February 22, 2024

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in the City of Visalia City Council Chambers {707 W. Acequia, Visalia, CA} on Wednesday February 28, 2024:

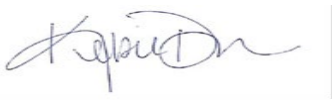
- 4:00PM Open meeting to approve the Closed agenda
- 4:01PM Closed meeting pursuant to Government Code 54956.9(d)(2), 54957(b)(1), and Health and Safety Code 1461, 32155, and 32106
- 5:00PM Open Meeting

In compliance with the Americans with Disabilities Act, if you need special assistance to participate at this meeting, please contact the Board Clerk (559) 624-2330. Notification 48 hours prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to the Kaweah Delta Health Care District Board of Directors meeting.

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

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

KAWEAH DELTA HEALTH CARE DISTRICT
David Francis, Secretary/Treasurer



Kelsie Davis
Board Clerk / Executive Assistant to CEO

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

KAWEAH DELTA HEALTH CARE DISTRICT
BOARD OF DIRECTORS MEETING

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

Wednesday February 28, 2024 {Regular Meeting}

OPEN MEETING AGENDA {4:00PM}

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 jurisdiction of the Board are requested to identify themselves at this time. For those who are unable to attend the beginning of the Board meeting during the public participation segment but would like to address the Board, please contact the Board Clerk (Kelsie Davis 559-624-2330) or kedavis@kaweahhealth.org to make arrangements to address the Board.
4. **APPROVAL OF THE CLOSED AGENDA – 4:01PM**
   - 4.1. **REPORT INVOLVING TRADE SECRETS {HEALTH AND SAFETY CODE 32106} –** Discussion will concern a proposed new services/programs – estimated date of disclosure is 05/2024.

     Jag Batth, Chief Operating Officer & Ben Cripps, Chief Compliance & Risk Officer
   - 4.2. **CONFERENCE WITH LEGAL COUNSEL – EXISITING LITGATION -** Significant exposure to litigation pursuant to Government Code 54956.9(d)(1) – Kaweah Delta Health Care District vs. George Christiansen, AIA – Tulare County Superior Court Case No.: VCU292789.

     Marc Mertz, Chief Strategy Officer and Rachele Berglund, Legal Counsel
   - 4.3. **REPORT INVOLVING TRADE SECRETS {HEALTH AND SAFETY CODE 32106} –** Discussion will concern a proposed new services/programs – estimated date of disclosure is 07/2024.

Jag Batth, Chief Operating Officer

4.4. **CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2).

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

4.5. **CONFERENCE WITH LEGAL COUNSEL - ANTICIPATED LITIGATION** – Pursuant to Government Code 54956.9(d)(2).

Rachele Berglund, Legal Counsel

4.6. **CREDENTIALING** - Medical Executive Committee (MEC) requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the MEC be reviewed for approval pursuant to Health and Safety Code 1461 and 32155.

Daniel Hightower, MD, Chief of Staff

4.7. **QUALITY ASSURANCE** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee.

Daniel Hightower, MD, Chief of Staff

4.8. **PERSONNEL**- Consideration of employment of a potential employee {Chief Medical & Quality Officer} per Government Code 54957(b)(1).

Board of Directors and Gary Herbst, Chief Executive Officer, and Rachele Berglund, Legal Counsel

4.9. **APPROVAL OF THE CLOSED MEETING MINUTES** –January 24, 2024 and February 8, 2024.

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 February 28, 2024, closed meeting agenda.

5. ADJOURN

CLOSED MEETING AGENDA {4:01PM}

1. CALL TO ORDER

2. **REPORT INVOLVING TRADE SECRETS {HEALTH AND SAFETY CODE 32106} –** Discussion will concern a proposed new services/programs – estimated date of disclosure is 03/2024.

Jag Batth, Chief Operating Officer & Ben Cripps, Chief Compliance & Risk Officer

3. **CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(1) – Kaweah Delta Health Care District vs. George Christiansen AIA, et al. Tulare County Superior Court Case VCU292789.

   Marc Mertz, Chief Strategy Officer and Rachele Berglund, Legal Counsel

4. **REPORT INVOLVING TRADE SECRETS {HEALTH AND SAFETY CODE 32106} –** Discussion will concern a proposed new services/programs – estimated date of disclosure is 07/2024.
   Jag Batth, Chief Operating Officer

5. **CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2).

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

6. **CONFERENCE WITH LEGAL COUNSEL - ANTICIPATED LITIGATION** – Pursuant to Government Code 54956.9(d)(2).

   Rachele Berglund, Legal Counsel

7. **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.

   Daniel Hightower, MD, Chief of Staff

8. **QUALITY ASSURANCE** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee.

   Daniel Hightower, MD, Chief of Staff

9. **PERSONNEL**- Consideration of employment of a potential employee {Chief Medical & Quality Officer} per Government Code 54957(b)(1).

   Board of Directors and Gary Herbst, Chief Executive Officer, and Rachele Berglund, Legal Counsel

10. **APPROVAL OF THE CLOSED MEETING MINUTES** –January 24, 2024 and February 8, 2024.

    Action Requested – Approval of the closed meeting minutes – January 24, 2024, and February 8, 2024.

11. **ADJOURN**

OPEN MEETING AGENDA {5:00PM}

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 jurisdiction of the Board are requested to identify themselves at this time. For those who are unable to attend the beginning of the Board meeting during the public participation segment but would like to address the Board, please contact the Board Clerk (Kelsie Davis 559-624-2330) or kedavis@kaweahhealth.org to make arrangements to address the Board.
4. **CLOSED SESSION ACTION TAKEN** – Report on action(s) taken in closed session.
5. **OPEN MINUTES** – Request approval of the January 24, 2024, and February 8, 2024, open minutes.

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

   Action Requested – Approval of the January 24, 2024, and February 8, 2024, open minutes.

6. **RECOGNITIONS**

   6.1. Presentation of Resolution 2220 to Carolyn Hainsworth, in recognition as the Kaweah Health World Class Employee of the month – February 2024 – Director *Francis*

   6.2. Presentation of Resolution 2221 to Cindy Moccio in recognition of her retirement from Kaweah Health –28 years of service – *Director Francis*

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

   Daniel Hightower, MD, Chief of Staff

   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 February 28, 2024, medical staff credentials report.

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

   Daniel Hightower, MD, Chief of Staff

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

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

Action Requested – Approval of the February 28, 2024, Consent Calendar

9.1. REPORTS

A. Physician Recruitment
B. Strategic Plan
C. Compliance
D. Throughput

9.2. POLICIES – ADMINISTRATIVE

A. AP29 – Patient Care Forms- New and Revisions to Existing – *Revised*
B. AP123 – Financial Assistance Program Full Charity and Partial Discount Programs – *Reviewed*
C. AP02 – Conditions of Admissions – *Revised*
D. AP28 – Computer Safety – *Revised*
E. AP130 – Community Managed Care Rate – *Revised*
F. AP46 – Commercial Card Expense Reporting (CCER) Program – *Revised*
G. AP99 – Abandoned New Born: Safe Surrender – *Revised*

9.3. POLICIES- ENVIRONMENT OF CARE

A. EOC 1021 – Monitoring of Temperature and Humidity Levels in Sensitive Areas - *Revised*
B. EOC 3000 – Security Management Plan – *Reviewed*
C. EOC 3007 – Emergency Department Security- *Reviewed*
D. EOC 3010 – Key Control Policy - *Revised*
E. EOC 3014 – Security Measures Involving VIP – *Reviewed*
F. EOC 4000 – Hazard Material Management Plan – *Revised*
G. EOC 4001 – Hazardous Materials and Waste Management Program – *Revised*

9.4. POLICIES- EMERGENCY MANAGEMENT

A. DM 2201 – Code Triage Activation Plan - *Revised*
B. DM 2211 – Decontamination Plan – *Revised*

9.5. POLICIES- EMPLOYEE HEALTH

A. EHS 01 – Infection Prevention Guidelines for Pregnant Healthcare Workers - *Revised*
B. EHS 02 – Employee Exposure to Bloodborne Pathogens - *Revised*

C. EHS 08 – Employee Health Standing Orders - *Revised*
D. EHS 11 – Immunization Requirements for Health Care Workers - *Revised*
E. EHS 13 – Respiratory Protection Program – *Revised*

9.6. POLICIES – HUMAN RESOURES
A. HR 03 – Just Culture Commitment- *Reviewed*
B. HR 04 – Special Pay Practices – *Reviewed*
C. HR 36 – New Hire Processing – *Reviewed*
D. HR 46 – Orientation of Kaweah Health Personnel - *Reviewed*
E. HR 47 - Professional Licensure and Certification – *Revised*
F. HR 49 – Education Assistance – *Reviewed*
G. HR 66 – Payroll Deductions - *Reviewed*
H. HR 75 – Differential Pay-Shift, Holidays and Weekend – *Reviewed*
I. HR 80 – Docking Staff - *Reviewed*
J. HR 128 – Employee Benefits Overview – *Reviewed*
K. HR 147 Pregnancy Disability Leave of Absence – *Reviewed*
L. HR 200 – Drug Free Work Place and Drug/Alcohol Testing – *Reviewed*
M. HR 216 – Progressive Discipline – *Reviewed*
N. HR 234 – PTO, EIB and Healthy Workplace Healthy Families Act of 2014 - *Reviewed*
O. HR 242 – Personal Medical Leave – *Reviewed*

9.7. Approval of rejection of claim of Adrianna Burton vs. Kaweah Delta Health Care District

9.8. Recommendations from the February 2024 Medical Executive Committee
Revised Privilege Form – Critical Care, Pulmonary & Sleep Medicine

9.9. Approval of the Kaweah Delta Health Care District dba Kaweah Health Graduate Medical Education diplomas certifying that the Kaweah Delta Health Care District duties for each residency has been fulfilled.

CAP
Reza John Emami, MD
Kristine Anne Jacoba Hwang, MD
Luis Cyrus Montes De Oca, DO

Transitional Year
Bruno Alonso, MD
Jeremy Craig Brown, DO
Stanley Chu, MD
Audelia Eben, DO
Arturo Hernandez, MD
Steven Lacombe, DO
Ashley Marie Lau, DO
Shant Malkasian, MD
April Yen Ngoy, DO
Ellie Nareae Ok, DO
Thomas Garrett Shomaker, MD
Yuan Quinton Yuan, DO

Anesthesiology
Haiyan Guo, DO
Kinh-Vy Ngueyen, MD
Edmund Wang, DO
Adrian Yabut, Do

Emergency Medicine
Matthew Bordbari, DO
David Fernando Castro Palomino, DO
Amy Chuang, DO
Giulia Di Bella, DO
Ethan Noah Hartman, MD
Melissa Kemp, DO
Kevin Lieu, MD
Aubtin Saedi, DO
Christina Lily Seto, MD
Maria Alejandra Tobar, MD
Alex Inchen Tsai, DO

Family Medicine
Eduardo Francisco Amezcua, MD
Jasmeen Chahil, MD
Grace Guadalupe, MD
Rebecca Rachel King Kawagoe, DO
Sparghai Sahar Ludin, MD
Dorathea Smith, MD

Psychiatry
Mithun Medagangoda, DO
Shashvat Patel, MD
Morgan Stanley, DO
Karanbir Randhawa, MD
Sherry Kwon, MD
James Harrison Collins, MD

Surgery
Natalie Ranya Joumblat, MD
Jacob Michael Kirkorowicz, MD
Julia B. Ruffo, MD
Brandi Hull, DO

9. **QUALITY REPORT – Annual review of the RRT/Code Blue** - A review of the Quality and Patient Safety prioritized initiatives for 2024, and reporting schedule for Quality Council.

