Kaweah Delta
MORE THAN MEDICINE. LIFE.

September 25, 2020

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in the Kaweah Delta Lifestyle Center Conference Room {5105 W. Cypress Avenue, Visalia} on Monday September 28, 2020 beginning at 3:30PM. Due to the maximum capacity allowed in this room per CDC social distancing guidelines {25}, members of the public are requested to attend the Board meeting via GoTo meeting - https://www.gotomeet.me/CindyMoccio/kaweahdeltaopenregularboardmeetings or you can also dial in 669-224-3412 Access Code: 468-246-165.

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

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Board of Directors meeting at 4:00PM pursuant to Government Code 54956.9(d)(2), and Health and Safety Code 1461 and 32155.

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

The Board of Directors of the Kaweah Delta Health Care District will meet in a closed session following the 4:30PM Open Session pursuant to Government Code 54957(b)(1).

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.

Due to COVID 19 visitor restrictions to the Medical Center - the disclosable public records related to agendas can be obtained by contacting the Board Clerk at Kaweah Delta Medical Center – Acequia Wing, Executive Offices (Administration Department) {1st floor}, 400 West Mineral King Avenue, Visalia, CA via phone 559-624-2330 or email: cmoccio@kdhcd.org, or on the Kaweah Delta Health Care District web page http://www.kaweahdelta.org.

KAWEAH DELTA HEALTH CARE DISTRICT
David Francis, 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

The Lifestyle Center – Conference Rooms
5105 W. Cypress Avenue, Visalia, CA 93277

Due to the maximum capacity (25) allowed in this room per CDC social distancing guidelines - members of the public are requested to attend via GoTo meeting

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

Monday September 28, 2020

OPEN MEETING AGENDA {3:30PM}

1. **CALL TO ORDER**
2. **APPROVAL OF AGENDA**
3. **PUBLIC PARTICIPATION –** Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the subject matter jurisdictions of the Board are requested to identify themselves at this time.
4. **PROVIDER NEEDS ASSESSMENT** – Review and discussion of the provider needs assessment for Kaweah Delta Medical Center.

   Marc Mertz, VP & Chief Strategy Officer and Eric Themm, Senior Principal Sg2

5. **APPROVAL OF THE CLOSED AGENDA – 4:00PM**
   - 5.1. **Approval of closed meeting minutes** – August 24, 2020 and September 24, 2020.
   - 5.2. **Conference with Legal Counsel – Anticipated Litigation –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 1 Case **–** *Dennis Lynch, Legal Counsel, Anu Banerjee, VP & Chief Quality Officer*
   - 5.3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee –– *Byron Mendenhall, MD Chief of Staff, Gary Herbst, CEO and Ben Cripps, Chief Compliance Officer*
   - 5.4. **Credentialing** - Medical Executive Committee (MEC) requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the MEC be reviewed for approval pursuant to Health and Safety Code 1461 and 32155 – *Byron Mendenhall, MD Chief of Staff*
   - 5.5. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee –– *Byron Mendenhall, MD Chief of Staff*
6. **ADJOURN**

CLOSED MEETING AGENDA {4:00PM}

1. **CALL TO ORDER**
2. **Approval of closed meeting minutes** – August 24, 2020.

   Recommended Action: Approval of the August 24 closed meeting minutes.
3. **Conference with Legal Counsel – Anticipated Litigation –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 1 Case

   Dennis Lynch, Legal Counsel, Anu Banerjee, VP & Chief Quality Officer
4. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee.

   Byron Mendenhall, MD Chief of Staff, Gary Herbst, CEO and Ben Cripps, Chief Compliance Officer
5. **Credentialing** - Medical Executive Committee (MEC) requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the MEC be reviewed for approval pursuant to Health and Safety Code 1461 and 32155.

   Byron Mendenhall, MD Chief of Staff
6. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee.

   Byron Mendenhall, MD Chief of Staff
7. **ADJOURN**

OPEN MEETING AGENDA {4:30PM}

Join from your computer, tablet or smartphone

https://www.gotomeet.me/CindyMoccio/kdhcd-board-regular-open-board-meetings

or Dial In: 646-749-3122 / Access Code: 144-318-117

1. **CALL TO ORDER**
2. **APPROVAL OF AGENDA**
3. **PUBLIC PARTICIPATION –** Members of the public may comment on agenda items before action is taken and after Board discussion. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the subject matter jurisdictions of the Board are requested to identify themselves at this time.
4. **CLOSED SESSION ACTION TAKEN** – Report on action(s) taken in closed session.
5. **OPEN MINUTES** – Request approval of the August 24, 2020 open meeting minutes.

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

   Action Requested – Approval of the open meeting minutes – August 24 and September 24, 2020 *open board of directors meeting minutes.*

6. RECOGNITIONS – *David Francis*

6.1. Presentation of Resolution 2091 to Susan Sorenson, RN, 3 North Charge Nurse, retiring from Kaweah Delta after 41 years of service.

6.2. Presentation of Resolution 2092 to Martha Cervantes, Certified Nursing Assistant, Service Excellence July 2020.

6.3. Presentation of Resolution 2093 to Melissa Jarrell, Dietary Clerk - Service Excellence August 2020.

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

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

Action Requested – Approval of the September 28, 2020 Consent Calendar.

7.1. REPORTS

A. Physician Recruitment
B. Cardiac Surgery, Cardiology, and Non-Invasive Cardiology
C. Hospice
D. Maternal Child Health
E. Subacute and Transitional Care Services
F. Quail Park (Cypress) and Laurel Court (Reviewed by the Finance, Property, Services, and Acquisition Committee on September 22, 2020)
G. Quail Park at Shannon Ranch (Reviewed by the Finance, Property, Services, and Acquisition Committee on September 22, 2020)
H. Environment of Care

7.2. POLICIES

A. Administrative
   1) AP.35 Computer Software Usage {Revised}
   2) AP.41 – Quality Improvement Plan {Revised}
   3) AP.57 - Access to Legal Counsel {Revised}
   4) AP.122 – Interpreter Services {Revised}
   5) AP.151 – Strategic Planning {Revised}
   6) AP.116 – Public Information Request (Reviewed)

B. Emergency Management
   1) DM 2117 - Staff Support Plan {Reviewed}
   2) DM 2116 - Reporting for Duty/Building Access {Reviewed}
   3) DM 2231 - Radioactive Disaster Procedure {Reviewed}
   4) DM 2115 - Person in Charge (Initial response Coordinator) {Reviewed}
   5) DM 2107 - Media Plan {Reviewed}
   6) DM 2104 - Emergency Impact Assessment {Reviewed}
   7) DM 2112 - Elevator Use During Emergency Situations {Reviewed}
   8) DM 2121 - Critical Incident Stress Management {Reviewed}
   9) DM 2207 - Code Red Activation {Reviewed}

C. Environment of Care

1) EOC 1021 - Monitoring of Temperature and Humidity Levels in Sensitive Areas Procedure/Sterile Rooms {Revised}
2) EOC 4000 - Hazard Material Management Plan {Revised}
3) EOC 1001 - Safety Management Plan {Revised}
4) EOC 7403 - Emergency Generator Testing and Fuel Levels {Revised}
5) EOC 1096 - Electrical Safety Distribution System {Reviewed}
6) EOC 1007 - Safety Officer Job Description {Reviewed}
7) EOC 1040 - Failure of High Pressure Boilers {Reviewed}
8) EOC 1036 - Disruption of Service, Natural Gas {Reviewed}
9) EOC 1043 - Failure or Absence of Nurse Call System While Caring for Patient {Reviewed}
10) EOC 5010 - Fire Prevention Code Compliance {Reviewed}
11) EOC 1034 - Disruption of Services, Electrical {Reviewed}
12) EOC 1045 - Failure of Piped Vacuum Systems and Compressed Air {Reviewed}
13) EOC 1041 - Disruption of Service, Elevator {Reviewed}
14) EOC 3014 - Security Measures Involving VIP(s) {Reviewed}
15) EOC 3007 - Emergency Department Security {Reviewed}
16) EOC 1020 - Indoor Air Quality {Reviewed}
17) EOC 4404 - Formaldehyde Spill {Reviewed}
18) EOC 6012 - Non Healthcare District Equipment Preventative Maintenance and Repair Policy {Reviewed}
19) EOC 1071 - Ergonomics {Reviewed}
20) EOC 8000 - Heat and Illness Prevention Program {Reviewed}
21) EOC 1002 - Environment of Care Communication Flow Chart {Reviewed}
22) EOC 5003 - Fire Watch {Reviewed}
23) EOC 5009 - Material Equipment Purchase {Reviewed}
24) EOC 5021 - Infection Control Risk Assessment {Reviewed}

7.3. BOARD COMMITTEE MINUTES
A. Patient Experience (August 26, 2020)
B. Marketing & Community Relations (September 2, 2020)
C. Quality Council (September 17, 2020)

7.4. Approval of Deferred Compensation Amount for Plan Year July 1, 2020 through June 30, 2021. In accordance with the provisions of Section 4.1 of the Kaweah Health Care District Nonqualified Deferred Compensation Plan for Gary Herbst (the "Plan"), the Board sets the amount of the CEO's compensation to be credited to the Account of the Participant for Plan Year July1, 2020 through June 30, 2021 at One Hundred Thirty-Five Thousand Dollars.

7.5. Approve Resolution 2095 rejecting the claim for Judy Carrasco vs. Kaweah Delta Health Care District.

7.6. Approval of the exclusive professional services agreement entered into effective October 1, 2020 by and between Kaweah Delta Health Care District and Oak Creek Anesthesia Services, Inc., a California professional medical corporation.

7.7. Recommendations from the Medical Executive Committee (September 2020)
A. Privileges in Psychiatric and Addiction Medicine
B. Advanced Practice Provider – Supervising Physician Agreement

8. QUALITY

8.1. Cardiology Quality Report - A review of quality measures and action plans associated with the care of cardiac patients.

Ashok Verma, MD, Medical Director of Cardiac Cath Lab

8.2. Cardiac Surgery Quality Report - A review of key quality indicators and actions related to the care of the cardiac surgery patient population.

Leheb Araim, MD, Medical Director of Cardiac Surgery

9. **STRATEGIC PLAN** – Strategic Growth and Innovation – Review and discussion of the metrics, strategies, and tactics of the strategic initiative; Strategic Growth and Innovation.

Marc Mertz, VP & Chief Strategy Officer

10. **IDEAL WORK ENVIRONMENT** – 2020 pulse survey goal update and next steps.

Dianne Cox, Vice President - Chief Human Resources Officer and Laura Goddard, Director of Organizational Development

11. **CREDENTIALS** - Medical Executive Committee requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the Medical Executive Committee be reviewed for approval.

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

Recommended Action: Whereas a thorough review of all required information and supporting documentation necessary for the consideration of initial applications, reappointments, request for additional privileges, advance from provision al status and release from proctoring and resignations (pursuant to the Medical Staff bylaws) has been completed by the Directors of the clinical services, the Credentials Committee, and the MEC, for all of the medical staff scheduled for reappointment, Whereas the basis for the recommendations now before the Board of Trustees regarding initial applications, reappointments, request for additional privileges, advance from provision al status and release from proctoring and resignations has been predicated upon the required reviews, including all supporting documentation, Be it therefore resolved that the following medical staff be approved or reappointed (as applicable), as attached, to the organized medical staff of Kaweah Delta Health Care District for a two year period unless otherwise specified, with physician-specific privileges granted as recommended by the Chief of Service, the Credentials Committee, and the Executive Committee of the Medical Staff and as will be documented on each medical staff member's letter of initial application approval and reappointment from the Board of Trustees and within their individual credentials files.

12. REPORTS

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

12.2. Chief Executive Officer Report -Report relative to current events and issues.

Gary Herbst, Chief Executive Officer

12.3. Board President - Report relative to current events and issues.

Nevin House, Board President

13. APPROVAL OF CLOSED AGENDA AS FOLLOWS: Closed Meeting Agenda – Kaweah Delta Medical Center Blue Room – Immediately following the open session

- **CEO Evaluation** – Discussion of with the Board and the Chief Executive Officer relative to the evaluation of the Chief Executive Officer pursuant to Government Code 54957(b)(1) – *Dennis Lynch, Legal Counsel & Board of Directors*

14. ADJOURN

CLOSED MEETING AGENDA

1. CALL TO ORDER

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

Dennis Lynch, Legal Counsel & Board of Directors

3. 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
MORE THAN MEDICINE. LIFE.

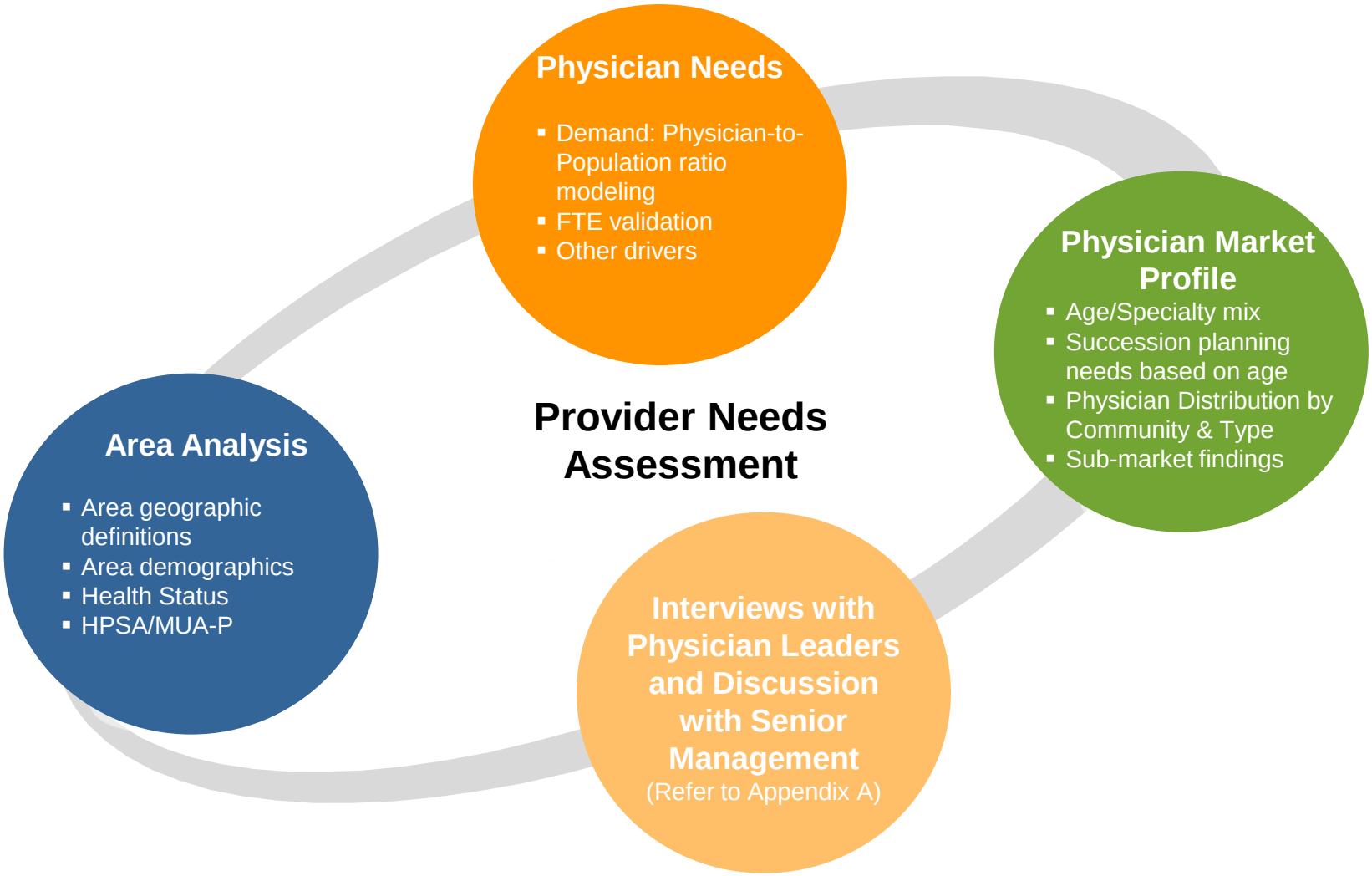
SG2
health care intelligence

Provider Needs Assessment for Kaweah Delta Medical Center

Leadership Discussion

September 28, 2020

Methodology



Interviewees

KDMC Interviewees	
Name	**Clinical Area/Administration**
Gary Herbst	CEO - Kaweah Delta
Dr. Bruce Hall	Internist/CMO of Kaweah Delta Medical Foundation
Marc Mertz	VP Chief of Strategy
Ryan Gates	VP of Population Health Management
Brent Boyd	CEO of Foundation for Medical Care of Tulare & Kings Counties, Inc.
Dr. Mandeep Bagga	Psychiatry
Dr. Seth Criner	Orthopedic Surgery/Trauma
Dr. Monica Manga	Internal Medicine, Vice Chief of Staff
Dr. Onsy Said	Adult Hospitalist
Dr. Lori Winston	EM/Designated Institution Officer

Executive Summary

- KDMC's total service area has an estimated population of approximately 600,000. The sub-markets evaluated range in population size from 388K to 600K residents.
- This area is designated as both a HPSA and MUA and is a fast-growing, young region with a high indigent population.
  - The percentage of Medi-Cal patients in the area ranges from 40% to 55% of the population.
  - The health status of the region is not favorable compared to California as a whole. Cancer and heart-related diseases are high.
- The area is surrounded by smaller acute care providers, which include Adventist Health and Sierra View Medical Center, with Kaweah being the preferred destination for care within this region.
- The physician operating landscape is a composite of several operating vehicles, providing flexibility and choice for physicians to operate under – Key Medical Associates, Visalia Medical Clinic (1206(l) medical foundation), and FQHC/RHC clinic models.
- On a geographic basis, the PSA has the highest per capita physician supply. As the geographic footprint expands, physician per capita continues to decrease at a higher rate. Care is heavily concentrated around the Hospital.

Executive Summary – cont'd

- Given the challenging market landscape (payer mix, location, etc), there are deficiencies in terms of manpower in many of the specialties in this analysis. Recruitment and retention has also been of concern and continues to be a challenge.
  - Many providers (Primary Care APPs) leave after fulfilling the requirements of their student loan forgiveness programs (typically 2-3 years).

- Aging of the physician workforce/succession planning vulnerability is a key theme for this region. While physicians in this market continue to provide care beyond the age of 65, there are anecdotes of older physicians expressing the desire to retire sooner than anticipated in response to COVID-19. The aging workforce and associated wave of potential retirements could leave the area with gaps in care.

- Specialties with particular vulnerabilities (aging workforce, supply challenges) include the following:

- Primary Care	- Oncology/Hematology	- Orthopedic Surgery
- Gastroenterology	- Urology	- ENT

Executive Summary – cont'd

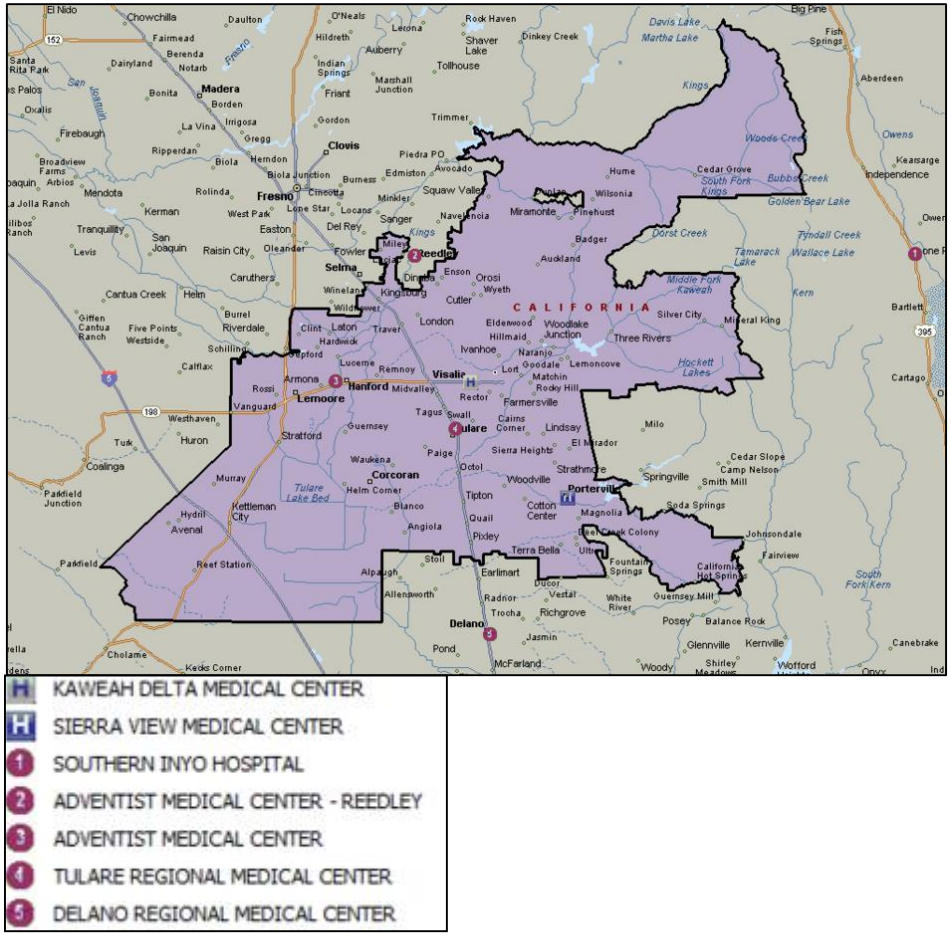
- Due to low reimbursement rates, many specialists in the region are not accepting Medi-Cal beneficiaries. This has been challenging for the residents in the community and also for hospital inpatient coverage.

- Physician recruitment in the area is challenging based on national shortages of (and competition for) physicians in several specialties, financial/economic realities, and lifestyle issues.
  - When evaluating physician needs, it is important to consider whether there is enough volume to support additional physicians given the large Medi-Cal population to which private practices are closed and the financial challenges that arise in operating practices that are largely skewed toward government payors.
  - As a way to ameliorate shortages and retain physicians in the area, KDMC continues to build out residency programs. Currently, there are five programs and a transitional year program. There are anecdotal reports of success in residents (about half) staying in the community upon completion of training.

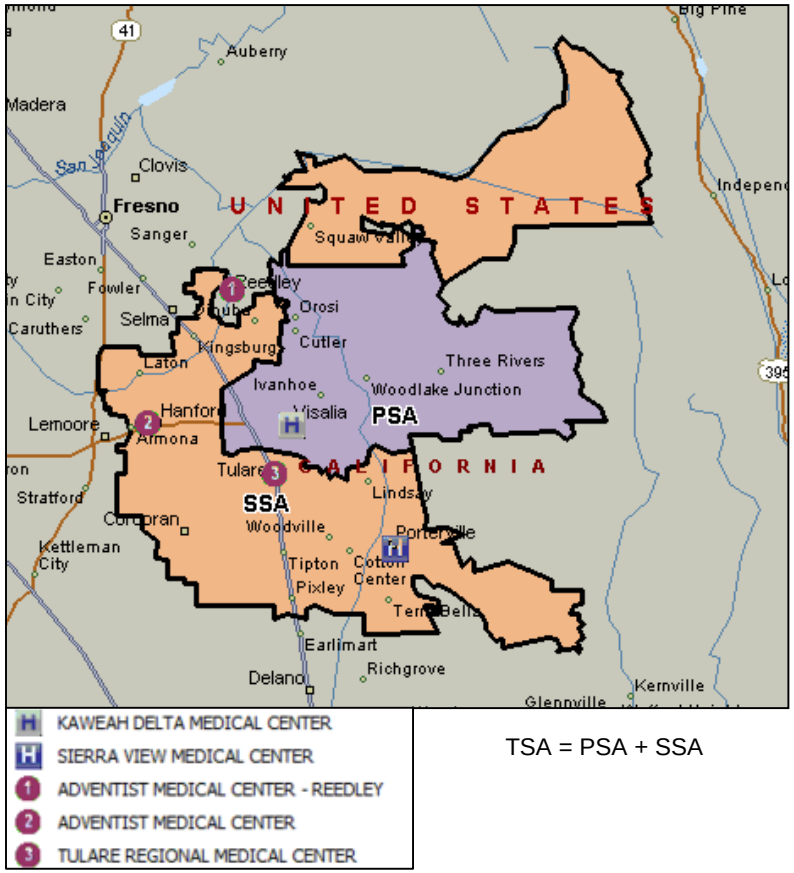
- The area is saturated with FQHCs which cater to Medi-Cal patients and care continuity has been a growing challenge. The model is very volume driven. APPs for primary care are heavily utilized under this model.

Service Area Depictions

Counties of Tulare & Kings

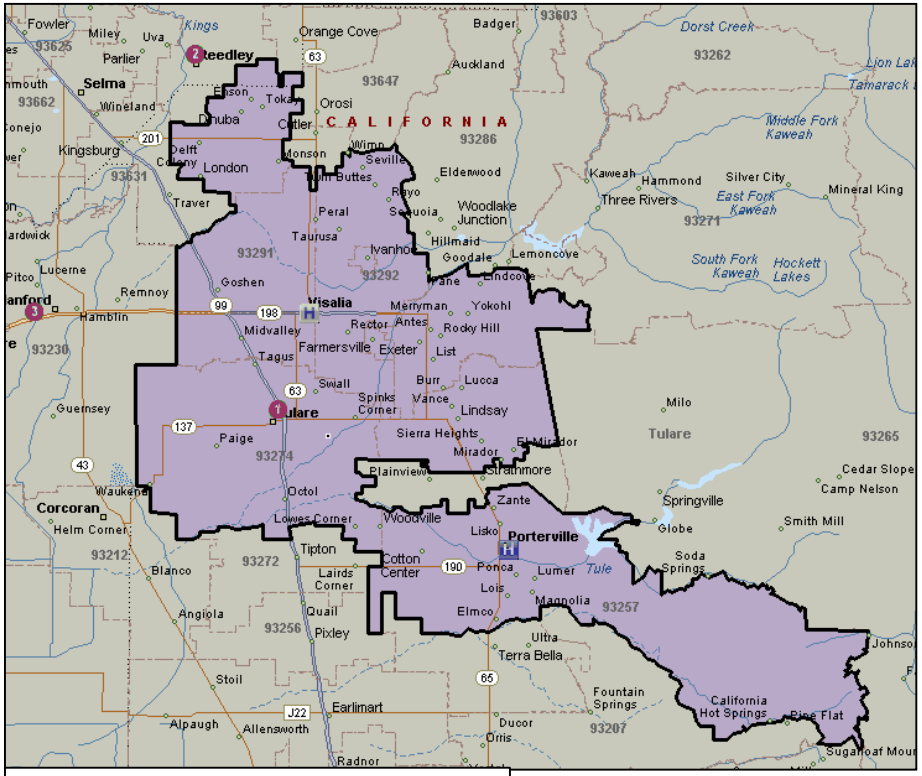


TSA



TSA = PSA + SSA

KDMC GASH Definition & Area Depiction



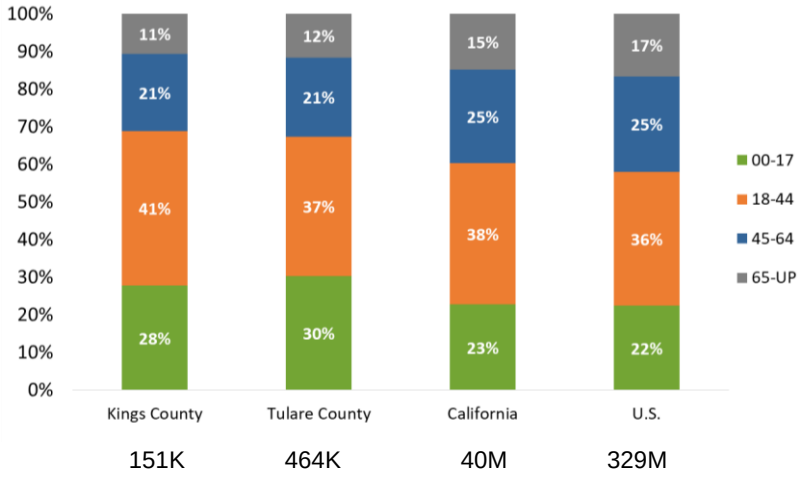
Kaweah Delta Medical Center
Patient Origin

		Inpatient Discharges		
ZIP Code	Community	Total	%	Cumulative %
93277	Visalia	4,377	15.7%	15.7%
93291	Visalia	4,362	15.7%	31.4%
93274	Tulare	4,267	15.3%	46.7%
93292	Visalia	3,177	11.4%	58.1%
93257	Porterville	1,191	4.3%	62.4%
93221	Exeter	1,138	4.1%	66.5%
93618	Dinuba	853	3.1%	69.5%
93223	Farmersville	851	3.1%	72.6%
93247	Lindsay	777	2.8%	75.4%
Subtotal		20,993	75.4%	
Other ZIPs		6,860	24.6%	
Total		**27,853**	**100.0%**	

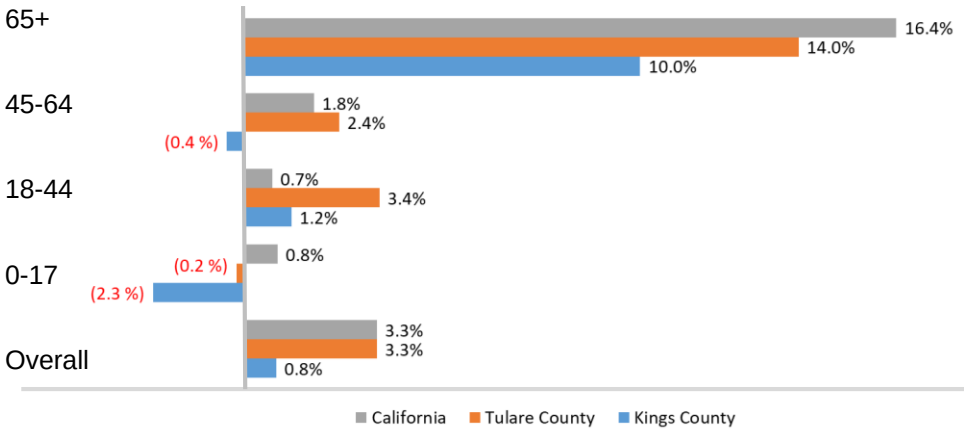
Note: Excludes normal newborns
Source: KDMC CY 2019

Age Profile – Tulare County & Kings County

Population by Age Cohort



% Change in Population by Age Cohort 2020 - 2025



- Residents in both Tulare and Kings County are proportionally younger when compared to the State.
- Tulare County is anticipated to grow by 3% while Kings County is projected to have minimal growth (0.8%) in the next five years.
- While the age 65+ cohort comprises a small percentage of both Tulare and Kings County residents when compared to the State and Nation, this group is projected to have to highest growth (14% and 10% respectively).

Comparison of Physician Needs by Service Area: Primary Care

Specialty	Population to Support One Physician	KDMC GASH	Tulare County	Kings County	Tulare County & Kings County	KDMC TSA
		Net Need (Surplus)	Net Need (Surplus)	Net Need (Surplus)	Net Need (Surplus)	Net Need (Surplus)
Primary Care						
Adult Primary Care (FM & IM)*	2,000	4.3	24.9	22.9	47.9	55.7
Pediatrics (General)	8,000	0.2	8.3	8.3	20.3	15.4
Service Area Population	Need	**388,430**	**463,814**	**151,233**	**615,047**	**597,438**
	Adequate Supply					

Note: Ratios rounded

*Primary Care Physician Supply includes APPs. APPs allocated 0.80 FTE

Comparison of Physician Needs by Service Area: Medical Specialties

Specialty	Population to Support One Physician	KDMC GASH	Tulare County	Kings County	Tulare County & Kings County	KDMC TSA
		Net Need (Surplus)	Net Need (Surplus)	Net Need (Surplus)	Net Need (Surplus)	Net Need (Surplus)
Medical						
Allergy & Immunology	75,000	(0.1)	0.9	1.7	2.7	2.5
Cardiology	22,000	3.4	6.9	4.7	11.5	10.7
- Electrophysiology	220,000	1.3	1.6	0.7	2.3	2.2
- Interventional/Invasive	63,000	0.2	1.4	1.2	2.6	2.3
- Medical/Non-Invasive	40,000	2.0	3.9	2.8	6.7	6.2
Dermatology	40,000	5.4	7.3	3.1	10.4	9.9
Endocrinology	60,000	3.6	4.8	2.3	7.2	6.9
Gastroenterology	40,000	3.9	5.8	2.7	8.5	8.0
Infectious Diseases	90,000	2.8	3.7	1.7	5.3	5.1
Nephrology	85,000	(9.3)	(8.4)	1.7	(6.8)	(7.0)
Neurology	50,000	(0.5)	1.0	2.5	3.5	3.1
Obstetrics/Gynecology	10,000	11.1	17.8	5.6	23.4	21.9
Oncology/Hematology	36,000	5.6	7.7	3.9	11.6	11.1
Gynecology Oncology	100,000	3.9	4.6	1.5	6.2	6.0
Physical Medicine & Rehabilitation	85,000	(0.9)	0.0	1.8	1.7	1.5
Psychiatry	20,000	7.6	11.4	1.8	13.2	12.3
Pulmonary Medicine/Critical Care	75,000	(0.2)	0.8	1.8	2.6	2.4
Radiation Oncology	95,000	1.3	2.1	1.6	3.7	3.5
Rheumatology	100,000	2.3	3.0	0.5	3.6	3.4
Service Area Population	Need	**388,430**	**463,814**	**151,233**	**615,047**	**597,438**
	Adequate Supply					

Note: Ratios rounded

Comparison of Physician Needs by Service Area: Surgical Specialties

Specialty	Population to Support One Physician	KDMC GASH	Tulare County	Kings County	Tulare County & Kings County	KDMC TSA
		Net Need (Surplus)	Net Need (Surplus)	Net Need (Surplus)	Net Need (Surplus)	Net Need (Surplus)
Surgical						
Surgery						
- Cardiothoracic/vascular Surgery	150,000	0.6	1.1	1.0	2.1	2.0
- Bariatric Surgery	100,000	3.4	4.1	1.5	5.7	5.5
- Colon & Rectal Surgery	200,000	1.9	2.3	0.8	3.1	3.0
- General Surgery	20,000	4.8	8.6	5.6	14.2	13.3
- Vascular Surgery	125,000	(0.2)	0.4	0.7	1.1	1.0
Neurosurgery	85,000	0.6	1.5	1.8	3.2	3.0
Ophthalmology	34,000	1.8	4.0	3.9	8.0	7.5
Orthopedic Surgery						
- General/Sports Medicine	26,000	6.6	9.5	4.3	13.9	13.2
- Foot/Ankle	295,000	1.3	1.6	0.5	2.1	2.0
- Hand Surgery	225,000	1.7	2.1	0.7	2.7	2.7
- Total Joint Reconstructive Surgery	175,000	1.5	2.0	0.9	2.8	2.7
- Trauma	160,000	2.1	2.6	0.9	3.5	3.4
Otorhinolaryngology	37,000	7.1	9.1	2.4	11.5	11.0
Plastic/Reconstructive Surgery	90,000	2.3	3.2	1.7	4.8	4.6
Spine Surgery	175,000	0.9	1.4	0.3	1.6	1.5
Urology	32,000	8.7	11.1	2.7	13.8	13.3
Service Area Population	Need	**388,430**	**463,814**	**151,233**	**615,047**	**597,438**
	Adequate Supply					

Note: Ratios rounded

Physician Landscape Scorecard

Physician Landscape			
Indicator	**Metric**	**Rating**	**Comments**
Physician age mix assessment	➢ Average age (53-55)		➢ 30% of physician workforce is over the age of 60 ➢ Some specialties are heavily skewed towards a more senior workforce
Physician supply/availability	➢ Need indicators		➢ There are many community shortages in the area
Succession planning/high risk for departures	➢ Key specialties present with above retirement age physicians		➢ Succession planning vulnerability present within the region ➢ Many high-producing providers are operating beyond retirement age (65)
Use of APPs	➢ Extent to use of APPs		➢ PCP APPs are heavily utilized in this area ➢ 1:1 Physician to APP ➢ Medical and surgical specialties have not fully adopted the use of APPs
Physician availability to all payor type/mix	➢ Physicians/providers available to provide coverage to the population		➢ Coverage in primary care is not restricted regardless of payor type (FQHC and RHC establishments) ➢ Many community-based/private physicians do not accept Medi-Cal

Physician Landscape Scorecard – cont'd

Physician Landscape			
Indicator	**Metric**	**Rating**	**Comments**
Physician use of telemedicine	➢ Extent of use of telemedicine to provide care		➢ Telemedicine availability and adoption is limited and behind.
Physician growth (net new providers)	➢ Recruitment ➢ Retention		➢ Recruitment – physician recruitment is challenging (location and payor mix). ➢ Retention of primary care providers has been difficult. PCP APPs are leaving after completing their student loan forgiveness obligation.
Presence of Value-based care	➢ Fee for value vs fee for service behavior ➢ Managed care coverage (Capitation/risk arrangements)		➢ Sequoia Integrated Healthcare – Medicare Advantage 15K full risk. ➢ Additional value-based delivery models are being discussed/contemplated (bundle payments, Medi-Cal cap).

Hospital Landscape Scorecard

Hospital Landscape			
Indicator	**Metric**	**Rating**	**Comments**
Hospital capacity and availability of services	➢ Occupancy rate ➢ Diversion ➢ Operating room capacity		➢ No diversion (emergency department volume)
Population health	➢ PCMH – primary care/disease management focus ➢ Telemedicine – both o/p and i/p ➢ Managed care ➢ Risk arrangements ➢ Clinically integrated network		➢ Kaweah application to form an FQHC integrated delivery medical home – to comprise of PCP, medical, and surgical specialist coverage ➢ SIQ – managed care full risk ➢ Moderate clinical alignment – 1206 (l) Visalia Medical Clinic fully clinically aligned (40+ providers), Key Medical Associates (growing)
Hospital and Physician Alignment/Relationship	➢ Relationship between physicians and hospital (positive/negative) ➢ Degree of physician/hospital alignment (fragmentation-silo'd/integrated)		➢ Relationship between the Hospital and the physicians have been positive. Kaweah has been flexible creating different vehicles to support physicians in the area and tightening the relationship- Delta Doctors, Key Medical Associates, Visalia Medical Clinic (employed-like), and SIQ risk arrangement ➢ The market is a hybrid - slightly more fragmented than integrated – but have made positive and progressive strides

Hospital Landscape Scorecard – cont'd

Hospital Landscape			
Indicator	**Metric**	**Rating**	**Comments**
Hospital competition	➢ Degree of competition present in the area (low/high)		➢ Low degree of competition ➢ Kaweah is the preferred hospital destination within Tulare County
Quality of care	➢ HCAHPs ➢ Timely Effective Care ➢ VBC		➢ Patient experience: 2 out of 5 stars ➢ Timely effective care: 2 out of 5 stars ➢ VBC: 2 out of 5 stars
Clinically Integrated Delivery Network	➢ Physician/Hospital Leadership ➢ Clinical Guidelines/Measurements ➢ Synchronized Data Technology ➢ Lateral or Vertical Alignment		➢ Sequoia Integrated Healthcare (Humana contract 10-15K senior lives)

Physician Market Summary

Physician Market Age Profile

The TSA has approximately 500 physicians of which an estimated 30% are over the age of 60 and the average age is 52.8. Certain specialties are vulnerable from a succession planning standpoint.

Physician Market by Type

While physician by type (PCP/medical/surgical/) are well represented, the area continues to have retention issues e.g. departures of APPs after fulfilling requirements of student loan forgiveness programs (est. 2-3 years).

Physician Distribution by Community

Physicians in the TSA are predominantly located in the Cities of Visalia, Hanford, Porterville, and Tulare.

Sub-market Physician Supply Comparison

The TSA is the most underserved service area overall while the PSA has the highest per capita physician supply.

Physician by Type

Primary Care	Medical Specialists	Surgical Specialists
210	190	90
42.9% of market	**38.8% of market**	**18.4% of market**

Physician Workforce Vulnerability Analysis

KDMC TSA	Total Physicians	Market Indicators			Succession Planning		
Specialty	Headcount	Current Supply % of Need	FTEs Needed*	Expressed Need through Interview	% of Physicians Age 60+	Succession/ Retirement	Risk Level
Adult Primary Care (FM & IM)	141	81%	55.7	Yes	33%	Yes	High
Gastroenterology	9	46%	8.0	No	78%	Yes	High
Oncology/Hematology	7	33%	11.1	Yes	86%	Yes	High
Urology	7	29%	13.3	Yes	71%	Yes	High
Orthopedic Surgery	13	69%	24.0	Yes	38%	Yes	High
Otorhinolaryngology	8	32%	11.0	Yes	63%	Yes	High
Cardiology	20	60%	10.7	No	55%	Yes	Moderate
General Surgery[(1)]	21	56%	21.8	Yes	24%	Yes	Moderate
Radiation Oncology	4	45%	3.5	No	75%	Yes	Moderate
Dermatology	9	33%	9.9	Yes	33%	Yes	Moderate
Obstetrics/Gynecology	44	63%	21.9	Yes	27%	Yes	Moderate
Rheumatology	3	44%	3.4	Yes	67%	Yes	Moderate
Endocrinology	4	31%	6.9	Yes	n/a	No	Moderate
Psychiatry	20	59%	12.3	Yes	15%	No	Moderate
Infectious Diseases	2	22%	5.1	Yes	n/a	No	Moderate
Allergy & Immunology	9	69%	2.5	No	33%	Yes	Moderate
Cardiothoracic/vascular Surgery	2	50%	2.0	No	n/a	No	Low
Vascular Surgery	7	78%	1.0	No	14%	No	Low
Neurosurgery	9	57%	3.0	No	33%	Yes	Low
Pulmonary Medicine/Critical Care	17	70%	2.4	No	24%	No	Low
Neurology	10	74%	3.1	Yes	10%	No	Low
Ophthalmology	15	57%	7.5	No	20%	No	Low
Pediatrics (General)	69	79%	15.4	No	23%	No	Low
Physical Medicine & Rehabilitation	10	78%	1.5	No	10%	No	Low
Plastic/Reconstructive Surgery	3	30%	4.6	No	33%	Yes	Low
Nephrology	22	199%	(7.0)	No	23%	No	Low

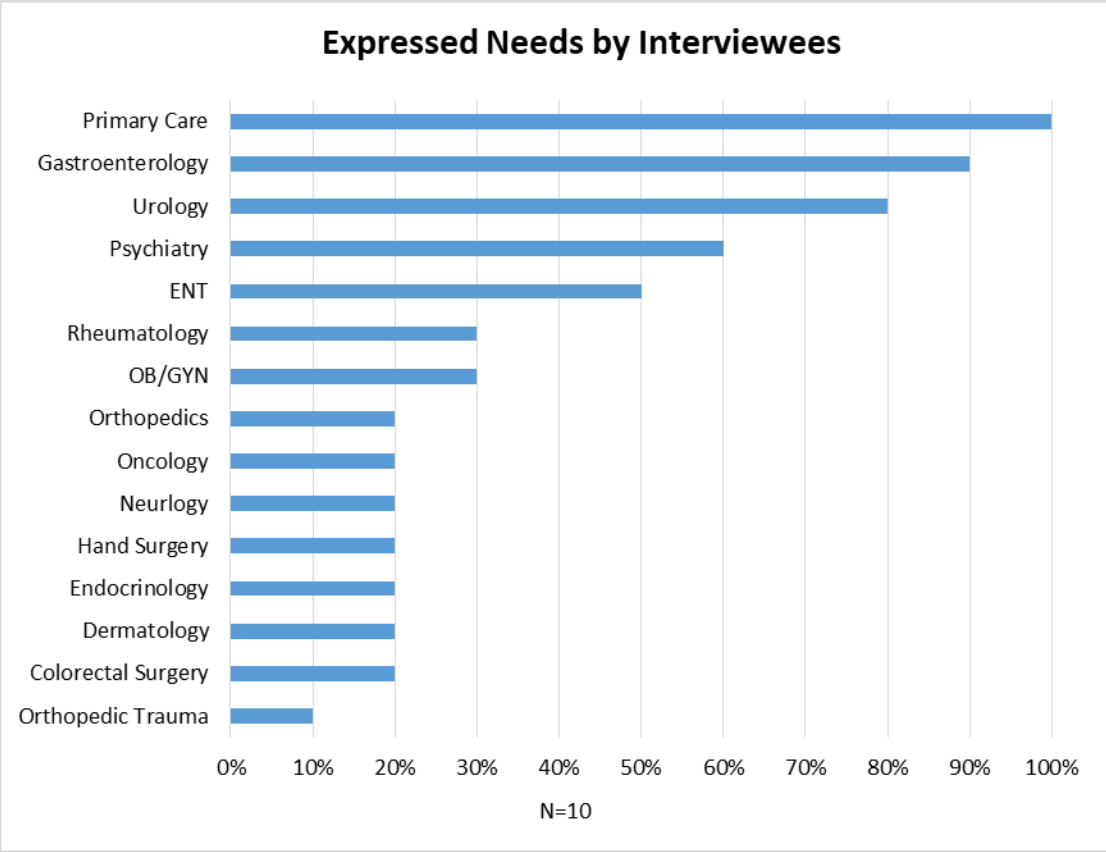
* () indicates adequate supply

[(1)]General Surgery incudes bariatric surgery and colorectal surgery

Note: Ages for all physcians not available. The above metrics are best estiamtes with current data.

Sg2 health care intelligence

Expressed Needs by Interviewees



Recommendation: Physician/Provider Recruitment and Development Targets

Specialty	Minimum FTEs Needed	Indicated Need Through Interviews	Potential Succession Planning Needed	Community Need for Physicians	Comments
FM/IM	3-4	✓	✓	✓	➢ Access issues ➢ Practice slow down
Dermatology	1-2	✓	✓	✓	➢ Practice slowdown
Endocrinology	1	✓	✓	✓	➢ Anticipated retirement
Gastroenterology	2-3	✓	✓	✓	➢ Access issues ➢ Medi-Cal population not being seen
OB/GYN	1-2	✓	✓	✓	➢ Need for OB/Gyns for Medi-Cal population
Psychiatry	1-2	✓	✓	✓	➢ Access issues ➢ Need for pediatric psychiatrist(s)
Rheumatology	1	✓	✓	✓	➢ Access issues ➢ Leakage

Recommendation: Physician/Provider Recruitment and Development Targets – cont'd

Specialty	Minimum FTEs Needed	Indicated Need Through Interviews	Potential Succession Planning Needed	Community Need for Physicians	Comments
Colon & Rectal Surgery	1	✓	✗	✓	➢ No physician currently present in the area
General Surgery	1-2	✓	✗	✓	➢ Access issues ➢ Growth
Orthopedic Surgery	1	✓	✓	✓	➢ Need for general and subspecialized surgeons ➢ Community leakage
ENT	1-2	✓	✓	✓	➢ Aging workforce
Urology	2-3	✓	✓	✓	➢ Aging workforce ➢ Access issues ➢ Community leakage

Sg2, a Vizient company, is the health care industry's premier authority on health care trends, insights and market analytics. Our analytics and expertise help hospitals and health systems achieve sustainable growth and ensure ongoing market relevance through the development of an effective System of CARE.

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY SEPTEMBER 28, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 30-55

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY SEPTEMBER 28, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 30-55

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY SEPTEMBER 28, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 30-55

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY SEPTEMBER 28, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 30-55

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY SEPTEMBER 28, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 30-55

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY SEPTEMBER 28, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 30-55

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY SEPTEMBER 28, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 30-55

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY SEPTEMBER 28, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 30-55

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY SEPTEMBER 28, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 30-55

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY SEPTEMBER 28, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 30-55

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY SEPTEMBER 28, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 30-55

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY SEPTEMBER 28, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 30-55

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY SEPTEMBER 28, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 30-55

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY SEPTEMBER 28, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 30-55

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY SEPTEMBER 28, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 30-55

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY SEPTEMBER 28, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 30-55

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY SEPTEMBER 28, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 30-55

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY SEPTEMBER 28, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 30-55

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY SEPTEMBER 28, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 30-55

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY SEPTEMBER 28, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 30-55

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY SEPTEMBER 28, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 30-55

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY SEPTEMBER 28, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 30-55

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY SEPTEMBER 28, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 30-55

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY SEPTEMBER 28, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 30-55

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY SEPTEMBER 28, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 30-55

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY SEPTEMBER 28, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 30-55

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS – MONDAY AUGUST 24, 2020 3:30PM, IN THE LIFESTYLE CENTER – CONFERENCE ROOMS / 5105 W. CYPRESS AVENUE, VISALIA AND VIA GOTO MEETING (CALL IN OPTION DUE TO STAY IN PLACE ORDER BY GOVENOR OF CALIFORINA) NEVIN HOUSE PRESIDING

PRESENT: Directors Francis, Gipson, Havard Mirviss, Hawkins & House; G. Herbst, CEO, B. Mendenhall, MD, Chief of Staff, C. Moccio, Recording K. Noeske, Interim VP & CNO, M. Tupper, VP & CFO; D. Cox, VP Chief Human Resources Officer, M. Mertz, VP Chief Strategy Officer, D. Leeper, VP & CIO; R. Gates, VP Population Health; A. Banerjee, VP Chief Quality Officer; D. Allain, VP Cardiac & Surgical Services; J. Batth, VP of Rehabilitation & Post Acute Services; D. Lynch, Legal Counsel

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

Director House asked for approval of the agenda.

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

PUBLIC PARTICIPATION – none

Director House called for the approval of the closed agenda.

APPROVAL OF THE CLOSED AGENDA – 3:31PM

4.1. **Approval of closed meeting minutes** – July 27, 2020

4.2. **Conference with Legal Counsel** – Existing Litigation – Pursuant to Government Code 54956.9(d)(1) – *Richard Salinas, Legal Counsel, Anu Banerjee, VP & Chief Quality Officer, and Alexandra Bennett, Director of Risk Management*

A. Edison v. Barcenas – Case # VCU265419
B. Martinez (Santillan) v. KDHCD – Case # VCU279163
C. Borges v. KDHCD – Case # 278212
D. Grant v. KDHCD – Case # 280250
E. Miller v. KDHCD – Case # 19CECG02595
F. Richards v. KDHCD – Case # 280708
G. Shirk v. KDHCD – Case # 280558
H. Valdovinos v KDHCD – Case # 279423
I. Delgado v KDHCD – Case # 280865
J. Souza v. KDHCD – Case # 281205
K. Saiz v. KDHCD – Case # 276364
L. Dowdy v. KDHCD – Case # 283475
M. Ibarra v. KDHCD – Case # 278288
N. Arroya v. KDHCD – Case # 278184
O. Minton v. KDHCD – Case # 277205
P. Hernandez v KDHCD – Case #280745

4.3. **Conference with Legal Counsel – Anticipated Litigation –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 14 Cases **-** *Richard Salinas, Legal Counsel, Anu Banerjee, VP & Chief Quality Officer, and Alexandra Bennett, Director of Risk Management*

4.4. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee –– *Anu Banerjee, VP & Chief Quality Officer, and Alexandra Bennett, Director of Risk Management*

4.5. **Credentialing** - Medical Executive Committee (MEC) requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the MEC be reviewed for approval pursuant to Health and Safety Code 1461 and 32155 – *Byron Mendenhall, MD Chief of Staff*

4.6. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee –– *Byron Mendenhall, MD Chief of Staff*

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

ADJOURN - Meeting was adjourned at 3:34PM

Nevin House, President
Kaweah Delta Health Care District and the Board of Directors

ATTEST:

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

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS – MONDAY AUGUST 24, 2020 4:00PM, IN THE LIFESTYLE CENTER – CONFERENCE ROOMS / 5105 W. CYPRESS AVENUE, VISALIA AND VIA GOTO MEETING (CALL IN OPTION DUE TO STAY IN PLACE ORDER BY GOVENOR OF CALIFORINA) NEVIN HOUSE PRESIDING

PRESENT: Directors Francis, Gipson, Havard Mirviss, Hawkins & House; G. Herbst, CEO, B. Mendenhall, MD, Chief of Staff, C. Moccio, Recording K. Noeske, Interim VP & CNO, M. Tupper, VP & CFO; D. Cox, VP Chief Human Resources Officer, M. Mertz, VP Chief Strategy Officer, D. Leeper, VP & CIO; R. Gates, VP Population Health; A. Banerjee, VP Chief Quality Officer; D. Allain, VP Cardiac & Surgical Services; J. Batth, VP of Rehabilitation & Post Acute Services; D. Lynch, Legal Counsel

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

Director House asked for approval of the agenda.

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

PUBLIC PARTICIPATION – none

CLOSED SESSION ACTION TAKEN: Approval of closed minutes July 27, 2020.

OPEN MINUTES – Request approval of the July 27 and August 18, 2020 meeting minutes.

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

MMSC (Havard Mirviss/Francis) Approval of the open meeting minutes – July 27 and August 18 2020 *open board of directors meeting minutes. This was supported unanimously by those present. Vote: Yes – Gipson, Francis, Havard Mirviss, Hawkins, and House*

RECOGNITIONS – Director Herb Hawkins presenting

- Presentation of Resolution #2088 to Brett Lange, Respiratory Therapist, retiring from Kaweah Delta after 38 years of service.
- Presentation of Resolution #2089 to Veronica (Pico) Griffith, Director of Clinical Services, retiring from Kaweah Delta after 35 years of service.

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

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

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

QUALITY – Stroke Program - A review of key quality measures and action plans related to the care of the stroke population (copy attached to the original of these minutes and considered a part thereof). Sean Oldroyd, OD, Stroke Program Medical Director, and Cheryl Smit, RN, Stroke Program Manager

QUALITY – Biovigil Electronic Hand Hygiene Monitoring – A review of the results of the Biovigil pilot study on 4N and ICU and plans for broad spread implementation (copy attached to the original of these minutes and considered a part thereof) - Jon Knudsen, FNP, Director of Critical Care Service

CREDENTIALING – Medical Executive Committee requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the Medical Executive Committee be reviewed for approval.

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

CREDENTIALING – Byron Mendenhall, 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 House requested a motion for the approval of the credentials report excluding Carla Aldaco NP-C {copy attached to the original of these minutes and considered a part thereof}.

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

Director House requested a motion for the approval of the credentials for Carla Aldaco NP-C {copy attached to the original of these minutes and considered a part thereof}.

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

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

CHIEF OF STAFF REPORT – Report from Byron Mendenhall, MD – Chief of Staff

- No report.

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

- The COVID admissions is dropping, PPE sources are improving, we are working on a public service announce about COVID for Labor Day to encourage people to not gather.

BOARD PRESIDENT REPORT – Report from Nevin House, Board President

- Inquired when we will have flu shots available for our staff – Mr. Herbst indicated it should be late September, October typically.

APPROVAL OF CLOSED AGENDA AS FOLLOWS: Closed Meeting Agenda –– Immediately following the open session

- PERSONNEL – Employment of the Chief Nursing Officer position per Government Code 54957(b)(1) – *Board of Directors, Dennis Lynch & Gary Herbst, CEO*

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

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

ADJOURN - Meeting was adjourned at 6:01PM

Nevin House, President
Kaweah Delta Health Care District and the Board of Directors

ATTEST:

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

Kaweah Delta
HEALTH CARE DISTRICT

RESOLUTION 2091

WHEREAS, Susan Sorenson, RN, 3 North Charge Nurse, is retiring from duty at Kaweah Delta Health Care District after 41 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 Susan Sorenson, RN for 41 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 28th day of September 2020 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
MORE THAN MEDICINE. LIFE.

RESOLUTION 2092

WHEREAS, the Department Heads of the KAWEAH DELTA HEALTH CARE DISTRICT are recognizing Martha Cervantes, with the Service Excellence Award for the Month of July 2020, 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 Martha Cervantes for this honor and in recognition thereof, have caused this resolution to be spread upon the minutes of the meeting.

PASSED AND APPROVED this 28th day of September 2020 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
MORE THAN MEDICINE. LIFE.

RESOLUTION 2093

WHEREAS, the Department Heads of the KAWEAH DELTA HEALTH CARE DISTRICT are recognizing Melissa Jarrell, with the Service Excellence Award for the Month of August 2020, 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 Melissa Jarrell for this honor and in recognition thereof, have caused this resolution to be spread upon the minutes of the meeting.

PASSED AND APPROVED this 28th day of September 2020 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 and Relations
Medical Staff Recruitment Report - September 2020

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

Date prepared: 9/23/2020

Central Valley Critical Care Medicine	
Adult Hospitalist	1
Intensivist	2

Delta Doctors Inc.	
OB/Gyn	1

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

Key Medical Associates	
Internal Medicine/Family Medicine	2

Other Recruitment	
Palliative Medicine	1
Colorectal Surgery	1
Anesthesiology - Cardiac	1

Valley Children's Health Care	
Maternal Fetal Medicine	2
Neonatology	1

Visalia Medical Clinic (Kaweah Delta Medical Foundation)	
Dermatology	2
Adult Primary Care	4
Gastroenterology	1
Gynecology	1
Neurology	1
OB/GYN	3
Orthopedic Surgery (Hand)	1
Otolaryngology	2
Pediatricts	1
Radiology - Diagnostic	1
Rheumatology	1
Urology	3

Candidate Activity						
Specialty/Position	**Group**	**Last Name**	**First Name**	**Availability**	**Referral Source**	**Current Status**
Colorectal Surgery	Visalia Medical Clinic (Kaweah Delta Medical Foundation)/IQ Surgical Associates	Ota, M.D.	Kyle	09/21	Current KD General Surgery resident	Offer extended
Dermatology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Maranda, M.D.	Eric	09/21	Fidelis Partners - 7/15/20	Site Visit: 8/21/2020 Offer extended
Dermatology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Saunders, M.D.	Kent	04/21	Fidelis Partners - 11/27/19	Site visit pending dates
Family Medicine	Visalia Family Practice/Key Medical Associates	Bashiri, M.D.	Maryam	08/20	Presented by Carson Kolb	Offer pending
Family Medicine	Visalia Medical Clinic (Kaweah Delta Medical Foundation)/Key Medical Associates	Bland, D.O.	Scott	08/21	Direct - 9/15/19	Pending site visit in late 2020
Family Medicine	Delta Doctors, Inc.	Castillo, M.D.	Fausto	08/20	Direct - 5/3/20	Site visit: 7/10/2020; Offer extended
Family Medicine/Core Faculty	Visalia Medical Clinic (Kaweah Delta Medical Foundation)/Kaweah Delta Faculty Medical Group	Geiger, D.O.	Michael	08/21	Direct - UCSF Fresno Career Fair	Site visit pending dates - October 2020
Family Medicine Core Faculty	Kaweah Delta Faculty Medical Group	Al-Tai, M.D.	Zeena	08/21	Pacific Companies - 7/13/20	Site visit pending dates
Family Medicine Core Faculty	Kaweah Delta Faculty Medical Group	Balachandran, M.D.	Banujan	08/21	Direct Referral	Site visit pending dates
Family Medicine Core Faculty	Kaweah Delta Faculty Medical Group	Gutierrez, M.D.	Mario	TBD	Referred by Dr. Martinez - 8/14/20	Site visit pending dates

Candidate Activity						
Specialty/Position	**Group**	**Last Name**	**First Name**	**Availability**	**Referral Source**	**Current Status**
Family Medicine Core Faculty	Kaweah Delta Faculty Medical Group	Mohamed, M.D.	Hashem	ASAP	Direct Referral	Site visit pending dates
Family Medicine Core Faculty	Kaweah Delta Faculty Medical Group	Rios, M.D.	Juan	08/21	Direct Referral	Currently under review
Family Medicine	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Patty, M.D.	Christina	08/20	Direct - Local Candidate	Site Visit: 2/5/19; Offer accepted; Start Date: 1/4/21
Gastroenterology	Valley Hospitalist Medical Group	Aita, M.D.	John	ASAP	Carson Kolb - 8/4/20	Site visit pending dates
Gastroenterology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Sherid, M.D.	Muhammed	ASAP	Pacific Companies - 7/28/20	Site visit pending dates
Hospitalist	Central Valley Critical Care Medicine	Malkhasian, M.D.	Armen	08/21	Direct - 9/8/20	Phone interview pending
Hospitalist	Central Valley Critical Care Medicine	Moers, D.O.	Diana	09/20	Direct - PracticeLink 3/24/2020	Offer accepted; Start date pending credentialing
Hospitalist	Central Valley Critical Care Medicine	Ramakuri, M.D.	Monica	09/20	Vista Staffing - 7/19/2020	Start Date: 10/7/20
Intensivist	Central Valley Critical Care Medicine	John, D.O.	Avinaj	08/21	Vista Staffing - 10/25/19	Site visit: 12/13/19; Offer accepted
Intensivist	Central Valley Critical Care Medicine	Agrawal, M.D.	Arun	08/21	Vista Staffing - 9/8/20	Currently under review
Intensivist	Central Valley Critical Care Medicine	Escobar, M.D.	Luis	07/20	Vista Staffing 8/19/20	Currently under review
Intensivist	Central Valley Critical Care Medicine	Leger, M.D.	Kathleen	08/21	Comp Health - 8/24/20	Site visit pending in December
Internal Medicine	Key Medical Associates	Awad, M.D.	Omnia	08/21	Physician Empire 8/17/20	Currently under review

Candidate Activity						
Specialty/Position	**Group**	**Last Name**	**First Name**	**Availability**	**Referral Source**	**Current Status**
Internal Medicine	Visalia Medical Clinic (Kaweah Delta Medical Foundation)/Key Medical Associates	Malik, M.D.	Sara	08/21	Direct - Dr. Umer Hayyat's spouse	Site visit pending dates - October 2020
Neonatology	Valley Children's Hospital	Alexander, M.D.	Steven	11/20	Valley Children's - 7/28/20	Virtual Interview: 7/31/20; Offer extended
OB/GYN	Delta Doctors, Inc.	Panneerselvam, D.O.	Priya	08/21	Pacific Companies, Inc. 8/19/20	Currently under review
Urology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Hamdi, M.D.	Anas	08/22	Direct - Referral	Initial site visit: 9/9/20 Formal site visit to follow
Urology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Patel, M.D.	Neil	TBD	Los Angeles Career MD Fair 9/14/19	Site Visit: 9/25/20
Urology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Sohlberg, M.D.	Ericka	08/21	MDStaffers - 8/21/20	Currently under review
Urology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Talanki, M.D.	Varun	08/21	HealtheCareers - 1/24/2020	Site visit pending dates

KDHCD ANNUAL BOARD REPORT

Cardiology Services - Summary

FY2020 Annualized

Board Meeting - May 27, 2020

KEY METRICS - FY 2020 Annualized on the Nine Months Ended March 31, 2020

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
29,492	$101,547,609	$80,224,268	$21,323,341	$1,769,065
▲ 17%	▲ 6%	▲ 9%	▼ -2%	▼ -23%

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

METRICS BY SERVICE LINE - FY 2020 ANNUALIZED

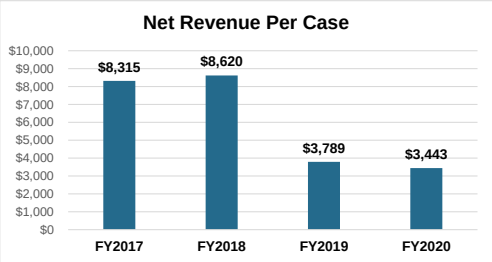
SERVICE LINE	PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
Inpatient Open Heart	300	$18,820,116	$19,535,956	($715,840)	($5,357,979)
Inpatient Cardiology	3,224	$55,038,104	$40,155,304	$14,882,800	$4,118,316
Outpatient Cardiac Cath Lab	2,957	$21,399,597	$14,975,899	$6,423,699	$3,398,401
Outpatient Cardiology Clinic	18,843	$4,156,628	$4,753,851	($597,223)	($1,453,301)
Outpatient Non-Invasive Cardiology	4,168	$2,133,164	$803,259	$1,329,905	$1,063,628
Cardiology Services Totals	29,492	$101,547,609	$80,224,268	$21,323,341	$1,769,065

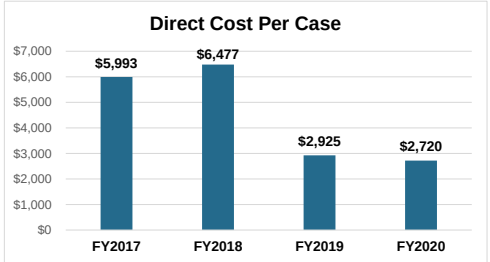
METRICS SUMMARY - 4 YEAR TREND

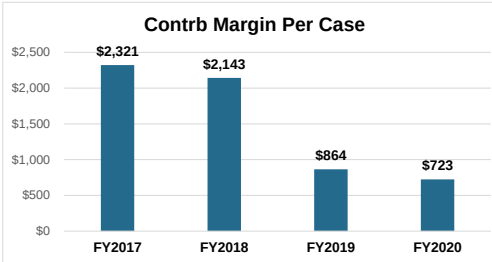
*Annualized

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	10,364	10,478	25,170	29,492	▲ 17%	
Net Revenue	$86,174,743	$90,325,023	$95,373,691	$101,547,609	▲ 6%	
Direct Cost	$62,115,230	$67,869,440	$73,614,778	$80,224,268	▲ 9%	
Contribution Margin	$24,059,513	$22,455,583	$21,758,913	$21,323,341	▼ -2%	
Indirect Cost	$15,033,892	$18,662,472	$19,450,491	$19,554,276	▲ 1%	
Net Income	$9,025,621	$3,793,111	$2,308,422	$1,769,065	▼ -23%	
Net Revenue Per Case	$8,315	$8,620	$3,789	$3,443	▼ -9%	
Direct Cost Per Case	$5,993	$6,477	$2,925	$2,720	▼ -7%	
Contrb Margin Per Case	$2,321	$2,143	$864	$723	▼ -16%	

GRAPHS







Note: FY2020 is annualized in graphs and throughout the analysis
Source: Inpatient and Outpatient Service Line Reports
Criteria: Inpatient Service Line (Open Heart and Cardiology)
Criteria: Outpatient Service Line (Cardiac Cath Lab, Cardiology Clinic and Non-Invasive Cardiology)

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

Cardiac Surgery

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

June 2020

Summary Issue/Service Considered

In Open Heart Surgery our program has grown in the past year. With the addition of Dr. Carrizo we are seeing an increase in surgical volume. The addition of an Nurse Practitioner on the surgical team will help staff to meet the demands of increased volume. We have a full complement of Cardiac Anesthesia, Staff and Surgeons to meet the needs of the community.

- Cases FY 19: 255
- Cases FY 20: 300 (projected)
    - 18% increase in surgical volume
    - 20% increase in net revenue
- Addition of CT surgeon has increased direct costs by 17%.
- Length of Stay (LOS) continues to be an opportunity for improvement.
    - Implementation of Same Day Admit (SDA) process began in July 2020
        - To date 16 patients have been admitted the day of surgery
        - Estimated $57,600 in savings regarding LOS
- Contribution margin has increased by 41%
    - Negative margin has reduced from $4,021 per case to $2,386 per case

Quality/Performance Improvement Data

In collaboration with Cleveland Clinic we have taken steps to:

- Increase staff retention
- Purchased additional instrumentation for minimally invasive procedures
- Implementation of Same Day Admit Process
    - Cross Department collaboration to streamline
    - Continue to review and refine process for SDA
- Completed an onsite visit with Cleveland Clinic to study and maximize OR time.

Policy, Strategic or Tactical Issues

- Supply chain management automation
    - Decrease direct costs of supplies
- Increase volume of minimally invasive surgery

Recommendations/Next Steps

- Decrease LOS:
    - At the start of FY 21, elective cases will no longer include courtesy admission the day before surgery.
- Completion of certification for additional RNFA on the Open Heart team
- Continue to collaborate with Cleveland Clinic on efficiency strategies

Approvals/Conclusions

We continue to provide high quality cardiovascular care for our community. Staff and physicians remain committed to maintaining our national Health Grade ranking of 50 best Cardiac Surgery programs.

