2228

Policy Number: DM 2228	Date Created: 08/10/2022
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Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Continuity of Operations and Recovery

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

Policy: The Continuity of Operations Plan (COOP) provides a mechanism to assist with the implementation of coordinated COOP strategies that initiate activation, relocation, and continuity of operations for the agency/organization. The COOP is an All-Hazards plan that addresses the full spectrum of threats from natural, manmade, and technological sources including national security emergencies.

Procedure:

1 Healthcare Continuity of Operations

1.2 Pre-Incident Risk Assessment

Kaweah Health has reviewed the following guidance to identify hazards, risks, and vulnerabilities to, regional and local health departments, Health Care Coalition, and Healthcare Organization.

CCMSA Hazard Vulnerability Analysis
Kaweah Health Hazard Vulnerability Analysis

Hazard Vulnerability Analysis

Kaweah Health Hazard Vulnerability Analysis-Pre-Identified Hazards and Risks

Hazard	Type	Probability	Human Impact	Property Impact	Business Impact	Preparedness	Internal Response	External Response	Risk
Epidemic	Natural	High	High	Low	High	High	Moderate	Moderate	High
Mass Casualty	Human	Moderate	Moderate	Low	High	Moderate	High	High	High
Patient Surge	Human	High	Moderate	n/a	Low	Moderate	Moderate	Low	High
Chemical Exposure	Haz. Material	High	Moderate	Low	Moderate	Moderate	Moderate	High	High
Fog	Natural	High	Moderate	Low	Moderate	High	Moderate	Moderate	High
Sewer Failure	Technologic	High	Low	Low	High	Moderate	Moderate	Moderate	High

Central California Health Care Coalition Hazard Vulnerability Analysis

Hazard	Type	Probability	Human Impact	Property Impact	Business Impact	Preparedness	Internal Response	External Response	Risk
Pandemic	Natural	High	High	Low	High	Moderate	Moderate	Moderate	High
Patient Surge	Human	High	High	Low	High	Moderate	Moderate	Moderate	High
Active Shooter	Human	Moderate	High	Moderate	High	Moderate	Low	Moderate	High
Hazmat Incident	Haz. Material	High	Moderate	Low	Moderate	Moderate	Moderate	High	High
Seasonal Influenza	Human	High	Low	Low	Moderate	Moderate	Moderate	Moderate	High
Flood	Natural	High	Moderate	High	High	Moderate	High	Moderate	High

1.3 Continuity Elements

ORDERS OF SUCCESSION

Kaweah Health has established and maintained Orders of Succession for key positions in the event leadership is incapable of performing authorized duties. The designation as a successor enables that individual to serve in the same position as the principal in the event of that principal's death, incapacity, or resignation.

Kaweah Health Succession Plan

Key Position (Position Title)	Successor 1	Successor 2	Successor 3
CEO	Chief Operating Officer	Chief Nursing Officer	Chief Strategy Officer
Chief Nursing Officer	Chief Operating Officer	Chief Population Health Officer	Chief Strategy Officer
Chief Human Resource Officer	Chief Compliance/Risk Officer	Chief Financial Officer	Chief Strategy Officer
Chief Operating Officer	Chief Nursing Officer	Chief Population Health Officer	Chief Human Resource Officer
Chief Finance Officer	CEO	Chief Compliance/Risk Officer	Chief Population Health Officer
Chief Strategy Officer	Chief Operations Officer	Chief Compliance/Risk Officer	Chief Population Health Officer
Chief Compliance/Risk Officer	Chief Human Resource Officer	Chief Strategy Officer	Chief Nursing Officer

DELEGATION OF AUTHORITY

Kaweah Health has established Delegations of Authority to provide successors the legal authority to act on behalf of the Organization for specific purposes and to carry out specific duties. Delegations of Authority will take effect when normal channels of direction are disrupted and will terminate when these channels are reestablished.

Kaweah Health Delegation of Authority

Authority	Type of Authority	Position Holding	Triggering Conditions
Close Facility/Evocation or alternate care sites	Emergency Authority	Executive Leadership	When conditions make coming to or remaining in the facility unsafe
Represent Organization when engaging Govt. Officials	Administrative authority	Senior Leadership	When the pre-identified senior leadership is not available
Activate Organization MOU's/MAA's	Administrative Authority	Senior Leadership	When the pre-identified senior leadership is not available

CONTINUITY FACILITIES

Kaweah Health has identified continuity facilities to conduct business and/or provide clinical care to maintain essential functions when the original property, host facility, or contracted arrangement where the Organization conducts operations is unavailable for the duration of the continuity event. The table below lists the pre-arranged Alternate Sites, Devolution Sites, and Telework Options.

Exhibit 4: Kaweah Health Facility Continuity Plan

Continuity Facility	Type of Facility	Location of Facility	Accommodations
Kaweah Health	Alternate Site	Emergency Department Parking Lot (Tent)	Identified meeting room with telephones internet access, satellite radio access, 2 desktop computers, laptop connectivity

Kaweah Health Rehab Hospital	Alternate Site	840 S. Akers St. Visalia Ca 93277	Possible meeting room with telephones, internet access, shared ham radio capability, shared satellite phone capability, No desktop computers, laptop connectivity
Kaweah Health Mental Health Hospital	Alternate Site	1100 S. Akers St. Visalia Ca 93277	Possible meeting room with telephones, internet access, shared ham radio capability, shared satellite phone capability, laptop connectivity
Kaweah Health South Campus	Alternate Site	1633 S. Court. St. Visalia Ca 93277	Possible meeting room with telephones, internet access, shared ham radio capability, shared satellite phone capability, No
Home Telework	Devolution Site	Home of Record HCC Leadership	Warm Site, telephones, internet access, no ham radio, no satellite phone, desktop computers, laptop connectivity

CONTINUITY COMMUNICATIONS

Kaweah Health maintains a robust and effective communications system to provide connectivity to internal response players, key leadership, and state and federal response and recovery partners. The Organization has established communication requirements that address the following factors:

- Organizations possess, operate and maintain, or have dedicated access to communication capabilities at their primary facilities, off-sites and pre-identified alternate care sites
- Organization leadership and members possess mobile, in-transit communications capabilities to ensure continuation of incident specific communications between leadership and partner emergency response points of contact
- Organizations have signed agreements with other pre-identified alternate care sites to ensure they have adequate access to communication resources
- Organizations possess interoperable redundant communications that are maintained and operational as soon as possible following a continuity activation, and are readily available for a period of sustained usage for up to 30 days following the event

ESSENTIAL RECORDS MANAGEMENT
Kaweah Health keeps all essential hardcopy records in a mobile container that can be relocated to alternate sites. In addition, electronic records, plans, and contact lists are maintained by the organization leadership and can be accessed online and retrieved on system hard drives when applicable and appropriate. Access to and use of these records and systems enables the performance of essential functions and reconstitution to normal operations.

DEVOLUTION OF CONTROL AND DIRECTION
Kaweah Health devolution option requires the transition of roles and responsibilities for performance of Organization essential functions through pre- authorized delegations of authority and responsibility. The authorities are delegated from Organization leadership to other representatives in order to sustain essential functions for an extended period. The devolution option will be triggered when one or more

Organization leaders are unable to perform the required duties of the position. The responsibilities of the position will be immediately transferred to designated personnel in the delegation of authority matrix. Personnel delegated to conduct Organization activities will do so until termination of devolution option.

1.4 Healthcare Primary Mission Essential Function (PMEF) & Mission Essential Functions (MEF's)

1.4.1 Health Care Service Delivery (PMEF)

The provision of health care continuity provided in all inpatient and outpatient environments.
State Health Authority Essential Supporting Activities include:

- Collect situational assessment data from Local/Regional Health Departments (L/RHD), Healthcare Coalitions (HCC), and Healthcare Organizations (HCOs) on their ability to provide patient care
- Collect L/RHD, HCC, and HCO data to generate regional and statewide health care service delivery situation report
- Disseminate health care service delivery situation reports to Federal ESF-8
- Prepare Action Request Forms (ARF) to request assistance from ESF-8 lead
- Local/Regional Health Department Essential Supporting Activities include:
- Collect situational assessment data on the impact of the disruption of public health service delivery in the local and regional area
- Partner with local emergency management and social services to determine public
- health priorities associated with services needed to recover from physical or mental/behavioral injury, illness, or exposure sustained as a result of the incident
- Work with U.S. Dept. of Health & Human Services (DHHS) Incident Response

- Coordination Team (IRCT) to assess requirements to return to normal public health care service delivery
  Disseminate health care service delivery data to state health authorities and ESF-8 partners
-

Healthcare Coalition Essential Supporting Activities include:

- Collect situational assessment data from member HCOs on their ability to provide patient care
- Collect individual facility data to generate coalition health care service delivery situational report
- Disseminate health care service delivery data to state health authorities
- Assist coalition members in returning to full operational status
- Healthcare Organization Essential Supporting Activities include:
- Determine the extent of disruption to health care service delivery
- Determine if event has caused a complete or partial disruption of health care service delivery
- Determine if relocation of health care service delivery to alternate care sites is an option for short-term continuation of service
- Work with local emergency management and regional HCC(s) to obtain assistance in returning to normal health care delivery operations

1.4.2 Access to Health Workforce (MEF)

The ability to deploy a credentialed health workforce to provide patient care to support healthcare service delivery in all environments.

State Health Authority Essential Supporting Activities include:

- Conduct statewide assessment of health workforce shortage
- Assist LHDs, HCCs, HCOs, and Public Health in activating volunteer registries
- In coordination with community partners, assist HCCs and HCOs with the deployment management of volunteers during response and continuity operations
- Prepare Action Request Forms (ARF) to request assistance from ESF-8 lead
- Local/Regional Health Departments Essential Supporting Activities include:
- Conduct Local/Regional assessment of health workforce shortage
- Coordinate the assignment of public health agency volunteers to public health, medical, mental/behavioral health, and non-specialized tasks as directed by the incident
- Refer spontaneous volunteers not needed for public health response to other organizations in need of volunteers to close gaps in the healthcare workforce during continuity operations
- Disseminate volunteer management situation reports to state health authorities
- Healthcare Coalition Essential Supporting Activities include:
- Conduct healthcare workforce shortage assessment within coalition boundaries

- Coordinate with volunteer groups to supplement medical & non-medical personnel
- Disseminate reports of regional staffing shortages to local & state health authorities

Healthcare Organization Essential Supporting Activities include:

- Identify medical and nonmedical staffing shortages during response and continuity operations
- Recall additional staff incrementally to assist in disaster continuity operations
- Coordinate with contracted staffing agencies to increase availability of critical medical staff
- Integrate credentialed, licensed, independent practitioners into continuity medical operations
- Coordinate with volunteer groups to supplement medical & non-medical personnel
- Disseminate reports of HCO staffing shortages to local incident management & state health authorities

1.4.3 Community/Facility Critical Infrastructure (MEF)

Fully operational critical community/facility infrastructure including power, water, and sanitation etc.., to support patient care environments

State Health Authority Essential Supporting Activities include:

- Identify and assess situational reports on critical infrastructure disruption affecting healthcare sector
- Work to ensure healthcare sector, especially hospitals, are included on the priority restoration plan
- Coordinate with ESF-8 to request assistance from ESF-3 for Public Works and
- Engineering support
- Local/Regional Health Department Essential Supporting Activities include:
- Determine local/regional disruption of critical infrastructure that affects public health sector
- Collect reports on critical infrastructure disruption
- Disseminate reports to state health authorities
- Advocate for priority service resumption for public health facilities through continuity operations and recovery phase
- Healthcare Coalition Essential Supporting Activities include:
- Determine local/regional disruption of critical infrastructure that affects public health sector
- Collect reports on critical infrastructure disruption
- Disseminate reports to state health authorities
- Advocate for priority service resumption for public health facilities through continuity operations and recovery phase

Healthcare Organization Essential Supporting Activities include:

- Determine extent of disruption/loss/damage of facility critical infrastructure

a. Electrical System

b. Water System
c. Ventilation
d. Fire Protection System
e. Fuel Sources
f. Medical Gas & Vacuum Systems
g. Communication Infrastructure

- Prioritize restoration efforts to meet the operational goals of health care service delivery
- Disseminate reports of HCO critical infrastructure disruption/loss/damage to local emergency management and to state health authorities
- Advocate for priority service resumption directly to local incident management

1.4.4 Access to Healthcare Supply Chain (MEF)

Full access to the healthcare supply chain including medical & non-medical supplies, pharmaceuticals, blood products, industrial fuels, and medical gases etc.

State Health Authority Essential Supporting Activities include:

- Determine statewide disruption of healthcare supply chain
- Determine priority medical and non-medical supply items needed by public health and HCOs
- Activate and distribute equipment and pharmaceutical cache contents to public health departments and HCOs
- Coordinate with ESF-8 to request assistance from ESF-7 Logistics Management and Resource Support
- Local/Regional Health Departments Essential Supporting Activities include:
- Determine local/regional disruption of healthcare supply chain
- Determine priority medical and non-medical supply items needed by public health departments
- Allocate and distribute medical countermeasures and pharmaceutical cache contents to identified recipients
- Coordinate with SHA for supply requests
- Disseminate healthcare supply chain disruption Situation Reports (Sitreps) to SHA

Healthcare Coalition Essential Supporting Activities include:

- Determine regional disruption of healthcare supply chain
- Determine specific medical and non-medical supply needs of members
- Coordinate with local/regional state health departments to distribute cache contents to HCOs
- Coordinate with private sector vendors on distribution and resumption of normal supply delivery
- Disseminate healthcare supply chain disruption SitReps to SHA
- Healthcare Organization Essential Supporting Activities include:
- Determine estimated shortfalls identified during the continuity event of needed supplies for the HCO
- Prioritize medical and non-medical supply items needed by HCO through medical/surgical supply formularies

- Redirect supplies already within the hospitals supply chain to areas first impacted
- Activate pre-event supply orders with vendors
- Coordinate with SHA for supply requests
- Disseminate HCO supply chain disruption Sitreps to SHA

1.4.5 Access to Medical/Non-Medical Transportation System (MEF)

Fully functional medical & non-medical transportation system that can meet the operational needs of the healthcare sector during the response & continuity phases of an event

State Health Authority Essential Supporting Activities include:

- Determine statewide medical transportation needs during response and continuity operations
- Prioritize state medical transportation assets to service highly impacted areas first
- Prepare and disseminate Action Request Forms to request assistance with medical transportation from ESF-8
- Coordinate with HHS/ESF8 to activate National Federal Ambulance Contracts
- Local/Regional Health Departments Essential Supporting Activities include:
- Determine local/regional medical transportation needs for public health
- Prioritize local/regional health department medical transportation assets to service highly impacted areas first
- Coordinate with SHA to request medical transportation assets
- Healthcare Coalition Essential Supporting Activities include:
- Determine regional medical transportation needs during response and continuity operations
- Determine specific needs of member HCOs
- Coordinate with regional EMS/Air Ambulance Providers to close gaps in system transportation needs
- Advocate for coalition members for medical transportation assistance
- Healthcare Organization Essential Supporting Activities include:
- Determine additional medical/non-medical transportation needs to support response and continuity operations
- Identify an EMS Coordinator and a Transportation Coordinator to manage patient
- transport
- Coordinate with regional EMS/Air Ambulance Providers to close gaps in system transportation needs
- Provide transportation assistance to staff that may need transportation to facility
- Disseminate requests for transportation assistance to local emergency management and SHA

1.4.6 Healthcare Information Systems (MEF)

Fully functional information technology and communications infrastructure that support high availability of the healthcare sector's data management and information sharing capability.

State Health Authority Essential Supporting Activities include:

- Determine statewide disruption of communication/information technology capabilities
- Activate redundant communication capabilities if necessary
- Coordinate with service providers to restore communication/information technology capabilities
- Coordinate with local/regional health departments, HCCs, and HCOs to disseminate critical response and recovery information to the public
- Coordinate with ESF-2 through ESF-8 for restoration or repair of telecommunications
- infrastructure
- Local/Regional Health Departments Essential Supporting Activities include:
- Determine local/regional disruption of public health communication/information technology capabilities
- Activate redundant communication capabilities if necessary
- Coordinate with local emergency management to secure priority service restoration to communication/information technology capabilities
- Coordinate with state health authorities to disseminate critical response and continuity operations information
- Healthcare Coalition Essential Supporting Activities include:
- Determine extent of disruption of communication/information technology capabilities within coalition boundaries
- Activate redundant communication capabilities if necessary
- Coordinate with local/state emergency management to secure priority service restoration to communication/information technology capabilities
- Coordinate with state health authorities to disseminate critical response and continuity operations information
- Healthcare Organization Essential Supporting Activities include:
- Determine extent of disruption of communication/information technology capabilities at facilities
- Activate redundant communication capabilities if necessary
- Coordinate with local/state emergency management to secure priority service restoration to communication/information technology capabilities
- Coordinate with state health authorities to disseminate critical response and continuity
- operations information

1.4.7 Healthcare Administration/Finance (MEF)

Fully operational administrative and financial capability including maintaining & updating patient records, adapting to disaster recovery program requirements, payroll continuity, supply chain financing, claims submission, and losses covered by insurance and legal issues.

State Health Authority Essential Supporting Activities include:

- Collect disaster response data to be used in After-Action Reports
- Monitor statewide patient movement and update patient records
- Modify state health program requirements as dictated by authorizing entities
- Keep track of disaster related expenditures
- Request disaster assistance from federal agencies
- Provide disaster assistance to regions and localities
- Monitor employee/contractor payroll systems

Local/Regional Health Departments Essential Supporting Activities include:

- Collect disaster response data to be used in After-Action Reports
- Monitor patient movement and update patient records
- Keep up with changing health program requirements and make modifications when directed by authorizing entity
- Monitor costs relating to supply chain management and acquisition
- Keep track of overall disaster related expenditures
- Monitor employee/contractor payroll systems

Healthcare Coalition Essential Supporting Activities include:

- Collect disaster response data to be used in After-Action Reports
- Keep coalition members informed on changing program requirements
- Keep coalition members informed about any available disaster assistance from federal, state and local authorities
- Healthcare Organization Essential Supporting Activities include:
- Collect disaster response data to be used in After-Action Reports
- Modify and maintain healthcare information management practices according to changing program requirements directed by authorizing entities
- Coordinate the use of paper systems to track patients, health issues and other critical
- data in the event electronic systems are compromised
- Explore possible sources of disaster assistance that may be available to an organization; request assistance when appropriate
- Monitor employee/contractor payment systems; implement alternative payment systems if available
- Activate disaster recovery contracts
- Initiate “disaster orders” to increase supply chain availability
- Monitor and adjust claims submission conditions according to changing federal & state requirements
- Monitor, document, and address legal issues
- Monitor document losses for the preparation of insurance claims

1.6 Hospital Mission Essential Functions

- Emergency Services (Emergency Department)
- Surgical Services (Operating Room)
- Laboratory Services (Lab)
- Health Information Management (HIM)
- Patient Care Unit (PCU)

- Central Supply (CS)
- Human Resources (HR)
- Obstetrics
- Pharmacy Services
- Public Relations
- Food Services
- Security
- Laundry
- Radiology
- Patient Access/Financial Services

1.7 Continuity Plan Operational Phases & Implementation

Kaweah Health continuity implementation process includes the following four phases:

Readiness & Preparedness:

- Develop Continuity of Operations Program (COOP)
- Review COOP Plans annually
- Facilitate COOP drills and exercises that activate plans in coordination with regional, state and federal plans
- Revise COOP plans accordingly

Activation:

- Utilizing state and regional information sharing platforms, initiate an alert and notification to all partners executing the transition from immediate emergency response to COOP activation
- Establish appropriate liaisons between LHD/HCC/HCO and state health disaster response and recovery officials
- Provide situational updates to response partners, state health authorities, and local/regional emergency management through information sharing platforms when applicable
- If the event disrupts the availability of response leadership to assist response partners in activating continuity operations procedures, delegation of authority and devolution options will be instituted to ensure continuation of essential functions

Continuity Operations:

- Prioritize COOP activities to focus on rapid resumption of Mission Essential Functions (MEF) and Essential Supporting Activities (ESA)
- Develop a Common Operating Picture (COP) to assess and inform key stakeholders of status
- Communicate needs to state health authorities and local emergency management officials to establish priority resumption of critical services
- Inform response partners of available Federal/State/Local resources and the process to access needed infrastructure, supplies, transportation, and human capital

- Assist response partners in preparing a reconstitution strategy when transitioning from immediate response activity through continuity operations to the recovery phase of the event

Reconstitution:

- Assist response partners in implementing reconstitution operations
- Collect situational assessment data from response partners who are reconstituting healthcare operations and provide updates to State Health Authorities and Local/County/State Emergency Management and Recovery personnel
- Partner through the SHA with State Emergency Management, applicable Federal
- Essential Support Functions (ESF), and Federal Recovery Support Functions (RSF) to ensure a timely and smooth transition of HCOs to:
    1. Re-Enter Healthcare Facilities
    2. Re-Open Healthcare Facilities
    3. Re-Patriation of Patients
    4. Resumption of Normal Healthcare Service Delivery

2 **Healthcare Disaster Recovery**

2.1 Purpose

To establish pre-incident disaster recovery planning and post-incident disaster recovery roles and responsibilities in accordance with the concepts and principles recommended from the National Disaster Recovery Framework (NDRF). Additional guidance was incorporated from the National Guidance for Healthcare System Preparedness, Healthcare System Recovery Capability, and the Public Health Preparedness, Community Recovery Capability.

2.2 Post-Incident Disaster Recovery Roles & Responsibilities

State Health Authority Disaster Recovery Roles/Responsibilities include

- Establish communication with State Disaster Recovery Manager
- Advocate for priority restoration of health care service delivery
- Maintain volunteer management systems; demobilize volunteer personnel according to demobilization plans
- Advocate for priority restoration of healthcare sector critical infrastructure
- Maintain and replenish state-owned healthcare supply caches
- Determine demobilization procedures for transportation assets
- Advocate for restoration of healthcare sector information technology and communication networks
- Prepare After-Action Reports, Corrective Action and Improvement Plans

Local/Regional Health Department Disaster Recovery Roles/Responsibilities include:

- Establish communication with the SHA Disaster Recovery POC

- Through established communication networks educate constituents regarding applicable health interventions being recommended by public health
- In conjunction with local response partners, inform the community of the availability of
- any disaster or community case management services being offered that provide assistance for community members impacted by the incident
- Maintain public health service delivery with an emphasis on patients with special medical
- needs, at-risk populations, and individuals with functional needs
- Maintain local volunteer deployment; demobilize personnel according to demobilization plan
- Work with local, state, and federal partners to ensure timely reconstruction of public health related critical infrastructure
- Maintain and replenish local public health supply caches
- Activate demobilization procedures for public health transportation assets
- Work with local emergency management and service providers to ensure full restoration of public health information technology and communication networks
- Prepare After-Action Reports, Corrective Action and Improvement Plans

Healthcare Coalition Disaster Recovery Roles/Responsibilities include:

- Advocate for full heath care service delivery restoration for member facilities and organizations within coalition boundaries
- Continue to interface with volunteer groups and staffing agencies to monitor and assess the needs of member organizations to supplement their workforce during the recovery phase
- Advocate for members to receive priority critical infrastructure restoration and reconstruction
- Replenish and demobilize regional supply caches maintained by the coalition
- Activate demobilization procedures for any transportation assets maintained by the coalition
- Advocate for full restoration information technology and communication systems for coalition members
- Prepare After-Action Reports, Corrective Action and Improvement Plans
- Healthcare Organization Disaster Recovery Roles/Responsibilities include:
- Prioritize health care service delivery recovery objectives by organizational essential functions
- Maintain, modify, and demobilize healthcare workforce according to the needs of the facility
- Work with local emergency management, service providers, and contractors to ensure priority restoration and reconstruction of critical building systems
- Maintain and replenish pre-incident levels of medical and non-medical supplies
- Work with local, regional, and state Emergency Medical System providers, patient transportation providers, and non-medical transportation providers to restore pre-incident transportation capability and capacity

- Work with local emergency management, service providers, and contractors to restore information technology and communications systems
- Prepare After-Action Reports, Corrective Action and Improvement Plan

Appendix B: Financial Sustainability

B.1 Federal Disaster Declaration

Robert T. Stafford Disaster Relief and Emergency Assistance Act

At the request of the Governor of an affected State, or a Chief Executive of an affected Indian Tribe, the President may declare a major disaster or emergency if an event is beyond the combined response capabilities of the State, Tribal, and jurisdictional governments. Among other things, this declaration allows Federal assistance to be mobilized and directed in support of State, Tribal, and jurisdictional response efforts. Under the Stafford Act, the President can also declare an emergency without a Gubernatorial request if primary responsibility for response rests with the Federal Government because the emergency involves a subject area for which the United States exercises exclusive responsibility and authority. In addition, in the absence of a specific request, the President may provide accelerated Federal assistance and Federal support where necessary to save lives, prevent human suffering, or mitigate severe damage, and notify the State of that activity.
FEMA administers disaster relief funding allowed under the Stafford Act. Reimbursement eligibility rules apply for certain aspects of emergency medical care including:

- Treatment and monitoring of disaster victims requiring medical care
- Vaccinations for disaster victims, emergency workers and medical staff
- Only private nonprofit healthcare facilities may directly apply for FEMA assistance grants
- For-Profit entities may be indirectly eligible through established mutual aid agreements, emergency operations plans or memorandums of understanding with other nonprofit entities
- FEMA’s role as “payer of last resort” requires individuals, as well as entities like hospitals and other medical facilities, to exhaust all other forms of insurance and reimbursement before seeking assistance FEMA

B.2 Hospital Reimbursement Issues

The Healthcare Coalition should pre-identify all member HCOs within the coalition boundaries that may be eligible for FEMA reimbursement under the Stafford Act. Special attention should be focused and explored on potential indirect reimbursement to other member HCO’s who are afforded eligibility through coalition agreements.

B.2.1 FEMA Reimbursement for Acute Care Hospitals

A Quick Guide: FEMA Reimbursement for Acute Care Hospitals provides an overview of FEMA’s reimbursement process and outlines the tasks and corresponding timelines

that must be met by acute care hospitals to successfully apply to FEMA for reimbursement of disaster related expenses incurred as a result of the event.

A copy of the guide can be downloaded here:
http://www.ynhhs.org/emergency/pdfs/FEMA-ACH_ReimbursementGuide.pdf
FEMA Disaster Assistance Policy: Emergency Medical Care and Medical Evacuations
http://www.fema.gov/pdf/government/grant/pa/9525_4.pdf

B.3 Pandemic Influenza & Reimbursement

In March 2007, FEMA issued a new Disaster Assistance Policy (DAP) that establishes the types of "emergency protective measures that are eligible under the Public Assistance Program during a Federal response to an outbreak of human influenza pandemic in the U.S. and its territories." The Pandemic DAP may cover additional reimbursement costs related to the management, control, and reduction of immediate threats to public health and safety. Specific health and social service expenditures that may be reimbursable include:

- Purchase and distribution of food, water, ice, medicine, and other consumable supplies
- The movement of supplies and personnel
- Emergency medical care in a shelter or temporary medical facility
- Temporary medical facilities when existing facilities are overloaded
- Sheltering for safe refuge of patients when existing facilities are overloaded
- Communicating health and safety information to the public
- Storage and internment of unidentified human remains
- Mass mortuary services

A copy of the FEMA Human Influenza Pandemic DAP can be downloaded here:
http://www.fema.gov/pdf/government/grant/pa/9523_17.pdf
Payment for care at Hospital Alternate Care Sites:
http://www.cms.gov/About-CMS/Agency-Information/H1N1/downloads/AlternativeCareSiteFactSheet.pdf

B.4 Waiver of Federal Laws & Program Requirements

Public Health Service Act
The Public Health Service (PHS)Act forms the foundation of HHS' legal authority for responding to public health emergencies. Among other things, it authorizes the HHS Secretary to lead all Federal public health and medical response to public health emergencies and incidents covered by the National Response Framework; to direct the U.S. PHS and other components of the Department to respond to a public health emergency; to declare a public health emergency (PHE) and take such actions as may be appropriate to respond to the PHE consistent with existing authorities; to assist states in meeting health emergencies; to control communicable diseases; to maintain the Strategic National Stockpile; to provide for the operation of the National Disaster

Medical System; to establish and maintain a Medical Reserve Corps; and to potentially provide targeted immunity for covered countermeasures to manufacturers, distributors, certain classes of people involved in the administration of a program to deliver covered treatments to patients, and their employees. The PHS Act was amended by the Pandemic and All-Hazards Preparedness Act of 2006 (PAHPA) and more recently by the Pandemic and All-Hazards Preparedness Reauthorization Act (PAHPRA) of 2013, which have broad implications for the Department's preparedness and response activities.

B.5 Medicare/Medicaid Waivers in Disasters

Section 1135 Waiver (See DM 2227)
The Social Security Act authorizes Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and social services programs of the Department. It authorizes the Secretary, among other things, to temporarily modify or waive certain Medicare, Medicaid, CHIP, and HIPAA requirements when the Secretary has declared a public health emergency and the President has declared an emergency or a major disaster under the Stafford Act, or a national emergency under the National Emergencies Act.
Sanctions may be waived under Section 1135 for the following requirements:

- Conditions of Participation
- Licensure Requirements
- EMTALA
- Physician Self-referrals
- HIPAA Regulations
- Out-of-network payments

Examples of requirements waived/modified under section 1135 waivers:

- Hospitals - recordkeeping requirements, certification for organ transplants
- Inpatient beds - modifications to expand the number of beds
- Critical Access Hospitals - waiver of classification requirements for critical access hospitals, inpatient rehabilitation facilities, long term care facilities, and psychiatric units
- EMTALA sanctions - waiving EMTALA sanctions for transferring patients to other facilities for assessment if the original facility is in the area where a public health emergency has been declared (other provisions of EMTALA remain in full effect)

EMTALA Medical Treatment and Labor Act (EMTALA) Requirements and Options for Hospitals in a Disaster:
http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter09_52.pdf

- HIPAA - waiving certain HIPPA privacy requirements so that healthcare providers can talk to family members (other provisions of HIPAA remain in full effect)

Information on requesting a Section 1135 waiver:
http://www.cms.gov/About-CMS/Agency-Information/H1N1/downloads/requestingawaiver101.pdf

Section 1115 Medicaid Waivers
Section 1115 authorizes the HHS Secretary to conduct demonstration projects that further the goals of Medicaid, Medicare and CHIP. This waiver has been used to ease some of the statutory requirements during a disaster for persons eligible for Medicaid, Medicare and CHIP.
The CMS template for the Section 1115 disaster waiver program noted the following "Standard Features" regarding healthcare provider reimbursement issues:
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section- 1115-Demonstrations.html

B.6 Claims Submission during a Disaster

The coalition and its member HCOs may experience operational circumstances that may impede their ability to meet many of the Medicare requirements, including conditions of participation, certification, and proper claims submission procedures. The coalition will assist its member HCOs in meeting federal and state requirements through the following methods:

- Monitor and report regional staffing issues that may affect claims submission
- Alert state and federal authorities on medical surge conditions that may overwhelm the healthcare system and create a backlog of claims submissions for both Medicaid/Medicare and private payer submissions
- Monitor and document volunteer and out-of-state personnel who are working with HCO's in the region to assess if they will impact the hospitals ability to be reimbursed by Medicare
- Monitor the impact of any declaration of Crisis Standards of Care in the region as it relates to claims submission and reimbursement
- Monitor and report issues relating to the HCO's ability to maintain records, submit electronic claims, and process checks to pay employees, contractors, and vendors.

B.7 Accelerated Payment/Advanced Payment from Medicare

The Medicare accelerated payment provisions all Part A healthcare providers to receive payment after services have been provided but before the healthcare provider submits a claim to CMS.
There are three situations that may justify accelerated payment:

1. A delay in payment from the Fiscal Intermediary (FI) for covered services rendered to beneficiaries whereby the delay causes financial difficulties for the healthcare provider;
2. Highly exceptional situations where a healthcare provider has incurred a temporary delay in its bill processing beyond the healthcare providers normal billing cycle; or
3. Highly exceptional situations where CHS deems an accelerated payment is appropriate.

Medicare Financial Management Manual: Chapter 3 Page 64 Section 150 Accelerated Payments

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/fin106c03.pdf

B.8 Insurance Strategies for Disaster Recovery

The healthcare coalition will engage its members' executive leadership, finance department officials, legal counsel, and emergency preparedness coordinators in discussions, seminars, and workshops to present hazard and risk assessments prepared in the region to assist member organizations in maintaining relevant insurance products to protect against losses from a disaster.

Topics should cover:

- Consequences of closure by government order
- Cancellation of services due to a lack of staff
- Activation of Crisis Standards of Care plans
- Lack of reimbursement for services provided
- Loss of power, water or communication
- Disruption of electronic payment system
- Disruption/failure of healthcare supply chain

B.8.1 Types of Insurance for Contingencies

Business Interruption Insurance: compensates the HCO for lost income if the HCO has to vacate the premises due to disaster related damage that is covered under its property insurance policy. Policies typically cover profits the HCO would have earned based on financial records had the disaster not occurred. The policy will cover operating expenses that are continuous through the disaster event.

Civil Authority Insurance (CAI): is an extension of business interruption coverage, and compensates an HCO for lost income and additional expenses arising out of suspension of the insured's operations necessitated by an order of civil authority ("closure order") which prevents access to the insured's property.

Ingress/Egress Insurance: similar to CAI coverage except that closure order from a civil authority is not necessary. To trigger coverage, many ingress/egress polices require, because of the damage to the property, that the property be completely inaccessible.

Contingent or Dependent Business Interruption Insurance: protects the earnings of the insured following physical loss or damage to the property of the insured's suppliers or customers, as opposed to its own property.

Dependent property is frequently defined as "property operated by others upon whom you depend to:

1. Deliver materials or services to you or to others for your account (not including utilities)
2. Accept your products or services
3. Manufacture products for delivery to your customers under contact for sale
4. Attract customers to your business"

Accounts Receivable Insurance: protects HCOs against their inability to collect their accounts receivable because of the loss of supporting records that have been destroyed by a covered-cost cause of loss. This type of insurance also covers "the extra collection

expenses that are incurred because of such loss or damage and other reasonable expenses incurred to re- establish records of accounts receivable after loss or damage."

If you have suffered substantial economic injury and are one of the following types of businesses located in a declared disaster area, you may be eligible for an SBA Economic Injury Disaster Loan (EIDL):

- Small business
- Small agricultural cooperative
- Most private nonprofit organizations

Loan Amounts and Use

Substantial economic injury means the business is unable to meet its obligations and to pay its ordinary and necessary operating expenses. EIDLs provide the necessary working capital to help small businesses survive until normal operations resume after a disaster.
The SBA can provide up to $2 million to help meet financial obligations and operating expenses that could have been met had the disaster not occurred. Your loan amount will be based on your actual economic injury and your company's financial needs, regardless of whether the business suffered any property damage.
Eligibility and Terms
The interest rate on EIDLs will not exceed 4 percent per year. The term of these loans will not exceed 30 years. The repayment term will be determined by your ability to repay the loan.
EIDL assistance is available only to small businesses when SBA determines they are unable to obtain credit elsewhere.
A business may qualify for both an EIDL and a physical disaster loan. The maximum combined loan amount is $2 million.
SBA Disaster Loan Application
https://disasterloan.sba.gov/ela/
SBA Disaster Loan Fact Sheets for Businesses of all Sizes

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."

One Time Exception

Kaweah Health

To: Medical Executive Committee

From: Shannon Vinson
Director, Medical Staff Services

Date: August 19, 2025

Re: Request for Special Exception to the Use of Outside Proctor Policy/Process

---

Background

A Vascular Surgeon expressed interest in offering an additional therapy option to treat patients with long complex Superficial Femoral Artery (SFA) disease. The DETOUR System (DETOUR) is a fully Percutaneous Transmural Arterial Bypass (PTAB) type of therapy. Under fluoroscopic guidance, DETOUR creates a femoropopliteal bypass routed through the femoral vein, delivering unobstructed flow from the superficial femoral artery (SFA) to the popliteal artery.

The vascular surgeon successfully completed a DETOUR training program consisting of didactic training and hands-on device procedure instruction. DETOUR was reviewed by the Value Analysis Committee (VAC) and received approval for two (2) procedures to help determine if this service can be fully supported by Kaweah Health. A new privilege was created and received required approvals from the medical staff and the Board.

All Practitioners must demonstrate competence for all new or additional clinical privileges/services. This is commonly known as *proctoring.* In most cases the Proctor is a member of good standing of our Active Medical Staff who has similar unrestricted privileges to those being proctored. There are instances where we may not have someone on staff that meets this requirement. This typically happens when the newly added privilege/service is a new device or technology, and we may need to use an external proctor. When this occurs, we follow the guidance of our **Use of Outside Proctors** policy.

The current version of the policy states:

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

This current policy does not allow for the use of a non-physician outside proctor and is a barrier to the surgeon being given an opportunity to demonstrate competence.

Kaweah Health

Request
The MEC is being asked to make a one-time exception to the requirement for the outside proctor to be a current member of the Active medical staff at a Joint Commission accredited acute care hospital where s/he currently holds privileges for the procedure s/he is proctoring.

The Medical Staff Office will make edits to the current policy to include verbiage such as:

> In cases of new technology or additional privileges for new technology, external proctors shall be certified as an External Proctor through an approved process.
>
> External Proctors, whether vendor sponsored or identified by other means, will be allowed to function **without patient contact** after having been appropriately authorized according to the approved process. This authorization will be processed administratively by the Medical Staff Services department.
>
> External Proctors who are not privileged through the medical staff process may serve as proctors in the following circumstances:
>
> - The privileged practitioner has a documented record of successfully performing the privilege via another approach; and
>
> - The privileged practitioner could reasonably expect to complete the procedure by an alternate approach without intervention by another practitioner.

Please note, the vascular surgeon identified the alternate approach as traditional surgical bypass and reasonably expects to be able to complete the alternate approach without intervention if necessary.

This special request, if approved, will help avoid cancelling a procedure already scheduled for Friday, August 22, 2025.

Tally of the MEC votes regarding the request for a one-time exception to the Use of Outside Proctors Policy.

Date/Time	VOTE	NAME
8/20/25 14:59:22	APPROVE.	Omar Guzman
8/20/25 15:19:14	APPROVE.	daniel Hightower MD
8/20/25 15:21:16	APPROVE.	Glade Roper
8/20/25 15:48:19	APPROVE.	Abdolreza Saadabadi
8/20/25 15:53:51	APPROVE.	Michael Tedaldi
8/20/25 16:02:56	APPROVE.	Khoa Tu
8/20/25 16:07:05	APPROVE.	Julianne Randolph
8/20/25 16:23:03	APPROVE.	Richard Pantera, MD
8/20/25 20:52:25	APPROVE.	Atul Singla
8/21/25 1:27:03	APPROVE.	Emanuele Maccalli
8/21/25 8:43:01	APPROVE.	Stephen C. Zerlang DO
8/21/25 10:07:28	APPROVE.	Onsy said

Semi Annual Investment Report

KAWEAH DELTA HEALTH CARE DISTRICT
FINANCE DIVISION MEMORANDUM

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

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

DATE: August 18, 2025

SUBJECT: **Semi-annual Investment Report – June 30, 2025**

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

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

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

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

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

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

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

General Deposit and Investment Policy

The District's current investment policy reflects strict compliance with the California Government Code (Code) sections 53600 through 53686 which govern the investment of surplus funds by governmental entities of the State of California, including political subdivisions thereof**. At June 30, 2025, the District's investment portfolio complies with all provisions of this policy**.

Statement of Purpose Guidelines District Funds

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

Summary of Investment Funds

This document depicts the carrying value, equal to cost, of investments held at June 30, 2025 in each of the various funds established by the District. As indicated in this report, the District's total adjusted surplus funds at June 30, 2025 were $233.2 million. The following table depicts the District's adjusted surplus funds over the past four years; the number of days cash on hand, a measure of liquidity; and the District's average daily operating expenses (excluding depreciation expense), the denominator used in the calculation of the liquidity measure; and the percent increase in each year over the prior year:

	June 30, 2025	December 31, 2024	December 31, 2023	December 31, 2022
Adjusted Surplus Funds	$233,211,000	$178,008,000	$183,602,000	$201,873,000
Days Cash on Hand	95.1	74.6	83.5	83.4
Average Daily Operating Expenses (excluding depreciation expense)	$2,453,000	$2,385,000	$2,199,000	$2,420,000
Percent Increase in Daily Expenses	2.9%	8.5%	-9.1%	7.6%
Days Cash on Hand Benchmarks:				
Moody's "A" Rated Hospitals	188.4 Days			
Revenue Bond Covenants	90 Days			

As illustrated in the above table, as of June 30, 2025 the District's liquidity ratio (days cash on hand) exceeded the covenant amount required by the District's revenue bond indentures, which is reported and measured for covenant compliance as of fiscal year end (June 30). Total surplus funds experienced a 15.5% increase from December 31, 2022 to June 30, 2025, and the number of days cash on hand increased 14.0% from 2022. The primary reasons for the increase in total surplus funds and days cash on hand include the timing of reporting as of June 30 versus December 31 as many of our supplemental fund programs are paid during the last six months of the fiscal year.

Given the District's current average daily operating expense total of $2.5 million, achievement of the Moody's "A"-rated hospitals' days cash on hand benchmark of 188.4 would require approximately $228.8 million of additional cash resources.

The District's surplus funds investment portfolio is separated into two different categories including short-term funds and long-term funds. The District's short-term funds included investment in the Local Agency Investment Fund (LAIF) and California Asset Management Program (CAMP). The annual yields for LAIF and CAMP were 4.4 % and 4.8%, respectively, for the year ended June 30, 2025. The District's long-term portfolio is managed by PFM Asset Management (PFM) and Allspring (formerly Wells Capital Management). The twelve-month total return of the portfolio managed by PFM was 6.5%, net of fees, while the twelve-month total return of the portfolio managed by Allspring was 6.0%, net of fees. The benchmark was 6.4% for the period. The benchmark for the managed portfolios is a custom index including 70% of the Merrill Lynch 1-5 year US Treasury Index and 30% of the Merrill Lynch 1-5 year A-AAA Corporate Index. The benchmark does include security types that the District is not allowed to purchase and that because of their nature tend to carry higher yields. These include foreign issuers and private placement securities. As of June 30, 2025, the District's investment portfolio had a weighted average prospective yield of 3.7%. The District's targeted rate of return of 2.8% was used to project interest income in the District's Annual Budget for the fiscal year. Both the budgeted yield and the prospective yield exclude market value fluctuations that are included in the total return figures noted above.

Investment Summary by Institution
This document depicts the amount of District investments held by various financial institutions as of June 30, 2025. In each case, the financial institution may be the issuer of an investment security, the custodian of securities, or the investment advisor managing the securities.

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

Investment Summary of Surplus Funds by Maturity
This document depicts the amount of District funds maturing each year over the five-year investment time horizon permitted by the District's investment policy. The measurement period for each year commences on July 1 and runs to June 30. The purpose of this schedule is to assess the overall liquidity of the District's portfolio, which has a weighted average maturity of 2.28 years at June 30, 2025.

Investment Summary of Surplus Fund's Unrealized Gains and Losses
All investment summaries referenced above include the cost of investments and do not reflect current market values. This document depicts the status of securities with respect to unrealized gains and losses at June 30, 2025. The District measures and records an adjustment to reflect the current fair market value of its total investment portfolio each quarter. The unrealized gain on the District's surplus fund portfolio at June 30, 2025 was $494,000.

Kaweah Delta Health Care District
General Deposit and Investment Policy

Scope

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

Goals and Objectives

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

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

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

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

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

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

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

Safekeeping

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

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

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

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

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

Ethics and Conflicts of Interest

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

Delegation of Authority

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

Reporting

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

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

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

Deposits

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

Permitted Investments

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

Authorized investments are limited to the following:

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

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

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

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

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

(f) Commercial paper of prime quality of the highest ranking or of the highest letter and numerical rating as provided for by a nationally recognized statistical rating organization (NRSRO).. Eligible paper is further limited to issuing corporations organized and operating within the United States and having total assets exceeding five hundred million dollars ($500,000,000) and is rated in a rating category of ”A” or its equivalent or higher rating for the issuer's debt, other than commercial paper, if any, as provided for by an NRSRO. Purchases of eligible commercial paper may not exceed 270 days maturity nor represent more than 10 percent of the outstanding paper of an issuing corporation. Purchases of commercial paper may not exceed 25 percent of surplus funds.

(g) Negotiable certificates of deposit issued by a nationally or state-chartered bank, a savings association or a federal association, a state or federal credit union, or by a federally licensed or state-licensed branch of a foreign bank. For purposes of this section, negotiable certificates of deposit do not come within Article 2 (commencing with Section 53630), except that the amount so invested shall be subject to the limitations of Section 53638. The legislative body of a local agency

and the treasurer or other official of the local agency having legal custody of the moneys are prohibited from investing local agency funds, or funds in the custody of the local agency, in negotiable certificates of deposit issued by a state or federal credit union if a member of the legislative body of the local agency, or a person with investment decision making authority in the administrative office manager's office, budget office, auditor-controller's office, or treasurer's office of the local agency also serves on the board of directors, or any committee appointed by the board of directors, or the credit committee or the supervisory committee of the state or federal credit union issuing the negotiable certificates of deposit. Purchases of all types of certificates of deposit may not exceed 30 percent of surplus funds.

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

(i) Medium-term notes, defined as all corporate and depository institution debt securities with a maximum of five years maturity, issued by corporations organized and operating within the United States or by depository institutions licensed by the United States or any state and operating within the United States. Notes eligible for investment shall be rated in a rating category of "A" or its equivalent or better by an NRSRO. Purchases of medium-term notes may not exceed 30 percent of surplus funds.

(j) Any mortgage passthrough security, collateralized mortgage obligation, mortgage-backed or other pay-through bond, equipment lease-backed certificate, consumer receivable passthrough certificate, or consumer receivable-backed bond. Securities eligible for investment under this subdivision shall be rated in a rating category of "AA" or its equivalent or better by an NRSRO and have a maximum remaining maturity of five years or less. Purchases of collateralized mortgage obligations may not exceed 20 percent of surplus funds.

(k) Shares of beneficial interest issued by diversified management companies that invest in securities and obligations as authorized by section 53601 or that are money market funds registered with the Securities and Exchange Commission under the Investment Act of 1940, and that have attained the highest ranking or the highest letter and numerical rating provided by not less than two NRSROs.

Purchases of shares of beneficial interest may not exceed 20 percent of surplus funds, and no more than 10 percent of surplus funds may be invested in shares of beneficial interest of any one mutual fund.

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

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

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

(p) Shares of beneficial interest issued by a joint powers authority (JPA) organized pursuant to Section 6509.7 that invests in the securities and obligations authorized under Section 53601 subdivisions (a) to (q), inclusive. Each share shall represent an equal proportional interest in the underlying pool of securities owned by the JPA. The JPA issuing the shares shall have retained an investment adviser registered or exempt from registration with the Securities and Exchange Commission, with not less than five years of experience investing in the authorized securities, and having assets under management in excess of five hundred million dollars.

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

Policy Considerations

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

Kaweah Delta Health Care District
STATEMENT OF PURPOSE GUIDELINES
DISTRICT FUNDS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Kaweah Delta Health Care District
SUMMARY OF INVESTMENT FUNDS
6/30/25

	Investment Amount (Cost)		
		June 30, 2025	December 31, 2024
Trust Accounts			
Self-Insurance Trust Fund		$ 1,729,000	$ 1,715,000
2014 General Obligation Bond Fund		5,375,000	4,168,000
2015A Revenue Bond Fund		512,000	1,090,000
2015B Revenue Bond Fund		368,000	373,000
2017C Revenue Bond Fund		951,000	3,214,000
2020 Revenue Bond Fund		193,000	577,000
2022 Revenue Bond Fund		436,000	1,468,000
Master Debt Reserve Fund		22,949,000	22,811,000
Operating Accounts		6,227,000	14,016,000
Board Designated Funds			
Plant Fund			
Committed for Capital Expenditure	$23,436,000		
Uncommitted	153,436,000	176,872,000	120,715,000
General Obligation Bond Reserve		1,332,000	1,993,000
Cost Report Settlement Fund		3,448,000	3,448,000
Development Fund		104,000	104,000
Workers' Compensation Liability Fund		21,788,000	17,626,000
Total Board Designated Funds		203,544,000	143,886,000
Total Investments		**$ 242,284,000**	**$193,318,000**
Sequoia Regional Cancer Center Funds		**$5,000**	**$0**
Kaweah Health Hospital Foundation		**$19,735,000**	**$18,867,000**

Kaweah Delta Health Care District
SUMMARY OF INVESTMENT FUNDS
June 30, 2025

	June 30, 2025	December 31, 2024	December 31, 2023	December 31, 2022
Total Surplus Funds	**$209,770,000**	$157,902,000	$167,524,000	$189,125,000
Add: Kaweah Health Medical Group	**0**	0	242,000	2,011,000
Sequoia Regional Cancer Ctr.	**5,000**	0	5,000	2,000
KH Foundation	**19,735,000**	18,867,000	17,425,000	20,188,000
Adjustment to record fair market value (FMV)	**2,621,000**	549,000	(2,247,000)	(10,096,000)
Accrued Investment Earnings	**1,080,000**	690,000	653,000	643,000
Adjusted Surplus Funds	$233,211,000	$178,008,000	$183,602,000	$201,873,000
Daily Operating Expenses (excluding depreciation expense)	**$2,453,000**	$2,385,000	$2,199,000	$2,420,000
Percent Increase	**2.9%**	8.5%	-9.1%	7.6%
Days Cash on Hand (Actual - consolidated financial statements)	**95.1**	74.6	83.5	83.4
Benchmark:				
Moody's "A" Rated Hospitals (2023)	**188.4**			
Cash spread to "A" rating	**$228,797,000**			
Surplus portfolio return (includes FMV adjustment) :				
12-Months Ended :				
LAIF	**4.41%**	4.38%	3.93%	1.06%
CAMP	**4.81%**	5.31%	5.50%	1.80%
Total Return:				
Long-Term (PFM - net of fees)	**6.48%**	4.13%	5.16%	-4.99%
Long-Term (Allspring - net of fees)	**6.04%**	4.78%	4.25%	-5.13%
Benchmark (70% ML 1-5 Treasury, 30% ML US Corp A-AAA)	**6.37%**	3.83%	4.78%	-5.37%
Prospective Yield of Portfolio (No FMV)	**3.72%**	3.45%	2.65%	1.50%
Fiscal Year Budget (No FMV)	**2.82%**	2.82%	1.65%	0.92%

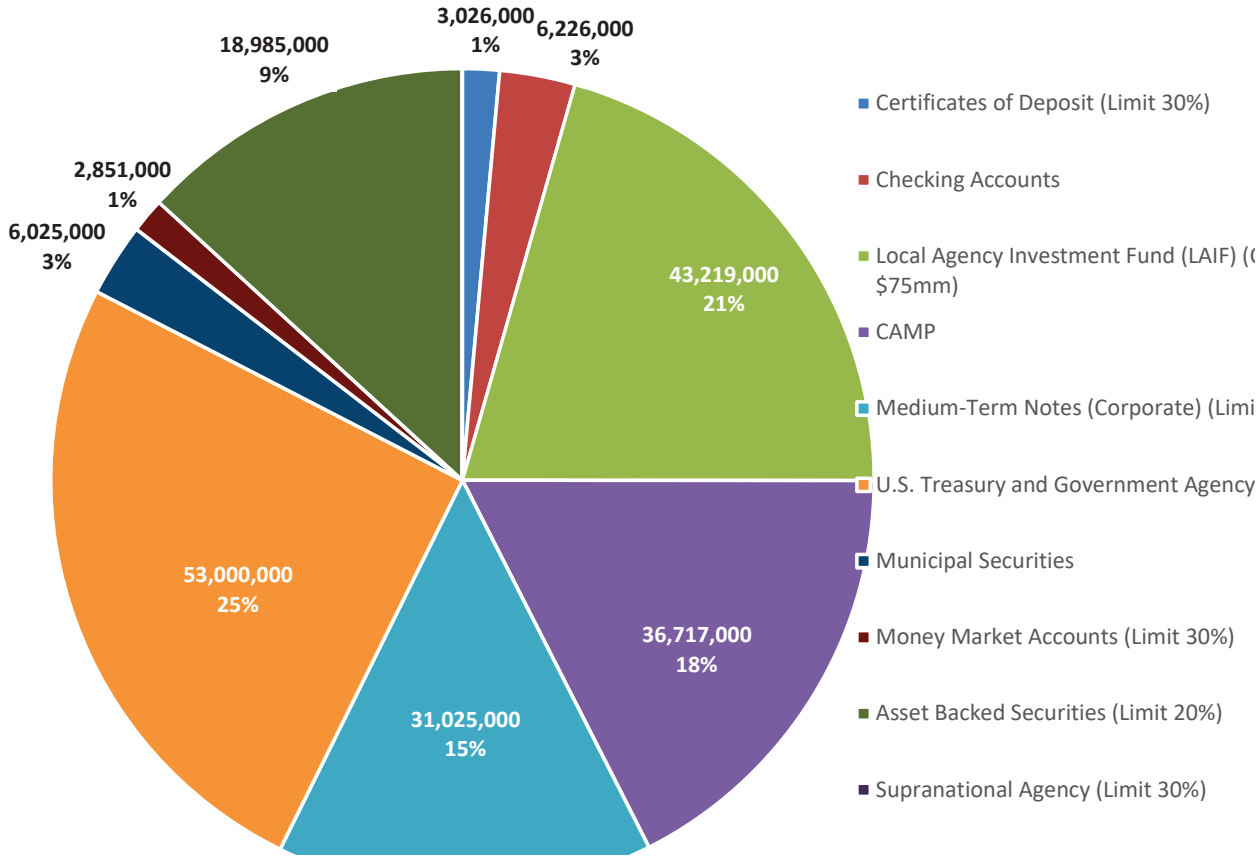
Note: All investment balances included in the attached investment summaries are stated at the cost value and do not reflect current fair market values. Please refer to the Investment Summary of Unrealized Gains and Losses for current market values.

Kaweah Delta Health Care District
INVESTMENT SUMMARY BY INSTITUTION
June 30, 2025

	Investment Amount (Cost)	
	June 30, 2025	December 31, 2024
US Bank (Bond Trustee)	$ 25,411,000	$ 29,533,000
Local Agency Investment Fund (LAIF)	43,219,000	9,773,000
PFM Asset Management (Manager) - US Bank Custodian	59,477,000	58,803,000
Allspring (Manager) - US Bank Custodian	60,974,000	57,459,000
Allspring (SITF)	1,729,000	1,715,000
CAMP (Managed by PFM)	42,092,000	17,303,000
Western Alliance (CD Placement GO Refinance)	3,156,000	3,000,000
Wells Fargo Bank (Operating accounts)	6,227,000	15,732,000
Total Investments	**242,285,000**	193,318,000
Less Trust Accounts	(32,515,000)	(35,416,000)
Total Surplus Funds	**$209,770,000**	$157,902,000
Kaweah Health Medical Group		
Wells Fargo Bank	**$0**	**$0**
Sequoia Regional Cancer Center		
Wells Fargo Bank	**$5,000**	**$0**
Kaweah Health Hospital Foundation		
Community West Bank	$343,000	$361,000
Various Short-Term and Long-Term Investments	19,392,000	18,506,000
	$19,735,000	**$18,867,000**

Kaweah Delta Health Care District
INVESTMENT SUMMARY OF SURPLUS FUNDS BY TYPE
June 30, 2025

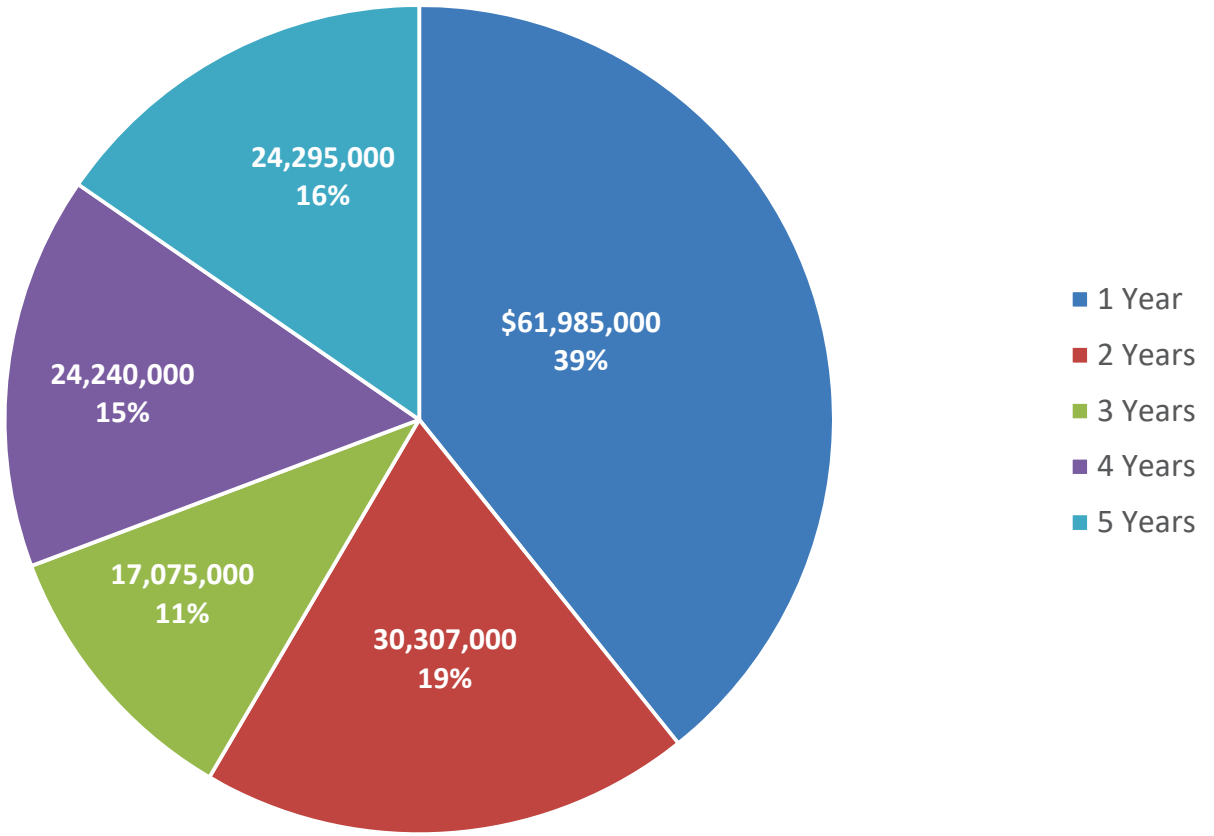
	Investment Amount (Cost)	%	$ or % Limit
Certificates of Deposit	$3,026,000	1.4%	30.0%
Checking Accounts	6,226,000	3.0%	
Local Agency Investment Fund (LAIF)	43,219,000	20.6%	$75 mm
CAMP	36,717,000	17.5%	
Medium-Term Notes (Corporate)	31,025,000	14.8%	30.0%
U.S. Treasury and Government Agency	53,000,000	25.3%	
Municipal Securities	6,025,000	2.9%	
Money Market Accounts	2,851,000	1.4%	20.0%
Commercial Paper	0	0.0%	25.0%
Asset Backed Securities	27,681,000	13.2%	20.0%
Supranational Agency	0	0.0%	30.0%
Total Surplus Funds	**$209,770,000**	**100.0%**	



Kaweah Delta Health Care District
INVESTMENT SUMMARY OF SURPLUS FUNDS BY MATURITY
June 30, 2025

	Investment Amount (Cost)	%
1 Year	$108,571,000	51.8%
2 Years	19,264,000	9.2%
3 Years	23,446,000	11.1%
4 Years	31,474,000	15.0%
5 Years	27,015,000	12.9%
Total Surplus Fund Investments	**$ 209,770,000**	100.0%

Weighted Average Maturity	**2.28 Years**



Kaweah Delta Health Care District
INVESTMENT SUMMARY OF SURPLUS FUND'S UNREALIZED GAINS AND LOSSES
June 30, 2025

Description	Maturity	Par Value	Amort Cost	Market Value	Unrealized Gain (Loss)
Medium-Term Notes (Corporate):					
PROCTER GAMBLE CO	10/29/2025	1,300,000	1,299,862	1,284,244	(15,618)
BANK OF AMERICA MTN	04/19/2026	295,000	298,061	292,959	(5,103)
MORGAN STANLEY BK	04/21/2026	1,000,000	996,758	1,002,820	6,062
IBM CORP	05/15/2026	410,000	417,651	406,158	(11,492)
ASTRAZENECA L P	05/28/2026	265,000	265,069	257,948	(7,120)
TOYOTA MTR CR MTN	06/18/2026	1,400,000	1,399,371	1,358,756	(40,615)
AMERICAN HONDA MTN	07/07/2026	145,000	144,940	146,218	1,278
COOPERATIEVE C D	07/17/2026	400,000	400,000	405,560	5,560
CATERPILLAR FINL MTN	09/14/2026	220,000	219,189	212,533	(6,655)
NATIXIS NY C D	09/18/2026	405,000	405,000	412,156	7,156
AMERICAN EXPRESS CO	11/04/2026	445,000	444,799	430,417	(14,382)
NATIONAL RURAL MTN	11/13/2026	160,000	159,976	162,690	2,714
CITIBANK N A SR NT	12/04/2026	1,000,000	1,003,870	1,015,840	11,970
TARGET CORP	01/15/2027	900,000	899,526	871,740	(27,786)
CISCO SYS INC	02/26/2027	260,000	259,817	263,154	3,337
STATE STR CORP SR	03/18/2027	335,000	335,000	339,847	4,847
HORMEL FOODS CORP	03/30/2027	115,000	114,938	116,172	1,234
HOME DEPOT INC SR NT	04/15/2027	220,000	216,759	214,139	(2,620)
PACCAR FIN MTN	05/13/2027	95,000	94,954	96,644	1,689
UNITEDHEALTH GROUP	05/15/2027	85,000	84,983	84,226	(757)
GOLDMAN SACHS BK	05/21/2027	1,100,000	1,106,949	1,109,075	2,126
GOLDMAN SACHS BK	05/21/2027	220,000	220,000	221,815	1,815
BLACKROCK FUNDING	07/26/2027	185,000	184,996	187,259	2,263
PACCAR FINANCIAL MTN	08/06/2027	900,000	898,167	910,404	12,237
BANK AMERICA CORP	09/15/2027	1,100,000	1,122,076	1,119,206	(2,870)
TOYOTA MTR MTN	10/08/2027	130,000	129,962	130,540	578
STATE STR CORP SR	10/22/2027	1,000,000	995,018	1,005,090	10,072
CATERPILLAR MTN	11/15/2027	1,000,000	999,319	1,011,980	12,661
BP CAP MKTS AMER INC	11/17/2027	310,000	310,000	315,654	5,654
MASTERCARD	01/15/2028	130,000	129,946	130,572	626
WELLS FARGO MTN	01/24/2028	145,000	145,000	146,050	1,050
BANK NY MELLON MTN	02/07/2028	300,000	293,797	296,628	2,831
ELI LILLY CO SR	02/12/2028	300,000	299,833	303,954	4,121
CISCO SYS INC	02/24/2028	70,000	69,933	70,925	992
HERSHEY CO	02/24/2028	80,000	79,951	81,012	1,061
CHEVRON USA INC	02/26/2028	340,000	340,000	344,056	4,056
JOHNSON JOHNSON SR	03/01/2028	80,000	79,959	81,355	1,396
JPMORGAN CHASE	04/22/2028	1,100,000	1,102,896	1,122,572	19,676
GOLDMAN SACHS	04/23/2028	155,000	155,000	156,207	1,207
CUMMINS INC	05/09/2028	20,000	19,987	20,091	104
MORGAN STANLEY	05/26/2028	280,000	280,221	285,914	5,693
TARGET CORP	06/15/2028	365,000	366,750	367,194	444
JOHN DEERE MTN	07/14/2028	700,000	709,713	717,178	7,465
JOHN DEERE MTN	07/14/2028	120,000	119,891	122,945	3,053
CITIBANK N A SR	09/29/2028	535,000	535,000	559,380	24,380
BANK NEW YORK MTN	10/25/2028	1,000,000	1,013,823	1,035,440	21,617
MORGAN STANLEY BK	01/12/2029	250,000	250,000	253,888	3,888
JPMORGAN CHASE CO	01/24/2029	140,000	140,000	141,880	1,880
PACCAR FINANCIAL MTN	01/31/2029	160,000	159,813	162,189	2,376
AIR PRODUCTS	02/08/2029	295,000	294,718	299,233	4,515
TEXAS INSTRS INC	02/08/2029	370,000	369,718	376,227	6,509
CUMMINS INC	02/20/2029	195,000	195,367	199,391	4,024
BRISTOL MYERS SQUIBB	02/22/2029	200,000	199,695	204,770	5,075
ASTRAZENECA FINANCE	02/26/2029	165,000	164,874	168,736	3,862
CISCO SYS INC	02/26/2029	225,000	224,943	230,576	5,633
BLACKROCK FUNDING	03/14/2029	270,000	270,019	275,713	5,694
ADOBE INC SR GLBL	04/04/2029	225,000	224,749	230,654	5,905
WELLS FARGO MTN	04/23/2029	205,000	205,000	207,868	2,868
AMERICAN EXPRESS CO	04/25/2029	245,000	245,000	247,786	2,786
BANK AMERICA MTN	05/09/2029	290,000	290,000	291,842	1,842
NATIONAL RURAL MTN	06/15/2029	850,000	859,871	874,863	14,991
HOME DEPOT INC	06/25/2029	500,000	497,441	510,365	12,924
HOME DEPOT INC	06/25/2029	95,000	94,514	96,969	2,456
PEPSICO INC SR	07/17/2029	280,000	279,650	284,463	4,813
TOYOTA MTR CR MTN	08/09/2029	195,000	194,880	196,564	1,684
ELI LILLY CO	08/14/2029	65,000	64,883	65,231	348
NOVARTIS CAPITAL	09/18/2029	365,000	364,252	361,905	(2,347)

Kaweah Delta Health Care District
INVESTMENT SUMMARY OF SURPLUS FUND'S UNREALIZED GAINS AND LOSSES
June 30, 2025

Description	Maturity	Par Value	Amort Cost	Market Value	Unrealized Gain (Loss)
ACCENTURE CAPITAL	10/04/2029	195,000	194,709	193,736	(973)
ADOBE INC	01/17/2030	900,000	898,750	929,547	30,797
ADOBE INC	01/17/2030	285,000	284,604	294,357	9,753
WELLS FARGO CO MTN	01/23/2030	500,000	509,351	512,150	2,799
CISCO SYS INC	02/24/2030	290,000	291,679	296,484	4,806
STATE STR CORP	04/24/2030	140,000	140,000	142,597	2,597
WALMART INC	04/28/2030	500,000	499,166	505,725	6,559
WALMART INC	04/28/2030	160,000	159,733	161,832	2,099
COLGATE PALMOLIVE CO	05/01/2030	180,000	179,908	180,742	834
TOYOTA MTR CORP MTN	05/15/2030	200,000	199,778	203,190	3,412
CITIBANK N A	05/29/2030	250,000	250,000	254,800	4,800
JOHN DEERE MTN	06/05/2030	285,000	284,851	287,642	2,791
ANALOG DEVICES INC	06/15/2030	435,000	434,620	438,554	3,934
		$ 31,025,000	$ 31,085,246	$ 31,309,184	$ 223,938

Kaweah Delta Health Care District
INVESTMENT SUMMARY OF SURPLUS FUND'S UNREALIZED GAINS AND LOSSES
June 30, 2025

Description	Maturity	Par Value	Amort Cost	Market Value	Unrealized Gain (Loss)
Municipal Securities:					
SANTA CRUZ CA	08/01/2025	400,000	400,000	399,332	(668)
SAN JUAN CA	08/01/2025	190,000	190,000	189,409	(591)
ANAHEIM CA PUB	07/01/2026	1,000,000	999,608	975,900	(23,708)
LOS ANGELES CA	07/01/2026	270,000	270,000	263,142	(6,858)
CALIFORNIA ST UNIV	11/01/2026	125,000	125,000	126,175	1,175
MASSACHUSETTS ST	07/15/2027	1,000,000	1,000,000	995,850	(4,150)
ALAMEDA CNTY CA	08/01/2027	500,000	500,000	496,060	(3,940)
SAN JOSE CA REDEV	08/01/2027	400,000	392,927	393,800	873
SAN FRANCISCO CA	10/01/2027	1,000,000	1,000,000	1,013,720	13,720
LOS ANGELES CA	07/01/2028	140,000	140,000	141,821	1,821
SAN DIEGO CA	08/01/2028	1,000,000	1,034,143	1,052,200	18,057
		$ 6,025,000	$ 6,051,679	$ 6,047,410	$ (4,269)
U.S. Treasury and Government Agency:					
F H L M C M T N	07/21/2025	1,500,000	1,499,918	1,496,730.00	(3,188)
F N M A	08/25/2025	1,500,000	1,499,788	1,490,805.00	(8,983)
F H L B DEB	09/04/2025	525,000	524,944	521,267.25	(3,676)
F H L M C M T N	09/23/2025	750,000	749,896	743,167.50	(6,729)
U S TREASURY NT	10/31/2025	770,000	769,637	759,720.50	(9,916)
U S TREASURY NT	11/30/2025	2,550,000	2,550,055	2,509,047.00	(41,008)
U S TREASURY NT	03/31/2026	675,000	674,540	658,347.75	(16,192)
U S TREASURY NT	06/30/2026	1,850,000	1,852,928	1,793,704.50	(59,223)
U S TREASURY NT	06/30/2026	990,000	983,118	959,874.30	(23,243)
U S TREASURY NT	07/31/2026	880,000	875,475	848,962.40	(26,513)
U S TREASURY NT	08/31/2026	800,000	794,680	771,032.00	(23,648)
U S TREASURY NT	09/30/2026	2,210,000	2,203,875	2,128,848.80	(75,026)
U S TREASURY NT	09/30/2026	1,000,000	996,965	963,280.00	(33,685)
U S TREASURY NT	10/31/2026	800,000	798,734	771,472.00	(27,262)
U S TREASURY NT	11/30/2026	2,000,000	1,999,263	1,928,440.00	(70,823)
U S TREASURY NT	04/30/2027	970,000	970,225	952,801.90	(17,423)
U S TREASURY NT	04/30/2027	250,000	239,692	235,732.50	(3,959)
U S TREASURY NT	04/30/2027	800,000	797,159	785,816.00	(11,343)
U S TREASURY NT	05/15/2027	925,000	916,417	902,124.75	(14,292)
U S TREASURY NT	07/31/2027	185,000	179,416	181,394.35	1,978
U S TREASURY NT	08/15/2027	190,000	183,188	184,300.00	1,112
U S TREASURY NT	08/31/2027	1,140,000	1,054,765	1,064,258.40	9,493
U S TREASURY NT	10/31/2027	1,500,000	1,363,578	1,393,125.00	29,547
U S TREASURY NT	02/29/2028	1,500,000	1,387,967	1,402,680.00	14,713
U S TREASURY NT	04/30/2028	600,000	554,112	560,790.00	6,678
U S TREASURY NT	04/30/2028	750,000	730,671	745,927.50	15,257
U S TREASURY NT	05/31/2028	730,000	708,823	728,459.70	19,637
U S TREASURY NT	06/30/2028	500,000	501,784	504,295.00	2,511
U S TREASURY NT	06/30/2028	1,300,000	1,283,088	1,311,167.00	28,079
U S TREASURY NT	09/30/2028	500,000	506,195	513,850.00	7,655
U S TREASURY NT	10/31/2028	2,275,000	2,081,303	2,109,448.25	28,145
U S TREASURY NT	12/31/2028	500,000	459,102	461,915.00	2,813
U S TREASURY NT	12/31/2028	1,200,000	1,198,089	1,201,080.00	2,991
U S TREASURY NT	02/28/2029	750,000	743,627	763,215.00	19,588
U S TREASURY NT	03/31/2029	1,000,000	988,689	1,013,520.00	24,831
U S TREASURY NT	03/31/2029	225,000	222,929	228,042.00	5,113
U S TREASURY NT	05/31/2029	1,000,000	1,001,907	1,027,270.00	25,363
U S TREASURY NT	06/30/2029	2,030,000	1,997,204	1,992,891.60	(4,313)
U S TREASURY NT	07/31/2029	500,000	506,300	504,670.00	(1,630)
U S TREASURY NT	07/31/2029	260,000	258,353	262,428.40	4,075
U S TREASURY NT	08/31/2029	750,000	735,695	746,280.00	10,585
U S TREASURY NT	09/30/2029	950,000	929,960	940,424.00	10,464
U S TREASURY NT	10/31/2029	1,000,000	988,441	1,014,300.00	25,859
U S TREASURY NT	10/31/2029	1,000,000	989,800	1,014,300.00	24,500
U S TREASURY NT	11/30/2029	1,700,000	1,699,410	1,724,973.00	25,563
U S TREASURY NT	12/31/2029	2,000,000	1,992,912	2,049,620.00	56,708
U S TREASURY NT	01/31/2030	295,000	295,202	300,820.35	5,619
U S TREASURY NT	02/28/2030	160,000	160,000	161,556.80	1,557
U S TREASURY NT	03/31/2030	700,000	702,915	706,510.00	3,595
U S TREASURY NT	04/30/2030	1,000,000	991,066	1,003,910.00	12,844
U S TREASURY NT	05/31/2030	1,000,000	1,001,553	1,009,690.00	8,137
U S TREASURY NT	05/31/2030	1,065,000	1,066,313	1,075,319.85	9,007
U S TREASURY NT	06/30/2030	1,000,000	1,002,996	1,003,672.00	676

Kaweah Delta Health Care District
INVESTMENT SUMMARY OF SURPLUS FUND'S UNREALIZED GAINS AND LOSSES
June 30, 2025

Description	Maturity	Par Value	Amort Cost	Market Value	Unrealized Gain (Loss)
		$ 53,000,000	$ 52,164,656	$ 52,127,277	$ (37,378)
Asset-backed Securities:					
F H L M C MLTCL MT	08/25/2025	162,294	161,960	161,770	(190)
HONDA AUTO REC OWN	07/20/2026	25,219	25,219	25,184	(35)
DAIMLER TRUCKS	03/15/2027	228,651	228,649	230,050	1,401
F H L M C MLTCL MT	03/25/2027	575,000	559,326	566,300	6,974
CARMAX AUTO OWNER	04/15/2027	197,657	197,656	197,227	(429)
CAPITAL ONE PRIME AT	05/17/2027	102,251	102,249	101,916	(333)
NISSAN AUTO LEASE	11/15/2027	500,000	499,998	505,370	5,372
MERCEDES BENZ AUTO	11/15/2027	100,532	100,526	100,529	3
MERCEDES BENZ AUTO	01/18/2028	1,000,000	999,918	1,012,210	12,292
GM FINL CONSUMER	02/16/2028	710,344	704,227	710,174	5,947
HONDA AUTO	02/18/2028	303,872	303,835	305,826	1,991
BMW VEH OWNER TR	02/25/2028	71,480	71,472	71,904	432
HYUNDAI AUTO	04/17/2028	99,614	99,612	100,254	642
ALLY AUTO RECV TR	05/15/2028	166,348	166,331	167,517	1,186
FORD CR AUTO OWNER	05/15/2028	146,929	146,928	147,733	805
GM FINL CON AUT RECV	06/16/2028	98,750	98,748	99,374	625
F H L M C MLTCL	06/25/2028	530,000	533,202	539,572	6,370
F H L M C MLTCL MT	06/25/2028	433,132	433,126	436,662	3,537
F N M A GTD REMIC	07/25/2028	515,773	510,395	515,866	5,471
FIFTH THIRD AUTO	08/15/2028	354,694	354,681	357,465	2,784
HARLEY DAVIDSON	08/15/2028	484,448	484,378	488,226	3,849
F H L M C MLTCL MTG	08/25/2028	545,000	539,865	552,930	13,065
F H L M C MLTCL	08/25/2028	545,000	537,235	554,379	17,145
AMERICAN EXPRESS	09/15/2028	445,000	444,987	450,042	5,055
CHASE ISSUANCE TRUST	09/15/2028	435,000	434,923	440,029	5,106
F H L M C MLTCL	09/25/2028	535,000	530,856	545,224	14,368
F H L M C MLTCL	09/25/2028	410,000	401,373	418,421	17,049
F H L M C MLTCL	10/25/2028	200,000	199,611	205,378	5,767
F H L M C MLTCL MTG	10/25/2028	300,000	299,414	306,558	7,144
BANK OF AMERICA	11/15/2028	394,000	392,944	398,169	5,224
F H L M C MLTCL	11/25/2028	280,000	281,805	287,162	5,358
F H L M C MLTCL	12/25/2028	315,000	317,222	320,623	3,401
F H L M C MLTCL MTG	12/25/2028	325,000	327,321	329,222	1,900
CHASE ISSUE TR	01/16/2029	490,000	489,947	493,587	3,640
WELLS FARGO CARD	02/15/2029	560,000	559,889	567,269	7,380
BMW VEHICLE OWNER	02/26/2029	1,100,000	1,099,870	1,113,871	14,001
HYUNDAI AUTO REC	03/15/2029	1,000,000	999,880	1,010,190	10,310
JOHN DEERE OWNER	03/15/2029	1,000,000	999,847	1,015,790	15,943
F H L M C MLTCL MTG	03/25/2029	315,000	315,974	325,534	9,560
FORD CR AUTO OWNER	04/15/2029	1,000,000	999,993	1,012,700	12,707
FORD CR AUTO OWNER	04/15/2029	415,000	414,997	420,271	5,274
HYUNDAI AUTO REC	05/15/2029	195,000	194,988	195,981	993
F H L M C MLTCL MTG	05/25/2029	460,000	462,279	468,956	6,677
VERIZON MASTER TRUST	06/20/2029	1,000,000	999,956	1,008,630	8,674
FHLMC REMIC SERIES 0.	06/25/2029	200,000	203,328	202,476	(852)
FORD CR AUTO OWNER	07/15/2029	360,000	359,998	359,500	(498)
AMERICAN EXPRESS	07/16/2029	1,025,000	1,024,962	1,037,044	12,082
F H L M C MLTCL MTG	07/25/2029	515,000	518,963	521,834	2,871
F H L M C MLTCL MTG	07/25/2029	410,000	415,917	416,695	778
TOYOTA AUTO	08/15/2029	260,000	259,991	262,400	2,409
GM FINL CON AUTO REC	08/16/2029	155,000	154,975	155,446	472
VOLKSWAGEN AUTO LN	08/20/2029	365,000	364,988	367,712	2,724
HONDA AUTO	09/21/2029	205,000	204,994	206,980	1,986
BMW VEHICLE	09/25/2029	140,000	139,987	141,198	1,211
F H L M C MLTCL MTG	09/25/2029	345,000	350,910	353,007	2,098
FORD CREDIT AUTO	10/15/2029	445,000	444,959	446,344	1,385
HONDA AUTO	10/15/2029	125,000	124,987	125,248	261
TOYOTA AUTO	11/15/2029	220,000	219,988	221,353	1,365
NISSAN AUTO REC OWN	12/17/2029	500,000	499,906	505,030	5,124
MERCEDES BENZ	12/17/2029	255,000	254,951	258,369	3,418
FHLMC REMIC SERIES 0.	01/25/2030	205,000	204,993	206,853	1,860
VERIZON MASTER TRUST	03/20/2030	440,000	439,982	441,932	1,950
AMERICAN EXPRESS	04/15/2030	410,000	409,993	412,509	2,516
GM FINANCIAL CONSUME	04/16/2030	95,000	94,986	95,511	525
BANK OF AMERICA	05/15/2030	265,000	264,999	266,794	1,795
WF CARD ISSUANCE	05/15/2030	515,000	514,992	519,032	4,041

Kaweah Delta Health Care District
INVESTMENT SUMMARY OF SURPLUS FUND'S UNREALIZED GAINS AND LOSSES
June 30, 2025

Description	Maturity	Par Value	Amort Cost	Market Value	Unrealized Gain (Loss)
F H L M C MLTCL MTG	05/25/2030	575,000	574,980	578,749	3,769
CITIBANK CREDIT	06/21/2030	580,000	579,843	583,381	3,538
		$ 27,680,991	$ 27,656,183	$ 27,967,441	$ 311,258

INCIDENT MANAGEMENT–

Incident Management & RCAs

Board of Directors (Open session)

August 2025

Evelyn McEntire, Director of Risk Management

Incident Management Process

Overview

Every Midas event report is now assigned a score (A – I), based on the new Kaweah Event Severity Scale. Events are scored a level ***B through E*** by the Risk Management department. They are referred to the appropriate unit leaders who investigate the events and present their findings at the Incident Management Meeting (IMM) each business day at 11:15 a.m.