Tom Gray, MD – Interim Chief Medical & Quality Officer and Shannon Cauthen, Director of Critical Care Services.

10. **STRATEGIC PLAN – Patient and Community Experience** – Detailed review of Strategic Plan Initiative.

Keri Noeske, Chief Nursing Officer & Deborah Volosin, Director of Community Engagement

11. **HEALTH EQUITY -** Review of new health equity efforts and outcomes.

Ryan Gates, Chief Population Health Officer & Sonia Duran-Aguilar, Director of Population Health Management

13. **FINANCIALS** – Review of the most current fiscal year financial results.

Malinda Tupper – Chief Financial Officer

14. **KAWEAH DELTA HEALTH CARE DISTRICT SERVICES PLANNING** – Review and discussion of long-term and short-term services planning concepts for Kaweah Health.

Jag Batth, Chief Operating Officer

15. REPORTS

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

Jag Batth, Chief Operating Officer

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

Mike Olmos, Board President

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MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD WEDNESDAY JANUARY 24, 2024, AT 5:00PM IN THE CITY OF VISALIA CITY COUNCIL CHAMBERS – 707 W. ACEQUIA, VISALIA, CA.

PRESENT: Directors Olmos, Francis, Havard Mirviss & Rodriguez; G. Herbst, CEO; D. Hightower, MD, Vice Chief of Staff, K. Noeske, CNO; M. Tupper, CFO; M. Mertz, Chief Strategy Officer; D. Leeper, Chief Information and Cybersecurity Office; R. Gates, Chief Population Health Officer; J. Batth, Chief Operating Officer; B. Cripps, Chief Compliance Officer; R. Berglund, Legal Counsel; E. McEntire, Director of Risk Management; and K. Davis, recording

The meeting was called to order at 5:00 PM by Director Olmos.

Director Olmos asked for approval of the agenda.

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

PUBLIC PARTICIPATION – None.

CLOSED SESSION ACTION TAKEN: Approval of the closed minutes from December 21, 2023, and January 9, 2024.

OPEN MINUTES – Requested approval of the open meeting minutes from December 21, 2023, January 9, 2024, and January 11, 2024.

PUBLIC PARTICIPATION – None.

MMSC (Havard Mirviss/Francis) to approve the open minutes from December 21, 2023, and January 11, 2024. This was supported unanimously by those present. Vote: Yes – Olmos, Havard Mirviss, Rodriguez, and Francis.

MMSC (Havard Mirviss/Francis) to approve the open minutes from January 9, 2024. This vote was supported by three yes votes: Olmos, Havard Mirviss, and Francis; and one abstention vote: Rodriguez for not being present at the meeting.

RECOGNITIONS

Presentation of Resolution 2218 by Mrs. Havard Mirviss to Elli Santana, LVN, in recognition as the Kaweah Health World Class Employee of the Month for January 2024.

Presentation of Resolution 2219 by Mrs. Havard Mirviss to Becky Stark, RN, in recognition of her retirement from Kaweah Health after 45 years of 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.

CHIEF OF STAFF REPORT – Report relative to current Medical Staff events and issues – *Daniel Hightower, MD, Vice Chief of Staff*

- No report.

Public Participation – None.

Director Olmos requested a motion for the approval of the credentials report.

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 – Olmos, Havard Mirviss, Rodriguez, and Francis

CONSENT CALENDAR – Director Olmos entertained a motion to approve the January 24, 2024, consent calendar. Mr. Francis pulled consent calendar item 9.1.D. Urology Services.

PUBLIC PARTICIPATION – None.

MMSC (Havard Mirviss/Rodriguez) to approve the January 24, 2024, consent calendar. This was supported unanimously by those present. Vote: Yes – Olmos, Havard Mirviss, Rodriguez, and Francis

CONSENT CALENDAR – After discussions**,** Director Olmos entertained a motion to approve the pulled consent calendar *item 9.1.D. Urology Services.*

PUBLIC PARTICIPATION – None.

MMSC (Francis/Rodriguez) to approve the January 24, 2024, pulled consent item 9.1.D. This was supported unanimously by those present. Vote: Yes – Olmos, Havard Mirviss, Rodriguez, and Francis

QUALITY REPORT – **ANNUAL REVIEW OF THE QUALITY AND PATIENT SAFETY PLANS** – A review of the Quality and Patient Safety prioritized initiatives for 2024, and reporting schedule for Quality Council. (Copy attached to the original of these minutes and considered a part thereof) – *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*

STRATEGIC PLAN – OUTSTANDING HEALTH OUTCOMES – Detailed review of Strategic Plan Initiative and requested approval of the new metrics from the original strategic plan. (Copy attached to the original of these minutes and considered a part thereof) – *LaMar Mack, MD, Quality & Patient Safety Medical Director & Sandy Volchko, Director of Quality & Patient Safety.*

PUBLIC PARTICIPATION – None.

Director Olmos requested a motion for the approval of the new outstanding health outcome metrics from the original strategic plan.

MMSC (Rodriguez/Havard Mirviss) to approve the new outstanding health outcome metrics as provided. Those present supported this unanimously. Vote Yes- Olmos, Havard Mirviss, Rodriguez and Francis.

STRATEGIC PLAN- ORGANIZATIONAL EFFECTIVENESS, EFFICIENCY AND THROUGHPUT - Review of the strategic plan initiative and monthly throughput update. (Copy attached to the original of these minutes and considered a part thereof.) - *Jag Batth, Chief Operating Officer*

FINANCIALS – Review of the most current fiscal year financial results. (Copy attached to the original of these minutes and considered a part thereof) – *Malinda Tupper – Chief Financial Officer*

REPORTS

Chief Executive Officer Report - Report relative to current events and issues – *Gary Herbst, CEO*

- *Mr. Herbst noted that the hospital is staying busy.*
- *Mr. Herbst noted he had a Moody's call and there are multiple credit downgrades across the nation for Hospitals.*
- The 21 Million dollar hospital loan has not been secured yet.
- *Mr. Herbst noted thanks to Marc Mertz, Shannon Grove has been a huge advocate for Kaweah and she is advocating for the Bridge Loan to be extended for four years.*
- *CHA is making Seismic Relief a big priority this year.*
- *Mr. Herbst just found out that the MCO tax is only a promise and not a law the way it is written.*

Board President **-** Report relative to current events and issues – *Mike Olmos, Board President*

- None.

PUBLIC PARTICIPATION – None.

MMSC (Havard Mirviss/Rodriguez) to approve the August 23, 2023, closed agenda. This was supported unanimously by those present. Vote: Yes – Olmos, Havard Mirviss, Gipson, Rodriguez, and Francis

ADJOURN - Meeting was adjourned at 7:26PM

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

ATTEST:

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

MINUTES OF THE SPECIAL OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD THURSDAY FEBRUARY 8, 2024, AT 4:00PM, IN SEQUOIA REGIONAL CANCER CENTER MAYNARD FAUGHT CONFERENCE ROOM.

PRESENT: Directors Francis, Havard Mirviss, Rodriguez, and Olmos; G. Herbst, CEO; R. Berglund, Legal Counsel and C. Moccio, recording

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

Director Olmos requested the approval of the open meeting agenda.

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

PUBLIC PARTICIPATION – None.

ZONE 3 INTERVIEWS – Interviews with Board of Directors relative to the Zone 3 Board of Directors vacancy. Appointment of Zone 3 Board seat. Selected candidate will serve until December 6, 2024.

Mr. John Schouten	4:15PM-4:45PM
Dr. Mathias Daniels	5:00PM-5:30PM
Dr. Dean Levitan	5:45PM-6:15PM

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 (Francis/Rodriguez) to select Dr. Dean Levitan to fill the Zone 3 board seat. Vote: Yes – Olmos, Rodriguez, and Francis No: Havard Mirviss

APPROVAL OF CLOSED AGENDA AS FOLLOWS: Closed Meeting Agenda – Immediately following the 4:00PM open session.

Personnel – Consideration of the employment of a potential employee {Board Clerk / Executive Assistant to CEO} per Government Code 54957(b)(1) – *Board of Directors and Gary Herbst, Chief Executive Officer*

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

Adjourned 6:38PM

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

ATTEST:

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

RESOLUTION 2220

WHEREAS, the Department Heads of the KAWEAH DELTA HEALTH CARE DISTRICT dba KAWEAH HEALTH are recognizing Carolyn Hainsworth with the World Class Service Excellence Award for the Month of February 2024 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 Carolyn Hainsworth 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 February 2024 by a unanimous vote of those present.

President, Kaweah Delta Health Care District

Secretary/Treasurer
Kaweah Delta Health Care District

Carolyn is positive, helpful, and full of ownership in her role as a Patient Access lead. She does not even try to but ends up going above and beyond by helping find great catches on reports, workflow improvements, and works hard to conclude and resolve what is causing a current issue. She is dedicated to our patients by being one of the first friendly faces they see as they walk in through our doors. Carolyn is the perfect example of someone who loves their job and demonstrates gratitude every time she is present. Her dedication proves it through her good intentions and due to the positive atmosphere she creates. She deserves a spotlight for being such a wonderful member of our team!

- Lilia Guzman

RESOLUTION 2221

WHEREAS, Cindy Moccio is retiring from duty at Kaweah Delta Health Care District dba Kaweah Health after 28 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;

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 appreciation to Cindy Moccio for 28 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 February 2024 by a unanimous vote of those present.

