June 20, 2019

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Board of Directors meeting at 5:30PM on Monday, June 24, 2019 in the Kaweah Delta Medical Center Blue Room {Mineral King Wing – 400 West Mineral King Avenue}.

The Board of Directors of the Kaweah Delta Health Care District will meet in a closed Board of Directors meeting at 5:31PM on Monday, June 24, 2019 in the Kaweah Delta Medical Center Blue Room {Mineral King Wing – 400 West Mineral King Avenue} pursuant to Government Code 54956.9(d)(1), Government Code 54956.9(d)(2), Health and Safety Code 32155, and Health and Safety Code 1461.

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Board of Directors meeting at 6:00PM on Monday, June 24, 2019 in the Kaweah Delta Medical Center Blue Room {Mineral King Wing – 400 West Mineral King Avenue}.

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 Delta Medical Center, Mineral King Wing entry corridor between the Mineral King lobby and the Emergency Department waiting room.

The disclosable public records related to agendas are available for public inspection at the Kaweah Delta Medical Center – Acequia Wing, Executive Offices (Administration Department) {1st floor}, 400 West Mineral King Avenue, Visalia, CA and on the Kaweah Delta Health Care District web page http://www.kaweahdelta.org.

KAWEAH DELTA HEALTH CARE DISTRICT
Nevin House, Secretary/Treasurer

Cindy Moccio

Cindy Moccio - Board Clerk / Executive Assistant to CEO

DISTRIBUTION:
Governing Board
Legal Counsel
Executive Team
Chief of Staff
www.kaweahdelta.org

KAWEAH DELTA HEALTH CARE DISTRICT
BOARD OF DIRECTORS MEETING

Kaweah Delta Medical Center {Blue Room}
400 West Mineral King Avenue, Visalia
www.KaweahDelta.org

Monday June 24, 2019

OPEN MEETING AGENDA {5:30PM}

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 the item has been 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 – 5:31PM**
   - 4.1. **Conference with Legal Counsel – Anticipated Litigation** – Significant exposure to litigation pursuant to Government Code 54956.9(d)(1) – 1 Case - *Dennis Lynch, Legal Counsel*
   - 4.2. **Credentialing** - Medical Executive Committee (May 2019) 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 pursuant to Health and Safety Code 1461 and 32155 – *Byron Mendenhall, MD, Vice Chief of Staff*
   - 4.3. **Approval of closed meeting minutes** – May 29, 2019.
5. **ADJOURN**

CLOSED MEETING AGENDA {5:31PM}

1. **CALL TO ORDER**
2. **CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION** – Significant exposure to litigation pursuant to Government Code 54956.9(d)(1) – 1 Case - *Dennis Lynch, Legal Counsel*
3. **CREDENTIALING** - Medical Executive Committee (May 2019) 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 pursuant to Health and Safety Code 1461 and 32155

   Byron Mendenhall, MD, Vice Chief of Staff
4. **APPROVAL OF CLOSED MEETING MINUTES – MAY 29, 2019.**
   Action Requested – Approval of the closed meeting minutes – May 29, 2019.
5. **ADJOURN**

OPEN MEETING AGENDA {6:00PM}

CALL TO ORDER

1. **APPROVAL OF AGENDA**
2. **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. 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.
3. **CLOSED SESSION ACTION TAKEN** – Report on action(s) taken in closed session.
4. **OPEN MINUTES** – Request for approval of the May 29th 5:30pm and 6:00pm and June 3rd 5pm and June 3rd 6pm open board of directors meeting minutes.

   Action Requested – Approval of the open meeting minutes – May 29th and June 3rd open board of directors meeting minutes.
5. **RECOGNITIONS** – *Lynn Havard Mirviss*
   - **5.1.** Presentation of Resolution 2032 to Kelly Gentner - Service Excellence Award – June 2019.
   - **5.2.** Presentation of Resolution 2033 to Ed Richert, Director of EAP, retiring from duty at Kaweah Delta after twenty-six (26) years of service.
   - **5.3.** Presentation of Resolution 2034 to Brenda Hudson, EAP Counselor, retiring from duty after eighteen (18) years of service.

5.4. Presentation of Resolution 2035 to Jody Kitchen, Secretary III – EAP, retiring from duty after twenty-one (21) years of service.

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

6.1. REPORTS

A. Medical Staff Recruitment
B. Cardiology Service Line
C. Non-Invasive Cardiology
D. Surgery
E. Anesthesia
F. Environment of Care

6.2. POLICIES

A. ADMINISTRATIVE

1.	Physician Recruitment Policy	AP.126	Reviewed

B. ENVIRONMENT OF CARE

1.	Disruption of Services, Telephone	EOC 1044	Revised
2.	Emergency Operations Plan	EOC 2000	Revised
3.	Emergency Department Security	EOC 3007	Revised
4.	Fire Prevention Management Plan	EOC 5000	Revised
5.	Clinical Engineering Management Plan	EOC 6001	Revised
6.	Hospital Electrical Safety Policy for Personal Items	EOC 6015	Revised
7.	Retirement/Deletion of Medical Equipment from MEM Program	EOC 6018	Revised
8.	Utilities Management Plan	EOC 7001	Revised
9.	Medical Equipment-Healthcare Device Modification Policy	EOC 6003	Reviewed
10.	Non Healthcare District Equipment Preventative Maintenance and Repair Policy	EOC 6012	Reviewed
11.	Safe Medical Device Act/Medical Device Tracking and Reporting Policy	EOC 6009	Reviewed

C. HUMAN RESOURCES

1.	Personal Leave of Absence	HR.148	Revised
2.	Leaves of Absence	HR.243	Revised
3.	Employee Emergency Relief	HR.173	Revised
4.	Extended Illness Bank (EIB) Donations	HR.239	Revised
5.	Paid Time Off (PTO) Cash Out	HR.241	Revised
6.	Professional Licensure and Certification	HR.47	Reviewed
7.	Payment of Wages	HR.65	Reviewed
8.	Telecommuting	HR.74	Reviewed

9.	Computer and Communication Devices and Social Media Code of Conduct	HR.236	Reviewed
10.	Paid Time Off (PTO), Extended Illness Bank (EIB) and Healthy Workplace Healthy Families Act of 2014	HR.234	Reviewed

6.3. Approval of the Chief of Staff Agreement between Kaweah Delta Health Care District and Byron Mendenhall, MD effective July 1, 2019 through June 30, 2021.

6.4. Approval of recommended revisions to the Medical Staff Bylaws and the Medical Staff Rules and Regulations.

6.5. RECOMMENDATION FROM THE MEDICAL EXECUTIVE COMMITTEE (JUNE 2019).

A. Privilege Forms

1. Anesthesia
2. Certified Registered Nurse Anesthetist
3. Emergency Medicine

B. Statement of the Medical Executive Committee's support of the Trauma Program - "Resolved, that the Kaweah Delta Medical Center Medical Executive Committee supports verification as Level III trauma center by the American College of Surgeons. The MEC commits to maintain the high standards needed to provide optimal care of all trauma patients. The multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions."

6.6. Approval of Resolution 2036 rejecting the application for leave to present a late claim for Bob Sansom vs. Kaweah Delta Health Care District.

Recommended Action: Approve the June 24, 2019 Consent Calendar.

7. PRESS GANEY EMPLOYEE SURVEY – Review and discussion of the results of the 2019 Kaweah Delta Employee Survey.

Press Ganey Associates, Inc. – Murat Philippe

8. QUALITY – Infection Prevention **-** A review of key infection prevention measures and action plans.

Shawn Elkin, MPA, BSN, RN, PHN, CIC

9. STRATEGIC PLAN – High performing outpatient delivery network – Review of strategic charter and summary.

Malinda Tupper, VP & CFO, and Ryan Gates, Director of Population Health Management

10. **CERNER** – Progress report – 1-year post conversion to Cerner {verbal report}.
Doug Leeper, Vice President & Chief Information Officer

11. **MASTER PLANNING STEERING COMMITTEE –** Progress report on the master plan.
Thomas Rayner, SVP & COO and Julieta Moncada, Facilities Planning Director

12. **CENTRAL VALLEY HEALTHCARE ALLIANCE** – Progress report on the Central Valley Healthcare Alliance activities.
David Francis, Chair & Marc Mertz, Secretary – Central Valley Healthcare Alliance

13. **FINANCIALS –** Review of the most current fiscal year 2019 financial results.
Malinda Tupper, VP & Chief Financial Officer

14. **2019/2020 ANNUAL OPERATING AND CAPITAL BUDGET** – Review of the annual operating and capital budget as reviewed by the Board of Director's Finance, Property Services, and Acquisition Committee.
Malinda Tupper –Vice President & Chief Financial Officer
Recommended action: Approval of the 2019/2020 Annual Operating and Capital Budget.

15. **CEP AMERICA-CALIFORNIA CONTRACT** – Review and requested approval of agreement regarding extension of agreements entered into as of July 1, 2019 between Kaweah Delta Health Care District and CEP America-California dba Vituity.
Dennis Lynch, Legal Counsel
Recommended Action: Approval of the Kaweah Delta Health Care District CEP America-California agreement regarding extension of agreements effective July 1, 2019 authorizing the agreement in good faith and finding that the contract is fair to Kaweah Delta and in its best interest.

16. **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.
Byron Mendenhall, MD, Vice Chief of Staff
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 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 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.

17. REPORTS

17.1. Chief of Staff – Report relative to current Medical Staff events and issues.
Byron Mendenhall, MD, Vice Chief of Staff

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

17.2.1. Chief Quality Officer recruitment update
17.2.2. Graduate Medical Education
17.2.3. Palliative care – Dr. Howard
17.2.4. Nursing recruitment

17.3. Board President **-** Report relative to current events and issues.
Lynn Havard Mirviss, 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 JUNE 24, 2019

CLOSED MEETING SUPPORTING DOCUMENTS

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KDHCD - BOARD OF DIRECTORS MEETING

MONDAY JUNE 24, 2019

CLOSED MEETING SUPPORTING DOCUMENTS

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KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY JUNE 24, 2019

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KDHCD - BOARD OF DIRECTORS MEETING

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KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY JUNE 24, 2019

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KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY JUNE 24, 2019

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KDHCD - BOARD OF DIRECTORS MEETING

MONDAY JUNE 24, 2019

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 8-22

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD WEDNESDAY MAY 29, 2019 5:30PM, IN THE KAWEAH DELTA MEDICAL CENTER MINERAL KING WING BLUE ROOM, LYNN HAVARD MIRVISS PRESIDING

PRESENT: Directors Havard Mirviss, Hawkins Hipskind, House, & Francis; G. Herbst, CEO; H. Lively, MD, Chief of Staff; T. Rayner, SVP & COO; R. Sawyer, VP & CNO, M. Tupper, VP & CFO; D. Cox, VP of Human Resources, Marc Mertz, VP of Strategic Planning and Business Development, B. Cripps, D. Lynch, Legal Counsel; C. Moccio, Board Clerk

The meeting was called to order at 5:30PM by Director Havard Mirviss.

Director Havard Mirviss asked for approval of the agenda.

MMSC (Hawkins/Hipskind) to approve the agenda. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Hawkins, House, Hipskind, and Francis

Public participation – none

Director Havard Mirviss called for the approval of the closed agenda.

APPROVAL OF THE CLOSED AGENDA – 5:31PM

4.1. Credentialing - Medical Executive Committee (May 2019) 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 pursuant to Health and Safety Code 1461 and 32155 - Harry Lively, MD, Chief of Staff

4.2. Conference with Legal Counsel – Anticipated Litigation – Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 10 Cases - Dennis Lynch, Legal Counsel & Ben Cripps, Compliance Officer

4.3. Conference with Legal Counsel – Anticipated Litigation – Significant exposure to litigation pursuant to Government Code 54956.9(d)(1) – 2 Cases - Dennis Lynch, Legal Counsel & Evelyn McEntire, Risk Manager

4.4. Approval of closed meeting minutes – April 22, 2019.

MMSC (Hawkins/House) to approve the closed agenda. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Hawkins, Hipskind, House, and Francis

Adjourn - Meeting was adjourned at 5:31PM

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

ATTEST:

Nevin House, Secretary/Treasurer
Kaweah Delta Health Care District Board of Directors

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD WEDNESDAY MAY 29, 2019 6:00PM, IN THE KAWEAH DELTA MEDICAL CENTER MINERAL KING WING BLUE ROOM, LYNN HAVARD MIRVISS PRESIDING

PRESENT: Directors Havard Mirviss, Hawkins Hipskind, House, & Francis; G. Herbst, CEO; H. Lively, MD, Chief of Staff; T. Rayner, SVP & COO, R. Sawyer, VP & CNO, M. Tupper, VP & CFO; D. Cox, VP of Human Resources, D. Leeper, VP & CIO; Marc Mertz, VP of Strategic Planning and Business Development, D. Volosin, B. Cripps, D. Lynch, Legal Counsel; C. Moccio, Board Clerk

The meeting was called to order at 6:00PM by Director Havard Mirviss.

Director Havard Mirviss entertained a motion to approve the agenda.

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

PUBLIC/MEDICAL STAFF PARTICIPATION – None

CLOSED SESSION ACTION TAKEN: Approval of the closed meeting minutes – April 22, 2019.

OPEN MINUTES – Request for approval of the April 22, 2019 and May 10, 2019 open board of directors meeting minutes.

Action Requested – Approval of the open minutes – April 22 and May 10, 2019.

MMSC (House/Francis) to approve of the open minutes – April 22 and May 10, 2019. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Hawkins, House, Hipskind, and Francis

RECOGNITIONS – *Lynn Havard Mirviss*

- Presentation of Resolution 2027 to Shaun Bagley, RN - Service Excellence Award – May 2019 (copy attached to the original of these minutes and considered a part thereof) .
- Presentation of Resolution 2028 to Harry Lively, MD, Chief of Staff 2017 to 2019 (copy attached to the original of these minutes and considered a part thereof).

CONSENT CALENDAR – Director Havard Mirviss entertained a motion to approve the consent calendar. Dennis Lynch requested the removal of item 6.4.

MMSC (Francis/Hawkins) to approve the consent calendar with the removal of item 6.4 {Approval of Resolution 2030 establishing the Kaweah Delta Health Care District Nonqualified Deferred Compensation Plan for Gary Herbst}. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Hawkins, House, Hipskind, and Francis

6.1. REPORTS

A. Medical Staff Recruitment
B. Compliance
C. Cardiac Critical Care Services

6.2. POLICIES

A. **ADMINISTRATIVE**

1.	Chaplain / Clergy Policy	AP.100	Revised
2.	Vendor Relationships	AP.40	Revised

B. Kaweah Delta Health Care District Financial Assistance Program Revised

Full charity and partial charity care programs

6.3. **RECOMMENDATION FROM THE MEDICAL EXECUTIVE COMMITTEE (MAY 2019).**

A. Medical Staff Policy
   1. MS.8710 Peer Review Process – Revised
B. Privilege Forms
   1. Nurse Practitioner / Physician Assistant
   2. Radiology
   3. Fluoroscopy

6.4. Approval of Resolution 2030 establishing the Kaweah Delta Health Care District Nonqualified Deferred Compensation Plan for Gary Herbst.

6.5. Approve Resolution 2031 rejecting the claim of Zachary Hernandez vs. Kaweah Delta Health Care District.

6.6. Approval of Resolution 2029 rejecting the claim of Jon Eric Souza vs. Kaweah Delta Health Care District.

6.4 - APPROVAL OF RESOLUTION 2030 ESTABLISHING THE KAWEAH DELTA HEALTH CARE DISTRICT NONQUALIFIED DEFERRED COMPENSATION PLAN FOR GARY HERBST.

- Mr. Lynch noted that upon the recommendation of Director Hipskind, he request that the Board authorize the modification of paragraph 2 of Resolution 2030 to include the underscored language below:

  Whereas, the District's Board of Directors ("Board") with the assistance of an independent consulting firm, Gallagher dba Integrated/Healthcare Strategies, experts in healthcare CEO compensation, has carefully examined the compensation package for Gary Herbst for equity with that of other comparable executives in the industry, and the Board has determined to include a supplemental retirement benefit to properly recognize the contribution he is making to the District; and

MMSC (Hipskind/Francis) to approve item 6.4 with the addition to paragraph 2; with the assistance of an independent consulting firm, Gallagher dba Integrated/Healthcare Strategies, experts in healthcare CEO compensation. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Hawkins, House, Hipskind, and Francis

COMMUNITY ENGAGEMENT - Community Advisory Committee Healthcare for Today and Tomorrow – Progress report of committee activities - Report on the Kaweah Del Community Engagement Initiative groups (copy attached to the original of these minutes and considered a part thereof) - *Deborah Volosin, Director of Community Engagement*

QUALITY - Sepsis Quality Focus Team - A review of key quality measures, performance, outcomes and action items relating to the Kaweah Delta Sepsis Program (copy attached to the original of these minutes and considered a part thereof) - *Thomas Gray, M.D., Quality and Patient Safety Medical Director & Kassie Waters, Quality Improvement Manager – Quality & Patient Safety*

CLEVELAND CLINIC – Status of implementation plans and opportunities relative to the Kaweah Delta affiliation with Cleveland Clinic Heart and Vascular Institute (copy attached to the original of these minutes and considered a part thereof) - *Regina Sawyer, RN, Vice President and Chief Nursing Officer, Barry Royce, Director of Cardiovascular Service Line and Cardiovascular Co-Management Program*

FINANCIALS – Review of the most current fiscal year 2019 financial results (copy attached to the original of these minutes and considered a part thereof) - *Malinda Tupper, VP & Chief Financial Officer*

PRELIMINARY REVIEW OF 2019/2020 ANNUAL OPERATING AND CAPITAL BUDGET – Preliminary review of the draft annual operating and capital budget as reviewed by the Board of Director's Finance, Property Services and Acquisition Committee (copy attached to the original of these minutes and considered a part thereof) - *Malinda Tupper –Vice President & Chief Financial Officer*

CREDENTIALING – Harry Lively, MD – Chief of Staff - Medical Executive Committee request 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.

Director Havard Mirviss requested a motion for the approval of the credentials report excluding the Emergency Medicine providers highlighted on Exhibit A {copy attached to the original of these minutes and considered a part thereof}.

MMSC (Francis/Hipskind) 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. Vote: Director Havard Mirviss, House, Hawkins, Francis & Hipskind – Yes.

Director John Hipskind, MD left the room for the vote on the credentials, for the Emergency Medicine providers as highlighted on Exhibit A {copy attached to the original of these minutes and considered a part thereof}.

MMSC (Hawkins/House) 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 Emergency Medicine providers 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 Emergency Medicine providers 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. Vote: Director Havard Mirviss, House, Francis & Hawkins – Yes. Director Hipskind – Absent

CHIEF OF STAFF REPORT – Report from Harry Lively, MD, Chief of Staff:

- Texting policy should be coming to the Board for approval soon. Beta testing is starting soon.
- Anti-harassment learning module has been adopted.

- Physician engagement survey – good response.

CHIEF EXECUTIVE OFFICER REPORT – Report from Gary Herbst, CEO

- 90% participation was achieved for the employee engagement survey.
- District Hospital Leadership Forum (DHLF)
  - DHLF is very important advocacy tool at the federal and state level.
  - The 340B program resulted in approximately $8 million in savings for Kaweah.
  - Medical DSH cuts have been delayed again.
  - Area wage index – there is a proposed bill to cut high wage states and balance it out with other states $600-700,000 - potential impact to CA.
  - PRIME is scheduled to end June 2020 but it could be extended another five years for District hospitals.
- Federally Qualified Health Clinic (FQHC) - We are still working on the clarification of application process.
- USC Medical School Affiliation – We are not affiliated with any UC school at this point, we are a standalone GME program. Marc Mertz and Dr. Winston have been engaging with USC and they appear to be very interested in an affiliation with Kaweah Delta and USC. The Medical Executive Committee is in full support.
- Acequia Wing 5th and 6th floor – 5th floor and 6th floor should have been done and opening soon. OSHPD during a final site inspection is requiring 27 additional fire dampers on the floors. This is a contraction to the approved plans at a cost of a 3 month delay and addition $400,000 in costs.

BOARD PRESIDENT REPORT – Report from Lynn Havard Mirviss, Board President:

- No report.

Adjourn - Meeting was adjourned at 7:41PM

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

ATTEST:

Nevin House, Secretary/Treasurer
Kaweah Delta Health Care District Board of Directors

MINUTES OF THE SPECIAL OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD MONDAY JUNE 3, 2019 5:00PM, IN THE KAWEAH DELTA MEDICAL CENTER ACEQUIA WING CONFERENCE ROOM, LYNN HAVARD MIRVISS PRESIDING

PRESENT: Directors Havard Mirviss, Hawkins Hipskind, House, & Francis; Gary Herbst, Chief Executive Officer; Tom Rayner, SVP & COO; Regina Sawyer, VP & CNO; Marc Mertz, VP of Strategic Planning and Business Development; Doug Leeper, VP & CIO; Deborah Volosin, Dennis Lynch, Legal Counsel; Cindy Moccio, Board Clerk

The meeting was called to order at 5:00pm by Director Havard Mirviss.

Director Havard Mirviss entertained a motion to approve the agenda.

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

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. 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.

- No public comment.

DISTRICT BOUNDARIES – Education session and discussion relative to district boundaries (copy attached to the original of these minutes and considered a part thereof) - *Marc Mertz – Vice President of Strategic Planning and Business Development*

- Mr. Mertz noted that Steve Brandt, Principal Planner with QK produced the report to be reviewed this evening and is present to address any questions.
- Following an in-depth review and discussion of the report presented, it was agreed that the information will be shared with the various Community Advisory Committee and Ambassador groups entertaining discussions relative to the pros and cons of potential district mergers.

Adjourn - Meeting was adjourned at 6:08PM

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

ATTEST:

Nevin House, Secretary/Treasurer
Kaweah Delta Health Care District Board of Directors

MINUTES OF THE SPECIAL OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD MONDAY JUNE 3, 2019 6:00PM, IN THE KAWEAH DELTA MEDICAL CENTER ACEQUIA WING CONFERENCE ROOM, LYNN HAVARD MIRVISS PRESIDING

PRESENT: Directors Havard Mirviss, Hawkins Hipskind, House, & Francis; Gary Herbst, Chief Executive Officer; Tom Rayner, SVP & COO; Regina Sawyer, VP & CNO; Marc Mertz, VP of Strategic Planning and Business Development; Doug Leeper, VP & CIO; Dennis Lynch, Legal Counsel; Cindy Moccio, Board Clerk; Dr.'s Bruce Hall, Darin Smith, Craig Calloway, and Ralph Kingsford; Paul Schofield, and Coby LaBlue

The meeting was called to order at 6:08pm by Director Havard Mirviss.

Director Havard Mirviss entertained a motion to approve the agenda.

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

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. 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.

- No public comment.

KAWEAH DELTA MEDICAL FOUNDATION – Financial performance and strategic planning for the Kaweah Delta Medical Foundation (copy attached to the original of these minutes and considered a part thereof) - *Kaweah Delta Medical Foundation: Paul Schofield, Chief Executive Officer, and Coby LaBlue, Chief Financial Officer*

- Discussion regarding the financial performance vs. the original profoma including the reasons for the variances. Discussion regarding physician recruitment goals and how to achieve these goals. There will be a retreat on Saturday for the leadership of the Foundation and the physicians to put together a plan for the future.

Adjourn - Meeting was adjourned at 7:51PM

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

ATTEST:

Nevin House, Secretary/Treasurer
Kaweah Delta Health Care District Board of Directors

Kaweah Delta
HEALTH CARE DISTRICT

RESOLUTION 2032

WHEREAS, the Department Heads of the KAWEAH DELTA HEALTH CARE DISTRICT are recognizing Kelly Gentner with the Service Excellence Award for the Month of June 2019, for consistent outstanding performance, 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 hospital staff, and the community they represent, hereby extend their congratulations to Kelly 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 June 2019 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

Kaweah Delta
HEALTH CARE DISTRICT

RESOLUTION 2033

WHEREAS, Ed Richert, Director of EAP, is retiring from duty at Kaweah Delta Health Care District after 26 years of service; and,

WHEREAS, the Board of Directors of the Kaweah Delta Health Care District is aware of his loyal service and devotion to duty;

NOW, THEREFORE, BE IT RESOLVED that the Board of Directors of the Kaweah Delta Health Care District, on behalf of themselves, the Hospital Staff and the community they represent, hereby extend their appreciation to Ed Richert for 26 years of faithful service and, in recognition thereof, have caused this resolution to be spread upon the minutes of this meeting.

PASSED AND APPROVED this 24th day of June 2019 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

Kaweah Delta
HEALTH CARE DISTRICT

RESOLUTION 2034

WHEREAS, Brenda Hudson, EAP Counselor, is retiring from duty at Kaweah Delta Health Care District after 18 years of service; and,

WHEREAS, the Board of Directors of the Kaweah Delta Health Care District is aware of her loyal service and devotion to duty;

NOW, THEREFORE, BE IT RESOLVED that the Board of Directors of the Kaweah Delta Health Care District, on behalf of themselves, the Hospital Staff and the community they represent, hereby extend their appreciation to Brenda Hudson for 18 years of faithful service and, in recognition thereof, have caused this resolution to be spread upon the minutes of this meeting.

PASSED AND APPROVED this 24th day of June 2019 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

Kaweah Delta
HEALTH CARE DISTRICT

RESOLUTION 2035

WHEREAS, Jody Kitchen, Secretary III EAP, is retiring from duty at Kaweah Delta Health Care District after 21 years of service; and,

WHEREAS, the Board of Directors of the Kaweah Delta Health Care District is aware of her loyal service and devotion to duty;

NOW, THEREFORE, BE IT RESOLVED that the Board of Directors of the Kaweah Delta Health Care District, on behalf of themselves, the Hospital Staff and the community they represent, hereby extend their appreciation to Jody Kitchen for 21 years of faithful service and, in recognition thereof, have caused this resolution to be spread upon the minutes of this meeting.

PASSED AND APPROVED this 24th day of June 2019 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

Kaweah Delta Physician Recruitment
Open Position Snapshot - June 2019

Prepared by: Brittany Taylor, Senior Physician Recruiter btaylor@kdhcd.org - (559)624-2899

Date prepared: 6/19/2019

Bryson Cancer Center	
Medical Oncologist	1
Nurse Practitioner	1

Central Valley Critical Care Medicine	
Intensivist	4
Hospitalist	4

Delta Doctors Inc.	
Adult Primary Care	1
OB/Gyn	2

IQ Surgical Associates	
GI Hospitalist	3

Key Medical Associates	
Adult Primary Care	3
Hospitalist	2

Orthopedics	
Orthopedic Surgery - Spine	1
Orthopedic Surgery - Hand	1

Sequoia Radiation Oncology Medical Associates	
Radiation Oncology	1

Somnia	
Anesthesiology - Cardiac/General	1
Anesthesiology - Regional	1

Valley Children's Health Care	
Maternal Fetal Medicine	2
Neonatology	2

Visalia Medical Clinic (Kaweah Delta Medical Foundation)	
Adult Primary Care	2
Dermatology	2
Gastroenterology	2
OB/GYN	3
Orthopedic Surgery	1
Pediatrics	2
Psychiatry	2
Radiology	1
Rheumatology	1
Urology	1
Palliative Medicine	2

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

Candidate Activity							
Specialty	**Group**	**Last Name**	**First Name**	**Availability**	**Board Certification**	**Miscellaneous**	**Current Status**
Anesthesiology - Cardiac	Somnia	Dahl, M.D.	Aaron	09/19	American Board of Anesthesiology, Certified; Critical Care Medicine, Certified	CA licensed	Site visit: 5/29/19
Anesthesiology - Pain	Somnia	Louka, M.D.	Sammy	07/19	American Board of Anesthesiology, Certified; Pain Medicine, Certified	CA licensed; Actively working as a locums.	Converting from locum to Per Diem; Contract pending
Anesthesiology - Pain	Somnia	Sandhu, M.D.	Navpark	05/19	American Board of Anesthesiology, Certified	CA licensed; Director of Acute Pain Services/Core Faculty	Contract pending
Cardiothoracic Surgery	Golden State Cardiac & Thoracic Surgery	Carrizo, M.D.	Gonzalo	08/19	American Board of Thoracic Surgery, Certified	CA licensed; Bilingual in Spanish; Responded directly through Cleveland Clinic Foundation posting on 7/27/18	Start Date pending
Endocrinology	Key Medical Associates	Chahal, M.D.	Rajinder	TBD	American Board of Internal Medicine, Certified	CA Licensed; Candidate identified from internal source	Currently under review
Endocrinology/Hospitalist	Key Medical Associates	Panach	Kamaldeep "Kim"	08/19	American Board of Internal Medicine, Certified; American Board of Endocrinology, Certified	Candidate applied to HealtheCareers job posting	Site Visit: 7/1/19
Family Medicine	Kaweah Delta Faculty Medical Group	Myrick, M.D., Ph.D.	Leila	07/20	American Board of Family Medicine, Eligible	Candidate applied to Practice Match email blast	Site Visit: 7/9/19
Family Medicine	Key Medical Associates	Janvelian, M.D.	Vladamir	07/20	American Board of Family Medicine, Eligible	Spouse is FNP; Also considering local private practices; Presented by local group on 11/28/18.	Site visit: 12/5/18; 2nd Site visit: 3/15/19; Offer extended
Family Medicine	Key Medical Associates	Lee, M.D.	Paul Jie	07/19	American Board of Family Medicine, Eligible	No CA license; Presented by Carson Kolb in 2/2019	Site Visit: 2/20/19; pending 2nd visit

Candidate Activity							
Specialty	**Group**	**Last Name**	**First Name**	**Availability**	**Board Certification**	**Miscellaneous**	**Current Status**
Family Medicine	Delta Doctors, Inc.	Amari, M.D.	Ahmed	09/19	American Board of Family Medicine, Eligible	No CA license; Candidate referred by Dr. Swehli, KEMG	Site Visit: 2/15/19; Offer accepted; Tentative Start Date: 9/13/19
Family Medicine	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Patty, M.D.	Christina	08/20	American Board of Family Medicine, Eligible	CA licensed; Currently completing training with UCSF in Fresno	Site Visit: 2/5/19; Offer accepted; Start Date: 8/31/20
Family Medicine	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Quakenbush, M.D.	Todd	9/3/2019	American Board of Family Medicine, Certified	CA Licensed; presented by Fidelis Partners on 4/16/19	Offer accepted; Start Date: 9/3/19
Gastroenterology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Shah, D.O.	Keval	43831	American College of Osteopathic Internists, Certified	CA license; Candidate reached out directly in 2017. Spouse is Diagnostic Radiologist	Site Visit: 7/13/19
Gastroenterology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Hsueh, M.D.	William	8/7/2019	American Board of Internal Medicine, Certified	No CA license; Presented by Fidelis Partners on 7/25/17	Site Visit: 11/10/17; offer accepted; Start Date: 8/7/2019
Hematology/Oncology	Bryson Cancer Center	Ilyas, M.D.	Omer	10/19	American Board of Internal Medicine, Certified	No CA license; Candidate reached out directly on 5/8/19; Spouse accepted position with FHCN	Tentative Site Visit: 6/27-28/2019
Hospitalist	Central Valley Critical Care Medicine	Bates, D.O.	Zhanna	07/19	American Osteopathic Board of Internal Medicine, Eligible	Presented by Vista Staffing on 3/5/2019	Site Visit: 3/19/19; Offer pending
Hospitalist	Central Valley Critical Care Medicine	Daryanani, D.O.	Michelle	07/19	American Osteopathic Board of Critical Care, Certified; American Osteopathic Board of Anesthesiology, Certified	No CA license; Presented by Merritt Hawkins on 1/9/2019	Site Visit: 1/25/19

Candidate Activity							
Specialty	**Group**	**Last Name**	**First Name**	**Availability**	**Board Certification**	**Miscellaneous**	**Current Status**
Hospitalist	Central Valley Critical Care Medicine	Malik, D.O.	Ankit	ASAP	American Board of Family Medicine, Certified; American Osteopathic Board of Family Physicians, Certified	CA licensed; Candidate applied directly to association job posting on 3/6/19	Currently under review
Hospitalist	Central Valley Critical Care Medicine	Mukhtar, D.O.	Nadeem	TBD	American Board of Internal Medicine, Eligible	No CA license; Candidate applied directly to Practice Match job position. Fluent in Urdu, Hindi, Punjabi, and basic Spanish	Site Visit: 4/13/19
Hospitalist	Central Valley Critical Care Medicine	Shurbaji, M.D.	Adam	TBD	TBD	Candidate identified by attendance at CareerMD Career Fair	Site visit pending
Hospitalist	Key Medical Associates	Thussu, M.D.	Neelesh	07/19	TBD	Presented by Carson Kolb in 3/2019	Site Visit: 3/22/19; Offer pending
Hospitalist	Central Valley Critical Care Medicine	Abdelmisseh, M.D.	Mariam	07/19	American Board of Family Medicine, Eligible	CA licensed; completing residency at Kern Medical in Bakersfield; Presented by Vista Staffing	Site Visit: 10/2/18; offer accepted
Hospitalist	Valley Hospitalist Medical Group	Khalid, M.D.	Ahmer	8/15/2019	American Board of Family Medicine, Eligible	CA licensed; Currently Kaweah Delta Family Medicine Resident	Offer accepted; Start Date: 8/15/19
Hospitalist	Valley Hospitalist Medical Group	Reddy, M.D.	Sandhya	9/1/2019	American Board of Internal Medicine, Eligible	CA licensed; Referred by local Cardiologist	Offer accepted; Start Date: 9/1/19
Hospitalist	Valley Hospitalist Medical Group	Tedaldi, M.D.	Michael	8/1/2019	American Board of Internal Medicine, Eligible	CA licensed; Spouse is currently Resident with KDHCD General Surgery program; Candidate reached out directly on 11/10/17	Site Visit: 11/14/17; offer accepted; Start Date: 8/1/19

Candidate Activity							
Specialty	**Group**	**Last Name**	**First Name**	**Availability**	**Board Certification**	**Miscellaneous**	**Current Status**
Intensivist	Central Valley Critical Care Medicine	Aftab, M.D.	Waqas	07/19	American Board of Internal Medicine, Certified; Nephrology, Certified; Critical Care, Eligible	CA licensed; Candidate applied directly on 1/3/19	Site Visit: 3/16/19; Offer pending
Intensivist	Central Valley Critical Care Medicine	Bharati, M.D.	Pankaj	TBD	American Board of Internal Medicine, Certified	CA licensed; Candidate presented by Merritt Hawkins	Site Visit: 04/19/19
Intensivist	Central Valley Critical Care Medicine	Sazgar, M.D.	Sasan	07/20	American Board of Internal Medicine, Certified	CA licensed; Candidate applied directly on 1/12/19 to HealtheCareers posting. Previously practiced in Fresno before going into fellowship.	Site Visit Pending dates in June/July
Internal Medicine	Key Medical Associates	Al-Khayyat, M.D.	Mohammed	07/20	TBD	No CA license; Presented by Carson Kolb	Site Visit: 5/29/19; offer pending
Internal Medicine	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Shams, M.D.	Sharmineh	8/1/2019	American Board of Internal Medicine, Certified	CA licensed; Worked with VMC previously; Spouse is Dr. Reza Rafie, Interventional Cardiologist.	Offer accepted; Start Date: 8/1/19
Interventional Cardiology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Rafie, M.D.	Reza	8/1/2019	American Board of Internal Medicine, Certified; American Board of Internal Medicine - Cardiovascular Disease, Certified	CA licensed; Worked with VMC previously; Spouse is Dr. Sharmineh Shams, Internal Medicine	Offer accepted; Start Date: 7/1/19
Interventional Radiology	Mineral King Radiology Group	Valles, M.D.	Francisco	8/15/2019	American Board of Radiology, Eligible	Presented by Fidelis Partners on 11/30/18	Offer accepted; Start Date: 8/15/19
Maternal Fetal Medicine	Valley Children's Hospital	Steller, M.D.	Jonathan	07/20	American Board of Pediatrics, Certified	No CA license; Presented by VCH on 4/1/2019	Site Visit: 5/06/19; Offer pending
Maternal Fetal Medicine - Medical Director	Valley Children's Hospital	Hole, D.O.	James	TBD	American Board of Obstetrics and Gynecology, Certified	No CA license; Presented by VCH on 4/3/19	Site Visit: 5/3/19; Offer accepted; Start Date: 9/23/19

Candidate Activity							
Specialty	**Group**	**Last Name**	**First Name**	**Availability**	**Board Certification**	**Miscellaneous**	**Current Status**
Neonatology	Valley Children's Hospital	Box, M.D.	David	08/20	TBD	Presented by VCH on 4/20/19	Site Visit: 5/13/19; Offer pending
Neonatology	Valley Children's Hospital	Hanna, M.D.	Mina	TBD	American Board of Pediatrics, Certified	No CA license; Presented by VCH on 5/6/2019	Site Visit: 5/20/19
Neonatology	Valley Children's Hospital	Patel, M.D.	Shalinkumar	TBD	American Board of Pediatrics, Certified	No CA license; Interested in VCH Main Campus; Presented by VCH on 5/6/2019	Site Visit: 5/14/19; Offer pending
Neonatology	Valley Children's Hospital	Reed, M.D.	Benjamin	TBD	American Board of Pediatrics, Certified	No CA license; Interested in VCH Main Campus; Presented by VCH on 5/6/2019	Site Visit: 5/24/19; Offer extended
Neonatology	Valley Children's Hospital	Gerard, M.D.	Kimberley	01/20	American Board of Pediatrics, Eligible	CA licensed; Presented by VCH on 11/28/18	Site Visit: 1/11/19; Tentative start date: 1/6/20
Neonatology	Valley Children's Hospital	Aboaziza, M.D.	Ahmad	06/19	American Board of Pediatrics, Certified	CA licensed; Candidate applied directly upon recommendation from Dr. Swehli, KEMG on 8/31/18	Site Visit: 11/06/18; offer accepted, tentative start date: 9/9/19
Orthopedic Surgery - Spine	Orthopaedic Associates	Daniels, M.D.	Mathias	TBD	American Board of Orthopedic Surgery, Certified	CA Licensed; Candidate presented by Fidelis Partners on 3/28/19	Site visit: 6/27/19
Orthopedic Surgery - Spine	Orthopaedic Associates	Srinivas, M.D.	Ravi	08/20	American Board of Orthopedic Surgery, Eligible	CA licensed; Candidate presented by Fidelis Partners on 3/19/19	Site Visit: 6/28/19
Orthopedic Surgery - Adult Reconstruction	Orthopaedic Associates	Kim, D.O.	Jun	09/19	American Board of Orthopedic Surgery, Eligible	CA licensed; Direct candidate referred by Dr. Bruce Le on 12/11/17	Site visit: 3/1/18; offer accepted; Start date: 9/3/19

Candidate Activity							
Specialty	**Group**	**Last Name**	**First Name**	**Availability**	**Board Certification**	**Miscellaneous**	**Current Status**
Otolaryngology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Roos, D.O.	Jason	04/20	American Osteopathic Board of Otolaryngology, Certified	Candidate presented by Fidelis Partners on 3/5/2019	Offer accepted; Start Date: 4/1/20
Pediatric Hospitalist	Valley Children's Hospital	Valladares, M.D.	Enrique	07/19	American Board of Pediatrics, Eligible	CA licensed; Spouse is Internal Medicine physician considering FHCN; Presented by VCH on 8/15/18	Site Visit: 8/24/18; offer accepted
Pediatrics	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Chaudhary, M.D.	Gulafsha	01/20	American Board of Pediatrics, Certified	No CA license; Candidate presented by Vista Staffing Solutions on 5/1/19	Site Visit: 5/21/19; Offer extended
Pediatrics	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Garcia, M.D.	Hector	01/20	American Board of Pediatrics, Certified	No CA license; Candidate presented by Fidelis Partners on 4/30/19	Site Visit: 5/31/19; Offer pending
Plastic Surgery/OMF	Sequoia Institute for Surgical Services, Inc.	Nair, M.D.	Narayanan	10/19	American Board of Surgery, Certified	Presented by Dr. Jonathan Liu on 10/4/18	2nd Site Visit: 3/25/19; Offer accepted, pending signed contract
Podiatry	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Ghai, D.P.M.	Ajay	9/3/2019	American Board of Podiatric Medicine, Eligible	CA licensed; Candidate applied directly on 8/1/2018	Site Visit: 9/27/18; offer accepted; Start Date: 9/3/19
Radiation Oncology	Sequoia Radiation Oncology Medical Associates	Chang, D.O.	Tangel	01/20	American Board of Radiology - Radiation Oncology, Certified	Candidate identified from ASTRO attendance in 2017	Currently under review
Radiology - Diagnostic	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Nasehi, M.D.	Leyla	07/20	American Board of Radiology, Eligible	Candidate applied to Practice Match text blast	References/site visit pending
Urology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Yang, M.D.	Hailiu	07/20	American Board of Urology, Eligible 2020	Candidate presented by Fidelis Partners on 6/11/19. Fiancé is completing GI fellowship in 2021	Phone Interview: 6/25/19 - 2PM

Candidate Activity							
Specialty	**Group**	**Last Name**	**First Name**	**Availability**	**Board Certification**	**Miscellaneous**	**Current Status**
Vascular Surgery	South Valley Vascular	Nye, D.O.	David	6/28/2019	American Osteopathic Board of Surgery - General Surgery, Eligible	No CA license; Candidate applied directly with group	Site Visit: 8/8/18; offer accepted; Start Date: 7/1/2019

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

Cardiovascular Services

Christine Aleman RN, MSN, Director of Cardiovascular Operations
June 2019

Summary Issue/Service Considered

- Continue to provide compassionate and professional care for our patients, physicians and staff.
- Maintain the highest quality care, compliance and profitability while sustaining and ideal work environment

Quality/Performance Improvement Data

Cardiac Cath Lab:

- Partnership with Cleveland Clinic focusing on quality, efficiency, and service line expansion.
- Initiate same day discharge for patients who have percutaneous coronary intervention (PCI)
- Increase radial access vs. femoral approach from 1% to 35% for PCI
    - Decrease risk of bleeding
    - Faster recovery and early mobility
    - Improve patient experience
- Continue participation for quality measures for American College of Cardiology (ACC).

Cardiothoracic Surgery:

- Continue participation for quality measures with Society of Thoracic Surgery (STS).
- Recipient of Healthgrades Cardiac Care Excellence Award 2018.
- Named among the top 5 percent in the nation for Cardiac Surgery 2018.

Policy, Strategic or Tactical Issues

- Additional cardiologists and cardiothoracic surgeons allows for the expansion of primary and secondary markets.
- Decrease length of stay by increasing access and efficiencies in the cardiovascular area.

Recommendations/Next Steps

- Annual strategic planning sessions to define opportunities for cardiovascular growth.
- Quarterly quality meeting with Cleveland Clinic for CT Surgery and cardiac lab.
- Strategic physician recruitment.

Approvals/Conclusions

The cardiovascular program fulfills a critical need for our community that we serve.

Kaweah Delta Health Care District
Annual Report to the Board of Directors
Financial & Statistical Information

Cardiac Catheterization

Christine Aleman

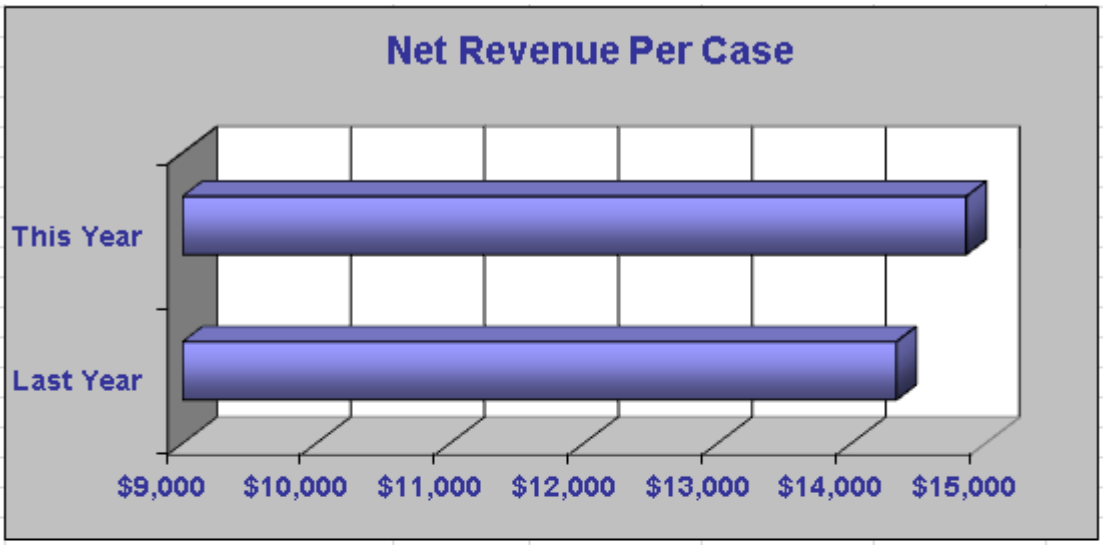
June 2019

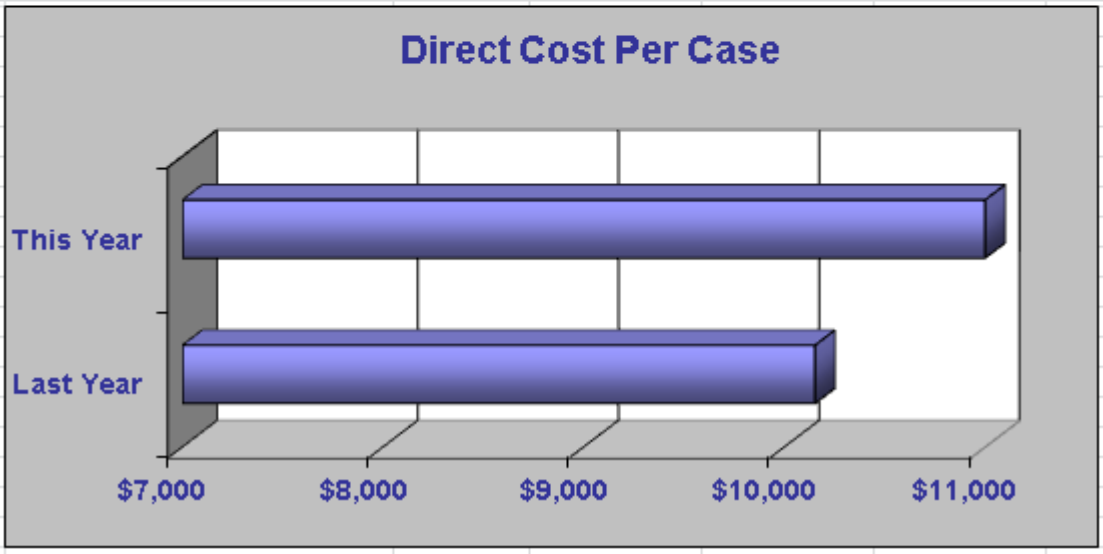
Service Line Report Data: Fiscal Year 2019 - Annualized Ten Months Ended April 30, 2019

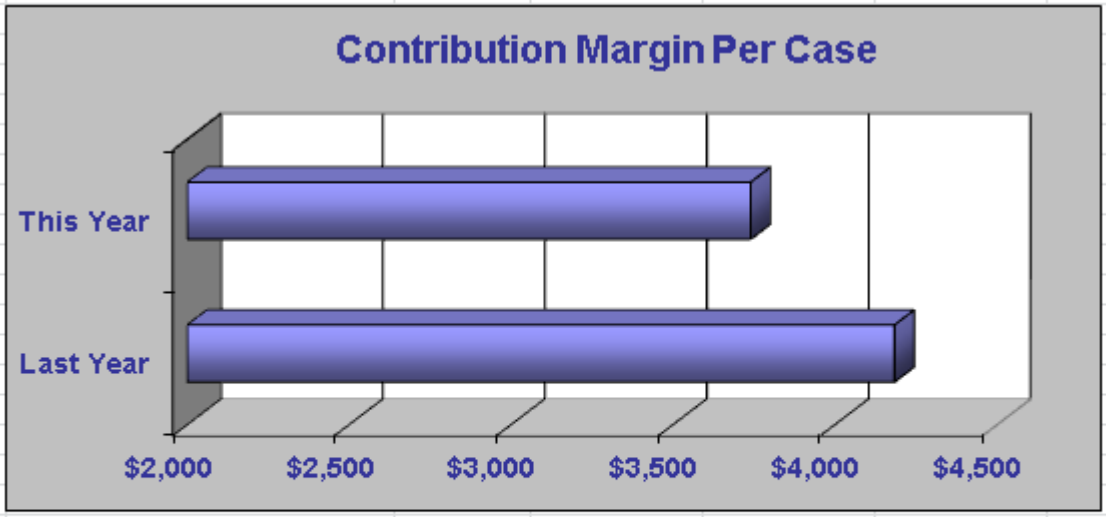
Service	Patient Cases	Net Revenue	Direct Costs	Contribution Margin	Indirect Costs	Net Income
Cardiac Cath Procedures - I/P	1,500	$44,469,753	$33,332,058	$11,137,695	$8,666,307	$2,471,388
Cardiac Cath Procedures - O/P	2,766	$18,913,483	$14,094,712	$4,818,771	$2,965,497	$1,853,274
Grand Total	**4,266**	**$63,383,236**	**$47,426,770**	**$15,956,466**	**$11,631,804**	**$4,324,662**
Per Case		*14,858*	*11,117*	*3,740*	*2,727*	*1,014*

Service Line Report Data: Fiscal Year 2018

Service	Patient Cases	Net Revenue	Direct Costs	Contribution Margin	Indirect Costs	Net Income
Cardiac Cath Procedures - I/P	1,447	$39,750,133	$27,403,015	$12,347,118	$7,424,719	$4,922,399
Cardiac Cath Procedures - O/P	2,849	$21,833,812	$16,207,941	$5,625,871	$3,733,265	$1,892,606
Grand Total	**4,296**	**$61,583,945**	**$43,610,956**	**$17,972,989**	**$11,157,984**	**$6,815,005**
Per Case		*14,335*	*10,152*	*4,184*	*2,597*	*1,586*
Increase (Decrease)	**(30)**	**$1,799,291**	**$3,815,814**	**($2,016,523)**	**$473,820**	**($2,490,343)**
Per Case		*3.6%*	*9.5%*	*-10.6%*		







	Last Year	This Year
Net Revenue Per Case	$14,335	$14,858
Direct Cost Per Case	$10,152	$11,117
Contribution Margin Per Case	$4,184	$3,740

Kaweah Delta Health Care District
Annual Report to the Board of Directors
Financial & Statistical Information

Cardiac Surgery

Christine Aleman

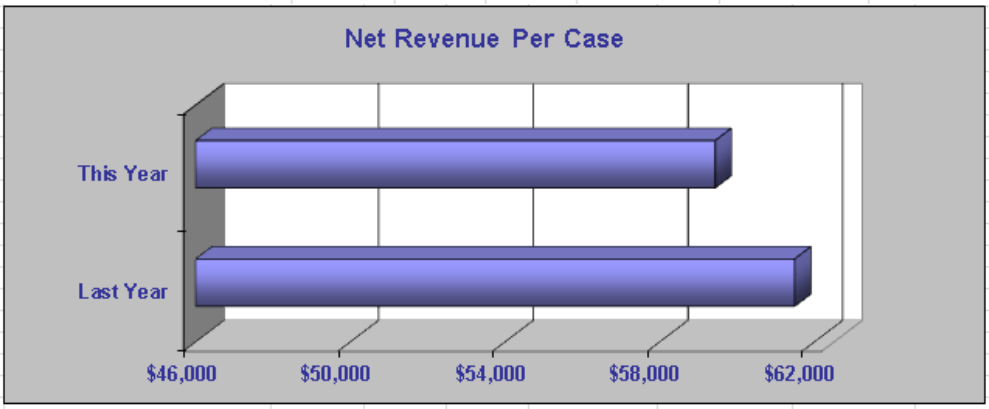
June 2019

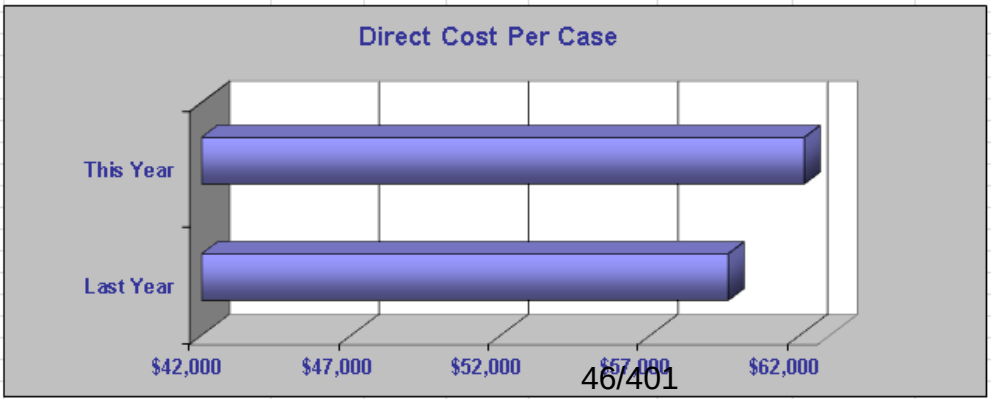
Service Line Report Data: Fiscal Year 2018

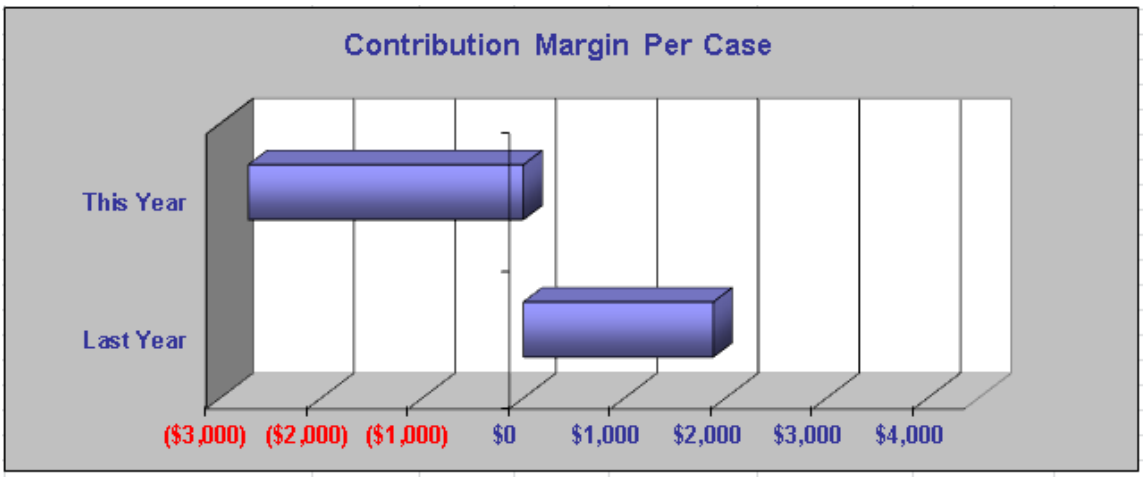
Service	Patient Cases	Patient Days	ALOS	Net Revenue	Direct Costs	Contribution Margin	Indirect Costs	Net Income
Cardiac Surgery	273	3,152	11.55	$16,224,742	$16,967,307	($742,565)	$4,188,955	($4,931,520)
Grand Total	**273**	**3,152**	**11.55**	**$16,224,742**	**$16,967,307**	**($742,565)**	**$4,188,955**	**($4,931,520)**
Per Case				*59,431*	*62,151*	*(2,720)*	*15,344*	*(18,064)*

Service Line Report Data: Fiscal Year 2017

Service	Patient Cases	Patient Days	ALOS	Net Revenue	Direct Costs	Contribution Margin	Indirect Costs	Net Income
Cardiac Surgery	227	2,594	11.43	$13,956,678	$13,530,098	$426,580	$3,065,193	($2,638,613)
Grand Total	**227**	**2,594**	**11.43**	**$13,956,678**	**$13,530,098**	**$426,580**	**$3,065,193**	**($2,638,613)**
Per Case				*61,483*	*59,604*	*1,879*	*13,503*	*(11,624)*
Increase (Decrease)	**46**	**558**	**0.12**	**$2,268,064**	**$3,437,209**	**($1,169,145)**	**$1,123,762**	**($2,292,907)**
Per Case				*-3.3%*	*4.3%*	*-244.7%*		







	Last Year	This Year
Net Revenue Per Case	$61,483	$59,431
Direct Cost Per Case	$59,604	$62,151
Contribution Margin Per Case	$1,879	($2,720)

Non-Invasive Cardiology

(Adult and Pediatric Echocardiography, Transesophageal Echocardiography, Peripheral Vascular-Venous, Arterial, Carotids, Cardiac Stress Tests, Tilt Tables, and Pacemaker/Holter monitoring)

Barry Royce, RN, MHA - Director of CVSL and Co-Mgmt. Program 624-4919
Cheryl Clark, RDMS - Manager Non-Invasive Cardiovascular Diagnostics 624-2654

June 2019

Summary of 2018 Report and New Services Considered

The Non-Invasive Cardiology Department has followed an 8.9% increase 2017 with an 11.1% increase in volume in 2018. This increase in volume has translated into a projected $2.9 million excess in Billed Revenue to Budgeted Revenue for FY '19. Additionally we have seen a nice increase of $100/case in Net Revenue; the addition of Definity and increased efficiencies have contributed to this increase. Below is an update on projects we worked on over the past year.

- Cheryl Clark continues to work with the Cleveland Clinic on our Intersocietal Accreditation Committee (IAC) Certification of our Non-Invasive Cardiology Lab.
  - We implemented monthly Quality and Education Conference with Continuing Education Units (CEU).
  - We also have increased our technology with upgraded machines and imaging technology
- Planned Sonographer support for the Kaweah Delta Sequoia Cardiology Clinic on our west campus was planned for one Sonographer; this need quickly grew to a requirement for a second Sonographer and FY '20 will likely see the need for a third.
- We are in early discussion about the consolidation of the 202 Willow site with the Sequoia Cardiology site. Items for consideration with this move include backfill of this 1206D clinic space, referral patterns of providers, and capacity issues at SCC.
- We have solidified Nurse Practitioner Support for:
  - Stress Testing
  - Bubble Studies
  - Image enhancement (Definity) Studies
  - Chemical Stress Testing
  - Tilt Table Exams

  This has allowed us to improve throughput for these exams, improve quality of imaging, and potentially assist with decreasing LOS by decreasing utilization of Nuclear Medicine Stress testing for low risk chest pain patients
- We continue our collaboration with Valley Children's Hospital to enhance our care of our neonatal and pediatric populations here at Kaweah Delta.

Quality/Performance Improvement Data

Ongoing monthly performance improvement monitors:

- Retrospective review of overall turnaround time (TAT) for echocardiograms: Benchmark from echocardiographs performed to final report by cardiologist <12 hours. Current TAT for 2018 is 86% compared to our goal of 85%; this is a 4% increase over 2017. We will remain steadfast in our commitment to work collaboratively with our Medical Director and Cardiologists to not only meet but exceed our desired goal of 85%.

2018 Echo TAT for Reads					
	# done	<12hrs	% <12hrs	Total Hrs	Mean TAT hrs
JAN	735	653	**89%**	3933	**5**
FEB	670	590	**88%**	3920	**6**
MAR	739	656	**89%**	4284	**6**
Q1	**2144**	**1899**	**89%**	**12137**	**6**
APR	675	613	**91%**	3406	**5**
MAY	652	559	**86%**	4064	**6**
JUN	590	524	**89%**	3492	**6**
Q2	**1917**	**1696**	**88%**	**10962**	**6**
JUL	674	567	**84%**	5240	**8**
AUG	650	555	**85%**	4264	**7**
SEP	593	462	**78%**	4624	**8**
Q3	**1917**	**1584**	**83%**	**14128**	**7**
OCT	651	538	**83%**	4705	**7**
NOV	687	595	**87%**	4134	**6**
DEC	706	627	**89%**	3781	**5**
Q4	**2044**	**1760**	**86%**	**12620**	**6**
Totals	8022	6939	**86%**	49847	**6**

Policy, Strategic or Tactical Issues

1. Complete preparation/application for successful IAC survey:
    - All staff must achieve certification in Echocardiography prior to application (IAC required). This is still in progress
    - Unanimous engagement/support from all Interpreting Cardiologists in achieving IAC quality measures and maintenance of 15 Echo related CMEs per 3 years (IAC required).
2. Explore possibility of IV certification and administration of Definity by Registered Sonographers.
    - Explore option of RN staff administering Definity on the floors to free up the NP staff.
3. Continue working with Hospitalist Group to order non-Nuclear Medicine Stress Testing.
4. Evaluate feasibility of moving Out-Patient services to SCC.

Recommendations/Next Steps

1. Successful acquisition of Intersocietal Accreditation Committee (IAC) Certification.

Approvals/Conclusions

1. Continue to evaluate and implement process improvements designed to enhance patient and physician satisfaction through increased quality, efficiency and productivity.

2. We remain committed to the delivery of highest quality care with uncompromising service excellence.

Kaweah Delta Health Care District
Annual Report to the Board of Directors
Financial & Statistical Information

Outpatient Noninvasive Cardiology Services

Barry Royce

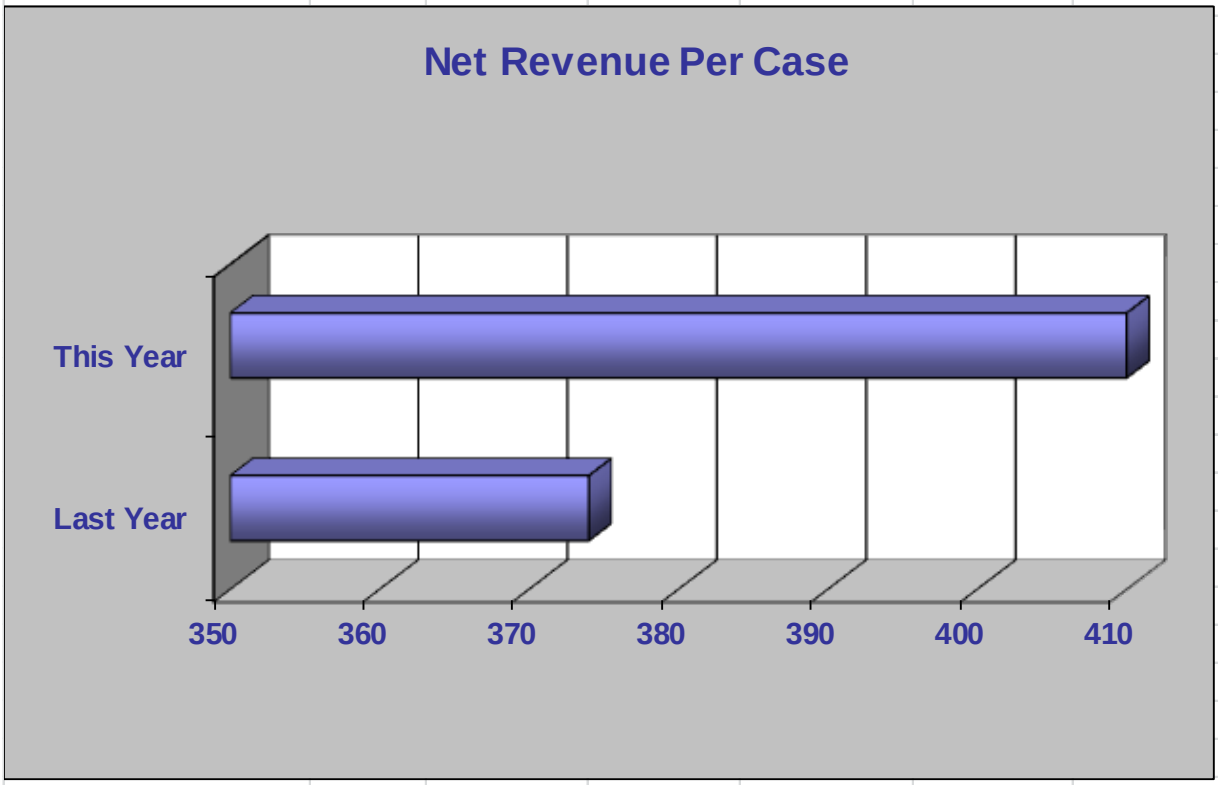
June 2019

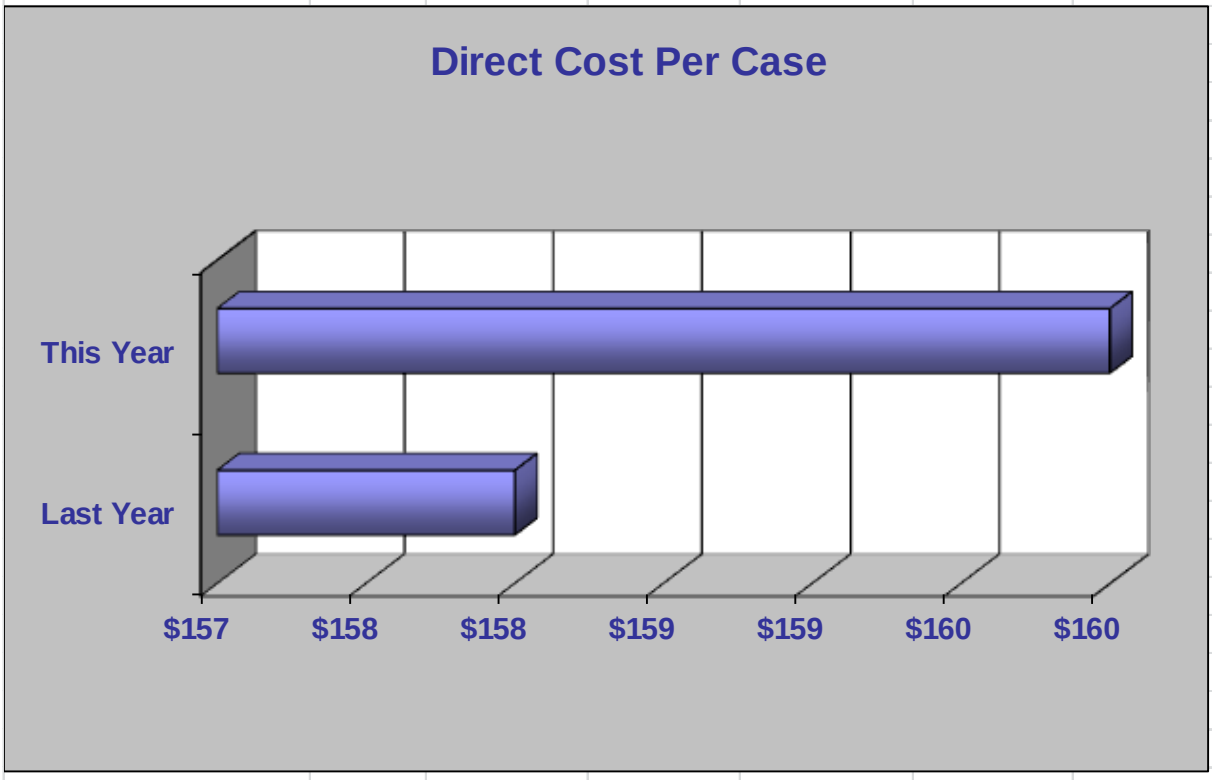
Service Line Report D Fiscal Year 2019 - Annualized Ten Months Ended April 30, 2019

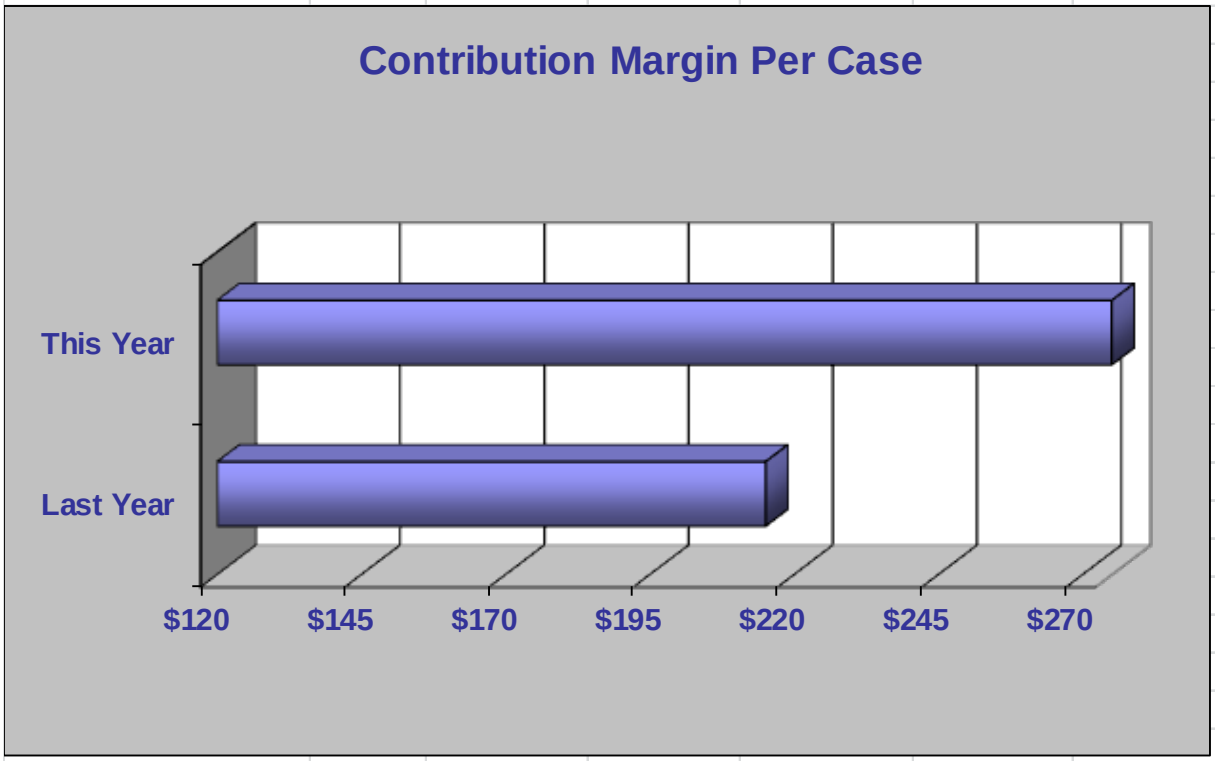
Service	Patient Cases	Net Revenue	Direct Costs	Contribution Margin	Indirect Costs	Net Income
Noninvasive Cardiology	4,082	$1,946,992	$670,466	$1,276,526	$248,174	$1,028,352
Grand Total	**4,082**	**$1,946,992**	**$670,466**	**$1,276,526**	**$248,174**	**$1,028,352**
Per Case		*477*	*164*	*313*	*61*	*252*

Service Line Report D Fiscal Year 2018

Service	Patient Cases	Net Revenue	Direct Costs	Contribution Margin	Indirect Costs	Net Income
Noninvasive Cardiology	3,925	$1,467,013	$621,950	$845,063	$249,233	$595,830
Grand Total	**3,925**	**$1,467,013**	**$621,950**	**$845,063**	**$249,233**	**$595,830**
Per Case		*374*	*158*	*215*	*63*	*152*
Increase (Decrease)	**157**	**$479,979**	**$48,516**	**$431,463**	**($1,059)**	**$432,522**
Per Case Change		*27.6%*	*3.7%*	*45.2%*		


Net Revenue Per Case
This Year
Last Year
350
360
370
380
390
400
410


Direct Cost Per Case
This Year
Last Year
$157
$158
$158
$159
$159
$160
$160



	Last Year	This Year
Net Revenue Per Case	$374	$477
Direct Cost Per Case	$158	$164
Contribution Margin Per Case	$215	$313

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

Surgery

Brian Piearcy, RN BSN Director of Surgical Services, (559) 624-2409
June 24, 2019

Summary Issue/Service Considered

- **Planning for refurbishment and use of the (2) former obstetrical surgical suites to allow for current volume and growth of the Surgery Department**
- **(4) new surgeons to start in the coming months in the main Operating Room (OR) in Orthopedics, Podiatry, Vascular, and Plastic Oral Maxillofacial Surgery.**

Quality/Performance Improvement Data

- **We continue to measure and monitor on-time starts, turnovers times, and report results to the OR Governance Committee and to the Department of Surgery for review.**
- **We continue to meet with quality and risk management teams to measure and improve processes that lead to improved care to patients. A major focus is Surgical Site Infections (SSI). For example, audits are done on room traffic, surgical preparation, and hand-washing to ensure compliance.**
- **Sterile processing of instruments is extremely important. A goal is to minimize the use of immediate use steam sterilization (IUSS) of instruments. We meet the nationally recognized benchmark and are currently at 2.9%.**
- **Working on several lean initiatives for cost savings and inventory control measures**
- **Formed an OR Efficiency Committee. Looking at the entire process from Kaweah Admissions and Testing Services, Pre-Operative, OR, and Post Anesthesia Care Unit (PACU) standpoints.**
- **Formed a Robotics Steering Committee. Looking at costs, supply and standardizations. Evaluating the new robotic series.**

Policy, Strategic or Tactical Issues

- **Continue partnership with the anesthesia group to improve efficiencies and quality:**
    - **Maintain on-time start times at ≥80%. This is currently being worked on through the OR Efficiency Committee.**
    - **Keep turnover times at target goals established by case type.**

    - **Allowing surgeons to "flip" rooms to decrease turnover time and increase case volume.**
    - **Pre and Post-operative pain control management**
- **Work with the marketing team to increase our exposure to the community and highlight new technology, and recent accomplishments.**
- **Continue to collaborate and meet the needs of the surgeons.**
- **Continue to work through logistical issues with the move of the Sterile Processing Department to the Acequia Wing basement**

Recommendations/Next Steps

- **Be Joint Commission ready.**
- **Continue strong financial performance.**

Approvals/Conclusions

Surgery has several positive projects planned for this coming year. Our surgeons and staff provide our patients with the best care. By investing in new technology, starting new surgical service lines, ensuring surgeons have the necessary tools, and by providing educational opportunities for staff, we will be successful in meeting our Mission, Vision, and Pillars

Kaweah Delta Health Care District
Annual Report to the Board of Directors
Financial & Statistical Information

Surgical Services

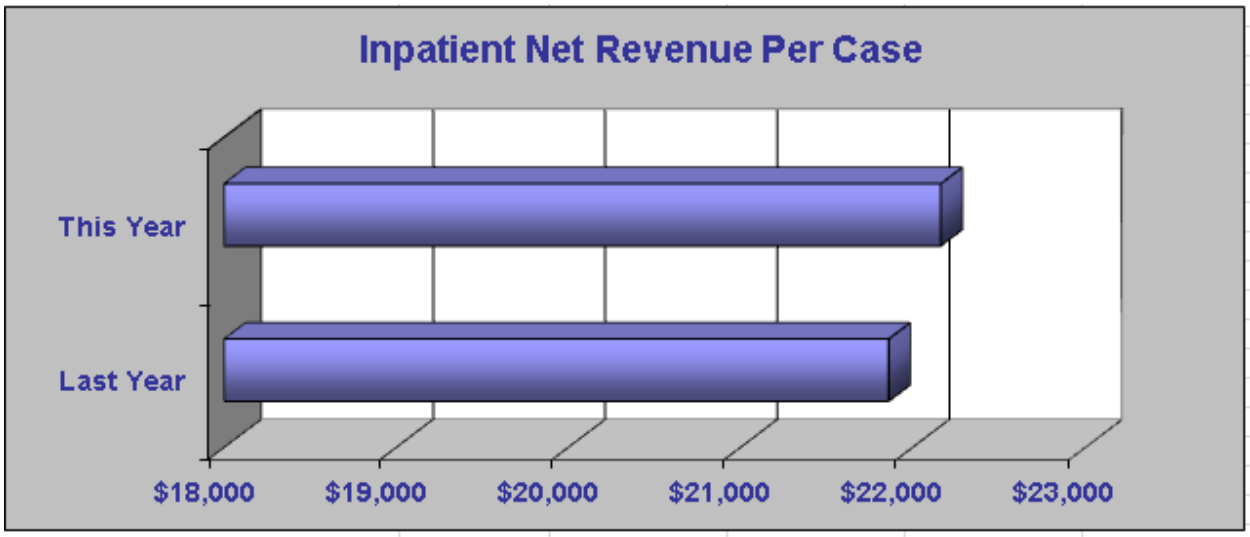
Brian Piearcy
June 2019

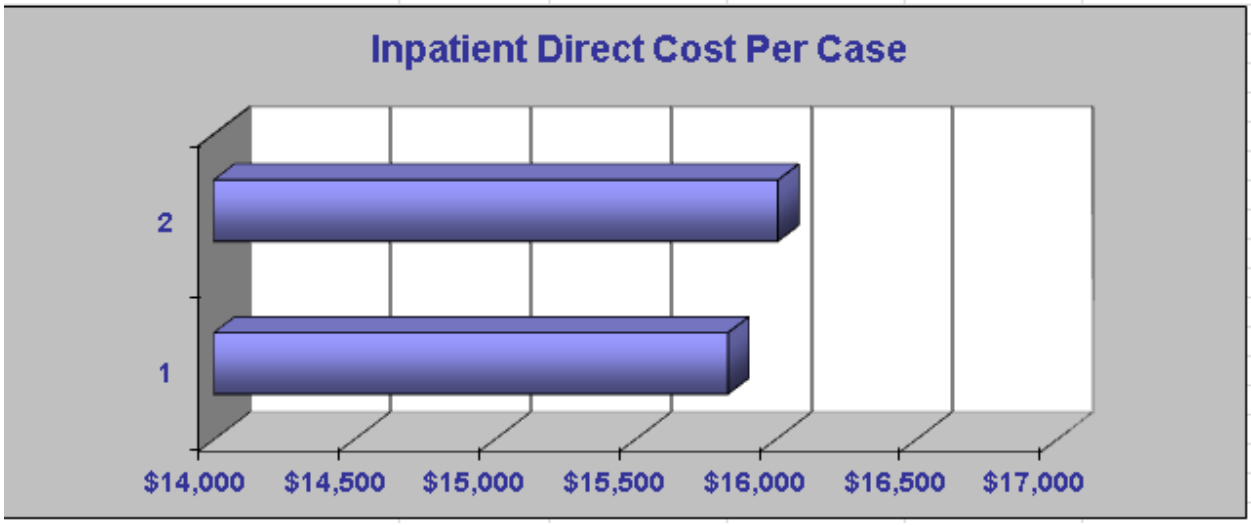
Service Line Report Data: Fiscal Year 2019 - Annualized Ten Months Ended April 30, 2019

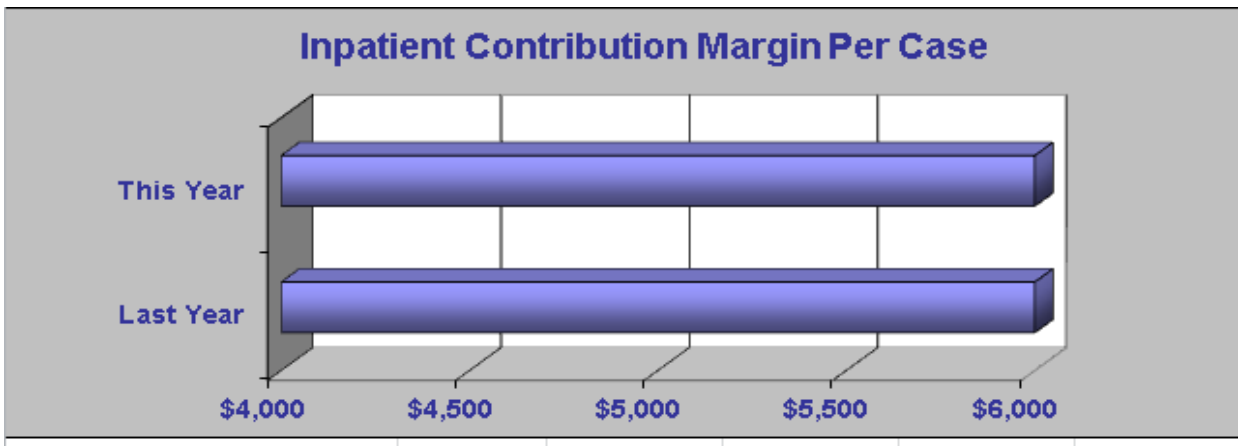
Service	Patient Cases	Net Revenue	Direct Costs	Contribution Margin	Indirect Costs	Net Income
Inpatient:						
General Surgery	1,250	$28,907,692	$20,654,656	8,253,036	$6,944,974	1,308,062
Orthopedics	1,522	28,072,235	19,469,709	8,602,526	5,425,653	3,176,873
Neurosurgery	101	3,550,851	2,493,020	1,057,831	731,470	326,361
Thoracic Surgery	30	2,946,308	2,413,937	532,371	779,415	(247,044)
Vascular Surgery	202	4,739,263	3,884,738	854,525	1,238,261	(383,736)
Gynecology	125	1,408,389	907,233	501,156	352,791	148,365
Urology	187	2,575,350	2,019,167	556,183	724,524	(168,341)
Surgery in other service lines	406	12,778,269	9,680,225	3,098,044	2,956,096	141,948
Robotics Surgery	43	706,230	365,061	341,169	149,754	191,415
Total Inpatient	**3,866**	**$85,684,587**	**$61,887,746**	**$23,796,841**	**$19,302,938**	**$4,493,903**
Per Case		*22,164*	*16,008*	*6,155*	*4,993*	*1,162*
Outpatient:						
Surgery	5,770	$ 19,652,283	$ 22,000,367	(2,348,084)	$ 6,494,386	(8,842,470)
Robotics	170	763,596	869,470	(105,874)	419,769	(525,643)
Total Outpatient	**5,940**	**$20,415,879**	**$22,869,837**	**($2,453,958)**	**$6,914,155**	**($9,368,113)**
Per Case		*3,437*	*3,850*	*(413)*	*1,164*	*(1,577)*
Grand Total	**9,806**	**$106,100,466**	**$84,757,583**	**21,342,883**	**$26,217,093**	**(4,874,210)**
Per Case		*10,820*	*8,643*	*2,177*	*2,674*	*(497)*

Service Line Report Data: Fiscal Year 2018

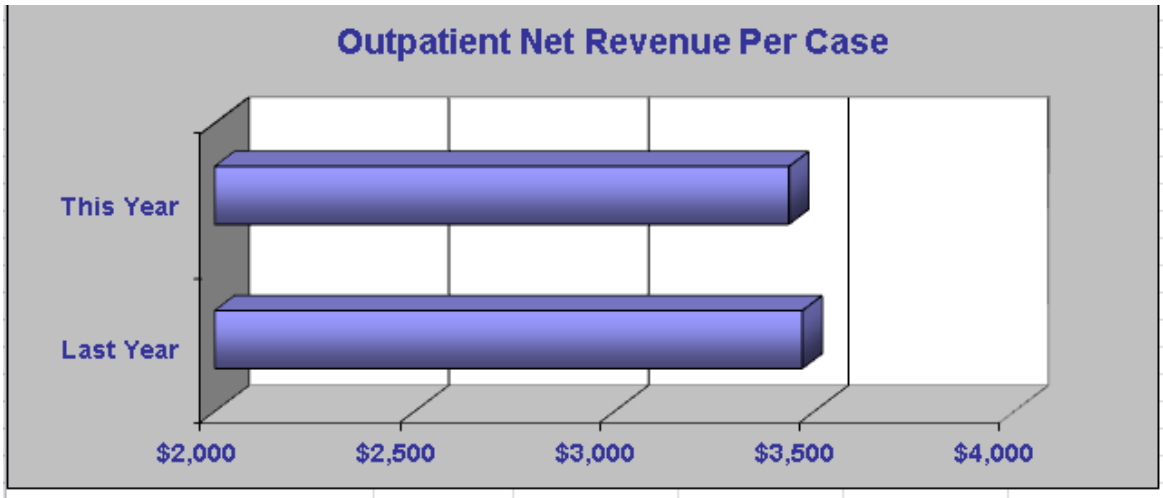
Service	Patient Cases	Net Revenue	Direct Costs	Contribution Margin	Indirect Costs	Net Income
Inpatient:						
General Surgery	1,174	$25,470,176	$17,357,505	8,112,671	$5,837,164	2,275,507
Orthopedics	1,365	26,971,110	20,005,398	6,965,712	4,941,235	2,024,477
Neurosurgery	63	2,589,165	2,051,100	538,065	504,054	34,011
Thoracic Surgery	47	3,231,068	2,641,865	589,203	769,907	(180,704)
Vascular Surgery	225	4,528,436	3,451,434	1,077,002	1,127,227	(50,225)
Gynecology	134	1,353,869	886,022	467,847	325,932	141,915
Urology	80	1,086,337	942,897	143,440	320,599	(177,159)
Surgery in other service lines	350	10,186,258	7,349,779	2,836,479	2,208,369	628,110
Robotics Surgery	41	640,649	385,540	255,109	178,002	77,107
Total Inpatient	**3,479**	**$76,057,068**	**$55,071,540**	**$20,985,528**	**$16,212,489**	**$4,773,039**
Per Case		*21,862*	*15,830*	*6,032*	*4,660*	*1,372*
Outpatient:						
Surgery	5,529	$ 18,985,549	$ 23,023,598	(4,038,049)	$ 7,046,521	(11,084,570)
Robotics	142	696,142	939,591	(243,449)	517,959	**(761,408)**
Total Outpatient	**5,671**	**$19,681,691**	**$23,963,189**	**($4,281,498)**	**$7,564,480**	**($11,845,978)**
Per Case		*3,471*	*4,226*	*(755)*	*1,334*	*(2,089)*
Grand Total	**9,150**	**$95,738,759**	**$79,034,729**	**16,704,030**	**$23,776,969**	**(7,072,939)**
Per Case		*10,463*	*8,638*	*1,826*	*2,599*	*(773)*
Inpatient Increase (Decrease)	**387**	**$9,627,519**	**$6,816,206**	**$2,811,313**	**$3,090,449**	**($279,136)**
Total Change %	*11.1%*	*12.7%*	*12.4%*	*13.4%*		
Per Case Change %		*1.4%*	*1.1%*	*2.0%*		
Outpatient Increase (Decrease)	**269**	**$734,188**	**($1,093,352)**	**$1,827,540**	**($650,325)**	**$2,477,865**
Total Change %	*4.7%*	*3.7%*	*-4.6%*	*-42.7%*		
Per Case Change %		*-1.0%*	*-8.9%*	*-45.3%*		
Total Increase (Decrease)	**656**	**$10,361,707**	**$5,722,854**	**4,638,853**	**$2,440,124**	**2,198,729**
Total Change %	*7.2%*	*10.8%*	*7.2%*	*27.8%*		
Per Case Change %		*3.4%*	*0.1%*	*19.2%*		

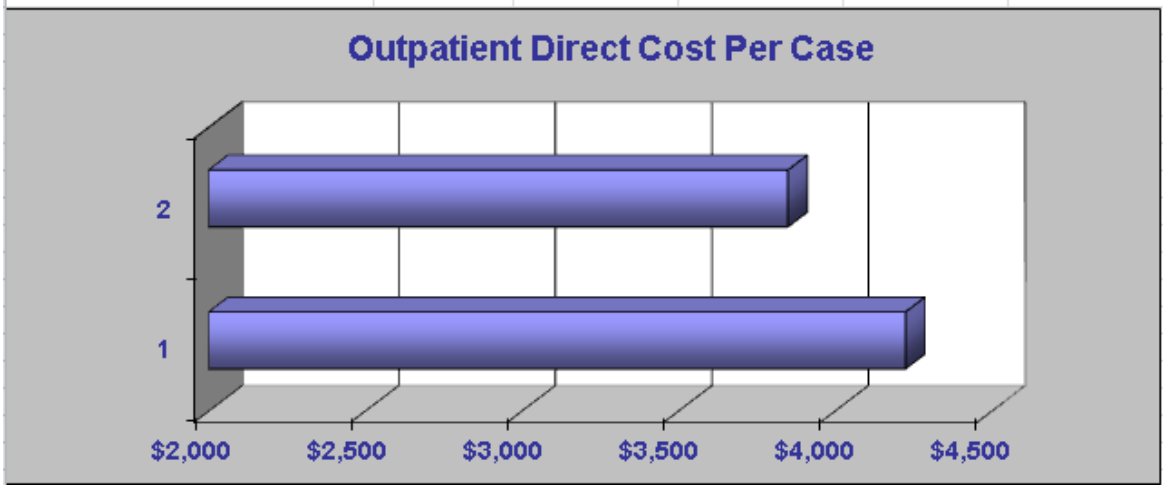


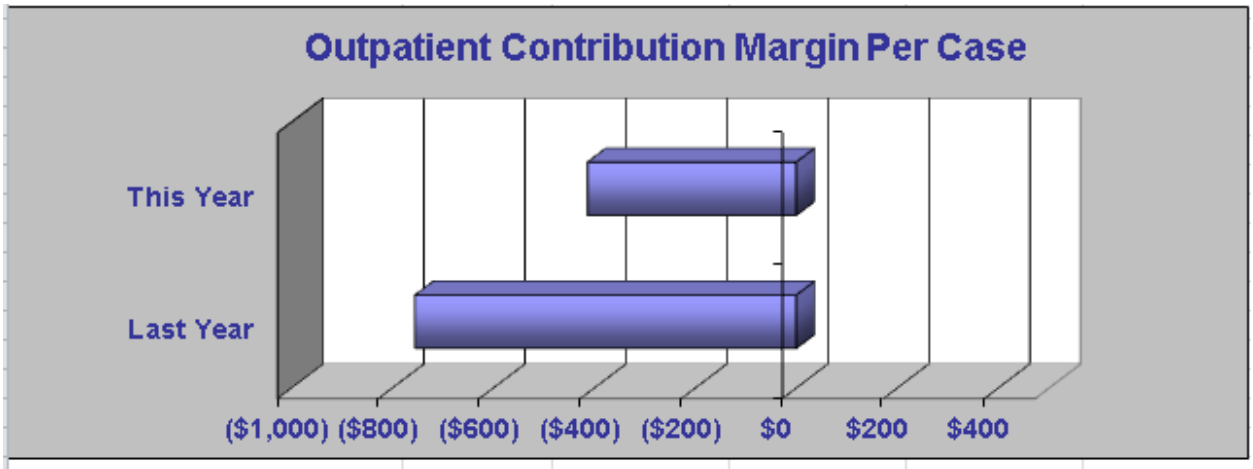




INPATIENT Results	Last Year	This Year
Net Revenue Per Case	$21,862	$22,164
Direct Cost Per Case	$15,830	$16,008
Contribution Margin Per Case	$6,032	$6,155







OUTPATIENT Results	Last Year	This Year
Net Revenue Per Case	$3,471	$3,437
Direct Cost Per Case	$4,226	$3,850
Contribution Margin Per Case	($755)	($413)

Anesthesia Annual Report

Primary Anesthesia Services, PC

May 14, 2019

Presented by:
Rob Goldstein, CMO
Hugh Morgan, VP Operations
Jorge Palacios, MD, Chief of Anesthesia
Erin Murphy, Administrator

Presented to:

Somnia ANESTHESIA
Local Teams. National Support. Exceptional Results.

Kaweah Delta
MORE THAN MEDICINE. LIFE.

Welcome to the 7th Annual Anesthesia Report

Somnia ANESTHESIA

Anesthesia Operations
-Staffing
-Professional Development
-Utilization

Anesthesia Coverage and Staffing

Somnia ANESTHESIA

Kaweah Delta Contracted Daily Staffing						
18 Anesthesia Staff Daily						
	Room Type	Days per week	Coverage Time	Hrs/day	Total Hours per Week	Model
OR Call	Call	5	3:00p - 7:00a	16	80	MD 1
COORDINATOR	NA	5	7:00a-07:00p	12	60	MD 2
FLOAT / Cardiac #2	NA	5	7:00a-07:00p	12	60	MD 3
Room 1:	General	5	7:30a-10:00p	14.5	72.5	CRNA 1 w/ MD 2
Room 2:	General	5	7:30a-7:30p	12	60	CRNA 2 w/ MD 2
Room 3:	General	5	7:30a-5:30p	10	50	CRNA 3 w/ MD 4
Room 4:	General	5	7:30a-5:30p	10	50	CRNA 4 w/ MD 4
Room 5:	General	5	7:30a-5:30p	10	50	CRNA 5 w/ MD 4
Room 6:	General	5	7:30a-4:00p	8.5	42.5	CRNA 6 w/ MD 4
Room 7:	General	5	7:30a-4:00p	8.5	42.5	CRNA 7 w/ MD 5
Room 8:	General	5	7:30a-4:00p	8.5	42.5	CRNA 8 w/ MD 5
Room 9:	General	5	7:30a-4:00p	8.5	42.5	CRNA 9 w/ MD 5
Room 10:	ACT / Add-Ons	5	7:00a-7:00a	24	120	CRNA 10 w/ MD 5
CARDIAC:	CARDIAC	5	7:00a-7:00a	24	120	MD 6
OOR	Endo	1				
OB 1	LE/Spinal/ CS	5	7:00a-7:00a	24	120	CRNA 11 w/ MD 2
OB 2	LE/Spinal/ CS	5	7:00a-3:00p	8	40	CRNA 12 w/ MD 2

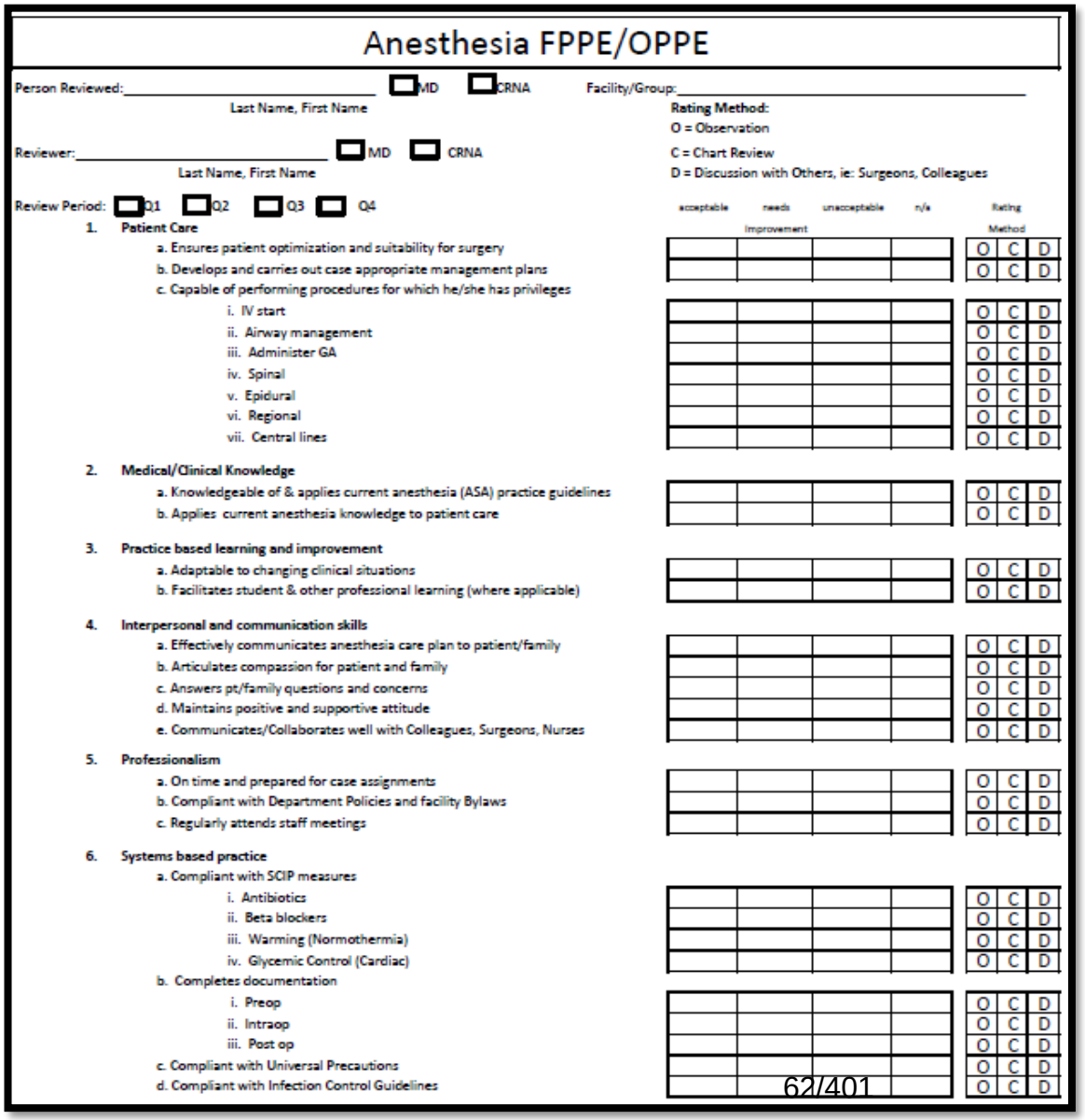
PRIMARY Anesthesia Services, PC

Provision of Anesthesia Services

KAWEAH DELTA MEDICAL CENTER

Anesthesia Staff Evaluation & Development (F/OPPE)

Somnia ANESTHESIA



Anesthesia FPPE/OPPE

Person Reviewed: _____ ☐ MD ☐ CRNA Facility/Group: _____
Last Name, First Name

Reviewer: _____ ☐ MD ☐ CRNA
Last Name, First Name

Review Period: ☐ Q1 ☐ Q2 ☐ Q3 ☐ Q4

Rating Method:
O = Observation
C = Chart Review
D = Discussion with Others, ie: Surgeons, Colleagues

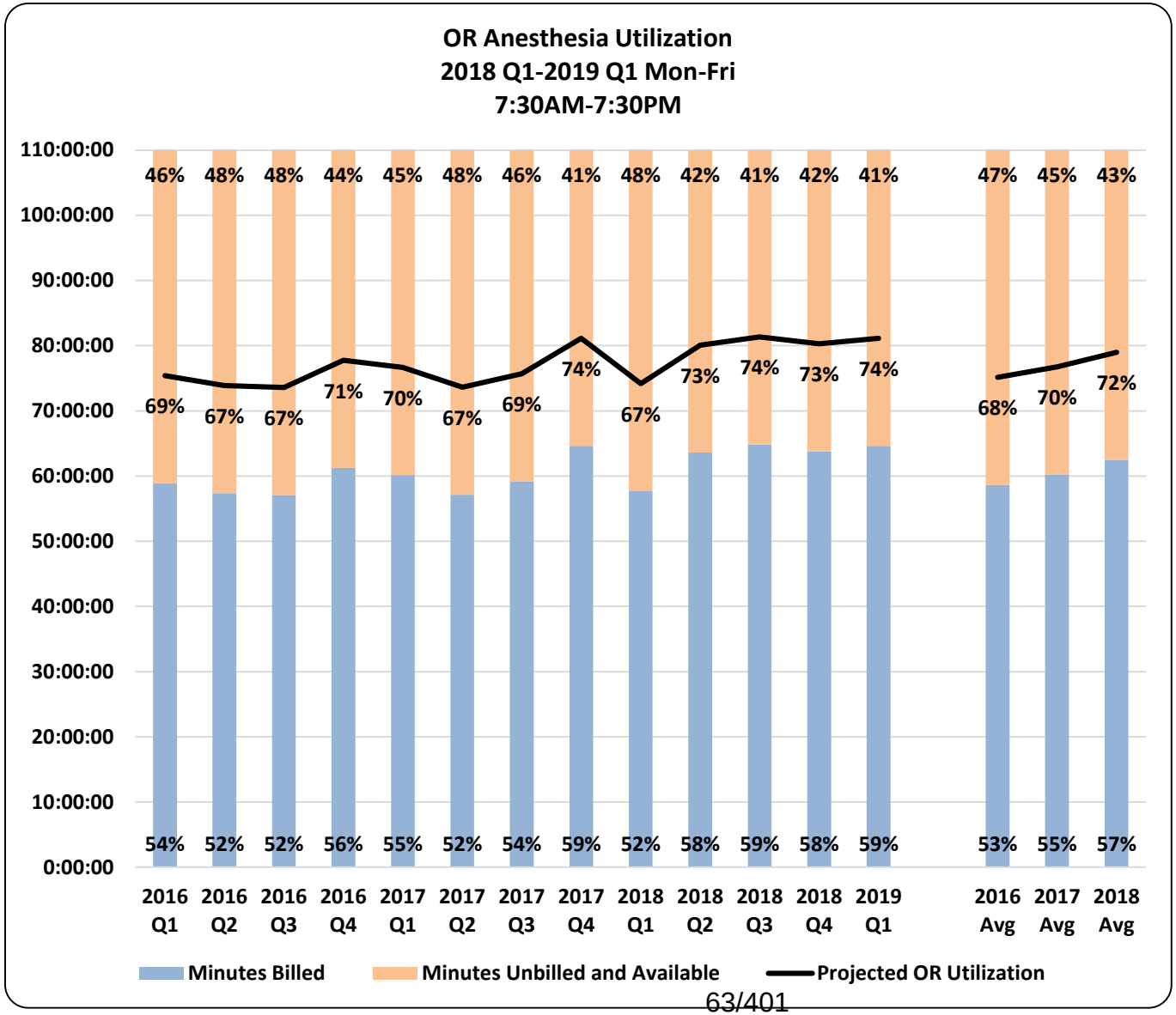
	acceptable	needs Improvement	unacceptable	n/a	Rating Method
1. Patient Care					
a. Ensures patient optimization and suitability for surgery					O C D
b. Develops and carries out case appropriate management plans					O C D
c. Capable of performing procedures for which he/she has privileges					
i. IV start					O C D
ii. Airway management					O C D
iii. Administer GA					O C D
iv. Spinal					O C D
v. Epidural					O C D
vi. Regional					O C D
vii. Central lines					O C D
2. Medical/Clinical Knowledge					
a. Knowledgeable of & applies current anesthesia (ASA) practice guidelines					O C D
b. Applies current anesthesia knowledge to patient care					O C D
3. Practice based learning and improvement					
a. Adaptable to changing clinical situations					O C D
b. Facilitates student & other professional learning (where applicable)					O C D
4. Interpersonal and communication skills					
a. Effectively communicates anesthesia care plan to patient/family					O C D
b. Articulates compassion for patient and family					O C D
c. Answers pt/family questions and concerns					O C D
d. Maintains positive and supportive attitude					O C D
e. Communicates/Collaborates well with Colleagues, Surgeons, Nurses					O C D
5. Professionalism					
a. On time and prepared for case assignments					O C D
b. Compliant with Department Policies and facility Bylaws					O C D
c. Regularly attends staff meetings					O C D
6. Systems based practice					
a. Compliant with SCIP measures					
i. Antibiotics					O C D
ii. Beta blockers					O C D
iii. Warming (Normothermia)					O C D
iv. Glycemic Control (Cardiac)					O C D
b. Completes documentation					
i. Preop					O C D
ii. Intraop					O C D
iii. Post op					O C D
c. Compliant with Universal Precautions					O C D
d. Compliant with Infection Control Guidelines					O C D

62/401

The Anesthesia Bi-Annual Clinician Evaluation (F/OPPE) used in compliance with the Joint Commission standards and 6 Core Competencies of Medical Professional Staff.

The 2018 Q3/Q4 second half annual OPPE anesthesia clinical evaluations consisted of 15 MDs, and 27 CRNAs. All providers received overall evaluations of "acceptable" in each rating category.

