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.

September 19, 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, September 24, 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.
- 4:45PM 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 September 24, 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 – ANTICIPATED LITIGATION / QUARTERLY COMPLIANCE REPORT –** Conference with legal counsel regarding potential exposure to litigation pursuant to Government Code 54956.9(d)(2); (One Case.) Matters involve compliance, risk management review, and related quality assurance issues.
3. **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

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

   Action Requested

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

   Action Requested

6. 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.

7. **APPROVAL OF THE CLOSED MEETING MINUTES** – August 27, 2025.
   Action Requested

8. **ADJOURN**

OPEN MEETING AGENDA {4:45PM}

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 2270 to Breane Tankersley in recognition as the Kaweah Health World Class Employee of the month – September 2025.

6.2. Team of the Month – CVICU

7. INTRODUCTION – New Directors

7.1. Terry Brown, Interim Director of Critical Care Services

7.2. Louise Saladino, Interim Director of Clinical Operations

7.3. Marianne Barrinuevo, Interim Director of Mental Health Services

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 September 24, 2025, Consent Calendar.

Section	Item	Description	Type
9.1. REPORTS	A	Physician Recruitment	Receive and File
	B	Monthly Throughput Report	Receive and File
	C	Overall Strategic Plan	Receive and File
	D	Urgent Care Centers	Receive and File
	E	Inpatient Medical Services	Receive and File
	F	Quarterly Compliance Report	Receive and File
	G	Rural Health Clinics	Receive and File
9.2. MINUTES	A	Human Resource Committee – August 13, 2025	Approve Minutes

	B	Audit and Compliance Committee- August 18, 2025	Approve Minutes
	C	Finance Property Services & Acquisition Committee – August 20, 2025	Approve Minutes
	D	Marketing Relations Committee Meeting- August 20, 2025	Approve Minutes
	E	Quality Council Committee – August 21, 2025	Approve Minutes
	F	Regular Open Board Meeting – August 27, 2025	Approve Minutes
9.3. POLICIES	**A**	**Administrative Policies**	
	1	AP119 Visitation Policy	Approve Revisions
	2	AP180 Weapons Brought into the District	Approve Revisions
	3	AP87 Sentinel Event and Adverse Event Response and Reporting	Approve Revisions
	6	AP160 Mobile Device and Mobile Voice and Data Services	Delete
	B	**Compliance Policies**	
	1	CP.01 Compliance Program Administration	Approve Revisions
	2	CP. 08 Governmental Payer Regulatory updates	Approve Revisions
	C	**Environment of Care Policies**	
	1	EOC 4001 Hazardous Materials and Waste Management Program	Approve Revisions
9.4. MEC	1	Privilege Form Revisions- Urology	Approve Revisions
	2	Privilege Form Revisions- Gastroenterology	Approve Revisions
	3	Privilege Form Revisions- Critical Care Pulmonary Sleep Medicine	Approve Revisions
9.5. DISTRICT			

10. **EMERGENCY DEPARTMENT QUALITY REPORT**– Presentation and discussion regarding key quality performances and action plans related to care process in the Emergency Department.

11. **PHYISICIAN CREDENTIALING PRESENTATION** – Presentation and discussion regarding the physician credentialing process, including requirements, timelines, and oversight responsibilities.

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. **STRAGEIC PLAN INITIATIVE PHYSICIAN ALIGNMENT-** Presentation and discussion regarding progress, activities, and performance measures related to the District's Strategic Plan Initiative

on Physician Alignment, including updates on physician engagement, recruitment, partnerships, and related action items.

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

15. REPORTS

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

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

CLOSED 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 2270

RESOLUTION 2270

Board Resolution Honoring
Breane Tankersley as Employee of the Month of September

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

WHEREAS, Breane Tankersley, of the Home Health Department, has consistently demonstrated exceptional commitment to their responsibilities, a strong work ethic, and a positive attitude that uplifts their team;

WHEREAS, She has made significant contributions during the month of September 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, Breane'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 Breane Tankersley as **Employee of the Month** for September 2025, and expresses its sincere appreciation for her outstanding contributions;

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

PASSED AND ADOPTED this 24th of September, 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
September 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 is traveling this month to career fairs in both New York and Phillidelpia. While on the east coast, we will be checking in with a couple different residencies programs to make introductions, drop off items, and hopefully lay the ground work for a new partnership.

Offers Extended:
1) Outpatient Pulmonologist
2) Family Medicine

Upcoming Site Visits:
1) General Surgery
2) Family Medicine - Outpatient x2
3) OB/GYN x 3
4) Gastroenterology x2
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 - Sept 2025

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

	Specialty	Group	Phase	Expected Start Date
49	Rheumatology	TBD	Applied	
50	Cardiac Anesthesia	Oak Creek	Applied	
51	Urogynecology	TBD	Applied	
52	Urogynecology	TBD	Applied	

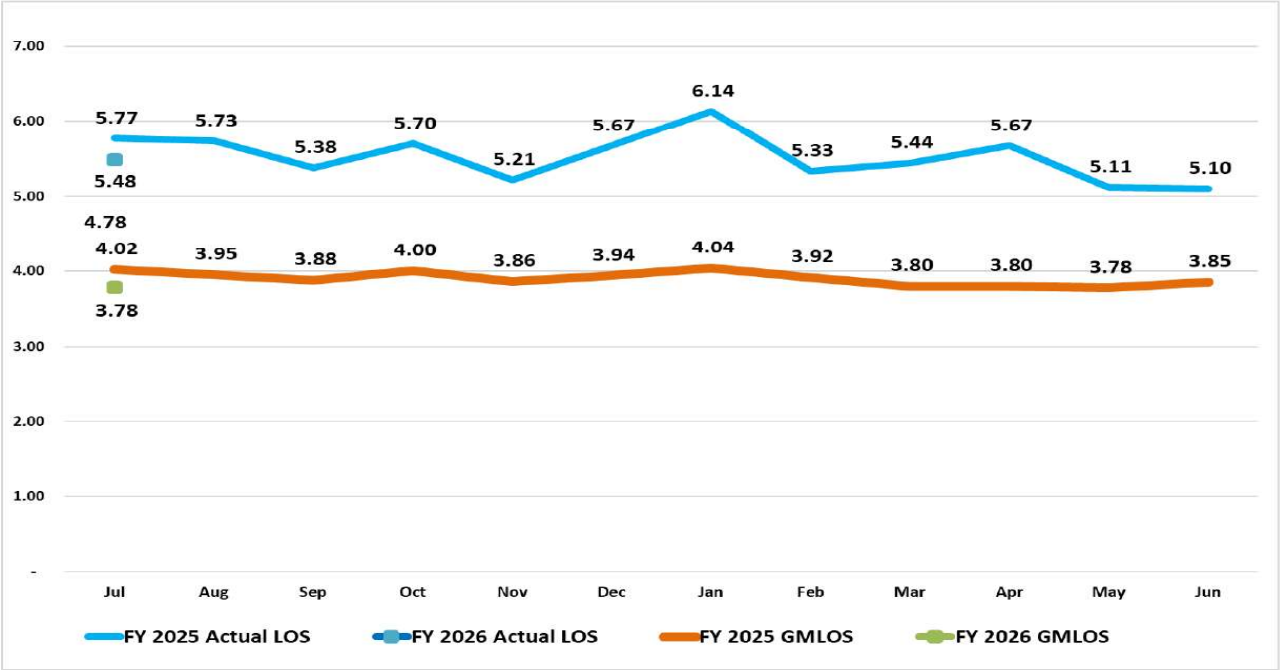
Separator Page

Monthly Throughput Report

Patient Throughput Committee

August 27, 2025

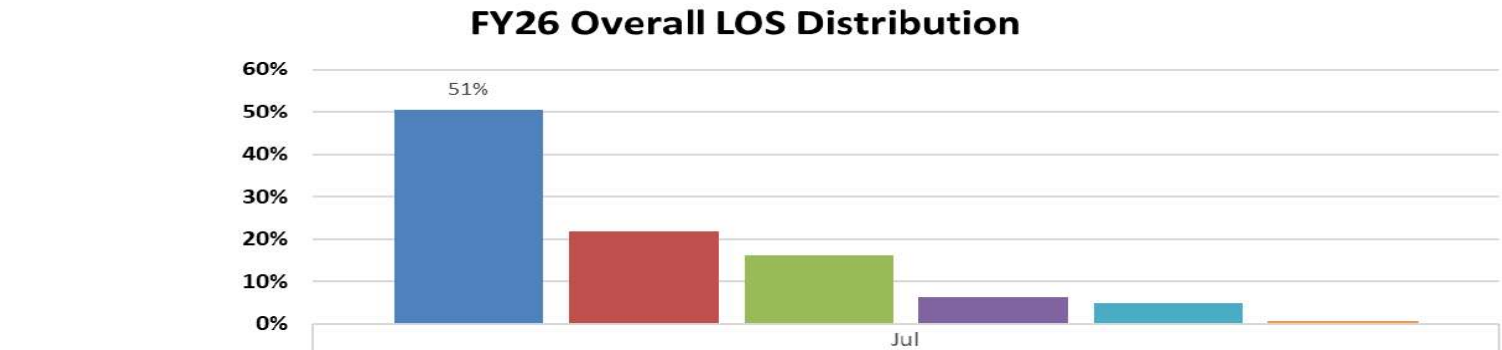
Average Length of Stay versus National Average (GMLOS)

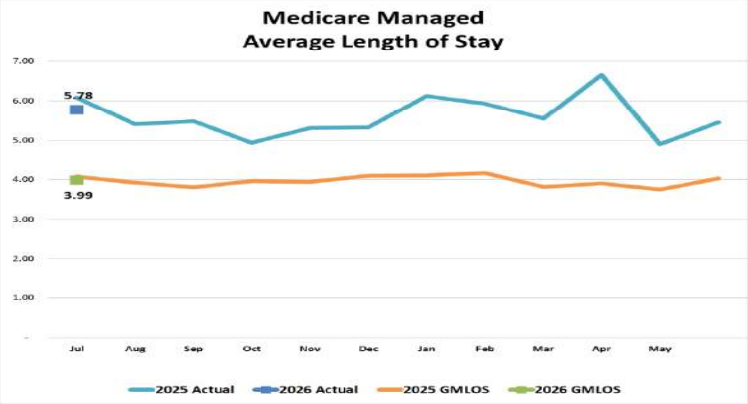


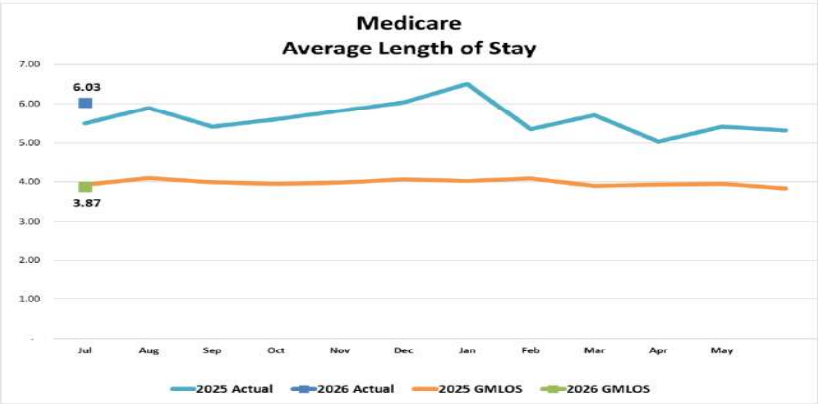
Average Length of Stay versus National Average (GMLOS)

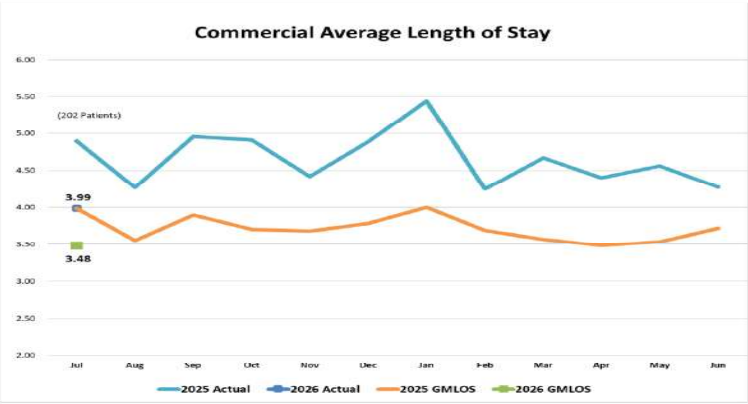
	Including COVID Patients		
	ALOS	GMLOS	GAP
Jul-23	5.50	3.84	1.66
Aug-23	5.29	3.82	1.47
Sep-23	5.46	3.95	1.51
Oct-23	5.98	3.99	1.99
Nov-23	5.81	4.06	1.75
Dec-23	5.58	3.99	1.59
Jan-24	6.10	4.10	2.00
Feb-24	5.74	4.11	1.63
Mar-24	6.06	3.93	2.13
Apr-24	5.47	3.90	1.57
May-24	6.06	3.86	2.20
Jun-24	5.66	4.04	1.62
Jul-24	5.50	4.02	1.48
Aug-24	5.29	3.95	1.34
Sep-24	5.46	3.88	1.58
Oct-24	5.98	4.00	1.98
Nov-24	5.81	3.86	1.95
Dec-24	5.58	3.94	1.65
Jan-25	6.10	4.04	2.06
Feb-25	5.74	3.92	1.83
Mar-25	6.06	3.80	2.27
Apr-25	5.47	3.80	1.67
May-25	6.06	3.78	2.28
Jun-25	5.66	3.85	1.81
Jul-25	5.48	3.78	1.70
Average	5.74	3.94	1.81

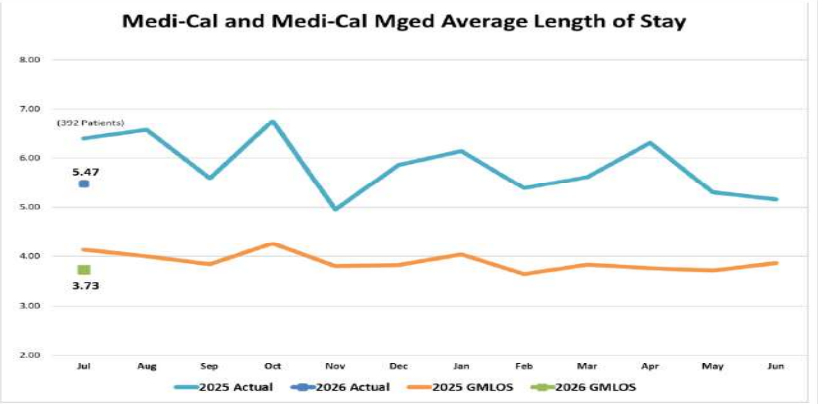
Average Length of Stay Distribution



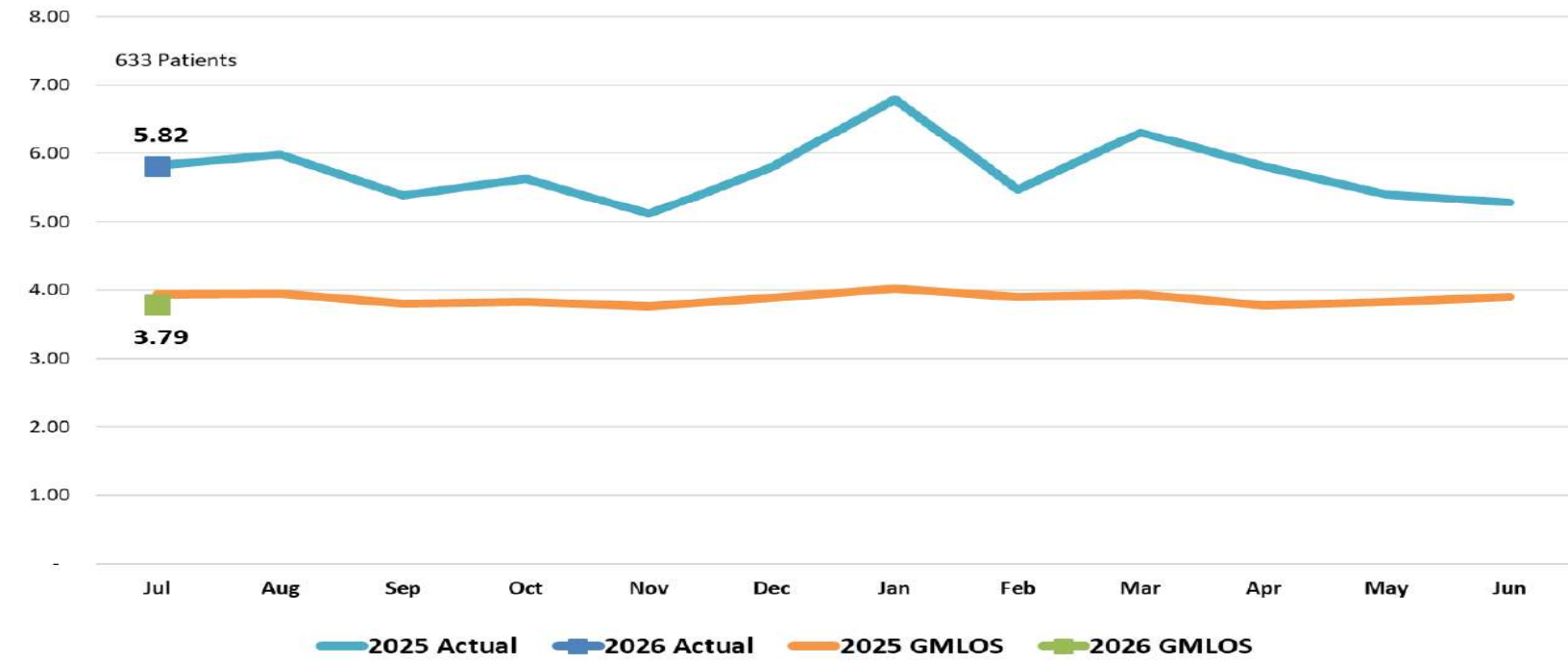

Medicare Managed
Average Length of Stay
7.00
6.00
5.00
4.00
3.00
2.00
1.00
-
5.78
3.99
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
2025 Actual
2026 Actual
2025 GMLOS
2026 GMLOS


Medicare
Average Length of Stay
7.00
6.00
5.00
4.00
3.00
2.00
1.00
-
6.03
3.87
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
2025 Actual
2026 Actual
2025 GMLOS
2026 GMLOS

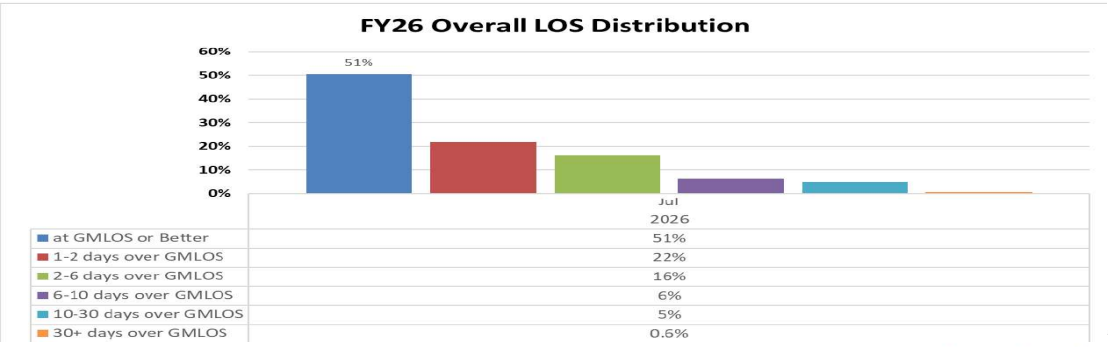

Commercial Average Length of Stay
6.00
5.50
5.00
4.50
4.00
3.50
3.00
2.50
2.00
(202 Patients)
3.99
3.48
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
2025 Actual
2026 Actual
2025 GMLOS
2026 GMLOS


Medi-Cal and Medi-Cal Mged Average Length of Stay
8.00
7.00
6.00
5.00
4.00
3.00
2.00
(392 Patients)
5.47
3.73
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
2025 Actual
2026 Actual
2025 GMLOS
2026 GMLOS

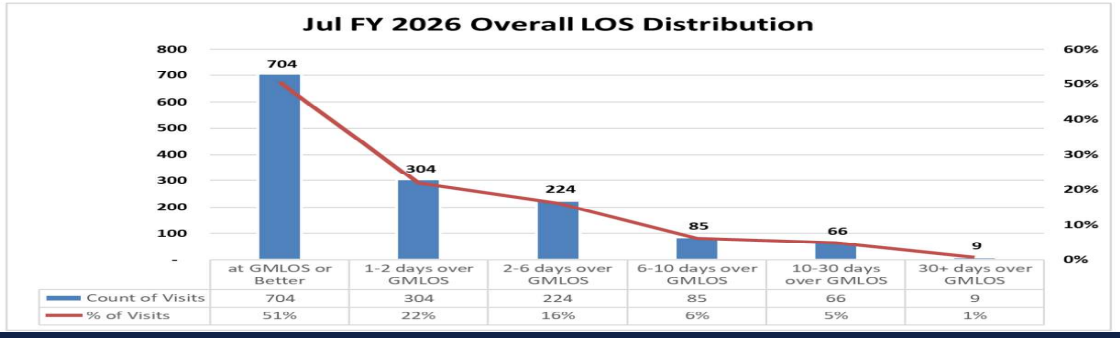
Hospitalist Average Length of Stay



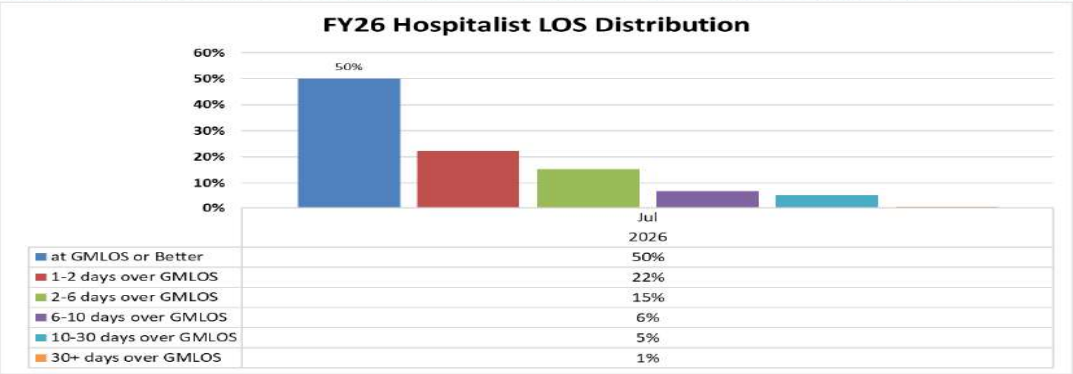
Average Length of Stay Distribution

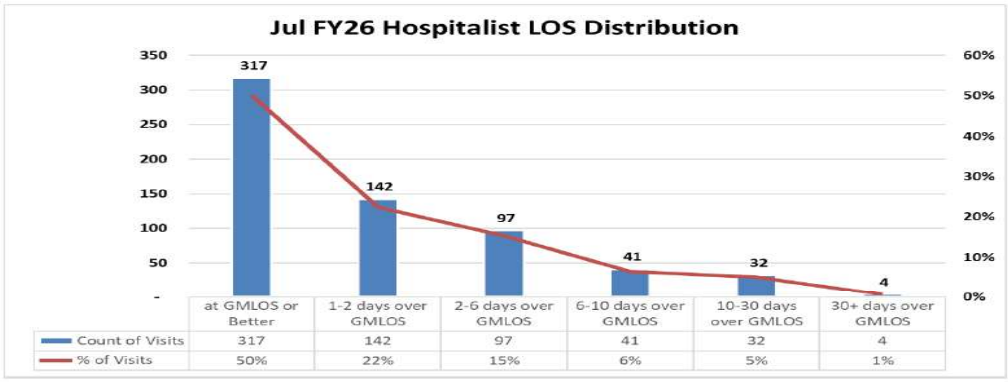


Length of Stay Distribution

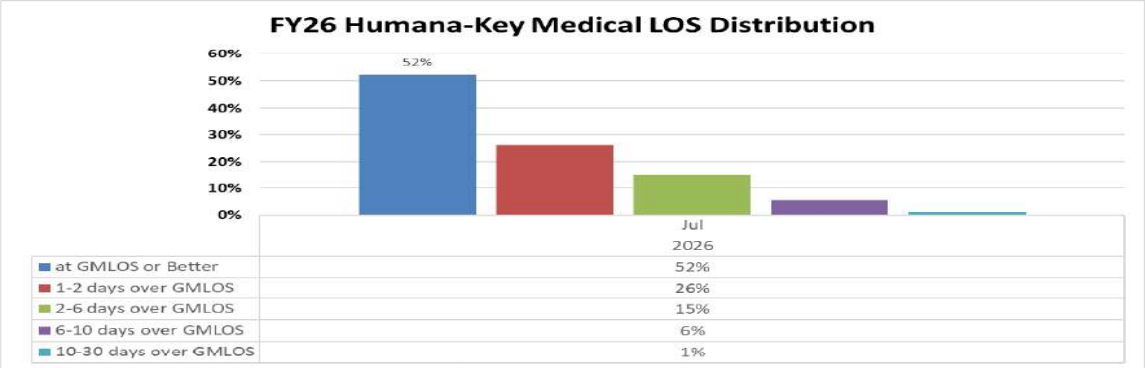


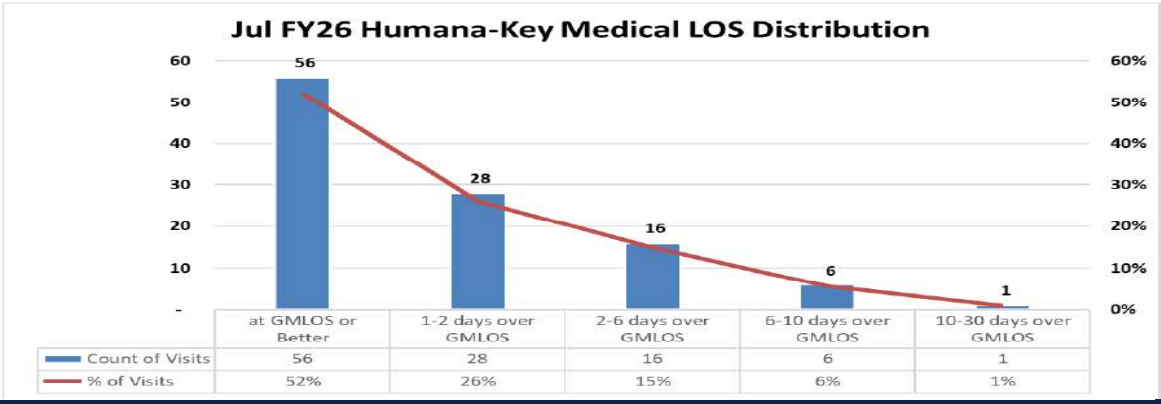
LOS Distribution



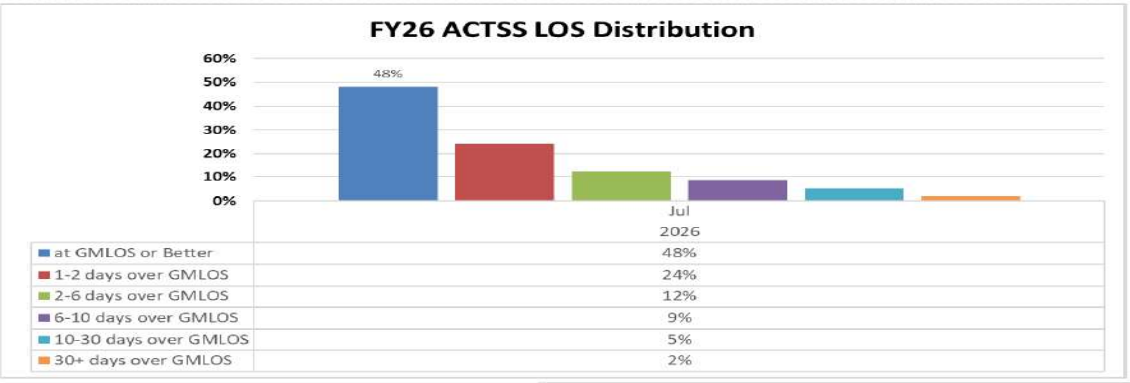


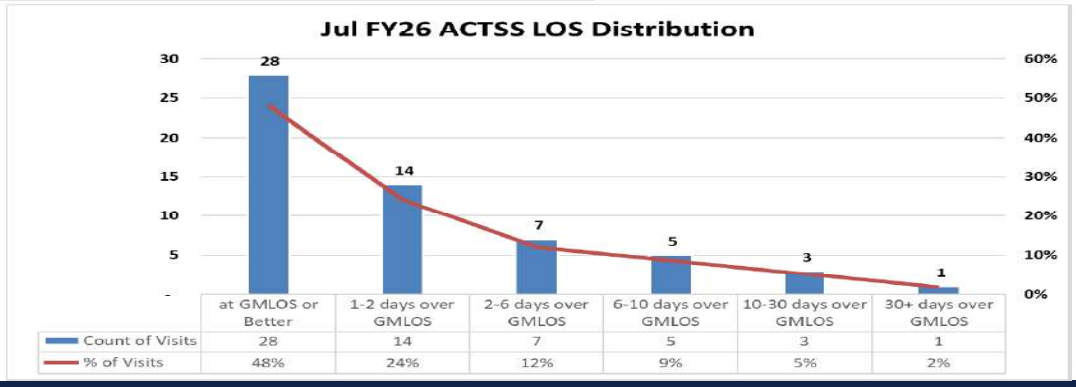
LOS Distribution

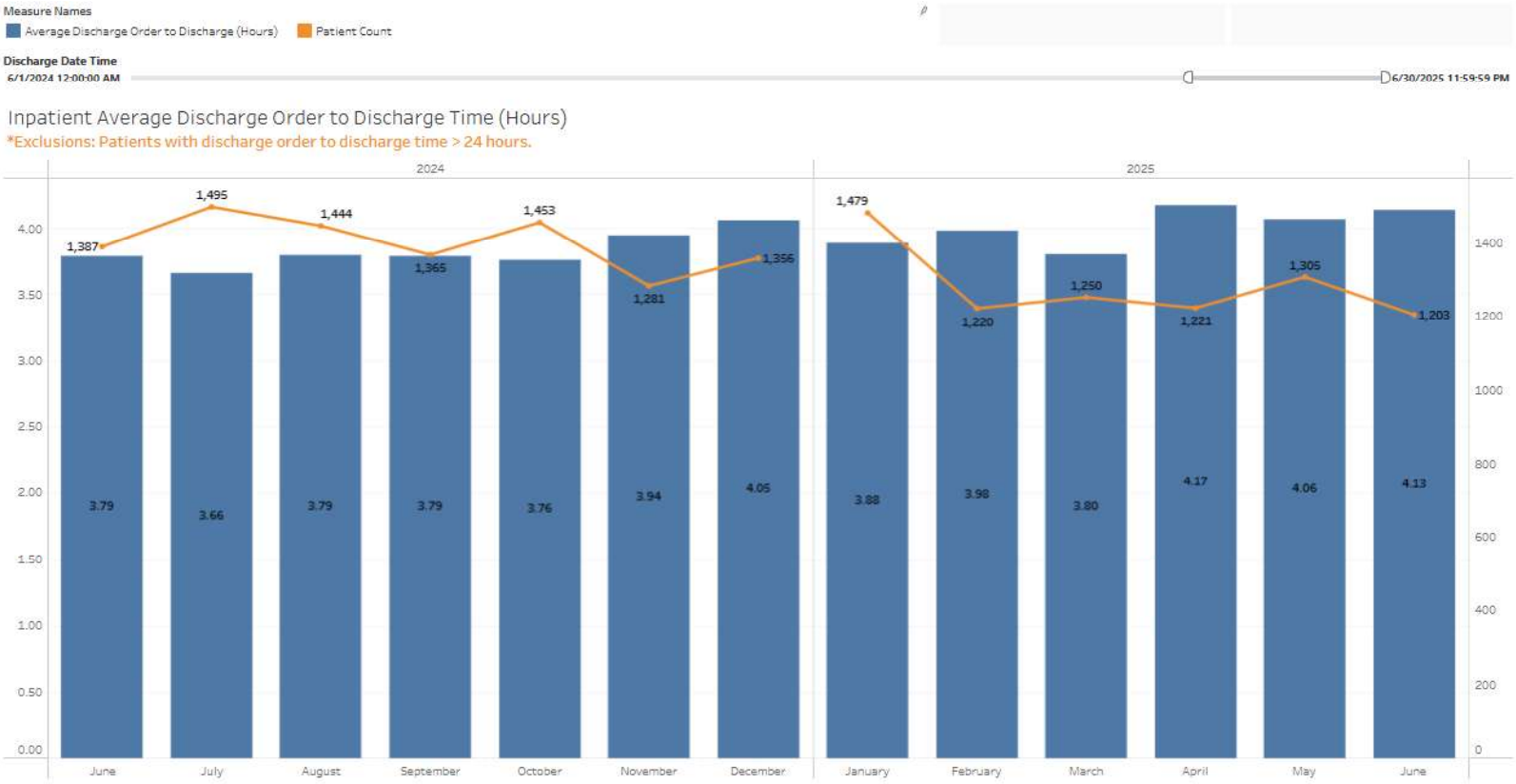




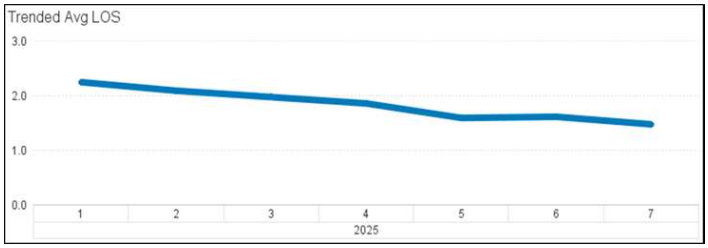
LOS Distribution






Measure Names
Average Discharge Order to Discharge (Hours)
Patient Count
Discharge Date Time
6/1/2024 12:00:00 AM
6/30/2025 11:59:59 PM
Inpatient Average Discharge Order to Discharge Time (Hours)
*Exclusions: Patients with discharge order to discharge time > 24 hours.
2024
2025
1,387
1,495
1,444
1,365
1,453
1,281
1,356
1,479
1,220
1,250
1,221
1,305
1,203
3.79
3.66
3.79
3.79
3.76
3.94
4.05
3.88
3.98
3.80
4.17
4.06
4.13
June
July
August
September
October
November
December
January
February
March
April
May
June

	2025 1	2025 2	2025 3	2025 4	2025 5	2025 6	2025 7
Admitted	215	213	209	218	238	225	189
AMA	18	21	18	20	16	18	7
Cancer / Children	0	0	1	0	1	0	0
Discharge to Court/Law Enfor	3	8	1	5	0	7	2
Expired	0	1	1	0	3	0	0
Home Hlth	54	60	68	76	67	55	54
Hospice-Home	3	1	6	5	3	5	3
Inter Care Fac	2	5	3	3	4	2	2
LDT	3	1	0	1	1	0	2
Oth Hosp	2	0	1	0	1	1	0
Oth Rehab	1	5	4	0	2	2	4
Psych Hosp/Unit	2	3	3	3	4	3	4
Routine	363	380	383	458	362	384	355
SNF	19	16	21	22	20	25	17
Sum:	**685**	**714**	**719**	**811**	**722**	**727**	**639**



ED Patient Flow

Scott Baker

Problem / Goals & Objectives / Metrics	Critical Issues / Barriers
Problem Statement: The Emergency Department is experiencing challenges in optimizing patient flow, leading to prolonged waiting times and potentially impacting patient experience. This is evidenced by: • Increased length of stay (LOS) for both discharged and admitted patients, suggesting inefficiencies in patient processing. • High ED occupancy rates, contributing to overcrowding, unsafe situations and further delays. These factors necessitate a comprehensive analysis and improvement of patient flow processes to reduce waiting times and enhance the overall patient experience within the Emergency Department. Goals and Objectives: To optimize patient flow within the Emergency Department to ensure timely, efficient, and high-quality care, resulting in improved patient experience and outcomes. Metrics: Decrease door-to-provider times, Reduce median door to discharge patients, LWBS rates to less than 1% monthly, EMS Wall Time, On target / not yet started (not due); delay/slight concern; off target/serious concerns	Critical Issues (e.g. Barriers): **Overcrowding:** The ED's demand exceeds its capacity to provide care. **Inpatient Bed Boarding:** Admitted patients are held in the ED for extended periods while waiting for an inpatient bed. – **June & July we've seen lower inpatient holds in the department – still challenges with Psychiatric holds** **Staffing Challenges:** Inadequate staffing levels or inappropriate staff mix **Staffing is improving – New Budget and Staffing Plan currently being assessed. Working on Traveler Reduction strategies.** **Patient Flow Bottlenecks:** Delays at various points in the patient's journe through the ED. **Current Metrics:** Median Door to Discharge – 300 minutes in December 2024, 295 minutes in January 2025, 271 minutes in February and 257 minutes in March, **259 minutes in July** LWBS – 2.5% in December 2024, 2% in January 2025, 0.8% in Februar 2025 and 0.6% in March 2025, **0.8% July** Door to Provider time – 22 minutes December 2024, 8 minutes February 2025 and 7 minutes in March 2025, **9 minutes July**
,	Deliverables: • Regular Performance Dashboards: Ongoing reports visualizing key metrics and progress towards goals. (Dashboards are being created in Healthy Analytics)

ED Stroke Care Improvements

Denice Cabeje

Problem / Goals & Objectives / Metrics	Critical Issues / Barriers
Problem Statement: The Emergency Department is experiencing critical delays in the timely recognition, diagnosis, and transfer of stroke patients, which directly impacts patient outcomes. Current processes are failing to meet key national and hospital-specific benchmarks, with a particular weakness in front-end activation and interdepartmental handoffs. This is evidenced by a median Door-to-Stroke Alert time of 15 minutes (target ≤ 10 min) and significant delays in transfer for both hemorrhagic (297 min vs. target ≤ 120 min) and Large Vessel Occlusion (LVO) stroke patients (162 min vs. target ≤ 120 min). These delays compromise the efficacy of time-sensitive interventions like IV thrombolytics and lead to a suboptimal patient care pathway, increasing the risk of disability and mortality. Critical Issues and Barriers Front-End Triage Recognition: Delays in initial recognition and activation of a Stroke Alert often occur at the front-end triage area. This may be due to staff inexperience with subtle stroke presentations or a lack of immediate, standardized tools for screening and escalation. Interdepartmental Communication Gaps: Inefficient communication with ancillary services (e.g., radiology) and inpatient teams contributes to delays in critical diagnostic and transfer processes. Process Inconsistency: The low ED Provider Power Plan usage (86% vs. target 95%) suggests a lack of consistent adherence to a standardized stroke care pathway, leading to variability in care and delayed interventions. Resource Bottlenecks: Delays in transfer for hemorrhagic and LVO stroke patients may be due to resource constraints, including transfer logistics, bed availability at destination hospitals, or delays in consultation with specialty services. Staff Knowledge Deficits: While dysphagia screening compliance is at the target of 80%, there may be opportunities for staff to improve their skills in recognizing and responding to stroke symptoms, which is contributing to the delay in Door-to-Stroke Alert times. Goals, Objectives, and Metrics Overall Goal: To optimize the stroke care pathway in the Emergency Department, ensuring rapid and efficient diagnosis, treatment, and transfer of stroke patients.	Feedback Loop: A multi-disciplinary stroke committee will meet bi-weekly to review all Stroke Alert cases (already in progress) Audits of patient charts will be conducted to identify delays and documentation gaps by the Stroke Manager. Frontline staff and providers will be encouraged to provide real-time feedback through a dedicated communication channel or during daily huddles. 3. Measures for Success: The primary measures for success will be the achievement of the target times for Door-to-Stroke Alert, Door-to-CT Scan, and Door-to-Transfer for all stroke patients. Secondary measures will include compliance with Power Plan usage and a sustained 80% or greater compliance rate for dysphagia screening. 4. Communication Plan: A department-wide email will be sent outlining the stroke protocol and its importance. Changes will be reinforced during daily ED huddles and monthly staff meetings.
	Deliverables: 77/429 • Regular Performance Dashboards: Ongoing reports visualizing

Patient Progression

Denice Cabeje

Problem / Goals & Objectives / Metrics

Problem Statement: between January 1 – August 31, 2021, observed-to-expected length of stay (O/E LOS) was 1.44 and discharges before noon were well below the organizational goal of 25%, which led to higher than optimal occupancy rates, a large volume of ED holds (census of upwards to 20-40 per day) and limited bed availability for elective surgical cases or external transfers

Goals and Objectives: clarify care team roles and responsibilities; streamline and standardized multidisciplinary huddles to support advanced discharge planning and discharge before noon goal

Metrics: DC before noon baseline and goals >25% of DC total. O/E LOS and goals <1.44. ED hold volumes baseline and goals <20.

Critical Issues / Barriers

Critical Issues (e.g. Barriers): staffing challenges; alignment of staff incentives and organizational goals

Deliverables:

- Clarify / update job descriptions and streamline corresponding workflows to allow Case Managers to operate at top of license
- Interdisciplinary structure standard for daily care facilitation, discharge planning and corresponding training tools
- Transparent anticipated discharge date for all care team and ancillary team members

Plan

(brief desciption of tasks, consider feedback loop, measures for success & communication plan)

#	Milestones	Start Date	Due Date	Who	Status R/Y/G
1	M/S units need a best practice robust multi discipline rounding process. Discuss PI, QI, safety, DC date, delay in care. Nursing, Pharmacy, Therapies, Physicians, Dietitians, CM, etc. Dr Said believes we can go to Zone Rounding by Sept 1st. Increase DC by noon	TBD	09/01/2025	M//S Leadership/Denice/Dr Said	
2	CM utilizing Delay of Care tabs to create worklist and actionable data. Decrease O/E LOS Need to run reports and track trends	01/27/25	09/01/2025	Denice/TS	
3	"Social Admit" pts are transitioned to a bed at 24 hours or less. OBS re-assessed by 18 hours in ED and OBS criteria clarified. Delays in Care by modality per hour. DC before noon. Failed discharges. Timely repatriations. Decrease ED Hold volumes.	04/13/25	05/01/2025	Denice/TS/ED CM/Bed Allocation/ED Physicians/Hospitalists	

On target / not yet started (not due); delay/slight concern; off target/serious concerns

Accomplishments / Next Steps

Accomplishments:

- Discharge Lounge- On Hold
- Have CM staff continuing to use Delays tab.
- Hospitalists agreed to write OBS orders for "Social Admits"
- ED CM positions posted, Lora working now, now will start training the RN ED-CM

Next Steps:

- **Had initial meeting with Pharm, Therapies and Dietitians to establish IDT Rounds processes**
- **Change back to Zone Coverage for consistent rounding times/processes.**
- **Consistent use of Delay in Care Tab=actionable data.**
- **ED CM permanent staff, trained on Best Practice processes in ED to Inpt flow.**

LOS by DC Dispo

Denice Cabeje

Problem / Goals & Objectives / Metrics

Problem Statement: Post Acute Discharge dispositions are all unique, each disposition brings its own challenges. Baseline data Post Acute DC accounts for 36% of total, with average LOS of 19.8 Days (Home=54% @ 2.9 LOS)

Goals and Objectives: Break down the LOS by disposition so we can create streamlined processes for each unique DC disposition.

Metrics: Dc Home w/HH, SNF, Rehab, Hospice, Acute Hospital, Assis Living/B &C, Psych Hospital, Sub-Acute, LTC

Critical Issues / Barriers

Critical Issues (e.g. Barriers): Clear and concise communication of next steps, streamlining processes between CM and PACPs. Using technology to our advantage

Deliverables:

- Process analysis, identifying challenges and discrepancies and remedying issues.
- PDSA-Plan-Do-Study-Act evaluate then pivot if needed.

Plan

(brief desciption of tasks, consider feedback loop, measures for success & communication plan)

#	Milestones	Start Date	Due Date	Who	Status R/Y/G
1	PACPs meetings discuss re-admissions, communication and DC processes that impact safe and timely transitions. Mitigating plans for decrease of each	March 25	Sept 25	Denice	🔴
2	Continue working with Molly, Kari M and Tiffany for our own PAC discharge LOS and processes for safe and timely transitions	Dec 2024	July 25	Denice	🟡
3	Working with CC services for quicker GOC discussions with families, timely decisions for transitions of care steps	April 25	Oct 25	Denice	🔴

On target / not yet started (not due); delay/slight concern; off target/serious concerns

Accomplishments / Next Steps

Accomplishments:

- PACPs meetings with great communication of challenges during meeting. Need to expand exchange of data.
- Setting expectations for Ensocare response time and reasons for denial
- Auth Nurse working directly with PACPs on timely auths for DC.
- Assist living and B/C transitioned to Complex Care quicker

Next Steps:

- **CM becoming more fluid at identifying needs for secondary ins before it is needed.**
- **Post Acute Care Partners-PACPs meetings more meaningful. Expectations set for Ensocare response times and auth times. We are weeding through Payers and average auth times for them for baseline data to use for goals to improve.**
- **Action for Improvement of auth time is to have our own dedicated Auth Nurse.**
- **Work through processes with Kaweah Rehab for referrals and acceptance times. Rehab had 118 DC in one quarter and had an average LOS of 11 days. Starting work with Molly-Rehab and Tiffany-Home Health, for efficient processes for discharges.**
- **Assist Living/Board & Care-These are primarily homeless or TBI patients. They are difficult placements. Complex Care will continue to work with PFS on these patients, we will transition**

Discharges Delineated by Disposition

FY25 Discharge Disposition	Qtr1 Fy25	Qtr2 Fy25	Qtr3 Fy25	Qtr4 Fy25	Avg LOS FY25
DC to Home (Routine)	2.9	2.9	3	2.8	2.90
DC/Trans to Home w/Home Health	5.5	5.5	5.7	4.9	5.40
DC/Trans to SNF	8.8	7.7	9.1	8.4	8.50
DC/Trans to Rehab	11	8.7	9.6	10.2	9.88
DC/Trans to Home w/Hospice	7.6	8.8	6.6	7.2	7.55
DC/Trans to Other Acute Hospital	8.5	7.4	7.2	5.7	7.20
DC/Trans to Assisted Living or Board and Care	12	4.4	8.3	25.6	12.58
DC/Trans to Psych Hospital or Unit	8.8	4.6	13.3	3.4	7.53
DC/Trans to LTC Hospital	76	47.7	52	48	55.93
DC/Trans to Sub Acute	73	21.9	15.9	25.7	34.13
Total Avg LOS of PACP dispo	21.41	11.96	13.07	14.19	15.16

FY25 Baseline

New FY26 Baseline

Update	Next Steps
Accomplishments: • 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. • EMS Wall Times – Currently 40 minutes on a goal of 45 minutes or less – challenge is with multiple agencies. We are only able to capture 60% of the EMS metrics – work in progress. • We have improved our metrics for this plan and will move to focusing on our Stroke, EGC and Sepsis times as our new process improvement project.	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)* Deliverables: • Regular Performance Dashboards: Ongoing reports visualizing key metrics and progress towards goals. (Dashboards are being created in Healthy Analytics) • Standard Operating Procedures (SOPs): Updated or new SOPs documenting the steps and protocols for the redesigned processes • Performance Improvement Plans: Documents outlining specific strategies and timelines for addressing any persistent challenges or areas needing further optimization.

Observations:
No updates to report as the department has transitioned to new leadership.

Next Meeting:

Wednesday, Sept 24, 2025
2:00p-3:30p
4T Multipurpose Room/GoTo

Separator Page

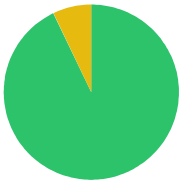
Overall Strategic Plan

FY 2026 Strategic Plan

Physician Alignment
Sept 24, 2025

Physician Alignment - Ryan Gates and JC Palermo

All Items



On Track 13 (93%)
Off Track 1 (7%)

Spotlight Items

Name	Aligns To	Status	Spotlight Comment
Recruit 15 Specialty Providers	Recruit Physicians and Advanced Practice Providers	On Track	In the first two months of the year we have signed four specialty physicians, including the second member of the Cardiothoracic surgery team.
Promote Kaweah Health services and the physicians that support them	Develop and Provide Practice Support for Physicians	On Track	With the advent of two new treatment modalities (EBUS and ION), pulmonologist, Dr. Gribben, has started providing life saving care to patients who otherwise would have to wait months to receive care outside of our market. This represents one element of a comprehensive lung cancer screening program at Kaweah Health which involves collaboration with multiple specialties.

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

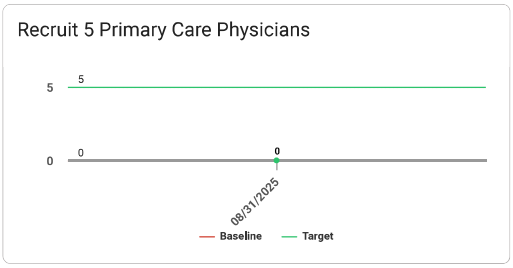
Description: *Refine and execute strategies for recruitment and retention of physicians and Advanced Practice Providers.*

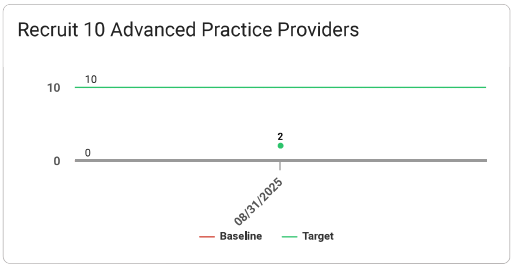
Work Plan (Tactics)

#	Name	Start Date	Due Date	Assigned To	Status	Last Comment
5.1.1	Beginning early in their residencies, educate and build partnerships with Central Valley medical residents related to practice opportunities and recruitment packages	07/01/2025	06/30/2026	JC Palermo	On Track	The physician recruitment team has been meeting with Kaweah Health GME leadership to brainstorm and better understand the opportunities for resident recruitment and retention. We are also reaching out to residency programs in the central valley to discuss partnership opportunities. We will be attending the UCSF Fresno Family Medicine Career Fair in October of 2025.
5.1.2	Continue to work directly with Key Medical Group, local physicians and other medical groups to assist in recruitment and placement of new physicians and APPs and explore strategies for long-term practice sustainability and growth	07/01/2025	06/30/2026	JC Palermo	On Track	We are in discussions with multiple local practices to assist with the recruitment of additional physicians. We have also just finalized a contract with a recent Kaweah Health Resident Graduate to join Key Medical Group to provide care to our community.
5.1.3	Continue efforts of the Physician Recruitment and Retention Strategy Committee to understand and refine physician recruitment needs, fair market value and physician and APP retention strategies	07/01/2025	06/30/2026	JC Palermo	On Track	The committee meets monthly to discuss recruitment strategy and how we can best utilize our available resources to support the community. We also regularly discuss our processes and procedures to ensure they are sound and position the committee to make objective and fair decisions.

Performance Measure (Outcomes)

#	Name	Start Date	Due Date	Assigned To	Status	Last Comment
5.1.4	Recruit 5 Primary Care Physicians	07/01/2025	06/30/2026	JC Palermo	On Track	We have an offer out to 1 physician, a site visit scheduled with 1 physician, and in the early stages of recruitment with 6 other candidates.
5.1.5	Recruit 15 Specialty Providers	07/01/2025	06/30/2026	JC Palermo	On Track	FYTD we have recruited: 1 Cardiothoracic Surgeon, 1 Intensivist, 1 Anesthesiologist, 1 Neonatologist.
5.1.6	Recruit 10 Advanced Practice Providers	07/01/2025	06/30/2026	JC Palermo	On Track	FYTD we have recruited: 1 Nurse Practitioner, 1 Certified Nursing Midwife





Develop Practice Support for Physicians Champions: Ryan Gates and JC Palermo

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

Work Plan (Tactics)

#	Name	Start Date	Due Date	Assigned To	Status	Last Comment
5.2.1	Support physicians and their respective medical groups by offering management services organization (MSO) services to alleviate the administrative burden and enable them to focus on patient care activities	07/01/2025	06/30/2026	Ryan Gates	Off Track	Identified vendor is unable to deliver the services requested. A qualified alternative has been identified and we are aggressively pursuing a partnership.
5.2.2	Promote Kaweah Health services and the physicians that support them	07/01/2025	06/30/2026	Ryan Gates	On Track	Significant work to implement lung cancer screening program with CME dinner and KSEE 24 news broadcast scheduled for November.

Physician Alignment through Integrated Delivery Network Champions: Ryan Gates and JC Palermo

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

Work Plan (Tactics)

#	Name	Start Date	Due Date	Assigned To	Status	Last Comment
5.3.1	Continue physician alignment efforts through our joint venture with Key Medical Group, Tulare-Kings Foundation for Medical Care and Sierra View Local Healthcare District (i.e. Sequoia Integrated Health) to contract with payers to become the provider network of choice	07/01/2025	06/30/2026	Ryan Gates	On Track	Ongoing meetings related to strategy, medical office locations and new contracting models for Kaweah primary care providers.
5.3.2	Work with providers to design and implement care models and invest in resources that improve quality outcomes, patient experience and decrease cost	07/01/2025	06/30/2026	Ryan Gates	On Track	Continue to expand NRC, patient satisfaction tool, throughout the clinic network. Intergration of RN navigators into cancer care programs. Continued investment in technology to empanel patients.
5.3.3	Invest in resources and infrastructure that supports physician practices and the management of their attributed, capitated or empaneled patients	07/01/2025	06/30/2026	Ryan Gates	On Track	Construction on the Kaweah Health Medical Clinic - Akers is complete and awaiting licensure. Expected go live for November 1, 2025.

FY 2026 Strategic Plan

Monthly Performance Report
Sept 24, 2025

Kaweah Health Strategic Plan: Fiscal Year 2026

Our Mission

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

Our Vision

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

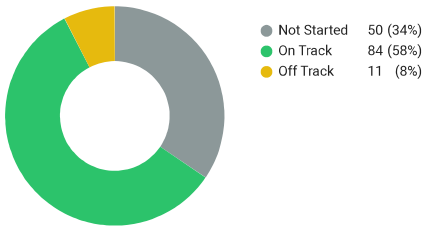
Our Pillars

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

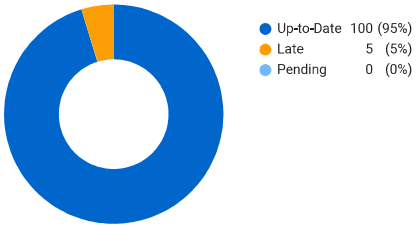
Our Five Strategic Plan Initiatives

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

Kaweah Health Strategic Plan FY2026 Overview: Status



Kaweah Health Strategic Plan FY2026 Overview: Updates



Ideal Environment

Champions: Dianne Cox and Hannah Mitchell

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

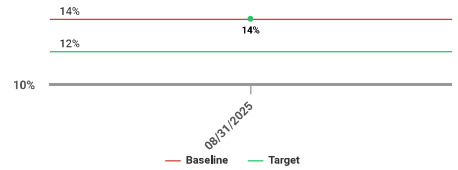
FY2026 Strategic Plan - Ideal Environment Strategies

#	Name	Description	Status	Assigned To	Last Comment
1.1	Integrate Kaweah Care Culture	Integrate Kaweah Care culture into the various aspects of the organization.	On Track	Dianne Cox	The Executive Team and Directors of Organizational Development, Patient and Community Experience, Marketing, Medical Staff and GME meet on a monthly basis to further projects and initiatives surrounding the culture. Details are presented at the Board sub-committees for Patient Experience and Human Resources. The outcomes will be measured by the performance of our Employee and Physician engagement surveys in June 2026.
1.2	Ideal Practice Environment	Ensure a practice environment that is friendly and engaging for providers, free of practice barriers.	On Track	Dianne Cox	There continues to be progress on new space for students/residents and computer access for all providers, a refurbished medical staff lounge, updated female surgery lounge, and a number of Cerner enhancements and efficiencies.
1.3	Growth in Nursing School Partnerships	Increase the pool of local RN candidates with the local schools to increase RN cohort seats and increase growth and development opportunities for Kaweah Health Employees	On Track	Dianne Cox	Our sixth cohort of 25 employees started in the Unitek program. We currently have about 145 employees participating, with three cohorts graduating in 2026. Successful partnerships continue with COS, SJVC, Porterville College, Fresno City College and Gurnick.

Employee Engagement Survey Score Greater Than 4.22%

Physician and APP Engagement Survey Score Greater Than 3.85%

Decrease Overall Turnover Rate



Strategic Growth and Innovation

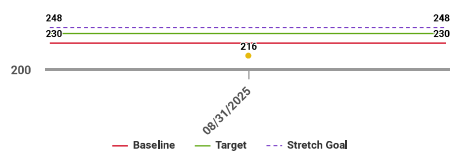
Champions: Marc Mertz and Kevin Bartel

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

FY2026 Strategic Plan - Strategic Growth and Innovation Strategies

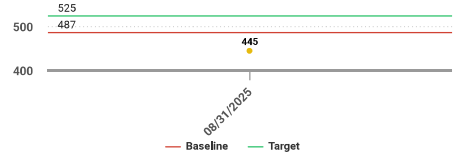
#	Name	Description	Status	Assigned To	Last Comment
2.1	Grow Targeted Service Line Volumes	Grow volumes in key service lines, including Orthopedics, Endoscopy, Urology and Cardio Thoracic services.	Off Track	Kevin Bartel	Orthopedic, Endoscopy and CTS volume goals all did not meet the target set for August. Vacations taken by surgeons in orthopedics and endoscopy areas directly impacted the total volume for the month.
2.2	Enhance Medical Center Capacity and Efficiency	Enhance existing spaces to grow capacity for additional and expanded services and focus on operational efficiency within the surgery areas.	On Track	Kevin Morrison	Projects to enhance the operational efficiency within the surgery areas are in various stages of design and permit approval.
2.3	Expand access for patients though Clinic Network Development	Strategically expand and enhance the existing ambulatory network to increase access at convenient locations for the community.	On Track	Ivan Jara	Outpatient clinic access continues to grow through the development of new locations and services and through the expansion of current services. Current efforts include physician recruitment (Primary and Specialty Care), advanced practice provider recruitment, new clinic locations (Specialty, Rural, and Commercial), and federal/state programs and grants.
2.4	Innovation	Implement and optimize new tools and applications to improve the patient experience, communication, and outcomes.	On Track	Kevin Bartel	The majority of the innovation plan elements are set to a quarterly update cycle (next updates will come in October), so this summary update will have more context at next month's update.
2.5	Enhance Health Plan Programs	Improve relationships with health plans and community partners and participate in local/state/federal programs and funding opportunities to improve overall outcomes for the community.	On Track	Sonia Duran-Aguilar	Monthly meetings take place with Medi-Cal Managed Care Health Plans (Anthem BC and HealthNet) to foster strong working relationships that result in revenue generating programs and grant funding. Collaboration with these plans span across several projects to include CalAIM Enhanced Care Management (ECM), CalAIM Community Supports (CS), Equity Practice Transformation (EPT) and MOVES grant (funded by Centene Foundation).

Perform 241 Orthopedic Surgery Cases Per Month



Perform 450 Endoscopy Cases Per Month

Increase Enrollment to 640 Lives in Enhanced Care Management



Outstanding Health Outcomes

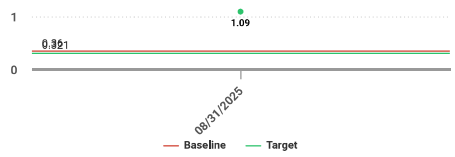
Champions: Dr. Paul Stefanacci and Sandy Volchko

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

FY2026 Strategic Plan - Outstanding Health Outcomes Strategies

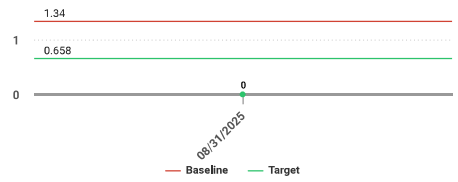
#	Name	Description	Status	Assigned To	Last Comment
3.1	Safety Program Enhancement	Improve the Patient Safety Program through enhanced proactive evidence based strategies.	On Track	Sandy Volchko	ACA training for Leadership 6/9/25; tracking and ongoing training under discussion as next steps. Serious Safety Event rate (SSER) numerator and denominator defined, monthly calculations reported into Quality Committees starting August 2025
3.2	Reduce Hospital Acquired Infections (HAI)	Reduce the Hospital Acquired Infections (HAIs) to the selected national percentile in FY26 as reported by the Centers for Medicare and Medicaid Services.	On Track	Sandy Volchko	Daily device rounds in place, significantly reducing utilization rates for lines. Enhanced leadership support for hand hygiene though BioVigil vendor.
3.3	Reduce Surgical Complications	Reduce the Patient Safety Indicator (PSI) 90 composite rate to the selected national percentile in FY26 as reported by the Centers for Medicare and Medicaid Services.	On Track	Sandy Volchko	Data analysis completed on individual measures included in PSI90 to identify targeted opportunities and evaluate evidenced based practices to impact outcomes. Concurrent individual case review process in place to identify opportunities and trends, analyze and act to address.

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



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

SIR MRSA FYTD </=.0658



Patient Experience and Community Engagement

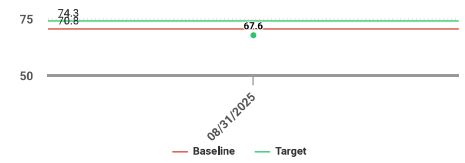
Champions: Marc Mertz and Deborah Volosin

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

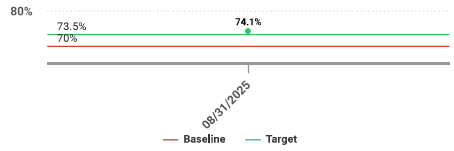
FY2026 Strategic Plan - Patient Experience and Community Engagement Strategies

#	Name	Description	Status	Assigned To	Last Comment
4.1	Empowering Leaders to Enhance Patient Experience	To improve patient experience, it is essential to cultivate a leadership culture that prioritizes patient-centered care. This strategy focuses on equipping leaders at all levels with the necessary skills, tools, and authority to drive meaningful improvements in patient interactions, service delivery, and overall satisfaction.	On Track	Deborah Volosin	We have spent the last several months educating and meeting with all leaders in inpatient areas to ensure they understand the scores, the NRC tool, and the importance of service recovery. We are sharing the organization's scores with the entire leadership team and sharing patient feedback to continue to push the importance of the patient's experience at every interaction.
4.2	Fostering a Culture of Empathy and Human Understanding	Creating a culture of empathy and human-centered care is essential for enhancing patient experience and community trust.	On Track	Deborah Volosin	Patient Experience has focused on the message of compassionate communication for several months and has highlighted the Human Understanding score for the organization. Since it is an area of focus on the survey and a national initiative, it is imperative that we continue to keep compassion at top-of-mind for all employees. Compassion to co-workers and teams is very important if we expect our teams to in-turn provide that to patients and families.
4.3	Transforming the Patient Environment for a Better Experience	A well-designed and patient-friendly physical environment plays a critical role in patient experience and overall well-being. This strategy focuses on improving the hospital's physical spaces to promote comfort, accessibility, and a sense of healing	On Track	Deborah Volosin	Rounding with our Facilities, EVS, and Patient Experience teams is helping to pinpoint areas that need updating and refurbishment. From entrance to discharge – our patients and families should experience clean and well-maintained facilities.
4.4	Strengthening Community Engagement	Building strong relationships with the community is essential for fostering trust, improving health outcomes, and increasing access to care. This strategy focuses on actively engaging with community members through outreach programs, partnerships, and educational initiatives.	On Track	Deborah Volosin	We continue to meet with our CAC's on a monthly basis and include them in decisions regarding patient and family care. We also continue to sponsor community events and have representatives in attendance to increase our community's awareness of our services.
4.5	Adopting a Patient-Centered Approach to the Entire Healthcare Experience		On Track	Deborah Volosin	We are focused on making sure that patients and their families have a good experience across the continuum of care.

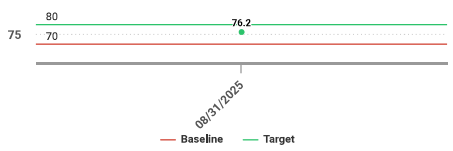
Achieve a score of 74.3 in HCAHPS Overall Rating



Achieve an Organizational-wide score of 73.5 in Human Understanding



Achieve a score of 80 in "Cleanliness of Clinic"



Physician Alignment

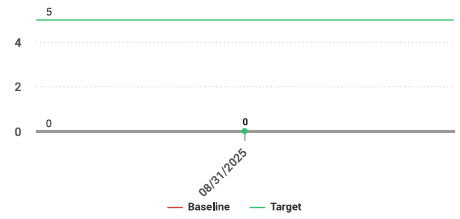
Champions: Ryan Gates and JC Palermo

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

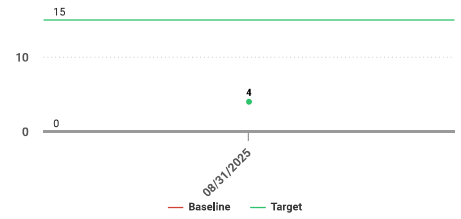
FY2026 Strategic Plan -Physician Alignment - Strategies

#	Name	Description	Status	Assigned To	Last Comment
5.1	Recruit Physicians and Advanced Practice Providers	Refine and execute recruitment strategy and employment options for physicians and advanced practice providers that will assist with recruitment of providers to support community needs and Kaweah Health's growth.	On Track	JC Palermo	The Physician Recruitment Strategy Committee continues to meet to discuss the most pressing community needs and how Kaweah Health can best deploy resources.
5.2	Develop and Provide Practice Support for Physicians	Continue to develop services and opportunities that improve alignment with and support for contracted and affiliated physician practices.	On Track	Ryan Gates	Continue work implementing the Lung Cancer Screening program. We are partnering with orthopedic surgeons to evaluate primary care referrals and to develop strategies to keep patients local.
5.3	Physician Alignment through Integrated Delivery Network (i.e. Sequoia Integrated Health)	With our physician community partners, continue to develop and strengthen relationships with health plans through Sequoia Integrated Health.	On Track	Ryan Gates	Efforts underway around access, expansion and implementation of tools that will improve.

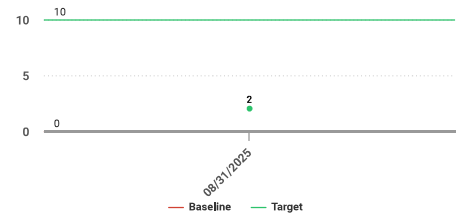
Recruit 5 Primary Care Physicians



Recruit 15 Specialty Providers



Recruit 10 Advanced Practice Providers



Urgent Care Centers

REPORT TO THE BOARD OF DIRECTORS

Urgent Care Court and Demaree

Ryan Gates, Chief Population Health Officer, 559-624-5647
Diana Saechao, Director of Medical Clinics and Urgent Cares, 559-624-5990
Date: September 24, 2025

Summary Issue/Service Considered

Kaweah Health currently operates two Urgent Care centers strategically located in central and northwest Visalia. These facilities serve as critical access points for timely, non-emergent medical care for residents of Tulare County and surrounding communities.

Our Urgent Care centers provide episodic care for conditions that require medical attention within 12 hours but do not necessitate emergency department services. Both locations offer extended hours of operation 365 days a year to meet the community's demand for convenient, same-day care. The Court Street Urgent Care is open daily from 9:00 a.m. to 9:00 p.m., while the Demaree Street location operates from 8:00 a.m. to 7:00 p.m.

Clinical services are delivered by a multidisciplinary team that include emergency medicine physicians, advanced practice providers (nurse practitioners and physician assistants), licensed vocational nurses (LVNs), and medical assistants. In addition to clinical evaluation and treatment, both sites offer on-site diagnostic imaging and laboratory services to support comprehensive, same-day care.

Patient Demographics and Payer Mix

The Urgent Cares serve a diverse patient population across all age groups, with a higher frequency of visits from pediatric patients aged 5–10 years and young adults aged 18–25 years. The overall payer mix is as follows:

- Medi-Cal: 31%
- Medicare: 24%
- Commercial/Private Insurance: 41%
- Self-pay/Cash Pay: 4%

There are notable variations in payer mix between the two locations. The Court Street site sees a higher proportion of Medi-Cal patients, reflecting its central location and accessibility to underserved populations. In contrast, the Demaree location reports a higher percentage of commercially insured patients.

Access and Technology Integration

To enhance patient access and improve the care experience, the Urgent Cares have implemented multiple pathways for service delivery. In addition to traditional walk-in appointments, patients can pre-register and "hold their place in line" via an online scheduling platform. This virtual queueing system allows patients to wait from home, reducing in-clinic wait times and enhancing overall convenience and safety.

Since the launch of telehealth services in 2020, virtual visits have expanded access to care during and post-pandemic. However, in FY 25, telehealth utilization declined, correlating with an increase in in-person patient volume. This trend suggests a patient preference for face-to-face care in the post-pandemic environment.

Quality/Performance Improvement Data

Financial Performance

In FY 25, Kaweah Health's Urgent Care service line realized a contribution margin of $3.8 million, equating to $78 per case, across a total of 48,889 patient visits. This represents the highest contribution margin over the past four fiscal years, largely attributable to enhanced reimbursement through the Medi-Cal Managed Care Directed Payments program.

The total visit volumes have continued to follow a three-year downward trend, primarily driven by the normalization of COVID-19-related demand, particularly for testing services and payer contract adjustments impacting referral patterns and reimbursement, operational constraints on provider capacity, including workforce shortages and schedule optimization challenges.

Telehealth visits accounted for 8% of total urgent care encounters in FY25—marking a four-year low in utilization. This decline is linked to restrictive billing guidelines that preclude on-site testing as part of telehealth visits, rendering previously implemented workflows (e.g., drive-through testing or test-only walk-ins) unbillable. In addition, reimbursement rates for telehealth services have declined, particularly among commercial payers, further limiting the financial viability of virtual care options.

While the service line continues to deliver a positive contribution margin, there has been a notable increase in cost per visit, reaching its highest point in four years. This is largely due to rising labor expenses, driven in part by California's recent minimum wage legislation, and fixed cost pressures with decreasing patient volumes.

Nevertheless, the urgent care program remains financially sustainable and strategically vital. It plays a key role in meeting the community’s lower-acuity medical needs and serves as a support and buffer for Kaweah Health’s Emergency Department, reducing avoidable ED utilization and improving patient flow system-wide.

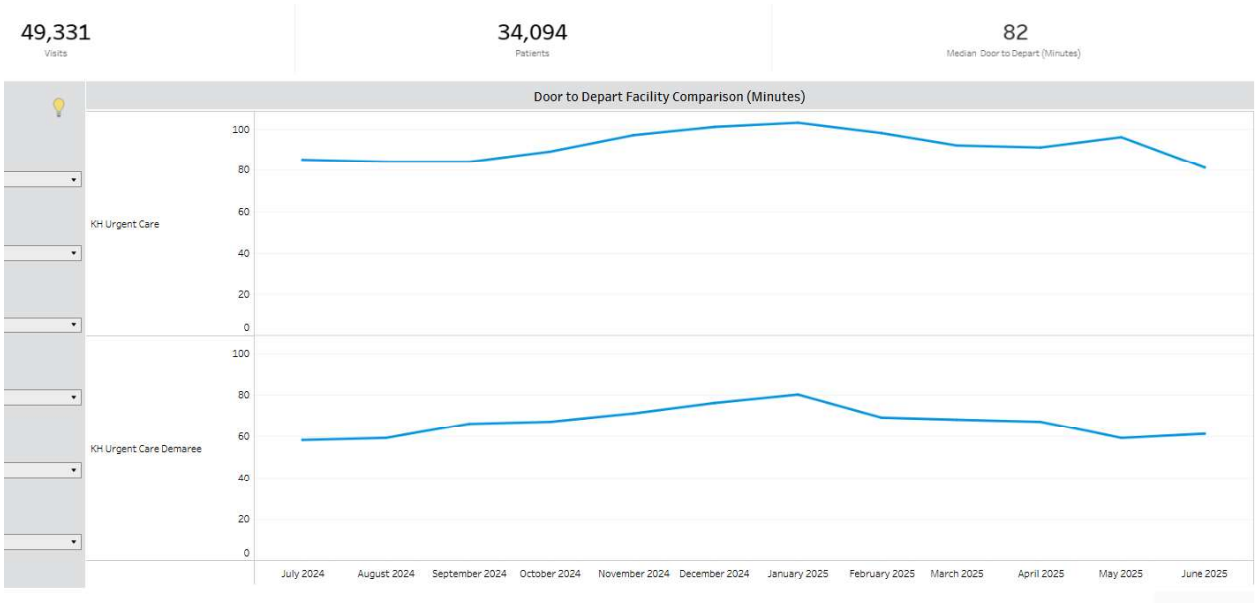
Operational Throughput

Throughput varies by location and is influenced by differences in patient acuity and service complexity:

- Urgent Care Demaree reports an average patient visit duration of 67 minutes from check-in to discharge.
- Urgent Care Court has a longer average duration of 92 minutes, reflecting the higher-acuity nature of the patients it serves.

Patients presenting with more complex conditions predominantly present at the UC Court versus UC Demaree. As a result, transfers from UC Court to the Emergency Department occur more regularly.

Across both sites, the average system-wide visit duration is 82 minutes. Ongoing process improvement efforts are focused on reducing cycle times, optimizing provider workflows, and enhancing the patient experience through timely, efficient care delivery.



Patient Experience

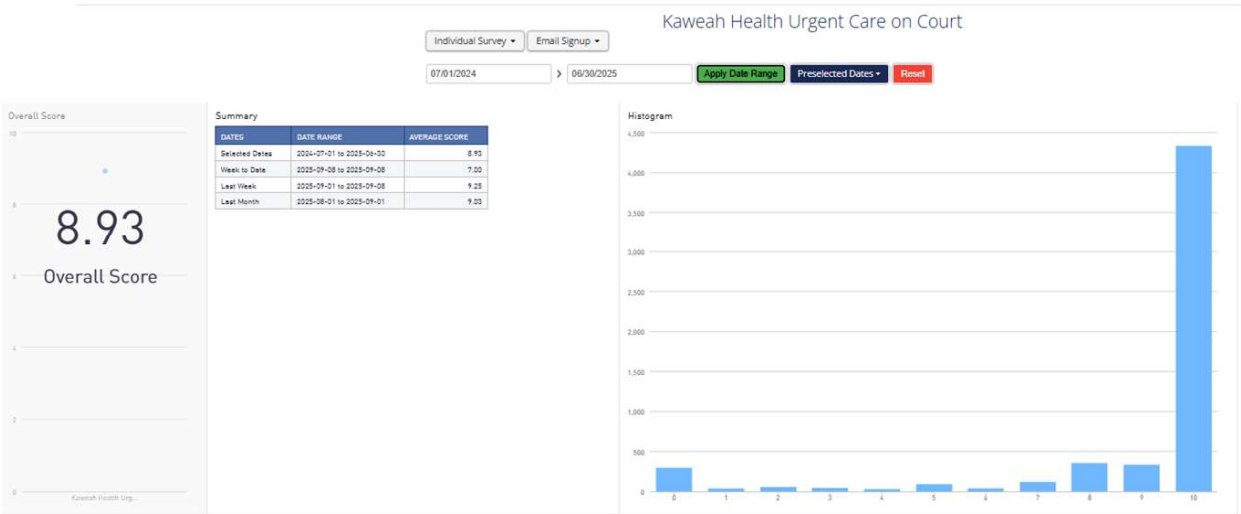
Kaweah Health Urgent Care centers utilize a virtual lobby platform not only for appointment management but also as a tool for patient engagement and experience feedback. At the conclusion of each visit, patients are invited to rate their overall experience and, optionally, leave comments recognizing staff or identifying areas for improvement.

In FY 25, patient satisfaction remained high across both locations:

- Urgent Care Demaree received an average score of 9.5 out of 10
- Urgent Care Court received an average score of 8.93 out of 10

These ratings reflect strong performance in service quality, efficiency, and staff interaction. Open-text feedback frequently includes positive recognition of individual staff members, as well as constructive suggestions to enhance the care environment or streamline processes.

Patient feedback continues to be a valuable quality improvement tool, supporting ongoing efforts to ensure high levels of satisfaction, patient-centered care, and responsiveness to community needs. As of August 2025, Urgent Care centers have transitioned to the NRC Health survey platform, which will provide greater insight into key drivers of patient experience.



Employee Engagement

Employee engagement remains a top priority for the urgent care leadership. During 2025, survey data represented a decrease in staff engagement, most likely attributed to the long-term effects of the pandemic and changes to the provider staffing from contracted to employed. Recent survey data signifies UC Demaree returning to near historical scores and is currently 0.10 points above the organizational average. UC Court has made great progress with 2025 survey data, while it was below 0.12 from the goal, it still represented a historical high for the department.

Workgroup	2025 Survey Averages	2024 Survey Averages	2022 Survey Averages	2021 Survey Averages	Increase/ Decrease from 2024	Respondents	Response Rate
Urgent Care Center-Demaree	4.32	4.30	4.15	4.26	0.02	16	67%
Urgent Care Center-South	4.10	3.88	3.90	3.97	0.22	29	85%

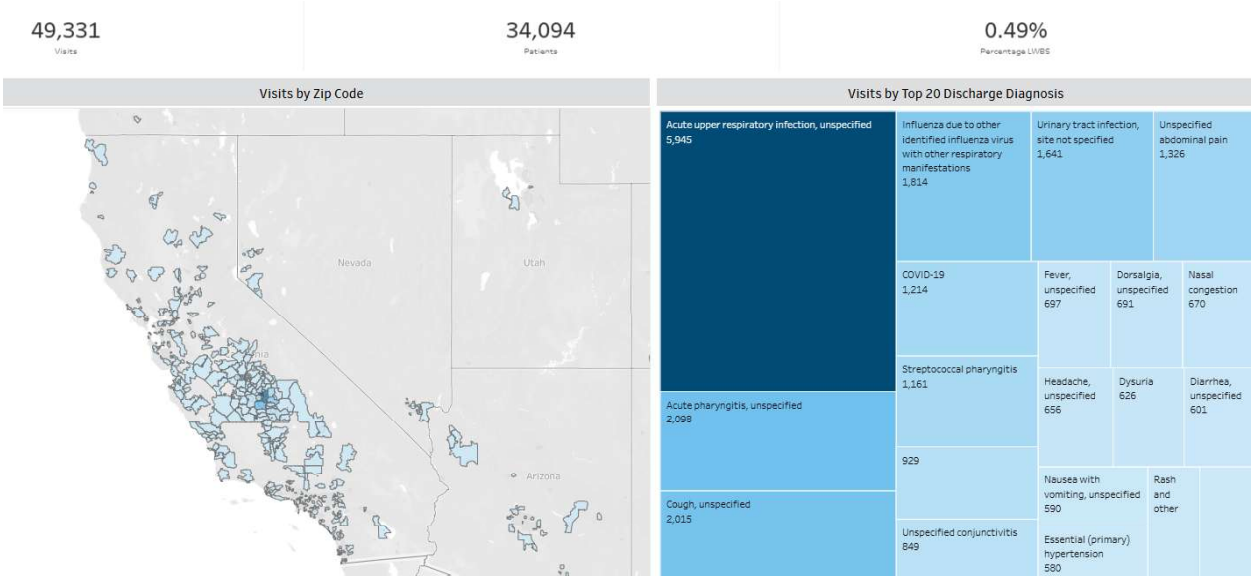
Policy, Strategic or Tactical Issues

By offering timely, convenient care for non-emergent, lower-acuity conditions, these clinics play a vital role in reducing the overutilization of emergency department services and improving overall patient flow within the health system.

The majority of patients presenting to the Urgent Cares seek treatment for common acute conditions, including:

- Acute upper respiratory infections
- Acute pharyngitis
- Common cold and influenza-like illnesses

Thanks to the extended hours and accessible locations, the Urgent Care centers attract patients not only from Tulare County but also from multiple surrounding counties and neighboring states, underscoring its regional importance as a care access point.



According to the 2025 NRC Community Insights Study for Urgent Cares, some notable insights were highlighted:

- 85% traveled less than 30 minutes to the clinics. The convenient location of our clinics allows for ease of access to care.
- 53% had 2-3 visits in the last two years.
- 48% preferred walk-ins and waiting, while 52% preferred scheduling in advance.
- 42% were seen within an hour of registration check-in.
- 51% rated 8 or higher on a 10-pt scale (10 being excellent) for overall experience.
- Most satisfying aspects of care were the 1) interactions with the provider, 2) check-in process, and 3) providers/staff listening to them.

The Urgent Care centers have maintained a strong presence and reputation in the community. The strategic goal for the urgent care service line is to rebuild and expand market share by focusing on key differentiators:

- Geographically convenient locations
- A user-friendly online “virtual waiting room” platform
- Expedited, efficient service
- Consistently high-quality clinical care
- Exceptional customer service rooted in empathy and responsiveness

Sustaining and enhancing these elements will be essential to strengthening community trust, driving volume growth, and supporting Kaweah Health’s broader mission of accessible, patient-centered care.

Recommendations/Next Steps

Kaweah Health Urgent Care centers will continue to serve as a key access point for high-quality, non-emergent medical care in Tulare County. With the broadest range of urgent care services and extended hours of operation, the clinics will maintain their role as a vital community resource and a critical support structure for Kaweah Health's Emergency Department.

Looking ahead, strategic priorities for the urgent care service line include:

- Sustaining year-round access with operating hours 365 days per year.
- Expanding capacity through targeted provider and staff recruitment.
- Preserving flexibility through both walk-in and scheduled visit options.
- Collaborating closely with Kaweah Health's Emergency Department to educate patients and coordinate seamless outpatient care services within our clinic network.
- Explore the development of new urgent care clinic location(s).

Continued collaboration with internal Kaweah Health departments and strong partnerships with community-based providers will remain central to supporting seamless care coordination and promoting the ongoing success of urgent care services.

Furthermore, with anticipated methodology changes to the District Hospital Directed Payments (DHDP) program, the strategic positioning of urgent care within the broader Kaweah Health network will be re-evaluated in FY 26. These changes may offer new opportunities to optimize financial sustainability and expand service offerings to better meet the growing and shifting healthcare needs of our community.

Approvals/Conclusions

No additional approvals are needed at this time.

The Kaweah Health Urgent Care centers continue to be a highly successful service line for the organization; providing outstanding episodic services to the community it serves.

Inpatient Medical Services

REPORT TO THE BOARD OF DIRECTORS

Inpatient Medicine Services (General Medicine, Gastroenterology, Neurology, Endocrine, Nephrology, Multiple Significant Trauma (MST), Dermatology)

Emma Mozier, MSN, RN, CNML
Director of Medical Surgical Services
559-624-2825
September 8, 2024

Summary Issue/Service Considered

- Case type examples for included medical services:
  - General Medicine: Mainly Sepsis
  - Gastroenterology: G.I. hemorrhage, Cirrhosis & alcoholic hepatitis, Disorders of pancreas & liver, GI Obstruction
  - Neurology: Intracranial hemorrhage or cerebral infarction, Transient ischemia, Seizures
  - Endocrine: Nutritional & misc metabolic disorders, Diabetes, Endocrine Disorders
  - Nephrology: Renal failure, Kidney & urinary tract infections
  - MST: Multiple Significant Trauma, Major Chest Trauma, Traumatic Injury, Non-extensive Burns
  - Dermatology: Cellulitis, Trauma to the skin, subcutaneous tissue & breast, Skin Ulcers
  - Urology was removed from this year's report and has their own.
- Main themes for FY 2025: patient days are stable- up 4% with average length of stay (LOS) at a 4-year low- a third of a day (0.34) reduction observed between FY23 and FY25 represents an annual cost savings of $4.4M, patient discharges continue to trend up at 6% for FY25, LOS opportunity is at 1.74 days, representing possible savings of $25.4M.
- Contribution margin for the selected inpatient medical services is $22.7 million for FY 2025, with $13.4 million (or, 59%) provided by supplemental government funding.
- Contribution Margin is elevated in more recent years due to major savings in Registry Nursing (beginning in FY 2024), declining ALOS, and increased reimbursement from our payers. Reduction of Registry Nursing will continue in FY26.
- Supplemental Funds have remained relatively stable over the last four years for these services.
- Quality initiatives continue to be a focus for our inpatient units: Catheter Associated Urinary Tract Infections (CAUTI), Central Line Associated Blood Stream Infections (CLABSI), Falls, Hospital Acquired Pressure Injuries (HAPI), and Hand Hygiene compliance in patient care areas.
- Nursing retention and recruitment continue to be a high priority for both nursing leadership as well as our Human Resources department.

Quality/Performance Improvement Data

CLINICAL QUALITY	Organization Wide			
	2Q24	3Q24	4Q24	1Q25
Central line associated blood stream infection (CLABSI)	0.537	0.608	1.196	0.847
Target	0.589	0.486	0.589	0.486
Catheter associated urinary tract infection (CAUTI)	0.592	0.539	0.203	0.27
Target	0.65	0.342	0.65	0.342
Falls/1000 pt days	1.75	1.82	1.63	1.74
Target	2.07	2.08	2.18	2.14
Injury Falls/1000 pt days	0.27	0.34	0.16	0.19
Target	0.46	0.45	0.45	0.45
HAPI Stage 2+/1000 pt days *Hospital Acquired Pressure Injury	1.95	1.69	1.04	0.95
Target	0.93	0.93	0.93	0.54
Hand Hygiene Compliance Pt Care Areas	94.27%	93.86%	93.9%	93.9%
Target	95%	95%	95%	95%

- Committees reviewing our quality initiatives (CLABSI, CAUTI, Falls HAPI, and Hand Hygiene) are established and have been on-going this last year. There are current efforts to re-align, streamline and ensure appropriate focus in all these quality areas.
- Recent work has been robust around recreating the function and scope of the Inpatient Wound Care Team. This work includes but not limited to ensuring accurate staging of wounds and collaborating with practitioners on appropriate treatment plans.
- Hand hygiene compliance also has had a reinvigorated focus for the entire organization. Standardized work for leaders and accountability expectations for staff have recently been created and shared. Monthly data review with leaders is also scheduled which has helped change some of the reports to get better information and increase use.
- Throughput initiatives continue and will be re-focused for this fiscal year based on past performance and current Executive Leadership expectations.

Policy, Strategic or Tactical Issues

- All units monitor clinical and LOS performance. As barriers and themes are identified, the leader works with the respective committee groups for support.
    - Our LOS committee continues its work to reduce LOS, identify and remove throughput and discharge barriers. Our hospitalist physician groups are also engaged and working to identify opportunities to care.
    - Unit based councils also discuss and brainstorm at the unit level to improve discharge processes, times and follow-up.
    - An interdisciplinary approach is in place to ensure collaboration in the inpatient process for patients receiving timely access to procedures, tests and decisions
    - Discharge rounds continue but a new element has been introduced which includes other disciplines to ensure we are talking about all patient needs (pharmacy, therapies, social workers, nutritionists, etc.).
- Leadership is engaged with their staff to increase completion of any Safety Attitude's Questionnaire and Employee Engagement Survey's as well as including them in action planning when opportunities are identified or to continue to do the things that work well.

- Working with Finance to create more robust and detailed reports for unit leaders to review and better understand gaps in our staffing/pay practices and areas for improvement.

Recommendations/Next Steps

- Continue to focus on quality and LOS initiatives to meet organizational goals.
- Work with Human Resources, Clinical Education, and the Advance Practice Nurses to onboard, support and train new and existing nurses to improve recruitment and retention.
- Promote active engagement of our practitioner partners to increase efficiency of care and use of resources and services while patient in our care.

Approvals/Conclusions

- Leadership continues to work through employee engagement opportunities and provide support to frontline care staff. We value the team members and want to ensure they have the best environment to care for their patients. Our CNO has created various town-hall sessions to reach patient care staff in a new way.
- Strive for overall quality outcomes and set goals to continue to improve. We still have opportunities to improve LOS as well as quality goals related to CLABSI, HAPI, and Hand Hygiene compliance. We will work to maintain and continue to keep below goal on our CAUTI and Fall/Fall with Injury Rates.
- Leadership remains vigilant, reviewing budget reports and striving for financial strength within each department. This includes monitoring staff pay practices, supply management, and LOS.