President
Kaweah Delta Health Care District

Vice President
Kaweah Delta Health Care District

Secretary/Treasurer
Kaweah Delta Health Care District

Board Member
Kaweah Delta Health Care District

Board Member
Kaweah Delta Health Care District

Physician Recruitment and Relations

Medical Staff Recruitment Report - February 2024

Prepared by: JC Palermo, Director Physician Recruitment - jpalermo@kaweahhealth.org - (559) 624-5456

Date prepared: 2/20/2024

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

Delta Doctors Inc.	
Family Medicine	2
OB/GYN	1
Adult Psychiatry	1

Key Medical Associates	
Endocrinology	1
Family Medicine/Internal Medicine	4
Gastroenterology	1
Pediatrics	1
Pulmonology	1
Rheumatology	1

Sequoia Oncology Medical Associates Inc.	
Hematology/Oncology	1

Orthopaedic Associates Medical Clinic, Inc.	
Orthopedic Surgery (General)	1
Orthopedic Surgery (Hand)	1
Orthopedic Surgery (Trauma)	1

Stanford Health Care	
Cardiothoracic Surgery	2

Sequoia Cardiology Medical Group	
EP Cardiology	1

Oak Creek Anesthesia	
Anesthesia - General/Medical Director	1
Anesthesia - Obstetrics	1
Anesthesia - Regional Pain	1
Anesthesia - Cardiac	1
CRNA	1

USC Urology	
Urology	3

Valley Hospitalist Medical Group	
GI Hospitalist	1

Other Recruitment/Group TBD	
Dermatology	2
Family Medicine	3
Gastroenterology	2
Hospice & Palliative Medicine	1
Neurology - Outpatient	1
Otolaryngology	2
Pediatrics	1
Pulmonology - Outpatient	1
Interventional Cardiology	1
General Cardiologist	1

Valley ENT	
Audiology	1
Otolaryngology	1

Mineral King Radiology Group	
Diagnostic Radiology	1
Interventional Radiology	1

Physician Recruitment and Relations

Medical Staff Recruitment Report - February 2024

Prepared by: JC Palermo, Director Physician Recruitment - jpalermo@kaweahhealth.org - (559) 624-5456

Date prepared: 2/20/2024

Candidate Activity

#	Specialty	Group	Date Added	Current Status
1	Occupational Medicine	TBD	2/2/2024	Prescreen call scheduled
2	Orthopedic Trauma	Orthopaedic Associates Medical Clinic, inc	2/2/2024	Prescreen call scheduled
3	Orthopedic Sports	Orthopaedic Associates Medical Clinic, inc	2/2/2024	Prescreen call pending
4	Orthopedic Hand	Orthopaedic Associates Medical Clinic, inc	2/2/2024	Prescreen call pending
5	Gasteroenterology	TBD	2/2/2024	Precreen call pending
6	EP Cardiologist	TBD	2/2/2024	Prescreen call pending
7	General Surgery	TBD	1/9/2024	Site Visit: Scheduling
8	General Surgery	TBD	1/9/2024	Site Visit: 2/1/24
9	General Surgery	TBD	1/9/2024	Site Visit: Scheduling
10	General Surgery	TBD	1/9/2024	Site Visit: 2/1/24
11	Pulmonolgy	TBD	1/9/2024	Currently under review
12	Pulmonolgy	TBD	1/9/2024	Site Visit: 2/16/24
13	ENT	TBD	11/1/2023	Currently under review
14	General Cardiology	TBD	11/1/2023	Currently under review
15	Gastroenterology	TBD	9/25/2023	Currently under review
16	EP	TBD	9/11/2023	Currently under review
17	Family Medicine	TBD	6/21/2023	Currently under review
18	Family Medicine	TBD	6/21/2023	Currently under review

Offer Extended

#	Specialty	Group	Offer Sent
1	OBGYN	Visalia OBGYN	TBD
2	Occupational Med	Direct/1099	2/2/2024
3	Neurology	Kaweah Nerology	1/4/2024
4	Psychiatry	TBD	12/5/2023
5	Neurology	Kaweah Nerology	11/8/2023
6	Family Medicine	Direct/1099	11/7/2023
7	Family Medicine	Direct/1099	11/2/2023
8	Interventional Cardiology	TBD	9/25/2023
9	Family Medicine	Direct/1099	9/14/2023
10	Anesthesia - Cardiac	Oak Creek	2/2/2024
11	Medical Oncology	Sequoia Oncology Medical Associates	9/1/2023

Offer Accepted

#	Group	Offer Sent	Expected Start Date
1	Anesthesia - General	Oak Creek Anesthesia	Spring 2024
2	CRNA	Oak Creek Anesthesia	Spring 2024
3	CRNA	Oak Creek Anesthesia	Spring 2024
4	CRNA	Oak Creek Anesthesia	Spring 2024
5	CRNA	Oak Creek Anesthesia	Spring 2024
6	CRNA	Oak Creek Anesthesia	Summer 2024
7	CRNA	Oak Creek Anesthesia	Spring 2024
8	Anesthesia	Oak Creek Anesthesia	Fall 2024
9	Anesthesia - Critical Care	Oak Creek Anesthesia	Fall 2024
10	Orthopedic Trauma	Orthopaedic Associates Medical Clinic	Summer 2024
11	Hospice & Palliative Medicine	Independent	Summer 2024
12	CRNA	Oak Creek Anesthesia	
13	Endocrinology	Direct/1099	Pending Credentialing
14	Radiation Oncology	SROSI	Summer 2024
15	Cardiothoracic Surgery	Stanford	Summer 2024

FY 2024 Strategic Plan

Monthly Performance Report

February 28, 2024

Kaweah Health Strategic Plan: Fiscal Year 2024

Our Mission

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

Our Vision

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

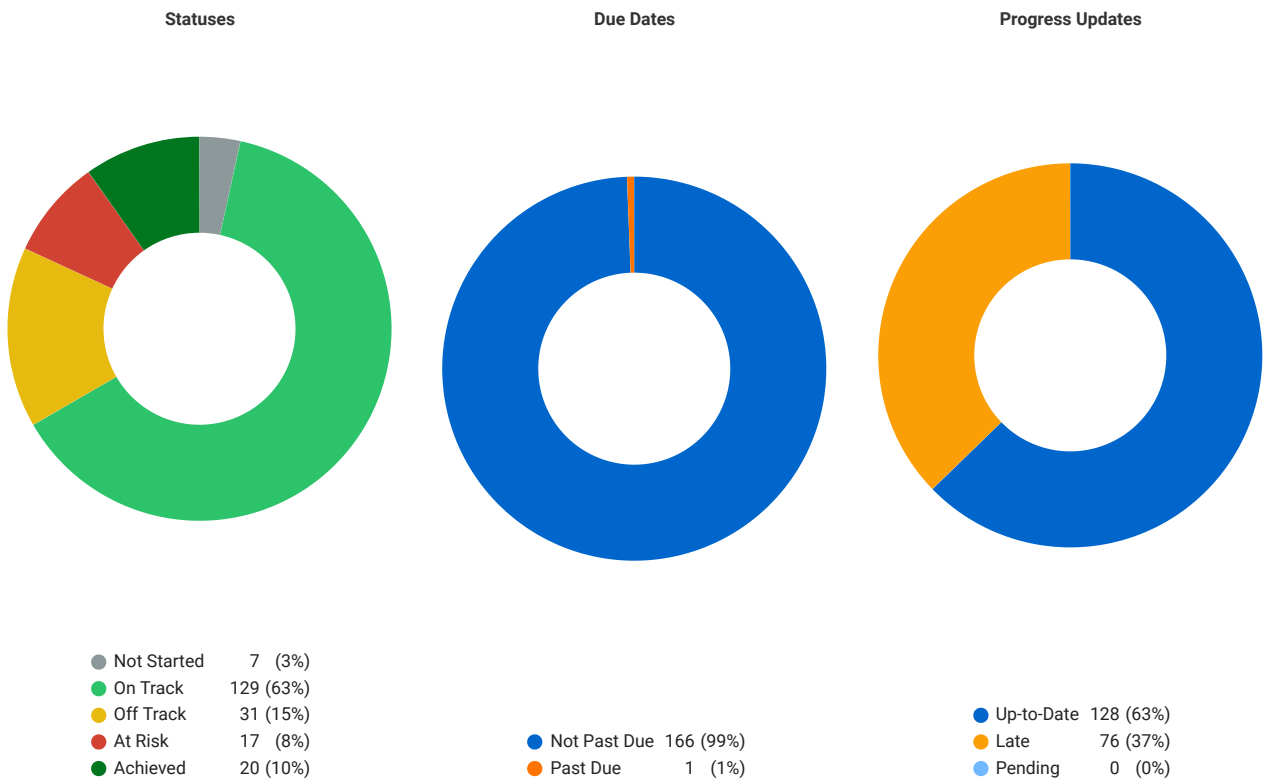
Our Pillars

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

Our Six Initiatives

Empower Through Education
Ideal Work Environment
Strategic Growth and Innovation
Organizational Efficiency and Effectiveness
Outstanding Health Outcomes
Patient Experience and Community Engagement

Kaweah Health Strategic Plan FY2024 Overview



Empower Through Education

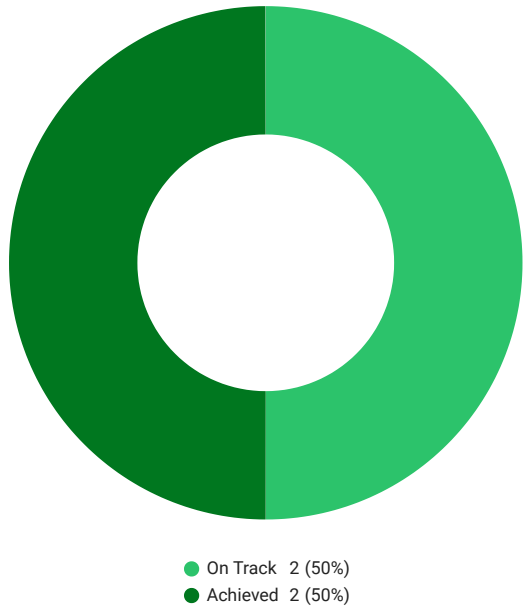
Champions: Dr. Lori Winston and Hannah Mitchell

*Objective: Implement inititatives to **develop the healthcare team** and **attract and retain** the very best talent in support of our mission.*

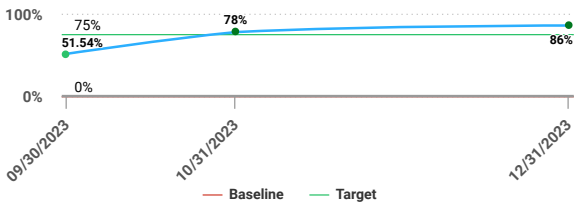
FY2024 Strategic Plan - Empower Through Education Strategies

#	Name	Description	Status	Assigned To	Last Comment
1.1	Expand Online Learning Opportunities and Participation	Increase and optimize existing and new educational opportunities and platforms to support on line and computer based learning.	Achieved	Hannah Mitchell	Goals have been met and exceeded.
1.2	Increase the Use of and Exposure to Simulation in Education	Develop and implement strategies to expand exposure to the SIM Lab and simulation concepts in training and education.	On Track	Kimberly Sokol	We are on track to meet all of the goals we have set for this strategy.
1.3	Expand Educational Opportunities for External Learners	Include external learners in existing and new training and educational opportunities.	Achieved	Kimberly Sokol	We have achieved all of the goals established for this strategy.
1.4	Improve Leadership Development and Education	Develop new and enhance existing educational and training opportunities for existing and emerging Kaweah Health and Medical Staff leaders.	On Track	Hannah Mitchell	We are on track to achieving the metrics for this strategy.