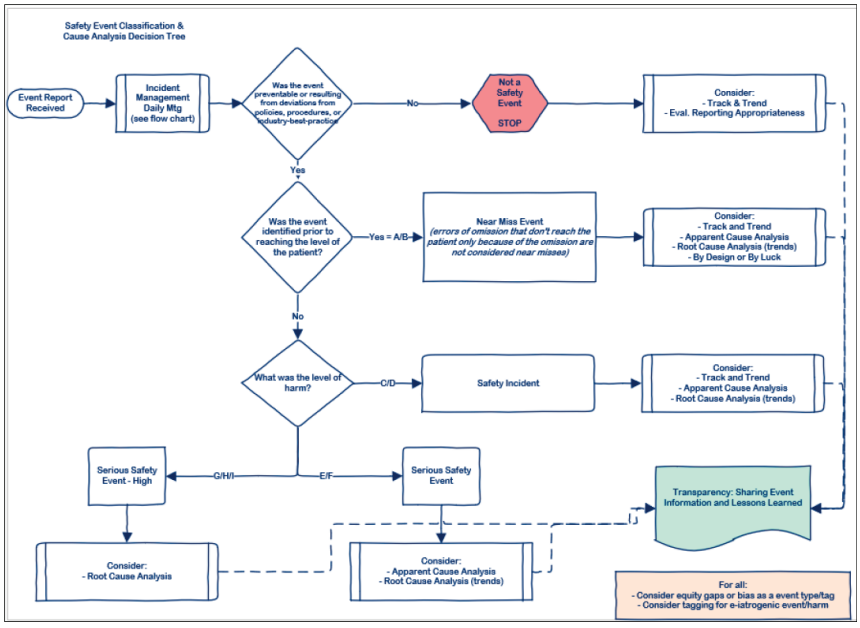
Using the IMM decision tree, the unit leader's investigation will determine:

1) Was there a deviation from policy or industry best practices?
2) Did the event reach the patient?
3) What was the level of harm to the patient?

The IMM process allows Kaweah leaders to obtain information about the events much quicker and escalate them to IMM for timely review and further escalation, if necessary. This also shows staff that we care about safety events in the organization and want to improve our communication with them and provide feedback on the outcome.

Incident Management Meeting Decision Tree

Incident Management Meeting



Midas Event Scoring

Severity*	Description	Also Consider	Example(s) for patients and caregivers
A	Circumstances or events that have the capacity to cause harm (unsafe conditions)		• Report of ice routinely forming on the stairs of parking garage • Plastic doors on medication dispensing machine bins often missing increasing chance of mis-loads
B1 – Design	An error occurred but the error did not reach the patient (an "error of omission" does reach the patient**) because of being caught by a barrier build into the system	Employee education needs regarding definition of reportability. For example, if an alert in the EMR fires and identifies an error that is corrected in the moment, it is still MIDAS reportable.	• An RN scans a medication prior to administration and discovers the incorrect concentration was loaded into the medication dispensing machine. • Wrong patient brought to OR identified during time out • An electrician conducts a required double check before performing work and recognizes lock-out/tag-out was not completed.
B2 – Chance	An error occurred but the error did not reach the patient (an "error of omission" does reach the patient) because it is caught by chance or incidentally by a barrier not built into the system		• Family member identifies incorrect medication just prior to administration. • EVS worker identifies confused patient climbing out of bed and intervenes to prevent a fall. • A caregiver stops a colleague from standing on a wheeled office chair to obtain items from a top shelf.
C	An error occurred that reached the patient but did not cause patient harm	Clear evidence must be evident that no harm exists.	• Transfusion of blood intended for another patient yet of the correct blood type • Preventable fall with imaging taken to confirm no injury
D	An error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm	Minor treatments (first aid) or ongoing monitoring fall into this category.	• Administration of insulin to a non-diabetic requiring blood glucose monitoring, resolved through eating and orange juice • Procedure performed with un-sterile instruments with no noted post-procedure infection or complications
E	An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention	"Intervention" generally described as care beyond "first aid." Intervention/ care that can only be provided by a licensed provider. May include change in therapy or active medical/surgical treatment.	• Overdose of pain medication requiring infusion of naloxone • IV infiltration of medication requiring administration of antidote • Fall resulting in laceration requiring suturing in non-cosmetic area • Caregiver suffers laceration while cleaning kitchen utensils requiring an ER visit, sutures, and returns to work
F	An error occurred that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization	Caregivers: injury or distress requiring medical intervention resulting in lost time or extended restricted duty.	• Medication error resulting in arrhythmia resulting in hospital admission and administration of IV anti-arrhythmic medications • Fall resulting in subdural hematoma and upgrade to ICU
G	An error occurred that may have contributed to or resulted in permanent patient harm	Caregivers: permanent disability, permanent inability to return to work or unable to return into previous position.	• Delayed diagnosis of stroke resulting in permanent impairment • Overdose of IV contrast resulting in kidney damage and need for permanent dialysis • Intra-operative burn resulting in scarring • Wrong site surgery resulting in amputation of a healthy limb
H	An error occurred that required intervention necessary to sustain life	Interventions include cardiovascular and respiratory support (CPR, intubation, defibrillation)	• Delayed diagnosis of fluid overload resulting in intubation and ICU transfer • Medication error inducing cardiac arrest with successful resuscitation
I	An error occurred that may have contributed to, or resulted in, death		• Medication error inducing cardiac arrest without successful resuscitation
Non-Event	A non-preventable event not related to deviations from policies, procedures, or best practices		• Unanticipated complication with evidence of appropriate care, timely recognition and treatment. Determined non-preventable.

Incident Management & RCAs

Events scored level ***F through I*** are not presented at IMM because they resulted in serious harm or death. A Root Cause Analysis (RCA) will be conducted for these events to ensure a formal systematic review is completed.

RCA Facilitators – A group of trained individuals from various departments throughout Kaweah Health such as Population Health, Food & Nutrition Services, HR, ISS, Pharmacy, Risk Management, Quality & Patient Safety, Employee Health.

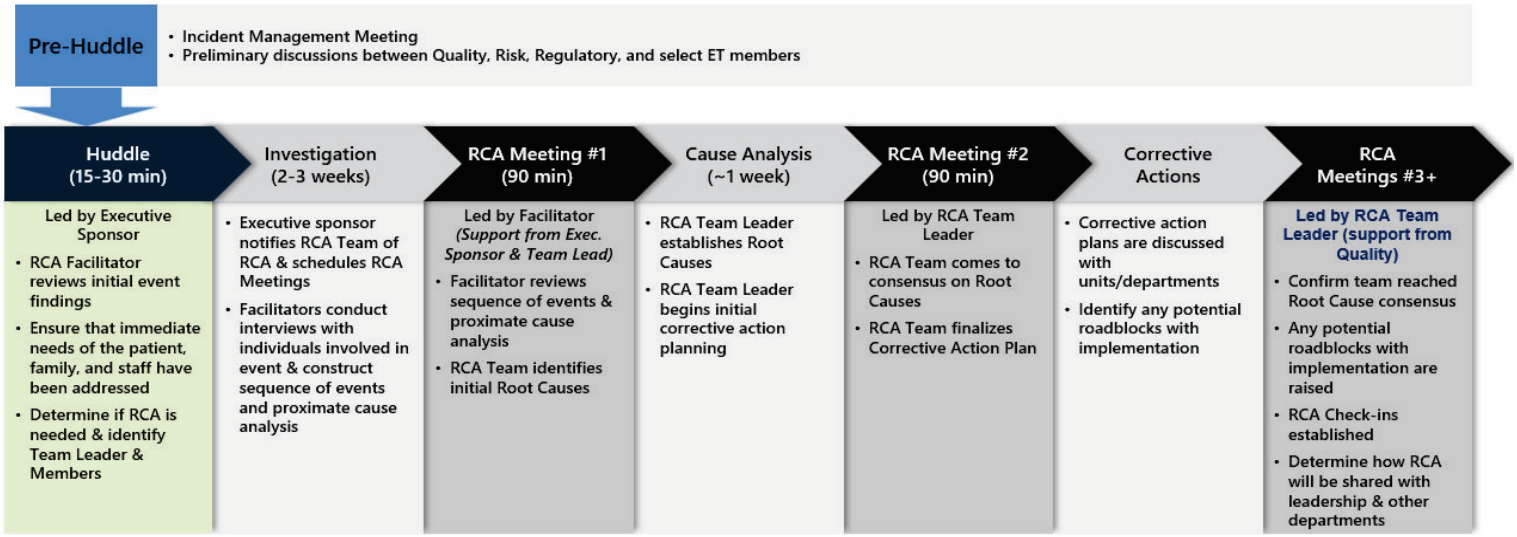
Huddle + 3-Meeting Model:

- ✓ Huddle (within 72 hours);
- ✓ Facilitator investigation (2-3 weeks);
- ✓ Meeting 1 – Facilitator reviews timeline and initial root causes (90 minutes);
- ✓ Meeting 2 – Root cause identification and action plan (90 minutes);
- ✓ Meeting 3 - APOC review and approval (30 – 60 minutes).

New due date timeline – 45 calendar days as recommended by The Joint Commission

Incident Management & RCAs

New RCA Completion Due Date: ***45 calendar days***



IMM Wins

- Unit leaders are investigating and responding to Midas reports within one week or less of submission
- Leaders' investigations are more thorough and corrective actions more meaningful
- Leaders and staff sharing positive experiences – Earlier investigations and earlier resolutions
- Increased number of Midas reports submitted by 40% (improved safety culture)
- Decreased number of events that reached the patient (67% → 48%)
- Decreased number of Anonymously reported events (19% → 7%)

Serious Safety Event Dashboard *Effective April 21, 2025*

Kaweah Health
MORE THAN MEDICINE. LIFE.

Serious Safety Event Dashboard

Monthly Metrics	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Rolling 12 Months
# of Serious Safety Events scoring a E, F, G, H, or I at Incident Management	2	0	9	5	6								22
Serious Safety Event Rate	n/a	n/a	7.26	4.04	4.9								

Description: Serious Safety Event (source: Chartis)

E: An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention.

F: An error occurred that may have contributed to or resulted in moderate to severe temporary harm resulting in initial or prolonged hospitalization.

G: An error occurred that may have contributed to or resulted in permanent patient harm.

H: An error occurred that required intervention necessary to sustain life.

I: An error occurred that may have contributed to, or resulted in, death.

RCAs in progress:

	Event Date	Name of RCA and Midas Event #	Status	Meeting Timeline? If not, explain	Comments
1	6/5/25	NICU – Pen G Medication Overdose	Complete	Compliant (Day 45 = 8/8/25)	APOC approval on 7/21/25; Not reportable
2	7/7/25	3S – Fall w/ Hip Fracture	In progress	Compliant (Day 45 = 9/2/25)	Huddle complete; Meeting #1 on 8/11/25; Not reportable

Beginning April 21, 2025, the timeline for completion of RCAs is 45 business days from the event date.

****Not all SSEs qualify for/require an RCA.****

Kaweah Health

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Separator Page

KAWEAH HEALTH PHYSICIAN RECRUITMENT REPORT

Kaweah Health

Physician Recruitment and Relations

What's on the Agenda?

1. Meet the Team
2. Did You Know?
3. Physician Recruitment and Relations Process
4. Strategy
5. Sourcing
6. Leadership Calls and Site Visits
7. Contracting and Credentialing
8. Liaison Work
9. Offer Breakdown
10. New Physicians 2024
11. New Physicians 2025
12. Offers Out…

Kaweah Health
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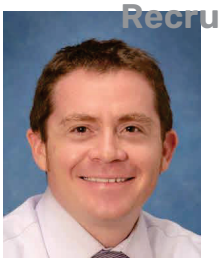
The Team

Sarah Bohde
Senior Physician Recruiter

Isalei Cedillo
Physician Recruiter

Stefani Salierno
Physician Liaison

Dee Sebert
Physician Liaison



JC Palermo
Director of Physician Recruitment and Relations

Did You Know?

Kaweah Health Does Not Hire Physicians

Kaweah Health Recruits for the Community

Kaweah Health Offers Recruitment Assistance to Local Practices

Physician Recruitment and Relations

Strategy

Gathering Data

- Community Physician Needs Assessment
- Community Feedback
- Provider Feedback
- Referral Patterns
- Barriers to Access

Prioritizing Needs

- Physician Recruitment Strategy Meeting
- Available Resources
- Practice Locations
- Local Partnerships
- Tiering System

Tier 1 - Recruitment Incentives

Specialty

• $50k sign-on
• $100k student loan

Primary

• $25k sign-on
• $100k student loan

Specialty	Total Score	Tier
FM/IM	10	Tier 1
GI	10	Tier 1
OB/GYN	10	Tier 1
Neurology	9	Tier 1
Rheumatology	9	Tier 1
Cardiac Surgery	9	Tier 1
Ortho - General	9	Tier 1
Urology	9	Tier 1
Radiology	9	Tier 1
Pulmonology	8	Tier 1
Anesthesia - General	8	Tier 1
Anesthesia - Regional	8	Tier 1
EP Cardiology	8	Tier 1
General Surgery	8	Tier 1
Anesthesia - Critical Care	8	Tier 1
UroGyn	8	Tier 1

Tier 2 - Recruitment Incentives

Specialty

• $30k sign-on
• $0-50k student loan

Primary

• $15k sign-on
• $0-50k student loan

Specialty	Total Score	Tier
Psychiatry	7	Tier 2
Anesthesia - Cardiac	7	Tier 2
Endocrinology	7	Tier 2
Hematology/Oncology	7	Tier 2
Ortho - Hand	7	Tier 2
Ortho - Spine	7	Tier 2
Ortho - TJR	7	Tier 2
Otolaryngology	7	Tier 2
Pediatrics (Outpatient)	7	Tier 2
PM&R	7	Tier 2
Dermatology	6	Tier 2
Occ Med	6	Tier 2
Interventional Radiology	6	Tier 2
Breast Surgery	6	Tier 2
Colorectal Surgery	6	Tier 2
Ortho - Trauma	6	Tier 2

Tier 3 - Recruitment Incentives

Specialty

• $20k sign-on
• $0 student loan

Primary

• $0 sign-on
• $0 student loan

Specialty	Total Score	Tier
Interventional Cardiology	5	Tier 3
Vascular Surgery	5	Tier 3
Neuropsychiatry	4	Tier 3
Ortho - Foot/Ankle	4	Tier 3
Allergy/Immunization	3	Tier 3
Gynecological Oncology	3	Tier 3
Infectious Disease	3	Tier 3
Neurosurgery	3	Tier 3
Plastic Surgery	3	Tier 3
Radiation Oncology	3	Tier 3
Hospitalist	3	Tier 3
GYN	3	Tier 3
Anesthesia - OB	2	Tier 3

Sourcing

- Online Sourcing Tools
- Career Fairs
- Provider Referrals
- Residency Programs
- LinkedIn
- Indeed
- Recruitment Agencies

PracticeMatch

DocCafe

PracticeLink

Monthly Emails Sent – 30,000

Text Messages Sent – 1,500

Phone Calls – 100

Leadership Calls and Site Visits

It Takes a Village

- Service Line Leadership
- Service Line Team Members
- Senior Leadership
- Physician Leadership

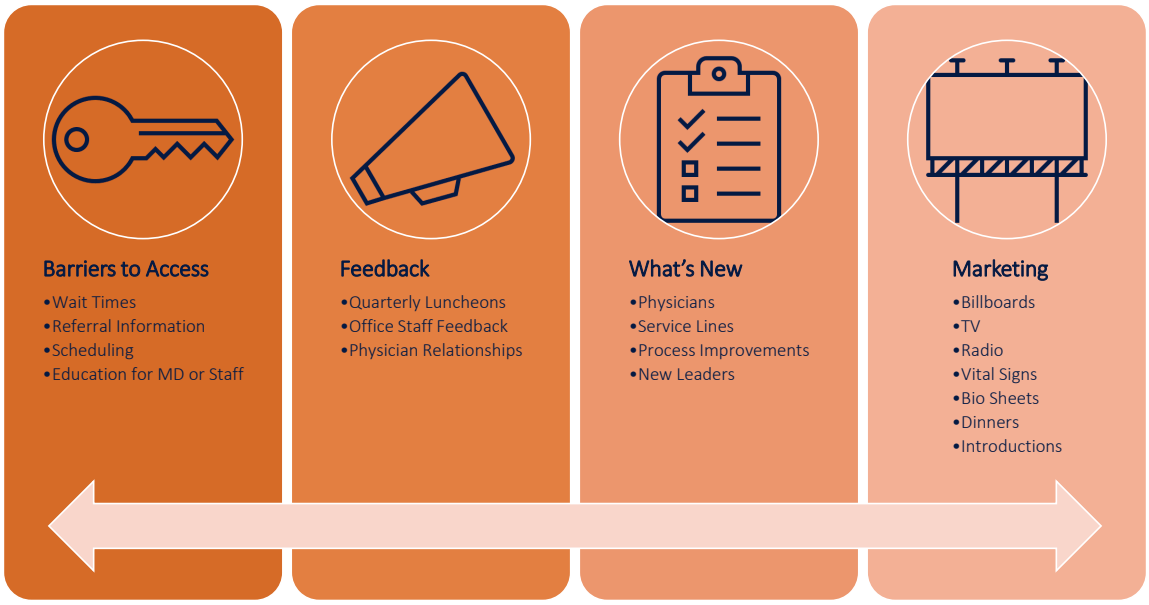
Rolling Out the Red Carpet

- Community Tours
- Welcome Bags
- Hospital/Clinic Tours
- Lunches/Dinners
- Time to Explore Visalia

Contracting and Credentialing

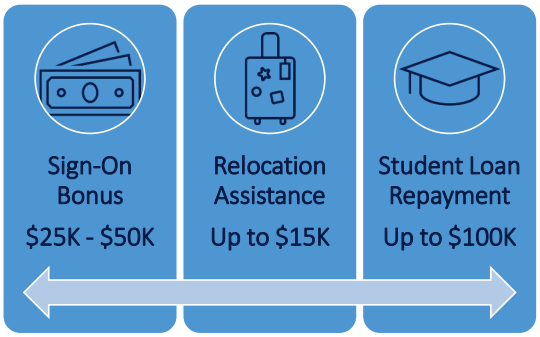
Letter of Intent	Physician Recruitment Agreement (PRA)	Professional Services Agreement (PSA)	Hospital Credentialing	Payer Credentialing	Approximate Time for Recruitment
Non-Binding Offer Letter	Sign-On Resident Retention Relocation Student Loan	Where When What	Background Check Professional References Clinical History	Based on Practice Location Medicare Medical Commercial Humana	Not Counting Sourcing, Interviews, Site Visits
~ 4 Weeks	+ ~ 6 Weeks	+ ~ 6 Weeks	+ ~ 6 Weeks	+ ~ 12 Weeks	= **34 Weeks 8-10 Months**

Liaison Work and Marketing



Offer Breakdown

Specialty	25th Percentile	50th Percentile	65th Percentile	Benefits	Malpractice
Neurology	$305,000	$363,000	$402,000	$48,000	FMV
OB/GYN	$323,000	$388,000	$438,000	$51,000	FMV
Gastroenterology	$455,000	$572,000	$646,000	$60,000	FMV



Forgivable Loans

- Income and Benefits Guarantee
- Sign-On Bonus
- Relocation Assistance
- Student Loan Repayment

Productivity + Benefits

- Ongoing Benefits Guarantee
- Ongoing Malpractice Guarantee
- wRVU Based Productivity Model
- 1099 Direct/Group Contracts
- W2 Model Coming Soon...

Physicians that Started in CY2024

Name	Specialty	Practice Location
Edmun Wang	Anesthesia (Regional)	KH Medical Center
Annie Shapiro	Anesthesia (Regional)	KH Medical Center
Tawny Louie (KHR)	Anesthesia (CC)	KH Medical Center
Reza Emami (KHR)	Child Psychiatry	KH Mental Health Hospital/ Lindsay & Exeter Clinics
Harleen Chahil	Interventional Cardiology	KH Cardiology Center
Amitoj Gill	Medical Oncology	SRCC
Holly Quinn	OBGYN	202 Willow (Women's Center)
Ryan Dean	Ortho Trauma	Orthopaedics Associates/ KH Medical Center
Aryandokht Fotros	Outpatient Psychiatry	Precision Psychiatry
Danny Vazquez	Radiation Oncology	SRCC

Physicians Starting in CY2025

Name	Specialty	Projected Start Date	Practice Location
Shelly Bansal	CT Surgery	Already Started	CT Clinic
Carla Herriford	Dermatology	Already Started	Dinuba Clinic
Walter Gribben	Pulmonology	Already Started	202 Willow
Immanuel Jacquez	Anesthesiology	Already Started	Oak Creek
Daniel Khahil (KHR)	Psychiatry	Already Started	Precision Psychiatry
Jared Caballes (KHR)	Adult Hospitalist	Already Started	Valley Hospitalist Medical Group
Gaylene Soloniuk-Tays	Primary Care	Already Started	Ben Maddox Clinic
Saina Gill (KHR)	Psychiatry	Already Started	Precision Psychiatry
Anthony Sabo	General Surgery	October	Akers Clinic
Yesenia Calderon (KHR)	Faculty Medical	July	Faculty Medical Group
Kevin Cowan (KHR)	General Surgery	October	Kyle B Potts MD Inc.

Physicians Starting in CY2025

Name	Specialty	Projected Start Date	Practice Location
Prem Sahasranam	Endocrinology	Fall	RHC
Boota Chahil	Neurology	Fall	RHC
Tyler Ellis	Intensivist	Summer	Sound Physicians
Shadi Alsmadi	Neonatologist	Summer	Children's Hospital
	Family Medicine	Summer	Key Medical

Offers Extended / Site Visits

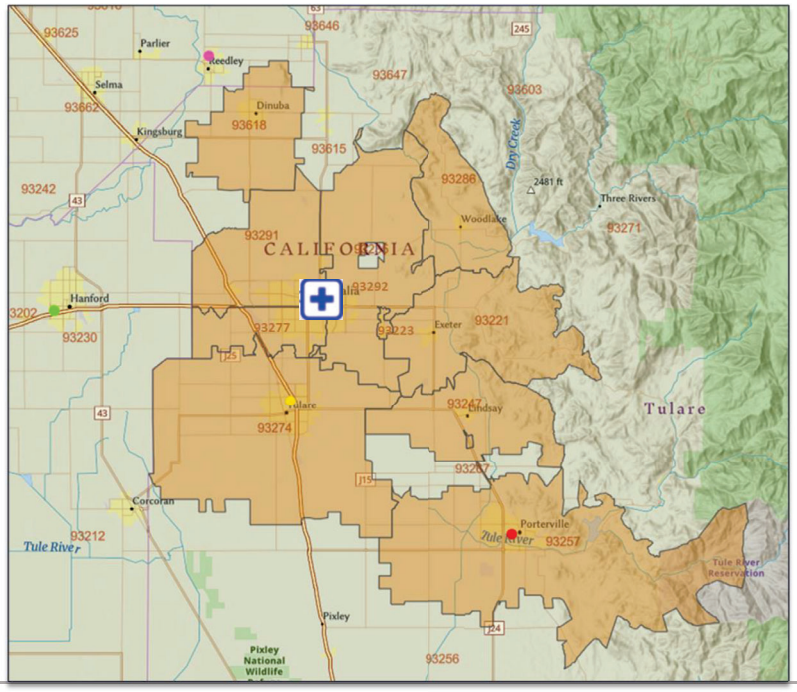
Specialty	Practice Location	Notes
Anesthesia (Regional)	Oak Creek	Offer Extended
Neonatology	Children's Hospital	Offer Extended
Family Medicine	Ben Maddox / Akers Clinic	Offer Extended
CT Surgery	CT Clinic	Offer Accepted
Intensivist	Kaweah Health Hospital	Offer Pending
Neurology	Akers Clinic/RHC	Offer Pending
Occupational Medicine	Plaza Clinic	Offer Pending
Gastroenterology	Akers Clinic/RHC	Site Visit 10/13/25
Hand Surgeon x2	Orthopedic Associates	Site Visit 8/9/25, 8/22/25
ENT	Valley ENT	Site Visit Pending

Thank You!!

Thank you for your time and support!!

JC Palermo
Director Physician Recruitment and Relations
jpalermo@kaweahhealth.org
(559)624-5456

Geographic Area Service By the Hospital



Kaweah Health GASH is approximately 956 square miles.

- Kaweah Health Medical Center
- Adventist Health Hanford
- Adventist Health Reedley
- Adventist Health Tulare
- Sierra View Medical Center

Geographic Area Service By the Hospital

ZIP Code	City	Discharges %	Discharges Cumulative %	Estimated 2023 Population
93291	Visalia	15.8%	15.8%	66,219
93277	Visalia	15.4%	31.3%	53,427
93274	Tulare	13.9%	45.1%	80,906
93292	Visalia	11.6%	56.7%	45,269
93257	Porterville	4.9%	61.5%	81,308
93221	Exeter	4.2%	65.7%	15,321
93618	Dinuba	3.4%	69.1%	32,801
93223	Farmersville	3.1%	72.2%	10,023
93286	Woodlake	2.9%	75.1%	10,031
93247	Lindsay	2.7%	77.8%	18,203
Subtotal		**77.8%**		**413,508**
Other ZIPs		**22.2%**		
TOTAL		**100.0%**		

Sources: Kaweah Health; Esri

Note: Excludes normal newborns.

GASH (regulatory definition) for Kaweah Health includes 10 ZIP Codes that constitute 77.8% of inpatient discharges for the hospital. An area map is displayed on the following page.

Provider Needs in the Community

Substantial Need > 10.0 FTEs Needed	Moderate Need 5.0 - < 10.0 FTEs Needed	Slight Need 1.0 - <5.0 FTEs Needed	Near Equilibrium 0.0 - < 1.0	Supplied <0.0 FTEs Needed *
Adult Primary Care	Gastroenterology Hematology/Oncology Obstetrics/Gynecology Ortho - (General) Otolaryngology Pediatrics (General)	Allergy and Immunology Breast Surgery Cardiac Surgery Cardiology - EP & Interventional Colorectal Surgery Dermatology Endocrinology General Surgery Gynecologic Oncology Infectious Diseases Neurology Neurosurgery Ortho -Trauma, Foot/Ankle, & TJR Plastic Surgery PM&R Psychiatry Pulmonology Radiation Oncology Rheumatology Urology Vascular Surgery	Cardiology - Medical Ophthalmology Ortho - Hand & Spine	Nephrology

**These specialties are at equilibrium or over oversupplied.*

- Table excludes hospital-based specialties.
- The tables on the following pages illustrate community provider needs by specialty.

Community Provider Needs:
Primary Care and Adult Medical Subspecialties

Specialty	Population to Support One Provider	2023 Gross Provider Need	2023 FTE Provider Supply	2023 Net Need (Surplus)
Primary Care				
Adult Primary Care	2,100	196.9	169.1	27.8
Family Practice (with NPs)	3,000	137.8	123.8	14.0
Internal Medicine	7,500	55.1	45.3	9.8
Pediatrics (General)	7,800	53.0	48.0	5.0
Medical				
Allergy and Immunology	90,000	4.6	2.9	1.7
Cardiology				
-EP	160,000	2.6	1.0	1.6
-Interventional	55,000	7.5	5.9	1.6
-Medical	50,000	8.3	7.6	0.7
Dermatology	45,000	9.2	5.7	3.5
Endocrinology	65,000	6.4	4.0	2.4
Gastroenterology	40,000	10.3	5.1	5.2
Hematology/Oncology	32,000	12.9	4.7	8.2
Infectious Diseases	90,000	4.6	2.3	2.3
Nephrology	64,000	6.5	12.3	(5.8)
Neurology	40,000	10.3	5.6	4.7
OB/GYN (including Midwives)	10,500	39.4	32.8	6.6
Physical Medicine and Rehabilitation	75,000	5.5	4.5	1.0
Psychiatry	20,000	20.7	16.0	4.7
Pulmonology	55,000	7.5	5.0	2.5
Radiation Oncology	80,000	5.2	4.1	1.1
Rheumatology	100,000	4.1	1.1	3.0
Estimated 2023 Service Area Population	**413,508**			

Need
Near Equilibrium(1)
Adequate Supply

- There is a substantial shortage of adult primary care providers in the GASH.
- Nephrology is the only specialty that is adequately supplied, all others show a need.

(1)Shows a need less than 1.0 FTE

Community Provider Needs: Surgical Subspecialties

Specialty	Population to Support One Provider	2023 Gross Provider Need	2023 FTE Provider Supply	2023 Net Need (Surplus)
Surgical				
Breast Surgery	175,000	2.4	1.4	1.0
Cardiac Surgery	150,000	2.8	1.8	1.0
Colorectal Surgery	200,000	2.1	0.9	1.2
General Surgery	25,000	16.5	14.5	2.0
Gynecologic Oncology	200,000	2.1	0.0	2.1
Neurosurgery	100,000	4.1	1.8	2.3
Ophthalmology	35,000	11.8	11.5	0.3
Orthopedic Surgery				
-Foot/Ankle	280,000	1.5	0.0	1.5
-General/Sports Medicine	25,000	16.5	6.8	9.7
-Hand	213,000	1.9	1.5	0.4
-Spine	166,000	2.5	2.1	0.4
-Total Joint Replacement	166,000	2.5	1.2	1.3
-Trauma	151,000	2.7	0.3	2.4
Otolaryngology	45,000	9.2	3.6	5.6
Plastic Surgery	85,000	4.9	1.5	3.4
Urology	45,000	9.2	5.6	3.6
Vascular Surgery	80,000	5.2	2.2	3.0

Estimated 2023 Service Area Population **413,508**

Need
Near Equilibrium(1)
Adequate Supply

- Nearly all surgical subspecialties show a community need of at least 1.0 FTEs.

(1)Shows a need less than 1.0 FTE

Separator Page

PATIENT EXPERIENCE AND SATISFACTION UPDATE

Patient Experience

August 2025

kaweahhealth.org

Kaweah Health
MORE THAN MEDICINE. LIFE.

Patient Experience Matters

Opportunities and insights to increase patient satisfaction.

Kaweah Health July 2025

Survey Scores

HCAHPS – 72.9
59th Percentile

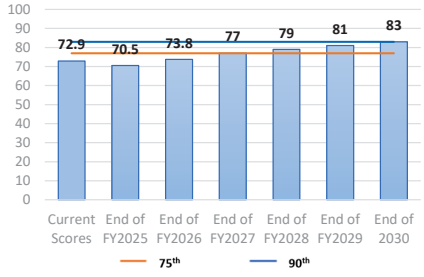
Inpatient
NPS – 62.4
37th Percentile

Medical Practice
NPS – 80.0
18th Percentile

Fiscal Year Data

July 2024 – June 2025

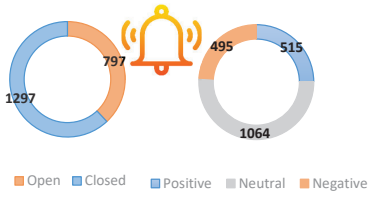
5 Year HCAHPS Goal



July 2025

- **Rounding** 152 Rounds
- **MIDAS** 73 Opened
- **PX Phone** 107 Calls

Service Alerts



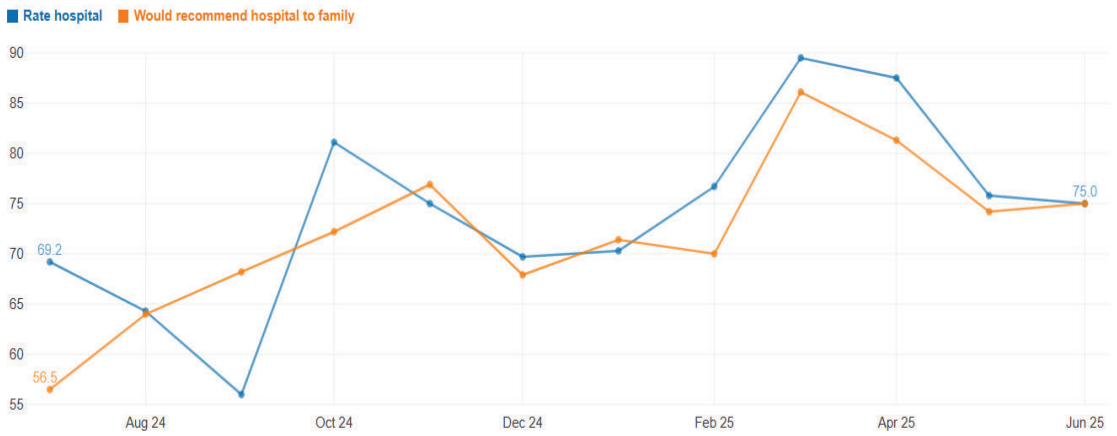
Human Understanding – 71.1
7th Percentile

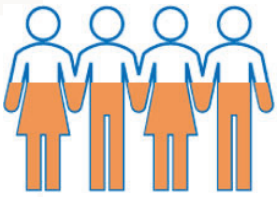
PRIORITIES FOR ORGANIZATION

- **Quiet rooms at night**
- **Informed of delays**
- **Providers explaining things understandably**
- **Explained what to do if not better after discharge**
- **Providing consistent information**

HCAHPS Trend

Favorite | Subscribe | Export | Jul 01, 2024 - Jun 30, 2025



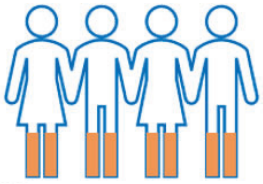


HCAHPS – 72.9
59th Percentile

Question	Benchmark	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
Rate hospital	71.5	69.2 n = 26	64.3 n = 28	56.0 n = 25	81.1 n = 37	75.0 n = 44	69.7 n = 33	70.3 n = 37	76.7 n = 30	89.5 n = 38	87.5 n = 32	75.8 n = 33	75.0 n = 36
Would recommend hospital to family	72.4	56.5 n = 23	64.0 n = 25	68.2 n = 22	72.2 n = 36	76.9 n = 39	67.9 n = 28	71.4 n = 35	70.0 n = 30	86.1 n = 36	81.3 n = 32	74.2 n = 31	75.0 n = 36

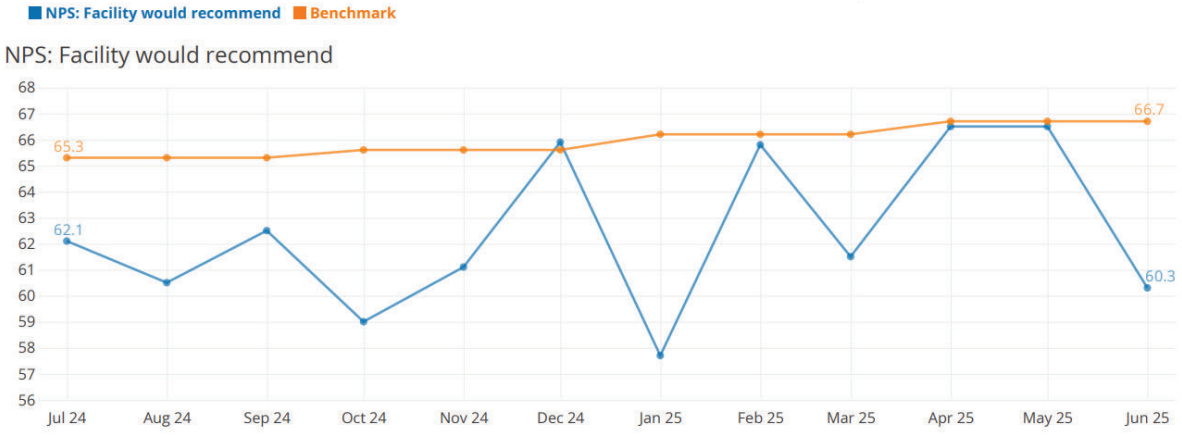
nrc HEALTH | Human understanding

Trend (Inpatient)



Respondents 2,976

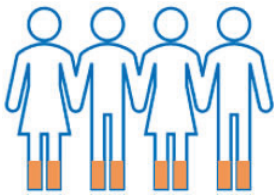
Inpatient
NPS – 62.4
37th Percentile



	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025
NPS: Facility would recommend	62.1 n = 256	60.5 n = 261	62.5 n = 267	59.0 n = 288	61.1 n = 239	65.9 n = 229	57.7 n = 220	65.8 n = 272	61.5 n = 257	66.5 n = 224	66.5 n = 221	60.3 n = 242

nrc HEALTH | Human understanding

Trend (Med Practice)

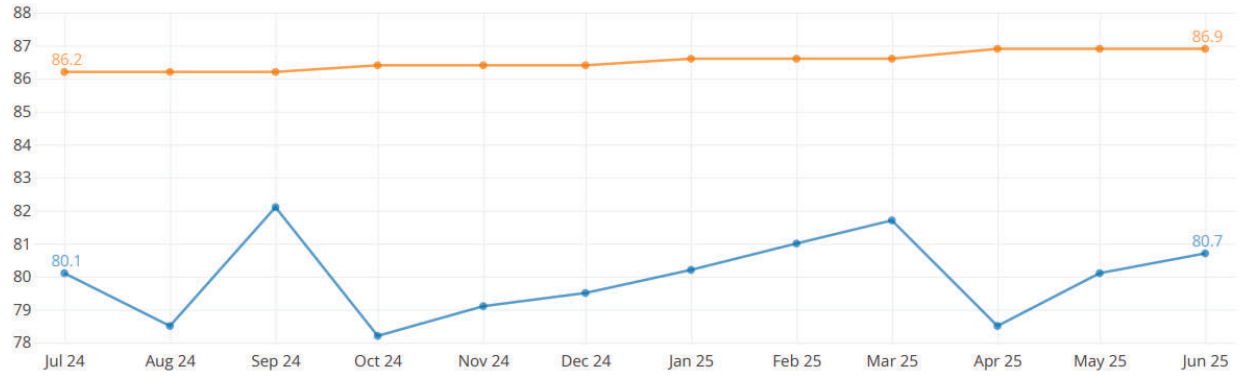


Respondents 9,827

Medical Practice
NPS – 80.0
18th Percentile

NPS: Provider would recommend ■ Benchmark

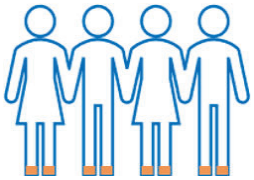
NPS: Provider would recommend



	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025
NPS: Provider would recommend	80.1 n = 893	78.5 n = 968	82.1 n = 792	78.2 n = 878	79.1 n = 722	79.5 n = 702	80.2 n = 966	81.0 n = 878	81.7 n = 857	78.5 n = 769	80.1 n = 733	80.7 n = 669

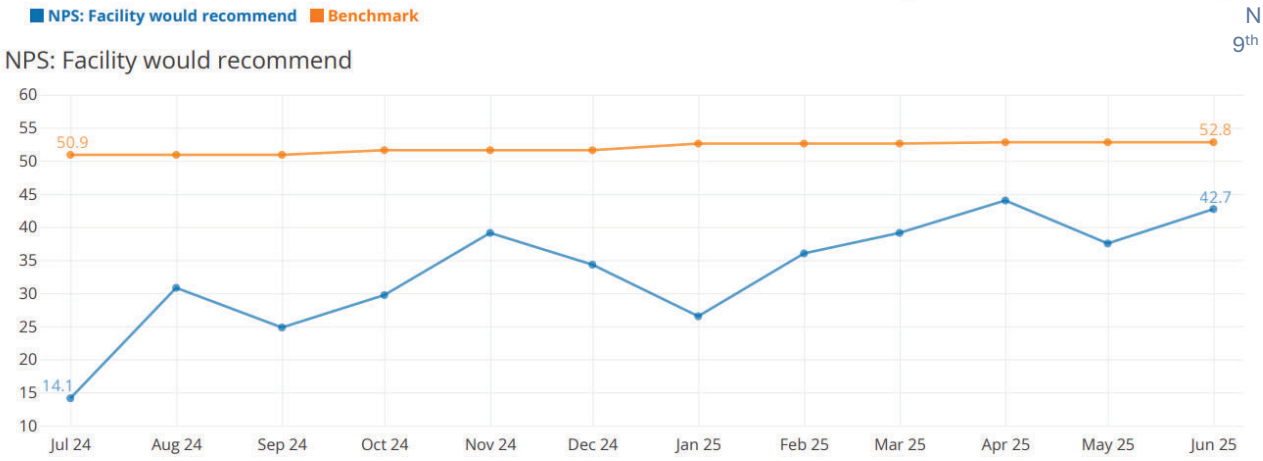
nrc HEALTH | Human understanding

Trend (Emergency Department)



Respondents 10,603

NPS – 33.0
9th Percentile

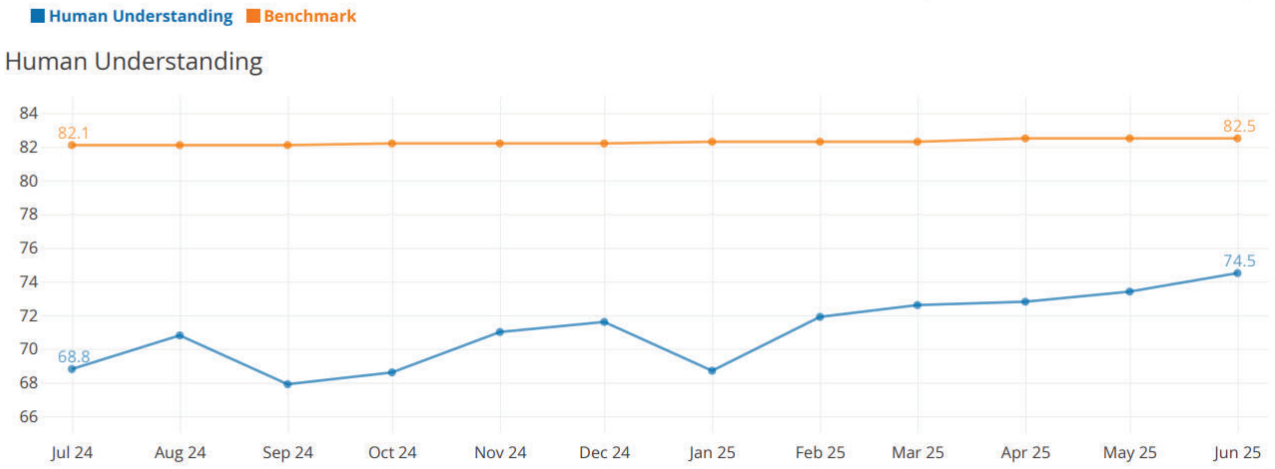


	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025
NPS: Facility would recommend	14.1 n = 765	30.8 n = 1,056	24.8 n = 1,009	29.7 n = 960	39.1 n = 886	34.3 n = 846	26.5 n = 889	36.0 n = 850	39.1 n = 883	44.0 n = 789	37.5 n = 920	42.7 n = 750

Human understanding

Trend (Org- Human Understanding)

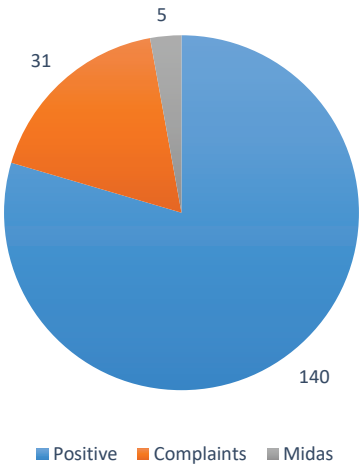
Respondents 33,738

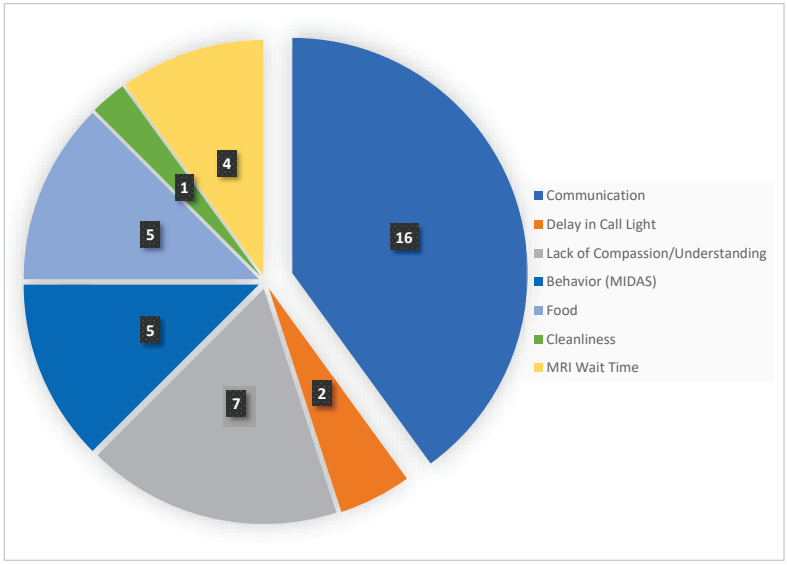


	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025
Human Understanding	68.8 n = 2,669	70.8 n = 3,027	67.9 n = 2,695	68.6 n = 2,884	71.0 n = 2,473	71.6 n = 2,365	68.7 n = 2,828	71.9 n = 2,726	72.6 n = 2,768	72.8 n = 2,584	73.4 n = 3,359	74.5 n = 3,360

Rounding: July

152 Rounds





ROUNDING

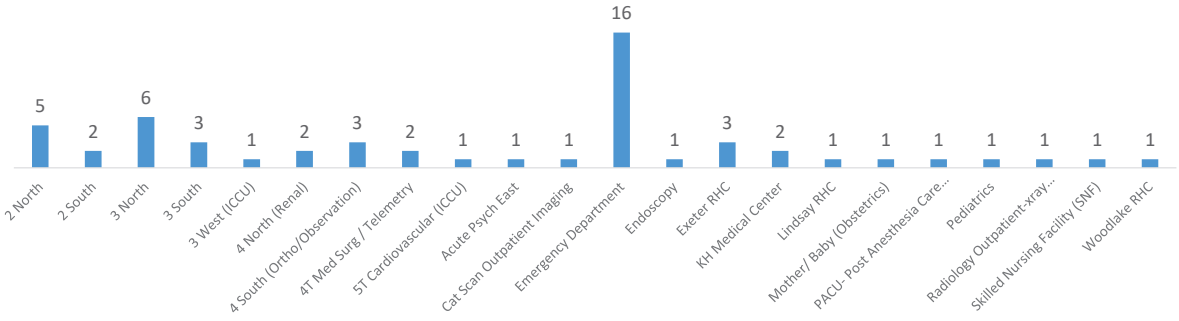
July Executive Team Rounds = 9 executive rounds

Executive	March	April	May	June	July
Gary H.		17-Apr	14-May	30-Jun	17-Jul
Marc M.		30-Apr	12-May	25-Jun	15-Jul
Jag B.	18-Mar		6-May	30-Jun	
Malinda T.	5-Mar		19-May	19-Jun	1-July
Dianne C.		9-Apr		26-Jun	23-Jul
Schlene P.			13-May	19-Jun	31-Jul
Ben C.	24-Mar		29-May	11-Jun	9-Jul
Ryan G.	11-Mar	23-Apr			2-Jul
Paul S.		21-Apr			8-Jul
Doug L.	24-Mar			5-Jun	15-Jul

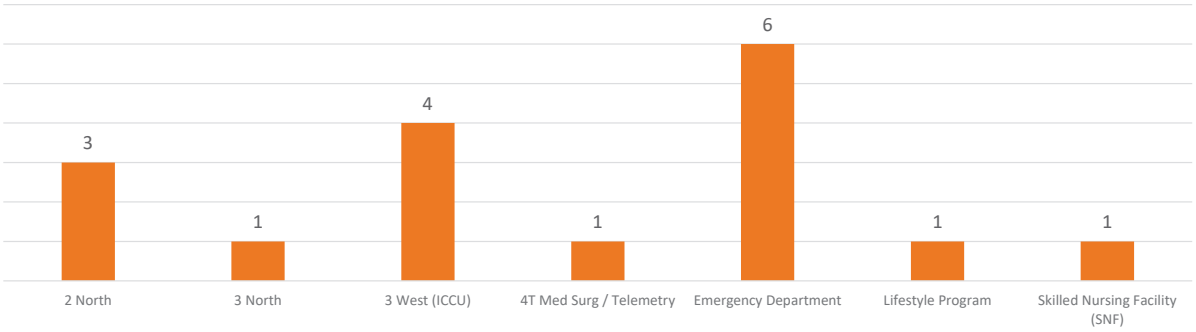
MIDAS: July

73 Opened

Complaints & Grievances

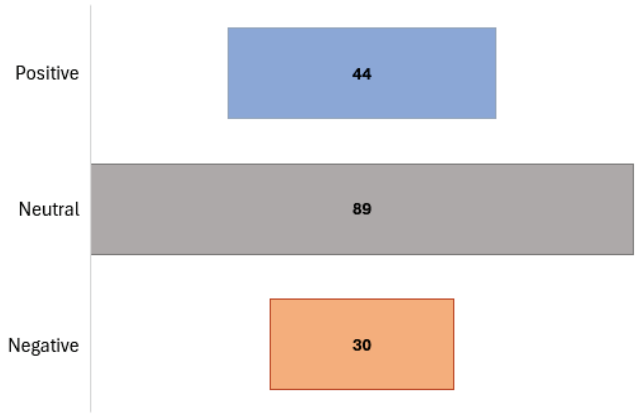


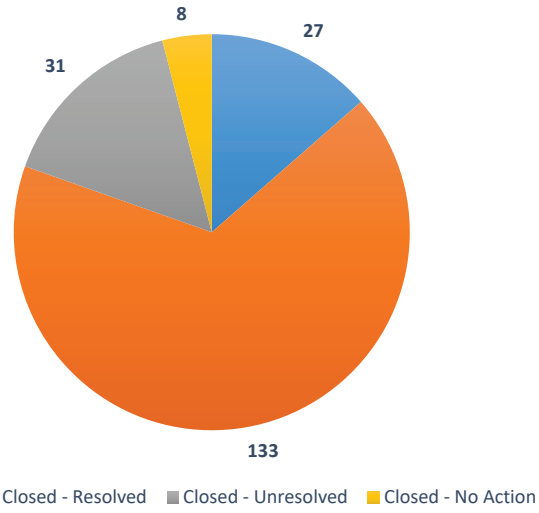
Lost Belongings = 17



Service Alerts: June

199 Total





This month's topic:

Patients are Someone's Someone

This is a powerful reminder of the humanity and worth of every patient. Each person receiving care is not just a number or a condition, but a loved individual - someone's parent, child, spouse, friend, or sibling. Pause before interacting. Take a moment to reflect: "If this were my parent or friend, how would I approach them?"

- HUMANIZE the Patient
  - Patients are more than tasks and medical problems. They have relationships, identities, and stories outside of this healthcare setting.
- ENCOURAGE Empathy
  - Imagine how we want our loved ones to be treated - with empathy, patience, and kindness.
- PROMOTE Dignity and Respect
  - Support a care approach rooted in dignity; treating each patient as a whole person, not just a diagnosis.
- MOTIVATE Compassionate Care
  - Especially in high-stress or fast-paced environments, this phrase can help us pause and reconnect with the deeper purpose of our work.
  - Create conditions, culture, and mindset that make compassionate care:
    - A priority
    - Sustainable
    - Part of the team's daily practice, not just an ideal.

What we do matters deeply. Every act of kindness, however small, can make a lasting difference in someone's life.

Happy patients. Happy families. Happy hospital

Kaweah Health
MORE THAN MEDICINE. LIFE.

August 2025

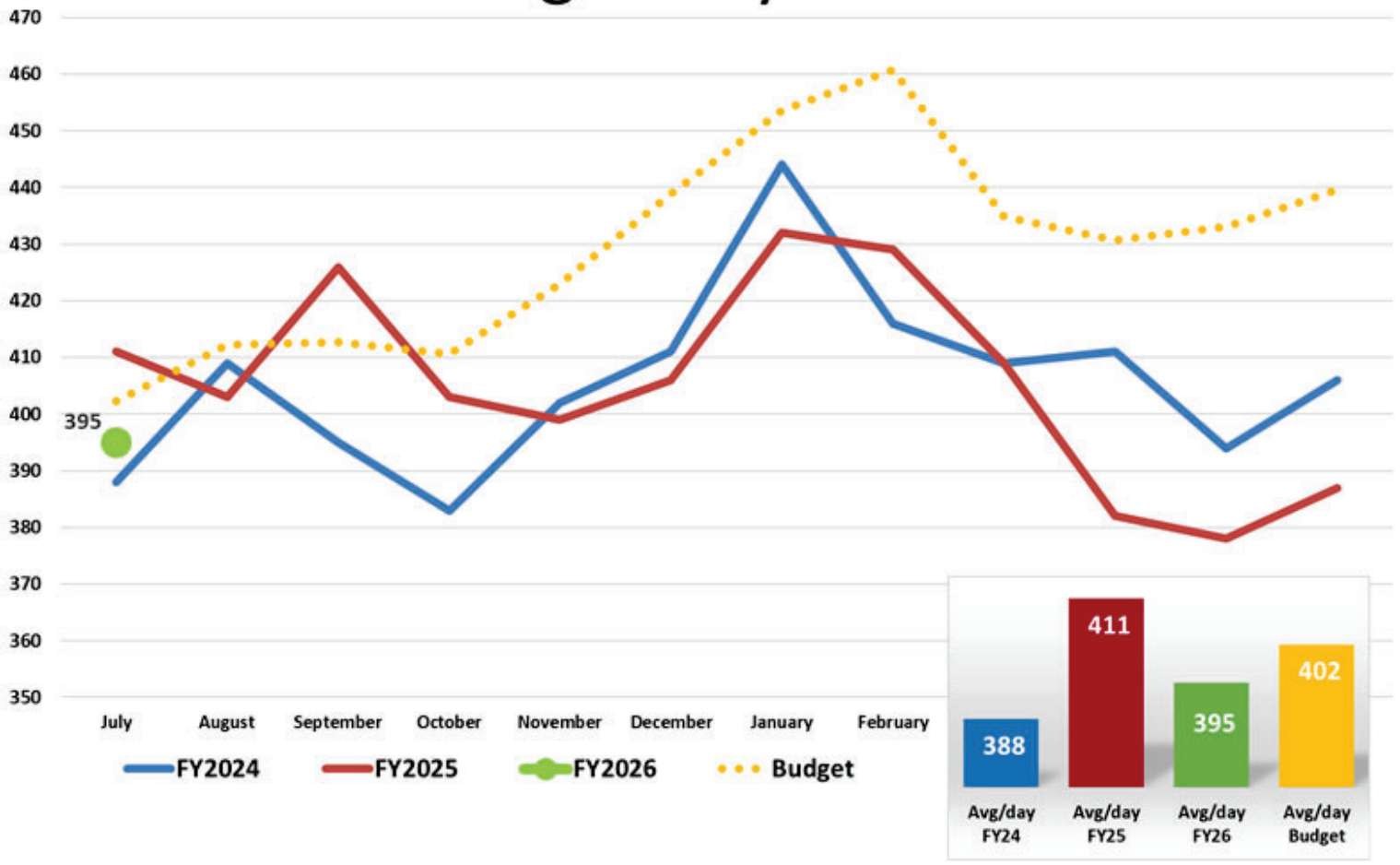
Separator Page

FINANCIALS

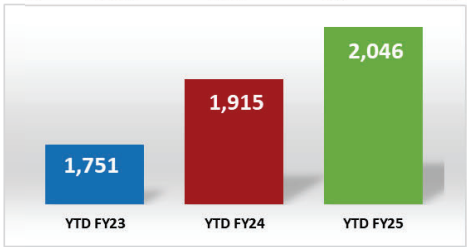
CFO Financial Report

Month Ending July 2025

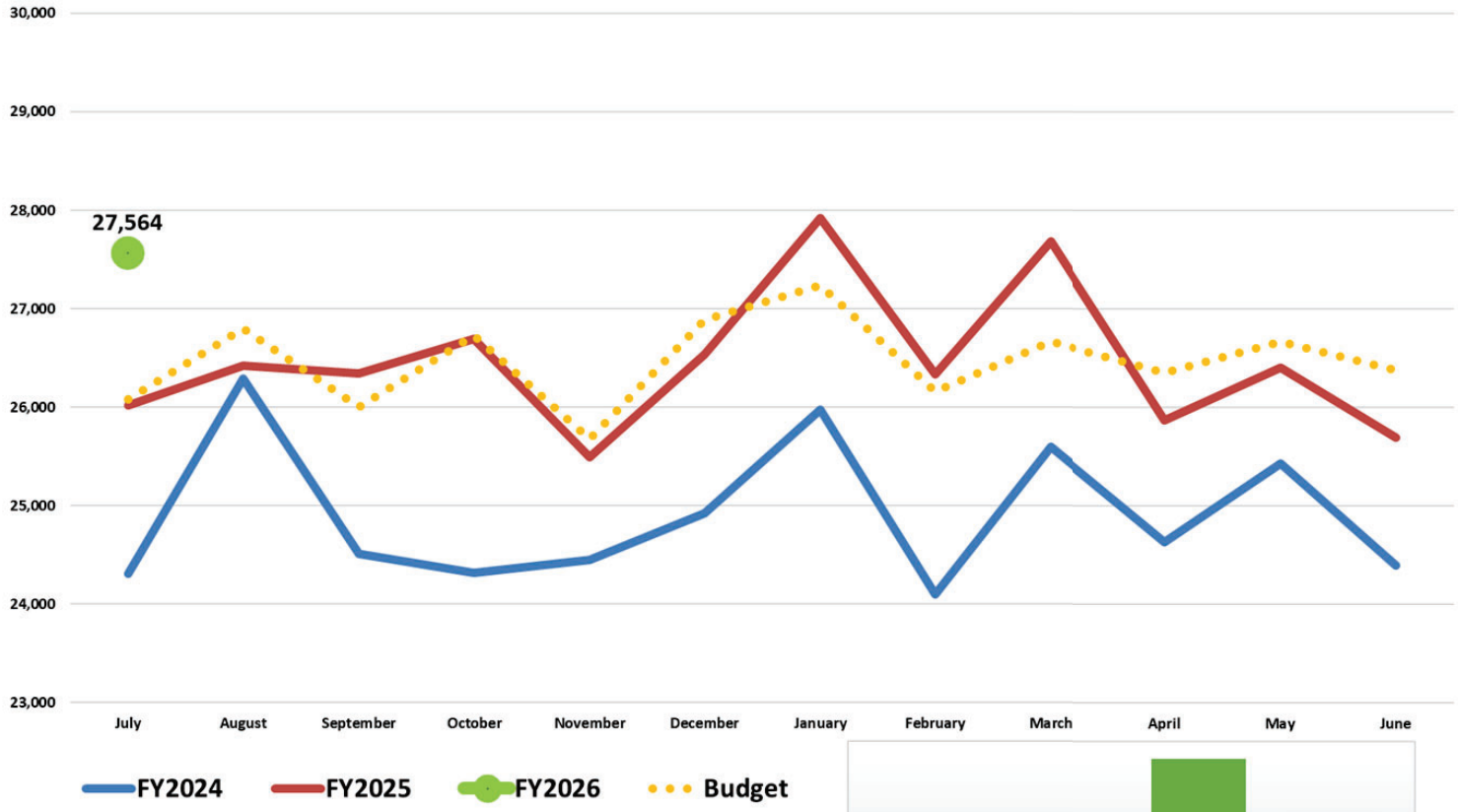
Average Daily Census

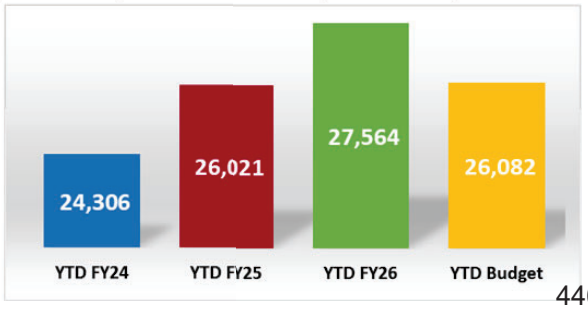


Outpatient Registrations Per Day



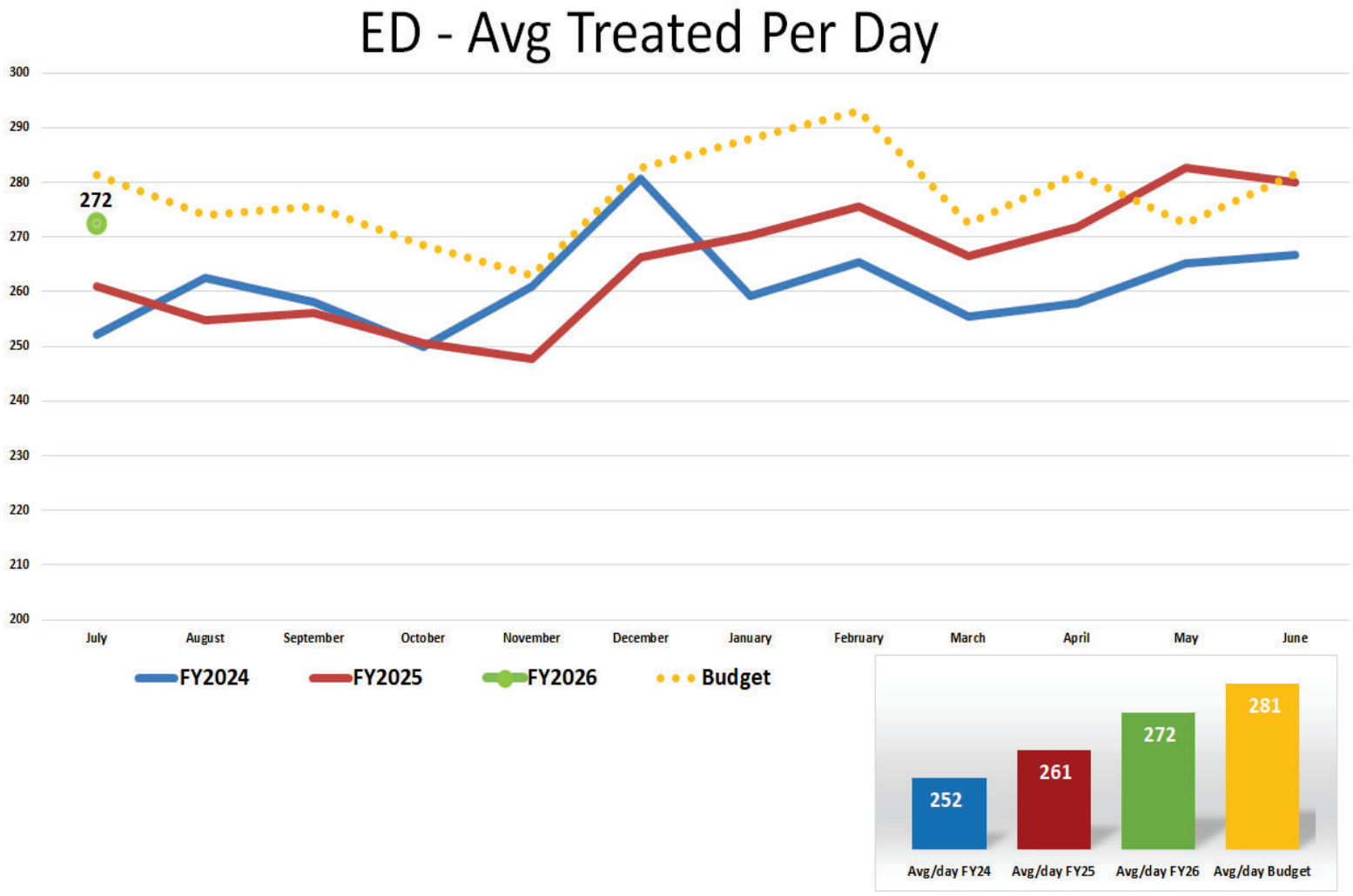
Adjusted Patient Days





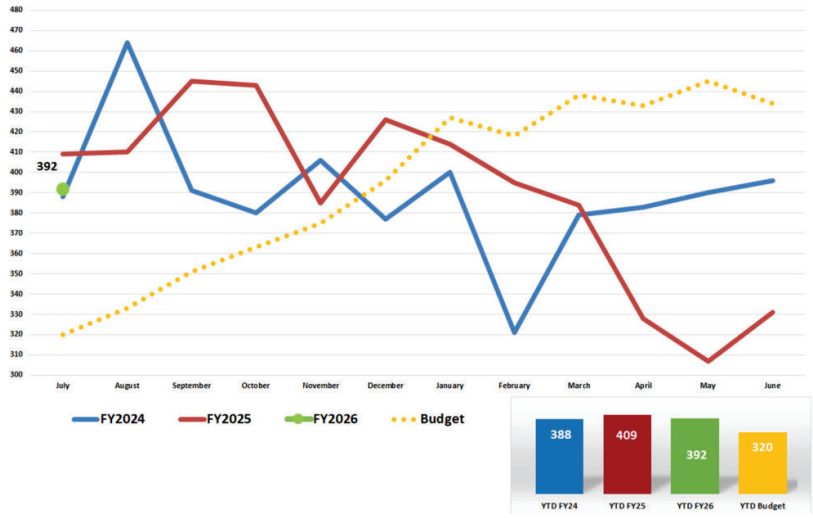
Statistical Results – Fiscal Year Comparison (July)

	Actual Results			Budget	Budget Variance	
	Jul 2024	Jul 2025	% Change	Jul 2025	Change	% Change
Average Daily Census	**411**	**395**	**(3.9%)**	**402**	**(7)**	**(1.8%)**
KDHCD Patient Days:						
Medical Center	9,207	7,998	(13.1%)	8,417	(419)	(5.0%)
Acute I/P Psych	1,114	1,402	25.9%	1,395	7	0.5%
Sub-Acute	882	881	(0.1%)	901	(20)	(2.2%)
Rehab	480	575	19.8%	600	(25)	(4.2%)
TCS-Ortho	268	450	67.9%	410	40	9.8%
NICU	376	418	11.2%	336	82	24.4%
Nursery	412	519	26.0%	411	108	26.3%
Total KDHCD Patient Days	**12,739**	**12,243**	**(3.9%)**	**12,470**	**(227)**	**(1.8%)**
Total Outpatient Volume	**59,365**	**63,426**	**6.8%**	**70,744**	**(7,318)**	**(10.3%)**

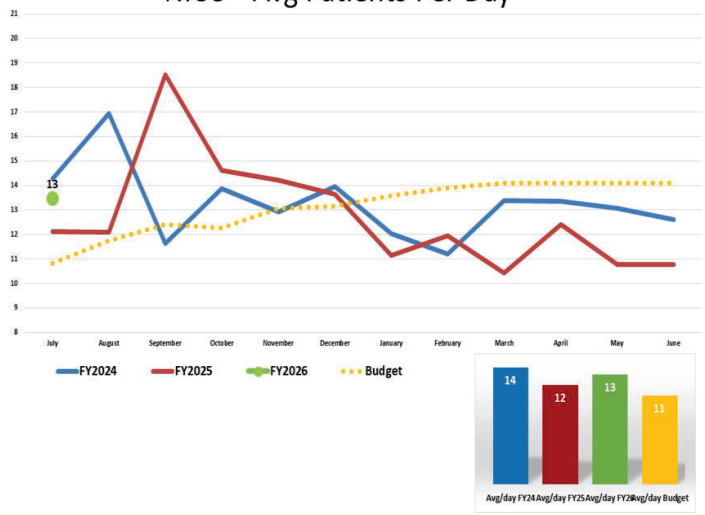

ED - Avg Treated Per Day
300
290
280
270
260
250
240
230
220
210
200
272
July
August
September
October
November
December
January
February
March
April
May
June
FY2024
FY2025
FY2026
Budget

252
261
272
281
Avg/day FY24
Avg/day FY25
Avg/day FY26
Avg/day Budget

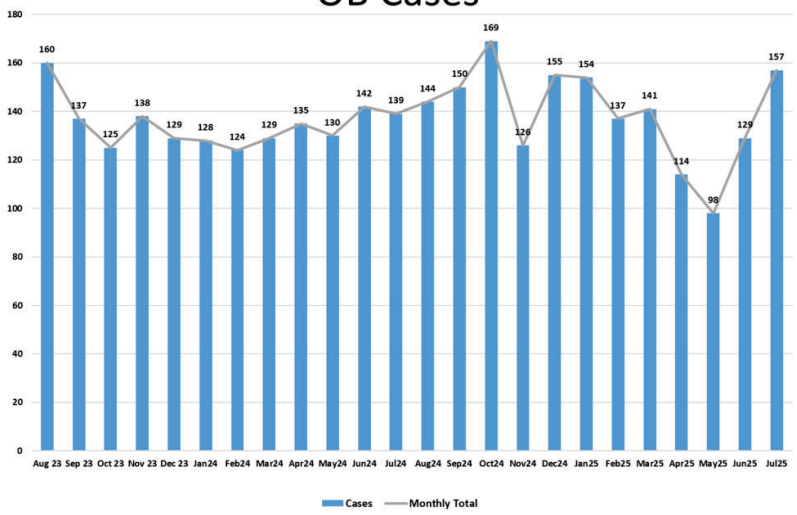
Deliveries



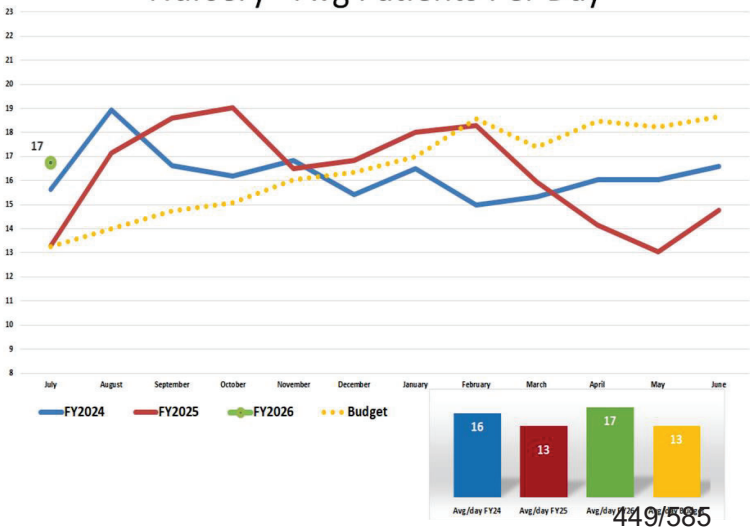
NICU - Avg Patients Per Day



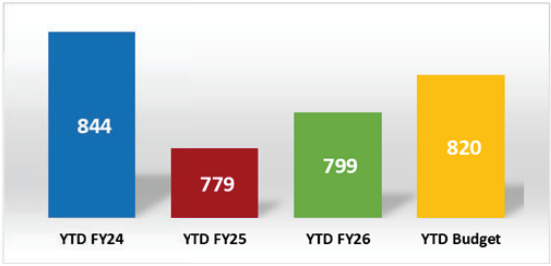
OB Cases



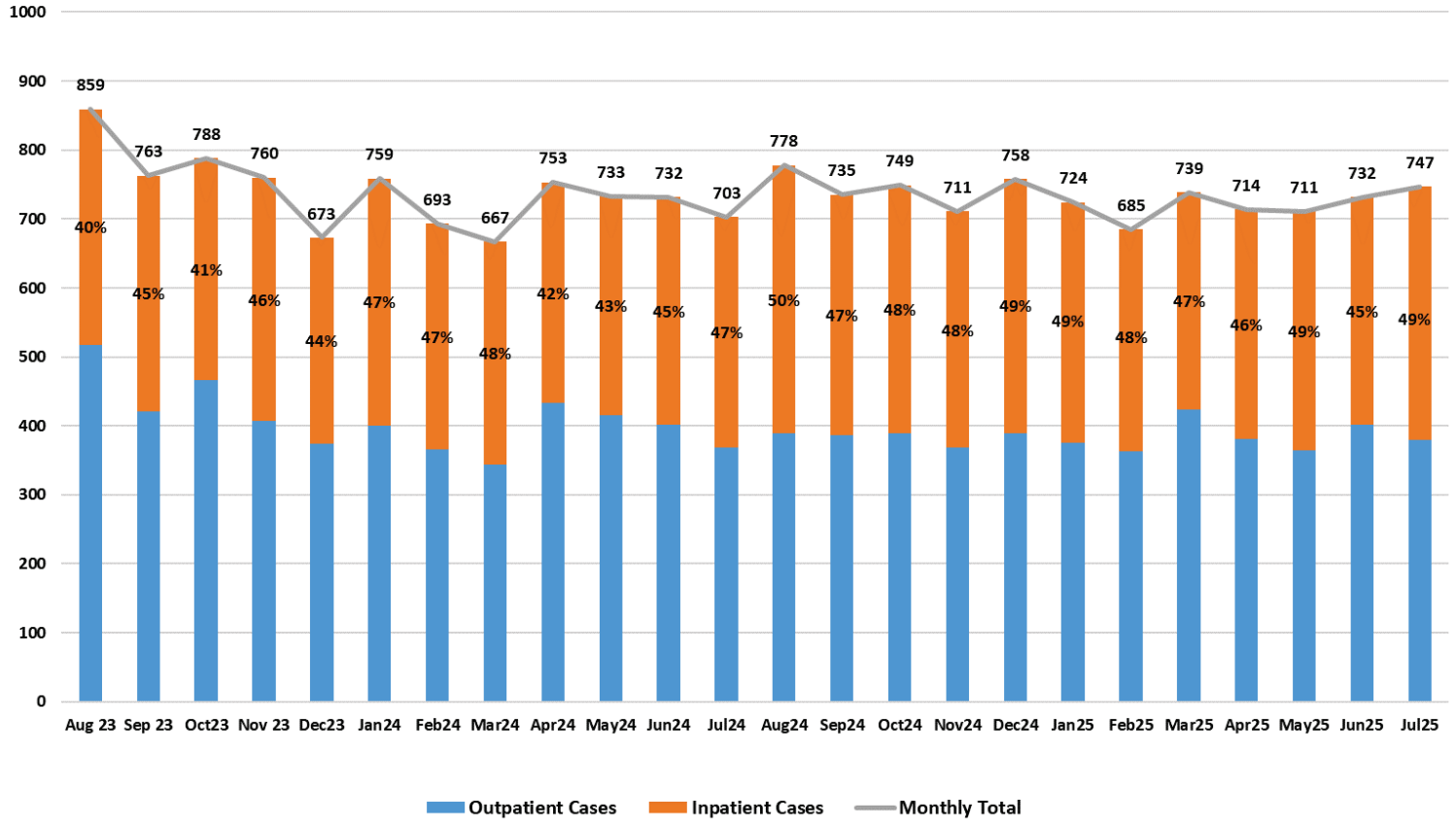
Nursery - Avg Patients Per Day

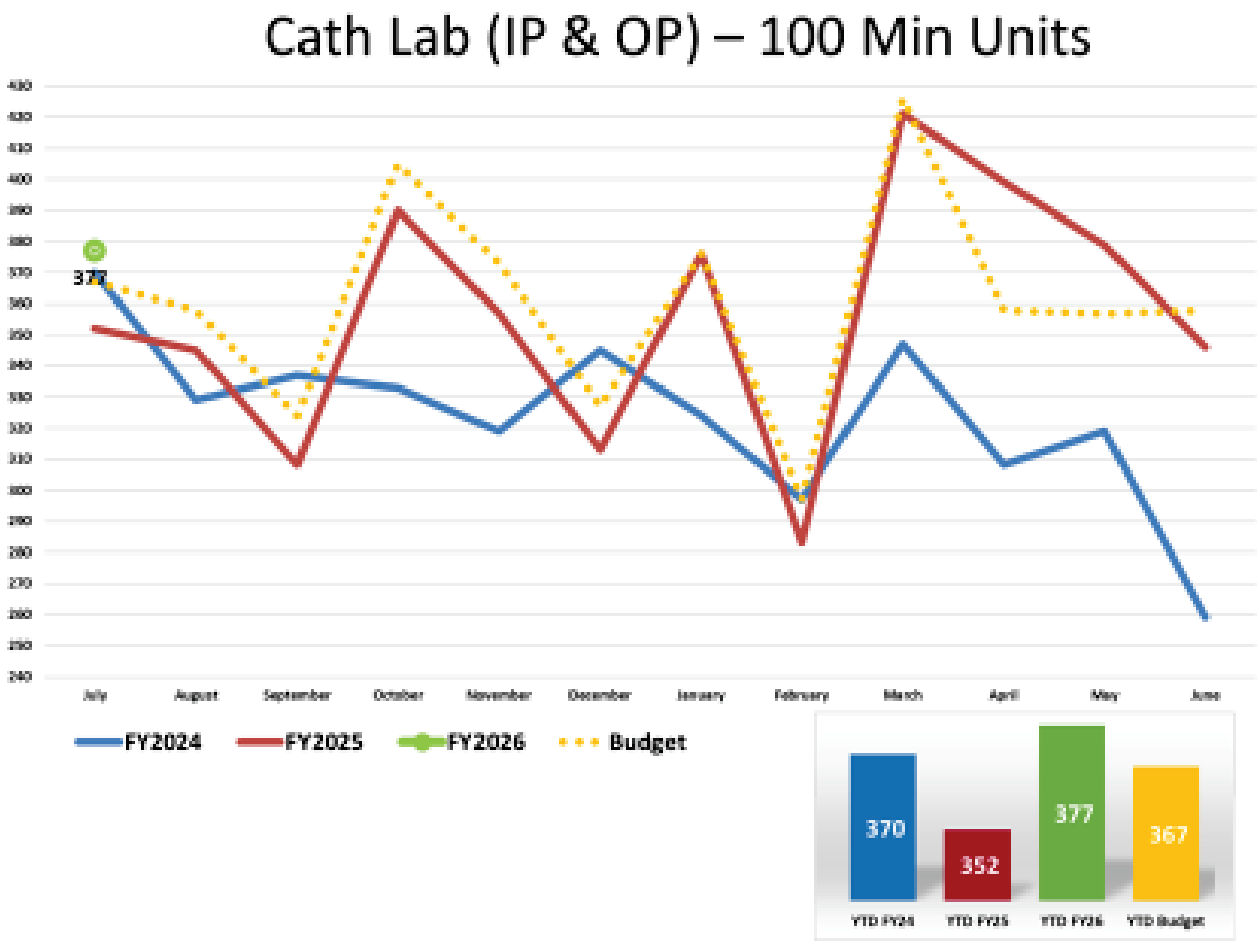


Surgery (IP & OP) – 100 Min Units

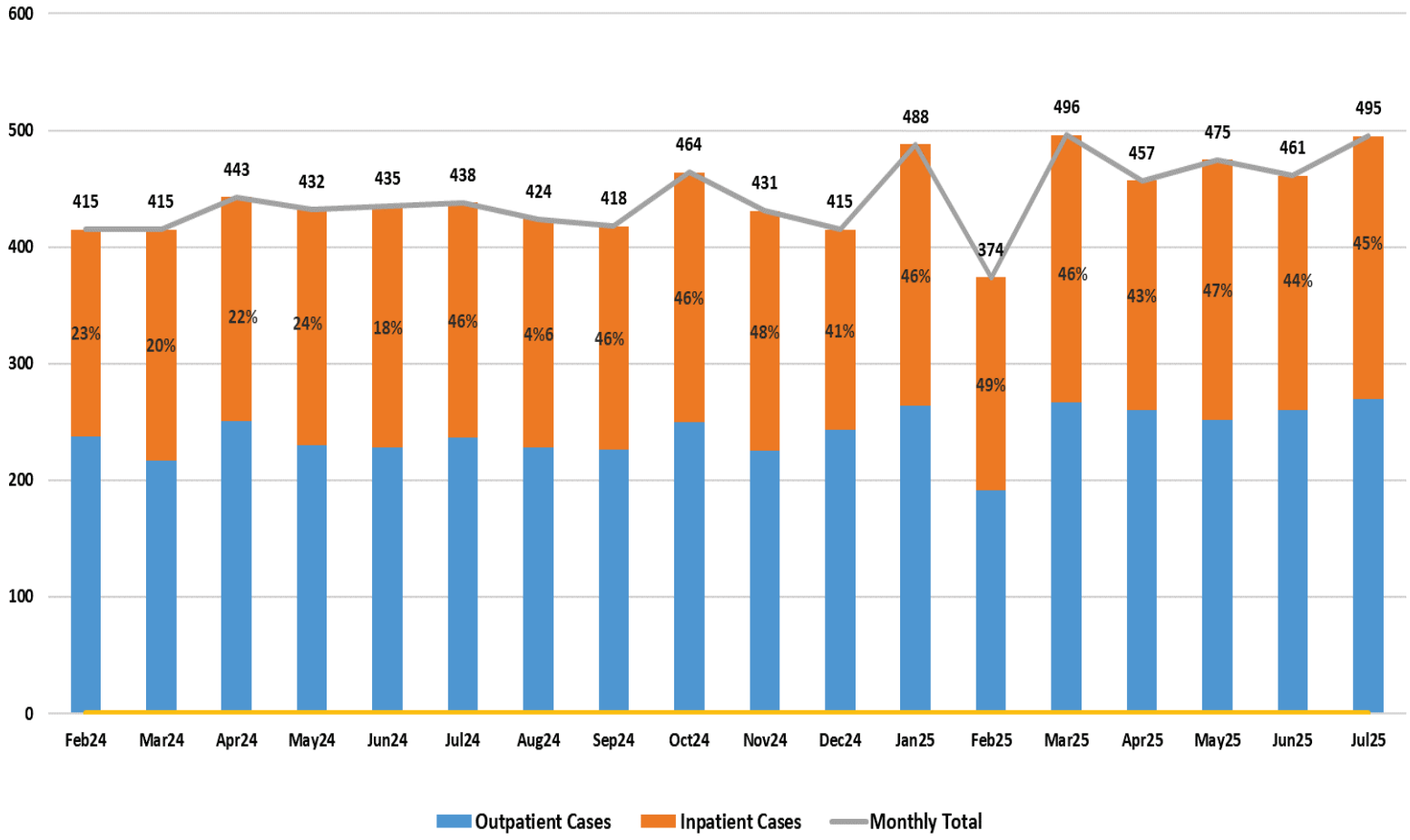


Surgery Cases (IP & OP)