KAWEAH HEALTH ANNUAL BOARD REPORT

FY2025

Inpatient Medical Service Lines (not already reported) - Inpatient Summary

KEY METRICS - FY 2025 Twelve Months Ended June 30, 2025

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
6,582	$99,850,965	$77,123,844	$22,727,121	($2,295,300)
▲ 6%	▲ 8%	▲ 12%	▼ -2%	▼ -273%

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

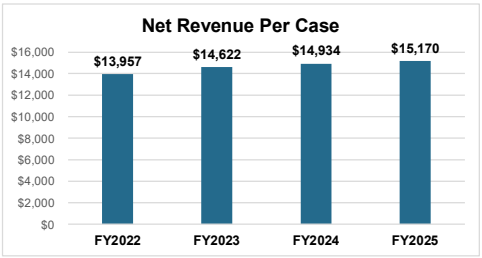
METRICS BY SERVICE LINE - FY 2025

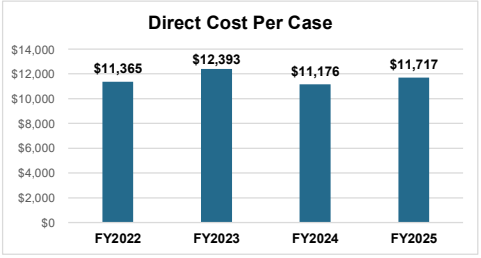
SERVICE LINE	PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
GASTROENTEROLOGY	1,693	$24,813,901	$18,032,112	$6,781,789	$1,006,452
NEUROLOGY	1,331	$22,108,728	$17,687,986	$4,420,742	($1,348,614)
GENERAL MEDICINE	930	$19,849,530	$15,660,945	$4,188,585	($758,639)
NEPHROLOGY	1,157	$13,815,648	$10,896,454	$2,919,194	($695,681)
ENDOCRINE	1,006	$12,699,869	$9,933,297	$2,766,572	($538,312)
DERMATOLOGY	366	$4,136,064	$3,217,237	$918,827	($140,730)
IP MEDICAL TRAUMA	99	$2,427,225	$1,695,813	$731,412	$180,224
IP MEDICAL SERVICES TOTAL	6,582	$99,850,965	$77,123,844	$22,727,121	($2,295,300)

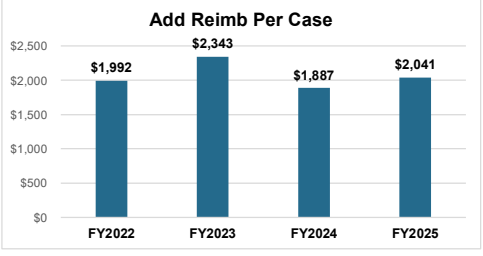
METRICS SUMMARY - 4 YEAR TREND

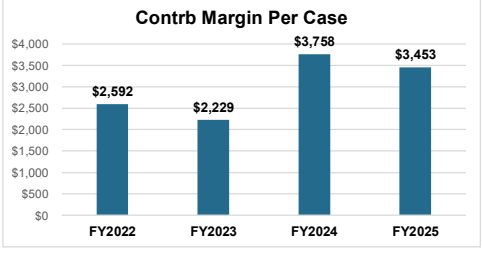
METRIC	FY2022	FY2023	FY2024	FY2025	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	6,239	6,015	6,187	6,582 ▲	6%	
Patient Days	34,828	33,808	33,290	34,750 ▲	4%	
ALOS	5.58	5.62	5.38	5.28 ▼	-2%	
Net Revenue	$87,074,951	$87,949,116	$92,396,182	$99,850,965 ▲	8%	
Additional Reimb	12,429,329	14,092,377	11,672,104	13,431,797 ▲	15%	
Direct Cost	$70,906,334	$74,541,960	$69,144,208	$77,123,844 ▲	12%	
Contribution Margin	$16,168,617	$13,407,156	$23,251,974	$22,727,121 ▼	-2%	
Indirect Cost	$20,750,486	$23,779,208	$21,924,616	$25,022,421 ▲	14%	
Net Income	($4,581,869)	($10,372,052)	$1,327,358	($2,295,300) ▼	-273%	
Net Revenue Per Case	$13,957	$14,622	$14,934	$15,170 ▲	2%	
Direct Cost Per Case	$11,365	$12,393	$11,176	$11,717 ▲	5%	
Add Reimb Per Case	$1,992	$2,343	$1,887	$2,041 ▲	8%	
Contrb Margin Per Case	$2,592	$2,229	$3,758	$3,453 ▼	-8%	

GRAPHS









Notes:
Source: Inpatient Service Line Reports
Criteria: Inpatient Medical Services, not yet reported.
Criteria: Service Name Kaweah Health Medical Center

KAWEAH HEALTH ANNUAL BOARD REPORT

FY2025

Inpatient Medical Service Lines - Gastroenterology

KEY METRICS - FY 2025 Twelve Months Ended June 30, 2025

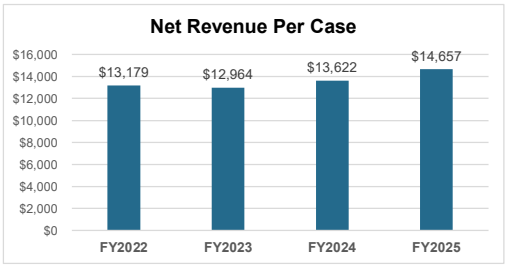
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
1,693	$24,813,901	$18,032,112	$6,781,789	$1,006,452
▲ 4%	▲ 11%	▲ 17%	▼ -1%	▼ -50%

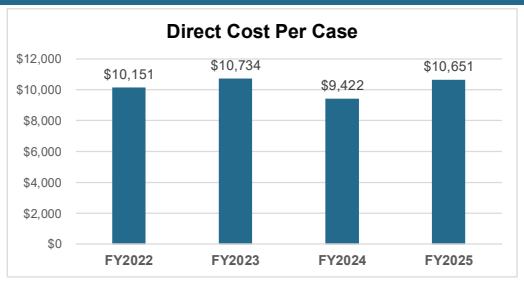
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

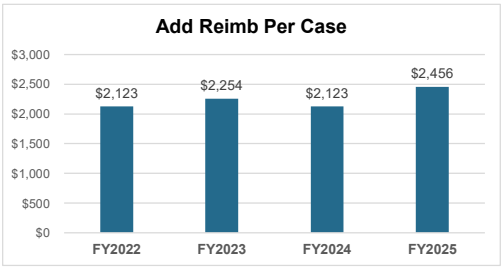
METRICS SUMMARY - 4 YEAR TREND

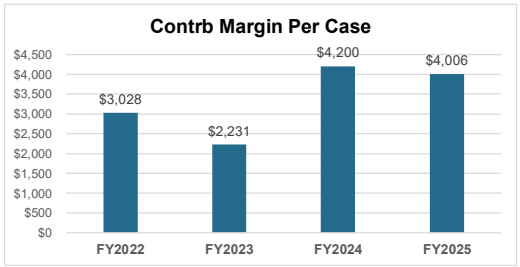
METRIC	FY2022	FY2023	FY2024	FY2025	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	1,584	1,509	1,635	1,693	▲ 4%	
Patient Days	7,937	7,656	7,535	7,963	▲ 6%	
ALOS	5.01	5.07	4.61	4.70	▲ 2%	
GM LOS	3.54	3.50	3.53	3.50	▼ -1%	
Net Revenue	$20,875,721	$19,563,324	$22,271,940	$24,813,901	▲ 11%	
Additional Reimb	$3,362,163	$3,401,233	$3,471,650	$4,158,251	▲ 20%	
Direct Cost	$16,078,939	$16,197,163	$15,404,402	$18,032,112	▲ 17%	
Contribution Margin	$4,796,782	$3,366,161	$6,867,538	$6,781,789	▼ -1%	
Indirect Cost	$4,774,945	$5,216,758	$4,861,997	$5,775,337	▲ 19%	
Net Income	$21,837	($1,850,597)	$2,005,541	$1,006,452	▼ -50%	
Net Revenue Per Case	$13,179	$12,964	$13,622	$14,657	▲ 8%	
Direct Cost Per Case	$10,151	$10,734	$9,422	$10,651	▲ 13%	
Add Reimb Per Case	$2,123	$2,254	$2,123	$2,456	▲ 16%	
Contrb Margin Per Case	$3,028	$2,231	$4,200	$4,006	▼ -5%	
Opportunity Days	1.47	1.57	1.08	1.20	▲ 11%	

PER CASE TRENDED GRAPHS



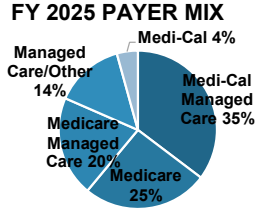






PAYER MIX - 4 YEAR TREND (GROSS CHARGES)

PAYER	FY2022	FY2023	FY2024	FY2025
Medi-Cal Managed Care	26%	29%	32%	35%
Medicare	31%	32%	30%	25%
Medicare Managed Care	17%	18%	18%	20%
Managed Care/Other	16%	15%	15%	14%
Medi-Cal	9%	5%	4%	4%



Source: Inpatient Service Line Report
Criteria: Service Name Kaweah Delta Medical Center
Service Line is Gastroenterology and DRG Type = Medical

KAWEAH HEALTH ANNUAL BOARD REPORT

FY2025

Inpatient Medical Service Lines - Neurology

KEY METRICS - FY 2025 Twelve Months Ended June 30, 2025

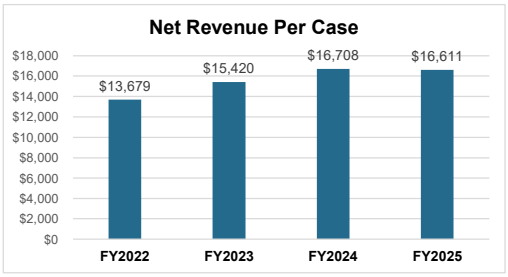
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
1,331	$22,108,728	$17,687,986	$4,420,742	($1,348,614)
▲ 1%	▶ 0%	▲ 10%	▼ -25%	▼ -292%

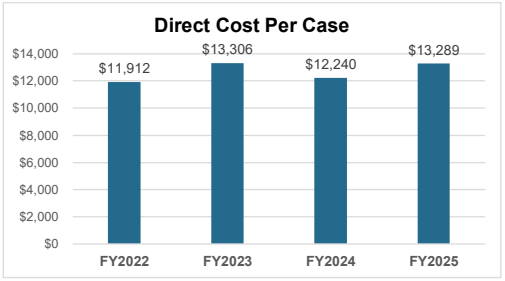
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

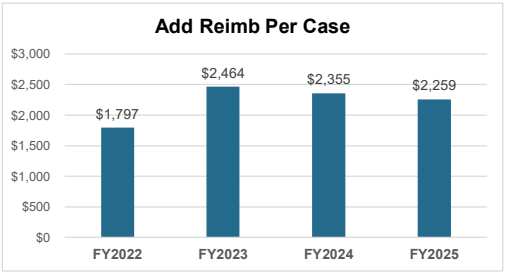
METRICS SUMMARY - 4 YEAR TREND

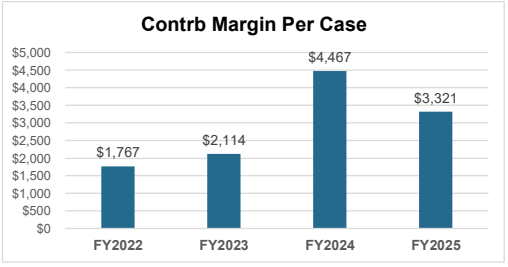
METRIC	FY2022	FY2023	FY2024	FY2025	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	1,256	1,232	1,317	1,331	▲ 1%	
Patient Days	7,573	7,594	8,020	8,368	▲ 4%	
ALOS	6.03	6.16	6.09	6.29	▲ 3%	
GM LOS	3.34	3.36	3.36	3.38	▲ 1%	
Net Revenue	$17,181,064	$18,997,955	$22,004,031	$22,108,728	▶ 0%	
Additional Reimb	$2,256,900	$3,035,733	$3,101,351	$3,006,428	▼ -3%	
Direct Cost	$14,962,036	$16,393,077	$16,120,731	$17,687,986	▲ 10%	
Contribution Margin	$2,219,028	$2,604,878	$5,883,300	$4,420,742	▼ -25%	
Indirect Cost	$4,405,558	$5,181,450	$5,181,345	$5,769,356	▲ 11%	
Net Income	($2,186,530)	($2,576,572)	$701,955	($1,348,614)	▼ -292%	
Net Revenue Per Case	$13,679	$15,420	$16,708	$16,611	▼ -1%	
Direct Cost Per Case	$11,912	$13,306	$12,240	$13,289	▲ 9%	
Add Reimb Per Case	$1,797	$2,464	$2,355	$2,259	▼ -4%	
Contrb Margin Per Case	$1,767	$2,114	$4,467	$3,321	▼ -26%	
Opportunity Days	2.69	2.80	2.73	2.91	▲ 7%	

PER CASE TRENDED GRAPHS



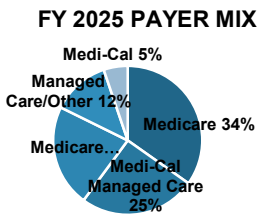






PAYER MIX - 4 YEAR TREND (GROSS CHARGES)

PAYER	FY2022	FY2023	FY2024	FY2025
Medicare	39%	34%	39%	34%
Medi-Cal Managed Care	23%	24%	23%	25%
Medicare Managed Care	17%	19%	18%	22%
Managed Care/Other	13%	15%	12%	12%
Medi-Cal	7%	6%	6%	5%



KAWEAH HEALTH ANNUAL BOARD REPORT

FY2025

Inpatient Medical Service Lines - General Medicine

KEY METRICS - FY 2025 Twelve Months Ended June 30, 2025

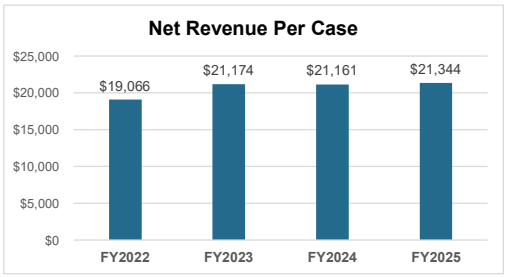
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
930	$19,849,530	$15,660,945	$4,188,585	($758,639)
▼ -1%	▶ 0%	▼ -5%	▲ 25%	▲ 55%

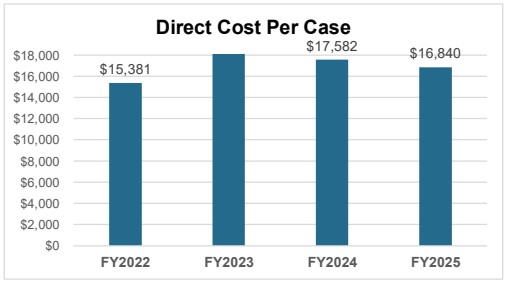
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

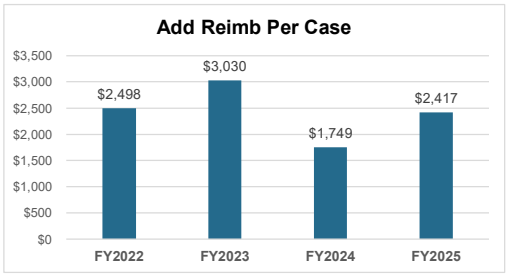
METRICS SUMMARY - 4 YEAR TREND

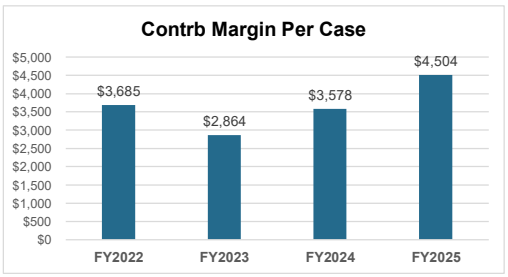
METRIC	FY2022	FY2023	FY2024	FY2025	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	1,416	1,095	935	930	▼ -1%	
Patient Days	9,483	7,673	6,404	5,962	▼ -7%	
ALOS	6.70	7.01	6.85	6.41	▼ -6%	
GM LOS	4.42	4.51	4.62	4.38	▼ -5%	
Net Revenue	$26,997,280	$23,185,039	$19,785,143	$19,849,530	▶ 0%	
Additional Reimb	$3,537,403	$3,317,477	$1,635,162	$2,248,060	▲ 37%	
Direct Cost	$21,779,788	$20,049,422	$16,439,521	$15,660,945	▼ -5%	
Contribution Margin	$5,217,492	$3,135,617	$3,345,622	$4,188,585	▲ 25%	
Indirect Cost	$6,127,244	$6,291,055	$5,013,188	$4,947,224	▼ -1%	
Net Income	($909,752)	($3,155,438)	($1,667,566)	($758,639)	▲ 55%	
Net Revenue Per Case	$19,066	$21,174	$21,161	$21,344	▲ 1%	
Direct Cost Per Case	$15,381	$18,310	$17,582	$16,840	▼ -4%	
Add Reimb Per Case	$2,498	$3,030	$1,749	$2,417	▲ 38%	
Contrb Margin Per Case	$3,685	$2,864	$3,578	$4,504	▲ 26%	
Opportunity Days	2.28	2.50	2.23	2.03	▼ -9%	

PER CASE TRENDED GRAPHS



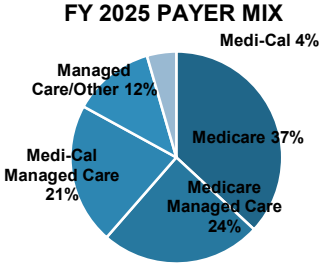






PAYER MIX - 4 YEAR TREND (GROSS CHARGES)

PAYER	FY2022	FY2023	FY2024	FY2025
Medicare	38%	39%	41%	37%
Medicare Managed Care	15%	17%	24%	24%
Medi-Cal Managed Care	22%	22%	18%	21%
Managed Care/Other	18%	15%	13%	12%
Medi-Cal	6%	6%	3%	4%



KAWEAH HEALTH ANNUAL BOARD REPORT

FY2025

Inpatient Medical Service Lines - Nephrology

KEY METRICS - FY 2025 Twelve Months Ended June 30, 2025

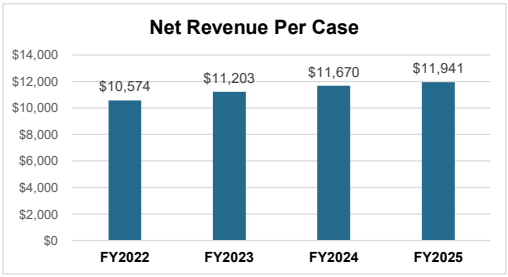
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
1,157	$13,815,648	$10,896,454	$2,919,194	($695,681)
▲ 14%	▲ 17%	▲ 22%	▲ 1%	▼ -4041%

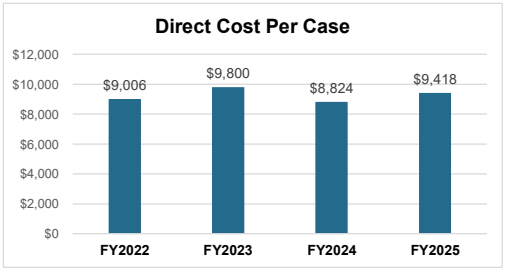
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

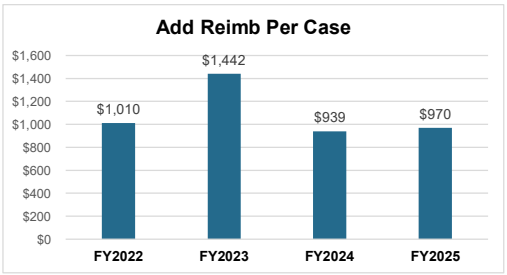
METRICS SUMMARY - 4 YEAR TREND

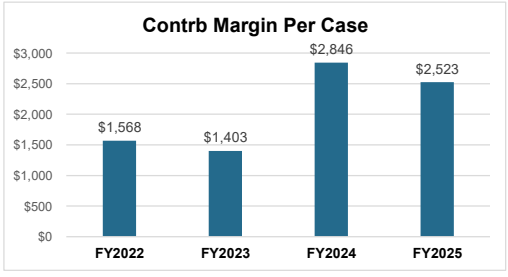
METRIC	FY2022	FY2023	FY2024	FY2025	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	798	934	1,013	1,157	▲ 14%	
Patient Days	4,059	4,878	4,977	5,533	▲ 11%	
ALOS	5.09	5.22	4.91	4.78	▼ -3%	
GM LOS	3.59	3.51	3.48	3.43	▼ -1%	
Net Revenue	$8,438,019	$10,463,447	$11,822,202	$13,815,648	▲ 17%	
Additional Reimb	$806,089	$1,346,747	$951,000	$1,121,751	▲ 18%	
Direct Cost	$7,186,840	$9,152,846	$8,938,711	$10,896,454	▲ 22%	
Contribution Margin	$1,251,179	$1,310,601	$2,883,491	$2,919,194	▲ 1%	
Indirect Cost	$2,164,788	$2,971,591	$2,900,290	$3,614,875	▲ 25%	
Net Income	($913,609)	($1,660,990)	($16,799)	($695,681)	▼ -4041%	
Net Revenue Per Case	$10,574	$11,203	$11,670	$11,941	▲ 2%	
Direct Cost Per Case	$9,006	$9,800	$8,824	$9,418	▲ 7%	
Add Reimb Per Case	$1,010	$1,442	$939	$970	▲ 3%	
Contrb Margin Per Case	$1,568	$1,403	$2,846	$2,523	▼ -11%	
Opportunity Days	1.50	1.71	1.43	1.35	▼ -6%	

PER CASE TRENDED GRAPHS



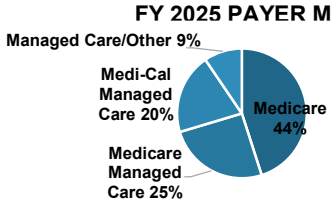






PAYER MIX - 4 YEAR TREND (GROSS CHARGES)

PAYER	FY2022	FY2023	FY2024	FY2025
Medicare	48%	43%	44%	44%
Medicare Managed Care	18%	20%	24%	25%
Medi-Cal Managed Care	19%	22%	19%	20%
Managed Care/Other	11%	11%	10%	9%



KAWEAH HEALTH ANNUAL BOARD REPORT

FY2025

Inpatient Medical Service Lines - Endocrine

KEY METRICS - FY 2025 Twelve Months Ended June 30, 2025

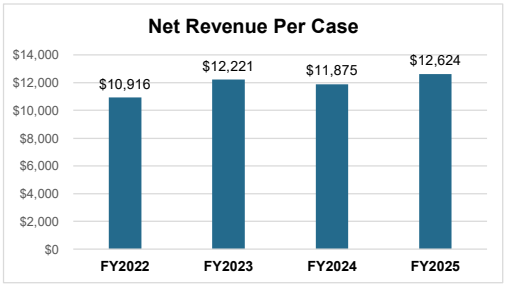
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
1,006	$12,699,869	$9,933,297	$2,766,572	($538,312)
▲ 20%	▲ 27%	▲ 29%	▲ 22%	▼ -123%

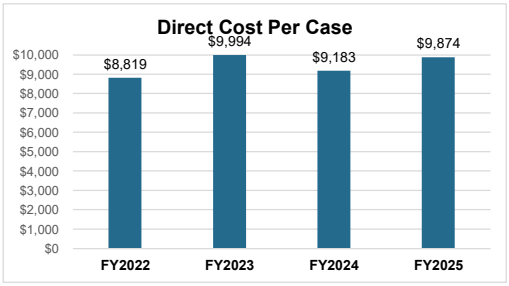
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

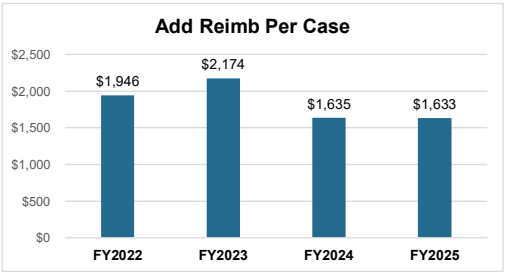
METRICS SUMMARY - 4 YEAR TREND

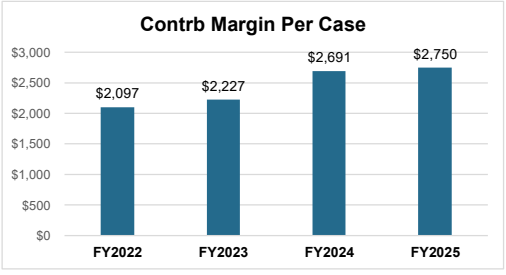
METRIC	FY2022	FY2023	FY2024	FY2025	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	757	869	841	1,006	▲ 20%	
Patient Days	3,395	3,917	3,958	4,520	▲ 14%	
ALOS	4.48	4.51	4.71	4.49	▼ -5%	
GM LOS	3.11	3.16	3.19	3.16	▼ -1%	
Net Revenue	$8,263,769	$10,620,077	$9,986,766	$12,699,869	▲ 27%	
Additional Reimb	$1,473,414	$1,889,604	$1,375,447	$1,643,293	▲ 19%	
Direct Cost	$6,676,182	$8,684,713	$7,723,313	$9,933,297	▲ 29%	
Contribution Margin	$1,587,587	$1,935,364	$2,263,453	$2,766,572	▲ 22%	
Indirect Cost	$1,986,658	$2,798,429	$2,504,364	$3,304,884	▲ 32%	
Net Income	($399,071)	($863,065)	($240,911)	($538,312)	▼ -123%	
Net Revenue Per Case	$10,916	$12,221	$11,875	$12,624	▲ 6%	
Direct Cost Per Case	$8,819	$9,994	$9,183	$9,874	▲ 8%	
Add Reimb Per Case	$1,946	$2,174	$1,635	$1,633	▶ 0%	
Contrb Margin Per Case	$2,097	$2,227	$2,691	$2,750	▲ 2%	
Opportunity Days	1.37	1.35	1.52	1.33	▼ -13%	

PER CASE TRENDED GRAPHS





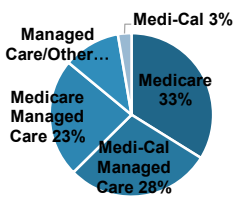




PAYER MIX - 4 YEAR TREND (GROSS CHARGES)

PAYER	FY2022	FY2023	FY2024	FY2025
Medicare	29%	32%	31%	33%
Medi-Cal Managed Care	34%	28%	28%	28%
Medicare Managed Care	19%	16%	24%	23%
Managed Care/Other	10%	16%	10%	11%
Medi-Cal	8%	6%	5%	3%

FY 2025 PAYER MIX



KAWEAH HEALTH ANNUAL BOARD REPORT

FY2025

Inpatient Medical Service Lines - Dermatology

KEY METRICS - FY 2025 Twelve Months Ended June 30, 2025

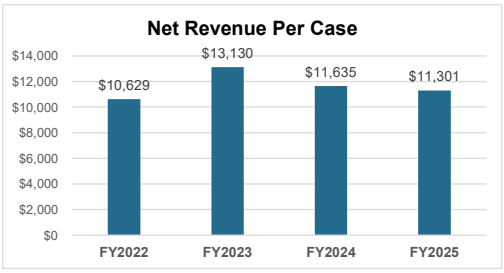
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
366	$4,136,064	$3,217,237	$918,827	($140,730)
▲ 7%	▲ 4%	▲ 10%	▼ -14%	▼ -224%

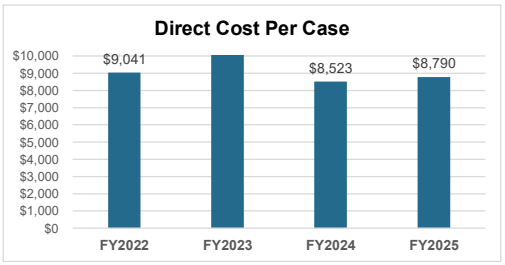
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

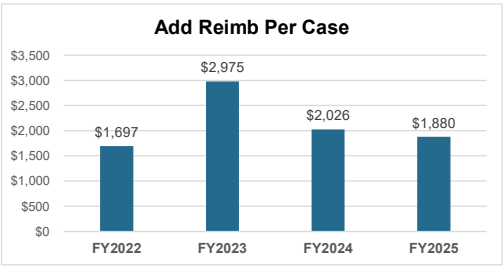
METRICS SUMMARY - 4 YEAR TREND

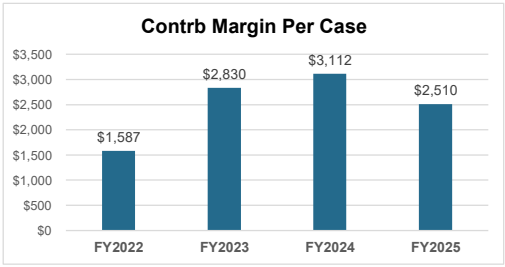
METRIC	FY2022	FY2023	FY2024	FY2025	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	330	300	343	366	▲ 7%	
Patient Days	1,736	1,687	1,674	1,703	▲ 2%	
ALOS	5.26	5.62	4.88	4.65	▼ -5%	
GM LOS	3.51	3.61	3.50	3.43	▼ -2%	
Net Revenue	$3,507,407	$3,938,931	$3,990,927	$4,136,064	▲ 4%	
Additional Reimb	$560,106	$892,528	$694,779	$687,909	▼ -1%	
Direct Cost	$2,983,624	$3,089,824	$2,923,396	$3,217,237	▲ 10%	
Contribution Margin	$523,783	$849,107	$1,067,531	$918,827	▼ -14%	
Indirect Cost	$902,639	$1,002,273	$954,212	$1,059,557	▲ 11%	
Net Income	($378,856)	($153,166)	$113,319	($140,730)	▼ -224%	
Net Revenue Per Case	$10,629	$13,130	$11,635	$11,301	▼ -3%	
Direct Cost Per Case	$9,041	$10,299	$8,523	$8,790	▲ 3%	
Add Reimb Per Case	$1,697	$2,975	$2,026	$1,880	▼ -7%	
Contrb Margin Per Case	$1,587	$2,830	$3,112	$2,510	▼ -19%	
Opportunity Days	1.75	2.01	1.38	1.22	▼ -12%	

PER CASE TRENDED GRAPHS



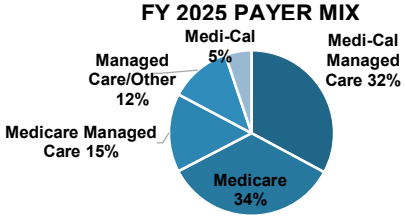






PAYER MIX - 4 YEAR TREND (GROSS CHARGES)

PAYER	FY2022	FY2023	FY2024	FY2025
Medi-Cal Managed Care	38%	31%	38%	32%
Medicare	30%	27%	35%	34%
Medicare Managed Care	12%	19%	13%	15%
Managed Care/Other	12%	11%	7%	12%
Medi-Cal	6%	10%	6%	5%



Notes:
Source: Inpatient Service Line Report
Criteria: Service Name Kaweah Delta Medical Center
Service Line is Dermatology and DRG Type is Medical

KAWEAH HEALTH ANNUAL BOARD REPORT

FY2025

Inpatient Medical Service Lines - Multiple Significant Trauma

KEY METRICS - FY 2025 Twelve Months Ended June 30, 2025

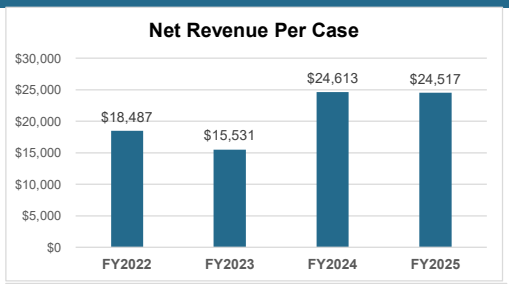
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
99	$2,427,225	$1,695,813	$731,412	$180,224
▼ -4%	▼ -4%	▲ 6%	▼ -22%	▼ -58%

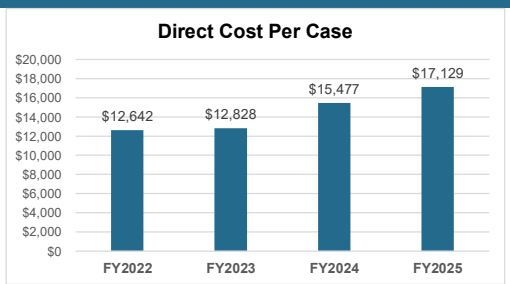
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

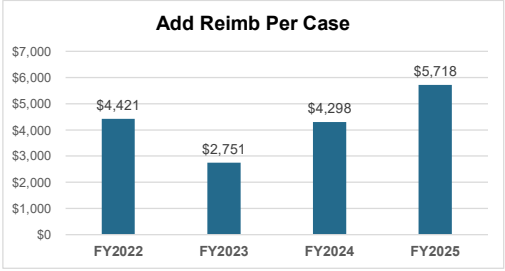
METRICS SUMMARY - 4 YEAR TREND

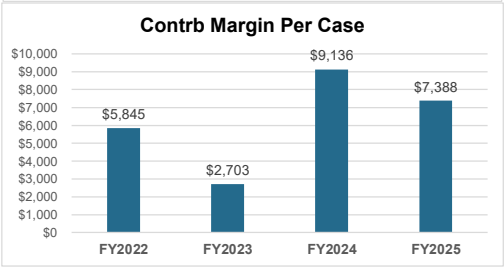
METRIC	FY2022	FY2023	FY2024	FY2025	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	98	76	103	99	▼ -4%	
Patient Days	645	403	722	701	▼ -3%	
ALOS	6.58	5.30	7.01	7.08	▲ 1%	
GM LOS	3.77	3.61	3.74	3.76	▲ 1%	
Net Revenue	$1,811,691	$1,180,343	$2,535,173	$2,427,225	▼ -4%	
Additional Reimb	$433,254	$209,055	$442,715	$566,105	▲ 28%	
Direct Cost	$1,238,925	$974,915	$1,594,134	$1,695,813	▲ 6%	
Contribution Margin	$572,766	$205,428	$941,039	$731,412	▼ -22%	
Indirect Cost	$388,654	$317,652	$509,220	$551,188	▲ 8%	
Net Income	$184,112	($112,224)	$431,819	$180,224	▼ -58%	
Net Revenue Per Case	$18,487	$15,531	$24,613	$24,517	▶ 0%	
Direct Cost Per Case	$12,642	$12,828	$15,477	$17,129	▲ 11%	
Add Reimb Per Case	$4,421	$2,751	$4,298	$5,718	▲ 33%	
Contrb Margin Per Case	$5,845	$2,703	$9,136	$7,388	▼ -19%	
Opportunity Days	2.81	1.69	3.27	3.32	▲ 2%	

PER CASE TRENDED GRAPHS



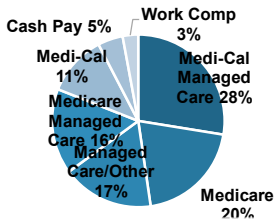






PAYER MIX - 4 YEAR TREND (GROSS CHARGES)

PAYER	FY2022	FY2023	FY2024	FY2025
Medi-Cal Managed Care	28%	29%	25%	28%
Medicare	24%	24%	15%	20%
Managed Care/Other	10%	18%	19%	17%
Medicare Managed Care	13%	13%	12%	16%
Medi-Cal	19%	9%	9%	11%
Cash Pay	4%	7%	3%	5%
Work Comp	3%	0%	16%	3%



Notes:
Source: Inpatient Service Line Report
Criteria: Service Name Kaweah Delta Medical Center
Service Line is Trauma and DRG Type is Medical

Quarterly Compliance Report

COMPLIANCE PROGRAM ACTIVITY REPORT – Open Meeting
Ben Cripps, Chief Compliance and Risk Officer
May 2025 through July 2025

EDUCATION

Live Presentations

- Compliance and Patient Privacy – New Hire Orientation
- Compliance and Patient Privacy – Management Orientation
- Patient Privacy – Charge Nurse Curriculum
- Compliance and Patient Privacy – Graduate Medical Education (GME) Resident Orientation

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

- Code of Conduct
- Patient Privacy Education
- District Facsimile and Email Communications

PREVENTION AND DETECTION

- **California Department of Public Health (CDPH) All Facility Letters (AFL) –** Review and distribute AFLs to areas potentially affected by regulatory changes; department responses reviewed and tracked to address the regulatory change and identify potential current/future risk
  - Four (4) AFL's distributed and tracked between May 2025 – July 2025

- **Medicare and Medi-Cal Monthly Bulletins** – Review and distribute bulletins to areas potentially affected by the regulatory change; department responses reviewed and tracked to address the regulatory change and identify potential current/future risk
  - Four Hundred (400) bulletins distributed as assignments to department leaders and tracked between May 2025 – July 2025
  - Eighty-seven percent (87%) compliance rate with assignment responses submitted within 15 days per policy. Fallouts are tracked and escalated as appropriate.

- **Office of Inspector General (OIG) Monthly Audit Plan Updates –** Review and distribute OIG Audit Plan issues to areas potentially affected by audit issue; department responses reviewed and tracked to identify potential current/future risk
  - Two (2) OIG audit plan issues distributed as assignments and tracked between May 2025 – July 2025

- **California State Senate and Assembly Bill Updates –** Review and track legislative updates to areas potentially affected by new or changed bills; department responses reviewed and tracked where necessary to address regulatory change and identify potential current or future risk
  - Thirty-one (31) newly presented Assembly Bills reviewed and tracked between May 2025 – July 2025

- Twenty (20) newly presented Senate Bills distributed and tracked between May 2025 – July 2025

- **Regulatory Signage Audit**– Quarterly observations of required regulatory signage were conducted throughout Kaweah Health's inpatient and outpatient facilities. Issues identified were communicated to area Management for follow-up and resolution. The findings of the quarterly regulatory signage audit performed between May 2025 – July 2025 noted missing signage at the following locations:
  - Charity Care Financial Assistance – OP Therapy Clinic, Hand Therapy
  - Interpreter Services – Ambulatory Surgery Department, Katz, Exeter RHC, Lindsay Behavioral Health
  - Medicaid Participation Notice – All locations
  - Multiple missing and outdated signs; inability to swap signage out due to specialized locked units – Inpatient Mental Health. Working with Safety and Mental Health Leadership to rectify
  - No Surprises Act – Lindsay Adolescent Behavioral Health Clinic
  - Notice to Consumer – Physician Assistant License – Cardiology Clinic, Urgent Care Demaree, RHC's Tulare, Dinuba, Lindsay
  - Notice to Consumer – Physician License – Ambulatory Surgery Department
  - Open Payments Database – SRCC Visalia, Lindsay Behavioral Health
  - Open Payments Database (Spanish) – Cardiothoracic Clinic
  - Patient Rights – Exeter RHC Behavioral Health, Pediatric, Women's Health clinics, Lindsay Behavioral Health and Adolescent Behavioral Health Clinics

- **Electronic Medical Record (EMR) User Access Privacy Audits** – Daily monitoring of EMR user access through the use of FairWarning electronic monitoring technology which analyzes user and patient data to detect potential privacy violations
  - Average of two hundred and twenty-one (221) daily alerts reviewed and investigated between May 2025 – July 2025.
  - A review of the FairWarning system identified approximately nine hundred and forty-six (946) unreviewed alerts that occurred due to personnel changes resulting in a lack of system functionality knowledge. Outstanding alerts are being reviewed, and focused training and education are taking place to ensure all active alerts are being captured.

- **Office of Inspector General (OIG) Exclusion Attestations** – Quarterly monitoring of OIG Exclusion List review and attestations. Monthly screening and review of OIG Exclusion List for non-credentialed providers who have ordered ancillary services for patients presenting at the medical center
  - Three (3) non-credentialed providers identified on the Medicare Opt-Out list between May 2025 – July 2025, findings tracked and logged in the system. No additional action required as the patients for whom services were ordered did not have Medicare coverage and/or the providers were referring only and not treating.

OVERSIGHT

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

- **Medicare Recovery Audit Contractor (RAC) Activity –** Records preparation, tracking, appeal timelines, and reporting
    - The following RAC Audit Activity took place between May 2025 – July 2025:
        - Twenty-two (22) new RAC audit findings from Kaweah Health Medical Group covering period from January, 2020 – March, 2023 resulted in a repayment to Noridian Healthcare Solutions totaling $21,549.17.
    - The number of RAC requests for the quarter is lower than it has historically been. However, Cotiviti has just renewed its contract with CMS, and we may see increasing activity as a result.

- **Licensing Applications and Medi-Cal/Medicare Facility Enrollment –** Forms preparation and submission of licensing applications to the California Department of Public Health (CDPH) and enrollment applications for Medi-Cal or Medicare; ongoing communication and follow-up regarding status of pending applications. Five applications for licensure and/or government payor enrollment were completed between May 2025 – July 2025.

- **KD Hub Non–Employee User Access –** Oversight and administration of non-employee user onboarding, privacy education, and user profile tracking; evaluate, document, and respond to requests for additional system access; on-going management of non-employee KD Hub users between May 2025 – July 2025:
    - One-hundred and fifty-three (153) system access applications were received and processed.

- **Compliance Policy Revisions and Additions –** New development, review and revision of Kaweah Health Compliance Program policies.
    - **CP.01: Compliance Program Administration:** Review and Revisions. Revisions include expanded definition related to workforce, addition of a framework for an Operational Compliance Committee, additional responsibilities language, expanded guidelines on Compliance Program functions and due care in employment and contracting to ensure alignment with HHS Office of Inspector General Compliance Program Guidance.
    - **CP.08: Government Payer Regulatory Updates:** Review and Revisions. Revisions include clarifications in workflow and responsibilities as well as regulatory agency and information sources being monitored.
    - **Physician Owned Distributorships (PODS):** New development. Outlines Kaweah Health's policy on and process for entering into a purchase agreement with a Physician Owned Distributorship (POD)

RESEARCH, CONSULTATION AND OVERSIGHT

- **Important Message from Medicare (IMM) Issuance Process –** Consultation; Compliance was engaged to evaluate the issuance process of the Important Message from Medicare (IM or IMM) notice to ensure compliance with The Centers for Medicare and Medicare Services (CMS) regulatory requirement that hospitals must notify Medicare beneficiaries who are hospital inpatients about their hospital discharge rights. CMS requires that the initial IMM notice be provided to all Medicare beneficiaries admitted as inpatients within two calendar days of admission, and again when a beneficiary is anticipated to discharge within the next two calendar days. The IMM must be delivered in a manner that allows sufficient time for the

patient to ask questions and understand their rights. Compliance worked with Case Management Leadership and the Chief Nursing Officer to ensure processes satisfy regulatory requirements.

AUDITING AND MONITORING

- **Outpatient Physical Therapy Targeted Probe and Educate -** On February 19, 2025, Medicare Administrative Contractor (MAC) Noridian initiated a prepayment Targeted Probe & Educate Review of thirty (30) outpatient physical therapy claims billed with the Current Procedural Terminology (CPT) code 042x, regarding outpatient physical therapy services. The review was initiated due to a six-month comparative billing report indicating that Kaweah Health's utilization of CPT code 042x increased by ninety-two percent (92%) within the review period. The purpose of the claim review was to ensure documentation supports the reasonable and necessary criteria of the services billed in accordance with Medicare rules and regulations. Based on an internal assessment of the increased code utilization, it is believed to be the result of the Wound Center's transition to episodic billing rather than treatment-series billing for recurring services. Twenty-nine (29) claims were approved, and one (1) partial denial for the failure to document medical necessity for a diagnosis, resulting in an overall passing claim error rate of 3.3%. The review is now closed.

- **Cardiac Catheterization Lab Targeted Probe and Educate -** On April 9, 2025, Medicare Administrative Contractor (MAC) Noridian initiated a prepayment Targeted Probe & Educate Review of Cardiac Catheterization Lab claims billed with the Current Procedural Terminology (CPT) code 93458, left heart catheterization with coronary angiography. The review was initiated due to a six-month comparative billing report indicating that Kaweah Health's utilization of CPT code 93458 increased by twenty-seven percent (27%) within the review period. The purpose of the claim review is to ensure documentation supports medical need (medical necessity) in accordance with Medicare rules and regulations. In total, twenty-eight (28) claims were requested and were 100% approved, and a claim error rate of 0%. The review is now closed.

- **Patient Status Audit –** As a part of Kaweah Health's ongoing monitoring of patient status billing, a review consisting of thirty (30) focused Medicare encounters for the period of August 2024 – March 2025 was conducted to determine if claims were submitted in compliance with Medicare billing guidelines for patient status claims reflecting observation, short stay, 2-midnight rule and outpatient surgery. The Electronic Health Record (EHR) and billing claim forms were used to validate billing and patient status. The results of the review noted that one (1) encounter that was billed in error, resulting in a 97% overall billing compliance rate and a total underpayment of $2,715.90. In accordance with guidance from the Medicare Physician Fee Schedule Final Rule (MLN SE20024), the error involved incorrect application of the payment window policy for mental health inpatient services. Specifically, the claim should have followed the 24-hour window for non-diagnostic outpatient services provided on the day before a mental health inpatient admission, rather than the standard 72-hour window used for other types of admissions. The findings of the review have been communicated to the Case Management, Patient Access, and Patient Accounting Departments Patient Access Leadership. The encounter identified as an error has been corrected and rebilled. The Compliance Department will continue to evaluate compliance with observation status billing guidelines annually.

- **Emergency Department Facility Fee Coding Audit –** To assess coding and billing accuracy of Emergency Department (ED) procedures, external coding audit agency AAPC conducted a review of forty-six (46) Medicare ED facility fee encounters, evaluating ICD-10-CM diagnosis code assignment, CPT/HCPCS procedure code assignment, modifier usage, billing units, and Ambulatory Payment Classification (APC) validation. APC is Medicare's payment methodology for hospital outpatient services, including ED visits, that groups outpatient services into clinically and resource-similar categories for reimbursement. The audit resulted in a one hundred percent (100%) accuracy rate across all evaluated coding elements, indicating full compliance with applicable Medicare billing requirements. Based on the findings, no corrections were necessary, and no financial impact was identified. The Compliance Department will continue routine risk-based monitoring of ED coding practices.

Rural Health Clinics

REPORT TO THE BOARD OF DIRECTORS

Rural Health Clinics

Ryan Gates, Chief Population Health Officer, 559-624-5647
Meredith Alvarado, Director of Rural Health Clinics, 559-592-7365
Date: September 6th, 2025

Summary

1. Kaweah Health currently operates six Rural Health Clinics located in our primary service area of Tulare County. The locations include Exeter, Dinuba, Lindsay, Woodlake, and Tulare. The populations served consist of approximately 50% Medi-Cal, 26% Medicare, 23% commercial/private, and 1% self/cash pay.
2. Kaweah's Health Rural Health Clinics continue to play an important role in expanding access to primary, specialty, and behavioral health care services in rural communities. We currently offer 18 specialty services across the clinics and support over 83 providers. During FY 25, the rural health clinics onboarded 9 new providers, increasing access and services to our patients and communities. The Rural Health Clinics also support a Graduated Medical Education (GME) Adult Psychiatry program, Child Psychiatry Fellowship, Family Medicine, and Medical and Advanced Practice student rotations.
3. The Rural Health Clinics have designed and implemented intentional organizational clinic structures to support growth, quality, and the services we provide. In addition, the operational and quality teams work side by side to deliver world-class care to the populations served. This collaboration has led to the implementation of a variety of changes that have improved efficiencies as well as quality and financial outcomes.
4. The team-based care model practiced at the Rural Health Clinics provides patients with access to their healthcare provider during all hours of operation. An engaged and dedicated clinician leadership team has brought a culture of learning and collaboration between primary care providers, specialists, and administration. Patients also have access to resources such as pharmacists, community care coordinators, and transportation services.
5. Care delivery is being reinvented through telehealth and by developing community partnerships with organizations within our service area to expand the reach of our high-quality care. These partnerships and technologies help bring needed care to our communities beyond our four walls.
6. Kaweah Health Rural Health Clinics are also largely responsible for the outcomes of our risk-based care transformation programs (i.e. Quality Improvement Program (QIP), Health Homes, Enhanced Care Management (ECM), Humana Medicare Advantage, etc.).

7. Intentional efforts are being made to improve the patient's experience in how they access their healthcare provider and clinic. Technologies that allow for bi-directional texting, emailing your healthcare team, and accessing your health information through a patient portal are available to all patients.

Quality/Financial Performance Data

1. **Quality Performance Data**
    a. Humana Medicare Advantage
        i. Risk Adjustment Factor (RAF): 1.099 in 2024
        ii. CMS Quality Score: HEDIS & Patient Safety Star Rating 3.50 in 2024 (increase of 0.18)
        iii. Practitioner Assessment Forms: 63.31% completed in 2024 (increase of 23% from 2023)

    b. Quality Improvement Performance
        i. The Rural Health Clinics reported on 15 quality measures and performed on 11 and overperformed on 8 quality measures during Program Year 7 (2024), bringing the overall quality score to 100%. The clinics achieved full performance on 9 quality measures, partial performance on 2 quality measures and no performance on 4 quality measures. **Total funding earned for the QIP program in 2024 totaled $9,502,336.72.**
        ii. Performance is achieved by meeting DHCS Targets and despite improving performance from 2023 to 2024, some measures did not hit DHCS target. Details included below.

Quality Measures Reported in 2024

Performance
No Performance
Partial Performance

	Measure Name	Type
1	Cervical Cancer Screening	Priority
2	Breast Cancer Screening	Priority
3	HIV Screening	Elective
4	Lead Screening in Children	Elective
5	Colorectal Cancer Screening	Priority
6	W30	Priority
7	GSD (A1c Control)	Priority
8	Q-FUA	Priority
9	Q-FUI	Elective
10	Controlling Blood Pressure	Priority
11	WAC/WCC	Elective
12	Advance Care Planning	Elective
14	Child & Adolescent Well Care Visits (WCV	Priority
14	Prenatal	Priority
15	Post Partum	Priority

Kaweah Health QIP Performance Scorecard	QIP Performance			
Quality Measure	**2022**	**2023**	**2024**	**Improvement 23-24**
Q-FUA Follow Up After ED Visit for Alcohol and Other Drug Abuse of Dependence (FUA) 30 Days ***(MCP reported rate 2025 for both 2023 & 2024)***	11.11%	38.35%	44.03%	5.68%
Q-FUA Follow Up After ED Visit for Alcohol and Other Drug Abuse of Dependence (FUA) 7 Days ***(MCP reported rate 2025 for both 2023 & 2024)- informational only***	5.56%	26.52%	15.67%	-10.84%
Q-FUI-Follow Up After High-Intensity Care for Substance Use Disorder (FUI) 30 Days ***(MCP reported rate 2025 for both 2023 & 2024)***		42.11%	58.76%	16.66%
Q-FUI-Follow Up After High-Intensity Care for Substance Use Disorder (FUI) 7 Days ***(MCP reported rate 2025 for both 2023 & 2024)- informational only***		15.79%	32.99%	17.20%
Q-CMS52 Preventive Care and Screening: Screening for Depression and Follow Up Plan (CDF) ***(Trending Break) (Transitioned to HEDIS Measure for 7)- Q DSF-E 2 rates Depression Screening & Follow Up on Positive Screen***	47.78%	56.10%	45.46%	-10.64%
Q-CBP Controlling High BP	64.65%	68.79%	66.76%	-2.03%
Q- CDC-H9 Comprehensive DM Poor Care HbA1c Poor Control (>9%) * ↓ ***(lower rate is better)***	30.33%	31.26%		
Q-GSD Glycemic Status Assessment for patients with Diabetes (GSD)			23.08%	8.17%
Q-QPP47 Advance Care Plan	64.61%	54.21%	52.76%	-1.45%
Q-CMS130 Colorectal Cancer Screening (1) ***(Trending Breack PY5, new Population 45-75)***	30.14%	27.32%	40.71%	13.39%
Q-CMS349 HIV Screening	33.54%	40.11%	45.32%	5.21%
Q-W30: Well-Child Visits in the First 15 Months	70.12%	80.83%	77.60%	-3.23%
Q-W30: Well-Child Visits in the First 30 Months of Life 15-30 Months	79.27%	75.37%	76.11%	0.74%
Q-WCC Weight Assessment & Counseling (3-17 year olds) BMI (WAC)	71.06%	82.48%	82.39%	-0.09%
Q-WCC Weight Assessment & Counseling (3-17 year olds) Counseling for Physical Activity (WAC)	35.84%	67.90%	71.49%	3.59%
Q-WCC Weight Assessment & Counseling (3-17 year olds) Counseling for Nutrition (WAC)	34.76%	67.45%	70.99%	3.54%
Q-WCV: Child and Adolescent Well-Care (WCV) ***(New in PY5)***	40.16%	39.80%	42.07%	2.27%
Q-LSC- Lead Screening in Children (2) ***(New in PY6)***	41.08%	56.21%	81.19%	24.98%
Q-PPC-PRE Prenatal Care	84.78%	88.10%	87.19%	-0.91%
Q-PPC-PST Post Natal Care	82.61%	78.91%	77.50%	-1.41%
Q-BCS Breast Cancer Screening	49.36%	48.63%	56.60%	7.98%
Q-CCS Cervical Cancer Screening (3)	52.84%	55.10%	55.82%	0.72%

2. **Financial Performance Data**
    a. Net Revenue: $31,692,752 (8% increase)
    b. Direct Cost: $24,121,372 (10% increase)
    c. Contribution Margin: $7,571,380 (1% increase)
        i. **2nd highest contribution margin in the past four years and very similar to FY24**
    d. Net Income: $1,502,869 (28% increase)
    e. Patient Cases: 148,000 (8% increase over prior year)
    f. Telehealth: 14,412 (9.7% of FY 2025 visits & 8% of contribution margin)
    g. Exeter Clinic:
        i. Accounts for 48% of visits and 46% of contribution margin
        ii. Net Revenue per visit increased (1%) to $209
        iii. Contribution Margin per visit increased (2%) to $49
    h. Lindsay Clinic:
        i. Accounts for 14% of visits and 10% of contribution margin
        ii. Net Revenue per visit $213
        iii. Contribution Margin per visit of $38
    i. Dinuba Clinic:
        i. Accounts for 11% of visits and 13% of contribution margin
        ii. Net Revenue per visit decreased (2%) to $230
        iii. Contribution Margin per visit of $59
    j. Woodlake Clinic:
        i. Accounts for 10% of visits and 17% of contribution margin
        ii. Net Revenue per visit increased (9%) to $249
        iii. Contribution Margin per visit increased (12%) to $90

k. Tulare Clinic:
    i. Accounts for 17% of visits and 13% of contribution margin
    ii. Net Revenue per visit $199
    iii. Contribution Margin per visit of $40

3. Employee Engagement Data:

a. The Rural Health Clinics biannual employee engagement report highlights a positive upward trend across the last several surveys. These results reflect the continued progress we're making in fostering a more engaged, connected, and supportive workplace for our teams.

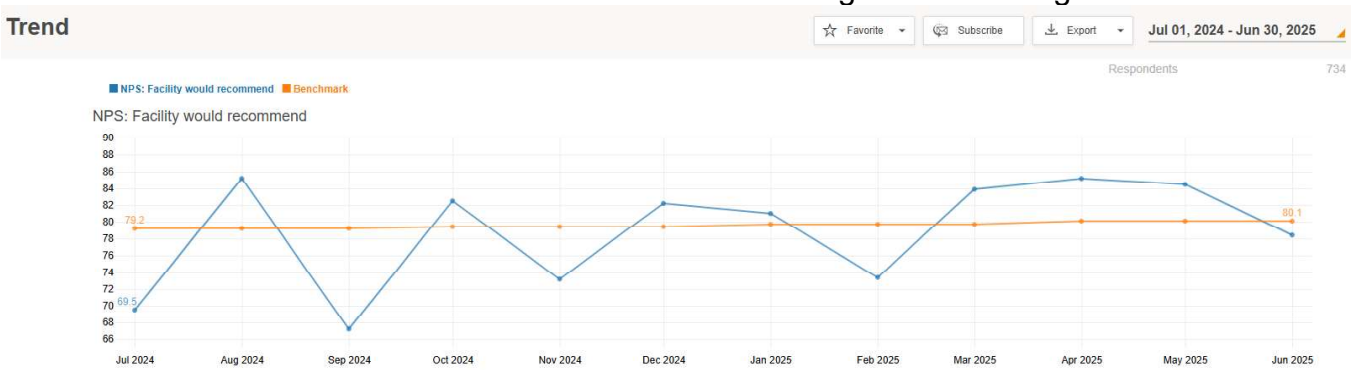
Workgroup	2024 Survey Averages	2022 Survey Averages	2021 Survey Averages	Increase/Decrease from 2022	Workgroup Size	Response Rate
RHC Tulare Clinic	4.47	3.97	4.38	0.50	19	100%
RHC-Dinuba Health Clinic	4.36	3.98	4.52	0.38	17	100%
RHC-Exeter Health Clinic	4.22	4.04	3.48	0.18	61	95%
RHC-Lindsay Health Clinic	4.07	3.79	3.75	0.28	16	100%
RHC-Woodlake Health Clinic	4.56	4.46	4.02	0.10	10	100%

b. Between full organizational surveys, a 27-question pulse survey is administered to staff. This instrument is utilized to monitor progress in areas of high engagement, assess improvement over time, and identify focus areas aligned with organizational priorities. Results consistently demonstrate strong staff engagement, while also providing valuable insight into opportunities to further enhance team morale and foster collaboration. These findings will continue to inform leadership strategies, guide resource allocation, and shape ongoing initiatives aimed at strengthening organizational culture and sustaining high levels of engagement.

Workgroup	2025 27 Item Survey Averages	2025 27 Item Average Goal	Actual Score vs. Goal	Workgroup Size	Response Rate
RHC Tulare Clinic	4.06	4.22	-0.16	22	95%
RHC-Dinuba Health Clinic	4.23	4.22	0.01	18	100%
RHC-Exeter Health Clinic	4.30	4.22	0.08	67	97%
RHC-Lindsay Health Clinic	3.88	4.22	-0.34	20	90%
RHC-Woodlake Health Clinic	4.29	4.22	0.07	13	100%

4. **Patient Experience**

    a. The Rural Health Clinics have demonstrated ongoing improvement in patient experience scores, particularly in the measure 'Provider would recommend.' We continue to make progress toward the 50th percentile benchmark and remain committed to achieving and sustaining it.



	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	69.5 n = 82	85.2 n = 61	67.2 n = 58	82.5 n = 57	73.2 n = 56	82.2 n = 45	81.0 n = 79	73.4 n = 64	83.9 n = 56	85.2 n = 54	84.5 n = 71	78.4 n = 51

Policy, Strategic or Tactical Issues

1. Pursue strategic growth by expanding community access through the development of new Rural Health Clinic opportunities, including the addition of a second Woodlake clinic to meet the growing need for care
2. Focus on providing consistent, high-quality customer service to all patients.
3. Maintain standardization in care delivery, workflows, access, policies, and practices across all clinics.

Recommendations/Next Steps

1. Kaweah Health Rural Health Clinics are to maintain their recognition status as a Patient-Centered Medical Home and their Behavioral Health Integration distinction through the National Committee for Quality Assurance. These efforts help drive quality initiatives, improve patient care standards, and increase access to care within the clinics.
2. Continue to partner with and support clinician leadership to collaboratively support high-quality patient care and access within our populations served.
3. Maintain a focus on employee engagement in efforts to drive high-performing teams, retention, and a culture of safety.
4. Execute Patient Navigation initiatives to support patient engagement, quality, workflow efficiencies, and care coordination.

5. Provide resources that include Community Care Coordinators, Pharmacists, Educators, and transportation services to support patients with social determinants of health.
6. Develop partnerships with Health Plans and local organizations to expand non-traditional access to care in a cost-effective manner.
7. Expand primary care and specialty access through the use of advanced practice providers.
8. Strive towards making healthcare access easy for our patients by driving telehealth accessibility, same-day appointments, and by having expanded methods of communicating with their healthcare team.

Approvals/Conclusions

The Kaweah Health Rural Health Clinics serve as important access points to care for our medically underserved communities. The revenues gained from efficiently operating the Rural Health Clinics support our organization's strategic pillar of maintaining financial strength. The Rural Health Clinics will continue to expand high-quality access to care for the communities we serve while in parallel supporting our valuable clinicians and staff members delivering care.

August 13, 2025

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HUMAN RESOURCES COMMITTEE MINUTES

Wednesday, August 13, 2025
Kaweah Health Medical Center
305 Acequia Avenue, Executive Office Conference Room

PRESENT: Directors: Lynn Havard Mirviss (chair) and Armando Murrieta; Gary Herbst, CEO; Ryan Gates, Chief Ambulatory Officer; Raleen Larez, Director of Employee Relations; Hannah Mitchell, Director of Organizational Development; JC Palermo, Director of Physician Recruitment; Paul Stefanacci, M.D., Chief Medical & Quality Officer; Kelsie Davis, recording

CALLED TO ORDER – at 4:00pm by Director Havard Mirviss

PUBLIC PARTICIPATION –None.

MINUTES- Reviewed from June 11, 2025.

MEDICAL STAFF RECRUITMENT – JC gave an updated overview and discussion of the monthly physician recruitment report. The report is attached hereto the minutes.

STAFFING REPORT – Jaime presented all new leaders that have joined the Kaweah family. We have hired 37 new directors and/or managers. We filled 12 directors in the last year and 8 are external, 4 are internal promotions. We hired 25 managers, 10 are external and 15 are internal promotions. Overall, we are down to 360 open positions.

KAWEAH CARE EMPLOYEE AND PHYSICIAN ENGAGEMENT – Hannah reviewed the employee portion of the presentation and Dr. Stefanacci reviewed the physician portion of the slides, which is attached hereto the minutes.

HUMAN RESOURCES POLICIES – Brittany and Raleen reviewed the Human Resources policies as revised and recommended to be presented to the Board for approval. Attached hereto the minutes.

ADJOURN – *at 5:03pm by Director Havard Mirviss*

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.

August 18, 2025

Kaweah Delta Health Care District
Board of Directors Committee Meeting

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

AUDIT AND COMPLIANCE COMMITTEE

Meeting Held: Monday, August 18, 2025 • Executive Office Conference Room

Attending: Board Members: Michael Olmos – Committee Chair, Dean Levitan, M.D.; Gary Herbst, Chief Executive Officer; Malinda Tupper, Chief Financial Officer; Rachele Berglund, Legal Counsel; Ben Cripps, Chief Compliance & Risk Officer; Jill Berry, Director of Corporate Compliance; Amy Valero, Compliance Manager; and Michelle Adams, Executive Assistant – Recording.

Guests: Brian Conner, Baker Tilly; Laura Kennedy, Baker Tilly; Jennifer Stockton, Director of Finance; Kari MacDonald, Finance Accounting & Reimbursement Manager

Michael Olmos, Chair, called to order at 1:00pm.

PUBLIC / MEDICAL STAFF PARTICIPATION – None

1. **Opening Audited Financial Statement Kick-Off Fiscal Year 2025 –** Brian Conner and Laura Kennedy, Baker Tilly provided the Committee with a high level overview noting:
    - The FY2025 audit will consist of the annual audit and the single audit, which relates to FEMA funding of FY2025.
    - Mr. Conner outlined that Kaweah Health management prepares the financial statements, Baker Tilly will form an opinion on whether the consolidated financial statements are fairly stated based on the Generally Accepted Accounting Principles.
    - The Audit will be conducted under government auditing standards, Baker Tilly is required to understand the design and implementation of internal controls, but the internal controls are not covered in the effectiveness of the opinion.
    - The Committee discussed the significant risks including:
        - Valuation of patient accounts receivable and patient service revenue are a significant risk due to being an estimate. Michael Olmos asked for an example of IBNR liabilities. Mr. Conner described IBNR liabilities as risk management professional liabilities. He further stated they are known claims and claims that have been incurred but not yet reported indicating the District is still obligated to that liability, which is most often an estimate. Gary Herbst described the risk management and finance process for the Committee and how it is recorded on the balance sheet.
        - Management override of controls.
        - Compliance with internal controls over federal grants.

- Baker Tilly will obtain reasonable assurance the consolidated financial statements are free from fraud or error.
- The financial opinion will be presented on October 22, 2025 to the Audit & Compliance Committee prior to the Board of Directors Meeting.
- Dean Levitan, M.D. asked if the report is shared with outside entities. Jennifer Stockton and Mr. Herbst indicated it is submitted to the county, the public repository for municipal bond holders, private banks that hold bonds, the state controller, and anyone else who has a financial interest. Ms. Stockton also noted it can be requested by any individual.
- Recent Accounting Developments.
    - GASB 101 is applicable to the current reporting period. Mr. Conner does not anticipate it having a big impact on the organization as it is almost exclusively related to general government.
    - GASB 102 is applicable to the current reporting period, but Mr. Conner does not believe it will have any impact on Kaweah Health. GASB 102 relates to statutory limitations on borrowing. Kaweah Health financial statements have all the appropriate disclosures.
    - GASB 103 will have an impact next year, relating to subsidies.
    - GASB 104 will go into effect next year and is not anticipated to have an impact on the organization.
- Staff excused themselves and the Board members continued to discuss the audit process.

Michael Olmos adjourned at 2:13pm

August 20, 2025

Kaweah Delta Health Care District
Board of Directors Committee
Meeting Minutes

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Finance, Property, Services, and Acquisition Committee – OPEN MEETING
Wednesday August 20, 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 10:01AM

Public Participation- None.

MINUTES- Minutes were not reviewed from July. Will be included next month.

ARA DIALYSIS- A review of the most recent plan financials was presented by Ryan Gates. (A copy is attached to the original of these minutes and is considered a part thereof.)

SEMI-ANNUAL INVESTMENTS REPORT- A review of the most current report of June 30, 2025, by Jennifer Stockton. (A copy is attached to the original of these minutes and is considered a part thereof.)

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*

Adjourned at 11:02 AM

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.

August 20, 2025

Kaweah Delta Health Care District
Board of Directors Committee
Meeting Minutes

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

Marketing & Community Relations Committee – OPEN MEETING
Wednesday August 20, 2025
Kaweah Health Medical Center – Executive Office Conference Room

Present: Directors: Dave Francis (Chair) & Armando Murrieta; Gary Herbst, Chief Executive Officer; Marc Mertz, Chief Strategy Officer; Karen Cocagne, Director of Marketing & Media Relations; Gary Rogers, Communications Manager; Samantha Torres, Social Media Specialist; Amee Longbottom, Sr. Communications Specialist; Jaclyn Bunting, Sr. Digital Strategist; Nou Her, Sr. Social Media Specialist; and Lisette Mariscal, Recording

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

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

MINUTES- The open meeting minutes from June 4, 2025, were reviewed.

INTRODUCTIONS – Nou Her, Sr. Social Media Specialist, was introduced.

COMMUNITY EXPERIENCE – A verbal update was provided regarding recent community engagement meetings and events.

MARKETING & MEDIA RELATIONS –

4.1.1 – A walkthrough of the new website (www.KaweahHealth.org) was conducted.
4.1.2 - Karen Cocagne verbally presented the results of the recent brand study.
4.1.3 – Jaclyn Bunting introduced a new digital campaign and quarterly eNewsletter.
4.1.4 – An update was provided on the upcoming edition of Vital signs.
4.2 – A report on recent marketing performance and engagement metrics was shared. (see attachment 4.2 of the agenda.)

Adjourned at 5:02 PM

Kaweah Delta Health Care District

Board of Directors Committee

Meeting Minutes

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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.

August 21, 2025

OPEN Quality Council Committee
Thursday, August 21, 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; Dr. Paul Stefanacci, Chief Medical Officer; Schlene Peet, Chief Nursing Officer; Mark Mertz, Chief Strategy Officer; Ryan Gates, Chief Ambulatory Officer; Dr. Lamar Mack, Medical Director of Quality & Patient Safety; Scott Baker, Director of Emergency and Trauma Services; Shawn Elkin, Infection Prevention Manager; Evelyn McEntire, Director of Risk Management; 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 July 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 Emergency Department Quality Report

5. **Incident Management –** A review summary of the Incident Management meting process & RCAs and event scoring. Evelyn McEntire, Director of Risk Management. – Reports reviewed and attached to minutes. No action taken.

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 8:48 AM.

August 27, 2025

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD WEDNESDAY AUGUST 27, 2025, AT 4:00PM IN THE CITY OF VISALIA CITY COUNCIL CHAMBERS – 707 W. ACEQUIA, VISALIA, CA.

PRESENT: Directors Olmos, Francis, Levitan, Havard Mirviss & Murrieta; G. Herbst, CEO; J. Randolph, Chief of Staff; M. Tupper, CFO; 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 AUGUST 27, 2025, AT 4:15PM IN THE CITY OF VISALIA CITY COUNCIL CHAMBERS – 707 W. ACEQUIA, VISALIA, CA.

PRESENT: Directors Olmos, Francis, Murrieta, Havard Mirviss & Levitan; G. Herbst, CEO; D. Hightower, Chief of Staff; M. Tupper, CFO; 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 4:16 PM by Director Olmos.

ROLL CALL- All Directors were present and a roll call is not necessary.

FLAG SALUTE- Director Levitan lead the flag salute.

PUBLIC PARTICIPATION – Alex Petrak, Russel Downing, Vincent Kirkpatrick, Cody Brazeal, Anne Shapiro, Yiran, Satish Kesavaramanujam, Nicole, Kyle Potts, Thomas Gray, Omar Guzman, Khoa Tu, Rita Aguilar.

CLOSED SESSION ACTION TAKEN: In closed session the board approved the action of rejecting a claim on its merits, the credentialing recommendations of the MEC, Revoking a physician's credentials and medical staff membership, and the closed July board minutes from July 1, 2025, and July 23, 2025.

RECOGNITIONS- Resolution 2268 and 2269.

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 August 27, 2025, consent calendar.

PUBLIC PARTICIPATION – None.

MMSC (Havard Mirviss/Murietta) to approve the August 27, 2025, consent calendar. This was supported unanimously by those present. Vote: Yes – Olmos, Havard Mirviss, Levitan, Murrieta and Francis.

INCIDENT MANAGEMENT – A presentation and discussion regarding the new Kaweah Health Incident Management process, including procedures for Root Cause Analysis, and Midas event scoring. Copy attached to the original of the minutes and to be considered a part thereof.

KAWEAH HEALTH PHYSICIAN RECRUITMENT REPORT – A presentation and discussion of current Kaweah Health physician recruitment efforts, including recent hires, open positions, and strategies to address identified staffing needs and retention. 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 and HR01. – *Gary Herbst, CEO*

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

ADJOURN - Meeting was adjourned at 6:22PM

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

AP119

Policy Number: AP119	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)	
Visiting Regulations for Kaweah Delta Health Care District	

PURPOSE: Kaweah Health understands how important it is for our patients to be surrounded by loved ones. Family and friends are a part of a patient's healing journey. Their presence makes a difference.

POLICY:

I. Kaweah Health does not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, disability, or any other protected class within federal or state guidelines.

II. All visitors are welcome to visit between 8:00 a.m. and 9:00 p.m. daily.

III. Patients (or parents, if the patient is a minor) have the right to decide who may visit them and when, as visitors can play an important role in the healing process. Patients may also request "no visitors" at any time, and a sign will be placed on the patient's door to indicate this.

IV. All visitors must check in at the front desk located at the designated facility entrance upon arrival. Visitors will be given a badge to wear during their visit. Entry is only allowed through designated entrances, and a visitor pass will be issued daily.

V. Children, ages 15 and under, must be accompanied by an adult and supervised at all times. Under no circumstances is a child to be left

Commented [VD1]: Added after PCD Meeting

alone in patient areas or waiting rooms and lobbies.

VI. The Unit Leadership, House Supervisor, Security, and/or Administration should be contacted for assistance as needed.

Commented [VD2]: Emma M.

GUIDELINES:

I. An adult family member who serves as an interpreter designated by family may stay at the bedside of patients, if necessary, for continuity of care.

Commented [VD3]: Added after PCD Meeting

II. While there is no limit on the total number of visitors per day, it is recommended that no more than 2 to 3 visitors be in the patient's room at one time at the same time. Visitor restrictions may be applied in collaboration with the patient and their nurse.

III. We encourage visitors to use waiting rooms and lobbies to help minimize the number of people in patient rooms at any one time.

IV. Quiet time is all the time. Both staff and families are expected to be quiet in the corridors and while visiting in the patient room and be considerate of all patients and other visitors.

V. Eating is allowed only in the public dining areas and, with the patient's permission, in the patient's room.

VI. Cell phones are prohibited in posted areas. Where allowed, cell phones are to be on vibrate/silent mode. For full details on use of cell phones, photography, and video recording reference policy AP163 "Photography and Video Recording of Patients and Staff".

VII. Special Situations: If a visitor has special circumstances or visitation requests – such as end-of-life visits or accessibility needs – please don't hesitate to involve the House Supervisor.

VIII. Kaweah Health reserves the right to remove any visitor that is determined to be disruptive to patient care or unit operations.

Commented [VD4]: Emma M.

IX. All patients are allowed one (1) visitor to stay overnight.

A. Overnight visitors must be a minimum age of 18.

Commented [VD5]: Added after PCD

B. Overnight visitors must check back in at the main entrances before 9:00 p.m. to receive an overnight visitor badge.

C. All entrance doors will be locked at 9:00 p.m., marking the end of regular visiting hours. Overnight visitors who leave the building after 9:00 p.m. will not be allowed to re-enter

D. Visitors are encouraged to not bring pillows and bedding from home.

Commented [VD6]:

Commented [VD7]: Facilities asked for this to be added and have now asked for this to be removed. Kevin would like something added about risk of pests and infection.

E. We reserve the right to remove any overnight visitors that are determined to be disruptive to patient care or unit operations.

F. If a visitor is found roaming freely in the hallways, that visitor may be asked to leave the facility.

Visitation in the Emergency Department:

A. Visitors are allowed to accompany a patient to the Emergency Department. There is a limit of four (4) visitors in the waiting room but only two (2) visitors can accompany the patient into the treatment rooms. Exceptions to this policy can be made for end-of-life or critically-ill patient circumstances.

B. Kaweah Health reserves the right to remove any visitor that is determined to be disruptive to patient care or unit operations.

Commented [VD8]: Emma M.

C. When hallway beds or chairs are utilized, only one (1) visitor may be allowed to remain with the patient. Children aged 12 and under may have two (2) visitors with them at all times.

D. Visitors must check-in with security to obtain visitor badges and gain access to the ED treatment areas. If the visitor is not wearing a visitor badge, they may be asked to leave the treatment area. All visitors will be screened by security for contraband/weapons prior to being given access to the treatment areas within the ED. Security staff will collect visitor badges upon discharge.

E. Visitors are not permitted to wait in hallways; all visitors must remain in the patient's room. When patients are out of the department, visitors will be asked to wait in the waiting room.

F. Visitors are not allowed in Zone 4 and cell phone usage is prohibited.

G. During Code Secure, Security and Charge Nurse will work together to limit treatment area access due to security, safety or patient treatment concerns.

H. During times of highly-infectious disease situations, ED has the right to limit or designate specific types of patients that will not be permitted to have any visitors. Parents with minor children or special needs adults with an infectious disease will be the exception.

I. During ED Saturation, visitors will be limited based on the following Saturation Codes:

i. Level 1 – Green

4 visitors in the waiting room, 2 in the treatment rooms.

ii. Level 2 – Yellow

2 visitors in the waiting room, 2 in the treatment rooms.

iii. Levels 3 & 4 – Red & Black

1 visitors in waiting room, 1 in the treatment rooms.

J. To maintain a safe environment, individuals whose behavior interferes with patient care or unit operations may be subject to removal from the premises.

Visitation in the Neonatal Intensive Care Unit, Post-partum, Pediatrics and Labor & Delivery:
These areas allow overnight visitors – details by location below. If the patient or guardian desires, this can be different people at different times. Those authorized to remain will be issued a visitor sticker which must be visibly displayed. Children under the age of 12 are not allowed unless they are accompanied by a guardian.

Commented [VD9]: Rhonda Q.

A. Pediatric patients are allowed two (2) banded guardian(s) per stay. Two additional visitors are allowed when accompanied by a banded guardian. Two (2) overnight visitors are allowed in this area.

B. Labor and Delivery patients may have two (2) visitors at all times. Visitors will receive pink armbands that allow 24-hour access. Any exceptions and/or restrictions will be made in collaboration with the laboring mother and the nurse.

C. Labor Triage patients are allowed one (1) visitor at the bedside.

D. For Post-partum patients, one support person will be issued a yellow armband for 24 hour access. Four (4) additional visitors are allowed at a time during hospital visiting hours. Siblings, of any age, will be allowed to visit during visiting hours with no restrictions on number of people in the room to facilitate family bonding.

E. For Neonatal Intensive Care Unit patients, two (2) banded guardian(s) per stay. Two (2) additional visitors are allowed, during hospital visiting hours, when accompanied by a banded guardian.

Visitation for Outpatient Services:

A. Surgery – One (1) visitor is allowed with the patient during pre-op and post-op. Two (2) visitors are allowed in the waiting room during the procedure.

B. Cath Lab – Two (2) visitors are allowed with the patient during pre-op, post-op. Two (2) visitors are allowed in the waiting room during the procedure.

C. Endoscopy – One (1) visitor with the patient during pre-op and post-op. Two (2) visitors allowed in the waiting room during the procedure.

Visitation for Other Campuses

A. Rehabilitation Hospital – Two (2) visitors at the bedside between 8:00 a.m. and 9:00 p.m. If more than two (2) visitors are wanting to visit with the patient, the staff will coordinate time in the activity room or cafeteria. One (1) visitor is allowed to stay overnight as long as there is a single occupancy room available. (Reference PR.04)

B. Sub Acute – While Sub-Acute follows the Kaweah Health Visitation Guidelines, Skilled Nursing falls under Title 22. (SNF V.2)

C. Mental Health – Two (2) visitors are allowed during visiting hours. (Reference MH.154)

D. Urgent Cares and Outpatient Therapy Clinics - Visitors are allowed to accompany a patient to these facilities. There is a limit of two (2) visitors in the waiting room but only one (1) visitor can accompany the patient into

the treatment rooms. Exceptions to this policy can be made for unique patient circumstances.

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~~**PURPOSE:** Visitor access guidelines balance the needs of all patients for privacy and rest, the environment needed by the medical staff and hospital staff to carry out their work, and everyone's need for safety and security with the presence of family or friends with the patient during the health care admission. In extenuating circumstances, exceptions to this policy may be considered by the Nurse Manager, House Supervisor or designee.~~

~~**POLICY:**~~

~~These regulations apply to all acute care areas of Kaweah Health Medical Center. Skilled Nursing (SNF V.2), Mental Health Hospital (MH.154) and Acute Rehabilitation (PR.04) have policies which are specific to those respective clinical areas.~~

~~General visiting hours are 8:00a.m. to 9:00p.m. All visitors must enter via designated locations and receive a visitor sticker each day.~~

~~Visitor Expectations~~

~~Generally patients are not permitted overnight visitors unless exceptions granted by the Unit Manager, House Supervisor, or designee. This may include situations but not limited to: support for a cognitive/mental disorder, end of life, change in level of care, deteriorating condition, and major surgery with high risk of death.~~

~~If a sleeping chair is available, it will be provided for the approved overnight visitor(s).~~

~~An interpreter designated by family may stay at the bedside of patients, if necessary for continuity of care.~~

~~Patients can request "no visitors" at any time. A sign will be posted on the door of the patient's room to that effect. (AP.49 No Information No Presence in Facility Patient Status)~~

~~It is suggested that no more than two (2) visitors be in a patient's room at one time as a limiting guideline. The nurse has the ability to allow more or less if it is in the patient's best interest, or at the request of a patient or physician.~~

~~Other visitors must go to public lobby areas by the visitor elevator, in the main lobby, or in the cafeteria to wait. An adult must accompany children (15 and younger) at all times and the child or children are allowed in the main 1st floor lobby or the cafeteria if not approved for visitation.~~

~~Staff may request that visitors leave the room while they provide patient care or if visitors are interfering with the treatment or rest of any patient. Nursing staff may also ask any visitor to leave the patient care area if the visitor is being loud or disruptive in anyway.~~

~~Children 12 years of age and younger are not allowed to visit unless cleared by the Unit Leader, House Supervisor or designee.~~

~~For the health of all patients and staff, once authorized, the visit should be as brief as possible and the visitor should be directed to stay in the patient room.~~

~~Cell phones are prohibited in posted areas (such as but not limited to Emergency Room, Mental Health Hospital, during delivery of a newborn) and during patient care. Where allowed, cell phones and pagers are to be on vibrate/silent mode. For full details on use of cell phones, photography, video recording reference policy AP163 "Photography and Video Recording of Patients and Staff".~~

~~Eating is allowed only in the public dining areas and, with the patient's permission, in the patient's room.~~

~~Patients in Neonatal Intensive Care Unit, Post-partum, Pediatrics and Labor Delivery are allowed overnight visitors – details by location below. If the patient or guardian desires, this can be different people and different times. Those authorized to remain will be issued a visitor sticker which must be visibly displayed. No minors allowed for visitation in NICU or Pediatrics.~~

~~Seasonal Restrictions: Seasonal or disease specific visitor restrictions may be recommended by Infection Prevention as indicated by public health authority. Annual visitor restrictions for flu and seasonal respiratory disease begins October 1st and ends March 31st unless otherwise advised by Infection Prevention.~~

~~For pediatric patients, two (2) banded guardian(s) per stay. 8am – 9pm visitors are allowed when accompanied by a banded guardian, max of two (2) persons in the room at any given time.~~

~~For Labor and Delivery two visitors will be issued pink arm bands for (24) hour access.~~

~~For Post-partum patients, one support person will be issued a yellow armband for 24 hour access. Two(2) additional visitors are allowed in a patient's room at a time during visiting hours . Siblings will be allowed to visit during visiting hours with no restrictions on number of people in the room to facilitate family bonding.~~

~~For Neonatal Intensive Care Unit patients, two (2) banded guardian(s) per stay. An additional 4 visits per day allowed when accompanied by a banded guardian, max of two (2) persons in the room at any given 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."*~~

AP180

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

Weapons Brought Into The District

PURPOSE:

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

DEFINITION:

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

Examples of weapons include, but are not limited to:

Firearms

Edged weapons (Swords, Knives)

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

Striking implements (Batons, Clubs)

Missile throwing objects (slingshots, bow/arrows)

Explosives

Incendiary devices

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

POLICY:

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

II. Weapons that are discovered after arrival should be returned to the owner's vehicle or turned in to Security for safekeeping.

LAW ENFORCEMENT/ OFF-DUTY PEACE OFFICER EXCEPTION:

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

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

On-duty law-enforcement officers

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

Off-duty law-enforcement officers

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

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

OFF-DUTY PEACE OFFICER FIREARMS RESTRICTIONS – SUICIDE RISK PATIENTS

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

EMPLOYEE EXCEPTION:

Understanding that our employee workforce is our greatest resource and that we have a shared value to keep our employees safe, Kaweah Health will permit

employees to carry mace/pepper spray and stun gun/taser electroshock self-defense devices tools when coming to and leaving work.

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

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

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

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

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

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AP87

Policy Number: AP87	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)	

Sentinel Event and Adverse Event Response and Reporting

PURPOSE:

This Policy describes the multidisciplinary framework in which Kaweah Delta (herein referred to as Kaweah Health) and its organized Medical Staff identifies and responds to all Sentinel Events/Adverse Events (SE/AE) occurring within the organization. Kaweah Health's response encompasses the identification, investigation, and action plan to reduce risks, implement process improvements, monitor the effectiveness of those improvements, and the appropriate reporting of Events consistent with The Joint Commission (TJC) and all applicable regulatory mandates.

Kaweah Delta recognizes that the commitment to Quality and Patient Safety is everyone's responsibility, and that this accountability begins at the unit level where individual unit staff and leadership play a critical role in the delivery of quality care and patient safety. Staff and leadership in every department should call the Risk Management Department to notify of a potential Sentinel or Adverse Event as soon as possible after an event is identified.

The Risk Management (RM) Director shall coordinate all investigations, Root Cause Analysis (RCAs), Plans of Correction~~Plans of Correction,~~ Action Plans and monitoring activities. The RM Director will coordinate with the Chief Executive Officer (CEO), ~~Chief Quality Officer/~~Chief Medical Officer (~~CQO/~~CMO), Chief Compliance & Risk Officer (CCRO), and any other appropriate ~~-~~Chief Officer to ensure the timely and complete compliance with all required notification(s) to California Department of Public Health (CDPH) or Center for Medicare and Medicaid Services (CMS). ~~The RM Director will coordinate with the CEO, CQO/CMO, or the appropriate Chief Officer to ensure the written Plan of Correction report is completed and received by CDPH.~~ The Quality and Patient Safety Director will coordinate with the CEO, CMO, or the appropriate Chief Officer to ensure the written Plan of Correction report is completed and received by CDPH.

DEFINITIONS:

For purposes of this policy, Sentinel Events and Adverse Events shall be considered as one: Sentinel Event/Adverse Event (SE/AE).

- **Sentinel Event (SE)** – ~~-~~is a term used by The Joint Commission to describe "a Patient Safety Event" that reaches a patient and results in any of the following:

a) Death
b) Permanent harm
c) Severe temporary harm and intervention required to sustain life

Reporting of Sentinel Events to The Joint Commission is strongly encouraged~~,~~ but not required. (Attachment C)

~~**Serious Safety Event (SSE) –** An incident where a deviation from generally accepted performance standards reaches the patient and results in moderate to severe harm (temporary or permanent) or death.~~

- **Adverse Events (AE)** – The list of CDPH reportable adverse events is defined by California Health and Safety Code Section 1279.1. These Adverse Events encompass "Sentinel Events" as well as other delineated (and reportable) situations as well as National Quality Forum's "never events." (See Attachment B).

- **Near-Miss** – Any process variation that did not affect an outcome, but for which a recurrence carries a significant chance of serious adverse outcome. Such a "near-miss" falls within the scope of the definition of a SE, but outside of the scope of those Events that are subject to review by TJC under its SE Policy.

- ~~**Quality Concern –** Events, errors, or situations that are either corrected before a patient is harmed, or that represent an opportunity to identify and correct flaws that jeopardize patient safety. They do not rise to the level of SE/AE or near-miss events, and are managed by the RM department utilizing the Focused Review process.~~

- ~~**METER (Midas Event Triage & Ranking)**~~**Incident Management (IM) Committee –** A multidisciplinary team including members from the organization and Medical Staff which reviews occurrence reports daily to rank and triage events so immediate notification of high-risk or unusual events can be made to hospital and Medical Staff leadership.

- ~~**Focused Review –** A process to evaluate Quality Concerns that hold less potential for severity and harm than would be appropriate for an RCA. In the absence of extenuating circumstances, Focused Reviews are conducted by Unit or Service Line leadership utilizing the Keaweah Health standardized process and documentation. RM staff shall serve as a resource to this process on an as needed basis. Focused Reviews are an integral part of Kaweah Health's Patient Safety and Quality Improvement program.~~

- **Center for Medicare and Medicaid Services (CMS)** – Federal agency responsible for enforcement of Medicare and Medicaid regulations.
- (Attachment D).

- ~~**Case Review Committee (CRC) –** A multidisciplinary team composed of:~~

- ~~Chief Executive Officer (CEO)~~
- ~~Chief Quality Officer (CQO) or Chief Medical Officer (CMO)~~
- ~~Chief Compliance & Risk Officer (CCRO)~~
- ~~Chief of Staff or designee (Chair), if Applicable,~~
~~Medical Staff Clinical Department Chair, if Applicable~~
- ~~, Chief Nursing Officer (CNO), in events involving nursing~~
- ~~Chief Officer of area in which event occurred, as available~~
- ~~Medical Director of Quality/Patient Safety, as available~~
- ~~Director of Risk Management (RM)~~
- ~~Director of Quality &Patient Safety~~
- ~~Director of area where SE/AE occurred~~

~~Others may be asked to participate as appropriate~~

- **Action Plan Oversight Committee (APOC) –** A multidisciplinary team who reviews, revises, and/or approves action items and monitoring plans developed as a result of systematic analyses also known as Root Cause Analyses (RCAs). The Committee is composed of:

  - Director of Risk Management
  - Director of Quality & Patient Safety
  - Director of Clinical Education
  - Director of ISS Clinical Informatics
  - Stakeholders (Department Director & Chief)
  - Chief Compliance & Risk Officer
  - Chief Operating Officer
  - Chief Nursing Officer
  - Chief Medical Officer
  - Others may be asked to participate as appropriate

- ~~**Root Cause**~~**Systematic Analysis** ~~**and Actions (RCA2)**~~ **–** ~~Root-Cause Analysis (RCA) – Root cause analysis is a~~ A comprehensive systematic analysis for identifying the factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A ~~root cause~~ systematic analysis focuses primarily, but not exclusively, on systems and processes, rather than individual performance. The analysis identifies changes that could be made in systems and processes through redesign or development of new systems or processes that will improve the level of performance and reduce the risk of particular serious adverse event occurring in the future. ~~Root Cause~~Systematic Analysis is an integral part of Kaweah Health's Patient Safety and Quality Improvement program.

  PROCESS for Sentinel/Adverse events and near-misses (Attachment A):

  A. The ~~METER~~ Incident Management Committee reviews occurrence reports submitted within the previous 24 hours each weekday to rank and triage events so immediate notification of high-risk or unusual events can be

made to hospital and Medical Staff leadership. Occurrence reports received on weekends/holidays will be reviewed the following business day. High-risk or unusual events which occur during weekends/holidays will be immediately escalated to the House Supervisor and/or the Risk Management ~~team member~~ on ~~-~~call.

B. When an event that is potentially a Sentinel/Adverse ~~or near-miss~~ occurs or is discovered~~,~~ staff will immediately notify the Risk Management Department ~~(624-2340)~~ or RM ~~staff member~~ on call through the House Supervisor.

C. Upon notification of the event, the Risk Management Department will immediately perform an initial assessment to determine the following:

1. The immediate safety of any patients, staff or other persons who are or may be at risk.

~~**2.** The RM Director or designee shall proceed directly to initiate a CRC meeting as described in Section C below.~~

~~**3.**~~**2.** RM will then initiate an ~~complete their~~ investigation in collaboration with unit leaders with an oversight of the area where the event occurred.

~~**D.** The Risk Management Director or designee will convene a CRC within 72 hours.~~

~~**E.**~~**D.** The ~~CRC~~Director of RM (or designee in their absence) will review the event in question and determine:

1. If the event is a Sentinel/Adverse or near-miss;

2. If the event requires reporting to either CDPH and/or TJC;

3. If the event requires a systematic analysis~~RCA~~, or if an alternate action is appropriate; and

4. If any immediate actions prior to the systematic analysis~~RCA~~ are required.

E. If the event is deemed reportable, the RM Director or designee will ensure that such reporting is done in compliance with~~-~~ Kaweah Health policy and all applicable regulatory and statutory requirements as well as notify the ~~CEO, CCO, and CNO~~Executive Team.

F. Upon determination that a Sentinel/Adverse event has occurred, the RM Director shall ensure the CEO and Executive Team are notified within 24 hours of score assignment. The CEO will then notify the BOD within 72 hours. The RM Director shall determine if~~conduct~~ a systematic analysis~~RCA~~ using methodology consistent with current TJC standards unless ~~the CRC determines that~~ an alternate action is appropriate. Directors shall also ensure to the best of their ability that their involved staff~~s~~ are available to attend the systematic analysis~~RCA~~, if their participation is needed. Leadership will be responsible for ensuring that support services for any involved individual are available. Patients and/or families may also be interviewed to gather information for the systematic analysis~~RCA~~, as appropriate.

G. The ~~RM Director (~~unit leader or designee with an oversight of the unit where the event occurred,~~)~~ in collaboration with the patient's physician~~,~~ or Chief of Staff (or designee) will ensure that an apology is offered and notice of the SE/AE is given to the patient involved, or the party responsible for the patient, of the nature of the Event by the time the initial

report is made to CDPH. A notation that this notice has occurred shall be placed in the patient's medical record. If process changes were implemented because of a preventable SE/AE, the patient/family ~~will~~may be informed of those changes. An apology or notice are not required for near-miss events or quality concerns.

H. While the focus of SE/AE is about improving patient care, ~~-~~Kaweah Health may also waive costs to the patient or a third party pay~~e~~or for costs directly related to the SE/AE. This will be reviewed on a case-by-case basis, and will be done in compliance with all applicable regulatory standards.

I. The patient or the party responsible for the patient shall not be provided with a copy of the CDPH report. The CDPH report will not be placed in the patient's medical record, and no reference that a report to CDPH has been made should be included in the medical record.

I. The systematic analysis~~RCA~~ shall be conducted and produce a ~~n~~final Action Plan within 45~~1720~~ days of the initial report of the event to Risk Management~~meeting~~ that includes a detailed review of what transpired prior to, during, and immediately following the event.

The systematic analysis~~RCA~~ will:

A. Focus on systems and processes related to the event using a Just Culture approach (see policy HR.03 Just Culture Commitment)~~t~~;

B. Identify changes that could be made in the systems and processes which would reduce to prevent future occurrences:

C. Develop a detailed written Action Plan for each of the opportunities identified, and will:

1. Identify the key accountable staff position (usually a Director) for ensuring changes are implemented,
2. A date for action implementation or completion,
3. How the department will monitor the effectiveness of such changes, including the accountable staff person and target dates for reporting;
4. When necessary, include references from relevant literature for "best practices" used in the systematic analysis~~RCA~~ and the development of the Action Plan.

D. All documentation related to ~~RCAs, Focused Reviews~~systematic analyses, Action Plans, ~~CDPH Plans of Correction, -~~and monitoring activities involving clinical practice or conduct by members of the Medical or Advanced Practice Provider staff will be maintained exclusively as confidential Medical Staff documents so as to be protected by California Evidence Code, Section 1157.

E. The RM Director~~,~~ and CQMO~~, and the Medical Director of Quality/Patient Safety a~~ are responsible for reporting finalized ~~RCA~~systematic analyses and Action Plans to the ~~following co~~APOC~~mmittees as appropriate~~ for approval and will be reported to the following committees:

- The Patient Safety Committee;

- ~~Professional Staff Quality Committee (Prostaff)~~Quality Committee (QComm)
- Medical Staff issues will be referred to the appropriate medical staff committee/department for follow-up prior to being referred on to the Medical Executive Committee.
- Quality Council

F. Board of Directors Organizational Learning: Every attempt will be made to use "teaching moments" and disseminate the "lesson learned" from these events to all appropriate areas of our organization. Department and unit meetings, in-service discussions, Grand Rounds, conferences, newsletters and other venues will be used in this effort to be sure that we collectively learn from, improve, and prevent similar occurrences in the future.

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REFERENCES:

The Joint Commission Perspectives, October 2022, Volume 42, Issue 10. "*Definition of Sexual Abuse/Assault Revised in Sentinel Event Policy*"

The Joint Commission Perspectives, December 2020, Volume 40, Issue 12

The Joint Commission Perspectives, June 2020, Volume 40, Issue 6

CHA Consent Manual, 2020, Chapter 19

National Quality Forum, 2011, h
~~h~~ttps://www.qualityforum.org/Topics/SREs/List_of_SREs.aspx

HR.03 Just Culture Commitment

Attachment A

~~Process~~

~~Suspected Sentinel/Adverse Event → CRC --- If SE/AE confirmed → RCA* (except HAPI)~~

~~Suspected Near-miss → CRC--- If near-miss confirmed: → RCA*~~

~~Quality Concern → Focused Review~~

~~*unless CRC determines that an alternate action is appropriate~~

Attachment A

Event Analysis Prioritization Matrix				
Minimal analysis required when event is not a known complication and/or not related to the natural course of the patient's illness or underlying condition				
Level of Harm and Probability of Reoccurence	**LEVEL 1:** Event causing moderate or severe permanent harm, serious injury, death, or sentinel or reportable event.	**LEVEL 2:** Event causing moderate temporary harm, or permanent minimal harm.	**LEVEL 3:** Event that reaches patient, does not cause harm, but is an opportunity for improvement.	**LEVEL 4:** Event that does not reach the patient, but is an opportunity for improvement (Near Miss)
Common	RCA	RCA/ACA	Learning from Defect	Learning from Defect
Uncommon		ACA	Debrief	Local follow up
Rare		ACA	Debrief	Local follow up

Analysis Types	
Comprehensive Systematic Analysis (CSA)	A methodology for identifying the causal and contributory factors of a sentinel event including ACA's, RCA's, learning from defects, debrief and other analysis tools.
Apparent Cause Analysis (ACA)	Analysis that focuses on the immediate causes of an event.
Root Cause Analysis (RCA)	Root Cause Analysis (RCA) – a process for identifying the causal factors that underlie variation in performance, including the occurrence or possible occurrence of a Maryland Level I adverse/ sentinel event. The RCA focuses primarily on systems and processes, not individual performance. (Policy Reference) **Entities may combine RCA for multiple events of the same analysis type (ie: Falls, HAPI)
Learning from Defect	CUSP Tool: Learning from Defects
Debrief	Event Debriefing Tool - A discussion that captures the team's understanding of a Safety Event and encourages shared learning to improve teamwork and communication. Understanding and replicating successful teamwork is a valuable benefit of the Debriefing process.

Levels of Harm Definitions	
Sentinel Event	Patient safety event (not related to natural course of patient's illness or underlying condition) that reaches the patient and results in death, severe harm (regardless of duration) or permanent harm (regardless of severity) (Policy Reference)
Permanent Harm	Any level of harm that permanently alters and/or affects an individual's baseline. (Policy Reference)
Serious Injury	Harm that causes a physical or mental impairment that substantially limits one or more major life activities.
Severe Harm	Harm that substantially limits one or more life activities interfering with or results in loss of functional ability or quality of life, that requires continuous physiological monitoring or surgery, invasive procedure, or treatment to resolve the condition. (Policy Reference)
Moderate Harm	Harm that requires an invasive procedure, significant additional medical visits, and/or significantly increased level of care or results in disfigurement, impaired function that does not interfere with activities of daily living.
Minimal Harm	Harm lasting for a limited time only and/or requires little to no intervention.
Near Miss	A patient safety event involving a deviation in care that did not reach the patient.

Probability of Reoccurence	
Common	Likely to reoccur; Multiple reports over a short period of time
Uncommon	Possible it will reoccur
Rare	Unlikely to reoccur

Attachment B

SPECIFIC DEFINITION OF SENTINEL/ADVERSE EVENT IN LAW

I. *California Health and Safety Code 1279.1*

1279.1. (b) For purposes of this section, "adverse event" includes any of the following:

(1) **Surgical events**, including the following:

(A) **Surgery performed on a wrong body part** that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.

(B) **Surgery performed on the wrong patient.**

(C) **The wrong surgical procedure performed on a patient**, which is a surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that occurs in the course of surgery, or a situation that is so urgent as to preclude the obtaining of informed consent.

(D) **Retention of a foreign object in a patient after surgery or other procedure**, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.

(E) **Death during or up to 24 hours after induction of anesthesia after surgery** of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

(2) **Product or device events**, including the following:

(A) **Patient death or serious disability associated with the use of a contaminated drug, device, or biologic** provided by the health facility when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product.

(B) **Patient death or serious disability associated with the use or function of a device** in patient care in which the device is used or functions other than as intended. For purposes of this subparagraph, "device" includes, but is not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.

(C) **Patient death or serious disability associated with intravascular air embolism** that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

(3) **Patient protection events**, including the following:

(A) An infant discharged to the wrong person. Attachment I

(B) Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have competency or decision making capacity.

(C) **A patient suicide or attempted suicide resulting in serious disability while being cared for in a health facility** due to patient actions after admission to the health facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health facility.

(4) **Care management events**, including the following:

(A) **A patient death or serious disability associated with a medication error**, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.

(B) A patient death or serious disability associated with hemolytic reaction due to the administration of ABO-incompatible blood or blood products.

(C) **Maternal death or serious disability associated with labor or delivery** in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days post-delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.

(D) **Patient death or serious disability directly related to hypoglycemia**, the onset of which occurs while the patient is being cared for in a health facility.

(E) Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. For purposes of this subparagraph, "hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter.

(F) **A Stage 3 or 4 ulcer**, acquired after admission to a health facility, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.

(G) **A patient death or serious disability due to spinal manipulative therapy** performed at the health facility.

(5) **Environmental events**, including the following:

(A) **A patient death or serious disability associated with an electric shock** while being cared for in a health facility, excluding events involving planned treatments, such as electric counter shock.

(B) **Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.**

(C) **A patient death or serious disability associated with a burn** incurred from any source while being cared for in a health facility.
(D) **A patient death associated with a fall** while being cared for in a health facility.
(E) **A patient death or serious disability associated with the use of restraints or bedrails** while being cared for in a health facility. See Attachment D.

(6) **Criminal events**, including the following:
(A) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.
(B) The abduction of a patient of any age.
(C) **The sexual assault on a patient** within or on the grounds of a health facility.
(D) **The death or significant injury of a patient or staff member resulting from a physical assault** that occurs within or on the grounds of a facility.

(7) An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor.
(c) The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made.
(d) "Serious disability" means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or the loss of a body part.

Attachment C

Definition of Sentinel Event – The Joint Commission

A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

- Death
- Permanent harm
- Severe temporary harm*

An event is also considered sentinel if it is one of the following:

- Suicide of any patient receiving care, treatment, and services in a staffed around-the clock care setting or within 72 hours of discharge, including from the hospital's emergency department (ED)
- Unanticipated death of a full-term infant
- Discharge of an infant to the wrong family
- Abduction of any patient receiving care, treatment, and services
- Any elopement (that is, unauthorized departure) of a patient from a staffed around the-clock care setting (including the ED), leading to death, permanent harm, or severe temporary harm to the patient
- Administration of blood or blood products having unintended ABO and non-ABO (Rh, Duffy, Kell, Lewis, and other clinically important blood groups) incompatibilities, hemolytic transfusion reactions, or transfusions resulting in severe temporary harm, permanent harm, or death
- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, and services while on site at the hospital
- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the hospital

- Surgery or other invasive procedure performed at the wrong site, on the wrong patient, or that is the wrong (unintended) procedure for a patient‖
- Unintended retention of a foreign object in a patient after an invasive procedure, including surgery
- Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)
- Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose
- Fire, flame, or unanticipated smoke, heat, or flashes occurring during direct patient care caused by equipment operated and used by the hospital. To be considered a sentinel event, equipment must be in use at the time of the event; staff do not need to be present.
- Any intrapartum (related to the birth process) maternal death
- Severe maternal morbidity (not primarily related to the natural course of the patient's illness or underlying condition) when it reaches a patient and results in permanent harm or severe temporary harm
- Fall resulting in any of the following: any fracture; surgery, casting, or traction; required consult/management or comfort care for a neurological (e.g., skull fracture, subdural or intracranial hemorrhage) or internal (e.g., rib fracture, small liver laceration) injury; a patient with coagulopathy who receives blood products as a result of the fall; or death or permanent harm as a result of injuries sustained from the fall (not from physiologic events causing the fall)

Definitions for Abuse or Assault:

- Sexual abuse/assault of any [patient/client] while receiving care, treatment, and services while on site at the organization/facility or while under the supervision/care of the organization*
- Sexual abuse/assault of a staff member, licensed independent practitioner, visitor, or vendor while on site at the organization/facility or while providing care/supervision to [patients/clients]*
- Physical assault of any [patient/client] (leading to death, permanent harm, or severe temporary harm) while receiving care, treatment, and services while on site at the organization/facility or while under the supervision/care of the organization.
- Physical assault (leading to death, permanent harm, or severe temporary harm) of a staff member, licensed independent practitioner, visitor, or vendor while on site at the organization/facility or while providing care/supervision to [patients/clients]
- Homicide of any [patient/client] while receiving care, treatment, and services while on site at the organization/facility or while under the supervision/care of the organization
- Homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the organization/facility or while providing care/supervision to [patients/clients]

* *Sexual abuse/assault is defined (beginning January 1, 2023) by The Joint Commission as "Nonconsensual sexual contact of any type with an individual. Sexual abuse includes, but is not limited to, the following: Unwanted intimate touching of any kind, especially of the breasts, buttocks or perineal area; All types of sexual assault or battery such as rape, sodomy, and coerced nudity (partial or complete); Forced observation of masturbation and/or sexually explicit images, including pornography, texts or social media; Taking sexually explicit photographs and/or audio/video recordings of an individual and maintaining and/or distributing them."*

~~*Sexual abuse/assault (including rape) as a sentinel event is defined as nonconsensual sexual contact, including oral, vaginal, or anal penetration or fondling of the individual's sex organ(s) by another individual.*~~

~~*One or more of the following must be present to determine that it is a sentinel event:*~~
~~**Any staff witnessed sexual contact as described above*~~
~~**Admission by the perpetrator that sexual contact, as described above, occurred on the premises*~~
~~**Sufficient clinical evidence obtained by the health care organization to support allegations of unconsented sexual contact*~~*Generally, sexual contact is nonconsensual in the following situations:*

- *When the individual lacks the cognitive of legal ability to consent even though appearing to want the contact to occur*
- *When the individual does not want the contact to occur.*
-

Attachment D

REPORTING REQUIREMENTS RELATED TO RESTRAINT OR SECLUSION

CMS Death Reporting and Recording Requirements

REPORTING REQUIREMENTS

Hospitals must report the following deaths associated with the use of seclusion or restraint to the Centers for Medicare & Medicaid Services (CMS) Regional Office no later than the close of business on the next business day following knowledge of the patient's death. The following events must be reported:

1. Each death that occurs while a patient is in restraint or seclusion, except for deaths subject to the "Documentation Requirement".
2. Each death that occurs within 24 hours after the patient was removed from restraint or seclusion (whether or not the hospital believes that the use of restraint or seclusion contributed to the patient's death), except for deaths subject to the "Documentation Requirement".
3. Each death known to the hospital that occurs within one week after restraint or seclusion where it is reasonable to assume that use of restraint or seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.

This requirement applies to deaths that occur in any unit of the hospital, including an ICU or critical care unit.

DOCUMENTATION REQUIREMENT

When no seclusion has been used and when the only restraints used on the patient are those applied exclusively to the patient's wrist(s), and which are composed solely of soft, non-rigid, cloth-like materials, the hospital staff does not need to notify CMS of a patient death by the next business day.

The date and time of the report to CMS must be documented in the patient's medical record.

Hospitals must report to the CMS Regional Office electronically using Form CMS-10455, “Report of a Hospital Death Associated with the Use of Restraint or Seclusion.”

FDA Restraint Reporting

FDA regulates restraint devices as it regulates other medical devices. Thus, hospitals and other device user facilities must report incidents involving restraints that have or may have caused or contributed to the serious injury or death of a patient.

For purposes of this reporting law, it should be noted that the FDA uses a different definition of restraint than does the Centers for Medicare & Medicaid Services Conditions of Participation or California law. The FDA defines a “protective restraint” as:

> a device, including but not limited to a wristlet, anklet, vest, mitt, straight jacket, body/limb holder, or other type of strap, that is intended for medical purposes and that limits the patient’s movements to the extent necessary for treatment, examination, or protection of the patient or others [21 C.F.R. Section 880.6760].

Whereas the CMS definition of restraint could include a geri-chair, a tray table, a side rail, a sheet, or even a staff member holding a patient, the FDA definition does not. Therefore, this reporting requirement is somewhat more narrow than the CMS reporting requirement for deaths associated with seclusion or restraints discussed under XII. “Reporting Requirements Related to Restraint or Seclusion”

Attachment E

List of National Quality Forum Serious Reportable Events (aka SRE or "Never Events")

1. SURGICAL OR INVASIVE PROCEDURE EVENTS

1A. Surgery or other invasive procedure performed on the wrong site (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1B. Surgery or other invasive procedure performed on the wrong patient (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1C. Wrong surgical or other invasive procedure performed on a patient (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1E. Intraoperative or immediately postoperative/post-procedure death in an ASA Class 1 patient (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

2. PRODUCT OR DEVICE EVENTS

2A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

3. PATIENT PROTECTION EVENTS

3A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3B. Patient death or serious injury associated with patient elopement (disappearance) (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4. CARE MANAGEMENT EVENTS

4A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration) (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4B. Patient death or serious injury associated with unsafe administration of blood products (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers

4D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy (new)
Applicable in: hospitals, outpatient/office-based surgery centers

4E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

4G. Artificial insemination with the wrong donor sperm or wrong egg (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

4H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen (new)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results (new)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5. ENVIRONMENTAL EVENTS

5A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5C. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

6. RADIOLOGIC EVENTS

6A. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area (new)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

7. POTENTIAL CRIMINAL EVENTS

7A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7B. Abduction of a patient/resident of any age (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7D. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

Attachment F: -REPORTING REQUIREMENTS UNDER STATE LAW

California Health and Safety Code – Pertaining to General Acute Care Hospitals

1279.1. (a) A health facility licensed pursuant to subdivision (a), (b), or (f) of Section 1250 shall report an adverse event to the department no later than five days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected. Disclosure of individually identifiable patient information shall be consistent with applicable law.

(c) The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made.

(d) "Serious disability" means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or the loss of a body part.

AP160

Policy Number: AP160	Date Created: 12/19/2013
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: 02/27/2023
Approvers: Board of Directors (Administration)	

Mobile Device (cellular phone, smartphone, tablet, laptop) and Mobile Voice & Data Services

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

POLICY: When an individual's job duties require the use of a mobile device including a cellular phone, smartphone, tablet or laptop to conduct Kaweah Delta Health Care District herein after referred to as Kaweah Health, Kaweah Health business, the following procedure shall apply.

PROCEDURE:

I. Only those individuals with a justifiable need, as determined by the department Director, and as approved by the Director of ISS Technical Services, shall use Kaweah Health issued or personal mobile devices (phone, smartphone, tablet, laptop) and mobile voice & data services (text, data) for the purpose of conducting Kaweah Health business.

II. Only those individuals with a justifiable need which includes the use of their own personal mobile device(s) and service(s) away from Kaweah Health work area(s) to conduct Kaweah Health business, as determined by the department Director, shall receive a monthly stipend for use of their personal phone.

Leaders/Administrative Assistants will use the Cell Phone Reimbursement Screen in HROnline to add employees that are approved for the monthly stipend. The current stipend is $23 per month. This will be a non-taxable stipend.

III. Limited exceptions will apply to provide Kaweah Health-owned mobile devices. Individuals using Kaweah Health-owned mobile devices agree to sign and abide by an *"Equipment Use and Security Agreement"* at the time they are issued a mobile device. This will be recorded by ISS and is subject to change.

IV. Cellular phones (hardware and service) are not provided for individual use by Kaweah Health unless deemed appropriate by the Director of ISS Technical Services. ISS will maintain ownership and operations of such devices.

V. Mobile devices are to be requested by Kaweah Health leaders in HROnline system. The system access request "Laptop TAB" should be used.

VI. Mobile phones shall not be used while driving unless hands free capability is utilized, and if the individual does not have a hands free capability, they need to pull safely to the side of the road to place a call. This policy is in adherence

with SB 1613 which prohibits the use of cellular phones while operating a vehicle unless hands free capability is utilized.

"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."