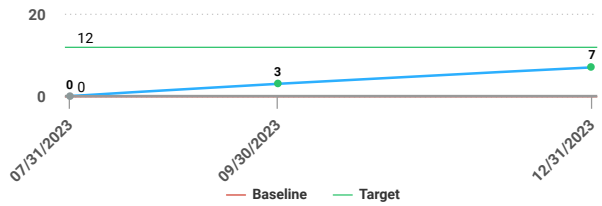
Objectives and Outcomes



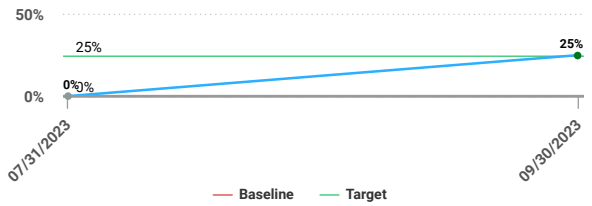
Automate the Week One Onboarding and Orientation Competencies for Patient Care Staff



Conduct Monthly in situ Simulations (Twelve in the Fiscal Year)



Host an Advanced Trauma Life Support Course with 25% Paying Participants



Ideal Work Environment

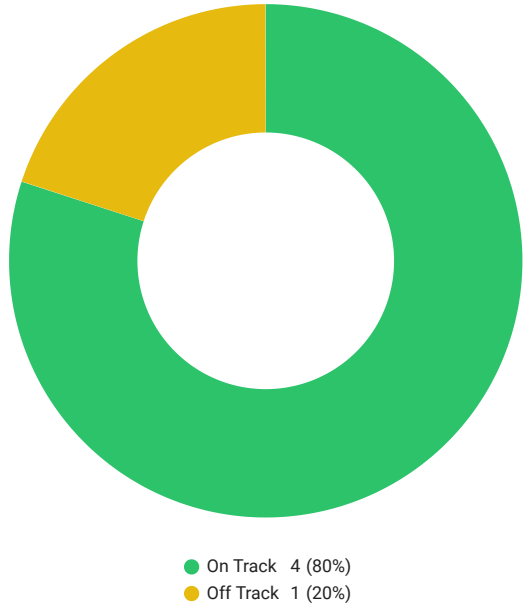
Champions: Dianne Cox and Raleen Larez

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

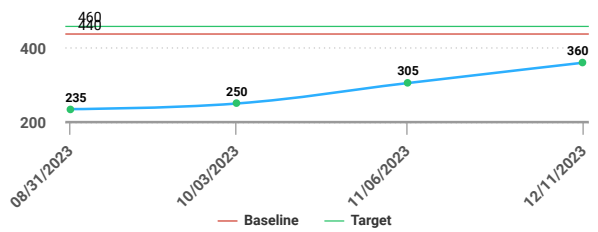
FY2024 Strategic Plan - Ideal Work Environment Strategies

#	Name	Description	Status	Assigned To	Last Comment
2.2	Ideal Practice Environment	Ensure a practice environment that is friendly and engaging for providers, free of practice barriers.	On Track	Lori Winston	Ongoing effort with the support of the Medical Staff Office.
2.5	Growth in Nursing School Partnerships	Increase the pool of local RN candidates with the local schools to increase RN cohort seats.	On Track	Dianne Cox	
2.1	Employee Retention and Resiliency	Kaweah Health is facing the same challenges as many employers in the labor market and must make retention a top priority.	Off Track	Dianne Cox	
2.3	Kaweah Care Culture	Recreate Kaweah Care culture into the various aspects of the organization.	On Track	Dianne Cox	1. Employee Engagement and Experience (To be presented to HR Committee of the Board 12/13/2023). 2. Ideal Practice Environment/Physician Engagement and Experience (To be presented at the February 2024 HR Committee of the Board). 3. Patient Experience (Keri presents to the respective Board).
2.4	Expand Volunteer Programs	Volunteer engagement has declined with the pandemic. Kaweah Health relies on a strong volunteer program to continue to spark career path engagement and to provide world class service.	On Track	Dianne Cox	

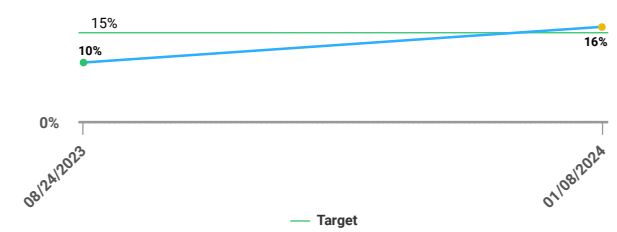
Objectives and Outcomes



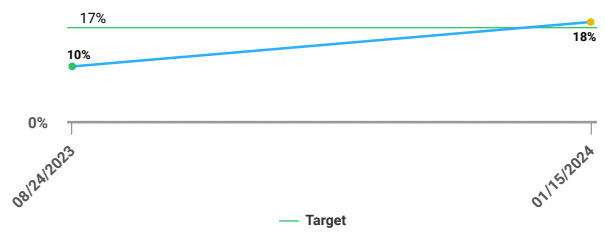
Increase to 460 Volunteers (by 6/30/24)



Decrease Overall KH Turnover Rate (< 15%)



Decrease Nursing Turnover Rate (< 17%)



Strategic Growth and Innovation

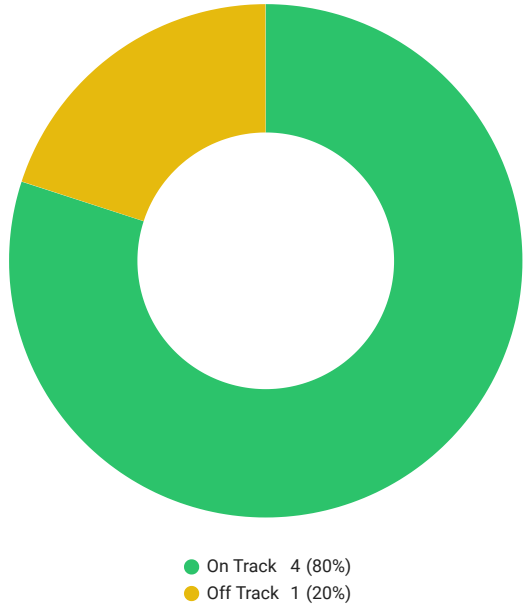
Champions: Ryan Gates and JC Palermo

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

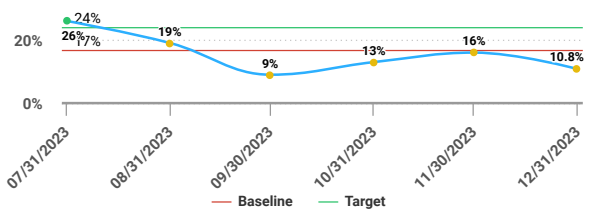
FY2024 Strategic Plan - Strategic Growth and Innovation Strategies

#	Name	Description	Status	Assigned To	Last Comment
3.1	Recruit and Retain Providers	Develop a recruitment strategy around top physician needs to recruit and retain physicians and providers to address unmet community needs and to support Kaweah Health's growth.	On Track	JC Palermo	Along with the completion of a new Physician Needs Assessment report, the prioritization of specialty recruitments is being guided by the projects outlined by the Strategic Growth Committee.
3.2	Grow Targeted Inpatient and Surgery Volumes	Grow our inpatient volumes, particularly the surgical cases, with an emphasis on key service lines such as Cardiac and Urology.	On Track	Kevin Bartel	Goals related to Urology are on track and we continue to work to improve our elective CABG case volume.
3.3	Grow Targeted Outpatient Volumes	Increase access to outpatient care in locations that are convenient to our community.	On Track	Ivan Jara	Other than the delay for the 202 Willow Clinic, due to physician recruitment, metrics within this area are on track.
3.4	Innovation	Implement and optimize new tools and applications to improve the patient experience, patient communication and patient outcomes.	Off Track	Jacob Kennedy	We have successfully implemented platforms to improve efficiencies and service for our patients over the past year. We will continue to work on optimizing and improving these systems to further enhance the patient experience and work toward achieving established goals.
3.5	Expand Health Plan & Community Partnerships	Improve and strengthen relationships with health plans, community partners, and participate in local/state/federal programs and funding opportunities to improve access, quality, and outcomes for the community.	On Track	Sonia Duran-Aguilar	We continue to grow the program and are currently at Capacity with both ECM and CS.

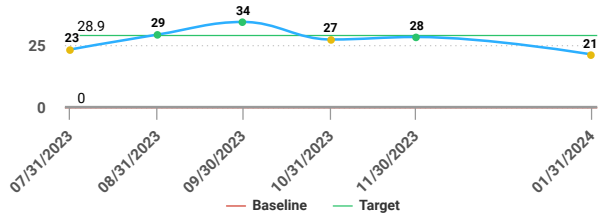
Objectives and Outcomes



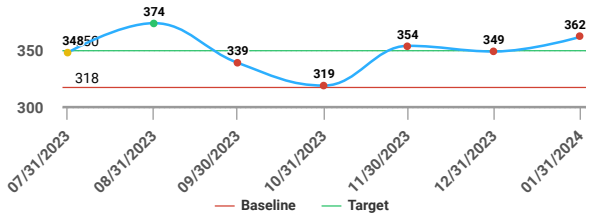
Increase the Percentage of Coronary Artery Bypass Graph Surgery Cases that are Elective



Increase Number of Urology Surgery Cases



Increase Monthly Endoscopy Case Volume



Organizational Efficiency and Effectiveness

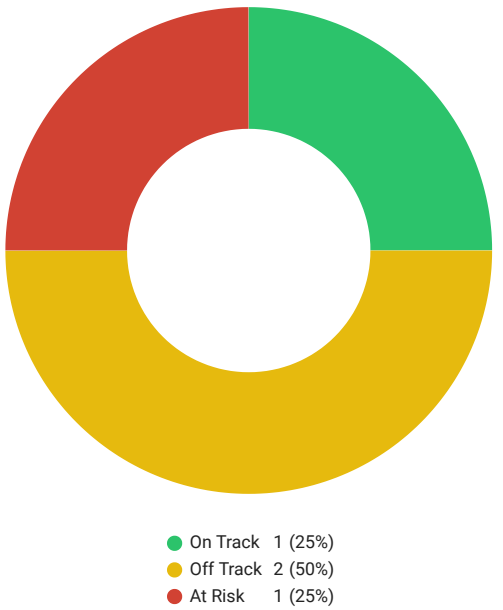
Champions: Jag Batth and Rebekah Foster

Objective: Increase the efficiency and effectiveness of the Organization *to reduce costs, lower length of stay and improve processes.*

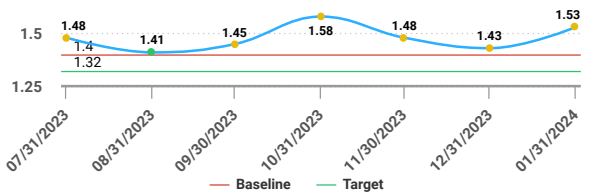
FY2024 Strategic Plan - Organization Efficiency and Effectiveness Strategies

#	Name	Description	Status	Assigned To	Last Comment
4.1	Patient Throughput and Length of Stay	Implement patient flow processes that are effective and efficient to improve patient throughput and lower the overall Length of Stay.	Off Track	Keri Noeske	All LOS metrics increased in January 2024. Efforts will take place to determine if January performance represents a trend or an outlier due to high patient volumes and strains on staffing and resources that led to slower turn around times related to tests, treatments and decisions.
4.2	Increase Main and Cardiac Operating Room Efficiency/Capacity	Improve Operating Room Efficiency, Capacity and Utilization to meet surgery volume needs.	Off Track	Lori Mulliniks	We continue to increase exception reporting to address improvements and are starting a weekly meeting to review each procedure resulting in a loss and address improvements. We have increased transparency with surgeons related to our goals by attending department meetings and providing monthly reports to surgeons. Four of our five metrics are off track and one is on track.
4.3	Create a Process to Monitor Use of Tests and Treatments	Create and initiate a workgroup to identify areas of focus and establish benchmarks related to the use of tests and treatments.	On Track	Suzy Plummer	Goals in the areas of Lab, Radiology and Therapies have been established and teams are working on tractics to move performance from baseline to goals.
4.4	Optimize Revenue Cycle Efforts	Focus efforts on key revenue cycle metrics to increase collections and reduce denials.	At Risk	Frances Carrera	The Patient Accounting team is down 7-9 FTEs and combined with regulatory billing changes, days in accounts receivable is increasing instead of decreasing. Our point of care efforts are improving, but we are still not meeting our monthly, and therefore, projected annual goals.