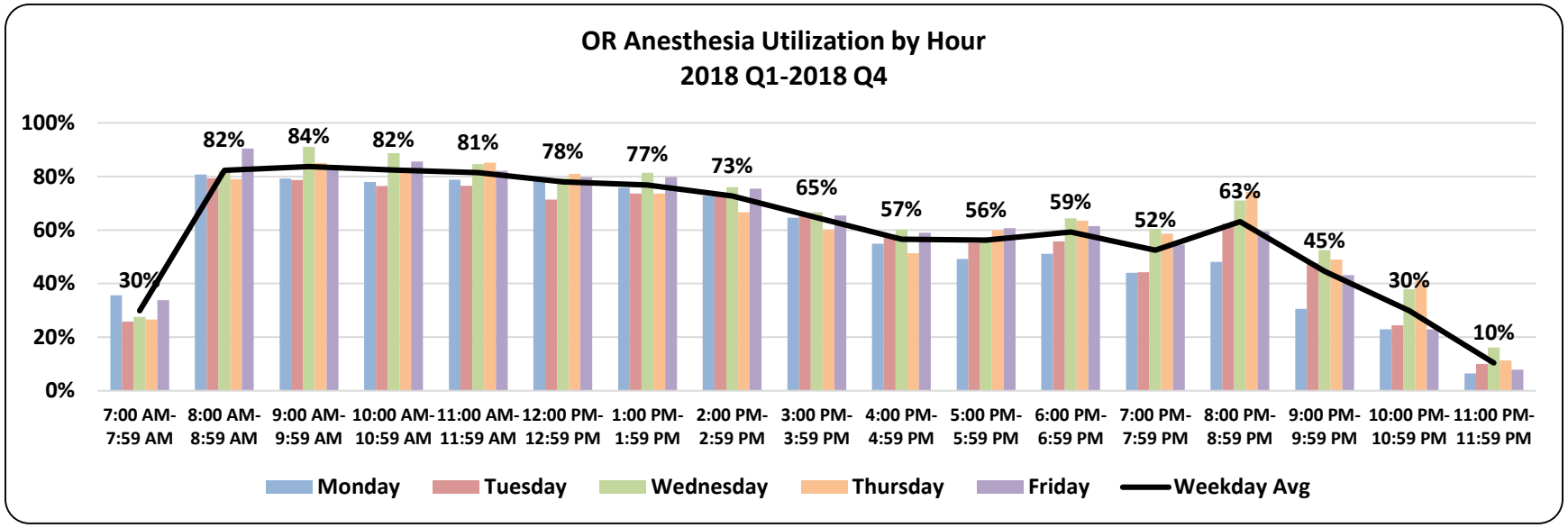
OR Anesthesia Utilization

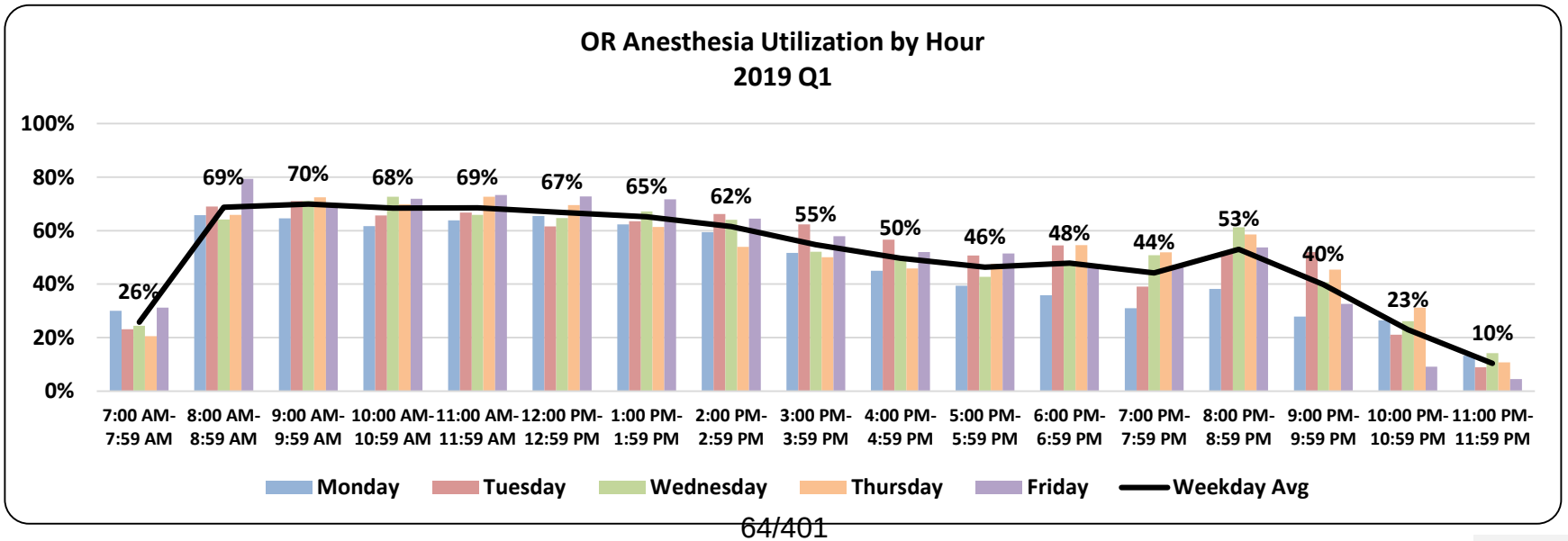


Coverage Model		
Trauma	7:30a-7:30a	24
OR 1	7:30a-7:30a	24
OR 2	7:30a-7:30p	12
OR 3	7:30a-7:30p	12
OR 4	7:30a-7:30p	12
OR 5	7:30a-5:30p	10
OR 6	7:30a-5:30p	10
OR 7	7:30a-5:30p	10
OR 8	7:30a-5:30p	10
OR 9	7:30a-5:30p	10
Total Hours		134
Total Hours 7:30a-7:30p		110

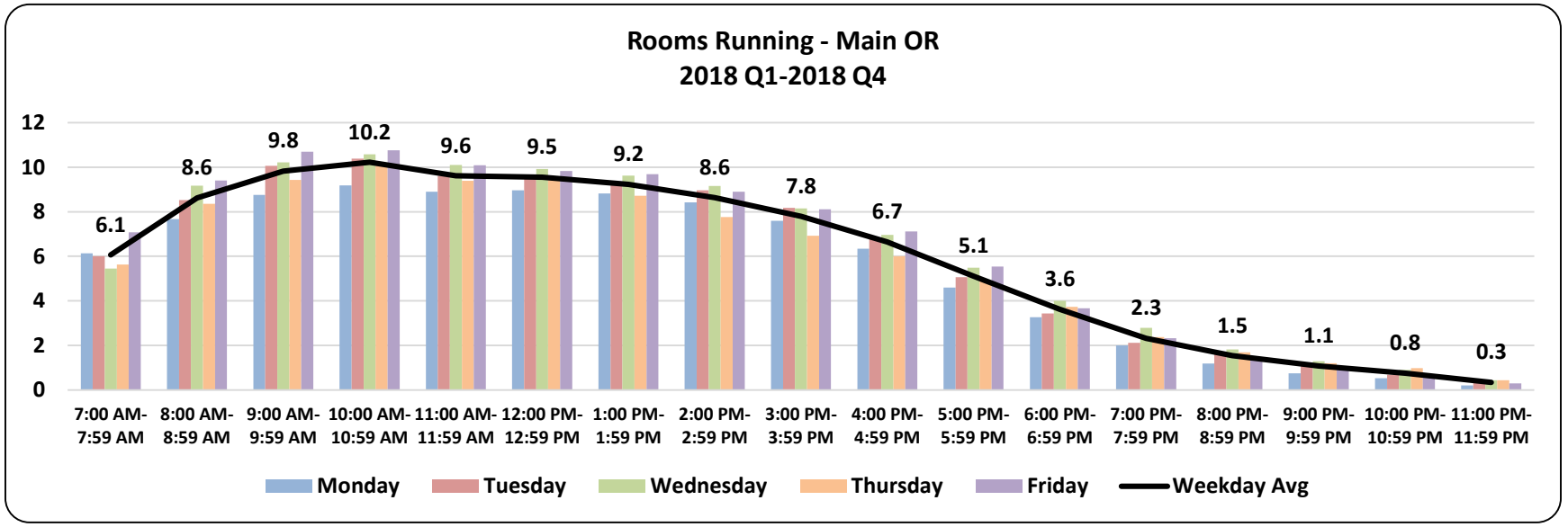
65% is national mean utilization

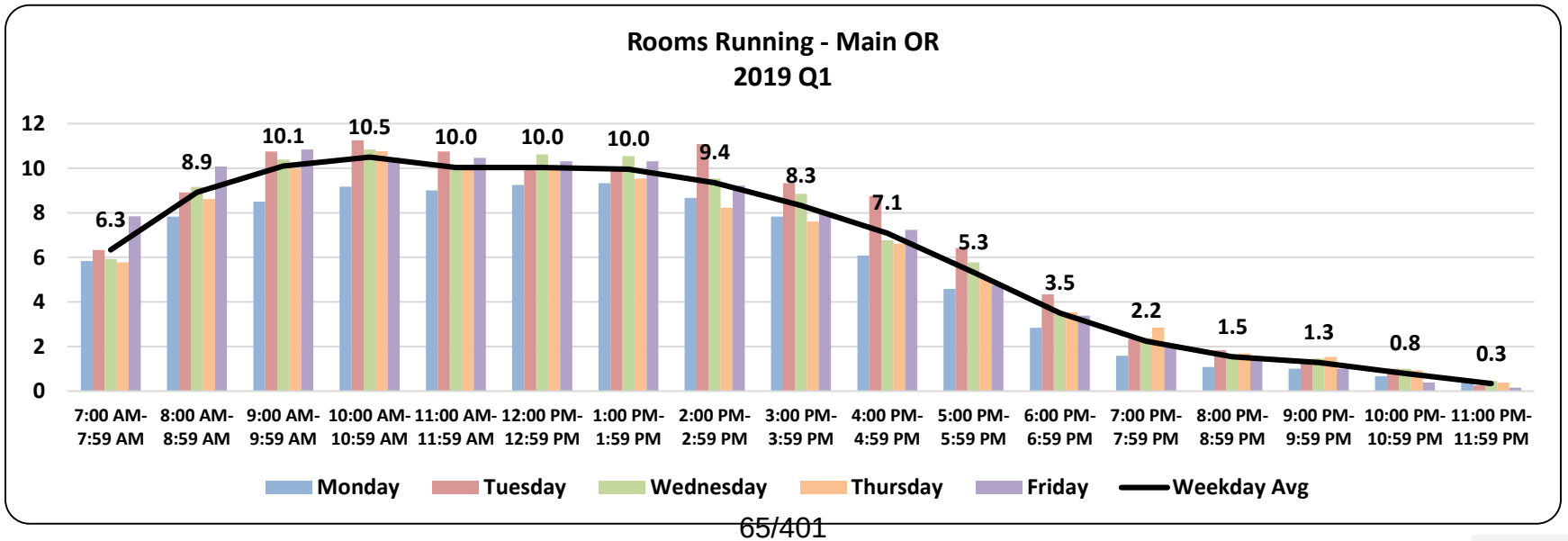
OR Anesthesia Utilization by Hour



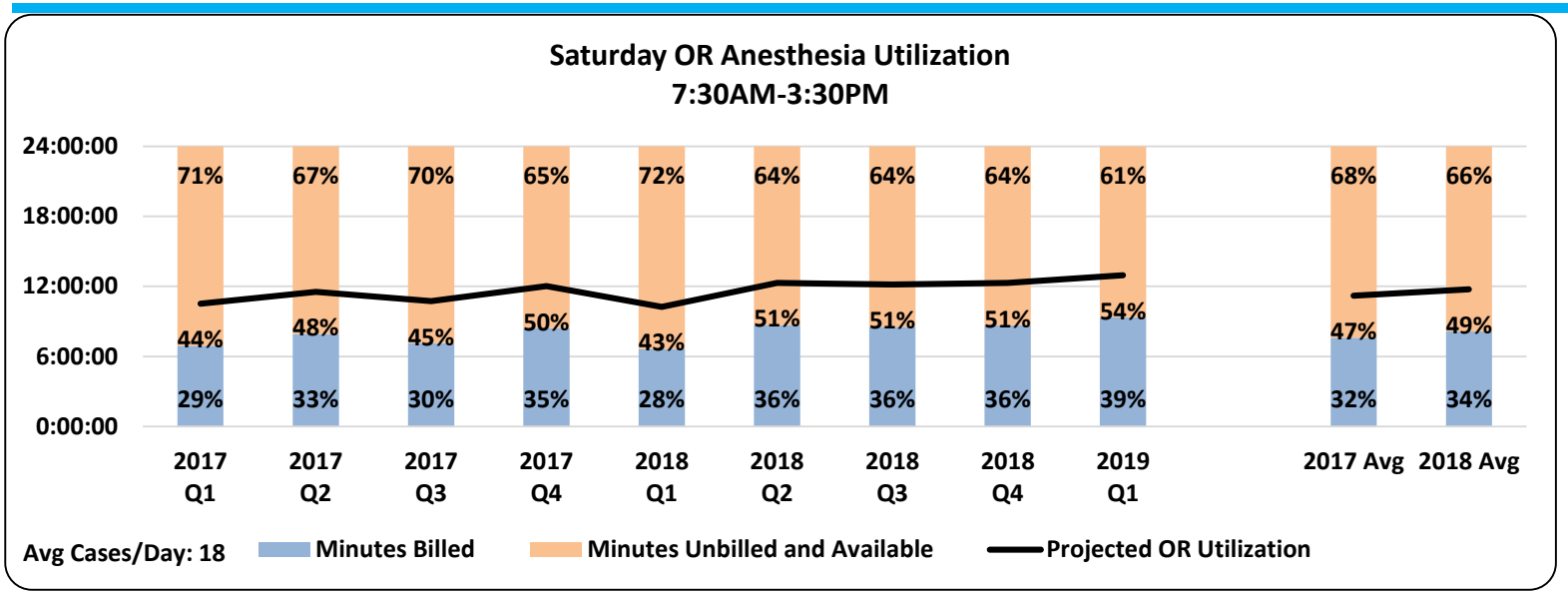


OR Anesthesia Utilization by Hour

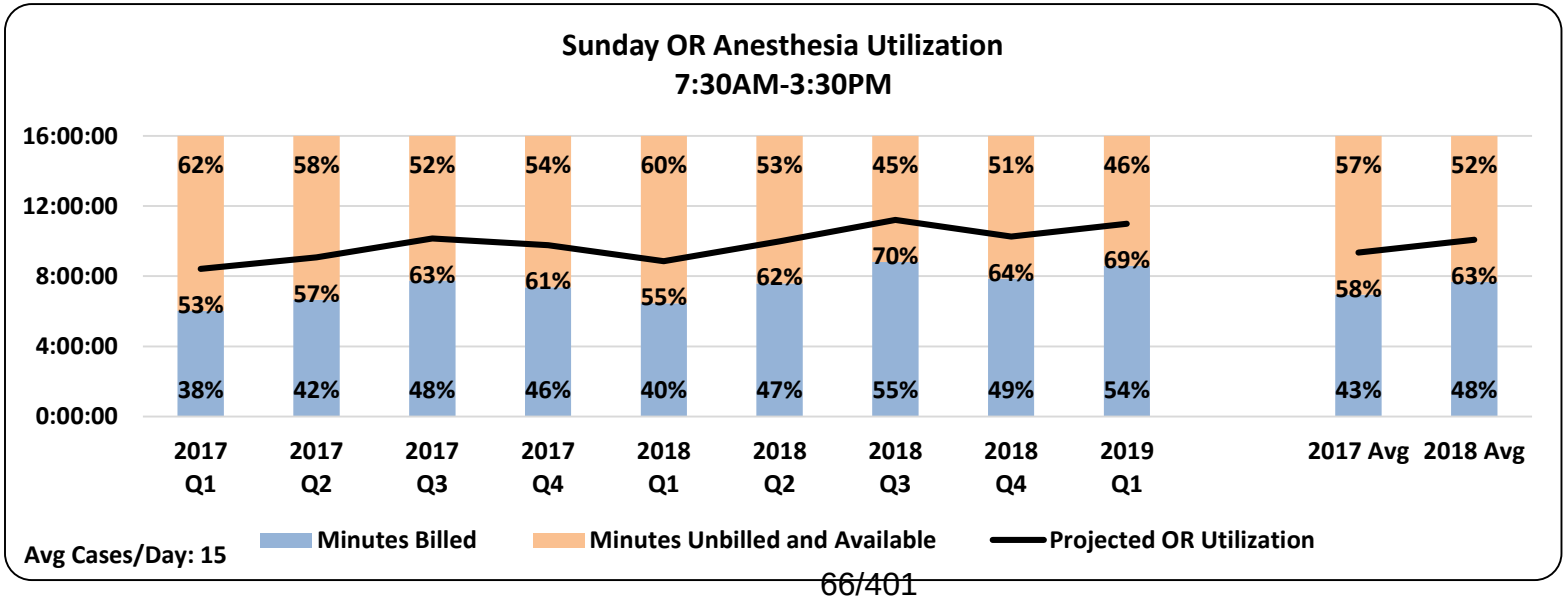




Weekend OR Anesthesia Utilization

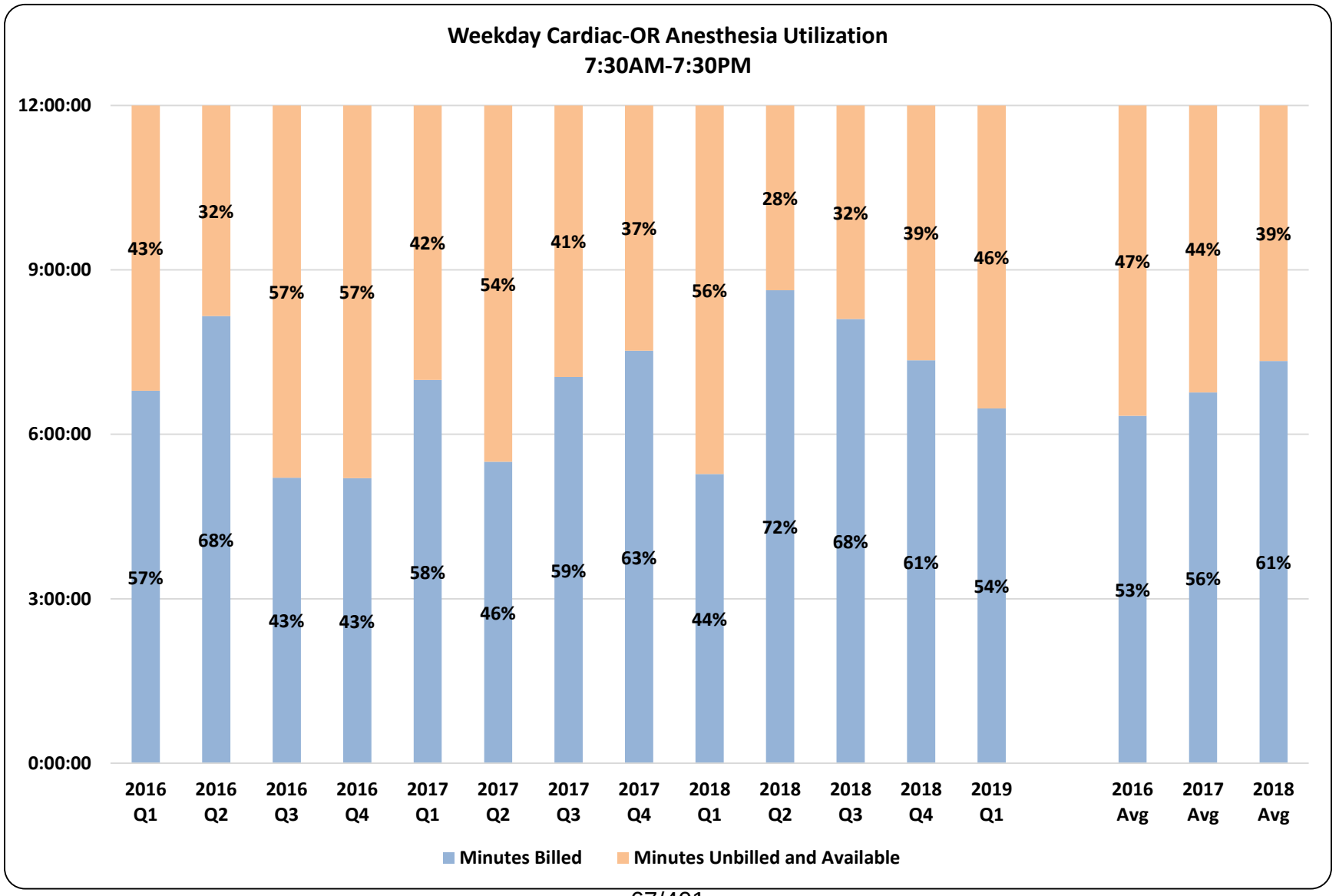


3 Rooms
7:30-3:30 =
24 Hours



2 Rooms
7:30-3:30 =
16 Hours

Weekday Cardiac Anesthesia Utilization



Anesthesia Productivity

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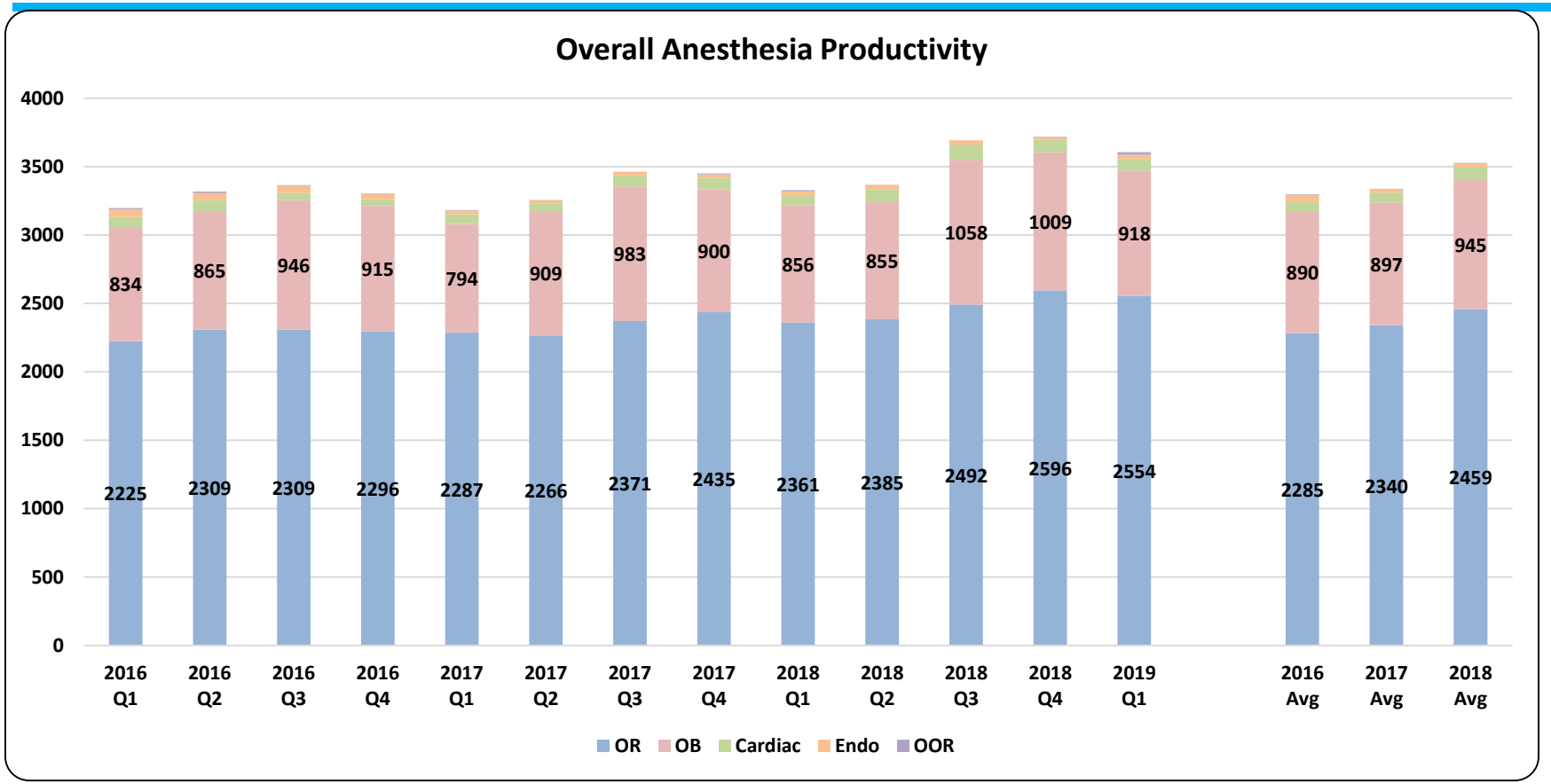
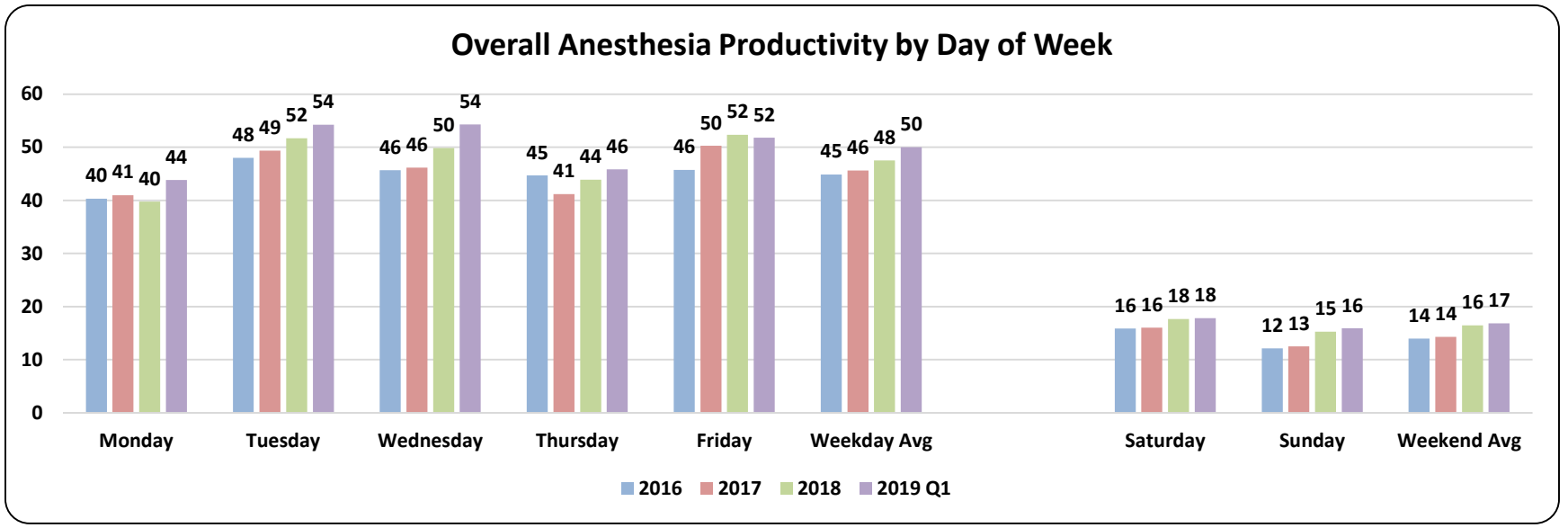
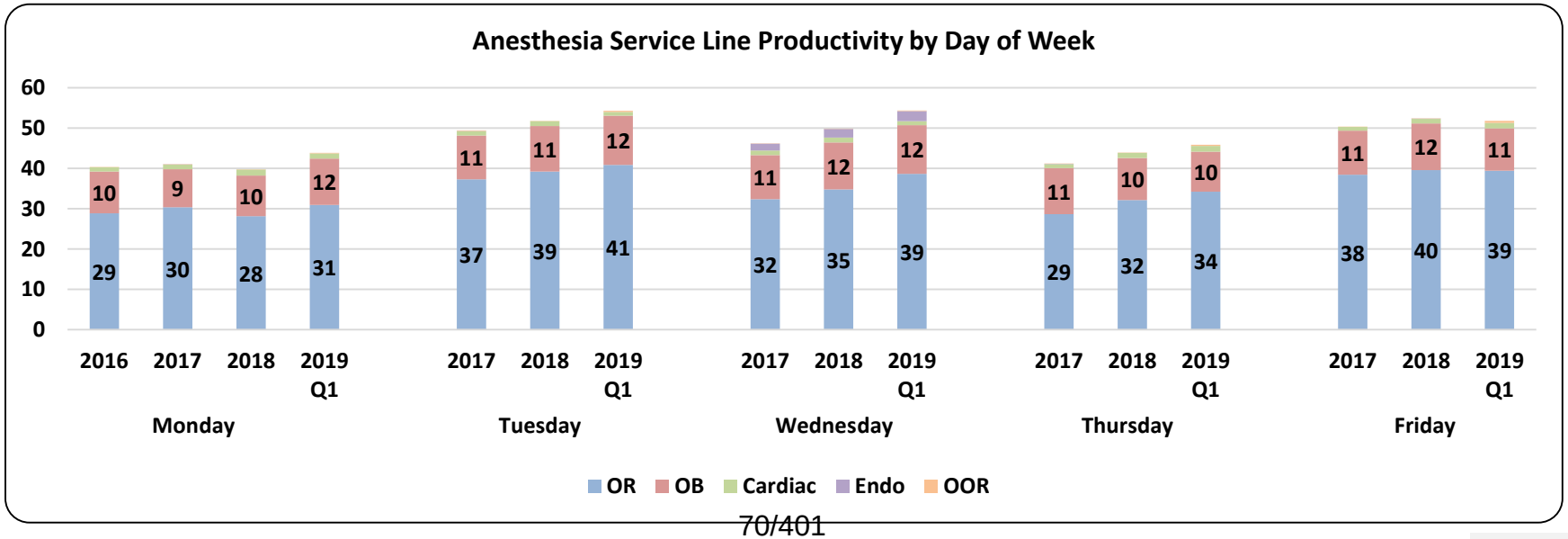
Total Anesthesia Productivity



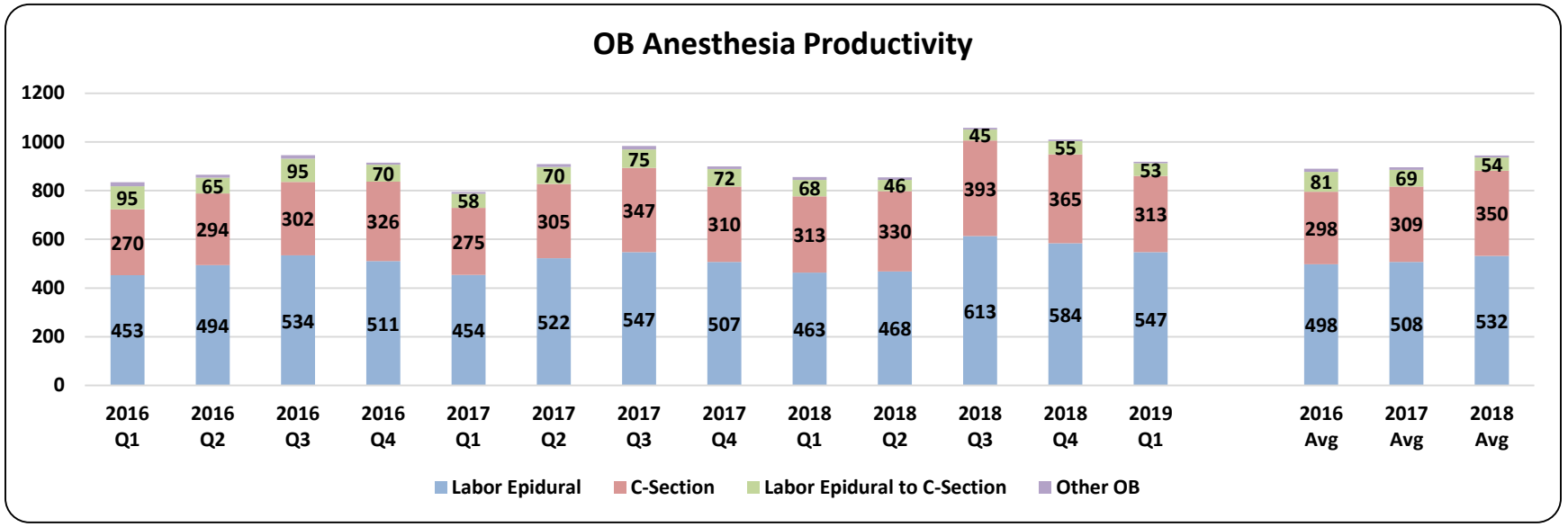
	Main OR	OB	Cardiac	Endo	OOR	Total Cases		Total Births	Labor Epidural	C-Section	Labor Epidural to C-Section	Other OB	Total OB
2016	9193	3560	260	203	24	13186		4625	1992	1192	325	51	3560
2017	9359 (+2.4%)	3586 (+0.7%)	291 (+11.9%)	102 (-49.8%)	13 (-45.8%)	13351 (+1.3%)		4429 (-4.2%)	2030 (+1.9%)	1237 (+3.8%)	275 (-15.4%)	44 (-13.7%)	3586 (+0.1%)
2018	9834 (+5.1%)	3778 (+5.4%)	366 (+25.8%)	114 (+11.8%)	14 (+7.7%)	14106 (+5.7%)		4739 (+7.0%)	2128 (+4.8%)	1401 (+13.3%)	214 (-22.2%)	35 (-20.5%)	3778 (+5.4%)
2019 Annualized	10216 (+8.9%)	3672 (-2.8%)	336 (-8.2%)	128 (+12.3%)	68 (+385.7%)	14420 (+2.2%)		4576 (-3.4%)	2188 (+0.4%)	1252 (-10.6%)	212 (-0.9%)	20 (-42.9%)	3672 (-2.8%)

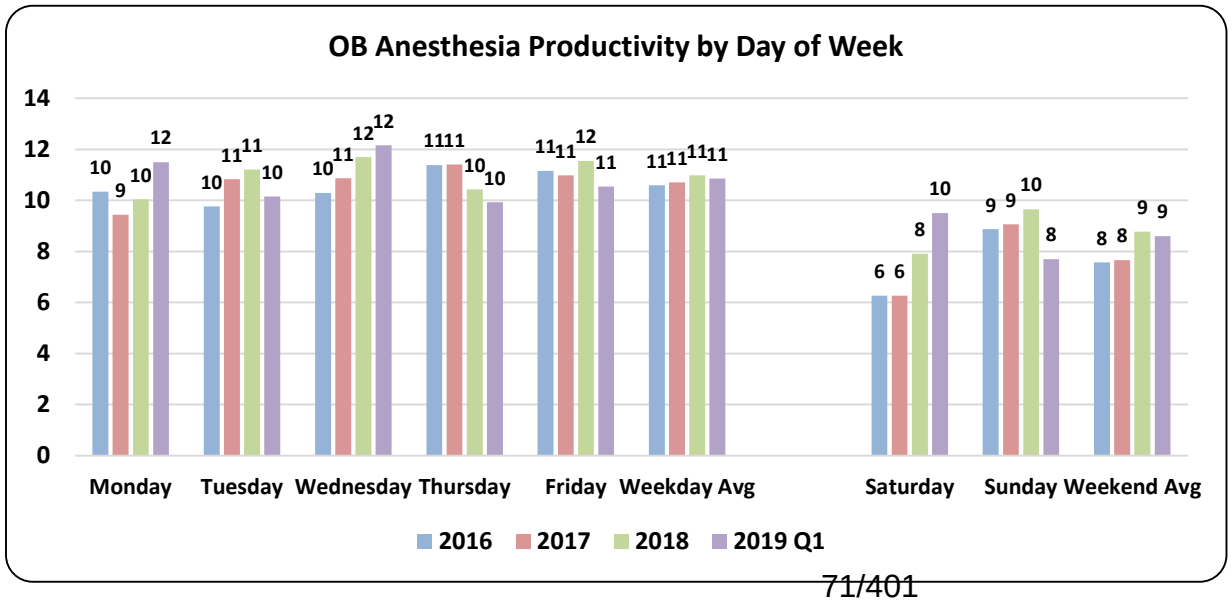
Total Anesthesia Productivity

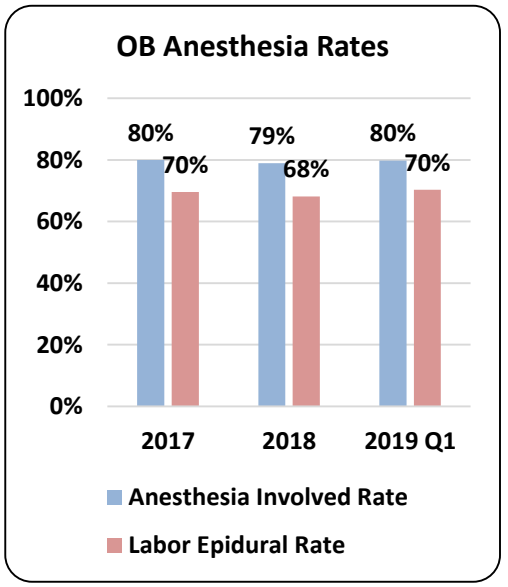




OB Anesthesia Productivity







Clinical Quality Excellence

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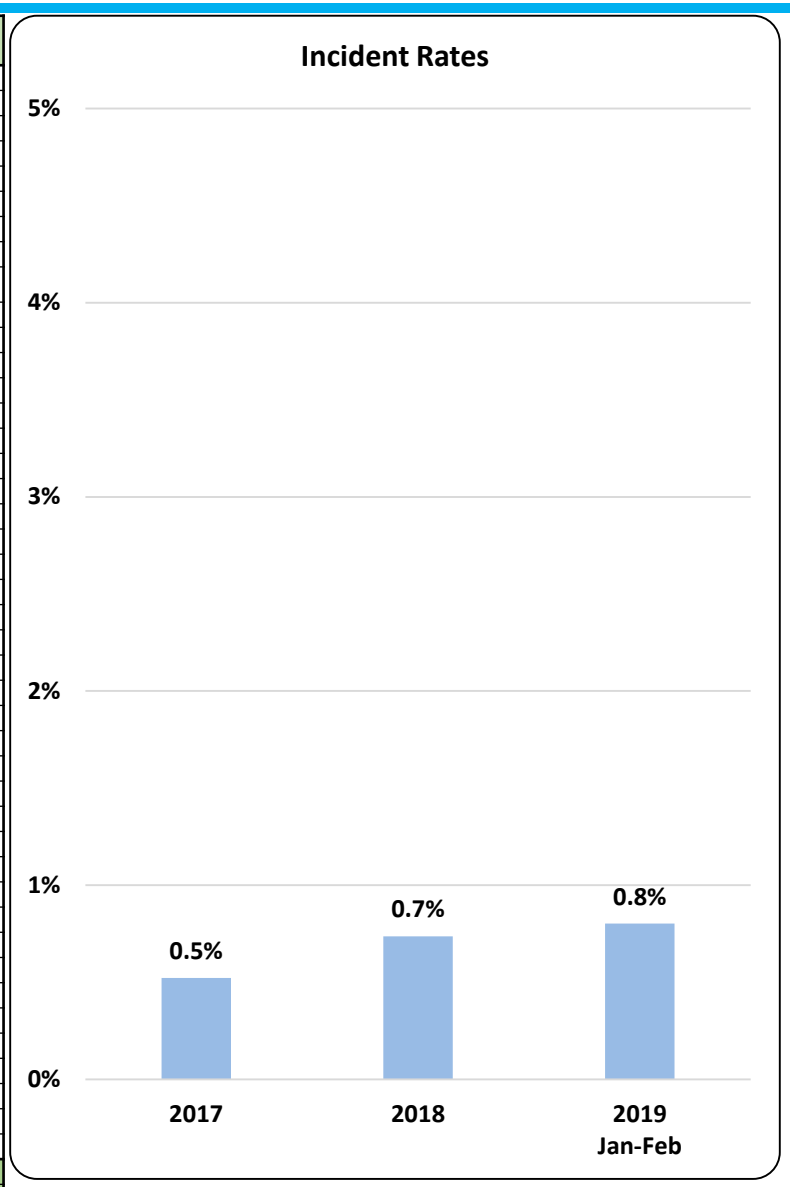
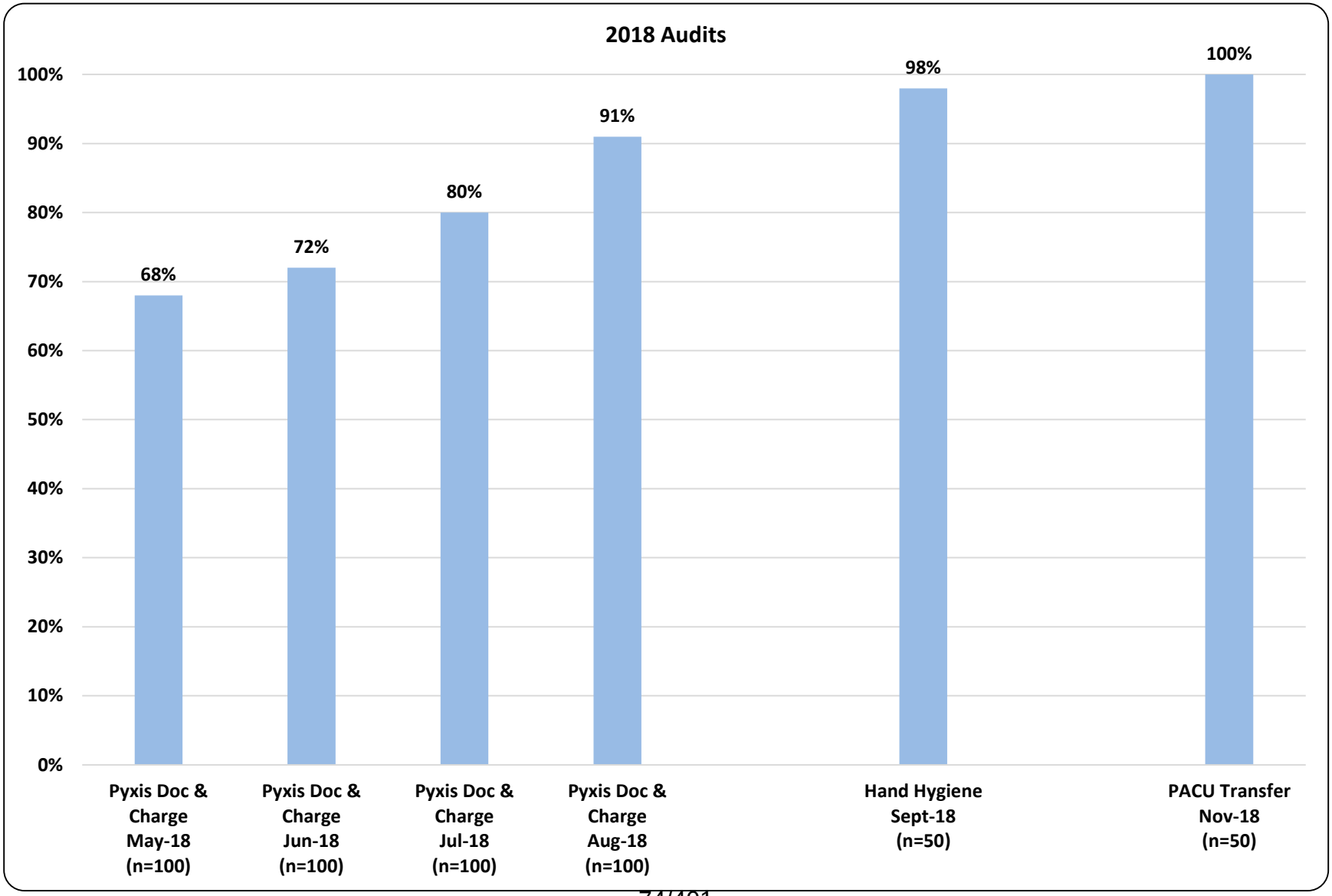
Incident Reporting

Occurrence Category	2017	2018	2019 Jan-Feb
Airway Trauma		1	1
Aspiration in Peri-Op (C)	1	3	
Cardiac arrest during or within 24 hrs of anes.	4	4	1
Case Cx Post-Induction			2
Corneal Abrasion (M)		1	
Dental Injury (M)	4	1	1
Development of unexpected significant dysrhythmia	6	5	5
Difficult Airway Equipment Used: Available/Planned (M)	1		
Difficult Airway Equipment Used: Unable to intubate trachea (M)	1		
Difficult intubation	2		
Equip. failure (anes. machine etc.)			1
Failed Regional or Spinal	9	12	
High epidural/spinal	2	1	
Hypertension		1	
Hypotension	3	9	2
Intra-operative awareness after anesthesia (C)		1	
Laryngospasm	2		
Local anesthesia toxicity		4	
Medication error(wrong med/dose/route)	1	1	
MI during or within 24 hrs of anesthesia care (C)	3	4	
Mortality <= 24 hrs. post anes. (C)	6		
Myocardial Eschemia		1	1
Ocular injury (Inactive)		2	
Pain control orders		1	
Patient Fall (ie. Off OR Table)		2	
Patient/Family Complaints		3	
PONVTreatment		10	1
Post-dural puncture headache			
Pulmonary Edema	1	2	1
Reintubation within 24 hrs of anes. care	1	2	1
Respiratory Arrest		2	
Reversal medication used (Narcan and/or Flumazenil)	3		
Seizure during/following anesthesia	3		
Stroke/coma following anesthesia (C)	2		
Unable to extubate		3	1
Unplanned admit day of surgery patient		5	
Unplanned dural puncture		4	1
Unplanned intubation/ventiliatory support		2	
Unplanned transfer/admit to higher level of care (ICU)	5	7	1
Unplanned PACU Ventilliatory Support		3	
UnplannedPostOpDispositionOther	2		
Unrecognized difficult airway	2	7	
Wet tap	5		
Total	69	104	20
Total Cases	13186	14108	2492
Incident Rate	0.5%	0.7%	0.8%



Audits


2018 Audits
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
68%
72%
80%
91%
98%
100%
Pyxis Doc & Charge May-18 (n=100)
Pyxis Doc & Charge Jun-18 (n=100)
Pyxis Doc & Charge Jul-18 (n=100)
Pyxis Doc & Charge Aug-18 (n=100)
Hand Hygiene Sept-18 (n=50)
PACU Transfer Nov-18 (n=50)

Anesthesia Patient Satisfaction

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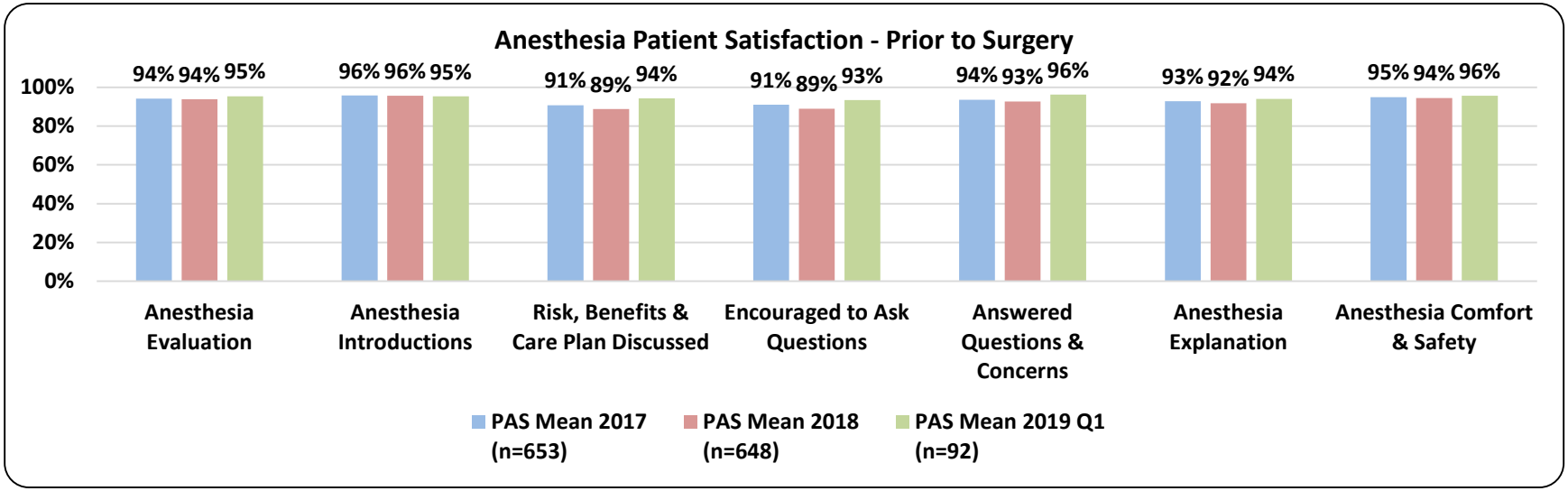
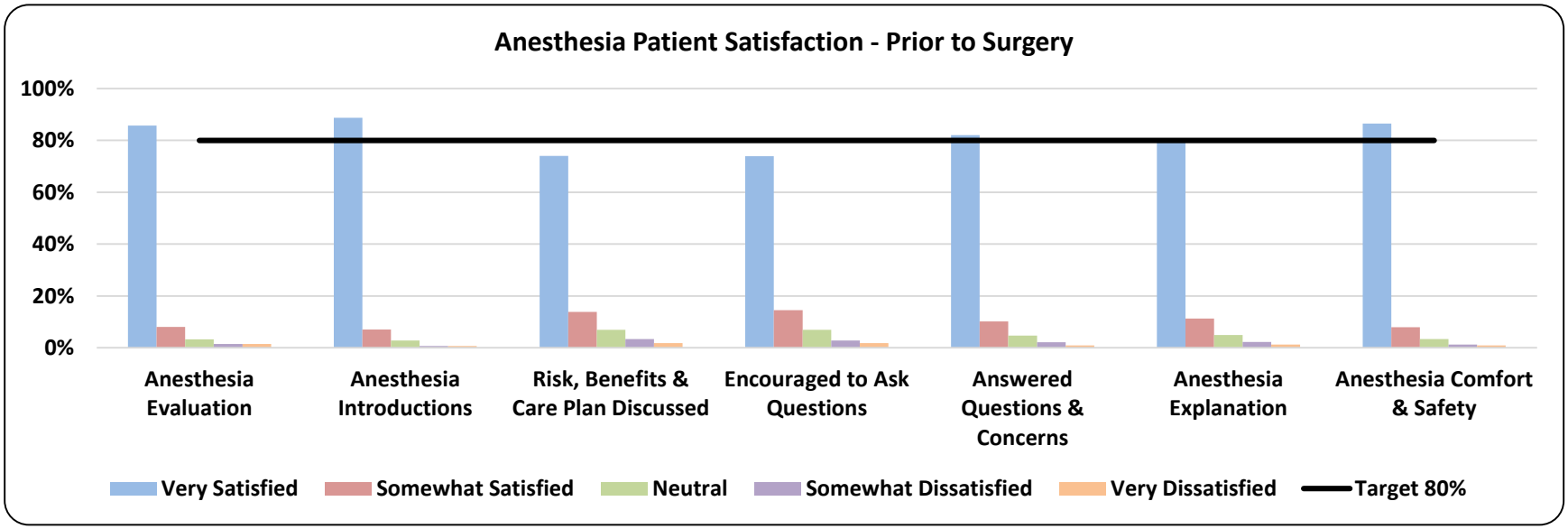
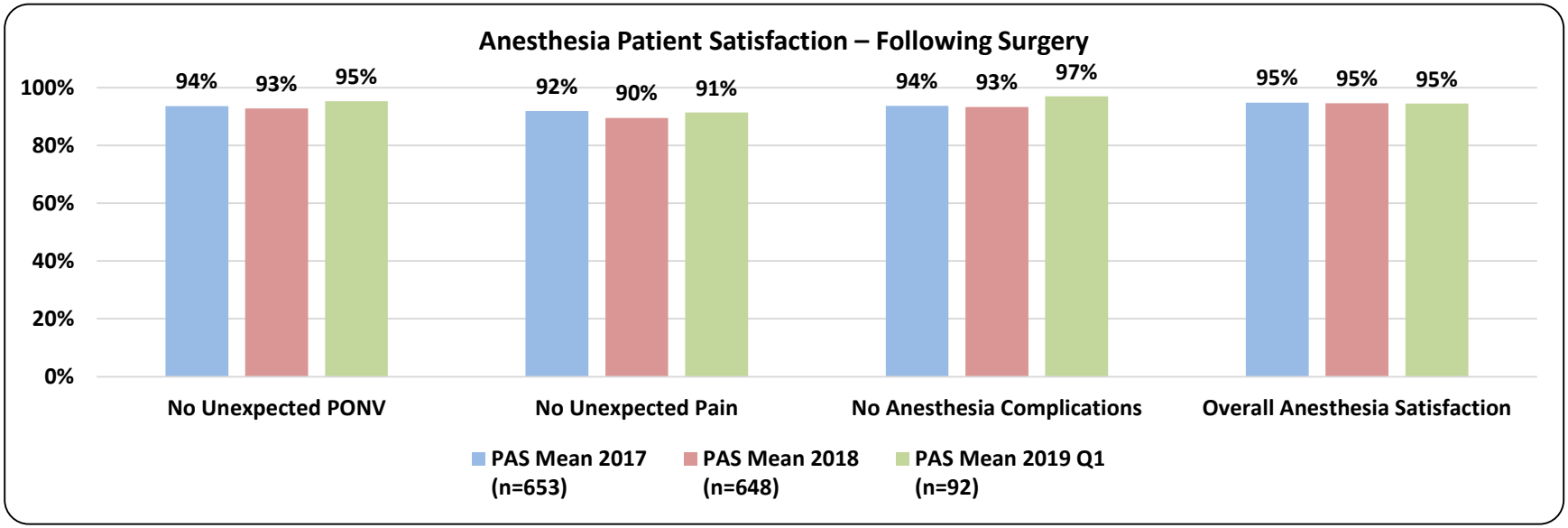
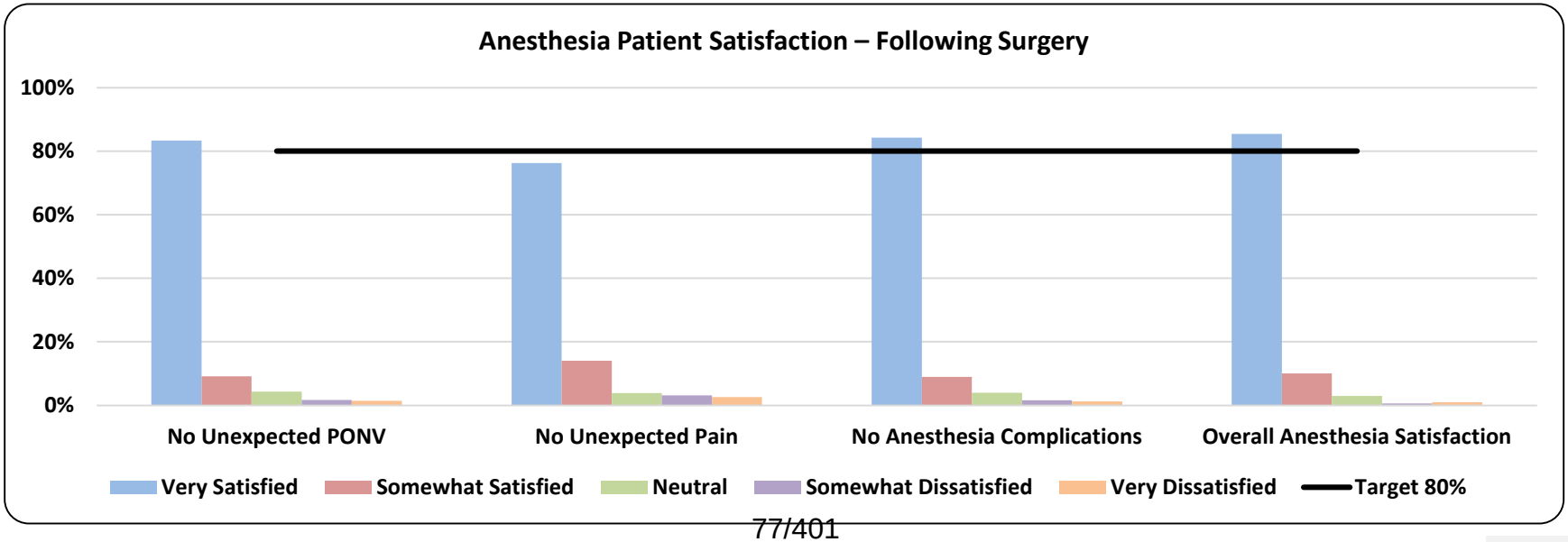
Surgical Anesthesia Patient Satisfaction – Prior to Surgery



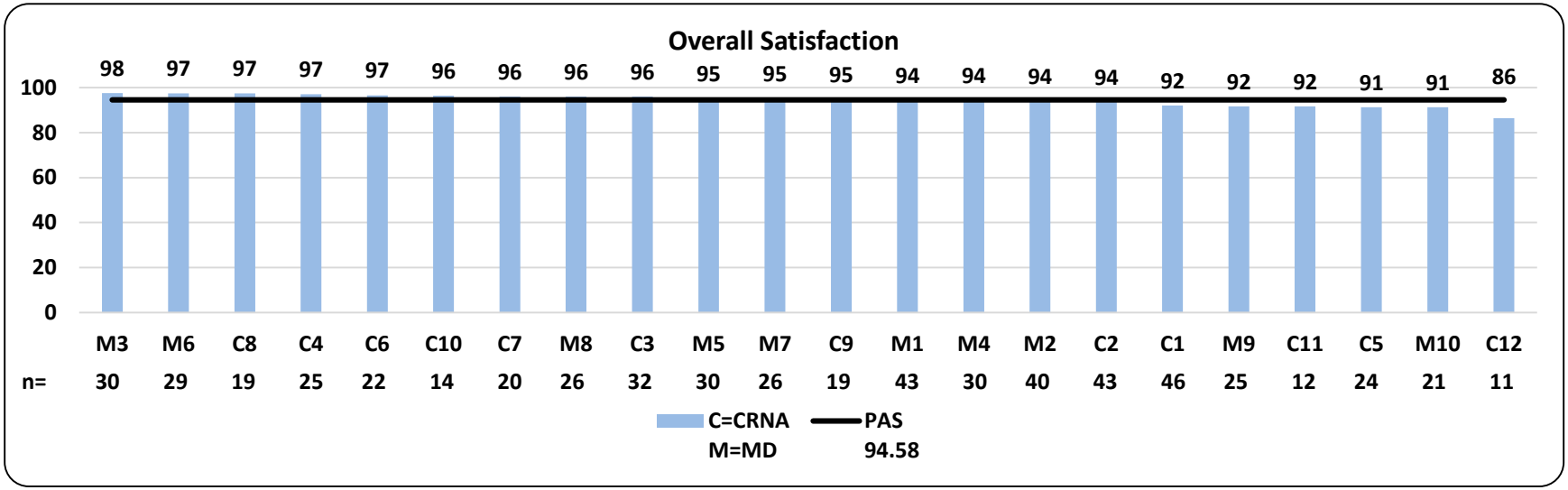


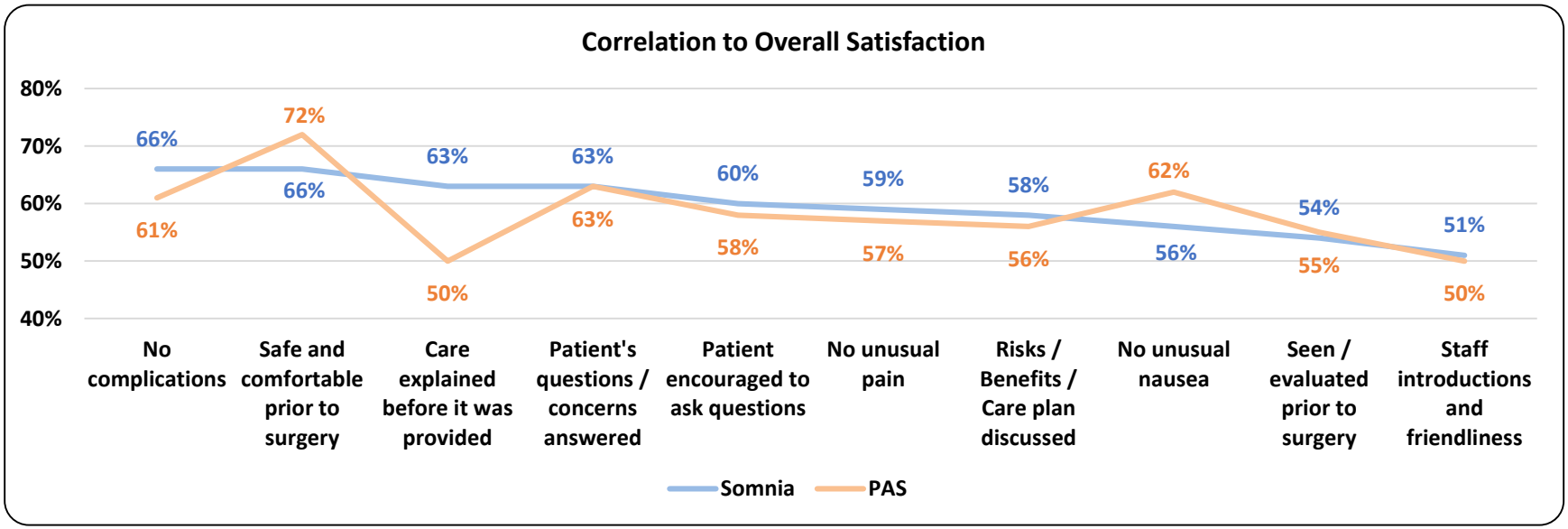
Surgical Anesthesia Patient Satisfaction – Following Surgery





Surgical Anesthesia Patient Satisfaction – Correlation and Provider





OB Anesthesia Patient Satisfaction

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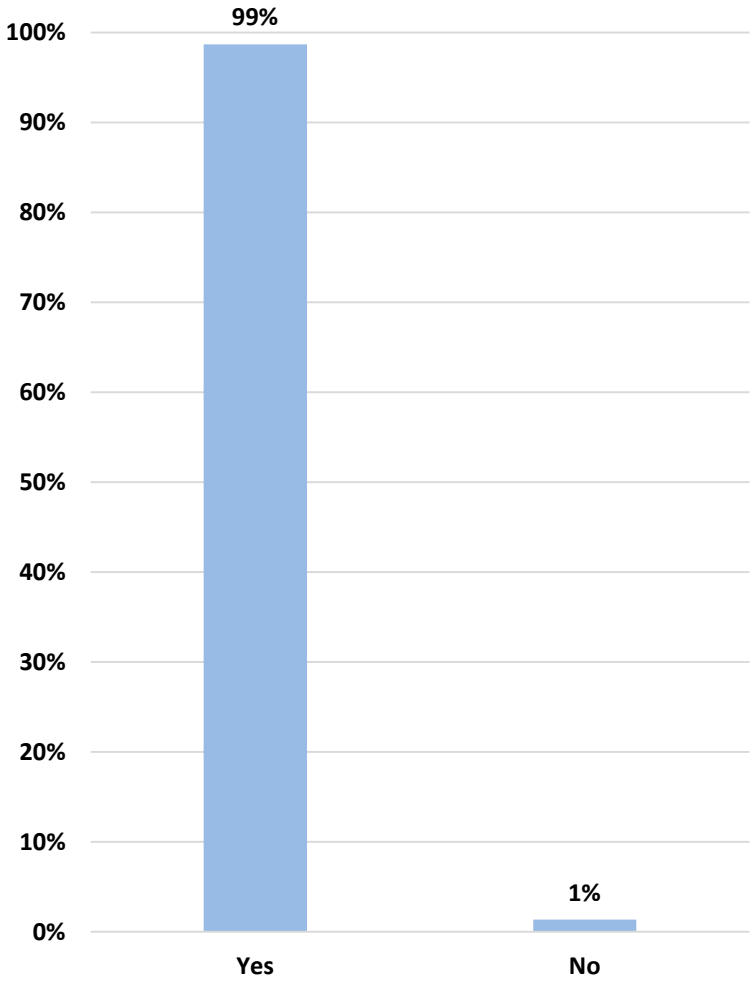
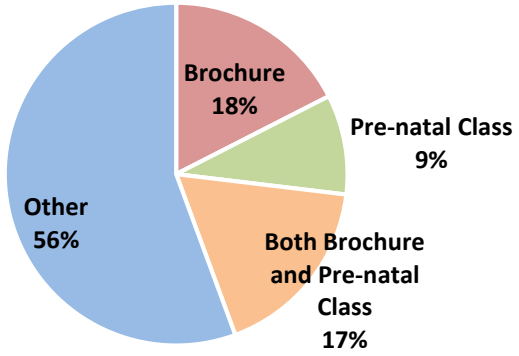
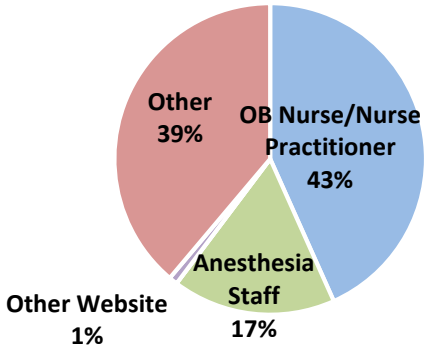
Was the information you received valuable in helping you make the important decisions about the risks and benefits of anesthesia during your delivery?



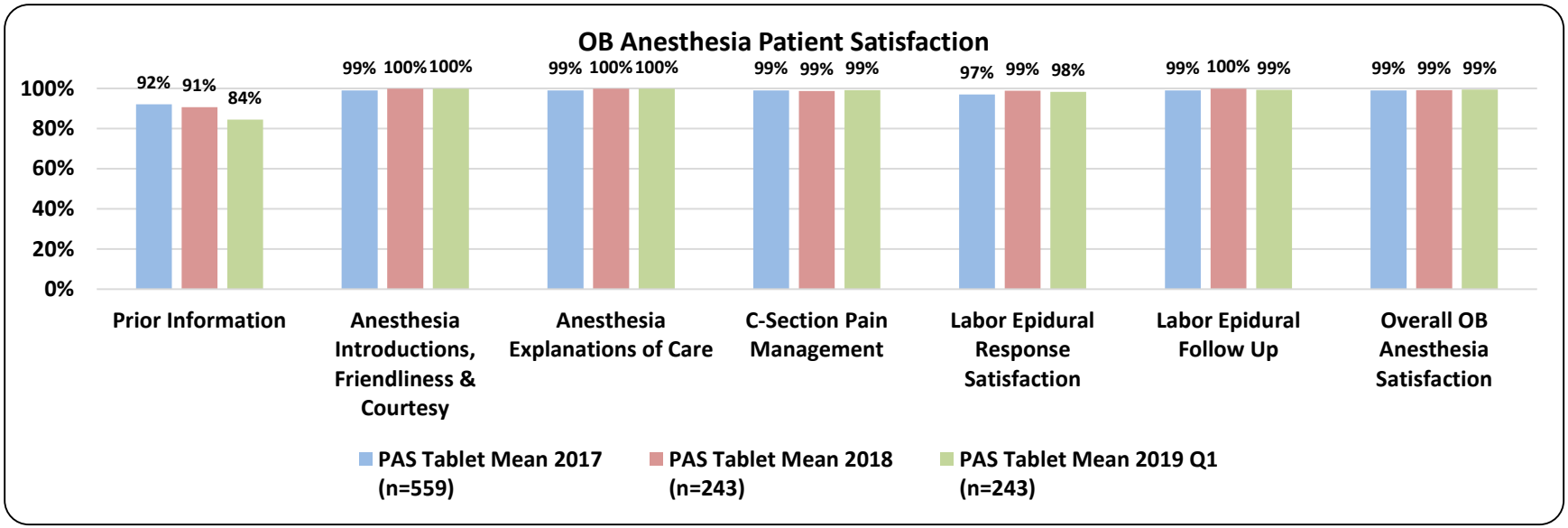
Where did you receive the information about anesthesia and/or pain management, ie: labor epidurals?

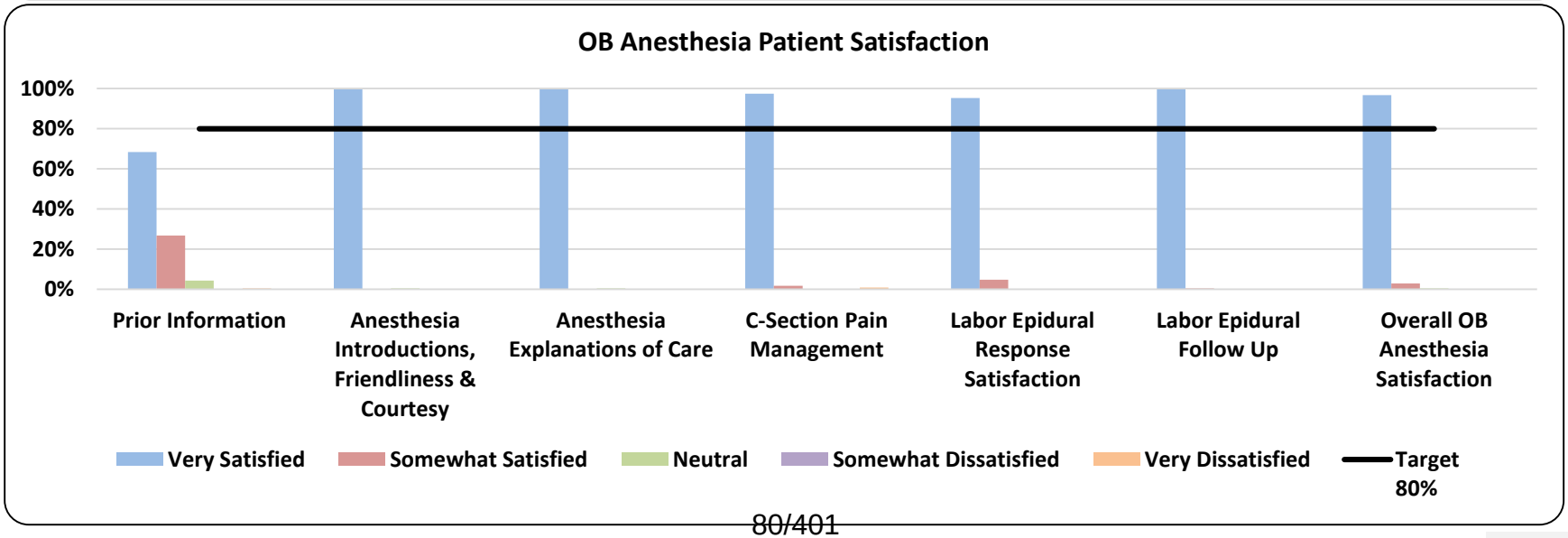


Who provided you with the information you received about anesthesia and/or pain management, ie: labor epidurals?

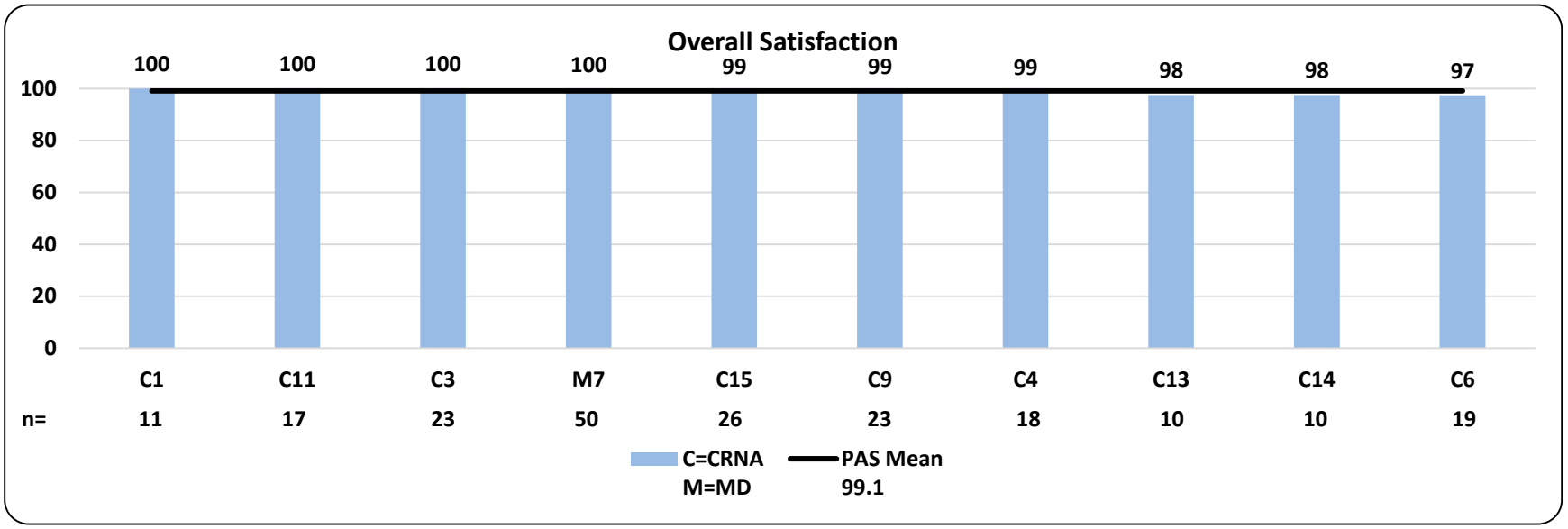


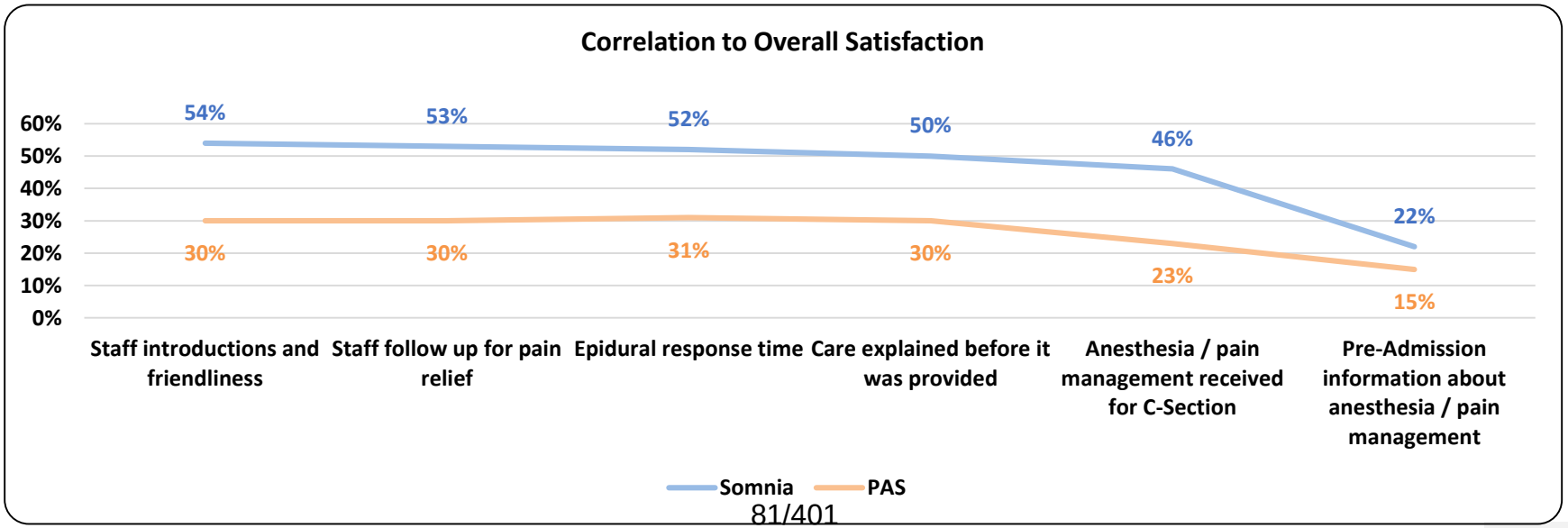
OB Anesthesia Patient Satisfaction





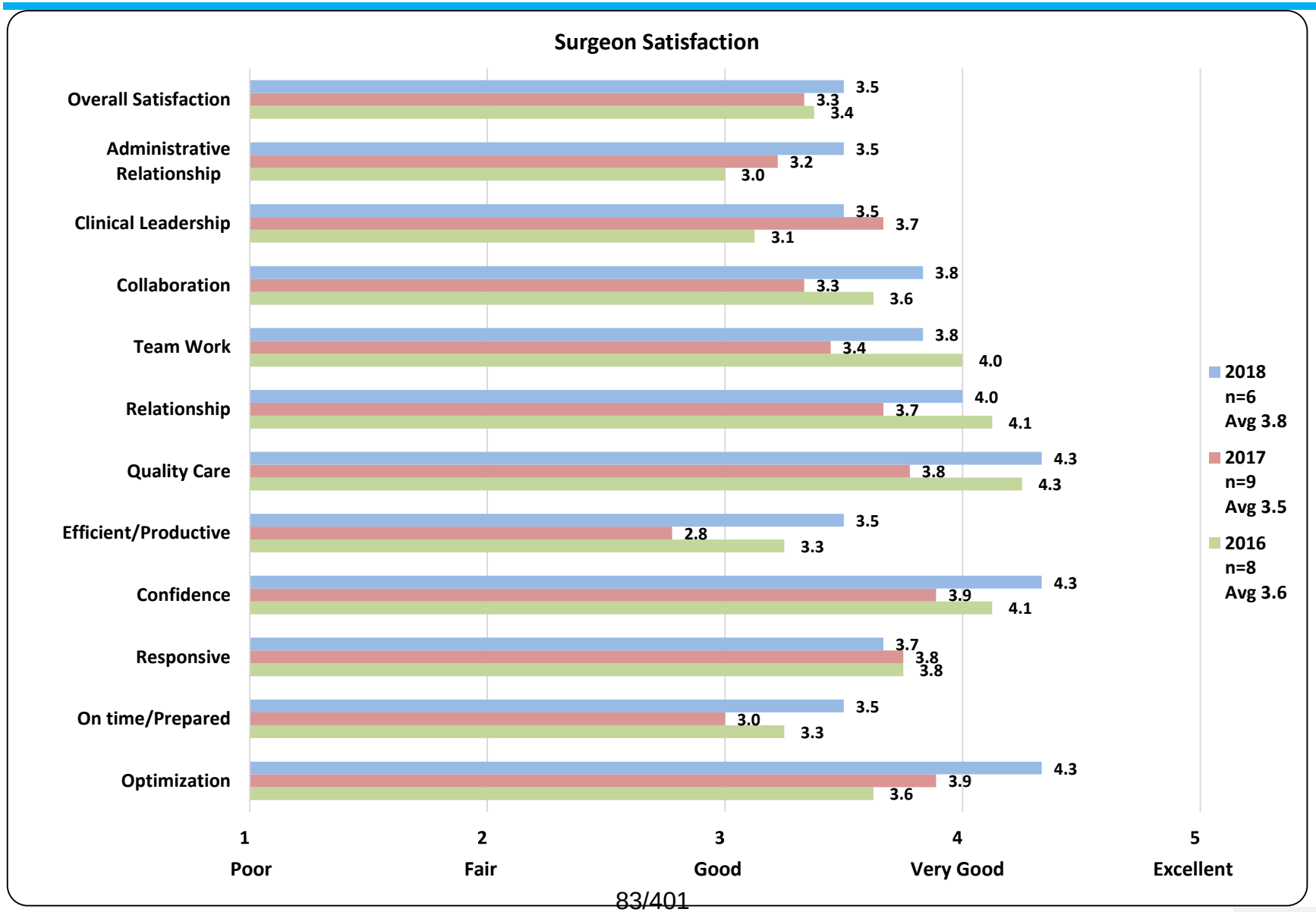
OB Anesthesia Patient Satisfaction – by Provider and Correlation





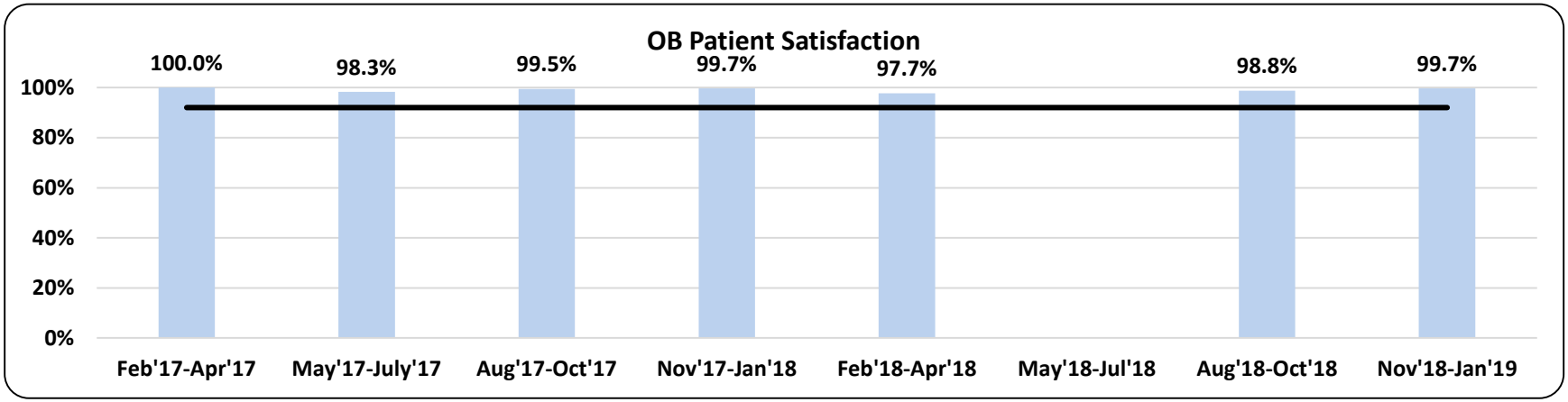
Surgeon Satisfaction

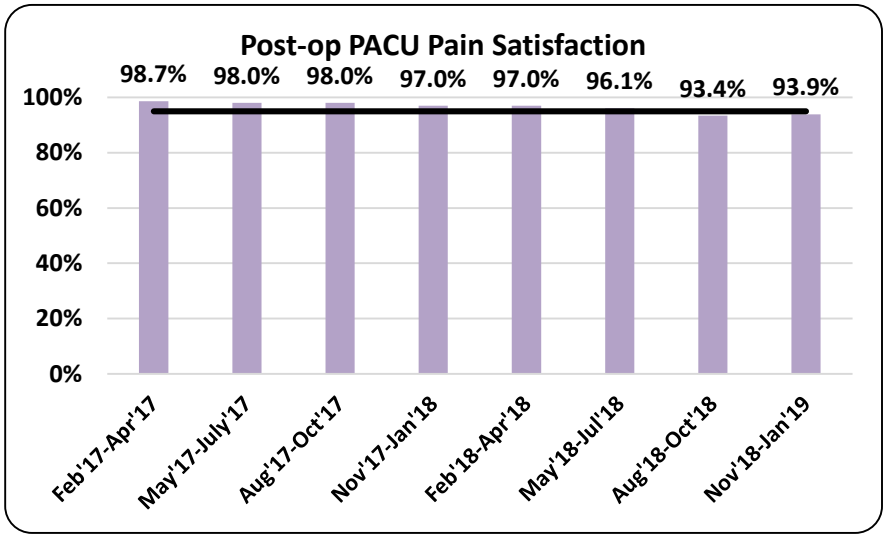
Surgeon Satisfaction

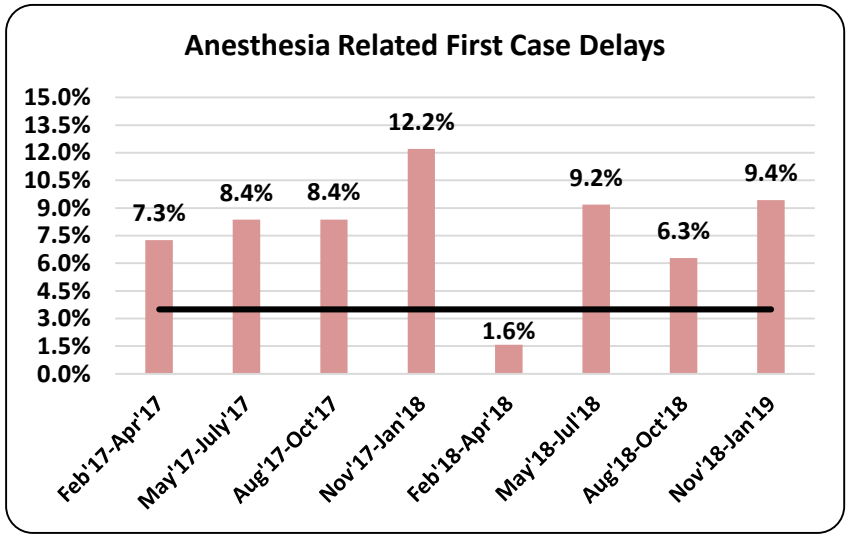


Summary

Performance Metrics







Metric Description	Metric for 2017-2018	Feb'17-Apr'17	May'17-July'17	Aug'17-Oct'17	Nov'17-Jan'18	Feb'18-Apr'18	May'18-Jul'18	Aug'18-Oct'18	Nov'18-Jan'19
OB Patient Satisfaction (overall)	>92%	100.0%	98.3%	99.5%	99.7%	97.7%		98.8%	99.7%
Post Op PACU Pain Satisfaction	>95%	98.7%	98.0%	98.0%	97.0%	97.0%	96.1%	93.4%	93.9%
Anesthesia Related First Case Delays	<3.5%	7.3%	8.4%	8.4%	12.2%	1.6%	9.2%	6.3%	9.4%

A Year in Review

- Contract renewal
- Stable leadership and full coverage/services
- Cerner implementation
- Student Registered Nurse Anesthetist (SRNA) partnership with Samuel Merritt University; restart with National University.
- 9 Certified Registered Nurse Anesthetist (CRNAs) and MDs recruited back to the practice
- Addressed medication reconciliation challenges to ensure charge capture for the hospital
- Achieved high levels of patient satisfaction with anesthesia services
- Dr. Tang official as Residency Program Director
- Residency 2nd year; start of clinical rotations

Looking Ahead

- Continued Partnership/Contract with Kaweah Delta
- Achieve full MD and CRNA staffing with no locum use
- Acute/chronic pain program development; non-opioid
- Expanding ERAS (Enhanced Recovery after Surgery) protocols beyond general surgery
- Support surgical growth/expansion; Orthopedics, etc.
- Support and expand cardiac cath lab services
- Interdisciplinary training; ie: nerve block mgt
- The Joint Commission survey preparation (Sept. 2019)
- Perioperative service line program development
- Surgeon satisfaction improvement
- Residency program development:
  - July 2019: 12 total residents; 2-4 daily in ORs

Thank You.

Local Teams. National Support. Exceptional Results.

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Kaweah Delta Health Care District

Administrative

Policy Number: AP126	**Date Created: Not Set**
Document Owner: Dianne Cox (VP Human Resources)	**Date Approved: 11/27/2018**
Approvers: Board of Directors (Administration)	

Physician Recruitment Policy

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

PURPOSE: The purposes of this Policy are: (1) to assure that all members (including Medicare and Medi-Cal beneficiaries) of the communities served by Kaweah Delta Health Care District ("Kaweah Delta") have adequate access to high quality primary care physicians, specialists and sub-specialists in the Kaweah Delta service area; and (2) that assistance provided by Kaweah Delta to recruited physicians is based upon identified community need and is in compliance with all applicable laws and regulations (including Section 32121.3 of the Local Healthcare District Law and the "physician recruitment" exception to the Stark Law (42 CFR 411.357(e).

Kaweah Delta provides a wide array of health care services including critical care, rural health care clinics, and assisted living. Kaweah Delta is the primary provider of inpatient and other health care services in its primary market (Visalia and immediate surrounding communities). Further, Kaweah Delta is the regional healthcare center for many subspecialty services for those communities south of Fresno and north of Bakersfield.

Local Health Care District law permits Kaweah Delta to provide financial assistance throughout the physician recruitment process when the use of such funds provides a public benefit. Income guarantees and other assistance to recruited physicians may be offered if 1) Kaweah Delta determines the community need, and 2) Kaweah Delta verifies that any financial assistance is "commercially reasonable" to induce a recruited physician to relocate his or her medical practice to the service area.

POLICY:

I. **Documentation of Community Need:**

A. Kaweah Delta is the only provider of inpatient services in Visalia and nearby surrounding communities and is a regional provider of numerous subspecialty services. Kaweah Delta will focus the resources that are available for physician recruitment as deemed necessary for meeting our community's most compelling needs. Objective measures of community need include: population to physician ratios, outside consultant recommendations, and the need for 24/7/365 emergency on-call services.

B. Where the communities served by Kaweah Delta have need for physicians other than inpatient primary care, specialty and subspecialty services, Kaweah Delta may collaborate in recruiting with other healthcare providers in the region.

II. **Conditions for Assistance:**

A. Kaweah Delta recognizes that there is a need to utilize its public resources to attract the physician(s) needed (e.g., the community's need for these particular services is determined based on (i) a lack of service availability or long waiting periods for the service; (ii) the lack of physicians serving the indigent or Medi-Cal population within Kaweah Delta's service area; or (iii) the need for ensuring on-call emergency coverage for the Emergency Department and other services). The recruited physician must commit to serving indigent and Medi-Cal patients.

B. A recruited physician must agree to establish (if new in practice) or relocate his or her existing practice to Kaweah Delta's service area, and maintain a practice, as defined in the recruitment agreement, to ensure the community obtains the necessary benefit from the physician's presence in the community.

C. A recruited physician must obtain and maintain appropriate staff privileges on the Medical Staff(s) of Kaweah Delta's facilities throughout the term of the recruitment agreement.

D. A recruited physician must be willing to provide full disclosure of necessary information and allow reasonable review of patient and financial records that may be necessary to audit compliance with the terms of the recruitment agreement.

E. A recruited physician must maintain a current California state medical license, current DEA license, professional liability insurance and eligibility or certification in his/her respective specialty.

F. A recruited physician may be required to participate in Medicare, Medi-Cal and other third party payor programs, and make good faith efforts to apply in a timely manner for credentialing with health plans that serve the communities of Kaweah Delta. Except as otherwise approved by Kaweah Delta, the recruited physician must contract with Kaweah Delta to assist in the payor credentialing process and to provide assistance in setting up the processes for the timely billing and collection of professional services.

G. A recruited physician must participate in the hospital's specialty on-call panel if applicable.

III. **Assistance:**

A. Requirements for physician recruitment assistance agreements must be reviewed by Kaweah Delta for compliance with applicable laws and regulations. In consideration of the foregoing, it is the policy of the Kaweah Delta Board of Directors that Kaweah Delta may provide the following types of physician recruitment assistance, each of which are

outlined in this Paragraph III:

- use of and payment for recruitment firms;
- loans for transition assistance, including practice start-up expenses and reimbursement of moving expenses and relocation costs paragraph III.B);
- loans for payment of net income guarantees, (including a benefit expense allowance (paragraph III.E);
- loans for payment of allowable practice expenses (paragraph III.E);
- loans for payment of a signing bonus (paragraph III.F.1);
- loans for payment for continuing medical education (paragraph III.C);
- loans for reimbursement of repayments of medical student loans (paragraph III.M);
- loans for payment of a stipend for a fellowship program (paragraph III.F.2).

B. A recruited physician may be provided with transition assistance for relocation and start-up expenses and costs. Expenditures for relocation and start-up expenses and costs must be reviewed and determined to be allowable in accordance with Exhibit A, Allowable Relocation Expenses Guidelines and Exhibit B, Allowable Start-Up Expenses Guidelines, except as otherwise agreed upon in writing and set forth in the recruitment agreement. The allowance for start-up and relocation costs and expenses, in the aggregate, shall not exceed $40,000.

C. Allowance for continuing medical education (CME) may be paid during the initial year of practice by the recruited physician, and shall be paid for the actual costs incurred in obtaining CME. The allowance for CME may not exceed $5,000.

D. The allowances for transition assistance and CME under paragraph B and C will be structured as repayable loans subject to forgiveness if the recruited physician maintains his or her practice in the community for a predetermined period of time, provides on-call coverage for the Emergency Department and renders health care services to all segments of the community, including Medi-Cal and indigent patients (all of which have been agreed upon in order to ensure the economic benefit to the recruited physician relative to the value of community benefit).

E. Kaweah Delta may recruit a physician(s) and guarantee his or her income and practice expenses, and provide for a benefit allowance:

1. The maximum assistance for an income guarantee is two years.

2. A determination of an appropriate compensation range for the applicable specialty or subspecialty will be approved by Compliance Department and provided to Kaweah Delta’s Physician Compensation Committee (Refer to section V & VI for the Physician Compensation Committee members). The Physician Recruitment Committee will review and approve the compensation amounts within the range provided by the Compliance Department. Any amounts exceeding the provided range will require Executive Fair Market Value Committee approval prior to any discussions with

physician candidates or recruitment firms.

3. Support staff, administrative services and practice expenses must be reviewed and determined to be allowable expenses and costs as established and administered under Exhibit C, Allowable Practice Expenses, except as otherwise agreed upon in writing and set forth in the recruitment agreement. If a physician is recruited through another physician or group practice, the support staff, administrative services and practice expenses must be reviewed and determined to be allowable expenses and costs as established and administered under Exhibit D, Allowable Incremental Practice Expenses for Joint Recruitment with an Existing Medical Practice, except as otherwise agreed upon in writing and set forth in the recruitment agreement.

4. The income guarantee advances, including practice expenses, must be structured as repayable loans subject to forgiveness if the physician maintains his or her practice in the community for a predetermined period of time, provides on-call coverage for the Emergency Department and renders health care services to all segments of the community, including Medi-Cal and indigent patients and (all of which have been agreed upon in order to ensure the economic benefit to the recruited physician relative to the value of community benefit).

F. Kaweah Delta may consider other types of permitted assistance to a physician in exchange for consideration and upon terms and conditions the Kaweah Delta Board of Directors deems reasonable and appropriate. See policy CP.03, Medical Director and Physician Provider Contracts, for additional information regarding the Fair Market Value process.

G. Types of assistance may include:

1. Payment of a signing bonus in exchange for the execution of the recruitment agreement. The signing bonus may be in full at the time of signing the recruitment agreement, or in one or more payments, including a payment concurrent with the recruited physician's commencement of practice in Kaweah Delta’s service area. The amount and schedule of a signing bonus will be approved by the Physician Compensation Committee and may not exceed $25,000 without the prior approval of Kaweah Delta’s Chief Executive Officer.

2. Payment of a stipend to a recruited physician who will participate in a specialty fellowship program prior to commencing his/her practice in Kaweah Delta’s service area. The stipend may be paid in one or more payments during the term of the fellowship program. The amount and schedule of a fellowship program stipend will be approved by the Physician Compensation Committee and may not exceed $25,000 without the prior approval of Kaweah Delta’s Chief Executive Officer.

H. If a recruited physician fails to meet the terms of the recruitment agreement, the District may suspend assistance for non-compliance until the default is corrected. However, if the default is not cured in a timely manner, the amounts paid out or loan balances remaining due shall be

due and payable generally within a period not exceeding one hundred twenty (120) days. However, balances may be due and payable within a period greater than one hundred twenty (120) days provided requisite approval is obtained by the Chief Executive Officer or Vice President.

I. In the event of death or permanent disability of the physician, the agreement may include provisions to forgive all or a portion of any remaining amounts due.

J. Each agreement will have a designated maximum amount of assistance authorized for a particular physician-recruit.

K. A recruited physician shall agree to the right of Kaweah Delta to inspect and audit his or her practice in order to verify compliance with the recruitment agreement.

L. A recruited physician agrees to retain his/her records of billings, collections, and expenses for at least five (5) years.

M. Recruitment loans shall be evidenced by a promissory note with a market-rate of interest approved by the Chief Financial Officer, and secured by the account receivables of the recruited physician.

N. In extraordinary circumstances, Kaweah Delta's Chief Executive Officer may authorize, as an additional incentive (within the meaning of §32121.3(a)(4) of the District Law) assistance to a recruited physician to assist in the repayment of his/her medical school student loans. See policy CP.03, Medical Director and Physician Provider Contracts, for additional information regarding the Fair Market Value process.

1. Student loan assistance will be provided based on the determination by Kaweah Delta's Chief Executive Officer that the assistance is necessary to recruit a physician who will fill a critical medical need at the Hospital or in the community, including such factors as a clinical specialty that Kaweah Delta has been unable to fill a need for a considerable period of time or the recruited physician, by virtue of his/her training, will expand the range of clinical modalities or other professional services not currently available in the community.

2. The assistance is subject to verification of the outstanding indebtedness.

3. Depending on the aggregate amount of the assistance, student loan assistance will be paid over a period of two or more years, with each annual payment subject to a one to two year forgiveness and interest at a market-rate of interest approved by the Chief Financial Officer. Payments of student loan assistance may be paid in one lump annual amount or in period payments as determined by the Chief Financial Officer.

4. All payments will be made to the recruited physician.

5. The recruitment agreement will stipulate that Kaweah Delta is not responsible, in any manner, for making payments to any lender(s) holding the student loans.

6. The recruited physician will certify at the end of each year that he/she has used the payments towards repayment of his/her student loans, and provide supporting documentation of the payments.

7. The student loan assistance will be subject to repayment under a promissory note in the event of a default by the recruited physician during the student loan assistance period and secured by a security agreement granting Kaweah Delta an interest in the accounts receivable of the recruited physician and such other collateral as may be available and necessary to secure the obligation.

IV. **Other Conditions:**

A. Kaweah Delta may share risk for recruitment costs and income guarantee payments with a physician or physician group who wish to jointly recruit with Kaweah Delta a new physician to the service area.

B. Kaweah Delta shall establish an annual or multi-year plan and budget for this program based on identified needs.

C. Agreements will be standardized, but terms may vary according to the specific request and situation.

D. Kaweah Delta, at its discretion, may obtain a life or disability insurance policy on a physician under a physician recruitment contract.

E. In accordance with the District law, no recruitment agreement shall do any of the following:

1. Impose as a condition any requirement that the recruited physician's patients or a quota of the physician's patients, be admitted or referred to a specified hospital;

2. Restrict the recruited physician from establishing staff privileges at, referring patients to, or generating business for another entity; or

3. Provide payment or other consideration to the recruited physician for the physician's referral of patients to any Kaweah Delta facility or affiliated organizations.

F. Agreements will be subject to ongoing compliance with this policy which is intended to comply with all applicable laws and regulations and which may be amended from time to time as the applicable laws and regulations change, and /or as the interpretations of the laws and regulations change.

PROCEDURE:

KDMF Recruitment

A. The Joint Operating Committee (JOC) recommends the Physician Staffing Plan (PSP) to the KDMF Board of Directors for approval.

B. The PSP is utilized for physician recruitment. Any changes to the approved PSP must be recommended by the JOC to the KDMF Board of Directors for approval.

C. Kaweah Delta Compliance Department is responsible to provide compensation ranges for each specialty and provides the information to the Physician Compensation Committee. Physician Compensation Committee members are VP of HR, KDMF CEO, KDMF CFO and VMC Executive Director. See policy CP.03, Medical Director and Physician Provider Contracts, for additional information regarding the Fair Market Value process.

D. The Physician Compensation Committee will review and approve the compensation amounts within the range provided by the Compliance Department. Any amounts exceeding the provided range will require Executive Fair Market Value Committee approval prior to any discussions with physician candidates or recruitment firms.

E. All recruitment agreements shall be prepared and approved by legal counsel as to form and compliance with applicable laws.

F. Kaweah Delta Board of Directors shall reserve the right to make the final decision, considering, among other things, Kaweah Delta's budget and the needs of the communities served.

Other Recruitment

A. Executive Team reviews requests for recruitment assistance based on community needs which includes, a lack of service availability or long waiting periods, lack of physicians serving the indigent or Medi-Cal population within Kaweah Delta's service area and the need for ensuring on-call emergency coverage for the Emergency Department and other services.

B. Kaweah Delta Compliance Department is responsible to provide compensation ranges for each specialty and provides the information to the Physician Compensation Committee. Physician Compensation Committee members are VP of HR, VP of Strategic Planning, KDMF CEO and VP of Service Line. See policy CP.03, Medical Director and Physician Provider Contracts, for additional information regarding the Fair Market Value process.

C. The Physician Compensation Committee will review and approve the compensation amounts within the range provided by the Compliance Department. Any amounts exceeding the provided range will require Executive Fair Market Value Committee approval prior to any discussions with physician candidates or recruitment firms.

D. All recruitment agreements shall be prepared and approved by legal counsel as to form and compliance with applicable laws pursuit to CP.03, Medical Director and Physician Contracts.

E. Kaweah Delta Board of Directors shall reserve the right to make the final decision, considering, among other things, Kaweah Delta's budget and the needs of the communities served.

RELATED EXHIBITS:

Exhibit A: Allowable Relocation Expenses
Exhibit B: Allowable Start-Up Expenses
Exhibit C: Allowable Practice Expenses

Exhibit D: Allowable Practice Expenses for Joint Recruitment with an Existing Medical Practice

"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 Submission Summary

Manual Name: Environment of Care			**Date: 6.10.19**
Support Staff Name: Maribel Aguilar			
Policy/Procedure Title	**#**	**Status – List policies in this order and identify if: New *, Revised *, Reviewed, or Deleted**	*** Name and phone extension of person who wrote or revised policy - * for New and Revised policies only**
Disruption of Services, Telephone	EOC 1044	Revised	Maribel Aguilar 624-2381
Emergency Operations Plan	EOC 2000	Revised	Maribel Aguilar 624-2381
Emergency Department Security	EOC 3007	Revised	Maribel Aguilar 624-2381
Fire Prevention Management Plan	EOC 5000	Revised	Maribel Aguilar 624-2381
Clinical Engineering Management Plan	EOC 6001	Revised	Maribel Aguilar 624-2381
Hospital Electrical Safety Policy for Personal Items	EOC 6015	Revised	Maribel Aguilar 624-2381
Retirement/Deletion of Medical Equipment from MEM Program	EOC 6018	Revised	Maribel Aguilar 624-2381
Utilities Management Plan	EOC 7001	Revised	Maribel Aguilar 624-2381
Medical Equipment-Healthcare Device Modification Policy	EOC 6003	Reviewed	
Non Healthcare District Equipment Preventative Maintenance and Repair Policy	EOC 6012	Reviewed	
Safe Medical Device Act/Medical Device Tracking and Reporting Policy	EOC 6009	Reviewed	

Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

Policy Number: EOC 1044	**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)	

Disruption of Service, Telephone

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

PURPOSE: To assure that communication shall be maintained when telephone system interruptions occur throughout the district.

POLICY: The following action is to be taken in the event of a telephone system failure.

PROCEDURE: ISS with facilities assistance, if requested, will assess the failure and initiate repairs. .

Communication

Telephone Downtime Procedures

In the event of a telephone system outage, using the Centrex lines call the ISS HelpDesk at 741-4741, and email the Helpdesk hd@kdhcd.org stating that the Cisco phones are down.

ISS and/or PBX will notify the House Supervisor of the telephone system outage via the house supervisor emergency pager at 559-501-0703.

The House Supervisor is to inform the Administrator on Call (AOC) and will determine if it becomes necessary to announce via PA system if able or via district urgent “the Telephone System is down, utilize downtime Centrex phones”.

I. DEPARTMENT RESPONSIBILITIES:

A. PBX:

In the event of a Code, any department may, on a downtime Centrex phone dial 713-5230 for the PBX Operator. The appropriate code team will be paged overhead if able, called over the radio, or paged by paging system.

For the Code Triage response by PBX refer to HICS procedures..

B. Telecommunications

1. Downtime Centrex phones shall become the primary mode of communication during the phone system downtime. District departments have been provided red phones. (Attachment A-Centrex phone list)

C. ISS

1. Cell phones shall become the secondary mode of communication during the phone system downtime for those departments possessing them.
2. Upon phone system downtime ISS will distribute cell phones and two way radios to departments (Attachment B- Cell phone list)

II. NURSING RESPONSIBILITIES

A. All Patients will be informed of telephone outage and reassured of stability and status of repairs as necessary or as directed by the house supervisor or AOC. If Nurse Call System is involved, refer to Policy EOC 1043.

Location	Number
2N	635-4196
2S	635-4191
ICU	635-4198
3N	635-4192
3S	636-3640
3W	635-4094
4S	635-4193
4N	635-4197
BP	635-4195
PEDS	635-4194
3T	635-6154
MB	635-4172
4T	635-6155
PBX	624-7844
Pharmacy	741-4818
Lab	TBD
Radiology	TBD
ISS	TBD
L&D	TBD
NICU	TBD

Downtime Cell Phone List- Appendix B

Number	Location
559-690-0075	2E L&D
559-690-0239	2 N
559-334-1575	2 S
559-690-1206	2W ICU
559-690-1267	3E PEDS
559-690-1392	3E BP
559-690-1481	3 N
559-690-1507	3 S
559-690-1567	3 W
559-690-1648	4C PT
559-690-1677	4 N
559-690-1830	4 S
559-690-1934	2T CVCU
559-690-1933	3T CVICU
559-690-1871	3T MB
559-690-1677	NICU
559-731-0050	4 T
559-731-0096	RADIOLOGY
559-731-0077	LAB
559-731-0100	ED ZONE 1
559-731-4068	ED ZONE 2
559-731-4239	ED ZONE 3
559-731-4971	ED INTAKE
559-731-5002	HOUSE SUPERVISOR
559-731-5042	DISTRIBUTION
559-731-5069	ED PHYSICIAN
559-731-5169	ED PHYSICIAN
559-731-5217	PHARMACY
559-731-5219	DIETARY
559-731-5230	PBX
559-901-1467	Housekeeping
559-901-0556	Patient Transport
559-901-0647	Bed Coordinator
559-901-0381	ED Case Management

Emergency Operations Plan

TABLE OF CONTENTS

Purpose
Kaweah Delta Health Care District (KDHCD) is committed to providing a healthy and safe environment for our patients, visitors and employees. This plan describes a comprehensive, organization-wide Emergency Management system that addresses KDHCD's emergency management program and ensures an effective response to a variety of disasters.

The purpose of the **Emergency Operations Plan** is to define the program that Kaweah Delta Health Care District to respond effectively to events that pose an immediate danger to the health and safety of patients, staff, and visitors. The Emergency Operations Plan consists of a number of procedures designed to respond to those situations most likely to disrupt the normal operations of the hospital. Each response is designed to assure availability of resources for the continuation of patient care during an emergency. *An emergency is an unexpected or sudden event that significantly disrupts the organization's ability to provide care, or the environment of care itself, or that results in a sudden, significantly changed or increased demand for KDHCD's services.* The emergency may be natural, such as an earthquake, or human-made, or a combination of both. Inherent in the Emergency Operations Plan, whenever possible, is the intent to collaborate with partnerships within the community, and with agencies having jurisdiction, such as the local fire, police, Department of Homeland Security, and County of Tulare.

This Emergency Operations Plan (EOP) has been developed so that Kaweah Delta Health Care District can effectively plan for, and respond to, emergencies in six critical areas:

• Communications

• Resources and Assets

• Safety and Security

• Staff Responsibilities

• Utilities Management

• Patient Clinical and Support Activities

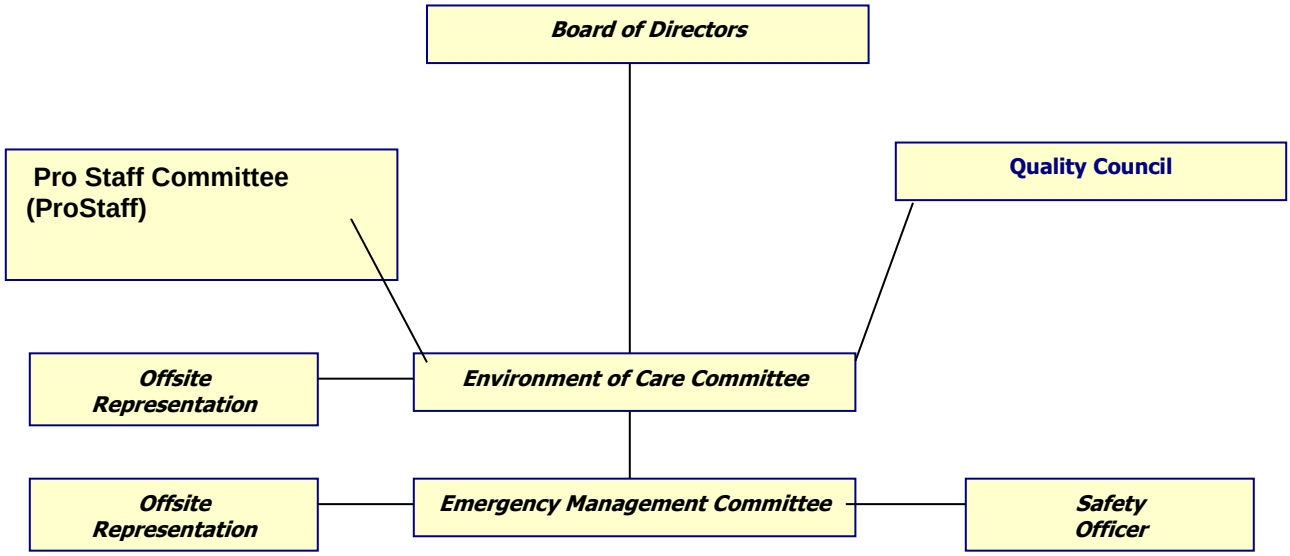
II. AUTHORITY

The authority for the establishment of an Emergency Operations Plan is with TJC EM.01.01.01. The authority for overseeing and monitoring the Emergency Operations Plan is with the Environment of Care Committee, and Emergency Management Subcommittee, Title 22, California Code of Regulations, additionally requires a written disaster plan. The Emergency Operations plan is developed at the Emergency Management Subcommittee level, and approved at the *Environment of Care* Committee. The plan is a multi-disciplinary effort of leadership within the District, including medical staff review and input.

III. ORGANIZATION

Reporting Structure: following represents how the Emergency Management program's reporting structure is organized:

Organization – Emergency Management Reporting
Kaweah Delta Health Care District



Responsibilities

1. **The Board of Directors.** The Board of Directors receives regular reports of the activities of the Emergency Operations Plan and program from the Environment of Care Committee in the form of a quarterly report. The Board of Directors also provides support to facilitate the ongoing activities of the Emergency Operations Plan.
2. **ProStaff Committee (ProStaff).** This Council **r**eceives an annual report from the Environment of Care Committee, which includes information relating to the Emergency Operations Plan, and provides assistance as needed in the development of quality indicators.

3. **Quality Management Committee:** Reviews annually reports of Emergency Preparedness, which are a part of the Environment of Care Committee report. Medical Staff serves on the Emergency Management Committee.
.
4. **Environment of Care Committee and Emergency Management Committee**. The Environment of Care Committee works in collaboration with the Emergency Management Committee for managing all aspects of the Emergency Operations Plan and Program.
5. **Management.** Managers are responsible for orienting new personnel to the procedures of the department and, as appropriate, to job and task specific responsibilities for emergency management.
6. **Staff.** Individual personnel are responsible for learning and following job and task specific procedures for emergency response and for participation in emergency activities as appropriate to their jobs.