CP.01 Compliance Program Administration

Policy Number: CP.01	**Date Created: 03/21/2022**
Document Owner: Jill Berry (Director of Corporate Compliance)	**Date Approved: 06/29/2022**
Approvers: Board of Directors (Administration), Compliance Committee, Amy Valero (Compliance Manager), Ben Cripps (Chief Compliance & Risk Management Officer), Jill Berry (Director of Corporate Compliance)	
Compliance Program Administration	

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

I. Purpose:

The Kaweah Delta Health Care District ("Kaweah Health") Compliance Program was developed to:

1.A. Establish standards and procedures to be followed by all Kaweah Health employeesWorkforce Members to effectpromote compliance with applicable federal, state and local laws, and regulations and ordinances, Administrative Regulations,; Medical Staff Bylaws, rules, and regulations; ethical standards, and Kaweah Health policies; and procedures;

Designate

2.B. Establish the overall structure related to compliance efforts and responsibilities and designate the Kaweah Health official responsible for directing the effort to enhance compliance including implementation of the Compliance Program;

Document

C. Set out certain processes, procedures, and mechanisms to assist in the detection, elimination, and remediation of possible violations of laws, regulations, policies, procedures, and/or ethical standards and practices, including the enforcement of consistent disciplinary mechanisms for compliance or privacy violations;

3.D. Establish standards for documentation of compliance efforts;

4. Ensure Discretionary Authority is given to appropriate persons;

Provide

5.E. Educate Workforce Members regarding the Kaweah Health Compliance Program and provide a means for communicating to all Kaweah Health employeesWorkforce Members the legal and ethical standards, policies, and procedures all employees are expectedeveryone is to follow;

Establish minimum standards for billing and collection activities, including

6.F. Establish a system of monitoring and oversight of billing activityand collection activities to ensureenhance adherence to the standards and procedures established;

7.G. Provide a means for reporting apparent illegal or unethical activity to the appropriate authorities;

Provide

8.H. Correct violations of and provide for the enforcement of imposition of sanctions for violations of laws, regulations, ethical and legal standards; /practices, policies, and procedures;

9.I. Provide a mechanism to investigate any alleged legal, regulatory, policy, and procedure violations and to prevent futuredecrease the likelihood of such violations;

10.J. Increase training of medical staff members and billing personnel concerning applicable billing requirements and Kaweah Health policies;

11.K. Provide for regular review of overall compliance efforts to ensure that practices reflect current requirements and that other adjustments are made to improve the Compliance Program;

12.L. Monitor provision of quality care to the patients served by Kaweah Health;

13.M. Promote effective communication between Kaweah Health's Legal Counsel, Executive Team, and Board of Directors; and

14.N. Preserve the financial viability of Kaweah Health; and .

15. Enforce consistent disciplinary mechanisms for compliance or privacy violations.

II. Policy:

Kaweah Health, and its affiliated health care facilities, requires all employees, agents and medical staff members to act, at all times, in an ethical and legal manner, consistent with all applicable legal, governmental, and professional standards and requirements. In order to avoid even the appearance of impropriety or conflict of interest, this Compliance Program applies to employees, agents, faculty, and medical staff within Kaweah Health, without regard to an individual's specific job duties or function. It is the policy of Kaweah Health that all services and business transactions rendered by Kaweah Health shall be carried out and documented in accordance with federal, state, and local laws, regulations, and interpretations. ThisThe Compliance Program is intended to enhance and further demonstrate Kaweah Health's commitment to honest and fair dealing by providing an effective means by which to prevent and detect illegal, unethical or abusive conduct. Kaweah Health will exercise due diligence in its efforts to ensure that the Compliance Program is effective in its design, implementation, and enforcement. Kaweah Health employees are expected to deal fairly and honestly with patients and their families, suppliers, third-party payors, and their professional associates. Adherence to the Compliance Program is a condition of employment at Kaweah Health. Likewise, the granting of medical staff privileges and the offer of employment at Kaweah Health is contingent upon acceptance of and compliance with the Compliance Program.

Kaweah Health encourages transparency and honesty in an effort to encourage

employees to report suspected fraud and improprieties. Kaweah Health will not tolerate retaliation against any employee who reports suspected wrongdoing. See CP.13 Federal and State False Claims Act and Employee Protection Provisions. All reported information will be investigated, tracked and remediated according to Kaweah Health policy and shall be kept confidential to the maximum extent possible.

Process:

The Kaweah Health is committed to having an effective Compliance Program **was developed to provide oversite** that consists of the primary components of compliance **administrative efforts** programs as set out in the guidelines established by the US Department of Health and Human Services Office of Inspector General (OIG) Supplemental Compliance Guidance for Hospitals (January 2005) as well as subsequent compliance guidance issued by the OIG. The key components of the Compliance Program include the following:

A. Compliance Leadership and Oversight, including (1) establishing operating protocol and standards; (2) designating Board compliance oversight, a Corporate Compliance and Risk Officer (CCRO), and designated individuals having specific compliance or compliance-related responsibilities; (3) providing employee compliance training; (4) monitoring and auditing; (5) supporting and facilitating open or who occupy key operational, financial or other business roles or positions and who contribute to the operation, management, and success of the Compliance Program.

B. Written Compliance policies and procedures including a written Code of Conduct.

C. Open lines of communication and reporting; (6) following through with enforcement and disciplinary procedures; and (7) establishing response and prevention plans. processes, including a toll-free hotline for reporting, which permits anonymous reporting without fear of retaliation.

Establishing Operating Protocol and Standards of Conduct – For the purposes of preventing illegal, unethical or abusive conduct, compliance Standards of Conduct and procedures shall be implemented and followed by all employees and agents of Kaweah Health.

D. Compliance-related education for all Workforce Members.

E. Risk Assessment, auditing, and monitoring activities.

F. Enforcement of appropriate standards with consequences and incentives.

G. Investigation and remediation of identified compliance-related problems with implantation of corrective action plans and reporting to the Government.

H. Management of third-party relationships.

III. Scope:

The Kaweah Health Compliance Program applies to all Workforce Members.

IV. Definitions:

Workforce Members or Workforce means the following:

A. Individuals employed by Hospital and all persons deemed to be employed by Hospital under any state or federal statute.
B. Agency employees, co-employees, leased employees, travelers, etc. who work under the control, direction, and supervision of Hospital while performing labor or while providing services at any of Hospital's facilities.
C. Members of the Medical Staff.
D. Physicians and independent licensed practitioners with whom Hospital has contracted to provide certain professional services whenever such individuals or entities are acting in such capacity and within the scope of such agreements.
E. Independent contractors, vendors, business associates and other persons or entities.
F. Individuals in learning programs, including but not limited to medical students, residents, fellows, nursing students, etc.
G. Volunteers.

V. Compliance Program Elements:

~~1.~~ **Leadership and** ~~The procedures shall include mechanisms for reporting fraud, waste, abuse, and other wrongdoing. The reporting procedures shall be set in a manner that promotes the internal discovery and reporting of wrongdoings and/or noncompliance.~~

A. ~~Designating~~ Oversight Responsibilities

1. Board of Directors:

The Board of Directors (the "Board") has the overall responsibility for the Kaweah Health Compliance Program. The Board created the Audit and Compliance Committee and appointed members for the purpose of coordinating compliance efforts throughout Kaweah Health.

2. Chief Compliance and Risk Officer

~~2.~~ The Chief Compliance and Risk Officer ~~– The Chief Compliance and Risk Officer and Kaweah Health Leadership~~ (CCRO) shall oversee, operate, and manage the day-to-day functions of the Compliance Program and enforce compliance standards and procedures. ~~The~~ The CCRO~~Chief Compliance and Risk Officer~~ shall have the authority to take appropriate action to assure effective implementation of compliance efforts. ~~The Chief Compliance and Risk Officer~~CCRO shall report directly to the Chief Executive Officer (CEO) and the Board of Directors. The CCRO at all times shall have direct access to

and the right to communicate directly with the Board of Directors or its members or committee(s) in regard to compliance.

The CCRO

The Chief Compliance and Risk Officer shall have unrestricted authority and access to review all entity records, physical properties, and personnel related to compliance audit and investigative activities. Any confidential information received or reviewed shall not be used in any manner which would be contrary to law or detrimental to the interests of Kaweah Health.

Kaweah Health shall employ individuals whose education, training, and abilities are appropriate to perform the jobs assigned to them. Kaweah Health shall use due care to delegate substantial discretionary authority to appropriate competent individuals and shall use due care to avoid delegation of such authority to individuals whom he or she knows, or should have known, have a propensity to engage in illegal activities.

The CCRO shall also direct the overall implementation of the Compliance Program and initiate risk analyses and assessments when appropriate; receive and review reports of all compliance activities being carried out; monitor compliance enforcement issues; initiate and/or coordinate internal and external reviews and/or investigations; and report at least annually to the Audit and Compliance Committee on the status of the Compliance Program and Kaweah Health's compliance efforts.

3. Operational Compliance Committee

The Operational Compliance Committee ("OCC") is established hereunder as a key structural component of the Compliance Program which shall advise the CCRO and Board in regard to Compliance policies and procedures; shall function as a source of and "clearinghouse" for compliance-related internal information and results of Kaweah's compliance monitoring activities; and shall otherwise assist in and facilitate the operations of the Compliance Program.

The OCC shall be a standing committee comprised of members of Kaweah's leadership team and other individuals who have significant responsibility for the administration of various aspects of Kaweah's Compliance Program and/or the conduct and/or the performance of internal compliance controls. The OCC membership will be established by an OCC charter which shall be reviewed and approved by the Audit and Compliance Committee.

The CCRO shall serve as the Chair of the OCC. The OCC shall meet from time to time as needed or appropriate, but no less frequently than quarterly. The CCRO shall determine the frequency, date and time of meetings and give appropriate notice of such meetings to all members.

The responsibilities of the OCC include the following:

a) Participate in the development and review of Kaweah policies, procedures and process created to govern compliance.
b) Support and advise the CCRO concerning compliance program activities,

including gathering compliance data generated through internal monitoring and audits, conducting the appropriate and timely risk assessments, and developing the annual compliance work plan.

c) Analyze the legal and regulatory environment affecting Kaweah.
d) Support appropriate compliance related education for all Workforce Members.
e) Provide input and recommendations on compliance-related auditing, monitoring, reporting, tracking, and trending.
f) Assist in implementing action plans when deficiencies are identified.
g) Promote a “culture of Compliance.”
h) Serve as a "clearinghouse" and avenue for the sharing and distribution of information regarding Compliance.
i) Support the evaluation and management of potential conflicts of interest that may affect Kaweah.
j) Facilitate and coordinate Compliance activities and programs among and across all departments, units, and locations of Hospital.

Certain responsibilities of the OCC, as appropriate, may be accomplished through the development of subcommittees, workgroups, and task forces designed to focus on specific compliance-related functions and goals. In furtherance of this, the OCC may identify and select members throughout Kaweah that are best suited in relation to area oversight, job responsibilities and subject matter expertise to participate in the workgroups in order to accomplish the goals established by the OCC.

B. Compliance Standards and Procedures

Kaweah’s business operations as a provider of health care services are subject to significant legal, regulatory, and ethical requirements and considerations. It is the fundamental policy of Kaweah that all of its business and other practices be conducted at all times in compliance with all applicable laws and regulations of the United States, the State of California, and applicable local laws and ordinances as well as ethical standards and practices of the industry. In order to accomplish compliance by providing written standards and guidelines, Kaweah has developed and implemented its Code of Conduct as well as written policies, procedures, and standards governing its activities.

1. Code of Conduct

Kaweah has developed its Code of Conduct, which applies to all Workforce Members, to promote honest and ethical conduct. The Code of Conduct details the fundamental principles, values and framework for compliance throughout the organization, provides guidance on acceptable behavior for Workforce Members, and makes it clear the expectation that Workforce Members will comply with all applicable governmental laws, rules, and regulations, and will report potential violations of the law, regulations, and company policies.

2. Policies and Procedures

For the purposes of decreasing the likelihood of illegal, unethical or abusive conduct, compliance Standards of Conduct and procedures shall be implemented and followed by all employees and agents of Kaweah Health. The procedures shall include

mechanisms for reporting fraud, waste, abuse, and other wrongdoing.

Providing The reporting procedures shall be set in a manner that promotes the internal discovery and reporting of wrongdoings and/or non- compliance.

3. Kaweah Leadership Responsibilities

It is the responsibility of Kaweah leaders to set an example and help create a culture that promotes high ethics and compliance. Kaweah leaders are also responsible for evaluating each Workforce Member's compliance performance, and such evaluation should be included in each Workforce Member's performance review.

4. Kaweah Workforce Member Responsibilities:

All Workforce Members are responsible for having knowledge of and adhering to Kaweah's fundamental policy of remaining compliant at all times with all applicable laws, regulations, and ethical standards in conducting its business activities. Workforce Members are expected to have a working knowledge of all legal and regulatory requirements that apply to their areas of responsibility. Workforce members are expected to ask questions prior to engaging in conduct that causes them concern. Workforce Members shall refrain from engaging in conduct which causes compliance concerns and shall bring such concerns to the timely attention of an appropriate Kaweah leader, a member of the Compliance Department, or the CCRO.

C. Employee Compliance Training

Kaweah Healthleaders will ensure all Workforce Members are provided with education about Kaweah's Compliance Program. Compliance Education for new Workforce Members will be formally incorporated into the Hospital New Employee Orientation (NEO) program.

3. Kaweah, through its Leadership, shall continue to effectively communicate its standards and procedures to all staff members and agents by requiring mandatory participation in compliance training programs and by disseminating publications that explain the new policies, procedures and standards. See Compliance Program Education. See CP.06 Compliance Program Education.

D. Monitoring and Auditing

4. Effective monitoring and auditing help Kaweah Healthdecrease the likelihood that compliance issues will occur and is essential to a successful compliance program. Kaweah, through its Leadership, shall take reasonable steps to achieve compliance with its standards by utilizing, monitoring and auditing systems including the use of legal reviews of policies and procedures, financial audits and providing all staff members access to a hotline. See Compliance Reviews and Assessments.
including the use of legal reviews of policies and procedures, financial audits. See CP.10 Compliance Reviews and Assessments.

The Kaweah Compliance Program will design and implement appropriate audit plans that are designed to minimize its risks. Audits may be conducted by internal Compliance Department team members or by qualified third parties, depending on the subject matter of the areas audited.

5. **Supporting and Facilitating Open Lines of Communication and Reporting** – Kaweah Health allows for anonymity and/or confidentiality, whereby employees and agents of Kaweah Health may report or seek guidance regarding potential or actual wrongdoings or non-compliance without fear of retaliation.

6. **Following through with Enforcement and Disciplinary Procedures** – Kaweah Health's compliance program shall be promoted and enforced consistently throughout the organization through appropriate disciplinary measures for engaging in criminal conduct, wrongdoings, non-compliance and/or for failing to take reasonable steps to prevent or detect criminal conduct. See HR.216 Progressive Discipline.

7. **Establishing Response and Prevention Plans** – The standards developed under the Kaweah Health Compliance Program shall be enforced consistently through appropriate disciplinary mechanisms including discipline of individuals responsible for failing to detect and report an offense. The Compliance Program shall take reasonable steps to investigate and respond appropriately to all reported concerns. See Compliance and Privacy Issues Investigation and Resolution.

Procedure:

Reporting and Investigative Process and Non-Retaliation

Kaweah Health employees aware of any illegal, unethical or abusive conduct or any other wrongdoing or non-compliance shall report the concern immediately to Leadership. If the employee is uncomfortable reporting their concern to Leadership for fear of retaliation or is concerned that no action may be taken, the employee should immediately contact:

Kaweah Health Chief Compliance and Risk Officer – (559) 624-5006

The Anonymous Compliance Line – (800) 998-8050

Kaweah Health's Compliance Advocate – Rachele Berglund
(559) 636-0200

Employees will not be subject to retaliation for reporting, in good faith, action that they feel violates Standards of Conduct, a law, and/or Kaweah Health policy. Any employee engaging in any action of retaliation or reprisal for good faith reporting shall be subject to disciplinary action up to, and including, termination.

Investigation of Concerns

Investigations of suspected illegal, unethical, or abusive conduct or any other wrongdoing or non-compliance will be coordinated and organized by the Chief Compliance and Risk Officer, the Compliance Advocate, and/or Compliance Staff.

Internal Investigations

Internal investigation and resolution of compliance issues will be managed pursuant to Compliance and Privacy Issues Investigation and Resolution.

All reports of suspected or actual fraud and subsequent investigations and outcomes must be reported to the Chief Compliance and Risk Officer. The Chief Compliance and Risk Officer will contact the Compliance Advocate, the Chief Executive Officer, and the Kaweah Health Chairperson of the Board of Directors (as necessary).

A financial audit will be conducted every year in accordance with Kaweah Health policy and under appropriate audit guidelines and standards. A financial audit provides no assurance that Kaweah Health complies with all federal laws and regulations; rather it provides an opinion as to the general strength of the internal operating controls and procedures.

All Workforce Members are expected to fully cooperate with all Compliance Program auditing and monitoring activities.

E. Supporting and Facilitating Open Lines of Communication and Reporting

1. Open communication is essential to maintaining an effective compliance program. Kaweah is committed to increasing its ability to identify and respond to compliance concerns and fostering an organizational culture that encourages open communication without fear of retaliation.

Employees will not be subject to retaliation for reporting, in good faith,

External Investigations

External investigations by a regulatory agency will be managed pursuant to Unannounced Regulatory Survey Plan for Response.

2. activities they feel violate the Code of Conduct, a law or regulation, and/or a Kaweah Health policies or procedures. Any employee engaging in any action of retaliation or reprisal for good faith reporting shall be subject to disciplinary action up to, and including, termination.

3. Kaweah Health employees aware of any illegal, unethical or abusive conduct or any other wrongdoing or non-compliance shall report the concern immediately to Leadership. If the employee is uncomfortable reporting their concern to Leadership for fear of retaliation or is concerned that no action may be taken, the employee should immediately contact:

Kaweah Health Chief Compliance and Risk Officer – (559) 624-5006

The Anonymous Compliance Line – (800) 998-8050
Kaweah Health's Compliance Advocate – Rachele Berglund (559) 636-0200

4. Failure to report or conceal a known compliance issue is a violation of Kaweah policy and may subject a Workforce Member to disciplinary action, up to and including termination of employment.

5. Kaweah leaders who receive a complaint or concern that raises a potential compliance issue are required to promptly report the complaint to a member of the Compliance Department. Kaweah leaders who fail to do so will be subject to disciplinary action, up to and including termination of employment.

F. Enforcement and Disciplinary Procedures

Kaweah Health 's compliance program shall be promoted and enforced consistently throughout the organization through appropriate disciplinary measures for engaging in criminal conduct, wrongdoings, non-compliance and/or for failing to take reasonable steps to prevent or detect criminal conduct. See HR.216 Progressive Discipline.

G. Response, Corrective Action, and Prevention

1. Kaweah is committed to responding consistently and decisively to detected deficiencies. As deficiencies are identified through audits, reporting mechanisms, and other Compliance Program activities, corrective measures, including disciplinary actions, will be applied to address noncompliance or achieve improvements in the compliance program.

2. The standards developed under the Kaweah Health Compliance Program shall be enforced consistently through appropriate disciplinary mechanisms including discipline of individuals responsible for failing to detect and report an offense. The Compliance Program shall take reasonable steps to investigate and respond appropriately to all reported concerns. See CP.05 Compliance and Privacy Issues Investigation and Resolution.

3. Investigation of Concerns:

Investigations of suspected illegal, unethical, or abusive conduct or any other wrongdoing or non-compliance will be coordinated and organized by the CCRO, the Compliance Advocate, and/or Compliance Department Staff.

4. Internal Investigations

Internal investigation and resolution of compliance issues will be managed pursuant to CP.05 Compliance and Privacy Issues Investigation and Resolution. All reports of suspected or actual fraud and subsequent investigations and outcomes must be reported to the Chief Compliance and Risk Officer. The Chief Compliance and Risk Officer will contact the Compliance Advocate, the Chief Executive Officer, and the Kaweah Health Chairperson of the Board of Directors (as necessary).

5. Audits and Investigations by Compliance Oversight Agencies

Compliance-related audits and investigations conducted by compliance oversight agencies will be overseen and managed by the Compliance Department.

H. Due Care in Employment, Contracting and Third-Party Relationships

Kaweah Health will make a reasonable inquiry into the background of potential Workforce Members, agents, and contractors to avoid utilizing anyone who has been convicted of an offense related to any governmental or private health care program or who has been excluded from participation in a governmental health care program. Hospital will not employ or retain anyone whom it knows has been excluded from any such program. If Hospital learns that a Workforce Member, agent, or contractor has in fact been excluded from participating in a governmental healthcare program while employed or during their contract term, Hospital will take immediate action as necessary to ensure Hospital is compliant with Federal and State laws and regulations and to ensure the protection of Hospital patients and the organization.

Kaweah Health shall employ individuals whose education, training, and abilities are appropriate to perform the jobs assigned to them. Kaweah Health shall use due care to delegate substantial discretionary authority to appropriate competent individuals and shall use due care to avoid delegation of such authority to individuals whom he or she knows, or should have known, have a propensity to engage in illegal activities.

"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 bioethical bio- ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

Policy Number: CP.01	Date Created: 03/21/2022
Document Owner: Jill Berry (Director of Corporate Compliance)	Date Approved: 06/29/2022
Approvers: Board of Directors (Administration), Compliance Committee, Amy Valero (Compliance Manager), Ben Cripps (Chief Compliance & Risk Management Officer), Jill Berry (Director of Corporate Compliance)	

Compliance Program Administration

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

Purpose:

The Kaweah Delta Health Care District ("Kaweah Health") Compliance Program was developed to:

1. Establish standards and procedures to be followed by all Kaweah Health employees to effect compliance with applicable federal, state and local laws, regulations and ordinances, Administrative Regulations, Medical Staff Bylaws, and Kaweah Health policies;

2. Designate the Kaweah Health official responsible for directing the effort to enhance compliance including implementation of the Compliance Program;

3. Document compliance efforts;

4. Ensure Discretionary Authority is given to appropriate persons;

5. Provide a means for communicating to all Kaweah Health employees the legal and ethical standards and procedures all employees are expected to follow;

6. Establish minimum standards for billing and collection activities, including a system of monitoring and oversight of billing activity to ensure adherence to the standards and procedures established;

7. Provide a means for reporting apparent illegal or unethical activity to the appropriate authorities;

8. Provide for the enforcement of ethical and legal standards;

9. Provide a mechanism to investigate any alleged violations and to prevent future violations;

10. Increase training of medical staff members and billing personnel concerning applicable billing requirements and Kaweah Health policies;

11. Provide for regular review of overall compliance efforts to ensure that practices reflect current requirements and that other adjustments made to improve the Compliance Program;

12. Monitor provision of quality care to the patients served by Kaweah Health;

13. Promote effective communication between Kaweah Health's Legal Counsel, Executive Team, and Board of Directors;

14. Preserve the financial viability of Kaweah Health; and

15. Enforce consistent disciplinary mechanisms for compliance or privacy violations.

Policy:

Kaweah Health, and its affiliated health care facilities, requires all employees, agents and medical staff members to act, at all times, in an ethical and legal manner, consistent with all applicable legal, governmental, and professional standards and requirements. In order to avoid even the appearance of impropriety or conflict of interest, this Compliance Program applies to employees, agents, faculty, and medical staff within Kaweah Health, without regard to an individual's specific job duties or function. It is the policy of Kaweah Health that all services and business transactions rendered by Kaweah Health shall be carried out and documented in accordance with federal, state, and local laws, regulations, and interpretations. This Compliance Program is intended to enhance and further demonstrate Kaweah Health's commitment to honest and fair dealing by providing an effective means by which to prevent and detect illegal, unethical or abusive conduct. Kaweah Health will exercise due diligence in its efforts to ensure that the Compliance Program is effective in its design, implementation, and enforcement. Kaweah Health employees are expected to deal fairly and honestly with patients and their families, suppliers, third-party payors, and their professional associates. Adherence to the Compliance Program is a condition of employment at Kaweah Health. Likewise, the granting of medical staff privileges and the offer of employment at Kaweah Health is contingent upon acceptance of and compliance with the Compliance Program.

Kaweah Health encourages transparency and honesty in an effort to encourage employees to report suspected fraud and improprieties. Kaweah Health will not tolerate retaliation against any employee who reports suspected wrongdoing. See CP.13 Federal and State False Claims Act and Employee Protection Provisions. All reported information will be investigated, tracked and remediated according to Kaweah Health policy and shall be kept confidential to the maximum extent possible.

Process:

The Compliance Program was developed to provide oversite of compliance administrative efforts including (1) establishing operating protocol and standards; (2) designating oversight responsibilities; (3) providing employee compliance training; (4) monitoring and auditing; (5) supporting and facilitating open lines of communication and reporting; (6) following through with enforcement and disciplinary procedures; and (7) establishing response and prevention plans.

1. **Establishing Operating Protocol and Standards of Conduct –** For the purposes of preventing illegal, unethical or abusive conduct, compliance Standards of Conduct and procedures shall be implemented and followed by all employees and agents of Kaweah Health. The procedures shall include mechanisms for reporting fraud, waste, abuse, and other wrongdoing. The reporting procedures shall be set in a manner that promotes the internal discovery and reporting of wrongdoings and/or non-compliance.

2. **Designating Oversight Responsibilities –** The Chief Compliance and Risk Officer and Kaweah Health Leadership shall oversee and enforce compliance standards and procedures. The Chief Compliance and Risk Officer shall have the authority to take appropriate action to assure effective implementation of compliance efforts. The Chief Compliance and Risk Officer shall report directly to the Chief Executive Officer (CEO) and the Board of Directors.

   The Chief Compliance and Risk Officer shall have unrestricted authority and access to review all entity records, physical properties, and personnel related to compliance audit and investigative activities. Any confidential information received or reviewed shall not be used in any manner which would be contrary to law or detrimental to the interests of Kaweah Health.

   Kaweah Health shall employ individuals whose education, training, and abilities are appropriate to perform the jobs assigned to them. Kaweah Health shall use due care to delegate substantial discretionary authority to appropriate competent individuals and shall use due care to avoid delegation of such authority to individuals whom he or she knows, or should have known, have a propensity to engage in illegal activities.

3. **Providing Employee Compliance Training –** Kaweah Health, through its Leadership, shall effectively communicate its standards and procedures to all staff members and agents by requiring mandatory participation in compliance training programs and by disseminating publications that explain the new policies, procedures and standards. See Compliance Program Education.

4. **Monitoring and Auditing –** Kaweah Health, through its Leadership, shall take reasonable steps to achieve compliance with its standards by

utilizing, monitoring and auditing systems including the use of legal reviews of policies and procedures, financial audits and providing all staff members access to a hotline. See Compliance Reviews and Assessments.

5. **Supporting and Facilitating Open Lines of Communication and Reporting** – Kaweah Health allows for anonymity and/or confidentiality, whereby employees and agents of Kaweah Health may report or seek guidance regarding potential or actual wrongdoings or non-compliance without fear of retaliation.

6. **Following through with Enforcement and Disciplinary Procedures** – Kaweah Health's compliance program shall be promoted and enforced consistently throughout the organization through appropriate disciplinary measures for engaging in criminal conduct, wrongdoings, non-compliance and/or for failing to take reasonable steps to prevent or detect criminal conduct. See HR.216 Progressive Discipline.

7. **Establishing Response and Prevention Plans** – The standards developed under the Kaweah Health Compliance Program shall be enforced consistently through appropriate disciplinary mechanisms including discipline of individuals responsible for failing to detect and report an offense. The Compliance Program shall take reasonable steps to investigate and respond appropriately to all reported concerns. See Compliance and Privacy Issues Investigation and Resolution.

Procedure:

Reporting and Investigative Process and Non-Retaliation

Kaweah Health employees aware of any illegal, unethical or abusive conduct or any other wrongdoing or non-compliance shall report the concern immediately to Leadership. If the employee is uncomfortable reporting their concern to Leadership for fear of retaliation or is concerned that no action may be taken, the employee should immediately contact:

Kaweah Health Chief Compliance and Risk Officer – (559) 624-5006

The Anonymous Compliance Line – (800) 998-8050

Kaweah Health's Compliance Advocate – Rachele Berglund
(559) 636-0200

Employees will not be subject to retaliation for reporting, in good faith, action that they feel violates Standards of Conduct, a law, and/or Kaweah Health policy. Any employee engaging in any action of retaliation or reprisal for good faith reporting shall be subject to disciplinary action up to, and including, termination.

Investigation of Concerns

Investigations of suspected illegal, unethical, or abusive conduct or any other wrongdoing or non-compliance will be coordinated and organized by the Chief Compliance and Risk Officer, the Compliance Advocate, and/or Compliance Staff.

Internal Investigations

Internal investigation and resolution of compliance issues will be managed pursuant to Compliance and Privacy Issues Investigation and Resolution.

All reports of suspected or actual fraud and subsequent investigations and outcomes must be reported to the Chief Compliance and Risk Officer. The Chief Compliance and Risk Officer will contact the Compliance Advocate, the Chief Executive Officer, and the Kaweah Health Chairperson of the Board of Directors (as necessary).

A financial audit will be conducted every year in accordance with Kaweah Health policy and under appropriate audit guidelines and standards. A financial audit provides no assurance that Kaweah Health complies with all federal laws and regulations; rather provides an opinion as to the general strength of the internal operating controls and procedures.

External Investigations

External investigations by a regulatory agency will be managed pursuant to Unannounced Regulatory Survey Plan for Response.

"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."

CP. 08 Governmental Payer Regulatory updates

Number: CP.08	Created: 04/21/2022
Content Owner: Jill Berry (Director of Corporate Compliance)	Approved: ~~05/26/2022~~
Approvers: Board of Directors (Administration), Compliance Committee, ~~Amy Valero~~ erry (Director of Corporate Compliance ~~Manager~~), Ben Cripps (Chief Compliance & Risk Management Officer), Michelle Adams (Executive Assistant)	
~~Governmental Payer~~ Regulatory Updates	

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

~~**Purpose:** To define the process used to identify and disseminate regulatory updates to the appropriate Department(s) and to provide a mechanism to evaluate and assess the effects and to implement regulatory changes and requirements that apply to Kaweah Delta Health Care District ("Kaweah Health") operations.~~

~~**Policy:** It is the policy of Kaweah Health that regulatory updates will be distributed to and reviewed by appropriate department management and staff. All applicable changes will be implemented in compliance with all governmental rules and regulations.~~

Purpose: To define the process used to identify and disseminate regulatory updates to the appropriate Department(s), to provide a mechanism to evaluate and assess the effects of regulatory updates, and to implement regulatory requirements that apply to Kaweah Delta Health Care District ("Kaweah Health") operations.

Policy: It is the policy of Kaweah Health that regulatory updates will be distributed to and reviewed by appropriate department management and staff. Applicable regulatory updates will be implemented in accordance with governmental rules and regulations.

Process:

I. Compliance Department Responsibilities:

A. The Compliance Department is responsible for monitoring, tracking, and coordinating the distribution~~, tracking, and monitoring of all regulatory updates.~~ of regulatory updates that affect Kaweah Health to responsible parties within the organization. The list of regulatory agencies and information sources being monitored for updates is set out in Attachment A to this policy.

~~I.~~B. Regulatory ~~changes~~updates will be reviewed monthly by the Compliance Department to evaluate the content of the regulatory update and to determine the appropriate ~~area~~department(s) and ~~Management~~management team members to whom the ~~information~~ regulatory update applies. As necessary, the Compliance Department will work with the applicable ~~area~~departments and management team members to assess the regulatory update.~~-~~

~~II.~~C. The Compliance Department will identify and distribute ~~the regulatory update, accompanied by~~ updates monthly to potentially affected departments and management team members, and a copy of the assignment log ~~identifying the required response.~~ will be provided. Items will be designated on the assignment log as:

1. Assignment:

   Bulletins or notifications from regulatory agencies, as identified by the Compliance Department, that may warrant revisions or updates to departmental operations.

2. FYI:

   Bulletins or notifications from regulatory agencies, as identified by the Compliance Department, that are informational in nature yet remain relevant to the responsibilities and operations of assigned departments.

3. Not Applicable:

   Regulatory updates that do not directly apply to Kaweah Health operations.

II. Department Responsibilities:

A. Designated management team members will review items on Assignment Log:

1. Items Designated as an Assignment:

(a) Evaluate assigned items to determine whether the regulatory changes may affect the operations of assignee's department or other departments.

(b) Assess the information, determine, and enter risk level the regulatory update is believed to have on the organization.

(c) When applicable, outline a clear action plan to ensure timely and effective compliance with the regulatory change or update.

(d) Provide an estimated implementation date to enable tracking and follow-up on progress.

(e) When bulletins or notifications may affect other departments, ensure it is shared accordingly. Document the departments notified.

2. Items Designated as FYI:

(a) Review items to determine if they will impact departmental operations.

(b) If an item designated as FYI is determined by the department to have an impact on departmental operations, please follow assignment steps in (a) through (e) above.

~~IV.~~B. Topics involving representatives from multiple areas shall collaborate, in the assessment and implementation of any corrective action or response.

~~V. Regulatory updates that do not directly apply to Kaweah Health operations will be documented as the non-applicable~~

~~VI.~~III. Regulatory updates requiring a response will be evaluated by Management. The response must include a comprehensive assessment of the issue and identify an action plan, risk level, and follow-up/monitoring (as appropriate). The evaluation and response must be completed in its entirety and returned to the Compliance Department within 15 calendar days from the date of distribution (unless otherwise communicated).

IV. Escalation Process

~~VII.~~A. As necessary, the appropriate member of the Executive Team and/or the Audit and Compliance Committee Meeting will be notified of Management failing to provide timely response.

~~VIII.~~B. Management of all areas affected by or involved with the regulatory updates affecting ~~billing and coding~~their areas will ensure that appropriate education and training are provided to all applicable staff.

C. Management of all areas affected by or involved with regulatory updates are responsible for implementing action plans designed to achieve compliance with the applicable regulatory updates.

"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 ~~bioethical~~bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

Attachment A

Regulatory Agencies and Information Sources Monitored Under this Policy

- US HHS Office of Inspector General (OIG)
- US Centers for Medicare and Medicaid Services (CMS)
- US Department of Health and Human Services (HHS)
- US Office of Civil Rights (OCR)
- US Centers for Disease Control and Prevention (CDC)
- US Food and Drug Administration (FDA)
- US Occupational Safety and Health Administration (OSHA)
- The Joint Commission (JCAHO)
- California Legislative Information
- California Department of Health Care Services (DHCS)
- California Department of Public Health (CDPH)
- California Department of Health Care Access and Information (HCAI)
- Medicare Administrative Contractor (MAC) Noridian Healthcare Solutions
- Medicare Administrative Contractor (MAC) National Government Services (NGS)
- Medicare Recovery Audit Contractor (RAC): Cotiviti
- California Hospital Association (CHA)
- American Hospital Association (AHA)

Policy Number: CP.08	Date Created: 04/21/2022
Document Owner: Jill Berry (Director of Corporate Compliance)	Date Approved: 05/26/2022
Approvers: Board of Directors (Administration), Compliance Committee, Amy Valero (Compliance Manager), Ben Cripps (Chief Compliance & Risk Management Officer), Michelle Adams (Executive Assistant)	

Governmental Payer Regulatory Updates

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

Purpose: To define the process used to identify and disseminate regulatory updates to the appropriate Department(s) and to provide a mechanism to evaluate and assess the effects and to implement regulatory changes and requirements that apply to Kaweah Delta Health Care District ("Kaweah Health") operations.

Policy: It is the policy of Kaweah Health that regulatory updates will be distributed to and reviewed by appropriate department management and staff. All applicable changes will be implemented in compliance with all governmental rules and regulations.

Process:

I. The Compliance Department is responsible for coordinating the distribution, tracking, and monitoring of all regulatory updates. Regulatory changes will be reviewed monthly to evaluate the content of the regulatory update and to determine the appropriate area(s) and Management to whom the information applies. As necessary, the Compliance Department will work with the applicable area to assess the regulatory update.

II. The Compliance Department will distribute the regulatory update, accompanied by a copy of the assignment log identifying the required response.

IV. Topics involving representatives from multiple areas shall collaborate, in the assessment and implementation of any corrective action or response.

V. Regulatory updates that do not directly apply to Kaweah Health operations will be documented as the non-applicable

VI. Regulatory updates requiring a response will be evaluated by Management. The response must include a comprehensive assessment of the issue and identify an action plan, risk level, and follow-up/monitoring (as appropriate). The evaluation and response must be completed in its entirety and returned to the Compliance Department within 15 calendar days from the date of distribution (unless otherwise communicated).

VII. As necessary, the appropriate member of the Executive Team and/or the Audit and Compliance Committee Meeting will be notified of Management failing to provide timely response.

VIII. Management of all areas affected by or involved with the regulatory updates affecting billing and coding will ensure that appropriate education and training are provided to all applicable staff.

"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 4001 Hazardous Materials and Waste Management Program

Kaweah Health

Subcategories of Department Manuals not selected.

Policy Number: EOC 4001	Date Created: 03/01/2006
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)	

Hazardous Materials and Waste Management Program

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

TABLE OF CONTENTS

I. POLICY OVERVIEW:

Kaweah Delta Health Care District herein after referred to as Kaweah Health (KH) is in the business of providing healthcare services. In order to conduct District business, certain materials must be used that require specific precautions to be taken to protect employee health. Therefore, it shall be the policy of Kaweah Health to communicate any hazards associated with handling hazardous materials to employees involved in those operations.

This policy is not intended to create new roles or responsibilities for Kaweah Health employees. This Hazardous Communication Program is intended to supplement normal safety activities. Current safety policies remain in effect.

The effectiveness of the Hazardous Material Communication Program, as with the normal Safety Program, depends upon the active support and involvement of all personnel.

II. POLICY AND PROCEDURE FOR MANAGEMENT OF HAZARDOUS MATERIALS AND WASTE:

PURPOSE:

- This plan describes how Kaweah Health is complying with the OSHA employee "right-to-know" (Hazard Communication) standard, 29 CFR 1910.1200, and Joint Commission EC.2.2.01. It applies to work operations where an employee may be exposed to hazardous chemicals under normal working conditions or during a foreseeable emergency situation. The following have been established as District priorities for the purpose of this plan:
  - To recognize the potential threats that hazardous materials and waste may pose to human health and the environment.
  - To establish, implement, monitor and document evidence of an ongoing program for the management of hazardous materials and waste.
  - To ensure that there is minimal risk to patients, personnel, visitors and the community environment within the confines of the hospital.

OBJECTIVES:

- To develop a system that addresses the identification of hazardous materials and waste from the point of entry into the hospital to the point of final disposal.
- To develop a system for managing hazardous materials and waste safely after identification.
- To ensure policies and procedures related to various hazardous materials and waste are reviewed, revised and approved by the Environment of Care Committee.
- To enhance adequate supervision of hospital personnel on hazardous materials and waste.

III. DEFINITIONS:

- Chemical Hazardous Material - A substance which by reason being explosive, flammable, poisonous, corrosive, oxidizing, irritating or otherwise poses a physical or health hazard.
- Physical Hazard- Any chemical for which there is a scientifically valid evidence that it is a combustible liquid, a compressed gas, explosive, flammable, an organic peroxide, an oxidizer, unstable (reactive) or water-reactive.
- Health Hazard - Any chemical for which there is statistically significant evidence based on at least one study conducted in accordance with established scientific principles that acute or chronic health effects may occur in exposed employees. The term "health hazard" includes chemicals which are carcinogens, toxic or highly toxic agents, reproductive toxic, irritants, corrosive, sensitizers, hematotoxins, nephrotoxins, neurotoxins, agents which act on the hematopoietic system, and agents which damage the lungs, skin, or mucous membranes.
- Infectious Hazardous Material - Any material possessing a significant potential for contagion or cross-infection.
- Radioactive Hazardous Material - Any material capable of giving off radiant energy in the form of particles or rays such as alpha, beta and gamma rays.
- Gaseous Hazardous Material - Any substance which may be dispersed through the air and act as a poison, irritant or asphyxiate.
- Label - Any written printed or graphic material displayed or affixed to containers of hazardous materials.

IV. ROLES AND RESPONSIBILITIES:

- **KAWEAH HEALTH**

  -The following will be provided to each employee by KD:

  1. A written hazard communication plan
  2. A List of hazardous chemicals at this facility or in each work area
  3. SDS for each hazardous chemical
  4. Assure all chemicals are labeled
  5. “Effective” training and information for all hazardous chemicals at this facility before initial assignment to work with a hazardous chemical , and also whenever the hazard changes.

- **ALL EMPLOYEES**

  -As an employee you must read this written hazard communication plan and:

  1. Follow all safety instructions provided by this plan and your employer
  2. Complete hazard communication training annually
  3. Obtain a SDS for any new chemical you may be required to purchase, and ensure that a SDS has been received prior to using any new product.
  4. Forward new SDSs to the District Safety Officer to facilitate updating the plan
  5. Label containers that are used for the transfer of chemicals (secondary or portable containers), and ensure that each chemical container has the appropriate labels.
  6. Read safe use guide information and chemical labels prior to working with a chemical
  7. Always wear personal protective equipment specific to each chemical
  8. The Spill Kits will be routinely checked to see that all required materials are present and in usable condition
  9. Immediately report any damaged containers or spills

- **CONTRACTORS**

  1. Follow all safety rules at this workplace

2. Always wear personal protective equipment for each hazardous chemical
3. Contractors and their employees must read this plan and provide the following information to the District Safety Officer:
    - A list of hazardous chemicals they will use while at this workplace
    - A SDS for each hazardous chemical being used by contractor

- **DISTRICT SAFETY OFFICER:**
    1. Review and update the Incora HazCom program, as necessary
    2. Submit new or revised SDSs to Incora MAXCOM™ Print new updated SDS Index and place into the Incora MAXCOM™ (SDS) Manual (to be coordinated with department Safety Leaders and SDS Contacts)
    3. Update Incora MAXCOM™ (SDS) Manual as needed
    4. Remove chemicals from service until a SDS is made available (to be coordinated with department Safety Leaders and SDS Contacts)
    5. Ensure that all hazardous chemicals are properly labeled (to be coordinated with department Safety Leaders and SDS Contacts)
    6. Remove any chemical from service that has a missing or damaged label (to be coordinated with department Safety Leaders and SDS Contacts)
    7. Label all portable secondary containers with appropriate information (to be coordinated with department Safety Leaders and SDS Contacts)
        a. The pharmacist shall be consulted on proper methods for repackaging and labeling of bulk cleaning agents, solvents, chemicals and poisons used throughout the hospital.
    8. Make certain employees wear personal protective equipment for hazardous chemicals (to be coordinated with department Safety Leaders and SDS Contacts)
    9. Perform an annual inventory of on-hand chemicals to ensure an accurate database for employee access (to be coordinated with department Safety Leaders and SDS Contacts)
    10. Implement and oversee employee training
    11. Involved in the District's hazardous communication program; collaborating with the applicable Pharmacist-in-Charge on program elements involving Hazardous Drugs.

ENGINEERING AND ENVIRONMENTAL SERVICES (EVS) DEPARTMENTS

1. Both departments will support all internal responses to the activation of ***Code Orange***.
2. EVS shall send trained personnel.
3. Hazardous Drug spill kits are located in the following areas:
    - Medical Center - main pharmacy (receiving area and Hazardous Drug sterile compounding room),3S and main OR
    - South Campus – Subacute A side medication room and receiving area of the pharmacy.
    - West Campus – Acute Mental Health Hospital medication rooms and Acute Care Rehabilitation Hospital medication room and receiving area of the pharmacy
    - Receiving area of Kaweah Health Retail Pharmacy, Kaweah Health Employee Pharmacy

- **DEPARTMENT DIRECTORS**
    1. The personnel of the department shall be oriented to the Incora MAXCOM™ (SDS) Manual.
    2. Staff orientation to the Incora MAXCOM™ (SDS) Manual:
        - Existence of the Manual and contents

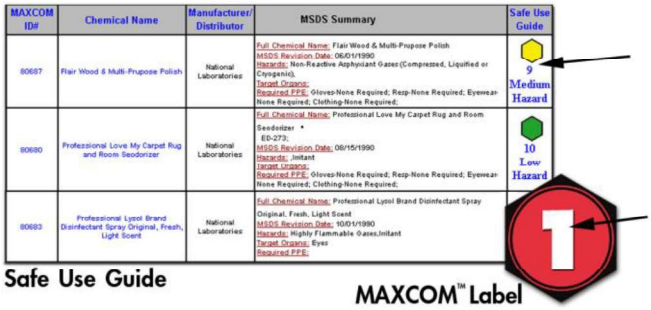
- Where it is kept (It is to be available to employees at all times)
- How to utilize the Incora MAXCOM™ system (manual and online), and read a standard SDS

3. Ensure that all departments utilizing hazardous materials have access to a manual
4. Assign and support a departmental SDS contact to assist the District Safety Officer in the coordination of each department's HAZMAT activities (see responsibilities for District Safety Officer)
5. Conduct accident investigations for all accidental exposures of employees

V. RESPONSE

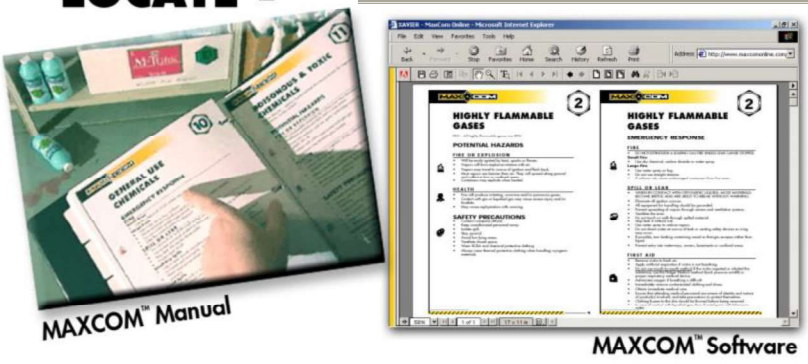
The following procedure illustrates an appropriate response to a chemical spill within the District:

IDENTIFY -



Identify the Safe Use Guide Number and Hazard Level in the SDS Index or from the Incora MAXCOM™ Label on the chemical container (if a MAXCOM™ Label is being used for this product).

LOCATE -



Locate the corresponding Safe Use Guide in Section 5 of the Incora MAXCOM™ Manual or using the Incora MAXCOM™ online database.

RESPOND -

Respond carefully and appropriately, using the information supplied for a Fire, Spill or Injury in the Safe Use Guide.

- Spills will be classified in one of two categories (minor or major).
    1. **MINOR**: A minor spill is characterized by the confidence and the capability of unit personnel to clean up the spill without the assistance of emergency personnel even though the cleanup procedure may require specialized knowledge and specialized equipment. A relatively small area is affected and only a relatively small number of personnel may need to leave the area until the spill is cleaned up.

    2. **MAJOR:** A major spill has occurred under the following conditions:
        - A life threatening condition exists, or there is an immediate danger posed to staff, patients or visitors.
        - You are not able to manage the spill on your own, and the condition requires the assistance of emergency personnel
        - The condition requires the immediate evacuation of all employees from the area or the building.
        - The spill is of a large enough quantity that additional assistance is required (threshold quantities will vary based on the chemical and can be verified on Safe Use Guides or SDSs, but is generally greater than 2 liters)
        - The contents of the spilled material is unknown
        - The spilled material is highly toxic
        - You feel physical symptoms of exposure
        - The chemical is biohazardous, radioactive or flammable

- Appropriate notifications are as follows for all Major spills:
  -**Main Campus**: dial **44** and notify PBX that you have a ***Code Orange*** (chemical spill)

    - PBX is then responsible for activating a ***Code Orange*** according to their established protocols.

  -**All other KH facilities**: Dial **9-911** and notify the emergency dispatch of the situation.

    - Be prepared to provide the following information when performing notifications:
        1. Your name and call back number
        2. Location of incident
        3. Name of chemical (if known), and any information about the properties of that chemical (i.e.: liquid, solid, gas, powder, odor, producing vapors…)

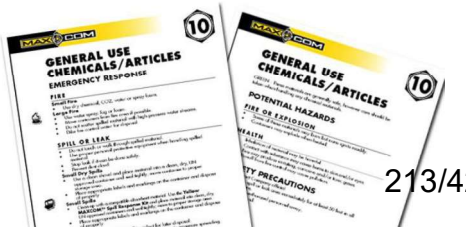
VI. LIST OF HAZARDOUS CHEMICALS

The list of hazardous chemicals is provided in Section 4 of the Incora MAXCOM™ MSDS Manual available through Kaweah Compass

Sample MSDS Index

MaxCom ID#	Chemical Name	Manufacturer/ Distributor	MSDS Summary	Safe Use Guide
80673	KnockDown	Ball Industries	MSDS Revision Date: 03/15/1995 Hazards: Non-Reactive Asphyxiant Gases (Compressed, Liquified or Cryogenic),Irritant Target Organs: Lungs/Skin/Eyes Required PPE: Gloves-Impervious; Resp-None Required w/Good Ventilation; Eyewear-Safety Glasses/Goggles; Clothing-Apron;	9 Medium Hazard
80677	N-L Concentrate All Purpose Cleaner	National Laboratories	ID#s: ED-302; MSDS Revision Date: 09/05/1990 Hazards: ,Irritant Target Organs: Required PPE: Gloves-None Required; Resp-None Required; Eyewear-None Required; Clothing-None Required;	10 Low Hazard
80674	Professional Love My Carpet Liquid Shampoo	National Laboratories	ID#s: ED-149; MSDS Revision Date: 09/01/1990 Hazards: Flammable & Combustible Liquids,Irritant/Carcinogen Target Organs: Skin/Eye Required PPE: Gloves-Rubber; Resp-None Required; Eyewear-Protective; Clothing-Protective;	1 High Hazard
80679	Professional Love My Carpet Rug Cleaner	National Laboratories	ID#s: DD-135; MSDS Revision Date: 09/01/1990 Hazards: ,Irritant/Carcinogen Target Organs: Required PPE: Resp-None Required; Clothing-None Required;	10 Low Hazard
80672	Blue X Glass Cleaner w/Ammonia	National Sanitary Supply Co.	MSDS Revision Date: 02/04/1994 Hazards: Flammable & Combustible Liquids,Irritant Target Organs: Skin/Eye Required PPE: Gloves-None Required; Resp-None Required; Eyewear-None Required; Clothing-None Required;	1 High Hazard

The chemical Index provides information about the hazard levels, physical and health hazards, target organs, and PPE for each chemical used at this facility or work area. The Hazard Level and Safe Use Guide Number is located the right side of the list. The safe use guide number corresponds with the numbered pages located in section 5 of this manual.



VII. SAFETY DATA SHEETS (SDS) AND OTHERINFORMATION

-There are several places to locate information for hazardous chemicals used at KH:

1. **The SDS Index** (chemical list)– located in Section 4 of the IncoraMAXCOM™ (SDS) Manual. The SDS Index provides valuable information about each chemical including the chemical name, hazard category, hazard level, target organ effects, and PPE. The chemical list also identifies the Incora MAXCOM™ identification number that can be used to locate the correct SDS.

2. The Safe Use Guide – Each hazardous chemical is grouped into a chemical category referred to as a safe use guide. The numbered Safe Use Guides for a particular chemical can be located in the SDS Index (see above) or from the supplemental Incora MAXCOM™ labels.

3. Each Safe Use Guide provides information such as safety precautions and potential hazards and the proper emergency response to fires, spills and first aid involving a chemical release.

   SDSs – provide valuable information specific to the chemicals you use. The District Safety Officer will maintain a SDS for every hazardous chemical at this facility. All SDSs for the District will be maintained on a backup disk in the following locations to ensure access for all employees if the online database becomes inaccessible: Employee Health, Emergency Department, and Safety. The backup disk shall be maintained in the department's SDS binder.

4. **Online Database** - All SDSs can be accessed via the Internet on District computers using one of the following three routes:
   - Logon to the Kaweah Compass and click on the SDS link located on the left side of the home page under apps.
   - Access Internet Explorer and logon to www.maxcomonline.com, you will be logged in automatically.

From the main IncoraMAXCOM™ site, further assistance can be found by clicking the 'HELP**'*

button onthe upper right hand side of this page.

VIII. SDS PROCEDURES

A SDS must accompany any chemical product that has been delivered to or is used within the district. Upon receiving a new SDS make certain that the District Safety Officer is given the SDS to ensure that the chemical information is updated in the SDS file, Incora MAXCOM™ (SDS) Manual and on the web based system. If you discover a misfiled, misplaced, or loose SDS alert the District Safety Officer immediately.

IX. EMPLOYEE INJURY FROM HAZARDOUS MATERIALS AND WASTE

In the event of an employee injury as a result from exposure to a chemical used in the District, the following procedures shall be followed:

1. *Retain a copy of the Safe Use Guide or SDS for that chemical and send it with the injured employee to Employee Health or the Emergency Department according to hospital policy.*
2. *An accident investigation shall be conducted by the immediate supervisor and submitted to the District Safety Officer for review*

X. PERSONAL PROTECTIVE EQUIPMENT (PPE)

Proper use of PPE will protect you from the effects of being exposed to hazardous chemicals. Long term, unprotected exposures to hazardous chemicals can cause severe damage to the target organs listed in the chemical index. It is important that you *always* wear the appropriate personal protective equipment for all chemicals that you are working with or may come into contact with at this facility or in your work area. For hazardous drug PPE requirements reference Policy PC 270 Medication: Hazardous Drug Handling.

XI. LABELS AND OTHER FORMS OF WARNING

Each department will be responsible for identifying and labeling all hazardous materials and wastes within their department/area. Upon ordering these materials, the Department Director (or designee) initiating the order will inform Materials Management that hazardous materials are being ordered. Materials Management shall be responsible for receiving, identifying and delivering these materials to their destination. A chemical manufacturer must label their chemicals with the name of the chemical, name, address, and phone number of the manufacturer and all appropriate hazard warnings.

If chemicals are transferred from a labeled container to a portable container, the container will be labeled with the chemical name, manufacturer and primary hazard of the chemical. Labels for each chemical can be printed on label sheets directly from the Incora MAXCOM™ System web tools.

When a manufacturer label becomes damaged or unreadable, the container will be relabeled with the chemical name, manufacturer, and primary hazard of the chemical using the labels mentioned above.

Departments may choose to utilize Incora MAXCOM™ "Red", "Yellow", and "Green" numbered Hazard Labels on containers to ***supplement*** OSHA mandated manufacturer labels. These labels provide immediate identification of the hazard level and correct safe use guide number for each chemical. Contact your departmental SDS coordinator to obtain supplemental labels. This procedure is not a mandate for all district departments due to volume of various products.

XII. TRAINING

Employees who work with or are potentially exposed to hazardous chemicals will receive training on the physical and health hazards of each group of hazardous chemicals located at this facility. These groups of hazardous chemicals are Flammable, Corrosive, Reactive, and Toxic Chemicals. Training will be conducted through the departmental SDS contacts or department Safety Leaders. Training will emphasize the following items:

- The requirements of the OSHA "Employee Right-to-Know" Hazard Communication Standard
- How to identify a chemical release or exposure
- Physical and Health Hazards of each group of chemical used at this facility.
- How to locate an SDS for each chemical at this facility

- Procedures to protect against chemical hazards such as personal protective equipment work practices or methods to ensure appropriate use and handling of chemicals, and emergency response procedures.

- Additional information and training is available from your departmental SDS coordinator or District Safety Officer. Chemical category training may be obtained online (this may also be obtained from the District Safety Officer).
- All persons required to handle hazardous chemicals or materials will be provided with appropriate orientation, equipment and on the job training. Each department shall be responsible for training each individual handling hazardous material and wastes according to the materials within that department they may come in contact with.

  All training shall be documented.

XIII. NON-ROUTINE TASKS

If an employee is required to perform hazardous non-routine tasks (e.g., cleaning tanks, entering confined spaces, etc.), a special training session will be conducted to explain any hazardous chemicals which may be present and the precautions to reduce or avoid exposure.

XIV. CONTRACTOR EMPLOYERS

The District Safety Officer upon notification by the responsible supervisor will ensure:

1. Outside contractors are advised of any chemical hazards that may be encountered in the normal course of their work on the premises
2. Availability of SDSs
3. Labeling system in use
4. Protective measures to be taken
5. Safe handling procedures to be used

Each contractor bringing chemicals on-site must provide the District Safety Officer with the appropriate hazard information for these substances, including SDSs, labels, and precautionary measures to be taken when working with or around these chemicals.

XV. MATERIAL ORDERING AND RECEIVING

To ensure that hazardous materials are ordered, received and handled in safe and expeditious manner.

- The Materials Management Department is responsible for ordering products for District use. Hazardous materials will be ordered in accordance with this department's policies and procedures.
- Buyers in the Materials Management Department, and any department performing their own procurement of hazardous materials, will be responsible for identifying whether a product to be purchased is hazardous or not. When a product is classified as hazardous, a SDS will then be requested from the vendor prior to delivery.

- User departments will be responsible for ensuring that each product has a SDS prior to using it within the District. If there is no SDS, that department is then responsible for acquiring one to be entered into the District's system.
- Any damaged products received shall be returned according to department policy.
- The vendor/manufacturer shall be notified of any deficiency and corrective action will be requested.
- The end-user department shall be responsible for ensuring that appropriate labeling is provided by the manufacturer.
- Any department that stores bulk quantities of hazardous items will routinely review inventory levels of all hazardous materials. This will be done to assess the appropriateness as a part of the overall inventory management program of the hospital.
- When any department receives a new SDS for the Hospital the following steps will be followed:
    - Verify that the product is indeed not in the database.
    - Send a copy of the SDS to the District Safety Officer. The sheets will then be sent to Incora MAXCOM™ to be entered into the database. The following routes may be used for submission:
        - **Standard mail addressed to:**
            - **Incora**
              840 W. Carver Rd, Suite 104
              Tempe, AZ 85284
              Att: Incora Hazcom Team
        - **Email an electronic copy to: addmsds@maxcomonline.com**
    - A complete, District-wide chemical inventory will be requested from Incora MAXCOM yearly and will be maintained as the District's backup if there is a failure of the online database. The backup shall be maintained in accordance with Section VII, Subsection 3 of this policy.

XVI. HAZMAT STORAGE

All hazardous materials used within the District shall be stored and maintained according to the manufacturer's recommendations. These recommendations may be found on the manufacturer's label located on the product, or on the SDS supplied by that manufacturer (located in the District's database). The District will make the necessary accommodations for such storage of chemicals. All designated storage areas shall comply with the following storage standards:

- Par levels shall be established for these hazardous chemicals, and purchases shall be made based upon these levels.
- Storage areas will be kept under lock and key until they are needed.
- The storage areas for hazardous chemicals will be kept clean and organized.
- Hazardous waste storage and processing areas will be free of clutter and effectively separated from patient care, food preparation and serving areas.
- Proper storage of hazardous materials is the responsibility of the department holding that product.

XVII. DISPOSAL OF HAZARDOUS WASTE

- A hazardous material is any material in use that is considered to represent a threat to human life or health. A hazardous waste is a material no longer in use that represents such a threat. Once a material is used, contaminated, or determined to be in excess of the amount required, it is considered waste. Biological, radiological and pharmaceutical wastes will be addressed individually later in the policy.
- All hazardous waste produced by the District will be disposed by following the manufacturer recommendations for the given chemical. The Plant Operations and Services Department is responsible for assuring that proper permits are obtained for disposal of all hazardous chemical waste generated at the facility. A certification of disposal will be obtained from an approved receiver for all hazardous chemicals disposed of off-site and will be disposed of in accordance with State and Federal regulations.
- No empty drums, buckets, jugs, pails, or any other container that has held toxic or corrosive materials will ever be reused for anything. These too shall be disposed of according to the above procedure.
- Methods for handling each type of waste is outlined in the following policies and procedures and monitored accordingly.
    - Waste from chemicals shall never be mixed together because they can react together and cause serious problems, such as explosions and/or deadly gas emission. The following is a simple, generalized, step-by-step process that could be used to handle and transport chemical waste:
        - The components of each type of chemical waste are clearly labeled.
        - If the original label is unclear, damaged, or missing, or if the container holds material that is different from the original material, a new label shall be attached.
        - The label clearly indicates that the material is Hazardous Waste and lists the component and the strength of the waste and type of hazard it represents, if the type of hazard is not obvious.
        - Labeled containers are removed from the area where they are used as soon as possible after filling, to reduce the hazards in the area.
        - The chemical containers are picked up in sturdy carts and transported in cardboard tote boxes.
        - Personnel who transport chemical wastes are trained to deal with spills and leaks.
        - Tote boxes are not over filled and the materials in a tote box are chemically compatible.

- The following are department specific hazardous waste disposal guidelines:
    - *ENGINEERING DEPARTMENT WASTE DISPOSAL*
        - Light Bulb, , Metal Filing: Disposed of in the trash compactor.
        - Used fluorescent tubes must be disposed in quantities of 24 or less.
        - Sawdust, Paper and Trash are collected separately in designated non-flammable basket and disposed of in the trash compactor.
        - Used Paint Thinner and Cleaning Solvents: stored in a non-flammable container, which is stored in designated flammables cabinets. When the container is full, it is disposed of using an outside pick-up service. A manifest for each pick-up is required and must be kept on file.

    - *DIETETIC DEPARTMENT/SERVICE WASTE DISPOSAL*

- To provide a safe and effective means of disposing food waste and other waste associated with the Dietetic Department/Service.
- Rubber gloves are provided and used when handling food and other waste.
- Food waste is removed from the Dietetic Department/Service through the city sewage system. Garbage disposal is located in Dietary.
- Trash receptacles are located throughout the department. They are emptied 3 - 4 times daily. These receptacles are UL approved, and lined with impervious liners. If the trash receptacle is not in continuous use, a lid covers it. Trash receptacles are transported in closed containers to the trash compactors located at the West end of the hospital.

- *ENVIRONMENTAL SERVICES WASTE DISPOSAL*
  - All contaminated waste or material will be red-bagged.
  - The Director of Environmental Services will have the contracted outside hauler pick-up the contaminated waste or material and take it to the area outside the hospital for proper disposal.
  - Under no circumstances will contaminated waste or material be mixed in with regular trash or linen.
  - All containers for contaminated waste will be thoroughly washed and disinfected daily.

XVIII. BIO-HAZARDOUS WASTE:

To ensure that all District staff appropriately handle and discard biohazardous materials. This shall be done in a manner that preserves both their safety and the safety of others who may come in contact with the materials.

All District personnel shall exercise extreme care when handling biohazardous materials and waste.

DEFINITION:

- Biohazard: Infectious or etiological (disease causing) agents, potentially infectious materials, certain toxins and other hazardous biological materials that are potentially hazardous to humans, animals and/or plants.
- Sharps**:** Objects capable of puncturing the skin, such as hypodermic needles, blades and suture needles.
- To prevent cross-contamination; the following preventative measures are to be followed:
  - When providing patient care:
    - Personnel must always utilize Standard Precautions.
    - Personnel must wear personal protective equipment as indicated when in contact with infectious patients.
  - Patient's linens shall be discarded in designated linen and trash receptacles.
  - Biohazard wastes will be discarded in designated receptacles labeled as biohazard.
  - Personnel shall wash hands before leaving patient rooms.
  - Red impervious containers appropriately labeled with "**BIOHAZARD"** signage will be used to collect sharps generated. These containers will be placed in biohazard waste containers in the soiled utility room
  - **DISPOSAL:**

        - Environmental Services transports "BIOHAZARDOUS" waste off of Nursing Units using designated routes to an on-site storage facility.
    - **THE FOLLOWING PATIENT ITEMS SHALL BE DISCARDED AND LABELED AS "BIOHAZARDOUS WASTES":**
        - Suction containers (disposable)
        - Wound suction and chest drainage systems
        - Soiled dressings that are saturated with blood or body fluids
        - Other disposables contaminated with blood or body fluids
- **EXPOSURE:**
    - Personnel shall exercise caution to prevent blood born pathogen exposure by using Body Substance Precautions and using appropriate protective apparel. Exposure to broken skin may require medical follow-up. Employee Injury Forms are to be completed in addition to notification of Supervisor and Employee Health Services.
- **SHARPS HANDLING:**
    - Personnel shall exercise extreme caution when handling sharps.
    - To prevent skin punctures, avoid needle cutting and recapping.
    - Wear double latex gloves when removing blades and unused sutures from suture trays.
    - **DISPOSAL:**
        - Dispose of all sharps in red impervious plastic containers appropriately labeled with biohazard signage. Avoid over spill of containers. Extra sharp containers are kept in soiled utility area.
        - Red impervious containers are to be utilized for disposal of all sharps from patients.
        - Red impervious containers are self-closing; do not force entry into containers.
        - Broken glass, blades and suture needles shall be disposed in sharps.
        - Environmental Services will transport off nursing units using designated routes.
    - **EXPOSURE: Personnel receiving a puncture wound from any sharp shall notify the Supervisor and the Employee Health Nurse.**
        - The Employee Health Nurse will evaluate the injury and send the employee to a designated physician if the wound was sustained from a hazardous material or wastes.
        - Report of Injury will be completed.
    - **SPILLS:**
        - Spills shall be picked up immediately using appropriate PPE.
        - Use extreme caution when picking up contaminated sharps: wear double latex gloves and use scoop obtained from Spill Kit.
    - Sharps are obtained from Central Logistics in original containers. **ALL SHARPS ARE STERILE PRIOR TO USE.**

XIX. RADIOACTIVE WASTE

All radioactive materials are disposed of in accordance with the Nuclear Regulatory Commission and State of California regulations.

NOTE: WHEN HANDLING RADIONUCLIDES, WEAR RUBBER GLOVES.

- Remove all expired radionuclides from the active storage area to the radioactive decay vault.

- Enter into the indicated log book the date of transfer, the activity transferred, the volume transferred and initial the entry.
- Place all radioactive waste materials; such as: used syringes, needles, test tubes and other contaminated items into containers labeled for such waste.
- Daily remove and seal the plastic bags, which contain the radioactive waste from the containers and place in the decay vault.
- Enter into the designated log book details showing radioactive materials disposed of, the date of disposal and the radioactivity present at the time of disposal.
- Enter into the designated logbook showing all disposals of radioactive materials, date of disposal, exposure level reading and the method used for disposal.
- ***LOG MAINTAINED BY Nuclear Medicine Technologists***
  ENTER IN LOG THE FOLLOWING:
  - Date
  - Radionuclide
  - Activity
  - Volume disposed of by sewage.
- Sr-82/Rb-82 generators will be returned to the manufacturer for disposal.
- ***LIQUID WASTE:***
  - Liquid waste will be disposed of in the sanitary sewer system only in accordance with Section 20.303 of 10 Code of Federal Regulation part 20.
  - All unused radioactive liquids will be transported and stored in lead wells located in Nuclear Medicine hot lab until safe for disposal.
  - All liquid waste will be monitored with Calibrated survey meters. If any radioactivity remains:
    - Determine amount of activity.
- Remove all radioactive labels and wash containers after liquid has been disposed of.

- ***SOLID WASTE:***
  - Solid waste; such as: syringes, sponges, liners, test tubes, empty bottles, etc. will be placed in bags which will be labeled "Radioactive" and held for decay.
  - When radiation levels have reached background levels, as measured with a low level survey meter with shielding removed, remove or obliterate all radiation labels and dispose in normal trash to be buried at the landfill.
  - Linens contaminated with radioactivity will be placed in plastic bags and held for decay until no radioactivity over background can be detected with a low-level survey meter before sending them to the Laundry.

XX. COMPRESSED GASES AND OXYGEN

This section is offered as a supplement to the Incora MAXCOM™ *'Safe Use Guides'* that are to be referenced for all compressed gases (including oxygen) during an emergency. The following protocols/procedures are specific for the District and should be routinely followed by employees and compressed gas suppliers alike:

- General Procedures:
  - All personnel involved with the use and transport of compressed gas shall be trained in the proper handling of cylinders, cylinder trucks and supports, and cylinder-valve protection caps.
  - All cylinder storage areas, outside and inside, shall be protected from extremes of heat and cold and from access by unauthorized individuals.

- Cylinders must be secured at all times so they cannot fall.
- Be sure cylinders are secure on rack and never hang anything on cylinder.
- Valve safety covers shall be left on until pressure regulators are attached.
- Containers must be marked clearly with the name of the contents.
    - Tanks with wired on tags or color code only shall not be accepted.
- Hand trucks or dollies must be used when moving cylinders. E-tanks may be carried by hand (one per staff member at a time).
- Do not roll or drag cylinders.
- The use of oil, grease or lubricants on valves, regulators or fittings is prohibited.
- Do not attempt to repair damaged cylinders or to force frozen cylinder valves.
- ***FLAMMABLE GASES****:*
    - Special care must be used when gases are utilized in confined spaces.
    - No more than two cylinders shall be connected by a manifold; however, several instruments or outlets are permitted for a single cylinder.
- ***PRESSURE REGULATORS AND NEEDLE VALVES****:*
  Needle valves and regulators are designed specifically for different families of gases. Use only the properly designed fittings.
- Throats and surfaces must be clean and tightly fitting. *Do not lubricate*.
- Tighten regulators and valves firmly with the proper sized wrench. Do not use adjustable wrenches or pliers. Do not force tight fits.
- Open valves slowly.
- Do not stand directly in front of gauges (the gauge face may blow out).
- Do not force valves that stick.
- Check for leaks at connections. Leaks are usually due to damaged faces at connections or improper fittings. Do not attempt to force an improper fit. (It may only damage a previously undamaged connection and compound the problem).
- Valve handles must be left attached to the cylinders.
- The high-pressure valve on the cylinder shall set the maximum rate of flow. Fine-tuning of flow shall be regulated by the needle valve.
- Shut off cylinder when not in use.
- *LEAK TESTING:*
    - "Snoop" or a soap solution shall be used to test cylinders and connections. First test the cylinders before regulators are attached, and test again after the regulators or gauges are attached.
- *EMPTY CYLINDERS:*
    - Once a cylinder is empty, it must be marked accordingly. The letters '**MT**' may be written on the cylinder to indicate that it is empty.
    - Cylinder valves must be turned off and valve safety caps replaced before securing.
    - All empty cylinders must be secured properly (similar to those that are not empty).
    - Empty or unused cylinders must be returned promptly to their designated holding area.
- *Oxygen Cylinders:*
    - Crack valves to clear them before bringing tank into Patient's room.
    - Read labels, tags and color code before administering any compressed gas.
    - Oxygen and other gases are potentially dangerous. Special safety precautions shall be followed at all times while using or storing oxygen.

- Do not use wool or nylon inside patient tents - they may cause sparks.
- Check oxygen supply regularly.
- Store oxygen cylinders upright and secured.

XXI. Pharmaceutical Waste

Pharmacy Director and personnel shall exercise extreme care when handling hazardous materials and waste. Additional emphasis will apply to cytotoxic drugs (CD's) and personnel from Pharmacy, 3 South and Cancer Care must follow the OSHA work practice guidelines that cover cytotoxic drugs.
Pharmaceutical Waste shall be handled with care and disposed of as follows:

Pharmaceutical Waste includes all pharmaceutical waste that is liquid, solid, paste and aerosol pharmaceuticals. All other NIOSH drugs based on facility risk assessment in PC.270 are disposed in the pharmaceutical waste container. Pharmaceutical waste does not include unused and intact non-hazardous pharmaceuticals in their original packaging directed for resale and reuse for its original intended purpose. Pharmaceutical Waste shall be discarded in the blue and white Pharmaceutical Waste container located in each unit.

ChemoTrace Chemotherapy Waste or Trace Chemo includes solid materials intended for discard that are **not** known to be contaminated with chemotherapy agents but were exposed to chemotherapy agents and are **not** a hazardous waste. This material includes uncontaminated personal protective equipment and empty packaging, vials, ampules, IVs, bottles, and tubing. These materials do not include hazardous pharmaceutical or chemotherapy agent spill cleanup materials. Trace Chemo may include regulated medical waste like syringes used in administration of chemotherapy agents.

Chemo Trace Chemotherapy Waste shall be discarded in the yellow Chemo Trace Containers located in units where chemo is dispensed.

RCRA Hazardous Waste as defined by the Resource Conservation and Recovery Act (RCRA), including liquid or pourable chemotherapy/biotherapy wastes.

- Hazardous Drugs are capable of causing toxicity to personnel and others who come in contact with them. Hazardous drugs pose a potential health risk to personnel who prepare, handle, administer and dispose of these drugs.
- Drugs may be classified as hazardous when they possess any one of the following characteristics: Genotoxicity, Charcinogenicity, Teratogenicity, Reproductive toxicity, Organ toxicity at low doses.

    - *LIQUID OR POURABLE* cytotoxic waste must be disposed of by a registered hazardous waste transporter with the use of a hazardous waste manifest. Personnel must follow the transporters procedures for disposing such waste.

RCRA Hazardous Waste should be placed in the black RCRA containers located in the designated areas.

XXII. PESTICIDE MANAGEMENT

- EPA considers sterilizing agents and disinfectants pesticides. Although, these chemicals are used to kill microorganisms in healthcare facilities. The use of these chemicals plays an important role for infection control and the continued use of these anti-microbial agents are essential. Insect sprays also fall into this category and their use is limited to the Engineering Department only. In general, the hazardous materials program will also apply to pesticides.

Additional information can be obtained through the California Department of Pesticide Regulation (CDPR).

- The pesticide label shall reflect the overall toxicity and hazards of the mixture.
- Signal words provide general information about injury potential.
- Training must be given before any staff uses the chemical. Training must also include common systems of poisoning, regulations, label requirements and immediate decontamination.

XXIII. HAZARDOUS GAS TESTING

POLICY: KDHCD will sample test on a described basis, potentially hazardous gases and chemicals. The gases/chemicals to be sample tested in ambient air are **GASES: Nitrous Oxide. CHEMICALS: Glutaraldehyde (Cidex) and Formaldehyde.**

PROCEDURES:

- Periodic sample testing of gases and chemicals will be conducted pursuant to Title 8 by a qualified agency. Testing periods will be increased when sample tests are confirmed to be over permissible levels. The following is the protocol for each identified gas or chemical to be tested:

PPM

- Time weighted average (TWA) 0.5

  - ***NITROUS OXIDE***: Surgery and Family Birth Center will be tested **ANNUALLY.** The testing shall be conducted in accordance with Cal/OSHA. Personnel exposed to Nitrous Oxide will be tested **ANNUALLY**. Utilizing the same PPM.

PPM

- Time weighted average (TWA) 50

  - ***GLUTARALDEHYDE***: Surgery, Respiratory Therapy and Endoscopy will be tested **ANNUALLY.** The testing shall be conducted in accordance with Cal/OSHA.

PPM

- Short term exposure limit (STEL) .2
- Time weighted average (TWA) N/A

  - ***FORMALDEHYDE***: Surgery, Laboratory, will be tested **annually**. . The testing shall be conducted in accordance with Title 8

PPM

- Short term exposure limit (STEL) 2
- Time weighted average (TWA) .75

All results will be reported annually to the Environment of Care Committee. Any results over the limits will be **IMMEDIATELY** reported to the Safety Officer for corrective action and follow-up testing.

XXIV. MAINTENANCE OF POLICIES AND PROCEDURES RELATING TO CHEMICAL AND PHYSICAL HAZARDS

Policies and procedures relating to chemical and physical hazards shall be reviewed by the District Safety Officer, and by the Infection Prevention Committee for infectious hazards on an annual basis. Recommendations, conclusions and actions will be reported to the Environment of Care Committee at least annually, and as needed to address/review situations as they arise.

XXV. SEMIANNUAL REVIEWS: (Hazard Surveillance)

Semiannual reviews shall be conducted by the departmental SDS contacts. Reviews will be conducted within their respective departments to check management techniques of hazardous materials for labeling, isolation, ventilation and possible substitution of less hazardous agents.

XVI. TRIENNIAL EVALUATION OF THE EFFECTIVENESS OF THE HAZARDOUS MATERIALS AND WASTE MANAGEMENT PROGRAM

Every three years an evaluation of the Hazardous Materials and Waste Management Program is conducted. The EOC Committee shall conduct this evaluation.

"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."

Urology

Kaweah Health

Privileges in Urology

Name: _____

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UROLOGY

Education & Training: MD or DO; **AND** Successful completion of a urology residency training program approved by the Accreditation Council for Graduate Medical Education (ACGME), by the American Osteopathic Association (AOA) or by the Royal College of Physicians Surgeons of Canada, if board certified by an ABMS board, or actively pursuing board certification by an ABMS board (Obtained within 5 years).

Current Clinical Competence: Documentation of the performance of at least 50 urological procedures in the past 2 years or successful completion of a hospital-affiliated formalized residency or clinical fellowship in the past 12 months

Renewal Criteria: Maintenance of Board Certification and documentation of 25 procedures reflective of the privileges requested.

FPPE: Direct observation of a minimum of five (5) ma or diverse procedures (i.e. Any Laparoscopic; Robotic surgery; or Nephrectomy; pyeloplasty; Partial Nx; Radical Prostate; Radical Cystectomy; medium or large turbt; Ureteroscopy with Laser Lithotripsy.)

Request	CORE PRIVILEGES	Approve
☐	The ability to evaluate, perform H P, diagnose, treat (surgically or medically), and provide consultation (may include telehealth) to patients of all ages presenting with medical and surgical disorders of the genitourinary system and the adrenal gland, including endoscopic, percutaneous, and open surgery of congenital and acquired conditions of the urinary and reproductive systems and their contiguous structures. The core privileges in this specialty include the following procedures list and such other procedures that are extensions of the same techniques and skills.	☐

General urology Anterior pelvic exenteration Appendectomy, Bowel resection, Enterostomy or as a component of a urologic procedure Closure evisceration Continent reservoirs Inguinal herniorrhaphy as related to a urologic operation Intestinal conduit Surgery of the lymphatic system, including lymph node dissection (inguinal, retroperitoneal, or pelvic), excision of retroperitoneal cyst or tumor, and exploration of retroperitoneum Management of congenital anomalies of the genitourinary tract (presenting in adults), including epispadias and hypospadias Microscopic surgery (epididymovasostomy and vasovasostomy) Open stone surgery on kidney, ureter, and bladder Performance and evaluation of urodynamic studies Surgery of the testicle, scrotum, epididymis, and vas deferens, including biopsy, excision and reduction of testicular torsion, orchiopexy, orchiectomy, epididymectomy, vasectomy, vasovasostomy, and repair of in ury Surgery upon the adrenal gland, including adrenalectomy and excision of adrenal lesion	Surgery upon the kidney, including total or partial nephrectomy, including radical transthoracic approach, renal surgery through established nephrostomy or pyelostomy, and open renal biopsy Surgery upon the penis, including circumcision, penis repair for benign or malignant disease, grafting, excision or biopsy of penile lesion, and insertion, repair, and removal of penile prosthesis Surgery of the urethra, including treatment of urethral valves (open and endoscopic), urethral fistula repair (all forms, including grafting), urethral suspension procedures (including grafting, all material types), visual rethrotomy, sphincter prosthesis, and periurethral in ections (e.g., collagen) Surgery of the urinary bladder for benign or malignant disease (including partial and complete resection), diverticulectomy and reconstruction, bladder instillation treatments, cystolithotomy, total or simple cystectomy, creation of neobladders, and repair of bladder in ury and bladder neck suspension Surgery of the prostate, including transrectal ultrasound-guided and other biopsy techniques, all forms of prostate ablation, and all forms of prostatectomy Use of Urethral Bulking Agent Implants	**Endoscopic surgery** Laparoscopic surgery, urologic for disease of the urinary tract Laparotomy for diagnostic or exploratory purposes (urologic-related conditions) Cystoscopy Percutaneous nephrolithotripsy Transurethral surgery, including resection of prostate and bladder tumors Ureteroscopy, including treatment of all benign and malignant processes Urethroscopy, including treatment of all benign and malignant processes **Reconstructive surgery** Plastic and reconstructive procedures on ureter, bladder, urethra, genitalia, and kidney Reconstructive procedures on external male genitalia requiring prosthetic implants or foreign materials Other plastic and reconstructive procedures on external genitalia

☐	**CORE PRIVILEGES T AT REQUIRE FLUOROSCOPY** ***(Prerequisite: Current & Valid CA Fluoroscopy or Radiology Supervisor Permit)*** The ability to evaluate, perform H P, diagnose, treat (surgically or medically), and provide consultation (may include telehealth) to patients of all ages presenting with medical and surgical disorders of the genitourinary system and the adrenal gland, including endoscopic, percutaneous, and open surgery of congenital and acquired conditions of the urinary and reproductive systems and their contiguous structures. The core privileges in this specialty include the following procedures list and such other procedures that are extensions of the same techniques and skills. Percutaneous aspiration or tube insertion Surgery of the ureter and renal pelvis, including utereolysis, insertion/removal of ureteral stent, and ureterocele repair (open or endoscopic) Endourology/stone disease Extracorporeal shockwave lithotripsy Endoscopic surgery Transvesical ureterolithotomy	☐
☐	Admitting Privileges (must request Active staff status)	☐

ADVANCED PROCEDURES

Request	Procedure	Initial Criteria	Renewal Criteria	Approve
☐	Use of surgical laser	~~Training in residency **OR** completion of an approved eight-hour minimum CME course that included training in laser principles – a letter of reference from preceptor experienced – credentialed in laser privileges **AND** a~~ Minimum of 24 laser procedures in the last 2 years. ***(Prerequisite: Current & Valid CA Fluoroscopy or Radiology Supervisor Permit)***	A minimum of 24 laser procedures in the last 2 years ***(Prerequisite: Current & Valid CA Fluoroscopy or Radiology Supervisor Permit)***	☐
☐	Laparoscopic radical nephrectomy	Minimum of 6 procedures in the last 2 years.	6 in the past 2 years	☐
☐	Robotic Procedures (e.g. Prostate; Kidney, etc)	Minimum of 12 procedures in the last 2 years.	12 in the past 2 years	☐
☐	Radium seed implantation for prostate cancer in con unction with radiation oncologist	Minimum of 6 procedures in the last 2 years.	6 in the past 2 years	☐
☐	Percutaneous nephrolithotomy (PCNL)	Minimum of 10 procedures in the last 2 years. Or completion of residency in the last 12 months. ***(Prerequisite: Current & Valid CA Fluoroscopy or Radiology Supervisor Permit)***	10 in the past 2 years ***(Prerequisite: Current & Valid CA Fluoroscopy or Radiology Supervisor Permit)***	☐
☐	Sacral nerve stimulation for treatment of bladder dysfunction	Minimum of 6 procedures in the last 2 years.	6 in the past 2 years	☐
☐	Fluoroscopy	Current and valid CA Fluoroscopy supervisor and Operator Permit or a CA Radiology Supervisor and Operator Permit	Current and valid CA Fluoroscopy supervisor and Operator Permit or a CA Radiology Supervisor and Operator Permit	☐
☐	Procedural Sedation	Pass Kaweah Health Sedation/Analgesia (Procedural Sedation) Exam	Pass Kaweah Health Sedation/Analgesia (Procedural Sedation) Exam	☐

☐	Outpatient Services at a Kaweah Health Clinic identified below. Privileges include performance of core privileges/procedures as appropriate to an outpatient setting and may include telehealth: **Dinuba E eter Lindsay Tulare Valencia oodlake MC – Akers MC – illow Specialty MC – illow Specialty Clinic Tulare Cardiology Clinic**	Initial Core Criteria AND Contract for Outpatient Clinical services with Kaweah Delta Health Care District.	Maintain initial criteria	☐

Acknowledgment of Practitioner:

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

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

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

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

Name: _____
Print

Signature: _____ _____
Applicant *Date*

Signature: _____ _____
Department of urgery Chair *Date*

Gastroenterology

Privileges in Gastroenterology

Name: _____ Date: _____

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GASTROENTEROLOGY PRIVILEGES - INITIAL CRITERIA
Education: M.D. or D.O. and successful completion of an accredited residency in Internal Medicine and fellowship in Gastroenterology approved by the ACGME, AOA or the Royal College of Physician & Surgeons of Canada *(if board certified by an ABMS Board or actively pursuing ABMS Board Certification).* Board certification must be obtained within 5 years of completion of residency. **Current Clinical Experience:** Documentation of inpatient or consultative services for at least 100 gastroenterology patients during the past 2 years OR Successful completion of an ACGME or AOA accredited residency or clinical fellowship within the past 12 months. **Renewal Criteria:** Inpatient or consultative services for at least 100 gastroenterology patients during the past 2 years AND Maintain certification or active participation in the examination process leading to certification in Gastroenterology by the ABIM/~~AOBIM:~~AOBIM. **FPPE:** Minimum of 1 concurrent review for Colonoscopy and EGD; 4 retrospective chart reviews

Request	GASTROENTEROLOGY CORE PRIVILEGES	Approve
☐	**Core Privileges include:** Perform Medical H&P; evaluate diagnosis, provide consultation and treat (may include telehealth) patients with illnesses, injuries, and disorders of the stomach, intestines, and related structures, such as the esophagus, liver, gallbladder, pancreas and nutrition. Core privileges include biopsy, polypectomy, injection/coagulation for hemostasis and/or tissue ablation and percutaneous liver biopsy, pH probe and esophageal manometry, Nonvariceal hemostasis - upper and lower, snare Polypectomy, Variceal hemostasis, Esophageal dilation, Flexible sigmoidoscopy, Colonoscopy (with or without biopsy; with or without polypectomy), Diagnostic Esophagogastroduodenoscopy (EGD), PEG	☐
☐	Admitting Privileges (must request Active staff status)	☐

GENERAL INTERNAL MEDICINE CORE PRIVILEGES
Renewal Criteria~~: 25~~; 25 patient contacts in the past two years AND Maintenance of Board Certification in Internal Medicine. **FPPE:** 6 retrospective chart reviews

Request	Privileges/Procedures	Approve
☐	Perform H&P, evaluate, diagnose, treat and provide consultation (may include telehealth) to adolescent and adult patients with common and complex illnesses, diseases and functional disorders of the circulatory, respiratory, endocrine, metabolic, musculoskeletal, hematopoietic, gastroenteric and genitourinary systems.	☐

ADVANCED GASTROENTEROLOGY PRIVILEGES

Request	Procedure	Initial Criteria	Renewal Criteria	FPPE	Approv
☐	EUS	Documentation of training during fellowship or a didactic and hand-on program during which the candidate has performed 150 supervised cases to include a minimum of 50 EUS-guided FNAs, 75 pancreaticobiliary cases, 75 mucosal cancer staging cases, and evaluation of 40 subepithelial lesions. If the training is older than 2 years, the candidate must provide proof of 50 cases successfully completed within 12 months of requesting privileges.~~.~~	20 procedures in the last 2 years.	Minimum of 4 concurrent review, to include 2 FNA	☐
☐	ERCP *Prerequisite: Fluoroscopy Certificate*	Documentation of training during fellowship or a didactic and hand-on program during which the candidate has performed 200 supervised cases. If the training is older than 2 years, the candidate must provide proof of 50 cases successfully completed within 12 months of requesting privileges.	25 in the last 2 years	Minimum of 2 concurrent review	☐

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☐	Endoscopic Sleeve Gastroplasty (ESG)	Documentation of successfully completing an: • ACGME or AOA Advanced Endoscopy Fellowship that included endoscopic suturing and bariatric endoscopy training, OR • Industry-recognized ESG training course (didactic + hands-on workshop), • A minimum of 10 cases in the last 12 months	1. Case Volume: A minimum of 20 ESG cases during the prior twenty-four (24) months, AND 2. Ongoing Education: Continuing Medical Education (CME) credits in bariatric endoscopy (e.g., 8 CME hours per cycle.)	Minimum of 5 cases to be reviewed concurrently to demonstrate the ability to: • Safely assemble and deploy endoscopic suturing system. • Create gastric sleeve pattern (≥ 6 – 8 sutures, proper tissue acquisition). • Managing complications (perforation, bleeding, leaks),	

ADDITIONAL PRIVILEGES

Request	Procedure	Initial Criteria	Renewal Criteria	FPPE	Approv
☐	Supervision of a technologist using fluoroscopy equipment	Current and valid CA Fluoroscopy supervisor and Operator Permit or a CA Radiology Supervisor and Operator Permit	Current and valid CA Fluoroscopy supervisor and Operator Permit or a CA Radiology Supervisor and Operator Permit	None	☐
☐	Procedural Sedation *Prerequisite: ACLS or Airway management course*	Successful completion of Kaweah Health Procedural Sedation Exam	Successful completion of Kaweah Health Procedural Sedation Exam	None	☐
☐	Outpatient Services at a Kaweah Health Clinic identified below. Privileges include performance of core privileges/procedures as appropriate to an outpatient setting and may include telehealth: **__Dinuba __Exeter __Lindsay __Tulare __Valencia __Woodlake __KHMC – Akers __KHMC – Willow Specialty 202 __KHMC - Willow 502 __Specialty Clinic __Tulare Cardiology Clinic**	Initial Core Criteria AND Contract for Outpatient Clinical services with Kaweah Delta Health Care District.	Maintain initial criteria		☐

Acknowledgment of Practitioner:

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

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

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

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

Name: _____
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Signature: _____ _____
Applicant *Date*

Signature: _____ _____
Department of Internal Medicine *Date*

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Critical Care Pulmonary Sleep Medicine

Privileges in Critical Care, Pulmonary & Sleep Medicine

Name: _____
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CRITICAL CARE CORE PRIVILEGES

Education & Training: M.D. or D.O. and Successful completion of an ACGME or AOA accredited program in the relevant medical specialty **AND** Successful completion of an accredited fellowship in critical care medicine and/or current subspecialty certification or active participation in the examination process leading to subspecialty certification in critical care medicine by the ABMS or AOA Boards within the timeframe determined by the certifying board
Current Clinical Competence: Documentation of provision of inpatient care to at least fifty (50) patients in the CCU over the past 24 months or completion of residency or clinical fellowship within the past 12 months. **OR** *CA licensed physicians involved in their 2nd or 3rd year Critical Care Fellowship Program
Renewal Criteria: Minimum 60 cases required in the past two years **AND** Maintain current certification or active participation in the examination process leading to certification in Critical Care Medicine by the ABMS or AOA Board.
FPPE Requirement: Minimum of 5 of the following cases reviewed concurrently or retrospectively.

Request	Procedure	Approve
☐	**Privileges include:** Privileges to evaluate, diagnose, perform history and physical exam, provide treatment or consultation (may include telehealth) to patients 18 years of age and older, with multiple organ dysfunction and in need of critical care **AND** • Airway management, including intubation • Arterial puncture and cannulation • Cardiopulmonary resuscitation • Cardioversion and defibrillation • Central venous and pulmonary artery catheter insertion • Flexible bronchoscopy (excluding biopsies) with or without established Airway (Endotracheal/Tracheostomy) • Lumbar puncture • Needle and tube thoracostomy • Paracentesis • Thoracentesis • Tracheostomy/cricothyroidotomy, emergency • Transthoracic Echocardiography • Swan Ganz Catheters	☐
☐	Admitting Privileges (Must request Active Staff Status)	☐

TELEMEDICINE PRIVILEGE REQUEST
Tele-Intensivist Privileges Only

Request	Procedure	Initial Criteria	Renewal Criteria	FPPE	Approve
☐	Privileges to evaluate, diagnose, perform history and physical exam, provide treatment or consultation to patients 18 years of age and older, with multiple organ dysfunction and in need of critical care	Same as Critical Care Core Privileges	Same as Critical Care Core Privileges	Minimum of 5 cases reviewed concurrently or retrospectively	☐

PULMONARY CORE PRIVILEGES

Education & Training: M.D. or D.O. and Successful completion of an ACGME or AOA-accredited fellowship in pulmonary medicine. **AND** ACLS Certification unless boarded in Critical Care **AND** Current certification or active participation in the examination process leading to certification in Pulmonary Disease OR Critical Care by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine within the timeframe determined by the certifying board
Current Clinical Competence: Documentation of provision of inpatient care to at least fifty (50) patients over the past 24 months or completion of residency or clinical fellowship within the past 12 months. **OR** *CA licensed physicians involved in their 2nd or 3rd year Pulmonary Fellowship Program
Renewal Criteria: Minimum 50 cases required in the past two years **AND** Maintenance of certification or active participation in the examination process leading to certification in Pulmonary Disease OR Critical Care by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine **AND** ACLS Certification unless boarded in Critical Care.
FPPE Requirements: Minimum of 5 diverse admissions concurrently or retrospectively (Critical Care Core can be counted)

Request	Procedure	Approve
☐	**Core Privileges include:** Evaluate, diagnose, consult, perform history and physical exam, and provide treatment and consultation (may include telehealth) to patients with disorders chest or thorax **AND** • Airway Management, including intubation • Arterial puncture and cannulation • Central venous and pulmonary artery catheter insertion • Flexible diagnostic bronchoscopy with Transbronchial biopsies • Inhalation challenge studies • Pulmonary function testing interpretation • Thoracentesis and related procedures • Flexible diagnostic bronchoscopy with Endobronchial biopsies	☐
☐	Admitting Privileges (Must request Active Staff Status)	☐

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ADVANCED PRIVILEGES
(Must meet the criteria for Pulmonary Core Privileges)

Request	Procedure	Initial Criteria	Renewal Criteria	FPPE	Approve
☐	Endobronchial Ultrasound (EBUS)	Documentation of completion of a dedicated training course **OR** Documentation from fellowship program director of proficiency in EBUS within the last 12 months; **OR** Current hospital EBUS privileges at another facility **AND** Performance of at least 10 cases in the last 2 years.	Minimum of 10 cases in the last 2 years	Minimum of 2 cases concurrently	☐

Privileges in Critical Care, Pulmonary & Sleep Medicine

Name: _____
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	Use of Robotic Navigational Assisted System for Bronchoscopy	Successful completion of an ACGME or AOA accredited residency/fellowship in Pulmonology Medicine within the past 12 months which included training in robotic navigational assisted bronchoscopy: letter from training director to support competency in procedure by completing at least 5 cases in the past twelve (12) months. OR Successful completion of an ACGME or AOA accredited Pulmonology Medicine residency/fellowship with current privileges to perform Bronchoscopy at site requested **AND** 1. Certificate of completion of the Manufacturers Training Course within the past 12 months (Documentation of the successful completion of an on-site training course provided by the manufacturer of the Ion system).	Demonstrated current competence and evidence of the performance of at least five (5) procedures in the past twenty-four (24) months.	First three (3) cases are concurrently proctored.	

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SLEEP MEDICINE CORE PRIVILEGES

Education & Training: M.D. or D.O. and Successful completion of an ACGME or AOA-accredited fellowship in sleep medicine, **AND** ACLS Certification unless boarded in Critical Care **AND/OR** Current sub-specialty certification or active participation in the examination process leading to certification within the time frame determined by the certifying board in Sleep Medicine by the by the relevant ABMS board or completion of a CAQ by the relevant AOA board. Current certification by the AASM is acceptable for applicants who became certified prior to 2007.
Current Clinical Competence: Documentation of provision of care to at least fifty (50) patients over the past 24 months or completion of residency or clinical fellowship within the past 12 months.
Renewal Criteria: Minimum of 50 cases required in the past two years **AND** Maintenance of certification or active participation in the process leading to certification in Sleep Medicine **OR** completion of a CAQ by the relevant AOA board. Current certification by the AASM is acceptable for applicants who became certified prior to 2007 **AND** Documentation of 10 Cat I or II CME hours in sleep medicine.
FPPE Requirements: Minimum of 3 cases reviewed concurrently or retrospectively

Request	Procedure	Approve
☐	**Core Privileges include:** Evaluate, diagnose, consult, perform history and physical exam, and provide treatment (may include telehealth) to patients presenting with conditions or sleep disorders **AND** • Actigraphy • Home/ambulatory testing • Maintenance of wakefulness testing • Monitoring with interpretation of EKGs, electroencephalograms, electro-oculographs, electromyographs, flow, oxygen saturation, leg movements, thoracic and abdominal movement, and CPAP/BI-PAP ~~titration~~titration • Multiple sleep latency testing • Oximetry • Sleep log interpretation	☐
☐	Admitting Privileges (Must request Active Staff Status)	☐

ADVANCED PRIVILEGES
(Must meet the criteria for Sleep Medicine Core Privileges)

Request	Procedure	Initial Criteria	Renewal Criteria	FPPE	Approve
☐	Polysomnography (including sleep stage scoring)	Documentation of 400 in the last 2 years.	400 in the last 2 years.	Minimum ~~of 20~~of 20 cases concurrently	☐

ADDITIONAL PRIVILEGES
(Must also meet the Criteria Above)

Request	Procedure	Initial Criteria	Renewal Criteria	FPPE	Approve
☐	Administration of Moderate Sedation	Successful completion of Kaweah Health sedation exam	Successful completion of Kaweah Health sedation exam	None	☐
☐	Percutaneous tracheostomy	Documentation of training and 5 procedures in the last 2 years	Minimum ~~of 5~~of 5 cases required in last 2 years	2 direct ~~observation~~observations	☐

Privileges in Critical Care, Pulmonary & Sleep Medicine

Name: _____
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☐	Fluoroscopy Privileges	Current and valid CA Fluoroscopy supervisor and Operator Permit or a CA Radiology Supervisor and Operator Permit	Current and valid CA Fluoroscopy supervisor and Operator Permit or a CA Radiology Supervisor and Operator Permit	None	☐

Acknowledgment of Practitioner:

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

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

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

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

Signature: _____ _____
Applicant *Date*

Signature: _____ _____
Department of Critical Care, Pulmonology, Adult Hospitalist Medicine Chairman *Date*

Separator Page

EMERGENCY DEPARTMENT QUALITY REPORT–

QUALITY COMMITTEE REPORT

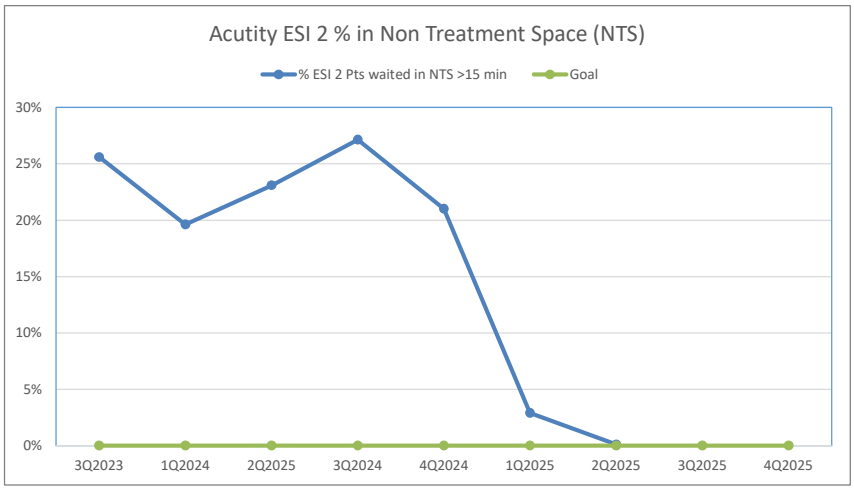
Emergency Department Quality Report

Scott D. Baker, DNP, MSN, RN, NEA-BC, CEN, CNL
Interim Director of Emergency & Trauma Services

August 2025

Refer to ED SBAR Reports, ED Kaizen Reports in QComm, and Patient Safety Committee Reports for detailed historical project information Pre Oct 2024.

ED Quality Report: Care of ESI 2 Patients in a Treatment Space



Emergency Department ESI 2 Management

High Level Action Plan

- Goal: 0% waiting greater than 15 min
- Current Performance: May & June 0%; 0.1% for 2nd Quarter 2025
- No ESI 2 Patients waiting; 100% of patients (All ESI levels) have an MSE done in the Intake process. If a patient is determined to be a level II in triage, patient is moved directly back to an open bed for MSE and stabilization.

ESI level-2 patients are high priority, and placement and treatment should be initiated rapidly. ESI level-2 patients have the potential to be very ill and at high risk for decompensation. ESI is a triage acuity algorithm that is valid for evaluating patient acuity and resource needs as determined by a trained triage nurse upon the patient's presentation to the emergency department. It is a process to differentiate between those who are at risk of decompensation and those who are more stable.