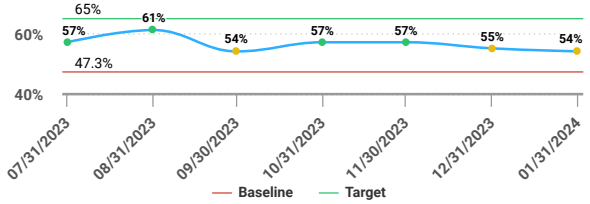
Objectives and Outcomes



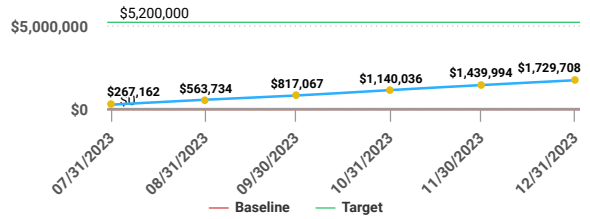
Decrease Inpatient Observed to Expected Length of Stay



Improve Elective Case Main Operating Room Utilization



Increase Front End Collections



Outstanding Health Outcomes

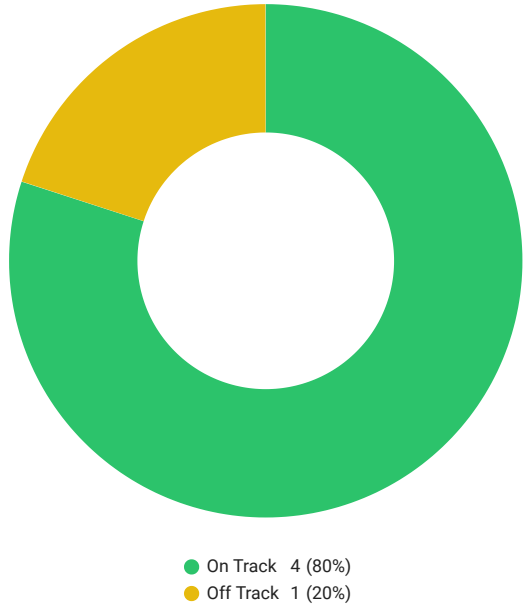
Champions: Dr. LaMar Mack and Sandy Volchko

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

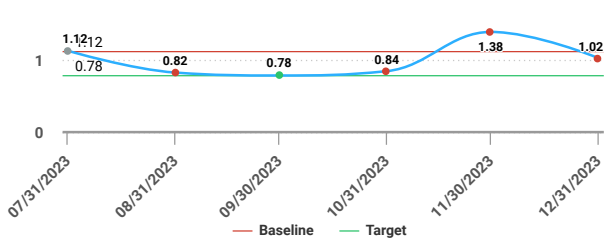
FY2024 Strategic Plan - Outstanding Health Outcomes Strategies

#	Name	Description	Status	Assigned To	Last Comment
5.1	Standardized Infection Ratio (SIR)	Reduce the Hospital Acquired Infections (HAIs) to the national 70th percentile in FYTD24 as reported by the Centers for Medicare and Medicaid Services	On Track	Sandy Volchko	Will be modifying the metric targets.
5.2	Sepsis Bundle Compliance (SEP-1)	Increase SEP-1 bundle compliance to overall 85% compliance rate for FY24 through innovative improvement strategies based on root causes.	On Track	Sandy Volchko	SEPSIS O/E Metric data is for June. Performance data not available. Will be modifying the metric/target.
5.3	Mortality and Readmissions	Reduce observed/expected mortality through the application of standardized best practices.	On Track	Sandy Volchko	Will be modifying metric targets.
5.5	Quality Improvement Program (QIP) Reporting	Achieve performance on the Quality Incentive Pool measures to demonstrate high quality care delivery in the primary care space.	On Track	Sonia Duran-Aguilar	Proxy Performance out of Cozeva Population Health Tool shows Kaweah Health is meeting 9 Quality Measures out of 10; performance at 90% up from 30% earlier in the year. A lot of QI efforts in the RHCs to finish strong by the end of the year. Final Performance will be known by May 2024 for Calendar Year 2023.
5.6	Inpatient Diabetes Management	Optimize inpatient glycemic management using evidence-based practices to improve patient's glycemic control and reduce hypoglycemic events.	On Track	Sonia Duran-Aguilar	SHM performance data reports twice a year. Current performance data is from 5/2023. Next report will be in Fall 2023.

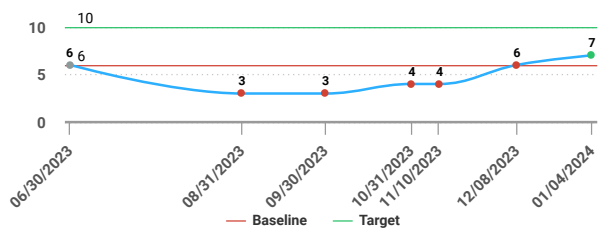
Objectives and Outcomes



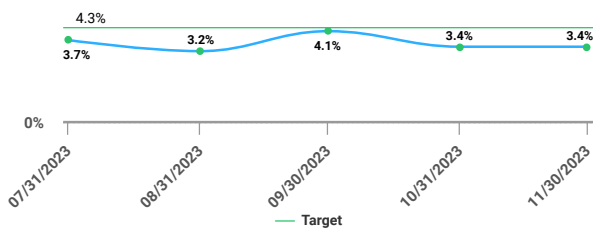
SEPSIS Mortality O/E



Meet 10 QIP Performance Measures



Hypoglycemia in Critical Care Patients (< 4.3%)



Patient and Community Experience

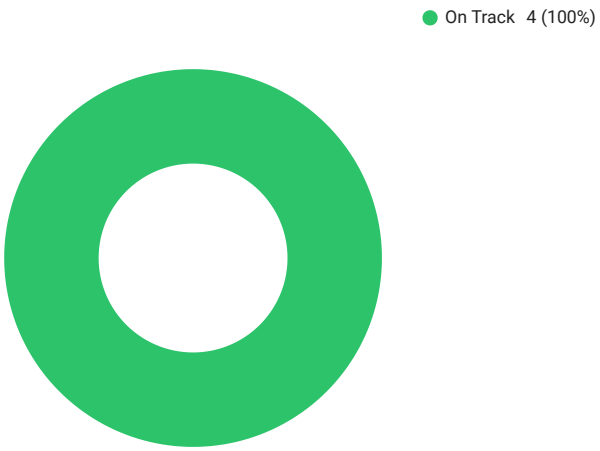
Champions: Keri Noeske and Deborah Volosin

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

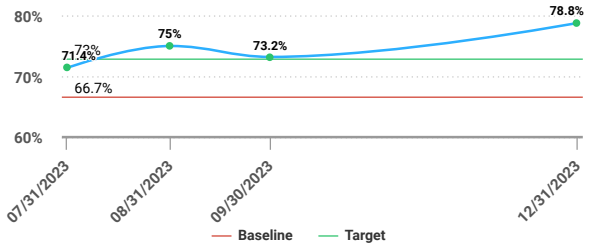
FY2024 Strategic Plan - Patient and Community Experience Strategies

#	Name	Description	Status	Assigned To	Last Comment
6.1	Highlight World-Class Service/Outcomes (Hospitality Focus)	Develop strategies that provide our health care team the tools they need to deliver a world-class health care experience.	On Track	Keri Noeske	HCAHPS Data: For FY24 will be 30 days behind d/t HCAHPS surveying timelines. Data for July 2023 will be updated in September 2023. ED Score: Value below baseline. ED Operations team to assess feedback and recommend an action plan to Patient Experience Committee to address decrease.
6.2	Increase Compassionate Communication	To reach the 50th percentile in physician and nursing communication and responsiveness of staff on the HCAHPS survey.	On Track	Keri Noeske	
6.3	Enhancement of Systems and Environment	To create a secure, warm and welcoming environment for patients and the community.	On Track	Keri Noeske	Two of seven lost belongings were located and returned to owners in July 2023. Investigations still pending on two items. Monitor departments for lost belongings trends and mandate action plans reported into patient care committee as needed.
6.4	Community Engagement	To provide an environment where community members and patients are able to assist staff in co-designing safe, high quality, and world-class care and services.	On Track	Deborah Volosin	

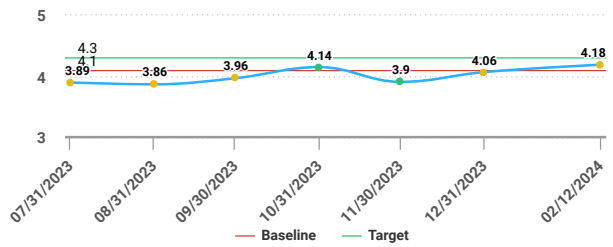
Objectives and Outcomes



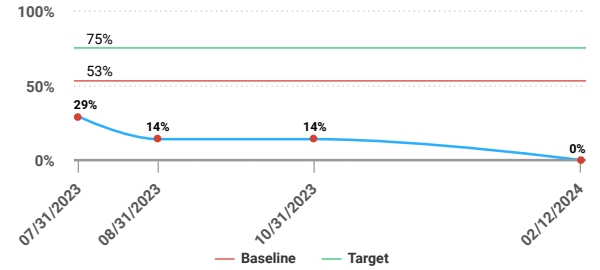
Achieve the 60th Percentile in Overall Rating Goal on HCAHPS Survey



Achieve 4.3 Patient Feedback Score Goal on ED Survey



Reunite 75% of Lost Belongings with Owners



Compliance Program Activity Report – Open Session

November 2023 through January 2024

Ben Cripps, Chief Compliance & Risk Officer

Education

Live Presentations

- Compliance and Patient Privacy
  - Dinuba Rural Health Clinic
  - New Leader Orientation
  - New Hire Orientation (In-Person) – Coming Soon!