IV. Objectives

The primary goal and objective of the Emergency Operations Plan is to mitigate harm to life and property due to unforeseen circumstances. The plan is intended to identify risks to the organization and balance these risks against preparedness and mitigation strategies in place and to use information relating to this risk analysis in design, planning, implementation and evaluation of the

overall plan. The Emergency Operations Plan comprehensively describes the District's approach to responding to emergencies within the organization or in its community that would suddenly and significantly affect the need for the District's services, or its ability to provide those services. The plan addresses four phases of emergency management: mitigation, preparedness, response and recovery as they relate to the above six critical areas.

Broad objectives of the Emergency Operations plan include:

• Identifying and assessing vulnerabilities and hazards, which may impact on the District.
• Strategic planning for emergency response
• Effectively managing disaster supplies and resources
• Exercising critical program elements
• Providing training and assessing staff knowledge

V. Scope

The scope of this management plan applies to Kaweah Delta Health Care District, and any off site areas per KDHCD license.

Each off site area is required to have a unit specific emergency plan that addresses the unique considerations of each area, including, but not limited to, initial emergency response. Off site areas are monitored for compliance with this plan by Environment of Care committee members.

EM. 01.01.01-EP1
The hospital's leaders, including leaders of the medical staff, participate in planning activities *prior* **to developing an Emergency Operations Plan.**
The District's leaders participate in planning activities at the Emergency Management Subcommittee. It is at this committee level that the *Hazard Vulnerability Analysis* is conducted, drill exercises are designed and planned, education relating to drill implementation is prepared, the inventory of organizational assets is developed and monitored, and activities relating KDHCD's Hospital Incident Command Center are developed.

All activities that emanate from the Emergency Management Subcommittee are integrated into the Emergency Operations plan, and are brought forth to the *Environment of Care* Committee.

EM. 01.01.01-EP 2 through 4
The hospital conducts a hazard vulnerability analysis (HVA) to identify potential emergencies that could affect demand for the hospital's services or its ability to provide those services, the likelihood of those events occurring, and the consequences of those events. The findings of this analysis are documented.

At the Emergency Management Subcommittee, in a multidisciplinary forum that includes medical staff involvement, the HVA is analyzed at least on an annual basis, or whenever experiences warrant additional review. Historical experience, geographical location, weather and climate conditions, local hazards, political conditions and populations served are factored into the analysis, and balanced against the District's mitigation strategies and preparedness activities. When the HVA is completed, collaboration with the local fire department, and other governmental or municipal agencies as applicable, occur to assist in defining priorities within the HVA and to ascertain capacities to support the needs of unexpected events. The HVA process is documented, and kept on file in the Emergency Management Subcommittee and *Environment of Care* minutes. The HVA is part of the routine agenda of the Emergency Management Subcommittee to keep members apprised of the current status, and to be easily accessible in the event changes are required. The HVA is kept current for each emergency management subcommittee meeting in order to determine how changing mitigation strategies may impact identified risks.

EM. 01.01.01-5
The hospital uses its hazard vulnerability analysis as a basis for defining mitigation activities (that is,

activities designed to reduce the risk of and potential damage from an emergency).
During the HVA process, mitigation strategies are defined that reduce the risk of potential damages that might occur from an emergency situation. See **ATTACHMENT A - HAZARD VULNERABILITY ANALYSIS(detailed analysis).** **The top five hazards have been identified as follows:**

HVA - 2018 – Top 5 Risks

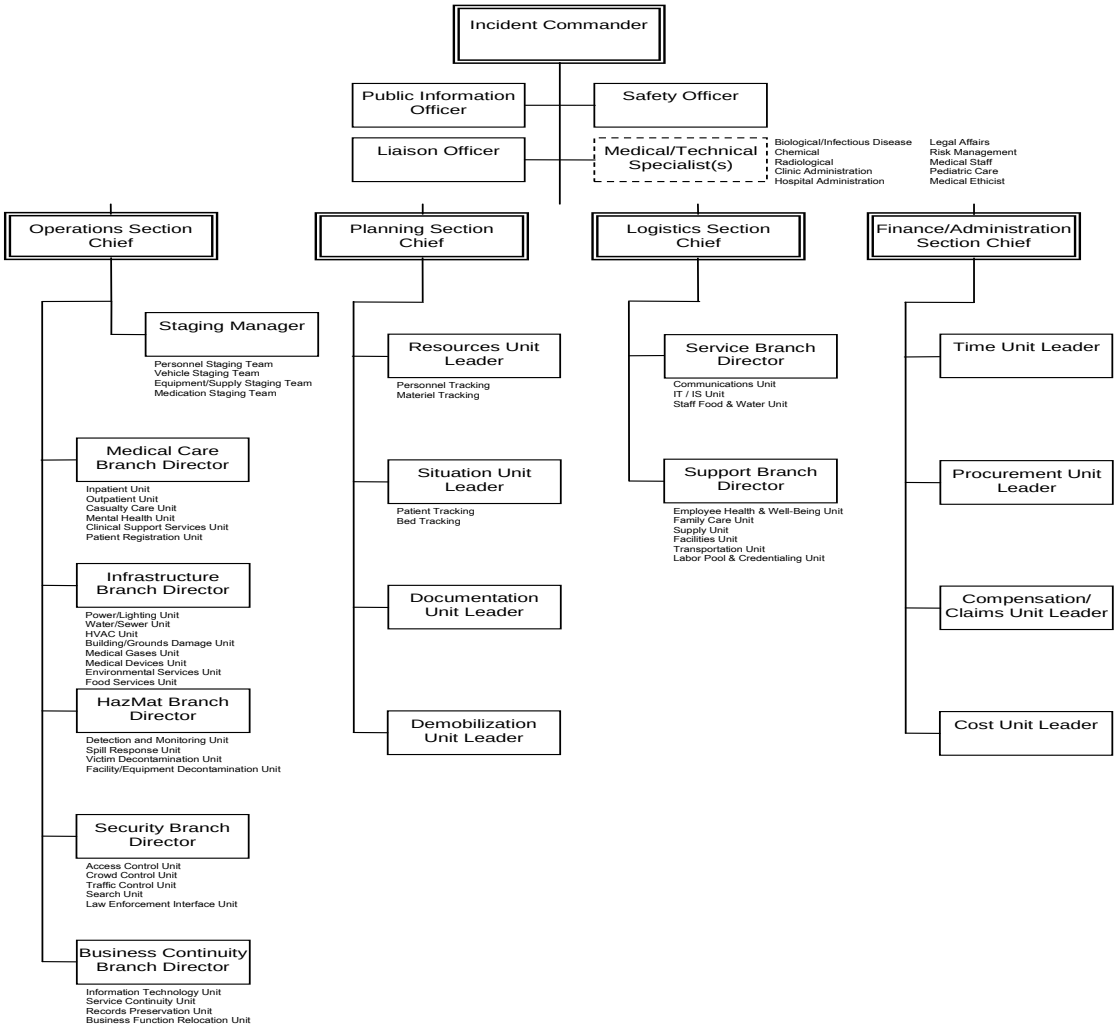
Event	Rationale
Epidemic 72%	An especially severe influenza pandemic could lead to high levels of illness, death, social disruption, and economic loss.
Chemical Exposure 56%	Pesticides are widely used in our agriculture areas.
Fog 56%	Central Valley fog is very heavy and there is a history of multi-vehicle (100+) accidents on local highways.
Helipad Incident 48%	With the addition of the helipad there is a great risk of an accident occurring at KDHCD
Mass Casualty (Medical/Infectious 50%	Mass Casualty can be expected from terrorist activities due to the political climate since 9/11
Dam Inundation 48%	Area dams are considered a risk: Kaweah Dam, Lake Success

EM. 01.01.01-6
The hospital uses its hazard vulnerability analysis as a basis for defining the preparedness activities that will organize and mobilize essential resources.
The HVA is used as a planning tool in defining preparedness activities that will organize and mobilize essential resources. It is also used to determine what assets may be needed to augment emergency preparedness at KDHCD, and what community partnerships may be invoked to strengthen response and or mitigation.

EM. 01.01.01-7
The hospital's incident command structure is integrated into and consistent with its community's command structure.

Kaweah Delta Health Care District uses the Hospital Incident Command System (HICS) as a scalable response to different types of emergencies. The District has adopted NIMS (National Incident Management System), and has integrated NIMS into pre-planning for disasters. Key personnel with the District are expected to respond to the Hospital Command Center if activated, and to assume functional responsibilities within the HICS command structure. HICS and NIMS training are required for staff that assumes leadership roles in the management of emergencies. HICS is compatible with an "all hazards approach" for the management of disasters, and is consistent with our local agencies having jurisdiction, such as the fire and police. HICS appointees are selected at the Emergency Management Subcommittee based upon parallel functions within their day-to-day job activities, and anticipated HICS response for a variety of scenarios. However, it is possible that a multiple number of employees can equally assume a HICS role due to the nature of standardized responses. For example, any member of the administrative team could be expected to assume the Incident Commander Role in the event pre-identified HICS appointees are unable to assume the Incident Commander role due to injury during a disaster or because he/she are not on site during the event. HICS education will apply to those individuals who could at any time assume a HICS role. At least annually HICS participants receive education/training relative to their role and anticipated responses during a drill or actual event. The education for HICS staff may be given "pre-drill", with "anticipated actions" identified for the planned scenario. It should be noted that not all HICS appointees may be activated during a disaster due to the "scalability" of the command response, i.e., only those HICS positions that are essentially needed for the planned scenario or actual event should be activated. The chart below identifies how HICS is organized at Kaweah Delta Health Care District:

Hospital Incident Command Structure* Kaweah Delta Health Care District



***** "Hospital Incident Command System Guidebook" – California Emergency Medical Services Authority, August 2014

EM. 01.01.01-8

The hospital keeps a documented inventory of the resources and assets it has on site that may be needed during an emergency, including, but not limited to, personal protective equipment, water, fuel, and medical, surgical and medication-related resources and assets.

Kaweah Delta Health Care District maintains an inventory of assets and resources that are maintained on-site that could be used in the event of an emergency. The inventory includes, at a minimum, but is not necessarily limited to, the following:

- Two trailers with supplies and equipment
- Personal protective equipment
- Water
- Fuel
- Medical supplies
- Pharmaceuticals
- Food supplies

The inventory is assessed by the Emergency Management Committee on an ongoing basis. During an emergency, KDHCD will monitor the quantities of assets and resources by using the inventory as a planning tool. The inventory will be updated daily by Materials Management, or "stakeholders" of information relating to

supplies/equipment/services for the duration of the emergency, and the updated inventory communicated to the Hospital Command Center. See **ATTACHMENT B: INVENTORY OF ASSETS AND RESOURCES**.

EM. 02.01.01-1 and 2
The hospital's leaders, including leaders of the medical staff, participate in the development of the Emergency Operations Plan.
The Emergency Operations Plan is developed as an outcome of pre-planning meetings at the Emergency Management Subcommittee. As members of the Emergency Management Subcommittee medical staff leadership participate in the development of the Emergency Operations Plan. Leadership within the Hospital Command Center will make decisions in an emergency. The EOP requires the Hospital Command Center to determine what specific response procedures are needed during an emergency, including the decision to continue operations if inventory supplies are used, and it is not imminent that re-stocking will occur. Response options may include minimizing operations or closure of operations. Relocation of patients and staff to an alternate care site may be another option. The Hospital Command Center may initiate collaboration with countywide Emergency Operations as needed when planning involves a loss or diminishing supplies, or when patients may need to be moved to an alternate care site. Other response options that will be determined at the Hospital Command Center may include staged or total evacuation.

EM.02.01.01-3
The Emergency Operations Plan identifies the hospital's capabilities and establishes response procedures for when the hospital cannot be support by the local community in the hospital's efforts to provide communications, resources and assets, security and safety, staff, utilities or patient care for at least 96 hours.

In the event of a disaster and it is known that KDHCD cannot be supported by the local community, an immediate assessment of the six critical areas will be initiated by the Hospital Command Center (communications, resources and assets such as food, fuel, water, linen, supplies and pharmaceuticals, staff security and utilities). The safety and security of patients will be assessed by managers and or lead personnel on every unit, and the security of the buildings will be assessed by the Security Branch Director and his appointed officers. The Infrastructure Branch Director will assess utilities, including power, HVAC, potable water and fuel. Patient clinical and support activities will be assessed when the District's infrastructure and resources are taxed. All managers will conduct bed availability and staffing needs for current patients, as well as for expected incoming patients if known. Hospital Command personnel will use the *Inventory of Organizational Assets* as a planning guide in determining resource needs and allocation, and whether or not conservation strategies will be initiated.

EM.02.01.01 EP 4
The hospital develops and maintains a written Emergency Operations Plan that describes the recovery strategies and actions designed to help restore the systems that are critical to providing care, treatment, and services after an emergency.

Kaweah Delta Health Care District has developed recovery strategies that will assist management in resumption of normal operations (**see Attachment C – "Manager's Recovery Guidelines**"). Within HICS are scenarios for various types of emergencies that include recovery guidelines, including which HICS participants are responsible for implementation.

EM.02.01.01-EP 5 and 6
The Emergency Operations Plan describes the processes for initiating and terminating the hospital's response and recovery phases of the emergency, including under what circumstances these phases are activated.

The individual who assumes the Incident Commander role at KDHCD has the authority to initiate and terminate the District's response and recovery phases of the emergency. The Emergency Operations Plan is activated when an unexpected or sudden event significantly disrupts KDHCD's ability to provide care, or that results in a sudden and increased demand for services.

EM.02.01.01 EP 7
The Emergency Operations Plan identifies alternative care sites for care, treatment and services that meet the needs of its patients during emergencies.

Alternate care sites have been identified as follows:
A. Alternate Care Site #1: Emergency Department Parking Lot
B. Alternate Care Site #2: Kaweah Delta Rehab Hospital
Phone number: 559-624-3700
C. Alternate Care Site #3: Kaweah Delta Mental Health
Phone: 559-624-3322
D. Alternate Care Site #4: KDHCD South Campus
Phone: 559-624-6204

EM.02.01.01 EP 8
If the hospital experiences an actual emergency, the hospital implements its response procedures related to care, treatment and services for its patients.

In the event of an actual emergency, Kaweah Delta Health Care District is prepared to respond using HICS to manage the event, which includes oversight of activities relating to the care, treatment and services for our patients. Activities relating to emergency management may include the establishment of a triage and/or decontamination area, deployment of staff, allocation of resources and equipment, monitoring of supplies and actions taken, and documentation of the event, if possible. Through the hazard vulnerability process, the KDHCD is poised to respond to emergencies, fully activating HICS, which is scalable to the event.

Crisis standards of care guidelines can be used for disaster situations when district healthcare resources are overwhelmed during a declared Code Triage. The decision to initiate Crisis Standards of Care will only be implemented on the order of the Incident Commander. When Crisis Standards of Care are initiated; district policies may be temporarily suspended in order to provide the best possible care for the greatest number of patients when district resources are overwhelmed during disaster situations.

EM.02.02.01 EP 1 through 15, EP 17, EP 20-22
As part of its Emergency Operations Plan, the organization prepares for how it will communicate during emergencies.

Communications
HOW STAFF WILL BE NOTIFIED THAT EMERGENCY RESPONSE PROCEDURES HAVE BEEN INITIATED

When the Emergency Operations Plan is activated, the Command Center will establish mechanisms for initial and ongoing communication with staff. The type of emergency will determine the specific modes of communication. Various types of communications available are: District telephone systems, Cisco phones, two-way radios, cellular phones, electronic mail, fax, and runners.
Key members of the Hospital Command Center, who have assumed a HICS role, will be notified upon activation of the Emergency Operations Plan. KDHCD leadership will be notified via the Xmatters web based messaging system. HICS staff ordinarily reports to the Hospital Command Center (HCC) for an initial briefing regarding the nature of the emergent event. At this time the scope of the event and its anticipated impact on the organization is determined, as well as the need for the activation of other HICS personnel.

Notification of staff in various departments will be managed by the following: overhead page (main hospital, telephone (Digital Display on all Cisco phones), e-mail and runner. Off site areas: Telephone Display on all Cisco phones, areas without Cisco phones will be notified by call tree, two way radios, email, and fax.

Staff not on duty at the time of the emergency are notified (if necessary) through activation of department / unit call- back procedures. Other ways to notify staff are as follows:
1. The Communications Unit Leader will set up a message phone for incoming employee calls and broadcast this through local radio and television networks.

2. Staff should monitor the Emergency Alert System/Network. Notice to return to work may be announced over this radio service. It is the responsibility of the Communications Unit Leader to notify the Emergency Alert System of any facility needs and information.

3. Local Radio stations: the local radio stations have agreed to broadcast hospital information for employees. The Public Information Officer will take responsibility for notifying the radio stations and compiling the information to be broadcast. Employees and physicians can monitor the following station:

Emergency Alert System (EAS) Network: KMJ – 580

The Hospital Command Center, throughout the duration of the emergency, will keep key response leaders apprised regarding the status of the emergency, the status of the organization, and any anticipated needs during the upcoming twenty-four hour period. Information will be provided to staff, from the Hospital Command Center, through various venues: by overhead page, e-mail, and through communication with managers and supervisors. Fax may be used for physicians.

HOW THE HOSPITAL WILL COMMUNICATE INFORMATION AND INSTRUCTION TO ITS STAFF AND LICENSED INDEPENDENT PRACTITIONERS DURING AN EMERGENCY

Staff in various departments and care areas on duty at the time of the emergency will be notified as follows, depending upon capability:
• By overhead page
• By telephone and or FAX if operating
• By email
• By runner
• By hand-held radios
• By combination of the above
Licensed Independent Practitioners who are within KDHCD premises will be notified as above. Licensed Independent Practitioners who may be in their private offices will be notified by telephone, by fax (if operating), by runners if they are located in close proximity to KDHCD. The Public Information Officer will also be making announcement for Licensed Independent Practitioners through radio and television media.

Staff not on duty at the time of the emergency are notified (if necessary) through activation of department /unit call- back procedures. If phone service is disrupted, the following will be considered:

• Notify staff through public service announcements on local television and radio (e.g., KMJ through the Public Information Officer)
• Notify staff through announcements placed on the District's website and social media sites.

HOW THE HOSPITAL WILL NOTIFY EXTERNAL AUTHORITIES THAT THE EMERGENCY RESPONSE MEASURES HAVE BEEN INITIATED

Communication with various external authorities may occur as follows:
Government Notification
The Hospital Incident Commander will confirm with the declaring authority whether the hospital is on ACTIVATION status. The Medical Health Operational Area Coordinator (MHOAC) will be notified by the Liaison Officer the status of the District.

Tulare County OES (Office of Emergency Services) Disaster and Mass Casualty Notification

The District will activate communication with the County OES Duty Officer by way of telephone (624-7499),
Email, and message services. Notifications may be activated for the following reasons:
1) Sharing of facilities for referral of casualties
2) Sharing of equipment and supplies
3) Supplementing, as needed, physicians, personnel and volunteers
4) Sharing transportation vehicles with personnel

HOW THE HOSPITAL WILL COMMUNICATE WITH EXTERNAL AUTHORITIES DURING AN EMERGENCY.

The District will activate communication with the external authorities by way of telephone, Emergency Department EMS Radio system, Satellite phone, message services and Status-Net. If Status-Net is utilized, communications will be handled by a Mobile Intensive Care Nurse (MICN) A MICN is an Emergency Department RN that is certified by the Central California Emergency Medical Services Agency. They receive specialized training in emergency communications including use of the Status-Net system.

HOW THE HOSPITAL WILL COMMUNICATE WITH PATIENTS AND THEIR FAMILIES, INCLUDING HOW IT WILL NOTIFY FAMILIES WHEN PATIENTS ARE RELOCATED TO ALTERNATE CARE SITES

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Patient Care providers will communicate with patients using routine methods, such as verbal, and though call light response. The PIO will establish processes to communicate pertinent information to patients and their families – including when patients are relocated to an alternative care site. Consistent with law and regulation and surrounding confidentiality of patient information, families may be apprised of the following:

• Verification that the patient is at the organization
• The general condition of the patient
• If the patient is going to be moved to an alternate care site, then the name, address, and specific care area of that site, as well as the anticipated timeframe for relocation.

HOW THE HOSPITAL WILL COMMUNICATE WITH THE COMMUNITY OR THE MEDIA DURING AN EMERGENCY

The Command Center will establish a Public Information Center for providing timely and accurate information to the public during a crisis or emergency situation. During an event, the Pubic Information Officer (PIO) will handle:
- Media and public inquiries;
- Emergency public information and
- Rumor monitoring and response;
- Media monitoring; and

Other functions required for coordinating, clearing with appropriate authorities, and disseminating accurate and timely information related to the incident, particularly regarding information on public health, safety and protection, and patient care and management issues. All media and community inquiries will be managed through the PIO. The effective use of the media to convey information during and following an incident is critical. The information provided to the public must include direction on what actions should and should not be taken, along with appropriate details about the incident and the actions being taken by the District. The PIO will work closely with the PIO at other community response agencies so that any contradictory or confusing messages coming from different sources can be avoided.

HOW THE HOSPITAL WILL COMMUNICATE WITH PURVEYORS OF ESSENTIAL SUPPLIES, SERVICES AND EQUIPMENT DURING AN EMERGENCY

The Logistics Section Chief and Operations Section Chief of the HICS Command Center will work collaboratively to assure that there is appropriate communication with vendors that may provide essential supplies, services, and equipment once emergency measures are initiated. Memorandums of understanding (MOU) may be invoked with key vendors to assure priority delivery and service to the organization during an emergency. For each vendor, the District has defined:

- Vendor contact information
- The type of critical supplies, equipment, and/or service that will be provided during an emergency

See Vendor List Page 12

HOW THE HOSPITAL WILL COMMUNICATE WITH OTHER HEALTHCARE ORGANIZATIONS IN ITS CONTIGUOUS GEOGRAPHIC AREA REGARDING THE ESSENTIAL ELEMENTS OF THEIR RESPECTIVE COMMAND STRUCTURES, INCLUDING THE NAMES AND ROLES OF INDIVIDUALS IN THEIR COMMAND STRUCTURE AND THEIR COMMAND STRUCTURE TELEPHONE NUMBERS

The Hospital Command Center will use normal methods of communication, e.g., phones (landlines and cellular), and email to communicate with other healthcare organizations, providing these services have not been interrupted. If communications have been interrupted, the Hospital Command Center will communicate to other healthcare facilities in our geographic area by Status Net through the County. At a minimum the following may be communicated to and from these healthcare organizations:

• Essential elements of the command structures and control centers for emergency responses
• Names and roles of individual(s) in their command structures and the telephone number of their command center.
• Resources and assets that could potentially be shared in an emergency response.
• If requested, and if in accordance with law and regulation, the names of patients and deceased individuals brought to the organization.

Names and individuals in other Hospital Command Centers are as follows:

Name of Hospital	Name of Emergency Coordinator	Number and email of Emergency Coordinator	Number of Hospital Command Center
Sierra View Hospital	David Wittington	559-788-6008	
St. Agnes Hospital, Fresno	Kristine Luke &	(559) 450-3721	559-237-3379
Veterans Administration Hospital - Fresno	Sean Hinds	559-0241-6637 or 559-228-5338 Sean.Hinds@va.gov	
Kaiser Permanente Fresno Medical Center	Samantha Samra	559-442-5753	559-448-2257
-Valley Children's Hospital	Ashely Ave	559-353-6227	559-353-8680
Community Regional Medical Center-Fresno	Evelyn Burruss	559-244-9346 or 559-917-8527 eburruss@communitymedical.org	
Fresno Surgical Hospital	Julie Gresham	559-447-7316	559-431-8000
Madera Community Hospital	Nick Noland	559-675-5521	559-675-5555

HOW THE HOSPITAL WILL COMMUNICATE WITH OTHER HEALTHCARE ORGANIZATIONS IN ITS CONTIGUOUS GEOGRAPHIC AREA REGARDING THE RESOURCES AND ASSETS THAT COULD BE SHARED IN AN EMERGENCY RESPONSE.
Kaweah Delta Health Care District will communicate with the above healthcare organizations through landline, and or email with respect to the sharing of resources and assets; however, if communications have failed, the Liaison Officer will communicate through Emergency cell phones or satellite phone, using the County to facilitate communications between hospitals. Runners may be used as a last resort, if they are able to use their vehicles.

HOW THE HOSPITAL WILL COMMUNICATE THE NAMES OF PATIENTS AND THE DECEASED WITH OTHER HEALTH CARE ORGANIZATIONS IN ITS CONTIGUOUS GEOGRAPHIC AREA.
Kaweah Delta Health Care District will communicate the names of the patients and the deceased with other healthcare organizations in its contiguous geographic area through normal communication channels if operational, only with an individual designated to be the Public Information Officer (PIO). If normal communications are not operating, the Liaison Officer, in coordination with the PIO, will transfer information to the County through emergency cell phones, or satellite phone (including agencies having jurisdiction, such as the police and fire).

HOW AND UNDER WHAT CIRCUMSTANCES, THE HOSPITAL WILL COMMUNICATE INFORMATION ABOUT PATIENTS TO THIRD PARTIES (SUCH AS OTHER HEALTH CARE ORGANIZATIONS, THE STATE HEALTH DEPARTMENT, POLICE AND THE FBI).
The Public Information Officer will establish a plan to communicate pertinent patient information to third parties – including when patients are relocated to an alternative care site. Every attempt will be made to remain consistent with law and regulation surrounding patient confidentiality. The Public Information plan to communicate patient information will include minimally the following:

- Verification that the patient is at the medical center.
- The general condition of the patient
- If the patient is going to be moved to an alternate care site, including the name, address, and specific care area of that site, as well as the anticipated timeframe for relocation.

THE EMERGENCY OPERATIONS PLAN DESCRIBES THE FOLLOWING: HOW THE HOSPITAL WILL COMMUNICATE WITH IDENTIFIED ALTERNATE CARE SITES.
Depending on the nature, scope, and duration of the emergency, the Hospital Command Center will establish periodic communication with designated alternate care sites. The first choice of communication will be landline, cellular phone and e-mail. If these forms of communication are disrupted, runners will be dispatched from the Labor Pool to send and retrieve information if it is safe to do so. The purpose of communication will be to:

- Apprise alternate care sites as to the status of the organization, its operational capability, and the anticipated need for assistance.
- Determine the status of the alternate care site(s), their operational capability, and their ability to receive patients should it become necessary.

THE HOSPITAL ESTABLISHES BACK UP SYSTEMS AND TECHNOLOGIES FOR THE COMMUNICATION ACTIVITIES IDENTIFIED IN EM.02.02.01 EP'S 1-13.
Kaweah Delta Health Care District has established the following as back-up communications in the event normal lines of communication are inoperable:

- Hand-held radios and satellite phones are available for internal communication between the Command Center and key patient care and other areas throughout the District.
- Runners can be dispatched from the Labor Pool to transmit information
- Cellular phones and satellite phones can be used for communication with external agencies.
- Radio communication between the Emergency Department and the EMS agency through the Emergency Department EMS Radio system
- Email and Internet capability is available in all sites of care.

THE HOSPITAL IMPLEMENTS THE COMPONENTS OF ITS EMERGENCY OPERATIONS PLAN THAT REQUIRE ADVANCE PREPARATION TO SUPPORT COMMUNICATIONS DURING AN EMERGENCY.
Through various activities, KDHCD participates in advance preparation to support communications during an emergency. These include, but are not limited to:

- Maintenance of communication equipment (e.g., hand-held radios, Satellite phones)
- Practice with alternate communications during drill exercises (e.g., hand-held radios, HAM radio, activation of runners)
- Practice with downtime procedures relative to email and internet capabilities (e.g., during routine service repairs and or equipment maintenance, electrical shut-downs)

AS PART OF ITS COMMUNICATION PLAN, KDHCD MAINTANINS THE NAMES AND CONTACT INFORMATON OF THE FOLLOWING

Staff, physicians, other hospitals and critical assess hospital ,volunteers ,entities providing services under arrangement, relevant federal, state, tribal, regional, and local emergency preparedness staff, other sources of assistance .The district, in the Incident Command Center, hold a listing pertinent phone numbers for disaster events.

THE HOSPITAL OPERATIONS PLAN DESCRIBES THE FOLLOWING
PROCESS FOR COMMUNICATING INFORMATION ABOUT THE GENERAL CONDITION AND LOCATION OF PATIENTS UNDER THE ORGANIZATIONS CARE TO PUBLIC AND PRIVATE ENTITIES ASSISTING WITH DISASTER RELIEF.

The district will activate communication with external authorities by way of telephone and via fax if required. If systems are compromised runners will be assigned to assist in such communication.

PROCESS IN THE EVENT OF AN EVACUATION TO RELEASE PATIENT INFORMATION TO FAMILY, PATIENT REPRESENTATIVE, OR OTHERS RESPONSIBLE FOR THE CARE OF THE PATIENT.

The PIO will establish a process to communicate pertinent information to patients and their families. During evacuation, the hospital command center will appoint an individual from each floor to gather patient information and have available for family or patient representative.
THE HOSPITAL MAINTANS DOCUMENTATION OF COMPLETED AND ATTEMPTED CONTACT WITH THE LOCAL, STATE, TRIBAL, REGIONAL, AND FEDERAL EMERGENCY PREPARNESS OFFICIALS IN ITS SERVICE AREA.

The District participated on a quarterly basis in planning meetings with Tulare County Public Health Emergency Preparedness program and with Central California Healthcare Coalition.

EM 02.01.01 EP 12 The Emergency Operations Plan included a continuity of operations strategy that covers: A succession plan that lists who replaces key leaders during an emergency.
KDHCD follows an administration chain of command structure. The house supervisor is the first point of contact for all district emergencies. They are supported by the Director on call and administrator on call.

EM 02.01.01 EP 14 The hospital has procedures for requesting an 1135 waiver for care and treatment at an alternate care site.
When the district has initiated their Incident Command Center and the President declares a disaster or emergency under the Stafford Act or National Emergencies Act and the HHS Secretary declares a public health emergency the liaison officer will submit a request to operate under a 1135 waiver for care and treatment at an alternate care site.

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EM 02.01.01 EP 15 The Emergency Operations Plan describes a means to shelter patients, staff and volunteers on site who remain in the facility.
The district will utilize all available office space to accommodate patient, staff and volunteers on site who remain in the facility. This includes all district properties in the surrounding areas.

EM.02.02.03 EP 1 through 12
As part of its Emergency Operations Plan, the [organization] prepares for how it will manage resources and assets during emergencies.

Resources and Assets

THE EMERGENCY OPERATIONS PLAN DESCRIBES HOW THE HOSPITAL WILL OBTAIN AND REPLENISH MEDICATIONS, MEDICAL SUPPLIES, AND NON-MEDICAL RELATED SUPPLIES THAT WILL BE REQUIRED THROUGHOUT THE RESPONSE AND RECOVERY PHASES OF AN EMERGENCY, INCLUDING ACCESS TO AND DISTRIBUTION OF MEDICATION CACHES THAT MAY BE STOCKPILED BY THE HOSPITAL, ITS AFFILIATES, OR LOCAL, STATE OR FEDERAL RESOURCES. The Operations Chief and Staging Manager will coordinate with Pharmacy and Materials Management the initial delivery of supplies, equipment and pharmaceuticals upon activation of a CODE TRIAGE ACTIVATION. Prioritization will be given to those areas either immediately impacted by the emergency, or are likely to be so.

Carts containing pre-positioned pharmaceuticals, supplies, and equipment, will be sent to designated staging areas. The contents of the carts will be rotated out on a regular basis to assure that inventory does not expire. Equipment designated for pre-positioning is included in the organization's medical equipment inventory and is maintained in accordance with pre-established preventive maintenance requirements.

ONGOING REPLENISHMENT OF SUPPLIES, EQUIPMENT, AND PHARMACEUTICALS

For the duration of the emergency – including response and recovery phases – the Operations Section Chief and Staging Manager are responsible for monitoring the inventory of supplies (including personal protective equipment), equipment, and pharmaceuticals in the various care areas. Replenishment from storage areas (Central Supply, Storeroom, etc) will occur on an as needed basis.

A general inventory of supplies (including personal protective equipment), equipment and pharmaceuticals will be taken in their respective storage areas on at least a daily basis (or more frequently if necessary) for the duration of the emergency. Remaining inventory shall be measured against the rate of consumption that is occurring as a result of the emergency. When existing inventory of critical supplies (including personal protective equipment), equipment, and/or pharmaceuticals are in danger of reaching insufficient levels, then contingency plans with outside vendors will be implemented. See Vendor List below:

Type of Service	Name of Vendor	Telephone Number
AIR/GAS	Air Liquide Guard	217-8195
BOILER	California Boiler	625-5151
	R.F Mcdonald	498-6949
BOTTLED WATER	US Food Service	1-800-682-1228
HVAC	American Air	651-1776
	Grants A/C	734-7361
	Brott Mechanical, Inc	688-7571
GENERATORS	Quinn Engine System	896-4040
HAZARDOUS MATERIALS	Atlas Enviornmental Healthwise Services	860-8871 834-3333
FUEL	Valley Pacific	7328381
PNEUMATIC CONTROLS/ENGERGY MANAGEMENT	Trane Summit Siemens Bldg Systems	271-4625 276-2600
PNEUMATIC TUBE SYSTEM 4" AND 6"	Swisslog/Translogic	800-525-1841
ELECTRICIANS	American	651-1776
EQUIPMENT SUPPLY	Grainger	635-2524
	Fastenal	739-2620
	McMaster Carr	562-692-5911
FIRE ALARMS	Siemens Inc	559-276-2600
MEDICAL SUPPLIES	Cardinal Healthcare	909-605-0900
NURSE CALL SYSTEM	Central Cal Electronics	485-1254
PHARMACIES	AmeriSource Bergen	800-635-4907
PLUMBERS	Robert Marks	625-8038
	American Air	651-1176
	Parker & Parker	625-4020
SECURITY	AAA Security	594-5600

RESPIRATORY CARE SERVICES	Certified Medical Testing	1800-243-5427
MEDICAL GASES	Air Liquide	445-1756

If emergency replenishment from outside vendors is not feasible, the community-wide EOC should be contacted to facilitate access to, and distribution of, stockpiled supplies, equipment, and pharmaceuticals. Other healthcare organizations in the immediate geographical location should also be contacted to see if necessary supplies, equipment, and pharmaceuticals could be made available.

ONGOING REPLENISHMENT OF NON-MEDICAL SUPPLIES

For the duration of the emergency – including response and recovery phases –
Logistics Section Chief and the Infrastructure Branch Director in coordination with Materials Management are responsible for monitoring the non-medical supply inventory. These supplies include, but are not necessarily limited to:

- Food
- Water
- Linen
- Fuel for Emergency Power Generators
- Fuel for Vehicles

A general inventory of non-medical supplies will be taken in their respective storage areas on at least a daily basis (or more frequently if necessary) for the duration of the emergency. Remaining inventory shall be measured against the rate of consumption that is occurring as a result of the emergency. When existing inventory of critical non-medical supplies are in danger of reaching insufficient levels, and then contingency plans with outside vendors will be implemented.

SUSTAINABILITY OF OPERATIONS WITHOUT EXTERNAL SUPPORT

It is possible that the nature, scope, and duration of the emergency may preclude outside agencies, vendors, authorities, or other vital entities from assisting the organization in a timely manner. Outside assistance may not be available for up to 96 hours following initiation of the Emergency Operations Plan.

Kaweah Delta Health Care District has designed its operations so that it can be self-sufficient for a designated time frame depending on resources and assets being affected. The table below summarizes the organization's ability to be self-sufficient in key areas. Hours of self-sufficiency is based on the following:

- The average amount of resource or asset within the organization at any given time.
- The estimated consumption of the resource or asset based on maximum capacity of patients and staff.

Resource or Asset	Hours Self Sufficient
1. Potable Water	168 with water conservation plan*
2. Food	168 with food rationing and dry food plan**
3. Fuel for Emergency Generators	96+
4. Pharmaceuticals – Analgesics / Narcotics	96+ with Cache supplies from local EOC
5. Pharmaceuticals – Broad Spectrum Antibiotics	96+ with Cache supplies from local EOC

Surgeries	Emergency Only Sterilization sent off site
Dialysis Patients	Diverted to other facilities (Clinic Patients)
In Patients	Sponge bath with "wipettes" Hand washing with alcohol gel
All Staff	Hand washing with alcohol gel

All Staff/Patients	Consume bottled drinks-try to limit to no more than 2 quarts per day; ration plan is implemented by Food/Nutritional Care Services
Toilets	If able to flush, flush after 3rd usage. If unable to flush, insert plastic bags into toilets, and seal when finished; EVS to remove to terminal waste collection area
Generators	Can run for approximately 7 days depending upon load usage.
HVAC System	On e-power.

***Food Supply – Patients Employees/MD/s, Other**	7 day supply for 1,000 total people per day, which includes patients, employees, physicians, & visitors Disaster menu established for 7 days	Meets 168-Hour sustainability: if food supplies begin to diminish, food-rationing plan will go into effect (e.g., 2 meals per day with snacks). **We will use food from cold sources first (refrigerator and freezers), then change to dry supplies.**

If critical assets and resources have neared depletion levels, and there is no anticipated assistance from external sources in the near future, then the Command Center will need to make a determination as to whether or not operational capability can be sustained. Possible actions include:

- Continuing current operational capability based on anticipated assistance from external sources
- Curtailing or modifying selected operational capability
- Closing and evacuating the facility(s)

Decisions involving curtailment, modification, or halting of operational capability will be made by the highest-ranking administrator in conjunction with the County of Tulare.

THE EMERGENCY OPERATIONS PLAN DESCRIBES HOW THE HOSPITAL WILL SHARE RESOURCES AND ASSETS WITH OTHER HEALTH CARE ORGANIZATIONS WITHIN THE COMMUNITY, AND OUTSIDE OF THE COMMUNITY IF NECESSARY.

Kaweah Delta Health Care District will share assets and resources with other local hospitals if needed. Within community, assets and resources will likely be shared with:

Name of Hospital	Name of Emergency Coordinator	Number and email of Emergency Coordinator	Number of Hospital Command Center
Sierra View Hospital	Jeff Suroweic	jsuroweic@sierra-view.com	559-794-1110
St. Agnes Hospital, Fresno	Matt Thomas	(559) 450-3721 (559) 779-6134	559-237-3379
Kaiser Permanente Fresno Medical Center	Samantha Samra	559-442-5753	559-448-2257

THE EMERGENCY OPERATIONS PLAN WILL DESCRIBE HOW THE HOSPITAL WILL MONITOR QUANTITIES OF ITS RESOURCES AND ASSETS DURING AN EMERGENCY.

Pharmacy, Food/Nutritional Services, and Materials Management, at the onset of any emergency, will determine the current quantities of medications, food/water, supplies, and linens. Daily usage will be measured against the current available quantities. If it is determined that the rate of usage/consumption is greater than expected replenishment, local resources will be accessed. If necessary, conservation measures will go into effect as stated above. If it is determined KDHCD can no longer support the care, treatment and services for the patients, a decision will be made by the Incident Commander to transfer and or evacuate patients.

THE EMERGENCY OPERATIONS PLAN WILL DESCRIBE ARRANGEMENTS FOR TRANSPORTING SOME OR ALL PATIENTS, THEIR MEDICATIONS, SUPPLIES, EQUIPMENT AND STAFF TO AN ALTERNATE CARE SITE WHEN THE ENVIRONMENT CANNOT SUPPORT CARE, TREATMENT. ALSO INCLUDED ARE THE ARRANGEMENTS FOR TRANSFERRING PERTINENT INFORMATION, INCLUDING ESSENTIAL CLINICAL AND MEDICATION-RELATED INFORMATION WITH PATIENTS MOVING TO ALTERNATE CARE SITES.
The Planning Section Chief, Security Branch Director, and the Patient Tracking Manager are responsible for coordinating the transfer and transporting of patients to alternate care sites should KDHCD need to be evacuated. This would include transporting the patient's medication, necessary equipment and supplies, as well as pertinent clinical and medication-related information.

A tracking system will be implemented that notes at least the following:

- The patient's name
- The patient's medical record or other identification number
- The disposition of the patient (where the patient was sent to)
- Whether or not family was notified (attempts should be made to notify family prior to transfer)
- Whether or not the patient's medical record was sent. At least copies of the H&P, operative reports, current medications (including last dose given), and most recent care records should be sent.
- When the patient was transferred
- When the patient arrived at the receiving facility and where the patient was placed
- When report was given on the patient to the receiving facility, and to whom the report on the patient was given.

Patients will be assessed to determine if they need to be transported by BLS or ALS as appropriate to their clinical condition. If necessary, qualified hospital staff will accompany the patient.

THE HOSPITAL IMPLEMENTS THE COMPONENTS OF ITS EMERGENCY OPERATIONS PLAN THAT REQUIRE ADVANCE PREPARATION TO PROVIDE FOR RESOURCES AND ASSETS DURING EMERGENCIES.

One function of the Emergency Management Subcommittee is to plan in advance, and in an ongoing fashion, an inventory of organizational assets and resources relating to emergency preparedness. This effort is a multi-disciplinary process, with monthly meetings that are driven by a standard agenda. The inventory is modified as new assets and resources are accumulated, and revised as quantities may be used during drills and or actual events.

EM.02.02.05 EP 1-10

As part of its Emergency Operations Plan, the medical center prepares for how it will manage security and safety during an emergency

Security and Safety

DESCRIPTION FOR INTERNAL SECURITY AND SAFETY

Upon initiation of Code Triage Activation, the Hospital Command Center will determine the need to activate the Security Branch Director position of HICS. This decision is based on the nature, scope, anticipated duration, and likely impact of the emergency on the safety of persons and the security of the facility. The *Job Action Sheet* for the Security Branch Director provides guidelines for the individual who assumes the role. Access control and hospital shutdown will be of primary importance.

COORDINATION OF SECURITY ACTIVITIES WITH COMMUNITY AGENCIES
It may become necessary to supplement internal security efforts with assistance from external law enforcement agencies, based upon the nature of the incident. The decision to request assistance from such agencies will be made by the Incident Commander based on incoming information, and the scope of the event. The Security Branch Director will work in coordination with the Operations Section Chief when coordinating with outside community agencies.

Once a decision is made to integrate with external law enforcement agencies, the Security Branch Manager will coordinate with a designated lead officer(s) of the agency having jurisdiction, and agree on the following issues:

- Incident Command
- Integration of Law Enforcement into Organization Operations
- Decision Making
- Rules of Engagement for Crowd Control
- Chain of Custody

Law enforcement will prevail, with consideration given to specific Kaweah Delta Health Care District concerns that may arise.

MANAGEMENT OF HAZARDOUS MATERIALS AND WASTE
During emergencies, when the structural integrity of the building may be impacted, for example, due to an earthquake or internal flood, the Safety Officer, in conjunction with Facilities staff, will assess all areas that contain hazardous materials to determine if there are any spillages as follows:

- Above ground diesel storage tank located at ISS
- Above ground diesel storage tank located at Facilities Plant
- Above ground diesel storage tank located in Acequia Wing Basement
- Laboratory located in Mineral King Basement
- Hazardous Materials Waste Storage Area located North of the Ambulance Bay (in dumpster enclosure)
- Surgery Soiled Utility Room
- OB Surgery Soiled Utility Room
- Environmental Services Chemical Storage Room located in West Basement
- Kitchen, 1st floor Mineral King Wing
- Laundry Area

If any spillages are determined, the area will be cordoned, with staff evacuated. The SDS for the spilled material will be obtained. If a spill kit can be safely used, this will be the procedural response. If the nature of the spilled material poses risk to the employee or the building, an outside hazardous materials response team will be called. In the interim, the areas will be cordoned, with staff evacuated. Any staff member that has experienced signs and symptoms relating to an exposure will be escorted to the Emergency Department for treatment. The Safety Officer will work in coordination with the outside hazardous materials response team.

RADIOACTIVE, BIOLOGICAL AND CHEMICAL ISOLATION/DECONTAMINATION
Kaweah Delta Health Care District has staff that is trained for decontamination response, including decontamination equipment. The Emergency Department follows district policies and has procedures for decontamination, which includes the care of the patient while minimizing risk to employees. Primary goals for emergency department personnel in handling a contaminated patient include termination of exposure to the patient, patient stabilization, and patient treatment, while not jeopardizing the safety of district emergency facilities and personnel. Termination of exposure can best be accomplished by removing the patient from the area of exposure and by removing contaminants from the patient.

Personnel must first address life-threatening issues and then decontamination and supportive measures if a radioactive exposure occurs. Priority is given to the ABC with simultaneous contamination reduction. Once life-threatening matters have been addressed, emergency department personnel can then direct attention to thorough decontamination, secondary patient assessment, and identification of materials involved. If a

chemical exposure has occurred, decontamination occurs first, and then emergency management of the patient.

Personal Protective Equipment. Any staff member providing patient care to a contaminated patient must wear the appropriate personal protective wear. Decontamination must occur outside of the Emergency Department by staff that are trained specifically for decontamination response within KDHCD. Should large-scale decontamination be required, HICS will be activated, with specific response guidelines implemented by staff that assumes HICS positions.

CONTROL OF ENTRANCE INTO AND OUT OF THE MEDICAL CENTER DURING AN EMERGENCY
It is likely that access to the organization's facility(s), and movement within the facility(s), will need to be monitored and controlled for the duration of the emergency. Upon activation of the Code Triage Activation, the following may occur:

1) Entrances to the Hospital will be staffed by Security or designated personnel through the Labor Pool. Visitors and other non-hospital personnel will be instructed to proceed to designated areas (DM 2225 Security Lockdown of Entry Doors). If necessary, entrances and exits will be locked down to prevent ingress or egress as warranted.
2) Movement by visitors and other non-hospital personnel will be restricted to a minimum. If visitors need to move beyond designated areas, they will be identified and their intended location within the facility will be ascertained.
3) Appropriate staff will be assigned to monitor vehicular access to the facility(s) and assure that access to the Emergency Department and other designated staging areas in unimpeded.

The Operations Section Chief and/or Security Branch Manager will assume responsibility for managing the aforementioned activities.

CONTROL OF MOVEMENT OF INDIVIDUALS WITHIN THE HEALTH CARE FACILITY DURING AN EMERGENCY, INCLUDING CONTROL OF VEHICULAR ACCESS
It is likely that access to the facilities in Kaweah Delta Health Care District, and movement within the facility, will need to be monitored and controlled for the duration of the emergency. Upon activation of the Code Triage, the following may occur, and will be under the responsibility of the Security Branch Director:

- Entrances to the facilities in Kaweah Delta Health Care District will be staffed by Security or designated personnel through the Labor Pool. Visitors and other non-hospital personnel will be instructed to proceed to designated areas. If necessary, entrances and exits will be locked down to prevent ingress or egress as warranted.
- Movement by visitors and other non-hospital personnel will be restricted to a minimum. If visitors need to move beyond designated areas, they will be identified and their intended location within the facility will be determined.
- Vehicular access to the facilities in Kaweah Delta Health Care District will be monitored by Security, including access to the Emergency Department and other designated staging areas is unimpeded.

ADVANCE PREPARATION FOR SECURITY AND SAFETY DURING AN EMERGENCY
Security and safety issues are regularly addressed at the Emergency Management Subcommittee, and various aspects are periodically rehearsed during pre-planned drills, which are designed and implemented through the Emergency Management Subcommittee.

EM.02.02.07 EP 1-11, EP 13-14
The medical center p**repares for the management of staff during an emergency.**
ROLES AND RESPONSIBILITIES FOR STAFF DURING EMERGENCIES
Roles and Responsibilities of staff for communications, resources and assets, safety and security, utilities and patient management begin at the Emergency Management Subcommittee through the HICS structure appointments, through the careful monitoring of the KDHCD's inventory of organizational assets, and through ongoing assessment of risk and mitigation strategies when assessing hazard vulnerabilities. Drills are designed with specific objectives relating to functional responsibilities of staff during exercises based upon risk to the District. Integrated into drill planning are resource and asset allocation and utilization. These activities are preplanned during ongoing Emergency Management Subcommittee meetings. These

activities additionally support ongoing training for staff that may include other types of learning, such as new hire orientation, annual re-training, and pre-drill training.
Staff roles and responsibilities in an emergency are largely determined by the priority emergencies identified as a result of the HVA, as well as the reporting relationships in the command and control operations of the organization.

Depending on the nature, scope, and durations of the emergency, staff may be asked to assume specific duties and responsibilities other than those normally noted in their position description. This most likely will involve assuming a HICS job function. In this case, the Job Action Sheet for that specific job function defines the staff person's role and responsibilities. Staff roles and responsibilities are identified in at least the following key areas with respect to the Job Action Sheet:

- Communications
- Resources and Assets
- Safety and Security
- Utilities
- Clinical Activities

In addition, staff roles and responsibilities may be further identified as it relates to unit-specific planning, policies and procedures and specific competencies.

All staff' have – at a minimum – the following responsibilities relative to the above mentioned areas:

- To communicate situational needs, observations, operational status, and issues in a clear, concise, and timely manner to the appropriate individual(s) or entity(s).
- To conserve resources and assets and utilize said resources and assets appropriately
- To be aware of, and maintain, the safety and security of themselves, their patients and the environment in which care, treatment, and service are rendered.
- To appropriately utilize and conserve utilities, and to report disruption or failure of utilities to the appropriate individual(s) or entity(s) in a timely manner.
- To assure that clinical activities are carried out in accordance with accepted standards of care, and in a safe and efficacious manner.

Staff are minimally trained relative to the codes for activation of the Emergency Operations Plan, and where to report for assignment. In addition, specific training is required for staff in accordance with the National Incident Command System (NIMS) as follows:

Staff Role	NIMS Based Training
• Personnel likely to be involved as initial responders	• ICS-100: Introduction to ICS or equivalent • FEMA IS-700: NIMS, An Introduction
• Personnel likely to function as Unit / Care Area Supervisors or Specialists in HICS	• ICS-100: Introduction to ICS or equivalent • ICS-200: Basic ICS or equivalent • FEMA IS-700: NIMS, An Introduction
• Personnel likely to function as Managers, Unit Leaders, and Branch Directors in HICS	• ICS-100: Introduction to ICS or equivalent • ICS-200: Basic ICS or equivalent • FEMA IS-700: NIMS, An Introduction

• Personnel likely to function as the Incident Commander, PIO, Safety Officer, Liaison Officer or Section Chief in HICS	• ICS-100: Introduction to ICS or equivalent • ICS-200: Basic ICS or equivalent • FEMA IS-700: NIMS, An Introduction • FEMA IS-800.A: National Response Plan (NRP), An Introduction* * NOTE: Personnel whose primary responsibility is emergency management must complete this training.

MANAGING STAFF SUPPORT ACTIVITIES DURING AN EMERGENCY

Depending on the nature, scope, and duration of the emergency, the Hospital Command Center will establish mechanisms to meet the needs of staff. Such mechanisms include, but are not necessarily limited to:

- Housing
- Transportation
- Communication
- Food and Water
- Stress Debriefing
- Child/Elder Care

If possible, unoccupied inpatient care areas of the facility will be converted into sleep rooms for staff and their children, including elder care. If unoccupied patient care areas are not available, unoccupied general areas may be converted into dormitory style housing with cots, blankets, etc.

It may be necessary to transport staff to the facility from a remote location. If so, a collection point will be determined, and staff reporting to the facilities in Kaweah Delta Health Care District will be instructed to meet there. Coordination with local transportation companies (bus, taxis, etc) will be used to transport staff to the facilities in Kaweah Delta Health Care District as needed. Chaplains and Social Workers shall be made available to staff on an as needed basis to cope with the stress of the emergency. The Logistics Section Chief and the Support Branch Director are responsible for implementing processes necessary to meet the needs of staff as noted above.

The Service Branch Director will coordinate with the Infrastructure Director to assure that adequate amounts of food and water are supplied to staff. Communications will include landlines, cell phones, E-mail, or runners and bull horn if normal communications are not operating.

Depending on the nature, scope, and duration of the emergency, it may be possible to share resources and assets with other healthcare organizations both within and outside the community. These assets and resources include, but are not necessarily limited to:

- Personnel
- Beds
- Transportation
- Linen
- Fuel
- Personal Protective Equipment
- Medical Equipment and Supplies

All licensed staff coming to work at the District will need competencies assessed by Human Resources and Nursing. If personnel from the District are going to be shared with another facility, staff will be apprised of the following information:

- The location and type of facility that they are being sent to
- The type of care, treatment, and service they are being asked to provide
- The expected duration of the assignment
- The contact information at the receiving organization.

Staff will be instructed to wear their identification badges. If possible, copies of pertinent documents such as licensure, competencies, etc. will be made and given to staff to take with them. An accurate record will be maintained of who went where and how long they stayed.

For equipment and supplies, an accurate inventory will be maintained of what was sent to other facilities and when, so that appropriate reimbursement can occur.

If resources and assets are to be shared outside of the organization's geographic service area, then the Liaison Officer will coordinate efforts from Kaweah Delta Health Care District with the County Emergency Operations Center.

THE IDENTIFICATION OF LICENSED INDEPENDENT PRACTITIONERS, STAFF, AUTHORIZED VOLUNTEERS
The role of licensed independent practitioners (LIP') as well as designated allied health practitioners (AHP') is to render medical evaluation and care during the emergency within the scope of their competence and privileges granted unto them by the medical staff. LIP's and AHP's are responsible for reporting to the Physician Labor Pool. Staff and physicians are responsible for wearing their name badges during the emergency period. In addition staff assigned to specific roles and responsibilities during the emergency (e.g. HICS positions) will be identified with color-coded vests.

Initial and ongoing training relevant to their emergency response role is provide to all staff, volunteers, and individual providing on-site services. Staff demonstrate knowledge in drills and exercises and critique activity.

EM.02.02.09
Preparation /Management of Utilities during an Emergency
EP 2-9
ALTERNATE MEANS OF PROVISION OF ELECTRICITY, WATER FOR CONSUMPTION AND ESSENTIAL CARE ACTIVITIES, EQUIPMENT/SANITARY PURPOSES, FUEL, MEDICAL GAS/VACUUM SYSTEMS, AND ESSENTIAL UTILITIES (VERTICAL/HORIZONTAL TRANSPORT, HEATING AND COOLING SYSTEMS, STEAM FOR STERILIZATION)
Complementing the efforts to meet the medical care needs of the patients and protecting the staff will be the maintenance of overall facility operations. This responsibility primarily rests with the Infrastructure Branch in the Operations Section. The responsibilities include maintaining the normal operational capability of the facility including power and lighting, water, HVAC, medical gases, and building/grounds, increasing capacities when patient surge requirements dictate; and identifying and fixing utility service-delivery failures. The acquisition of equipment parts or outside contractors will be coordinated with the Support Branch.

The Infrastructure Branch Director is also responsible for assuring that there is an alternate means of meeting essential utilities when normal supply mechanisms are compromised or disrupted. At a minimum, this means identifying alternate providers both within and outside the local community, and invoking memoranda of understanding for priority delivery and supply during an emergency. A summary of the key utility and alternate means / providers is as follows:

Essential Utility	Alternate Means of Provision
• Electricity-power and lighting	Self-Generation
• Water for Consumption and Essential care Activities	**Arrowhead – Memorandum of Understanding on file for priority delivery.** Water Conservation Plan will be implemented (page 12) if quantities begin to diminish before water deliveries can occur. See EOC Policy 1038, Disruption of Service: Water Service.
• Water Needed for Equipment & Sanitary Purposes	Water for Equipment: If water supplies diminish and equipment is no longer able to be supported, a decision will be made by the Incident Commander to divert patients, evacuate patients and close operations.

	Water for Sanitary Purposes: If water supplies diminish before replenishment can occur, water conservation will be implemented (page 13).
• Medical Gases/Air	3000 Gallon bulk oxygen storage is available, which will provide oxygen for 7-10 days, depending upon usage; plus, we have a 500-gallon back-up tank, which will provide approximately one day of usage.(Downtown Campus).
• Heating, Ventilation & Air Conditioning	Loss of HVAC will be dependent upon seasonal requirements. Windows will be opened if we are experiencing high heat, with cooling measures instituted (extra water consumption, cold trays, no blankets). If it is winter, extra blankets will be obtained, warm tray menu will go into effect. In both cases, if the HVAC loss is sustained for greater than four hours, patients will go on divert until the HVAC issue is resolved. If the HVAC loss results in adverse effects for patient and staff, a decision to close operations and evacuate patients will be made by the Incident Commander.
• Steam for Sterilization	If there is no water for steam sterilization, instruments will be sent to an outside vendor for sterilization, and or an adjacent hospital with whom we have made arrangements.
• Fuel required for building operations, generators and essential transport that the hospital would typically provide.	Conservation plan will be put in place and memorandum of understandings will be invoked for fuel.

EM.02.02.11 EP 2-8, 11-12
Management of Patients during Emergencies
2-11
PATIENT SCHEDULING, TRIAGE, ASSESSMENT, TREATMENT, ADMISSION, TRANSFER AND DISCHARGE
MANAGEMENT OF CLINICAL ACTIVITIES
When the Emergency Operations Plan is initiated, and for the duration of the emergency event, the Hospital Command Center will implement processes relating to the following:

- Triage of Patients
- Scheduling of Patients
- Assessment and Treatment of Patients
- Admission, Transfer, Discharge, and, if necessary, evacuation of patients

Within HICS, there are job action sheets that outline the specific duties and responsibilities of the Section Chiefs, Branch Directors and Unit Leaders relative to the above. In addition, the following general guidelines will apply:

Triage of Patients (Done by Emergency Department MICN)

During an emergency, victims of an internal or external disaster will be triaged to determine their necessary level of care. Patients will be assigned to one of the following triage categories utilizing the START and Jump START triage system:

- Immediate Treatment
- Delayed Treatment area

- Minor Treatment
- Deceased

Patients whose clinical needs fall outside of the scope of services or ability of KDHCD to care for them will be promptly identified and transferred to a healthcare facility equipped to provide appropriate care.

Scheduling of Patients

Depending on the nature, scope, and duration of the emergency, non-urgent tests, procedures, diagnostic studies, and care appointments may need to be delayed or canceled. When possible, patients will be notified of any delay or cancellation and when routine service is expected to resume. A record will be maintained of any cancellations so that patients can be contacted at the conclusion of the emergency to have their medical care needs met.

Admitting Patients

Admissions during an emergency will be limited to the following:

- Emergency Department Patients
- Disaster Victims
- Pregnant Patients in Labor
- Critically Ill Persons

Non-disaster and/or emergency admissions will be screened to determine their necessity for admission. Routine admissions may be resumed if authorized by the Command Center. Patient admissions will follow normal procedure as much as possible.

Potential Discharge & Transfer of Patients

Patients housed on the various care units will be evaluated for possible transfer or discharge in the event that it becomes necessary to release selected existing patients in order to make room for more seriously injured patients. Patients will be classified for transfer or discharge as follows:

- Patients that can be safely discharged to the care of relatives or friends.
- Patients that can be safely transferred to another medical care facility. (NOTE: Critical Care Units will identify patients who can be transferred to a nursing floor)

Evacuation of Patients

If the nature, scope, and/or duration of the emergency is such that KDHCD can no longer support care, treatment, or service, then it may become necessary to evacuate part or all of the facility(s).
The decision to evacuate shall be made by the Incident Commander in collaboration with the Section Chiefs within the Command Center. If necessary, communication will also occur with the County Emergency Operations Center, Central California Emergency Medical Services Agency, and the Department of Health Services.
The order to evacuate a given area is based on the safety of remaining in that area as compared to the risk of moving the patient population in question. Familiarity with several types of evacuation is necessary for all hospital personnel. Specific plans must be worked out within individual departments. Evacuation must take into consideration the number and types of patients, as well as alternative means of life support and cessation of invasive procedures when possible and considering the available resources at the disposal of the staff at the time the evacuation is to take place. There are generally four types of evacuation. Each may be a separate and complete operation or all may have to be used in successive stages if circumstances dictate. (KDHCD DM2810)

Partial Evacuation. Partial evacuation is removing the patient(s) and staff from a dangerous area to one of safety within the Hospital. The area being vacated will be marked as *unsafe* by Security. Once the area has been cleared of patients and staff, the area will remain off limits until repaired or cleared of the danger by the local agency having jurisdiction.

Horizontal Evacuation. Horizontal evacuation is the removal of all patients laterally by bed, wheelchair, stretcher or other type of transport, to an adjacent protected area. The patients in immediate danger are removed first, including those that might be separated from safety if fire or other danger enters the corridor. Ambulatory patients are moved next. Contrary to some opinions, panic is never caused by helpless people. Ambulatory patients are to be instructed to line up outside of their rooms forming a chain by holding hands and following the lead staff member. All rooms are to be carefully checked for

stragglers, looking particularly in all closets, under the bed and in the bathrooms. Each room door, after it is checked, is to be sealed with tape in such a manner that each room door cannot be opened without breaking the seal. Once in the evacuation area, patients must be rechecked to see that no one is missing.

Total Evacuation. In the hospital, patients will be evacuated to the nearest evacuation collection point outside of the hospital, with the goal to transfer to either: an alternate care site near the premises, or Kaweah Delta Health Care District. Patients requiring ventilator support will need special assistance during evacuation and must be moved with caution. In the event of total failure, electrical systems and building integrity, ventilator dependent patients will be maintained with manual support using a bag valve tube or mask. The order to evacuate is made by the person in the highest authority at the time of the disaster. Coordination with the Central California EMS Agency will be necessary to procedure the large number of ambulances that will be required to transport of patients to other sites.

CLINICAL SERVICES FOR VULNERABLE POPULATIONS

Special consideration will be given to vulnerable patient populations, including but not necessarily limited to, the following:

- Pediatric Patients
- Geriatric Patients
- Disabled Patients
- Patients with a Serious Chronic Medical Condition
- Patients with Addictions

Staff, within their scope of practice, in the various care areas will be required to identify vulnerable patients and their specific care needs. These will be noted in their plan of care and communicated to other care providers as warranted by the patient's condition and circumstances. Each patient identified will be escorted by a patient care provider.

PATIENT HYGIENE AND SANITATION NEEDS

Technical specialist experts (e.g., Infection Control) will be appointed by the Incident Commander to be responsible for assuring that patent and staff hygiene and sanitation needs are met during the emergency. The following will be considered:

- All non-essential environmental cleaning services will be discontinued and resources reallocated to patient care and treatment areas, as well as staff mobilization areas.
- Central Supply will re-supply personal hygiene articles such as toothbrushes, toothpaste, shaving articles, feminine hygiene articles, soap, and alcohol based hand gel or foam.
- If necessary, arrangements will be made to bring in additional portable restrooms to handle increases in-patient, visitor, and staff volumes.
- Waterless bath packets can be procured to allow for personal hygiene in a waterless environment.

PATIENT MENTAL HEALTH NEEDS

The mental and emotional needs of patients will be monitored by chaplains and social workers within the District. If it is feasible during the event, psychiatrists and clinical psychologists will be requested to assist as needed. Nurses will be requested to provide psycho-social support as needed, within their scope of practice, to patients exhibiting emotional or mental duress during the emergency.

MORTUARY SERVICES

If morgue services become unable to accommodate increasing fatalities, the following actions will be taken:

- The County Emergency Operations and Public Health Department will be contacted to provide temporary morgue services such as an environmentally controlled trailer.
- Local mortuaries will additionally be contacted to arrange for direct transport of deceased individuals to the mortuary.
- If the County local mortuaries are not available, body bags will be used to protect each expired patient, and stacked until other arrangements can be made.

DOCUMENTATION AND TRACKING OF PATIENT'S CLINICAL INFORMATION

Documentation will occur per normal protocol throughout the emergency. Each patient is provided with a unique clinical record identifier (i.e., a medical record number or account number). All clinical information about the patient will be noted on forms or other documentation tools with the patient's name and assigned number. In addition the location of the receiving facility or alternate site shall be documented. If normal documentation procedures have been disrupted because of the emergency, then downtime or designated alternate procedures will be used.

EM.02.02.13 EP 1-9

During disasters, the medial center may grant disaster privileges to volunteer licensed independent practitioners.

THE GRANTING OF DISASTER PRIVILEGES

Definitions. Volunteer practitioners include:

- Licensed independent practitioner: physicians (M.D, or D.O.), podiatrist (DPM), dentist or oral maxillofacial surgeon (DDS, DMD), Psychologist.
- Physician Assistants and Advanced practice registered nurses (NP and PA)

Authority for granting privileges. During disaster(s) in which the emergency management plan has been activated and the hospital is unable to meet immediate patient needs, the chief executive officer/designee and/or chief of staff/designee has the option to grant privileges during a disaster. The responsible individual is not required to grant privileges to any individual and is expected to make such decisions on a case-by-case basis in accordance with the needs of the hospital and its patients, and on the qualifications of its volunteer practitioners. The medical staff oversees the professional performance of volunteer licensed independent practitioners, either by direct observation, mentoring or clinical record review.

Once the immediate disaster situation is under control, the privileges are terminated. Additionally, privileges granted during a disaster may be terminated at any time without any reason or cause. Termination of privileges granted in a disaster does not entitle the individual to a hearing or other due process.

. The procedure for granting disaster privileges include the following processes:

1. The individual being given privileges during a disaster (applicant) must:

   A. Complete the privilege form: This form includes the applicant's statement that he/she is licensed, the license number, the state issuing the license and his/her area of specialty.

   B. Present a valid government issued photo identification issued by a state or federal agency, e.g., driver's license or passport, and at least one of the following:

      - A current picture hospital ID card that clearly identifies professional designation
      - A current license to practice
      - Primary source verification of the license
      - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organizations or groups
      - Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances **(**such authority having been granted by a federal, state or municipal entity)
      - Identification by current hospital or medical staff member(s) who possesses personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster

2. The CEO/designee and/or the chief of staff/designee may grant privileges during a disaster.

3. Medical staff coordination is accomplished by the chief of staff/designee who will assign physicians to appropriate areas.

4. The privilege form shall be forwarded as soon as possible to the medical staff office to immediately verify as much information as possible, including verification of licensure, hospital affiliation, National Practitioner Data Bank and OIG query. A record of this information will be retained by the medical staff office. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. In the extraordinary circumstances that primary source verification cannot be completed in 72 hours (for example, no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster privileges.

5. The CEO/designee, in consultation with the chief of staff/designee, makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted.

6. To ensure oversight of the professional performance of volunteer licensed independent practitioners:

    a. If medical staff members are available, concurrent mentoring will occur; the volunteer will be paired with a current member of the medical staff. Should medical staff members not be available due to the extent of the disaster, practitioner-specific outcome data will be collected when conducting record reviews after the disaster situation is resolved.
    b. Staff and patient satisfaction surveys will be conducted to assess care provided by volunteer practitioners.

    1. Any information gathered that is not consistent with that provided by the individual must be referred to the chief of staff/designee immediately, who will determine any additional necessary action. A physician's privileges approved during a disaster will be immediately terminated in the event that any information received through the verification process indicates any adverse information or suggests the person is not capable of rendering services in an emergency.

    2. Each physician will be required to wear a hospital badge signifying that the volunteer is authorized.

***Disaster Clinical/Privilege/Practice Prerogative Approval* Form.** A *Disaster Clinical Privilege /Practice Prerogative Approval* form will be completed for each volunteer, which includes unique identifying information about the volunteer, such as specialty, office address, phone number license/certification/registration number and expiration date, driver's license or passport number, date of birth, social security number, name of professional liability insurance carrier and limits of liability, etc.

Primary Source Verification. Kaweah Delta Health Care District personnel involved in the credentialing process will use the appropriate licensing/certification/registration on-line and print verification if possible:

- Medical Board of California: www.medbd.ca.gov (for MDs, DPMs and PAs)
- California Osteopathic Medical Board: www.ombc.ca.gov (for D.O.s)
- California Board of Registered Nursing: www.rn.ca.gov (for RNs, NPs)
- Board of Behavioral Sciences: www.bbs.ca.gov (for MFCC's, and LCSWs)
- California Psychology Board: www.psychboard.ca.gov (for clinical psychologists)

If computer access is not available, a copy of the practitioner's license/certification/registration and driver's license or other identification will be made and attached to the *Disaster Privilege/Prerogative Approval* form. If a copier is not available, the hospital representative will perform a visual verification of the above documents, and document such verification. If primary source verification cannot be accomplished at the

time of initial credentialing, it must be performed as soon as the immediate situation is under control, and completed no later than 72 hours from the time the volunteer presented to the hospital. In extraordinary circumstances when primary source verification cannot be completed, the following must be documented:

- Why primary source verification could not be performed in the required timeframe
- Evidence of a demonstrated ability to continue to provide adequate care, treatment and services, and
- An attempt to rectify the situation as soon as possible.

Medical Staff Services shall query the National Practitioner Data Bank and other sources as needed per *Temporary Privilege* policy for purposes of an important patient care need as soon as the emergency situation has been contained. Primary source verification is not required if the volunteer has not provided care, treatment and services under the disaster privileges.

Identification. Practitioners granted disaster privileges shall be issued a temporary badge or sticker to allow staff to readily identify these individuals. Badges should contain the volunteer's name, specialty or AHP category, and a notation stating, "practicing with disaster privileges".

Oversight. If possible, the practitioner should be paired with a medical staff member and should act only under the direct supervision of a medical staff, AHP, or hospital employee, as appropriate, to observe or mentor the volunteer. If partnering is not possible, oversight will be conducted by medical record review. Based on the oversight, the Chief Executive Officer or Chief of Staff or their designees have the authority to determine if the granted disaster privileges should continue. Disaster privileges may be terminated at any time without any stated reason or cause. The declaration by the CEO or designee, which the emergency is over will automatically terminate all emergency privileges. Termination of disaster privileges shall not afford hearing rights under the Medical Staff Bylaws or any other authority.

EM.02.02.15 EP 1-9

The medical center may assign disaster responsibilities to volunteer practitioners who are not licensed independent practitioners, but who are required by law and regulation to have a license, certification or registration.

Granting Privileges. When the disaster plan has been implemented, and the immediate needs of the patients cannot be met, KDHCD may implement a modified credentialing and privileging process for eligible volunteer practitioners and or allied health practitioners. A process is in place, which provides safeguards to assure volunteer practitioners are competent to provide safe and adequate care, treatment and services. This section applies to individuals that are not licensed independent practitioners (i.e., individuals who are required by law and regulation to have a license, certificate or registration to practice their profession, such as registered nurses, licensed vocational nurses, MFCC's, LCSWs and Clinical Psychologists).

Assignment of Disaster Privileges. The Chief Executive Officer or Chief of Staff or their designees have the authority to grant disaster privileges. Designees for the CEO include the COO and CNO. Designees for the Chief of Staff include the Vice Chief of Staff, Secretary-Treasurer, or any Department Chairperson. The responsible individual is not required to grant privileges to any individual and is expected to make decisions on a case-by-case basis. The procedure for granting disaster privileges include the following processes:

- Current picture hospital ID card
- Current license to practice
- Primary source verification of the license
- Identification that the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRC, ESAR-VHP, or other recognized state or federal organization or group
- Identification indicating that the individual has been granted authority to render patient care treatment and services in disaster circumstances, such authority having been granted by a federal, state or municipal entity
- Identification by current hospital or medical staff member(s) who possess personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster

Primary Source Verification. Kaweah Delta Health Care District personnel involved in the credentialing process will use the appropriate licensing/certification/registration on-line and print verification if possible:

- California Board of Registered Nursing: www.rn.ca.gov (for RNs, NPs)

- Board of Behavioral Sciences: www.bbs.ca.gov (for MFCC's, and LCSWs)
- California Psychology Board: www.psychboard.ca.gov (for clinical psychologists)

If computer access is not available, a copy of the practitioner's license/certification/registration and driver's license or other identification will be made and attached to the *Disaster Privilege/Prerogative Approval* form. If a copier is not available, the hospital representative will perform a visual verification of the above documents, and document such verification. If primary source verification cannot be accomplished at the time of initial credentialing, it must be performed as soon as the immediate situation is under control, and completed no later than 72 hours from the time the volunteer presented to the hospital. In extraordinary circumstances when primary source verification cannot be completed, the following must be documented:

- Why primary source verification could not be performed in the required timeframe
- Evidence of a demonstrated ability to continue to provide adequate care, treatment and services, and
- An attempt to rectify the situation as soon as possible.

Primary source verification is not required if the volunteer has not provided care, treatment and services under the disaster privileges.

Identification. Volunteer practitioners granted disaster privileges shall be issued a temporary badge or sticker to allow staff to readily identify these individuals. Badges should contain the volunteer's name, specialty or AHP category, and a notation stating, "practicing with disaster privileges".

Oversight. If possible, the voluntary practitioners should be paired with a staff member who is similar licensed, and should act only under their direct supervision as appropriate, who will observe or mentor the volunteer. If partnering is not possible, oversight will be conducted by medical record review. Based on the oversight, the Chief Executive Officer or Chief of Staff or their designees have the authority to determine if the granted disaster privileges should continue. Disaster privileges may be terminated at any time without any stated reason or cause. The declaration by the CEO or designee, which the emergency is over will automatically terminate all emergency privileges.

EM.03.01.01 EP 1-4
Evaluation of the effectiveness of emergency management planning activities

On an annual basis, at the Environment of Care Committee, KDHCD will conduct an annual review of the effectiveness of emergency management planning activities. This review will be forwarded to senior leadership for review. The annual review will include the following processes:

- The Objectives of the Emergency Operations Plan will be evaluated as follows: The intent of the objectives will be reviewed to determine if still relevant and applicable, and if change or modification is required.
- The Scope of the Emergency Operations Plan will be evaluated as follows: Planning activities will be reviewed to determine if modifications are required due to changes within the District, its structure, the patient population served, community planning partners or other factors that may have an impact on disaster response to emergencies.
- The *Hazard Vulnerability Analysis* will be reviewed to determine if risks, preparedness and mitigation strategies have changed or altered to lower or increase overall probability of defined risks.
- The *Inventory of Organizational Assets* will be reviewed to determine if resources and assets relating to emergency preparedness have been changed, or require change.

EM.03.01.03 EP 1-17
Evaluation of the effectiveness of the Emergency Operations Plan

Kaweah Delta Health Care District conducts exercises to assess the effectiveness of the Emergency Operations Plan at least twice a year, stressing the limits of the plan to support assessment of preparedness and performance. The design of exercises will reflect likely disasters, and will test the District's ability to respond to emergencies, and to provide care, treatment and services under stressed situations. Off-site areas classified as business occupancy (as defined by the *Life Safety Code*) will conduct one such drill a year.

INFLUX OF PATIENTS, ESCALATING EVENT AND COMMUNITY PARTICIPATION: At least one drill a year conducted by the District will include an influx of simulated patients, and one drill will simulate an

escalating event in which the surrounding community is unable to support the hospital. This portion of the drill may be conducted separately or in conjunction with a community wide drill, or tabletop exercise. One exercise will be conducted in participation with the County and or State of California.

EVALUATION OF DRILLS: Exercises will incorporate likely scenarios as identified on Kaweah Delta Health Care District's *Hazard Vulnerability Analysis*, with an evaluation tool used that monitors and assesses staff response to handling of communications, resources and assets, security, staff, utilities and patients. An individual(s) will be selected whose sole responsibility during exercises is to monitor performance. Opportunities for improvement will be addressed during debriefing by a multidisciplinary process, which includes independent practitioners, and documented, with a final evaluation completed at the Emergency Management Subcommittee. It will be the responsibility of the Emergency Management Subcommittee members to follow-through with documented deficiencies, with information provided to the Environment of Care Committee. Identified deficiencies are expected to be resolved prior to the next planned exercise, with interim measures put in place until final modifications are made. Subsequent exercises reflect modifications made and or interim measures identified.

-Description	Quantities/Descriptions	96 Hour Sustainability and Critical Asset	Individual Responsible Phone
Accommodations – Employees/Families	Kaweah Kids Child Care Center will accommodate childcare during a disaster. The rationale was to offer support/care to employees during a disaster, letting them know that their children could remain close by if no other accommodations could be made for them. Individuals to oversee setting up the accommodations, assuming childcare responsibility would be appointed from the Hospital Command Center.		Kaweah Kids Director 624-2471
Alternate Care Site	Alternate Care Site #1: Emergency Department Parking Lot Surge Tent Policy # Alternate Care Site #2: Kaweah Delta Rehab Hospital Phone: 559-624-3700 Alternate Care Site #3: Kaweah Delta Mental Health Phone: 559-623-3322 Alternate Care Site #4: KDHCD South Campus Phone: 559-624-6204 Emergency Room Triage Area- Acequia Wing Conference Room		Safety Dept. 624-2381
Bulk Oxygen Storage	3000 Gallon bulk oxygen storage, which will provide oxygen for 7-10 days, provide approximately one day of usage	3000 gallon will provide oxygen for 7-10 days. 500 gallon will provide approximately 1 day use.	Maintenance Director 624-2327
***Communications – Alternate types**	**Districtwide** • HT 1250 Radios, charger, battery and clips. • Xmatter messaging available for Leadership employees • Emergency cell phones available at each campus • Text Messaging • Landlines throughout the medical center • Runners • Satellite Phone available at campuses: South Campus - 00881651456907 KDRH - 00881651456906 Exeter - 00881651456908 Porterville Dialysis - 00881651456905 KDMC – 00881651456904 **Emergency Department** • StatusNet911: Multi-Agency Emergency Communication System capable of communicating with all area regional hospitals & EMS Dispatch Centers • Kenwood TK-2140 hand portable radio capable of communicating with all area regional hospitals & EMS Dispatch Centers. •Two Motorola MIP 5000 radios with Hospital Emergency Administrative Radio System, Hospital Med Channels & EMS Dispatch Centers. •	**-Hand-held radios available at each campus** **-Emergency cell phones available at each campus** **-Runners available via Labor Pool.** **-PBX (on emergency power) will extend to 96 hour sustainability if not damaged.**	Communications Manager 624-2118
Cots	20 sleeping cots are available in Disaster trailers		Safety Dept. 624-2381

Decontamination Shower	**(3) Portable Decontamination Shower located in Emergency Department**		Safety Dept. 624-2381
Education Plan – Decontamination	Employees trained on 5/2018		Safety Dept. 624-2381
Emergency Operations Plan	Revised approved by BOD 2018		Safety Dept. 624-2381
Emergency Equipment Inventory and Location	See Attached Emergency Equipment Inventory Equipment located in Lab Basement Cage, Trailers at CHC, Trailer at Warehouse.		Safety Dept. 624-2381624-2381
Food Plan - Disaster	We will utilize food from cold sources first (refrigerators & freezers), then change to dry supplies	We will utilize food from cold sources first (refrigerators & freezers), then change to dry supplies	Director Nutritional Services 624-5081
Food Supply – Patients, Employees/MDs, other	In the event of a disaster existing food inventories will be utilized to feed patients, staff, others. Menus will be adjusted to utilize (on-hand at the time) food supplies. Typically enough food is on site to feed 800-1,000 people per day for 3 – 4 days.	If food supplies begin to diminish, “Memos of Understanding” (M.O.U.s) are in place with Costco & Smart & Final to procure supplies as needed. Emergency plans have also been set up with US Foods & Sysco.	Director Nutritional Services 624-5081
***Fuel**	4000 gallon tank located on premises; however, usually the tank has approximately 3600 gallons of diesel fuel available		Maintenance Director 624-2327
Generator-portable	3 available		Maintenance Director 624-2327
HEPA Filters	5 available		Maintenance Director 624-2327
Letters of Agreement • Cardinal Health • Professional Hospital Supply • Medline • Sysco (Food)	LOA for Cardinal Health – priority delivery agreement LOA LOA for PHS – priority delivery agreement LOA LOA for Medline – priority delivery agreement Agreements with local vendors	Cardinal has agreed to deliver from alternate sites. If Cardinal cannot deliver we have agreements with secondary suppliers. If those suppliers cannot deliver we have agreements with local vendors	624-2596

<table>
<tr>
<td>Water – For All</td>
<td>Cal-Water Management Team has placed a back-up engine tied to a water pump that supplies water to the main campus. So in the event of a major power failure they will be able to provide water to our main campus.

Secondary Plan:
Nutritional Services has Emergency Water Plans for KDMC, West Campus and South Campus to provide water for 4 days. Emergency Water is stored in Nutritional Services Storage Areas.
Water Conservation Strategies
<table>
<tr><td>Surgeries</td><td>Emergency only Sterilization sent off site</td></tr>
<tr><td>Dialysis Patients</td><td>Diverted to other facilities</td></tr>
<tr><td>In Patients</td><td>Sponge bath with “wipettes”
Hand washing with alcohol gel</td></tr>
<tr><td>All Staff</td><td>Hand washing with alcohol gel</td></tr>
<tr><td>All Staff/Patients</td><td>Consume bottled drinks-try to limit to no more
than 2 quarter per day; ration plan is implemented by Nutrition Services</td></tr>
<tr><td>Toilets</td><td>If able to flush, flush after 3rd usage. If unable
to flush, insert plastic bags into toilets, and seal when finished. EVS to remove to terminal waste collection area</td></tr>
<tr><td>Sinks</td><td>Affix signs: “Do Not Use”</td></tr>
<tr><td>Chillers</td><td>This is only affected if boilers can no longer run.</td></tr>
<tr><td>Boilers</td><td>Season will determine heating and or chilling needs.</td></tr>
<tr><td>Generators</td><td>Can run for approximately 7 days depending upon load usage.</td></tr>
<tr><td>HVAC</td><td>On e-power.</td></tr>
</table>
</td>
<td>168 hours sustainability with
water conservation measures if needed</td>
<td>Maintenance Director
624-2327</td>
</tr>
<tr>
<td>Linens</td>
<td>24-hour supply on hand
Daily deliveries
Linen Conservation Plan will need to go into effect if there is interference with deliveries:
○ Bed Bath every 3rd day
○ Change linen every 3rd day if not soiled; clean chux daily
○ Use alcohol gel or wipes for hand washing
○ Whenever possible use wipes instead of wash cloths
○ Change hospital gowns every 3rd day unless soiled; encourage use of personal sleeping attire if at the hospital
○ Agreement in place with Mission Linen</td>
<td>Meets 96 hour sustainability with power by cogeneration plant.
Agreement in place with Mission Linen a local firm</td>
<td>EVS Director
624-2380</td>
</tr>
</table>

<table>
<tr>
<td>Hazard Vulnerability Completed – Top Seven Hazards – revised August 2018</td>
<td>2018 HVA- Top 5 Risks
<table>
<tr><th>Event</th><th>Rational</th></tr>
<tr><td>Epidemic
72%</td><td>An especially severe influenza pandemic could lead to high levels of illness, death, social disruption, and economic loss.</td></tr>
<tr><td>Chemical Exposure
56%</td><td>Pesticides are widely used in our agriculture areas.</td></tr>
<tr><td>Fog
56%</td><td>Central Valley fog is very heavy and there is a history of multi-vehicle (100+) accidents on local highways.</td></tr>
<tr><td>Helipad Incident
48%</td><td>With the addition of the helipad there is a great risk of an accident occurring at KDHCD.</td></tr>
<tr><td>Mass Casualty (Medical/Infectious
50%</td><td>Mass Casualty can be expected from terrorist activities due to the political climate since 9/11</td></tr>
<tr><td>Dam Inundation
48%</td><td>Area dams are considered a risk: Kaweah Dam, Lake Success
With the addition of the helipad there is a great risk of an accident occurring at KDHCD.</td></tr>
<tr><td></td><td></td></tr>
</table>
</td>
<td></td>
<td>Safety
624-2380</td>
</tr>
<tr>
<td>Isolation Rooms – Negative Pressure</td>
<td>Total Number of Isolation Rooms: 9</td>
<td></td>
<td>Director – House Supervision
624-2642</td>
</tr>
<tr>
<td>Licensed Beds</td>
<td>246 Unspecified General Acute Care
89 Perinatal Services
41 Intensive Care
15 Intensive Care Newborn Nursery
12 Pediatric Services
45 Rehabilitation Center at KDRH</td>
<td></td>
<td>Director – House Supervision
624-2642</td>
</tr>
<tr>
<td>Personal Protective Equipment</td>
<td>Mask – respirator TB – 14 cases (210 masks per case) in Materials
85 cases (210 masks per case) in Emergency Supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Pharmacy Meds on Supply</td>
<td>Pharmacy Cache from the State: two chem. Packs
(1) for approximately 450
(1) for hospital, servicing 1000 employees
Can request syringes from Tenet Cache and/or obtain from local sister hospital</td>
<td>Can reach 96-hour sustainability with access to Tenet Cache and from other Tenet hospitals.</td>
<td>Pharmacy Director
624-2470</td>
</tr>
</table>

<table>
<tr>
<td>Pharmacy Chem Pack contents

Emergency Operations Plan</td>
<td>Emergency Medical Services: Treatment Capacity 454 Patients
EMS Chempack Contents*
<table>
<tr><th>Drug/Dosage Form/Device</th><th>NDC/Product #</th><th>Number of units/box</th></tr>
<tr><td>Antidote Treatment-Nerve Agent Auto-Injector (ATNAA)</td><td>11704-777-01</td><td>200</td></tr>
<tr><td>Atropine Sulfate 0.4 mg/ml 20 ml vial</td><td>63323-234-20</td><td>100</td></tr>
<tr><td>Pralidoxime 1 gm 20 ml vial</td><td>60977-141-01</td><td>276</td></tr>
<tr><td>Diazepam 5 mg/ml Auto Injector</td><td>6505-01-274-0951</td><td>150</td></tr>
<tr><td>Diazepam 5 mg/ml 10 ml vial</td><td>0409-3213-02</td><td>25</td></tr>
<tr><td>Sterile H2O Inj 20 ml</td><td>0409-4887-20</td><td>100</td></tr>
<tr><td>Atropen 0.5 mg*</td><td>11704-104-01</td><td>144</td></tr>
<tr><td>Atropen 1 mg*</td><td>11704-105-01</td><td>144</td></tr>
</table>
*KD has 2 Chempacks on the Medical Center premises; each Chempak is designed to treat 454 patients.</td>
<td>Can reach 96-hour sustainability with Pharmacy Chem Pack contents</td>
<td></td>
</tr>
<tr>
<td>Pharmacy Supplies</td>
<td>Our hospital pharmacies disaster drug procurement plan is outlined in Pharmacy Manual 6.25.0. We have an established plan that was developed in conjunction with our primary drug distributor (AmeriSourceBergen). We have a list of medications that would be available for use in the event of a disaster. In the event of a disaster, we would notify the distributor of such an event and processes put in place to assure drug procurement based on the pre-developed drug list is executed. Per our Disaster Recovery Plan with our distributor, they will obtain assistance from local Emergency Services companies, the CA Office of Emergency Services, local law enforcement agencies, private contractors, the media, and military organizations. These agencies will be used to transport product overland or via helicopter if necessary.</td>
<td>Can reach 96-hour sustainability with our Disaster Recovery Plan</td>
<td>Pharmacy Director
624-2470</td>
</tr>
<tr>
<td>Surge Capacity Plan</td>
<td>Surge Capacity Plan in place; key issues addressed:
○ Census Saturation Plan AP. 114 in place
○ Identification of Isolation Rooms with Negative Pressure Availability of Infection Control Nurses x24 hours/7 days week
○ Bio-Safety Level 2 rating for Microbiology Laboratory, and is capable of testing for: influenza A&B antigens, RSV antigen, C. diffile toxin, E coli 0157, VRE and MRSA, routine cultures and anti-microbial susceptibilities, fungus and yeast isolation/identification. The Clinical Lab is equipped to rule out bio-terrorism organisms and rare and unusual organisms. The lab is able to refer specimens to reference labs and Tulare County Public Health Department</td>
<td></td>
<td>Director – House Supervision
624-2642
Safety
624-2380</td>
</tr>
</table>

<table>
<tr><td></td><td>○ (3) month supply of small regular size Tecnol N-95 respirators; high risk departments have designated fit-testers who can fit test employees if needed; N-95 respirators may be able to be accessed from Tulare County cache
○ Pharmacy – Disaster Drug Procurement Plan in conjunction with our primary drug distributor based on pre-developed drug list.
○ Employee/family accommodations will be made available as needed</td><td></td><td>Safety
624-2380</td></tr>
<tr><td>Tents</td><td>Have two tents available for use</td><td></td><td>Director
624-2327</td></tr>
<tr><td>*Security – Ways to Increase</td><td>Security Staff is in-house. We have a current contract with Triple A Security for additional security staff if needed in an emergency.</td><td>Can reach 96 hours sustainability with In- house staff and contract with Triple A Security.</td><td>Security Manager
624-5591</td></tr>
<tr><td>*Staffing hours – Ways to increase</td><td><table><tr><th>Priority</th><th>Strategy</th></tr><tr><td>One</td><td>Adapt staffing ratios to need. Each of the designated patient care levels (critical, complex/ critical, basic, and supportive) will require different staffing ratios.</td></tr><tr><td>Two</td><td>8-hour shifts may be changed to 12-hour shifts.</td></tr><tr><td>Three</td><td>Prioritize tasks so only essential patient care tasks are provided by staff.</td></tr><tr><td>Four</td><td>• Use media to contact volunteer healthcare workers. • Acquire staff through established MOUs and partnerships with other sister facilities. • Consider alternate labor sources such as MRCs, Community Emergency Response Teams (CERTs), etc., through County</td></tr><tr><td>Five</td><td>Consider flexing scope of practice of staff to provide necessary care with available staff (when authorized by the Governor during a declared state of emergency) to allow flexed scope of practice)</td></tr></table></td><td>Can reach 96-hour sustainability with our Staffing Strategies.</td><td>House Supervisor
624-2642</td></tr>
<tr><td>Staffing – Physicians</td><td>Must report to the Physician Labor Pool</td><td></td><td>Medical Staff Director
624-2358</td></tr>
<tr><td>Ventilators</td><td>33 total ventilators plus 3 in storage which will be on preventive maintenance inventory and kept maintained for emergencies</td><td></td><td>Director Respiratory Services
624-2417</td></tr>
</table>

Decontamination Shower	Emergency Department – 3 Portable decon shower	
Equipment – Bioterrorism – located in (2) of the County provided trailer (at South Campus) 1633 S. Court St. Visalia, Ca 93292		
	55 Gal. Containment Drums w/ dollies	4
	Don-It Post Decon Personal Privacy Kits – Adult – 20 per case	7 cs
	3M Nickel Batteries	5
	4'X100' Safety Fence	3
	Boxes Nitril Gloves (LG)	10
	Boxes Nitril Gloves (MD)	10 bx
	Boxes Nitril Gloves (SM)	10
	Case Gatorade Mix	1
	Casualty Manager shelter	1
	Container 2 buckets, brush and sponges	1
	Cooling Vests	23
	Decon Tent	1
	Don-It Personal Privacy Kit (Adult)	16
	Don-It Personal Privacy Kit (Youth)	8
	Don-It Post Decon Personal Privacy Kits – Child – 20 per case	4 cs
	Extraction Litters	4
	Hard Hats	4
	Hazorb Booms	7
	Honda 10,000 Generator	1

	Honda 3000 Generator with Tele Lite Kit	2
	hoses	3
	Igloo 10 gallon water jug	1
	Igloo Ice Chest (40 QT)	1
	Level B Suits	5
	Level B Suits (M)	5
	Level D Suits (LG)	25
	Manometer	1
	Minute Man Heppa	1
Equipment – Bioterrorism – located in (2) of the County provided trailer (at South Campus) 1633 S. Court St. Visalia, Ca 93292		
	Model Pelair 24,000 Portable air conditioner	2
	On Scene Bio Protective Kit (XL)	320
	On Scene Bio-Tec Kit (2XL)	400
	On Scene Bio-Tech Kit (2XL)	582
	PAPR FR-57 Filters (cases)	9
	Pig Spill Blocker Dikes	4
	Pop-Up Tent	2
	Powered Air Purifying Respirators (PAPR) –	26
	Quick Shade Instant Canopy (10'X10')	2
	Quick Shade Instant Canopy (10X10)	2
	Rubbermaid 5 Drawer Tool Box	1
	Rubbermaid Cart (grey)	1
	Safety Vests- Orange	1

	Safety Vests w/ White Reflectors	11
	Safety vests-Green	3
	Spill Berm Rub Orange	2
	System CPF 3 Keppler Suits (LG)	2
	Tool Box	1
	Traffic Cones	10
	Traffic Delineators	11
	Red Helmets(10)	10
	Caution Tape and Hazard Tape *(tub)*	1
	Tyvek Coverall (XL)	25
	Tyvex Coverall White (2X)	25
	Tyvex Coverall White (3X)	25
	Used Air Filters (Practice)	14
	Wrench Set	1
Equipment – Warehouse 240 South Dunsworth, Visalia Ca	Clean Air RX Air 3000 Air Purifier	1
	Generator Cord	1
	Mintie 1000V Hepa	2
	Mintie ECU 2 Bundle	1
	OmniAire 1000 V (Hepa Air Units)	2
	Poly Pad	1
	Pressure Kit	1
	Star Heater	1
	Don-It Personal Privacy Kit	
Equipment- Lab Basement	3M 10 Unit battery Charger (PAPR)	2

	3M Battery Packs	15
	5 Unit Charging Stations	3
	Asbestos Vac	1
	Bar Code Reader	2
	Booties (10LG)	1 cs
	Booties (6-SM/6-2XL)	1 cs
	Booties (8XL)	1 cs
	Booties (9 Med)	1 cs
	Non Researchable PAPR Batteries (26)	1 bx
	Bull Horns	2
	Cases 3M Cartridges of filters (6 each)	15 cs
	Chemical Tape (20 rolls)	2 bx.
	Communication Radio Batteries	20
	Decon Suits (2XL)	12
	Decon Suits (3XL)	33
	Decon Suits (L)	6
	Decon Suits (Med)	6
	Decon Suits (XL)	18
	EPV 200 Ventilator	3
	Green Duffle Bags	2 bag
	Level B Suits (XL)	18
	Level B Suits (3XL)	6
	Level B Suits (L)	34
	Level B Suits (M)	6
	Level D Suits (LG)	25
	Level D Suits (XL)	9

	Lithium Mag Disposable batteries	5
	Modular ECU 2 Tent	1
	Multi casualty triage kit	1
	Nickel Cadmium Batteries	3
	Orange Duffle Bags	1bag
	PAPR bags with unit and filters	22
	PAPR Cartridges	117cs
	Personal belongings bags	2 bx
	Phillips Heart Start Defibrillators	2
Equipment- Lab Basement	Pocket Hand Held Computers	2
	Portable Decon Shower	3
	Portable Suction Units	9
	Power Heart AED 3 Defibrillators	2
	Pre and Post Decon Bags (Small/Med)	2 bx
	Pre and Post Decon Bags (Youth).	1 bx
	Radiation Detector	1
	Radio Chest Packs	10
	Rubber Gloves (Size 7)	12
	Rubber Gloves (Size11)	12
	Scissors	33
	Spinal Immobilization Board	12
	Steel Toe Boots (1-Size 8, 3- Size 10)	1
	Steel Toe Boots (Size 10 Green)	3
	Steel Toe Boots (Size 11 Orange)	3
	Steel Toe Boots (Size 12 Orange)	3
	Steel Toe Boots (Size 6 Green)	2
	Steel Toe Boots (Size 7 Orange)	3

	Steel Toe Boots (Size 7 Orange)	4
	Steel Toe Boots (Size 8 Green)	8
	Steel Toe Boots (Size 8 Orange)	7
	Steel Toe Boots (Size 9 Green)	3
	Stereoscopes	13
	Clipboards (suite case)	1
Equipment – Evacuation	• Stryker evacuation chair at staff elevator landings on the 3rd and 4th floors.	

ATTACHMENT C

Manager's Recovery Guidelines (Recovery Checklist Post Disaster)

Manager's Recovery Guidelines

Damage Assessment	Staff Requirements	Equipment Requirements	Document Requirements	Other
Assess patient safety post incident.	Assess current capacity of staff and possible overtime hours.	Assess equipment for operational status	**Document requirements are critical to financial recovery.**	Data safety: whenever possible, data in your computer(s) should be on back up files
Assess employee safety post incident	Determine if staffing needs were met, and if additional staff was utilized, or overtime was used.	Identify what alternates to current equipment can be used.	Document hours worked by staff during the incident, and post incident and until the incident is declared resolved.	
Assess area safety to determine where it is safe to move	Ensure staff hours worked during the incident are disaster-coded properly to the disaster cost center.	Notify Biomed for equipment needs.	Photograph damages to building and equipment. Contact photography or departments with digital cameras , videos (Engineering)	
Complete Damage Assessment in your area. If damage has occurred, obtain photographs of the area—preferably by camera or digital camera. Keep as part of records; originals to the Cost Officer with date, time, location, contact person.		Document all rental usage. Try to rent as opposed to purchase as rental fees are more easily recoverable, than purchase fees.	Maintain files for P.O's relating to rental of equipment needs, or purchase of supplies relating to the incident. If in doubt, write "PO-Emergency Incident", and the P.O.'s will be evaluated at a later date. Originals to Cost Officer	
Make copy of completed *Damage Assessment form* and maintain in your records		Photograph damaged equipment. Originals to Cost Officer: date, time, location, contact person.	All food/nutrition/supply need to be documented as distributed during the disaster to determine cost of nutritional deliveries for patients, staff, visitors.	
Bring *Damage Assessment form* to the Command Post				
Be on the alert for other damages that may occur (eg., noticeable structural or non-structural damages from after shocks post earthquake).				**NOTE:** Ensure all disaster worked hours, purchased or rented services or equipment or supplies are coded to the Disaster Cost Center—obtained from Payroll or Purchasing.
Document any new damages on a second *Damage Assessment form* and bring to the Command Post.				

DESCRIPTION	YES	NO

A. Damage Assessment Form 1. Area assessed for visual damages using *Damage Assessment Form.* If an earthquake occurred, and there are "aftershocks", area must be re-assessed using the same form, and resent to the Command Post.	**If Yes, describe major damages: (use separate pages if necessary)**	
B. Staff Requirements 1, Were staff requirements assessed?	***If Yes, describe how many staff personnel were required and what job codes:***	
2, Are hours worked by staff being charged to the Disaster Cost Center?	Cost Center being used on timecard is:	
C. Equipment Requirements 1. **Identify what type of equipment is being purchased or rented for the disaster. Rent whenever possible.**	***If Yes, identify type of equipment, quantity, duration of rental and cost per unit. Copies of all P.O.'s to the Cost Officer.***	
D. Document Requirements		
1. **Have you photographed the area?**	**If Yes, ensure photograph and copies are maintained; original to Cost Officer. If "No", request immediate Photography Services.**	
2 Have you maintained copies of all P.O's related to the Disaster?	**If Yes, copies of all P.O's to the Cost Officer. If you are unsure if the P.O. is related to the disaster, note your concerns on a separate piece of paper attached to the P.O.**	
3 If involved with Food Services, have you itemized all food services related to the care of victims, families, staff, etc., during the time of the disaster?	**If Yes, copies of all P.O's to the Cost Officer. If you are unsure if the P.O. is related to the disaster, note your concerns on a separate piece of paper attached to the P.O**	
4. Have you itemized all P.O's during the disaster.	**If Yes, copies of all P.O's to the Cost Officer. If you are unsure if the P.O. is related to the disaster, note your concerns on a separate piece of paper attached to the P.O.**	
E. Other Any other itemizations should be stated on a separate page, and attached.	**If Yes, state all itemizations on a separate page and attach. If more space is required, categorize each entry with letters and numbers on this page (EG. A1, D2, etc.)**	
F. Consequential Events. Were there any consequential events as a result of this disaster?	**If yes, describe on a separate page, using an UOR, and attach.**	
Business Loss. Were services closed as a result of this incident?	If yes, state what services were closed, with best estimate of loss of revenue. Identify in detail on a separate piece of paper, with heading entitled "Business Loss", and bundle with other information, sending to Cost Officer. Identify your name, department and phone number.	

Appendix A

Procedures for specific areas of high risk as determined by hazard vulnerability analysis:

Epidemic

Procedure:

1. Determine how many patients have been infected
2. Ensure implementation of surge plan, proper triage and infection precautions
3. Anticipate an increased need for medical supplies, antivirals, IV fluids and pharmaceuticals, oxygen, ventilators, suction equipment, respiratory protection/PPE, and respiratory therapists, transporters and other personnel
4. Conduct disease surveillance, including number of affected patients/personnel
5. Continue isolation activities as needed
6. Consult with infection control for disinfection requirements for equipment and facility
7. Continue patient management activities, including patient cohorting, patient/staff/visitor medical care issues.

Chemical Exposure

In the event of a chemical incident where patients are being brought into the facility the following measures will be taken:

a. Notify Administration, House Supervisor, Hospital Safety Officer, Security and Emergency Department Nurse Manager.
b. Determine area of decontamination and staging.
c. See DM 2211 Decontamination plan for more detailed information
d. Consider HICS activation

Fog

In times where fog is too dense and staff are unable to report to work the following steps shall be taken.

a. Notify Administration, House Supervisor, Hospital Safety Officer, and Security
b. Gather information regarding staff shortage
c. Begin call back procedures
d. Consider cancelling elective procedures
e. Begin discharging patients as appropriate

Helipad Incident

In the event of a helipad incident where the helipad or any surrounding area is compromised the following measures will be taken.

a. Notify Administration, House Supervisor, Hospital Safety Officer, Security and Emergency Department Nurse Manager.
b. Security to secure a perimeter around the area to keep people out of the area.
c. Notify Fire and EMS agencies.
d. Consider activating HICS.

Dam Inundation

The purpose of this policy is to provide precautionary and preventative measures for staff and patients during a potential dam inundation.

a. Notify Administration, House Supervisor, Hospital Safety Officer, and Security.

b. Consider activating HICS

c. Notify County of Tulare Public Health Emergency Preparedness.

d. Prepared for evacuation/movement within the hospital.

e. Prepare for incoming patients from outside facilities.

f. Evaluate the need and contact county for supplies.

Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

Policy Number: EOC 3007	**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)	

Emergency Department Security

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

PURPOSE:
To provide a safe environment for patients, staff and visitors in the Emergency Department.

POLICY:
All staff working in the Emergency Department will follow procedures, which address the safety and security of patients, staff and visitors.

PROCEDURE:
Only authorized personnel and visitors will be allowed access to the Emergency Department.

All Emergency Department and Security personnel shall receive crisis intervention training and special training on handling disruptive and violent patients during orientation and every 12 months thereafter.

Panic alarms located at the registrar's desk and at the Physician casework shall be activated in case of emergency. The alarm will ring in PBX. The PBX operator will notify Hospital Security and they will respond immediately.

NOTIFICATION OF EMERGENCY CALLS TO VISALIA POLICE DEPARTMENT (VPD):
PBX will call the VPD for an emergency response whenever called by any employee or by Security. Typically the PBX will not immediately notify the VPD of an emergency call that is generated by an electronic system within the District until it is verified by anyone involved. Any time the VPD is called for an emergency response, the Charge Nurse will immediately be notified and involved.

Visalia Police Department personnel will typically respond to all service calls from the PBX and will meet with Hospital Security. Here they will receive additional information regarding the situation. If there is a need to have the police respond directly to an alternate location, this request should be made to the PBX when making the request.

NOTE: All hidden silent emergency alarms shall be convenient, unobtrusive, and easy to reach, and can be actuated without notice of the aggressor. The receiving center for the alarm, PBX will be staffed 24 hours a day.

Specific Emergency Department policies addressing the following risk factors associated with assaultive behavior shall be in place and considered by all personnel when caring for the patient:

History of assaultive behavior.
Diagnosis of dementia.
Drug or alcohol intoxication or history of abuse.
Inflexible treatment or milieu routines.

Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

Policy Number: EOC 5000	Date Created: 06/01/2009
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)	
Fire Prevention Management Plan	

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

I. OBJECTIVES

The objectives of the Management Plan for Fire Prevention Life Safety at Kaweah Delta Health Care District (KDHCD) are to provide an environment wherein patient care can be safely administered, to provide a fire safe *environment of care* to protect patients, personnel, visitors and property from fire and the products of combustion, and to provide for the safe construction and use of building and grounds in accordance with applicable codes and regulations for the State of California.

II. SCOPE

The scope of this management plan applies to **all buildings within KDHCD**

Each off site area is required to have a unit-specific fire plan that addresses the unique considerations of the environment, including, but not limited to, building evacuation requirements. Off-site areas are monitored for compliance with this plan during routine environmental surveillance by Environment of Care (EOC) committee members.

It is the responsibility of the Safety Officer to assess and document compliance with the Fire Prevention Plan for the off-site areas, using an environmental surveillance checklist.

III. AUTHORITY

The authority for overseeing and monitoring the fire prevention management plan and program lies with the *Environment of Care* Committee, whose members will ensure that fire prevention activities are identified, monitored and evaluated, and will also ensure that regulatory activities are monitored and enforced, as necessary.

IV. RESPONSIBILITIES

KDHCD Leadership have varying levels of responsibility and work together in the management of fire risks as identified below:

Board of Directors: The Board of Directors supports the Fire Prevention Management Plan through review and feedback, if applicable, of the quarterly and annual *Environment of Care* reports and endorsing budget support.

Professional Staff Quality Committee/PROSTAFF: Reviews the annual *Environment of Care* report from the *Environment of Care* Committee, providing feedback, if necessary.

Quality Council: Reviews annual *Environment of Care* report from the *Environment of Care* Committee and provides broad direction in the establishment of performance monitoring standards relating to fire prevention and fire risks.

Administrative Staff: Administrative staff provides active representation during the *Environment of Care* Committee meetings and sets an expectation of accountability for compliance with the Fire Prevention Program.

Environment of Care Committee: Environment of Care Committee members review and approve the quarterly *Environment of Care* reports, which contain a Fire Prevention component and oversee any issues relating to the overall fire prevention program.

Directors and Department Managers: Support the Fire Prevention Management Program by:

1. Reviewing and correcting deficiencies identified through the hazard surveillance process that relate to fire risks
2. Communicating recommendations from the Environment of Care Committee to affected staff in a timely manner.
3. Developing education programs within each department that ensure compliance with the policies of the Fire Prevention Management Program.
4. Supporting all required employee fire prevention education and training to include a disciplinary policy for employees who fail to meet the expectations.
5. Serving as a resource for staff on matters of fire prevention.

Employees: Employees of KDHCD are required to participate in the Fire Prevention Life Safety Management program by:

1. Completing required fire prevention education.
2. Participating in fire drills
3. Reporting any observed or suspected unsafe conditions to his or her department manager as soon as possible after identification that may pose a fire risk.

Medical Staff: Medical Staff will support the Fire Prevention Management Program by abiding by the District's policies and procedures relating to fire prevention and Life Safety.

V. MANAGEMENT OF FIRE RISKS

KDHCD has multiple processes in place that minimize the potential for harm from fire, smoke and other products of combustion, they include, but are not limited to:

1. This written plan serves to identify the overall components of the *Management Plan for Fire Prevention and Life Safety*.
2. Life Safety policies and procedures, which include an overall fire response plan for all staff
3. Fire Drills: Fire drills are performed per code to test staff response relating to the overall fire plan and to keep staff trained through rehearsal.
4. Procedures for testing, inspection and maintenance: Procedures are in place to ensure fire equipment testing and suppression equipment are properly tested, inspected and maintained.

5. Risk Assessment: Risk assessment for life safety includes ongoing hazard surveillance, *the Interim Life Safety Assessment* process, loss audits, regulatory, insurer and accreditation surveys.
6. Performance Standards: Performance standards are in place, based upon risk to the medical center, and monitored quarterly.
7. Education: Education and training of staff, physicians, temporary workers, students and volunteers is in place.
8. Testing, Inspection and maintenance: Testing, inspection and maintenance of fire extinguishing and suppression equipment, and fire alarm systems is in place.
9. *Statement of Conditions*: A Statement of Conditions is in place and is current. The deemed responsibility for the Statement of Conditions lies, jointly, with the Safety Office and the Facilities Director.

