May 21, 2021

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in the Kaweah Health Support Services Building - 520 West Mineral King – Graduate Medical Education Conference Room – 5th floor beginning at 3:30PM on Monday May 24, 2021. Due to the maximum capacity allowed in this room per CDC social distancing guidelines, members of the public are requested to attend the via GoTo - https://www.gotomeet.me/CindyMoccio/kaweahdeltaopenregularboardmeetings or you can also dial in 669-224-3412 Access Code: 468-246-165.

The Board of Directors of the Kaweah Delta Health Care District will meet in an Open Board of Directors at 3:30PM (location and GoTo information above).

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Board of Directors meeting at 3:31PM pursuant to Health and Safety Code 1461 and 32155, Government Code 54956.9(d)(2).

The Board of Directors of the Kaweah Delta Health Care District will meet in an Open Board of Directors meeting at 4:30PM (location and GoTo information above).

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 entry corridor between the Mineral King lobby and the Emergency Department waiting room.

Due to COVID 19 visitor restrictions to the Medical Center - 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) {1st floor}, 400 West Mineral King Avenue, Visalia, CA via phone 559-624-2330 or email: cmoccio@kaweahhealth.org, or on the Kaweah Delta Health Care District web page http://www.kaweahhealth.org.

KAWEAH DELTA HEALTH CARE DISTRICT
Garth Gipson, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
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

Kaweah Health Medical Center / Support Services Building
520 West Mineral King – GME Conference Room (5th floor)

Join from your computer, tablet or smartphone
https://www.gotomeet.me/CindyMoccio/kaweahdeltaopenregularboardmeetings
or Dial In: 669-224-3412 / Access Code: 468-246-165

Monday May 24, 2021

OPEN MEETING AGENDA {3:30PM}

1. **CALL TO ORDER**
2. **APPROVAL OF AGENDA**
3. **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 subject matter jurisdictions of the Board are requested to identify themselves at this time.
4. **APPROVAL OF THE CLOSED AGENDA – 3:31PM**
   - 4.1. **Approval of closed meeting minutes** – April 26, 2021.
   - 4.2. **Conference with Legal Counsel** – Existing Litigation – Pursuant to Government Code 54956.9(d)(1) – *Richard Salinas, Legal Counsel, Ben Cripps, Chief Compliance Officer, and Evelyn McEntire, Interim Director of Risk Management*
     - A. Edison v. Barcenas: Case # VCU265419
     - B. Martinez (Santillan) v. KDHCD Case # VCU279163
     - C. Miller v KDHCD Case # 19CECG02595
     - D. Richards v KDHCD Case # VCU280708
     - E. Shirk v KDHCD Case # VCU280558
     - F. Foster v KDHCD Case # 280726
     - G. Dowdy v KDHCD Case # VCU283475
     - H. Snow v KDHCD Case # VCU284063
     - I. Stalcup v KDHCD Case # 284918
     - J. Stanger v Visalia Medical Center Case # VCU284760
     - K. Weaver v KDHCD Case # VCL195709
     - L. Taylor v KDHCD Case # VCU285079
     - M. Dunlap v KDHCD Case # VCU285988

N. Borges v KDHCD Case # VCU280819
O. Valdovinos v KDHCD Case # VCU279423
P. Grant v KDHCD Case # 280250
Q. Delgado v KDHCD Case # VCU280865
R. Souza v KDHCD Case # VCU281205

4.3. **Conference with Legal Counsel – Anticipated Litigation –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 4 Cases **-** *Richard Salinas, Legal Counsel, Ben Cripps, Chief Compliance Officer, and Evelyn McEntire, Interim Director of Risk Management*

4.4. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee –– *Ben Cripps, Chief Compliance Officer, and Evelyn McEntire, Interim Director of Risk Management*

4.5. **Conference with Legal Counsel – Anticipated Litigation –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 12 Case **–** *Ben Cripps, Chief Compliance Officer and Rachele Berglund, Legal Counsel*

4.6. **Credentialing** - 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 Health and Safety Code 1461 and 32155 – *Monica Manga, MD Vice Chief of Staff*

4.7. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee –– *Monica Manga, MD Vice Chief of Staff & Gary Herbst, CEO*

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

Action Requested – Approval of the May 24, 2021 closed meeting agenda.

5. ADJOURN

CLOSED MEETING AGENDA {3:31PM}

1. CALL TO ORDER

2. APPROVAL OF CLOSED MEETING MINUTES – April 26, 2021.

Recommended Action: Approval of the closed meeting minutes from April 26, 2021.

2.1. Conference with Legal Counsel – Existing Litigation – Pursuant to Government Code 54956.9(d)(1)

Richard Salinas, Legal Counsel, Ben Cripps, Chief Compliance Officer, and Evelyn McEntire, Interim Director of Risk Management

A. Edison v. Barcenas: Case # VCU265419
B. Martinez (Santillan) v. KDHCD Case # VCU279163

C. Miller v KDHCD Case # 19CECG02595
D. Richards v KDHCD Case # VCU280708
E. Shirk v KDHCD Case # VCU280558
F. Foster v KDHCD Case # 280726
G. Dowdy v KDHCD Case # VCU283475
H. Snow v KDHCD Case # VCU284063
I. Stalcup v KDHCD Case # 284918
J. Stanger v Visalia Medical Center Case # VCU284760
K. Weaver v KDHCD Case # VCL195709
L. Taylor v KDHCD Case # VCU285079
M. Dunlap v KDHCD Case # VCU285988
N. Borges v KDHCD Case # VCU280819
O. Valdovinos v KDHCD Case # VCU279423
P. Grant v KDHCD Case # 280250
Q. Delgado v KDHCD Case # VCU280865
R. Souza v KDHCD Case # VCU281205

2.2. **Conference with Legal Counsel – Anticipated Litigation** – Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 4 Cases

Richard Salinas, Legal Counsel, Ben Cripps, Chief Compliance Officer, and Evelyn McEntire, Interim Director of Risk Management

2.3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee.

Ben Cripps, Chief Compliance Officer, and Evelyn McEntire, Interim Director of Risk Management

2.4. **Conference with Legal Counsel – Anticipated Litigation –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 12 Case

Ben Cripps, Chief Compliance Officer and Rachele Berglund, Legal Counsel

2.5. **Credentialing** - 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 Health and Safety Code 1461 and 32155

Monica Manga, MD Vice Chief of Staff

2.6. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee

Monica Manga, MD Vice Chief of Stafff & Gary Herbst, CEO

3. ADJOURN

OPEN MEETING AGENDA {4:30PM}

Join from your computer, tablet or smartphone

https://www.gotomeet.me/CindyMoccio/kaweahdeltaopenregularboardmeetings

or Dial In: 669-224-3412 / Access Code: 468-246-165

1. **CALL TO ORDER**

2. **APPROVAL OF AGENDA**

3. **PUBLIC PARTICIPATION –** Members of the public may comment on agenda items before action is taken and after Board discussion. 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 subject matter jurisdictions of the Board are requested to identify themselves at this time.

4. **CLOSED SESSION ACTION TAKEN** – Report on action(s) taken in closed session.

5. **OPEN MINUTES** – Request approval of the April 21, April 26, and May 18, 2021 open minutes.

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

   Action Requested – Approval of the open meeting minutes – April 21, April 26, and May 18, 2021 open board of directors meeting minutes.

6. **RECOGNITIONS** – *Mike Olmos*

   6.1. Presentation of Resolution 2129 to Liset Magallanes, RN, Float Pool-General Nursing in recognition of as the World Class Employee of the Month recipient – May 2021

   6.2. Presentation of Resolution 2130 to Molly Niederreiter, Director of Rehabilitaton Services in recognition of as the Employee of the Year.

7. **CREDENTIALS** - Medical Executive Committee 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 Medical Executive Committee be reviewed for approval.

   Monica Manga, MD Vice Chief of Staff

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

   Recommended Action: Whereas a thorough review of all required information and supporting documentation necessary for the consideration of initial applications, reappointments, request for additional privileges, advance from provision al status and release from proctoring and resignations (pursuant to the Medical Staff bylaws) has been completed by the Directors of the clinical services, the Credentials Committee, and the MEC, for all of the medical staff scheduled for reappointment, Whereas the basis for the recommendations now before the Board of Trustees regarding initial applications, reappointments, request for additional privileges, advance from provision al status and release from proctoring and resignations has been predicated upon the required reviews, including all supporting documentation, Be it therefore resolved that the following medical staff be approved or reappointed (as

applicable), as attached, to the organized medical staff of Kaweah Delta Health Care District for a two year period unless otherwise specified, with physician-specific privileges granted as recommended by the Chief of Service, the Credentials Committee, and the Executive Committee of the Medical Staff and as will be documented on each medical staff member's letter of initial application approval and reappointment from the Board of Trustees and within their individual credentials files.

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

Monica Manga, MD Vice Chief of Staff

9. CONSENT CALENDAR - *All matters under the Consent Calendar will be approved by one motion, unless a Board member requests separate action on a specific item.*

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

Action Requested – Approval of the May 24, 2021 Consent Calendar.

9.1. REPORTS

A. Cardiovascular Services
B. Risk Management
C. Compliance
D. Physician Recruitment

9.2. POLICIES

A. Administrative
   1) Quality Improvement Plan – AP41 **Revised**
   2) Patient Safety Plan – AP.175 **Revised**
   3) No Information No presence in facility patient status AP.49 **Revised**
   4) Grants AP.148 **Revised**
   5) Occurrence Reporting Process – AP.10 **Revised**
   6) Sentinel Event and Adverse Event Response and Reporting – AP.87 **Revised**
   7) Protocol for Moves Within Kaweah Delta Health Care District – AP.83 **Revised**
   8) Guild member work-sustained injury coverage – AP.81 **Reviewed**

B. Environment of Care
   1) Helipad Policy - EOC 1050 **Revised**
   2) Interim Life Safety Measures - EOC 5020 **Revised**
   3) Utilities Management Program - EOC 7401 **Revised**
   4) Utilities Management Plan - EOC 7001 **Reviewed**
   5) Key Control Policy - EOC 3010 **Reviewed**

C. Human Resources
   1) Just Culture Committee – HR.03 **Revised** {As reviewed and approved at the April Board Human Resources Committee}
   2) Drug Free Work Place and Drug Alcohol Testing – HR.200 **Revised**

9.3. Board Bylaws – Approval of revision of Board Bylaws to reflect the addition of the dba Kaweah Health, update to leadership titles, removal of reference to Chief Operating Officer (COO) and Chief Medical Officer (CMO), etc.

9.4. Approval of revised Kaweah Health Annual Physician Recruitment Plan – 2021 based on the Provider Needs Assessment for Kaweah Health Medical Center presented at the September 28, 2020 Board of Director meeting. This document has been revised to include Medical Oncology. Having reviewed and analyzed the Provider Needs Assessment conducted by Sg2 in 2020, which includes a specific list of the needed physician specialties for 2020 and 2021 in communities served by the District "Needed Physician Specialties," the Board hereby finds that it will be in the best interests of the public health of the communities served by the District to have the District provide appropriate assistance in order to obtain licensed physicians and surgeons in the Needed Physician Specialties to practice in the communities served by the District. Therefore, the Board authorizes the District to provide the types of assistance authorized by Cal. Health & Safety Code §32121.3, to obtain licensed physicians and surgeons in the Needed Physician Specialties to practice in the communities served by the District.

9.5. Recommendations from the Medical Executive Committee (May 2021)

A. Medical Staff Bylaws Revision {attached}
   1) Preamble – 1.1 Purposes of the Bylaws
   2) 8.C.1 Initial Review
   3) 8.C.2 Initiation of Investigation
   4) 8.F Leaves of Absence
   5) Article V Consultations – 5.7 Concerns

B. Privileges in Emergency Medicine

C. Medical Staff Policy – Late Career Policy MS50 **Revised**

10. **QUALITY – MATERNAL CHILD HEALTH QUALITY REPORT** - A review of key quality measures and improvement actions associated with care of the maternal child health population.

Tracie Sherman, Director of Maternal Child Health

11. **QUALITY – SURGICAL SERVICES** - A review of key quality measures, and quality improvement projects related to surgical services.

Brian Piearcy, Director of Surgical Services

12. **STRATEGIC PLAN – ORGANIZATIONAL EFFECTIVENESS AND EFFICIENCY –** Review of the Kaweah Delta Strategic Plan Initiative – Organizational Effectiveness and Efficiency including a review of the metrics and strategies/tactics.

Keri Noeske, RN, Vice President & Chief Nursing Officer and Rebekah Foster, Director Throughput/Specialty Care

13. **BUDGET FY22** – Review and discussion relative to the guiding principles for our fiscal year 2022 budget.

Malinda Tupper, Vice President, Chief Financial Officer

14. **REPORTS**

14.1. Chief Executive Officer Report - Report relative to current events and issues.
Gary Herbst, Chief Executive Officer

- COVID-19
- Emergency Department – Zone 5

14.2. Board President **-** Report relative to current events and issues.
David Francis, Board President

ADJOURN

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.

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY MAY 24, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 9-90

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD TUESDAY MARCH 16, 2021, AT 4:00PM, IN THE KAWEAH DELTA MEDICAL CENTER SUPPORT SERVICES BUILDING 520 WEST MINERAL KING AVENUE – GME CONFERENCE ROOM – 5TH FLOOR, VISALIA AND VIA GOTO MEETING DAVID FRANCIS PRESIDING

PRESENT: Directors Francis, Gipson, Havard Mirviss, Olmos & Rodriguez; G. Herbst, CEO; K. Noeske, VP & CNO; M. Tupper, VP & CFO; D. Cox, VP Chief Human Resources Officer; M. Mertz, VP & Chief Strategy Officer; D. Leeper, VP & CIO; R. Gates, VP Population Health; A. Banerjee, VP & Chief Quality Officer; D. Allain, VP Cardiac & Surgical Services; J. Batth, VP of Rehabilitation & Post-Acute Care Services; R. Berglund, Legal Counsel; and Rosie Gonzalez, recording

The meeting was called to order at 4:04PM by Director Francis.

Director Francis entertained a motion to approvee the agenda.

MMSC (Havard Mirviss/Gipson) to approve the open agenda. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

PUBLIC PARTICIPATION – none

2020/2021 ANNUAL OPERATING & CAPITAL BUDGET AND FINANCIALS – Review of the annual operating & capital budget and strategies and the most current fiscal year financial results (copy attached to the original of these minutes and considered a part thereof).

INVESTMENT REPORT – Semi-annual review of the Kaweah Delta Health Care District Investment Report (copy attached to the original of these minutes and considered a part thereof) - *Jennifer Stockton, Director of Finance*

MMSC (Havard Mirviss/Olmos) to approve the semi-annual investment report and approval of the investment policy (and any changes proposed) as well as the delegation of authority contained within the policy. *Vote: Yes – Havard Mirviss, Olmos, Rodriguez, and Francis* – Abstained - Gipson

ADJOURN - Meeting was adjourned at 6:00PM

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

ATTEST:

Garth Gipson, Secretary/Treasurer
Kaaweah Delta Health Care District Board of Directors

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD MONDAY APRIL 26, 2021, AT 4:30PM, IN SUPPORT SERVICES BUILDING 4TH FLOOR GRANITE ROOM (CALL IN OPTION DUE TO STAY IN PLACE ORDER BY GOVENOR OF CALIFORNIA), DAVID FRANCIS PRESIDING

PRESENT: Directors Francis, Gipson, Havard Mirviss, Olmos & Rodriguez; G. Herbst, CEO; K. Noeske, VP & CNO; M. Tupper, VP & CFO; D. Cox, VP Chief Human Resources Officer; M. Mertz, VP & Chief Strategy Officer; D. Leeper, VP & CIO; R. Gates, VP Population Health; D. Allain, VP Cardiac & Surgical Services; J. Batth, VP of Rehabilitation & Post-Acute Care Services; R. Berglund, Legal Counsel; and Cindy Moccio, recording

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

Director Francis asked for approval of the agenda.

MMSC (Gipson/Havard Mirviss) to approve the open agenda. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

PUBLIC PARTICIPATION – none

CLOSED SESSION ACTION TAKEN: Approval of closed minutes from March 22, 2021.

OPEN MINUTES – Request approval of the meeting minutes March 16 and March 22, 2021.

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

MMSC (Havard Mirviss/Olmos) Approval of the open meeting minutes March 16, 2021 and March 22, 2021. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

CREDENTIALING – Medical Executive Committee 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 Medical Executive Committee be reviewed for approval.

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

Director Francis requested a motion for the approval of the credentials report {copy attached to the original of these minutes and considered a part thereof}.

MMSC (Gipson/Havard Mirviss) Whereas a thorough review of all required information and supporting documentation necessary for the consideration of initial applications, reappointments, request for additional privileges, advance from provisional status and release from proctoring and resignations (pursuant to the Medical Staff bylaws) has been completed by the Directors of the clinical services, the Credentials Committee, and the Executive Committee of the Medical Staff, for all of the medical staff scheduled for

reappointment, Whereas the basis for the recommendations now before the Board of Trustees regarding initial applications, reappointments, request for additional privileges, advance from provisional status and release from proctoring and resignations has been predicated upon the required reviews, including all supporting documentation, Be it therefore resolved that the following medical staff, excluding Emergency Medicine Providers as highlighted on Exhibit A (copy attached to the original of these minutes and considered a part thereof), be approved or reappointed (as applicable), to the organized medical staff of Kaweah Delta Health Care District for a two year period unless otherwise specified, with physician-specific privileges granted as recommended by the Chief of Service, the Credentials Committee, and the Executive Committee of the Medical Staff and as will be documented on each medical staff member's letter of initial application approval and reappointment from the Board of Trustees and within their individual credentials files . This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

CHIEF OF STAFF REPORT – Report from Monica Manga, MD – Vice Chief of Staff

- Bylaws revisions are going out for a vote and will go to the Board for final approval.

QUALITY – STROKE PROGRAM - A review of key quality measures, and quality improvement projects related to the care of the stroke population {copy attached to the original of these minutes and considered a part thereof} - *Cheryl Smit, Stroke Program Manager*

CONSENT CALENDAR – Director Francis entertained a motion to approve the consent calendar (copy attached to the original of these minutes and considered a part thereof).

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

Director Olmos commended the excellent work relative to the Maternal Child Health Department, Mr. Herbst noted that we can have this service line report under the quality reports for the May board meeting.

MMSC (Havard Mirviss/Gipson) to approve the consent calendar. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

CHIEF EXECUTIVE OFFICER REPORT – Report relative to current events and issues - Gary Herbst, Chief Executive Officer

- COVID – On June 15th the tier system should be going away as this is the tentative date that the State will fully open.
- We recently had a press conference and unveiled the new Kaweah Care sign on the Acequia Wing during a press conference.
- The Gateway project is still in escrow, the ditch still needs to be moved and the soil compacted.

- The application for the ACGME Child / Adolescent fellowship for Psychiatry has received accreditation, however still need to have a preform completed and will need Board approval.
- Relative to the recruitment of our Chief Quality Officer position – we will be using another firm to recruit this position and we are revisiting the combined CMO/CQO position. An organization of our size needs a person dedicated to quality – the Board supports a dedicated CQO.

BOARD PRESIDENT REPORT – Report from David Francis, Board President

- Director Francis addressed the need for the Board to have a consistent location for Board of Director meetings so that public, should they wish to attend, have a consistent location. Mr. Herbst noted that Mr. Mertz is working on several plans to develop more meeting space in the District and will report back to the Finance Property and Services Committee and the Board on this topic.

ADJOURN - Meeting was adjourned at PM

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

ATTEST:

Garth Gipson, 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 TUESDAY MAY 18, 2021, AT 3:30PM, IN EXECUTIVE OFFICE CONFERENCE ROOM, KAWEAH HEALTH MEDICAL CENTER, 305 W. ACEQUIA VISALIA, CA AND VIA GOTO MEETING DAVID FRANCIS PRESIDING

PRESENT: Directors Francis, Gipson, Olmos & Rodriguez; G. Herbst, CEO; K. Noeske, VP & CNO; M. Tupper, VP & CFO; D. Cox, VP Chief Human Resources Officer; M. Mertz, VP & Chief Strategy Officer; D. Leeper, VP & ClO; R. Gates, VP Population Health; D. Allain, VP Cardiac & Surgical Services; J. Batth, VP of Rehabilitation & Post-Acute Care Services; R. Berglund, Legal Counsel; and Rosie Gonzalez, recording

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

Director Francis entertained a motion to approvee the agenda.

MMSC (Havard Mirviss/Olmos) to approve the open agenda. This was supported unanimously by those present. Vote: Yes – Olmos, Rodriguez, Gipson, and Francis Absent: Havard Mirviss

PUBLIC PARTICIPATION – none

2020/2021 ANNUAL OPERATING & CAPITAL BUDGET AND FINANCIALS – Review of the annual operating & capital budget and strategies and the most current fiscal year financial results (copy attached to the original of these minutes and considered a part thereof).

- The first review of the budget with the Board will be at the May Board of Directors meeting.
- Discussion of proposed meeting schedule between now and the end of June for the Board to review, discuss, and give feedback to leadership relative to the budget that will be presented to the Board at the June 28th regular Board meeting.
  - June 16th special Board meeting for finances/budget.
  - June 23rd special Board meeting for finances/budget.
  - June 28th budget presented to the Board for their approval.

CHIEF EXECUTIVE OFFICER REPORT – Report relative to current events and issues - Gary Herbst, Chief Executive Officer

- Emergency Department Zone 5, 24 bed unit will open upon final approval by the California Department of Public Health. Discussion relative to the survey and the action plan to resolve any concerns.
- We have concluded the 2nd mediation session with the Visalia Medical Clinic.
- Discussion regarding recent CMS survey and the 250+ report that we have to respond to. Originally it was due by May 21st however we have received an extension to June 1st. Our team is working with Greely to complete the response for a timely submission to CMS.

BOARD PRESIDENT REPORT – Report from David Francis, Board President

- No Report.

ADJOURN - Meeting was adjourned at 5:00PM

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

ATTEST:

Garth Gipson, Secretary/Treasurer
Kaweah Delta Health Care District Board of Directors

RESOLUTION 2129

WHEREAS, Kaweah Delta Health Care District dba Kaweah Health recognizes Liset Magallanes, RN, with the World Class Employee of the Month Award – May 2021 for consistent outstanding performance and,

WHEREAS, Liset embodies the Mission of Kaweah Health; *Health is our passion, Excellence is our focus, Compassion is our promise* and,

WHEREAS, Liset embraces the Pillar of Kaweah Health - *Deliver Excellent Service* and,

WHEREAS, the Board of Directors of the Kaweah Delta Health Care District is aware of her excellence in caring and service,

NOW, THEREFORE, BE IT RESOLVED that the Board of Directors of the Kaweah Delta Health Care District on behalf of themselves, the Kaweah Health staff, and the community they represent, hereby extend their congratulations to Liset for this honor and in recognition thereof, have caused this resolution to be spread upon the minutes of the meeting.

PASSED AND APPROVED this 24th day of May 2021 by a unanimous vote of those present.

President, Kaweah Delta Health Care District

ATTEST:

Secretary/Treasurer, Kaweah Delta Health Care District
and of the Board of Directors, thereof

11/18/2020 Liset Magallanes lmagalla@kdhcd.org Sandra Echeverria Wow. What can I say about Liset Magallanes. One of Kaweah Delta's finest nurses. I have had the pleasure to work alongside Liset when she has floated the the ICCU numerous times and let me just say; if the slogan "World Class Care" was in the dictionary, you would find a picture of Liset slapped right next to it. Liset advocates for her patients, never complains about her assignment, and always carries a smile on her face even under the most troublesome circumstances. With Liset's unmatched compassion for every patient that comes into her care, it is fair to say that Kaweah Delta's patient satisfactory scores will skyrocket through the roof! Liset Magallanes is an excellent choice to receive this prestigious nomination. An empowering nurse that provides an ideal work environment, delivers excellent service, and comes to work every night to SERVE.

- 9 years of Service
- R.N.
- Sandra Echeverria.
- good Standing.

RESOLUTION 2130

WHEREAS, Kaweah Delta Health Care District dba Kaweah Health recognizes Molly Niederreiter as the Employee of the Year for her consistent outstanding performance, her leadership, her kindness, her collaboration with her colleagues and,

WHEREAS, Molly embodies the Mission of Kaweah Health; *Health is our passion, Excellence is our focus, Compassion is our promise* and,

WHEREAS, Molly embraces the Pillar of Kaweah Health - *Deliver Excellent Service* and,

WHEREAS, the Board of Directors of the Kaweah Delta Health Care District is aware of her excellence in caring and service,

NOW, THEREFORE, BE IT RESOLVED that the Board of Directors of the Kaweah Delta Health Care District on behalf of themselves, the Kaweah Health staff, and the community they represent, hereby extend their congratulations to Molly for this honor and in recognition thereof, have caused this resolution to be spread upon the minutes of the meeting.

PASSED AND APPROVED this 24th day of May 2021 by a unanimous vote of those present.

President, Kaweah Delta Health Care District

ATTEST:

Secretary/Treasurer, Kaweah Delta Health Care District
and of the Board of Directors, thereof

Molly Niederreiter—Employee of the Year

Therapists are known for their healing hands, gentle hearts, compassion, integrity and patience. They restore hope, dignity and a sense of normalcy for patients who have experienced traumatic injuries. After a life changing injury, autonomy may be the only thing they have left. Therapists do so much more than simply promoting movement, they transform lives.

Through encouragement, inspiration and expertise, therapists impact not only a person's confidence and independence but their entire physical and emotional wellbeing.

They dedicate their lives to restoring function and relieving pain. If our patients stumble or experience a setback, they are the ones holding their hand every step of the way.

Molly Niederreiter has been faithfully serving our patients, staff and community since 1994. For the last 4 years, she has managed our Therapy Department. In addition to her managerial duties, she also happily provides direct patient care at the bedside.

Molly was recognized by her team for working 7 days a week to ensure that our COVID-19 patients received therapy. She was one of the very first therapists who pioneered the road to recovery for our COVID population. Molly's determination to help these patients through the early stages of an extremely-difficult and potentially-discouraging recovery was extraordinary.

She is a leader, educator and advocate within the walls of the hospital, however, her selfless nature is also evident in her contributions to the community. She has coached local sports teams, and most recently she opened up the doors of her own local business to try and alleviate childcare challenges during the peak of the pandemic.

She leads by example with grace and integrity. Her staff define her as caring, calm, objective and fair. Her leadership has unified and inspired her team. Molly's work ethic is remarkable – she listens carefully to her staff, follows up on their concerns, advocates for improvement within the department and across the organization, and readily steps in to care for patients whenever it is needed. She recognizes and celebrates her staff on a regular basis. She collaborates intentionally with providers, nurses and other integral team members. Molly consistently on-boards new residents and presents at staff meetings with the intention of helping her colleagues understand the role of the therapy department. She is a fierce advocate for continuing education. Within her own department, she has maintained a robust student and volunteer program because she understands how critical this is not only for our patients and hospital, but for our community.

Molly is an impact player and has contributed to practice changes that benefit our entire organization. She focuses on eliminating practice barriers for staff and patients. She has been instrumental in introducing and implementing state of the art technology that promotes best practices and patient safety.

Molly is a resilient leader whose kindness, strength and positivity have a profound impact every day, not just on her team, but on her patients and her colleagues throughout Kaweah Health.

Molly we are honored and blessed to call you our colleague and friend and we couldn't be more delighted or excited to name you this year's Kaweah Health Employee of the Year. Congratulations!!

KAWEAH HEALTH ANNUAL BOARD REPORT

Cardiovascular Services - Summary

FY2021 Annualized

KEY METRICS - FY 2021 Annualized on the Nine Months Ended March 31, 2021

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
30,868	$92,405,921	$67,160,992	$25,244,929	$6,059,311
▲ 8%	▼ -10%	▼ -14%	▲ 1%	▲ 64%

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

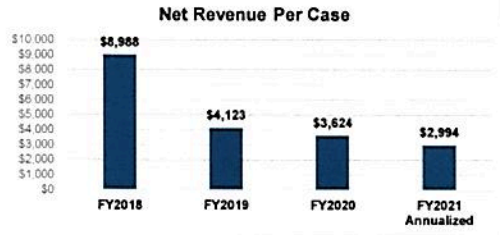
METRICS BY SERVICE LINE - FY 2021 ANNUALIZED

SERVICE LINE	PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
Inpatient Cardiology	2,577	$44,109,972	$30,134,244	$13,975,728	$4,689,499
Outpatient Cardiac Cath Lab	2,861	$21,662,343	$12,331,847	$9,330,496	$5,762,833
Outpt. Cardiology Clinic & Non-Inv. Cardi	25,159	$7,934,508	$6,089,923	$1,844,585	$495,360
Inpatient Cardiothoracic Surgeries	271	$18,699,099	$18,604,979	$94,120	($4,888,381)
Cardiovascular Services Totals	30,868	$92,405,921	$67,160,992	$25,244,929	$6,059,311

METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2018	FY2019	FY2020	FY2021 Annualized	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	10,497	24,381	28,462	30,868	▲ 8%	
Net Revenue	$94,352,121	$100,532,890	$103,138,337	$92,405,921	▼ -10%	
Direct Cost	$71,340,148	$77,455,916	$78,026,925	$67,160,992	▼ -14%	
Contribution Margin	$23,011,973	$23,076,974	$25,111,412	$25,244,929	▲ 1%	
Indirect Cost	$19,554,350	$20,271,549	$21,412,288	$19,185,619	▼ -10%	
Net Income	$3,457,623	$2,805,424	$3,699,124	$6,059,311	▲ 64%	
Net Revenue Per Case	$8,988	$4,123	$3,624	$2,994	▼ -17%	
Direct Cost Per Case	$6,796	$3,177	$2,741	$2,176	▼ -21%	
Contrb Margin Per Case	$2,192	$947	$882	$818	▼ -7%	

GRAPHS



Note: FY2021 is annualized in graphs and throughout the analysis
Source: Inpatient and Outpatient Service Line Reports
Criteria: Inpatient Cardiothoracic Surgeries and Cardiology Service Line
Criteria: Outpatient Service Line (Cardiac Cath Lab, Combined Cardiology Clinic and Non-Invasive Cardiology, all locations)

KAWEAH HEALTH ANNUAL BOARD REPORT

Cardiovascular Services - Inpatient Cardiology Service Line

FY2021 Annualized

KEY METRICS - FY 2021 Annualized on the Nine Months Ended March 31, 2021

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
2,577	$44,109,972	$30,134,244	$13,975,728	$4,689,499
▼ -14%	▼ -17%	▼ -19%	▼ -13%	▼ -4%

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

METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2018	FY2019	FY2020	*Annualized FY2021 Annualized	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	3,261	3,505	3,014	2,577	▼ -14%	
Patient Days	14,542	14,931	13,035	11,489	▼ -12%	
ALOS	4.46	4.26	4.32	4.46	▲ 3%	
GM LOS	3.50	3.37	3.47	3.51	▲ 1%	
Opportunity Days	0.95	0.89	0.86	0.95	▲ 10%	
Net Revenue	$50,648,688	$55,871,389	$52,969,470	$44,109,972	▼ -17%	
Direct Cost	$34,094,066	$38,979,979	$36,995,387	$30,134,244	▼ -19%	
Contribution Margin	$16,554,622	$16,891,410	$15,974,083	$13,975,728	▼ -13%	
Indirect Cost	$10,522,516	$11,558,791	$11,080,954	$9,286,229	▼ -16%	
Net Income	$6,032,106	$5,332,619	$4,893,129	$4,689,499	▼ -4%	
Net Revenue Per Case	$15,532	$15,940	$17,574	$17,115	▼ -3%	
Direct Cost Per Case	$10,455	$11,121	$12,275	$11,692	▼ -5%	
Contrb Margin Per Case	$5,077	$4,819	$5,300	$5,423	▲ 2%	

PER CASE TRENDED GRAPHS

PAYER MIX - 4 YEAR TREND (GROSS REVENUE)

PAYER	FY2018	FY2019	FY2020	FY2021 Annualized
Medicare	52%	51%	46%	45%
Medi-Cal Managed Care	17%	18%	16%	19%
Medicare Managed Care	11%	14%	16%	17%
Managed Care/Other	13%	12%	16%	13%
Medi-Cal	6%	5%	5%	5%
Cash Pay	1%	1%	0%	1%

Notes:
Source: Inpatient Service Line Report
Selection Criteria: Inpatient Service Line - Cardiology

KAWEAH HEALTH ANNUAL BOARD REPORT

Cardiovascular Services - OP Cardiac Cath Lab

FY2021 Annualized

KEY METRICS - FY 2021 Annualized on the Nine Months Ended March 31, 2021

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
2,861	$21,662,343	$12,331,847	$9,330,496	$5,762,833
▲ 1%	▲ 6%	▼ -7%	▲ 31%	▲ 45%

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

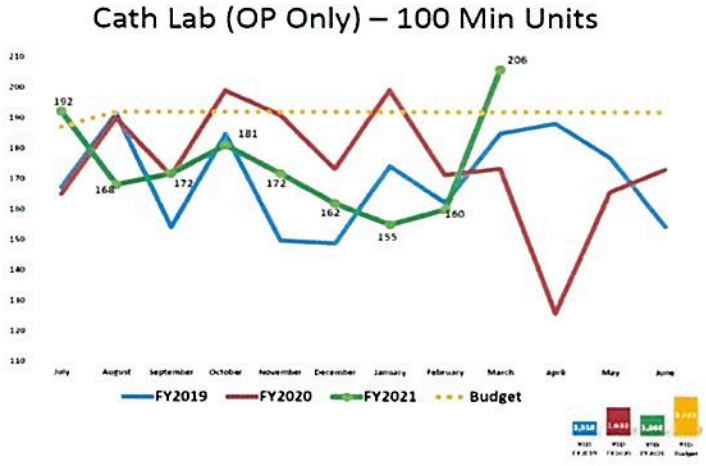
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2018	FY2019	FY2020	FY2021 Annualized	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	2,848	2,750	2,821	2,861	▲ 1%	
Net Revenue	$21,838,563	$18,688,990	$20,391,498	$21,662,343	▲ 6%	
Direct Cost	$16,138,881	$12,696,561	$13,279,346	$12,331,847	▼ -7%	
Contribution Margin	$5,699,682	$5,992,429	$7,112,152	$9,330,496	▲ 31%	
Indirect Cost	$3,696,727	$2,753,820	$3,140,140	$3,567,663	▲ 14%	
Net Income	$2,002,955	$3,238,609	$3,972,012	$5,762,833	▲ 45%	
Net Revenue Per Case	$7,668	$6,796	$7,228	$7,571	▲ 5%	
Direct Cost Per Case	$5,667	$4,617	$4,707	$4,310	▼ -8%	
Contrb Margin Per Case	$2,001	$2,179	$2,521	$3,261	▲ 29%	

PER CASE TRENDED GRAPHS

PAYER MIX - 4 YEAR TREND (GROSS REVENUE)

PAYER	FY2018	FY2019	FY2020	FY2021 Annualized
Medicare	48%	50%	47%	46%
Medicare Managed Care	17%	16%	18%	21%
Managed Care/Other	25%	23%	21%	20%
Medi-Cal Managed Care	9%	9%	12%	11%
Medi-Cal	1%	1%	0%	1%



Notes:
Source: Outpatient Service Line Reports
Criteria: Outpatient Service Line Cardiac Cath Lab

Kaweah Delta Health Care District
Annual Report to the Board of Directors

Cardiac Catheterization Lab

Christine Aleman, RN, MSN - Director of Cardiovascular Operations – 624-2696

May 2021

Summary Issue/Service Consider

This past year has posed many challenges due to COVID. While our case volume has slightly decreased our net revenue has increased 4% per case which equates to roughly $600 per case.

- Contributing factors
  - No reliance on Contract Labor
    - Cath Lab has remained fully staffed over the past year with no need for travelers
  - Renegotiations with our vendors has resulted in a 7% decrease in supply cost
    - Leveraging our affiliation with Cleveland Clinic was a contributing factor to successful renegotiations
  - Decreased Length of Stay (LOS)
    - Same Day Discharge (SDD) of elective PCI's has increased exponentially
      - Currently over 60% of our PCIs are discharged same day
      - Estimated savings per patient discharged same day: $1,500
      - National standing – top 90th percentile

Quality/Performance Improvement Data

Radial access approach has increased to over 50% for coronary heart procedures.

- Faster Recovery
  - Patients no longer need to lay flat for six hours in recovery
  - Able to walk and eat immediately post procedure
- Dr. Ashok Verma has championed this approach based on research for best practices by the American College of Cardiology
  - Radial access approach has Increased patient satisfaction
  - Kaweah Health Cath Lab has experienced zero case complications utilizing the radial access approach

Policy, Strategic or Tactical Issues

Implementation of structured reporting is currently being trialed by our physician champions.

- Structured reporting will give us consistent data points reported in real time
  - This will give us meaningful insights on quality metrics and help to bolster process improvement
- Reports will become standardized, increasing the speed and accuracy of data collection for quality improvement

Recommendations/Next Steps

- Continue to work on implementation of structured reporting
- Continue to utilize our affiliation with Cleveland Clinic to improve efficiencies and quality metrics

Approvals/Conclusions

Operations within the Cath Lab have returned to pre COVID volume levels within the last two months. Staff remains focused and leadership remains committed to providing world class patient care. This is evident by the decrease in staff turnover and overall patient satisfaction. We will work to continue the upward financial trend for Cardiovascular Operations.

KAWEAH HEALTH ANNUAL BOARD REPORT

FY2021 Annualized

Cardiovascular Services - Inpatient Cardiothoracic Surgeries [1]

KEY METRICS - FY 2021 Annualized on the Nine Months Ended March 31, 2021

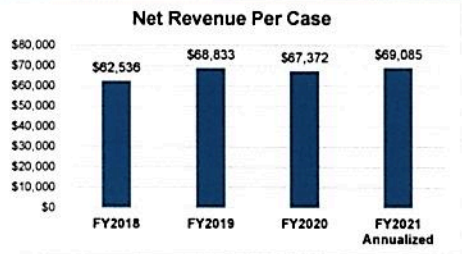
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
271	$18,699,099	$18,604,979	$94,120	($4,888,381)
▼ -20%	▼ -18%	▼ -16%	▼ -87%	▲ 5%

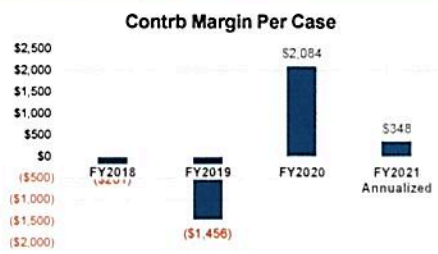
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2018	FY2019	FY2020	FY2021 Annualized	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	326	304	340	271 ▼	-20%	
Patient Days	4,080	3,905	3,779	3,223 ▼	-15%	
ALOS	12.52	12.85	11.11	11.91 ▲	7%	
GM LOS	9.04	9.50	9.37	9.39 ▶	0%	
Opportunity Days	3.48	3.35	1.74	2.52 ▲	44%	
Net Revenue	$20,386,732	$20,925,323	$22,906,440	$18,699,099 ▼	-18%	
Direct Cost	$20,452,210	$21,367,977	$22,197,764	$18,604,979 ▼	-16%	
Contribution Margin	($65,478)	($442,654)	$708,676	$94,120 ▼	-87%	
Indirect Cost	$5,085,409	$5,262,559	$5,874,390	$4,982,501 ▼	-15%	
Net Income	($5,150,887)	($5,705,213)	($5,165,714)	($4,888,381) ▲	5%	
Net Revenue Per Case	$62,536	$68,833	$67,372	$69,085 ▲	3%	
Direct Cost Per Case	$62,737	$70,289	$65,288	$68,738 ▲	5%	
Contrb Margin Per Case	($201)	($1,456)	$2,084	$348 ▼	-83%	

PER CASE TRENDED GRAPHS





PAYER MIX - 4 YEAR TREND (GROSS REVENUE)

PAYER	FY2018	FY2019	FY2020	FY2021 Annualized
Medicare	41%	39%	39%	41%
Managed Care/Other	21%	20%	22%	17%
Medicare Managed Care	12%	20%	17%	19%
Medi-Cal Managed Care	16%	12%	14%	15%
Medi-Cal	8%	5%	7%	6%

FY 2021 Payer Mix

Notes:
1. Source: Inpatient Service Line Report
Selection Criteria: Inpatient Surgeon Specialty = Cardiothoracic Surgery

Kaweah Delta Health Care District
Annual Report to the Board of Directors

Cardiac Surgery

Christine Aleman, RN, MSN – Director of Cardiovascular Operations – 624-2696

May 2021

Summary Issue/Service Considered

COVID has affected all areas of healthcare including open heart surgery. Despite a 20% decrease in case volume, FYE 2020 and FYE 2021 have had a positive contribution margin after being negative in prior years.