KDHCD ANNUAL BOARD REPORT

Cardiology Services - Inpatient Open Heart Surgery

FY2020 Annualized

Board Meeting - May 27, 2020

KEY METRICS - FY 2020 Annualized on the Nine Months Ended March 31, 2020

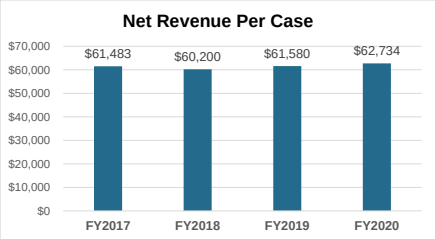
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
300	$18,820,116	$19,535,956	($715,840)	($5,357,979)
▲ 18%	▲ 20%	▲ 17%	▲ 30%	▼ -4%

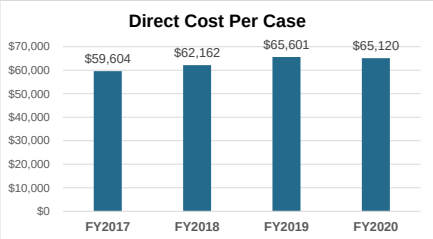
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

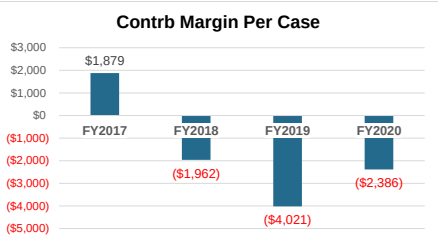
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020 *Annualized	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	227	273	255	300	▲ 18%	
Patient Days	2,594	3,152	3,005	3,328	▲ 11%	
ALOS	11.43	11.55	11.78	11.09	▼ -6%	
GM LOS	9.41	8.91	9.05	9.23	▲ 2%	
Net Revenue	$13,956,678	$16,434,580	$15,702,797	$18,820,116	▲ 20%	
Direct Cost	$13,530,098	$16,970,259	$16,728,218	$19,535,956	▲ 17%	
Contribution Margin	$426,580	($535,679)	($1,025,421)	($715,840)	▲ 30%	
Indirect Cost	$3,065,193	$4,190,496	$4,106,234	$4,642,139	▲ 13%	
Net Income	($2,638,613)	($4,726,175)	($5,131,655)	($5,357,979)	▼ -4%	
Net Revenue Per Case	$61,483	$60,200	$61,580	$62,734	▲ 2%	
Direct Cost Per Case	$59,604	$62,162	$65,601	$65,120	▼ -1%	
Contrb Margin Per Case	$1,879	($1,962)	($4,021)	($2,386)	▲ 41%	

PER CASE TRENDED GRAPHS





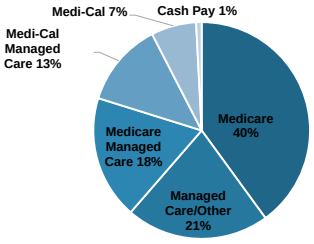


Note: FY2020 is annualized in graphs and throughout the analysis

PAYER MIX - 4 YEAR TREND

PAYER	FY2017	FY2018	FY2019	FY2020 *Annualized
Medicare	47%	45%	43%	40%
Managed Care/Other	21%	22%	24%	21%
Medicare Managed Care	15%	15%	17%	18%
Medi-Cal Managed Care	9%	13%	8%	13%
Medi-Cal	7%	6%	5%	7%
Cash Pay	0%	0%	2%	1%
Work Comp	0%	0%	0%	0%
County Indigent	0%	0%	0%	0%

FY 2020 PAYOR MIX - Annualized



Notes:
Source: Inpatient Service Line Report
Selection Criteria: Inpatient Service Line - Opent Heart

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 2020

Summary of 2019 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 2019 is 86% compared to our goal of 85%. Compared to 2018 we have been able to maintain an 86% TAT. 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%.

2019 Echo TAT for reads					
	# done	<12hrs	% <12hrs	Total Hrs	Mean TAT hrs
JAN	721	621	**86%**	4301	**6**
FEB	687	586	**85%**	4541	**7**
MAR	751	657	**87%**	4696	**6**
Q1	**2159**	**1864**	**86%**	**13538**	**6**
APR	492	432	**88%**	2994	**6**
MAY	663	591	**89%**	3651	**6**
JUN	626	545	**87%**	4037	**6**
Q2	**1781**	**1568**	**88%**	**10682**	**6**
JUL	677	601	**89%**	3679	**5**
AUG	684	572	**84%**	4991	**7**
SEP	582	510	**88%**	3664	**6**
Q3	**1943**	**1683**	**87%**	**12334**	**6**
OCT	722	625	**87%**	4650	**6**
NOV	660	533	**81%**	4502	**7**
DEC	670	566	**84%**	4399	**7**
Q4	**2052**	**1724**	**84%**	**13551**	**7**
Totals	7935	6839	**86%**	50105	**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.
2. Move 202 Willow OP services to 820 Akers

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.

KDHCD ANNUAL BOARD REPORT

Cardiology Services - Inpatient Cardiology Service Line

FY2020 Annualized

Board Meeting - May 27, 2020

KEY METRICS - FY 2020 Annualized on the Nine Months Ended March 31, 2020

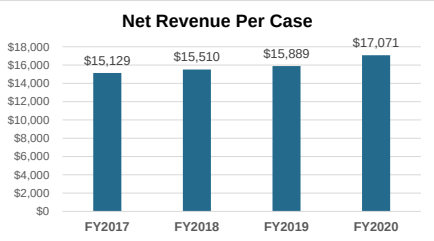
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
3,224	$55,038,104	$40,155,304	$14,882,800	$4,118,316
▼ -8%	▼ -1%	▲ 2%	▼ -10%	▼ -15%

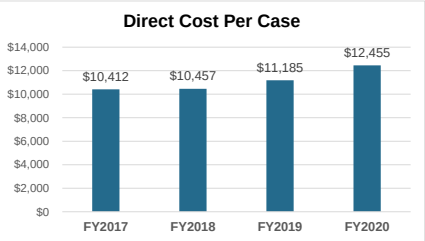
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

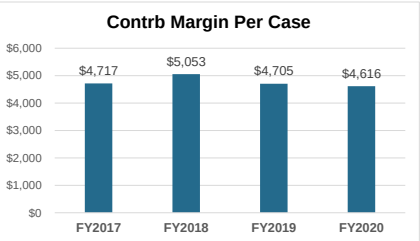
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	*Annualized FY2020	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	3,103	3,261	3,506	3,224 ▼	-8%	
Patient Days	13,729	14,542	14,917	13,949 ▼	-6%	
ALOS	4.42	4.46	4.25	4.33 ▲	2%	
GM LOS	3.58	3.50	3.37	3.45 ▲	2%	
Net Revenue	$46,945,923	$50,579,052	$55,708,534	$55,038,104 ▼	-1%	
Direct Cost	$32,309,749	$34,099,909	$39,214,275	$40,155,304 ▲	2%	
Contribution Margin	$14,636,174	$16,479,143	$16,494,259	$14,882,800 ▼	-10%	
Indirect Cost	$8,340,339	$10,524,741	$11,661,844	$10,764,484 ▼	-8%	
Net Income	$6,295,835	$5,954,402	$4,832,415	$4,118,316 ▼	-15%	
Net Revenue Per Case	$15,129	$15,510	$15,889	$17,071 ▲	7%	
Direct Cost Per Case	$10,412	$10,457	$11,185	$12,455 ▲	11%	
Contrb Margin Per Case	$4,717	$5,053	$4,705	$4,616 ▼	-2%	

PER CASE TRENDED GRAPHS





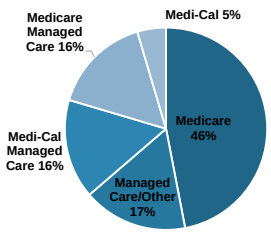


Note: FY2020 is annualized in graphs and throughout the analysis

PAYER MIX - 4 YEAR TREND

PAYER	FY2017	FY2018	FY2019	*Annualized FY2020
Medicare	53%	52%	51%	46%
Managed Care/Other	16%	13%	12%	17%
Medi-Cal Managed Care	17%	17%	18%	16%
Medicare Managed Care	10%	11%	14%	16%
Medi-Cal	4%	6%	5%	5%
Cash Pay	1%	1%	1%	1%
Work Comp	0%	0%	0%	0%
County Indigent	0%	0%	0%	0%

FY 2020 Payer Mix - Annualized



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

KDHCD ANNUAL BOARD REPORT

Cardiology Services - OP Non-Invasive Cardiology

FY2020 Annualized

Board Meeting - May 27, 2020

KEY METRICS - FY 2020 Annualized on the Nine Months Ended March 31, 2020

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
4,168	$2,133,164	$803,259	$1,329,905	$1,063,628
▲ 1%	▲ 4%	▲ 6%	▲ 2%	▲ 1%

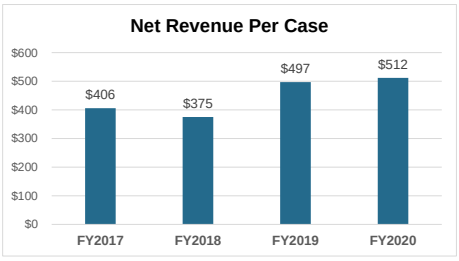
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

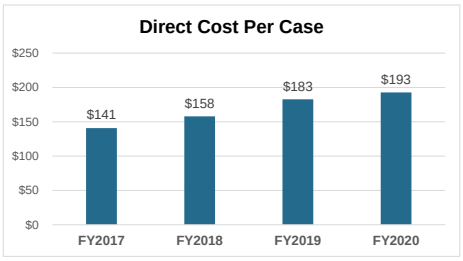
METRICS SUMMARY - 4 YEAR TREND

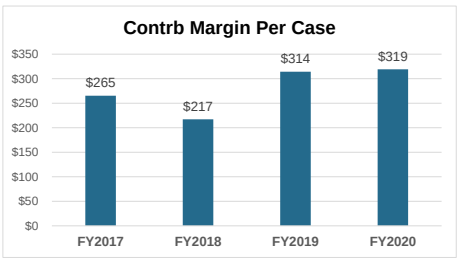
*Annualized

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	3,866	3,923	4,140	4,168 ▲	1%	
Net Revenue	$1,569,723	$1,471,384	$2,057,419	$2,133,164 ▲	4%	
Direct Cost	$544,065	$619,597	$756,415	$803,259 ▲	6%	
Contribution Margin	$1,025,658	$851,787	$1,301,004	$1,329,905 ▲	2%	
Indirect Cost	$217,409	$247,957	$242,929	$266,277 ▲	10%	
Net Income	$808,249	$603,830	$1,058,075	$1,063,628 ▲	1%	
Net Revenue Per Case	$406	$375	$497	$512 ▲	3%	
Direct Cost Per Case	$141	$158	$183	$193 ▲	5%	
Contrb Margin Per Case	$265	$217	$314	$319 ▲	2%	

PER CASE TRENDED GRAPHS







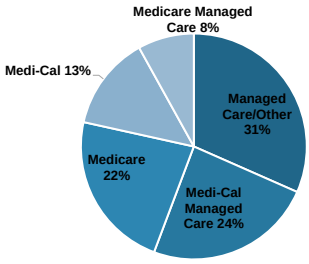
Note: FY2020 is annualized in graphs and throughout the analysis

PAYER MIX - 4 YEAR TREND

*Annualized

PAYER	FY2017	FY2018	FY2019	FY2020
Managed Care/Other	26%	25%	30%	31%
Medi-Cal Managed Care	41%	44%	28%	24%
Medicare	21%	19%	21%	22%
Medi-Cal	6%	6%	14%	13%
Medicare Managed Care	4%	4%	7%	8%
Cash Pay	1%	1%	1%	2%
Work Comp	0%	0%	0%	0%
County Indigent	0%	0%	0%	0%

FY 2020 Payer Mix - Annualized



Notes:
Source: Outpatient Service Line Reports
Criteria: Outpatient Service Line Non-Invasive Cardiology

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

Cardiac Catheterization Lab

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

June 2020

Summary Issue/Service Consider

In partnership with the Cardiologists, we have made tremendous improvements in the Cath Lab within the last year. The Outpatient Cath Lab case volume has increased 7% along with the contribution margin 8% and overall net revenue 12%. In collaboration with Cleveland Clinic we have developed new processes that have increased efficiency of the Cath Lab.

- Cath Lab is fully staffed without relying on contract labor (Travelers)
  - Able to run 5 Cath Lab Rooms daily, which is an increase from previously being able to run 3-4 room per day.
- Revision of Block Schedule has increased available Cath Lab time
- Decrease Length of Stay (LOS)
  - Same Day Discharge (SDD) of elective PCI's
  - Daily block time available for in house patients
  - Staffed Add-on Room for Cardiac Alerts and add-on cases

Quality/Performance Improvement Data

In collaboration with Cleveland Clinic we have implemented a Same Day Discharge process for cardiac interventions.

- SDD Goal: 40% of all elective cardiac interventions discharged same day

We have increased radial access 40% for coronary heart procedures.
Increased patient satisfaction

- Patients immediately walking post procedure as opposed to lying flat for 6 hours with a femoral approach
- Decrease in risk of bleeding

Policy, Strategic or Tactical Issues

Implementation of Mobile Supply Chain to facilitate inventory control.

- Coordination with Materials Management to bring system online

Currently working with the cardiologists to enhance our Structural Heart program by adding additional procedures.

Recommendations/Next Steps

- Continue to work on efficiency programs utilizing Cleveland Clinic as a resource.
- Continue to support a collaborative environment between physicians and staff

Approvals/Conclusions

Despite challenges presented by COVID staff and physicians continue to provide world class care. In the past year we have laid a solid foundation for growth, efficiency, and quality improvement. Positive feedback from our patients confirm our efforts are worthwhile and the increase in our case volume and revenue are measurable.

KDHCD ANNUAL BOARD REPORT

Cardiology Services - OP Cardiac Cath Lab

FY2020 Annualized

Board Meeting - May 27, 2020

KEY METRICS - FY 2020 Annualized on the Nine Months Ended March 31, 2020

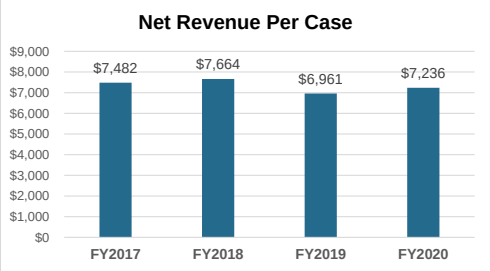
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
2,957	$21,399,597	$14,975,899	$6,423,699	$3,398,401
▲ 7%	▲ 12%	▲ 14%	▲ 8%	▲ 13%

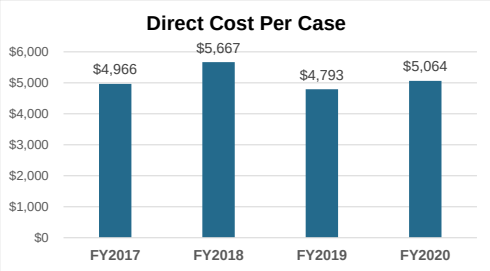
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

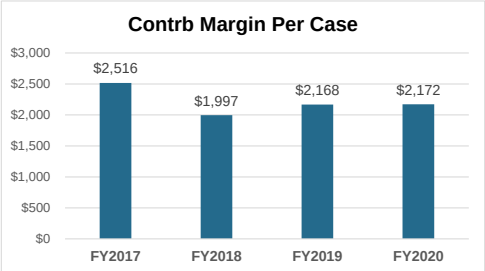
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020 *Annualized	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	3,168	2,848	2,752	2,957	▲ 7%	
Net Revenue	$23,702,419	$21,826,316	$19,155,878	$21,399,597	▲ 12%	
Direct Cost	$15,731,318	$16,139,147	$13,190,413	$14,975,899	▲ 14%	
Contribution Margin	$7,971,101	$5,687,169	$5,965,465	$6,423,699	▲ 8%	
Indirect Cost	$3,410,951	$3,696,743	$2,966,537	$3,025,297	▲ 2%	
Net Income	$4,560,150	$1,990,426	$2,998,928	$3,398,401	▲ 13%	
Net Revenue Per Case	$7,482	$7,664	$6,961	$7,236	▲ 4%	
Direct Cost Per Case	$4,966	$5,667	$4,793	$5,064	▲ 6%	
Contrb Margin Per Case	$2,516	$1,997	$2,168	$2,172	▶ 0%	

PER CASE TRENDED GRAPHS





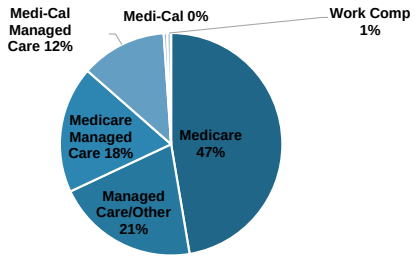


Note: FY2020 is annualized in graphs and throughout the analysis

PAYER MIX - 4 YEAR TREND

PAYER	FY2017	FY2018	FY2019	FY2020 *Annualized
Medicare	51%	48%	50%	47%
Managed Care/Other	22%	25%	23%	21%
Medicare Managed Care	15%	17%	16%	18%
Medi-Cal Managed Care	10%	9%	9%	12%
Medi-Cal	0%	1%	1%	0%
Work Comp	1%	0%	1%	1%
Cash Pay	0%	0%	0%	0%
County Indigent	0%	0%	0%	0%

FY 2020 PAYOR MIX - Annualized



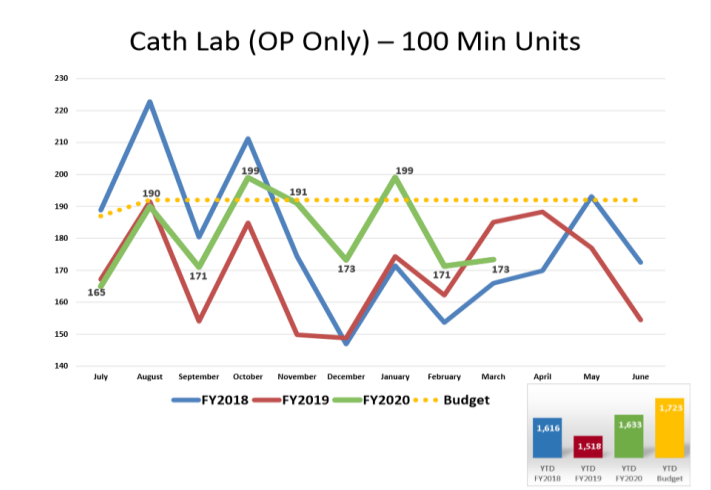
KDHCD ANNUAL BOARD REPORT

Cardiology Services - OP Cardiac Cath Lab

FY2020 Annualized

Board Meeting - May 27, 2020

KEY METRICS - FY 2020 Annualized on the Nine Months Ended March 31, 2020



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

REPORT TO THE BOARD OF DIRECTORS

Sequoia Cardiology Clinic

Barry Royce, RN, MHA – Director of CVSL & Co-Mgmt. Program 624-4919
September 28th, 2020

Summary Issue/Service Considered

Sequoia Cardiology Clinic (SCC) began the Fiscal year in its 10th month of operation. Since opening the clinic much work has been done to optimize flow through the clinic and utilization of the EMR in OP, Specialty Clinic. Clinic volumes for FY 20 ended at 219 encounters, per month, above budgeted volumes. Some of this volume was from higher than expected Non-Invasive testing, which includes Echo-Sonography and Nuclear Medicine.

- Board report changes/highlights
  - Clinic volumes are up 30% over FY 2019
  - Direct cost per case changed for FY 2020, from $269 to $252 from the original report in April
  - With the cost accounting changes for the Cardiology areas, SCC has no direct allocations. A 6.48% allocation from Dept. 7021 Cardiovascular Co-Mgmt. was removed from 7088 for FY 2019 and FY 2020
  - Direct cost per case is now 2% below FY 2019
  - We continue to evaluate the Physician cost that is attributed to the clinic, but accumulated on IP charges. Approximately 42% of MD charges are related to Medical Center charges.
  - Reimbursement per case averages $221 in FY 2020, up from $189 in FY 2019, however the DFR rate (percentage we don't get paid) was consistent at 78%
  - Major payers are Medicare/Medicare Managed 56%, Medi-Cal/Medical Managed 24% and Managed Care 19%
  - No Show Rate for the clinic is 8%.

Quality/Performance Improvement Data

Our Clinic was intended to serve the MediCal patient population, this past year 24% of our patient population was MediCal; serving this population creates a significant negative margin. We use Clockwise as an adjunct to our scheduling system. Clockwise has the ability to send out a patient survey after each visit with a 1 – 10 satisfaction rating; our monthly average rating was 9.6.

The clinic has implemented:
1. Remote monitoring of Pacemakers so patients do not need to come into clinic as often to have their device interrogated. Remote monitoring can be done three times a year and in person once.
2. Engaged outside monitor company to provide unlimited supply of devices for Holter and continuous Monitoring. This has decreased wait time for getting this type of monitoring done.

3. Registered Nurse administration of Definity an image enhancing agent for greater definition of Echo tests, in patients where image quality is low. This was previously only done by the Nurse Practitioner staff, which limited their capacity to perform higher level duties

Our percent of new patients is 19% of our total clinic physician encounters. This is well above a national average of 13%, but is a number we will want to continue to track. A new patient is someone who has not previously been seen anywhere in the District.

Policy, Strategic or Tactical Issues

We currently have Nurse Practitioner support to assist with efficient throughput of our Stress Testing; volumes have created challenges with getting patients scheduled. We are looking at making some changes that will allow us to have our Registered Nurse be of greater assistance to the process, which will increase our capacity.

We have been working on consolidating the 202 Willow Outpatient Non-Invasive Cardiology testing with the Sequoia Cardiology testing; this will allow for use of Definity.

Work has begun on the installation of the new PET CT which will allow for us to perform Cardiac PET CT, a world class version of Cardiac Nuclear Imaging. This will also allow for us to eliminate our PET trailer, outside of Sequoia Regional Cancer Center, we have been leasing and save hundreds of thousands of dollars annually; this trailer is used for our Oncology PET scanning.

We will need to replace our Nuclear Medicine Camera due to End of Life issues with current camera

Recommendations/Next Steps

1. Complete the move of 202 Willow services
2. Complete construction and installation of PET CT
    a. Need to complete most cost effective contract for Cardiac Isotopes
3. Complete training and education for Registered Nurse support with Stress Testing
4. Purchase and secure new Nuclear Medicine camera

Approvals/Conclusions

1. Move of 202 Willow will be completed by the end of September.
2. PET CT installation will be complete by end of September.
    a. Training will begin after installation.
        i. Will need to wait for CDPH for inspection prior to training – application submitted
    b. Isotope procurement still needs to be completed.
    c. Go – Live likely in November.
3. Will move forward with having Nursing staff working at the top of their licensure
4. Will complete the transition to Kaweah Delta Diagnostic Center. Work with Marketing has already begun with local providers.
5. Install new Nuclear Medicine camera

KDHCD ANNUAL BOARD REPORT

Cardiology Services - Outpatient Cardiology Clinic

FY2020 Annualized

Board Meeting - May 27, 2020

KEY METRICS - FY 2020 Annualized on the Nine Months Ended March 31, 2020

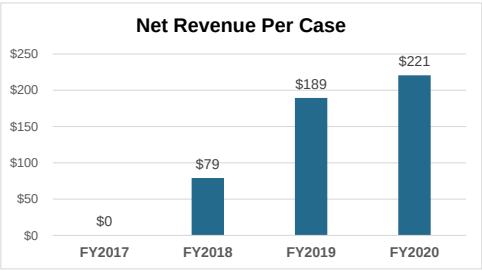
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
18,843	$4,156,628	$4,753,851	($597,223)	($1,453,301)
▲ 30%	▲ 51%	▲ 28%	▲ 39%	▶ 0%

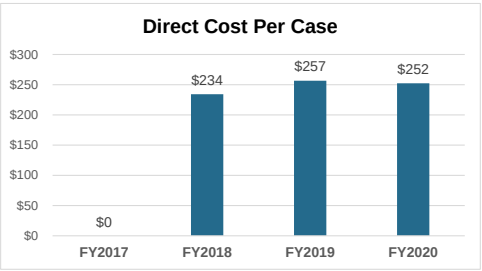
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

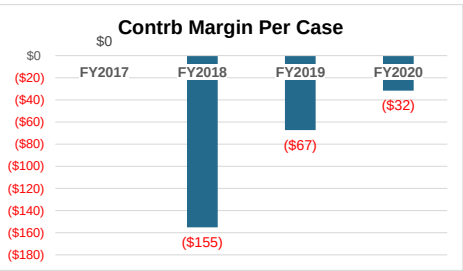
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020 *Annualized	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	0	173	14,517	18,843 ▲	30%	
Net Revenue	$0	$13,691	$2,749,063	$4,156,628 ▲	51%	
Direct Cost	$0	$40,528	$3,725,457	$4,753,851 ▲	28%	
Contribution Margin	$0	($26,837)	($976,394)	($597,223) ▲	39%	
Indirect Cost	$0	$2,535	$472,947	$856,079 ▲	81%	
Net Income	$0	($29,372)	($1,449,341)	($1,453,301) ▶	0%	
Net Revenue Per Case	$0	$79	$189	$221 ▲	16%	
Direct Cost Per Case	$0	$234	$257	$252 ▼	-2%	
Contrb Margin Per Case	$0	($155)	($67)	($32) ▲	53%	

PER CASE TRENDED GRAPHS





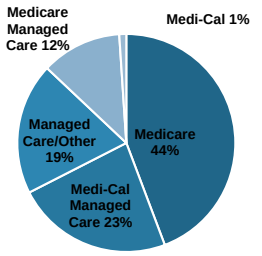


Note: FY2020 is annualized in graphs and throughout the analysis

PAYER MIX - 4 YEAR TREND

PAYER	FY2017	FY2018	FY2019	FY2020 *Annualized
Medicare	0%	43%	48%	44%
Medi-Cal Managed Care	0%	14%	20%	23%
Managed Care/Other	0%	32%	19%	19%
Medicare Managed Care	0%	5%	11%	12%
Medi-Cal	0%	2%	1%	1%
Work Comp	0%	4%	0%	1%
Cash Pay	0%	0%	0%	0%
County Indigent	0%	0%	0%	0%

FY 2020 Payer Mix - Annualized



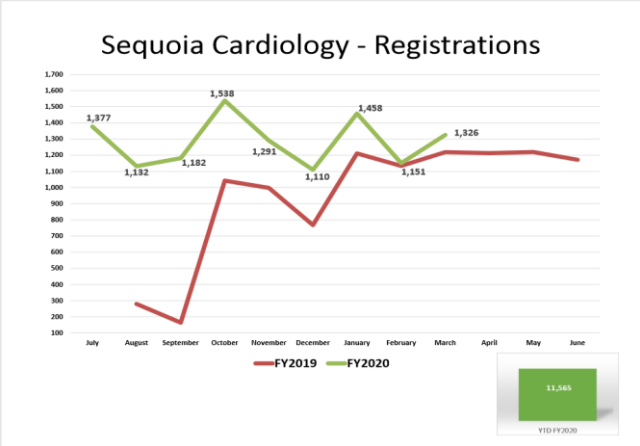
KDHCD ANNUAL BOARD REPORT

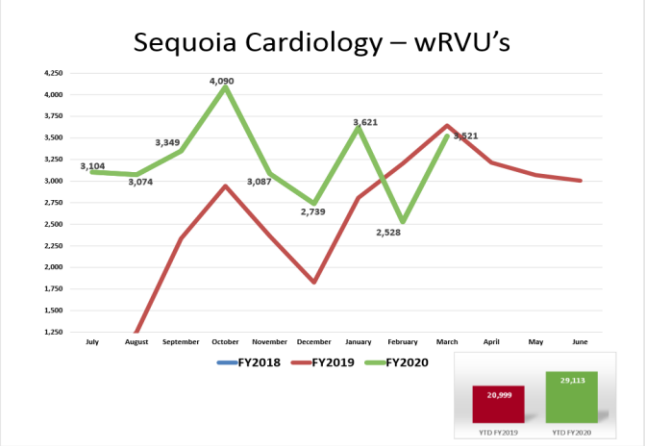
Cardiology Services - Outpatient Cardiology Clinic

FY2020 Annualized

Board Meeting - May 27, 2020

KEY METRICS - FY 2020 Annualized on the Nine Months Ended March 31, 2020





Notes:
Cardiology Clinic Opened May 2018
Source: Outpatient Service Line Reports
Criteria: Outpatient Service Line Cardiology Clinic

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

Hospice Services

Lizabeth McClain, MSN, RN
Director of Hospice Services. Contact number: 559-624-6840
March 13, 2020

Summary Issue/Service Considered

- Hospice's mission is to deliver optimal end-of-life care to pediatric and adult populations in Kings and Tulare counties via the hospice and concurrent care program.
- Achieve optimal program outcomes with a priority on quality of care, compliance, profitability and quality of work environment.
- Hospice: A team approach for end-of-care care with the goal to improve quality of life and comfort through symptom management.
- Concurrent Care: A team approach for children with life-limiting diseases. The goal of pediatric concurrent care is to provide care that will optimize health, maximize function, and prevent hospitalizations.
- KD Hospice continues to see an increase in children seeking concurrent care. Total Patient Days/Average Daily Census (ADC) has increased by 5% over the past year.
- Referrals to hospice and concurrent care have increased by 22% for adults, and 7% for pediatric patients.

Financial/statistical Analysis

- Hospice days for FY 2020 increased by 4% (41,498 annualized).
- Net revenue increased by 9% ($6,919,241) for FY 2020. Additional revenue captured related to authorizations. Overall, contribution margin increased by 69% in FY 2020 ($1,401,516)
- Overall net income at $332,954, increase of 210% compared to FY 2019.
- Reduction in direct costs per unit of service to $133, which resulted in a 3% reduction overall
- Indirect costs decreased by 6%, overall decrease of $64,040 in FY2020 compared to 2019
- Medical supply expenses and pharmaceutical costs are under budget by 17% each.

Quality/Performance Improvement Data

Quality reporting

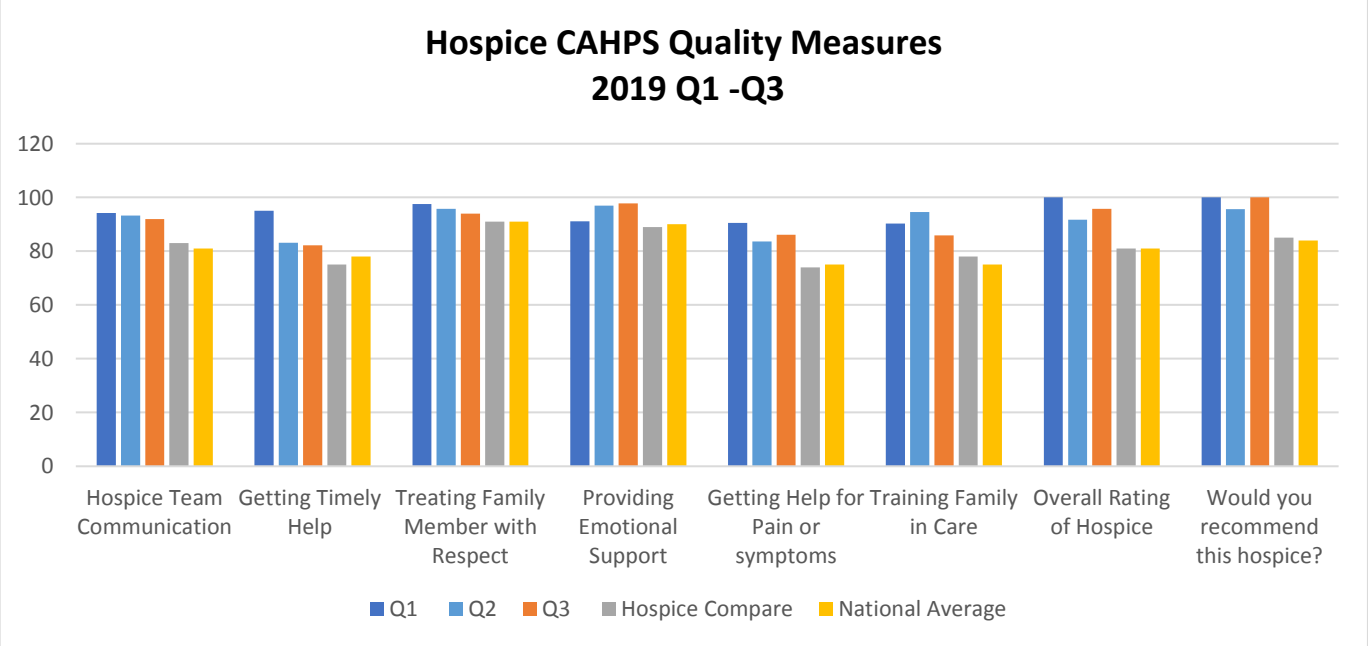
- Hospice Item Set (HIS) data – Mandated reporting of data collected and reported to the Centers for Medicare & Medicaid Services (CMS) at admission and at time of death or discharge. Reporting time frames have been met. We exceed the national benchmark in all elements. Overall, average score at 98%.

  Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey – This is a CMS mandated survey that measures caregiver experience. We exceed the national percentage in all element. See below for details.

Measures were selected from CAHPS domain questions. "Getting Timely Care" and "Getting Support/Emotional" were selected since they were below national average for the past 2 years. We significantly improved both measures.

- Getting timely Care-The goal was to exceed the national average (78%). We are currently at 82.2%: This is a significant improvement since 2018.
- Getting Support/Emotional – Goal of 89%, exceeded target with score of 97.8%.

The graph below reflects real time data through Qtr. 3 from Press Gamey and Percy & Company (our new reporting company)



Employee Engagement Survey

- Employee Engagement Survey was completed in 2019 with 89% staff participation. The Engagement Indicator was 4.32 and was slightly higher than the overall organization score.
- The hospice manager score was 4.2, which was an improvement of 0.12 compared to the last survey
- Findings and action plans: Top employee concerns included documentation burden.
- Substantial revisions with the electronic health record (EMR) workflow. Average documentation time was reduced for a routine visit as well an admission visits. Overall, documentation time for an admission visit was reduced by 1 hour.
- An added benefit with the EMR revisions is better extrapolation of required data for TJC audits.

Policy, Strategic or Tactical Issues

- Successful Joint Commission survey with 4 findings. Policies and processes were changed to resolve issues. All identified deficiencies were addressed and demonstrated compliance in subsequent monitoring.

- Implementation of General In-Patient (GIP) has been put on hold until an in-depth analysis of cost, workflow burden, and impact on hospital mortality rate can be evaluated.
- Efforts are underway to recruit additional qualified RNs by working with HR to meet the referral demands, and not refer to other agencies due to staffing challenges
- We are now accepting complex respiratory patients that had been traditionally referred to other hospice agencies in the past.
- Closely monitoring admission time to the hospice program. Goal is to admit patients within 24 hours. Working on implementation strategies to achieve the 24-hour target in the coming year.
- Working closely with the hospital, palliative care program, and other referral sources to make referrals early to the hospice program to maintain a stable LOS.

Recommendations/Next Steps

- Continue to increase referral sources through monthly collaborative meetings.
- Ongoing pre and post billing monitoring to ensure regulatory requirements are met as well as revenue is collected timely. The hospice office specialist and the patient billing staff will work closely to ensure both previous and current accounts stay current.
- Improvement in financial performance with the adoption of electronic insurance authorizations.
- Community outreach: Provision of more education opportunities for Skilled Nursing Facilities continues. Goal is to be the preferred hospice provider.
- Implementation of General In-Patient (GIP) program in 2020 once analysis is completed. GIP education content is completed for hospital staff, hospice staff and MDs and can be provided as soon as GIP moves forward.
- We have begun a shift in care models that will include LVNs. Registered Nurse extenders such as LVNs, and non-licensed admission liaisons reduce the cost of care, increase the number of patient visits, and increase patient and staff satisfaction.
- Dr. Ryan Howard assumes role of Palliative Care and Hospice Medical Director on April 30 2020. Projections are that a significant increase in number of referrals and earlier referrals will occur under his leadership.

Approvals/Conclusions

In the coming year, Hospice will focus on:

1. Working with key District leadership and staff to implement GIP level of care.
2. Transition to an RN/LVN model of care, which increases patient visits, lowers cost of care, and increases satisfaction for patients and staff.
3. Cultivating relationships with skilled nursing facilities to become the preferred hospice provider.
4. Continued review of profitability, look for means to increase contribution margins, lower cost of care, increase patient satisfaction, increase staff satisfaction, and achieve clinical excellence.

KDHCD ANNUAL BOARD REPORT

Hospice Services

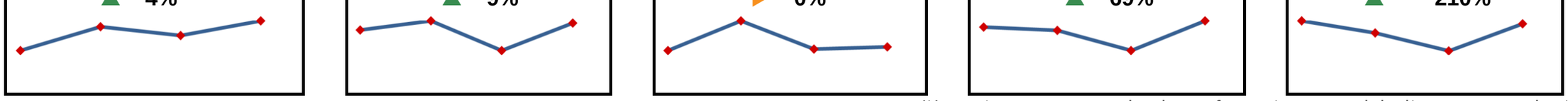
FY2020 Annualized

*** FY 2020 ANNUALIZED ON THE SEVEN MONTHS ENDED JANUARY 31, 2020**

Board Meeting: March 23, 2020

KEY METRICS - FY 2020 ANNUALIZED*

UNIT OF SERVICE (Hospice Days)	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
41,498	$6,919,241	$5,517,725	$1,401,516	$332,954
▲ 4%	▲ 9%	▶ 0%	▲ 69%	▲ 210%



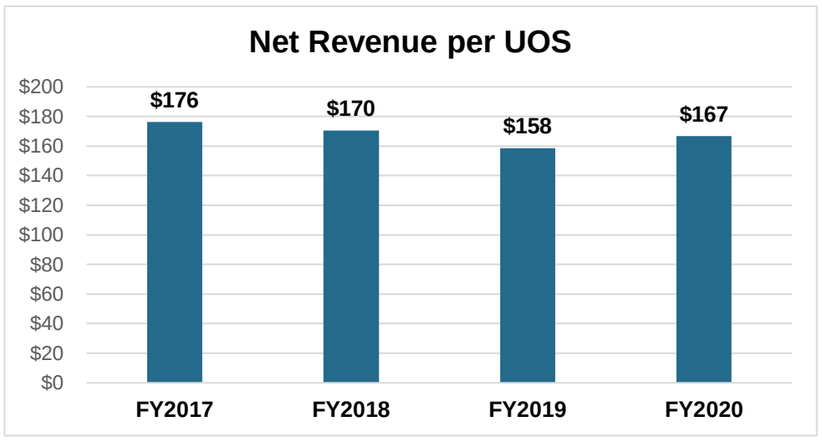
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

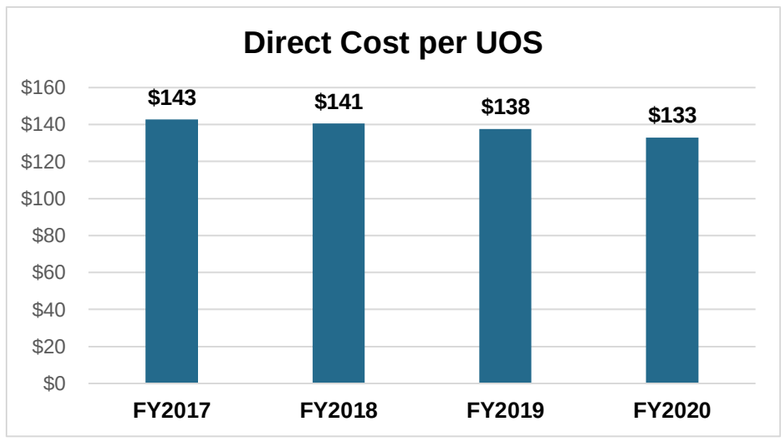
METRICS SUMMARY - 4 YEAR TREND

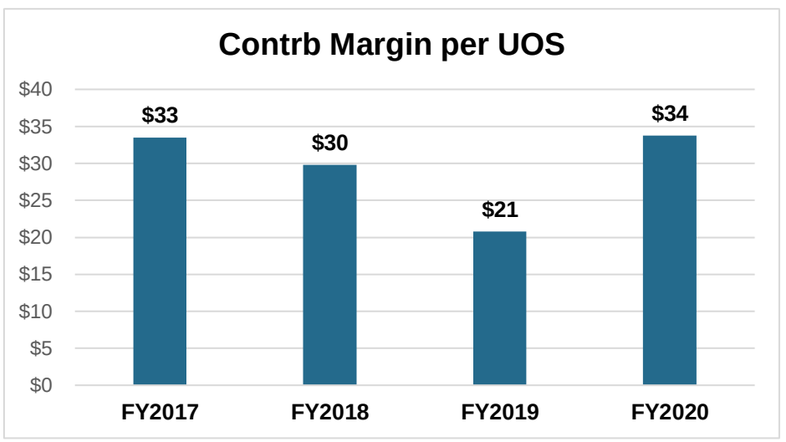
*Annualized

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR		4 YR TREND
Unit of Service (Hospice Days)	38,387	40,878	39,947	41,498	▲	4%	
Net Revenue	$6,768,798	$6,962,860	$6,326,527	$6,919,241	▲	9%	
Direct Cost	$5,483,557	$5,743,789	$5,495,420	$5,517,725	▶	0%	
Contribution Margin	$1,285,241	$1,219,071	$831,107	$1,401,516	▲	69%	
Indirect Cost	$882,544	$1,102,684	$1,132,602	$1,068,562	▼	-6%	
Net Income	$402,697	$116,387	($301,495)	$332,954	▲	210%	
Net Revenue per UOS	$176	$170	$158	$167	▲	5%	
Direct Cost per UOS	$143	$141	$138	$133	▼	-3%	
Contrb Margin per UOS	$33	$30	$21	$34	▲	62%	

PER CASE TRENDED GRAPHS







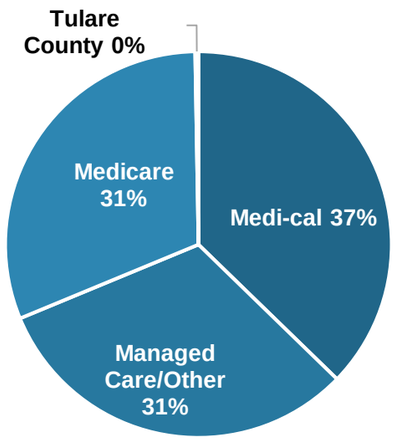
Note: FY2020 is annualized in graphs and throughout the analysis

PAYER MIX - 4 YEAR TREND

*Annualized

PAYER	FY2017	FY2018	FY2019	FY2020
Medi-cal	34%	35%	37%	37%
Managed Care/Other	28%	30%	33%	31%
Medicare	37%	34%	30%	31%
Tulare County	0%	1%	1%	0%
Medi-cal Managed Care	0%	0%	0%	0%
Medicare Managed Care	0%	0%	0%	0%
Work Comp	0%	0%	0%	0%
Cash Pay	0%	0%	0%	0%

FY 2020 Payer Mix - Annualized



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

Maternal Child Health

Tracie Plunkett MSN, RNC-OB, NE-BC
Director Maternal Child Health
tplunket@kdhcd.org
Ph. 624-5338
April 2020

Summary Issue/Service Considered

- Seek opportunities to grow volumes in Labor and Delivery, Post-Partum, Labor Triage, NICU, and Pediatrics.
- Continue to recruit to and develop the Laborist Program.
- Complete recruitment of Neonatologists. Only one open position as of September 2020
- Continue to lower Gestational Age in the Neonatal Intensive Care Unit (NICU).
- Seek opportunities to decrease labor and supply costs.
- Continue to increase exclusive breast-feeding rates for new moms.

Quality/Performance Improvement Data

- HCAHPS Scores for overall patient satisfaction for Fiscal Year 2020 for Postpartum and Labor & Delivery were 79.1%. This surpassed the organizational goal of 76.5
- The exclusive breast-feeding rate for 2019 was 54.5%. This is above the Joint Commission benchmark of 52%.
- The Postpartum Unit continues to focus on increasing Exclusive Breastfeeding. This year a Breastfeeding Bundle was implemented. The bundle included adjusting lactation staff schedules to improve our ability to assist new mothers 7 days a week with breast-feeding. We have shifted half of the lactation staff hours to be spent on the Labor & Delivery, Labor Triage and Antenatal Units to increase the focus on education and commitment prior to delivery. This has allowed patients to have a lactation counselor to be present for the first feeding with is crucial to successful breastfeeding. A new survey was developed and is handed out to our mothers asking them what their feeding preference for their baby was on admission, whether or not they met their goals and why or why not? This has given us valuable information related to when and why patients are failing to achieve exclusive breastfeeding of their babies. We will continue to use feeding orders to help increase collaboration with our physician staff when a mother decides to formula feed. In collaboration with the Information Technology (IT) Department, we now have a report to that shows us exactly when a patient fails to meet their goal of exclusive breastfeeding and who was caring for the patient at that time. This allows us to follow up and coach or make improvements where indicated. We have started a new Breast is Best Committee. This includes members of all areas of MCH as well as leaders and physicians. This committee reviews the patients who did not meet their goals. Subsequently, their nurse and physician come to the meeting to discuss the barriers that caused their patient not to meet their goal of exclusive breastfeeding. These actions have caused our current breastfeeding rates to improve to 60% for July and 64% for August.

- The Neonatal Intensive Care Unit (NICU) continues to participate in the California Perinatal Quality Care Collaborative (CPQCC). The NICU has had zero Ventilator Associated Pneumonia (VAP) and one Central Line Associated Blood Stream Infection (CLABSI) for 2019. NICU continues to hire new nursing staff and develop them with the new core curriculum for all NICU and Respiratory Therapists working in the NICU. This education is focused on the care of Very Low Birth Weight (VLBW) Babies. We have been successful in our ability to keep more VLBW babies in our NICU and keeping them in our community. We have been successful in keeping babies as low as 26 weeks gestation weighing 800 grams, for the duration of their care through discharge. The NICU Staff are growing in their abilities to care for these tiny patients every day.
- The Clinical Partnership Committee continues to meet and collaborate on our pediatric and neonatal population in all areas of the hospital where these patients are cared for. This includes members from multiple disciplines including physicians and nurses from NICU, Pediatrics, and ED, pharmacists, radiology staff, case managers, Performance Improvement, and Respiratory Therapy.
- New Perinatal Safety Committee started May 2019. This committee includes physicians, managers and staff from all Maternal Child Health Departments, plus members from the Anesthesia Department. Topics that this committee has worked on are collaborating with the Maternal Fetal Medicine Physicians to develop workflows to get patient information sent to us in order to develop plans of care for high-risk patients prior to admission. We have also developed the Early Recovery after C-section (ERAC) Program. This is similar to the Early Recovery After Surgery (ERAS) Program, which was implemented in the Main Operating Rooms for orthopedic and gastrointestinal surgeries. This committee has been on hold during the COVID Pandemic; however, we will start meeting again this fall.
- Labor and Delivery continues to participate in the California Maternal Quality Care Collaborative (CMQCC) Program to develop policies and procedures to minimize non-medically indicated (elective) deliveries before 39 weeks gestation, also known as Early Elective Deliveries (EED). We achieved an EED rate of zero for 2019.The current benchmark for this measure is Zero. We continue to monitor administration of Antenatal Steroids for patients between 24-34 weeks gestation who are at risk for pre-term delivery where we are 100% compliant for 2019. Primary C-Section Rates for Low Risk Pregnancies is another area we continue working on and are at 24.7% for 2019, the state average is 24%. Nitrous Oxide is a new service, introduced to Kaweah Delta Labor & Delivery as another tool available for patients to help them cope with the discomfort and pain of labor. Labor & Delivery implemented a new Mentor Program for registered nurses. This is a one-year program that has enhanced the process of onboarding new nursing staff into the department; extending past the initial orientation period. Staff in this program will be assigned a “mentor” nurse as a resource for one year following orientation. Staff are required to complete a debrief checklist after each shift to identify any issues, concerns, or things that went well. Newly hired nursing staff will also attend scheduled meetings every two to three weeks with managers and leaders for a period of one year after completing orientation. This allows leaders to identify any issues that could be barriers to the staffs’ success and ultimately the loss of that nurse if not addressed. New staff have voiced appreciation for this program and it seems to have helped in retention of new nursing staff.
- Pediatrics is at zero for Central Line Associated Blood Stream Infections (CLABSI) and Catheter Associated Urinary Tract Infections (CAUTI). Pediatrics had four patient falls in 2019. Collaboration between the Pediatric Nursing Department and the Pediatric Hospitalist Physicians has led to the implementation of a very robust Pediatric Rapid Response Team (RRT). This team responds to all Pediatric RRT’s in the hospital including the Emergency Department. A Pediatric Code White/RRT Policy has been developed and is currently going through the approval process. The whole Pediatric Department in collaboration with the Emergency Department staff, physicians, educators and leaders are responsible for making this happen for the betterment and safety of our pediatric patients in all areas.

Policy, Strategic or Tactical Issues

- Valley Children's' Medical Group continues to provide Pediatric Hospitalist and Neonatology Services to our patients. All Pediatric Hospitalist positions are now filled. All Neonatologist positions are filled except for one. The last position has been offered to a viable candidate and we are waiting confirmation of his acceptance. We are no longer using Neonatal Nurse Practitioners (NNP) in the NICU. We staff 24/7 with on-site neonatologists.
- The Laborist Program was implemented on March 16, 2019. This program will and has improved patient safety for all Obstetrical Patients in the hospital. To date this program is going very well. The goal of this program is to provide 24/7 on site Obstetric Physician coverage. We continue to recruit for this program. Currently we are able to staff night shift and 24-hour weekend coverage on site. Day shifts are covered with off-site providers. However, progress is being made, in that recently, we have been able to staff 2 days shifts per week on-site as well.
- The New 23 Bed NICU Unit was complete and occupied in April 2020.
- Nitrous Oxide Gas for pain management was implemented in July 2019. This is widely used in labor and delivery units across the nation, and is a very safe less invasive alternative for those patients who are not candidates or do not desire an epidural for pain relief and do not want narcotics.

Recommendations/Next Steps

- Continue to encourage Shared Governance and Unit Based Councils, as well as participation in our Comprehensive Unit Based Safety Programs (CUSP). Implement the Just Culture Program throughout our Departments. These initiatives have continued with minor interruption during the COVID Pandemic. Staff are engaged and invested in these committees as a way to work together for the good of our patients and to improve workflows.
- Collaborate with Marketing to promote our Labor Triage Unit, our NICU and Maternal Fetal Medicine Program, Laborist Program and Pediatric Departments. Marketing has been very instrumental in communicating with our community during the COVID Pandemic.
- Continue to collaborate with our Emergency Department Colleagues to improve pediatric care and outcomes. There was much collaboration with the Emergency Department over the last year to improve care for pediatric patients in the hospital.
- Collaborate with Marketing and Physicians' offices to promote breastfeeding as the most beneficial and preferred way to feed your baby, as well as informing the public about breastfeeding classes offered.
- Support new Obstetrician's and Pediatricians practicing at Kaweah Delta. Continue to recruit Obstetricians to the Kaweah Delta Clinic to increase those participating in our Laborist Program and increase on site coverage in the daytime hours.
- Fill the last Neonatologist Position
- Continue to hire and fill all nursing vacancies in the Maternal Child Health areas. We will continue to over-hire to address the staffing issues related to employees on Leaves of Absence. We will continue the mentor program and roll out to all Maternal Child Health Units as a way to address nurse retention. Maternal Child Health is very close to being fully staffed.

Approvals/Conclusions

- Strive for overall quality outcomes and set goals to continue to improve.

- OB/Delivery: Volume decreased by 4%. We are unsure of the reason for this decline. It has been very difficult to get out-migration data. According to vital statistics data, the surrounding hospitals in Tulare County are also lower than usual. Staff and physicians who work in other hospitals in Kings and Fresno Counties are not reporting any increase there to indicate that patients are going elsewhere.
- NICU: Patient cases are up by 3%, patient days are slightly down, and Average Length of Stay is slightly down.
- Pediatrics: Admissions remained the same, patient days increased by 7%, Average Length of Stay was slightly up.
- Labor Triage: Visits increased by 4%
- Contribution Margin: Contribution margin for the Maternal Child Health Service Lines was $14,946,956 for Fiscal Year 20. This is lower than Fiscal Year 19, however, it was noted by finance that Fiscal Year 19 was an unusually high performing year across the board in the organization. Fiscal Year 20 is comparable with Fiscal Year 18.
- Net Patient Revenue: Net patient revenue is again lower than 2019 but $4,000,000 higher than Fiscal Year 18, for all Maternal Child Health Departments combined. Of note is that due to our payor mix we received $3,000,000 less in additional reimbursement than last year.
- Direct Costs: Direct Costs are up 5%.This was primarily due to special pay practices implemented to staff the Labor & Delivery and NICU Departments. The use of contract labor or Travel Nurses has continued to be necessary to cover the open positions and Leaves of Absences experienced on these nursing units. There were 13 open nursing positions on Labor & Delivery last year. We have also experienced nursing turn over in the NICU with 10 vacancies and multiple Leaves of Absence at the same time. Currently Labor and Delivery has only one open position and the NICU has two open positions. We have eliminated Travel Nurses on Labor & Delivery and in the NICU. We will continue to hire staff to fill vacancies and to fill gaps from those on leaves of absence. The cost of the Locum Neonatal Nurse Practitioners continued through March. They were eliminated as of April 2020. The staffing model for the NICU has been changed to an all Neonatologist model and we will no longer staff with NNP's. This will include one Neonatologist 24/7 on site with two for eight hours during daytime. All positions are filled with the exception of one, which has been offered to a viable candidate. Until the last position is filled we will continue to have one locum neonatologist in the NICU, however the cost of locum NNP's has been eliminated.

KDHCD ANNUAL BOARD REPORT

Maternal Child Health Services - Summary

FY2020 Annualized

*FY 2020 ANNUALIZED ON THE NINE MONTHS ENDED MARCH 31, 2020

Board Meeting: April 27, 2020

KEY METRICS - FY 2020 ANNUALIZED*

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
17,167	$58,208,361	$43,261,405	$14,946,956	$296,822
▼ -1%	▼ -9%	▲ 5%	▼ -35%	▼ -96%

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

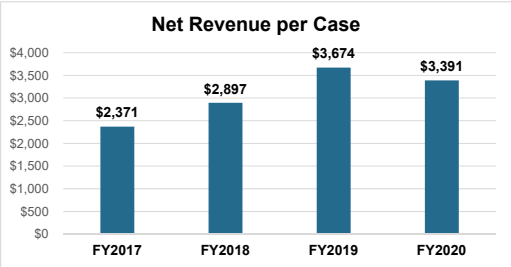
METRICS BY SERVICE LINE - FY 2020 ANNUALIZED*

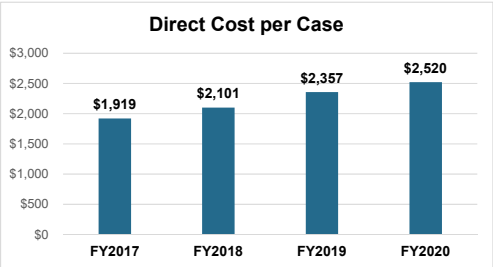
SERVICE LINE	PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME	CONTRB MARGIN PER CASE
OB/Delivery	4,539	$29,313,686	$18,655,269	$10,658,417	$3,173,633	$2,348
Normal Newborns	3,097	$5,004,195	$2,957,551	$2,046,644	$842,595	$661
Neonatology	1,555	$17,723,154	$14,873,209	$2,849,944	($359,688)	$1,833
Pediatrics	369	$3,037,655	$2,708,363	$329,292	($759,281)	$892
Outpatient OB	7,292	$1,015,363	$2,830,837	($1,815,474)	($3,031,225)	($249)
Other OB	315	$2,114,308	$1,236,176	$878,132	$430,788	$2,791
Maternal Child Health Total	17,167	$58,208,361	$43,261,405	$14,946,956	$296,822	$871

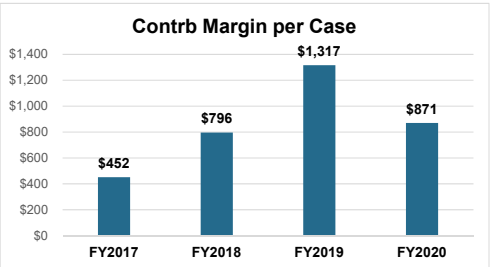
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	*Annualized FY2020	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	17,738	18,201	17,399	17,167	▼ -1%	
Net Revenue	$42,057,704	$52,726,617	$63,915,541	$58,208,361	▼ -9%	
Additional Reimb	$0	$2,529,731	$19,329,281	$16,160,237	▼ -16%	
Direct Cost	$34,046,286	$38,231,635	$41,008,461	$43,261,405	▲ 5%	
Contribution Margin	$8,011,418	$14,494,982	$22,907,080	$14,946,956	▼ -35%	
Indirect Cost	$11,842,321	$14,672,838	$15,057,624	$14,650,134	▼ -3%	
Net Income	($3,830,903)	($177,856)	$7,849,456	$296,822	▼ -96%	
Net Revenue per Case	$2,371	$2,897	$3,674	$3,391	▼ -8%	
Direct Cost per Case	$1,919	$2,101	$2,357	$2,520	▲ 7%	
Contrb Margin per Case	$452	$796	$1,317	$871	▼ -34%	

GRAPHS







Report Notes:

1.) First 5 funding was effective FY 2018 and prior. The funds were netted against expenses in cost accounting for the appropriate time periods. The annual amount of funding was $781,000.

2.) Cost accounting changes were made for physician contract expense allocation. The changes were made for all four years.

KDHCD ANNUAL BOARD REPORT

FY2020 Annualized

Maternal Child Health Services - Inpatient OB/Delivery Service Line

*FY 2020 ANNUALIZED ON THE NINE MONTHS ENDED MARCH 31, 2020

Board Meeting: April 27, 2020

KEY METRICS - FY 2020 ANNUALIZED*

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
4,539	$29,313,686	$18,655,269	$10,658,417	$3,173,633
▼ -4%	▼ -4%	▲ 4%	▼ -17%	▼ -39%

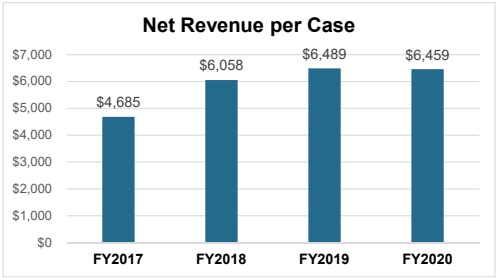
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

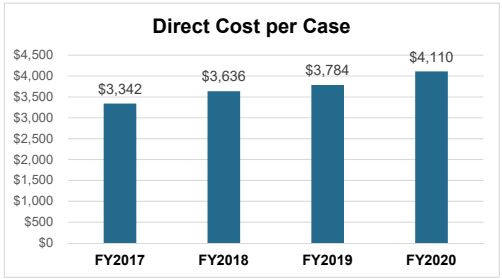
METRICS SUMMARY - 4 YEAR TREND

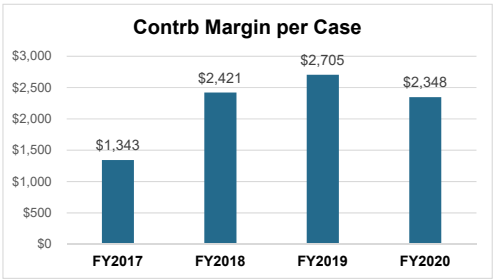
*Annualized

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	4,484	4,627	4,730	4,539	▼ -4%	
Patient Days	9,246	9,414	9,920	9,269	▼ -7%	
ALOS	2.06	2.03	2.10	2.04	▼ -3%	
Net Revenue	$21,006,534	$28,028,884	$30,693,350	$29,313,686	▼ -4%	
Additional Reimb	$0	$930,409	$7,402,664	$6,896,535	▼ -7%	
Direct Cost	$14,983,553	$16,825,279	$17,896,955	$18,655,269	▲ 4%	
Contribution Margin	$6,022,980	$11,203,605	$12,796,395	$10,658,417	▼ -17%	
Indirect Cost	$6,333,095	$7,970,117	$7,567,637	$7,484,784	▼ -1%	
Net Income	($310,114)	$3,233,487	$5,228,758	$3,173,633	▼ -39%	
Net Revenue per Case	$4,685	$6,058	$6,489	$6,459	▶ 0%	
Direct Cost per Case	$3,342	$3,636	$3,784	$4,110	▲ 9%	
Contrb Margin per Case	$1,343	$2,421	$2,705	$2,348	▼ -13%	

PER CASE TRENDED GRAPHS







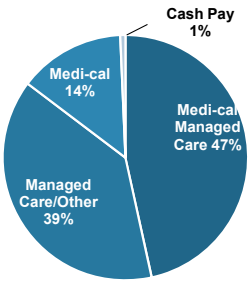
Note: FY2020 is annualized in graphs and throughout the analysis

PAYER MIX - 4 YEAR TREND

*Annualized

PAYER	FY2017	FY2018	FY2019	FY2020
Medi-cal Managed Care	44%	45%	47%	47%
Managed Care/Other	40%	38%	38%	39%
Medi-cal	15%	16%	15%	14%
Cash Pay	0%	0%	0%	1%
Medicare	0%	0%	0%	0%
Medicare Managed Care	0%	0%	0%	0%
Work Comp	0%	0%	0%	0%
Tulare County	0%	0%	0%	0%

FY 2020 Payer Mix - Annualized



Report Notes:

1.) First 5 funding was effective FY 2018 and prior. The funds were netted against expenses in cost accounting for the appropriate time periods. The annual amount of funding was $781,000.

KDHCD ANNUAL BOARD REPORT

FY2020 Annualized

Maternal Child Health Services - Inpatient Normal Newborns Service Line

*FY 2020 ANNUALIZED ON THE NINE MONTHS ENDED MARCH 31, 2020

Board Meeting: April 27, 2020

KEY METRICS - FY 2020 ANNUALIZED*

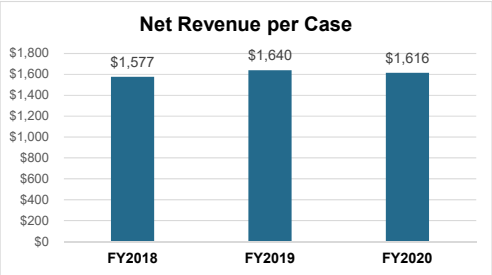
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
3,097	$5,004,195	$2,957,551	$2,046,644	$842,595
▼ -8%	▼ -10%	▼ -1%	▼ -20%	▼ -33%

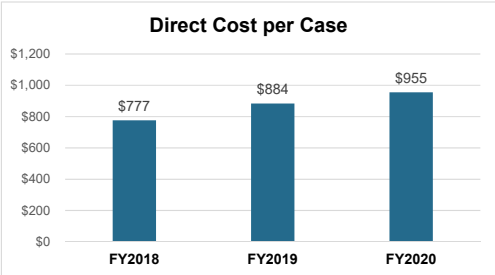
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

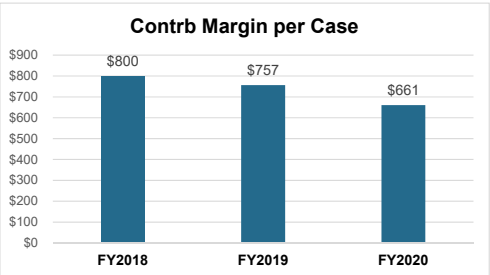
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020 *Annualized	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	2,950	3,021	3,383	3,097	▼ -8%	
Patient Days	4,599	4,665	5,064	4,480	▼ -12%	
ALOS	1.56	1.54	1.50	1.45	▼ -3%	
Net Revenue	$4,261,639	$4,764,714	$5,549,094	$5,004,195	▼ -10%	
Additional Reimb	$0	$172,627	$1,271,569	$1,118,829	▼ -12%	
Direct Cost	$1,977,033	$2,347,043	$2,989,801	$2,957,551	▼ -1%	
Contribution Margin	$2,284,606	$2,417,671	$2,559,293	$2,046,644	▼ -20%	
Indirect Cost	$809,030	$1,077,212	$1,310,773	$1,204,050	▼ -8%	
Net Income	$1,475,576	$1,340,459	$1,248,520	$842,595	▼ -33%	
Net Revenue per Case	$1,445	$1,577	$1,640	$1,616	▼ -2%	
Direct Cost per Case	$670	$777	$884	$955	▲ 8%	
Contrb Margin per Case	$774	$800	$757	$661	▼ -13%	

PER CASE TRENDED GRAPHS





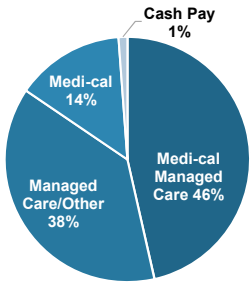


Note: FY2020 is annualized in graphs and throughout the analysis

PAYER MIX - 3 YEAR TREND

PAYER	FY2018	FY2019	FY2020 *Annualized
Medi-cal Managed Care	44%	47%	46%
Managed Care/Other	39%	37%	38%
Medi-cal	16%	16%	14%
Cash Pay	1%	1%	1%
Medicare	0%	0%	0%
Medicare Managed Care	0%	0%	0%
Work Comp	0%	0%	0%
Tulare County	0%	0%	0%

FY 2020 Payer Mix - Annualized



Report Notes:

1.) First 5 funding was effective FY 2018 and prior. The funds were netted against expenses in cost accounting for the appropriate time periods. The annual amount of funding was $781,000

KDHCD ANNUAL BOARD REPORT

FY2020 Annualized

Maternal Child Health Services - Inpatient Neonatology Service Line

*FY 2020 ANNUALIZED ON THE NINE MONTHS ENDED MARCH 31, 2020

Board Meeting: April 27, 2020

KEY METRICS - FY 2020 ANNUALIZED*

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
1,555	$17,723,154	$14,873,209	$2,849,944	($359,688)
▲ 3%	▼ -15%	▲ 8%	▼ -60%	▼ -110%

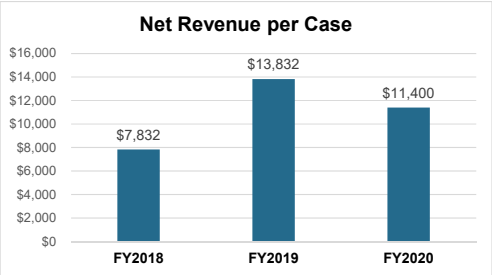
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

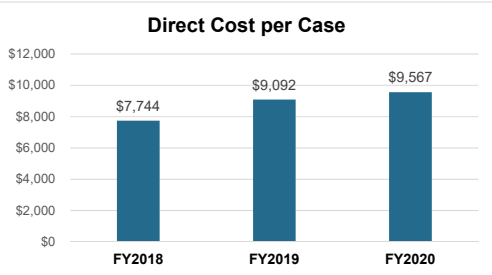
METRICS SUMMARY - 4 YEAR TREND

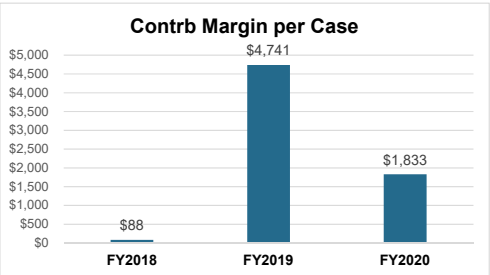
*Annualized

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	1,704	1,740	1,511	1,555	▲ 3%	
Patient Days	6,960	6,950	7,368	6,835	▼ -7%	
ALOS	4.08	3.99	4.88	4.40	▼ -10%	
Net Revenue	$12,065,026	$13,627,818	$20,900,849	$17,723,154	▼ -15%	
Additional Reimb	$0	$1,250,518	$8,937,710	$6,551,016	▼ -27%	
Direct Cost	$12,295,899	$13,474,967	$13,737,572	$14,873,209	▲ 8%	
Contribution Margin	($230,873)	$152,851	$7,163,277	$2,849,944	▼ -60%	
Indirect Cost	$2,985,396	$3,581,772	$3,419,986	$3,209,632	▼ -6%	
Net Income	($3,216,270)	($3,428,921)	$3,743,291	($359,688)	▼ -110%	
Net Revenue per Case	$7,080	$7,832	$13,832	$11,400	▼ -18%	
Direct Cost per Case	$7,216	$7,744	$9,092	$9,567	▲ 5%	
Contrb Margin per Case	($135)	$88	$4,741	$1,833	▼ -61%	

PER CASE TRENDED GRAPHS







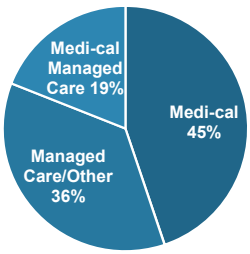
Note: FY2020 is annualized in graphs and throughout the analysis

PAYER MIX - 3 YEAR TREND

*Annualized

PAYER	FY2018	FY2019	FY2020	
Medi-cal	22%	51%	45%	
Managed Care/Other	31%	31%	36%	
Medi-cal Managed Care	47%	18%	19%	*
Cash Pay	0%	1%	0%	
Medicare	0%	0%	0%	
Medicare Managed Care	0%	0%	0%	
Work Comp	0%	0%	0%	
Tulare County	0%	0%	0%	

FY 2020 Payer Mix - Annualized



Report Notes:

1.) First 5 funding was effective FY 2018 and prior. The funds were netted against expenses in cost accounting for the appropriate time periods. The annual amount of funding was $781,000.