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

- Compliance Matters Privacy
- Before You Act You've Been Given A FairWarning
- Compliance Education

Prevention & Detection

- California Department of Public Health (CDPH) All Facility Letters (AFL) – Review and distribute AFLs to areas potentially affected by regulatory changes; department responses reviewed and tracked to address the regulatory change and identify potential current/future risk.

- Medicare and Medi-Cal Monthly Bulletins – Review and distribute bulletins to areas potentially affected by the regulatory change; department responses reviewed and tracked to address the regulatory change and identify potential/current risk.

- Office of Inspector General (OIG) Monthly Audit Plan Updates – Review and distribute OIG Audit Plan issues to areas potentially affected by audit issue; department responses reviewed and tracked to identify potential current/future risk.

- California State Senate and Assembly Bill Updates – Review and distribute legislative updates to areas potentially affected by new or changed bill; department responses reviewed and tracked to address regulatory change and identify potential current/future risk.

Prevention & Detection

- User Access Privacy Audits – Fairwarning daily monitoring of user access to identify potential privacy violations.
  - Kaweah Health Employees
  - Non-employee users

- Office of Inspector General (OIG) Exclusion Attestations – Quarterly monitoring of department OIG exclusion list review and attestations.

- Medicare PEPPER Report Analysis – Quarterly review of Medicare Inpatient PEPPER statistical reports to identify outlier and/or areas of risk; evaluate with Kaweah Health leadership quarterly at PEPPER Review meeting; Distribution of Rehabilitation, Hospice, Home Health, and Mental Health PEPPER Reports to leadership for evaluation.

- Patient Privacy Walkthrough – Observation of regulatory signage and privacy practices throughout Kaweah Health; issues identified communicated to area management for follow-up and education.

- Centers for Medicare and Medicaid Services (CMS) Final Rule – Review and distribution of the 2024 CMS Final Rule for Inpatient Prospective Payment System (IPPS), Outpatient Prospective Payment System (OPPS), Inpatient Psychiatric Facility (IPF), Inpatient Rehabilitation Facility (IRF), Home Health and Hospice, and Physician Fee Schedule (PFS) policy and payment updates; department responses reviewed and tracked to address the regulatory change and identify potential current/future risk.

Oversight, Research & Consultation

New

Coding Guidance Documentation for Cardiothoracic Locum – Research to determine whether coding for post operative follow up visits, which are considered to be part of the global period are necessary to be completed. It was confirmed that a claim should never be submitted with the knowledge and understanding that the code being submitted is not supported by documentation and is not compliant with coding standards. The findings were shared with HIM leadership. The Physician ultimately completed the documentation necessary and the claims were coded and billed.

Oversight, Research & Consultation

New

Dialysis Billing Concerns – Workgroups, Root Cause Analysis and Resolutions – Consultation and oversight to determine the root cause of multiple charging and billing issues for Outpatient Dialysis claims. Multiple charging and billing errors have been identified resulting in compliance log issues as a result of Clarity EMR system limitations and integration with the Soarian Financial billing system. Three multidisciplinary workgroups have been established to analyze root cause issues and implement resolutions. The system workgroups have been tasked with two focuses: (1) planned and unplanned drug changes, and (2) bulk medications.

In addition to the system workgroups, a multidisciplinary workgroup made up of leadership from the Compliance, Pharmacy, ISS, Revenue Integrity and Dialysis departments has been established to assess two primary goals: (1) system interface resolution from Clarity to Soarian Financials, ensuring that the data being entered in Clarity is interfacing appropriately in Soarian Financials, and (2) identifying a Dialysis charging expert/resource who is versed in clinical and CPT code regulations, tasked with overseeing Dialysis charging and billing. Work is underway amongst the two workgroups, and resolutions are expected in February.

Oversight, Research & Consultation

Ongoing

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

Licensing & Enrollment

New

Licensing Applications – Forms preparation and submission of licensing application to the California Department of Public Health (CDPH); ongoing communication and follow-up regarding status of pending applications.

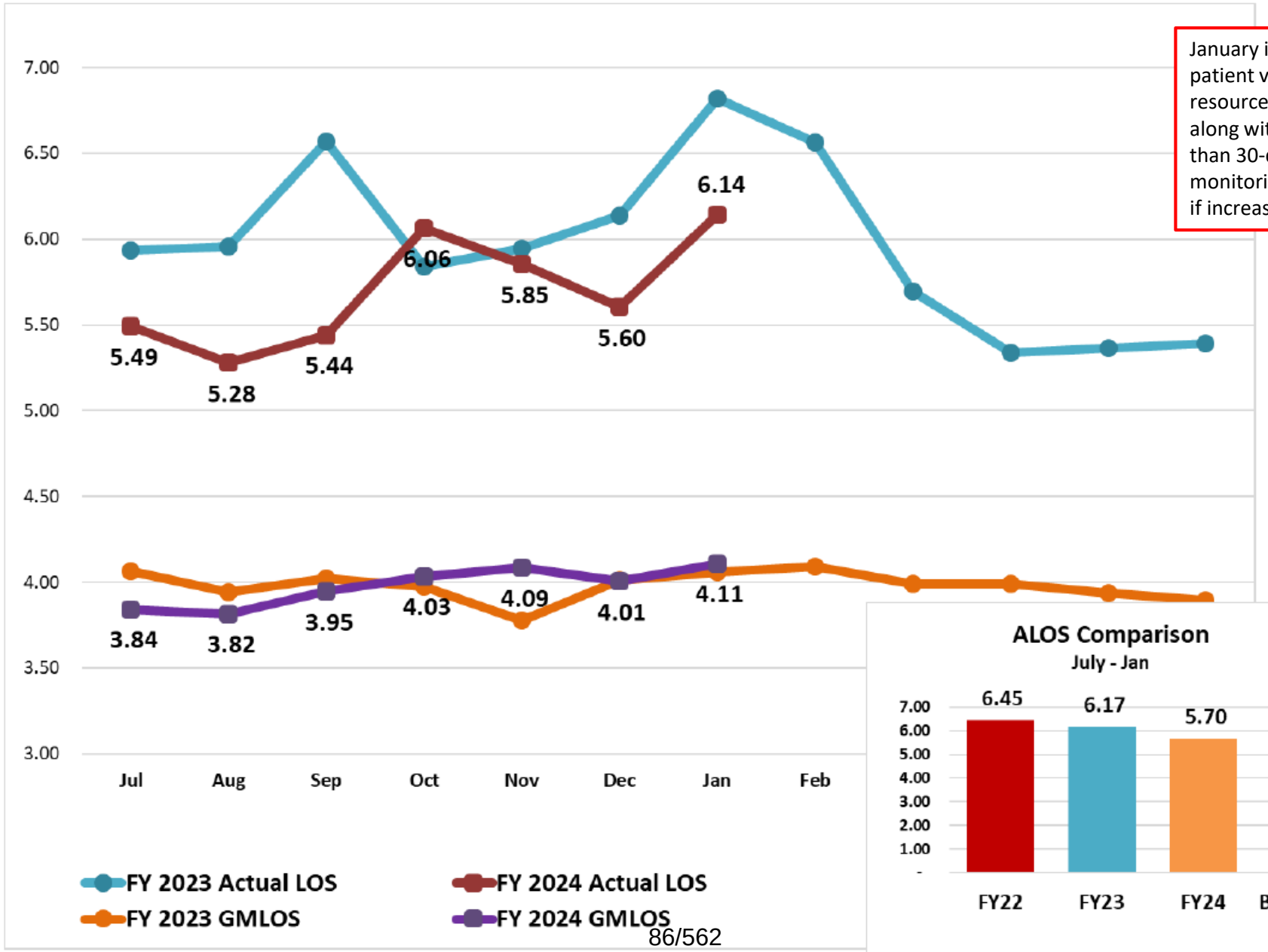
- *Change of Director of Nursing (DON) Skilled Nursing Akers & Court*
- *Lindsay Rural Health Clinic Revalidation*
- *Exeter Rural Health Clinic Revalidation*
- *Acute Rehabilitation Revalidation*
- *Specialty Clinic Infusion Expansion*

The pursuit of healthiness

Kaweah Health
MORE THAN MEDICINE. LIFE.

Throughput Board Update
February 2024

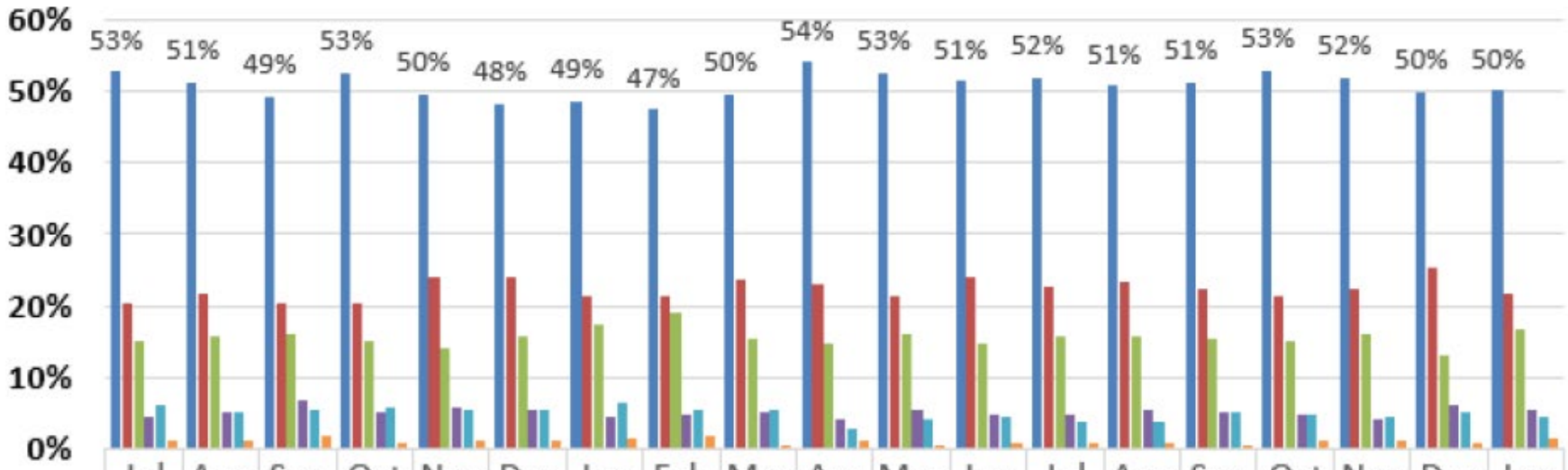
Average Length of Stay versus National Average (GMLOS)



January increase attributed to high patient volumes, high demand for resources and increased LOS by 2-6 days along with higher than normal greater than 30-day patient discharges. Team monitoring closely and will adjust efforts if increase turns into a trend.