Reviewing Proposed Acquisitions:

To minimize the risks associated with flammable products brought into KDHCD, a process is in place for the review of proposed acquisitions of bedding, window draperies, furnishings, decorations, wastebaskets and other equipment and materials. KDHCD has all "requests for purchases" submitted to Facilities for review. The materials are acquired or approved through Facilities and Purchasing, and ensures:

1. Product(s) meets smoke and flame-resistant standards
2. Waste baskets are of noncombustible materials, or other approved material
3. Flame resistant coating and covering are maintained to retain their effectiveness
4. Attention is given to heat-generating combustible material and placement of equipment close to heat sources.

Staff will acquire samples and/or specification to assure that they have Class A rating (flame spread 0-25 and smoke development of 0-450) or rating such as Plenum, Fire rated per material. Staff will proceed with acquisition only when approved specifications are met, and are responsible for maintaining the specifications on file for each acquisition. Furniture purchased for the hospital meets state technical bulletin requirements, which requires a rating tag be attached to each article of furniture.

All materials within the hospital shall meet federal, state and local requirements for system construction, and treating and testing by approved testing agencies. Records of all materials shall be maintained on the hospital premises in the form of independent test laboratory reports, i.e., tags, or construction documentation.

These items include, but are not limited to:

Item	Verification
Finish materials	Independent Test Report
Low Voltage Wire	UL Smoke Rating/Independent Test
Construction Materials	Approved As-Builts
Furniture (State bulletins)	Test Report/Tags
Bedding/Curtains	Test report/Tags/Treat
Decorations	Test report/Tags/Treat
Holiday Trees	Office of State Fire Marshal Tag/Treat
Waste Baskets (similar items)	Location/Material/Approved

Contractors:

All contractors, before starting work at KDHCD, are responsible for adhering to the following criteria.

1. All equipment installed in the facility (high and low voltage) will be listed and approved by an independent testing lab (approved by the State of California).
2. All components will be hospital grade.
3. Modifications to existing equipment cannot be made without written approval of the KDHCD (re-certification may be required).
4. All finish material will be approved and meet code requirements.
5. All furniture will meet state bulletin requirements for sprinkled and non-sprinkled areas.
6. All construction will meet federal/state and local requirements.
7. Contractors will become familiar with KDHCD's Fire Procedures.
8. Contractors are to act in a professional manner, and to maintain proper identification and demonstrate respect for patient privacy and confidentiality.

Before initiation of a construction project, interim life safety measures (ILSM) will be assessed by the ssafety ddepartment, and an Infection Control permit will be issued. Ongoing ILSM's are the responsibility of the Safety Officer. A policy is in place that identifies in detail the ILSM process, including individuals who are responsible for implementation.

Newly constructed and existing environments of care are designed and maintained to comply with the *Life Safety Code.*

To minimize the potential for harm from fire, when newly constructed and existing environment of care are designed, only licensed architects are used, who oversee the process of subcontractors, who are independently licensed and bonded. Local, state and federal regulations are followed.

Exceptions to this are made on an case by case basis, by the Facilities Department, in conjunction with authorized personnel ensuring that all applicable regulations, codes and standards are followed.

Other Methods in Place to minimize the potential for harm from Fire, Smoke and other Products of Combustion include the following:

1. Fire/Smoke Doors: All doors are held open only by approved devices, i.e. electromagnetic or electromechanical. At NO TIME may doors be propped open with doorstops or other devices not connected to the fire alarm system.

2. General Environment: All areas of KDHCD are kept clean and orderly. Trash is removed regularly from designated holding areas.

3. Portable Electric Equipment: All plugs must be grounded. Extension cords must comply with the extension cord policy. Equipment must be in good operating condition.

4. Smoking: "No Smoking" regulations are strictly enforced, policy HR.193.

5. Ventilation Hoods: Ventilation hoods are cleaned on a regular basis, to code, to prevent buildup. The automatic fire extinguishing systems are properly charged and inspected and all nozzles securely fastened.

6. Storage Areas: Every attempt is made to arrange stock in an orderly fashion, with a minimum of eighteen (18) inches below the sprinkler heads and a minimum of twenty four (24) inches below the ceiling in non-sprinkled areas.

7. Aisles: Aisles between storage shelves are at least three feet apart. No storage is permitted within thirty-six (36) inches in front of electrical panels. Combustible materials shall not be stored in electrical rooms.

8. Space Heaters: Portable space heating devices shall be prohibited in all District areas, with the following exception: Approved portable space heating devices may be allowed in **non-patient care areas** as long as they conform to the following:
   - Heating elements of such devices do not exceed 212 degrees Fahrenheit (NFPA 101©, 2000 Edition, §19.7.8)
   - Required for medical or extreme necessity
   - Approval of the Director of Facilities, Clinical Engineering and Chief Operating Officer
   - The heating device must be equipped with a tip over shut off
   - The heater shall not be plugged into a surge protector or extension cord

9. Flammable Liquids: (Such as acetone, alcohol, benzene, and ether) limit the amount on hand to a minimum working supply. If possible, keep in metal container. Where safety cabinets or storage rooms are available, keep these materials in them and maintain the door to such storage in the closed position. No smoking, open flame or sparking device shall be allowed around flammable liquids or compressed gas. Oxygen and nitrous oxide shall not be stored with flammable gases, such as cyclopropane and ethylene, or with flammable liquids.

10. Electrical Hazards: Report promptly any frayed, broken or overheated extension cords or electrical equipment. Do not operate light switches, or connect or disconnect equipment where any part of your body is in contact with metal fixtures or is in water. Specially built equipment is in use in the operating and delivery rooms to eliminate electric sparks, and to control static electricity.

11. Acids: All concentrated or corrosive acids must be handled with extreme care. Avoid storing these materials on high shelves, or in locations where they are likely to be spilled or the containers broken. Organic acids and inorganic acids shall not be stored together. Any spillage shall be immediately diluted or neutralized and cleaned up.

Minimization of risk to patients who smoke:

See policy HR.193 “Tobacco Free Campus.”

Maintaining free and unobstructed access to all exits:

Surveillance activities allow *Environment of Care* Committee members to monitor compliance with *Life Safety Code* requirements, including maintaining free and unobstructed access to all exits. Should an exit need to be obstructed for some reason (i.e. construction, renovation, etc.) an ILSM assessment will be made before the exit path is impeded and Interim Life Safety Measures will be put into place.

The District has a written fire response plan:

See policy EOC.5002 “Fire Response Plan.”

Specific roles and responsibilities of Staff, Licensed Independent Practitioners (LIPs) and Volunteers in preparing for building evacuation:

Specific roles and responsibilities of staff, LIPs and volunteers in preparing for building evacuation are integrated into new-hire orientation and annual safety training, the information is also discussed during fire drills.

The District conducts fire drills:

1. Fire drills are conducted quarterly on all shifts in each building defined by the *Life Safety Code* as the following:
   - Ambulatory Health Care Occupancy
   - Health Care Occupancy

2. Fire drills are conducted annually in all free standing buildings classified as a business occupancy as defined by the *Life Safety Code*.

3. At least 50% of fire drills are unannounced at KDHCD facilities.

4. Staff who work in buildings where patients are housed or treated participate in fire drills

   Note: Staff participate in fire drills in all areas of the hospital, with the exception of those who cannot leave patient care during the time of a drill.

5. KDHCD critiques fire drills to evaluate fire safety equipment, fire safety-building features, and staff response to fire.
   - The evaluation is documented and reported to the *Environment of Care* on a quarterly basis.
   - Fire drills are critiqued post drill to identify deficiencies and opportunities for improvement.

The District maintains fire safety equipment and fire safety building features:
The following types of equipment or features exist within the District, with the following maintenance, testing and inspection requirements in place. All tests and/or inspections are documented and maintained in the Facilities Department.

1. At least quarterly, KDHCD tests supervisory signal devices (except valve tamper switches).
   a. Note: Supervisor signals include the following: control valves; pressure supervisor; pressure tank, pressure supervisory for a dry pipe, steam pressure; water level supervisor signal initiating device; water temperature supervisory; and room temperature supervisory.

2. Every six months, KDHCD tests valve tamper switches and water flow devices.

3. Every 12 months, KDHCD tests duct detectors, , heat detectors, manual fire alarm boxes and smoke detectors.

4. Every 12 months KDHCD tests visual and audible fire alarms, including speakers and door realizing devices on the inventory.

5. Every quarter, KDHCD tests fire alarm equipment for notifying off-site fire responders.

6. Every week KDHCD tests diesel fire pumps under no-flow conditions.

7. Every month KDHCD tests electric motor driven fire pumps under no-flow conditions.

8. Every 12 months KDHCD tests main drains at system low point or at all system risers.

9. Every quarter, KDHCD inspects all fire department water supply connections.

10. Every 12 months KDHCD tests fire pumps under flow conditions.

11. Every 5 years, KDHCD conducts water-flow tests for standpipe systems.

12. Every 6 months KDHCD inspects any automatic fire-extinguishing systems in a kitchen.

13. Every 12 months, KDHCD tests carbon dioxide and other gaseous automatic fire-extinguishing systems.

14. At least monthly, KDHCD inspects portable fire extinguishers.

15. Every 12 months KDHCD performs maintenance on portable fire extinguishers.

16. KDHCD operates fire and smoke dampers one year after installation and then at least every 6 years to verify that they fully close.

17. Every 12 months KDHCD tests automatic smoke-detection shutdown devices for air-handling equipment.

18. Every 12 months, KDHCD tests sliding and rolling fire doors for proper operation and full closure.

19. Every 12 months, KDHCD tests and inspects door assemblies.

20. Elevators with fire fighters' emergency operations are tested monthly.

Monitoring Conditions in the Environment:

The District establishes a process for continually monitoring, internally reporting, and investigating fire safety management problems, deficiencies and failures.

Through the *Environment of Care* Committee structure, the above elements are reported and investigated on a routine basis by managerial or administrative staff, with oversight by the committee. Minutes and agendas are kept for each *Environment of Care* meeting and filed in Performance Improvement.

Patient Safety: Periodically there may be an *Environment of Care* issue that has impact on the safety of our patients relating to life safety and or fire prevention. This may be determined from *Sentinel Event* surveillance, environmental surveillance, patient safety standards or consequential actions identified through the risk management process. When a patient-safety issue relating to life safety or fire prevention emerges, it is the responsibility of the Safety Officer or designee to bring forth the issue through the patient safety process.

Annual Evaluation of the Fire Prevention Management Plan:

On an annual basis *Environment of Care* Committee members evaluate the Fire Prevention Life Safety Management Plan, as part of a risk assessment process. Validation of the plan occurs to ensure contents of each plan support ongoing activities within the District.

Based upon findings, goals and objectives will be determined for the subsequent year.

A report will be written and forwarded to the Board of Directors.

The annual evaluation will include a review of the following:

1. Objectives: The objective of the Fire Prevention Management plan will be evaluated to determine continued relevance for the District (i.e., the following questions will be asked; was the objective completed? Did activities support the objective of the plan? If not, why not? What is the continuing plan? Will this objective be included in the following year? Will new objective(s) be identified? Will specific goals be developed to support the identified objective?)

2. The scope: The following indicator will be used to evaluate the effectiveness of the scope of the Fire Prevention Life Safety Management Plan: the targeted population for the management plan will be evaluated (e.g., did the scope of the plan reach employee populations in throughout the entire District?)

3. Performance Standards: Specific performance standards for the Fire Prevention Life Safety Management Plan will be evaluated, with plans for improvement identified.

   Performance standards will be monitored for achievement.

   Thresholds will be set for the performance standard identified. If a threshold is not met, an analysis will occur to determine the reasons and actions will be identified to reach the identified threshold in the subsequent quarter.

4. Effectiveness: The overall effectiveness of the objectives, scope and performance standards will be evaluated, with recommendations made to continue monitoring, add new indicators, if applicable, or take specific actions for ongoing review.

The District analyzes identified Environment Of Care issues:

EC.04.01.03-EP-1-2
Environment of care issues relating to Life Safety and/or fire prevention are identified and analyzed through the *Environment of Care* Committee with recommendations made for resolution.

It is the responsibility of the *Environment of Care* Committee chairperson to establish an agenda, set the meetings, coordinate the meeting and ensure follow-up occurs where indicated.

Quarterly *Environment of Care* reports are communicated to Performance Improvement, PROSTAFF and the Board of Directors.

Priority Improvement Project:

At least annually, a performance improvement project is selected by the Environment *of Care* Committee members. The priority improvement activity is based upon ongoing performance monitoring and identified risk within the environment. Based upon risk assessment, a priority improvement project may be related to Life Safety or Fire Prevention issues.

Improvement of the Environment of Care:

EC.04.01.05-EP1-3
Performance standards are identified monitored and evaluated that measure effective outcomes in the area of fire prevention management.

Performance standards are also identified for Safety, Security, Hazardous Materials, Emergency Management, Medical Equipment management and Utilities management.

The standards are approved and monitored by the *Environment of Care* Committee with appropriate actions and recommendations made. Whenever possible, the *environment of care* is changed in a positive direction by the ongoing monitoring and changes in actions that promote an improved performance.

Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

Policy Number: EOC 6001	**Date Created: 07/01/2009**
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)	

Medical Equipment Management Policy

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

I. OBJECTIVES

EC 02.04.01 – The hospital manages medical equipment risks.

The objectives of the Medical Equipment Management Policy which governs Kaweah Delta Health Care District (KDHCD) are to provide environment that works to ensure medical equipment is safe, reliable, properly maintained and efficiently used in the delivery of patient care. To ensure operational reliability of medical equipment, the development of a medical equipment inventory contained and managed in a Computerized Maintenance Management System (CMMS), where an inspection and maintenance program designed to minimize risks to our patients has been established and is continually managed. Specific goals of the Medical Equipment Management Policy include the following:

- Inventory Management Program
- Preventive Maintenance Program
- Corrective Maintenance Program
- User and Maintainer Training
- Performance Indicators
- Annual Evaluation of the Medical Equipment Management Plan
- Equipment Selection and Review Process
- Contract Review and Financial Oversight

This Policy including the following policies and others are part of the District's Medical Equipment Management Plan (MEMP):

EOC 6002	Medical Equipment Defective Repairs Policy
EOC 6004	Medical Equipment / Hazardous Device Notification and Recall Policy
EOC 6009	District Safe Medical Device / Device Tracking and Reporting Policy
EOC 6018	Retirement and Deletion of Medical Equipment
AP.60	Technology Assessment Process (Administrative Policy Manual)

II. SCOPE

The scope of this management plan applies to KDHCD, and any off-site areas as listed on the KDHCD License, and for all medical equipment that is used on our patients, whether it be owned, rented, leased or non-hospital owned.

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Off site areas are monitored for compliance with this plan during routine surveillance by *Environment of Care* committee members. It is the responsibility of the Safety Officer to assess and document

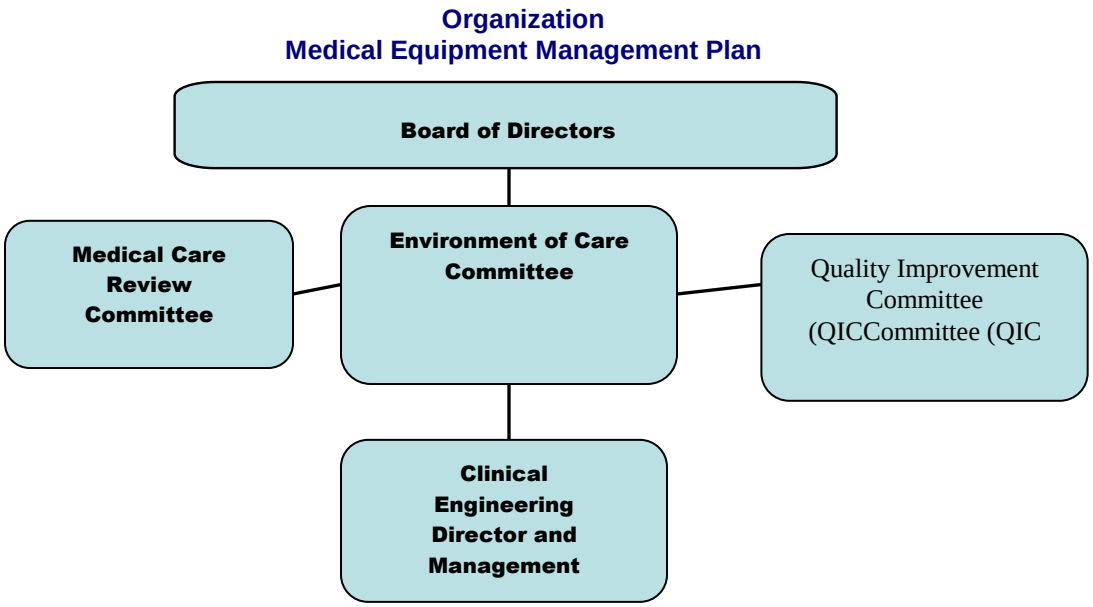
compliance with the Medical Equipment program for the offsite areas through the structure of the *Environment of Care* (EOC) Committee.

III. AUTHORITY

The authority for the Management Plan for Medical Equipment is EC. 02.04.01. The authority for overseeing and monitoring the Medical Equipment Management Policy and MEMP lies in the **(EOC)** Committee, whose members will ensure activities relating to medical equipment management are identified, monitored and evaluated, and for ensuring that regulatory activities are monitored and enforced as necessary.

IV. ORGANIZATION

The following represents the organization of the Management Plan for Medical Equipment at the medical center:



V. RESPONSIBILITIES

Leadership within the medical center have varying levels of responsibility and work together in the management of medical equipment as identified below:

Governing Board: The Board of Directors supports the Medical Equipment Management Policy by:

- Review and feedback if applicable of the quarterly and annual **(EOC)** report
- Endorsing budget support as applicable to fund and empower implementation of the Medical Equipment Management Plan (MEMP)

Medical Care Review Committee: Reviews annual **(EOC)** reports from the **(EOC)** Committee, providing feedback if applicable.

Quality Council: Reviews annual **(EOC)** report from the **(EOC)** Committee, and provides broad direction in the establishment of performance monitoring standards relating to medical equipment risks.

Administrative Staff: Administrative staff provide active representation at the **(EOC)** Committee meetings and set an expectation of accountability for compliance with the MEMP.

(EOC) Committee: **(EOC)** Committee members review and approve the quarterly *EOC* reports, which contain a medical equipment component, and oversee any issues relating to the overall MEMP.

Directors and Department Managers: These individuals support the Medical Equipment Management Policy by:

- Reviewing and correcting deficiencies identified through the hazard surveillance process that relate to medical equipment risks.
- Communicating recommendations from the **(EOC)** Committee to affected staff in a timely manner.
- Developing education programs within applicable departments that insure compliance with the policies of the **MEMP.**.
- Supporting all required medical equipment education and training to include a disciplinary policy for employees who fail to meet the expectations.
- Serving as a resource for staff on matters of medical equipment usage.

Clinical Engineering Director: The Director or designated Manager of the Clinical Engineering Department is responsible for the coordination, liaison, development and establishment of the overall organization and management of the Medical Equipment Management Plan (MEMP).

- Submits completed reports at least every three months to the EOC Committee on findings, recommendations, actions, and monitoring conducted.
- Provides an annual evaluation of the effectiveness of the **MEMP** which is to be submitted to the EOC Committee.
- Coordinates and/or participates in the development of departmental as well as facility-wide medical equipment management policies and procedures.
- Ensures that departmental clinical equipment management policies and procedures are consistent with and integrated into the facility-wide safety management plan; reviews these procedures as frequently as needed, but at least every three years.
- Ensures that medical equipment incidents are reported to the appropriate authorities/committees/departments/individuals. (HH-L-4-012 Occurrence Reporting)
- Monitors the Hemodialysis facilities to ensure completion of Infection Prevention activities (e.g., water treatment analysis) for dialysis units.

Employees. Employees of the medical center are required to participate in the **MEMP** by:

Completing applicable medical equipment training..

- Not using medical equipment with patients without ensuring a non-expired Clinical Engineering issued inspection sticker exists on the device to reduce risk.
- Reporting medical equipment failures to their supervisor and Clinical Engineering.
- Reporting any observed or suspected unsafe conditions to department manager as soon as possible upon identifying a medical equipment risk.
- Reporting any medical equipment with expired PM Inspection stickers to management and Clinical Engineering.

Medical Staff: Medical Staff will support the **MEMP** by abiding by the hospital's policies and procedures relating to the use, care and reporting of failures and incidents as related to medical equipment.

The hospital solicits input from individuals who operate and service equipment when it selects and acquires medical equipment.
EC.02.04.01- EP 01

Selecting / Acquiring of New Clinical Equipment: The selecting and acquiring of Clinical Medical Equipment is a combined effort of Clinical Engineering, the Value Analysis Committee, Materials Management, the using Departments/Services, Medical Staff, Administration and vendors as required.

New and upgraded clinical equipment is evaluated and selected through the combined efforts of the Clinical Engineering Department, various management committees, and using departments and/or physicians. These devices:

* Must meet NFPA standards
* Must meet guidelines specified in UL / FDA / IEC Standard 60601-1

* Must meet or exceed KDHCD electrical safety standards
* Will be evaluated through the Value Analysis Committee for purchase and through requests submitted through this entity by District Management.
* Clinical Engineering department staff will provide technical evaluations for new device selections or technology requests as necessary.
* Must be approved through the procedures contained in Administrative Policy AP.60
* Equipment shall meet or exceed the standards set for in the ANSI/AAMI, NFPA-02, UL60601-1 .

The hospital maintains a written inventory of all medical equipment.
EC.02.04.01- EP 02

Equipment Inventory: All owned, leased, rented and borrowed/loaned clinical equipment is evaluated for inclusion in the program, including equipment at all off site locations.

The assessing and minimizing of clinical and physical risks of equipment use through inspection, testing and maintenance is a combined effort of the Clinical Engineering Department, designated users, and contract services managed by the Clinical Engineering Department.

The monitoring and acting on equipment hazard notices and recalls is coordinated through Risk Management, the EOC Committee, Materials Management and Clinical Engineering.

Monitoring and reporting of incidents in which a medical device is connected to the death, serious injury, or serious illness of any individual (as required by the Safe Medical Device Act) is to be reported immediately but not to exceed 24 hours and coordinated through Risk Management.

The reporting and investigation of equipment management problems, failures and user errors are accomplished on a quarterly basis with reports to the EOC Committee.

Items that may be included into the Medical Equipment Management Program's Medical Equipment Database Inventory, shall include, but not be limited to; Any and All Electrical, Electronic, Mechanical, and Electro-Mechanical Healthcare Devices. Devices shall be evaluated in one of two areas:

- **High Risk (Including Life Support Equipment)**
- **Non-High Risk**

Each item shall be further categorized as listed below.

All items to be included into this Inventory will be added to the Medical Equipment Database (MEDB) and shall be evaluated for excessive, inherent risks to patients and categorized accordingly. Each device shall be inspected prior to its initial use, after major repairs or upgrades and at intervals to be identified utilizing a Risk Based evaluation system listed below. Each device shall be evaluated according to the following criteria:

1. **Device Function**: Is the device function critical to life support, diagnosis, or monitoring.

2. **Risk associated with Device Use**: Does the use of the device itself create a risk to the patient or operator.

3. **Device Maintenance Requirements**: How frequently is the device to be used? What are the manufacturer's recommended requirements for maintaining the device? Will the device be cost effective.

4. **Likelihood of Failure**: Is there a history of incidents related to the device failure during patient use, and how often this device might be expected to fail based on similar device history.

5. **Environmental Use**: Identify what will be the most common area in which this device shall be expected to be used.

The above five categories are given specific values which are then added together to provide each individual device with a specific Equipment Maintenance number. This EM number shall be the determining factor with which device inclusion into the MEDB shall use.

Evaluated or projected high failure rate Devices with an EM number assigned with a value of five (5) or greater, shall be included in the Clinical Equipment Management Program Inventory Database, and its schedule shall be assigned according to specific needs.

DEVICE FUNCTION shall be assigned values in the range of 2 - 10 as below:

10 - Life Support Device
9 - Surgical and Intensive Care Device
8 - Physical Therapy and Treatment Device
7 - Surgical and Intensive Care Monitoring Device
6 - Additional Physiological Monitoring and Diagnostics
5 - Analytical Laboratory
4 - Laboratory Accessories
3 - Computer and Related Devices
2 - Patient Related and Other

DEVICE RISK shall be assigned values in the range of 1 - 5 as below:

5 - Patient Death
4 - Patient or Operator Injury
3 - Inappropriate Therapy or Misdiagnosis
2 - Minimal Impact or Risk
1 - No Significant Risk

DEVICE MAINTENANCE REQUIREMENTS shall be assigned values in the range of 1 - 5 as below:

5 - Extensive
4 - Above Average
3 - Average
2 - Below Average
1 - Minimal

LIKELIHOOD OF FAILURE REQUIREMENTS shall be assigned values in the range of 1 - 5 as listed below:

5 - Less than three months
4 - Approximately six months
3 - Approximately one year
2 - Approximately three years
1 - Greater than five years

ENVIRONMENTAL USE REQUIREMENTS shall be assigned values in the range of 1 – 5 as listed below:

5 - Anesthetizing Locations
4 - Critical Care Locations
3 - Wet Locations
2 - General Care Locations
1 - Non-Patient Care Areas

The hospital identifies the activities and associated frequencies, in writing, for maintaining, inspecting and testing for all medical equipment on the inventory. These activities and associated frequencies are in accordance with manufacturers' recommendations or with strategies of an alternative equipment maintenance (AEM) program.
EC.02.04.01-EP04

Equipment Maintenance: The Clinical Engineering Department at KDHCD shall be responsible, unless otherwise specified, for all Scheduled Preventive Maintenance, Demand Repairs, Calibrations, and Adjustments required for the maintainence of all Electrical/ Electronic / Electromechanical, and certain Non-Electrical Health Care Devices contained in the Clinical Equipment Management Program used to treat patients of KDHCD.

The Manager of Clinical Engineering shall have the ultimate responsibility for ensuring that all Scheduled Preventive Maintenance, Initial Receipt, Safety, Operational, Functional, and Calibration Inspections, as well as Unscheduled Demand Repairs, are completed in a timely, efficient, and effective manner. Emphasis to cost effectiveness, and ensuring that device down time is kept to an absolute minimum will be an objective of this program continuously.

Preventive Maintenance Inspection Intervals shall reference the suggested manufacturer service guidelines for each device contained in the Clinical Equipment Database Inventory. These inspection intervals can and shall be modified as the service history, and equipment needs dictate, but not less than the recommended inspection / calibration intervals required by the manufacturer of the device. Required Title 22 and OSHA regulations; (All devices included in the Clinical Equipment Management Program Inventory database, shall be inspected on a No Less Than annual basis). A criteria will be used should an Alternate Maintenance Equipment strategy be used, and the equipment shall so be identified in the inventory, and evaluated annually to determine the effectiveness of the alternate maintenance strategy.

Each device that has been inspected shall have a dated inspection sticker affixed to it, which will indicate it's current Preventive Maintenance Inspection status.

Note: Devices contained within the Clinical Equipment Management Inventory Database that cannot be located for a minimum of two (2) consecutive PMI cycles, shall be considered "lost" and shall be removed from the Active Inventory and PM Inspection cycle unless other device status is supplied by the responsible owning department for the device.

Service records for all devices contained in the CMMS shall be maintained for a period of not less than three (3) years. Method of storage shall be on computer server, with backup copies on long term storage server. Records, PM Inspection and Repair, older than three (3) years may be purged from the system in order to keep program within a reasonable working database size.

Devices that are brought into the District through Rental companies shall be tracked and logged separately, but shall meet the above policy with specific regards to Preventive Maintenance and Electrical Safety inspections of each device. The vendor responsible for supplying these devices shall provide documentation supporting the current Preventive Maintenance Inspection status of each device. Further, upon delivery to the District, each device shall be accompanied by a current Electrical Safety inspection sheet, which shall be retained by the Requesting Department for the duration of the rental period. The Rental Supply Company shall notify the District of any devices that are due for Preventive Maintenance Inspection(s), and shall make all necessary arrangements for the removal and replacement of these devices. Replacement devices shall meet all necessary documentation requirements listed above. All requests for such items will be in accordance with the procedures and directives contained in AP.132.

The hospital monitors and reports all incidents in which medical equipment is suspected in or attributed to the death, serious injury, or serious illness of any individual, as required by the Safety Medical Devices Act of 1990.
EC.02.04.01-5

Equipment Safety: The Clinical Engineering Department will be the cornerstone in maintaining the medical device-reporting program, investigating incidents, and evaluating the safety of the medical devices. The Clinical Engineering Department works very closely with the Risk Management Department

in the investigation of any event to determine whether a device caused or contributed to the event. The Clinical Engineering Department, in their investigation of an event, does the following:

- Assists the Risk Management Department in the collection of data, which includes device service and history information as well as other relevant information made known by those involved.
- Submits appropriate reports to the Food and Drug Administration (FDA), and/or the medical device manufacturer in accordance with the law, regulations and procedures contained in EOC 6009.
- Ensures that the applicable data, along with the Risk Management Department and Safety Officer are incorporated into the occurrence reporting system.

The District will ensure compliance with the Safe Medical Device Act of 1990, and Device Tracking Regulations set forth by the Food and Drug Administration. Also, to specify actions which are necessary to minimize patient risk resulting from Medical Device related incidents.

In the event of receipt of a Hazardous Device Notification, Medical Device Recall, or Notification of Event, (Occurrence Report), the procedures contained in the District Safe Medical Device Act / Hazardous Device Tracking and Reporting Policy, EOC 6009, will be strictly adhered to without exception.

The hospital has written procedures to follow when medical equipment fails, including using emergency clinical interventions and backup equipment.
EC.02.04.01-6

1. What to do in the event of equipment disruption or failure
2. When and how to perform emergency clinical interventions when medical equipment fails
3. Availability of backup equipment
4. How to obtain repair services

Emergency Plans: Emergency plans that specifically address emergency response, which include, appropriate clinical interventions, alternative life supporting procedures (e.g., manual ventilation), access to back-up equipment, and listings of alternate sources of back up equipment and repair services are in place in the Patient Care Manual, Policy MS.04, and subsequent policies.

Before initial use of medical equipment on the medical equipment inventory, the hospital performs safety, operational and functional checks.
EC.02.04.03-1

Incoming Inspection: Before initial use of medical equipment identified in the medical equipment inventory, Clinical Engineering staff perform safety, operational and functional safety checks. This is referred to as the Incoming Inspection process.

The Hospital inspects tests and maintains all high risk equipment. These activities are documented.
EC. 02.04.03-2 and 3

High Risk Equipment: Maintenance records of equipment used for **High Risk** is maintained in the Clinical Engineering Department. The hospital uses a risk-based criteria for identifying and evaluating **High Risk** versus non-life support medical equipment. The criteria addresses equipment function (**High Risk** versus diagnosis, care, treatment and monitoring), and the physical risks associated with use. The initial inspection of the medical equipment includes an evaluation of the complexity of the equipment for its role in life support. Does the medical equipment support life while in use, or is it used to diagnose conditions and diseases, or treat a condition, or provide monitor function? Also included in the evaluation of the medical equipment when determining if it is a **High Risk** piece of medical equipment, is the physical risk of usage of the equipment. For example, the physical risk of a ventilator or anesthesia machine includes the possibility of death or serious injury if failure occurs

The hospital conducts performance testing of and maintains all sterilizers. These activities are documented.
EC.02.04.03-4

Sterilizer Support Equipment: Maintenance records of equipment that is used for Sterilizer support is maintained in the Clinical Engineering Department.

The hospital performs equipment maintenance and chemical and biological testing of water used in hemodialysis. These activities are documented.
EC.02.04.03-5

Renal Dialysis Equipment: Chemical and biological testing of water used in renal dialysis, and other applicable tests based upon regulations, manufacturer's recommendations and hospital experience are performed by Hemodiaysis personnel.

For hospitals that use Joint Commission accreditation for deemed status purposes: Qualified hospital staff inspect, test and calibrate nuclear medicine equipment annually. The dates of these activities are documented.
EC.02.04.03-14

Nuclear Medicine Equipment: Clinical Engineering Department maintains a copy of the maintenance records provided by the Radiology Department Maintenance records of equipment that is used for nuclear medicine support is maintained in the Clinical Engineering Department.

For hospitals in California that provide computed tomography (CT) services: A qualified medical physicist measures the actual radiation dose* produced by each diagnostic CT imaging system at least annually and verified that the radiation dose displayed on the system for standard adult brain, adult abdomen, and pediatric brain protocols is within 20 percent of the actual amount of radiation dose delivered. The dates of these verifications is documented.
*for the definition of radiation dose refer to section 115111(f) of the California Health and Safety Code.
EC.02.04.03-17

Computed Tomography Equipment: Clinical Engineering Department records the date a computed tomography (CT) physicist measures the accuracy of the CT system. A copy of the preliminary and final report are to be maintained by the Radiology Department and a copy provided to the Clinical Engineering Department will be maintained.

EC.02.04.03-19
A QUALIFIED MEDICAL PHYSICIST, AT LEAST ANNUALLY, CONDUCTS A PERFORMANCE EVALUATION OF ALL CT IMAGING EQUIPMENT. THE RESULTS, ALONG WITH ANY CORRECTIVE ACTIONS, ARE DOCUMENTED. THE EVALUATION INCLUDES THE USE OF PHANTOMS TO ASSESS THE FOLLOWING IMAGING METRICS:

- Image uniformity
  - Slice thickness accuracy
  - Slice position accuracy (when prescribed from a scout image)
  - Alignment light accuracy
  - Table travel accuracy
  - Radiation beam width
  - High-contrast resolution
  - Low-contrast resolution
  - Geometric or distance accuracy
  - CT number accuracy and uniformity
  - Artifact evaluation

Biomedical staff members work in collaboration with Imaging leadership to ensure an annual performance evaluation of all CT Imaging equipment is completed, with the use of Phantoms to measure the specified imaging metrics identified above.

EC.02.04.03-20
A QUALIFIED MEDICAL PHYSICIST, AT LEAST ANNUALLY, CONDUCTS A PERFORMANCE EVALUATION OF ALL

MRI IMAGING EQUIPMENT. THE RESULTS, ALONG WITH ANY CORRECTIVE ACTIONS, ARE DOCUMENTED. THE EVALUATION INCLUDES THE USE OF PHANTOMS TO ASSESS THE FOLLOWING IMAGING METRICS:

- Image uniformity for all radiofrequency (RF) coils used clinically
- Signal-to-noise ratio (SNR) for all coils used clinically
- Slice position accuracy
- Alignment light accuracy
- High-contrast resolution
- Low-contrast resolution (or contrast-to-noise ratio)
- Geometric or distance accuracy
- Magnetic field homogeneity
- Artifact evaluation

Biomedical staff members work in collaboration with Imaging leadership to ensure an annual performance evaluation of all MRI Imaging equipment is completed, with the use of Phantoms to measure the specified imaging metrics identified above.

EC.02.04.03-21

A QUALIFIED MEDICAL PHYSICIST, AT LEAST ANNUALLY, CONDUCTS A PERFORMANCE EVALUATION OF ALL NUCLEAR MEDICINE IMAGING EQUIPMENT. THE RESULTS, ALONG WITH ANY CORRECTIVE ACTIONS, ARE DOCUMENTED. THE EVALUATIONS ARE CONDUCTED FOR ALL OF THE IMAGE TYPES PRODUCED CLINICALLY BE EACH NM SCANNER (FOR EXAMPLE, PLANAR AND /OR TOMOGRAPHIC) AND INCLUDE THE USE OF PHANTOMS TO ASSESS THE FOLLOWING IMAGING METRICS:

- Image uniformity/system uniformity
- High-contrast resolution/system spatial resolution
- Low-contrast resolution or detectability (not applicable for planar acquisitions)
- Sensitivity
- Energy resolution
- Count-rate performance
- Artifact evaluation

Biomedical staff members work in collaboration with Imaging leadership to ensure an annual performance evaluation of all Nuclear Medicine Imaging equipment is completed, with the use of Phantoms to measure the specified imaging metrics identified above.

EC.02.04.03-22

A QUALIFIED MEDICAL PHYSICIST, AT LEAST ANNUALLY, CONDUCTS A PERFORMANCE EVALUATION OF ALL PET IMAGING EQUIPMENT. THE RESULTS, ALONG WITH ANY CORRECTIVE ACTIONS, ARE DOCUMENTED. THEVALUATIONS ARE CONDUCTED FOR ALL OF THE IMAGE TYPES PRODUCED CLINICALLY BE EACH PET SCANNER (FOR EXAMPLE, PLANAR AND OR TOMOGRAPHIC) AND INCLUDE THE USE OF PHANTOMS TO ASSESS THE FOLLOWING IMAGING METRICS:

- Image uniformity/system uniformity
- High-contrast resolution/system spatial resolution
- Low-contrast resolution or detectability (not applicable for planar acquisitions)
- Artifact evaluation **(A-D)**

Note: *The following tests are recommended, but not required, for PET scanner testing: sensitivity, energy resolution, and count-rate performance.*

Biomedical staff members work in collaboration with Imaging leadership to ensure an annual performance evaluation of all PET Imaging equipment is completed, with the use of Phantoms to measure the specified imaging metrics identified above.

EC.02.04.03-24 – ALTERNATE MAINTENANCE STRATEGIES

The hospital inspects, tests, and maintains the following in accordance with manufacturers' recommendations:

- Medical lasers
- Imaging and radiologic equipment (whether used for

diagnostic or therapeutic purposes)
- New medical equipment with insufficient maintenance history to support the use of alternative maintenance strategies

Biomedical Management will develop maintenance strategies for medical lasers, imaging and radiological equipment or diagnostic and therapeutic purposes, and new medical equipment with insufficient maintenance history, based upon manufacturers' recommendations.

Preferred Vendor Policy. In the event a piece of medical equipment is needed in an emergency situation, biomedical management will allow certain preferred vendors to deliver the medical equipment to the affected department for usage on a patient in critical need of the equipment. The affected manager must notify biomedical management when they arrive, and biomedical management will conduct an inspection no later than a 24-hour interval from the time the medical equipment was initiated for use on the critical patient. The preferred vendor is one in which their preventive maintenance standards equal those at the medical center. At least annually the biomedical manager visits preferred vendors and audits their preventive maintenance records for specific types of equipment that are used by the medical center. The visit and assessment process is documented and maintained with biomedical management. A *Preferred Vendor* policy is in place with biomedical management.

Ongoing Education for Users and Maintainers
HR.01.05.03-1

Each individual who is tasked with the use, operation, or application of a Medical Device shall be fully trained in those areas of responsibility. On newly purchased devices and current inventory, a factory trained representative, or an appropriate clinician or staff member may be designated to provide training. Documentation shall be maintained.

INFORMATION COLLECTION SYSTEM TO MONITOR CONDITIONS IN THE ENVIRONMENT
EC.04.01.01-EP's 1-11

The hospital establishes process(es) for continually monitoring, internally reporting, and improving the following:

- Medical or laboratory equipment management problems, failures and user errors
- Medical or laboratory equipment management problems, failures and user errors are investigated by biomedical staff, and reported to the *Environment of Care* Committee. A *user error* is an equipment related problem that is reported by using staff as an equipment failure. However, upon investigation by biomedical staff, the equipment failure cannot be duplicated through established testing procedures, and biomedical staff confirms the using staff has likely used the equipment incorrectly.

ANNUAL EVALUATION OF THE MEDICAL EQUIPMENT MANAGEMENT PLAN
EC.04.01.01-EP-15

To ensure effectiveness, and compliance with all areas of concern in the Clinical Equipment Management Plan, and to promote confidence in the operation of this process in the Environment of Care, an annual evaluation of this Program Effectiveness shall be conducted, and a report shall be submitted to the District Environment of Care Committee for review. Included in the annual evaluation will be an evaluation of the objectives, scope, performance and overall effectiveness of the Medical Equipment Management Plan. The annual evaluation of the Medical Equipment Management plan shall be done every 12 months with a 30 day grace period.

THE HOSPITAL ANALYZES IDENTIFIED ENVIRONMENT OF CARE ISSUES
EC.04.01.03-EP-1-2

EOC issues relating to medical equipment are identified and analyzed through the *EOC* Committee with recommendations made for resolution. It is the responsibility of the *EOC* Committee chairperson to establish an agenda, set the meetings, coordinate the meeting and ensure follow-up occurs where indicated.

PRIORITY IMPROVEMENT PROJECT
EC.04.01.03-EP-3

Annually, one or more priority Improvement activities are selected by the *EOC* Committee members. If risk has been determined with respect to medical equipment processes, the result may be a performance improvement project for this *EOC* component.

THE HOSPITAL IMPROVES ITS ENVIRONMENT OF CARE
EC.04.01.05-EP1-3
Performance standards are identified monitored and evaluated that measure effective outcomes in the area of medical equipment management. Performance standards are also identified for Safety, Security, Hazardous Materials, Emergency Management, Fire Prevention and Utilities management. Whenever possible, the *environment of care* is changed in a positive direction by the ongoing monitoring, and changes in actions that promote an improved performance.

PATIENT SAFETY
Periodically there may be an *environment of care* issue that has impact on the safety of our patients relating to medical equipment. This may be determined from *Sentinel Event* surveillance, environmental surveillance, user adverse event reporting, patient safety standards or consequential actions identified through the risk management process. When a patient-safety issue relating to medical equipment emerges, it is the responsibility of the Clinical Engineering Director or Safety Officer to bring forth the issue to the Patient Safety Committee.

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Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

Policy Number: EOC 6015	**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)	

Hospital Electrical Safety Policy for Personal Items

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

Policy:

Kaweah Delta Health Care District is committed to providing a safe environment for our patients, visitors, and staff members. To this end, and to ensure this environment, the following policy and procedures has been developed.

Kaweah Delta Healthcare District reserves the right to remove ANY personal electrical device that, in its opinion, presents a significant risk.

Definitions:

Pertinent 2012 NFPA 99 Definitions:

• "Patient bed location" is defined in section 3.3.136 as the location of a patient sleeping bed, or the bed or procedure table of a critical care area.

• "Patient-care-related electrical equipment" is defined in section 3.3.137 as electrical equipment that is intended to be used for diagnostic, therapeutic, or monitoring purposes in the patient care vicinity;

• "Patient care room" is defined in section 3.3.138 as any room of a health care facility wherein patients are intended to be examined or treated. Note that this term replaces the term "patient care area" used in the 1999 NFPA 99, but the definition has not changed.

• "Patient care vicinity" is defined in section 3.3.139 as a space, within a location intended for the examination and treatment of patients (i.e., patient care room) extending 6 ft. beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment and extends vertically 7 ft. 6 in. above the floor.

Procedure:

1. All Privately Owned Medical Devices, or Personal Electrical Items **MUST** be inspected by the Clinical Engineering Department, PRIOR to use, to ensure compliance with the existing Healthcare District Electrical Safety Policy, EOC 1085, when the patient is admitted to a Nursing Unit.

   The Clinical Engineering Dept On-Call Technician will be notified immediately upon arrival of any patient owned personal electrical item, or personal use medical device, (i.e., Cpap, BiPap, Portable Ventilator), etc.. The patient's Nurse, Unit Charge Nurse, or HUC, shall notify Clinical Engineering by

calling the Hospital PBX Operator and requesting the Clinical Engineering On-Call Technician be notified of a Patient Owned incoming device inspection.

Incoming Patient owned Medical Device requests shall be immediately responded to when notification is received by Clinical Engineering staff. Personal Electrical convenience or entertainment devices, such as Gameboy consoles, DVD Players, Radio's, etc., shall be responded to, on the next Medical Device call in or within four (4) hours.

All items shall meet the following criteria for approval:

All line powered (AC) devices must have an Underwriter's Laboratories LISTED label or equivelant.

Line powered devices must be in safe condition, without evidence of wear, deterioration, or repair.

The following conditions apply for use:

Personal Owned Medical Device:

- Must be unplugged while not in use.
- May only be plugged into a wall outlet in the Patient Care Vicinity.
- May not be plugged into a power strip in the Patient Care Vicinity.

Personal Use Electrical Device:

- Must be unplugged when not in use.
- May not be plugged in to a power strip in the Patient Care Vicinity.
- May be plugged into a wall outlet or an approved power tap with UL1364 or 1364A rating in the Patient Care Room outside the patient care vicinity.

Power cords for such devices must be in good condition, with no exposed wires, cracked insulation, or broken, bent, or missing blades on the power plug.

2. Certain areas of the Hospital shall be restricted from any Personal Use Electrical Devices. These areas shall include, but not be limited to the following:

   Intensive Care Units - ICU, NICU, CVICU
   Surgical Rooms - OR, Delivery OR
   Cardiac Cath Lab
   PACU, Flex-Care
   Certain specific Exam/Treatment Rooms of ER
   Cardiology Treatment Areas
   Nuclear Medicine, MRI, Ultrasound and Radiology Treatment Rooms

3. In addition, patient clinical condition may prohibit the use of certain electrical items. Use of any device shall be restricted if, in the opinion of the Nurse, or Physician, the patient's ability to operate the device is compromised by medication, physical abilities, or care environment.

   Hair dryers, or any device that can produce a spark, shall not be used in areas where oxygen is being administered. Wall powered electric shavers shall not be used if the patient is attached to any medical device.

4. The Hospital reserves the right to remove, any personal electrical device that, presents or develops a significant risk to the patient, visitor, staff or equipment of Kaweah Delta Healthcare District.

5. The following devices are generally permitted for use:

   Small battery-powered devices: Clocks, Radios, MP-3 & CD players**,** Cell phones and computer tablets. Use of head or earphones is encouraged with these devices.

   The above devices should be used in a manner that does not disturb other patients or visitors.

   Electric hair dryers or shavers. **(Hair dryers are NOT permitted for use in areas where oxygen is being administered.)**

   No portable communication devices or cellular telephone shall be permitted or used in any area which is considered electrically sensitive or where Intensive patient monitoring is being conducted.

6. The following devices are prohibited from use:

   Portable televisions, Extension cords, power strips, heating pads, space heaters, heating blankets, and any heating device with exposed heating surface. (Ie. Cooking ware, curling irons, hair irons, coffeepots, and coffee makers.)

   General Mobile Radio Service (GMRS) RF Transmitting Devices Ie. CB-Radios, Walkie-talkies, Amateur Radios, FRS Radios etc.

7. PLEASE NOTE: Kaweah Delta Health Care District reserves the right to refuse to treat a patient who, in the opinion of the Nursing Supervisor On-Duty at the time, and in consultation with, and concurrence of, the attending physician, presents a safety risk to a visitor, patient, or staff member, by refusing to comply with the above policy and procedures. Continued refusal to comply, and with concurrence of the attending physician, will result in notification of the patient's physician, for potential discharge of the patient for Safety Reasons.

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Policy Number: EOC 6018	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)	

Retirement/Deletion of Medical Equipment From MEM Program

POLICY:

When a medical device is no longer a viable unit of service and has reached the end of its useful life, it shall be removed from the Medical Equipment Inventory and an Exit Record will be created in the Medical Equipment Data Base (MEDB) with a specific status applied to the device. This device shall not be placed back into service except under specific circumstances.

PROCEDURE:

I. Guidelines for authorization of retiring medical equipment devices from the Inventory:

A. Circumstances that authorize the retiring of a device from the Active Inventory:

1. Age
2. Operational Condition
3. Repair / Support Costs
4. End of Original Equipment Manufacturer Support
5. New Technology
6. Lack of qualified trained personnel to operate device/system
7. Service history marked Could Not Locate with no other Corrective Maintenance records for greater than 24 months.

B. Circumstances that authorize the deletion of a device from Medical Equipment Inventory.

1. End of regulatory period which requires storage of device information.

II. The following guidelines will be strictly adhered to when retiring or deleting equipment:

A. Retirement of equipment:

1. The Clinical Engineering (CE) Department shall be notified, by request through the use of a clinical engineering work order, to remove the device from service by the device's owning department Unit Manager, or designee.

2. The device in question shall be removed by Clinical Engineering Staff no later than the next business week.

3. The CE Staff member shall pick up the device(s) and take it to the Clinical Engineering Department, or to a temporary holding location for processing.

4. ALL identification labels, (I.D. tags, inspection stickers, etc.), shall be removed from the device and returned to the Manager of the Clinical Engineering Department.

5. The device shall be physically transferred to a **SECURED** holding area, located in the basement of the Main Hospital Facility, or at the off-site warehouse facility.

6. The Clinical Engineering Dept or Materials Management will control access to this holding area.

7. The device shall be classified as "RETIRED" in the Sentinel Infinity MEM Program along with the date so retired.

8. Any information pertaining to the device status, shall be recorded on the device history page "Notes Section".

9. The manager of the "Unit of Ownership" of the device will be notified of the device retirement, along with the appropriate representative of Finance.

(NOTE: ALL procedures contained herein shall be in compliance with Administrative Policy AP-86 for the Sale or Disposal of District Equipment).

The following information shall be provided:

a. Device Nomenclature
b. Manufacturer
c. Model
d. Serial
e. Biomedical I.D. Number
f. Hospital Asset Tag Number
g. Unit of ownership (Cost Center)
h. Date of Retirement
i. Device Disposition status (Hold for sale / trade-in, scrapped, etc)

10. Devices shall be placed in storage holding under the following guidelines, with NO exceptions:

    a. Devices retired from service with no subsequent plans for use or reuse, shall be held in storage for not more than thirty (30 days), after which they will be sold or scrapped.
    b. Devices retired from service for future trade-in value, shall be held in storage for not more than ninety (90) days. Vendor trade-in devices shall be accounted for by the Vendor and removed from the District within that time period.
    c. The Clinical Engineering Department shall maintain a listing of retired devices that are placed in storage, and will ensure it is updated on a monthly basis. Access to this listing shall be made available to all requesting department directors/managers.

11. AT NO TIME SHALL A DEVICE THAT HAS BEEN DESIGNATED AS RETIRED BE RETURNED TO ACTIVE SERVICE UNTIL INSPECTED BY A MEMBER OF THE CLINICAL ENGINEERING DEPARTMENT AND DESIGNATED AS SAFE TO PLACE INTO SERVICE.

    a. A device that has been placed in storage under the above guidelines may be returned to active service under the following guidelines

        I. The device service history shall not have expired during the storage period, (preventive maintenance (PM) Inspection interval shall not have been exceeded).
        II. If the PM inspection cycle has expired, the device shall be inspected under the Scheduled Preventive Maintenance procedure designated for the device and an electrical safety inspection shall also be performed.
        III. The device shall have a new Sentinel Infinity MEM Program I.D. tag, (Clinical Engineering I.D. tag), affixed and that number shall be logged into the existing database.
        IV. The Finance department will be notified of the re-activation of the device, (if the depreciated value of the device is in excess of $500.00)

B. Deletion of Equipment

1. Sentinel Infinity MEM Program

    a. In conjunction with District Policies and Directives, all device histories and information, shall remain a

permanent part of the Sentinel Infinity MEM database for a period of seven (7) years after date of retirement. This data shall be stored on computer disk, (CD), and access shall be controlled through the Division Director, the District Risk Manager, and the Manager of the Clinical Engineering Department.

REFERENCE: Administrative Policy AP-86
Clinical Engineering Policy CEDPM-026

"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 7001	**Date Created: 07/01/2010**
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Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Utilities Management Plan

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

I. OBJECTIVES

The objectives of the Management Plan for Utility Equipment at Kaweah Delta Health Care District (KDHCD) are to manage effective, safe, and reliable operations of utility equipment that provides a safe, controlled physical environment for the patients, employees, physicians, and visitors who enter the premises. Inherent in utility equipment processes are operational reliability of utility equipment, the development of a utility equipment inventory and program, and an inspection and maintenance program designed to minimize risks to our patients and the physical environment. Specific programs in place to support the objectives of the utility equipment management plan include the following:

- Preventive Maintenance Program
- Corrective Maintenance Program
- Annual maintenance on inventoried equipment/systems
- User/maintainer training
- Performance indicators
- Annual Evaluation of the Management Plan for Utility Equipment

SCOPE

The scope of the Utility Management Plan applies to KDHCD with the Director of Facility Operations and Support Services, overseeing the management of the utility systems, and with broad oversight by the *Environment of Care (EOC)* Committee. With respect to the offsite areas per KDHCD license, the Facilities Director has oversight responsibility for the utility system that provides services to the offsite areas. Each offsite area manager will have the responsibility of the day-to-day operations relating to utility services, which often means working in partnership with a lessor, or building owner if applicable. Utility failure plans are required for each offsite area, and are the responsibility of the offsite manager. Utility issues for the offsite areas may be brought to the attention of the *EOC* Committee.

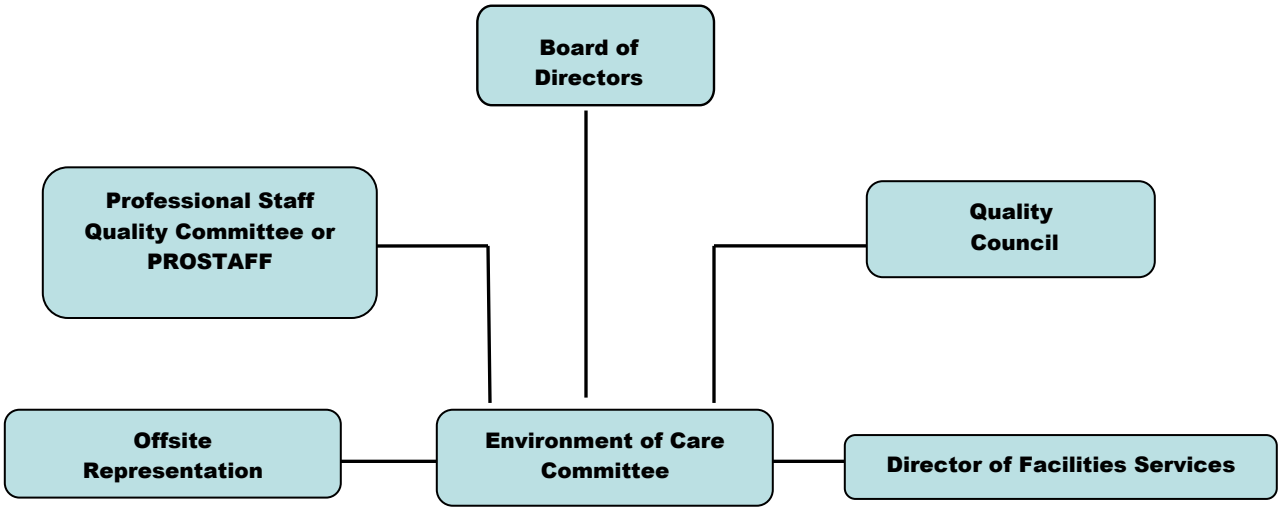
AUTHORITY

The authority for the Management Plan for Utility Equipment is EC. 02.05.01. The authority for overseeing and monitoring the utility equipment plan and program lies in the *EOC* Committee, whose members will ensure activities relating to utility equipment management are identified, monitored and evaluated, and for ensuring that regulatory activities are monitored and enforced as necessary.

ORGANIZATION

The following represents the organization of the Management Plan for Utility Equipment at KDHCD:

Organization – Management Plan for Utility Equipment



RESPONSIBILITIES

Leadership within Kaweah Delta Health Care District have varying levels of responsibility and work together in the management of utility equipment as identified below:

Board of Directors: The Board of Directors supports the Utility Equipment Management Plan by:

- Review and feedback if applicable of the quarterly and annual *EOC* reports.
- Endorsing budget support as applicable for capital purchases relating to utility equipment.

Quality Council: Reviews annual *EOC* report from the *EOC* Committee, and provides broad direction in the establishment of performance monitoring standards relating to utility equipment risks.

Professional Staff Quality Committee or PROSTAFF: Reviews annual *EOC* report from the *EOC* Committee, providing feedback if applicable.

Administrative Staff: Administrative staff provides active representation on the *EOC* Committee meetings and sets an expectation of accountability for compliance with the Utility Equipment Program

***Environment of Care* Committee:** *EOC* Committee members review and approve the quarterly *EOC* reports, which contain a Utility Equipment component, and oversee any issues relating to the overall utility equipment program.

Directors and Department Managers: These individuals support the Utility Equipment Management Program by:

- Reviewing and correcting deficiencies identified through the hazard surveillance process that relate to utility equipment risks.
- Communicating recommendations from the *EOC* Committee to affected staff in a timely manner.
- Providing information/in-services to staff that insure compliance with applicable policies of the within the Utility Equipment Management program.
- Serving as a resource for staff on matters of utility equipment usage.

Employees: Employees of Kaweah Delta Health Care District are required to participate in the Utility Equipment Management program by:

- Completing applicable utility equipment training.
- Reporting utility equipment failures to their supervisor and to Facilities

- Reporting any observed or suspected unsafe conditions to his or her department manager as soon as possible after identification that may pose a utility equipment risk, which include, but are not limited to: frayed electrical cords, use of extension cords, overuse of power adaptors, equipment brought in by patients, or any loss of utility power.

Medical Staff: Medical Staff will support the Utility Equipment Management Program by abiding by the District's policies and procedures relating to the use of utility equipment

The [organization] manages risks associated with its utility systems.
EC. 02.05.01-1
EC.02.06.05-1,2

When planning for new, altered or renovated space that will impact utility systems, KDHCD uses one of the following design criteria:
-State rules and regulations, and
-*Guidelines for Design and Construction of Hospitals and Healthcare Facilities*, current edition, published by the American Institute of Architects.
When the above rules, regulations and guidelines do not meet specific design needs, other reputable standards and guidelines are used that provide equivalent design criteria. When planning for demolition, construction or renovation, a pre-construction risk assessment is used that addresses utility requirements that affect care, treatment and services. If any utility-related risks are identified during the pre-construction assessment, KDHCD will take action to minimize the identified utility risks. After construction projects are completed, the Director of Facility Services will ensure the acquisition of as-built drawings, and in addition will insure that other utility system maps and drawings are updated and current.

The District maintains a written inventory of all operating components of utility systems or maintains a written inventory of selected operating components of utility systems based on risk for infection, occupant needs, and systems critical to patient care (including all life support systems). The District evaluates new types of utility components before initial use to determine whether they should be included in the inventory.
EC.02.05.01-3 through 7
EC.02.05.05, EPs 1through 6

Written Inventory
KDHCD maintains a written inventory of utility systems, which includes (but not limited to) the following:

Water Supply System
Irrigation Water System
Domestic Hot Water System
Hot Water Heat Recovery System
Water Softening System
Patio Storm Drain System
Sewage System
Basement Sump Pump
Natural Gas System
Fuel Oil System
Steam Boilers and Distribution System
Condensate Return
Medical Air System
Medical Vacuum System
Medical Oxygen System
Heating, Ventilation and Air Conditioning System
Electrical System 7 Emergency Generators 7 Transfer Switch
Elevator System
Nurse Call System
Kitchen Fire Extinguishing System
Fire Sprinkler System
MRI Halon Fire Extinguisher System
Fire Alarm Monitoring System – API
Paging System
Telephone System and Telephones

Two-Way Radio System
Pagers
ICU/CCU Monitor System
Master Clock System
Sterilizers
ETO Abator System
Trash Compactor
Bailer

Any new utility equipment purchased for KDHCD is evaluated for inclusion into the written inventory. The utility management program includes equipment that meets the following criteria:

- Equipment maintains the climatic environment in patient care areas.
- Equipment that constitutes a risk to patient life support upon failure.
- Equipment is a part of a building system, which is used for infection control.
- Equipment that is part of the communication system, which may affect the patient or the patient care environment.
- Equipment is an auxiliary or ancillary part of a system control or interface to patient care environment, life support, or infection control.

Inspection and Maintenance Activities

Documentation of inspection, testing and maintenance demonstrates systems and components performance within prescribed limits and adherence to established schedules. The minimum required documentation is exception reporting. This documentation lists all items tested and indicates pass or fail. Those items that fail have additional documentation of repair and subsequent testing indicating performance within standards. As part of utility system operational plans, planned or preventive maintenance is a key factor in assuring the ongoing performance and reliability of utility systems whereby each system is properly identified, operated, and maintained. A system is no more reliable than the individual pieces of equipment, or components, within it. Each component within a system is evaluated to determine the content and frequency of testing procedures, inspections, calibrations, and the servicing and replacement of parts. In the development of preventive maintenance programs, a review is made from various sources of information, such as manufacturers recommendations, codes, standards, and federal, state, and local laws and regulations. The basic sources of information are invaluable as start-up aids; however, over time it is essential that local operating experience be factored in to modify the program. Through this process, initial levels of risk are maintained or reduced.

Minimization of Pathogenic Biological Agents

The Utility Management plan includes processes for activities that will reduce the potential for hospital-acquired illnesses that could be transmitted through the Utility Systems. These include policies and or procedures relating to:

- **Cooling Towers/Open and Closed Water Systems:** Biological and/or chemical treatment(s) and testing or cultures are in place wherein the potential for hospital-acquired illness could occur within the District's cooling and heating systems.
- **Domestic Hot and Cold Water Systems:** Periodic biological testing of the hot and cold water systems are in effect as part of the utility management program.
- **Equipment Maintenance - HVAC:** A filter change program is in effect to reduce the risks associated with air borne contaminants within the major air handling systems.
- **Air Pressure Monitoring/Maintenance:** A program is in place in Facilities that allows for the air pressure monitoring, maintenance, and balancing for the following critical areas: surgical operating rooms, critical care areas, including ICU, special procedure rooms, isolation rooms and the labor and delivery suites.
- **Construction.** Protocol and procedures are in place to coordinate Infection Control and construction activities that establishes how an area will be assessed before and during construction for the purpose of minimizing the risks associated with air-borne biological contaminants (e.g., aspergillosis).

The Facilities Director/Safety Officer is responsible for the proper and safe functioning of all equipment within the facility and the general condition of the facility. Facilities management requires written procedures that are developed and specify the action to be taken during the failure of essential equipment and major utility services. The written procedures include a call system for summoning essential personnel and outside assistance when required. The following essential equipment and services are included: Major air conditioning equipment, air handling systems (ventilation, filtration, quantitative exchanges, humidity), boilers, electrical power services, fire alarm and extinguishing systems, water supply, all waste disposal systems, and

medical gas and vacuum systems. Qualified engineering consultative advice is available as needed. In the event that the in-house personnel cannot correct the problem and restore the operation of the equipment, then Administration, the Facilities Director and Safety Officer, or their designated representative shall have full authorization to call in an outside resource to correct the situation.

The District maps the distribution of its utility systems
EC.02.05.01-17
Layout maps or blueprints for utilities with complicated infrastructures are maintained to enhance troubleshooting effectiveness. Distribution maps are located in Facilities, and are for plumbing, medical gases and electrical.

The District labels utility system controls to facilitate partial or complete emergency shutdowns.
EC.02.05.01-9
Controls for Utility Systems are labeled in an efficient manner. Most importantly, controls that are located remotely from related equipment are clearly labeled. The label explains the equipment that is controlled and the power source panel identification. Medical gas valves are clearly labeled as to what areas they isolate. Other plumbing valves are labeled in correspondence with a master valve list.

The District has written procedures for responding to utility system disruptions
EC.02.05.01-10
Policies and procedures are in place in Facilities, which identify emergency procedures for utility system disruptions or failures. Systems are in place to mitigate the consequences of a utility failure, such as the emergency generators, battery operated equipment, staff interventions in the event equipment fails and the use of outside vendors for emergency assistance as may be needed.

The District's procedures address shutting off the malfunctioning system and notifying staff in affected areas.
EC.02.05.01-11
Staff and employees are notified in affected areas when a partial or total system shutdown is necessary. When a utility system must be shutdown, notification is made to Administration, Nursing, and the Department Director(s)/managers of the affected department(s), and agencies having jurisdiction if applicable.

The District's procedures address performing emergency clinical interventions during utility systems disruptions.
EC.02.05.01-12
In the event of a utility system disruption that impacts the flow of electrical-operated medical equipment, clinical interventions are to be provided based upon the scope of practice of the patient care provider, and may include such interventions as:

- Use of portable monitors and ventilators
- Manual bagging of a patient if the patient is on a ventilator that loses power and does not have a battery back-up
- Battery-operated equipment
- Manual intravenous administration in the event IV equipment fails, and does not have battery back-up

The [organization] has a reliable emergency electrical power source
EC.02.05.03-1-16
KDHCD provides and maintains a reliable emergency power system that is adequately sized, designed and fueled as required by the LSC occupancy requirements and the services provided, and supplies emergency power to the following areas and systems:

i. Alarm Systems
ii. Egress illumination
iii. Elevator (1)
iv. Emergency Communication Systems
v. Exit Sign Illumination
vi. Blood, Bone and Tissue Storage Units
vii. Emergency Care Areas (Urgent Care)
viii. Intensive Care
ix. Medical Air Compressors

x. Medical/Surgical Vacuum Systems
xi. Newborn Nurseries
xii. OB Delivery Rooms
xiii. Operating Rooms
xiv. Recovery Rooms
xv. Special Care Units
xvi. Lighting at emergency generator locations
xvii. Emergency Rooms
xviii. Dispensing Cabinets
xix. Medication Carousels
xx. Central Medication Robots (if applicable)
xxi. Medication Refrigerators
xxii. Medication Freezers

The [organization] inspects, tests, and maintains utility systems.
Note: At times, maintenance is performed by an external service, and KDHCD must have access to this documentation.
EC.02.05.05- 2and 4 through 6

On a regular and consistent basis, inspection, testing, and maintenance is part of a process to assure system and component performance. The initial inspection and test are part of the acceptance of new systems and components. Ongoing inspection, testing and maintenance increases reliability, systems and components life, and user confidence. The intervals for inspection, testing and maintenance are based on the needs of the systems and components. The intervals may be less than or more than one year. The exception is the required weekly testing of the emergency generators. If an interval greater than one year is selected, it must be approved by the *EOC* committee. The Facilities Director will apply or obtain professional judgment to set intervals so known risks, hazards and maintenance needs are managed. In Facilities a computerized maintenance system is used to facilitate the scheduling, inspection, testing, maintenance, monitoring, and documentation of equipment for the utilities systems.

Equipment Currently in Inventory:

- Scheduled maintenance work orders are issued on a monthly basis to Facility's staff.
- Maintenance is performed in accordance with the instructions included in the work order. The assigned engineer documents the maintenance, including any pertinent observations, on the work order. When maintenance and documentation are completed, the engineer returns the work order to the Facility's department.
- If scheduled maintenance cannot be performed (i.e., parts not available), the reason is documented on the work order and returned to Facilities. There is a system of evaluation for equipment not serviced within the scheduled time frame.
- If systems' equipment must be removed from the user area for more than one day, the engineer prepares a corrective maintenance work order.
- If scheduled maintenance is to be performed by an outside vendor, the Facility Director or designee contacts the vendor and instructs the vendor to perform the maintenance as detailed in the work order, document the maintenance and any associated work done on the work order. A copy of this documentation is maintained in Facilities.

Incoming Equipment:

- Requests for new equipment are reviewed and approved by the Facility Director or designee for proper safety features, including electrical needs, drainage needs, ventilation needs and space consideration as required by manufacturer specifications.
- After receipt of new equipment, but prior to its installation, it must be inspected, with electrical and mechanical tests performed, and determined by Facilities that it meets all appropriate safety standards.
- If the equipment fails to pass the required tests and inspection, the engineer will return the equipment to Purchasing unless the deficiency is corrected. The equipment is not assigned an identification number until the equipment has passed all the requirements.
- After passing inspection, and if recommended by manufacturer, the new equipment will be entered on the Preventive Maintenance Data Base. At this time, the equipment is assigned an identification number, and the engineer performing the inspection will install the respective tag with the assigned equipment number, and then process the necessary data entry of the specific procedures and frequency to be followed during the preventive maintenance as recommended by the manufacturer.

- If the manufacturer does not recommend preventive maintenance to the equipment, i.e., microwave oven, addressograph, the engineer performing the inspection will apply a tag with the date the inspection was performed, and will place the equipment on the Non-Clinical Equipment Inspection Log, and will be subject to visual inspection once a year to verify proper operation.
- In the event that equipment not belonging to the District is brought into the District for use, they must be inspected and determined to be safe by the Clinical Engineering Department. This would apply to any items brought by patients, visitors or employees (radios, televisions, coffee makers, etc.). The Facility Director or designee is authorized to remove any item, which is found to be unsafe for use in the District. This will include any demonstration equipment brought in by any vendor.

Documentation is maintained in the Facilities Department, and includes, but is not limited to the following:

- A current, accurate and separate inventory of utility components identified in this plan
- Performance and safety testing of each critical component before initial use.
    - Maintenance of critical components of High Risk Utility systems/equipment consistent with the maintenance strategies identified in this plan.
    - Maintenance of critical components of infection control utility systems/equipment for consistent with the maintenance strategies identified in this plan.
    - Maintenance of critical components of non-high risk utility systems/equipment on the inventory consistent with maintenance strategies identified in this plan.

The [organization] inspects, tests and maintains emergency power systems
EC.02.05.07- 1 through 10

1. At 30-day intervals, a functional test is performed of battery-powered lights required for egress for a minimum duration of 30 seconds. The completion date of the test is documented and maintained in Facilities.
2. Every 12 months, performs a functional test of battery-powered lights required for egress for a duration of 1 ½ hours. The completion date of the tests or replacement is documented and maintained in facilities.
3. SEPSS (Stored Electrical Energy Emergency and Standby Power Systems) testing: **Not applicable**.
4. At least weekly, the hospital inspects the emergency power supply system (EPSS), including all associated components and batteries. The results and completion dates of weekly inspections are documented-**Not applicable**.
5. The generators are tested monthly by Facilities for at least 30 continuous minutes. The completion date of the tests is documented and kept on file in Facilities.
6. The emergency generator tests are conducted with a dynamic load that is at least 30% of the nameplate rating of the generator or meets the manufacturer's recommended prime movers' exhaust gas temperature.
7. Monthly, the automatic transfer switches are tested, and the completion date of the tests is documented and maintained in Facilities.
8. At least annually, the hospital tests the fuel quality to ASTM standards. The test results and completion dates are documented.
9. At least once every 36 months, each emergency generator is tested for a minimum of 4 continuous hours. The completion date of the tests is documented and maintained in Facilities.
10. The 36-month emergency generator test uses a dynamic or static load that is at least 30% of the nameplate rating of the generator or meets the manufacturer's recommended prime movers' exhaust gas temperature.

    If the required emergency power system test fails, KDHCD will implement measures to protect patients, visitors and staff until necessary repairs or corrections are completed. This is the responsibility of Facilities personnel. If a required emergency power system test fails, Facilities personnel will perform a retest after making the necessary repairs or corrections.

The [organization] inspects, tests and maintains medical gas and vacuum systems.
EC.02.05.09-1 through 14

Facilities inspects, tests, and maintains critical components of piped medical gas systems, including master signal panels, area alarms, automatic pressure switches, shutoff valves, flexile connectors, and outlets. The plan for inspecting, testing and maintaining medical gas and vacuum system includes, but is not limited to:

- Annual inspection of alarm panel
- Annual inspection of area alarms

A routine PM schedule is in place for automatic pressure switches, shutoff valves, flexible connectors and outlets (annual testing for patient-care areas, and annual for non-patient care areas).
When the systems are installed, modified, or repaired including cross-connections testing, piping purity testing and pressure testing, a qualified individual (e.g., a contractor/certified licensed technician) insures that the medical gas systems are installed/maintained/repaired. When the installation is completed, or when maintenance or repair work is done, the qualified individual ensures that cross connection testing, piping purity testing and pressure testing are included in the process, and that code requirements are met. The systems will be additionally tested (to ensure it is connected properly so that a sufficient volume is yielded at each outlet) following periods of construction or if there is evidence that the system has been breached.

KDHCD maintains the main supply valve and area shut-off valves of piped medical gas and vacuum systems and ensure they are accessible and clearly labeled. To maintain safety in the event of an emergency, a current and complete set of documents indicating the distribution of the medical gas systems and control for partial or complete shutdown is maintained. The documents include "as-built" drawings, construction or design drawings, line or isometric drawings, shop drawings, or any combination of these if they reflect present conditions.

When the hospital has bulk oxygen systems above ground, they are in a locked enclosure (such as a fence) at least 10 feet from vehicles and sidewalks. There is permanent signage stating “OXYGEN – NO SMOKING – NO OPEN FLAMES.”
The hospital’s emergency oxygen supply connection is installed in a manner that allows a temporary auxiliary source to connect to it.

The hospital tests piped medical gas and vacuum systems for purity, correct gas, and proper pressure when these systems are installed, modified, or repaired. The test results and completion dates are documented.

The hospital makes main supply valves and area shutoff valves for piped medical gas and vacuum systems accessible and clearly identifies what the valves control.

Locations containing only oxygen or medical air have doors labeled "Medical Gases: NO Smoking or Open Flame." Locations containing other gases have doors labeled “Positive Pressure Gases: NO Smoking or Open Flame. Room May Have Insufficient Oxygen. Open Door and Allow Room to Ventilate Before Opening.”

Ongoing Education for Users and Maintainers

HR.01.05.03-1

The Facility’s Education Department and the department managers hold responsibility for coordinating and implementing the education and training of the utility equipment users jointly.
USER EDUCATION:
Employees will receive a general overview of the Utility Equipment Plan at initial and annual orientation. Department Directors will provide department specific orientation and education to their employees to insure that utility equipment users will be able to describe and/or demonstrate the following items:

1. Basic operating and safety features for users to follow
2. Emergency procedures to follow when utility equipment fails.
3. KDHCD’s process for reporting utility equipment Management problems, failures and user errors (i.e., they are reported to Facilities, who in turn reports this information to the *EOC* Committee.

Maintainer Education

For the maintainers of utility equipment, thorough training about the capabilities and limitations of equipment is made by the manufacturer. Self-assessment can be used annually, through the competency process, to determine the need for additional training. Training may be provided by:

- Formal academic courses
- Seminars, in-service training
- On-the-job training
- Service schools

Information collection system to monitor conditions of the environment.

1. The District establishes a process(es) for continually monitoring, internally reporting, and investigating the following:
    - Utility equipment management problems, failures and user errors

Through the *EOC* Committee structure, utility problems, failures and user errors are reported by Facilities, who investigate the issue, and provide corrective actions. Minutes and agendas are kept for each Environment of Care meeting and filed in Performance Improvement.

Annual Evaluation of the Utility Management Plan.
EC.04.01.01-EP-15
On an annual basis *EOC* Committee members evaluate the Management Plan for Utility Equipment, as part of a risk assessment process. Validation of the management plan occurs to ensure contents of each plan support ongoing activities within KDHCD. Based upon findings, goals and objectives will be determined for the subsequent year. A report will be written and forwarded to the Governing Board. The annual evaluation will include a review of the following:

- The objectives: The objective of the Utility Equipment Management plan will be evaluated to determine continued relevance for KDHCD (i.e., the following questions will be asked; was the objective completed? Did activities support the objective of the plan? If not, why not? What is the continuing plan? Will this objective be included in the following year? Will new objective(s) be identified? Will specific goals be developed to support the identified objective?)
- The scope. The following indicator will be used to evaluate the effectiveness of the scope of the utility equipment management plan: the targeted population for the management plan will be evaluated (e.g., did the scope of the plan reach applicable employee populations in the off-site areas, and throughout KDHCD?)
- Performance Standards. Specific performance standards for the Utility Equipment Management plan will be evaluated, with plans for improvement identified. Performance standards will be monitored for achievement. Thresholds will be set for the performance standard identified. If a threshold is not met an analysis will occur to determine the reasons, and actions will be identified to reach the identified threshold in the subsequent quarter.
- Effectiveness. The overall effectiveness of the objectives, scope and performance standards will be evaluated with recommendations made to continue monitoring, add new indicators if applicable or take specific actions for ongoing review.

KDHCD analyzes identified *EOC* issues.
EC.04.01.03-EP-2
EOC issues relating to utility equipment are identified and analyzed through the *EOC* Committee with recommendations made for resolution. It is the responsibility of the *EOC* Committee chairperson to establish an agenda, set the meetings, coordinate the meeting and ensure follow-up occurs where indicated. Quarterly Environment of Care reports are communicated to Performance Improvement, the Medical Executive Committee and the Board of Directors.

KDHCD improves its *EOC*
EC.04.01.05-EP1
Performance standards are identified monitored and evaluated that measure effective outcomes in the area of utility equipment management. Performance standards are also identified for Safety, Security, Hazardous Materials, Emergency Management, Fire Prevention and Medical equipment management. The standards are approved and monitored by the *EOC* Committee with appropriate actions and recommendations made. Whenever possible, the *environment of care* is changed in a positive direction by the ongoing monitoring, and changes in actions that promote an improved performance.

Patient Safety.
Periodically there may be an *EOC* issue that has impact on the safety of our patients relating to utility equipment. This may be determined from *Sentinel Event* surveillance, environmental surveillance, user errors, patient safety standards or consequential actions identified through the risk management process. When a patient-safety issue relating to utility equipment emerges, it is the responsibility of the Safety Officer or designee to bring forth the issue through the patient safety process.

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

Policy Submission Summary

Manual Name: Human Resources			**Date: 6/19/19**
Support Staff Name: Blanca Bedolla			
Policy/Procedure Title	**#**	**Status** (New, Revised, Reviewed, Deleted)	**Name and Phone # of person who wrote the new policy or revised an existing policy**
Physician Recruitment Policy	AP.126	Reviewed	Brittany Taylor, Sr. Physician Recruiter 624-2899
Professional Licensure and Certification	HR.47	Reviewed	Linda Hansen, Director 624-2583
Payment of Wages	HR.65	Reviewed	Linda Hansen, Director 624-2583
Telecommuting	HR.74	Reviewed	Dianne Cox, VP Human Resources 624-2362
Computer and Communication Devices and Social Media Code of Conduct	HR.236	Reviewed	Dianne Cox, VP Human Resources 624-2362
Paid Time Off (PTO), Extended Illness Bank (EIB) and Healthy Workplace, Healthy Families Act of 2014	HR.234	Reviewed	Dianne Cox, VP Human Resources 624-2362
Personal Leave of Absence	HR.148	Revised	Dianne Cox, VP Human Resources 624-2362
Leaves of Absence	HR.243	Revised	Dianne Cox, VP Human Resources 624-2362
Employee Emergency Relief	HR.173	Revised	Dianne Cox, VP Human Resources 624-2362
Extended Illness Bank (EIB) Donations	HR.239	Revised	Dianne Cox, VP Human Resources 624-2362
Paid Time Off (PTO) Cash Out	HR.241	Revised	Dianne Cox, VP Human Resources 624-2362

Policy Number: HR.148	Date Created: 06/01/2007
Document Owner: Dianne Cox (VP Human Resources)	Date Approved: 07/26/2016
Approvers: Board of Directors (Administration)	

Personal Leave of Absence

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

POLICY:

To allow employees time off for personal reasons and time off not covered by legislative requirements.

Leaves not covered under legislative requirements may be considered to be personal leaves of absence and are subject to approval by the department head. Leaves may be approved for a period of up to one month, in the case of pending licensure, leave may be extended up to 12-weeks, based on the employee's length of service, performance, level of responsibility, reason for the request, and the District's ability to obtain a satisfactory replacement during the time the employee will be away from work.

PROCEDURE:

1. Employees requesting a personal leave of absence are required to complete a request for Leave of Absence form. Requests and approvals for a personal leave of absence must indicate the specific beginning and ending dates. This request will be given to the employee's department head for approval. The employee will be send a pamphlet from the state Employment Development Department ("EDD") entitled "For your Benefit: California's Program for the Unemployed."

2. Employees have the option to use accrued Paid Time Off (PTO) during a personal Leave of Absence, and need to coordinate this with their timekeeper if they would like to utilize their accrued PTO time.

3. Efforts will be made to hold the employee's position open for the period of the approved leave. However due to business needs, there will be times when positions cannot be held open and it is not possible to guarantee reinstatement. If an employee's former position is unavailable when he/she is to return to work, a reasonable effort will be made to place the employee in a comparable position for which he/she is qualified. An employee who does not accept the position offered will be considered to have voluntarily terminated his/her employment effective the date the refusal is made. If the District does not have any positions available for which the employee is qualified, the employee will be terminated.

4. Employee Benefits:

    a. An employee taking leave will continue to receive coverage under the District's employee benefit plan for up to a maximum of four (4) months per 12-month period at the level and under the conditions of coverage as if the employee had continued in employment continuously for the duration of such leave. The District will continue to make the same premium contribution as if the employee had continued working.
    b. Insurance premiums (health, vision, dental, life, etc.) are to be paid by the employee and the District, under the same conditions as existed prior to the leave, for a maximum period of four (4) months in a 12-month period.
    c. If on paid status (utilizing PTO), an employee may continue his/her normal premiums through payroll deduction. If on unpaid status, he/she is required to pay the District his/her portion of the premiums monthly while on a leave of absence for a total of four months. After four months, employees will be offered COBRA Continuation Coverage for applicable benefits.
    d. An employee whose insurance is canceled due to nonpayment of premiums will have to satisfy a new waiting period after returning to work and will be considered a "new employee" for insurance purposes. The employee may have to provide proof of insurability.
    e. An employee may cancel his/her insurance(s) within thirty (30) days of the end of his/her paid leave and will be re-enrolled upon return without a waiting period. Cancellation must be done in writing to the Human Resources Department. The employee must reinstate coverage within thirty (30) days of his/her return to work.
    f. Group medical, dental and vision insurance coverage will cease on the last day of the month in which an employee reaches four months of leave or employment ends except that continuation is allowed under COBRA regulations if applicable to the plan.
    g. If the employee fails to return to work at the expiration of the leave, he/she must repay any health insurance premiums paid by the District while on leave, unless failure to return to work is due to a continuation of his/her own serious health condition or other reasons beyond his/her control.
    h. The employee must complete all outstanding job requirements and documentation (licensure, CPR, ACLS, NRP, PALS, and TB testing, as applicable) prior to a return to work. Competency-related documentation must be completed within two weeks of the employee's return.

5. Benefit Accrual:
   The employee will continue to accrue Paid Time Off (PTO) and EIB as long as he/she is being paid by the District (receiving a paycheck).

6. Merit Review Date:
   The merit review date will be adjusted by the number of days of paid and/or unpaid leave of absence over eighty-four (84) days.

"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: HR.243	**Date Created: 02/22/2016**
Document Owner: Dianne Cox (VP Human Resources)	**Date Approved: 07/26/2016**
Approvers: Board of Directors (Administration), Cindy Moccio (Board Clerk/Exec Assist-CEO)	

Leaves of Absence

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

Purpose:

To allow time off to employees who have no other recourse than to be away from work. To establish a system to continue to receive compensation through accessible benefits, such as Extended Illness Bank (EIB), Paid Time Off (PTO), State Disability Insurance, and Workers' Compensation. To advise employees of their rights and responsibilities.

To comply with applicable laws ensuring equal employment opportunities to qualified individuals with a disability, the District will make reasonable accommodations for known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or an employee, unless undue hardship would result. A leave of absence may be considered as a type of reasonable accommodation. Any applicant or employee who requires an accommodation in order to perform the essential functions of the job should contact their supervisor, department head, or Human Resources and make a request to participate in a timely interactive process to explore reasonable accommodations. The individual with the disability is invited to identify what accommodation he or she needs to perform the job. The District will take steps to identify the barriers that make it difficult for the applicant or employee to perform his or her job, and will identify possible accommodations, if any, that will enable the individual to perform the essential functions of his or her job. If the accommodation is reasonable and will not impose an undue hardship, the District will meet the request.

Policy:

1. Leaves of absence may be granted to all employees on a non-discriminatory basis for health conditions, personal, or family medical needs. A leave of absence may be granted to or provided for an employee for periods of longer than three (3) consecutive calendar days. Leaves pursuant to legislative requirements (Family and Medical Leave Act of 1993 - FMLA; California Family Rights Act of 1991, amended 1993 - CFRA; Pregnancy Disability Leave - PDL; Workers' Compensation; Organ and Bone Marrow Donation Leave of 2011) will be granted in accordance with those Acts. In addition, Leave will be granted to "emergency rescue personnel" who are health care providers, including employees of a disaster medical response entity sponsored or requested by the State. Employees must be designated as such and be activated for duty. All other requests for leave will be considered on the basis of the employee's length of service, performance, level of responsibility, reason for the request and the District's ability to obtain a satisfactory replacement during the time the employee will be away from work.

2. Employees on leave of absence continue to be bound by all other Policies and Procedures of the District during the length of the leave. However, the District may hold in abeyance the requirement to complete job requirement documentation (e.g. Competency Forms, TB testing, performance reviews, counselings, etc.) until the employee returns from leave. The employee must complete all outstanding job requirements and documentation (licensure,

CPR, ACLS, NRP, PALS, and TB testing, as applicable) prior to a return to work. Competency-related documentation must be completed within two weeks of the employee's return. Requesting or receiving a leave of absence in no way relieves an employee of his or her obligation while on the job to perform his or her job responsibilities and to observe all District policies, rules and procedures.

3. At the start of leave, the employee's access will be suspended pending their return to work.

4. Employees on Leave for any reason will not be eligible to participate in employee recognition programs.

5. The following leaves of absence may be granted to or provided for employees. Separate policies, including information on allowable lengths of leave, pay and benefits during a leave of absence, are available on each of the following:

    a. Personal Leave of Absence
    b. Family Medical Leave of Absence
    c. Paid Family Leave (2004)
    d. Personal Medical Leave of Absence
    e. Pregnancy Disability Leave of Absence
    f. Military Leave (Active and Reserve) of Absence
    g. Workers' Compensation Disability Leave of Absence
    h. Organ and Bone Marrow Donation Leave

LEAVES OF ABSENCE

Leave Type (Eligibility)	Maximum Duration	Same or Comparable Job if Return By	The Leave May Run Concurrently With
Personal (30 days)	30 Days (in the case of pending licensure leave may be extended up to 12 weeks.)	30 Days	All Leaves
Medical Leave (Upon Hire)	4 Months	No Job Protection Rights	
Family Medical Leave of Absence (FMLA) (1,250 hours during the previous 12 months; 1 year of service)	12 weeks in a rolling 12-month period. The District adds 4 weeks to equal 4 months.	12 weeks in a rolling 12-month period. The District adds 4 weeks to equal 4 months.	CFRA Pregnancy Leave Workers' Compensation Leave ADA
California Family Rights Act Leave (CFRA) (1,250 hours during the previous 12 Months; 1 year of service)	12 weeks in a rolling 12-month period.	12 weeks in a rolling 12-month period.	FMLA Workers' Compensation Leave ADA
Pregnancy Leave (Upon Hire)	17 1/3 weeks	17 1/3 weeks	FMLA ADA
Military Leave (Upon Hire)	Per Requirements of the Military Service Order	Depends on the length of the leave, please refer to policy.	ADA
Workers' Compensation Disability Leave (Upon Hire)	Until released by Physician.	Until released by Physician.	FMLA CFRA ADA
Organ and Bone Marrow Donation Leave (Upon Hire)	30 days in a rolling 12-month period for each of Organ Donation and Bone Marrow Donation	30 days in a rolling 12-month period for each of Organ Donation and Bone Marrow Donation	

6. REQUIRED FORMS:

The following forms are required and are available by contacting Human Resources.

a. "Leave of Absence Policy" is a copy of this policy and provides required notice to the employee, and is referred to as "Notice" throughout this policy.

b. "Request for Leave of Absence" provides notice of the need for leave to the District, and is referred to as "Request" throughout this policy.

c. "Certification of Physician or Practitioner" provides proof of need for leave and suitability for return to work to the District for a leave related to a medical condition for the employee or a family member, and is referred to as "Certification" throughout this policy.

d. "Request for Information" memo will be sent to the employee in the event the Human Resources department needs more information regarding the leave.

e. "Leave Designation" memo and the Employment Development Department ("EDD") entitled "For Your Benefit: California's Program For the Unemployed" will be provided to the requesting employee to communicate the approval status and other important information related to leaves.

PROCEDURE:

1. Employees must contact their department head and Human Resources as soon as they learn of the need for leave to obtain the Notice and related forms. Because of the complexity of the regulations, employees should consult with Human Resources to ensure they are knowledgeable about the process and how the leave may affect pay and benefits.

2. The employee requesting a leave of absence for more than three (3) days must submit to his/her department head or Human Resources, as soon as possible, the Request form and, if the leave is for a health condition, the Certification form or an Off-Work Notice.

3. If the Request is received by the department head, the department head will sign and date the Request, and submit it, along with the Certification form or Off-Work Notice, if applicable, to Human Resources.

4. Upon receipt of the Request and Certification form or Off-Work Notice, Human Resources can mail a copy of the Notice to the employee's home address, if the employee indicates he/she does not already have a copy of the Notice.

5. Based on the documentation provided by the employee, Human Resources will determine leave coverage, and notify the employee and his/her department head using the Leave Designation memo. The beginning date of the leave may be delayed or leave may be denied if Certification or an Off-Work Notice is not available or the employee does not provide the District with sufficient notice of the need or leave. Additional information needed will be requested from the employee by phone or via the Request for Information memo.

6. A doctor's release and a clearance with Employee Health Services will be required when an employee is returning from a medical leave of absence.

7. The District will make reasonable accommodations for known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or an employee, unless undue hardship would result. A leave of absence may be considered as a type of reasonable accommodation. Any applicant or employee who requires an accommodation in

order to perform the essential functions of the job should contact their supervisor, department head, or Human Resources and make a request to participate in a timely interactive process to explore reasonable accommodations. The individual with the disability is invited to identify what accommodation he or she needs to perform the job. This includes providing reasonable medical documentation confirming that the employee has a physical/mental condition that limits a major life activity and a description of why the employee needs a reasonable accommodation. The District will take steps to identify the barriers that make it difficult for the applicant or employee to perform his or her job, and will identify possible accommodations, if any, that will enable the individual to perform the essential functions of his or her job. If the accommodation is reasonable and will not impose an undue hardship, the District will meet the request.

8. Employees should review the Benefits Overview Policy for information on employee benefit eligibility and COBRA rights.

"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: HR.173	Date Created: 06/01/2007
Document Owner: Dianne Cox (VP Human Resources)	Date Approved: 08/23/2016
Approvers: Board of Directors (Administration)	

Employee Emergency Relief

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

POLICY:
This policy was developed to assist employees in time of personal financial emergency. The funding of this program is through unused Section 125 funds and donations by employees of the District. The unused Section 125 funds will be donated to the Kaweah Delta Hospital Foundation and restricted to use for the Kaweah Delta Employee Emergency Relief and STARRS Committee.

PROCEDURE:
The STARRS Committee meets monthly or as needed to process applications. At least five members of the STARRS Committee must be present at the meeting to approve any disbursements.

To seek assistance from the emergency fund, an application (attached Exhibit) must be fully completed and signed by the employee and department manager/director. The application must be submitted to the Human Resources Department.

Applications for assistance shall be reviewed by members of the STARRS Committee. The decision as to whether to make an award as well as the amount of the award is solely within the discretion of the STARRS Committee.

I. Eligibility

A. All full-time and part-time employees are eligible after successfully completing the introductory period of employment. Employees may not be in the Disciplinary Action Process with a Level II counseling or higher.

B. One application per household.

C. Requests must be submitted to the STARRS Committee in writing by the employee needing assistance. A Manager/Director acknowledgment of submission for STARRS Committee review is required.

D. Employees requesting assistance must meet at least one of the required criteria.

E. Application must be submitted to the STARRS Committee within sixty (60) days of the emergency event or condition resulting in a need for assistance.

F. Application expires after 90 days of submission. If all required documentation is not provided within the 90 day timeframe the application must be resubmitted.

G. Any misrepresentation on this application may be sufficient cause for rejection of the application, and disciplinary action up to and including termination of employment.

II. Criteria

The requesting employee may be asked to provide documentation for any of the criteria listed below (i.e. direct financial impact that creates a hardship for the household):

1. Expenses associated with a major medical emergency or condition of the employee or an immediate family member;
2. Expenses associated with the death of an immediate family member; and,
3. Expenses associated with a catastrophic event affecting the employee.

III. Definition of Immediate Family

For the purpose of this policy, immediate family is defined as current spouse, mother, father, sister, brother, child, (natural or legal guardian, domestic partner, current mother- or father-in-law, grandchildren and employee's grandparents.)

IV. Disbursement

Awards will be disbursed as approved by the Committee Chair or designee provided funds are available.

Awards are not to exceed a maximum of $2,000.

Employees are eligible to reapply for assistance every five (5) years. Exceptions to the policy can be approved by the Vice President of Human Resources after review and approval by the committee.

V. Committee

Committee members will consist of representatives from the STARRS Committee. The Committee will be chaired by the Vice President of Human Resources or designee. Each member of the Committee has an equal vote. A vote of majority by Committee members is required for any award.

VI. Donations

Should the Employee Emergency Relief program be discontinued, the Kaweah Delta Hospital Foundation and the STARRS Committee will determine the use of the funds. No additional donations to the Employee Emergency Relief Fund will be accepted.

Kaweah Delta District Hospital
Employee Emergency Relief Application
(Submit to the Human Resources Department)

Employee Name:_____ Date: _____ Department:_____

Title: _____Employee #_____ Phone #_____
Amount of Request $_____

Emergency Criteria (Please check one)

( ) Major medical emergency of the employee or an immediate family member.
( ) Death of an immediate family member.
( ) A catastrophic event affecting the employee. (Example: Fire or Natural Disaster)

Funds may take up to one month to be distributed.

(Brief explanation of your situation): _____ Date of Incident: _____

Our goal is to pay some of your expenses to help assist you with this unforeseen emergency. Please list expenses that you need assistance with as well as the amount of assistance needed. Please attach unpaid invoices. (Unfortunately, we can only make payments to third parties. We cannot write a check directly to you. Funds cannot be used to pay **Medical Insurance Premiums**.)

I certify that all statements above are true and correct. Any misrepresentation on this application may be sufficient cause for rejection of the application. I also certify that I have read the Employee Emergency Relief Policy HR 173.

_____ _____
Requestor's Signature Date Department Director/Manager Verification Date

****

Human Resources use only

Date Received: _____ STARRS Committee meeting date: _____

Has employee applied and been awarded in the past three (3) years? ___ Date: _____ Amount: _____

Approved: (Amount)_____ Denied (Reason):_____

Given to the Foundation (Date):_____ Check to be ready on (Date): _____

Funds distributed to (Co. Name):_____ Date: _____

Kaweah Delta Health Care District

Policy Number: HR.239	**Date Created: 07/08/2015**
Document Owner: Dianne Cox (VP Human Resources)	**Date Approved: 9/24/2018**
Approvers: Board of Directors (Administration), HR Advisory Committee, Blanca Bedolla (Executive Assistant), Cindy Moccio (Board Clerk/Exec Assist-CEO)	

Extended Illness Bank (EIB) Donations

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

POLICY:

To provide a program where employees can donate personal Extended Illness Bank (EIB) hours to other EIB eligible employees because of a life threatening or serious extended illness.

Upon review and approval of the Director, Vice President and Vice President of Human Resources, Human Resources will establish EIB Donation Agreements for those employees who wish to donate a portion of their accrued EIB hours to a EIB eligible employee who has need of additional time (salary continuation) because of a life-threatening or serious extended illness.

PROCEDURE:

1. The request to establish EIB donation agreements will be made by a department director and vice president to the Vice President of Human Resources.

2. EIB hours may be donated under the following guidelines:

    a. The donor employee is limited to a donation of 25% of his/her EIB balance, up to 40 hours per calendar year. The donor employee must retain a minimum balance of 80 hours in his/her EIB bank. EIB donations used are non-refundable to the donating employee.

    b. EIB hours will be utilized evenly by all donated employees each pay period to supplement the recipients wages, up to their normal status.

c. EIB donations are converted from the donor employee's rate of pay to the recipient's rate of pay, so that appropriate taxes are applied.

d. The recipient may receive donated hours at amounts equal to his/her own coordination with SDI/Workers' Compensation, after his/her EIB/PTO bank has been exhausted and as long as donated EIB hours are available. Employees will not be paid more than their normal status.

e. The anonymity of the donation is at the donor's discretion.

3. Any employee donating EIB will complete an "Extended Illness Bank Transfer Agreement."

Policy Number: HR.241	**Date Created: 10/26/2015**
Document Owner: Dianne Cox (VP Human Resources)	**Date Approved: 02/23/2016**
Approvers: Board of Directors (Administration), Cindy Moccio (Board Clerk/Exec Assist-CEO)	

Paid Time Off (PTO) Cash Out

Policy:

Kaweah Delta Health Care District (KDHCD) encourages employees to take vacation time; however, the District recognizes that, in a 24-hour setting, employees may not take the amount of Paid Time Off (PTO) they are generally granted yearly, thus accruing maximum amounts in their PTO bank.

Procedure:

Employees who meet eligibility requirements have the option of cashing out a portion of their PTO. However, to meet Internal Revenue Service regulations, calendar year PTO cash-out elections are made during a special Open Enrollment in the December preceding each calendar year.

I. All hours are cashed-out at the employee's base rate of pay.

II. During the Open Enrollment, the employee must submit an irrevocable PTO Cash-Out Election Form to Human Resources. PTO cash-outs are paid to the employee with their regular paycheck on the dates indicated on the Election form.

III. The minimum cash-out for the calendar year which can be requested is 20 hours and the maximum is 120 hours. There are three dates available for cash-outs and any amount of hours may be requested so long as the minimum and maximum rules are met. KDHCD requires that an employee keep available a "minimum utilization" of 40 hours of PTO in his/her accrual bank at the time of the cash-out, and cash-outs will be modified if 40 hours are not available.

Policy Number: HR.47	Date Created: 06/01/2007
Document Owner: Dianne Cox (VP Human Resources)	Date Approved:
Approvers: Board of Directors (Administration)	

Professional Licensure and Certification

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

POLICY:

To ensure appropriate licensure and certification on all employees and contracted staff (not subject to the medical staff privilege process, e.g., Allied Health Professionals) in compliance with appropriate licensing agencies. Employee Health requirements for immunizations and PPD are available for Licensed Independent Practitioners and Physicians who practice at the Kaweah Delta.

It is the policy of Kaweah Delta to employ only those individuals and/or to utilize contract services staff that meet all job requirements (TB Screening/PPD testing, etc.) and have proper licensure, certification or registration by the appropriate licensing agency in those jobs requiring such status. Current employees who provide direct patient care will have a Heart Saver card on file with Human Resources (or in the nursing office or applicable department if Contract Staff). Employees and Contract Staff working in positions with a requirement for ACLS, NRP, and PALS, , etc., will also provide proof of certification.
Employees driving their own vehicles for ongoing business will be required to produce proof of current California Driver's License.

All job requirements and current status of documentation shall be maintained by the employee/contract staff member. The employee will furnish proof of this status with original documents before employment or service begins and Human Resources will photocopy the document which will be placed on record in the Personnel file. At each time the status requires updating and/or renewal, the employee will provide further documentation to Human Resources as proof of update and/or renewal.

For employees on a Leave of Absence, Kaweah Delta may hold in abeyance the requirement to complete job requirement documentation (i.e., updated competencies, TB testing, etc.) until the employee returns from leave. The employee must complete all outstanding job requirements and documentation (licensure, CPR, ACLS, NRP, PALS, TB Testing, as applicable) prior to returning to work. Competency-related documentation must be completed within two weeks of the employee's return to work.

Current job requirement documentation will be maintained by Human Resources and by those department heads responsible for such individuals.

Failure on the part of the employee to provide such documentation or proof of current status, or failure to meet any job requirement will result in Progressive Discipline, up to and including, termination of employment. In addition, the employee will be ineligible for participation in the Educational Assistance Program for one year.

PROCEDURE:

I. Definitions

Licensure/certification: Refers to any license/certifications required for an employee's job from the time of hire going forward. Examples are: CA RN License, Clinical Dietitian Registration, and Radiology Tech Certification. BLS (Basic Life Support for Healthcare Providers), Heartsaver AED (Automated External Defibrillator). Licensure /Certification requirements are listed in job descriptions, employee offer letters, and also can be found in HRIS.

II. Verification Licensure/Certification at Time of Hire/Transfer/Renewal

a. It is the responsibility of the Human Resources Department to print the primary source verification prior to hire date. Renewals of Licensure/Certifications will be tracked, verified and printed by the Human Resources Department prior to the expiration date.

b. Human Resources will process the hire/transfer/renewal of an employee to a job that requires valid licensure/certification only after obtaining printed or verbal clearance from the appropriate licensing board. This verification must be from a primary source website or documented if obtained by phone.

c. Primary source verification applies only to licensure/certifications required to practice a profession. It is not required for organizational requirements such as advanced cardiac life support (ACLS) or pediatric advanced life support (PALS) or clinical certification such as peripherally inserted catheter (PICC) line certification.

d. Only the American Heart Association (AHA) or American Red Cross (ARC) certification programs will be acceptable for employment or continued employment. KDHCD has established appropriate paid time for hourly employees, upon approval of your supervisor. Classes taken outside of Kaweah Delta must be AHA or ARC courses and documentation of completion must include the following:

1. Course completion card from AHA or ARC training center

OR

2. Paperwork from the AHA or ARC training center stating the following:

i. Student's name
ii. Type of course
    1. AHA HSAED (Heart Saver Automated External Defibrillator)
    2. AHA BLS for Health Care Providers
    3. ARC CPR/AED adult, child & infant
    4. ARC CPR for the Professional Rescuer or CPR for the health care provider
iii. Date of Course
iv. Successful Completion
v. Name of Training Center
vi. Signature of training center representative

For option 2 above, the provider course card must be submitted to Human Resources within 30 days of course completion to avoid suspension and disciplinary action.

e. Employees are to give 24 hours' notice for cancellation of any Kaweah Delta paid certification class. Employees must be on time to any Kaweah Delta paid classes or will be considered a No Show, which are grounds for discipline. Refer to Progressive Discipline policy HR 216.

f. Any employee that allows their required licensure/certification to lapse for any reason will be given a Disciplinary Action and removed from the schedule.

Employees may return to work once they have shown proof of renewed licensure/certification from a primary source.

Exception for MICN Certification: If regional EMS agency cancels MICN certification class, the employee will be permitted to work without updated certification and no disciplinary action. Employee will be required to attend the next scheduled regional MICN class.

III. Manager's Responsibilities

A. Management is responsible to ensure that all licensed/certified staff has current licensure at all times while working and is not working if license/certification has expired. If the employee has missed two weeks of work from the expiration date, the manager will place the employee on an administrative leave of absence and the employee is subject to termination.

B. Managers and Directors may also be subjected to Disciplinary Action, including suspension and possible termination should licensed/certified employees within their responsibility be working without proper licensure/certification.

IV. Employee's Responsibilities

Employees who have failed to renew their required license or certification, by the expiration date will not be permitted to work. In addition, if the employee has missed two weeks of work from the expiration date, the employee will be placed on a personal leave of absence and is subject to termination. Employees who allow required licensure/certification to expire will be given a written warning. Refer to Progressive Discipline policy HR 216.

V. Interim Permit or Temporary License Processing

Employees must obtain licensure in accordance with the requirements of the applicable licensing board. Employees whose temporary license or interim permit expires, or is otherwise invalidated will be placed on a personal leave of absence for a maximum of 12-weeks. During the 12-weeks period, if licensure is obtained, current employees may apply for a transfer to an open position. If licensure and/or transfer to an eligible position is not obtained, employment will be terminated at the end of the 12-week leave of absence.

VI. Employees on Leave of Absence

Employees on a Kaweah Delta approved Leave of Absence are responsible for being in compliance with all license/certification requirements prior to their return to work. .

VII. Display of License/Certification

As required by law, some licensure/certifications must be displayed in the department.

"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: HR.65	Date Created: 06/01/2007
Document Owner: Dianne Cox (VP Human Resources)	Date Approved:
Approvers: Board of Directors (Administration), Dianne Cox(VP Human Resources)	

Payment of Wages

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

POLICY:

Employees of Kaweah Delta are paid bi-weekly for all the time worked during the past pay period the Friday after the end of each 14-day work period. There are 26 pay periods per year. Employees may elect to receive their paycheck by direct deposit, pay card, or paper check. The preferable payment method is direct deposit.

PROCEDURE:

I. All employees receive their pay stub notification via email shortly after the bi-weekly payroll process is complete on Wednesday evenings or Thursday morning before pay day. The notifications are emailed per the pay stub delivery set up employees have entered in HRONLINE.

Supplemental pay given to employees is paid with paper checks unless a pay card has been agreed upon between the employee and the payroll department. All Employees that possess a pay card are instructed to keep their cards for future use if the need arises. The issuance of pay cards is determined by the payroll department.

II. When payday falls on a holiday observed by Kaweah Delta and banking institutions, paychecks will be distributed one-day earlier

III. Employees who resign providing at least seventy-two (72) hours-notice will receive their final pay after the end of their last worked shift. If termination occurs on a weekday, the final pay will be ready for pick up at Human Resources by 4:00 pm. If termination occurs on a weekend or legal holiday and the required notice has been submitted by the employee, payroll will process the check and the manager or supervisor on duty will deliver the final payment to the employee after the end of their last work shift. Employees who provide less than seventy-two (72) hours-notice will have their final pay available within forty-eight (48) hours of their last hour worked.

Employees who are terminated, as a result of disciplinary action will receive their final pay upon notice of termination.

Final pay will include all hours worked and accrued Paid Time Off bank. Deductions from final pay will include statutory deductions, insurance premiums, voluntary deductions and any amounts the employee owes the District through sign-on bonus, etc. that the employee has agreed to repay in writing.

Policy Number: HR.74	Date Created: 06/01/2007
Document Owner: Dianne Cox (VP Human Resources)	Date Approved: 03/17/2014
Approvers: Board of Directors (Administration),	

Telecommuting

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

POLICY

This policy on telecommuting applies to affected employees and provides for security for all records by limiting and monitoring access to the communication and computer systems.

Kaweah Delta considers telecommuting to be a viable work option for certain employees which, benefits both Kaweah Delta and the telecommuter. A telecommuter is an employee who works for Kaweah Delta from a home, or other remote office for some part of the regularly scheduled workweek. Telecommuting does not change the basic terms and conditions of employment with Kaweah Delta. All Kaweah Delta employees, including telecommuters, are subject to Kaweah Delta's employment policies and procedures. A telecommuter will be required to sign a copy of this Policy as a condition of being a telecommuter. These documents will be kept in the employee's Personnel file.

Kaweah Delta may change the conditions under which the telecommuter is authorized to telecommute or it may cancel the privileges of telecommuting with or without cause and with or without notice.

PROCEDURE:

The employee may request to be considered for telecommuting privileges and/or department leadership may request the employee to work remotely according to the needs of the department.

General

1. Employees entering into a telecommuting agreement may be required to forfeit use of a designated onsite workstation in favor of a shared arrangement to maximize office space needs.

2. Telecommuters who request a change in telecommuting status to return to work onsite must provide a written notice to their manager before returning to work onsite in order to provide management time to arrange for a work station. Kaweah Delta will consider the request and if agreed, will ensure a transition within a reasonable timeframe. Kaweah Delta reserves the right to deny the request.

Eligibility

The management team will determine which position/roles qualify for telecommuting. Telecommuters must be able to perform functions of their job in a remote setting.

1. The telecommuter must be proficient in all aspects of their assigned job functions. Department quality and productivity standards may be a condition of approval for telecommuting.