KDHCD ANNUAL BOARD REPORT

FY2020 Annualized

Maternal Child Health Services - Inpatient Pediatrics (Age < 14)

Exludes Normal Newborn, OB/Delivery and Neonatology Service Lines

***FY 2020 ANNUALIZED ON THE NINE MONTHS ENDED MARCH 31, 2020**

Board Meeting: April 27, 2020

KEY METRICS - FY 2020 ANNUALIZED*

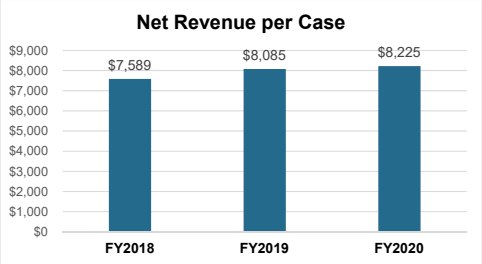
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
369	$3,037,655	$2,708,363	$329,292	($759,281)
▶ 0%	▲ 2%	▲ 10%	▼ -36%	▼ -45%

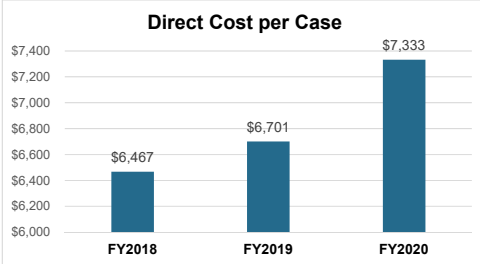
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

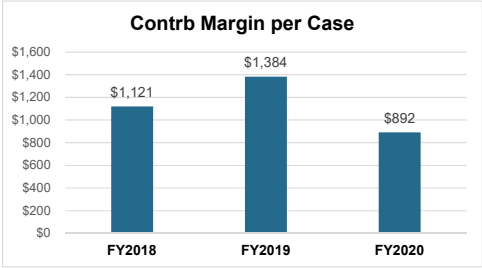
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	*Annualized FY2020	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	425	402	369	369	▶ 0%	
	927	918	845	908	▲ 7%	
ALOS	2.18	2.28	2.29	2.46	▲ 7%	
Net Revenue	$2,413,833	$3,050,589	$2,983,470	$3,037,655	▲ 2%	
Additional Reimb	$0	$103,108	$917,737	$1,023,032	▲ 11%	
Direct Cost	$2,468,071	$2,599,773	$2,472,852	$2,708,363	▲ 10%	
Contribution Margin	($54,239)	$450,816	$510,618	$329,292	▼ -36%	
Indirect Cost	$812,087	$723,076	$1,035,021	$1,088,573	▲ 5%	
Net Income	($866,326)	($272,260)	($524,403)	($759,281)	▼ -45%	
Net Revenue per Case	$5,680	$7,589	$8,085	$8,225	▲ 2%	
Direct Cost per Case	$5,807	$6,467	$6,701	$7,333	▲ 9%	
Contrb Margin per Case	($128)	$1,121	$1,384	$892	▼ -36%	

PER CASE TRENDED GRAPHS



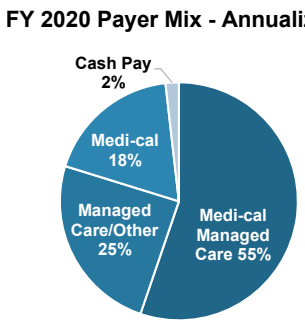




Note: FY2020 is annualized in graphs and throughout the analysis

PAYER MIX - 3 YEAR TREND

PAYER	FY2018	FY2019	*Annualized FY2020
Medi-cal Managed Care	64%	66%	55%
Managed Care/Other	20%	17%	25%
Medi-cal	15%	17%	18%
Cash Pay	0%	0%	2%
Medicare	0%	0%	0%
Medicare Managed Care	0%	0%	0%
Work Comp	0%	0%	0%
Tulare County	0%	0%	0%



Report Notes:

1.) First 5 funding was effective FY 2018 and prior. The funds were netted against expenses in cost accounting for the appropriate time periods. The annual amount of funding was $781,000.

KDHCD ANNUAL BOARD REPORT

FY2020 Annualized

Maternal Child Health Services - Outpatient Obstetrics Service Line

*FY 2020 ANNUALIZED ON THE NINE MONTHS ENDED MARCH 31, 2020

Board Meeting: April 27, 2020

KEY METRICS - FY 2020 ANNUALIZED*

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
7,292	$1,015,363	$2,830,837	($1,815,474)	($3,031,225)
▲ 4%	▲ 12%	▲ 15%	▼ -16%	▼ -12%

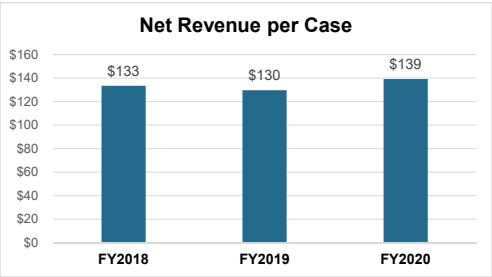
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

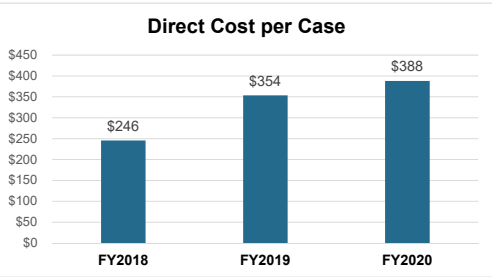
METRICS SUMMARY - 4 YEAR TREND

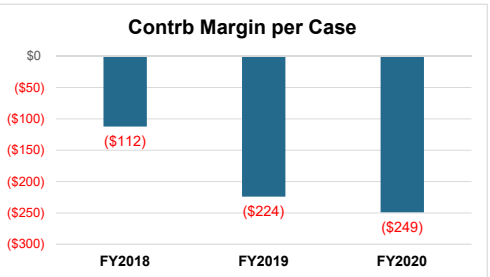
*Annualized

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	7,879	8,091	6,987	7,292	▲ 4%	
Net Revenue	$951,521	$1,079,809	$906,446	$1,015,363	▲ 12%	
Direct Cost	$1,527,092	$1,986,707	$2,471,354	$2,830,837	▲ 15%	
Contribution Margin	($575,571)	($906,898)	($1,564,908)	($1,815,474)	▼ -16%	
Indirect Cost	$627,154	$916,340	$1,143,303	$1,215,751	▲ 6%	
Net Income	($1,202,725)	($1,823,238)	($2,708,211)	($3,031,225)	▼ -12%	
Net Revenue per Case	$121	$133	$130	$139	▲ 7%	
Direct Cost per Case	$194	$246	$354	$388	▲ 10%	
Contrb Margin per Case	($73)	($112)	($224)	($249)	▼ -11%	

PER CASE TRENDED GRAPHS







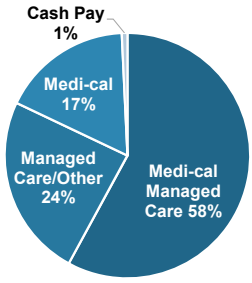
Note: FY2020 is annualized in graphs and throughout the analysis

PAYER MIX - 3 YEAR TREND

*Annualized

PAYER	FY2018	FY2019	FY2020
Medi-cal Managed Care	55%	61%	58%
Managed Care/Other	22%	23%	24%
Medi-cal	22%	16%	17%
Cash Pay	1%	0%	1%
Medicare	0%	0%	0%
Work Comp	0%	0%	0%
Medicare Managed Care	0%	0%	0%
Tulare County	0%	0%	0%

FY 2020 Payer Mix - Annualized



Report Notes:

1.) First 5 funding was effective FY 2018 and prior. The funds were netted against expenses in cost accounting for the appropriate time periods. The annual amount of funding was $781,000.

KDHCD ANNUAL BOARD REPORT

FY2020 Annualized

Maternal Child Health Services - Inpatient Other OB Service Line

*FY 2020 ANNUALIZED ON THE NINE MONTHS ENDED MARCH 31, 2020

Board Meeting: April 27, 2020

KEY METRICS - FY 2020 ANNUALIZED*

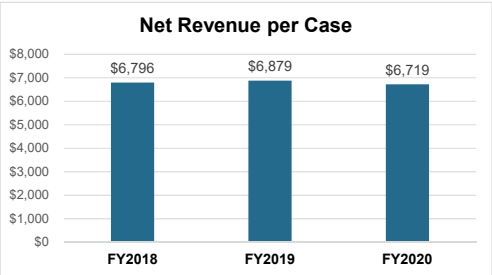
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
315	$2,114,308	$1,236,176	$878,132	$430,788
▼ -25%	▼ -27%	▼ -14%	▼ -39%	▼ -50%

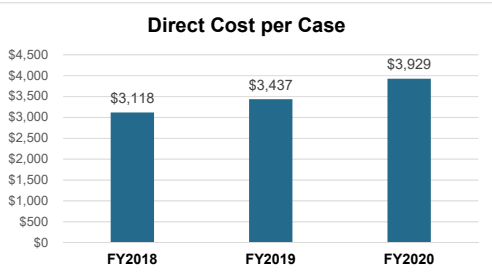
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

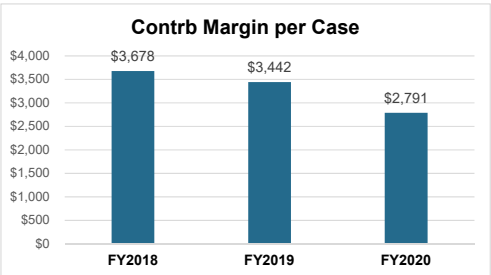
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	*Annualized FY2020	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	296	320	419	315	▼ -25%	
	596	716	984	751	▼ -24%	
ALOS	2.01	2.24	2.35	2.39	▲ 2%	
Net Revenue	$1,359,152	$2,174,803	$2,882,332	$2,114,308	▼ -27%	
Additional Reimb	$0	$73,070	$799,600	$570,824	▼ -29%	
Direct Cost	$794,637	$997,866	$1,439,927	$1,236,176	▼ -14%	
Contribution Margin	$564,515	$1,176,937	$1,442,405	$878,132	▼ -39%	
Indirect Cost	$275,559	$404,319	$580,903	$447,344	▼ -23%	
Net Income	$288,956	$772,617	$861,501	$430,788	▼ -50%	
Net Revenue per Case	$4,592	$6,796	$6,879	$6,719	▼ -2%	
Direct Cost per Case	$2,685	$3,118	$3,437	$3,929	▲ 14%	
Contrb Margin per Case	$1,907	$3,678	$3,442	$2,791	▼ -19%	

PER CASE TRENDED GRAPHS





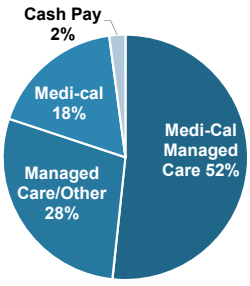


Note: FY2020 is annualized in graphs and throughout the analysis

PAYER MIX - 3 YEAR TREND

PAYER	FY2018	FY2019	*Annualized FY2020
Medi-Cal Managed Care	50%	55%	52%
Managed Care/Other	27%	26%	28%
Medi-cal	23%	18%	18%
Cash Pay	0%	1%	2%
Medicare	0%	0%	0%
Medicare Managed Care	0%	0%	0%
Work Comp	0%	0%	0%
Tulare County	1%	0%	0%

FY 2020 Payer Mix - Annualized



Report Notes:

1.) First 5 funding was effective FY 2018 and prior. The funds were netted against expenses in cost accounting for the appropriate time periods. The annual amount of funding was $781,000.

Skilled Nursing Facility (SNF): Transitional Care Services (TCS South and West Campus) and Subacute Care Services: Fiscal Year 2020

Lisa Harrold, Administrator (559) 624-3854
March 13, 2020

Summary Issue/Service Considered

- **TCS South Campus (22 bed unit):**
  - Average daily census was 16, compared to 15 the prior fiscal year. Census was somewhat suppressed in fiscal year 2019 due to a roof replacement project that reduced bed capacity for approximately 5 months.
  - Net revenue per day has increased to $544 from $461 the prior year, an increase of 18%, and overall net revenue increased by 25%. Payment under the new payment model, Patient Driven Payment Model (PDPM) that began Oct 1, 2019 appears to be higher, with an average net revenue per day of $565 since Oct 1.
  - Payer mix is fairly stable, with some increase noted in Medi-Cal managed care and in commercial insurance.
  - The overall contribution margin remained negative, though improved from prior year by approximately 13%. Direct expense per day increased from $706 to $745, a 6% increase. Staff hours per patient day decreased by 8%, so the added direct costs are a reflection of increased salary expense and increased ancillary costs.

  - **Short Stay (SS)Ortho West Campus (16 bed unit):**
  - Average daily census of 14.23, an increase of 9% from prior year.
  - Net revenue increased from $502 to $565 per day.
  - Direct costs per day increased by 3% from $545 to $561. Hours per patient day increased compared to prior year, and hours per unit of service are running about 5% over budget, representing $18 per patient day in added cost. In addition, some new allocated administrative expenses were added from departments such as the float pool and bed allocation. Patient and family services and case management allocations to this unit also increased significantly. The allocated administrative costs increased by $32 per patient day, the most significant of the direct expense increases for this department
  - Contribution margin is positive at $23,128, a 111% improvement compared to prior year. The program has shown a positive contribution margin each month since the payment model was changed in October.

- **Sub acute (32 bed unit):**
  - Average daily census year to date is 29.8, a decrease of one patient from prior year.
  - Payer mix has remained fairly stable, with Medi-Cal remaining the dominant payer at 90% over the past few years, but with an increasing percentage of that coming from managed care rather than fee for service Medi-Cal.
  - Net revenue per day of $793 is a 2% increase from prior year, which was negatively impacted by the 25% timely filing penalties incurred during the Cerner conversion.

- Direct cost per day increased to $718 from $679 prior year, a 6% increase. Staff productivity has dropped about 3% from prior year, with lower census a contributing factor. There was also an increase in allocated administrative costs due to increased physician fees (dentist, medical director), increased time to complete the patient assessments that determine payment due to new payment model, and leadership transition resulting in overlap of hours between outgoing and incoming nursing directors. Case management costs per patient day have also increased as have pharmacy costs. Pharmacy leadership is reviewing this data to assist in identification of any actionable items, but that review is not yet completed. The other area of significant daily cost increase over the past three years is in respiratory therapy. There were initially issues during the Cerner conversion with charges being doubled, so investigation is under way to see if the service line report is still capturing data that overstates those costs.
- As a result of these factors, contribution margin remained positive, at $809,972, but remains significantly lower than prior years. Direct expenses have increased $148 per patient day since 2017. $32, or 22% is due to increased expenses for nursing care. The remaining 78% is in allocated direct expenses.

Combined contribution margin for the District SNF program: ($320,596), a 28% improvement from prior year. As detailed in later sections of this report, some changes that will positively impact future revenue include:

- Performance in the top 3% of skilled nursing facilities nationwide on the Value Based Purchasing measure on readmissions, resulting in a 3% bonus on Medicare Fee for Service payments for federal fiscal year 2020.
- Ongoing improved payment under PDPM payment model.

Quality/Performance Improvement Data

- U.S. News and World Report recognized Kaweah Delta's short term skilled nursing program as a top nursing home in the country, placing the facility in the top 19% of facilities nationwide. This award is based on a comprehensive review of quality data, outcomes and evidence of a patient centered approach to care.
- The overall rating of District skilled nursing programs in the Centers for Medicare/Medicaid Services (CMS) 5 star Nursing Home Compare rating program is currently 5 stars. The program continues to average 5 out of 5 stars. Highlights of these results include no long term residents with falls with major injury or urinary tract infections in the last 5 quarters. In the top 1% of facilities for total falls. No short term residents with new or worsened pressure ulcers. Higher return to home percentages and lower readmissions and emergency room visits for short term residents.
- Continued focus on reduction of urinary tract infection together with antibiotic stewardship to ensure that antibiotics are used only when indicated and that the appropriate antibiotic is used. An infection preventionist is now based part time in the skilled nursing arena, and is working closely with staff and leadership to monitor practice, provide education, analyze data and recommend improvement strategies.
- Skilled Nursing Value Based Purchasing involves one measure, all cause readmissions. Kaweah Delta's program again achieved the highest attainable program rank, resulting in bonus payments of 3% on all Medicare fee for service claims submitted between Oct 1, 2019 –Sept 30 2020. Clinical leadership and medical directors are conducting ongoing monitoring of all readmissions to evaluate and correct preventable causes of readmissions.

Policy, Strategic or Tactical Issues

- Efforts are underway to expand the skilled nursing beds at the rehabilitation hospital by converting 7 acute rehab beds to skilled nursing. The acute rehab program will maintain 38 beds, adequate for current demand while also preserving the quiet hall that allows for a healing environment for neurologically impaired patients. The skilled nursing program will then have 23 beds, and will expand its scope to include admissions for patients whose medical needs are more complex than could typically be managed in the skilled nursing environment but who no longer need to be in the acute care environment. This should help with overall throughput for the organization.
- Monitor results of payment under the revised payment model for skilled nursing. Early data indicates that payments will on average be higher than costs for Medicare fee for service patients, which has not historically been the case. The new model focuses on patient characteristics that drive care costs, and shifts reimbursement away from rehabilitation and more to medical management.
- 2019 annual CDPH survey was very successful, with a total of 3 findings on the federal standards and no findings on the Title 22 standards. All identified deficiencies were addressed and demonstrated 100% compliance in subsequent monitoring.
- Physical plant improvement during the year included replacement of the roof, as well as flooring updates in the therapy area.
- We continue our engagement with California Hospital Association Center for Post-Acute Care through involvement with advisory board and participation in the skilled nursing monthly forum for members.
- The referral process has been consolidated, with all referrals to our inpatient post acute settings (acute rehab, Short Stay unit, Transitional Care Services, Subacute) at both south and west campuses being managed by the same team of nurse liaisons. This should assist with keeping our skilled nursing beds more consistently filled. A liaison is now based at the medical center in order to meet in person with patients and families as well as round with clinical staff to facilitate appropriate referrals.

Recommendations/Next Steps

- Obtain necessary licensure to adjust bed configuration at the rehabilitation hospital. Restructure staffing and leadership to reflect the changes in patient composition and program size of the short stay program. Work with involved staff to address workflow issues that negatively impact employee satisfaction.
- Continue our work to monitor transfers to acute care during skilled nursing stay as well as acute care re-admissions after discharge to community. Work together with our medical directors to identify any trends, and develop action plans to minimize re-admissions.
- Maintain 5 star rating for the facility.
- Optimize effectiveness of new Cerner product by ensuring accuracy of data entry, and coaching team with best charting practices, particularly in documentation that will impact the MDS Assessment submissions and billing.
- Continue close partnership with LTC pharmacist and KD antimicrobial stewardship program.
- Continue to support and grow our unit based safety (CUSP) team on South Campus; develop a CUSP team for West Campus. Continue to work on safety issues identified by CUSP teams, as well as by annual Safety Attitudes Questionnaire
- Ensure full implementation of new requirements in the conditions of participation.

Approvals/Conclusions

- Assure compliance with all regulatory requirements

- Work to improve contribution margin by optimizing reimbursement while controlling costs.
- Continue to develop clinical practice and documentation and achieve increased ratings on quality measures

KDHCD ANNUAL BOARD REPORT

FY2020 Annualized

Subacute and Transitional Care Services

Note: Includes patients at the Subacute and Transitional Care Services South Campus locations and TCS-Ortho Unit at West Campus.

Board Meeting - March 23, 2020

KEY METRICS -- FY 2020 ANNUALIZED ON THE SIX MONTHS ENDED DECEMBER 31, 2019

PATIENT DAYS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
21,804	$14,680,304	$15,000,900	($320,596)	($6,813,148)
▲ 2%	▲ 7%	▲ 6%	▲ 28%	▼ -1%

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

METRICS BY SERVICE LINE - FY 2020 ANNUALIZED

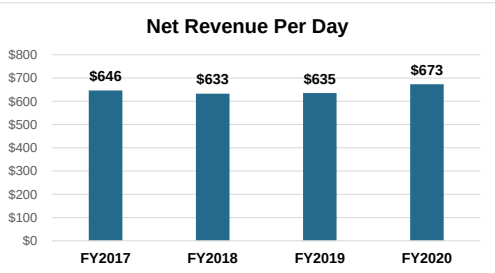
SERVICE LINE	Patient Days	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
Inpatient Subacute	10,886	$8,631,106	$7,821,134	$809,972	($2,390,534)
Transitional Care Services	5,724	$3,113,468	$4,267,164	($1,153,696)	($2,875,152)
Transitional Care Ortho	5,194	$2,935,730	$2,912,602	$23,128	($1,547,462)
Long Term Care Totals	21,804	$14,680,304	$15,000,900	($320,596)	($6,813,148)

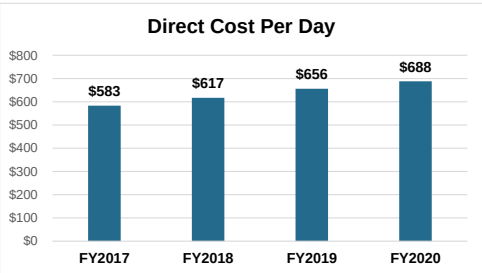
METRICS SUMMARY - 4 YEAR TREND

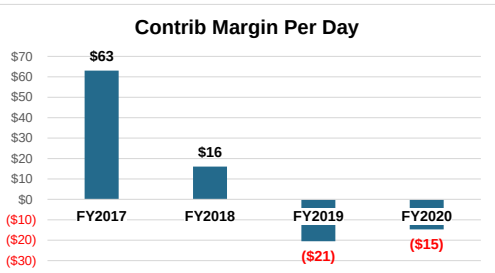
*Annualized

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Days	21,234	21,559	21,558	21,804 ▲	1%	
Net Revenue	$13,723,655	$13,642,909	$13,697,683	$14,680,304 ▲	7%	
Direct Cost	$12,384,426	$13,297,078	$14,140,077	$15,000,900 ▲	6%	
Contribution Margin	$1,339,229	$345,831	($442,394)	($320,596) ▲	28%	
Indirect Cost	$4,961,285	$6,414,835	$6,303,203	$6,492,552 ▲	3%	
Net Income	($3,622,056)	($6,069,004)	($6,745,597)	($6,813,148) ▼	-1%	
Net Revenue Per Day	$646	$633	$635	$673 ▲	6%	
Direct Cost Per Day	$583	$617	$656	$688 ▲	5%	
Contrib Margin Per Day	$63	$16	($21)	($15) ▲	28%	

GRAPHS







Note: FY2020 is annualized in graphs and throughout the analysis

KDHCD ANNUAL BOARD REPORT

FY2020 Annualized

Subacute Services - South Campus

Note: Includes all patients at the Subacute South Campus location.

Board Meeting - March 23, 2020

KEY METRICS -- FY 2020 ANNUALIZED ON THE SIX MONTHS ENDED DECEMBER 31, 2019

PATIENT DAYS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
10,886	$8,631,106	$7,821,134	$809,972	($2,390,534)
▼ -2%	▼ -2%	▲ 1%	▼ -26%	▼ -10%

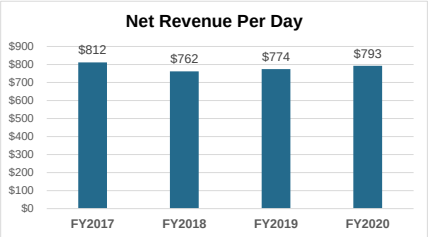
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

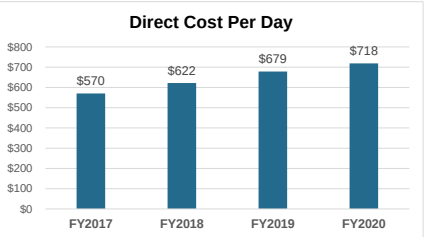
METRICS SUMMARY - 4 YEAR TREND

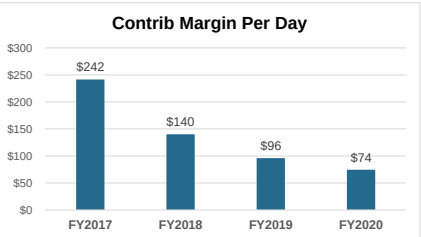
*Annualized

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Days	11,166	11,324	11,368	10,886	▼ -4%	
Net Revenue	$9,063,020	$8,627,240	$8,803,935	$8,631,106	▼ -2%	
Direct Cost	$6,365,954	$7,040,924	$7,713,728	$7,821,134	▲ 1%	
Contribution Margin	$2,697,066	$1,586,316	$1,090,207	$809,972	▼ -26%	
Indirect Cost	$2,592,434	$3,156,949	$3,257,014	$3,200,506	▼ -2%	
Net Income	$104,632	($1,570,633)	($2,166,807)	($2,390,534)	▼ -10%	
Net Revenue Per Day	$812	$762	$774	$793	▲ 2%	
Direct Cost Per Day	$570	$622	$679	$718	▲ 6%	
Contrib Margin Per Day	$242	$140	$96	$74	▼ -22%	

PER CASE TRENDED GRAPHS





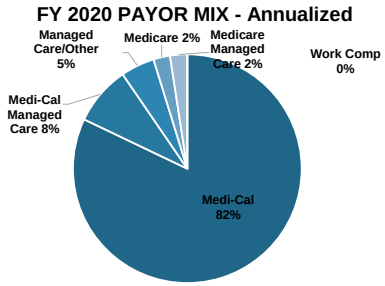


Note: FY2020 is annualized in graphs and throughout the analysis

PAYER MIX - 4 YEAR TREND

*Annualized

PAYER	FY2017	FY2018	FY2019	FY2020
Medi-Cal	90%	81%	84%	82%
Medi-Cal Managed Care	1%	1%	7%	8%
Managed Care/Other	2%	7%	6%	5%
Medicare	7%	9%	2%	2%
Medicare Managed Care	0%	1%	0%	2%
Work Comp	0%	0%	1%	0%
Cash Pay	0%	0%	0%	0%
County Indigent	0%	0%	0%	0%



KDHCD ANNUAL BOARD REPORT

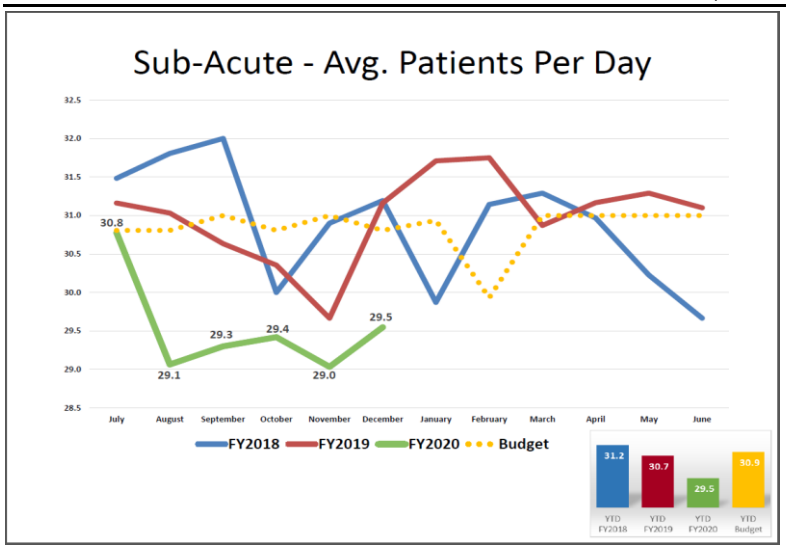
FY2020 Annualized

Subacute Services - South Campus

Note: Includes all patients at the Subacute South Campus location.

Board Meeting - March 23, 2020

KEY METRICS -- FY 2020 ANNUALIZED ON THE SIX MONTHS ENDED DECEMBER 31, 2019



Note: FY 2020 is annualized in graphs and throughout the analysis

Source: Inpatient Service Line Report, Sub-Acute -Avg Patients Per Day slide

Selection criteria: EntyID = KDSA - Kaweah Delta Subacute facility, excluding Exeter Rural Health Clinic visits.

KDHCD ANNUAL BOARD REPORT

FY2020 Annualized

Transitional Care Services - South Campus

Note: All patients at the Transitional Care Services South Campus location. This excludes cases at TCS-Ortho West Campus location.

Board Meeting - March 23, 2020

KEY METRICS -- FY 2020 ANNUALIZED ON THE SIX MONTHS ENDED DECEMBER 31, 2019

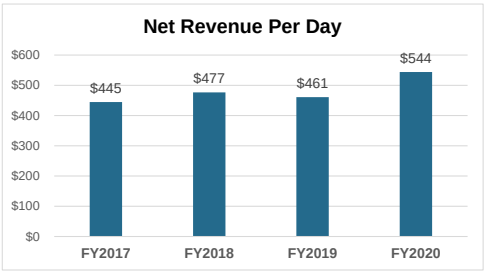
PATIENT DAYS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
5,724	$3,113,468	$4,267,164	($1,153,696)	($2,875,152)
▲ 7%	▲ 25%	▲ 12%	▲ 13%	▲ 1%

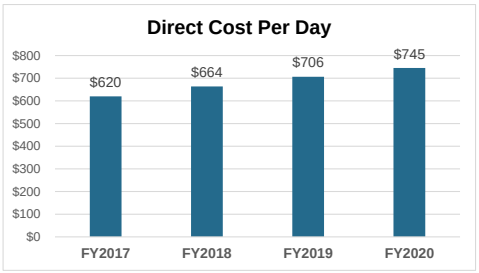
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

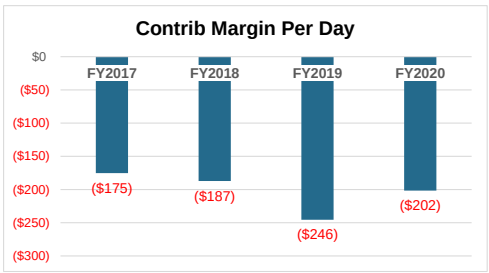
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	*Annualized FY2020	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Days	6,323	5,744	5,412	5,724 ▲	6%	
Net Revenue	$2,810,913	$2,737,195	$2,494,064	$3,113,468 ▲	25%	
Direct Cost	$3,919,592	$3,812,338	$3,822,784	$4,267,164 ▲	12%	
Contribution Margin	($1,108,679)	($1,075,143)	($1,328,720)	($1,153,696) ▲	13%	
Indirect Cost	$1,486,108	$1,802,623	$1,578,230	$1,721,456 ▲	9%	
Net Income	($2,594,787)	($2,877,766)	($2,906,950)	($2,875,152) ▲	1%	
Net Revenue Per Day	$445	$477	$461	$544 ▲	18%	
Direct Cost Per Day	$620	$664	$706	$745 ▲	6%	
Contrib Margin Per Day	($175)	($187)	($246)	($202) ▲	18%	

PER CASE TRENDED GRAPHS



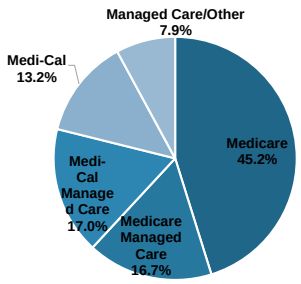




Note: FY2020 is annualized in graphs and throughout the analysis

PAYER MIX - 4 YEAR TREND

PAYER	FY2017	FY2018	FY2019	*Annualized FY2020
Medicare	33.4%	48.8%	44.0%	45.2%
Medicare Managed Care	24.2%	15.1%	22.3%	16.7%
Medi-Cal Managed Care	17.9%	12.3%	12.2%	17.0%
Medi-Cal	19.2%	14.9%	15.7%	13.2%
Managed Care/Other	5.1%	7.7%	5.4%	7.9%
Work Comp	0.2%	0.4%	0.3%	0.0%
Cash Pay	0.0%	0.7%	0.0%	0.0%
County Indigent	0.0%	0.0%	0.0%	0.0%



KDHCD ANNUAL BOARD REPORT

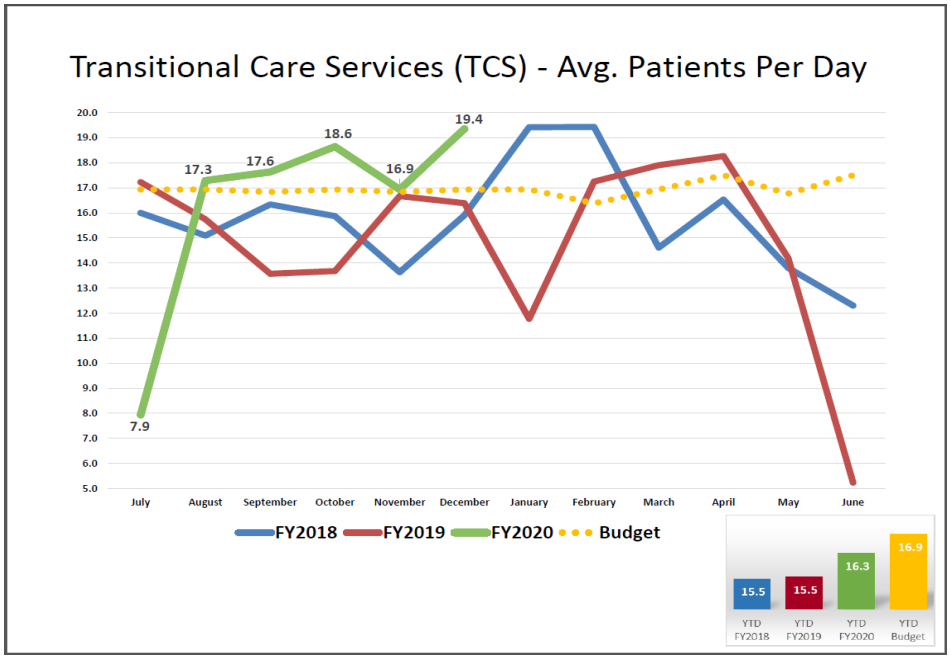
FY2020 Annualized

Transitional Care Services - South Campus

Note: All patients at the Transitional Care Services South Campus location. This excludes cases at TCS-Ortho West Campus location.

Board Meeting - March 23, 2020

KEY METRICS -- FY 2020 ANNUALIZED ON THE SIX MONTHS ENDED DECEMBER 31, 2019



Note: FY 2020 is annualized in graphs and throughout the analysis
Source: Inpatient Service Line Report, Transitional Care Services - Avg Patients Per Day stats slide
Selection criteria: EntyID = KDSN - Kaweah Delta Skilled Nursing/Transitional Care Services,
patients having a room charge in department 6581.

KDHCD ANNUAL BOARD REPORT

FY2020 Annualized

Transitional Care Services Orthopedics - West Campus

Note: All patients at the Transitional Care Services West Campus location. This excludes cases at Transitional Care Services South Campus location.

Board Meeting - March 23, 2020

KEY METRICS -- FY 2020 ANNUALIZED ON THE SIX MONTHS ENDED DECEMBER 31, 2019

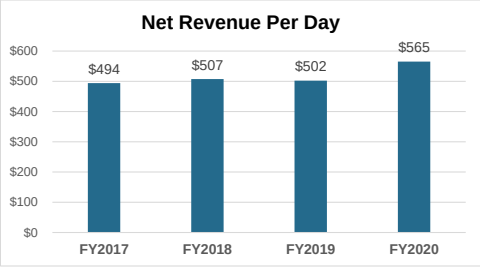
PATIENT DAYS	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
5,194	$2,935,730	$2,912,602	$23,128	($1,547,462)
▲ 2%	▲ 22%	▲ 12%	▲ 111%	▲ 7%

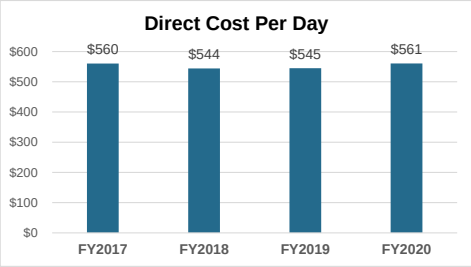
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

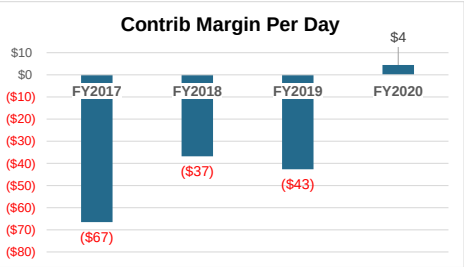
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	*Annualized FY2020	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Days	3,745	4,491	4,778	5,194	▲ 9%	
Net Revenue	$1,849,722	$2,278,474	$2,399,684	$2,935,730	▲ 22%	
Direct Cost	$2,098,880	$2,443,816	$2,603,565	$2,912,602	▲ 12%	
Contribution Margin	($249,158)	($165,342)	($203,881)	$23,128	▲ 111%	
Indirect Cost	$882,743	$1,455,263	$1,467,959	$1,570,590	▲ 7%	
Net Income	($1,131,901)	($1,620,605)	($1,671,840)	($1,547,462)	▲ 7%	
Net Revenue Per Day	$494	$507	$502	$565	▲ 13%	
Direct Cost Per Day	$560	$544	$545	$561	▲ 3%	
Contrib Margin Per Day	($67)	($37)	($43)	$4	▲ 110%	

PER CASE TRENDED GRAPHS



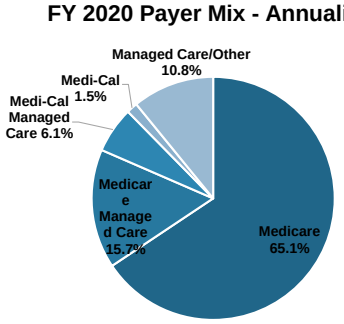




Note: FY2020 is annualized in graphs and throughout the analysis

PAYER MIX - 4 YEAR TREND

PAYER	FY2017	FY2018	FY2019	*Annualized FY2020
Medicare	66.5%	60.8%	61.3%	65.1%
Medicare Managed Care	19.6%	24.2%	23.5%	15.7%
Medi-Cal Managed Care	4.3%	3.7%	4.9%	6.1%
Medi-Cal	1.1%	1.1%	0.5%	1.5%
Managed Care/Other	7.0%	9.3%	8.3%	10.8%
Work Comp	0.9%	1.0%	1.6%	0.8%
Cash Pay	0.5%	0.0%	0.0%	0.0%
County Indigent	0.0%	0.0%	0.0%	0.0%



KDHCD ANNUAL BOARD REPORT

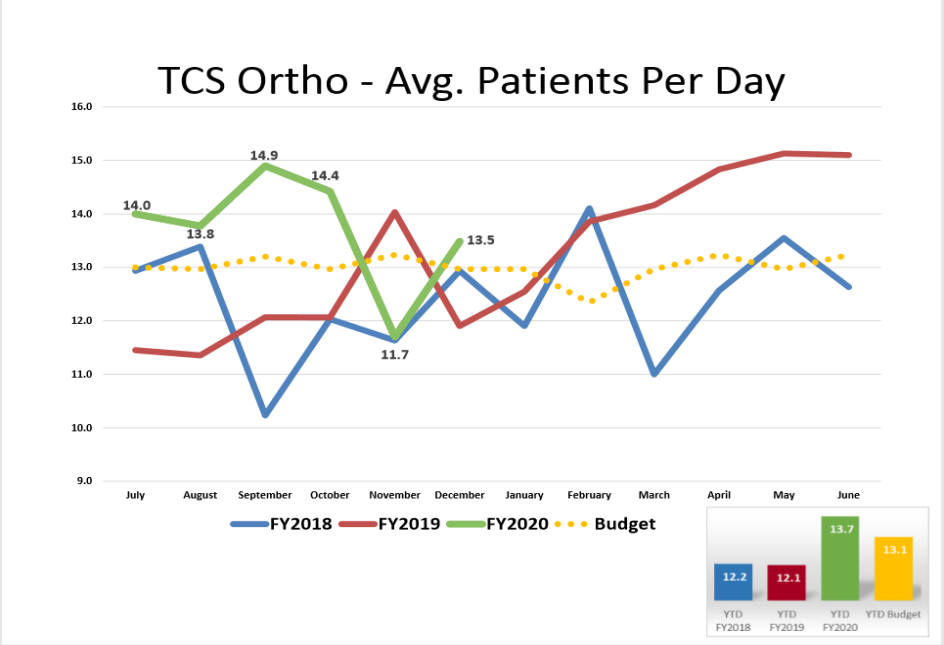
FY2020 Annualized

Transitional Care Services Orthopedics - West Campus

Note: All patients at the Transitional Care Services West Campus location. This excludes cases at Transitional Care Services South Campus location.

Board Meeting - March 23, 2020

KEY METRICS -- FY 2020 ANNUALIZED ON THE SIX MONTHS ENDED DECEMBER 31, 2019



Note: FY 2020 is annualized in graphs and throughout the analysis
Source: Inpatient Service Line Report, Transitional Care Services - Avg Patients Per Day stats slide
Selection criteria: EntyID = KDSN - Kaweah Delta Skilled Nursing/Transitional Care Services West patients having a room charge in department 6587.

REPORT TO THE BOARD OF DIRECTORS

Quail Park (Cypress) and Laurel Court

Marc Mertz, VP/Chief Strategy Officer, 624-2511
September 28, 2020

Summary Issue/Service Considered

Quail Park (Cypress campus) consists of a senior independent living facility and a secure memory care facility. These are organized as separate legal entities.

The independent living facility is a 127-unit senior retirement village owned 44 percent by Kaweah Delta Health Care District and 56 percent by Living Care Senior Housing. Denis Bryant from Living Care is the Managing Member.

The 40 unit Memory Care Center (Laurel Court) is an Alzheimer's/Dementia facility located east of the Rehabilitation Hospital on Kaweah Delta's west campus. It has the same ownership percentage split as Quail Park.

Denis Bryant is the manager of both entities. Lynn Havard Mirviss and Marc Mertz represent Kaweah Delta on the Quail Park and Memory Care Center Boards of Members. Cathy Boshaw and Elling Halverson (recently deceased) represent Living Care Senior Housing on the two boards. Kaweah Delta and Living Care have equal voting rights on the boards.

Quality/Performance Improvement Data

Quail Park has historically operated nearly at capacity, far above industry benchmarks. As recently as June 2019, Quail Park had a 28-unit waiting list. Like all senior living facilities, Quail Park has been impacted by COVID-19. Many individuals have chosen to delay moving into the facility. As of August 2020, occupancy in Quail Park was 87.4%, down more than 10% from prior year. According to The National Investment Center for Seniors Housing & Care (NIC), national senior housing occupancy rates were 84.9% in July 2020.

During fiscal year 2020 (July 2019 and June 2020), Quail Park paid Kaweah Delta $528,000 in quarterly profit distributions based on Kaweah Delta's 44 percent ownership. The first profit distributions were made in 2003. Since then, Quail Park has paid Kaweah Delta profit distributions totaling $5,272,500 through the second quarter of calendar year 2020. In addition, through a series of loan refinancing activities, Kaweah Delta has received an addition $5,934,840 in distributions. Total distributions to Kaweah Delta for this property are $11,207,340 based on an original investment of $1,589,000. $900,000 of the initial investment was made via donation of land, with the remaining $688,770 being invested in cash.

The 40-unit Memory Care Center, which opened in July 2012, is operating at 82.5% occupancy, well below its historic near-capacity rate.

The Memory Care Center paid Kaweah Delta a $242,000 profit distribution between July 2019 and June 2020. The Memory Care Center has paid Kaweah Delta a total of $1,408,000 in profit distributions through the second quarter of calendar year 2020. Kaweah Delta has received an

additional $1,505,040 in refinance distributions from this property. Total distributions are $2,913,040 based on an original Kaweah Delta investment of $990,936. Of the $990,936 investment, $720,000 was invested via land donation and $270,936 was invested in cash. The first profit distributions were made in 2012.

Policy, Strategic or Tactical Issues

COVID-19 has had a significant negative impact on the occupancy rates of senior living facilities nationwide. The Quail Park independent living and memory care centers were not spared. Fortunately, they continue to operate at or above industry occupancy rates and they remain profitable.

Management has reinvested operating profits and funds from last year's debt refinancing into both Cypress properties. Some of these investments were simply due to the age of the buildings, while others were to ensure that the facilities remain comparable to the new facilities opening at Shannon Ranch. Some of these investments include a newly decorated dining room, parking lot refinishing, exterior improvements, landscaping, new carpeting, new keyless entry system, and a refurbishment of the hair/nail salon.

Management was taken significant precautions to keep residents and employees safe during COVID-19, including restricting visitation, mandatory quarantine at move-in, frequent testing, and enhanced cleaning and sanitizing practices.

Recommendations/Next Steps

Continue to operate Quail Park and the Memory Care facility as high level senior retirement centers with services ranging from independent living to assisted living to expanded dementia care.

Approvals/Conclusions

Despite a challenging 2020 due to COVID-19, Quail Park is filling a significant health care need in our community, providing exceptional services to its residents, and at the same time generating an income stream for Kaweah Delta.

REPORT TO THE BOARD OF DIRECTORS

Quail Park at Shannon Ranch

Marc Mertz, VP/Chief Strategy Officer, 624-2511
September 28, 2020

Summary Issue/Service Considered

In 2016 Kaweah Delta approved construction of a new 120-unit independent, assisted, and memory care senior living project called Quail Park at Shannon Ranch near the intersection of Demaree and Flagstaff in northwest Visalia. The 139,000 square foot project is located on a 3.65 acre site next to the 6,100 square foot Urgent Care Center which Kaweah Delta opened on a 1.01 acre parcel on the east side of Demaree. The main independent living facility has 100 units ranging from studios to 2-bedroom units, and the secure memory care facility has 20 rooms.

Kaweah Delta owns 33 and one third percent of the new project, which is held by Northwest Visalia Senior Housing. Other partners are Shannon Senior Care, LLC, BTV Senior Housing, LLC, BEE, Inc., and Millennium Advisors. Shannon Senior care is owned by members of the Shannon family; BTV is owned by Bernard te Velde, Jr.; BEE is owned by Cathy Boshaw and Doug Eklund of the Seattle area; Millennium Advisors is owned primarily by Denis Bryant, the current managing partner of Quail Park and the Memory Care Center.

The new approximately $40 million project broke ground in March 2018 and was completed in early 2020. All Kaweah Delta equity contributions to the project have originated from the Bettie Quilla Fund at Kaweah Delta Hospital Foundation. The Quilla Fund is restricted by the donor for support of senior living projects in collaboration with Kaweah Delta Health Care District. Kaweah Delta has made its total equity contribution of $3,997,000.

Quality/Performance Improvement Data

Before COVID-19, management expected that occupancy of the main building would reach 50% within 90 days of opening and that the memory care center would be completely filled within that time frame. Early deposits and waiting lists supported this. However, occupancy of the independent living building is 9% as of August 2020 and the memory care is at 35%. An additional 18 deposits have been received, but the individuals have not moved in.

As a result, Quail Park at Shannon Ranch generated an operating loss of $631,569 from March 2020 to June 2020. Combined with non-operating expenses, which include pre-opening expenses, loan fees, interest, depreciation, and management, the total net income/(loss) was ($3,248,955) through June 2020. Owners of Northwest Visalia Senior Housing have made a series of four cash calls to fund operations. These contributions are being treated as loans payable. Through June 30, 2020, Kaweah Delta has made loan payments totaling $373,750, which was paid from the Quilla Fund. Since July 1, 2020, Kaweah Delta has made two more loan payments totaling $290,416, also made from the Quilla Fund. The total loan balance of $664,166 has a maturity date of December 31, 2021 and pay 5% interest. Kaweah Delta's accrued interest is $5,454 as of June 30, 2020.

Policy, Strategic or Tactical Issues

The COVID-19 pandemic and its impact on senior living could not have been predicted. Management of Quail Park at Shannon Ranch have continued to actively promote the facility, providing both in-person and virtual tours. The sales staff routinely delivers meals to individuals that have expressed interest in Quail Park as a way to stay in touch with potential residents. The facility is also very active on social media. Various discounts are being offered to entice people to move in now.

It is anticipated that once COVID-19 volumes decline, Quail Park at Shannon Ranch will see a significant increase in deposits and people moving into the facilities.

Recommendations/Next Steps

Continue to support the startup of Quail Park at Shannon Ranch during these challenging times.

Approvals/Conclusions

Quail Park at Shannon Ranch opened at perhaps the worst possible time in recent memory. However, the facility is the premier senior living in Visalia and perhaps the Central Valley. The amenities and services offered are unrivaled. As the pandemic abates, this facility will be a significant asset to the community.

Kaweah Delta
HEALTH CARE DISTRICT

Environment of Care
2nd Quarter Report
April 1, 2020 through July 31st, 2020
Presented by
Maribel Aguilar, Safety Officer
559-624-2381

Kaweah Delta Healthcare District
Performance Monitoring 2nd Quarter 2020

EOC Component: SAFETY

Performance Standard:

Employee Health: Reduce Occupational Safety & Health Administration (OSHA) recordable work related injury cases by 10% from 2019. No more than 193 injuries in 2020.
Goal: Reduce OSHA recordable injuries by 10% in 2020.
Minimum Performance Level: Reduce OSHA recordable injuries by 10% in 2020.

Evaluation:

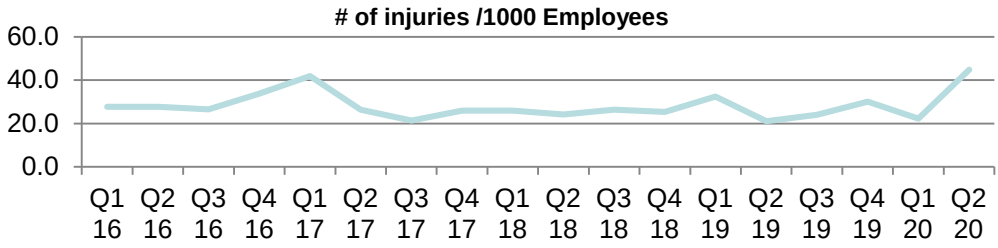
There were 117 Occupational Safety & Health Administration (OSHA) reportable injuries during the 2nd quarter 2020.

Provided 9 ergonomic evaluations in 2nd quarter to prevent cumulative trauma injuries/claims.

We had 13 sharps exposures during 2nd quarter 2020.

There were 71 Covid 19+ cases in 2nd Qtr. All of which were OSHA recordable, therefore without Covid19+ 2nd Qtr. OSHA recordable cases goal would be met.

Goal for 2nd quarter was not met.



Type of injury	Q1	Q2	Q3	Q4	Totals 2020	Annual % chg	Totals 2019	Per 1000 employees
Total Incidents	112	226			338	28.3%	527	22.24
OSHA recordable	43	117			160	48.8%	215	8.54
Lost time cases	20	99			119	66.4%	143	3.97
Strain/sprain	27	26			53	-0.9%	107	5.36
Bruise/ Contusion	6	5			11	-38.9%	36	1.19
Cum Trauma	1	1			2	-20.0%	5	0.20
Sharps Exp	21	13			34	-15.0%	80	4.17
Covid 19+	4	71			75	n/a	0	0.79
BBF Splash	5	0			5	-47.4%	19	0.99
# EE end of QTR	5037	5036						

Plan for Improvement:

- Identify employees with ≥ 3 OSHA recordable injuries in last 2 year = 7 employees. Identify trends and educational opportunities. Detail will be sent to Managers/Directors to determine prevention opportunities, re-education and/or re-training.
- Departments with 3 or more OSHA recordable injuries Qtr. 2- NONE Same day on-site incident investigation with employee. Follow-up with manager for prevention opportunities and/or process.
- Increase Sharps education in general orientation and Manager orientation with Infection Prevention.
- Utilize physical therapy assistant in Employee Health for Ergo evaluations, evaluate for proper body mechanics to prevent injury, stretching exercises and equipment recommendations to ensure safety with our jobs.

OSHA reportable injuries and illnesses are as follows:
•Fatalities, regardless of the time between the injury and death or the length of the illness.
•Any case, other than a fatality that resulted in lost workdays.
•Cases that did not have lost workdays but where the employee was transferred to another job or was terminated.
•Cases that required medical treatment other than first aid.
•Cases that involve loss of consciousness or restriction of work or motion
(this includes any diagnosed occupational illnesses that are reported but not classified as fatalities or lost workdays).

EOC Component: EMERGENCY PREPAREDNESS

Performance Standard:

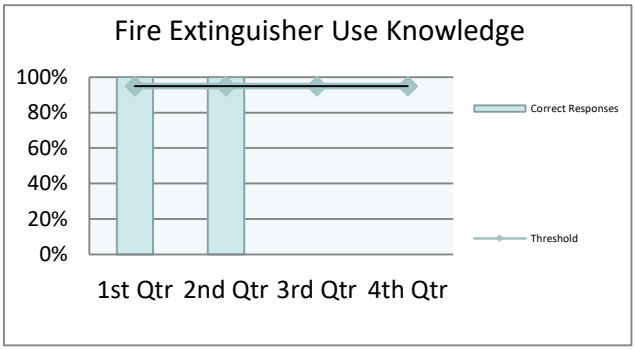
During routine hazard surveillance rounds employees will be queried on proper use of a fire extinguisher
Goal: 100% Compliance.

Minimum Performance Level: Employees able to answer correctly 95% of the time.

Evaluation:

Fourteen departments were surveyed in the 2nd quarter. In all departments surveyed staff where able to verbalize proper use of the fire extinguisher, which resulted in a 100% compliance rate.

Goal for 2nd quarter was met.



Plan for Improvement:

In each department visited there was knowledge of Fire Extinguisher Use.
Employees have been able to verbalize proper procedure when using a fire extinguisher.

We will continue to monitor through hazard surveillance rounding and during the quarterly mini drills.

EOC Component: SAFETY

Performance Standard:

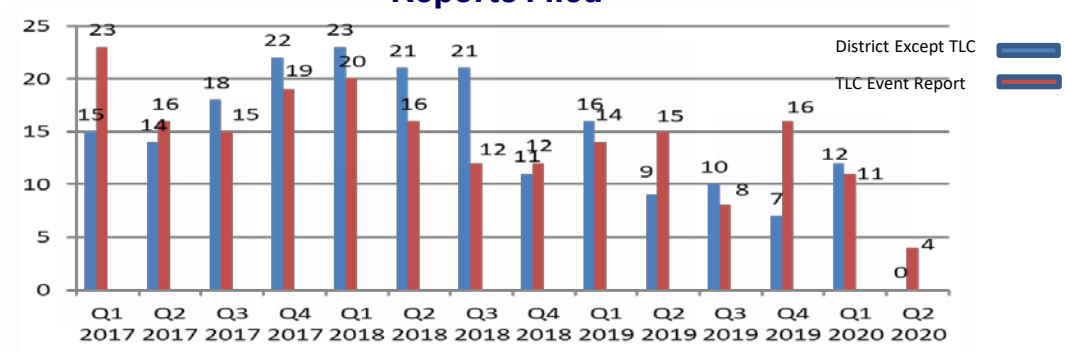
Risk Management: Non-patient injuries will be monitored to ensure reports are made within 7 days of events.
Goal: 100% of non-patient safety related events reported within 7 days
Minimum Performance Level: 90% of events reported within 7 days.

Evaluation:

There were 4 non-patient safety reports filed during the 2nd quarter 2020, all were received within 7 days of event.

Goal for 2nd quarter was met.

Risk Management – Non-Patient Safety Reports Filed



Plan for Improvement:

This performance standard is being met or exceeded. Risk Management will continue to conduct a trend analysis of all visitor falls and injuries that have occurred to identify trends. Likely due to service closures and visitor restrictions, we have experienced a decrease in non-patient events; no identifiable preventable or non- preventable trends have been identified.

TLC Types of Events:
Falls related to pool and Rockwall padding

District Type of Events:
Slip and Fall
Self-trips

EOC Component: SECURITY

Performance Standard:

In order to improve Code Gray event outcomes, the Security Department will track: 1, number of CPI responders arriving to a Code Gray event; 2, identify if roles/assignments are clearly stated; 3, debriefing taking place after every event.
Goal: 90% compliance with Code Grey event outcomes.

Evaluation:

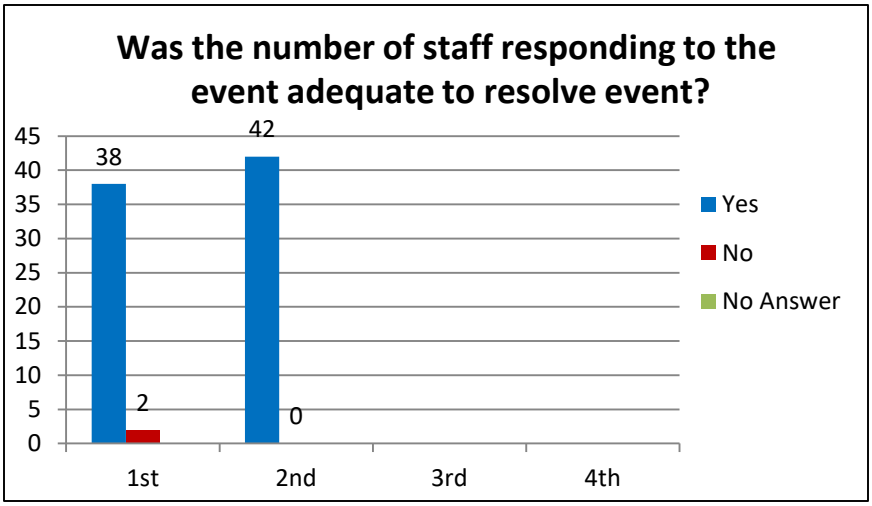
- Item 1: There were 42 recorded code gray events in the Medical Center in the Second Quarter. Out of 42 Code Gray events, all events had an appropriate staffing response. Goal for 2nd quarter was met.
- Item 2: Of the 42 reported Code Gray events, 95% of the events resulted in effective role delegation with responding CPI trained personnel. Goal for 2nd quarter was met.
- Item 3: Of the 42 reported events, 67% of the events resulted in group debriefing after the event.

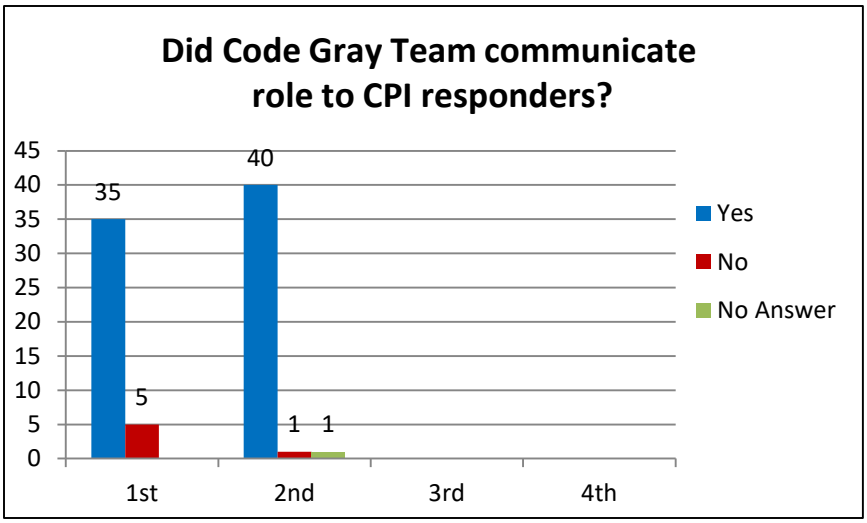
Goal for 2nd quarter was not met.

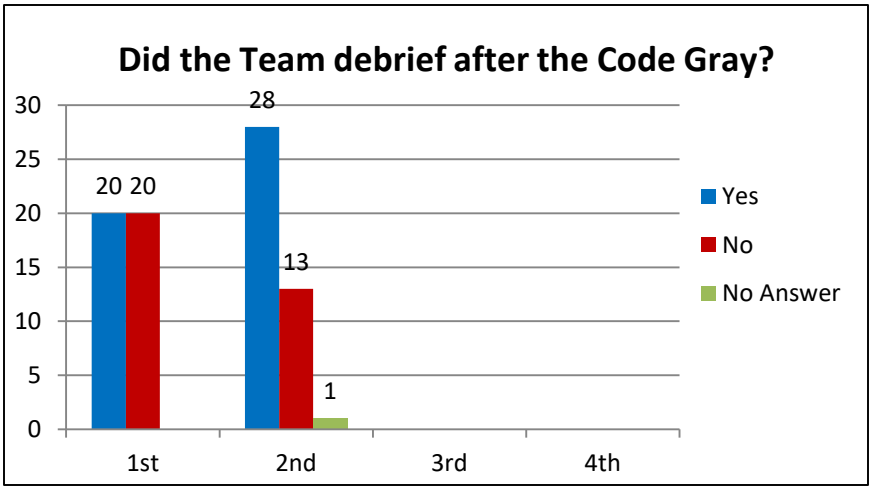
Plan for Improvement:

Improvement has been made with respect to debriefing after every Code Gray event. Data shows that of the 42 Code Grays, 10 events were repeat events for the same four (4) patients.

Security personnel responding to Code Gray events will help prompt the patient care Nurse or event Team Leader to debrief with the team after the event has resolved.







EOC Component: SAFETY

Performance Standard:

Risk Management: No patient death or serious disability* associated with a fall while being cared for in a KDHCD facility.
Goal: 100% Compliance.
Minimum Performance Level: 100% Compliance.

Evaluation:

There were no incidents of patient death or serious disability associated with a fall while being cared for in a KDHCD facility.

Goal for 2nd quarter was met.

*Serious disability means physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function if the impairment lasts more than seven (7) days, or is still present at the time of discharge, or loss of a body part.

Plan for Improvement:

Hazardous Surveillance inspections of all KDHCD facilities conducted on a scheduled basis. Safety issues identified are resolved by department manager.

Continue to monitor.

EOC Component: UTILITIES MANAGEMENT

Performance Standard:

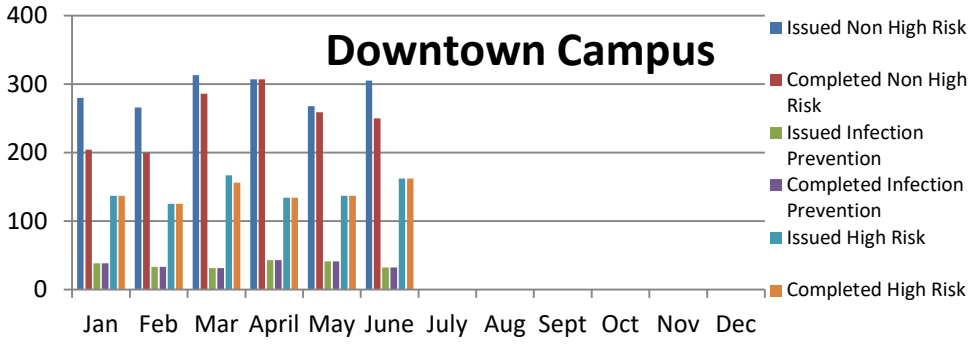
High Risk, Non-High Risk and Infection Control systems preventive maintenance will be performed on a regular basis.
Goal: 100% of **High Risk, Non-High Risk and Infection Control** systems will be serviced and/or inspected on schedule.
Minimum Performance Level: 100% of critical utility systems will be serviced and/or inspected schedule.

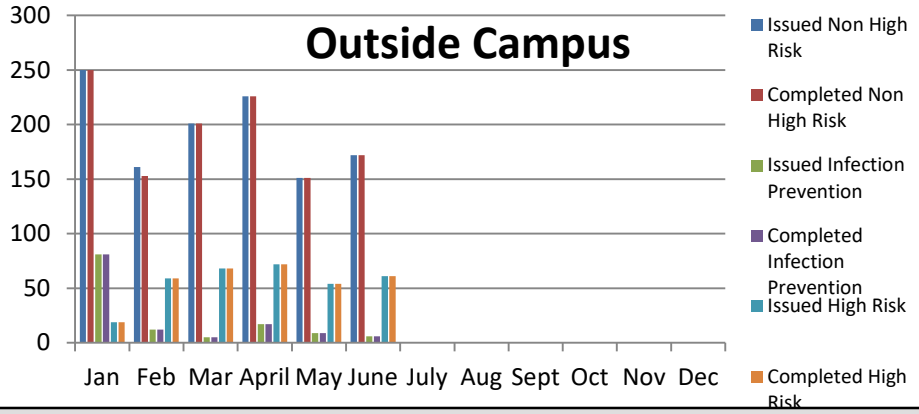
Evaluation:

For the downtown campus there were 816/880 Non-high risk, 116/116 Infection prevention and 433/433 High-risk preventative maintenance work orders completed, an average 97% completion rate. The non-high risk work orders were all related to HVAC in patient rooms, due to census were unable to gain access.

For the outside campus there were 549/549 Non-high risk, 32/32 Infection prevention and 187/187 High-risk preventative maintenance work orders completed, 100% completion rate.

Goal for 2nd quarter was not met.





Plan for Improvement:
Downtown campus: Facilities Team and Nursing scheduled to meet to discuss ensuring room availability for Regulatory Compliance mandatory preventative & safety work orders. These rooms must have their PM work completed per the requirements or the rooms will need to be reviewed and possibly taken out of service until compliance is re-established.

Outside campus: Working with staff to review work orders before due date. All work orders will be reviewed 1 week before the end of the month to ensure compliance.

EOC Component: SAFETY

Performance Standard:

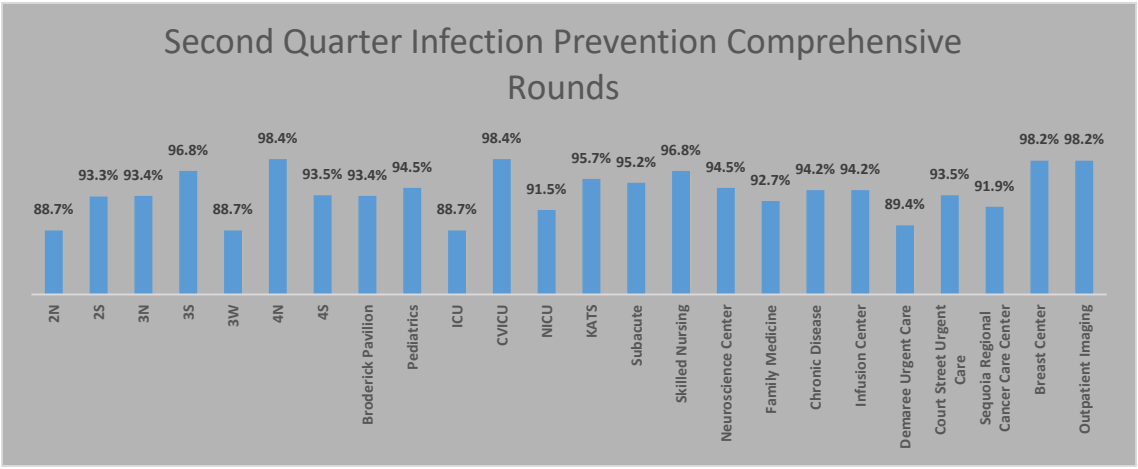
Infection Prevention: Enhance patient safety, optimize the environment of care and identify opportunities for improvement complying with regulatory guidelines by rounding each unit twice yearly.

Goal: Units will demonstrate 100% compliance with IP best practices
Minimum Performance Level: Units will demonstrate 90% compliance with IP best practices.

Evaluation:

During the 2nd quarter many locations achieved 90% or greater compliance with infection prevention practices. Only fallouts were 2N,3W, ICU and Demaree Urgent Care.

Goal for 2nd quarter was not met.



Plan for Improvement:

Each manager receives their completed observation checklist. If there are fallouts they are required submit a plan for improvement within 7 days to infection prevention. Some of the actions taken to resolve fallouts include:

- Recommend assigning staff on a rotating schedule to check for outdated supplies monthly.
- Deploy covered drink corrals, designated spots for healthcare personnel drinks. Staff food is prohibited in clinical workspaces.
- Close monitoring of refrigerator/freezer temperatures.
- Enforce compliance with hospital policy related to multi-dose vials.