- Contributing factors
  - 69 fewer Open Heart cases in FYE 2021
  - Direct cost increase of 5% per case ($1,700 per case)
    - Anesthesia cost per case increase $2,100
    - Direct allocations are spread across a lower case volume
  - Increased cost of supplies
    - $450 increase for Non Implants
    - $450 increase for Implants
  - Length of Stay increased 7%
    - `Cost of opportunity savings $3.9 Million

Quality/Performance Improvement Data

- Healthgrades Awards
  - 50 Best Cardiac Surgery – 4th consecutive year in row
- Same Day Admission process - Implemented beginning of FY 2021
  - Process improvement to eliminate courtesy preadmission stays
    - Decreases length of stay
    - Increases bed availability hospital wide
    - Increases patient satisfaction
      - Family is able to spent more time with patient prior to surgery
      - Increases patient familiarity with facility and entire care team
    - Improved process highlighted and published by Cleveland Clinic in their affiliate magazine
  - In collaboration with Cleveland Clinic updated patient care materials that follow the patient through their continuum of care.

Policy, Strategic or Tactical Issues

- Cost of Supplies
  - Goal: $800,000 decrease in overall supply cost for FYE 2022

Recommendations/Next Steps

- Cost of Supplies
  - Renegotiation of vendor selection and pricing in collaboration with Materials Management team
  - Implementation of a waste efficiency project to review wasted supplies after each case
- Length of Stay
  - Cross department collaboration to identify barriers to timely discharge
- Continue to work with Cleveland Clinic on efficiencies within the cardiac surgery program

Approvals/Conclusions

Our award winning open heart program continues to focus on improving patient quality outcomes while remaining fiscally responsible. Supply cost reduction and decreased length of stay will be our primary focus in the coming year. Patient satisfaction and favorable outcomes are always a top priority for our community.

KAWEAH HEALTH ANNUAL BOARD REPORT

Cardiovascular Services - Outpatient Cardiology Clinic & Non-Invasive Cardiology

FY2021 Annualized

KEY METRICS - FY 2021 Annualized on the Nine Months Ended March 31, 2021

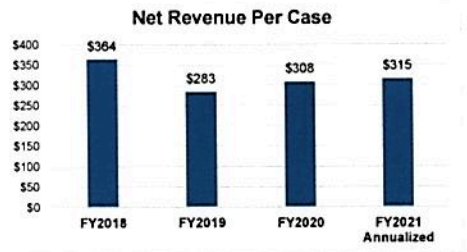
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
25,159	$7,934,508	$6,089,923	$1,844,585	$495,360
▲ 13%	▲ 15%	▲ 10%	▲ 40%	▲ 163397%

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

METRICS SUMMARY - 4 YEAR TREND

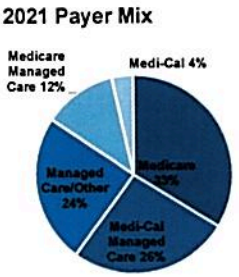
METRIC	FY2018	FY2019	FY2020	FY2021 Annualized	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	4,062	17,822	22,287	25,159	▲ 13%	
Net Revenue	$1,478,138	$5,047,188	$6,870,929	$7,934,508	▲ 15%	
Direct Cost	$654,991	$4,411,399	$5,554,428	$6,089,923	▲ 10%	
Contribution Margin	$823,147	$635,789	$1,316,501	$1,844,585	▲ 40%	
Indirect Cost	$249,698	$696,379	$1,316,804	$1,349,225	▲ 2%	
Net Income	$573,449	($60,591)	($303)	$495,360	▲ 163397%	
Net Revenue Per Case	$364	$283	$308	$315	▲ 2%	
Direct Cost Per Case	$161	$248	$249	$242	▼ -3%	
Contrb Margin Per Case	$203	$36	$59	$73	▲ 24%	

PER CASE TRENDED GRAPHS



PAYER MIX - 4 YEAR TREND (GROSS REVENUE)

PAYER	FY2018	FY2019	FY2020	FY2021 Annualized
Medicare	19%	38%	36%	33%
Medi-Cal Managed Care	44%	23%	24%	26%
Managed Care/Other	25%	23%	23%	24%
Medicare Managed Care	4%	10%	11%	12%
Medi-Cal	6%	6%	5%	4%



Notes:
Source: Outpatient Service Line Reports
Criteria: Outpatient Service Linea: Combined Non-Invasive Cardiology & Sequoia Cardiology Clinic, all locations.

Kaweah Health
Annual Report to the Board of Directors

Kaweah Health Cardiology Clinic

Tracy Salsa, RN, BSN, MBA - Director of Cardiovascular Service Line – 624-4084

May 2021

Summary Issue/Service Consider

Kaweah Health Cardiology Clinic (Sequoia Cardiology Clinic) volumes for the past year were increasing exponentially up until the pandemic. Despite the challenges that accompanied the restrictions of COVID19, we managed to move our Non-Invasive Cardiology operations & team (Oct. 2020) from 202 W. Willow to the cardiology clinic, implement a successful PET CT program (Nov. 2020) that is bringing a much needed service to our community, and purchase a new nuclear camera (for SPECT) in Jan. 2021.

Board report changes/highlights

- Clinic volumes are up 13% over FY 2020
- Direct cost per case decreased from $249 to $242
- Contribution Margin per case steadily increasing year-over-year now at $73 per case which is a 24% increase from FY20
- Net income dramatically increased due to consolidation of non-invasive cardiology service line into the cardiology center location; financials from this service line are now combined with the OP Cardiology Clinic
- Payor mix has essentially remained the same
- No Show Rate for the clinic is averaging 9%

Quality/Performance Improvement Data

The clinic has implemented:

1. Remote monitoring of pacemakers so patients do not need to come into clinic as often to have their device interrogated. Remote monitoring can be done three times a year and in person once. The majority of pacemaker patients are monitored remotely.
2. Engaged BioTel Heart, an outside company, to provide event monitoring, and AMI for unlimited supply of Holter devices for continuous monitoring (for both 24 and 48 hour time frames). This has decreased wait time for getting this type of monitoring done. By utilizing these companies, Kaweah Health Cardiology Center has complete oversight of this monitoring and allows for no outsourcing the monitoring to a different entity.
3. Registered echo technicians now administering Definity – improved patient throughput, better quality of images/tests, less labor costs, increase in number of tests performed, and prevents patients from repeat testing due to poor image quality.

Policy, Strategic or Tactical Issues

Now that our cardiology clinic includes our diagnostic center, continued focus on growing our market share for non-invasive testing (i.e. stress testing, echocardiograms) continues. Also

continued focus on growing our nuclear medicine program (SPECT and PET). Our team of echo technicians are all working towards becoming registered which is a goal as we work towards delivering world-class service. We continue our affiliation with Cleveland Clinic, incorporating evidence-based care, maximizing our purchasing relationships to decrease costs, and shape clinical policies and workflows all centered around world-class service to our patients.

Recommendations/Next Steps

Several focused areas:

- Move to pre-registration for all patients (clinic & diagnostic center); this moves allows:
  - Increase productivity by reducing check-in time
  - Utilize Clear Quote® which would increase up-front collections
  - Increase patient satisfaction
  - Decrease errors in information collected at front desk during check-in
  - Decrease no show rate
- Utilize Clarify to help identify trends in market share/referral patterns
- Solidify agreement with radiologists regarding PET imaging reads
- Continue offering telehealth visits for patients that prefer not to be seen in person (if clinically appropriate)

Approvals/Conclusions

Despite the global pandemic, the cardiology clinic demonstrated sustainability within the confines of the challenges of COVID19. The clinic was able to implement within a week's time the ability to provide cardiologist services via a telehealth platform. Moving the diagnostic center operations, implementation of a new nuclear medicine camera, and starting a completely new service line (PET) set Kaweah Health's cardiology services apart from our competition. Kaweah Health Cardiology Clinic offers world-class cardiology services in one location.

Risk Management Report – Open
2nd Quarter 2021

Evelyn McEntire, Interim Director of Risk Management
559-624-2876 / emcentir@kaweahhealth.org

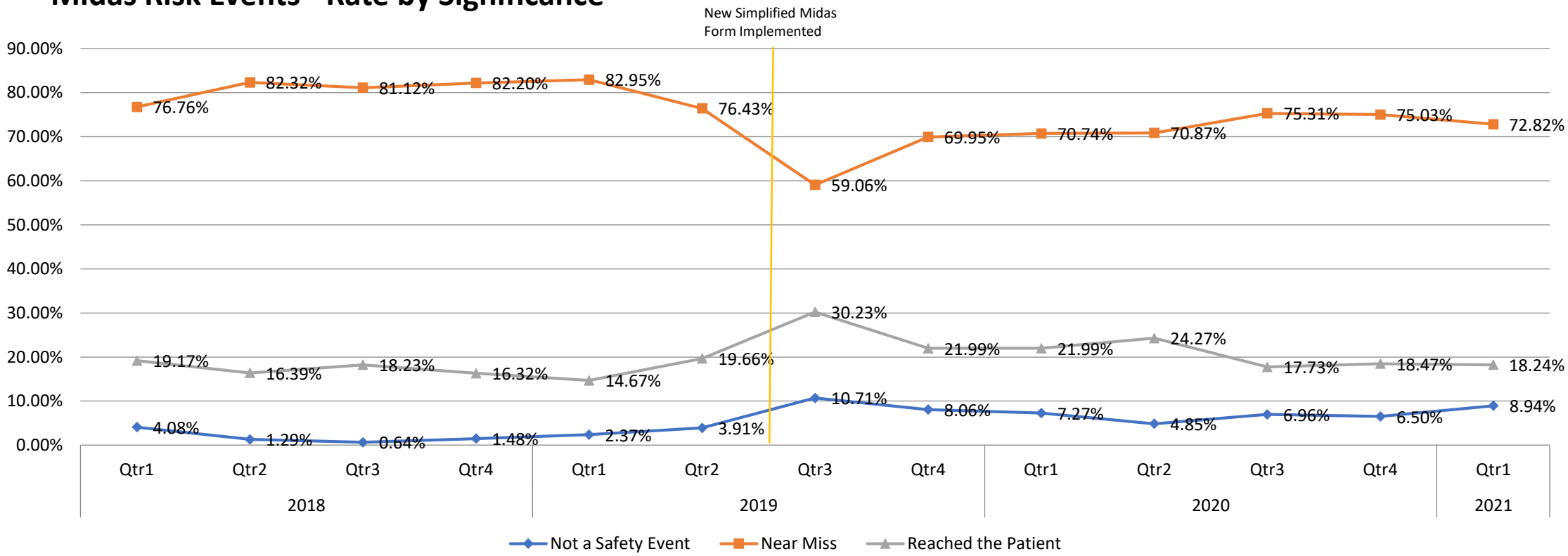
Risk Management Goals

1. Promote a safety culture as a proactive risk reduction strategy.

2. Reduce frequency and severity of harm (patient and non-patient).
   - Zero incidents of "never events"

3. Reduce frequency and severity of claims.

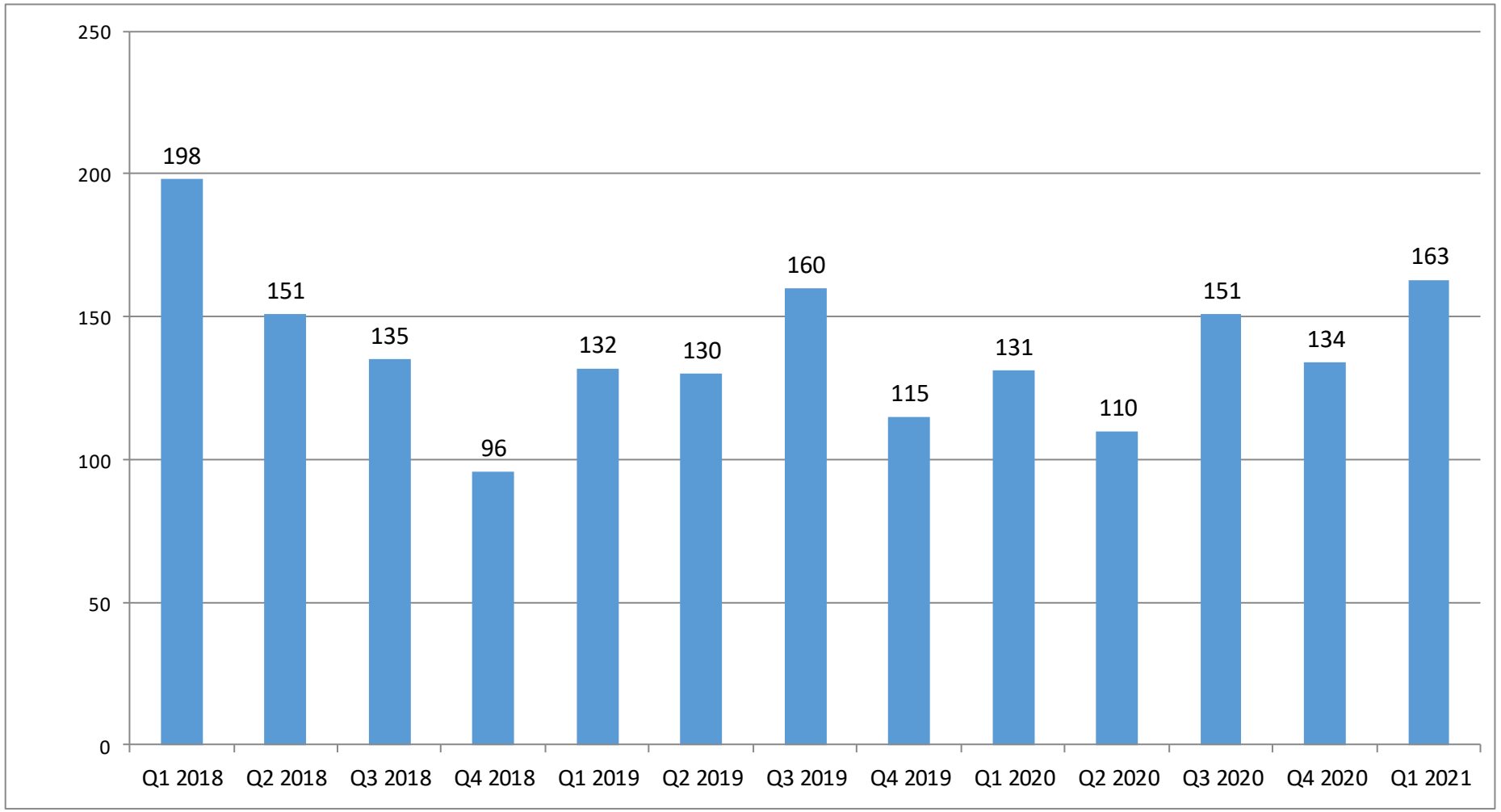
Midas Risk Events - Rate by Significance



This graph represents the total number of Midas event reports submitted per quarter. The events are categorized by "*Not a safety event*," "*Near miss*," or "*Reached the patient*."

Goal: To increase the total number of event reports submitted by staff/providers while decreasing those events which reach the patient.

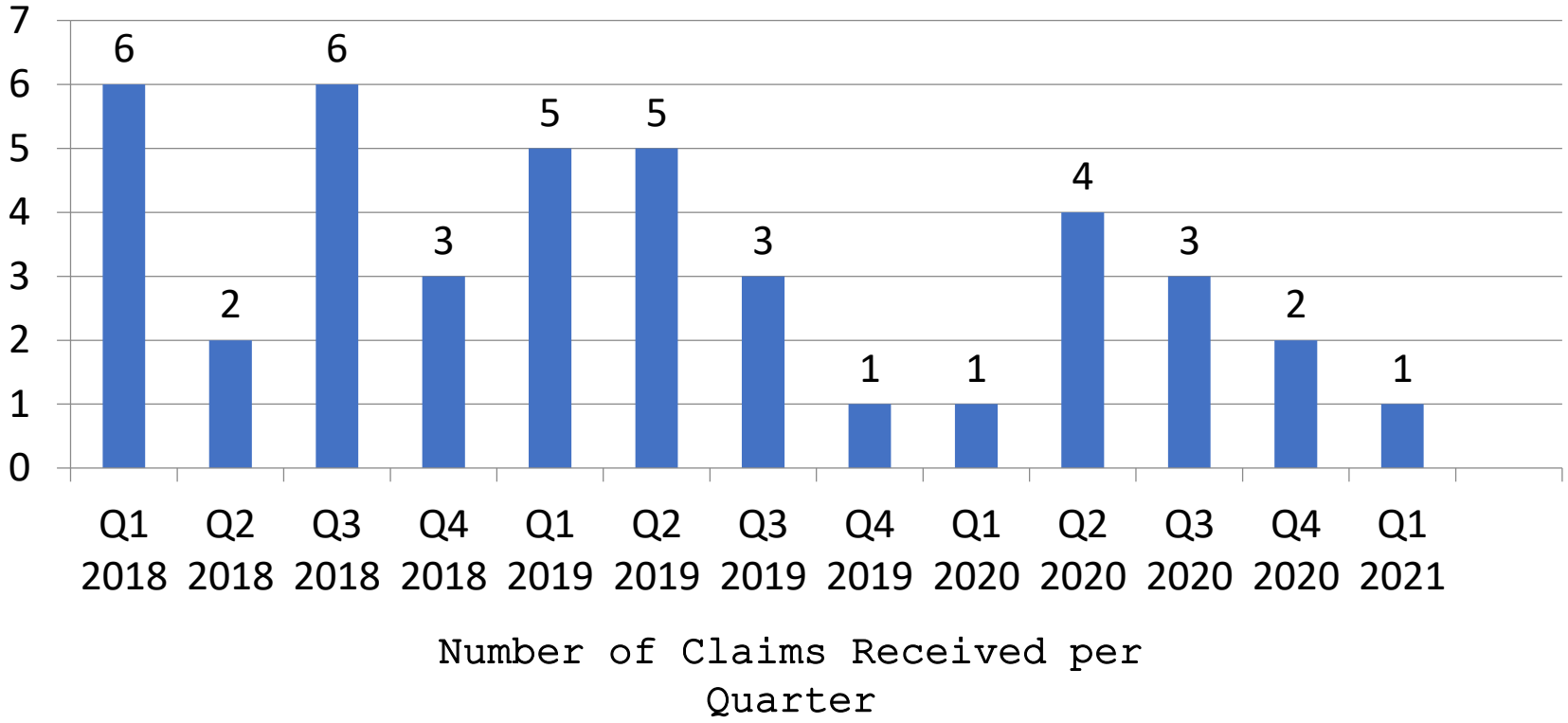
Complaints & Grievances 2018-2021



Most Common Complaints:

- Lost Belongings
- Physician Care
- Nursing Care

Claims
2018 - 2021



Total cases closed during 1st Quarter 2021 – (3) Three
Total cases closed during 2020 – (16) Sixteen

COMPLIANCE PROGRAM ACTIVITY REPORT – Open Meeting
Ben Cripps, Chief Compliance Officer
February 2021 through April 2021

EDUCATION

Live Presentations by Compliance Department

- Compliance and Patient Privacy – New Hire
- Compliance and Patient Privacy – Management Orientation

Written Communications sent from Compliance Department – Bulletin Board / All Staff Communication

Area Compliance Expert (ACE) Program – Email Distribution List

- FairWarning Privacy Monitoring Tool – All Staff

PREVENTION AND DETECTION

- **California Department of Public Health (CDPH) All Facility Letters (AFL)** – Review and distribute AFL's to areas potentially affected by regulatory changes; department responses reviewed and tracked to address the regulatory change and identify potential current/future risk
- **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
- **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
- **California State Senate and Assembly Bill Updates** – Review and distribute legislative updates to areas potentially affected by new or changed bill; department responses reviewed and tracked to address regulatory change and identify potential current/future risk
- **Patient Privacy Walkthrough** – Monthly observations of privacy practices throughout Kaweah Health; issues identified communicated to area Management for follow-up and education
- **User Access Privacy Audits** – Daily monitoring of user access to identify potential privacy violations
- **Office of Inspector General (OIG) Exclusion Attestations** – Quarterly monitoring of department OIG Exclusion List review and attestations
- **Medicare PEPPER Report Analysis** – Quarterly review of Medicare Inpatient Rehabilitation, Hospice, Mental Health, and Acute Inpatient PEPPER statistical reports to identify outlier and/or areas of risk; evaluate with Kaweah Health leadership quarterly at PEPPER Review meeting

OVERSIGHT, RESEARCH & CONSULTATION

- **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) and Medicare Probe Audit Activity** – Records preparation, tracking, appeal timelines, and reporting

- **Licensing Applications** – Forms preparation and submission of licensing application to the California Department of Public Health (CDPH); ongoing communication and follow-up regarding status of pending applications
- **Federally Qualified Health Center (FQHC)** – Participation in current and future state planning/working sessions; ongoing regulatory counsel and support, evaluating impact and identifying risk mitigation strategies; clinic licensing modifications in progress
- **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 approximately 1,001 non-employee KD Hub users; the annual renewal process with the new Compliance 360 workflow is currently in process
- **Covid-19 Incident Response** – Participation in Section Chief Meetings to advise on regulatory matters and to ensure ongoing compliance; ongoing oversight and review of Covid-19 regulatory review and response
- **Information ("Info") Blocking** – Research and consultation; participation in the review, assessment, and implementation of new regulatory guidance concerning Information Blocking (start date April 5, 2021); Info Blocking is a practice that prevents or materially discourages access, exchange, or use of Electronic Health Information (EHI); a Committee has been established to provide clear guidance surrounding the new requirements to departments that release patient information. A process has been developed by the Committee to review EHI release denials to ensure compliance of this new regulation
- **Operational Compliance Committee** – Consultation, oversight, and prevention; in July 2020, the Compliance Department created the Operational Compliance Committee comprised of five (5) high-risk departments including Patient Accounting, Health Information Management, Revenue Integrity, Case Management and Patient Access; meetings are held monthly to discuss regulations, policies, auditing and monitoring, and educational efforts within the departments; additional joint meetings consisting of all five (5) departments aide in cross-departmental discussion surrounding compliance efforts and procedures; beginning January 2021, Compliance developed and implemented the use of departmental dashboards designed to develop focused goals and measure effectiveness of the program; in May 2021, the Clinical Documentation Improvement (CDI) Department was added to the Operational Compliance Committee; the CDI workgroup will meet monthly and participate as an attendee for joint session meetings
- **Vaccine Billing for Rural Health and Urgent Care** – Research and consultation; participation in review and assessment of regulatory/billing guidance concerning Covid-19 vaccinations for all Rural Health Clinic and Urgent Care locations
- **Kaweah Health Rebranding Initiative** – Participation and consultation; provided regulatory counsel and support in the Kaweah Health Rebranding Initiative; worked with the California Department of Public Health to update the Kaweah Delta Health Care District Consolidated License
- **Kaweah Health Rehabilitation Commission on Accreditation of Rehabilitation Facilities (CARF) Audits** – Research and consultation; assisted the Rehabilitation Department in conducing quarterly audits of internal CARF audit standards to address billing accuracy, medications, supplies, therapies and standards, and identify trends for areas of improvement
- **Virtual Conditions of Admission** – Research and consultation; participation in the review and assessment of regulatory guidance for a virtual registration process and Conditions of Admission; following a review of State and Federal laws, California Hospital Association (CHA) Consent Manual, and required Notices to the patient outlining the requirements of the registration process; Compliance provided guidance to Patient Access Leadership on the proposed process
- **Complaint California Department of Insurance** – Research and consultation; worked with the Health Information Management (HIM) Department to support an investigation by the California

Department of Insurance on behalf of Aflac for potential fraudulent claims submitted by their insured; supplied response stating that the insured did not have services at Kaweah Health on the dates in question. Kaweah Health was not notified of the outcome of the investigation.

- **Chronic Disease Management Clinic (CDMC) Pharmacist Oversight** – Research and consultation; participation in review and assessment of regulatory guidance concerning pharmacist oversight and scope of practice; additional guidance and clarification was provided for the use of the Memorandum of Understanding for CDMC
- **Urgent Care Follow up: Patient Education Visits –** Research and consultation; participation in review and assessment of regulatory guidance concerning follow up visits for laboratory results and education-based visits in a Urgent Care setting; regulatory guidance provided to Urgent Care Leadership on the proposed process
- **Medicare Conditions of Participation (COP) with Discharge, Transfer Notifications** – Oversight and consultation; participation in review and assessment of regulatory guidance concerning the current electronic medical record (EMR); new CoP's require hospitals to allow patients to consent to electronic notifications to be sent to the provider of their choice; a work plan was established to satisfy the requirement until the EMR system upgrade can take place; the Compliance Department is monitoring the progress and implementation of the work plan
- **Kaweah Health Medical Group (KHMG) Kick-Off** – Oversight, administration, and consultation; leading a comprehensive review and evaluation of Compliance and Privacy practices at KHMG; a comprehensive assessment was completed to identify opportunities of improvement; follow-up meetings will be held with KHMG leadership to establish an action plans for implementation of identified opportunities
- **OIG Sanction Screening for Non-Credentialed Physicians** – Research and consultation; evaluated the regulatory guidance and operational processes for completing the required OIG Sanction Screening for Non—credentialed Physicians; the Compliance Department partnered with ISS, Patient Access and Patient Accounting to develop a process by which non-credentialed Physicians will be reviewed monthly for exclusions through the Verysis Provider Credentialing system; we anticipate the new process to be fully implemented by the end of May 2021

AUDITING AND MONITORING

- **Noridian Post Payment Probe Audit of Lab Metabolic Panel** – Noridian (Medicare Claims Administrator) completed a post-payment Targeted Probe review of Outpatient Comprehensive Metabolic Panel claims. The review of twelve (12) claims completed in February 2021 noted a 91.5% compliance rate. Education was provided and a corrective action plan was developed by Management. Based on the findings, Noridian has determined that our facility will not proceed to the next round of the audit process
- **Physician Reappointment and Office of Inspector General (OIG) Exclusion List** – A review of thirty (30) randomly selected physician credentialing reappointments were compared to the OIG List of Excluded Individuals and Entities (LEIE) and the System for Award Management. Compliance confirmed that none of the physicians included in the sampling population were identified on the LEIE; and thus not excluded from participation in the Medicare Program
- **Outpatient Dialysis Standing Orders** – A review of calendar year 2021 Outpatient Dialysis Standing Orders was completed to determine if the annual standing orders were appropriately updated per Medicare regulations. In 2020, a Noridian Review identified situations where standing orders had not been updated. The 2021 review noted a 100% compliance rate with. Based on the results of the review, no further action is required at this time

Physician Recruitment and Relations
Medical Staff Recruitment Report - May 2021

Prepared by: Brittany Taylor, Director of Physician Recruitment and Relations - btaylor@kdhcd.org - (559)624-2899

Date prepared: 5/17/2021

Central Valley Critical Care Medicine	
Intensivist (1- Part-Time; 1 - Full-Time)	2

Delta Doctors Inc.	
OB/Gyn	1

Kaweah Delta Faculty Medical Group	
Family Medicine Associate Program Director	1
Family Medicine Core Faculty	2

Key Medical Associates	
Internal Medicine/Family Medicine	2

Oak Creek Anesthesia	
General Anesthesia	3
Certified Registered Nurse Anesthetist	3
Program Director - Anesthesia	1

Other Recruitment	
Neurology	1
Orthopedic Surgery (Trauma)	1
Pulmonology	1

Valley Children's Health Care	
Maternal Fetal Medicine	2

Kaweah Health Medical Group	
Dermatology	2
Family Medicine	4
Internal Medicine	1
Gastroenterology	2
Orthopedic Surgery (Hand)	1
Otolaryngology	2
Radiology - Diagnostic	1
Rheumatology	1
Urology	3

Candidate Activity						
Specialty/Position	**Group**	**Last Name**	**First Name**	**Availability**	**Referral Source**	**Current Status**
Colorectal Surgery	Kaweah Health Medical Group	Ota, M.D.	Kyle	08/21	Current KD General Surgery resident	Offer accepted; Start Date: 8/2/2021
Anesthesia	Oak Creek Anesthesia	Cammarano, M.D.	Caitlin	08/22	Kaweah Health Resident	CV Requested
Anesthesia	Oak Creek Anesthesia	Eslahpazir, M.D.	Benjamin	TBD	CompHealth - 4/9/21	Site Visit Pending - Tentative June 2021
Anesthesia - Program Director	Oak Creek Anesthesia	Husain, M.D.	Kamran	TBD	Direct - 5/17/21	Currently under review
Anesthesia	Oak Creek Anesthesia	Parson, MD	Algenon Martell	ASAP	Direct - 5/3/21	Offer Accepted; Start Date pending hospital privileges
CRNA	Oak Creek Anesthesia	Baldwin	Joy	TBD	Direct - 4/15/21	Site visit pending dates
Dermatology - Mohs Surgery	Kaweah Health Medical Group	Chu, M.D.	Thomas	08/21	Curative - 2/24/21	Site Visit: 4/6/21; Offer pending
Family Medicine	Kaweah Health Medical Group - Cherry Street	Fakeh, M.D.	Ayman	TBD	MDStaffers - 4/27/21	Site visit: 5/20/21
Family Medicine	Kaweah Health Medical Group	Hsueh, D.O.	Marion	09/21	Direct referral	Site Visit: 3/23/21; Offer accepted
Family Medicine Core Faculty	Kaweah Delta Faculty Medical Group	Bassali, M.D.	Mariam	08/21	Referred by Dr. Martinez - 10/14/20	Site Visit: 3/10/21; offer accepted
Family Medicine Core Faculty	Kaweah Delta Faculty Medical Group	Rangel-Orozco, M.D.	Daniela	08/22	Kaweah Health Resident	Site visit pending dates
Hospitalist	Central Valley Critical Care Medicine	Malik, M.D.	Sara	08/21	Direct - Dr. Umer Hayyat's spouse	Site Visit: 10/7/20; Offer accepted
Hospitalist	Central Valley Critical Care Medicine	Reed, M.D.	Jennifer	08/21	Vista Staffing - 1/18/21	Offer accepted
Intensivist	Central Valley Critical Care Medicine	Dierksheide, M.D.	Julie	08/21	Vista Staffing - 4/15/21	Offer accepted

Candidate Activity						
Specialty/Position	**Group**	**Last Name**	**First Name**	**Availability**	**Referral Source**	**Current Status**
Intensivist	Central Valley Critical Care Medicine	Hansen, M.D.	Diana	TBD	Vista Staffing - 2/25/21	Offer accepted
Intensivist	Central Valley Critical Care Medicine	John, D.O.	Avinaj	08/21	Vista Staffing - 10/25/19	Site visit: 12/13/19; Offer accepted
Intensivist	Central Valley Critical Care Medicine	Akinjero, M.D.	Akintunde	08/21	Vista Staffing - 10/20/20	Virtual Interview: 11/30/20 Offer accepted
Intensivist	Central Valley Critical Care Medicine	Chemtob, M.D.	Gilles	TBD	Vista Staffing - 5/4/21	Currently under review
Intensivist	Central Valley Critical Care Medicine	Islam, M.D.	Tasbirul	TBD	PracticeLink - 5/5/21	Virtual visit - reviewing draft contract
Neonatology	Valley Children's	Singh, M.D.	Himanshu	08/22	Valley Children's - 3/31/21	Site Visit: 4/19/2021; Offer extended
Orthopedic Surgery - Hand	Kaweah Health Medical Group/ Orthopaedic Associates	Tomooka, D.O.	Beren	08/21	Direct referral	Phone Interview: 12/2/20; Site Visit: 3/12/21; Offer extended
Otolaryngology	Kaweah Health Medical Group	Head, M.D.	Christian	ASAP	Curative - 5/5/21	Currently under review
Otolaryngology	Kaweah Health Medical Group	Hussaini, M.D.	Adnan	07/22	Curative - 5/12/21	Currently under review
Otolaryngology	Kaweah Health Medical Group	Nguy, M.D.	Peter	07/22	Curative - 5/5/21	Currently under review
Otolaryngology	Kaweah Health Medical group	Nguyen, D.O.	Cang	07/22	Curative - 3/15/21	Site Visit: 5/18/21
Palliative Medicine	Independent	Grandhe, M.D.	Sundeep	08/21	Direct -12/7/20	Virtual Interview: 12/28/20; Offer accepted; Start Date: 9/1/21
Psychiatry	Precision Psychiatry	Eslami, M.D.	Setare	07/21	Kaweah Health Resident	Tentative Start Date: 7/19/2021

Candidate Activity						
Specialty/Position	**Group**	**Last Name**	**First Name**	**Availability**	**Referral Source**	**Current Status**
Psychiatry	Precision Psychiatry	Le, D.O.	Christine	07/21	Kaweah Health Resident	Tentative Start Date: 7/19/2021
Psychiatry - Child & Adolescent	Precision Psychiatry	Pereyra, M.D.	Aubree	07/21	Kaweah Health Resident	Tentative Start Date: 7/19/2021
Urology APP	Kaweah Health Medical Group	Dhanoa	Kirat	06/21	Direct	Virtual Interview: 3/17/21; Offer accepted
Urology	Kaweah Health Medical Group	Patel, M.D.	Neil	06/21	Los Angeles Career MD Fair 9/14/19	Site Visit: 9/25/20; Part-Time; Start date pending

Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

Policy Number: AP41	**Date Created: No Date Set**
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration)	

Quality Improvement Plan

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

I. Purpose

The purpose of Kaweah Delta Health Care District's (KDHCD) Quality Improvement Plan is to have an effective, data-driven Quality Assessment Performance Improvement program that delivers high-quality, excellent clinical services and enhances patient safety.

II. Scope

All KDHCD facilities, departments, patient care delivery units and/or service areas fall within the scope of the quality improvement plan requirements.

III. Structure and Accountability

Board of Directors

The Board of Directors retain overall responsibility for the quality of patient care. The Board approves the annual Quality Improvement Plan and assures that appropriate allocation of resources is available to carry out that plan.

The Board receives reports from the Medical Staff and Quality Council. The Board shall act as appropriate on the recommendations of these bodies and assure that efforts undertaken are effective and appropriately prioritized.

Quality Council

The Quality Council is responsible for establishing and maintaining the organization's Quality Improvement Plan and is chaired by a Board member. The Quality Council shall consist of the Chief Executive Officer, representatives of the Medical Staff and other key hospital leaders. It shall hold primary responsibility for the functioning of the Quality Assessment and Performance Improvement program. Because District quality improvement activities may involve both the Medical Staff and other representatives of the District, membership is multidisciplinary. The Quality Council requires the Medical Staff and the organization's staff to implement and report on the activities for identifying and evaluating opportunities to improve patient care and services throughout the organization. The effectiveness of the quality improvement and patient safety activities will be evaluated and reported to the Quality Council.

Medical Staff

The Medical Staff, in accordance with currently approved medical staff bylaws, shall be accountable for the quality of patient care. The Board delegates authority and responsibility for the monitoring, evaluation and improvement of medical care to the Professional Staff Quality Committee "Prostaff", chaired by the Vice Chief of Staff. The Chief of Staff delegates accountability for monitoring individual performance to the Clinical Department Chiefs. Prostaff shall receive reports from and assure the

appropriate functioning of the Medical Staff committees. “Prostaff” provides oversight for medical staff quality functions including peer review.

Quality Improvement Committee (QIC) QIC has responsibility for oversight of organizational performance improvement. Membership includes key organizational leaders including the Medical Director of Quality and Patient Safety or Chief Quality Officer, Chief Operating Officer, Chief Nursing Officer, Assistant Chief Nursing Officer, Directors of Quality and Patient Safety, Nursing Practice, and Risk Management; Manager of Quality and Patient Safety and Manager of Infection Prevention. This committee reports to Prostaff and the Quality Council.

The QIC shall have primary responsibility for the following functions:

1. **Health Outcomes:** The QIC shall assure that there is measureable improvement in indicators with a demonstrated link to improved health outcomes. Such indicators include but are not limited to measures reported to the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC), and other quality indicators, as appropriate.
2. **Quality Indicators:**
    a. The QIC shall oversee measurement, and shall analyze and track quality indicators and other aspects of performance. These indicators shall measure the effectiveness and safety of services and quality of care.
    b. The QIC shall approve the specific indicators used for these purposes along with the frequency and detail of data collection.
    c. The Board shall ratify the indicators and the frequency and detail of data collection used by the program.
3. **Prioritization:** The QIC shall prioritize quality improvement activities to assure that they are focused on high- risk, high- volume, or problem- prone areas. It shall focus on issues of known frequency, prevalence or severity and shall give precedence to issues that affect health outcomes, quality of care and patient safety. The QIC is responsible to establish organizational Quality Focus Teams who:
    a. Are focused on enterprise-wide high priority, high risk, problem prone QI issues
    b. May require elevation, escalation and focus from senior leadership
    c. Have an executive team sponsor
    d. Are chaired by a Director or Vice President
    e. May have higher frequency of meetings as necessary to focus work and create sense of urgency.
    f. Report quarterly into the QAPI program
4. **Improvement:** The QIC shall use the analysis of the data to identify opportunities for improvement and changes that will lead to improvement. The QIC will also oversee implementation of actions aimed at improving performance.
5. **Follow- Up:** The QIC shall assure that steps are taken to improve performance and enhance safety are appropriately implemented, measured and tracked to determine that the steps have achieved and sustained the intended effect.
6. **Performance Improvement Projects:** The QIC shall oversee quality improvement projects, the number and scope of which shall be proportional to the scope and complexity of the hospital’s services and operations. The QIC must also ensure there is documentation of what quality improvement projects are being conducted, the reasons for

conducting those projects, and the measureable progress achieved on the projects.

Medical Executive Committee

The Medical Executive Committee (MEC) receives, analyzes and acts on performance improvement and patient safety findings from committees and is accountable to the Board of Directors for the overall quality of care.

Nursing Practice Improvement Council

The Nursing Practice Improvement Council is designed to ensure quality assessment and continuous quality improvement and to oversee the quality of patient care (with focus on systems improvements related to nursing practices and care outcomes).

The Nursing Practice Improvement Council is chaired by the Director of Nursing Practice and facilitated by a member of the Quality and Patient Safety department. This Council has staff nurse representation from a broad scope of inpatient and out-patient nursing units, and procedural nursing units. The Council will report to Patient Care Leadership, Professional Practice Council (PPC) and the Professional Staff Quality Committee.

Graduate Medical Education
Graduate Medical Education (Designated Institutional Official (DIO), faculty and residents, are involved in achieving quality and patient safety goals and improving patient care through several venues including but not limited to:

a) Collaboration between Quality and Patient Safety Department, Risk Management, and GME Quality Subcommittee
b) GME participation in Quality Improvement Committee and Patient Safety Committee
c) GME participation in KDHCD quality committees and root cause analysis (including organizational dissemination of lessons learned)

Methodologies:

Quality improvement (QI) models present a systematic, formal framework for establishing QI processes within an organization. QI models used include the following:

- Model for Improvement (FOCUS Plan-Do-Study-Act [PDSA] cycles)
- Six Sigma: Six Sigma is a method of improvement that strives to decrease variation and defects with the use of the DMAIC roadmap.
- Lean: is an approach that drives out waste and improves efficiency in work processes so that all work adds value with the use of the DMAIC roadmap..

1. The **FOCUS**-**Plan, Do, Check, Act (PDCA)** methodology is utilized to plan, design, measure, assess and improve functions and processes related to patient care and safety throughout the organization.