Average Length of Stay Distribution

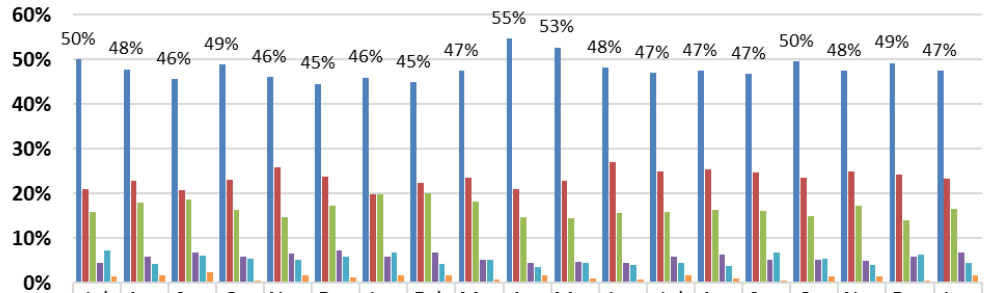
Overall



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
at GMLOS or Better	53%	51%	49%	53%	50%	48%	49%	47%	50%	54%	53%	51%	52%	51%	51%	53%	52%	50%	50%
1-2 days over GMLOS	20%	22%	20%	20%	24%	24%	21%	21%	24%	23%	21%	24%	23%	23%	22%	21%	22%	25%	22%
2-6 days over GMLOS	15%	16%	16%	15%	14%	16%	17%	19%	16%	15%	16%	15%	16%	16%	15%	15%	16%	13%	17%
6-10 days over GMLOS	5%	5%	7%	5%	6%	5%	5%	5%	5%	4%	6%	5%	5%	6%	5%	5%	4%	6%	5%
10-30 days over GMLOS	6%	5%	6%	6%	5%	6%	7%	5%	6%	3%	4%	5%	4%	4%	5%	5%	4%	5%	4%
30+ days over GMLOS	1.2%	1.2%	1.7%	1.0%	1.2%	1.1%	1.6%	1.9%	0.5%	1.2%	0.5%	0.8%	0.9%	0.8%	0.6%	1.2%	1.2%	0.7%	1.6%

LOS Distribution

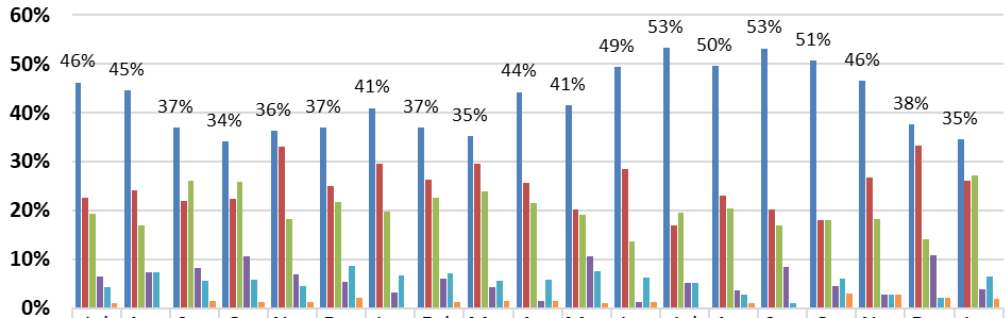
FY24 Hospitalist LOS Distribution



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
at GMLOS or Better	50%	48%	46%	49%	46%	45%	46%	45%	47%	55%	53%	48%	47%	47%	47%	50%	48%	49%	47%
1-2 days over GMLOS	21%	23%	21%	23%	26%	24%	20%	22%	23%	21%	23%	27%	25%	25%	25%	24%	25%	24%	23%
2-6 days over GMLOS	16%	18%	19%	16%	15%	17%	20%	20%	18%	15%	15%	16%	16%	16%	16%	15%	17%	14%	17%
6-10 days over GMLOS	5%	6%	7%	6%	7%	7%	6%	7%	5%	4%	5%	4%	6%	6%	5%	5%	5%	6%	7%
10-30 days over GMLOS	7%	4%	6%	5%	5%	6%	7%	4%	5%	3%	4%	4%	4%	4%	7%	5%	4%	6%	4%
30+ days over GMLOS	1%	2%	2%	0%	2%	1%	2%	2%	1%	2%	1%	1%	2%	1%	1%	1%	1%	1%	2%

Valley Hospitalists and Family Health Care Network providers focusing on goal of 50% or more of patients being discharged on or before the GMLOS to increase bed capacity for new admissions.
Teams are collaborating with tests and treatment group and observation group to streamline care and decision making.
Plan to add group specific data to monthly report reflective of surgical group, Humana group and county providers group. Expand collaboration with more medical staff focused on goals with patient length of stay.

FY24 FHCN LOS Distribution



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
at GMLOS or Better	46%	45%	37%	34%	36%	37%	41%	37%	35%	44%	41%	49%	53%	50%	53%	51%	46%	38%	35%
1-2 days over GMLOS	23%	24%	22%	22%	33%	25%	30%	26%	30%	26%	20%	28%	17%	23%	20%	18%	27%	33%	26%
2-6 days over GMLOS	19%	17%	26%	26%	18%	22%	20%	23%	24%	21%	19%	14%	19%	20%	17%	18%	18%	14%	27%
6-10 days over GMLOS	6%	7%	8%	11%	7%	5%	3%	6%	4%	1%	11%	1%	5%	4%	9%	4%	3%	11%	4%
10-30 days over GMLOS	4%	7%	5%	6%	5%	9%	7%	7%	6%	6%	7%	6%	5%	3%	1%	6%	3%	2%	7%
30+ days over GMLOS	1%	0%	1%	1%	1%	2%	0%	1%	1%	1%	1%	1%	0%	1%	0%	3%	3%	2%	2%

Performance Scorecard

Leading Performance Metrics – Inpatient & Observation

Metric	Patient Type	Definition	Goal	Baseline**	Discharge Date 9/1/2023 to 1/31/2024				
					Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024
Observation Average Length of Stay (Obs ALOS) *(Lower is better)**	**Overall**	Average length of stay (hours) for observation patients	**36**	**45.04**	**48.79**	**43.89**	**44.24**	**43.63**	**49.26**
					Sep 2023	**Oct 2023**	**Nov 2023**	**Dec 2023**	**Jan 2024**
Inpatient Average Length of Stay (IP ALOS) *(Lower is better)**	**Overall**	Average length of stay (days) for inpatient discharges	**5.64**	**5.81**	**5.51**	**6.08**	**5.98**	**5.75**	**6.20**
					Sep 2023	**Oct 2023**	**Nov 2023**	**Dec 2023**	**Jan 2024**
Inpatient Observed-to-Expected Length of Stay *(Lower is better)***	**Overall**	Observed LOS / geometric mean length of stay for inpatient discharges	**1.32**	**1.48**	**1.45**	**1.58**	**1.48**	**1.43**	**1.53**
					Sep 2023	**Oct 2023**	**Nov 2023**	**Dec 2023**	**Jan 2024**
Discharges*	Inpatient	Count of inpatient discharges	**N/A**	**1,274**	**1,196**	**1,244**	**1,227**	**1,264**	**1,431**
	Observation	Count of observation discharges	**N/A**	**434**	**431**	**427**	**440**	**462**	**375**
	Overall	Count of inpatient and observation discharges	**N/A**	**1,708**	**1,627**	**1,671**	**1,667**	**1,726**	**1,806**

***All metrics above exclude Mother/Baby, Behavioral Health, and Pediatrics encounter data**

***O/E LOS to be updated to include cases with missing DRG when available**

**Baseline calculation: Previous 6-month rolling median or average based on the metric's calculation

Performance Scorecard

Leading Performance Metrics – Emergency Department

Metric	Patient Type	Definition	Goal	Baseline**	Check In Date and Time: 9/1/2023 12:00:00 AM to 1/31/2024 11:59:59 PM				
					Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024
ED Boarding Time *(Lower is better)**	Inpatient	Median time (minutes) for admission order written to check out for admitted patients	**150**	**222**	**184**	**165**	**188**	**309**	**585**
	Observation	Median time (minutes) for admission order written to check out for observation patients	**150**	**278**	**256**	**147**	**313**	**405**	**661**
	Overall	Median time (minutes) for admission order written to check out for inpatient and observation patients	**150**	**223**	**185**	**165**	**190**	**315**	**588**
					Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024
ED Admit Hold Volume *(Lower is better)**	**Overall >4 Hours**	Count of patients (volume) with ED boarding time ≥ 4 hours	**N/A**	**480**	**351**	**307**	**393**	**631**	**899**
					Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024
ED Length of Stay (ED LOS) *(Lower is better)**	Discharged	Median ED length of stay (minutes) for discharged patients	**214**	**300**	**298**	**285**	**295**	**312**	**315**
	Inpatient	Median ED length of stay (minutes) for admitted patients	**500**	**654**	**590**	**558**	**567**	**762**	**1,120**
	Observation	Median ED length of stay (minutes) for observation patients	**500**	**624**	**569**	**548**	**572**	**715**	**1,124**
	Overall	Median ED length of stay (minutes) for admitted and discharged patients	**N/A**	**357**	**352**	**334**	**354**	**369**	**392**
					Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024
ED Visits*	Discharged	Count of ED visits for discharged patients	**N/A**	**5,141**	**5,033**	**5,010**	**4,843**	**5,390**	**5,125**
	Inpatient	Count of ED Visits for admitted patients	**N/A**	**1,154**	**1,073**	**1,089**	**1,126**	**1,168**	**1,313**
	Observation	Count of ED Visits for observation patients	**N/A**	**442**	**450**	**415**	**469**	**456**	**401**
	Overall	Count of ED visits	**N/A**	**6,737**	**6,556**	**6,514**	**6,438**	**7,014**	**6,839**

Strong throughput progress for ED – with high volumes in December and January – did not experience significant increase in discharged LOS.