EOC Component: FIRE PREVENTION/LIFE SAFETY

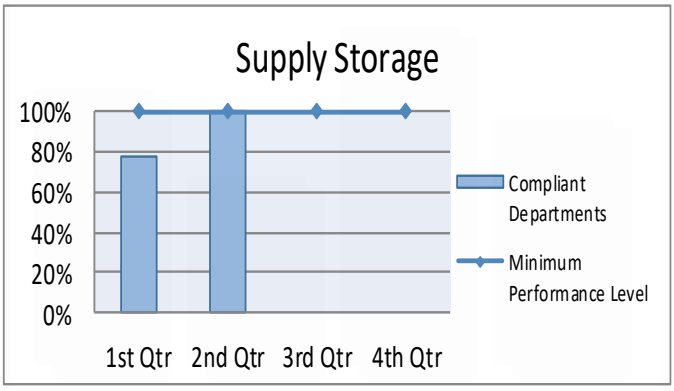
Performance Standard:

Equipment and supply storage compliance will be monitored during hazard surveillance inspections. Supplies are not to be stored on the floor. There also needs to be a clearance of 18" to the ceiling in sprinklered rooms and 24" in non-sprinklered rooms per California Fire Code & The Joint Commission requirements.
Goal: 100% of departments inspected will be compliant.
Minimum Performance Level: 100% of department inspected will be compliant.

Evaluation:

Fourteen departments were surveyed in the 2nd quarter. Of all surveyed departments, none were found to have supplies stored too close to the ceiling (18" clearance required). This resulted in an 100% compliance rate.

Goal for 2nd quarter was met



Plan for Improvement:

We will continue to monitor through hazard surveillance and report to appropriate director and VP. Non-compliant departments will be sent reminder email regarding storage and proper clearance.

Continue to monitor through rounding during hazard surveillance

EOC Component:

CLINICAL ENGINEERING 2nd Quarter CY 2020

Performance Standard:

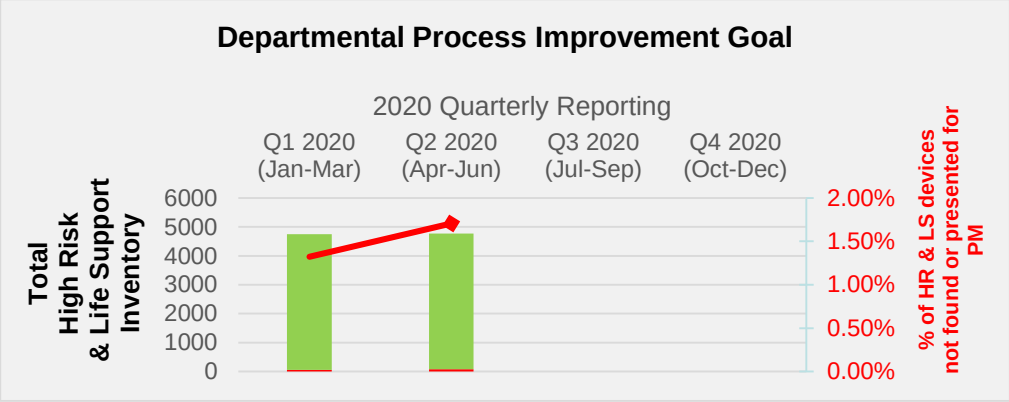
To ensure PM Completion of High Risk including Life Support Devices is managed effectively; Keep number of missing high risk devices less than 1% of total. High Risk Inventory measured quarterly.
Goal: Attain <1% Missing in Action Count on High Risk devices Quarterly.
Minimum Performance Level: <1% Missing in Action(MIA) of total High Risk Device

Evaluation:

Department staff will strive to keep the High Risk (HR) and Life Support (LS), unable to locate device count under 1% of the total inventory of those devices

Goal of <1% HR including LS Devices in a MIA status:

Goal for 2nd quarter was not met.



Quarter	Q1 2020 (Jan-Mar)	Q2 2020 (Apr-Jun)	Q3 2020 (Jul-Sep)	Q4 2020 (Oct-Dec)
Total HR & LS equipment MIA	62	80		
High Risk inc. Life Support Inventroy count	4686	4686		
% of HRLS inventory	1.32%	1.71%		

Plan for Improvement:
The data will be reviewed, inventory corrections will be identified and made and the final list of devices officially "Missing in Action" will be distributed to the departments that own the equipment. The department manager will be expected to report on the status of the equipment and make it available for maintenance completion ASAP. Clinical Engineering will continue to search for the device until removed from active inventory.
At the end of June 2020 if still not located, these devices will be marked Missing in Action (MIA) per Joint Commission guidelines. The machine has a PM Sticker on it with a due date between January and March 2020. If the device is found, it is to be reported to the Clinical Engineering Department whereby it will be assessed for proper operation to the manufacturers standards and returned to its department for use.

EOC Component:

CLINICAL ENGINEERING 2nd Quarter CY 2020

Evaluation:
PM Compliance:

High Risk (including Life Support):
Goal **100.0%**

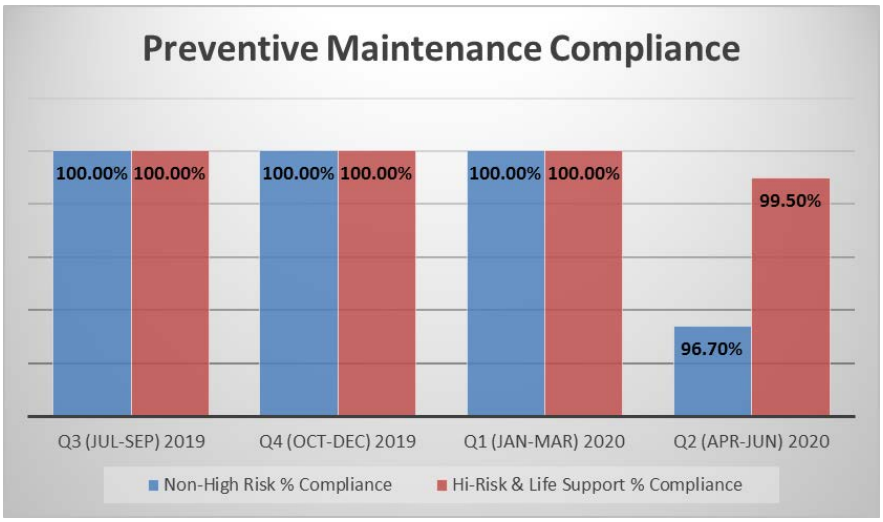
2nd Qtr. Compliance 99.5%
Goal for 2nd quarter was not met.

Non-High Risk:
Goal **100.0%**

2nd Qtr. Compliance: 96.7%
Goal for 2nd quarter was not met.

The Clinical Engineering Department will complete preventative maintenance for 12184 assigned preventive maintenance tasks as required per policy EOC 6001.
Goal: 100% Compliance **Minimum Performance Level: 100**% Compliance

Medical Equipment
Preventative Maintenance Compliance



Plan for Improvement:
Past due preventative maintenance prioritized for all technicians.

Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

Policy Number: AP35	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	

Computer Software Usage

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

POLICY: Kaweah Delta Health Care District's computer systems and/or other hardware shall not be utilized to manufacture or duplicate unauthorized copies of copyrighted software where such manufacture or duplication is restricted or prohibited by copyright law.

Computer software which has been illegally manufactured and/or duplicated in violation of copyright law may not be installed or in any way put to use on computer systems and/or other hardware owned or operated by Kaweah Delta Health Care District. All software installed on Kaweah Delta Health Care District's computers must be approved the director of ISS Technical Services.

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

Quality Improvement Plan

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

I. Purpose

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

II. Scope

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

III. Structure and Accountability

Board of Directors

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

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

Quality Council

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

Medical Staff

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

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

~~Professional Staff~~ Quality Improvement Committee (QIC)~~: "Prostaff":~~ ~~The Prostaff Committee~~ QIC has responsibility for oversight of organizational performance improvement. Membership includes key organizational leaders including the Medical Director of Quality and Patient Safety or Chief Quality Officer, Chief Operating Officer, Chief Nursing Officer, Assistant Chief Nursing Officer, Directors of Quality and Patient Safety, Nursing Practice, and Risk Management; Manager of Quality and Patient Safety and Manager of Infection Prevention. ~~ing: Medical Executive Committee members, Medical Director of Quality and Patient Safety, Chief Executive Officer, Chief Operating Office, Chief Medical Officer/Chief Quality Officer, Chief Nursing Officer, member of the Board of Directors, and Directors of Nursing, Quality and Patient Safety, Risk Management and Pharmacy.~~
This committee reports to Prostaff and the Quality Council.

The QIC ~~Prostaff Committee~~ shall have primary responsibility for the following functions:

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

Formatted: Font: Not Bold, Not Italic
Formatted
Formatted: Font: Not Italic
Formatted: Font: Not Bold, Not Italic
Formatted: Font: Not Italic
Formatted: Font: Not Bold, Not Italic
Formatted: Font: Not Italic
Formatted: Font: Not Bold, Not Italic
Formatted: Font: Not Italic
Formatted: Font: Not Bold, Not Italic
Formatted: Font: Not Italic
Formatted: Font: Not Bold, Not Italic
Formatted: Font: Not Italic
Formatted: Indent: Left: 2.25", No bullets or numbering

5. **Follow- Up:** The QIC ~~Prostaff Committee~~ shall assure that steps are taken to improve performance and enhance safety are appropriately implemented, measured and tracked to determine that the steps have achieved and sustained the intended effect.
6. **Performance Improvement Projects:** The QIC ~~Prostaff Committee~~ shall oversee ~~performance~~quality improvement projects, the number and scope of which shall be proportional to the scope and complexity of the hospital's services and operations. The QIC ~~Prostaff Committee~~ must also ensure there is documentation of what quality improvement projects are being conducted, the reasons for conducting those projects, and the measureable progress achieved on the projects.

Medical Executive Committee

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

Nursing Practice Improvement Council

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

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

Graduate Medical Education

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

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

Methodologies:

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

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

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

Formatted: Indent: Left: 1"
Formatted: Default Paragraph Font, Font: (Default) Times New Roman
Formatted: Indent: Left: 1.25", Tab stops: 1.5", List tab + Not at 0.5"
Formatted: Default Paragraph Font, Font: (Default) Times New Roman
Formatted: Default Paragraph Font, Font: (Default) Times New Roman
Formatted: Indent: Left: 1"
Formatted: Indent: Left: 1.25", Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: -0.5" + Indent at: -0.25"

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

- **Plan:**
  - Objective and statistically valid performance measures are identified for monitoring and assessing processes and outcomes of care including those affecting a large percentage of patients, and/or place patients at serious risk if not performed well, or performed when not indicated, or not performed when indicated; and/or have been or likely to be problem prone.
  - Performance measures are based on current knowledge and clinical experience and are structured to represent cross-departmental, interdisciplinary processes, as appropriate.
- **Do:**
  - Data is collected to determine:
    - Whether design specifications for new processes were met
    - The level of performance and stability of existing processes
    - Priorities for possible improvement of existing processes
- **Check:**
  - Assess care when benchmarks or thresholds are reached in order to identify opportunities to improve performance or resolve problem areas
- **Act:**
  - Take actions to correct identified problem areas or improve performance
  - Evaluate the effectiveness of the actions taken and document the improvement in care
  - Communicate the results of the monitoring, assessment and evaluation process to relevant individuals, departments or services

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

- **Define** the problem, improvement activity, opportunity for improvement, the project goals, and customer (internal and external) requirements. QI tools that may be used in this step include:
  - Project charter to define the focus, scope, direction, and motivation for the improvement team

Formatted: List Paragraph, No bullets or numbering, Allow hanging punctuation, Adjust space between Latin and Asian text, Adjust space between Asian text and numbers, Font Alignment: Auto

Formatted: Font: (Default) Arial

Formatted: Indent: Left: 1.5", No bullets or numbering

- Process mapping to provide an overview of an entire process, starting and finishing at the customer, and analyzing what is required to meet customer needs
- **Measure** process performance.
  - Run/trend charts, histograms, control charts
  - Pareto chart to analyze the frequency of problems or causes
- **Analyze** the process to determine root causes of variation and poor performance (defects).
  - Root cause analysis (RCA) to uncover causes
  - Failure mode and effects analysis (FMEA) for identifying possible product, service, and process failures
- **Improve** process performance by addressing and eliminating the root causes.
  - Pilot improvements and small tests of change to solve problems from complex processes or systems where there are many factors influencing the outcome
  - Kaizen event to introduce rapid change by focusing on a narrow project and using the ideas and motivation of the people who do the work
- **Control** the improved process and future process performance.
  - Quality control plan to document what is needed to keep an improved process at its current level
  - Statistical process control (SPC) for monitoring process behavior
  - Mistake proofing (poka-yoke) to make errors impossible or immediately detectable

IVIV. Confidentiality

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

V. Annual Evaluation

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

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

Attachment 1:	Quality Improvement Committee Structure
Attachment 2:	KDHCD- Prostaff Reporting Documents
Attachment 3:	20198-2020196 Value Based Purchasing (VBP) Objectives

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard

Formatted: Default Paragraph Font, Font: Times New Roman, 10 pt, Font color: Custom Color(RGB(9,9,9))

Formatted: Default Paragraph Font, Font: Times New Roman, 10 pt, Font color: Custom Color(RGB(9,9,9))

Formatted: Default Paragraph Font, Font: Times New Roman, 10 pt, Font color: Custom Color(RGB(9,9,9))

Formatted: Default Paragraph Font, Font: Times New Roman, 10 pt, Font color: Custom Color(RGB(9,9,9))

Formatted: Default Paragraph Font, Font: Times New Roman, 10 pt, Font color: Custom Color(RGB(9,9,9))

Formatted: Default Paragraph Font, Font: Times New Roman, 10 pt, Font color: Custom Color(RGB(9,9,9))

Formatted: Default Paragraph Font, Font: Times New Roman, 10 pt, Font color: Custom Color(RGB(9,9,9))

Formatted: Space Before: Auto, After: Auto, Bulleted + Level: 2 + Aligned at: 2.25" + Indent at: 2.5", Allow hanging punctuation, Adjust space between Latin and Asian text, Adjust space between Asian text and numbers, Font Alignment: Auto, Pattern: Clear (White)

Formatted: Font: Helvetica, 10.5 pt, Font color: Custom Color(RGB(9,9,9))

Formatted: List Paragraph, No bullets or numbering, Allow hanging punctuation, Adjust space between Latin and Asian text, Adjust space between Asian text and numbers, Font Alignment: Auto

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 1.79" + Indent at: 2.04"

Formatted: Indent: Left: 0", First line: 0.5"

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: AP57	**Date Created: No Date Set**
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration)	

Access to Legal Counsel

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

POLICY: In order to control the costs of legal fees, and to streamline the dissemination of legal advice, direct access to legal counsel is limited to certain specific individuals.

Individuals authorized for direct and immediate access to District Administrative legal counsel are limited to:

A. any member of the ~~District~~Kaweah Delta Board of Directors;
B. the Chief Executive Officer (CEO);
C. the ~~District~~ Executive Assistant ~~to Board/~~CEO & Board Clerk;
D. any ~~individual with the title of~~ Kaweah Delta ~~Health Care District Senior~~ Vice President~~,~~; ~~Vice President or Division Director;~~
~~D.~~E. the Kaweah Delta Medical Foundation (KDMF) CEO and~~,~~ Chief Financial Officer (CFO);
~~E.~~F. the Director of Risk Management;
~~F.~~G. the ~~District~~ Chief Compliance & Privacy Officer;
~~G.~~H. the Director of Internal Audit;
~~H.~~I. the Chief of Medical Staff;
~~I.~~J. the Chair of the Medical Staff Credentials Committee;
~~J.~~K. the Chair of the Medical Staff By-Laws Committee;
~~K. the Director of Patient Accounting Services or Credit Manager.~~

Formatted: Indent: Left: 1.25", No bullets or numbering

Directors or ~~O~~other staff members may be authorized for direct and immediate access to District legal counsel provided they are acting at the specific request or direction of an individual occupying any of the positions indicated above.

Individuals authorized for direct and immediate access to Medical Staff legal counsel are limited to:

A. any member of the District Board of Directors;
B. the Chief Executive Officer;
C. any Medical Staff Officer;
D. the Chair of the Medical Staff Credentials Committee;
~~the~~ ~~the Chief Medical Officer~~
E. Director of Medical Staff Services

Other staff members may be authorized for direct and immediate access to Medical

Staff legal counsel provided they are acting at the specific request or direction of an individual occupying any of the positions indicated above.

"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: AP122	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	

Interpreter Services

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

PURPOSE:

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

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

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

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

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

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

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

chooses to use a family member or friend who volunteers to interpret, then a Waiver of Interpreter Services will be initiated and entered into the patient ~~file~~medical record.

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

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

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

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

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

m. Discussing Advanced Directives;
n. Discussing end of life decisions; and,
o. Obtaining financial and insurance information.

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

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

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

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

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

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

a. Signage/postings
    i. Multilingual notices are to be placed in conspicuous locations informing patients of available bilingual services and how to access them. These notices shall also contain the telephone number where patients can file complaints about interpretation services.
    Each notice shall also include a TTY number for the hearing impaired. (See attached notices in English/Spanish.)

ii. Notices shall be posted in conspicuous areas around the facility including, but not limited to, the emergency room and major entrances, admitting areas and lobbies.
iii. Educational and vital documents and materials shall also be translated to Spanish and be made available to Spanish only speaking patients, as this population comprises at least 5% of KDHCD patient population.

J. It will be the policy of KDHCD to translate and make available all Vital Documents in Threshold Languages. The translation of other hospital written materials in Frequently Encountered or other languages shall be at the discretion of the issuing staff. Vital Documents that are not produced in a written translation shall be verbally translated to the patient or surrogate decision-maker. The provision of oral translation of all Vital Documents to patients shall be documented and documentation shall become a part of the medical record.
   a. Prior to the assignment of work to a translator, the Interpreter Services Department will provide a Materials Review process for all materials that are to be translated into Spanish to ensure:
      i. Appropriate reading level for the target population;
      ii. Plain language will be used. The language is simple and clear;
      iii. Messages and illustrations are culturally appropriate;
      iv. Document prints clearly in black and white if it will be posted on the internet for public download
   b. The KDHCD Interpreter Services Department will translate all Spanish translations, unless they are unable to meet indicated timelines. All requests for translations in any language will be routed through the Interpreter Services Department. Approved agencies may be used by the Interpreter Services Department to provide translation of patient information or education.
   c. The Interpreter Services Department will review all translations returned by approved translation agencies before translations are returned to the department for duplication and/or distribution.
   d. The Interpreter Services Department will assist the Marketing Department with the Spanish translation of forms, signs, pamphlets, etc. for display or distribution by KDHCD. (See Policy #: AP.18)

PROCEDURE

I. Notification of Interpreter Services
   a. Notices in the form of Language ID Posters ~~and Language Easels~~ are posted in the main hallway of each facility, Emergency Dept. and outpatient areas advising patients and their families about the availability of free interpretation services, a list of available languages, and how to access an interpreter.

II. Patient Identification
   a. The first access point in which a patient acquires services

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

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

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

V. The Health Care Interpreter Network (HCIN)
a. Simply dial 8989.
b. Available 24 hours a day to assist with video and phone Interpretation via any KDHCD telephone, mobile phone or video phone.
~~c. Procedures are outlined on KDCentral under Department/Interpreter Services/Health Care Interpreter Network.~~
~~d.~~c. ~~If you are asked for your Access Code, it is 841263~~.

VI. Requesting an Interpreter
a. Staff must utilize the appropriate interpreter for explanations of tests/procedures, surgery, to obtain informed consent, and to give critical instructions.
b. If the staff person determines that an "in person" interpreter is required, he/she may contact the Interpreter Services Department

at Ext. 2501, 5981, 5902);

c. A Language Resource Assistant (LRA) may also be called and is listed under KDNet/Directories/Interpreter Directory.
d. Necessary emergency care will not be withheld pending the arrival of interpreter services.
e. All necessary contact numbers ~~and access codes~~ for ~~the direct contact of~~ contracted interpreter services shall be available to Emergency Room staff and in KDCentral.

VII. Hearing Impaired Patients

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

VIII. Documentation:

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

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

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

i. All interpretation encounters performed by KDHCD Interpreter Services Staff.

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

IX. Waiver of Interpreter Services

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

X. Qualified Providers of Healthcare Interpreting

a. Certified Medical Interpreters:

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

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

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

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

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

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

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

c. Contracted Interpreter Services

XI. VIDATAK EZ Board

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

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

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

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

Formatted

Formatted: No underline

Formatted: Indent: Left: 1.25", No bullets or numbering

Definition of Terms

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

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

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

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

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

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

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

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

Language Resource Assistant (LRA)
Kaweah Delta Health Care District staff member who is bilingual and who is willing to provide language interpretation. This person’s language competency has been

tested and is classified as general or clinical/advanced. They are identified by either an Orange LRA pin for General or a Dark Blue LRA pin for Clinical/Advanced that must be worn on their badge. Based on the designated level of language competency, the LRA will receive additional compensation to their current salary:

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

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

Auxiliary Aids

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

Contracted Services

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

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

See Administrative Policy AP.18

Kaweah Delta Health Care District
400 W. Mineral King • Visalia, CA 93277-6263 • 559 624 2000

WAIVER OF INTERPRETER SERVICES

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

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

NAME:

_____

ADDRESS:

_____

PHONE:

_____

RELATIONSHIP TO PATIENT:

_____

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

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

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

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

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

NOMBRE:

_____

DOMICILIO:

_____

TELÉFONO:

_____

RELACIÓN AL PACIENTE:

_____

Entiendo que podré revocar esta renuncia en cualquier momento y solicitar los servicios de un intérprete sin cargo alguno.

También entiendo que esta renuncia no autoriza a ningún intérprete a actuar como mi representante autorizado.

Este formulario fue traducido para mí y entiendo su contenido.

Signature / Firma del paciente	Date / Fecha

Formatted: Spanish (Mexico)

Formatted: Spanish (Mexico)

Formatted: Spanish (Mexico)

Formatted: Spanish (Mexico)

Formatted: Spanish (Mexico)

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

Label

WAIVER OF INTERPRETER SERVICES

Page 1 of 2

CVBF #934 Rev. 11/07

340

Kaweah Delta Health Care District

400 W. Mineral King • Visalia, CA 93277-6263 • 559 624 2000

WAIVER OF INTERPRETER SERVICES

Bill of Rights for People with Limited English Skills

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

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

Declaración de derechos para personas con conocimiento limitado del idioma inglés

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

- Recibir ayuda de un intérprete que pueda traducir del inglés a su idioma. Este servicio es gratuito para usted y su familia;
- Ser tratado con cortesía y respeto;
- Ser tratado de manera sensible a sus necesidades étnicas y culturales;
- Recibir servicios sin enfrentar discriminación, abuso ni hostigamiento;
- Recibir información sobre servicios de atención de la salud en su idioma;
- Participar en el proceso de evaluación de su salud y en el desarrollo de un plan para sus servicios de salud;
- Recibir información, en su idioma, sobre lo que podría pasar si usted acepta servicios o los rechaza;

- Expresar sus preocupaciones sobre los servicios que recibe;
- Recibir información, en su idioma, sobre la forma de presentar quejas sobre proveedores de atención de la salud;
- Recibir información, en su idioma, sobre sus derechos y responsabilidades al utilizar servicios;
- Recibir información, en su idioma, sobre las leyes y normas que deben respetar los proveedores de atención de la salud;
- Que sus registros de atención de la salud se mantengan en privado.

Label

WAIVER OF INTERPRETER SERVICES

Page 2 of 2

CVBF #934 Rev. 11/07

AVAILABILITY OF INTERPRETERS

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

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

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

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

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

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

You will not be penalized for filing a complaint.

DISPONIBILIDAD DEL SERVICIO DE INTÉRPRETES

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

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

The Health Care Interpreter Network

Formatted: Spanish (Mexico)

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

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

Formatted: Spanish (Mexico)

The Health Care Interpreter Network

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

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

Formatted: English (United States)

No se le penalizará por presentar una queja.

Supported Languages and Dialects by Language

Formatted: Spanish (Mexico)

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

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

"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: AP151	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	

Strategic Planning

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

Policy: Strategic planning will be a disciplined process of envisioning a set of future desired outcomes for the District. The Strategic Plan, and any revisions to the Plan, will be approved by the District's Board of Directors and will be reflective of the District's mission, vision, values and organizational goals. The Strategic Plan will be regularly evaluated to ensure its relevance to the District's current health care environment and community needs. Input regarding strategic and capital equipment issues will be regularly solicited from the Board of Directors, the Medical Staff, management and any other key stakeholders.

Procedure: The strategic planning process will include an annual review of the strategic planning statement and the set of enduring objectives which, when pursued over time, should ensure that Kaweah Delta is a viable and growing enterprise that meets the community's needs. Review and approval of the Strategic Plan will be completed by March of each year to ensure that strategic objectives are considered in the annual budget process. This review will include input from the Board of Directors, District management and from the Medical Staff using periodic Strategic Planning Committee meetings and other Medical Staff meetings as appropriate. The Strategic Planning Committee shall include representation from the Board of Directors, Executive Team, Medical Executive Committee and others as are appropriate relative to the agenda.

While strategic planning entails long-term visionary planning, it also must focus energies on what will be done today to ensure that desired realities emerge as a result of our planning and action. For each enduring objective, key initiatives will be identified with specific action plans for the ensuing year. Progress relative to these initiatives and action plans will be reviewed with the Board, management and the Medical Staff at periodic Strategic Planning Committee meetings and other forums as appropriate. The agendas for these meetings will be tailored to the interests and concerns of our Medical Staff and Board.

The District's Ten-Year Financial Forecast, a component of the Annual Budget, will prescribe the amount of recurring capital equipment

funding to be made available each fiscal year and will include those initiatives identified in the Strategic Plan. During the annual budget process, management will compile a list of requested capital equipment totaling no more than the prescribed amount. During the compilation process, management will take capital issues to the appropriate Medical Directors and Department Chairs for input and advice. New technologies under consideration must be taken to the Medical Technology Assessment and Coordination Team (MTACT) for discussion and recommendation for approval by the District Board of Directors, who ultimately decide whether or not to approve the technology for use in the District. The final compilation of capital equipment will be approved by the Board of Directors as a component of the Annual Budget.

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

Policy Number: EOC 1021	Date Created: 12/13/2012
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)	

Monitoring of Temperature and Humidity Levels in Sensitive Areas Procedural/Sterile Rooms

POLICY:

Temperature and Humidity levels are to remain within the defined ranges identified in the following tables. These ranges may be adjusted when it is determined the needs of medical staff and/or patient requires temperatures outside of the stated range. See References.

PROCEDURE:

A. **Monitoring and maintenance of temperature and humidity in the environment will occur in the following areas (Title 24/AORN):** There will be no changes to room location or names unless approved by EOC Committee and or Space Committee.

Area	Temperature Range in Fahrenheit	Humidity in %
OR1 through OR 12	60-75	30-60
OR 14 (ANTE RM)	60-75	30-60
OR 14 (URO)	60-75	30-60
OR Substerile (RM 2-6)	60-78	30-60
OR Substerile (RM 7/8)	60-78	30-60
OR Substerile (RM 9/10)	60-78	30-60
OR Substerile (RM 11/12)	60-78	30-60
OR Sterile Storage 1 (Basement)	60-78	30-60
OR Sterile Storage 2 (ASC)	60-78	30-60
MK LD C-Section OR 1	60-75	30-60
MK LD C-Section OR 2	60-75	30-60
AW OBOR 1	60-75	30-60
AW OBOR 2	60-75	30-60
MK LD Sterile Storage	60-78	30-60
AW LD Sterile Storage	60-78	30-60
AW CVL Sterile Storage Supply	60-78	30-60
CVL 1	60-75	30-60
CVL 2	60-75	30-60

Area	Temperature Range in Fahrenheit	Humidity in %
CVL 3	60-75	30-60
CVL 4	60-75	30-60
CVL 5	60-75	30-60
CVL Core Sterile Storage Supply	60-78	30-60
EVOR 6	60-75	30-60
CVOR 7	60-75	30-60
CVOR 8	60-75	30-60
CVOR 9	60-75	30-60
CVOR Sterile Core	60-78	30-60
SPD packaging/storage	60-73	30-60
Endo A	68-73	30-60
Endo B	68-73	30-60
Endo Clean Room	68-73	<70

***No Recommendation (NR)**

B. **Data collection:**

1. Temperature and humidity will be monitored and recorded a minimum of once daily by Facilities designee.

    a. Initial readings will be evaluated for being in range.
    b. If the measurements are found to be out of range, the designee will make adjustments and temperature will be rechecked in 30-minutes and documented.
    c. If the parameter is not met, the designee will notify the surgery charge staff and/or manager.
    d. The nurse manager or designee will evaluate the area and determine if patients and or equipment and instruments are at risk and take appropriate actions.
    e. If the parameter cannot be met, the nurse manager or designee will notify medical staff, who shall collaboratively decide whether it is safe to continue current and/or future cases.
    f. All corrective actions will be documented in the data base.
    g. The temperature and humidity deficiency logs shall be reviewed by Facilities and Infection Prevention (IP) Department on an as needed basis.
    h. Infection Prevention department will take notice of ~~note~~ any outside range readings and take into consideration these events during document review. The IP department may be consulted at any time for related questions or concerns.

C. Log Key

- A-temperature out of range
- B-humidity out of range
- C-unable to correct, management/proceduralist is notified

- D-proceduralist preference mgr/charge staff informed, case deemed safe to proceed
- E-temp and humidity within range
- F-temp and/or humidity out of range but case deemed safe to continue by proceduralist and manager
- G-room closed

A- temperature out of range
B- humidity out of range
C- unable to correct, management/proceduralist is notified
D- proceduralist preference mgr/charge staff informed, case deemed safe to proceed
E- temp and humidity within range
F- temp and/or humidity out of range but case deemed safety to continue by proceduralist and manager
G- room closed

REFERENCES:

ANSI/ASHRAE/ASHE (American National Standards Institute, American Society of Heating, Refrigerating and Air Conditioning and Engineers, American Society for Healthcare Engineers) Standard 170-2008

Association for the Advancement of Medical Instrumentation.2010. *Comprehensive guide to steam sterilization and sterility assurance in health care facilities.* ANSI/AAMI ST79.Arlington, VA.

California Mechanical Code. (2013). *Air Conditioning and Heating Systems*, 325.0. 51-52.

Perioperative Standards and Recommended Practices.(2019). Association of Operating Room Nurses. Denver, CO.

Risk Assessment as performed by Kaweah Delta Medical Center

"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 4000	Date Created: 10/01/2009
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)	

Hazard Material Management Plan

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

I. OBJECTIVE

The objectives of the Management Plan for Hazardous Materials and Waste Management at Kaweah Delta Health Care District (KDHCD) is to emphasize safety within the premises and off site areas, to promote safety awareness as a means of prevention, and to comply with all federal, state and local laws on safety and health. The hazardous materials and waste management program is designed to minimize the risks associated with exposures to hazardous materials and waste, to identify hazards, recommend appropriate corrective action, and evaluate implemented corrective action. This is accomplished through the inventory and control of hazardous materials and waste as defined by the authorities having jurisdiction, from point of entry into the facility to disposal.

II. SCOPE

The scope of this management plan applies to **KDHCD**, and any off site areas, per KDHCD License.

Off-site areas are monitored for compliance with this plan during routine surveillance by Environment of Care (EOC) committee members. It is the responsibility of the Safety Officer to assess off site areas relative to their usage of hazardous materials and waste. Hazardous materials -related issues may be brought to the attention of the EOC Committee. The scope of the plan and program includes, but is not limited to the following safety-related activities: surveillance activities, and applicable safety policies and procedures, educational and performance improvement
activities.

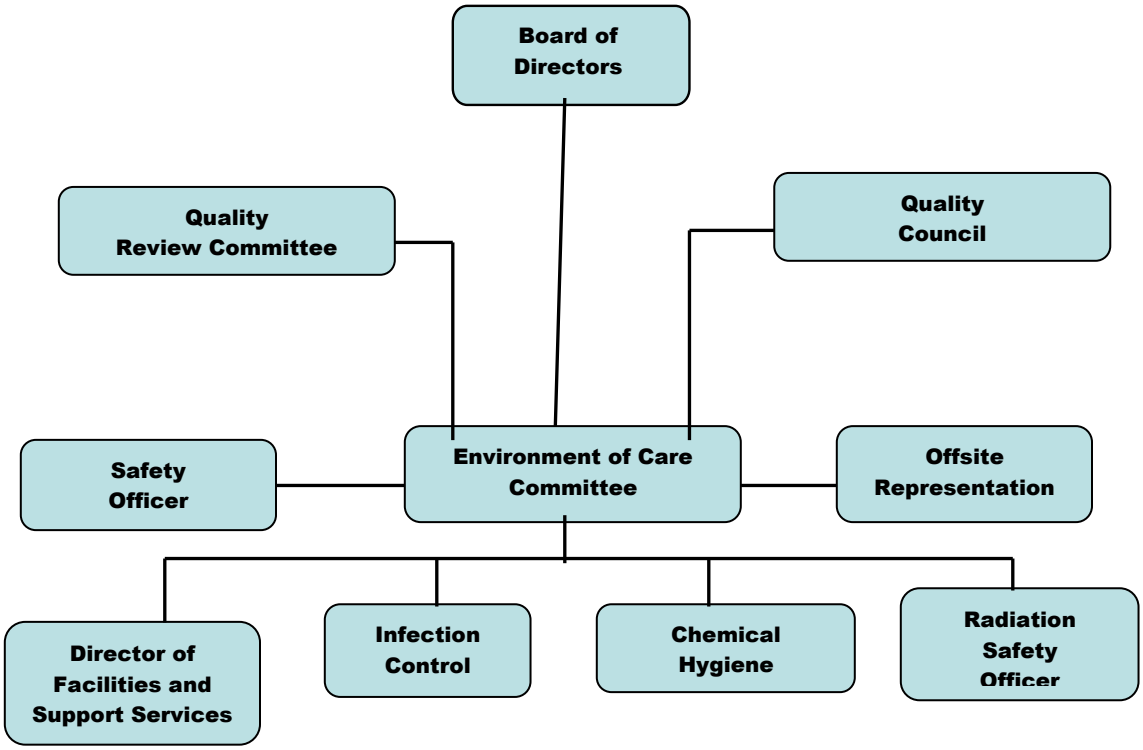
III. AUTHORITY

The authority for the Management Plan for Safety is EC. 01.01.01 and EC. 02.02.01. The authority for overseeing and monitoring the hazardous materials management plan and program lies in the **EOC** Committee, for the purpose of ensuring that hazardous materials activities are identified, monitored and evaluated, and for ensuring that regulatory activities are monitored and enforced as necessary. The Director of Facilities has the authority to oversee the hazardous materials and waste program at KDHCD.

IV. ORGANIZATION

The following represents the organization of hazardous materials management at KDHCD:

Organization – Hazardous Materials Management



V. RESPONSIBILITIES

Leadership, managers and staff have varying levels of responsibility relating to the Hazardous Materials and Waste Management program as follows:

Board of Directors: The Board of Directors supports the Hazardous Materials and Waste Management plan by:

- Review and feedback if applicable of the quarterly **EOC** reports
- Endorsing budget support as applicable, which is needed to implement a safety or health improvement identified through the activities of the Hazardous Materials and Waste Management Program.

Quality Council: Reviews annual **EOC** Committee report, and provides broad direction in the establishment of performance monitoring standards.

Administrative Staff: Administrative staff provides active representation on the **EOC** Committee meetings and sets an expectation of accountability for compliance with the Hazardous Materials and Waste Management Program.

Environment of Care Committee: **EOC** Committee members review and approve the quarterly **(EOC)** reports, which contain a Hazardous Materials and Waste Management component. Members also monitor and evaluate the Hazardous Materials and Waste Management program (EC .04.01.01-1), and afford a multidisciplinary process for resolving issues relating to hazardous materials and hazardous waste. Committee members represent clinical, administrative and support services when applicable.

Directors and Department Managers: These individuals support the Hazardous Materials and Waste Management Program by:

- Reviewing and correcting hazardous materials and waste management deficiencies identified through the hazard surveillance process.
- Communicating recommendations from the **EOC** Committee to affected staff in a timely manner.
- Developing education programs or training within each department that ensures compliance with hazardous materials and waste management policies.
- Setting clear expectations for employee participation in safe practices relating to hazardous materials and hazardous waste to include a disciplinary policy for employees who fail to meet the expectations.
- Serving as a resource for staff relating to applicable hazardous materials and waste management practices.
- Ensuring that the procedure for work-related exposures to hazardous materials is followed, and that accident investigation is completed immediately post injury or exposure, and documented on the appropriate form.
- Ensuring employees have access to the applicable spill kits in their department
- Informing employees of the location of Safety Data Sheets (SDS) and other information related to hazardous substances, and teaching employees how to obtain an SDS from the KDNET: Through KD Central.

  A Hard copy of SDS is available in Emergency Department and Safety

Employees. Employees of KDHCD are required to participate in the Hazardous Materials and Hazardous Waste Management Program by:

- Knowing where the SDS contact information is located
- Properly labeling hazardous waste
- Ensuring labels are present on hazardous materials
- Completing unit-specific and annual education as required, which includes a hazardous materials component
- Wearing the appropriate personal protective equipment.
- Ensuring that hazardous waste is disposed of properly.
- Staff is responsible for knowing how to access spill kits, and for following safety procedures when working with hazardous chemicals.

Radiation Safety Officer: The Radiation Safety Officer implements the various aspects of the radiation safety program. Some of the responsibilities are: required radiation surveys, personnel radiation exposure monitoring program, maintenance of the hospital radioactive materials license, radiation protection training program, radiation incident response, radioactive waste management and radioactive material inventory records. The Radiation Safety Officer ensures that radiation safety activities are being performed according to approved policies and procedures, and that all ALARA guidelines and regulatory requirements are complied with in the daily operation of the licensed program.

Chemical Hygiene Officer, Pathology: Provides guidance with spills procedures and prevention including transportation issues, oversees air monitoring requirements in Pathology and is responsible for keeping a current updated Chemical Hygiene Plan, and related requirements within the plan. The Chemical Hygiene Officer acts as a resource for departments relating to hazardous materials and waste.

Director of Facilities and Safety Officer:

- Provides technical guidance relating to the following, as they may impact on the Hazardous Materials program: Hazardous materials storage: site construction, planning, transportation, relocation as necessary, permits for air discharge, water discharge, UST, waste treatment and waste disposal, and any follow-up related to Air Toxic Hot Spots and Industrial Wastewater Discharge, Underground Storage Tank Monitoring,
- Ensures no hazardous waste is left on the premises from construction activities, and ensures the appropriate SDS is provided in the event hazardous materials in a product is used for work within the premises.
- Performs air-monitoring activities in the OR on an annual basis and in departments requiring monitoring due to the use of regulated chemicals (e.g., formaldehyde, xylene, glutaraldehyde).

Medical Staff: Medical Staff will support the Hazardous Materials and Waste Management Program by practicing safe work practices while performing procedures that include hazardous materials, and assisting in the care of employees who receive a hazardous materials exposure.

EC. 02.02.01-EP 1The hospital maintains a written, current inventory of hazardous materials and waste that it uses, stores, or generates. The only materials that need to be included on the inventory are those that address handling, use and storage by law and regulation.

Criteria for Identifying, Evaluating and Inventorying Hazardous Materials:

A. **Identification**. The Radiation Safety Officer identifies the criteria for radioactive usage and waste at the hospital. Infection Control defines infectious waste in accordance with the applicable regulation. The Facilities Director/Safety Officer identifies the definitions of hazardous chemicals in accordance with the applicable law or regulation. Labels and warning signs are placed on hazardous chemicals, to further assist staff in knowing what the physical and health hazards are. Hazardous substances are those that create a health or physical hazard.

Any substance on the following lists is considered a hazardous material:

- 29 CFR 1910, Subpart Z, Toxic and Hazardous Substances
- The Threshold Limit Values for Chemical Substances and Physical Agents in the Work Environment, published by the American Conference of Governmental Industrial Hygienists (ACGIH).
- The Annual Report on Carcinogens published by the National Toxicology Program (NTP).
- Monographs published by the International Agency for Research on Cancer (IARC).
- If the hazardous material causes or significantly contributes to an increase in mortality or an increase in serious irreversible illness or death or if the hazardous material poses a substantial hazard to human health or the environment when improperly treated, stored, transported, or disposed of or otherwise managed.

Categories of Hazardous Waste Include:

- Flammable/Ignitable: Substances with a flashpoint of less than 140 degrees F. (Examples: acetone, benzene, ethylene, methanol and xylene).
- Corrosives. Substances with a pH of less than 2.0 or greater than 12.5; that can cause destruction of or irreversible damage to living tissue (Examples include: hydrochloric acid, sulfuric acid and sodium hydroxide).
- Chemically Reactive: substances such as hydrogen peroxide and picric acid that are unstable in air.
- Toxic Substances: Substances that meet certain specified toxicity criteria or that are included in the State EPA list of hazardous or extremely hazardous materials. (Examples include lead, mercury, chromium, arsenic and chemotherapeutics).

The definition of hazardous does not apply to the following:

- Tobacco
- Wood or wood product
- A manufactured item which is formed to a specific shape and does not release or result in exposure to a hazardous chemical, under normal conditions of use, such as pens, typewriter ribbons, and the like.
- Food, drugs, or cosmetics intended for personal consumption by employees.
- Any consumer product or hazardous substance which is used in the same manner as normal consumers use, and which use results in a duration and frequency of exposure which is not greater than exposure experienced by a consumer.
- Any drug in solid, final form for direct administration to the patient, (i.e., tablets or pills).

B. **Use of Alternate Sources**. Whenever possible, alternate chemicals are evaluated for use in an effort to contain the use of hazardous materials. For example, when possible, alkaline batteries may be substituted where mercury batteries are used, and lead-based paint will not be used. Or water-based paint will be used instead of oil-based; flammable thinners will be avoided, and only organic fertilizers will be used on the grounds. Whenever possible, evaluation will be made for hazardous materials that may be recycled, such as waste oil.

Other hazardous waste reduction strategies include:

- Available Waste Reduction Methods (source reduction, recycling) and source reduction techniques (good housekeeping practices, material substitution, modification of the technology, inventory control, regular inspections of hazardous materials and waste storage areas).

- Hazardous Items: fluorescent light tubes (recycled or manifested as hazardous waste), small household batteries (disposed as hazardous waste), asbestos waste (manifested), waste elemental mercury (subject to regulations until it is recycled), waste oil (subject to regulations until it is recycled), silver waste (treated and recycled offsite), chemotherapeutic waste and trace cytotoxic wastes (manifested), lead acid batteries (sent to a facility that fully complies with the waste management requirements for hazardous wastes).

C. **Inventory**. Policy and procedure identify the inventory process at the hospital. On an annual basis, it is the responsibility of the department directors to complete an annual

chemical inventory for the Safety Officer, and submit copies of SDS. This process increases the likelihood that the central file of all SDS is as current as possible.

EC.02.02.01-3 and 4
The hospital has written procedures, including the use of precautions and personal protective equipment to follow in response to hazardous material and waste spills or exposures. KDHCD ensures Safety Data Sheets (SDS) are available for staff using hazardous materials, which identify the appropriate precautions and required personal protective equipment to be used when handling the hazardous material. Written procedures to follow in response to a hazardous material and waste spill or exposure include the following:
Emergency Procedures

A. **Spills**

Major Spills, i.e., spills constituting a danger or threat: In the event a hazardous spill occurs that creates an unsafe condition for personnel, patients or the hospital, 9-911 will be dialed and the local Haz-Mat Team will be summoned from the Fire Department. In addition, PBX is called, by dialing 44, to ensure that proper internal procedures are established to prevent further contamination from spills, without endangering employees (which may include evacuating staff, closing doors to contain the spill, providing caution tape to deny entry to the area). A major spill occurs under the following conditions:

- A life-threatening condition exists;
- The condition requires the assistance of emergency personnel
- The condition requires the immediate evacuation of all employees from the area or the building
- The spill involves quantities that exceed a specified volume
- The contents of the spilled material is unknown
- The spilled material is highly toxic, bio-hazardous, radioactive or flammable
- Employees feel physical symptoms from the exposure.

Minor Spills: Minor spills are spills that constitute no immediate danger or threat. Spills causing no immediate danger or threat to personnel or the District may be safely cleaned with the appropriate spills kit by the staff member involved in the spill.

EC.02.02.01-5 and 6
KDHCD minimizes risks associated with selecting, handling, storing, transporting, using and disposing hazardous chemicals and radioactive materials.

Selecting, Handling, Storing, Using and Disposing Hazardous Materials (Chemicals)

Selecting: Hazardous materials are ordered and received by the Materials Management Department, and transported to the end users. The Materials Management Department is responsible for distributing the SDS to the using department.

Handling: SDS provide guidelines to users regarding the handling of hazardous materials and wastes, including the appropriate personal protective equipment to be worn (e.g., gloves, goggles, aprons, masks,etc.), appropriate storage and proper disposal. Any questions regarding disposal are to be referred to the supervisor or Safety Officer. All chemicals must be properly labeled so they can be properly identified prior to use. Department specific policies will address handling and use

in areas such as Radiology – for radioactive substances, Laboratory – for chemicals, Environmental Services and Nursing for infectious materials.

Storing: Hazardous materials are stored, with attention to the appropriate segregation practices. These are determined by the using site, and by the type of chemicals to be stored. For example, acids are stored separately from bases, flammables are stored in a flammable-resistant container. Hazardous Materials waste may not be stored on the hospital premises for more than 90 days.

Using. The SDS show staff information relating to specific usage regarding the hazardous chemicals. In certain instances, policies and procedures are in place, and when necessary, specialized education where necessary, that describes to staff how hazardous chemicals will be used.

Transporting. Hazardous materials must be transported in approved containers and carts to minimize the risk of spill or damage to the primary container. Pressure vessels/cylinders must be transported in approved carts.

Disposing: Disposal methods used depend on the nature of the waste material. Bio-hazardous waste is separate from hazardous waste, governed by the Medical Waste Act of 2017, and disposed in special containers, both at a terminal collection point on the using unit, and in a terminal collection point outside the hospital. Pharmaceuticals may be returned to the manufacturer/distributor, or disposed in accordance with Pharmacy policy. RCRA pharmaceutical waste is disposed of in special containers at a terminal collection point on the unit. Radioactive materials are decayed to background radiation levels on site and then disposed as normal waste or returned to the manufacturer/distributor. Trace amounts of chemotherapeutic drugs are disposed of in special chemotherapy waste receptacles. Pourable or scrapable amounts are disposed of as chemotherapy waste. If the nature of hazardous waste is not known, the Safety Officer will contract with a licensed hazardous waste hauler and request a profile of the unknown hazardous waste, and when the profile has been completed, the waste will be manifested. When a hazardous waste is manifested, the District's generator identification must be used (i.e., EPA number).

The Management of Waste. It is the responsibility of the hospital to determine if the waste generated is hazardous. Hazardous wastes are separated into hazardous waste streams according to their compatibility and similarity, handling requirements, recycling and disposal. Each waste stream can consist of more than one type of waste provided they are chemically and physically compatible and can be treated or recycled in the same manner. Separation is important for economic reasons. Disposal costs for different types of wastes vary, and mixing a small amount of a waste having a high disposal cost with a larger volume of other waste may not be economically feasible. Hazardous chemical waste comes from a variety of sources within the hospital. It is collected at the point of use and segregated into containers intended for only one kind of chemical waste. Waste from chemicals is not to be mixed together because of the potential for reactions. Chemical waste must be treated as follows:

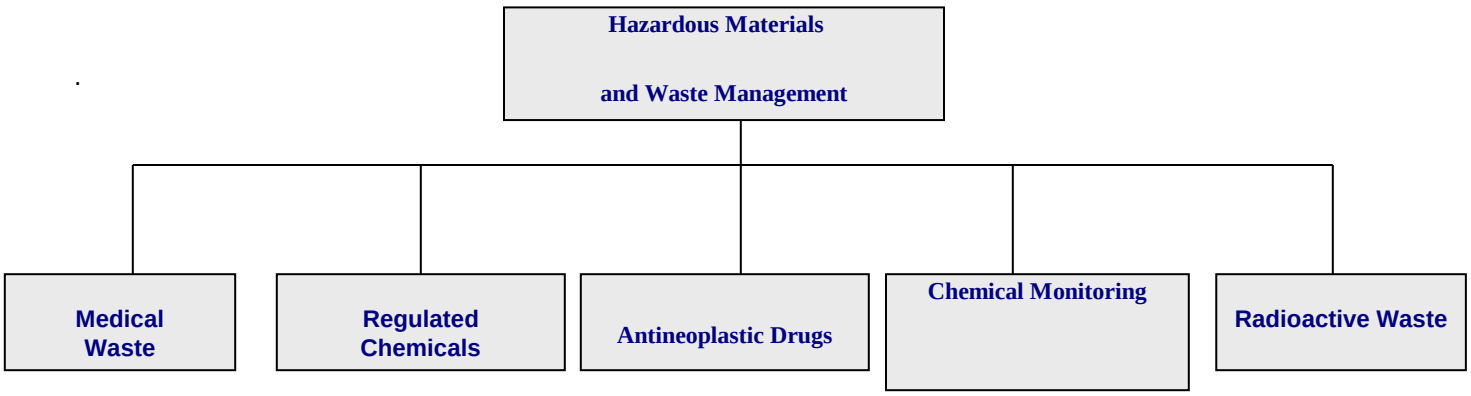
1.The chemical waste is labeled.
2. The chemical waste is placed in the appropriate container.
3. The chemical waste is removed from the area as soon as possible.
4. The chemical waste may not be stored for more than 90 days
5. The chemical waste is manifested in accordance with regulation.

Radioactive Waste

A large proportion of the radioactive materials used in the District have a relatively short half-life. Materials with a short half-life can be handled by storage in a safe location on-site until the radioactivity level has decayed to the point where the level of radioactivity is approaching the natural background level. The materials can be safely discharged into the regular waste stream. The following applies to radioactive waste:

- All containers of radioactive materials are to be appropriately labeled.
- Areas where radioactive materials and waste are stored must be secured against unauthorized entry and possible removal of the materials.
- All "hot" and "decay" areas are to be designated as controlled areas for the purpose of surveillance and posting, and appropriate caution signs are to be used in these areas.
- Controlled areas are to be tested or monitored with equipment capable of detecting and measuring airborne radioactive levels in order to ensure the safety and integrity of the storage area.
- Appropriate personal protective equipment such as disposable gloves are worn whenever personnel handle radioactive materials.
- Special handling procedures are in place for contaminated linen, water, equipment and supplies.

Special Note: Radioactivity and Safeguards: Precautions are in place relating to safeguards that minimize risk during the use, transport, storage and disposal of radioactive materials. Direct deliveries are made to the using areas by trained, certified Fed Ex personnel, and all deliveries are logged upon entering and exiting the District. The logs are kept indefinitely, under the oversight of the Radiation Safety Officer (RSO). Unused radioactive sources are shipped back to the vendor. The radioactive waste is kept at the facility for decay-in-storage and deposited in the normal trash after ten half-lives, as determined by the RSO. If radioactive materials are brought to the OR, they are carried by the RSO or Medical Physicist, with any leftover sources brought directly back to the Hot Lab by the RSO.



EC.02.02.01-7

KDHCD **minimizes risks associated with selecting and using hazardous energy sources**. Note: Hazardous emergency sources include, but are not limited to, those generated while using ionizing or non-ionizing radiation equipment and lasers.

Radiation Safety The hospital has a Radiation Safety Officer and radiation safety policies. Quarterly radiation safety meetings are held to monitor overall compliance with radiation and radioactive activities, and legal requirements as defined by the applicable codes. The principle of "ALARA" (As Low as Reasonably Achievable) drives how the radiation safety activities are be implemented and monitored (ALARA= keeping radiation exposure as low as reasonably achievable): Radiation safety processes in place include the following, but are not limited to:

- Identification of qualifications for physicians who practice fluoroscopy.
- Record keeping, and monitoring of radiation exposures (doses, personnel dosemitry, posting, labeling, warning system. For CT, PET or NM services, staff dosimetry results are reviewed at least quarterly by the Radiation Safety Officer or diagnostic medical physicist to assess whether staff radiation exposure levels are as low as reasonably achievable (ALARA) and below regulatory limits.
- Leak testing for sealed sources
- Appropriate signage for areas where radiation may be present.
- Regulations and reporting of theft of loss of licensed materials
- Correct usage of personal protective equipment
- Equipment calibration

Laser Safety

Laser safety is the avoidance of laser accidents, especially those involving eye injuries. The safe usage of laser is subject to governmental regulations. Laser safety in the Operating Room is the responsibility of the Laser Safety Officer. Maximum permissible exposure limits are in place, and monitored. A classification system defines the type of warning labels that must be in place at specific laser emission levels.

EC.02.02.01-8 and MM.01.01.03-4)

The hospital minimizes risk associated with disposing hazardous medications

Managing Chemotherapeutic Waste Chemotherapeutic waste is defined as toxic substance waste, and must be placed in designated containers with covers. The container must have the appropriate label affixed to it. Chemotherapeutic waste must be segregated into two waste classifications or waste streams as follows:

1. "Trace Chemotherapeutic Waste" for trace amounts and,
2. "Pourable Hazardous Chemotherapeutic Waste" for pourable/scrapable amounts.

The Pharmacy is responsible for labeling the "Pourable Hazardous Chemotherapeutic Waste" container, and the waste generating department is responsible for labeling the "Chemotherapeutic Waste" (trace amounts).

Procedures are in place that identify where the chemotherapeutic waste will be stored, how long it will be stored, and how frequently the pick-up will be. The responsibility for the collection of trace waste is identified (Environmental Services). Hazardous chemo waste is transported through the hospital in a hazardous materials cart, separate from other wastes, to the approved storage area. Chemotherapeutic waste (trace) is transported separately from non-medical waste and manifested within 90 days as hazardous waste. The appropriate tracking documents are generated (manifests) and only licensed haulers are used to transport the waste.

EC. 02.02.01-9

The hospital minimizes risks associated with selecting, handling, storing, transporting, using and disposing hazardous gases and vapors. Note: Hazardous gases and vapors include, but are not limited to, glutaraldehyde, ethylene oxide, vapors generated while using cauterizing equipment and lasers, and gases such as nitrous oxide.

Minimization of Risks

- There are practices in place to minimize the risks associated with selecting, handling, storing, transporting, using and disposing hazardous gases and vapors.

- Selection of hazardous gases and vapors. The selection of hazardous gases and vapors is based upon the effectiveness of the hazardous substance with respect to treatment options, infection prevention, and or other benefits to the care of the patient.
- Handling/Storing/Transporting/Using hazardous gases and vapors. Hazardous gases are stored in rigid containers, and handled with care by staff who transport or use the hazardous gas. Or hazardous gas may be piped into critical units, based upon need and usage (e.g., nitrous oxide). Employees are knowledgeable of the use of hazardous gases by labeling, reading the appropriate Safety Data Sheet, or by receiving unit-specific training at the department level.
- Disposal of hazardous gases and vapors. Engineering controls and or alarms are in place to minimize the escape of hazardous gases and vapors.

EC. 02.02.01-10

The hospital monitors levels of hazardous gases and vapors to determine if they are in safe range.

Note: Law and regulation determine the frequency of monitoring hazardous gases and vapors as well as acceptable ranges.

Internal processes that support this standard include:

1) Scheduled monitoring plan for hazardous gases and vapors. Annual monitoring occurs in Pathology for xylene, formaldehyde, and glutaraldehyde.
2) WAG System Checking in the Operating Room. The Operating room is scheduled annually for waste anesthetic gas monitoring (nitrous oxide), coordinated by Facilities.
3) Equipment in the OR. Procedures are in place in the Operating Room to prevent the possibility of oxygen ignition. These include "Oxygen-enriched Environment Education", and at least one fire drill is conducted annually in the OR.

EC.02.02.01-11

For managing hazardous materials and waste, the hospital has the permits, licenses, manifests, and materials safety data sheets required by law and regulation.

Internal processes that support these activities include:

Permits, Licenses: All permits and licenses (e.g., permit to generate hazardous and biological waste, permit for an Underground Storage Tank, Hazardous Materials disclosure fees,) are maintained in the Facilities Department. It is the responsibility of Facilities personnel to ensure the permits are current on an annual basis with the agency having jurisdiction.

EC.02.02.01-12

KDHCD **labels hazardous materials and waste. Labels identify the contents and hazard warnings.**

Footnote: The Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogens and Hazard Communications Standards and the National Fire Protection (NFPA) provide details on labeling requirements.

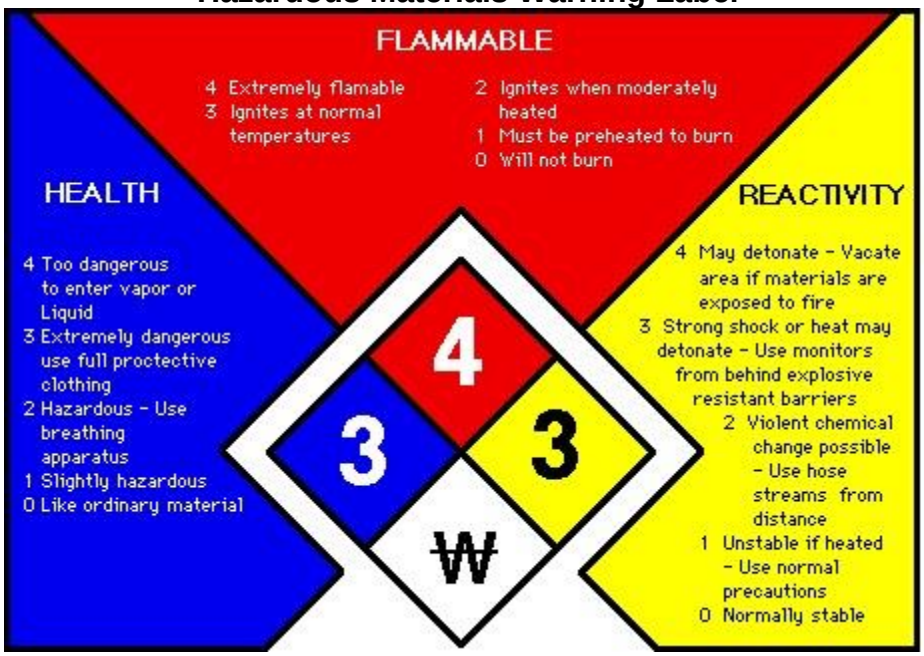
Labeling of Hazardous Materials: All hazardous materials used throughout the District must be labeled with the information that is generated from the manufacturer. If a hazardous material is transferred from the original container to a secondary container, the secondary container must have the same information as the manufacturer's label, unless all of the hazardous material in the secondary container is going to be used immediately after pouring. The user of the hazardous materials is responsible for affixing the appropriate label to the secondary container

EC 02.02.01-17-18
The results of staff dosimetry monitoring are reviewed at least quarterly by the radiation safety officer, diagnostic medical physicist, or health physicist to assess whether staff radiator exposure levels are "as low as reasonably achievable" (ALARA) and below regulatory limits.
Radiation workers are checked periodically, by the use of exposure meters or badge tests, for the amount of radiation exposure.

The Radiation safety committee meets on a regular basis to review all radiation safety topics.
Staff working in those areas wear exposures meters to measure amount of radiation exposure.

Labeling of Hazardous Wastes: All spent hazardous wastes must have the appropriate label affixed to the container holding the hazardous waste. The name of the chemical must be on the container, as well as the "start accumulation date" relating to the storage of the hazardous waste. No hazardous waste will be stored for more than 90 days. The following information from NFPA 704 and the Bloodborne Pathogen standard is used on warning labels:

Hazardous Materials Warning Label

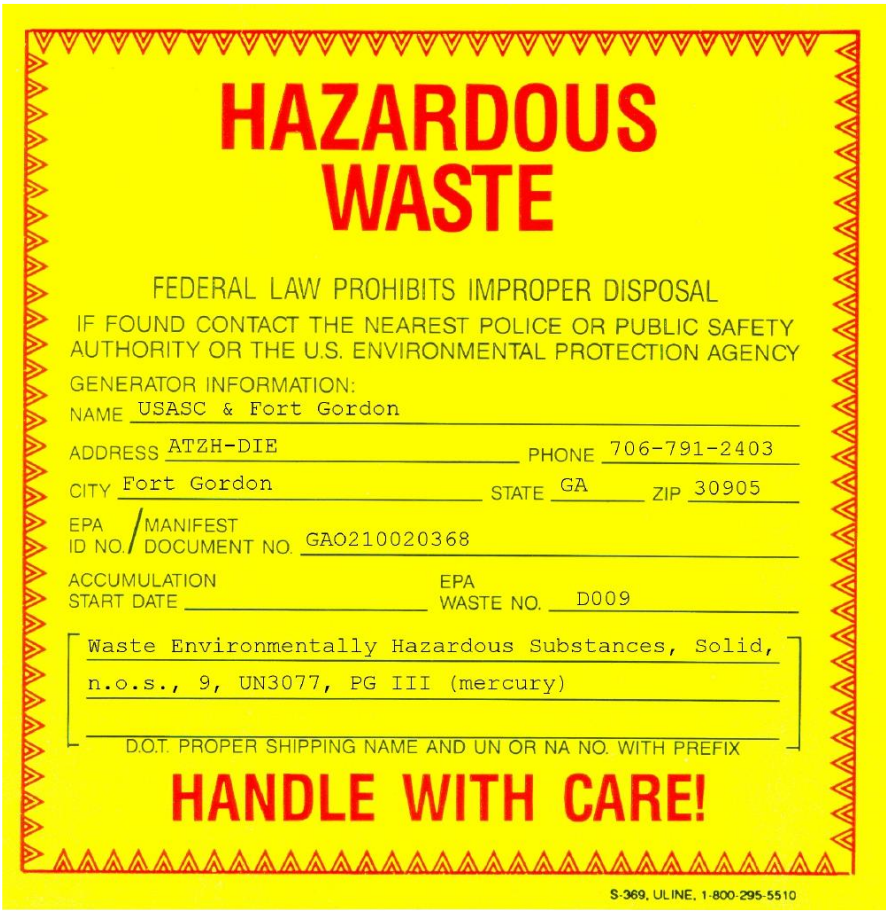


Bloodborne Pathogen Warning

.

All hazardous waste must contain a hazardous waste label that identifies the name of the medical center, address, phone number, manifest document, and EPA Waste Number as follows:

Hazardous Waste Label for Manifest - Sample



INFORMATION COLLECTION SYSTEM TO MONITOR CONDITIONS IN THE ENVIRONMENT
EC.04.01.01-EP's 1-11
The hospital establishes a process(es) for continually monitoring, internally reporting, and investigating the following:

- **Hazardous materials and waste spills and exposures**

Through the Environment of Care Committee structure, hazardous materials and waste spills and exposures are reported quarterly. Minutes and agendas are kept for each Environment of Care meeting and filed in the Safety office.

ANNUAL EVALUATION OF THE HAZARDOUS MATERIALS AND WASTE MANAGEMENT PLAN
EC..04.01.01-EP-15

Every twelve months, *Environment of Care* Committee members evaluate the Management Plan for Hazardous Materials and Waste Management, as part of a risk assessment process. Validation of the management plan occurs to ensure contents of each plan support ongoing activities within the medical center. 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 Hazardous Materials and Waste Management plan will be evaluated to determine continued relevance for the medical center (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 Hazardous Materials and Waste Management plan: the targeted populations for the management plan will be evaluated (e.g.) did the scope of the plan reach employee populations in the off-site areas, and throughout the medical center?)

Performance Standards.
Specific performance standards for the Hazardous Materials and Waste Management plan will be evaluated, with plans for improvement identified. Performance standards with 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.

PRIORITY IMPROVEMENT PROJECT
EC.04.01.03-EP-3
At least annually, one or more priority Improvement activities may be selected by the *Environment of Care* Committee. The priority improvement activity is based upon ongoing performance monitoring and identified risk within the environment. The priority improvement activity may be related to processes within the Hazardous Materials and Waste Management program if risk has been identified.

(KDHCD) **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 Hazardous Materials and Waste 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.

Patient Safety
Periodically there may be an environment of care issue that has impact on the safety of our patients. This may be determined from Sentinel Event surveillance, environmental surveillance, patient safety standards or consequential actions identified through the risk management process. When a patient-safety issue emerges it is the responsibility of the Safety Officer or designee to bring forth the issue through the patient safety process. If there is risk identified within the Hazardous Materials and Waste Management processes that impact the safety of the patient, the issues will be brought forth to Patient Safety.

"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 1001	**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)	

Safety Management Plan

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

I. OBJECTIVES

The objectives of the Management Plan for Safety at Kaweah Delta Health Care District (KDHCD) is to provide a built-environment wherein patient care can be optimized~~,~~ and to create an environment that minimizes physical harm and hazards for the patient-care population, staff, volunteers, physicians, contracted workers and visitors. It is an accreditation/standards-based and regulatory driven program, which is assessed for effectiveness during the annual evaluation process.

II. SCOPE

The scope of this management plan applies to KDHCD and any off site area as per KDHCD license. Off-site areas are monitored for compliance with this plan during routine surveillance by Environment of Care (EOC) committee members. Each off site area is required to have a unit-specific safety plan that addresses the unique considerations of the building environment. Off-site areas are monitored for compliance with this plan during routine environmental surveillance by EOC Committee members. It is the responsibility of the Safety Officer to assess and document compliance with the Safety Management Plan. Safety-related issues may be brought to the attention of the EOC Committee. The scope of the plan and program includes, but is not limited to the following safety-related activities: surveillance activities, applicable safety policies and procedures, educational and performance improvement activities.

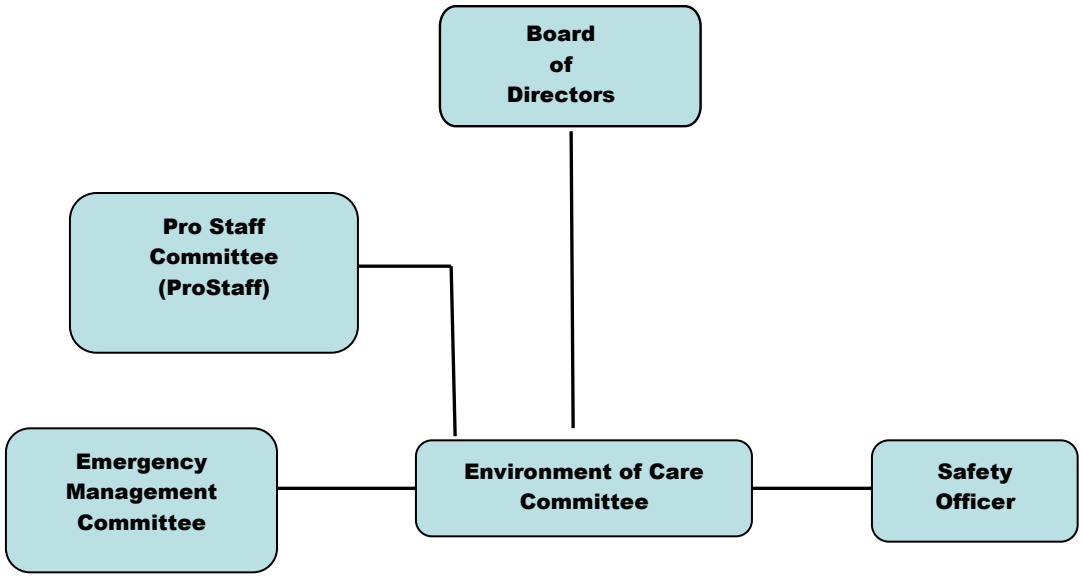
III. AUTHORITY

The authority for the Management Plan for Safety is EC. 01.01.01 and EC. 04.01.01. The authority for overseeing and monitoring the safety management plan and program lies in the EOC Committee, for the purpose of ensuring that safety management activities are identified, monitored and evaluated, and for ensuring that regulatory activities are monitored and enforced as necessary. Whenever possible, regulatory requirements are integrated with accreditation standards to avoid duplication of efforts and to assist in meeting or exceeding the requirements or the accreditation standards. The Chief Executive Officer and Board of Trustees have given the Safety Officer the authority to intervene whenever a hazard exists that poses a threat to life or property at a KDHCD facility.

IV. ORGANIZATION

The following represents the organization of safety management at KDHCD:

Organization - Safety Management



V. RESPONSIBILITIES

Leadership within KDHCD has varying levels of responsibility and work together in the management of risk and in the coordination of risk reduction activities in the physical environment as follows:

Board of Directors: The Board of Directors supports the Safety Management Plan by:

- Review and feedback if applicable of the quarterly and annual *Environment of Care* reports
- Endorsing budget support as applicable, which is needed to implement a safe and healthy environment, identified through the activities of the Safety Management Program.

ProStaff: Reviews annual *Environment of Care* report from the EOC Committee, providing feedback if applicable.