    - **F**—**Find** a process to improve
    - **O**—**Organize** effort to work on improvement
    - **C**—**Clarify** knowledge of current process
    - **U**---**Understand** process variation
    - **S**—**Select** improvement

    - **Plan:**

        - Objective and statistically valid performance measures are identified for monitoring and assessing processes and outcomes of care including those affecting a large percentage of patients, and/or place patients at serious risk if not

performed well, or performed when not indicated, or not performed when indicated; and/or have been or likely to be problem prone.

- Performance measures are based on current knowledge and clinical experience and are structured to represent cross-departmental, interdisciplinary processes, as appropriate.

- **Do:**
  - Data is collected to determine:
    - Whether design specifications for new processes were met
    - The level of performance and stability of existing processes
    - Priorities for possible improvement of existing processes

- **Check:**
  - Assess care when benchmarks or thresholds are reached in order to identify opportunities to improve performance or resolve problem areas

- **Act:**
  - Take actions to correct identified problem areas or improve performance
  - Evaluate the effectiveness of the actions taken and document the improvement in care
  - Communicate the results of the monitoring, assessment and evaluation process to relevant individuals, departments or services

2. DMAIC (Lean Six Sigma): DMAIC is an acronym that stands for Define, Measure, Analyze, Improve, and Control. It represents the five phases that make up the road map for Lean Six Sigma QI initiatives.

- **Define** the problem, improvement activity, opportunity for improvement, the project goals, and customer (internal and external) requirements. QI tools that may be used in this step include:
  - Project charter to define the focus, scope, direction, and motivation for the improvement team
  - Process mapping to provide an overview of an entire process, starting and finishing at the customer, and analyzing what is required to meet customer needs
- **Measure** process performance.
  - Run/trend charts, histograms, control charts
  - Pareto chart to analyze the frequency of problems or causes
- **Analyze** the process to determine root causes of variation and poor performance (defects).
  - Root cause analysis (RCA) to uncover causes
  - Failure mode and effects analysis (FMEA) for identifying possible product, service, and process failures
- **Improve** process performance by addressing and eliminating the root causes.

- Pilot improvements and small tests of change to solve problems from complex processes or systems where there are many factors influencing the outcome
- Kaizen event to introduce rapid change by focusing on a narrow project and using the ideas and motivation of the people who do the work

- **Control** the improved process and future process performance.
  - Quality control plan to document what is needed to keep an improved process at its current level
  - Statistical process control (SPC) for monitoring process behavior
  - Mistake proofing (poka-yoke) to make errors impossible or immediately detectable

IV. Confidentiality

All quality assurance and performance improvement activities and data are protected under the Health Care Quality Improvement Act of 1986, as stated in the Bylaws, Rules and Regulations of the Medical Staff, and protected from discovery pursuant to California Evidence Code §1157.

V. Annual Evaluation

Organization and Medical Staff leaders shall review the effectiveness of the Quality Improvement Plan at least annually to insure that the collective effort is comprehensive and improving patient care and patient safety. An annual evaluation is completed to identify components of the plan that require development, revision or deletion. Organization and Medical Staff leaders also evaluate annually their contributions to the Quality Improvement Program and to the efforts in improving patient safety.

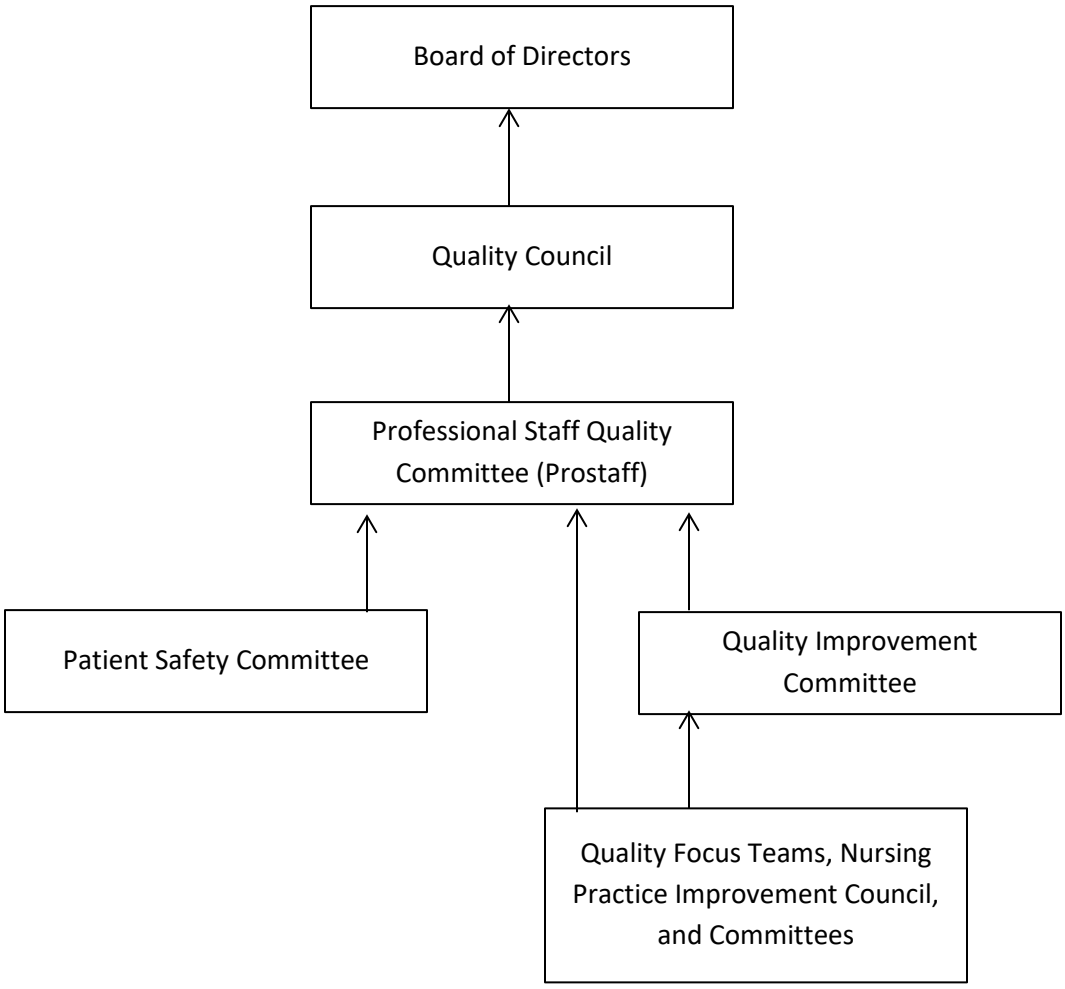
VI. Attachments-- Components of the Quality Improvement and Patient Safety Plan:

Attachment 1:	Quality Improvement Committee Structure
Attachment 2:	KDHCD- Prostaff Reporting Documents
~~Attachment 3:~~	~~VBP Objectives~~

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

Attachment 1

Kaweah Health
Quality Reporting Structure



Attachment 2

Kaweah Health ~~DHCD~~ – QUALITY IMPROVEMENT COMMITTEE REPORTING DEPARTMENTS

Departments within KDHCD participate in the Quality Improvement plan by prioritizing performance improvement activities based on high-risk, high-volume, or problem-prone areas. Department level indicators shall focus on issues of known frequency, prevalence or severity and shall give precedence to issues that affect health outcomes, quality of care and patient safety. Departments include, but are not limited to:

PROFESSIONAL and PATIENT CARE SERVICES
Laboratory
Nursing Quality Dashboard
Advanced Nursing Practice
Wound Care, Inpatient (Skin and Wound Committee)
Patient Access
Community Outreach
Patient & Family Services
Case Management/Utiliz Mgt & Bed Alloc
Interpreter Services
EOC (Security, facilities, Clinical Engineering, EVS)
Chaplain Services
Exeter Health Clinic (includes Lindsay, Woodlake, Dinuba)
Inpatient Pharmacy
Conscious Sedation (ED) Annual
Organ Donation (Annual)
Maternal Child Health
Labor & Delivery
Mother Baby
Neonatal Intensive Care Unit
Pediatrics
Mental Health Services
Mental Health
Episodic Care
Emergency
Trauma Service
Urgent Care
Cardiovascular Services
Dept of Cardiovascular Services (ACC/STS/) - Cath lab, IR, CVCU and Cardiac Surgery
CVICU
2N
4T
Critical Care Services
Intensive Care Unit
3W
Rehabilitation Services
Rehabilitation

Inpatient Therapies (KDMC, Rehab, South Campus)
Outpatient Therapies: Medical Office Building (MOB), Exeter, Sunnyside, Dinuba, Lovers Lane, Therapy Specialists at Rehab
Outpatient Wound Care at Rehab
Post Acute Services
KD Home Infusion Pharmacy
Home Care Services (Home Health & Hospice)
Transitional Care Svc/Short-Stay Rehab
Skilled Nursing Services
Surgical Services
Ambulatory Surgery Center/PACU/KATS
Operating Room
SPD
Broderick Pavilion
3N
4 South
Renal Services
4 North -
CAPD/ CCPD (Dialysis Maintenance)
Visalia Dialysis
Med/Surg
2S
3S
PUBLICALLY REPORTED MEASURES
Infection Prevention
Patient Safety Indicators/HACs
Value Based Purchasing Report
Patient Experience
Core Measures
Hospital Compare Quarterly Report
Healthgrades
Leapfrog Hospital Safety Score
COMMITTEES
Med Safety & ADE
Disparities in care
Falls committee
RRT/Code Blue
Pain Management
Resource Effectiveness Committee
Sepsis Quality Focus Team
Stroke
Diabetes QFT
Blood Utilization
Handoff Communication QFT
Accreditation Regulatory Committee
Diversion Prevention Committee

Policy Number: AP175	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Cindy Moccio (Board Clerk/Exec Assist-CEO)	

Patient Safety Plan

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

I. Purpose

- Encourage organizational learning about medical/health care risk events and near misses
- Encourage recognition and reporting of medical/health events and risks to patient safety using just culture concepts
- Collect and analyze data, evaluate care processes for opportunities to reduce risk and initiate actions
- Report internally what has been found and the actions taken with a focus on processes and systems to reduce risk
- Support sharing of knowledge to effect behavioral changes in itself and within Kaweah Delta Healthcare District (KDHCD)

II. Scope

All KDHCD facilities, departments, patient care delivery units and/or service areas fall within the scope of the quality improvement and patient safety plan requirements.

III. Structure and Accountability

A. Board of Directors

The Board of Directors retains overall responsibility for the quality of patient care and patient safety. The Board approves annually the Patient Safety Plan and assures that appropriate allocation of resources is available to carry out that plan.

The Board receives reports from the Patient Safety Committee through the Professional Staff Quality Committee. The Board shall act as appropriate on the recommendations of these bodies and assure that efforts undertaken are effective and appropriately prioritized.

B. Quality Council

The Quality Council is responsible for establishing and maintaining the organization's Patient Safety Plan and is chaired by a Board member. The Quality Council shall consist of the Chief Executive Officer, representatives of the Medical Staff and other key hospital leaders. It shall hold primary responsibility for the functioning of the Quality Assessment and Performance Improvement program. Because District performance improvement activities may involve both the Medical Staff and other representatives of the District, membership is multidisciplinary. The Quality Council requires the Medical Staff and the organization's staff to implement and report on the activities for identifying and evaluating opportunities to improve patient care and services throughout the organization. The effectiveness of the quality improvement and patient safety activities will be evaluated and reported to the Quality Council.

C. Patient Safety Committee

The Patient Safety Team is a standing interdisciplinary group that manages the organization's Patient Safety Program through a systematic, coordinated, continuous approach. The Team will meet monthly to assure the maintenance and improvement of Patient Safety in establishment of plans, processes and mechanisms involved in the provision of the patient care.

The scope of the Patient Safety Team includes medical/healthcare risk events involving the patient population of all ages, visitors, hospital/medical staff, students and volunteers. Aggregate data* from internal (IS data collection, incident reports, questionnaires,) and external resources (Sentinel Event Alerts, evidence based medicine, etc.) will be used for review and analysis in prioritization of improvement efforts, implementation of action steps and follow-up monitoring for effectiveness. The Patient Safety Committee has oversight of KDHCD activities related to the National Quality Forum's (NQF) Safe Practices (SP) Medication Safety, Section #4 Maternity Care, #5 ICU physician staffing, #6 A-D Culture of Safety Leadership Structures & System Documentation, Culture Measurement, Feedback & Intervention Documentation, Nursing workforce and Hand Hygiene, #7 Managing Serious Errors, and #8 Bard Code Medication Administration.

1. The Patient Safety Officer is the Chief Quality Officer
2. The Patient Safety Committee is chaired by the Patient Safety Officer or designee.
3. The responsibilities of the Patient Safety Officer include institutional compliance with patient safety standards and initiatives, reinforcement of the expectations of the Patient Safety Plan, and acceptance of accountability for measurably improving safety and reducing errors. These duties may include listening to employee and patient concerns, interviews with staff to determine what is being done to safeguard against occurrences, and immediate response to reports concerning workplace conditions.
4. Team membership includes services involved in providing patient care, such as: Pharmacy, Laboratory, Surgical Services, Risk Management, Infection Prevention, Medical Imaging, and Nursing. The medical staff representative on the team will be the Vice Chief of Staff.

D. Medication Safety Quality Focus Team

The Medication Safety Quality Focus Team (MSQFT) is an interdisciplinary group that manages the organizations Medication Safety Program including the District Medication Error Reduction Plan (MERP).

The purpose of the MSQFT is to direct system actions regarding reductions in errors attributable to medications promoting effective and safe use of medication throughout the organization. Decisions are made utilizing data review, approval of activities, resource allocation, and monitoring activities. Activities include processes that are high risk, high volume, or problem prone, some of which may be formally approved by the MSQFT as a District MERP goal (see Policy AP154 Medication Error Reduction Plan).

The MSQFT provides a monthly report to the Pharmacy and Therapeutics Committee and quarterly reports to the Professional Staff Quality Committee and directly to Quality Council. The MSQFT Chair is a member of the Patient Safety Committee. A quarterly report is presented at Patient Safety Committee in addition to active participation in patient safety activities related to medication use.

IV. Organization and Function

A. The mechanism to insure all components of the organization are integrated into the program is through a collaborative effort of multiple disciplines. This is accomplished by:

1. Reporting of potential or actual occurrences through the Occurrence Reporting Process Policy (AP10) by any employee or member of the medical staff. Examples of potential or actual occurrences include pressure ulcers, falls, adverse drug events, and misconnecting of: intravenous lines, enteral feeding tubes and epidural lines.

~~1.~~2. Reporting of potential or actual concerns in a daily leadership safety huddle which involves issues which occurred within the last 24 hours, a review the steps taken to resolve those matters when applicable, and anticipate challenges or safety issues in the next 24 hours. The daily safety huddle occurs Monday to Friday with the exception of holidays and includes directors and vice presidents that represent areas throughout the organization. The purpose of the daily safety huddle is immediate organizational awareness and action when warrented. Examples of issues brought forth in the Daily Safety Huddle include, patients at risk for elopement, violence, or suicide, and also can include potential diversion events, patient fall events, and medication related events.

2.3. Communication between the Patient Safety Officer and the Chief Operating Officer to assure a comprehensive knowledge of not only clinical, but also environmental factors involved in providing an overall safe environment.

3.4. Reporting of patient safety and operational safety measurements/activity to the performance improvement oversight committeesgroup, Professional Services Quality Committee "Prostaff" and Quality Improvement Committee (QIC). .—Prostaff is a multidisciplinary medical staff committee composed of various key organizational leaders including: Medical Executive Committee members, Chief Executive Officer, Chief Operating Officer, Chief Medical Officer/Chief Quality Officer, Chief Nursing Officer, Member of the Board of Directors, and Directors of Nursing, Performance Improvement, Risk Management, and Pharmacy. QIC is a multidisciplinary committee comprised of various key organizational leaders including the CEO, CNO, CIO, CFO, VP of Human Resources, VP Surgical Services, VP of Post Acute Care and Ancillary Services, Directors of Quality & Patient Safety, Risk Management, and the manager of Infection Prevention.

4.5. Graduate Medical Education

i. Graduate Medical Education (Designated Institutional Official (DIO), faculty and residents, are involved in achieving quality and patient safety goals and improving patient care through several venues including but not limited to:

1. Collaboration between Quality and Patient Safety Department, Risk Management, and GME Quality Subcommittee
2. GME participation in Quality Improvement Committee and Patient Safety Committee
3. GME participation in KDHCD quality committees and root cause analysis (including organizational dissemination of lessons learned)

B. The mechanism for identification and reporting a Sentinel Event/other medical error will be as indicated in Organizational Policies AP87. Any root cause analysis of hospital processes conducted on either Sentinel Events or near misses will be submitted for review/recommendations to the Patient Safety Committee, Professional Staff Quality Committee and Quality Council.

C. As this organization supports the concept that events most often occur due to a breakdown in systems and processes, staff involved in an event with an adverse outcome will be supported by:

1. A non-punitive approach without fear of reprisal (just culture concepts).
2. Voluntary participation into the root cause analysis for educational purposes and prevention of further occurrences.
3. Resources such as Pastoral Care, Social Services, or EAP should the need exist to counsel the staff
4. Safety culture staff survey (i.e. the Safety Attitudes Questionnaire) administered at least every 2 years to targeted staff and providers.

D. As a member of an integrated healthcare system and in cooperation with system initiatives, the focus of Patient Safety activities include processes that are high risk, high volume or problem prone, and may include:

1. Adverse Drug Events
2. Nosocomial Infections
3. Decubitus Ulcers
4. Blood Reactions
5. Slips and Falls
6. Restraint Use
7. Serious Event Reports
8. DVT/PE

E. A proactive component of the program includes the selection at least every 18 months of a high risk or error prone process for proactive risk assessment such as a Failure Modes Effects Analysis (FMEA), ongoing measurement and periodic analysis. The selected process and approach to be taken will be approved by the Patient Safety Committee and Quality Council.

The selection may be based on information published by The Joint Commission (TJC) Sentinel Event Alerts, and/or other sources of information including risk management, performance improvement, quality assurance, infection prevention, research, patient/family suggestions/expectations or process outcomes.

F. Methods to assure ongoing inservices, education and training programs for maintenance and improvement of staff competence and support to an interdisciplinary approach to patient care is accomplished by:

1. Providing information and reporting mechanisms to new staff in the orientation training.
2. Providing ongoing education in organizational communications such as newsletters and educational bundles.
3. Obtaining a confidential assessment of staff's willingness to report medical errors at least once every two years.

G. Internal reporting – To provide a comprehensive view of both the clinical and operational safety activity of the organization:

1. The minutes/reports of the Patient Safety Committee, as well as minutes/reports from the Environment of Care Committee will be submitted through the Director of Performance Improvement and Patient Safety to the Professional Staff Quality Committee.
2. These monthly reports will include ongoing activities including data collection, analysis, and actions taken and monitoring for the effectiveness of actions.
3. Following review by Professional Staff Quality Committee, the reports will be forwarded to Quality Council.

H. The Patient Safety Officer or designee will submit an Annual Report to the KDHCD Board of Directors and will include:

1. Definition of the scope of occurrences including sentinel events, near misses and serious occurrences
2. Detail of activities that demonstrate the patient safety program has a proactive component by identifying the high-risk process selected
3. Results of the high-risk or error-prone processes selected for proactive risk assessment.
4. The results of the program that assesses and improves staff willingness to report medical/health care risk events
5. A description of the examples of ongoing in-service, and other education and training programs that are maintaining and improving staff competence and supporting an interdisciplinary approach to patient care.

V. Evaluation and Approval

The Patient Safety Plan will be evaluated at least annually~~every three years~~ or as significant changes occur, and revised as necessary at the direction of the Patient Safety Committee, Professional Staff Quality Committee, and/or Quality Council. Annual evaluation of the plan's effectiveness will be documented in a report to the Quality Council and the KDHCD Board of Directors.

VI. Confidentiality

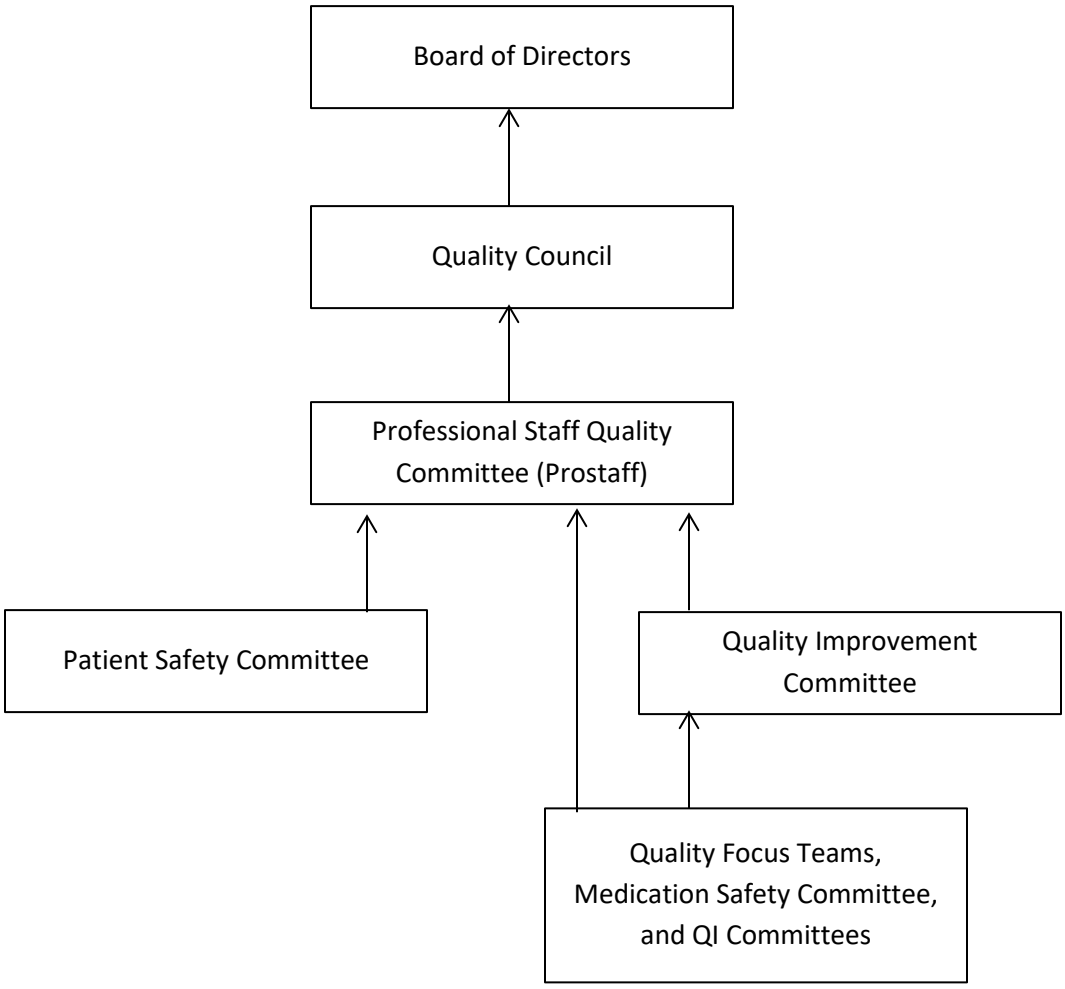
All quality assurance and performance improvement activities and data are protected under the Health Care Quality Improvement Act of 1986, as stated in the Bylaws, Rules and Regulations of the Medical Staff, and protected from discovery pursuant to California Evidence Code §1157.

Attachments - Attachment 1: Quality Improvement/Patient Safety Committee Structure

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

Attachment 1

Kaweah Health
Quality Reporting Structure



Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

Policy Number: AP49	**Date Created: No Date** Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	**Date Approved: Not Approved** Yet
Approvers: Board of Directors (Administration)	
No information No presence in facility patient status	

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

PURPOSE: To provide for the privacy and safety of KDHCD patients and staff when there is a determined risk or per the patient's request.

POLICY: The status of "No Information" may be initiated for personal reasons, at the specific request of a patient or a patient's legal representative, as a result of a directive from a law enforcement agency regarding a patient in custody, or at the discretion of a KDHCD supervisor if a patient and/or staff are at risk of endangerment.

DEFINITION: *No Information Status*: Information regarding the patient will not be divulged and their presence in the facility will not be acknowledged.

PROCEDURE:

I. Any patient that comes into the Emergency Room as a result of a violent crime will be assigned a "No Information" status.

II. A "No information" status may be requested through direct contact with the physician, the staff assigned to the patient's care, the nurse manager, the nurse supervisor, or through the admission office. The individual receiving the request will inform the other individuals indicated.

III. The admission office will assure that the appropriate status code is entered into the patient care computer system. This code will "flag" the patient on the census to indicate the "No Information" status.

A. Nursing and Patient Care staff on the nursing units will see the "No Information" ~~Pad Lock (🔒) on the Soarian~~ star next to the patients name on the Cerner electronic patient census. The nursing staff who access to the Care Compass patient record will see a flag next to the patient name. Patient Access will see ~~an asterisk (*)~~ a red stop sign on the patient census indicating "No Info." status. ~~There are other reports used that have different indicators for "No Information" status.~~

B. Other staff responding to inquiry regarding a patient on another unit will search for

the patient by name.

C. Whenever a ~~padlock or asterisk (*)~~ star or flag appears , the staff person shall not acknowledge the patients presence in the facility.

D. The census for PBX staff and Information Desk staff/volunteers will not show the patient on the census if they have been ~~flagged~~ identified as "No Information."

IV. When a patient has been placed under the "*No Information"* status:

A. Any media requests for information on the patient will be directed to the Nursing Supervisor or Marketing Manager. They will respond that no information is available and, where appropriate, the media will be referred to the law enforcement agency.

B. If a visitor calls or arrives at the hospital, no information regarding the patient will be given and the patient's presence will not be acknowledged.

C. The global statement that can be used for inquiries about a "No Info" patient is, "I cannot confirm or deny that this person is a patient at this facility. I have no information for you."

V. When a patient is made "No Information" status, staff will provide to the patient ~~and 2 selected visitors~~ and/or 2 patient identified visitors a summary sheet describing the "No Information" status (see patient/visitor handout).

~~A. A card with the patient's passcode will be given to 2 designated visitors. The patient and the 2 designated visitors will be instructed not to give any information regarding the patient's presence in this facility .~~

AB~~.~~. ~~.~~ The patient ~~and visitors~~ under the "No Information" status will be required to follow the rules and regulations stated in the patient/visitor handout.

VI. Cancellation of "*No Information"* status may be made by the patient or patient's legal representative if that is where it originated. ~~If originated by patient or legal representative, but they disseminated information, it will be cancelled by the hospital staff~~. If a patient or their legal representative requests "No information" status and fails to follow any rules associated with "No information" status, including informing visitors of their presence in the facility, hospital staff ~~wil~~ may~~l~~ cancel the "No information" status. If originated by law enforcement or hospital staff and information is disseminated, further restrictions may be applied.

~~I.~~ VII. Law Enforcement may request "No Information" status for a patient who is in custody. . If *"No Information"* status was originated by law enforcement, there will be ~~a~~ consistent communication between the District and law enforcement agencies.

~~"~~

Formatted: Outline numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0.5" + Indent at: 0.5", No widow/orphan control

VIII. In cases where “No Information” status can be voluntarily changed prior to discharge from the facility, the staff member receiving the change request is responsible to ensure that the House Supervisor and admitting are notified. Any victim of a violent crime will remain in “No Information” status until discharge. The House Supervisor may evaluate each case individually and in collaboration with all necessary parties change status prior to discharge.

PATIENT/VISITOR HANDOUT

You are being place under Kaweah Delta's "No Information" status.

- What that means to you and your family or friends:

- Anyone that calls or comes to the hospital and asks about you will be told you are not here.
- You will not receive any incoming telephone calls because the operator does not know you are here.
- Do not make any telephone calls to family or friends from your cell phone or room phone.
- ~~You can pick **2** people to visit. These visitors will receive a passcode that only they can use to come see you. No Limited medical information will be given to these people over the phone even with the passcode. Staff will give these identified visitors more in depth information in person as they are able.~~
- You may choose 2 people to visit. These visitors will receive a pass code that only they can use to come see you. Limited medical information will be provided for these identified visitors over the phone even with the pass code. Staff will give more in depth information to these visitors in person as they are able. These identified visitors will be expected to share any appropriate information with other family members as needed. No calls from non-approved visitors will be accepted, and no information about you or your condition will be released to non-approved individuals.
- Any flowers or gifts being delivered to you will be refused at the front desk. They do not know you are here.
- You may ask to stop the "No Information" status if you were the one who asked for it to start.
- If you asked for the "No Information" status and you or your visitors ~~talk to~~ share with other people ~~about your stay~~ where you can be found in the hospital, the "No Information" status ~~will~~ may be

Formatted: Left

Formatted: List Paragraph, Left, No bullets or numbering, Widow/Orphan control, Adjust space between Latin and Asian text, Adjust space between Asian text and numbers

cancelled by hospital staff.

- If the “No Information” status was started by the hospital and you or your visitors talk to other people about your stay in the hospital, stricter rules may be used.
- You and your visitors must agree to follow these rules for the full time you are in the hospital.

THIS IS NOT A PART OF THE PERMANENT RECORD

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

Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

Policy Number: AP148	**Date Created: No Date Set**
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration)	

Grants

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

PURPOSE: To ensure that the appropriate guidelines and procedures are followed when applying for, administering and closing grants, regardless of which Kaweah Delta Health Care District department manages the grants.

POLICY: All grant requests will be prepared and submitted under the auspices of the Development Department following the procedures outlined in this policy.

Kaweah Delta Health Care District and Kaweah Delta Hospital Foundation by written agreement state that all grant funds awarded to the Foundation will be held by the Foundation and that the District will implement the grant programs. The Foundation will reimburse the District for appropriate grant expenditures after they are incurred.

DEFINITION: A "grant" is defined as: A funding commitment or contract that is received upon approval of the submitted "Application", "Request for Proposal" (RFP), "Request for Application" (RFA), inquiry letter or other such request that includes, at a minimum, a reason for the request, how the funds will be used and the amount of funds requested.

A "match" is defined as a requirement on the part of the District and/or grant partners to provide in-kind services and/or dollars matching the requested grant amount or a portion of it.

PROCEDURE:

All grants, at a minimum, must be approved by the Vice President of the requesting Department and the ~~Vice President~~Director of the Development Department.

Process for grants under $50,000

For a grant under $50,000, the ~~Vice President~~Director of Development has the authority to approve the grant request and submit it to the granting agency. The requesting department's vice president must approve the request and have the ~~Grants~~ Development ~~Manager~~ Coordinator review/edit/assist in the completion of the application.

Process for grants over $50,000

For grants over $50,000, the Executive Team, at the recommendation of the ~~Vice President~~Director of Development, must approve the grant request. Minutes of the

Executive Team meeting where approval is given are filed in the grant file maintained at the Development Department. A summary of the grant program and a proposed budget range, including any match requirements, is presented to the Executive Team by the Vice President of the department requesting submission of the grant.

Preparation and submission of grant applications for all District departments

Upon receipt of the appropriate approvals as outlined above, the vice president of the requesting department will assign a staff person to work with the ~~Grants~~ Development ~~Manager~~ Coordinator to complete the application, which may include the development of the proposed project, collection of data, development of the budget contract policy compliance, financial requirements and any other requirements of the granting agency.

The ~~Grants~~ Development ~~Manager~~ Coordinator will complete the grant application in collaboration with the vice president and/or designated department staff. In some instances additional planning meetings may occur. Department staff will be responsible for coordinating these strategic planning sessions and including other staff and/or agencies. Completion of the proposal will be reviewed by the Grants Development Manager and department staff. The ~~Vice President~~Director of Development will review the final application prior to submission.

The ~~Grants~~ Development ~~Manager~~ Coordinator is responsible for submitting the grant application to the potential funder on time, with all pertinent and required information including a budget in a format established by the funder. The vice president and/or designee of the department submitting the proposed program for funding will receive a copy of the final grant application. The official version of the submitted grant application will be maintained in the grant file residing in the Development Department.

Drafts of grant application sections assigned to the departments and collaborating (outside) partners are due no later than 10 days prior to grant submission due date. If the draft is not provided by that time it may not be possible to submit the grant or the partner may not be included in the final grant application.

Grant acceptances / denials and grant contracts

All notifications from the grantors of grant proposal acceptances or denials will be received by the Development Department. The ~~Grants~~ Development ~~Manager~~ Coordinator will notify the department personnel, ~~–~~finance department staff and department Vice President of the grantor's decision.

Once the grant contract is received by the Development Department, it will be reviewed by the ~~Grants~~ Development ~~Manage~~Coordinator~~r~~, the ~~Vice President~~Director of Development, the department vice president, a finance department representative, and the grant program director. The ~~Grants~~ Development ~~Manager~~ Coordinator will coordinate any questions or proposed edits (if allowed) to the grant contracts with the grantor. The final contract will be signed by the ~~Vice President~~Director of Development on behalf of the Foundation. AP.179 Bridge Policy for Federal Grants and Awards Management may be included in compliance policies for HRSA grants.

Education and training requirements for program managers

Upon receipt of the grant, an orientation session will be provided by the Grants ~~Development Manager~~Coordinator and the Development Coordinator. This session will review the grant contractual agreement, scope of work, budget, implementation process, necessary programmatic and fiscal documentation, subcontract process, if appropriate, and any other issue pertinent to the implementation of the particular grant.

Acquisition, management and disposal of equipment acquired with grant funds

Unless a grant agreement states otherwise, all equipment acquired by the District for use in grant programs for which the Foundation reimburses the District is the property of the District.

Grant management and changes

The responsibility of the implementation and management of a grant-funded project lies with the vice president of the department in which the program resides. At the discretion of the vice president, this responsibility can be delegated to a director, coordinator or a position specific to the grant.

All proposed budget or program changes must be approved by the vice president of the department where the grant is being implemented and the Grants ~~Development Manager~~Coordinator, Development Coordinator or Director of Development. Once this internal approval is given and documented, the request for changes can be submitted to the funding agency by the director in charge of program implementation.

All progress and final grant reports (both programmatic and budgetary) are to be prepared by in conjunction with both development staff and grant program personnel. Reports ~~and~~ must be reviewed by the Vice President of that department~~, the Grants Development Manager~~ and the Development Coordinator as evidenced by the signatures of these parties on the draft and/or final copies of the reports. All reports are expected to be submitted in accordance with the grantor's requirements.

A quarterly review of all District and Foundation grants is completed by the ~~District's Grants Review Committee, comprised of the Chief Operating Officer, Vice President of Development, Chief Nursing Officer, Grants Development Manager, and Development Coordinator. The~~ Foundation Grants Committee. The Committee will meet quarterly to review the report in person or via email~~as well~~. If the meeting is held via email, it will be documented by a return email of a majority of committee members. Departmental personnel responsible for the grants may be called upon to present information and/or answer questions about their grants at these quarterly meetings of the ~~Grants Review~~Foundation Grants Committee.

Grant Expenditure Review and Payment Process (Responsibility of Development Coordinator)

The reimbursement of all grant expenditures will comply with District reimbursement policies (see Administrative Policy Manual, AP 19) and any grant specific guidelines stated in the grant contract. All grant expenditures must have appropriate backup such as an invoice, receipt, etc. and any purchases from inventory will not be reimbursed. In the event of HRSA grants, Bridge Policy AP XX

Is included in the expenditure review and payment process.

A review of all grant expenses by the department director, Development Coordinator and Grants ~~Development Manager~~Coordinator is completed prior to submission to the District for reimbursement is required.

Proper expenditure of grant funds is the ultimate responsibility of the vice president of the department implementing the grant. At their discretion they may delegate a staff person (program coordinator or department director) in the department implementing the grant.

Employee Salaries and Benefits Reimbursed by Grants

If a grant limits the dollar amount of total payroll reimbursement and a grant employee's full salary is not able to be reimbursed under the grant without a modification to the benefit percentage, the reason for modification should be clearly documented within the grant file.

District employee benefit percentages are established each year by the Director of Strategic Planning. When the grant budgets are being created, this percentage will be used. It will be clear what the grant will pay for, determined by the grant guidelines, and any match that KD is responsible to cover.

Grant Salary Information

District personnel salary information is used both for grant writing and reporting purposes. Salary and benefits information is made available to personnel who are directly responsible for the management of grant activity and also to those who are responsible for the preparation of grant reporting. The Director~~Vice President~~ of Development ensures that all personnel who handle salary information are informed that they are expected to keep this information in the strictest confidence and are not to use this information for any other purpose other than grant-related business. The Director~~Vice President~~ of Development has access to everyone's salary in the District in PeopleSoft reports. If Executive Team salary information is needed, either the appropriate vice president or the Vice President of Human Resources will provide this information.

Bioterrorism Grant Processes

The funds for Bioterrorism grants are distributed through the Tulare County Health and Human Services Agency and are paid out to the grantees either through expense reimbursement or by the County making the purchases on behalf of the grantees. The policies and procedures outlined herein shall be followed in the case of Bioterrorism Grant funds with the following exceptions:

A. Receive letter or e-mail from the County verifying the amount of grant funds.

B. Complete non-stocks of order and have signed by Supervisor, vice president of the department and submit to Development Department. Include all equipment costs, including shipping and tax. Must be signed that Development Department will reimburse by (1) Development Coordinator, and (2) ~~Vice President~~Director of Development.

C. Order from vendor through purchasing.

D. Development Department will bill the county based upon the non-stocks submitted.

E. Development Coordinator will reimburse the District once the items are received. This is tracked by approval of each item on the General Ledger report on the monthly performance report and then submitted to the Development Coordinator.

F. Copy the Development Coordinator or ~~Development~~ Grant ~~Manager~~Coordinator on correspondence.

Grant Close-Out Processes

Grants ~~Development Manager~~Coordinator will contact all grantor agencies during the process of closing grants if any fund balances remain to determine what should be done with these balances, unless already specified in the agreement with the grantor agency. All correspondence with the grantor agencies should be documented and kept in the grant files. If contact with any of the grantor agencies is made by telephone, a request should be made to the contact person at such agencies to document via letter or email the agreement that was reached related to the remaining funds. If grantor gives permission to use the remaining funds, efforts should be made to use the funds as soon as possible for the uses the grantor specifies. If the grantor requests return of unused funds, the Grants Coordinator ~~Development Manager~~ will forward the request including all appropriate backup for the request, to the Development Coordinator so that refund check can be processed.

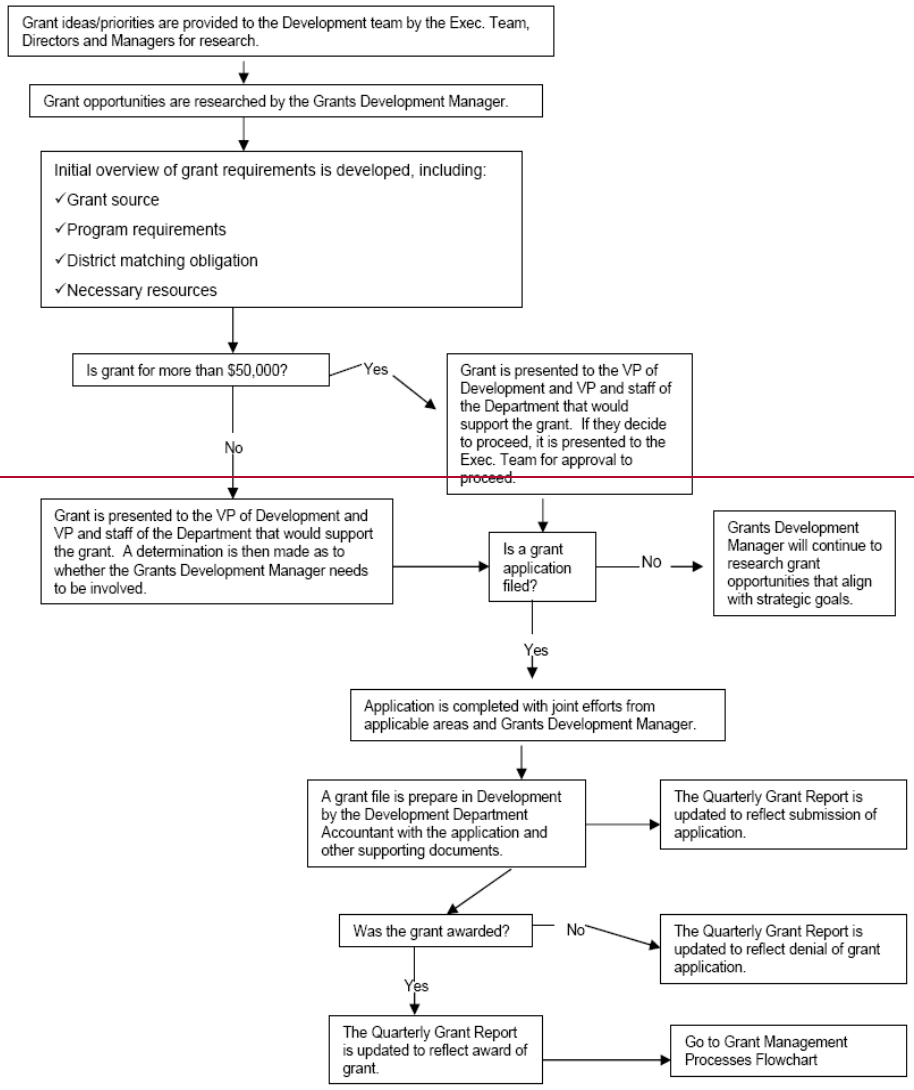
The Finance Department will post monthly interest to those grants requiring it. The Finance Department will be notified by the Development Coordinator when grant funds are exhausted and/or a grant is closed to help avoid the continued accrual of interest.