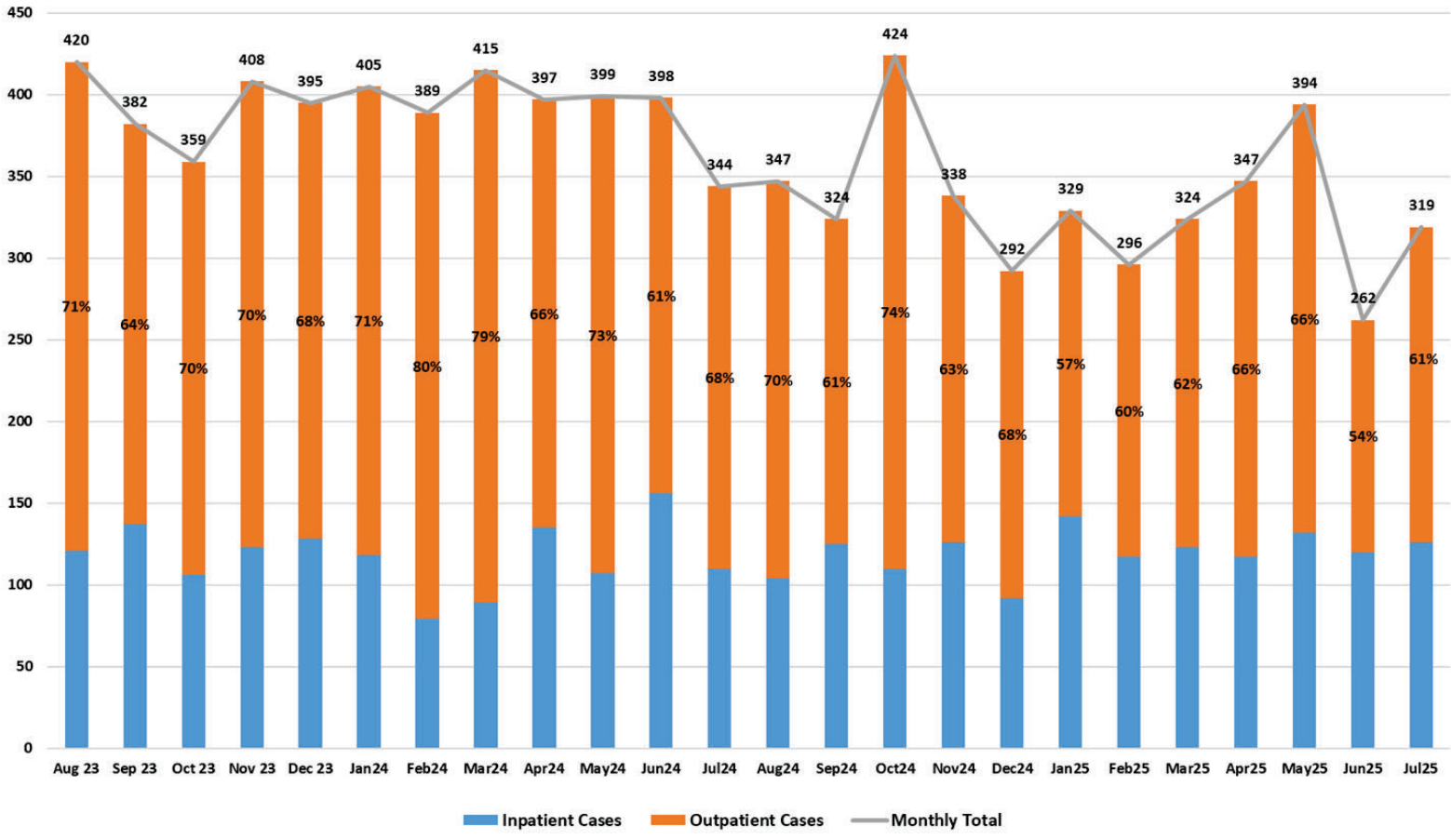



Cath Lab (IP & OP) – 100 Min Units
377
July
August
September
October
November
December
January
February
March
April
May
June
FY2024
FY2025
FY2026
Budget
370
352
377
367
YTD FY24
YTD FY25
YTD FY26
YTD Budget

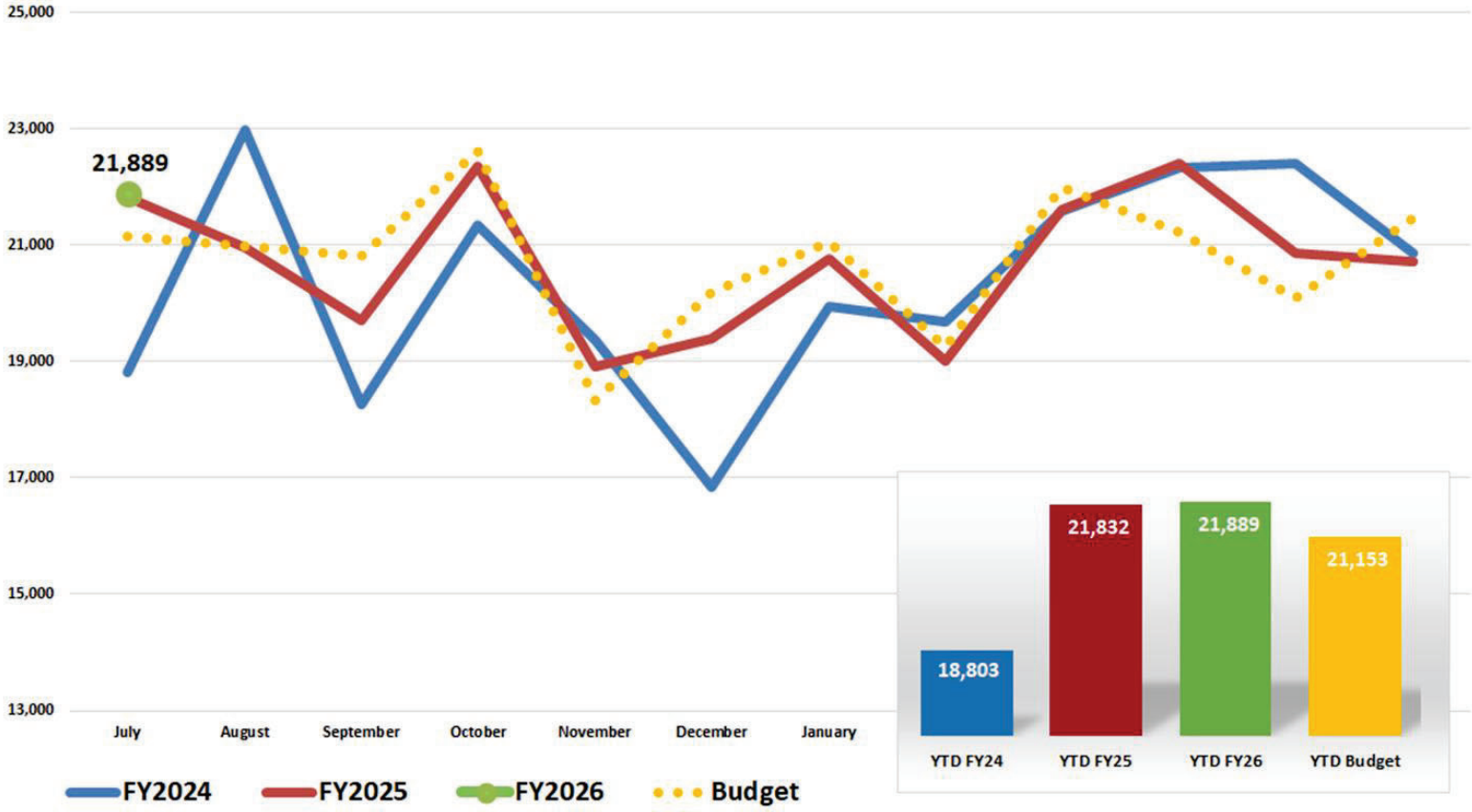
Cath Lab Patients (IP & OP)

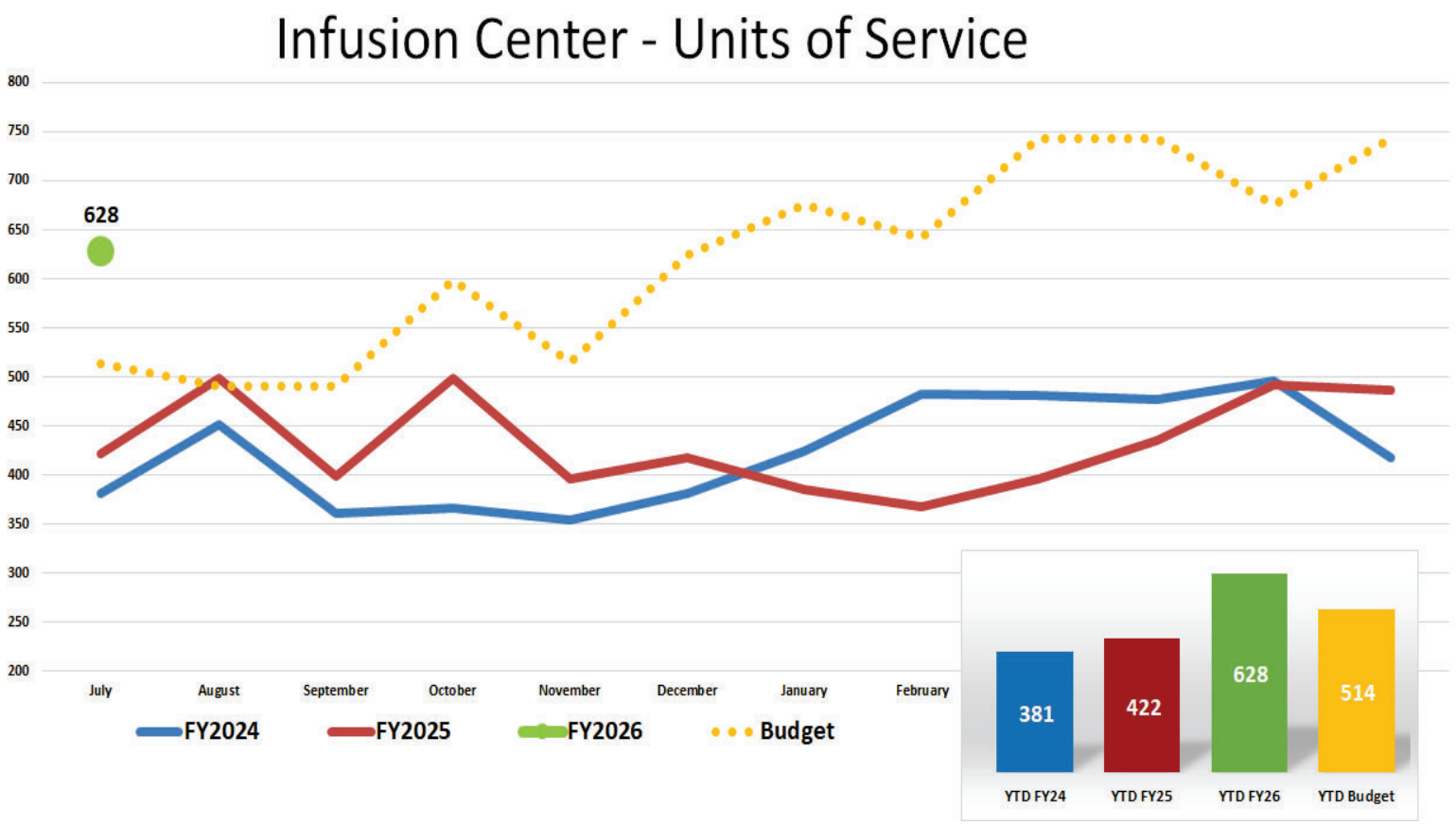


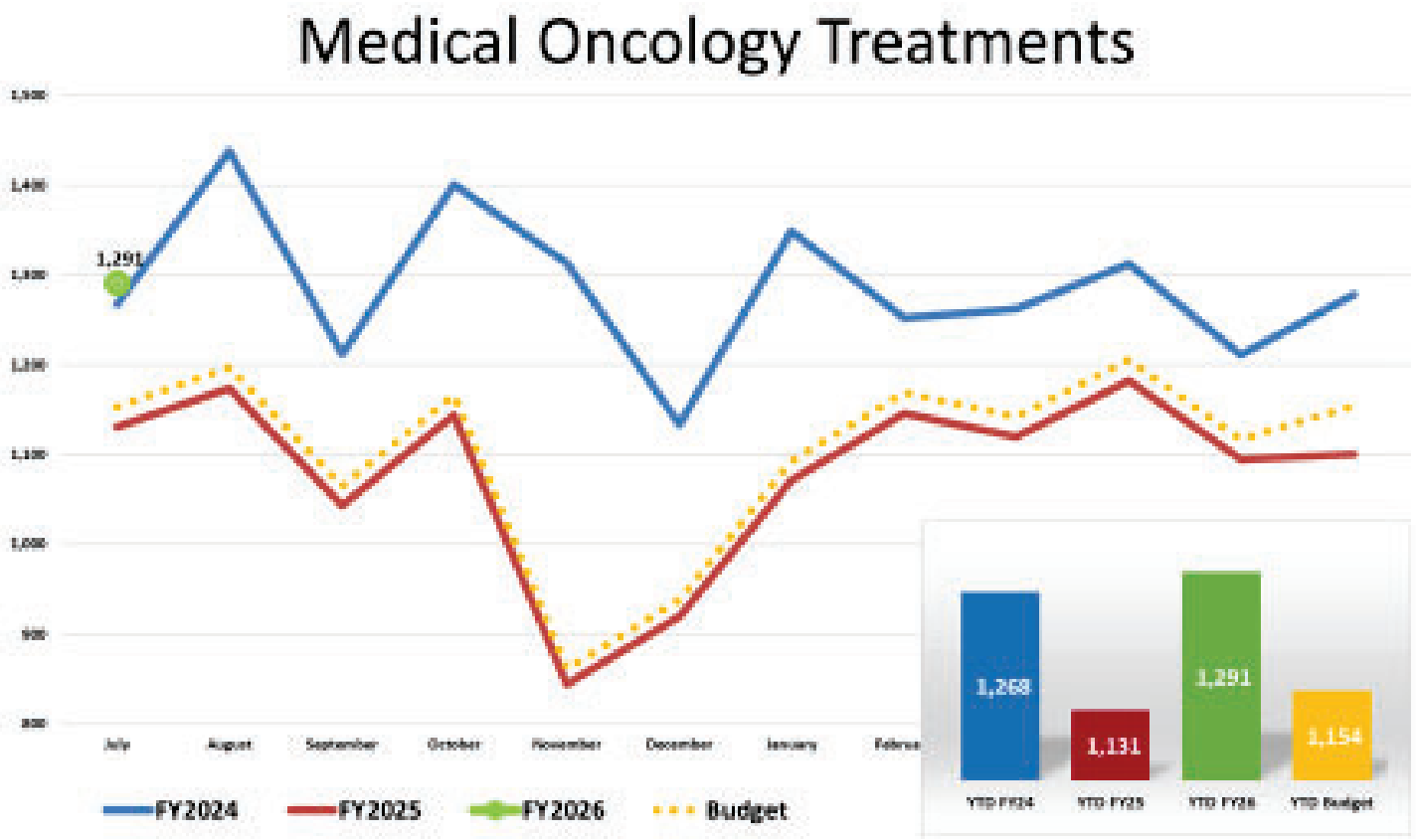
Endo Cases (Suites A & B and OR)



All O/P Rehab Svcs Across District




Infusion Center - Units of Service
800
750
700
650
600
550
500
450
400
350
300
250
200
628
July
August
September
October
November
December
January
February
FY2024
FY2025
FY2026
Budget
381
422
628
514
YTD FY24
YTD FY25
YTD FY26
YTD Budget


Medical Oncology Treatments
1,291
July
August
September
October
November
December
January
FY2024
FY2025
FY2026
Budget
1,268
1,131
1,291
1,154
YTD FY24
YTD FY25
YTD FY26
YTD Budget

Other Statistical Results – Fiscal Year Comparison (July)

	Actual Results				Budget	Budget Variance	
	Jul 24	Jul 25	Change	% Change	Jul 25	Change	% Change
ED - Avg Treated Per Day	261	272	11	4.4%	281	(9)	(3.1%)
Surgery (IP & OP) – 100 Min Units	779	799	20	2.6%	820	(21)	(2.6%)
Endoscopy Procedures	632	563	(69)	(10.9%)	557	6	1.0%
Cath Lab (IP & OP) - 100 Min Units	352	377	25	7.1%	367	10	2.7%
Cardiac Surgery Cases	30	30	0	0.0%	36	(6)	(17.1%)
Deliveries	409	392	(17)	(4.2%)	320	72	22.5%
Clinical Lab	255,814	263,627	7,813	3.1%	281,395	(17,769)	(6.3%)
Reference Lab	8,209	8,062	(147)	(1.8%)	7,954	108	1.4%
Dialysis Center - Visalia Visits	1,529	1,432	(97)	(6.3%)	1,550	(118)	(7.6%)
Infusion Center - Units of Service	422	628	206	48.8%	514	114	22.2%
Hospice Days	3,455	3,866	411	11.9%	4,090	(224)	(5.5%)
Home Health Visits	3,021	3,057	36	1.2%	2,939	118	4.0%
Home Infusion Days	23,746	26,375	2,629	11.1%	23,690	2,685	11.3%

Other Statistical Results – Fiscal Year Comparison (July)

	Actual Results				Budget	Budget Variance	
	Jul 24	Jul 25	Change	% Change	Jul 25	Change	% Change
All O/P Rehab Svcs Across District	21,832	21,889	57	0.3%	21,153	736	3.5%
Physical & Other Therapy Units (I/P & O/P)	18,881	19,239	358	1.9%	20,807	(1,568)	(7.5%)
Radiology - CT - All Areas	4,868	5,085	217	4.5%	4,618	467	10.1%
Radiology - MRI - All Areas	921	945	24	2.6%	912	33	3.6%
Radiology - Ultrasound - All Areas	3,284	3,148	(136)	(4.1%)	3,093	55	1.8%
Radiology - Diagnostic Radiology	10,018	9,482	(536)	(5.4%)	10,057	(575)	(5.7%)
Radiology – Main Campus	16,393	15,665	(728)	(4.4%)	15,845	(180)	(1.1%)
Radiology - Ultrasound - Main Campus	2,580	2,397	(183)	(7.1%)	2,289	108	4.7%
West Campus - Diagnostic Radiology	1,087	1,264	177	16.3%	1,129	135	12.0%
West Campus - CT Scan	465	549	84	18.1%	463	86	18.5%
West Campus - MRI	442	431	(11)	(2.5%)	439	(8)	(1.8%)
West Campus - Ultrasound	704	751	47	6.7%	804	(53)	(6.6%)
West Campus - Breast Center	1,806	1,487	(319)	(17.7%)	1,806	(319)	(17.7%)
Med Onc Visalia Treatments	1,131	1,291	160	14.1%	1,154	137	11.9%
Rad Onc Visalia Treatments	1,697	1,860	163	9.6%	1,748	112	6.4%
Rad Onc Hanford Treatments	294	307	13	4.4%	240	67	28.1%

Other Statistical Results – Fiscal Year Comparison (July)

	Actual Results				Budget	Budget Variance	
	Jul 24	Jul 25	Change	% Change	Jul 25	Change	% Change
Rural Health Clinics Registrations	12,958	13,948	990	7.6%	13,405	543	4.1%
RHC Exeter - Registrations	5,962	6,609	647	10.9%	6,450	159	2.5%
RHC Lindsay - Registrations	1,890	1,958	68	3.6%	2,000	(42)	(2.1%)
RHC Woodlake - Registrations	1,261	821	(440)	(34.9%)	730	91	12.5%
RHC Woodlake Valencia - Registrations	0	548	548	0.0%	704	(156)	(22.2%)
RHC Dinuba - Registrations	1,640	1,569	(71)	(4.3%)	1,800	(231)	(12.8%)
RHC Tulare - Registrations	2,205	2,443	238	10.8%	2,425	18	0.7%
Urgent Care – Court Total Visits	2,160	2,340	180	8.3%	2,700	(360)	(13.3%)
Urgent Care – Demaree Total Visits	1,005	1,596	591	58.8%	1,850	(254)	(13.7%)
KH Medical Clinic - Ben Maddox Visits	739	965	226	30.6%	1,000	(35)	(3.5%)
KH Medical Clinic - Plaza Visits	283	174	(109)	(38.5%)	283	(109)	(38.5%)
KH Medical Willow Clinic Visits	0	1,445	1,445	0.0%	560	885	158.0%
KH Cardiology Center Visalia Registrations	1,563	1,418	(145)	(9.3%)	1,581	(163)	(10.3%)
KH Mental Wellness Clinic Visits	312	359	47	15.1%	390	(31)	(7.9%)
Urology Clinic Visits	224	358	134	59.8%	308	50	16.2%

July Financial Summary (000's) Comparison to Budget

	Comparison to Budget - YTD July			
	Budget YTD Jul-2025	Actual YTD Jul-2025	$ Change	% Change
Operating Revenue				
Net Patient Service Revenue	$56,868	$56,501	($366)	-0.6%
Other Operating Revenue	$22,010	$21,848	($162)	-0.7%
Total Operating Revenue	**$78,878**	**$78,349**	**($528)**	**-0.7%**
Operating Expenses				
Employment Expenses	$42,562	$43,550	$988	2.3%
Other Expenses	$37,663	$38,923	$1,261	3.2%
Total Operating Expenses	**$80,225**	**$82,473**	**$2,249**	**2.7%**
Operating Margin	**($1,347)**	**($4,124)**	**($2,777)**	
Stimulus/FEMA	$0	$0	$0	
Operating Margin after Stimulus/FEMA	**($1,347)**	**($4,124)**	**($2,777)**	
Nonoperating Revenue (Loss)	$846	$1,059	$213	
Excess Margin	**($501)**	**($3,065)**	**($2,563)**	

July Financial Summary (000's) Comparison to Prior Year

	Comparison to Prior Year - YTD July			
	Actual YTD Jul-2024	Actual YTD Jul-2025	$ Change	% Change
Operating Revenue				
Net Patient Service Revenue	$50,866	$56,501	$5,636	10.0%
Other Operating Revenue	$19,487	$21,848	$2,361	10.8%
Total Operating Revenue	**$70,353**	**$78,349**	**$7,997**	**10.2%**
Operating Expenses				
Employment Expenses	$38,264	$43,550	$5,286	12.1%
Other Expenses	$35,811	$38,923	$3,113	8.0%
Total Operating Expenses	**$74,075**	**$82,473**	**$8,398**	**10.2%**
Operating Margin	**($3,722)**	**($4,124)**	**($402)**	
Stimulus/FEMA	$0	$0	$0	
Operating Margin after Stimulus/FEMA	**($3,722)**	**($4,124)**	**($402)**	
Nonoperating Revenue (Loss)	$1,190	$1,059	($130)	
Excess Margin	**($2,533)**	**($3,065)**	**($532)**	

July Financial Comparison (000's)

	Comparison to Budget - YTD July-July				Comparison to Prior Year - YTD July-July			
	Budget July 2025	Actual July 2025	$ Change	% Change	Actual July 2024	Actual July 2025	$ Change	% Change
Operating Revenue								
Net Patient Service Revenue	**$56,868**	**$56,501**	**($366)**	**-0.6%**	**$50,866**	**$56,501**	**$5,636**	**10.0%**
Supplemental Gov't Programs	$10,258	$9,453	($805)	-8.5%	$7,693	$9,453	$1,761	18.6%
Prime Program	$689	$689	$0	0.0%	$792	$689	($103)	-14.9%
Premium Revenue	$6,931	$6,978	$47	0.7%	$7,107	$6,978	($129)	-1.9%
Management Services Revenue	$0	$0	$0	0.0%	$0	$0	$0	#DIV/0!
Other Revenue	$4,132	$4,728	$596	12.6%	$3,895	$4,728	$833	17.6%
Other Operating Revenue	$22,010	$21,848	($162)	-0.7%	$19,487	$21,848	$2,361	10.8%
Total Operating Revenue	**$78,878**	**$78,349**	**($528)**	**-0.7%**	**$70,353**	**$78,349**	**$7,997**	**10.2%**
Operating Expenses								
Salaries & Wages	$32,329	$33,283	$954	2.9%	$31,568	$33,283	$1,714	5.2%
Contract Labor	$2,541	$2,482	($59)	-2.4%	$918	$2,482	$1,563	63.0%
Employee Benefits	$7,693	$7,786	$93	1.2%	$5,778	$7,786	$2,008	25.8%
Total Employment Expenses	**$42,562**	**$43,550**	**$988**	**2.3%**	**$38,264**	**$43,550**	**$5,286**	**12.1%**
Medical & Other Supplies	$14,285	$14,552	$267	1.8%	$14,820	$14,552	($268)	-1.8%
Physician Fees	$7,512	$8,276	$765	9.2%	$7,061	$8,276	$1,216	14.7%
Purchased Services	$1,907	$1,681	($227)	-13.5%	$1,581	$1,681	$100	5.9%
Repairs & Maintenance	$2,662	$2,212	($450)	-20.3%	$1,664	$2,212	$548	24.8%
Utilities	$974	$929	($45)	-4.9%	$874	$929	$55	5.9%
Rents & Leases	$140	$117	($24)	-20.3%	$124	$117	($8)	-6.5%
Depreciation & Amortization	$3,505	$3,217	($288)	-9.0%	$3,160	$3,217	$57	1.8%
Interest Expense	$572	$572	($1)	-0.1%	$609	$572	($38)	-6.6%
Other Expense	$2,384	$1,908	($477)	-25.0%	$1,964	$1,908	($56)	-2.9%
Humana Cap Plan Expenses	$3,720	$5,460	$1,740	31.9%	$3,953	$5,460	$1,507	27.6%
Total Other Expenses	**$37,663**	**$38,923**	**$1,261**	**3.2%**	**$35,811**	**$38,923**	**$3,113**	**8.0%**
Total Operating Expenses	**$80,225**	**$82,473**	**$2,249**	**2.7%**	**$74,075**	**$82,473**	**$8,398**	**10.2%**
Operating Margin	**($1,347)**	**($4,124)**	**($2,777)**		**($3,722)**	**($4,124)**	**($402)**	
Stimulus/FEMA	**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	
Operating Margin after FEMA	**($1,347)**	**($4,124)**	**($2,777)**		**($3,722)**	**($4,124)**	**($402)**	
Nonoperating Revenue (Loss)	$846	$1,059	$213		$1,190	$1,059	($130)	
Excess Margin	**($501)**	**($3,065)**	**($2,563)**		**($2,533)**	**($3,065)**	**($532)**	

Month of July - Budget Variances

- **Supplemental Funds:** The $805K unfavorable budget variance was due to reductions to our various programs through recent legislation
- **Other Revenue:** The $596K favorable budget variance is due to the retail pharmacy revenue.
- **Salaries and Wages:** The $954K unfavorable variance is due to increases in registered nurse expenses compared to budget in inpatient settings.
- **Physician Fees:** The $765K unfavorable variance is due to Radiology, Cardiology and Hospitalist group that were higher than anticipated.
- **Humana Cap Expenses:** The unfavorable variance of $1.7M is due to higher than anticipated third party expenses.

Next steps due to the reduction in supplemental funds:

Relook at Budget FY26: Adjusting Budget

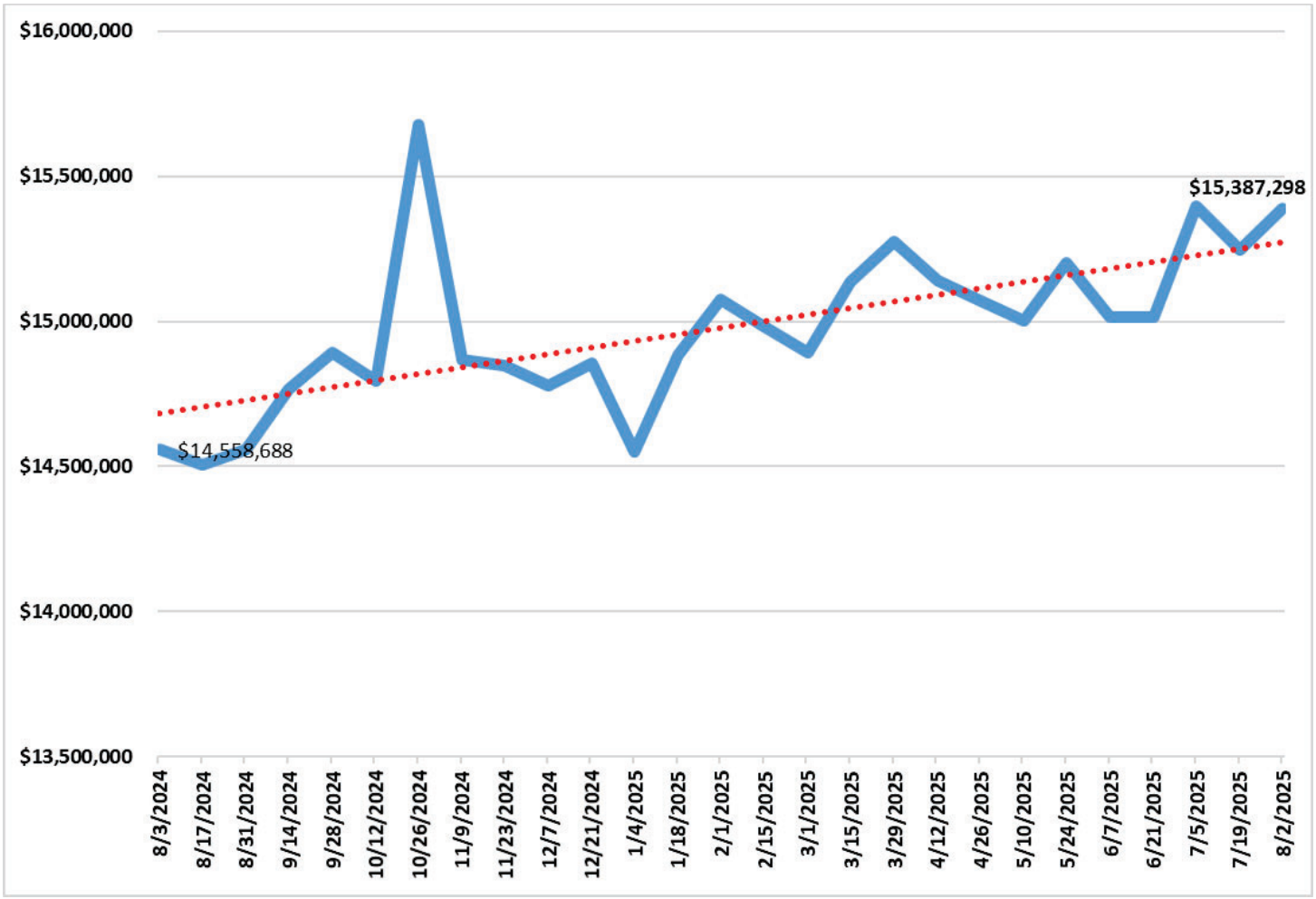
Goal: Improve our bottom line by $25M keeping 401K match and annual merit raises intact

- Broke out the $25M gap across all departments with a calculated goal
- Relook at staffing levels / efficiencies across health system
- Relook at “Must Have” versus “Nice to Have”
- Productivity Ratios: accountability with daily/weekly matrix variance reports
- Relook at various pay practices
- Overtime, Standby, Sitter Pay, Call Back, Shift Bonus, Meal Break
- Maximize focus on throughput
- Renegotiations in payers contracts
- Renegotiations on supplies and increase supply standardizations
- Relook at Authorizations, Denials, Scheduling
- Continue to explore additional strategic initiatives such as OB ED

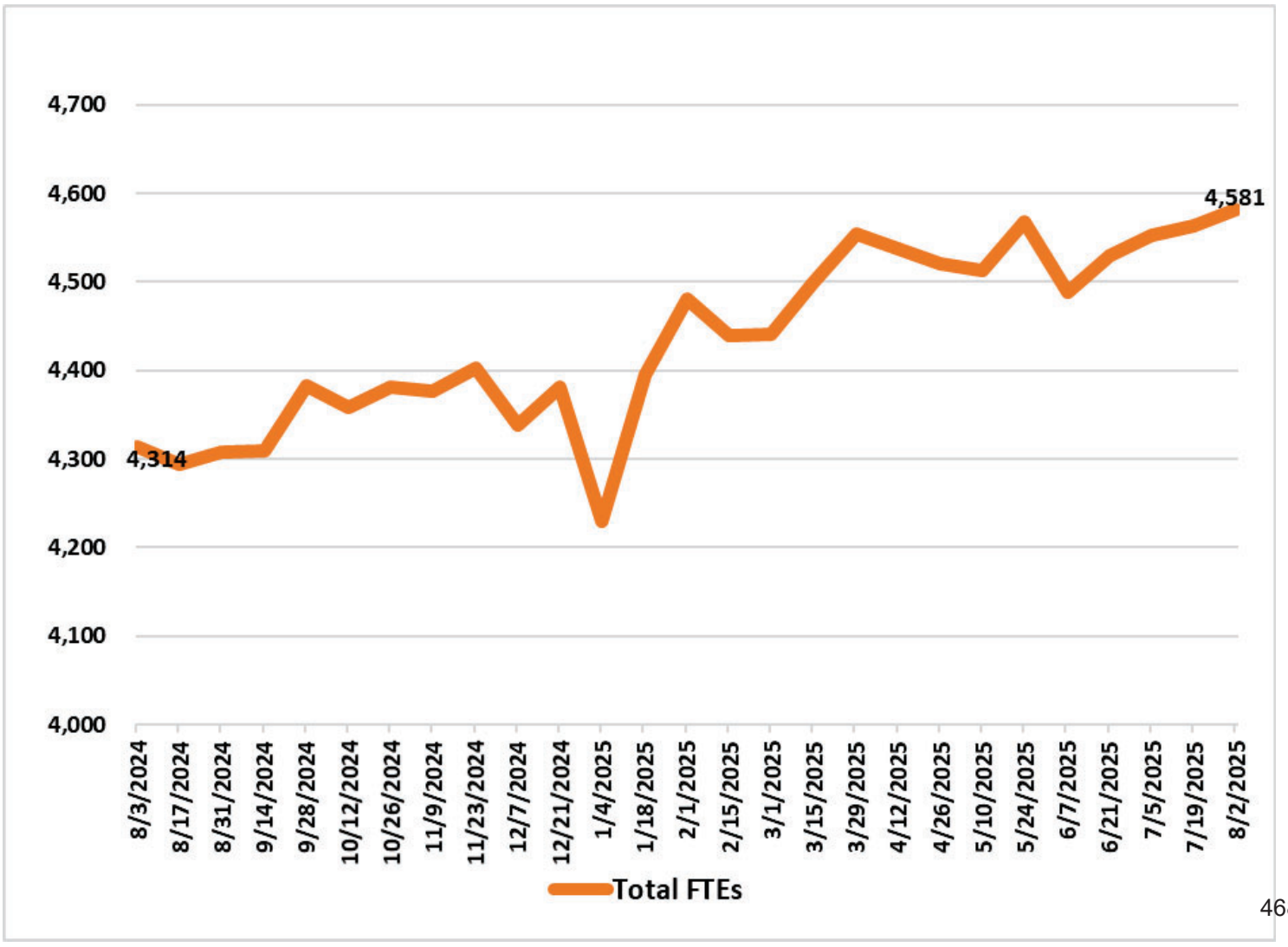
Budget and Actual Fiscal Year 2026: Trended Operating Margin (000's)

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	FY 2026
Patient Service Revenue	$61,895	$53,731	$57,324	$55,188	$56,648	$44,489	$56,501	$56,501
Other Revenue	$18,042	$18,979	$21,231	$20,234	$20,167	$35,618	$21,848	$21,848
Total Operating Revenue	$79,938	$72,710	$78,555	$75,422	$76,815	$80,107	$78,349	$78,349
Employee Expense	$39,859	$38,637	$42,423	$43,595	$46,037	$42,136	$43,550	$43,550
Other Operating Expense	$36,630	$33,796	$36,024	$34,988	$38,656	$44,317	$38,923	$38,923
Total Operating Expenses	$76,489	$72,433	$78,446	$78,583	$84,693	$86,454	$82,473	$82,473
Net Operating Margin	$3,448	$277	$109	($3,161)	($7,878)	($6,347)	($4,124)	($4,124)
Stimulus/FEMA	$0	$0	$690	$0	$0	$0	$0	$0
NonOperating Income	$845	$1,166	$1,313	$1,114	$955	$2,597	$1,059	$1,059
Excess Margin	$4,293	$1,443	$2,111	($2,047)	($6,923)	($3,749)	($3,065)	($3,065)
Profitability								
Operating Margin %	4.3%	0.4%	0.1%	(4.2%)	(10.3%)	(7.9%)	(5.3%)	(5.3%)
Operating Margin %excl. Int	5.1%	1.1%	0.9%	(3.4%)	(9.5%)	(7.1%)	(4.5%)	(4.5%)
Operating EBIDA	$7,207	$4,052	$4,115	$920	($3,534)	($1,857)	($336)	($336)
Operating EBIDA Margin	9.0%	5.6%	5.2%	1.2%	(4.6%)	(2.3%)	(0.4%)	(0.4%)
Liquidity Indicators								
Day's Cash on Hand	80.3	88.9	88.1	95.7	90.5	95.7	102.1	102.1
Day's in Accounts Rec.	70.6	73.0	68.6	63.6	71.3	68.8	71.9	71.9
Debt & Other Indicators								
Debt Service Coverage (MADS)	3.20	3.90	4.10	4.00	3.70	4.00	0.40	0.40
Discharges (Monthly)	2,339	2,352	2,347	2,357	2,276	2,277	2,249	2,249
Adj Discharges (Case mix adj)	8,294	8,320	8,053	8,500	8,534	8,538	8,420	8,420
Adjusted patient Days (Mo.)	27,924	26,332	27,682	25,868	26,409	25,593	26,673	26,673
Cost/Adj Discharge	$9.2	$8.7	$9.7	$9.2	$9.9	$10.1	$9.8	$9.8

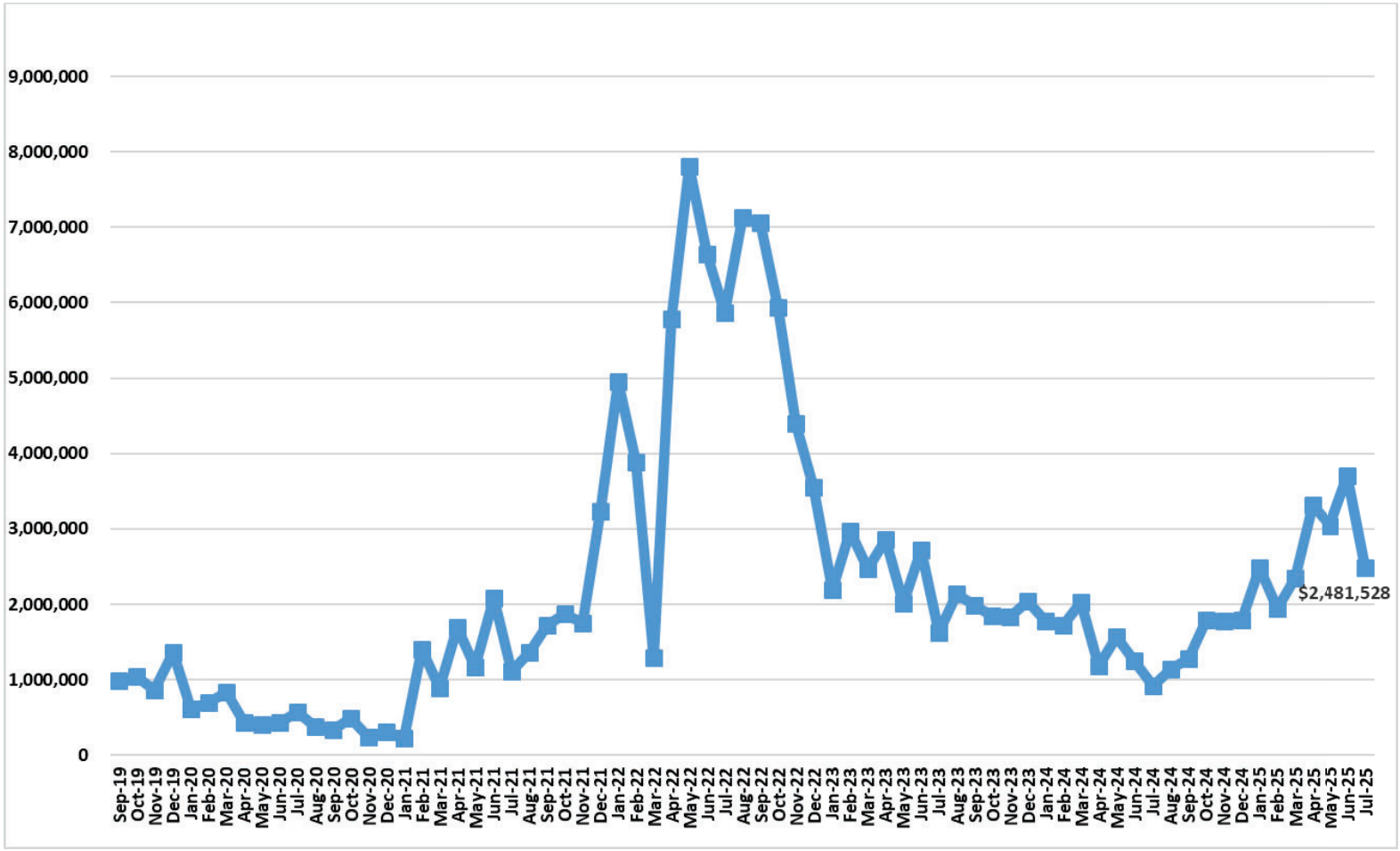
Biweekly Payroll Costs excluding Contract Labor



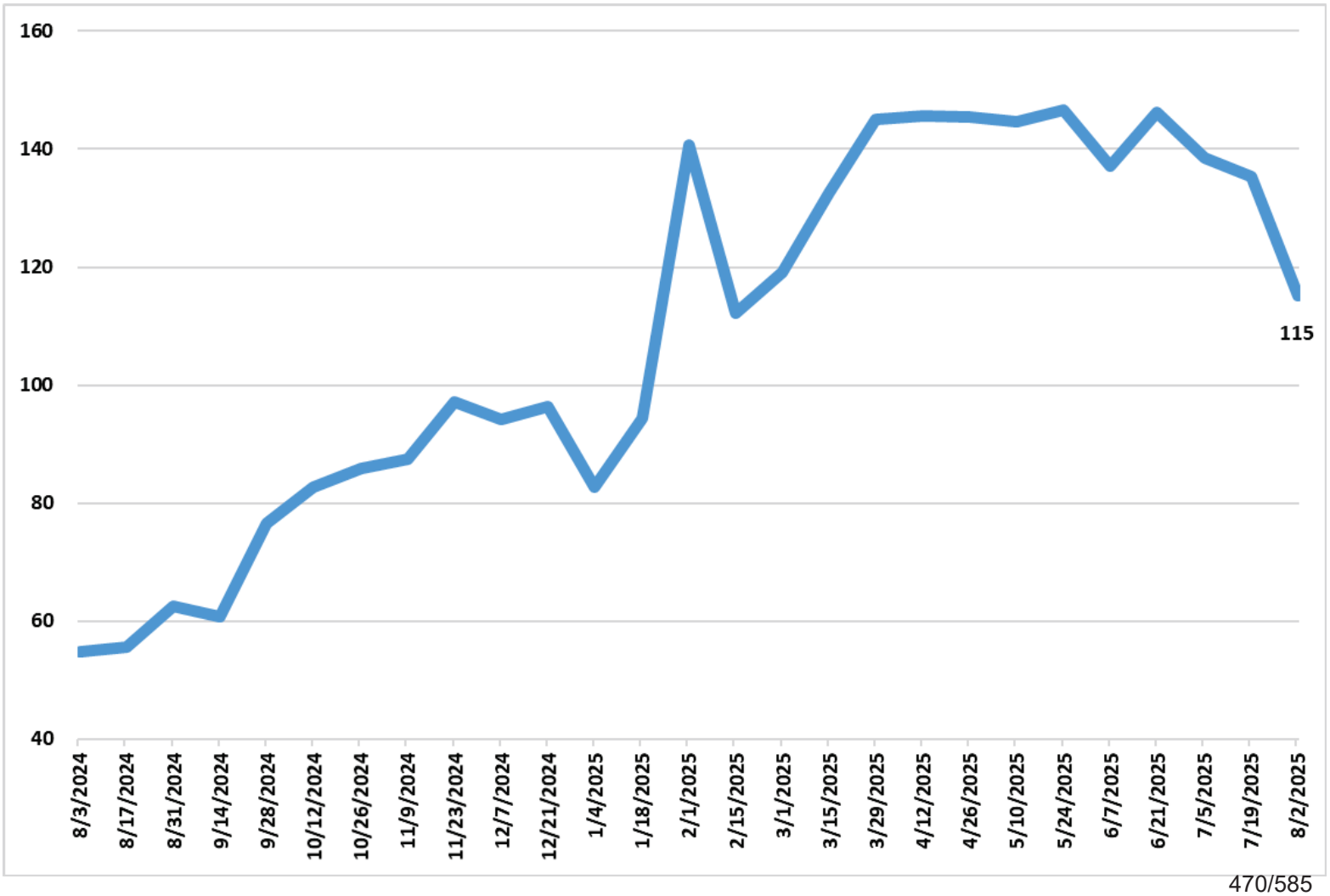
Total FTEs (includes Contract Labor)



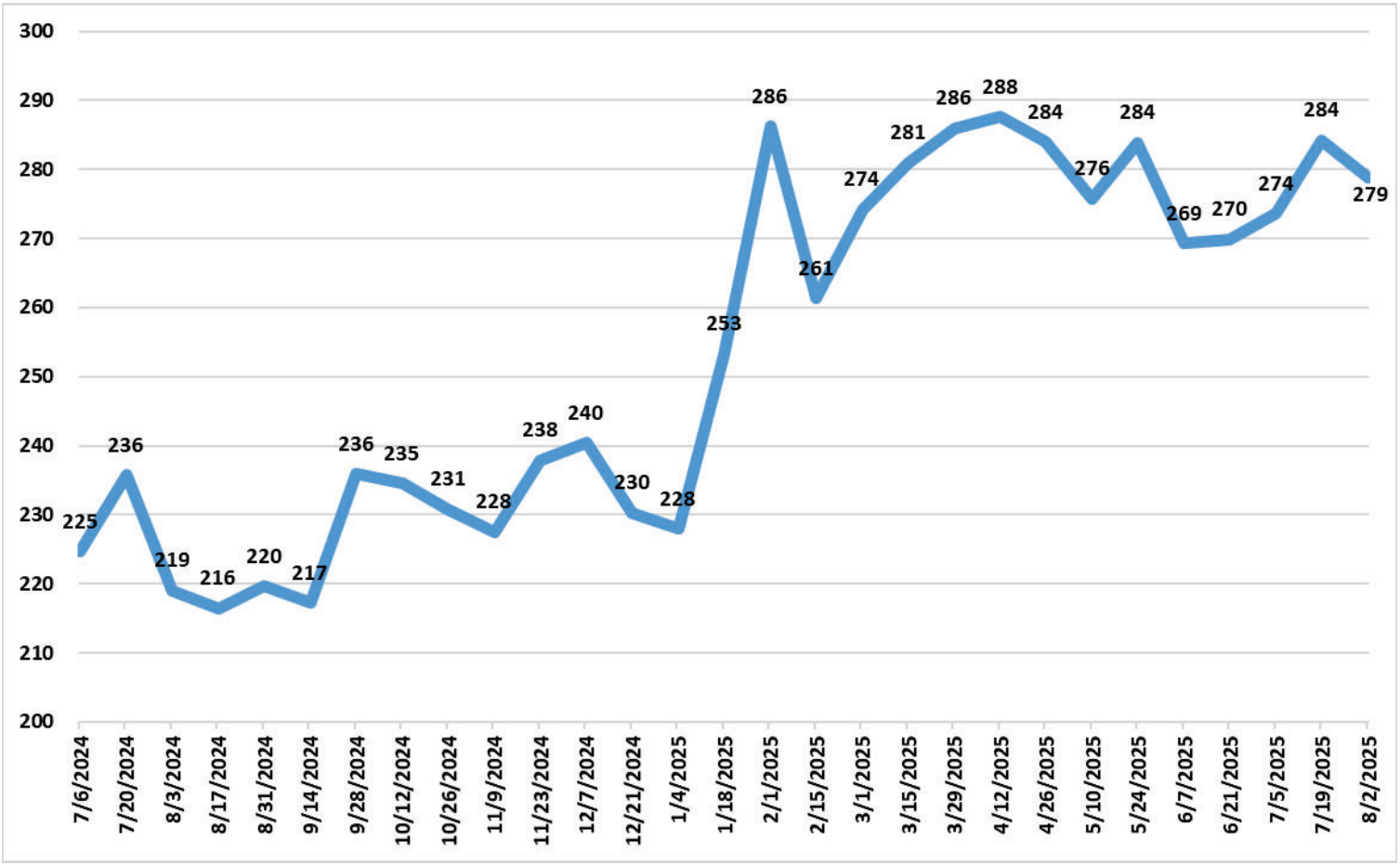
Monthly Contract Labor Costs



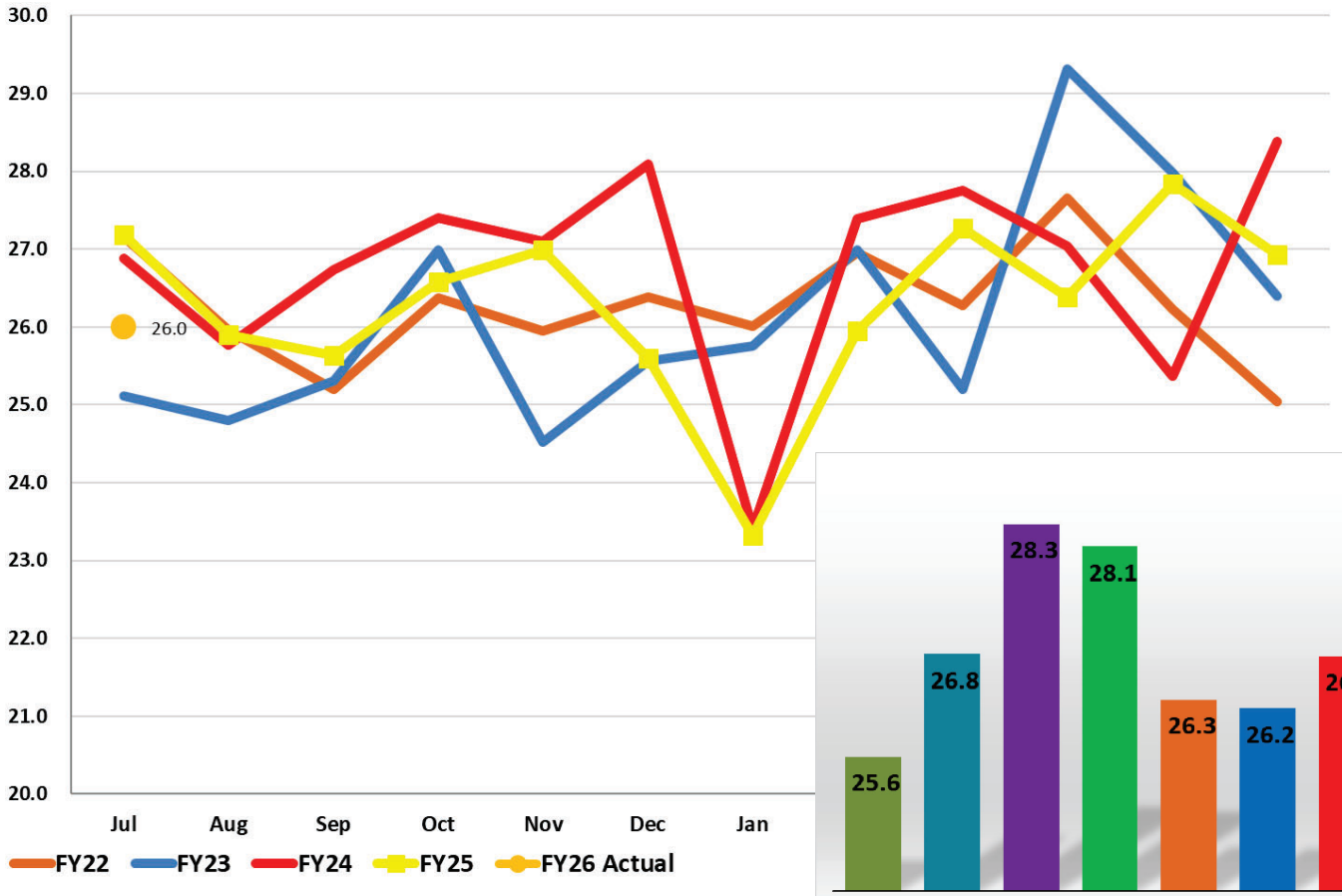
Contract Labor Full Time Equivalents (FTEs)



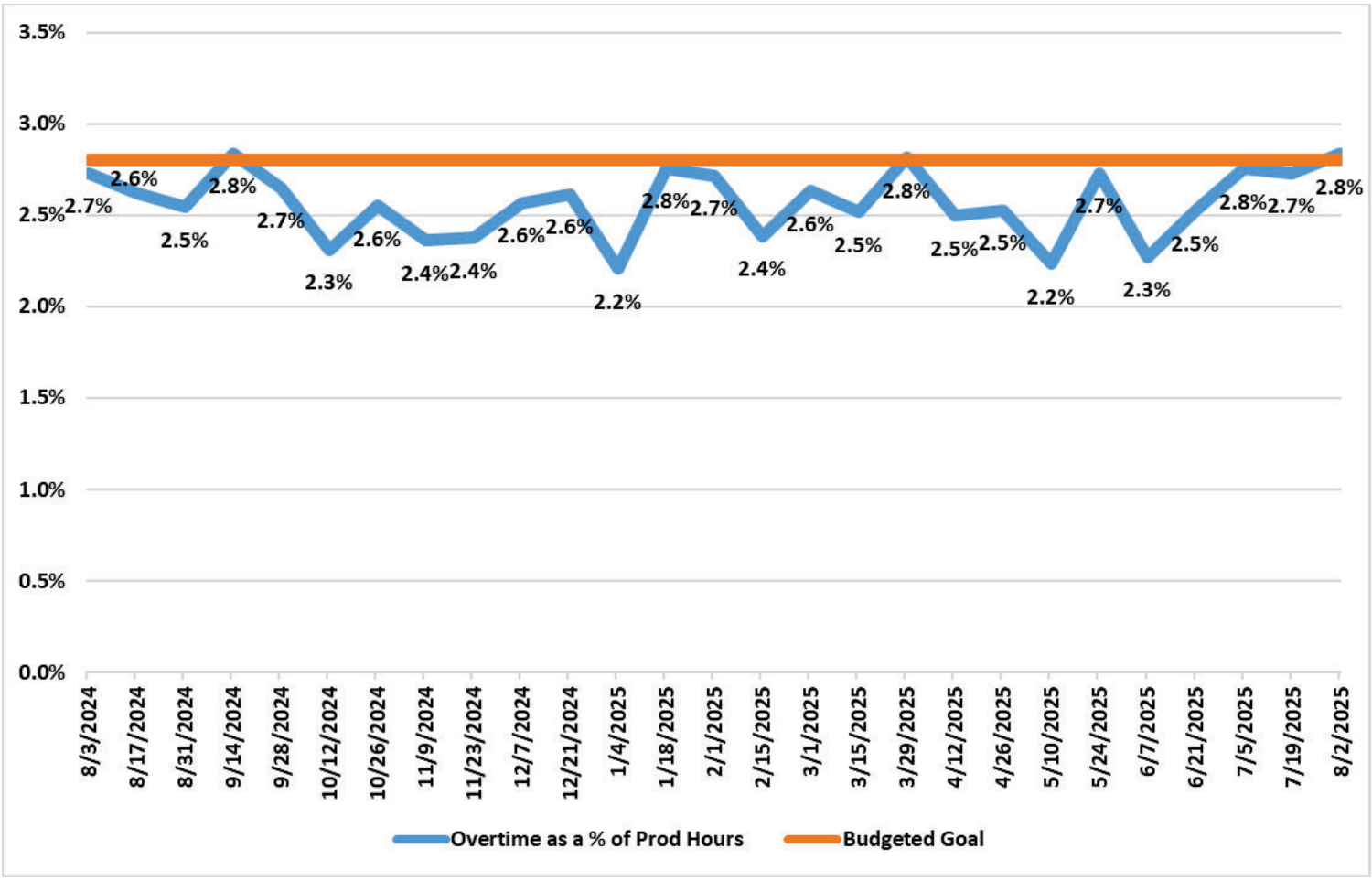
Emergency Department FTEs: Includes Contract

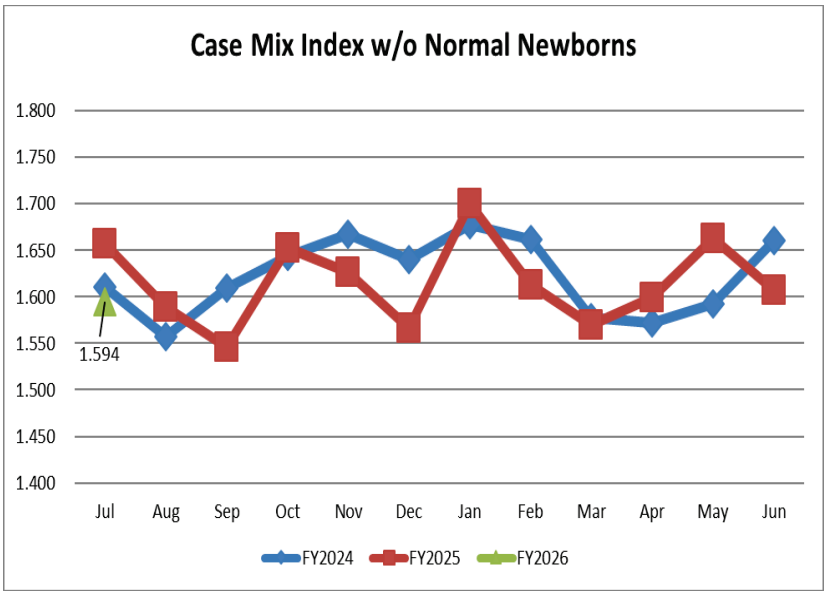


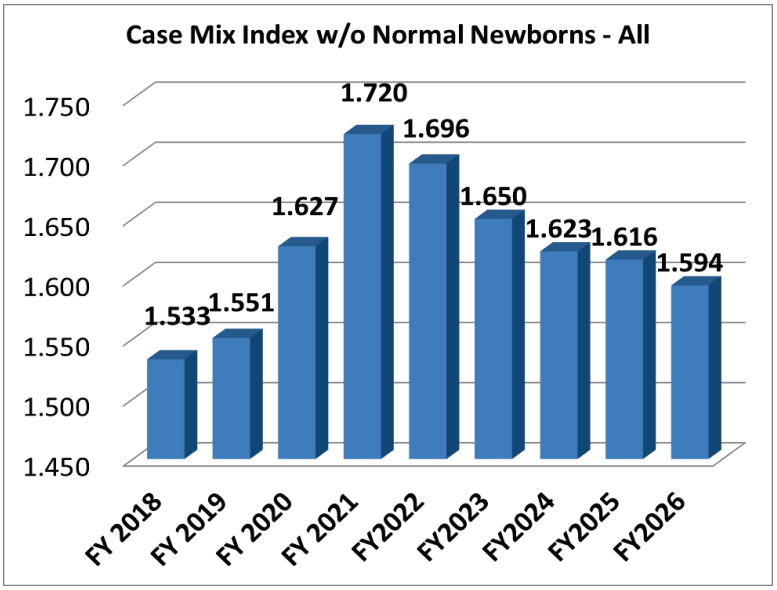
Productivity Measure : Worked Hours/ Adj. Patient Days

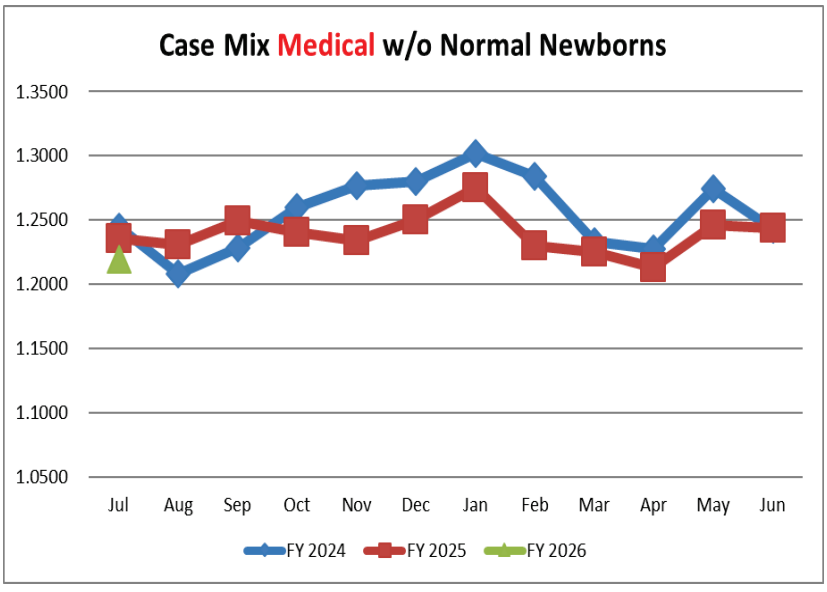


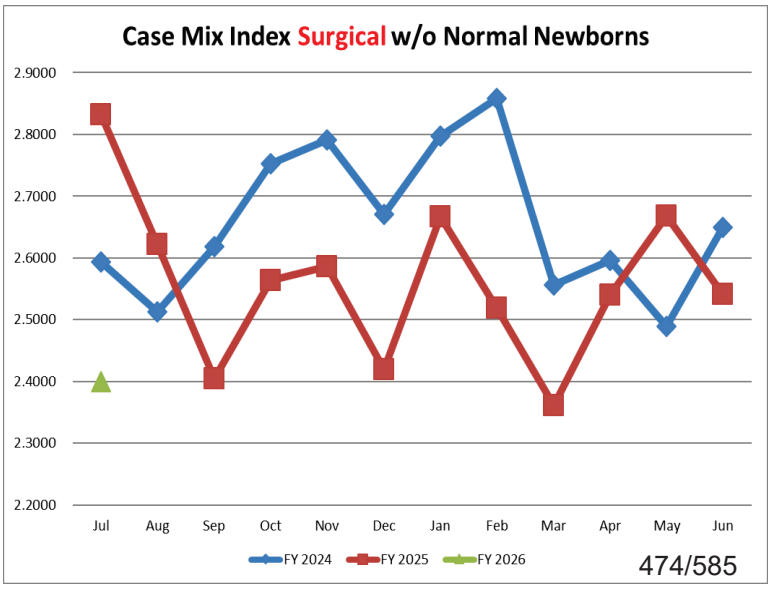
Overtime as a % of Productive Hours



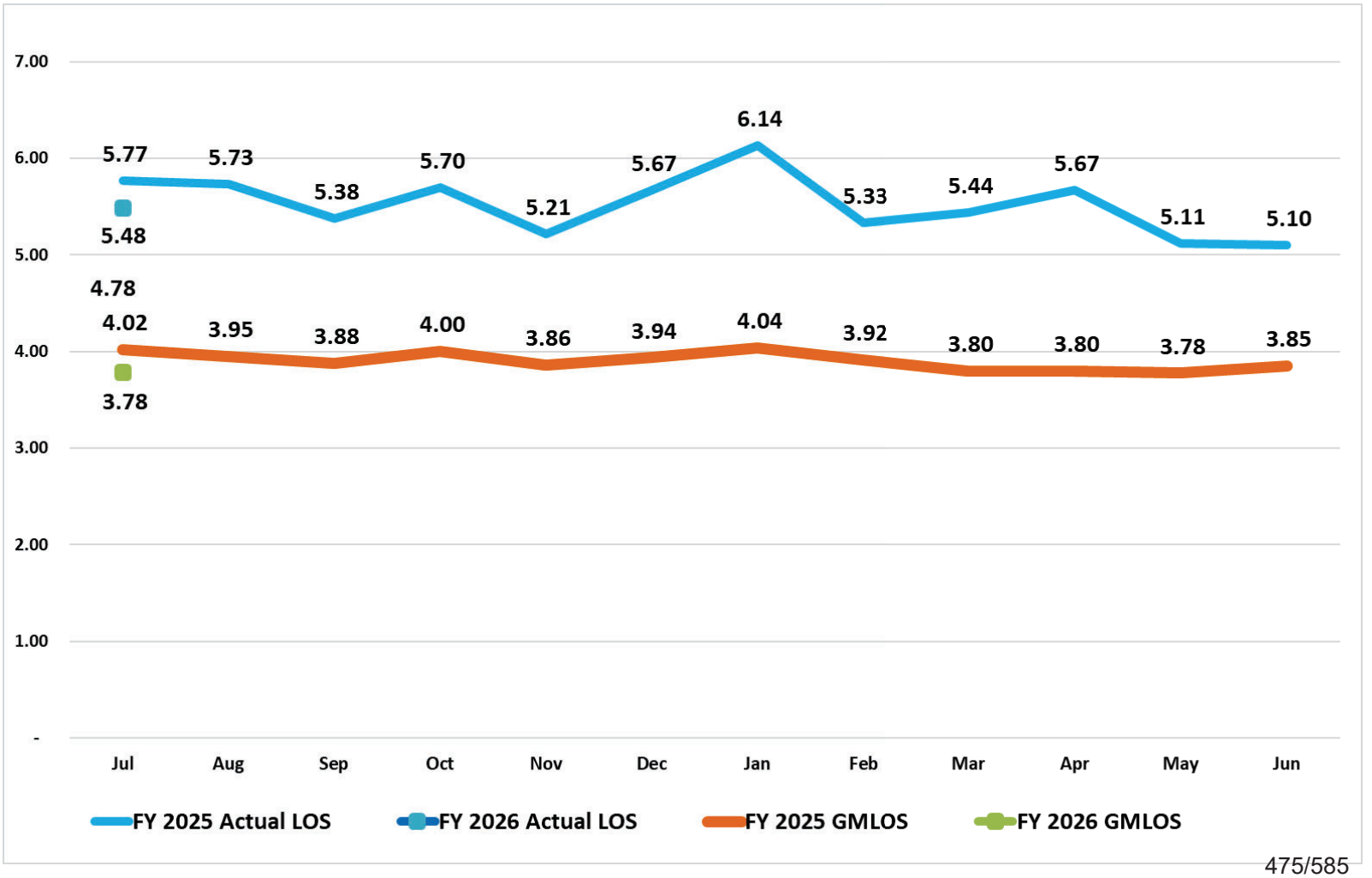

Case Mix Index w/o Normal Newborns
1.800
1.750
1.700
1.650
1.600
1.550
1.500
1.450
1.400
1.594
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY2024
FY2025
FY2026


Case Mix Index w/o Normal Newborns - All
1.750
1.700
1.650
1.600
1.550
1.500
1.450
1.533
1.551
1.627
1.720
1.696
1.650
1.623
1.616
1.594
FY 2018
FY 2019
FY 2020
FY 2021
FY2022
FY2023
FY2024
FY2025
FY2026

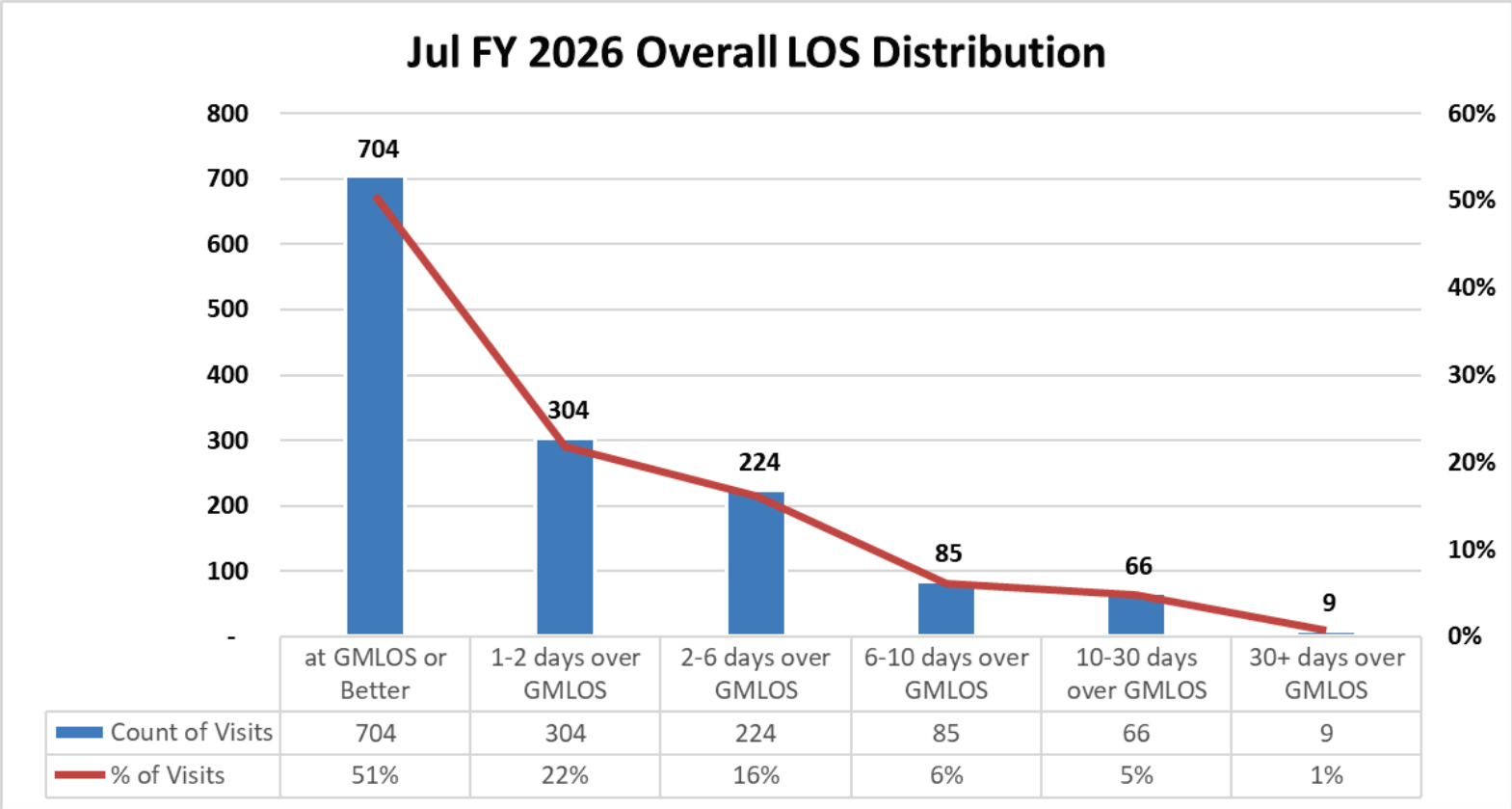

Case Mix Medical w/o Normal Newborns
1.3500
1.3000
1.2500
1.2000
1.1500
1.1000
1.0500
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY 2024
FY 2025
FY 2026


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

Average Length of Stay versus National Average (GMLOS)

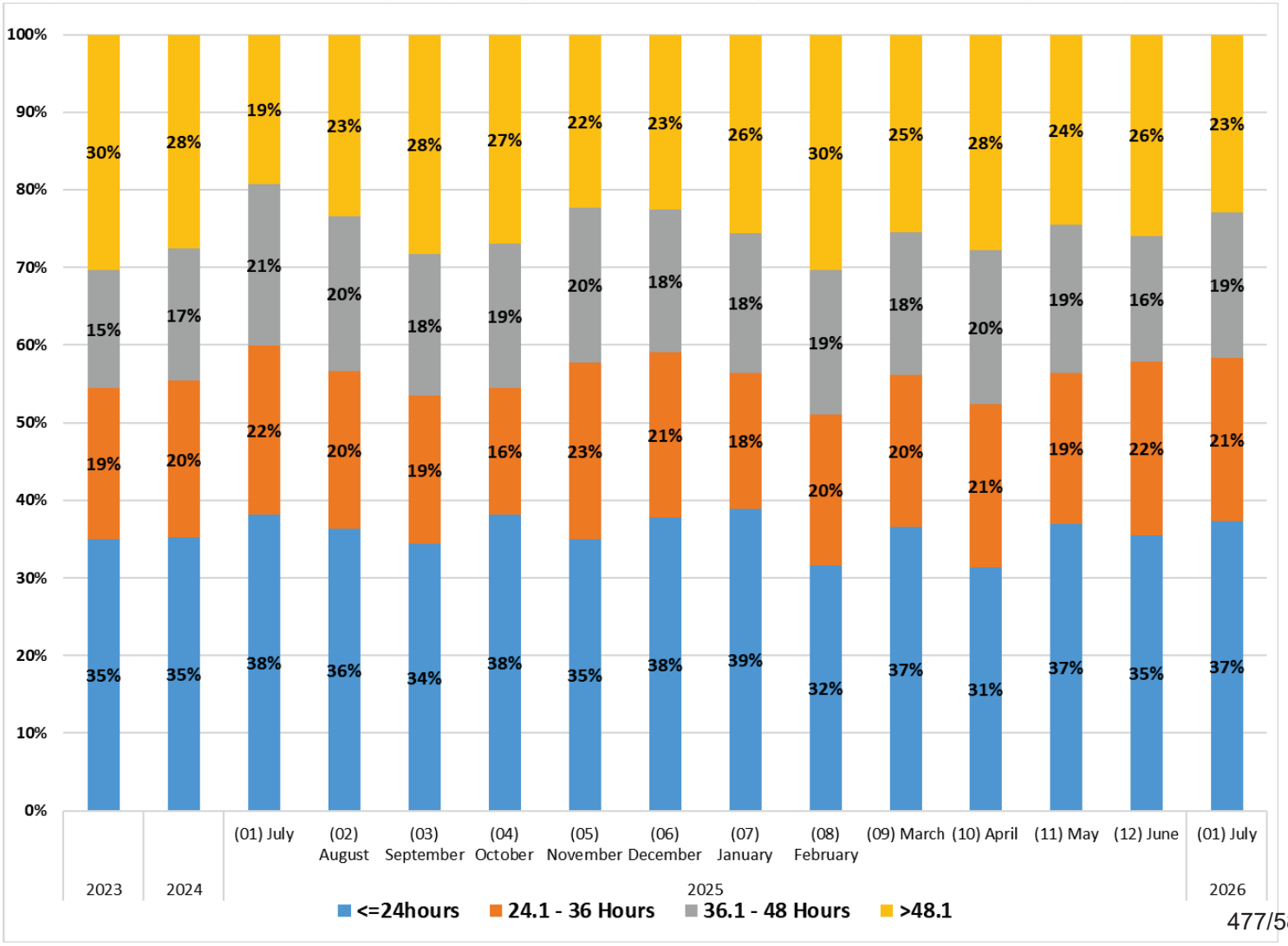


Length of Stay Distribution

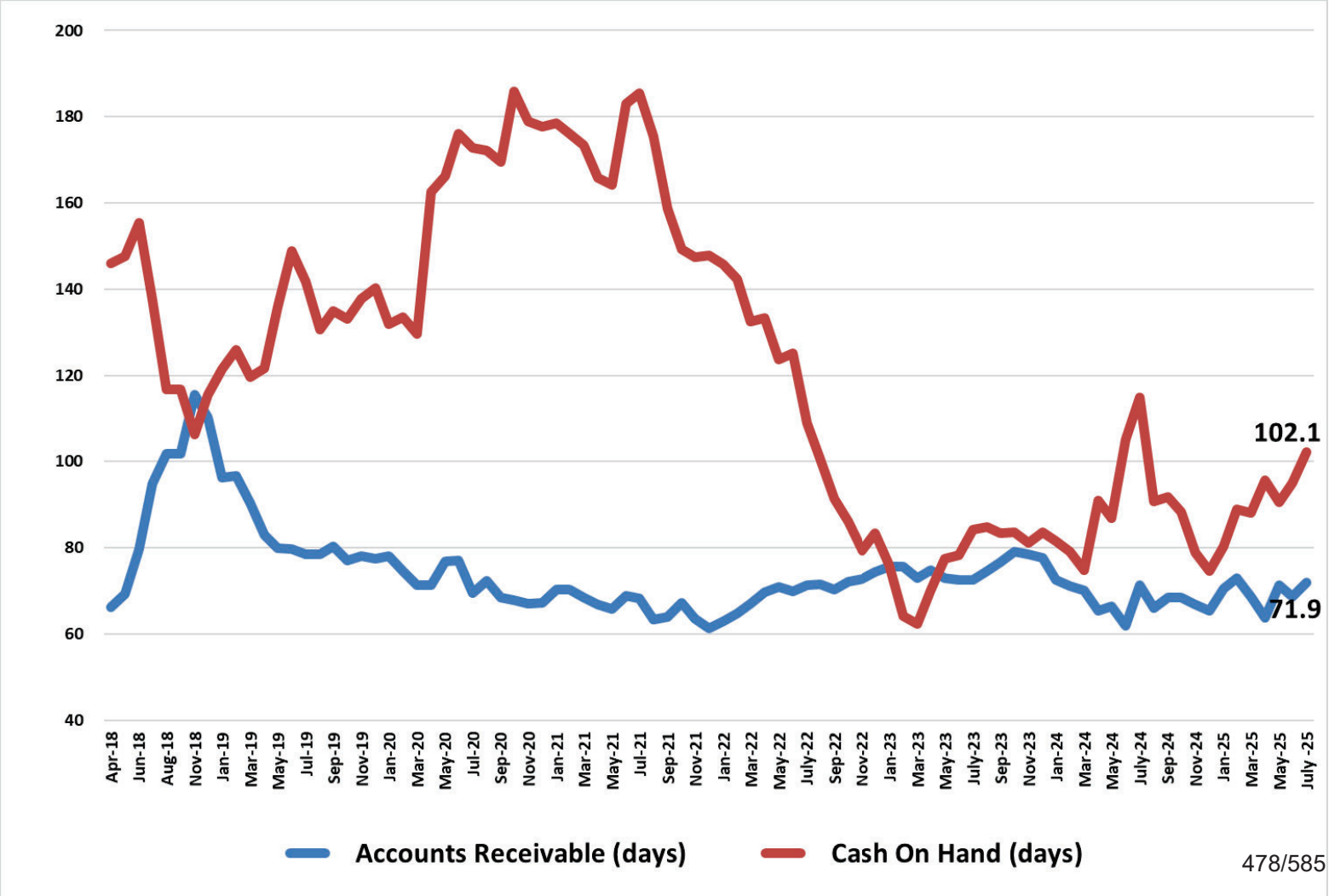


	at GMLOS or Better	1-2 days over GMLOS	2-6 days over GMLOS	6-10 days over GMLOS	10-30 days over GMLOS	30+ days over GMLOS
Count of Visits	704	304	224	85	66	9
% of Visits	51%	22%	16%	6%	5%	1%

Monthly Discharges of Observation Patients by their Length of Stay



Trended Liquidity Ratios



Ratio Analysis Report

JULY 31, 2025

	Current Month Value	Prior Month Value	June 30, 2025 Unaudited Value	2023 Moody's Median Benchmark		
				Aa	A	Baa
LIQUIDITY RATIOS						
Current Ratio (x)	2.7	2.5	2.5	1.7	**1.8**	1.7
Accounts Receivable (days)	71.9	68.7	68.7	47.8	**47.7**	47.8
Cash On Hand (days)	102.1	95.1	95.1	273.9	**188.4**	134.1
Cushion Ratio (x)	12.2	10.9	10.9	44.7	**24.2**	16.6
Average Payment Period (days)	49.1	53.8	53.8	70.9	**62.7**	64.0
CAPITAL STRUCTURE RATIOS						
Cash-to-Debt	128.7%	114.9%	114.9%	271.7%	**164.5%**	131.0%
Debt-To-Capitalization	31.4%	32.9%	31.1%	22.5%	**31.1%**	35.0%
Debt-to-Cash Flow (x)	32.2	2.6	2.6	2.4	**3.6**	6.9
Debt Service Coverage	0.4	3.6	3.6	6.7	**4.5**	2.1
Maximum Annual Debt Service Coverage (x)	0.3	4.6	4.6	6.8	**3.8**	1.9
Age Of Plant (years)	14.4	13.6	13.6	11.1	**12.8**	13.9
PROFITABILITY RATIOS						
Operating Margin	(5.3%)	(3.7%)	(3.7%)	2.1%	**0.5%**	(2.3%)
Excess Margin	(3.9%)	3.3%	3.3%	5.5%	**2.7%**	(.9%)
Operating Cash Flow Margin	(.4%)	1.5%	1.5%	6.7%	**5.5%**	3.0%
Return on Assets	(4.1%)	3.6%	3.6%	3.9%	**2.4%**	(.7%)

Kaweah Health: Patient Financial Assistance Updates

Financial Assistance Policy (AP123) Purpose & Scope

Kaweah Health offers **full charity care** and **discounted payment options** to uninsured, underinsured, or financially struggling patients.