2. The telecommuter must have the ability to work independently with minimal assistance and/or supervision.

3. The telecommuter must demonstrate familiarity with computer operations and software and must be able to troubleshoot computer and technical issues and communicate effectively with the management team, ISS Helpdesk and other technical support personnel.

4. Remote opportunities may not be extended/offered to employees who are currently in disciplinary action or have low scores on a performance evaluation.

5. Department management will establish the manner and frequency of communication.

Telecommuter Scheduled Workweek:

1. The telecommuter agrees that he or she will be accessible during their regularly scheduled hours while working from his or her home office or any other remote office. A non-exempt telecommuter must also take his or her required meal periods and rest breaks and must obtain pre-approval to work any overtime in accordance with Kaweah Delta policy. Changes to the telecommuter's work schedule must be approved by department management.

2. Telecommuters may be scheduled a portion of their time to routinely work onsite at the discretion of management.

3. Telecommuters will continue to utilize KRONOS to clock in and out or other timekeeping protocol as per existing policies. Worked hours may be verified by examining the production reports as well as computer log-in and log-out times. Falsification of any records will be grounds for progressive discipline up to and including termination of employment.

4. Telecommuters will request management approval for time off by completing the department PTO process.

Telecommuter Workplace:

1. The telecommuter is responsible for designating and maintaining a workplace that is free from recognized hazards and that complies with all occupational safety and health standards, rules and regulations.

2. To ensure that safe work conditions exist, the telecommuter will allow representatives of Kaweah Delta to have prompt access to and to inspect the telecommuter's designated workplace at any reasonable time on any regularly scheduled workday. The telecommuter is responsible for setting up and maintaining an ergonomically correct workstation. Employees requiring assistance in this regard should contact Human Resources.

3. The telecommuter agrees that he or she is responsible for any tax implications related to his or her home workspace.

Telecommuter Equipment:

1. Kaweah Delta may provide the telecommuter with equipment to be used in his or her home office. The telecommuter agrees to use all equipment for its intended purpose, in accordance with the manufacturer's instructions and in a safe manner, and in accordance with the Kaweah Delta Equipment Use Security Agreement, and Acceptable Use Policy (ISS.001)

2. Kaweah Delta may install one or more telephone lines in the telecommuter's designated work space to be used by telecommuter for making and receiving business phone calls and for use with the computer and facsimile machine that may be provided by Kaweah Delta. All phone lines installed in the telecommuter's home office by Kaweah Delta shall be in the name of Kaweah Delta, unless another arrangement has been made. The telecommuter shall have no right in, or title to, Kaweah Delta phone lines.

3. Kaweah Delta shall be responsible for the installation, repair and maintenance of all District-owned telecommuting equipment, office equipment, and furniture. The telecommuter agrees to promptly notify Kaweah Delta if any of the office equipment described above malfunctions or performs improperly or unsafely.

4. All office equipment, telecommuting equipment, furniture and any other items used in the performance of Kaweah Delta business shall be located within the work space designated by the telecommuter and may be used only be authorized employees. Kaweah Delta shall not be liable for any loss, damages, or wear of any equipment, furniture, or supplies owned by the telecommuter. The telecommuter is responsible for insuring their equipment under his or her homeowner's or renter's insurance policy.

Telecommuter Internet/Intranet Access:

1. Internet or Kaweah Delta intranet access may be provided by Kaweah Delta to the telecommuter for the benefit of Kaweah Delta and its customers, vendors and suppliers. This access enables the telecommuter to connect to information and other resources within and outside Kaweah Delta.

2. When accessing Kaweah Delta's own intranet, the telecommuter agrees to do so only for business purposes. Accordingly, all such communications should be for professional, business reasons and should not be for personal use. Electronic mail may be used for non-confidential business contracts. Kaweah Delta's intranet should not be used for personal gain or advancement of individual views. Solicitation of non-Kaweah Delta business is strictly prohibited.

3. The Telecommuter will be given an Active Directory user name and password when granted access to Kaweah Delta's intranet. The Human Resources and the Information Systems department will further be able to access all Kaweah Delta computer equipment and electronic mail. All passwords issued will be kept confidential and are not be used by any other person. Any employee found to

knowingly allow their password to be used by anyone else, or who is found to be using another's password will be subject to disciplinary action up to and including termination of employment.

Equipment Ownership and Usage:

1. All telecommuting systems provided by Kaweah Delta, including the equipment and the data stored in the system, are and remain at all times, whether located on Kaweah Delta premises or even though located in the telecommuter's home or at another remote location, the property of Kaweah Delta. As a result, all messages created, sent or retrieved over Kaweah Delta's electronic mail system or via voicemail are the property of Kaweah Delta, and should be considered public information. Kaweah Delta reserves the right to retrieve and read any message composed, sent or received on Kaweah Delta's computer equipment electronic mail system or voicemail system. The telecommuter should be aware that, even when a message is erased, it is still possible to recreate the message; therefore, ultimate privacy of messages cannot be ensured. Accordingly, the telecommuter expressly consents to electronic monitoring of these systems. Furthermore, all communication including text and images can be disclosed to law enforcement or other third parties without the prior consent of the sender or receiver.

2. Kaweah Delta will provide access to all necessary programs, systems, and software necessary to perform job functions.

Telecommuter Confidentiality:

1. The telecommuter agrees that all trade secrets, confidential information, and business records that come into his or her possession, or that he or she prepares, are the property of Kaweah Delta. During his/her employment with Kaweah Delta the telecommuter agrees not to disclose, directly or indirectly, any of the trade secrets, confidential data, or business records of Kaweah Delta to any other individual or entity, including the telecommuter's family, except as required in the course of his/her employment. In addition, the telecommuter agrees not to use, directly or indirectly, any of the trade secrets, confidential data, or business records of Kaweah Delta for the benefit of any other individual or entity, including the telecommuter's family, except as required in the course of his or her employment. In furtherance of these principles, telecommuter agrees to file all business records in a locked filing cabinet or otherwise take all other steps necessary to protect the confidentiality of information.

2. The telecommuter is responsible to protect any and all Patient Health Information from disclosure to anyone that does not have a business or clinical reason to have such information.

3. Only email via Kaweah Delta email system shall be utilized for purposes of communicating patient information to and from the facility.

Telecommuter Liability for Injuries:

1. Kaweah Delta and the telecommuter agree that any injury that occurs while the telecommuter is performing work on behalf of Kaweah Delta from his/her home

office shall be covered by Kaweah Delta's Workers' Compensation insurance. The telecommuter agrees to promptly report any work-related injuries to his or her manager or Employee Health.

2. The telecommuter agrees that he or she will conduct all business meeting at Kaweah Delta's offices. The telecommuter further agrees not to invite third parties to visit his or her home office for the purpose of conducting Kaweah Delta business.

3. The telecommuter shall hold harmless and otherwise indemnify Kaweah Delta for any injuries that occur to third parties, including members of telecommuter's family, on the telecommuter's premises.

Telecommuter Harassment and Discrimination:

1. The telecommuter understands that any form of discrimination or harassment is strictly prohibited. The telecommuter further agrees to take all reasonable steps to prevent discrimination and harassment from occurring while conducting Kaweah Delta business or while acting on behalf of Kaweah Delta. The telecommuter also agrees that he or she will immediately report all instances of discrimination or harassment occurring at the telecommuter's workplace to Kaweah Delta.

Workplace Violence:

The telecommuter agrees that he or she will immediately report all instances of violence, harassment, sexual or otherwise, occurring at the telecommuter's workplace to Kaweah Delta.

Scheduled/Unscheduled System Downtime:

1. Equipment malfunction must be reported immediately to management, and if applicable, the ISS Help Desk. The technician on duty will inform the telecommuter when systems are back and running.

2. Telecommuters may not be paid for equipment/system downtime. The telecommuter must be available to work onsite during an equipment failure expected to exceed two hours, unless other arrangements are approved by management. Other options may include a flex schedule to make up this time, or used Paid Time Off at the discretion of management.

Leave of Absence or Termination of Employment:

1. Upon extended leave of absence or termination of employment, the telecommuter agrees to return or have returned Kaweah Delta-owned office equipment, furniture, business records, files and supplies.

2. The Information Systems Department will be notified immediately of the leave of absence or termination by Human Resources. The employee's access will be deactivated upon an extended leave of absence or date of termination.

1. The Department Director must review any telecommuting requests with their Vice President and the Vice President of Human Resources before telecommuting begins.

"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.236	**Date Created: 06/01/2007**
Document Owner: Dianne Cox (VP Human Resources)	**Date Approved: 04/29/2019**
Approvers: Board of Directors (Administration)	

Computer and Communication Devices and Social Media Code of Conduct

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

POLICY:

This policy applies to all those who have access to Kaweah Delta computer and electronic systems (i.e. telephones, Kaweah Delta provided cell phones required for use while working, facsimile machines, computers, laptops, iPads, electronic mail, and internet/intranet access), whether on Kaweah Delta premises or off site and regardless of employee status.

Computer Systems:

Access to Kaweah Delta's computer system is provided for business purposes. The system is not to be used for personal gain or advancement of individual views; employees need to exercise responsibility and not abuse privileges when sending or receiving messages for personal, non-business purposes. Solicitation of non-Kaweah Delta business is strictly prohibited.

Computer and Information Security:

Kaweah Delta will maintain a secure computing environment, employing appropriate procedural and technical controls designed to safeguard information and supporting technologies. Kaweah Delta provides security awareness education for staff members and implements workplace practices where staff understands their responsibilities for ensuring confidentiality and where their workflow encourages protection of information. All employees receive security awareness education during Orientation and annual through Mandatory Annual Training (MAT) e-learning. The underlying rule of information protection is 'the need to know,' i.e. one should only access information when access is required to fulfill one's responsibilities or perform an authorized and assigned business function. Access to patient records are tracked and recorded by the system. Users who violate security, confidentiality, and/or integrity of information intentionally or through carelessness will be subject to loss or restriction of use of the computer systems and/or disciplinary action up to and including termination of employment. Loss or restriction of the use of the computer systems may include loss of permanent access even if employed by another employer who has access to Kaweah Delta systems. (See AP64 Confidentiality Security and Integrity of Health Information)

Individual persons who access or use Kaweah Delta information or data are expected to fulfill certain responsibilities according to the roles they are assigned.

The expectation is to maintain a secure work area, protect computer access, to not divulge security codes or other confidential information to unauthorized persons, including to other staff members or employees of Kaweah Delta. It is expected that staff or employees will report observed or suspected breaches of information to management, Corporate Compliance, and/or to the Information Systems Services department.

Social Media:

This policy establishes the requirements for Kaweah Delta employees in accessing, opening, viewing, and posting Social Media content, videos, and/or comments about Kaweah Delta or related entities (including blogs, videos, pictures, podcasts, discussion forums, social networks, multi-media sites). Social Media sites may include, but are not limited to, Facebook, Twitter, Instagram, YouTube, LinkedIn, Snapchat, and the like.

Kaweah Delta understands that social media sites have joined the mainstream of day-to-day communications. It is expected that employees understand the impact that social media can have on Kaweah Delta's reputation, co-workers, physicians, patients, and business relationships. We emphasize the importance of common sense and good judgment. Employees are to follow the same standards that apply to other activities and behavior when communicating on social media sites or online. Employees should know that postings and communications transmitted on social media sites are not private, and thus, should consider how any communication might be perceived.

Kaweah Delta's Media Relations Department has the responsibility to manage and monitor the information on Social Media sites, and will include Human Resources, Risk Management, Corporate Compliance, and other applicable departments or individuals if violations or concerns of violations of this policy occur.

Internet Access:

Internet access is intended to support research, education and patient care, and is provided to enhance the ability to develop, design and implement improved methods for delivering patient care, information and related services. All staff are expected to use appropriate professional ethics and judgment when using internet or intranet access, including the use of Social Media, telephones and personal cell phones, including a prohibition on messaging or text messaging any Protected Health Information (PHI) or Personally Identifiable Information (PII). (See ISS.001 Information Security)

Electronic Communication Systems:

All electronic communication systems provided by Kaweah Delta, including the equipment and the data stored in the system, are and remain at all times, whether located on Kaweah Delta premises or if located at another remote location, the property of Kaweah Delta. As a result, all messages created, sent or retrieved over Kaweah Delta's electronic mail system or via voicemail are the property of Kaweah

Delta. Employees should not maintain any expectation of privacy with respect to information transmitted over, received by, or stored in any electronic communications device owned, leased, or operated in whole or in part by or on behalf of Kaweah Delta.

Kaweah Delta reserves the right to retrieve and read any message composed, sent, or received on Kaweah Delta's computer equipment, electronic mail system or voice mail system. Employees are informed that, even when a message is erased, it is still possible to recreate the message; therefore, ultimate privacy of messages should not be expected. Accordingly, employees expressly consent to electronic monitoring of these systems. Furthermore, all communications including text and images can be disclosed to law enforcement, licensing boards, or other third parties without the prior consent of the sender or the receiver. Kaweah Delta can request and require an employee to disclose their username and/or password to gain access to any Kaweah Delta-provided electronic device or software system.

Kaweah Delta Issued Mobile Devices:

Only those individuals with a justifiable need, as determined by department leadership and the Director of ISS Technical Services, shall be issued Kaweah Delta devices (i.e. phone, smartphone, tablet, laptop) and/or mobile voice and text/data services for the purpose of conducting business on behalf of Kaweah Delta. The individual using Kaweah Delta-owned devices is required to sign the "KDHCD Equipment Use and Information Technology Security Agreement" at the time they are issued a device. The device must be kept in the employee's personal possession at all times. Kaweah Delta may rescind the agreement and require the return of any devices at any time. When employment ends at Kaweah Delta, all devices must be returned by the last day of work. Failure to return all property to Kaweah Delta in the same working condition that it was received may be considered theft of property and may lead to criminal prosecution.

Mobile phones may not be used while driving unless hands-free capability is utilized. This applies to use of the employee's personal vehicle and/or the use of Kaweah Delta vehicles while on Kaweah Delta business.

PROCEDURE:

Electronic Communication:

1. Internet or the Kaweah Delta intranet access may be provided by Kaweah Delta to employees for the benefit of Kaweah Delta and its customers, vendors and suppliers. This access enables the employee to connect to information and other resources within or outside of Kaweah Delta. Contract services staff who work at Kaweah Delta may be given access to the computer system and must comply with all provisions of this policy.

   The employee will be given a password when granted access to Kaweah Delta's computer systems. The employee must change passwords to these systems when prompted to do so as define in Policy ISS.003. Because the system may need to be accessed by Kaweah Delta, the Human Resources, Compliance, and Information Systems departments will further be able to

access all Kaweah Delta computer equipment and electronic mail. Any employee found to knowingly allow their password to be used by anyone else, or who is found to be using another's password will be subject to disciplinary action up to and including termination of employment.

2. When accessing the internet or Kaweah Delta's own intranet, employees agree to do so for business purposes. Accordingly, such communications should be for professional and business reasons; personal use must be limited to what may be considered regular break times.

3. All staff are expected to use appropriate professional ethics and judgment when using internet or intranet access, including the use of Social Media, Kaweah Delta provided cell phones, and telephones and personal cell phones, including a prohibition on messaging or text messaging any PHI or PII related information. Employees are expected to maintain employee, patient, customer, medical staff, and volunteer confidentiality (PHI and PII). (See ISS.015 Use of Portable Devices to "Text" ePHI or KDHCD Proprietary Data) Employees may not post any material that is obscene, defamatory, profane, libelous, threatening, harassing, abusive, hateful, or embarrassing to another person or Kaweah Delta when posting to sites. This policy applies to employees using Social Media while at work. It also applies to the use of Social Media when away from work, when the employees' or medical staffs' Kaweah Delta affiliation is identified, known, or presumed. If employees acknowledge their relationship with Kaweah Delta in an online community, they must include disclaimers in their online communications advising that they are not speaking officially on behalf of Kaweah Delta.

4. Unless an individual is serving as an approved, official spokesperson for Kaweah Delta in online communications, such communications are the individual's personal opinions and do not reflect the opinion of Kaweah Delta. Employees are personally responsible for his/her posts (written, audio, video, or otherwise). Communications must not contain Kaweah Delta confidential, proprietary or trade-secret information.

5. Kaweah Delta urges employees to report any violations or possible or perceived violations to supervisors, managers or the HR Department or Compliance Department. Violations include discussions of Kaweah Delta and its employees and clients, any discussion of proprietary information, and any unlawful activity related to blogging or social networking. Inappropriate use shall be subject to disciplinary action, up to, and including, termination. In addition, breach of patient information may also be subject to legal proceedings and/or criminal charges. (See HR.216 Progressive Discipline policy)

6. All employees who have access to computer information will sign an Agreement. In addition, employees will be required to sign certain other Agreements that apply to their position. The electronic copy of these Agreements will be kept in ISS.

Employee Harassment and Discrimination:

1. Any form of discrimination or harassment is strictly prohibited and employees must take all reasonable steps to prevent discrimination and harassment from occurring while conducting business or while acting on behalf of Kaweah Delta. No messages with derogatory or inflammatory remarks about an individual or group's age, disability, gender, race, religion, national origin, physical attributes, sexual preference or any other classification protected by Federal, State or local law may be transmitted using any type of telecommunications technology.

2. Employees must immediately report all instances of discrimination or harassment to Kaweah Delta. Please refer to HR.13 Anti-Harassment policy.

3. Nothing in this policy is intended to prohibit employees from communicating with co-workers about the terms and conditions of their employment.

Termination of Employment:

Upon termination of employment, the Information Systems Services Department will be notified immediately by Human Resources. The employee's password and all accounts will be deactivated. All Kaweah Delta devices, equipment, and other property must be returned by the last day of on-site work. Failure to return all property to Kaweah Delta in the same working condition that it was received may be considered theft of property and may lead to criminal prosecution.

"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: HR.234	Date Created: 06/01/2007
Document Owner: Dianne Cox (VP Human Resources)	Date Approved: 05/08/2019
Approvers: Board of Directors (Administration), HR Advisory Committee	

Paid Time Off (PTO), Extended Illness Bank (EIB) and Healthy Workplace, Healthy Families Act of 2014

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

POLICY:

Paid Time Off (PTO), Extended Illness Bank (EIB) and Healthy Workplace, Healthy Families Workplace Act of 2014 – Paid Sick Leave (PSL) benefits are offered to all employees as defined in this policy. PTO is offered to full-time and part-time eligible employees for leisure, celebration of holidays, short-term illness and other personal needs. EIB is offered to full-time and part-time eligible employees for extended illness and Kin Care. Private Home Care staff, temporary staff/interims and Per Diem staff are not eligible for PTO or EIB but are eligible for Paid Sick Leave (PSL) as defined in this policy. Excessive occurrences of unapproved time off may result in disciplinary action. See Policy HR.184 Attendance and Punctuality.

PROCEDURE:

Eligibility and Accrual for PTO and EIB

Full-time and benefited part-time employees are eligible to receive PTO and EIB. If an eligible employee is changed to a non-eligible status, the PTO and EIB time accrual will cease. The employee will receive a lump-sum payment for all accrued PTO paid at 100% of their hourly rate of pay prior to the status change. During the non-eligible status, the employee will accrue PSL.

If a non-eligible employee is changed to an eligible status, the employee begins accruing PTO and EIB as of the first pay period in which the status change became effective; PSL accrual will cease. At no time will an employee accrue PTO and EIB as well as PSL. An employee accrues either PTO and EIB or PSL.

The rate of PTO and EIB accrual received is based on qualified service hours. Qualified service hours which count toward the accrual rate include the following: regular hours worked (non-overtime), Blood Donation, Education Reduced Shift, Flex Time Off, PTO FMLA, PTO unscheduled, PTO/PSL, PTO Sick/Pregnancy, PTO Holiday, PTO/Workers Compensation, Sitter Pay, Sleep Pay, PTO hours, bereavement hours, jury duty hours, training/workshop hours, orientation hours, and mandatory dock hours. Neither EIB nor PTO accruals will be earned while employees are being paid EIB hours.

Eligibility and Accrual for PSL

PSL eligible employees include Per-Diem, Private Home Care, and Part-Time non-benefit eligible employees. PSL eligible employees will accrue at the rate of one hour per every 30 hours worked (.033333 per hour); accrual begins as of the first pay period. A new employee is entitled to use PSL beginning on the first day of employment. Employees are limited to 24 hours of use of accrued time in each 12-month rolling period. PSL will carry over to the following calendar year not to exceed 48 hours of accrual in any calendar year.

Description	Service Hours	Approximate Yrs. of Service required to obtain this rate	**Earned 1st Pay Period:** Accrual (8 & 10hrs up to 80 eligible hrs a pp) (12hrsup to 72 eligible hrs a pp)	**Earned at 520 Eligible Hours of Employment:** Additional Accrual earned on up to 72 eligible hours a pp.
8hr, 10hr, FT & PT Staff	0	5 years	.038461 (80) – Accrual rate during first 90 days in eligible status	.051282 (96hrs)
8hr, 10hr, FT & PT Staff	10400	5 – 10 years	.057692 (120)	.051282 (96hrs)
8hr, 10hr, FT & PT Staff	20800	10+ years	.076923 (160)	.051282 (96hrs)
12hr FT & PT Staff	0	5 years	.038461 (72)	.051282 (96hrs)
12hr FT & PT Staff	9360	5 – 10 years	.057692 (108)	.051282 (96hrs)
12hr FT & PT Staff	18720	10+ years	.076923 (144)	.051282 (96hrs)

Maximum Accruals

The Maximum PTO accrual allowed is 400 hours. The accrual will cease once the maximum accrual is reached until PTO hours are used or cashed out. The maximum EIB accrual is 2000 hours; the maximum PSL accrual is 48 hours in a calendar year. No Payment is made for accrued EIB or PSL time when employment with Kaweah Delta ends for any reason.

Requesting, Scheduling, and Access to PTO, EIB and PSL

Routine unpaid time off is not allowed. Any requests for unpaid time should be considered only on a case-by-case basis taking into consideration the need for additional staffing to replace the employee and other departmental impacts. It is the responsibility of management to monitor compliance. Employees should be aware that unpaid time off could potentially affect their eligibility for benefits.
In addition, any request for PTO time, whether for traditional holiday, for vacation time, or otherwise must be approved in advance by management. Management will consider the employee's request as well as the needs of the department. In unusual circumstances, management may need to change the PTO requests of employees based upon the business and operational needs of Kaweah Delta. In such situations, Kaweah Delta is not responsible for costs employees may incur as a result of a change in their scheduled PTO time.

AB 1522 Healthy Workplace Healthy Families Act of 2014

An employee may utilize up to 24 hours of PTO or PSL in a rolling 12-month period for the following purposes:

a) Diagnosis, care, or treatment of an existing health condition, or preventative care for, an employee or an employee's family member, as defined as employee's parent, child, spouse, registered domestic partner, grandparent, grandchild, and siblings.

b) "Family Member" means any of the following:
    i. A child, which for purposes of this policy means a biological, adopted or foster child, stepchild, legal ward, or a child to whom the employee stands in loco parentis; this definition of child is applicable regardless of age or dependency status.
    ii. A biological, adoptive, or foster parent, stepparent, or legal guardian of an employee or the employee's spouse or registered domestic partner, or a person who stood in loco parentis when the employee was a minor child.
    iii. A spouse
    iv. A registered domestic partner
    v. A grandparent
    vi. A grandchild
    vii. A sibling

c) For an employee who is a victim of domestic violence, sexual assault or stalking, as specified.

There is no cash out provision for the PSL accrual, including upon termination of employment or with a status change to a benefit eligible position. However, if an employee separates from Kaweah Delta and is rehired within one year, previously accrued and unused PSL will be reinstated.

PSL and PTO time shall be utilized at a minimum of 2-hour increments and no more than the length of the employee's shift.

PTO and PSL time taken under this section is not subject to the Progressive Discipline Policy HR.216.

Time Off Due To Extended Illness

Employees who are absent due to illness for more than three (3) consecutive work days should notify their manager and contact the Human Resources Department to determine if they are eligible for a leave of absence. Accrued EIB can be utilized for an approved continuous leave of absence beyond 24 hours and on the first day of surgery in an acute-care or outpatient surgery center or admission to the hospital.

Employees who are absent due to illness for more than seven (7) consecutive days should file a claim for California State Disability Insurance. Claim forms are available in Human Resources. State Disability payments will be supplemented with any accrued EIB time by the Payroll Department, and PTO at the employee's request.

Time Off Due to Kin Care

Kin Care allows eligible employees to use up to one-half (1/2) of the Extended Illness Bank (EIB) that they accrue annually in a rolling 12 months to take time off to care for a sick family member. Only employees who accrue EIB are eligible for Kin Care. No more than one-half of an employee's EIB accrual in a rolling 12-month period can be counted as Kin Care. For example, for full-time employees this would mean no more than 24 hours can be utilized as Kin Care in a rolling 12-month period. An employee must have EIB available to use on the day of the absence for that absence to be covered under Kin Care. An employee who has exhausted his/her EIB and then is absent to care for a sick family member cannot claim that absence under Kin Care. Kin Care can be used to care for a sick family member, to include a spouse or registered domestic partner, child of an employee, "child" means a biological, foster, or adopted child, a stepchild, a legal ward, a child of a domestic partner, or a child or a person standing in loco parentis, parents, parents-in-law, siblings, grandchildren and grandparents. A Leave of Absence form does not need to be submitted unless the employee will be absent and use sick leave for more than three continuous workdays. In addition, an employee taking Kin Care does not need to submit a doctor's note or medical certification. However, in instances when an employee has been issued Disciplinary Action and directed to provide a doctor's note for all sick days, then an employee may need to submit a doctor's note.

EIB time taken under this section to care for an immediate family member is not subject to the Progressive Discipline Policy HR.216.

Holidays

Kaweah Delta observes 72 holiday hours each year. Eligible employees may be scheduled a day off and will be paid provided adequate accrual exists within their PTO bank account for each observed holiday. Time off for the observance of holidays will always be in accordance Kaweah Delta needs.

New Year's Day (January 1st)
President's Day (Third Monday in February)
Memorial Day (Last Monday in May)
Independence Day (July 4th)
Labor Day (First Monday in September)
Thanksgiving Day (Fourth Thursday in November)
Friday following Thanksgiving Day (Friday following Thanksgiving)
Christmas Day (December 25th)
Personal Day

Business departments and/or non-patient care areas will typically be closed in observance of the noted holidays. Where this is the case, employees assigned to and working in these departments will be scheduled for a day off on the day the department is closed. Employees affected by department closures for holidays should maintain an adequate number of hours within their PTO banks to ensure that time off is with pay.

In the first 90 days of employment, benefit eligible employees who have not accrued sufficient PTO to cover holidays may be paid and their PTO accrual bank will go into the negative, until accrual is earned back in successive pay periods, unless otherwise specified by the employee.

In business departments and/or non-patient care areas, holidays, which fall on Saturday, will typically be observed on the Friday proceeding the actual holiday and holidays, which fall on Sunday, will be observed on the Monday following the actual holiday.

Employees who work hours on some of these holidays may be eligible for holiday differential. For more information of eligibility, see policy HR.75 Differential Pay-Shift, Holiday, and Weekend.

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CHIEF OF STAFF AGREEMENT
BETWEEN
KAWEAH DELTA HEALTH CARE DISTRICT
AND
BYRON MENDENHALL, M.D.

This Chief of Staff Agreement ("**Agreement**"), is entered into effective **July 1, 2019,** by and between **KAWEAH DELTA HEALTH CARE DISTRICT** ("**District**"), a local health care district organized and existing under the laws of the State of California, Health and Safety Code §§ 32000 *et seq*. and **BYRON MENDENHALL, M.D.** ("**Physician**"):

RECITALS

A. District owns and operates acute care hospital facilities (acute hospital, acute rehabilitation, skilled nursing facility, mental health center and outpatient programs) ("**Hospital**") located in Visalia, California, which serve communities in and around Tulare County, California (the "**Service Area**").

B. District desires to retain Physician to serve as the Chief of Staff as required by The Joint Commission and District Medical Staff Bylaws, Article 7, Section 8.2 ("**Services**"), and Physician desires to provide those Services all upon the terms and conditions stated below.

AGREEMENT

In consideration of the mutual agreements set out below, the parties agree as follows:

Article 1. Term and Termination.

1.1 This Agreement shall be effective as of **July 1, 2019** ("**Effective Date**"). Unless sooner terminated, this Agreement shall expire and be of no further force and effect as of **June 30, 2021**.

1.2 Either party may terminate this Agreement, without cause, by providing not less than thirty (30) days' prior written notice stating the intended date of termination. Following a termination pursuant to this Section 1.2, the parties shall not enter into another agreement or reinstate this Agreement for the Services on different financial terms within one (1) year of the Effective Date or any subsequent amendment of the financial terms, whichever date is later.

1.3 Either party may terminate this Agreement at any time in the event the other party engages in an act or omission constituting a material breach of any term or condition of this Agreement. The party electing to terminate this Agreement pursuant to this Section shall first provide the breaching party with not less than ten (10) days' written notice specifying with reasonable certainty the nature and extent of the material breach. The breaching party shall then have ten (10) days from the date of the notice in which to remedy the breach and conform its conduct to this Agreement. If such corrective action is not taken within the time specified, this Agreement shall terminate at the end of the ten (10) day period without further notice or demand.

1.4 District may terminate this Agreement immediately upon any of the following events:

1.4.1 Upon District's loss of certification as a Medicare provider;

1.4.2 Upon the death or permanent disability of Physician;

1.4.3 Upon revocation or suspension of Physician's license to practice medicine in the State of California;

1.4.4 Upon Physician's resignation from the District's Medical Staff;

1.4.5 Upon expulsion or suspension of Physician from District's or any other medical staff; or

1.4.6 If Physician becomes excluded, debarred or otherwise ineligible to participate in federal health care programs or in federal procurement or non-procurement programs, or if Physician is convicted of a crime.

1.5 **Survival**. Upon any termination of this Agreement, neither party shall have further rights against, or obligations to, the other party except with respect to any rights or obligations accruing prior to the date and time of termination and any obligations, promises or arrangements which expressly extend beyond the termination, including, but not limited to, the following: Section 1.2 (Term and Termination); Section 4.2.11 (Books and Records); Section 4.4 (Confidentiality); Section 7 (Indemnification); Section 8.6 (Dispute Resolution); and Section 8.11 (HIPAA).

Article 2. Appointment. Physician is hereby designated as **CHIEF OF STAFF**, subject to the recommendation of the MEC ***and*** the approval of District's Board of Directors.

Article 3. Independent Contractor Relationship. The parties acknowledge that (i) Physician shall be an independent contractor with respect to District, (ii) this Agreement is not a contract of employment within the meaning of California Labor Code § 2750 and that Physician is not an employee of District for any purpose, (iii) nothing contained in this Agreement shall be construed to create a partnership, agency or joint venture between District and Physician or to authorize either District or Physician to act as a general or special agent of the other in any respect, except as may be specifically set forth in this Agreement, and (iv) District shall have no obligation under this Agreement to compensate or pay applicable taxes for, or provide employee benefits of any kind to or on behalf of Physician or any person employed or retained by Physician.

Article 4. Physician's Obligations.

4.1 **Organizational Status**. Physician represents and warrants that Physician is:

4.1.1 An individual health care provider duly licensed to practice medicine in the State of California;

4.1.2 Free to enter into this Agreement, and not violating any terms of any other agreement between Physician and any third party by entering into this Agreement;

4.1.3 Not an excluded, debarred or suspended provider for any federal health care program, federal procurement program or of the U.S. Food and Drug Administration.

4.2 **Time Commitment**. Physician shall expend the time as necessary to perform the duties and obligations required of the Chief of Staff, including availability to members of Medical Staff and other staff in connection with the performance of Services and performance of the following undertakings:

4.2.1 **Key Responsibilities**. Physician shall:

4.2.1.1 Act in coordination and in cooperation with District's Chief Executive Officer in all matters of mutual concern within the Hospital and Service Area.

4.2.1.2 Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff and MEC.

4.2.1.3 Serve as an *ex officio* member of all other Medical Staff Committees without vote, unless a Chief of Staff membership in a particular committee is required by the Medical Staff Bylaws.

4.2.1.4 Enforce the Medical Staff Bylaws, Rules and Regulations, conduct or coordinate investigations, implement sanctions where indicated, and promote compliance with procedural safeguards where corrective action has been requested or initiated.

4.2.1.5 Appoint a chairperson and approve members of all Standing, Special or Multidisciplinary Medical Staff Committees except the MEC, where each clinical department shall select its particular chief and departmental committees.

4.2.1.6 Represent the views, policies, needs and grievances of the Medical Staff to the governing body and to District's Chief Executive Officer.

4.2.1.7 Be the spokesperson for the Medical Staff in its external professional and public relations.

4.2.1.8 Recommend the removal of the chair of any Standing, Special or Multidisciplinary Medical Staff Committee with concurrence by vote of the MEC.

4.2.1.9 Perform such other functions as may be assigned to Chief of Staff by the Medical Staff Bylaws, the Medical Staff or by the MEC.

4.2.1.10 Serve on liaison committees with District's Board of Directors and administration, as well as outside licensing or accreditation agencies.

4.2.1.11 Appoint Medical Staff representatives, as needed, to participate in hospital infection control, internal and external disaster planning, pharmacy and therapeutics, hospital safety review and risk management activities.

4.2.1.12 Attend all Board meetings, representing the Medical Staff as their designated spokesperson, and attend the Joint Planning, Facilities Task Force and Quality Council Board Committee meetings and such other meetings of the Board, as requested by the President of the Board, where Medical Staff input is deemed necessary and appropriate.

4.2.1.13 Receive and interpret the policies of the governing body on behalf of the Medical Staff and report to the governing body on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care.

4.2.1.14 Be responsible for the educational activities of the Medical Staff.

4.2.2 The Services shall be conducted during such days and times as are necessary in order to properly address patient needs and effectively coordinate with other operations. The parties anticipate that Physician shall provide **twenty (20) hours per month** in performance of the Services.

4.2.3 Physician shall at all times keep and maintain a valid license to engage in the practice of medicine in the State of California and Medical Staff membership and/or privileges as may be required under the Bylaws of District for Physician to provide the services contemplated by this Agreement.

4.2.4 Physician shall prepare such administrative and business records and reports related to the Services in such format and upon such intervals as District may require.

4.2.5 Physician shall furnish any and all information, records and other documents related to Physician's service hereunder which District may request in furtherance of its quality assurance, utilization review, risk management and any other plans and/or programs adopted by District to assess and improve the quality and efficiency of District's services. As reasonably requested, Physician shall participate in one or more of such plans and/or programs.

4.2.6 Physician shall assist District in obtaining and maintaining any and all licenses, permits and other authorizations, plus achieving accreditation standards, which are dependent upon, or applicable to, in whole or in part, Physician's services under this Agreement.

4.2.7 Physician shall inform District of any other arrangements which may present a conflict of interest or materially interfere in Physician's performance of duties under this Agreement. In the event Physician pursues conduct which does in fact constitute a conflict of interest or which materially interferes with (or is reasonably anticipated to interfere with) Physician's performance under this Agreement, District may exercise its rights and privileges under Section 1.

4.2.8 Physician shall not enter into any contract in the name of the District or otherwise bind District in any way without the express consent of District because Physician does not have the right or authority.

4.2.9 Physician shall perform all services under this Agreement in accordance with any and all requirements and accreditation standards applicable to District and the Service, including, without limitation, those requirements imposed by The Joint Commission, the Medicare/Medicaid conditions of participation and any amendments thereto.

4.2.10 Physician shall comply with the bylaws, rules and regulations, policies and directives of District and the Medical Staff.

4.2.11 To the extent required by law, upon written request of the Secretary of Health and Human Services, the Comptroller General or any of their duly authorized representatives, Physician shall make available those contracts, books, documents and records necessary to verify the nature and extent of the costs of providing services under this Agreement. Such inspection shall be available for up to four (4) years after the rendering of such services. If Physician carries out any of the duties of this Agreement through a subcontract with a value of ten thousand dollars ($10,000.00) or more over a twelve (12) month period with a related individual or organization, Physician agrees to include this requirement in any such subcontract. This Section is included pursuant to and is governed by the requirements of 42 C.F.R. Sections 300-304. No attorney-client, accountant-client or other legal privilege shall be deemed to be waived by District or Physician by virtue of this Agreement.

4.2.12 Physician shall not use any part of District premises for any purpose other than the performance of Services under this Agreement. Without limiting the generality of the foregoing, Physician agrees that no part of District premises shall be used at any time as an office for private practice and delivery of care for non-District patients. This provision shall not, however, be construed as prohibiting Physician from maintaining an office for private practice at any professional building owned by District or any of its affiliates.

4.2.13 Physician shall comply with all District policies, procedures and codes of conduct ("**Standards**"), sign and adhere to any disclosures or attestations related to District's compliance program; and participate in and support the compliance program. With respect to Physician's business dealings with District and performance of the Services, Physician shall not act in any manner that conflicts with or violates the Standards, nor cause another person to act in any manner that conflicts with or violates the Standards. Physician shall comply with the Standards (as they may be revised in the future), as they relate to Physician's business relationship with District and its affiliates, employees, agents, contractors and suppliers.

4.2.14. Physician shall also perform the following CMO Duties:

4.2.14.1 Leads and guides quality improvement efforts throughout the District.

4.2.14.2 Assists in the development and implementation of the District clinical information systems to optimize data collection and reporting for performance improvement initiatives.

4.2.14.3 Prioritizes, distributes and/or makes determinations to process all of the above CMO Duties with appropriate resources (e.g., Medical Director for Quality, Credentials, Nursing, Management, etc.) to address Medical Staff issues, concerns and operations.

4.2.14.4 Be available for consultations and recommendations for action and direction to manage the activities of the Medical Staff.

4.2.15. In performing the CMO Duties under Section 4.2.14 of this Agreement, Physician may delegate in writing certain of the CMO Duties to one or more Officers of the Medical Staff who accept the responsibility to perform the delegated duties. A copy of the written delegation shall be provided to the Officer performing the delegated duties under this Section, the Chief Operating Officer of the District and the District Director of Medical Staff Services. Physician shall remain responsible for the performance of the delegated duties by the Officer, and may modify the scope of the delegation or terminate the delegation at any time and for any reason. The compensation terms, if any, for the performance of any delegated duties under this Section shall be solely between Physician and the Officer, and the Officer shall not seek payment from the District for performing any of the delegated duties. Nothing in this Section 3 shall require Physician to delegate any of the CMO Duties nor limit the scope or recipient of any delegation.

4.3 **Notification of Certain Events**. Physician shall notify District, in writing, within twenty-four (24) hours of the occurrence of any of the following: (i) Physician becomes the subject of, or otherwise materially involved in, any government investigation of Physician's business practices, the provision of Services pursuant to this Agreement or the provision of professional services, including, without limitation, being served with a search warrant in connection with such activities; (ii) Physician's Medical Staff membership or clinical privileges at any hospital are denied, suspended, restricted, revoked or voluntarily relinquished, regardless of the availability of civil or administrative hearing rights or judicial review with respect thereto; (iii) Physician becomes the subject of any suit, action or other legal proceeding arising out of Physician's professional services and/or the Services provided pursuant to this Agreement; (iv) Physician is required to pay damages or any other amount in any professional liability (malpractice) action by way of judgment or settlement; (v) Physician becomes the subject of any disciplinary proceeding or action before any state's medical board or similar agency responsible for professional standards or behavior; (vi) Physician

becomes incapacitated or disabled from providing the Services, or voluntarily or involuntarily retires from the practice of medicine; (vii) Physician's license to practice medicine in the State of California is restricted, suspended or terminated, regardless of the availability of civil or administrative hearing rights or judicial review with respect thereto; (viii) Physician changes his medical specialty; (ix) Physician is charged with or convicted of a criminal offense other than one classified by law as an infraction; (x) Physician's federal Drug Enforcement Agency ("DEA") Number is revoked; (xi) any event or occurrence which has a material adverse effect on Physician's ability to perform any or all of the Services under this Agreement; or, (xii) Physician is debarred, suspended or otherwise ineligible to participate in any federal or state health care program.

4.4 **Confidentiality**. Physician acknowledges that Physician shall have (i) access to confidential information ("**Confidential Information**") concerning District's business and (ii) a duty at all times not to use such information in competition with District or to disclose such information or permit such information to be disclosed to any other person, firm, corporation, entity or third party, during the term of this Agreement or at any time thereafter. For purposes of this Agreement, "Confidential Information" shall include, without limitation, any and all secrets or confidential technology, proprietary information, customer or patient lists, trade secrets, records, notes, memoranda, data, ideas, processes, methods, techniques, systems, formulas, patents, models, devices, programs, computer software, writings, research, personnel information, customer or patient information, plans or any other information of whatever nature in the possession or control of District that is not generally known or available to members of the general public or the medical profession, including any copies, worksheets or extracts from any of the above. Physician further agrees that if this Agreement is terminated for any reason, Physician shall neither take nor retain, without prior written authorization from District, originals or copies of any records, papers, programs, computer software, documents, x-rays or other imaging materials, slides, medical data, medical records, patient lists, fee books, files or any other matter of whatever nature which is or contains Confidential Information. This Section shall survive the termination or expiration of this Agreement.

Article 5. District's Obligations. District shall perform the following undertakings:

5.1 **Compensation**. District shall compensate Physician for the performance of Physician's obligations, as identified in Section 4 pursuant to this Agreement, as follows:

5.1.1 **Monthly Compensation.** District shall disburse the sum of **six thousand five hundred dollars ($6,500.00)** per month for the Services rendered to and during the term of this Agreement. Compensation for Physician's performance in accordance with this Agreement is limited annually to **seventy-eight thousand dollars ($78,000.00).** The parties agree that **$2,500.00** of the monthly amount shall be for the performance of the duties as specified in Section 4.2.1 to 4.2.13, and **$4,000.00** of the monthly amount shall be for the performance of the CMO Duties as specified in Section 4.2.14.

5.1.2 **Additional Compensation from Medical Staff**. Physician shall receive corresponding monthly compensation from Kaweah Delta's Medical Staff. The Medical Staff shall disburse the sum of **one thousand six hundred sixty-six dollars and sixty-seven cents ($1,666.67)** per month for Services rendered during the term of this Agreement. However, both parties understand the aforementioned additional compensation is disbursed exclusively at Medical Staff's discretion, and Physician does not have any recourse or claim to such compensation by this Agreement or through Kaweah Delta. Additional Compensation from Medical Staff is limited annually to twenty thousand dollars ($20,000.00)."

5.2 **Facilities and Services Provided by District**.

5.2.1 District shall provide on District premises the space designated by District for the Services, plus any expendable supplies, equipment and services necessary for the proper operation of the Services. The minimum services to be provided by District are janitor, standard facility telephone, laundry and utilities.

5.2.2 District shall employ all non-physician technical and clerical personnel it deems necessary for the proper operation of the Services. Physician shall direct and supervise the technical work and services of such personnel. However, District retains full administrative control and responsibility for all such personnel.

5.2.3 District shall provide Physician with a cellular telephone for Physician's use in providing the Services. District shall pay the cost of a coverage plan for the cellular telephone. If the coverage plan provides a fixed number of monthly minutes, Physician shall reimburse District for any incidental personal minutes that exceed the monthly allowance (e.g., if the allowance is 100 minutes, the monthly use is 105 minutes and the incidental personal use is 10 minutes, Physician shall reimburse District for 5 minutes). The parties further agree that the cellular telephone is and shall remain the property of District, and shall be returned to District promptly without further use upon the termination of this Agreement.

5.3 **Insurance**. District, at its sole cost and expense, shall provide insurance coverage in amounts satisfactory to Physician with respect to Physician's administrative duties under this Agreement. It is understood by both parties that District is self-insured for professional and public liability.

5.4 **District's Professional and Administrative Responsibilities**. To the extent required by Title 22, California Code of Regulations § 70713, District retains professional and administrative responsibility for the Services rendered by Physician pursuant to this Agreement. District's retention of these responsibilities shall not alter or modify, in any way the hold harmless, indemnification, insurance or independent contractor provisions set forth in this Agreement. Physician shall apprise District's Vice President responsible for the administrative oversight of the Services of recommendations, plans for implementation and continuing assessment through dated and signed reports, which shall be retained by District's Vice President responsible for the administrative oversight of the Services for follow-up action and evaluation of performance.

Article 6. Change of Circumstances. In the event (i) Medicare, Medicaid, any third party payor or any federal, state or local legislative or regulatory authority adopts any law, rule, regulation, policy, procedure or interpretation thereof which establishes a material change in the method or amount of reimbursement or payment for services under this Agreement, or if (ii) any or all such payors/authorities impose requirements which require a material change in the manner of either party's operations under this Agreement and/or costs related thereto, then, upon the request of either party materially affected by any such change in circumstances, the parties shall enter into good faith negotiations for the purpose of establishing such amendments or modifications as may be appropriate in order to accommodate the new requirements and change of circumstances while preserving the original intent of this Agreement to the greatest extent possible. If, after thirty (30) days of such negotiations, the parties are unable to reach an agreement as to how or whether this Agreement shall continue, then either party may terminate this Agreement upon thirty (30) days' prior written notice.

In the event the District appoints a new Chief Medical and Qualify Officer, or other position that will have the responsibility to perform the CMO Duties, Section 4.2.14 shall be deemed terminated and compensation terms in Section 5.1.1 amended upon the date specified in a written notice from District to Physician without the

necessity of a signed, written amendment to the Agreement.

Article 7. Indemnification. Each party shall defend, indemnify and hold the other party, its officers, Physicians, employees and agents harmless from and against any and all liability, loss, expense, attorneys' fees or claims for injury or damages arising out of its own performance of this Agreement but only in proportion to and to the extent such liability, loss, expense, attorneys' fees or claims for injury or damages are caused by or result from the negligent acts or omissions of itself, its officers, Physicians, employees or agents. This Section shall survive the expiration or earlier termination of this Agreement.

Article 8. Miscellaneous Provisions.

8.1 **Notice**. Notice to either party may be given by the other party, in writing, personally delivered, or deposited in the United States mail, postage prepaid and addressed to the appropriate party, as follows:

If to District:
Kaweah Delta Health Care District
Attn: Tom Rayner (SVP and COO)
400 West Mineral King Avenue
Visalia, California 93291-6263

If to Physician:
Byron Mendenhall, M.D.
400 West Mineral King Avenue
Visalia, California 93291

With copy to both of the following:
Kaweah Delta Health Care District
Attn: Ben Cripps, Kaweah Delta Compliance Officer
400 West Mineral King Avenue
Visalia, California 93291-6263

Law Offices Lynch & Tanner
Post Office Box 2685
Visalia, California 93279-2685

8.2 **Entire Agreement**. This Agreement contains the entire agreement of the parties hereto and supersedes all prior agreements, contracts and understandings, whether written or otherwise, between the parties relating to the subject matter hereof. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

8.3 **Partial Invalidity**. In the event any provision of this Agreement is found to be legally invalid or unenforceable for any reason, the remaining provisions of the Agreement shall remain in full force and effect provided the fundamental rights and obligations remain reasonably unaffected.

8.4 **Assignment**. Because this is a personal service contract, Physician may not assign any of its rights or obligations hereunder without the prior written consent of District. District may assign this Agreement to any successor to all, or substantially all, of District's operating assets or to any affiliate of District. This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective successors and permitted assigns.

8.5 **Regulatory Requirements**. The parties expressly agree that nothing contained in this Agreement shall require Physician to refer or admit any patients to, or order any goods or services from, District. Notwithstanding any unanticipated effect of any provision of this Agreement, neither party shall knowingly or intentionally act in such a manner as to violate the prohibition against fraud and abuse in connection with the Medicare and Medicaid programs (42 U.S.C. Section 1320a-7b).

8.6 **Dispute Resolution**. The parties desire to resolve all disputes arising hereunder without resort to litigation in order to protect their respective business reputations and the confidential nature of their

relationship. Accordingly, any controversy or claim arising out of or relating to this Agreement, or breach thereof, shall first be addressed by and between Physician and the District's Vice President responsible for the administrative oversight of the Services. If still unresolved to the mutual satisfaction of the parties, the dispute shall be referred to the MEC for recommendation to District's Board of Directors for final resolution. The Board of Directors shall, within a reasonable time, notify Physician of its decision with regard to any matter submitted to it with a recommendation by MEC in accordance with the requirements of this Section. The parties expressly agree litigation may not be commenced regarding the terms and conditions of this Agreement or any controversy or dispute hereunder unless and until the contractual procedures and remedies described in this Section are exhausted.

8.7 **Third Party Beneficiaries**. This Agreement is entered into for the sole benefit of District and Physician. Nothing contained herein or in the parties' course of dealing shall be construed as conferring any third party beneficiary status on any person or entity not a party to this Agreement.

8.8 **Governing Law**. This Agreement shall be governed by the laws of the State of California.

8.9 **Approvals**. Neither this Agreement nor any amendment of or modification hereto shall be effective or legally binding upon any officer, Physician, employee or agent of District thereof, unless and until it has been reviewed and approved in writing by a Vice President of District and District's Legal Counsel.

8.10 **Attorneys' Fees**. If any legal action at law or in equity, or any arbitration proceeding, is brought for the interpretation or enforcement of this Agreement or any part hereof, or because of an alleged dispute, breach, default or misrepresentation in connection with any of the provisions of this Agreement, the prevailing party shall be entitled to recover its reasonable attorneys' fees and other costs incurred in that action or arbitration proceeding, in addition to any other relief to which it may be entitled.

8.11 **HIPAA**. For the purposes of compliance with the privacy provisions of the Health Information Portability and Accountability Act of 1996 (HIPAA), Physician's relationship with District may be considered as that of "Business Associate." As used hereunder, the terms "Business Associate," "Protected Health Information," "use," and "disclosure" shall have the meanings ascribed to them in 42 C.F.R. Section 164.101 and 164.501. If Physician is a "Business Associate," then Sections 8.11.1 through 8.11.9 shall apply:

8.11.1 Physician agrees to conduct business with District in accordance with all applicable laws and regulations, including HIPAA and the regulations promulgated thereunder. Physician further agrees to comply with all policies and procedures adopted by District related to use and disclosure of Protected Health Information.

8.11.2 Disclosure by District to Physician of any Protected Health Information shall be made for the sole purpose of helping District carry out its healthcare functions and to allow Physician to perform the Service obligations pursuant to this Agreement. Protected Health Information shall not be disclosed for independent use by Physician. Physician represents and warrants that Protected Health Information shall be used only to complete the Service obligations pursuant to this Agreement, and as may otherwise be required by law.

8.11.3 Physician represents and warrants that all Protected Health Information shall be safeguarded and protected from misuse and/or disclosure, and that upon Physician's knowledge of any misuse or improper disclosure of such Protected Health Information, Physician shall take immediate steps to stop such impermissible use or disclosure and to prevent further dissemination and misuse of such Protected Health Information. Physician further represents and warrants any use or

disclosure of Protected Health Information not provided for by this Agreement shall be immediately reported to District when Physician becomes aware.

8.11.4 Any breach by Physician of the obligations under the confidentiality provisions of this Agreement and/or HIPAA shall be grounds for immediate contract termination at the discretion of District.

8.11.5 Physician represents and warrants any agents or subcontractors to whom Physician may provide Protected Health Information, agree to the same restrictions and conditions that apply to Physician with respect to Protected Health Information. Physician further agrees to incorporate in any and all agreement(s) with subcontractor(s) a provision naming District as an intended third party beneficiary with respect to the enforcement of, and right to benefit from, the subcontractor's covenants regarding the use and disclosure of Protected Health Information.

8.11.6 Physician agrees to make available Protected Health Information in accordance with the requirements of 42 C.F.R. Sections 164.524, 164.526, 164.528.

8.11.7 Physician agrees to make available to the Secretary of Health and Human Services, or any designated representative thereof, any and all internal policies, books and records relating to the use and disclosure of Protected Health Information for the purposes of determining District's compliance with HIPAA.

8.11.8 Physician agrees that upon termination of this Agreement, Physician shall, at the election of the District, return or destroy all Protected Health Information, and Physician agrees to refrain from maintaining any copies of such Protected Health Information in any form. The provisions of this Agreement regarding uses and disclosures of Protected Health Information shall continue beyond termination of this Agreement.

8.11.9 Notwithstanding any other provision of this Agreement to the contrary, if any, nothing in this Agreement, or in the parties' course of dealings, shall be construed as conferring any third party beneficiary status on any person or entity not named a party to this Agreement.

8.12 **Cross Referenced Agreements**. According to regulations implementing 42 U.S.C. §1395nn et seq., respecting the prohibition of physician referrals to entities with which those physicians or their family members have financial arrangements, all arrangements shall be cross referenced for audit purposes. In accordance with 42 C.F.R. §411.357(d)(ii), any arrangements between Medical Group and District, or between any Group Physician and District, are listed in a master list of contracts that is maintained by District and updated centrally, preserves the historical record of contracts and is available for review by the Secretary of Health and Human Services upon request.

8.13 **Modification**. This Agreement may be modified only by written signed instrument.

8.14 **Compliance with Laws**. District and Physician agree to comply with all applicable statutes and regulations, both state and federal, governing the operation and administration of District, as well as standards set forth by the Joint Commission.

8.14.1 In addition to the obligations of the parties to comply with applicable federal, state and local laws respecting the conduct of their respective businesses and professions, District and Physician each acknowledge that they are subject to certain federal and state laws governing the referral of patients which are in effect or will become effective during the term of this Agreement. These laws include:

8.14.1.1 Prohibition on payments for referral or to induce the referral of patients (California Business and Professions Code §650; California Labor Code §3215; and the Medicare/Medicaid Fraud and Abuse Law, §1128B of the Social Security Act); and

8.14.1.2 Prohibition on the referral of patients by a physician for certain designated health care services to an entity with which the physician (or his/her immediate family) has a financial relationship including (California Business and Professions Code §§650.01 and 650.02, and §1877 of the Social Security Act).

8.14.2 Nothing in this Agreement is intended or shall be construed to require either party to violate the California or federal laws described in Section 8.14.1, and this Agreement shall not be interpreted to:

8.14.2.1 Require Physician to make referrals to District, be in a position to make or influence referrals to District, or otherwise generate business for the District.

8.14.2.2 Restrict Physician from establishing staff privileges at, referring any patient to, or from otherwise generating any business for any other entity of Physician's choosing.

8.14.2.3 Provide for payments in excess of the fair market value or comparable compensation paid to physicians for similar services in comparable locations and circumstances.

8.14.3 In the event of any changes in law or regulations implementing or interpreting the Internal Revenue Act or the Medicare and Medicaid Patient Protection Act of 1987, including the adoption or amendment of Medicare Fraud and Abuse Safe Harbor Regulations, or to any other Federal or State law relating to the subject matter of such Acts, to fraud and abuse, or to payment-for-patient referral, including the laws referenced in Section 8.14.1, the parties shall use all reasonable efforts to revise this Agreement to conform and comply with such changes.

8.15. **Force Majeure**. Neither party shall be liable nor deemed to be in default for any delay or failure in performance under the Agreement or other interruption of service or employment deemed resulting, directly or indirectly, from: Acts of God; acts of civil or military authority; acts of terrorism, bioterrorism, or public enemy; bomb threats; computer virus; epidemic; power outage; acts of war; accidents; fires; explosions; earthquakes; floods; failure of transportation, machinery, or supplies; vandalism; strikes or other work interruptions by District's employees; or any similar or dissimilar cause beyond the reasonable control of either party. Both parties shall, however, make good faith efforts to perform under this Agreement in the event of any such circumstance.

8.16. **Legal Counsel**. Each party understands the advisability of seeking legal counsel and financial/tax advice and has exercised its own judgment in this regard.

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement effective on the date first set forth above. This Agreement shall be binding when all signatories listed below have executed this Agreement.

DISTRICT: **KAWEAH DELTA HEALTH CARE DISTRICT**

By: _____

Tom Rayner, SVP and Chief Operating Officer

PHYSICIAN: **BYRON MENDENHALL, M.D.**

_____

Byron Mendenhall, M.D., Chief of Staff

Bylaws:

5.B. TEMPORARY CLINICAL PRIVILEGES

5.B.1 Eligibility to Request Temporary Clinical Privileges:

(b) Locum Tenens. The CEO, upon recommendation of the Chief of Staff, the CMO, and the applicable department chair, may grant temporary privileges to an individual serving as a locum tenens for a member of the Medical Staff who is on vacation, attending an educational seminar, or ill, or when necessary to prevent a lack or lapse of services in a needed specialty area. The following conditions apply:

(5) the individual may exercise locum tenens privileges for a maximum of 120 days, consecutive or not, anytime during the ~~24~~12-month period following the date they are granted, on the condition that the individual must inform the Medical Staff Services Department of any material change that has occurred to any of the information provided on the initial application for locum tenens privilege.

Rationale: Locum Tenens Privileges are only granted the 12-month period following the date they are granted.

ADVANCED PRACTICE PROVIDERS

7.A. CATEGORIES

Subject to approval by the Board, the MEC shall determine those categories of Advanced Practice Providers (APPs) that shall be eligible to exercise privileges within the District. ~~Such~~ Except as set forth below, APPs shall be subject to the supervision requirements developed in each department and approved by the Interdisciplinary Practice Committee, the Credentials Committee, the MEC, and the Board. A current listing~~s~~ of the categories of APP functioning in the District is set forth in Appendix B to these Bylaws.

7.B. PRIVILEGES AND RESPONSIBILITIES

(b) Applications for initial granting of APP privileges and biennial renewal thereof shall be submitted and processed in a parallel manner to that provided for Medical Staff members. ~~To~~ With the exception of Certified Registered Nurse Anesthetists ("CRNAs"), to qualify for credentialing consideration, the APP~~s~~ must have a supervision agreement with a physician who is appointed to the Medical Staff (the "Supervising Physician").

7.C. SUPERVISION REQUIREMENTS

(a) These supervision requirements do not apply to CRNAs.

(b) Any activities permitted to be performed by APPs at the District shall be performed only under the supervision or direction of a Supervising Physician.

(~~b~~c) APPs may function at the District only so long as (i) they are supervised by a Supervising Physician who is currently appointed to the Medical Staff, and (ii) they have a current, written supervision agreement with the Supervising Physician.

(~~c~~d) As a condition of clinical privileges, the APP and the Supervising Physician must provide the District with a copy of any written supervision agreement required by state law as well as notice

of any revisions or modifications that are made to such agreements. This notice must be provided to the Medical Staff Services Department within three days of any such change.

7.D. RESPONSIBILITIES OF SUPERVISING PHYSICIAN

(a) Physicians who wish to utilize the services of an APP (other than a CRNA) in their clinical practice at the District must notify the Medical Staff Services Department in advance and must ensure that the individual has been appropriately credentialed in accordance with this Article before the APP participates in clinical or direct patient care of any kind in the District.

Rationale: California State Law does not require supervision of CRNA's.

7.H. PROCEDURAL RIGHTS OF ADVANCED PRACTICE PROVIDERS

(a) Nothing contained in the Medical Staff Bylaws shall be interpreted to entitle an APP to the procedural rights set forth in Article 9.

(b) An APP shall have a right to an informal hearing ~~and appeal proceedings~~ to challenge any recommendation or action by the MEC not to grant or renew clinical privileges or to restrict or terminate clinical privileges by filing a written grievance with the MEC within fifteen (15) days of notice of such recommendation or action. Upon receipt of the grievance, the MEC shall arrange an informal hearing to be conducted before a hearing committee composed of ~~by one~~two or more persons appointed by the MEC or ~~its designee~~the Medical Staff Officers. The hearing committee may, but need not, be comprised of APPs or members of the Medical Staff.~~,~~ ~~h~~However, in cases involving clinical competency or performance, and subject to feasibility, the MEC should attempt to include at least one individual who is a professional peer of the affected APP. This informal hearing need not be conducted in accordance with the provisions of Article 9. Rather, the following ~~provisions~~ procedures shall apply: The APP shall be informed of the general nature and circumstances giving rise to the action and the APP may present information relevant thereto at the informal hearing. Evidence in support of the adverse recommendation will be presented by a representative of the MEC, the Credentials Committee, or the Interdisciplinary Practice Committee, as determined by the Chief of Staff. Neither the APP nor Medical Staff may be represented by counsel at the informal hearing. A record of the proceeding shall be made. The hearing committee's findings and conclusion shall be reported to the APP and MEC, and shall be ~~appealable~~ forwarded to ~~an appeal committee appointed by~~ the Board for final action.

~~(c) Appeals shall be based solely upon the record of the informal hearing. The recommendation of the appeal committee shall be forwarded to the Board (or authorized committee thereof) for final action.~~

Rationale: Recommendation from legal counsel.

Rules & Regulations:

7.1. General:

(a) Anesthesia may only be administered by the following qualified practitioners:

(1) an anesthesiologist;

(2) an M.D. or D.O. (other than an anesthesiologist) with appropriate clinical privileges;

(3) a dentist, oral surgeon or podiatrist, in accordance with state law, with appropriate clinical privileges; or

(4) a Certified Registered Nurse Anesthetist ("CRNA");

(b) ~~An anesthesiologist is considered "immediately available" when needed by a CRNA under the anesthesiologist's supervision only if he/she is physically located within the same area as the CRNA (e.g., in the same operative suite, or in the same labor and delivery unit, or in the same procedure room, and not otherwise occupied in a way that prevents him/her from immediately conducting hands-on intervention, if needed).~~

~~(c)~~ "Anesthesia" means general or regional anesthesia, monitored anesthesia care or deep sedation. "Anesthesia" does not include topical or local anesthesia, minimal, moderate or procedural sedation, or analgesia via epidurals/spinals for labor and delivery.

(~~d~~c) Because it is not always possible to predict how an individual patient will respond to minimal, moderate or procedural sedation, a qualified practitioner with expertise in airway management and advanced life support must be available to return a patient to the originally intended level of sedation when the level of sedation becomes deeper than initially intended.

(~~e~~d) General anesthesia for surgical procedures will not be administered outside of the operating room unless the surgical and anesthetic procedures are considered lifesaving.

7.2. Pre-Anesthesia Procedures:

(b) The evaluation will be recorded in the medical record and will include:

Except in cases of emergency, this evaluation must be recorded prior to the patient's transfer to the operating area and before any pre-operative medication has been administered. All patients scheduled for surgery shall be examined pre operatively by an anesthesiologist or ~~Certified Registered Nurse Anesthetist (~~CRNA~~)~~ within 24 hours prior to the scheduled surgery. If the anesthesia evaluation has been completed within the 30-day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record. However, in these circumstances, the patient must also be evaluated within 24 hours prior to surgery/invasive procedure, and an update recorded in the medical record by an individual who has been granted clinical privileges by the district to perform Anesthesia services.

Rationale: California State Law does not require supervision of CRNA's.

PHARMACY

9.1. General Rules:

(c) The pharmacist shall be able to write orders for therapeutic substitutions or interchanges for pharmacokinetic drug therapy/lab order as approved by the Pharmacy and Therapeutics Committee and shall sign the order with his or her name and note "per ~~P&T~~ protocol."

Rationale: KDHub does not allow for the per P&T protocol any longer.

Kaweah Delta HEALTH CARE DISTRICT

Privileges in Anesthesia

Name: _____ Date: _____

Please Print

ANESTHESIA PRIVILEGE CRITERIA

Initial Criteria: Successfully completed a post-graduate residency program in Anesthesiology approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA); **AND** Documentation of provision of inpatient care to at least 250 anesthesia patients over the past 24 months; **AND** current certification or active participation in the examination process leading to certification in Anesthesiology by the ABOA or the AOBA or active participation in the examination process leading to certification in 5 years. Active enrollment in Maintenance of Certification in Anesthesiology (not required for those with lifetime certification)

Certification: ACLS

ADULT AND ADOLESCENT CORE PRIVILEGES

Request	Procedure	Renewal Criteria	FPPE	Approve
☐	• Performance of H&P; • Assessment of, consultation for, and preparation of patients for anesthesia; Clinical management of cardiac & pulmonary resuscitation; • Evaluation of respiratory function and application of respiratory therapy; • Monitoring and maintenance of normal physiology during the perioperative period; • Relief and prevention of pain during and following surgical, obstetrical, therapeutic, and diagnostic procedures using sedation/analgesia, general anesthesia, and regional anesthesia • Diagnosis and treatment of acute, chronic, and cancer-related pain • Image-guided procedures; Management of critically ill patients; • Supervision of CRNAs • Treatment of patients for pain management (excluding chronic pain management) • Anesthetic management of patients for cardiac pacemaker and automatic implantable cardiac defibrillator placement, surgical treatment of cardiac arrhythmias, cardiac catheterization, and cardiac electrophysiological diagnostic/therapeutic procedures	Minimum of 250 cases required in the past two years AND Maintain current certification or active participation in the examination process leading to certification in Anesthesiology by the ABOA or the AOBA	6 retrospective or concurrent reviews with a Minimum of one direct observation	☐

ADULT CARDIOTHORACIC CORE PRIVILEGES

Request	Procedure	Initial Criteria	Renewal Criteria	FPPE	Approve
☐	• Performance of H&P • Anesthetic management for patients undergoing minimally invasive cardiac surgery for congenital/Non-congenital cardiac procedures including off pump procedures • Anesthetic management of patients undergoing surgery on the ascending or descending thoracic aorta requiring full cardiopulmonary bypass (CPV), left heart bypass, and/or deep hypothermic circulatory arrest • Anesthetic management of patients undergoing non cardiac thoracic surgery; Image-guided procedures • Management of intra-aortic balloon counter pulsation • Management of nonsurgical cardiothoracic patients • Management of cardiothoracic surgical patients in a critical care (ICU) setting; **Swan Ganz Catheter**; Transesophageal echocardiography (TEE) • Anesthetic Management for insertion of Ventricular Assist Devices	Initial Core Criteria **AND** Completion of Cardiac Anesthesia fellowship **AND** Board Certification in Perioperative Echocardiography within 2 years of Medical Staff appointment ***(Current members of Department of Anesthesia with adult cardiothoracic core privileges will have 2 years to obtain Board Certification)*** **AND** a minimum of 100 open heart surgeries in the past two years	Minimum 50 cases required in the past two years; **AND** Maintenance of Perioperative Echocardiography Board Certification up to age 65 ~~**AND** 10 CMEs per year pertaining to Peri-Operative TEE~~ **AND** Maintenance of ACLS	6 retrospective or concurrent reviews with a Minimum of one direct observation	☐

OBSTETRIC CORE PRIVILEGES

Request	Procedure	Initial Criteria	Renewal Criteria	FPPE	Approve
☐	• Performance of H&P; Consultation and management for pregnant patients requiring non-obstetric surgery • General anesthesia for cesarean deliver; Image-guided procedures • All types of neuraxial analgesia (including epidural, spinal, combined spinal, and epidural analgesia) and different methods of maintaining analgesia such as bolus, continuous infusion, and patient-controlled epidural analgesia • Anesthetic management of both spontaneous and operative vaginal delivery, retained placenta, cervical dilation, and uterine curettage, as well as postpartum tubal ligation, cervical cerclage, and assisted reproductive endocrinology interventions • Interpretation of antepartum and intrapartum fetal surveillance tests	Initial Core Criteria **AND** A minimum of ~~15 epidural anesthetics **AND**~~ ~~A minimum of 15 spinal anesthetics~~ 3 labor epidurals AND 3 spinals in the past two years	Minimum of 15 cases required in the past two years.	~~6 retrospective or concurrent reviews with~~ a Minimum of ~~one~~ 3 labor epidurals AND 3 spinals with direct observation	☐

PEDIATRIC CORE PRIVILEGES					
Request	**Procedure**	**Initial Criteria**	**Renewal Criteria**	**FPPE**	**Approve**
☐	• Performance of H&P; Consultation for medical and surgical patients; Interpretation of laboratory results • Management of normal perioperative fluid therapy and massive fluid and/or blood loss • Management of children requiring general anesthesia for elective and emergent surgery for a wide variety of surgical conditions, including neonatal surgical emergencies, and congenital disorders • Image-guided procedures • Management of normal and abnormal airways	Initial Core Criteria **AND** Pediatric subspecialty training or equivalent experience ; **AND** PALS certification **AND** at least 10 pediatric procedures in the last 24 month	Minimum of 25 pediatric cases required in the past two years **AND** Maintenance of PALS certification	2 retrospective or concurrent reviews with a minimum of one direct observation	☐

ADDITIONAL PRIVILEGES					
	Procedure	**Initial Criteria**	**Renewal Criteria**	**FPPE**	**Approve**
☐	Supervision of a technologist using fluoroscopy equipment	Current and valid Fluoroscopy supervisor and Operator Permit or a Radiology Supervisor and Operator Permit	Maintenance of Fluoroscopy Permit	None	☐
☐	Trans Thoracic Echo Cardiography (TTE)	1) Completion of an ACGME or AOA approved residency training program that included training specific to TTE; ***OR*** 2) Documentation of completion of a training course specific to point of care ultrasound that includes TTE. *(Module must be a minimum of 8 hours and include the physics of ultrasound and hands on-training.)* **AND** Documentation of a minimum of 20 TTEs **IF** training completed **prior to** the last 24 months	Minimum of 10 procedures in the past 24 months	3 direct observation and 5 over-reads	☐
☐	Trans Esophageal Echo Cardiography (TEE)	1) Completion of an ACGME or AOA approved residency training program that included training specific to TEE; ***OR*** 2) Documentation of completion of a training course specific to point of care ultrasound that includes TEE. *(Module must be a minimum of 50 hours and include the physics of ultrasound and hands on-training.)* **AND** Documentation of a minimum of 50 TEEs **IF** training completed **prior to** the last 24 months	Minimum of 50 procedures in the past 24 months	5 direct observation and 5 over-reads	☐
☐	Swan Ganz Catheters	1) Completion of an ACGME or AOA approved residency training program that included training specific to SGC. Document of a minimum of 12 SGC placements if training completed prior to the last 24 months; ***OR*** 2) Documentation of successful placement of 6 SGCs by direct concurrent observation of a member of the Medical Staff with SGC privileges.	Minimum of 6 procedures in the past 24 months	A minimum of 1 direct observation	☐
☐	Outpatient Services at a Kaweah Delta Health Care District Rural Health or 1206(d) Clinics. Please identify: **__ Dinuba __ Exeter __Lindsay __ Woodlake ___Family Medicine Clinic __ Chronic Disease Management Center** **__ Sequoia Cardiology Clinic**	Executed contract with Kaweah Delta Health Care District or KDHCD ACGME Family Medicine Program	Maintain initial criteria	None	☐

Acknowledgment of Practitioner:

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

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

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

Signature: _____ _____

Applicant *Date*

Signature _____ _____

Department of Anesthesia Chair *Date*

Provider Name: _____ Date: _____

Please Print

CERTIFIED REGISTERED NURSE ANESTHETIST

CERTIFIED REGISTERED NURSE ANESTHESIST
Initial Criteria

Education: Master of Registered Nursing Degree. Current licensure as an Advanced Nurse Practitioner in the state of California.

Formal Training: Successful completion of a nurse anesthesia educational program accredited by the AANA, CANAEP; Certification by the CCNA or recertification by the Council on Recertification; Current active licensure to practice professional nursing or advanced practice nursing in the nurse anesthetist category by the State of California Board of Nursing.

Certifications: ~~BLS and~~ ACLS or equivalent certification **AND** current certification by NBCRNA

Clinical Experience: Documentation of patient care for 250 patients in an acute care setting in the past two years OR certification within the last 12 months

Renewal Criteria: Documentation of patient care for 250 patients in the past 24 months AND Maintenance of current certification by ~~NCCPA, ANCC, AANP or ANCC~~NBCRNA **AND** ~~BLS and~~ ACLS or equivalent certification

FPPE: A minimum of Six (6) cases representative of privileges requested (3- Direct Observation; 3- Retrospective Review)

ADULT AND ADOLESCENT CORE PRIVILEGES

Request	Procedure	Approve
☐	• Performance of H&P; • Assessment of, consultation for, and preparation of patients for anesthesia; Clinical management of cardiac & pulmonary resuscitation; • Evaluation of respiratory function and application of respiratory therapy; • Monitoring and maintenance of normal physiology during the perioperative period; • Relief and prevention of pain during and following surgical, obstetrical, therapeutic, and diagnostic procedures using sedation/analgesia, general anesthesia, and regional anesthesia • Diagnosis and treatment of acute, chronic, and cancer-related pain • Ultrasound guided regional nerve blocks • Management of critically ill patients; • Treatment of patients for pain management (excluding chronic pain management) • Post anesthesia care and discharge	☐

OBSTETRIC CORE PRIVILEGES

Clinical Experience: A minimum of ~~15 epidural anesthetics **AND** A minimum of 15 spinal anesthetics~~ 3 labor epidurals AND 3 spinals in the past two years

Renewal Criteria: A Minimum of 15 obstetric cases required in the past two years.

FPPE: A Minimum of 3 labor epidurals AND 3 spinals with direct observation

Request	Procedure	Approve
☐	• Performance of H&P • All types of neuraxial analgesia (including epidural, spinal, combined spinal, and epidural analgesia) and different methods of maintaining analgesia such as bolus, continuous infusion, and patient-controlled epidural analgesia • Anesthetic management of both spontaneous and operative vaginal delivery, retained placenta, cervical dilation, and uterine curettage, as well as postpartum tubal ligation, cervical cerclage, and assisted reproductive endocrinology interventions • Consultation and management for pregnant patients requiring non-obstetric surgery • General anesthesia for cesarean deliver	☐

PEDIATRIC CORE PRIVILEGES

Clinical Experience: Pediatric subspecialty training or equivalent experience and current PALS certification and at least 10 pediatric procedures in the last 2 years

Renewal Criteria: A Minimum of 25 pediatric cases required in the past two years AND maintenance of PALS certification.

Request	Procedure	Approve
☐	• Performance of H&P • Consultation for medical and surgical patients • Interpretation of laboratory results • Management of normal perioperative fluid therapy and massive fluid and/or blood loss • Management of children requiring general anesthesia for elective and emergent surgery for a wide variety of surgical conditions, including neonatal surgical emergencies, and congenital disorders • Management of normal and abnormal airways	☐

Provider Name: _____ Date: _____

Please Print

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

_____ _____

Advanced Practice Provider Signature *Date*

_____ _____

Collaborating/Supervising Physician Signature *Date*

_____ _____

Department of Anesthesiology Chairman Signature *Date*

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.)
OR Physicians licensed in California and enrolled in the 3rd or last year of an ACGME accredited Residency Program can apply for privileges to work under the indirect supervision of a Board Certified physician. ***(PGY3 or above may not moonlight at sites that are part of their training rotation, or supervise other learners)***

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, 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 Procedural Sedation ***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
☐	~~Procedural Sedation~~	~~Successful completion of KDHCD sedation exam~~	~~Completion of sedation exam~~	~~None~~	☐
☐	Emergency Ultrasound, **Basic** applications, which includes Aorta, Cardiac, Trans Thoracic, FAST, Pregnancy, Biliary, Urinary tract, Soft Tissue and Occular	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.	Maintain EM Board Certification	3 retrospective reviews via Q-Path Not required for KDHCD EM Residency graduates within last 2 years.	☐
☐	Emergency Ultrasound, **Advanced** applications: (Check request) ☐ DVT ☐ Endovaginal US for ovarian torsion/mass ☐ Scrotal US for torsion/flow/mass ☐ Adnexel US for mass/flow/torsion ☐ Bowel US to include appendicitis, bowel obstruction, pyloric stenosis and diverticulitis	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	3 retrospective reviews for each application via Q-Path	☐
☐	Trans Esophageal Echo Cardiography (TEE): Limited to Patients undergoing CPR to evaluate for 1) reversible causes (pericardial tamponade, pulmonary embolism, valve pathology) 2) to visualize and confirm the location and quality of CPR compressions and return of spontaneous circulation.	1) Completion of an ACGME or AOA approved residency training program that included training specific to TEE; ***OR*** 2) Credentialed in Basic Emergency Ultra Sound 3) Completion of 2 or more hours of TEE specific CME or didactics including web based resources i.e., http://pie.med.utoronto.ca/TEE/index.htm AND 10 TEE exams including probe placement. A maximum of 5 out of the 10 may be simulation	Minimum of 5 procedures in the past 24 months	5 direct and or over reads, at the discretion of the proctor.	☐

☐	Supervision of a technologist using fluoroscopy equipment	Current and valid CA Fluoroscopy supervisor and Operator Permit or a CA Radiology Supervisor and Operator Permit AND pass KD annual safe fluoroscopy practices exam within 3 weeks of granting privilege	Current and valid CA Fluoroscopy supervisor and Operator Permit or a CA Radiology Supervisor and Operator Permit AND pass KD annual safe fluoroscopy practices exam	None.	☐

Acknowledgment of Practitioner:

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

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

(b) **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*

_____ _____
Department of Emergency Medicine Chairperson's Signature *Date*

Nichole Atherton, M.D., Trauma Medical Director is asking for approval of the following statement as MEC's support of the Trauma Program as required by ACS certification process:

"Resolved, that the Kaweah Delta District Hospital Medical Executive Committee supports verification as Level III trauma center by the American College of Surgeons. The MEC commits to maintain the high standards needed to provide optimal care of all trauma patients. The multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions."

RESOLUTION 2036

WHEREAS, a claim on behalf of Bob L. Sansom has been presented on May 22, 2019 to the Board of Directors of the Kaweah Delta Health Care District,

IT IS HEREBY RESOLVED AS FOLLOWS:

1. The aforementioned claim is hereby rejected.

2. In accordance with Government Code Section 913, the Secretary of the Board of Directors is hereby directed to give notice of rejection of said claim to Jennifer A. Lenze, in the following form:

"Notice is hereby given that the claim which you presented to the Board of Directors of the Kaweah Delta Health Care District on May 22, 2019, was rejected by the Board of Directors on June 24, 2019."

WARNING

"Subject to certain exceptions, you have only six (6) months from the date this notice was personally delivered or deposited in the mail to file a court action on this claim. See Government Code Section 945.6.

You may seek the advice of an attorney of your choice in connection with this matter. If you desire to consult an attorney, you should do so immediately."

PASSED AND ADOPTED by unanimous vote of those present at a regular meeting of the Board of Directors of the Kaweah Delta Health Care District on June 24, 2019.

_____
President, Kaweah Delta Health Care District

ATTEST:

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

/cm

Kaweah Delta
HEALTH CARE DISTRICT

June 24, 2019

Sent Via Certified Mail
No. 70160340000002569968
Return Receipt Requested

Jennifer Lenze, Esq.,
Lenze Lawyers, PLC
1300 Highland Avenue, Suite 207
Manhattan Beach, CA 90266

NOTICE OF ACTION ON APPLICATION FOR LATE CLAIM RELIEF (Gov. Code sec. 911.4)

To Bob L. Sansom and attorney Jennifer A. Lenze:

NOTICE IS HEREBY GIVEN that your application, which you presented on May 22, 2019, for leave to present a claim after expiration of the time allowed by law for doing so was **denied** on June 24, 2019.

WARNING

If you wish to file a court action on this matter, you must first petition the appropriate court for an order relieving you from the provisions of Government Code 945.4 (claims presentation requirement). See Government Code Section 946.6. Your petition must be filed with the court within six (6) months after the date, set forth above, on which your application for leave to present a late claim was denied.

You may seek the advice of an attorney of your choice in connection with this matter. If you wish to consult an attorney, you should do so immediately.

Sincerely,

Nevin House
Secretary/Treasurer, Board of Directors

cc: Richard Salinas, Attorney at Law

Board Report
Infection Prevention

KAWEAH DELTA HEALTH CARE DISTRICT

Board Report ● Infection Prevention

Definitions for terms provided in the Infection Prevention Dashboard:

Central Line Associated Bloodstream Infection (CLABSI): an event in which an intravenous line that terminates in a large blood vessel near or at the heart is implicated as the source of a patient's bloodstream infection while admitted to the hospital.

Methicillin Resistant Staphylococcus aureus bloodstream infection (MRSA BSI): A Bloodstream infection caused by Methicillin Resistant Staphylococcus aureus bacteria after day 3 of a hospital admission.

Catheter Associated Urinary Tract Infection (CAUTI): an event in which an indwelling urinary catheter is implicated as the source of a patient's urinary tract infection.

Surgical Site Infection (SSI): an event in which a superficial (SIP), deep (DIP) or an organ space infection occurs within 30 to 90 days post-operatively and is attributed to the hospital in which the procedure was performed.

- Colon surgery (COLO): an organ space SSI involving the large intestine.
- Total Abdominal Hysterectomy (HYST): an organ space SSI involving removal of the uterus through the abdomen.
- Cesarean Section (CSEC): a SSI (SIP/DIP) involving a C-section procedure for removal of the fetus from the uterus through the abdomen.
- Spinal Fusion (FUSN): a SSI (SIP/DIP) involving a procedure in which the vertebrae of the spine are mechanically fused.

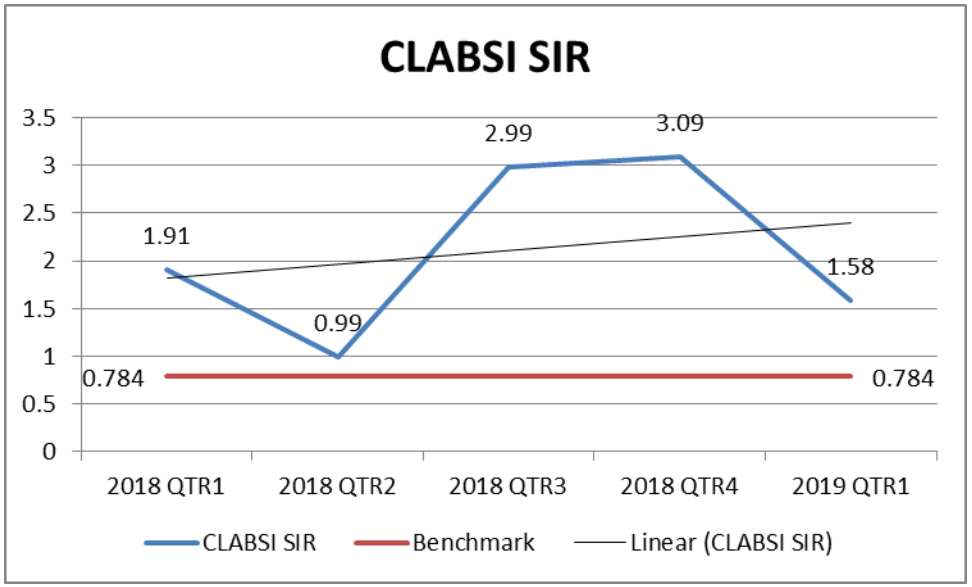
Ventilator Associated Event (VAE): Complications such as pneumonia associated with mechanical ventilation during admission to a hospital.

CLABSI – KDHCD
All Units – 2018 to 2019 1st QTR

Define: Central line associated bloodstream infections (CLABSI) are infections that occur as a result of insertion or maintenance of a central line.

Measure: Standardized Infection Ratio of 0.784 or less. In other words only 1 CLABSI event per quarter.

Analyze: Several interventions of the CLABSI prevention bundle implemented. Results were discouraging late 2018 calendar year. Initiated an IV Safety Team that started January 2019 with the goal of significantly decreasing CLABSI rate. Comparison between 4th QTR 2018 to 1st QTR 2019 there was approximately a 50% reduction in CLABI [SIR = 3.09 to 1.58].



Improve: Implementing "Operation Stomp-Out CLABSI" interventions (29 in all). IV Safety Team has been hard at work gathering daily data from observations and intervening in the moment to ensure safe and effective CVC line and PIV line management. Transitioning interventions toward providers and GME residents. Discussing different options such as rotating the line in the IJ position for more effective dressing securement, investigating axillary vein access for subclavian line placement. Contacting hospital affiliate- Cleveland Clinic Infection Prevention to determine CLABSI prevention practices employed by that organization. Developing CLABSI prevention CBL for residents. Continuing to offer Safety Symposium regarding CLABSI prevention for nurses.

Control: Wil closely monitor this metric for elements of improvement over the 2nd QTR 2019.

MRSA BSI – KDHCD
All Units – 2018 to 2019 1st QTR

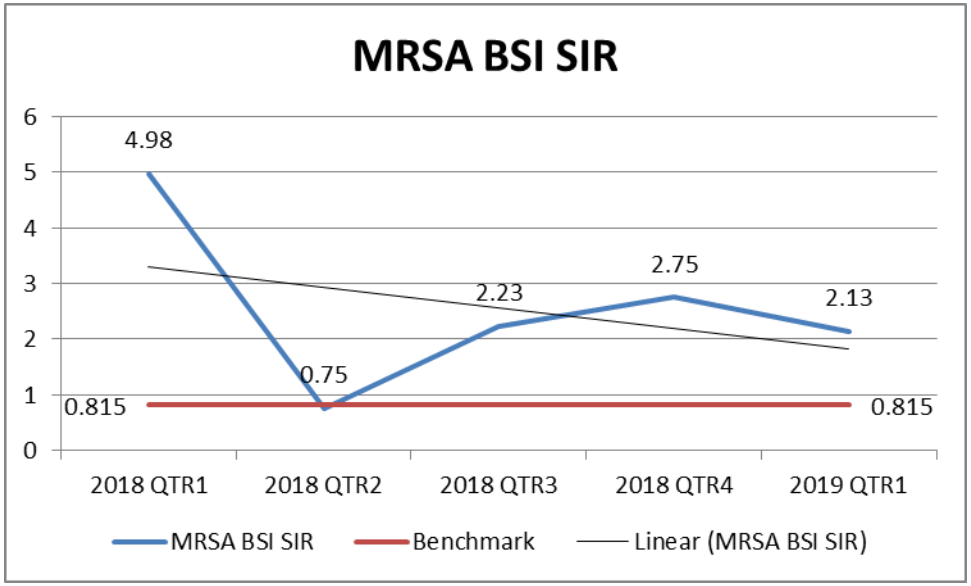
Define: Bloodstream infection caused by Methicillin Resistant Staphylococcus aureus bacteria after day 3 of a hospital admission.

Measure: Standardized Infection Ratio of 0.815 or less.

Analyze: MRSA bloodstream infections are elevated in part to expired peripheral IV lines left in place becoming contaminated with skin colonizing bacteria. In addition, blood culture collection practices such as "pan-cultures" contributed to increases in MRSA BSI events.

Improve: Infection Prevention staff pursue nurses to remove/replace expired peripheral IVs. Policy was changed to replace peripheral IVs to every 72 hours from every 96 hours, as staff was not performing timely replacements. Initiated the IV Safety Team during January 2019. The IVST assists with peripheral IV restarts and advocates for the patient by encouraging nurses to replace/remove peripheral IVs. Many of the identified MRSA BSI also met CLABSI definition criteria and thereby were reported as two individual events for the same patient. Reviewing culture practices with providers through our Operation Stomp-Out CLABSI campaign. Also, working on initiating a "Do U Disinfect Every time (D.U.D.E.) campaign to highlight the importance of hand hygiene compliance, "scrub-the-hub" and cleaning the patient environment. Trialed and will be universally using Prevantics CHG wipes to perform "scrub-the-hub" a 5 second process. Stakeholders are supporting all these interventions.

Control: Wil closely monitor this metric for elements of improvement over the 2nd QTR 2019.



CAUTI - KDHCD
All Units – 2018 to 2019 1st QTR

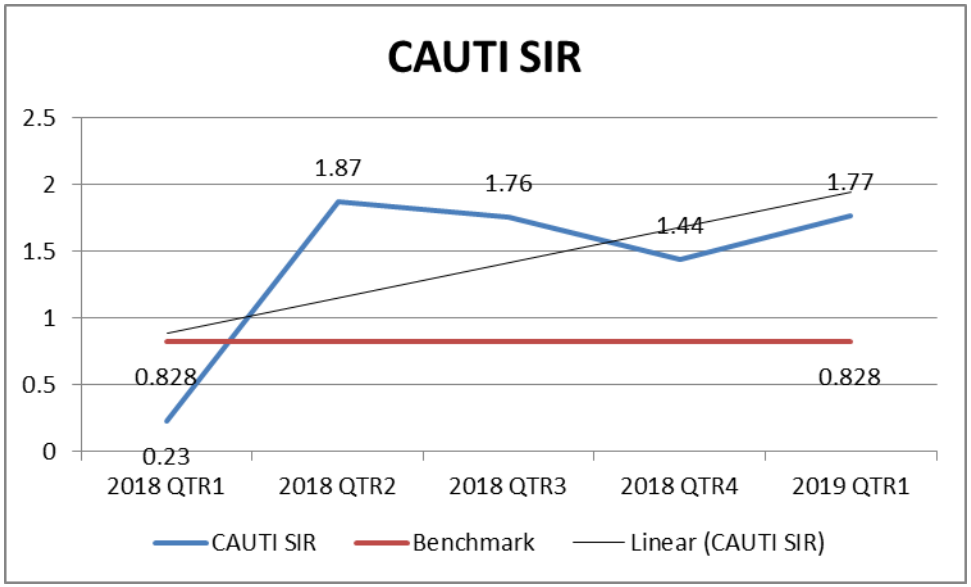
Define: Catheter Associated Urinary Tract Infection (CAUTI) is an infection that occurs as a result of insertion or maintenance of an indwelling urinary catheter.

Measure: Standardized Infection Ratio of 0.828 or less.

Analyze: CAUTI increased through the latter part of the year. Lacking peri-care, patient bathing and prolonging use of indwelling urinary catheters beyond their indication are some contributing factors for increased CAUTI events. Additionally, indiscriminate urine culture practices have resulted in identification of bacteria colonizers within the urinary tract.

Improve: Current measures involve encouraging patient bathing and peri-care, and discouraging "the culture-of-culturing" practices. Physician's order for urine culture is being revised to guide providers in the direction of testing appropriateness based on signs and symptoms of urinary tract infection (UTI). Implementation of a CAUTI algorithm will be starting soon. Considering dual nurse insertion of indwelling urinary catheters to reduce risk of contamination during insertion.

Control: Metric demonstrates sustained rates above predicted. Implementation of robust interventions are in the works to reduce CAUTI events to predicted/ below predicted rates.



SSI HYST - KDHCD
All Units – 2018 to 2019 1st QTR

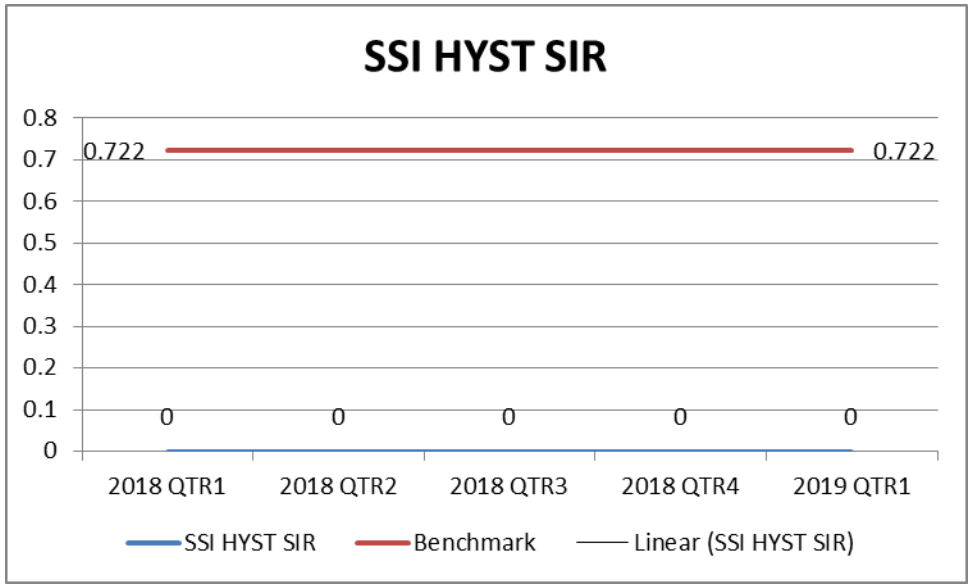
Define: Deep or organ space surgical site infection involving the Uterus 30 days post-abdominal hysterectomy operation.

Measure: CDPH 2017 Annual Benchmark of 0.722 or less.

Analyze: There have been no SSI events for this metric.

Improve: No improvement interventions implemented at this time.

Control: Metric is under control.



SSI COLO - KDHCD
All Units – 2018 to 2019 1st QTR

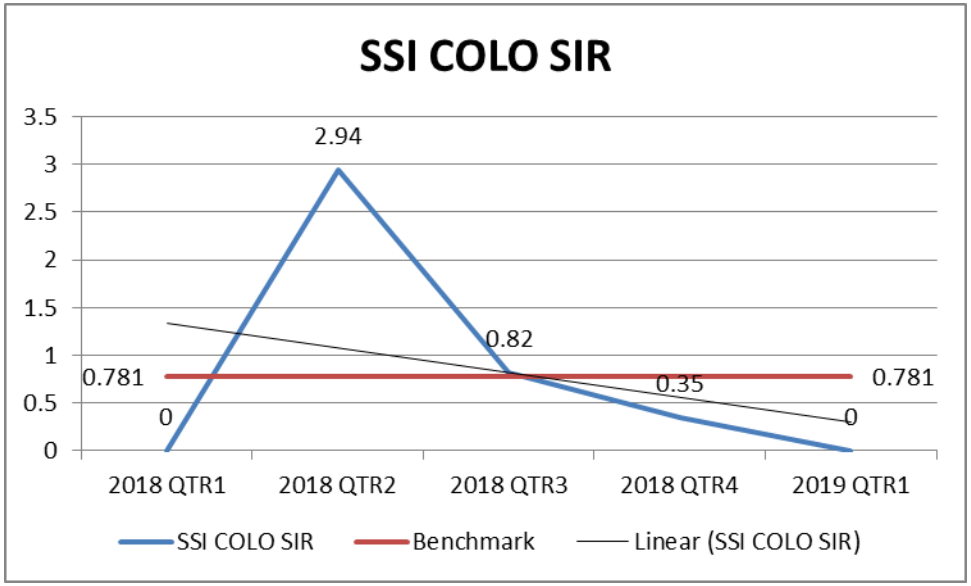
Define: Deep or organ space surgical site infection involving the large intestine 30 to 90 days post-operation.

Measure: Standardized Infection Ratio of 0.781 or less.

Analyze: The practice of clean-closure for colon surgeries had caused some surgeons to question the effectiveness of this intervention. The lack of clean-closure contributed to a few of the COLO SSI events identified. Pre-op and post-op glucose results widely varied in Diabetic patients, often exceeding 180 dg/ml. Inappropriate pre-op antibiotic selection and late administration to cut time are other variables that contributed to COLO SSI events.

Improve: Antimicrobial Stewardship Pharmacist developed a reference document for Anesthesiologists to refer to for appropriate antibiotic selection/timing. Multiple time-out interventions have been scripted to help ensure practices and assessments are performed. A new Diabetes Nurse Practitioner is available in the acute care hospital to assist with glucose control measures pre/ post-op. Clean Closure is an evidence-based intervention supported by data meta-analysis and presented in professional guidance. There is ongoing literature review that will be presented to surgeons concerned about the Clean Closure intervention.

Control: Metric has improved demonstrating sustained reduction below predicted values for two quarters.



SSI CSEC - KDHCD
All Units – 2018 to 2019 1st QTR

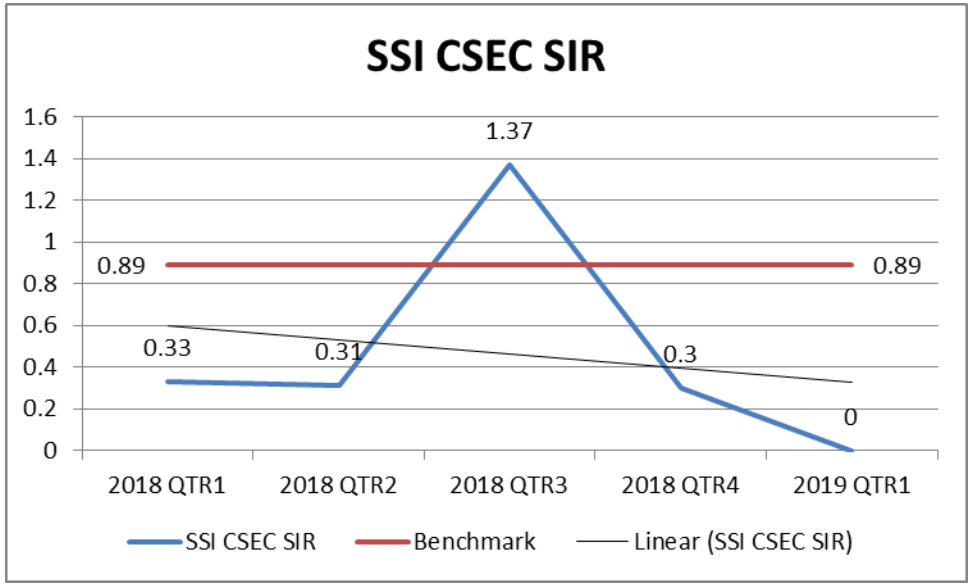
Define: Deep or organ space surgical site infection involving the intraabdominal space 30 days post-cesarean operation.

Measure: CDPH 2017 Annual Benchmark of 0.89 or less.

Analyze: A combination of variables contribute to Cesarean Section procedures becoming infected in patients cared for at KDCHD. Some of these variables include emergent need for C-section very short time between pre-op antibiotic administration and cut-time. Pregnant patients presenting with multiple comorbidities (i.e. Diabetes, Obesity, Cardiac ailments). Lastly, because C-section infections can be reported up to 30 days post-op, patients themselves have contributed to their own infections in the home setting.

Improve: Infection Prevention observations in the L&D OR have begun to review intra-operative practices.

Control: Metric has improved demonstrating sustained reduction below predicted values for two quarters.



SSI FUSN - KDHCD
All Units – 2018 to 2019 1st QTR

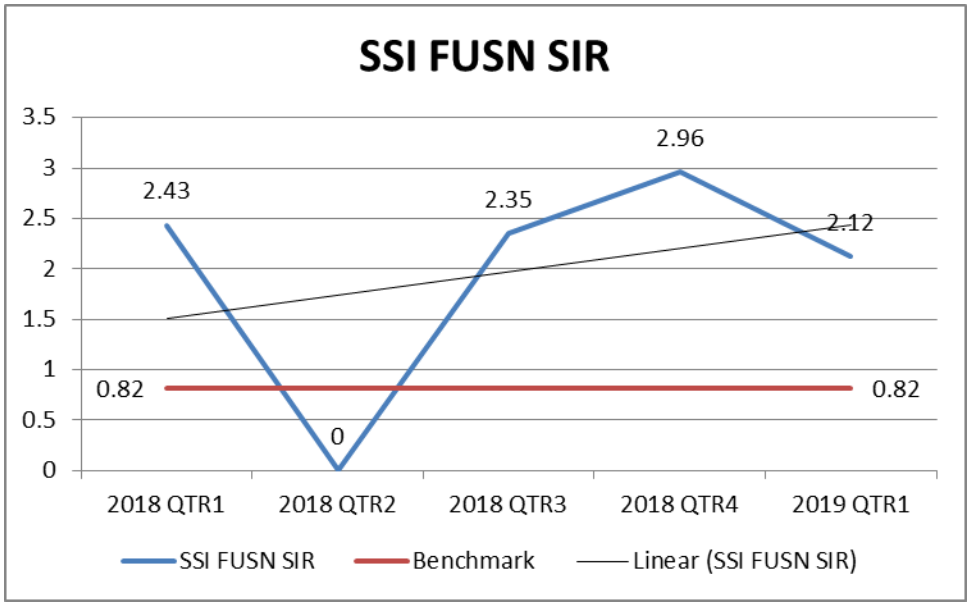
Define: Deep or organ space surgical site infection involving the spine 30 to 90 days post-spinal fusion operation.

Measure: CDPH 2017 Annual Benchmark of 0.82 or less.

Analyze: A trend was identified with this particular type of SSI event. Spinal Fusion patients are transferred from the acute care setting to the District's long-term rehab facility. Identified a gap in continuity-of-care through communication of discharge orders, specialists do not follow their patients to long-term care rehab and will not be consulted regarding surgical wound healing and evaluation. Long-term care rehab nurses are unfamiliar with some interventions related to the SSI prevention bundle.

Improve: Neurosurgery and Orthopedic service line representatives will now be attending SSI Prevention Committee. A midlevel practitioner from the orthopedic service line will now follow patients to long-term rehab to assess incision sites and consult. Long-term rehab nurses will be reintroduced to SSI Prevention Bundle interventions as a part of annual competency training.

Control: Wil closely monitor this metric for elements of improvement over the 2nd QTR 2019.



VAE - KDHCD
All Units – 2018 to 2019 1st QTR

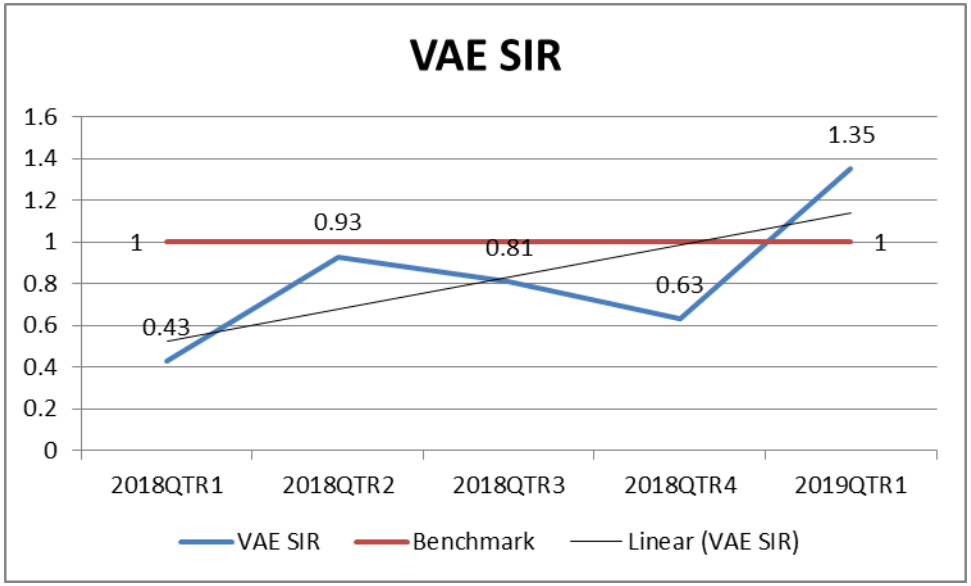
Define: Complications such as pneumonia associated with mechanical ventilation during admission to a hospital.

Measure: Standardized Infection Ratio of 1.0 or less.

Analyze: Upward trend in VAE during 1st Quarter 2019. Mechanical ventilator utilization rate is significantly higher than predicted values. Oral care interventions not consistently performed. Subglottic suctioning not regularly performed. Generally head-of-bed does remain at 30-40^0, and Proton Pump Inhibitors are rarely ordered for ventilated patients. Some of the pneumonia ventilator associated events were deemed unpreventable upon thorough review.

Improve: There is ongoing oral care product trials in critical care areas; oral care performance has improved. Ventilators have been labeled with a small laminated reference card outlining the criteria for VAE. Respiratory therapy and Infection Prevention introduced and commenced subglottic suctioning for ventilated patients. Starting February 2019, Infection Prevention working with Patient Safety/Quality is assessing patients who are deemed high-risk based on review of VAE prevention bundle compliance – patients too unstable for a particular prevention bundle intervention are closely monitored to ensure other prevention bundle interventions are adhered to meticulously.

Control: Wil closely monitor this metric for elements of improvement over the 2nd QTR 2019.



Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2019

		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
I. Overall Surgical Site Infections (SSI)	**IR/SIR**						**SSIs calculated internally though standard incidence rate and externally through Standardized Infection Ratio (SIR) from National Health and Safety Network (NHSN).**
A. #Total Procedure Count		1458					**Annual running total:** 1458
B. Total Infection Count *[note: SSI events can be identified up to 90 days from the last day of the month in each quarter]*		**5**					**1st QTR:** 5 **Predicted:** 17.45
C. Incidence Rate (IR) [# of total SSI infections/# total procedures x 100]	Internal 0.70 Goal	**0.34**					**1st QTR:** Well exceeded the District's goal of 0.70 SSI incidence rate - 36% better.
D. SIR Confidence Interval (CI-KDHCD predicted range, based on risks)		0.105 - 0.635					**1st QTR:** Better than California 2017 SSI Benchmark of 0.89. *[Benchmark provided by CDPH 2017 Annual Report for overall top performance]*
E. Standardized Infection Ratio (SIR)	NHSN	**0.29**					**1st QTR:** SB, FUSN x 2, KPRO, FX, CHOL, PACE, COLO, VHYS, CSEC, CBGB (6 of these events were superficial and are not counted by CMS or by CDPH for public reporting)
F. Action Plan for Improvement							**1st QTR:** Scripting for 3 different Time-Out sessions almost complete (1st pre-op antibiotic administration check; 2nd universal timeout; 3rd debrief timeout verfiy whether a change in wound status occurred). Pursuuing questions about clean closure for colorectal surgeries - some surgeons have resevations about the process, whether or not it is an effective process for reducing SSI (it is supported by data meta-analysis and described prevention guidelines).
II. Specific Surgical Review	**SIR**						
A. Colon Surgery (COLO) CMS/VBP							
1. #Total Procedure Count		53					**Annual running total:** 53
2. Total Infection Count		**0**					**1st QTR:** 0 **Predicted:** NA
3. SIR CI (KDHCD predicted range, based on risks)		0 - 0.959					**1st QTR:** No different than 2019 National Benchmark of 0.781.
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]		**0** **[0]**					**1st QTR:** 1 COLO event (superficial SSI - not reported to CMS or CDPH). Intra-operatively there were 7 observers (non-staff) observing this procedure and a lot of activity going in and out of the surgery.
B. Cesarean Section (CSEC)							
1. #Total Procedure Count		351					**Annual running total:** 351
2. Total Infection Count		**0**					**1st QTR:** 0 **Predicted:** NA
3. SIR CI (KDHCD predicted range, based on risks)		0 - 0.908					**1st QTR:** No different than California 2016 CSEC Benchmark of 0.89.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2019							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
4. SIR (Standardized Infection Ration) total		0					**1st QTR:** 1 CSEC event (deep SSI); this case was likely unpreventable. Patient had a spontaneous appendiceal rupture post-operatively that complicated the post-operative course.
C. Spinal Fusion (FUSN)							
1. #Total Procedure Count		37					**Annual running total:** 37
2. Total Infection Count		1					**1st QTR:** 1 **Predicted:** 0.47
3. SIR CI (KDHCD predicted range, based on risks)		NA					**1st QTR:** Worse than California 2016 FUSN Benchmark of 0.82.
4. SIR (Standardized Infection Ration) total		2.12 [2.12]					**1st QTR:** 2 FUSN events (2 deep SSI); A trend was identified with this particular type of SSI event. Spinal Fusion patients are transferred from the acute care setting to the District's long-term rehab facility. Identified a gap in continuity-of-care through communication of discharge orders, specialists do not follow their patients to long-term care rehab and will not be consulted regarding surgical wound healing and evaluation. Long-term care rehab nurses are unfamiliar with some interventions related to the SSI prevention bundle. Neurosurgery and Orthopedic service line representatives will now be attending SSI Prevention Committee. A midlevel practioner from the orthopedic service line will now follow patients to lont-term rehab to assess incision sites and consult. Long-term rehab nurses will be reintroduced to SSI Prevention Bundle interventions as a part of annual compentency training.
D. Hysterectomy (HYST) CMS/VBP							
1. #Total Procedure Count		23					**Annual running total:** 23
2. Total Infection Count		0					**1st QTR:** 0 **Predicted:** NA
3. SIR CI (KDHCD predicted range, based on risks)		NA					**1st QTR:** Better than 2018 Benchmark of 0.722.
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]		0 [0]					**1st QTR:** No events.
II. Ventilator Associated Events (VAE)	**SIR**						
A. Ventilator Device Use SUR (standardized utilization ratio)		1.23					**1st QTR:** 758vd **Predicted:** 615.75vd
B. Total VAEs ICU (NHSN Reportable)	Includes IVAC Plus	4					**1st QTR:** 4 **Predicted:** 3.97
1. SIR Total VAE CI (KDHCD predicted range, based on risks)		0.320 - 2.432					This is an internal quality driven metric. A State or National benchmark has not been made available.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2019							
		Q1	**Q2**	**Q3**	**Q4**	**AVG. or TOTAL YTD**	**SUMMARY / ACTION**
2. Total VAEs SIR		**1.35**					**1st QTR:** ICU had 2 VAC, 1 IVAC, 1 PVAP event.
C. Total IVAC Plus -ICU		**2**					**1st QTR:** 2 **Predicted:** 1.48
1. Total IVAC Plus CI (KDHCD predicted range, based on risks)		0.226 - 4.455					This is an internal quality driven metric. A State or National benchmark has not been made available.
2. Total IVAC *Plus* ICU SIR		**1.01**					**1st QTR:** 2 PVAP events
D. CVICU/**KDHCD** Total VAEs (not NHSN/Internal)		**2**					**1st QTR:** 1 PVAP event
E. Total VAEs-Both Units		**6**					**1st QTR:** 3 VAC,1 IVAC, 2 PVAP; pursuing implementation of subglottic suctioning, and scheduled oral care.
III. Central Line Associated Blood Stream Infections (CLABSI) CMS/VBP	**NHSN SIR**						
A. Total number of Central Line Days (CLD)		3648					**Annual running total:** 3648
B. Central Line Device Use SUR (standardized utilization ratio)		**0.76**					**1st QTR:** 3648 **Predicted:** 4,787.70
C. Total Infection Count Valule Based Purchasing (VBP) # events = [ ]		**5** **[4]**					**1st QTR:** 5 **Predicted:** 3.17
D. SIR Confidence Interval		0.577 - 3.492					**1st QTR:** No different than 2019 National Benchmark of 0.784.
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]		**1.58** **[1.82]**					**1st QTR:** 5 events - must attempt to achieve 1 or less CLABSI events per Quarter. Implementing "Operation Stomp-Out CLABSI" interventions (29 in all). IV Safety Team has been hard at work gathering daily data from observations and intervening in the moment to ensure safe and effective line CVC and PIV line management. Transitioning interventions toward providers and GME residents. Discussing different options such as rotating the line in the IJ position for more effective dressing securement, investigating axillary vein access for subclavian line placement. Contacting hospital affiliate- Cleveland Clinic Infection Prevention to determine CLABSI prevention practices employed by that organization. Developing a CLABSI prevention CBL for residents. Continuing to offer Safety Symposium regarding CLABSI prevention for nurses.
IV. Catheter Associated Urinary Tract Infections (CAUTI) CMS/VBP	**NHSN SIR**						
A. Total number of Catheter Device Days (CDD)		3908					**Annual running total:** 3908

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2019							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
B. Catheter Device Days SUR (Standardized Utilization Ratio)		0.743					**1st QTR:** 3908 **Predicted:** 5257.86
C. Total Infection Count Value Based Purchasing (VBP) # of events = [ ]		7 [6]					**1st QTR:** 7 **Predicted:** 3.95
D. SIR Confidence Interval		0.720 - 0.767					**1st QTR:** Worse than 2019 National Benchmark of 0.828
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]		1.77 [2.89]					**1st QTR:** Many of these events are due to keeping the indwelling urinary catheter longer than indicated; collecting urine cultures when not indicated. Approvals are occuring for implementation of a new order set for Urine Cultures (to help ensure when cultures are ordered they are really indicated), also implementation of a CAUTI algorithim will be starting soon. Considering dual nurse insertion of indwelling urinary catheters to reduce risk of contamination during insertion.
V. Clostridium *difficile* Infection (CDI) CMS/VBP	**SIR**						
A. Total Infection Count	All units	5 [5]					**1st QTR:** 5 **Predicted:** 16.93
B. SIR CI (KDHCD predicted range, based on risks)		0.108 - 0.655					**1st QTR:** Better than 2019 National Benchmark of 0.852
C. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]		0.3 [0.30]					**1st QTR:**
VI. Hand Hygiene	**95%**						
A. All units Percentage of correct Hand Hygiene observations/opportunities (30 observations/month/unit)		88%					**1st QTR:** 3,397 of 3,877 hand hygiene observations were compliant.
VII. VRE (HAI) Blood-Hospital Onset (HO)	**BM**						
A. Total Infection Count		0					**1st QTR:** 0 **Predicted:** 0
B. Prevalence Rate (x100)		0					**1st QTR:** 0
C. Number Admissions		7236					
VIII. MRSA (HAI) Blood CMS/VBP	**SIR**						
A. Total Infection Count (IP Facility-wide)		3 [3]					**1st QTR:** 3 **Predicted** 1.41
B. SIR CI (KDHCD predicted range, based on risks)		0.541 - 5.785					**1st QTR:** No better than 2019 National Benchmark of 0.815.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2019							
		Q1	**Q2**	**Q3**	**Q4**	**AVG. or TOTAL YTD**	**SUMMARY / ACTION**
C. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]		**2.13** **[2.13]**					**1st QTR:** Many of the identified MRSA BSI are also CLABSI events. Reviewing culture practices with providers through our Operation Stomp-Out CLABSI campaign. Also, working on initiating a "Do U Disinfect Everytime (D.U.D.E.) campaign to highlight the importance of hand hygiene compliance, "scrub-the-hub" and cleaning the patient environment. Trialed and will be universally using Prevantics CHG wipes to perform "scrub-the-hub" a 5 second process. Stakeholders are supporting all these interventions.
IX. Influenza Rates (Year 2018-2019)	**NHSN**						
A. All Healthcare Workers 5,384 working/5,279 total vaccination (90 declined)		**98.0%**					**Season 2018-2019**: **Action:** Once again Kaweah Delta has consistently exceeded the Healthy People 2020 goal of 90% vaccination rate.
Approved IPC: Approved IPC: Approved IPC: Approved IPC: Prepared by Shawn Elkin, MPA, BSN, RN, PHN, CIC Infection Prevention Manager							

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2018							
		Q1	**Q2**	**Q3**	**Q4**	**AVG. or TOTAL YTD**	**SUMMARY / ACTION**
I. Overall Surgical Site Infections (SSI)	**IR/SIR**						**SSIs calculated internally though standard incidence rate and externally through Standardized Infection Ratio (SIR) from National Health and Safety Network (NHSN).**
A. #Total Procedure Count		1042	1270	1168	1478	4958	**Annual running total:** 4,953
B. Total Infection Count *[note: SSI events can be identified up to 90 days from the last day of the month in each quarter]*		**3**	**12**	**12**	**6**	**33**	**1st QTR:** 2 **Predicted:** 10.5 **2nd QTR:** 10 **Predicted**: 14.3 **3rd QTR:** 12 **Predicted:** 12.428 **4th QTR:** 6 **Predicted:** 16.891
C. Incidence Rate (IR) [# of total SSI infections/# total procedures x 100]	Internal 0.70 Goal	**0.287**	**0.945**	**0.794**	**0.41**	**0.609**	
D. SIR Confidence Interval (CI-KDHCD predicted range, based on risks)		0.071 - 0.764	0.444 - 1.393	0.523 - 1.641	0.144 - 0.739		**1st QTR:** Better than California 2016 Total SSI Benchmark of 0.971 **2nd QTR:** Better than California 2016 Total SSI Benchmark of 0.971 **3rd QTR:** Better than California 2016 Total SSI Benchmark of 0.971 **4th QTR:** Better than California 2016 Total SSI Benchmark of 0.971
E. Standardized Infection Ratio (SIR)	NHSN	**0.622**	**0.819**	**0.966**	**0.356**	**0.69**	**1st QTR:** 62% of predicted, doing o.k. No CMS VBP procedures. (1 FUSN; 1 CSEC; 1 CRAN). **2nd QTR:** 82% of predicted, could do better. 3 CMS VBP procedures. (2 APPY; 5 COLO; 1 CRAN; 1 CSEC; 2 PVBY; 1 SB). **3rd QTR:** 97% of predicted, too close for comfort. 1 CMS VBP procedure. (1 APPY; 1 CBGB; 1 COLO; 5 CSEC;1 FUSN;1 FX; 1 HER; 1 HPRO) **4th QTR:** 36% of predicted, doing well. 1 CMS VBP procedure. (1 COLO; 1 CSEC; 1 FX; 1 FUSN; 1 KPRO; 1 SB) **ANNUAL SUMMARY:** Overall SSI rates remain low. However, opportunities for improvement exist with COLO; CSEC, and FUSN procedures.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2018							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
F. Action Plan for Improvement							**1st QTR:** Working with Anesthesia to administer pre-op antibiotics in an effective manner, chiefly appropriate timing well before cut-time and right dosing/re-dosing based on patient BMI and length of surgery. **2nd QTR:** Assembled a meeting with surgery, anesthesia, pharmacy, infectious disease, infection prevention, and quality to determine a single process that best ensures pre-op antibiotic administration 60 minutes prior to cut-time, right dosing and re-dosing based of BMI and length of surgery. **3rd QTR:** Two meetings with Pre-op antibiotic Taskforce. Redesigning pre-op antibiotic delivery process making it more effective. Submitted CSEC cases to OB for review. Submitted all non-OB cases to ASC for review. Units received cases with time spent on unit. Clean-closure practices identified as area needing improvement. **4th QTR:** Continued work on ensuring timely and appropriate pre-op antibiotic administration. Glucose management needs more attention. Literature review underway regarding Clean-closure (IP and nursing in support of this activity). Door entry rates less of an issue. Patient teaching may need to be enhanced. **ANNUAL SUMMARY:** Recommend removal of HYST procedures from the Dashboard. Continue to monitor
II. Specific Surgical Review	**SIR**						
A. Colon Surgery (COLO) CMS/VBP							
1. #Total Procedure Count		26	34	23	56	139	**Annual running total:** 139
2. Total Infection Count		**0** **[0]**	**3** **[3]**	**1** **[0]**	**1** **[1]**	**5** **[4]**	**1st QTR:** 0 **Predicted:** 0.748. **2nd QTR:** 3 **Predicted:** 0.956 **3rd QTR:** 1 **Predicted:** 1.221 **4th QTR:** 1 **Predicted:** 2.863

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2018							
		Q1	**Q2**	**Q3**	**Q4**	**AVG. or TOTAL YTD**	**SUMMARY / ACTION**
3. SIR CI (KDHCD predicted range, based on risks)		0 - 2.655	0.680 - 5.164	0.041 - 4.039	0.030 - 2.936		**1st QTR:** Better than 2018 National Benchmark of 0.781. Value is within the lower limit of 2017 confidence interval (0.881-1.019) **2nd QTR:** Worse than 2018 National Benchmark of 0.781. Value exceeds upper limit of 2017 confidence interval. **3rd QTR:** Better than 2018 National Benchmark of 0.781. Value is within the lower limit of 2017 confidence interval. **4th QTR:** Better than 2018 National Benchmark of 0.781. Value is less than the lower limit of 2017 confidence interval.
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]		**0** **[0]**	**2.942** **[3.14]**	**0.819** **[0]**	**0.349** **[0.686]**	**1.028** **[0.957]**	**1st QTR:** 0% of predicted, very good! No CMS VBP procedures. **2nd QTR:** 194%, [214%] above predicted, unacceptable. These 3 events are both CMS VBP procedures. *(Note: the SIR was manually calculated as the predicted value is less than 1 and not provided by NHSN)* . **3rd QTR:** 22% below predicted, very good. No CMS VBP procedure. **4th QTR:** 35% of predicted [69% of predicted], acceptable. One event that involved a patient from the CMS population. Clean-closure was not performed on this case. **ANNUAL SUMMARY:** Must advocate that Clean-closure continue to be performed for all GI procedures. Tighter glucose control required. Monitor pre-op antibiotic selection now that a reference document is available.
B. Cesarean Section (CSEC)							
1. #Total Procedure Count		370	359	412	392	1533	**Annual running total:** 1,533
2. Total Infection Count		**1**	**1**	**5**	1	8	**1st QTR:** 1 **Predicted:** 3.073 **2nd QTR**: 1 **Predicted:** 3.263 **3rd QTR:** 4 **Predicted:** 2.606 **4th QTR:** 1 **Predicted:** 3.351

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2018							
		Q1	**Q2**	**Q3**	**Q4**	**AVG. or TOTAL YTD**	**SUMMARY / ACTION**
3. SIR CI (KDHCD predicted range, based on risks)		0.016 - 1.605	0.015- 1.512	0.502 - 3.039	0.015 - 1.472		**1st QTR:** No different than California 2016 CSEC Benchmark of 0.96. **2nd QTR:** No different than California 2016 CSEC Benchmark of 0.96. **3rd QTR:** No different than California 2016 CSEC Benchmark of 0.96. **4th QTR:** No different than California 2016 CSEC Benchmark of 0.96.
4. SIR (Standardized Infection Ration) total		**0.325**	**0.307**	**1.371**	**0.30**	**0.58**	**1st QTR:** 33% of predicted, good. Not a CMS VBP procedure. **2nd QTR:** 31% of predicted, good. Not a CMS VBP procedure. **3rd QTR:** 37% above predicted, must do better. Not a CMS VBP procedure. **4th QTR:** 30% of predicted, good. Not a CMS VBP procedure**.** **ANNUAL SUMMARY:** CSEC procedures have been difficult due to very short time between pre-op antibiotic administration and cut-time. Additionally, in some CSEC procedures Clean Closure might apply if a hysterectomy is done simultaneously.
C. Spinal Fusion (FUSN)							
1. #Total Procedure Count		31	28	39	46	144	**Annual running total:** 144
2. Total Infection Count		**1**	**0**	**1**	**1**	**3**	**1st QTR:** 1 **Predicted:** 0.411 **2nd QTR:** 0 **Predicted:** 0.364 **3rd QTR**: 1 **Predicted:** 0.425 **4th QTR:** 1 **Predicted:** 0.338
3. SIR CI (KDHCD predicted range, based on risks)		NA	NA	NA	NA	NA	**1st QTR:** Worse than California 2016 FUSN Benchmark of 0.78. **2nd QTR:** Better than California 2016 FUSN Benchmark of 0.78. **3rd QTR:** Worse than California 2016 FUSN Benchmark of 0.78. **4th QTR:** Worse than California 2016 FUSN Benchmark of 0.78.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2018							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
4. SIR (Standardized Infection Ration) total		2.43	0	2.35	2.959	1.94	**1st QTR:** 143% above predicted. Low volume of procedures and 1 infection results in high SIR. **2nd QTR:** 0% above predicted. Excellent! **3rd QTR:** 135% above predicted. The 1 infection is a superficial surgical site infection that occurred 15 days post-op. **4th QTR:** Nearly 200% above predicted. Low volume of procedures none-the-less there is an SSI each quarter. Considering patient teaching and MRSA screening for this patient population. **ANNUAL SUMMARY:** Too many infections for this low volume procedure. Must consider different options for this patient population. Two procedures were superficial and one deep with an abscess. Consider patient discharge teaching and MRSA screening for this population. **UPDATE**: 4/9/19 it was identified that the FUSN cases had one commonality. They were all discharged to Short Stay at Rehab. Specialist don't follow their patients to this location and nursing care provided at this location is very different from the acute care setting. Discharge instructions are not carried over to the new location. Familiarity with the different dressings is somewhat lacking. **ACTION PLAN:** Meghan, PA will provide onsite evaluations for surgical paitents from Broderick Pavilion discharged to Short Stay. Short Stay staff will be trained on surgical site infection prevention bundles at their upcoming Competency Fair. Nursing and Providers at both Acute Care and Short Stay will work on enhancing their lines of communication to ensure orders and instructions are carried out without
D. Hysterectomy (HYST) CMS/VBP							
1. #Total Procedure Count		16	19	13	21	69	**Annual running total:** 69
2. Total Infection Count		0	0	0	0	0	**1st QTR:** 0 **Predicted:** 0.231 **2nd QTR:** 0 **Predicted**: 0.266 **3rd QTR:** 0 **Predicted:** 0.183 **4th QTR:** 0 **Predicated:** 0.298

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2018							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
3. SIR CI (KDHCD predicted range, based on risks)		NA	NA	NA	NA	NA	**1st QTR:** Better than 2018 Benchmark of 0.722. **2nd QTR:** Better than 2018 National Benchmark of 0.772. **3rd QTR:** Better than 2018 National Benchmark of 0.772. **4th QTR:** Better than 2018 National Benchmark of 0.772.
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]		**0** **[0]**	**0** **[0]**	**0** **[0]**	**0** **[0]**	**0** **[0]**	**1st QTR:** 0% of predicted, very good! This is a CMS VBP procedure. **2nd QTR:** 0% of predicted, excellent! This is a CMS VBP procedure. **3rd QTR:** 0% of predicted, excellent keep up the great work!. This is a CMS VBP procedure. **4th QTR:** 0% of predicted, wonderful job! This is a CMS VBP procedure. **ANNUAL SUMMARY:** Recommend removing this metric from dashboard.
II. Ventilator Associated Events (VAE)	**SIR**						
A. Ventilator Device Use SUR (standardized utilization ratio)		**2.118**	**1.225**	**1.435**	**1.64**	**1.6**	**1st QTR:** 1022 ventilator days (vd) **Predicted:** 482.5 **2nd QTR:** 632 ventilator days (vd) **Predicted:** 515.9 **3rd QTR:** 548 ventilator days (vd) **Predicted:** 381.9 **4th QTR:** 941 ventilator days (vd) **Predicted:** 573.64
B. Total VAEs ICU (NHSN Reportable)	Includes IVAC Plus	**3**	**4**	**3**	**4**	**14**	**1st QTR:** 3 **Predicted:** 6.945 **2nd QTR:** 4 **Predicted**:4.295 **3rd QTR:** 3 **Predicted:** 5.185 **4th QTR:** 4 **Predicted:** 6.395
1. SIR Total VAE CI (KDHCD predicted range, based on risks)		0.110 - 1.176	0.296 - 2.247	0.205 - 2.193	0.199 - 1.509		This is an internal quality driven metric. A State or National benchmark has not been made available.
2. Total VAEs SIR		**0.432**	**0.931**	**0.806**	**0.626**	**0.7**	**1st QTR:** 43% of predicted, good. **2nd QTR:** 93% of predicted, cutting it a little close. **3rd QTR:** 80% of predicted, better still room for improvement. **4th QTR:** 63% of predicted, good.
C. Total IVAC Plus -ICU		**1**	**2**	**0**	**2**	**5**	**1st QTR:** 1 **Predicted:** 2.572 **2nd QTR:** 2 **Predicted**:1.591 **3rd QTR:** 0 **Predicted:** 1.920 **4th QTR:** 2 **Predicted:** 2.368

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2018							
		Q1	**Q2**	**Q3**	**Q4**	**AVG. or TOTAL YTD**	**SUMMARY / ACTION**
1. Total IVAC Plus CI (KDHCD predicted range, based on risks)		0.019 - 1.917	0.211 - 4.154	0 - 1.560	0.142 - 2.790		**1st QTR:** Reported in NHSN. Ensuring that the VAP prevention bundle is being implemented and documented. **2nd QTR:** Number of events has increased compared to 1st QTR. Initiated installation of a small laminated reference card on ventilators that displays critieria for a VAE. Rationale: often ventilator settings are changed indiscriminately and patient has a change with antibiotics this results in an IVAC. Will offer information to residents during 3rd QTR. **3rd QTR:** The third quarter does reflect the start of a new group of residents. VAE subcommittee has contacted two physicians on the subcommittee to attend the meetings and support tighter controls over ventilator settings. There were no VAP events identified during 3rd QTR. **4th QTR:** 50% of events were related to adjustments made to the ventilator and 50% of events were due to the patient developing a pneumonia.
2. Total IVAC *Plus* ICU SIR		**0.389**	**1.591**	**0**	**0.844**	**0.706**	**1st QTR:** 39% of predicted, good. **2nd QTR**: 59% above predicted, unacceptable. **3rd QTR:** 0% of predicted, excellent job!! **4th QTR:** 84% of predicted, ok but room for improvement.
D. CVICU/**KDHCD** Total VAEs (not NHSN/Internal)		**2**	**1**	**3**	**0**	**6**	**1st QTR:** Not reported to State or Federal government. Yet there is room for improvement from a quality perspective. 1 IVAC; 1 PVAP. **2nd QTR:** There was 1 IVAC. **3rd QTR:** Total of 2 VAC; 1 IVAC. **4th QTR:** No VAE in CVICU.
E. Total VAEs-Both Units		**5**	**6**	**6**	**4**	**21**	**1st QTR:** 2 VAC and 2 IVAC, 1 VAP events. Carefully monitor PEEP and FiO2 parameter variations after stability has been met. **2nd QTR:** 2 PVAP, 1 IVAC, 2 VAC. **3rd QTR:** 1 IVAC, 6 VAC. **4th QTR:** 2 VAC, 1 IVAC, 1 PVAP **ANNUAL SUMMARY:** Total of 3 PVAP. VAE Subcommittee pursuing subglottic suction and oral care interventions. Will continue to encourage compliance with all other aspects of VAE prevention bundle.
III. Central Line Associated Blood Stream Infections (CLABSI) CMS/VBP	**NHSN SIR**						

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2018							
		Q1	**Q2**	**Q3**	**Q4**	**AVG. or TOTAL YTD**	**SUMMARY / ACTION**
A. Total number of Central Line Days (CLD)		4162	3486	3382	3313	14343	**Annual running total:** 14,343
B. Central Line Device Use SUR (standardized utilization ratio)		**0.899**	**0.738**	**0.713**	**0.696**	**0.762**	**1st QTR:** 4,162 CLD **Predicted:** 4,627.7 CLD **2nd QTR:** 3,486 CLD **Predicted:** 4,723.49 CLD **3rd QTR:** 3,382 CLD **Predicted:** 4,740.04 CLD **4th QTR:** 3,313 CLD **Predicted**: 4,761.998 CLD
C. Total Infection Count Valule Based Purchasing (VBP) # events = [ ]		**7** **[3]**	**3** **[3]**	**9** **[3]**	**9** **[6]**	**28** **[15]**	**1st QTR:** 7 total **Predicted:** 3.658 **2nd QTR:** 3 total **Predicted:** 3.028 **3rd QTR:** 9 total **Predicted:** 3.007 **4th QTR:** 9 total **Predicted:** 2.912
D. SIR Confidence Interval		0.837 - 3.786	0.252 - 2.697	0.690 - 0.738	1.507 - 5.671		**1st QTR:** Worse than 2018 National Benchmark of 0.784 **2nd QTR:** Worse than 2018 National Benchmark of 0.784. **3rd QTR:** Worse than 2018 National Benchmark of 0.784. **4th QTR:** Worse than 2018 National Benchmark of 0.784.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2018							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]		1.914 [1.209]	0.991 [1.553]	2.993 [1.573]	3.09 [2.651]	2.247 [1.75]	**1st QTR:** 91%, [20%] above predicted. Expired peripheral IV lines and poor central IV line maintenance/infection prevention practice contributing to this increase. Current Actions: Focus studies on central line maintenance; blood collection from lines; medication administration through lines; third party central line prevalence study; daily reminders to remove expired peripheral IV lines; reminders about relocating femoral access central venous catheters ;implementation of new dressing kit and application of a CHG impregnated patch at insertion of central lines. **2nd QTR:** 0.9% below predicted, [55%] above predicted. Similar issues identified during 1st QTR exist during 2nd QTR. New Actions: Full implementation of new Bard All Points dressing kit and GuardIVa CHG patch. Active Train-the-trainer and active training on the units. Nursing Safety Summit started 7/25/18 with an onsite eduction module related to CLABSI. CLABSI Focus Study and now Manager's HAI Prevention Focus Study being completed routinely. **3rd QTR:** 199% [57%] above predicted. Manager HAI Audit Tool; CLABSI Focus Study; Nursing Safety Summit on CLABSI Prevention are all underway continuously. Train-the-trainer on "All Points Dressing kit and GuardIVa patch" completed. Training for all nursing staff near completion. New residency group started June.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2018							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
							Recent CLABSI events are occuring earlier (3-5 days post insertion). Will be requesting physician support at CLABSI prevention subcommittee. Providers need to understand prevention activities. Additionally, provider insertion documentation needs to improve and CLIP form completion needs to be performed by nursing. **4th QTR:** 231% [187%] above predicted. Central Venous Catheter utilization rates are decreasing steadily which does help reduce the risk of CLABSI events. However, management of the central lines indicated and in use must be better. IV Safety Team service line initiated 1/7/19. The team alerts, instructs, and facilitates policy (evidence based practice) driven actions to decrease CLABSI and improve patient outcomes. **ANNUAL SUMMARY:** Several interventions of the CLABSI prevention bundle implemented. Results have been discourage throughout the year. Initiated an IV Safety Team that started January 2019 with the goal of significantly decreasing CLABSI rate.
IV. Catheter Associated Urinary Tract Infections (CAUTI) CMS/VBP	**NHSN SIR**						
A. Total number of Catheter Device Days (CDD)		4500	4806	4518	4164	17988	**Annual running total:** 17,988
B. Catheter Device Days SUR (Standardized Utilization Ratio)		**0.892**	**0.938**	**0.921**	**0.799**	**0.888**	**1st QTR:** 4500 CCD **Predicted:** 5043.6 CDD **2nd QTR:** 4806 CDD **Predicted:** 5,122.64 CDD **3rd QTR:** 3232 CDD **Predicted:** 3,507.83 CDD **4th QTR:** 4164 CDD **Predicted:** 5,210.741 CDD
C. Total Infection Count Value Based Purchasing (VBP) # of events = [ ]		**1** **[1]**	**9** **[4]**	**8** **[6]**	**6** **[2]**	**24** **[13]**	**1st QTR:** 1 **Predicted:** 4.444 **2nd QTR**:9 **Predicted:** 4.794 **3rd QTR:** 8 **Predicted:** 4.554 **4th QTR:** 6 **Predicted:** 4.179
D. SIR Confidence Interval		0.011 - 1.110	0.916 - 3.445	0.816 - 3.336	0.582 - 2.986		**1st QTR:** No Different than 2018 National Benchmark of 0.828 **2nd QTR:** Worse than 2018 National Benchmark of 0.828 and the 2017 upper limit confidence interval of 1.104. **3rd QTR:** Worse than 2018 National Benchmark of 0.828 and the 2017 upper limit confidence interval of 1.104. **4th QTR:** Worse than 2018 National Benchmark of 0.828 and the 2017 upper limit of confidence interval of 1.104.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2018							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]		0.225 [0.331]	1.87 [1.284]	1.76 [2.286]	1.436 [0.821]	1.32 [1.18]	**1st QTR:** 27% [39%] of predicted, good. This is a CMS VBP procedure. **2nd QTR:** 125% [55%] above predicted, unacceptable. This is a CMS VBP procedure. Reviewing catheter utilization rates. Determining why catheters are not being removed when no longer indicated. Also looking at documentation to determine whether the switch over to Cerner has resulted in an increase in CAUTI events. **3rd QTR:** 112% [176%] above predicted, unacceptable. Urinary catheter utilization continues to hover around 90-95% of predicted. Removal of indwelling catheter and patient bathing are some improvement efforts underway. **4th QTR:** 73% above predicted total CAUTI. [CMS population = 0.01% below predicted]. Indwelling urinary catheter utilization is declining slowly. **ANNUAL SUMMARY:** CAUTI increased through the latter part of the year. Current measures involve encouraging patient bathing and pericare, and discouraging "the culture-of-culturing" practices. Physician's order for urine culture is being revised to guide providers in the direction of testing
V. Clostridium *difficile* Infection (CDI) CMS/VBP	**SIR**						
A. Total Infection Count	All units	12	4	4	8	28	**1st QTR:** 12 **Predicted:** 17.661 **2nd QTR:** 4 **Predicted:** 16.401 **3rd QTR:** 4 **Predicted:** 11.397 **4th QTR:** 8 **Predicted:** 14.604
B. SIR CI (KDHCD predicted range, based on risks)		0.368 - 1.155	0.077 - 0.588	0.112 - 0.847	0.254 - 1.040		**1st QTR:** No Different than 2018 National Benchmark of 0.852 **2nd QTR:** Better than 2018 National Benchmark of 0.852 and Better than 2017 lower limit confidence interval of 0.891. **3rd QTR:** Better than 2018 National Benchmark of 0.852 and Better than 2017 lower limit confidence interval of 0.891. **4th QTR:** Better than 2018 National Benchmark of 0.852 and No different than 2017 lower limit confidence interval of 0.891.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2018							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
C. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]		0.679 [0.679]	0.244 [0.244]	0.351 [0.351]	0.548 [0.548]	0.456 [0.454]	**1st QTR:** 68% of predicted, doing o.k., certainly improving. This is a CMS VBP procedure. **2nd QTR:** 24% of predicted, doing much better!!. This is a CMS VBP procedure. ID Pharmacist is working on modifying the order for C. difficile testing to automatically discontinue after 24 hours. This action should help keep our C. difficile rates consistently low. **3rd QTR:** 0% of predicted, excellent job!!!! Still working on modifying order for C. difficile testing to automatically discontinue after 24 hours. **4th QTR:** 55% of predicted, doing o.k., must continue to keep a tight control on appropriateness for C. difficile testing. **ANNUAL SUMMARY:** By far our best metric for the year! Hospital-onset Clostrdium diffcile rates remain low. Still educating staff and providers not to perform C. diff. testing for patients receiving a bowel regimen and/or Lactulose.
VI. Hand Hygiene	**95%**						

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2018							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
A. All units Percentage of correct Hand Hygiene observations/opportunities (30 observations/month/unit)		92%	89%	87%	89%	91%	**1st QTR:** 92%, just under our 95% goal. Current actions to increase hand hygiene include review of technology for monitoring complaince. Continued secret shopper and Infection Prevention hand hygiene monitoring. IP Liaison committee is generating ideas to enhance hand hygiene through a campaign and other measures to ensure greater complaince. **2nd QTR:** 89%, well under our 95% goal. IP Liaison committee provided a list of barriers to hand hygiene compliance and a list of potential solutions to poor hand hygiene compliance. Need IP Committee and Executive Leadership to support a higher standard and accountability to better hand hygiene compliance. **3rd QTR:** 87%, consistently decreasing compliance and way off the mark of the now 90% compliance goal. Of 3,519 observations, 3,071 were compliant and 448 were not compliant. Will need to re-evaluate our current hand hygiene campaign. **4th QTR:** 89%, improving slightly. 3N CUSP team is evaluating the best methods to increase hand hygiene compliance on their unit. BioVigil electronic hand hygiene monitoring will be trialed x 12 months on 4N and ICU. IP Liaison continues actively perform hand hygiene observations throughout the district. **ANNUAL SUMMARY:** Capturing more accurate results with employment of the IP Liaisons performing "secret-shopper" hand hygiene audits. Waiting on exective team approval for deployment of an electronic hand hygiene surveillance trial to be performed in the ICU and on 4N for 12 months.
							Reinforcing with all healthcare personnel that hand hygiene is the primary method to reduce disease transmission.
VII. VRE (HAI) Blood-Hospital Onset (HO)	**BM**						
A. Total Infection Count		0	0	0	0	0	**1st QTR:** 0 **Predicted:** 0 **2nd QTR:** 0 **Predicted:** 0 **3rd QTR:** 0 **Predicted:** 0 **4th QTR:** 0 **Predicted: 0**

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2018							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
B. Prevalence Rate (x100)		0	0	0	0	0	**1st QTR:** 0 **2nd QTR:** 0 **3rd QTR:** 0 **4th QTR:** 0 **ANNUAL SUMMARY:** Recommend removal of this metric from the dashboard.
C. Number Admissions		6179	5832	6126			18,137 admissions
VIII. MRSA (HAI) Blood CMS/VBP	**SIR**						
A. Total Infection Count (IP Facility-wide)		7	1	3	4	15	**1st QTR:** 7 **Predicted** 1.406 **2nd QTR:** 1 **Predicted:** 1.343 **3rd QTR:** 3 **Predicted:** 1.347 **4th QTR:** 4 **Predicted:** 1.452
B. SIR CI (KDHCD predicted range, based on risks)		2.177 - 9.846	0.037 - 3.673	0.566- 6.061	0.875 - 6.644		**1st QTR:** Worse than 2018 National Benchmark of 0.815. **2nd QTR:** Better than 2018 National Benchmark of 0.815 and Better than 2017 lower limit confidence interval of 0.867. **3rd QTR:** No different than 2018 National Benchmark of 0.815. **4th QTR:** Worse than 2018 National Benchmark of 0.815.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2018							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
C. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]		4.977 [4.977]	0.745 [0.745]	2.227 [2.227]	2.75 [2.754]	2.67 [2.67]	**1st QTR:** 416% above predicted, unacceptable. MDRO-Committee meets monthy to address issues related to Hospital Onset MRSA BSI prevalence. Infection Prevention is working with Antimicrobial Stewardship Pharmacist to ensure right drug/bug match. However, added focus is being made recently toward shifting cultural awareness toward meticulous hand hygiene and cooperative environmental cleaning practices. **2nd QTR:** 75% of predicted, on the right track. Infection Prevention continues to be tenacious pushing for removal of expire peripheral IVs. Pharmacy is looking at enhancing Antimicrobial Stewardship Committee (increasing meeting frequency, using assistance from Pharmacy Residents) and continues to work closely with Infectious Disease and Infection Prevention. **3rd QTR:** 141% above predicted. Will be trialing remote hand hygiene compliance sensor system (BioVigil) in February 2019. Emphasizing removal of peripheral IVs that remain as "just-in-case" access. Performing surveillance on expired peripheral IV lines. Changed peripheral IV replacement frequency back to Q72 hours. **4th QTR:** 194% above predicted number of events, unacceptable. Majority of these events are associated with an expired or infiltrated peripheral IV in the presence of a central line. CLABSI and MRSA BSI are closely associated because of this relationship. **ANNUAL SUMMARY:** MRSA BSI rates are elevated in-part to expired peripheral IV lines. IP staff pursue the nursing units daily to remove/replace expired PIV. IV Safety Team will be doing the same.
IX. Influenza Rates (Year 2017-2018)	**NHSN**						
A. All Healthcare Workers 4,844 working/4,769 total vaccination (75 declined)		98.5%					**Season 2017-2018: 98.5%.** Slight Improvement from year 2016/2017- 98%. Reported to CDHP/NHSN. **Action**: MS and HR implemented processes to assure increased gathering of information. **Season 2018-2019**: Will not be available until the end of March 2019.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2018							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
Approved IPC: March 21, 2018 approved Approved IPC: June 20, 2018 approved Approved IPC: December 19, 2018 approved Approved IPC: March 21, 2019 approved Prepared by Shawn Elkin, MPA, BSN, RN, PHN, CIC Infection Prevention Manager							

Strategic Initiative Summary: High Performing OP Delivery Network

Objective

Improve care coordination and maximize access to care

Chair

Minty Dillon
Ryan Gates

ET Sponsor

Malinda Tupper

High Priority Performance Measures	Baseline	2019 Goal	2020 Goal	2021 Goal
Improve Patient Access and Experience				
Improve PCP Identification at Point of Registration	4%="Misc PCP"	<2%	<1%	0%
Outpatient Patient Satisfaction Score (CG-CAHPS)	73.81%	74.91%	TBD**	TBD
% of referrals completed (closing the referral loop)	40.06%	45.05%	TBD**	TBD
% of referrals with initial response within 5-days	24.52%	31.07%	TBD**	TBD
Improve Outpatient Outcomes				
% performance on Outpatient PRIME Metrics	67%	80%	TBD**	TBD
Composite MIPS Score (Quality/Advancing Care/Imp Activities)	83.6%*	+5% improvement	TBD**	TBD

Strategies (Tactics)	Net Annual Impact ($)
Improve referral processing	$619,453.85 (2 PRIME Metrics)
Use current patient satisfaction scores to drive specific interventions	$309,726.92 (1 PRIME Metric)
Improve care-coordination (CDMC, Transitions of Care, Care Navigators, CHWs)	$2,168,08 (7 PRIME metrics)
Develop IT/ data sharing & population health analytics to support proactive patient engagement & management	$8,052,900 (26 PRIME Metrics)

Team Members

Marc Mertz
Dr. Sakona Seng
Dr. Monica Manga
Ben Cripps
Jill Anderson
Leslie Bodoh
Jag Batth
Clint Brown

* MIPS is Calendar Year (Baseline is CY 17)
** PRIME updated benchmarks released in fall 2020

High Performing OP Delivery Network

Strategic Initiative: Patient Access and Experience

Key Components

1.Improve referral processing
- Education on authorization requirements/process by payer
- Centralized support for closing referral loop

2.Implement single point scheduling for entire District
- Centralized phone – Online – App / Universal visibility/ability to schedule
- Onsite (Kiosk vs iPad)
- From home (online/App)

4.Use current patient satisfaction scores to drive specific interventions

5.Continue Community Outreach efforts to improve patient satisfaction
- Empowerment for Better Living, Diabetes Support groups, etc.

6.Evaluate strategies to improve/increase access to care for uninsured

High Performing OP Delivery Network

Strategic Initiative: Improved Outcomes

Key Components

1. **Develop IT/ data sharing and population health analytics to support proactive patient engagement and management**
    - Current state: PI reports. Future state: Health-e Analytics and Health-e Intent
    - Cozeva for at-risk lives
2. **Improve care coordination:**
    - Improve PCP identification
    - Transitions of Care Program
    - Post-Acute Care coordination
    - Patient Care Navigators in PCMH model
    - Community Health Worker assignment to patients meeting complex care criteria
3. **High-Utilizer/Risk Identification and management strategies**
    - Predicted analytics/tool (HUGS, PI report)
    - MIDAS report with PCP identification
4. **Collaborate, review, develop with providers defined outcomes in which to align agreements**
5. **Develop method to collect and present performance/quality to physicians to:**
    - Identify high/low performers
    - Identify best practices and develop/offer help where needed
    - Drive behavior change via peer group/bench mark comparison

MASTER PLANNING STEERING COMMITTEE UPDATE

June 24, 2019

- May 8, 2019 committee meeting discussions:
  - KPMG final report on market analysis
  - Bed count scenarios and selected service lines scenarios
  - Preliminary concepts
  - Start of Space Programming – functional questionnaires distributed to departments (current state and space needs)

- Next steps
  - Draft space program based on data gathered from functional questionnaires (questionnaires were answered and sent back to RBB on June 7, 2019)
  - RBB will schedule next steering committee meeting when draft space program is ready

MASTER PLANNING SCHEDULE	2018		2019										
	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV
CONCEPTUAL / PROGRAMMATIC PHASE													
Data collection, Needs projections, **Functional questionnaires, Space program**, Conceptual costs, Report & presentation to steering committee													
SCHEMATIC PHASE													
Design/ Options, Cost estimate, Report & presentation to steering committee													
DESIGN DEVELOPMENT PHASE													
Design / Options, Cost estimate, Report & presentation to steering committee													
FINAL PHASE													
Complete design, phasing studies, Cost estimate, Final report & presentation to steering committee													

- Mineral King Building Seismic Analysis
  - Currently in Phase 1 – materials testing and conditions assessment
  - OSHPD approved the Testing Program May 23, 2019
  - Next steps for Phase 1 :
    - develop construction documents for plan review (July 2019)
    - OSHPD plan review and building permit (September 2019)
    - Construction – core sampling and testing (October 2019)

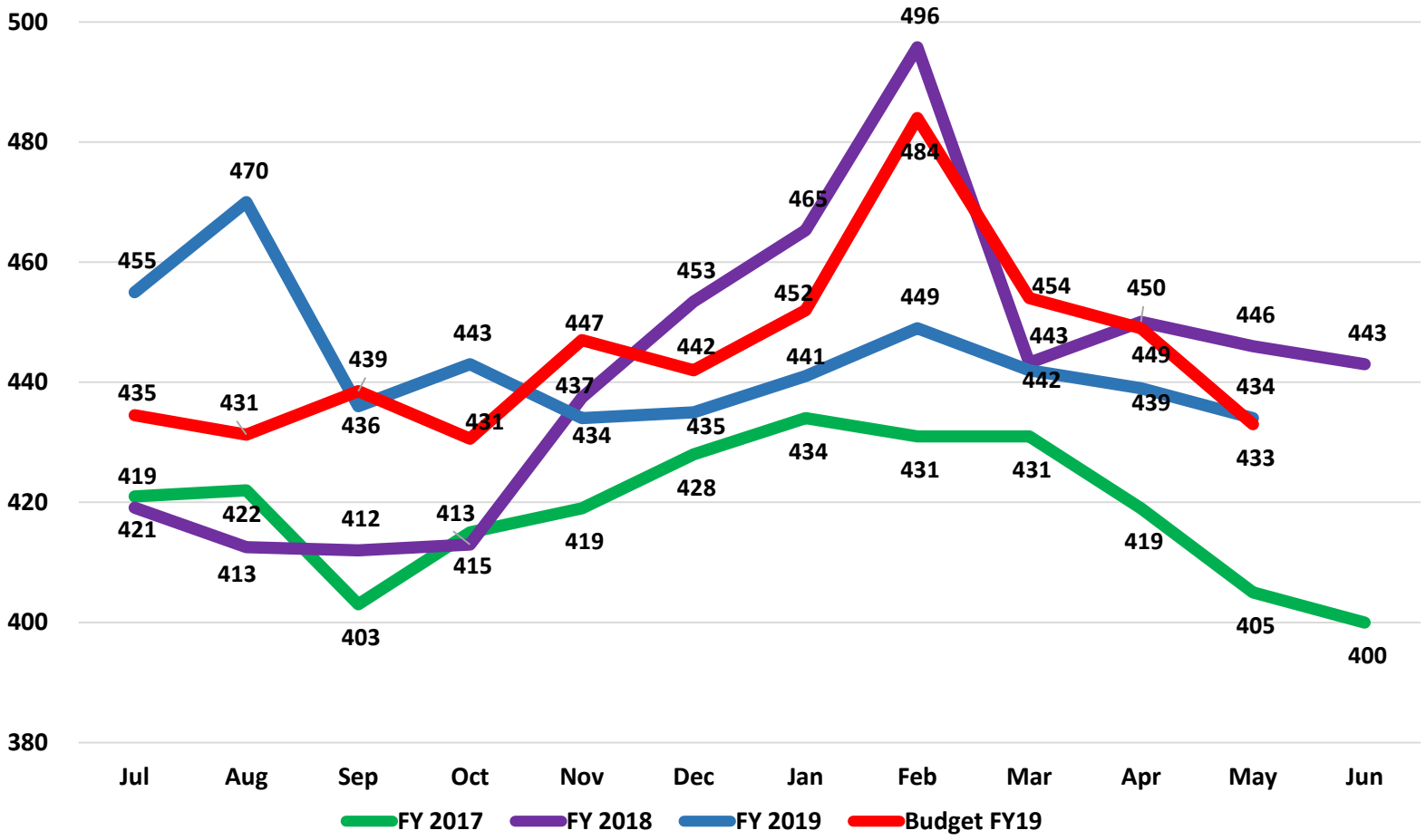
CFO Report MAY19 BOD 62119

CFO Financial Report

June 24, 2019

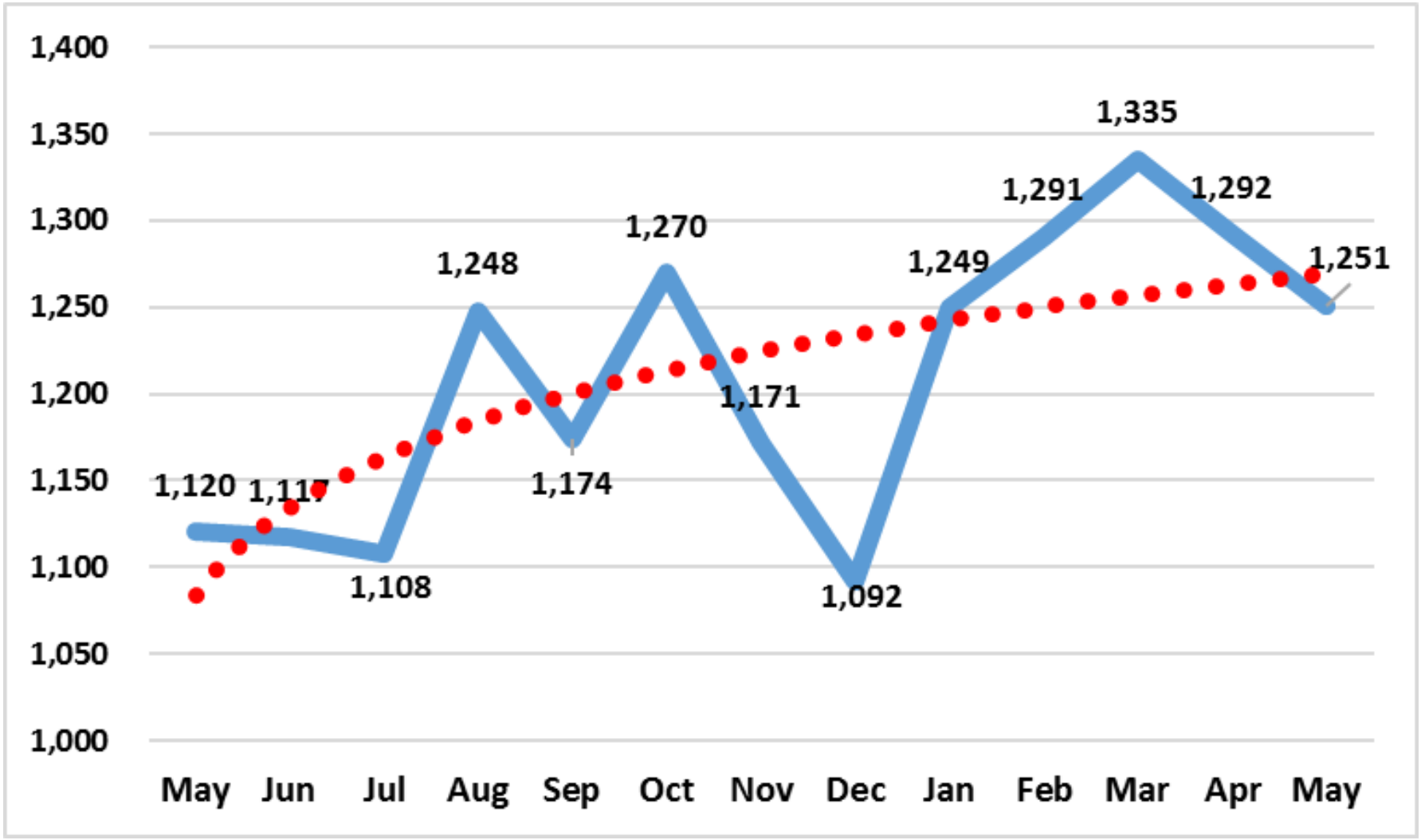
Kaweah Delta
HEALTH CARE DISTRICT

Average Daily Census



	ADC
FYTD 2017	4,628
FYTD 2018	4,848
FYTD 2019	4,878
Budget FYTD19	4,896

Outpatient Registrations per Day



Statistical Results – Fiscal Year Comparison (May)

	Actual Results			Budget	Budget Variance	
	May 2018	May 2019	% Change	May 2019	Change	% Change
Average Daily Census	**446**	**434**	**(2.8%)**	**433**	**1**	**0.2%**
KDHCD Patient Days:						
Medical Center	9,062	8,496	(6.2%)	8,544	(48)	(0.6%)
Acute I/P Psych	1,341	1,462	9.0%	1,449	13	0.9%
Sub-Acute	937	970	3.5%	944	26	2.8%
Rehab	548	620	13.1%	593	27	4.6%
TCS-Ortho	420	469	11.7%	370	99	26.8%
TCS	428	440	2.8%	549	(109)	(19.9%)
NICU	558	500	(10.4%)	389	111	28.5%
Nursery	530	483	(8.9%)	573	(90)	(15.7%)
Total KDHCD Patient Days	**13,824**	**13,440**	**(2.8%)**	**13,411**	**29**	**0.2%**
Total Outpatient Volume	**12,946**	**12,927**	**(0.1%)**	**13,340**	**(413)**	**(3.1%)**

Statistical Results – Fiscal Year Comparison (Jul-May)

	Actual Results			Budget	Budget Variance	
	FY 2018	FY 2019	% Change	FY 2019	Change	% Change
Average Daily Census	**440**	**443**	**0.7%**	**445**	**(1)**	**(0.3%)**
KDHCD Patient Days:						
Medical Center	95,362	95,535	0.2%	95,270	265	0.3%
Acute I/P Psych	15,577	15,766	1.2%	15,932	(166)	(1.0%)
Sub-Acute	10,380	10,378	(0.0%)	10,384	(6)	(0.1%)
Rehab	6,229	6,198	(0.5%)	6,525	(327)	(5.0%)
TCS-Ortho	4,148	4,363	5.2%	4,069	294	7.2%
TCS	5,371	5,252	(2.2%)	6,039	(787)	(13.0%)
NICU	4,173	4,842	16.0%	4,368	474	10.9%
Nursery	6,256	6,201	(0.9%)	6,396	(195)	(3.0%)
Total KDHCD Patient Days	**147,496**	**148,535**	**0.7%**	**148,983**	**(448)**	**(0.3%)**
Total Outpatient Volume	**133,077**	**132,552**	**(0.4%)**	**139,407**	**(6,855)**	**(4.9%)**

Other Statistical Results – Fiscal Year Comparison (May)

	May 2018	May 2019	Change	% Change
Adjusted Patient Days	**26,770**	**26,367**	**(403)**	**(1.5%)**
GME Clinic visits	647	1,134	487	**75.3%**
Endoscopy Procedures (I/P & O/P)	371	520	149	**40.2%**
KDMF RVU	23,756	33,259	9,503	**40.0%**
Surgery Minutes (I/P & O/P)	899	1,050	151	**16.8%**
Urgent Care Visits	4,600	5,242	642	**14.0%**
Hospice Days	3,286	3,737	451	**13.7%**
Radiology/CAT/US/MRI Proc (I/P & O/P)	14,696	16,178	1,482	**10.1%**
Radiation Oncology Treatments (I/P & O/P)	2,023	2,147	124	**6.1%**
Home Health Visits	2,715	2,861	146	**5.4%**
Physical & Other Therapy Units	18,243	19,168	925	**5.1%**
Dialysis Treatments	1,967	1,991	24	**1.2%**
O/P Rehab Units	21,024	21,132	108	**0.5%**
ED Visit	7,585	7,191	(394)	**(5.2%)**
Home Infusion Days	11,924	10,687	(1,237)	**(10.4%)**
OB Deliveries	467	350	(117)	**(25.1%)**

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

	FY 2018	FY 2019	Change	% Change
Adjusted Patient Days	**280,315**	**281,087**	**772**	**0.3%**
Surgery Minutes (I/P & O/P)	9,385	11,167	1,782	**19.0%**
KDMF RVU	292,850	333,694	40,844	**13.9%**
GME Clinic visits	9,752	10,870	1,118	**11.5%**
Urgent Care Visits	57,847	63,385	5,538	**9.6%**
Physical & Other Therapy Units	182,701	196,499	13,798	**7.6%**
Home Health Visits	28,140	29,559	1,419	**5.0%**
Dialysis Treatments	20,377	21,388	1,011	**5.0%**
O/P Rehab Units	209,769	217,757	7,988	**3.8%**
OB Deliveries	4,341	4,388	47	**1.1%**
Radiology/CAT/US/MRI Proc (I/P & O/P)	165,752	164,359	(1,393)	**(0.8%)**
Hospice Days	37,656	36,418	(1,238)	**(3.3%)**
Home Infusion Days	127,087	118,667	(8,420)	**(6.6%)**
ED Visit	84,735	77,715	(7,020)	**(8.3%)**
Endoscopy Procedures (I/P & O/P)	5,807	5,249	(558)	**(9.6%)**
Radiation Oncology Treatments (I/P & O/P)	25,791	22,814	(2,977)	**(11.5%)**

May Financial Results Comparison (000's)

	Actual Results			Budget	Budget Variance	
	May-18	May-19	% Change	May-19	Change	% Change
Operating Revenue						
Net Patient Service Revenue	**$48,498**	**$47,078**	**(2.9%)**	**$50,776**	**($3,697)**	**(7.3%)**
Supplemental Gov't Programs	2,656	8,876	234.2%	3,608	5,267	146.0%
Prime Program	0	604	100.0%	997	(393)	(39.4%)
Premium Revenue	2,777	3,716	33.8%	3,264	453	13.9%
Management Services Revenue	2,599	3,185	22.6%	2,486	699	28.1%
Other Revenue	1,669	2,134	27.9%	1,578	556	35.2%
Other Operating Revenue	**9,700**	**18,515**	**90.9%**	**11,933**	**6,582**	**55.2%**
Total Operating Revenue	**58,198**	**65,593**	**12.7%**	**62,709**	**2,885**	**4.6%**
Operating Expenses						
Salaries and Wages	21,910	24,556	12.1%	24,198	358	1.5%
Contract Labor	1,037	884	(14.8%)	312	572	183.3%
Employee Benefits	5,902	6,665	12.9%	6,181	484	7.8%
Total Employment Expenses	**28,849**	**32,104**	**11.3%**	**30,690**	**1,414**	**4.6%**
Medical and Other Supplies	9,240	9,728	5.3%	9,203	525	5.7%
Physician Fees	6,939	8,403	21.1%	6,839	1,564	22.9%
Purchased Services	3,549	3,801	7.1%	3,131	671	21.4%
Repairs and Maintenance	2,232	2,501	12.0%	2,136	365	17.1%
Utilities	436	447	2.5%	499	(52)	(10.4%)
Rents and Leases	542	538	(0.8%)	544	(6)	(1.1%)
Depreciation and Amortization	2,522	2,667	5.7%	3,124	(458)	(14.6%)
Interest Expense	582	460	(21.0%)	501	(41)	(8.1%)
Other Expenses	2,391	(14)	(100.6%)	1,817	(1,830)	(100.8%)
Management Services Expenses	2,592	2,866	10.6%	2,441	425	17.4%
Total Operating Expenses	**59,875**	**63,501**	**6.1%**	**60,924**	**2,577**	**4.2%**
Operating Margin	**($1,677)**	**$2,093**	**224.8%**	**$1,785**	**$308**	**17.3%**
Nonoperating Revenue (Loss)	562	585	4.1%	516	69	13.5%
Excess Margin	**($1,115)**	**$2,678**	**340.2%**	**$2,300**	**$378**	**16.4%**
Operating Margin %	**(2.9%)**	**3.2%**		**2.8%**		

YTD Financial Results Comparison (000's)

	Actual Results FYTD Jul-May			Budget FYTD	Budget Variance FYTD	
	May-18	May-19	% Change	May-19	Change	% Change
Operating Revenue:						
Net Patient Service Revenue	**$521,567**	**$514,728**	**(1.3%)**	**$555,093**	**($40,365)**	**(7.3%)**
Supplemental Gov't Programs	29,214	66,942	129.1%	39,692	27,250	68.7%
Prime Program	17,091	12,237	(28.4%)	10,967	1,270	11.6%
Premium Revenue	29,328	36,251	23.6%	32,667	3,584	11.0%
Management Services Revenue	26,585	29,387	10.5%	26,862	2,525	9.4%
Other Revenue	17,370	21,864	25.9%	16,839	5,025	29.8%
Other Operating Revenue	**119,588**	**166,681**	**39.4%**	**127,027**	**39,653**	**31.2%**
Total Operating Revenue	**641,155**	**681,409**	**6.3%**	**682,121**	**(712)**	**(0.1%)**
Operating Expenses:						
Salaries and Wages	244,095	263,897	8.1%	263,612	286	0.1%
Contract Labor	8,113	14,050	73.2%	3,377	10,673	316.1%
Employee Benefits	66,239	68,811	3.9%	66,769	2,042	3.1%
Total Employment Expenses	**318,447**	**346,758**	**8.9%**	**333,757**	**13,001**	**3.9%**
Medical and Other Supplies	101,731	106,000	4.2%	103,821	2,179	2.1%
Physician Fees	68,724	77,866	13.3%	75,501	2,365	3.1%
Purchased Services	35,130	35,699	1.6%	32,506	3,193	9.8%
Repairs and Maintenance	21,835	23,964	9.7%	23,442	521	2.2%
Utilities	5,014	5,186	3.4%	5,392	(206)	(3.8%)
Rents and Leases	5,238	5,532	5.6%	5,985	(453)	(7.6%)
Depreciation and Amortization	22,558	27,987	24.1%	30,315	(2,328)	(7.7%)
Interest Expense	4,507	5,015	11.3%	5,506	(491)	(8.9%)
Other Expenses	16,654	15,754	(5.4%)	19,632	(3,878)	(19.8%)
Management Services Expenses	26,074	28,612	9.7%	26,378	2,234	8.5%
Total Operating Expenses	**625,911**	**678,373**	**8.4%**	**662,236**	**16,138**	**2.4%**
Operating Margin	**$15,244**	**$3,035**	**(80.1%)**	**$19,885**	**($16,850)**	**(84.7%)**
Nonoperating Revenue	3,204	8,744	172.9%	5,586	3,158	56.5%
Excess Margin	**$18,448**	**$11,779**	**(36.1%)**	**$25,471**	**($13,692)**	**(53.8%)**
Operating Margin %	**2.4%**	**0.4%**		**2.9%**		

Kaweah Delta Medical Foundation
Fiscal Year Financial Comparison (000's)

	Actual Results FYTD Jul-May			Budget FYTD	Budget Variance FYTD	
	2018	2019	% Change	2019	Change	% Change
Operating Revenue:						
Net patient service revenue	**$35,856**	**$40,199**	**12.1%**	**$42,022**	**($1,823)**	**(4.3%)**
Other Revenue	328	481	47.0%	383	99	25.8%
Other operating revenue	**328**	**481**	**47.0%**	**383**	**99**	**25.8%**
Total Operating Revenue	**36,184**	**40,680**	**12.4%**	**42,405**	**(1,725)**	**(4.1%)**
Operating Expenses:						
Salaries and wages	9,241	10,497	13.6%	10,486	11	0.1%
Contract labor	30	132	340.9%	0	132	0.0%
Employee benefits	2,487	2,744	10.3%	2,664	79	3.0%
Total Employment Expenses	**11,757**	**13,373**	**13.7%**	**13,150**	**223**	**1.7%**
Medical and other supplies	4,635	5,564	20.0%	5,375	189	3.5%
Physician fees	17,853	20,728	16.1%	20,890	(162)	(0.8%)
Purchased services	1,170	1,233	5.3%	1,255	(22)	(1.7%)
Repairs and maintenance	1,819	1,660	(8.7%)	1,884	(224)	(11.9%)
Utilities	336	370	10.0%	420	(51)	(12.0%)
Rents and leases	2,299	2,462	7.1%	2,666	(204)	(7.7%)
Depreciation and amortization	1,041	1,136	9.1%	951	185	19.5%
Interest Expense	32	20	(38.0%)	35	(15)	(43.3%)
Other Expenses	1,191	1,582	32.8%	1,155	426	36.9%
Total Operating Expenses	**42,134**	**48,126**	**14.2%**	**47,781**	**346**	**0.7%**
Excess Margin	**($5,951)**	**($7,446)**	**(25.1%)**	**($5,376)**	**($2,070)**	**(38.5%)**
Excess Margin %	**(16.4%)**	**(18.4%)**		**(12.7%)**		

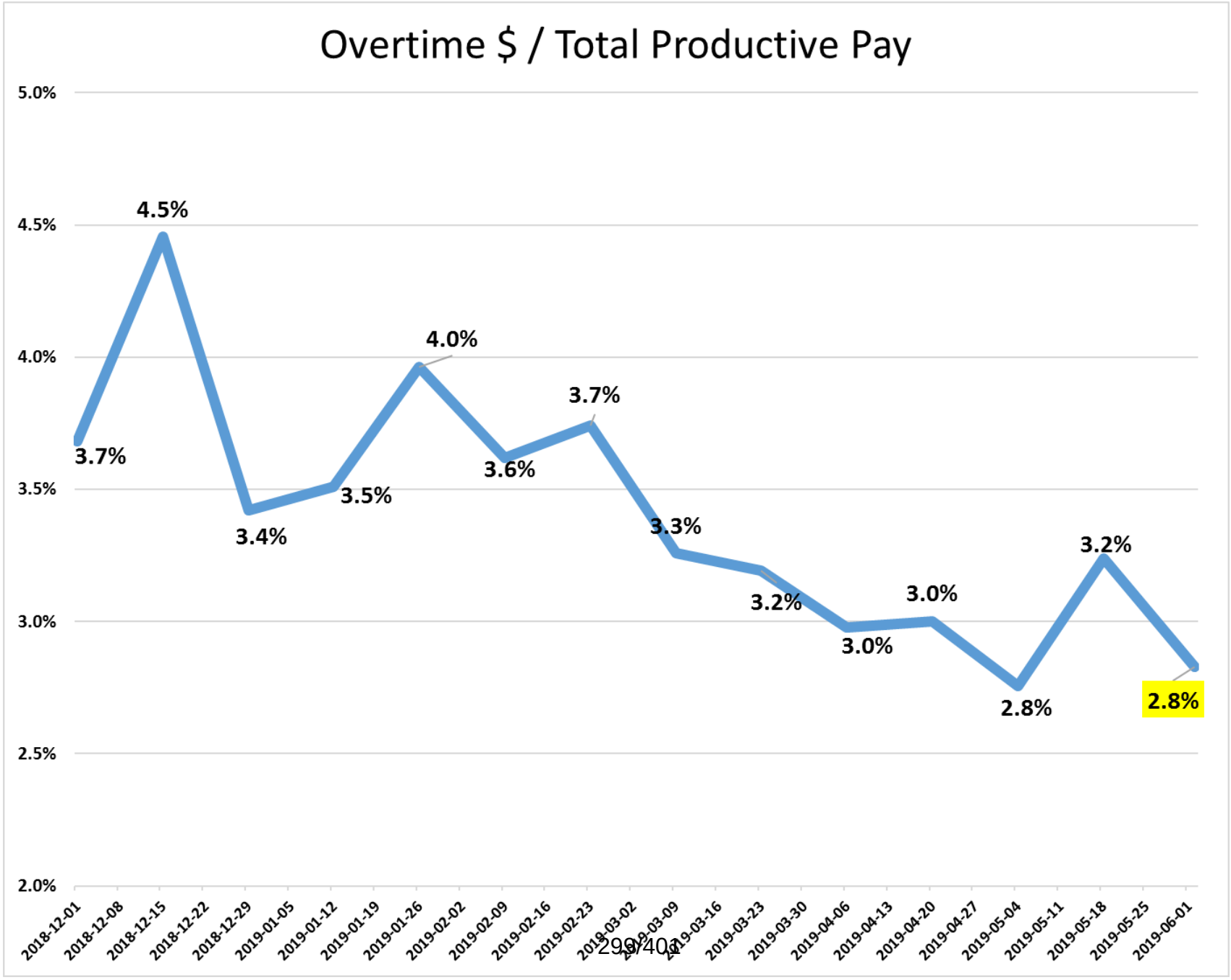
Unrecorded Pending Impacts FY 19

Prime High Performing Metrics	$4,251,891
Medicare Bad Debt – Cost report FY 15-FY19	$1,870,000
Establish Inventory for OR	$1,250,000
Operation Bottom Line	$2,023,961
Humana MA Year End Settlement	$955,000
Workers Compensation Accrual Adjustment	$1,400,000
Reduction Pension Expense	$1,418,000
Total Possible	$13,168,852

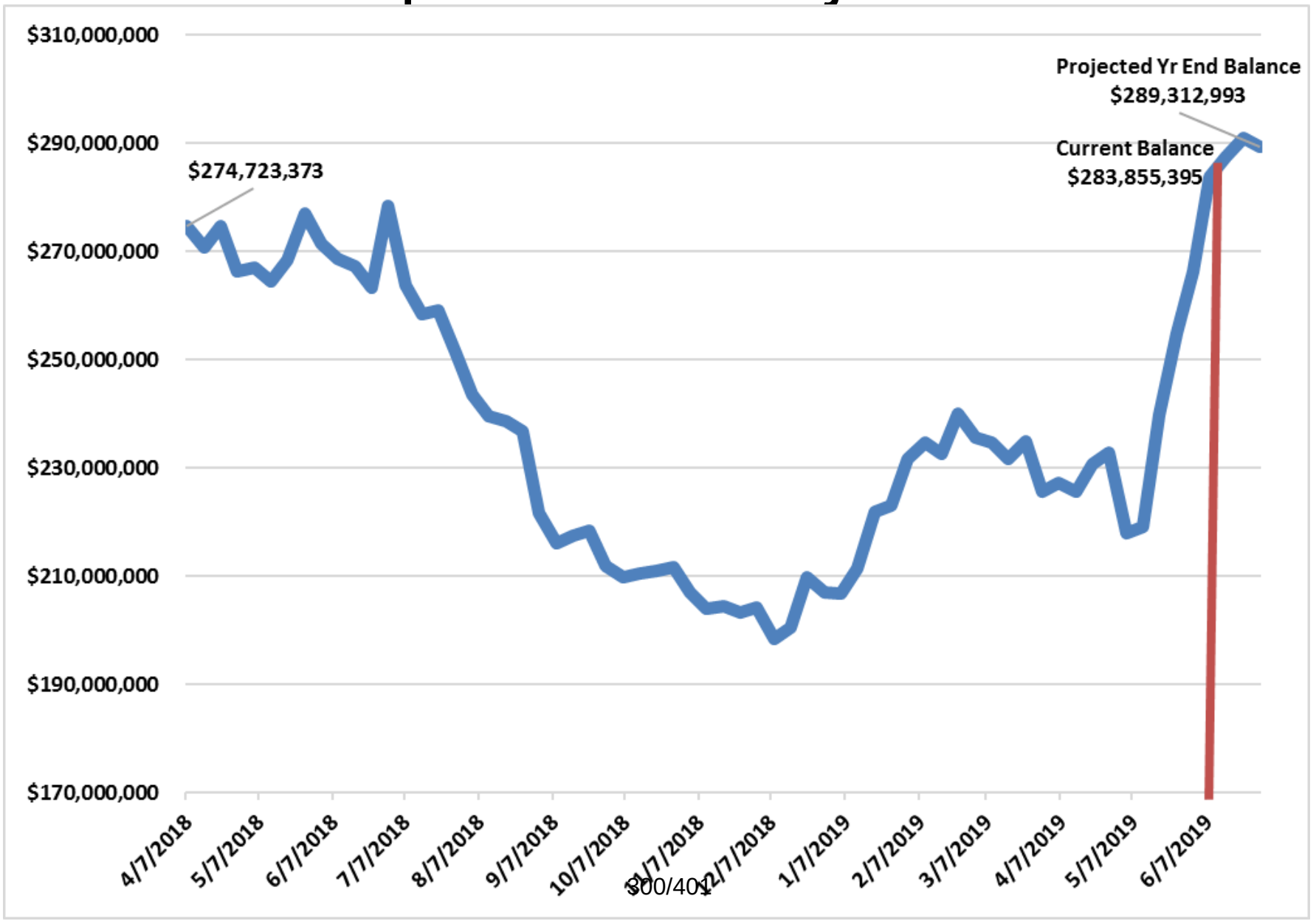
Operation Bottom Line Results

Target Hit!

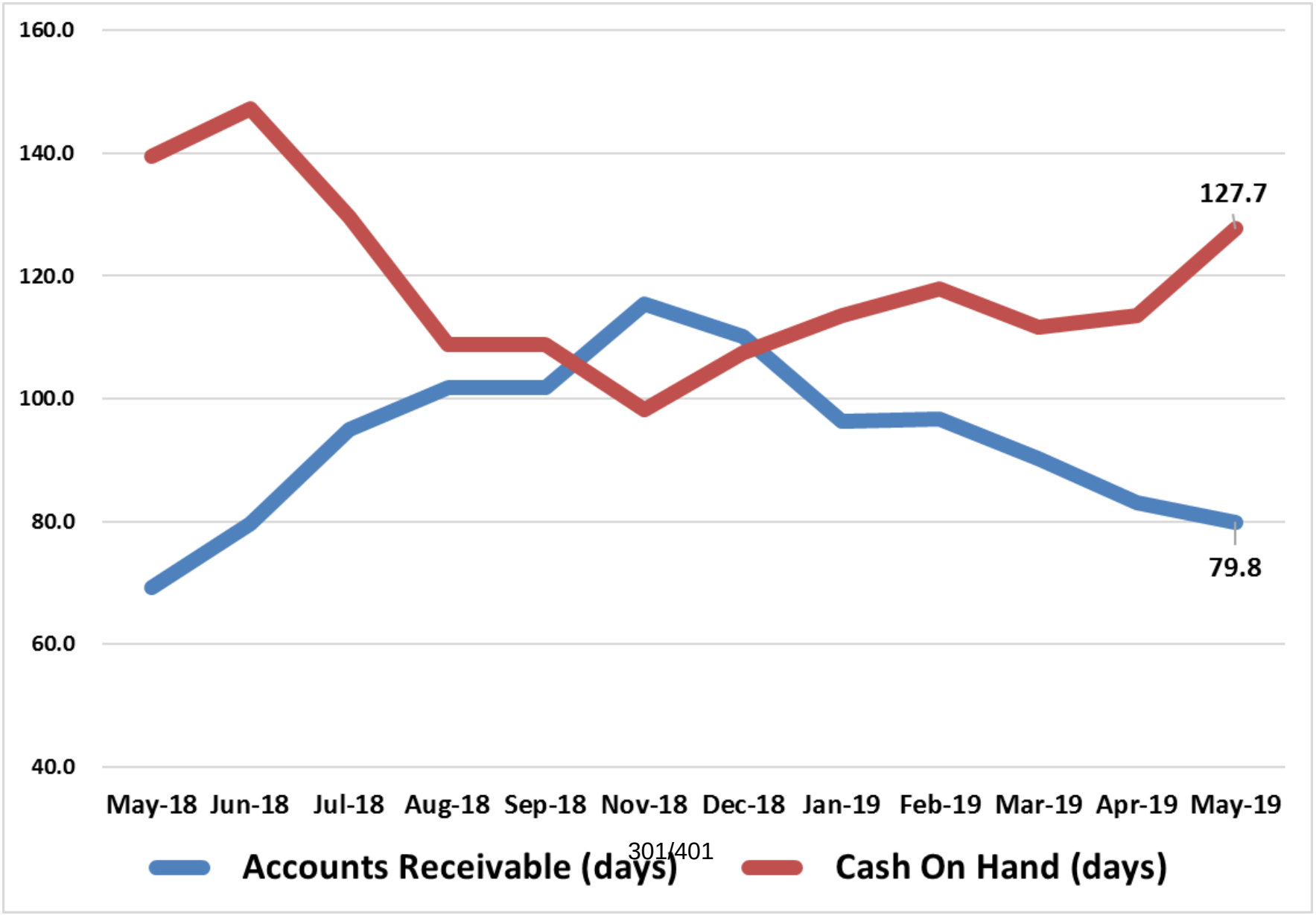
Initiative Groupings	March 2019			April 2019			Total		
	Original	Actual	Diff.	Original	Actual	Diff.	Original	Actual	Diff.
Increases Revenue/Volume	1,256,379	1,375,109	118,730	1,591,327	1,950,913	368,835	2,847,706	3,326,022	**487,565**
Decreases in Supply Costs	1,942,199	2,155,033	212,833	1,115,441	1,418,924	326,236	3,057,640	3,573,957	**539,069**
Decreases in Worked Hours	466,634	295,307	(171,327)	524,310	337,965	(107,294)	990,944	633,271	**(278,621)**
Decreases in Other Expenses - Legal, Phone, Consults	190,872	340,155	149,284	467,851	344,003	(118,445)	658,722	684,158	**30,839**
Reduction in Length of Stay	178,794	0	(178,794)	254,544	377,896	139,756	433,338	377,896	**(39,038)**
Decreases in Prem. Pay Code Usage (OT, Call back)	196,094	151,890	(44,205)	253,204	239,089	(115,456)	449,298	390,978	**(159,660)**
Decreases in Purchases Services	233,151	124,505	(108,646)	128,906	114,937	(72,641)	362,057	239,442	**(181,287)**
Reduction in Contract Labor	184,241	102,914	(81,327)	123,632	85,521	(42,182)	307,874	188,435	**(123,509)**
Reduction in Travel / Seminars	144,459	65,486	(78,973)	110,945	47,448	(64,294)	255,404	112,934	**(143,267)**
Reduction in Meetings/ Catering	57,156	59,325	2,170	85,574	103,879	8,520	142,729	163,204	**10,690**
Total	**4,849,979**	**4,669,723**	**(180,256)**	**4,655,733**	**5,020,574**	**323,036**	**9,505,713**	**9,690,297**	**142,780**


Overtime $ / Total Productive Pay
5.0%
4.5%
4.0%
3.5%
3.0%
2.5%
2.0%
3.7%
4.5%
3.4%
3.5%
4.0%
3.6%
3.7%
3.3%
3.2%
3.0%
3.0%
2.8%
3.2%
2.8%
2018-12-01
2018-12-08
2018-12-15
2018-12-22
2018-12-29
2019-01-05
2019-01-12
2019-01-19
2019-01-26
2019-02-02
2019-02-09
2019-02-16
2019-02-23
2019-03-02
2019-03-09
2019-03-16
2019-03-23
2019-03-30
2019-04-06
2019-04-13
2019-04-20
2019-04-27
2019-05-04
2019-05-11
2019-05-18
2019-05-25
2019-06-01

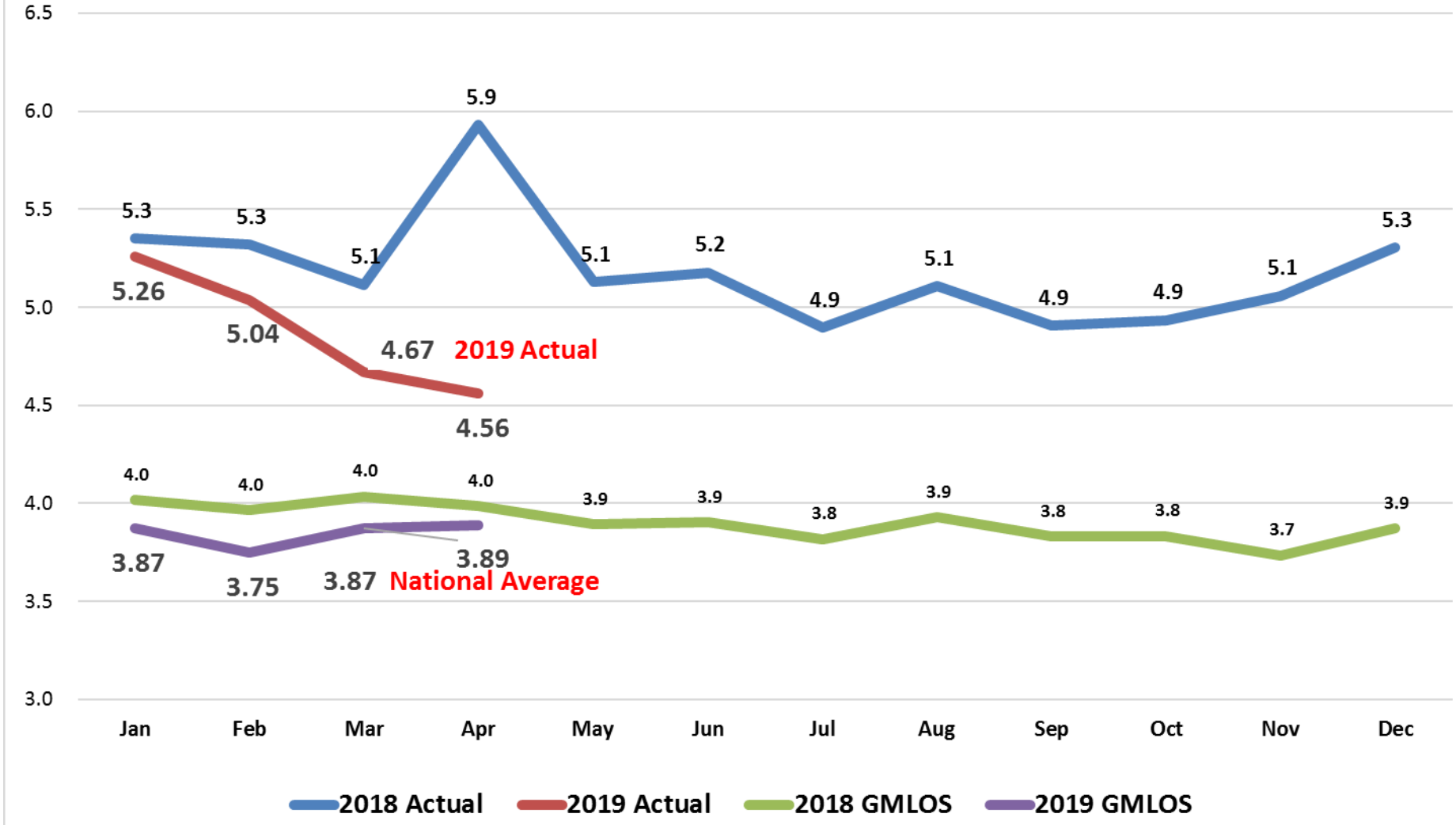
Surplus Cash Projection

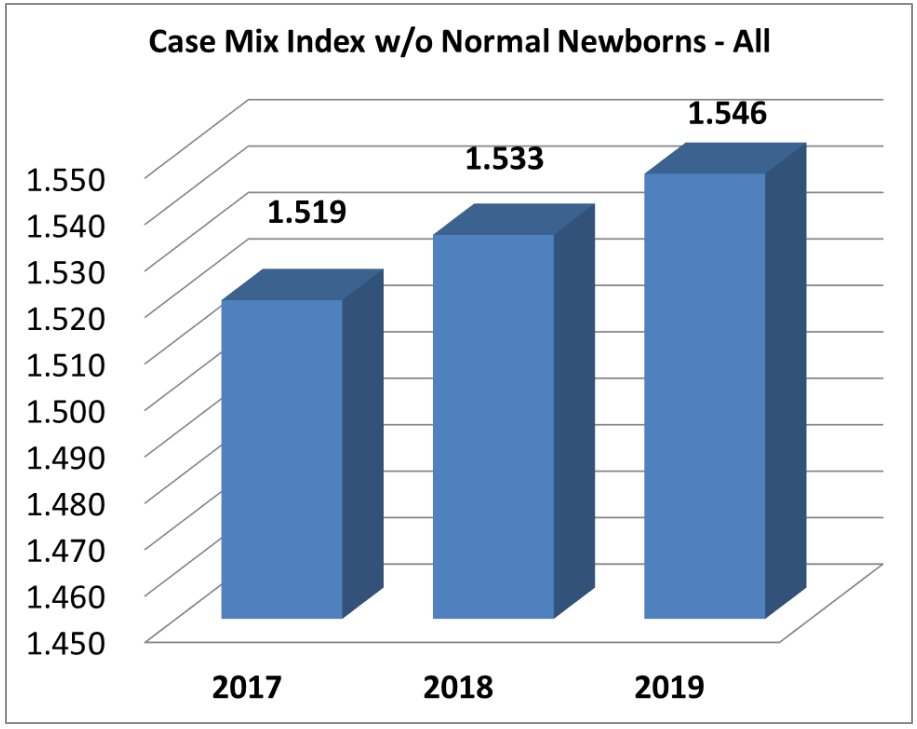


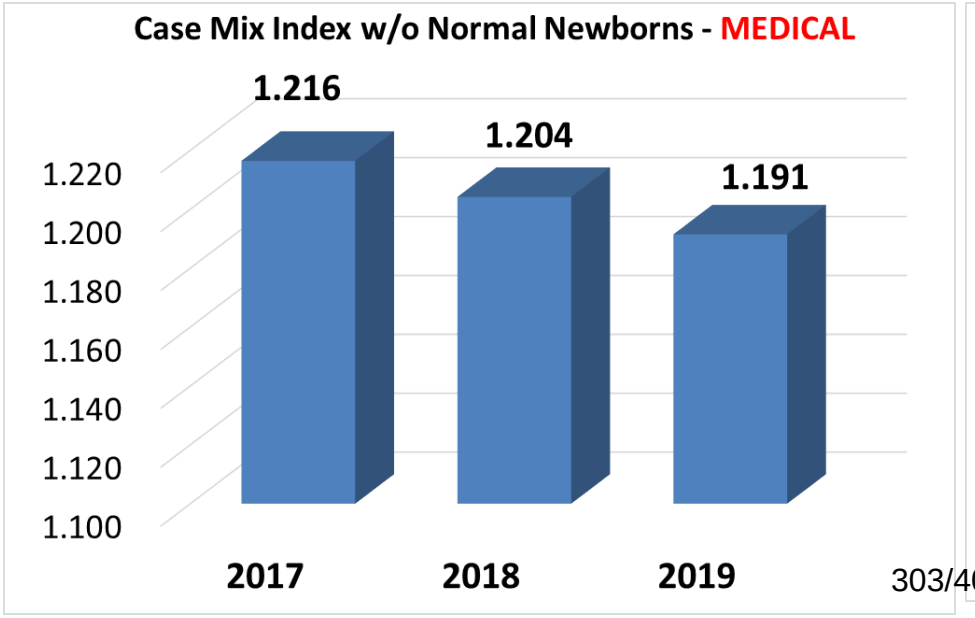
Days in Cash - Days in Accounts Receivable



Average Length of Stay versus National Average (GMLOS)




Case Mix Index w/o Normal Newborns - All
1.550
1.540
1.530
1.520
1.510
1.500
1.490
1.480
1.470
1.460
1.450
1.519
1.533
1.546
2017
2018
2019


Case Mix Index w/o Normal Newborns - MEDICAL
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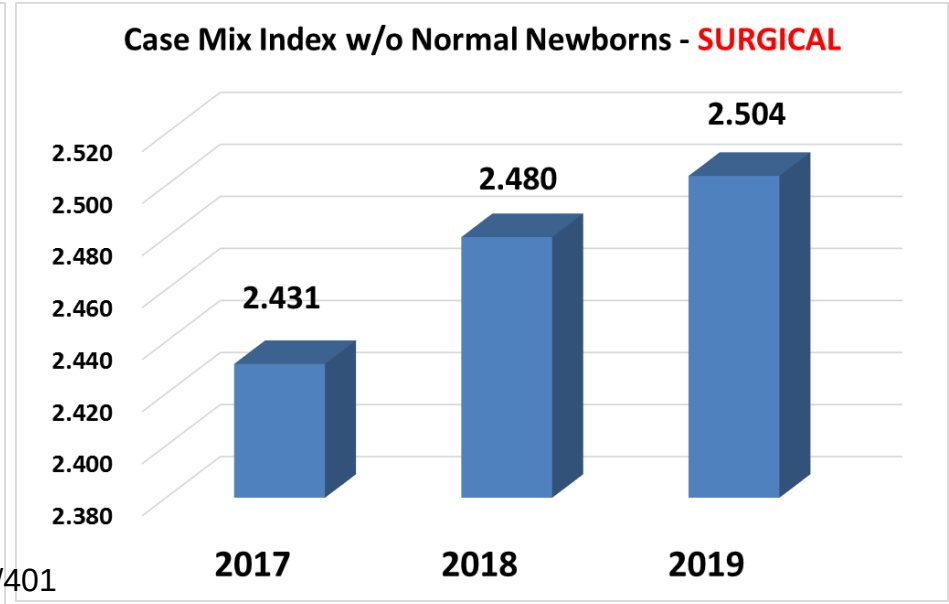
1.200
1.180
1.160
1.140
1.120
1.100
1.216
1.204
1.191
2017
2018
2019


Case Mix Index w/o Normal Newborns - SURGICAL
2.520
2.500
2.480
2.460
2.440
2.420
2.400
2.380
2.431
2.480
2.504
2017
2018
2019

KAWEAH DELTA HEALTH CARE DISTRICT
CONSOLIDATED INCOME STATEMENT (000's)
FISCAL YEAR 2018 & 2019

	Operating Revenue			Operating Expenses									
Fiscal Year	Net Patient Revenue	Other Operating Revenue	Operating Revenue Total	Personnel Expense	Physician Fees	Supplies Expense	Other Operating Expense	Operating Expenses Total	Operating Income	Non-Operating Income	Net Income	Operating Margin %	Excess Margin
2018													
Jul-17	45,574	9,538	55,112	27,540	5,046	8,360	11,461	52,407	2,705	492	3,197	4.9%	5.8%
Aug-17	45,582	10,283	55,865	27,549	5,506	8,905	12,236	54,197	1,669	462	2,131	3.0%	3.8%
Sep-17	43,354	10,246	53,599	27,950	5,505	8,372	11,751	53,577	22	855	877	0.0%	1.6%
Oct-17	46,452	17,695	64,146	29,020	6,309	8,908	12,147	56,384	7,762	378	8,140	12.1%	12.7%
Nov-17	50,375	9,591	59,965	29,430	6,430	9,654	12,441	57,955	2,010	541	2,551	3.4%	4.3%
Dec-17	49,412	8,979	58,391	27,470	6,035	9,768	12,155	55,428	2,963	(326)	2,637	5.1%	4.5%
Jan-18	50,813	9,879	60,692	29,912	6,289	10,672	12,175	59,047	1,645	612	2,256	2.7%	3.7%
Feb-18	46,636	9,308	55,944	28,254	6,600	9,212	11,136	55,202	742	666	1,408	1.3%	2.5%
Mar-18	49,209	10,487	59,696	32,141	7,348	9,693	13,554	62,736	(3,040)	(1,621)	(4,660)	(5.1%)	(7.8%)
Apr-18	45,936	13,610	59,546	30,332	6,715	8,948	13,107	59,103	443	583	1,026	0.7%	1.7%
May-18	48,498	9,700	58,198	28,849	6,939	9,240	14,847	59,875	(1,677)	562	(1,115)	(2.9%)	(1.9%)
Jun-18	46,257	24,860	71,116	31,029	6,325	8,658	16,702	62,713	8,403	502	8,905	11.8%	12.5%
2018 FY Total	**$ 568,097**	**$ 144,175**	**$ 712,272**	**$ 349,476**	**$ 75,049**	**$ 110,389**	**$ 153,711**	**$ 688,624**	**$ 23,647**	**$ 3,706**	**$ 27,353**	**3.3%**	**3.8%**
2019													
Jul-18	49,124	11,390	60,514	30,147	6,300	9,585	12,701	58,733	1,781	434	2,215	2.9%	3.7%
Aug-18	52,124	11,471	63,594	31,602	7,668	10,624	12,980	62,874	721	451	1,171	1.1%	1.8%
Sep-18	46,634	11,659	58,293	29,835	6,524	8,862	13,361	58,582	(289)	912	624	(0.5%)	1.1%
Oct-18	48,769	11,646	60,414	32,849	7,145	9,867	13,066	62,927	(2,513)	343	(2,169)	(4.2%)	(3.6%)
Nov-18	43,870	18,365	62,235	31,066	7,310	10,195	13,900	62,470	(235)	449	214	(0.4%)	0.3%
Dec-18	43,717	14,732	58,449	31,115	7,023	10,329	12,736	61,202	(2,753)	613	(2,140)	(4.7%)	(3.7%)
Jan-19	44,312	18,178	62,489	34,290	6,624	8,909	13,104	62,927	(438)	460	22	(0.7%)	0.0%
Feb-19	45,261	15,334	60,595	30,249	6,989	9,473	13,280	59,991	604	565	1,169	1.0%	1.9%
Mar-19	48,012	18,073	66,085	32,229	6,775	9,219	13,608	61,832	4,253	3,328	7,580	6.4%	11.5%
Apr-19	45,828	17,318	63,146	31,272	7,105	9,209	15,748	63,334	(188)	604	416	(0.3%)	0.7%
May-19	47,078	18,515	65,594	32,104	8,403	9,728	13,265	63,501	2,093	585	2,678	3.2%	4.1%
2019 FY Total	**$ 514,728**	**$ 166,681**	**$ 681,409**	**$ 346,758**	**$ 77,866**	**$ 106,000**	**$ 147,749**	**$ 678,373**	**$ 3,035**	**$ 8,744**	**$ 11,779**	**0.4%**	**1.7%**
FYTD Budget	**555,093**	**127,027**	**682,121**	**333,757**	**75,501**	**103,821**	**149,157**	**662,236**	**19,885**	**5,586**	**25,471**	**2.9%**	**3.7%**
Variance	**$ (40,365)**	**$ 39,653**	**$ (712)**	**$ 13,001**	**$ 2,365**	**$ 2,179**	**$ (1,408)**	**$ 16,138**	**$ (16,850)**	**$ 3,158**	**(13,692)**		
Current Month Analysis													
May-19	**$ 47,078**	**$ 18,515**	**$ 65,594**	**$ 32,104**	**$ 8,403**	**$ 9,728**	**$ 13,265**	**$ 63,501**	**$ 2,093**	**$ 585**	**$ 2,678**	**3.2%**	**4.1%**
Budget	**50,776**	**11,933**	**62,709**	**30,690**	**6,839**	**9,203**	**14,192**	**60,924**	**1,785**	**516**	**2,300**	**2.8%**	**3.7%**
Variance	**$ (3,697)**	**$ 6,583**	**$ 2,885**	**$ 1,414**	**$ 1,564**	**$ 525**	**$ (927)**	**$ 2,577**	**$ 309**	**$ 69**	**$ 378**		

KAWEAH DELTA HEALTH CARE DISTRICT

FISCAL YEAR 2018 & 2019

Fiscal Year	Patient Days	ADC	Adjusted Patient Days	I/P Revenue %	DFR & Bad Debt %	Net Patient Revenue/ Ajusted Patient Day	Personnel Expense/ Ajusted Patient Day	Physician Fees/ Ajusted Patient Day	Supply Expense/ Ajusted Patient Day	Total Operating Expense/ Ajusted Patient Day	Personnel Expense/ Net Patient Revenue	Physician Fees/ Net Patient Revenue	Supply Expense/ Net Patient Revenue	Total Operating Expense/ Net Patient Revenue
2018														
Jul-17	12,992	419	25,148	51.7%	72.8%	1,812	1,095	201	332	2,084	60.4%	11.1%	18.3%	115.0%
Aug-17	12,788	413	25,508	50.1%	73.9%	1,787	1,080	216	349	2,125	60.4%	12.1%	19.5%	118.9%
Sep-17	12,360	412	24,864	49.7%	72.9%	1,744	1,124	221	337	2,155	64.5%	12.7%	19.3%	123.6%
Oct-17	12,802	413	25,261	50.7%	73.8%	1,839	1,149	250	353	2,232	62.5%	13.6%	19.2%	121.4%
Nov-17	13,124	437	24,731	53.1%	71.6%	2,037	1,190	260	390	2,343	58.4%	12.8%	19.2%	115.0%
Dec-17	14,056	453	25,502	55.1%	73.4%	1,938	1,077	237	383	2,173	55.6%	12.2%	19.8%	112.2%
Jan-18	14,425	465	26,797	53.8%	73.4%	1,896	1,116	235	398	2,204	58.9%	12.4%	21.0%	116.2%
Feb-18	13,882	496	25,172	55.1%	73.2%	1,853	1,122	262	366	2,193	60.6%	14.2%	19.8%	118.4%
Mar-18	13,741	443	25,441	54.0%	73.9%	1,934	1,263	289	381	2,466	65.3%	14.9%	19.7%	127.5%
Apr-18	13,502	450	25,380	53.2%	74.4%	1,810	1,195	265	353	2,329	66.0%	14.6%	19.5%	128.7%
May-18	13,824	446	26,770	51.6%	73.6%	1,812	1,078	259	345	2,237	59.5%	14.3%	19.1%	123.5%
Jun-18	13,238	441	24,831	53.3%	72.3%	1,863	1,250	255	349	2,526	67.1%	13.7%	18.7%	135.6%
2018 FY Total	**160,734**	**440**	**305,158**	**52.7%**	**73.3%**	**1,862**	**1,145**	**246**	**362**	**2,257**	**61.5%**	**13.2%**	**19.4%**	**121.2%**
2019														
Jul-18	14,096	455	26,287	53.6%	72.4%	1,869	1,147	240	365	2,234	61.4%	12.8%	19.5%	119.6%
Aug-18	14,569	470	28,016	52.0%	76.0%	1,861	1,128	274	379	2,244	60.6%	14.7%	20.4%	120.6%
Sep-18	13,052	435	24,371	53.6%	73.5%	1,914	1,224	268	364	2,404	64.0%	14.0%	19.0%	125.6%
Oct-18	13,744	443	25,579	53.7%	73.5%	1,907	1,284	279	386	2,460	67.4%	14.7%	20.2%	129.0%
Nov-18	13,013	434	23,625	55.1%	74.9%	1,857	1,315	309	432	2,644	70.8%	16.7%	23.2%	142.4%
Dec-18	13,497	435	25,399	53.1%	76.2%	1,721	1,225	277	407	2,410	71.2%	16.1%	23.6%	140.0%
Jan-19	13,671	441	26,407	51.8%	76.9%	1,678	1,299	251	337	2,383	77.4%	14.9%	20.1%	142.0%
Feb-19	12,584	449	23,811	52.8%	75.9%	1,901	1,270	294	398	2,519	66.8%	15.4%	20.9%	132.5%
Mar-19	13,707	442	26,032	52.7%	76.9%	1,844	1,238	260	354	2,375	67.1%	14.1%	19.2%	128.8%
Apr-19	13,162	439	25,125	52.4%	76.9%	1,824	1,245	283	367	2,521	68.2%	15.5%	20.1%	138.2%
May-19	13,440	434	26,367	51.0%	75.3%	1,785	1,218	319	369	2,408	68.2%	17.8%	20.7%	134.9%
2019 FY Total	**148,535**	**443**	**281,087**	**52.8%**	**75.4%**	**1,831**	**1,234**	**277**	**377**	**2,413**	**67.4%**	**15.1%**	**20.6%**	**131.8%**
FYTD Budget	**148,983**	**445**	**288,390**	**51.7%**	**72.5%**	**1,925**	**1,157**	**262**	**360**	**2,356**	**60.1%**	**13.6%**	**18.7%**	**119.3%**
Variance	**(448)**	**(1)**	**(7,303)**	**1.2%**	**2.8%**	**(94)**	**76**	**15**	**17**	**57**	**7.2%**	**1.5%**	**1.9%**	**12.5%**
Current Month Analysis														
May-19	**13,440**	**434**	**26,367**	**51.0%**	**75.3%**	**1,785**	**1,218**	**319**	**369**	**2,408**	**68.2%**	**17.8%**	**20.7%**	**134.9%**
Budget	**13,411**	**433**	**26,751**	**50.1%**	**72.5%**	**1,898**	**1,147**	**256**	**344**	**2,311**	**60.4%**	**13.5%**	**18.1%**	**120.0%**
Variance	**29**	**1**	**(384)**	**0.8%**	**2.8%**	**(113)**	**70**	**63**	**25**	**98**	**7.8%**	**4.4%**	**2.5%**	**14.9%**

KAWEAH DELTA HEALTH CARE DISTRICT

RATIO ANALYSIS REPORT

MAY 31, 2019

	Current Month Value	Prior Month Value	June 30, 2018 Audited Value	2017 Moody's Median Benchmark		
				Aa	A	Baa
LIQUIDITY RATIOS						
Current Ratio (x)	2.6	2.8	2.0	1.7	**1.9**	2.1
Accounts Receivable (days)	79.8	83.0	79.6	48.4	**48.4**	46.5
Cash On Hand (days)	127.7	113.6	147.3	264.6	**226.5**	156.5
Cushion Ratio (x)	16.9	15.1	18.2	36.6	**23.9**	13.8
Average Payment Period (days)	47.5	44.9	52.6	75.0	**59.6**	59.6
CAPITAL STRUCTURE RATIOS						
Cash-to-Debt	107.2%	95.1%	114.2%	217.6%	**169.6%**	111.7%
Debt-To-Capitalization	32.3%	32.4%	33.6%	26.0%	**32.9%**	39.3%
Debt-to-Cash Flow (x)	4.9	5.1	4.5	2.2	**3.0**	4.5
Debt Service Coverage	3.1	3.0	3.5	7.1	**5.4**	3.0
Maximum Annual Debt Service Coverage (x)	3.0	2.9	3.6	6.4	**4.7**	2.8
Age Of Plant (years)	12.1	12.1	13.3	10.1	**11.6**	12.1
PROFITABILITY RATIOS						
Operating Margin	0.4%	0.2%	3.3%	3.5%	**2.3%**	(.4%)
Excess Margin	1.7%	1.5%	3.6%	6.6%	**5.2%**	1.9%
Operating Cash Flow Margin	5.3%	5.0%	7.6%	9.2%	**8.6%**	6.0%
Return on Assets	1.4%	1.2%	3.1%	5.3%	**4.0%**	1.7%

KAWEAH DELTA HEALTH CARE DISTRICT
CONSOLIDATED STATEMENTS OF NET POSITION

	May-19	Apr-19	Change	% Change	Jun-18 (Audited)
ASSETS AND DEFERRED OUTFLOWS					
CURRENT ASSETS					
Cash and cash equivalents	$ 11,765	$ 2,704	$ 9,061	335.03%	$ 5,325
Current Portion of Board designated and trusted assets	20,352	19,138	1,215	6.35%	12,643
Accounts receivable:					
Net patient accounts	145,502	152,525	(7,023)	(4.60%)	138,502
Other receivables	17,658	22,106	(4,449)	(20.12%)	7,863
	163,159	174,631	(11,471)	(6.57%)	146,365
Inventories	8,786	8,841	(55)	(0.62%)	8,408
Medicare and Medi-Cal settlements	35,061	44,738	(9,677)	(21.63%)	20,088
Prepaid expenses	9,299	10,734	(1,435)	(13.37%)	10,967
Total current assets	248,422	260,785	(12,363)	(4.74%)	203,796
NON-CURRENT CASH AND INVESTMENTS -					
less current portion					
Board designated cash and assets	246,249	227,626	18,623	8.18%	272,414
Revenue bond assets held in trust	33,889	34,073	(185)	(0.54%)	57,845
Assets in self-insurance trust fund	4,642	4,637	5	0.12%	4,607
Total non-current cash and investments	284,781	266,337	18,444	6.92%	334,866
CAPITAL ASSETS					
Land	16,137	16,137	-	0.00%	15,869
Buildings and improvements	355,910	354,433	1,477	0.42%	343,422
Equipment	273,967	272,253	1,713	0.63%	265,819
Construction in progress	40,894	41,375	(482)	(1.16%)	25,196
	686,907	684,198	2,708	0.40%	650,306
Less accumulated depreciation	354,911	352,338	2,573	0.73%	328,323
	331,996	331,860	135	0.04%	321,983
Property under capital leases - less accumulated amortization	3,280	3,355	(76)	(2.26%)	4,123
Total capital assets	335,275	335,216	60	0.02%	326,106
OTHER ASSETS					
Property not used in operations	3,731	3,737	(6)	(0.16%)	3,796
Health-related investments	7,399	7,674	(275)	(3.59%)	6,252
Other	8,798	8,574	224	2.61%	8,337
Total other assets	19,927	19,984	(57)	(0.29%)	18,385
Total assets	888,405	882,322	6,083	0.69%	883,154
DEFERRED OUTFLOWS	2,926 307/401	2,964	(38)	(1.28%)	3,344
Total assets and deferred outflows	**$ 891,331**	**$ 885,286**	**$ 6,045**	**0.68%**	**$ 886,498**

KAWEAH DELTA HEALTH CARE DISTRICT
CONSOLIDATED STATEMENTS OF NET POSITION

	May-19	Apr-19	Change	% Change	Jun-18 (Audited)
LIABILITIES AND NET ASSETS					
CURRENT LIABILITIES					
Accounts payable and accrued expenses	$ 32,023	$ 30,769	$ 1,254	4.07%	$ 44,529
Accrued payroll and related liabilities	56,201	52,302	3,898	7.45%	46,064
Long-term debt, current portion	8,668	8,668	-	0.00%	8,976
Total current liabilities	96,892	91,740	5,152	5.62%	99,569
LONG-TERM DEBT, less current portion					
Bonds payable	264,473	264,530	(57)	(0.02%)	266,631
Capital leases	15	221	(205)	(93.15%)	2,156
Notes payable	-	-			-
Total long-term debt	264,488	264,751	(262)	(0.10%)	268,787
NET PENSION LIABILITY	37,871	38,147	(276)	(0.72%)	40,902
OTHER LONG-TERM LIABILITIES	29,058	30,354	(1,296)	(4.27%)	26,768
Total liabilities	428,309	424,991	3,318		436,026
NET ASSETS					
Invested in capital assets, net of related debt	99,627	99,522	105	0.11%	110,175
Restricted	37,761	36,401	1,360	3.74%	29,668
Unrestricted	325,634	324,373	1,261	0.39%	310,627
Total net position	463,022	460,295	2,727	0.59%	450,471
Total liabilities and net position	**$ 891,331**	**$ 885,286**	**$ 6,045**	**0.68%**	**$ 886,498**

CFO Report SOF - May19

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
May 31, 2019

Board designated funds	Maturity Date	Yield	Investment Type		Amount	Total
LAIF		2.45	Various		29,896,863	
Cal Trust		2.37	Cal Trust		16,346,227	
CAMP		2.55	CAMP		33,038,301	
Wells Cap		0.02	Money market		8,629	
PFM		0.02	Money market		529,949	
PFM	25-Sep-19	1.65	ABS	FNMA	27,664	
PFM	7-Feb-20	2.67	CD	Credit Suisse	750,000	
PFM	20-Feb-20	2.72	CD	Nordea Bank	1,800,000	
Torrey Pines Bank	5-Mar-20	1.00	CD	Torrey Pines Bank	3,000,000	
PFM	15-Mar-20	1.57	ABS	Ally Auto	9,754	
PFM	5-Jun-20	3.08	CD	Bank of Nova	1,600,000	
PFM	5-Jun-20	1.80	MTN-C	Home Depot Inc	425,000	
PFM	15-Jun-20	1.25	ABS	John Deere	18,334	
Wells Cap	15-Jun-20	1.50	U.S. Govt Agency	US Treasury Bill	950,000	
PFM	22-Jun-20	1.95	MTN-C	John Deere	200,000	
Wells Cap	29-Jun-20	2.63	MTN-C	BB T Corp	1,280,000	
PFM	20-Jul-20	2.00	MTN-C	American Honda Mtn	420,000	
PFM	22-Jul-20	1.41	MTN-C	Wells Fargo Company	1,150,000	
PFM	3-Aug-20	2.05	CD	Westpac Bking CD	1,570,000	
Wells Cap	18-Aug-20	2.55	MTN-C	State Street Corp	830,000	
Wells Cap	31-Aug-20	1.38	U.S. Govt Agency	US Treasury Bill	1,055,000	
PFM	4-Sep-20	1.85	MTN-C	Caterpillar Finl Mtn	670,000	
PFM	15-Sep-20	1.56	ABS	Hyundai Auto	19,088	
Wells Cap	15-Sep-20	2.25	MTN-C	Automatic Data	800,000	
Wells Cap	15-Sep-20	2.75	MTN-C	Goldman Sachs	350,000	
Wells Cap	30-Sep-20	1.38	U.S. Govt Agency	US Treasury Bill	400,000	
Wells Cap	30-Sep-20	1.50	U.S. Govt Agency	US Treasury Bill	1,500,000	
Wells Cap	15-Oct-20	1.95	MTN-C	Unitedhealth Group	595,000	
PFM	16-Oct-20	3.39	CD	Sumito MTSU	805,000	
Wells Cap	26-Oct-20	1.75	U.S. Govt Agency	FFCB	1,400,000	
Wells Cap	31-Oct-20	1.25	U.S. Govt Agency	US Treasury Bill	400,000	
PFM	13-Nov-20	2.00	MTN-C	Apple, Inc	900,000	
PFM	16-Nov-20	2.27	CD	Swedbank	1,800,000	
Wells Cap	30-Nov-20	1.63	U.S. Govt Agency	US Treasury Bill	150,000	
Wells Cap	14-Dec-20	2.20	MTN-C	Visa Inc	700,000	
Wells Cap	14-Dec-20	2.20	MTN-C	Visa Inc	400,000	
PFM	15-Dec-20	2.13	Supra-National Age	Inter Amer Dev Bk	1,800,000	
Wells Cap	31-Dec-20	1.63	U.S. Govt Agency	US Treasury Bill	600,000	
PFM	8-Jan-21	2.35	MTN-C	John Deere	750,000	
PFM	20-Jan-21	1.80	MTN-C	IBM	900,000	
Wells Cap	25-Jan-21	2.25	Supra-National Age	Intl Bk	750,000	
PFM	16-Feb-21	1.73	ABS	Toyota Auto Recvs	126,873	
Wells Cap	18-Feb-21	1.38	U.S. Govt Agency	FHLB	980,000	
Wells Cap	23-Feb-21	2.25	MTN-C	Apple, Inc	615,000	
Wells Cap	28-Feb-21	1.13	U.S. Govt Agency	US Treasury Bill	700,000	
PFM	12-Mar-21	2.75	MTN-C	Texas Instruments	180,000	
Wells Cap	12-Mar-21	2.75	MTN-C	Texas Instruments	630,000	
Wells Cap	15-Mar-21	1.71	ABS	Smart Trust	537,005	
Wells Cap	31-Mar-21	1.25	U.S. Govt Agency	US Treasury Bill	935,000	
PFM	1-Apr-21	2.80	Municipal	California ST	530,000	
Wells Cap	1-Apr-21	2.63	Municipal	California ST High	1,250,000	
Wells Cap	1-Apr-21	3.54	Municipal	Sacramento Ca Publi	1,200,000	
PFM	2-Apr-21	2.83	CD	Credit Agricole CD	825,000	
Wells Cap	13-Apr-21	2.95	MTN-C	Toyota Motor	350,000	
Wells Cap	13-Apr-21	2.95	MTN-C	Toyota Motor	600,000	
PFM	15-Apr-21	1.29	ABS	Hyundai Auto	220,352	
PFM	15-Apr-21	2.50	MTN-C	Bank of NY	900,000	
Wells Cap	19-Apr-21	2.63	MTN-C	Bank of America	435,000	
Wells Cap	19-Apr-21	2.63	MTN-C	Bank of America	600,000	
PFM	21-Apr-21	2.50	MTN-C	Morgan Stanley	450,000	
PFM	21-Apr-21	2.50	MTN-C	Morgan Stanley	450,000	
Wells Cap	21-Apr-21	2.50	MTN-C	Morgan Stanley	750,000	
Wells Cap	29-Apr-21	2.15	MTN-C	PNC Bank	525,000	
Wells Cap	29-Apr-21	2.15	MTN-C	PNC Bank	400,000	
Wells Cap	30-Apr-21	1.38	U.S. Govt Agency	US Treasury Bill	875,000	
PFM	5-May-21	2.25	MTN-C	American Express	450,000	