- Emergency Severity Index Handbook Fifth Edition (2023), Emergency Nurses Association: https://californiaena.org/wp-content/uploads/2023/05/ESI-Handbook-5th-Edition-3-2023.pdf

ED Quality Report: Care of ESI 2 Patients in a Treatment Space

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ED Safe Care Patient Flow Dashboard

ESI-2 Patients Flow NTS: Non-Treatment Space	Target	May 2025	Jun 2025	Jul 2025	Aug 2024	Sept 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	Rolling 12M Av
# ESI 2 pts waited in NTS >15 min	0	0	0	0	141	125	160	130	206	274	24	2	0	134
% ESI 2 Pts waited in NTS >15 min	0%	0%	0%	0%	17%	16%	20%	16%	22%	26%	2%	0.9%	0.1%	15%
Avg. LOS ESI 2 pts waited in NTS >15 min	0	0	0	0	79	62	67	59	53	59	42	21	8	58
Max LOS ESI 2 Pt's waiting in NTS >15 min	0	0	0	0	741	288	650	408	365	897	292	28	15	490

NTS: Non-Treatment Space where a complete care team (nurse and provider) is not assigned to the patient

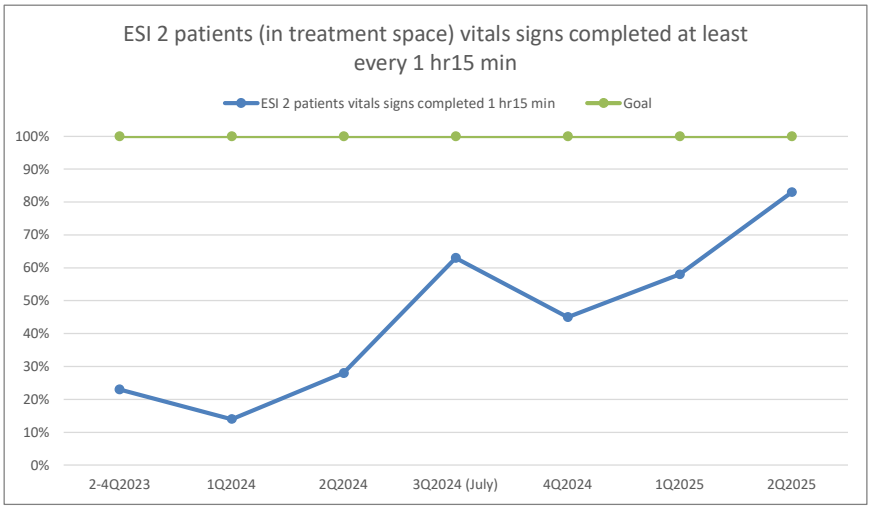
Targeted Opportunities (why goal not achieved in most recent month)

1. History: Goal is being achieved now. The report tracking these patients was pulling data from arrival, not at the point of triage when the patient is assigned the ESI level. Reporting process was changed in May to adjust the numbers to meet the actual assignment of the ESI level decision.
2. History: We should not be seeing any ESI level II's in the waiting room any longer with the redesigned front-end process as all patients are not being placed back in the waiting room without moving through our Intake process and receiving an MSE by a provider.
3. Following implementation of the new front-end design, designated treatment spaces were evaluated and corrected in the data report logic along with an adjustment to the way the data is collected.

ED Quality Report: Care of ESI 2 Patients in a Treatment Space

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS/UPDATES
New Front End Design - Change in flow patterns • Re-opened intake space which added "MSE" spaces (Medical Screening Evaluation) • Opened Fast track which created an additional 8 rooms	March 2025	Completion of the new Front-End Re-design on March 1, 2025
Change in flow patterns (goal: Keeping patients who need beds in beds, and moving patient who can be treated in other care spaces ("vertical") • Lower acuity is seen at front, moved to fast track if a treatment is needed, leaving ED beds in the back for ESI 2 patients and EMS patients • Zone 1 opened as "chest pain unit" • Increase in provider staffing, staggered shifts so MSEs are being done handoff times (no loss of flow during transitions)	February 2025	Barriers: We now have the ability to staff the department to full capacity barring any sick calls.
Identification of ESI 3-5 who's acuity changes to ESI 2 • LVN and Tech in Waiting Room, rounding and checking vital signs	1/22/25	We now have the staff to place a clinical team member in the waiting room 24 hours a day to watch and re-assess patients.

ED Quality Report: ESI 2 Patient Vital Sign (VS) Monitoring



Emergency Department ESI 2 Management

High Level Action Plan

- Evaluate best practices and industry standards on:
  - frequency and components of VS checks
  - Policy adjusted to ensure national standards maintained for ESI vital signs assessment/reassessment
- July 2025 is 95% compliant
- 2nd Quarter 2025 83% complaint

ESI level-2 patients are high priority, and placement and treatment should be initiated rapidly. ESI level-2 patients have the potential to be very ill and at high risk for decompensation.

Emergency Severity Index Handbook Fifth Edition (2023), Emergency Nurses Association: https://californiaena.org/wp-content/uploads/2023/05/ESI-Handbook-5th-Edition-3-2023.pdf

ED Quality Report: ESI 2 Patient Vital Sign Monitoring

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ED Safe Care Patient Flow Dashboard

ESI-2 Vital Signs (patients in treatment space)(		July 2024	Aug 2024	Sept 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Rolling 12M Av
Retired Metric Feb 2025 – VS completed per SOC for ESI 2	100%	63%	No Audit	45%	42%	50%	42%	33%						
Evidence that vital signs are completed per provider orders									58%	66%	72%	94%	87%	54%

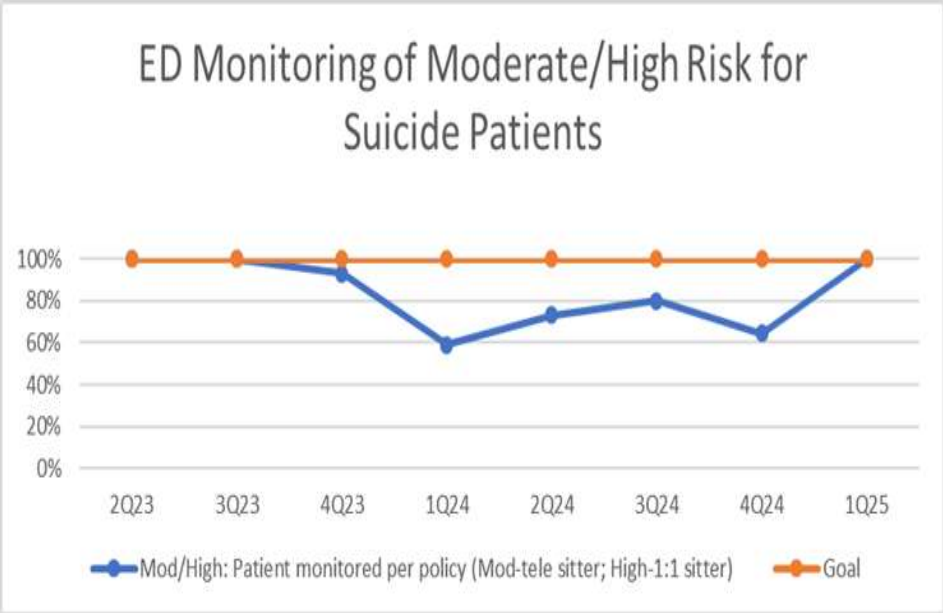
Targeted Opportunities (why goal not achieved in most recent month)

1. Following medical evaluation of an ESI 2 patient VS checks every hour are current practice, even though the patient's condition does not require VS checks every hour. Creates inefficient use of resources. – Providers are now placing orders for changing the frequency of Vital Sign Assessment.
2. Temperature checks – Temperature checks have changed so it is assessed on arrival, change in condition (Sepsis, ICU patients) or provider reassessment request.
3. All behavioral health patients are designated as ESI 2, but do not require VS checks every 1 hour. These vital signs will be assessed every shift.
4. Reviewing the potential of revising the assessment/re-assessment policy to update the frequency of vital signs to be more aligned with other organizations across the country. ENA has no specific guidelines regarding vital sign assessment based on ESI. Previous organizations were ESI Level 1, Q1 Hour, ESI Level 2, Q2 hours, ESI 3, Q4 hours, and ESI 4 & 5 on arrival and prior to discharge if in ED longer than 90 minutes. With the higher acuity ESI levels, the vital signs will be reassessed more frequently for changes in condition. **Policy updated and moving through approval process.**

ED Quality Report: ESI 2 Patient Vital Sign (VS) Monitoring

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
Revise standards of care (SOC) for VS check frequency and components of the VS checks that are aligned with best practice and industry standards. SOC revisions ensure that patients receive the appropriate monitoring based on provider medical evaluation. Currently policy revised and moving through policy approval process.	September 2025	Frontline Staff seeing the order from the physician indicating the revised frequency of vital sign reassessment for the patient.
Revise ESI assignment criteria at Triage for behavioral Health patients to ensure the correct acuity is assigned and necessary monitoring can occur based on medical need	Completed	No barriers. Behavioral health patients are screened at triage as ESI 2; they are promptly moved to Zone 4 for care based on the Columbia Suicide Risk scale.
Challenges with obtaining a higher percentage of vital sign re-assessment compliance.	September 2025	During the month of June, ED team was still auditing for ESI 2 V/S Q 1 hour- corrected to “per physician order” in July with higher compliance.

ED Quality Report: Monitoring of Moderate/High Risk for Suicide



ED – Monitoring of Mod/High Risk for Suicide

High Level Action Plan

- Goal: 100% monitored per policy (1:1)
- Current Performance: Quarter Q2 2025 is 100%.
- Ensure MHW/ED Tech staffing is maintained to ensure all high-risk patients are 1:1 monitored

ED Quality Report: Monitoring of Moderate/High Risk for Suicide

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Suicide Risk Daily Compliance Surveillance Data

*Non-compliance is corrected in the moment during daily rounds, or risk is mitigated by implementing strategies per PC.26

ED

Question	Goal	Jan-24	Feb-24	Mar-24	Apr-25	May-25	Jun-25	Jul-25	Aug-24
4a. Mod/High: Patient monitored per policy (Mod-tele sitter; High-1:1 sitter)	100%	68% 68/100	46% 76/166	69% 91/131	100% 51/51	100% 34/34	100% 21/21	100% 48/48	75.00% 84/112
4b. Mod/High: Patients without a Sitter- volume					0	0	0	0	3

Targeted Opportunities (why goal not achieved in most recent month)

1. We've hired additional ER Tech's and MHW's and as of April are meeting the 1:1 monitoring criteria
2. Ability to staff consistently has been better; with sick calls, the house has been able to support our needs.

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS/UPDATES
Ensure training is complete for all new hire MHW's. Assure we are staffing high-risk patients 1:1 – meeting 100% compliance	4/1/2025	None
All MHW positions have been filled. We fully staffed with ER Techs	5/01/2025	None

ED Improving Lab and EKG Turnaround Times for Chest Pain Patients

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS/UPDATES
Our Emergency Department (ED) aims to improve the turnaround time for laboratory tests and EKGs for patients presenting with chest pain. This is crucial for efficient patient care and timely diagnosis, especially for such a time-sensitive complaint.	On-going	Awaiting Reports to pull data.
Our strategy moving forward is to collect baseline data for key metrics, including: • **Check-in to Order Input:** Time from patient arrival to lab/EKG order entry. • **Order Input to Lab Draw/EKG Performed:** Time from order entry to the actual performance of the test. • **Lab Draw/EKG Performed to Results Completion:** Time from test performance to the availability of results. This data will allow us to establish a clear baseline reflecting the impact of our recent front-end changes.	August 2025	Awaiting Reports to be built by Melissa Nevers and her team. Met on 7/8/2025 and requested to expedite report build.

ED Improving Lab and EKG Turnaround Times for Chest Pain Patients

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
Left During Treatment (LDT) / AMA Rates: These also decreased to an all-time low of only **3% and 1%**, respectively.	On-Going	Continue monitoring rates along with LWBS rates.
Assessing revision of the assessment/re-assessment policy for frequency of vital signs assessment.	September 2025	Assessment frequency not consistent with standards for ESI assessment/reassessment.

Thank you

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Separator Page

PHYISICIAN CREDENTIALING PRESENTATION

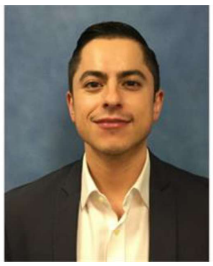
Credentialing & Privileging

Medical Staff Office Personnel

Paul Stefanacci, MD, FACS, MBA
Chief Medical Officer

Shannon Vinson, MBA, CPMSM
Director

Ody DaSilva, CPCS
Manager



Estevan Campos
Medical Staff Coordinator

Matthew Higgins, RN
Peer Review Coordinator

Angelica Lara
Medical Staff Coordinator

Cristine Pettibone
Medical Staff Coordinator

Debbie Roeben, CPCS
Medical Staff Coordinator

DEMOGRAPHICS

- Anesthesiology: 65
- Cardiovascular Services: 50
- Critical Care, Pulmonary & Adult Hospital Medicine: 106
- Emergency Medicine: 68
- Family Medicine: 63
- Internal Medicine: 64
- OB/GYN: 47
- Pediatric Medicine: 86
- Psychiatry & Neurosciences: 57
- Radiology: 31
- Surgery: 71

Credentialing vs Privileging

- Credentialing

  A comprehensive examination through a review of documents and other means to validate the competency of a licensed independent practitioner.

- Privileging

  Authorization given by a governing body to a practitioner to treat certain conditions and/or perform clinical services on patients.

- **Collectively both processes are critical to ensuring the provision of high quality and safe patient care, regulatory compliance, and avoiding fraud.**

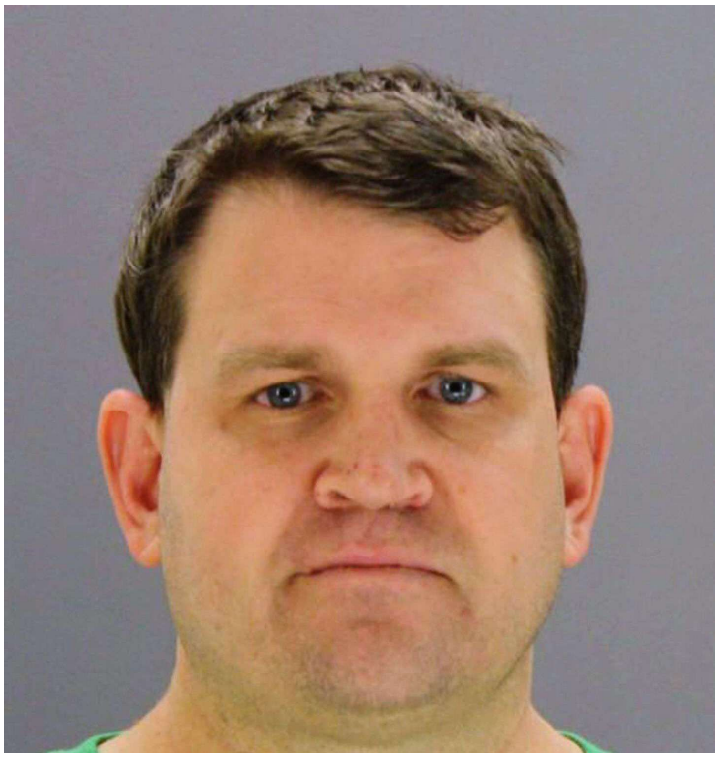
Who is responsible?

- Board delegates Credentialing & Privileging to the Organized Medical Staff
  - Medical Staff Office
  - Delegated Credentialing arrangements
- 'Credentialing' process focuses on document gathering, review, along with file evaluations and analysis. **We Trust but ALWAYS verify.**
- Decision-making can't be delegated. The Organized Medical Staff is responsible for performing a thorough review of the candidate's information and making recommendations to the Board.
- Only the Board can grant appointments (membership) to the medical staff.

Why is this important?

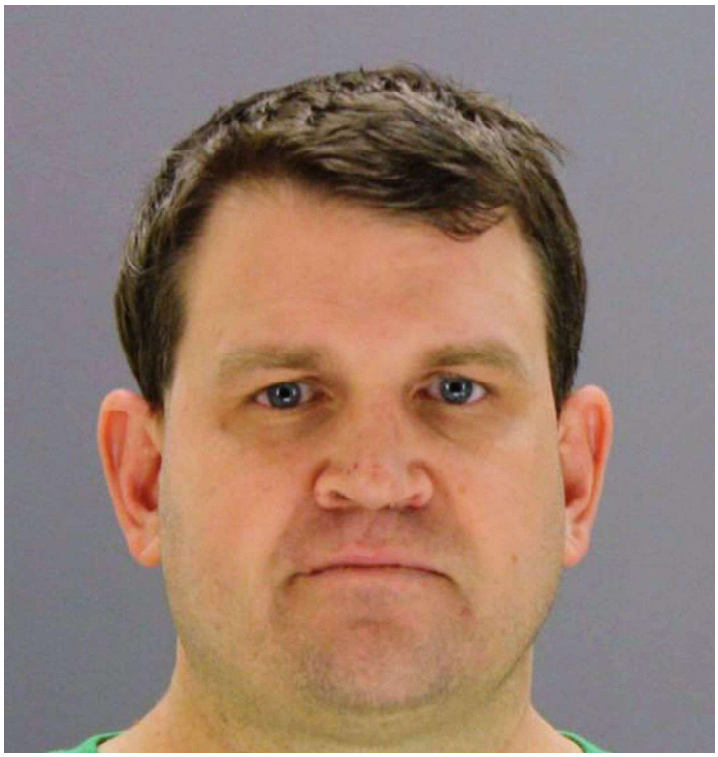
Christopher Duntsch, MD
"Dr. Death"

- Accused of injuring more than 30 patients in a short time
- Colleagues who watched him perform surgery or attempted to repair his mistakes reported grabbing instruments away from him and filing multiple complaints.
- Allegedly removed bone from an area that wasn't required by any clinical or anatomical standards.



Christopher Duntsch, MD
“Dr. Death”

- Allegedly injured 30+ patients during a two-year surgical career.
- Individuals injuries were life changing and include nerve damage, chronic pain and paralysis
- Two patient deaths attributed to botched surgeries performed in 2012
- In 2013 medical license revoked
- In 2017 sentenced to life in prison.



Causes: Systemic Failures

- Administrative Loopholes
  - ✓Some hospitals were aware of the problems and allowed him to voluntarily resign to avoid mandatory reporting.
- Inadequate peer review
  - ✓Hospitals did not properly and/or timely investigate complaints or issues using the peer review process.
- Ineffective Reporting
  - ✓Privileges approved at hospitals despite allegations of clinical incompetence, drug use despite warnings from other physicians.
- Slow to act Medical Board
  - ✓The Texas Medical Board receive many complaints but took more than a year to investigate.

Credentialing & Privileging Process

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Credentialing & Privileging Process

- Number of Applications Processed YTD: 104
- Number of Reappointments Processed: 200
- Timeline
  - On average a “clean” file is processed in 4 to six weeks.
  - We are required to close a file in 120 days.

Appointments

- Initial Appointment
  - Most initial appointments are 24 months. Joint Commission states no appointment can be longer than 36 months.
- Reappointment
  - Privileges expire at the end of each appointment & must be re-requested
  - Re-verification of current competency & database queries as part of the ongoing surveillance of credentials

Verification Sources

- Primary Source Verification
  - Information received directly from the original issuing entity.
- Equivalent Sources
  - Some entities are approved to verify data through the primary source. These sources vary by state and accrediting organizations.
- Secondary Sources
  - Verification that is done from another facility through a review of primary sourced documentation by another entity. Unacceptable form of validation for many data elements. Should only be used when all other options to obtain the information are exhausted.

Industry Standards/Best Practice

- Verification of Identity
- Military Service
- Professional Licensure
- Federal and State Drug Enforcement Agencies
- Board Certification
- Education and Training
- Professional and Clinical Practice History

Industry Standards/Best Practice

- National Practitioner Data Bank (NPDB)
- Malpractice Insurance
- Procedure logs
- Peer Evaluations
- Criminal Background Checks
- Sanctions: Office of Inspector General (OIG)
- Ability to Perform (Health/Mental Status)

Common Challenges/Pitfalls

- Previous work History
- Unexplained time gaps (practice, training, malpractice insurance, etc.)
- Short tenure at previous facilities
- Pressure by Physician Groups or even Hospital Administration
- Incomplete applications
- Incorrect information

QUESTIONS

Separator Page

PATIENT EXPERIENCE AND SATISFACTION UPDATE

Patient Experience

Board Report
September 2025

Patient Experience Matters

Opportunities and insights to increase patient satisfaction.

Kaweah Health

Organization Survey Data

Fiscal Year Data

July 2025

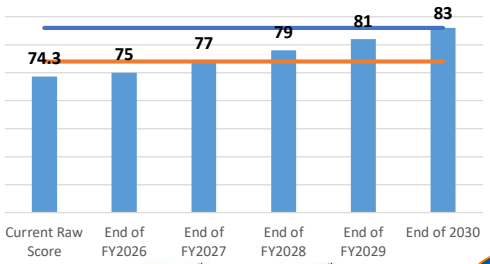
Survey Scores

HCAHPS – 74.3
65th Percentile

Inpatient
NPS – 60.2
32nd Percentile

Medical Practice
NPS – 85.2
14th Percentile

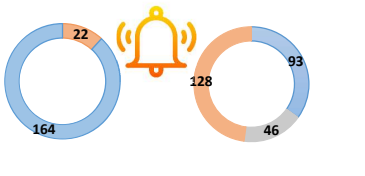
5 Year HCAHPS Goal



August 2025

- **Rounding** 150 Rounds
- **MIDAS** 73 Opened
- **PX Phone** 79 Calls

Service Alerts



Human Understanding – 74.1
10th Percentile

PRIORITIES FOR ORGANIZATION

- **Quiet rooms at night**
- **Informed of delays**
- **Explained what to do if not better after discharge**
- **Providing consistent information**
- **Explaining things understandably**

Patient Experience Phone Line – X5151
Patient Experience Office Hours – Tuesday 9:00am-10:00am, Friday 2:00pm-3:00pm; (G2Meeting)

Patient Experience Team – Deborah, Director (X2529), Sintayehu, Advocate (X2592), Teresa, Analyst (X2593)

nrc HEALTH | Human understanding

HCAHPS Dashboard

Percent Submittable: 137.7% Submittable: 413 Needed: 300 Submittable Date Range: Sep 5, 2024 — Sep 4, 2025

CURRENT DATE RANGE
Jul 1, 2024 — Jul 31, 2025

PREVIOUS DATE RANGE
Jul 1, 2023 — Jul 31, 2024

Dimension	Previous Score	Current Score & Benchmark	n-size	Difference
Care Coordination	-	76.0% | 72.5%	250	-
Care Transitions	48.8%	42.5% | 52.1%	190	-6.3% ↓
Cleanliness	69.2%	69.3% | 69.6%	440	0.1% ↑
Communication About Meds	68.9%	73.2% | 61.4%	205	4.3% ↑
Communication with Doctors	81.8%	82.5% | 80.2%	445	0.7% ↑
Communication with Nurses	82.4%	82.5% | 79.7%	446	0.1% ↑
Discharge Information	91.3%	90.3% | 87.4%	404	-1.0% ↓
Information About Symptoms	-	80.5% | 73.1%	220	-
Overall Rating of Hospital	75.0%	74.3% | 71.5%	432	-0.7% ↓
Responsiveness of Hospital Staff	70.0%	66.7% | 62.2%	421	-3.3% ↓
Restfulness of Hospital Environment	66.3%	66.4% | 56.7%	444	0.1% ↑
Would Recommend Hospital	73.6%	73.0% | 72.4%	407	-0.6% ↓

HCAHPS Trend

Favorite | Subscribe | Export | Jul 01, 2024 - Jul 31, 2025

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

	Benchmark	Jul 25
Rate hospital	71.5	67.6 n = 34
Would recommend hospital to family	72.4	74.3 n = 35

nrc HEALTH | Human understanding

Trend (Inpatient)

Respondents 3,235

	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

	Jul 2025
NPS: Facility would recommend	60.2 n = 259

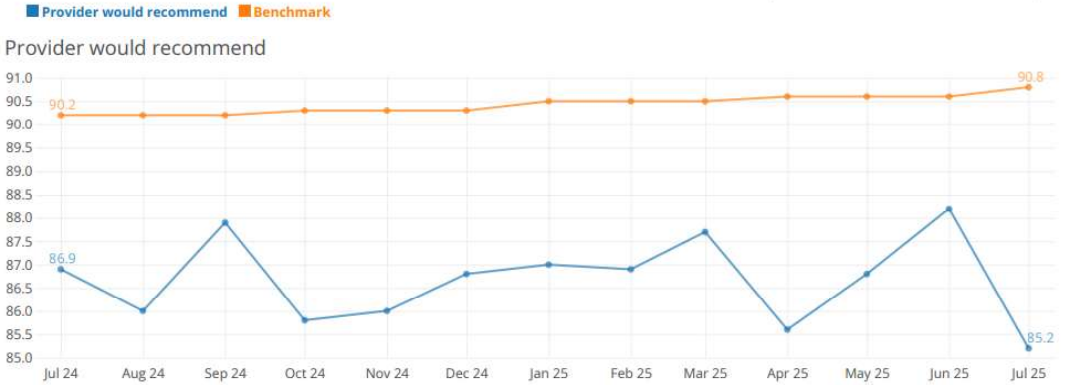
nrc HEALTH | Human understanding

Benchmark | Question (Inpatient)

nrc HEALTH | Human understanding

Trend (Med Practice)

Respondents 10,597



	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025
Provider would recommend	86.9 n = 893	86.0 n = 968	87.9 n = 792	85.8 n = 878	86.0 n = 722	86.8 n = 702	87.0 n = 966	86.9 n = 878	87.7 n = 857	85.6 n = 769	86.8 n = 733	88.2 n = 669

	Jul 2025
Provider would recommend	85.2 n = 770

nrc HEALTH | Human understanding

Benchmark | Question (Med Practice)

nrc HEALTH | Human understanding

Trend (Emergency Department)

Respondents 11,448

	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

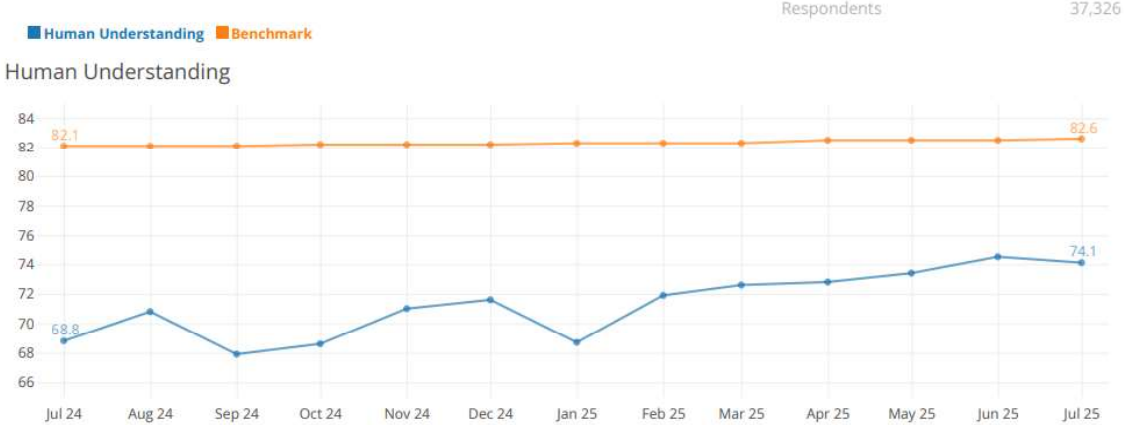
	Jul 2025
NPS: Facility would recommend	39.5 n = 845

nrc HEALTH | Human understanding

Benchmark | Question (Emergency Department)

Human understanding **Trend** **(Org- Human Understanding)**

Respondents 37,326

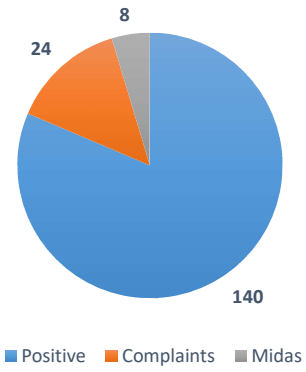


	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025
Human Understanding	68.8 n = 2,669	70.8 n = 3,027	67.9 n = 2,695	68.6 n = 2,884	71.0 n = 2,473	71.6 n = 2,365	68.7 n = 2,828	71.9 n = 2,726	72.6 n = 2,768	72.8 n = 2,584	73.4 n = 3,359	74.5 n = 3,360

	Jul 2025
Human Understanding	74.1 n = 3,588

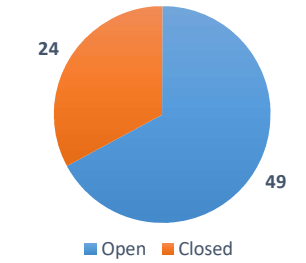
Rounding: August

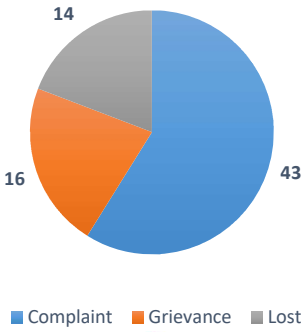
150 Rounds



MIDAS: August

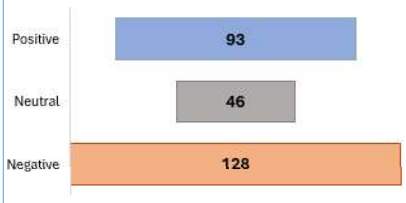
73 Opened

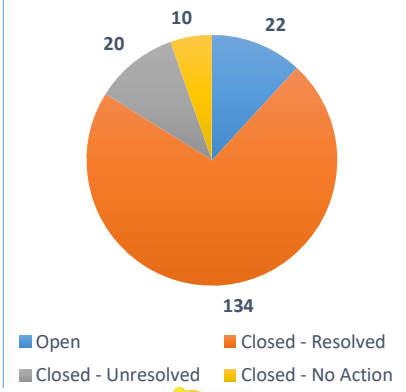




Service Alerts: July

186 Total

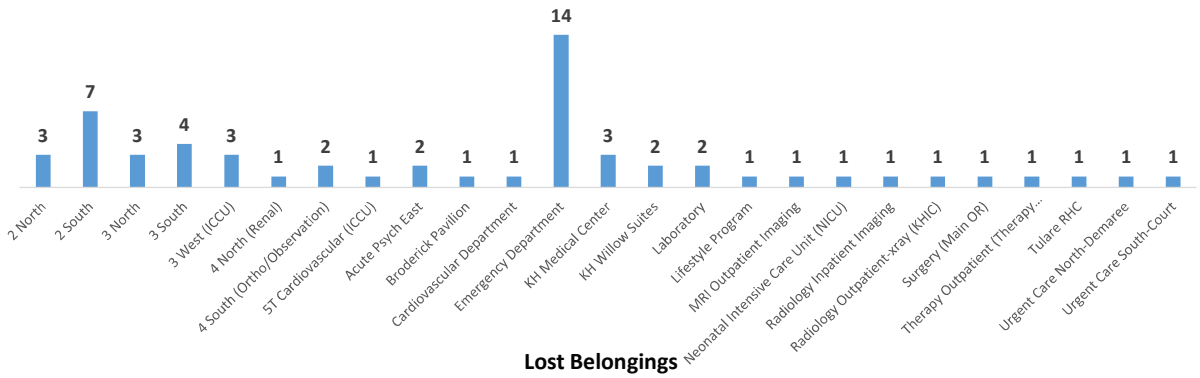




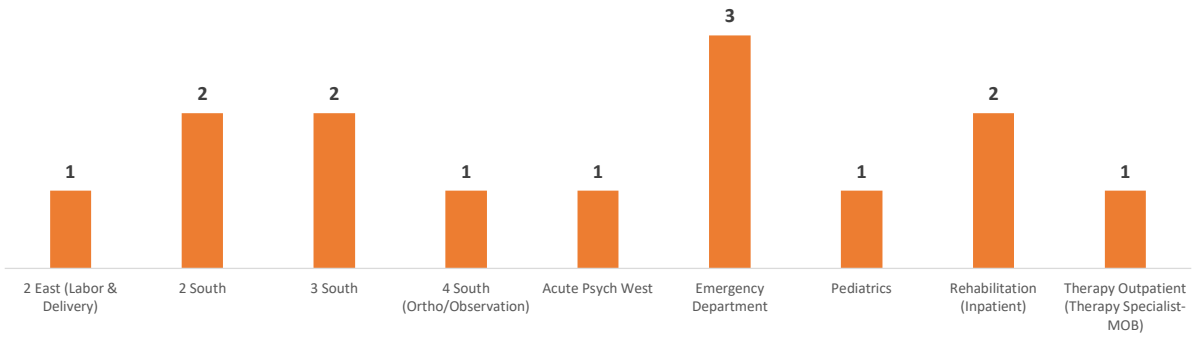
MIDAS: August

73 Opened

Complaints & Grievances



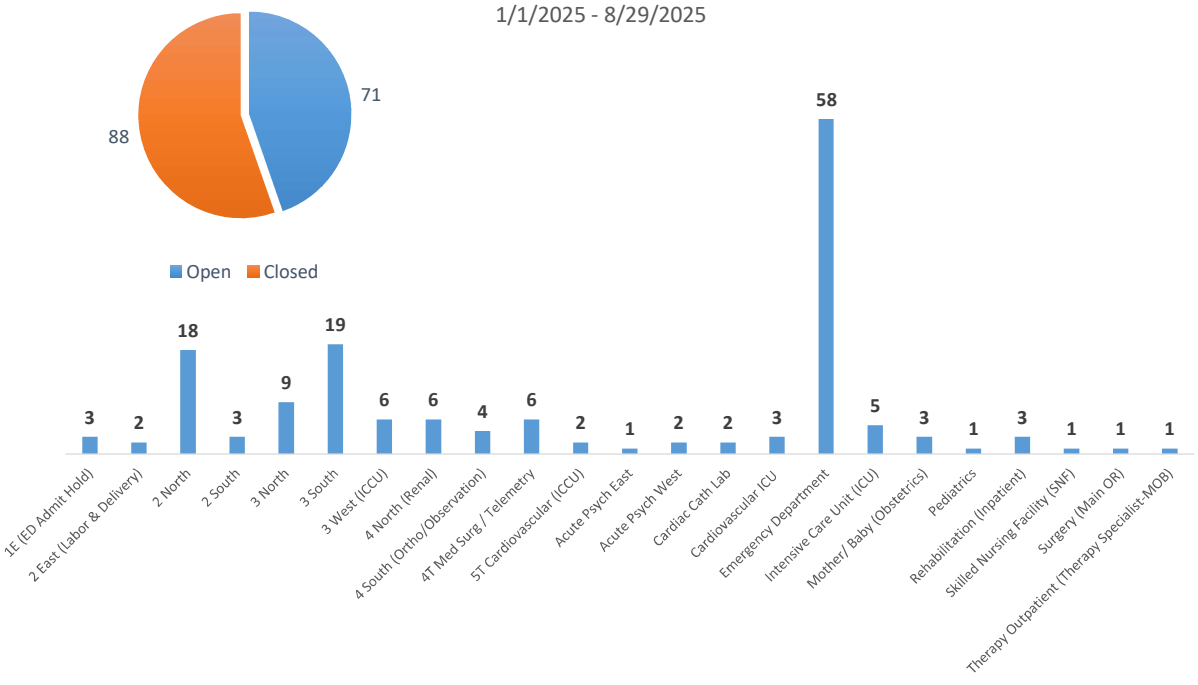
Lost Belongings



Lost Belongings

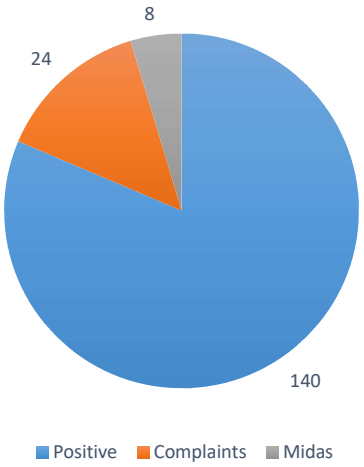
Year to Date Total: 159

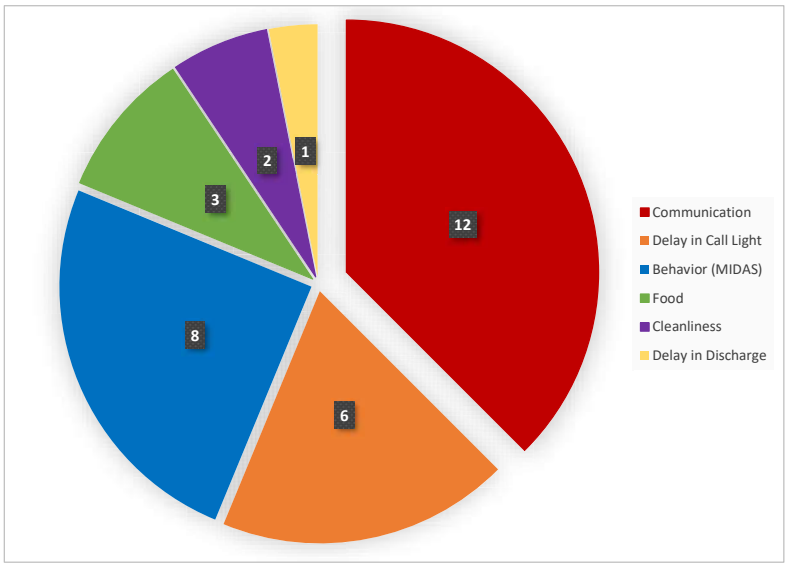
1/1/2025 - 8/29/2025



Rounding: August

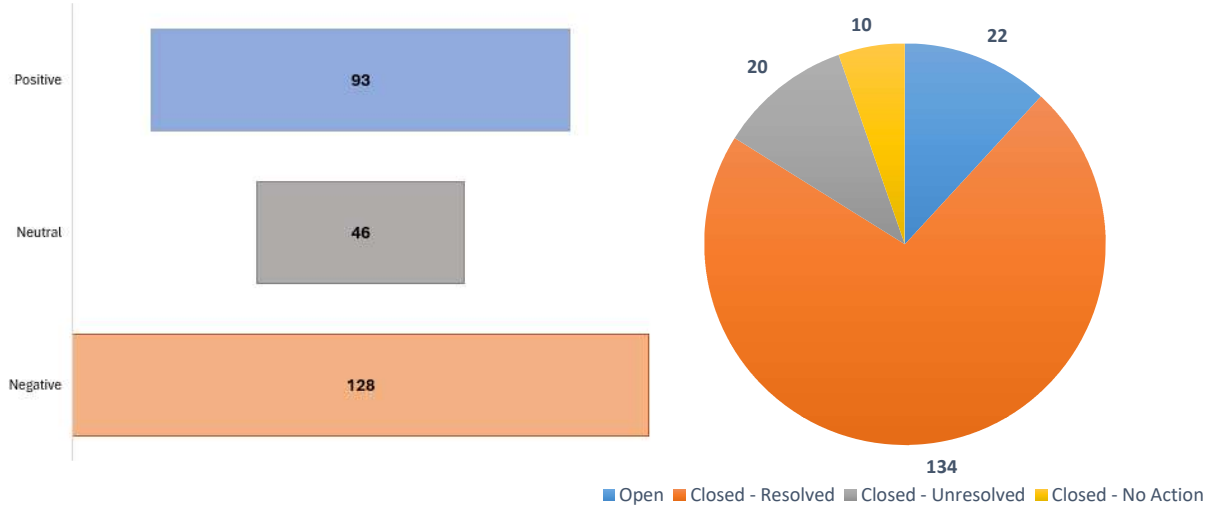
150 Rounds





Service Alerts: July

186 Total



ROUNDING

August Executive Team Rounds = 10 executive rounds

Executive	March	April	May	June	July	August
Gary H.		17-Apr	14-May	30-Jun	17-Jul	23-Sep
Marc M.		30-Apr	12-May	25-Jun	11-Jul	11-Sep
Jag B.	18-Mar		6-May	30-Jun		16-Sep
Malinda T.	5-Mar		19-May	19-Jun		22-Sep
Dianne C.		9-Apr		26-Jun	23-Jul	30-Sep
Schlene P.			13-May	19-Jun	31-Jul	10-Sep
Ben C.	24-Mar		29-May	11-Jun	9-Jul	25-Sep
Ryan G.	11-Mar	23-Apr				29-Sep
Paul S.		21-Apr			8-Jul	
Doug L.	24-Mar			5-Jun	15-Jul	3-Sep

Separator Page

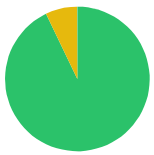
STRAGEIC PLAN INITIATIVE PHYSICIAN ALIGNMENT-

FY 2026 Strategic Plan

Physician Alignment
Sept 24, 2025

Physician Alignment - Ryan Gates and JC Palermo

All Items



On Track 13 (93%)
Off Track 1 (7%)

Spotlight Items

Name	Aligns To	Status	Spotlight Comment
Recruit 15 Specialty Providers	Recruit Physicians and Advanced Practice Providers	On Track	In the first two months of the year we have signed four specialty physicians, including the second member of the Cardiothoracic surgery team.
Promote Kaweah Health services and the physicians that support them	Develop and Provide Practice Support for Physicians	On Track	With the advent of two new treatment modalities (EBUS and ION), pulmonologist, Dr. Gribben, has started providing life saving care to patients who otherwise would have to wait months to receive care outside of our market. This represents one element of a comprehensive lung cancer screening program at Kaweah Health which involves collaboration with multiple specialties.

Recruit and Retain Physicians and Advanced Practice Providers

Champions: Ryan Gates and JC Palermo

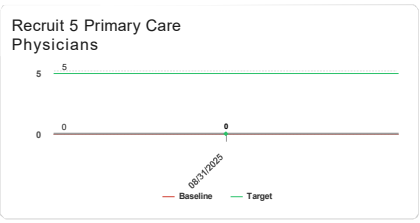
Description: *Refine and execute strategies for recruitment and retention of physicians and Advanced Practice Providers.*

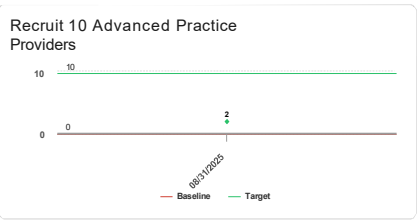
Work Plan (Tactics)

#	Name	Start Date	Due Date	Assigned To	Status	Last Comment
5.1.1	Beginning early in their residencies, educate and build partnerships with Central Valley medical residents related to practice opportunities and recruitment packages	07/01/2025	06/30/2026	JC Palermo	On Track	The physician recruitment team has been meeting with Kaweah Health GME leadership to brainstorm and better understand the opportunities for resident recruitment and retention. We are also reaching out to residency programs in the central valley to discuss partnership opportunities. We will be attending the UCSF Fresno Family Medicine Career Fair in October of 2025.
5.1.2	Continue to work directly with Key Medical Group, local physicians and other medical groups to assist in recruitment and placement of new physicians and APPs and explore strategies for long-term practice sustainability and growth	07/01/2025	06/30/2026	JC Palermo	On Track	We are in discussions with multiple local practices to assist with the recruitment of additional physicians. We have also just finalized a contract with a recent Kaweah Health Resident Graduate to join Key Medical Group to provide care to our community.
5.1.3	Continue efforts of the Physician Recruitment and Retention Strategy Committee to understand and refine physician recruitment needs, fair market value and physician and APP retention strategies	07/01/2025	06/30/2026	JC Palermo	On Track	The committee meets monthly to discuss recruitment strategy and how we can best utilize our available resources to support the community. We also regularly discuss our processes and procedures to ensure they are sound and position the committee to make objective and fair decisions.

Performance Measure (Outcomes)

#	Name	Start Date	Due Date	Assigned To	Status	Last Comment
5.1.4	Recruit 5 Primary Care Physicians	07/01/2025	06/30/2026	JC Palermo	On Track	We have an offer out to 1 physician, a site visit scheduled with 1 physician, and in the early stages of recruitment with 6 other candidates.
5.1.5	Recruit 15 Specialty Providers	07/01/2025	06/30/2026	JC Palermo	On Track	FYTD we have recruited: 1 Cardiothoracic Surgeon, 1 Intensivist, 1 Anesthesiologist, 1 Neonatologist.
5.1.6	Recruit 10 Advanced Practice Providers	07/01/2025	06/30/2026	JC Palermo	On Track	FYTD we have recruited: 1 Nurse Practitioner, 1 Certified Nursing Midwife





Develop Practice Support for Physicians Champions: Ryan Gates and JC Palermo

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

Work Plan (Tactics)

#	Name	Start Date	Due Date	Assigned To	Status	Last Comment
5.2.1	Support physicians and their respective medical groups by offering management services organization (MSO) services to alleviate the administrative burden and enable them to focus on patient care activities	07/01/2025	06/30/2026	Ryan Gates	Off Track	Identified vendor is unable to deliver the services requested. A qualified alternative has been identified and we are aggressively pursuing a partnership.
5.2.2	Promote Kaweah Health services and the physicians that support them	07/01/2025	06/30/2026	Ryan Gates	On Track	Significant work to implement lung cancer screening program with CME dinner and KSEE 24 news broadcast scheduled for November.

Physician Alignment through Integrated Delivery Network Champions: Ryan Gates and JC Palermo

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

Work Plan (Tactics)

#	Name	Start Date	Due Date	Assigned To	Status	Last Comment
5.3.1	Continue physician alignment efforts through our joint venture with Key Medical Group, Tulare-Kings Foundation for Medical Care and Sierra View Local Healthcare District (i.e. Sequoia Integrated Health) to contract with payers to become the provider network of choice	07/01/2025	06/30/2026	Ryan Gates	On Track	Ongoing meetings related to strategy, medical office locations and new contracting models for Kaweah primary care providers.
5.3.2	Work with providers to design and implement care models and invest in resources that improve quality outcomes, patient experience and decrease cost	07/01/2025	06/30/2026	Ryan Gates	On Track	Continue to expand NRC, patient satisfaction tool, throughout the clinic network. Intergration of RN navigators into cancer care programs. Continued investment in technology to empanel patients.
5.3.3	Invest in resources and infrastructure that supports physician practices and the management of their attributed, capitated or empaneled patients	07/01/2025	06/30/2026	Ryan Gates	On Track	Construction on the Kaweah Health Medical Clinic - Akers is complete and awaiting licensure. Expected go live for November 1, 2025.

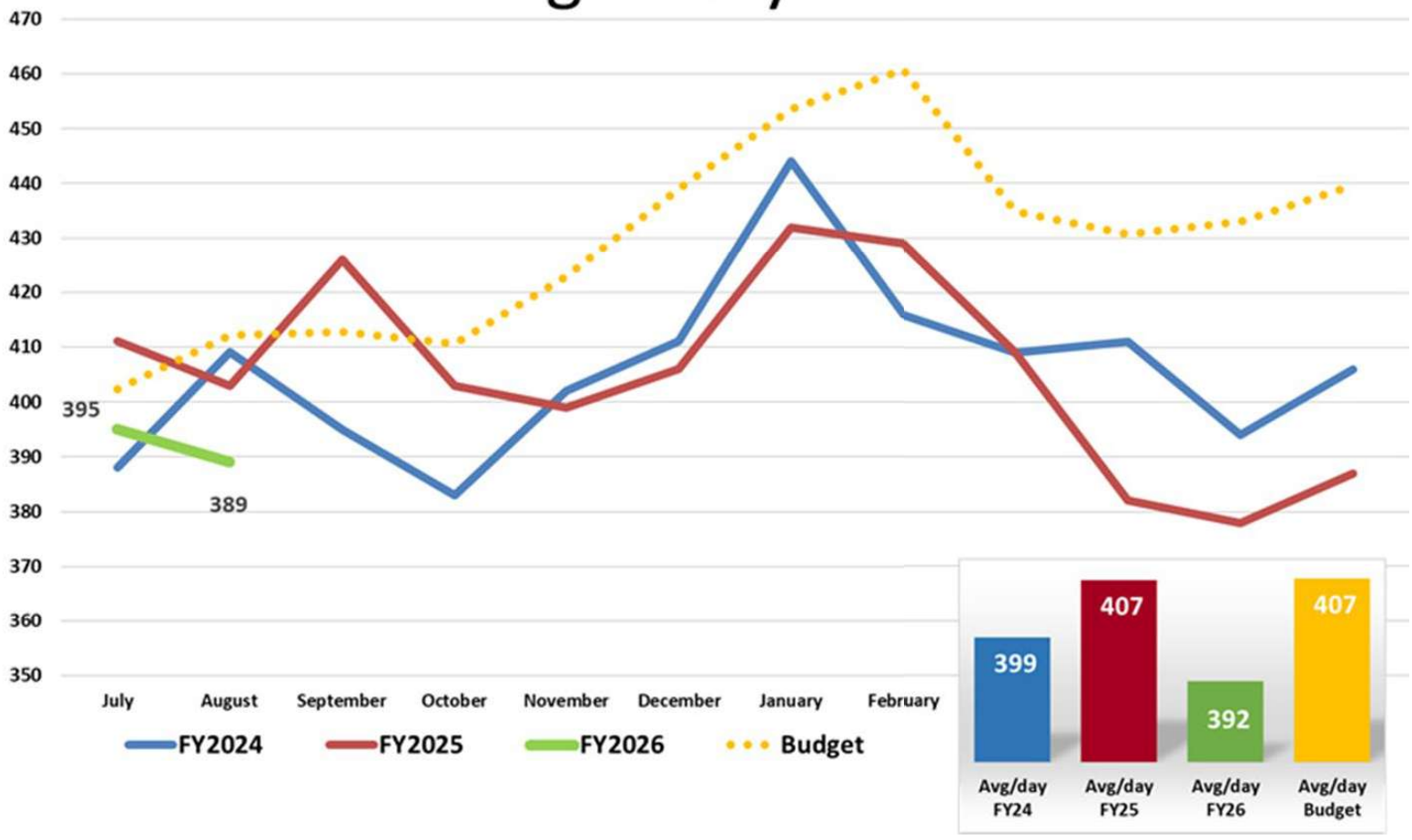
Separator Page

FINANCIALS

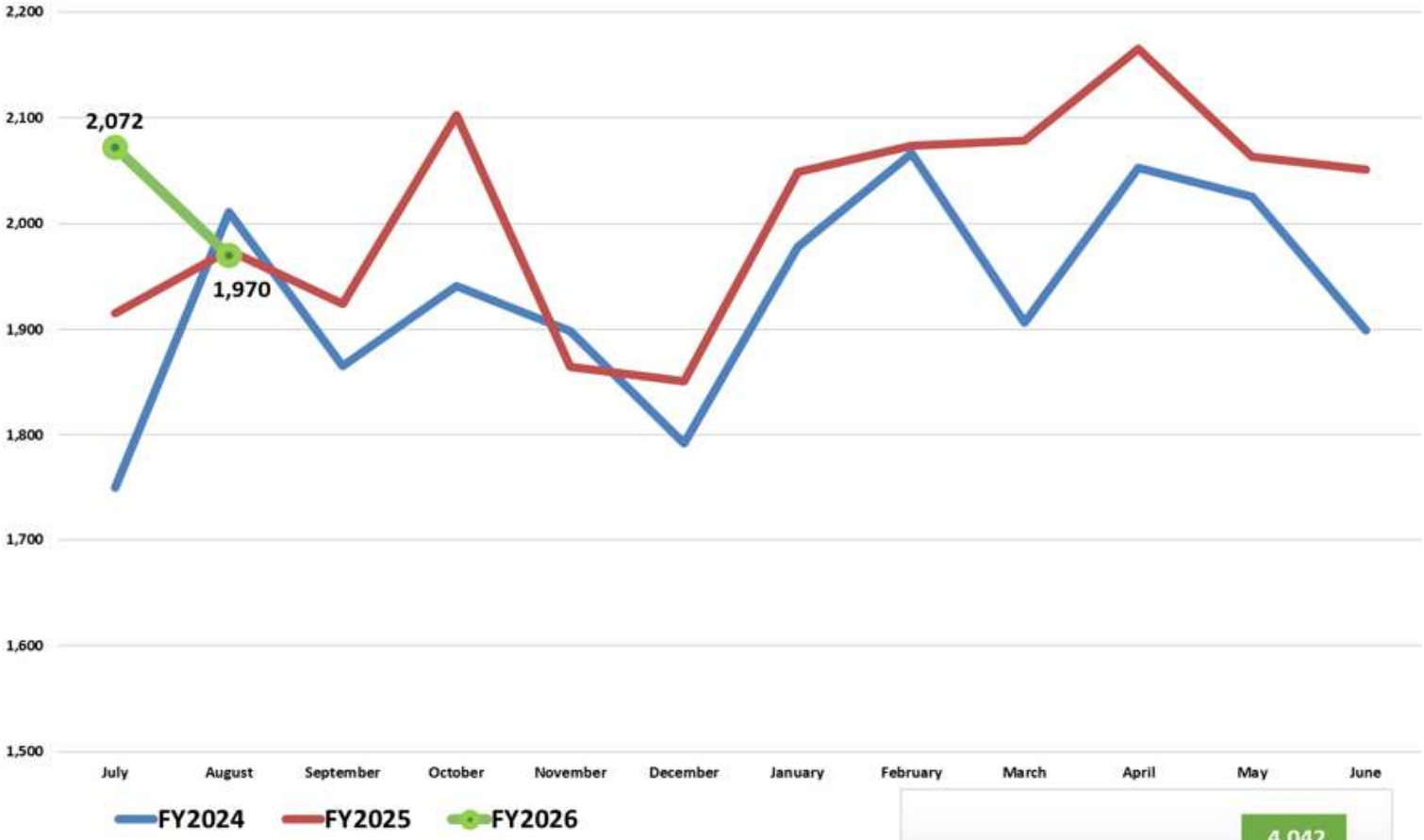
CFO Financial Report

Month Ending August 2025

Average Daily Census



Outpatient Registrations Per Day



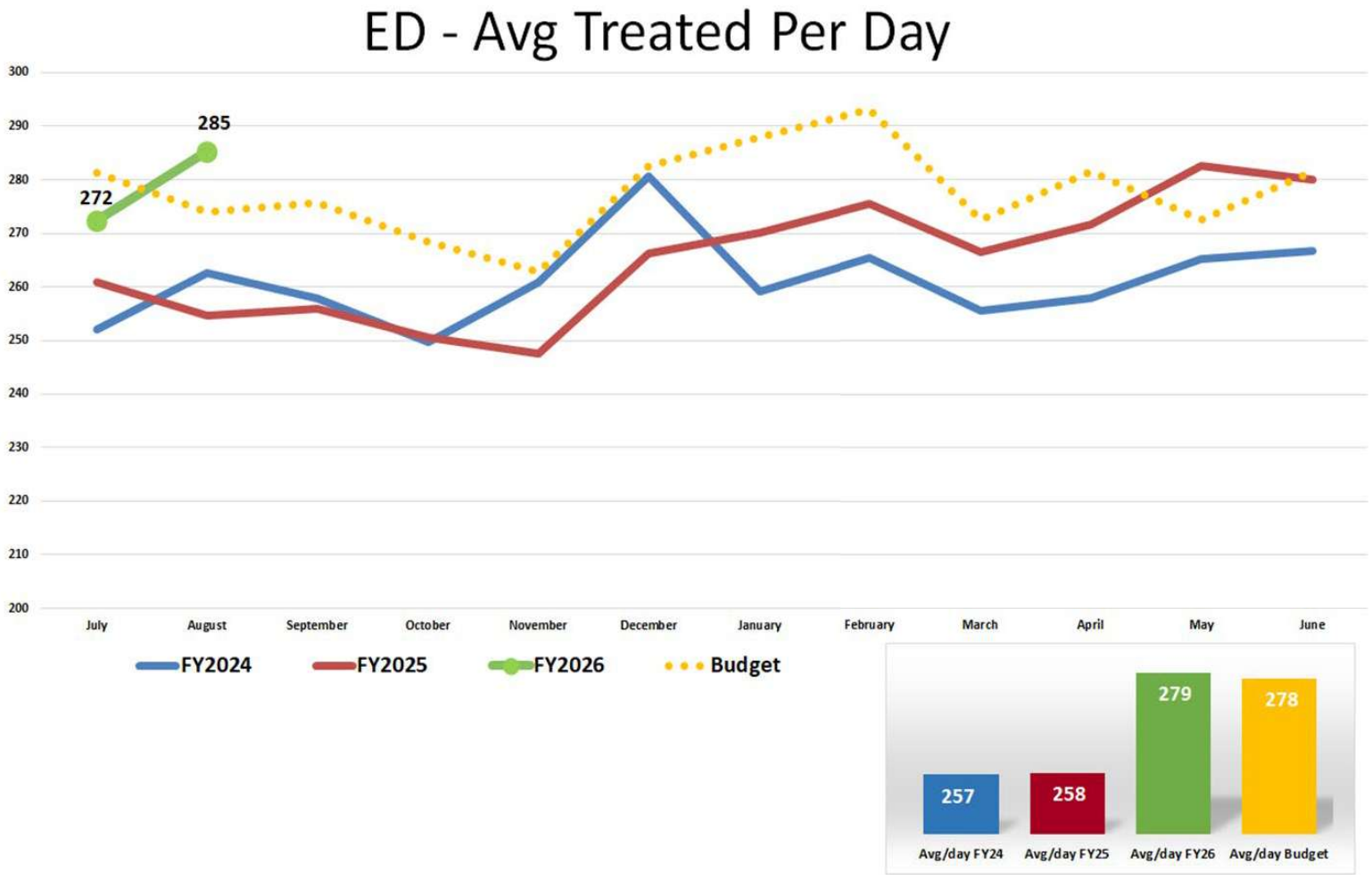
Adjusted Patient Days

Statistical Results – Fiscal Year Comparison (Aug)

	Actual Results			Budget	Budget Variance	
	Aug 2024	Aug 2025	% Change	Aug 2025	Change	% Change
Average Daily Census	**403**	**389**	**(3.7%)**	**412**	**(24)**	**(5.7%)**
KDHCD Patient Days:						
Medical Center	8,711	7,754	(11.0%)	8,587	(833)	(9.7%)
Acute I/P Psych	1,166	1,399	20.0%	1,457	(58)	(4.0%)
Sub-Acute	906	872	(3.8%)	925	(53)	(5.7%)
Rehab	452	626	38.5%	602	24	4.0%
TCS-Ortho	362	433	19.6%	408	25	6.1%
NICU	375	470	25.3%	364	106	29.1%
Nursery	532	493	(7.3%)	434	59	13.6%
Total KDHCD Patient Days	**12,504**	**12,047**	**(3.7%)**	**12,777**	**(730)**	**(5.7%)**
Total Outpatient Volume	**61,225**	**61,070**	**(0.3%)**	**70,744**	**(9,674)**	**(13.7%)**

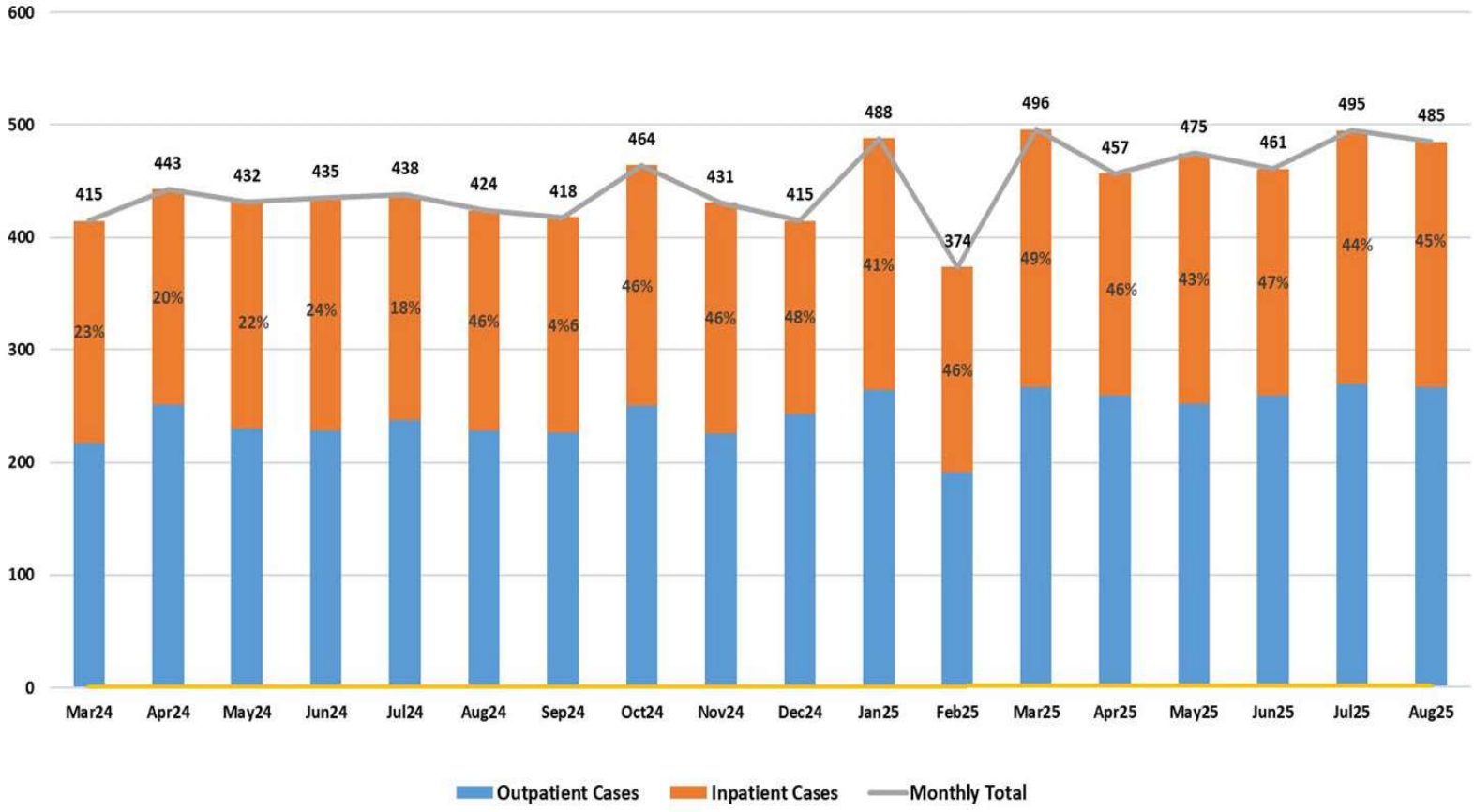
Statistical Results – Fiscal Year Comparison (Jul-Aug)

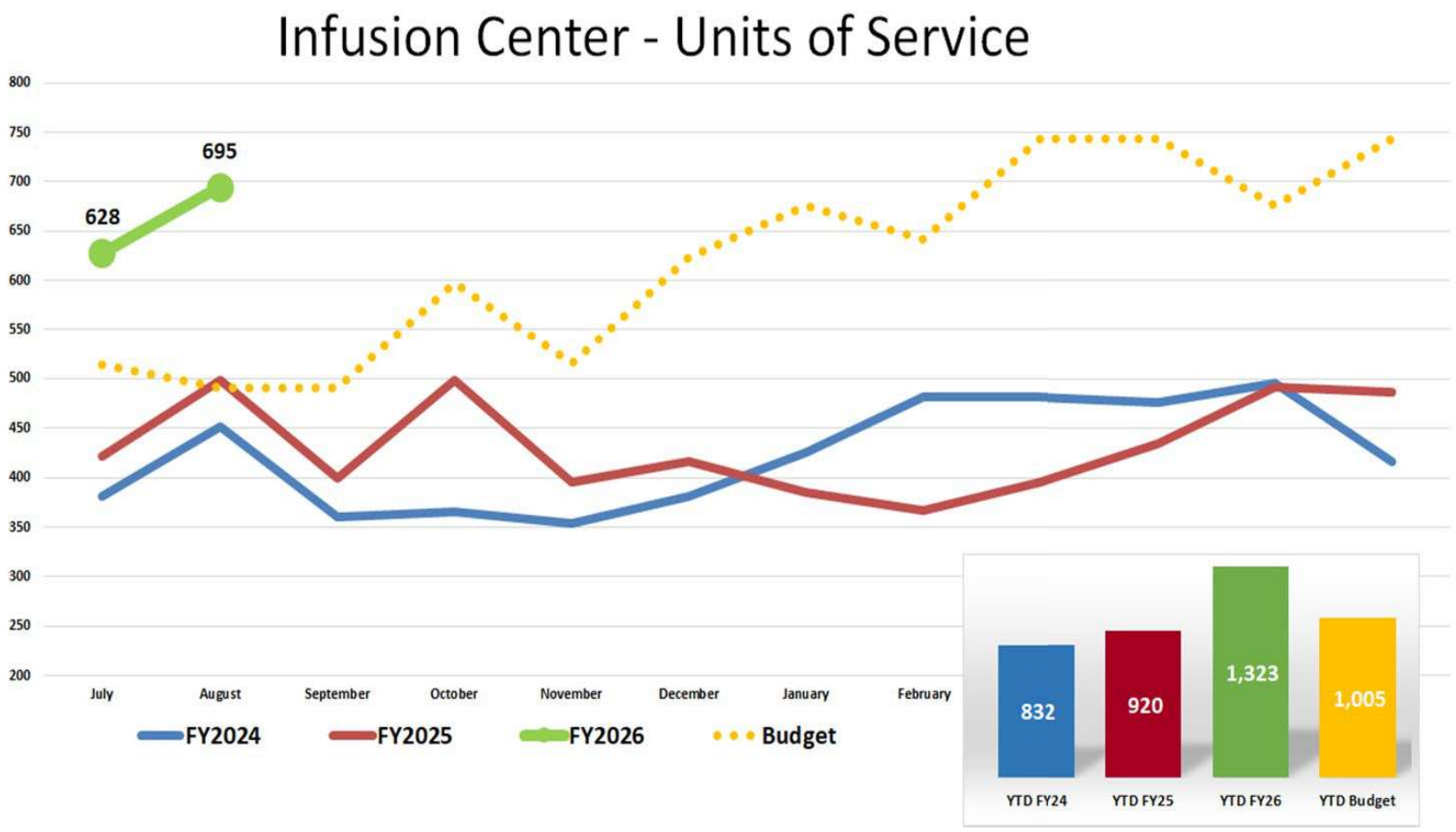
	Actual Results			Budget	Budget Variance	
	FYTD 2025	FYTD 2026	% Change	FYTD 2025	Change	% Change
Average Daily Census	**407**	**392**	**(3.7%)**	**407**	**(15)**	**(3.8%)**
KDHCD Patient Days:						
Medical Center	17,918	15,752	(12.1%)	17,005	(1,253)	(7.4%)
Acute I/P Psych	2,280	2,801	22.9%	2,852	(51)	(1.8%)
Sub-Acute	1,788	1,753	(2.0%)	1,826	(73)	(4.0%)
Rehab	932	1,201	28.9%	1,202	(1)	(0.1%)
TCS-Ortho	630	883	40.2%	818	65	7.9%
NICU	751	888	18.2%	700	188	26.9%
Nursery	944	1,012	7.2%	845	167	19.8%
Total KDHCD Patient Days	**25,243**	**24,290**	**(3.8%)**	**25,248**	**(958)**	**(3.8%)**
Total Outpatient Volume	**120,590**	**125,302**	**3.9%**	**141,488**	**(16,186)**	**(11.4%)**


ED - Avg Treated Per Day
300
290
280
270
260
250
240
230
220
210
200
285
272
July
August
September
October
November
December
January
February
March
April
May
June
FY2024
FY2025
FY2026
Budget

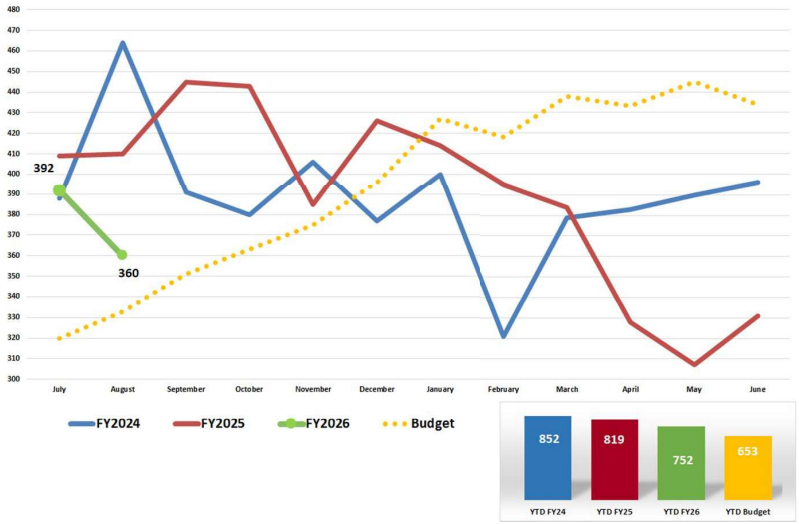
257
258
279
278
Avg/day FY24
Avg/day FY25
Avg/day FY26
Avg/day Budget

Cath Lab Patients (IP & OP)

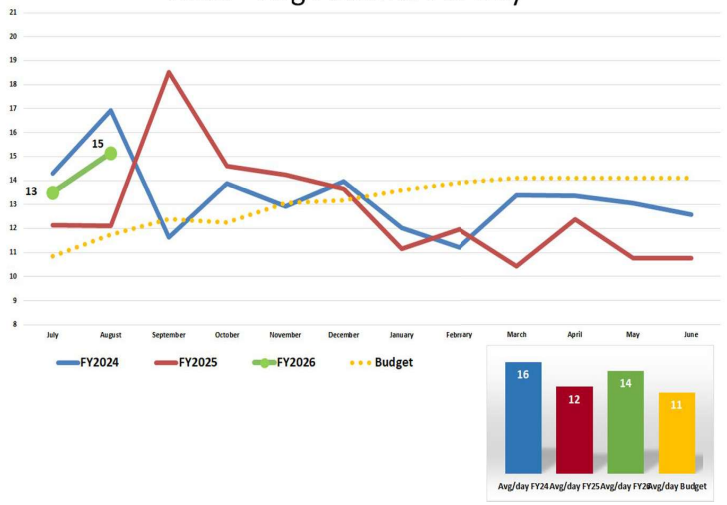



Infusion Center - Units of Service
800
750
700
650
600
550
500
450
400
350
300
250
200
695
628
July
August
September
October
November
December
January
February
FY2024
FY2025
FY2026
Budget
832
920
1,323
1,005
YTD FY24
YTD FY25
YTD FY26
YTD Budget

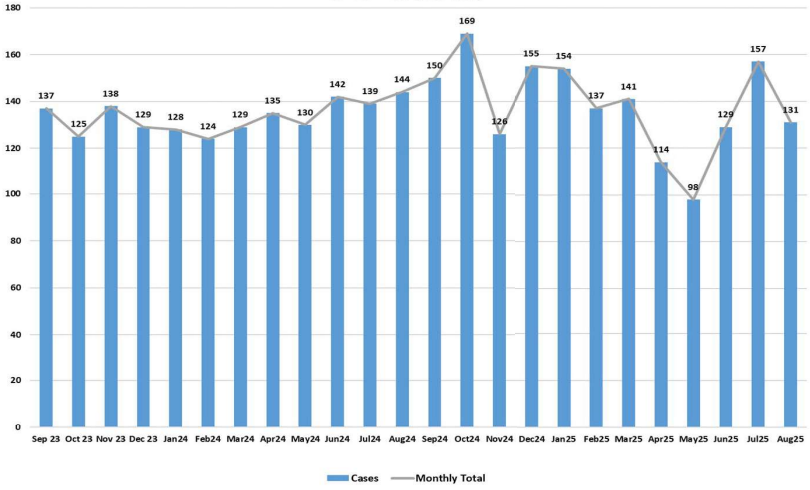
Deliveries



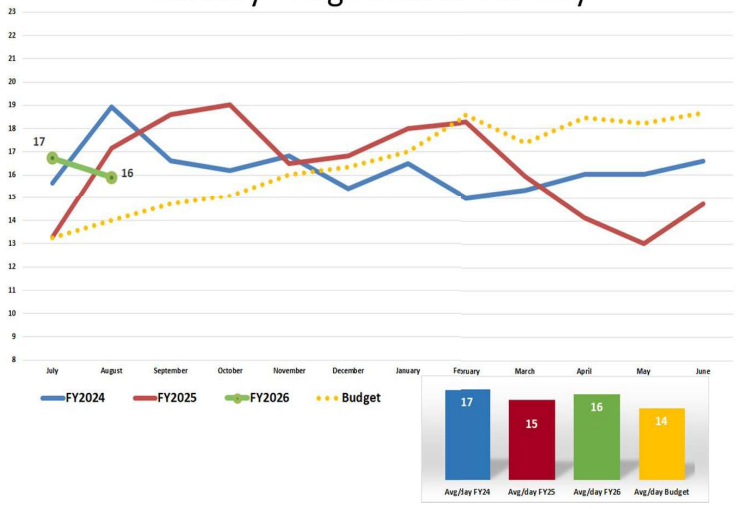
NICU - Avg Patients Per Day



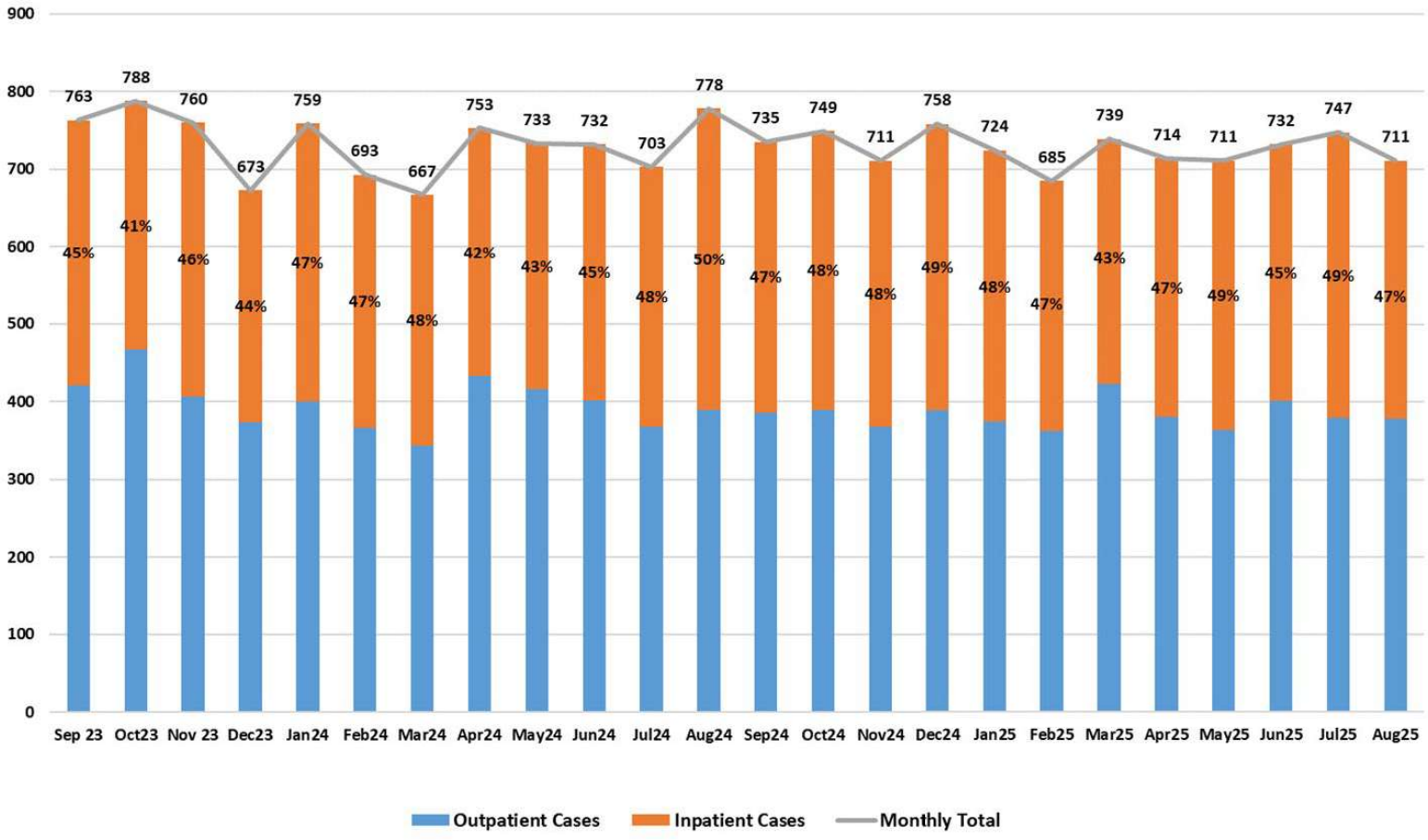
OB Cases

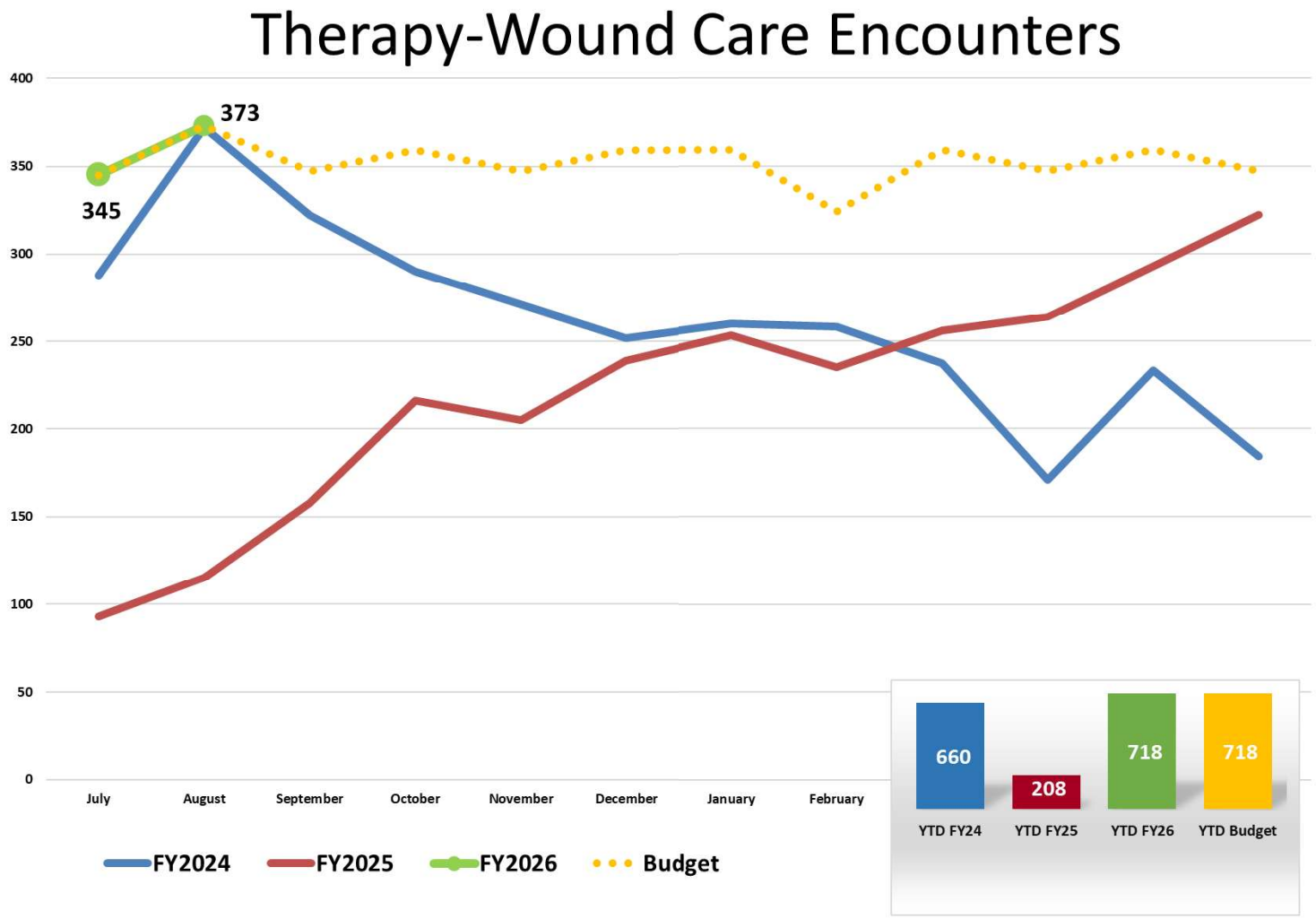


Nursery - Avg Patients Per Day

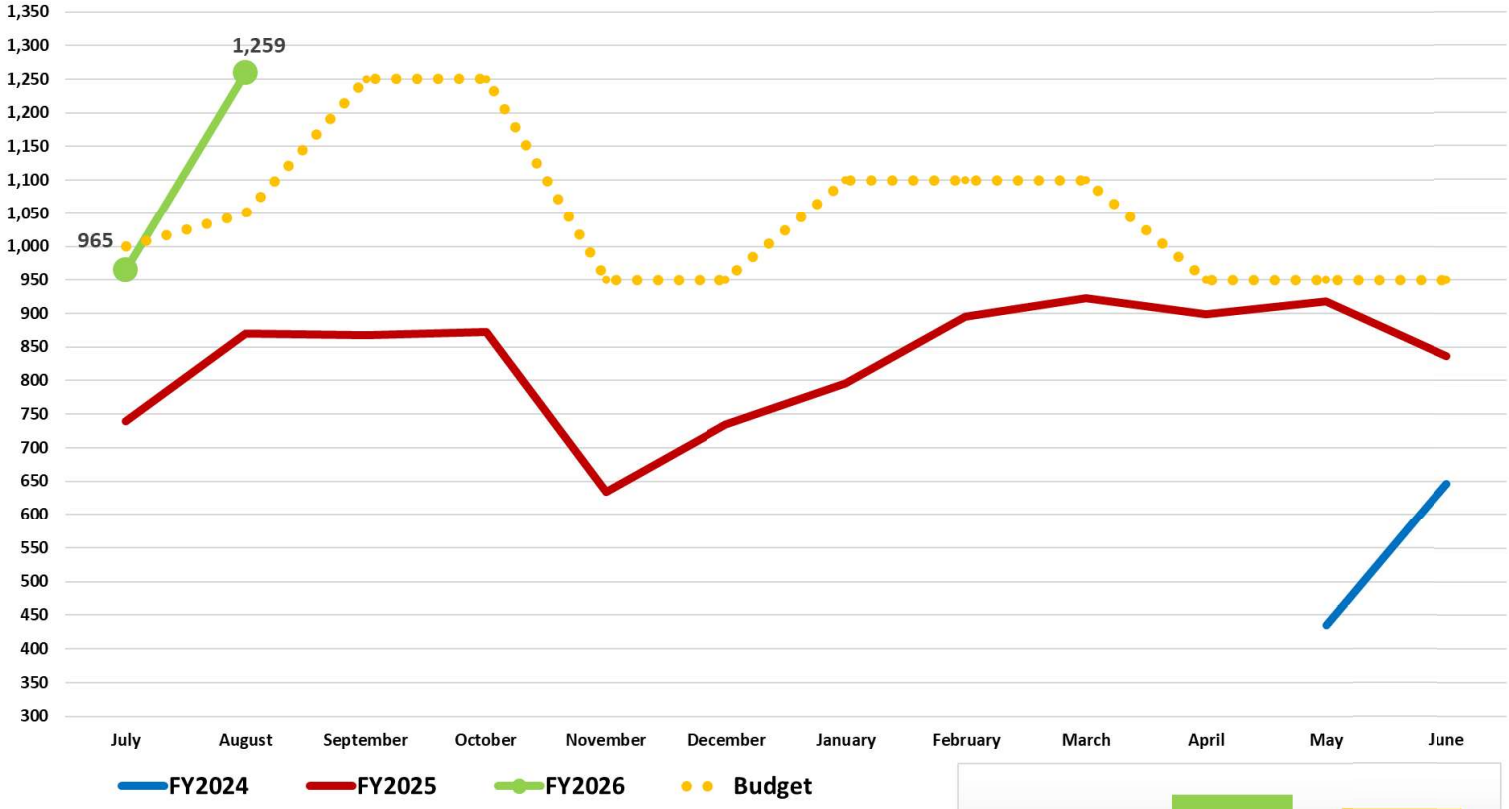


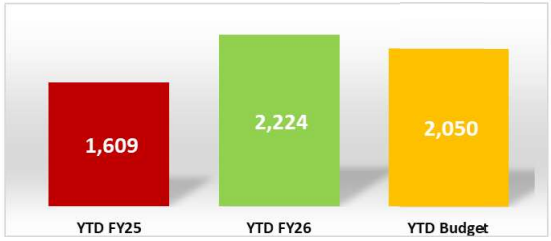
Surgery Cases (IP & OP)



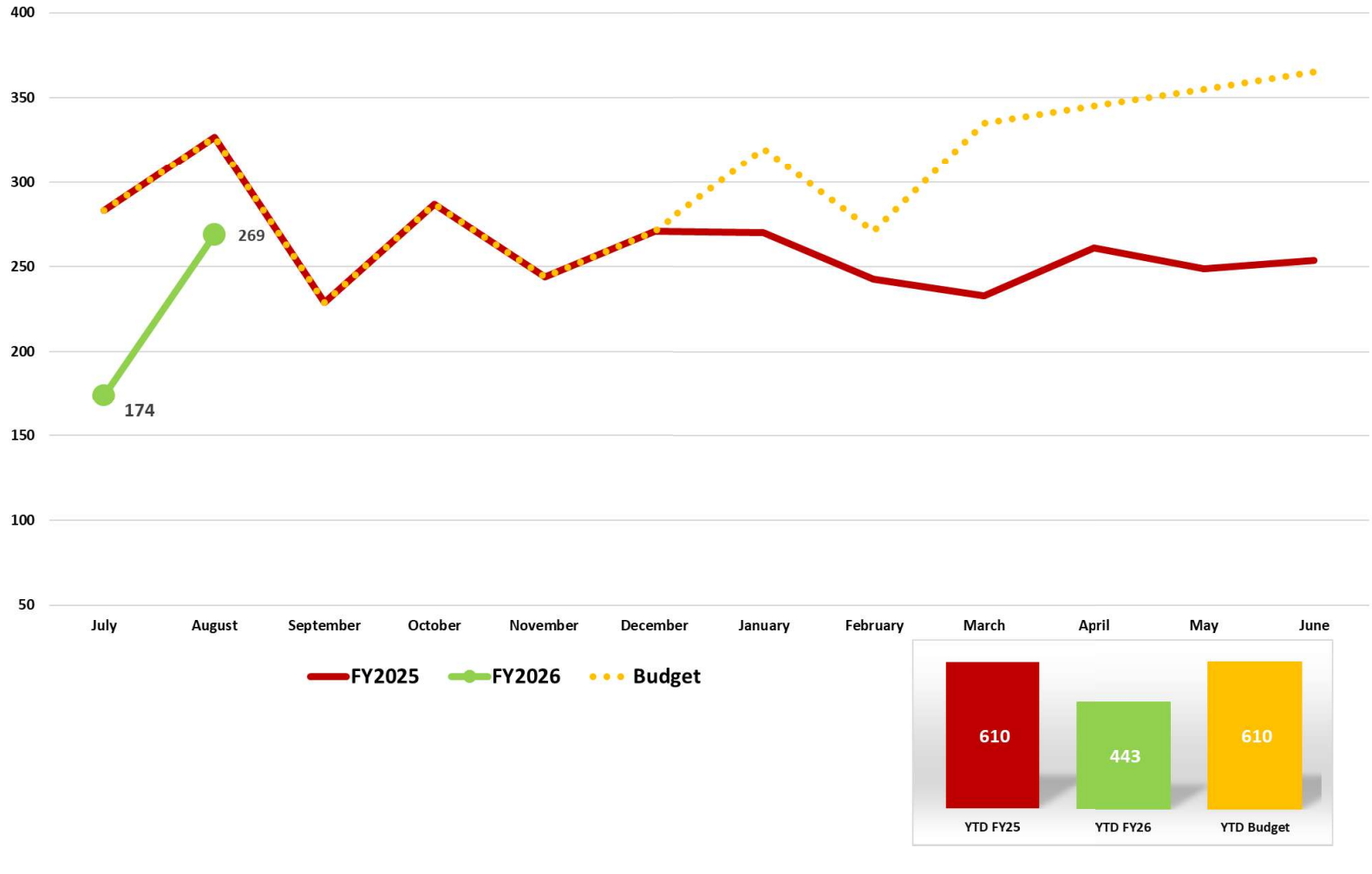

Therapy-Wound Care Encounters
400
350
300
250
200
150
100
50
0
373
345
July
August
September
October
November
December
January
February
FY2024
FY2025
FY2026
Budget
660
208
718
718
YTD FY24
YTD FY25
YTD FY26
YTD Budget

KH Medical Clinic - Ben Maddox





KH Medical Clinic - Plaza



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

	Actual Results				Budget	Budget Variance	
	Aug 24	Aug 25	Change	% Change	Aug 25	Change	% Change
ED - Avg Treated Per Day	255	285	30	12.0%	274	11	4.1%
Surgery (IP & OP) – 100 Min Units	873	747	(125)	(14.4%)	886	(139)	(15.6%)
Endoscopy Procedures	629	382	(247)	(39.3%)	503	(121)	(24.1%)
Cath Lab (IP & OP) - 100 Min Units	345	371	26	7.5%	358	13	3.6%
Cardiac Surgery Cases	29	28	(1)	(3.4%)	36	(8)	(22.6%)
Deliveries	410	360	(50)	(12.2%)	333	27	8.1%
Clinical Lab	238,296	253,309	15,013	6.3%	262,126	(8,818)	(3.4%)
Reference Lab	7,771	8,273	502	6.5%	7,620	653	8.6%
Dialysis Center - Visalia Visits	1,545	1,380	(165)	(10.7%)	1,554	(174)	(11.2%)
Infusion Center - Units of Service	498	695	197	39.6%	491	204	41.5%
Hospice Days	3,514	3,982	468	13.3%	4,076	(94)	(2.3%)
Home Health Visits	2,898	3,003	105	3.6%	3,160	(157)	(5.0%)
Home Infusion Days	22,963	23,783	820	3.6%	21,630	2,153	10.0%

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

	YTD Actual Results				Budget	Budget Variance	
	YTD Aug 24	YTD Aug 25	Change	% Change	YTD Aug 25	Change	% Change
ED - Avg Treated Per Day	258	279	21	8.1%	278	1	0.4%
Surgery (IP & OP) – 100 Min Units	1,652	1,546	(105)	(6.4%)	1,706	(160)	(9.4%)
Endoscopy Procedures	1,261	945	(316)	(25.1%)	1,060	(115)	(10.9%)
Cath Lab (IP & OP) - 100 Min Units	697	689	(8)	(1.1%)	725	(36)	(5.0%)
Cardiac Surgery Cases	59	58	(1)	(1.7%)	72	(14)	(19.8%)
Deliveries	819	752	(67)	(8.2%)	653	99	15.2%
Clinical Lab	494,110	516,935	22,826	4.6%	543,521	(26,586)	(4.9%)
Reference Lab	15,980	16,335	355	2.2%	15,574	761	4.9%
Dialysis Center - Visalia Visits	3,074	2,812	(262)	(8.5%)	3,104	(292)	(9.4%)
Infusion Center - Units of Service	920	1,323	403	43.8%	1,005	318	31.6%
Hospice Days	6,969	7,848	879	12.6%	8,166	(318)	(3.9%)
Home Health Visits	5,919	6,060	141	2.4%	6,099	(39)	(0.6%)
Home Infusion Days	46,709	50,158	3,449	7.4%	45,321	4,837	10.7%

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

	Actual Results				Budget	Budget Variance	
	Aug 24	Aug 25	Change	% Change	Aug 25	Change	% Change
All O/P Rehab Svcs Across District	20,955	19,411	(1,544)	(7.4%)	20,987	(1,576)	(7.5%)
Physical & Other Therapy Units (I/P & O/P)	18,024	18,405	381	2.1%	20,828	(2,423)	(11.6%)
Radiology - CT - All Areas	4,411	5,135	724	16.4%	4,699	436	9.3%
Radiology - MRI - All Areas	847	916	69	8.1%	899	17	1.9%
Radiology - Ultrasound - All Areas	3,046	3,114	68	2.2%	3,122	(8)	(0.2%)
Radiology - Diagnostic Radiology	9,081	9,384	303	3.3%	9,354	30	0.3%
Radiology – Main Campus	14,631	15,579	948	6.5%	15,020	559	3.7%
Radiology - Ultrasound - Main Campus	2,347	2,393	46	2.0%	2,227	166	7.5%
West Campus - Diagnostic Radiology	1,116	1,334	218	19.5%	1,212	122	10.0%
West Campus - CT Scan	531	492	(39)	(7.3%)	519	(27)	(5.2%)
West Campus - MRI	408	423	15	3.7%	428	(5)	(1.2%)
West Campus - Ultrasound	699	721	22	3.1%	895	(174)	(19.4%)
West Campus - Breast Center	1,838	1,331	(507)	(27.6%)	1,838	(507)	(27.6%)
Med Onc Visalia Treatments	1,174	1,052	(122)	(10.4%)	1,197	(145)	(12.1%)
Rad Onc Visalia Treatments	1,469	1,715	246	16.7%	1,518	197	13.0%
Rad Onc Hanford Treatments	210	262	52	24.8%	249	13	5.3%

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

	YTD Actual Results				Budget	Budget Variance	
	YTD Aug 24	YTD Aug 25	Change	% Change	YTD Aug 25	Change	% Change
All O/P Rehab Svcs Across District	42,787	41,300	(1,487)	(3.5%)	42,140	(840)	(2.0%)
Physical & Other Therapy Units (I/P & O/P)	36,905	37,644	739	2.0%	41,635	(3,991)	(9.6%)
Radiology - CT - All Areas	9,279	10,220	941	10.1%	9,317	903	9.7%
Radiology - MRI - All Areas	1,768	1,861	93	5.3%	1,811	50	2.8%
Radiology - Ultrasound - All Areas	6,330	6,262	(68)	(1.1%)	6,215	47	0.8%
Radiology - Diagnostic Radiology	19,099	18,866	(233)	(1.2%)	19,411	(545)	(2.8%)
Radiology – Main Campus	31,024	31,244	220	0.7%	30,864	380	1.2%
Radiology - Ultrasound - Main Campus	4,927	4,790	(137)	(2.8%)	4,516	274	6.1%
West Campus - Diagnostic Radiology	2,203	2,598	395	17.9%	2,342	256	11.0%
West Campus - CT Scan	996	1,041	45	4.5%	982	59	6.0%
West Campus - MRI	850	854	4	0.5%	867	(13)	(1.5%)
West Campus - Ultrasound	1,403	1,472	69	4.9%	1,699	(227)	(13.4%)
West Campus - Breast Center	3,644	2,818	(826)	(22.7%)	3,644	(826)	(22.7%)
Med Onc Visalia Treatments	2,305	2,343	38	1.6%	2,351	(8)	(0.3%)
Rad Onc Visalia Treatments	3,166	3,575	409	12.9%	3,266	309	9.5%
Rad Onc Hanford Treatments	504	569	65	12.9%	488	81	16.5%

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

	Actual Results				Budget	Budget Variance	
	Aug 24	Aug 25	Change	% Change	Aug 25	Change	% Change
Rural Health Clinics Registrations	14,062	13,654	(408)	(2.9%)	14,155	(501)	(3.5%)
RHC Exeter - Registrations	6,717	6,288	(429)	(6.4%)	6,950	(662)	(9.5%)
RHC Lindsay - Registrations	2,010	1,938	(72)	(3.6%)	2,200	(262)	(11.9%)
RHC Woodlake - Registrations	1,218	773	(445)	(36.5%)	730	43	5.9%
RHC Woodlake Valencia - Registrations	0	716	716	0.0%	704	12	1.7%
RHC Dinuba - Registrations	1,587	1,477	(110)	(6.9%)	1,750	(273)	(15.6%)
RHC Tulare - Registrations	2,530	2,462	(68)	(2.7%)	2,525	(63)	(2.5%)
Urgent Care – Court Total Visits	2,235	2,562	327	14.6%	2,800	(238)	(8.5%)
Urgent Care – Demaree Total Visits	1,400	1,776	376	26.9%	1,950	(174)	(8.9%)
KH Medical Clinic - Ben Maddox Visits	870	1,259	389	44.7%	1,050	209	19.9%
KH Medical Clinic - Plaza Visits	327	269	(58)	(17.7%)	327	(58)	(17.7%)
KH Medical Willow Clinic Visits	0	761	761	0.0%	630	131	20.8%
KH Cardiology Center Visalia Registrations	1,552	1,470	(82)	(5.3%)	1,625	(155)	(9.5%)
KH Mental Wellness Clinic Visits	316	364	48	15.2%	390	(26)	(6.7%)
Urology Clinic Visits	430	49	(381)	(88.6%)	308	(259)	(84.1%)
Therapy-Wound Care Svcs Encounters	115	373	258	224.3%	373	0	0.0%

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

	YTD Actual Results				Budget	Budget Variance	
	YTD Aug 24	YTD Aug 25	Change	% Change	YTD Aug 25	Change	% Change
Rural Health Clinics Registrations	27,020	27,602	582	2.2%	27,560	42	0.2%
RHC Exeter - Registrations	12,679	12,897	218	1.7%	13,400	(503)	(3.8%)
RHC Lindsay - Registrations	3,900	3,896	(4)	(0.1%)	4,200	(304)	(7.2%)
RHC Woodlake - Registrations	2,479	1,594	(885)	(35.7%)	1,460	134	9.2%
RHC Woodlake Valencia - Registrations	0	1,264	1,264	0.0%	1,408	(144)	(10.2%)
RHC Dinuba - Registrations	3,227	3,046	(181)	(5.6%)	3,550	(504)	(14.2%)
RHC Tulare - Registrations	4,735	4,905	170	3.6%	4,950	(45)	(0.9%)
Urgent Care – Court Total Visits	4,395	4,902	507	11.5%	5,500	(598)	(10.9%)
Urgent Care – Demaree Total Visits	2,405	3,372	967	40.2%	3,800	(428)	(11.3%)
KH Medical Clinic - Ben Maddox Visits	1,609	2,224	615	38.2%	2,050	174	8.5%
KH Medical Clinic - Plaza Visits	610	443	(167)	(27.4%)	610	(167)	(27.4%)
KH Medical Willow Clinic Visits	0	1,680	1,680	0.0%	1,190	490	41.2%
KH Cardiology Center Visalia Registrations	3,115	2,888	(227)	(7.3%)	3,206	(318)	(9.9%)
KH Mental Wellness Clinic Visits	628	723	95	15.1%	780	(57)	(7.3%)
Urology Clinic Visits	654	407	(247)	(37.8%)	616	(209)	(33.9%)
Therapy-Wound Care Svcs Encounters	208	718	510	245.2%	718	0	0.0%

August Financial Summary (000's) Comparison to Budget

	Comparison to Budget - Month of August			
	Budget Aug-2025	Actual Aug-2025	$ Change	% Change
Operating Revenue				
Net Patient Service Revenue	$56,762	$53,289	($3,473)	-6.5%
Other Operating Revenue	$22,109	$23,904	$1,795	7.5%
Total Operating Revenue	**$78,871**	**$77,193**	**($1,678)**	**-2.2%**
Operating Expenses				
Employment Expenses	$42,849	$42,743	($106)	-0.2%
Other Expenses	$38,016	$36,987	($1,029)	-2.8%
Total Operating Expenses	**$80,865**	**$79,730**	**($1,134)**	**-1.4%**
Operating Margin	**($1,993)**	**($2,537)**	**($544)**	
Stimulus/FEMA	$0	$0	$0	
Operating Margin after Stimulus/FEMA	**($1,993)**	**($2,537)**	**($544)**	
Nonoperating Revenue (Loss)	$846	$1,243	$397	
Excess Margin	**($1,148)**	**($1,295)**	**($147)**	

August Financial Summary (000's) Comparison to Prior Year

	Comparison to Prior Year - Month of August			
	Actual Aug-2024	Actual Aug-2025	$ Change	% Change
Operating Revenue				
Net Patient Service Revenue	$53,450	$53,289	($161)	-0.3%
Other Operating Revenue	$20,024	$23,904	$3,880	16.2%
Total Operating Revenue	**$73,474**	**$77,193**	**$3,719**	**4.8%**
Operating Expenses				
Employment Expenses	$39,058	$42,743	$3,686	8.6%
Other Expenses	$37,908	$36,987	($921)	-2.5%
Total Operating Expenses	**$76,965**	**$79,730**	**$2,765**	**3.5%**
Operating Margin	**($3,492)**	**($2,537)**	**$954**	
Stimulus/FEMA	$0	$0	$0	
Operating Margin after Stimulus/FEMA	**($3,492)**	**($2,537)**	**$954**	
Nonoperating Revenue (Loss)	$896	$1,243	$347	
Excess Margin	**($2,596)**	**($1,295)**	**$1,301**	

Year to Date Financial Summary (000's)

	Comparison to Budget - YTD August			
	Budget YTD Aug-2025	Actual YTD Aug-2025	$ Change	% Change
Operating Revenue				
Net Patient Service Revenue	$113,601	$109,790	($3,811)	-3.5%
Other Operating Revenue	$44,119	$45,752	$1,633	3.6%
Total Operating Revenue	**$157,720**	**$155,542**	**($2,178)**	**-1.4%**
Operating Expenses				
Employment Expenses	$85,486	$86,293	$807	0.9%
Other Expenses	$75,548	$75,471	($77)	-0.1%
Total Operating Expenses	**$161,035**	**$161,764**	**$730**	**0.5%**
Operating Margin	**($3,314)**	**($6,222)**	**($2,908)**	
Stimulus/FEMA	$0	$0	$0	
Operating Margin after Stimulus/FEMA	**($3,314)**	**($6,222)**	**($2,908)**	
Nonoperating Revenue (Loss)	$1,692	$2,302	$610	
Excess Margin	**($1,622)**	**($3,920)**	**($2,298)**	

August Financial Comparison (000's)

	Comparison to Budget - Month of August				Comparison to Prior Year - Month of August			
	Budget Aug-2025	Actual Aug-2025	$ Change	% Change	Actual Aug-2024	Actual Aug-2025	$ Change	% Change
Operating Revenue								
Net Patient Service Revenue	**$56,762**	**$53,289**	**($3,473)**	**-6.5%**	**$53,450**	**$53,289**	**($161)**	**-0.3%**
Supplemental Gov't Programs	$10,258	$9,985	($273)	-2.7%	$7,485	$9,985	$2,500	25.0%
Prime Program	$689	$572	($117)	-20.4%	$792	$572	($220)	-38.4%
Premium Revenue	$6,931	$8,057	$1,126	14.0%	$7,596	$8,057	$461	5.7%
Management Services Revenue	$0	$0	$0	0.0%	$0	$0	$0	0.0%
Other Revenue	$4,231	$5,290	$1,059	20.0%	$4,151	$5,290	$1,139	21.5%
Other Operating Revenue	$22,109	$23,904	$1,795	7.5%	$20,024	$23,904	$3,880	16.2%
Total Operating Revenue	**$78,871**	**$77,193**	**($1,678)**	**-2.2%**	**$73,474**	**$77,193**	**$3,719**	**4.8%**
Operating Expenses								
Salaries & Wages	$32,621	$34,223	$1,602	4.7%	$32,301	$34,223	$1,922	5.6%
Contract Labor	$2,417	$2,475	$58	2.3%	$1,146	$2,475	$1,329	53.7%
Employee Benefits	$7,811	$6,045	($1,766)	-29.2%	$5,611	$6,045	$434	7.2%
Total Employment Expenses	**$42,849**	**$42,743**	**($106)**	**-0.2%**	**$39,058**	**$42,743**	**$3,686**	**8.6%**
Medical & Other Supplies	$14,511	$14,705	$194	1.3%	$14,959	$14,705	($254)	-1.7%
Physician Fees	$7,462	$8,260	$798	9.7%	$7,546	$8,260	$714	8.6%
Purchased Services	$1,903	$2,040	$137	6.7%	$1,606	$2,040	$434	21.3%
Repairs & Maintenance	$2,663	$2,197	($465)	-21.2%	$2,561	$2,197	($364)	-16.6%
Utilities	$1,195	$949	($247)	-26.0%	$955	$949	($7)	-0.7%
Rents & Leases	$126	$94	($32)	-33.8%	$122	$94	($27)	-28.9%
Depreciation & Amortization	$3,505	$3,169	($336)	-10.6%	$3,145	$3,169	$25	0.8%
Interest Expense	$572	$568	($5)	-0.8%	$586	$568	($18)	-3.2%
Other Expense	$2,384	$2,079	($305)	-14.6%	$1,992	$2,079	$87	4.2%
Humana Cap Plan Expenses	$3,695	$2,925	($770)	-26.3%	$4,436	$2,925	($1,511)	-51.7%
Total Other Expenses	**$38,016**	**$36,987**	**($1,029)**	**-2.8%**	**$37,908**	**$36,987**	**($921)**	**-2.5%**
Total Operating Expenses	**$80,865**	**$79,730**	**($1,134)**	**-1.4%**	**$76,965**	**$79,730**	**$2,765**	**3.5%**
Operating Margin	**($1,993)**	**($2,537)**	**($544)**		**($3,492)**	**($2,537)**	**$954**	
Stimulus/FEMA	**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	
Operating Margin after Stimulus/FEMA	**($1,993)**	**($2,537)**	**($544)**		**($3,492)**	**($2,537)**	**$954**	
Nonoperating Revenue (Loss)	$846	$1,243	$397		$896	$1,243	$347	
Excess Margin	**($1,148)**	**($1,295)**	**($147)**		**($2,596)**	**($1,295)**	**$1,301**	

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

	Comparison to Budget - YTD August				Comparison to Prior Year - YTD August			
	Budget YTD Aug-2024	Actual YTD Aug-2025	$ Change	% Change	Actual YTD Aug-2024	Actual YTD Aug-2025	$ Change	% Change
Operating Revenue								
Net Patient Service Revenue	**$113,601**	**$109,790**	**($3,811)**	**-3.5%**	**$104,316**	**$109,790**	**$5,474**	**5.0%**
Supplemental Gov't Programs	$20,517	$19,438	($1,078)	-5.5%	$15,177	$19,438	$4,261	21.9%
Prime Program	$1,378	$1,261	($117)	-9.2%	$1,584	$1,261	($322)	-25.6%
Premium Revenue	$13,862	$15,035	$1,173	7.8%	$14,703	$15,035	$332	2.2%
Management Services Revenue	$0	$0	$0	0.0%	$0	$0	$0	0.0%
Other Revenue	$8,363	$10,017	$1,655	16.5%	$8,046	$10,017	$1,971	19.7%
Other Operating Revenue	$44,119	$45,752	$1,633	3.6%	$39,510	$45,752	$6,241	13.6%
Total Operating Revenue	**$157,720**	**$155,542**	**($2,178)**	**-1.4%**	**$143,826**	**$155,542**	**$11,716**	**7.5%**
Operating Expenses								
Salaries & Wages	$64,949	$67,505	$2,556	3.8%	$63,869	$67,505	$3,636	5.4%
Contract Labor	$4,958	$4,957	($1)	0.0%	$2,064	$4,957	$2,892	58.4%
Employee Benefits	$15,579	$13,832	($1,747)	-12.6%	$11,389	$13,832	$2,443	17.7%
Total Employment Expenses	**$85,486**	**$86,293**	**$807**	**0.9%**	**$77,322**	**$86,293**	**$8,971**	**10.4%**
Medical & Other Supplies	$28,761	$29,257	$497	1.7%	$29,779	$29,257	($522)	-1.8%
Physician Fees	$14,923	$16,097	$1,174	7.3%	$14,607	$16,097	$1,490	9.3%
Purchased Services	$3,806	$3,720	($85)	-2.3%	$3,187	$3,720	$533	14.3%
Repairs & Maintenance	$5,324	$4,410	($915)	-20.7%	$4,226	$4,410	$184	4.2%
Utilities	$2,168	$1,877	($290)	-15.5%	$1,829	$1,877	$48	2.6%
Rents & Leases	$255	$211	($44)	-20.9%	$246	$211	($35)	-16.5%
Depreciation & Amortization	$7,010	$6,386	($624)	-9.8%	$6,304	$6,386	$82	1.3%
Interest Expense	$1,145	$1,139	($5)	-0.5%	$1,195	$1,139	($56)	-4.9%
Other Expense	$4,767	$3,987	($780)	-19.6%	$3,956	$3,987	$31	0.8%
Humana Cap Plan Expenses	$7,390	$8,385	$996	11.9%	$8,389	$8,385	($4)	0.0%
Total Other Expenses	**$75,548**	**$75,471**	**($77)**	**-0.1%**	**$73,718**	**$75,471**	**$1,752**	**2.3%**
Total Operating Expenses	**$161,035**	**$161,764**	**$730**	**0.5%**	**$151,040**	**$161,764**	**$10,724**	**6.6%**
Operating Margin	**($3,314)**	**($6,222)**	**($2,908)**		**($7,214)**	**($6,222)**	**$992**	
Stimulus/FEMA	**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	
Operating Margin after Stimulus/FEMA	**($3,314)**	**($6,222)**	**($2,908)**		**($7,214)**	**($6,222)**	**$992**	
Nonoperating Revenue (Loss)	$1,692	$2,302	$610		$2,086	$2,302	$216	
Excess Margin	**($1,622)**	**($3,920)**	**($2,298)**		**($5,129)**	**($3,920)**	**$1,208**	

Month of August - Budget Variances

- **Net Patient Service Revenue:** The unfavorable budget variance in revenue is primarily due to the decrease in our inpatient volumes in our downtown campus.
- **Premium Revenue:** The $1.1M favorable budget variance was due to additional Humana revenue recognized due to an increase in our capitated rates.
- **Other Revenue:** The $1M favorable budget variance is primarily due to an increase over budget in our retail pharmacy revenue.
- **Salaries and Wages:** The $1.6K unfavorable variance is due to increases in registered nurse expenses ($1.4M) and ($519K) in Clerical staff as compared to budget.
- **Employee Benefits:** In August our health insurance claims were lower than anticipated. In addition, we had 3 pay periods which increased the employee related deposits that were made.
- **Physician Fees:** The $798K unfavorable variance is due to Acute Psych, Intensivist, OB Laborist program and our Cardiology Center.