The policy applies to medically necessary services and complies with California law, the IRS, and federal healthcare regulations.

Who Qualifies (with proof of income and household size)

- ✓ **Self-pay patients**: No insurance or third-party coverage.
- ✓ **Underinsured patients**: Have insurance but still face high medical costs.
- ✓ **High Medical Cost patients**: Income ≤ 400% of Federal Poverty Guidelines *and* medical expenses exceed 10% of annual income.
- ✓ **Patients covered by Medi-Cal:** Including those with Share of Cost or denied coverage, may also qualify.

Application Process

- ➢ **Available online, in person, by phone, or via mailed request.**
- ➢ **Offered in English, Spanish, and other needed languages.**
- ➢ **Patients must submit income documentation (e.g., pay stubs, tax returns).**
- ➢ **Applications can be submitted anytime—even during collections.**

Kaweah Health: Patient Financial Assistance Updates

To qualify for Financial Assistance, we require the patient to show proof of income and family size to determine their qualification range as shown in the Financial Assistance Calculator below.

Program	Income Range	Benefit
Charity Care	≤200% FPL Federal Poverty Level	Full balance write-off
Discounted Care	201–600% FPL	Bill capped at Medicare/Medi-Cal equivalent

Kaweah Health

2025 Financial Assistance Calculator - effective 1/17/2025

		Category A	Category B						Category C	
Family Size	2025 FPL	*Full Assistance* Below 200%	*30% of Medicare Allowable* 201%		*50% of Medicare Allowable* 251%		*85% of Medicare Allowable* 301%		*100% of Medicare Allowable* 351%	
				250%		300%		350%		600%
1	$ 15,650	$ 31,300	$ 31,301	$ 39,125	$ 39,126	$ 46,950	$ 46,951	$ 54,775	$ 54,776	$ 93,900
2	$ 21,150	$ 42,300	$ 42,301	$ 52,875	$ 52,876	$ 63,450	$ 63,451	$ 74,025	$ 74,026	$ 126,900
3	$ 26,650	$ 53,300	$ 53,301	$ 66,625	$ 66,626	$ 79,950	$ 79,951	$ 93,275	$ 93,276	$ 159,900
4	$ 32,150	$ 64,300	$ 64,301	$ 80,375	$ 80,376	$ 96,450	$ 96,451	$ 112,525	$ 112,526	$ 192,900
5	$ 37,650	$ 75,300	$ 75,301	$ 94,125	$ 94,126	$ 112,950	$ 112,951	$ 131,775	$ 131,776	$ 225,900
6	$ 43,150	$ 86,300	$ 86,301	$ 107,875	$ 107,876	$ 129,450	$ 129,451	$ 151,025	$ 151,026	$ 258,900
7	$ 48,650	$ 97,300	$ 97,301	$ 121,625	$ 121,626	$ 145,950	$ 145,951	$ 170,275	$ 170,276	$ 291,900
8	$ 54,150	$ 108,300	$ 108,301	$ 135,375	$ 135,376	$ 162,450	$ 162,451	$ 189,525	$ 189,526	$ 324,900

We write off on average $3M/year (“expected payments”) to Charity Care

Bad Debt vs Charity Care: Patient Financial Assistance Updates

Bad debt (uncompensated care) refers to the portion of patient accounts receivable that a hospital is unable to collect, despite reasonable collection efforts. It typically arises when patients are **expected to pay** (e.g., uninsured, underinsured, or with high deductibles) but **do not**, and **do not qualify for financial assistance**.

Key Types of Bad Debt

Patient Responsibility: The balance was the patient's obligation after insurance (or in absence of insurance).

Collection Efforts Made: The hospital attempted to collect through billing statements, phone calls, and possibly third-party collections.

No Financial Assistance: The patient did not apply for or qualify under the hospital's charity care or financial assistance policy.

Written Off: After exhausting collection efforts, the account is written off as bad debt and removed from active receivables.

Kaweah Health wrote off on average $10M-$12M/year ("expected net patient payments") in bad debt / uncompensated care.

The standard healthcare industry benchmark for bad debt is 2-3% of Net Patient Revenue. We are averaging within that range.

Consolidated Statements of Net Position (000's)

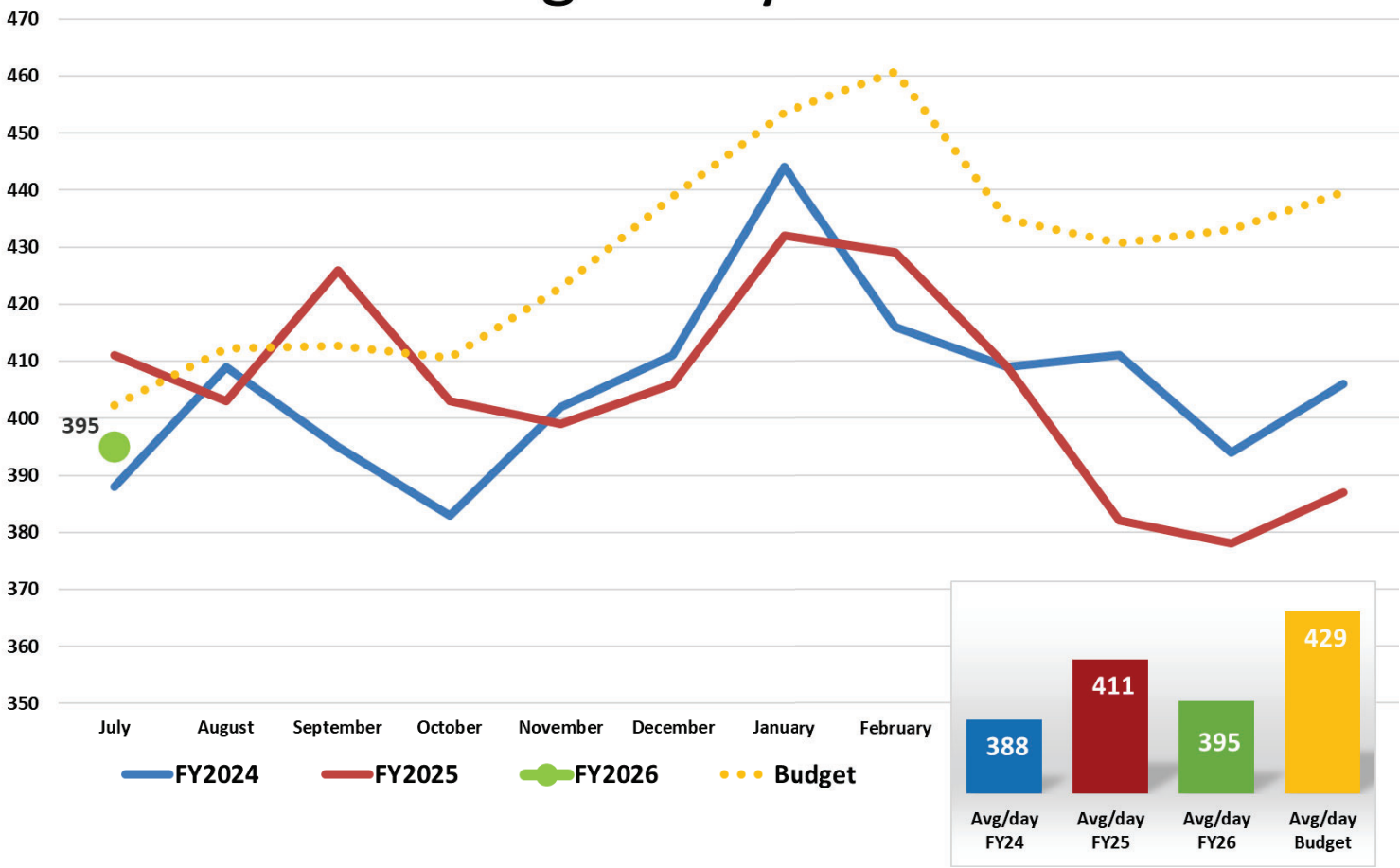
	Jul-25	Jun-25
		(Unaudited)
ASSETS AND DEFERRED OUTFLOWS		
CURRENT ASSETS		
Cash and cash equivalents	$ 49,315	$ 6,595
Current Portion of Board designated and trusted assets	15,430	$ 16,118
Accounts receivable:		$ -
Net patient accounts	149,297	$ 154,663
Other receivables	21,947	$ 70,810
	171,244	225,473
Inventories	14,080	$ 13,871
Medicare and Medi-Cal settlements	72,285	$ 62,746
Prepaid expenses	12,540	$ 8,234
Total current assets	334,893	333,038
NON-CURRENT CASH AND INVESTMENTS - less current portion		
Board designated cash and assets	204,478	$ 219,320
Revenue bond assets held in trust	22,990	$ 22,950
Assets in self-insurance trust fund	756	$ 747
Total non-current cash and investments	228,224	243,017
INTANGIBLE RIGHT TO USE LEASE, net of accumulated amortization	16,085	$ 15,613
INTANGIBLE RIGHT TO USE SBITA, net of accumulated amortization	7,719	$ 8,062
CAPITAL ASSETS		
Land	17,542	$ 17,542
Buildings and improvements	437,751	$ 437,186
Equipment	340,908	$ 340,589
Construction in progress	19,408	$ 18,729
	815,609	814,047
Less accumulated depreciation	544,039	$ 541,607
	271,570	272,440
OTHER ASSETS		
Property not used in operations	5,151	$ 5,155
Health-related investments	2,295	$ 2,303
Other	21,138	$ 20,922
Total other assets	28,584	28,380
Total assets	887,074	900,550
DEFERRED OUTFLOWS	13,848	$ 13,958
Total assets and deferred outflows	**$ 900,922**	**$ 914,508**

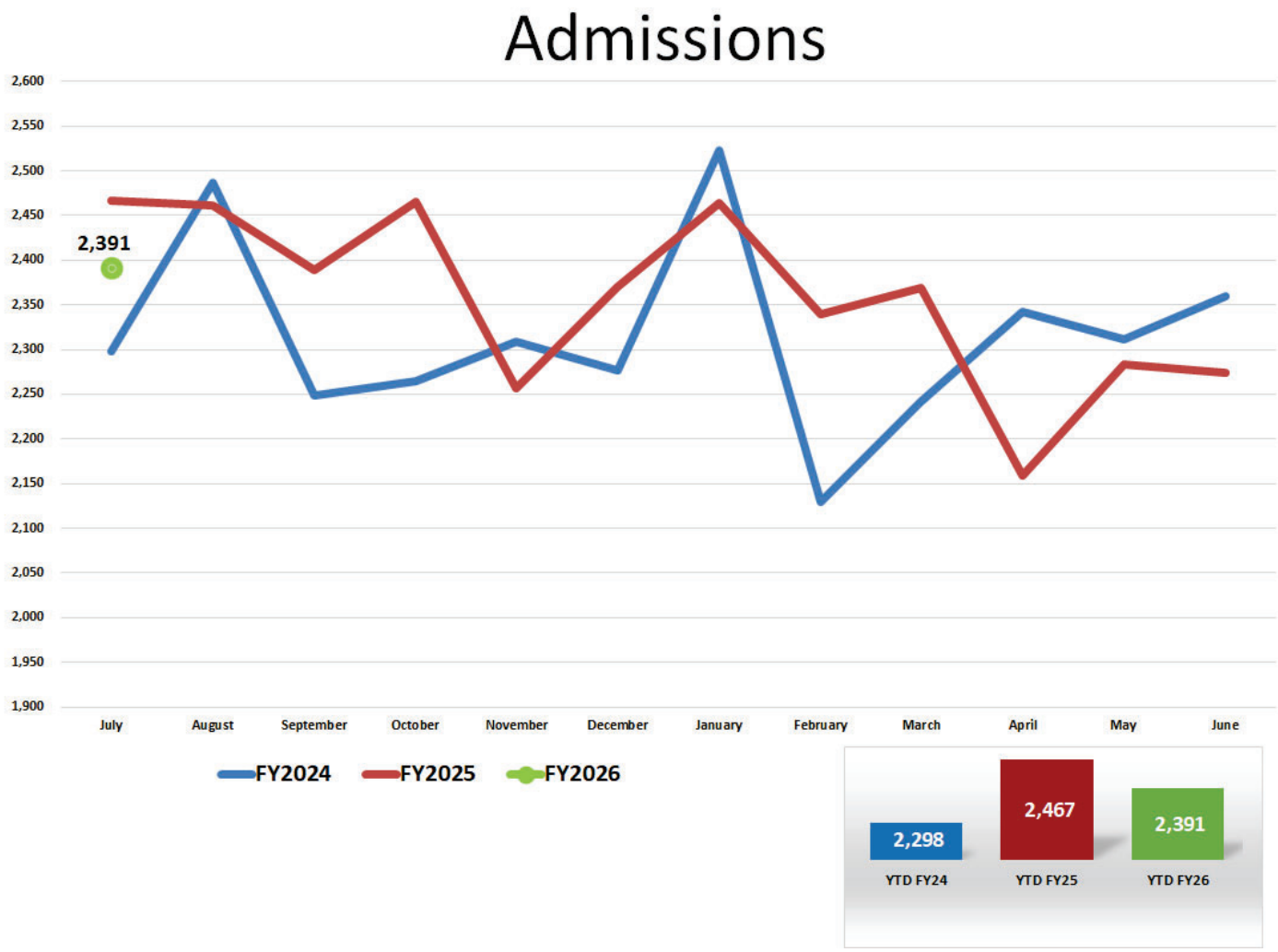
Consolidated Statements of Net Position (000's)

	Jul-25	Jun-25
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accounts payable and accrued expenses	$ 33,838	$ 44,058
Accrued payroll and related liabilities	72,352	$ 68,595
SBITA liability, current portion	3,031	$ 3,031
Lease liabiilty, current portion	3,204	$ 3,204
Bonds payable, current portion	13,014	$ 13,014
Notes payable, current portion	-	$ -
Total current liabilities	125,439	131,902
LEASE LIABILITY, net of current portion	13,341	$ 12,850
SBITA LIABILITY, net of current portion	2,963	$ 3,941
LONG-TERM DEBT, less current portion		
Bonds payable	199,232	$ 201,619
Notes payable	20,750	$ 20,750
Total long-term debt	219,982	222,369
NET PENSION LIABILITY	20,531	$ 21,666
OTHER LONG-TERM LIABILITIES	45,186	$ 45,297
Total liabilities	427,442	438,025
NET ASSETS		
Invested in capital assets, net of related debt	56,944	$ 60,146
Restricted	59,316	$ 59,709
Unrestricted	357,221	$ 356,629
Total net position	473,480	$ 476,483
Total liabilities and net position	**$ 900,923**	**$ 914,509**

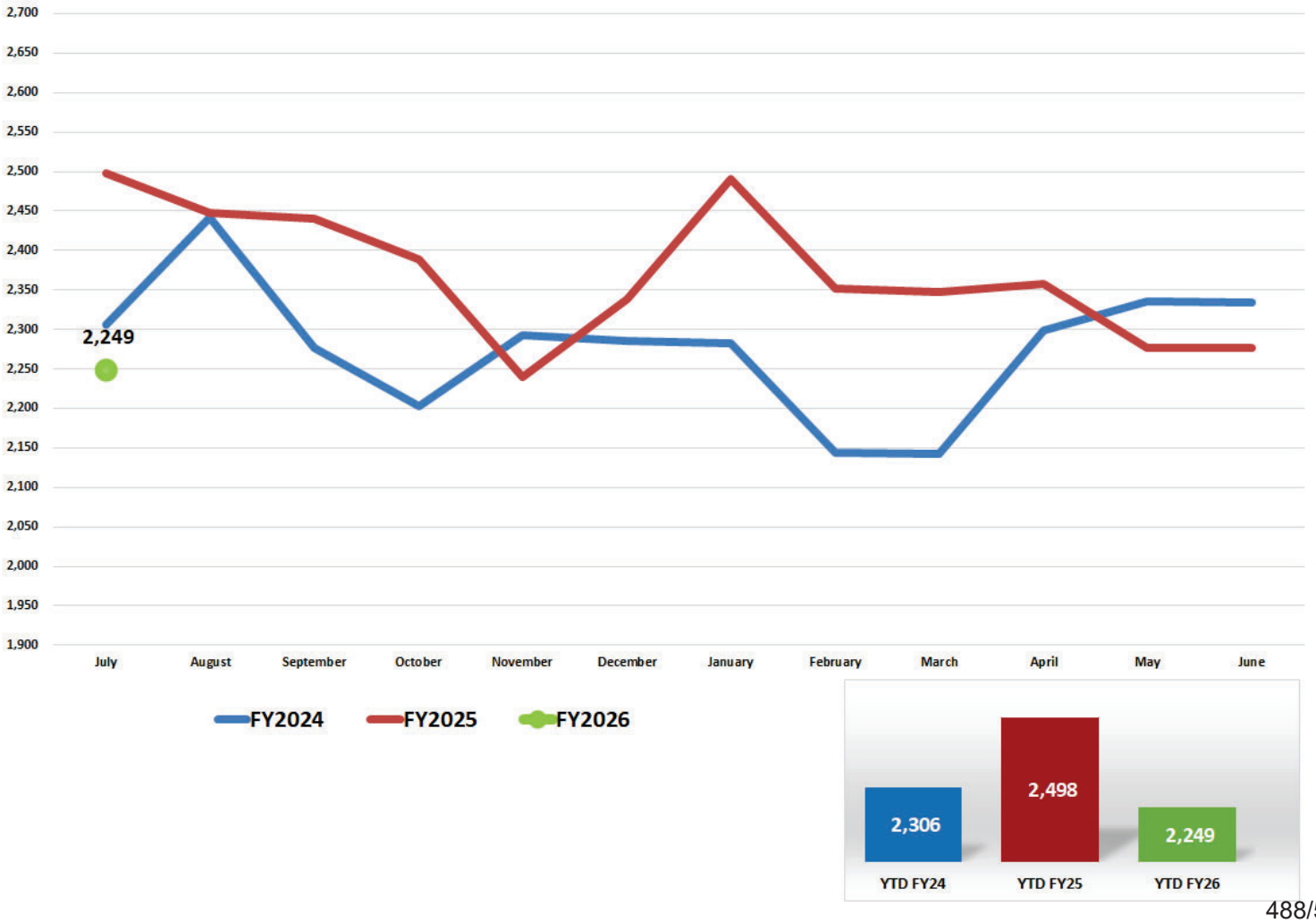
Statistical Report
July 2025

Average Daily Census




Admissions
2,600
2,550
2,500
2,450
2,400
2,350
2,300
2,250
2,200
2,150
2,100
2,050
2,000
1,950
1,900
2,391
July
August
September
October
November
December
January
February
March
April
May
June
FY2024
FY2025
FY2026
2,298
YTD FY24
2,467
YTD FY25
2,391
YTD FY26

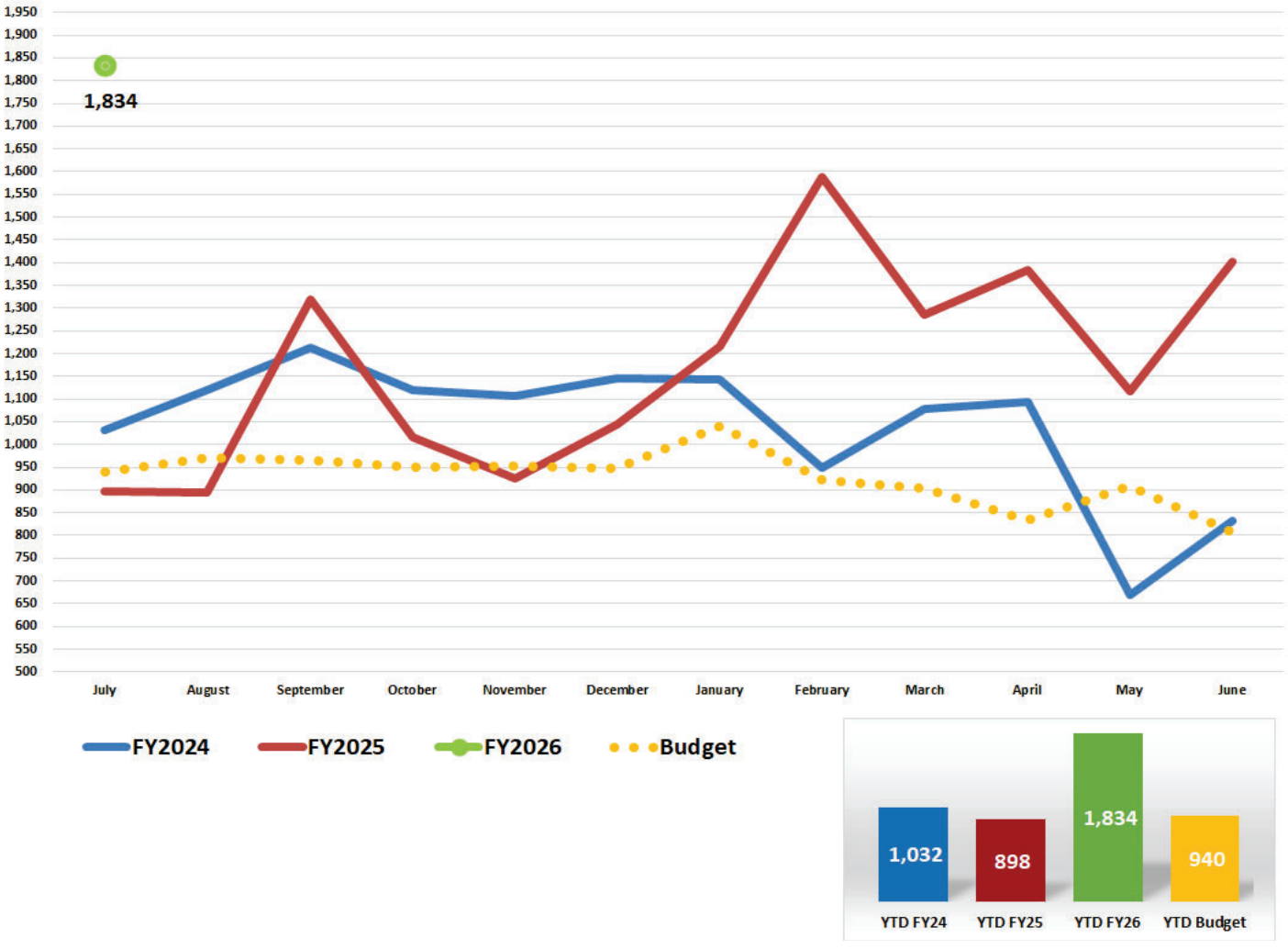
Discharges


2,700
2,650
2,600
2,550
2,500
2,450
2,400
2,350
2,300
2,250
2,200
2,150
2,100
2,050
2,000
1,950
1,900
2,249
July
August
September
October
November
December
January
February
March
April
May
June
FY2024
FY2025
FY2026

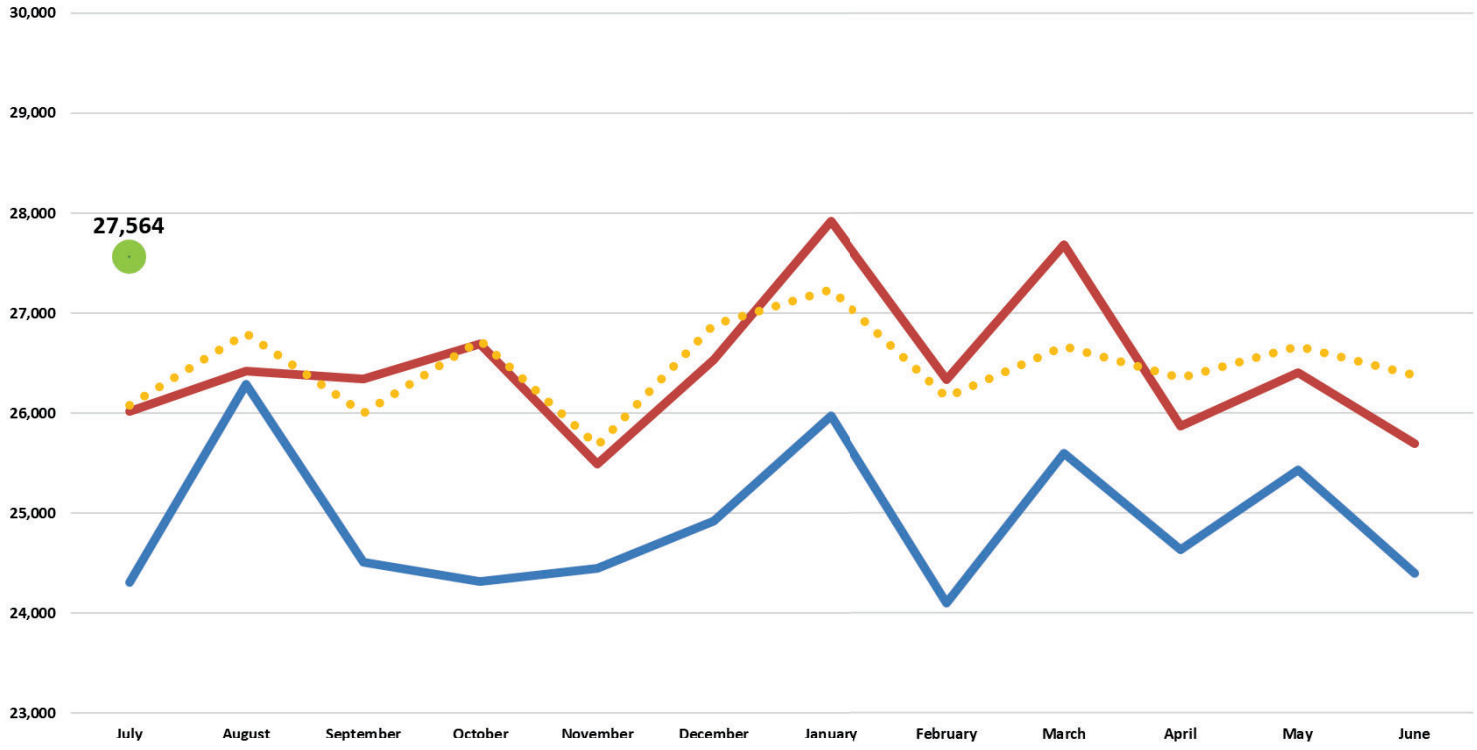
2,306
2,498
2,249
YTD FY24
YTD FY25
YTD FY26

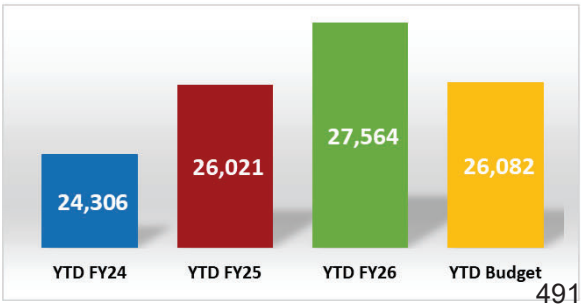
Average Discharges per Day

Observation Days

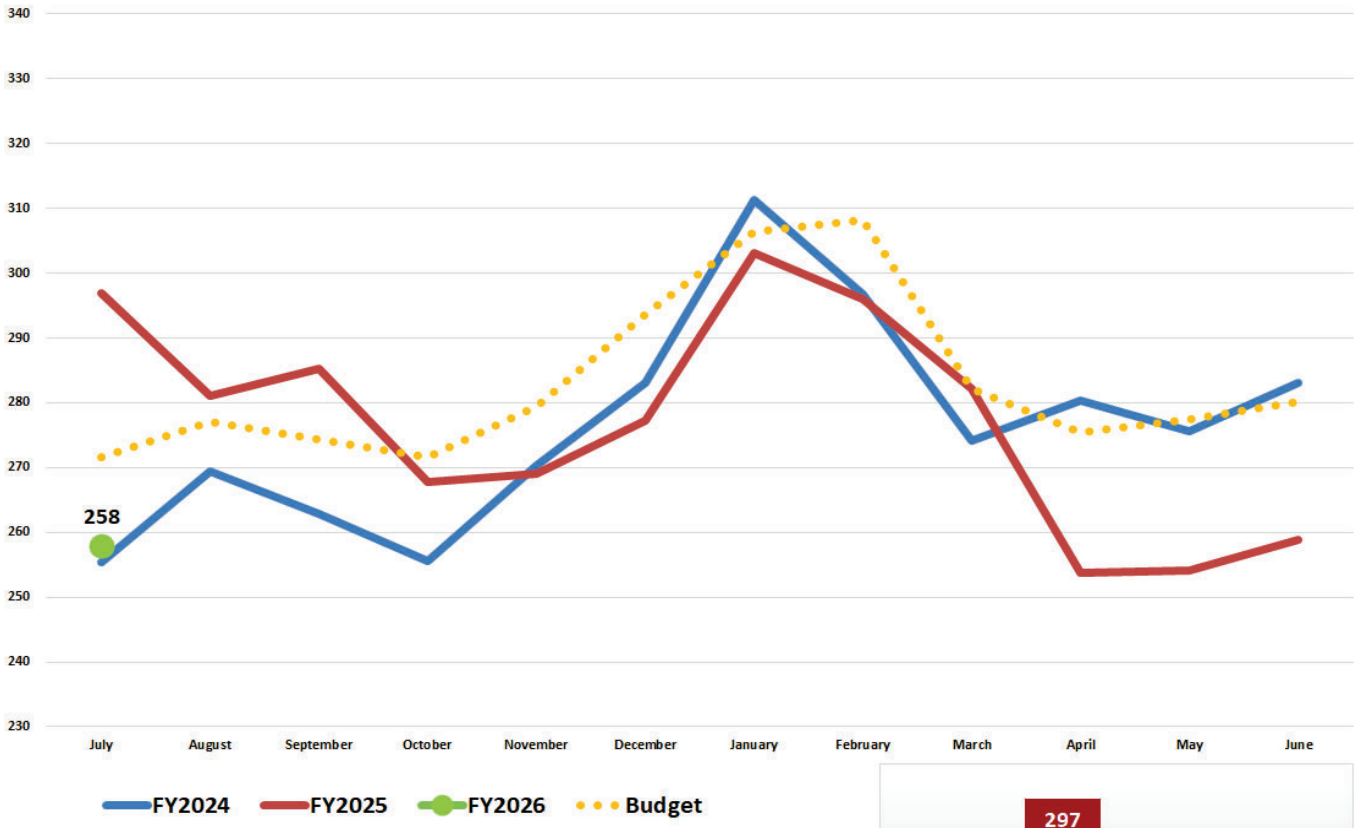


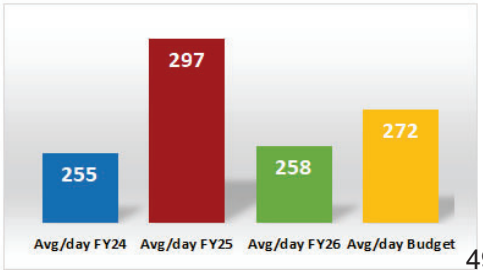
Adjusted Patient Days



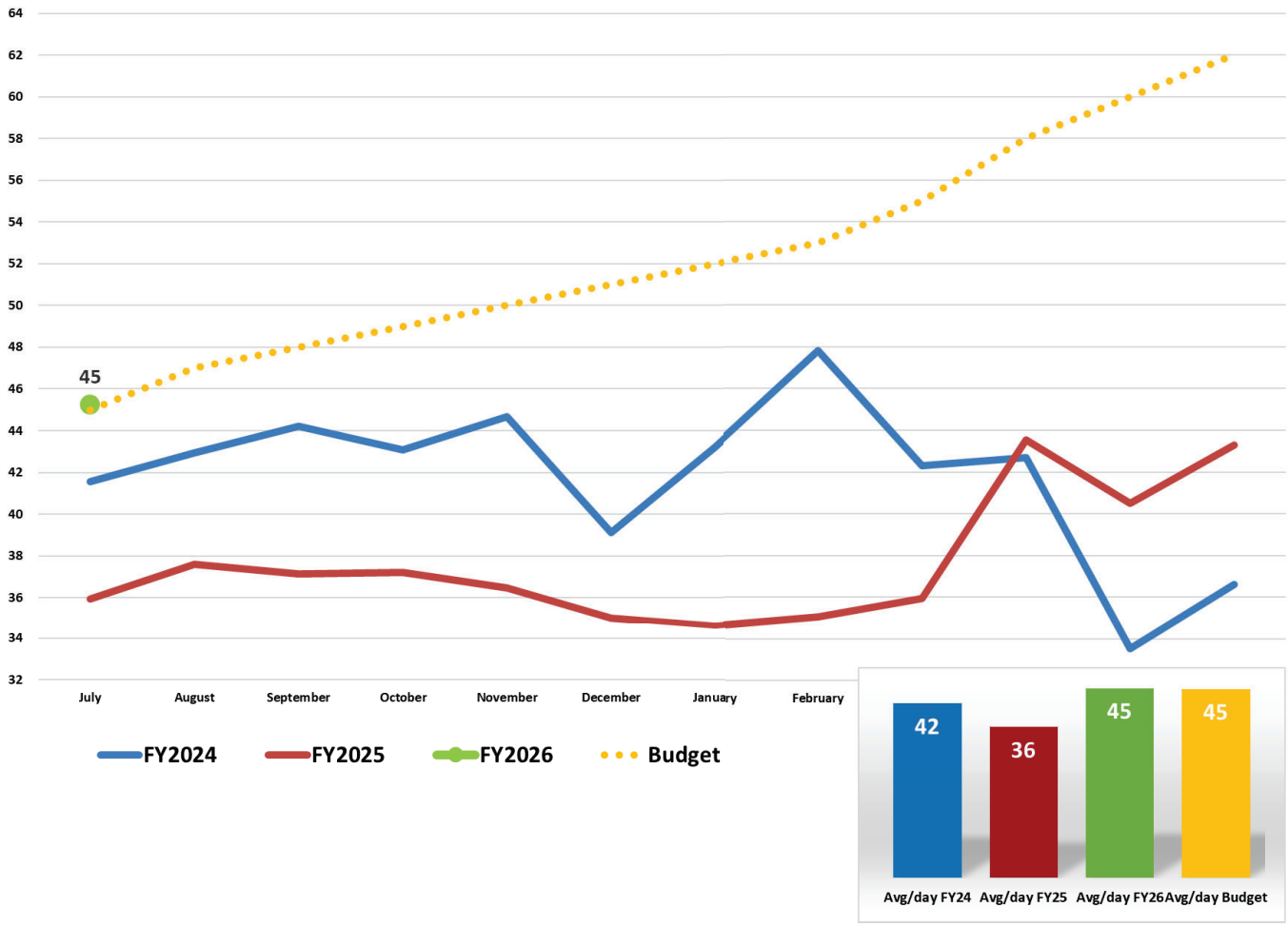


Medical Center (Avg Patients Per Day)

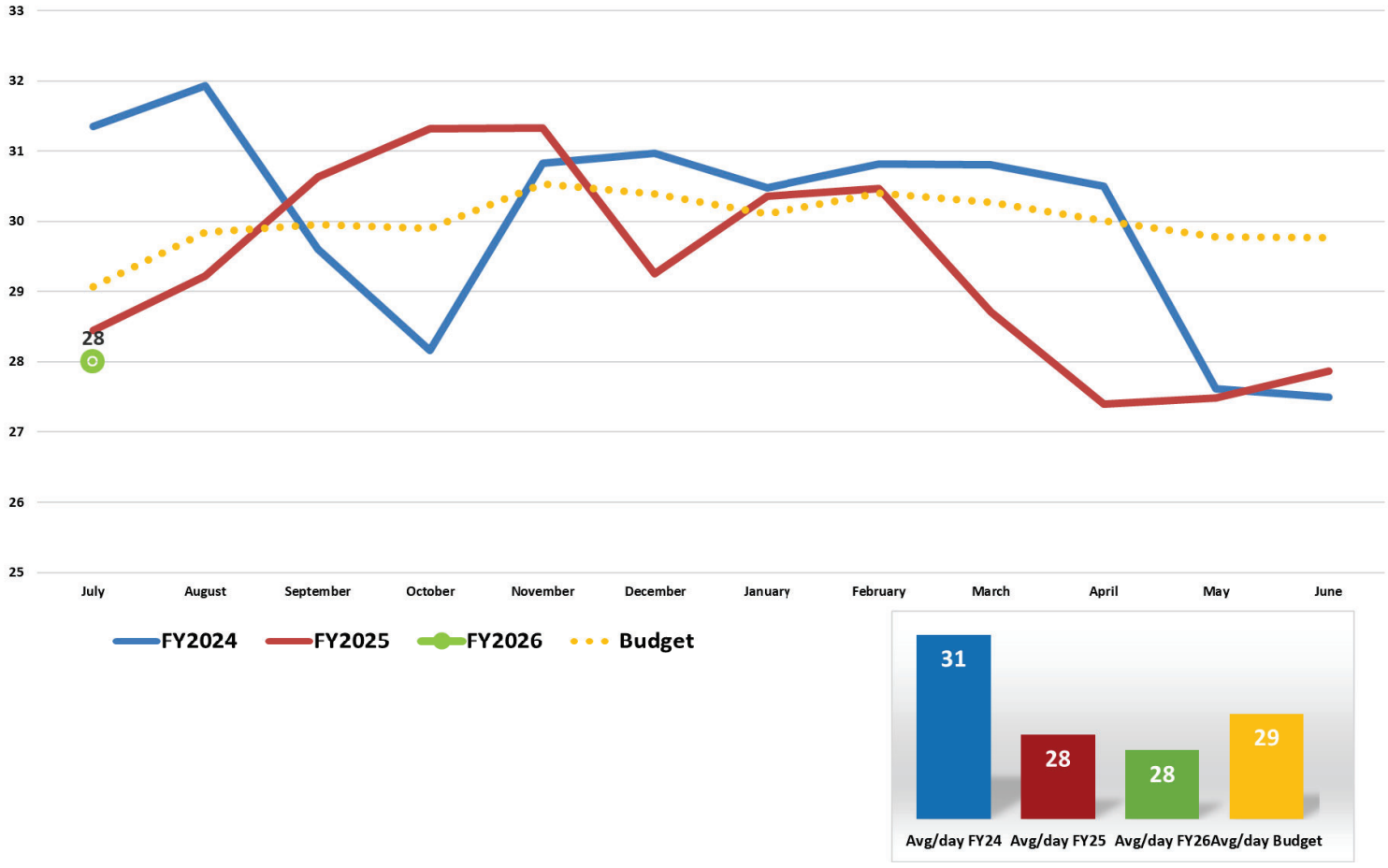




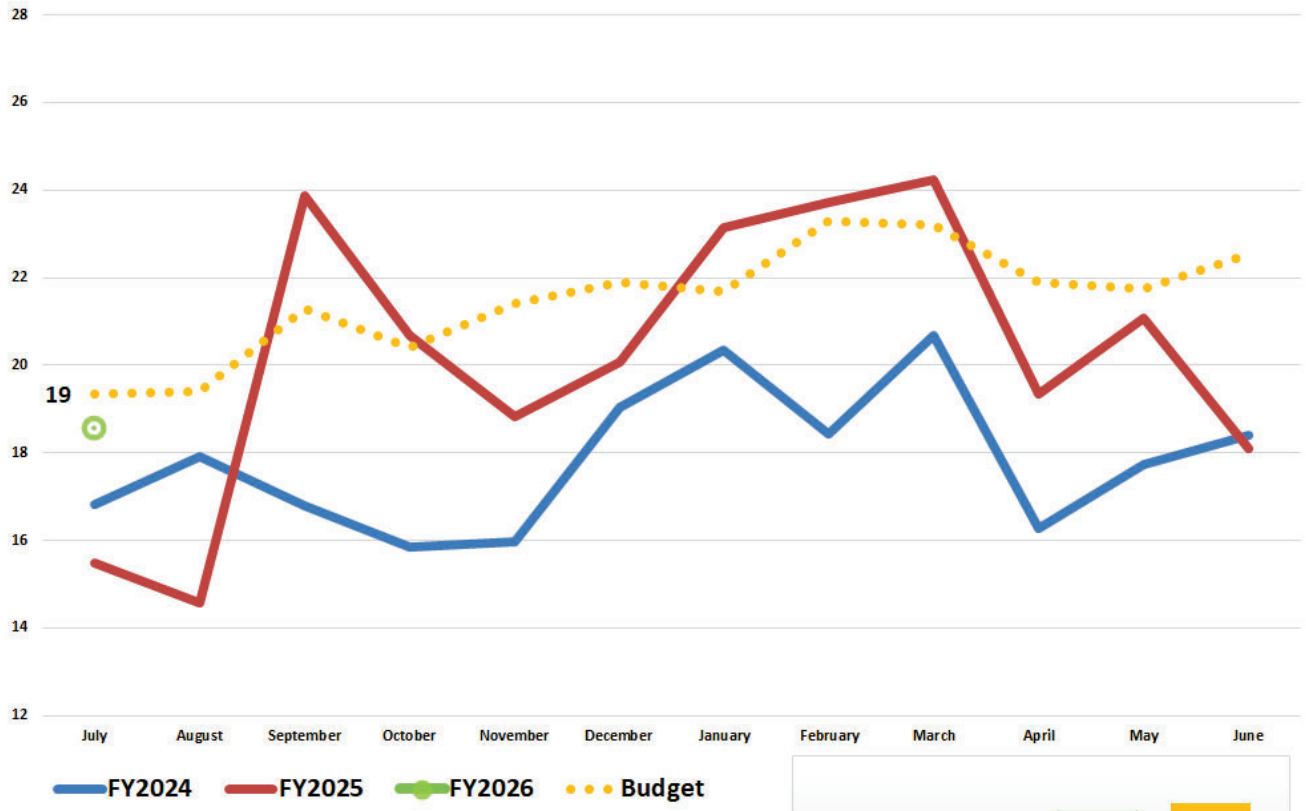
Acute I/P Psych (Avg Patients Per Day)

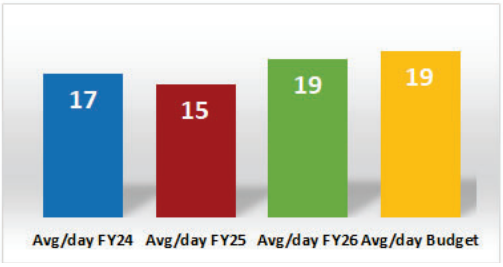


Sub-Acute - Avg Patients Per Day

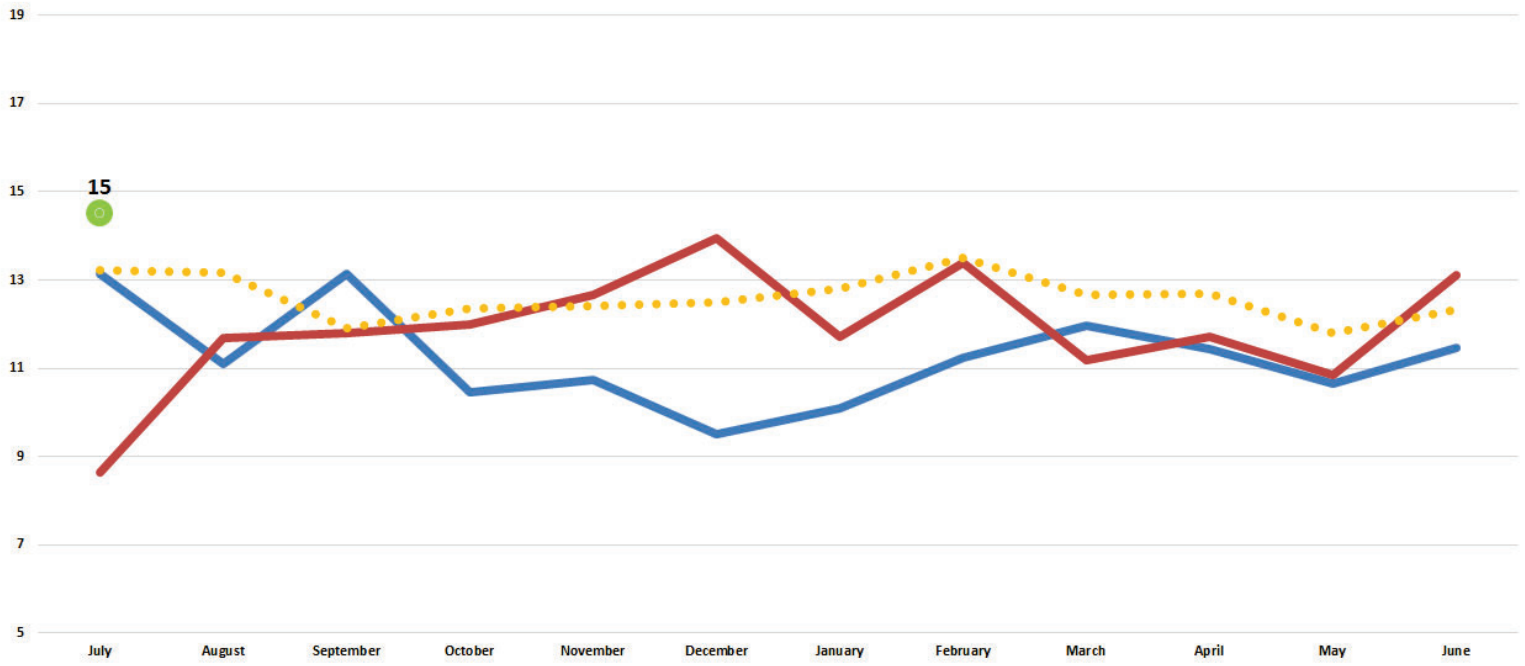


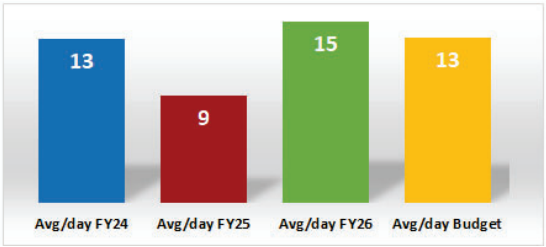
Rehabilitation Hospital - Avg Patients Per Day



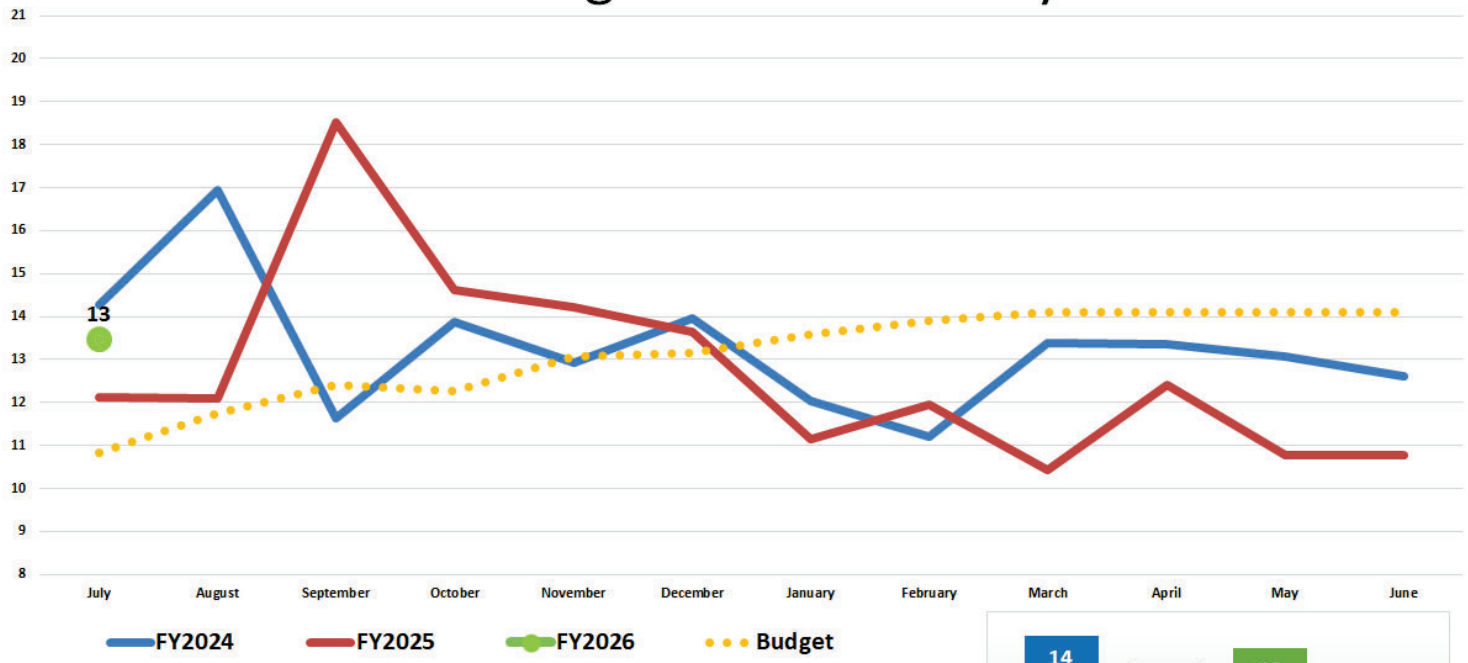


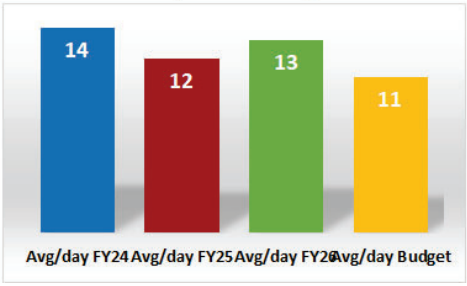
TCS Ortho - Avg Patients Per Day



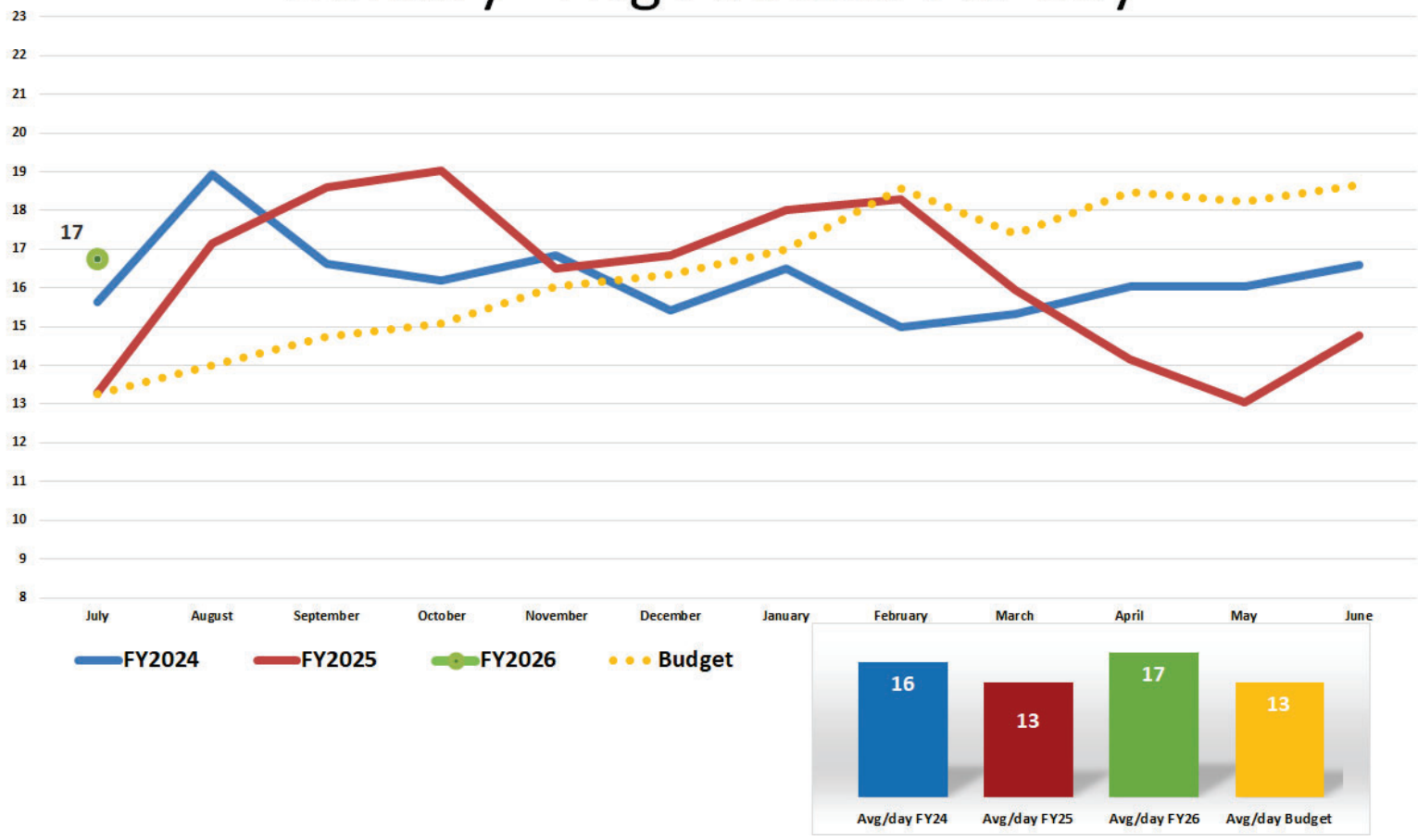


NICU - Avg Patients Per Day

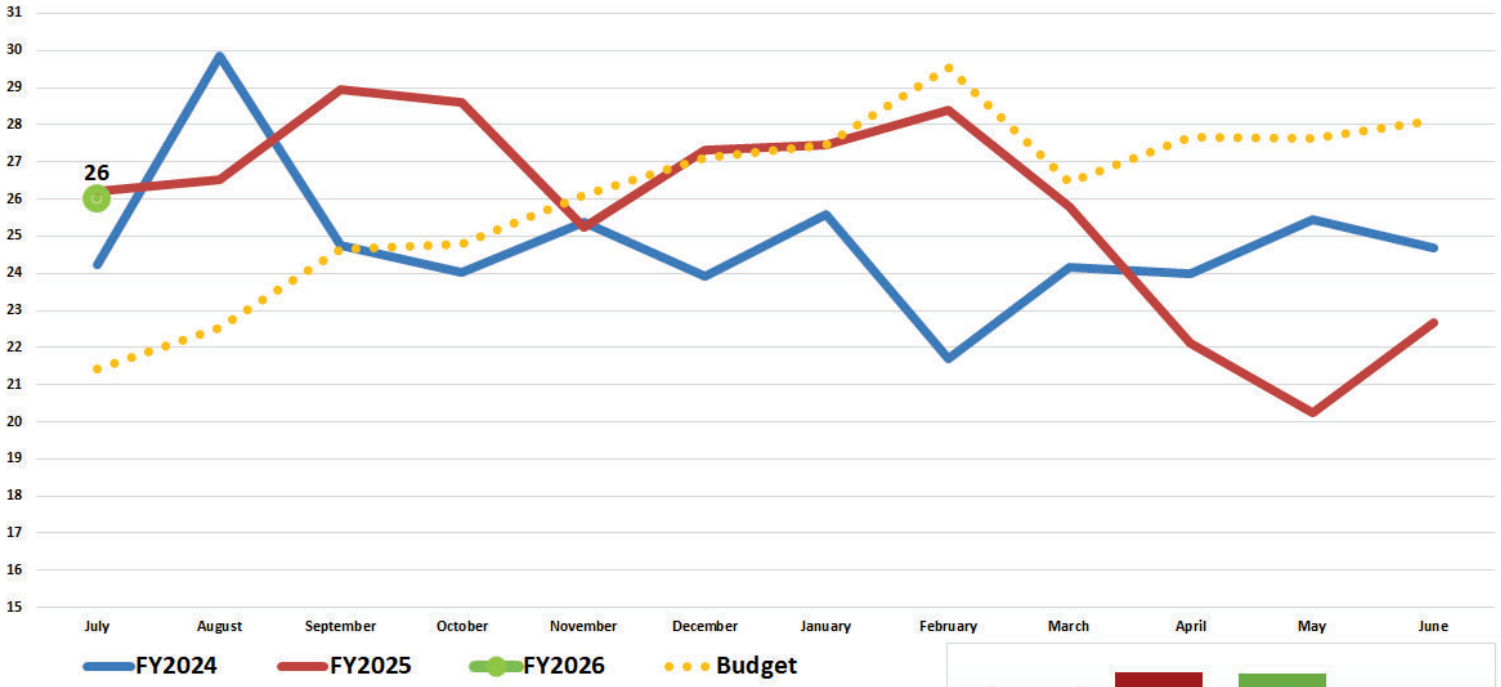


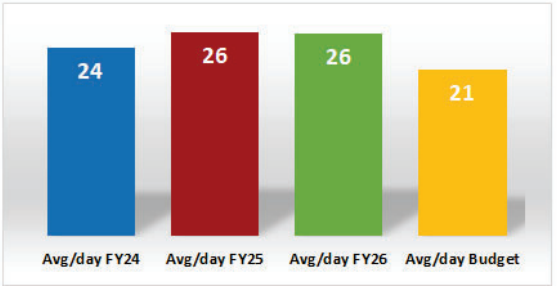


Nursery - Avg Patients Per Day

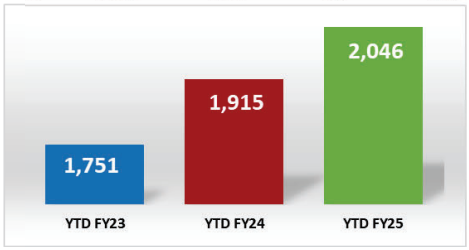


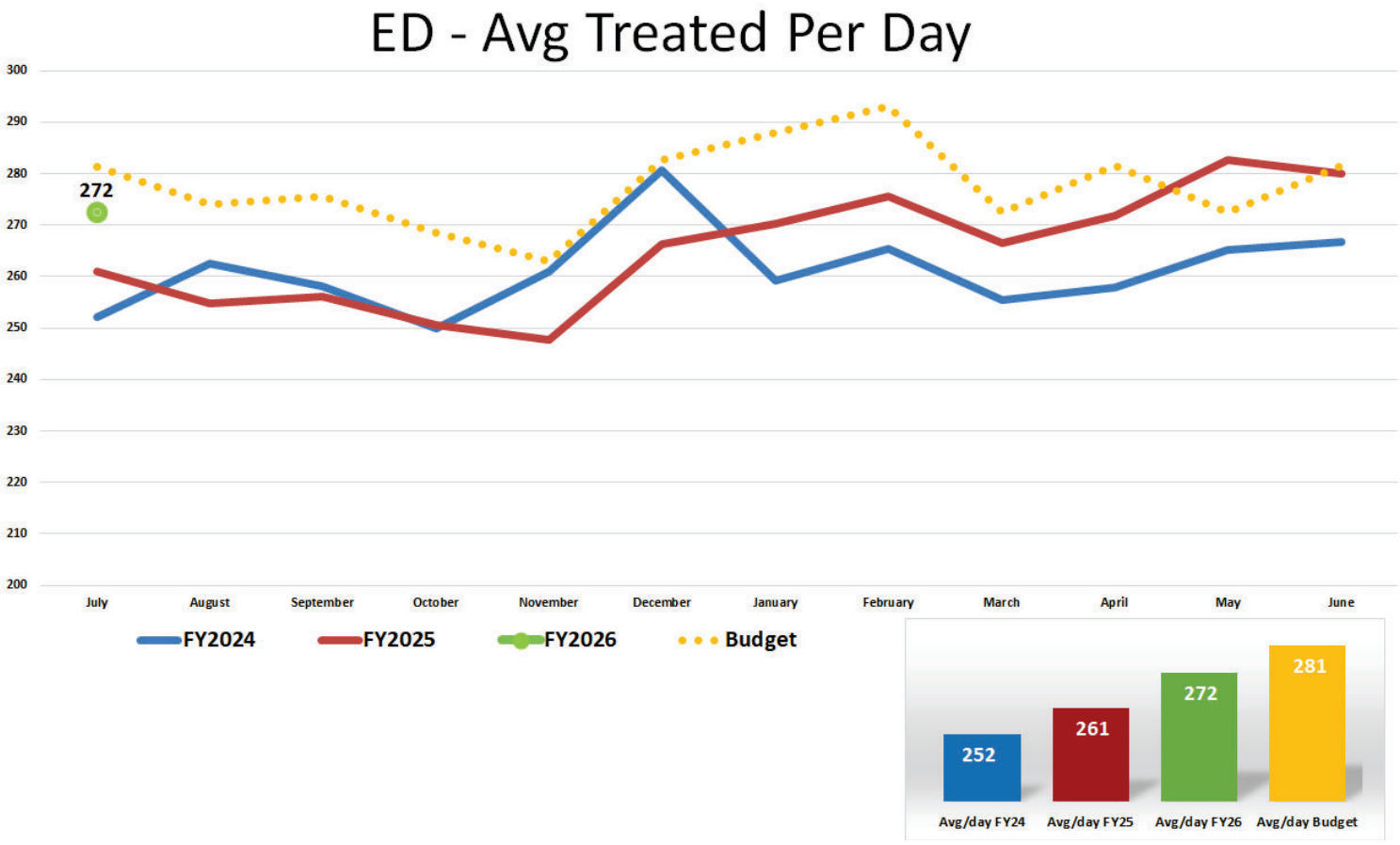
Obstetrics - Avg Patients Per Day





Outpatient Registrations Per Day

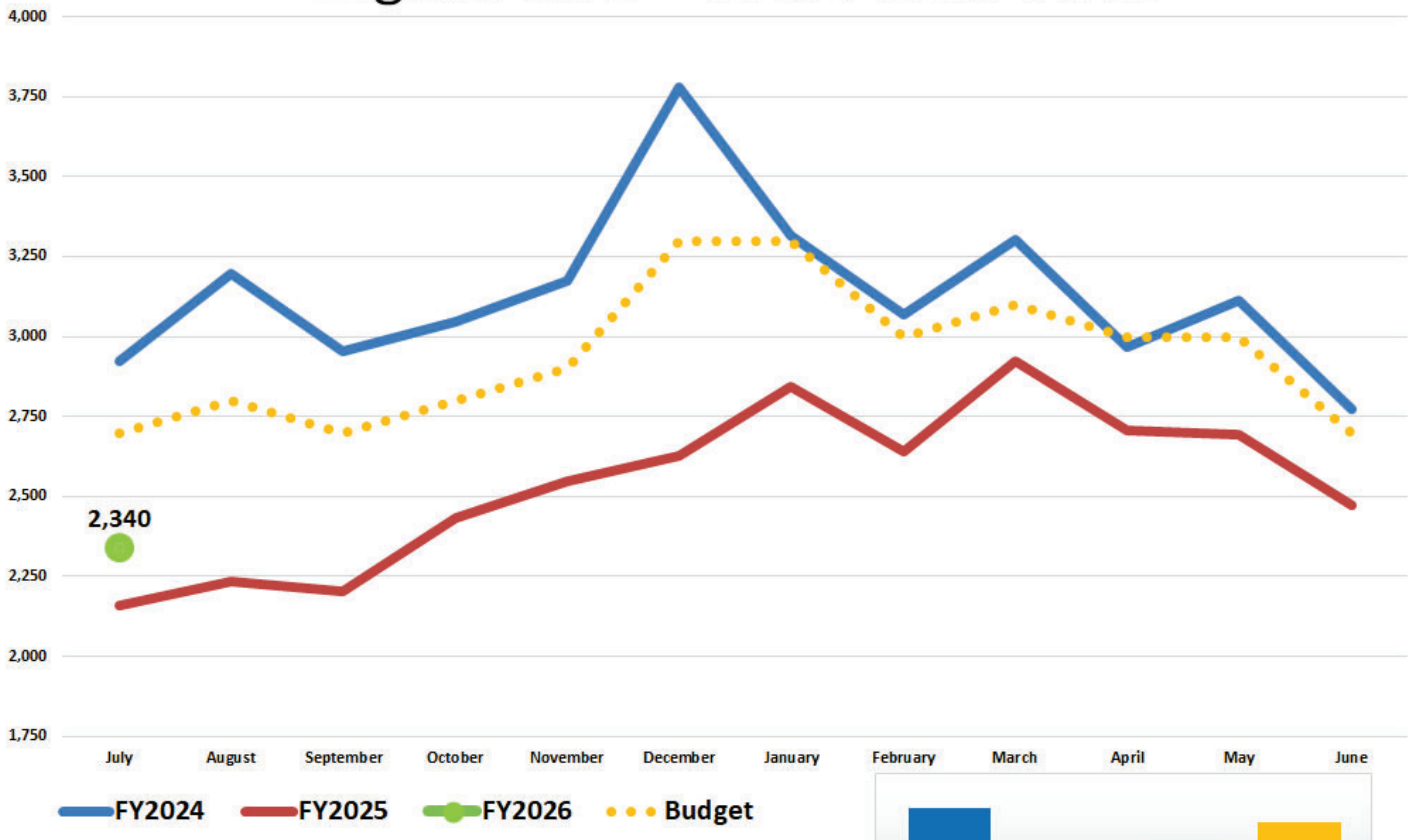


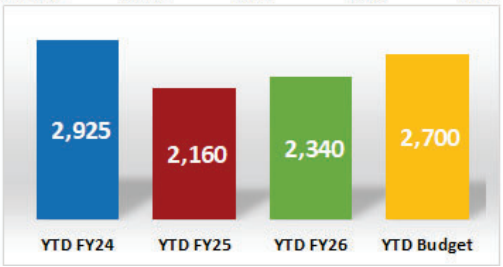

ED - Avg Treated Per Day
300
290
280
270
260
250
240
230
220
210
200
272
July
August
September
October
November
December
January
February
March
April
May
June
FY2024
FY2025
FY2026
Budget