Administrative Staff: Administrative staff provides active representation on the EOC Committee meetings and sets an expectation of accountability for compliance with the Safety Management Program

Environment of Care Committee: EOC Committee members review and approve the quarterly *Environment of Care* reports, which contain a Safety Management component. Members also monitor and evaluate the Safety Management program **(EC .04.01.01-1)** and afford a multidisciplinary process for resolving EOC issues. Committee members represent clinical, administrative and support services when applicable. The committee addresses *EOC* issues in a timely manner, and makes recommendations as appropriate for approval. *EOC* issues are communicated to the KDHCD's leaders through quarterly and annual evaluation reports. At least annually, one Process Improvement activity is selected by EOC Committee members, based upon risk to the organization. EOC issues are communicated to those responsible for managing the patient safety program as applicable.

Directors and Department Managers: These individuals support the Safety Management Program by:

- Reviewing and correcting deficiencies identified through the hazard surveillance process.
- Communicating recommendations from the EOC Committee to affected staff in a timely manner.
- Developing education programs within each department that insure compliance with the policies of the Safety Management Program including, but not limited to department-

specific safety training for new hires, students, volunteers, contracted workers, annual safety reorientation and unit-specific hazard training applicable to their areas.

- Supporting all required employee safety education and training by monitoring employee participation and setting clear expectations for employee participation to include a disciplinary policy for employees who fail to meet the expectations.
- Serving as a resource for staff on matters of health and safety.
- Ensuring employees are knowledgeable on how to access EOC Policies on KDNet or Policy Tech.
- Ensuring that the procedure for work-related injuries is followed, and that accident investigation is completed immediately post injury or exposure, and documented on the appropriate form.

Employees. Employees of KDHCD are required to participate in the Safety Management program by:

- Completing required safety education.
- Using the appropriate personal protective equipment when applicable.Practicing safe work habits and reporting any observed or suspected unsafe conditions to his or her department manager as soon as possible after identification.

Medical Staff: Medical Staff will support the Safety Management Program by practicing safe work practices while performing procedures at KDHCD, and assisting in the care of employees who receive a work-related injury.

SAFETY OFFICER AUTHORITY

Safety Officer. A qualified individual, is appointed by executive leadership to assume the safety officer role, and oversees the development, implementation and monitoring of safety management at KDHCD. The Safety Officer is responsible for responding to system or process failures that may have an impact on employee, patient or building safety.

MANAGEMENT OF SAFETY RISKS

(KDHCD) identifies safety risks associated with the environment of care. Risks are identified from internal sources such as ongoing monitoring of the environment, results of root-cause analyses, results of annual proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts. If a risk is identified, a risk/benefit analysis process is used to determine if actions and monitoring activities are required. This information is documented and presented to the EOC committee.

Risk Assessment: The management of risks within KDHCD **is multi-focal, and consists of the following processes:**

1. **Policy/Plan/Program Development**. Inherent in risk assessment are the development of safety policies (e.g., Safety Manual or unit-specific), management plans, and program development for safety through the structure of the EOC Committee. Regulations, accreditation or industry standards (e.g., TJC, Title 8 – Employee Illness and Injury Prevention Program, Title 22-licensing requirements for acute care facilities, Title 17-Radiation Safety, OSHA 29 CFR 1910-Chemical Hygiene Officer and Plan) provide the basis and authority for policy/plan and program development.
2. **Environmental Surveillance, Results of Root-Cause Analyses, Pro-active Risk Assessment of high-risk processes.** Included in risk assessment are findings during environmental surveillance that reflect risk identification, and findings from root-cause analyses that require follow-up and improvement actions. During the annual evaluation process, risk identification may occur from a retrospective analysis of performance monitoring of high-risk processes, which will require a plan for improvement to minimize unfavorable outcomes from the possibility of consequential risks. Accountability for assessment and improvement activities are with the EOC committee.
3. **External Sources:** *Sentinel Event Alerts*, Regulatory and Insurer inspections, Audits, and Consultants. Risk assessment may occur as a result of findings or recommendations generated from external sources, such as *Sentinel Event Alerts,* Regulatory and/or Insurer

surveys, or audits conducted by recruited consultants. Accountability for assessment and improvement activities is with the EOC committee.

4. **Education:** Education is implemented to provide information~~,~~ and thereby mitigate risk and includes, but is not limited to:
    - New hire
    - Annual Reorientation
    - Department Specific Education
    - Education for patients, staff, physicians, volunteers, students
    - Education based upon a needs assessment for any specific population.
    - Education based upon risk assessment or the results of surveys, inspections or Audits
5. **Drills – Planned Exercises:** Conducting drills such as fire, disaster, and infant security constitute activities designed to inform, educate and thereby mitigate risk when areas of risk are identified during the debriefing and or evaluation process.
6. **Interim Life Safety Risk Assessment.** The *Interim Life Safety Risk Assessment* process is used to identify potential risks associated with construction, with the intent to develop interim life safety measures to mitigate the risks associated with construction projects. Concurrent building safety guidelines/processes are used to mitigate the risks associated with new construction (e.g., permits, Life Safety Code compliance, current *Statement of Conditions, Guidelines for Design and Construction of Hospitals and Health Care Facilities).*
7. **Reporting and Investigation of Incidents:** Complementary to risk assessment is proper reporting and investigation of incidents. There are multiple processes within KDHCD wherein reporting and investigating elements contribute to risk assessment. Internal processes and activities that support risk assessment include reporting and investigation mechanisms which may identify the opportunity to mitigate risk, such as:
    - Security investigation of property damage, thefts, vandalism, burglary, assault, battery and any violent incidents.
    - Risk Management investigations of patient and visitor incidents, including incidents on the grounds and premises.
    - Employee Health investigations that addresses employee incidents and injuries within Kaweah Delta Health Care District and on the grounds and premises.
    - Infection Control investigations and or surveillance that pro-actively identify practices that provide the opportunity to mitigate risks
    - Material Distribution recalls for products that may pose risk and the opportunity to proactively mitigate the potential for adverse outcomes
    - Pharmaceutical recalls, medication errors or near-misses that may provide the opportunity to proactively mitigate risk

ACTIONS TO MINIMIZE OR ELIMINATE IDENTIFIED SAFETY RISKS

KDHCD **takes action to minimize or eliminate identified safety risks.**

When risks are identified from the above processes, the EOC Committee uses the risks identified to select and implement procedures and controls to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people coming to KDHCD. Moreover the identified risks may serve as the basis for the selection of performance standards, with the criteria identified as follows:

- The performance standard represents a high-volume activity, thereby representing risk by virtue of ongoing occurrences.
- The performance standard could represent a sentinel event activity (e.g., infant abduction). These types of activities, though rare in occurrence, represent risk due to their seriousness.
- The performance standard represents an activity or finding that needs improvement due to the possibility of adverse outcomes

Risk Reduction Strategies-Proactive

The following strategies are in place at KDHCD to proactively minimize or eliminate safety risks:

1. **Worker Safety Program with Safety Officer Role**. The *Environment of Care* Committee outlines the broad objectives of the safety program for (KDHCD), and implements various activities to ensure the program is viable, as well as defines, through the Safety Management Plan, how the overall plan and program will be evaluated for

effectiveness. The Safety Officer has the authority to intervene whenever a hazard exists that poses a risk to the safety of the patients and or building. Alternate individuals are identified in the absence of the Safety Officer. A Chemical Hygiene Officer role is in place within the Laboratory that oversees policies and procedures relating to lab safety for employees. An Infection Control Nurse oversees surveillance and infection control programs to minimize exposure risks.

2. **Committees.** The EOC Committee is the structure through which safety-related problems and issues can be identified and resolved. It should be noted that the EOC Committee is closely integrated with patient safety functions. The purpose of the EOC Committee with respect to the Patient Safety standards is to remain aware of sentinel event alert information from the Joint Commission and to assess organizational practices against current information relating to patient safety. Additionally, when recommendations are made for hospitals, each recommendation is critically reviewed, with a plan of action established. If sentinel events occur within the District setting that reflect *environment of care* issues, the EOC Committee will participate in improving outcomes relating to patient safety.

   The Radiation Safety Committee impacts worker safety as it oversees the radiation safety program and issues relating to the safety of the worker and radiation exposures. The Emergency Management Subcommittee convenes for the purpose of minimizing risks associated with unforeseen emergent situations that have the potential for consequential or adverse events.

3 **Reporting and Investigation Mechanisms:** Multiple sources of reporting and investigating mechanisms are in place (as identified above) that have the potential to identify risk and thereby implement action as needed to mitigate or minimize the identified risks.

4 **Policies/Procedures.** Safety policies and procedures are in place to assist the employee in the performance of safe-related activities related to the nature of their job tasks or their work areas. Policies and procedures are reviewed at least every three years.

5. **Education** – for Newly-hired Staff and Ongoing

   New hire education. Education relating to general safety processes is given during new hire orientation, and covers such topics as introductory information, an employee ‘s role with respect to general safety processes, types of safety materials and resources available for the employee on his/her unit, preliminary introduction to the concepts of “RACE” and compartmentalization”, emergency management, and introductory information relating to “Employee Right to Know”. This education is documented. Licensed Independent practitioners (LIP’s) receive *Environment of Care* education through the re-credentialing process, which identifies how LIP’s can eliminate or minimize physical risks in the environment of care, actions to take in the event of an incident, and how to report risks.

   a) **Area Specific Safety**. Area specific safety is covered for new employees and contracted workers on each department within (KDHCD) and is the responsibility of the department manager and is documented. Information may include, but not be limited to location of the department’s fire alarms, fire extinguishers, exits, evacuation plans; and location of unit- specific policies and procedures.

   b) **Specific Job-Related Hazards**. Education relating to specific job-related hazards may be part of the new employee’s competencies, and part of the competency reorientation process. Examples of this may include job-related hazards related to the use of chemotherapy for nurses, “lock-out-tag out” for engineering staff, or use of certain cutting materials in the kitchen. Education for specific job-related hazards is the responsibility of the department manager and is documented.

Educational sources

Various types of experience at (KDHCD) provide sources from which educational material is developed. These include, but will not necessarily be limited~~,~~ to, the following:

a) **Environmental surveillance trends**. Through trending of surveillance results, it may be determined that staff need additional education. The survey process itself may be an educational tool for staff. For example, when staff are asked specific questions relating to fire or disaster roles, or

location of SDS, or relating to their responsibilities with respect to defective equipment.

b) **Fire and Disaster drills**. When staff performance is evaluated during fire and disaster drills, educational topics may be developed if a knowledge deficit exists or if staff performance was not at the expected level.
c) **Changes in Operational Practices**. Whenever changes occur within (KDHCD) that requires additional safety education, the education will be determined by the EOC committee.
d) **Needs Assessment**. Another source of education is determined from periodic needs assessment tools. These can be gathered from educational evaluations wherein the staff may be asked, "What other types of educational topics would you like to see?" Or it may be done at the unit level, for example, with the use of medical equipment when user errors occur.
e) **Illness and Injury Trends**. When illness and injury trends demonstrate an increase, the increase may be the catalyst for further education. Increasing back or needle stick injuries, or falls are examples of using injury trends to substantiate the need for additional education.
f) **Consequential Events or Risk of Consequential Events**. An incident may occur that results in an adverse patient, visitor or employee injury. This will warrant investigation, and the possibility of additional education.
g) ***Environment of Care*** **Committee**. The EOC Committee may impose education upon staff due to various regulatory and/or accreditation agencies that require updating.
h) **Risk Assessment Activities**. When risks have been identified, the risks will serve as a source of education for staff, based upon the severity and type of risk assessed.

Risk Reduction Strategies – When Risks Have Been Identified
When proactive risks have been assessed, risk reduction strategies will be the responsibility of the EOC Committee, unless the risk poses the potential for serious consequential events (i.e., death, serious injury or building threat). In this instance, the individual who has assessed the risk will notify the Safety Officer and Risk Management leadership who will then assume responsibility for reduction of the risk threat. Risk reduction strategies for the possibility of non-serious or non-imminent consequential events may be addressed through the *Sentinel Event Review* or *Intensive Assessment Processes,* or EOC Committee, based upon the severity and type of risk identified. Risk reduction strategies include, but are not limited to the following:

1. Policies and Procedures. Policies and procedures may require development or revision, with applicable training completed for affected staff.
2. Education. New or reinforced education may be implemented to minimize the potential for future risk.
3. Equipment. The purchase of new equipment or the use of current equipment may require evaluation.
4. Administrative Controls. Administrative controls such as changes in staffing, or changes in staffing patterns may require evaluation and implementation.
5. Equipment Training. Training on equipment may be implemented or re-enforced.
6. Repairs/ Upgrades on Equipment. Repairs and or upgrades on medical, utility, or building equipment may be required.
7. Elimination of the Risk. Elimination of the risk through removal of a hazard may occur.
8. Product or Equipment Change-out or Recall. Faulty or defective products or equipment may be recalled and replaced.

MAINTENANCE OF GROUNDS AND EQUIPMENT
(KDHCD) manages risks associated with the grounds and equipment in order to minimize consequential events or adverse outcomes related to accidents.
Environmental surveys are done routinely by EOC Committee personnel. Additionally, routine and varied security patrols are conducted wherein any safety hazards are brought to the attention of the EOC Committee. Routine building/grounds surveys with a contractor's representative are conducted when construction activities are occurring. Special investigations by the Safety Officer and other designated staff, when requested, are conducted. Additionally, Risk Management reviews data from

reported incidents that may identify patterns, trends and opportunities for improvements. The data involves all patient and visitor incidents related to accidents or other unusual events which are not consistent with routine patient care and treatment. Incidents that involve patients or visitors, wherein some aspect of the building/grounds plays a consequential role, the Safety Officer will be notified so the hazard may be investigated and corrected as necessary. All of these activities contribute to an overall monitoring plan for the grounds and safety-related equipment.

Equipment - Imaging Risk Reduction:
The hospital provides MRI services, and manages safety risks associated with MRI for the following circumstances:

- Patients who may experience claustrophobia, anxiety or emotional distress: Medication may be provided by the physician to help the patient relax or to decrease his/her anxiety or emotional distress, and/or the RN/MRI technician may provide psycho-social counseling.
- Patients who may require urgent or emergency medical care: for these patients, a crash cart is available if needed, with transfer to the Emergency Room or Critical Care an option if needed.
- Patients with medical implants, devices or imbedded foreign objects (such as shrapnel): All patients receive a pre-screening questionnaire to determine if he/she has any imbedded implants, devices or foreign object that will require a clinical judgment to proceed or terminate the MRI.
- Ferromagnetic objects entering the MRI environment: MRI staff have been trained to decrease/eliminate any ferromagnetic objects from entering the MRI environment.
- Acoustic noise: The noise made by the MRI can be bothersome to some patients. Patients are informed of this possibility, and that the MRI may be stopped if the noise becomes unbearable. Headphones can be provided to reduce MRI noise.
- Restricting access to everyone not trained in MRI safety or screened by MRI-trained staff from the scanner room and the area that immediately precedes the entrance to the MRI scanner room: Signage is in place that prohibits unauthorized personnel from entering the MRI area. Door is secure with key pad which effectively restricts entrance to only those who have been safety trained.
- Making sure that these restricted areas are controlled by and under the direct supervisor of MRI-trained staff: Controlled areas to the MRI are under the direct supervision of MRI-trained staff.
- Posting signage at the entrance to the MRI scanner room that conveys that potentially dangerous magnetic fields are present in the room. Signage should also indicate that the magnet is always on. Signage is posted at the entrance to the MRI stating that the MRI scanner room has potentially dangerous magnetic fields present, and no one is allowed except authorized personnel.

Performance evaluation of Imaging Equipment.
To reduce the potential of risks relating to the operation and function relating to imaging equipment, the following activities and processes are in place:
For Diagnostic Radiology Equipment:

- A least annually a diagnostic medical physicist conducts a performance evaluation of all Diagnostic Imaging equipment that produce ionizing radiation. The evaluation, along with any recommendations and corrections, are documented. The evaluation utilizes phantoms to measure accuracy of dosages; alignment of beam, light, and collimators; and any functional process involved in acquiring images. Image quality of Computerized Radiography Reading units, Digital Detector Plates, workstations and monitors throughout the Imaging are also evaluated annually for image quality and accuracy, to include high and low contrast resolution, and artifact evaluation

For MRI Equipment:

- A least annually a diagnostic medical physicist or MRI scientist conducts a performance evaluation of all MRI imaging equipment. The evaluation, along with any recommendations, are documented. The evaluation includes the use of phantoms to assess the following: image uniformity for all radiofrequency coils used clinically, slice position accuracy, alignment light accuracy, high and low contrast resolution, geometric or distance accuracy, magnetic field homogeneity, and artifact evaluation.

FOR CT Equipment:

- Quality control and maintenance is in effect to maintain the clarity/quality of diagnostic images produced. Biomedical leadership identifies the frequency of maintenance activities for Imaging from a risk-based standpoint, and or manufacturer's recommendations.
- Annually, a medical physicist completes the following: measures the radiation dose (in the form of volume computed tomography dose index [CTDIvol] for the adult brain, adult abdomen, pediatric brain and pediatric abdomen.
- Verifies that the radiation dose in the form of the CTDIvol that is displayed by the CT imaging system for each tested protocol is within 20% of the CTDIvol displayed on the CT console. The dates, results and verifications of these measurements are documented (Note: this is only applicable for systems capable of calculating and displaying radiation doses in the form of CTDIvol.
- Annually a medical physicist conducts a performance evaluation of all CT Imaging equipment, with the evaluation, along with recommendations for correcting any problems, documented. The evaluation includes the use of phantoms to assess the following: image uniformity, slice thickness accuracy, slice position accuracy (when prescribed from a scout image), alignment light accuracy, table travel accuracy, radiation beam width, high contrast resolution, low contrast resolution, geometric or distance accuracy, CT number accuracy and uniformity, artifact evaluation.

FOR Nuclear Medicine Equipment:

- At least annually, a diagnostic medical physicist conducts a performance evaluation of all Nuclear Medicine imaging equipment. The evaluation, along with recommendations for correcting any problems identified, are documented.
- The evaluations are conducted for all the image types produced clinically by each type of Nuclear Medicine scanner (e.g., planar and or tomographic) and include the use of phantoms to assess the following imaging metrics: image uniformity/system uniformity, high contrast resolution/system spatial resolution, low contrast resolution or detectability (not applicable for planar), sensitivity, energy resolution, count rate performance and artifact evaluation.

FOR PET Imaging:

- At least annually, a diagnostic medical physicist conducts a performance evaluation of all PET Imaging equipment. The evaluation results, along with recommendations for corrections, are documented. The evaluations are conducted for all of the image types produced clinically by each PET scanner (for example, planar and or tomographic), and include the use of phantoms to assess the following imaging metrics: image uniformity/system uniformity, high contrast resolution/system spatial resolution, low-contrast resolution or detectability (not applicable for planar acquisitions), and artifact evaluation. Note: the following tests are recommended, though not required for PET: sensitivity, energy resolution and count-rate performance; this is at the discretion of the Imaging leadership.

FOR Diagnostic X-Ray, MRI, CT, NM, PET Equipment: the annual performance evaluation conducted by the medical physicist includes testing of image acquisition display monitors for maximum and minimum luminance, luminance uniformity, resolution and spatial accuracy.

Product Notices and Recalls

Product Notices and Recalls. Product safety recall reports are presented to the EOC Committee with follow-up and outcome(s) on a quarterly basis. Noted are whether or not there were any adverse actions for the patient, the type of the product and the disposition of the product. Affected managers are notified when the product is identified within our inventory.

Pharmacy Safety: In support of safe and sterile conditions within the Pharmacy during compounding or admixing, sterility of packaging is present with "event shelf life" or dated products. Infection Control surveillance observes for sterility of packaging, and Pharmacy implements quality control by observing for sterility prior to the use of a product. The only exception is in an urgent situation in which a delay could harm the patient or when the product's stability is short. (KDHCD) is constructed to allow for clean, uncluttered and functionally separate areas for product preparation, and pharmacy staff is trained to use clean or sterile techniques. During preparation of pharmaceutical drugs and solutions, pharmacy staff is trained to visually inspect the medications for particulates, discoloration or other loss

of integrity, and to remove the product from usage, and report the information to the vendor. To support pharmaceutical safety, (KDHCD) has a laminar airflow hood for the preparation of intravenous admixtures or any other sterile product. The laminar airflow receives preventive maintenance in accordance with the manufacturer's recommendations.

Prohibition of Smoking
A nonsmoking policy is in place at (KDHCD) and is enforced and monitored throughout all buildings by management, employees and Security staff. The purpose of the policy is to restrict smoking at KDHCD and to reduce risks to patients who have a history of smoking, including possible adverse effects on treatment, and to reduce the risks to others of passive smoking and fire. The smoking policy prohibits smoking anywhere on District property. The smoking policy is addressed with all new employees upon hire and new patients upon admission. Security personnel are the primary monitoring personnel for enforcement. If breaches of policy are noted, the EOC Committee will develop strategies in conjunction with Security as enforcement, to eliminate the incidence of policy violations.

Information Collection System to monitor conditions in the Environment
1. (KDHCD) establishes a process(es) for continually monitoring, internally reporting, and investigating the following:
    - Injuries to patients or others within the District's facilities
    - Occupational illnesses and injuries to staff
    - Incidents of damage to its property or the property of others
    - Security incidents involving patients, staff or others within its facilities
    - Hazardous materials and waste spills and exposures
    - Fire safety management problems, deficiencies and failures
    - Medical or laboratory equipment management problems, failures and use errors
    - Utility systems management problems, failures or use errors

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

Environmental Tours
(KDHCD) conducts environmental tours to identify deficiencies, hazards and unsafe practices**.**

Department environmental tours are conducted throughout the District, including offsite locations by EOC Committee members for both the patient care and non-patient care areas. Environmental tours are conducted in the patient care areas, and in the non-patient care areas, with deficiencies, hazards and unsafe practices identified and corrected, or with a plan implemented.

Annual Evaluation of the Safety Management
On an annual basis EOC Committee members evaluate the Management Plan for Safety, as part of a risk assessment process. Validation of the management plan occurs to ensure contents of each plan support ongoing activities within 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 Safety Management plan will be evaluated to determine continued relevance for Kaweah Delta Health Care 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?).
- The scope. The following indicator will be used to evaluate the effectiveness of the scope of the safety management plan: the targeted population for the management plan will be evaluated (e.g., did the scope of the plan reach employee populations in the off-site areas, and throughout KDHCD?)
- Performance Standards. Specific performance standards for the Safety Management plan will be evaluated, with plans for improvement identified. Performance standards will be monitored for achievement. Thresholds will be set for the performance standard identified. If a threshold is not met an analysis will occur to determine the reasons, and actions will be identified to reach the identified threshold in the subsequent quarter.

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

(KDHCD) analyzes identified Environment of Care Issues
Environment of care issues are identified and analyzed through the EOC Committee with recommendations made for resolution. It is the responsibility of the EOC Committee chairperson to establish an agenda, set the meetings, coordinate the meeting and ensure follow-up occurs where indicated. Quarterly *Environment of Care* reports are communicated to Performance Improvement, the Medical Executive Committee and the Governing Board.

Priority Improvement Project
At least annually, one or more priority Improvement activities may be selected by Environment of Care Committee members. The priority improvement activity is based upon ongoing performance monitoring and identified risk within the environment.

KDHCD improves its Environment of Care
Performance standards are identified monitored and evaluated that measure effective outcomes in the area of safety management. Performance standards are also identified for Security, Hazardous Materials, Emergency Management, Fire Prevention, Medical Equipment management and Utilities management. The standards are approved and monitored by the EOC Committee with appropriate actions and recommendations made. Whenever possible, the *environment of care* is changed in a positive direction by the ongoing monitoring, and changes in actions that promote an improved performance.

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

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

Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

Policy Number: EOC 7403	**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 Generator Testing and Fuel Levels

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

POLICY:

Kaweah Delta Health Care District maintains and tests emergency power generators at: Kaweah Delta Medical Center, Kaweah Delta Skilled Nursing Services, Kaweah Delta Rehabilitation Hospital and Kaweah Delta Mental Health Hospital.

PURPOSE:

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

PROCEDURE:

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

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

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

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

FUEL TANKS:

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

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

Marketing & Community Relations Committee
Wednesday, September 2, 2020
Kaweah Delta Medical Center – 520 West Mineral King Avenue
Support Services Building- Granite Room 4TH Floor

ATTENDING: Directors Nevin House (Chair) and Garth Gipson; Gary Herbst, Chief Executive Officer; Marc Mertz, Vice President of Strategic Planning & Business Development; Jennifer Corum, Senior Marketing Specialist; Raymond Macareno, Senior Communications Specialist; Laura Florez-McCusker, Director of Media Relations; Melissa Withnell, Communications Specialist; Jennifer Manduffie, Senior Graphic Designer; Yolanda Chavez, Senior Graphic Designer; Kaci Hansen, Social Media Specialist; Maria Rodriguez Ornelas, Communications Specialist; and Kelsie Davis, recording.

Called to order at 2:00PM

Public/Medical Staff Participation- None.

Social Media Update- Laura Florez-McCusker, Director of Media Relations

- Laura gave an update on the public information officer meetings that happens weekly as a result of COVID.
- Laura updated the group on the press conference that happened this morning with the Sherriff office regarding COVID and Labor Day Weekend.
- Laura noted that there is a new COVID snapshot that was redesigned and is out on social media.
- Spanish Facebook is not getting as much traffic as anticipated so the team is trying to utilize different avenues to promote it. The team is working on content and boosting. Also partnering with the Spanish Chamber and our interpreting department to help promote the page.
- Laura thought about doing 30 second videos on our equipment and information. To call it Technology Tuesday's.
    - Gary asked Laura and team to look into doing podcasts.
    - Nevin told Laura to work on a permanent studio.
- Laura updated on the review trackers and online analytics.

Marketing- *Karen Tellalian, Interim Director of Marketing*

- Jennifer Corum updated the group with the current marketing campaigns such as Cardiovascular, Telehealth Services and our webpage on our Miracle Man and his story.
- Raymond Macareno updated the group on the campaign for SRCC.

Community Engagement- *Deborah Volosin, Director of Community Engagement*

- Deborah noted that our next Town Hall is October 1st with Nevin House hosting.
- Deborah reviewed the slides that are attached to the minutes the statistics and views from our community engagement and employee huddles that happen weekly.
- Deborah noted that the Speaker's Bureau will start again via zoom.

- Gary Herbst and Nevin noted that we should be hosting our Community Engagement Groups in person and via zoom.

Adjourned- 3:30PM

Nevin House, Chair

THESE COMMITTEE MINUTES WERE APPROVED FOR DISTRIBUTION TO THE BOARD BY THE COMMITTEE CHAIR ON XX-XX-XXXX.

Quality Council – Open Session

Thursday, September 17, 2020
8:00am – 9:00am
The Lifestyle Center / GoToMeeting

Attendees: Board Members – Herb Hawkins, David Francis; Anu Banerjee; Tom Gray, MD; Sandy Volchko; Gary Herbst; Shawn Elkin; Keri Noeske; Thomas Siminski; Kassie Waters; Daniel Allain; Ben Cripps; Tracie Plunkett; Ed Largoza; Byron Mendenhall; Malinda Tupper; Michelle Adams – Recording

Call to order: 8:10am

TOPICS	LEADER	FOLLOW-UP
Written Quality Reports • **3.6** Handoff Communication Quality Focus Team Report – Observed the handoff and the receiver. Often times the receiver does not feel like they got all of the information. Many times this happens because there is not a standard element between the sender and receiver. If we establish a standardized handoff, that number will greatly improve. Dave asked if there is a process in Cerner that will help with a handoff. There is a tool and as a quality project the team wants advice from the frontline staff to see how it works. Working on cleaning up the EMR handoff tool so it is more concise, to the point and more user friendly. Sandy stated, "We looked at event reporting which is how this team was established. Handoff is such a critical process that can lead to events, it is high risk. The handoff tool is very multifactorial. There are different pieces needed for each unit. Some of them are the same, but some are different. The team sat with ISS and went through every single area of what they liked and did not like. Felt that they needed an urgent fix so the absolute elements that they felt should be on it is in all nursing orientation and binders. • The 10 absolute items that have to be discussed during a handoff has been implemented. Educators in four tower are going to pilot it and make those changes. The more we can automate the handoff and enforce it, the better it will be. It's multifactorial – what are we doing different today? Is that what is going to change it when we implement this? It is two fold. One is the timeliness of the handoff between education and admissions. Lean system of getting with the front desk staff and identifying the root causes and directing the process itself and making it timelier.	Kassie Waters	

Looking at the quality and elements of the handoff. We are going to have to build accountability in order for this process to succeed. Two units will pilot it in October. Improvements will be outlined and ready to go to be presented hospital wide in December. • **CLABSI/MRSA** – Questions were posed about the bathing situation. An assessment is being completed on what the unit process are for prioritizing bathing for patients with lines so that standardization can occur. There needs to be one standard process. During a KAIZEN, one CNA did not feel confident that her colleagues were aware of how to bath patients who have a central line. Clinical education is going to do an assessment on proper bathing. • **Complete documentation** – Eighty percent seems like a theme. People are not documenting things the way they should. For value based purchasing, the more documentation there is the better we are. Need to set the expectation of the attending physician to be doing what they are supposed to be doing. Rebekah Foster's team is rounding throughout the hospital to see things are documented properly. Team calls physicians to have them complete the documentation. Tracked by the physicians name and their willingness to complete the documentation. Yellow indicates you are 10 percent within goal. Will be changed to five percent so you see a lot of changes. Summary of this information is sent out nurse managers to remind them that 99.9 percent, is that good enough? Eighty some patients a month do not have a clean and dry dressing. • **Medication dosing errors –** There is no stop on pyxis. If a patient is supposed to have three tablets a nurse can pull ten. There is a mismatch. How do we break down the process to reduce those errors? Gary stated that is a lot bigger conversation. Perfect care and zero harm is what our expectation should be? Is it reasonable hat we are green and always green? We don't ever make dosing errors? Is that an unrealistic expectation? It happens in all hospitals across the country. At least try to minimize it to the greatest extent possible. Human judgment and human error will never allow for perfect care. Anu stated, "If an event can be stopped before making it to the patient, that stop is the critical part. It won't be zero harm, but we won't dispense it to the patient. **COVID-19 Clinical Quality Review** • 700 plus patients who were COVID positive. Not all patients are included in this report because the data is from administrative data set, billing claims. In order to be included a patients has to be discharged, the chart has to be sent out for billing. The	Sandy Volchko	

chart does not represent every single COVID patient to date, but it helps us understand trends in quality outcomes for this new population. Reviewed Volumes and length of stay. July's average length of stay is lower. Shows how many patients get discharged with comorbid conditions by month. Diabetes and hypertension are the majority of the comorbid conditions that our patients have. Dave asked if these patients are at higher risk for COVID? Sandy stated the data doesn't show causality, but that would be a reasonable inference. • Reviewed percentage of COVID patients in ICU that are ventilated. Saw a huge spike in May where 14.9 percent of patients required ventilation. July saw a decrease to 10.3 percent of patients. COVID patients that are coming in now are less sick and the age range of the patients is shifting younger. Dr. Gray commented that the treatment paradigm has also changed as new information on treatment becomes available. Used to put patients on ventilators early, but now we are allowing the saturation of oxygen in blood to be lower. Patients are tolerating the respiratory failure for a longer period of time. Dexamethasone may have reduced the need for ventilation. Remdesivir was also implemented after May. Mortality and readmission rates are all following the same downward trend. Dr. Haley did an analysis of COVID mortality reporting it through September 5th. Over 60 percent of mortality is patients over the age of 60. Dr. Malli and the intensivists looked at the standard of care and were able to implement it within the ICU back in May. Order sets were standardized from ED to critical care to med surge and discharge in less than 10days. Sandy will pull the next months data next week and see if the trends are continuing. All quality outcomes are getting better each month. **Clinical Quality Goals Update** • Sepsis July results are to be determined. Goal is 70 percent compliance with the bundle. We ended fiscal year 2020 at 67 percent, which is exactly where we started. We did not get worse, but we did not get better. Adding the second sepsis coordinator will help, he began in June 2020. We were 85 percent compliant for the month of June. Working on reporting it monthly when combined with the proper sample size. Second sepsis coordinator allowed us to provide coverage seven days a week. When COVID happened our coordinators went back to bedside leaving us with coverage 5 days a week resulting in a decline in our lower percentage rate. But there has been an enormous amount of progress. Very confident we will reach higher than 70 percent this year. Sepsis coordinators are notifying physicians when the sepsis alert fires. Relying on the nurses to see it, execute and follow up when the coordinators are not	Sandy Volchko	

here. The team is working with ISS to make the physician notification of the sepsis alert mandatory. • CAUTI, CLABSI, MRSA – we have CAUTI and CLABSI cases that meet the criteria. Sometimes things get pulled in or pulled out and you might not see the result for two months after it has been submitted. Have reconciled and came up with the final numbers. Ended fiscal year to date at a 0.98 for CAUTI and goal was 0.828 or less. CLABSI we ended the year at 1.09, goal was 0.784 or less. MRSA ended the fiscal year at 1.00 and goal was 0.815. CLABSIs jumped to five because we had a lot of very critically ill patients and a lot of them had a number of central lines and peripheral IVs. Femoral lines need to be changed out when possible and if a patient is too critical you cannot always do that. Out of the five CLABSIs, three of them were COVID patients. Anu stated he would be extremely worried if this trend continued. All of our goals have decreased. We have to get even better. We have always used the 50th percentile, that we should be at least better than half the hospitals in the United States. Trying to set achievable goals. The last six months we were at 0.85 for CAUTI, 0.83 for CLABSI and 0.55 for MRSA which is lower than where we set out goals. • Biovigil went live throughout the medical center. It is going really well. Barrier has been that during gemba rounds a patient has been identified with a femoral line and no one is clear why the patient still has the line. During rounding we have to advocate and talk to the provider to get the line out. Gemba group does not see why we need the line, but the provider insists it is needed. We need the providers to give us a clear explanation what the line is for and if the line is no longer indicated it should be voiced to the physician. The problem is in the follow up and advocating to get the line out. Working on doing a follow up gemba round with a resident to address line necessity. Dr. Winston has been on board and is thrilled to be a part of it. Will be able to report back on it next month.		

Adjourned: 9:24am

Approved By: COMMITTEE MINUTES WERE APPROVED FOR DISTRIBUTION TO THE BOARD BY THE COMMITTEE CHAIR ON September 24, 2020.

Kaweah Delta
HEALTH CARE DISTRICT

September 28, 2020

Sent via Certified Mail
No. 70160340000002569098
Return Receipt Required

Sharifi Firm, APC
2330 Westwood Blvd., Second Floor
Los Angeles, CA 90064

RE: Notice of Rejection of Claim of Judy Carrasco vs. Kaweah Delta Health Care District

Notice is hereby given that the claim, which you presented to the Board of Directors of the Kaweah Delta Health Care District on August 18, 2020, was rejected on its merits by the Board of Directors on September 28, 2020

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.

Sincerely,

David Francis
Secretary/Treasurer, Board of Directors

cc: Richard Salinas, Attorney at Law

KAWEAH DELTA HEALTH CARE DISTRICT
EXCLUSIVE PROFESSIONAL SERVICES AGREEMENT

Regarding the Service of ANESTHESIOLOGY

This Exclusive Professional Services Agreement ("**Agreement**") is entered into effective October 1, 2020 ("**Effective Date**"), 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 **OAK CREEK ANESTHESIA SERVICES, INC.,** a California professional medical corporation ("**Medical Group**" or "**Contractor**"):

BACKGROUND

A. District is the operator of a general acute care Hospital known as Kaweah Delta Medical Center (the "Hospital") in Visalia, California, in which there is located and operated an Anesthesia Department (the "Department").

B. Medical Group is a medical corporation whose shareholders, subcontractors and professional personnel are physicians licensed to practice medicine in the State of California and who are (or will be by the Effective Date) members in good standing of the Medical Staff of the Hospital (the "Medical Staff"), or registered nurses licensed to practice nursing and certified to practice nurse anesthesia by the California Board of Registered Nursing ("CRNAs"), and who have been (or will by the Effective Date have been) approved by the administration and the appropriate Medical Staff committee to practice within the Hospital. The physicians providing services under this Agreement are referred to as "Physicians." CRNAs and Physicians providing services under this Agreement are referred to as "Providers." The services to be provided by the Providers under this Agreement are referred to as the "Services."

C. Medical Group intends to subcontract for the provision of the Services by other professional medical corporations (each, a "Subcontractor"). Unless the context indicates otherwise, the term "Medical Group," as used in this Agreement, includes Medical Group's Subcontractors, and the terms "Physician," "CRNA" and "Provider" include physicians and CRNAs employed by or contracted to Medical Group's Subcontractors, as applicable. The express mention of the Subcontractors in any context does not imply that they are not included in the term "Medical Group" in any other context. However, only Oak Creek Anesthesia Services, Inc. shall have any rights under this Agreement.

D. District, in accordance with its Bylaws administered through its Board of Directors, has determined that the best interests of patients, insofar as the quality of medical care is concerned, and insofar as the future quality of medical care and the availability of anesthesia at Hospital are concerned, shall be served by having Medical Group exclusively provide professional services within the Department as provided in Section 2.1 and in accordance with the Bylaws and Rules and Regulations of the Medical Staff ("Medical Staff Bylaws").

E. It is anticipated that this exclusive agreement with Medical Group will facilitate the administration of the Department and the training of personnel therein, enhance interdepartmental communications within District, simplify and permit more flexibility in scheduling, promote better availability of anesthesia services, enhance convenience to and safety of patients, encourage more efficient use of equipment and personnel, and ultimately lower the cost of anesthesia services for the patients of District.

F. In view of the foregoing, District desires that Medical Group assume the full and exclusive right to provide professional services within the Department as provided in Section 2.1, and Medical Group desires to accept such sole and exclusive rights and responsibilities.

G. District and Medical Group desire to enter into this Agreement in order to provide a full statement of their respective rights and responsibilities in connection with the operation of the Department and the provision of professional anesthesia services at District during the term of this Agreement.

THEREFORE, in consideration of the foregoing recitals, the mutual covenants, conditions and promises hereinafter set forth, and other good and valuable consideration, the sufficiency of which is hereby acknowledged, and intending to be legally bound, District and Medical Group agree as follows:

Section 1. Term and Termination.

1.1. **Term**. This Agreement shall be effective on the Effective Date and shall continue in full force and effect until **September 30, 2023**. The execution and delivery of this Agreement is subject to approval by the District's Board of Directors. For purposes of this Agreement, a "**Contract Year**" is a twelve-month period beginning on the Effective Date or any anniversary of the Effective Date.

1.2. **Termination without Cause**. Either party may terminate this Agreement at any time, without cause, by providing not less than one hundred twenty (120) days' prior written notice stating the intended date of **termination**.

1.3. **Material Breach**. 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 provide the breaching party with not less than ten (10) days prior written notice specifying the nature and extent of the material breach. The breaching party shall have ten (10) days from the date of the notice to remedy the breach and conform its conduct to this Agreement. If corrective action is not taken within the time specified to the satisfaction of the party giving the notice, this terminating party may terminate this Agreement upon written notice to the breaching party. For purposes of this Section, "**material breach**" shall mean any breach of the terms or conditions of this Agreement which is substantial and material to the stated purpose of this Agreement as set forth in the Recitals hereto.

1.4. **Termination by District.** District may terminate this Agreement on notice to Medical Group upon the occurrence of any of the following:

1.4.1. The death, disability, termination or withdrawal of any Provider which materially impairs Contractor's ability to provide services under this Agreement, unless such Provider is replaced as soon as practicable, and in any event within thirty (30) days.

1.4.2. Any of the following events affecting a Provider, unless Medical Group immediately causes the Provider to cease providing services under this Agreement, and continues to provide the services required by this Agreement:

1.4.2.1. The revocation or suspension of the license of a Physician Provider to practice medicine as issued by the California Medical Board, or of the certification of a CRNA Provider to practice as a nurse anesthetist as issued by the California Board of Registered Nursing.

1.4.2.2. The revocation or suspension of the Drug Enforcement Administration (DEA) licensure of a Physician Provider issued by the United States Department of Justice Drug Enforcement Administration for just cause.

1.4.2.3. The loss of or suspension from membership on the Medical Staff of Hospital of a Physician Provider for just cause after appropriate hearing procedures in accordance with the Medical Staff Bylaws and other applicable rules and regulations and other applicable law, or the loss or suspension of the approval by the appropriate Medical Staff committee of the practice of a CRNA within the Hospital.

1.4.2.4. Failure of any Physician to comply with any of the qualifications set forth or referred to in Section 4.2, or of any CRNA to comply with the requirements of Section 4.3, unless the Physician or CRNA is promptly removed from service under this Agreement without impairing Contractor's ability to fulfill its obligations hereunder.

1.4.3. Failure to comply with any of the representations set forth in Section 4.1 of this Agreement, which failure continues uncured for more than thirty (30) days following receipt of written notice from District of such failure, unless the failure relates to a particular Physician or CRNA, and the Physician or CRNA is promptly removed from service under this Agreement without impairing Contractor's ability to fulfill its obligations hereunder. Notice of failure shall specify with reasonable certainty the nature and extent of the failure.

1.4.4. Failure to provide any of the services and anesthesia coverage set forth in this Agreement, including the attached Exhibits, in accordance with the requirements of this Agreement, which failure continues uncured for more than thirty (30) days following receipt of written notice from District of such failure. Notice of failure shall specify with reasonable certainty the nature and extent of the failure.

1.4.5. Failure to use commercially reasonable efforts to manage its revenue cycle, except for causes beyond the reasonable control of Contractor or its agents or contractors, which failure is not cured within sixty (60) days following receipt of written notice from District of such failure.

1.4.6. Failure of Contractor to promptly address and resolve issues of non-performance or inappropriate conduct on the part of any of its Physicians or CRNAs (which failure continues uncured for more than thirty (30) days following receipt of written notice from District of such failure. Notice of failure shall specify with reasonable certainty the nature and extent of the failure to comply) provided, however, that nothing contained in this Agreement is intended to supersede or supplant the role of the Chief of Staff, the MEC or the Medical Staff's Wellness Committee in addressing issues raised by the personal conduct of any of Contractor's Physicians or CRNAs.

Termination for any of the reasons set forth above shall be considered as termination with cause.

1.5. **Termination of a Provider**. Upon request by District or Medical Staff's Medical Executive Committee ("**MEC**"), subject to any applicable cure period set forth in this section, Medical Group shall remove from service under this Agreement any Provider: (i) who is convicted of a crime other than a minor traffic violation; (ii) who has a guardian or trustee of its person or estate appointed by a court of competent jurisdiction; (iii) who becomes permanently disabled so as to be unable to perform the duties required by this Agreement; (iv) who fails to maintain professional liability insurance required by this Agreement; (v) who has his/her license(s) and/or privileges required to provide services for the Department either suspended, revoked or otherwise limited; (vi) who discontinues services on a permanent basis; (vii) who is excluded, debarred or otherwise ineligible to participate in any federal health care program or in federal procurement or non-procurement programs or is convicted of or pleads no contest to a crime; (viii) who fails to comply with any of the terms and conditions of this Agreement after being given notice of that failure and a reasonable opportunity to comply; (ix) who fails to comply with the Standards and/or Codes described in Section 5.26; or (x) whose removal is requested pursuant to Section 4.9.1. For purposes of this Section 1.2, the term "permanently disabled" means the inability of a Physician, as a result of sickness or injury, to perform his or her duties under this Agreement for a period of more than one hundred eighty (180) days in the aggregate during any twenty-four (24) month period, despite reasonable accommodation.

1.6. **Immediate Termination**. District may terminate this Agreement immediately upon the occurrence of any of the following events:

1.6.1. Upon District's loss of certification as a Medicare provider;

1.6.2. Upon the closure of the Hospital or the Program; or

1.6.3. If Medical Group is excluded, debarred or otherwise ineligible to participate in federal health care programs or in federal procurement or non-procurement programs or if Medical Group is convicted of a crime. For purposes of this Paragraph, "**crime**" shall mean a felony as defined by the laws of the State of California or the United States of America punishable by imprisonment for a term of at least one (1) year.

1.7. **Tax-Exempt Financing**. If District is advised by its bond counsel that any amendment is required to this Agreement in order to establish or maintain the exemption from federal income tax of any obligations issued by or on behalf of the District, the parties shall, at the request of the District, cooperate to effect such amendment. If the parties fail to agree to such an amendment within thirty (30) days of the District's request, the District may terminate this Agreement on thirty (30) days' notice to Medical Group. The Medical Group agrees that it is not entitled to and will not take any tax position that is inconsistent with being a service provider to the District with respect to the Department. For example, the Medical Group shall not to claim any depreciation or amortization deduction, investment tax credit, or deduction for any payment as rent with respect to the Department.

1.8. **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 (Term and Termination); Section 5.23 (Books and Records); Section 5.28 (Confidentiality); Section 8 (Insurance and Indemnification); Section 9.6 (Dispute Resolution); Section 9.11 (HIPAA); and Paragraphs 3 (Billing and Collection), 5 (Reports), 6(f) (Audit) and 6(h) (Post-Termination Collections) of Exhibit 4.

1.9. **Effect of Termination on Medical Staff Membership and Clinical Privileges**. Medical Group and each Provider agrees and acknowledges that: (a) upon termination of this Agreement without cause or for any cause or reason, the clinical privileges and Medical Staff membership of each Provider who provides Services that are exclusively granted under this Agreement shall be immediately terminated, without further action by or on behalf of the District or the Medical Staff, and without right of review, fair hearing or appeal; and (b) the clinical privileges and Medical Staff membership of any Provider to provide services in the Department shall similarly terminate if he/she ceases, without cause or for any cause or reason, to be contracted by Medical Group to provide services under this Agreement. Upon termination of this Agreement, Medical Group and its Providers shall immediately vacate the Department. Medical Group shall obtain a written acknowledgement in the form attached hereto as Exhibit 5 from each Provider providing Services under this Agreement, and shall provide the acknowledgement to District before the Provider is assigned to provide services under this Agreement.

Section 2. Independent Contractor Relationship.

2.1. The parties acknowledge that, in performing the Service, (i) Medical Group and each Subcontractor 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 no provider shall be an employee of District for any purpose; and (iii) nothing contained in this Agreement shall be construed to create a partnership, agency or joint venture between District and Medical Group or any Subcontractor, or to authorize either District or Medical Group to act as a general or special agent of the other in any respect, except as may be specifically set forth in this Agreement.

2.2. Medical Group shall be solely responsible for all compensation, benefits and required employment-related taxes, contributions and insurance for all of the Providers and, as between the District and Medical Group, for all compensation, benefits and required employment-related taxes, contributions and insurance for all of the Subcontractors District shall have no obligation under this Agreement to compensate or pay taxes for, or provide employee benefits of any kind (including contributions to government mandated, employment-related insurance and similar programs) to, or on behalf of, the Subcontractors, the Providers or any other person employed or retained by Medical Group.

Section 3. Medical Group's Representations. Medical Group represents and warrants, with respect to itself and each of its Subcontractors, that:

3.1. Medical Group and each Subcontractor is duly organized and operated in good standing as a professional medical corporation in the State of California;

3.2. Medical Group and each Subcontractor is free to enter into this Agreement and is not violating any terms of any other agreement between Medical Group or the Subcontractor and any third party by entering into this Agreement;

3.3. Medical Group and each Subcontractor is a participating provider in the Medicare and Medi-Cal programs, and in other governmental health plans in which District participates, and conversely, is 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;

3.4. Medical Group and each Subcontractor are covered by one or more policies of professional liability insurance maintained by Medical Group or the Subcontractor pursuant to Section 8.

3.5. No action, proceeding, inquiry, enforcement action, investigation, suit, claim or demand or legal, administrative, arbitration, or other method of settling disputes, whether legal or administrative or in mediation or arbitration (any of the foregoing, a "**Dispute**"), is pending or, to Medical Group's knowledge, threatened against Medical Group, or any of its officers, directors, employees, agents or Subcontractors (collectively, **"Medical Group's Personnel**") as a result of their activities hereunder as such, including (without limitation) (1) any Dispute concerning Medical Group's or the Subcontractor's billing practices or alleging healthcare fraud or abuse on the part of Medical Group or the Subcontractor, (2) any Dispute that relates in any way to Medical Group's or a Subcontractor's services to or activities at the District or its facilities, (3) any dispute between Medical Group or a Subcontractor and any of Medical Group's or Subcontractor's personnel relating to services provided under this Agreement, including any Dispute concerning Medical Group's or a Subcontractor's employment or contracting practices, or (4) any Dispute that could otherwise have a material adverse effect on Medical Group's or a Subcontractor's continued ability to perform any or all of its duties and obligations under this Agreement; nor is Medical Group aware of any basis for any such Dispute. Medical Group agrees to promptly notify the District's Compliance Officer in writing of the assertion or occurrence of any Dispute, and of any material change in status of any Dispute throughout the term of this Agreement.

Section 4. Providers.

4.1. Medical Group represents and warrants to District, and agrees with District, as follows:

4.1.1. All Providers shall be employees or contractors of Medical Group or a Subcontractor. The Providers providing services under this Agreement as of the Effective Date are mutually agreed upon by the parties. No person shall become a Provider thereafter without the approval of District, and without appropriate Medical Staff privileges.

4.1.2. All Providers meet, and shall continue to meet, the applicable requirements of Section 4.2 or Section 4.3, as applicable.

4.1.3. Neither Medical Group nor any Provider is bound by any agreement or arrangement which would preclude Medical Group or any Provider from entering into, or from fully performing the services required under, this Agreement.

4.1.4. No Physician's license to practice medicine in the State or in any other jurisdiction or Drug Enforcement Agency number has ever been denied, suspended, revoked, terminated, relinquished under threat of disciplinary action, or restricted in any way.

4.1.5. No Physician's medical staff privileges at any health care facility have ever been denied, suspended, revoked, terminated, relinquished under threat of disciplinary action, or made subject to terms of probation or any other restriction.

4.1.6. No CRNA's license to practice nurse anesthesia in the State of California or in any other jurisdiction has been denied, suspended, revoked, terminated, relinquished under treat of disciplinary action or restricted in any way.

4.1.7. No CRNA's allied health practitioner prerogatives or privileges at any health care facility have ever been denied, suspended, revoked, terminated, relinquished under threat of disciplinary action or made subject to terms of probation or any other restriction.

4.1.8. Medical Group and each Provider shall perform the services required by this Agreement in accordance with: (1) all applicable federal, state, and local laws, rules and regulations; (2) all applicable standards of the accreditation organizations and any other relevant accrediting organizations, and (3) all applicable bylaws, rules, regulations, procedures, and policies of Hospital and the Medical Staff.

4.1.9. Medical Group and each Subcontractor and Provider is or shall be a participant in Medicare and the State's Medicaid program.

4.1.10. Neither Medical Group nor any Provider has in the past conducted, and is not presently conducting, its or his/her medical practice in such a manner as to cause Medical Group or the Provider to be suspended, excluded, debarred or sanctioned under the Medicare or Medicaid Programs or by any government licensing agency, and has never been charged with or convicted of an offense related to health care, or listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation.

4.1.11. The compensation paid or to be paid by Medical Group or any Subcontractor to any Provider is and shall, at all times during the term of the Agreement, be fair market value for services actually provided by such Provider, not taking into account the value or volume of referrals or other business generated by such Provider for District. Medical Group represents to District that Medical Group or a Subcontractor has and shall at all times maintain a written agreement with each Provider receiving compensation from Medical Group or the Subcontractor, which written agreement is or shall be signed by the parties, and does or shall specify the services covered by the arrangement. Further, Medical Group shall comply with all relevant claim submission and billing laws and regulations. Each of the representations and warranties set forth herein shall be continuing and in the event any such representation or warranty fails to remain true and accurate during the Term, Medical Group shall immediately notify District.

4.1.12. Prior to the Effective Date, Medical Group has submitted to District copies of all its contracts Subcontractors, and of all Medical Group's or its Subcontractors' contracts with Providers. Thereafter, if Medical Group or a Subcontractor proposes to enter into a contract with a Provider in a form substantially different from the forms previously approved by the District, Medical Group shall submit the form of agreement to District for approval at least thirty (30) days prior to execution the contract. Neither Medical Group nor any Subcontractor shall enter into any agreement with a Provider in a form substantially different from the approved form unless the form of agreement has been approved by District, which may grant or withhold its approval in its discretion, provided that District shall not

unreasonably withhold its approval. Medical Group shall provide District with copies of all its contracts with Subcontractors and Providers, of all its Subcontractors' contracts with Providers, from time to time upon request.

4.1.13. Medical Group shall compensate Providers, and shall ensure that each of its Subcontractors compensates Providers, on a payer-neutral basis.

4.1.14. Medical Group shall provide statistical analyses to its Providers on a periodic basis related to their productivity and performance under this Agreement.

4.1.15. An equitable surgery schedule and an equitable call schedule have been identified in this Agreement and in Exhibit 1 and shall be adhered to in accordance with the terms of the contracts with Providers and this Agreement.

4.1.16. Medical Group and its Subcontractors and their respective Providers acknowledge and agree that the primary professional responsibility of Medical Group and its Subcontractors and full-time Providers is to provide services under this Agreement. Medical Group shall not, and shall not permit its Subcontractors or full-time Providers to, become involved in any other contracts or professional obligations that materially interfere with the ability of Medical Group to honor all of the terms and conditions of this Agreement, including, but not limited to, the responsibilities detailed on the Exhibits attached to this Agreement.

4.1.17. Medical Group shall ensure that each Provider complies with all terms and conditions contained herein. Providers shall also: (a) cooperate with District's employee health program and the designated employee health nurse in providing, reviewing and developing health services for employees who work at District; (b) attend any and all meetings within District that Providers are asked to attend by District's Chief Nursing Officer (the "CNO"); and (c) perform such other duties as may from time to time be reasonably requested by District's Governing Board, or Medical Staff, Chief Executive Officer (the "CEO") and/or CNO.

4.1.18. The foregoing representations and covenants (except for those relating expressly to the Effective Date) shall be deemed to continue throughout the term of this Agreement.

4.2. **Qualifications of Physicians**. Each Physician Provider who provides Services under this Agreement shall:

4.2.1. Maintain an unrestricted license to practice medicine in the State of California;

4.2.2. Be Board Certified by the American Board of Anesthesiology ("ABA"), or Board Eligible (defined as having an application filed for Board Certification with the ABA, and having been accepted into the process). If Board Eligible, the Physician shall obtain certification within five (5) years of acceptance into the process. If Board Certified, the Physician shall maintain Board Certification at all times during the performance of Services hereunder. Medical Group shall provide proof of such certification or eligibility to District upon District's request;

4.2.3. Maintain membership on the Medical Staff with appropriate clinical privileges;

4.2.4. Be a participating provider in the Medicare and Medi-Cal programs, and in other government health plans in which District participates;

4.2.5. Participate in continuing education as necessary to maintain licensure, professional competence and skills commensurate with the standards of the medical community, as applicable, and as otherwise required by Medical Group's continuing medical. education policy;

4.2.6. Be covered by the policy or policies of professional liability insurance maintained by Medical Group, a Subcontractor the Provider pursuant to Section 8.

4.3. **Qualifications of CRNAs**. Each CRNA who provides Services under this Agreement shall:

4.3.1. Be an advanced practice registered nurse ("APRN") who has acquired graduate level education in anesthesia overseen by the American Association of Nurse Anesthetists ("ARNA") Council on Accreditation of Nurse Anesthesia Educational Programs;

4.3.2. Be duly licensed and qualified as a certified registered nurse anesthetist in the State of California;

4.3.3. Be approved for practice prerogatives or privileges as an Advanced Practice Provider on the Medical Staff in accordance with the Medical Staff Bylaws, and

4.3.4. Be covered by the policy or policies of professional liability insurance maintained by Medical Group, a Subcontractor the Provider pursuant to Section 8.

4.4. **Acknowledgment**. Each Provider who provides Services under this Agreement shall have executed an acknowledgement in the form set forth in Exhibit 5 prior to the commencement of such Services.

4.5. **Use of Temporary Providers**. Medical Group shall make commercially reasonable efforts to staff the Department with Providers who are dedicated to the Hospital, and will not rely on locum tenens and temporary anesthesia providers retained through third party staffing companies ("**Temporary Providers**") except with the prior approval of the District, and only as necessary to cover temporary absences of regularly scheduled Providers, or while Medical Group is making commercially reasonable efforts to hire dedicated personnel. Such Temporary Providers must meet the qualifications set forth above, must be approved by the District prior to their assignment, and may not be retained beyond the period approved by the District. If Medical Group's use of a Temporary Provider is expected to extend beyond the period approved by the District, Medical Group shall notify the District promptly (and in any event no later than three (3) working days before the expiration of the period); provided that the District shall not be required to agree to any extension of the approved period.

4.6. **Use of CRNAs**. District and Medical Group agree that the provision of sufficient qualified staff may include CRNAs to provide anesthesia services. CRNAs shall provide services under this Agreement in accordance with such protocols as are appropriate to allow proper functioning of CRNAs in the Hospital and approved by Medical Group, District, the OR Policy Committee and the Medical Staff. Medical Group may vary the CRNA staffing schedule based on workload, vacancies and the like, provided that coverage is provided as set forth in Exhibit 1, and the total number of hours of coverage provided by Medical Group's Physicians and CRNAs in the aggregate, is not reduced.

4.7. **Composition of Providers**. So long as Medical Group continues to provide the coverage and other obligations called for herein, including all of the coverage set forth on Exhibit 1, Medical Group shall be primarily responsible for determining the number of Providers necessary to meet anesthesia requirements of District's patient load. Medical Group may change the composition of Providers to meet temporary needs so long as changes in the composition of Providers do not cause disruption within the Department, but any sustained change shall require the approval of the District and the OR Policy Committee.

4.8. **Addition of Providers.** If Medical Group proposes to add a new Provider, Medical Group shall notify District not less than seven (7) days prior to contracting with the new Provider and provide to District, on request, the proposed contract with the Provider prior to its execution in order to verify that it is consistent with this Agreement and requires compliance by the Provider with terms and conditions of this Agreement.

4.9. **Termination of Providers**.

4.9.1. At all times while this Agreement is in effect, the CEO or CNO of the District shall have the right to request removal in writing, with specification of cause, of any Provider from providing the Services hereunder for reasons related to clinical performance or failure to comply with this Agreement or with the policies, bylaws, rules, regulations or codes of conduct of the District or the Medical Staff. Medical Group shall comply with such a request.

4.9.2. Medical Group shall notify District not less than five (5) working days prior to Medical Group's proposed termination of a Provider, whether with or without cause, which shall be subject to prior consultation with District. The notification shall include if the termination is for reasons related to clinical performance or compliance with clinical or conduct standards adopted by the Medical Staff. The notification need not be in writing, and the District shall keep the notification of the proposed termination confidential.

4.9.3. Medical Group shall promptly notify District of the termination by a Provider of his or her contract with Medical Group, or its expiration without extension or renewal.

4.9.4. Upon the termination of the contract between Medical Group and a Provider, whether by the Provider or the Medical Group, or automatically under the terms of the contract, the Provider shall be immediately removed by Medical Group from the schedule for Services.

4.10. **Subcontractors**. District acknowledges that Medical Group may provide the Services through subcontracts (each, a "**Subcontract**") with the Subcontractors. The identity and organization of each Subcontractor, and Medical Group's subcontract with each Subcontractor, shall be subject to the prior written approval of District. Any material amendment to any Subcontract, or the termination of a Subcontract, shall be subject to the prior written approval of the District. Each Subcontract shall require the Subcontractor to comply fully with the terms of this Agreement, as applicable to the services provided by the Subcontractor. Medical Group shall make commercially reasonable efforts to enforce the terms of its Subcontracts, and shall promptly notify the District of any material failure by a Subcontractor to comply with the terms of its Subcontract or this Agreement.

4.11. **Compensation of Providers**. All Guarantee Payments and other payments, other than the amounts for Practice Expense (as set forth in Exhibit 4), shall be passed through to Medical Group's providers as salary or benefits on an equitable basis, and shall not be retained or used by Medical Group or any Subcontractor for administrative costs or profit. The District shall have the right from time to time upon request to review Contractor's agreements with its Personnel to determine their compensation and benefits.

4.12. **Exclusion Lists Screening**. Medical Group shall screen all of its current and prospective owners, legal entities, officers, directors, employees, contractors, and agents ("**Screened Persons**") to ensure that none of the Screened Persons are currently excluded, debarred, suspended, or otherwise ineligible to participate in Federal healthcare programs or in Federal procurement programs, or have been convicted of a criminal offense that falls within the scope of 42 U.S.C. § 1320a-7(a), but have not yet been excluded, debarred, suspended, or otherwise declared ineligible (each, an "**Ineligible Person**"). If, at any time during the term of this Agreement any Screened Person becomes an Ineligible Person, Medical Group shall immediately notify Hospital of the same. Screened Persons shall not include any employee, Medical Group or agent who is not providing Services under this Agreement.

Section 5. Anesthesia Services.

5.1. **Medical Group's Services**.

5.1.1. Medical Group shall have the exclusive right and the responsibility to provide all professional anesthesiology services required for daily scheduled surgery at Hospital, except for: (1) consulting services requested by the admitting physician; and (2) local anesthetics administered by a treating physician (including for pain management), where such treating physician elects to do his or her own

local anesthetic, if and when permissible pursuant to applicable Medical Staff Bylaws (the "Services"). Without limiting the foregoing, the Services include sedation integral to the performance of operative procedures in the surgery suites at the Hospital, and to obstetrical services performed in the Hospital's labor and delivery department and other departments of the Hospital as needed, including endoscopy, emergency department, critical care and (subject to the exception set forth above) pain management for acute pain.

5.1.2. Notwithstanding anything to the contrary set forth in this Agreement, the parties acknowledge and agree that there may be certain members of the Medical Staff who are not affiliated with Medical Group and currently or shall hold clinical privileges in pain management, acute and/or chronic, and that such clinical privileges shall not constitute a breach of Section 5.1.1.

5.1.3. Medical Group shall have the ability to provide services to patients twelve (12) months of age and older through appropriately trained and supervised Providers.

5.1.4. All Services shall be provided in accordance with all applicable laws, regulations, accreditation requirements, and Medical Staff Bylaws and standards. District and Medical Group recognize that the treating physician or surgeon is the primary customer of the anesthesiologist along with the needs of the patient, and that anesthesia services are subject to the availability of sufficient anesthesia providers. Medical Group shall devote its best efforts and sufficient time to provide for the proper management and operation of the Department.

5.1.5. Medical Group shall provide, on premises, a sufficient number of anesthesiologists and CRNAs to cover the Services, on a twenty-four (24) hours per day basis, every day of the calendar year, with a sufficient number of Physicians and CRNAs physically present to provide full coverage the Services at all times as described in detail in the OR Schedule in Exhibit 1, as that Exhibit may be modified from time to time, subject to reasonable and workable hours being established for elective surgery, and subject to the needs of the treating physician surgeon and the needs of the patients. The District, in consultation with the Medical Staff's O.R. Policy Committee ("O.R. Policy Committee"), shall determine, and Medical Group shall abide by, scheduling and coverage needs, including modification of the days and/or hours on Exhibit 1, provided that (i) in the event that the District increases the coverage obligations, Medical Group shall be given a reasonable time (not exceeding three months) to secure any additional staff necessary to meet the increased coverage obligations and District shall provide additional income support at the rate set forth in Exhibit 4; and (ii) to the extent practicable under the circumstances, the District shall give Medical Group reasonable notice of any material reduction in required coverage. Medical Group has and shall maintain a sufficient number of Physician and CRNA full-time equivalent (FTE) Providers to provide full coverage of the Services as described in Exhibit 1, including vacation coverage; provided that it shall be Medical Group's responsibility to provide whatever number of Providers is necessary to provide the Services and coverage required by this Agreement. References in this section and elsewhere in this Agreement to Exhibit 1 refer to the exhibit as modified from time to time in accordance with this section.

5.1.6. It shall be Medical Group's responsibility to provide adequate numbers of Providers to fulfill the coverage requirements set forth in Exhibit 1, in compliance with all applicable laws, regulations, accreditation requirements, and Medical Staff Bylaws and standards. The parties acknowledge that the obligation of District to make payments under Exhibit 4 is predicated on Medical Group's providing the coverage set forth in Exhibit 1 in compliance with the provisions of this Agreement, and not on the provision of any particular number of Providers.

5.1.7. The ratio of CRNAs to Physicians providing services under this Agreement shall not exceed 3:1 based on total hours worked, except for occasional variations from schedule to accommodate vacancies, volumes unexpected events or preferences of the medical staff.

5.2. **Emergency OR Call Coverage**.

5.2.1. Medical Group shall exclusively provide first call emergency anesthesiology coverage twenty-four (24) hours per day, seven (7) days per week, including holidays. This call emergency coverage shall not be "in house" coverage, but rather shall be on-call coverage and Medical Group shall exercise all reasonable efforts to have an appropriate Provider at Hospital within thirty (30) minutes from the time Medical Group is paged for the on-call physician. Exhibit 1 sets forth additional detail with respect to Medical Group's obligations in this regard. As set forth in Exhibit 1, at the request of the District Medical Group will provide an additional Provider to provide call coverage on Saturdays and Sundays.

5.2.1.1. When a third (3rd) call room is made available to the Medical Group, the Medical Group will provide in-house first call emergency anesthesiology coverage twenty-four (24) hours per day, seven (7) days per week, including holidays. The Medical Group shall exercise all reasonable efforts to have an appropriate Provider report to the Operating Room within five (5) minutes from the time Medical Group is paged for the on-call physician. The District will make reasonable efforts to provide this call room as soon as possible, and the Medical Group shall be the first recipient of an available Call Room prior to all other entities providing services for the District.

5.2.2. If an emergency C-Section occurs at the Hospital, a Provider will come to the Hospital to continue epidurals and be available for another simultaneous emergency C Section. If a trauma or emergency surgery occurs simultaneously during these obstetrical emergencies, a Provider will come to the Hospital, and another Provider will come in if there is a further emergency.

5.3. **On-Call Requirement – No Discrimination**. In accordance with California Health and Safety Code §1317.3(b), Medical Group shall provide on-call emergency services without discrimination to patients based on: race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, HIV status, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

5.4. **Obstetrical Coverage**.

5.4.1. Medical Group shall exclusively provide obstetrical anesthesiology coverage for obstetrical (OB) cases at Hospital, including, but not limited to, epidural administration, twenty-four (24) hours per day, seven (7) days per week, including holidays. Exhibit 1 sets forth additional detail with respect to Medical Group's obligations in this regard. Medical Group shall have an anesthesiologist/CRNA physically present in Hospital within thirty (30) minutes after a call is placed to Medical Group for emergency OB anesthesia services. The opinion of the responsible obstetrician that an emergency exists shall be conclusive.

5.4.2. Medical Group shall include the obstetrical call schedule with its regular operating room call schedule. This schedule shall be posted with Operating Room Management and locations requested by District, and Medical Group shall notify District of any changes as soon as possible.

5.5. **Unscheduled Surgeries**.

5.5.1. Medical Group agrees to respond to unscheduled surgeries in an expeditious manner. The O.R. Policy Committee has established standardized policies regarding unscheduled surgeries, which shall be adhered to by Medical Group, as modified by the O.R. Policy Committee from time to time. Medical Group shall provide the surgeon who shall be performing the unscheduled procedure, with an approximate time for the procedure and that time shall be adhered to insofar as possible. During normal surgery hours as set forth on the attached Exhibit 1, as that Exhibit may be modified from time to time, add-on cases shall be scheduled pursuant to existing policies. Unscheduled cases shall be divided into three categories: emergent surgery, urgent surgery, and routine add-on surgery.

5.5.2. An emergent surgery (e.g., ruptured AAA, post-operative bleeding, C-Section for fetal distress) shall be done in the first available room by the first available Provider even if this requires interrupting a scheduled room and another surgeon.

5.5.3. An urgent surgery (e.g., appendectomy, open fracture, etc.) shall be done in an appropriate room within one (1) to three (3) hours of the patient being available for surgery. Medical Group shall make a good-faith effort not to interrupt a scheduled room, but the parties acknowledge that on occasion this may be necessary. When it is necessary to interrupt a scheduled room, the interrupted surgeon shall be notified by the interrupting surgeon, in accordance with the policy of the O.R. Policy Committee.