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

- **Current Identified Savings $18.3M**
  - $11.4M Support services
  - $5.3M Clinics/Lab/Pharmacy
  - $1.4M Nursing Departments

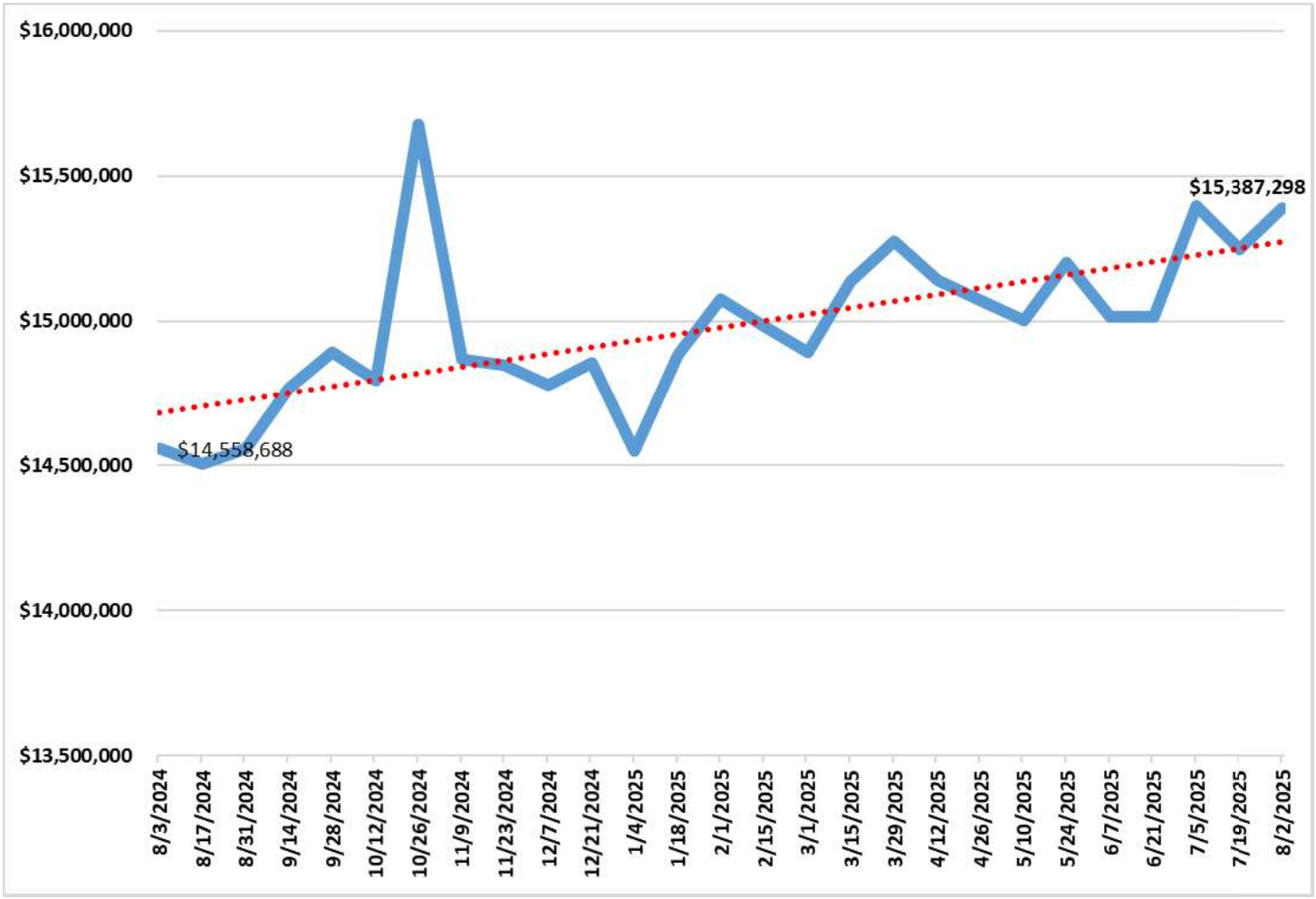
- **Types of Savings**
  - 28% Revenue increase $5.1M
  - 29% Employment Cost decrease $5.6M
  - 43% Other Expenses decrease $7.8M

- **Pending:** $6.7M Contract labor and Staffing

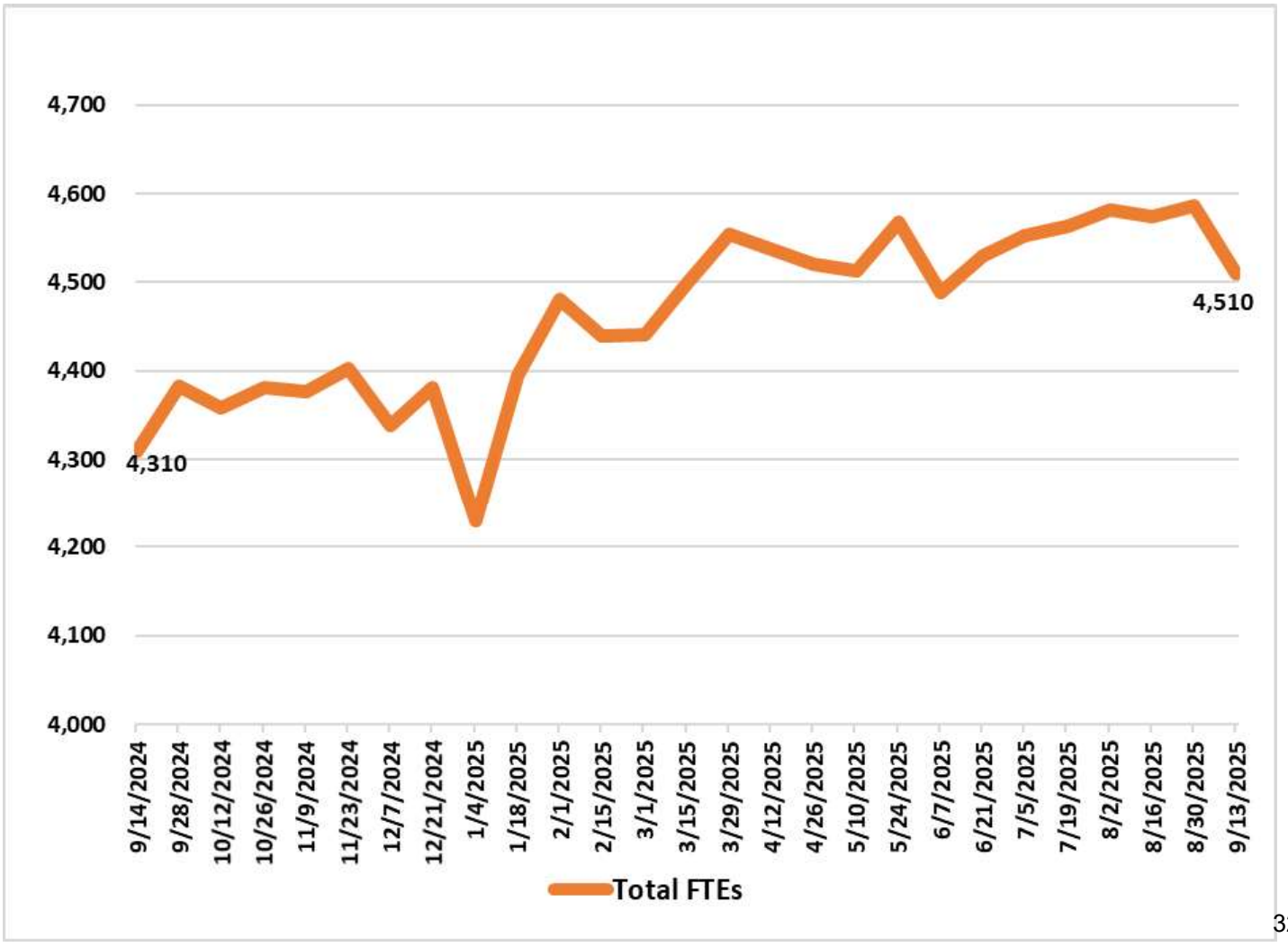
Budget and Actual Fiscal Year 2026: Trended Operating Margin (000's)

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	FY 2026
Patient Service Revenue	$61,895	$53,731	$57,324	$55,188	$56,648	$44,489	$56,501	$53,289	$109,790
Other Revenue	$18,042	$18,979	$21,231	$20,234	$20,167	$35,618	$21,848	$23,904	$45,752
Total Operating Revenue	**$79,938**	**$72,710**	**$78,555**	**$75,422**	**$76,815**	**$80,107**	**$78,349**	**$77,193**	**$155,542**
Employee Expense	$39,859	$38,637	$42,423	$43,595	$46,037	$42,136	$43,550	$42,743	$86,293
Other Operating Expense	$36,630	$33,796	$36,024	$34,988	$38,656	$44,317	$38,484	$36,987	$75,471
Total Operating Expenses	**$76,489**	**$72,433**	**$78,446**	**$78,583**	**$84,693**	**$86,454**	**$82,034**	**$79,730**	**$161,764**
Net Operating Margin	**$3,448**	**$277**	**$109**	**($3,161)**	**($7,878)**	**($6,347)**	**($3,685)**	**($2,537)**	**($6,222)**
Stimulus/FEMA	$0	$0	$690	$0	$0	$0	$0	$0	$0
NonOperating Income	$845	$1,166	$1,313	$1,114	$955	$2,597	$1,059	$1,243	$2,302
Excess Margin	**$4,293**	**$1,443**	**$2,111**	**($2,047)**	**($6,923)**	**($3,749)**	**($2,625)**	**($1,295)**	**($3,920)**
Profitability									
Operating Margin %	**4.3%**	**0.4%**	**0.1%**	**(4.2%)**	**(10.3%)**	**(7.9%)**	**(4.7%)**	**(3.3%)**	**(4.0%)**
Operating Margin %excl. Int	**5.1%**	**1.1%**	**0.9%**	**(3.4%)**	**(9.5%)**	**(7.1%)**	**(4.0%)**	**(2.6%)**	**(3.3%)**
Operating EBIDA	**$7,207**	**$4,052**	**$4,115**	**$920**	**($3,534)**	**($1,857)**	**$104**	**$1,200**	**$1,303**
Operating EBIDA Margin	**9.0%**	**5.6%**	**5.2%**	**1.2%**	**(4.6%)**	**(2.3%)**	**0.1%**	**1.6%**	**0.8%**
Liquidity Indicators									
Day's Cash on Hand	**80.3**	**88.9**	**88.1**	**95.7**	**90.5**	**95.7**	**102.7**	**96.4**	**96.4**
Day's in Accounts Rec.	**70.6**	**73.0**	**68.6**	**63.6**	**71.3**	**68.8**	**72.0**	**71.2**	**71.2**
Debt & Other Indicators									
Debt Service Coverage (MADS)	**3.20**	**3.90**	**4.10**	**4.00**	**3.70**	**4.00**	**0.50**	**0.90**	**0.70**
Discharges (Monthly)	**2,339**	**2,352**	**2,347**	**2,357**	**2,276**	**2,277**	**2,249**	**2,249**	**2,249**
Adj Discharges (Case mix adj)	**8,294**	**8,320**	**8,053**	**8,500**	**8,534**	**8,255**	**8,071**	**8,643**	**16,714**
Adjusted patient Days (Mo.)	**27,924**	**26,332**	**27,682**	**25,868**	**26,409**	**25,593**	**27,564**	**27,906**	**55,470**
Cost/Adj Discharge	**$9.2**	**$8.7**	**$9.7**	**$9.2**	**$9.9**	**$10.5**	**$10.2**	**$9.2**	**$9.7**
Compensation Ratio	**64%**	**72%**	**74%**	**79%**	**81%**	**95%**	**77%**	**80%**	**79%**

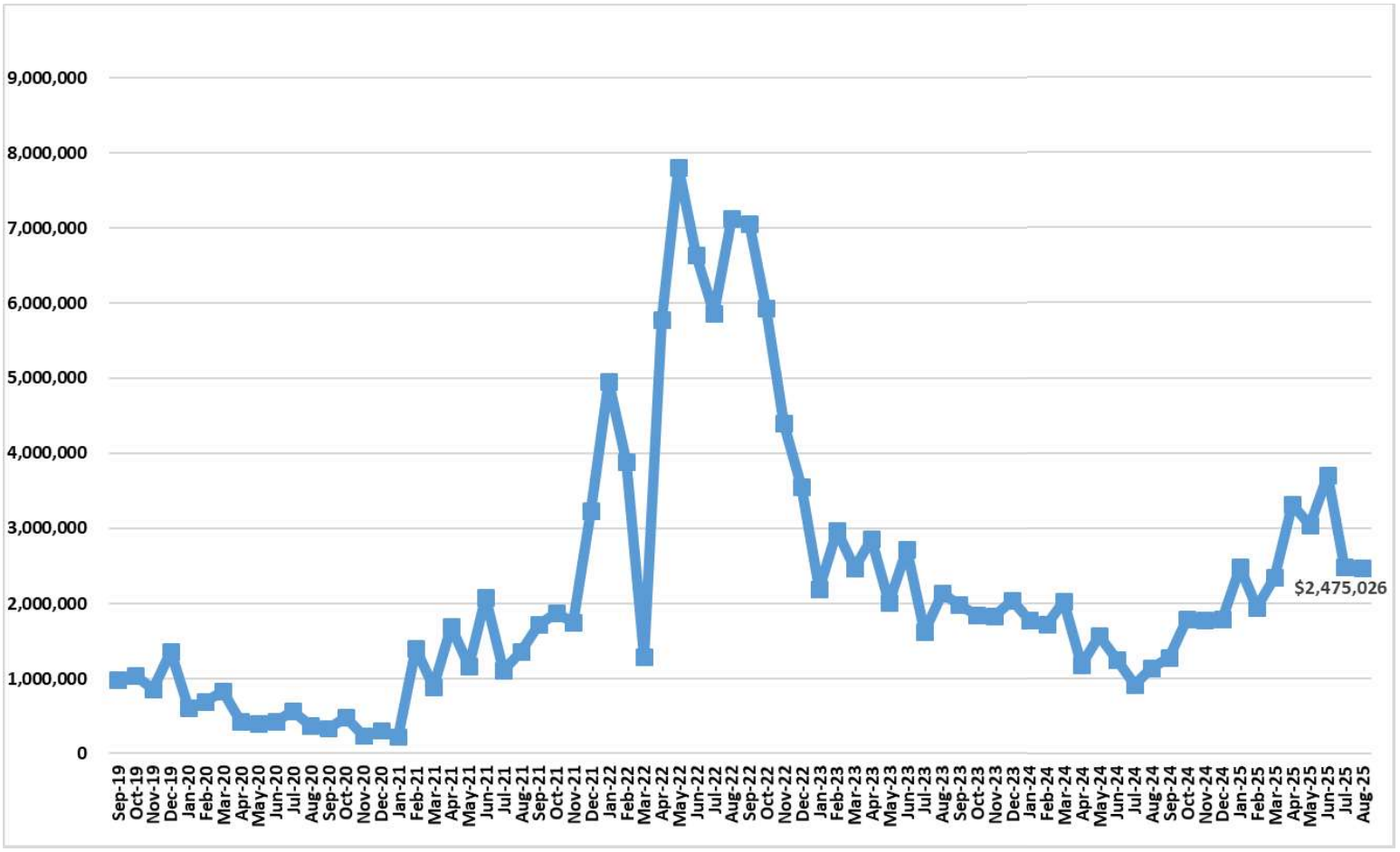
Biweekly Payroll Costs excluding Contract Labor



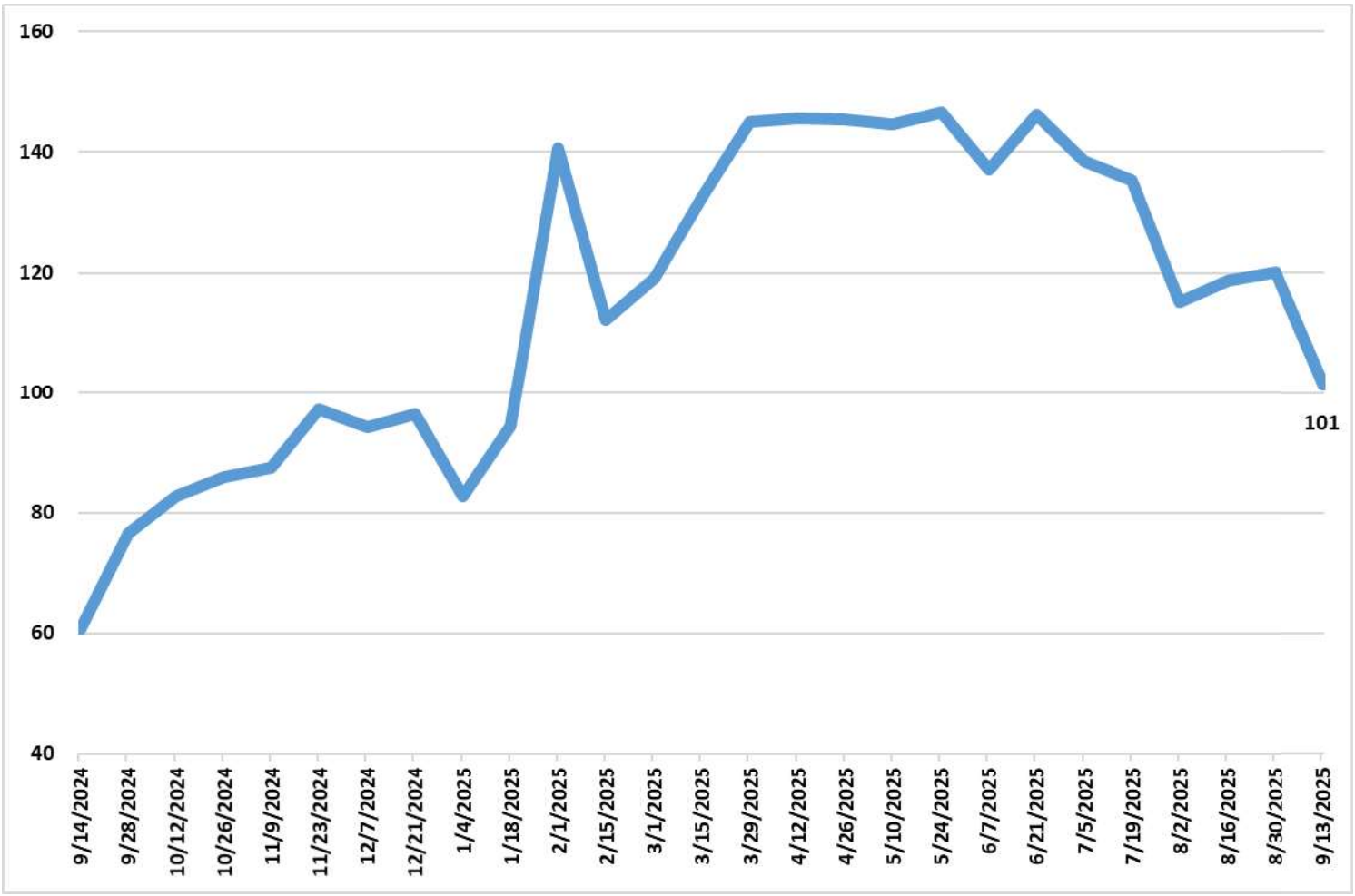
Total FTEs (includes Contract Labor)



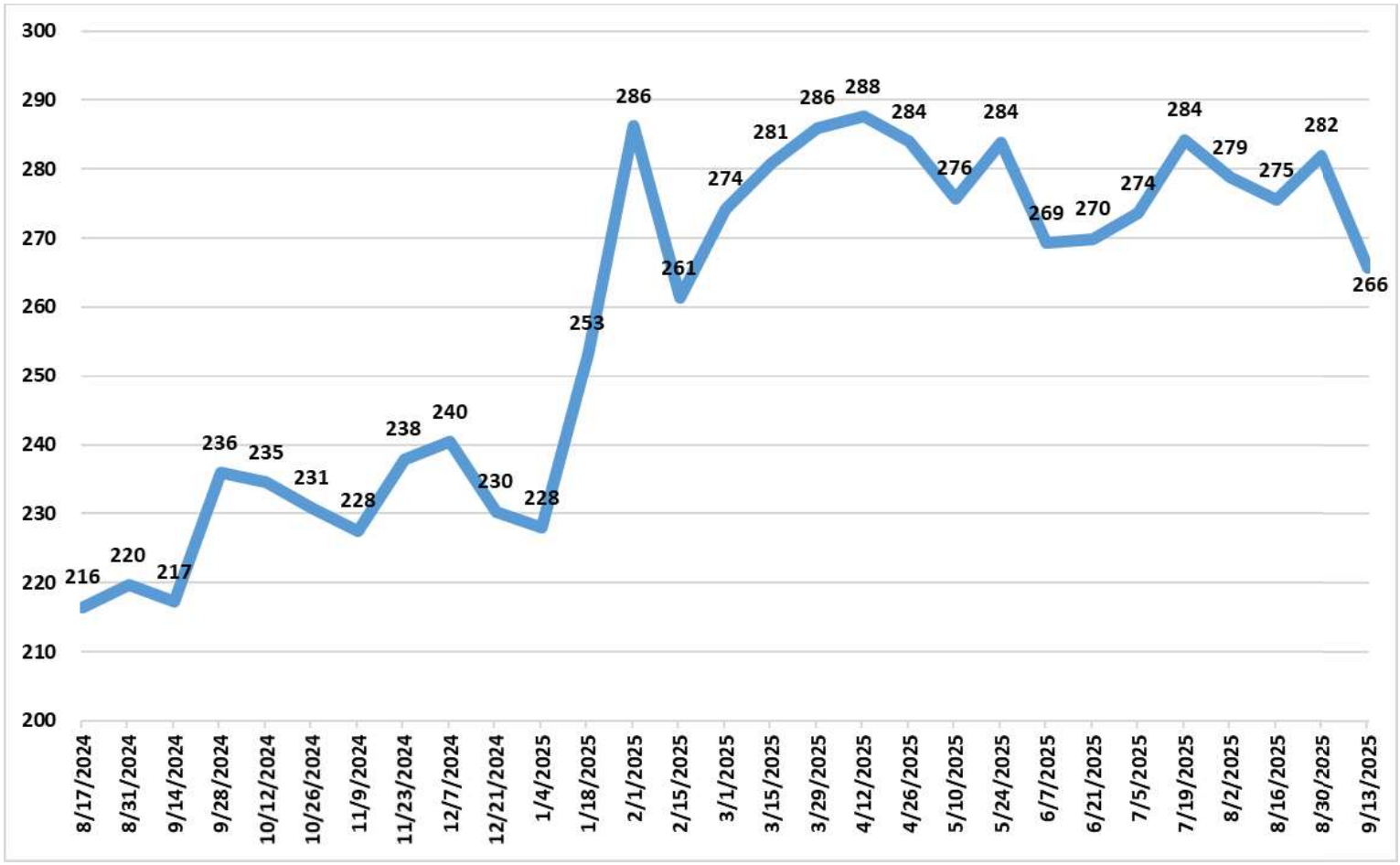
Monthly Contract Labor Costs



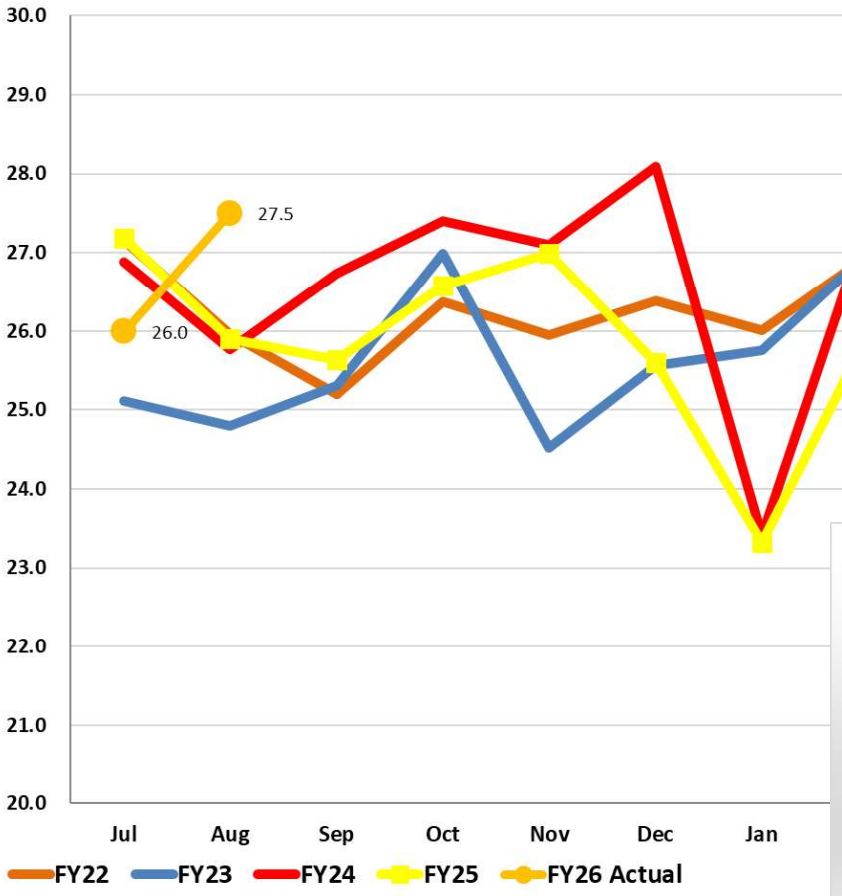
Contract Labor Full Time Equivalents (FTEs)

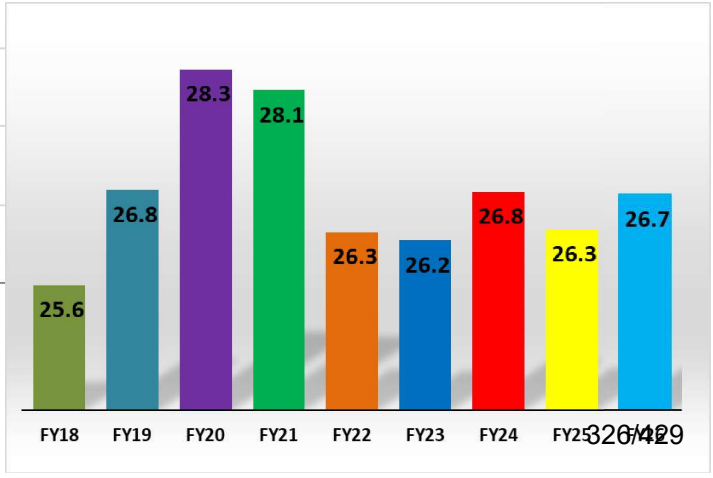


Emergency Department FTEs: Includes Contract

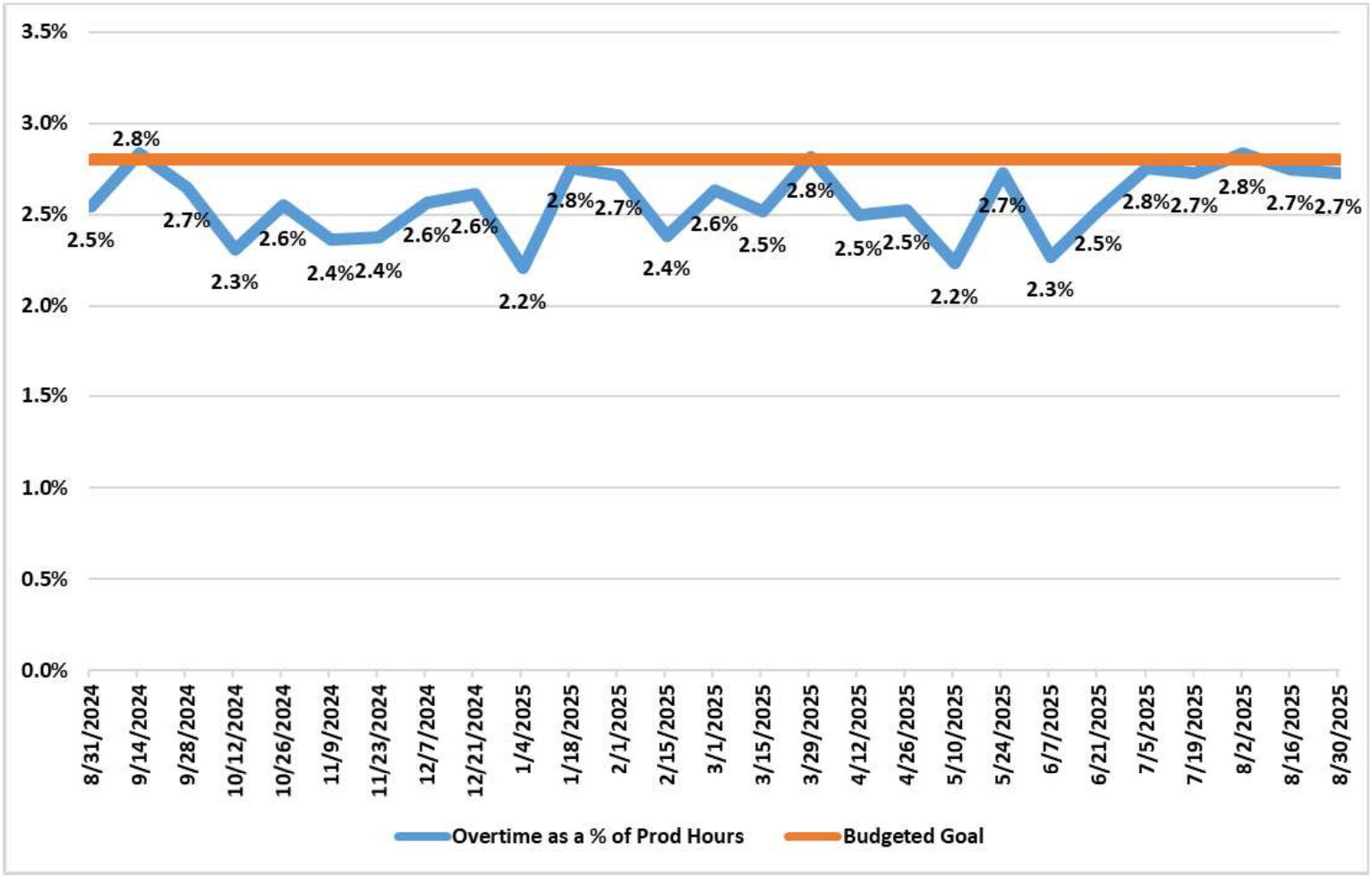


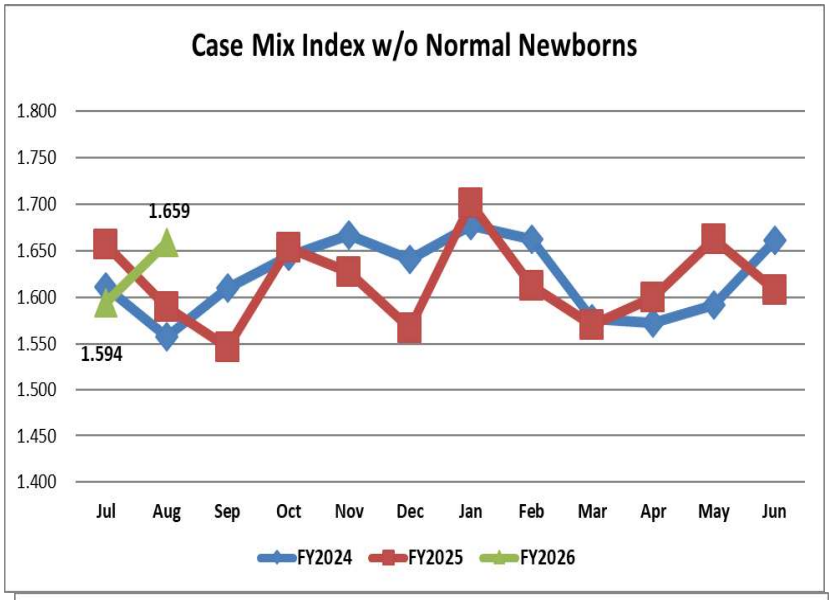
Productivity Measure : Worked Hours/ Adj. Patient Days

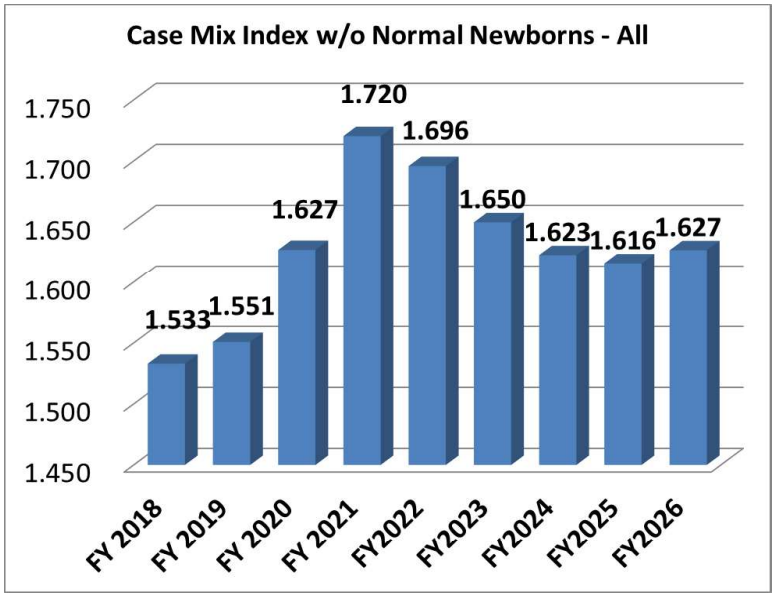


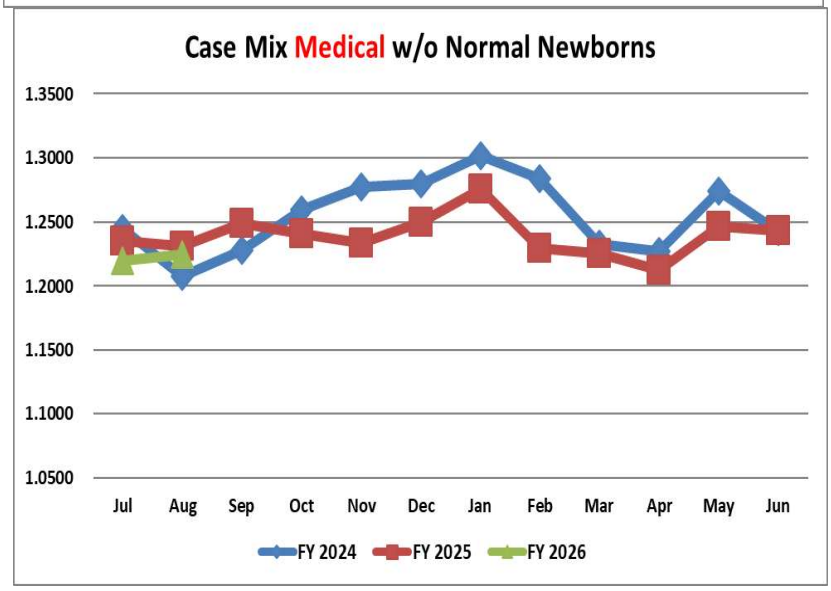


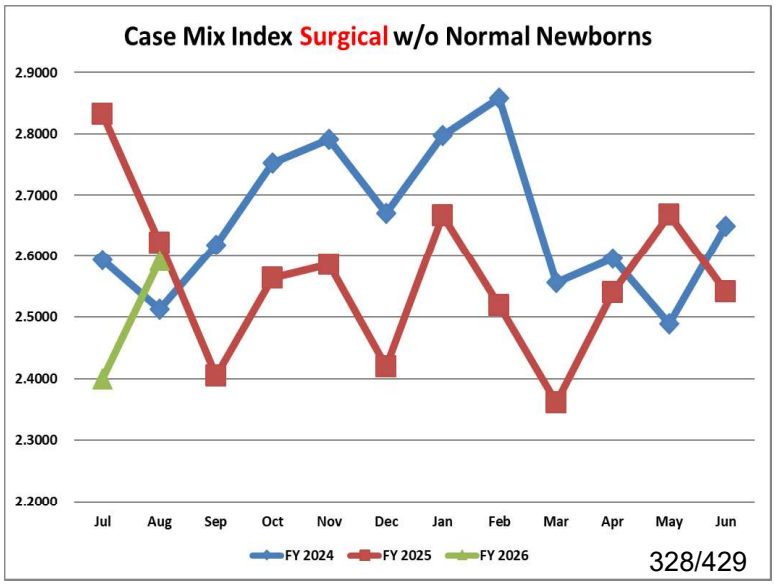
Overtime as a % of Productive Hours



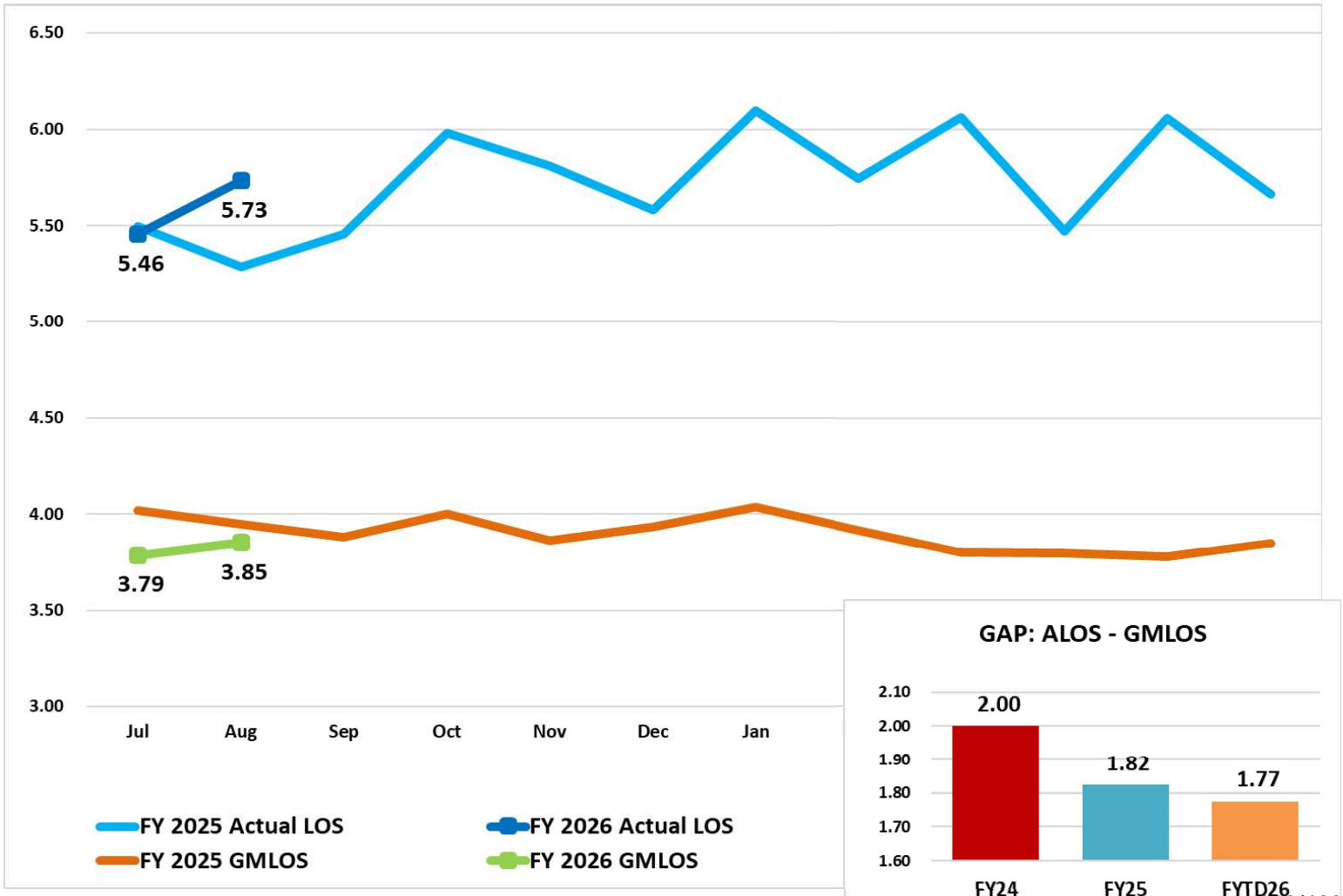

Case Mix Index w/o Normal Newborns
1.800
1.750
1.700
1.650
1.600
1.550
1.500
1.450
1.400
1.659
1.594
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY2024
FY2025
FY2026


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
1.627
FY 2018
FY 2019
FY 2020
FY 2021
FY2022
FY2023
FY2024
FY2025
FY2026

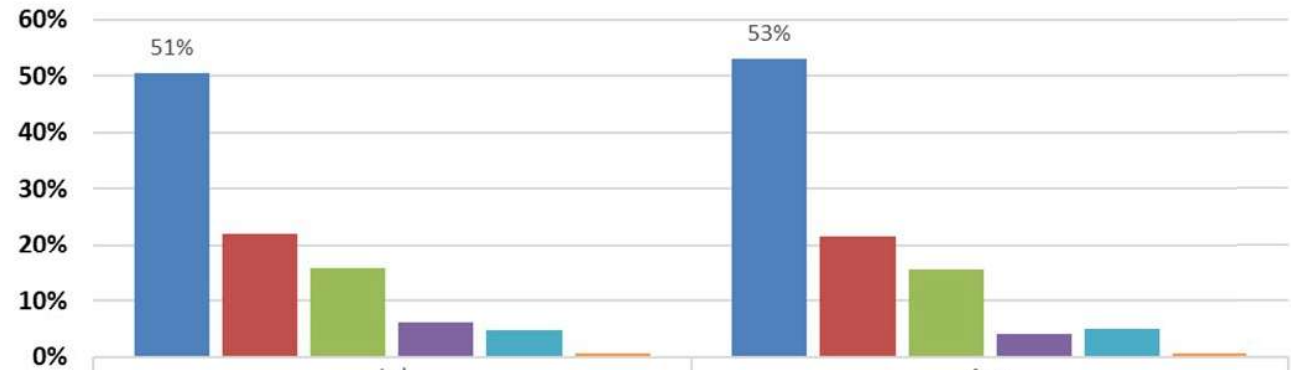

Case Mix Medical w/o Normal Newborns
1.3500
1.3000
1.2500
1.2000
1.1500
1.1000
1.0500
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY 2024
FY 2025
FY 2026


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)

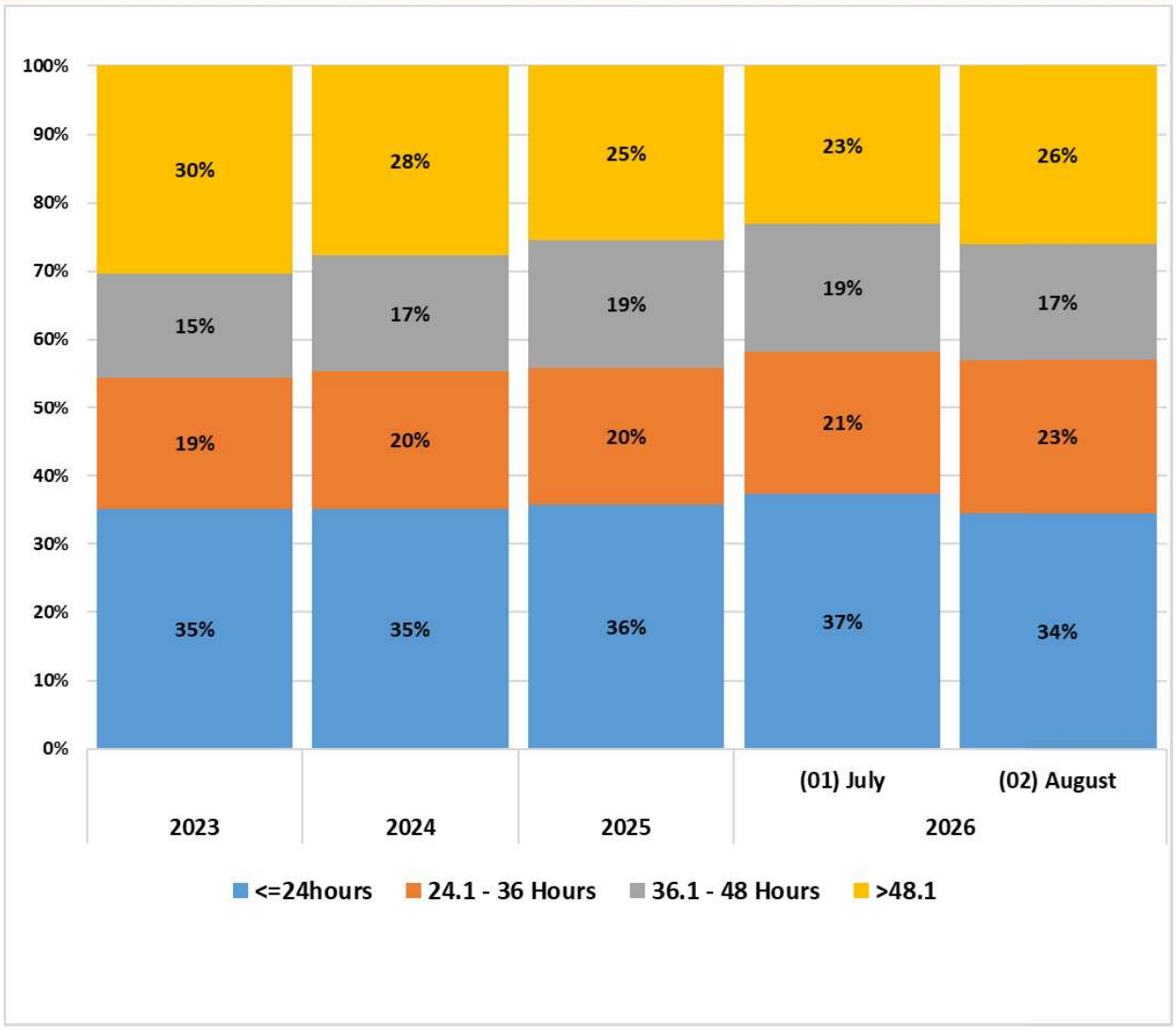


Length of Stay Distribution

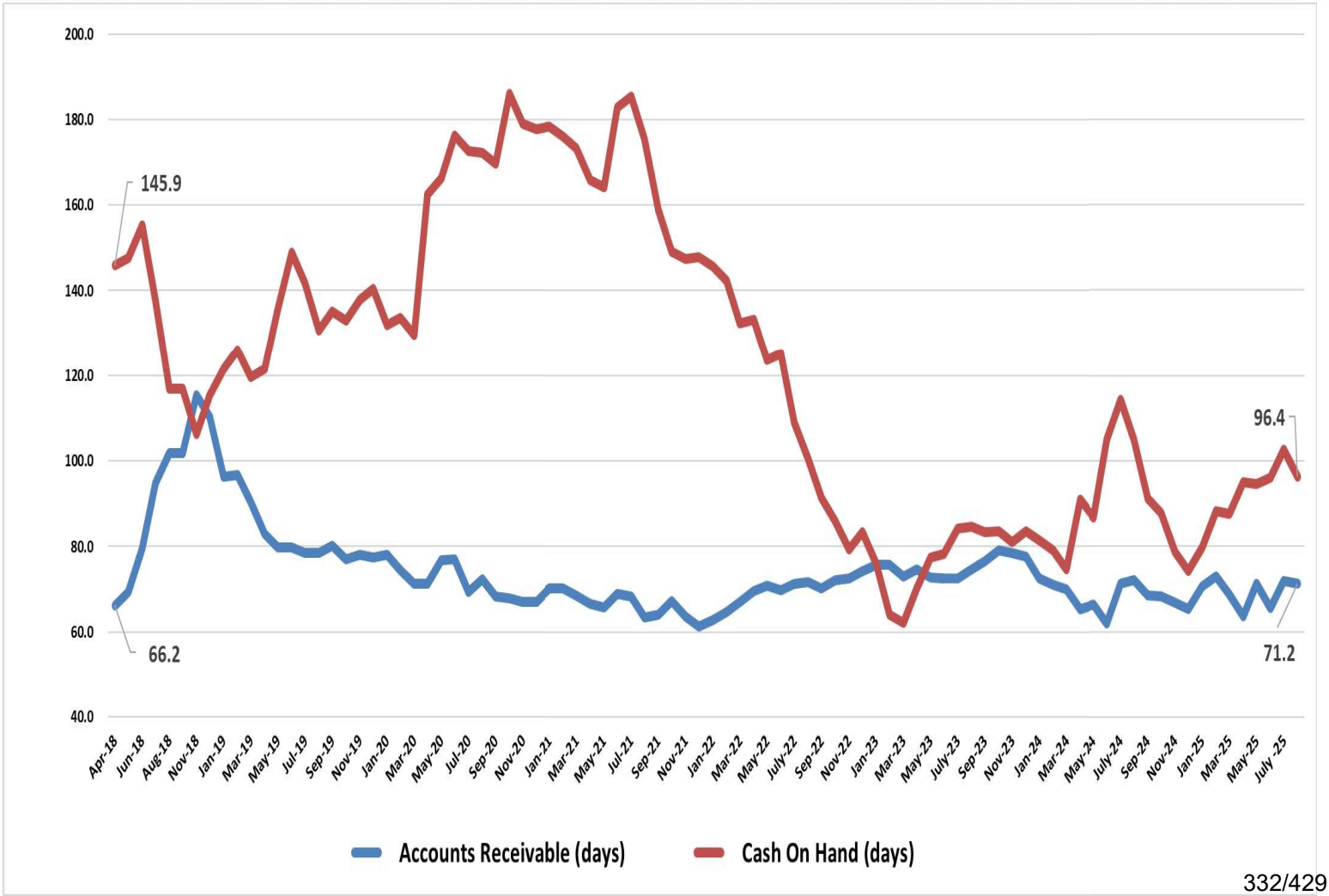


	Jul	Aug
at GMLOS or Better	51%	53%
1-2 days over GMLOS	22%	22%
2-6 days over GMLOS	16%	16%
6-10 days over GMLOS	6%	4%
10-30 days over GMLOS	5%	5%
30+ days over GMLOS	0.6%	0.7%

Monthly Discharges of Observation Patients by their Length of Stay



Trended Liquidity Ratios



Ratio Analysis Report

AUGUST 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)	2.5	2.6	2.5	1.7	**1.8**	1.7
Accounts Receivable (days)	71.2	72.0	72.2	47.8	**47.7**	47.8
Cash On Hand (days)	96.4	102.7	95.2	273.9	**188.4**	134.1
Cushion Ratio (x)	11.3	12.2	10.9	44.7	**24.2**	16.6
Average Payment Period (days)	48.6	50.3	53.9	70.9	**62.7**	64.0
CAPITAL STRUCTURE RATIOS						
Cash-to-Debt	119.0%	128.7%	114.9%	271.7%	**164.5%**	131.0%
Debt-To-Capitalization	31.4%	31.3%	31.1%	22.5%	**31.1%**	35.0%
Debt-to-Cash Flow (x)	10.7	17.7	2.6	2.4	**3.6**	6.9
Debt Service Coverage	1.1	0.7	4.6	6.7	**4.5**	2.1
Maximum Annual Debt Service Coverage (x)	0.9	0.5	3.6	6.8	**3.8**	1.9
Age Of Plant (years)	14.5	14.4	13.6	11.1	**12.8**	13.9
PROFITABILITY RATIOS						
Operating Margin	(4.0%)	(4.7%)	(3.6%)	2.1%	**0.5%**	(2.3%)
Excess Margin	(2.5%)	(3.3%)	3.4%	5.5%	**2.7%**	(.9%)
Operating Cash Flow Margin	0.8%	0.1%	1.6%	6.7%	**5.5%**	3.0%
Return on Assets	(2.6%)	(3.5%)	3.6%	3.9%	**2.4%**	(.7%)

Consolidated Statements of Net Position (000's)

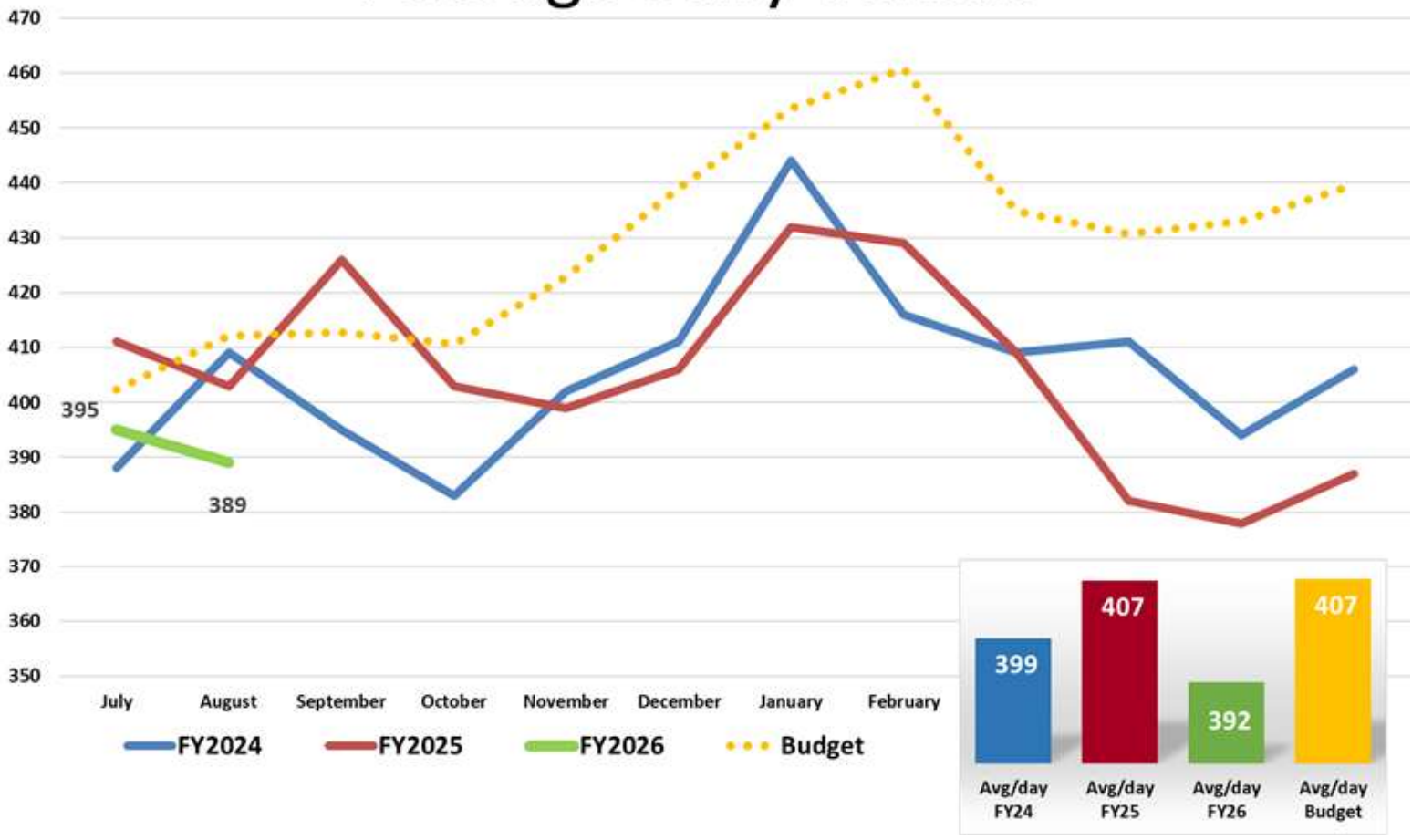
	Aug-25	Jun-25
		(Unaudited)
ASSETS AND DEFERRED OUTFLOWS		
CURRENT ASSETS		
Cash and cash equivalents	$ 2,248	$ 6,595
Current Portion of Board designated and trusted assets	19,106	$ 17,533
Accounts receivable:		$ -
Net patient accounts	147,397	$ 154,634
Other receivables	31,329	$ 70,335
	178,726	224,969
Inventories	14,400	$ 13,871
Medicare and Medi-Cal settlements	73,594	$ 62,463
Prepaid expenses	13,189	$ 8,234
Total current assets	301,264	333,666
NON-CURRENT CASH AND INVESTMENTS -		
less current portion		
Board designated cash and assets	230,610	$ 218,025
Revenue bond assets held in trust	23,093	$ 22,950
Assets in self-insurance trust fund	612	$ 626
Total non-current cash and investments	254,315	241,602
INTANGIBLE RIGHT TO USE LEASE, net of accumulated amortization	15,835	$ 15,613
INTANGIBLE RIGHT TO USE SBITA, net of accumulated amortization	7,416	$ 8,062
CAPITAL ASSETS		
Land	17,542	$ 17,542
Buildings and improvements	438,040	$ 437,184
Equipment	341,103	$ 340,593
Construction in progress	22,458	$ 18,729
	819,144	814,048
Less accumulated depreciation	546,532	$ 541,607
	272,612	272,441
OTHER ASSETS		
Property not used in operations	5,148	$ 5,155
Health-related investments	1,829	$ 2,147
Other	21,131	$ 20,922
Total other assets	28,108	28,224
Total assets	879,550	899,608
DEFERRED OUTFLOWS	12,912	$ 13,133
Total assets and deferred outflows	**$ 892,462**	**$ 912,741**

Consolidated Statements of Net Position (000's)

	Aug-25	Jun-25
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accounts payable and accrued expenses	$ 31,821	$ 43,963
Accrued payroll and related liabilities	70,548	$ 71,620
SBITA liability, current portion	2,912	$ 3,031
Lease liabiilty, current portion	3,396	$ 3,204
Bonds payable, current portion	13,184	$ 13,014
Notes payable, current portion	-	$ -
Total current liabilities	121,860	134,831
LEASE LIABILITY, net of current portion	12,900	$ 12,850
SBITA LIABILITY, net of current portion	3,040	$ 3,941
LONG-TERM DEBT, less current portion		
Bonds payable	199,056	$ 201,619
Notes payable	20,750	$ 20,750
Total long-term debt	219,806	222,369
NET PENSION LIABILITY	15,629	$ 16,169
OTHER LONG-TERM LIABILITIES	45,726	$ 45,297
Total liabilities	418,962	435,457
NET ASSETS		
Invested in capital assets, net of related debt	60,372	$ 60,147
Restricted	61,235	$ 58,980
Unrestricted	351,893	$ 358,158
Total net position	473,500	$ 477,285
Total liabilities and net position	**$ 892,463**	**$ 912,742**

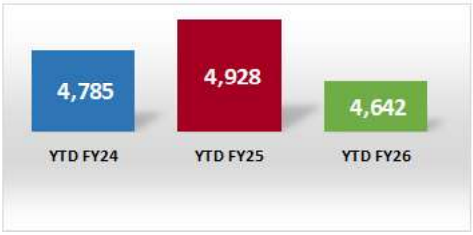
Statistical Report
August 2025

Average Daily Census



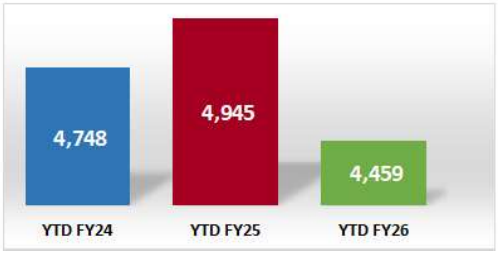
Admissions

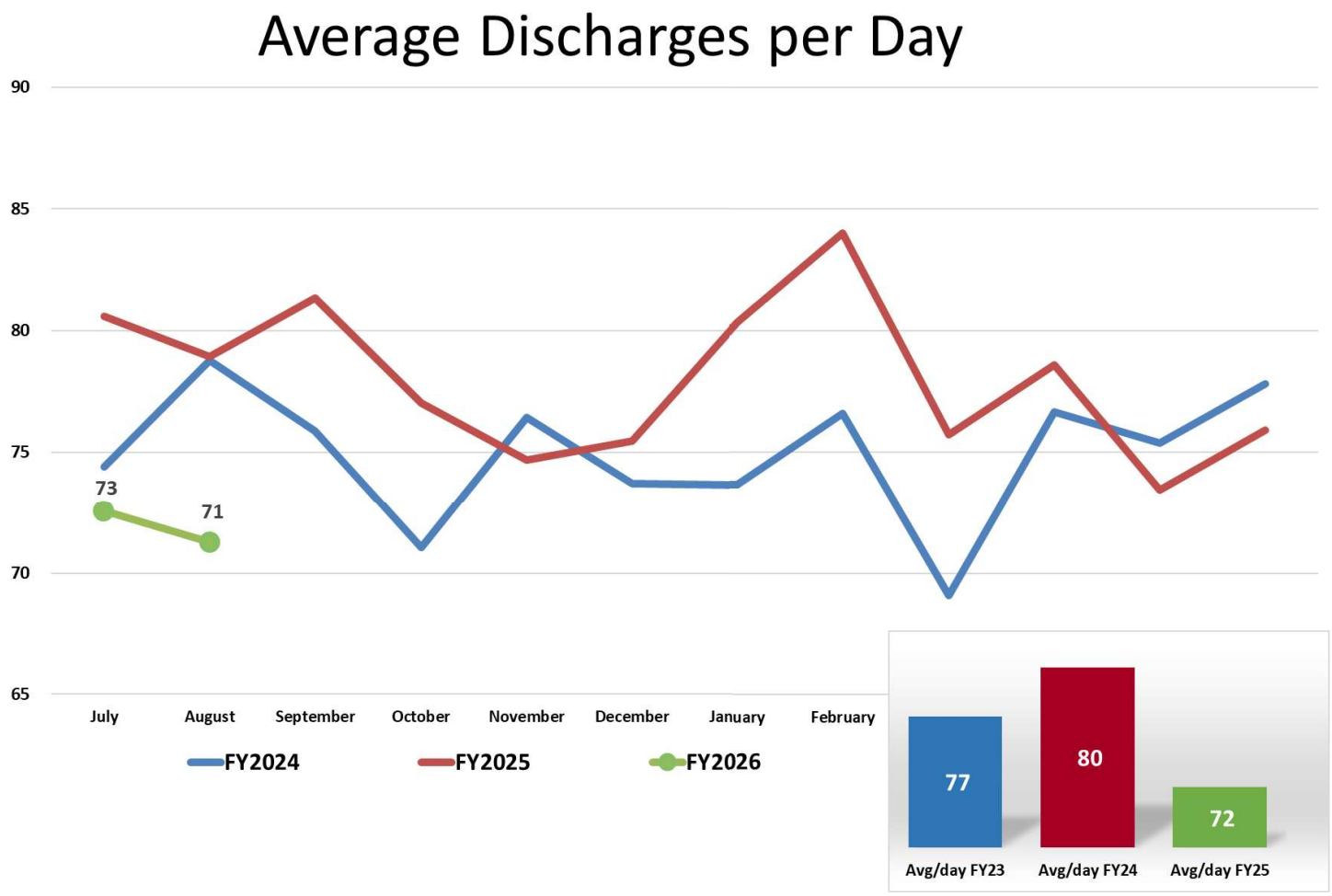

2,600
2,550
2,500
2,450
2,400
2,350
2,300
2,250
2,200
2,150
2,100
2,050
2,000
1,950
1,900
2,391
2,251
July
August
September
October
November
December
January
February
March
April
May
June
FY2024
FY2025
FY2026


4,785
4,928
4,642
YTD FY24
YTD FY25
YTD FY26

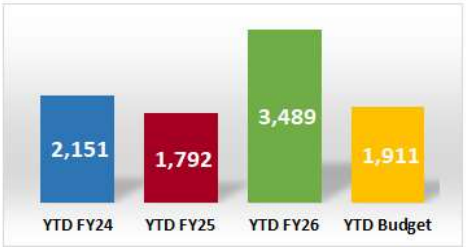
Discharges


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
2,210
July
August
September
October
November
December
January
February
March
April
May
June
FY2024
FY2025
FY2026

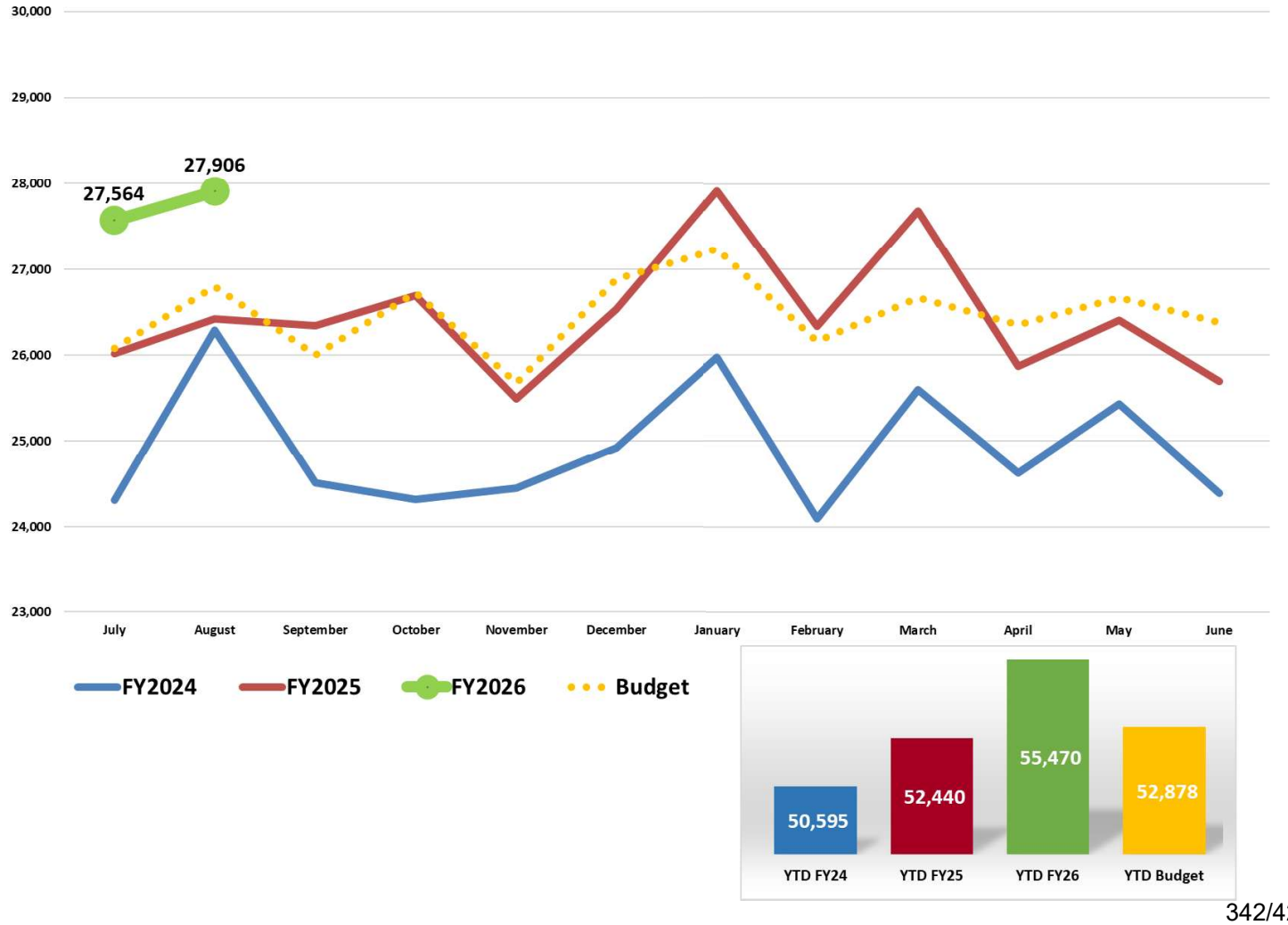

4,748
4,945
4,459
YTD FY24
YTD FY25
YTD FY26


Average Discharges per Day
90
85
80
75
70
65
73
71
July
August
September
October
November
December
January
February
FY2024
FY2025
FY2026
77
80
72
Avg/day FY23
Avg/day FY24
Avg/day FY25

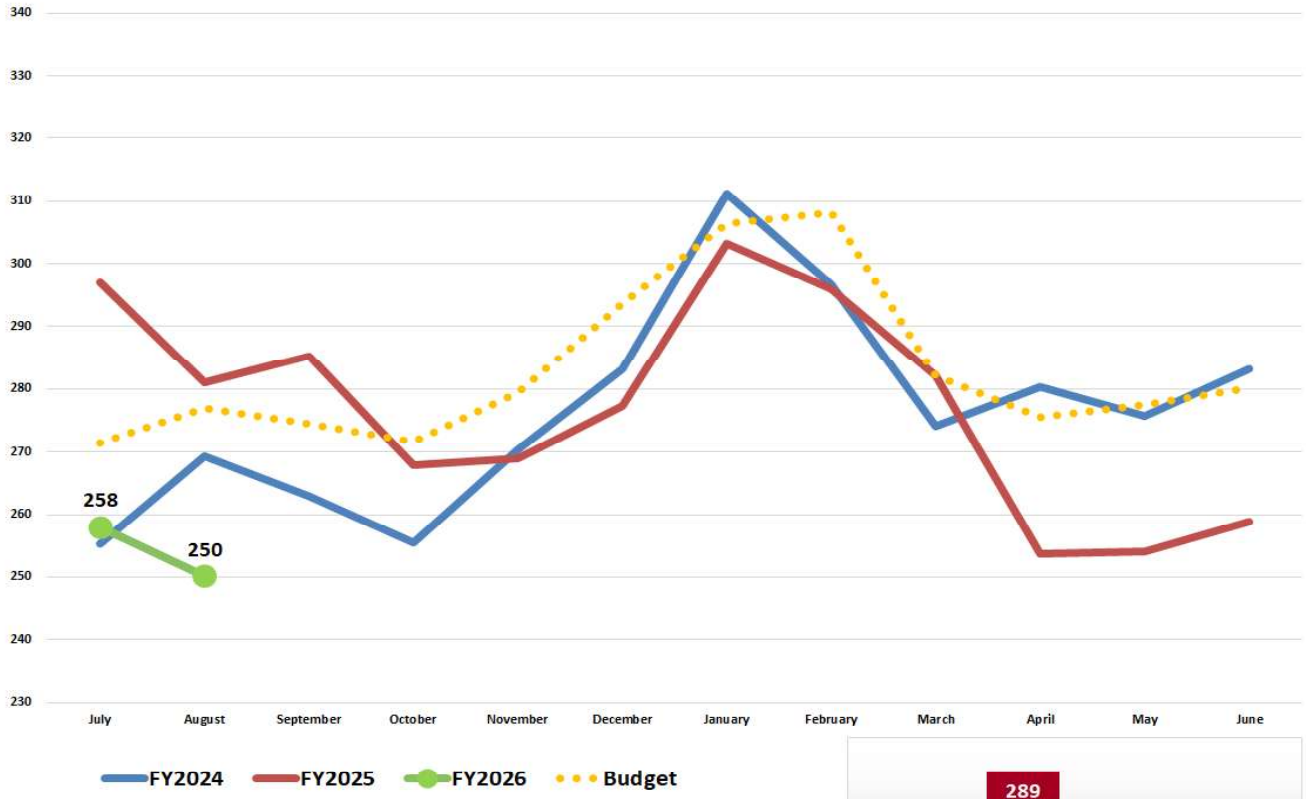
Observation Days

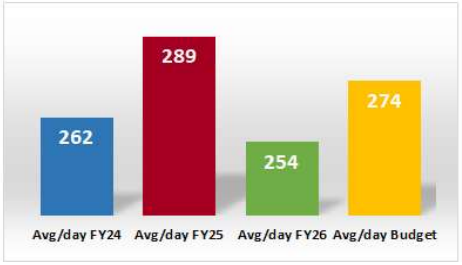


Adjusted Patient Days

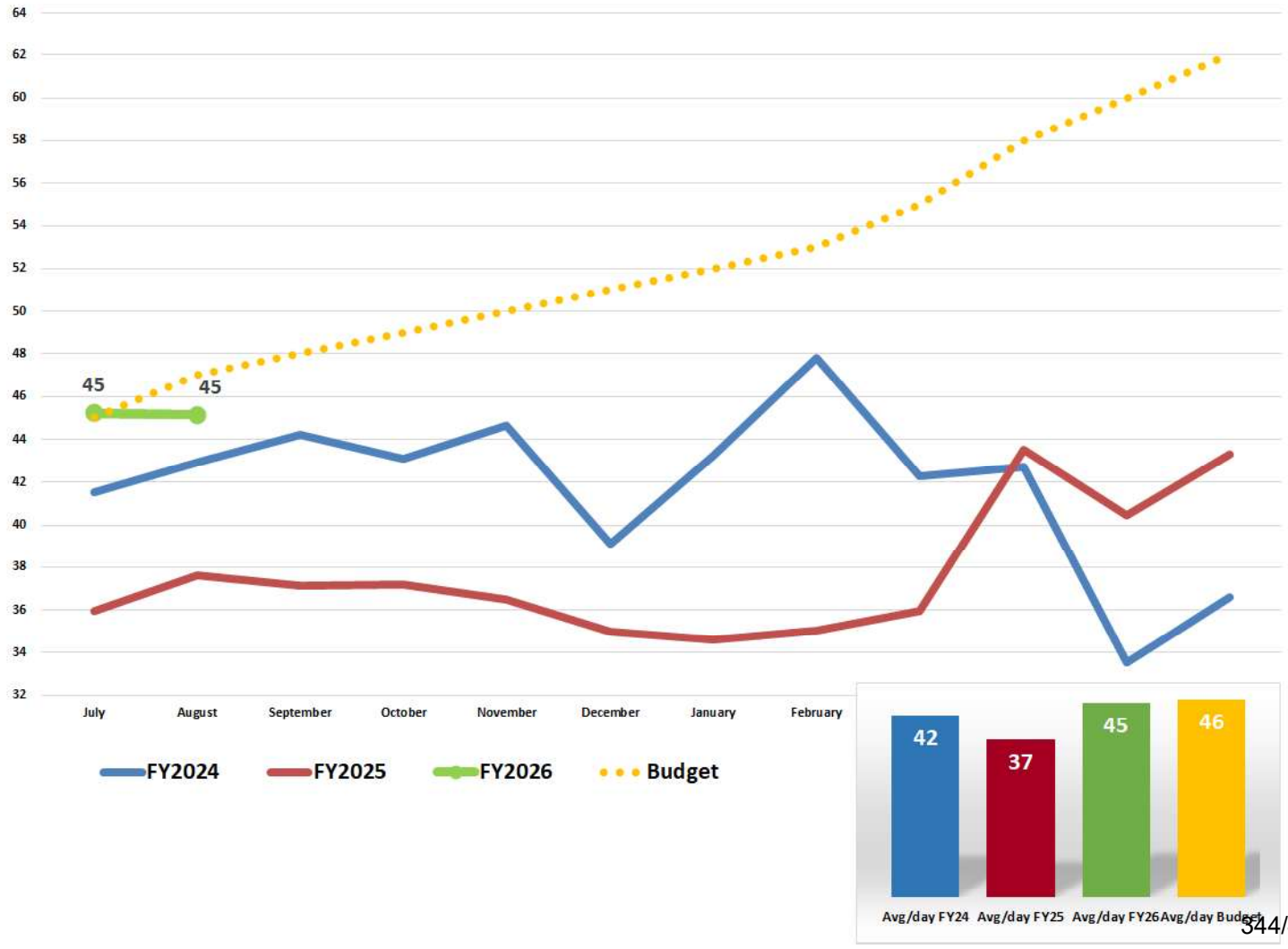


Medical Center (Avg Patients Per Day)

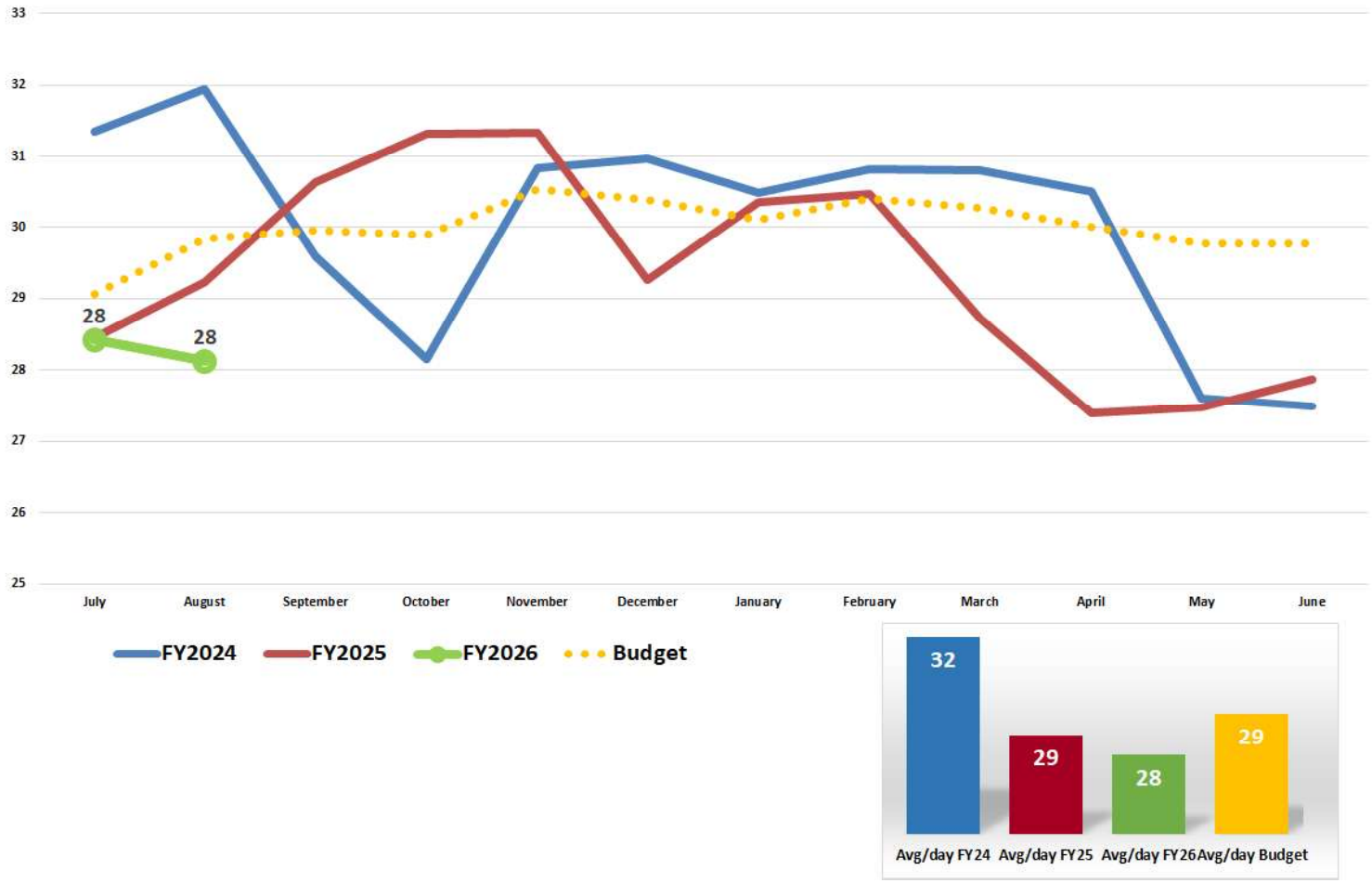




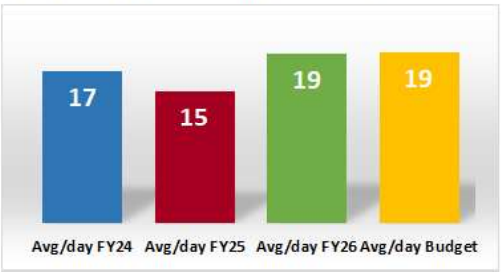
Acute I/P Psych (Avg Patients Per Day)



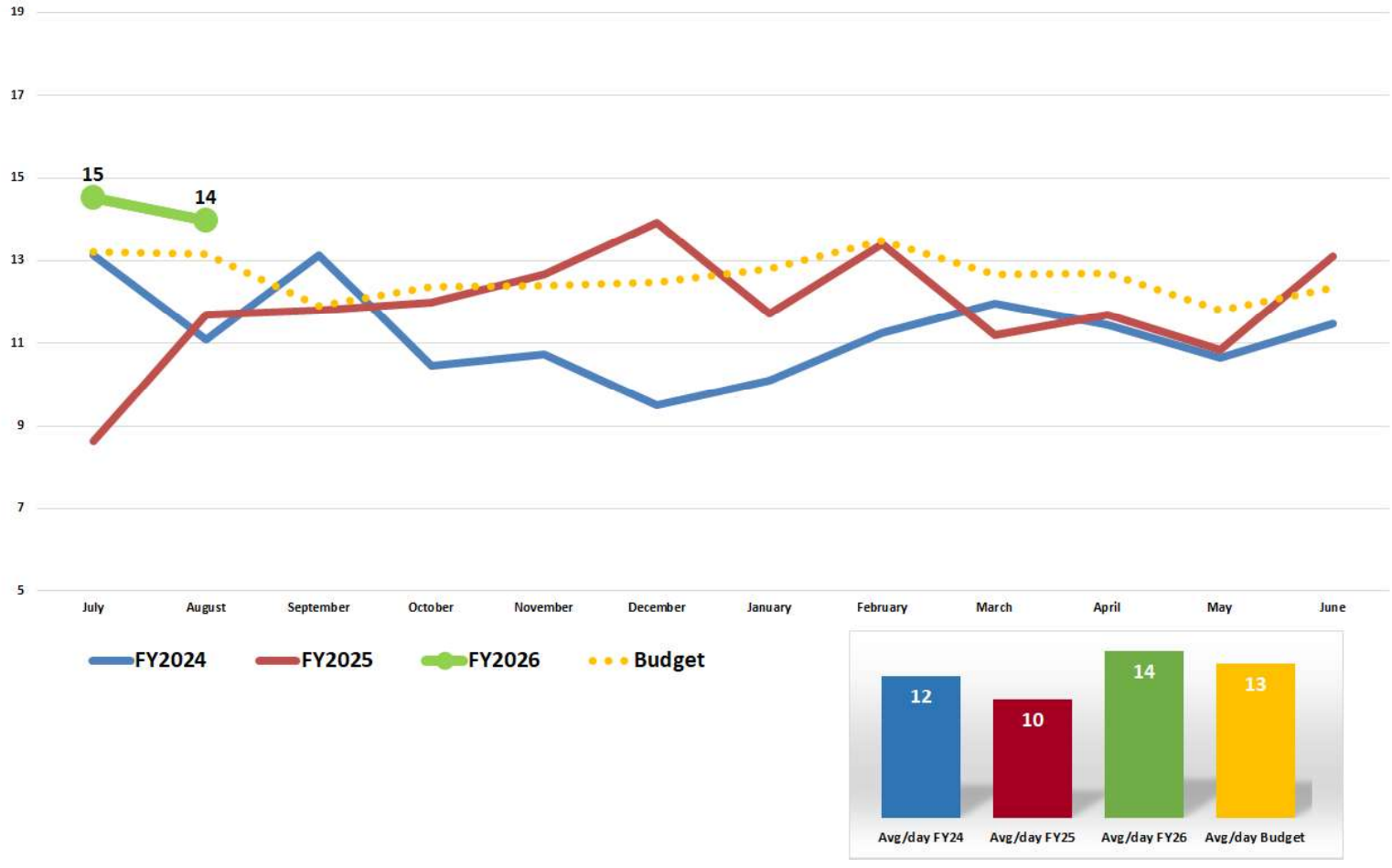
Sub-Acute - Avg Patients Per Day



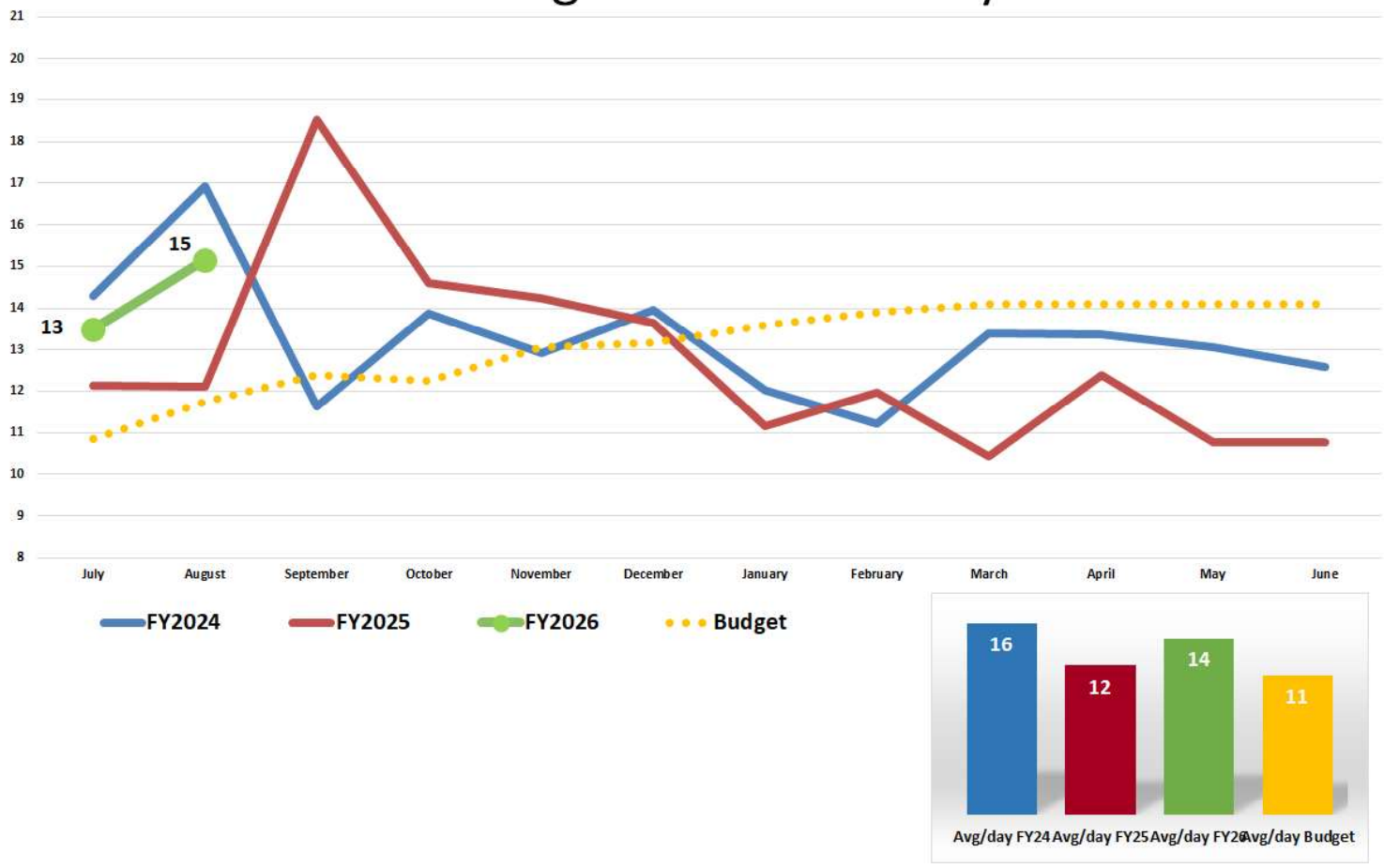
Rehabilitation Hospital - Avg Patients Per Day