252
261
272
281
Avg/day FY24
Avg/day FY25
Avg/day FY26
Avg/day Budget

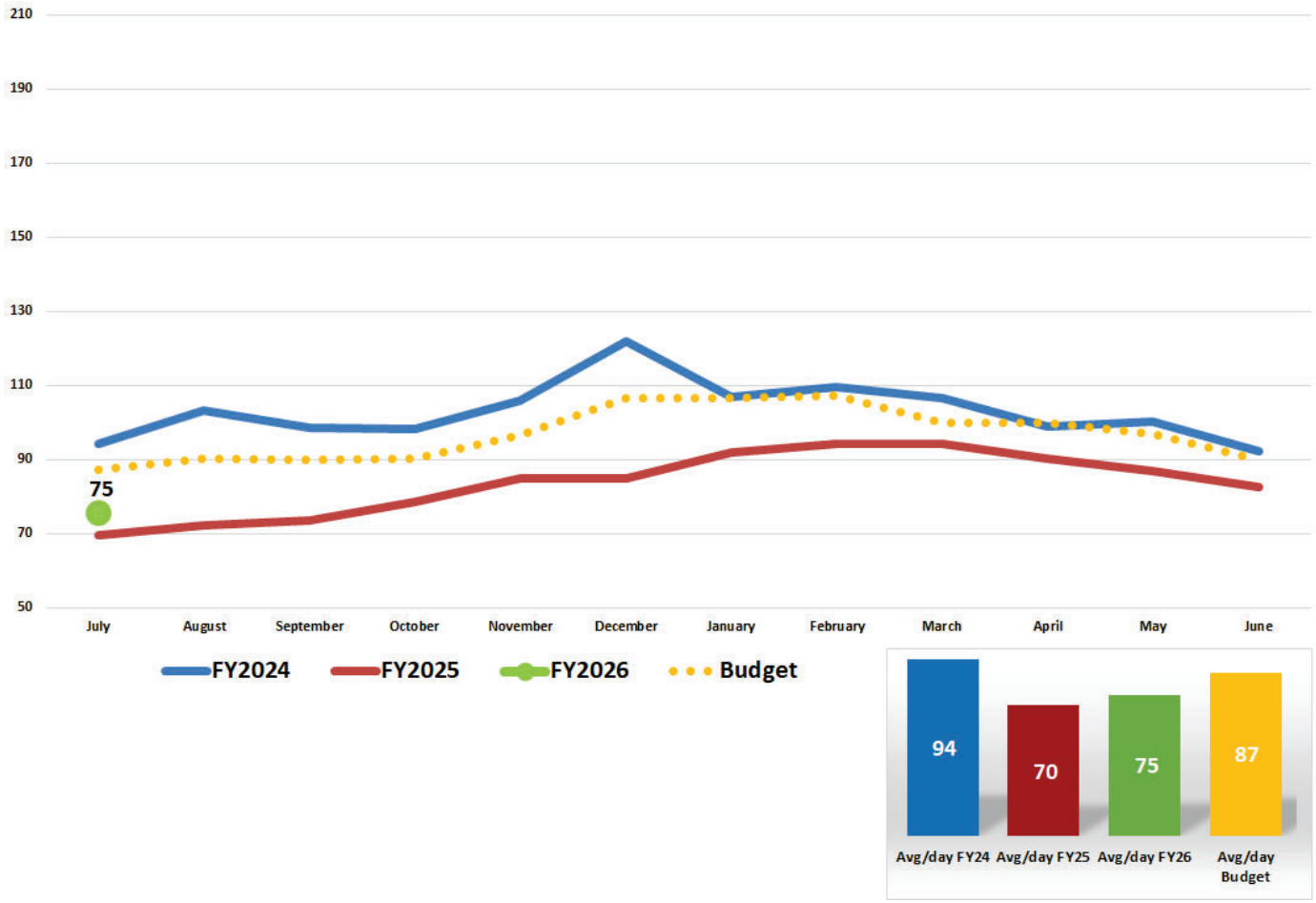
Outpatient Registrations

Urgent Care – Court Total Visits

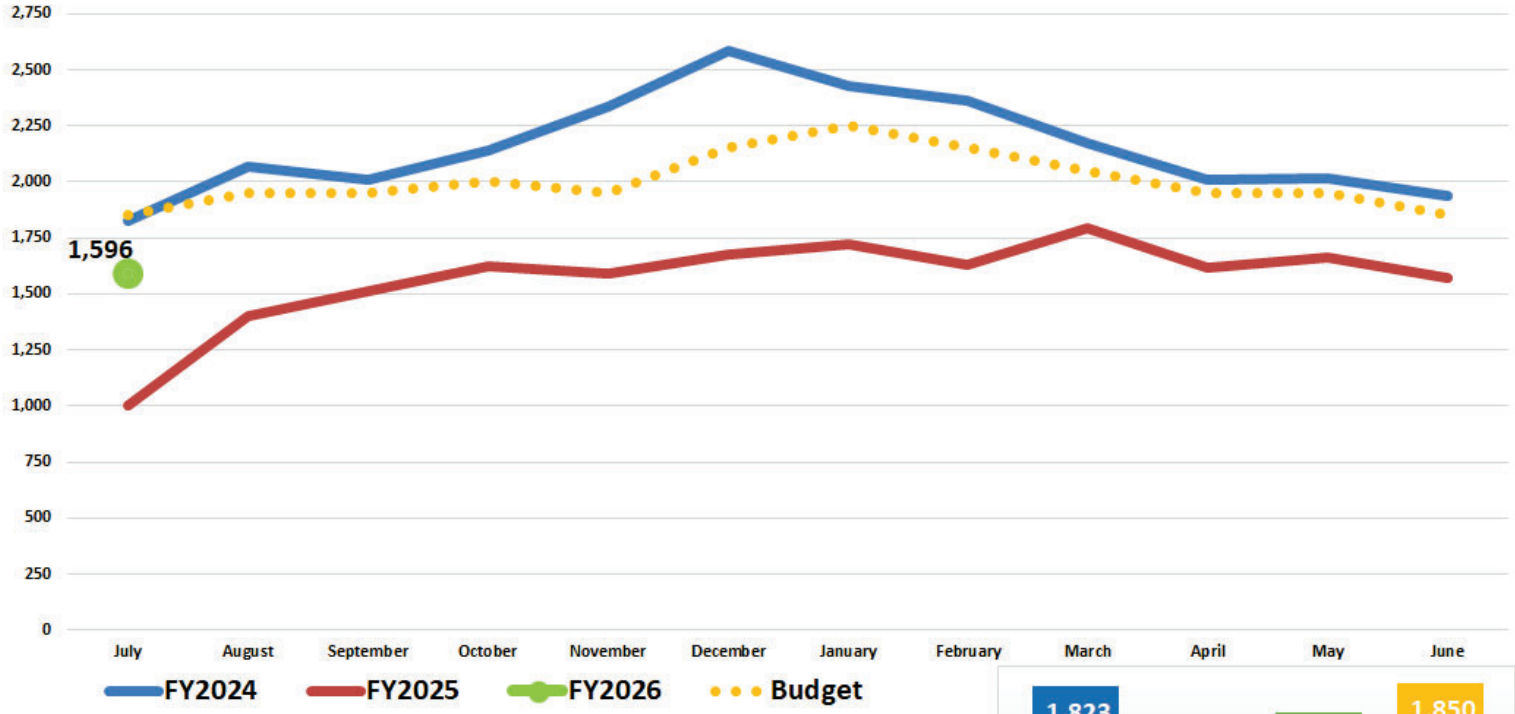


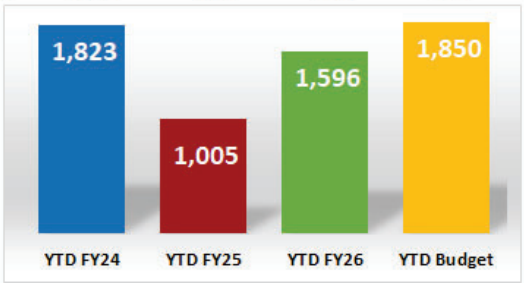


Urgent Care – Court Avg Visits Per Day

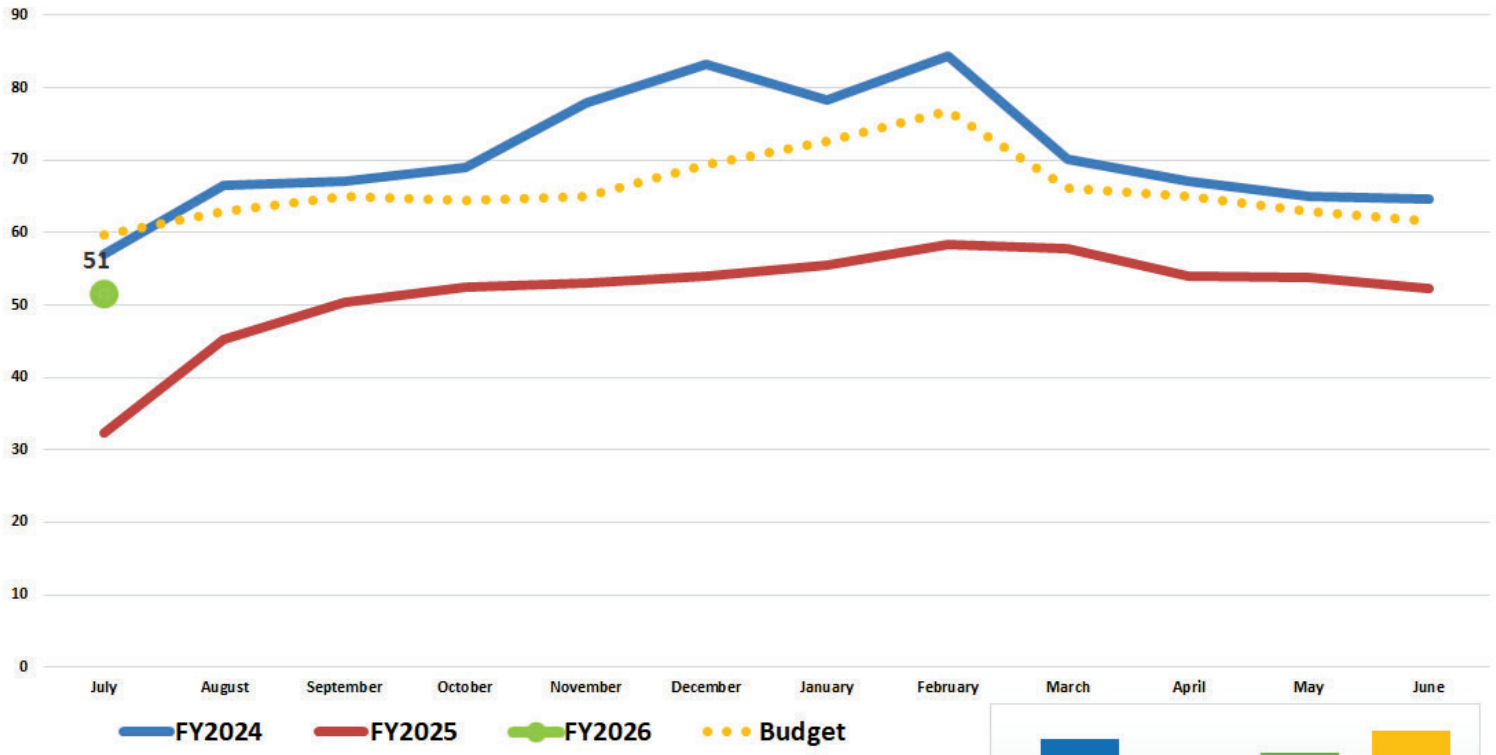


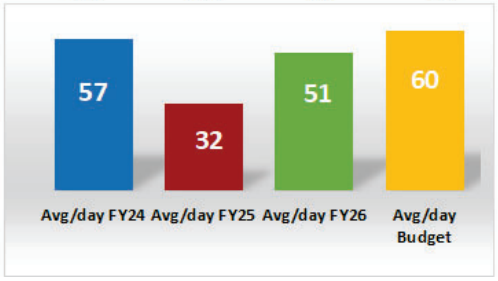
Urgent Care – Demaree Total Visits



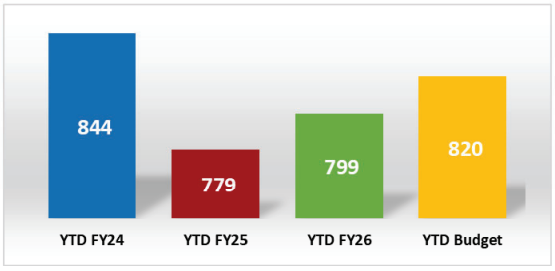


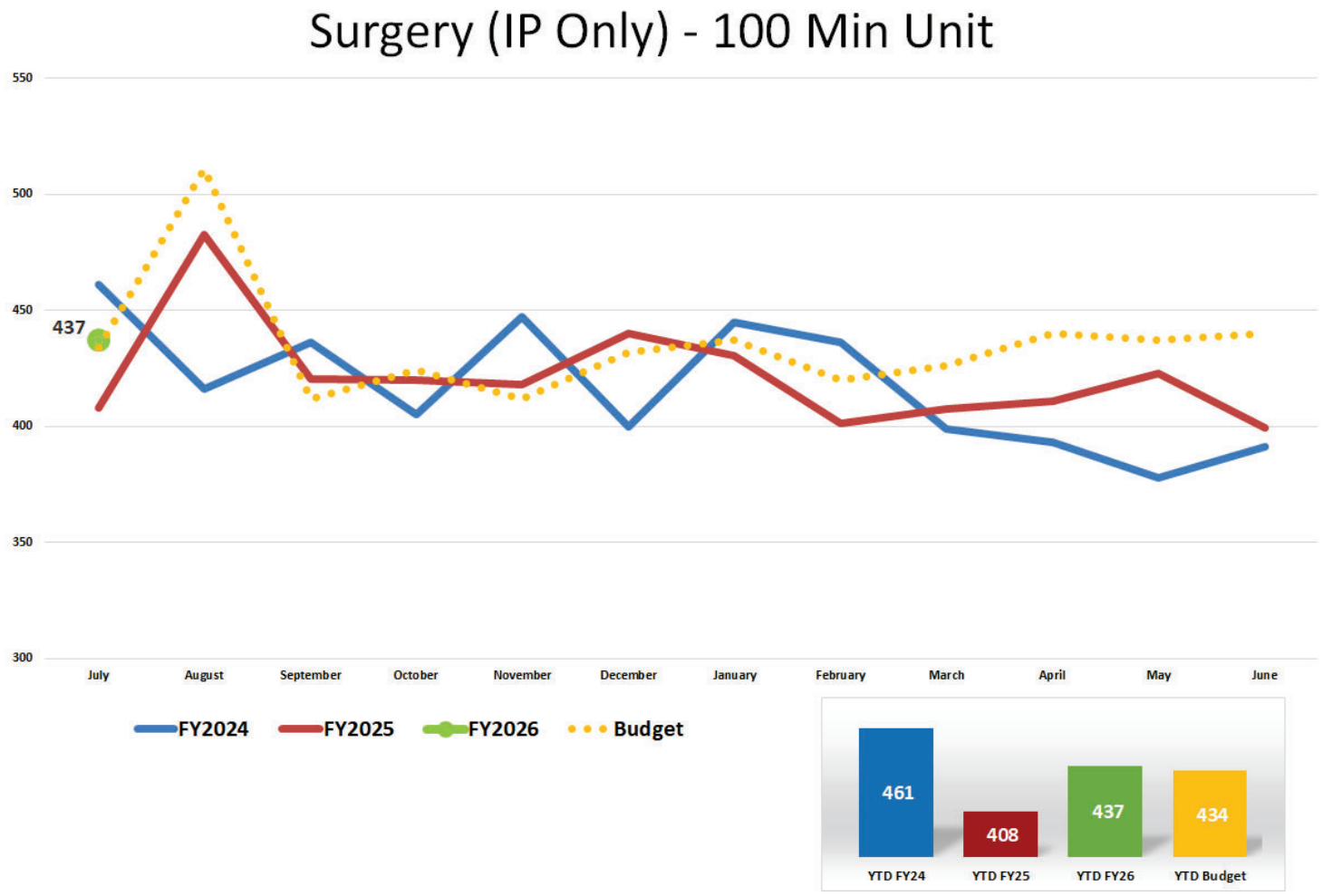
Urgent Care – Demaree Avg Visits Per Day





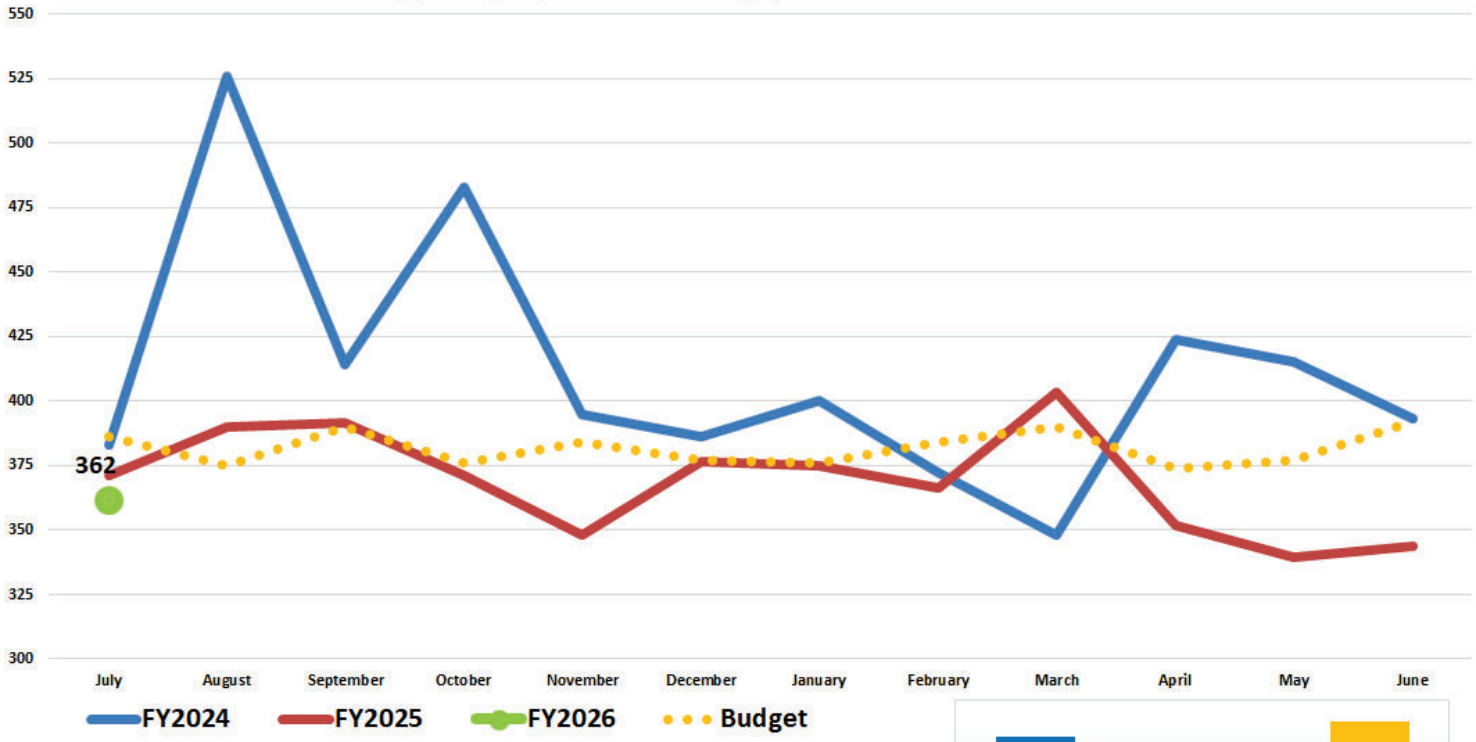
Surgery (IP & OP) – 100 Min Units

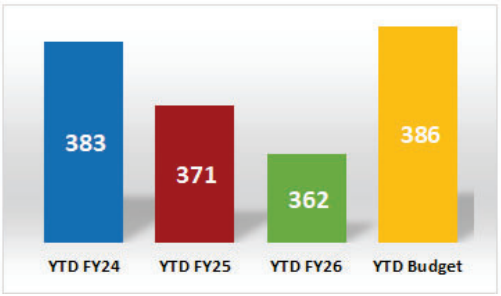



Surgery (IP Only) - 100 Min Unit
550
500
450
400
350
300
437
July
August
September
October
November
December
January
February
March
April
May
June
FY2024
FY2025
FY2026
Budget

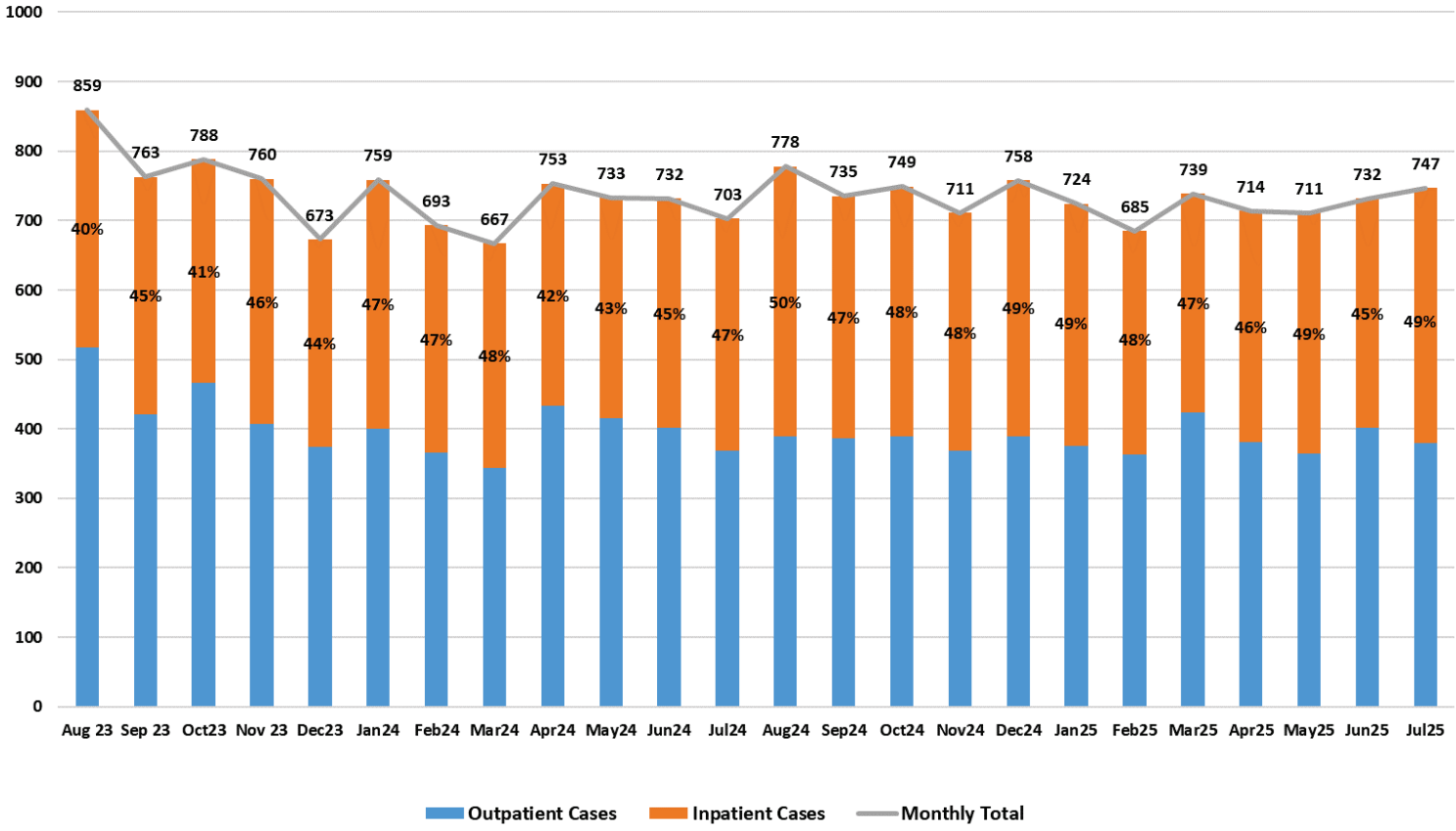
461
408
437
434
YTD FY24
YTD FY25
YTD FY26
YTD Budget

Surgery (OP Only) - 100 Min Units

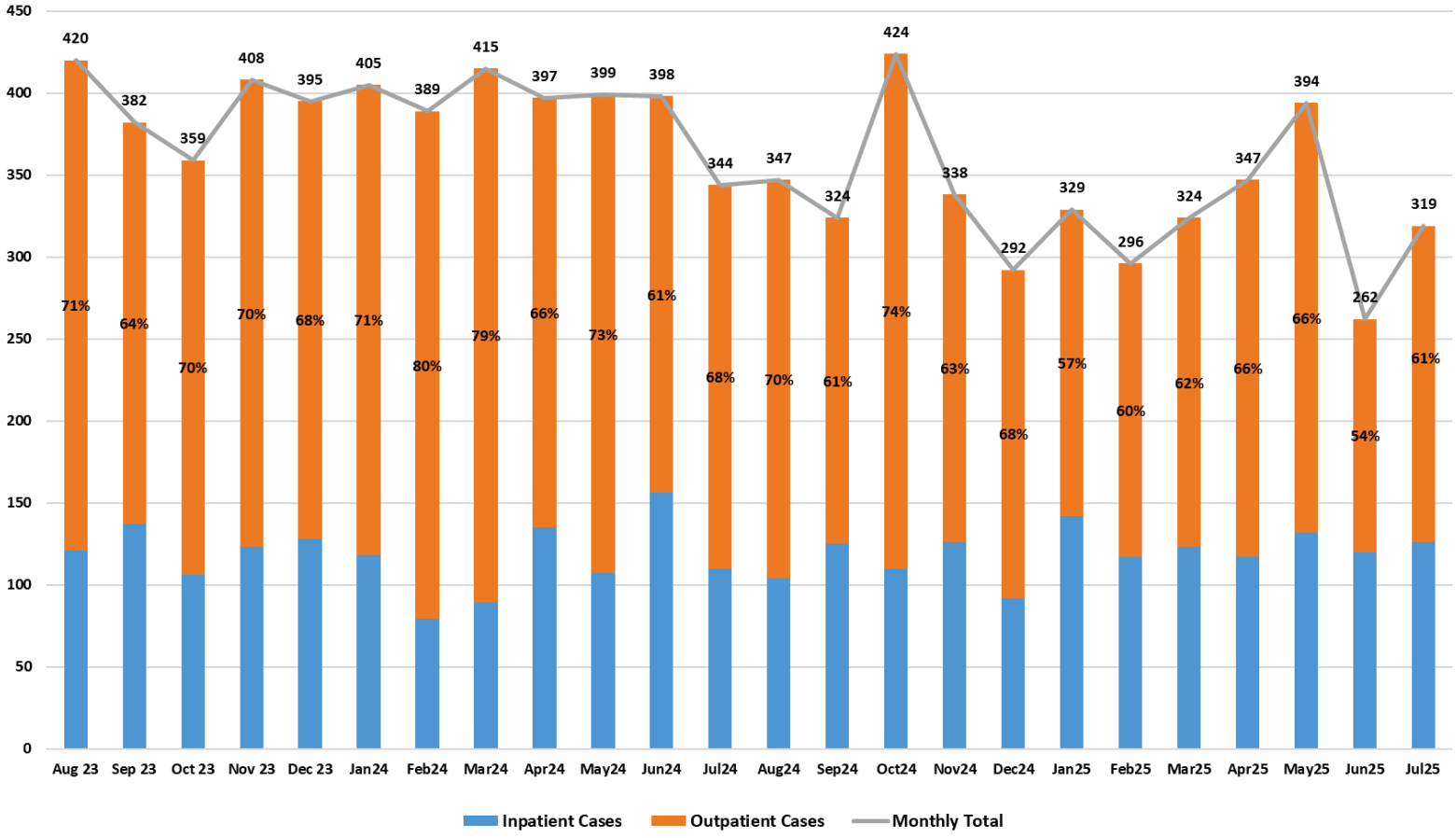




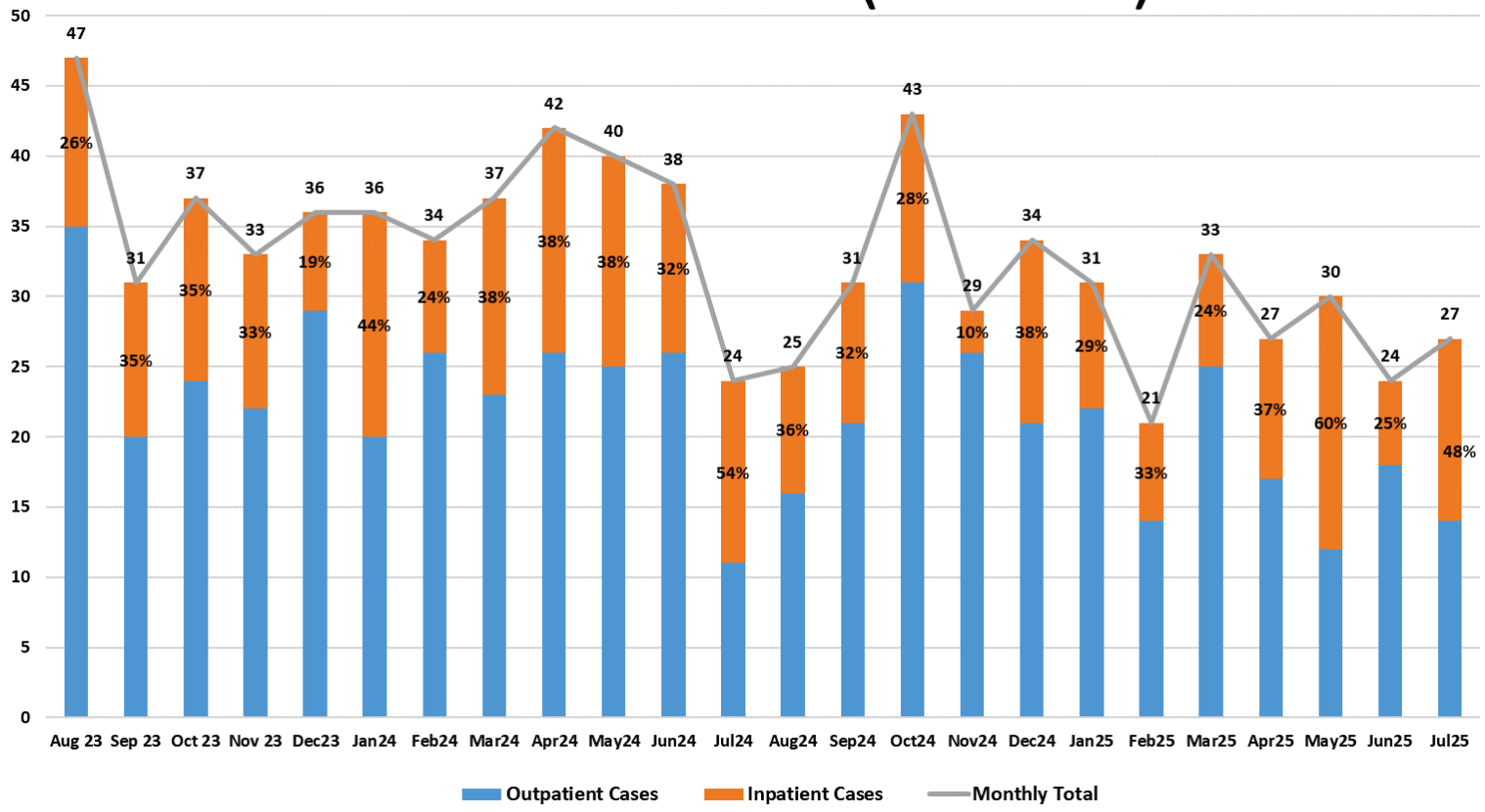
Surgery Cases (IP & OP)



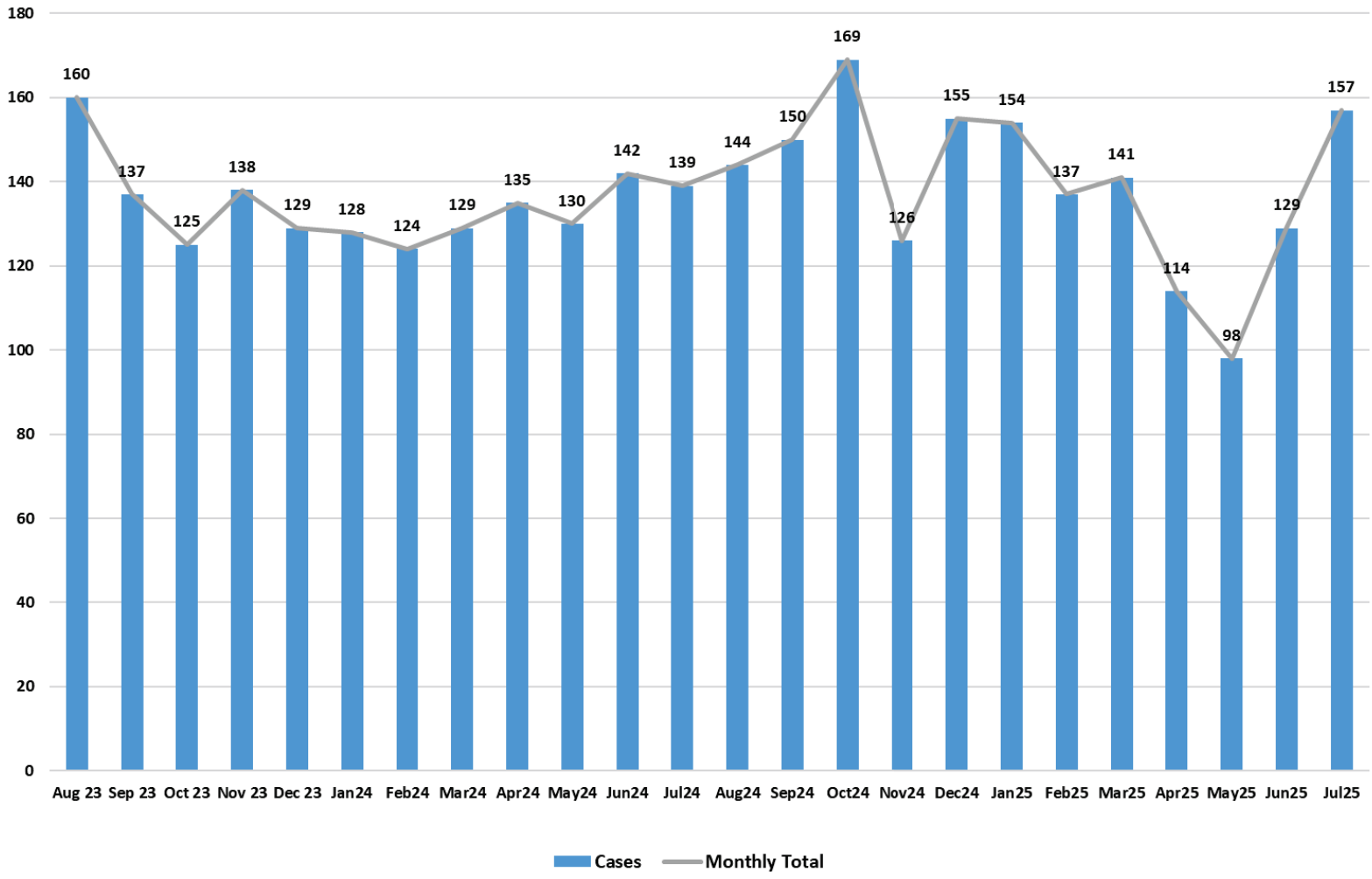
Endo Cases (Suites A & B and OR)

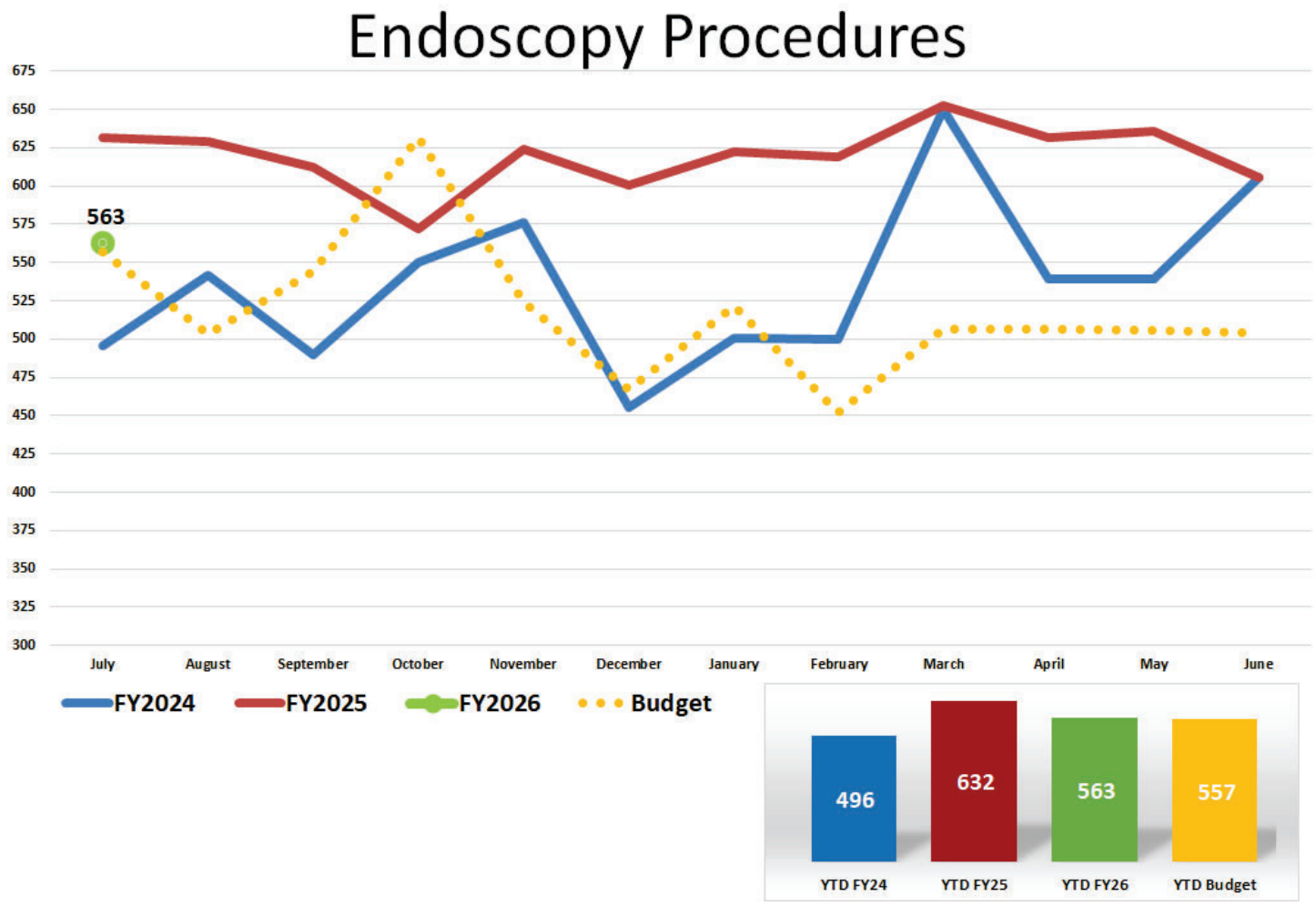


Robotic Cases (IP & OP)

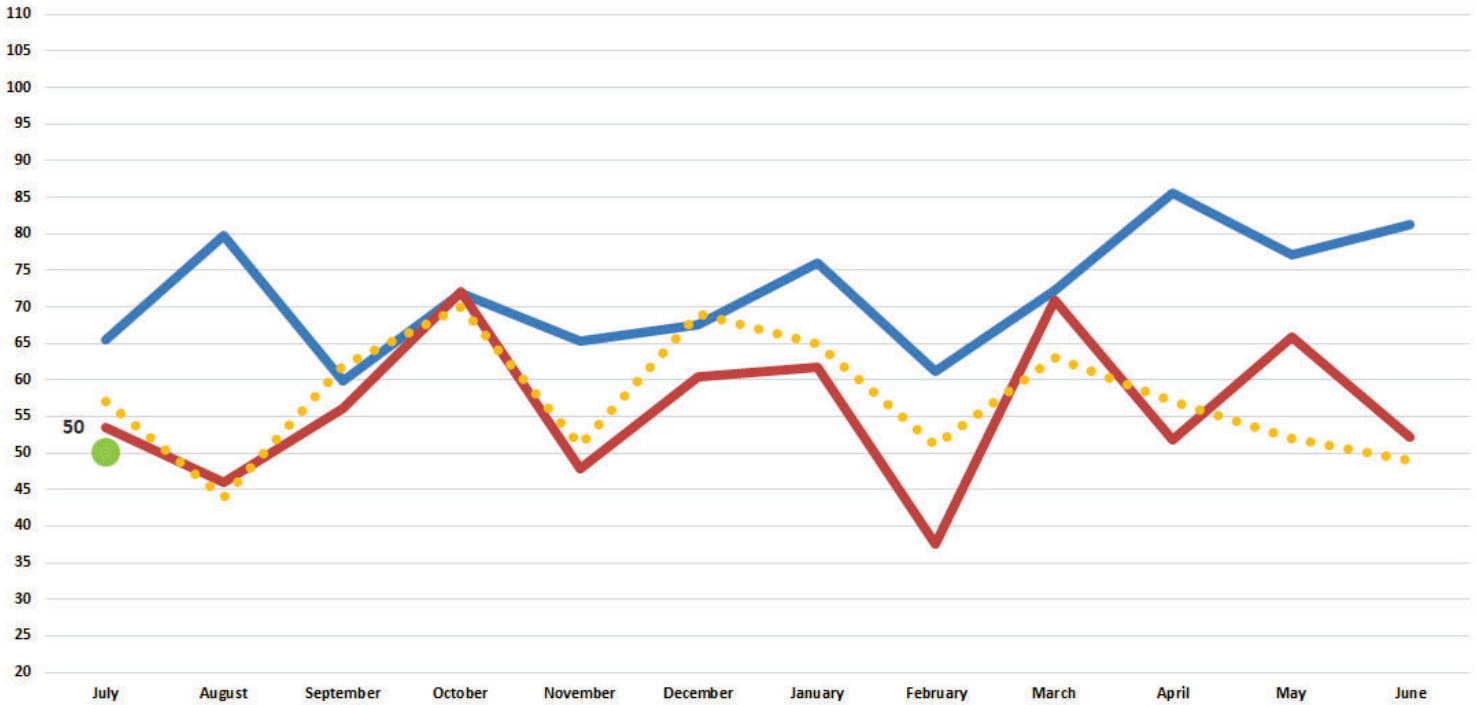


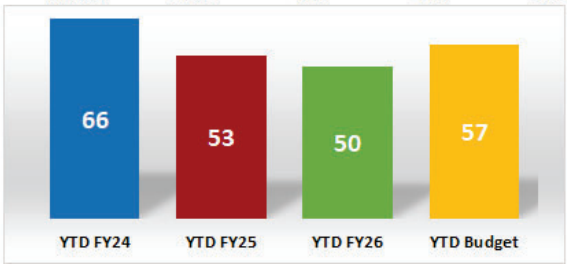
OB Cases


180
160
140
120
100
80
60
40
20
0
160
137
125
138
129
128
124
129
135
130
142
139
144
150
169
126
155
154
137
141
114
98
129
157
Aug 23
Sep 23
Oct 23
Nov 23
Dec 23
Jan24
Feb24
Mar24
Apr24
May24
Jun24
Jul24
Aug24
Sep24
Oct24
Nov24
Dec24
Jan25
Feb25
Mar25
Apr25
May25
Jun25
Jul25
Cases
Monthly Total

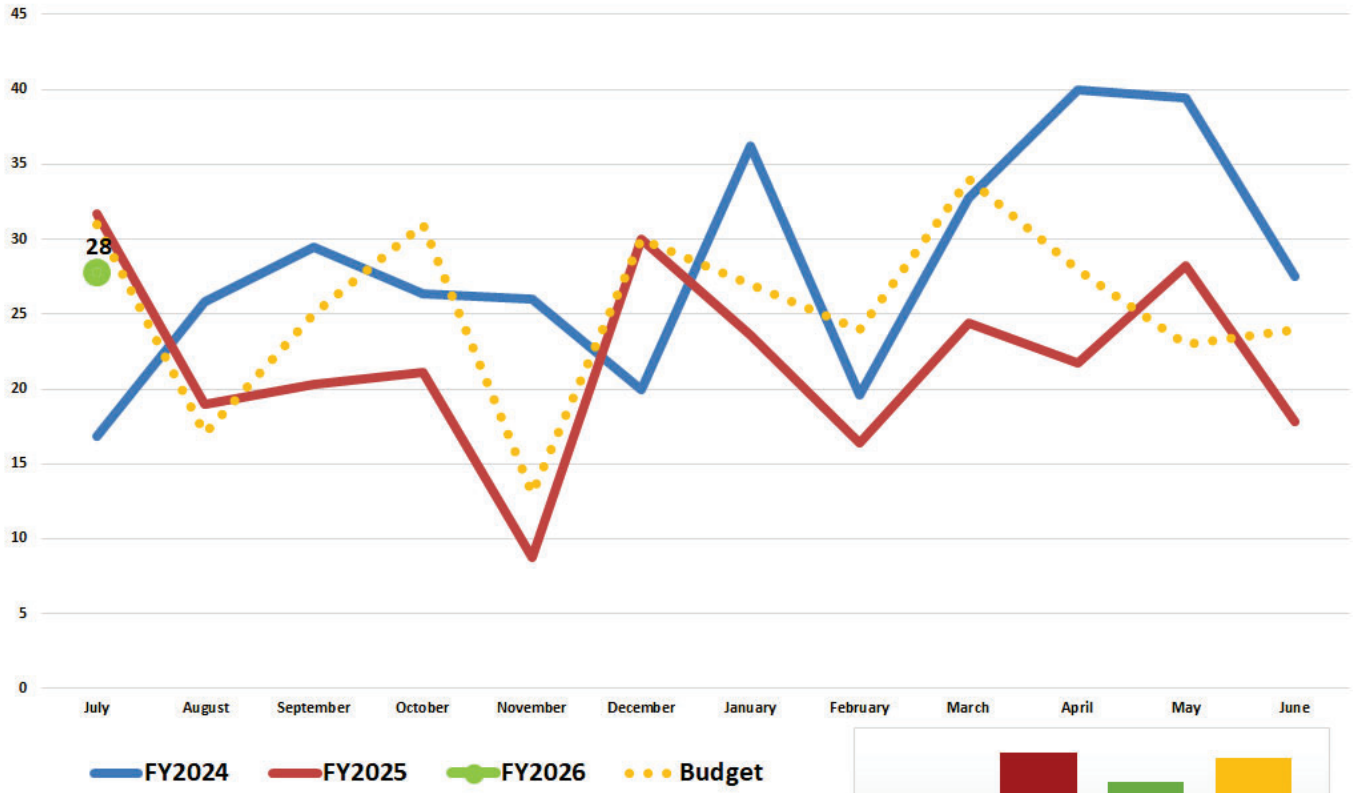

Endoscopy Procedures
675
650
625
600
575
550
525
500
475
450
425
400
375
350
325
300
563
July
August
September
October
November
December
January
February
March
April
May
June
FY2024
FY2025
FY2026
Budget
496
632
563
557
YTD FY24
YTD FY25
YTD FY26
YTD Budget

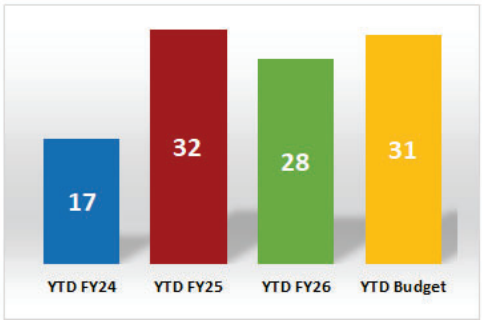
Robotic Surgery (IP & OP) - 100 Min Units



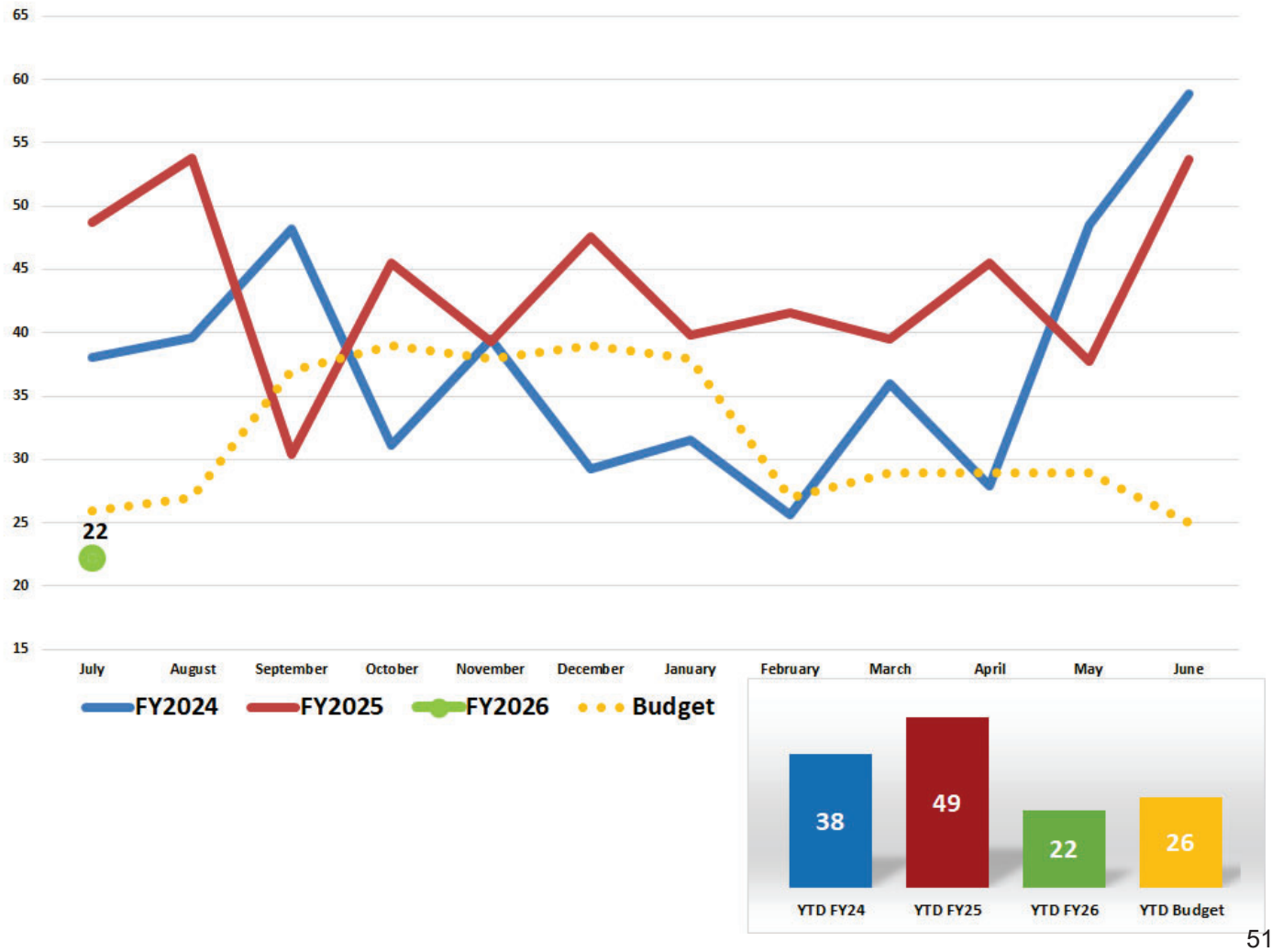


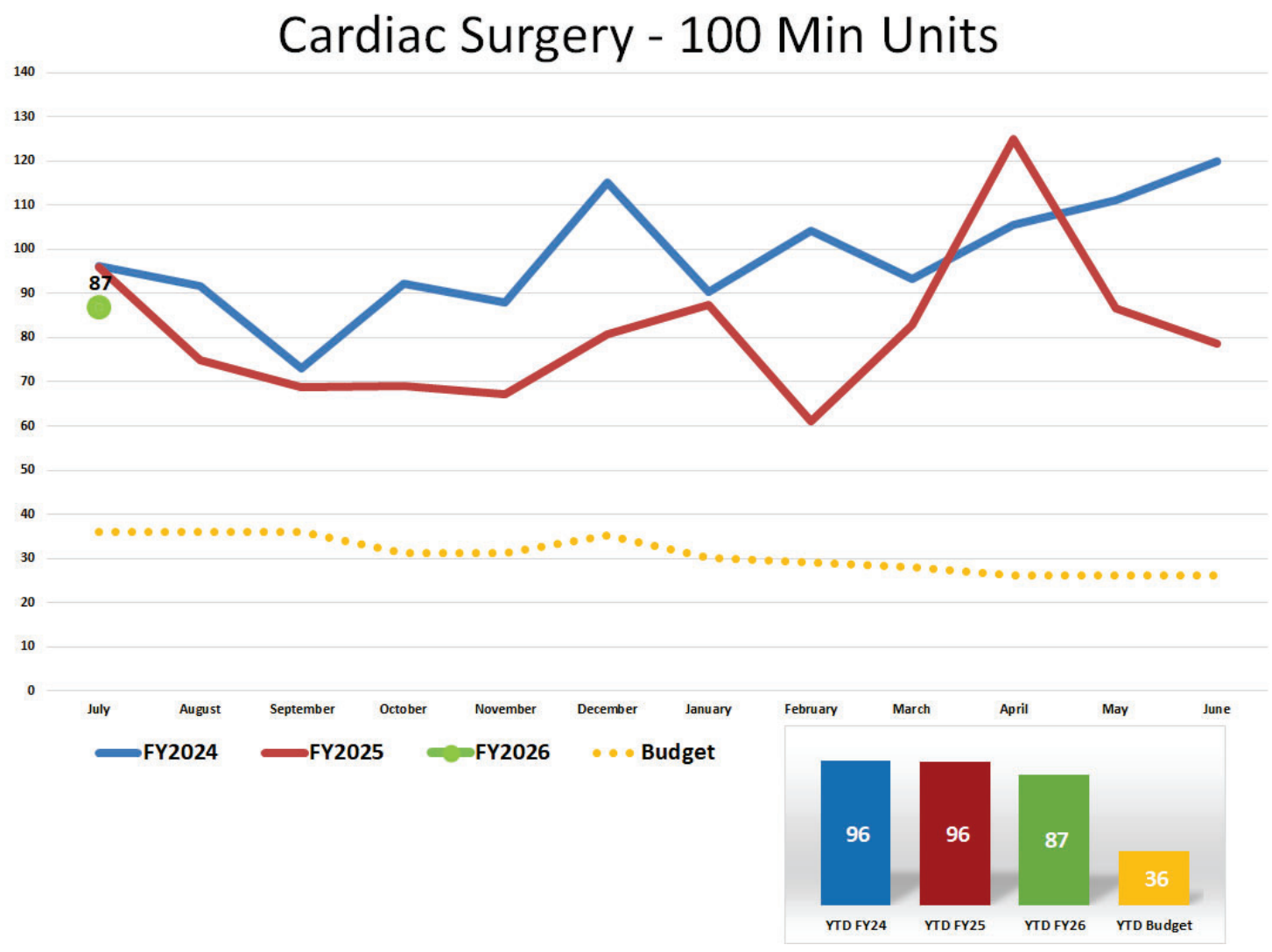
Robotic Surgery Minutes (IP Only)

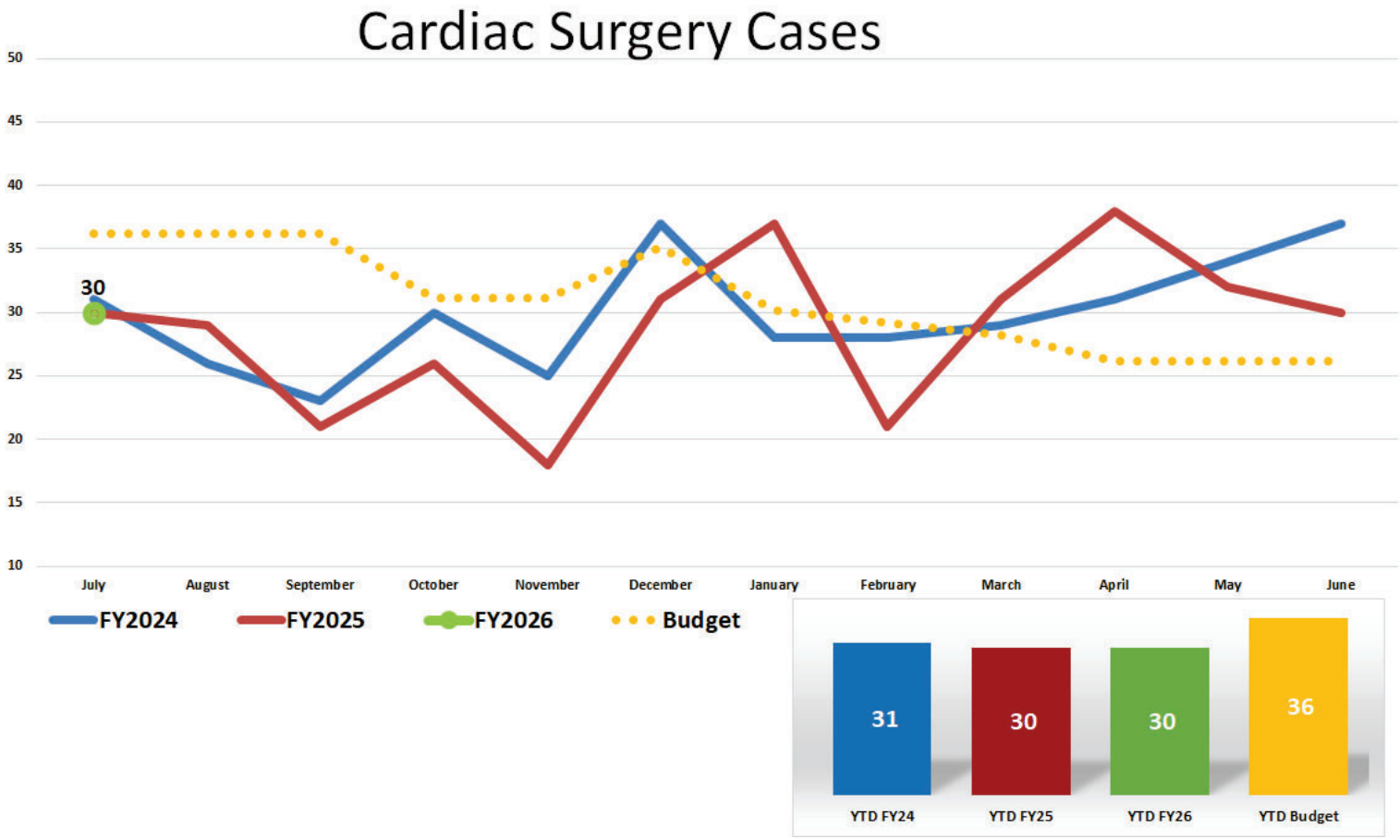




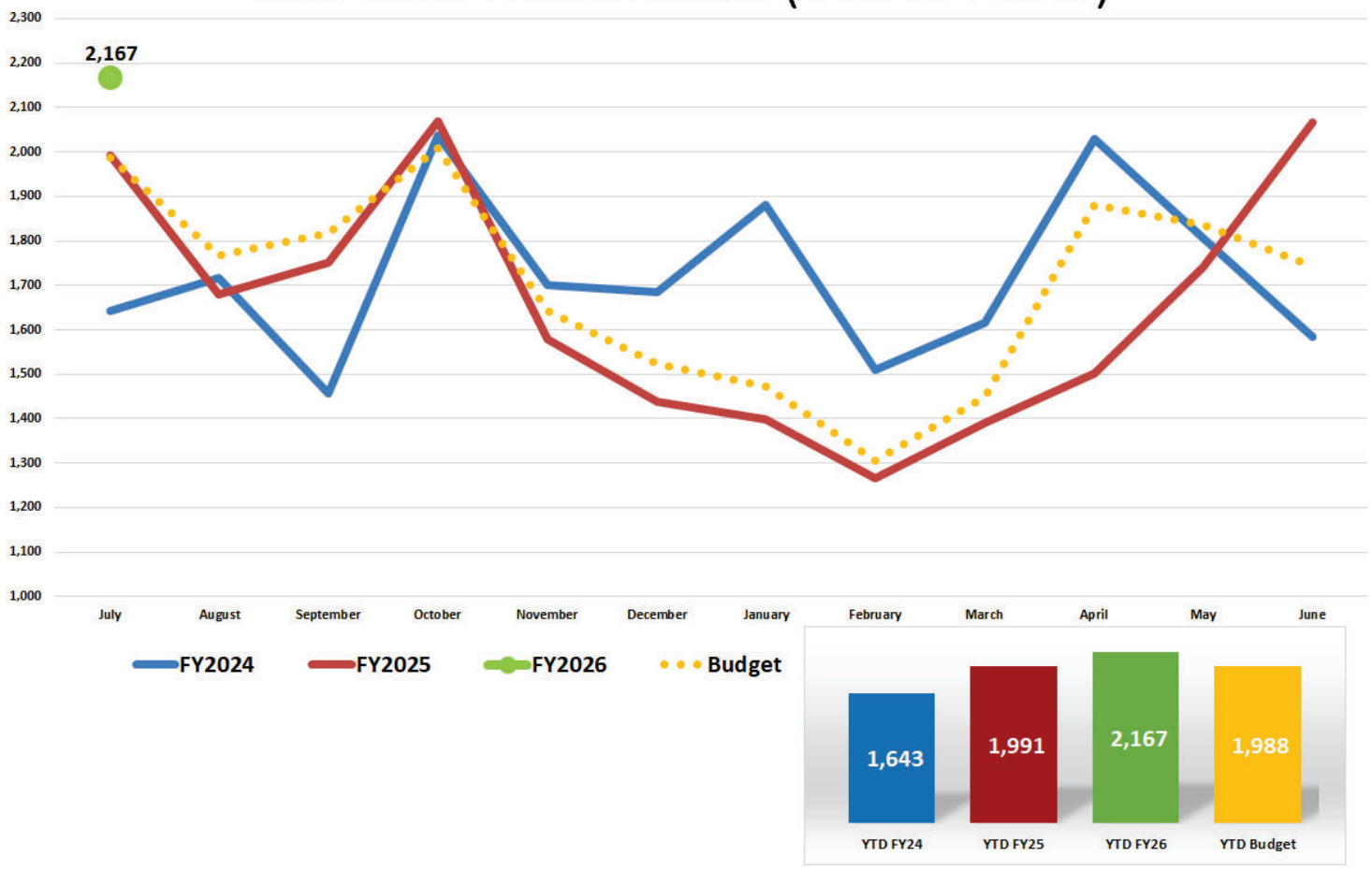
Robotic Surgery Minutes (OP Only)



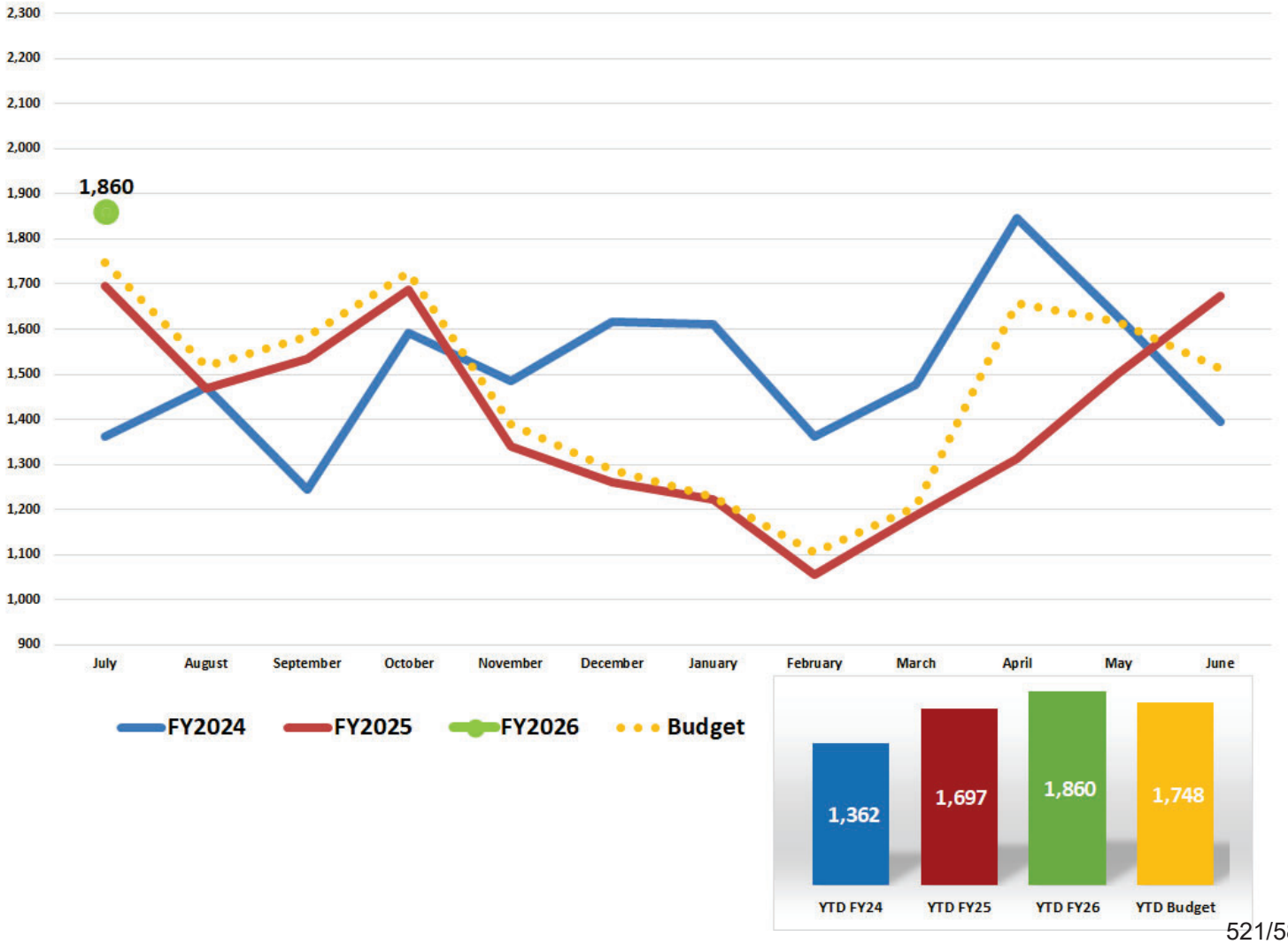

Cardiac Surgery - 100 Min Units
140
130
120
110
100
90
80
70
60
50
40
30
20
10
0
87
July
August
September
October
November
December
January
February
March
April
May
June
FY2024
FY2025
FY2026
Budget
96
96
87
36
YTD FY24
YTD FY25
YTD FY26
YTD Budget


Cardiac Surgery Cases
50
45
40
35
30
25
20
15
10
30
July
August
September
October
November
December
January
February
March
April
May
June
FY2024
FY2025
FY2026
Budget
31
30
30
36
YTD FY24
YTD FY25
YTD FY26
YTD Budget

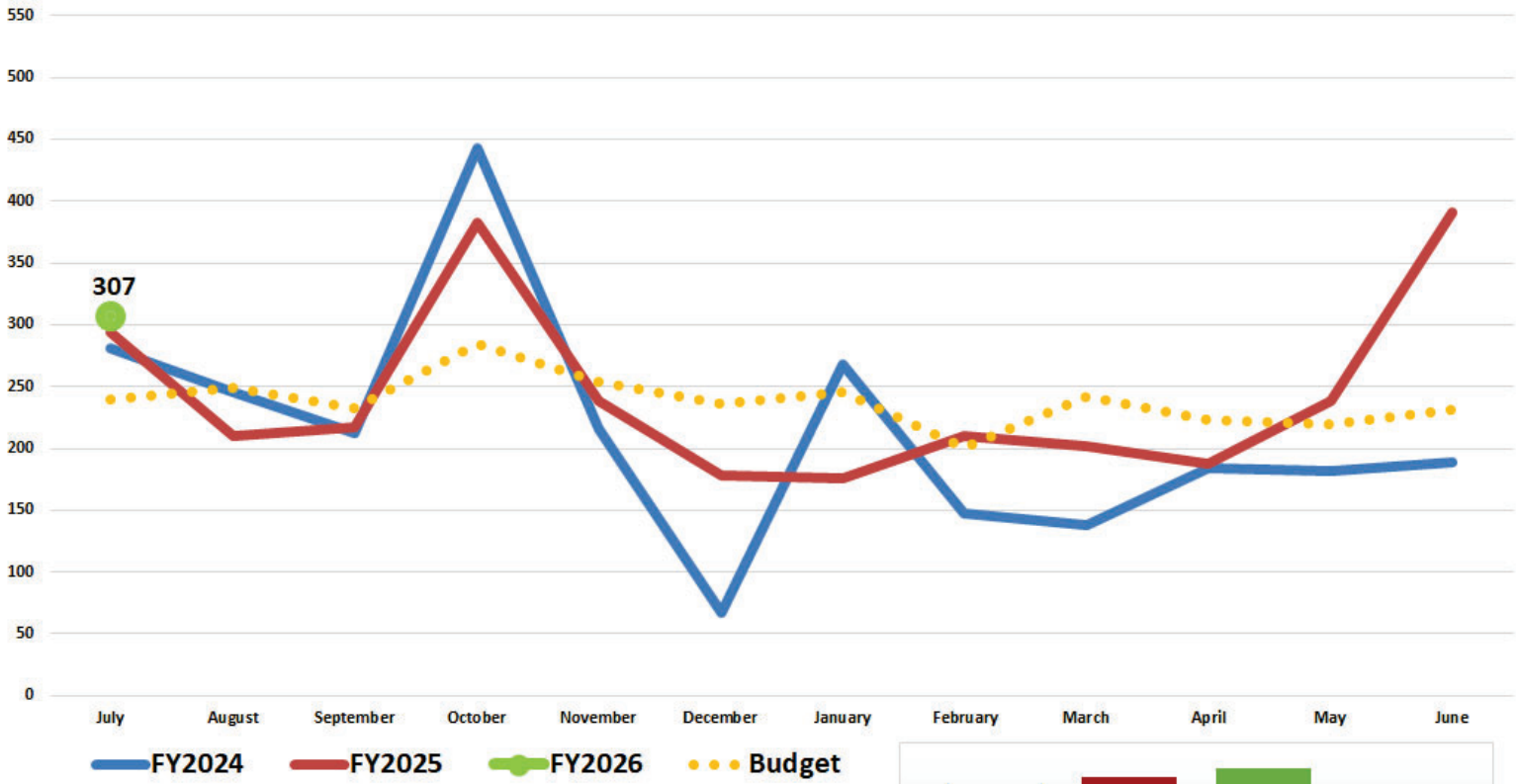
Rad Onc Treatments (Vis. & Hanf.)

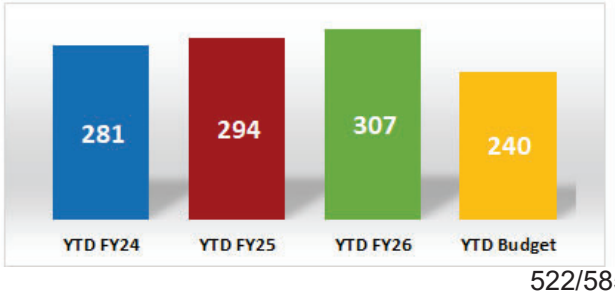


Rad Onc Visalia

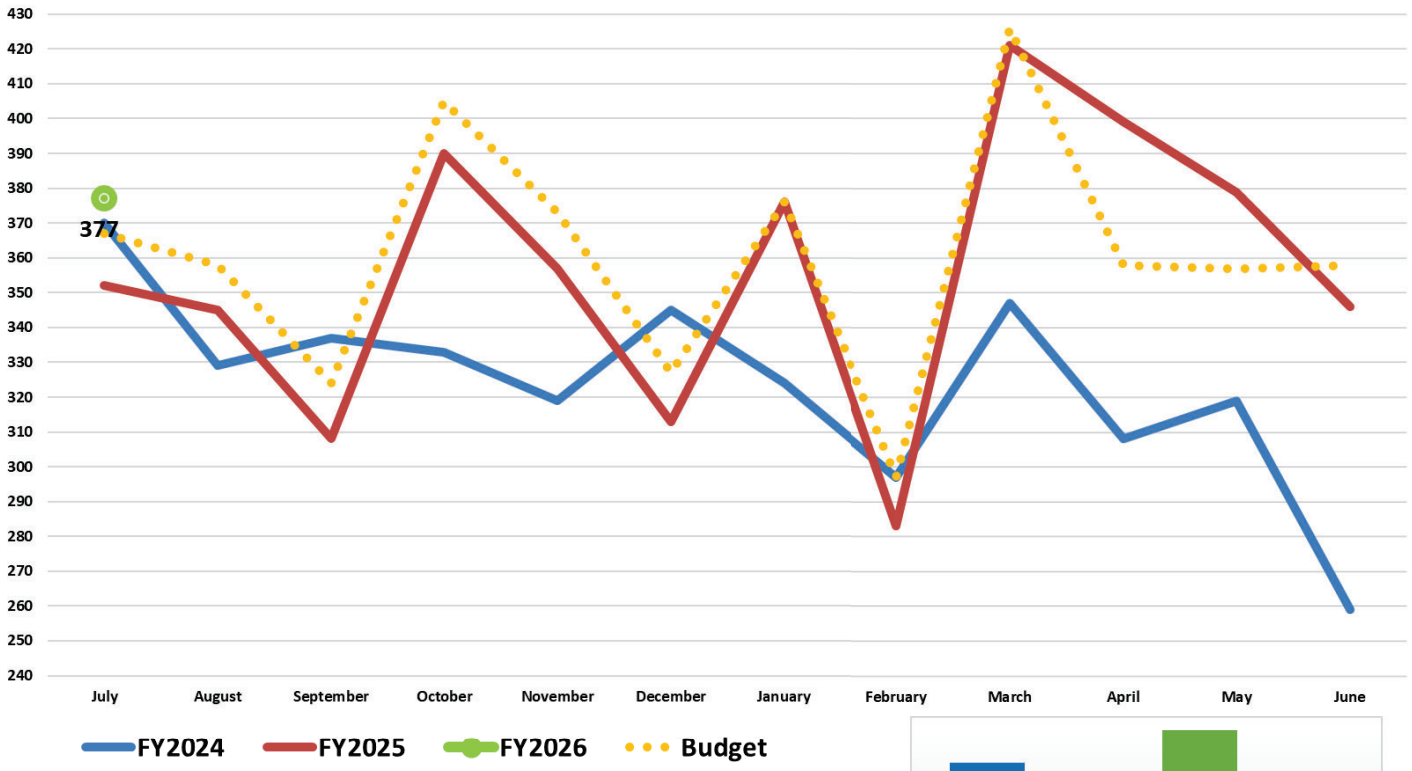


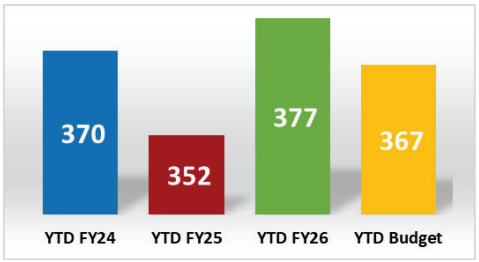
Rad Onc Hanford



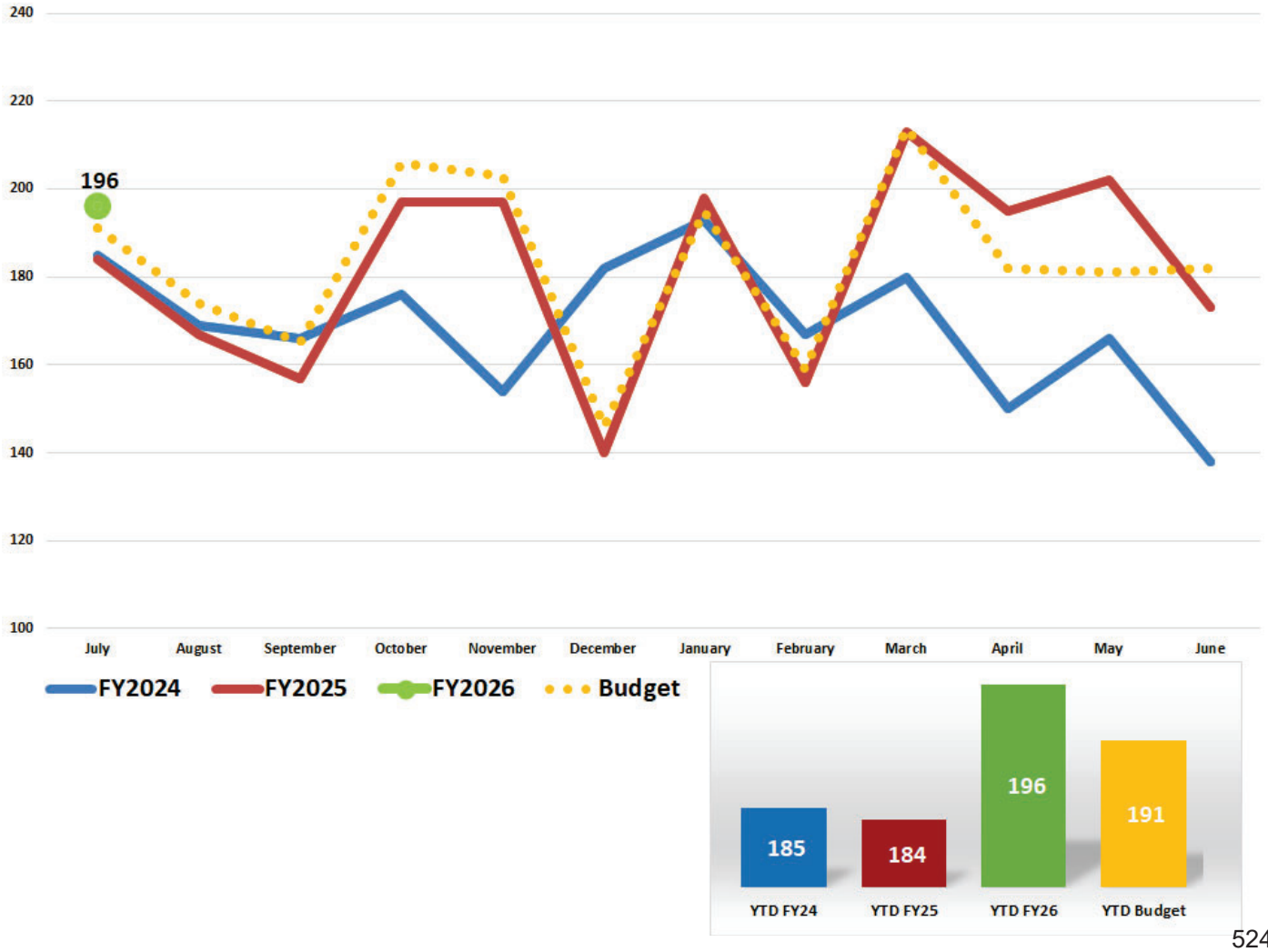


Cath Lab (IP & OP) – 100 Min Units

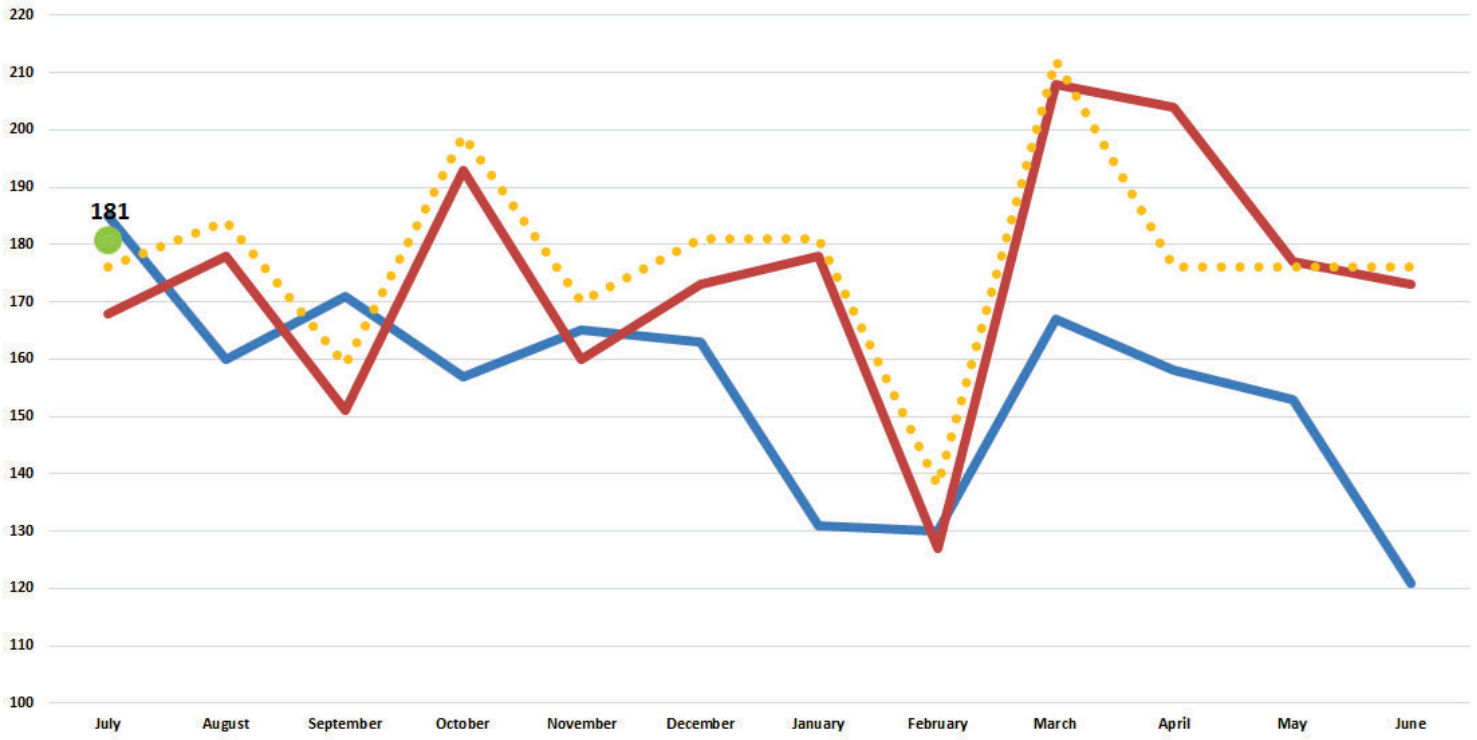


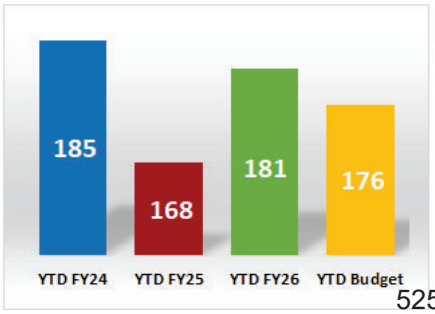


Cath Lab (IP Only) – 100 Min Units

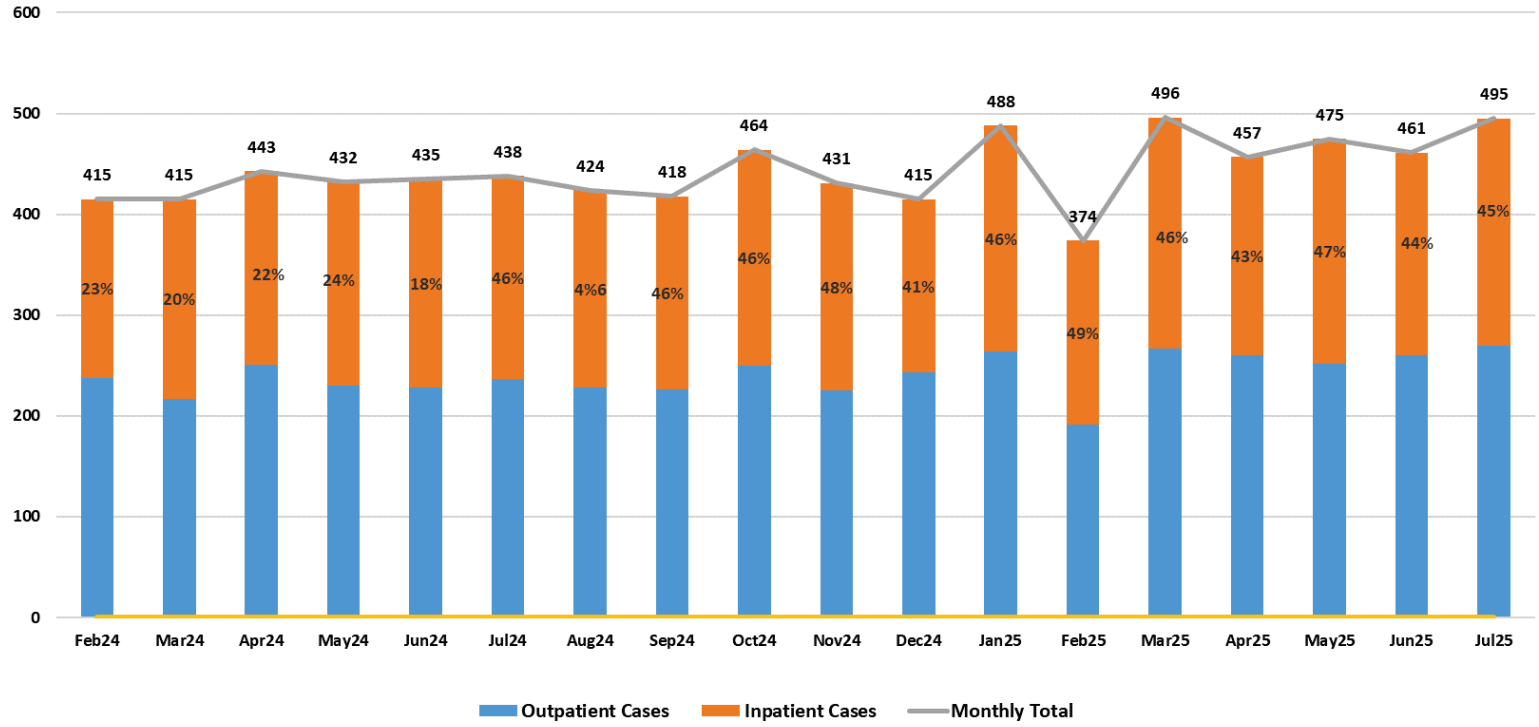


Cath Lab (OP Only) – 100 Min Units

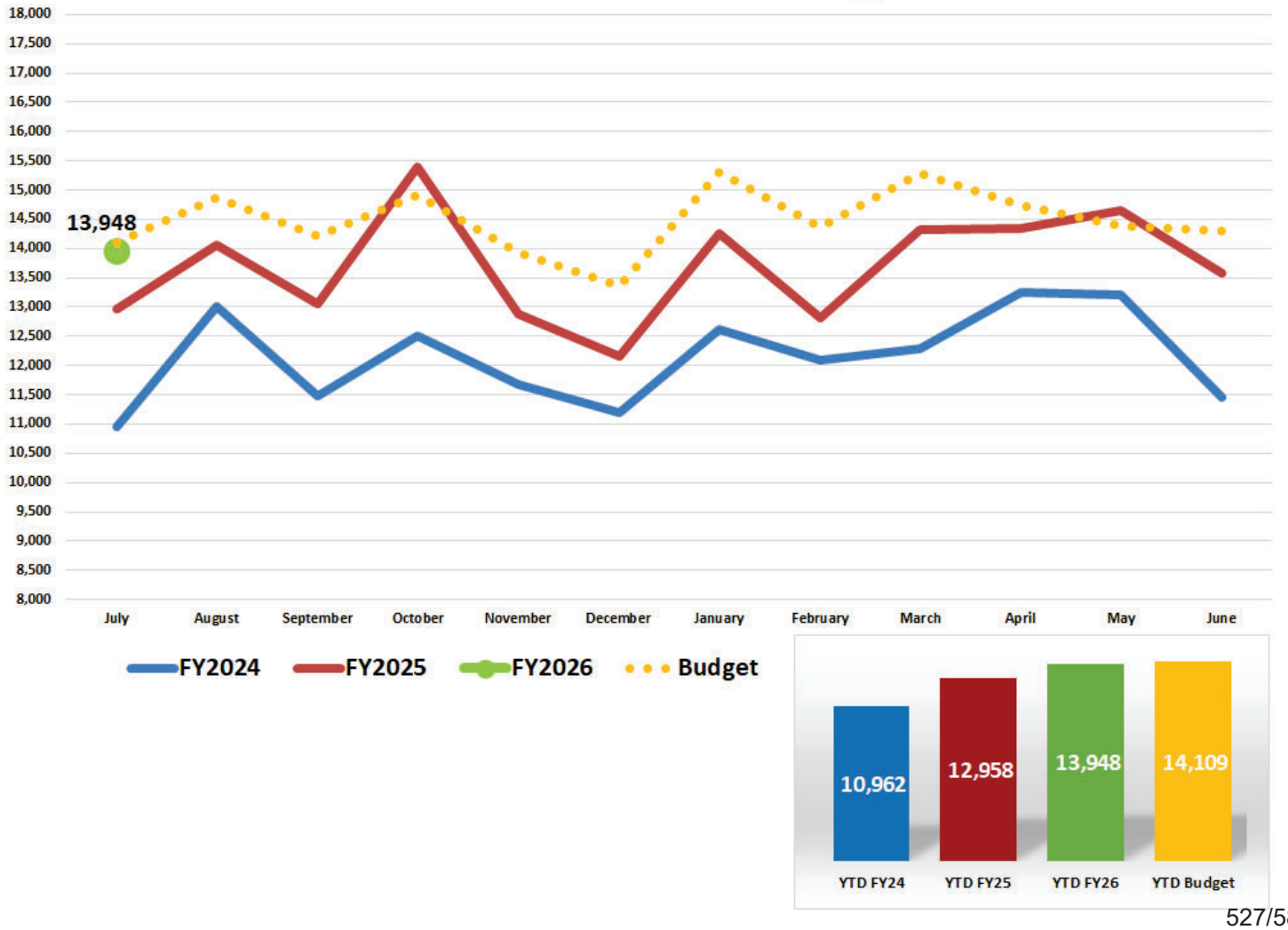




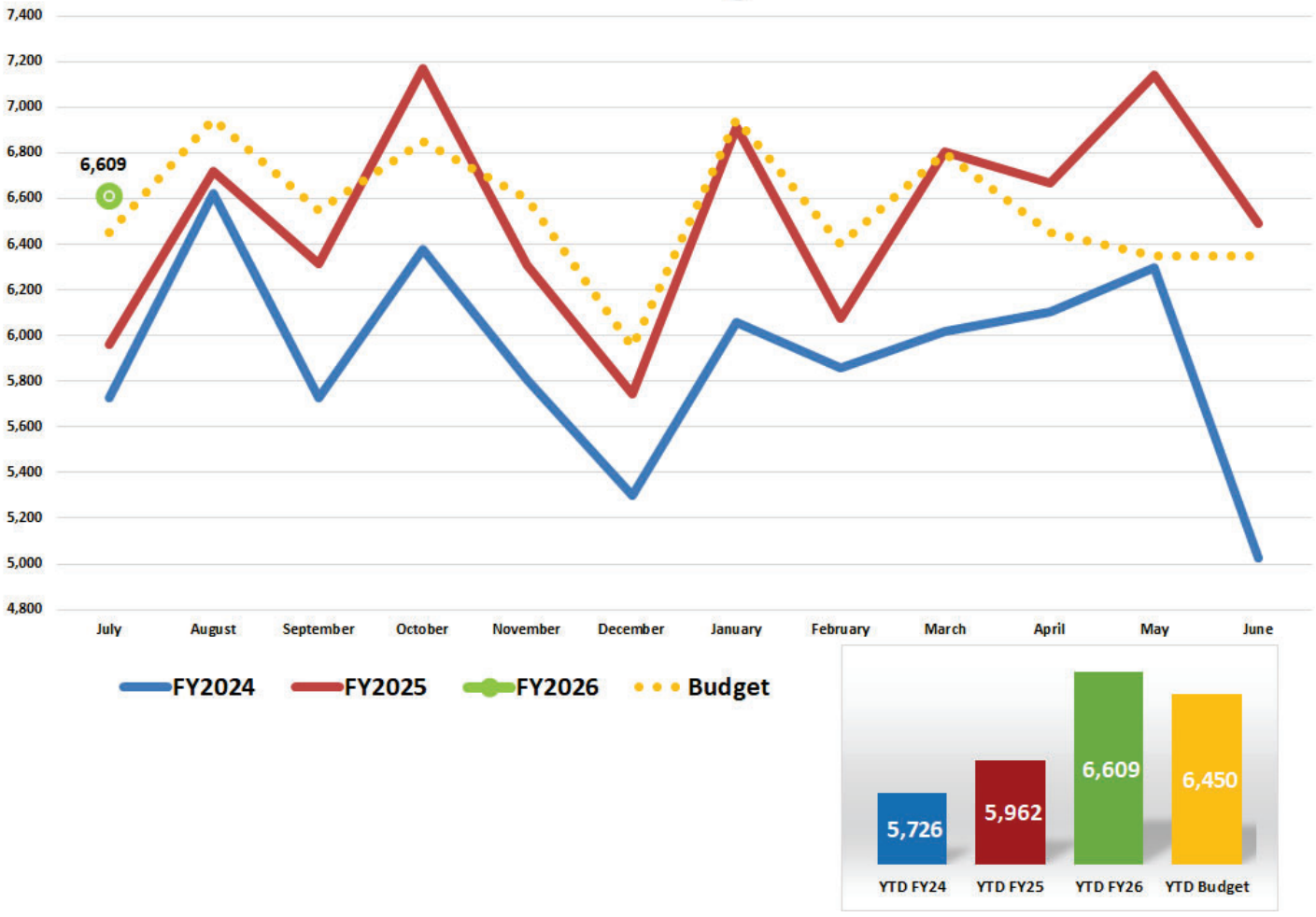
Cath Lab Patients (IP & OP)