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
May 31, 2019

Wells Cap	6-May-21	1.25	U.S. Govt Agency	FNMA	700,000
PFM	10-May-21	2.05	MTN-C	BB T Corp	450,000
Wells Cap	17-May-21	1.70	ABS	USAA Auto Owner	237,590
Wells Cap	17-May-21	2.65	MTN-C	Caterpillar Finl Mtn	700,000
PFM	19-May-21	1.95	MTN-C	State Street Corp	245,000
PFM	24-May-21	4.13	MTN-C	US Bancorp	900,000
Wells Cap	7-Jun-21	2.40	MTN-C	JP Morgan	910,000
Wells Cap	14-Jun-21	2.25	MTN-C	Fifth Third Bank	800,000
PFM	15-Jun-21	1.67	ABS	Ford Credit Auto	215,551
Wells Cap	30-Jun-21	1.00	U.S. Govt Agency	US Treasury Bill	400,000
Wells Cap	1-Jul-21	2.39	Municipal	San Francisco	935,000
PFM	14-Jul-21	1.13	U.S. Govt Agency	FHLB	950,000
PFM	23-Jul-21	2.75	Supra-National Age	Intl Bk	1,800,000
PFM	15-Aug-21	1.87	ABS	Honda Auto	690,458
PFM	16-Aug-21	1.76	ABS	Hyundai Auto	314,083
Wells Cap	16-Aug-21	1.74	ABS	Nissan Auto	781,123
Wells Cap	17-Aug-21	1.25	U.S. Govt Agency	FNMA	1,400,000
Wells Cap	17-Aug-21	1.25	U.S. Govt Agency	FNMA	1,500,000
Wells Cap	1-Sep-21	2.25	MTN-C	Ryder System Inc	420,000
PFM	15-Sep-21	6.72	ABS	FHLMC	1,127
PFM	15-Sep-21	1.90	MTN-C	Oracle Corp	900,000
PFM	20-Sep-21	1.85	MTN-C	Cisco Systems Inc	800,000
PFM	6-Oct-21	1.70	MTN-C	Pepsico Inc	1,320,000
PFM	15-Oct-21	1.82	ABS	John Deere	298,045
PFM	31-Oct-21	1.25	U.S. Govt Agency	US Treasury Bill	290,000
PFM	31-Oct-21	2.00	U.S. Govt Agency	US Treasury Bill	1,520,000
PFM	15-Nov-21	2.00	ABS	Toyota Auto Recvs	250,000
PFM	30-Nov-21	1.75	U.S. Govt Agency	US Treasury Bill	2,000,000
Wells Cap	30-Nov-21	1.75	U.S. Govt Agency	US Treasury Bill	1,160,000
PFM	15-Dec-21	1.75	ABS	Ally Auto	314,935
PFM	31-Dec-21	2.13	U.S. Govt Agency	US Treasury Bill	3,600,000
Wells Cap	31-Dec-21	2.00	U.S. Govt Agency	US Treasury Bill	1,225,000
PFM	15-Jan-22	1.63	MTN-C	Comcast Corp	450,000
PFM	18-Jan-22	1.93	ABS	Toyota Auto	625,000
Wells Cap	18-Jan-22	2.60	U.S. Govt Agency	FFCB	250,000
Wells Cap	7-Feb-22	2.60	MTN-C	Bank of NY	1,000,000
PFM	12-Feb-22	2.38	MTN-C	Microsoft Corp	450,000
Wells Cap	15-Feb-22	2.50	U.S. Govt Agency	US Treasury Bill	1,500,000
Wells Cap	15-Feb-22	2.50	U.S. Govt Agency	US Treasury Bill	500,000
Wells Cap	28-Feb-22	1.88	U.S. Govt Agency	US Treasury Bill	390,000
Wells Cap	3-Mar-22	2.25	MTN-C	Johnson Johnson	500,000
PFM	4-Mar-22	2.45	MTN-C	Walt Disney Co	375,000
PFM	8-Mar-22	3.30	MTN-C	PNC Funding Corp	494,000
PFM	15-Mar-22	1.99	ABS	Ally Auto	735,000
PFM	15-Mar-22	2.01	ABS	Ford Credit Auto	945,000
PFM	1-Apr-22	2.75	MTN-C	BB T Corp	450,000
Wells Cap	5-Apr-22	1.88	U.S. Govt Agency	FNMA	920,000
Wells Cap	15-Apr-22	2.25	U.S. Govt Agency	US Treasury Bill	900,000
PFM	25-Apr-22	2.75	MTN-C	Citigroup	1,000,000
Wells Cap	25-Apr-22	2.40	MTN-C	National Rural	950,000
Wells Cap	26-Apr-22	3.00	MTN-C	Goldman Sachs	440,000
Wells Cap	30-Apr-22	1.88	U.S. Govt Agency	US Treasury Bill	800,000
PFM	15-May-22	1.75	U.S. Govt Agency	US Treasury Bill	2,300,000
Wells Cap	15-May-22	3.28	Municipal	Univ Of CA	400,000
PFM	16-May-22	2.35	MTN-C	United Parcel	450,000
PFM	17-May-22	3.50	MTN-C	Bank of America	300,000
Wells Cap	18-May-22	2.30	MTN-C	Costco Wholesale	1,000,000
Wells Cap	25-May-22	2.20	MTN-C	Coca Cola Co	500,000
PFM	1-Jun-22	3.38	MTN-C	Blackrock Inc.	395,000
Wells Cap	30-Jun-22	1.75	U.S. Govt Agency	US Treasury Bill	660,000
PFM	31-Aug-22	1.88	U.S. Govt Agency	US Treasury Bill	2,000,000
Wells Cap	31-Aug-22	1.75	U.S. Govt Agency	US Treasury Bill	590,000
PFM	8-Sep-22	2.15	MTN-C	Toyota Motor	450,000
PFM	30-Sep-22	1.88	U.S. Govt Agency	US Treasury Bill	750,000
Wells Cap	5-Oct-22	2.00	U.S. Govt Agency	FNMA	950,000
Wells Cap	27-Oct-22	2.70	MTN-C	Citigroup	750,000
Wells Cap	31-Oct-22	2.00	U.S. Govt Agency	US Treasury Bill	3,150,000
Wells Cap	30-Nov-22	2.00	U.S. Govt Agency	US Treasury Bill	2,770,000
PFM	15-Dec-22	3.02	ABS	Toyota Auto	915,000

PFM	15-Dec-22	2.70	MTN-C	Intel Corp	415,000
PFM	31-Dec-22	2.13	U.S. Govt Agency	US Treasury Bill	1,810,000
PFM	17-Jan-23	3.00	ABS	Ally Auto	965,000
PFM	17-Jan-23	3.03	ABS	Mercedes Benz Auto	565,000
PFM	20-Jan-23	2.49	ABS	Citibank Credit	1,900,000
PFM	31-Jan-23	1.75	U.S. Govt Agency	US Treasury Bill	1,200,000
Wells Cap	31-Jan-23	2.38	U.S. Govt Agency	US Treasury Bill	350,000
Wells Cap	28-Feb-23	2.63	U.S. Govt Agency	US Treasury Bill	2,100,000
PFM	15-Mar-23	2.25	MTN-C	3M Company	540,000
PFM	15-Mar-23	2.75	MTN-C	Berkshire Hathaway	370,000
Wells Cap	20-Mar-23	2.83	ABS	Honda Auto	1,135,000
Wells Cap	20-Apr-23	3.38	MTN-C	Verizon Owner Trust	600,000
PFM	24-Apr-23	2.88	MTN-C	Bank of America	640,000
PFM	15-May-23	1.75	U.S. Govt Agency	US Treasury Bill	1,400,000
PFM	15-May-23	1.75	U.S. Govt Agency	US Treasury Bill	1,100,000
PFM	15-May-23	1.75	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	16-May-23	3.02	ABS	GM Financial	415,000
PFM	18-May-23	2.70	MTN-C	JP Morgan	1,000,000
PFM	26-Jun-23	3.40	MTN-C	Walmart Inc.	800,000
Wells Cap	17-Jul-23	2.91	ABS	John Deere	400,000
PFM	24-Jul-23	2.91	MTN-C	Goldman Sachs	900,000
PFM	25-Jul-23	3.20	ABS	FHLMC	338,209
Wells Cap	31-Aug-23	2.75	U.S. Govt Agency	US Treasury Bill	1,240,000
PFM	20-Sep-23	3.45	MTN-C	Toyota Motor	550,000
PFM	10-Oct-23	3.63	MTN-C	American Honda Mtn	395,000
PFM	31-Oct-23	1.63	U.S. Govt Agency	US Treasury Bill	4,280,000
Wells Cap	31-Oct-23	3.00	U.S. Govt Agency	US Treasury Bill	550,000
PFM	15-Nov-23	2.51	ABS	Capital One Prime	480,000
Wells Cap	15-Nov-23	2.51	ABS	Capital One Prime	900,000
Wells Cap	30-Nov-23	2.13	U.S. Govt Agency	US Treasury Bill	700,000
PFM	31-Dec-23	2.25	U.S. Govt Agency	US Treasury Bill	3,000,000
Wells Cap	31-Jan-24	2.50	U.S. Govt Agency	US Treasury Bill	3,575,000
PFM	5-Feb-24	2.50	U.S. Govt Agency	FNMA	1,110,000
PFM	13-Feb-24	2.50	U.S. Govt Agency	FHLB	1,220,000
PFM	29-Feb-24	2.38	U.S. Govt Agency	US Treasury Bill	3,425,000
Wells Cap	29-Feb-24	2.38	U.S. Govt Agency	US Treasury Bill	2,825,000
PFM	7-Mar-24	2.90	MTN-C	Merck Co Inc.	405,000
PFM	15-Mar-24	2.95	MTN-C	Pfizer Inc.	465,000
Wells Cap	31-Mar-24	2.13	U.S. Govt Agency	US Treasury Bill	260,000
Wells Cap	31-Mar-24	2.13	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	1-Apr-24	3.38	MTN-C	Mastercard Inc.	395,000
PFM	30-Apr-24	2.00	U.S. Govt Agency	US Treasury Bill	1,700,000
Wells Cap	30-Apr-24	2.25	U.S. Govt Agency	US Treasury Bill	500,000
Wells Cap	31-May-24	2.00	U.S. Govt Agency	US Treasury Bill	500,000
Wells Cap	1-Oct-26	8.00	Municipal	San Marcos Ca Rede	1,185,000
					$ 236,744,160

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
May 31, 2019

	Maturity Date	Yield	Investment Type		Amount	Total
Self-insurance trust						
Wells Cap			Money market		718,314	
Wells Cap			Fixed income - L/T		4,630,205	
						5,348,519
2012 revenue bonds						
US Bank			Principal/Interest payment fund		3,802,611	
						3,802,611
2015A revenue bonds						
US Bank			Principal/Interest payment fund		932,336	
						932,336
2015B revenue bonds						
US Bank			Principal/Interest payment fund		2,077,310	
US Bank			Project Fund		33,832,023	
						35,909,333
2017A/B revenue bonds						
US Bank			Principal/Interest payment fund		599,273	
						599,273
2017C revenue bonds						
US Bank			Principal/Interest payment fund		1,448,104	
						1,448,104
2014 general obligation bonds						
LAIF			Interest Payment fund		3,270,938	
						3,270,938
Operations						
Wells Fargo Bank		0.20	Checking		(1,454,690)	
Wells Fargo Bank		0.20	Checking		9,954,112	
					8,499,422	
Payroll						
Wells Fargo Bank		0.20	Checking		(41,998)	
Wells Fargo Bank		0.20	Checking	Benesyst	25,991	
Wells Fargo Bank			Checking	Resident Fund	1,503	
Bancorp			Checking		44,986	
					30,482	
						8,529,904
						$ 296,585,178
Kaweah Delta Medical Foundation						
Wells Fargo Bank			Checking			**$ 2,511,082**
Sequoia Regional Cancer Center						
Wells Fargo Bank			Checking		$ 67,911	
Wells Fargo Bank			Checking		-	
						$ 67,911
Kaweah Delta Hospital Foundation						
VCB Checking			Investments		$ 634,794	
Various			S/T Investments		4,818,078	
Various			L/T Investments		10,570,776	
Various			Unrealized G/L		1,495,068	
						$ 17,518,716

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
May 31, 2019

Summary of board designated funds:

Plant fund:

Uncommitted plant funds		$ 178,751,414
Committed for capital		19,745,573
		198,496,987
GO Bond reserve - L/T		2,014,220
401k Matching		12,772,660
Cost report settlement - cur	2,135,384	
Cost report settlement - L/T	1,312,727	
		3,448,111
Development fund/Memorial fund		104,184
Workers compensation - cu	5,368,000	
Workers compensation - L/	14,539,998	
		19,907,998
		$ 236,744,160

Investment summary by institution:

	Total Investments	%	Trust Accounts	Surplus Funds	%
Bancorp	$ 44,986	0.0%		44,986	0.0%
Cal Trust	16,346,227	5.5%		16,346,227	6.7%
CAMP	33,038,301	11.1%		33,038,301	13.5%
Local Agency Investment Fund (LAIF)	29,896,863	10.1%		29,896,863	12.2%
Local Agency Investment Fund (LAIF) - GOB Ta	3,270,938	1.1%	3,270,938	-	0.0%
Wells Cap	76,807,866	25.9%	5,348,519	71,459,347	29.1%
PFM	83,003,422	28.0%		83,003,422	33.8%
Torrey Pines Bank	3,000,000	1.0%		3,000,000	1.2%
Wells Fargo Bank	8,484,918	2.9%		8,484,918	3.5%
US Bank	42,691,657	14.4%	42,691,657		0.0%
Total investments	$ 296,585,178	100.0%	$ 51,311,114	$ 245,274,064	100.0%

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
May 31, 2019

Investment summary of surplus funds by type:			**Investment Limitations**	
Negotiable and other certificates of deposit	$	12,150,000	$ 73,582,000	(30%)
Checking accounts		8,529,904		
Local Agency Investment Fund (LAIF)		29,896,863	65,000,000	
Cal Trust		16,346,227		
CAMP		33,038,301		
Medium-term notes (corporate) (MTN-C)		42,579,000	73,582,000	(30%)
U.S. government agency		77,965,000		
Municipal securities		5,500,000		
Money market accounts		538,578	49,055,000	(20%)
Asset Backed Securties		14,380,191	49,055,000	(20%)
Supra-National Agency		4,350,000	73,582,000	(30%)
	$	245,274,064		

Return on investment:

Current month	**1.95%**
Year-to-date	**1.50%**
Prospective	**2.23%**
LAIF (year-to-date)	**2.25%**
Budget	**1.66%**

Material current-month nonroutine transactions:

Sell/Called/Matured:	FFCB, $1,050,000, 1.550%
	US Treasury Nt, $330,000, 1.50%
	US Treasury Nt, $50,000, 1.50%
	BMW Vehicle Owner, $190,261.56, 1.16%
	E I Du Pont De, $500,000, 2.20%
	Honda Auto, $311,239.88, 1.210%
	John Deere, $500,000, 2.660%
	US Treasury, $480,000, 2.00%
	American Express, $420,000, 2.670%
	Bank of America, $1,000,000, 1.950%
	Sumito Mtsu CD, $820,000, 2.05%
Buy:	US Treasury Nt, $500,000, 2.00%
	Capital One Prime, $900,000, 2.510%
	Caterpillar Finl Mtn, $700,000, 2.650%
	Honda Auto, $1,135,000, 2.830%
	US Treasury Nt, $1,400,000, 1.750%
	US Treasury Nt, $1,700,000, 2.00%
	Capital One Prime, $480,000, 2.510%

Fair market value disclosure for the quarter ended March 31, 2018 (District only):	**Quarter-to-date**	**Year-to-date**
Difference between fair value of investments and amortized cost (balance sheet effe	N/A	$ (253,164)
Change in unrealized gain (loss) on investments (income statement effect)	$ 1,800,200	$ 3,471,846

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
May 31, 2019

Investment summary of CDs:

Bank of Nova	1,600,000
Credit Agricole CD	825,000
Credit Suisse	750,000
Nordea Bank	1,800,000
Sumito Mtsu	805,000
Swedbank	1,800,000
Torrey Pines Bank	3,000,000
Westpac Bking CD	1,570,000
	$ 12,150,000

Investment summary of asset backed securities:

Ally Auto	$ 2,024,689
Capital One Prime	1,380,000
Citibank Credit	1,900,000
FHLMC	339,336
FNMA	27,664
Ford Credit Auto	1,160,551
GM Financial	415,000
Honda Auto	1,825,458
Hyundai Auto	553,523
John Deere	716,379
Mercedes Benz Auto	565,000
Nissan Auto	781,123
Smart Trust	537,005
Toyota Auto	1,540,000
Toyota Auto Recvs	376,873
USAA Auto Owner	237,590
	$ 14,380,191

Investment summary of medium-term notes (corporate):

American Express	$ 450,000
American Honda Mtn	815,000
Apple, Inc	1,515,000
Automatic Data	800,000
Bank of America	1,975,000
Bank of NY	1,900,000
BB T Corp	2,180,000
Berkshire Hathaway	370,000
Blackrock Inc.	395,000
Caterpillar Finl Mtn	1,370,000
Cisco Systems Inc	800,000
Citigroup	1,750,000
Coca Cola Co	500,000
Comcast Corp	450,000
Costco Wholesale	1,000,000
Fifth Third Bank	800,000
Goldman Sachs	1,690,000
Home Depot Inc	425,000
IBM	900,000
Intel Corp	415,000
John Deere	950,000
Johnson Johnson	500,000
JP Morgan	1,910,000
Mastercard Inc.	395,000
Merck Co Inc.	405,000
Microsoft Corp	450,000
Morgan Stanley	1,650,000
National Rural	950,000
Oracle Corp	900,000
Pepsico Inc	1,320,000
Pfizer Inc.	465,000
PNC Bank	925,000
PNC Funding Corp	494,000

Ryder System Inc		420,000
State Street Corp		1,075,000
Texas Instruments		810,000
Toyota Motor		1,950,000
Unitedhealth Group		595,000
United Parcel		450,000
US Bancorp		900,000
Visa Inc		1,100,000
Verizon Owner Trust		600,000
Walmart Inc.		800,000
Walt Disney Co		375,000
Wells Fargo Company		1,150,000
3M Company		540,000
	$	42,579,000

Investment summary of U.S. government agency:

Federal National Mortgage Association (FNMA)	$	6,580,000
Federal Home Loan Bank (FHLB)		3,150,000
Federal Farmers Credit Bank (FFCB)		1,650,000
US Treasury Bill		66,585,000
	$	77,965,000

Investment summary of municipal securities:

California ST High	$	1,250,000
California ST		530,000
Sacramento Ca Public		1,200,000
San Francisco		935,000
San Marcos Ca Redev		1,185,000
Univ Of CA		400,000
	$	5,500,000

Investment summary of Supra-National Agency:

Intl Bk	$	2,550,000
Inter Amer Dev Bk		1,800,000
	$	4,350,000

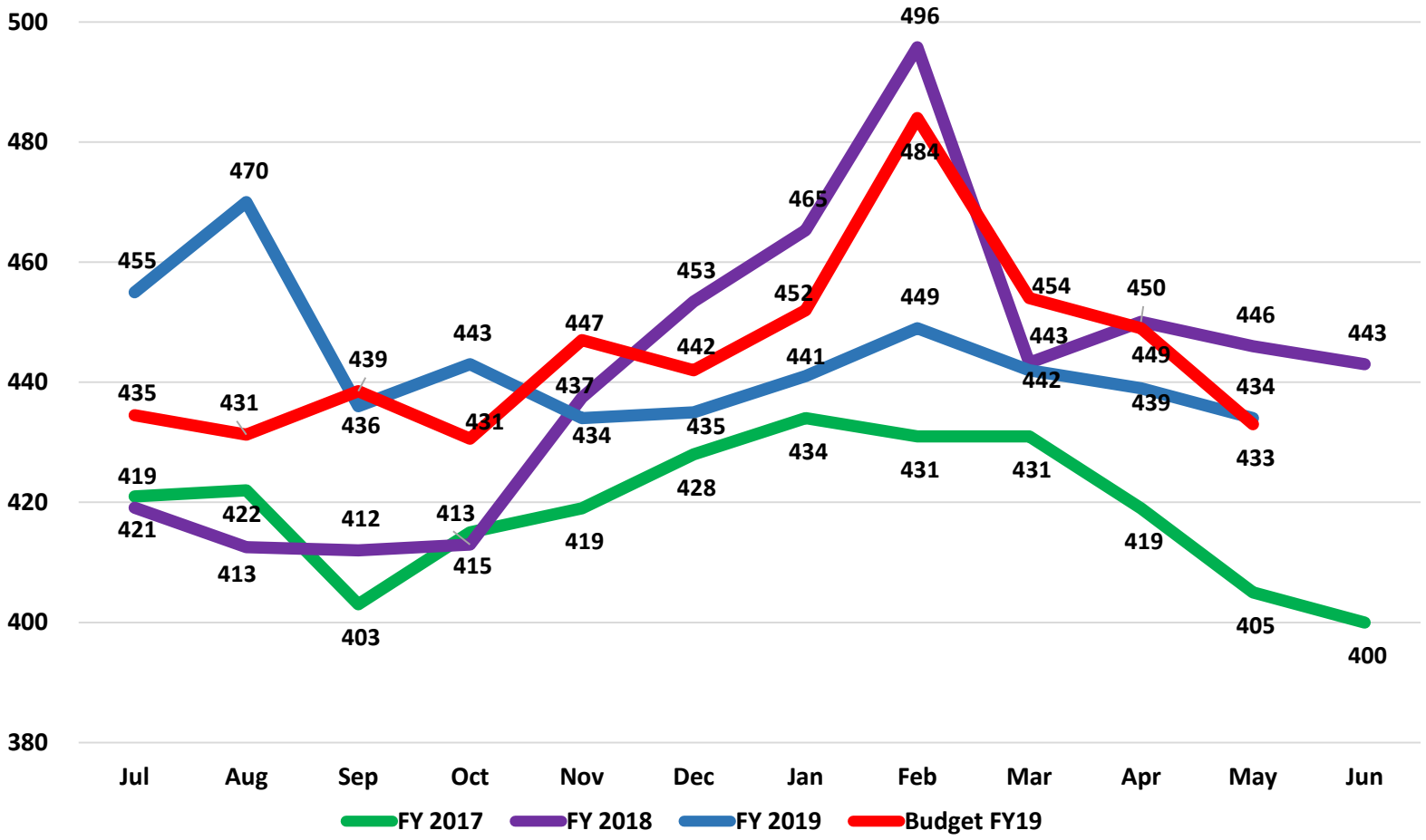
CFO Report Stat Slides BOD-May FY19

Statistical Report

June 24, 2019

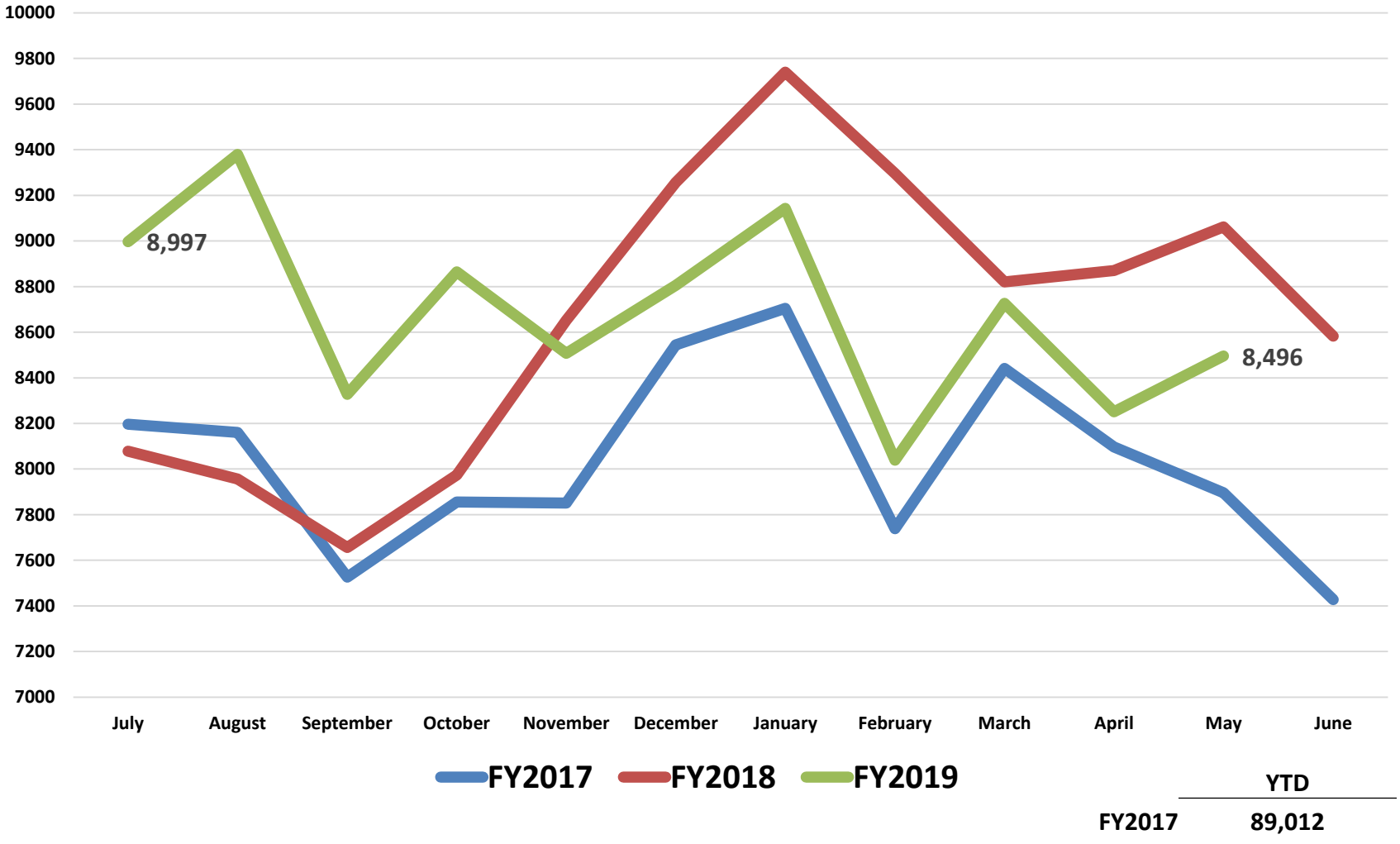
Kaweah Delta
HEALTH CARE DISTRICT

Average Daily Census



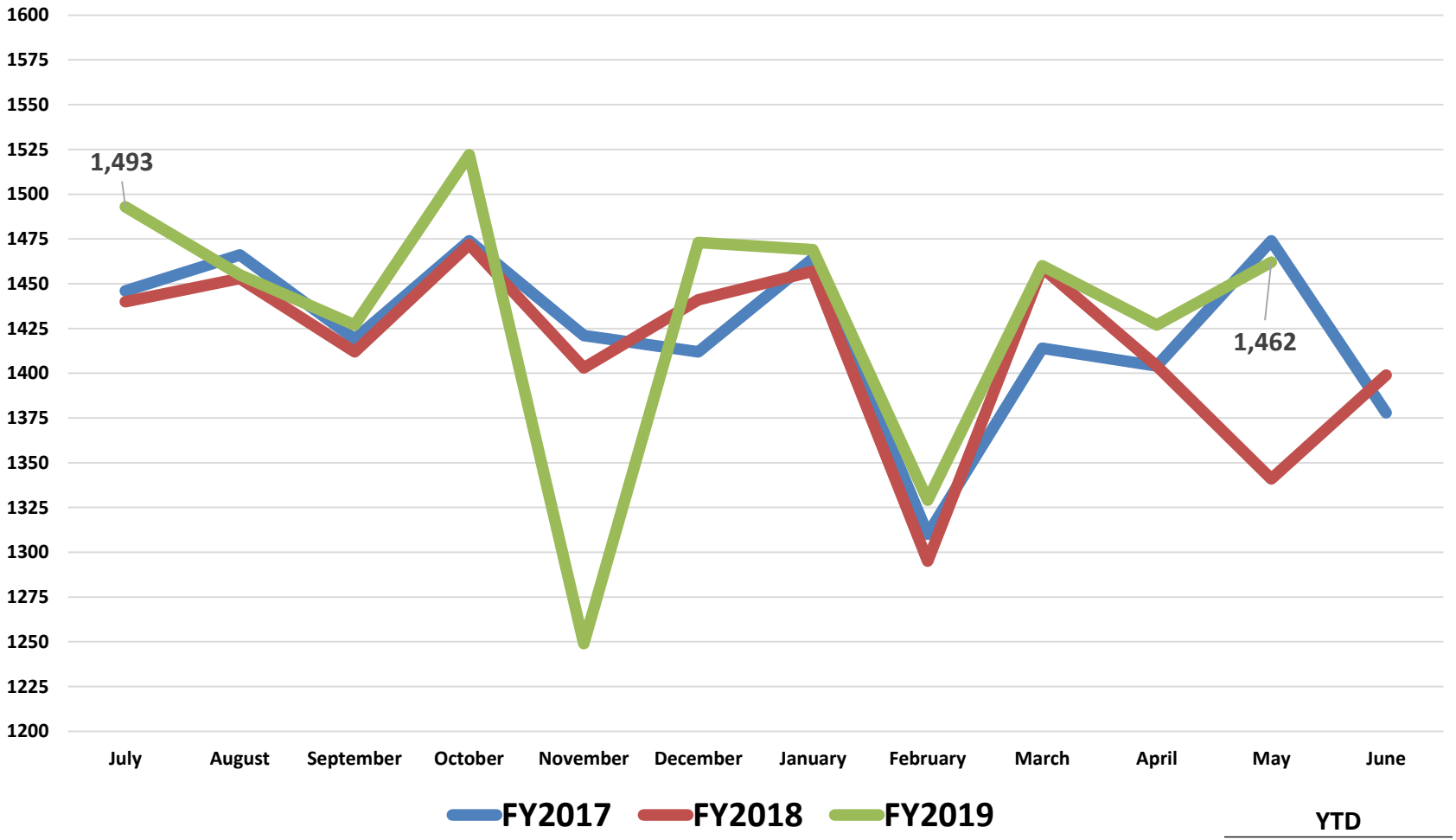
	ADC
FYTD 2017	4,628
FYTD 2018	4,848
FYTD 2019	4,878
Budget FYTD19	4,896

Medical Center Patient Days



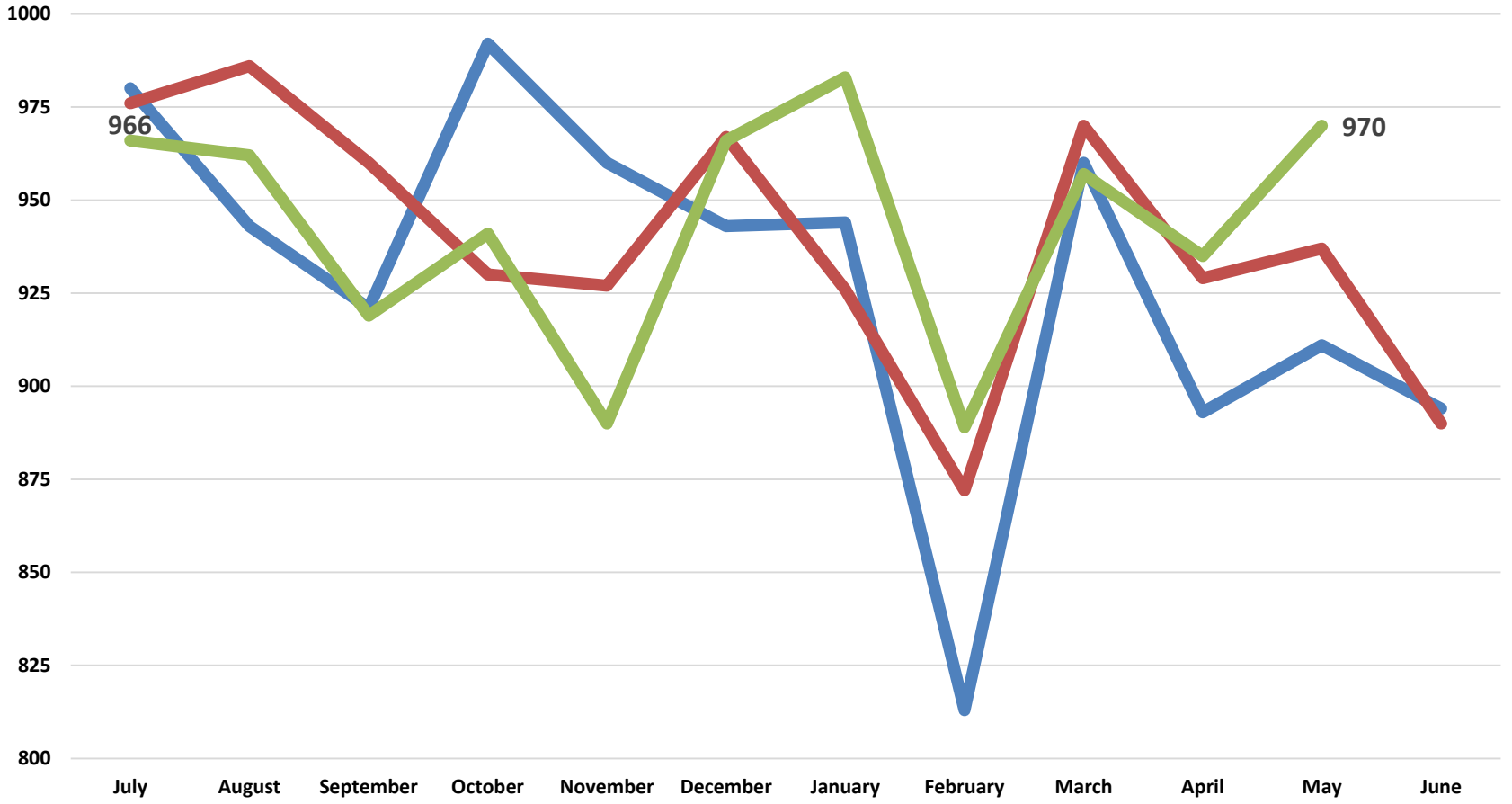
	YTD
FY2017	89,012
FY2018	95,362
FY2019	95,535
Budget	95,270

Acute I/P Psych Patient Days



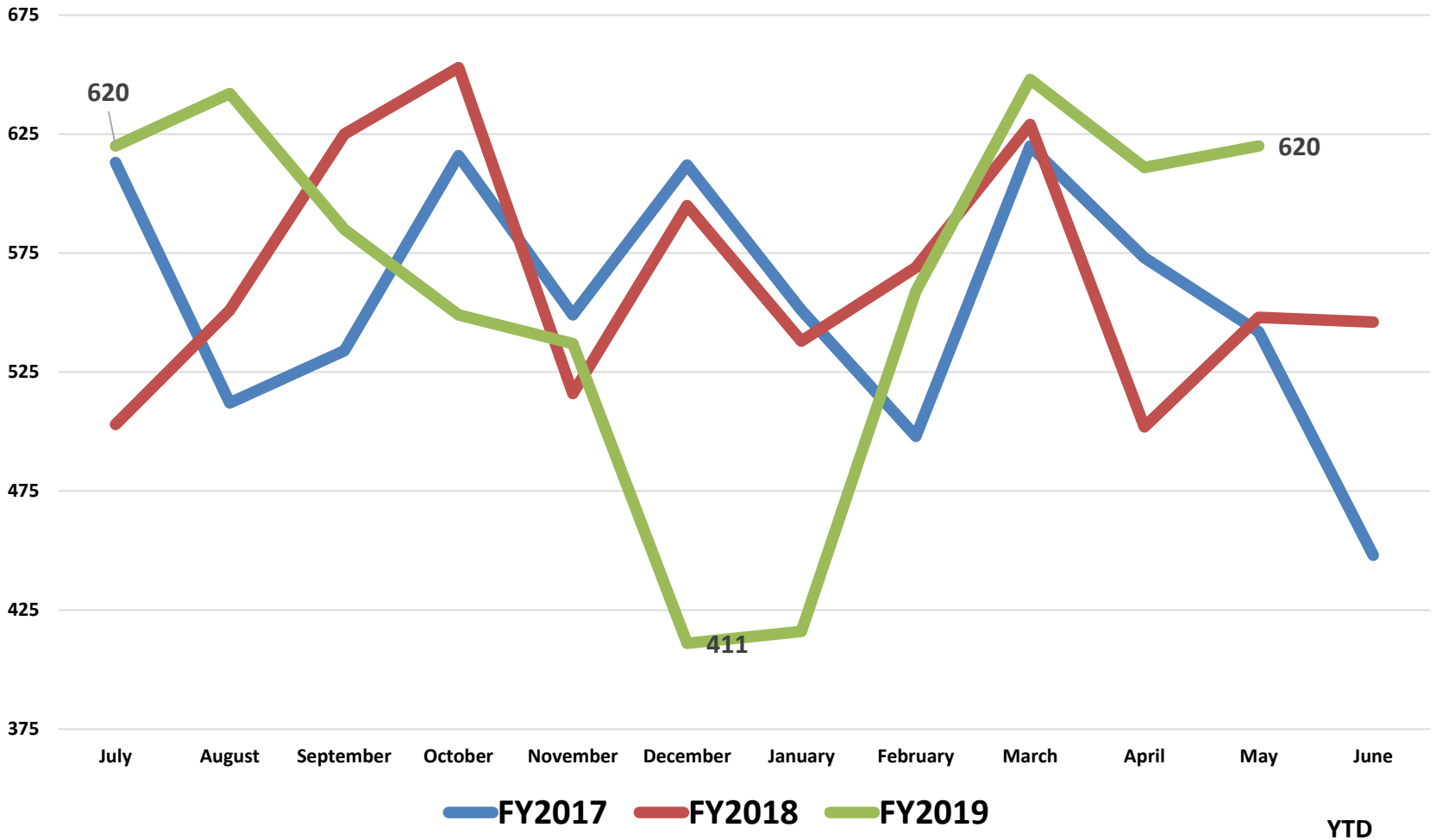
	YTD
FY2017	15,704
FY2018	15,577
FY2019	15,766
Budget	15,932

Sub-Acute Patient Days



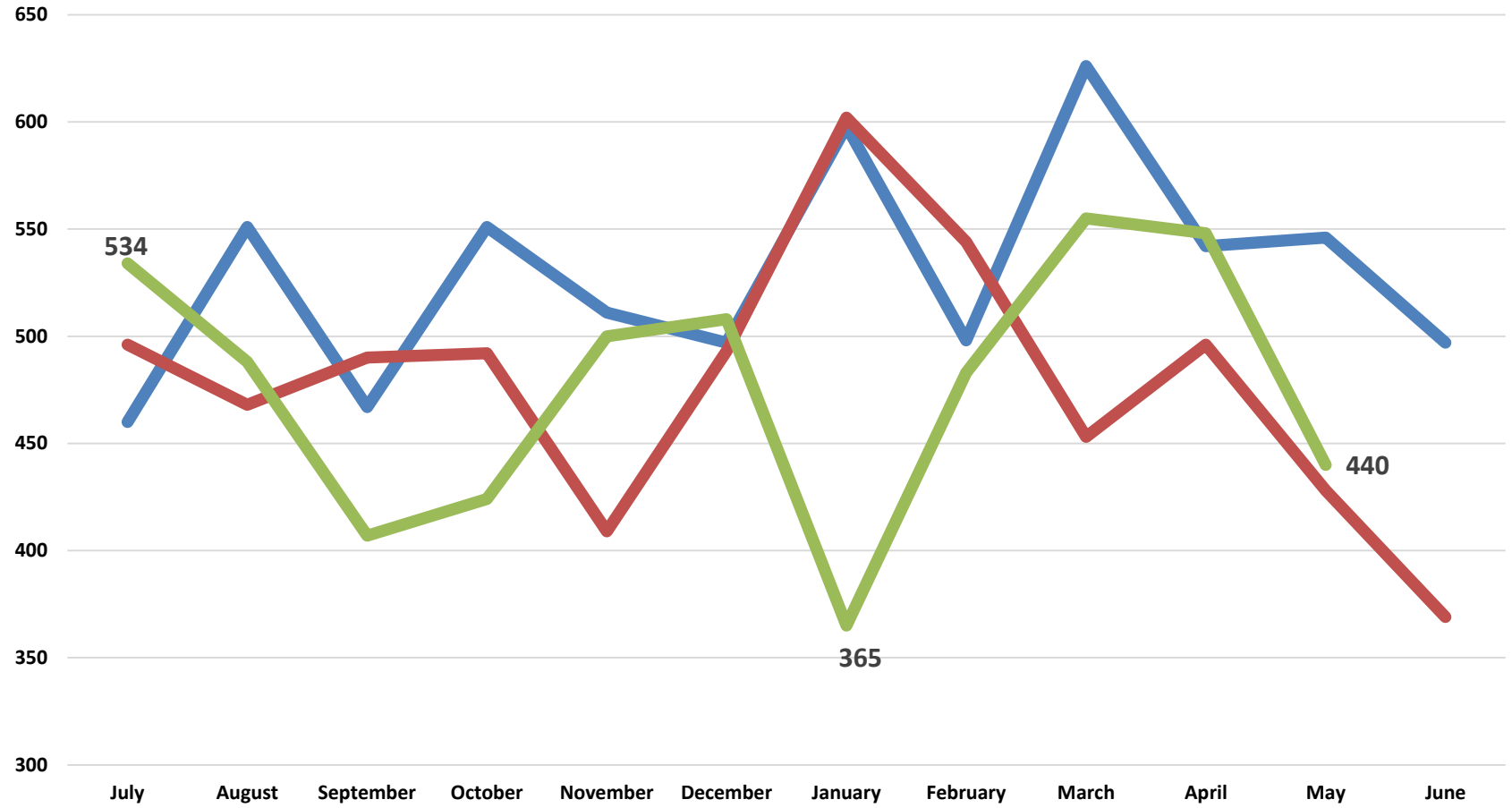
	YTD
FY2017	10,260
FY2018	10,380
FY2019	10,378
Budget	10,384

Rehabilitation Hospital Patient Days



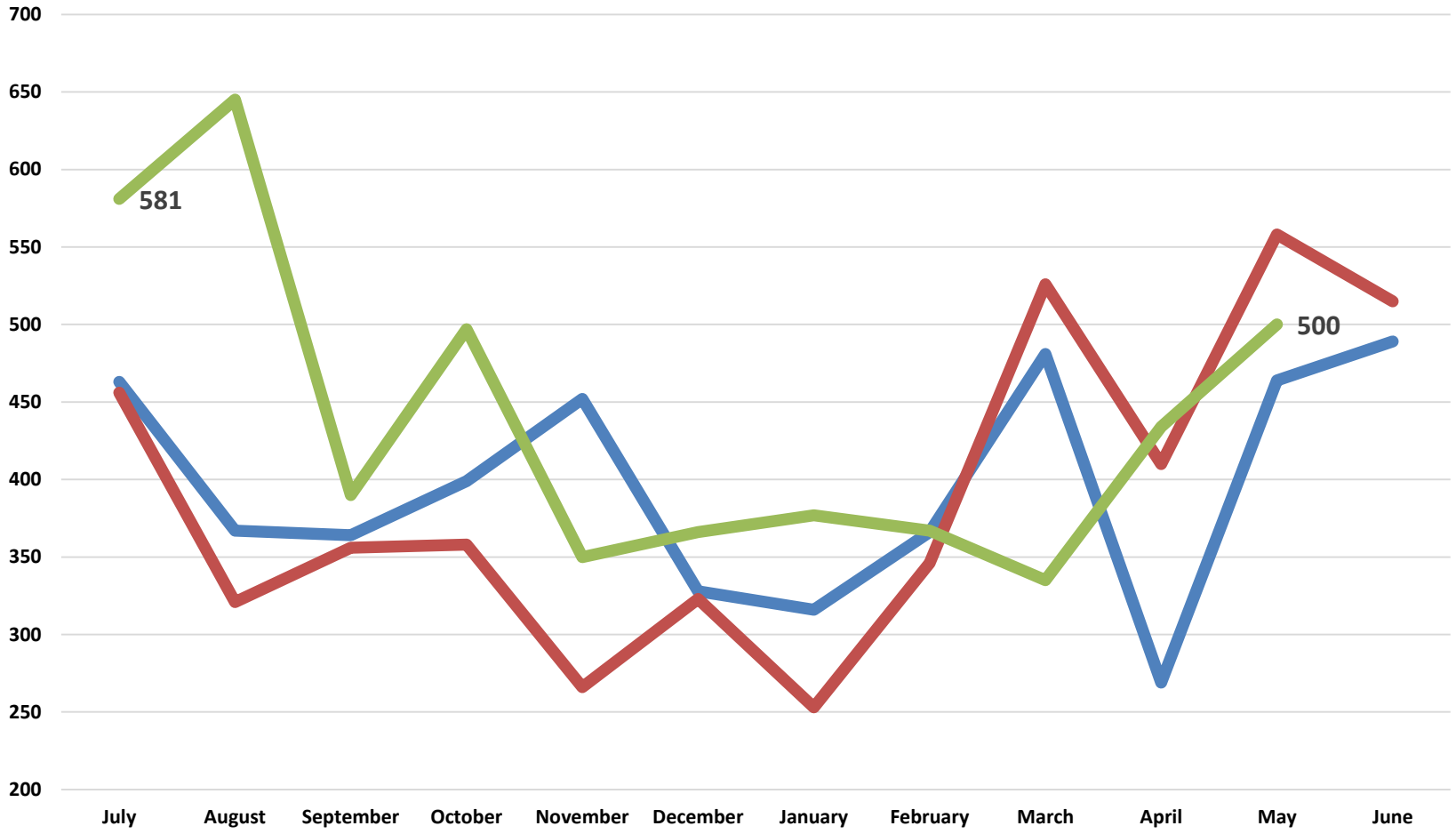
	YTD
FY2017	6,220
FY2018	6,229
FY2019	6,198
Budget	6,525

Transitional Care Services (TCS) Patient Days



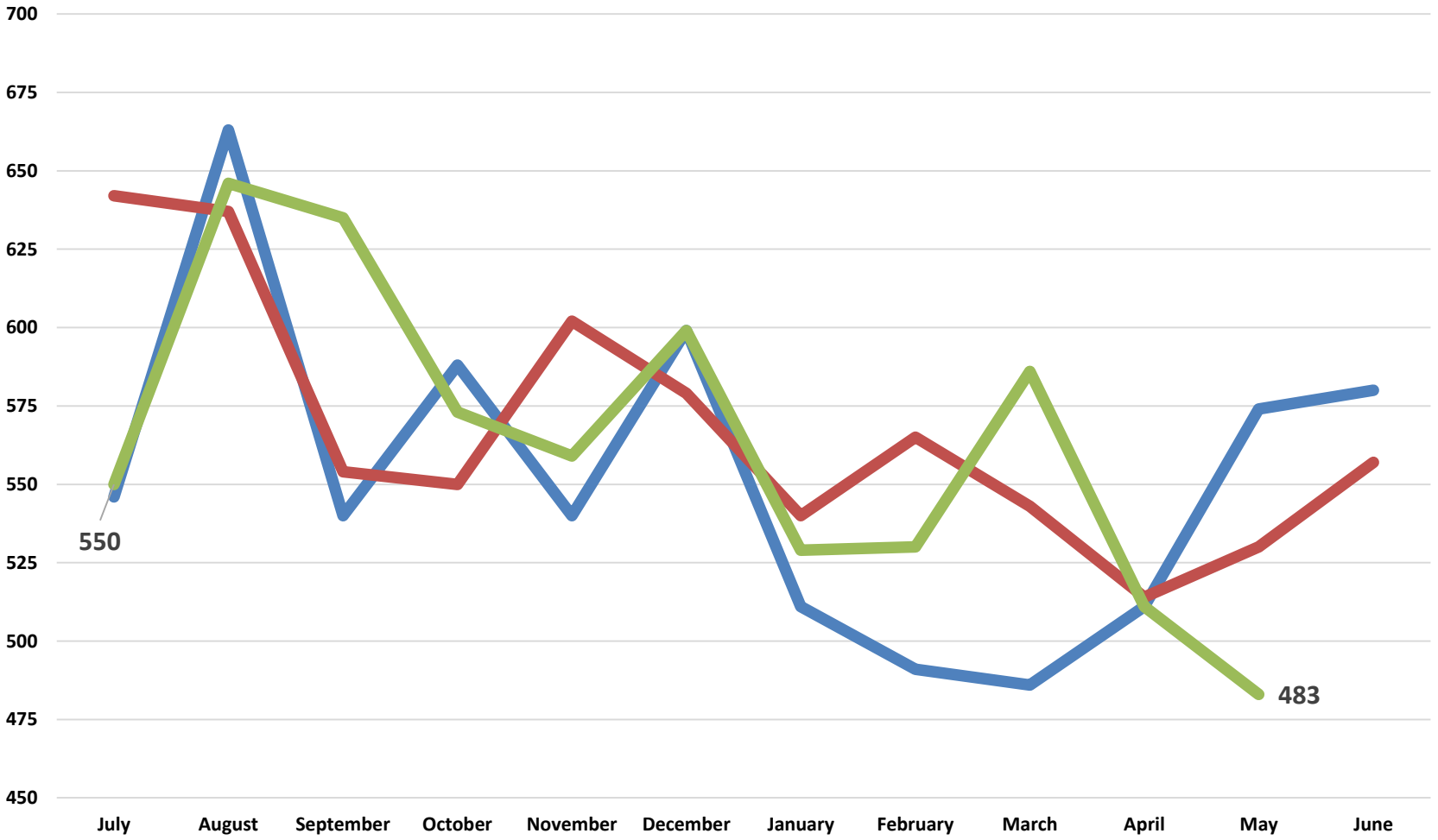
	YTD
FY2017	5,847
FY2018	5,371
FY2019	5,252
Budget	6,039

NICU Patient Days



	YTD
FY2017	4,269
FY2018	4,173
FY2019	4,842
Budget	4,368

Nursery Patient Days

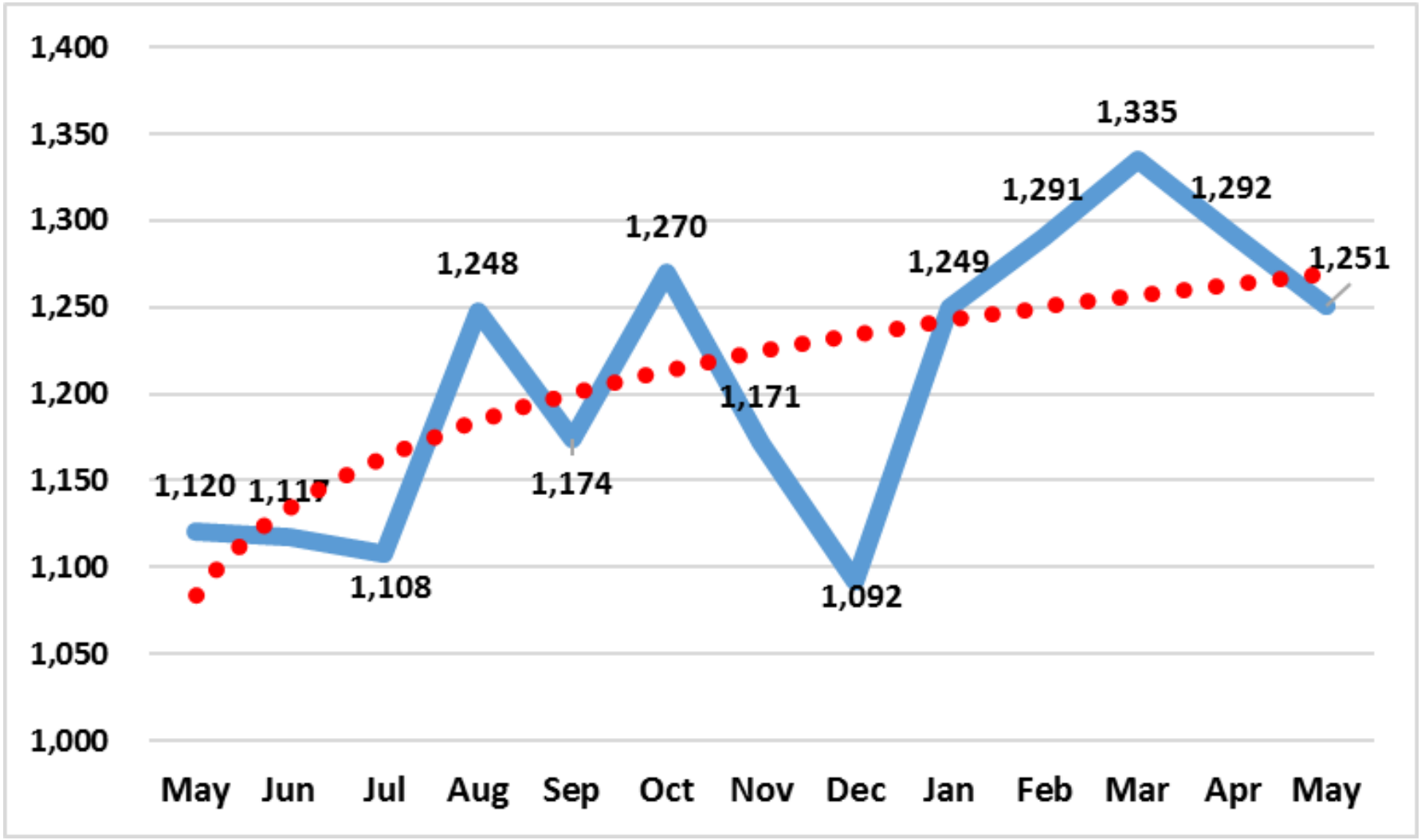


	YTD
FY2017	6,049
FY2018	6,256
FY2019	6,201
Budget	6,396

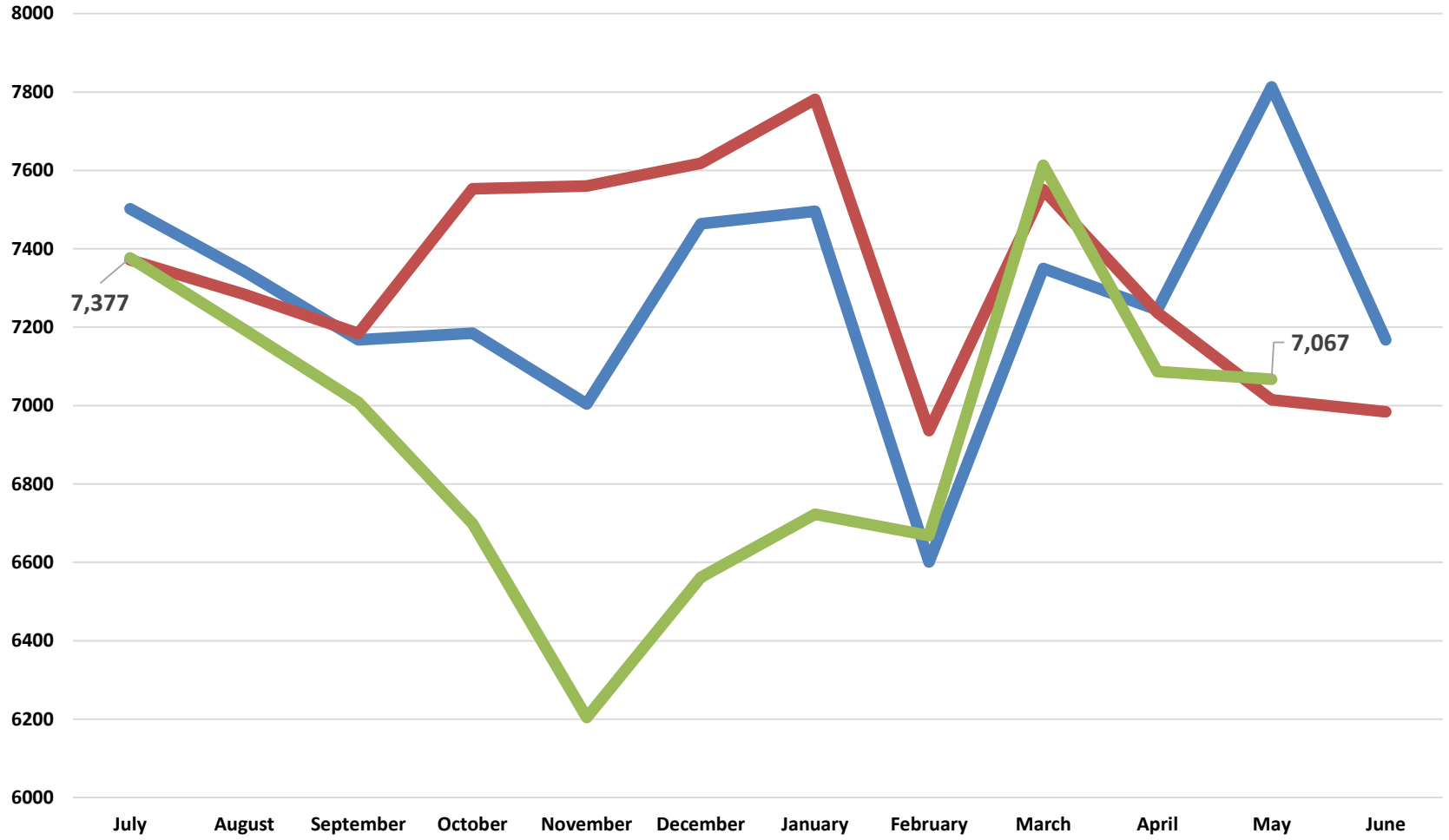
Obstetrics Patient Days

	YTD
FY2017	8,430
FY2018	8,545
FY2019	8,957
Budget	8,730

Outpatient Registrations per Day

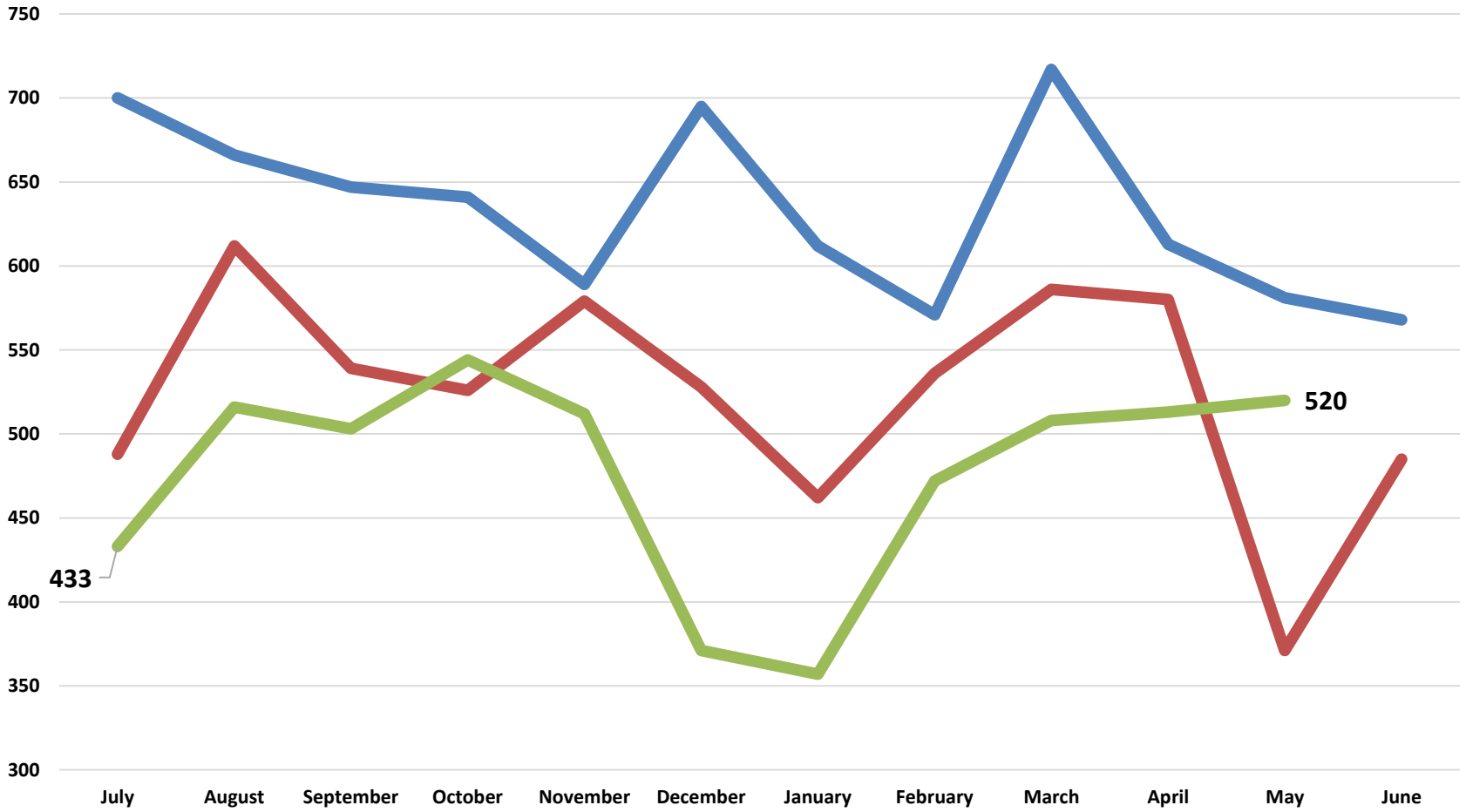


Emergency Department – Total Treated



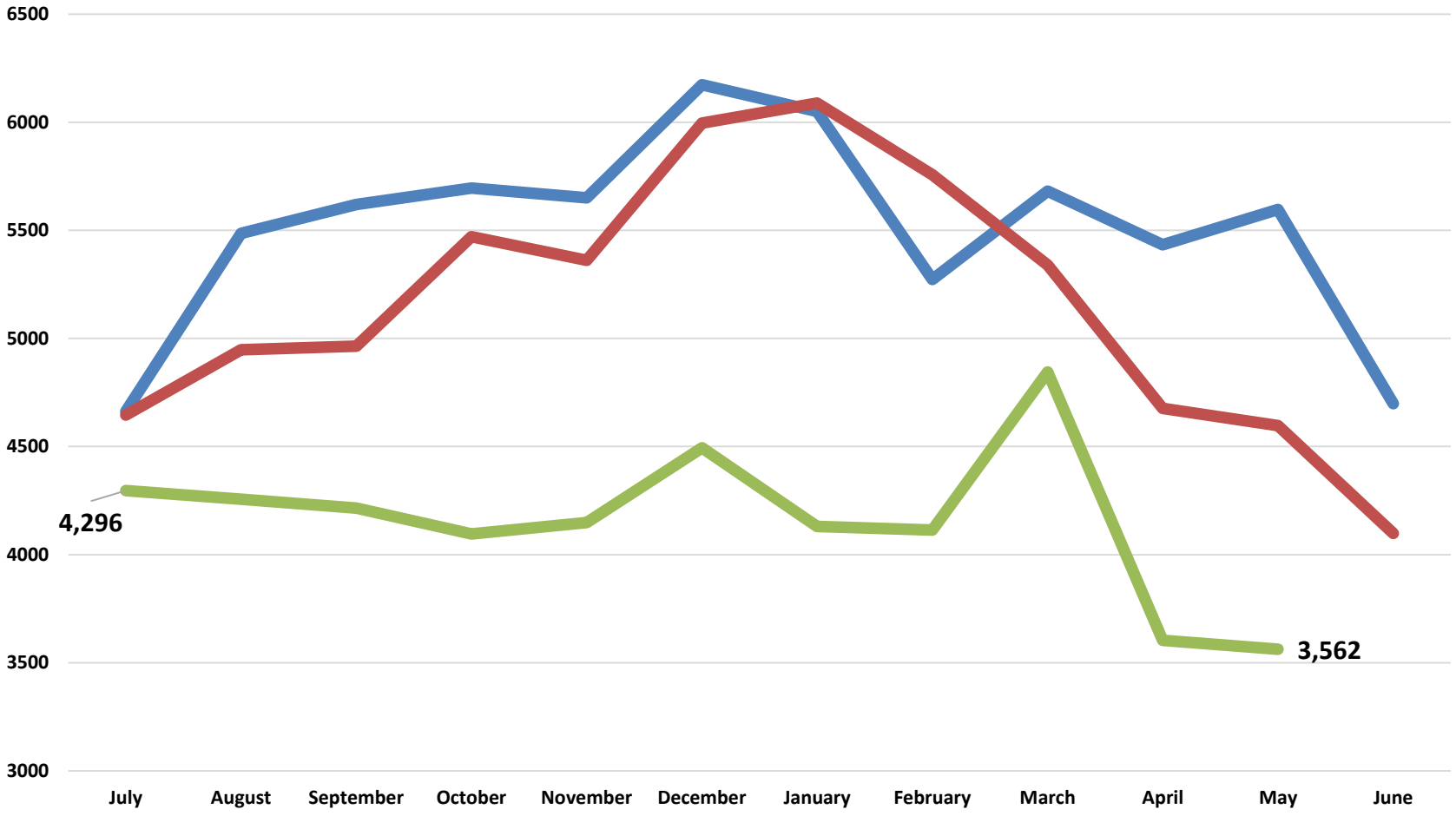
	YTD
FY2017	80,170
FY2018	81,091
FY2019	76,202
Budget	85,497

Endoscopy Procedures



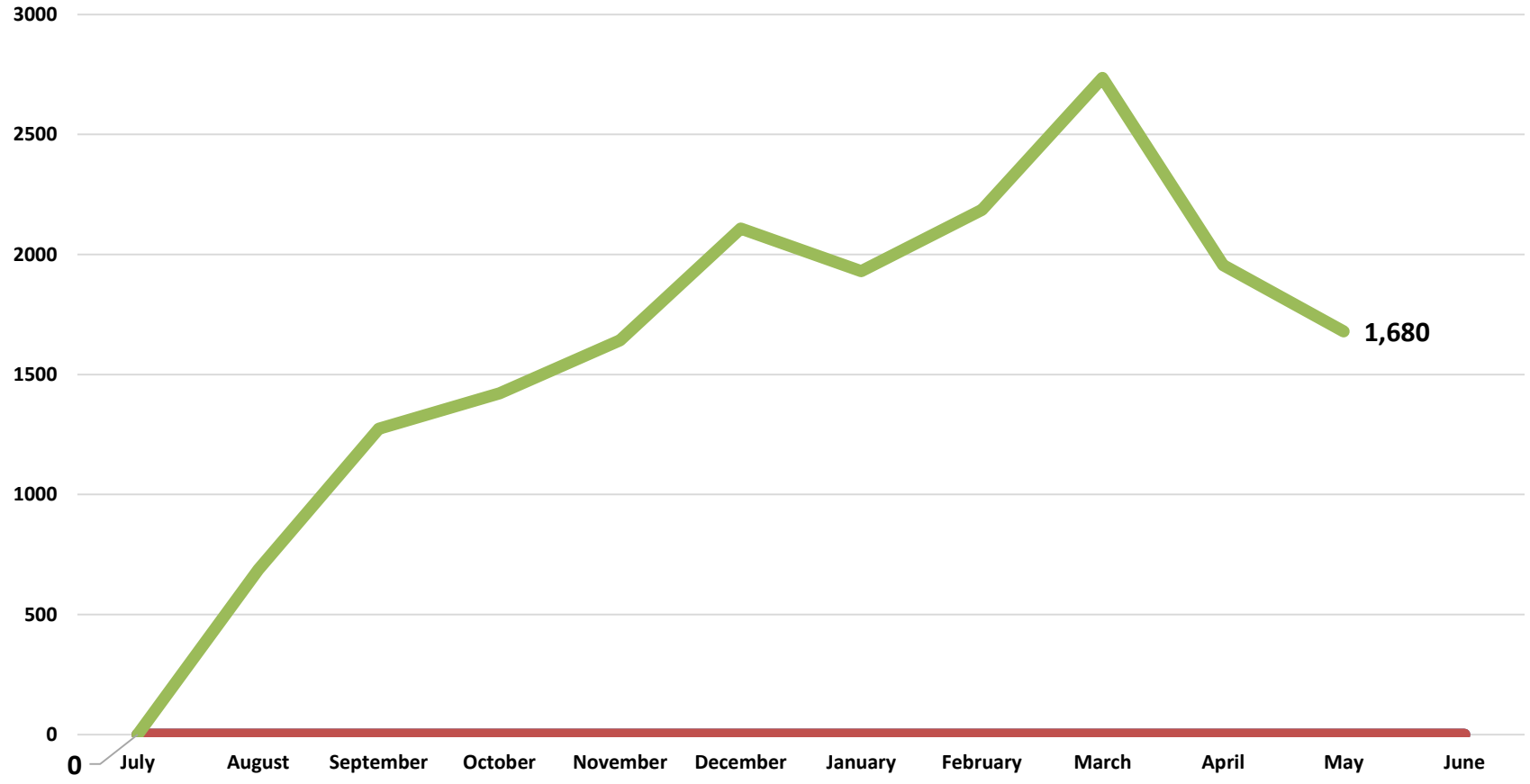
	YTD
FY2017	7,032
FY2018	5,807
FY2019	5,249
Budget	6,445

Urgent Care – Court Visits



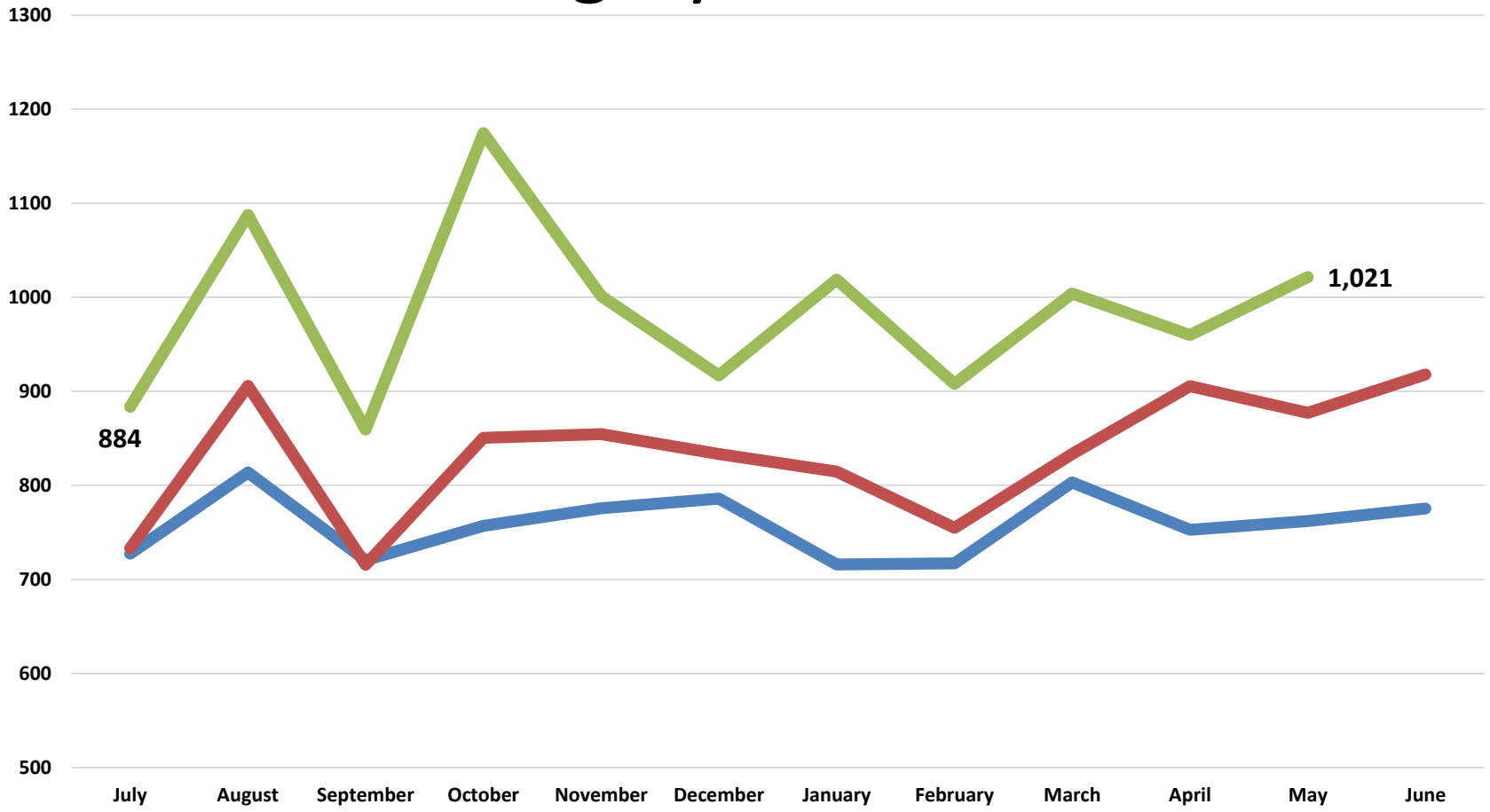
	YTD
FY2017	61,321
FY2018	57,844
FY2019	45,761
Budget	64,364

Urgent Care – Demaree Visits



	YTD
FY2019	17,624
Budget	11,378

Surgery Minutes



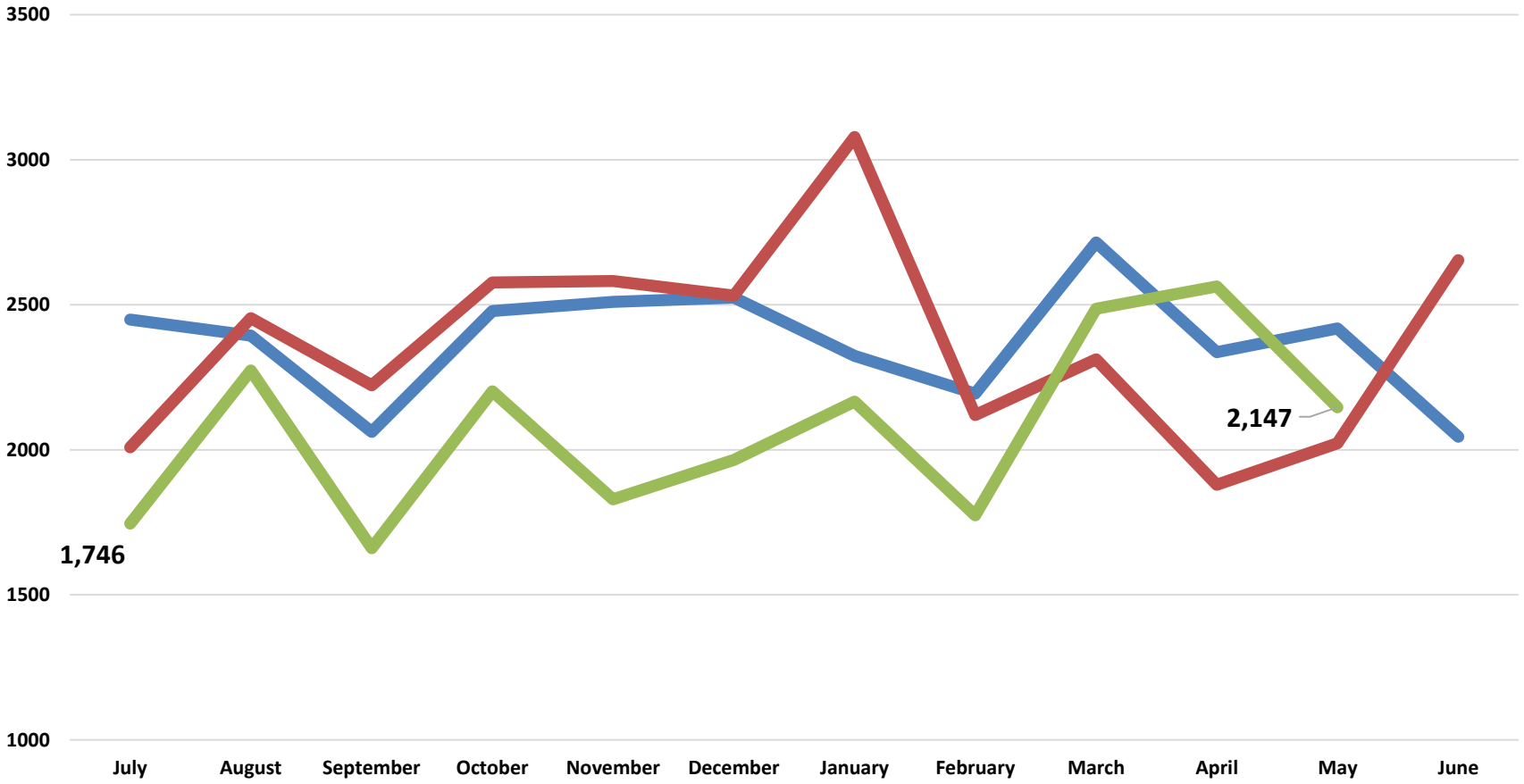
YTD Minutes	
FY2017	8,331
FY2018	9,445
FY2019	10,835
Budget	9,220

FY2017 FY2018 FY2019

	FY 18 Jul-May	FY 19 Jul-May	Change	% Change
Surgeries - IP Cases	3,467	4,266	799	23%
Surgeries - OP Cases	5,068	5,204	136	3%
Total Surgery Cases	8,535	9,470	935	11%

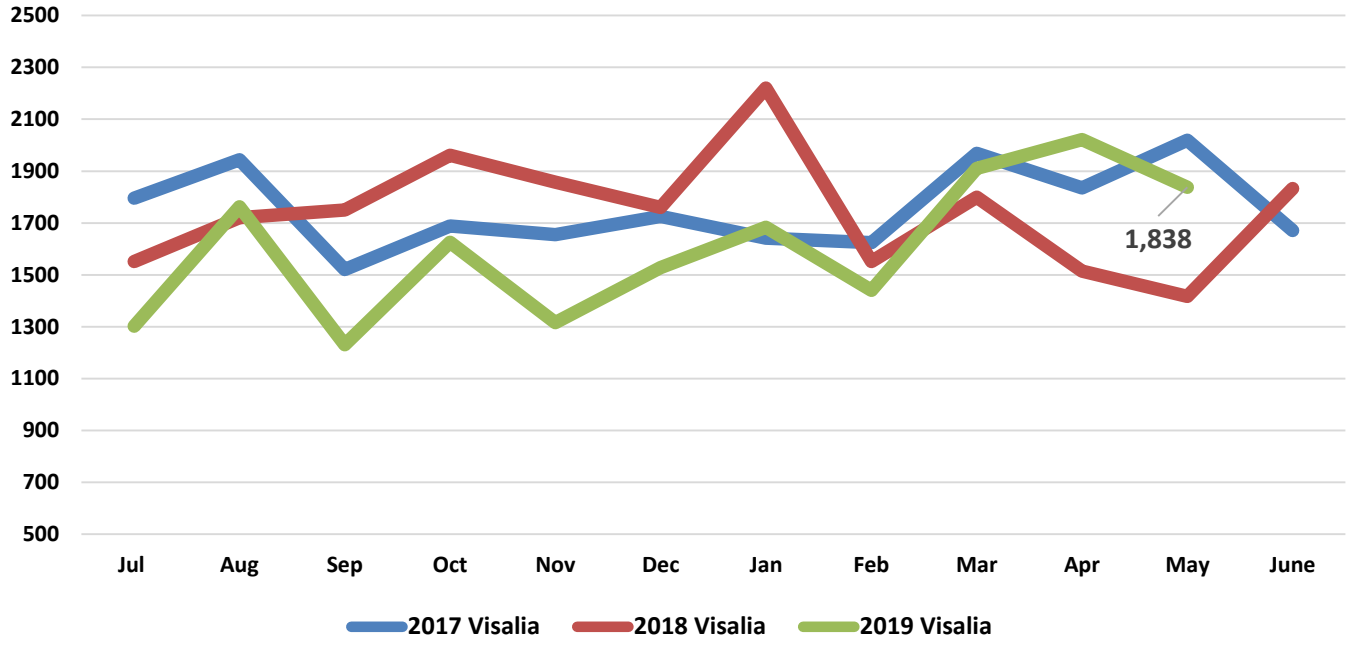
Radiation Oncology Treatments

Hanford and Visalia

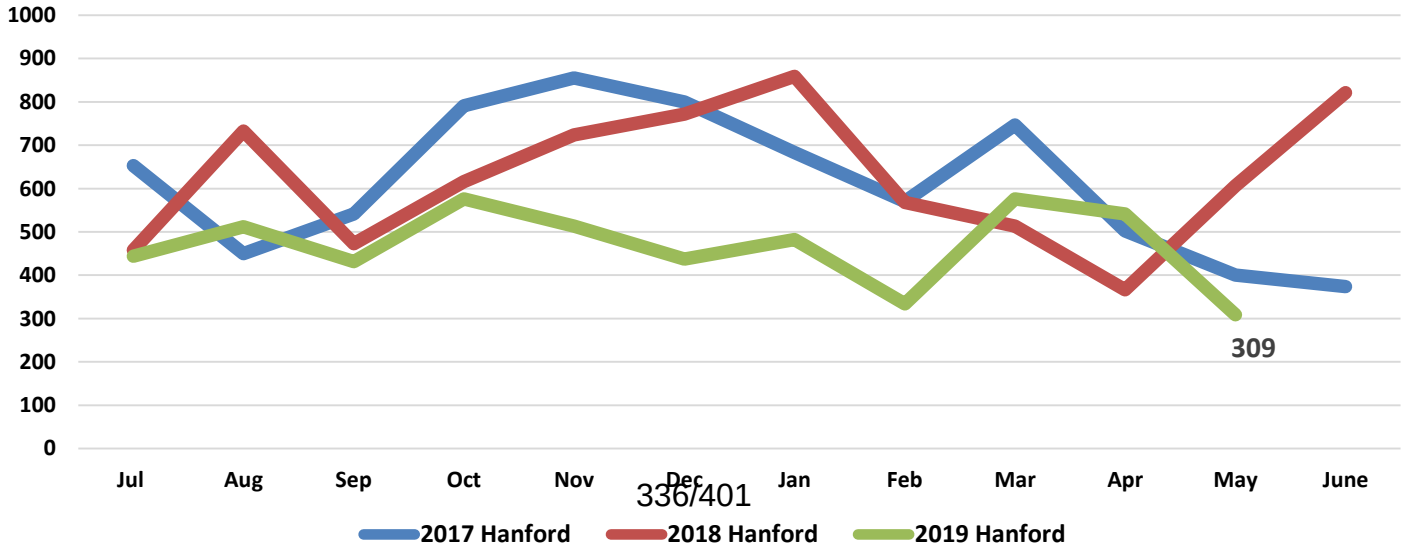


	Combined YTD	Hanford YTD	Visalia YTD
FY2017	26,408	6,992	19,416
FY2018	25,791	6,688	19,103
FY2019	22,814	5,155	17,659
Budget	28,412	7,583	20,829

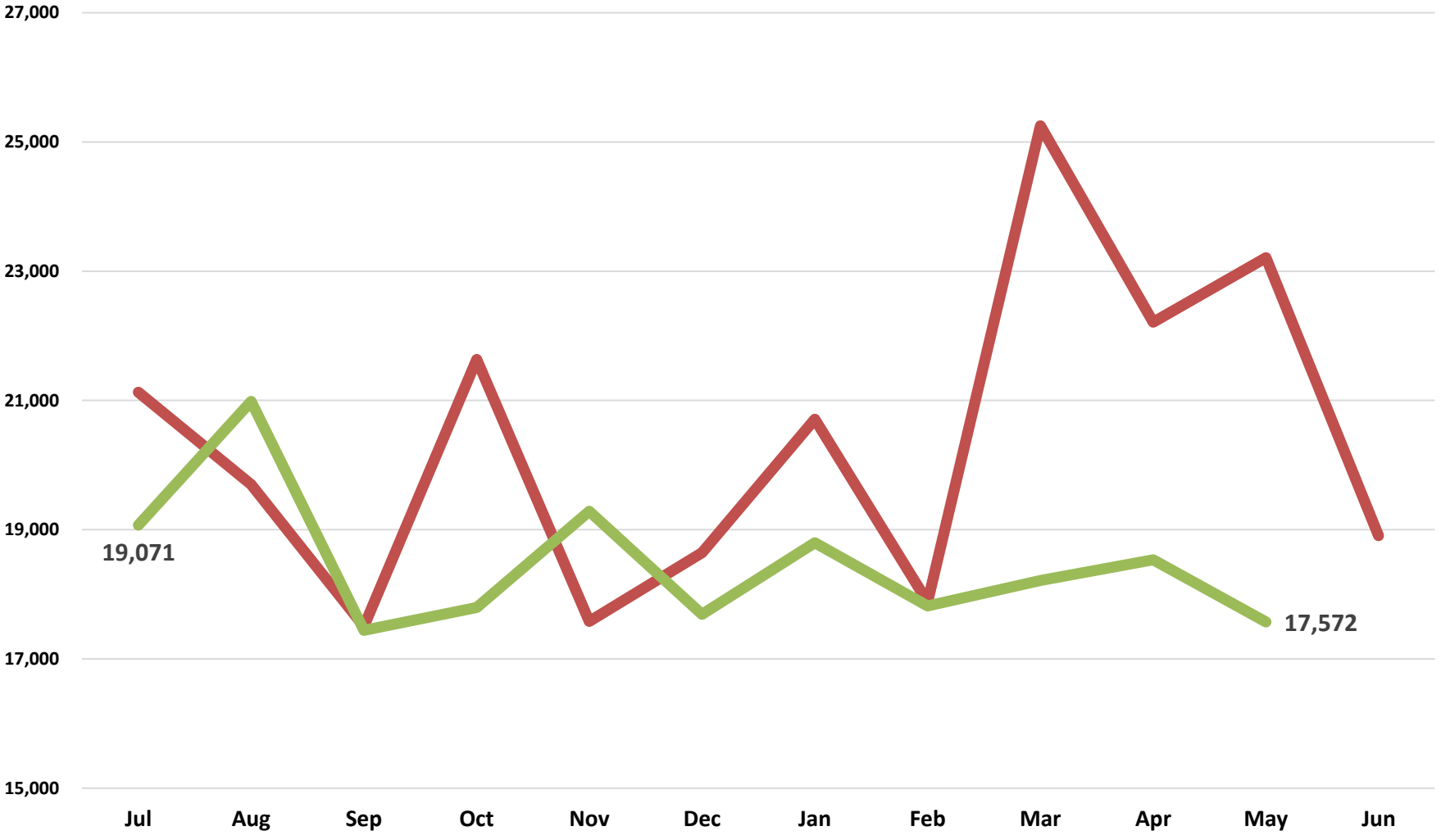
Radiation Oncology Visalia Treatments



Radiation Oncology Hanford Treatments

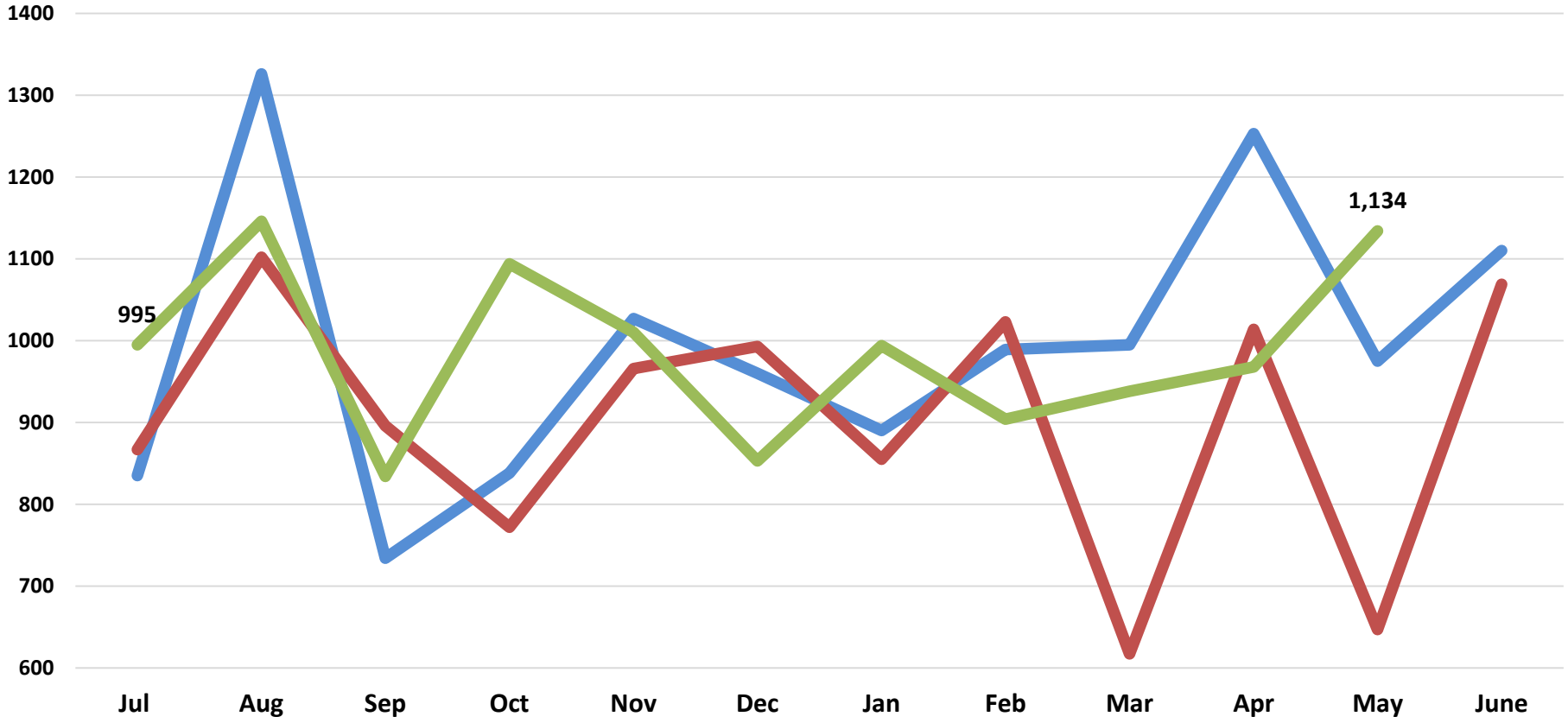


Cath Lab Minutes



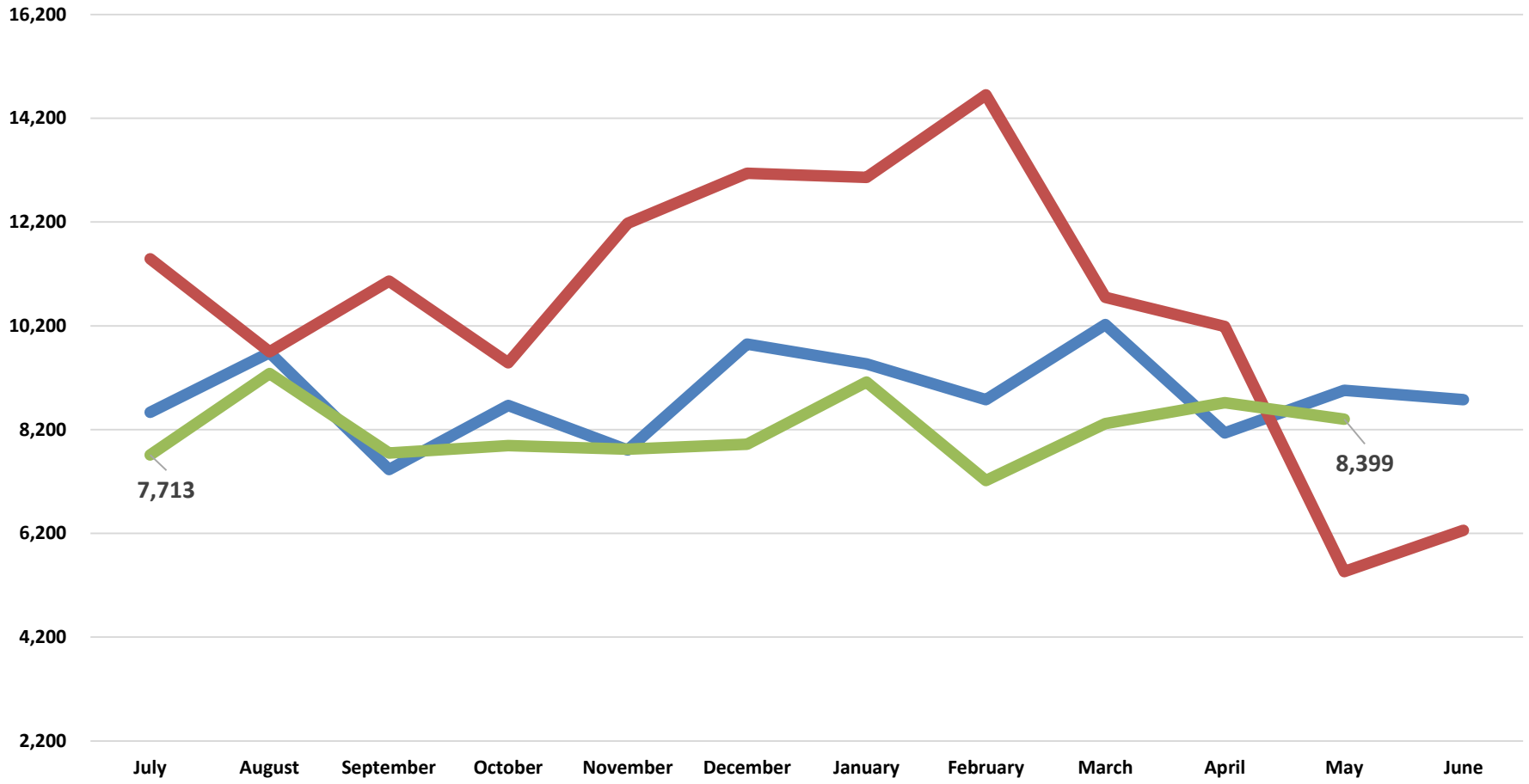
	YTD
FY 2018	225,447
FY 2019	203,210

GME Family Medicine Clinic Visits



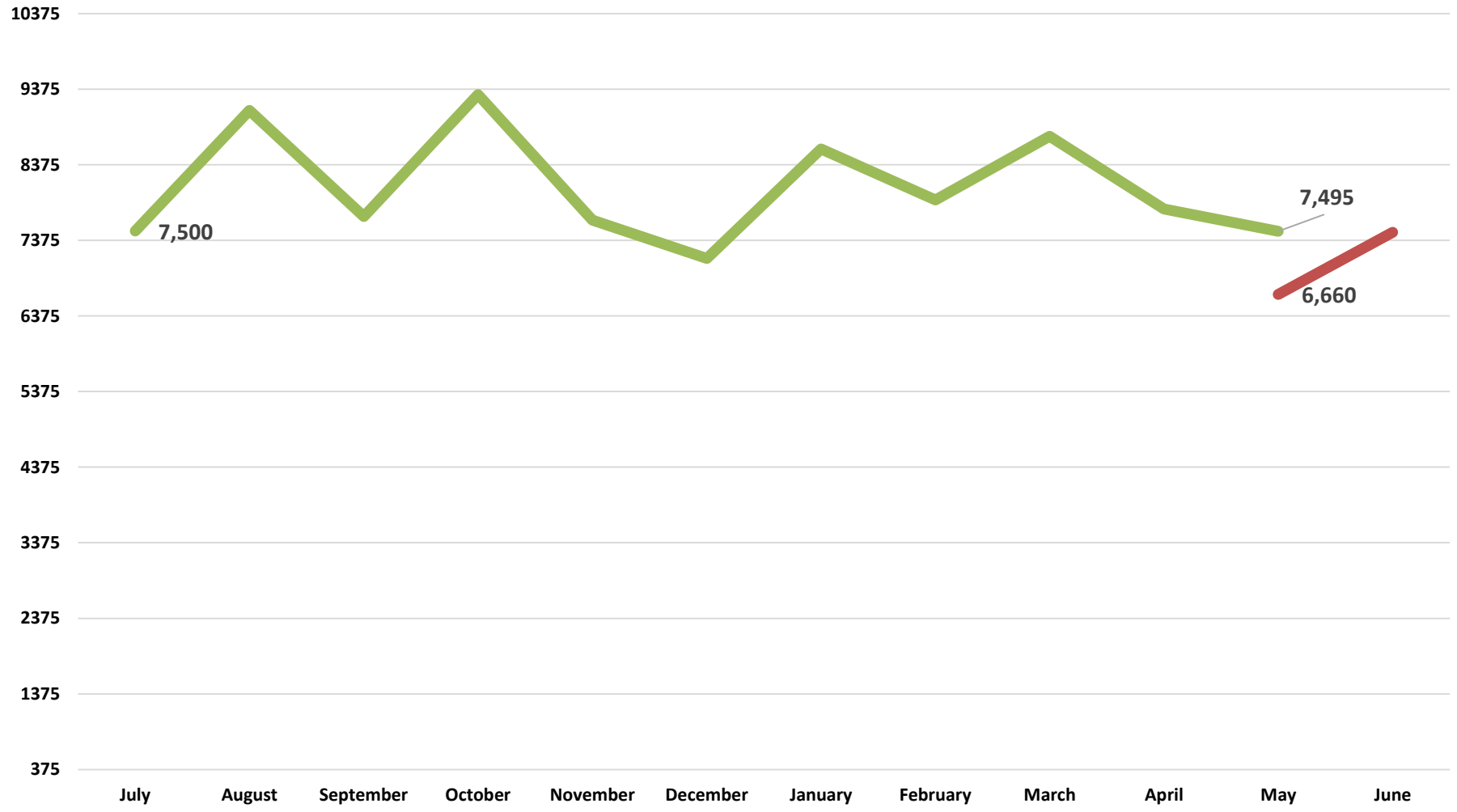
	YTD
FY2017	10,822
FY2018	9,752
FY2019	10,870
Budget	10,384

Rural Health Clinic Procedures



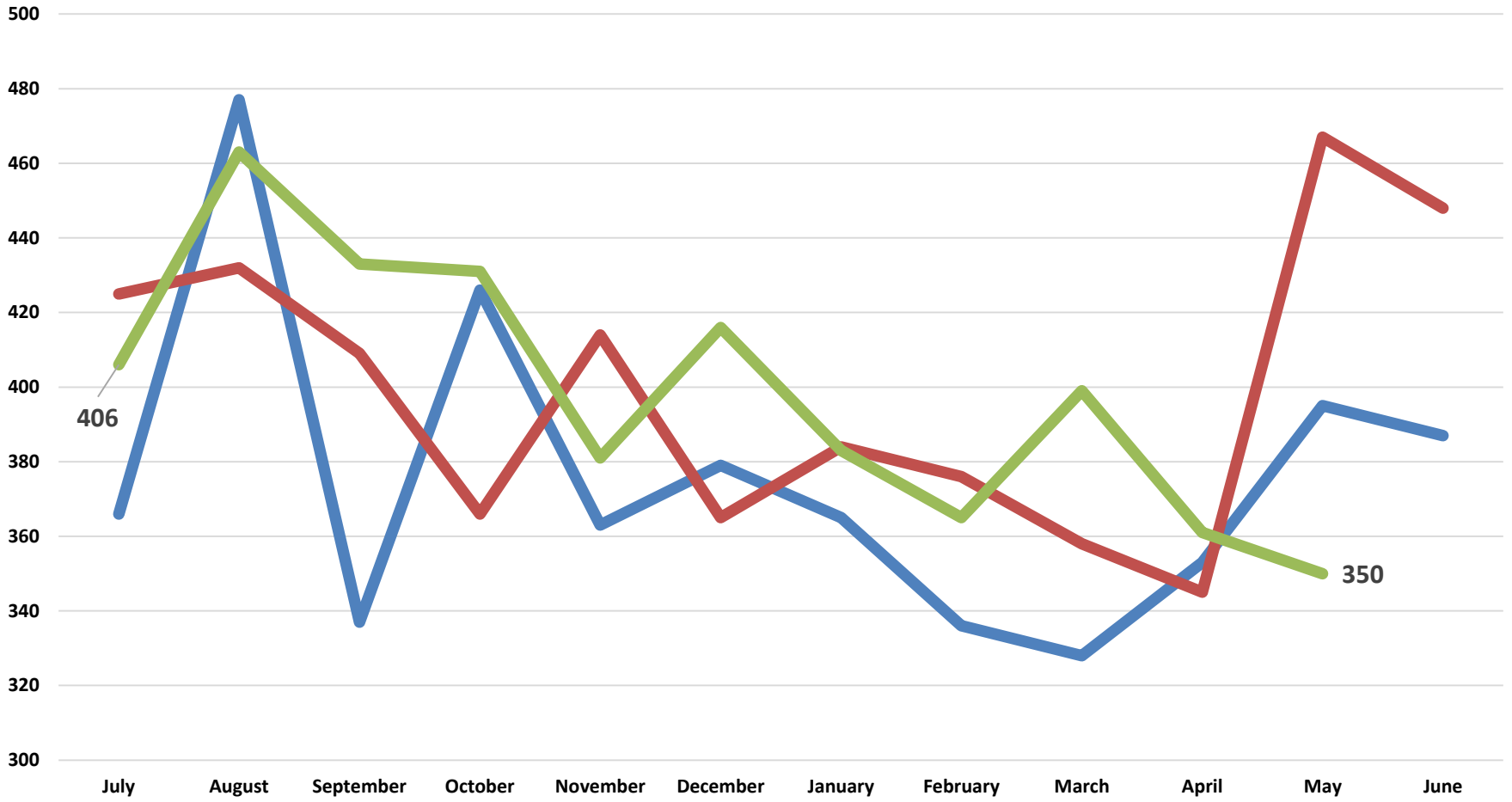
	YTD
FY2017	97,529
FY2018	121,166
FY2019	90,135
Budget	128,152

Rural Health Clinics Registrations



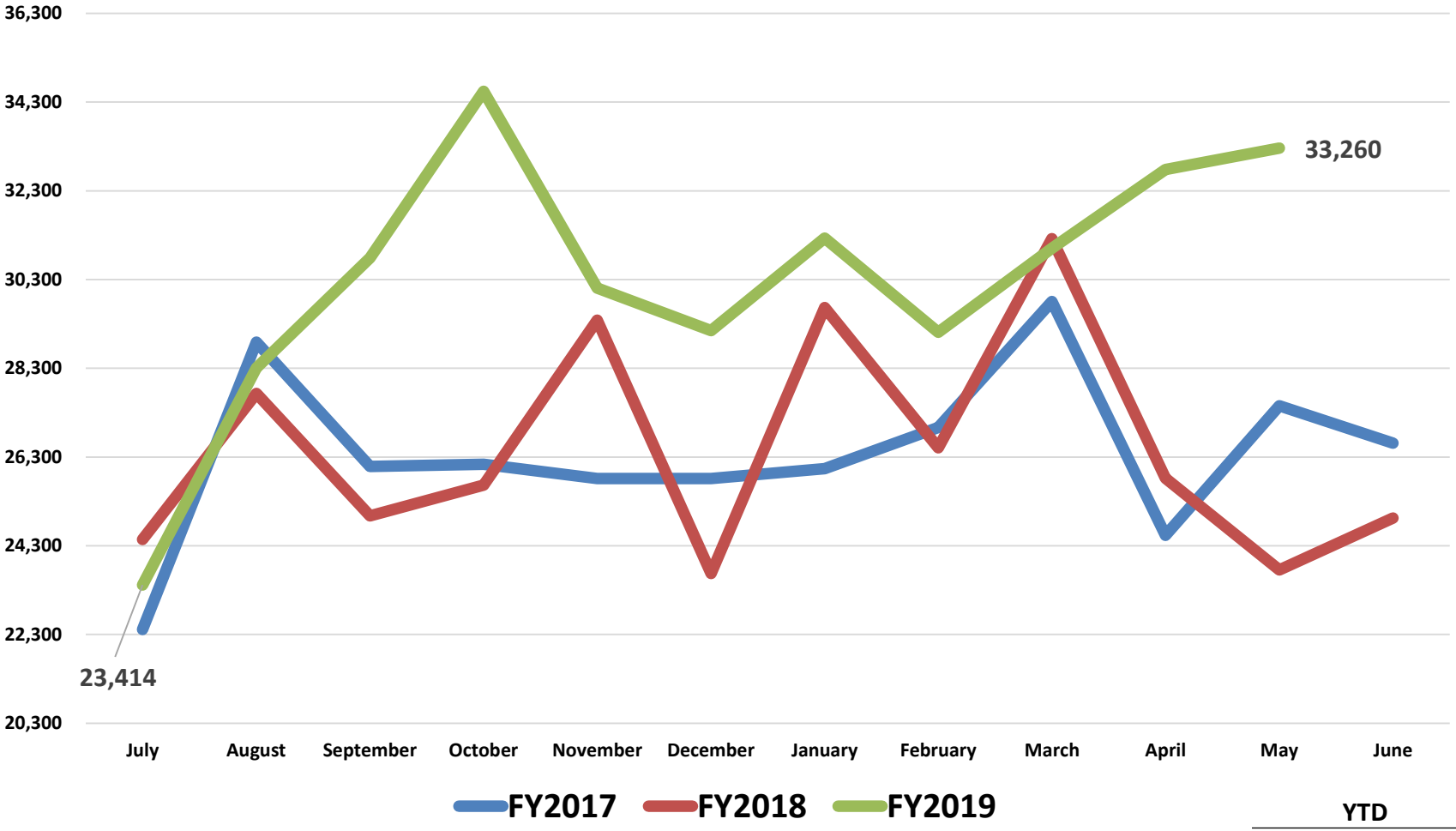
	YTD
FY2019	88,895

Deliveries



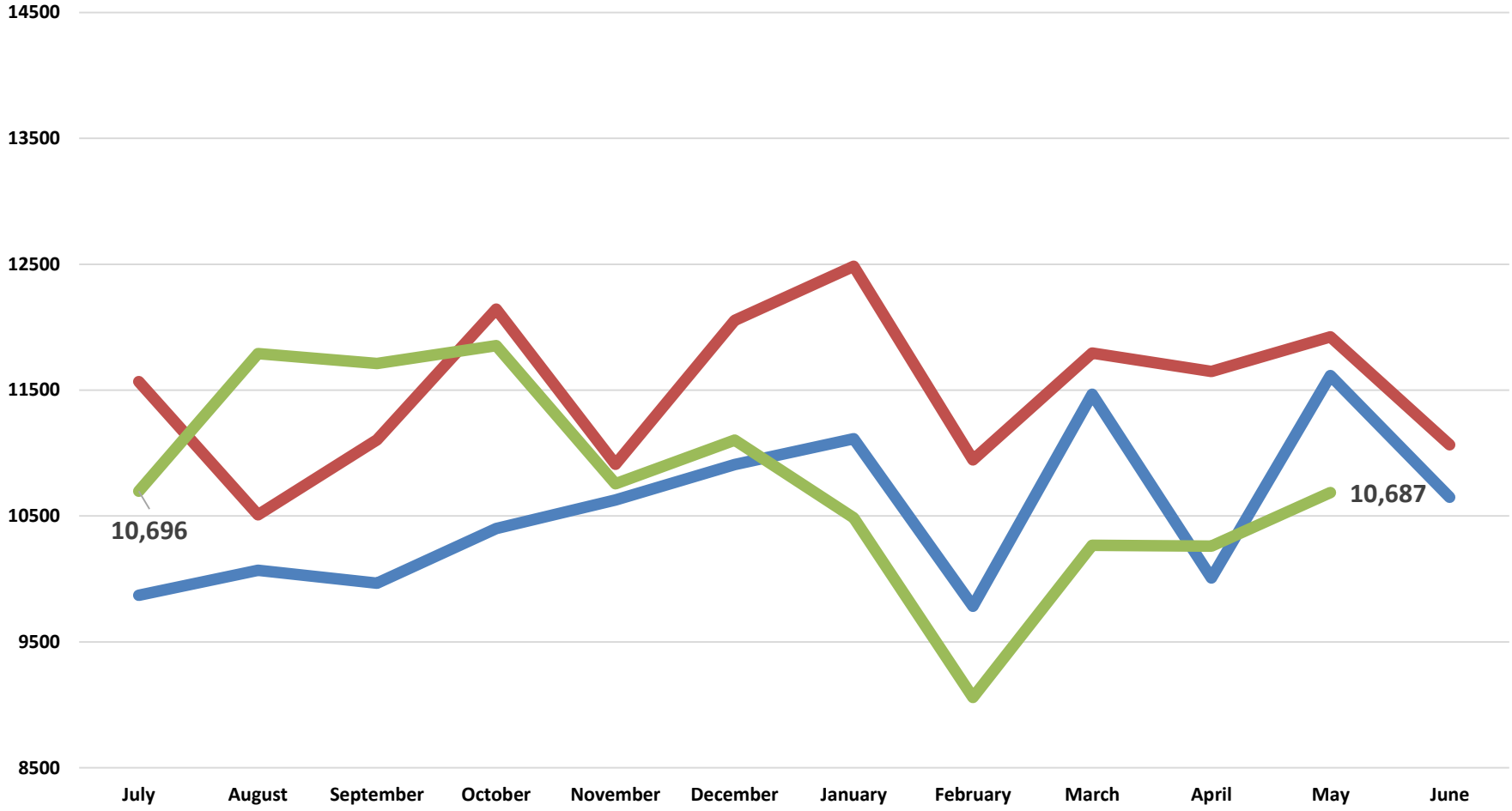
	YTD
FY2017	4,125
FY2018	4,341
FY2019	4,388
Budget	4,439