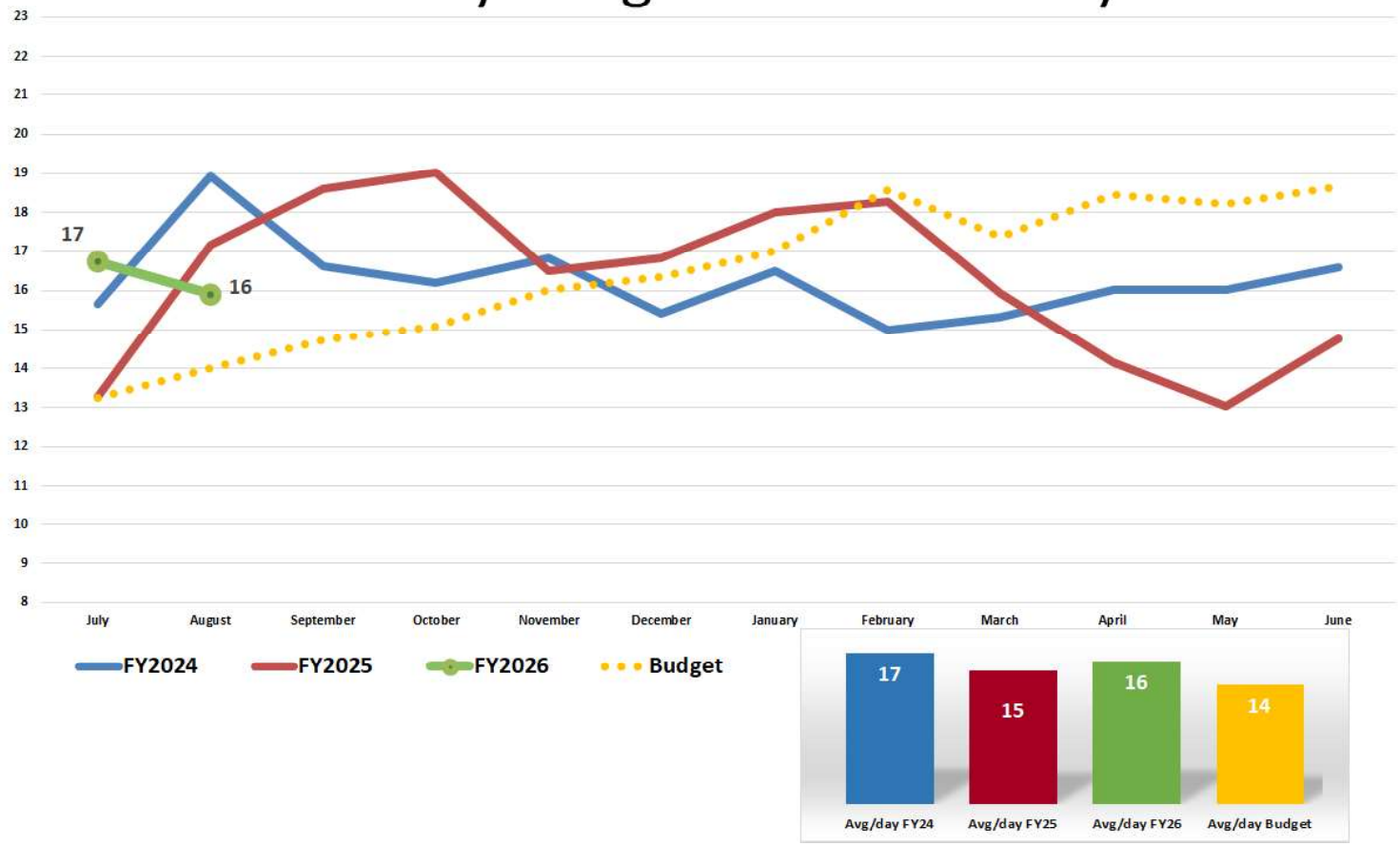
TCS Ortho - Avg Patients Per Day



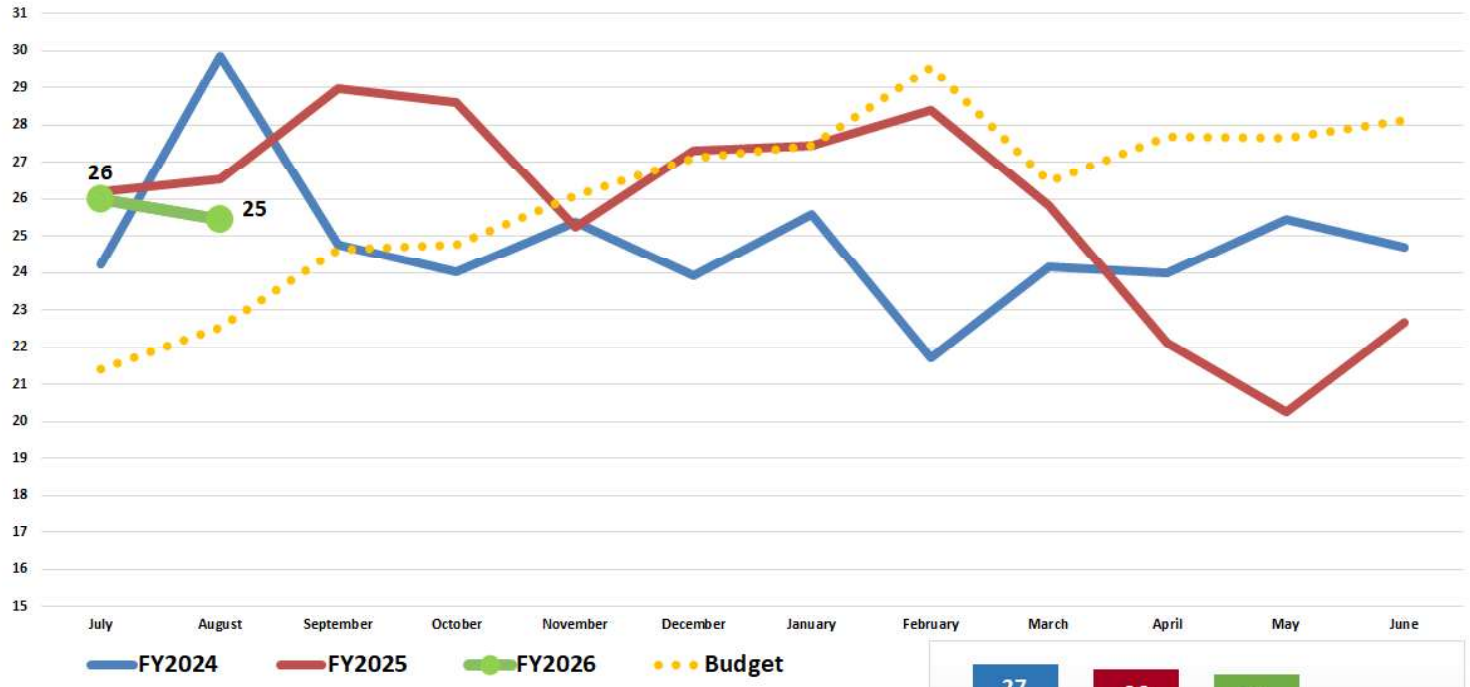
NICU - Avg Patients Per Day

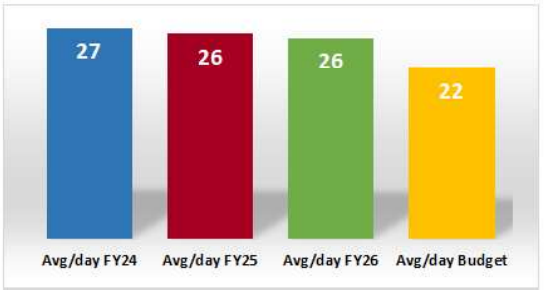


Nursery - Avg Patients Per Day

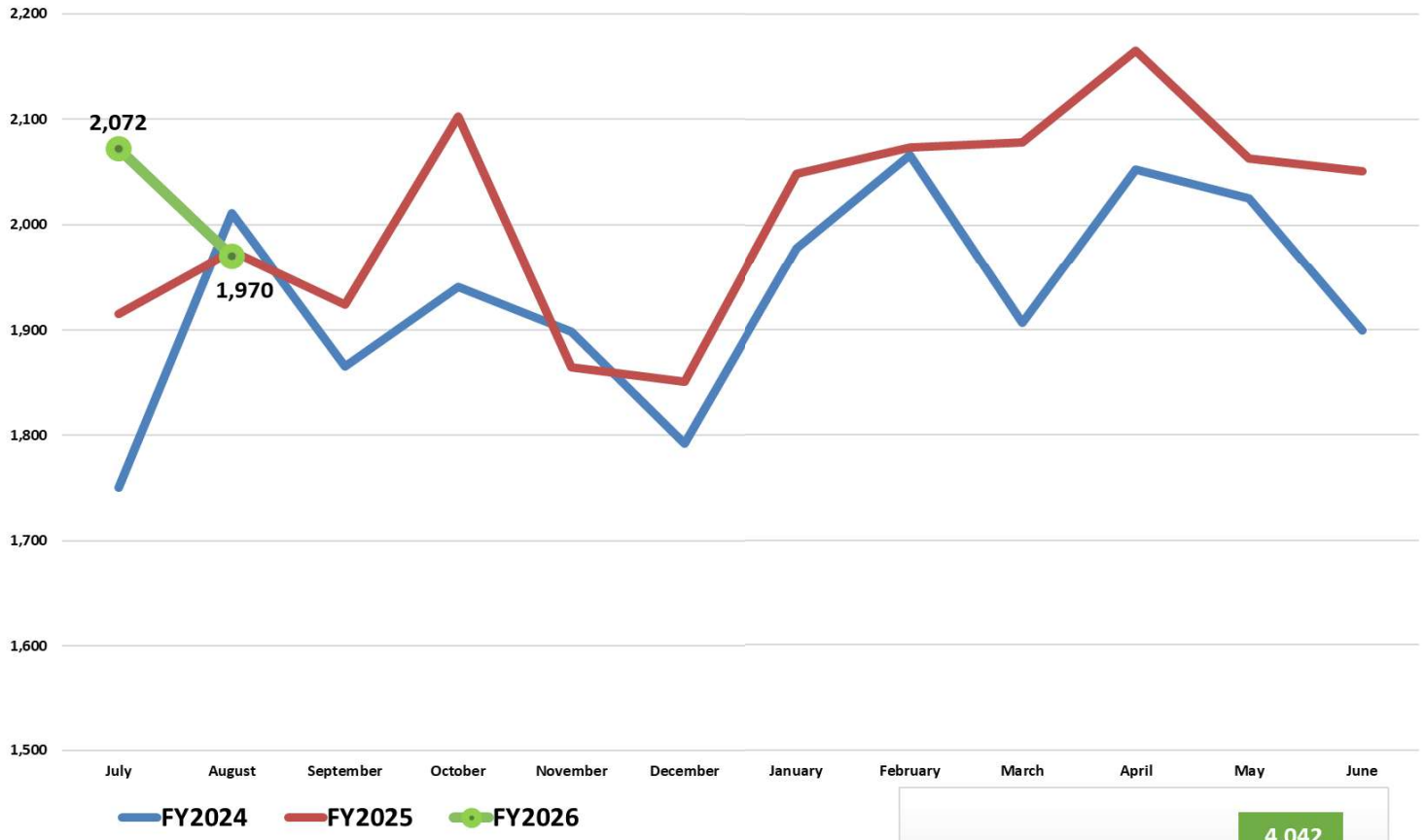


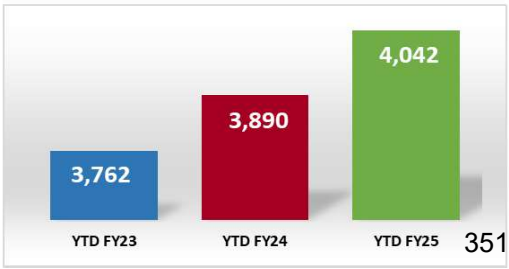
Obstetrics - Avg Patients Per Day

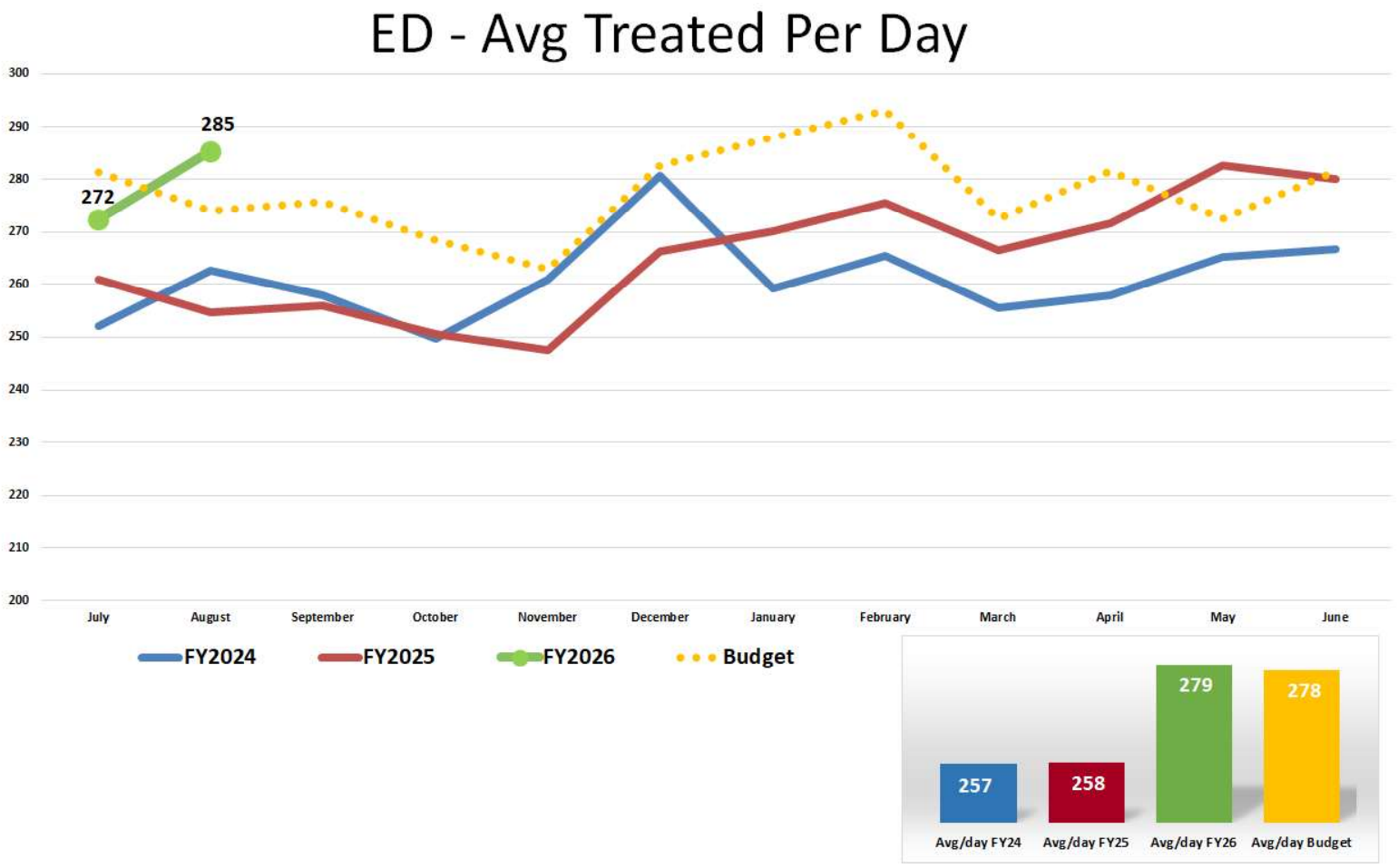




Outpatient Registrations Per Day

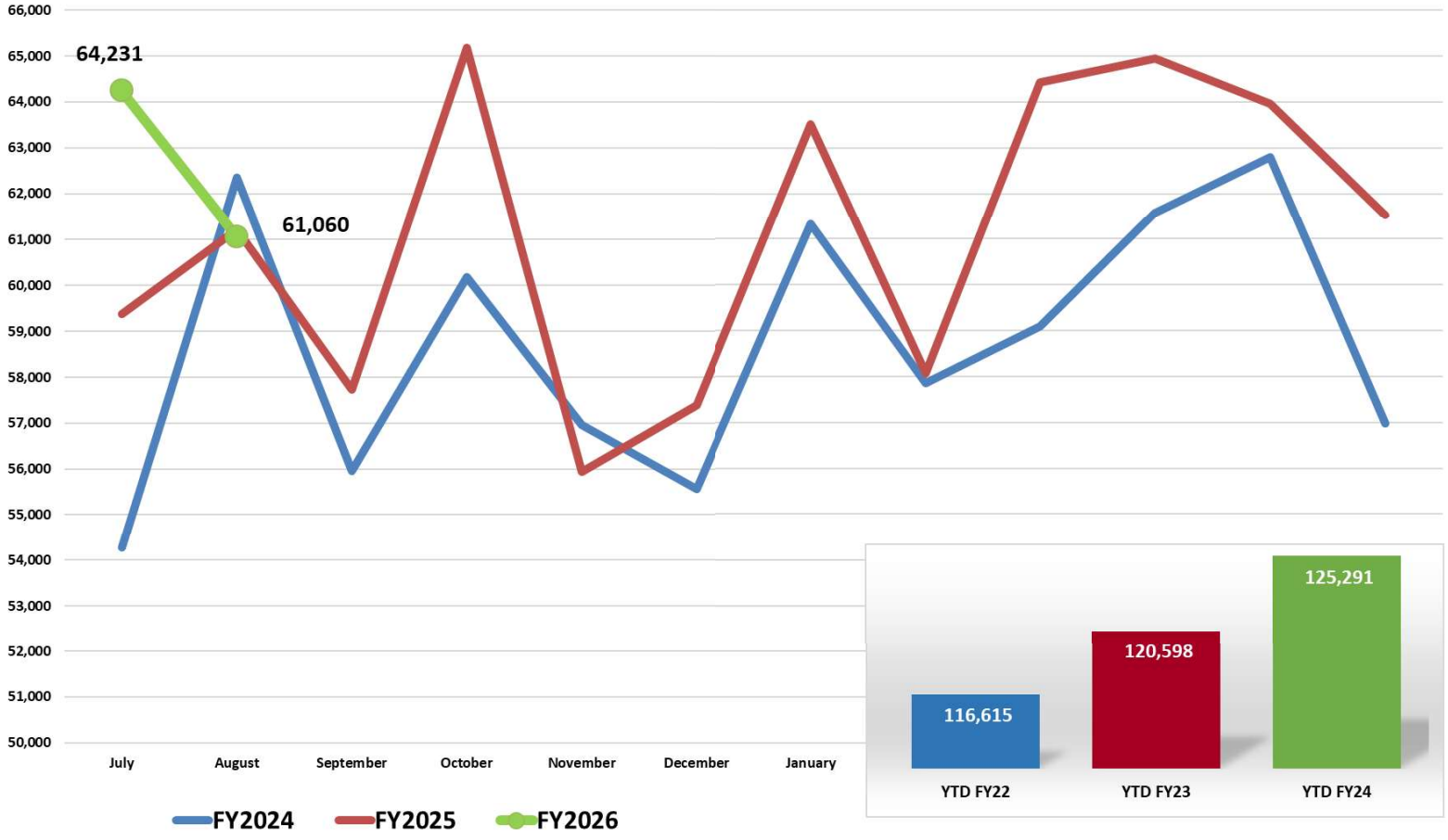




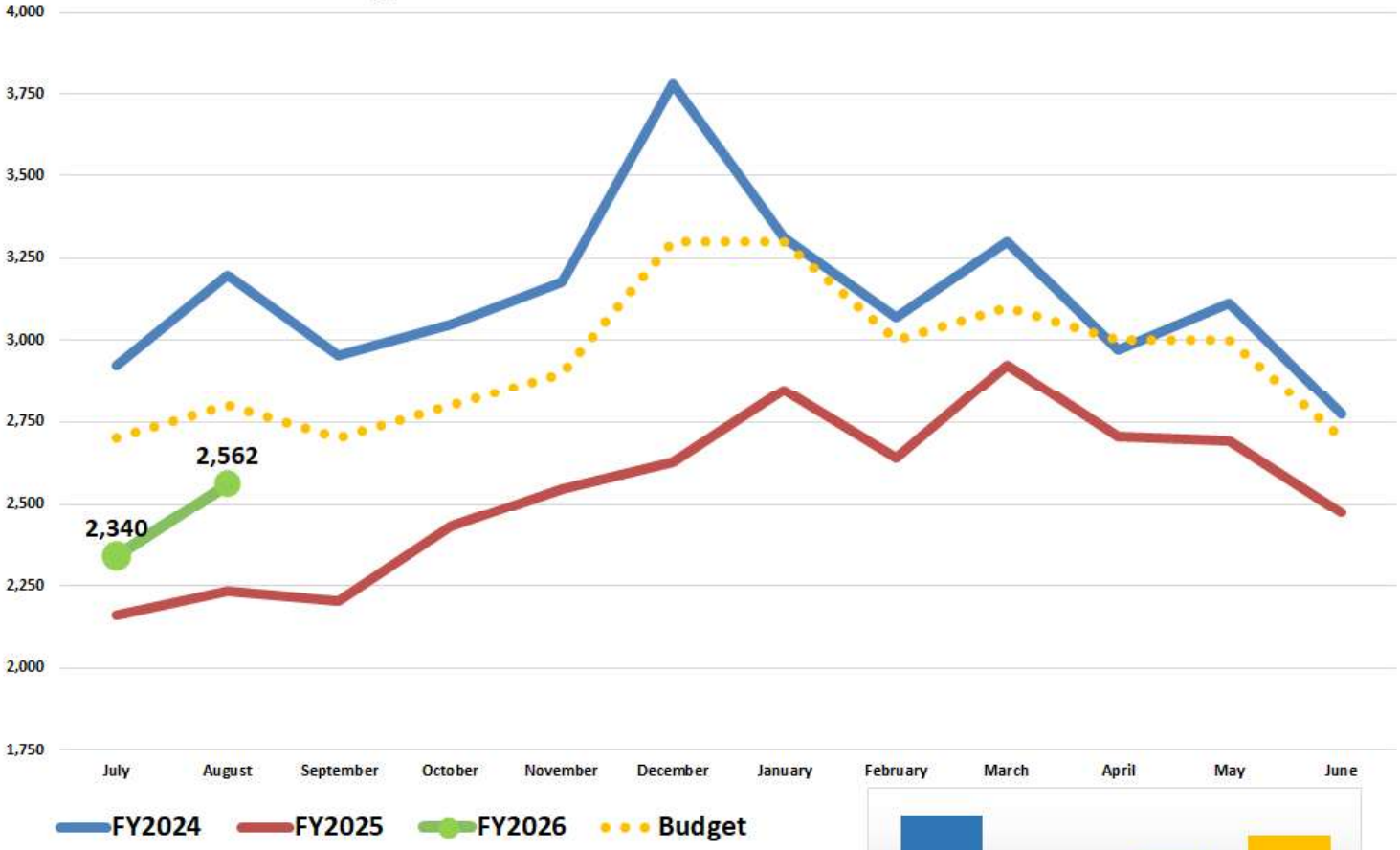

ED - Avg Treated Per Day
300
290
280
270
260
250
240
230
220
210
200
285
272
July
August
September
October
November
December
January
February
March
April
May
June
FY2024
FY2025
FY2026
Budget

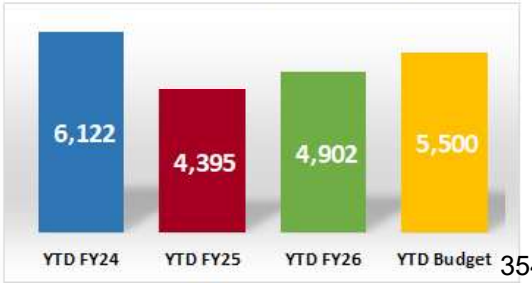
257
258
279
278
Avg/day FY24
Avg/day FY25
Avg/day FY26
Avg/day Budget

Outpatient Registrations

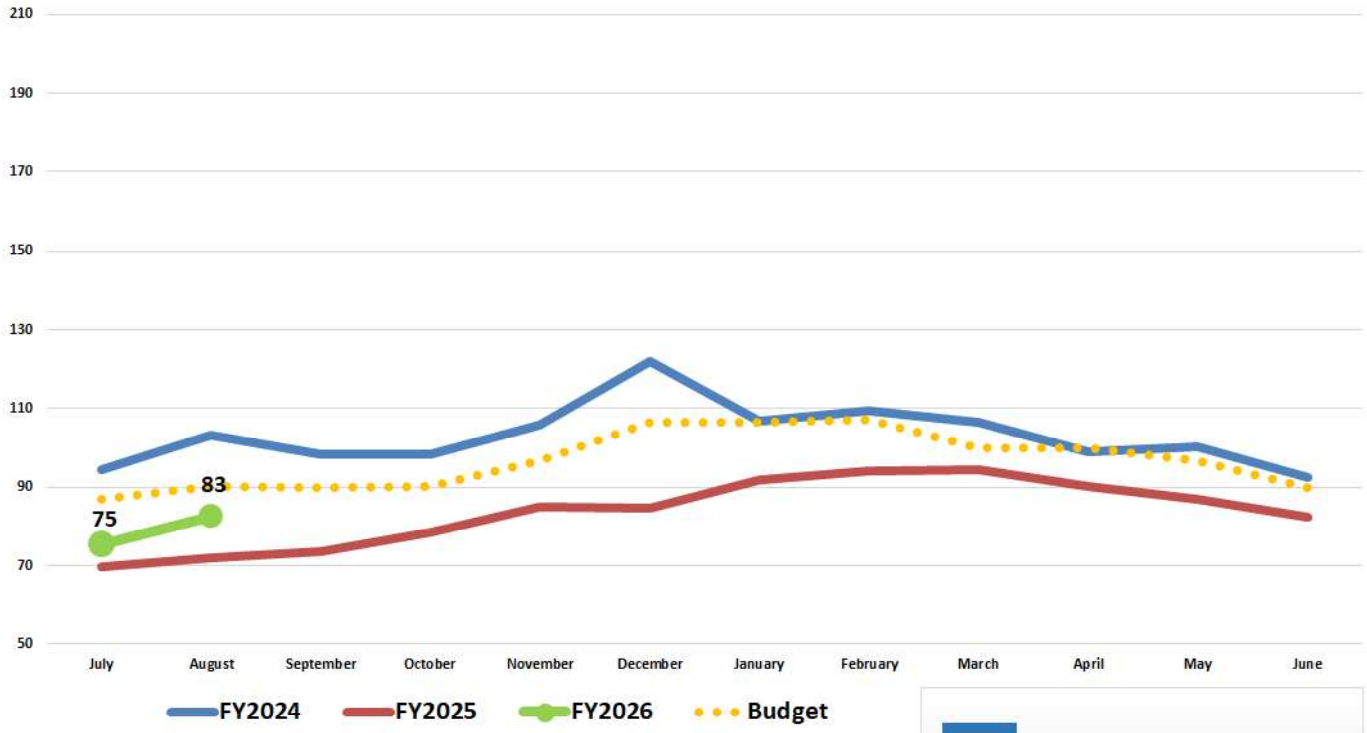


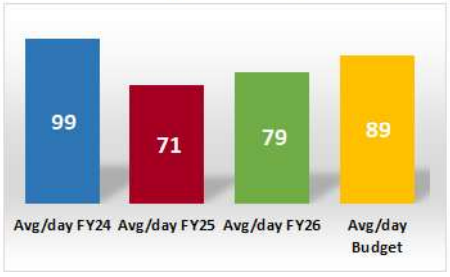
Urgent Care – Court Total Visits



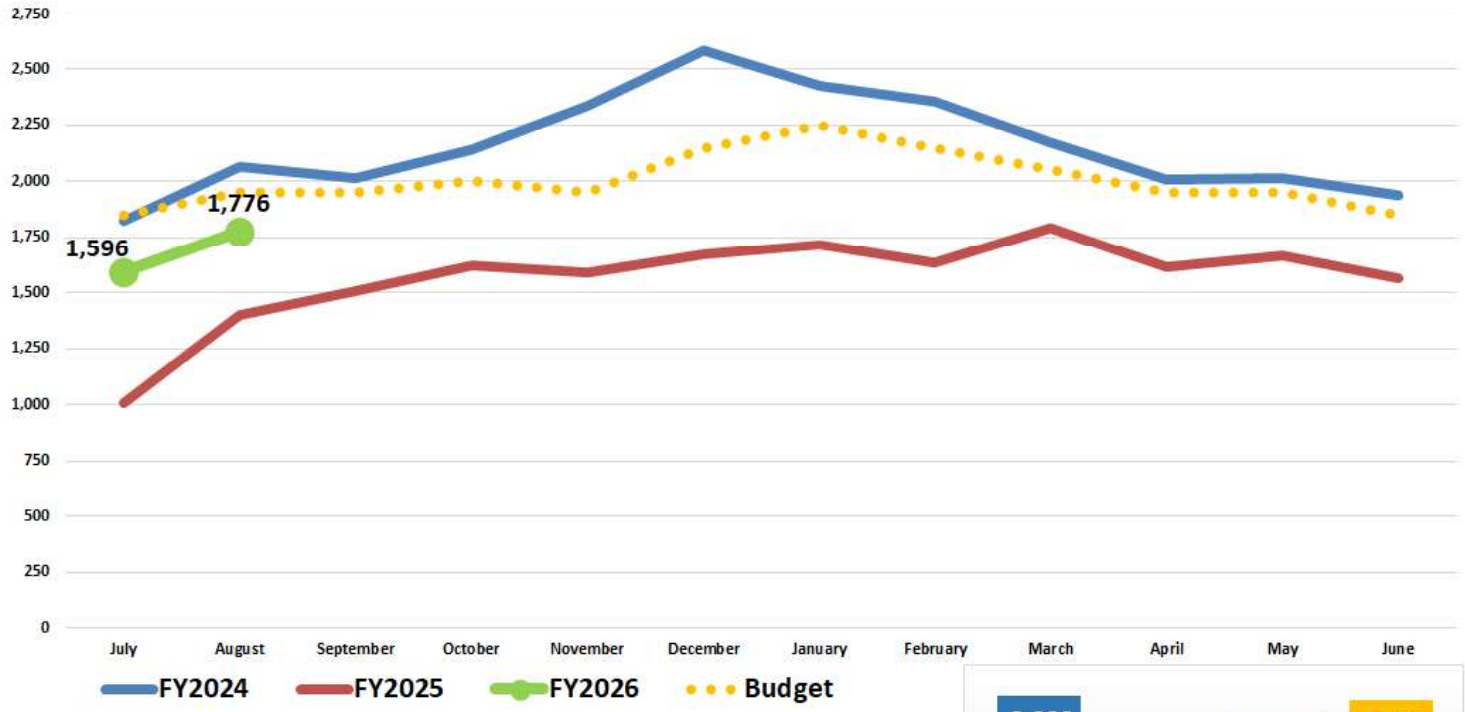


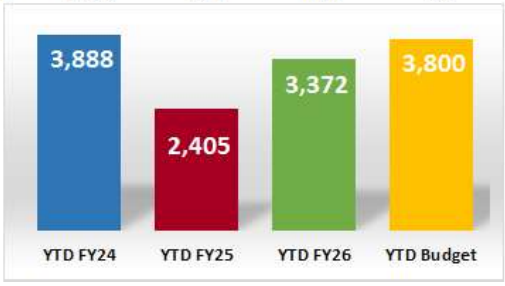
Urgent Care – Court Avg Visits Per Day



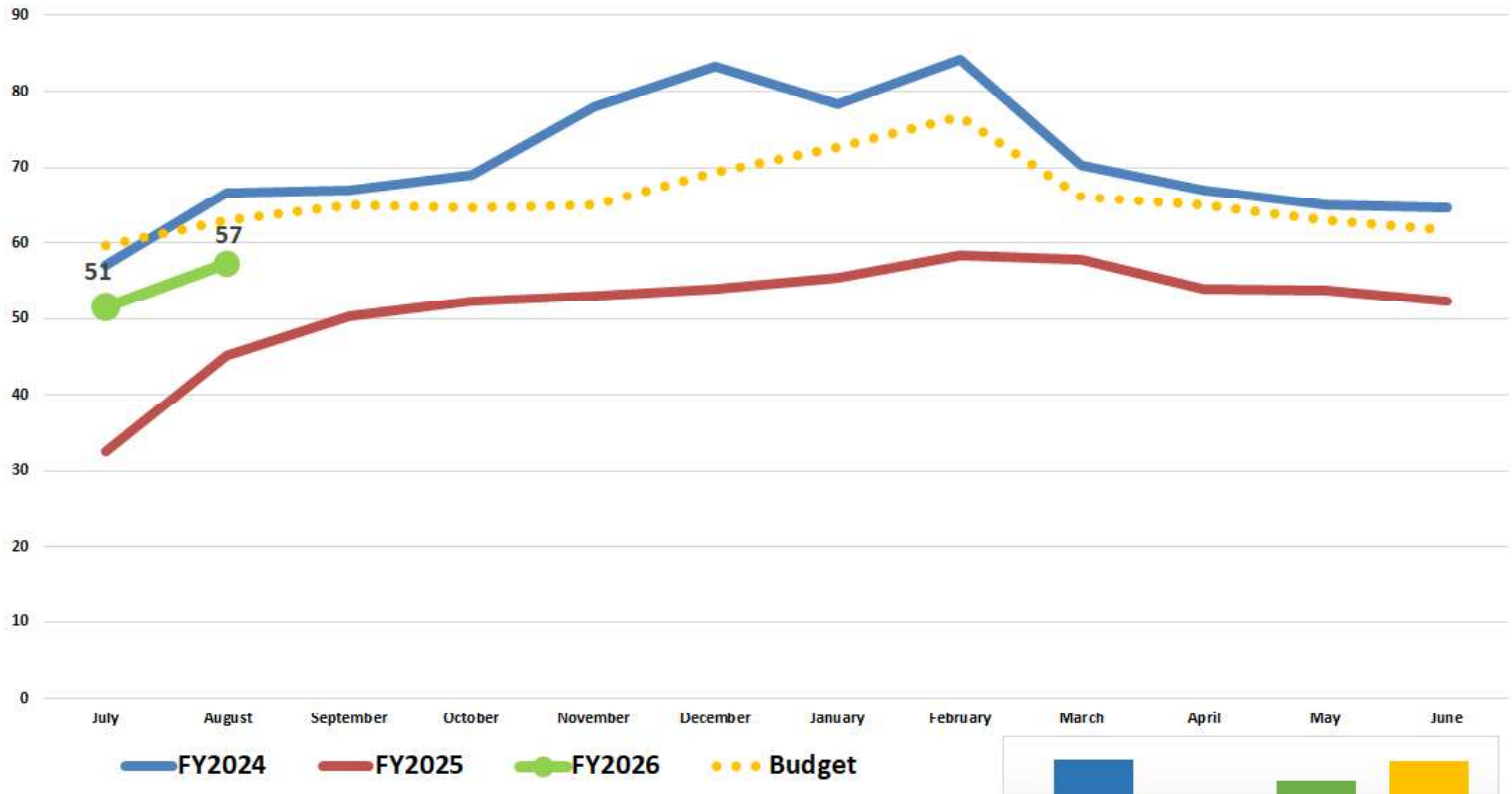


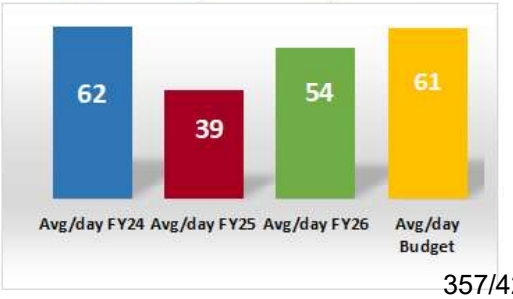
Urgent Care – Demaree Total Visits





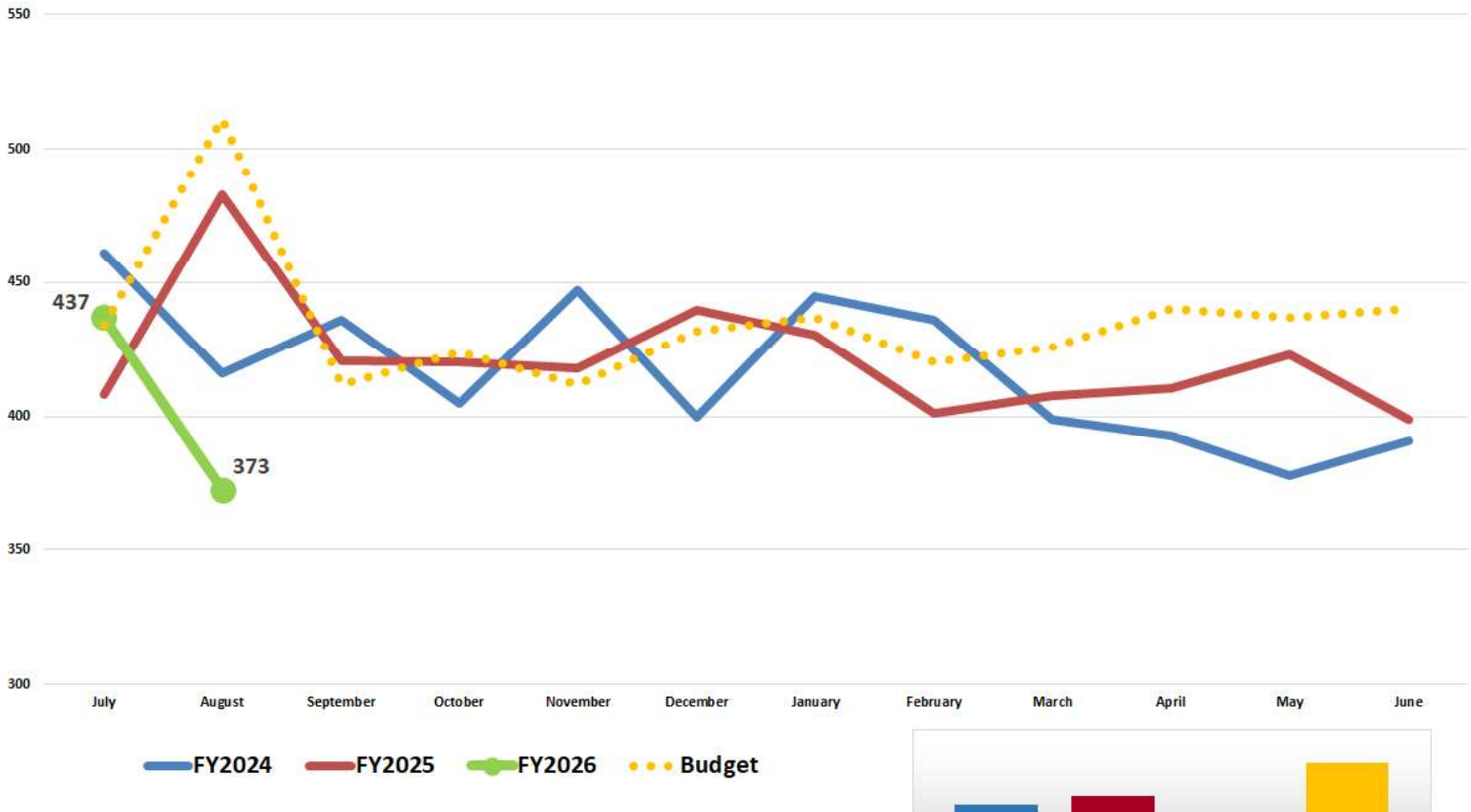
Urgent Care – Demaree Avg Visits Per Day

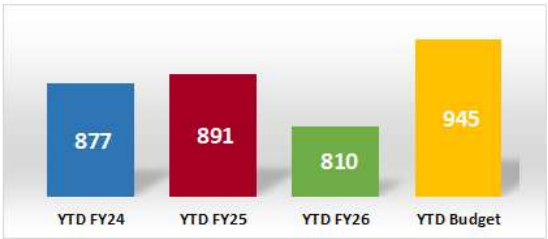




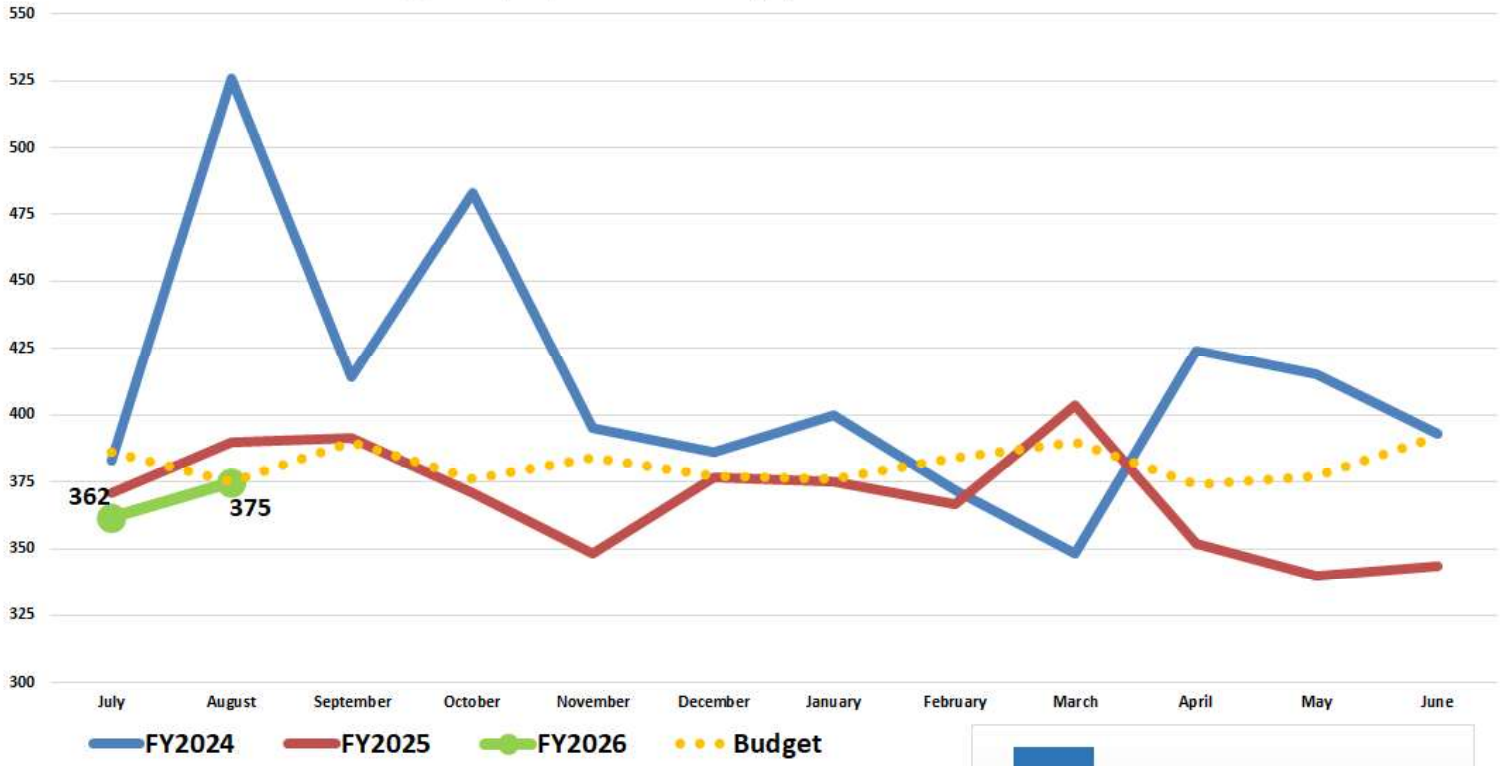
Surgery (IP & OP) – 100 Min Units

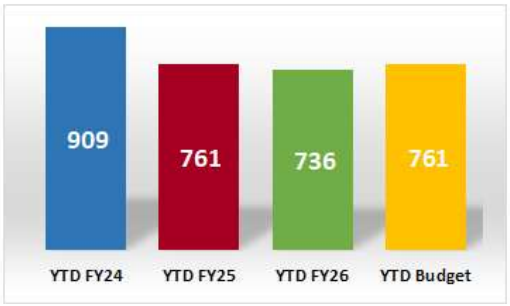
Surgery (IP Only) - 100 Min Unit



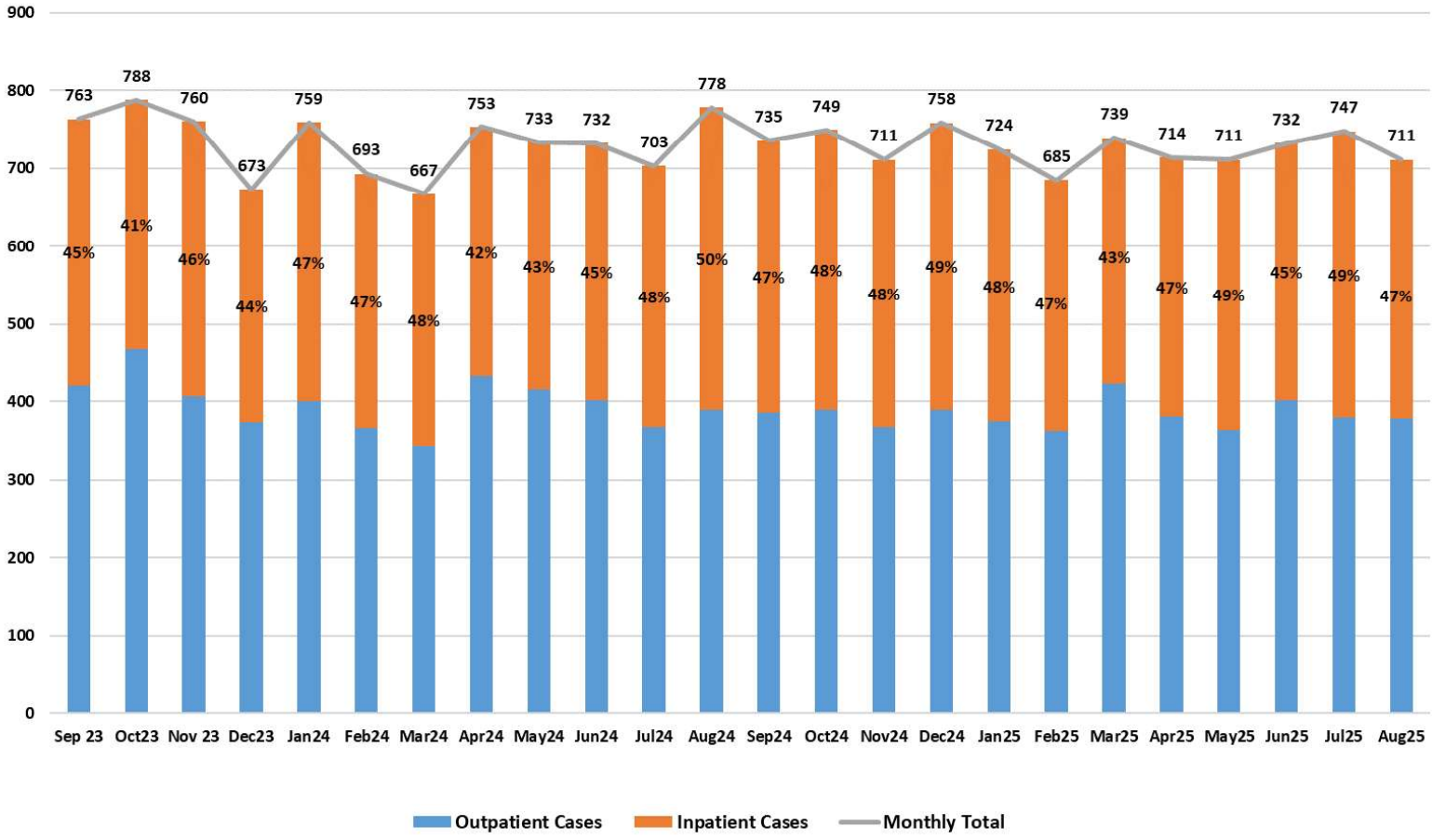


Surgery (OP Only) - 100 Min Units

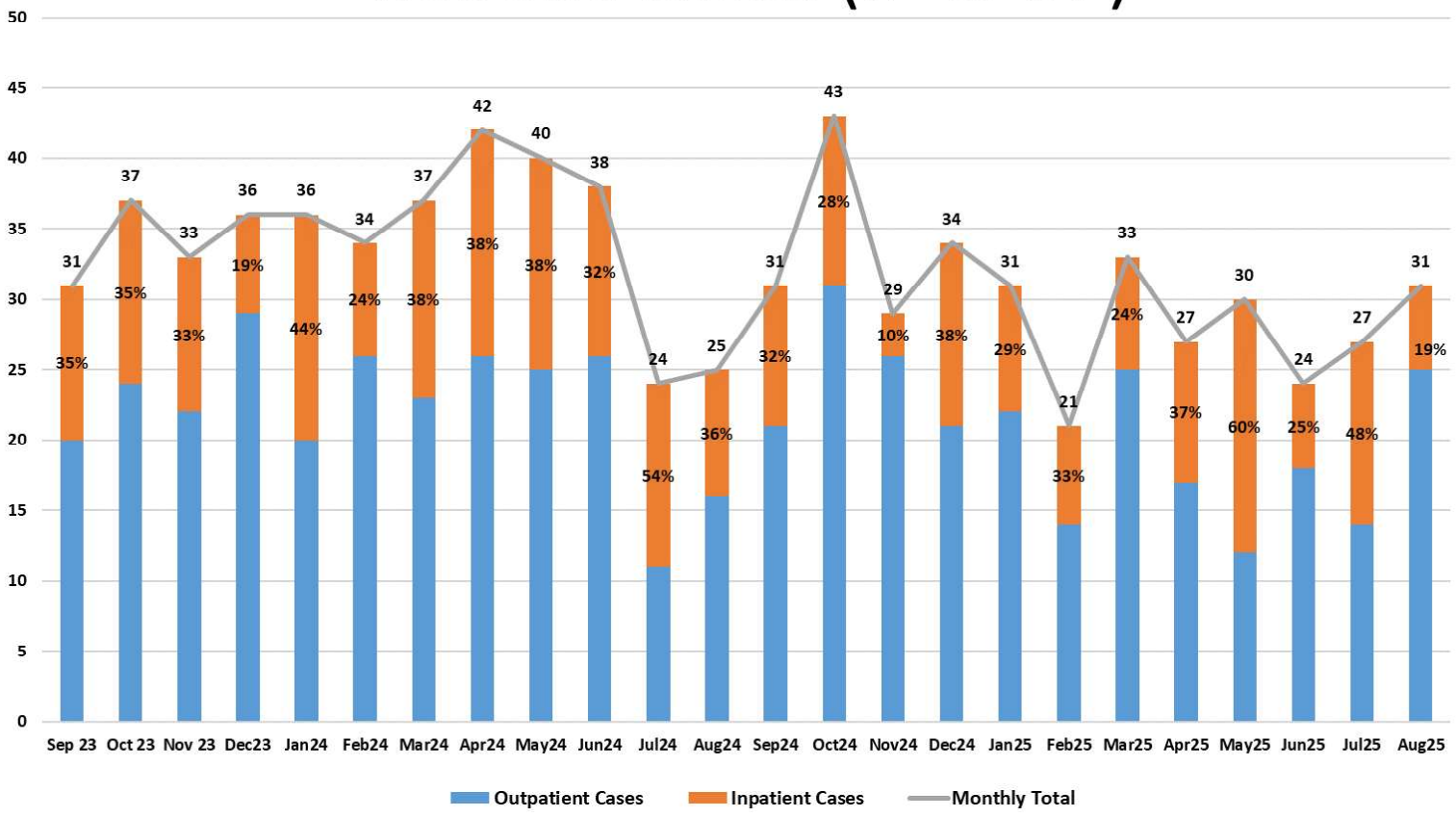




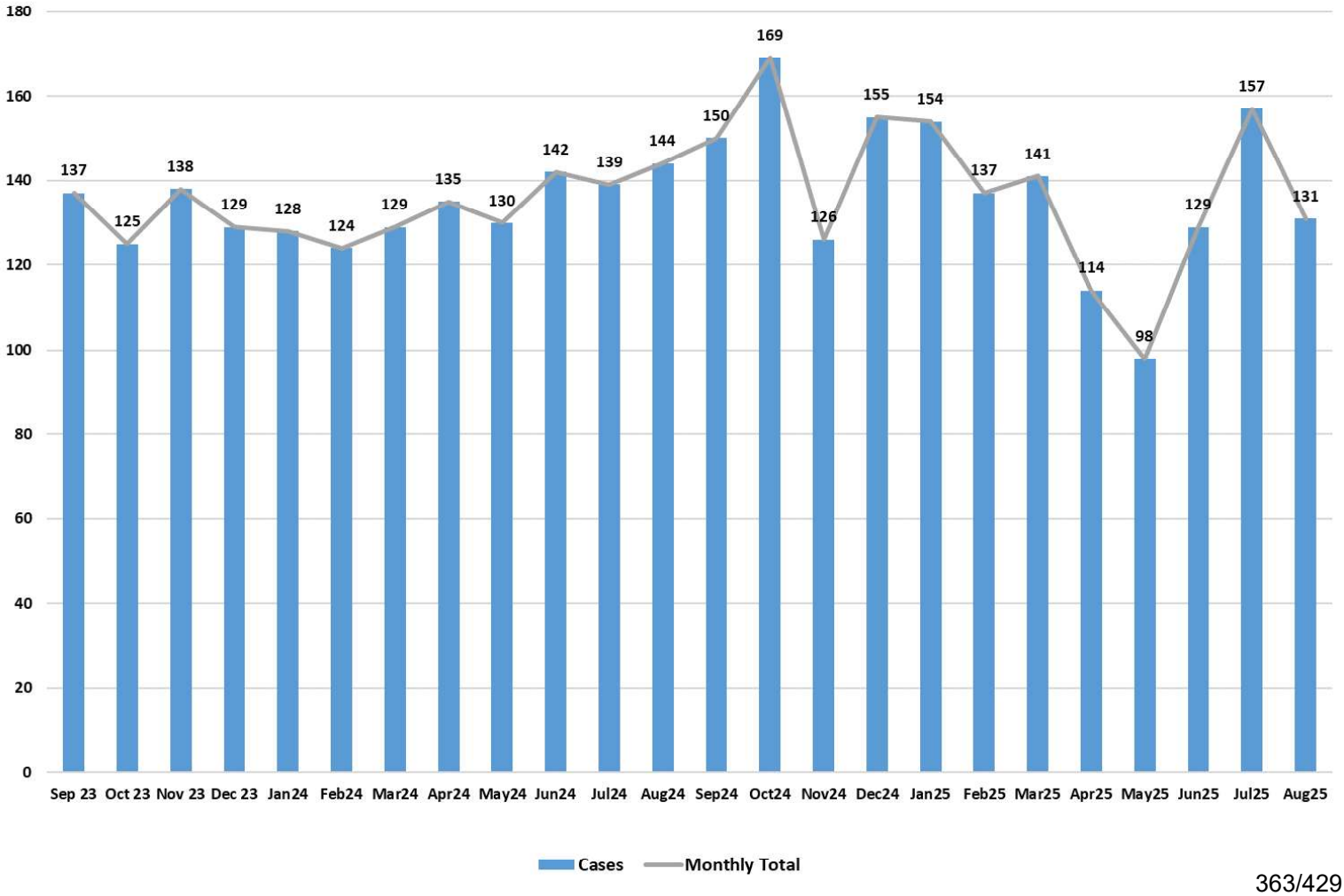
Surgery Cases (IP & OP)



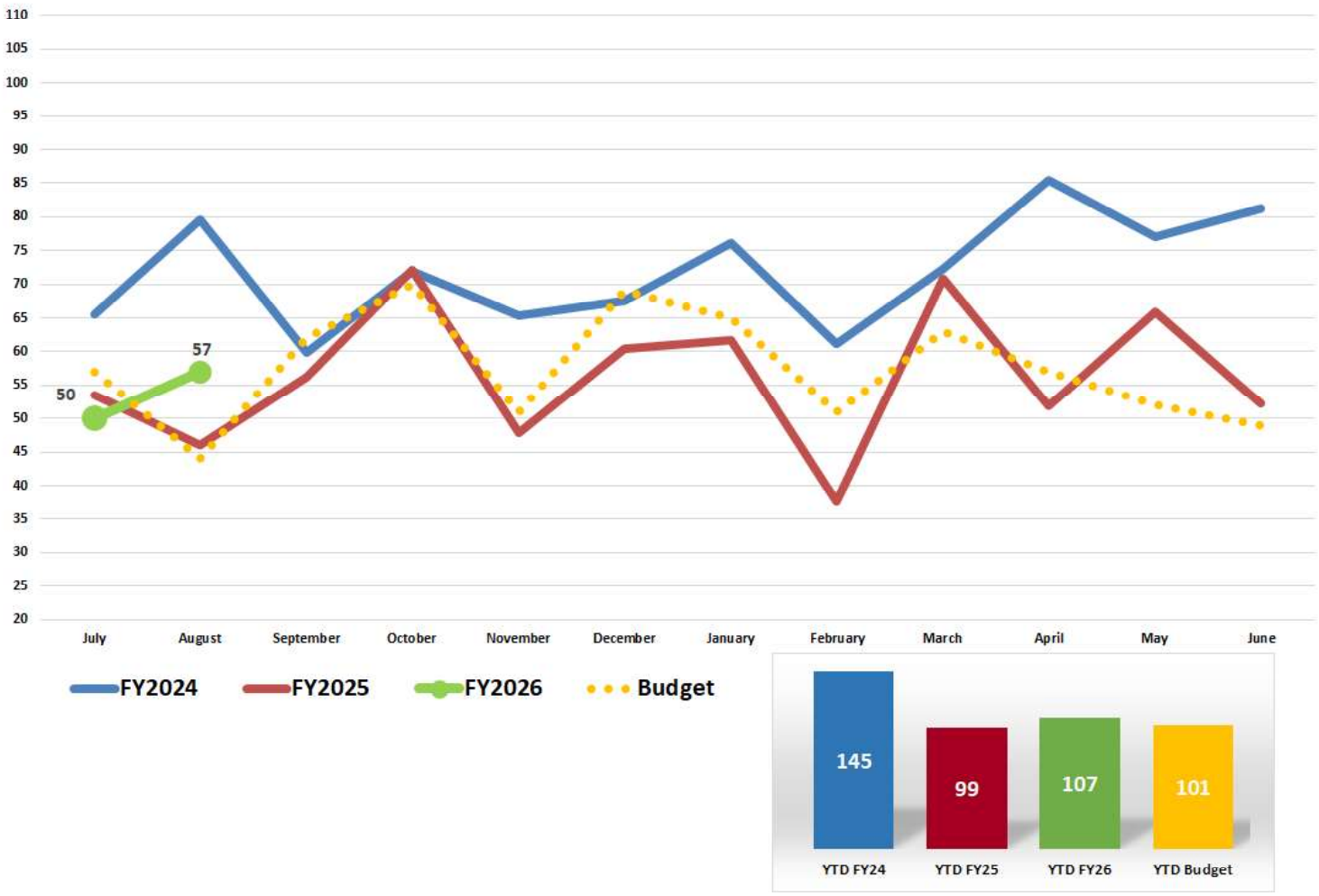
Robotic Cases (IP & OP)



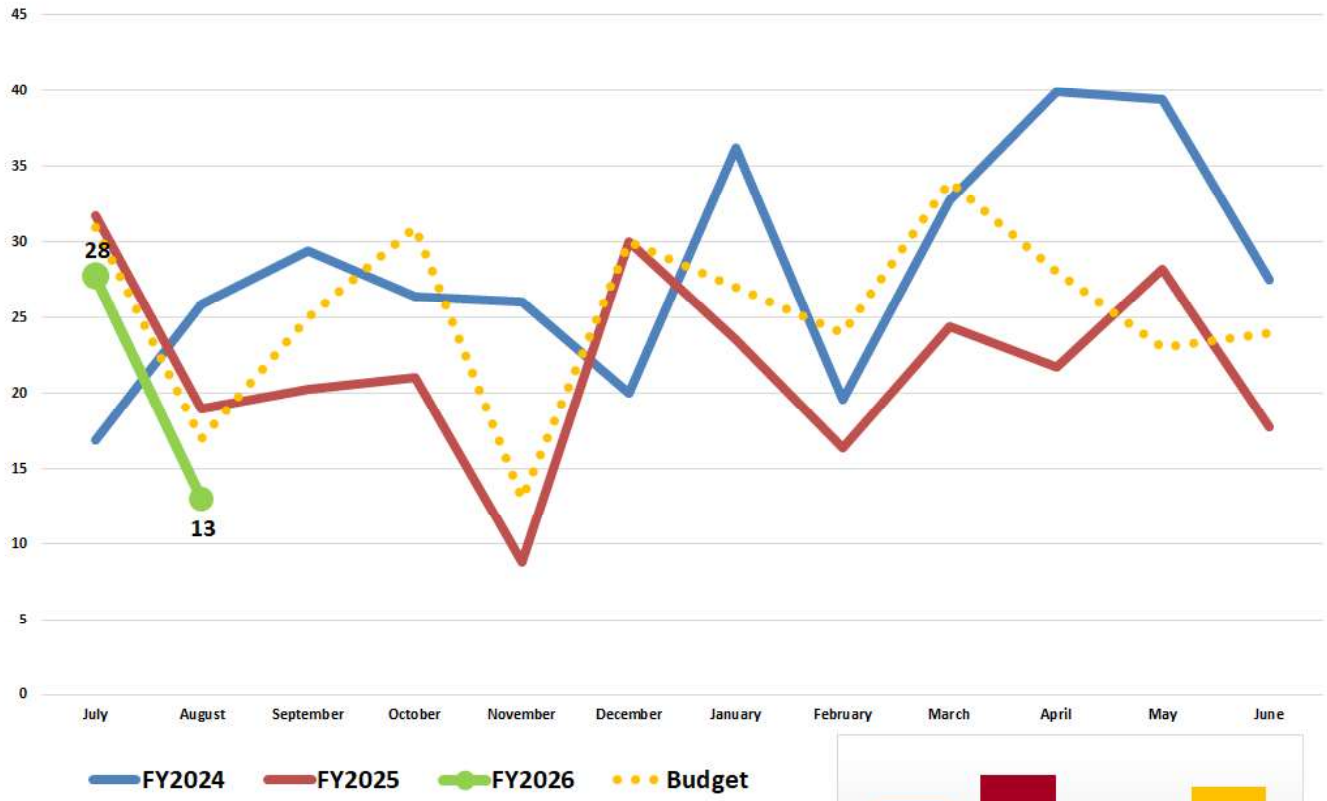
OB Cases

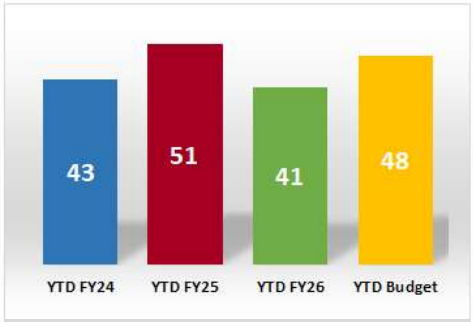

180
160
140
120
100
80
60
40
20
0
137
125
138
129
128
124
129
135
130
142
139
144
150
169
126
155
154
137
141
114
98
129
157
131
Sep 23
Oct 23
Nov 23
Dec 23
Jan24
Feb24
Mar24
Apr24
May24
Jun24
Jul24
Aug24
Sep24
Oct24
Nov24
Dec24
Jan25
Feb25
Mar25
Apr25
May25
Jun25
Jul25
Aug25
Cases
Monthly Total

Robotic Surgery (IP & OP) - 100 Min Units

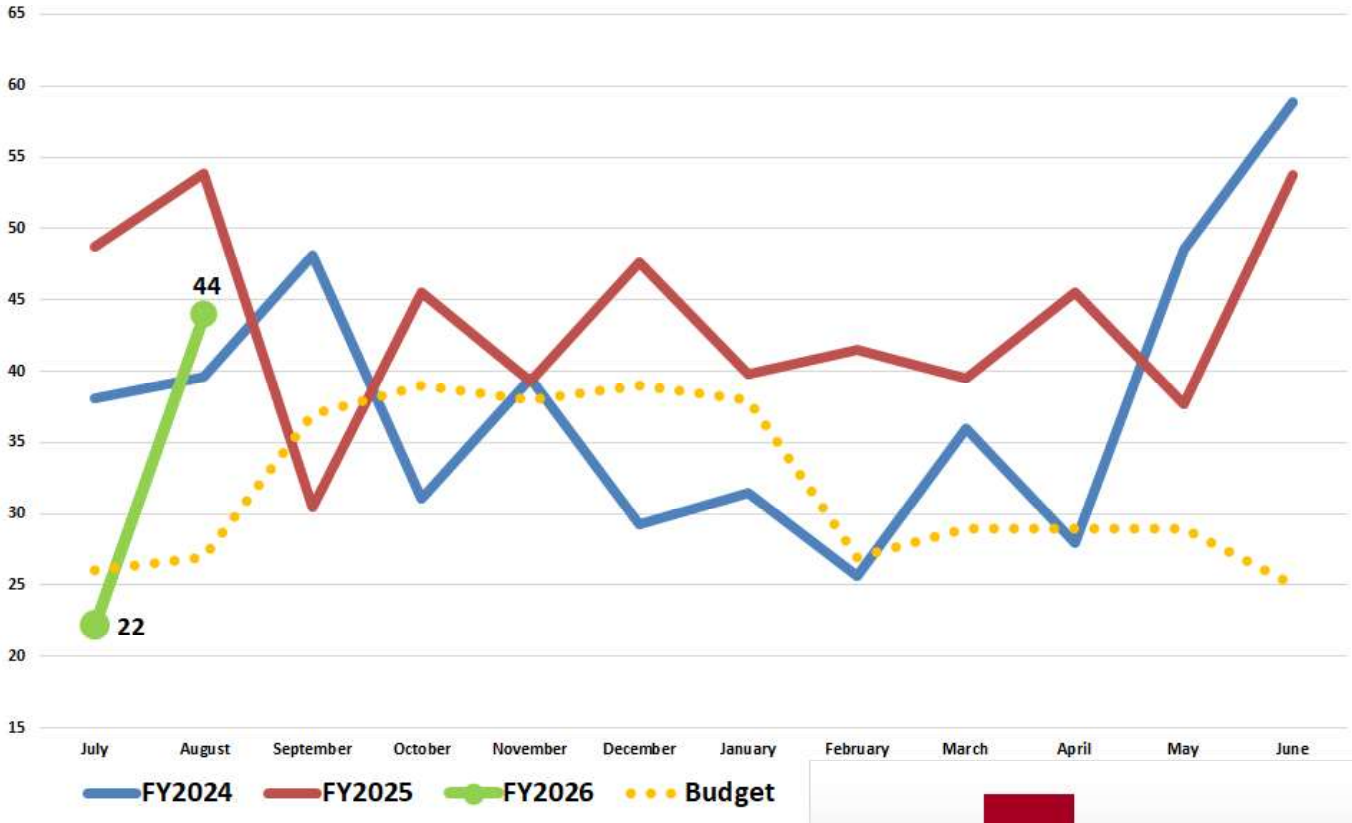


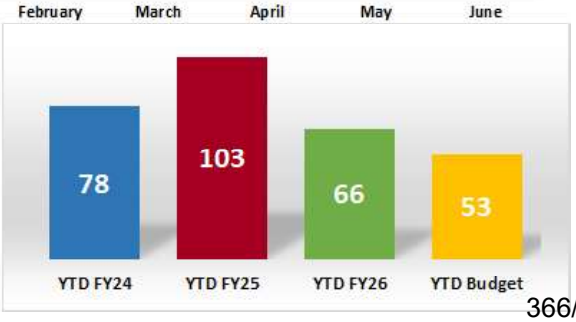
Robotic Surgery Minutes (IP Only)



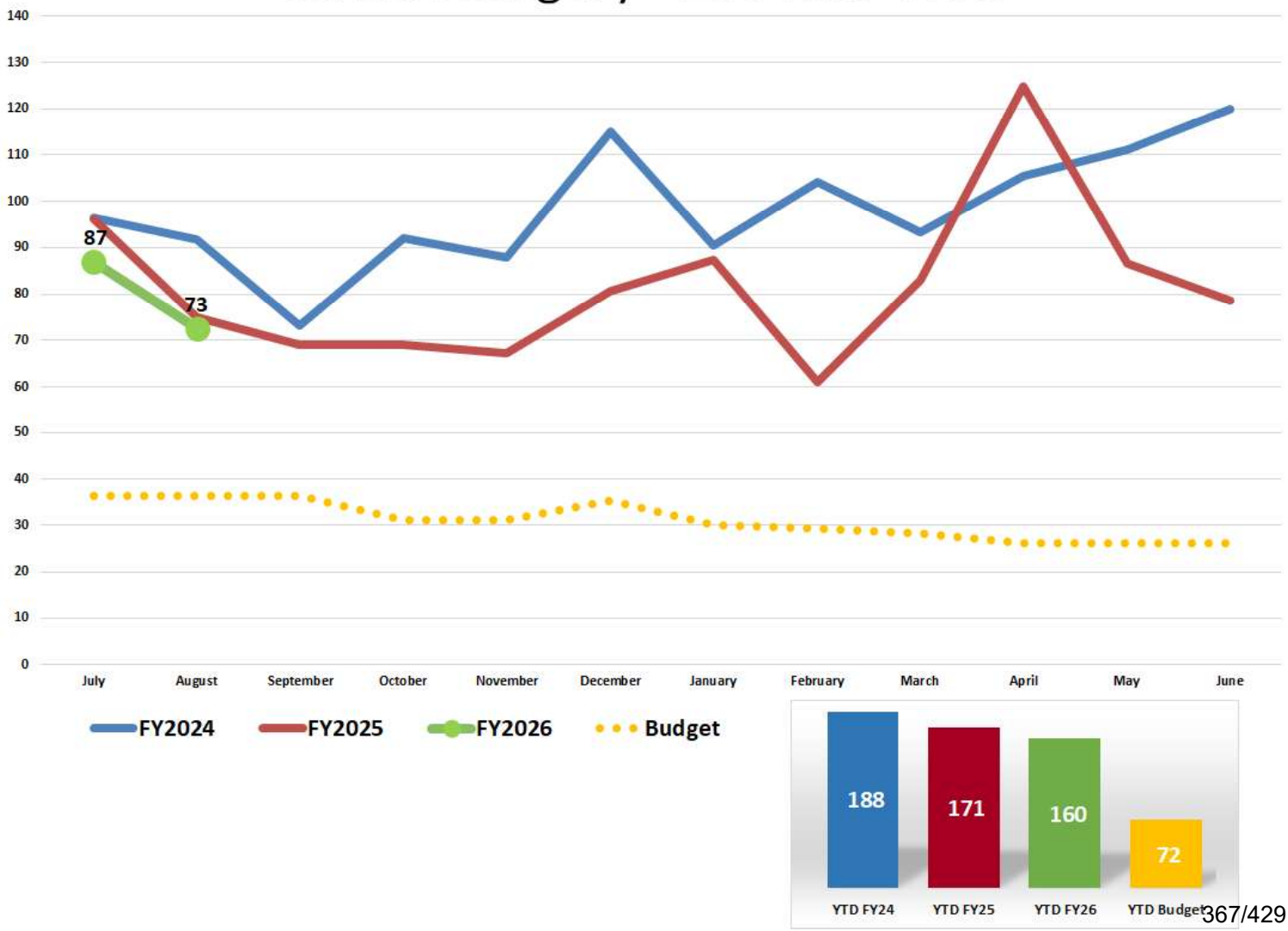


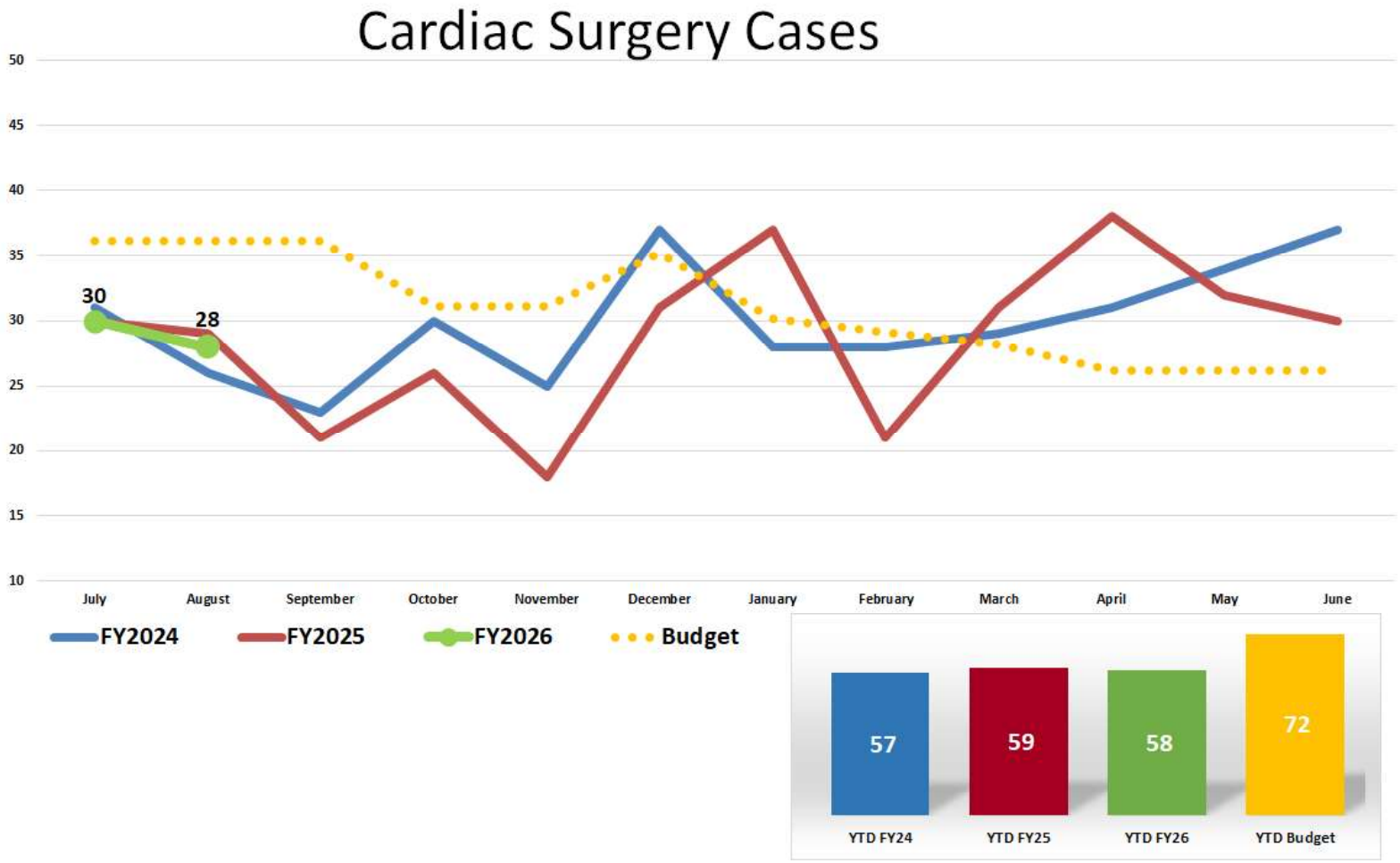
Robotic Surgery Minutes (OP Only)





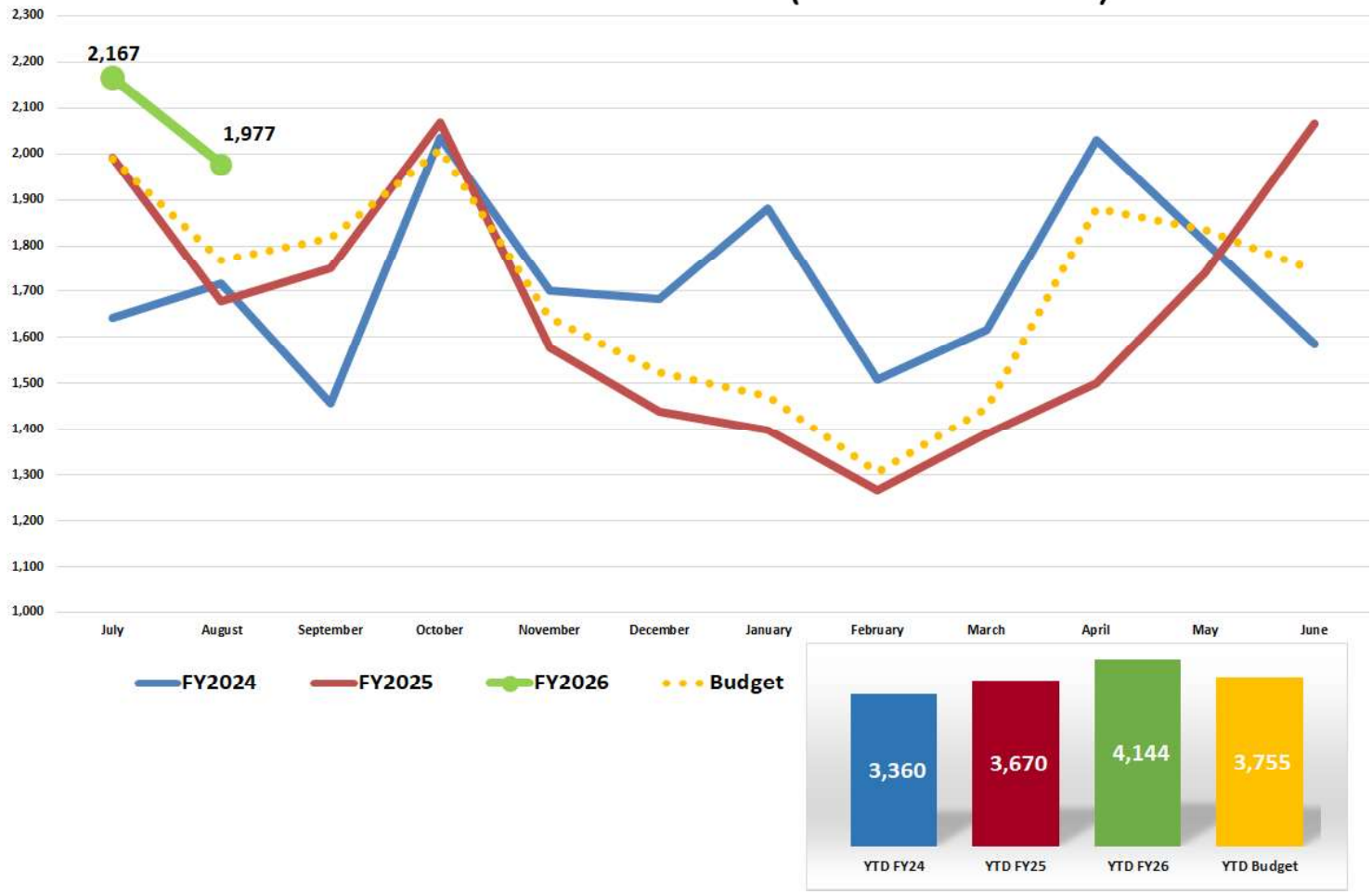
Cardiac Surgery - 100 Min Units



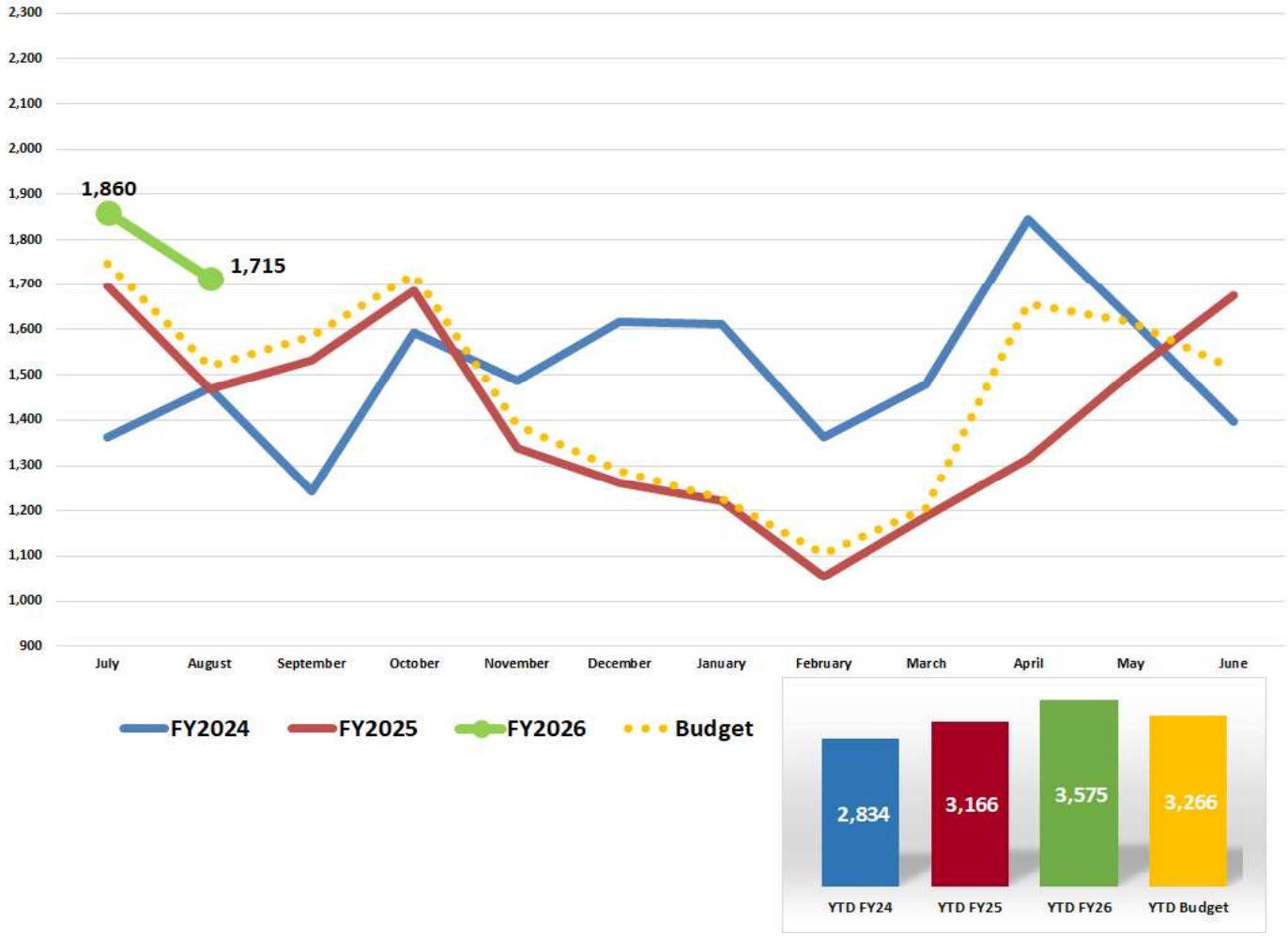

Cardiac Surgery Cases
50
45
40
35
30
25
20
15
10
30
28
July
August
September
October
November
December
January
February
March
April
May
June
FY2024
FY2025
FY2026
Budget

57
59
58
72
YTD FY24
YTD FY25
YTD FY26
YTD Budget

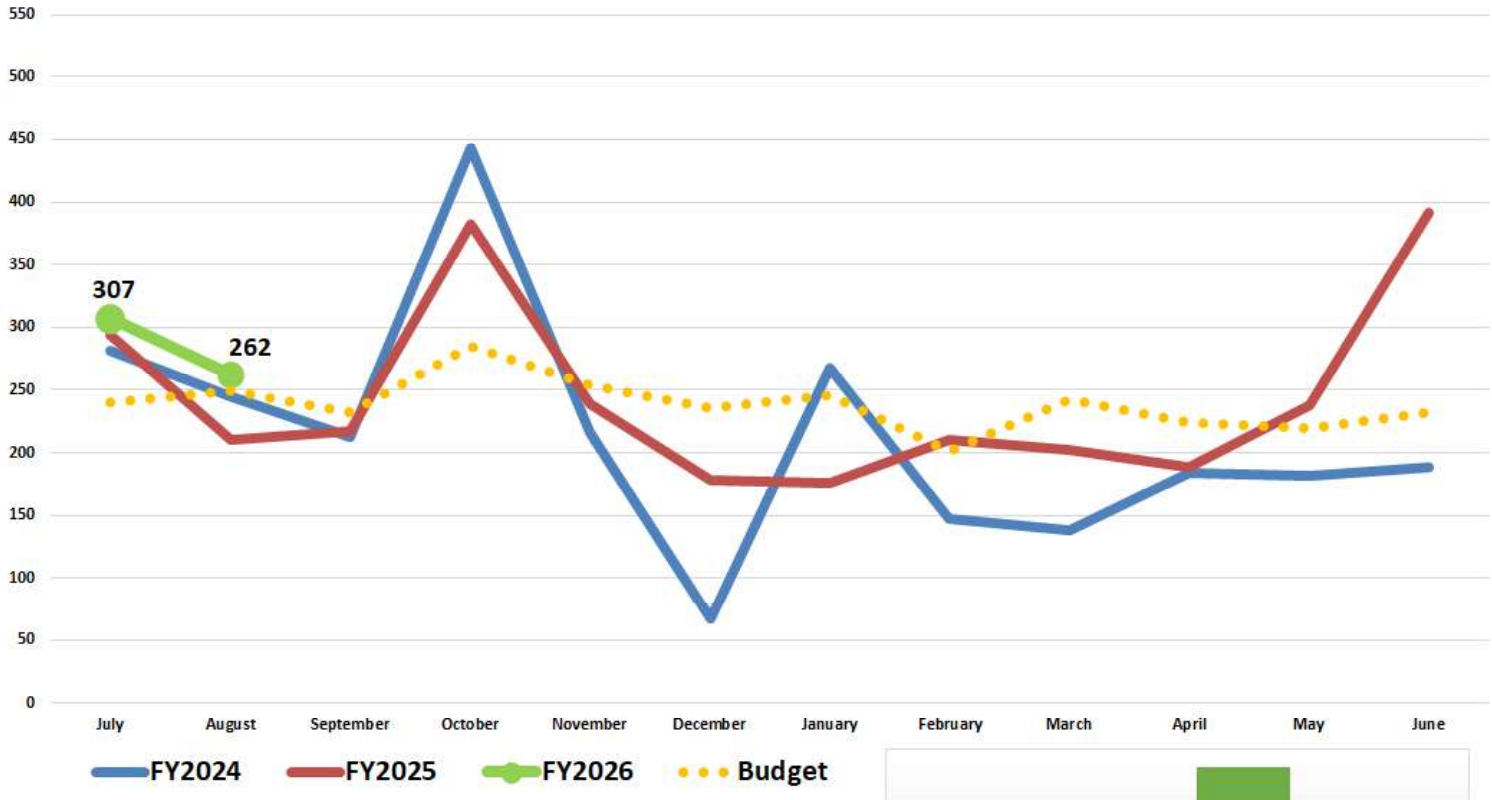
Rad Onc Treatments (Vis. & Hanf.)



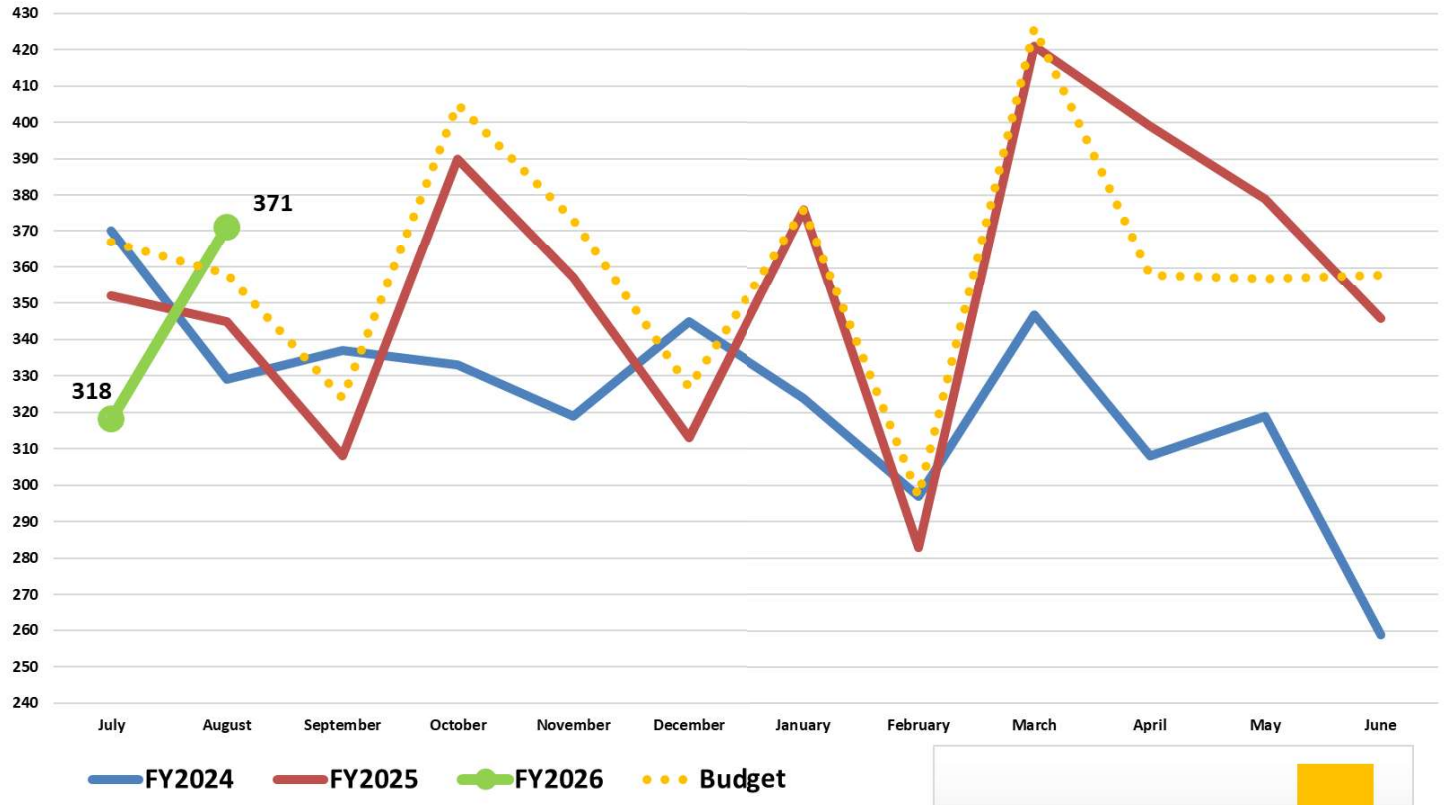
Rad Onc Visalia

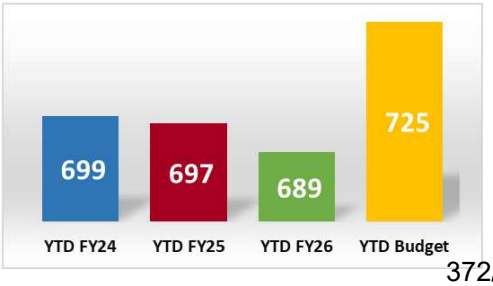


Rad Onc Hanford

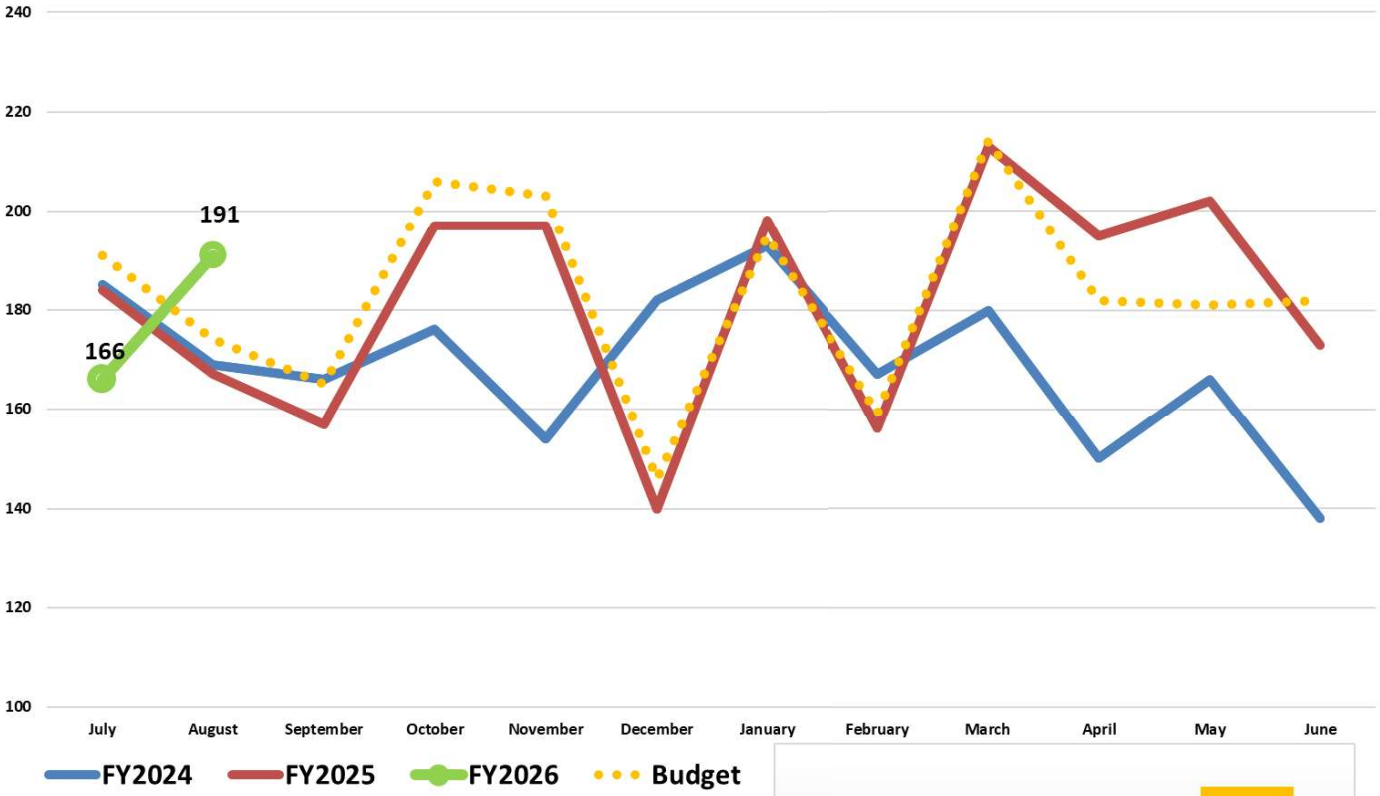


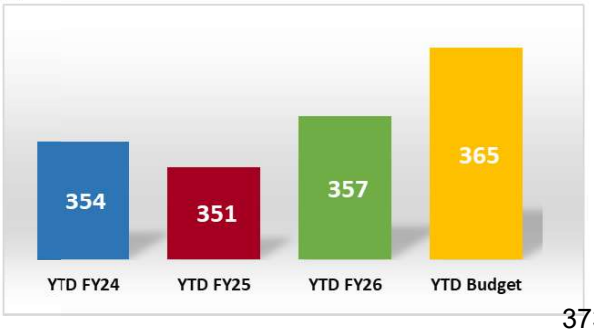
Cath Lab (IP & OP) – 100 Min Units



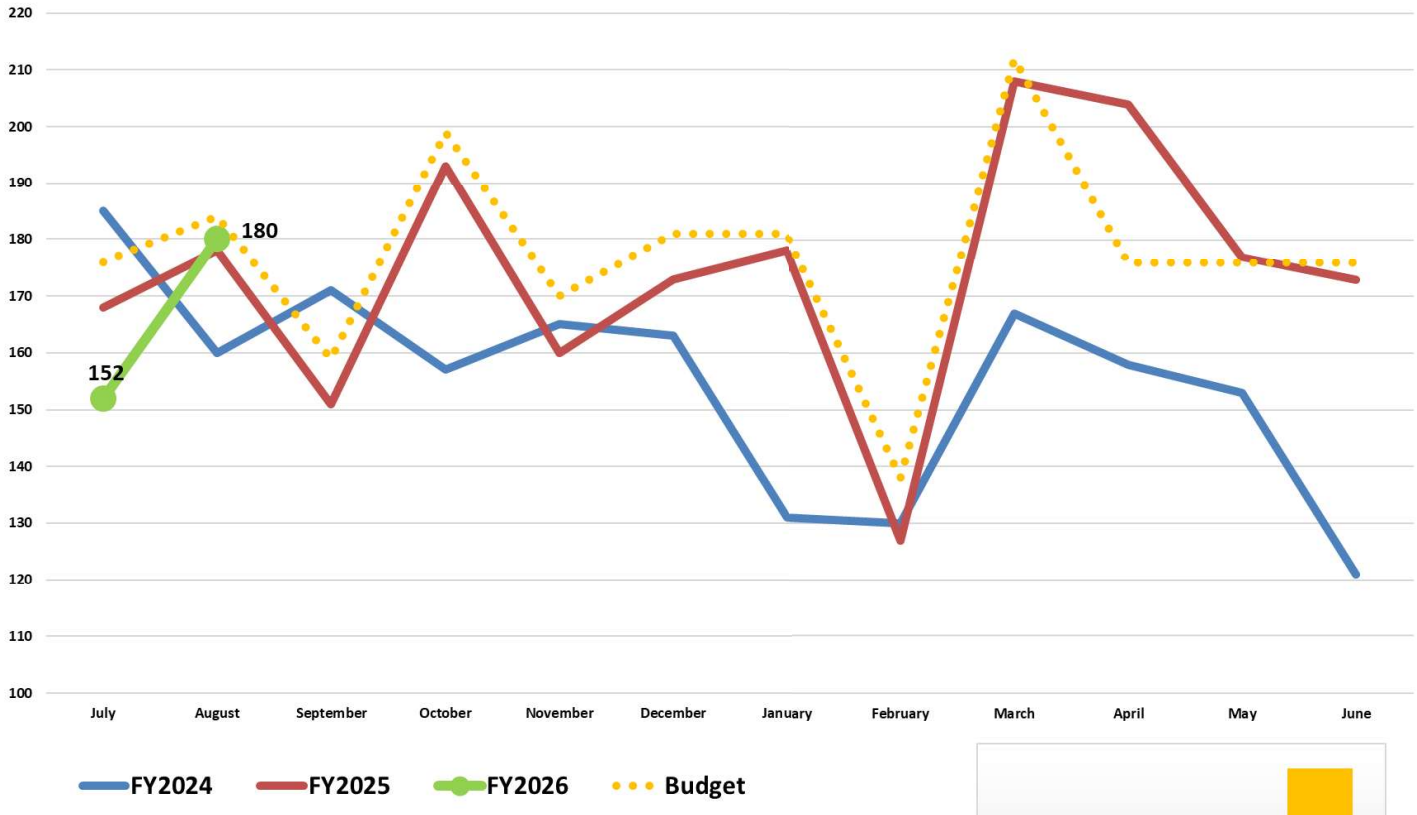


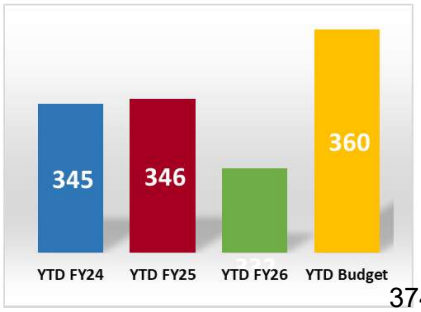
Cath Lab (IP Only) – 100 Min Units



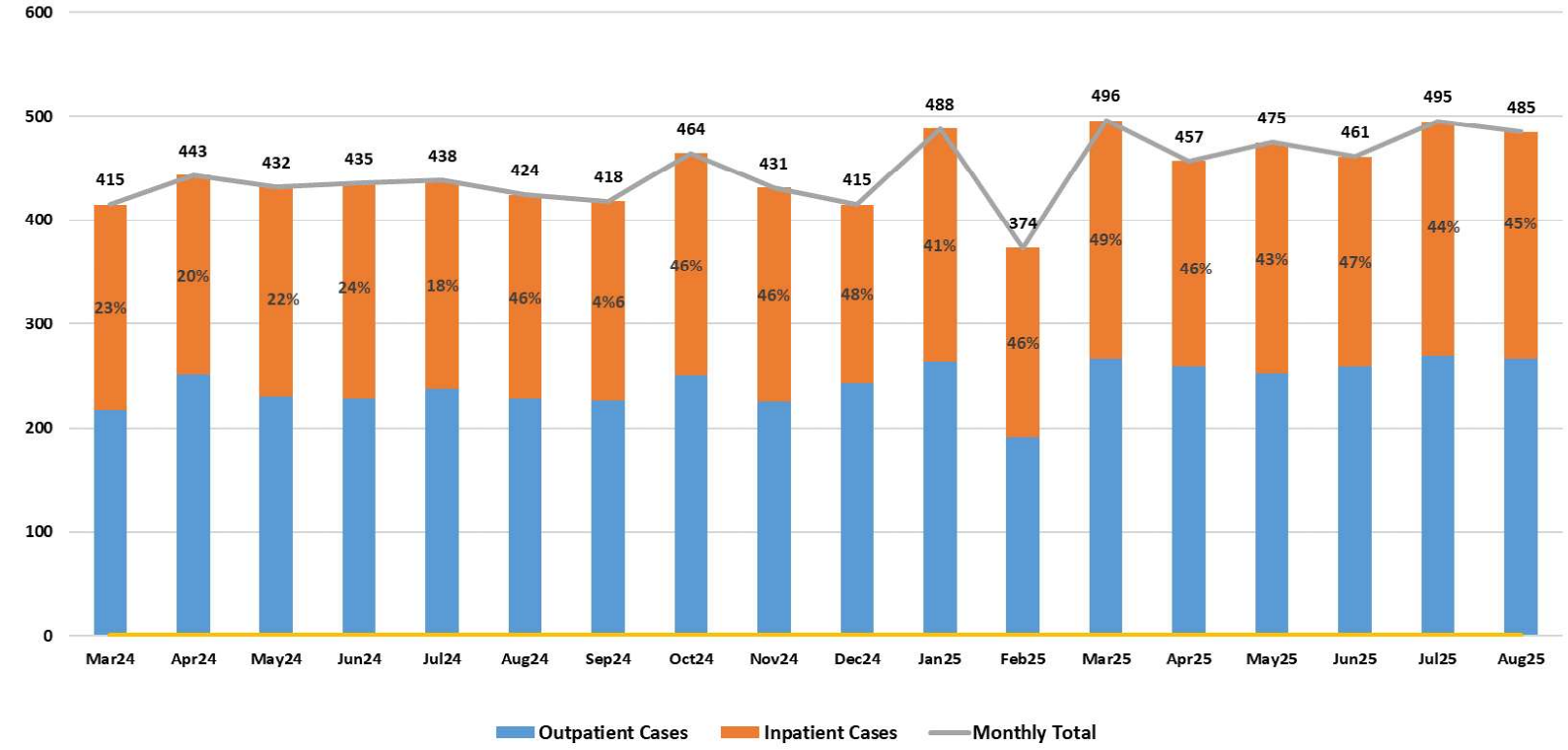


Cath Lab (OP Only) – 100 Min Units

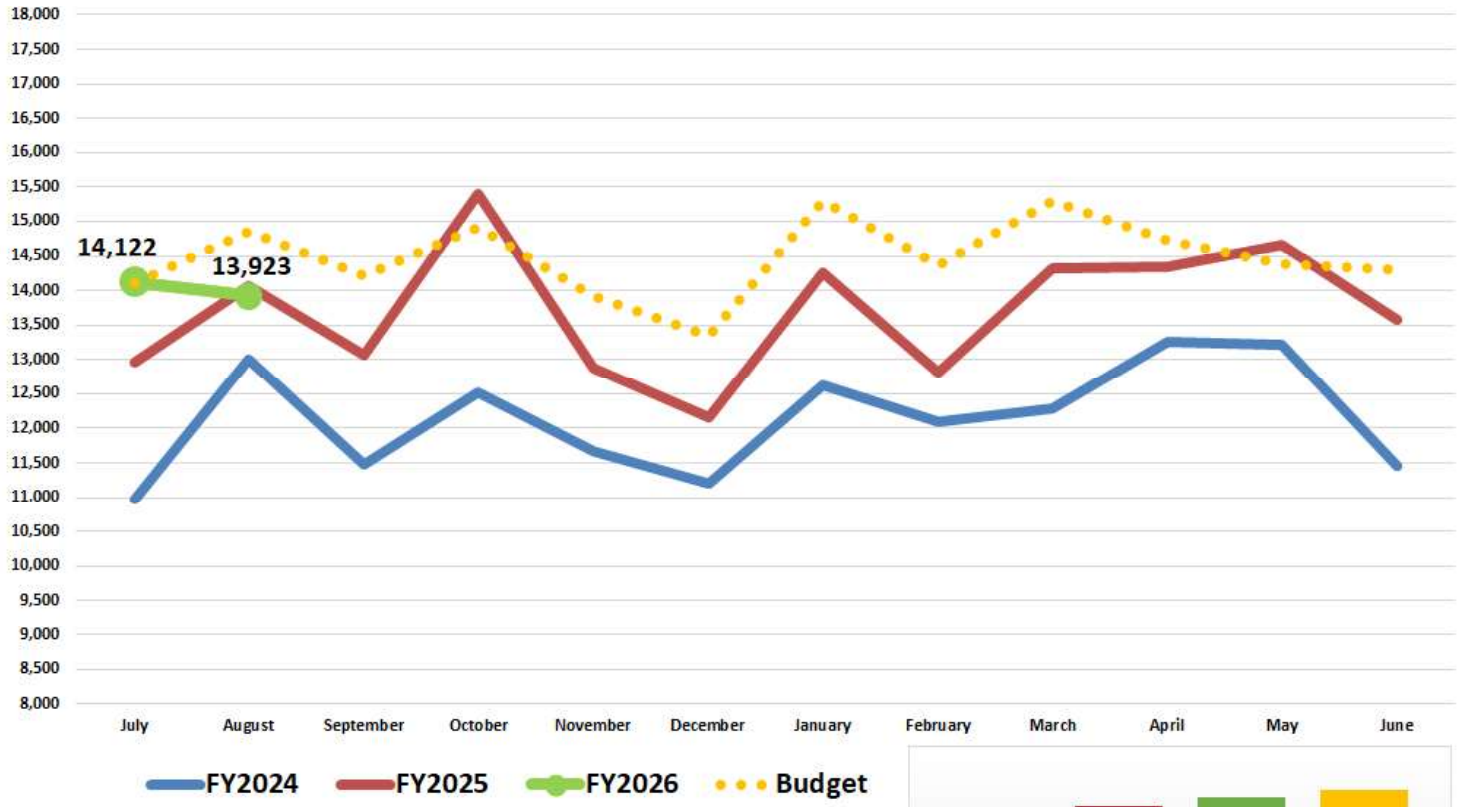


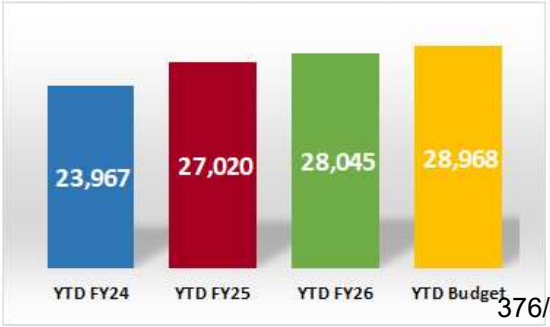


Cath Lab Patients (IP & OP)