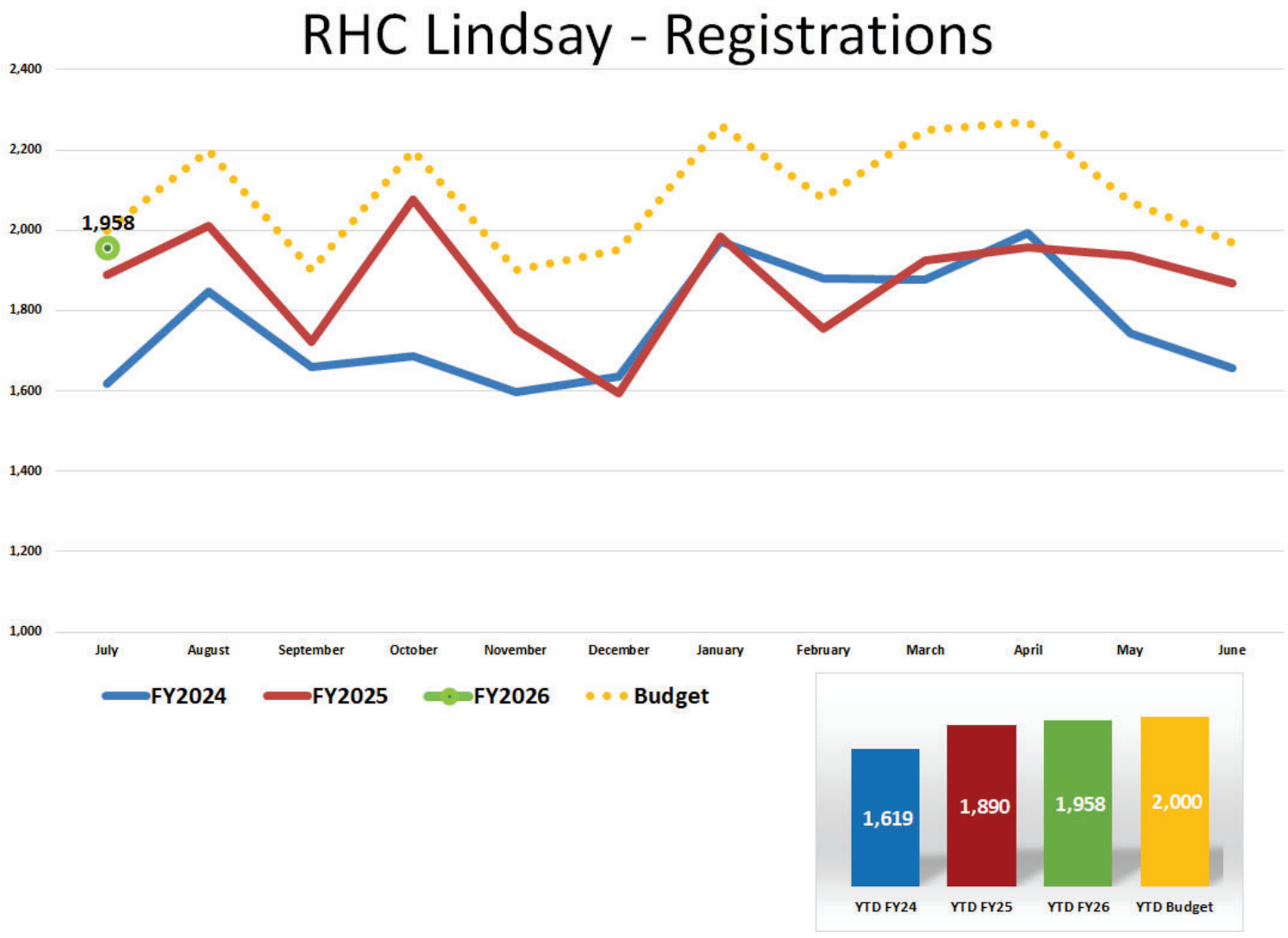


Rural Health Clinics Registrations

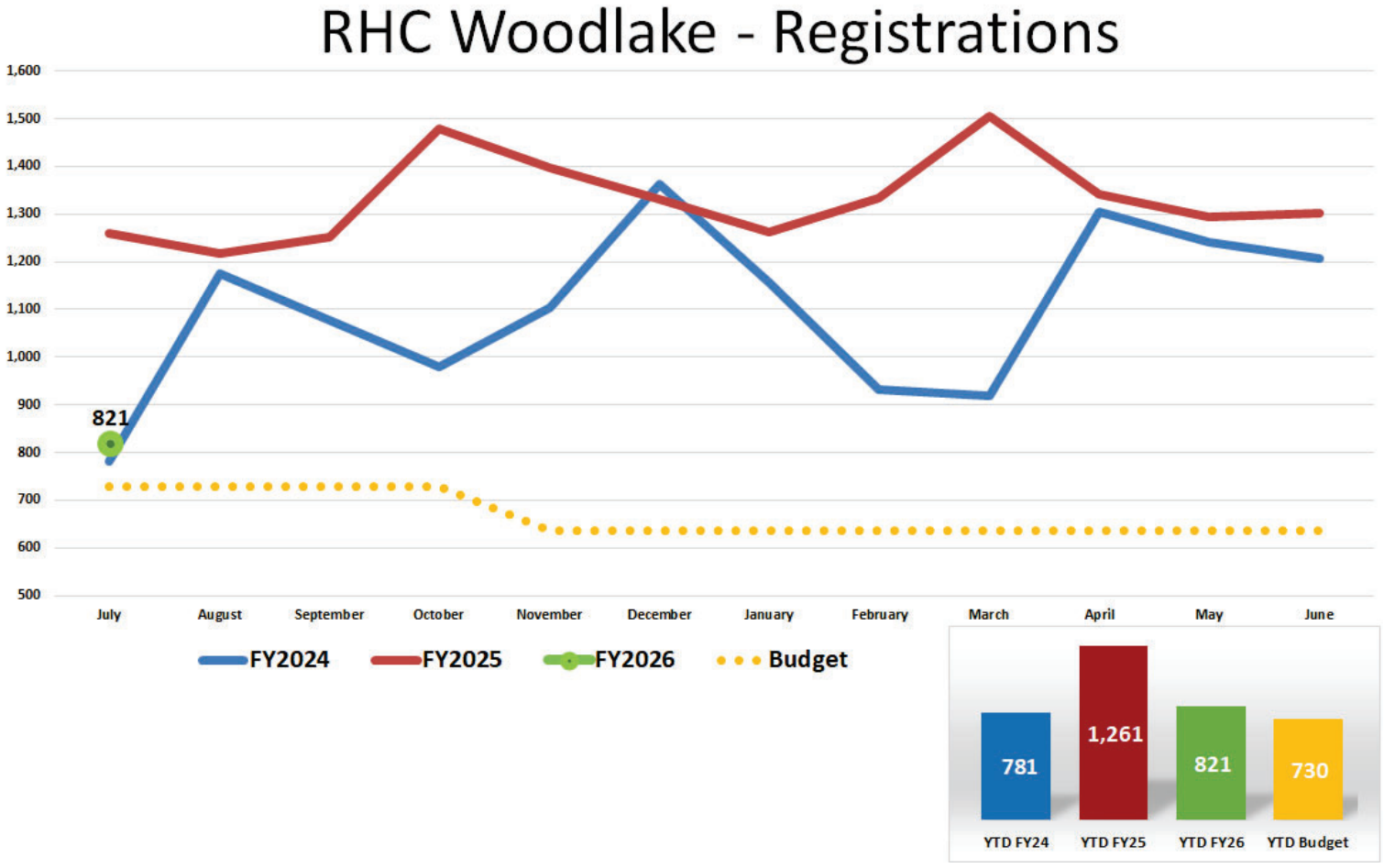


RHC Exeter - Registrations

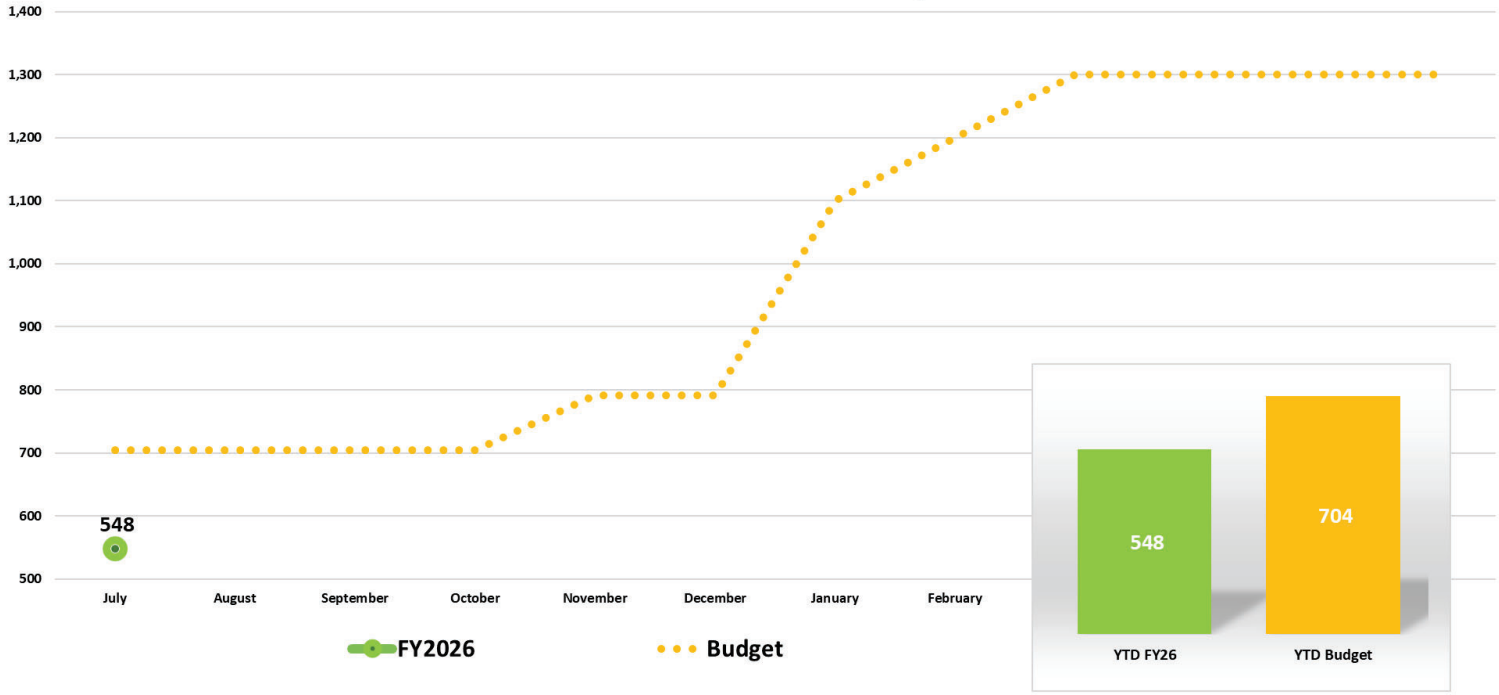



RHC Lindsay - Registrations
2,400
2,200
2,000
1,800
1,600
1,400
1,200
1,000
1,958
July
August
September
October
November
December
January
February
March
April
May
June
FY2024
FY2025
FY2026
Budget

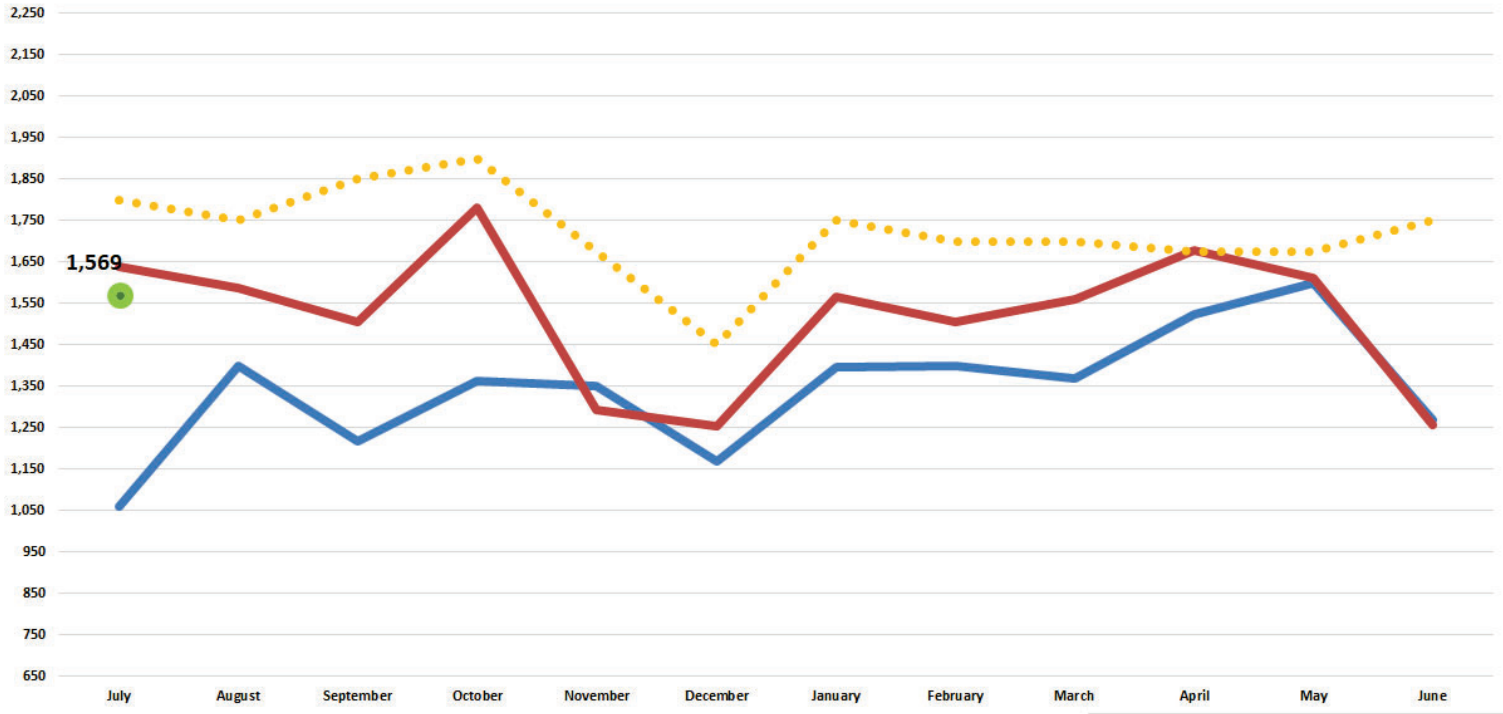
1,619
1,890
1,958
2,000
YTD FY24
YTD FY25
YTD FY26
YTD Budget

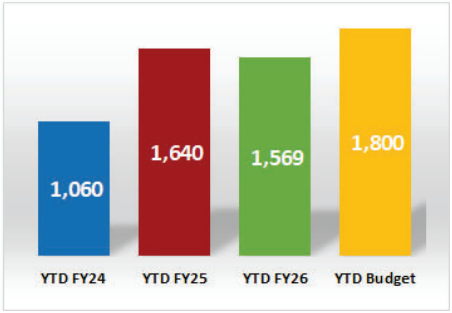

RHC Woodlake - Registrations
1,600
1,500
1,400
1,300
1,200
1,100
1,000
900
800
700
600
500
821
July
August
September
October
November
December
January
February
March
April
May
June
FY2024
FY2025
FY2026
Budget
781
1,261
821
730
YTD FY24
YTD FY25
YTD FY26
YTD Budget

RHC Woodlake Valencia - Registrations

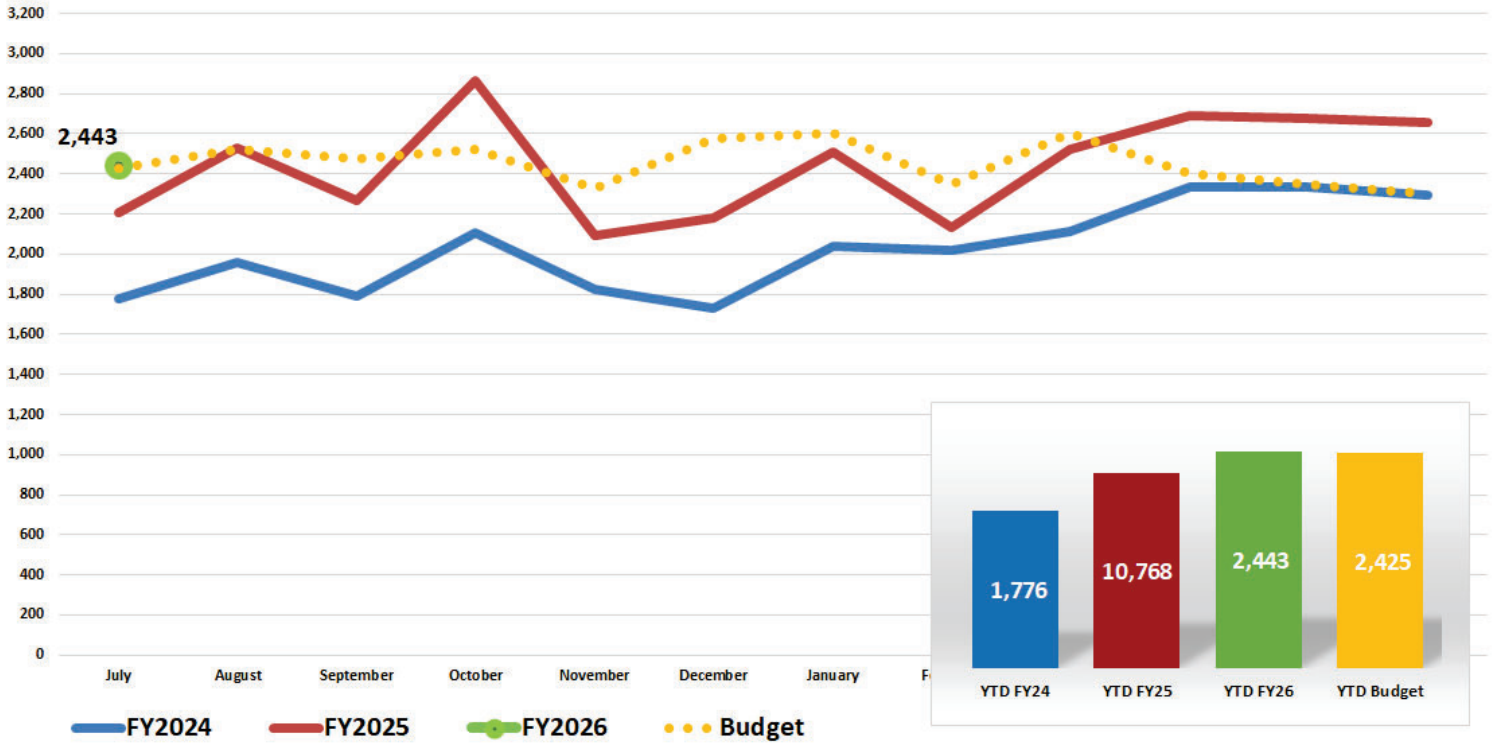


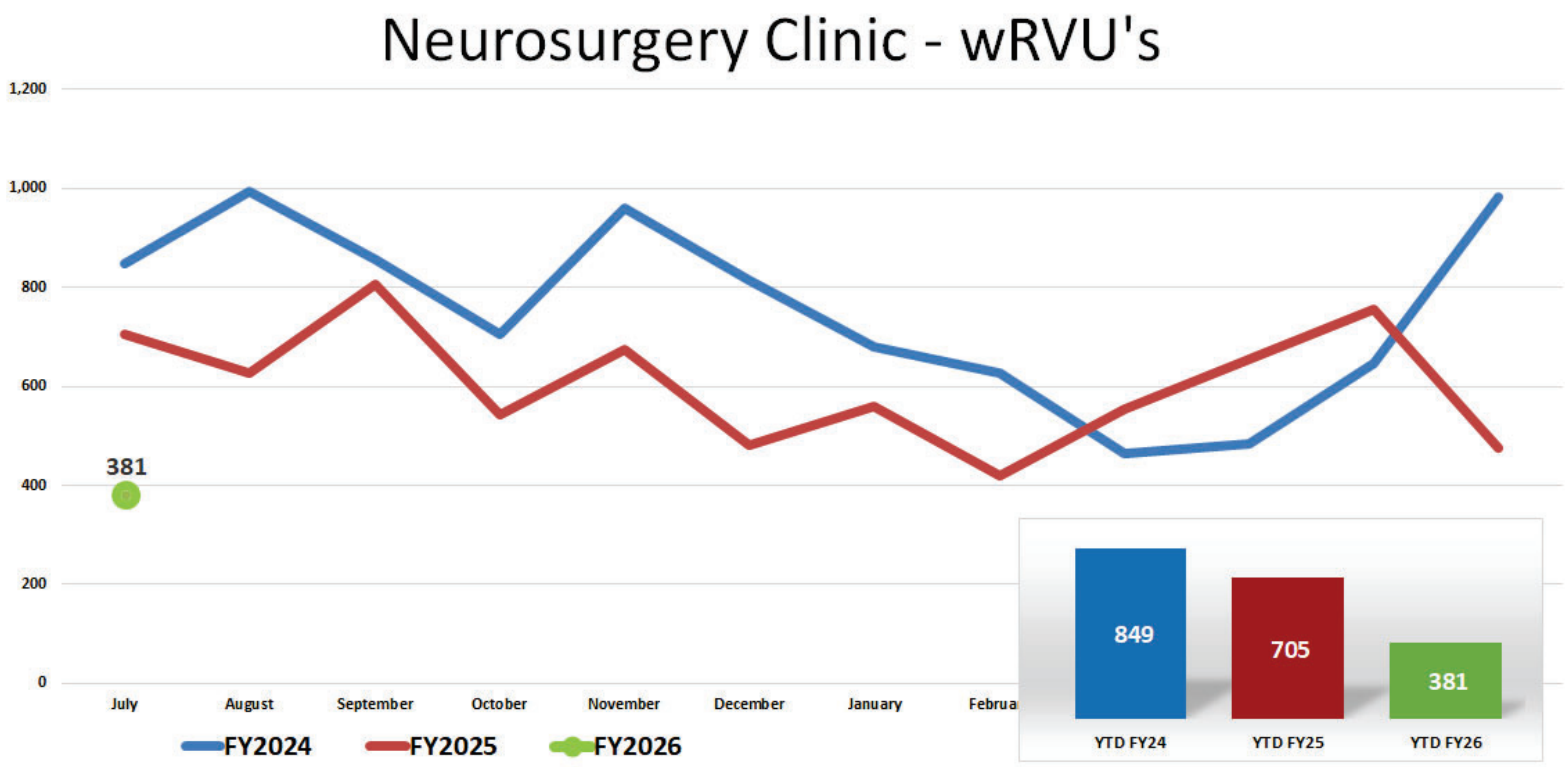
RHC Dinuba - Registrations



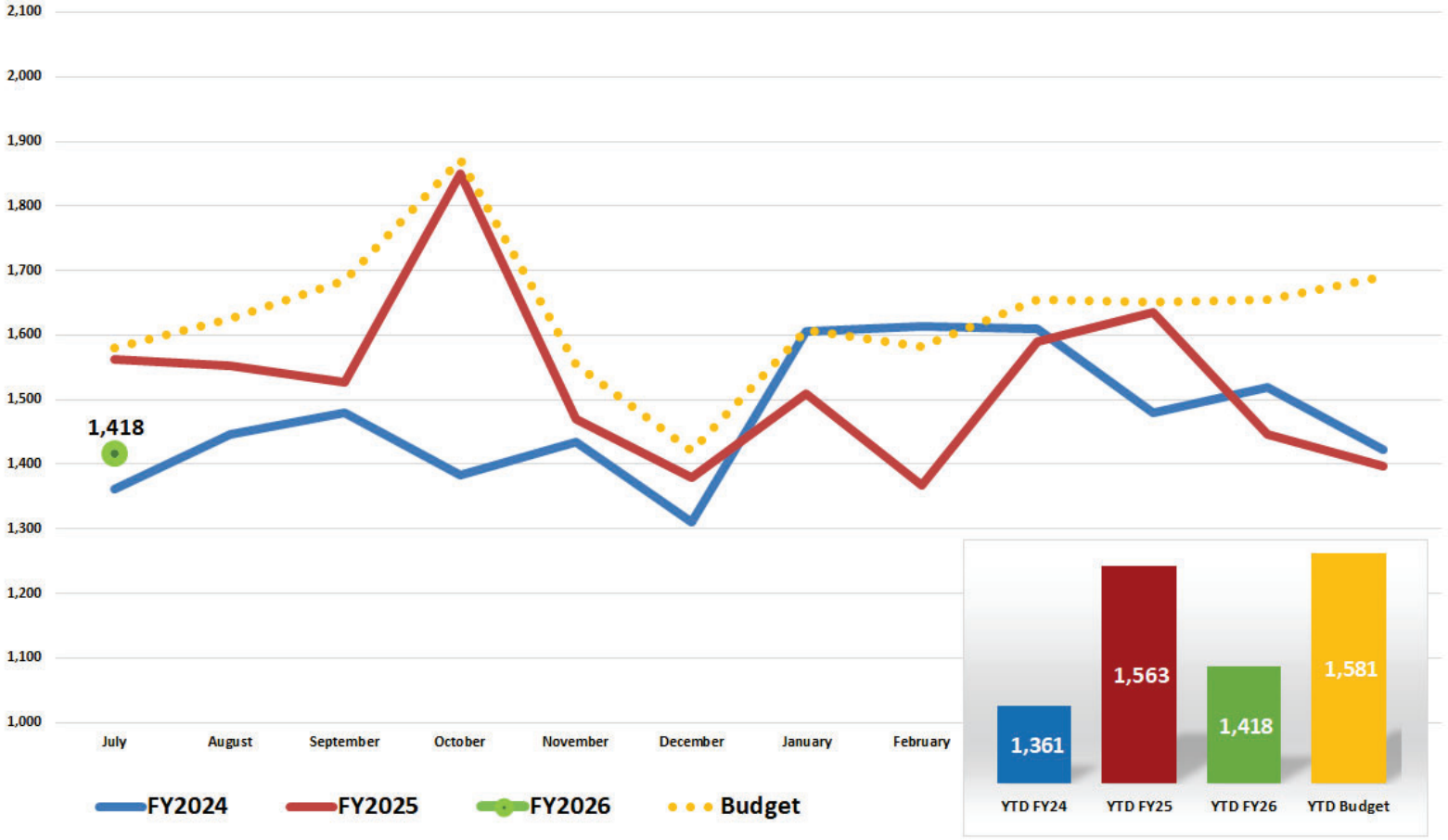


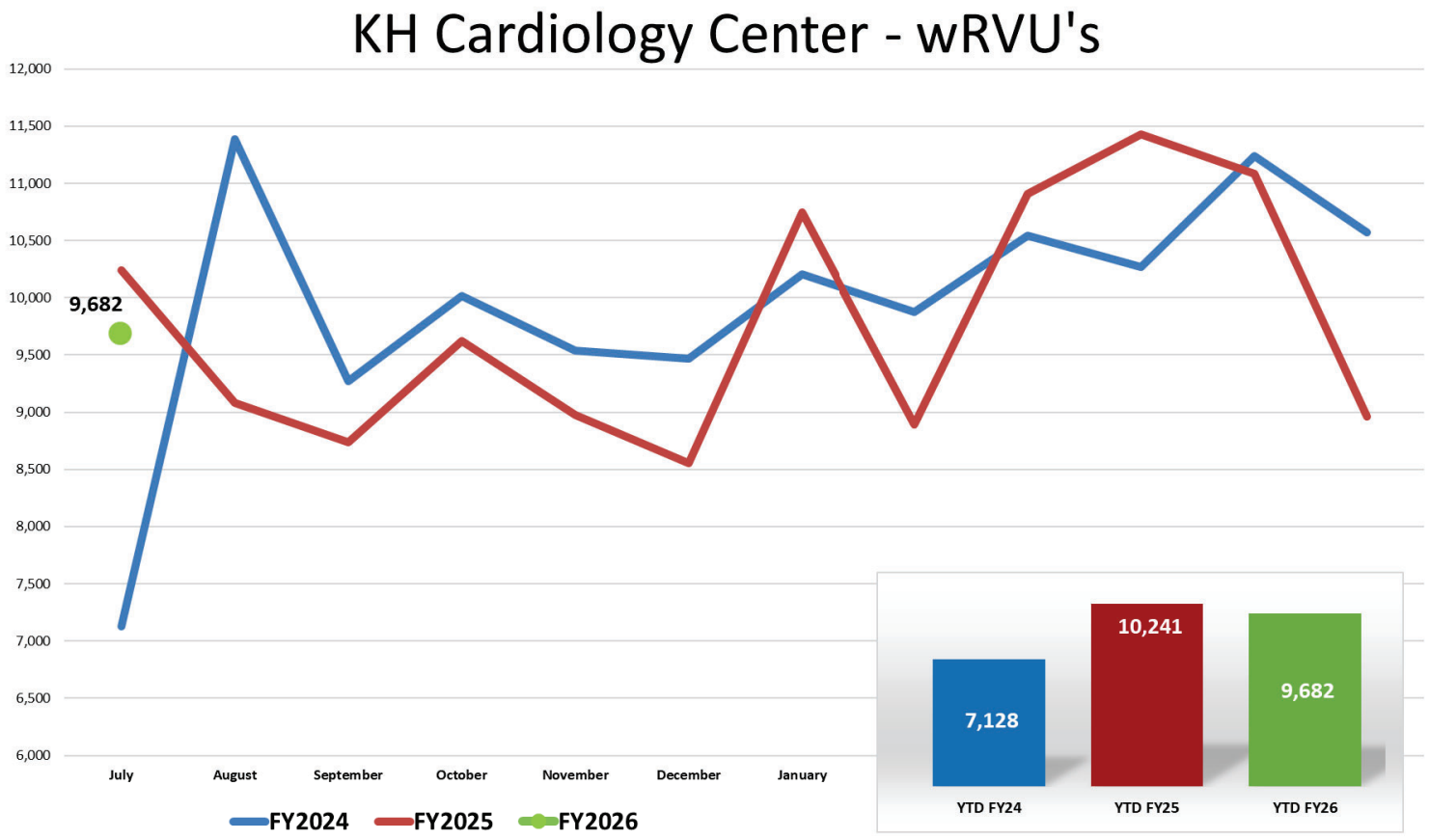
RHC Tulare - Registrations



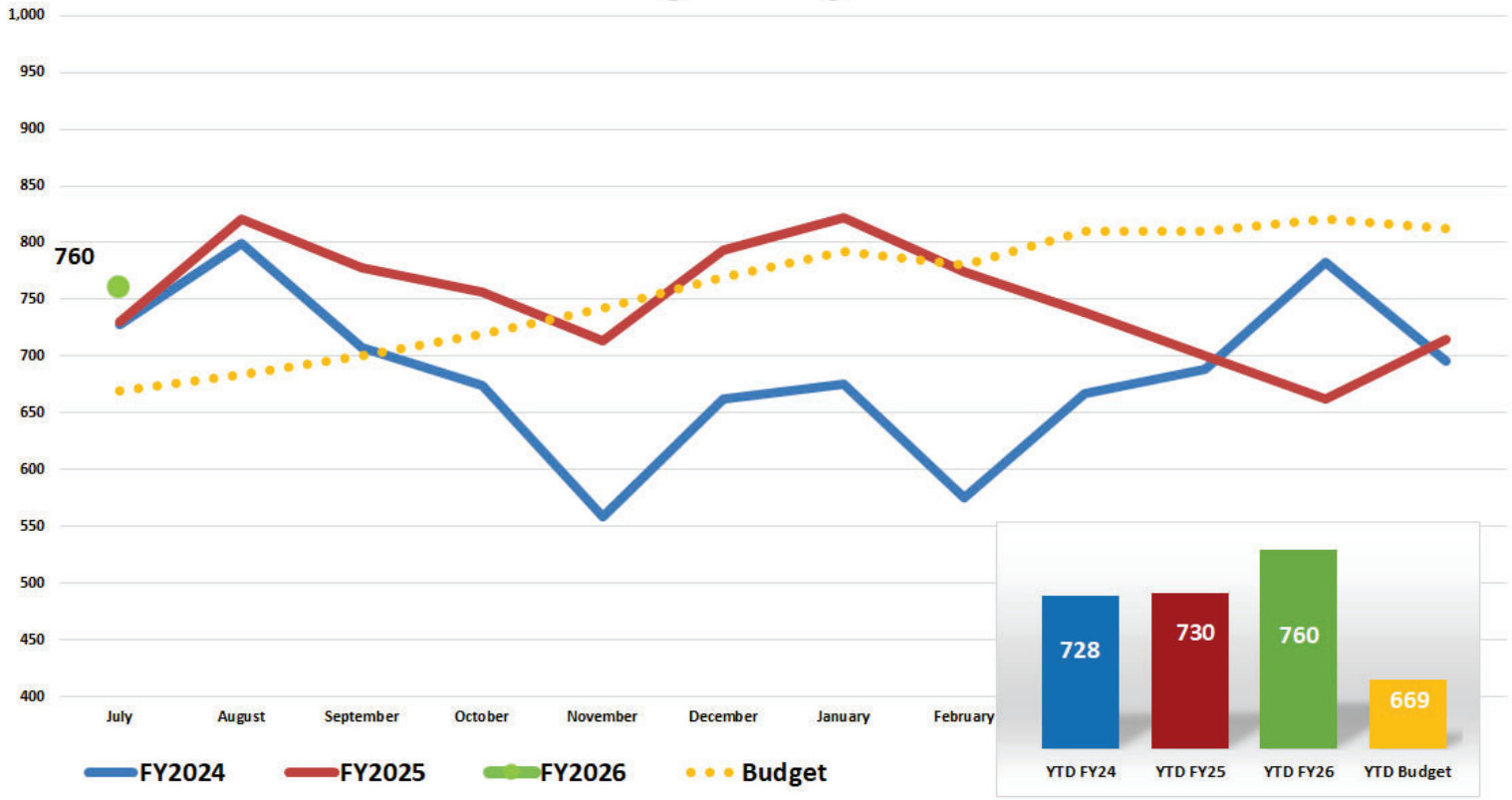

Neurosurgery Clinic - wRVU's
1,200
1,000
800
600
400
200
0
381
July
August
September
October
November
December
January
Februa
FY2024
FY2025
FY2026
849
705
381
YTD FY24
YTD FY25
YTD FY26

KH Cardiology Center Registrations

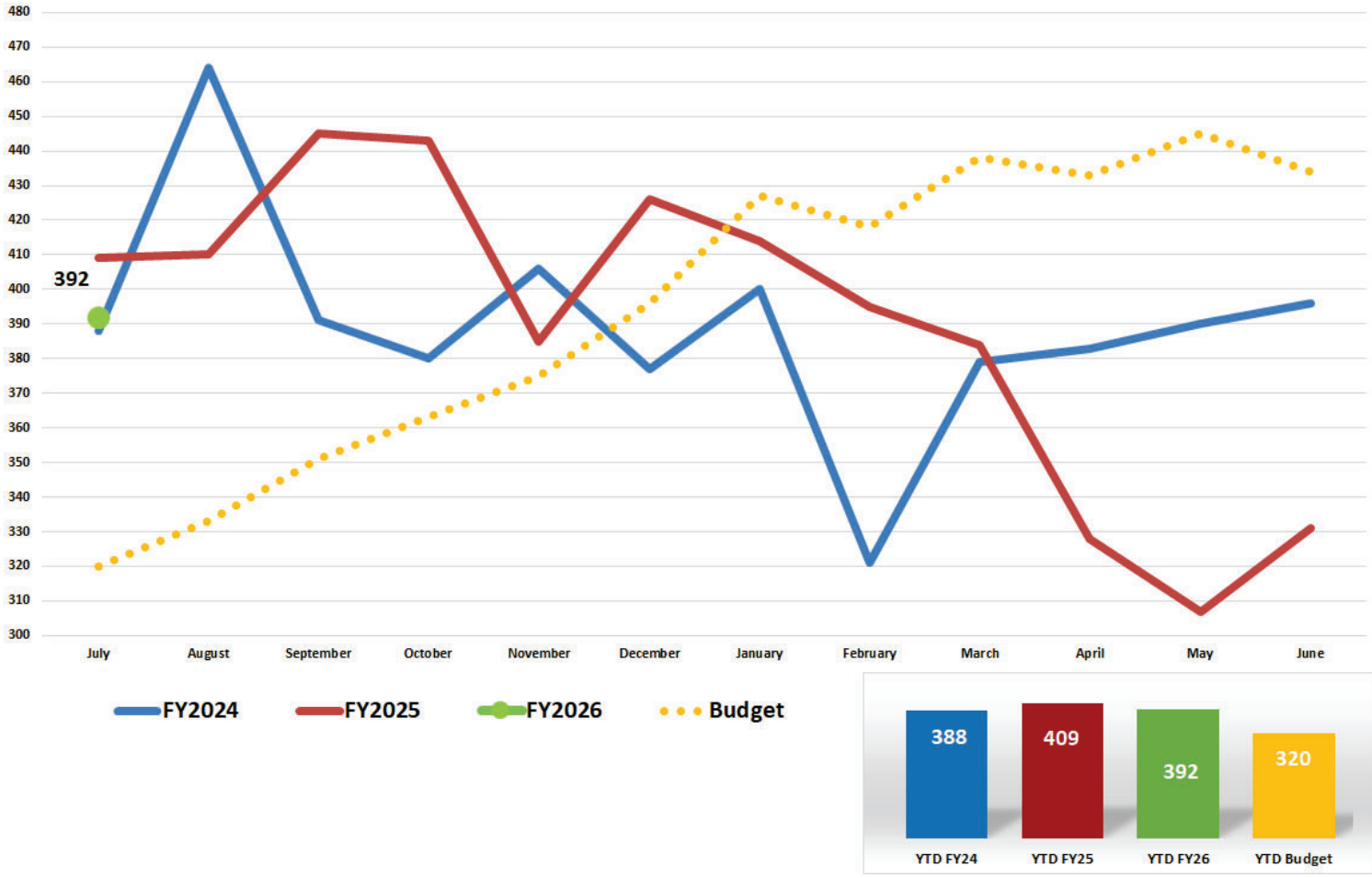



KH Cardiology Center - wRVU's
12,000
11,500
11,000
10,500
10,000
9,500
9,000
8,500
8,000
7,500
7,000
6,500
6,000
9,682
July
August
September
October
November
December
January
FY2024
FY2025
FY2026
10,241
7,128
9,682
YTD FY24
YTD FY25
YTD FY26

Labor Triage Registrations

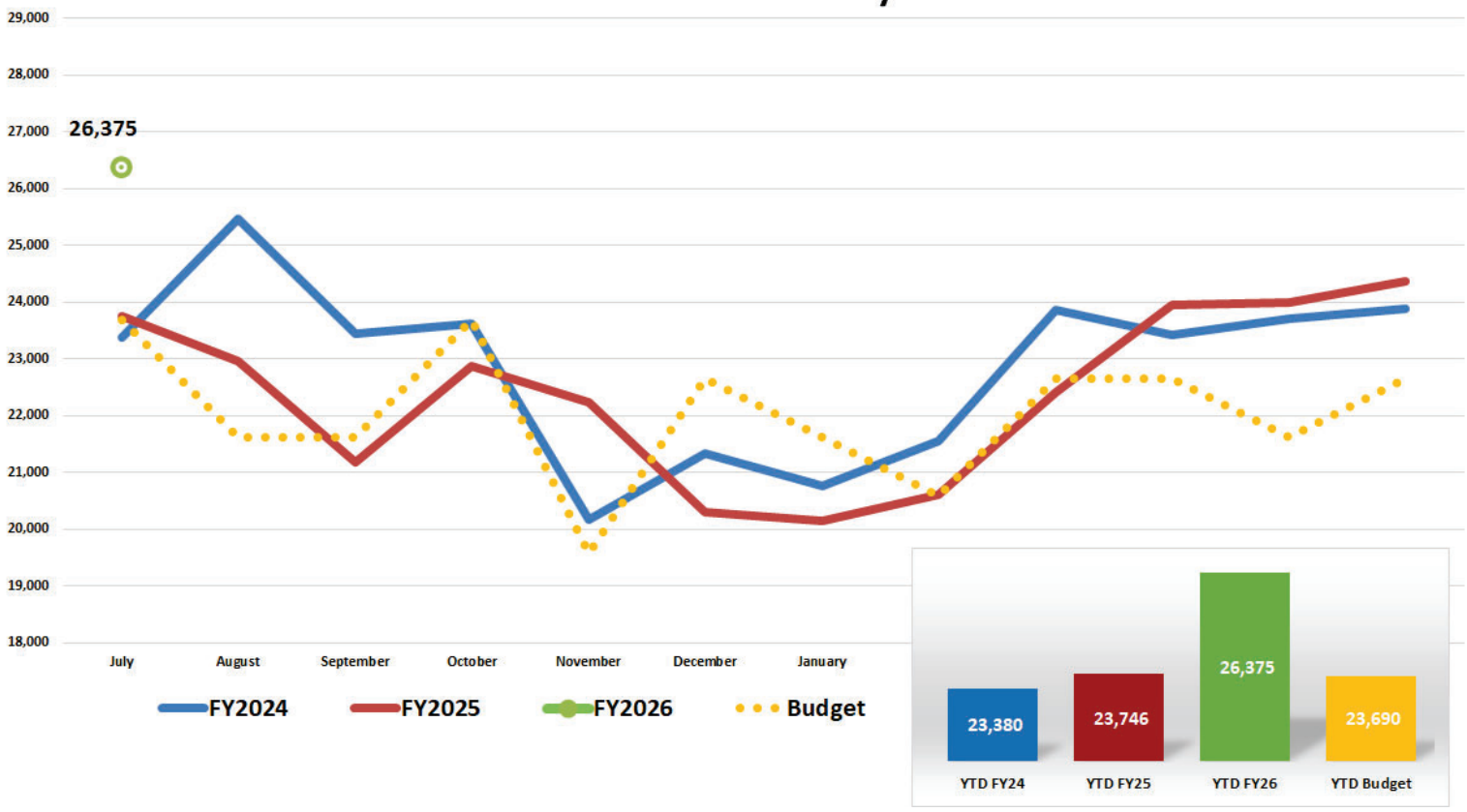


Deliveries

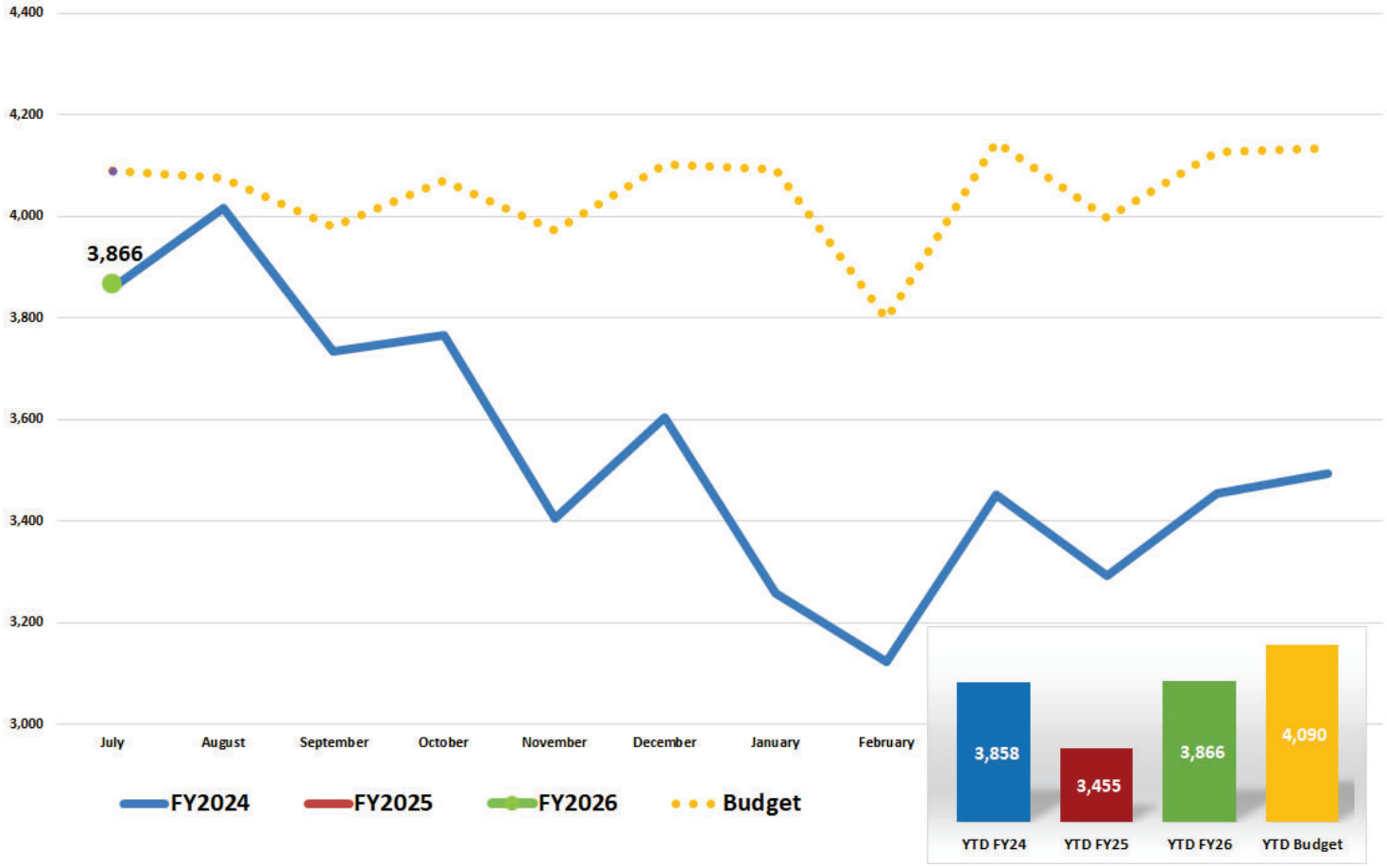

480
470
460
450
440
430
420
410
400
390
380
370
360
350
340
330
320
310
300
392
July
August
September
October
November
December
January
February
March
April
May
June
FY2024
FY2025
FY2026
Budget

388
409
392
320
YTD FY24
YTD FY25
YTD FY26
YTD Budget

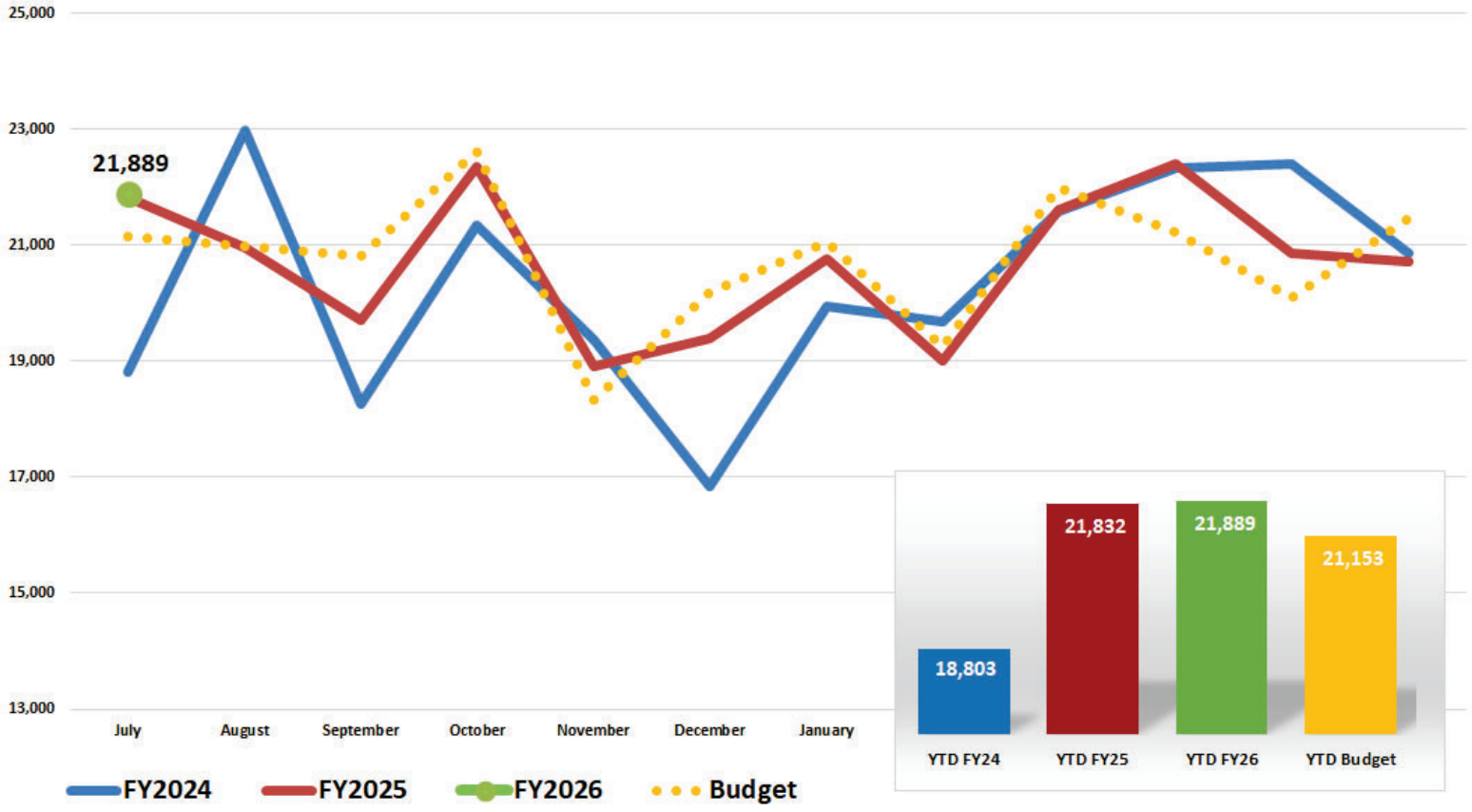
Home Infusion Days



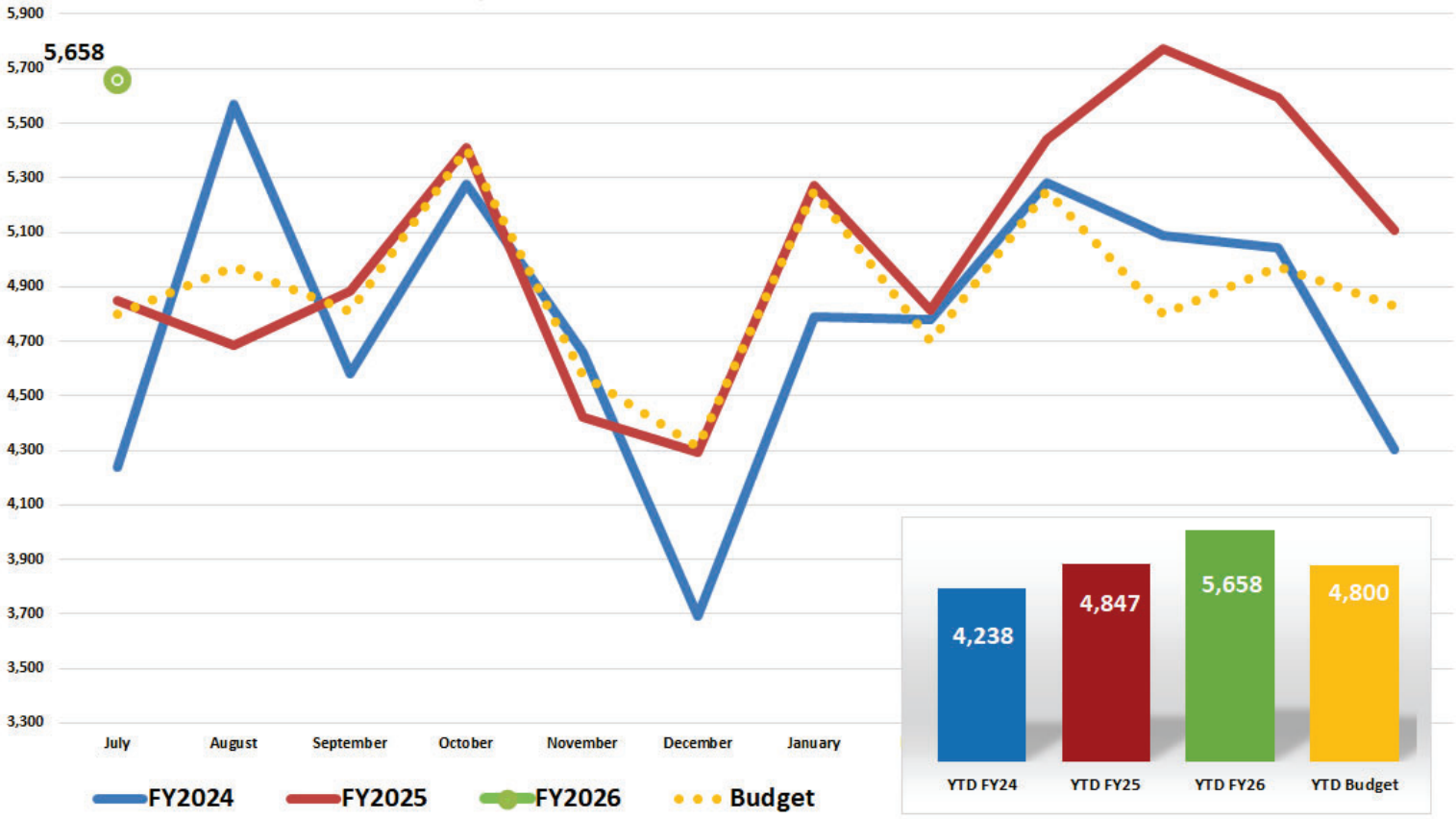
Hospice Days



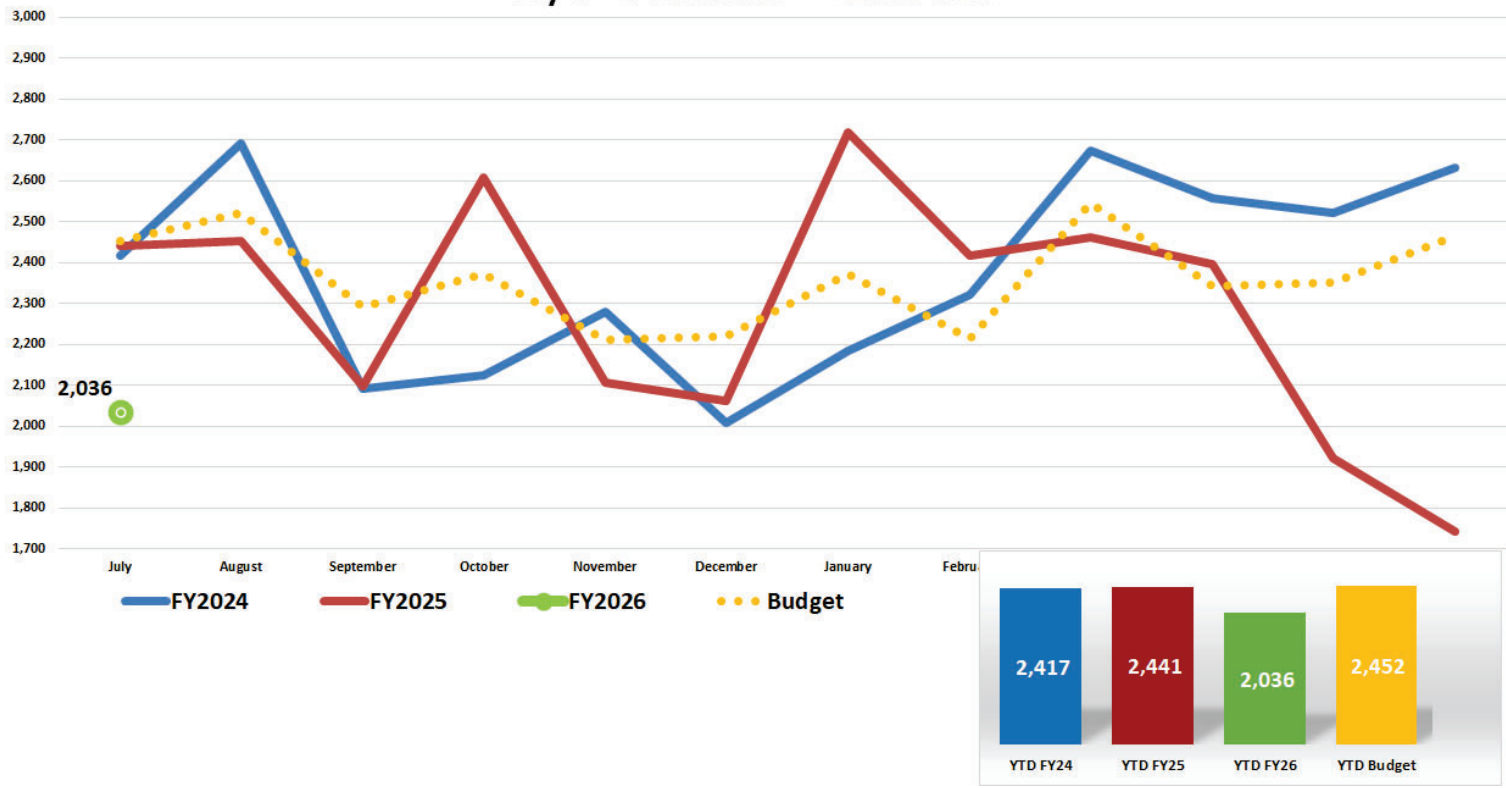
All O/P Rehab Svcs Across District



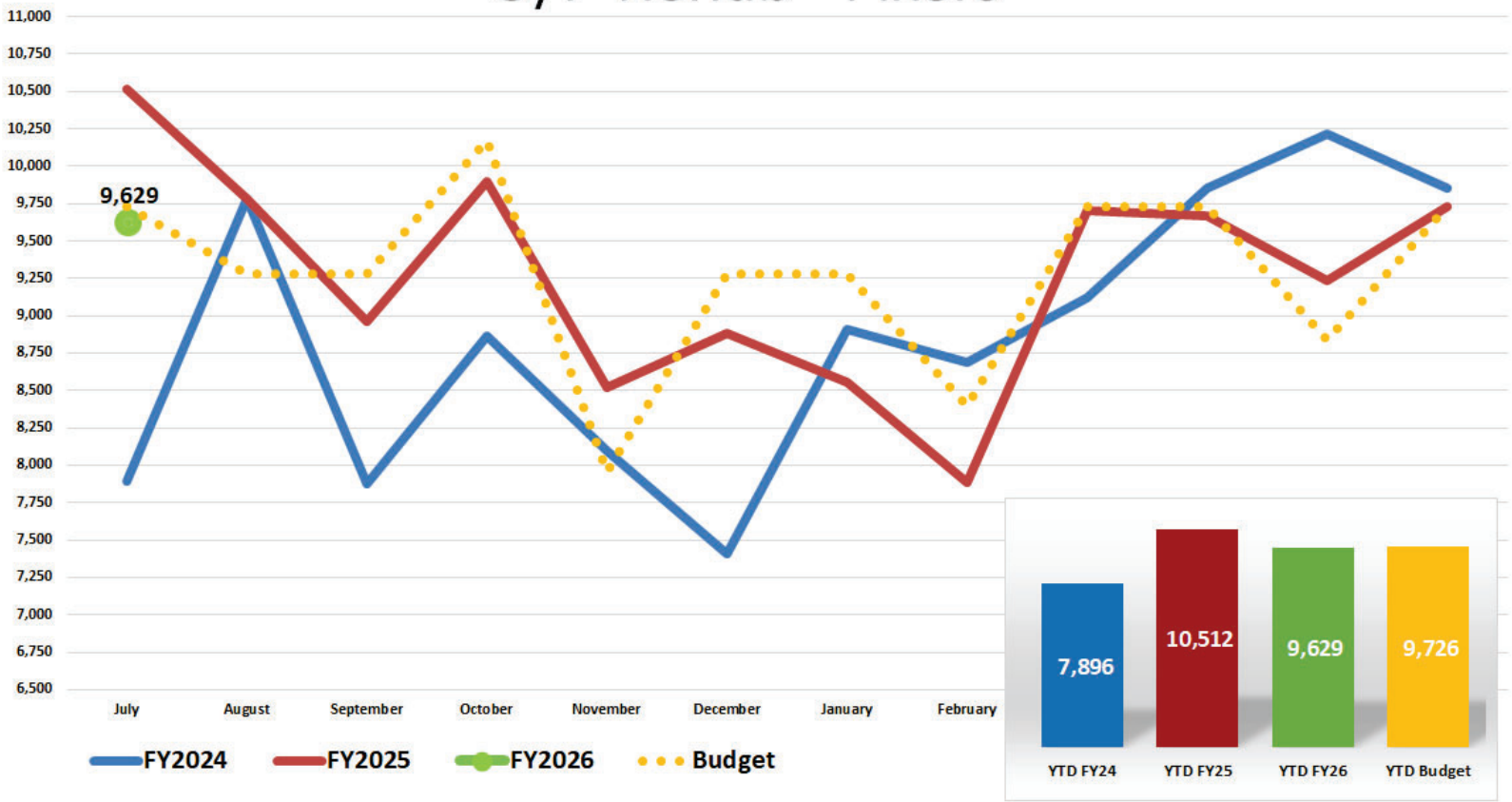
O/P Rehab Services

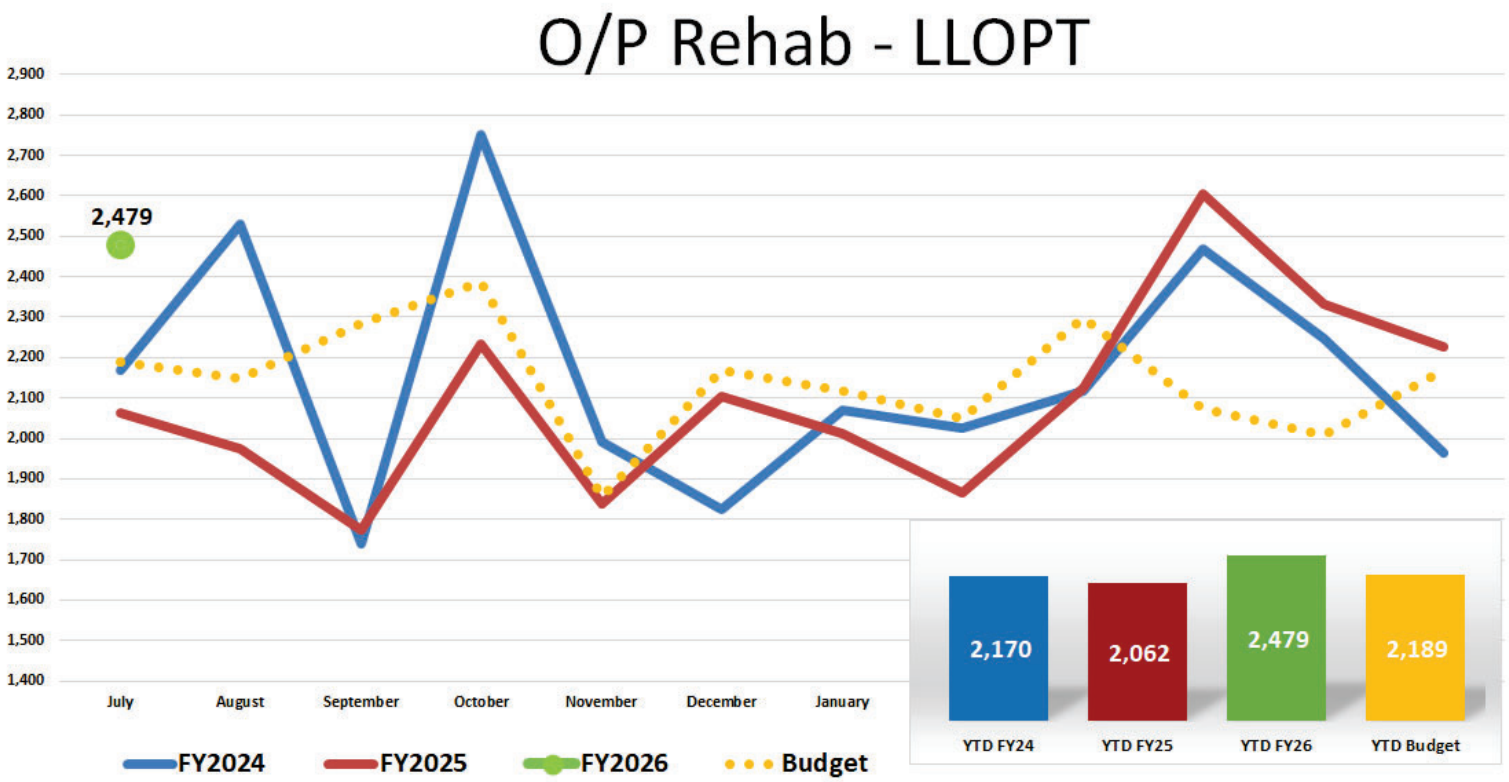


O/P Rehab - Exeter

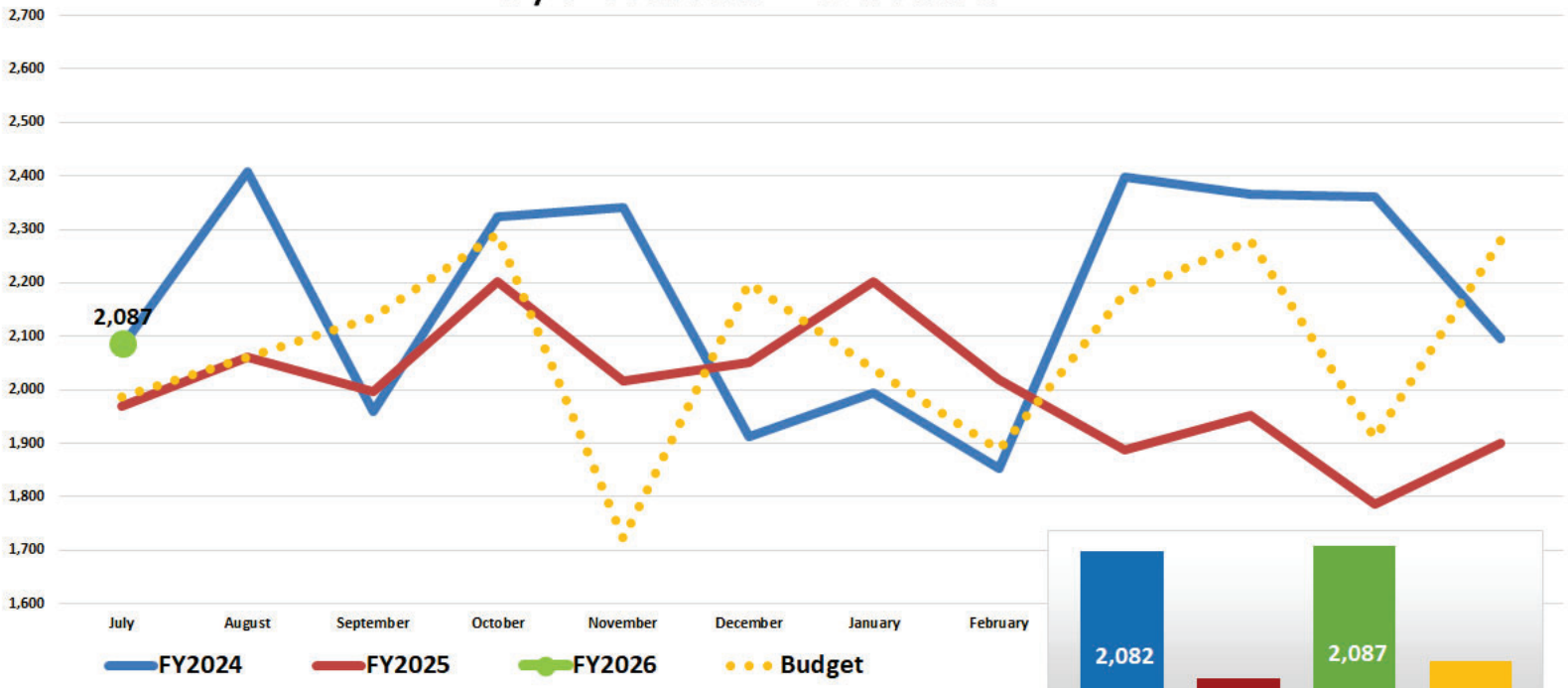


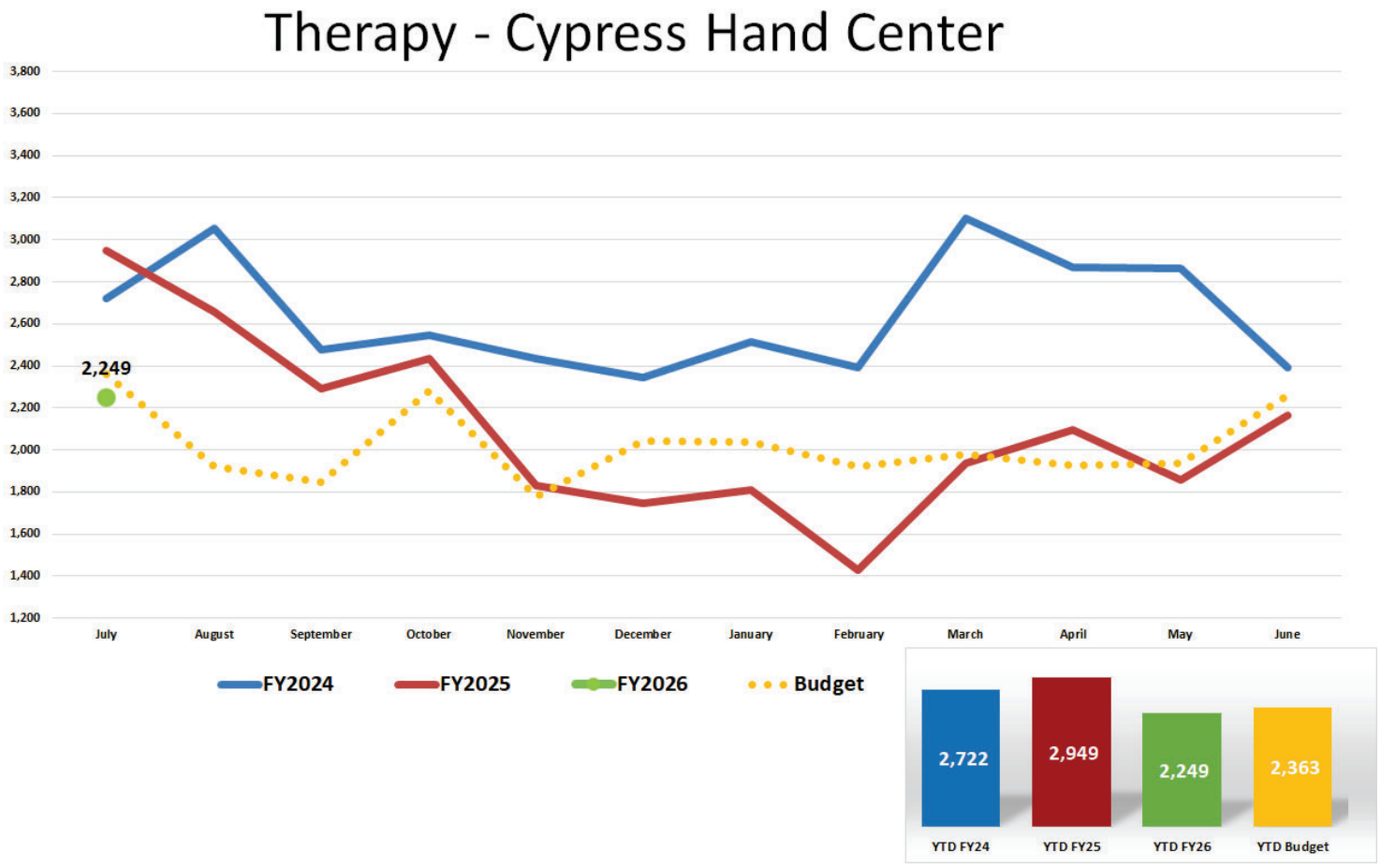
O/P Rehab - Akers



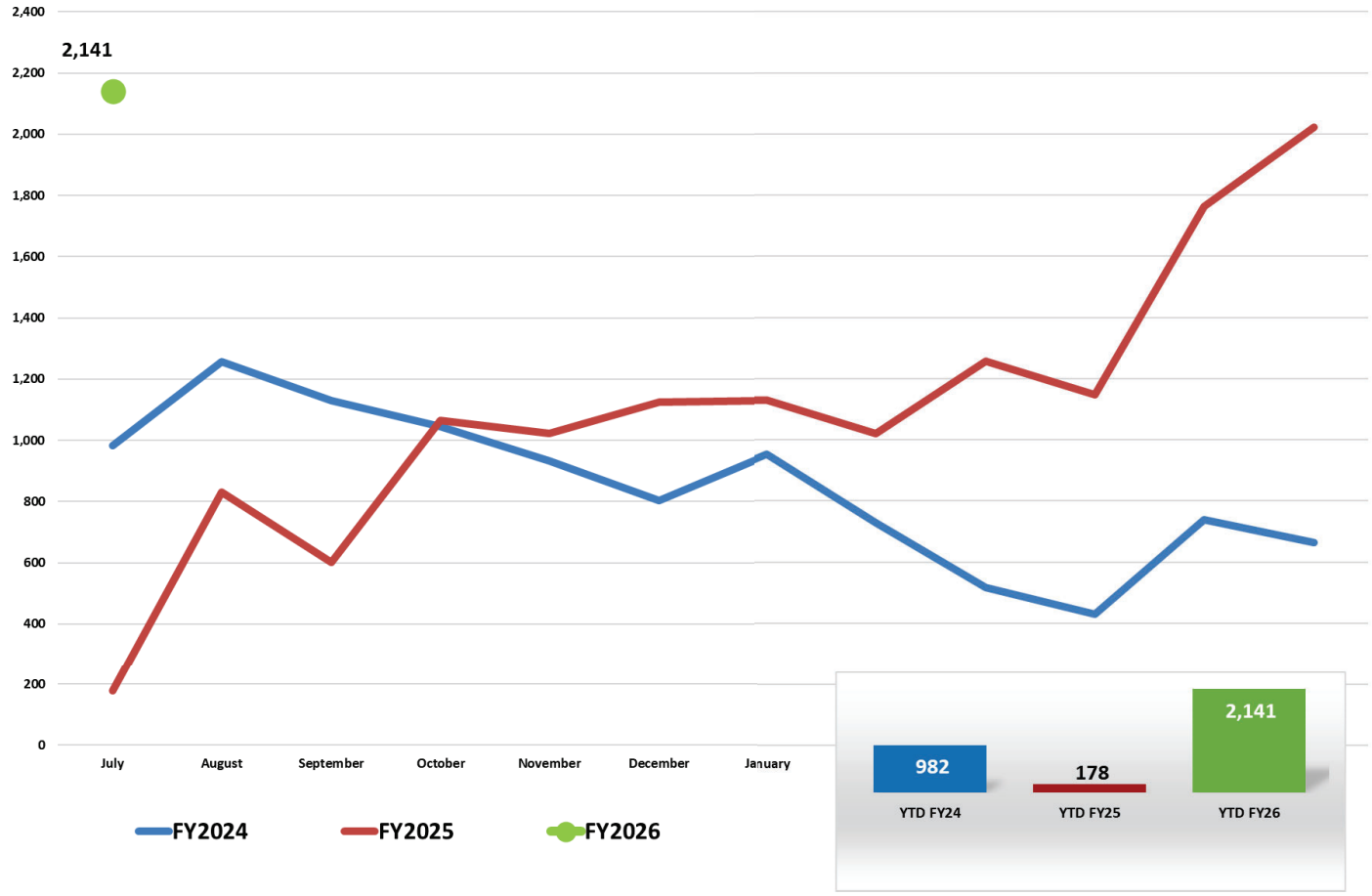

O/P Rehab - LLOPT
2,900
2,800
2,700
2,600
2,500
2,400
2,300
2,200
2,100
2,000
1,900
1,800
1,700
1,600
1,500
1,400
2,479
July
August
September
October
November
December
January
FY2024
FY2025
FY2026
Budget
2,170
2,062
2,479
2,189
YTD FY24
YTD FY25
YTD FY26
YTD Budget