KDMF RVU's



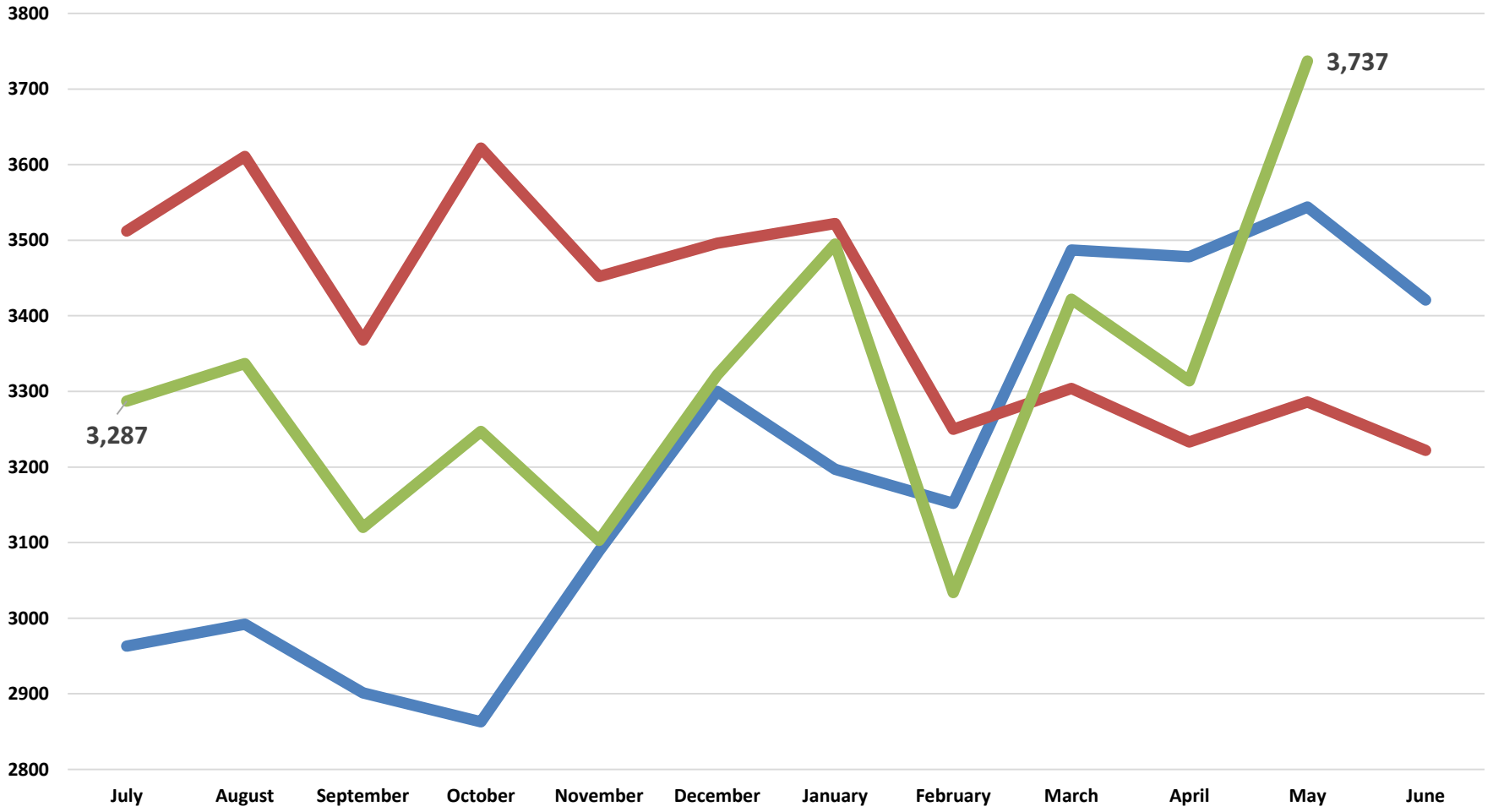
	YTD
FY2017	289,958
FY2018	292,850
FY2019	333,695
Budget	339,937

Home Infusion Days



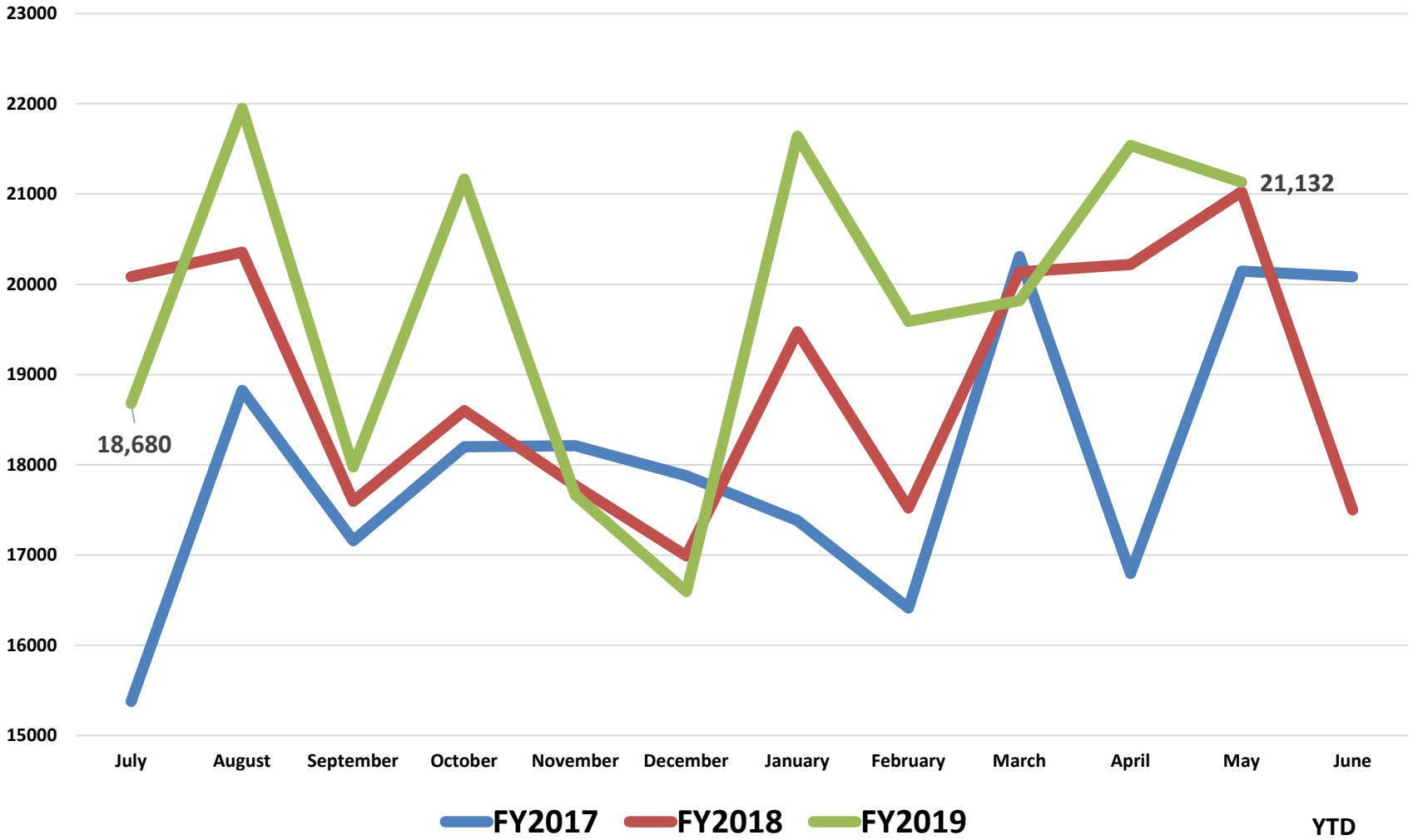
	YTD
FY2017	115,828
FY2018	127,088
FY2019	118,667
Budget	126,937

Hospice Days



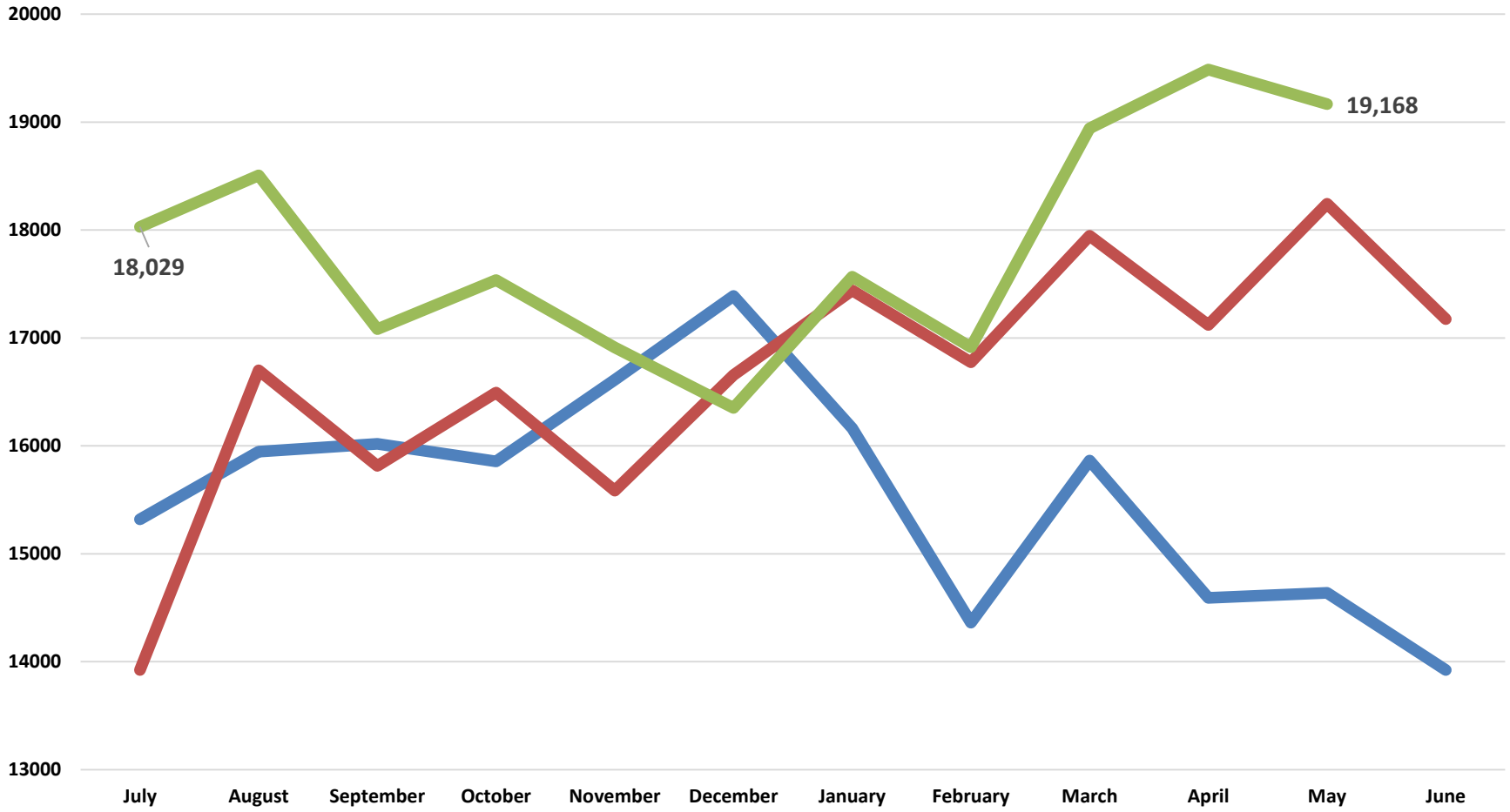
	YTD
FY2017	34,966
FY2018	37,656
FY2019	36,418
Budget	39,849

O/P Rehab Units



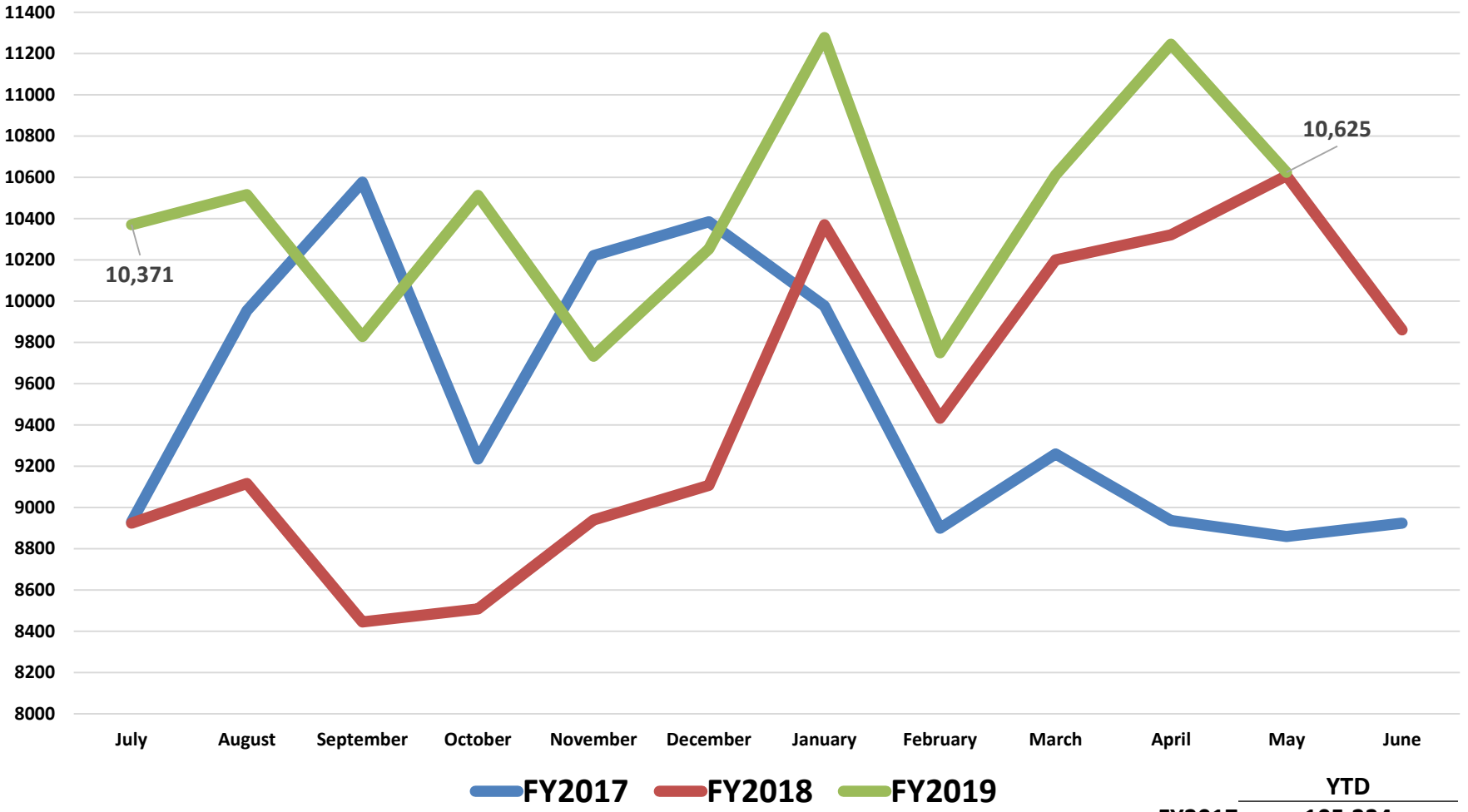
	YTD
FY2017	196,691
FY2018	209,769
FY2019	217,757
Budget	214,621

Physical & Other Therapy Units (I/P & O/P)



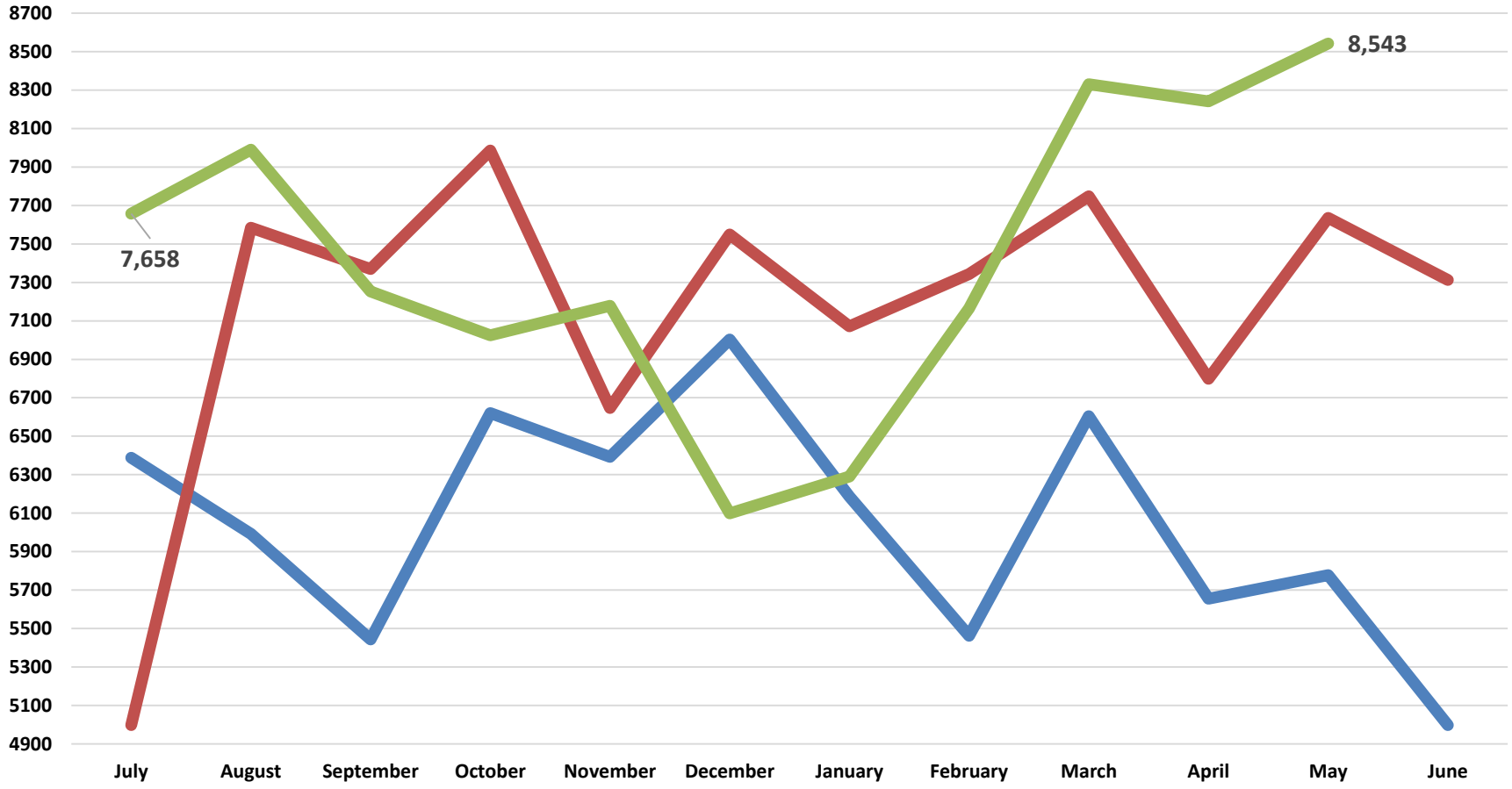
	YTD
FY2017	172,758
FY2018	182,701
FY2019	196,499
Budget	196,829

Physical & Other Therapy Units (I/P & O/P)-Main Campus



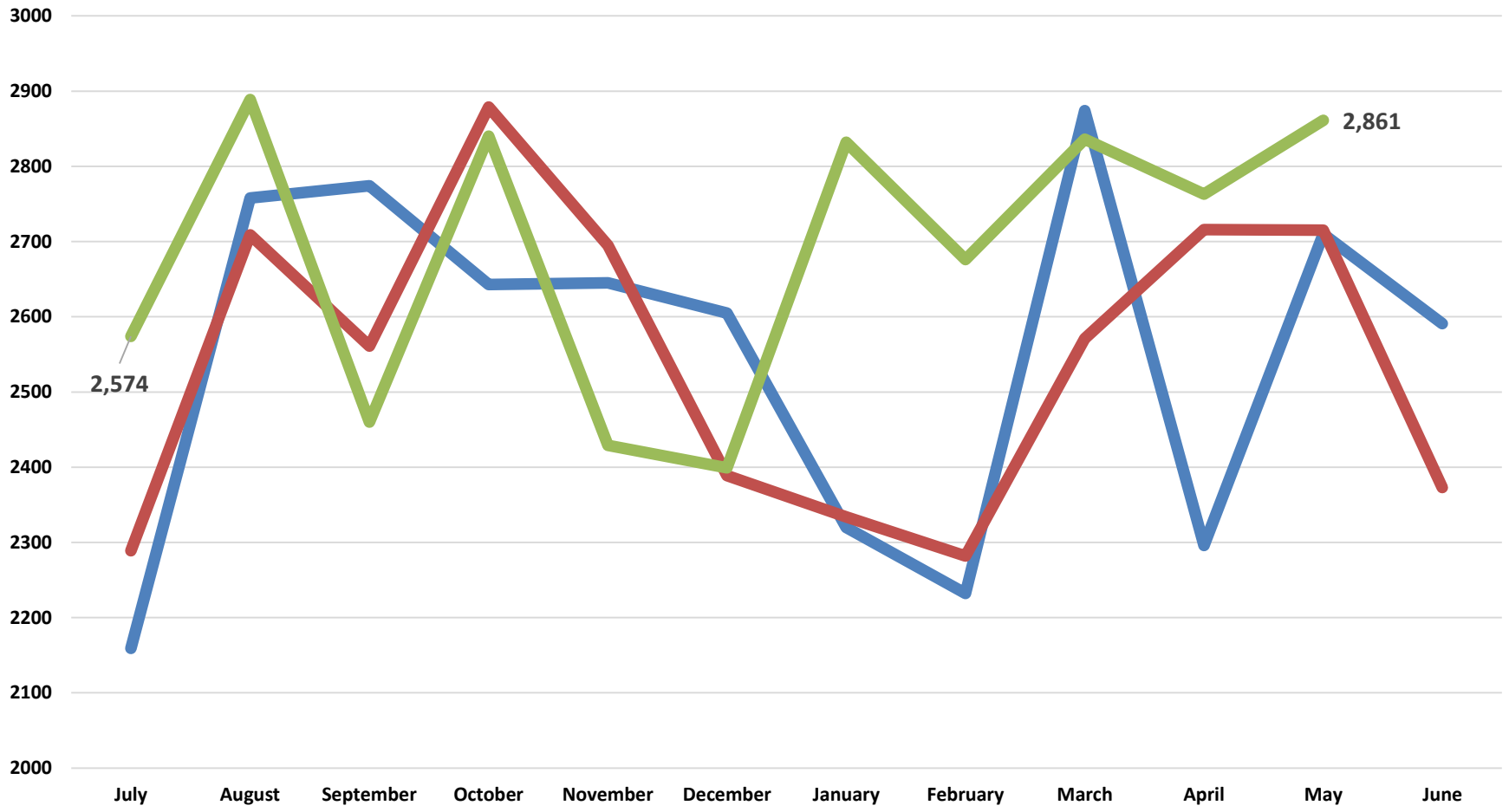
	YTD
FY2017	105,234
FY2018	103,971
FY2019	114,726
Budget	115,730

Physical & Other Therapy Units (I/P & O/P)-KDRH & South Campus



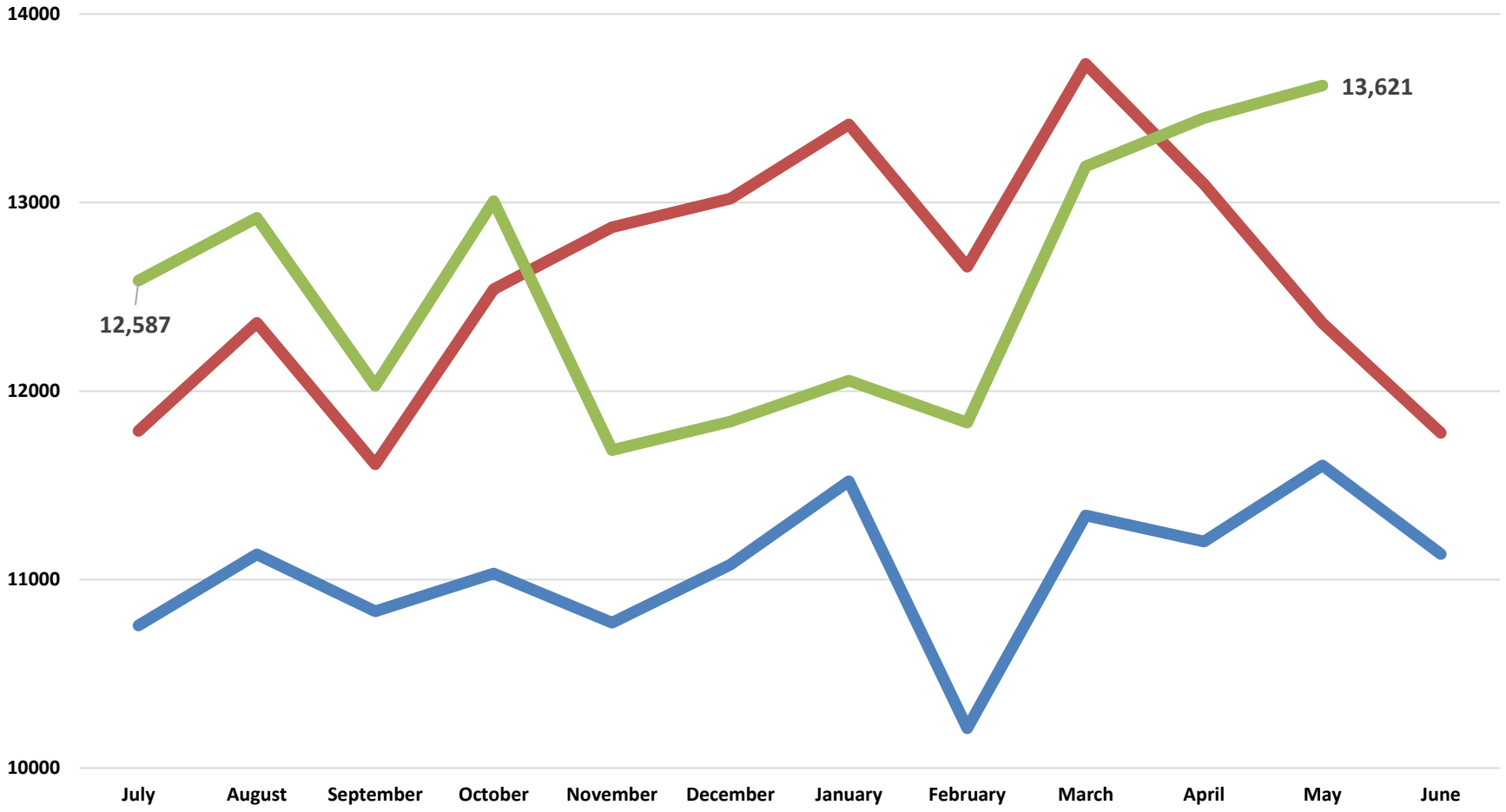
	YTD
FY2017	67,524
FY2018	78,730
FY2019	81,773
Budget	81,099

Home Health Visits



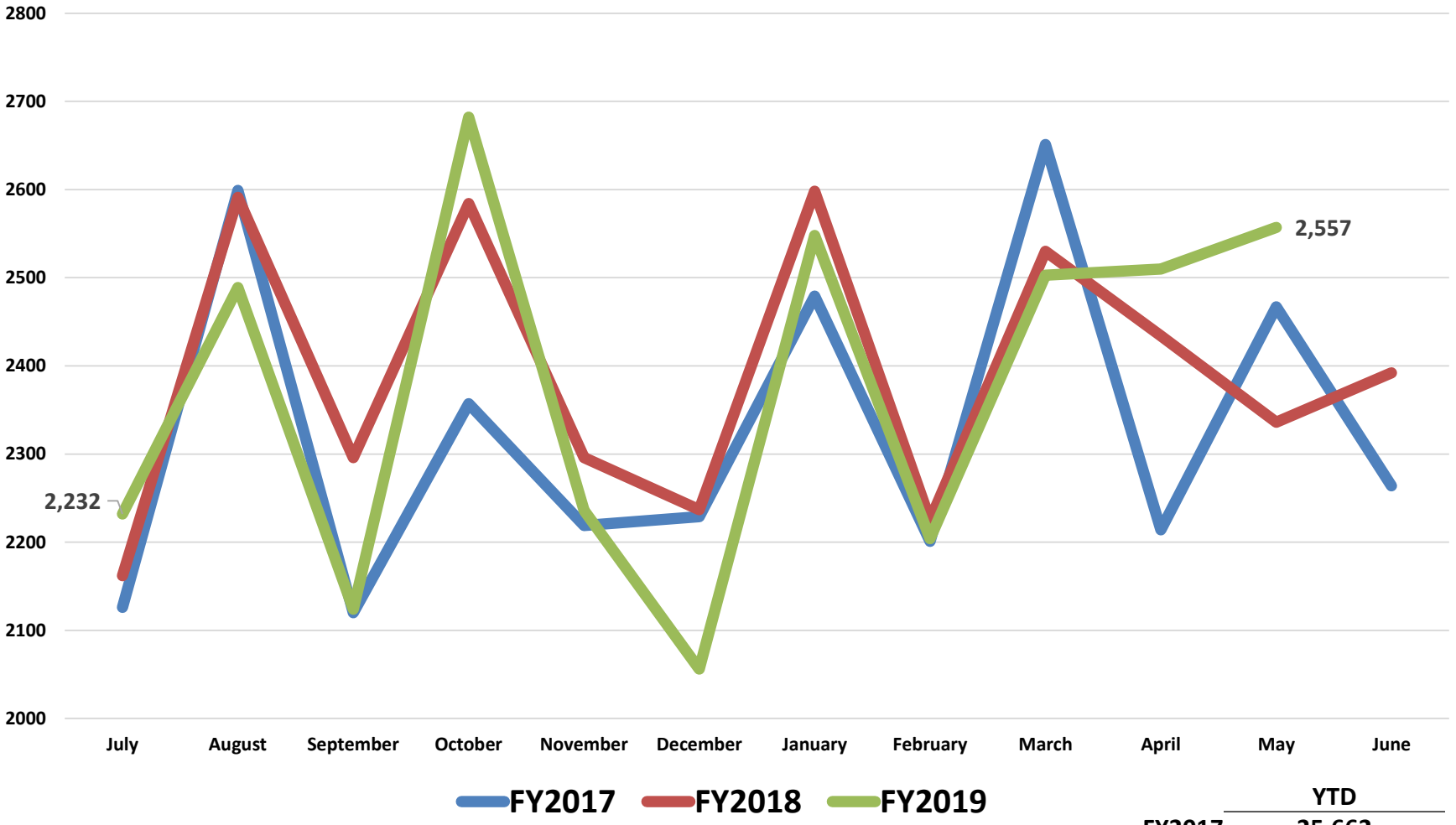
	YTD
FY2017	28,016
FY2018	28,140
FY2019	29,559
Budget	28,920

Radiology – Main Campus



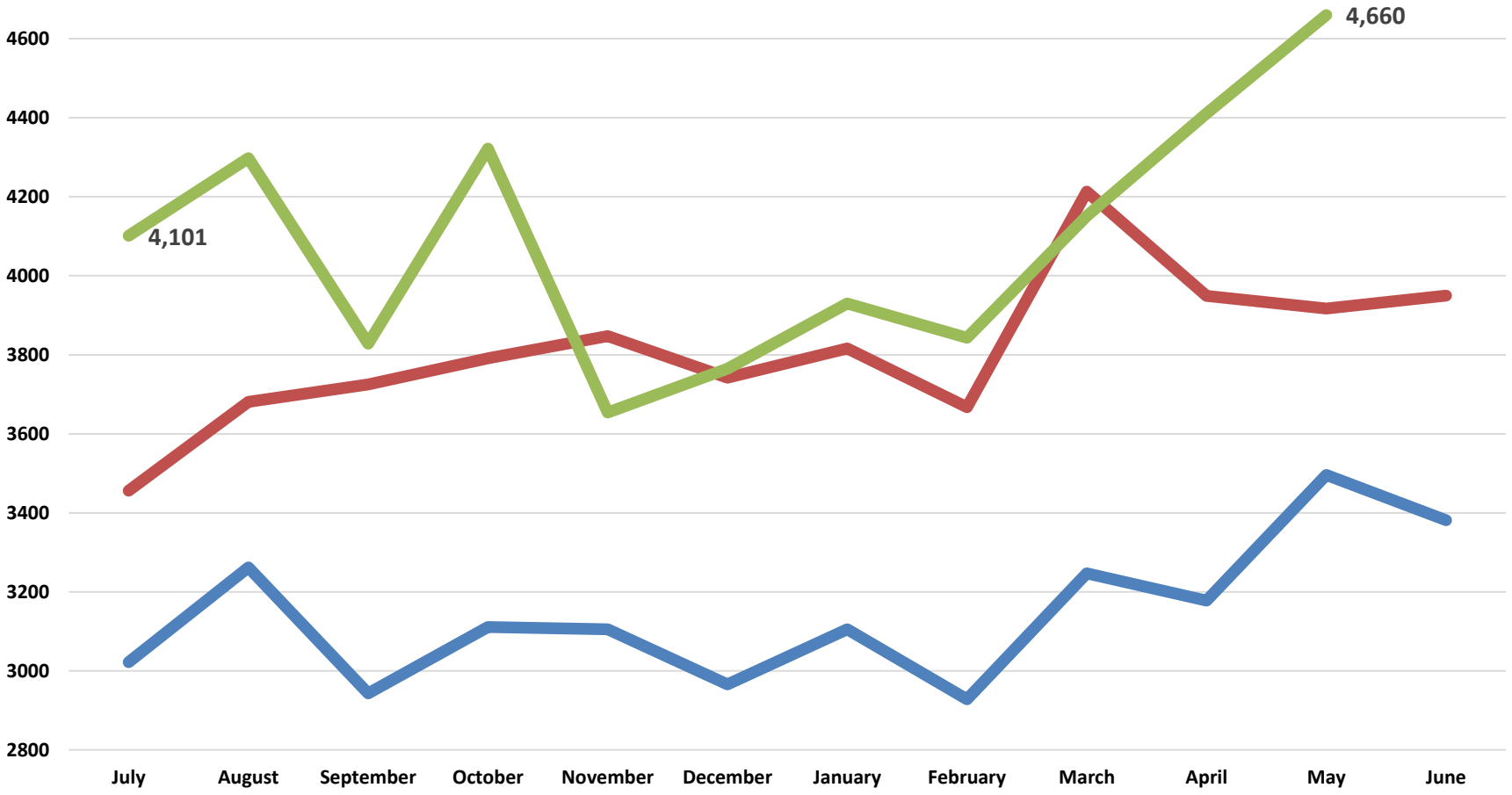
	YTD
FY2017	121,482
FY2018	139,463
FY2019	138,218
Budget	141,221

Radiology – SIC



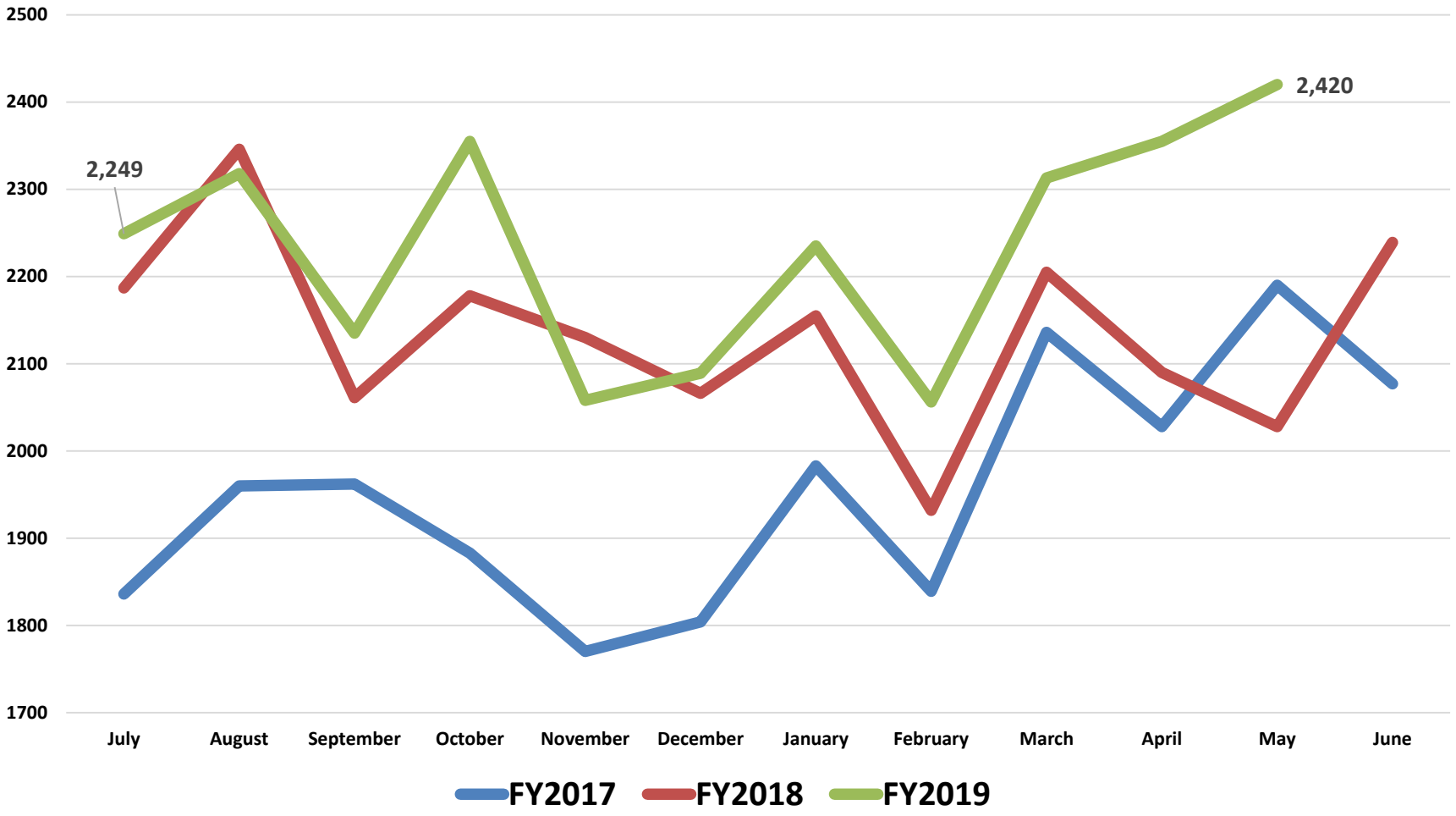
	YTD
FY2017	25,662
FY2018	26,289
FY2019	26,141
Budget	27,814

Radiology – CT



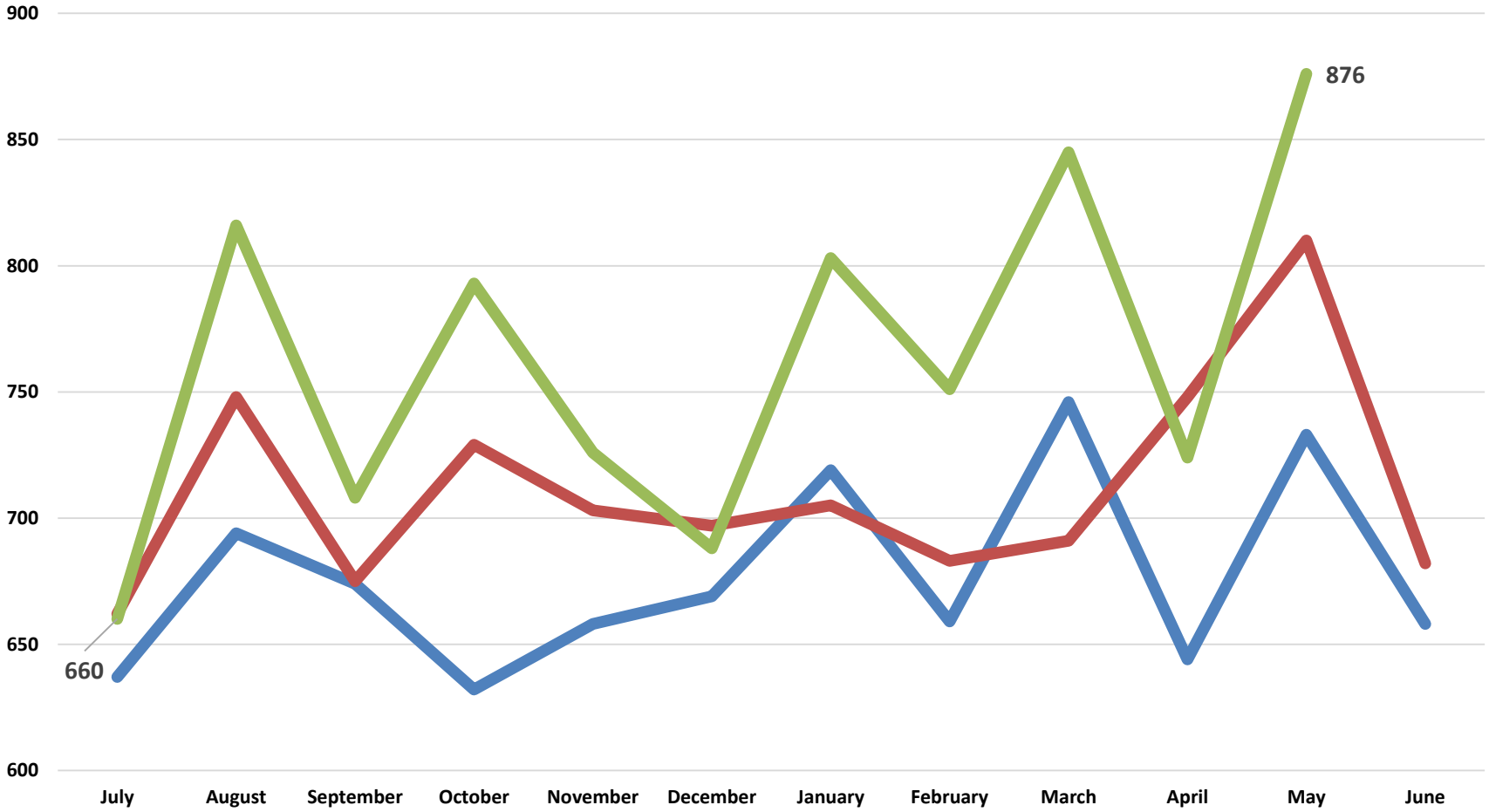
	YTD
FY2017	34,363
FY2018	41,804
FY2019	44,963
Budget	41,251

Radiology – Ultrasound



	YTD
FY2017	21,391
FY2018	23,378
FY2019	24,583
Budget	25,743

Radiology – MRI



	YTD
FY2017	7,465
FY2018	7,851
FY2019	8,390
Budget	7,817

Budget 2020 Executive Summary

Kaweah Delta Health Care District
2019-2020 Budget
Executive Summary

After several months of considerable effort by the District's leadership team, the resulting 2019-2020 budget meets financial objectives but underscores the need for Kaweah Delta to become increasingly-more efficient and cost effective. While this 2019-2020 annual budget exceeds the minimum level of performance required by our creditors and provides the financial resources necessary to carry out our mission and strategic initiatives, it will only be accomplished if we are successful in our planned efforts to reduce our acute inpatient length of stay; our consumption of supplies; and our performance of unnecessary clinical tests and treatments; improve our labor productivity; and meet our performance metrics relative to our health care delivery system improvement initiatives under the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program.

In terms of overall profitability, the District's consolidated excess margin is projected at $24.1 million, or 3.1%, which is higher than the $23.2 million (3.1%) estimated for 2018-2019. Of the $24.1 million excess margin, $6.6 million, or 27.6%, is derived from investment earnings. The District's 2019-2020 operating margin (excluding investment earnings) is projected at 2.3% which represents an increase from the estimated 2018-2019 operating margin of 2.0%. The 2019-2020 annual budget continues the District's fiscally-responsible practice of full payment of annual principal and interest on external debt, a contribution to the general and professional liability self-insurance trust fund equal to the amount recommended by the District's actuarial firm, and full compliance with all external debt covenants. In addition, in an effort to achieve full funding of the District's defined benefit pension plan liability within a targeted timeframe, this budget also reflects an $11.4 million contribution to the pension trust fund.

The District's 2019-2020 annual budget reflects an operating expense budget of $755.1 million, an increase of $19.6 million, or 2.7%, over the prior year. After considering the effects of increases in patient service volumes, the District's cost per adjusted patient day is projected to decrease by 0.2%, from $2,392 for 2018-2019 to $2,387 for 2019-2020. Over the past four years the District's cost per adjusted patient day has increased by a cumulative 17.1% from $2,038 in 2016 to $2,387 for fiscal year 2019-2020. Over this same four-year period, the District's average hourly wage rate has increased annually on average 4.2% from $29.47 in 2016 to $34.43 for fiscal year 2019-2020.

The 2019-2020 budget reflects an increase of $6.3 million, or 1.7%, in total personnel expenses, comprising 32% of the increase in total operating expenses. This increase includes a $17.5 million, or 6.1%, increase in payroll expense and a $931,000, or 1.3%, increase in benefits offset by a $12.1 million, or 76.2%, decrease in contract labor. Although the budget reflects a 1.1% decrease in full-time equivalent employees from last, the average hourly wage increased by 4.9% due to $7.0 million in merit increases and $7.6 million in pay-range market and minimum wage adjustments. Non-labor expenses are expected to increase $13.3 million, or 3.7%, from 2018-2019. The primary areas showing material increases are physician fees, depreciation expense, professional liability costs, purchased medical services and physician and employee recruiting expenses. After considering the effects of increases in patient service volumes, non-labor costs expressed as an amount per adjusted patient day are projected to increase by 0.8%.

The District's 2019-2020 capital expenditures budget reflects a total outlay of $16.0 million for recurring capital assets and completion of strategically-important projects and infrastructure improvements, which represents no change from the capital expenditures budget for fiscal year 2019. Total capital expenditures represent 52% of 2019-2020 depreciation expense reflecting the District's continued commitment to replenish aging assets and maintain an Average Age of Plant ratio consistent with that of other "A"-rated hospitals (12.1 years at May 31,2019 versus Moody's benchmark of 11.6 years). Of the $16.0 million capital budget, $11.5 million has been committed to complete strategically-important projects and upgrade aging infrastructure, $1.8 million committed to replacement of patient monitoring equipment and $1.4 million to information systems. The remaining $1.4 million of available capital funds will be used to meet recurring capital needs as identified by management. The District's management team will use its discretion in determining the expenditures most critical to patient care and the District's strategic interests. In addition to the $16.0 million capital expenditures budget, management has separately budgeted $820,000 for

"enterprise capital", funds allocated for specific investment in District service lines that operate in a uniquely-competitive environment, such as the Lifestyle Center and the District's rural health clinics, and to provide funding for pursuit of other business opportunities that may arise during the coming year. Furthermore, management has also provided for a "general capital contingency fund" of $340,000 to respond to unforeseen capital equipment needs or enhancement of operating systems. Combined, the District's capital expenditures budget plan for 2019-2020 approximates $17.2 million.

Operating Budget Analysis

After several months of preparation, analysis, and revision, the resulting 2019-2020 annual budget reflects the generation of net cash flows equal to $57.2 million (excess margin plus amortization and depreciation) which will be expended to acquire capital equipment and make principal debt service payments. After making these expenditures, the anticipated cash flows will provide for a $24.7 million increase in the District's surplus funds.

Budgeted excess margin (net income) for the District of $24.1 million represents a $863,000, or 3.7%, increase from 2018-2019, comprised of a $2.4 million, or 16.3%, increase in operating margin and a $1.6 million, or 19.2%, decrease in investment income. The projected 2019-2020 excess margin of 3.1% is below the 5.2% median benchmark performance achieved by hospitals awarded an "A" rating by the Moody's bond rating agency for 2017. The District's projected 2.3% operating margin is equal to the median ratio of 2.3%, generally regarded by rating agencies as a more-important reflection of a hospital's financial performance.

Patient Utilization

Inpatient utilization for 2019-2020 reflects an average daily patient census of 449, representing a 1.5% increase from the estimated average daily patient census for 2018-2019. The patient days total of 164,020 for 2019-2020 reflects general population growth in the District's primary service area and the presence of new physicians, tempered by the industry trend of increasingly moving patient care from inpatient to outpatient settings and the District's ongoing initiative to improve patient throughput and reduce its average length of stay. The acute medical/surgical patient days total of 104,735 (comprised of ICU and the primary medical/surgical units on the main campus) represents an increase of 1.4% from 2018-2019 and an overall average occupancy rate of 75.1%. The remaining acute patient days total of 37,031 for the ICN, nursery, rehabilitation and acute psychiatry areas represents an increase of 2.1%. 2019-2020 outpatient activity expressed in equivalent inpatient days is projected to increase 4.4% from 2018-2019 due primarily to increased patient activity in Imaging, Surgery, Cardiac Catheterization Lab, Emergency/Urgent Care, Rural Health Clinics, Kaweah Delta Neurosciences Center, Kaweah Delta Medical Foundation and the Kaweah Delta Sequoia Cardiology Center.

Gross Patient Service Revenue

Gross patient service revenue for 2019-2020 will increase by 4.1% due primarily to increased patient care volumes. The 2019-2020 budget does not reflect an increase to retail charges. The primary areas of gross patient service revenue increase are Routine Nursing, Surgery, Cardiac Catheterization Lab, Emergency/Urgent Care services, Rural Health Clinics, Kaweah Delta Neurosciences Center, Kaweah Delta Sequoia Cardiology Center and the Kaweah Delta Medical Foundation. Numerous other ancillary service areas are projecting modest increases in volume and gross patient revenue.

Deductions from Revenue

Budgeted deductions from revenue (DFR) for 2019-2020 represent 74.3% of gross patient service revenue, an improvement from the 75.3% DFR rate experienced in 2018-2019. DFR include contractual allowances for the Medicare and Medi-Cal programs, discounts negotiated directly with employers and other third-party payers, and provisions for bad debts and charity care. DFR for 2019-2020, as a percent of gross patient

revenue, improves from 2018-2019 levels primarily from the beneficial effects of slightly-increased Medicare, Medi-Cal managed care and commercially-insured managed care reimbursement rates, improved Medicare reimbursement related to the District's ongoing clinical documentation improvement initiative and receipt of direct and indirect medical education payments. This budget reflects the increases and decreases currently residing in existing laws and regulations applicable to our fiscal year 2019-2020 as well as the Centers for Medicare & Medicaid Services' (CMS) proposed rule for Federal fiscal year 2020.

With respect to Medicare, our largest payer, representing 44.0% of the District's gross patient revenue, the budgeted Medicare DFR percentage reflects reimbursement rate increases and decreases in a number of District programs. These projected rate increases reflect a combination of both proposed and approved changes as published by CMS in various Federal Registers. With respect to general acute inpatient services reimbursed under the Prospective Payment System, it is estimated that Kaweah Delta will experience an overall increase of 1.2% beginning October 1, 2019, the start of Federal fiscal year 2019. The 2019-2020 budget also reflects a 1.4% increase in outpatient reimbursement rates, a 13.7% increase in acute rehabilitation rates, a 46.2% increase in skilled nursing, a 2.5% increase in subacute rates, a 1.7% increase in acute psychiatric reimbursement rates, a 2.2% increase in home health reimbursement rates, and a 1.5% increase in rural health clinic reimbursement rates. Lastly, the Medicare DFR rate also includes $1.0 million additional direct and indirect medical education payments associated with the increase of additional physician resident FTEs.

Medi-Cal and Medi-Cal Managed Care represent 30.3% of gross patient revenue. The Medi-Cal DFR projection recognizes the reimbursement of services furnished to Medi-Cal managed care enrollees at negotiated rates and fee-for-service (FFS) reimbursement rates paid for most inpatients and outpatients in aid categories not eligible for the managed care program. With respect to patients covered under the Medi-Cal managed care program, the District is anticipating overall reimbursement rate increases of approximately 1.6% based on scheduled rate increases already included in multi-year contracts. This budget reflects no change in reimbursement for Medi-Cal FFS inpatient and outpatient services.

In regard to the remaining nongovernment category of patients representing 25.7% of gross patient revenues, the 2019-2020 budget assumes that 80.6% of this nongovernment payer category will be covered by some form of commercial insurance (excluding Medicare and Medi-Cal managed care) where the District has agreed to accept reimbursement at a fixed price per patient day, per case or per procedure. Reimbursement rates for this nongovernment payer category are expected to increase an average of 2.9%, reflective of scheduled rate increases negotiated in prior years with many of the District's major managed care payers.

The budget also reflects approximately $3.0 million in additional reimbursement resulting from our continuing efforts to improve clinical documentation and $2.7 million in additional reimbursement from the new Cerner system functionality that will better allow us to limit underpayments and denials.

Medi-Cal Supplemental Payment Programs

The 2019-2020 budget also includes $58.1 million of Medi-Cal supplemental payment programs paid as either Inter-Governmental Transfer (IGT) payments or direct grants. This total includes $13.0 million of Medi-Cal Managed Care "rate range" IGT payments, $11.0 million in Medi-Cal FFS IGT revenue, $16.1 million in disproportionate share payments (with funding for graduate medical education), and $11.7 million in Quality Assurance Fee payments.

Other Operating Revenue

Other operating revenue for 2019-2020 of $111.5 million represents a $897,000, or 0.8%, decrease from 2018-2019. Other operating revenue includes revenue generated from cafeteria food sales, operation of the Lifestyle Center and Kaweah Kids Center, the District's appropriation of general County taxes, management services revenue generated by the medical oncology component of Sequoia Regional Cancer Center (a joint venture with Sequoia Oncology Medical Associates and Adventist Health), and income received from the District's joint venture ownership in Quail Park Retirement Village, LLC; Laurel Court at Quail Park, LLC; Sequoia Surgery Center, LLC; and Cypress Company, LLC. Additionally, 2019-2020 other operating revenue includes $10.9 million in Federal funding made available to district hospitals (non-designated public hospitals) under the 5-year Medicaid waiver (the PRIME healthcare delivery system improvement program previously referenced) and approximately $47.6 million in capitation payments to be received related to the Humana fully-capitated Medicare Advantage plan.

Operating Expenses

Operating expenses for 2019-2020 of $755.1 million represent a $19.6 million, or 2.7%, increase from 2018-2019. This increase is the combined effect of a $6.3 million, or 1.7%, increase in employment costs and a $13.3 million, or 37%, increase in non-labor expenses. The salaries budget reflects an average 2.45% pay-for-performance increase for District employees for 2019-2020 and provides for $7.6 million in funding for market and minimum wage adjustments. Total paid man-hours are projected to decrease by 1.1%. Full-time equivalents (FTEs) per adjusted occupied bed, a measure of labor productivity, is projected to be 4.97 in 2019-2020, a 3.6% increase from the productivity levels experienced in 2018-2019 but 2.2% lower than four years ago. Expense per adjusted patient day, which indicates overall cost-efficiency, is projected to decrease 0.2% in 2019-2020, but is 27.5% higher than four years ago.

Employee benefits for 2019-2020 of $72.7 million represents a $931,000, or 1.3%, increase from 2018-2019 due primarily to increased workers' compensation costs ($1.8 million) and increased social security costs ($1.3 million) offset by reduced employee health plan expense ($1.8 million). Benefits as a percentage of salaries for 2019-2020 are 23.9% compared to 25.0% for 2018-2019.

Other direct expenses for 2019-2020 of $374.1 million represent a $13.4, or 2.7%, increase from 2018-2019. This results primarily from a $9,7 million, or 11.4%, increase in physician fees and a $2,3 million, or 10.1%, increase in depreciation expense. Various efficiency initiatives are projected to reduce the District's overall ratio of supplies expense to total operating revenue from 15.9% for 2018-2019 to 15.0% for 2019-2020.

Summary

While the 2019-2020 annual budget reflects the maintenance of financial strength prescribed by the District's pillars, it also reflects the challenging environment in which it operates. However, our community's expectation of us to achieve outstanding community health and deliver excellent service, while providing an ideal work environment and empowering through education, remains constant. Continued achievement of these expectations will require a very-disciplined use of the limited resources available to us. We believe this 2019-2020 annual budget is reflective of this discipline.

2020 Budget Presentation Final BOD Mtg 62419

2019-2020 Annual Budget Review

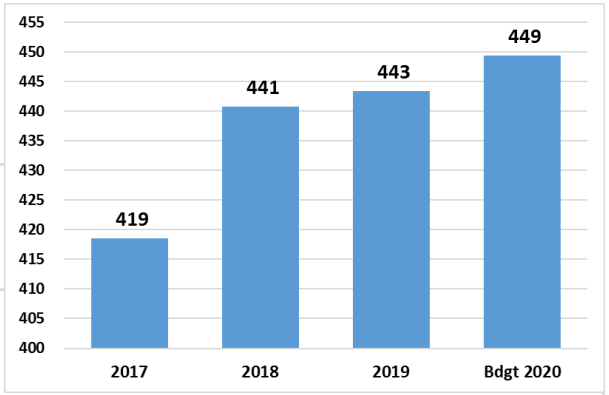
June 24, 2019

Kaweah Delta
HEALTH CARE DISTRICT

2019-2020 Annual Budget Review

- Budget Assumptions Volume
- FY 20 Budgeted Income Statement Comparison
- Initiatives
- Explanations Behind Significant Variances
- Budgeted Capital Purchases
- Projected Cash Flow
- Financial Ratios

Average Daily Census



Inpatient Volumes

	FY 19 Actuals	FY 20 Budget	Change	% Change	% Occupancy
Average Daily Census	**443**	**449**	**6**	**1.5%**	
Patient Days:					
Medical Center	103,337	104,735	1,398	1.4%	75.1%
Acute I/P Psych	17,173	17,369	196	1.1%	75.5%
Sub-Acute	11,299	11,289	(10)	(0.1%)	96.7%
Rehab	6,824	7,200	376	5.5%	43.8%
TCS-Ortho	4,760	4,760	0	0.0%	81.5%
TCS	5,869	6,205	336	5.7%	77.3%
NICU	5,347	5,449	102	1.9%	99.5%
Nursery	6,927	7,013	86	1.2%	
Total Patient Days	**161,536**	**164,020**	**2,484**	**1.5%**	

Other Volume Assumptions

	FY 19 Actuals	FY 20 Budget	Change	% Change
Adjusted Patient Days	**307,502**	**316,397**	**8,895**	**2.9%**
Equivalent Outpatient Volume	**145,966**	**152,377**	**6,411**	**4.4%**

Surgery Minutes	11,820	13,469	**1,649**	14.0%
Cath Lab Minutes	221,684	243,852	**22,168**	10.0%
Deliveries	4,787	5,100	**313**	6.5%
Rural Health Clinic Visits	98,329	131,495	**33,166**	33.7%
Emergency Department Visits	83,129	91,000	**7,871**	9.5%
Sequoia Cardiology Clinic	11,150	12,813	**1,663**	14.9%
Neuroscience Center	4,758	6,370	**1,612**	33.9%
Outpatient Rehabilitation Units	237,553	246,109	**8,556**	3.6%
Physical & Other Therapy Units	214,363	217,558	**3,195**	1.5%
Home Health Visits	29,559	31,600	**2,041**	6.9%
Radiology CT	49,051	51,125	**2,074**	4.2%
Radiology MRI	26,818	29,019	**2,201**	8.2%
Radiology US	9,153	9,468	**315**	3.4%

Comparison of FY 2020 Budget to FY 2019 Projected Actual (000's)

	FY 19 Projected Actual	FY 20 Budget	Variance	% Change
Operating Revenue				
Net Patient Service Revenue	**$562,240**	**$609,205**	**$46,965**	**8.4%**
Supplemental Gov't Programs	75,818	51,830	(23,988)	(31.6%)
Prime Program	17,093	10,862	(6,231)	(36.5%)
Premium Revenue	40,923	47,558	6,635	16.2%
Management Services Revenue	31,585	32,321	736	2.3%
Other Revenue	22,816	20,779	(2,037)	(8.9%)
Other Operating Revenue	188,235	163,350	(24,885)	(13.2%)
Total Operating Revenue	**750,475**	**772,555**	**22,080**	**2.9%**
Operating Expenses				
Salaries and Wages	287,045	304,523	17,478	6.1%
Contract Labor	15,914	3,781	(12,133)	(76.2%)
Employee Benefits	71,759	72,690	931	1.3%
Total Employment Expenses	**374,718**	**380,994**	**6,276**	**1.7%**
Medical and Other Supplies	114,151	111,269	(2,882)	(2.5%)
Physician Fees	85,136	94,805	9,669	11.4%
Purchased Services	39,047	36,787	(2,260)	(5.8%)
Repairs and Maintenance	26,811	26,828	17	0.1%
Utilities	5,945	5,981	36	0.6%
Rents and Leases	6,269	6,373	104	1.7%
Depreciation and Amortization	30,824	33,122	2,298	7.5%
Interest Expense	5,455	6,285	830	15.2%
Other Expenses	16,020	20,843	4,823	30.1%
Management Services Expenses	31,081	31,807	726	2.3%
Total Operating Expenses	**735,457**	**755,094**	**19,637**	**2.7%**
Operating Margin	**$15,018**	**$17,461**	**$2,443**	**16.3%**
Nonoperating Revenue	8,228	6,648	(1,580)	(19.2%)
Excess Margin	**$23,246**	**$24,109**	**$863**	**3.7%**

Operating Margin %	**2.0%**	**2.3%**
Excess Margin %	**3.1%**	**3.1%**

Comparison per Adjusted Patient Day

In (000's):	FY 19 Projected Actual	FY 20 Budget	Variance	% Change	PER APD FY 19 Projected Actual	PER APD FY 20 Budget	PER APD Variance	PER APD % Change
Operating Revenue								
Net Patient Service Revenue	**$562,240**	**$609,205**	**46,965**	**8.4%**	**$1,828**	**$1,925**	**97.0**	**5.3%**
Supplemental Gov't Programs	75,818	51,830	(23,988)	(31.6%)	247	164	(82.7)	(33.6%)
Prime Program	17,093	10,862	(6,231)	(36.5%)	56	34	(21.3)	(38.2%)
Premium Revenue	40,923	47,558	6,635	16.2%	133	150	17.2	12.9%
Management Services Revenue	31,585	32,321	736	2.3%	103	102	(0.6)	(0.5%)
Other Revenue	22,816	20,779	(2,037)	(8.9%)	74	66	(8.5)	(11.5%)
Other Operating Revenue	188,235	163,350	(24,885)	(13.2%)	612	516	(95.9)	(15.7%)
Total Operating Revenue	**750,475**	**772,555**	**22,080**	**2.9%**	**2,441**	**2,442**	**1.2**	**0.0%**
Operating Expenses								
Salaries and Wages	287,045	304,523	17,478	6.1%	933	962	29.0	3.1%
Contract Labor	15,914	3,781	(12,133)	(76.2%)	52	12	(39.8)	(76.9%)
Employee Benefits	71,759	72,690	931	1.3%	233	230	(3.6)	(1.6%)
Total Employment Expenses	**374,718**	**380,994**	**6,276**	**1.7%**	**1,219**	**1,204**	**(14.4)**	**(1.2%)**
Medical and Other Supplies	114,151	111,269	(2,882)	(2.5%)	371	352	(19.5)	(5.3%)
Physician Fees	85,136	94,805	9,669	11.4%	277	300	22.8	8.2%
Purchased Services	39,047	36,787	(2,260)	(5.8%)	127	116	(10.7)	(8.4%)
Repairs and Maintenance	26,811	26,828	17	0.1%	87	85	(2.4)	(2.7%)
Utilities	5,945	5,981	36	0.6%	19	19	(0.4)	(2.2%)
Rents and Leases	6,269	6,373	104	1.7%	20	20	(0.2)	(1.2%)
Depreciation and Amortization	30,824	33,122	2,298	7.5%	100	105	4.4	4.4%
Interest Expense	5,455	6,285	830	15.2%	18	20	2.1	12.0%
Other Expenses	16,020	20,843	4,823	30.1%	52	66	13.8	26.4%
Management Services Expenses	31,081	31,807	726	2.3%	101	101	(0.5)	(0.5%)
Total Operating Expenses	**735,457**	**755,094**	**19,637**	**2.7%**	**2,392**	**2,387**	**(5.2)**	**(0.2%)**
Operating Margin	**$15,018**	**$17,461**	**$2,443**	**16.3%**	**$49**	**$55**	**6.3**	**13.0%**
Nonoperating Revenue	8,228	6,648	(1,580)	(19.2%)	27	21	(5.7)	(21.5%)
Excess Margin	**$23,246**	**$24,109**	**$863**	**3.7%**	**$76**	**$76**	**0.6**	**0.8%**

Revenue Generating/Cost Reducing Initiatives

- Continued focus on our **throughput / length of stay** initiatives
- Reduction in the **over-utilization** of resources through our Resource Effectiveness Committee and leveraging Cerner applications with provider practices / protocols
- **Charge capture, documentation, and underpayment** focus with Cerner applications and new oversight group (UDC)
- Continued reduction in **overtime, call back** and **unnecessary differential pay hours and practices** through consistent daily and biweekly monitoring by leadership

Revenue Generating/Cost Reducing Initiatives

- Reduction in **contract labor** through focused recruitment and innovative retention & scheduling options
- Reduction of **unnecessary hours** through biweekly efficiency variance reviews with departments using their budgeted unit of service per volume metric
- Improve **supply controls** through the development of applications, inventory management and a more stringent procurement process
- Continued the disciplined focus on **Operation Bottom Line** initiatives and **budget variance** reporting to drive accountability
- Continued expansion of **services and payment / risk models** and reconsideration on those with limited profitability

Comparison of FY 2020 Budget to FY 2019 Projected Actual (000's)

	FY 19 Projected Actual	FY 20 Budget	Variance	% Change
Operating Revenue				
Net Patient Service Revenue	**$562,240**	**$609,205**	**$46,965**	**8.4%**
Supplemental Gov't Programs	75,818	51,830	(23,988)	(31.6%)
Prime Program	17,093	10,862	(6,231)	(36.5%)
Premium Revenue	40,923	47,558	6,635	16.2%
Management Services Revenue	31,585	32,321	736	2.3%
Other Revenue	22,816	20,779	(2,037)	(8.9%)
Other Operating Revenue	188,235	163,350	(24,885)	(13.2%)
Total Operating Revenue	**750,475**	**772,555**	**22,080**	**2.9%**
Operating Expenses				
Salaries and Wages	287,045	304,523	17,478	6.1%
Contract Labor	15,914	3,781	(12,133)	(76.2%)
Employee Benefits	71,759	72,690	931	1.3%
Total Employment Expenses	**374,718**	**380,994**	**6,276**	**1.7%**
Medical and Other Supplies	114,151	111,269	(2,882)	(2.5%)
Physician Fees	85,136	94,805	9,669	11.4%
Purchased Services	39,047	36,787	(2,260)	(5.8%)
Repairs and Maintenance	26,811	26,828	17	0.1%
Utilities	5,945	5,981	36	0.6%
Rents and Leases	6,269	6,373	104	1.7%
Depreciation and Amortization	30,824	33,122	2,298	7.5%
Interest Expense	5,455	6,285	830	15.2%
Other Expenses	16,020	20,843	4,823	30.1%
Management Services Expenses	31,081	31,807	726	2.3%
Total Operating Expenses	**735,457**	**755,094**	**19,637**	**2.7%**
Operating Margin	**$15,018**	**$17,461**	**$2,443**	**16.3%**
Nonoperating Revenue	8,228	6,648	(1,580)	(19.2%)
Excess Margin	**$23,246**	**$24,109**	**$863**	**3.7%**

Operating Margin %	**2.0%**	**2.3%**
Excess Margin %	**3.1%**	**3.1%**

Reimbursement – Net Patient Revenue (000's)

	FY 19 Projected Actual	FY 20 Budget	Variance	% Change
Net Patient Service Revenue (000's)	$562,240	$609,205	**46,965**	8.4%
Patient Volume/Service Increase			$23,005	
Commercial Insurance Rate Increase			$4,222	
Legacy AR			$4,106	
Medicare rate increases			$3,243	
Reduction in Underpayments			$3,000	
Clinical Documentation Improvement			$2,740	
Medi-Cal Managed Care rate increases			$1,912	
Increase reimbursement for new residents			$981	
All other (including payer and service mix)			$3,756	
			$46,965	

Comparison of FY 2020 Budget to FY 2019 Projected Actual (000's)

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Operating Revenue				
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Supplemental Gov't Programs	75,818	51,830	(23,988)	(31.6%)
Prime Program	17,093	10,862	(6,231)	(36.5%)
Premium Revenue	40,923	47,558	6,635	16.2%
Management Services Revenue	31,585	32,321	736	2.3%
Other Revenue	22,816	20,779	(2,037)	(8.9%)
Other Operating Revenue	188,235	163,350	(24,885)	(13.2%)
Total Operating Revenue	**750,475**	**772,555**	**22,080**	**2.9%**
Operating Expenses				
Salaries and Wages	287,045	304,523	17,478	6.1%
Contract Labor	15,914	3,781	(12,133)	(76.2%)
Employee Benefits	71,759	72,690	931	1.3%
Total Employment Expenses	**374,718**	**380,994**	**6,276**	**1.7%**
Medical and Other Supplies	114,151	111,269	(2,882)	(2.5%)
Physician Fees	85,136	94,805	9,669	11.4%
Purchased Services	39,047	36,787	(2,260)	(5.8%)
Repairs and Maintenance	26,811	26,828	17	0.1%
Utilities	5,945	5,981	36	0.6%
Rents and Leases	6,269	6,373	104	1.7%
Depreciation and Amortization	30,824	33,122	2,298	7.5%
Interest Expense	5,455	6,285	830	15.2%
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Management Services Expenses	31,081	31,807	726	2.3%
Total Operating Expenses	**735,457**	**755,094**	**19,637**	**2.7%**
Operating Margin	**$15,018**	**$17,461**	**$2,443**	**16.3%**
Nonoperating Revenue	8,228	6,648	(1,580)	(19.2%)
Excess Margin	**$23,246**	**$24,109**	**$863**	**3.7%**

Operating Margin %	**2.0%**	**2.3%**
Excess Margin %	**3.1%**	**3.1%**

Other Operating Revenue (000's)

	FY 19 Projected Actual	FY 20 Budget	Variance	% Change
Other Operating Revenue	$188,235	$163,350	**($24,885)**	(13.2%)

Prior Period Supplemental Funds recorded in FY19	($23,988)	Supplemental
Prime Grant Payments	($6,231)	Prime
Humana MA and Health Homes – Volume and rate	$6,635	Premium Rev.
SRCC - MO Management Revenue – Volume	$736	Mgmt Rev.
Decrease in Quail Park due to refinancing in FY19	($3,185)	Investments
Sequoia Surgery – impact of investor change	$375	Investments
Increase in Foundation Contributions	$263	Other
Retail Pharmacy and Pharmacy O/P Care Coordination	$454	Other
Other	$56	
	($24,885)	

Comparison of FY 2020 Budget to FY 2019 Projected Actual (000's)

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Operating Revenue				
Net Patient Service Revenue	**$562,240**	**$609,205**	**$46,965**	**8.4%**
Supplemental Gov't Programs	75,818	51,830	(23,988)	(31.6%)
Prime Program	17,093	10,862	(6,231)	(36.5%)
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Other Operating Revenue	188,235	163,350	(24,885)	(13.2%)
Total Operating Revenue	**750,475**	**772,555**	**22,080**	**2.9%**
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Salaries and Wages	287,045	304,523	17,478	6.1%
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Physician Fees	85,136	94,805	9,669	11.4%
Purchased Services	39,047	36,787	(2,260)	(5.8%)
Repairs and Maintenance	26,811	26,828	17	0.1%
Utilities	5,945	5,981	36	0.6%
Rents and Leases	6,269	6,373	104	1.7%
Depreciation and Amortization	30,824	33,122	2,298	7.5%
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Total Operating Expenses	**735,457**	**755,094**	**19,637**	**2.7%**
Operating Margin	**$15,018**	**$17,461**	**$2,443**	**16.3%**
Nonoperating Revenue	8,228	6,648	(1,580)	(19.2%)
Excess Margin	**$23,246**	**$24,109**	**$863**	**3.7%**

Operating Margin %	**2.0%**	**2.3%**
Excess Margin %	**3.1%**	**3.1%**

Personnel Expenses

	FY 19 Projected Actual	FY 20 Budget	Variance	% Change
Total Personnel Expense	$374,718	$380,994	**$6,276**	**1.70%**
Market and Minimum Wage Adjustments			$7,586	
Pay for Performance Annual Reviews (2.45%)			$6,969	
Patient Volume			$5,574	
New Positions			$5,304	
Employee Benefits Increase			$932	
Other			$165	
Overtime Decrease			($990)	
Impact Throughput and Efficiencies			($7,131)	
Contract Labor Decrease			($12,133)	
			$6,276	

Comparison of FY 2020 Budget to FY 2019 Projected Actual (000's)

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Supplemental Gov't Programs	75,818	51,830	(23,988)	(31.6%)
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Other Revenue	22,816	20,779	(2,037)	(8.9%)
Other Operating Revenue	188,235	163,350	(24,885)	(13.2%)
Total Operating Revenue	**750,475**	**772,555**	**22,080**	**2.9%**
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Contract Labor	15,914	3,781	(12,133)	(76.2%)
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Physician Fees	85,136	94,805	9,669	11.4%
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Repairs and Maintenance	26,811	26,828	17	0.1%
Utilities	5,945	5,981	36	0.6%
Rents and Leases	6,269	6,373	104	1.7%
Depreciation and Amortization	30,824	33,122	2,298	7.5%
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Operating Margin	**$15,018**	**$17,461**	**$2,443**	**16.3%**
Nonoperating Revenue	8,228	6,648	(1,580)	(19.2%)
Excess Margin	**$23,246**	**$24,109**	**$863**	**3.7%**

Operating Margin %	**2.0%**	**2.3%**
Excess Margin %	**3.1%**	**3.1%**

Other Operating Expense

	FY 19 Projected Actual	FY 20 Budget	Variance	% Change
Total Other Operating Expense	$360,739	$374,100	**$13,361**	3.7%
Physician Fee Increase			$9,669	
Depreciation Increase			$2,298	
Professional Liability Insurance			$2,006	
Humana MA Cost of Claims			$1,661	
Recruiting			$1,089	
Interest Expense Increase			$830	
Pharmaceuticals Increase			$810	
Management fees			$726	
Education and Travel			$507	
Collection Fees			$458	
Decrease in Purchase Services - Coding			($1,953)	
Decrease in Purchase Service - ISS			($2,279)	
Initiatives to Reduce LOS, Supply Consumption and Pricing			($2,461)	
			$13,361	

Physician Fee Expense

	FY 19 Projected Actual	FY 20 Budget	Variance	% Change
Total Physician Fee Expense	$85,136	$94,805	**$9,669**	11.4%
Kaweah Delta Medical Foundation			$3,712	
Kaweah Delta Hospitalist programs			$1,506	
Anesthesia Group			$1,006	
Kaweah Delta Sequoia Cardiology Center			$950	
Cardiac Services			$858	
GME Faculty			$721	
OB Laborist program			$645	
Kaweah Delta Rural Health Clinics			$358	
All other			($87)	
			$9,669	

2019-2020 Capital Budget

Projects and Infrastructure	$11,450,312
ISS Capital	$1,390,126
Patient Monitoring Equipment	$1,787,973
Available for all other Capital Requests	$1,371,589
Recurring Capital	**$16,000,000**
Enterprise Capital	$820,000
General Contingency Capital	$340,000
FY 2020 Capital Budget	**$17,160,000**

2019-2020 Surplus Cash Flows (000's)

Excess Margin	**$24,109**
<u>Additional Sources (Uses) of Cash:</u>	
Capital Expenditures:	
Annual Recurring	($16,000)
Enterprise Capital	($820)
General Capital Contingency Fund	($340)
Depreciation/Amortization (Non-Cash)	$33,122
Capitalized Interest Payments	($1,202)
Capitalized Employment Expense	($1,397)
Additional DB Plan Funding	($5,215)
Debt Service Payments (Principal)	($7,593)
Total Additional Net Sources (Uses) of Cash	**$555**
Projected Surplus Cash Flow (Deficit)	**$24,664**

General Fund Cash Reserves (000's)

District without Kaweah Delta Hospital Foundation:

Projected Balance at July 1, 2019	$279,648
Cash Flow from 2019-2020 Operations	24,664
Balance at June 30, 2020	$304,312

Credit Highlights (000's)

Consolidated District:

Ratio/Statistic	Moody's A (1)	2017	2018	2019	2020
Operating Income	$23,139	$15,521	$23,647	$15,018	$17,461
Net Income	$56,012	$17,588	$25,962	$23,246	$24,109
Unrestricted Cash	$659,022	$281,003	$285,242	$297,166	$321,830
Operating Margin	2.3%	2.4%	3.3%	2.0%	2.3%
Excess Margin	5.2%	2.7%	3.6%	3.1%	3.1%
Operating Cash Flow Margin	8.6%	6.8%	7.6%	6.8%	7.4%
Debt Service Coverage x	4.7	2.9	3.6	3.7	4.0
Days Cash on Hand	**226.5**	**169.3**	**157.0**	**153.1**	**162.7**

(1) Represents 2017 median ratios for all non-profit hospitals rated "A" by Moody's Investor Services (hospitals rated A1, A2 or A3).

Kaweah Delta Health Care District
2019-2020 Budget

Questions?

Additional Supporting Information

Annual Budget 2019-2020 – Operating Revenues

	2018-2019 Budget	2018-2019 Projected	2019-2020 Budget
Net Patient Service Revenue			
Medicare	$239,809,000	$247,938,000	**$265,837,000**
Medi-Cal	177,363,000	130,617,000	**140,088,000**
Other	187,672,000	183,685,000	**203,280,000**
	604,844,000	562,240,000	**609,205,000**
Supplemental Funds	43,300,000	75,818,000	**51,830,000**
Other operating revenue			
NonPatient Food Sales	2,873,000	3,274,000	**3,371,000**
Lifestyle Center	3,663,000	3,614,000	**3,761,000**
Kaweah Kids Center	892,000	917,000	**939,000**
Employee Assistance Care Network	163,000	163,000	**0**
County Taxes	1,309,000	1,319,000	**1,319,000**
Management Services	29,268,000	31,585,000	**32,321,000**
Premium Revenue	35,931,000	40,923,000	**47,558,000**
Prime Projects Revenue	11,964,000	17,093,000	**10,862,000**
Other	9,517,000	13,529,000	**11,389,000**
	95,580,000	112,417,000	**111,520,000**
Net Operating Revenue	$743,724,000	$750,475,000	**$772,555,000**

Annual Budget 2019-2020 – Operating Expenses

	2018-2019 Budget	2018-2019 Projected	2019-2020 Budget
Payroll:			
Directors/Managers/Supervisors	$31,127,000	$32,329,000	**$33,059,000**
Technical/Instructors	83,906,000	81,462,000	**85,180,000**
RN	93,671,000	94,363,000	**103,893,000**
LVN	5,833,000	5,138,000	**4,664,000**
Aide/Orderly	22,703,000	23,203,000	**23,433,000**
Clerical	24,368,000	25,053,000	**26,437,000**
Environmental	12,057,000	12,389,000	**13,426,000**
Other	13,157,000	13,108,000	**14,431,000**
	286,822,000	287,045,000	**304,523,000**
Travelers and Contracted Staffing:			
Therapist Fees	577,000	2,885,000	**561,000**
Nurse Registry	2,449,000	11,176,000	**2,330,000**
Contract Staff	687,000	1,853,000	**890,000**
	3,713,000	15,914,000	**3,781,000**
Employee benefits:			
Social Security	20,134,000	20,711,000	**21,972,000**
State Unemployment Insurance	338,000	400,000	**424,000**
Medical, Dental and Vision	27,376,000	29,455,000	**27,681,000**
Life Insurance	213,000	380,000	**286,000**
Workers' Compensation	5,337,000	3,921,000	**5,677,000**
Employee Retirement Plans	17,029,000	15,260,000	**14,961,000**
Accrued Vacation	1,785,000	892,000	**946,000**
Tuition/Scholarships	400,000	598,000	**600,000**
Other Benefits	143,000	142,000	**143,000**
	72,755,000	71,759,000	**72,690,000**
Total Payroll and Benefits	$363,290,000	$374,718,000	**$380,994,000**

Annual Budget 2019-2020 – Operating Expenses

	2018-2019 Budget	2018-2019 Projected	2019-2020 Budget
Other Direct Expenses:			
Physician Fees	$82,306,000	$85,136,000	**$94,805,000**
Consulting Fees	2,478,000	2,133,000	**2,266,000**
Legal Fees	1,242,000	1,473,000	**1,338,000**
Audit Fees	171,000	168,000	**150,000**
Other Professional Fees	168,000	93,000	**172,000**
Prosthesis	22,938,000	20,731,000	**19,800,000**
Medical/Surgical Supplies	37,888,000	41,360,000	**38,494,000**
Oxygen	502,000	659,000	**625,000**
IV Solutions	739,000	831,000	**845,000**
Pharmaceutical Supplies	32,243,000	32,401,000	**33,211,000**
Radioactive Material	980,000	769,000	**943,000**
Radiology Film	3,000	2,000	**1,000**
Cost of Goods Sold	6,485,000	6,020,000	**6,104,000**
Food	2,523,000	2,725,000	**2,685,000**
Linen	291,000	266,000	**267,000**
Maintenance Supplies	1,515,000	1,520,000	**1,499,000**
Office Supplies	2,031,000	1,947,000	**1,805,000**
Uniforms	99,000	108,000	**116,000**
Minor Medical Equipment	811,000	830,000	**896,000**
Other Minor Equipment	3,791,000	3,886,000	**3,870,000**
Books	140,000	96,000	**108,000**
Medical Purchased Services	22,924,000	23,732,000	**25,324,000**
Repairs and Maintenance	25,517,000	26,811,000	**26,828,000**
Collection Services	1,792,000	1,100,000	**1,558,000**

Annual Budget 2019-2020 – Operating Expenses

	2018-2019 Budget	2018-2019 Projected	2019-2020 Budget
Other Direct Expenses (continued):			
Other Purchased Services	$10,885,000	$14,215,000	**$9,905,000**
Amortization	1,764,000	1,120,000	**1,044,000**
Depreciation – Building	5,987,000	6,057,000	**6,061,000**
Depreciation - Leasehold Improvements	106,000	352,000	**367,000**
Depreciation - Equipment/Building Impr	25,951,000	23,295,000	**25,650,000**
Rent	6,511,000	6,269,000	**6,373,000**
Electricity	3,094,000	3,191,000	**3,220,000**
Gas	2,034,000	2,032,000	**2,041,000**
Water and Sewer	747,000	722,000	**720,000**
Professional Liability Insurance	2,116,000	309,000	**2,315,000**
Other Insurance	752,000	827,000	**909,000**
Licenses and Taxes	905,000	928,000	**1,017,000**
Telephone	1,563,000	1,592,000	**1,710,000**
Dues and Subscriptions	1,225,000	1,209,000	**1,331,000**
Education	1,219,000	671,000	**972,000**
Travel	1,508,000	1,032,000	**1,238,000**
Recruiting	1,738,000	1,711,000	**2,800,000**
Other Direct Expenses	6,306,000	3,874,000	**4,625,000**
Interest	6,007,000	5,455,000	**6,285,000**
Management Services	28,740,000	31,081,000	**31,807,000**
	358,735,000	360,739,000	**374,100,000**
Total Operating Expenses	$722,025,000	$735,457,000	**$755,094,000**

Annual Budget 2019-2020

	2018-2019 Budget	2018-2019 Projected	2019-2020 Budget
Operating Margin	$21,699,000	$15,018,000	**$17,461,000**
Investment Income	5,153,000	8,228,000	**6,648,000**
Excess Margin	26,852,000	23,246,000	**24,109,000**
Additional Sources (Uses) of Cash			
Capital Expenditures			
Annual Recurring	(16,000,000)	(16,000,000)	**(16,000,000)**
Enterprise Capital	(820,000)	(820,000)	**(820,000)**
General Capital Contingency Fund	(340,000)	(340,000)	**(340,000)**
Debt Service Payments	(7,602,000)	(7,334,000)	**(7,593,000)**
Capitalized Interest Payments	(1,796,000)	(2,336,000)	**(1,202,000)**
Capitalized Employment Expenses	(1,393,000)	(1,186,000)	**(1,397,000)**
Unfunded DB Plan Amortization	(3,307,000)	(4,818,000)	**(5,215,000)**
Non-Cash Expenses			
Amortization	1,764,000	1,120,000	**1,044,000**
Depreciation	32,044,000	29,704,000	**32,078,000**
Increase in Total Surplus Funds	$29,402,000	$21,236,000	**$24,664,000**
Operating Margin	2.9%	2.0%	**2.3%**
Excess Margin	3.6%	3.1%	**3.1%**
Operating Cash Flow Margin	8.3%	6.8%	**7.4%**
Deductions from Revenue Percentage	72.5%	75.3%	**74.3%**
Compensation Ratio	40.7%	42.1%	**41.6%**
Maximum Annual Debt Service Coverage Ratio	4.24x	3.66x	**4.04x**
Supplies as percent of Net Operating Revenue	15.8%	15.9%	**15.0%**

Five-Year Comparative Analysis

	2016	2017	2018	Projected 2019	**Budget 2020**
Total FTEs					
Total	3,785	3,983	4,131	4,342	**4,294**
Net of Excluded Services *	3,513	3,731	3,895	4,108	**4,046**
**FTEs per adjusted occupied bed ** **					
Total	4.86	4.93	4.94	5.15	**4.97**
Net of Excluded Services *	4.71	4.79	4.80	5.03	**4.81**
Average Hourly Wage	$29.47	$29.75	$31.22	$32.82	**$34.43**
Adjusted Patient Days	285,080	294,889	305,158	307,502	**316,397**
Adjusted Discharges	53,806	58,063	59,963	60,776	**62,878**
Total Operating Expenses (Millions)	$581.12	$629.73	$688.62	$735.46	**$755.09**
**Expense per Adjusted Patient Day ** **	$2,038	$2,135	$2,257	$2,392	**$2,387**
Increase (decrease) from prior year:					
Dollars	$165	$97	$122	$257	**($5)**
Percent	8.8%	4.8%	5.7%	12.0%	**(0.2%)**

* Excluded services: Home Health, Private Homecare, Chronic Dialysis, Lifestyle Center and Kaweah Kids Center.

** Incorporates outpatient activity

Five-Year Comparative Analysis

	2016	2017	2018	Projected 2019	**Budget 2020**
Expense per adjusted discharge **	$10,800	$10,846	$11,484	$12,101	**$12,009**
Increase (decrease) from prior year:					
Dollars	$934	$46	$638	$1,255	**($92)**
Percent	9.5%	0.4%	5.9%	11.6%	**(0.8%)**
Inpatient/outpatient revenue mix					
Inpatient	53.6%	51.9%	52.7%	52.7%	**51.8%**
Outpatient	46.4%	48.1%	47.3%	47.3%	**48.2%**
	100.0%	100.0%	100.0%	100.0%	**100.0%**
Financial classification of revenue					
Medicare	43.6%	43.6%	42.3%	43.8%	**44.0%**
Medi-Cal	30.7%	30.7%	31.7%	30.7%	**30.3%**
Other	25.7%	25.7%	26.0%	25.5%	**25.7%**
	100.0%	100.0%	100.0%	100.0%	**100.0%**

* Excluded services: Home Health, Private Hospice, Chronic Dialysis, Lifestyle Center and Kaweah Kids Center.

** Incorporates outpatient activity

Capital Budget

	2019-2020	2020-2021	2021-2022
Projects and Infrastructure			
PET CT machine	$ 1,920,000		
Cardiac Cath Room # 4 Upgrade	1,365,115		
Chemistry Line and Total Lab Auto conf. Siemens	1,272,025		
BD Pumps - 8015 Model Only (PC/General/Brain)	860,000		
Laboratory Remodel	820,000		
Linet Beds ICU	522,339		
Cath Lab 4 Equipment	500,000		
Building Automation system replacement KDMC campus (Phase 3)	400,000		
Steris Washer, Etc.	399,302		
Alscripts	360,000		
Dialysis machines	260,000		
KDMF SAN	254,641		
USP 800 Pharmacy remodel (supplement)	225,000		
BD Pumps - BD Syringe Pump (Replaces 3500 and InfusOR)	164,409		
Stryker Surgical Display (Payment 3 of 3)	158,415		
Sterrad Cool Sterilizer	140,459		
CVOR 7, 8, & 9 Surgery Lights	140,000	50,000	50,000
Kaweah Care District Refurbish	138,000	200,000	200,000
Washer	134,195		
South Campus Radiology Rms 2 & 5 Equipment	130,000		

Capital Budget

	2019-2020	2020-2021	2021-2022
Projects and Infrastructure			
MKW N/S core HVAC replacement (3 nursing units)	120,000		
MK Radiology Rms 2 & D Equipment	120,000		
Stryker Lights	111,647	111,647	111,647
KDMH Flooring	110,000		
PET CT Construction	100,000		
KDRH Refurbish Phase 6	100,000		
Stryker Lights	72,247		
KDMH Exterior Paint	70,000		
Keckler Work Sink	63,760		
Build Out of Sterile Processing Room (Plumbing)	57,319		
Steelco Instrument Washer	53,397		
Dryer	41,847		
Elevator Door edge safety upgrade (Elevators 1,2,3,6,7,8 & 9)	40,000		
Misc Moves/Furnishings	36,000	100,000	100,000
SRCC Fire alarm panel replacement add funds	30,000		
Telephone Upgrade/Migrate NEC SV9300	29,928		
Loading Dock Chain-Link Enclosure	25,000		
205 west mini-gym remodel (MSC basement)	22,000		
Small Projects Contingency	17,000	100,000	100,000
Double Bowl Work Sink	15,997		
Loading Dock Door	15,000		
StoreEver MSL LTO-8 Ultrium 30750 Tape Library	13,037		
R640 w/8 x 1.8TB Drives Backup Server	10,150		
Stainless Steel Prep and Pack Table	6,083		

Capital Budget

	2019-2020	2020-2021	2021-2022
Projects and Infrastructure			
KDRH Physician Therapy Doors	6,000		
BD Pumps - 8100 Model Only (LVP/Soldier/Pump)		1,415,780	
Building Automation system replacement KDRH Rehab Hospital		1,100,000	
MK Nurse Call Upgrades		500,000	500,000
Facilities Renovation		500,000	500,000
Nihon Kohden Monitor (Year 3 of 4) (ED Zone 5)		397,433	
GE Cardiac CTA Acquisition		255,013	
Hospital Duct cleaning (ongoing)		200,000	200,000
Linet Beds Stepdown CVICU		148,604	
West Elevator Remodel and Repair		132,046	
Nihon Kohden Monitor (Year 4 of 4) (Endoscopy)		85,124	
Air pressure relationship testing semiannually (policy EOC1046)		50,000	50,000
Paracentisis Pump		21,700	
Central Men’s Restroom ADA Remodel		8,000	
Key Machine		6,500	
Building Automation system replacement South Campus and TLC			635,000
BD Pumps - 8110, 8120 and 8300 Model Only (Syringe & PCA & EtCO2)			223,846
Total Projects and Infrastructure	$ 11,450,312	$ 5,381,847	$ 2,670,493

Capital Budget

	2019-2020	2020-2021	2021-2022
Information Systems			
Smart Pump Implementation	$ 503,030		
Hardware/Software Additions, Replacements, Upgrades	250,000	$ 250,000	$ 250,000
Network Equipment (P)	238,500	192,000	156,000
SAN Storage (P)	208,000	250,000	300,000
Server Infastructure (P)	77,500	425,000	450,000
Legacy HR/Payroll Archiving	38,000		
ePrescribe Script Enhancement	30,500		
Pre hospital Care Report	24,400		
NiceLabel (NEPS) Replacement	20,196		
PowerChart Cardiology Implementation		1,116,519	
ERP Replatform		1,000,000	
Capacity Management Implementation		566,497	
Ambulatory EMR Downtime Implementation		425,000	
Network Wiring (P)		350,000	350,000
Legacy EMR Archiving		250,000	250,000
New Intranet Website		250,000	
Summetra UPS Refresh		47,271	
PACS Upgrade		47,000	
Microsoft Licensing		18,000	
Time & Attendance System Upgrade			50,000
Total Information Systems	$ 1,390,126	$ 5,187,287	$ 1,806,000
Patient Monitoring - Nihon Kohden	$ 1,787,973	$ 863,328	
	$ 14,628,411	$ 11,432,462	$ 4,476,493
Management Discretionary	$ 1,371,589		
TOTAL CAPITAL EXPENDITURES	$ 16,000,000	$ 11,432,462	$ 4,476,493

395/401

KAWEAH DELTA HEALTH CARE DISTRICT

CEP AMERICA-CALIFORNIA
AGREEMENT REGARDING EXTENSION OF AGREEMENTS

This Agreement Regarding Extension of Agreements is entered into as of the 1st day of July, 2019 (the "**Effective Date**"), by and between **KAWEAH DELTA HEALTH CARE DISTRICT** ("**KDHCD**" or the "**District**"), a local health care district organized and operating pursuant to California Health & Safety Code Sections 32000 et seq., and **CEP AMERICA-CALIFORNIA (formerly CALIFORNIA EMERGENCY PHYSICIANS MEDICAL GROUP),** a California general partnership d/b/a Vituity ("**CEP**").

BACKGROUND

The District and CEP are party to the following agreements (collectively, as amended to date, the "**Agreements**"):

(2) Designated Institutional Officer Agreement, dated as of October 1, 2014, as amended by the First Addendum to Designated Institutional Officer Agreement, dated as of October 1, 2016 (the "**DIO Agreement**");

(3) Program Director Agreement – Emergency Medicine Residency Program, dated as of November 1, 2012 (the "**Program Director Agreement**");

(4) Associate Program Director Agreement (Emergency Medicine Residency Program), dated as of November 1, 2016 (the "**APD Agreement**");

(5) Core Faculty Agreement – Emergency Medicine Residency Program, dated as of November 1, 2016, as amended by the First Addendum to the Core Faculty Agreement, dated as of November 1, 2017 (the "**Core Faculty Agreement**"); and

(6) Transitional Year Program Director Agreement, dated as October 1, 2014, as amended by the First Addendum to Transitional Year Program Director Agreement, dated as of October 1, 2016, (the "**Transitional Year Program Director Agreement**").

The parties wish to extend the Agreements and to amend certain terms of the Agreements, and therefore agree as follows:

AGREEMENT

Section 1. **Extension.** Each of the Agreements is hereby extended on its current terms through June 30, 2022.

Section 2. **Amendments to Terms Addressing Compensation and Hours.**

2.1. Section 5.1.1 of the DIO Agreement is hereby deleted in its entirety and replaced with the following:

Subject to Section 5.1.4, District shall pay Medical Group the annual sum of **three hundred nine thousand six hundred dollars ($309,600.00)** for the Services rendered by the DIO under this Agreement. Compensation shall paid in equal monthly installments of **$25,800.00.**

Compensation for the DIO's performance in accordance with this Agreement is based on the DIO spending not more than **120 hours** per month providing the Services.

2.2. Section 5.1.1 of the Program Director Agreement is hereby deleted in its entirety and replaced with the following:

Subject to Section 5.1.2, District shall pay Medical Group the sum of **two hundred forty one thousand two hundred dollars ($241,200.00)** per year for the Services rendered by Director during the term of this Agreement. Compensation for Director's performance in accordance with the Agreement is based on Director spending average of 100 hours per month (or 1200 hours per year) providing the Services, and the rate of **two hundred one dollars ($201.00)** per hour. Payments made under this paragraph shall be made in equal monthly installments of **twenty thousand one hundred dollars ($20,100.00).** From time to time, the parties shall review any material shortfall (i.e., more than 10% variance, excluding vacations and other scheduled absences) and mutually agree on an amendment to this Agreement that parties agree more accurately reflects the level of effort required of Director.

2.3. Section 5.1.1 of the APD Agreement is hereby deleted in its entirety and replaced with the following:

District shall pay medical group the sum of **two hundred one dollars ($201.00)** per hour for Services rendered during the term of this Agreement. Compensation for the Services shall be limited to **two hundred eighty thousand four hundred forty dollars ($289,440.00)** per year. Payments made under this paragraph shall be made in equal monthly installments of **twenty four thousand one hundred twenty dollars ($24,120.00)**. From time to time, the parties shall review any material shortfall (i.e., more than 10% variance, excluding vacations and other scheduled absences) and mutually agree on an amendment to this Agreement that parties agree more accurately reflects the level of effort required of Director.

2.4. Section 5.1.1 of the Core Faculty Agreement is hereby deleted in its entirety and replaced with the following:

Subject to Section 5.1.2, District shall pay Medical Group the sum of **two hundred one dollars ($201.00)** per hour for the Services rendered by each Core Faculty Member during the term of this Agreement. Compensation for each Core Faculty Member's performance in accordance with this Agreement is based on the applicable Core Faculty Member spending the hours per year for his/her position as set forth in **Exhibits A-1 to A-6**. From time to time, the parties shall review any material shortfall (i.e., more than 10% variance, excluding vacations and other scheduled absences) and mutually agree on an amendment to this Agreement that more accurately reflects the level of effort required of the applicable Core Faculty Member.

2.5. Paragraph 1.2 of Exhibit A-3 to the Core Faculty Agreement is hereby deleted in its entirety and replaced with the following:

The Medical Student Clerkship Director shall devote up to **nine hundred sixty (960)** hours per year (or up to an average of **eighty (80)** hours per month) providing Program Services under this Agreement. Payments are subject to the prior receipt of complete, accurate, and contemporaneous time records as specified in Section 4.2.1 of the Agreement for all time spent in providing services under this **Exhibit A-3**

2.6. Paragraph 1.2 of Exhibit A-4 to the Core Faculty Agreement is hereby deleted in its entirety and replaced with the following:

> The Simulation Laboratory Director shall devote up to **nine hundred sixty (960)** hours per year (or up to an average of **eighty (80)** hours per month) providing Program Services under this Agreement. Payments are subject to the prior receipt of complete, accurate, and contemporaneous time records as specified in Section 4.2.1 of the Agreement for all time spent in providing services under this **Exhibit A-4**.

2.7. Paragraph 1.2.1 of Exhibit A-5 to the Core Faculty Agreement is hereby deleted in its entirety and replaced with the following:

> The Ultrasound Director shall devote up to **nine hundred sixty (960)** hours per year (or up to an average of **eighty (80)** hours per month) providing Program Services under this Agreement.

2.8. Section 5.1.1 of the Transitional Year Program Director Agreement is hereby deleted in its entirety and replaced with the following:

> The Director shall devote up to **nine hundred sixty (960) hours per year** (or up to an average of **eighty (80) hours per month**) providing Program Services under this Agreement. Payments made under this Section shall be made in equal monthly installments of sixteen thousand eighty dollars ($16,080.00). From time to time, the parties shall review any material shortfall (i.e., more than 10% variance, excluding vacations and other scheduled absences) and mutually agree on an amendment to this Agreement that parties agree more accurately reflects the level of effort required of Director.

2.9. Each of the hourly rates set forth in in this Section 2, as well as any monthly or annual limits on payments, shall be increased by two percent (2%) on each annual anniversary of the effective date of this Agreement Regarding Extension of Agreements.

Section 3. Additional Amendments to Core Faculty Agreement.

3.1. The Core Faculty Agreement is amended to remove Exhibit A-2 in its entirety.

3.2. Paragraph 1.1 of **Exhibit A** to the Core Faculty Agreement is amended to insert the following sentence at the end of the paragraph:

> CEP shall ensure that there is a sufficient number of Core Faculty Members for the Program to satisfy ACGME program guidelines.

3.3. Section 4.2.1 of the Core Faculty Agreement is deleted in its entirety and replaced with the following:

> **Time Records**. Each Core Faculty Member shall submit complete, accurate and contemporaneous time records documenting all time spent in providing services pursuant to this Agreement. The time records shall be submitted in intervals and on such forms as District may require. The Time Record shall include the date, the length of time and a description of services provided, and demonstrate the satisfaction of the standards set forth in this Agreement, including the standards for Core Faculty Members set forth in **Exhibit A** hereto. The time record is used to account for time spent fulfilling duties specified in this Agreement. Compensation shall be disbursed ***only*** on properly completed records in accordance with the

terms of this Agreement. Each Core Faculty Member shall attest that the hours shown on the time records as "incurred" are actually performed by the Core Faculty Member. Additionally, each Core Faculty Member shall attest that the hours shown on the time records are only for services consistent with those required in this Agreement.

Each Core Faculty Member shall submit complete and accurate Time Records for Services rendered during the previous month to the Chief Medical Officer on *a monthly basis* by the third (3rd) day of each month. No payment shall be made to Medical Group for a Core Faculty Member's services until and unless the Core Faculty Member's monthly time report has been submitted in the manner required by this Section 4.2.1, and in no event if the monthly time report has not been submitted within sixty (60) days of the services rendered.

Section 4. **Additional Amendments to APD Agreement**.

4.1. The recitals to the APD Agreement are amended to strike the final sentence of the fourth paragraph and to insert the following in its place:

> As of the Effective Date of the Agreement Regarding Extension of Agreements, Dr. Sean H. Oldroyd and Dr. Madeleine A. Alexeeva are hereby appointed as joint Associate Program Directors ("**Directors**").

4.2. All references in the APD Agreement to a "Director" shall be replaced with references to both "Directors."

Section 5. **Compensation and Performance Measures.** Any compensation payable under any of the Agreements on a basis other than monthly shall be pro-rated for the period of the extension. If an Agreement contains performance standards for incentive compensation, and the end of this extension does not coincide with the end of a period for measuring performance under the Agreement, the performance standards will be separately measured over the period of this extension that extends beyond the end of the performance measuring period.

Section 6. **Tax Position.**

6.1. The DIO Agreement is amended to insert the following as a new Section 4.9:

> Medical Group and DIO agree that Medical Group and DIO are not entitled to and will not take any tax position that is inconsistent with being a service provider to the District. For example, Medical Group shall not claim any depreciation or amortization deduction, investment tax credit, or deduction for any payment as rent with respect to the District.

6.2. The Program Director Agreement is amended to insert the following as a new Section 4.9:

> Medical Group and Director agree that Medical Group and Director are not entitled to and will not take any tax position that is inconsistent with being a service provider to the District. For example, Medical Group shall not claim any depreciation or amortization deduction, investment tax credit, or deduction for any payment as rent with respect to the District.

6.3. The APD Agreement is amended to insert the following as a new Section 4.9:

Medical Group and Directors agree that Medical Group and each Director are not entitled to and will not take any tax position that is inconsistent with being a service provider to the District. For example, Medical Group shall not claim any depreciation or amortization deduction, investment tax credit, or deduction for any payment as rent with respect to the District.

6.4. The Transitional Year Program Director Agreement is amended to insert the following as a new Section 4.9:

Medical Group and Transitional Year Program Director agree that Medical Group and Transitional Year Program Director are not entitled to and will not take any tax position that is inconsistent with being a service provider to the District. For example, Medical Group shall not claim any depreciation or amortization deduction, investment tax credit, or deduction for any payment as rent with respect to the District.

6.5. The Core Faculty Agreement is amended to insert the following:

Medical Group and each Core Faculty Member agree that Medical Group and each Core Faculty Member are not entitled to and will not take any tax position that is inconsistent with being a service provider to the District. For example, Medical Group shall not claim any depreciation or amortization deduction, investment tax credit, or deduction for any payment as rent with respect to the District.

Section 7. Approval of Rates.

7.1. The DIO Agreement is amended to insert the following as a new Section 4.10:

The rates charged by Medical Group shall be approved by the District, except for reasonable and customary rates consistent with those negotiated with third-party health plans.

7.2. The Program Director Agreement is amended to insert the following as a new Section 4.10:

The rates charged by Medical Group shall be approved by the District, except for reasonable and customary rates consistent with those negotiated with third-party health plans.

7.3. The APD Agreement is amended to insert the following as a new Section 4.10:

The rates charged by Medical Group shall be approved by the District, except for reasonable and customary rates consistent with those negotiated with third-party health plans.

7.4. The Core Faculty Agreement is amended to insert the following as a new Section 4.10:

The rates charged by Medical Group shall be approved by the District, except for reasonable and customary rates consistent with those negotiated with third-party health plans.

7.5. The Transitional Year Program Director Agreement is amended to insert the following:

The rates charged by Medical Group shall be approved by the District, except for reasonable and customary rates consistent with those negotiated with third-party health plans.

Section 8. **Cross-Referenced Agreements.** According to regulations implementing 42 U.S.C. §1395nn et seq., respecting the prohibition of physician referrals to entities with which those physicians or their family members have financial arrangements, all arrangements shall be cross referenced for audit purposes. In accordance with 42 C.F.R. §411.357(d)(ii), any arrangements between CEP and District, or between any member of CEP and District, are listed in a master list of contracts that is maintained by District and updated centrally, preserves the historical record of contracts and is available for review by the Secretary of Health and Human Services upon request.

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement Regarding Extension of Agreements as of the date first written above. This Agreement shall be binding when all signatories listed below have executed this Agreement.

KAWEAH DELTA HEALTH CARE DISTRICT

By: _____
Gary K. Herbst
Chief Executive Officer

Date: _____

CEP AMERICA-CALIFORNIA

By: _____
David Birdsall, M.D.
Chief Operations Officer

Date: _____