5.5.4. A routine add-on surgery shall be done in the first available room with the first available Provider as soon as he/she is done with his/her elective schedule. A routine add-on shall not interrupt a scheduled room and shall not inconvenience scheduled cases. Upon receiving an add-on request, Medical Group and the charge nurse shall promptly provide the surgeon requesting the add-on with an approximate time for the surgery. Routine add-ons shall be accommodated in the same order in which the requests are received by Medical Group. If a request is made after normal surgery hours as reflected on Exhibit 1, it shall be accommodated at the discretion of Medical Group. Rooms shall be made available for add-ons consistent with current requirements set by the O.R. Policy Committee working in consultation with Medical Group and consistent with the days and hours set forth on Exhibit 1, as that Exhibit may be modified from time to time.

5.5.5. Medical Group shall respond in a courteous, timely, professional manner to requests to do these non-scheduled cases.

5.6. **Phone Number for Requesting Anesthesia Services**. As part of the increased efficiency to be realized through this exclusive provider arrangement, Medical Group shall be available for contact by District's House Supervisor through the PBX Operator twenty-four (24) hours per day, seven (7) days per week, including holidays. District's House Supervisor through the PBX Operator shall contact Medical Group by making a direct telephone call to the anesthesiologist on-call, as is the current practice. District's PBX number shall be the only number which a physician or District representative (other than the PBX Operator) shall be required to call to make a request of Medical Group for anesthesia coverage. The Nursing Supervisor through District's PBX Operator shall promptly relay the request for anesthesia services to Medical Group by means of the telephone number, which Medical Group has provided, to District's PBX Operator for the date and time of the call. In contacting Medical Group, the House Supervisor through District's PBX Operator shall be required only to communicate to the authorized representative of Medical Group who answers the call, the identity of the physician who requested anesthesia coverage and whether the physician identified the need for anesthesia services as an emergency. Once this number has been called and the request relayed by the House Supervisor through District's PBX Operator, Medical Group shall be deemed paged for the purposes of this Agreement.

5.7. **Responses to Requests for Anesthesia Services**. Medical Group agrees to respond to calls for anesthesia services by having a Provider in Hospital ready to perform the procedure within the following times:

5.7.1. Hospital Emergency and Emergency Room Call: As soon as possible but no later than thirty (30) minutes;

5.7.2. Emergency Obstetrical Call: As soon as possible but no later than thirty (30) minutes;

5.7.3. Urgent Case Call: One (1) to three (3) hours.

5.7.4. The medical judgment of the responsible surgeon at the time of surgery shall be conclusive as to the classification of the case as emergency, urgent, or non-urgent. Retrospectively, any disagreements with the classification used by the surgeon should be brought to the attention of the O.R. Policy Committee.

Medical Group agrees to have a Provider physically present at Hospital within these designated response times.

5.8. **Assignments for Scheduled Surgery**.

5.8.1. Medical Group acknowledges that it is the desire of District that surgeons at Hospital retain the ability to request which of the Providers employed or engaged by Medical Group shall provide anesthesiology services during a scheduled surgical procedure. Therefore, every reasonable effort shall be made to honor a surgeon's request for a specific Provider, as well as any of the following:

5.8.1.1. A bona fide request by a surgeon for the expertise of a particular Provider;

5.8.1.2. A specific patient request; or

5.8.1.3. A request for legitimate patient care needs based on the careful following of protocols and/or clinical pathways that have been pre-established to eliminate variabilities.

5.8.2. It is further acknowledged by Medical Group that patient care is enhanced by a surgeon knowing, in advance, which of the Providers shall provide anesthesia services during a scheduled surgical procedure. Therefore, Medical Group agrees to post the surgical assignments for the Providers in the Operating Room Scheduling Office before the start of that day's scheduled surgery and thereafter to endeavor to accommodate reasonable requests by surgeons to adjust those assignments.

5.9. **Membership of the Department**. All Providers who provide anesthesia services at Hospital shall be members of the Department of Anesthesia, and all anesthesia services contemplated by this Agreement shall be provided by Physicians in their capacity as members of the Department of Anesthesia, or by CRNAs approved by the appropriate committee of the Medical Staff. With the approval of District administration, Providers with locum tenens privileges (granted by Medical Group and the Medical Staff) may also provide services under this Agreement.

5.10. **Department Premises**. During the term of this Agreement, District shall continue to provide to or on behalf of Medical Group, at District's sole cost and expense, the use of the Department's premises located in, on, or about the Hospital as currently used in connection with the Department and as expanded or relocated as may in the determination of the District be reasonably necessary in the future for the safe and efficient operation of the Department and the provision of anesthesia to patients at the Hospital. Medical Group shall inform District as to future increased needs for Department premises. The District shall, at no cost to Medical Group, provide two (2) offices suitable for an on-site administrator and the Medical Director of Anesthesia Services, and three (3) on-call rooms (one for OB, one for Surgery, and one for OR Call when available).

5.11. **Use of Premises**. Medical Group shall use the Department's premises solely for the practice of anesthesia, pain management and related procedures provided by the Department under this Agreement, and the administrative and clerical activities attendant to that practice. Use of the premises by Medical Group shall be limited to Medical Group's Providers and administrative staff. No part of the premises shall be used at any time by Medical Group, nor shall Medical Group permit anyone else to use the premises, as an office for the private practice of medicine unless a separate agreement in writing is reached by the parties to that effect.

5.12. **Professional Standards**. Medical Group and its Providers shall perform their duties under this Agreement in accordance with the rules of ethics of the medical profession and, in the case of CRNAs, the nursing profession. Medical Group and its Providers also shall perform their duties under this Agreement in accordance with the appropriate standard of care for their respective professions and specialties including the guidelines of the American Society of Anesthesiologists and the Medical Staff Bylaws.

5.13. **Medical Direction and Administration**.

5.13.1. Spokesperson.

5.13.1.1. Medical Group shall designate a spokesperson (the "**Spokesperson**") for Medical Group, and may change its designation from time to time on prior notice to the District. The Spokesperson shall communicate in all matters involving the terms and conditions of this Agreement. Medical Group shall arrange for the Spokesperson to be available to consult with District or its designees at reasonable times on a regular basis to discuss any matters concerning this Agreement or the administration or operation of the Department.

5.13.1.2. In addition, the Spokesperson shall act as the facilitator to ensure that the duties of Medical Group described in this Agreement are met in a timely manner. Communications by District or its designee made to the Spokesperson shall be considered as made to Medical Group and the Spokesperson shall be responsible for the forwarding of all such communications by District to the appropriate boards, committees, or Providers of Medical Group. Statements made by the Spokesperson regarding this Agreement or the administration or operation of the Department shall be deemed by District as the statements of Medical Group.

5.13.2. Medical Director. Medical Group shall provide a Physician who is Board Certified by the American Board of Anesthesiology, approved by the District and the MEC, and otherwise meets the qualifications required by this Agreement to provide the services of Medical Director for Anesthesia Services (the "**Medical Director**"), subject to the approval of District. During the term of this Agreement, each party reserves the right to remove an existing Medical Director, in which case the proposed substitute Medical Director shall be subject to District approval, and shall be a Physician who (i) has Medical Staff clinical privileges at Hospital, (ii) is employed by or contracted with Medical Group to provide Services under this Agreement; and (iii) is subject to the requirements set forth in this Agreement, including the duties for the Medical Director as set forth in Exhibit 2 to this Agreement. Medical Group shall ensure that the Medical Directors, or his/her designee, is on-call to respond to operational issues during off-hours, weekends and holidays. The Medical Director shall serve as the Chief of the Anesthesia Department, subject to the adoption of revisions to the Medical Staff Bylaws and MEC approval.

5.13.3. Director for Cardiac Anesthesia, OB Anesthesia, and CRNA Services. Medical Group shall provide a Director for Cardiac Anesthesia (the "**Cardiac Anesthesia Director**"), a Director for OB Anesthesia (the "**OB Anesthesia Director**"), and a Director for CRNA Services (the "**CRNA Director**"), who are approved by the District and the MEC. The Cardiac Anesthesia Director and the OB Anesthesia Director shall be credentialed in cardiac anesthesia and OB anesthesia, respectively, all of whom shall be approved by the District. The Cardiac Anesthesia Director, the OB Anesthesia Director and the CRNA Director shall be responsible under the Director for the provision of Anesthesia Services for cardiac surgery and obstetrical surgery, and for the direction of CRNA services, respectively, and shall perform the duties set forth in Exhibit 2, as they pertain to their respective responsibilities.

5.13.4. Practice Leadership. The Medical Group shall provide the services of one or more qualified Physicians and one or more qualified CRNAs to provide practice leadership services, consisting of meeting attendance, policy review, personnel matters, scheduling, recruitment, and other administrative duties as appropriate.

5.14. **Additional Services**. In addition to the above coverage, Medical Group agrees, in the operation of the Department, to provide to District the additional services listed on the attached Exhibit 3, it being understood by both parties that these additional services are a material part of the consideration for this Agreement.

5.15. **Service Obligations**. Medical Group shall provide the Services in accordance with the Service obligations set forth in **Exhibit B** to this Agreement.

5.16. **Services to Medicare and Other Patients**. Medical Group shall provide Services in a manner consistent with District's charitable purpose of providing medical service to a broad class of patients in the Service Area, maintaining Medicare and Medi-Cal provider status and treating Medicare and Medi-Cal inpatients in a nondiscriminatory manner throughout the term of this Agreement. Medical Group shall provide uncompensated care to patients as reasonably requested by District throughout the term of this Agreement. District and Medical Group shall cooperate in designating the patient recipients of uncompensated care.

5.17. **Reports**. Medical Group shall prepare such administrative and business records and reports related to the Service in such format and upon such intervals as District may reasonably require.

5.18. **Conflicts of Interest**. Medical Group shall inform District of any other arrangements which may present a conflict of interest or materially interfere in the performance of its duties under this Agreement. In the event Medical Group or any Provider pursues conduct which constitutes a conflict of interest or which materially interferes with (or is reasonably anticipated to interfere with) Medical Group's performance under this Agreement, District may exercise its rights and privileges under Section 1.

5.19. **Use of Hospital**. Medical Group shall use the Department's premises solely for the practice of anesthesia, pain management and related procedures provided by the Department under this Agreement, and the administrative and clerical activities attendant to that practice. Use of the premises by Medical Group shall be limited to Medical Group's Providers and administrative staff. Medical Group shall not use, or permit any Provider to use, any part of the Hospital or other District facility for any purpose other than the performance of Services under this Agreement. Without limiting the generality of the foregoing, Medical Group agrees that no part of the premises of Hospital shall be used at any time as an office for private practice and delivery of care for non-Hospital patients. This provision shall not apply to any office for private practice at any professional building owned by District or any of its affiliates, pursuant to a separate lease agreement, or other private patients and practices of Medical Group independent of this Agreement.

5.20. **Authority**. Neither Medical Group nor any Provider may enter into any contract in the name of District or otherwise bind District in any way without the express consent of District.

5.21. **Compliance with Laws**. Medical Group 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 California Departments of Health Care Services and Public Health, The Joint Commission and the Medicare/Medicaid conditions of participation.

5.22. **Compliance with District Policies and Bylaws**. Medical Group and Physicians shall at all times comply with the bylaws, rules and regulations, policies and directives of District and the Medical Staff.

5.23. **Books and Records**.

5.24. Record-Keeping and Auditing. Medical Group shall maintain current and detailed records of all its Services, its billing and collection activities and results, its personnel services and costs of compensation and benefits, and all other expenses that are included in the expenses guaranteed in Exhibit 4, in accordance with accepted accounting and record-keeping practices, and sufficient to document and support such expenses and the Monthly Reports to be provided pursuant to Exhibit 4. District may at its sole discretion audit, either internally or through an independent consultant, Medical Group's coding, billing and collection activities, and its compensation records relating to Services provided under this Agreement by Medical Group's employees and independent contractors. Without limiting the foregoing, District shall have access to Medical Group's records relating to billing, collection, accounting, timekeeping, payroll and independent contractor services and compensation. At District's request, Medical Group shall provide copies of any records described in this paragraph.

5.25. Access. Upon written request of the Secretary of Health and Human Services, the Comptroller General or any of their duly authorized representatives, Medical Group 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 Medical Group 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, Medical Group 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. §§ 300-304. No attorney-client, accountant-client or other legal privilege shall be deemed to be waived by District or Medical Group by virtue of this Agreement. This Section shall survive the termination or expiration of this Agreement.

5.26. **Compliance Program**. Medical Group and each Physician shall (i) comply with all District policies, procedures and codes of conduct ("**Standards**"); (ii) sign and adhere to any disclosures or attestations related to District's compliance program (the "**Compliance Program**"); and (iii) participate in and support the Compliance Program. With respect to Medical Group's and each Provider's business dealings with District and their performance of the Services, neither Medical Group nor any Provider shall act in any manner that conflicts with or violates the Standards, nor cause another person to act in any manner which conflicts with or violates the Standards. Medical Group and each Physician shall comply with the Standards (as they may be revised in the future), as they relate to Medical Group's business relationship with District and its affiliates, employees, agents, contractors, and suppliers. Medical Group further acknowledges and agrees that, pursuant to the Compliance Program, Medical Group shall be subject to routine monitoring and review, and, potentially, external audit (limited to Medical Group's office(s) used in the performance of this Agreement). Medical Group agrees to cooperate fully in any such review conducted in connection with the administration of the Compliance Program

5.27. **Notification of Certain Events**. Medical Group shall notify District, in writing, promptly (and where feasible, within twenty-four (24) hours) of the occurrence of any of the following: (i) Medical Group or any Provider becomes the subject of, or otherwise materially involved in, any government investigation regarding 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) the Medical Staff membership or clinical privileges of a Provider 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) Medical Group or any Provider becomes the subject of any suit, action or other legal proceeding arising out of Medical Group's professional services and/or the Service provided pursuant to this Agreement; (iv) Medical Group or any Provider is required to pay damages or any other amount in any professional liability (malpractice) action by way of judgment or settlement; (v) any Provider become the subject of any disciplinary proceeding or action before any state's medical board or similar agency responsible for professional standards or behavior; (vi) any Provider becomes incapacitated or disabled from providing the Services, or voluntarily or involuntarily retire from the practice of medicine; (vii) any Provider'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) Medical Group or any Provider becomes the subject of any disciplinary proceeding or action before any state's medical board, nursing board or similar agency responsible for professional standards or behavior; (ix) any Provider changes his/her medical specialty; (x) any Provider is charged with or convicted of a criminal offense other than an infraction; (xi) the federal Drug Enforcement Agency Number of any Provider is revoked; (xii) any event or occurrence which has a material adverse effect on a Provider's ability to perform any or all of the Service under this Agreement; (xiii) Medical Group or any of Provider is debarred, suspended or otherwise ineligible to participate in any federal or state health care program, (xiv) Medical Group or any Provider is charged with or convicted of a felony, or any criminal offense related to the provision of health care, (xv) any act of nature or any other event occurs which has a material adverse effect on Medical Group's or any Provider's ability to perform the Services, (xvi) any Provider ceases to meet the requirements set forth in Section 4, or (xvii) Medical Group

gives notice of termination to any Provider for reasons relating to clinical performance or compliance with clinical standards or standards of conduct adopted by the Medical Staff.

5.28. **Confidentiality**. Medical Group understands and acknowledges that Medical Group shall have access to confidential information ("**Confidential Information**") concerning District's business and that Medical Group has 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. Medical Group further agrees that if this Agreement is terminated for any reason, it will 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.

5.29. **Quality**. Medical Group shall provide Services in accordance with high professional standards of care in the area and consistent with the quality standards of District, as determined by the applicable oversight committee, the standards of The Joint Commission and District's quality assurance/ performance improvement programs and in compliance with all laws and regulations. Medical Group shall, upon reasonable notice by District, make available to District the examination of its records and data with respect to the Services, including all quality data. Medical Group shall, upon reasonable notice by District, permit District to audit and inspect all such records and data necessary to ensure compliance with the terms of this Agreement.

5.30. **Medical Residency Programs**. Medical Group acknowledges that District is a teaching facility accredited by the Accreditation Council for Graduate Medical Education (ACGME) for teaching and training of medical residents, including residency programs in anesthesiology, family medicine, emergency medicine, behavioral medicine, general surgery and transitional year. Medical Group further acknowledges that the resident physicians are trainees practicing on a progressive continuum of independence and authority, and accordingly the residents must have collegial access to attending staff and medical directors for consultation and teaching, and that all patient care services provided by the residents are supervised by attending physicians. Medical Group (i) acknowledges the present and future participation (after consultation with Medical Group) of its employees and contractors as Core Faculty Members, Faculty Members and Program Director for the Program; (ii) will support and accommodate the Core Faculty Members, Faculty Members and Program Director in providing Faculty Services and otherwise meeting their Program duties, including supervision of the residents in the operating rooms and other locations; (iii) will provide prior notice and an opportunity to meet and confer with the District before terminating or restricting surgery room or other assignments of a participating anesthesiologist who is the Program Director or a Core Faculty Member or Faculty Member of the Program; and (iv) will otherwise support and facilitate the Program and the performance of services by the anesthesiology residents in the operating rooms and other hospital departments that are covered by this Agreement, provided that this provision shall not require Medical Group to accommodate any faculty activities that would impair its ability to provide services under this Agreement, and provided, further, Medical Group will not be required to incur any material cost in connection with such support.

Section 6. District's Obligations. District shall perform the following undertakings:

6.1. **Compensation**. The compensation terms are set forth in Exhibit 4 to this Agreement.

6.2. **Facilities and Service Provided by District**.

6.2.1. District shall provide on District premises the space designated by District for the Department, plus expendable supplies, equipment and services necessary for the proper operation of the Department.

6.2.2. District shall employ all technical and clerical personnel it deems necessary for the proper operation of the Department. District, with input from Medical Group and Providers, shall direct and supervise the technical work and services of such Department personnel, with District retaining full administrative control and responsibility for all non-physician Service personnel. All personnel furnished by District shall be subject to the direction of Medical Group while performing any clinical work or duties in the Department; however, all such personnel are not and shall not be made or considered to be agents of Medical Group, but rather shall remain employees of District and under its general supervision and report to the management of the Surgery Department.

6.2.3. District agrees to provide, at its expense, a Practice Manager to oversee the day-to-day operations of Medical Group within the Department, and at least one full-time on-site Administrative Analyst for the Service. These costs shall not be applied against practice expense caps set forth in Exhibit 4.

6.3. **District's Professional and Administrative Responsibilities**. To the extent required by Title 22, California Code of Regulations §70713, District shall retain the professional and administrative responsibility for the Service. 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. Medical Group shall apprise District of recommendations, plans for implementation and continuing assessment through dated and signed reports, which shall be retained by District for follow-up action and evaluation of performance.

Section 7. 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, either party may terminate this Agreement upon thirty (30) days' prior written notice.

Section 8. Insurance and Indemnification.

8.1. **Medical Group's Coverage**. Medical Group shall ensure that Medical Group, each Subcontractor and each Provider maintains professional liability insurance coverage with such insurance companies, issued upon such forms and containing such terms and limitations as required by the Medical Staff and as reasonably acceptable to District. The insurance coverage shall provide District defense for claims arising solely on the basis of vicarious liability or ostensible or apparent agency, for the act or inaction of Medical Group and/or its Subcontractors and/or their respective Providers. As a minimum, the insurance shall provide coverage in the amount of one million dollars ($1,000,000.00) per occurrence, three million dollars ($3,000,000.00) in the aggregate. If the insurance is maintained on a claims-made basis, the insurance shall continue throughout the term of this Agreement; and upon the termination of this Agreement, or the expiration or cancellation of the insurance, Medical Group shall ensure that it and/or each Provider purchases, or arranges for the purchase of, either (i) an extended reporting endorsement ("**Tail Coverage**") for the maximum period that may be purchased from its insurer (ii) "Prior Acts" coverage from the new insurer with a retroactive date on or prior to the date Medical

Group (or a Subcontractor or Provider, as the case may be) began performing services at Hospital under this Agreement or (iii) maintain continuous coverage with the same carrier for the period of the statute of limitations for personal injury. In the event Medical Group is unable to obtain the required insurance for or on behalf of Providers, Medical Group shall require Providers to keep and maintain such insurance coverage individually. All such insurance shall be kept and maintained without cost or expense to District. In the event neither Medical Group nor Providers purchase required coverage, District, in addition to other rights it may have under the terms of this Agreement or under law, shall be entitled, but not obligated to purchase such coverage. District shall be entitled to immediate reimbursement from Medical Group for the cost thereof. District may enforce its right of reimbursement through set-off against any sums otherwise payable to Medical Group or any Provider who failed to maintain the required coverage. Medical Group shall provide District with one or more certificates of insurance certifying the existence of all coverages required hereunder. Medical Group and Providers shall require their insurance carrier to provide District with not less than thirty (30) days' prior written notice in the event of a change in the professional liability policies of Medical Group or Providers.

8.2. **District's Coverage**. District shall maintain, at its sole cost and expense, professional and general liability coverage for the acts and omissions of District, its officers, directors, employees and agents (excluding Medical Group, Subcontractors and Providers should it or they be deemed to be agents notwithstanding the contrary intent of the parties). The District's coverage may be provided through one or more programs of self-insurance.

8.3. **Indemnification**.

8.3.1. District shall defend, indemnify, and hold Medical Group, its shareholders and Providers harmless from and against any and all liability, loss, expense, attorneys' fees, or claims for injury or damages arising out of the 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 or intentional acts or omissions of District, its officers, directors, employees, or agents.

8.3.2. Medical Group shall defend, indemnify, and hold District, its officers, directors, and employees harmless from and against any and all liability, loss, expense, attorneys' fees, or claims (i) for injury or damages arising out of the 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 or intentional acts or omissions of Medical Group, its shareholders, officers, Providers, Subcontractors, employees, or agents, (ii) any claim, loss or liability arising out of or with respect to its obligations to its employees or Subcontractors for compensation or benefits, or arising from Medical Group's or a Subcontractor's failure to withhold or pay required employment-related taxes or compensation, and (iii) any claim, action and cause of action (not including claims, actions and causes of action related to actions taken by Medical Group in compliance with Section 2.9(e) of this Agreement) arising out of, or in any way connected to, a claim by a Provider, or other Subcontractor or employee of Medical Group, that he or she has in any way been treated wrongfully by Medical Group or any of its present or future officers, directors, shareholders Subcontractors or employees.

8.3.3. Medical Group shall be solely responsible for compliance will all employment-related laws and regulations with respect to Providers, including California Assembly Bill 5 of 2019, and shall indemnify, defend and hold the District harmless against any claim, cost or liability arising from any claim that any Provider is or was an employee of the District. Without limiting the foregoing, if District is required to compensate or pay taxes for, or provide employee compensation or benefits of any kind (including contributions to government mandated, employment-related insurance and similar programs) to, or on behalf of, any Subcontractor or Provider or any other person employed or retained by Medical Group or a Subcontractor, or to pay any costs or penalties resulting from its failure to pay any such compensation, benefits or other amount, the amount of all such costs, claims and liabilities shall be an obligation of Medical Group to District, for which Medical Group shall reimburse District within thirty (30) calendar days after being notified thereof; provided that District may, at its option, set off the amount of the obligation against any sums otherwise due to Medical Group under this Agreement.

8.3.4. The provisions of this Section 8.3 shall survive termination of this Agreement.

Section 9. Miscellaneous Provisions.

9.1. **Notice**. Any notice required or desired to be given in respect to this Agreement shall be deemed to be given upon the earlier of (i) actual delivery to the intended recipient or its agent, or (ii) upon the third business day following deposit in the United States mail, postage prepaid, certified or registered mail, return receipt requested. 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: Gary Herbst, CEO
400 West Mineral King Avenue
Visalia, California 93291-6263

If to Medical Group:
Oak Creek Anesthesia Services, Inc.
Attn: Bradlee Bachar, M.D.
400 West Mineral King Avenue
Visalia, California 93291

With copies to each of the following:
Law Offices of Dennis M. Lynch
Attn: Dennis Lynch
922 West Center Avenue
Visalia, California 93291-5916

Baker, Manock & Jensen, PC
Attn: Peter Zeitler
5260 North Palm, Suite 421
Fresno, California 93704

With a copy to:
Benjamin Cripps, Chief Compliance Officer
Kaweah Delta Health Care District
400 West Mineral King Avenue
Visalia, California 93291-6263

9.2. **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; provided, however, that in the event that Medical Group or a Subcontractor incurs any Start Up Costs (as defined in the Kaweah Health Care District – Oak Creek Anesthesia Memorandum of Understanding) through October 31, 2020, District will reimburse such Start Up Costs in accordance with the terms of Section 4 of the MOU, which Start Up Costs shall not be applied against any Practice Expense Annual Cap.

9.3. **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.

9.4. **Assignment**. Because this is a personal service contract, Medical Group may not assign or subcontract 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.

9.5. **Regulatory Requirements**. The parties expressly agree that nothing contained in this Agreement shall require Medical Group or any Provider 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. §1320a-7b).

9.6. **Dispute Resolution**. The parties firmly desire to resolve all disputes arising hereunder without resort to litigation in order to protect their respective business reputations and the confidential nature of certain aspects 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 Medical Group and the District's Vice President responsible for the administrative oversight of the Service. If still unresolved to the mutual satisfaction of the parties, the dispute shall be referred to the Board of Directors for final resolution, subject to receiving the recommendation of the MEC to the extent required under the Medical Staff Bylaws. The Board of Directors shall, within a reasonable time, notify Medical Group of its decision 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. Nothing in this Section 9.6, however, shall require either party to complete the pre-litigation dispute resolution process in this Section 9.6 prior to exercising its respective rights under Section 1 to terminate this Agreement.

9.7. **Third Party Beneficiaries**. This Agreement is entered into for the sole benefit of District and Oak Creek Anesthesia Services, Inc. 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, including any Subcontractor or Provider.

9.8. **Governing Law**. This Agreement shall be governed by the laws of the State of California.

9.9. **Approvals**. Neither this Agreement nor any amendment of or modification hereto shall be effective or legally binding upon either party unless it is set forth in a written document executed by the parties hereto.

9.10. **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.

9.11. **HIPAA**. The parties acknowledge that they are part of an "organized health care arrangement" for purposes of the privacy provisions of the Health Information Portability and Accountability Act of 1996 ("**HIPAA**"). Medical Group and each Provider shall perform the Services in accordance with (i) applicable state and federal laws and regulations relating to health information privacy and security, including the California Confidentiality of Medical Information Act (Civil Code § 56 and following), and regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA); (ii) the District's policies and procedures relating to health information privacy and security; and (iii) the District's notice of privacy practices.

9.12. **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 CFR §411.357(d)(ii), any arrangements between Medical Group and District, or between any Group Physician of Medical Group 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.

9.13. **Modification**. This Agreement may be modified only by a signed, written instrument.

9.14. **Compliance with Laws.** District and Medical Group 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.

9.14.1. 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 Medical Group 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:

9.14.1.1. 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

9.14.1.2. 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).

9.14.2. Nothing in this Agreement is intended or shall be construed to require either party to violate the California or federal laws described in Section 7.14.1, and this Agreement shall not be interpreted to:

9.14.2.1. 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.

9.14.2.2. Restrict any Physician from establishing staff privileges at, referring any patient to, or from otherwise generating any business for any other entity of Physician's choosing.

9.14.2.3. Provide for payments in excess of the fair market value or comparable compensation paid to physicians for similar services in comparable locations and circumstances.

9.14.3. 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 7.14.1, the Parties shall use all reasonable efforts to revise this Agreement to conform and comply with such changes.

9.15. **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/pandemic, 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. This force majeure provision shall not relieve aa party of the obligation to make any monetary payments provided for hereunder.

9.16. **Counterparts**. This Agreement may be executed in two or more counterparts, each of which shall be deemed an original, but all of which shall constitute one and the same agreement.

9.17. **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: _____
Gary K. Herbst, Chief Executive Officer

MEDICAL GROUP: **OAK CREEK ANESTHESIA SERVICES, INC.**
a California professional medical corporation

By: _____
Bradlee Bachar, M.D., President

EXHIBIT 1
ANESTHESIA OR COVERAGE SCHEDULE

Contractor has the responsibility to provide all anesthesia services necessary for the proper operation of the Department twenty-four (24) hours per day, seven (7) days per week, except for services provided by others pursuant to Section 5.1 and this Agreement.

Both parties agree that the hours listed below are mutually agreed upon and obtainable standards. The District, in consultation with the O.R. Policy Committee, shall have authority to modify the coverage schedule as needed per Section 5.1. In the event the District determines that additional coverage is necessary in addition to the coverage set forth below, Medical Group shall have a reasonable period (not exceeding three (3) months) to supply the additional coverage.

1. **Coverage**. Medical Group shall have adequate communications between Providers and District, including the Surgical Charge Nurse and OR Management, with respect to changes in the Anesthesia OR Coverage Schedule.

2. **Endoscopy Coverage**. In addition to the schedule set forth below, Medical Group shall provide up to 30 hours of anesthesia coverage per month for Outpatient endoscopy, at variable hours confirmed by the Endoscopy Department and Medical Group.

3. **OR Coverage Hours Schedule**.

The OR Coverage Schedule in effect as of the Effective Date is as set forth below:

Monday - Friday

CVOR	24 hr (call)	0700 - 0700	All cases performed by Cardiac Surgeons
	8 hr	0700 - 1500	All cases performed by Cardiac Surgeons
Main OR	1	0700 - 0700 Call (MD1/R1) 24	Scheduled cases daily / on call after last surg complete
	2	0700 - 0700 Call (CRNA) 24	After scheduled cases CRNA back up for OB overnight
	3	1100 - 2300 (CRNA) 12	Late Shift General & add on's
	4	0700 - 1900 (CRNA) 12	General OR
	5	0700 - 1900 (CRNA) 12	General OR
	6	0700 - 1900 (CRNA) 12	General OR
	7	0700 - 1900 (CRNA) 12	General OR
	8	0700 - 1700 (CRNA) 10	Float/Break
	9	0700 - 1700 (MD) 10	General (MD1/R2)
	10	0700 - 1700 (MD) 10	General (MD2/R3)
	11	0700 - 1700 (MD) 10	General (MD2/R4)
	AOD	0700 - 1700 (MD) 10	Anesthesiologist of the Day MD4

	Acute Pain	0700 - 1700 (MD) 10	APS MD5
	Vascular	0700 - 1700 (MD) 10	Vascular MD3
	Float	0700 - 1700 (CRNA) 10	Float/Break
	Endo	0800 - 1600 (CRNA) 8	Endo
OB	24 hr (Call)	0600 - 0600 (CRNA)	Scheduled & Emergent C-Sections, Epidural Coverage
	OB II 10 hr	0630 - 1630 (MD6)	Available for all additional C-Sections, Epidural Coverage

Weekend Sat/Sun

CVOR	24 hr (Call)	0700 - 0700	All cases performed by Cardiac Surgeons
Main OR	1	0700 - 0700 Call (MD1/R1) 24	Scheduled cases daily / on call after last surg complete
	2	0700 - 0700 Call (CRNA) 24	After scheduled cases CRNA back up for OB overnight
	3	1100 - 2300 (CRNA) 12 Sat 0900 – 2100 (CRNA) 12 Sun	Late Shift general & add on's
	4	0800 - 1600 (CRNA/MD) 8	Endo (Saturday Only)
OB	24 hr (Call)	0600 - 0600 (CRNA)	Scheduled & Emergent C-Sections, Epidural Coverage
	OB II 8 hr	0630 1430 (CRNA)	Available for all additional C-Sections, Epidural Coverage

EXHIBIT 2
MEDICAL DIRECTORS FOR ANESTHESIA SERVICES

1. The Medical Director for Anesthesia Services shall be responsible for the professional direction of the Department. His or her duties shall include:

(a) Participating in the educational programs conducted by District and the Medical Staff in order to assure Hospital's overall compliance with accreditation and licensing requirements, and performing such other reasonable teaching functions as District may request;

(b) Directing non-physician personnel in the performance of professional services for patients;

(c) Advising District with respect to the selection, retention and termination of all personnel who may be required for the proper performance of anesthesia services; provided, however, that District shall retain the ultimate decision-making authority regarding the selection, retention and termination of all such personnel;

(d) Establishing schedules for all services provided by Providers in accordance with the terms of this Agreement;

(e) Supervising the development and implementation of Hospital quality assurance and quality improvement programs and procedures relative to the Services;

(f) Assisting District in the preparation and conduct of surveys by The Joint Commission and/or any other national, state or local agency relating to the Anesthesia Service and the Services provided under this Agreement; and

(g) Performing any other duties related to the Anesthesia Services contemplated herein that District's Governing Board, Medical Staff and/or the CNO may reasonably request.

2. The Cardiac Anesthesia Director, the OB Anesthesia Director and the CRNA Director shall be responsible under the Medical Director for the provision of Anesthesia Services for cardiac surgery and obstetrical surgery, and for the direction of CRNA services, respectively, and shall perform the duties set forth above, as they pertain to their respective responsibilities.

EXHIBIT 3
ADDITIONAL SERVICE AND STAFFING REQUIREMENTS

Medical Group shall meet the following service and staffing requirements, all of which shall be considered material requirements of this Agreement, as provided in Section 5.14 of the Agreement:

1. **General Requirements**:

(a) An adequate number of anesthesia providers shall be qualified to perform epidural, spinal, regional, MAC, total intravenous anesthesia (TIVA), central line placement, double lumen endotracheal tube intubation, fiber-optic bronchoscopy, use of glide scope, and general anesthesia to support institutional demand.

(b) Two dedicated CV Anesthesiologists shall be assigned to CV Surgery. Call is dedicated primarily to this area, but the anesthesiologists may respond to emergent needs in other areas.

(c) The OB Anesthesia Director shall be dedicated primarily to Obstetrics & Gynecology on 2 East, but the anesthesiologists may respond to emergent needs in the main OR and other areas.

(d) Medical Group shall be responsible for the monitoring of medication administration and correction of medication charge errors to ensure billing compliance for District.

(e) All Providers shall be ACLS certified as of the Effective Date, except for new Providers and Providers who have served less than one year under this Agreement, who shall be certified within one (1) year of commencing Services under this Agreement.

(f) Medical Group shall actively participate with all hospital quality or improvement initiatives related to Surgical Services and Anesthesia Services

(g) Medical Group shall exert commercially reasonable efforts to improve Physician Satisfaction results year-over-year as related to Surgical Services and Anesthesia.

(h) Medical Group shall strive to improve Patient Satisfaction (HCAHPS) scores year-over-year as related to Anesthesia. Medical Group shall cooperate with Hospital's Perioperative Medical Director on initiatives to improve quality and service in the main operating room and Surgical Center.

(i) Medical Group shall participate in and cooperate with Hospital's OR Policy Committee, and shall collaborate with Hospital's surgical medical director.

(j) Medical Group shall actively support Hospital's Quality initiatives, including the reduction of anesthesia-related OR case delays by assuring that patients have been interviewed and are ready on time for their scheduled surgical start times and that all anesthesiologists are consistently on time.

(k) Medical Group shall conduct a minimum of one post-anesthesia evaluation on all inpatients and outpatients.

(l) Medical Group, through a designated member, shall reasonably participate in the medical and paramedical educational programs conducted by District.

(m) Medical Group shall comply with regulations and standards as outlined by The Joint Commission and California Code of Regulations ("CCR") Title 22, the State Board of Pharmacy, CMS Conditions of Participation and other agencies having authority over the Hospital and the Department, to include medication safety and control, appropriate documentation in the medical record, pre-induction assessments, and full compliance with all hazardous waste streams and HIPAA regulations, or as otherwise set forth in the Agreement.

(n) The Medical Director for Anesthesia Services shall assure that anesthesia section meetings are held regularly, that minutes are reported to the appropriate medical staff committees in accordance with the Medical Staff Bylaws, that appropriate quality indicators are reviewed at each meeting with corrective action taken, and that the quality indicators and actions taken are subsequently reported to the Medical Care Review Committee, Quality Council or O.R. Policy Committee as appropriate.

(o) Medical Group shall be responsible for and have authority to ensure District's compliance with anesthesia requirements of accrediting bodies such as the American Medical Association, The Joint Commission and California Department of Public Health, to include active participation in the Department and District-wide quality monitoring activities.

(p) Medical Group shall on an ongoing basis participate through the Medical Director or his/her designee, at meetings of all required Performance Improvement committees and assigned activities.

(q) Medical Group shall make available to the Performance Improvement Department on a consistent and systematic basis all relevant information in the computerized or paper patient record for collection, display, and analysis.

(r) Medical Group shall comply on an ongoing basis with all of The Joint Commission requirements, including dating and timing of pre-induction physicals.

(s) Medical Group shall have bi-monthly Department meetings, and shall maintain, on an ongoing basis, Departmental minutes which accurately reflect appropriate and consistent involvement in the Performance Improvement process.

(t) Medical Group shall on an ongoing basis demonstrate a multi-Departmental team approach to solving quality problems that involve multi-Departmental processes.

(u) Medical Group shall on an ongoing basis demonstrate responsibility and accountability in the protection of the patient and with respect to unsolved problems that involve interdepartmental responsibility.

(v) Medical Group shall maintain, on an ongoing basis, bi-monthly Departmental minutes which accurately reflect review of data, problems, mortality, and outcomes, with analysis and action appropriate to the solution of problems in a timely and effective manner.

(w) Medical Group shall collaborate to support educational programs as requested by the District.

(x) Medical Group shall direct and arrange for anesthesiologists proctoring per applicable Medical Staff Bylaws.

(y) Medical Group and its Providers shall participate actively in the affairs of the Medical Staff, including, without limitation, serving on committees and discharging such other obligations as may be requested by the Medical Staff, or any duly appointed officer or committee thereof.

(z) Medical Group and its Providers shall conform to any and all lawful administrative directive issued from time to time by the CEO, COO and/or CMO, provided that such directives are consistent with the scope and principles of this Agreement.

2. **Monthly Meeting**. The Medical Director shall meet with District's Medical Director for Surgical Services and Director for Surgical Services at the monthly meeting to review performance of services identified in this Exhibit 3 and any other operational issues of concern.

3. **Quality Assurance**. Specific anesthesia criteria shall be developed by the Department of Anesthesia ("Department") that shall identify variances in Hospital practice/medical care (e.g. difficult intubations, OPs admitted to Hospital due to N & V, etc.) A medical record review shall be conducted by the Department when a patient's criteria are not satisfied. This information accompanied with any corrective action implemented shall be reported monthly to the O.R. Policy Committee and Medical Care Review Committee.

4. **Documentation Requirements**. Medical Group shall promptly complete all records, forms and reports reasonably required by District and the Medical Staff. District has developed an integrated computerized information system so as to more efficiently interface and collate medical data for patient care and billing. Medical Group shall actively utilize District's electronic medical records technology and tools. It is expected that anesthesia records, both computerized and written, prepared by Providers shall be accurate, complete and timely in accordance with Title 22.

5. **Qualifications**. In order to assure and enhance present and on-going clinical qualifications of Contractor and its Providers:

(a) Medical Group shall ensure that any Provider providing pediatric anesthesiology shall have training in pediatric anesthesiology and PALs certification. Pediatric definition by age to be determined by Surgery, Anesthesia, and Pediatrics Departments.

(b) All Providers, to the extent eligible, shall be trained, privileged and expected to place arterial/central lines and fiber optic difficult intubations.

(c) Whenever possible, all staffing assignments by Medical Group shall be based on Provider competency in the required skills.

(d) Medical Group or Medical Group's representatives shall acknowledge receipt all complaints within two (2) business days or sooner after receipt of notification.

6. **Dress Code**. All Providers shall adhere to the OR attire/dress code and the prohibitions on food and drink in the operating room, as required by the Surgical Services Policy.

7. **Professional Behavior**.

(a) Medical Group shall ensure that its Providers comply with the Code of Professional Conduct for Medical Staff/Allied Staff and the Conduct Guidelines of Medical/Allied Staff Granted Privileges at Kaweah Delta Medical Center, each as adopted by the Medical Staff of Hospital.

(b) Medical Group's Providers shall maintain professional behavior toward District's patients, patient's family members, Medical Staff members, visitors, and District staff as required by the Department of Anesthesia Policy and Procedure Manual, all related District Policies and the Medical Staff Bylaws.

(c) Providers shall arrive for scheduled cases at a reasonable time in order to allow for appropriate assessment, possible intervention, orders, etc., to avoid delays in surgery.

8. **Medication Management**. All Providers shall document and practice the following:

(a) Appropriate syringe labeling practices;

(b) Documentation of drugs received from Pyxis to ensure accountability of drug and restocking;

(c) Documentation of drug charges in collaboration with the Hospital pharmacy in appropriate systems;

(d) In collaboration with the District, Medical Group shall achieve one hundred percent (100%) accountability for all drugs used and their disposition;

(e) Medical Group shall achieve greater than an 85% initial charting accuracy compliance rate.

(f) Comply with District policies to ensure proper disposal of sharps and/or pharmaceutical waste in collaboration with the Hospital pharmacy;

(g) Comply with District Policy to ensure compliance, as applicable, with any compounding standards in collaboration with the Hospital pharmacy, such as aseptic techniques.

(h) Assure that Providers standardize their use of drug utilization with best practices, where feasible.

(i) When the mass transfusion protocol is in effect, Providers shall abide by the protocol until it is terminated.

9. **Anesthesia Business Indicators –** Unless specified differently, the following anesthesia business indicators will be monitored and reported quarterly and annually to the O.R. Policy Committee, O.R. Management, and Administration:

(a) **Anesthesia -** Staffing in comparison to anesthesia O.R. coverage schedule – will be reviewed quarterly with O.R. Management

(b) **Anesthetic Volume**

- By anesthetic location
- By anesthesia type
- By ASA class

(c) **Number of Clinicians**

- By type (Physician, Resident, CRNA, etc.)

(d) **Total Minutes (and Units) Billed**

- By anesthetic coverage location

(e) **Anesthesia Clinical Indicators.** The following anesthesia clinical indicators will be monitored and reported quarterly and annually to the Chief Medical Officer and Administration:

- Number of cases completed eventfully
- Occurrence of critical events (by location/service; definitions):
    - Death
    - Cardiac Arrest
    - Perioperative MI
    - Anaphylaxis
    - Malignant Hyperthermia
    - Transfusion Reaction
    - New Stroke

- Visual Loss
- Incorrect Surgical Site
- Incorrect Patient
- Medication Error
- Unplanned Admission
- Unplanned ICU Admission
- Intraoperative Awareness
- Unplanned Difficult Airway
- Unplanned Reintubation
- Dental Trauma
- Perioperative Aspiration
- Vascular Access Complication
- Pneumothorax
- Infection After Regional Anesthesia
- Epidural Hematoma
- High Spinal
- Postdural Puncture Headache
- Local Anesthetic Toxicity
- Peripheral Neurologic Deficit

The Medical Director for Anesthesia Services shall review the performance of these staffing and services requirements with the CEO or the CNO (or designee) at least quarterly.

10. **Performance Expectations**. In addition to the general service requirements of this Agreement, the Medical Group shall use commercially reasonable efforts to ensure that its Providers meet specific performance expectations from time to time set by agreement by the parties. The performance expectations in effect on the Effective Date are as follows:

Indicators	
OB Patient Satisfaction (overall)[1]	>90%
Post Op PACU Pain Satisfaction	>90%
Anesthesia Related OR Case OR Delays[2]	<4%
On-time starts for Scheduled Surgery[2]	>90%
On-time start for Scheduled Endoscopy, Electrophysiology Studies, AICD's, and Cardioversions[2]	>90%

[1] As measured by MTC Health.

[2] Medical Group and District to work together to establish a mutually agreeable definition.

EXHIBIT 4
COMPENSATION

1. Entire Compensation. Except as provided in this Agreement, neither District nor Medical Group shall charge the other for Services provided pursuant to this Agreement.

2. Meet and Confer. The parties shall meet and confer at least quarterly to discuss the performance of the Medical Group, including Provider recruitment and retention, billing and collection for Services, and Practice Expenses.

3. Billing and Collection of Fees for Services.

(a) Fee Schedule. Medical Group shall prepare a schedule of fees representing its full professional charges for Services rendered to District patients under this Agreement. The fee schedule, and any change thereto, shall be approved in advance by District in order for District to ensure that fees are reasonable, fair and consistent with the basic commitment of District to provide adequate health care to all residents within the Service Area. The fee schedule shall, at all times, comply with all applicable laws, rules, regulations and payer agreements. The fees shall at all times be reasonable and competitive. Nothing herein shall be construed to cause Medical Group to violate any federal or state laws concerning the establishment of fees. Medical Group shall provide prompt notice to District of any and all proposed changes in Medical Group's fee structures

(b) Documentation of Services. Medical Group shall ensure that its Providers document all Services fully, completely, accurately and promptly in the District's electronic medical records, including entering appropriate billing codes, and provide such additional documentation as the District or the contracted billing company requires to ensure prompt billing of and payment for Medical Group' Services.

(c) Billing Services. Medical Group shall use the services of a qualified contractor approved by District for the billing and collection of claims for all Services provided during the term of this Agreement. The approved billing service provider is R1 RCM. Medical Group shall obtain such assignments as are necessary to enable the services of its Subcontractors and their Providers to be billed in the name and for the account of Medical Group.

(d) Provider Enrollment and Participation Agreements. Medical Group shall diligently pursue and maintain, participation in good standing for Medicare, Medi-Cal and all managed care contracts for health care services in which District participates, e.g., health maintenance organizations (HMOs) and preferred provider organizations (PPOs), and shall ensure that its Subcontractors do the same. Medical Group shall follow the same procedures for credentialing new Physicians in order to obtain payment for Services in a timely manner.

(e) Global Contracts. To the extent that District enters into a contract with a health plan or other payor that does not permit Medical Group and District to separately bill for their respective professional and technical services ("**Global Contract**"), Medical Group shall look solely to District for payment and District shall compensate Medical Group for such services by a mutually agreeable amount (to be set in advance in writing), but in no event shall the amount be less that the amount that Medical Group would have received for such services, but for the Global Contract. Any such reimbursement shall be Program Collections for purposes of this Agreement.

(f) Collections.

(i) Program Collections. For purposes of this this Exhibit, "**Program Collections**" means revenues or receipts received by or on behalf of Medical Group or any of its Subcontractors or Providers during the applicable month from any and every source in any way related to Services performed at the District's facilities, including (without limitation) (i) payments under policies of business interruption insurance, and grants from government agencies relating to Services provided, lost revenues, or reimbursement of costs (except insofar as such grants are intended and used to cover unanticipated costs that are not reimbursable under this Agreement), and (ii) Abandoned Collections, as defined below; but excluding Guarantee payments made by the District under this Agreement, and less refunds, recoupments, offsets, takebacks or withholds.

(ii) Audit; Abandoned Collections. District may at its sole discretion, audit, either internally or through an independent consultant, Medical Group's documentation and coding practices. If, as a result of an audit or otherwise, District identifies claims that have not been billed (i) because of the failure of Medical Group, a Subcontractor or a Provider to document or code its services promptly and appropriately in accordance with industry standards, or (ii) because of the failure of Medical Group or a Subcontractor to reasonably cooperate with the District's efforts to establish its eligibility, or the eligibility of any Provider, for payment from any third-party payor, or to bill for and collect claims for services, and the billing contractor is not able to resubmit such claims to the payor by statute or payor requirements for timely claim submission ("Abandoned Collections"), the amount of Abandoned Collections, adjusted to reflect the Medical Group's historical collections rate for the payor, shall be added to Medical Group's Program Collections during the Term of this Agreement; provided that the Abandoned Collections shall not include the professional portion of any global rates that were billed and collected by District. For purposes of this Agreement, Abandoned Collections shall not include any charity care discount or other appropriate decision to reduce the charges to or payable by a Program patient; however, Abandoned Collections shall include any courtesy discount (including professional courtesy to a health provider or any family members of a health care provider) unrelated to individual need or appropriate exigent circumstances. The amount of Abandoned Collections identified subsequent to the expiration or termination of this Agreement that relate to Services performed by Medical Group during the Term of this Agreement shall be promptly repaid by Medical Group to District in an amount equal to, taking into consideration the historical collections rate for the payor, what would have been paid by the payor to Medical Group had the collections not been abandoned.[1]

(g) District Billing. District shall be responsible to bill and collect for all technical Hospital services provided to District patients during their Hospital stay.

(h) Billing Errors. The parties shall have reasonable access to records necessary to verify each party's compliance with this Agreement. Each party shall promptly correct or assist the other party in correcting any billing errors.

4. Submission of Pro Forma Estimates. On an annual basis, commencing three (3) months before each anniversary of this Agreement, Medical Group shall provide to District (i) a pro forma estimate of the Program Collections, all Variable Provider Expenses (as defined below), by category, and all Practice Expenses (as defined by below (by Category) for the then current year, and (ii) a pro forma estimate of Program Collections, all Variable Provider Expenses (by category) and all Practice Expenses (by category) for the following year. At its option, District may request Medical Group to provide information as necessary for District to evaluate the adequacy of the Practice Expenses.

5. Reports; Other Information.

(a) Documentation of Time. Medical Directors shall report their time through the District's Physician Time Study Database. With the exception of CV Anesthesiologists, all Clinical Providers shall be required to clock in and out via ADP Geo-fencing technology. Medical Director, Practice Leadership and GME/Faculty hours (payable under a separate Agreement) may not be recorded for time spent while the Provider is providing clinical shifts, except as approved in advance by District, or on occasional instances where avoidance would be impractical.

(b) Monthly Reports. Within fifteen (15) days after the end of each month of this Agreement, Medical Group shall submit to District an itemized report ("**Monthly Report**") setting forth the following in form and content reasonably satisfactory to the District, for the month just ended and for the Contract Year to date:

(i) The number of shifts and hours of Services performed each day of the month, with a description of the Services provided each day, and an indication of any variations from the staffing schedule set forth in Exhibit 1;

[1] To be discussed.

(ii) The number, identities and schedules of the individuals who provided Services during the month;

(iii) Medical Group's billings for Services;

(iv) Program Collections;

(v) Abandoned Collections;

(vi) Refunds, recoupments and offsets of or to Program Collections, and any claims for any of these;

(vii) Accounts receivable, and an accounts receivable aging report;

(viii) A report on Medical Group's performance during the month with respect to the goals set forth in Exhibit 4-2 (the "**Billing and Collection Targets**").

(ix) The Medical Group's cost of Provider compensation and benefits ("**Variable Provider Expenses**")

(x) For each category and subcategory of Practice Expense (as defined below), the actual amount expended during the month and during the Contract Year to date in each of the categories and subcategories set forth below, with such supporting documentation and detail as the District may reasonably request;

(xi) Other financial information maintained by Medical Group or its billing agent as may be reasonably requested by District in order to determine its obligations under this Agreement or monitor compliance with this Agreement.

(c) The Medical Group shall continue to submit the Monthly Report for each of the twelve (12) months following the termination or expiration of this Agreement for any cause or reason (the "**Tail Period**") in accordance with subsection (b), except that the reports for the Tail Period need contain only the information described in clauses (b)(iii) through (b)(vii) and (b)(xi).

(d) Quarterly Report. As soon as practicable after the end of each quarter of each Contract Year, Medical Group shall submit to District an itemized report ("**Quarterly Report**") for the prior quarter, setting forth the information required to be included in the Monthly Report, but aggregated for the quarter, in form and content reasonably satisfactory to the District.

(e) Annual Report. As soon as practicable after the end of each Contract Year, Medical Group shall submit to District an itemized report ("**Annual Report**") for the prior Contract Year, setting forth the information required to be included in the Monthly Report, but aggregated for the Contract Year, in form and content reasonably satisfactory to the District.

(f) Other Information. In addition to the Monthly, Quarterly and Annual Reports, Medical Group shall provide District with such additional reports and information as the District may reasonably request, including but not limited to collections activity, etc., with such frequency as the District may reasonably request.

(g) Production of Reports. If the District requests any report or information under this Section 5 that is not available as a standard report from the reporting systems of the Medical Group or its contractors, the Medical Group shall within fifteen (15) days of the District's request notify the District when the report may be available, or if the report is not available in the form or format requested by the District, how the Medical Group proposes to make the information available to the District. The District shall not unreasonably withhold its approval of the Medical Group's proposal, as long as the proposal would provide the information requested by the District in a timely manner. Once the parties have agreed upon the form and format of the report, the Medical Group shall provide it in accordance with the District's request.

6. Compensation.

(a) Retention of Program Collections. Medical Group shall retain all Program Collections, except as provided in Paragraph (f) (as to adjustments of estimated and actual Program Collections) and Paragraph (h) (as to Post-Termination Collections).

(b) Guaranty. Provided that Medical Group submits Monthly, Quarterly and Annual Reports as required by Section 5, and subject to the provisions of this Exhibit, the District shall pay Medical Group the amount, if any, by which Medical Group's Total Allowed Expenses exceeds its Program Collections during the term of this Agreement on an aggregate term-to-date basis (the "**Guaranty**"). Payments in relation to the Guaranty shall be made as provided in subsection (e) below. For purposes of this Exhibit, "**Total Allowed Expenses**" means the aggregate of Medical Group's actual and reasonable expenses incurred in in connection with the provision of Services, as set forth in (and not exceeding the amounts set forth in) the relevant Schedule 4.A, 4.B, 4.C or 4.D (each, a "Schedule," and collectively, the "Schedules"). The expense limitations in the Schedules shall be applied on a line-item basis, not an aggregate basis.

(c) Contract Year. The amounts set forth in the Schedules are for a Contract Year, which means each year of the term of this Agreement commencing October 1 and ending September 30 of the following year (or sooner if this Agreement is terminated before the end of the current Contract Year); and the terms "per year" or "annually" mean for each Contract Year.

(d) Total Allowed Expenses. In determining Total Allowed Expenses:

(i) Except with the approval of the District, which it may give or withhold in its discretion:

(A) The number of FTE Providers of each class whose compensation and benefit expense is included in Total Allowed Expenses shall not exceed the respective numbers in Schedules 4.B, 4.C, or 4.D, or such lesser number as may be reasonably necessary to meet the coverage schedule from time to time set forth in Exhibit 1, as modified pursuant to Section 5.1.1 of the Agreement. The FTE status of Providers shall be determined in accordance with the criteria set forth in the relevant Schedule. The Parties acknowledge and agree that the number and categories of FTEs set forth in Schedules 4.B, 4.C, and 4.D are sufficient to enable the provision of the coverage set forth in Exhibit 1, taking account of paid time off. The Parties acknowledge and agree that Medical Group may, with the approval of District, deviate temporarily from the actual number of Medical Doctors and CRNAs set forth in Schedules 4.B, 4.C, or 4.D, so long as the coverage set forth in Exhibit 1 is provided and the deviation does not increase the District's expenses under this Agreement without its prior approval.

(B) For any period during which the Medical Director, the Cardiac Anesthesia Director, the OB Anesthesia Director or the CRNA Director does not provide the services required by this Agreement (except for regular time away from practice for vacation, continuing medical education and the like), upon prior notice the relevant expense for MD or CRNA Leadership Stipends shall be reduced proportionately.

(ii) The District shall reimburse Medical Group's cost of billing and collection directly to the Medical Group's contracted billing service, and the costs of billing and collection shall not be Allowed Expenses.

(iii) The Total Allowed Expenses shall not include any expense, cost, charge, reduction, recoupment or offset incurred prior to the Effective Date, or arising from circumstances or events existing or occurring prior to the Effective Date, and the Medical Group shall provide the District with such information as the District may reasonably request to satisfy itself that all charges and expenses included in the Monthly Reports arose or were incurred on or after the Effective .

(iv) The Total Allowed Expenses shall also include the cost to Medical Group of sign-on bonuses not exceeding $30,000 for a new Physician and $10,000 for a new CRNA, subject to the prior approval of the District in each case, and contingent upon a two-year service commitment by the Physician or CRNA in form approved by the District.

(e) Payment Obligations and Reconciliation.

(i) Monthly Guarantee Payments. The District shall make the following payments to Medical Group, each an "**Estimated Monthly Guarantee Payment**," and all of which shall be deemed to be "**Guarantee Payments**" for purposes of this Agreement, and which shall be reduced in the aggregate by the amount of Program Collections for the most recent month for which the Monthly Report is available, and shall be subject to periodic reconciliation as provided in Paragraph (ii) below:

(a) Clinical Services. By the fifth (5th) day of each month District will pay Medical Group an amount equal to District's estimate of Medical Group's expenses for the month for the salaries and benefits for the clinical services of Providers, based on budgeted Provider hours, adjusted to add or deduct any amount necessary to reflect any difference in actual hours, as reflected in the reports referred to in Section 5(a), as against estimated hours for the most recent month for which such reports are available, and based on the relevant hourly rate set forth in the relevant schedule.

(b) Medical Director and Physician Leadership Costs. By the twentieth (20th) day of each month District will pay Medical Group the amount due for Medical Director Services and Physician Leadership costs for the prior month. Payment for Medical Director and Physician Leadership shall be in accordance with the hours documented via the Physician Time Study Database, at the hourly rates and subject to the monthly caps set forth in the relevant Schedule.

(c) Practice Expenses.

(i) Based on the Monthly Report submitted under Paragraph 5(b), District shall reimburse Medical Group on a monthly basis for the actual and reasonable expenses in the following categories incurred by Medical Group or its Subcontractors in connection with the performance of Services, subject to the limitations set forth below ("**Practice Expenses**"):

- Bank Service Charges
- Computer Software & Internet
- Continuing Education
- Health Insurance
- Malpractice and Employment Insurance
- Worker's Compensation
- Meals and Entertainment
- Office Expense
- Office Supplies
- Payroll Expenses
- Payroll Fees
- Payroll Taxes
- Payroll Taxes (Federal)
- Payroll Taxes (State)
- Postage/Printing
- Professional Fees
- Accounting Fees

- Credentialing Fees
- Consulting/Management Fees
- Consulting/Management Travel
- Legal Fees
- State Tax
- Communications Expense
- Utilities
- Financial Planning and Retirement Fees
- Recruitment

(ii) All Practice Expenses shall be reasonable and necessary for the maintenance and support of the medical practices of Medical Group and its Subcontractors solely for the purpose of providing Services to the District under this Agreement. If any such expense is incurred in part in connection with the performance of the Services and in part for other purposes, the Medical Group shall disclose this in the relevant Monthly Report, with its basis for apportioning the cost.

(iii) The Medical Group shall provide the District with any information that the District may reasonably request to document any Practice Expense, and the District may withhold reimbursement of any such expense pending receipt of requested documentation.

(iv) In no event shall the Practice Expenses reimbursable under this Agreement exceed the Practice Expense Cap set forth in the relevant Schedule, either individually for each subcontractor or in the aggregate.

(v) Prior to the start of the second Contract Year the parties will meet and confer with a view to amending this Agreement to provide for an allowance for Practice Expenses determined as a percentage of Medical Group's Clinical Compensation, or by some other method that does not require proof of actual expenses.

(ii) Periodic Reconciliation. Following delivery of the Quarterly Report and the Annual Report to the District, the District shall reconcile the Estimated Monthly Guarantee Payments over the term of this Agreement to date to the Medical Group's actual Total Allowed Expenses and Program Collections over the term of this Agreement (each such reconciliation, a "**Reconciliation**"). If the amount determined by subtracting aggregate actual Program Collections for the quarter or the year from aggregate actual Total Allowed Expenses for the period (the "**Deficit**") exceeds the aggregate Guarantee Payments for the period, the District shall forthwith pay the excess to the Medical Group by ACH transfer. If the aggregate Guarantee Payments for the period exceed the Deficit, the Medical Group shall forthwith pay the excess to the District; provided that the District may in its discretion recover the excess by setting it off against future Estimated Monthly Guarantee Payments.

(iii) Cost of Locum Tenens Providers. Provided the conditions set forth in Section 4.5 of the Agreement are met, District shall pay the cost of locum tenens and Temporary Providers either to the Medical Group or directly to the Providers, at the District's election. Medical Group shall promptly forward invoices for the services to the District.

(iv) Incentive Compensation. During the first year of this Agreement, District shall guarantee Medical Group's Program Collections in an additional amount up to one hundred fifty thousand dollars ($150,000) ("**Performance Compensation**") for the achievement of certain mutually agreed upon objectives and performance standards related to Anesthesia Services ("**Performance Objectives**"). Payment of Performance Compensation shall be considered a "Guaranty Payment" for purposes of this Agreement.

(a) Performance Objectives. The Performance Objectives shall be mutually established by the parties, including the metrics and allocation of the Performance Compensation. The initial Performance Objectives, metrics and allocation of Performance Compensation are set forth in Exhibit 4-1.

(b) Annual Review and Modification. At least ninety (90) days before each anniversary date of this Agreement, the parties shall meet and confer to determine the Performance Objectives, metrics and allocation of Performance Compensation for the coming year. Notwithstanding the foregoing, all adjustments to compensation shall be made in good faith, taking into account fair market value compensation for the Services provided under this Agreement, and memorialized in a signed, written amendment to the Agreement.

(c) Disagreements. Any dispute relating to the amount (if any) of Performance Compensation from time to time due shall be resolved in accordance with the dispute resolution process set forth in Section 9.6 of this Agreement

(f) Additional Information; Adjustments. The District may from time to time reasonably request supporting documentation for the Monthly Report or the Quarterly Report, and may from time to time, on not less than ten (10) days' prior written notice to Medical Group, audit (through its employees or independent accountants) Medical Group's books and records relating to the Services, the Program Collections, and the expenses for which Medical Group has claimed reimbursement under this Agreement. If District determines that any Guarantee Payment has exceeded the amount to which Medical Group is entitled, it shall give the Medical Group written notice of its determination (an "**Overpayment Notice**"), and (subject to Medical Group's right to dispute the determination) the excess shall be an obligation of Medical Group to District, which District may recoup by deduction from future Guarantee Payments, or otherwise. If Medical Group disputes District's determination, it shall give the District written notice of the dispute within thirty (30) days of delivery of the Overpayment Notice, and if the parties are unable to settle the dispute informally it shall be resolved in accordance with Section 9.6 of the Agreement.

(g) Excess Collections. If in any month Medical Group's Program Collections exceed its Total Allowed Expenses for the month, the excess shall be offset against the next Guarantee Payment; provided that the aggregate amount to be paid to the District under this paragraph over the term of this Agreement shall not exceed the aggregate amount of expenses reimbursed by the District over the term of this Agreement, plus the District's costs of billing for the Medical Group's Services. If District determines that any Guarantee Payment was less than the amount to which Medical Group is entitled, it shall give the Medical Group written notice of its determination, and shall pay the deficit to the Medical Group (less any amount owed to the District by the Medical Group under this Agreement).

(h) Post-Termination Collections. Upon expiration or termination of this Agreement which is not superseded by an extended or new agreement between parties for Services, District shall determine the aggregate Guarantee Payments made to Medical Group, plus the District's aggregate costs of billing services, that were not offset by Program Collections during the term **("Net Payments**"). The following shall apply so long as the District has Net Payments that have not been repaid by Medical Group.

(i) Any Program Collections in excess of the Monthly Guarantee Payments as of the expiration or termination of the Agreement shall be remitted to the District within ten (10) days after the termination of the Agreement, but in no event shall Medical Group remit to District any Program Collections that are greater than the amount of Net Payments then outstanding.

(ii) If there are still Net Payments then outstanding, District shall be entitled to Program Collections for Program Services rendered by Medical Group prior to the expiration or termination date but not collected prior to the expiration or termination date ("**Post-Termination Collections**"). Throughout the Tail Period, Medical Group shall (i) continue to bill and collect for the Post-Termination Collections with the same diligence as during the term of this Agreement; (ii) continue to submit to District the Monthly Report; and (iii) pay District the amount of the Post-Termination Collections, but in no event shall Medical Group

remit any Post-Termination Collections that are greater than the amount of Net Payments then outstanding. Medical Group may deduct its actual costs related to managing billing and collection activities of the Post-Termination Collections.

Exhibit 4-1

Performance Incentives

[To follow]

Allowable Expenses – Oak Creek Anesthesia Services, Inc.
(Subject to the terms of the foregoing Agreement)

Practice Expenses

1. Annual Cap - $25,000

Leadership – Annual Cap - $25,000

1. Group Leadership – Oak Creek Anesthesia Services President to provide up to 100 hours (annually) at $250.00 per hour conducting Group Leadership duties for Oak Creek Anesthesia. Payment subject to documentation submitted via the Physician Time Study Database or alternative, mutually agreeable, format.

Incentive Compensation – up to $150,000 per year

1. As set forth in Exhibit C, Section 1(a)(iv)

Schedule 4.B

Allowable Expenses – Cardiac Anesthesia Subcontractor
(Subject to the terms of the foregoing Agreement)

Clinical Compensation Terms:

1. FTE Definition: 2,530 hours worked per year providing services under this Agreement
2. FTE Total: $590,000
3. FTE's Required: 2.0 (subject to adjustment as provided in Section 5.1.1)
4. Call Compensation: $182,500 (all evenings and weekends)
    a. Additional Provider – If a third provider is added to the Call Panel, the parties will meet and confer to discuss the call compensation amount.
5. Payment Terms
    a. Annual Increase – 2% increase in base compensation (only)
6. Administrative Days – Each Provider FTE will receive 30 administrative days per year (based upon the anniversary date of the agreement) to be used for vacation (Monday – Friday) or holidays that fall on a weekday (based upon the District's holiday schedule). Annually, the District, in collaboration with the Medical Group, will calculate the number of administrative days used per FTE during the prior 12-month period. The District agrees to reimburse the Medical Group $1,865.00 per day for remaining, unused administrative days. For the sake of clarity, the per day administrative rate is calculated by dividing total FTE Compensation ($590,000.00) by the FTE annual hours requirement (2,530 hours), multiplied by eight (8) hours per the Anesthesia Staffing and Coverage Schedule (Exhibit 1).
    a. Providers are required to provide Uninterrupted Coverage. Providers must use their best efforts to arrange coverage to ensure their contractual obligations are met (2 physicians Monday – Friday). Providers shall give the District as much advance notice as practicable of any anticipated interruption in coverage, and not less than seven (7) days' notice of any interruption resulting from a planned absence.
7. Locum Tenens – District reimbursement for the use of Locums or Temporary Providers contemplated in Section 4.5 of the Agreement and Section 6(e)(iii) of Exhibit 4 will be limited to 12 weeks annually. The use of Locums or Temporary Providers for Call Coverage will result in a proportional decrease to the stated Call Compensation Amount.
    a. Providers are required to provide Uninterrupted Coverage. Providers must use their best efforts to arrange coverage to ensure their contractual obligations are met (2 physicians Monday – Friday). Providers shall give the District as much advance notice as practicable of any anticipated interruption in coverage, and not less than seven (7) days' notice of any interruption resulting from a planned absence.

Group Leadership and Medical Direction – Annual Cap - $25,000

1. Medical Director of CV Anesthesia and Group Leadership – Medical Group to be paid $25,000 annually to provide at least 100 hours (annually) conducting Medical Director and Group Leadership duties for CV Anesthesia. Amount subject to monthly attestation and will be paid in equal monthly payments (1/12 of total).

Practice Expenses

1. Annual Cap - $22,500

Sign-on Bonus

1. $30,000 for new Full-Time Physicians – 2 year commitment

Allowable Expenses – General Anesthesia Subcontractor

Clinical Compensation Terms:

1. FTE Definition: 2,530 hours per FTE (46 weeks at 55 hours per week)
2. FTE Base Compensation and Benefits: $538,510.50
3. FTE's Required: 8.6 (subject to adjustment as provided in Section 5.1.1)
4. Payment Terms
    a. Payment based on hours worked (payroll reports) at $209.00 per hour.
    b. Incentive Compensation Allowance – Medical Group will be reimbursed up to $156,000 annually for incentive shift compensation. Amount reimbursed upon invoice.
    c. Annual Increase – 2% increase in base compensation (only)

Leadership – Annual Cap - $181,516

1. OR Anesthesia Medical Director (Dr. Palacios) – OR Anesthesia Medical Director to provide up to 235 annual hours at $212.85 per hour (50,020 annually). Payment subject to documentation submitted via the Physician Time Study Database.
2. OB Anesthesia Medical Director (Dr. Morell) – OB Anesthesia Medical Director to be paid $25,000 annually to provide at least 120 hours (annually) conducting duties for OB Anesthesia. Amount subject to monthly attestation and will be paid in equal monthly payments (1/12 of total).
3. Group Leadership – Medical Group to be paid $106,496 annually to provide at least 416 hours (annually) conducting Group Leadership Duties for Main OR Anesthesia. Amount subject to monthly attestation and will be paid in equal monthly payments (1/12 of total).