At the conclusion of each grant the Grants ~~Development Manager~~Coordinator will insure that a grant completion report containing a cost/benefit analysis is prepared within 30 days of grant completion utilizing the approved grant completion form. The Grants ~~Development Manager~~Coordinator will submit the grant completion report to the ~~Vice President~~Director of Development who will review it for completeness and then present it to the Kaweah Delta Executive Team.

HIPAA Compliance in Grant Reporting

The ~~Vice President~~Director of Development and Grants Coordinator~~Development Manager~~ will review each grant before application is made to ensure that U.S. Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations are followed. All Development staff members must inform the Director~~Vice President~~ of Development of “informal” grant reporting requirements as well as formal grant reporting requirement.

Kaweah Delta Hospital Foundation
Grant Application and Approval Processes



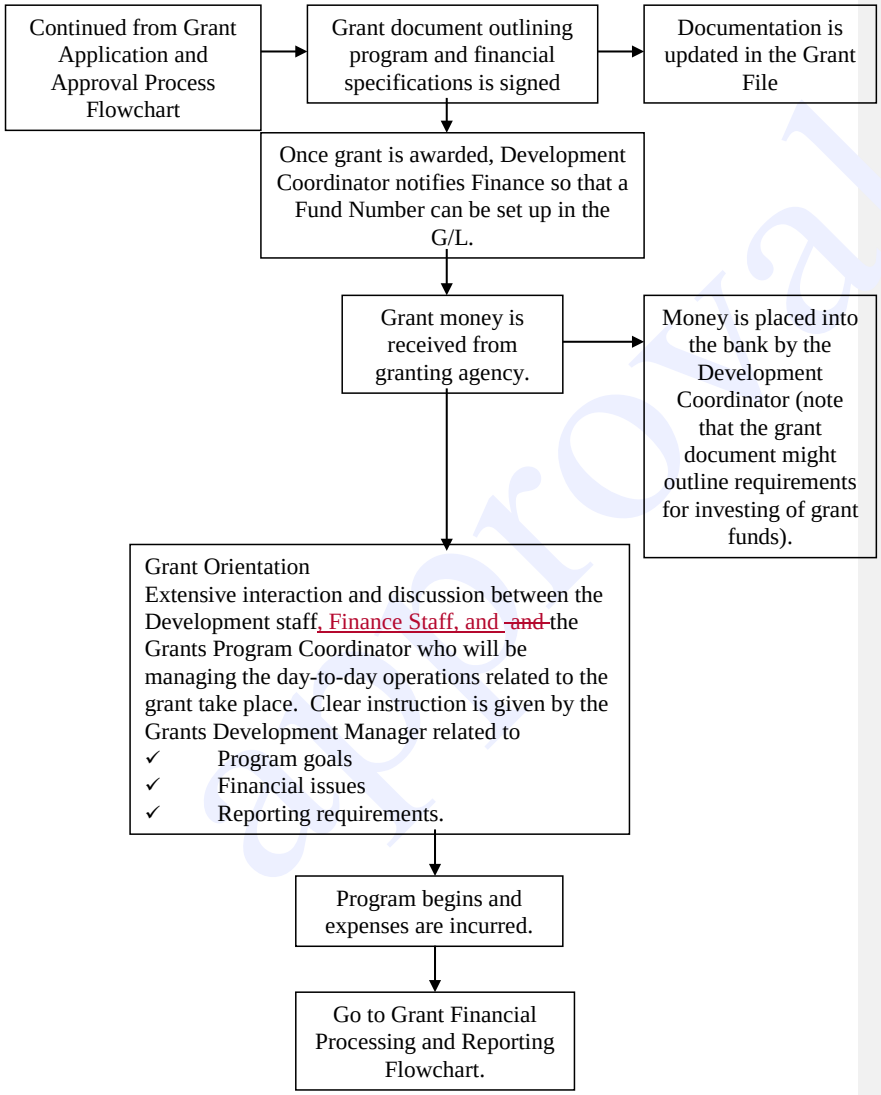
Kaweah Delta Hospital Foundation
Grant Application and Approval Processes

Formatted: Font: Times New Roman, 15.5 pt, Font color: Auto

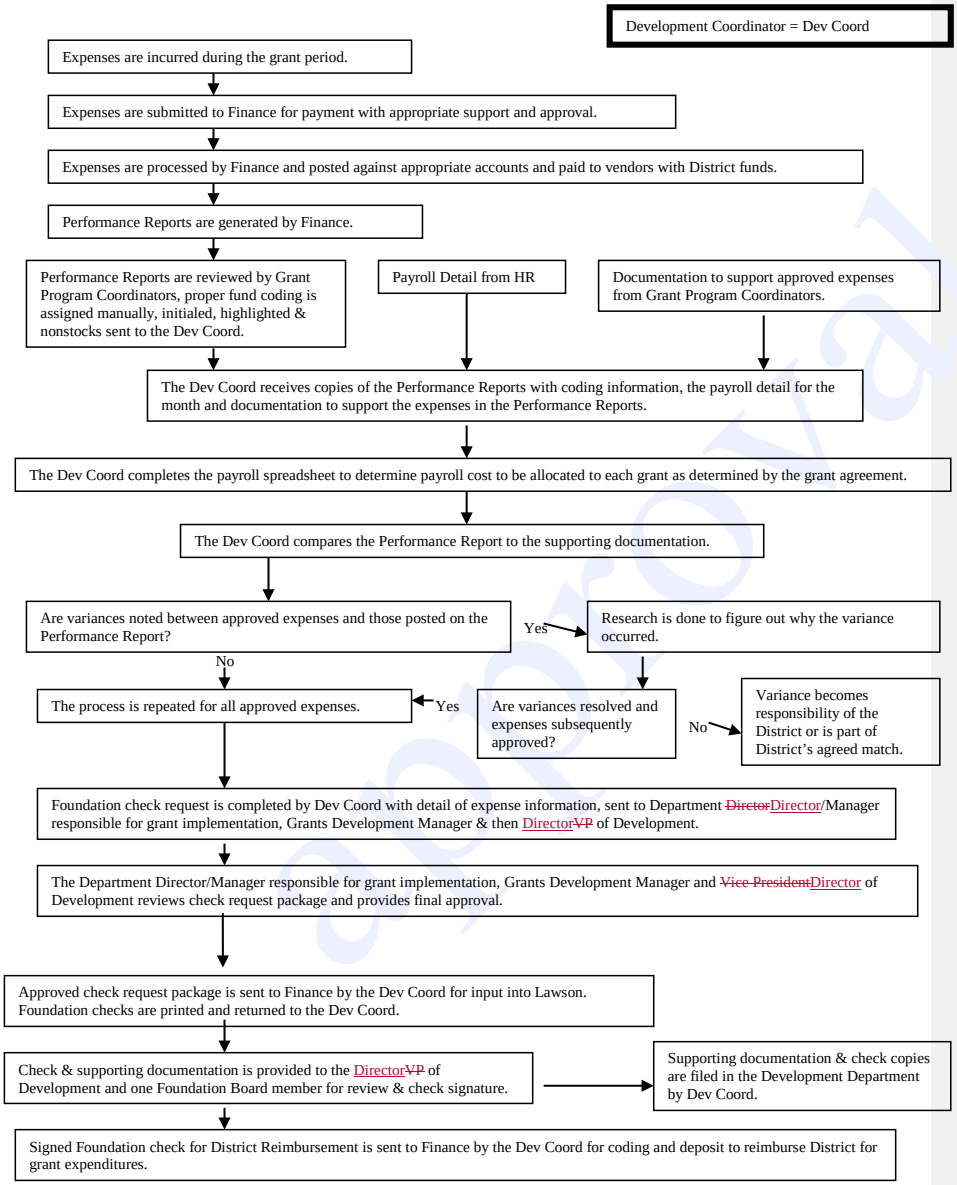
Formatted: Font: 15.5 pt

Grant ideas/priorities are provided to the Development team by the Exec. Team,

Kaweah Delta Hospital Foundation
Grant Management Processes



Kaweah Delta Hospital Foundation
Grant Financial Processing and Reporting



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

Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

Policy Number: AP10	**Date Created: 09/30/2007**
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration)	
Occurrence Reporting Process	

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

PURPOSE: Describes Occurrence Reporting process that supports District Performance Improvement, Patient Safety, Risk Management and Compliance activities by collecting data on unusual events or process variances.

DEFINITIONS:

Occurrence - *An unusual or unexpected event, whether or not causing harm or potential harm to patients, visitors or staff that places the District at risk.*

Statement of Concern – *An event related to an unresolved interpersonal (behavioral) issue.*

Adverse Drug Event - *A variance related to the use of omission of a drug as well as "close calls" or "safe catches." Adverse drug events (ADEs) are comprised of medication errors and medication incompatibilities. Adverse Drug Reaction - (ADR) An unusual or unintended noxious reaction that occurs at doses normally used for prophylaxis, diagnosis, therapy of disease and/or for the modification of physiological function.*

Significant ADE- *Any ADE that caused, or had the potential to cause, harm. Harm is defined as the impairment of the physical, emotional, or psychological function or structure of the body and/or pain resulting therefrom.*

Medication Error – *A preventable medication-related event that adversely affects a patient and that is related to professional practice, health care products, procedures, systems, including but not limited to prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring and use.*

Medication Incompatibility — *A state in which two or more medications undesirably interact in a way that would interfere with their administration, safety or efficacy.*

POLICY:
Occurrences which may result in actual or potential harm to patients, staff members, or District visitors, or otherwise expose the District or any of its employees or agents to liability ~~shall be~~are reported in an accurate and timely manner. In addition to its use as a Risk Management tool, the Occurrence Reporting process facilitates District Performance Improvement, Patient Safety, Risk Management and Compliance activities.

The Occurrence Reporting process also encompasses unresolved behavioral "Statement of Concern" reporting, complaint and grievance reporting and ADE reporting. The paper and/or electronic forms are the data collection tools of the Occurrence Reporting process.

The forms and/or their electronic equivalents are maintained within the Risk Management ~~(RM)~~ Department as confidential documents, and as such are protected from discovery pursuant to California Evidence Code section 1157(b). The forms are NOT a part of the medical record. Occurrence Reporting policy and procedure ~~shall be~~is observed as follows:

I. Unusual events, significant ADEs, patient/family grievances or statements of concern ~~will be~~are reported by completing an Occurrence Reporting form and submitting it to the Risk Management Department as soon as possible.

II. Staff ~~will~~ telephone the Risk Management Department of any unusual event, which results in patient injury immediately. If the Risk Manager is unavailable, the House Supervisor ~~shall be~~is notified. Staff ~~will also~~ complete an Occurrence Reporting form immediately and submit to the Risk Management Department within **24 hours**. (See Sentinel Event Policy AP.87).

III. Staff ~~will~~ telephone the Clinical Engineering Department and the Risk Management Department for any unusual event, which results in patient injury and is directly related to equipment malfunction within **24 hours** of the event or discovery of the event. Staff ~~will also~~ complete an Occurrence Reporting form and send it to the Risk Management Department within **24 hours**. The equipment in question ~~shall be~~is removed intact from the patient care area, and placed in the area designated by Clinical Engineering for retrieval.

IV. A multidisciplinary team including members from the organization and Medical Staff (METER Committee) review occurrence reports submitted within the previous 24 hours each weekday to rank and triage events so immediate notification 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 Manager on-call as described in Section II above.

~~III.~~

Formatted: List Paragraph, No bullets or numbering

Formatted: No bullets or numbering

~~IV.~~V. Significant ADEs are reported immediately to the patient's attending or covering physician. Physician notification is documented in the patient's medical record. The Pharmacy Director or designee will be notified of ADEs and events which do not constitute an ADE, but pertain to medications (i.e.: medication loss, medication storage, potential drug diversion).
~~Significant ADEs must be reported immediately to the patient's attending or covering physician. Physician notification will be documented in the patient's medical record.~~

~~V.~~VI. Any unusual event which is directly or potentially related to equipment malfunction, which DID NOT result in patient injury, ~~shall be~~is reported by completing an Occurrence Report and sending it to the Risk Management Department within **5 days**. The equipment and/or parts (i.e., stapler parts, drill bits, etc.) in question ~~shall be~~are immediately removed intact from the patient care area, and placed in the area designated by Clinical Engineering for retrieval.

~~VI.~~VII. Any lost or damaged property issues ~~shall be~~are investigated by the Department Manager or designee, an Occurrence Report completed, and sent to the Risk Management Department.

~~VII.~~VIII. The ~~RM~~Risk Management Department ~~shall~~ provides Department Directors with monthly Occurrence Reporting aggregate data. Data ~~is~~ are trended and used to improve District processes. Data obtained from the Occurrence Reporting process ~~is~~ are also used in medical staff peer review for re-credentialing purposes, and by the Risk Management and Compliance Departments to report and trend data related to the Complaint and Grievance processes.

~~VIII.~~IX. All patient events ~~will be~~are documented in the medical record. Documentation ~~will~~ does **NOT** indicate that an Occurrence Report was generated.

PROCEDURE:

I. When an incident or unusual event occurs, the individual most familiar with the situation, or to whom a grievance was reported, ~~shall~~ completes the Occurrence Reporting form. The form ~~will be~~is submitted to the ~~RM~~Risk Management Department within **5 days** of the event, or at the time in which the event is discovered.

II. Staff ~~will~~ telephone the ~~RM~~Risk Management Department of any unusual event, which results in patient injury **immediately**.~~.~~

A. If the Risk Manager is unavailable, the House Supervisor ~~shall be~~is notified.

~~II.~~B. Staff ~~will also~~ complete an Occurrence Reporting form immediately and deliver to ~~RM~~Risk Management Department within 24 hours. (See Sentinel Event Policy AP.87).

Formatted: List Paragraph, No bullets or numbering

Formatted: Numbered + Level: 1 + Numbering Style: A, B, C, … + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Indent at: 1"

III. When the unusual event results in patient injury AND is directly related to equipment malfunction, the individual discovering the event is responsible to ~~shall~~:

~~III. :~~

~~A.~~ ~~Notify the Director, House Supervisor, and Nurse Manager;~~
A. Notify the Director, House Supervisor, and Nurse Manager;
~~A.~~B. Notify the physician;
~~B.~~C. Telephone the Clinical Engineering Department and Risk Management within **24 hours** of event;
~~C.~~D. Complete and submit an Occurrence Reporting form to the ~~RM~~Risk Management Department within **24 hours**;
~~D.~~ Remove the intact defective equipment from the patient care area, including all attached peripheral devices (tubing, hoses, power cords, catheters, etc.)~~;~~;
E.
~~E.~~ Attach a completed red tag, “Defective Equipment Tag”, to device (refer to Environment of Care policy 1106 – Electronic/Electromechanical Devices);
F.
~~F.~~G. Store equipment in designated area for pick-up by Clinical Engineering.

IV. If the unusual event is directly related to equipment malfunction, but did not cause patient injury, the individual that discovered the event incident is responsible to ~~must~~:

A. Complete and submit an Occurrence Reporting form to the ~~RM~~Risk Management Department within 5 days.
B. Remove the intact defective equipment from the patient care area;
C. Complete and attach a red tag, “Defective Equipment Tag”, to device (refer to Environment of Care policy 1106 – Electronic/Electromechanical Devices);
D. Notify Clinical Engineering for pick-up of defective equipment;
E. Store equipment in designated area for pick-up by Clinical Engineering.

V. Events related to ADE’s, patient falls, ~~,~~ pressure injuries/skin breakdown, ~~-~~and equipment/medical device issues ~~should be~~are reported electronically through the Occurrence Report process. Paper reports may be submitted during times of workstation or network outage

VI. If any questions arise, staff may ~~call~~ contact their Manager, the House Supervisor, or the ~~RM~~Risk Management Department.

VII. The individual completing the Occurrence Reporting form ~~must notify~~notifies and submits the completed report to their Nurse Manager or Department Director. All incomplete forms submitted to the ~~RM~~Risk Management Department ~~shall be~~are returned to the Department Director for completion.

VIII. The Occurrence Reporting Form ~~will~~ documentation includes:

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, … + Start at: 1 + Alignment: Left + Aligned at: 0" + Tab after: 0.5" + Indent at: 0.5"

Formatted: Indent: Left: -0.25", Numbered + Level: 1 + Numbering Style: A, B, C, … + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Indent at: 1"

Formatted: Indent: Left: 0"

Formatted: No bullets or numbering

Formatted: Indent: Hanging: 0.25", Outline numbered + Level: 2 + Numbering Style: A, B, C, … + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Tab after: 1" + Indent at: 1"

A. Event description~~Describe the event~~ using only pertinent facts surrounding the event.
B. ~~Contain documentation of a~~Description of any/all action(s) taken to eliminate the possibility of the event reoccurring;
C. ~~Contain a~~List ~~l~~of individuals familiar with the circumstances of the event.
D. Physician notification of the event. ~~Document whether or not the patient's physician was notified of the event.~~ Note: The patient's attending physician, covering physician, or clinical psychologist will be immediately notified of significant ADEs as defined in this policy.
E. ~~Document whether or not the~~Notification of ~~RM~~Risk Management Department ~~was notified of the incident.~~

IX. The Department Director, ~~or~~ Nurse Manager or designee ~~shall~~ conducts the initial investigation and documents ~~their~~ findings on the Occurrence Reporting form.

The ~~RM~~Risk Management Department ~~shall~~ reviews each Occurrence Reporting form submitted. Graphical representation of data findings ~~will be~~are reported at Patient Safety Committee meeting monthly.

References: California Code of Regulations, Title CCR, Division 17, §1711.

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

Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

Policy Number: AP87	**Date Created: No Date Set**
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration), Keri Noeske (VP Chief Nursing Officer)	
Sentinel Event and Adverse Event Response and Reporting	

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

PURPOSE:

This Policy describes the multidisciplinary framework in which Kaweah Delta (KD) and its organized Medical Staff identifies and responds to all Sentinel Events/Adverse Events (SE/AE) occurring within the organization. KD'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, Action Plans and monitoring activities. The RM Director will coordinate with the Chief Executive Officer (CEO), Chief ~~Medical~~Quality Officer (C~~M~~QO), Chief Medical Officer (CMO), Chief Compliance Officer, and any other appropriate Vice President (VP) 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, C~~M~~QO, CMO, or the appropriate VP 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).

I. **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

Formatted: Left, Indent: Left: 0", First line: 0"

Formatted: Font: (Default) Arial, 12 pt

Formatted: Font: (Default) Arial, 12 pt

Formatted: Font: (Default) Arial, 12 pt

Formatted: Font: (Default) Arial, 12 pt

Formatted: Font: (Default) Arial, 12 pt

Formatted: Font: (Default) Arial, 12 pt

Formatted: Font: (Default) Arial, 12 pt

Formatted: Font: (Default) Arial, 12 pt

Formatted: Font: (Default) Arial, 12 pt

Formatted: No bullets or numbering

Formatted: Font: Not Bold

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, … + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

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)

~~I.~~II. **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).

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

~~I~~III. **Near-Miss** – ~~a~~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.

IV. **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 ~~Sentinel/Adverse~~SE/AE or near-miss events, and are managed by the RM department utilizing the Focused Review process.

~~II.~~ **METER (Midas Event Triage & Ranking) 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.

V. **Focused Review –** A process ~~similar to an RCA,~~ 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 KD standardized process and documentation. ~~(Attachment C)~~ RM staff shall serve as a resource to this process on an as needed basis. Focused Reviews are an integral part of KD's Patient Safety and Quality Improvement program.

~~III.~~VI. **Center for Medicare and Medicaid Services (CMS)** – Federal agency responsible for enforcement of Medicare and Medicaid regulations.

~~A. CMS requires a report within 24 hours of any deaths associated with the use of restraints~~ (Attachment D).

Formatted: Indent: Left: 0.25", No bullets or numbering

Formatted: Indent: Left: 0.25"

Formatted: Indent: First line: 0.04"

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, … + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: Not Bold, No underline

Formatted: Font: Bold

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, … + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, … + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: Bold

Formatted: List Paragraph, Left, No bullets or numbering

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, … + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, … + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: List Paragraph, Left, No bullets or numbering, Tab stops: Not at 0.5"

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, … + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Indent: Left: 0.25", No bullets or numbering

~~IV.~~VII. **Case Review Committee (CRC)** – A multidisciplinary team composed of:

~~Chief Executive Officer,~~

- Chief Executive Officer (CEO)
- Chief Quality Officer (CQO) or Chief Medical Officer (CMO)
- Chief Compliance Officer (CCO)
- Chief of Staff or designee (Chair), if Applicable,
  - Medical Staff Clinical Department Chair, if Applicable,
  - ~~Chief Medical Officer (CMO),~~
  - Chief Nursing Officer (CNO), in events involving nursing
  - ~~Chief Operating Officer (COO)~~
- Vice President of area in which event occurred, as available
- Medical Director of Quality/Patient Safety, as available
- Director of Risk Management (RM) ~~Director~~
- Director of Quality ~~&/~~Patient Safety~~,~~
- Director of area where SE/AE occurred
- Others may be asked to participate as appropriate

~~A quorum for taking action by the CRC shall require at least two Medical Staff members and at least two Administrative members.~~

~~V.~~VIII. **Root Cause Analysis and Actions (RCA2)** – Root-Cause Analysis (RCA) – Root cause analysis is 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 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 o~~f~~r 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 Analysis is an integral part of KD's Patient Safety and Quality Improvement program.

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

~~**(see Algorithm, Attachment A):**~~

A. The METER 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 Manager on-call.

~~A.~~**B.** When an event that is potentially a Sentinel/Adverse or near-miss occurs or is discovered, staff will immediately notify the ~~RM Director or RM staff~~

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, … + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Indent: Left: 1", No bullets or numbering, Tab stops: Not at 1"

Formatted: Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Indent: Left: 0.69", Tab stops: 1.19", List tab + Not at 1"

Formatted: Indent: Left: 0.69", Hanging: 0.5", Tab stops: 1.19", List tab + Not at 0.56" + 1"

Formatted: Indent: Left: 0.69", Tab stops: 1.19", List tab + Not at 1"

Formatted: Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Indent: Left: 0.69", Hanging: 0.5", Tab stops: 1.19", List tab + Not at 0.56" + 1"

Formatted: Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Indent: Left: 0"

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, … + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

~~member on call.~~Risk Management Department (624-2340) or RM staff member on call through the House Supervisor.

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

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

~~B.~~2. ~~Whether the event in question may require the convening of the CRC. If this is thought to be the case, the RM Director will notify the CMO to confirm this determination. Upon confirmation, the COS & CEO shall be notified in a timely manner. Those events, in which there is no question as to the fact that a SE/AE or near-miss has occurred as determined by the RM Director in consultation with the CMO, will not require the convening of a CRC. In these situations,~~ ~~t~~The RM Director or designee shall proceed directly to initiate a~~n~~ CRC meeting~~. RCA~~ as described in Section C~~,~~ below.

~~C.~~3. RM will then complete their investigation.

D. The ~~convening of the CRC will be the responsibility of the RM Director~~ or designee ~~with assistance as required from the Chief Medical~~Quality ~~Officer, the Medical Director of Quality &/Patient Safety, or their designee's, and will occur~~Risk Management Director or designee will convene a CRC within 72 hours.

~~C.~~E. The CRC ~~responsibility is to consider~~will review the event in question and determine:

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

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

~~C.~~3. If the event ~~does NOT~~ require~~s~~ a~~n~~ RCA, ~~and~~ or if an alternate action is appropriate; and

~~D.~~4. If any immediate actions prior to the 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 KD policy and all applicable regulatory and statutory requirements as well as~~,~~ notify the CEO, CC~~O~~O, and CNO.

F. Upon determination that a Sentinel/Adverse event has occurred, the RM Director shall conduct a RCA using methodology consistent with current TJC standards unless the CRC determines that an alternate action is appropriate. ~~To create a safe environment, intended attendees at RCA's are exclusively those individuals that were directly involved in the event. In unusual circumstances, and at the discretion of the RM Director, other participants, including managers and/or Directors may be included only if their participation is of clear value. Staff involved in the event will make every effort to attend the RCA.~~ Directors shall also ensure to the best of their ability that their involved staffs are available to attend the RCA, if their participation is needed. Leadership will be responsible for ensuring that support services for any involved individual ~~needing them~~ are available. Patients and/or families may also be interviewed to gather information for the RCA, as appropriate.

G. The RM Director (or designee) in collaboration with the patient's physician, 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

Formatted: Indent: Left: 1", Hanging: 0.5", Tab stops: 1.5", List tab

Formatted: Indent: Left: 1.06", Hanging: 0.44", Tab stops: 1.5", List tab

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 ~~as a result~~because of a preventable SE/AE, the patient/family will 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~~s~~/AE~~s~~ is about improving patient care, KD may also waive costs to the patient or a third party payer 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.

~~VI.~~I. The RCA shall be conducted and produce an Action Plan within 20 days of the initial meeting that includes a detailed review of what transpired prior to, during, and immediately following the event.

The RCA will:

A. Focus on systems and processes related to event;
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~~If possible~~, include references from relevant literature for "best practices" used in the RCA and the development of the Action Plan.
D. All documentation related to RCAs, Focused Reviews, 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, C~~M~~QO, and the Medical Director of Quality/Patient Safety are responsible for reporting finalized RCAs and Action Plans to the following committees as appropriate for approval:

- The Patient Safety Committee;
- Professional Staff Quality Committee (Prostaff)~~staff~~
- 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.

Formatted: Font: Not Bold

Formatted: Font: Not Bold

Formatted: Font: Bold

Formatted: Indent: Left: 1", Hanging: 0.5", Bulleted + Level: 1 + Aligned at: 0.75" + Indent at: 1", Tab stops: 1.5", Left + Not at 1.13"

Formatted: Font: Bold

Formatted: Font: Bold

- 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.

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

REFERENCES:

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,
https://www.qualityforum.org/Topics/SREs/List_of_SREs.aspx

Formatted: Font: Bold
Formatted: Left, Tab stops: 0.74", Left
Formatted: Font: Not Bold

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 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

Formatted: Font: (Default) Arial, 12 pt

Formatted: Font: (Default) Arial, 12 pt

Formatted: Font: (Default) Arial, 12 pt

Formatted: Font: (Default) Arial, 12 pt

(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.**

Formatted: Font: (Default) Cambria Math, 12 pt
Formatted: Font: (Default) Arial, 12 pt
Formatted: Font: (Default) Arial, 12 pt
Formatted: Font: (Default) Cambria Math, 12 pt
Formatted: Font: (Default) Arial, 12 pt
Formatted: Font: (Default) Cambria Math, 12 pt
Formatted: Font: (Default) Arial, 12 pt
Formatted: Font: (Default) Arial, 12 pt
Formatted: Font: (Default) Arial, 12 pt
Formatted: Font: (Default) Arial, 12 pt

(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 ofthe adverse event by the time the report is made.
(d) “Serious disability” means a physical or mental impairment that substantiallylimits one or more of the major life activities of an individual, or the loss of bodilyfunction, if the impairment or loss lasts more than seven days or is still present at thetime of discharge from an inpatient health care facility, or the loss of a body part.

~~*Title 22, Division 5, Chapter 12, Article 5, Section 79787*~~
~~(c) Events constituting an unusual occurrence shall include, but not be limited to:~~
~~(1) Poisonings.~~
~~(2) Fires or explosions.~~
~~(3) Death of an inmate-patient, employee, or visitor because of unnatural causes.~~
~~(4) Sexual acts involving inmate-patients who are minors, nonconsenting adults, or persons incapable of consent.~~
~~(5) Physical assaults on inmate-patients, employees, or visitors.~~
~~(6) All suspected criminal acts involving inmate-patients, employees, or visitors.~~
~~(7) All suspected incidents of physical or sexual abuse to an inmate-patient.~~
~~(8) Unexplained or illicit disappearance or loss of an inmate-patient or inmate-patient remains.~~
~~(9) Disruption of services of the licensed correctional treatment center.~~

Attachment C

Definition of Sentinel Event – The Joint Commission

Formatted: Font: (Default) Arial, 12 pt
Formatted: Font: (Default) Arial, 12 pt
Formatted: Font: (Default) Arial, 12 pt, Not Bold
Formatted: Font: Not Bold
Formatted: Indent: Left: 1"
Formatted: Font: Not Bold
Formatted: Indent: First line: 0"
Formatted: Font: (Default) Arial, 12 pt
Formatted: Font: (Default) Arial, 12 pt
Formatted: Font: (Default) Cambria Math, 12 pt
Formatted: Font: (Default) Arial, 12 pt
Formatted: Font: (Default) Cambria Math, 12 pt
Formatted: Font: (Default) Arial, 12 pt
Formatted: Font: (Default) Cambria Math, 12 pt
Formatted: Font: (Default) Arial, 12 pt
Formatted: Font: (Default) Cambria Math, 12 pt
Formatted: Font: (Default) Arial, 12 pt
Formatted: Font: (Default) Cambria Math, 12 pt
Formatted: Font: (Default) Arial, 12 pt
Formatted: Font: (Default) Cambria Math, 12 pt
Formatted: Font: (Default) Arial, 12 pt
Formatted: Font: (Default) Cambria Math, 12 pt
Formatted: Font: (Default) Arial, 12 pt
Formatted: Indent: Left: 0"
Formatted: Font: Bold
Formatted: Font: Not Bold
Formatted: Font: Arial, 14 pt

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)

~~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 n 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
- Hemolytic transfusion reaction involving administration of blood or blood products
  having major blood group incompatibilities (ABO, Rh, other blood groups)
- Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure‡
- 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 >1500 rads to a single field or any delivery of radiotherapy to the wrong region or >25% above the planned dose.

Sentinel FALL EVENT: Fall resulting in any of the following: any fracture; surgery, casting, or traction; required consult/management or comfort care for a neurological (for example, skull, fracture, subdural or intracranial hemorrhage) or internal (for example, rib fracture, small liver laceration) injury; or a patient with coagulopathy who receives blood products as a result of the fall; death or permanent harm as a result of injuries sustained form the fall (not from physiologic events causing the fall)

REVISED Definitions for Abuse or AssaultEFINITIONS:

- 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 (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*

Formatted: Indent: Left: 0"
Formatted: Font: Bold
Formatted: Font: Bold
Formatted: Font: Bold
Formatted: Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"
Formatted: Indent: Left: 0.5"
Formatted: Font: 10 pt, Italic
Formatted: Indent: Left: 0"

**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*

Formatted: Font: (Default) Arial, Italic

Attachment C Attachment I REPORTING REQUIREMENTS UNDER STATE LAW

Formatted: Font: (Default) Arial, 12 pt

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.

(b) Omitted – see definitions of adverse/sentinel events per Health and Safety Code in previous section.

Formatted: Font: (Default) Arial, 12 pt

(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.

(e) Nothing in this section shall be interpreted to change or otherwise affect hospital reporting requirements regarding reportable diseases or unusual occurrences, as provided in Section 70737 of Title 22 of the California Code of Regulations. The department shall review Section 70737 of Title 22 of the California Code of Regulations requiring hospitals to report "unusual occurrences" and consider amending the section to enhance the clarity and specificity of this hospital reporting requirement.

1279.2. (a) (1) In any case in which the department receives a report from a facility pursuant to Section 1279.1, or a written or oral complaint involving a health facility licensed pursuant to subdivision (a), (b), or (f) of Section 1250, that indicates an ongoing threat of imminent danger of death or serious bodily harm, the department shall make an onsite inspection or investigation within 48 hours or two business days, whichever is greater, of the receipt of the report or complaint and shall complete that investigation within 45 days.

(2) Until the department has determined by onsite inspection that the adverse event has been resolved, the department shall, not less than once a year, conduct an unannounced inspection of any health facility that has reported an adverse event pursuant to Section 1279.1.

(b) In any case in which the department is able to determine from the information available to it that there is no threat of imminent danger of death or serious bodily harm to that patient or other patients, the department shall complete an investigation of the report within 45 days.

(c) The department shall notify the complainant and licensee in writing of the department's determination as a result of an inspection or report.

(d) For purposes of this section, "complaint" means any oral or written notice to the department, other than a report from the health facility, of an alleged violation of applicable requirements of state or federal law or an allegation of facts that might constitute a violation of applicable requirements of state or federal law.

(e) The costs of administering and implementing this section shall be paid from funds derived from existing licensing fees paid by general acute care hospitals, acute psychiatric hospitals, and special hospitals.

(f) In enforcing this section and Sections 1279 and 1279.1, the department shall take into account the special circumstances of small and rural hospitals, as defined in Section 124840, in order to protect the quality of patient care in those hospitals.

(g) In preparing the staffing and systems analysis required pursuant to Section 1266, the department shall also report regarding the number and timeliness of investigations of adverse events initiated in response to reports of adverse events.

Title 22, Division 5, Chapter 12, Article 5, Section 79787– Pertaining to Correctional Treatment Centers

(a) Reportable communicable diseases shall be reported to the local health officer and all unusual occurrences shall be reported to the Department by the licensed correctional treatment center within twenty four (24) hours, either by telephone with written confirmation or by telephone facsimile (FAX).

(b) The reporting of communicable diseases and outbreaks shall be in conformance with Sections 2500, 2502, 2503 and 2504 of Title 17, California Code of Regulations.

(c) Omitted – see definitions of adverse/sentinel events per Health and Safety Code in previous section.

(d) The licensed correctional treatment center shall furnish other pertinent information related to such occurrences as the local health officer or the Department shall require.

(e) All reports required in this Section shall be retained on file by the licensed correctional treatment center for three (3) years.

(f) Every fire or explosion that occurs in or on the premises shall be additionally reported immediately to the local fire authority, or in the areas not having an organized fire service, to the State Fire Marshal.

(g) The local health officer of the county to which an inmate patient is to be released shall be notified at least one day in advance before an inmate patient on any tuberculosis medication is released from the correctional facility.

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:

Formatted: Font: (Default) Cambria Math, 12 pt
Formatted: Font: (Default) Arial, 12 pt
Formatted: Font: (Default) Arial, 12 pt
Formatted: Font: (Default) Cambria Math, 12 pt
Formatted: Font: (Default) Arial, 12 pt
Formatted: Font: (Default) Cambria Math, 12 pt
Formatted: Font: (Default) Arial, 12 pt
Formatted: Font: (Default) Cambria, 16 pt
Formatted: Font: (Default) Arial, 12 pt
Formatted: Line spacing: single

- ~~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 n 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~~
- ~~Hemolytic transfusion reaction involving administration of blood or blood products~~
  ~~having major blood group incompatibilities (ABO, Rh, other blood groups)~~
- ~~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~~
- ~~Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure‡~~
- ~~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 >1500 rads to a single field or any delivery of radiotherapy to the wrong region or >25% above the planned dose.~~

Formatted: Font: (Default) Arial, 12 pt

~~Attachment C~~

Formatted: Centered

Kaweah Delta HEALTH CARE DISTRICT

FOCUSED REVIEW

Patient Name:

Date of Admission:

Acct #:

Safety Event ID#: Event Date:

Brief Description of Event:

A. Intended Process Flow

- What is the intended process flow according to policy & procedure, protocol, guideline?
- Were there any steps in the process that did not occur as intended? Yes ☐ No ☐

B. Communication

- To what degree was the communication among participants adequate for this situation?
- What communication barriers exist?

Please explain:

C. Human Factors

- Did any of the following human factors contribute to the event: Boredom, failure to follow P&P, fatigue, inability to focus on task, inattentional blindness, personal problems, lack of complex critical thinking skills, rushing to complete task, trust.

Please explain:

D. People

- Did staffing factor into the event? Yes ☐ No ☐
- Was staff properly qualified and competent? Yes ☐ No ☐
- How can orientation/training be revised to reduce the risk of such events?

Please explain:

E. Equipment & Environment

- Was this the appropriate physical environment for the processes being carried out? Were there any equipment failures? Unknown ☐
- Was available technology used as intended? Yes ☐ No ☐
- What systems are in place to identify this environmental risk? N/A

If no, please explain
F. Action Plan:
G. Measures of Success:

Formatted: Centered, Indent: Left: 0", First line: 0", Tab stops: Not at -1"

Formatted: Centered

Attachment D

REPORTING REQUIREMENTS RELATED TO RESTRAINT OR SECLUSION

~~There are several state and federal reporting requirements potentially implicated when an adverse event occurs to a patient who is, or has been, in restraints or seclusion. These reporting requirements are described below. One incident can easily lead to multiple reports being required. The reporting requirements related to the Safe Medical Devices Act, adverse event reporting, and unusual occurrences should be reviewed and all necessary reports should be made in the event of an adverse event involving 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~~,~~", ~~page 19.16.~~
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~~,~~" ~~page 19.16.~~
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. ~~However, critical access hospitals are required to report to CMS only if they have a psychiatric or rehabilitative distinct part unit. (Critical access hospitals may be required to report an adverse event related to restraints or seclusion under another reporting requirement described in this chapter.)~~

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.

Formatted: Font: (Default) Arial
Formatted: Font: (Default) Arial
Formatted: Centered
Formatted: Font: 12 pt
Formatted: Heading 2
Formatted: Heading 2, Indent: Left: 0.5"
Formatted: Font: (Default) Arial, 12 pt
Formatted: Default Paragraph Font, Font: (Default) Arial, 10 pt
Formatted: Font: 12 pt
Formatted: Heading 2, Indent: Left: 0.5"
Formatted: Font: (Default) Arial, 12 pt
Formatted: Font: (Default) Arial
Formatted: Font: (Default) Arial, 12 pt
Formatted: Font: (Default) Arial, 12 pt
Formatted: Indent: Left: 0", Hanging: 0.25", Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0" + Indent at: 0"
Formatted: Font: (Default) Arial, 12 pt
Formatted: Indent: Left: 0.25", No bullets or numbering
Formatted: Font: (Default) Arial, 12 pt
Formatted: Default, Space After: 0 pt
Formatted: Font: 12 pt, Font color: Black

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

[42 C.F.R. Section 482.13(g)]

B. Electronic Reporting Form

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." Reporting by email, fax or phone is not acceptable. To start the electronic reporting process, go to https://restraintdeathreport.gov1.qualtrics.com/jfe/form/SV_5pXmjlw2WAzto8J.

The hospital submits the form electronically when all information has been entered. It will automatically be sent to the appropriate Regional Office. A confirmation page containing the date and time the form was submitted will display on the hospital's computer screen. A copy of the submitted form can be downloaded, saved, or printed.

Hospitals with questions about the reporting requirement may send an email to QSOG_Hospital@cms.hhs.gov. A CMS memo on the reporting process and a link to an instructional video may be found at www.cms.gov/files/ document/qso-20-04-hospital-cah-dpu-revised.pdf.