O/P Rehab - Dinuba

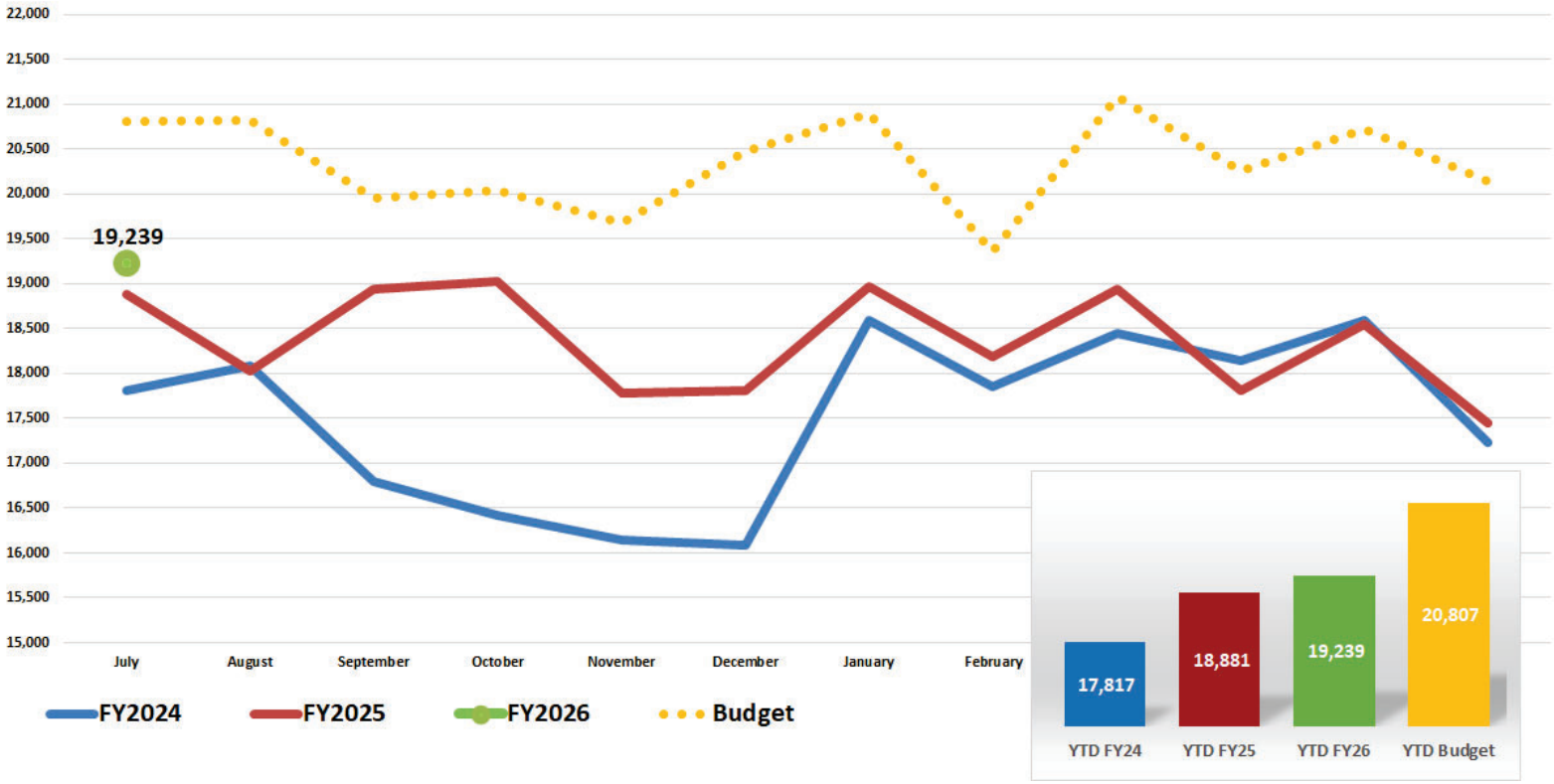


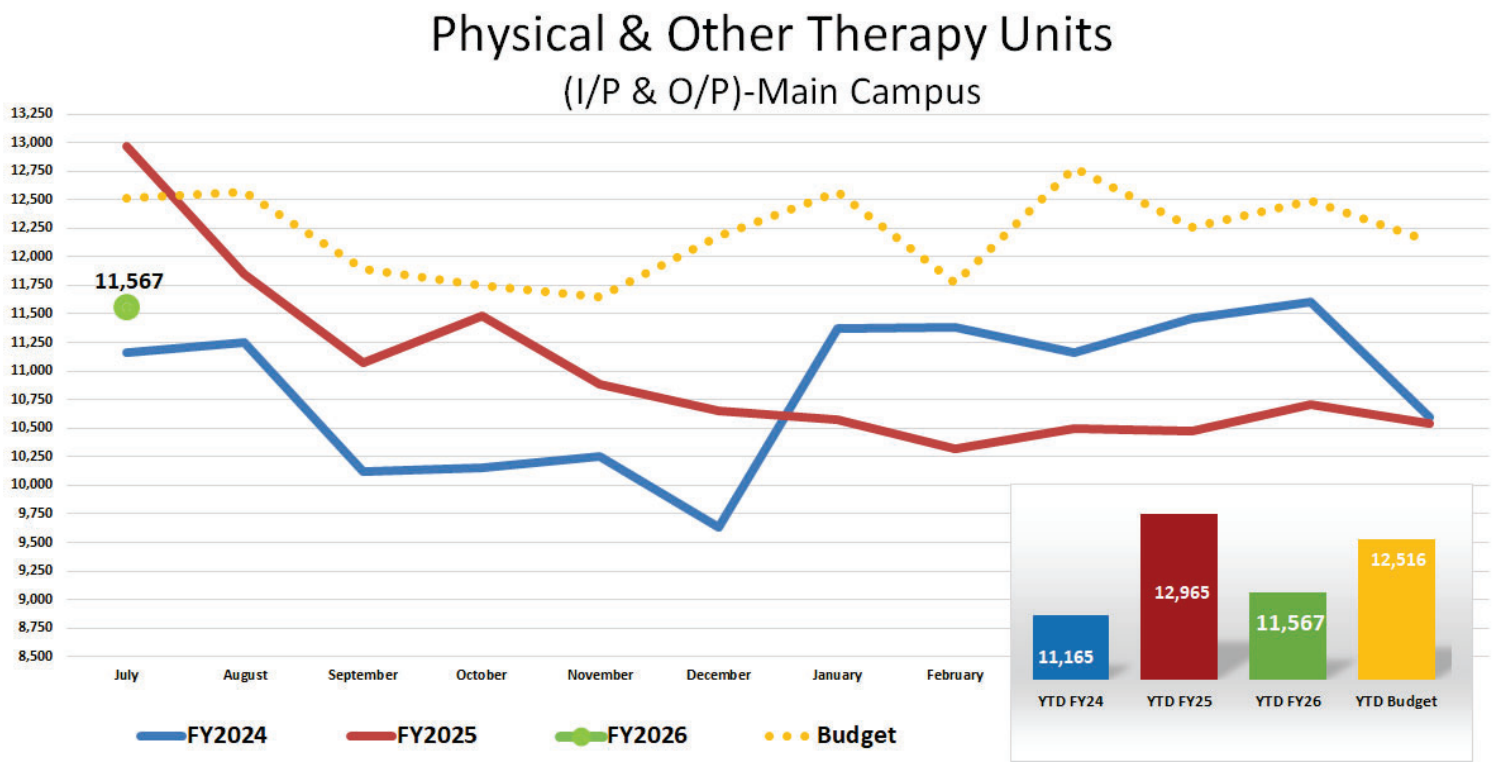

Therapy - Cypress Hand Center
3,800
3,600
3,400
3,200
3,000
2,800
2,600
2,400
2,200
2,000
1,800
1,600
1,400
1,200
2,249
July
August
September
October
November
December
January
February
March
April
May
June
FY2024
FY2025
FY2026
Budget
2,722
2,949
2,249
2,363
YTD FY24
YTD FY25
YTD FY26
YTD Budget

Therapy-Wound Care Visits

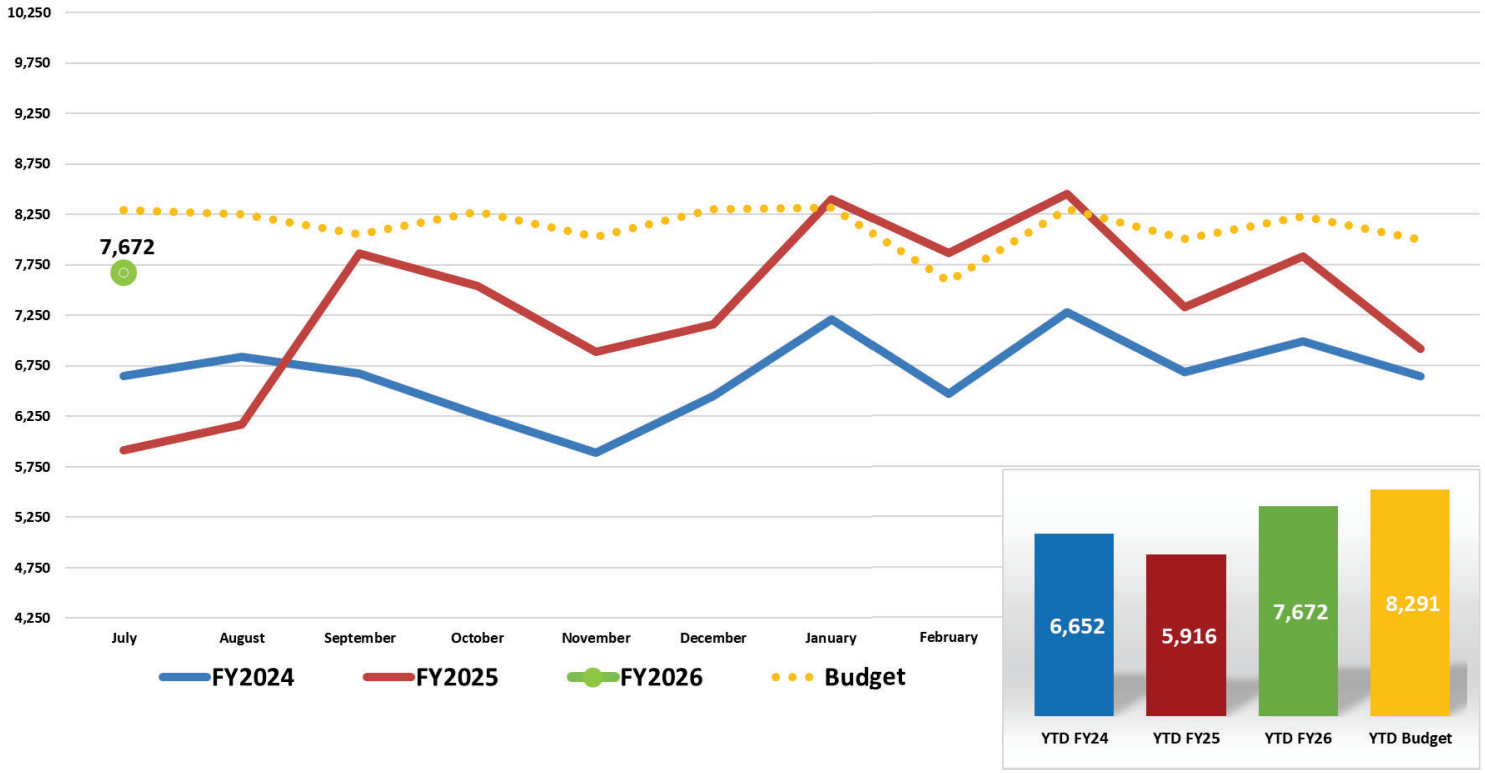


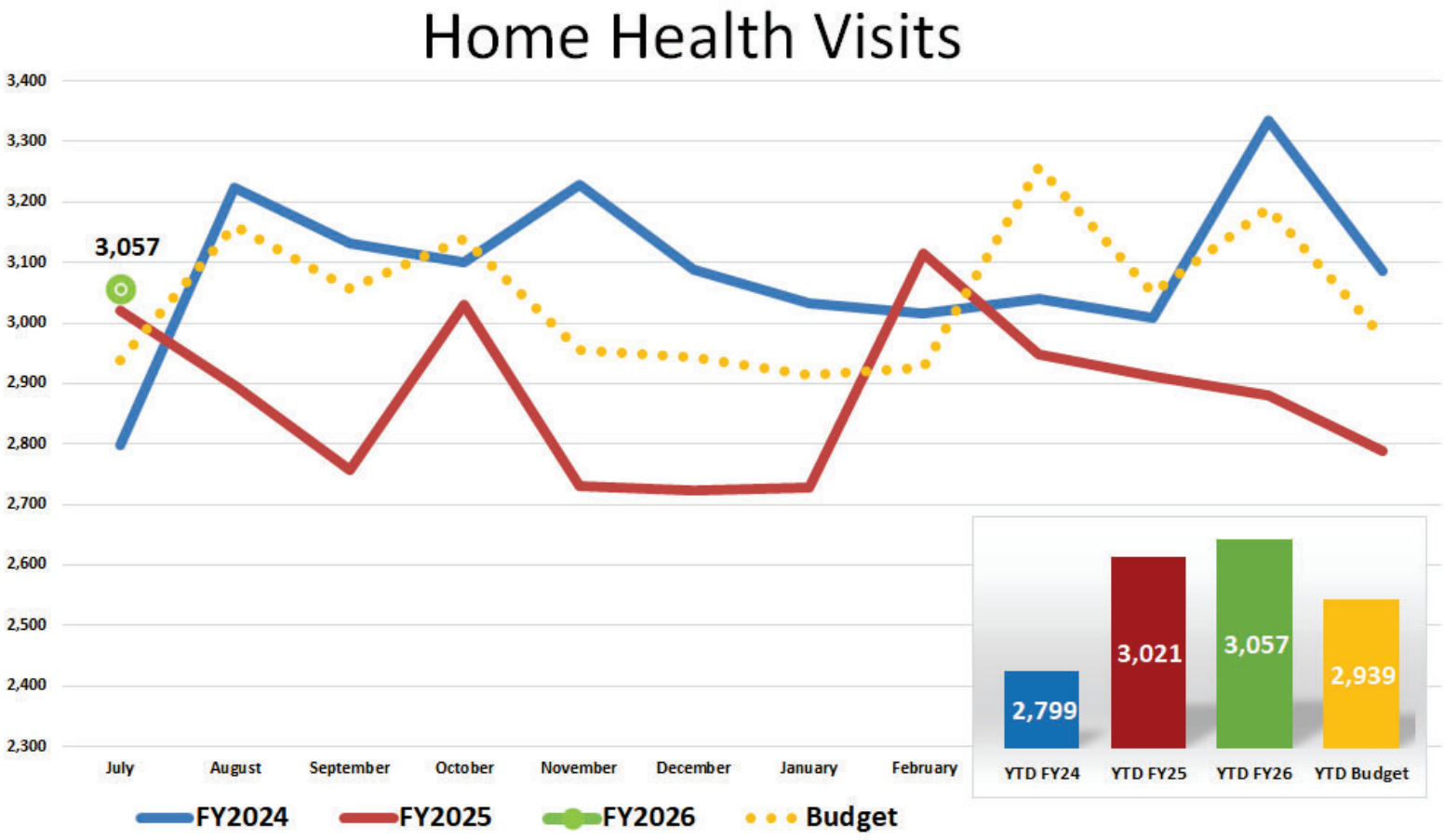
Physical & Other Therapy Units (I/P & O/P)

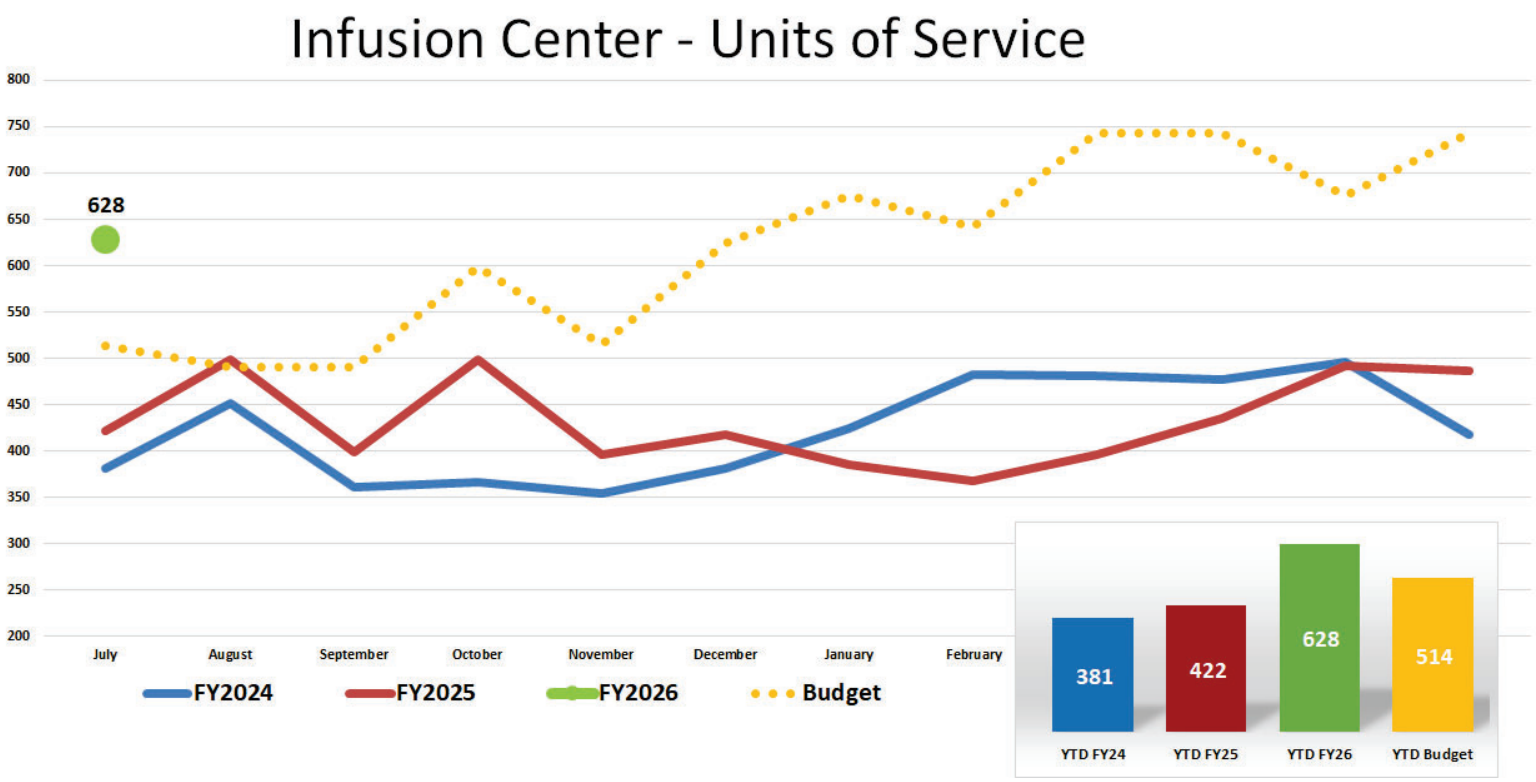



Physical & Other Therapy Units
(I/P & O/P)-Main Campus
13,250
13,000
12,750
12,500
12,250
12,000
11,750
11,500
11,250
11,000
10,750
10,500
10,250
10,000
9,750
9,500
9,250
9,000
8,750
8,500
11,567
July
August
September
October
November
December
January
February
FY2024
FY2025
FY2026
Budget
11,165
12,965
11,567
12,516
YTD FY24
YTD FY25
YTD FY26
YTD Budget

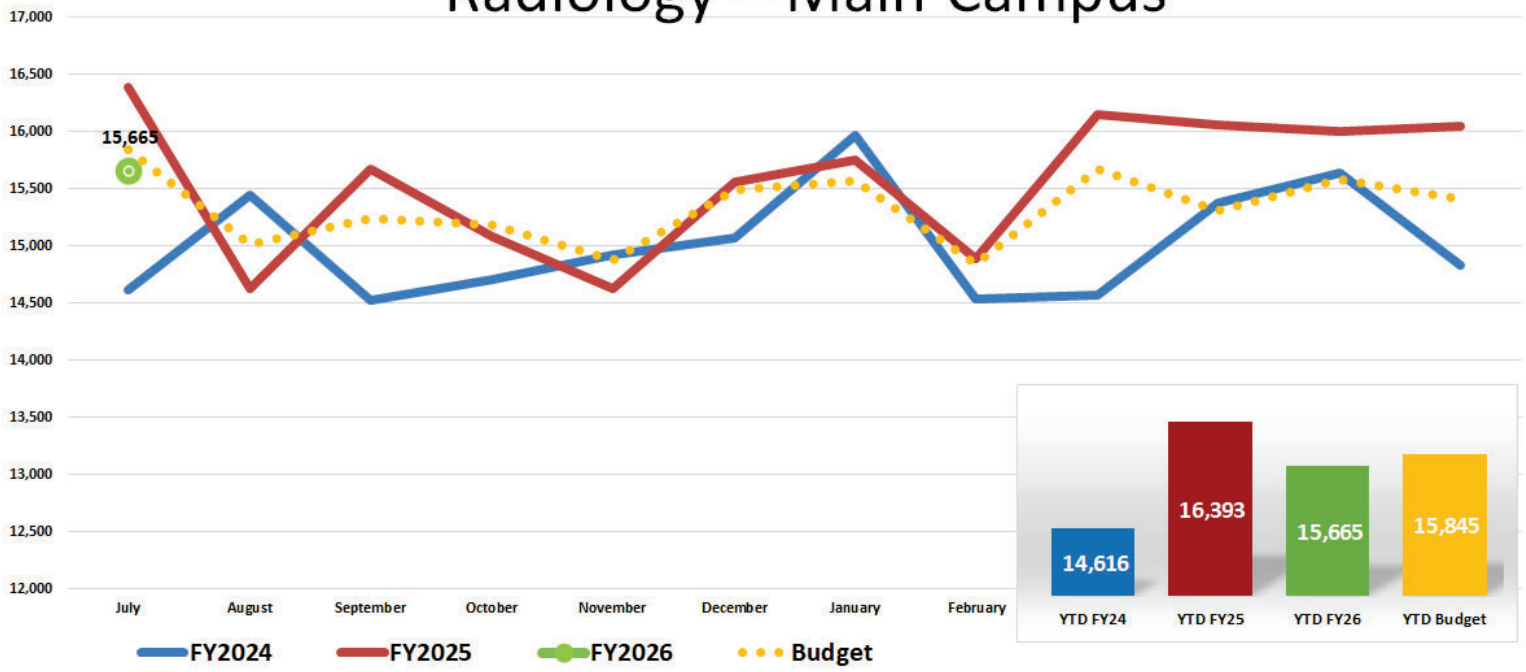
Physical & Other Therapy Units (I/P & O/P)-KDRH & South Campus



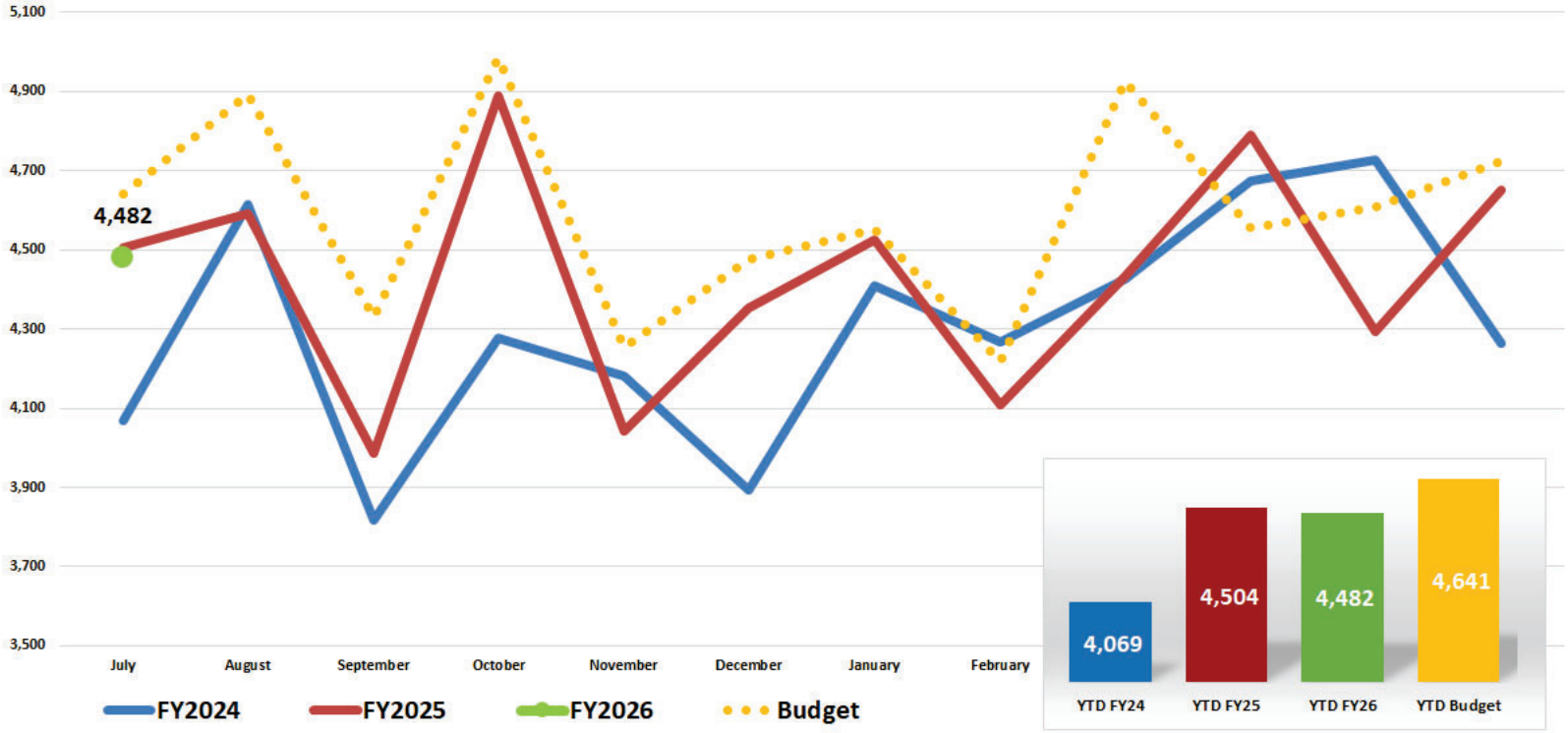

Home Health Visits
3,400
3,300
3,200
3,100
3,000
2,900
2,800
2,700
2,600
2,500
2,400
2,300
3,057
July
August
September
October
November
December
January
February
FY2024
FY2025
FY2026
Budget
2,799
3,021
3,057
2,939
YTD FY24
YTD FY25
YTD FY26
YTD Budget

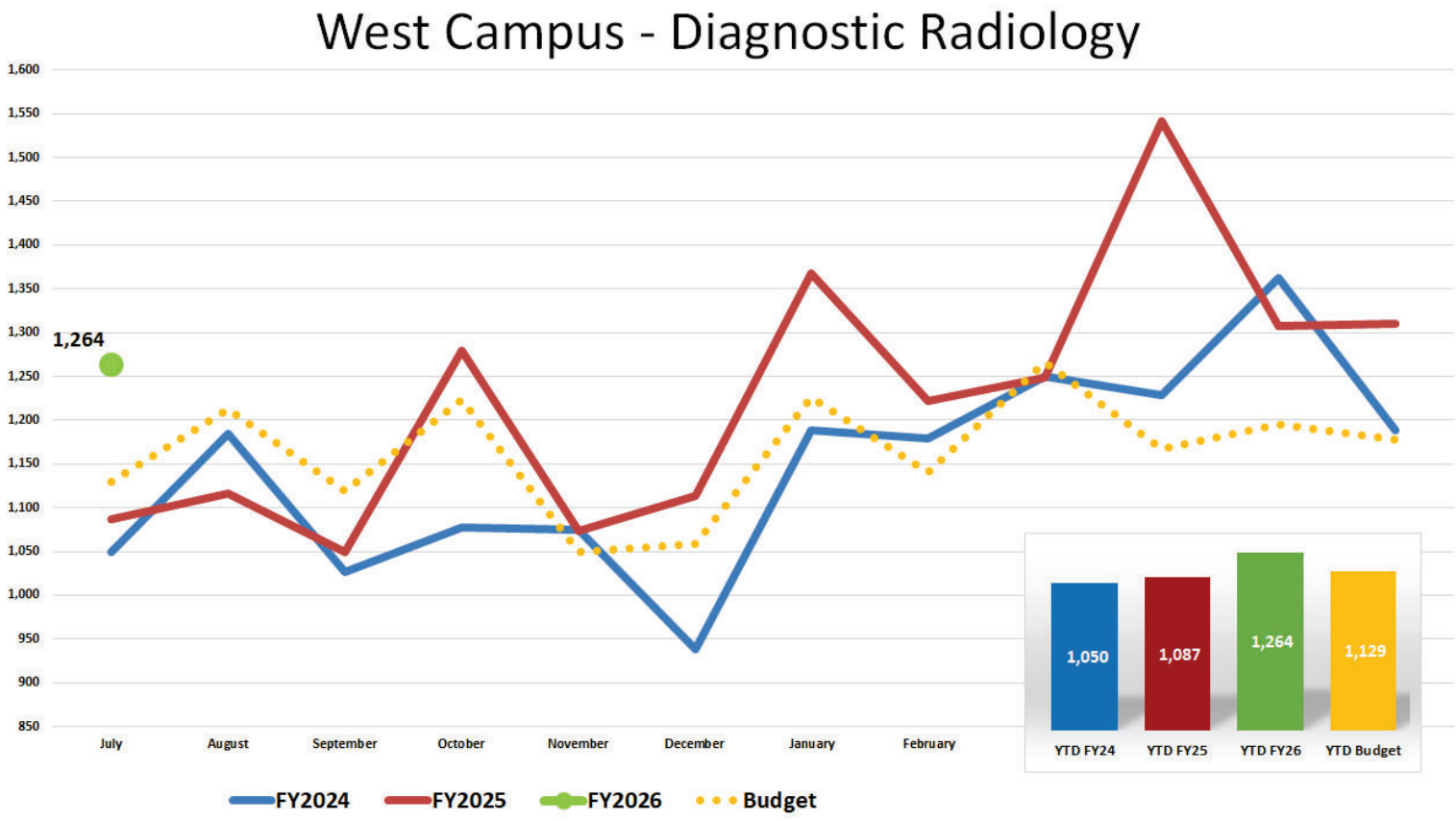

Infusion Center - Units of Service
800
750
700
650
600
550
500
450
400
350
300
250
200
628
July
August
September
October
November
December
January
February
FY2024
FY2025
FY2026
Budget
381
422
628
514
YTD FY24
YTD FY25
YTD FY26
YTD Budget

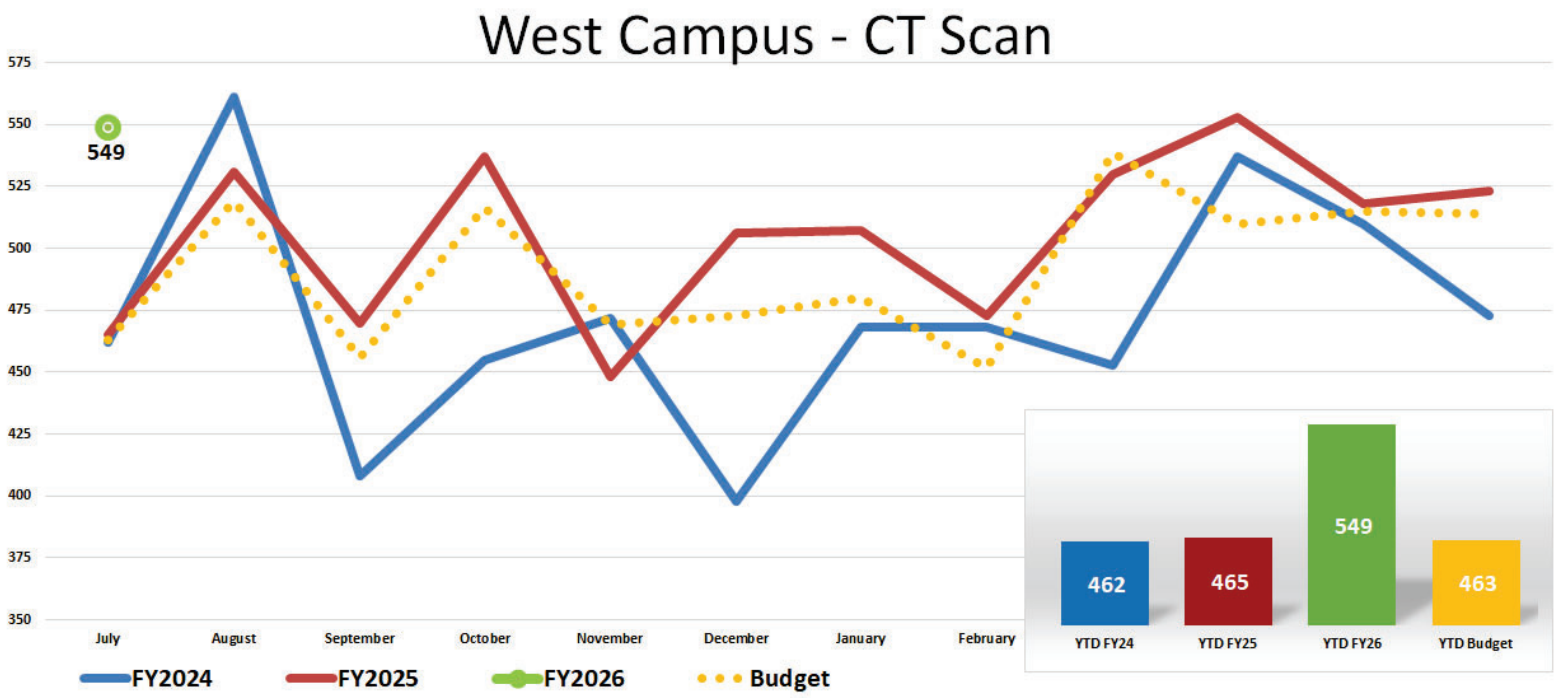
Radiology – Main Campus

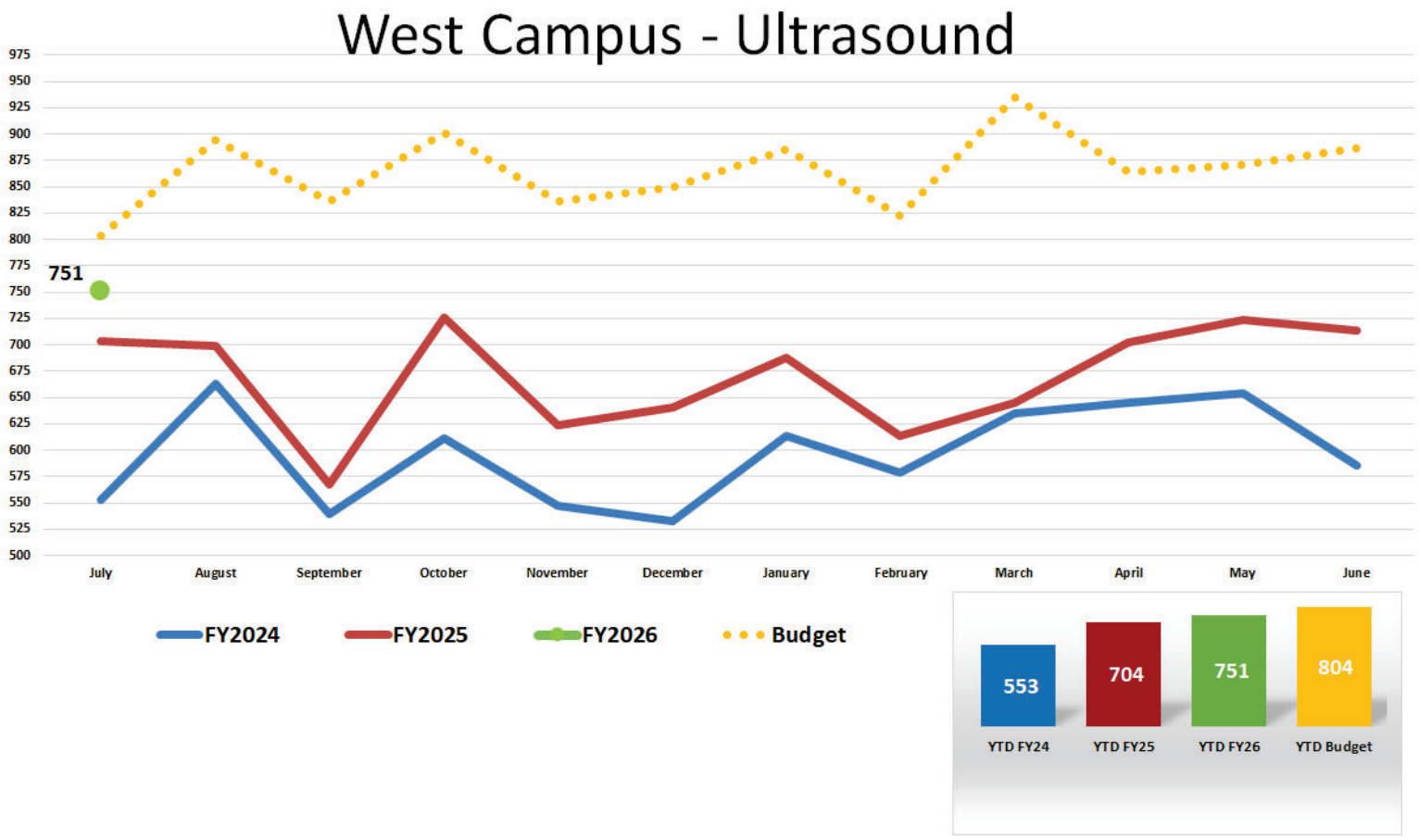


Radiology - West Campus Imaging

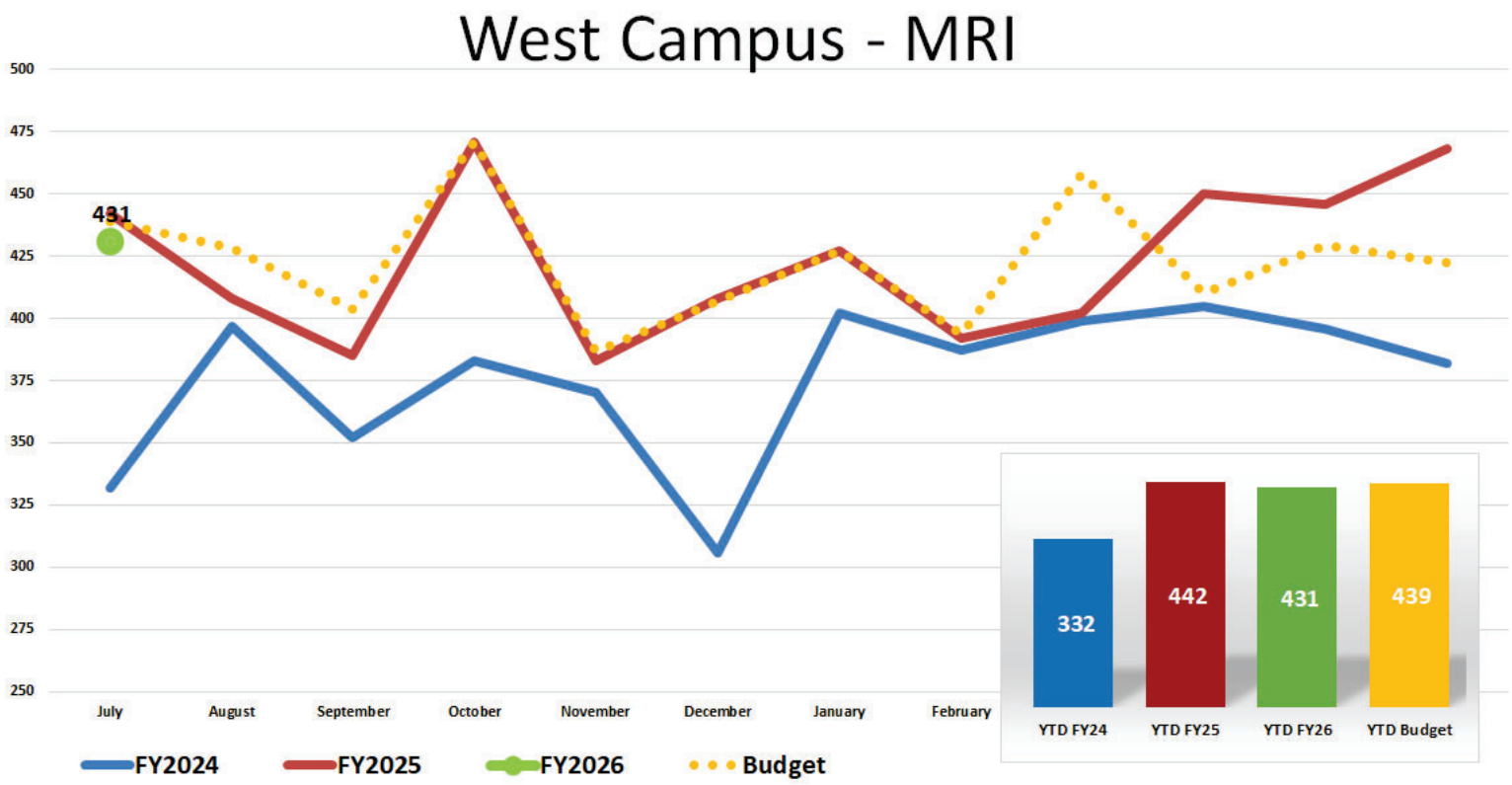


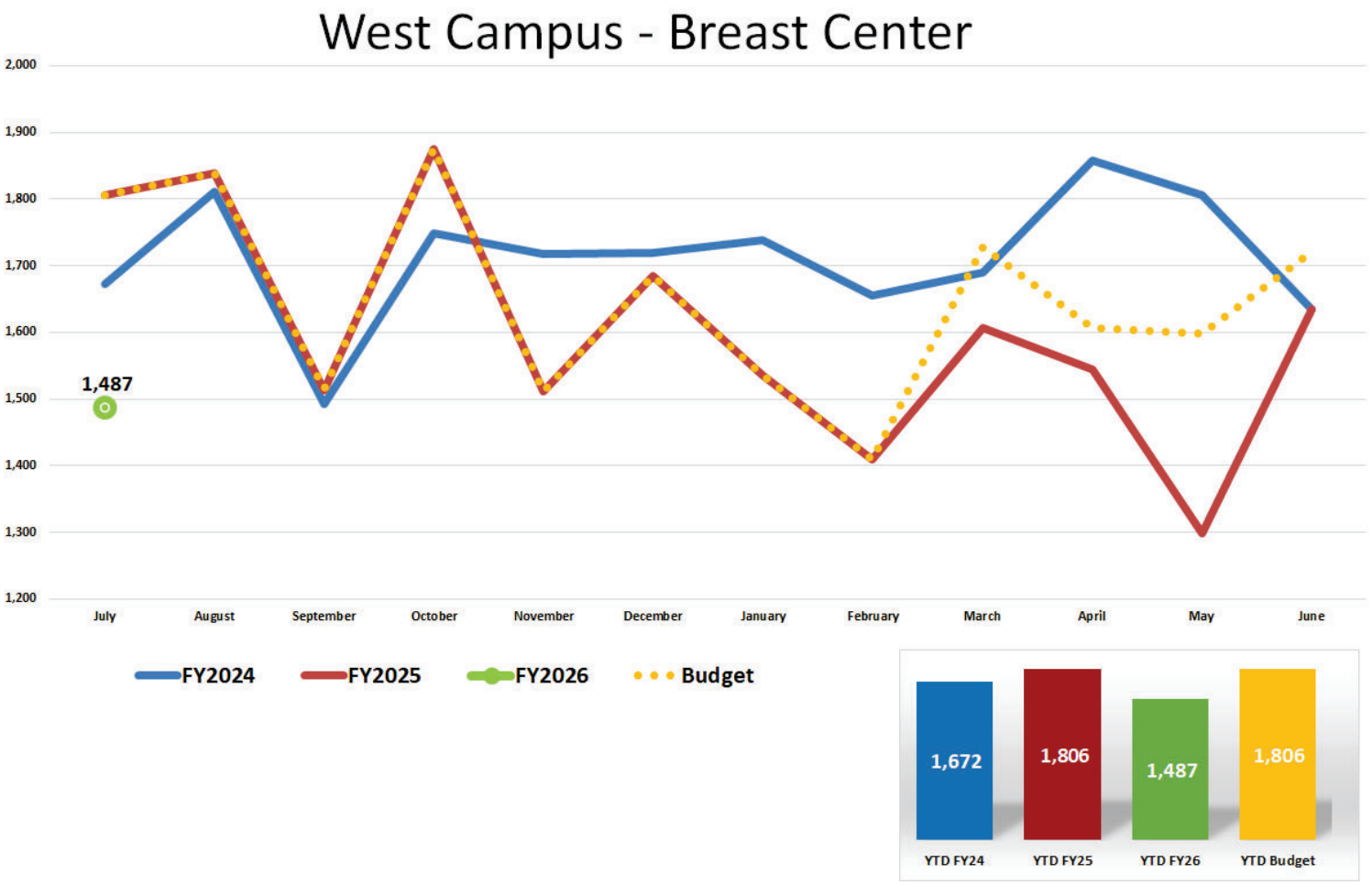

West Campus - Diagnostic Radiology
1,600
1,550
1,500
1,450
1,400
1,350
1,300
1,250
1,200
1,150
1,100
1,050
1,000
950
900
850
1,264
July
August
September
October
November
December
January
February
1,050
1,087
1,264
1,129
YTD FY24
YTD FY25
YTD FY26
YTD Budget
FY2024
FY2025
FY2026
Budget

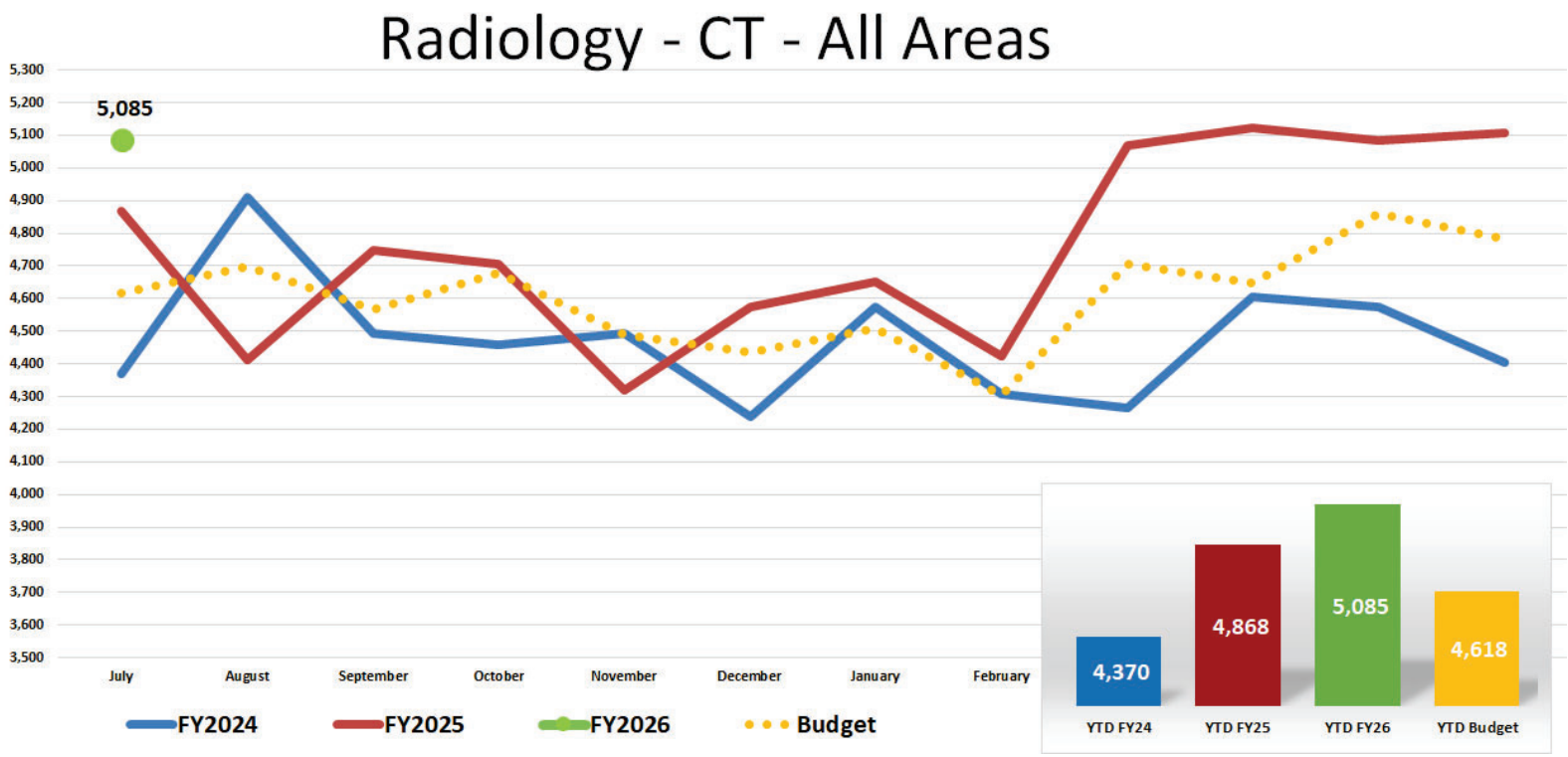

West Campus - CT Scan
575
550
525
500
475
450
425
400
375
350
549
July
August
September
October
November
December
January
February
FY2024
FY2025
FY2026
Budget
462
465
549
463
YTD FY24
YTD FY25
YTD FY26
YTD Budget


West Campus - Ultrasound
975
950
925
900
875
850
825
800
775
750
725
700
675
650
625
600
575
550
525
500
751
July
August
September
October
November
December
January
February
March
April
May
June
FY2024
FY2025
FY2026
Budget

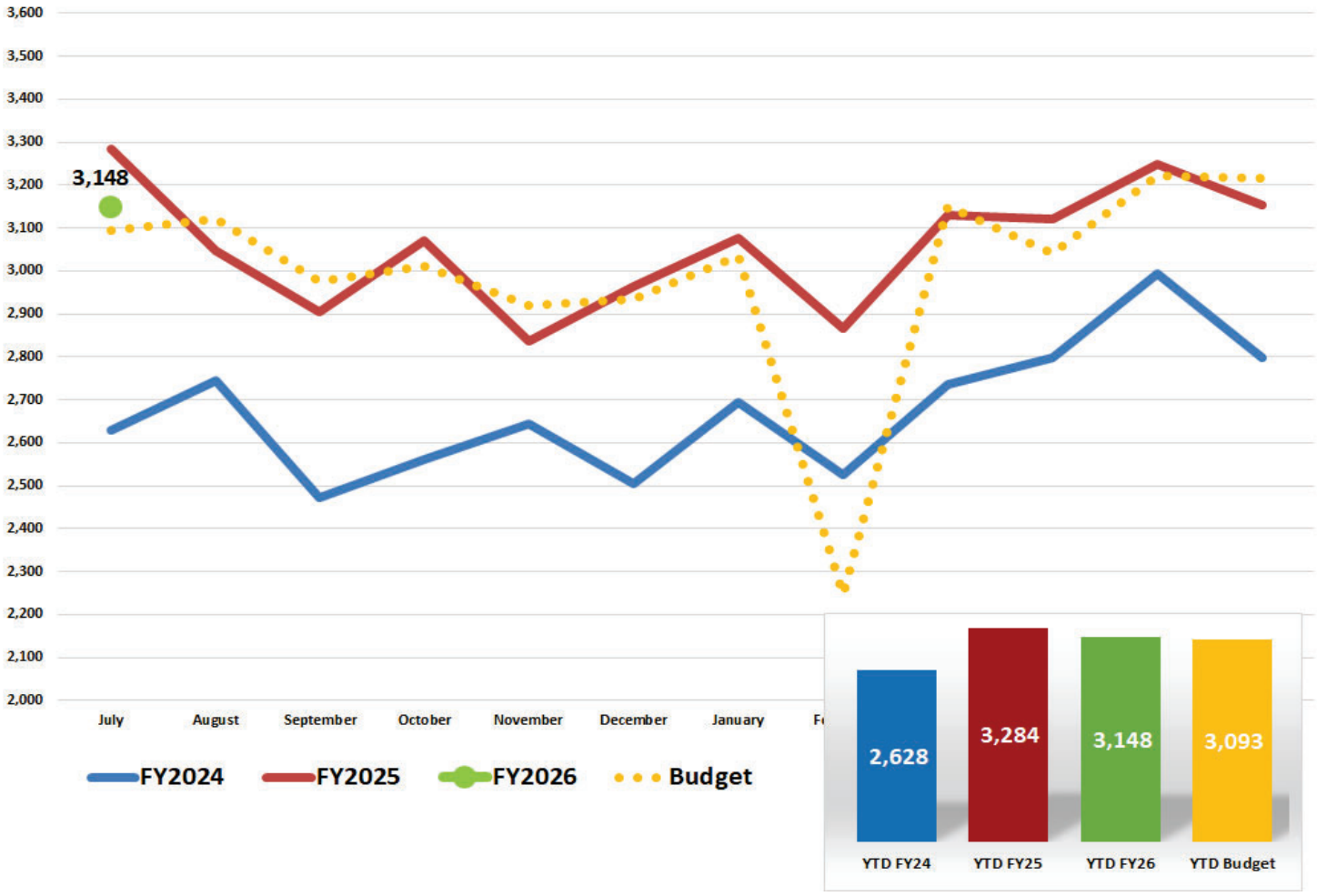
553
704
751
804
YTD FY24
YTD FY25
YTD FY26
YTD Budget


West Campus - MRI
500
475
450
425
400
375
350
325
300
275
250
431
July
August
September
October
November
December
January
February
FY2024
FY2025
FY2026
Budget
332
442
431
439
YTD FY24
YTD FY25
YTD FY26
YTD Budget

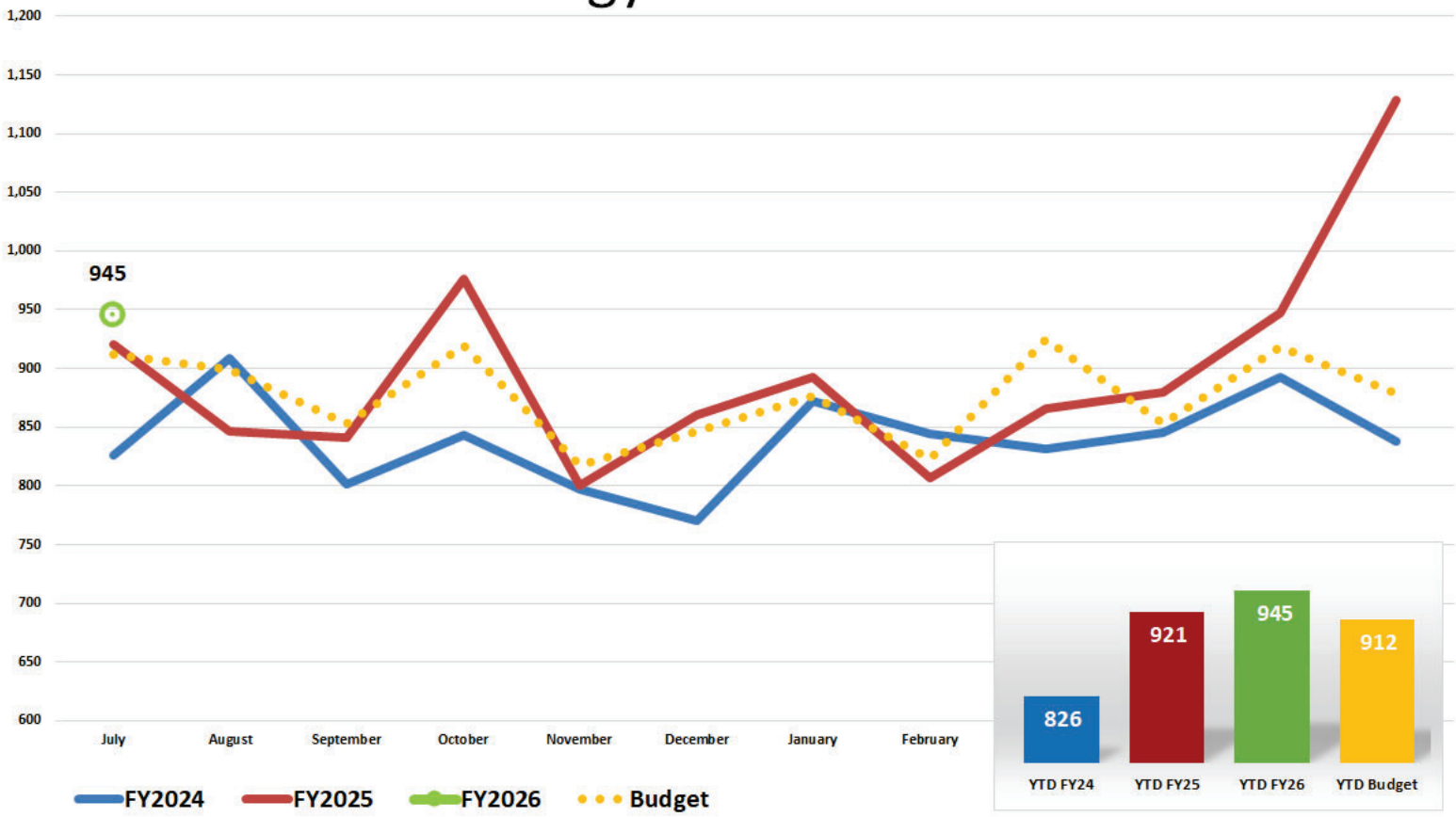

West Campus - Breast Center
2,000
1,900
1,800
1,700
1,600
1,500
1,400
1,300
1,200
1,487
July
August
September
October
November
December
January
February
March
April
May
June
FY2024
FY2025
FY2026
Budget
1,672
1,806
1,487
1,806
YTD FY24
YTD FY25
YTD FY26
YTD Budget


Radiology - CT - All Areas
5,300
5,200
5,100
5,000
4,900
4,800
4,700
4,600
4,500
4,400
4,300
4,200
4,100
4,000
3,900
3,800
3,700
3,600
3,500
5,085
July
August
September
October
November
December
January
February
FY2024
FY2025
FY2026
Budget
4,370
4,868
5,085
4,618
YTD FY24
YTD FY25
YTD FY26
YTD Budget

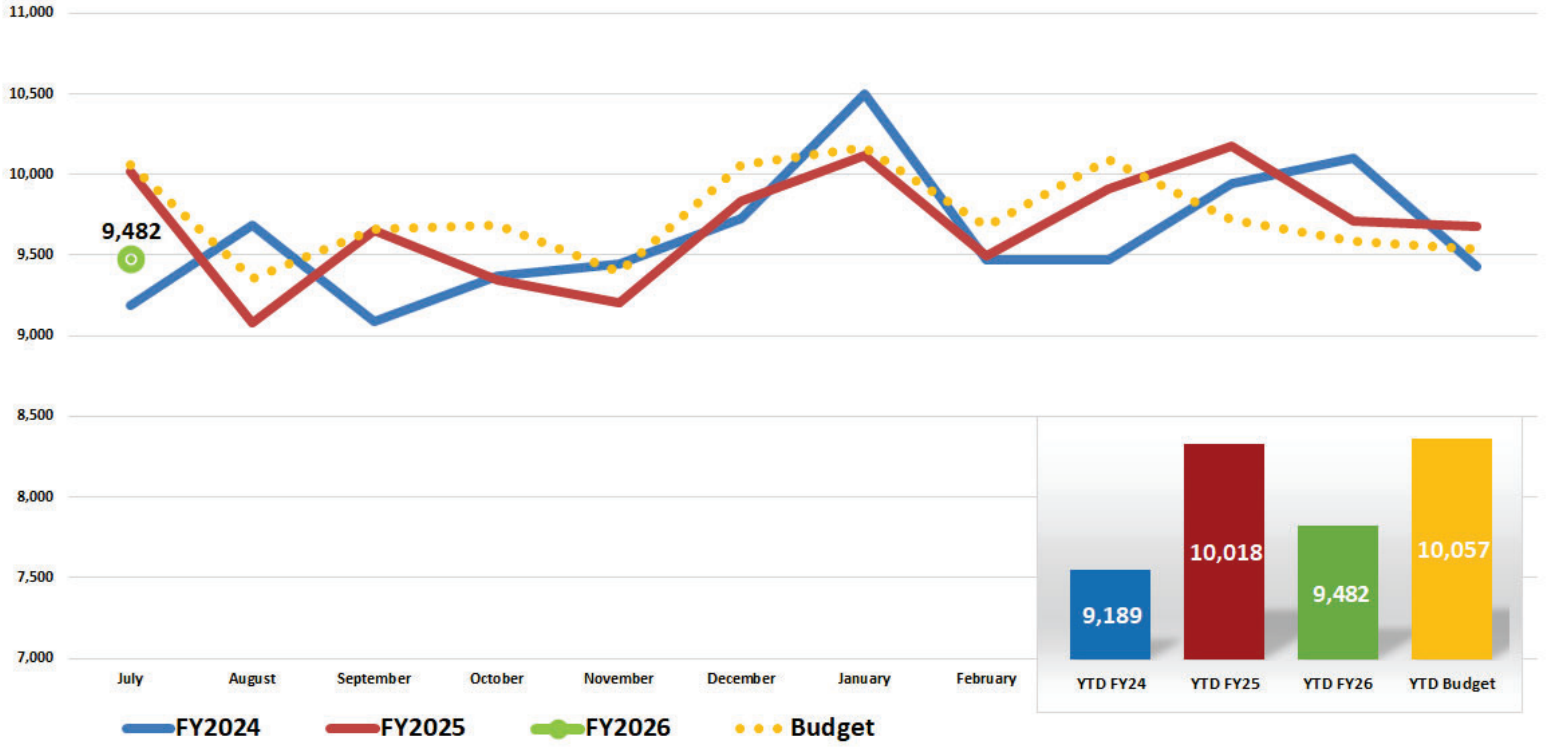
Radiology - Ultrasound - All Areas



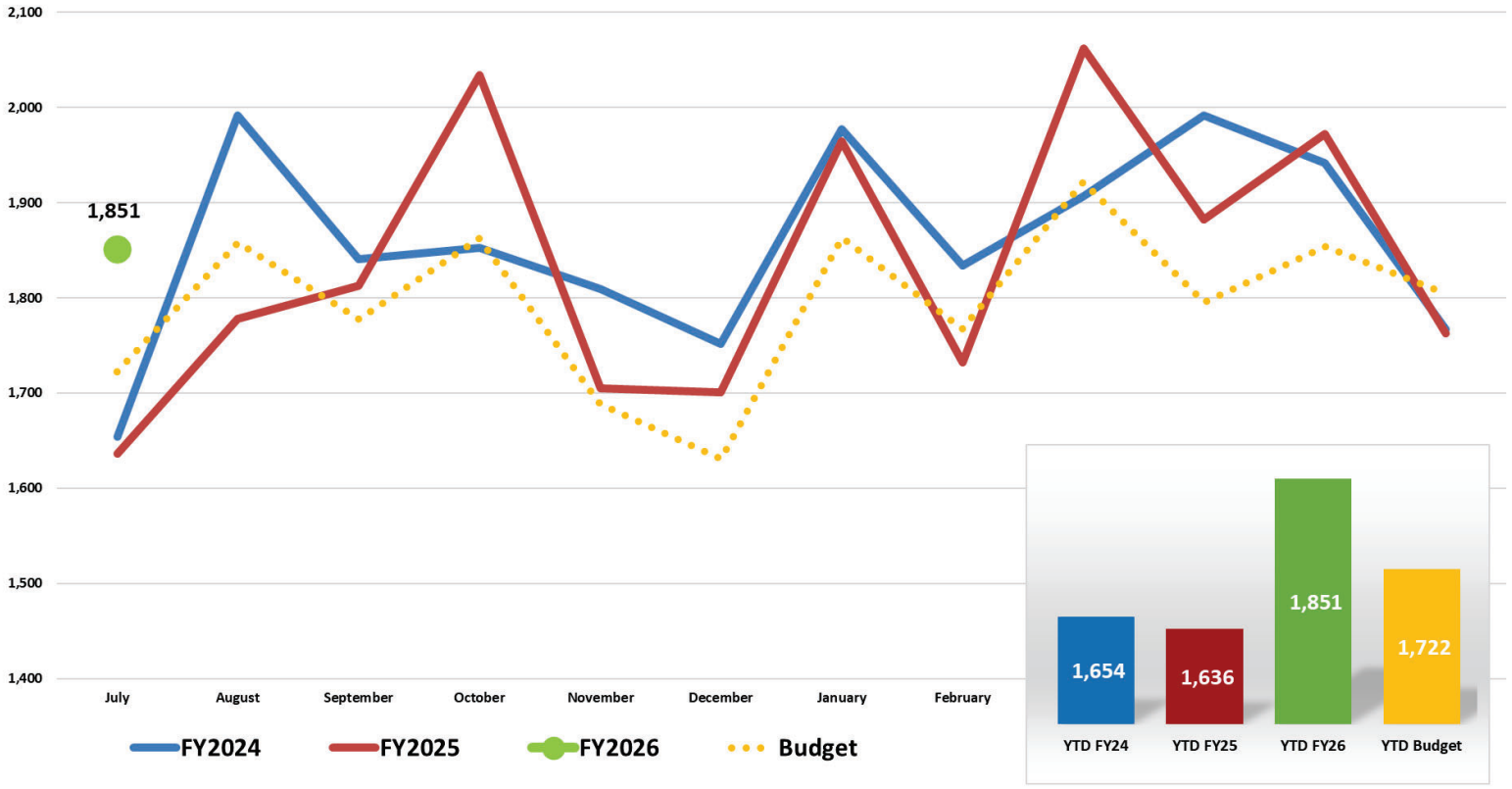
Radiology - MRI - All Areas



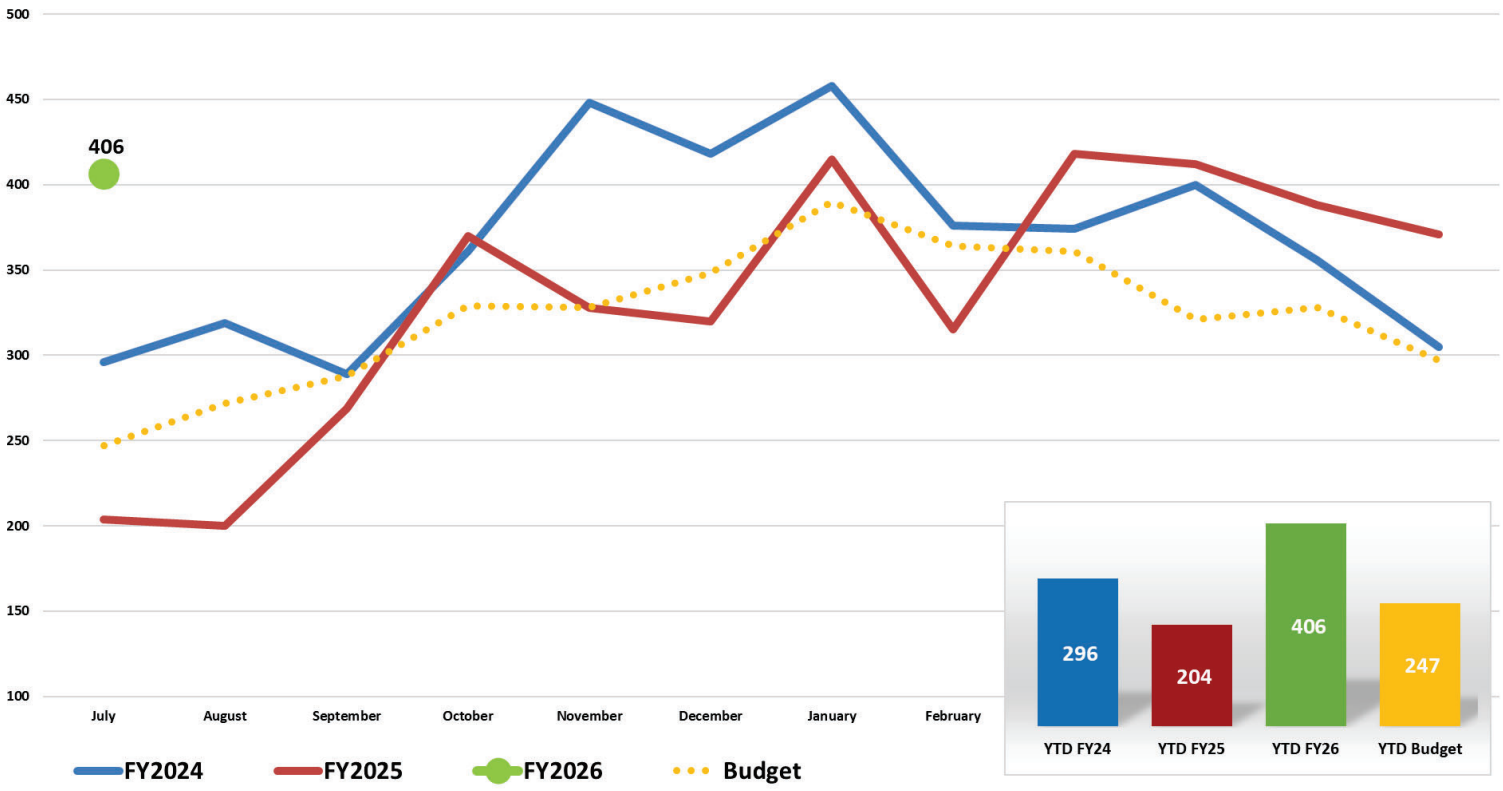
Radiology Modality - Diagnostic Radiology