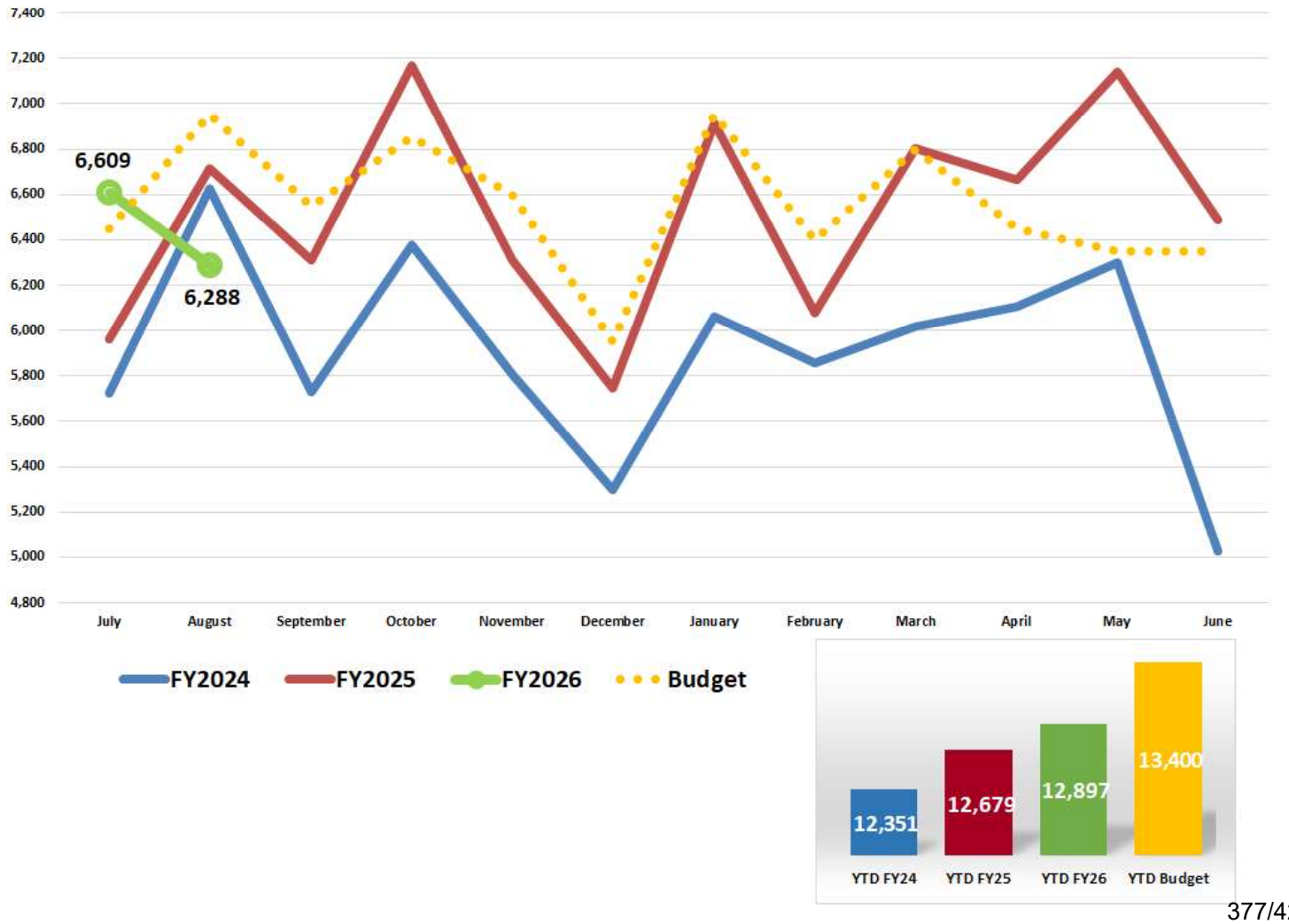


Rural Health Clinics Registrations

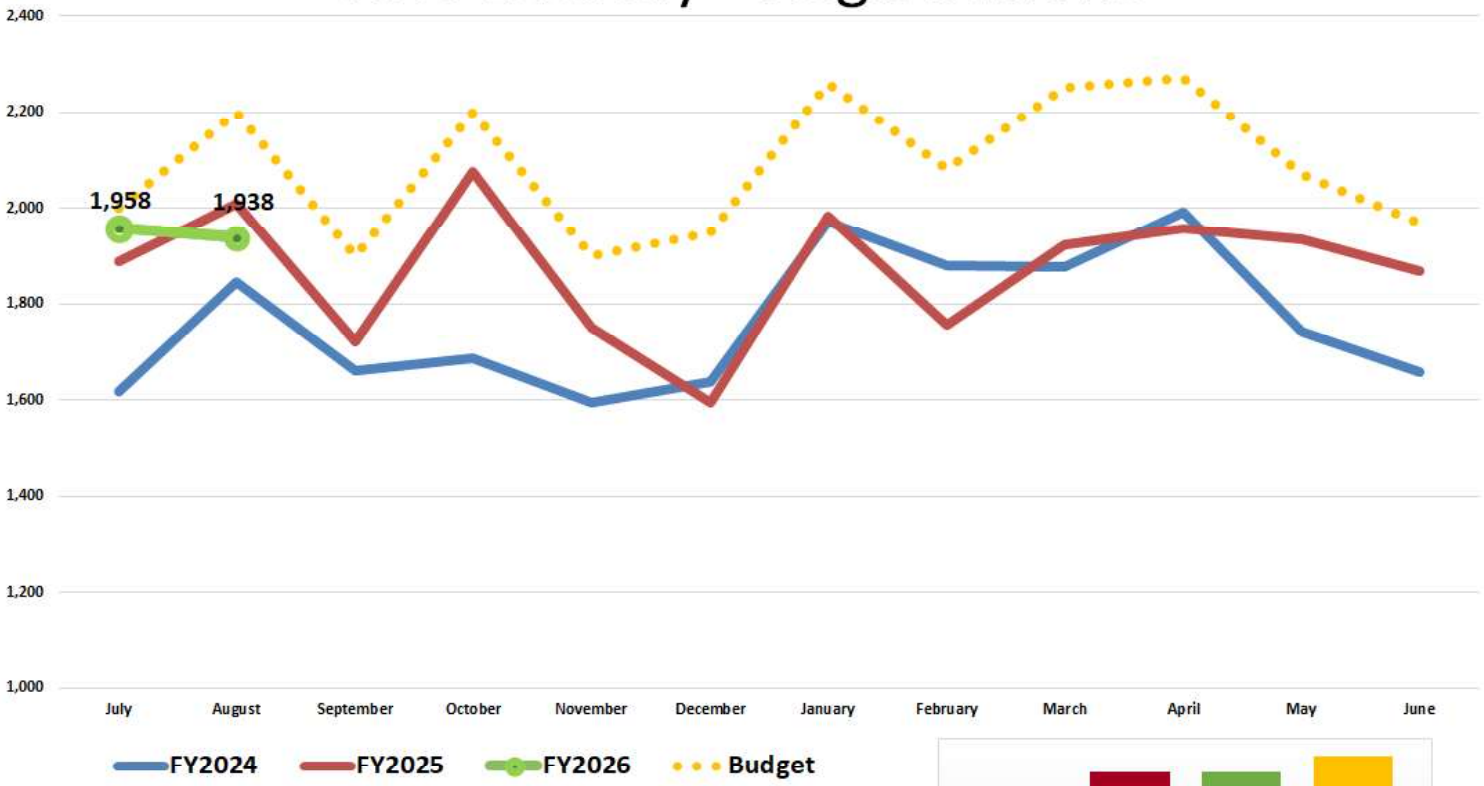


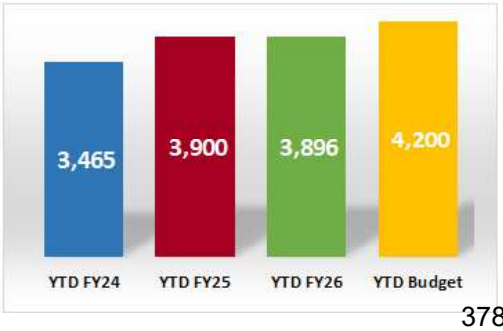


RHC Exeter - Registrations

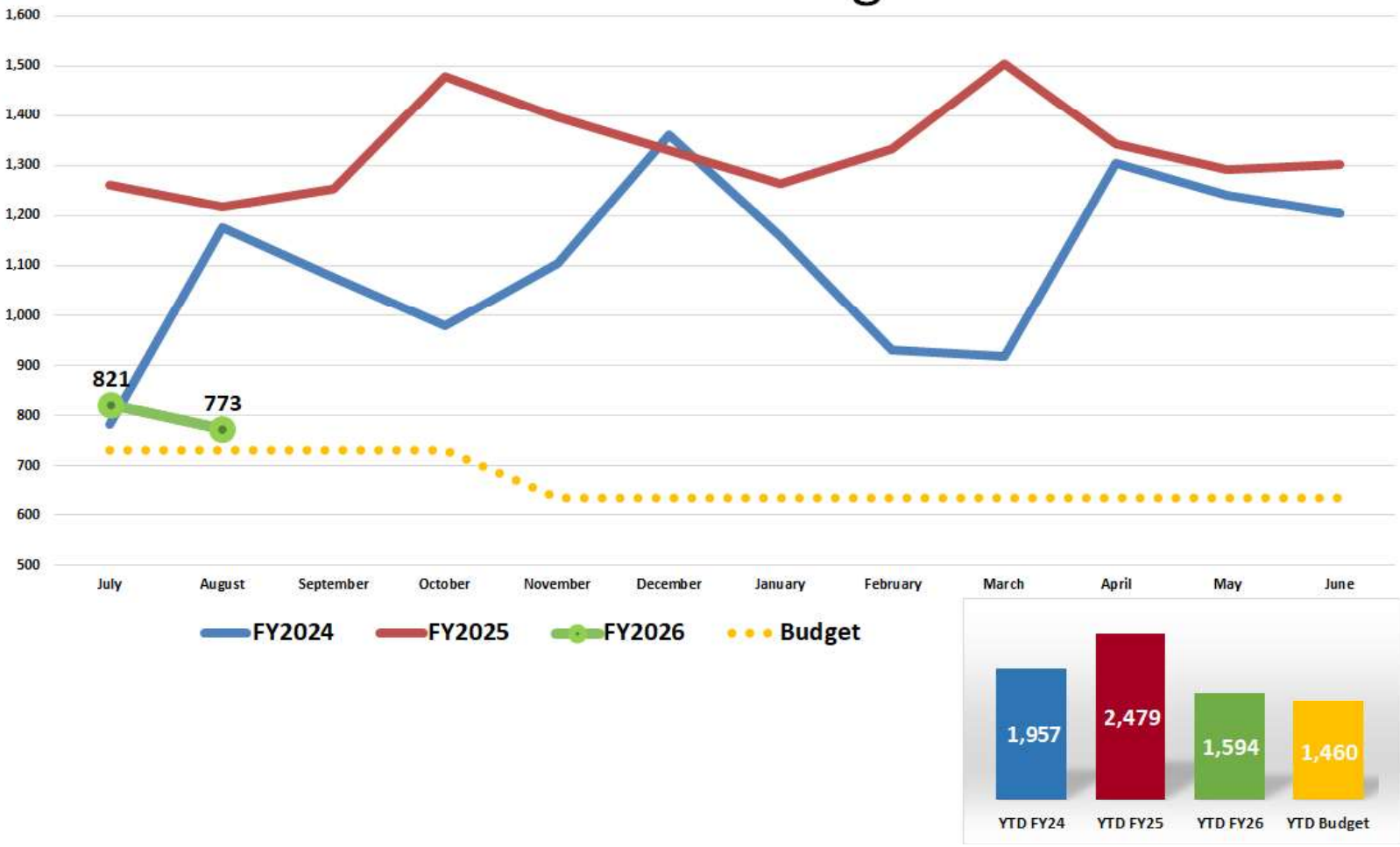


RHC Lindsay - Registrations

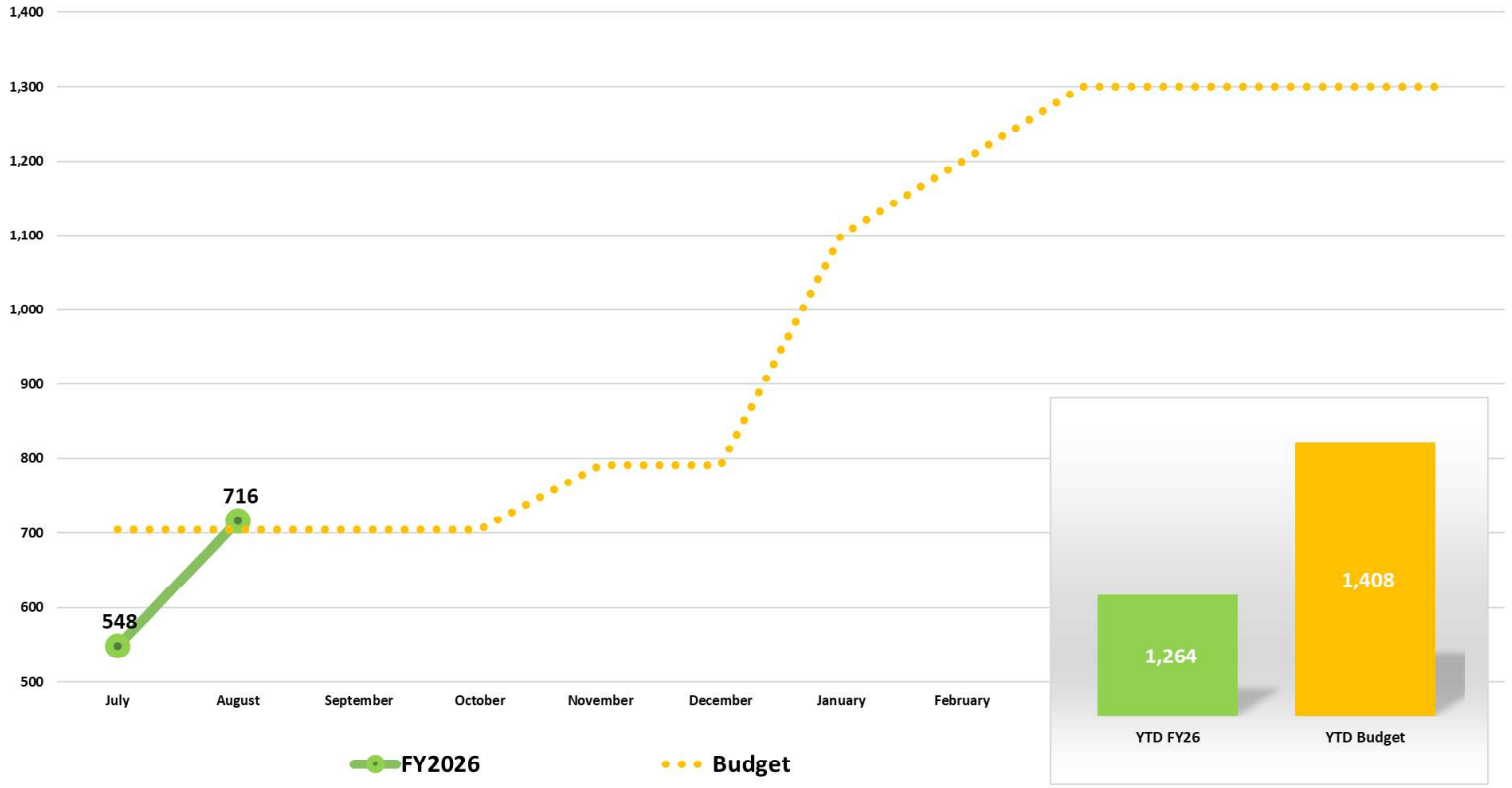




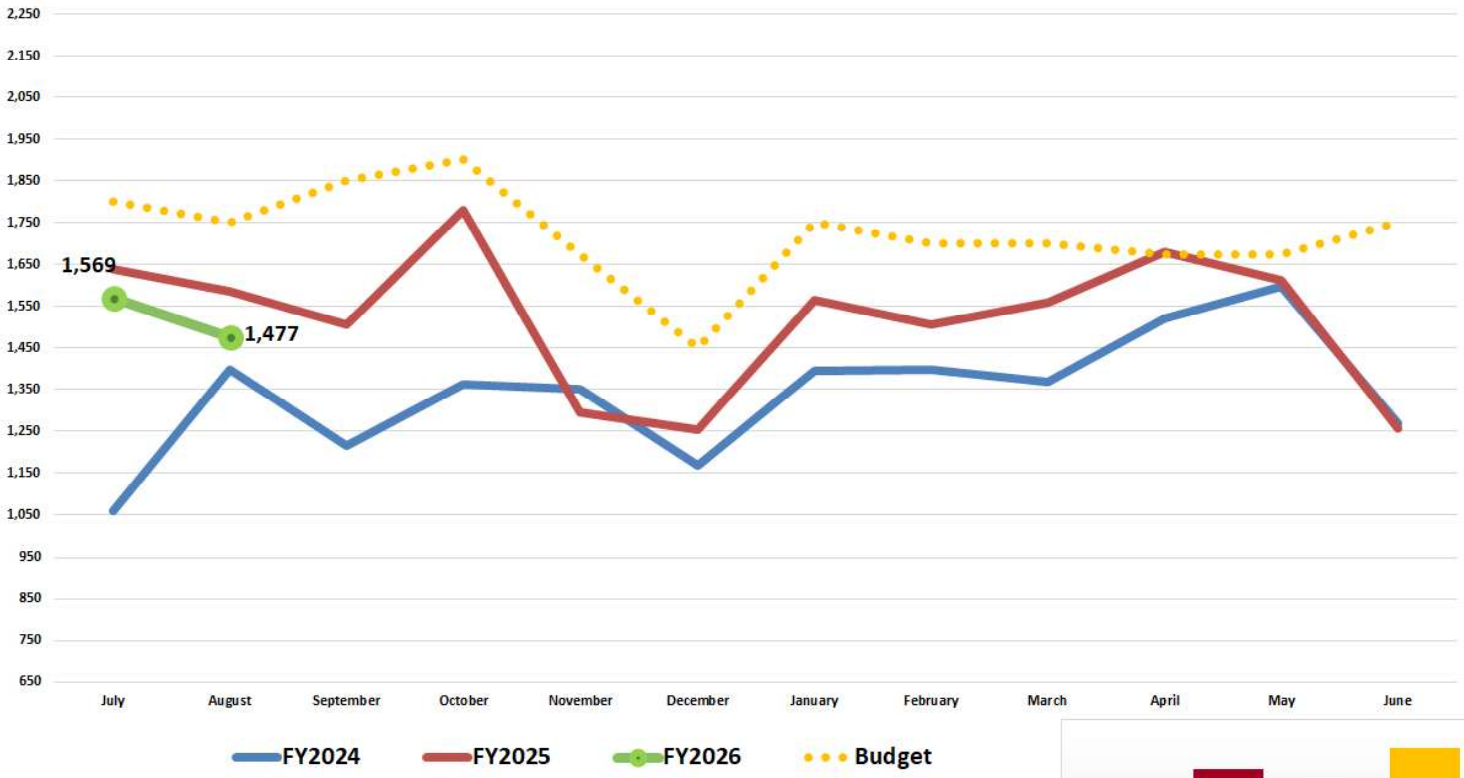
RHC Woodlake - Registrations

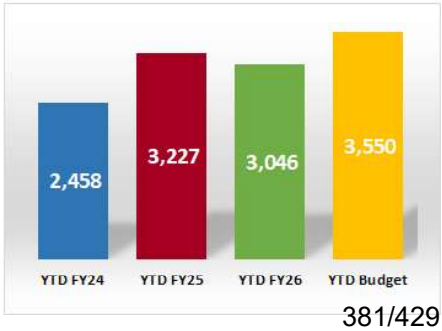


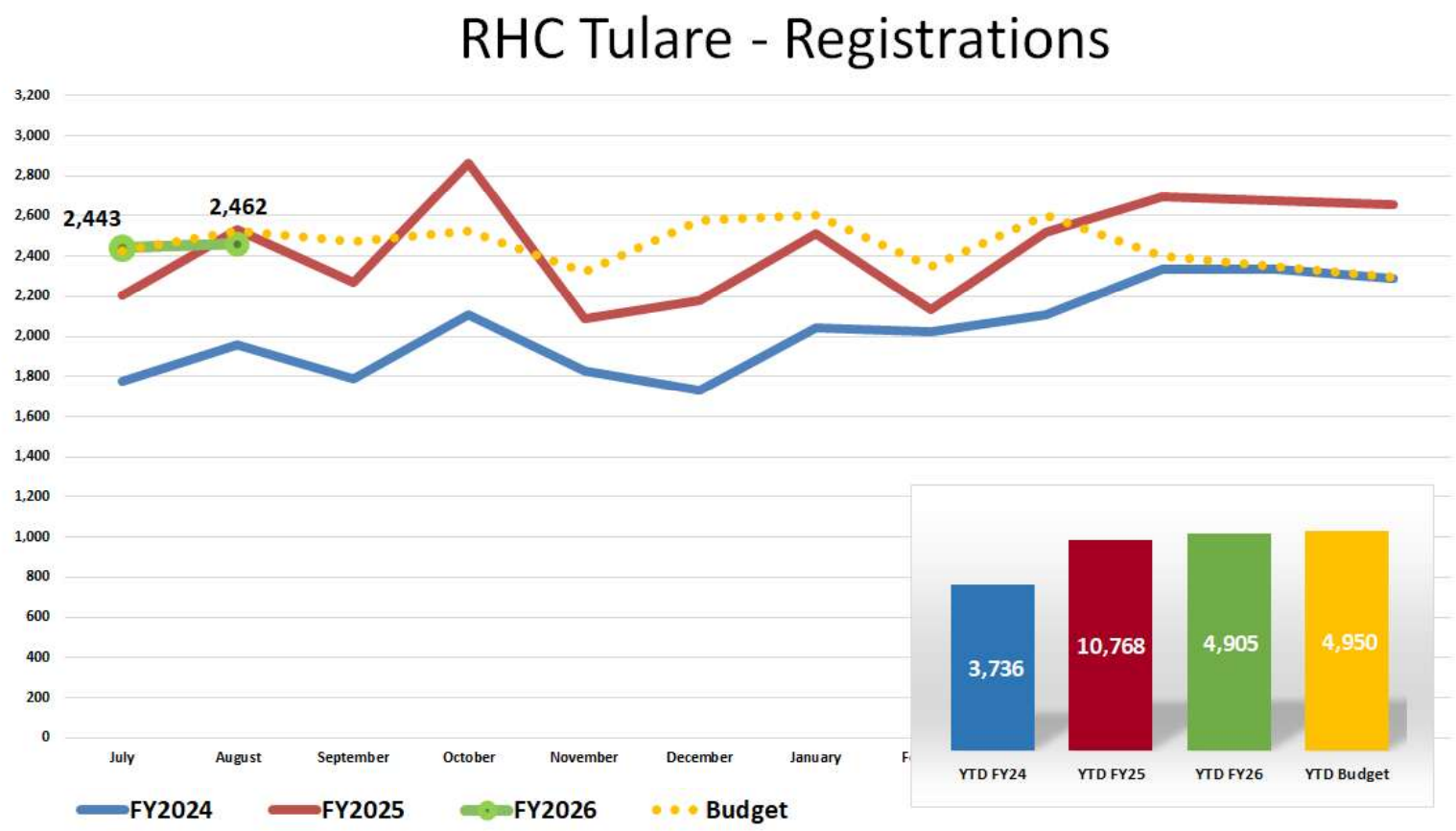
RHC Woodlake Valencia - Registrations

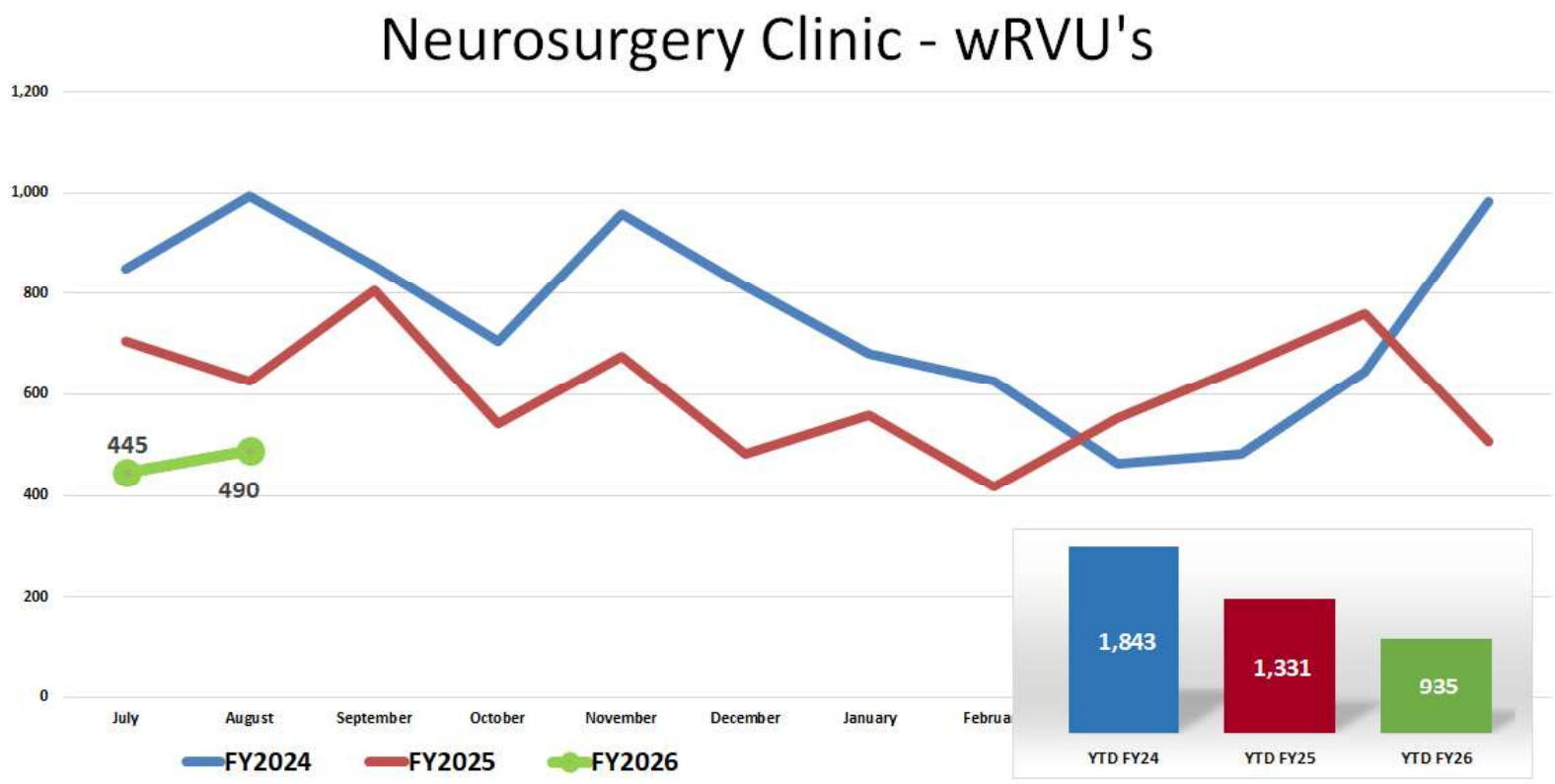


RHC Dinuba - Registrations

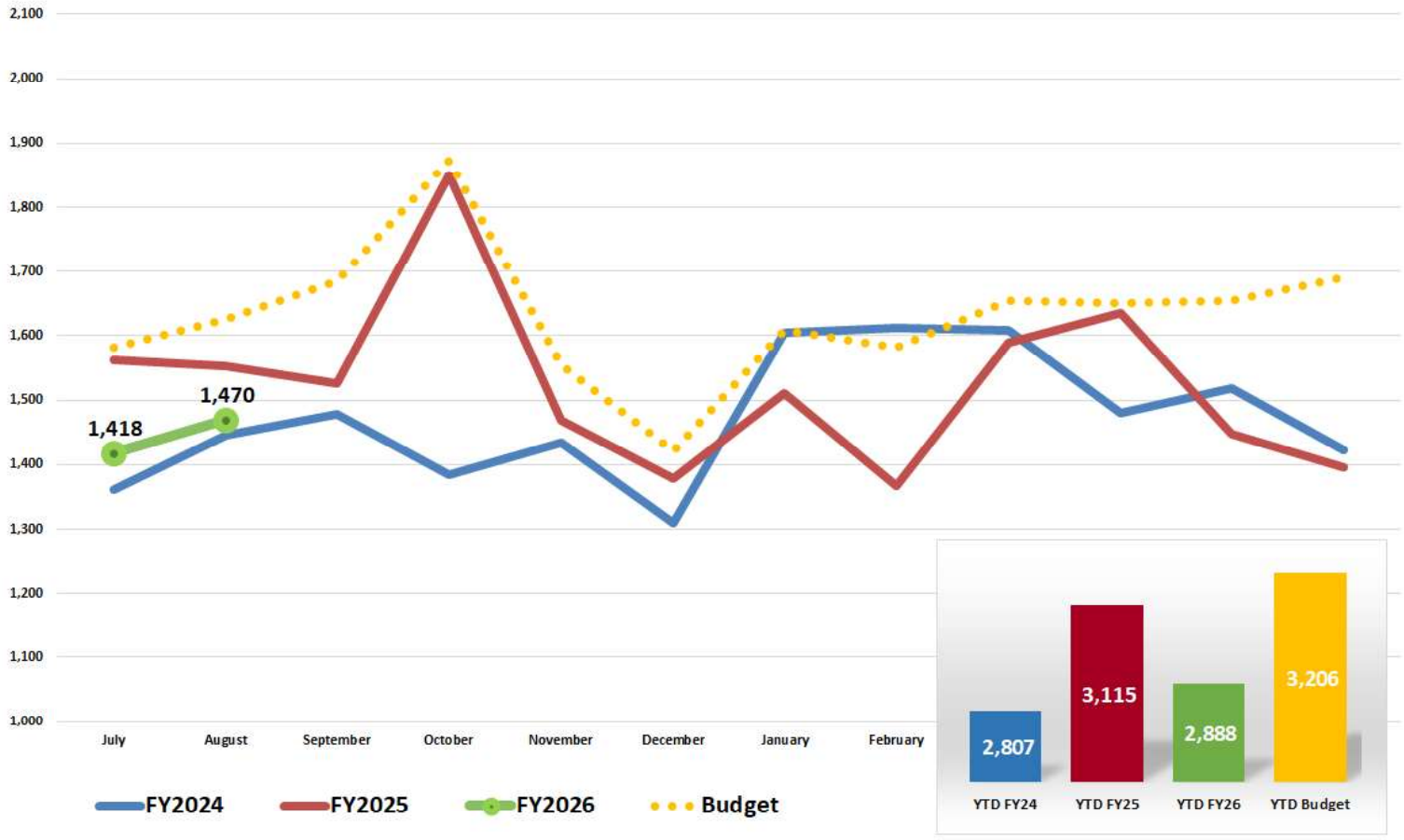


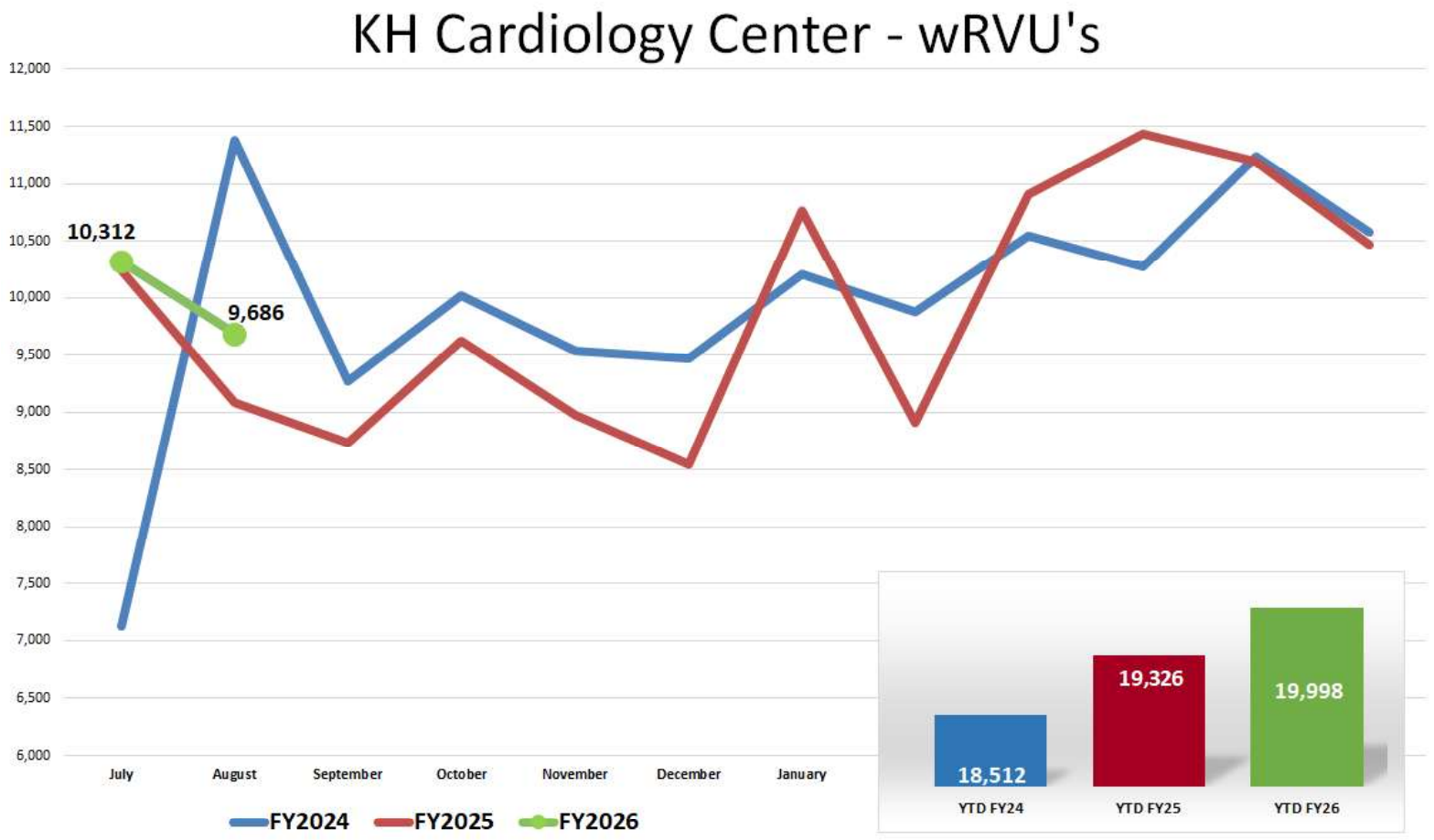



RHC Tulare - Registrations
3,200
3,000
2,800
2,600
2,400
2,200
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
2,443
2,462
July
August
September
October
November
December
January
FY2024
FY2025
FY2026
Budget
3,736
10,768
4,905
4,950
YTD FY24
YTD FY25
YTD FY26
YTD Budget

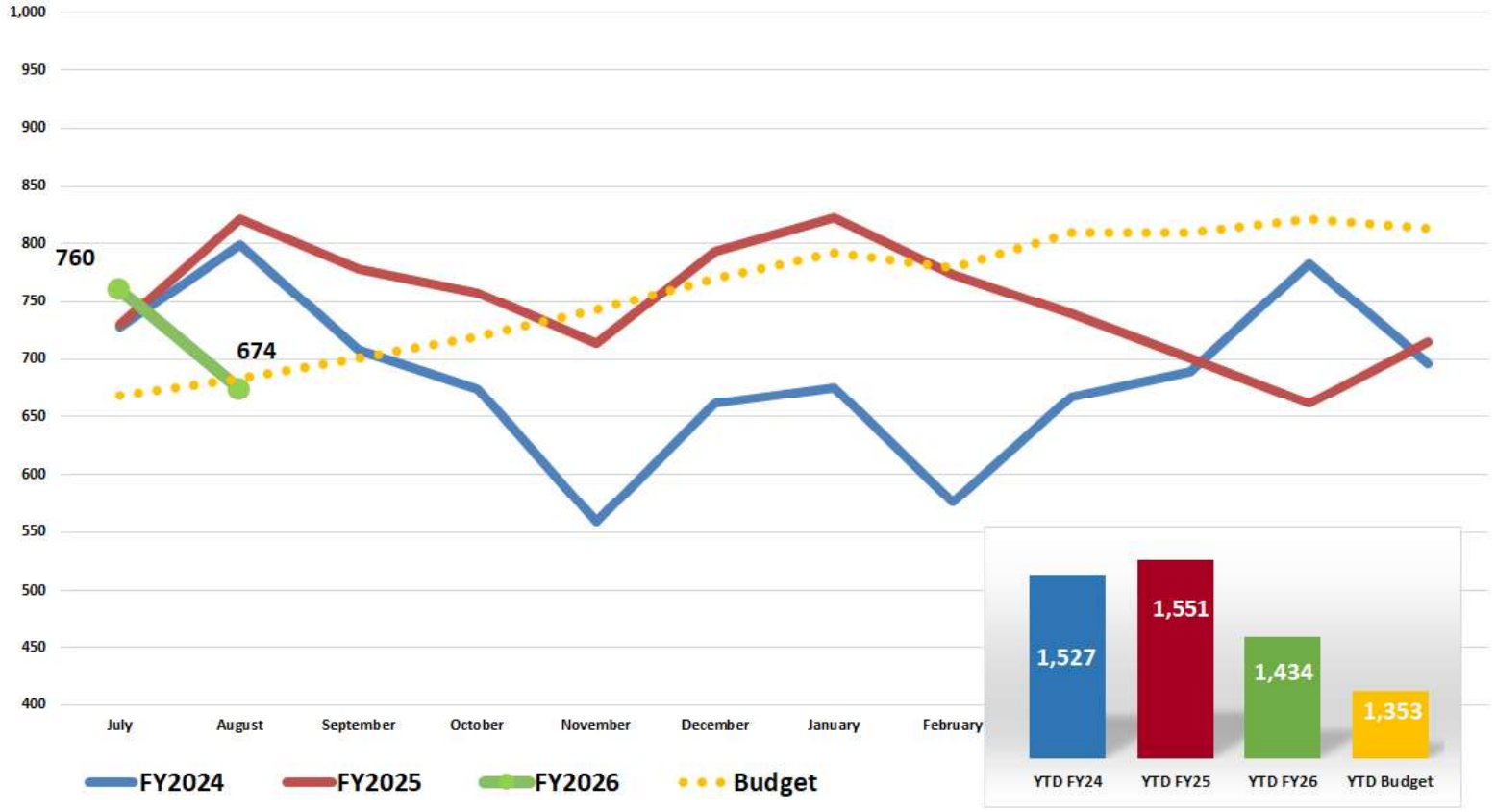

Neurosurgery Clinic - wRVU's
1,200
1,000
800
600
400
200
0
445
490
July
August
September
October
November
December
January
Februa
FY2024
FY2025
FY2026
1,843
1,331
935
YTD FY24
YTD FY25
YTD FY26

KH Cardiology Center Registrations

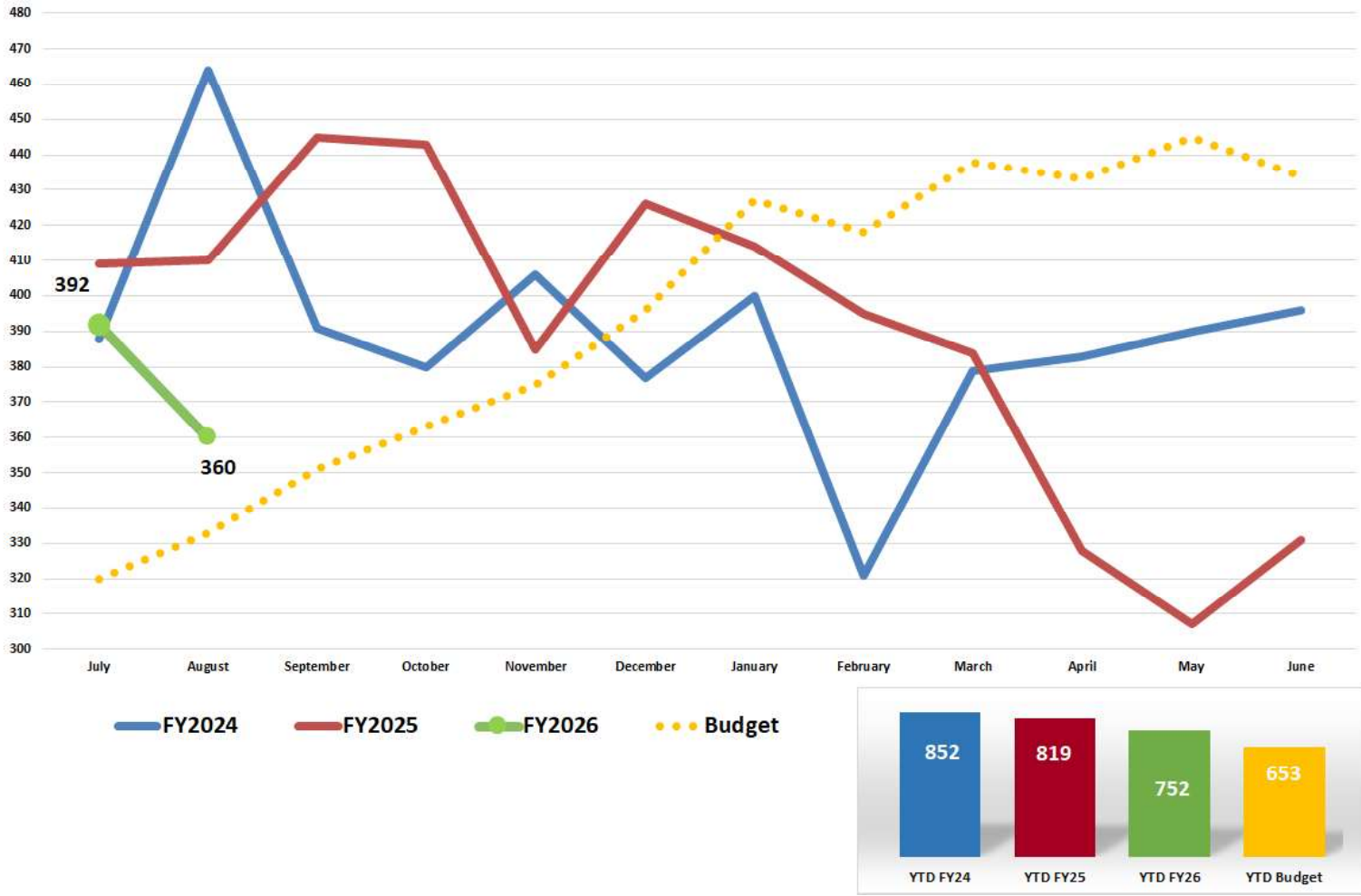



KH Cardiology Center - wRVU's
12,000
11,500
11,000
10,500
10,000
9,500
9,000
8,500
8,000
7,500
7,000
6,500
6,000
10,312
9,686
July
August
September
October
November
December
January
FY2024
FY2025
FY2026
18,512
19,326
19,998
YTD FY24
YTD FY25
YTD FY26

Labor Triage Registrations

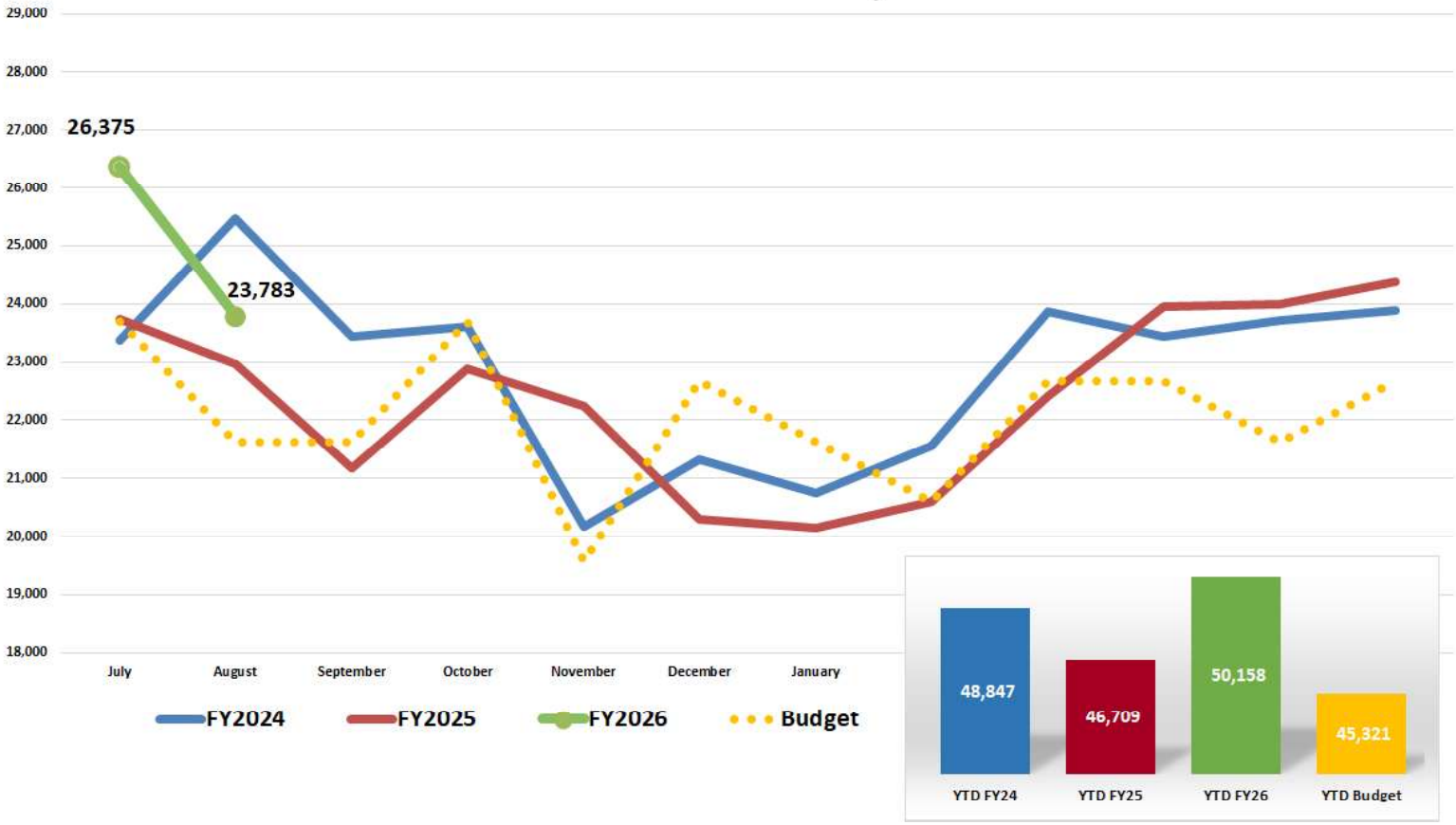


Deliveries

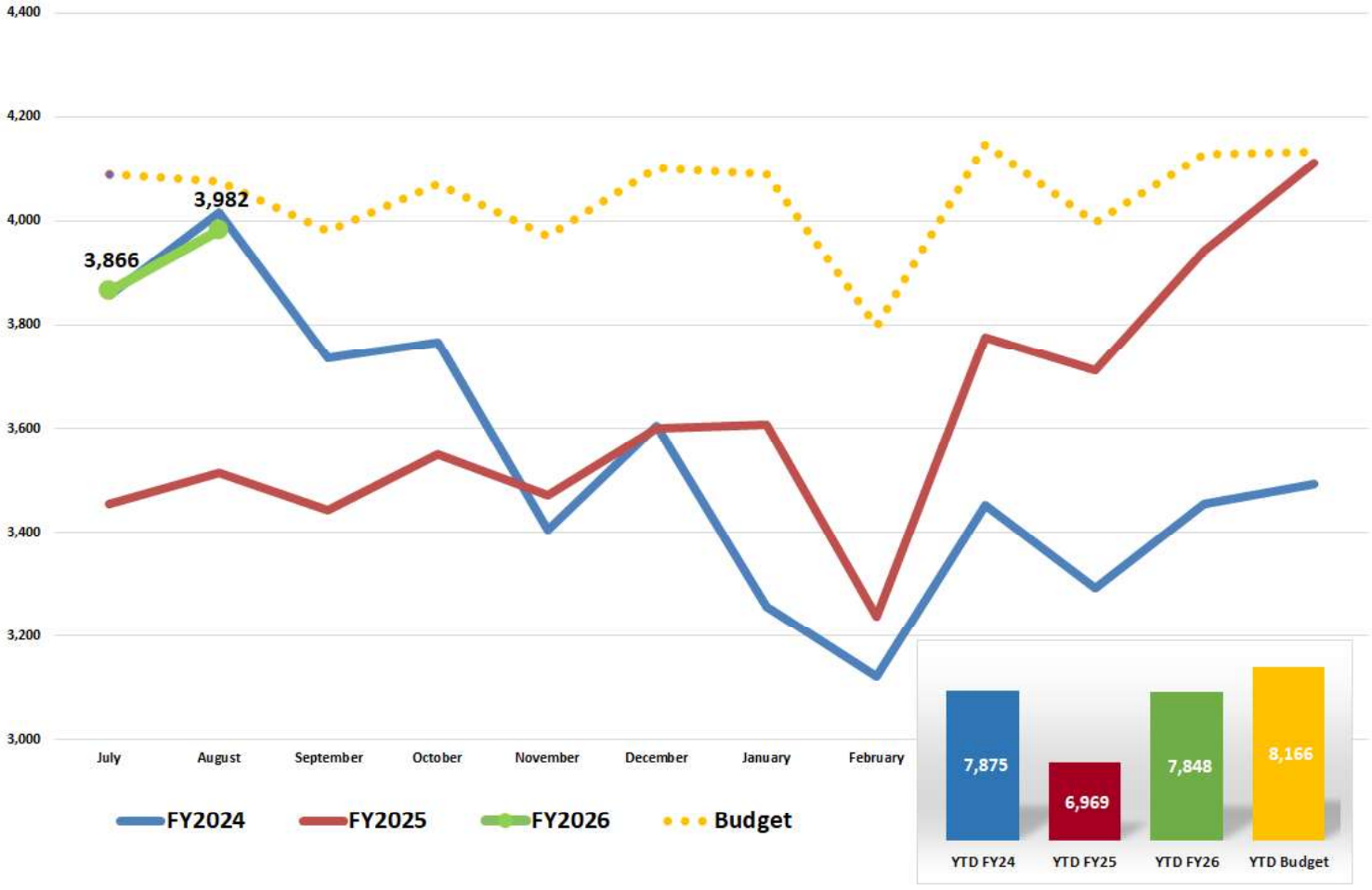

480
470
460
450
440
430
420
410
400
390
380
370
360
350
340
330
320
310
300
392
360
July
August
September
October
November
December
January
February
March
April
May
June
FY2024
FY2025
FY2026
Budget

852
819
752
653
YTD FY24
YTD FY25
YTD FY26
YTD Budget

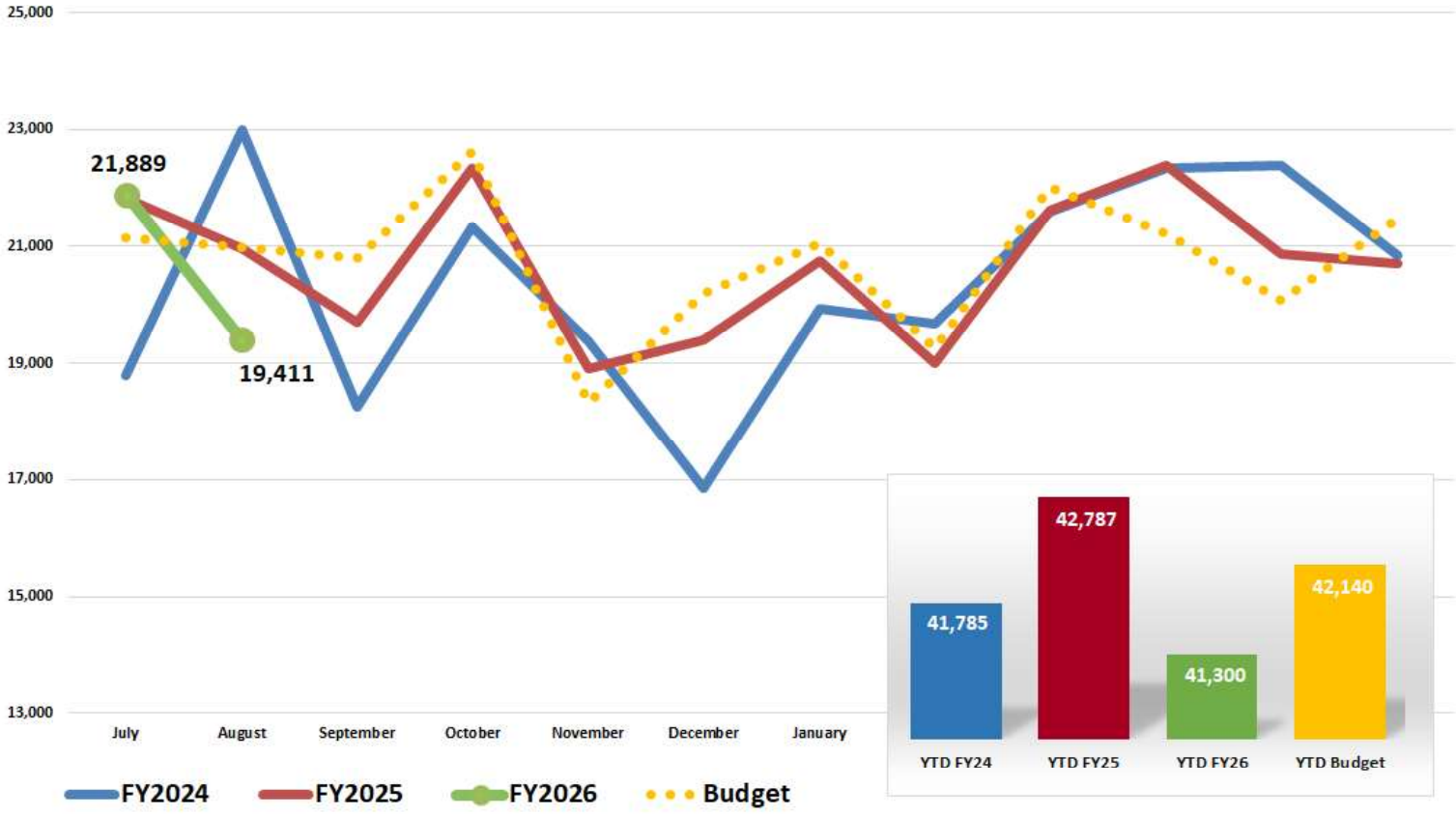
Home Infusion Days



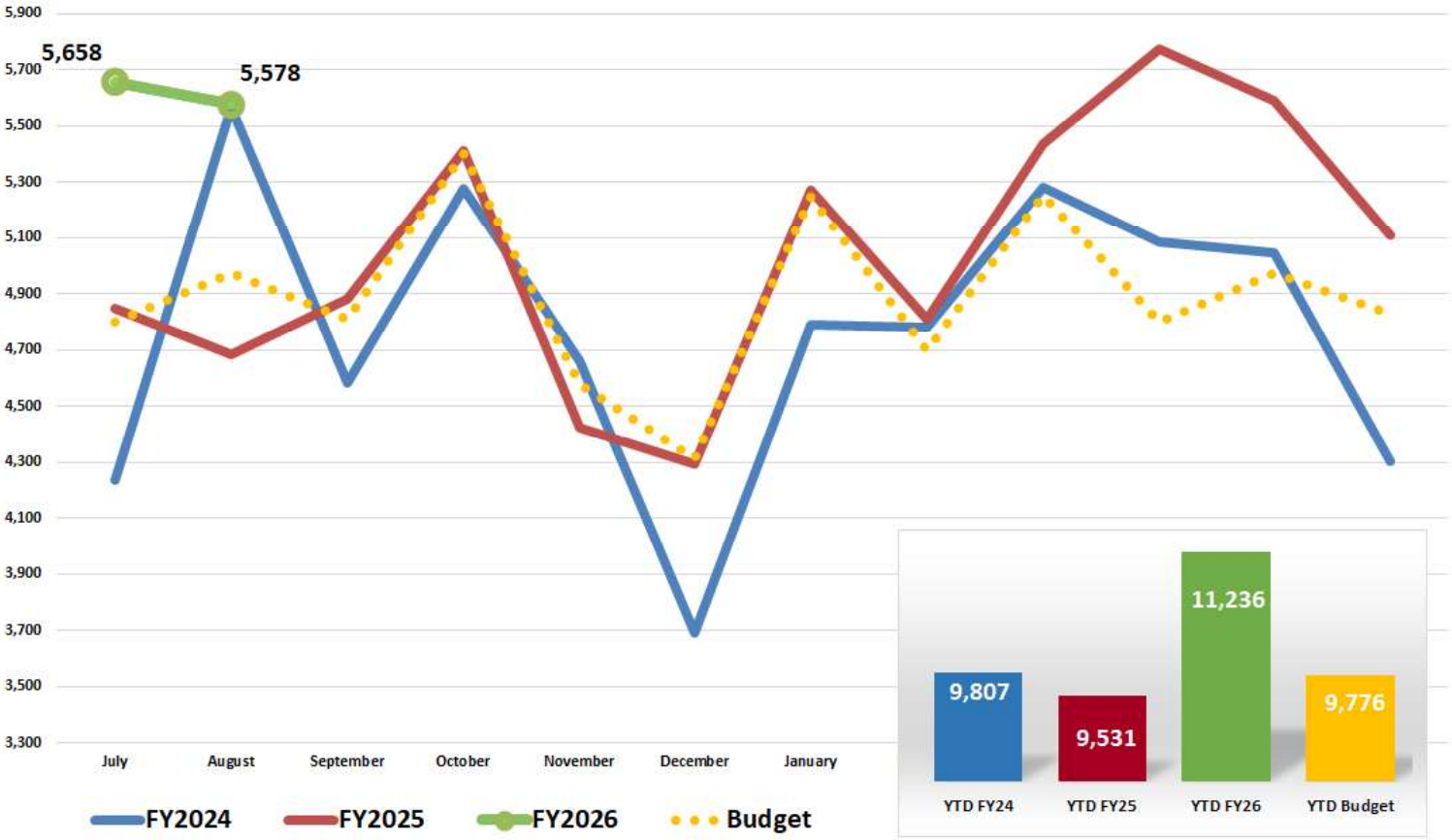
Hospice Days



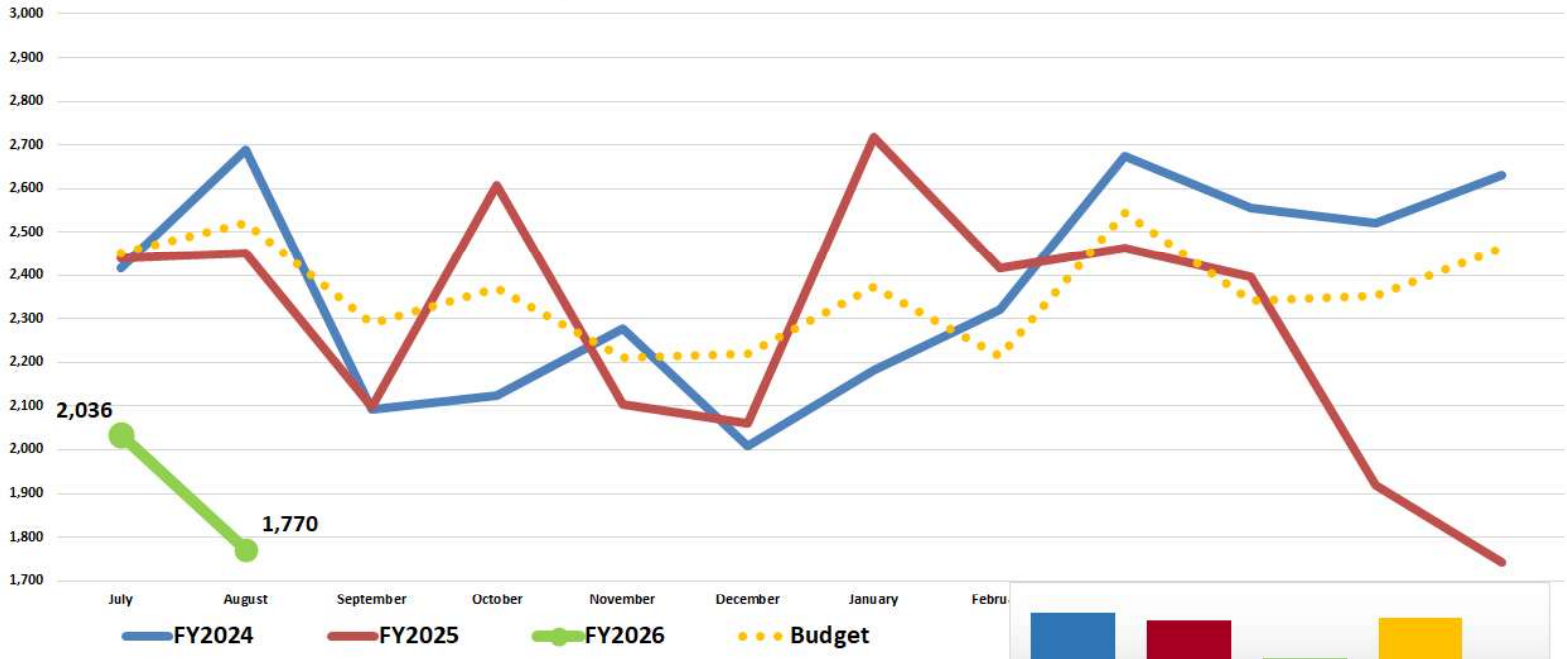
All O/P Rehab Svcs Across District

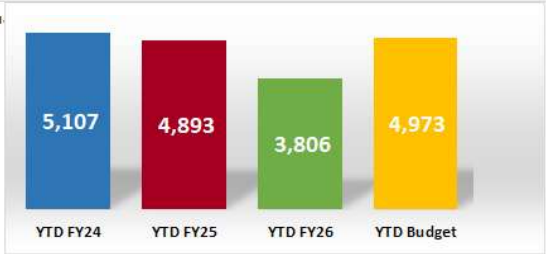


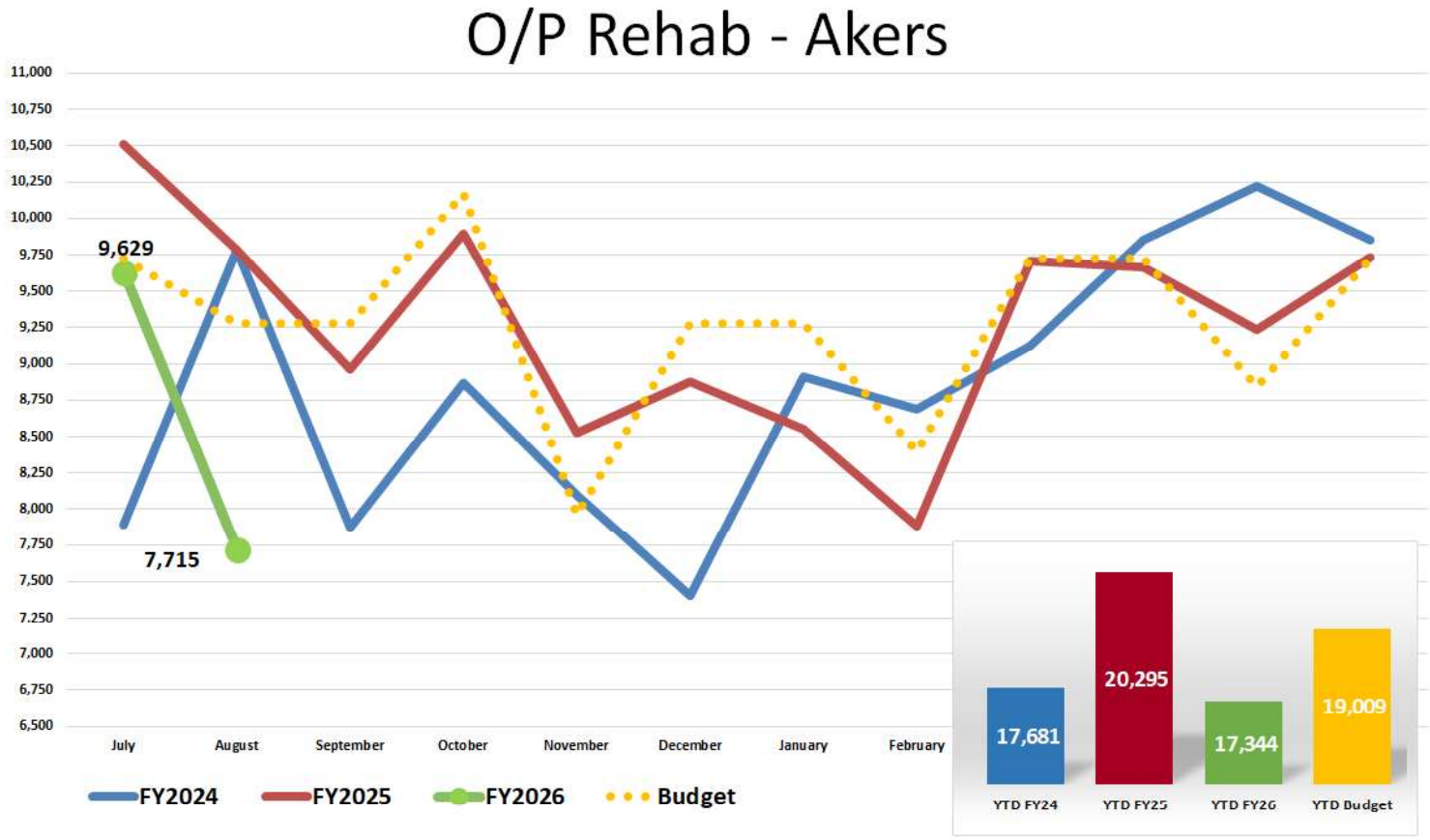
O/P Rehab Services

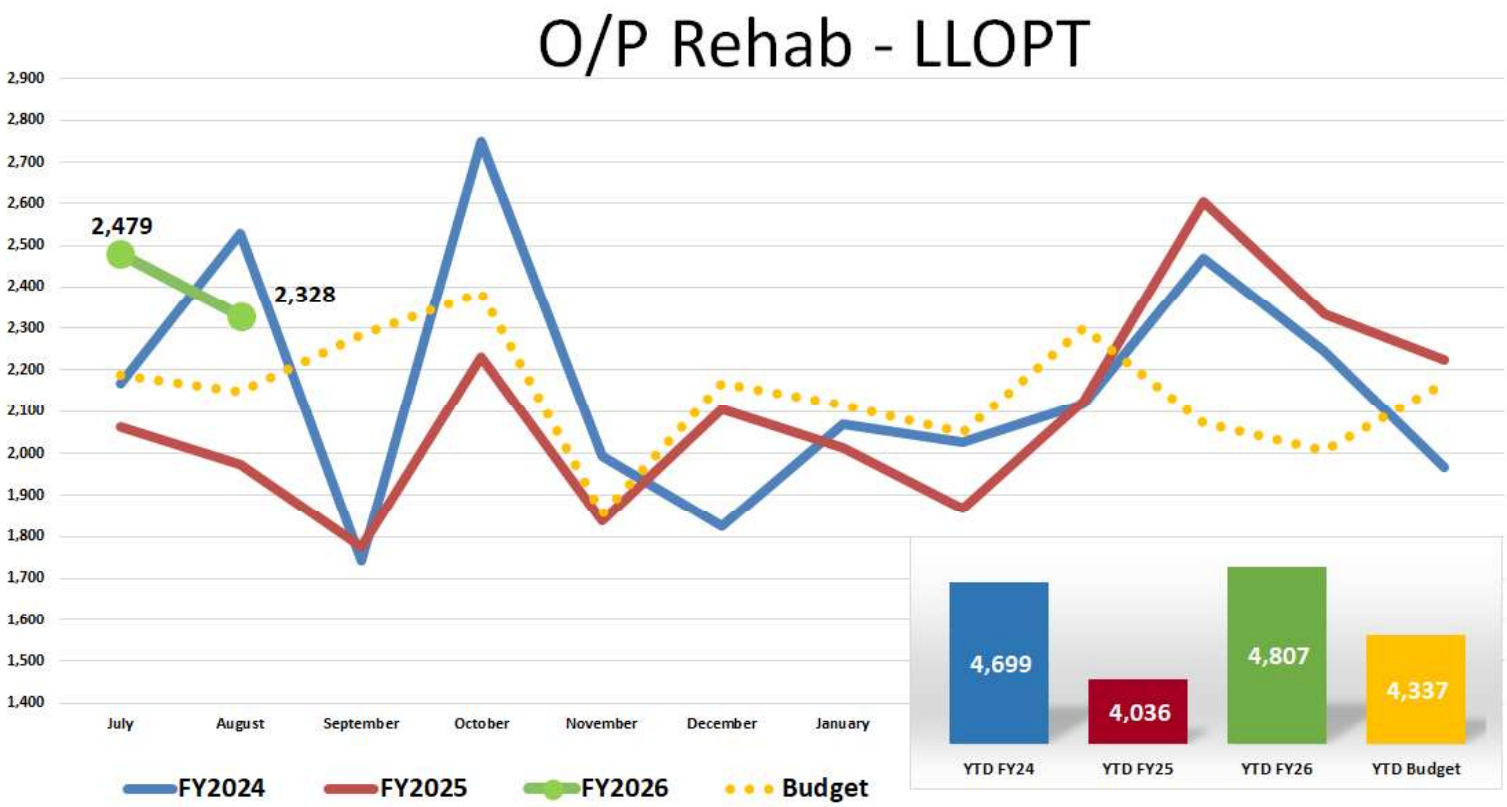


O/P Rehab - Exeter



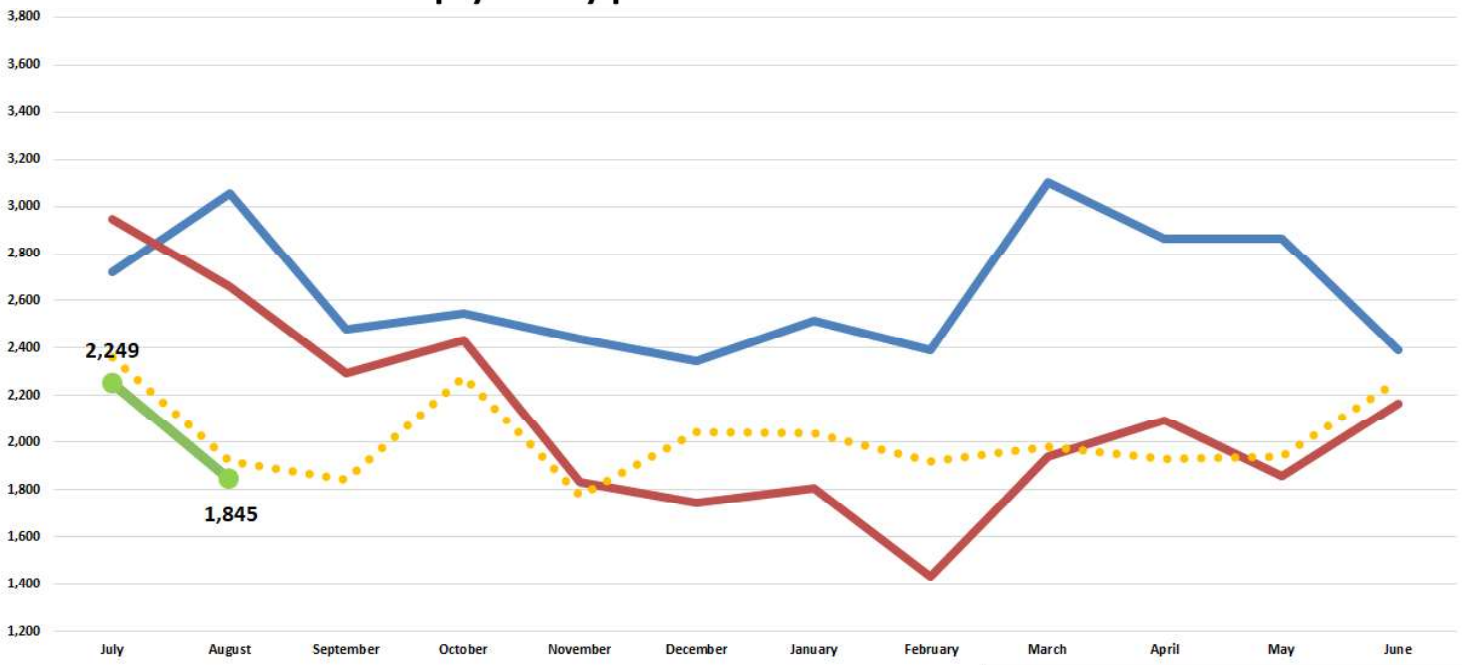


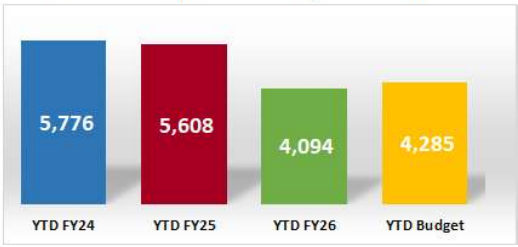

O/P Rehab - Akers
11,000
10,750
10,500
10,250
10,000
9,750
9,500
9,250
9,000
8,750
8,500
8,250
8,000
7,750
7,500
7,250
7,000
6,750
6,500
9,629
7,715
July
August
September
October
November
December
January
February
FY2024
FY2025
FY2026
Budget
17,681
20,295
17,344
19,009
YTD FY24
YTD FY25
YTD FY26
YTD Budget

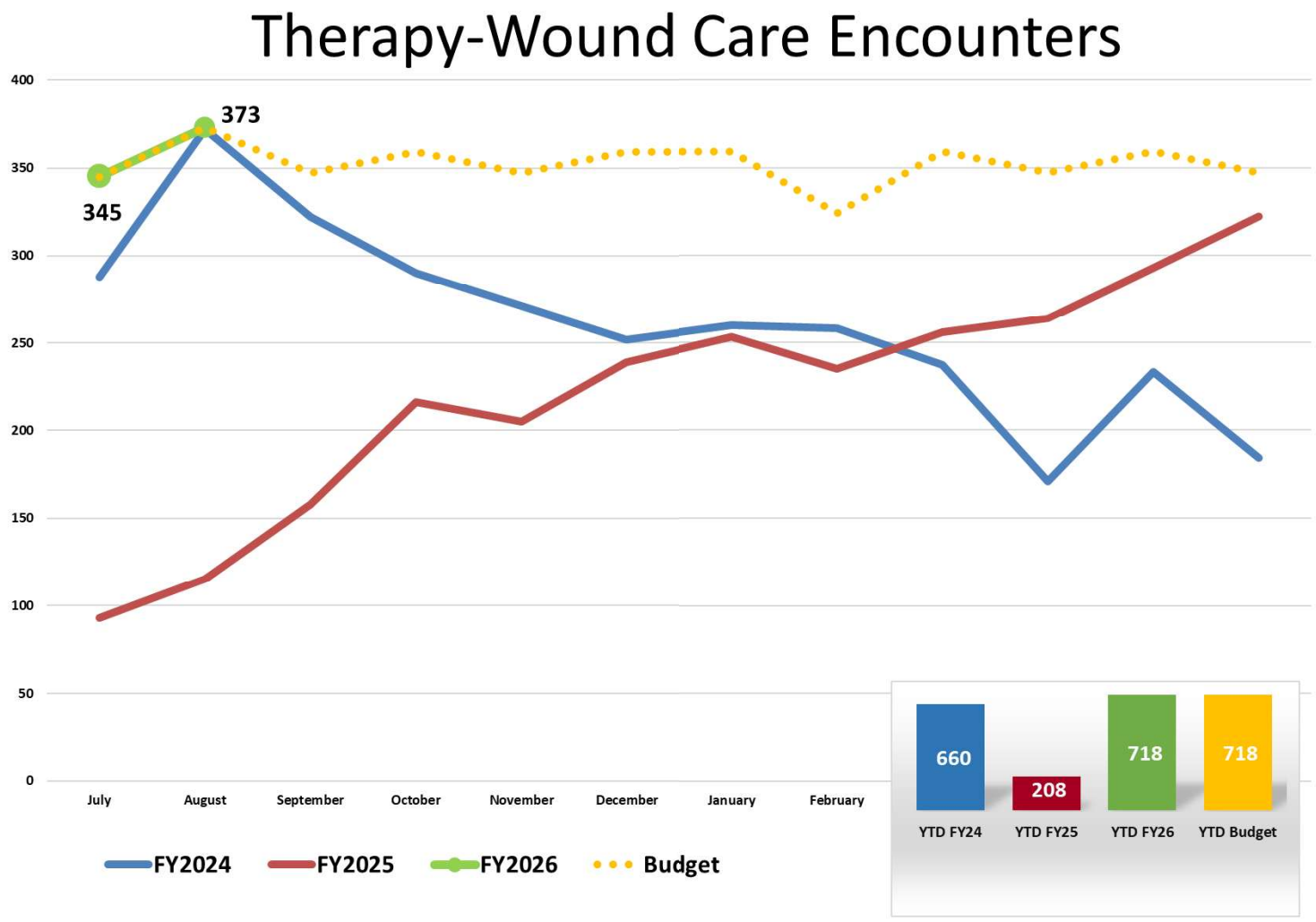

O/P Rehab - LLOPT
2,900
2,800
2,700
2,600
2,500
2,400
2,300
2,200
2,100
2,000
1,900
1,800
1,700
1,600
1,500
1,400
2,479
2,328
July
August
September
October
November
December
January
FY2024
FY2025
FY2026
Budget
4,699
4,036
4,807
4,337
YTD FY24
YTD FY25
YTD FY26
YTD Budget

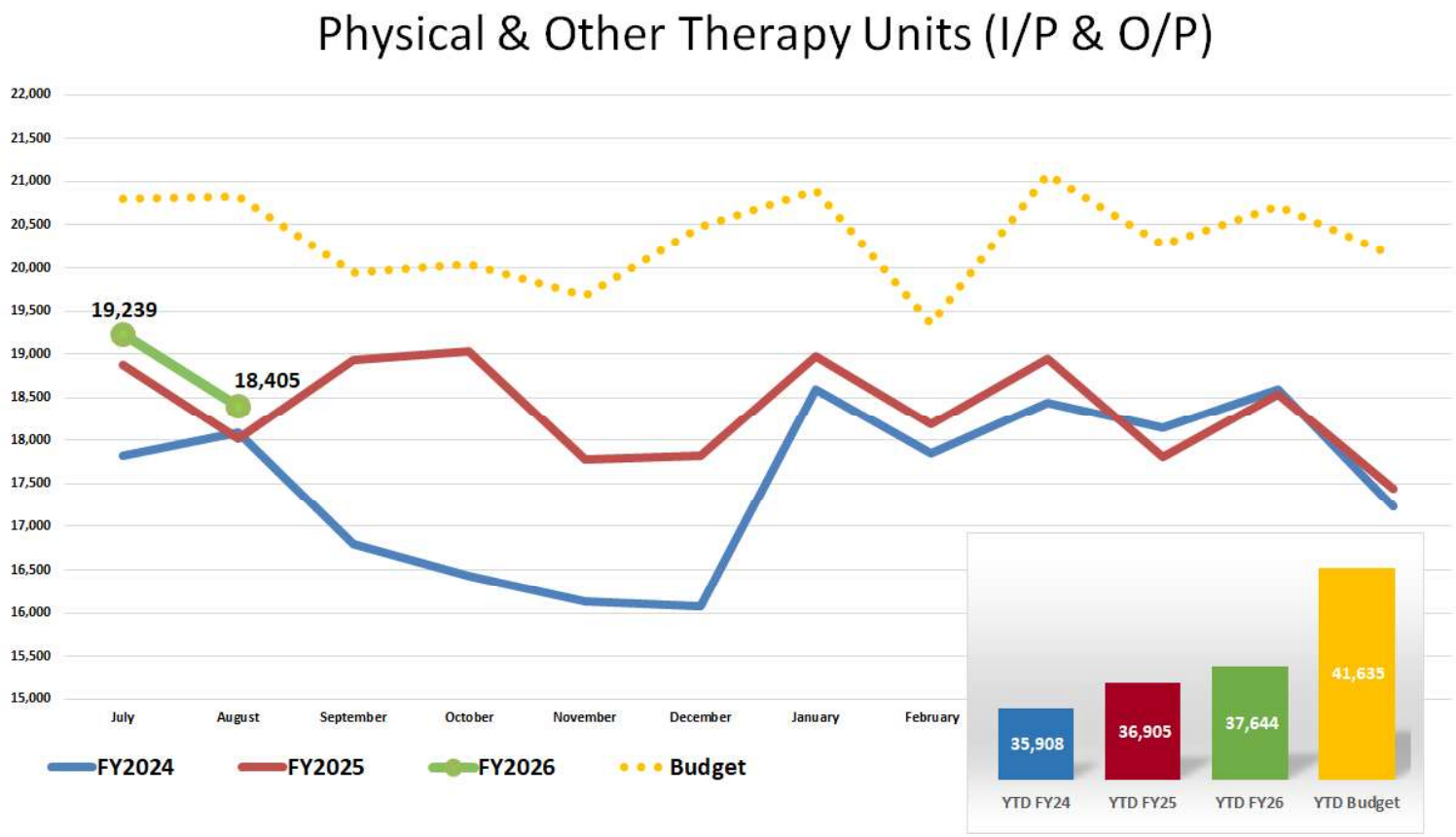
O/P Rehab - Dinuba

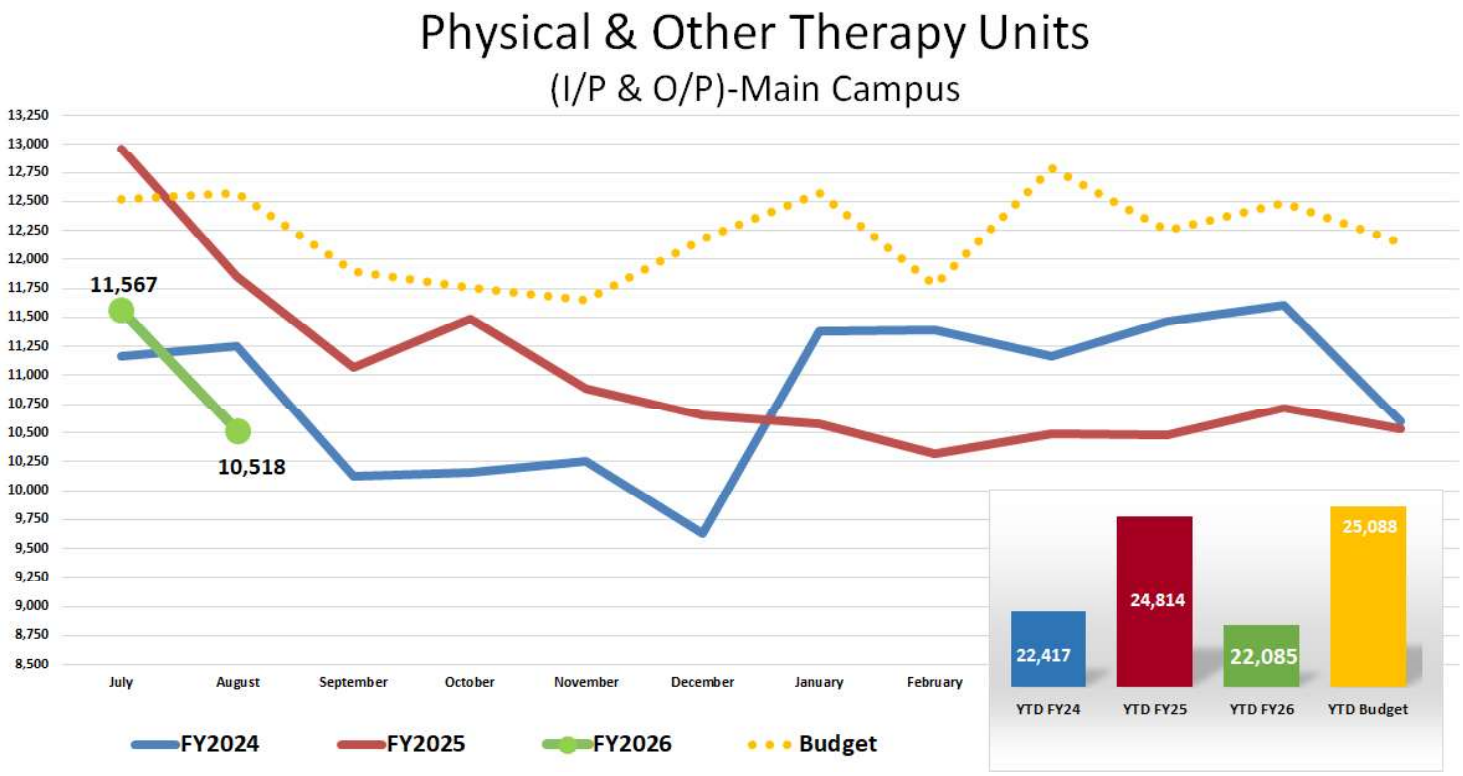
Therapy - Cypress Hand Center



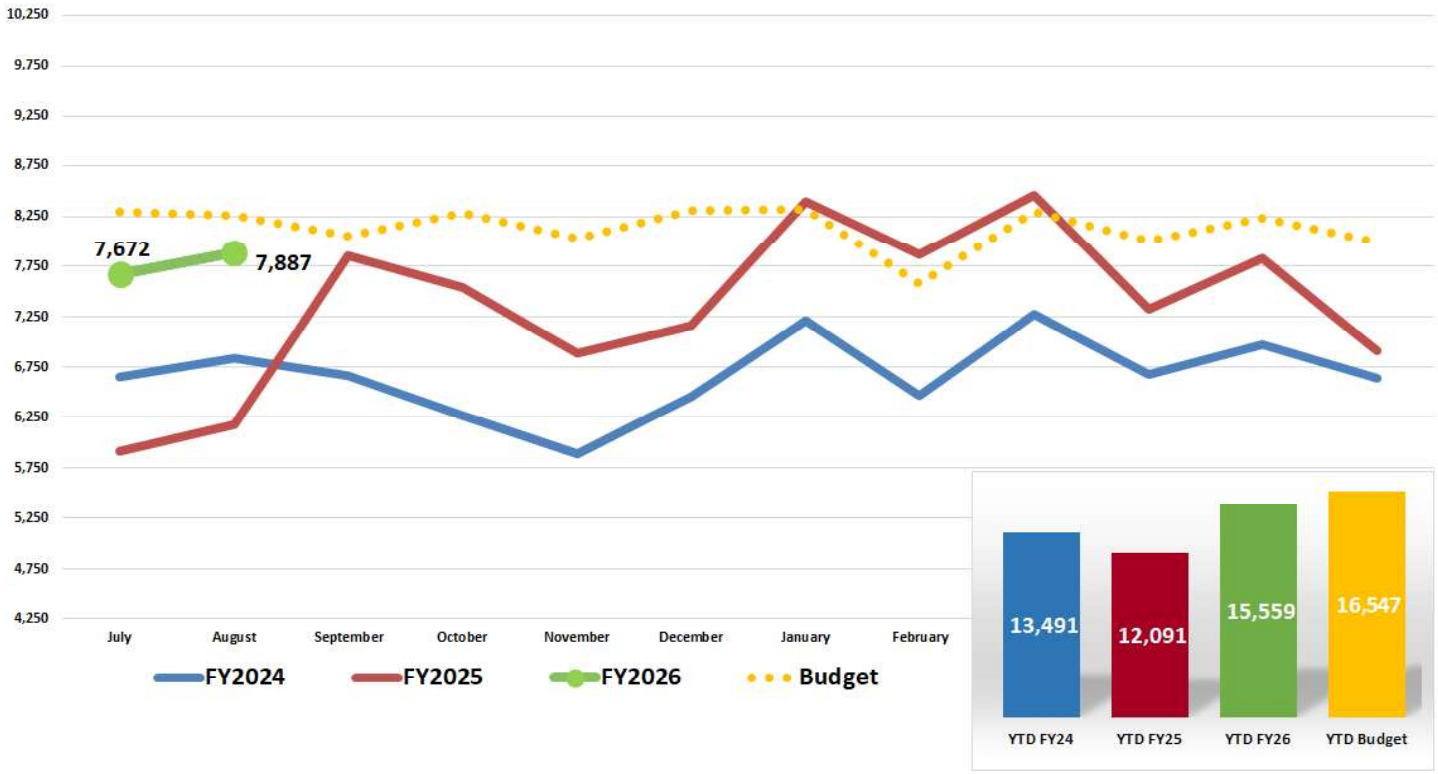


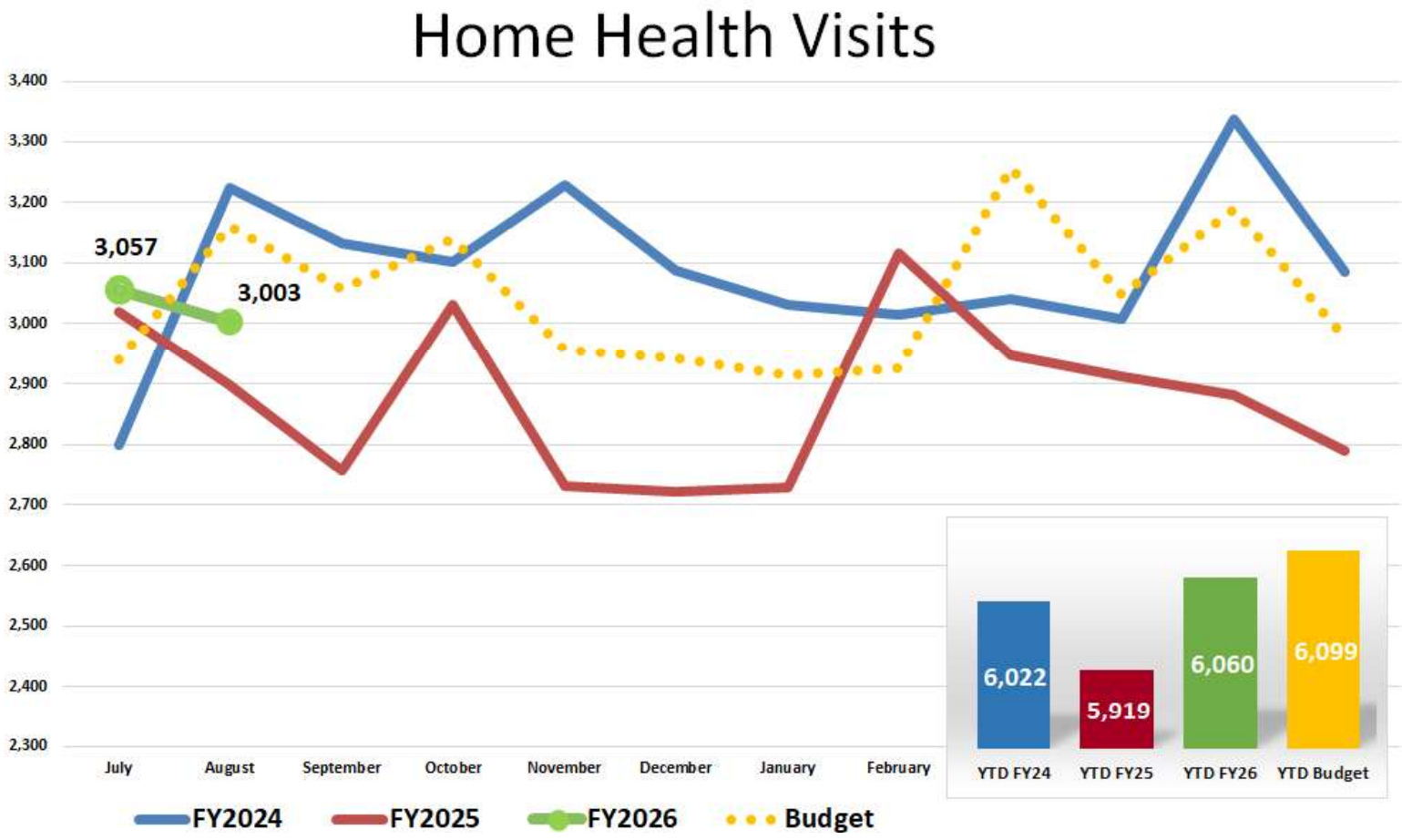

Therapy-Wound Care Encounters
400
350
300
250
200
150
100
50
0
373
345
July
August
September
October
November
December
January
February
FY2024
FY2025
FY2026
Budget
660
208
718
718
YTD FY24
YTD FY25
YTD FY26
YTD Budget

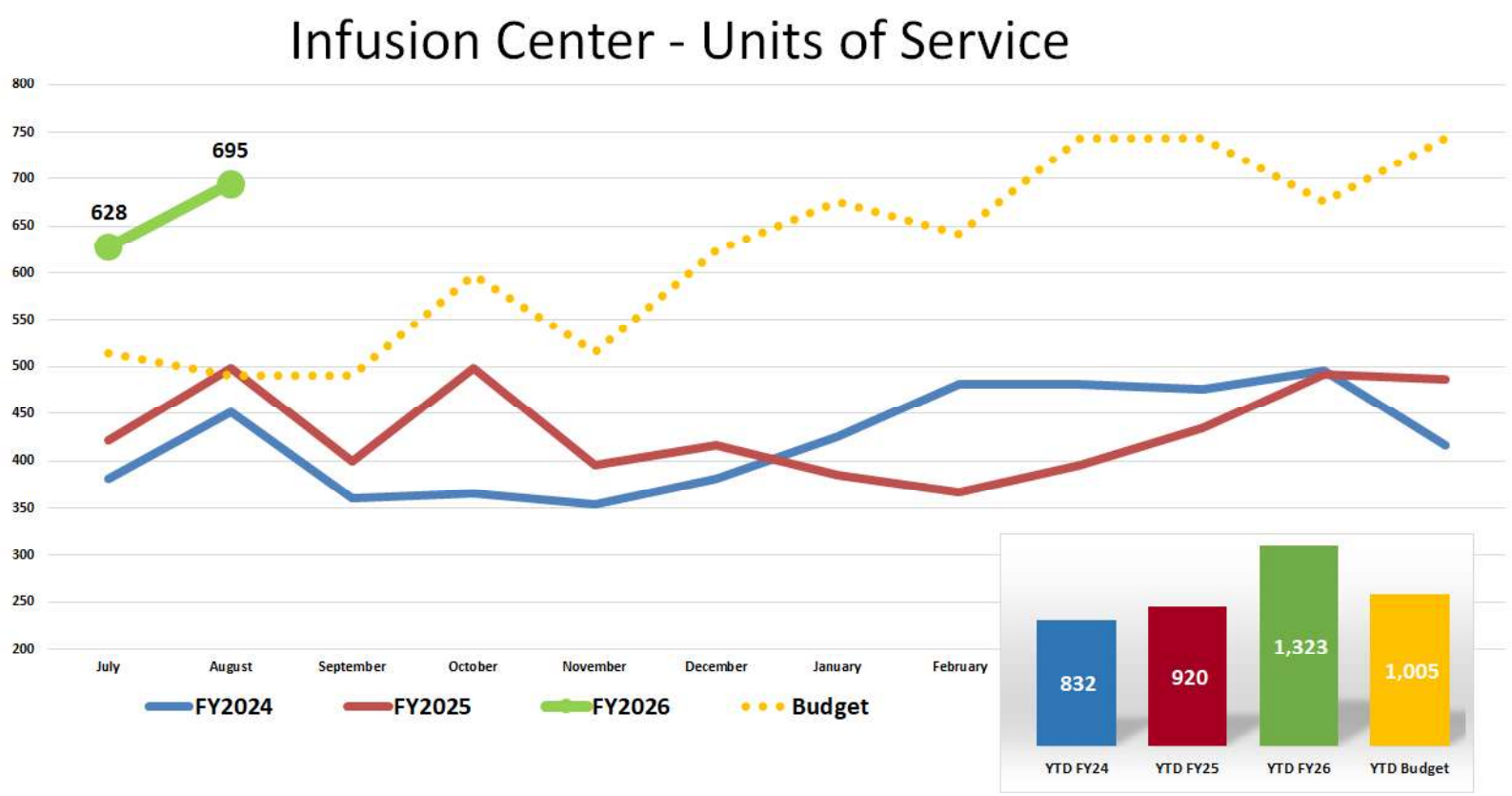

Physical & Other Therapy Units (I/P & O/P)
22,000
21,500
21,000
20,500
20,000
19,500
19,000
18,500
18,000
17,500
17,000
16,500
16,000
15,500
15,000
19,239
18,405
July
August
September
October
November
December
January
February
FY2024
FY2025
FY2026
Budget
35,908
36,905
37,644
41,635
YTD FY24
YTD FY25
YTD FY26
YTD Budget