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. Instead, hospital staff must record the following information in an internal log or other system:

- The patient's name,
- The patient's date of birth,
- The patient's date of death,
- The name of attending physician or other LIP who is responsible for the care of the patient,
- The patient's medical records number, and
- The patient's primary diagnosis(es).

Each entry must be made not later than seven days after the date of death. An entry must be made for:

- Any death that occurs while a patient is in restraints as described above.
- Any death that occurs within 24 hours after a patient has been removed from restraints as described above.

The log or other system must be made available in either written or electronic form to CMS immediately upon request.

Formatted: Font: (Default) Arial, 12 pt

Formatted: Font: 12 pt, Font color: Black

Formatted: Default, Space After: 0 pt

Formatted: Font: (Default) Arial, 12 pt

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial, 12 pt

Formatted: Font: (Default) Arial, 12 pt

Formatted: Indent: Left: 0.25", No bullets or numbering

~~The date and time of the log entry must be documented in the patient's medical record.~~

~~C. CMS Response~~

~~CMS will use the information reported by the hospital to:~~

- ~~Authorize an onsite investigation (complaint survey) of the hospital by CDPH, which is the state survey agency for CMS, and~~
- ~~Inform the federally-mandated protection and advocacy entity, which in California is Disability Rights California (DRC). DRC's role and responsibilities are described in VII. "Mental Health Advocacy Programs," page 16.10.~~

FDA Restraint Reportings

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," ~~page 19.16.~~

~~Required Policies and Procedures~~

~~Hospitals must develop and implement written policies and procedures that provide for the following:~~

- ~~Timely and effective identification, communication and evaluation of events that may be subject to medical device reporting requirements;~~
- ~~A standardized review process/procedure for determining when an event meets the criteria for reporting to the FDA; and~~
- ~~Timely transmission of complete medical device reports to the FDA and/or the device manufacturer.~~

~~The policies and procedures must also include documentation and record keeping requirements as described under "Required Documentation," below, including information that was evaluated to determine if an event was reportable [21 C.F.R. Section 803.17].~~

~~*REQUIRED DOCUMENTATION*~~

Formatted: Font: (Default) Arial
Formatted: Font: (Default) Arial, 12 pt
Formatted: Font: (Default) Arial, 12 pt
Formatted: Font: (Default) Arial, 12 pt
Formatted: Font: (Default) Arial, 12 pt, Bold
Formatted: Indent: Left: 1"
Formatted: Font: (Default) Arial, 12 pt
Formatted: Font: (Default) Arial
Formatted: Font: (Default) Arial, 12 pt
Formatted: Indent: Hanging: 0.94", Numbered + Level: 1 + Numbering Style: A, B, C, … + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Tab after: 1" + Indent at: 1", Tab stops: 0.25", List tab + Not at 1"
Formatted: Font: (Default) Arial, 12 pt
Formatted: Normal, Indent: Left: 0", Hanging: 0.25", Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0" + Indent at: 0", Don't adjust space between Latin and Asian text, Don't adjust space between Asian text and numbers

Facilities must establish and maintain medical device reporting (MDR) event files. MDR event files must be prominently identified as such and filed to facilitate timely access. The files may be written or electronic, and may incorporate references to other information, such as medical records or engineering reports, in lieu of copying and maintaining duplicates in this file. MDR event files must include the following:

- Information related to adverse events, including all documentation of the hospital's deliberations and decision-making processes used to determine if a device-related death, serious injury or malfunction was or was not reportable under this part; and
- Copies of all Safe Medical Devices Act forms and other information related to the event that was submitted to the FDA or manufacturer.

MDR event files must be retained for two years following an adverse event. Hospitals must permit FDA employees to access, copy and verify the records noted above [21 C.F.R. Sections 803.13, 803.17 and 803.18].

Formatted: Font: (Default) Arial, 12 pt

F. Request From FDA For Additional Information

The FDA may determine that protection of the public health requires additional or clarifying information for the medical device reports submitted to the FDA under this law. In these instances, and in cases when the additional information is beyond the scope of FDA reporting forms or is not readily accessible, the agency will notify the reporting entity in writing of the additional information that is required.

Any request from the FDA must state the reason or purpose for which the information is being requested, specify the due date for submitting the information and clearly identify the reported event. All verbal requests will be confirmed in writing by the FDA. [21 C.F.R. Section 803.15]

G. Device Tracking

Formatted: Normal, Space After: 0 pt

Device manufacturers and distributors are required to develop formal schemes for tracking specified ("tracked") medical devices [21 U.S.C. Section 360i(e)]. Hospitals, licensed practitioners, retail pharmacists and other types of device user facilities are considered "final distributors" [21 C.F.R. Section 821.3].
Under the regulations, a final distributor must provide the manufacturer with specified information at the time that it purchases a tracked device [21 C.F.R. Section 821.30(a)] and at the time that a tracked device is implanted in or provided to a patient [21 C.F.R. Section 821.30(b)].

At the time that the device is implanted in or provided to the patient, the hospital must provide to the device manufacturer the following information:

- The name and address of the final distributor (i.e., the hospital itself).
- The unique device identifier (UDI), lot number, batch number, model number or serial number of the device, or other identifier used by the manufacturer to track the device.
- The name, address, telephone number and Social Security number (if available) of the patient receiving the device unless not released by the patient *(see "Patient Confidentiality Rights," page 19.14)*.
- The date the device was provided to the patient or for use in the patient.

- The name, mailing address and telephone number of the prescribing physician.
- The name, mailing address and telephone number of the physician regularly following the patient if different from the prescribing physician.
- When applicable, the date the device was explanted, and the name, mailing address and telephone number of the explanting physician, the date of the patient's death, or the date the device was returned to the manufacturer, permanently retired from use or otherwise permanently disposed of.

[21 C.F.R. Section 821.30(b)]

PATIENT CONFIDENTIALITY RIGHTS

A patient receiving a device subject to tracking may refuse to release, or refuse permission to release, his or her name, address, telephone number and Social Security number, or other identifying information for the purpose of tracking [21 CFR Section 821.55]. FDA guidance states that hospitals must document the refusal and the forwarding of such documentation back to the device manufacturer.

DEVICE TRACKING RECORDS

Hospitals must permit FDA employees to access, copy and verify device tracking records, as well as all other records and information related to the events and persons identified in such records [21 C.F.R. Section 821.50]. In addition, hospitals must make any records required to be kept by the device tracking law available to the manufacturer of the tracked device for audit upon written request by an authorized representative of the manufacturer [21 C.F.R. Section 821.30(d)].

Device tracking records must be maintained for the useful life of the tracked device. The useful life of a device is the time a device is in use or in distribution for use. A record may be retired if the person maintaining the record becomes aware that the device is no longer in use, has been explanted, returned to the manufacturer or the patient has died. [21 C.F.R. Section 821.60]

Records required to be kept by the device tracking law must be kept in a centralized point [21 C.F.R. Section 821.50].

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)

Formatted: Font: Not Bold, No underline
Formatted: No underline
Formatted: Font: Not Bold, No underline
Formatted: No underline
Formatted: Font: Not Bold, No underline

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/postprocedure 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

Formatted: Left

Formatted: No underline

Attachment F: REPORTING REQUIREMENTS UNDER STATE LAW

Formatted: Centered

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.

Formatted: Default Paragraph Font, Font: (Default) Times New Roman, 12 pt

Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

Policy Number: AP83	**Date Created: 12/01/2001**
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration)	

Protocol for Moves Within Kaweah Delta Health Care District

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

POLICY: This policy applies to ~~District~~ Kaweah ~~Delta~~Health moves for individual staff or groups that involve the relocation of computer equipment, removal or relocation of office furniture, repainting, flooring repair or replacement, supplies, and other services necessary. Moves must be accomplished in an organized, cost effective and timely manner, while providing good customer service for ~~District~~ Kaweah ~~Delta~~Health staff.

PROCEDURE:

1. ~~A request to~~ To move an individual or a group from one office or work area to another a Request for New or Additional Space/Office form must be forwarded to the Facilities Planning Director~~, with a completed 'Move Request Form'~~ (form attached to this policy).

   ~~1.1 The 'Move Request Form' identifies selected departments who must sign the form to acknowledge the request.~~

   ~~1.2 The 'Move Request Form' identifies items of work necessary to complete the move satisfactorily.~~

2. The Facilities Planning Director will forward the Request for New or Additional Space/Office form ~~bring forward move move requests to~~ to the Facilities and Property Committee for review and approval.

3. If approved, an Approved Moves Number will be assigned and a Moves Request Form will be ~~the approval will be~~ e-mailed to the requesting department Director. Once the Moves Request form is completed, ~~, and~~ a copy will be sent to the EVS Manager, the Facilities Manager, the IT Services Delivery Manager, and the ISS Project Analyst. ~~The request will be assigned an Approved Move Number.~~ If disapproved, the requesting department Director will be notified.

   1.1 The 'Move Request Form' identifies selected departments who must sign the form to acknowledge the request.

   1.2 The 'Move Request Form' identifies items of work necessary to complete the move satisfactorily.

4. Once approved, the requesting department will be responsible to submit maintenance work orders, ISS service requests, EVS service requests, and any

other related services necessary for the move. Work orders and service requests must refer to the Approved Move Number.

5. To maintain an organized and efficient support delivery process, service departments responding to move-related work orders and service requests must verify that the move is approved.

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

KAWEAH HEALTH
REQUEST FOR NEW OR ADDITIONAL SPACE/OFFICE

Director Requesting: _____ Dept. No. _____
Director Signature: _____ Date: _____
VP Signature: _____ Date: _____

Detail the needs being addressed by this Request:
(Please include number of employees, number of offices/cubicles, etc.)

Preferred location for the new space:

Please forward completed form to the Executive Assistant to Vice President, Chief Strategy Officer

Facilities & Space Committee Approval

- ☐ Yes *(Once approved, you will be assigned a Move # and the Moves Request form.)*
- ☐ No

KAWEAH DELTA HEALTH CARE DISTRICT POLICY AP83
MOVE REQUEST FORM

Director Requesting : _____ Dept No. _____

Director Signature : _____ Date: _____

Details of Move

How many staff is/are moving: _____

Name(s) of staff moving: _____

_____

Moving From: Unit/Rm # _____ Floor _____ Building _____

Moving To: Unit/Rm # _____ Floor _____ Building _____

Briefly explain reason(s) for moving: _____

_____

ISS SERVICES REQUIRED (check box, which applies):

☐ Computer move

☐ Printer/copier/fax move

☐ Telephones and/or other IT hardware move

☐ New phone/data outlet(s), how many _____

Acknowledged by ISS Technical Services, signature required:

ISS Director or Designee: _____ Date: _____

MAINTENANCE SERVICES REQUIRED (check box, which applies):

☐ New power outlet(s); how many: _____

☐ Furniture move (relocation or removal); describe furniture: _____

☐ Vinyl flooring /carpet; please check if _____repair or _____replacement

☐ Repainting

☐ Door keys; how many _____

Acknowledged by Facilities Maintenance, signature required:

Maintenance Director or Designee: _____ Date: _____

☐ EVS clean up required.

Acknowledged by EVS Department, signature required:

EVS Director or Designee: _____ Date: _____

PLEASE FORWARD THIS FORM, WITH REQUIRED SIGNATURES, TO THE FACILITIES PLANNING DIRECTOR FOR REVIEW AND APPROVAL. THANK YOU.

☐ Approved ☐ Not Approved Date: _____ **APPROVED MOVE NUMBER**_____

Policy Number: EOC 1050	Date Created: 11/09/2011
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Helipad Policy

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

Policy: The following procedures will be implemented for all landings and departures of helicopters at Kaweah Delta Medical Center (KDMC).

Definitions: MICN (Mobile Intensive Care Nurse), Emergency Department Registered Nurses trained and certified by the local EMS Agency to handle EMS Base Hospital Operations and EMS Communications.

Procedure:

A. Notification of Helicopter Landings or Departures:

1. The MICN will be responsible for the activation of the appropriate systems when there is incoming or departing helicopter traffic. MICN will complete a “Base Hospital Care Report” to document helicopter communications and helipad coordination.

2. ED Unit secretary or MICN will immediately notify PBX by dialing 44 to activate hospital security once notification has been received for an incoming or departing helicopter. MICN will also need to notify ED Team Leader. Security will also need to be notified if the large SkyLife Helicopter is en route..

3. Security and ED Helipad Tech will attend all helicopter arrivals and any departures with a patient on board to secure the parking lot and helipad, provide emergency assistance as needed, and activate fire extinguisher system if necessary.

4. Prior to helicopter arrival and departure, Security will inspect helipad for debris. Security will monitor and control foot and vehicle traffic in the main parking lot when the helicopter is landing or departing.

5. For patients going to the ED, the ED Helipad Tech will obtain an ED gurney that will be used for the patient during their ED stay. The ED Helipad Tech will obtain the dedicated helipad gurney for patients not going to the ED . They will also assist in loading and unloading of patients.. If patient is going to a unit other than the ED, the ED Helipad Tech will accompany the patient to the receiving unit and retrieve the gurney once the patient is received. The ED Team Leader may also designate other authorized ED Helipad Personnel to assist with helipad operations if the ED Helipad Tech is not available. **All personnel will stay off the helipad and remain in the helipad elevator building until the rotor**

blades have completely stopped turning and a flight crew member signals that it is ok to approach the helicopter.

6. Case Management, Patient Family Services, Nursing Supervisor, and Transfer Center Responsibilities: All inbound and outbound Interfacility Transfers that utilize a helicopter must be communicated to the MICN at extension 2129 as they are responsible for coordination of helipad utilization. Early MICN notification is essential in this process.

B. General Responsibilities:

1. KDMC personnel are not allowed to assist in “Hot off-loads” (i.e., with rotors turning). All off-loads will be performed cold (without rotors turning) unless special circumstances exist. All hot off-loads will need to be done by the aircrew without any assistance from KDMC personnel.

2. Helipad keys will be kept by the ED Team Leader, PBX, Maintenance Department and Safety/HICSDepartment.

3. All ED Tech and RNs , Security Officers, or any other personnel directly involved with helipad operations must complete the KDMC Helipad safety in-service and competency.

4. While a helicopter is landing or taking off, the use of artificial light is not permitted for filming or photography. In dark conditions the helicopter pilots will typically be wearing night vision goggles (NVGs). Ensure the helipad walkway flood lights are turned off anytime the pilot is wearing NVGs as those lights impair the pilot vision. Those lights shall only be turned on when it is deemed safe by the flight crew for personnel to be out on the helipad.

5. If the helipad elevator is broken or helipad is out of service for maintenance or repairs the MICN will place KDMC on Helipad Diversion in accordance with Central California EMS Agency policies. MICN will also need to notify Valley Children’s Hospital Transfer Center and Hall Air Ambulance in Bakersfield of Helipad Diversion status as they do not receive Central California EMS Agency Diversion Alerts. All agencies will need to be notified by the MICN when Helipad Diversion status is terminated.

C. Safety:

1. In the event of compromised vision of anyone on the helipad, due to foreign body in the eyes, that person should immediately kneel on the ground in a stationary position.

2. Staff are to stay away from the edges of helipad. Keep gurneys away from the helipad edges to minimize tip-over potential.

D. Multiple Helicopters:

1. If more than one aircraft is enroute to our helipad, the MICN will notify both flight crews that another helicopter is enroute.

2. If the helipad is occupied and another helicopter is enroute , the MICN will notify the in-bound helicopter that the helipad is currently occupied. If time permits, attempt to contact the pilot of the occupying helicopter to request if it is possible to move the helicopter so that the in-bound helicopter can land. Note: Getting the helicopter moved (if possible) is not a quick process.

General Information:

A. The heliport is designed to accommodate one helicopter at a time. No helicopter over a gross weight of 12,000 pounds or with a main rotor diameter of over 48 feet will be allowed on the heliport.

B. Unauthorized personnel are not allowed on the helipad unless accompanied by personnel authorized for helipad operations.

C. The ED Helipad Tech will complete the helipad check off list every shift.

D. Security will maintain the helipad log to record all helicopter landings and inspect the helipad lighting systems, nightly.

E. The MICN will maintain the helipad status board, which is located in the ED Radio Room.

F. The Security Department will conduct a daily shift helipad safety inspection. These inspections will take place during daylight and nighttime hours when all safety equipment can be properly assessed.

G. The Maintenance Department will inspect the helipad warning signs and windsock condition semi-annually. The Maintenance Department will also inspect the helipad and helipad lighting systems according to the manufacturer’s recommendations,

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

Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

Policy Number: EOC 5020	**Date Created: 05/04/2007**
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	
Interim Life Safety Measure Plan	

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

I PURPOSE

The hospital shall ensure the appropriate management of all areas in which new construction, renovations, significant repairs or other activities conditions result in impairments of the life safety systems and any deficiencies identified through the PFI (Plan for Improvement) process by providing for the appropriate evaluation for, and implementation of Interim Life Safety Measures (ILSMs) to minimize or eliminate those risks. In those cases in which the organization implements ILSMs, failure to adhere to implemented measures will result in immediate cessation of work.

II SCOPE

This program applies to all Kaweah Delta locations, including off-site facilities. (This standard does not apply to facilities classified as business occupancy by the Life Safety Code). The evaluation for ILSMs is required for all construction, repair, renovation or maintenance activities that can or do result in the impairment of any life safety system. Appropriate Measures will be implemented based on that evaluation.

IIIRESPONSIBILITY

The Safety Officer, in collaboration with the Director of Facilities, is responsible for managing the Interim Life Safety Measures program.

The Safety Officer, Director of Facilities and the Facilities Construction Manager coordinate the risk assessment for construction, renovation and other activities and serve as the interpreting authorities relative to the need and scope of Interim Life

Safety Measures implementation. These individuals, in collaboration with appropriate regulatory authorities and others, as applicable, will determine what, if any, Interim Life Safety Measures are necessary to compensate for any life safety conditions found to be deficient as the result of any event or activity, including surveillance, maintenance, construction and renovation activities.

The Safety Officer, Director of Facilities and the Facilities Construction Manager share the primary responsibility for ensuring compliance, providing ongoing monitoring of performance, and enforcement of all implemented Interim Life Safety Measures.

The Safety Officer is responsible for communicating the findings to appropriate managers, staff, contractors, and senior leaders. In addition, the Safety Officer, in concert with the Director of Facilities and Facilities Construction Manager, is responsible for monitoring implementation of the ILSM and taking action when they are not being observed.

The schedule of monitoring and documentation is determined on a per project basis. The Safety Officer is responsible for maintaining all ILSM documentation from the onset through elimination of the deficiencies. In the event of ILSM program implementation, regular reports of ILSM program performance are submitted to the EOC Committee.

Security staff will be responsible for conducting rounds and other related activities (fire watches, etc.) as necessary, including off-shifts and weekends.

IV PROCEDURE

Assessment:

A hazard-specific risk assessment process is used to evaluate each situation or condition to determine if the degree of deficiency warrants ILSM and what specific measures are required to appropriately manage the effects of the deficiency. The ILSM Data Collection Tool is used to review deficient conditions or the potential thereof, and then to identify an appropriate slate of ILSMs for implementation

The evaluation includes consideration of:

- Construction design and work practices and whether unobstructed egress can be maintained. KDHCD will provide alternate routes for public access if work affects normal access routes. All appropriate staff will receive education regarding alternative / altered egress routes if they are designated.
- Temporary partitions and whether their construction appropriately complies with requirements for protection and non-combustibility.

- Temporary partitions and whether their construction appropriately protects adjacent and other areas from the infiltration of dust and/or smoke.
- Modifications to fire alarm, detection, and suppression systems and whether those modifications result in impairment to their appropriate operation. Before any of these systems are taken out of service, KDHCD will identify and implement strategies and activities to compensate for the deficiencies. Facilities staff will undergo education, as appropriate, to provide support and oversight of those strategies and activities.
- Provision of additional fire-fighting equipment, including type, numbers, and placement to provide appropriate coverage / mitigation of deficient conditions. Should provision equipment exceed complement / type of equipment found in the Hospital, education will be provided to appropriate staff.
- Identification and implementation of strategies for maintaining construction and renovation spaces in an appropriate fashion. This includes consideration of hazardous storage (flammable liquids & gases), housekeeping, debris removal, noise levels, and access control. KDHCD staff, as well as construction staff must pay particular attention to identifying penetrations in rated partitions and ensuring timely remediation of identified deficiencies.
- Appropriate programs of fire drills, hazard surveillance activities, and staff education programs to ensure all areas and persons affected by conditions are adequately prepared and provided sufficient oversight. The frequency and scope of these activities will be assessed and revised as conditions dictate.

Compliance, monitoring, and enforcement:

The authorities noted above, to ensure consistent compliance with all implemented Interim Life Safety Measures, will conduct surveillance rounds of applicable locations when indicated by the assessment, for the duration of implementation. In the event a determination is made that the conditions of any (or all) implemented ILSM are not met, actions to immediately resolve the resulting condition will be initiated.

A completed and signed ILSM assessment is appropriate documentation of compliance by KDHCD with its Interim Life Safety Measures Plan and Process. Record copies of completed assessments will be maintained in the Facilities Departments.

ILSM Data Collection Tool

Project Name:	
Project Description (Brief):	
Estimated Start Date:	Estimated Completion Date:
Contractor:	

Contractor Representative(s):
Hospital Representative(s):

Life Safety Project Data (place a mark in the applicable box):

Will the project include general construction, renovation, or significant repairs within or immediately adjacent (connected) to an occupied building?		Yes		No
If yes, document assessment of ILSM #1, 5, & 7				
Does the project involve the major renovation of an occupied floor or department?		Yes		No
If yes, document assessment of ILSM # 1, 2, 5, 6, & 7				
Will the project result in the total or partial obstruction of an approved exit or egress path?		Yes		No
If yes, document assessment of ILSM # 1, 5, 6, 7				
Will the project result in obstructed access to the Hospital by emergency services – fire, police, or other emergency forces?		Yes		No
If yes, document assessment of ILSM # 2, 4				
Will the project result in the rerouting of emergency vehicles to the Emergency Department?		Yes		No
If yes, document assessment of ILSM # 2, 4				
Does the project involve the significant modification of smoke and/or fire barrier walls?		Yes		No
If yes, document assessment of ILSM # 1, 5, 7				
Does the project involve an addition to an existing structure?		Yes		No
If yes, document assessment of ILSM # 2, 4, 7				
Does the project involve the replacement or impairment of the fire alarm, detection, or suppression system.		Yes		No

Which systems?	Alarm	Detection	Suppression
If yes, document assessment of ILSM # 1, 3, 4, 6, 7			
Will the project require implementation of temporary fire alarm, detection, or suppression system?		Yes	No
If yes, document assessment of ILSM # 1, 3, 4, 6, 7			
Will the project require the use of temporary construction partitions for any reason (security, infection control, etc.)?		Yes	No
If yes, document assessment of ILSM # 5, 7			
Will the project result in any of the following:			

Excavation		Yes		No	Construction Area(s)		Yes		No
Construction Storage		Yes		No	Field Offices		Yes		No
If yes, document assessment of ILSM # 1, 5, 7									
Will the project require disruption of the sprinkler system for < 4 hours?							Yes		No
If yes, document assessment of ILSM # 1, 3, 4, 5, 6, 7									

Will the project require disruption of the sprinkler system for > 24 hours?		Yes		No
If yes, document assessment of ILSM # 1, 3, 5, 6, 7 ILSM; #4 is mandatory				
Will the project result in any other Life Safety Code deficiencies? (Describe below)		Yes		No
Other Life Safety Code Deficiencies:				
If yes, document assessment of ILSM #				

A "yes" response to any of these questions automatically triggers an assessment for the implementation of Interim Life Safety Measures.

NB – Deficient conditions noted while project is under way may trigger an additional review of the project, including a reassessment for ILSM implementation.

Place a check mark in each applicable ILSM activity as determined by an assessment of the risks identified in the Project Data Collection tool.

#1 INSPECTIONS / SURVEILLANCE

- ☐ Increased surveillance of buildings, grounds, and equipment: shift / daily / other:
- ☐ Means of exiting construction areas inspected daily
- ☐ Implementation of Fire Watch
- ☐ Not applicable

#2 ACCESSIBILITY

- ☐ Maintenance of escape/egress routes from construction areas
- ☐ Maintenance of access to emergency services for emergency equipment, fire alarm pull stations, Fire Department connections (internal & external)
- ☐ Not applicable

#3 EQUIPMENT – LIFE SAFETY

- ☐ Temporary fire alarm, detection, suppression system in place
- ☐ Monthly testing and inspection of temporary
- ☐ Provide additional firefighting equipment in project area
- ☐ Provide additional firefighting equipment in adjacent areas
- ☐ Not applicable

#4 COMMUNICATIONS

- ☐ Notification of municipal Fire Department (or applicable emergency forces group)
- ☐ Not applicable

#5 CONSTRUCTION MATERIALS / PRACTICES

- ☐ Partitions smoke tight and constructed of noncombustible or limited combustible materials
- ☐ Prohibition of smoking throughout building and in and near construction areas
- ☐ Implement appropriate storage practices
- ☐ Implement appropriate housekeeping practices
- ☐ Implement appropriate debris removal practices
- ☐ Not applicable

#6 FIRE DRILLS

- ☐ 2 fire drills per shift per quarter throughout Hospital (one additional drill beyond requirement of EC.5.30).
- ☐ 2 fire drills per shift per quarter in areas adjacent to project (one additional drill beyond requirement of EC.5.30)
- ☐ >2 fire drills per shift per quarter throughout Hospital. If yes, how many
- ☐ >2 fire drills per shift per quarter in areas adjacent to project. If yes, how many
- ☐ Not applicable

#7 TRAINING

- ☐ Additional training for staff in immediate area
- ☐ Additional training for staff throughout hospital
- ☐ Additional training for incident response team
- ☐ Training to promote awareness of fire-safety building deficiencies, construction hazards, ILSM
- ☐ Training on changes in physical environment (egress routes)
- ☐ Training on firefighting equipment
- ☐ Training on compensating for impaired structural or compartmentalization features of fire safety
- ☐ Not applicable

Interim Life Safety Measures Assessment Summary

Date: _____

Project: _____

_____

Building location: _____ Floor: _____Rooms: _____

Project safety coordinator: _____

Title: _____

General contractor: _____

Estimated construction start date: _____

Estimated construction completion date: _____

Implementation checklist:	
☐	Review the scope of the construction or renovation project for actions required by the ILSM assessment.
☐	Notify the general contractor of his or her responsibilities regarding ILSMs.
☐	Notify the maintenance/facilities department about potential shutdowns of fire alarms, sprinkler systems, smoke detector systems, etc. Prior to modifications that necessitate shutdowns, implement the necessary ILSMs to provide equivalent system protection. The safety and security department will coordinate the scheduling of fire drills as appropriate.
☐	Develop a plan and train appropriate hospital staff and construction personnel on ILSMs
☐	Regularly inspect and report on the construction site regarding ILSMs (see the ILSM checklist and fire watch documentation).
Note: If the above construction project does not warrant implementation of ILSMs, indicate the reasons below:	
Project Safety Coordinator:	

INTERIM LIFE SAFETY MONITORING

Date of Survey	
Inspector	
Area Surveyed	
Project Number	
Project Name	
Date Safety was Notified of the Project	

		YES	NO	N/A
A.	**EXITS**			
1.	Do exits provide free and unobstructed egress?			
2.	Did personnel receive training for alternative exits?			
3.	Are means of egress in construction area inspected daily?			
4.	Is there free and unobstructed access to Emergency Department/Services and for emergency forces?			
B.	**FIRE EQUIPMENT**			
1.	Are fire alarms, detection, and suppression systems in an operational function?			
2.	Are fire alarms, detection and suppression systems impaired?			
3.	Have temporary fire alarm, detection, and suppression systems been inspected and tested monthly.			
4.	Have training and additional fire equipment been provided for personnel?			
C.	**FIRE SYSTEMS**			
1.	Power properly secured at the end of each workday?			
2.	Has the no smoking policy been implemented in adjacent to the construction areas?			
3.	Are construction areas free of storage and housekeeping materials, food, food waste, and debris for daily operations to reduce flammable and combustible fire load of the building?			
4.	Has there been a minimum of two fire drills conducted per shift per quarter?			
5.	Has hazard surveillance in construction area been inspected daily?			
6.	Have safety education programs been conducted to ensure awareness of any Interim Life Safety Measures Life Safety Code deficiencies and construction hazards?			
D.	**GENERAL SAFETY**			
1.	Is power properly secured at the end of each workday?			
2.	Are hand and safety rails in place and in good condition?			
3.	Are extension cords grounded and in good condition?			
4.	Are power tools in good condition?			

5. Are hard hats used regularly?			
6. Are cutting and welding operations properly conducted?			
7. Are new employees instructed in Right-To-Know regulations?			
8. Do fire watch personnel receive appropriate training?			
9. Are all construction activities conducted in a safe manner?			
10. Does all scaffolding comply with OSHA requirements (1926.421)?			
11. Are employees trained in fall hazards in work areas near roof edge?			
E. INFECTION CONTROL			
1. No construction activity takes place within 25 feet of existing fresh air intakes?			
2. Materials used (i.e., fire retardants) comply with necessary safety regulations?			
3. Monitoring of impervious construction barriers to verify negative pressure?			
4. Demonstrated compliance with traffic patterns?			
5. Demonstrated compliance with appropriate use of cover garbs when outside construction area?			
6. Demonstrated use of appropriate equipment to prevent airborne particulate matter/debris; this includes HEPA filtration units, HEPA vacuum equipment, and continuous use of exhaust fans?			
7. Ducts remain sealed/capped?			
8. Doors are closed and gaskets/hardware are intact?			
9. Methods of debris transport are monitored and found to be consistent with process designed to minimize airborne particulate matter/debris?			
10. All windows and doors remain closed to prevent circulation of dust/debris?			
11. Carpet or adhesive strips are clean and available at doorways for shoe dust collection?			
12. Areas are found to be cleaned at the end of each day?			
13. No signs of water leakage?			
14. No signs of pests?			

Comments: (Corrective Action for "No" responses)

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

Policy Number: EOC 7401	Date Created: 04/01/2010
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Utilities Management Program

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

POLICY:
Maintenance Department shall maintain for all health care District facilities a Utilities Management Program designed to accurately plan, operate, assess and manage all activities with-in the utility systems environment.

The Utilities Management Program shall include equipment that meets the following criteria:

Maintains the climatic environment in Patient care areas.
Risk potential to Patient life support upon failure.
Building systems, which are involved with infection control.
Communication systems which may affect the Patient or the Patient care environment.
Auxiliary or ancillary part of a system control or interface to Patient care environment, life support, or infection control.

The following systems are included in the Utilities Management Program:

Electrical Distribution Panels
Emergency Power Equipment including Transfer Switches
H.V.A.C. Equipment
Heating and Exhaust Equipment
Plumbing, Water Heating and Distribution Equipment
Boiler, Steam
Medical/Surgical Air and Vacuum Equipment
Domestic Water
Sewage Removal Systems
Alarm Systems

The following systems are included in the Utilities Management Program but due to complexity of maintenance, will be serviced by District Vendors:

Vertical Transport Systems
Medical Gas Delivery Equipment, Manifolds, Bulk Oxygen Storage, including Alarm Panels, Valves, Automatic Pressure Switches, Flexible Connectors and Outlets
Sterilization Equipment
Automatic Fire Extinguishing Systems

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

Kaweah Delta Health Care District

Human Resources

Policy Number: HR.03	**Date Created: 10/29/2019**
Document Owner: Dianne Cox (VP Chief HR Officer)	**Date Approved: 11/11/2019**
Approvers: Cindy Moccio (Board Clerk/Exec Assist-CEO)	
Just Culture Commitment	

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

Purpose:

Kaweah Delta is committed to building, maintaining, and supporting a Just Culture. In a Just Culture, we all share the responsibility for safety, and we work together to improve both our systems and our behaviors. It is a learning environment that encourages and empowers individuals to report errors, risky behaviors, near misses, adverse events, and system issues, including gaps in our processes and unsafe conditions, by treating individuals in a fair and just manner and using the information to identify changes that will improve the safety and quality of care and services we deliver. Just Culture supports our Kaweah Care commitment to personal, professional and compassionate experiences for every person, every time through patient-centered, employee and physician-driven continuous improvement.

Policy:

To foster this culture, Kaweah Delta will utilize a fair and systematic approach that balances a non-punitive learning environment with the equally important need for accountability and continuous improvement toward safety goals. This shall include assessing the quality of a choice based on intent toward the action and recognition of risk, evaluating for system contributors that allow or encourage the behavior and making reasonable efforts to work with physicians, staff, leaders and volunteers to redesign the system or its components to prevent and/or mitigate unintended risks or harm.

Individuals will not be disciplined or retaliated against for reporting an error, risky behavior, near miss, adverse event or system issue. Kaweah Delta's response will be consistent with Just Culture principles and the disciplinary policy and procedures of Kaweah Delta (refer to policy HR.216 Progressive Discipline). Instead of holding individuals accountable for outcomes that may be outside of their control due to system issues, Kaweah Delta will look at how their actions fit within the core behaviors listed in the following table and respond accordingly to the system and individual.

Deleted: POLICY

Formatted: Right: 0.22"

Deleted: A Just Culture is one where accountability is balanced fairly between the organization and its staff members.

Deleted: culture in which

Deleted: events

Deleted: ,

Deleted: ,

Deleted:

Deleted: system problems can be easily reported without retaliation, and are seen as a means to

Deleted: system and behavior

Deleted: This environment

Deleted: will encourage and empower each person to take part in improving the quality of care and services delivered by Kaweah Delta and will

Deleted: ¶
A Just Culture recognizes that adverse events and unanticipated outcomes are often the results of human error or system failures, rather than the result of reckless or intentionally malicious behavior, and that individuals are accountable for their individual actions, but generally not errors or problems in system design.¶

Formatted: Space Before: 0 pt

Deleted: rocedure

Deleted: of

Deleted: on

Deleted: unwanted human error or behavioral choices

Deleted: identification of system modifications that will prevent recurrence or minimize potential harm.Kaweah Delta will make

Moved (insertion) [2]

Deleted:

Deleted: ¶
¶
Staff

Deleted: ,

Deleted: problem, safety or quality concern. When indicated, staff members will be held accountable and appropriate corrective action taken.

Deleted: Actions

Deleted: ,

Deleted: with

Deleted: Staff will not be held accountable for system flaws over which they have no control.

Moved up [2]: Kaweah Delta will make reasonable efforts to work with staff to redesign the system or its components to prevent and/or mitigate unintended risks or harm.¶

Moved down [1]: This policy applies anyone working at any Kaweah Delta department or facility including and but not limited to: regular and

CORE BEHAVIORS	RESPONSE TO SYSTEMS AND INDIVIDUALS
Human Error (unintended action or mistake where something else should have been done)	• Assess for contributing factors, and redesign the system to prevent and/or mitigate risk (as applicable). • Console the individual. • Continued human error of a similar nature that has been unresponsive to changes in choices and/or systems may result in additional training, reassignment of tasks, or disciplinary action (as applicable).
At-Risk Behavior (i.e. drift, choice where the risk was not fully recognized or where the choice or is mistakenly believed to be justified)	• Assess for contributing factors, and redesign the system to prevent and/or mitigate risk (as applicable). • Coach the individual to help them better recognize the risk and the right choice in the future. • Continued at-risk behavior of a similar nature that has been unresponsive to coaching and/or system improvements may result in additional training, reassignment of tasks, or disciplinary action (as applicable).
Reckless Behavior (choice to take a substantial and unjustifiable risk)	• Assess for contributing factors, and redesign the system to prevent and/or mitigate risk (as applicable). • Take immediate steps to stop the individual from engaging in further reckless behavior and consider disciplinary action to strongly discourage this type of choice in the future.

This policy applies to anyone working at any Kaweah Delta department or facility including ,but not limited to: regular and contingent employees, physicians, agency staff, volunteers and contract workers.

This policy does not replace existing organizational policies and procedures related to reporting, responding to, investigating, and documenting any observed or reported errors, near misses, adverse events, complaints or safety/quality concerns.

The interpretation, administration and monitoring for compliance of this policy shall be the responsibility of operational leadership in conjunction with Human Resources, Quality/Risk leadership and other departments where necessary.

"Responsibility for the review and revision of this Policy is assigned to the Vice President of Human Resources. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Delta 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 Delta Policies and Procedures."

Formatted Table

Deleted: and

Formatted: Space Before: 0 pt

Formatted: Space Before: 0 pt

Deleted: The interpretation, administration and monitoring for compliance of this policy shall be the responsibility of operational leadership in conjunction with Human Resources, Quality/Risk leadership and other departments where necessary.¶
¶
This policy does not replace existing organizational policies and procedures related to reporting, responding to, investigating, and documenting an observed or reported errors, near misses, adverse events, complaints, or safety or quality concerns, etc.¶
¶
The table below should be used to help ensure appropriate application of Just Culture principles and aid in determining the right course of action when there has been an error, near miss, adverse event or unexpected outcome, or when a staff member has otherwise not met their obligation to the organization.¶
¶

Deleted: ERROR AND BEHAVIORAL CHOICES ...

Formatted Table

Deleted: ¶
behavioral choices.¶
Counsel and provide remedial action.¶
If there is history of similar at-risk behavioral choices by the same individual, add additional remedial actions and/or disciplinary action (as applicable).¶
Repetitive at-risk behavior may rise to the level or reckless behavior. ...

Formatted: Indent: Left: 0", Right: 0.52", Space Before: 10.25 pt

Formatted Table

Moved (insertion) [1]

Kaweah Delta Health Care District

Human Resources

Policy Number: HR.200	**Date Created: 06/01/2007**
Document Owner: Dianne Cox (VP Chief HR Officer)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration)	
Drug Free Work Place and Drug/Alcohol Testing	

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

POLICY:

As a part of our commitment to safeguard the health of our employees and volunteers and provide a safe work environment, Kaweah Delta Health Care District (KDHCD) has established this policy on the use or abuse of alcohol and illegal drugs or other controlled substances by employees, contract staff or volunteers (all three categories are referred to as employee in this policy for reference only). At work or otherwise, substance abuse seriously endangers the safety of the work environment, as well as our patients and the general public.

As a condition of employment all employees are required to abide by this policy. KDHCD has established this policy to detect users and remove abusers of drugs and alcohol and to prevent the use and/or presence of these substances in the workplace. Confirmed incidents of drug diversion will be reported to the appropriate licensing, regulatory, and/or law enforcement agencies. Confirmed incidents of potential violations of the Definitions below will be reported to any applicable agency. If an individual quits or leaves their assignment prior to a drug test or investigation, they will be reported to any applicable agency.

Formatted: Not Highlight

A violation of this policy by an employee or job applicant may subject the employee or applicant to Disciplinary Action up to and including termination of employment or rescission of the job offer. KDHCD may suspend employees without pay under this policy pending the results of a drug test or investigation.

Whenever a District employee observes evidence of possible impairment or diversion of drugs by a Provider/Practitioner while on hospital premises, the staff member must immediately inform his or her supervisor who shall inform the CEO or Designee. The CEO or Designee shall immediately inform the Chief of Staff/Designee.

DEFINITIONS:

The definitions of words and terms as set forth in this policy are as follows:

1. "Illegal drugs or other controlled substances" means any drug or substance that
   a) is not legally obtainable; or
   b) is legally obtainable but has not been legally obtained; or
   c) has been legally obtained but is being sold or distributed unlawfully.

2. “Legal drugs” means any drug, including prescription drugs and over-the-counter drugs, that has been legally obtained and that is not unlawfully sold or distributed.

3. Marijuana or marijuana-related products are prohibited while on KDHCD premises, or while conducting / performing district business.

4. “Abuse of any legal drug” means the use of any legal drug:
    a) for any purpose other than the purpose for which it was prescribed or manufactured;
    b) in a quantity, frequency, or manner that is contrary to the instructions or recommendations of the prescribing physician or manufacturer.

5. “Reasonable suspicion” includes suspicion that is based on specific personal observations such as an employee’s manner, disposition, muscular movement, appearance, behavior, speech, or breath odor; information provided to management by an employee, by law enforcement officials, or by other persons believed to be reliable; or suspicion that is based on other surrounding circumstances, including but not limited to, protracted poor job performance, continued unexplained absences, chronic tardiness, and/or audit findings or charting issues.