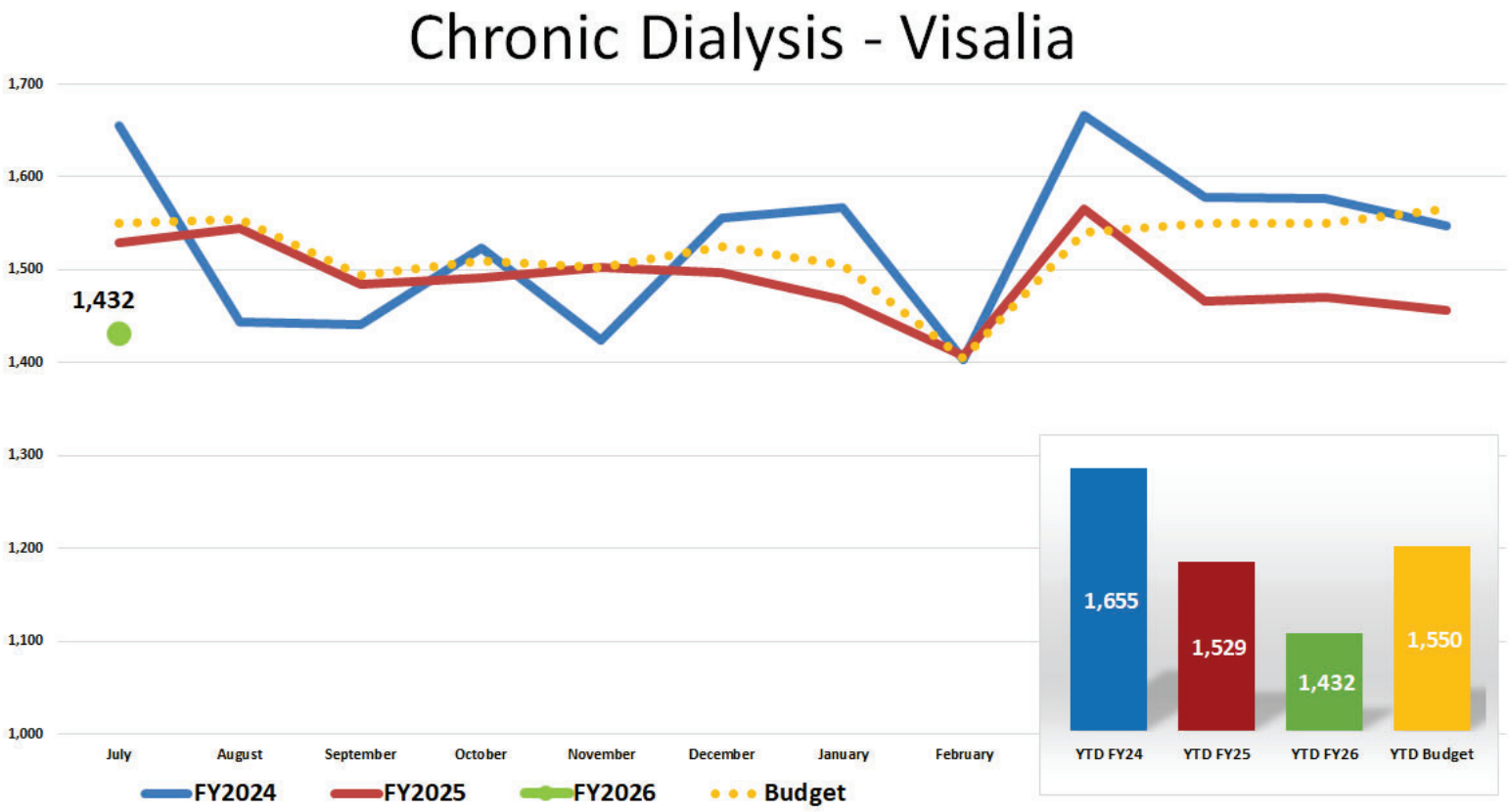


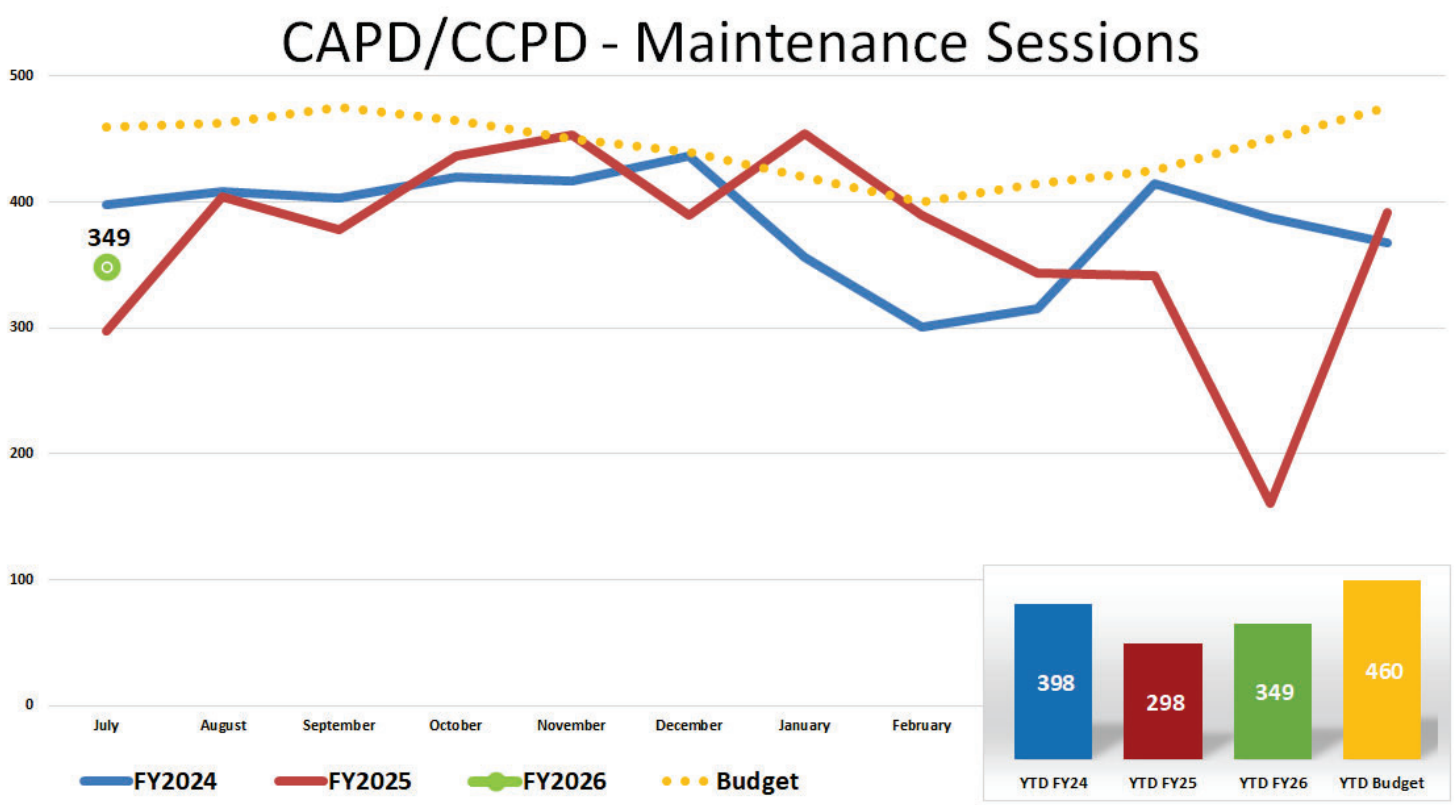
Radiology - UC Court/South Campus



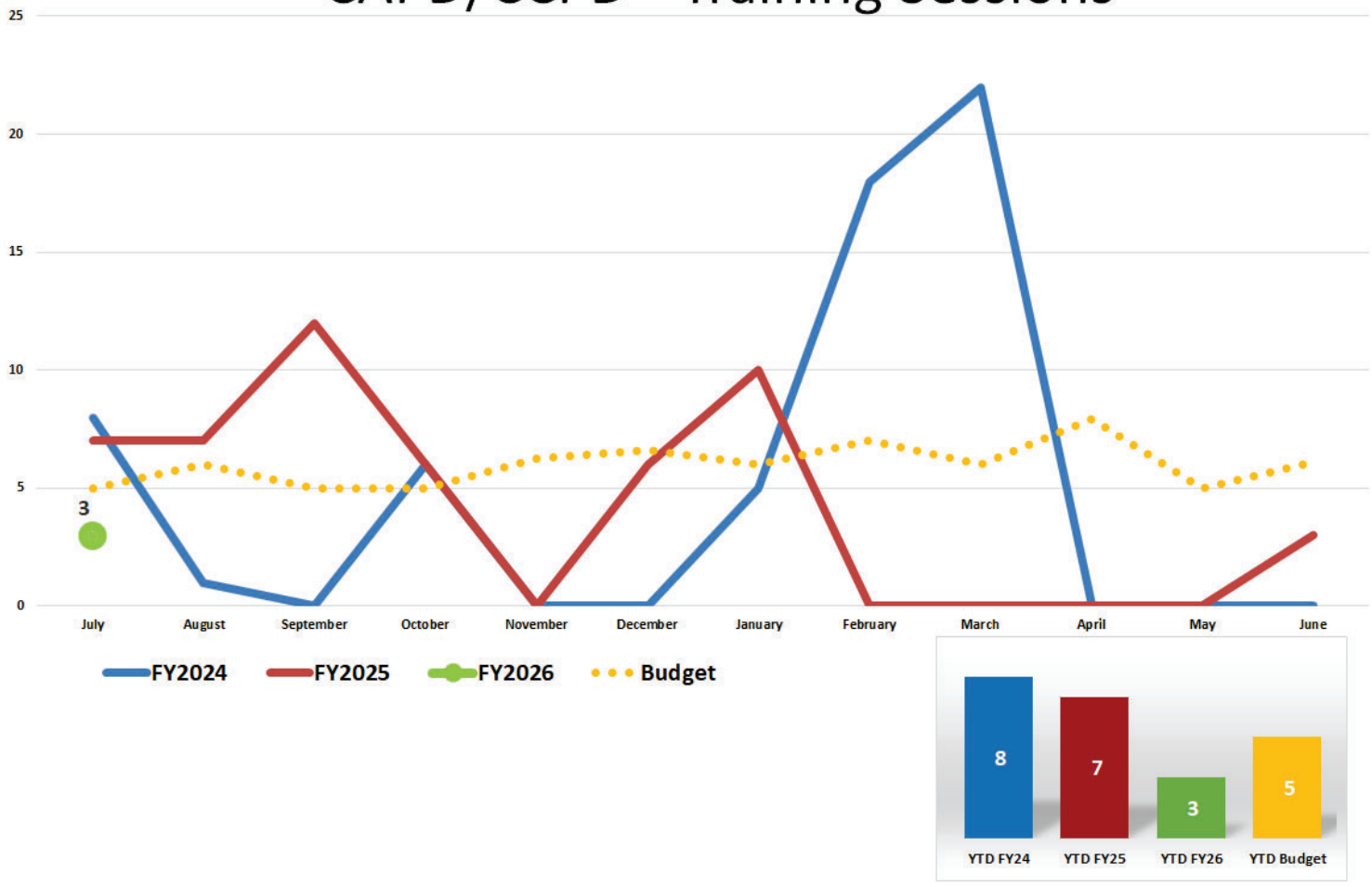
Radiology - UC Demaree/North Campus

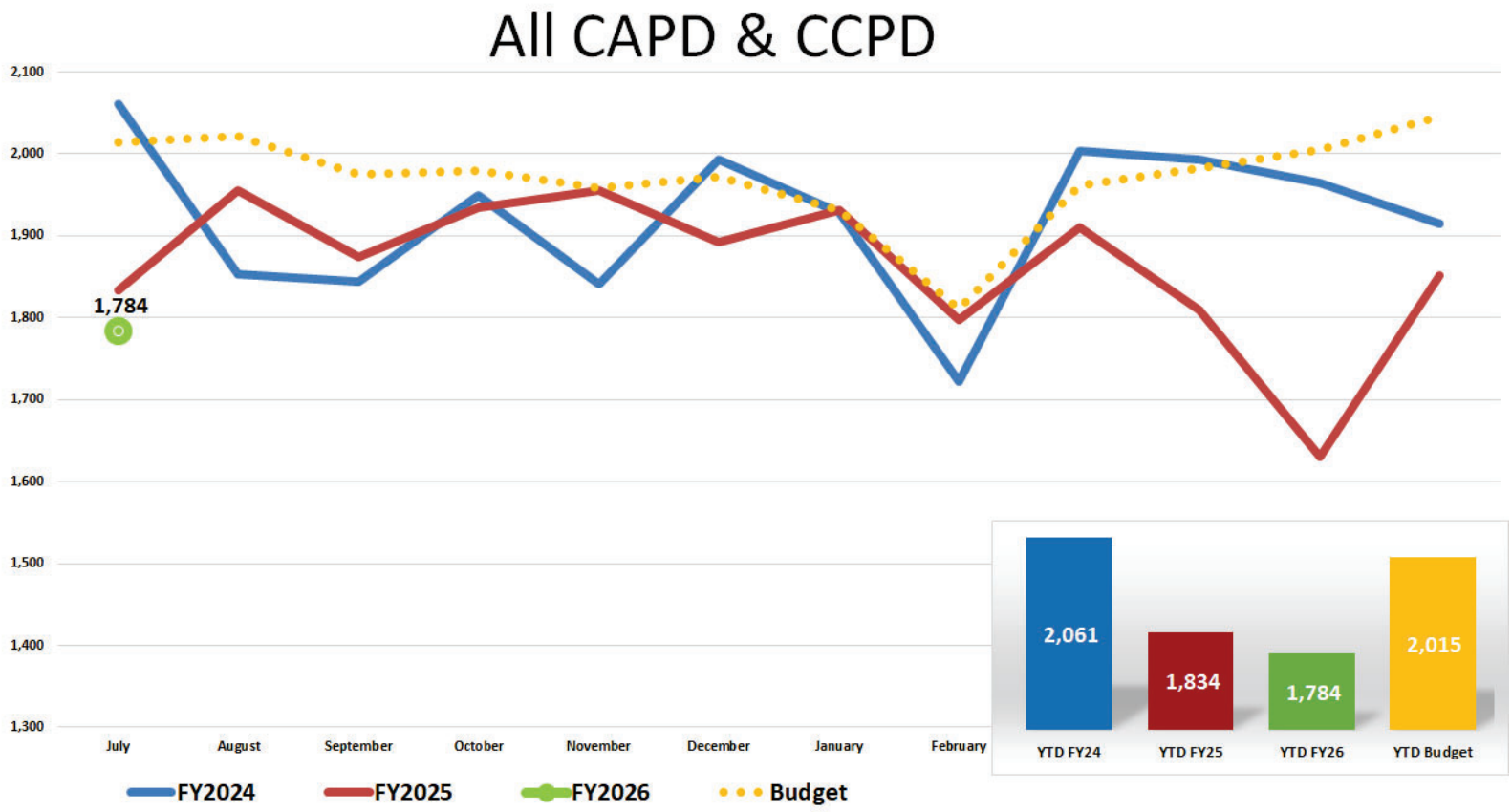



Chronic Dialysis - Visalia
1,700
1,600
1,500
1,400
1,300
1,200
1,100
1,000
1,432
July
August
September
October
November
December
January
February
FY2024
FY2025
FY2026
Budget
1,655
1,529
1,432
1,550
YTD FY24
YTD FY25
YTD FY26
YTD Budget

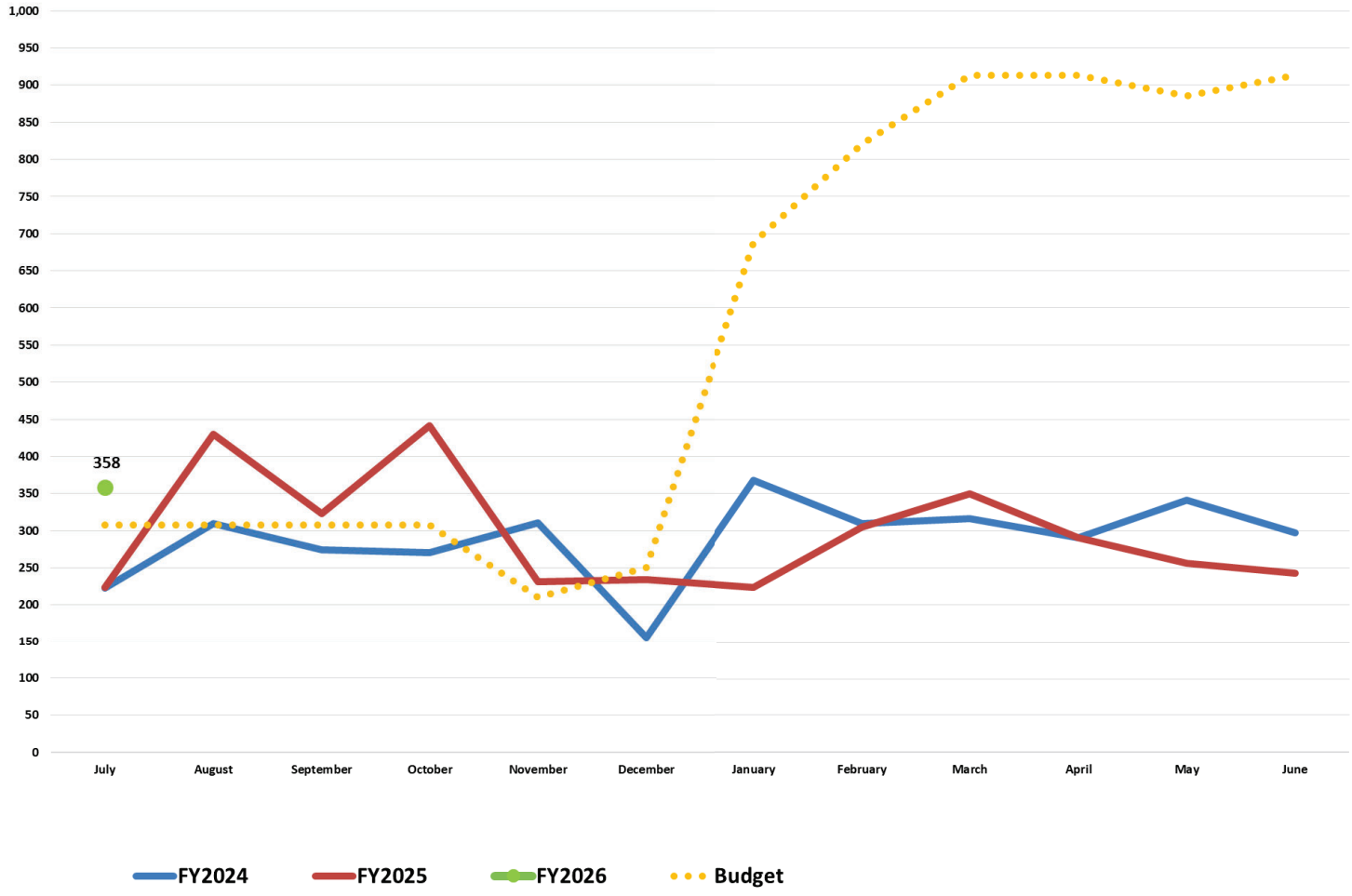

CAPD/CCPD - Maintenance Sessions
500
400
300
200
100
0
349
July
August
September
October
November
December
January
February
FY2024
FY2025
FY2026
Budget
398
298
349
460
YTD FY24
YTD FY25
YTD FY26
YTD Budget

CAPD/CCPD - Training Sessions

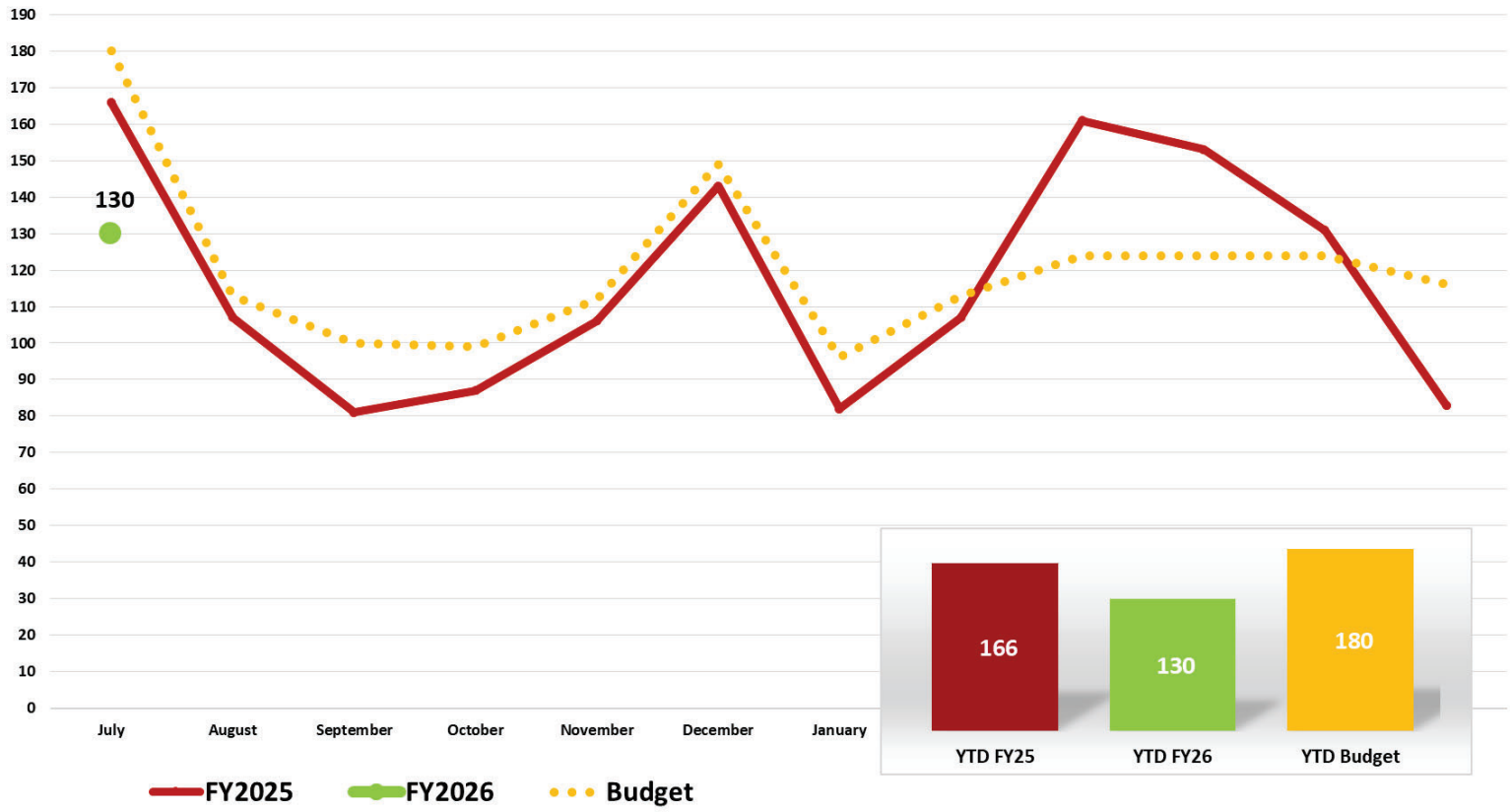


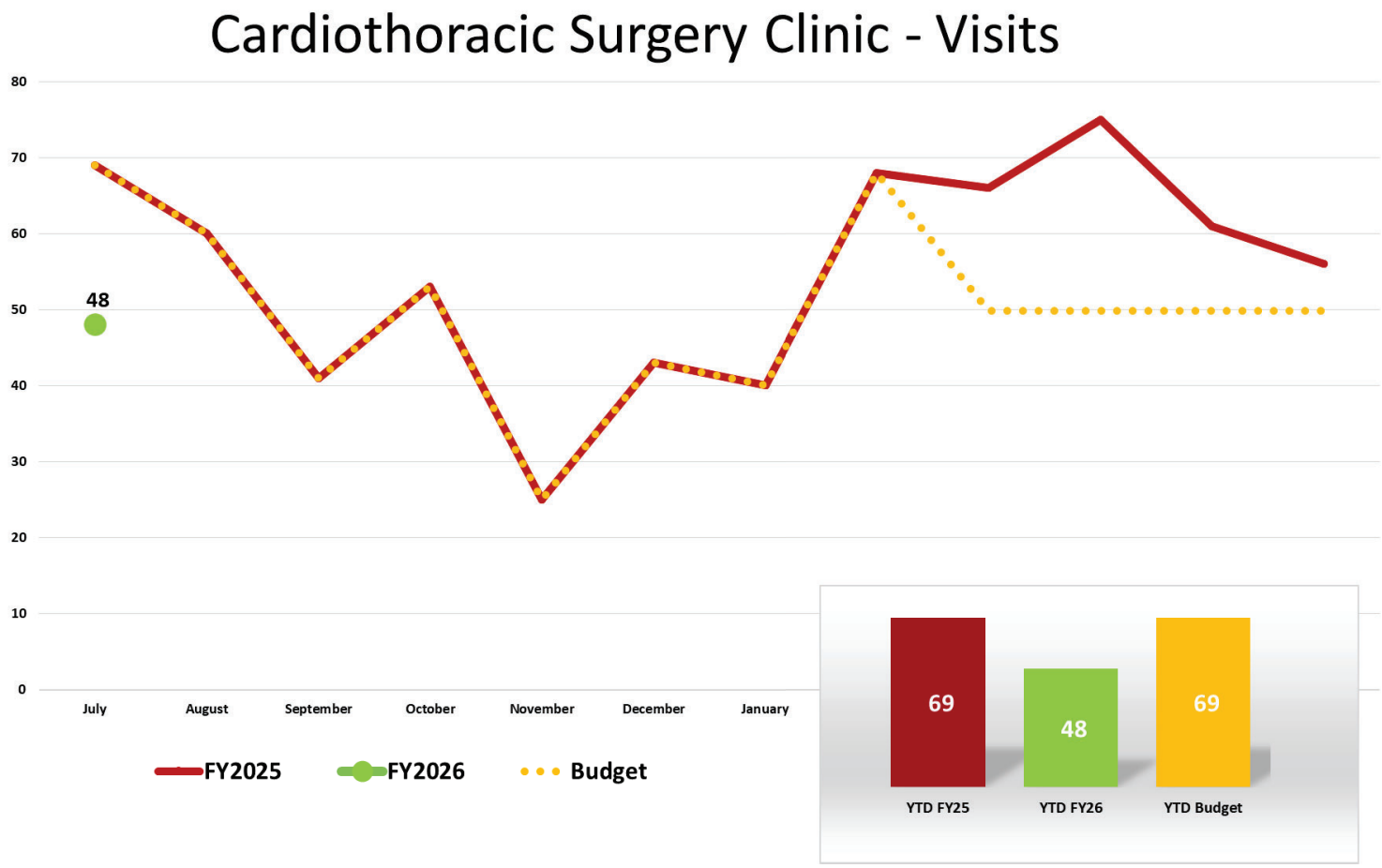

All CAPD & CCPD
2,100
2,000
1,900
1,800
1,700
1,600
1,500
1,400
1,300
1,784
July
August
September
October
November
December
January
February
FY2024
FY2025
FY2026
Budget
2,061
1,834
1,784
2,015
YTD FY24
YTD FY25
YTD FY26
YTD Budget

Urology Clinic Visits

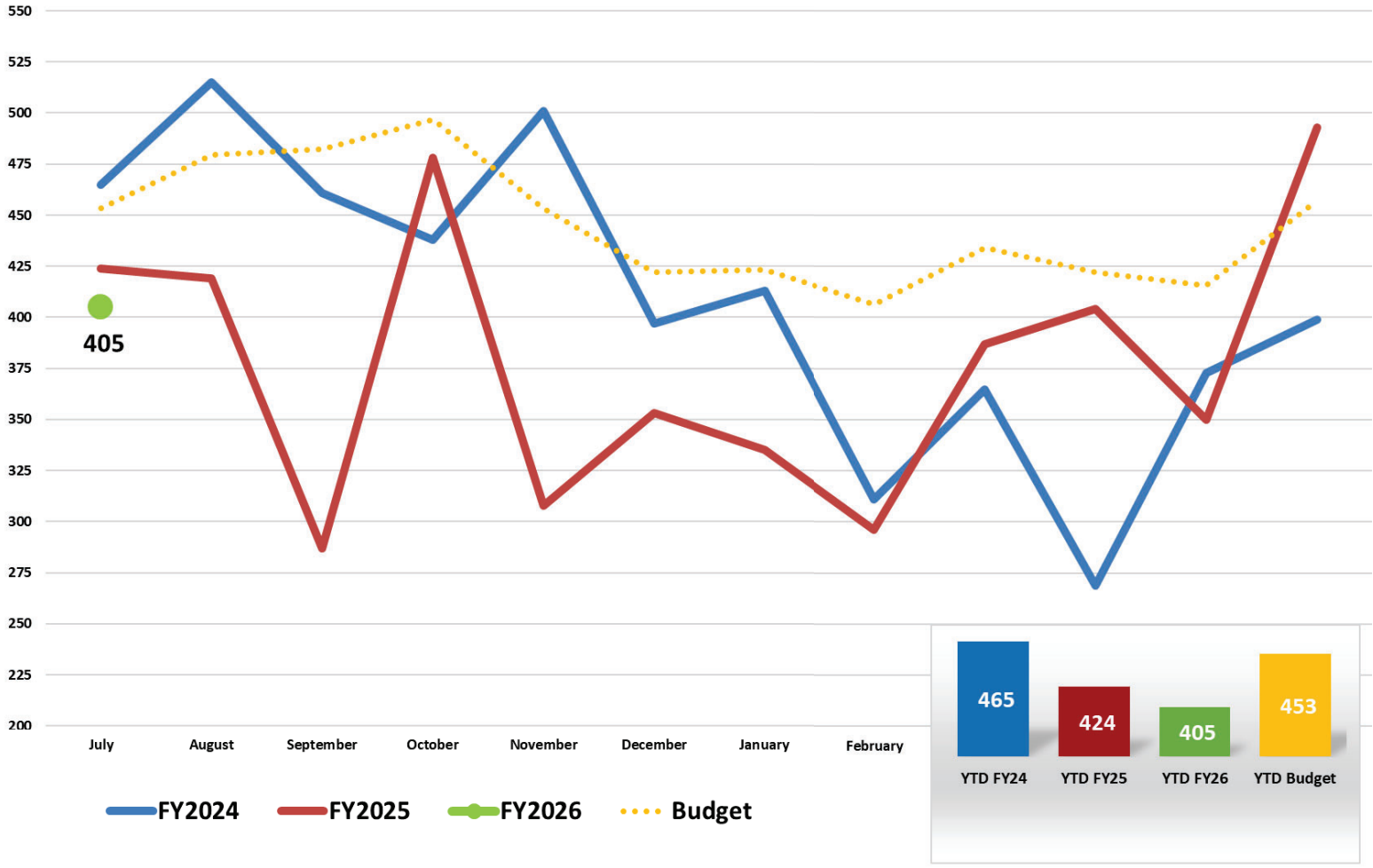


Open Arms House - Patient Days

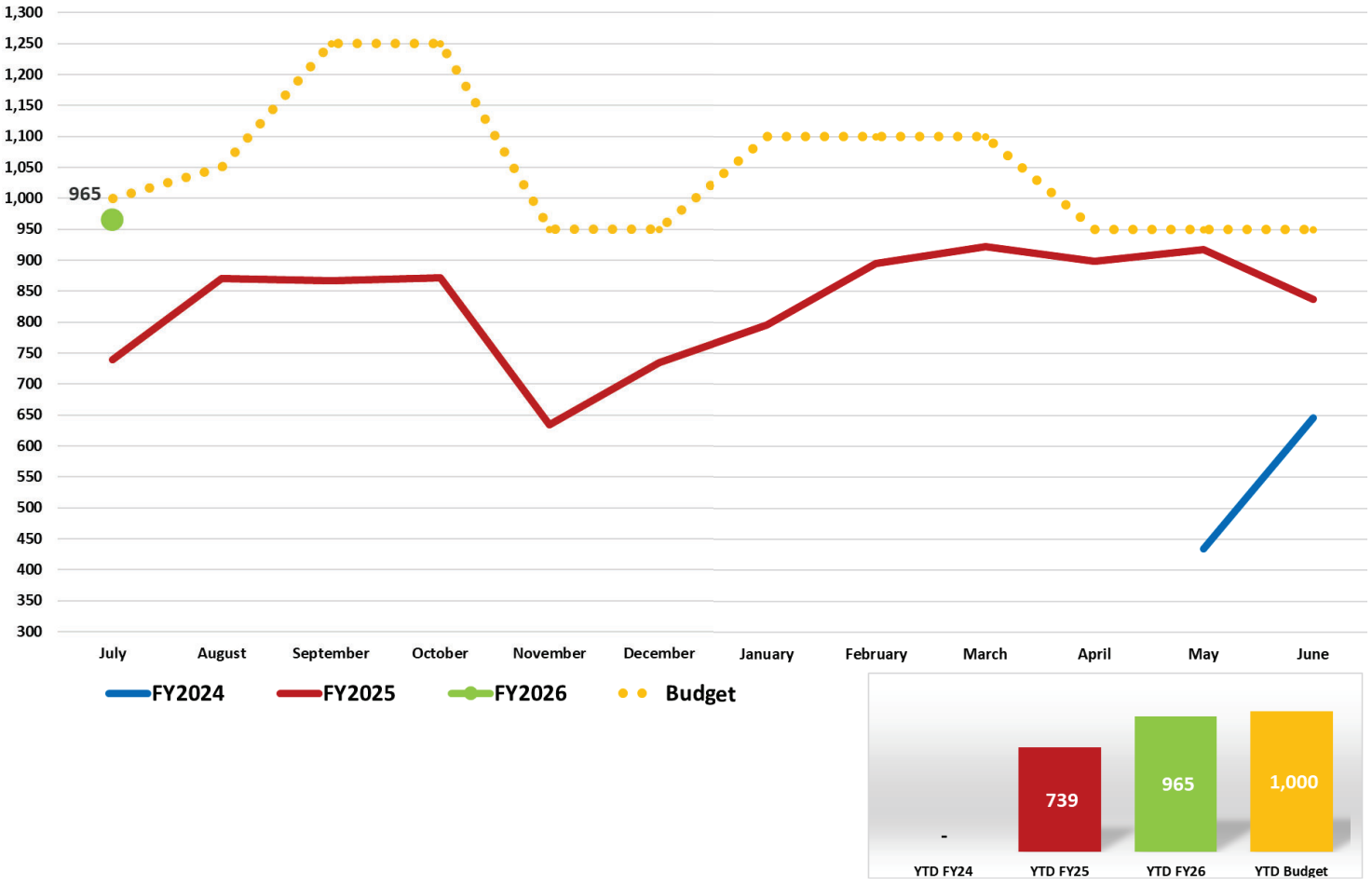



Cardiothoracic Surgery Clinic - Visits
80
70
60
50
40
30
20
10
0
48
July
August
September
October
November
December
January
FY2025
FY2026
Budget
69
48
69
YTD FY25
YTD FY26
YTD Budget

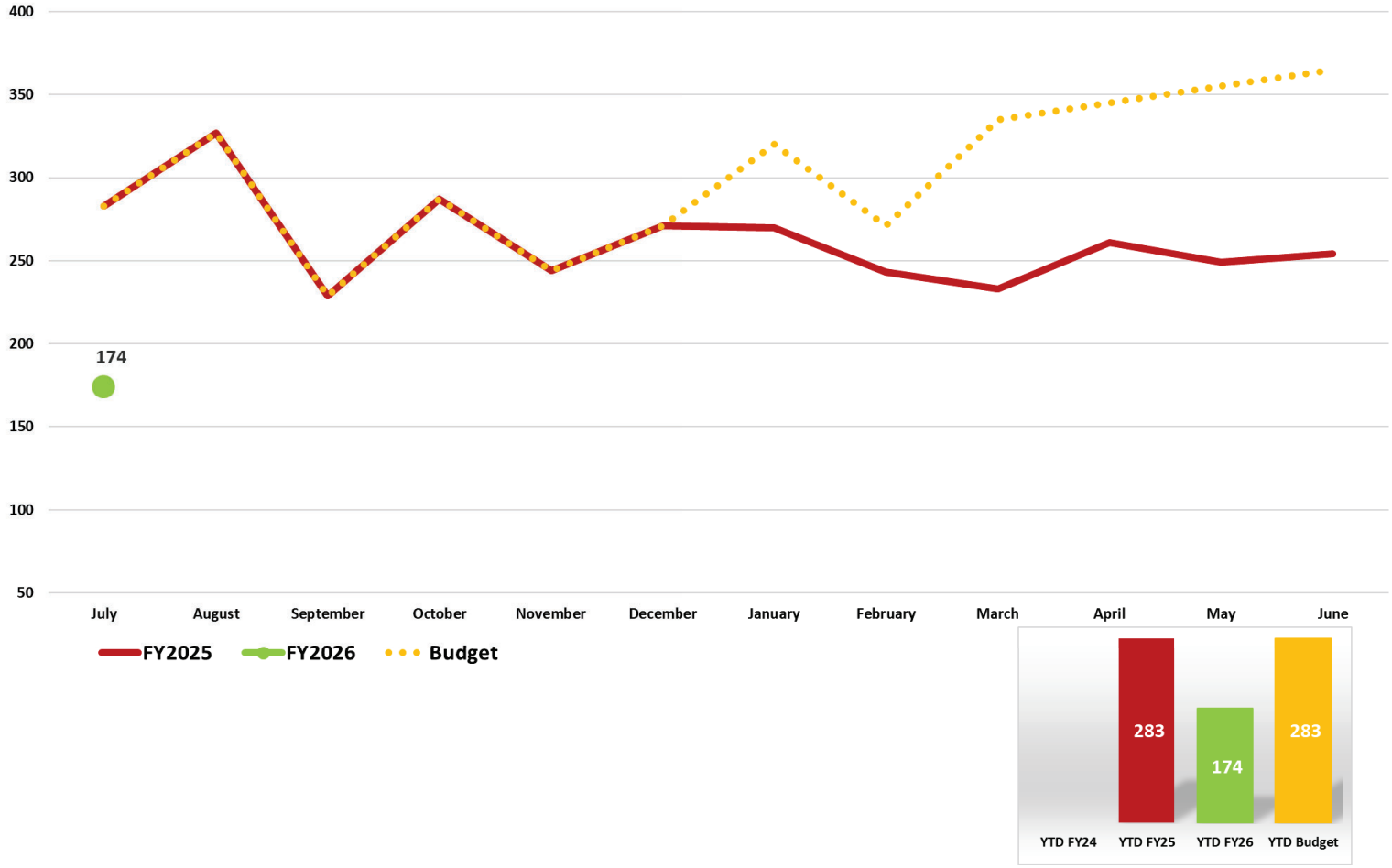
Cardiac Rehabilitation



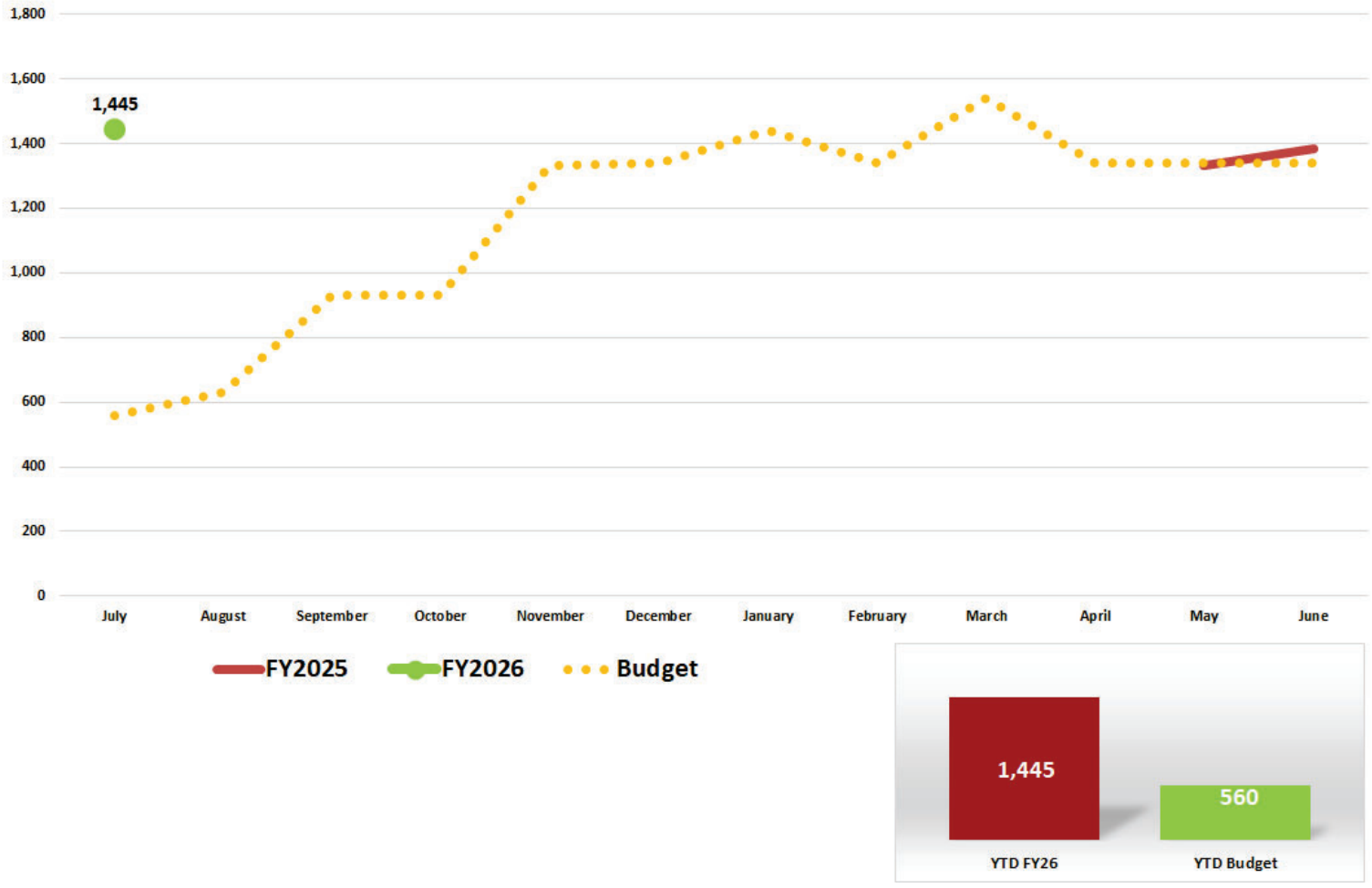
KH Medical Clinic - Ben Maddox



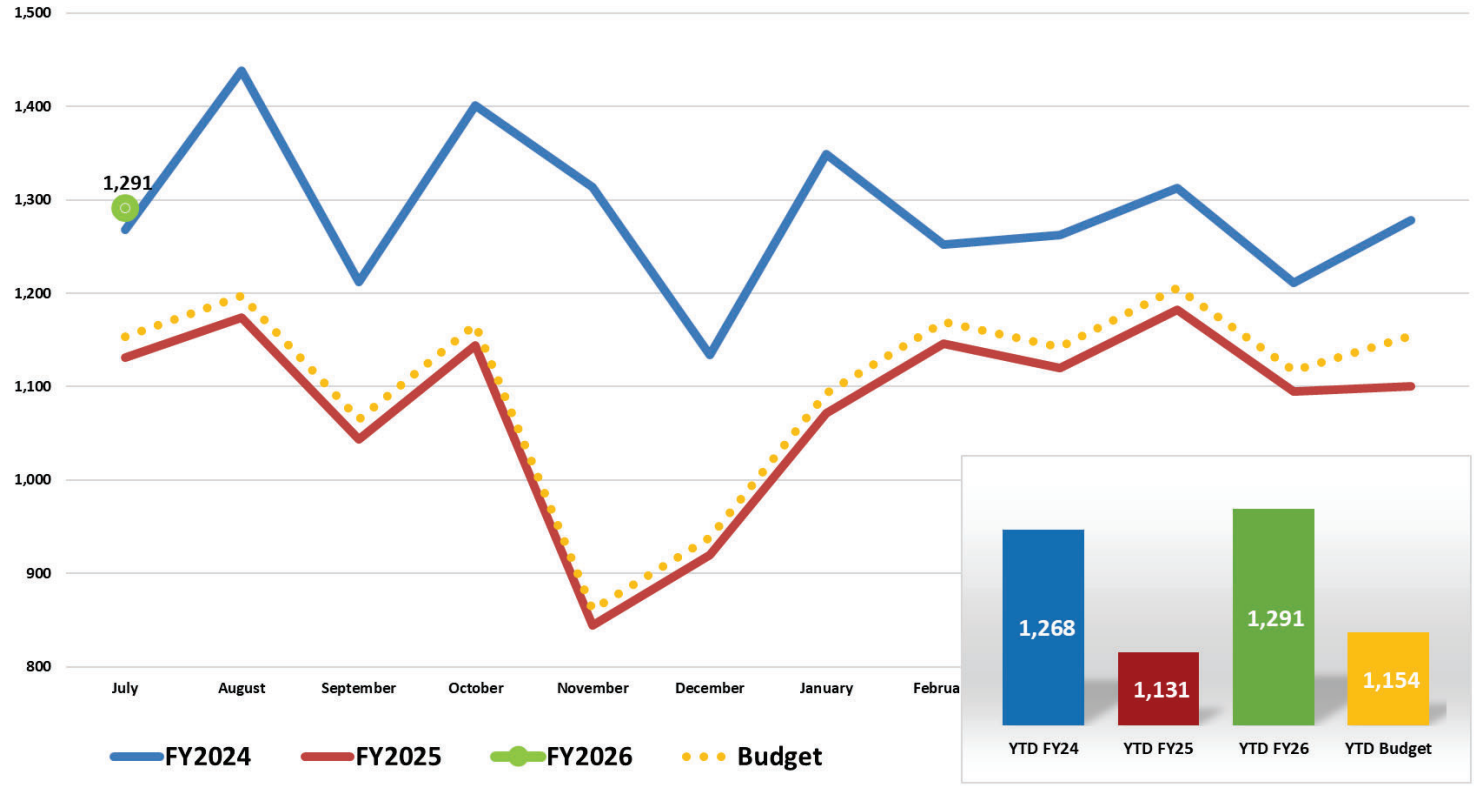
KH Medical Clinic - Plaza



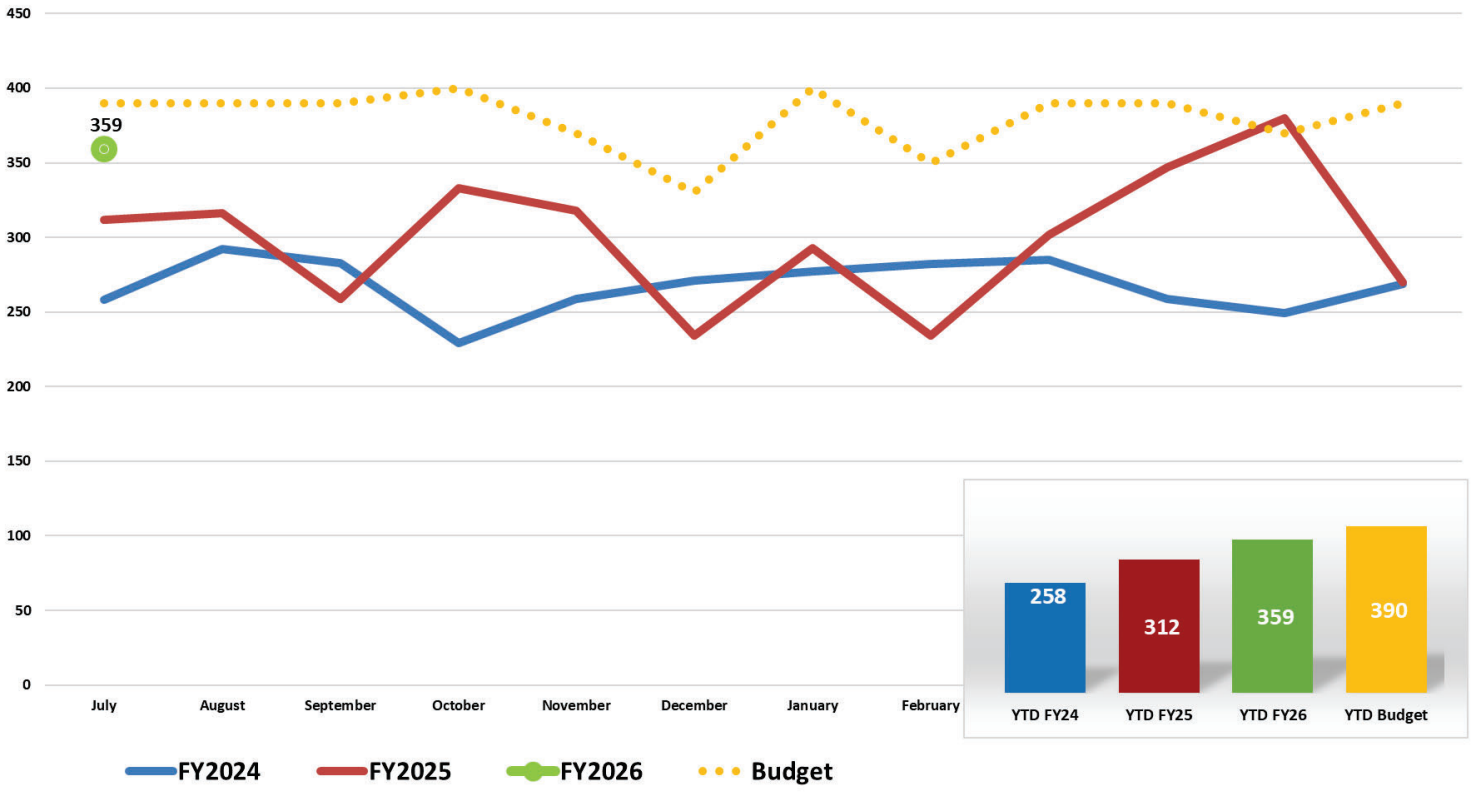
KH Willow Clinic



Medical Oncology Treatments



Mental Wellness Clinic



KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
July 31, 2025

Board designated funds	Maturity Date	Yield	Investment Type	G/L Account	Amount	Total
LAIF		4.40	Various		36,608,632	
CAMP		4.41	CAMP		28,800,996	
Allspring		3.91	Money market		80,605	
PFM		3.91	Money market		607,431	
Western Alliance		0.25	Money market		140,781	
Allspring	1-Aug-25	2.17	Municipal	Santa Cruz Ca	400,000	
PFM	1-Aug-25	0.85	Municipal	San Juan Ca	190,000	
Allspring	25-Aug-25	0.38	U.S. Govt Agency	FNMA	1,500,000	
PFM	25-Aug-25	3.75	U.S. Govt Agency	FHLMC	66,465	
Allspring	4-Sep-25	0.38	U.S. Govt Agency	FHLB	525,000	
Allspring	23-Sep-25	0.38	U.S. Govt Agency	FHLMC	750,000	
Allspring	29-Oct-25	0.55	MTN-C	Procter Gamble Co	1,300,000	
Allspring	31-Oct-25	0.25	U.S. Govt Agency	US Treasury Bill	770,000	
Allspring	30-Nov-25	0.38	U.S. Govt Agency	US Treasury Bill	2,550,000	
Allspring	31-Mar-26	0.75	U.S. Govt Agency	US Treasury Bill	675,000	
Western Alliance - CDARS	2-Apr-26	4.01	CD	First Heritage Bank	238,007	
Western Alliance - CDARS	2-Apr-26	4.01	CD	Farmers & Merchants Bank	13,586	
Western Alliance - CDARS	2-Apr-26	4.01	CD	Citizens Bank & Trust	22,597	
Western Alliance - CDARS	2-Apr-26	4.01	CD	American Plus Bank, N.A.	238,007	
Western Alliance - CDARS	2-Apr-26	4.01	CD	BOKF, National Association	238,007	
Western Alliance - CDARS	2-Apr-26	4.01	CD	CalPrivate Bank	238,007	
Western Alliance - CDARS	2-Apr-26	4.01	CD	Centreville Bak	238,007	
Western Alliance - CDARS	2-Apr-26	4.01	CD	Citizens Bank & Trust	215,411	
Western Alliance - CDARS	2-Apr-26	4.01	CD	City Natl Bank of Sulphur Springs	238,007	
Western Alliance - CDARS	2-Apr-26	4.01	CD	Farmer & Merchants Bank	176,797	
Western Alliance - CDARS	2-Apr-26	4.01	CD	First Oklahoma Bank	201,033	
Western Alliance - CDARS	2-Apr-26	4.01	CD	Homeland Federal Savings Bank	16,013	
Western Alliance - CDARS	2-Apr-26	4.01	CD	Locus Bank	238,007	
Western Alliance - CDARS	2-Apr-26	4.01	CD	Old National Bank	238,007	
Western Alliance - CDARS	2-Apr-26	4.01	CD	River City Bank	238,007	
Western Alliance - CDARS	2-Apr-26	4.01	CD	Solera National Bank	238,007	
Allspring	21-Apr-26	4.75	MTN-C	Morgan Stanley	1,000,000	
PFM	15-May-26	3.30	MTN-C	IBM Corp	410,000	
PFM	28-May-26	1.20	MTN-C	Astrazeneca LP	265,000	
Allspring	18-Jun-26	1.13	MTN-C	Toyota Motor	1,400,000	
Allspring	30-Jun-26	0.88	U.S. Govt Agency	US Treasury Bill	1,850,000	
PFM	30-Jun-26	0.88	U.S. Govt Agency	US Treasury Bill	990,000	
Allspring	1-Jul-26	1.89	Municipal	Anaheim Ca Pub	1,000,000	
PFM	1-Jul-26	1.46	Municipal	Los Angeles Ca	270,000	
PFM	7-Jul-26	5.25	MTN-C	American Honda Mtn	145,000	
PFM	20-Jul-26	3.73	ABS	Honda Auto Rec Own	19,021	
PFM	31-Jul-26	0.63	U.S. Govt Agency	US Treasury Bill	880,000	
PFM	31-Aug-26	0.75	U.S. Govt Agency	US Treasury Bill	800,000	
PFM	14-Sep-26	1.15	MTN-C	Caterpillar Finl Mtn	220,000	
PFM	18-Sep-26	5.61	MTN-C	Natixis Ny	405,000	
Allspring	30-Sep-26	0.88	U.S. Govt Agency	US Treasury Bill	2,210,000	
PFM	30-Sep-26	0.88	U.S. Govt Agency	US Treasury Bill	1,000,000	
Allspring	31-Oct-26	1.13	U.S. Govt Agency	US Treasury Bill	800,000	
PFM	1-Nov-26	4.76	Municipal	California St Univ	125,000	
PFM	4-Nov-26	1.65	MTN-C	American Express Co	445,000	
PFM	13-Nov-26	5.60	MTN-C	National Rural Mtn	160,000	
Allspring	30-Nov-26	1.25	U.S. Govt Agency	US Treasury Bill	2,000,000	
Allspring	4-Dec-26	5.49	MTN-C	Citibank N A	1,000,000	
Allspring	15-Jan-27	1.95	MTN-C	Target Corp	900,000	
PFM	26-Feb-27	4.80	MTN-C	Cisco Sys Inc	260,000	
PFM	15-Mar-27	5.90	ABS	Daimler Trucks	206,267	
PFM	18-Mar-27	4.99	MTN-C	State Street Corp	335,000	
PFM	25-Mar-27	3.22	U.S. Govt Agency	FHLMC	575,000	
PFM	30-Mar-27	5.39	MTN-C	Hormel Food Corp	115,000	
PFM	15-Apr-27	2.50	MTN-C	Home Depot Inc	220,000	
PFM	15-Apr-27	3.97	ABS	Carmax Auto Owner	172,194	
Allspring	30-Apr-27	2.75	U.S. Govt Agency	US Treasury Bill	970,000	
PFM	30-Apr-27	0.50	U.S. Govt Agency	US Treasury Bill	250,000	
PFM	30-Apr-27	2.75	U.S. Govt Agency	US Treasury Bill	800,000	
PFM	1-May-27	5.41	MTN-C	Goldman Sachs	220,000	
PFM	13-May-27	5.00	MTN-C	Paccar Financial Mtn	95,000	
PFM	15-May-27	3.70	MTN-C	Unitedhealth Group	85,000	
PFM	15-May-27	2.38	U.S. Govt Agency	US Treasury Bill	925,000	
PFM	17-May-27	3.66	ABS	Capital One Prime	90,372	
Allspring	21-May-27	5.41	MTN-C	Goldman Sachs	1,100,000	
Allspring	15-Jul-27	3.68	Municipal	Massachusetts St	1,000,000	
PFM	26-Jul-27	4.60	MTN-C	Blackrock Funding	185,000	
PFM	31-Jul-27	2.75	U.S. Govt Agency	US Treasury Bill	185,000	
Allspring	1-Aug-27	3.23	Municipal	San Jose Ca Redev	400,000	
Allspring	1-Aug-27	3.46	Municipal	Alameda Cnty Ca	500,000	
Allspring	6-Aug-27	4.45	MTN-C	Paccar Financial Mtn	900,000	
PFM	15-Aug-27	2.25	U.S. Govt Agency	US Treasury Bill	190,000	
PFM	31-Aug-27	0.50	U.S. Govt Agency	US Treasury Bill	1,140,000	
Allspring	15-Sep-27	5.93	MTN-C	Bank of America	1,100,000	
Allspring	1-Oct-27	4.66	Municipal	San Francisco Ca	1,000,000	
PFM	8-Oct-27	4.35	MTN-C	Toyota Motor	130,000	
Allspring	22-Oct-27	4.33	MTN-C	State Street Corp	1,000,000	
PFM	31-Oct-27	0.50	U.S. Govt Agency	US Treasury Bill	1,500,000	
Allspring	15-Nov-27	5.49	ABS	Nissan Auto Lease	500,000	
Allspring	15-Nov-27	4.60	MTN-C	Caterpillar Finl Mtn	1,000,000	
PFM	15-Nov-27	4.51	ABS	Mercedes Benz Auto	91,635	
PFM	17-Nov-27	5.02	MTN-C	Bp Cap Mkts Amer	310,000	
PFM	15-Jan-28	4.10	MTN-C	Mastercard	130,000	
Allspring	18-Jan-28	5.66	ABS	Mercedes Benz Auto	1,000,000	
PFM	24-Jan-28	4.90	MTN-C	Wells Fargo MTN	145,000	
PFM	7-Feb-28	3.44	MTN-C	Bank New York Mellon Mtn	300,000	
Allspring	12-Feb-28	4.55	MTN-C	Eli Lilly Co	300,000	
Allspring	16-Feb-28	4.47	ABS	GM Finl Consumer	654,214	
PFM	18-Feb-28	5.41	ABS	Honda Auto	282,203	
PFM	24-Feb-28	4.55	MTN-C	Cisco Sys Inc	70,000	
PFM	24-Feb-28	4.55	MTN-C	Hershey Co	80,000	
PFM	25-Feb-28	5.47	ABS	BMW Vehicle Owner	65,927	
PFM	26-Feb-28	4.48	MTN-C	Chevron USA Inc	340,000	
PFM	29-Feb-28	1.13	U.S. Govt Agency	US Treasury Bill	1,500,000	
PFM	1-Mar-28	4.55	MTN-C	Johnson Johnson Sr	80,000	
PFM	17-Apr-28	5.48	ABS	Hyundai Auto	92,749	
Allspring	22-Apr-28	5.57	MTN-C	JP Morgan	1,100,000	
PFM	23-Apr-28	4.89	MTN-C	Goldman Sachs	155,000	
PFM	30-Apr-28	3.50	U.S. Govt Agency	US Treasury Bill	750,000	

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PFM	30-Apr-28	1.25	U.S. Govt Agency	US Treasury Bill	600,000
PFM	9-May-28	4.25	MTN-C	Cummins INC	20,000
PFM	15-May-28	5.23	ABS	Ford CR Auto Owner	136,643
PFM	15-May-28	5.46	ABS	Ally Auto Rec	155,875
PFM	26-May-28	5.50	MTN-C	Morgan Stanley	280,000
PFM	31-May-28	3.63	U.S. Govt Agency	US Treasury Bill	730,000
PFM	15-Jun-28	4.35	MTN-C	Target Corp	75,000
PFM	15-Jun-28	4.35	MTN-C	Target Corp	290,000
PFM	16-Jun-28	5.45	ABS	GM Finl con Auto Rec	92,256
PFM	25-Jun-28	4.82	U.S. Govt Agency	FHLMC	530,000
PFM	25-Jun-28	4.78	U.S. Govt Agency	FHLMC	432,624
Allspring	30-Jun-28	4.00	U.S. Govt Agency	US Treasury Bill	500,000
PFM	30-Jun-28	4.00	U.S. Govt Agency	US Treasury Bill	1,300,000
PFM	1-Jul-28	4.42	Municipal	Los Angeles Ca	140,000
PFM	6-Jul-28	4.66	MTN-C	Morgan Stanley	250,000
Allspring	14-Jul-28	4.95	MTN-C	John Deere Mtn	700,000
PFM	14-Jul-28	4.95	MTN-C	John Deere Mtn	120,000
PFM	24-Jul-28	4.42	MTN-C	Truist Bk Sr Nt	275,000
PFM	25-Jul-28	4.18	U.S. Govt Agency	FNMA	515,719
Allspring	1-Aug-28	5.75	Municipal	San Diego County	1,000,000
PFM	15-Aug-28	4.15	MTN-C	Lockheed Martin	40,000
PFM	15-Aug-28	5.53	ABS	Fifth Third Auto	332,140
PFM	15-Aug-28	5.69	ABS	Harley Davidson	453,835
PFM	25-Aug-28	4.74	U.S. Govt Agency	FHLMC	545,000
PFM	25-Aug-28	4.65	U.S. Govt Agency	FHLMC	545,000
PFM	15-Sep-28	5.16	ABS	Chase Issuance Trust	435,000
PFM	15-Sep-28	5.23	ABS	American Express	445,000
PFM	25-Sep-28	4.85	U.S. Govt Agency	FHLMC	410,000
PFM	25-Sep-28	4.80	U.S. Govt Agency	FHLMC	535,000
PFM	29-Sep-28	5.80	MTN-C	Citibank N A	535,000
PFM	30-Sep-28	4.63	U.S. Govt Agency	US Treasury Bill	500,000
Allspring	25-Oct-28	5.80	MTN-C	Bank New York Mtn	1,000,000
PFM	25-Oct-28	5.07	U.S. Govt Agency	FHLMC	200,000
PFM	25-Oct-28	4.86	U.S. Govt Agency	FHLMC	300,000
PFM	31-Oct-28	1.38	U.S. Govt Agency	US Treasury Bill	1,500,000
PFM	31-Oct-28	1.38	U.S. Govt Agency	US Treasury Bill	775,000
Allspring	15-Nov-28	4.98	ABS	Bank of America	394,000
PFM	25-Nov-28	5.00	U.S. Govt Agency	FHLMC	280,000
PFM	25-Dec-28	4.57	U.S. Govt Agency	FHLMC	325,000
PFM	25-Dec-28	4.72	U.S. Govt Agency	FHLMC	315,000
PFM	31-Dec-28	3.75	U.S. Govt Agency	US Treasury Bill	1,200,000
PFM	31-Dec-28	1.38	U.S. Govt Agency	US Treasury Bill	500,000
PFM	12-Jan-29	5.02	MTN-C	Morgan Stanley	250,000
PFM	16-Jan-29	4.60	ABS	Chase Issuance Trust	490,000
PFM	24-Jan-29	4.92	MTN-C	JP Morgan	140,000
PFM	31-Jan-29	4.60	MTN-C	Paccar Financial Mtn	160,000
PFM	8-Feb-29	4.60	MTN-C	Air products	295,000
PFM	8-Feb-29	4.60	MTN-C	Texas Instrs	370,000
PFM	15-Feb-29	4.94	ABS	Wells Fargo Card	560,000
PFM	20-Feb-29	4.90	MTN-C	Cummins INC	195,000
PFM	22-Feb-29	4.90	MTN-C	Bristol Myers Squibb	200,000
Allspring	26-Feb-29	5.18	ABS	BMW Vehicle Owner	1,100,000
PFM	26-Feb-29	4.85	MTN-C	Cisco Sys Inc	225,000
PFM	26-Feb-29	4.85	MTN-C	Astrazeneca	165,000
PFM	28-Feb-29	4.25	U.S. Govt Agency	US Treasury Bill	750,000
PFM	14-Mar-29	4.70	MTN-C	Blackrock Funding	50,000
PFM	14-Mar-29	4.70	MTN-C	Blackrock Funding	220,000
Allspring	15-Mar-29	5.20	ABS	John Deere Owner	1,000,000
Allspring	15-Mar-29	5.38	ABS	Hyundai Auto Rec	1,000,000
PFM	25-Mar-29	5.18	U.S. Govt Agency	FHLMC	315,000
Allspring	31-Mar-29	4.13	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	31-Mar-29	4.13	U.S. Govt Agency	US Treasury Bill	225,000
PFM	4-Apr-29	4.80	MTN-C	Adobe Inc	225,000
Allspring	15-Apr-29	5.10	ABS	Ford CR Auto Owner	1,000,000
PFM	15-Apr-29	5.10	ABS	Ford CR Auto Owner	415,000
PFM	23-Apr-29	4.91	MTN-C	Wells Fargo co	205,000
PFM	25-Apr-29	4.73	MTN-C	American Express	245,000
PFM	9-May-29	4.62	MTN-C	Bank America Mtn	290,000
PFM	15-May-29	4.42	ABS	Hyundai Auto Rec	195,000
PFM	25-May-29	4.72	U.S. Govt Agency	FHLMC	460,000
Allspring	31-May-29	4.50	U.S. Govt Agency	US Treasury Bill	1,000,000
Allspring	15-Jun-29	5.15	MTN-C	National Rural Mtn	850,000
Allspring	20-Jun-29	5.98	ABS	Verizon Master Trust	1,000,000
Allspring	25-Jun-29	4.75	MTN-C	Home Depot Inc	500,000
PFM	25-Jun-29	4.75	MTN-C	Home Depot Inc	95,000
PFM	25-Jun-29	4.64	U.S. Govt Agency	FHLMC	200,000
PFM	30-Jun-29	3.25	U.S. Govt Agency	US Treasury Bill	2,030,000
PFM	15-Jul-29	4.76	ABS	Ford CR Auto Owner	360,000
Allspring	16-Jul-29	4.65	ABS	American Express	1,025,000
PFM	17-Jul-29	4.50	MTN-C	Pepsico inc	280,000
PFM	25-Jul-29	4.54	U.S. Govt Agency	FHLMC	515,000
PFM	25-Jul-29	4.62	U.S. Govt Agency	FHLMC	410,000
Allspring	31-Jul-29	4.00	U.S. Govt Agency	US Treasury Bill	500,000
PFM	31-Jul-29	4.00	U.S. Govt Agency	US Treasury Bill	260,000
PFM	9-Aug-29	4.55	MTN-C	Toyota Motor	195,000
PFM	14-Aug-29	4.20	MTN-C	Eli Lilly Co	65,000
PFM	16-Aug-29	4.27	ABS	GM Finl con Auto Rec	155,000
PFM	18-Aug-29	4.64	ABS	Toyota Auto	260,000
PFM	20-Aug-29	4.92	ABS	Volkswagen Auto Ln	365,000
PFM	31-Aug-29	3.63	U.S. Govt Agency	US Treasury Bill	750,000
PFM	18-Sep-29	3.80	MTN-C	Novartis Capital	365,000
PFM	21-Sep-29	4.57	ABS	Honda Auto	205,000
PFM	25-Sep-29	4.85	ABS	BMW Vehicle Owner	140,000
PFM	25-Sep-29	4.79	U.S. Govt Agency	FHLMC	345,000
Allspring	30-Sep-29	3.50	U.S. Govt Agency	US Treasury Bill	950,000
Allspring	1-Oct-29	4.35	Municipal	Los Angeles Ca	250,000
PFM	4-Oct-29	4.05	MTN-C	Accenture Capital	195,000
PFM	15-Oct-29	4.15	ABS	Honda Auto	125,000
PFM	15-Oct-29	4.45	ABS	Ford Credit Auto	445,000
Allspring	31-Oct-29	4.13	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	31-Oct-29	4.13	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	15-Nov-29	4.77	ABS	Toyota Auto	220,000
Allspring	30-Nov-29	4.13	U.S. Govt Agency	US Treasury Bill	1,700,000
Allspring	15-Dec-29	4.49	ABS	Nissan Auto Rec	500,000
PFM	17-Dec-29	4.78	ABS	Mercedes Benz Auto	255,000
Allspring	31-Dec-29	4.38	U.S. Govt Agency	US Treasury Bill	1,000,000
Allspring	31-Dec-29	4.38	U.S. Govt Agency	US Treasury Bill	1,000,000

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Allspring	17-Jan-30	4.95	MTN-C	Adobe Inc	900,000	
PFM	17-Jan-30	4.95	MTN-C	Adobe Inc	285,000	
Allspring	23-Jan-30	5.20	MTN-C	Wells Fargo co	500,000	
PFM	25-Jan-30	0.00	U.S. Govt Agency	FHLMC	205,000	
PFM	31-Jan-30	4.25	U.S. Govt Agency	US Treasury Bill	295,000	
PFM	24-Feb-30	4.75	MTN-C	Cisco Sys Inc	290,000	
PFM	28-Feb-30	4.00	U.S. Govt Agency	US Treasury Bill	160,000	
PFM	20-Mar-30	4.51	ABS	Verizon Master Trust	440,000	
PFM	31-Mar-30	4.00	U.S. Govt Agency	US Treasury Bill	700,000	
PFM	15-Apr-30	4.28	ABS	American Express	410,000	
PFM	16-Apr-30	4.66	ABS	GM Finl Consumer	95,000	
PFM	24-Apr-30	4.76	MTN-C	State Street Corp	140,000	
Allspring	28-Apr-30	4.35	MTN-C	Walmart Inc	500,000	
PFM	28-Apr-30	4.30	MTN-C	Walmart Inc	160,000	
Allspring	30-Apr-30	3.88	U.S. Govt Agency	US Treasury Bill	1,000,000	
PFM	1-May-30	4.20	MTN-C	Colgate Palmolive	180,000	
PFM	15-May-30	4.31	ABS	Bank of America	265,000	
PFM	15-May-30	4.34	ABS	WF Card Issuance	515,000	
PFM	15-May-30	4.80	MTN-C	Toyota Motor	200,000	
PFM	25-May-30	4.35	U.S. Govt Agency	FHLMC	575,000	
PFM	29-May-30	4.91	MTN-C	Citibank N A	250,000	
Allspring	31-May-30	4.00	U.S. Govt Agency	US Treasury Bill	1,000,000	
PFM	5-Jun-30	4.55	MTN-C	John Deere Mtn	285,000	
PFM	15-Jun-30	4.50	MTN-C	Analog Devices	435,000	
PFM	21-Jun-30	4.30	ABS	Citibank Credit	580,000	
PFM	25-Jun-30	4.33	U.S. Govt Agency	FHLMC	575,000	
PFM	25-Jun-30	0.00	U.S. Govt Agency	FHLMC	590,000	
Allspring	30-Jun-30	3.88	U.S. Govt Agency	US Treasury Bill	1,000,000	
PFM	30-Jun-30	3.88	U.S. Govt Agency	US Treasury Bill	540,000	
Allspring	30-Jun-30	3.88	U.S. Govt Agency	US Treasury Bill	1,000,000	
Allspring	15-Jul-30	4.16	ABS	Chase Issuance Trust	1,000,000	
PFM	15-Jul-30	4.30	ABS	American Express	330,000	
PFM	25-Jul-30	4.29	U.S. Govt Agency	FHLMC	460,000	
PFM	29-Jul-30	4.30	MTN-C	GE Aerospace	65,000	
						$ 188,768,091

	Maturity Date	Yield	Investment Type		G/L Account	Amount	Total
Self-insurance trust							
Wells Fargo Bank			Money market		110900	1,087,518	
Wells Fargo Bank			Fixed income - L/T		152300	641,555	
							1,729,073
2015A revenue bonds							
US Bank			Principal/Interest payment fund		142110	993,557	
							993,557
2015B revenue bonds							
US Bank			Principal/Interest payment fund		142110	709,401	
							709,401
							-
2017C revenue bonds							
US Bank			Principal/Interest payment fund		142110	1,812,226	
							1,812,226
2020 revenue bonds							
US Bank			Principal/Interest payment fund		142110	370,272	
							370,272
2022 revenue bonds							
US Bank			Principal/Interest payment fund		142110	830,555	
							830,555
2014 general obligation bonds							
CAMP			Interest Payment fund		152440	2,430,980	
							2,430,980
Master Reserve fund							
US Bank					142102	(422,246)	
US Bank					142103	23,411,932	
							22,989,686
Operations							
Wells Fargo Bank		0.38	Checking	100100	100100	(3,815,428)	
Wells Fargo Bank		0.38	Checking	100500	100500	52,129,850	
						48,314,421	
Payroll							
Wells Fargo Bank		0.38	Checking		100200	(126,610)	
Wells Fargo Bank		0.38	Checking	Flexible Spending	100300	662,654	
Wells Fargo Bank		0.38	Checking	Benefits	100300	39,851	
Wells Fargo Bank		0.00	Checking	HSA	100300	28,155	
						604,050	
							48,918,472
					Total investments		**$ 269,552,314**

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Sequoia Regional Cancer Center

Wells Fargo Bank	Checking	100500	(7,577)	
				$ (7,577)

Kaweah Delta Hospital Foundation

Central Valley Community Checking	Investments	100100	382,897	
Various	S/T Investments	142200	5,731,793	
Various	L/T Investments	142300	13,798,877	
Various	Unrealized G/L	142400	2,901,293	
				$ 22,814,860

Summary of board designated funds:

Plant fund:

Uncommitted plant funds		$ 120,656,196	142100	
Committed for capital		25,229,689	142100	
		145,885,885		
GO Bond reserve - L/T		1,992,658	142100	
401k Matching		15,549,254	142100	
Cost report settlement - cur	2,135,384		142104	
Cost report settlement - L/T	1,312,727		142100	
		3,448,111		
Development fund/Memorial fund		104,184	112300	
Workers compensation - cu	6,475,000		112900	
Workers compensation - L/T	15,313,000		113900	
		21,788,000		
		$ 188,768,091		

Investment summary by institution:

	Total Investments	%	Trust Accounts	Surplus Funds	%
CAMP	28,800,996	10.7%		28,800,996	12.1%
Local Agency Investment Fund (LAIF)	36,608,632	13.6%		36,608,632	15.4%
CAMP - GOB Tax Rev	2,430,980	0.9%	2,430,980	-	0.0%
Allspring	60,103,819	22.3%	1,729,073	58,374,746	24.6%
PFM	60,088,357	22.3%		60,088,357	25.3%
Western Alliance - CDARS	3,025,506			3,025,506	1.3%
Western Alliance	140,781			140,781	0.1%
Wells Fargo Bank	50,647,545	18.8%		50,647,545	21.3%
US Bank	27,705,698	10.3%	27,705,698	-	0.0%
Total investments	$ 269,552,314	100.0%	$ 31,865,752	237,686,563	100.0%

KAWEAH DELTA HEALTH CARE DISTRICT
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Investment summary of surplus funds by type:			**Investment Limitations**	
Negotiable and other certificates of deposit	$	3,025,506	71,306,000	(30%)
Checking accounts		48,918,472		
Local Agency Investment Fund (LAIF)		36,608,632	75,000,000	
CAMP		28,800,996		
Medium-term notes (corporate) (MTN-C)		30,960,000	71,306,000	(30%)
U.S. government agency		62,199,808		
Municipal securities		6,275,000		
Money market accounts		828,818	47,537,000	(20%)
Commercial paper		-	59,422,000	(25%)
Asset Backed Securties		20,069,331	47,537,000	(20%)
Supra-National Agency		-	71,306,000	(30%)
	$	237,686,563		

Return on investment:	
Current month	**3.88%**
Year-to-date	**3.88%**
Prospective	**3.05%**
LAIF (year-to-date)	**4.26%**
Budget	**4.22%**

Fair market value disclosure for the quarter ended June 30, 2025 (District only):	**Quarter-to-date**	**Year-to-date**
Difference between fair value of investments and amortized cost (balance sheet effect)	N/A	485,552
Change in unrealized gain (loss) on investments (income statement effect)	$ 894,350	4,529,081

Investment summary of CDs:		
American Plus Bank, N.A.	$	238,007
BOKF, National Association		238,007
CalPrivate Bank		238,007
Centreville Bak		238,007
Citizens Bank & Trust		238,007
City Natl Bank of Sulphur Springs		238,007
Farmer & Merchants Bank		176,797
Farmers & Merchants Bank		13,586
First Heritage Bank		238,007
First Oklahoma Bank		201,033
Homeland Federal Savings Bank		16,013
Locus Bank		238,007
Old National Bank		238,007
River City Bank		238,007
Solera National Bank		238,007
	$	3,025,506

Investment summary of asset backed securities:		
Ally Auto Rec	$	155,875
American Express		2,210,000
Bank of America		659,000
BMW Vehicle Owner		1,305,927
Capital One Prime		90,372
Carmax Auto Owner		172,194
Chase Issuance Trust		1,925,000
Citibank Credit		580,000
Daimler Trucks		206,267
Fifth Third Auto		332,140
Ford CR Auto Owner		1,911,643
Ford Credit Auto		445,000
GM Finl con Auto Rec		247,256
GM Finl Consumer		749,214
Harley Davidson		453,835
Honda Auto		612,203
Honda Auto Rec Own		19,021
Hyundai Auto		92,749
Hyundai Auto Rec		1,195,000
John Deere Owner		1,000,000
Mercedes Benz Auto		1,346,635
Nissan Auto Lease		500,000
Nissan Auto Rec		500,000
Toyota Auto		480,000
Verizon Master Trust		1,440,000
Wells Fargo Card		560,000
WF Card Issuance		515,000
Volkswagen Auto Ln		365,000
	$	20,069,331

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Investment summary of medium-term notes (corporate):		
Accenture Capital	$	195,000
Adobe Inc		1,410,000
American Express		245,000
American Express Co		445,000
American Honda Mtn		145,000
Analog Devices		435,000
Air products		295,000
Astrazeneca		165,000
Astrazeneca LP		265,000
Bank America Mtn		290,000
Bank of America		1,100,000
Bank New York Mellon Mtn		300,000
Bank New York Mtn		1,000,000
Blackrock Funding		455,000
Bp Cap Mkts Amer		310,000
Bristol Myers Squibb		200,000
Chevron USA Inc		340,000
Caterpillar Finl Mtn		1,220,000
Cisco Sys Inc		845,000
Citibank N A		1,785,000
Colgate Palmolive		180,000
Cummins INC		215,000
Eli Lilly Co		365,000
GE Aerospace		65,000
Goldman Sachs		1,475,000
Hershey Co		80,000
Home Depot Inc		815,000
Hormel Food Corp		115,000
IBM Corp		410,000
John Deere Mtn		1,105,000
Johnson Johnson Sr		80,000
JP Morgan		1,240,000
Lockheed Martin		40,000
Mastercard		130,000
Morgan Stanley		1,780,000
National Rural Mtn		1,010,000
Natixis Ny		405,000
Novartis Capital		365,000
Paccar Financial Mtn		1,155,000
Pepsico inc		280,000
Procter Gamble Co		1,300,000
State Street Corp		1,475,000
Target Corp		1,265,000
Texas Instrs		370,000
Truist Bk Sr Nt		275,000
Toyota Motor		1,925,000
Unitedhealth Group		85,000
Walmart Inc		660,000
Wells Fargo Mtn		145,000
Wells Fargo co		705,000
	$	30,960,000
Investment summary of U.S. government agency:		
Federal National Mortgage Association (FNMA)	$	2,015,719
Federal Home Loan Bank (FHLB)		525,000
Federal Home Loan Mortgage Corp (FHLMC)		10,459,089
US Treasury Bill		49,200,000
	$	62,199,808
Investment summary of municipal securities:		
Alameda Cnty Ca	$	500,000
Anaheim Ca Pub		1,000,000
California St Univ		125,000
Los Angeles Ca		660,000
Massachusetts St		1,000,000
San Diego County		1,000,000
San Francisco Ca		1,000,000
San Jose Ca Redev		400,000
San Juan Ca		190,000
Santa Cruz Ca		400,000
	$	6,275,000