Practice Expenses

1. Annual Cap - $56,000

Sign-on Bonus

1. $30,000 for new Full-Time Physicians – 2 year commitment

Allowable Expenses – CRNA Subcontractor

Clinical Compensation Terms:

1. Rate: $143.75
2. FTE Definition: 1,840 hours per FTE
3. FTE Base Compensation and Benefits: $264,500
4. FTE's Required: 21.6 (subject to adjustment as provided in Section 5.1.1)
5. Payment Terms
    a. Payment based on hours worked (payroll reports) at $143.75 per hour
        i. Exceptions – OR C1 Call Compensation based on 19.2 hours at $143.75. OB Call compensated at 24 hours ($143.75 per hour)
    b. Annual Increase – No increase in years 1 and 2. A 2% increase in year 3 (base compensation only)

Leadership – Annual Cap - $106,080

1. CRNA Medical Director and Group Leadership – Medical Group to be paid $106,080 annually to provide at least 624 hours (annually) conducting CRNA Medical Director and Group Leadership duties. Amount subject to monthly attestation and will be paid in equal monthly payments (1/12 of total).

Practice Expenses

1. Annual Cap - $126,500

Sign-on Bonus

1. $10,000 for new Full-Time CRNAs – 2 year commitment

Exhibit 5

PROVIDER ACKNOWLEDGEMENT

The undersigned, a Physician or CRNA providing anesthesia services within the Anesthesia Department at Kaweah Delta Medical Center (the "Hospital") pursuant to an Exclusive Provider Agreement for Anesthesia Services (the "Provider Agreement") between Kaweah Delta Health Care District (the "District"), and Oak Creek Anesthesia Services, Inc., a California professional medical corporation (the "Contractor") agrees and acknowledges as follows:

(a) The Provider Agreement does not confer any contractual rights on the undersigned or any other individuals who currently are under contract with Contractor in any capacity.

(b) If the undersigned is a physician, the clinical privileges of the undersigned to provide services in the Department that are exclusively assigned under the Provider Agreement (and if these are the only clinical privileges of the undersigned, his or her Medical Staff membership also) shall forthwith terminate, without further action by or on behalf of the District or the Medical Staff, and without right of review, fair hearing or appeal (which the undersigned expressly waives), if (i) the Provider Agreement expires or is terminated for any cause or reason, or without cause, or (ii) if the undersigned is providing services under a subcontract with Contractor, the subcontract expires or is terminated for any cause or reason, or without cause, or (iii) the undersigned ceases, without cause or for any cause or reason, to be employed or contracted by Contractor (or Contractor's subcontractor) to provide services under the Provider Agreement.

(c) If the undersigned is a CRNA, the status of the undersigned as an Advanced Practice Provider having clinical privileges or approvals to provide nurse anesthetist services in the Department shall forthwith terminate, without further action by or on behalf of the District or the Medical Staff, and without right of review, fair hearing or appeal (which the undersigned expressly waives), if (i) the Provider Agreement expires or is terminated for any cause or reason, or without cause, or (ii) if the undersigned is providing services under a subcontract with Contractor, the subcontract expires or is terminated for any cause or reason, or without cause, or (iii) the undersigned ceases, without cause or for any cause or reason, to be employed or contracted by Contractor (or Contractor's subcontractor) to provide services under the Provider Agreement.

(d) Upon termination of the Provider Agreement or of his or her employment or service agreement with the Contractor or Contractor's subcontractor, the undersigned shall immediately vacate the Department.

ACKNOWLEDGED:

_____
Sign

_____
Print Name

Date: _____

Name: _____ _____

Please Print *Date*

Privileges in Psychiatric & Addiction Medicine

CORE PRIVILEGES PSYCHIATRY & ADDICTION MEDICINE

Education: Successful completion of an ACGME or AOA-accredited Residency Program in psychiatry. **AND** Current certification or active participation in the examination process leading to certification in Psychiatry by the American Board of Psychiatry & Neurology or the American Osteopathic Board of Psychiatry & Neurology.

Initial Clinical Experience: A minimum of 24 patient contacts in the last 24 months.

Physicians licensed in California and enrolled in the 3rd or last year of a non-KDHCD ACGME accredited Residency Program can apply for privileges ~~to work under the indirect supervision of a Board Certified physician~~ to work independently, but cannot supervise any learners. ***(KDHCD residents may not moonlight at sites that are part of their training rotation, or supervise other learners)***

Physicians licensed in California who are board-certified or board-eligible and currently enrolled in a fellowship program can apply for privileges to work independently and may be permitted to supervise learners at KDHCD.

Renewal Criteria: Appropriate number of cases performed per year as based on Category. Minimum 12 cases required in the past two years.

FPPE Requirements: Minimum 6 chart reviews

Request	Procedure	Approved
☐	**Core Privileges include:** Evaluate, diagnose, consult, perform history & physical, and provide treatment to patients the age of 13 and above presenting with mental, behavioral, or emotional disorders **AND** • Consult with physicians in other fields to assess, triage, and treat mental, behavioral, emotional, and psychiatric disorders and their interactions with physical disorders for patients the age of 13 and above, in medical/surgical inpatient settings, skilled nursing, and acute rehabilitation. • Psychopharmacology • Providing individual, group and family therapy • Behavior modification • Consultation to the courts • Emergency psychiatry • Chemical dependency intervention and therapy	☐
☐	Admitting Privileges (must request Active or Courtesy staff status)	☐
☐	Telehealth: Provide interpretive, diagnostic or treatment services by means of telemedicine devices (including interactive audio, video or data communications)	☐

CORE PRIVILEGES IN CHILD & ADOLESCENT PSYCHIATRY

Education: Successful completion of an ACGME or AOA-accredited Residency Program in psychiatry with two additional years of fellowship training in child and adolescent psychiatry. **AND** Current certification or active participation in the examination process leading to certification in Psychiatry by the American Board of Psychiatry & Neurology or the American Osteopathic Board of Psychiatry & Neurology. ~~**AND** A minimum of one additional year of residency training in child and adolescent psychiatry~~

Renewal Criteria: Minimum 12 cases required in the past two years.

FPPE Requirements: Minimum 6 chart reviews

Request	Procedure	Approved
☐	**Core Privileges include:** Evaluate, diagnose, consult, perform history & physical, provide treatment to children & adolescents presenting with mental, behavioral, or emotional disorders **AND** consultation with physicians in other fields regarding mental, behavioral, emotional, and psychiatric disorders and their interactions with physical disorders including Psychopharmacology; Providing individual, group and family therapy; Behavior modification; Consultation to the courts; Emergency psychiatry	☐
☐	Admitting Privileges (must request Active or Courtesy staff status)	☐

ADVANCED PRIVILEGES
(Must also meet the Criteria Above)

Request	Procedure	Additional Criteria	Renewal Criteria	FPPE Requirements	Approved
☐	Outpatient Services at a Kaweah Delta Health Care District Clinic identified below. Privileges include performance of core privileges/procedures appropriate to the outpatient setting and may include telehealth: **__ Dinuba __ Exeter __Lindsay** **__ Woodlake ___Family Medicine Clinic** **___Chronic Disease Management Center**	Initial criteria AND Contract for services with Kaweah Delta Health Care District or KDHCD ACGME Family Medicine Program	Maintain initial criteria	None if currently active in the hospital; otherwise, 2 chart reviews	☐
☐	~~**Telehealth:** assess, diagnose, triage and treat by means of telemedicine devices (live interactive audio/video conferencing; known as telepsychiatry (TP) and telemental health (TMH))~~	~~Meets Initial Criteria for Core Privileges. 6 (Six) of 24 patient encounters in the last 24 months must be TP or TMH;~~ ~~**OR**~~ ~~Two Training consultations~~	~~Documentation of 12 consultations.~~	~~2 Chart reviews~~	☐

Name: _____ _____
Please Print *Date*

		~~**OR**~~ ~~Telehealth training (2 hours)~~ ~~**OR**~~ ~~education (2 hours of Telehealth CME/CE)~~			
☐	**Hypnotherapy**	Evidence of graduate school or post graduate school training course in hypnosis **OR** Documentation of at least 3 supervised cases by a physician with like privileges.	Minimum of 6 cases required in the past two years	3 Chart reviews	☐

Acknowledgment of Practitioner:

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

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

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

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

Signature: _____ _____
Applicant *Date*

Signature _____ _____
Department of Psychiatry & Addiction Medicine Chair *Date*

Advanced Practice Provider Name: _____ Date: _____

Please Print

Collaboration/Supervision Requirements for all Advanced Practice Providers

As required by CCR Title 16 Division 13.8 Physician Practice Act Section 1399.545 (g); CA Business and Professions Code Section 3502, at all times, the collaborating/supervising Physician must not supervise more than four (4) Advanced Practice Providers at one time.

Consultation and Referral:
The Advanced Practice Provider will seek physician consultation in a timely manner for the following situations:

- Conditions which fail to respond to management in an appropriate time.
- Any condition, which is beyond the Advanced Practice Provider's scope of training or experience.
- Any unexplained physical examination or historical finding.
- All unstable or potentially unstable patients, after initial care has been started.
- Any patient who requests to see a physician rather than an Advanced Practice Provider.

Collaborating/supervising physician agreement: ~~As a member of the medical staff at Kaweah Delta Health Care District, I do hereby apply to serve as~~ As a collaborating/supervising physician for the Advanced Practice Provider noted above. I agree to accept full professional responsibility for the collaboration or supervision and direction of the applicant in the performance of functions and services for which the applicant is granted authorization to provide ~~in the Hospital~~. To the best of my knowledge and belief, the applicant is duly qualified to perform the services for which authorization has been requested in this application. I hereby certify that the applicant is covered by malpractice liability insurance as required ~~by the District~~. I am covered by malpractice liability insurance to supervise applicant as required ~~by the District~~. I agree to notify the medical staff office in the event that either insurance coverage is reduced, restricted or terminated, or if there is a change in the employment status of applicant. I have read and agree to be bound by the ~~Medical Staff Bylaws and Rules & Regulations~~Governing documents as applicable.

Nurse Practitioner

Supervising Physician's Responsibility for Supervision and/or Collaboration
Once initial competency is established, and the Nurse Practitioner's (NP) standardized procedures have been defined and approved, the NP is authorized to perform approved standardized procedures without the direct observation, supervision, or approval of a physician. Physician consultation must be available at all time, either on-site or by immediate electronic communication, when needed for any reason, as defined by the individual standardized procedure. With respect to the ordering or furnishing of drugs or devices by the NP, the supervising physician must be available by telephone at the time of patient examination by the NP.

Delegation of Services Agreement for Physician Assistant

Supervising Physician's Responsibility for Supervision of Physician Assistants:
As outlined in Section 1399.545 of the Physician Assistant Regulations, the Supervising Physician will:

- Be available by electronic communication, or in person, at all times when the PA is caring for patients.
- Delegate to the PA only those procedures and tasks that are part of the usual and customary practice of the Supervising physician and which the PA has demonstrated competence in performing.
- Review, sign, and date the medical record of every patient treated by the PA within thirty (30) days of the patient encounter or, if operating under adopted protocols, the Supervising Physician shall review, countersign, and date a minimum of 5% sample of medical records of patients treated by the PA functioning under these protocols within thirty (30) days. The Physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to the patient.
- Review, sign, and date the medical record of every patient in which the PA has administered a Schedule II medication, or issued a drug order for a Schedule II medication, within seven (7) days of the patient encounter.
- Maintain continuing responsibility for the progress of the patients and all services provided by the PA.

_____	_____	_____
Supervising Physician's Signature	*Printed Name*	*Date*

Advanced Practice Provider Declaration: My signature below signifies that I fully understand the Collaboration/Supervising Requirements, as pertains to me, and agree to comply with its terms without reservation.

_____	_____	_____
Advanced Practice Provider Signature	*Printed Name*	*Date*

Advanced Practice Provider Name: _____ Date: _____

Please Print

ADVANCED PRACTICE PROVIDER
MULTIPLE SUPERVISING PHYSICIANS SIGNATURE PAGE

SUPERVISING/COLLABORATING PHYSICIANS' ATTESTATION

I have evaluated the Advanced Practice Provider's Delegation of Services Agreement (as applicable), education, experience, knowledge, and ability to perform safely and competently as an ~~AHP~~APP. I therefore endorse the clinical privileges requested and I hereby request the privilege to supervise and direct the above-named Advanced Practice Provider applicant, and do hereby agree to be responsible for the medical care of the patients for whom he/she proposes to render services ~~in the hospital~~.

Signature	*Printed Name*	*Specialty*	*Date*

Quality Improvement for Institutions

AMERICAN COLLEGE of CARDIOLOGY

Kaweah Delta Medical Center
PCI Data Quality Analysis

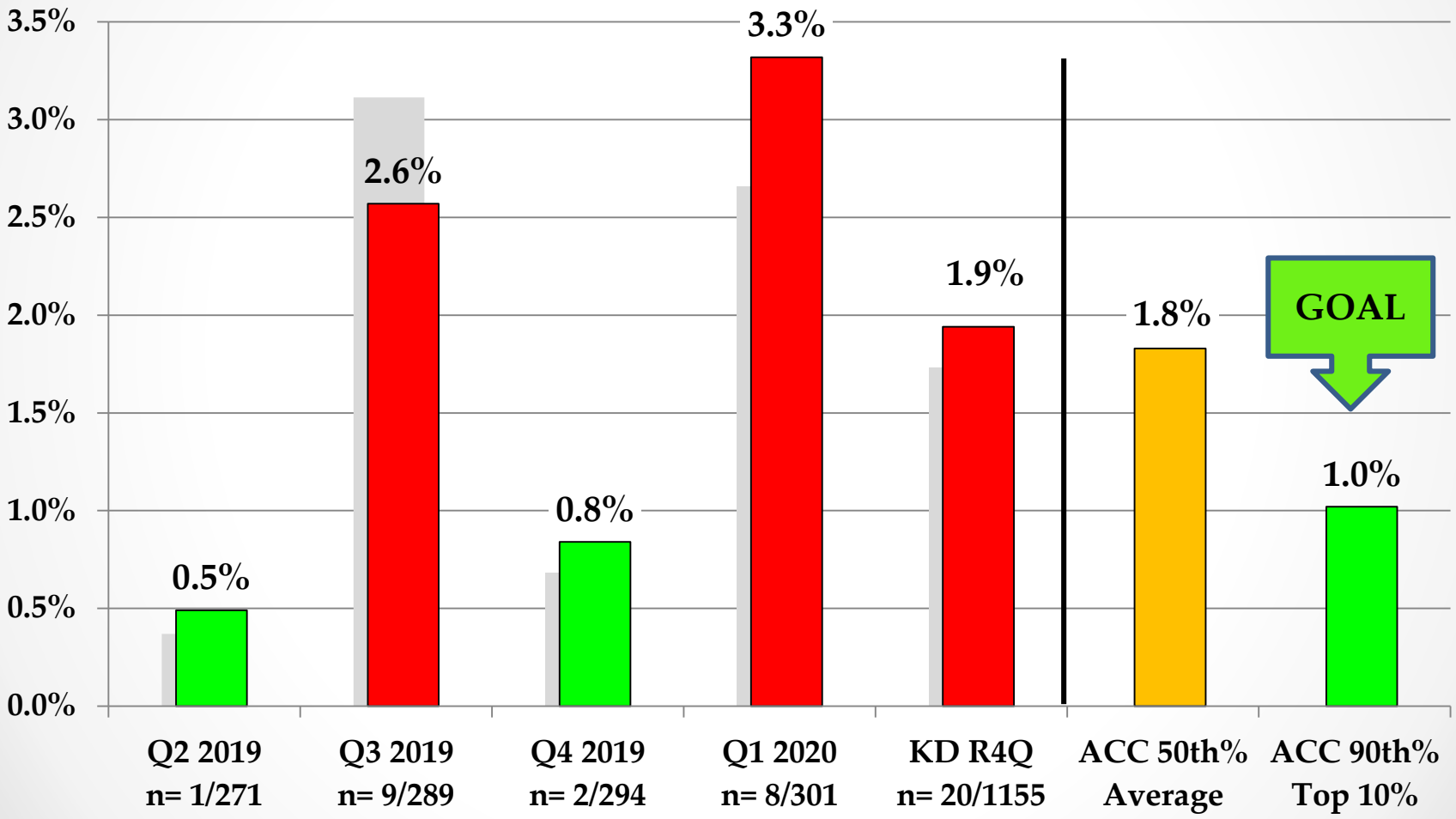
2019 Q2 – 2020 Q1

Green = In the Top 10% of the Nation
Yellow = Better or Equal to the National Average
Red = Worse than National Average
Gray = Non-Risk Adjusted Value (for Reference only)

***Comparison reporting period 04/01/19 through 03/31/20**

PCI In-Hospital Mortality Rate[1]

Risk Adjusted[InColor] (All patients)



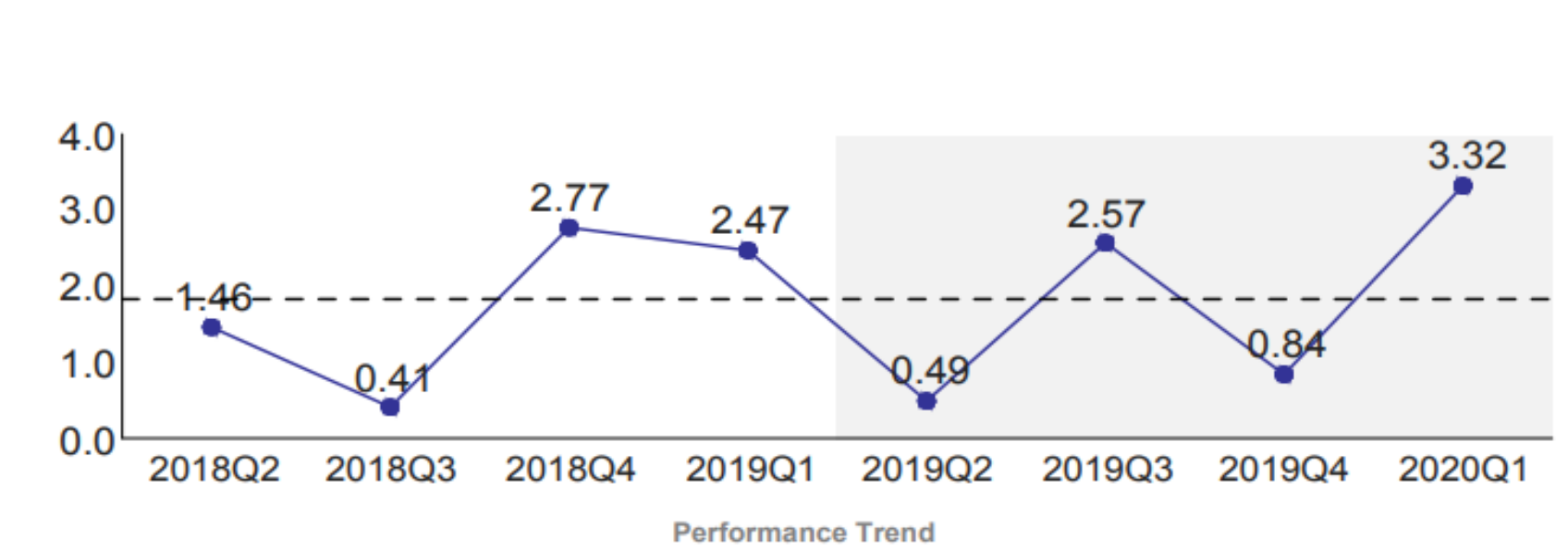
R4Q O/E = 1.03

[1] PCI in-hospital mortality rate for all patients, risk adjusted. Exclusions include patients with a discharge location of "other acute care hospital." (ref: 4739)

***Comparison reporting period is 04/01/19 through 03/31/20**

PCI In-Hospital Mortality Rate[1]
Risk Adjusted (All patients)

- TWO-YEAR TRENDING

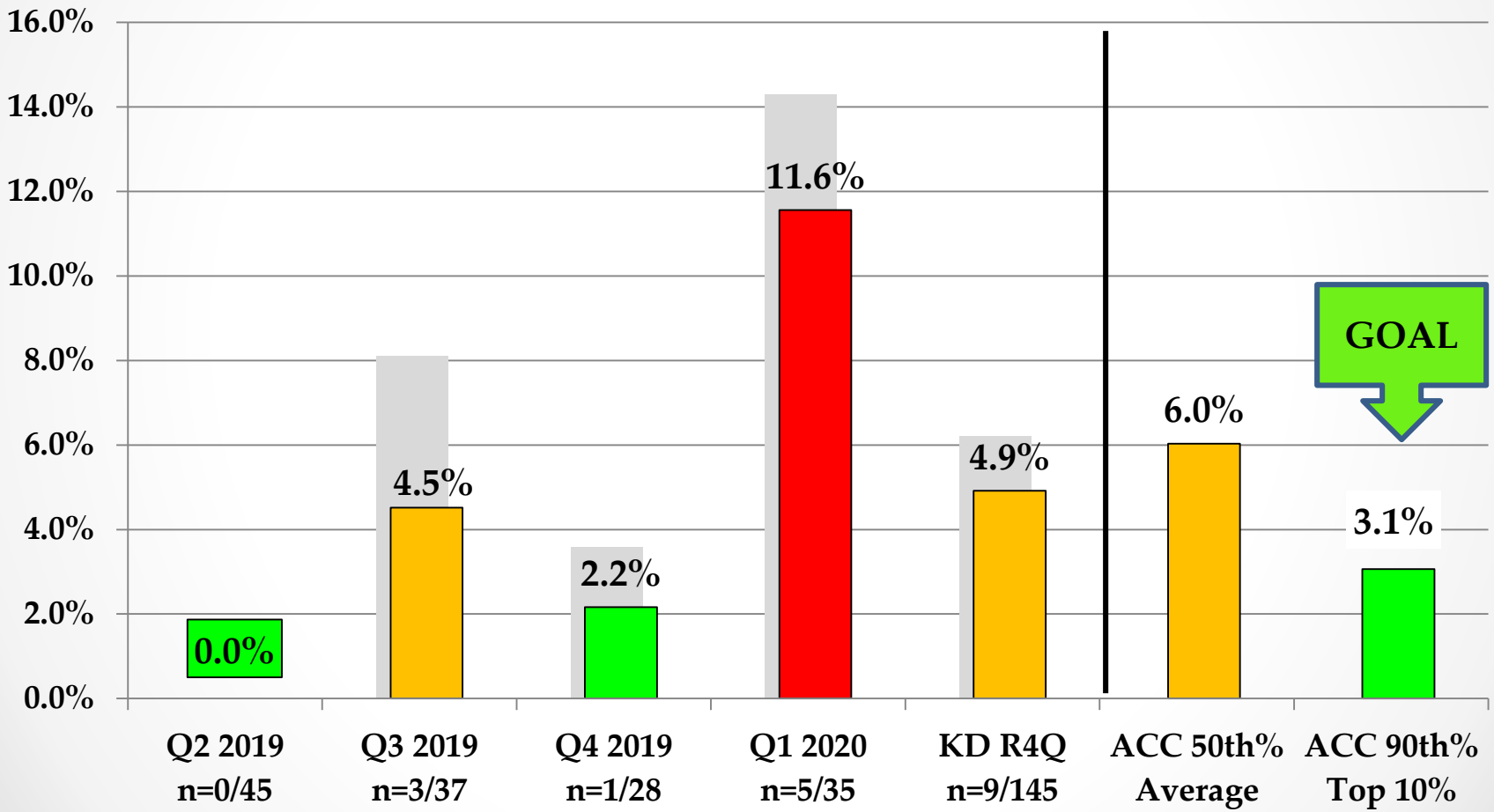


R4Q O/E = 1.03

[1] PCI in-hospital mortality rate for all patients, risk adjusted. Exclusions include patients with a discharge location of "other acute care hospital." (O/E ref: 4748)

PCI In-Hospital Mortality Rate[1]

Risk Adjusted In Color (STEMI patients)



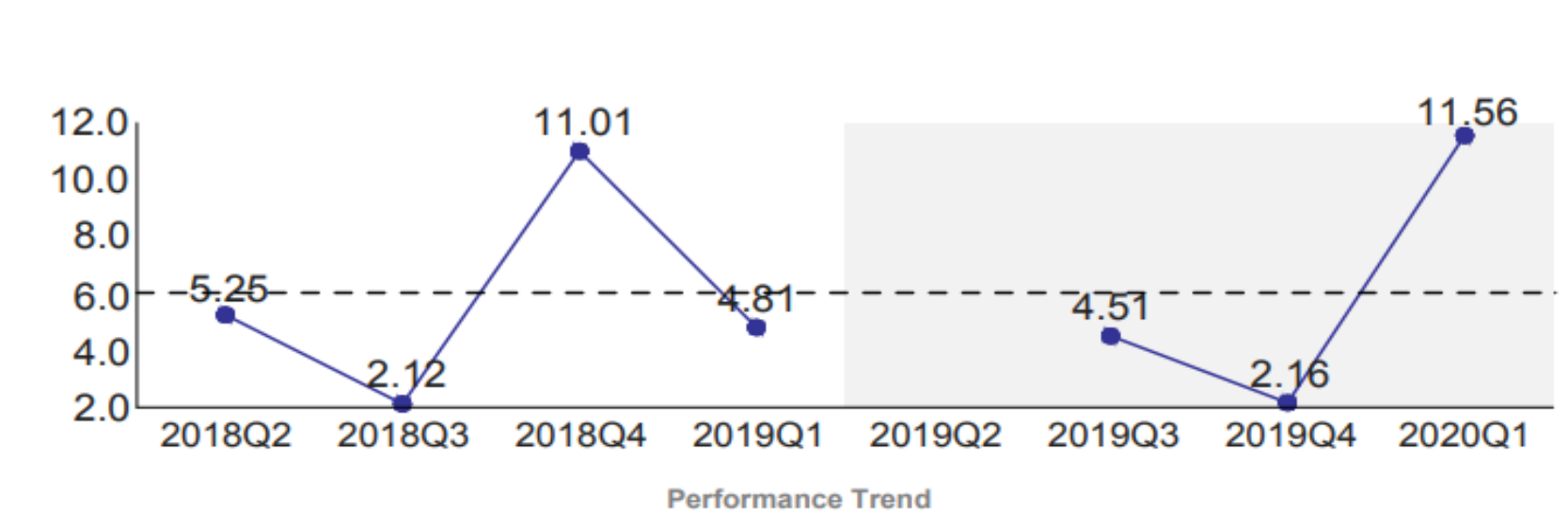
R4Q O/E = 0.78

[1] PCI in-hospital mortality rate for STEMI Pt.'s. (ref: 4740)

***Comparison reporting period 04/01/19 through 03/31/20**

PCI In-Hospital Mortality Rate[1]
Risk Adjusted (STEMI patients)

- TWO-YEAR TRENDING

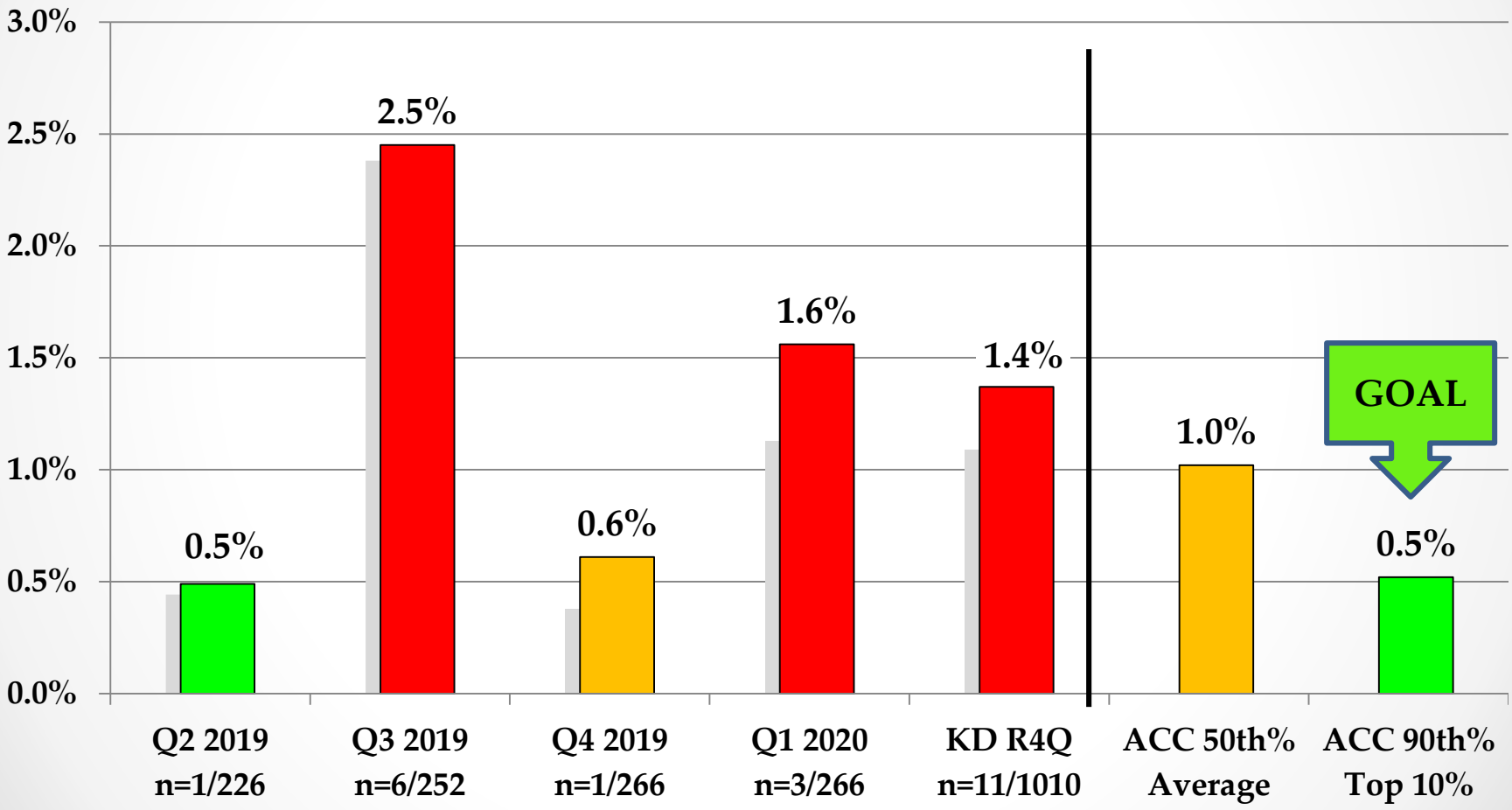


R4Q O/E = 0.78

[1] PCI in-hospital mortality rate for STEMI Pt.'s. (O/E ref: 4749)

PCI In-Hospital Mortality Rate[1]

Risk Adjusted[InColor] (NSTEMI, unstable angina, electives)



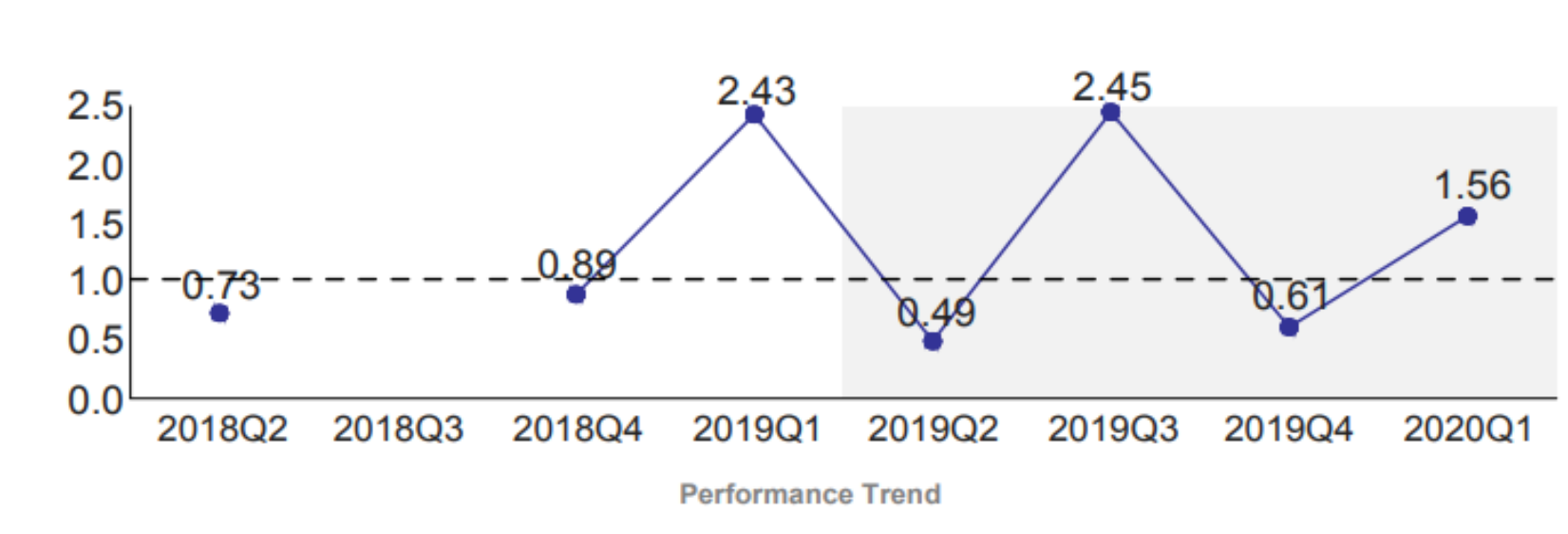
R4Q O/E = 1.39

[1] PCI in-hospital mortality rate for all patients Excluding STEMI. Exclusions include patients with a discharge location of "other acute care hospital." (ref: 4741)

***Comparison reporting period is 04/01/19 through 03/31/20**

PCI In-Hospital Mortality Rate[1]
Risk Adjusted (NSTEMI, unstable angina, electives)

- TWO-YEAR TRENDING



R4Q O/E = 1.39

[1] PCI in-hospital mortality rate for all patients Excluding STEMI. Exclusions include patients with a discharge location of "other acute care hospital." (O/E ref: 4750)

STEMI Triage Guidelines
Thoughtful Pause

- Should go to CVICU First, not the Cath Lab
  - Cardiac Arrest with CPR ≥ 20 minutes and un/minimally responsive
  - Cardiogenic Shock, age ≥ 80
  - STEMI ≥ 24 hours without Chest Pain
  - Excess risk of bleeding (e.g. active internal bleed, ICH<3 mos, Hct<22, PLT<30K)
  - Altered Mental Status
  - Apparent sepsis or other conditions (other than pure cardiogenic shock) that would markedly increase the risk of dying within 30 days
  - Pre-existing DNR / No Code Status

❖ Consider lytic agents for symptoms < 3 hours, anticipated DTB time > 120 minutes and low risk of bleeding

❖ These are intended as guidelines, not to supersede clinical judgement

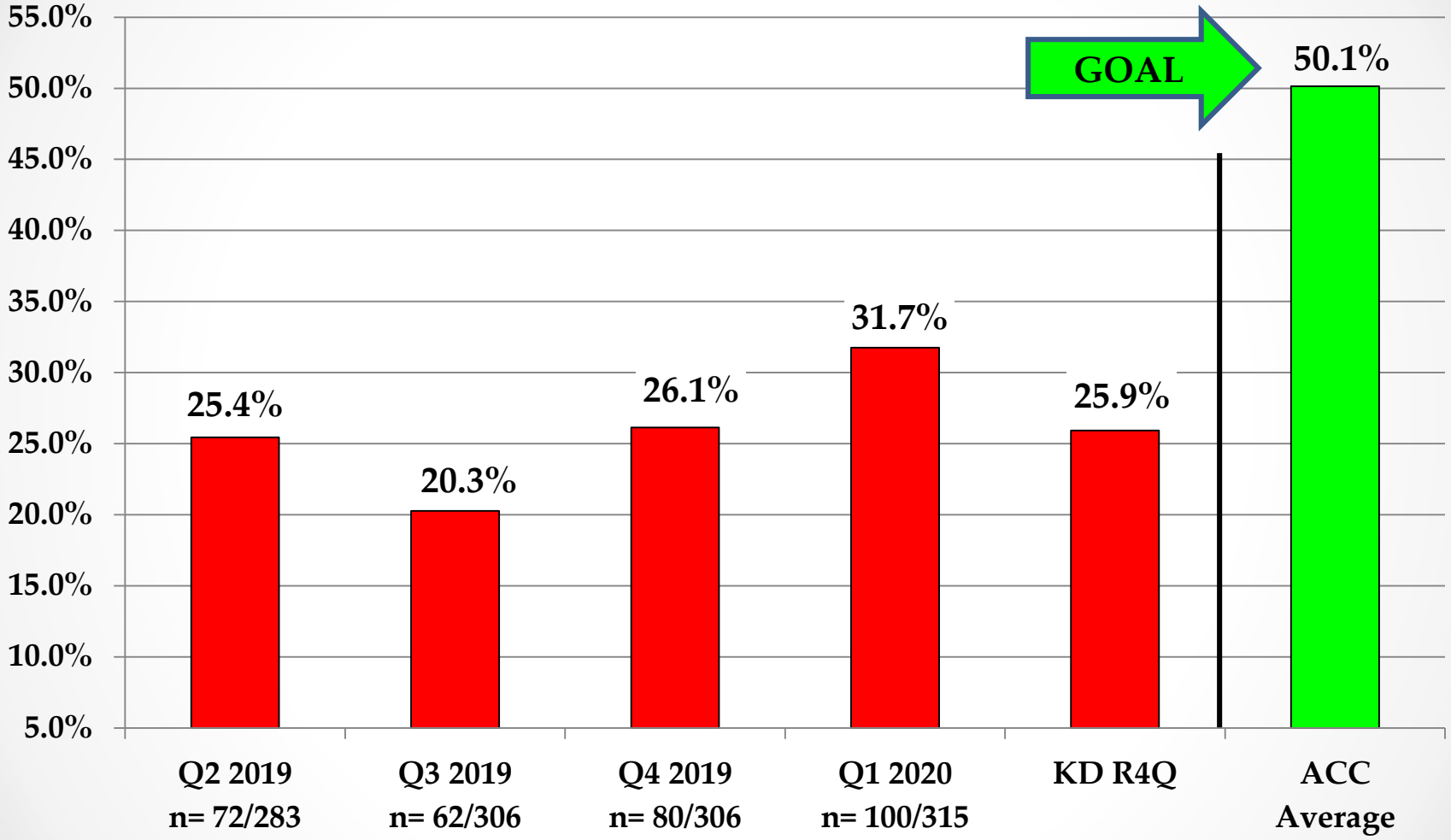
Adopted from The Cleveland Clinic Heart Institute: Triage Guidelines for STEMI patients.

Predicted Mortality Risk Factors

- STEMI
- Age >70
- BMI
- Cerebral Vasc. Disease
- Peripheral Vasc. Disease
- Chronic Lung Disease
- Previous PCI
- NIDDM
- IDDM
- GFR
- Renal Failure / Dialysis
- Ejection Fraction
- Cardiogenic Shock
- NYHA Class I/II/III
- NYHA Class IV
- Cardiac Arrest
- Thrombosis w/in 1 month
- PCI of Prox LAD
- PCI of LM
- >=2VD
- Total Chronic Occlusion

*Risk Factors taken from the American College of Cardiology inclusion list for their Risk Model for Predicted Mortality: version 4.4

PCI Radial Artery Access

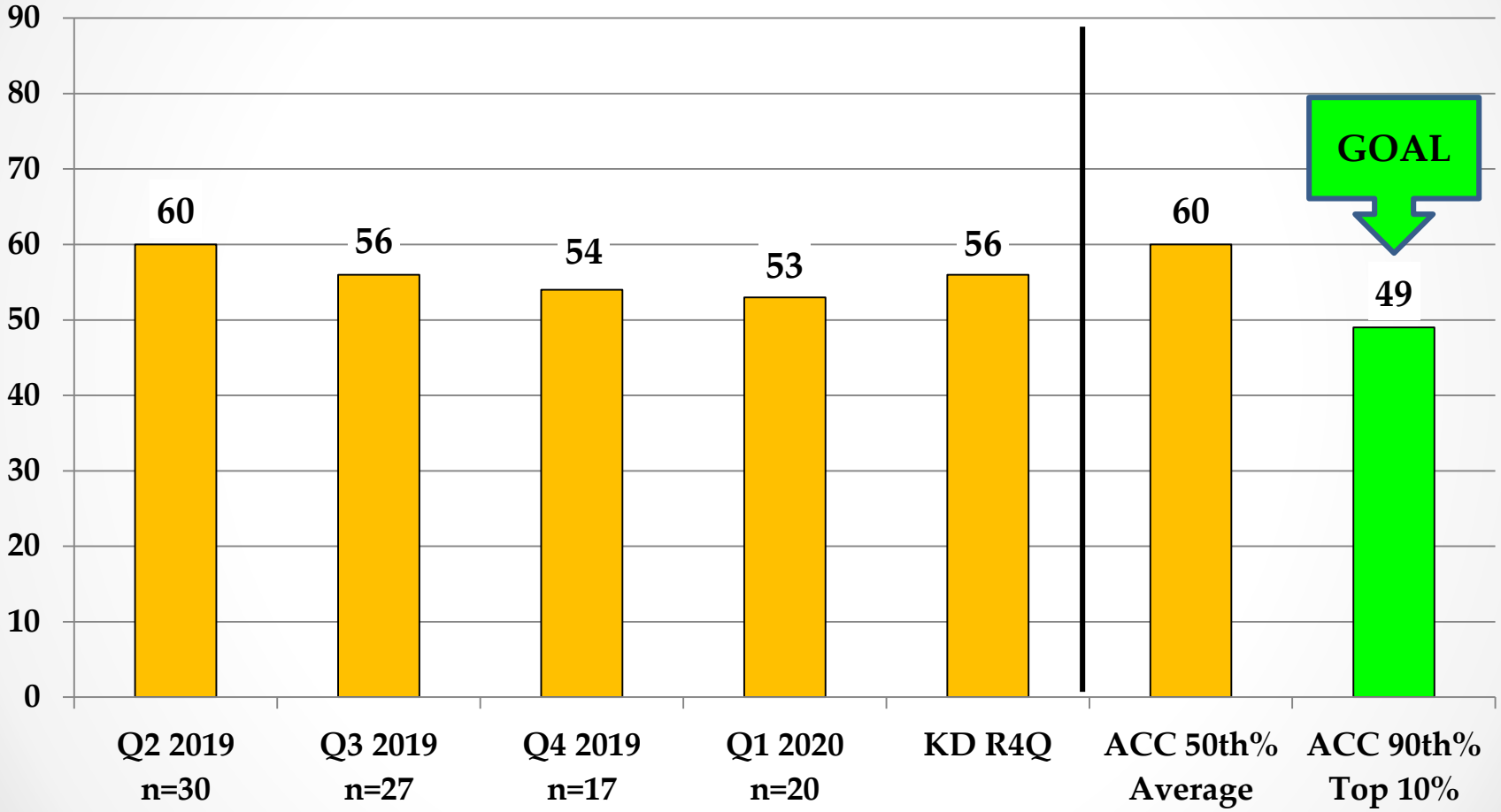


R4Q O/E = 0.5

PCI Procedures - Arterial Access Site equaling "Radial", no exclusions (ref: 4163)

***Comparison (ACC Average) reporting period is 04/01/19 through 03/31/20**

Immediate PCI for STEMI
(in minutes)[1]

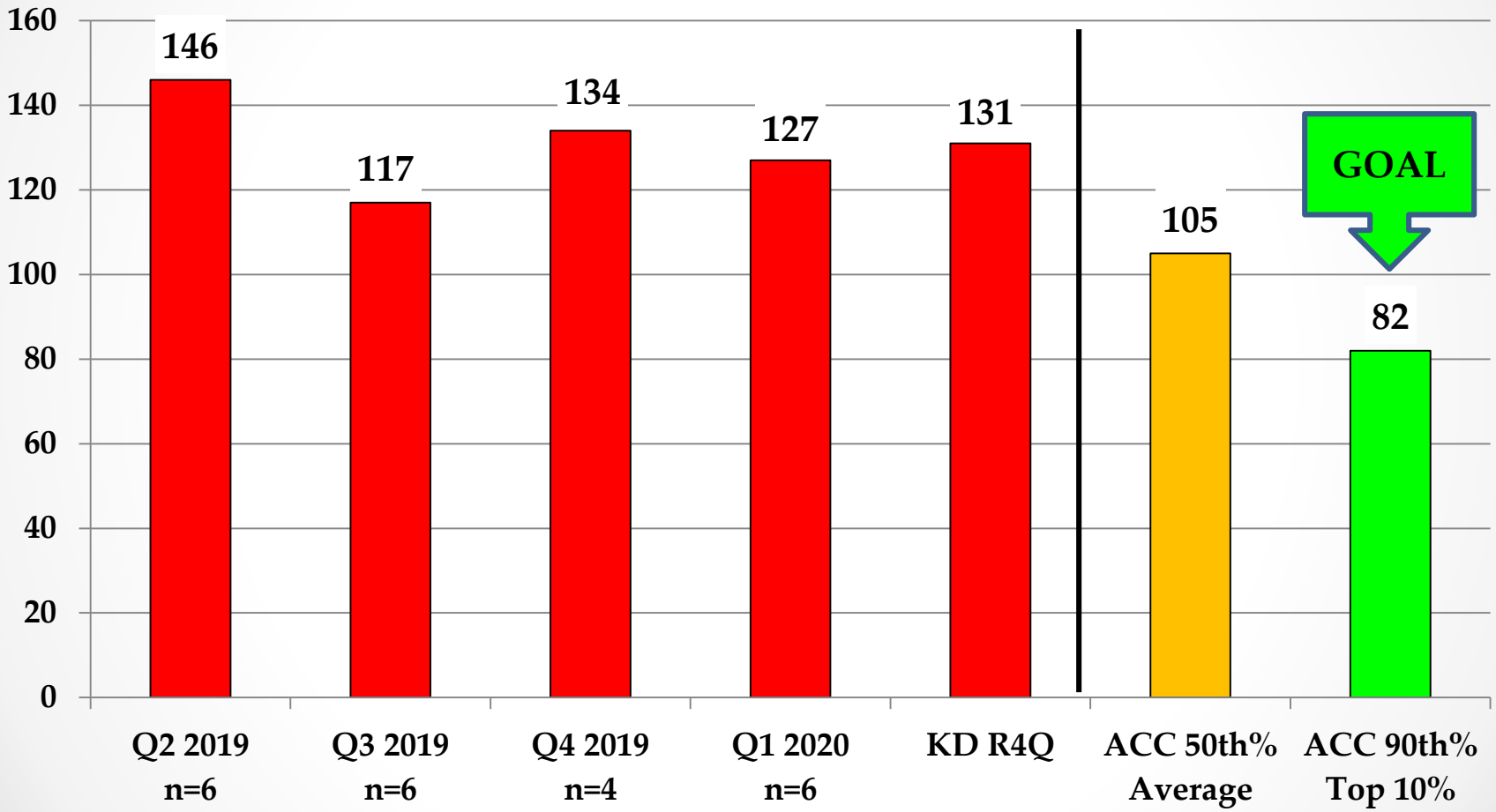


R4Q O/E = 0.9

[1] Median time frame from hospital arrival to immediate PCI for STEMI pts in minutes. Exclusions: Patients transferred in from another acute care facility; Reasons for delay does not equal none. (ref:4448)

***Comparison reporting period is 04/01/19 through 03/31/20**

Immediate PCI for STEMI Transfers
(in minutes)[1]



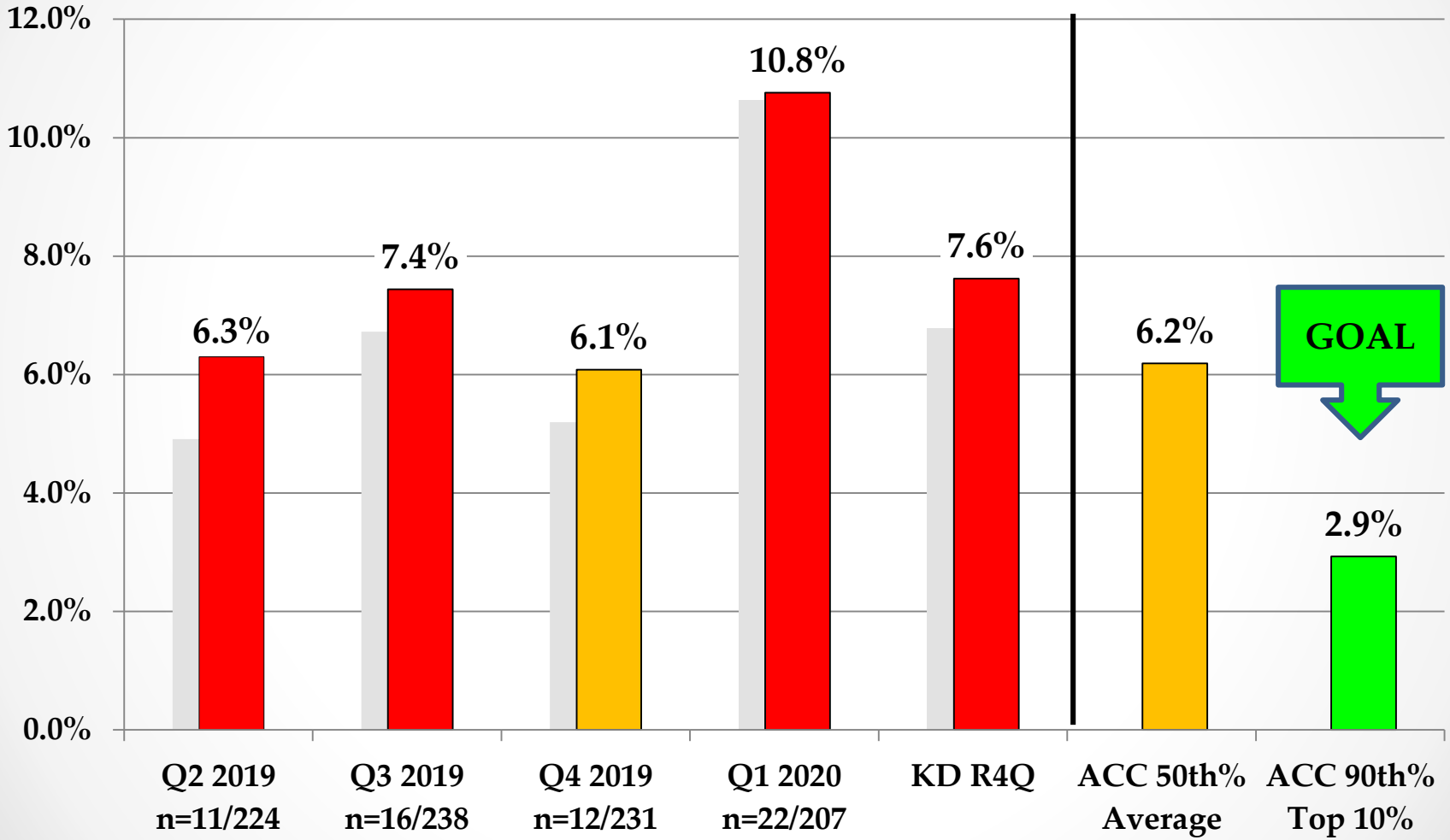
R4Q O/E = 1.2

[1] Median time from ED arrival at STEMI transferring facility to immediate PCI at STEMI receiving facility among transferred patients (excluding reason for delays); Reasons for delay does not equal none. (ref:4452)

***Comparison reporting period is 04/01/19 through 03/31/20**

Acute Kidney Injury[1] Post PCI

Risk Adjusted InColor



R4Q O/E = 1.11

[1] Proportion of pt's with a rise of serum creatinine of > 50% or ≥0.3 mg/dL over the pre-procedure baseline; all pt's w/ New Requirement for Dialysis. Exclusions: pt's on dialysis pre-procedure; pt's second PCI within this episode of care; same day discharges. (ref: 4882: O/E ref: 4881) ***Comparison reporting period is 04/01/19 through 03/31/20**

Quality Initiative:

Contrast Induced Nephropathy

Renal impairment = estimated glomerular filtration rate ≤ 60mL/min

Pre-arrival:

- Oral hydration is encouraged the day before the procedure. Patients are instructed to drink clear liquids up to 2 hours prior to arrival

Pre-procedure:

- Intravenous hydration to be started upon admission and continued post-cath. IV fluids at 250 ml/hour

Intra-procedure:

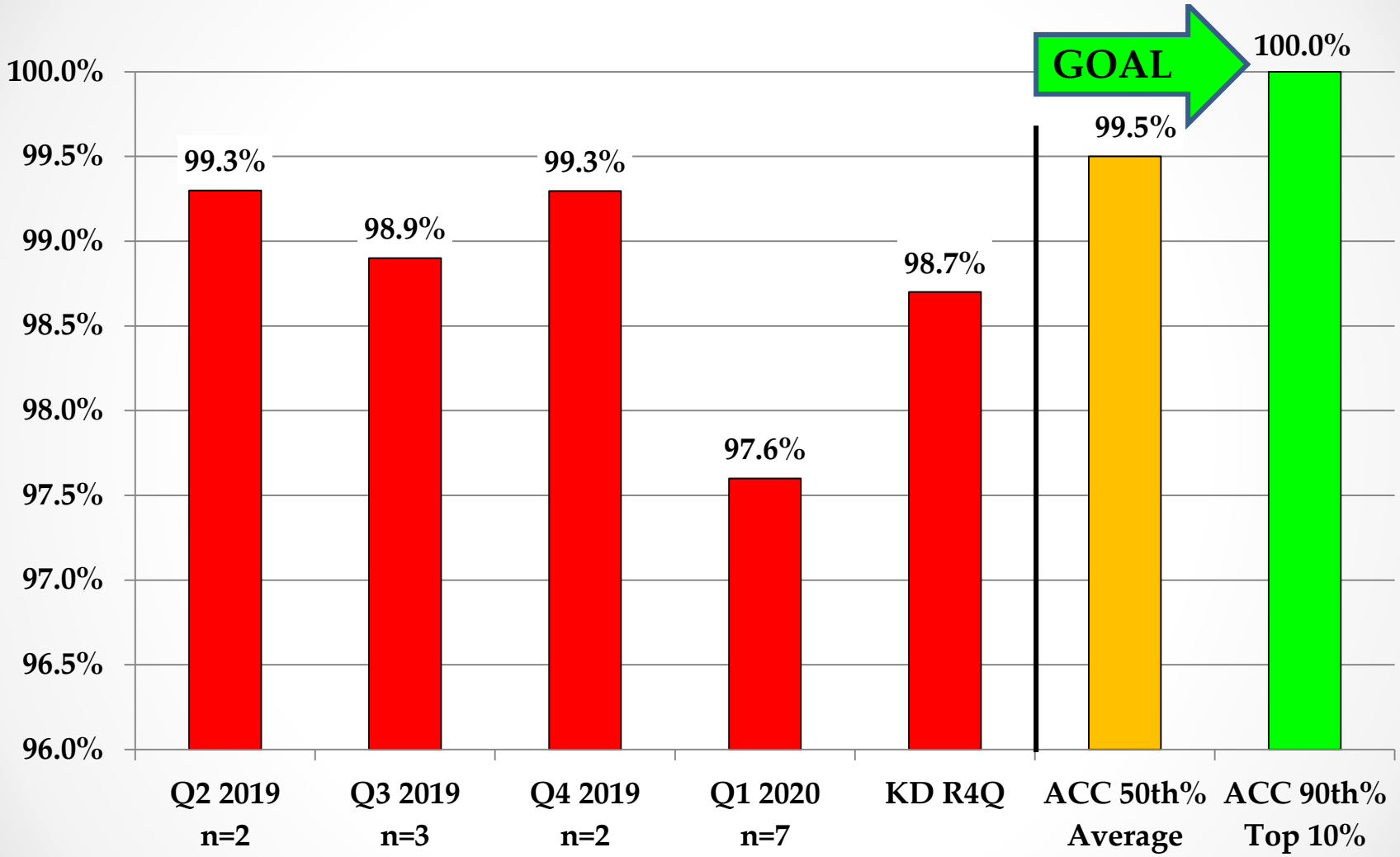
- LVEDP < 18 NS 500/hr for 4 hours
- LVEDP > 19 NS 250 ml/hr for 4 hours

- Post procedure labs must be ordered.
- Continue to track and record contrast utilization for diagnostic and interventional procedure.
- Fluids orders are pre-checked on orders (completed 8/2020)

<u>Next Steps/Recommendations/Outcomes</u>:

- Continue to monitor cardiologist without completed orders.
- ISS physician support to follow up with cardiologist.

ASA Prescribed at DC[1]

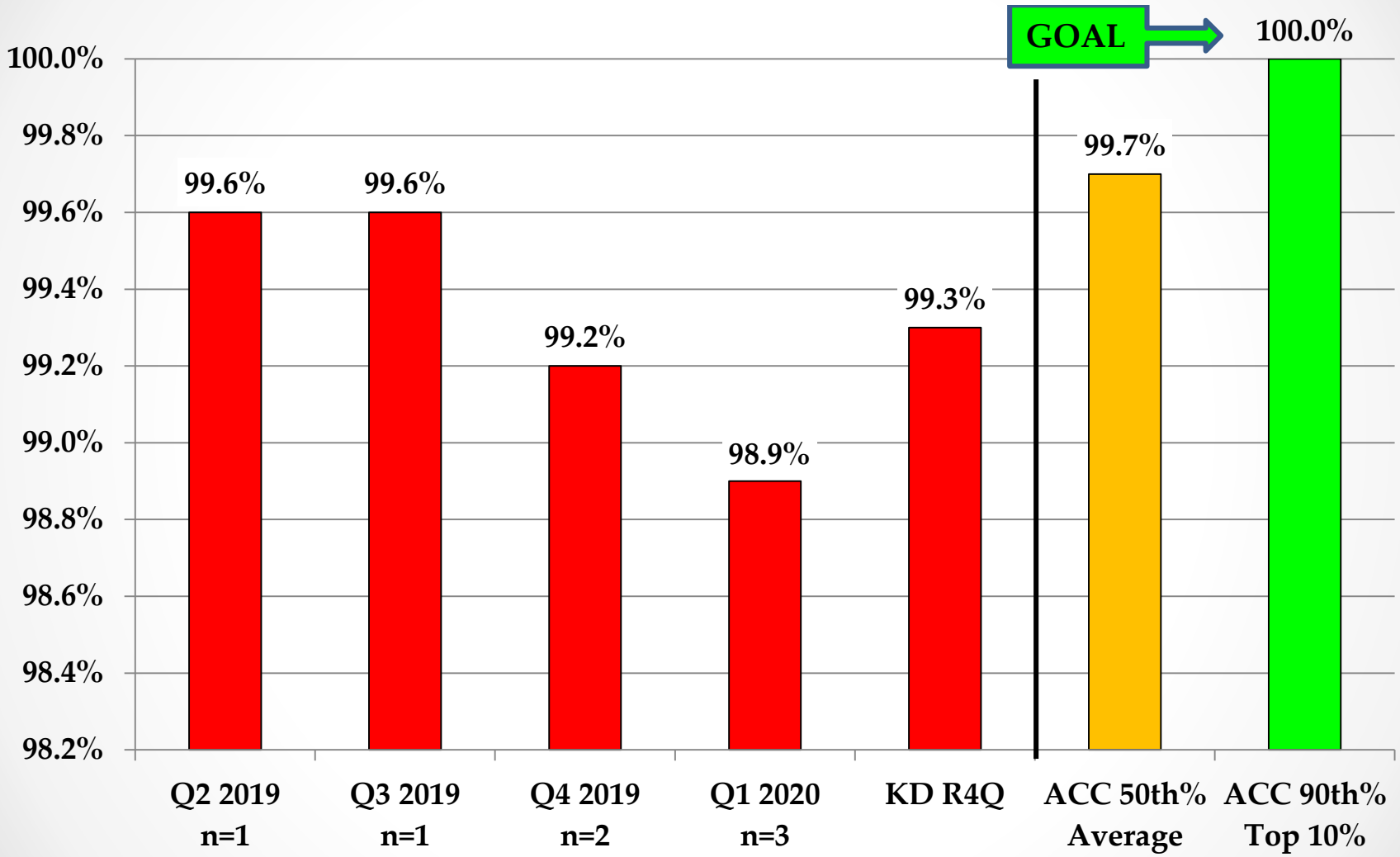


R4Q O/E = 1.0

[1] Proportion of pt.'s (without a documented contraindication) with a PCI attempted or performed that were prescribed aspirin at discharge. Exclusions: pt.'s that were discharged on Comfort Measures only; discharged to "Other acute care hospital", "Hospice", "Left against medical advice (AMA)" or deaths. (ref: 4702)

***Comparison reporting period is 04/01/19 through 03/31/20**

P2Y12 Inhibitor Prescribed at DC[1]

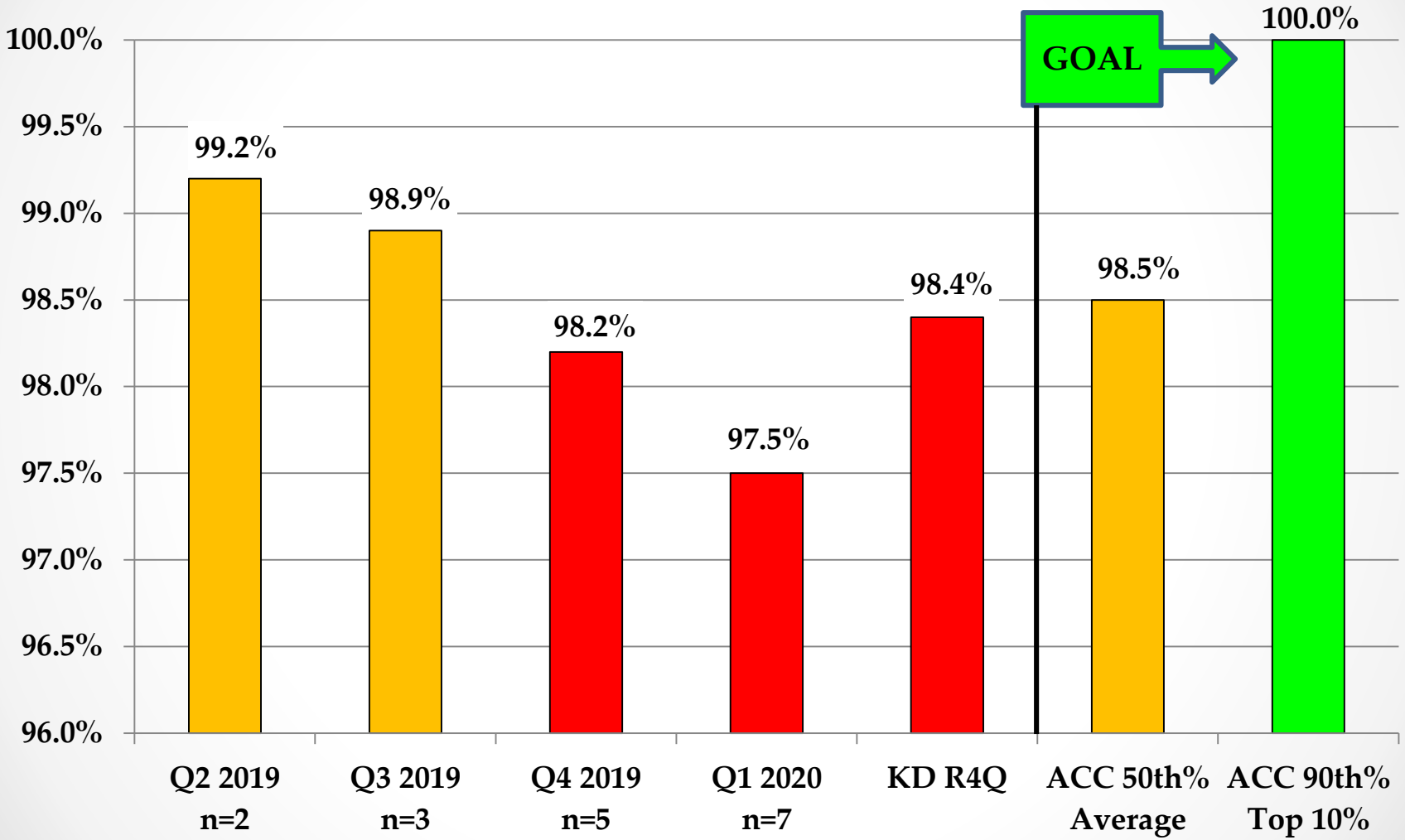


R4Q O/E = 1.0

[1] Proportion of pt.'s (without a documented contraindication) with a cardiac stent placed that were prescribed a thienopyridine/P2Y12 inhibitor at discharge. Exclusions: pt.'s that were discharged on Comfort Measures only; discharged to "Other acute care hospital", "Hospice", "Left against medical advice (AMA)" or deaths (ref: 4711)

***Comparison reporting period is 04/01/19 through 03/31/20**

Statins Prescribed at DC[1]



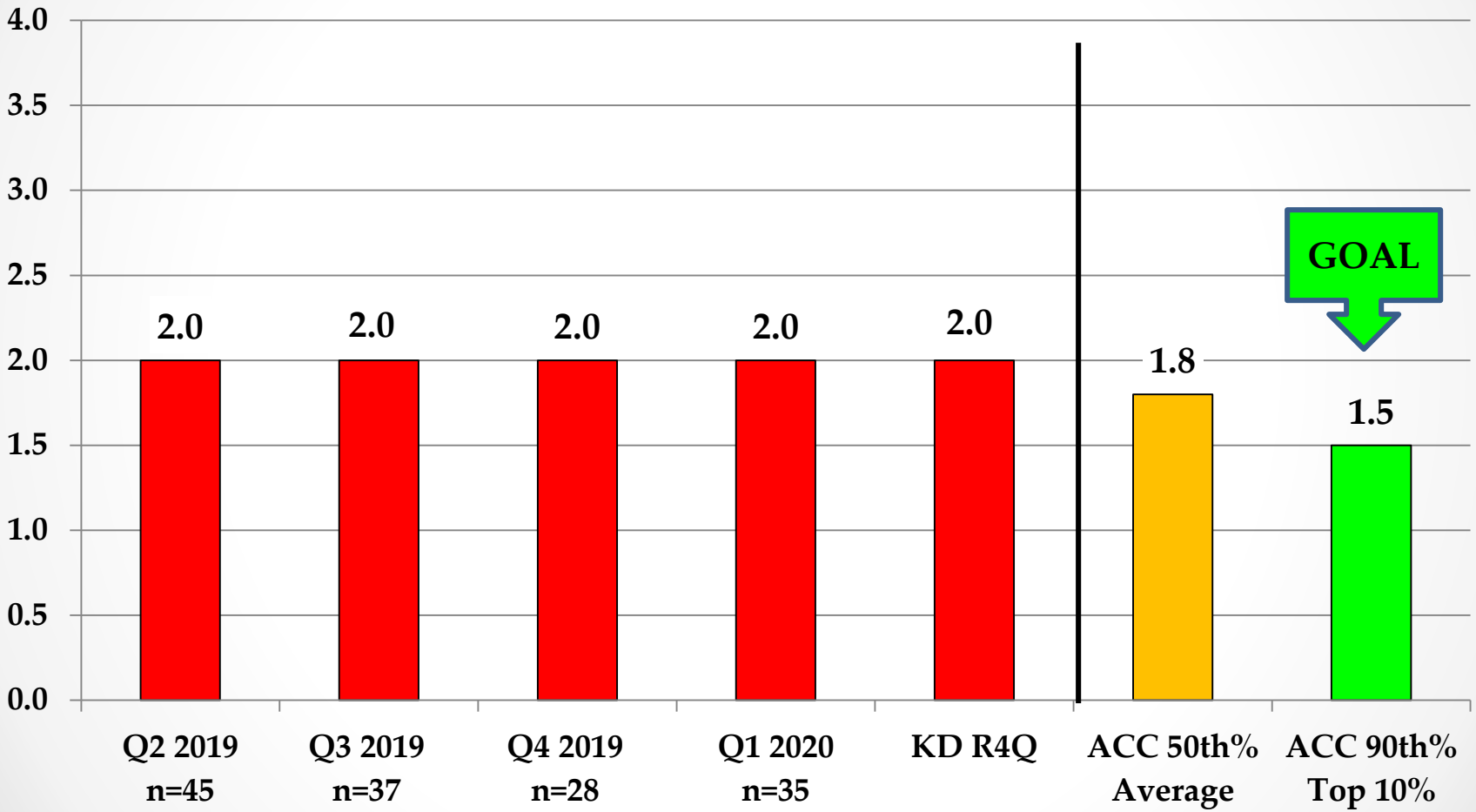
R4Q O/E = 1.0

[1] Proportion of pt.'s (without a documented contraindication) with a PCI attempted or performed that were prescribed a statin at discharge. Exclusions: pt.'s that were discharged on Comfort Measures only; discharged to "Other acute care hospital", "Hospice", "Left against medical advice (AMA)" or deaths. (ref: 4707) ***Comparison reporting period is 04/01/19 through 03/31/20**