6. “Possession” means that an employee has the substance on his or her person or otherwise under his or her control.

7. “Drug diversion” means to obtain, possess, prescribe or use any controlled substance or drug in violation of state or federal law.

ALCOHOL USE PROHIBITIONS:

It is against policy to report to work or to work if an employee’s ability to work safely or efficiently may be impaired because the employee is under the influence of alcohol.

1. For the purpose of this policy, an employee is presumed to be under the influence of alcohol if a blood test shows forensically acceptable positive proof.

2. Any employee who is perceived to be under the influence of alcohol will be removed immediately from their work for evaluation of impairment and possible testing. KDHCD may take further action (i.e., reporting to a licensing agency and/or-Disciplinary Action) based on medical information, work history and other relevant factors. The determination of what action is appropriate in each case rests solely with KDHCD.

3. Refusal to submit to, efforts to tamper with, or failure to pass an alcohol test may result in Disciplinary Action, up to and including termination of employment.

Violation of any of the following will result in reporting the employee to a licensing board or agency, and/or Disciplinary Action, up to and including termination of employment:

1. The consumption of alcohol on KDHCD property or while on duty is prohibited. There may be occasions, removed from the usual work setting, at which it is permissible to consume alcohol in moderation, on KDHCD property or at KDHCD sanctioned events authorized by the Chief Executive Officer or designee.

2. Off-duty abuse of alcohol which adversely affects an employee's job performance or adversely affects or threatens to adversely affect other interests of KDHCD is prohibited.

3. The personal possession (i.e., on the person, or in a desk, or locker) of alcohol on KDHCD property or on duty is prohibited.

4. The possession of alcohol in a personal vehicle while on duty or a KDHCD-assigned vehicle is prohibited.

5. Employees arrested for an alcohol-related incident must immediately notify their department management and Human Resources of the arrest if the incident occurs in any of the following circumstances:

   a) During scheduled working hours; or
   b) While operating a KDHCD vehicle on KDHCD or personal business, or
   c) While operating a personal vehicle on KDHCD business.

DRUG USE PROHIBITIONS:

Violation of any of the following will result in reporting the employee or individual to ~~a licensing board~~ certain ~~or agency, law enforcement~~ agencies as appropriate, and/or Disciplinary Action, up to and including termination of employment. This applies if the employee or individual quits or leaves their assignment. ~~–~~The Director of Pharmacy or designee will determine the necessity of reporting to Drug Enforcement Agencies, the California Board of Pharmacy and police. Human Resources will report to the employee's licensing or certifying Board as necessary. The Risk Management department will report to the California Department of Public Health or law enforcement as appropriate.

1. The unlawful use, sale, purchase, possession, manufacture, distribution, or dispensation of any drug or un-prescribed controlled substance on property or during work time is against policy.

2. It is also against policy to report to work or work if a prescription or non-prescription medication may adversely affect the employee's ability to perform his/her normal job duties.

3. Prescription drugs or non-prescription drugs may also affect the safety of the employee or fellow employees or members of the public. Therefore, any employee who is taking any prescription or, non-prescription drug which might

impair safety, performance, or any motor, cognitive functions must advise his/her supervisor or department head before reporting to work under such medication. Employees will not be required to identify such medications or the underlying illnesses. If KDHCD determines that such use does not pose a safety risk, the employee will be permitted to work.

TESTING:

1. Testing of Applicants

    a. All applicants considered final candidates for a position will be tested for the presence of illegal or un-prescribed drugs as a part of the application process;

    b. Any job applicant who refuses to submit to drug or alcohol testing, refuses to sign the consent form, fails to appear for testing, tampers with the test, or fails to pass the post-offer employment drug test will be ineligible for hire and any job offer will be rescinded.

2. Testing of Current Employees

    a. Employees must submit to a drug test if reasonable suspicion exists to indicate that their ability to perform work safely or effectively may be impaired. Reasonable suspicion testing means drug testing based on a belief that an employee is using or has used drugs in violation of KDHCD policy. Among other things, such facts and inferences may be based upon:

        1) Direct observation of drug use or physical symptoms or manifestations of being under the influence of a drug.
        2) Abnormal conduct or erratic behavior while at work or a significant deterioration in work performance.
        3) A report of drug use, provided by a reliable and credible source.
        4) Evidence that an individual has tampered with a drug test during his/her employment with KDHCD.
        5) Information that an employee has caused or contributed to, or been involved in an accident while at work.
        6) Evidence that an employee has used, possessed, sold, solicited, or transferred drugs while working or while on KDHCD's premises or while operating KDHCD's vehicles, machinery or equipment.
        7) Audit findings or charting issues.

3. Actions to be taken by Management

    There may be instances where supervisors/managers have reasonable cause to believe that an employee has consumed drugs on KDHCD's premises or reported to work under the influence of one or both. In these instances, management may request a drug test from the employee. If management has reason to consider requiring a drug or alcohol test, use the following process:

    a. Escort the employee personally to your office or other private area. Have another supervisor/ manager present as a witness.

b. Discuss with the employee your reasons for suspecting drug and/or alcohol policy violations, including audit findings and charting issues if applicable. From your conversation with the employee, determine whether or not you believe the employee has either consumed drugs or alcohol on KDHCD's premises or during work duty or is under the influence of either, or is diverting drugs.

c. If you conclude the employee does not appear to be under the influence of alcohol or drugs, including controlled substances and prescription drugs, and the employee is able to perform regular work duties, have him/her return to the work unit and resume work. Please document incident and notify Human Resources.

d. If you believe that the employee is under the influence of or has consumed drugs and/or alcohol on KDHCD's premises or during work duty, report this to Human Resources or the House Supervisor. The employee will be advised that the policy may have been violated and that he/she is being requested to provide blood sample for testing. Provide a copy of this Policy and the Consent to Submit to Drug and Alcohol testing.

e. Upon signing the Consent Form, if the employee is able, the employee is to be escorted to Employee Health Services to provide a sample. If the employee refuses to sign the consent or provide a sample, he/she will be subject to Disciplinary Action up to and including termination of employment.

f. If you believe the employee is impaired, make arrangements to have the employee taken home or contact a cab company, which will be paid for by KDHCD. Do not permit him/her to leave the premises or to drive alone. If the employee refuses any assistance, make sure the witnessing supervisor can verify that the employee refused such assistance.

g. If the employee cannot control his/her actions and departs without assistance, call the local police or law enforcement agency immediately to inform them of the employee's condition and refusal of assistance. Tell the law enforcement agency the employee's name, and a description of the vehicle, including the license number.

DRUG-FREE CONTRACT AND FOLLOW-UP TESTING:

As a condition of employment and/or continued employment, participants in a rehabilitation program for drug and/or alcohol abuse must consent in writing via a KDHCD Drug-Free Contract to periodic unannounced testing for a period of up to two (2) years after returning to work. An employee who has a positive, confirmed test is subject to Disciplinary Action, up to and including termination of employment.

1. Additional Testing
   Additional testing may also be conducted as required by applicable State or Federal laws, rules, or regulations or as deemed necessary by KDHCD, such as post-accident or injury testing.

2. Refusal to Test
   Employees who refuse to submit to a drug and/or alcohol test are subject to Disciplinary Action, up to and including termination from employment.

TESTING PROCEDURE:

1. Job applicants and all employees will be provided with the Drug Free Work Place and Drug Testing Policy and must sign both the Employee Acknowledgment of Receipt and Understanding and Consent to Submit to Drug and/or Alcohol Testing.

2. Urine and/or blood samples will be used for the initial test and confirmation for all drugs and alcohol. Samples will be analyzed by a qualified laboratory selected by KDHCD.

3. A specimen for a drug test will be taken or collected by:

4. Testing Laboratory

   a. The laboratory used to analyze initial or confirmation drug specimens will be licensed to perform such tests.

   b. All laboratory security, chain of custody, transporting and receiving of specimens, specimen processing, retesting, storage or specimens, instrument calibration and reporting of results will be in accordance with State and Federal laws.

   c. The laboratory will provide technical assistance to the employee or job applicant or Medical Review Office ("MRO") for the purpose of interpreting any positive confirmed test results.

5. Applicants and employees will be given an opportunity via the testing laboratory and a Medical Review Office (MRO) prior to and after testing to provide any information they consider relevant to the test including listing all drugs they have taken recently, including prescribed drugs, to explain the circumstances of the use of those drugs in writing or other relevant medical information.

6. An employee injured at the workplace and required to be tested will be taken for immediate treatment of injury. If the employee is not at a designated collection site, the employee will be transported to one as soon as it is medically feasible and specimens will be obtained. If it is not medically feasible to move the injured employee, specimens will be obtained at the treating facility under the procedures set forth in this policy.

7. KDHCD will pay the cost of initial and confirmation drug tests required of employees and job applicants. An employee or job applicant will pay the cost of any additional drug tests not required by KDHCD.

TEST RESULTS:

1. Reporting Results

   a. The laboratory will report positive test results to the Medical Review Officer (MRO) results will be reported to the Employee Health Nurse. The MRO may request the laboratory to provide quantification of test results.

   b. The laboratory will report as negative all specimens which are negative on the initial test or negative on the confirmation test; results will be reported to the Employee Health Nurse.

   c. The laboratory will transmit results in a manner designed to ensure confidentiality of the information. The laboratory and MRO will ensure the security of the data transmission and restrict access to any data transmission, storage and retrieval system.

2. Medical Review Officer (MRO)

   a. Prior to the transmittal of the positive test results to KDHCD, the test results shall be reviewed and verified by a MRO. The MRO shall be a licensed physician, under contract with KDHCD, with knowledge of substance abuse disorders, medical use of prescription drugs and pharmacology and toxicology of illicit drugs.

   b. The MRO shall follow all of the requirements set forth in applicable State and Federal regulations. The MRO shall evaluate the drug test result(s), verify the chain of custody forms and ensure that the donor's identification number on the laboratory report and the chain of custody form accurately identifies the individual.

   c. The MRO shall notify the employee or the job applicant of a confirmed positive test result within three (3) days of receipt of the test result from the laboratory and inquire as to whether prescriptive or over-the-counter medications could have caused the positive test result. Within five (5) days of notification to the donor of the positive test result, the MRO shall provide an opportunity for the employee or job applicant to discuss the positive test result and to submit documentation of any prescriptions relative to the positive test result.

   d. The MRO shall properly identify the employee or job applicant, inform them that the MRO is an agent of KDHCD whose responsibility is to make a determination on test results and report them to KDHCD, inform them that medical information revealed during the MRO's inquiry will be kept confidential, unless the MRO believes the employee or job applicant is in a safety sensitive or special risk position with KDHCD.

   e. Additionally, the MRO shall outline the rights and procedures for a retest of the original specimen and process any employee or job applicant requests for retest of the original specimen within one hundred, eighty (180) days of notice of the positive test result in another licensed laboratory selected by the

employee or job applicant. The employee or job applicant requesting the additional test shall be required to pay for the cost of the retest, including handling and shipping expense. The MRO shall contact the original testing laboratory to initiate the retest.

f. Upon receipt of information and/or documentation from the employee or job applicant, the MRO shall review any medical records provided, authorized and/or released by the individual's physician, to determine if the positive test result was caused by a legally prescribed medication. The MRO shall inquire about over-the-counter medications which could have caused the positive test result. The donor shall be responsible for providing all necessary documentation (i.e., a doctor's report, signed prescription, etc.) within the five (5) day period after notification of the positive test result.

g. If the MRO determines that there is a legitimate medical explanation for the positive test result, the MRO shall report a negative test result to KDHCD.

h. If the MRO has any questions as to the accuracy or validity of a test result or has a concern regarding the scientific reliability of the sample, the MRO may request the individual to provide another sample. Once an MRO verifies a positive test result, the MRO may change verification of the result if the employee or job applicant presents information which documents that a serious illness, injury, or other circumstance unavoidably prevented them from contacting the MRO within the specified time frame and if they present information concerning a legitimate explanation for the positive test result.

i. If the MRO is unable to contact a positively tested donor within three (3) days of receipt of the test results from the laboratory, the MRO shall contact KDHCD and request that KDHCD direct the employee to contact the MRO as soon as possible. If the MRO has not been contacted by the employee or job applicant within two (2) days from the request of KDHCD, the MRO shall verify the report as positive.

j. If the employee or job applicant refuses to talk with the MRO regarding a positive test result, the MRO shall validate the result as a positive and annotate such refusal in the remarks section. If the employee or job applicant voluntarily admits to the use of the drug in question without proper prescription, the MRO shall advise them that a verified positive test result will be sent to KDHCD.

k. The MRO shall notify KDHCD in writing of the verified test result, negative, positive, or unsatisfactory and appropriately file chain of custody forms to KDHCD.

3. KDHCD Notification of Test Results

a. Within five (5) working days after receipt of a positive confirmed test result, KDHCD will attempt to inform the employee or job applicant in writing of such positive test results, the consequences of such results, and the options available to the employee or job applicant.

b. KDHCD will provide to the employee or job applicant a copy of the test results upon request.

c. For all tests based on reasonable suspicion, KDHCD will detail in writing the circumstances which formed the basis of the determination that reasonable suspicion existed to warrant the testing. A copy of the report will be given to the employee upon request. The original report will be kept confidential and retained by KDHCD.

4. Challenges to Test Results

   Within 5 (five) working days after receiving notice of a positive confirmed test result, the employee or job applicant may submit information to KDHCD explaining or contesting the test results. The employee or job applicant will be notified in writing if the explanation or challenge is unsatisfactory to KDHCD. The written notice will be given to the employee or job applicant, and will include why the employee's or job applicant's explanation is unsatisfactory, along with the report of positive confirmed test results. All such documentation will be kept confidential and will be retained by KDHCD.

5. Employee and Job Applicant Protection

   a. During the one hundred eighty (180) day period after written notification of a positive test result, the employee or job applicant will be permitted by KDHCD to have a portion of the specimen retested at the employee's or job applicant's expense. The retesting must be done at another State licensed laboratory. The second laboratory must test at equal or greater sensitivity for the drug in questions as the first laboratory. The first laboratory which performed the test for KDHCD will be responsible for the transfer of the portion of the specimen to be retested, and for the integrity of the chain of custody for such transfer.

   b. KDHCD will not request or receive from the testing facility any information concerning the personal health, habit or condition of the employee or job applicant.

   c. KDHCD will not discharge, discipline, refuse to hire, discriminate against, or request or require rehabilitation of an employee or job applicant on the sole basis of a positive test result that has not been verified by a confirmation test.

   d. KDHCD will not discharge, discipline, or discriminate against an employee solely upon the employee's voluntarily seeking treatment, while under the employ of KDHCD.

INVESTIGATION:

1. To ensure that illegal drugs and alcohol do not enter or affect the workplace, KDHCD reserves the right to search all vehicles, containers, lockers, or other items on KDHCD property in furtherance of the policy. Individuals may be requested to display personal property for visual inspection upon KDHCD request. Searches will be conducted only where KDHCD has reason to believe that the employee has violated KDHCD's policy.

2. Failure to consent to a search or display of personal property for visual inspection will be grounds for Disciplinary Action up to and including termination of employment or denial of access to KDHCD property.

3. Searches of an employee's personal property (purses, pockets, etc.) will take place only in the employee's presence, to the extent possible. All searches under

this policy will occur with the utmost discretion and consideration for the employee involved.

3.4. In the course of the investigation, the patient care or work the employee or individual was assigned to will be reviewed and audited, including patient record audits if applicable. In addition, the Pharmacy will conduct a review of patient drug utilization trends if applicable to the position of the employee or individual.

4.5. Because the primary concern is the safety of its employees and their working environment, KDHCD will not normally prosecute in matters involving illegal substances. However, KDHCD may turn over all confiscated drugs to the proper law enforcement authorities. Further, KDHCD reserves the right to cooperate with or enlist the services of proper law enforcement authorities in the course of any investigation subject to the confidentiality requirements in the statutes and regulations.

5.6. An Employee may be placed on Administrative Leave pending the results of the investigation.

ARREST OR CONVICTION FOR DRUG-RELATED CRIME:

1. If an employee is arrested for or convicted of a drug-related crime, KDHCD will investigate all of the circumstances, and KDHCD may utilize the drug-testing procedure if cause is established by the investigation. In most cases, an arrest for a drug-related crime constitutes reasonable suspicion of drug use under this policy. The following procedure will apply:

    a. During investigation, an employee may be placed on leave. When the investigation is complete, the leave may be converted to a suspension or the employee may be reinstated depending upon the facts and circumstances.

    b. If convicted of a drug-related crime, an employee will be terminated.

    c. Because of the seriousness of such situations, KDHCD reserves the right to alter or change its policy or decisions on a given situation depending upon its investigation and the totality of the circumstances.

2. As a condition of employment, an employee will notify Human Resources in writing of any criminal drug conviction, including manufacturing, distributing, dispensing, possessing, or using controlled substances. The employee must give notice to KDHCD within five (5) calendar days of the conviction.

CONFIDENTIALITY:

All information, interview, reports, statement memoranda and drug test results, written or otherwise, received by KDHCD as part of this drug testing program are confidential communications. Unless authorized by State laws, rules or regulations, KDHCD will not release such information.

Formatted: Strikethrough

Formatted: No bullets or numbering, Tab stops: Not at 0.5"

"Responsibility for the review and revision of this Policy is assigned to the Vice President of Human Resources. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Delta 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 Delta Policies and Procedures."
~~"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."~~

Kaweah Delta Health Care District Bylaws

Article I The District and Its Mission

Section 1 Kaweah Delta Health Care District dba Kaweah Health is a community venture, operating under the authority granted through the California Health and Safety Code as a health care district. The purpose of the District is to provide quality health care within defined areas of expertise. It is the intent of the District that no person shall be denied emergency admission or emergency treatment based upon ability to pay. It is further the intent of the District that no person shall be denied admission or treatment based upon race, color, national origin, ethnic, economic, religious or age status or on the basis of sexual preference. The medical welfare of the community and its particular health needs will be fulfilled to the capacity of the District's financial limitations.

Section 2 Kaweah Delta Health Care District operates under the authority of California Code for a health care district. {California Health & Safety Code – Division 23 – Hospital Districts – Sections 32000-32492} As such, Kaweah Delta Health Care District is publicly owned and operates as a non-profit entity.

Section 3 As permitted by law, the District may, by resolution of the Board, conduct any election by all-mailed ballots pursuant to Division 4 (commencing with Section 4,000) of the California Elections Code.

Section 4 The Mission of Kaweah Delta Health Care District is; Health is our passion. Excellence is our focus. Compassion is our promise.

Section 5 The Vision of Kaweah Delta Health Care District is: To be your world-class healthcare choice, for life.

Section 6 The Pillars of Kaweah Delta Health Care District are:

1. Achieve outstanding community health
2. Deliver excellent service
3. Provide an ideal work environment
4. Empower through education
5. Maintain financial strength

Section 7 The mission, vision, and pillars of the District support the safety and quality of care, treatment, and service. {Joint Commission Standard LD.02.01.01}

Section 8 The Code of Conduct of Kaweah Delta Health Care District is a commitment to ethical and legal business practices, integrity, accountability, and excellence. The Code is a founding document of the Compliance Program, developed to express Kaweah Health's understanding and obligation to comply with all applicable laws and regulations. {Joint Commission Standard LD.04.01.01}

Article II The Governing Body

Section 1 The Governing Body of the Kaweah Delta Health Care District is a Board of Directors constituted by the five (5) publicly elected directors, who are elected by zone, each for four (4) year terms, with two (2) being elected on staggered terms and three (3) being elected two (2) years later on staggered terms. {Health and Safety Code 32100} The election of the directors is to conform with the applicable California Code. {Government Code 1780} This publicly elected Governing Body is responsible for the safety and quality of care, treatment, and services, establishes policy, promotes performance improvement, and provides for organizational management and planning {Joint Commission Standard LD.1.10}.

Section 2 The Governing Body, in accordance with applicable California Code, adopts the Bylaws of the organization.

Section 3 The principal office of Kaweah Delta Health Care District is located at Kaweah Health Medical Center - Acequia Wing, Executive Offices, 400 West Mineral King Avenue, Visalia, CA 93291. Correspondence to the Board should be addressed to the Board of Directors at this address. Kaweah Health also maintains a Web site at www.kaweahhealth.org. All noticed meeting agendas and supporting materials for Board meetings and Board committee meetings can be obtained at **www.kaweahhealth.org/About-Us/Board-of-Directors**.

Section 4 The duties and the responsibilities of the Governing Body are:

PRIMARY RESPONSIBILITY - This Board's primary responsibility is to develop and follow the organization's mission statement, which leads to the development of specific policies in the four key areas of:

A. Quality Performance
B. Financial Performance
C. Planning Performance
D. Management Performance

The Board accomplishes the above by adopting specific outcome targets to measure the organization's performance. To accomplish this, the Board must:

1) Establish policy guidelines and criteria for implementation of the mission. The Board also reviews the mission statements of any subsidiary units to ensure that they are consistent with the overall mission.
2) Evaluate proposals brought to the Board to ensure that they are consistent with the mission statement. Monitor programs and activities of the hospital and subsidiaries to ensure mission consistency.
3) Periodically review, discuss, and if necessary, amend the mission statement to ensure its relevance.

A. QUALITY PERFORMANCE RESPONSIBILITIES - This Board has the final moral, legal, and regulatory responsibility for everything that goes on in the

organization, including the quality of services provided by all individuals who perform their duties in the organization's facilities or under Board sponsorship. To exercise this quality oversight responsibility, the Board must:

1) Understand and accept responsibility for the actions of all physicians, nurses, and other individuals who perform their duties in the organization's facilities.
2) Review and carefully discuss quality reports that provide comparative statistical data about services, and set measurable policy targets to ensure continual improvement in quality performance.
3) Carefully review recommendations of the Medical Staff regarding new physicians who wish to practice in the organization and be familiar with the termination and fair hearing policies.
4) Reappoint individuals to the Medical Staff using comparative outcome data to evaluate how they have performed since their last appointment.
5) Appoint physicians to governing body committees and seek physician participation in the governance process to assist the Board in its patient quality-assessment responsibilities.
6) Fully understand the Board's responsibilities and relationships with the Medical Staff and maintain effective mechanisms for communicating with them.
7) Regularly receive and discuss malpractice data reflecting the organization's experience and the experience of individual physicians who have been appointed to the Medical Staff.
8) Adopt a Performance Improvement Plan and Risk Management Plan for the District and provide for resources and support systems to ensure that the plans can be carried out.
9) Regularly receive and discuss data about the Medical Staff to assure that future staffing will be adequate in terms of ages, numbers, specialties, and other demographic characteristics.
10) Ensure that management reviews and assesses the attitudes and opinions of those who work in the organization to identify strengths, weaknesses, and opportunities for improvement.
11) Monitor programs and services to ensure that they comply with policies and standards relating to quality.
12) Take corrective action when appropriate and necessary to improve quality performance.

B. FINANCIAL PERFORMANCE RESPONSIBILITIES - This Board has the ultimate responsibility for the financial soundness of the organization. To accomplish this the Board must:

1) Annually review and approve the overall financial plans, budgets {Joint Commission Standard LD.04.01.03}, and policies for implementation of

those plans and budgets on a short and long-term basis. The plan must include and identify in detail the objective of, and the anticipated sources of financing for each anticipated capital expenditure:

2) Approve an annual audited financial statement prepared by a major accounting firm and presented directly to the Board of Directors.
3) Approve any specific expenditure in excess of $75,000, which is not included in the annual budget.
4) Approve financial policies, plans, programs, and standards to ensure preservation and enhancement of the organization's assets and resources.
5) Monitor actual performance against budget projections and review and adopt ethical financial policies and guidelines.
6) Review major capital plans proposed for the organization and its subsidiaries.

C. PLANNING PERFORMANCE RESPONSIBILITIES - The Board has the final responsibility for determining the future directions that the organization will take to meet the community's health needs. To fulfill this responsibility, the Board must:

1) Review and approve a comprehensive strategic plan and supportive policy statements.
2) Develop long term capital expenditure plans as a part of its long range strategic planning.
3) Determine whether or not the strategic plan is consistent with the mission statement.
4) Assess the extent to which plans meet the strategic goals and objectives that have been previously approved.
5) Periodically review, discuss, and amend the strategic plan to ensure its relevance for the community.
6) Regularly review progress towards meeting goals in the plan to assess the degree to which the organization is meeting its mission.
7) Annually meet with the leaders of the Medical Staff to review and analyze the health care services provided by Kaweah Health and to discuss long range planning for Kaweah Health.

D. MANAGEMENT PERFORMANCE RESPONSIBILITES - The Board is the final authority regarding oversight of management performance by our Chief Executive Officer, Chief Compliance Officer, and Director of Audit & Consulting and support staff. To exercise this authority, the Board must:

1) Oversee the recruitment, employment, and regular evaluations of the performance of the Chief Executive Officer, the Chief Compliance Officer, and the Director of Audit & Consulting.
2) Evaluate the performance of the CEO annually using goals and objectives agreed upon with the CEO at the beginning of the evaluation cycle. Provide input to and have final approval of the annual

evaluations of the Chief Compliance Officer, and the Director of Audit & Consulting.

3) Communicate regularly with the CEO, the Chief Compliance Officer and the Director of Audit & Consulting regarding goals, expectations, and concerns.

4) Periodically survey CEO, Chief Compliance Officer, and Director of Audit & Consulting employment arrangements at comparable organizations to assure the reasonableness and competitiveness of our compensation package.

5) Periodically review management succession plans to ensure leadership continuity.

6) Ensure the establishment of specific performance policies which provide the CEO, the Chief Compliance Officer, and the Director of Audit & Consulting with a clear understanding of what the Board expects, and ensure the update of these policies based on changing conditions.

E. The Board is also responsible for managing its own governance affairs in an efficient and successful way. To fulfill this responsibility, the Board must:

1) Evaluate Board performance bi-annually. Members of the governing body are elected by the public and, accordingly, are judged on their individual performance by the electorate.

2) Maintain written conflict-of-interest policies that include guidelines for the resolution of existing or apparent conflicts of interest. {Board of Directors policy BOD.05 – Conflict of Interest}

3) Participate both as a Board and individually in orientation programs and continuing education programs both within the organization and externally. As such, the District shall reimburse reasonable expenses for both in-state and out-of-state travel for such educational purposes. {Board Of Directors policy BOD.06 – Board Reimbursement for Travel and Service Clubs} {Health and Safety Code 32103}

4) Periodically review Board structure to assess appropriateness of size, diversity, committees, tenure, and turnover of officers and chairpersons.

5) Assure that each Board member understands and agrees to maintain confidentiality with regard to information discussed by the Board and its committees.

6) Assure that each Board member understands and agrees to adhere to the Brown Act ensuring that Board actions be taken openly, as required, and that deliberations be conducted openly, as required.

7) Adopt, amend, and, if necessary, repeal the articles and bylaws of the organization.

8) Maintain an up-to-date Board policy manual, which includes specific policies covering oversight responsibilities in the area of quality

performance, financial performance, strategic planning performance, and management performance.

9) Review Kaweah Health's Mission, Vision & Pillar statements every two years.

Section 5 The Board of Directors of the Kaweah Delta Health Care District shall hold regular meetings at a meeting place on the premises of the Kaweah Delta Health Care District on the fourth Monday of each month, as determined by the Board of Directors each month. {Health and Safety Code 32104}

The Board of Directors of the Kaweah Delta Health Care District may hold a special meeting of the Board of Directors as called by the President of the Board or in his/her absence the Vice President. In the absence of these officers of the Board a special meeting may be called by a majority of the members of the Board. A special meeting requires a 24-hour notice before the time of the meeting. {Government Code 54956}

Meetings of the Board of Directors shall be noticed and held in compliance with the applicable California Code for Health Care Districts. {The Ralph M. Brown Act - Government Code 54950}

Sections 32100.2 and 32106 of the Health and Safety Code of the State of California, as amended, indicate the attendance and quorum requirements for members of the Board of Directors of any health care district in the State of California. For general business the Board may operate under the rules of a small committee, however, upon the request of any member of the Governing Body immediate implementation of the Standard Code of Parliamentary Procedure (Roberts Rules of Order) shall be adopted for the procedure of that meeting.

Section 6 The President of the Board of Directors shall appoint the committees of the Board and shall appoint the Chairperson and designate the term of office in a consistent and systematic approach. All committees of the Governing Body shall have no more than two (2) members of the Governing Body upon the committee and both Board members shall be present prior to the Board committee meeting being called to order. All committees of the Governing Body shall serve as extensions of the Governing Body and report back to the Governing Body for action. Minutes of all committee meetings shall be distributed to all members of the Governing Body in such fashion that discussion and recommendations to the Governing Body are clearly presented.

The President of the Board of Directors may appoint, with concurrence of the Board of Directors, any special committees needed to perform special tasks and functions for the District.

Any special committee shall limit its activities to the task for which it was appointed, and shall have no power to act, except as specifically conferred by action of the Board of Directors.

The Chief of Staff shall be notified and shall facilitate Medical Staff participation in any Governing Board Committee that deliberates the discharge of Medical Staff responsibility.

The standing committees of the Governing Body are:

A. Academic Development

The members of this committee shall consist of two (2) Board members, Chief Executive Officer (CEO), Vice President of Medical Education, Director of Graduate Medical Education, Director of Pharmacy, and any other members designated by the Board President.

This committee will provide Board direction and leadership for the Graduate Medical Education Program, the Pharmacy Residency Program, and achievement of Kaweah Health's foundational Pillar "Empower through Education".

B. Audit and Compliance

The members of this committee shall consist of two (2) Board members (Board President or Secretary/Treasurer shall be a standing member of this committee), CEO, Chief Financial Officer (CFO),, Director of Audit & Consulting, Chief Compliance Officer, Compliance Specialist, legal counsel, and any other members designated by the Board President. The Committee will engage an outside auditor, meet with them pre audit and post audit, and review the audit log of the internal auditor. The Committee will examine and report on the manner in which management ensures and monitors the adequacy of the nature, extent and effectiveness of compliance, accounting and internal control systems. The Committee shall oversee the work of those involved in the financial reporting process including the internal auditors and the outside auditors, to endorse the processes and safeguards employed by each. The Committee will encourage procedures and practices that promote accountability among management, ensuring that it properly develops and adheres to a compliant and sound system of internal controls, that the internal auditor objectively assesses management's accounting practices and internal controls, and that the outside auditors, through their own review, assess management and the internal auditor's practices. This committee shall supervise all of the compliance activities of the District, ensuring that Compliance and Internal Audit departments effectively facilitate the prevention, detection and correction of violations of law, regulations, and/or District policies. The Chief Compliance Officer will review and forward to the full Board a written Quarterly Compliance Report.

This committee, on behalf of the Board of Directors, shall be responsible for overseeing the recruitment, employment, evaluation and dismissal of the Chief Compliance Officer and the Director of Audit & Consulting. These responsibilities shall be performed primarily by the CEO and/or the CEO's designees, but final decisions on such matters shall rest with this committee, acting on behalf of the full Board.

C. Community-Based Planning

The members of this committee shall consist of two (2) Board members {Board President or Secretary/Treasurer shall be a standing member of this committee}, CEO, Facilities Planning Director and any other members designated by the Board President as they deem appropriate to the topic(s) being considered: community leaders including but not limited to City leadership, Visalia Unified School District (VUSD) leadership, College Of the Sequoias leadership, County Board of Supervisors, etc.

The membership of this committee shall meet with other community representatives to develop appropriate mechanisms to provide for efficient implementation of current and future planning of the organization's facilities and services and to achieve mutual goals and objectives.

D. Finance / Property, Services & Acquisitions

The members of this committee shall consist of two (2) Board members - (Board President or Secretary/Treasurer will be a standing member of this committee), CEO, CFO, , Chief Strategy Officer, Facilities Planning Director, and any other members designated by the Board President.

This committee will oversee the financial health of the District through careful planning, allocation and management of the District's financial resources and performance. To oversee the construction, improvement, and maintenance of District property as well as the acquisition and sale of property which is essential for the Health Care District to carry out its mission of providing high-quality, customer-oriented, and financially-strong healthcare services.

E. Governance & Legislative Affairs

The members of this committee shall consist of two (2) Board members {Board President or the Board Secretary/Treasurer}, CEO and any other members designated by the Board President. Committee activities will include: reviewing Board committee structure, calendar, bylaws and, planning the bi-annual Board self-evaluation, and monitor conflict of interest. Legislative activities will include: establishing the legislative program scope & direction for the District, annually review appropriation request to be submitted by the District, effectively communicating and maintaining collegial relationships with local, state, and nationally elected officials.

F. Human Resources

The members of this committee shall consist of two (2) Board members, CEO, Chief Human Resources Officer, Chief Nursing Officer (CNO) and any other members designated by the Board President. This committee shall review and approve all personnel policies. This committee shall annually review and recommend changes to the Salary and Benefits Program, the Safety Program and the Workers' Compensation Program.

This committee will annually review the workers compensation report, competency report & organizational development report.

G. Information Systems

The members of this committee shall consist of two (2) Board members, CEO, CFO, CNO, Chief Information Officer (CIO), Medical Director of Informatics, and any other members designated by the Board President. This committee shall supervise the Information Systems projects of the District.

H. Marketing and Community Relations

The members of this committee shall consist of two (2) Board members and CEO, Chief Strategy Officer, Marketing Director, and any other members designated by the Board President.

This committee shall oversee marketing and community relations activities in the District in order to increase the community's awareness of available services and to improve engagement with the population we serve. Additionally, create a brand that builds preference for Kaweah Health in the minds of consumers and creates a public image that instills trust, confidence, and is emblematic of Kaweah Health's mission and our vision to become "world-class". Further develops and fosters a positive perception that will attract the highest caliber of employees and medical staff

I. Patient Experience

The members of this committee shall consist of two (2) Board members and Chief Human Resources Officer, Director of Patient Experience, Director of Emergency Services, and any other members designated by the Board President.

This committee will work with the patient experience team and leadership to develop a patient experience strategy to ensure that patient experiences are meeting the Mission and Vision of Kaweah Health and its foundational Pillar "Deliver excellent service".

J. Quality Council

The members of this committee shall consist of two (2) Board members, CEO or designate, , CNO, Chief Quality Officer, Chief of the Medical Staff, chair of the Professional Staff Quality Committee (Prostaff), Medical Directors of Quality and Patient Safety, Director of Quality and Patient Safety, Director of Risk Management, and members of the Medical Staff as designated by the Board.

This committee shall review and recommend approval of the annual Quality Improvement (QI) plan and Patient Safety plans to the Board of Directors, determine priorities for improvement, monitor key outcomes related to Quality Focus Team activities, evaluate clinical quality, patient safety, and patient satisfaction, monitor and review risk management activities and outcomes, evaluate the effectiveness of the performance improvement program, foster commitment and collaboration between

the District and Medical Staff for continuous improvement, and review all relevant matters related to Quality within the institution, including Performance Improvement, Peer Review, Credentialing/Privileging and Risk Management..

K. Strategic Planning

The members of this committee shall consist of two (2) Board members, CEO, Chief Strategy Officer, other Executive Team members, Medical Staff Officers, Immediate past Chief of Staff along with other members of the Medical Staff as designated by the Board and the CEO.

This committee shall review the budget plan, review the strategic plan and organize objectives, review changes or additions to service lines.

The Strategic Planning Committee will provide oversight and forward to the full Board the following reports:

1. Review of the Strategic Plan Annually
2. Strategic Plan initiatives progress and follow-up bi-monthly to full Board.

L. Independent Committees

The following independent committees may have Board member participation.

1. Cypress Company, LLC
2. Graduate Medical Education Committee (GMEC)
3. Joint Conference
4. Kaweah Health Medical Group
5. Kaweah Health Hospital Foundation
6. Quail Park {All entities}
7. Retirement Plans' Investment Committee
8. Sequoia Integrated Health, LLC
9. Sequoia Surgery Center, LLC
10. Sequoia Regional Cancer Center – Medical & Radiation, LLC
11. Tulare Kings Cancer (TKC) Development, LLC
    - The Board President shall serve as General Manager for TKC Development, LLC.
12. 202 W. Willow – Board of Owners
13. Central Valley Health Care Alliance - JPA

M. Medical Affairs

1) A member of the Board, as appointed by the President, shall also serve on the following Medical Staff Committees:
   a) Joint Conference Committee - This committee shall regularly meet to discuss current issues/concerns with Medical Staff, Board, and Administration.
   b) Credentials Committee - The Board shall participate in this committee to observe the Medical Staff process.

Section 7 The Governing Body Bylaws:

The Governing Body Bylaws and any changes thereto may be adopted at any regular or special meeting by a legally constituted quorum of the Governing Body. All portions of Governing Body Bylaws must be in compliance with applicable California Code, which is the ruling authority.

Any member of the Governing Body may request a review for possible revision of the Bylaws of the organization.

The Chief Executive Officer and the Governing Body shall review the Bylaws and recommend appropriate changes every year.

Section 8 Members of the Governing Body shall annually sign a job description which outlines the duties and responsibilities of the Governing Body members including but not limited to adherence to the Board conflict of interest policy {Board of Directors policy - BOD5 – Conflict of Interest}, confidentiality, and the Brown Act.

Section 9 Members of the Governing Body are publicly elected. The members of the Governing Body are expected to participate actively in the functions of the Governing Body and its committees and to serve the constituency who elected them. Notwithstanding any other provision of law, the term of any member of the board of directors shall expire if he or she is absent from three consecutive regular meetings, or from three of any five consecutive meetings of the board and the board by resolution declares that a vacancy exists on the board. {Health and Safety Code 32100.2}

Section 10 The Chief Executive Officer shall provide an orientation program to all newly elected members of the Governing Body. {Board of Directors policy – BOD1 – Orientation of a New Board Member} All members of the Board of Directors shall be provided with current copies of the District Bylaws and the Medical Staff Bylaws and any revisions of these Bylaws.

Section 11 All members of the Governing Body shall be provided with a copy of the Bylaws which govern the Board of Directors, a job description for the District Governing Body and the Board President or Individual Board Member as applicable.

Article III Officers of the Board

Section 1 The offices of President, Vice President, and Secretary/Treasurer shall be selected at the first regular meeting in December of a non-election year of the District. To hold the office of President, Vice President, or Secretary/Treasurer, a Board member must have at least one year of service on the Board of Directors. These officers shall hold office for a period of two (2) years or until the successors have been duly elected (or in the case of an unfulfilled term, appointed) and qualified. The officer positions shall be by election of the Board itself.

Section 2 The duties and responsibilities of the Governing Body President are:

A. Keep the mission of the organization at the forefront and articulates it as the basis for all Board action.

B. Understand and communicate the roles and functions of the Board, committees, Medical Staff, and management.

C. Understand and communicate individual Board member, Board leader, and committee chair responsibilities and accountability.

D. Act as a liaison between the Board, management, and Medical Staff.

E. Plan agendas.

F. Preside over the meetings of the Board.

G. Preside over or attend other Board, Medical Staff, and other organization meetings.

H. Enforce Board and hospital bylaws, rules, and regulations (such as conflict of interest and confidentiality policies).

I. Appoint Board committee chairs and members in a consistent and systematic approach.

J. Act as a liaison between and among other Boards in the healthcare system.

K. Direct the committees of the Board, ensuring that the committee work plans flow from and support the hospital and Board goals, objectives, and work plans.

L. Provide orientation for new Board members and arrange continuing education for the Board.

M. Ensure effective Board self-evaluation.

N. Build cohesion among the leadership team of the Board President, CEO, and Medical Staff leaders.

O. Lead the CEO performance objective and evaluation process.

Section 3 The duties and responsibilities of the Governing Body Vice President are:

A. The Vice President shall act as President in the absence of the President or the Secretary/Treasurer in the absence of the Secretary/Treasurer, and so acting shall have all the responsibility and authority of that position.