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
10,518
July
August
September
October
November
December
January
February
FY2024
FY2025
FY2026
Budget
22,417
24,814
22,085
25,088
YTD FY24
YTD FY25
YTD FY26
YTD Budget

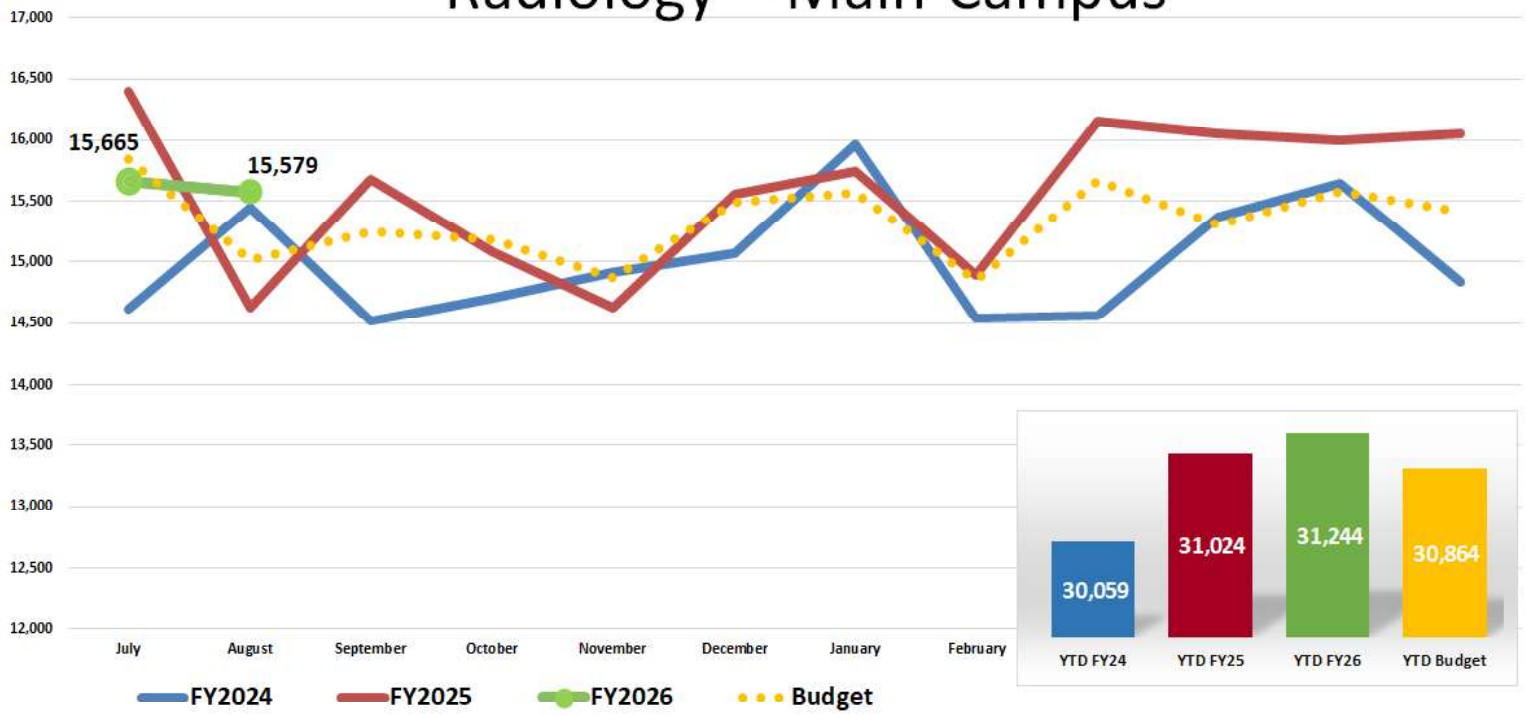
Physical & Other Therapy Units (I/P & O/P)-KDRH & South Campus

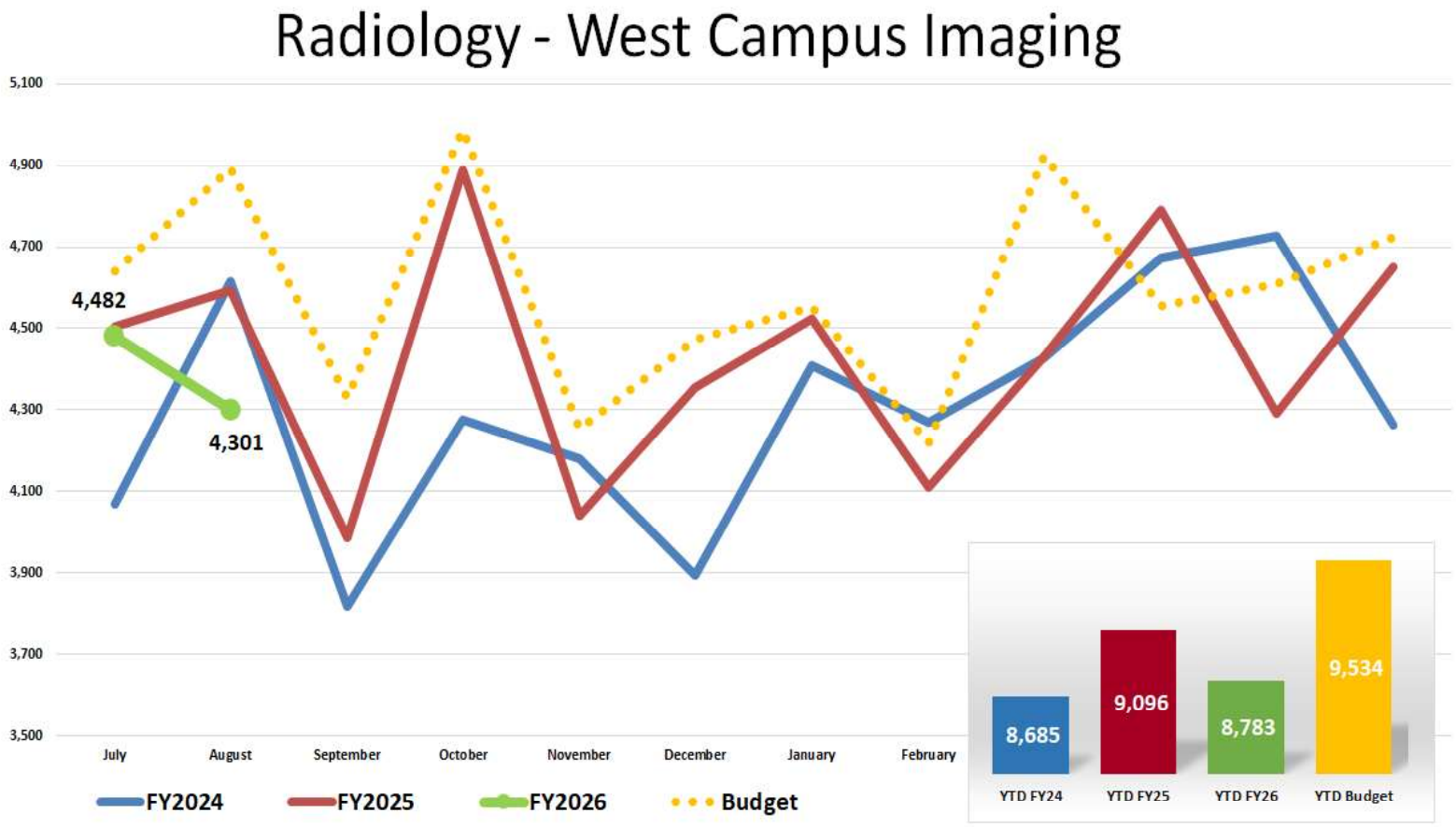


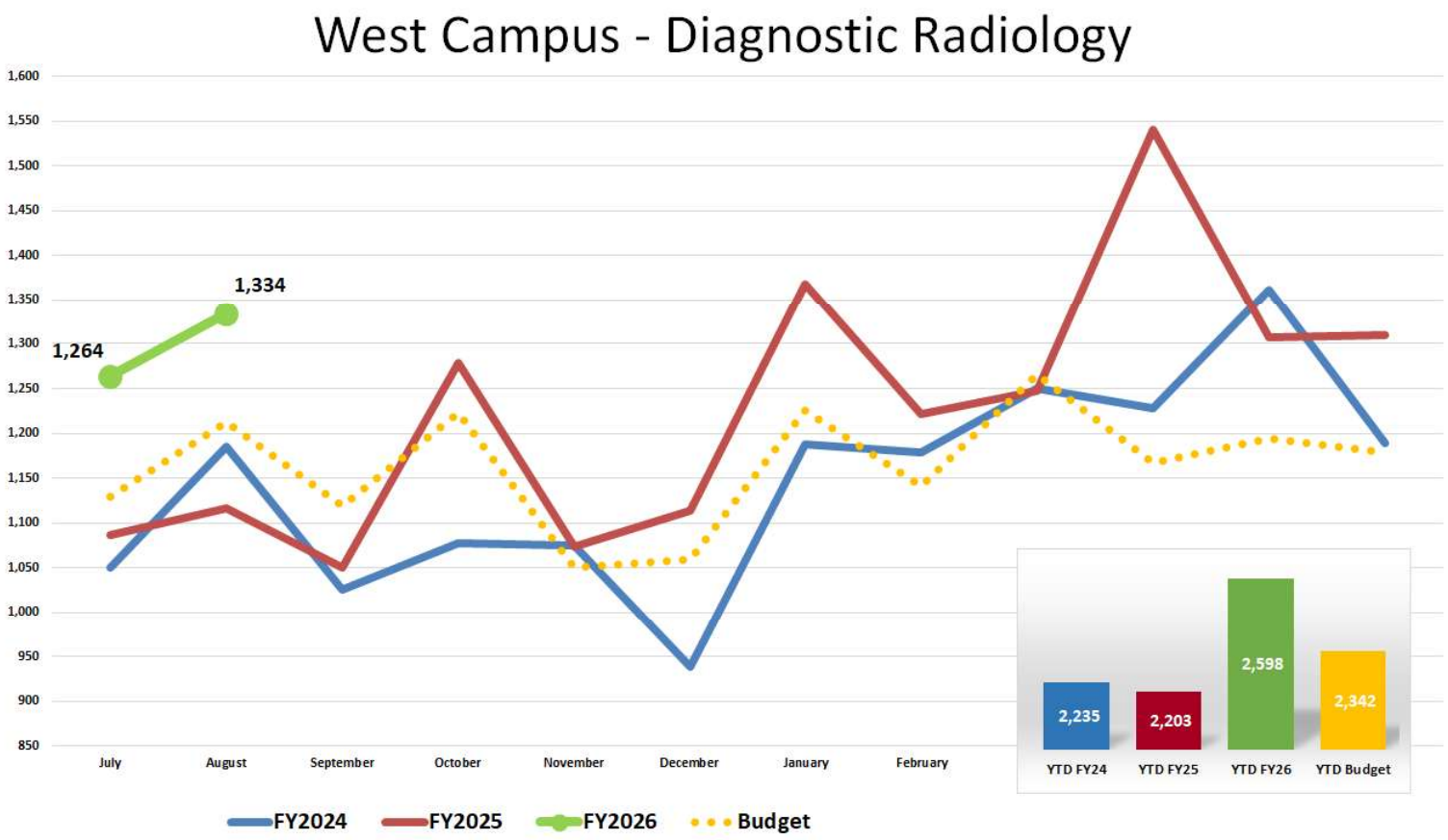

Home Health Visits
3,400
3,300
3,200
3,100
3,000
2,900
2,800
2,700
2,600
2,500
2,400
2,300
3,057
3,003
July
August
September
October
November
December
January
February
FY2024
FY2025
FY2026
Budget
6,022
5,919
6,060
6,099
YTD FY24
YTD FY25
YTD FY26
YTD Budget

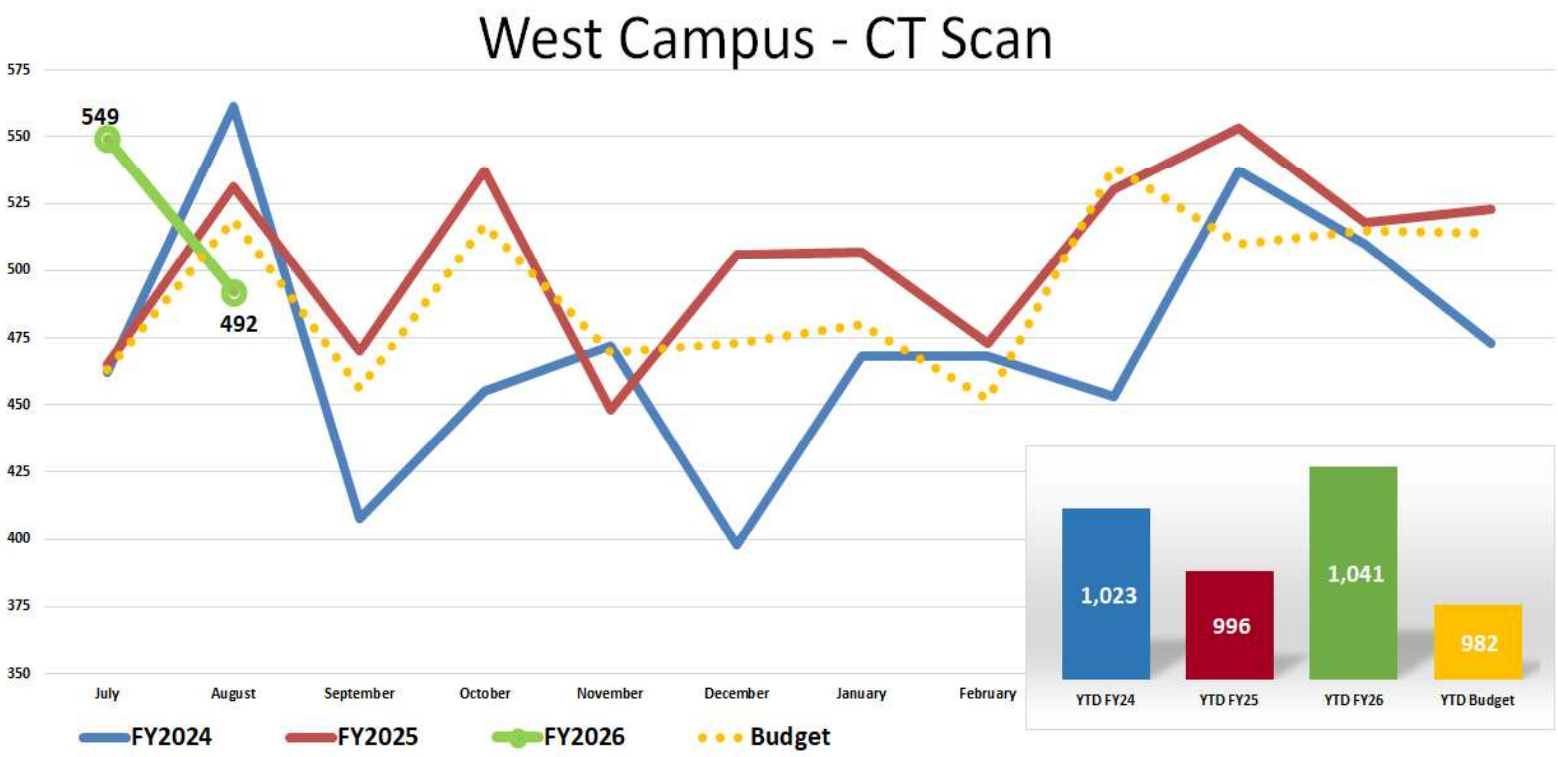

Infusion Center - Units of Service
800
750
700
650
600
550
500
450
400
350
300
250
200
695
628
July
August
September
October
November
December
January
February
FY2024
FY2025
FY2026
Budget
832
920
1,323
1,005
YTD FY24
YTD FY25
YTD FY26
YTD Budget

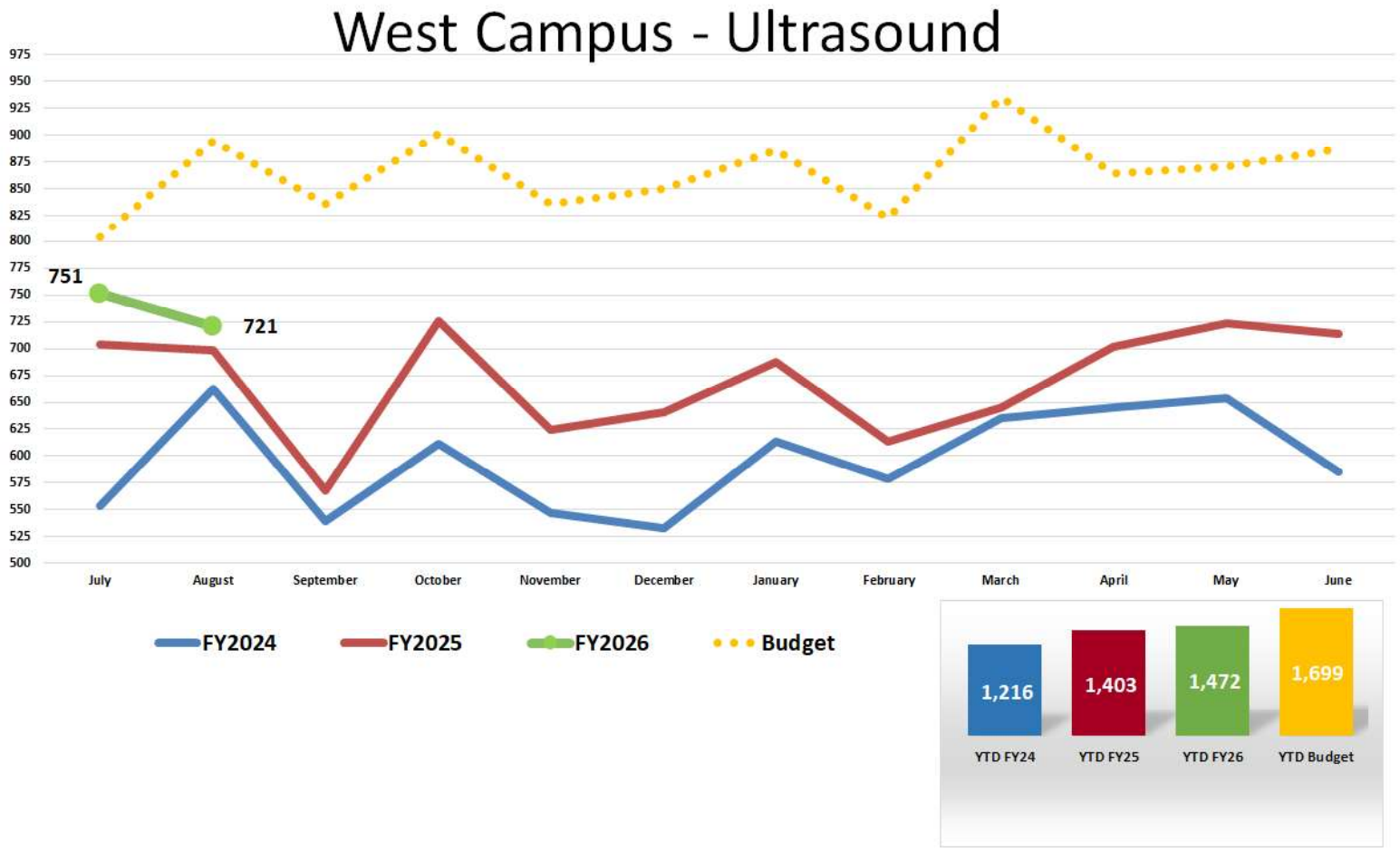
Radiology – Main Campus

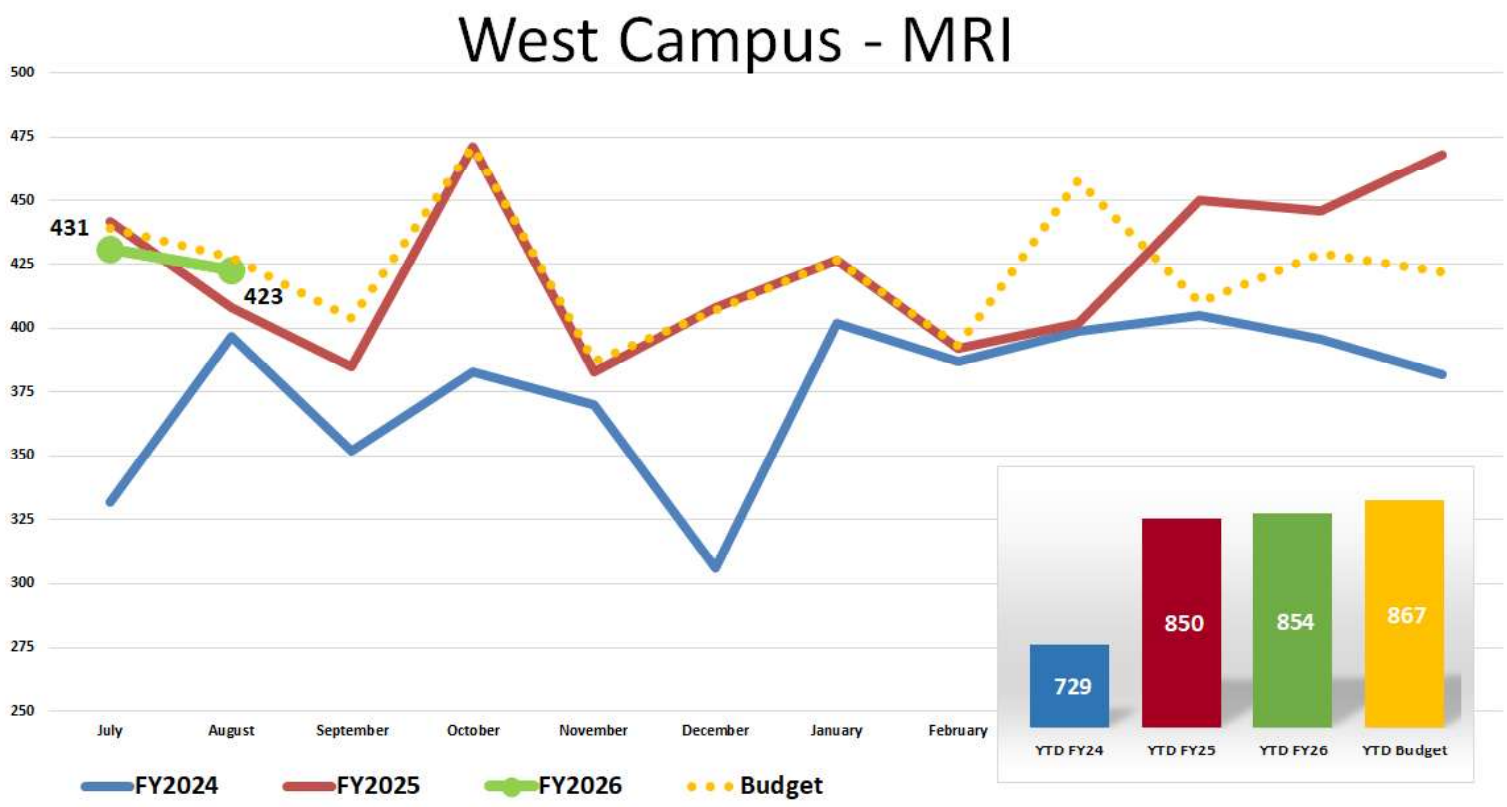


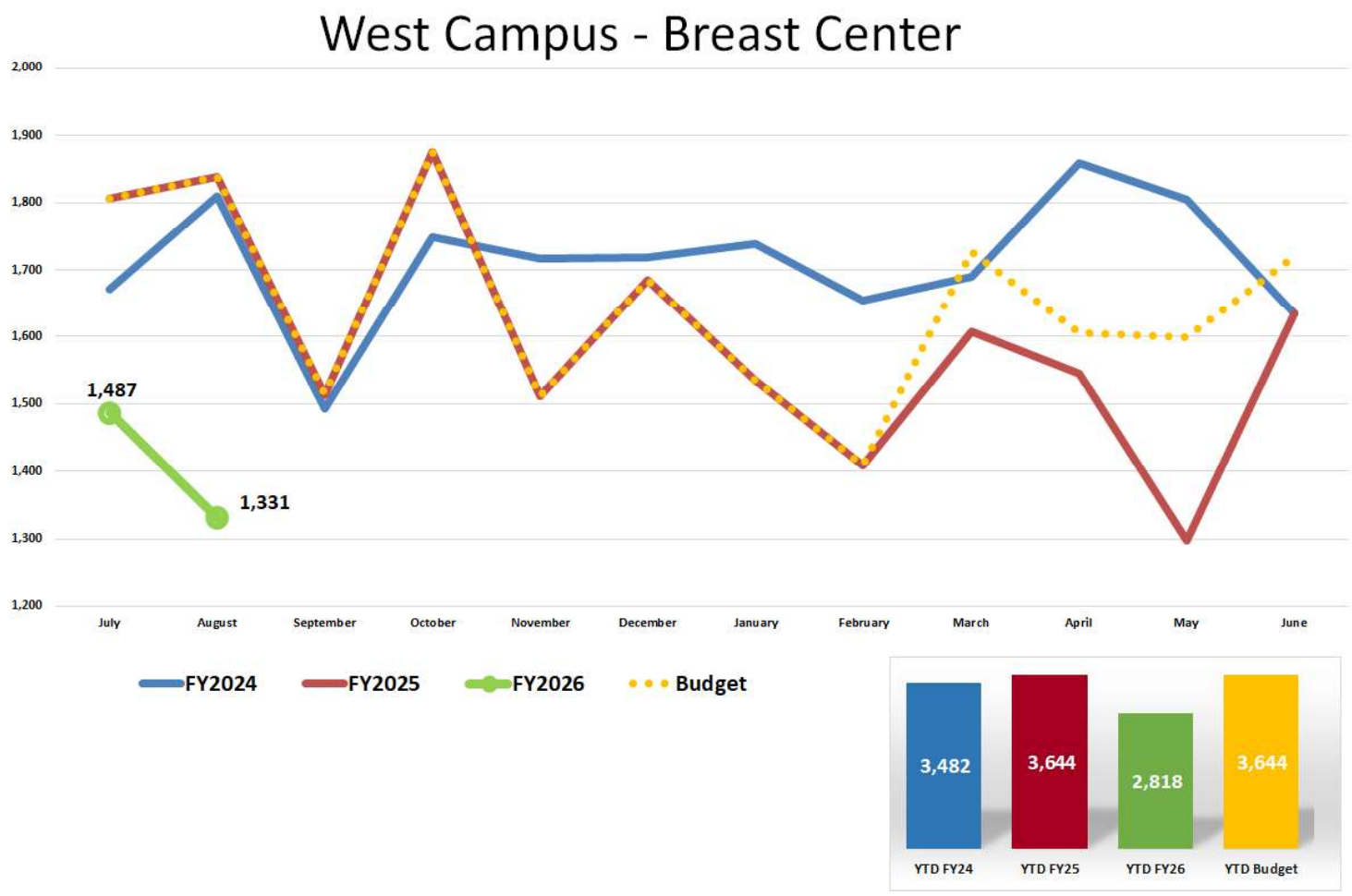

Radiology - West Campus Imaging
5,100
4,900
4,700
4,500
4,300
4,100
3,900
3,700
3,500
4,482
4,301
July
August
September
October
November
December
January
February
FY2024
FY2025
FY2026
Budget
8,685
9,096
8,783
9,534
YTD FY24
YTD FY25
YTD FY26
YTD Budget

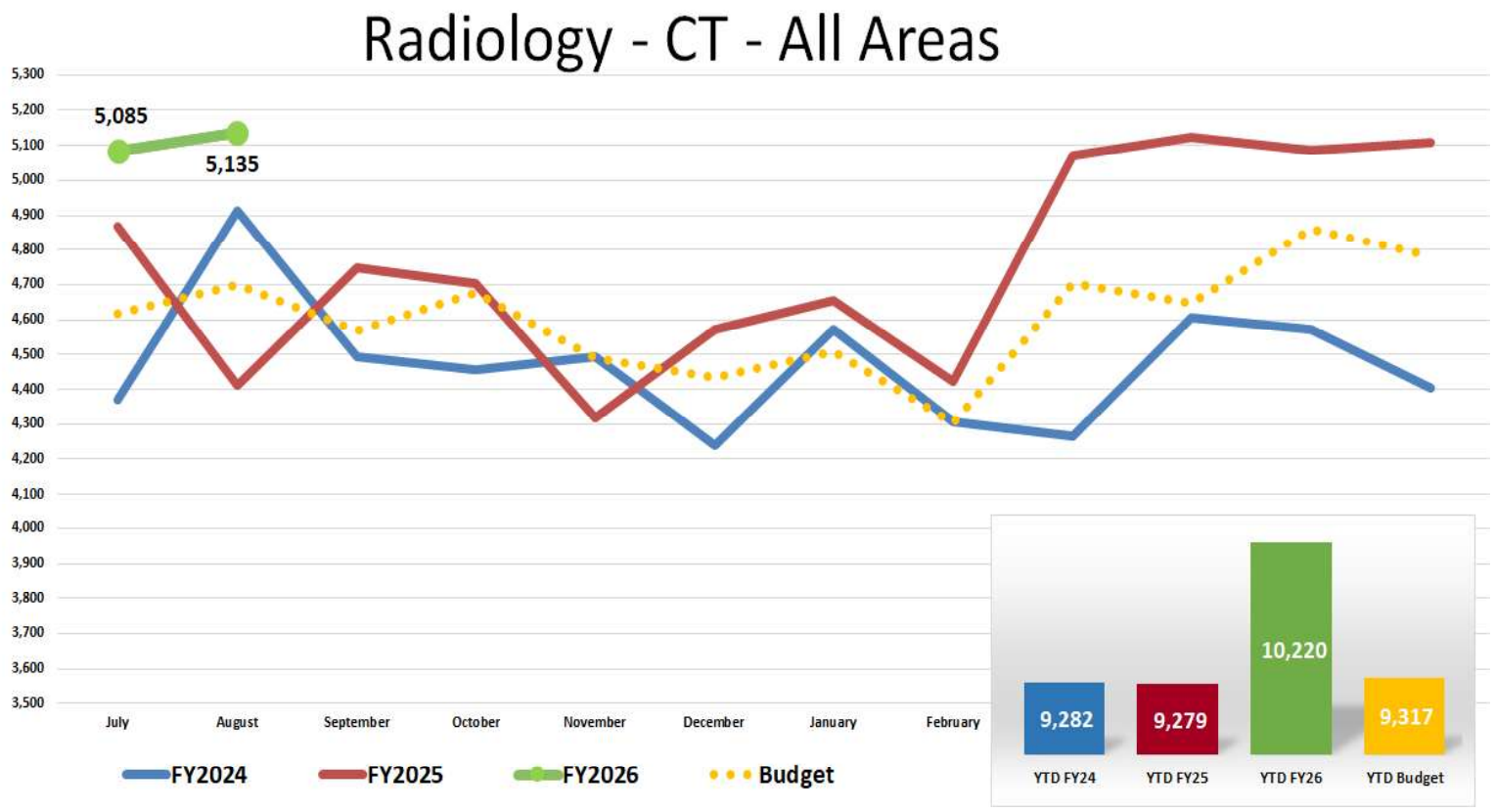

West Campus - Diagnostic Radiology
1,600
1,550
1,500
1,450
1,400
1,350
1,300
1,250
1,200
1,150
1,100
1,050
1,000
950
900
850
1,334
1,264
July
August
September
October
November
December
January
February
2,235
2,203
2,598
2,342
YTD FY24
YTD FY25
YTD FY26
YTD Budget
FY2024
FY2025
FY2026
Budget


West Campus - CT Scan
575
550
525
500
475
450
425
400
375
350
549
492
July
August
September
October
November
December
January
February
FY2024
FY2025
FY2026
Budget
1,023
996
1,041
982
YTD FY24
YTD FY25
YTD FY26
YTD Budget

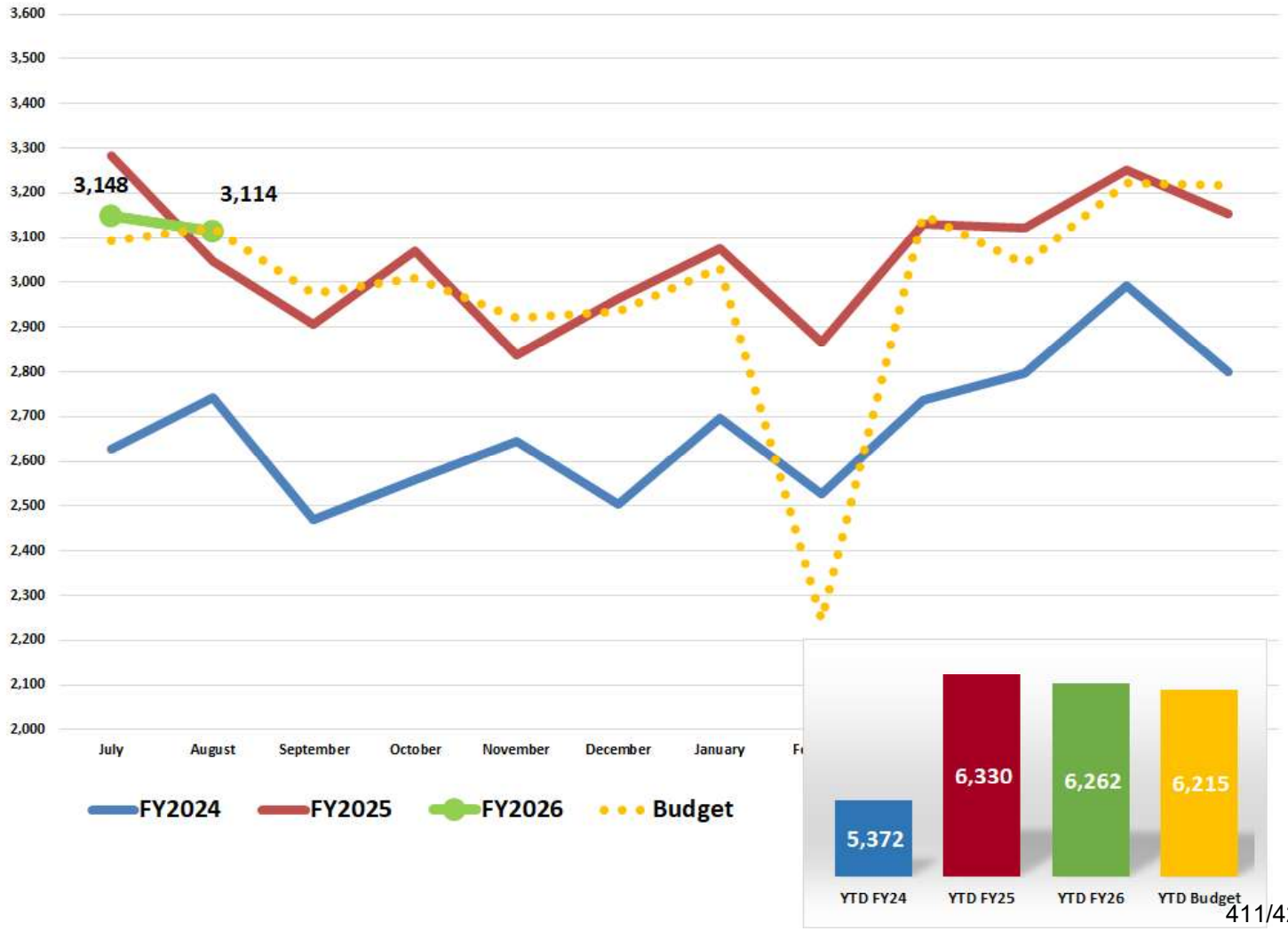

West Campus - Ultrasound
975
950
925
900
875
850
825
800
775
750
725
700
675
650
625
600
575
550
525
500
751
721
July
August
September
October
November
December
January
February
March
April
May
June
FY2024
FY2025
FY2026
Budget
1,216
1,403
1,472
1,699
YTD FY24
YTD FY25
YTD FY26
YTD Budget


West Campus - MRI
500
475
450
425
400
375
350
325
300
275
250
431
423
July
August
September
October
November
December
January
February
FY2024
FY2025
FY2026
Budget
729
850
854
867
YTD FY24
YTD FY25
YTD FY26
YTD Budget

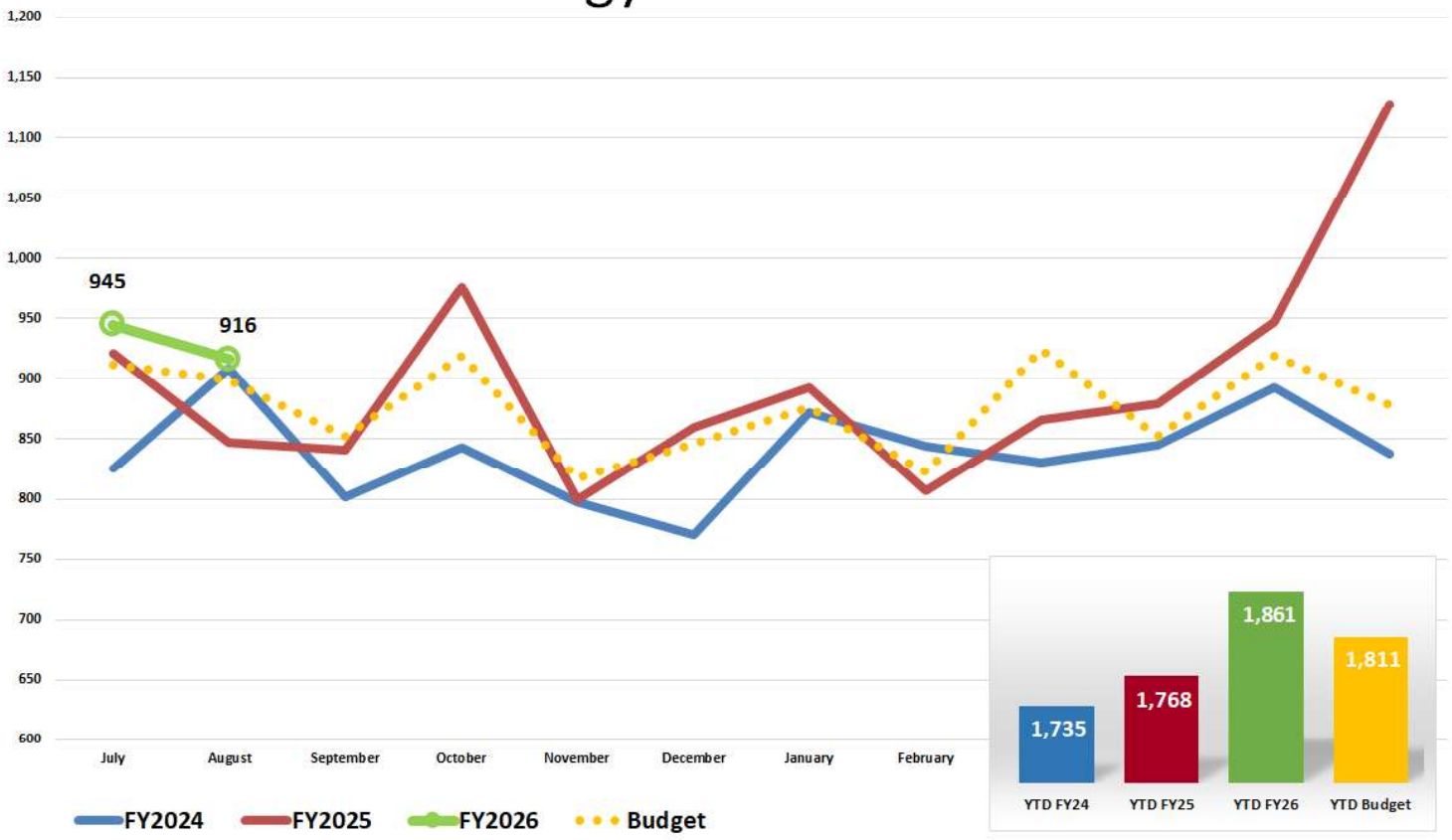

West Campus - Breast Center
2,000
1,900
1,800
1,700
1,600
1,500
1,400
1,300
1,200
1,487
1,331
July
August
September
October
November
December
January
February
March
April
May
June
FY2024
FY2025
FY2026
Budget
3,482
3,644
2,818
3,644
YTD FY24
YTD FY25
YTD FY26
YTD Budget


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
5,135
July
August
September
October
November
December
January
February
FY2024
FY2025
FY2026
Budget
9,282
9,279
10,220
9,317
YTD FY24
YTD FY25
YTD FY26
YTD Budget

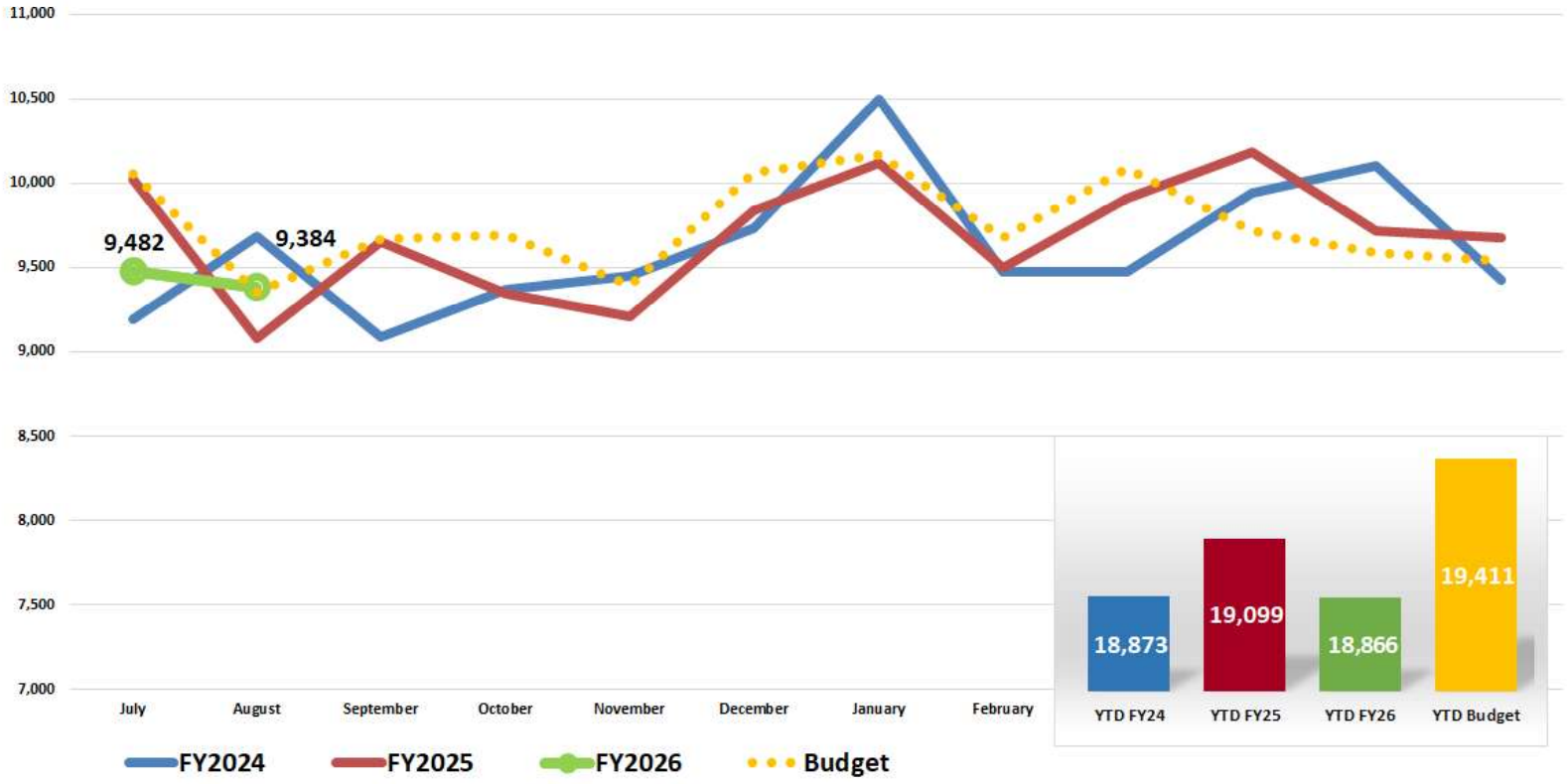
Radiology - Ultrasound - All Areas



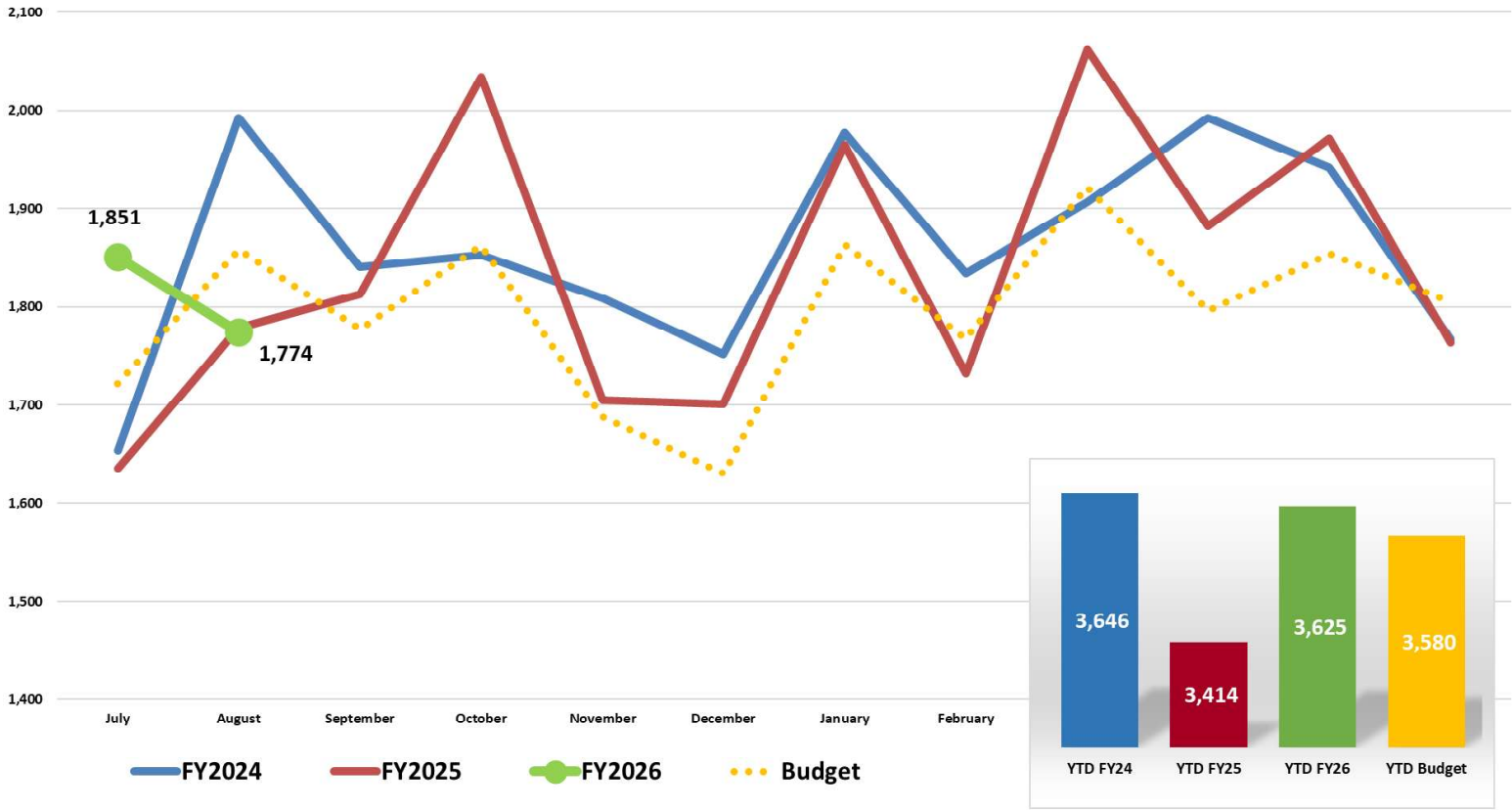
Radiology - MRI - All Areas

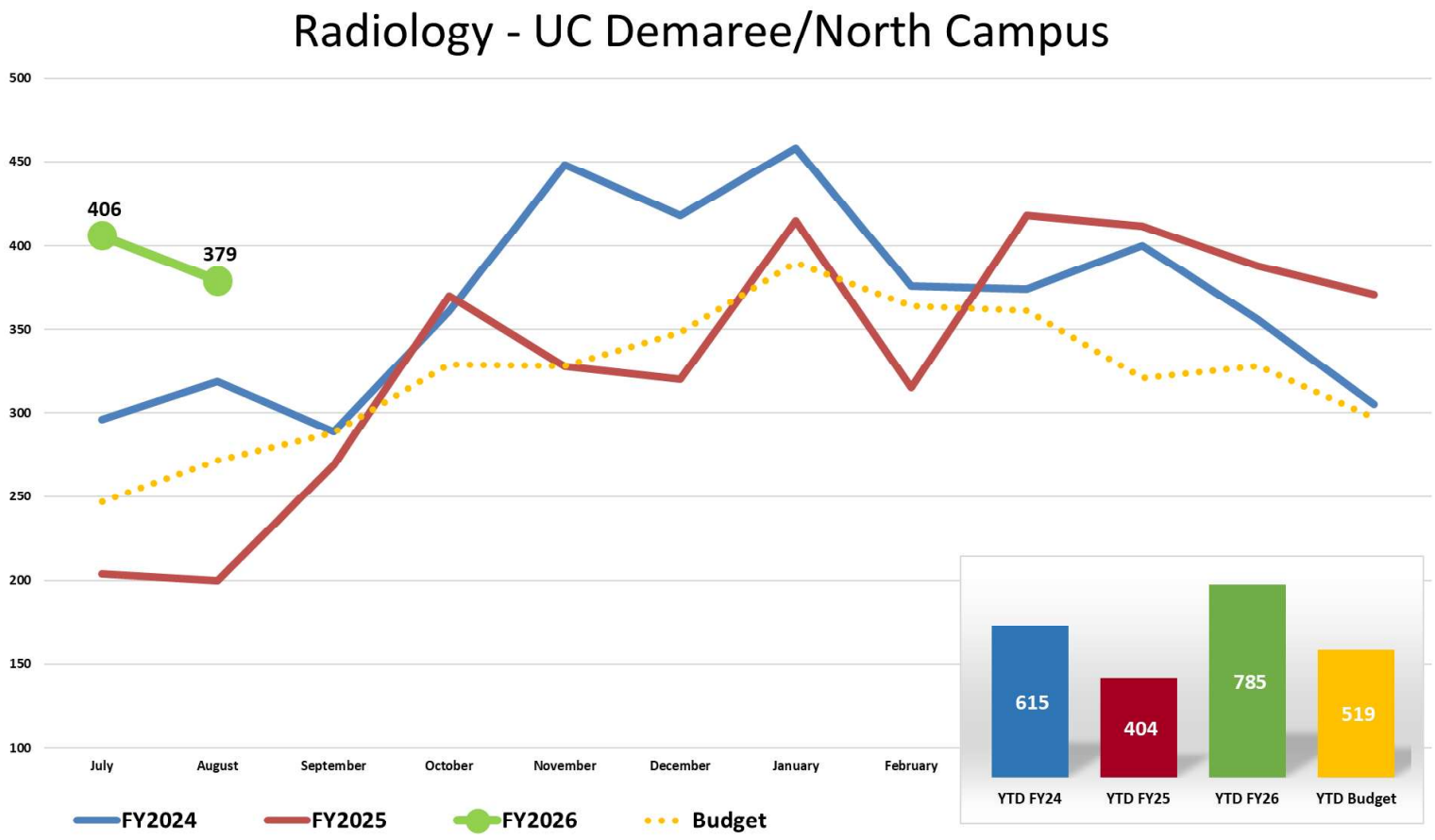


Radiology Modality - Diagnostic Radiology

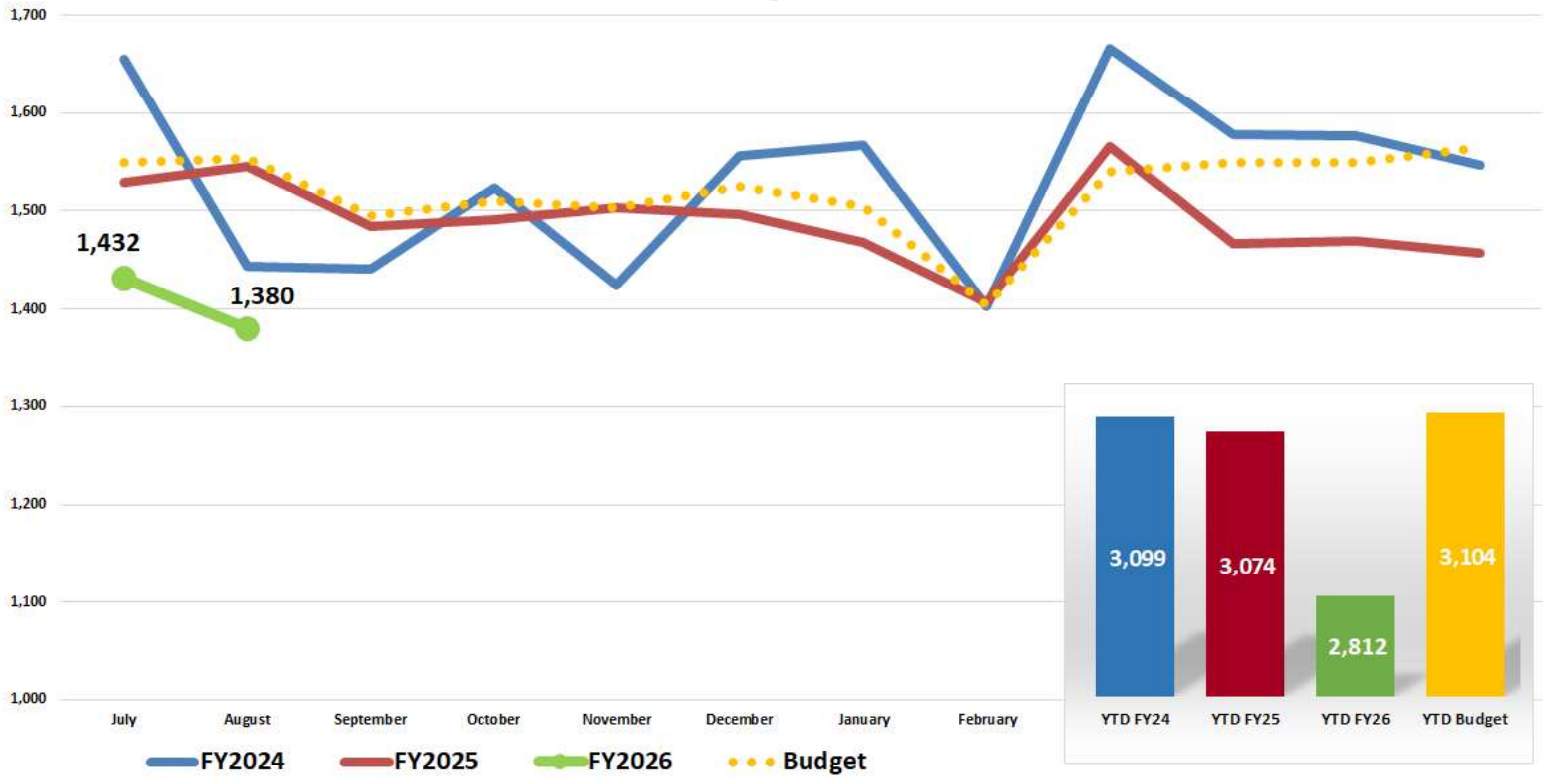


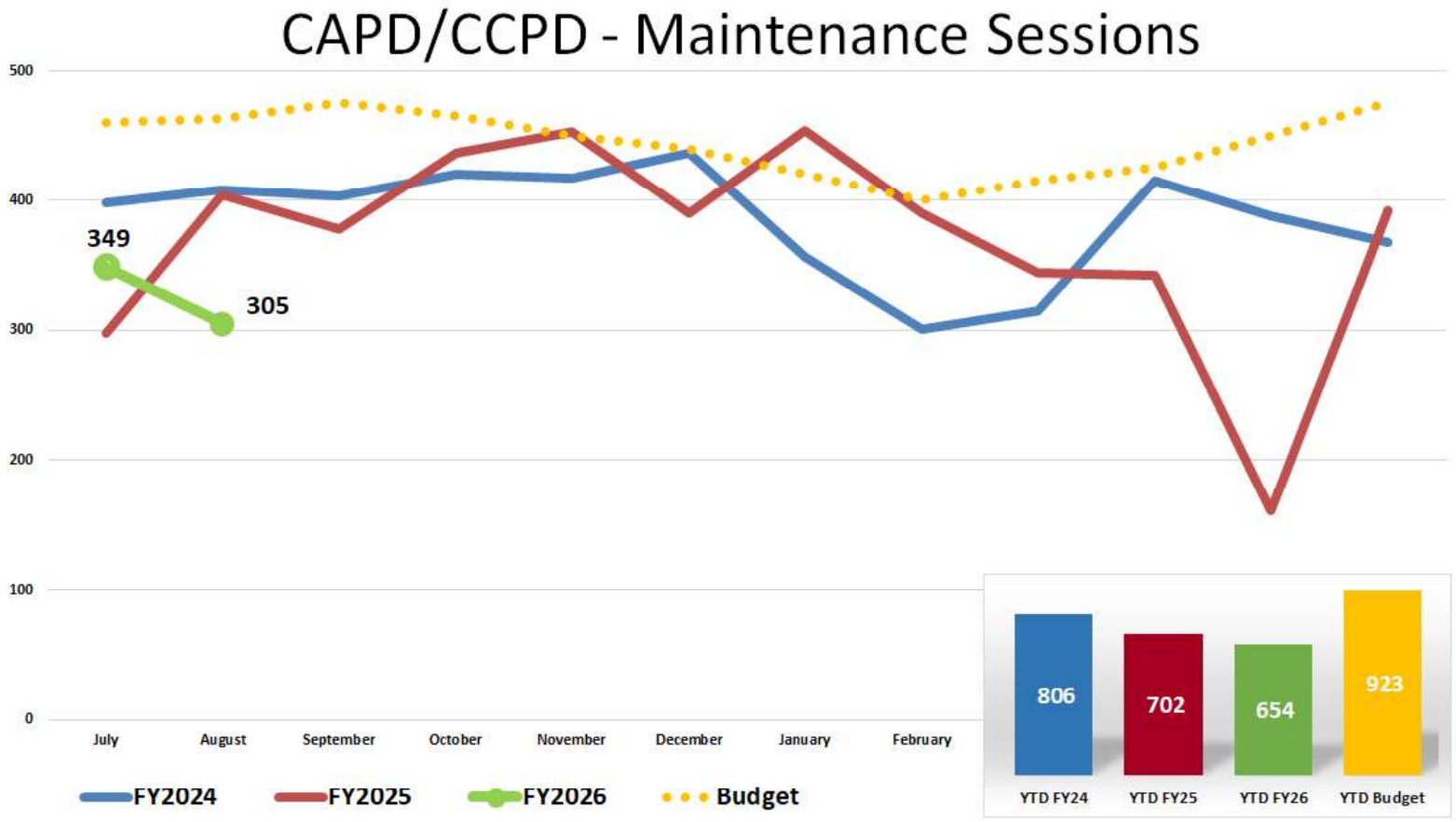
Radiology - UC Court/South Campus



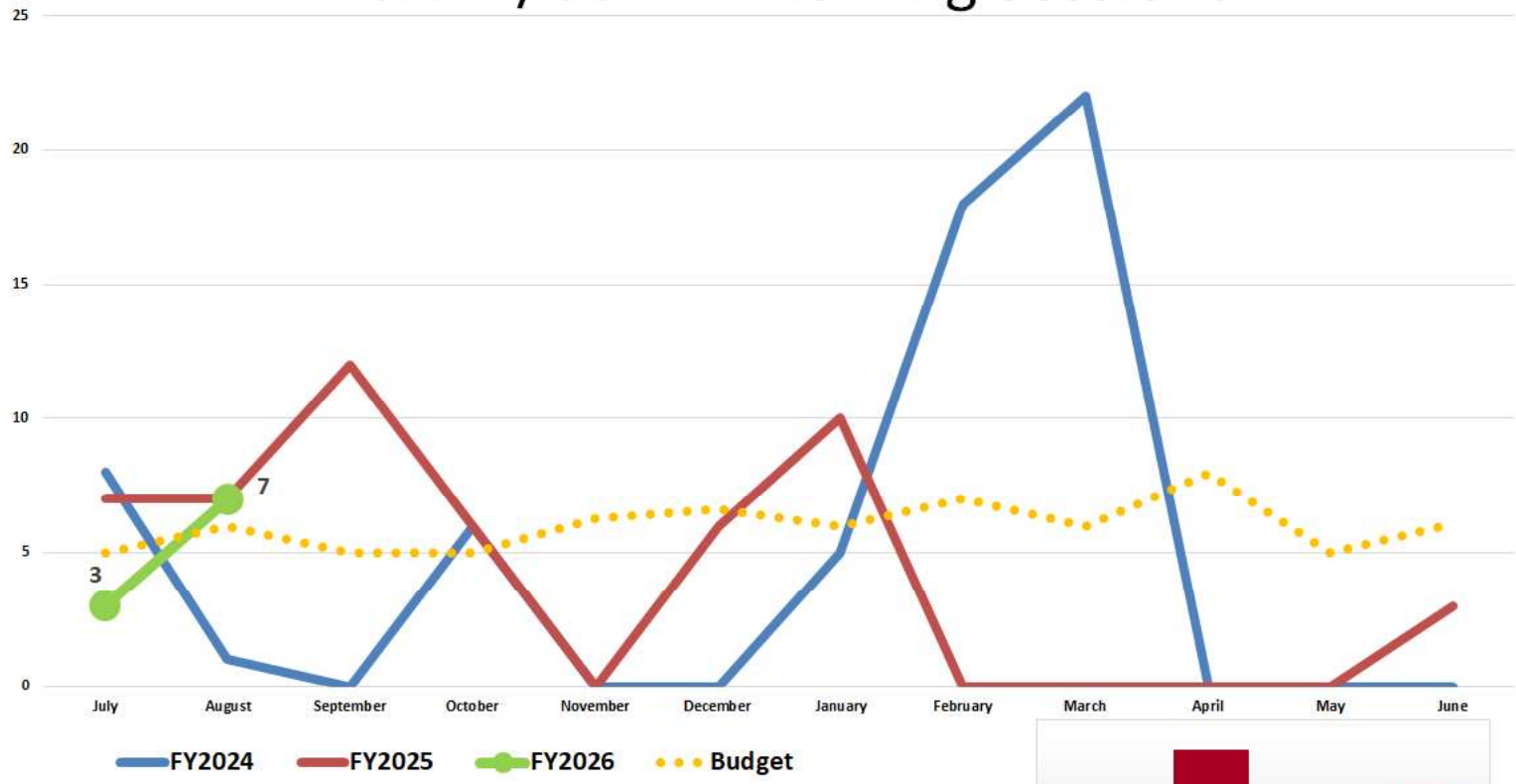

Radiology - UC Demaree/North Campus
500
450
400
350
300
250
200
150
100
406
379
July
August
September
October
November
December
January
February
FY2024
FY2025
FY2026
Budget
615
404
785
519
YTD FY24
YTD FY25
YTD FY26
YTD Budget

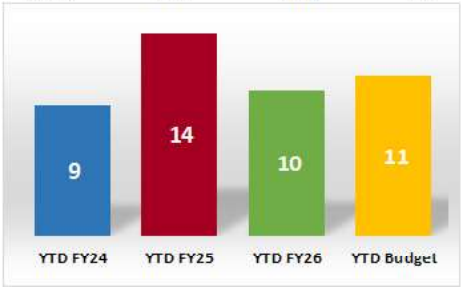
Chronic Dialysis - Visalia

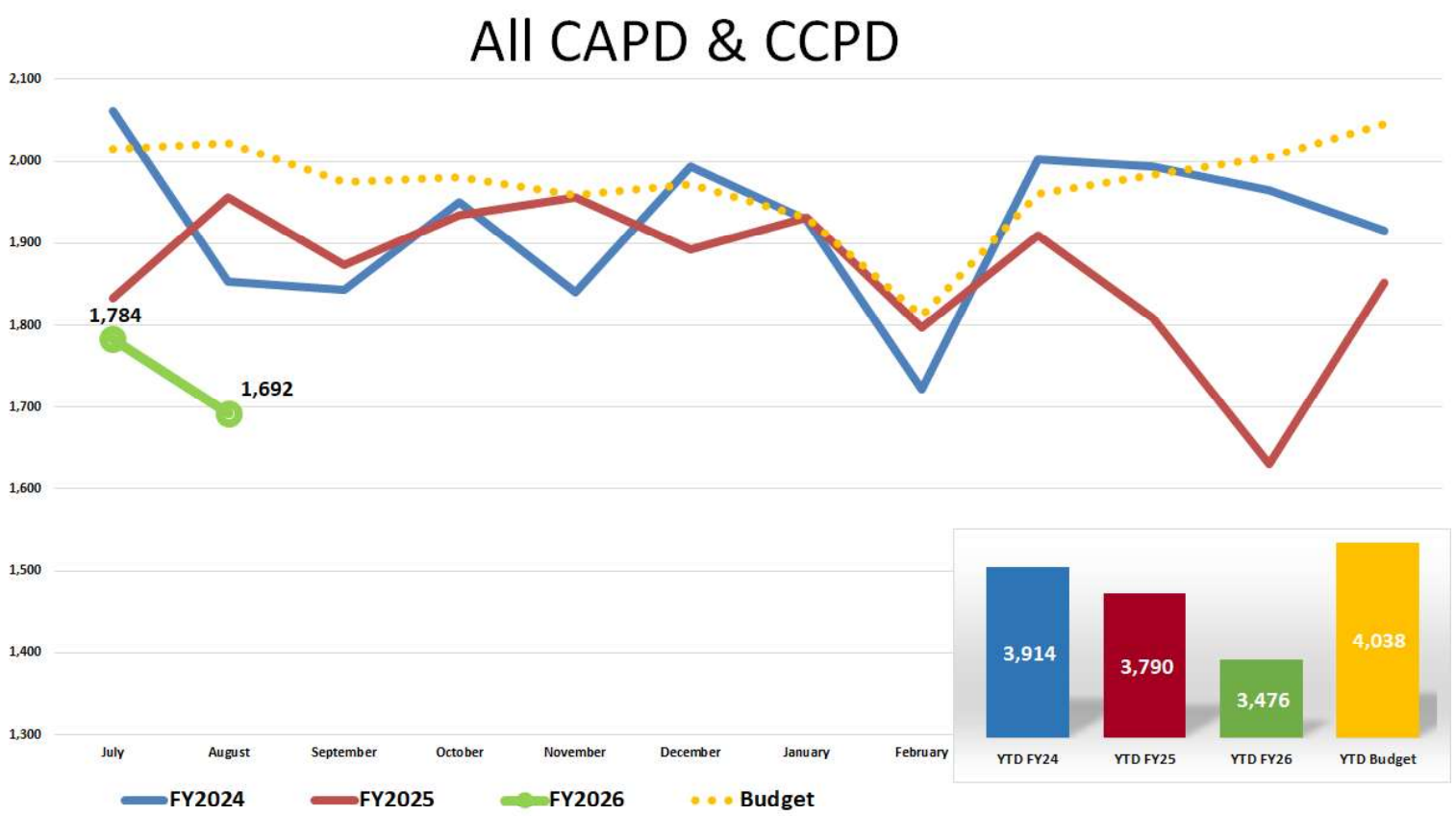



CAPD/CCPD - Maintenance Sessions
500
400
300
200
100
0
349
305
July
August
September
October
November
December
January
February
FY2024
FY2025
FY2026
Budget
806
702
654
923
YTD FY24
YTD FY25
YTD FY26
YTD Budget

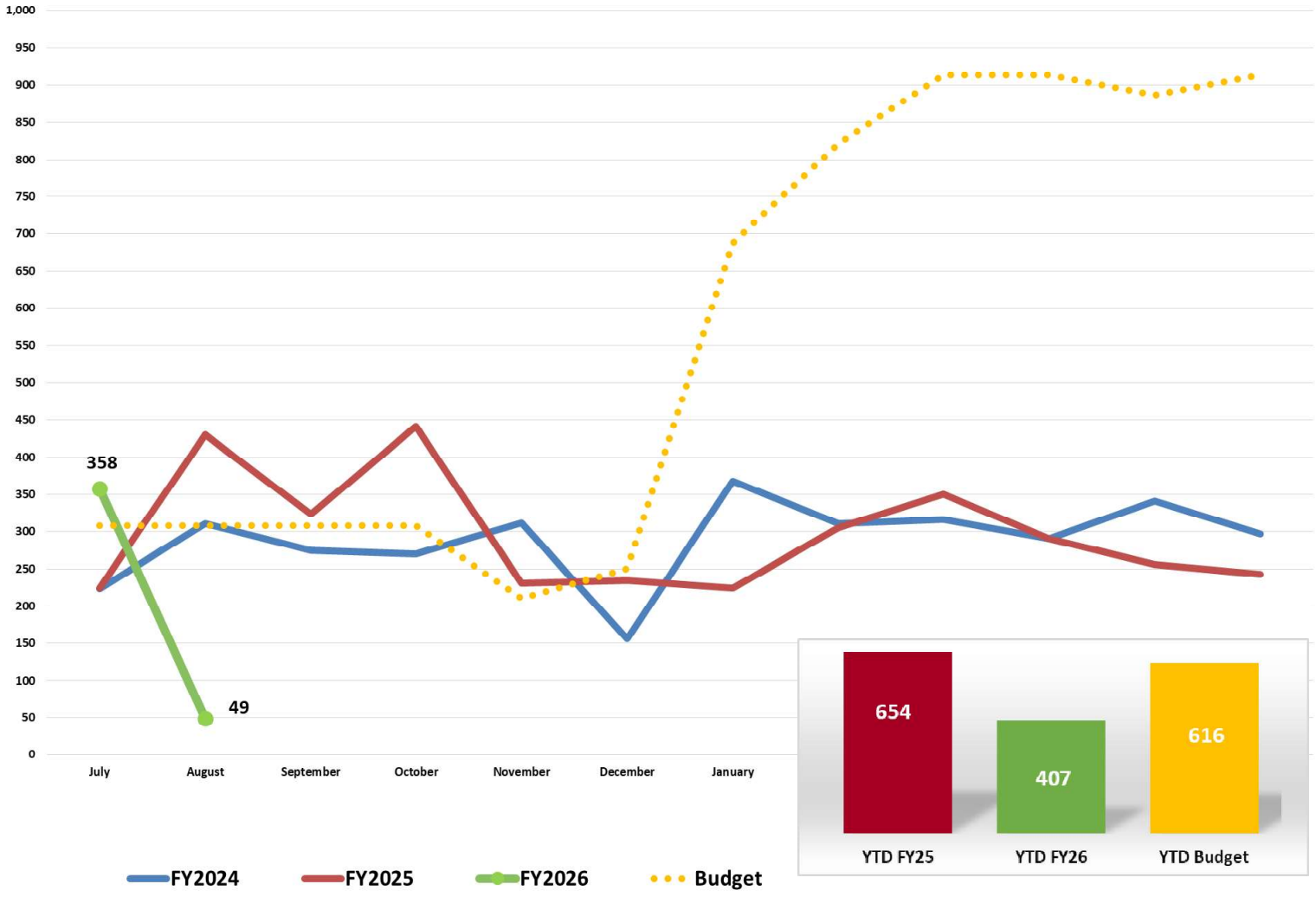
CAPD/CCPD - Training Sessions



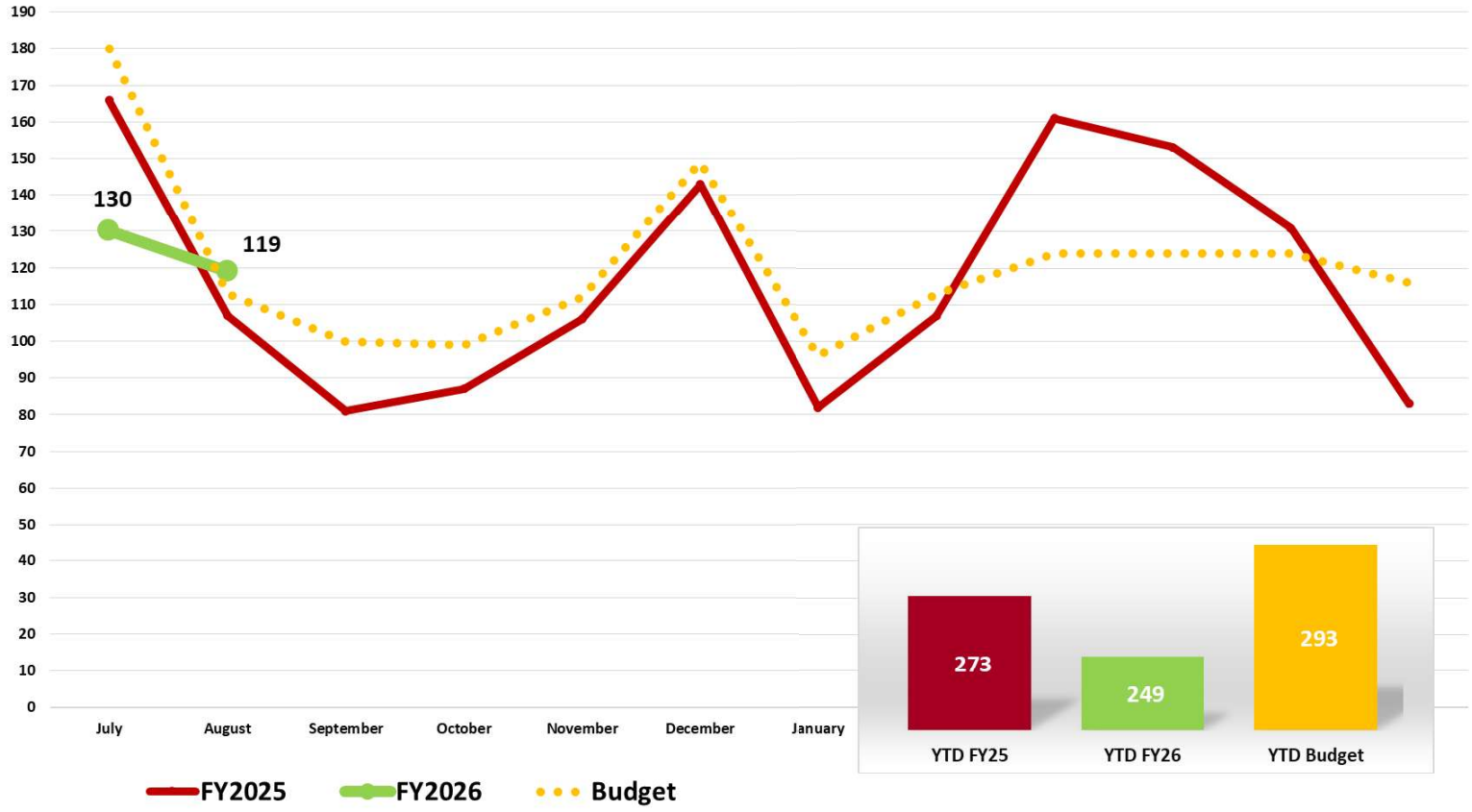



All CAPD & CCPD
2,100
2,000
1,900
1,800
1,700
1,600
1,500
1,400
1,300
1,784
1,692
July
August
September
October
November
December
January
February
FY2024
FY2025
FY2026
Budget
3,914
3,790
3,476
4,038
YTD FY24
YTD FY25
YTD FY26
YTD Budget

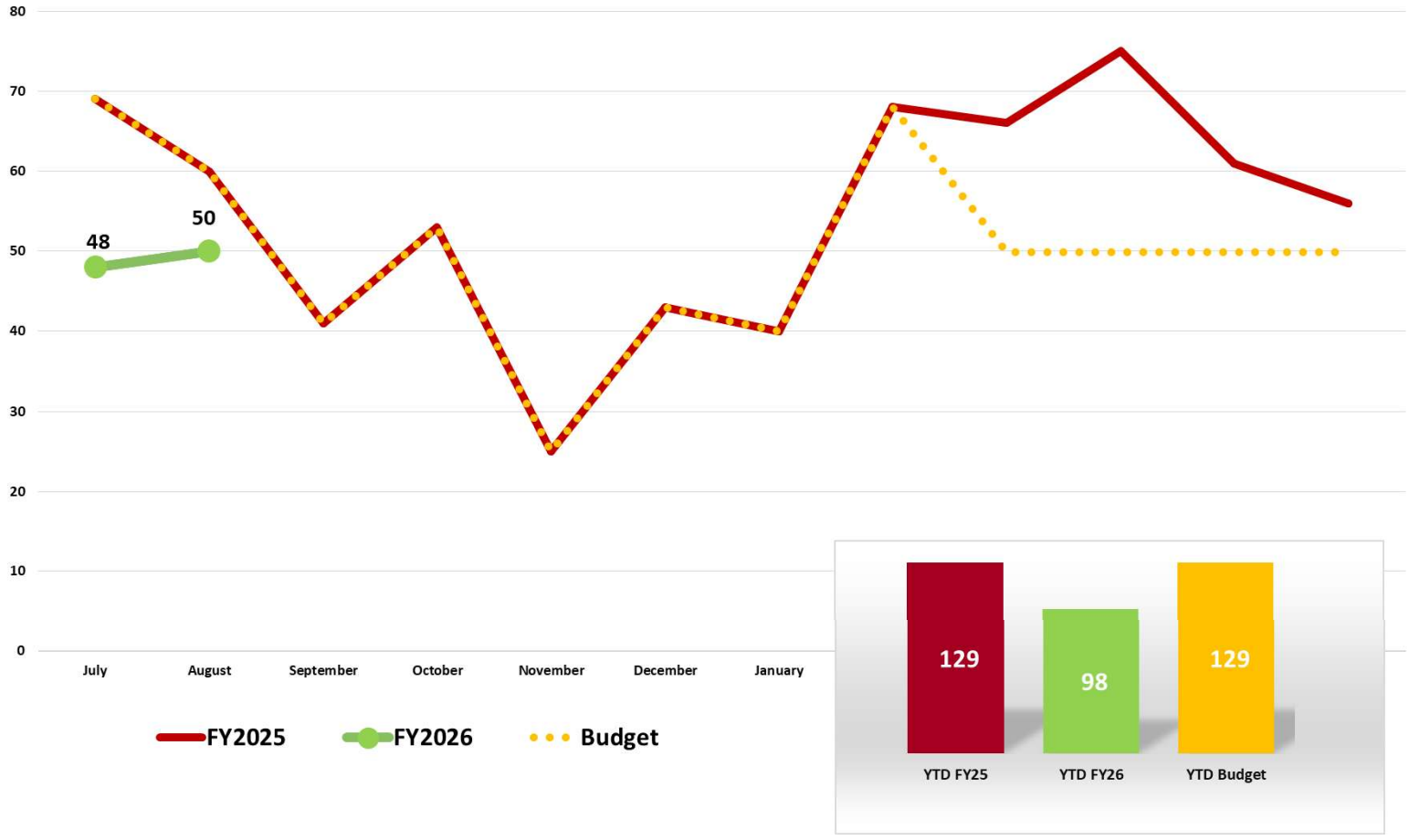
Urology Clinic Visits



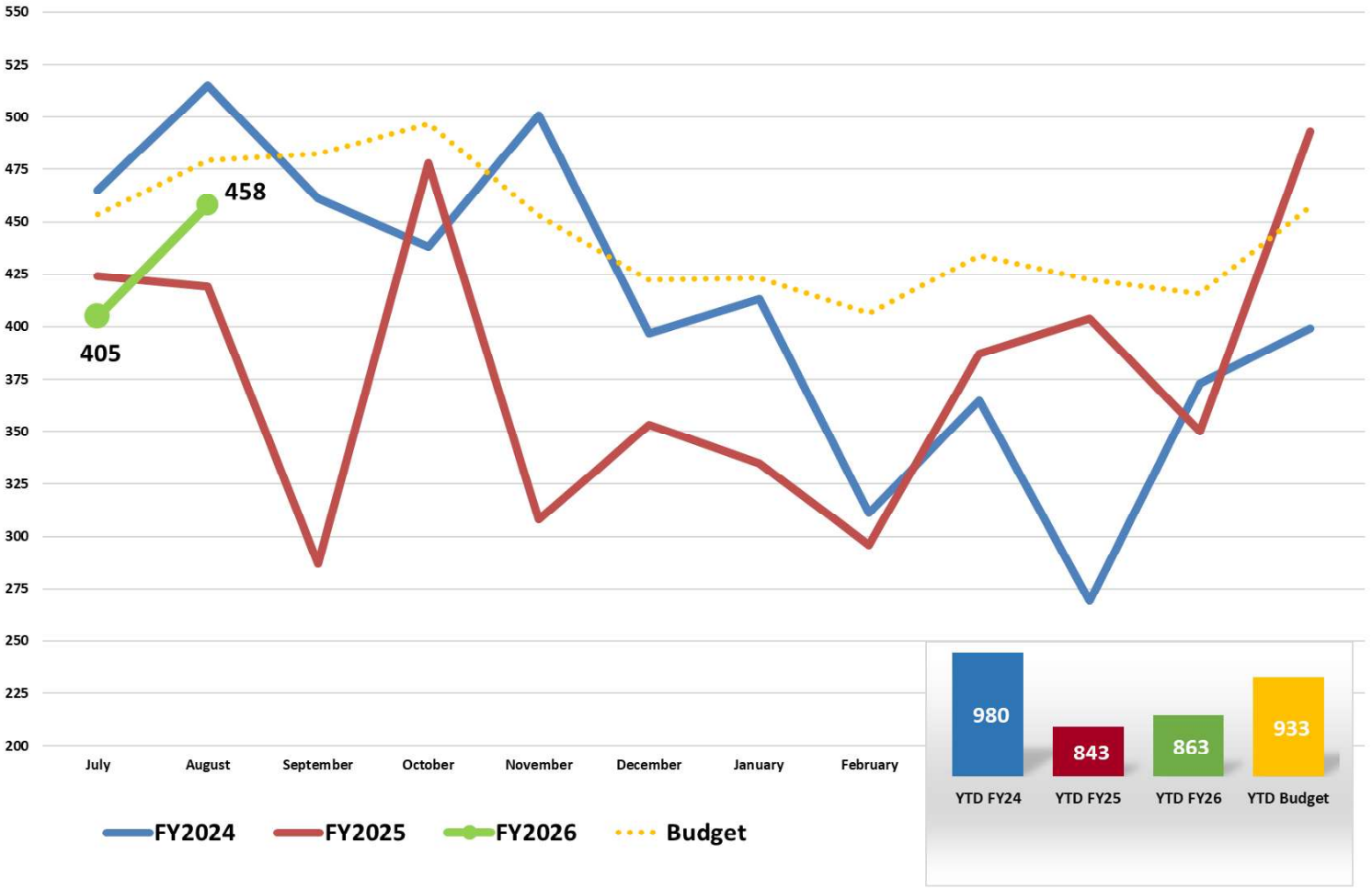
Open Arms House - Patient Days



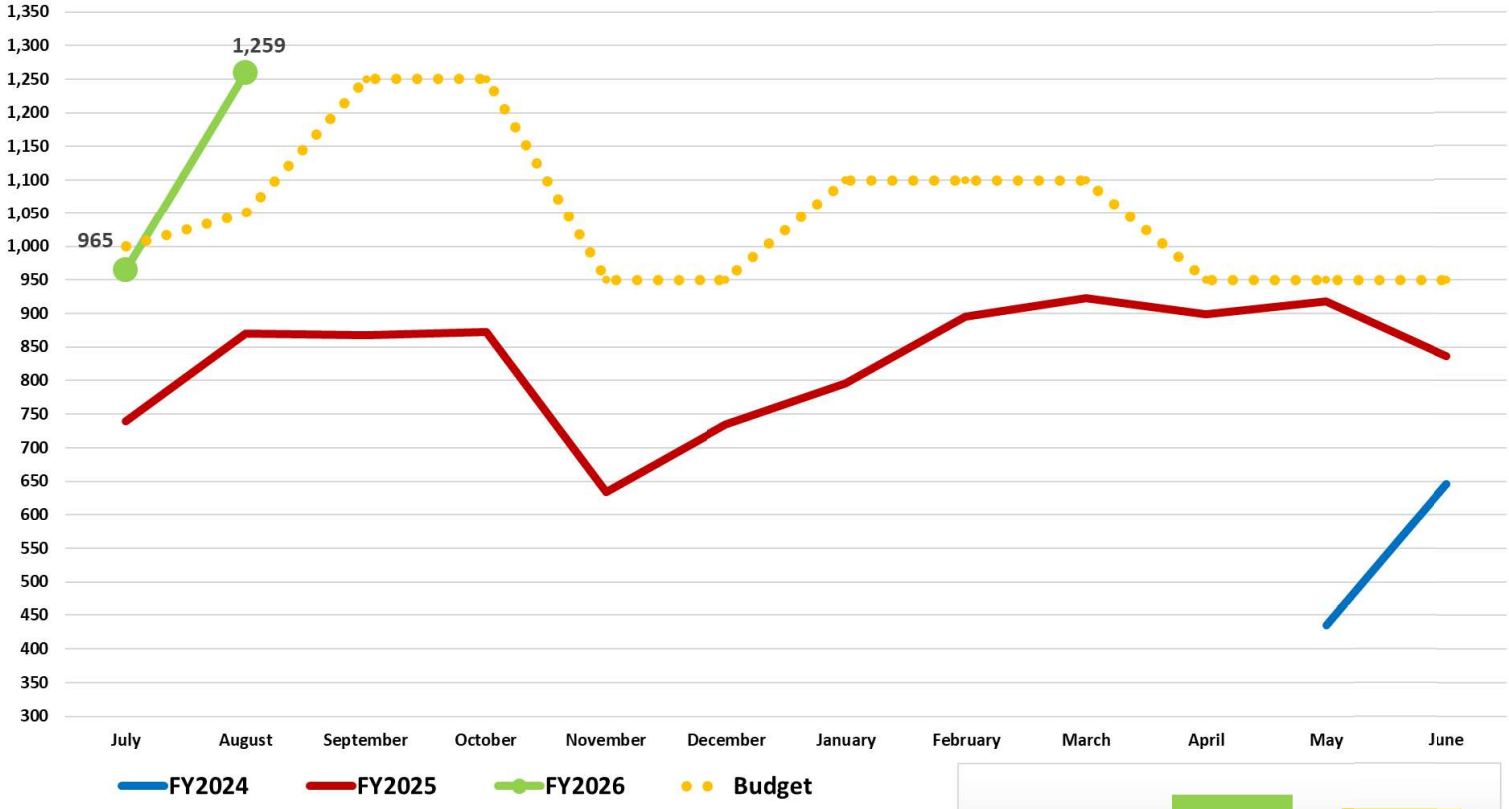
Cardiothoracic Surgery Clinic - Visits

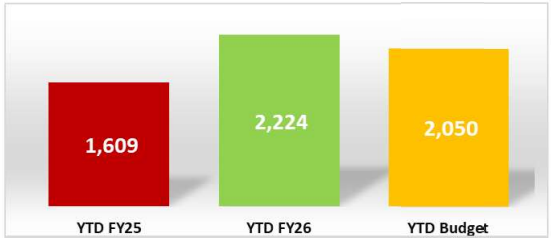


Cardiac Rehabilitation

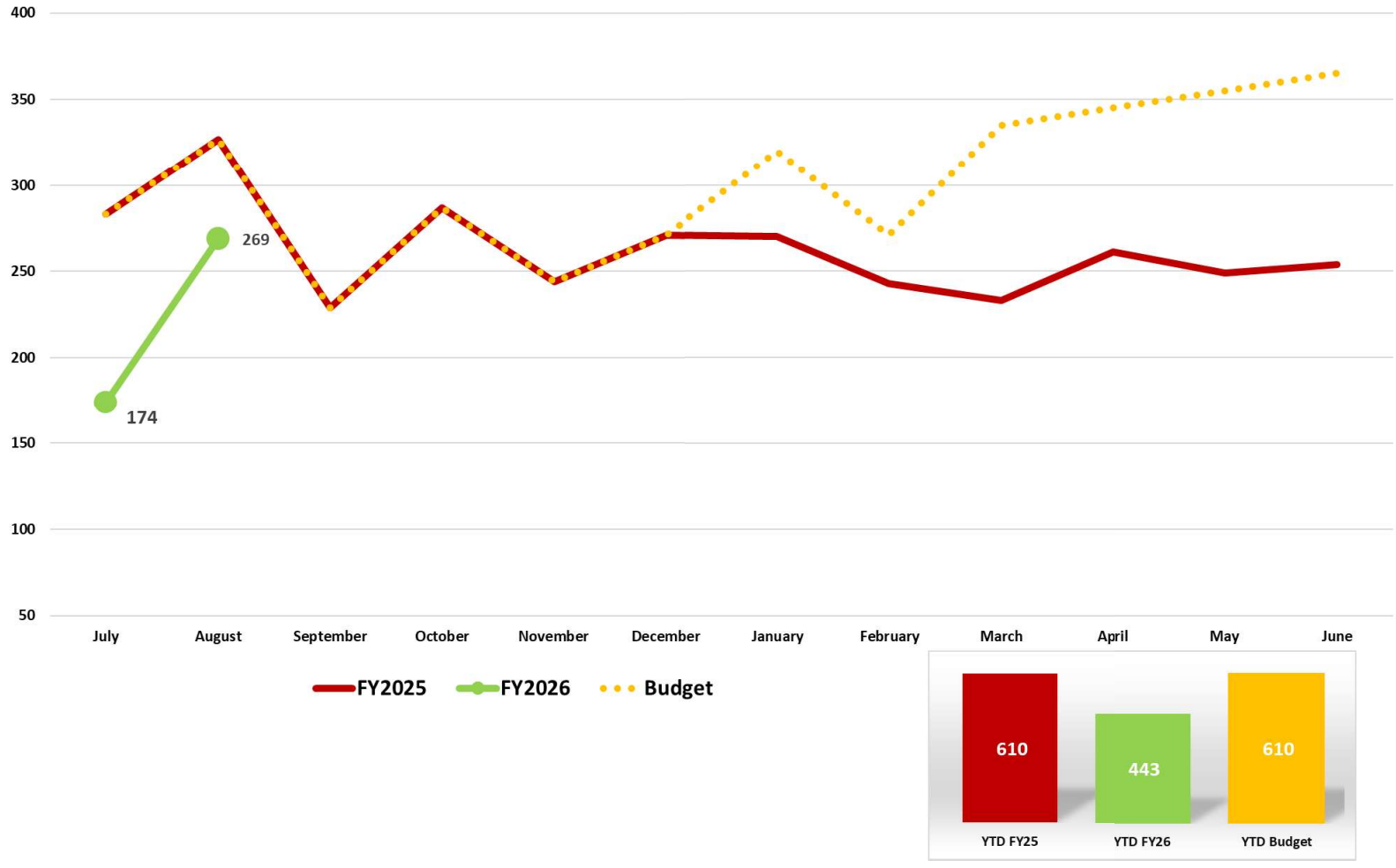


KH Medical Clinic - Ben Maddox

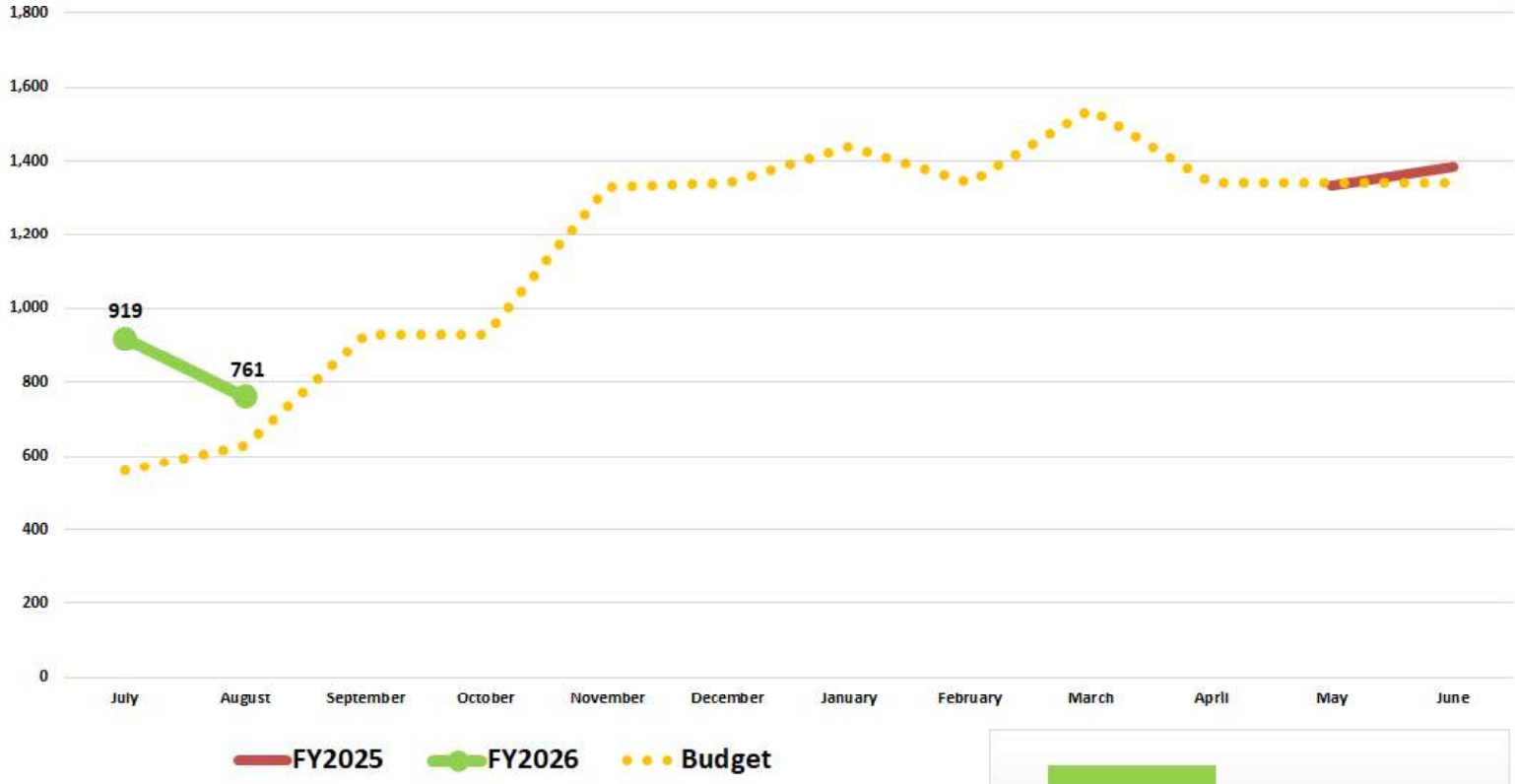




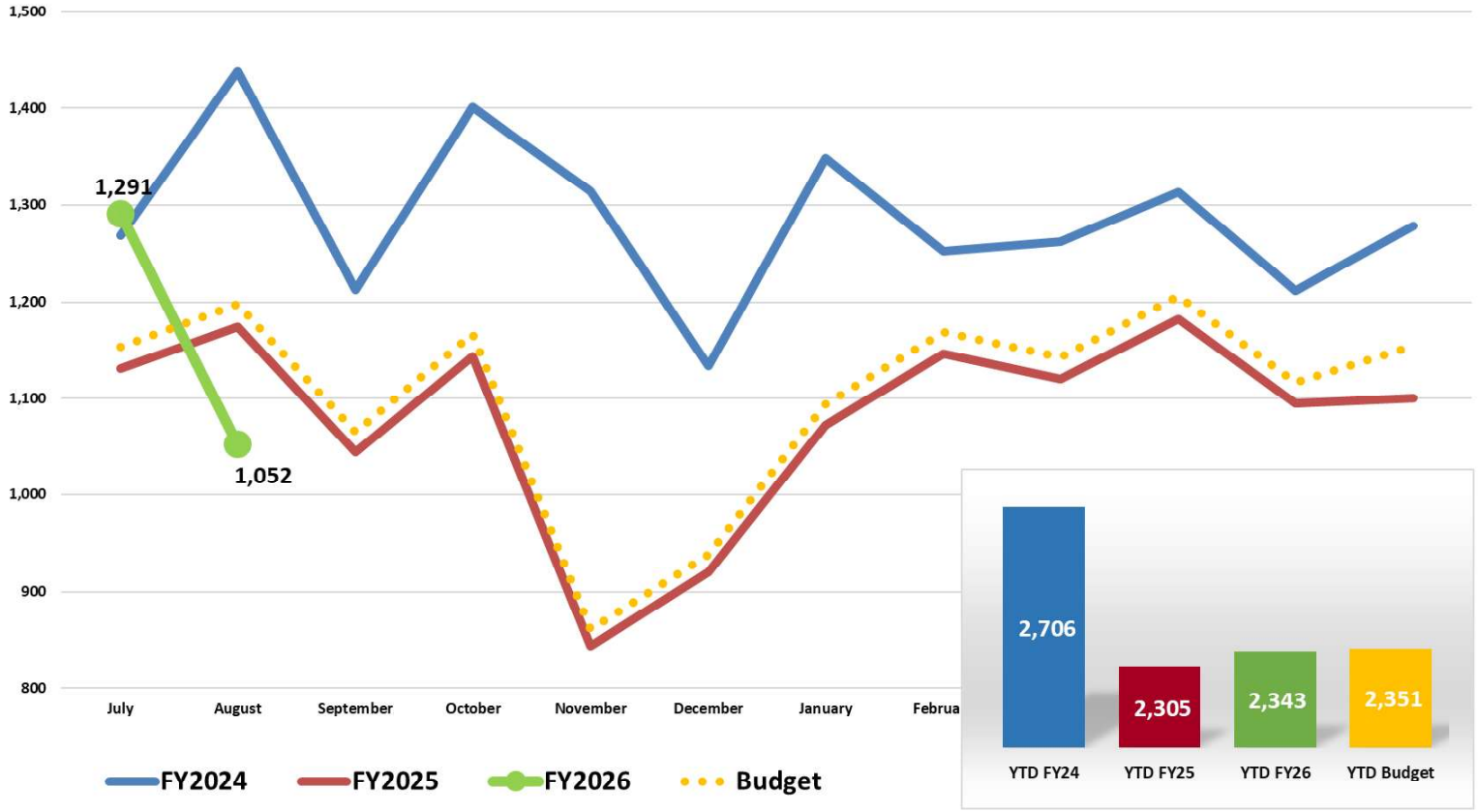
KH Medical Clinic - Plaza



KH Willow Clinic



Medical Oncology Treatments



Medical Oncology Visits

Mental Wellness Clinic