Quality Initiative:
Discharge Medications

- Develop and implement PCI specific discharge order set
- Re-educate Hospitalists and Nurse Practitioners on importance of specific discharge medications in this patient population and utilization of new Order Set.
- Track utilization of order set
- Contact Lead Hospitalist or Nurse Practitioner with all fallouts and track
- Improving Clinical documentation in the Discharge Summary of any contraindications
- Improving Clinical documentation in the Discharge Summary clarifying any pending diagnosis (i.e. possible NSTEMI, possible MI)

Post-PCI Length of Stay[1] – STEMI

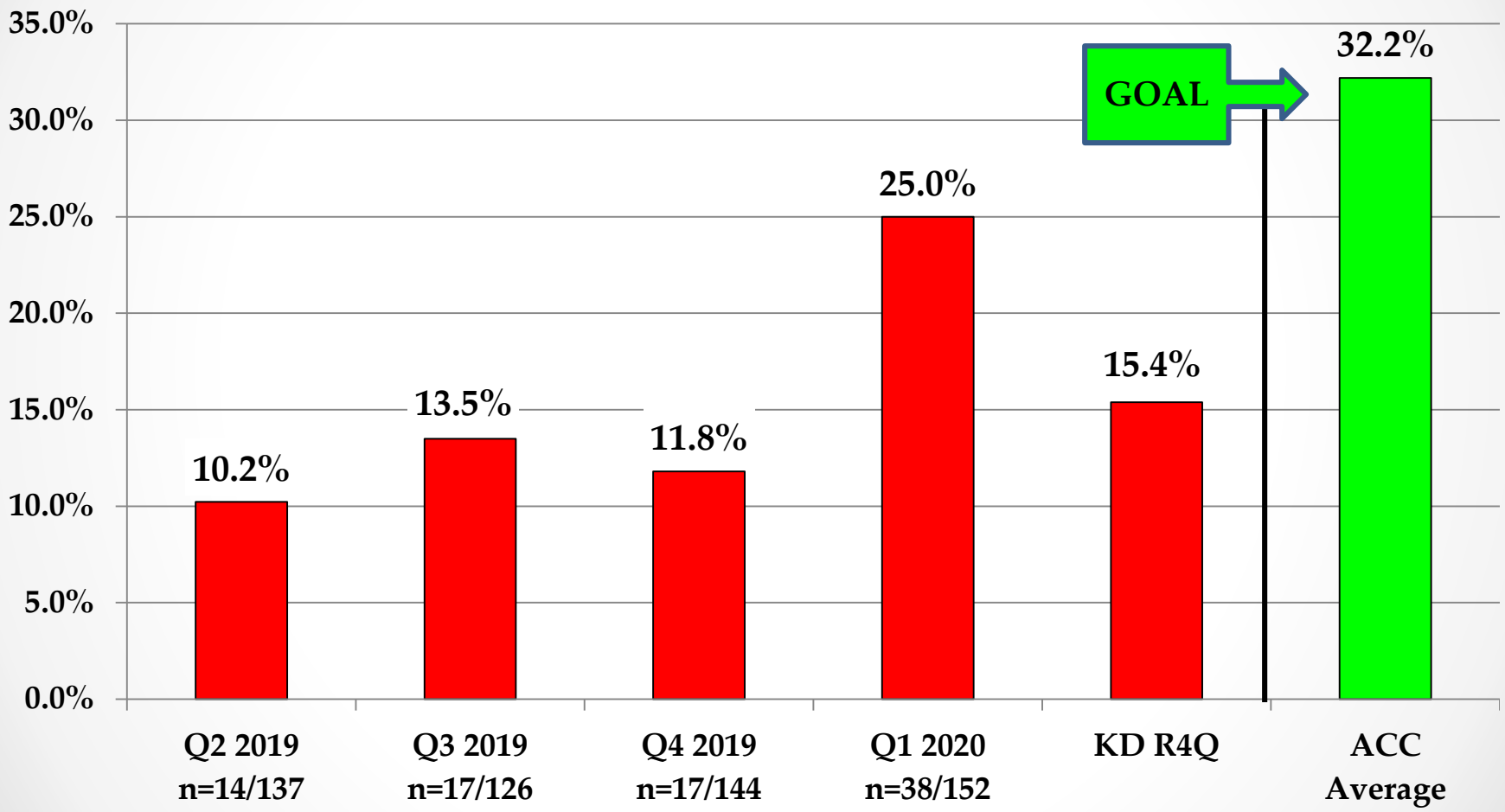


R4Q O/E = 1.1

[1] Median Post-procedure length of stay in STEMI patients. Exclusions: pt.'s discharged to Another Acute Care Facility; pt.'s who die during procedure (ref:4340)

***Comparison reporting period is 04/01/19 through 03/31/20**

Post-PCI Same Day Discharge - Electives



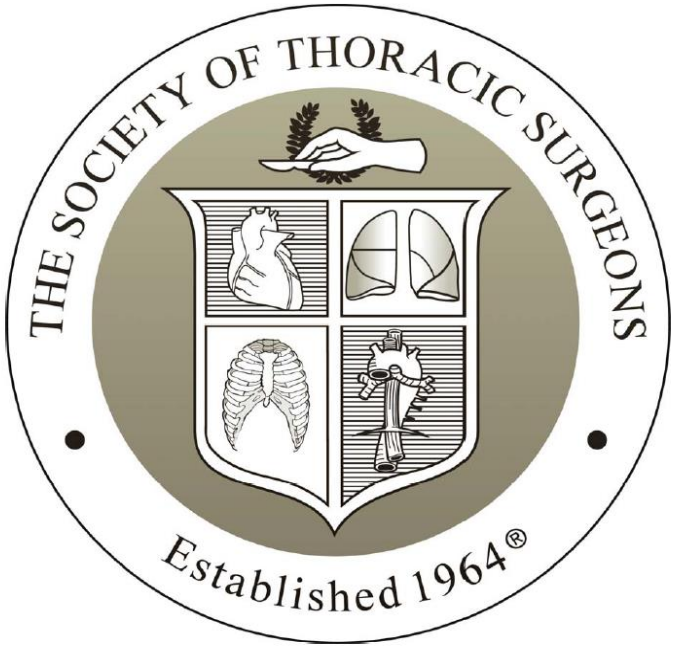
R4Q O/E = 0.5

[1] Patients discharged on the same day as procedure. Exclusions: mortalities and pt.'s discharged to Another Acute Care Facility or AMA (ref:4971)

***Comparison reporting period is 04/01/19 through 03/31/20**

Cardiac Surgery Data

2019 Q1-Q3



Duke Clinical Research Institute
DUKE UNIVERSITY MEDICAL CENTER

DATA ANALYSES BY THE SOCIETY OF THORACIC SURGEONS
NATIONAL ADULT CARDIAC SURGERY DATABASE

***Comparison STS reporting period 01/01/2019 through 9/30/2019**

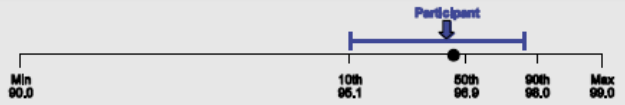
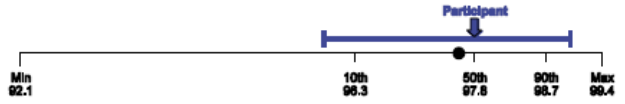
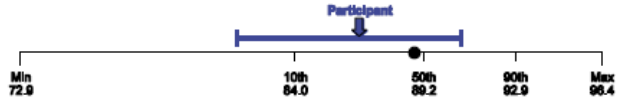
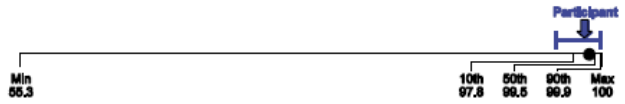
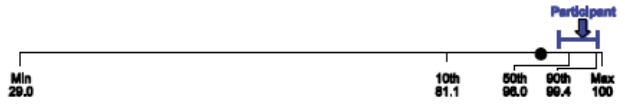
Star Ratings 2018

Isolated CABG - (3 stars possible)

STS CABG Composite Quality Rating

Participant 30045
STS Period Ending 12/31/2018

Duke Clinical Research Institute

Quality Domain	Participant Score (98% CI)	STS Mean Participant Score	Participant Rating[1]	Distribution of Participant Scores • = STS Mean
Jan 2018 - Dec 2018 Overall	96.6% (95.1 , 97.8)	96.7%	★★	
Jan 2018 - Dec 2018 Absence of Mortality	97.8% (95.9 , 99.0)	97.6%	★★	
Jan 2018 - Dec 2018 Absence of Morbidity[2]	86.6% (81.6 , 90.7)	88.8%	★★	
Jan 2018 - Dec 2018 Use of IMA[2]	98.7% (96.4 , 99.8)	99.0%	★★	
Jan 2018 - Dec 2018 Medications[2]	97.7% (94.6 , 99.4)	92.5%	★★★	

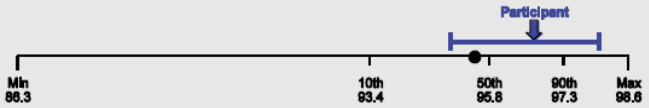
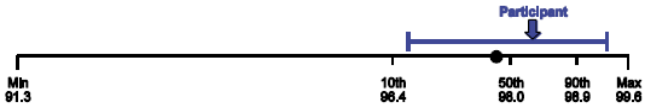
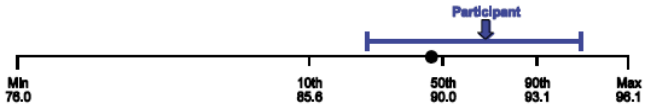
[1]* = Participant performance is significantly lower than the STS mean based on 99% Bayesian probability
* * = Participant performance is not significantly different than the STS mean based on 99% Bayesian probability
* * * = Participant performance is significantly higher than the STS mean based on 99% Bayesian probability
[2]Please refer to Report Overview - STS Composite Quality Rating and NQF-Endorsed Measures for full details

AVR

STS AVR Composite Quality Rating

Participant 30045
STS Period Ending 12/31/2018

Duke Clinical Research Institute

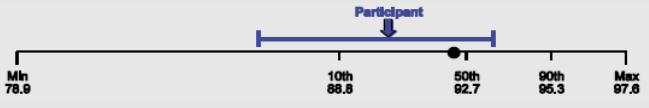
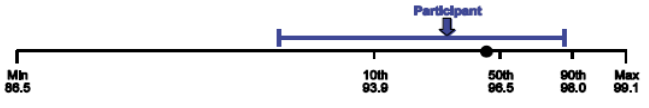
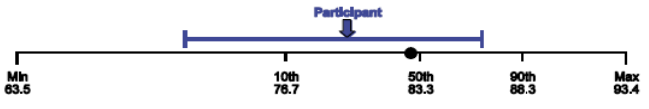
Quality Domain	Participant Score (95% CI)	STS Mean Participant Score	Participant Rating[1]	Distribution of Participant Scores • = STS Mean
Jan 2016 - Dec 2018 Overall	96.7% (95.0 , 98.0)	95.5%	★★	
Jan 2016 - Dec 2018 Absence of Mortality	98.3% (96.6 , 99.3)	97.8%	★★	
Jan 2016 - Dec 2018 Absence of Morbidity[2]	91.4% (87.5 , 94.5)	89.6%	★★	

AVR+CAB

STS AVR + CABG Composite Quality Rating

Participant 30045
STS Period Ending 12/31/2018

Duke Clinical Research Institute

Quality Domain	Participant Score (95% CI)	STS Mean Participant Score	Participant Rating[1]	Distribution of Participant Scores • = STS Mean
Jan 2016 - Dec 2018 Overall	90.3% (86.3 , 93.5)	92.3%	★★	
Jan 2016 - Dec 2018 Absence of Mortality	95.4% (91.9 , 97.8)	96.2%	★★	
Jan 2016 - Dec 2018 Absence of Morbidity[2]	79.7% (71.7 , 86.3)	82.8%	★★	

Healthgrades

Specialty Clinical Quality Awards & Ratings

America's 50 Best Hospitals for Cardiac Surgery Award™ (2019, 2018)

Superior clinical outcomes in heart bypass surgery and heart valve surgery

America's 100 Best Hospitals for Cardiac Care Award™ (2019, 2018)

Superior clinical outcomes in heart bypass surgery, coronary interventional procedures, heart attack treatment, heart failure treatment, and heart valve surgery

Cardiac Surgery Excellence Award™ (2017)

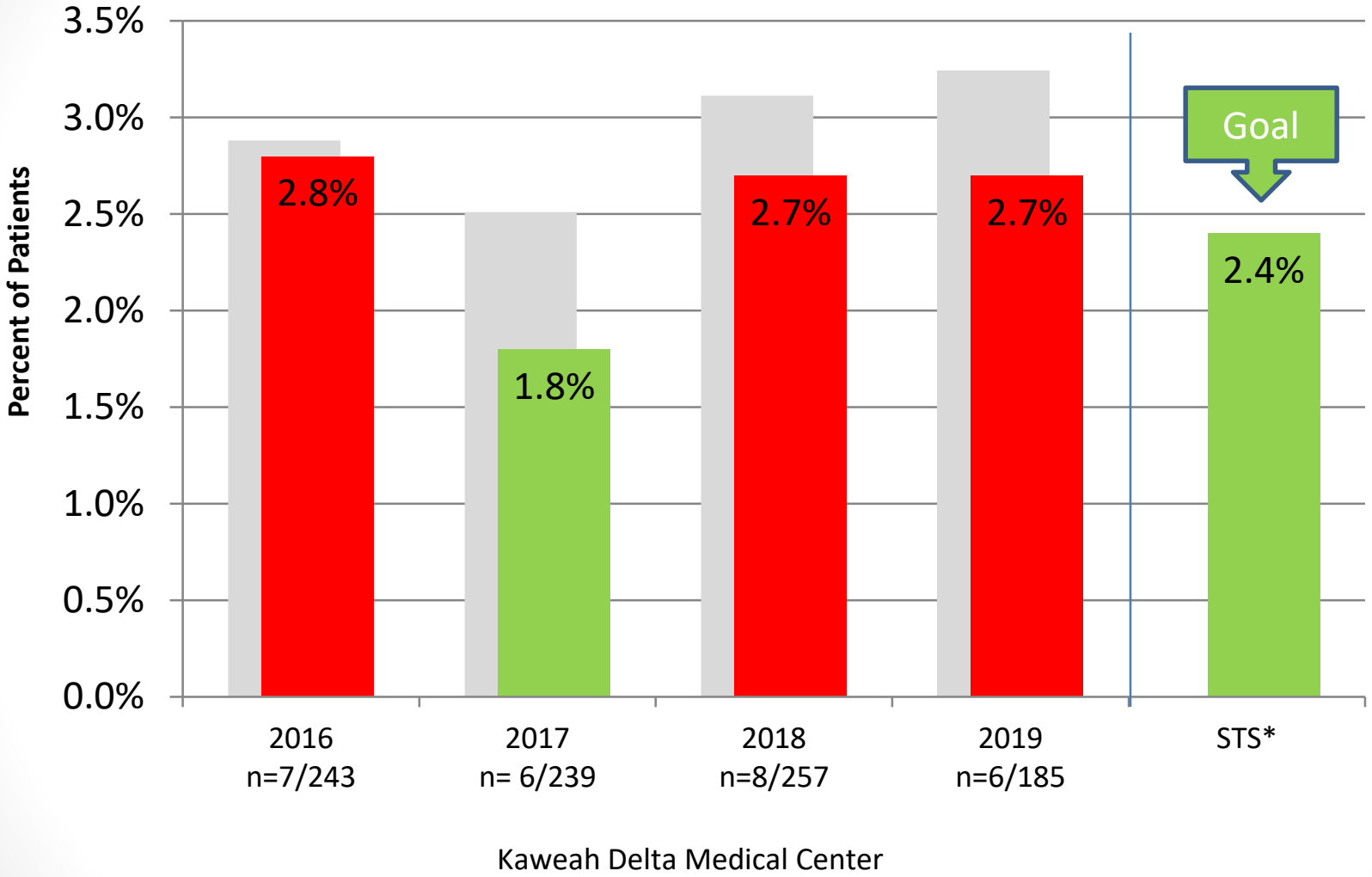
Superior clinical outcomes in heart bypass surgery and heart valve surgery

Mortality Based Ratings

Procedure/Condition	Mortality In-Hospital	Mortality within 30 days
Coronary Artery Bypass Graft (CABG) Surgery	★★★★★ Better than Expected	★★★★★ Better than Expected

All Operative Mortality[1]

Risk Adjusted in Color



Kaweah Delta Medical Center

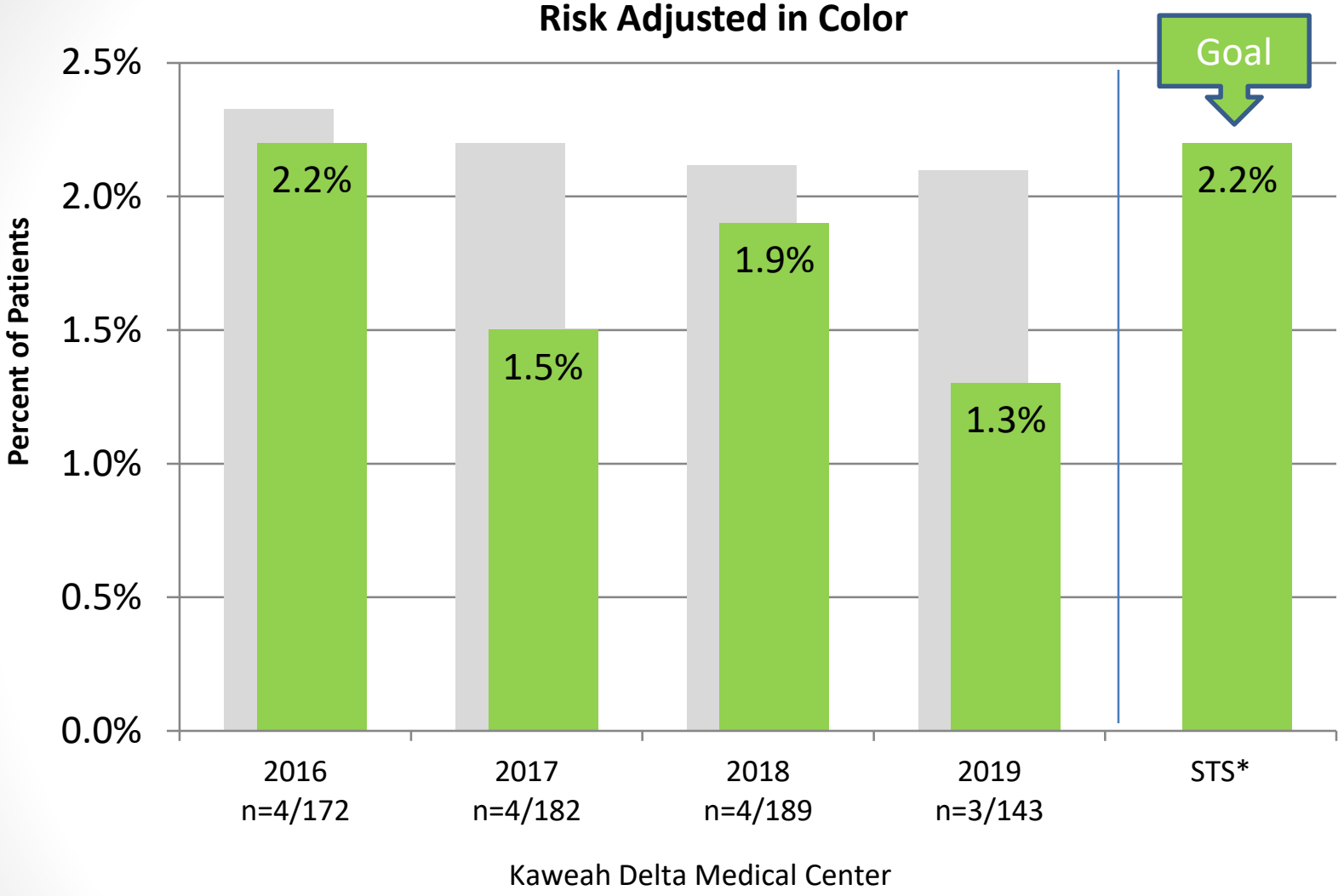
2019 Risk-Adjusted O/E = 1.1

***Comparison reporting period 1/1/2019 through 9/30/2019**

1- Includes all 7 Major Procedure Categories (CABG, AVR, AVR+CABG, MVR, MVR+CABG, MVP, MVP+CABG) Excludes Other category procedures

CABG Operative Mortality

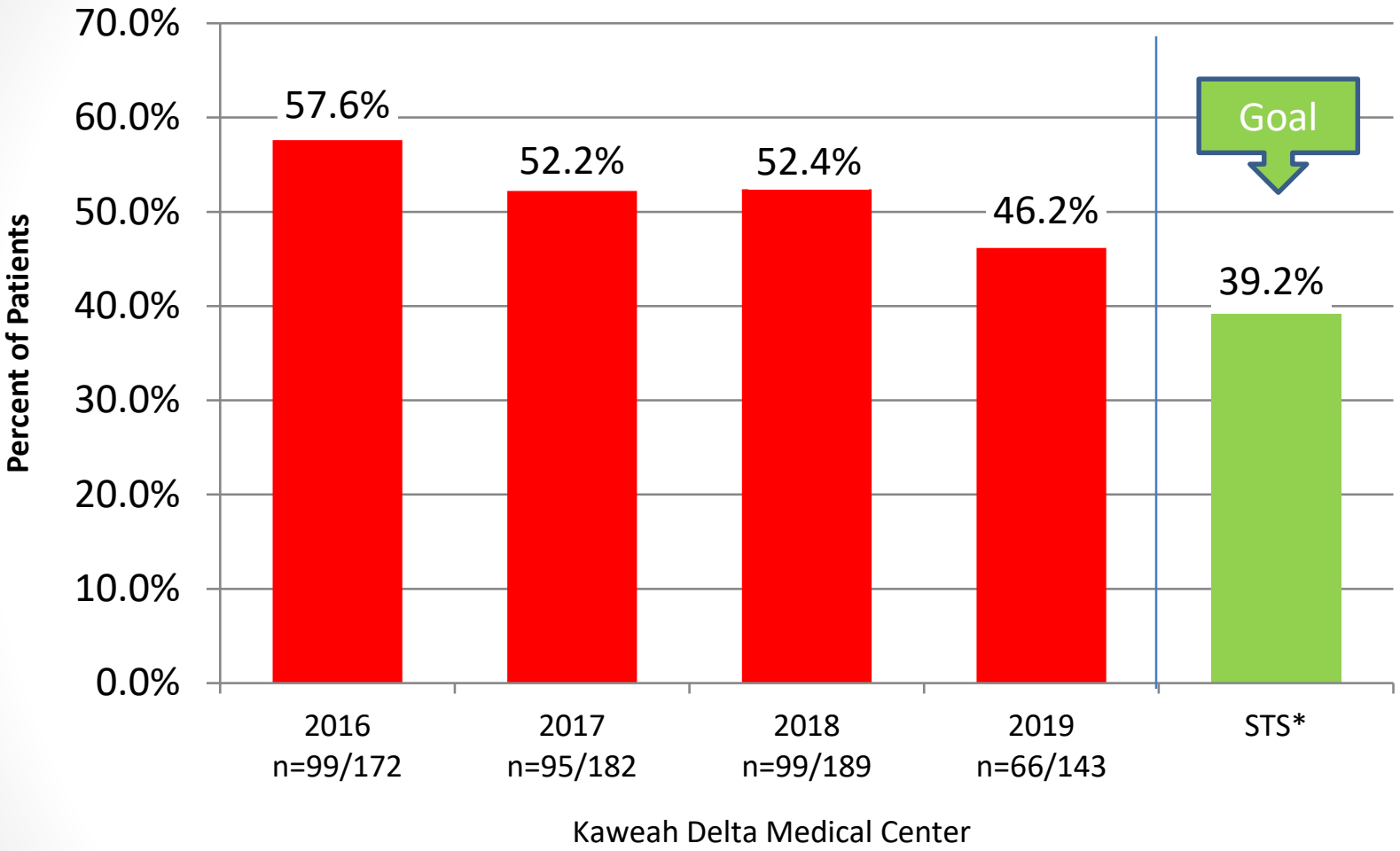
Risk Adjusted in Color



2019 Risk-Adjusted O/E = 0.7

***Comparison reporting period 1/1/2019 through 9/30/2019**

CABG Intra & Post-Op Blood Product Usage[1]



2019 O/E = 1.2

***Comparison reporting period 1/1/2019 through 9/30/2019**

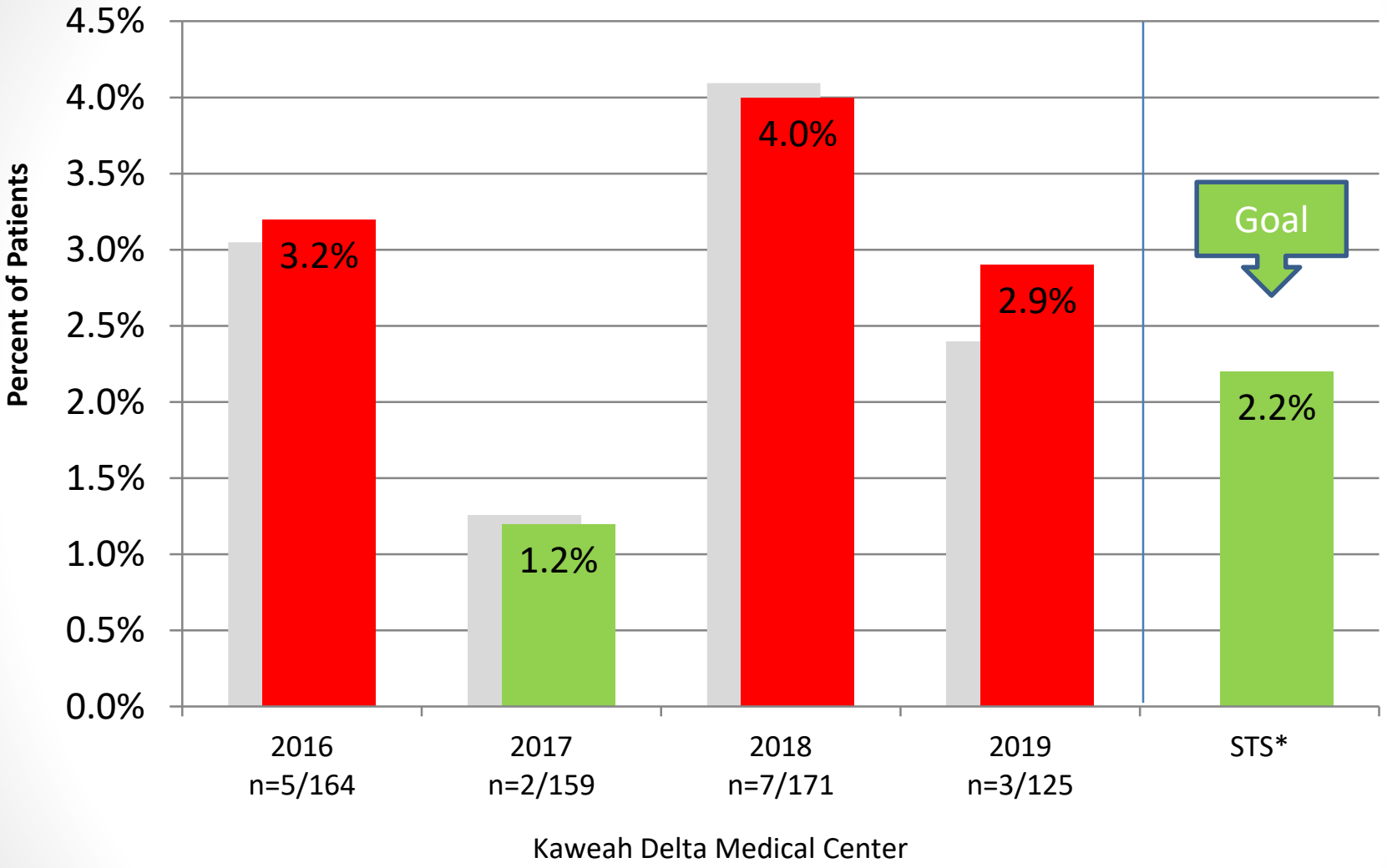
[1]Surgeries where at least one unit of blood product (RBC, Plasma, Platelet) was given Intra-and/or Post-operatively.

Quality Initiative: Bleeding, blood usage

- Quarterly review of blood usage throughout Pt. stay
- TEG coagulation monitoring
- Antifibrinolytic agents
- Heparin monitoring
- Heparin coated circuits
- Hemostasis achieved during procedure
- Cell saver utilized during surgery
- Restrictive transfusion criteria
- Surgeon approval of each transfusion
- Treatment of pre-operative anemia or transfusion as needed

CABG Post-Op Renal Failure[1]

Risk Adjusted in Color



2019 Risk Adjusted O/E = 1.3

***Comparison reporting period 1/1/2019 through 9/30/2019**

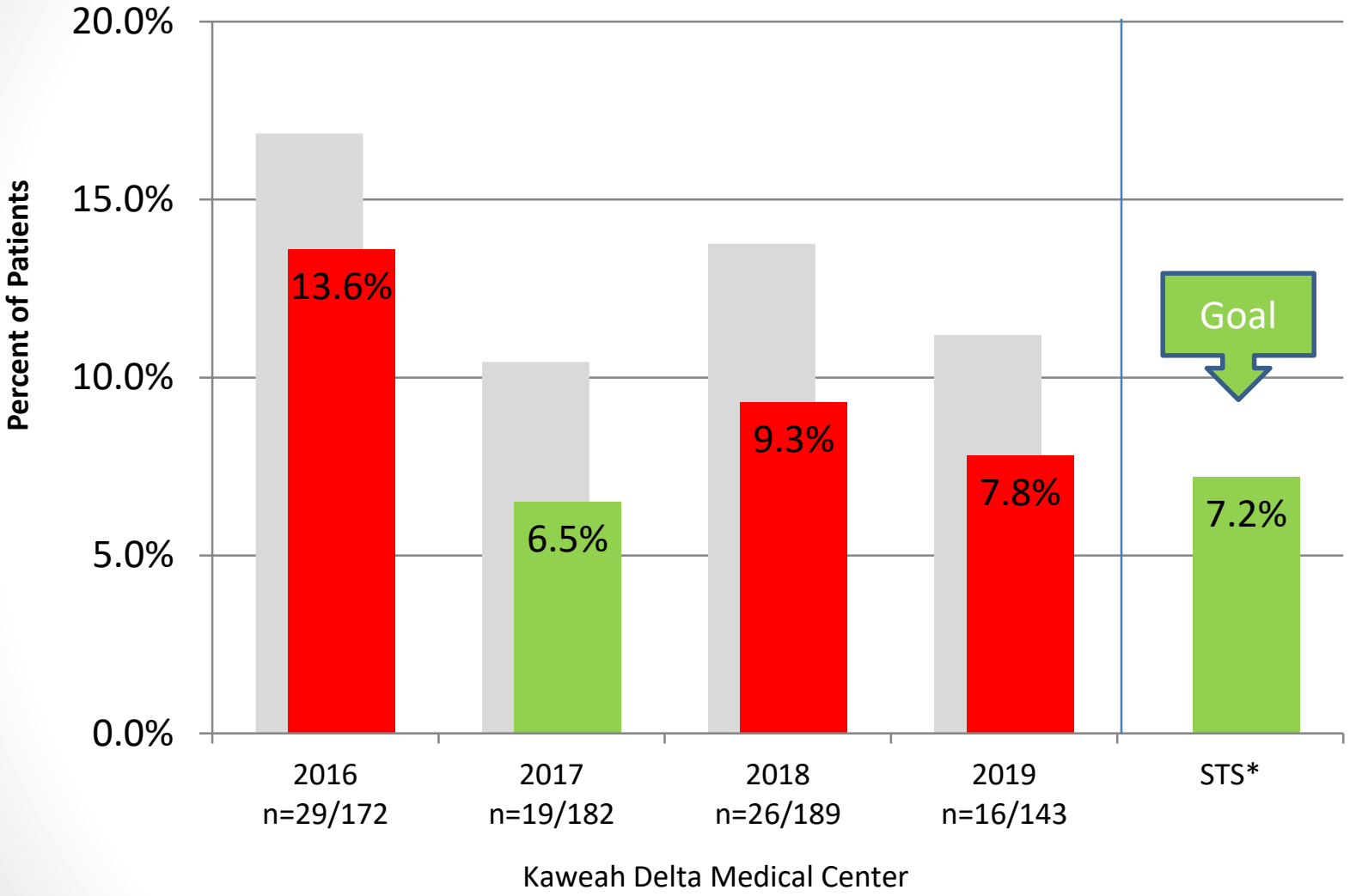
1 – Excludes patients with preoperative dialysis or preoperative Creatinine ≥ 4

Quality Initiative: Renal failure prevention

- Risk factor evaluation pre-operatively
- Timing of surgery considered
- Diabetes control
- Liberal hydration
- Intra-operative blood flow & pressure controlled by perfusion and anesthesia
- Blood pressure management peri-operatively

CABG Prolonged Ventilation

Risk Adjusted in Color



Kaweah Delta Medical Center

2019 Risk Adjusted O/E = 1.1

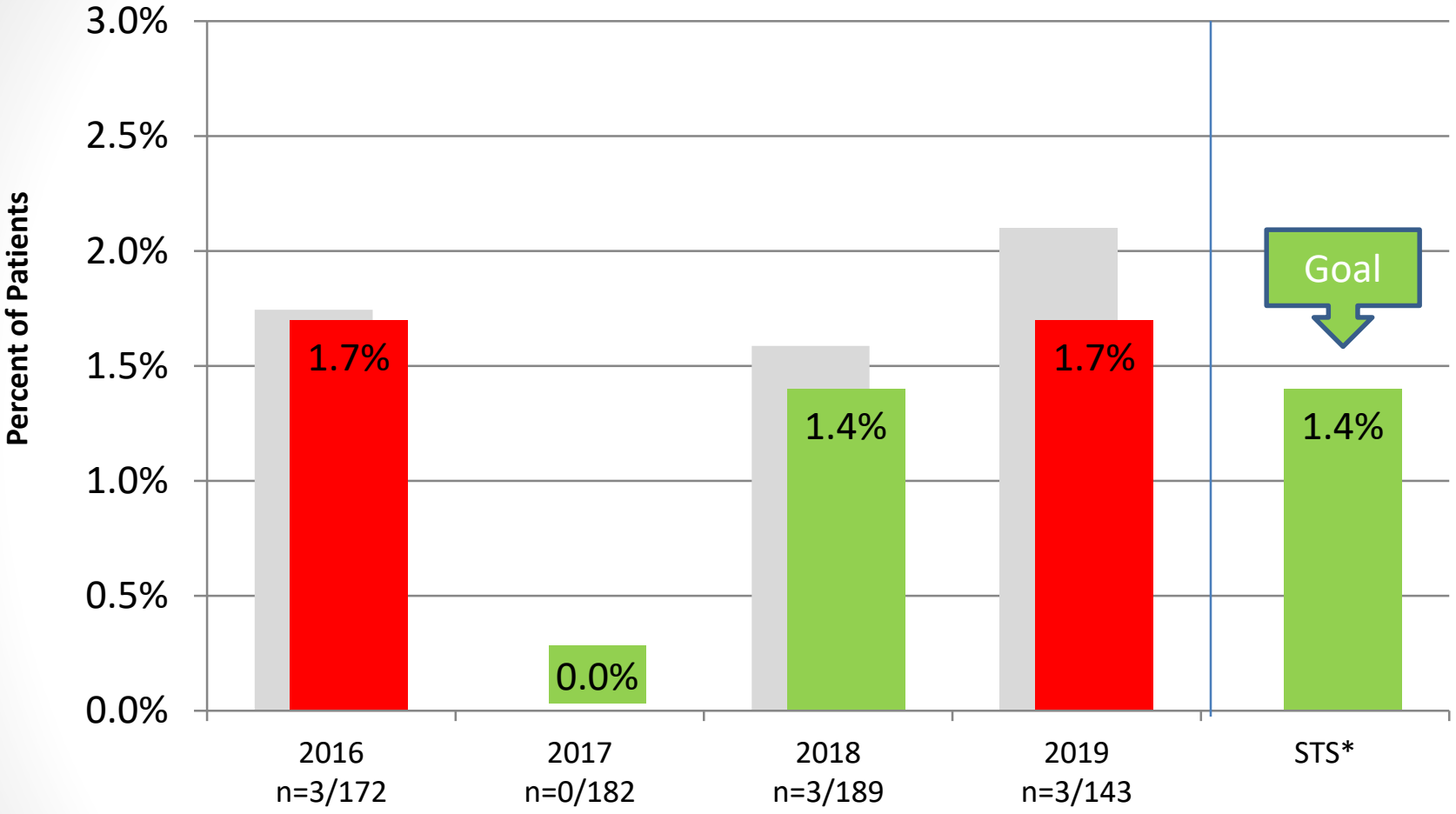
***Comparison reporting period 1/1/2019 through 9/30/2019**

Quality Initiative: Prolonged Ventilation

- Monthly audit & analysis of prolonged ventilation times and delayed Extubation cases due to medical necessity
- Action Plan for 100% compliance in completing Cardiac Extubation Tool ~ followed daily by CVICU nurse manager
- Sedation and Analgesia to be used in an appropriate and conservative manner
  - Avoid Benzodiazepines and narcotic drips
  - To illicit calm awakening utilize Propofol & precedex drips when medically necessary
- Train nursing, medical and ancillary staff on the revised Fast Track Extubation Protocol available in PolicyTech
- Address ventilation time of each Pt. in rounds and shift reports by RN, RT & MD
- Promote Respiratory Therapy Education Tool for patients
- Review of Anesthesia Protocols
  - Positive Base excess or > -2.0 on CVICU arrival
  - Core Temperature > 36.0°C on CVICU arrival

CABG Post Op Permanent Stroke

Risk Adjusted in Color



Kaweah Delta Medical Center

2019 Risk Adjusted O/E = 1.3

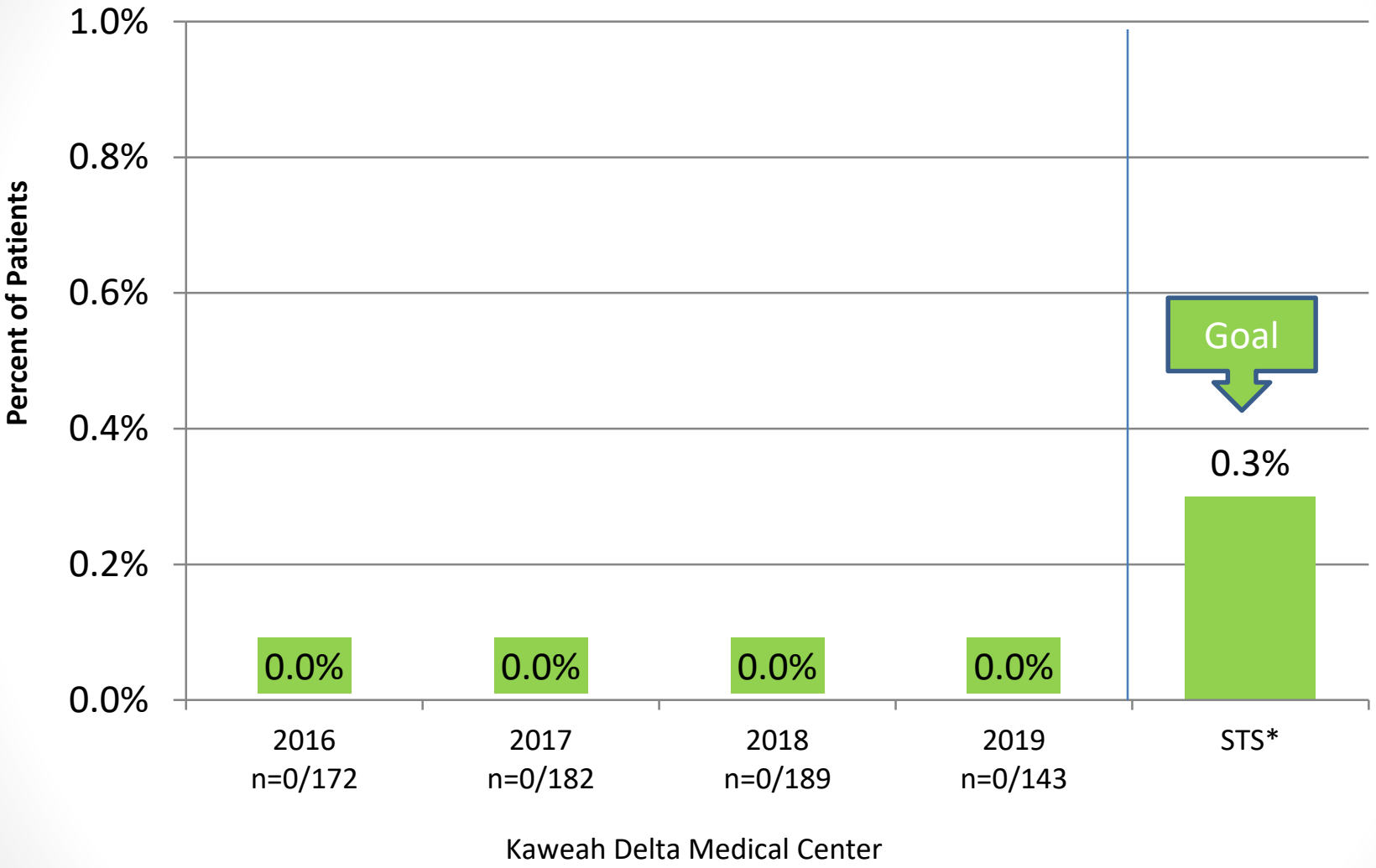
***Comparison reporting period 1/1/2019 through 9/30/2019**

Quality Initiative: Stroke prevention

- Risk factor, neurological evaluation
- TEE, CT of the aorta with evaluation as needed
- Carotid Doppler ~ Ultrasound
- Invox cortical brain monitoring
- Intraoperative blood flow & pressure control by perfusion and anesthesia
- Intraoperative temperature control

CABG Post Op Deep Sternal Wound Infection

Risk Adjusted in Color



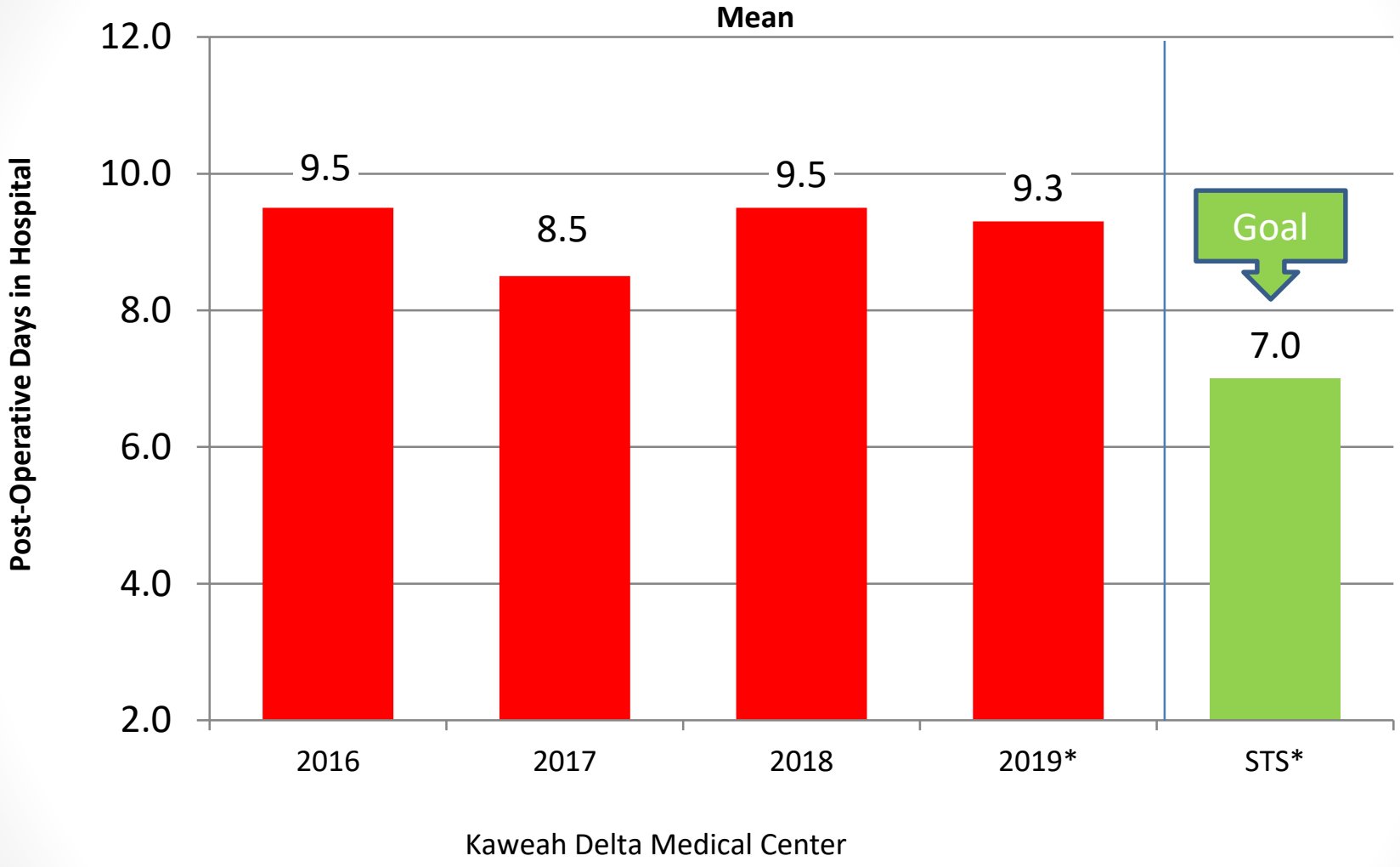
2019 Risk Adjusted O/E = ~

***Comparison reporting period 1/1/2019 through 9/30/2019**

Quality Initiative: Infection Prevention

- Glucose control w/ Glucommander – insulin drip or subcutaneous
- Two Chlorhexidine baths prior to surgery
- Chlorhexidine mouth wash used morning of surgery
- MRSA screening of each patient
- Terminal cleaning of operating rooms monitored daily
- Disposable ECG monitoring cables on each patient
- Use of Early closure technique for vein harvest incisions
- Vancomycin paste for sternal application
- Silver Nitrate or Prevena suction dressing applied to sternum
- Prophylactic antibiotic treatment for 48 hours
- Early removal of central lines and Foley catheter

CABG Post Op Length of Stay

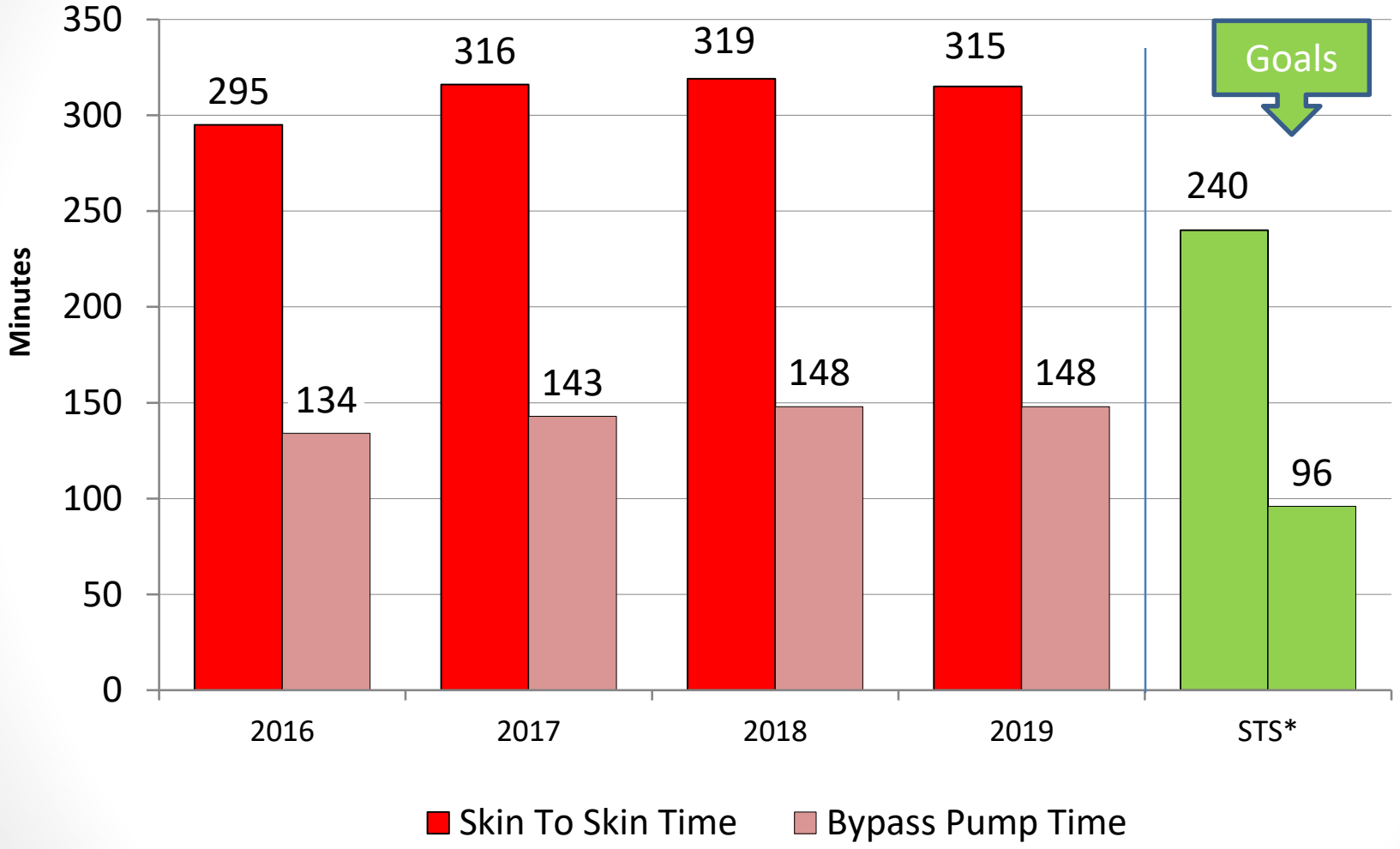


Kaweah Delta Medical Center

2019 O/E = 1.3

***Comparison reporting period 1/1/2019 through 9/30/2019**

CABG Skin-to-Skin and Bypass Pump Durations [1]

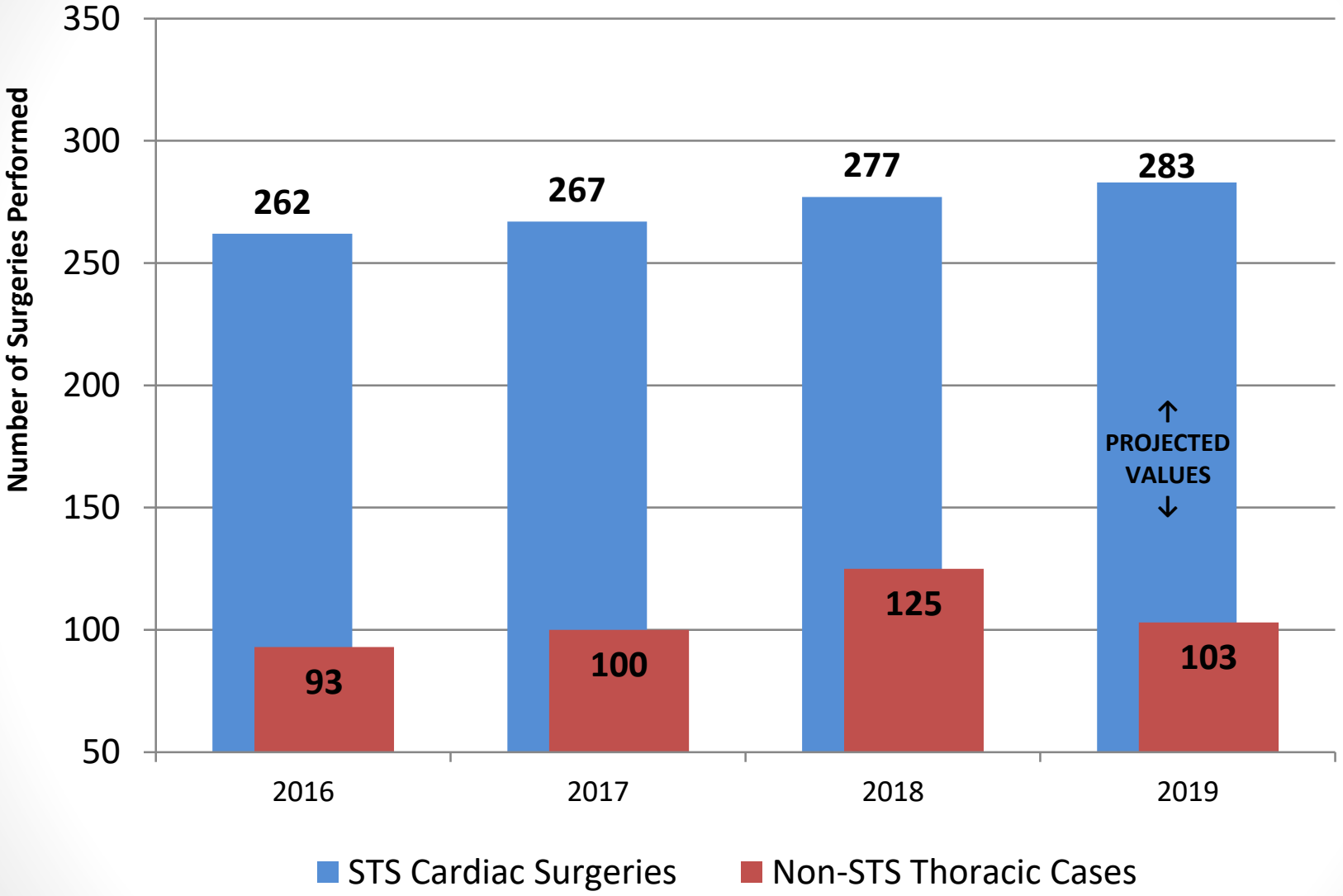


2019 O/E Skin Times = 1.3

2019 O/E Pump Times = 1.5

***Comparison reporting period 1/1/2019 through 9/30/2019**

Cardiothoracic Surgery Volumes [1]



[1] Cardiac surgery as defined per STS database. Includes all 7 Major Procedure Categories **(CABG, AVR, AVR+CABG, MVR, MVR+CABG, MVP, MVP+CABG) + Other Heart only procedures.**

Kaweah Delta Strategic Plan Framework 2020-2021

Our Mission
(*The reason we exist*)

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

Our Vision
(*What we aspire to be*)

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

Our Pillars

Achieve ***outstanding community health***

Deliver ***excellent service***

Provide an ***ideal work environment***

Empower through ***education***

Maintain ***financial strength***

Strategic Initiative	Metrics	Strategies/ Tactics
Organizational Efficiency and Effectiveness ***Increase the efficiency and the effectiveness of the organization*** *to reduce costs, lower length of stay, and improve outcomes.*	• **ALOS within 0.75 days of GMLOS** • Surgical implant standardization- 5% reduction • Staffing metrics- at budget/ mandated staffing ratios • OR patient-out-patient-in within 28 minutes • Spending per beneficiary score < 0.97	• Utilize the updated Resource Effectiveness Committee (REC) structure to improve patient throughput and remove discharge barriers • Better align staffing levels with patient volumes/units of service. • Standardize surgical (ortho/spine) implants • Improve OR efficiency and block utilization
Kaweah Care Culture ***Recruit, develop, and retain the best staff and physicians*** *to create an ideal work environment and ensure that patients receive excellent compassionate care.*	• EE Engagement survey - 4.19 engagement score (65th ptile) • Physician Engagement survey – 3.68 alignment score • SAQ Teamwork: 66%; Safety 73% • **HCAHPS Overall Rating: 76.5% 9s and 10s during FY21** • **ED Patient experience: Overall Rating: 70% during FY21**	• Pulse & Employee Engagement Survey and action planning • Leadership Development programs • Just Culture Commitment – Staff awareness • GME faculty and Medical Staff Leader Development • Physician Engagement Committee work • Operation Always - Patient engagement • Safety attitudes questionnaire (SAQ) and action planning • Increase Kaweah Care recognitions and celebrations • Develop performance scorecards for leaders, physicians, medical directors and department chairs
Outstanding Health Outcomes ***Demonstrate that we are a high-quality provider*** *so that patients and payers choose Kaweah Delta.*	• Leapfrog B • **CAUTI ≤ 0.774** • **CLABSI ≤ 0.687** • **MRSA ≤ 0.763** • **Sepsis bundle ≥70%** • 100% of Leapfrog/NQP Safe Practices points • Zero Defect performance- 100%	• Quality focus teams • Daily catheter and central line Gemba rounds • Improve compliance with sepsis bundle • Create diagnosis-specific committees to address mortality and readmissions • Infection prevention hand hygiene program • Expand adoption and compliance with Cleveland Clinic quality metrics and best practices
Strategic Growth and Innovation ***Grow intelligently*** *by expanding existing services, adding new services, and serving new communities.*	• 2% growth in market share (FPSA) • 11.2% increase in IP surgical volume • Net 30 increase in the number of physicians in the market • Retain 11 KD residents (40%) in the Central Valley • Two new ambulatory locations • Increased total OR capacity (available hours/minutes) • Launch telehealth services • Introduce new branding	• Develop a comprehensive and coordinated ambulatory network strategy • Better monitor and manage patient referrals to ensure continuity of care • Enhance physician relations capabilities to improve recruitment, onboarding, and retention of physicians • Promote key service lines to a broader geographic market (e.g. Fresno and Kern Counties) • Continue work with community advisory groups and use public perception data to improve community relations • Refresh of organization branding and naming strategy • Complete master facility plan to modernize and expand facilities
High Performing OP Delivery Network ***Improve the performance of our ambulatory services*** *to provide greater access to care and keep people healthy.*	• Employee engagement ≥ 50th percentile • OP patient satisfaction score ≥ 50th percentile • OP Outcome measures (A1c < 9), blood pressure, depression screening, flu vaccine) at target • Clinic visits ≥ 100% of budget • Net income ≥ 100% of budget • Labor productivity ≥ 100% of budget • Provider deficiencies 0% • RAF score of 1.2, resulting in $750,000 increase in revenue	• People: Leadership rounding with staff and physicians • Service: Leadership rounding with patients • Population health: Improve documentation/coding/billing processes for clinical documentation • Growth: Develop existing provider productivity/opportunity reports and identify new primary/specialty care opportunities • Finance: Monthly accountability meetings around operational measures

Note: **Blue bolded** font indicates organizational goals

Strategic Growth and Innovation

Strategic Initiative Charter: Strategic Growth and Innovation

Objective

Grow intelligently by expanding existing services, adding new services, and serving new communities.

Chair

Coby La Blue

ET Sponsor

Marc Mertz

Performance Measure	Baseline	FY21 Goal	FY22 Goal	FY23 Goal
Market Share (FPSA)[1]	63%	65%	67%	69%
Net new physicians in the market	n/a	30	TBD	TBD
New ambulatory locations	n/a	2	3	1
Increased IP surgery volume	n/a	11.2%	TBD	TBD

Strategies (Tactics)	Net Annual Impact ($)*
Ambulatory Network Strategy	
Physician Recruitment and Retention	
Service Line Expansion and Optimization	
New Service Line Growth	
Branding	
Facility Planning	

[1] Based on OSHPD data CY2018; FPSA is the facility planning service area

* Average annual impact over 3 years

Team Members

John Leal
Ryan Gates
Dan Allain

Strategy Summary for: Ambulatory Network Strategy

Strategic Initiative: Strategic Growth and Innovation

Objective

Provide access to care for all of the population through expansion of Kaweah Delta's network reach through acquisition/expansion of service locations, service areas, and innovative payer contracting strategies.

Key Components

- Develop a comprehensive and coordinated ambulatory care strategy that expands access across a broad range of service models and locations (FQHC, RHC, KDMF, school/employer-based medicine)
- Develop Kaweah Connect, a centralized patient access program that will enable patients to contact KD and to schedule appointments via phone, email, text, web/online, and chat. Ultimately expand service to referring physicians.
- Assess the opportunities of a managed Medi-Cal strategy
- Develop additional strategic affiliations that will increase patient access points, brand awareness, and market share
- Expand access to specialty physicians (e.g. cardiology, neurosurgery, urology, gastroenterology, etc.) in the RHCs and FQHC

Outcomes	FY21	FY22	FY23
Increased "at risk" lives within a Managed Medi-Cal strategy	7,500	10,000	12,000
Overall referral rate to in-network providers	Baseline	+5%	+5%

Financial Impact	FY21	FY22	FY23
Capital Requirements	$6,000,000	$10,500,000	$4,000,000
Revenue			
Expenses			
Labor			
Supplies			
Other			
Total Costs			
Contribution Margin			

Team Members

Coby La Blue, Marc Mertz, Ryan Gates, Malinda Tupper

Strategy Summary for: Physician Recruitment and Retention

Strategic Initiative: Strategic Growth and Innovation

Objective

Increase the number of primary and specialty physicians in the community.

Key Components

- Recruit needed primary care providers and key specialists (GI, Urology, Psychiatry) according to community needs
- Increase the number of physicians in KDMF
- Evaluate the development of new residency and fellowship programs
- Develop residential facilities in downtown Visalia to support rotating medical students, residents, and other individuals
- Build on affiliation with USC and potentially other institutions, as appropriate
- Development of a comprehensive physician onboarding program
- Expand physician relations and liaison programs/activities

Outcomes	FY21	FY22	FY23
Achieve a net gain of physicians year-over-year	30	TBD	TBD
Achieve the increase in KDMF physicians projected in the KDMF budget and Physician Staffing Plan	12	TBD	TBD
Reduce the number of practicing physicians that leave the area	<7% (national average)	<7%	<7%
Increase retention of KD residents in Central Valley	11 physicians (40%)	40%	40%

Financial Impact	FY21	FY22	FY23
Capital Requirements			
Revenue			
Expenses			
Labor			
Supplies			
Other			
Total Costs			
Contribution Margin			

Team Members

Coby La Blue, Marc Mertz, Ryan Gates, Dan Allain, Jessica Rodriguez, Brittany Taylor

Strategy Summary for: Service Line Expansion and Optimization

Strategic Initiative: Strategic Growth and Innovation

Objective

Expand key Kaweah Delta Service lines through addition of related services not currently offered, new affiliations, new specialty or sub-specialty providers, and new locations.

Key Components

- Expand operating room capacity through improved efficiency, expanded hours/days, and/or development of new rooms
- Expand neurosciences, urology, and gastroenterology service offerings through marketing, potential partnerships, and improved physician relations/alignment
- Target new markets for growth of key service lines (e.g. Fresno and Kern Counties)

Outcomes	FY21	FY22	FY23
Increase number of patients/enrolled lives in condition-specific clinics	15%	15%	15%
Increase volume in IP surgery volume	11.2%	TBD	TBD
Increase volume in OP surgery volume	16.7%	TBD	TBD
Neurosurgery market share (FPSA)[1]	35%	40%	45%
Orthopedic market share (FPSA)[1]	57%	60%	64%
Open heart surgery market share (FPSA)[1]	70%	72%	75%
Recruit additional urologists	2	2	0

[1] Based on OSHPD data CY2018; FPSA is the facility planning service area

Financial Impact	FY21	FY22	FY23
Capital Requirements			
Revenue			
Expenses			
Labor			
Supplies			
Other			
Total Costs			
Contribution Margin			

Team Members

Coby La Blue, Marc Mertz, Ryan Gates, and Dan Allain

Strategy Charter for: New Service Line Growth

Strategic Initiative: Strategic Growth and Innovation

Objective

Implement new and innovative services needed by the communities served by Kaweah Delta.

Key Components

- Develop comprehensive outpatient behavioral health program, potentially supported by state BHI grant, including expansion of services in RHCs and new Medicare/Commercial clinic
- Launch expanded telehealth / home monitoring services, to include local physicians
- Evaluate establishment a comprehensive bariatric surgery program
- Consider addition of other needed services (e.g. adult day care, adolescent residential behavioral health services) either as a Kaweah Delta service or with strategic partners
- Evaluate the opportunity to develop a hospital at home service line

Outcomes	FY21	FY22	FY23
Bariatric IP cases	50	100	120
Telehealth visits	8,800	10,000	15,000
New behavioral health locations (via pending BHI grant)	3	1	0

Financial Impact	FY21	FY22	FY23
Capital Requirements			
Revenue			
Expenses			
Labor			
Supplies			
Other			
Total Costs			
Contribution Margin			

Team Members

Coby La Blue, Dan Allain, Ryan Gates, Marc Mertz, Tracy Salsa, Jessica Rodriguez

Strategy Charter for: Branding

Strategic Initiative: Strategic Growth and Innovation

Objective

Increase community awareness of the Kaweah Delta name and services offered through consistent branding, marketing and community education.

Key Components

- Market additional capabilities of key services such as cardiology/CV surgery, neurosurgery, orthopedics, and vascular surgery
- Refresh of organization branding and naming strategy
- Promote affiliations with Cleveland Clinic and University of Southern California to increase awareness and market share
- Marketing with emphasis on community involvement and full continuum of services
- Continue work with community advisory groups to use public perception survey results to improve community relations

Outcomes	FY21	FY22	FY23
Successful launch of new branding	Launch		
PSA market share	79%	80%	81%
SSA market share	34%	36%	38%
FPSA market share	65%	67%	69%
Measured improvement in public perception surveys	Baseline- TBD	+5%	+5%

Financial Impact	FY21	FY22	FY23
Capital Requirements	$575,000		
Revenue			
Expenses			
Labor			
Supplies			
Other			
Total Costs	$165,000		
Contribution Margin			

Team Members

Coby La Blue and Marc Mertz

Strategy Charter for: Facility Planning

Strategic Initiative: Strategic Growth and Innovation

Objective

Modernize and expand Kaweah Delta's facilities to better meet the needs of our growing community.

Key Components

- Complete the master facility planning process
- Launch a community engagement campaign to share and solicit input on facility planning options
- Add primary care access points in new markets
- Develop plans to increase access to outpatient surgery and endoscopy services
- Develop multi-year plan to increase OR capacity
- Work with local providers to increase access to skilled nursing homes so that KD patients can be discharged earlier
- Develop plan for increasing conference room space on the Downtown campus

Outcomes	FY21	FY22	FY23
New RHC locations	1	1	0
New KDMF locations	1	1	0
New FQHC locations (not including conversions)	0	1	1
Increased OR capacity (IP and OP)	TBD	TBD	TBD

Financial Impact	FY21	FY22	FY23
Capital Requirements			
Revenue			
Expenses			
Labor			
Supplies			
Other			
Total Costs			
Contribution Margin			

Team Members

Marc Mertz, Deborah Volosin, Ryan Gates, Paul Schofield, Dan Allain, Julieta Moncada, Jessica Rodriguez

Ideal Work Environment:
2020 Pulse Survey Goal Update

PULSE EMPLOYEE ENGAGEMENT SURVEY

Fast Facts

- Follow-up from 2019 engagement survey
- Included 22 Tier 3 workgroups
  - Tiers are based on performance on 15 core survey items known as *Power Items*
  - *Power Items* are actionable and most predictive of engagement
- **Our Goal** - Move ≥ 50% to Tier 2 status or higher (≥ 3.8)

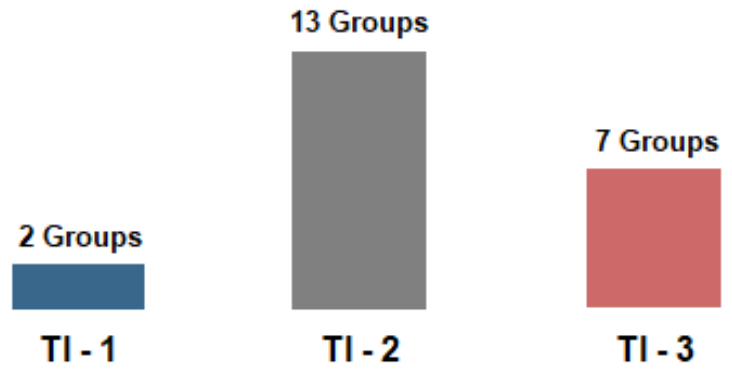
Engagement Comparison and Tiers

Engagement Indicator

3.97

+0.16 vs. 2019 Results (22 WGs)

Team Index



Next Steps

- Week of September 28 - Workgroup detail reports distribution
- October 1 - Pulse Survey Leaders Results webinar
- October through December - Communication and action planning

Questions?