Section 4 The Secretary/Treasurer shall act as the Secretary for the Board of Directors of Kaweah Delta Health Care District and in so doing shall:

A. maintain minutes of all meetings of the Board of Directors;

B. be responsible for the custody of all records and for maintaining records of the meetings;

C. be assured that an agenda is prepared for all meetings.

Section 5 The Secretary/Treasurer shall be custodian of all funds of Kaweah Delta Health Care District as well as the health care facilities operated by the District. The Secretary/Treasurer shall assure that administration is using proper accounting systems; that this is a true and accurate accounting of the transactions of the District; that these transactions are recorded and accurate reports are regularly reported to the Board of Directors. The Secretary/Treasurer in conjunction with the Board Audit and Compliance Committee shall see that a major accounting firm provides ongoing overview and scrutiny of the fiscal aspects of the District, and shall further assure that an annual audit is prepared by a major accounting firm and presented directly to the Board of Directors.

Article IV The Medical Staff

Section 1 The Governing Body shall appoint the Medical Staff composed of licensed physicians, surgeons, dentists, podiatrists, clinical psychologists, and all Allied Health Practitioners (including Physician Assistants, Nurse Practitioners and Nurse Midwives) duly licensed by the State of California. {Health and Safety Code of the State of California, Section 32128} The Governing Body, upon consideration of the recommendations of the Medical Staff coming from the Medical Executive Committee, through the Credentials Committee, affirms or denies appointment and privileges to the Medical Staff of Kaweah Delta Health Care District in accordance with the procedure for appointment and reappointment of medical staff as provided by the standards of the Joint Commission on Accreditation of Healthcare Organizations. {Joint Commission Standard MS.01.01.01} The Board of Directors shall reappoint members to the Medical Staff every two (2) years, as set forth in the Medical Staff Bylaws. The Governing Body requires that an organized Medical Staff is established within the District and that the Medical Staff submits their Bylaws, Rules and Regulations and any changes thereto, to the Governing Body for approval.

Section 2 Members of the Medical Staff are eligible to run in public election for membership on the Governing Body in the same manner as other individuals.

Section 3 All public meetings of the Governing Body may be attended by members of the Medical Staff. The Chief of Staff of Kaweah Delta Health Care District shall be notified and invited to each regular monthly meeting of the Governing Body and the Chief of Staff's input shall be solicited with respect to matters affecting the Medical Staff.

Section 4 The Chief of Staff of Kaweah Delta Health Care District shall be invited to all meetings of the Governing Body at which credentialing decisions are made concerning any member of the Medical Staff of Kaweah Health Medical Center or at which quality assurance reports are given concerning the provision of patient care at Kaweah Health Medical Center. Quality assurance reports shall be made to the Board periodically. Credentialing decisions shall be scheduled on an as-needed basis. The Chief of Staff shall be encouraged to advise the Board on the content and the quality of the presentations, and to make

recommendations concerning policies and procedures, the improvement of patient care and/or the provision of new services by the District.

Annually, the Governing Body shall meet with leaders of the Medical Staff to review and analyze the health care services provided by the District and to discuss long range planning as noted in Article II, Section 4, Item C7.

Section 5 **The District has an organized Medical Staff that is accountable to the Governing Body. {Joint Commission Standard LD.01.05.01}** The organized Medical Staff Executive Committee shall make recommendations directly to the Governing Body for its approval. Such recommendations shall pertain to the following:

A. the structure of the Medical Staff;
B. the mechanism used to review credentials and delineate clinical privileges;
C. individual Medical Staff membership;
D. specific clinical privileges for each eligible individual;
E. the organization of the performance improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate, and revise such activities;
F. the mechanism by which membership on the Medical Staff may be terminated;
G. the mechanism for fair hearing procedures.

Section 6 The Governing Body shall act upon recommendations concerning Medical Staff appointments, re-appointments, termination of appointments, and the granting or revision of clinical privileges within 120 days following the regular monthly meeting of the Governing Body at which the recommendations are presented through the Executive Committee of the organized Medical Staff.

Section 7 The Governing Body requires that only a member of the organized Medical Staff with admitting privileges at Kaweah Health Medical Center may admit a patient to Kaweah Health Medical Center and that such individuals may practice only within the scope of the privileges granted by the Governing Body and that each patient's general medical condition is the responsibility of a qualified physician of the Medical Staff.

Section 8 The Governing Body requires that members of the organized Medical Staff and all Allied Health Practitioners (including Physician Assistants, Nurse Practitioners and Nurse Midwives) maintain current professional liability insurance with approved carriers and in the amounts of $1,000,000/$3,000,000 (per occurrence / annual aggregate) or such other amounts as may be established by the Governing Body by resolution.

Section 9 The Governing Body holds the Medical Staff responsible for the development, adoption, and annual review of its own Medical Staff Bylaws, Rules and Regulations that are consistent with Kaweah Health policy, applicable codes, and other regulatory requirements. Neither the Medical Staff nor The Governing

Body may make unilateral amendments to the Medical Staff Bylaws or the Medical Staff Rules and Regulations.

The Medical Staff Bylaws and the Rules and Regulations adopted by the Medical Staff, and any amendments thereto, are subject to, and effective upon, approval of the Governing Body, such approval not to be unreasonably withheld.

Section 10 The Medical Staff is responsible for establishing the mechanism for the selection of the Medical Staff Officers, Medical Staff Department Chairpersons, and Medical Staff Committee Chairpersons.

This mechanism will be included in the Medical Staff Bylaws.

Section 11 The Governing Body requires the Medical Staff and the Management to review and revise all department policies and procedures as often as needed. Such policies and procedures must be reviewed at least every three (3) years.

In adherence with Title 22, {70203} Policies relative to medical service {those preventative, diagnostic and therapeutic measures performed by or at the request of members of the organized medical staff} shall be approved by the governing body as recommended by the Medical Staff.

In adherence with Title 22, {70213} Nursing Service Policies for patient care shall be developed, maintained and implemented by nursing services; policies which involve the Medical Staff shall be reviewed and approved by the Medical Staff prior to implementation.

Section 12 Individuals who provide patient care services (other than District staff members), but who are not subject to the Medical Staff privilege delineation process, shall submit their credentials to the Interdisciplinary Practice Committee of the Medical Staff which shall, via the Executive Committee, transmit its recommendations to the Governing Body for approval or disapproval.

Section 13 The quality of patient care services provided by individuals who are not subject to Medical Staff privilege delineation process, shall be included as a portion of the District's Performance Improvement program.

Section 14 The Governing Body specifies that under the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA), the Medical Staff and the District are in an Organized Health Care Arrangement (OHCA). The OHCA is a clinically integrated care setting in which individuals receive heath care from more than one provider and the providers hold themselves out to the public as participating in a joint arrangement. The Medical Staff is in an OHCA with the District for care provided at District facilities. This joint arrangement is disclosed to the patients in the Notice of Privacy Practices given to patients when they access care at any of the District's facilities.

Article V Joint Committees

Section 1 The President of the Governing Body or a member of the Board appointed by the President shall participate, along with the CEO, in the Joint Conference Committee, which is a committee of the Medical Staff. This committee shall serve as a systematic mechanism for communication between members of the Governing Body, Administration, and members of the Medical Staff. Specifically, issues which relate to quality of patient care shall be regularly addressed. Additionally, other matters of communication which are of importance to maintaining a sound working relationship between the Governing Body and the Medical Staff shall be discussed. These meetings shall be held at a minimum of every other month and minutes, if any, shall be kept by the organized Medical Staff under the direction of its President. The proceedings and records of this committee are protected by Section 1157 of the evidence Code.

Article VI Chief Executive Officer

Section 1 The Governing Body shall be solely responsible for appointment or dismissal of the Chief Executive Officer. {Board of Directors policy – BOD2 – Chief Executive Officer (CEO) Transition}

Section 2 The Governing Body shall assure that the Chief Executive Officer is qualified for their responsibilities through education and/or experience. {Board of Directors policy – BOD3 – Chief Executive Officer (CEO) Criteria}

Section 3 The Chief Executive Officer shall act on behalf of the Governing Body in the overall management of the District.

Section 4 In the absence of the Chief Executive Officer, a Vice President designated by the Chief Executive Officer or by the President of the Governing Body shall assume the responsibilities of this position. The Governing Body retains final authority to name the person to act during the absence or incapacity of the Chief Executive Officer.

Section 5 Annually the Governing Body shall meet in Executive session to monitor the performance of the Chief Executive Officer. The conclusions and recommendations from this performance evaluation will be transmitted to the Chief Executive Officer by the Governing Body.

Section 6 The Chief Executive Officer shall select, employ, control, and have authority to discharge any employee of the District other than any individual with the title or equivalent function of Vice President, Chief Compliance Officer, Director of Audit & Consulting, or Board Clerk. Employment of new personnel shall be subject to budget authorization granted by the Board of Directors.

Section 7 The Chief Executive Officer shall organize, and have the authority to reorganize the administrative structure of the District, below the level of CEO, subject to the limitations set forth in in Section 6 above. The District's organizational chart shall reflect that the Chief Compliance Officer, and the Director of Audit & Consulting have direct, solid-line reporting relationships to the Board (functional) and to the CEO (administrative).

Section 8 The Chief Executive Officer shall report to the Board at regular and special meetings all significant items of business of Kaweah Delta Health Care District and make recommendations concerning the disposition thereof. The Chief Executive Officer shall, directly and through the District's Vice Presidents, keep the Chief Compliance Officer, and the Director of Audit & Consulting well-informed of District operations and shall promptly inform them of any matter that may expose the District to a material legal, regulatory or financial liability.

Section 9 The Chief Executive Officer shall submit regularly, in cooperation with the appropriate committee of the Board, periodic reports as required by the Board.

Section 10 The Chief Executive Officer shall attend all meetings of the Board when possible and shall attend meetings of the various committees of the Board when so requested by the committee chairperson.

Section 11 The Chief Executive Officer shall serve as a liaison between the Board and the Medical Staff. The Chief Executive Officer shall cooperate with the Medical Staff and secure like cooperation on the part of all concerned with rendering professional service to the end that patients may receive the best possible care.

Section 12 The Chief Executive Officer shall make recommendations concerning the purchase of equipment and supplies and the provision of services by the District, considering the existing and developing needs of the community and the availability of financial and medical resources.

Section 13 The Chief Executive Officer shall keep abreast and be informed of new developments in the medical and administrative areas of hospital administration.

Section 14 The Chief Executive Officer shall oversee the physical plants and ground and keep them in a good state of repair, conferring with the appropriate committee of the Board in major matters, but carrying out routine repairs and maintenance without such consultation.

Section 15 The Chief Executive Officer shall supervise all business affairs such as the records of financial transactions, collections of accounts and purchase and issuance of supplies, and be certain that all funds are collected and expended to the best possible advantage.

Section 16 The Chief Executive Officer shall supervise the preservation of the permanent medical records of the District and act as overall custodian of these records.

Section 17 The Chief Executive Officer shall keep abreast of changes in applicable laws and regulations and shall insure that a District compliance program, appropriate educational programs, and organizational memberships are in place to carry out this responsibility.

Section 18 The Chief Executive Officer shall be responsible for assuring the organization's compliance with applicable licensure requirements, laws, rules, and regulations, and for promptly acting upon any reports and/or recommendations from authorized agencies, as applicable.

Section 19 The Chief Executive Officer will ensure that the business of the Health Care District is conducted openly and transparently, as required by law.

Section 20 The Chief Executive Officer will oversee the activities of the Health Care District's community relations committees to ensure meaningful participation of community members and communication of the input and recommendation from the committee to the Board and to organization's management.

Section 21 The Chief Executive Officer shall perform any special duties assigned or delegated to them by the Board.

Article VII The Health Care District Guild

Section 1 The Governing Body recognizes the Kaweah Delta Health Care District Guild in support of the staff and patients of the District.

Section 2 The Chief Executive Officer is charged with effecting proper integration of the Guild within the framework of the organization.

Article VIII Performance Improvement (PI)

Section 1 The Governing Body requires that the Medical Staff and the Health Care District staff implement and report on the activities and mechanisms for monitoring and evaluating the quality of patient care, for identifying and resolving problems, and for identifying opportunities to improve patient care within the District.

Section 2 The Governing Body, through the Chief Executive Officer, shall support these activities and mechanisms.

Section 3 The Governing Body shall adopt a Performance Improvement Plan and Risk Management Plan for the District and shall provide for resources and support systems to ensure that the plans can be carried out.

Section 4 The Governing Body requires that a complete and accurate medical record shall be prepared and maintained for each patient; that the medical record of the patient shall be the basis for the review and analysis of quality of care. The Governing Body holds the organized Medical Staff responsible for self-governance with respect to the professional work performed in the hospital and for periodic meetings of the Medical Staff to review and analyze at regular intervals their clinical experience. Results of such review will be reported to the Governing body at specific intervals defined by the Board.

Section 5 The quality assurance mechanisms within any of the District's facilities shall provide for monitoring of patient care processes to assure that patients with the same health problem are receiving the same level of care within the District.

Article IX Conflict of Interest

Section 1 The Administration Policy Manual of Kaweah Delta Health Care District and the Board of Directors Policy Manual has a written Conflict of Interest Policy {Administrative Policy AP23 and Board of Directors Policy BOD5}, which requires

the completion and filing of a Conflict of Interest Statement disclosing financial interests that may be materially affected by official actions and provides that designated staff members must disqualify themselves from acting in their official capacity when necessary in order to avoid a conflict of interest. The requirements of this policy are additional to the provisions of Government Code §87100 and other laws pertaining to conflict of interest; and nothing herein is intended to modify or abridge the provisions of the policies of Kaweah Delta Health Care District which apply to:

A. members of the Governing Body,
B. the executive staff,
C. employees who hold designated positions identified in Exhibit "A" of the District Conflict of Interest Code.

Section 2 Each member of the Governing Body, specified executives, and designated employees must file an annual Conflict of Interest Statement as required by California Government Code – Section 87300-87313.

Section 3 The Board shall assess the adequacy of its conflict-of-interest/confidentiality policies and procedures {Board of Directors Policy - BOD5 - and Administrative Policy 23 – Conflict of Interest} at least every two years.

Article X Indemnification of Directors, Officers, and Employees

Section 1 Actions other than by the District. The District shall have the power to indemnify any person who was or is a party, or is threatened to be made a party, to any proceeding (other than an action by or in the right of the District to procure a judgment in its favor) by reason of the fact that such person is or was a director, officer or employee of the District, against expenses, judgments, fines, settlements, and other amounts actually and reasonably incurred in connection with such proceeding if that person acted in good faith and in a manner that the person reasonably believed to be in the best interest of the District and, in the case of a criminal proceeding, had no reasonable cause to believe the conduct of that person was unlawful. The termination by any proceeding by judgment, order, settlement, conviction or upon a plea of nolo contendere or its equivalent, shall not, of itself, create a presumption that the person did not act in good faith and in the manner that the person reasonably believed to be in the best interests of the District person's conduct was unlawful.

Section 2 Actions by the District. The District shall have the power to indemnify any person who was or is a party, or is threatened to be made a party, to any threatened, pending, or completed action by or in the right of the District to procure a judgment in its favor by reason of the fact that such person is or was a director, officer, or employee of the District, against expenses actually and reasonably incurred by such person in connection with the defense or settlement of that action, if such person acted in good faith, in a manner such person believed to be in the best interest of the District and with such care,

including reasonable inquiry, as an ordinarily prudent person in a like position would use under a similar circumstance.

No indemnification shall be made under this Section:

A. with respect to any claim, issue or matter as to which such person has been adjudged to be liable to the District in their performance of such person's duty to the District, unless and only to the extent that the court in which that proceeding is or was pending shall determine upon application that, in view of all the circumstances of the case, such person is fairly and reasonably entitled to indemnity for the expenses which the court shall determine;

B. of amounts paid in settling or otherwise disposing of a threatened or pending action, with or without court approval;

C. of expenses incurred in defending a threatened or pending action that is settled or otherwise disposed of without court approval.

Section 3 Successful defense by director, officer, or employee. To the extent that a director, officer or employee of the District has been successful on the merits in defense of any proceeding referred to in Section 1 or Section 2 of this Article X, or in defense of any claim, issue or matter therein, the director, officer or employee shall be indemnified as against expenses actually and reasonably incurred by that person in connection therewith.

Section 4 Required approval. Except as provided in Section 3 of this Article, any indemnification under this Article shall be made by the District only if authorized in the specific case, upon a determination that indemnification of the officer, director or employee is proper in the circumstances because the person has met the applicable standard of conduct set forth in Sections 2 and 3 of this Article X, by one of the following:

A. a majority vote of a quorum consisting of directors who are not parties to the proceeding; or

B. the court in which the proceeding is or was pending, on application made by the District or the officer, director or employee, or the attorney or other person rendering services in connection with the defense, whether or not such other person is opposed by the District.

Section 5 Advance of expenses. Expenses incurred in defending any proceeding may be advanced by the District before the final disposition of the proceeding upon receipt of an undertaking by or on behalf of the officer, director or employee to repay the amount of the advance unless it shall be determined ultimately that the officer, director or employee is entitled to be indemnified as authorized in this Article.

Section 6 Other contractual rights. Nothing contained in this Article shall affect any right to indemnification to which persons other than directors and officers of this District may be entitled by contract or otherwise.

Section 7 Limitations. No indemnification or advance shall be made under this Article except as provided in Section 3 or Section 4, in any circumstance where it appears:

A. that it would be inconsistent with the provision of the Articles, a resolution of the Board, or an agreement in effect at the time of accrual of the alleged cause of action asserted in the proceeding in which the expenses were incurred or other amounts were paid, which prohibits or otherwise limits indemnification; or

B. that it would be inconsistent with any condition expressly imposed by a court in approving a settlement.

Section 8 Insurance. If so desired by the Board of Directors, the District may purchase and maintain insurance on behalf of any officer, director, employee or agent of the corporation, insuring against any liability asserted against or incurred by the director, officer, employee or agent in that capacity or arising out of the person's status as such, whether or not the District would have the power to indemnify the person against that liability under the provisions of this Article.

If any article, section, sub-section, paragraph, sentence, clause or phrase of these Bylaws is for any reason held to be in conflict with the provisions of the Health and Safety Code of the State of California, such conflict shall not affect the validity of the remaining portion of these Bylaws.

These Bylaws for Kaweah Delta Health Care District are adopted, as amended, this 24th day of May, 2021.

President
Kaweah Delta Health Care District

Secretary/Treasurer
Kaweah Delta Health Care District

Physician Recruitment Annual Physician Recruitment Plan - 2021

As supported by the Provider Needs Assessment conducted by Sg2 in 2020, below is a list of the specialties included in our 2021 physician recruitment plan.

- Adult Hospitalist
- Anesthesiology
- Colorectal Surgery
- Dermatology
- Diagnostic Radiology
- EP Cardiology
- Family Medicine
- Family Medicine Associate Program Director
- Family Medicine Core Faculty
- Gastroenterology
- General Surgery
- Gynecology
- Intensivist
- Internal Medicine
- Maternal Fetal Medicine
- Medical Oncology (Added)
- Neonatology
- Neurology
- OB/GYN
- Orthopedic Surgery_Hand
- Orthopedic Surgery_Trauma
- Otolaryngology
- Palliative Medicine
- Psychiatry
- Pulmonology
- Rheumatology
- Urology

Date Prepared: November 13, 2020
Approved: March 22, 2021 | Revised: May 7, 2021
Prepared by: Brittany Taylor, Director of Physician Recruitment and Relations | btaylor@kdhcd.org | (559)624-2899

1.1 PURPOSES OF THE BYLAWS

These Bylaws are adopted in recognition of the mutual accountability, interdependence and responsibility of the Medical Staff and the Board of Directors of Kaweah Health Care District in protecting the quality of medical care provided in the District and assuring the competency of the District's Medical Staff. The Bylaws provide for the organization of the Medical Staff of Kaweah Delta Health Care District and~~,~~ provide a framework for self-governance in order to permit the Medical Staff to discharge its responsibilities as defined in these bylaws~~in matters involving the quality of medical care, and to govern the orderly resolution of those purposes~~. These Bylaws provide the professional and legal structure for Medical Staff operations, ~~organized~~ define Medical Staff relations with the Board of Directors, and ~~relations~~ define medical staff interactions with applicants, members of the Medical Staff, others who exercise clinical privileges, and Advanced Practice Providers.

These Bylaws recognize that the organized Medical Staff has the authority to establish and maintain patient care standards, including full participation in the development of hospital-wide polic~~y~~ies involving the oversight of care, treatment, and services provided by members and others in the District. The Medical Staff is involved with all aspects of delivery of health care within the District including, but not limited to, the treatment and services delivered by practitioners credentialed and privileged through the mechanisms described in these Bylaws and the functions of credentialing and peer review.

These Bylaws acknowledge that the provision of quality medical care in the District depends on the mutual accountability, interdependence, and responsibility of the Medical Staff and the Board of Directors for the proper performance of their respective obligations.

Rationale: Clearly define the scope in which the Medical Staff Bylaws apply.

8.C.1 Initial Review:

(a) Whenever a serious question has been raised, or where collegial efforts or actions under the ~~professional practice evaluation~~Code of Conduct or Ongoing Professional Practice Evaluation (OPPE) / Focused Professional Practice Evaluation (FPPE) policy have not resolved an issue~~,~~ regarding:

(1) the clinical competence or clinical practice of any member of the Medical Staff, including the care, treatment or management of a patient or patients;

(2) the safety ~~or proper care being provided to~~of patients;

(3) ~~the~~ known or suspected unethical behavior ~~violation~~ by any member of the Medical ~~Staff of applicable ethical standards~~Staff including but not limited to fraudulent billing, theft or destruction of hospital property, violation of patient privacy laws, or knowingly providing false information;

~~(3) or the Bylaws, rules and regulations, and policies of the District or the Medical Staff; and/or~~

(4) conduct by any member of the Medical Staff that is ~~considered lower than the standards of the District or~~ disruptive to the orderly operation of the District or its Medical Staff, including the inability of the member to work harmoniously with others; or~~,~~

~~(4)~~(5) known or suspected violation of any other Medical Staff Bylaws, Rules and Regulations or Policies, or applicable District Policies.

the matter may be referred to the Chief of Staff, the chair of the department, the chair of a standing committee, or the CMO. No member of the Medical Staff who makes such a referral confidentially and in good faith shall be subject to retaliation~~,~~ or other disciplinary action.

(b) In addition, if the Board becomes aware of information that raises concerns about any Medical Staff member, the matter shall be referred to the Chief of Staff, the chair of the department, the chair of a standing committee, the CMO, or the CEO for review and appropriate action in accordance with this Article.

(c) The person to whom the matter is referred shall conduct or arrange for an inquiry, which shall include the Chief of Staff (if the Chief of Staff was not the individual to whom the matter was originally forwarded) or designee. Results of the inquiry will be forwarded to the MEC for information or further action.~~, to determine whether the question raised has sufficient credibility to warrant further review and, if so, shall forward it in writing to the MEC. If the Chief of Staff is the subject of the concern, the matter shall be referred to the Vice Chief of Staff for further inquiry.~~

(d) No action taken pursuant to this Article shall constitute an investigation.

Rationale: To provide definition to ethical behavior and inform MEC of significant physician issues that the Chief of Staff is managing. Transparency and support for the Chief of Staff. Gramatical Changes.

8.C.2 Initiation of Investigation:

(a) When a question involving clinical competence or professional conduct is referred to, or raised by~~,~~ the MEC~~,~~ the MEC shall review the matter and determine whether to conduct an investigation, to direct the matter to be handled pursuant to another policy (e.g., ~~Disruptive Medical Staff Member/Advanced Practice ProviderPolicy~~Code of Conduct, Impaired ~~Provider~~ Practitioner Policy, Peer Review Process Policy), or to proceed in another manner. In making this determination, the MEC may discuss the matter with the individual. An investigation shall begin only after a formal determination by the MEC to do so.

(b) The MEC shall inform the individual that an investigation has begun. Notification may be delayed if, in the MEC's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the District or Medical Staff.

Rationale: Correction of Policy titles.

8.F. LEAVES OF ABSENCE

(1) An individual appointed to the Medical Staff may request a leave of absence by submitting a written request to the relevant department chair, through the Medical Staff Services Department. ~~Whenever possible~~With the exception of an unplanned Medical Leave of Absence, members are expected to submit this request ~~at least 30 days~~ prior to the anticipated start of the leave in order to permit the individual to make adequate coverage arrangements necessary for patient care and assure adequate coverage of any administrative activities. The request must state the beginning and ending dates of the leave, which shall not exceed one year, and the reasons for the leave.

(2) The Chief of Staff shall determine whether a request for a leave of absence shall be granted. In determining whether to grant a request, the Chief of Staff shall consult with the relevant department chair. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.

(3) Except for maternity leaves, members of the Medical Staff must report to the Medical Staff Services Department any time they are away from Medical Staff and/or patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Under such circumstances, the Chief of Staff may trigger an automatic medical leave of absence.

(4) During the leave of absence, the individual shall not exercise any clinical privileges.~~, but may continue to access the~~The electronic medical record may continue to be accessed during a leave of absence, as appropriate, unless otherwise determined by the Chief of Staff. In addition, the individual shall be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, and any applicable emergency service call obligations) during this period.

(5) Individuals seeking reinstatement from a leave of absence shall submit a written request ~~at least 30 days~~ before the end of the leave, accompanied by a summary of their professional activities during the leave, and any other information that may be requested by the Medical Staff and/or District. If the leave of absence was for health reasons (except for maternity leave), the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested. In the event the individual has been on a medical leave of absence under supervision of the Well Being Committee, the request for reinstatement must be first considered by the Well Being Committee, which will make a recommendation as to reinstatement to the relevant department chair and Chief of Staff.

~~(5)~~(6) Requests for reinstatement shall be reviewed by the relevant department chair and the Chief of Staff. If these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the District. If either individual reviewing the request has any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the ~~Credentials Committee,~~ MEC for final determination~~, and Board for review and recommendation~~. If a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual shall be entitled to request a hearing and appeal under Article 9.

~~(6)~~(7) ~~If the leave of absence was for health reasons (except for maternity leave), the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested.~~

~~(7)~~(8) Absence for longer than one year shall result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the relevant department chair, the Chief of Staff, and the CMO. Extensions shall be considered only in extraordinary cases where the extension of a leave is in the best interest of the District.

~~(8)~~(9) If an individual's current appointment is due to expire during the leave, the individual must apply for reappointment, otherwise appointment and clinical privileges shall lapse at the end of the appointment period.

~~(9)~~(10) Failure to request reinstatement from a leave of absence in a timely manner shall be deemed a voluntary resignation of Medical Staff appointment and clinical privileges.

~~(10)~~(11) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no right to a hearing and appeal under Article 9.

Rationale: Clarification of process for Leave of Absence vs Medical Leave of Absence.

ARTICLE V

CONSULTATIONS

5.7. Concerns:

(a) If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, he or she shall activate the chain of command to communicate their concern.

(b) A practitioner who believes that an individual has not responded in a timely and appropriate manner to a request for a consultation or a consultant who believes that a planned procedure is medically inappropriate may discuss the issue with the applicable Department Chair, the Chief of Staff, or the Chief Medical Officer.

Rationale: Provide process for consultant disagreement regarding procedures to be escalated.

Privileges in Emergency Medicine

Name: _____

Please Print

EMERGENCY MEDICINE PRIVILEGES - INITIAL CRITERIA

Education: M.D. or D.O. and successful completion of an ACGME or AOA accredited residency/fellowship in emergency medicine **AND** Current certification or active participation in the examination process leading to certification in Emergency Medicine by the ABEM or AOBEM, with certification obtained within 5 years of completion of residency. (Physicians on staff prior to 2015, not fulfilling the Emergency Board Certification requirement, are grandfathered in under their specialty Board Certification.)

Certifications: ACLS, ATLS, and PALS or APLS. ***Required ONLY for physicians not Board Certified or not actively participating in the examination process leading to certification by the ABEM or AOBEM in Emergency Medicine.***

Current Initial Clinical Criteria: A minimum of 1 year of continuous, full time experience in an emergency department, to include completion of the final year of residency training.

FPPE Requirement: Concurrent and/or retrospective review of the first 5 cases.

Renewal Criteria: Minimum of 600 hours in an Emergency Department required in the past two years

CORE PRIVILEGES

Request	Procedure	Approve
☐	**Core Privileges include:** • Assess, work up and perform differential diagnosis by means of H&P, medical decision making, laboratory and/or other studies (may include telehealth), ECG's and diagnostic imaging; • Provide services necessary to ameliorate minor illnesses or injuries; AND stabilizing treatment to patients who present with major illnesses or injuries and determine whether more definitive services are necessary. • Administration of Moderate/Deep Procedural Sedation including but not limited to the following • May perform any necessary procedures to stabilize and diagnose patient including but not limited to: o Airway management, including intubation o Arterial puncture and cannulation o Cardiopulmonary resuscitation o Cardioversion and defibrillation o Central venous and pulmonary artery catheter insertion o Lumbar puncture o Needle and tube thoracostomy o Paracentesis o Thoracentesis o Tracheostomy/cricothyroidotomy, emergency o Delivery of Newborn o Please reference EMS clinical privilege white paper for complete list of procedures that are approved for the Emergency Physician ***Privileges do not include admitting privileges, long-term care of patients on an inpatient basis, or the performance of scheduled elective procedures.***	☐

ADDITIONAL PRIVILEGES

Request	Procedure	Initial Criteria	Renewal	FPPE	Approve
☐	Emergency Ultrasound, **Core** applications: Aorta, Trans Thoracic Echocardiography, EFAST, DVT, Pregnancy, Biliary, Urinary tract, Soft Tissue/Musculoskeletal, Bowel, Ocular and procedural guidance	1) Board Certified in Emergency Medicine ***OR*** board eligible and actively pursuing Certification 2) Completion of an ACGME/ AOA approved residency training program that included training specific to point of care ultrasound within the past 2 years; ***OR*** 3) Completion of a practice based program that meets ACEP recommendations for ultrasound interpretation. If training was completed more than 2 years ago for (#2 or #3), documentation required for a minimum of **25** point of care ultrasound exams in the past 2 years or a total of 150 ultrasounds if seeking global ultrasound privileges.	Maintain EM Board Certification	2 reviewed exams per each application Not required for Accredited ACGME EM residency within last 2 years.	☐
☐	Emergency Ultrasound, **Advanced** applications: (Check request) ☐ Scrotal US for torsion/flow/mass ☐ Adnexal US for mass/flow/torsion ☐ Transcranial	1) Board Certified in Emergency Medicine ***OR*** 2) Completion of an ACGME/AOA approved residency training program that included training specific to point of care ultrasound **or** an EM Ultrasound Fellowship; ***OR*** 3) Completion of a practice based program that meets ACEP recommendations for ultrasound interpretation. **AND** documentation of **25** successful procedures for each application requested.	5 procedures per application in 2 years	2 Reviewed exams per each application	☐

☐	Trans Esophageal Echocardiography (TEE): Limited to use during CPR or in intubated patients when TTE does not provide adequate views	1) Completion of an ACGME or AOA approved residency training program that included training specific to TEE; ***OR*** 2) Credentialed in TTE and; 3) Completion of 2 or more hours of TEE specific CME, didactics, or web based resources AND 10 TEE exams A maximum of 5 out of the 10 may be simulation	25 procedures in the past 2 years of which up to 15 may be done in SimLab.	2 direct and or over reads, at the discretion of the proctor.	☐

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 Emergency Medicine Chair *Date*

Kaweah Delta Health Care District

Medical Staff Services

Policy Number: MS 50	**Date Created: 05/10/2021**
Document Owner: April McKee (Medical Staff Svcs Manager)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration), April McKee (Medical Staff Svcs Manager), Cindy Moccio (Board Clerk/Exec Assist-CEO), Teresa Boyce (Director of Medical Staff Svcs)	
Late Career Policy	

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

Policy:

The purpose of this policy is to

- ensure patients receive safe, high quality medical care
- identify issues that may be pertinent to the health and clinical practice of medical staff members
- support members of the medical staff; and
- apply Medical Staff evaluation criteria objectively, equitably, respectfully, and confidentially

Any practitioner age 75 or older during the month of their appointment or reappointment to the Medical Staff will obtain as part of the application process, documentation of their health status from a primary care provider (PCP), approved by the Medical Staff Officers. If the Department Chair, Credentials Committee or Medical Executive Committee deems appropriate, they may request that any practitioner, regardless of age, provide similar documentation at the time of appointment or reappointment.

Procedure:

I. Notification of the practitioner

a. With initial or reappointment notification, the practitioner will be provided a copy of this policy and informed that
   i. The applicant must return the "Release of Information" form (Attachment C) with the completed application/reapplication to the Medical Staff Office.
   ii. Upon receipt of the Release of Information form from the applicant, the Medical Staff Office will provide
      1. The applicant with contact information of the PCP available to perform a health screening exam.
      2. The PCP with a cover letter, blank questionnaire (Attachments A & B), the signed release of information form, and a copy of the applicants requested privileges.
   iii. The applicant will be responsible for making an appointment with the approved PCP.
   iv. the application will be deemed incomplete without receipt of the completed questionnaire from the PCP.

If, due to inaction by the applicant, the assessment from the PCP is delayed such that an application for reappointment remains incomplete and cannot be considered by the Department Chair, Well Being Committee, Credentials Committee, Medical Executive Committee, and Board of Directors before the end of the member's current term, the application will be deemed withdrawn and the practitioner's appointment and/or privileges will lapse at the end of the current term without any procedural rights under Article 9 of the Medical Staff Bylaws.

II. Processing the Assessment from the Primary Care Provider

a. After completion of the applicant's health screening the PCP will return a completed questionnaire to the Medical Staff Office. This information will be kept confidential and forwarded to the Well Being Committee for evaluation.

i. If the health document identifies health conditions that may interfere with the practitioner's ability to safely and competently exercise the privileges requested, the Well Being Committee will meet with the provider to discuss concerns and possible options. At this time the practitioner may choose to modify the privileges requested and re-submit to the Medical Staff Office (this would not require a report to the NPDB or an 805 report).

ii. If additional evaluation is warranted the Well Being Committee will assist the practitioner in obtaining the appropriate evaluation(s).

~~ii.~~1. A Fit for Duty exam will be automatically required if ~~a~~ ~~C~~cognitive ~~Deficit~~deficiency or physicial deficiency related to the specific practice of the practitioner is identified in the health screening exam. The cost of the Fit for Duty exam will be the responsibility of the applicant

Formatted: Tab stops: 2.06", Left

III. Outcomes of Review sent to the Credentials Committee:

a. No known concerns: If the findings do not identify potential patient care concerns, the results will be filed in a confidential file maintained by the Medical Staff Services Department, and the Credentials File will only reflect that the assessment process has been completed with no significant concerns identified. The appointment process will proceed as specified in the Medical staff Bylaws.

b. Concerns: If the findings identify potential patient care concerns and the practitioner, after meeting with the Well Being Committee elects not to modify the privileges requested, the Department Chair and the Credentials Committee will, on a confidential basis, evaluate the Well Being Committee's recommendation in addition to the entire contents of the (re)application file. A representative of the committee, the Department Chair or Chief of Staff will meet with the practitioner to discuss alternative practice patterns or modification of requested privileges. *The goal of such discussion is to be supportive and respectful of the practitioner and to suggest resources to assist the practitioner.*

c. Practitioner Rights: If the Credentials Committee recommends denial of some or all privileges requested, or that certain conditions or restrictions be placed on privileges, and if that recommendation is approved by the MEC, the

practitioner will be entitled to the procedural rights in Article 9 of the Medical Staff Bylaws.

IV. Throughout this process the intent of each step is to enhance quality healthcare, protect patient safety and, provide support to the practitioner by assisting in any resulting changes in practice patterns or transitions.

References:

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

ATTACHMENT A

Primary Care Physician Questionnaire (to be completed by your Primary Care Physician)

Patient Name: _____ DOB:_____

I attest that I have performed a comprehensive history and physical examination on this practitioner, and that I have reviewed the clinical privileges requested by this practitioner.

- In the history and physical examination the practitioner has no apparent findings that would necessarily preclude the practitioner from performing the privileges requested.
  - Agree: _____ Disagree: _____ If disagree, please elaborate below:
    _____
- In tests and studies performed on the practitioner, the practitioner has no apparent findings that would necessarily preclude the practitioner from performing the privileges requested.
  - Agree: _____ Disagree: _____ If disagree, please elaborate below:
    _____
- Do you have any recommendation for further study or evaluation?
  - No: _____ Yes: _____
    If yes, please elaborate below:_____
    _____
- Additional Comments:
  -
    _____
    _____

ATTACHMENT B

Sample cover letter to PCP

CONFIDENTIAL PEER REVIEW INFORMATION
Protected by California Evidence Code §1157

[DATE]

RE: History and Physical Examination

Dear Dr. _____,

The Medical Staff of Kaweah Delta Health Care District, as part of its efforts to protect both patients and practitioners, requires a comprehensive history and physical examination of practitioners applying or reapplying for clinical privileges beyond the age of seventy-five (75). Important components of this assessment include a review of systems that addresses functional status, and comprehensive sensory examination including tests of hearing, visual acuity with eye chart and exam, and a thorough neurological examination including a mini mental status examination. The elements of the examination should be modified as appropriate to address the age, clinical condition, medical problems and the clinical privileges requested by the practitioner. Included is a copy of the clinical privileges requested by the practitioner.

Please review the practitioner's clinical privileges before conducting your examination.

In order to respect the confidentiality of the practitioner's medical information, please submit only the form that is enclosed. The form is to be returned to the Kaweah Delta Health Care District Medical Staff Services Department (see enclosed envelope).
As noted on the form, the Medical Staff is interested only in, and should only receive a detailed report on, those aspects of the practitioner's health, if any, that have the potential to adversely affect the practitioner's ability to safely perform the requested privileges or that document the practitioner's ability to perform the privileges. You may supply additional information that you feel would be beneficial to the Medical Staff in this assessment, such as if you feel additional studies or further evaluation is indicated. The report is confidential and will be provided to the Medical Staff Wellness Committee.

ATTACHMENT C

Sample Release

CONFIDENTIAL PEER REVIEW INFORMATION
Protected by California Evidence Code §1157

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize _____ to release information of my health evaluation, and to provide information regarding my present medical condition and fitness to perform the duties identified on the enclosed privilege form to Stephen Smith, M.D., Chair of the Well Being Committee.

_____ _____ _____
Print Name Signature Date

Reports are to be mailed to

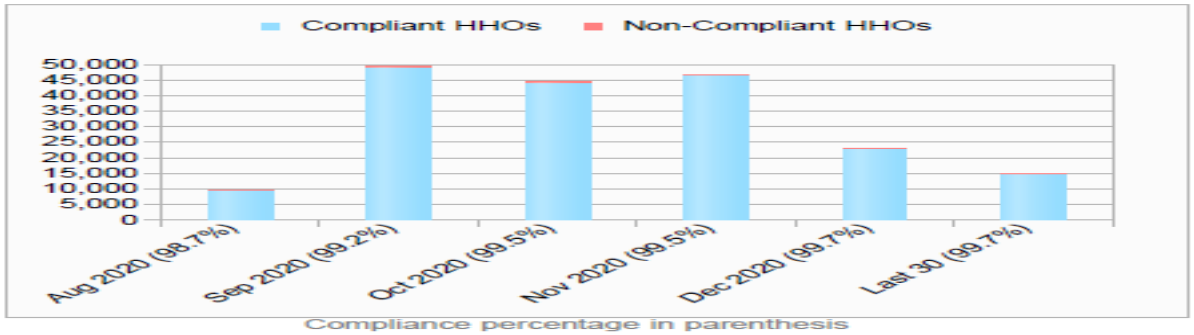
Kaweah Delta Health Care District
Medical Staff Office
%Teresa Boyce
400 Mineral King Ave
Visalia, CA 93291

kaweahhealth.org

Kaweah Health
MORE THAN MEDICINE. LIFE

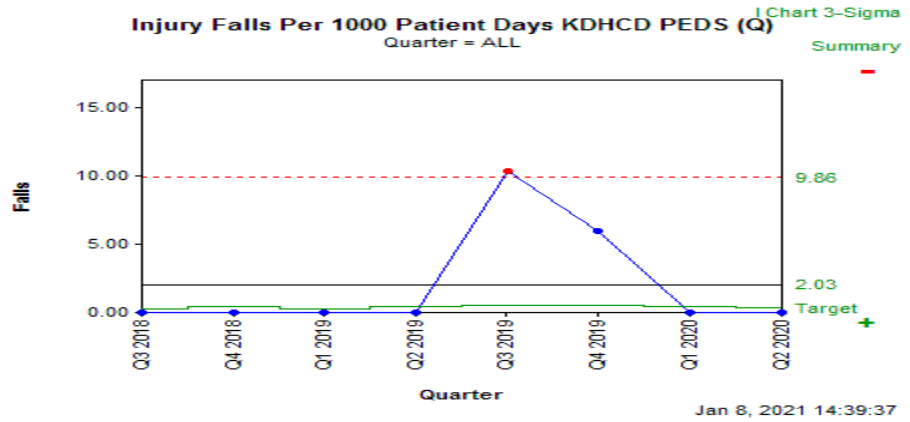
NICU 2020 Data

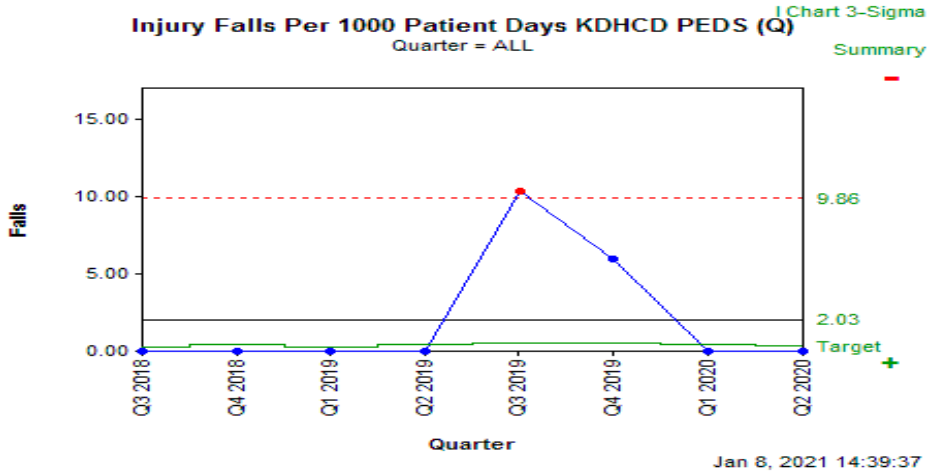
- Central Line Associated Blood Stream Infections: 0/511 central line days
- Ventilator Associated Pneumonia: 0/140 vent days
- Biovigil Hand Hygiene Compliance: 99.6%

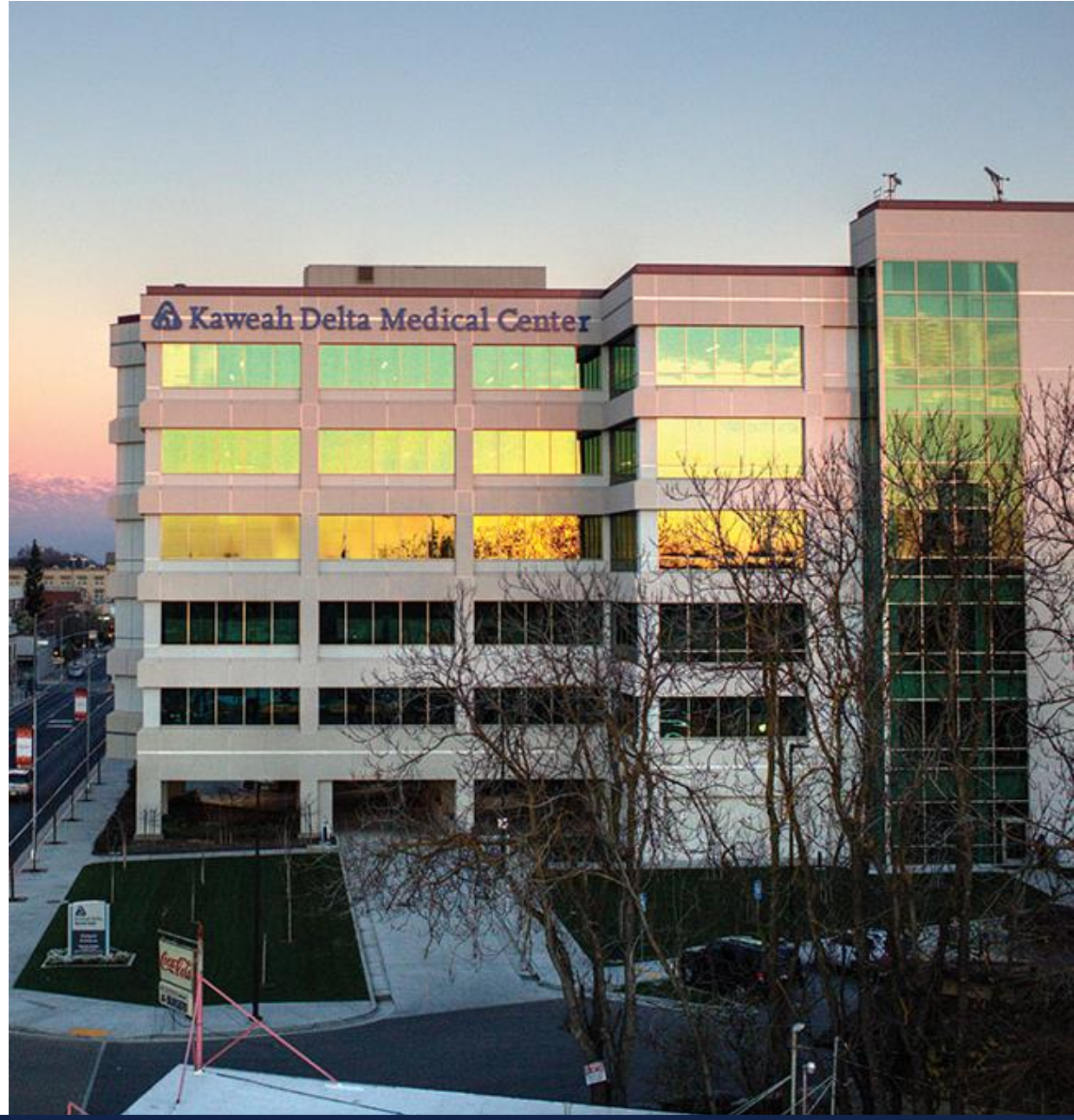


Kaweah Health

Pediatric Data



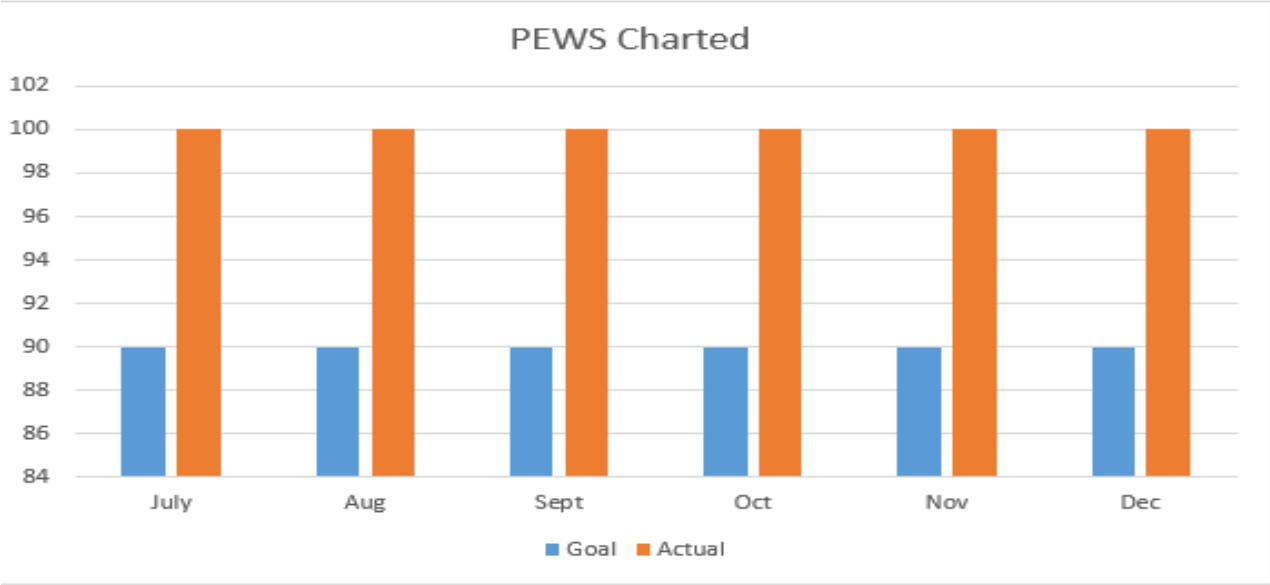




Kaweah Health

Pediatric Data Cont.

Percent of PEWS fallouts-PEWS score charted every 4 hours on every patient



Kaweah Health

Kaweah Health

Labor & Delivery Data

Measure Objective/Goal:

1. Early Elective Delivery of patients with no medical indication/ Goal is 0%

This goal is met at 0%

2. Physician notification and Timely treatment in identified women with acute onset of severe hypertension within 60 minutes./ Goal is 90%

This goal is met at 92%

3. Decision to ready time of less than or equal to 30 minutes in identified nonscheduled cesarean section/ Goal is 90%

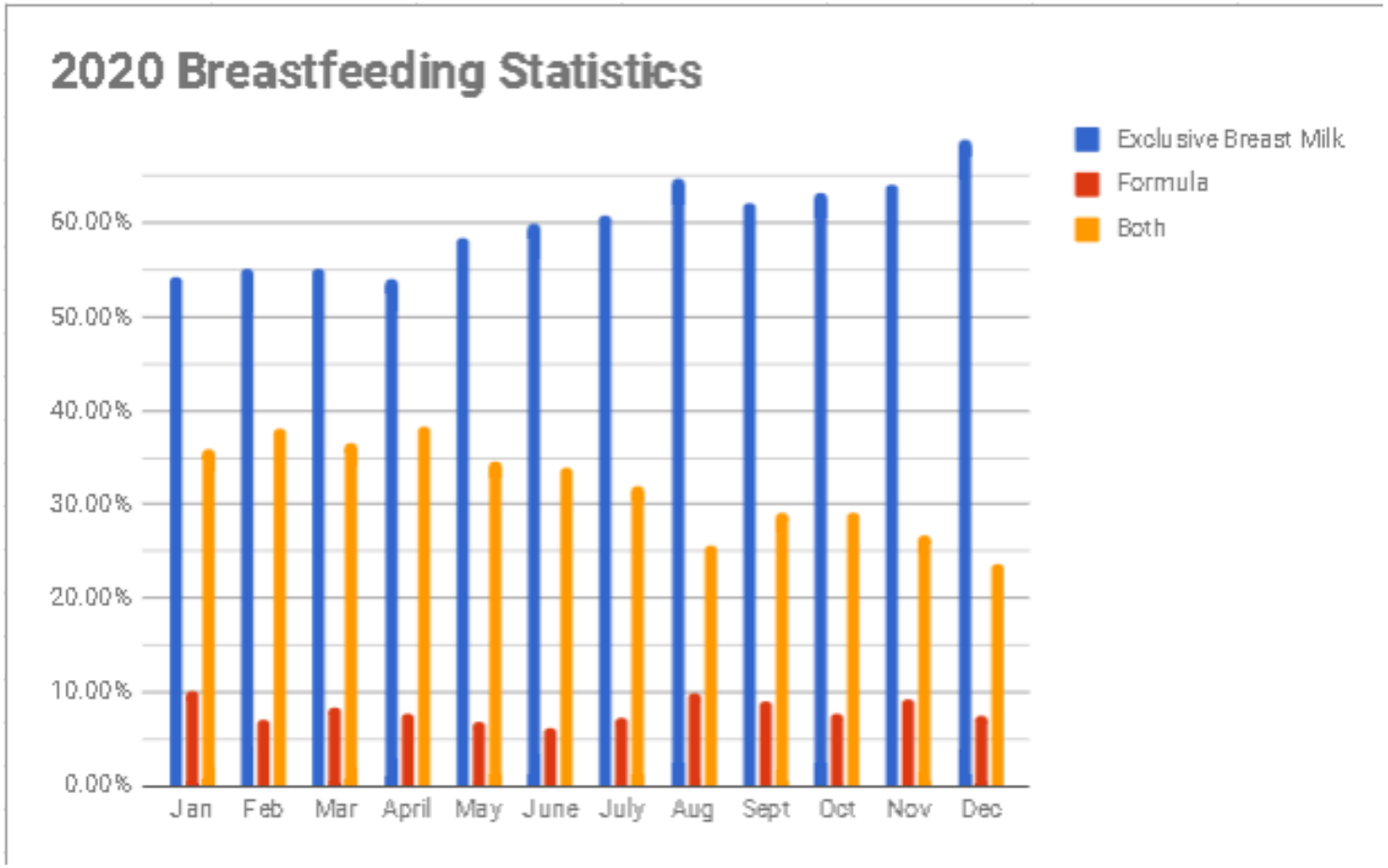
This goal is not met at 60%

4. Surgical Site Infections

No infections since January 2020

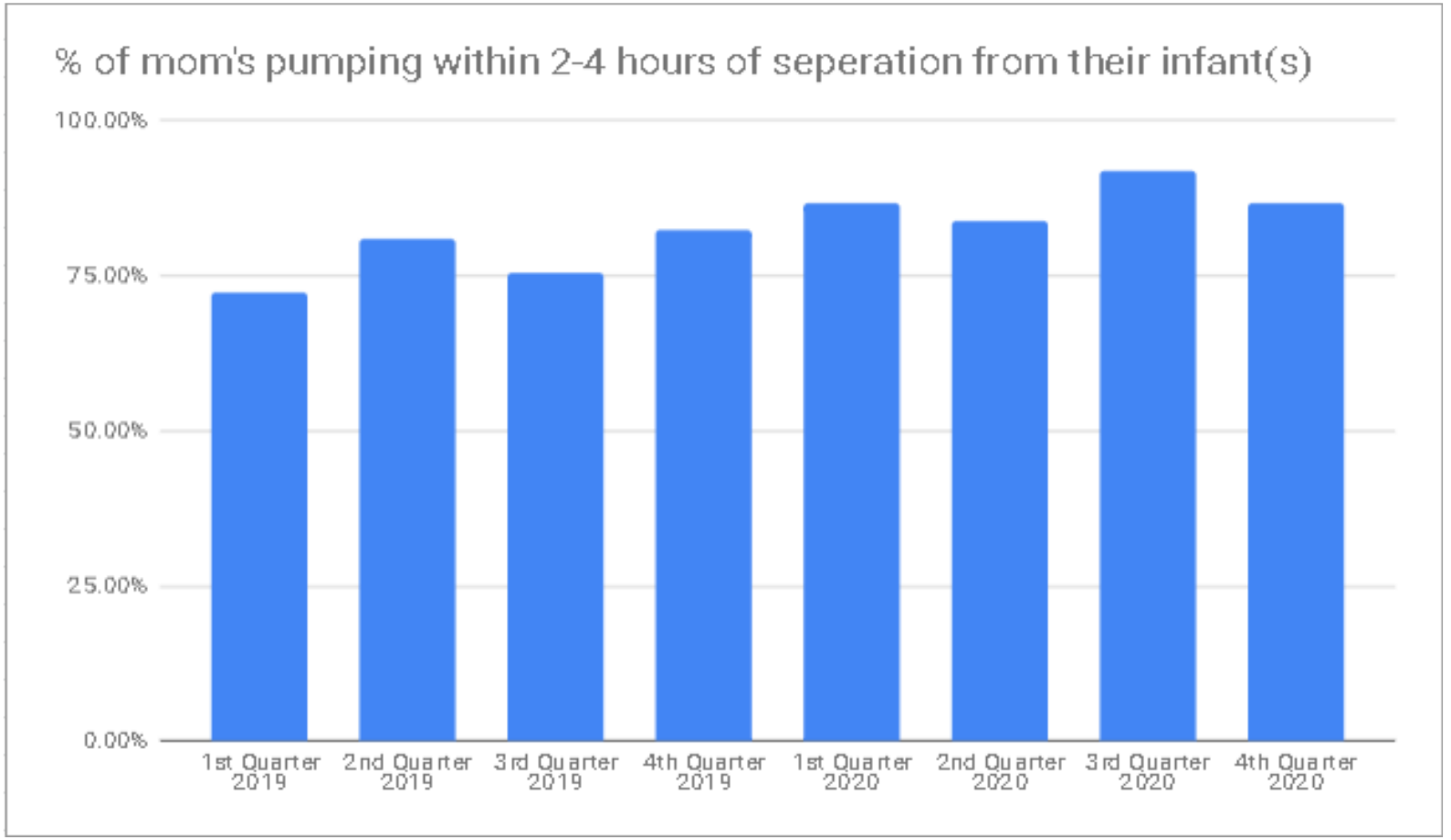
Kaweah Health

Mother-Baby Data



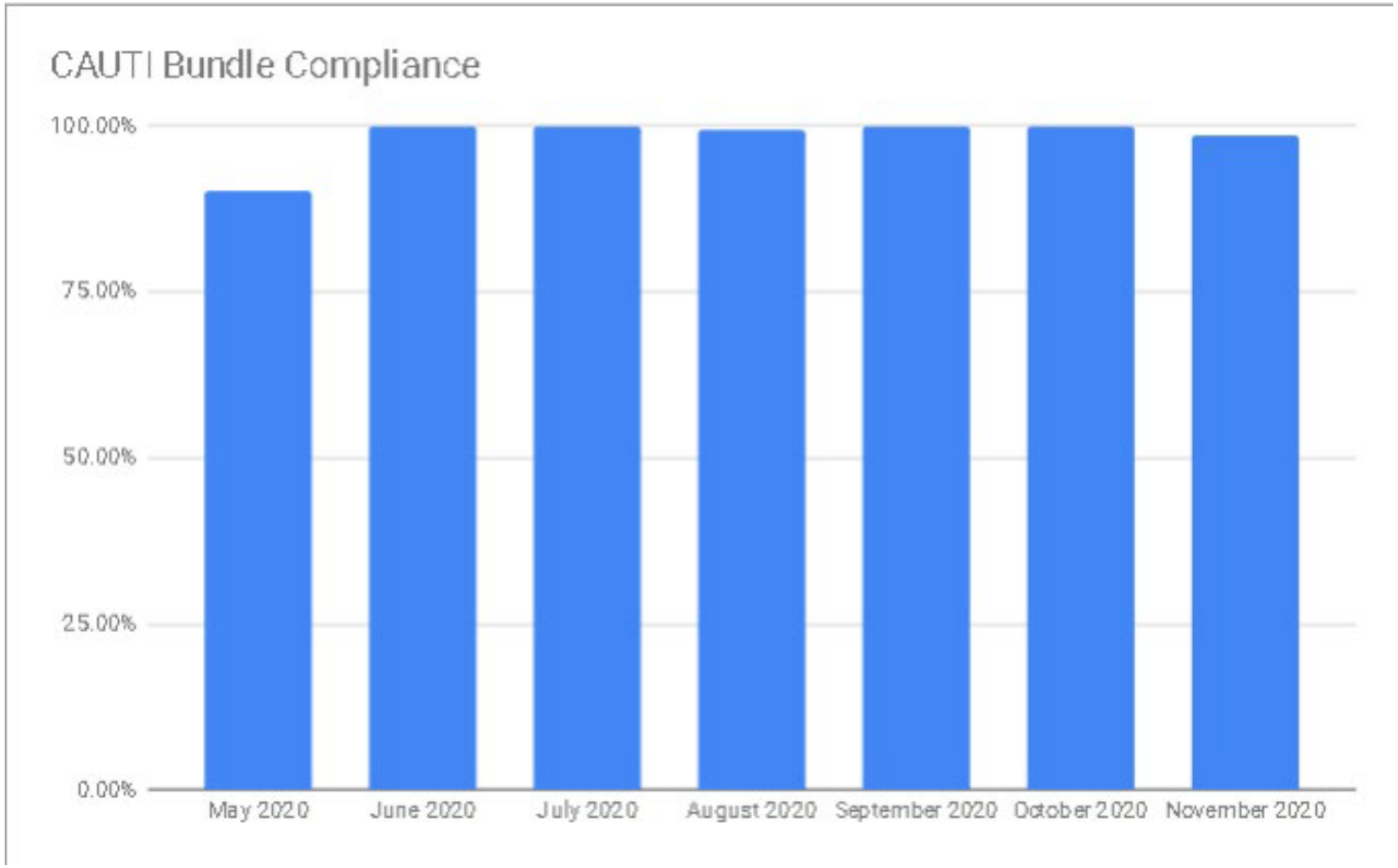
Kaweah Health

Mother Baby Data Cont.



Kaweah Health

Mother Baby Data Cont.



Live with passion.

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

Kaweah Health

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: Surgery **ProStaff Report:** April 12, 2021

Measure Objective/Goal:

1. **Immediate Use Sterilization (IUSS):** Goal 2.0%
2. **First case delays:** Decrease by 20%
3. **Block Utilization:** 60%
4. **Turnover:** 28 minutes
5. **Non-Operative Time "Surgeon Wait Time":** 70 minutes
6. **Enhanced Recovery after Surgery (ERAS):** ASC/PACU will be measuring this objective.

Date range of data evaluated:

1. **Immediate Use Sterilization (IUSS):** March 2020- April 2021
2. **First Case Delays:** March 2020- April 2021
3. **Block Utilization:** March 2020- April 2021
4. **Turnover:** March 2020- April 2021
5. **Non-Operative Time "Surgeon Wait Time:** March 2020- April 2021

Analysis of all measures/data: (Include key findings, improvements, opportunities)
(If this is not a new measure, please include data from your previous reports through your current report):

1. **Immediate Use Sterilization (IUSS):** *(IUSS is compared to the total # of cases)*
2. **First Case Delays:**
3. **Block Utilization:**
4. **Turnover:**
5. **Non-Operative Time "Surgeon Wait Time":**

2020-2021 Surgical Department Quality Dashboard (ProStaff/QIC)

Throughput	KD Goal	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21
First Case Delay Minutes in O.R.	650	750	1385	1507	925	594	757	429	715	926	719
Block Utilization	60%	51%	53%	46%	53%	53%	40%	22%	41%	51%	51%
Patient Safety	**Percentage**										
Immediate Use Steam Sterilization (IUSS)	2%	2%	2%	1%	2%	2%	1%	2%	1%	1%	2%
O.R. Efficiency	**Minutes**										
Turnover Data	28	24	27	36	28	28	30	30	25	32	30
Surgeon (Non-Op) Wait Time	70	76	83	85	82	78	86	83	80	86	73

Better than target
Within 10% of target
Does not meet target

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

If improvement opportunities identified, provide action plan and expected resolution date:

1. **Immediate Use Sterilization (IUSS):**
    a. Continue to purchase instrumentation to decrease IUSS.
    b. Increase Vender Tray inventory to decrease IUSS for the cases that follow.
    c. Decrease scheduling conflicts to allow sterile processing adequate time to turn over trays/instrumentation.
    d. Continue a 1430 huddle. The huddle consists of Surgery Manager, Sterile Processing Manager, Surgery Charge Nurse, Sterile processing a.m. and p.m. Team Leads, Radiology Tech lead, and 2 Surgery Schedulers.
        1. Each person comes to the meeting prepared to discuss the following day's schedule. This has eliminated miscommunication between departments, scheduling conflict, etc…
2. **First Case Delays:**
    b. Educate staff in pre-op and intra-op on proper delay codes.
    c. Delay codes will be reported at the OR Governance Committee, Department of Surgery, and Department of Anesthesia.
    d. Data will be displayed on the electronic communication board in the surgeons lounge for transparency.
    e. Trends with specific surgeons will be addressed by the OR Governance Committee representatives. Trends with specific surgeons could affect their allotted block time.
    f. First case delays due to anesthesia are reported to the Medical directors and reported at the Department of Anesthesia.
3. **Block Utilization:**
    a. There is a need for block time in the Operating Room and there are underutilized block times surgeons currently have.
    b. Utilization is defined as total allotted minutes for a specific surgeon compared to the total minutes used.
    c. The goal is to decrease wasted OR utilization time and give time to current surgeons who need more time and to new surgeons who are entering the district.
    d. Dr. Wiseman, Dr. Tang and Surgical Services Leadership have created a formalized way to track utilization time.
        i. Formula: Surgery minutes + Turnover minutes / Block minutes – Released block minutes = Block Utilization.
    e. Letters have been sent to surgeons regarding their utilization data. If they are below 50% utilization, they have 1 quarter to increase their volume to maintain or it will be released back to the department.
        i. March was the first round of restructuring and removing block.
        ii. We assigned block to eight surgeons who did not have time and to surgeons who needed more time.
        iii. *Due to the COVID-19, block utilization data for March through January will not be counted against surgeon's utilization.*
    f. O.R. Governance and Department of Surgery have approved block to release 1 week in advance instead of 72 hours in advance.
        i. Provides more time for other surgeons looking for block to schedule.
    g. O.R. Governance and Department of Surgery approved for schedules to be finalized 48° in advance. This created more efficiency on the operations side.

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

h. November 2, 2020 started staggering surgeon first case start times. This will provide surgeons with more block time to add more cases.
   ii. Goal is to have 2-3 surgeons a day be in the room at 0700 instead of 0730.
   iii. Helps with anesthesia residency program.
   iv. As of December 2020, we have seven surgeons who start block at 0700.

Next Steps/Recommendations/Outcomes:

1. Immediate Use Sterilization (IUSS):

a. Continue to meet with new surgeons to understand their need vs want. Budget accordingly to their expected volume.
b. Surgery/Sterile Processing Liaison committee makes recommendations for more instrumentation purchases.
c. Surgery and Sterile Processing have a small list in the departments on instrumentation they need or have replaced. These lists are looked at on a monthly basis by the Sterile Processing
   i. Supervisor
      a) **Outcome: New goal IUSS at 2.0%.**

2. First Case Delays:

a. Clean up the current delay codes available in the EMR. *Completed*
b. Provide education to staff on proper coding. *Ongoing education*
c. Present at the above committees for transparency. *Ongoing*
d. Display First case start (patient in the room) broken down into minutes. *Ongoing*
e. Hold surgeons accountable for delaying first cases. *In progress through the O.R. Governance*
f. Anesthesia accountability. *In process*
   * 1/13/21, had a meeting with anesthesia medical directors to discuss anesthesia delays.
   * 2/3/21, had a meeting to discuss delay codes, communication between anesthesia and the surgical team.

3. Block Utilization:

a. Complete data extraction, present the data to the OR Governance Committee, and have a letter sent to individual surgeons who have underutilization. *Ongoing*
b. Give the surgeons who have underutilized time 1 quarter to increase their volume.
c. After the quarter, remove time currently allotted to surgeons who have not met criteria and give the new time to surgeons who need more block and to new surgeons.

4. Turnover:

a. Completed a Surgical Team Assistant Boot camp with the assistance of Alexandra Bennett.
b. Proposing through the budget process an additional three STAs. One will be for the day-to-day operations and two will be for supply management. The focus of the supply is to ensure it is always there and stock supply in between cases.
c. This will help with staff having appropriate supply in all areas.

5. Non-Operative "Surgeon Wait Time".

a. Working with ISS to help with surgical services data. We need to be able to break the data into specialty. Larger cases will automatically have longer non-operative times due to room set-up.
b. Once the data is broken down, we can focus on the specialties that have longer non-op times.

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

c. Budgeting to have 1.4 RN FTE per room. This will provide support when needed to the rooms that are larger with longer non-op times.
d. Non-operative times will then have a goal per specialty. Having an overall non-operative goal with every specialty included will be hard to meet.

Example: Orthopedics will have a longer goal due to the set-up and positioning compared to a general laparoscopic gallbladder surgery with minimal instrumentation and standard positioning.

Submitted by Name:
Brian Piearcy, Director Surgical Services

Date Submitted:
April 12, 2021
Updated: May 13, 2021

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

FY 21 Strategic Plan

Organizational Efficiency and Effectiveness

kaweahhealth.org

Kaweah Health
MORE THAN MEDICINE. LIFE.

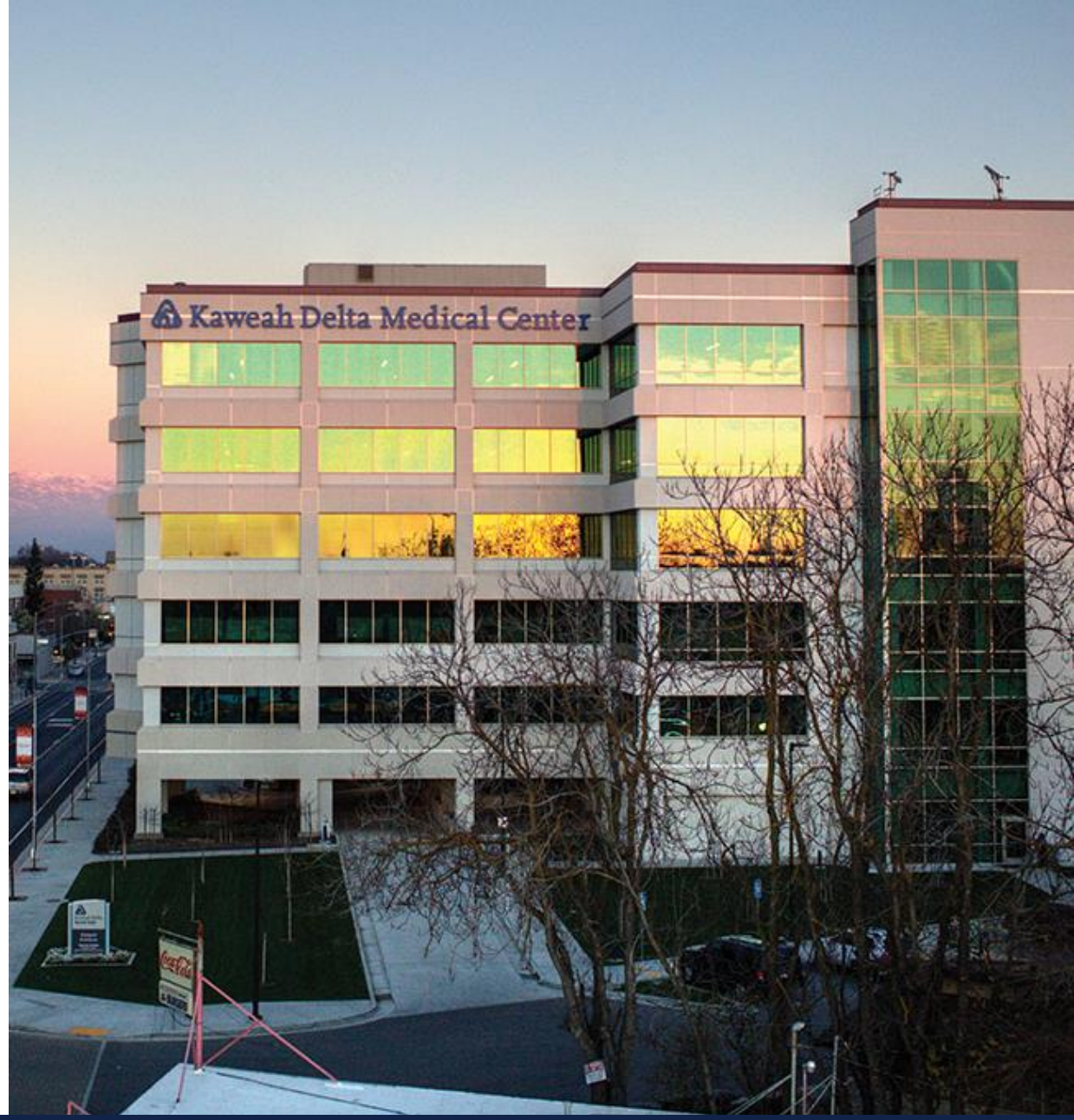
Summary

FY 21 Goals Included:

- Reduction in LOS – resulting in cost savings
- Staffing within ratios per matrices for inpatient units
- Standardization of surgical equipment and use
- Improved efficiency in the OR procedures to increase surgery capacity.

FY 21 Focus:

- Continuous operational changes to adapt to COVID
- Crisis response for surges of inpatients
- Rapid onboarding – permanent, temporary and disaster relief staff
- Onboarding and development of new leadership – restructure of leaders in patient care
- Resumption of surgical activities after periods of closure, limited cases and operational impacts



Strategic Initiative Charter: Organizational Efficiency & Effectiveness

Objective

Increase the efficiency and the effectiveness of the organization *to reduce costs, lower length of stay, and improve outcomes.*

Chair

Keri Noeske

ET Sponsor

Keri Noeske

Performance Measure	Baseline	FY21 Goal
Adult Acute Med/Surg Length of Stay	1.08 above GMLOS (4/2020)	ALOS within 0.75days of GMLOS
Registered Nurse Staffing Metrics	Mandated ratios	Meet budget/ratios*
Surgical implant standardization or spend (orthopedics and spine)	$3,500 average direct cost	5% reduction; $250,000 savings
Average patient-out-patient-in time in the OR	30 minutes	28 Minutes
Spending per beneficiary score	0.97	0.97

Team Members

Dan Allain
Doug Leeper
Malinda Tupper
Suzy Plummer
Steve Bajari
Brian Piearcy

Strategies (Tactics)	Net Annual Impact ($)*
Utilize the updated Resource Effectiveness Committee (REC) structure to improve patient throughput and remove discharge barriers.	$4,775,000
Better align staffing levels with patient volumes/units of service.	TBD
Standardize supplies and surgical implants to increase operational efficiency and reduce costs	$2,079,864
Improve OR efficiency	TBD

Kaweah Health

* Subject to change due to COVID-19 and census changes

Strategy Summary for: Resource Effectiveness Committee

Strategic Initiative: Organizational Efficiency & Effectiveness

Objective

Through effective processes and practices, we will achieve maximum productivity with minimum wasted effort or expense.

Key Components

- Implement performance improvement strategies to impact patient throughput and length of stay initiatives throughout the Kaweah Delta continuum.
- Identify barriers to improvement strategies, implement action plans related to the barriers with engagement from both Kaweah Delta staff and medical staff.
- Provide resources and remove barriers to REC teams to facilitate success of the identified goals and improvement strategies.
- Ensure REC and subcommittees are aligned with the strategic plan goals of the organization.

Outcomes	FY21 Goal	FY21 YTD
Reduced Adult Acute Medical Surgical Length of Stay (1.08 above GMLOS effective April 2020)	ALOS w/i 0.75days of GMLOS	1.7 days over ALOS
Reduced expenses from lower LOS	$4,775,000	Goal not met

Financial Impact	FY2021	FY2022	FY2023
Capital Requirements			
Revenue			
Expenses			
Labor			
Supplies			
Other			
Total Costs	($4,775,000)		
Contribution Margin			

Team Members

Keri Noeske, Malinda Tupper, Frances Carrera, Rebekah Foster

Strategy Summary for: Efficient Staffing Levels

Strategic Initiative: Organizational Efficiency & Effectiveness

Objective

Ensure that staffing levels align with patient volumes and/or units of service.

Key Components

- Use daily labor and productivity reports to make decisions regarding staffing levels and flexing
- Daily leadership accountability for staffing levels relative to ratios and budgets
- Identify and execute on opportunities to reduce overtime and contract labor

Outcomes	FY21 Goal	FY21 YTD
Registered Nurse Staffing Metrics	Meet budget/ratios in inpatient nursing units	Overall – 4.4 hours/patient day over (12.7 FTEs)

Financial Impact	FY2021	FY2022	FY2023
Capital Requirements			
Revenue			
Expenses			
Labor			
Supplies			
Other			
Total Costs			
Contribution Margin			

Team Members

Keri Noeske, Malinda Tupper, Kassie Waters, Emma Mozier, Tracie Sherman, Kari Knudsen, Amy Baker, Elisa Venegas

Strategy Summary for: Standardize Use of Supplies and Implants

Strategic Initiative: Organizational Efficiency & Effectiveness

Objective

Increase the standardization of supplies and surgical implants to achieve cost savings and operational efficiency.

Key Components

- Work with orthopedic co-management committee to reduce the number of implant vendors (currently 7)
- Assess the utilization rate of supplies, identify opportunities, and execution of improvement strategies
- Standardize supply vendors and negotiate pricing

Outcomes	FY21 Goal	FY21 Update
Implant utilization or spend	5% reduction; $250,000 savings	In progress – PODs notified that cost negotiations are in progress, target is an average price reduction of 20% 75th percentile
Number of orthopedic implant vendors	6	97% of knee implants provided by 5 vendors; 94% of hip implants provided by 3 vendors

Financial Impact

Financial Impact	FY2021	FY2022	FY2023
Capital Requirements			
Revenue			
Expenses			
Labor			
Supplies			
Other			
Total Costs			
Contribution Margin			

Team Members

Keri Noeske, Malinda Tupper, Dan Allain, Steve Bajari, Brian Piearcy

Strategy Summary for: Operating Room Efficiency

Strategic Initiative: Organizational Efficiency & Effectiveness

Objective

Improve operating room efficiency to reduce costs and increase patient capacity.

Key Components

- Work with physicians to improve the percentage of on-time start times for the first OR cases of the day; increase physician accountability
- Process improvement initiatives to reduce room turn around times
- Work with surgeons to reduce physician wait times between cases
- Increase OR capacity with expanded hours of operation (M-F)
- Work with OR governance committee to reallocate block times to increase utilization and to provide more surgeons with necessary block time

Outcomes	FY21 Goal	FY21 YTD (April 2021)
Average patient-out-patient-in time	28 minutes	29 minutes
Block time utilization rate (currently 49%)	60%	51%
First case on-time start rate (currently 35%)	70%	pending

Financial Impact

Financial Impact	FY2021	FY2022	FY2023
Capital Requirements			
Revenue			
Expenses			
Labor			
Supplies			
Other			
Total Costs			
Contribution Margin			

Team Members

Keri Noeske, Malinda Tupper, Dan Allain, Brian Piearcy

Kaweah Health

Organizational Effectiveness Summary – FY 2021

- Discharge Management
  - Identification of standardized work – implemented practice changes (CM, House Supervisors, Nursing)
  - Implementation of second generation Throughput Rounding Tool with Case Management and Discharge Rounds
  - Development of onsite Physician Advisor program – (Impact LOS, denials, medical necessity and improved documentation)
  - Increased contact with primary care physicians in community for timely follow-up
- Surgery
  - Vendor reductions and standardization
  - Process changes to respond to COVID safety
    - Resumed surgeries safely to meet community needs
- COVID Operations
  - Creation of Precaution Rooms and Units for COVID related care
  - Onboarding of 783 staff (346 RN staff)
  - Availability and sustainability of Personal Protective Equipment
  - Education and Enforcement of PPE/Isolation changes
  - Organization, Department and Individual Levels of Communication
  - Hospital Incident Command Operations (14 months) – varying levels of time commitment
  - Creation of new orientation model to increase onboarding –ensuring safety
  - Regulatory Compliance – Rapidly changing environment

Organizational Efficiency and Effectiveness – Continued Opportunities

- Standardization of Work
  - Discharge
    - Leadership
    - Social Workers
    - Case Managers
    - Nurses/Physicians
  - Regulatory Requirements/Updates
- Patient Throughput Improvements
  - Standardize response for increased patient volumes in ED
  - Accountability measures for discharge expectations
  - Assessments of use of inpatient resources for secondary findings
  - Access to consultants (in person and telehealth) for timely decision making
- Reduction in Length of Stay
  - Rapid escalation of discharge barriers
  - Early identification of discharge related needs
  - Reduction in assessment and treatment of secondary conditions
  - Increased collaboration/ownership of length of stay outcomes with medical staff
- Stabilization of Staffing/Teams
  - Create stable teams, competent in skill area
  - Keep team members in place to maximize productivity as experience grows.
- Reduce clinical variation
  - Evidence Based Practice Teams – Quality
  - Increase collaboration with Medical Staff Departments (Nursing/Medical Staff)

Live with passion.

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

Kaweah Health