***All metrics above exclude Mother/Baby, Behavioral Health, and Pediatrics encounter data.**

**Baseline calculation: Previous 6-month rolling median or average based on the metric's calculation

Discharges Before Noon

Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024
12.8%	13.8%	11.0%	12.4%	11.4%	11.3%	12.8%	11.5%	10.5%	11.9%	12.7%	12.2%	12.4%

Discharges Before Noon by Nurse Unit

Month of Discharge Date

% of Total Count of Mig.. 2.7% – 14.0%

Unit Group	Loc Nurse Unit	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Med/Surg	KHMC 1E Emergency Room ..	22.7%	37.5%	35.7%		25.0%	25.0%	25.0%	57.1%	50.0%		50.0%	57.1%	31.4%
	KHMC 2N Medical Surgical	14.5%	11.4%	8.2%	13.7%	12.4%	12.4%	16.7%	7.1%	10.2%	11.9%	13.8%	14.2%	8.1%
	KHMC 2S Medical Surgical	5.7%	9.4%	12.2%	13.0%	17.9%	19.7%	12.8%	12.1%	6.5%	14.1%	11.3%	8.5%	6.0%
	KHMC 3N Medical Surgical	11.7%	16.3%	11.3%	11.3%	12.2%	10.1%	17.0%	17.0%	12.2%	12.9%	16.7%	7.7%	17.9%
	KHMC 3S Medical Surgical	12.7%	11.6%	8.7%	12.0%	15.2%	12.3%	10.3%	14.6%	10.3%	10.6%	8.6%	15.2%	14.0%
	KHMC 4N Medical Surgical	7.4%	6.7%	9.8%	4.5%	5.0%	5.1%	7.5%	5.7%	4.6%	11.5%	9.9%	9.8%	7.9%
	KHMC 4S Medical Surgical	14.4%	17.9%	9.2%	6.8%	6.8%	6.4%	9.7%	8.9%	8.1%	6.5%	6.5%	8.3%	12.6%
	KHMC 14 Medical Surgical	7.6%	8.6%	8.6%	8.3%	2.7%	3.3%	4.7%	6.5%	11.2%	7.1%	6.7%	9.6%	6.3%
	KHMC BP Broderick Pavilion	21.7%	14.8%	18.6%	23.5%	14.6%	21.5%	15.5%	20.8%	14.7%	17.0%	25.6%	19.1%	18.7%
	KHMC PE Pediatrics			11.1%										
ICU	KHMC 3W ICCU	20.0%	45.5%	21.2%	35.3%	28.6%	24.0%	13.3%	19.0%	13.0%	21.1%	29.2%	19.4%	11.4%
	KHMC 15 ICCU	10.7%	8.8%	8.6%	22.2%	18.3%	13.3%	17.9%	3.4%	11.9%	13.0%	15.0%	8.6%	12.3%
	KHMC CV Intensive Care	13.5%	14.8%	12.5%	28.6%	29.4%	7.1%	23.5%	35.3%	15.4%	21.4%	25.8%	15.8%	7.3%
	KHMC IC Intensive Care	18.2%	23.3%	29.0%	23.5%	21.1%	37.5%	31.3%	6.7%	21.7%	27.3%	25.0%	13.6%	16.2%

Discharge lounge staffing – setting up a role in the lounge for a CNA who can help with patient care type work while patients are waiting. This will help increase number of patients before noon who can be moved to the discharge lounge and increase available beds before noon.

Discharges Before Noon by Nurse Unit Calendar Year

Discharge Date

% of Total Count of Mig.. 6.0% – 14.0%

Unit Group	Loc Nurse Unit	2023	2024
Med/Surg	KHMC 1E Emergency Room Overflow	34.0%	31.4%
	KHMC 2N Medical Surgical	12.2%	8.1%
	KHMC 2S Medical Surgical	12.3%	6.0%
	KHMC 3N Medical Surgical	13.1%	17.9%
	KHMC 3S Medical Surgical	11.9%	14.0%
	KHMC 4N Medical Surgical	7.3%	7.9%
	KHMC 4S Medical Surgical	9.0%	12.6%
	KHMC 14 Medical Surgical	7.0%	6.3%
	KHMC BP Broderick Pavilion	19.1%	18.7%
	KHMC PE Pediatrics	11.1%	
ICU	KHMC 3W ICCU	24.0%	11.4%
	KHMC 15 ICCU	12.4%	12.3%
	KHMC CV Intensive Care	19.0%	7.3%
	KHMC IC Intensive Care	23.6%	16.2%

Discharges Before Noon by Month

Discharge Date

% of Total Count of Mig.. 10.0% – 14.0%

Month of Discharge D..	2023	2024
January	12.5%	12.1%
February	13.4%	
March	11.1%	
April	12.0%	
May	11.3%	
June	11.1%	
July	12.5%	
August	11.3%	
September	10.4%	
October	11.6%	
November	12.7%	
December	12.1%	

Discharges Before Noon by Calendar Year

Discharge Date

% of Total Count of Mig.. 11.5% – 14.0%

Year of Discharge Date	2023	2024
2023	11.8%	
2024		12.1%

Patient Throughput Updates – February 2024

Update	Next Steps
Patient Progression: Compiled list of barriers for discharge and reviewed to initiate new projects to eliminate barriers to discharge of patients. Discharge Lounge open and successfully taking patients. Increasing each month with patient bed hours saved. Discharge nurse is also very successful. 13-18 patients discharged per day and 4-6 pts discharged by noon just through her efforts.	Patient Progression: Increase ownership and role of the case manager in the patient progression. Collaborate with medical staff/attending physicians on earlier decision making around discharge plans. Ensure discharge medical equipment ordering underway as soon as identified as a need – Case Management. Working with the team to identify LOS barriers and will start working through workflow for those areas. Throughput Supervisors working on staff orientation education. Will roll out in ongoing orientation as well as in staff meetings routinely Working with radiology leaders on procedures workflow to streamline weekend resource use for IR procedures
ED to Inpatient Admission Process: HealtheAnalytics data availability – Cerner developed access to the data, dashboard complete, validating data and creating access for leaders. ED and Throughput leaders will analyze and monitor data for gaps in the process from admit order to physical placement in inpatient bed.	ED to Inpatient Admission Process: Create subgroup to determine order sets and track the long-term patients that are "holding " in the ED for mental health or SNF placement or social admits Identify and action plan opportunities – data review pending.
Transfer Center Operations: Repatriation of patients back to sending facility complete. Routine return of patients to Kaweah after transfer to higher level of care achieved. Developed routine script and delivered education to eliminate variability in transfer decision making. Completed negotiation transport rate with ambulance company for returns from Bay area health center partners.	Transfer Center Operations: Moving this project to monitor phase. Transfer center operations stable, will evaluate opportunities for increased external transfer into facility as bed capacity/availability stabilizes.
Observation Program: Dashboard for observation patients in HealtheAnalytics completed Slight increase LOS from prior months, one pt with a 78 day stay impacted the overall numbers Powerplans live for diagnosis specific order sets	Observation Program: Working on cohorting observations patients on 2S, dashboard will track patient location by unit Managed Care team (Kim) working on blanket pre-authorization process for Humana and other plans managed by Key Medical for observation pts Follow up with PT, recommendations for SNF vs HH due to patients not meeting criteria for SNF placement due to not having an inpatient 3 day stay Outpatient Procedure process implementation Review Observation Dashboard and share with key stakeholders Working to enforce and encourage use of diagnosis specific order sets with medical staff
Tests and Treatments: • Identified focus areas for study - Blood Use, Biofire Use, CT and MRI in the ED and Therapy orders for Observation patients • Launched Blood Utilization Committee with New Participants • Launched New Observation Order Set that should impact use of tests and treatments in identified focus areas • Developed Observation Dashboard that can be leveraged for use with this workgroup	Tests and Treatments: • Request updates to the Observation dashboard to provide more detailed data in the specific focus areas. Determine if a separate Tests and Treatments Dashboard needs to be developed to encompass entire hospital • Identify goals related to reduction of tests and treatments in the identified focus areas.

Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

Policy Number: AP29	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Patient Care Forms – New and Revisions to Existing	

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

POLICY:
All patient care forms shall be approved by the Documentation Standardization Committee (DSC) before printing and inclusion in the Medical Record. Patient Care forms requiring a physician's signature require Health Information Management (HIM) Committee approval.

PROCEDURE:

I. All hospital personnel requesting a new or revised form shall complete the "Request for New or Revised Form" (attached), ensure form design meets form standardization rules, and obtain necessary approval prior to submission of request to the DSC. For urgent or minor changes, ~~the Director of HIM or~~ DSC Chair ~~the Chief Nursing Officer.~~ can authorize a form between Document Standardization meetings. The form can then be presented by the ~~Director~~ form owner or his or her agent at the next DSC meeting.

A. Complete "Request for New or Revised Form" and attach a sample form designed according to standardization rules. Include original for comparison when submitting revision.
B. Obtain Department Head and/or physician's approval on the request and forward these to the ~~Forms Coordinator (Executive Assistant to the CIO).~~ HIM Data Analysts (HIMDataAnalyst@kaweahhealth.org).
C. Completed requests for new or revised forms shall be processed within sixty (60) days.

II. Upon receipt of completed "Request for New or Revised Form" the HIM Data Analysts shall add the form to the next agenda packet and schedule the requestor to attend the next DSC meeting. ~~Forms Coordinator~~ DSC Chair ~~shall coordinate the preliminary review process~~. ~~The~~ The form requester will present forms at the DSC meeting.

~~A. Upon receipt of the request, the Forms Coordinator DSC Chair shall log the request and complete preliminary review process.~~
~~B. Schedule the requester to bring new or revised form to the DSC for approval.~~

III. The DSC shall be responsible for ensuring that all new or revised form requests do not duplicate existing forms. All forms will be designed to conform to the forms standardization rules.

A. When appropriate the ~~Optical Imaging Coordinator~~ DSC Chair will research the master file to identify similar forms. If similar forms exist, then notify requester to:

1. determine if requester can use existing form; or,
2. request that requester explain and justify needed changes.

3. determine if changes are significant enough to warrant a new form or whether they can be made to an existing form.

IV. Whenever possible, patient care forms shall be "piloted" prior to submission before the final approval process.

A. A~~n~~ DSC member may assist in form development and provide "pilot" forms for use.
B. DSC member provided forms should be used for a minimum of thirty (30) days without revision or correction.
C. Revision and/or correction shall be made prior to finalizing document.
D. No "pilot" form will be used for a period exceeding six (6) months.

V. Final Approval

~~A. DSC shall complete the approval process then forward the patient care form to the HIM Committee for final approval. Only those patient care forms requiring a physician's signature go on to HIM Committee for approval.~~

~~1.~~A. DSC shall return forms not approved to the requester with reason for non-approval. Form standardization rules will be attached as appropriate.
B. Approved forms will receive bar code assignment.
~~2.~~C. Approved forms will be provided to the appropriate individual for printing and distribution as needed.
~~3.~~ Method of printing and/or online location will be determined by the committee.
D. Patient Care forms requiring a physician's signature will be placed on HIM Committee agenda for approval.
a) The form will be reviewed by the HIM Committee within the established policy time frame of sixty (60) days.
b) A copy of the final version of the form will be sent to the Medical Executive Committee by HIM Data Analyst.
E. The form will be added to the eForms Master List once completed by ISS.

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B. If necessary the HIM Committee shall review the form at their monthly meeting within the established policy time frame of sixty (60) days.

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1. Forward the approved form to the appropriate individual for printing and distribution as needed.
2. Return non-approved forms to the requester with reason for non-approval.
3. A copy of the final version of the form will be sent to the Medical Executive Committee by the Forms Coordinator.

C. Optical Imaging CoordinatorDSC Chair will ensure printing and distribution of the new or revised form.

D. Optical Imaging CoordinatorDSC Chair to file copy final draft in Forms Binder or electronic Forms Library.

Form Standardization ~~Rules~~Guidelines

1. ~~All forms created for the district shall be labeled with KAWEAH DELTA HEALTH CARE DISTRICT in the header. *"A division of Kaweah Delta Health Care District"* in italics under the 'header line' is acceptable when more specific location identification is appropriate. When a form is used District wide, location specific names will not be permitted.~~

2. ~~Place the title of the form in the header, on the right. Translate into Spanish when translated.~~

3. ~~Leave a one inch high by two inch wide (1" x 2") space in the lower right hand corner for the form bar code and name.~~

4. ~~Allow a 1 3/4" high by 3 1/2" wide area in the lower left hand corner for patient identifiers (Patient name, MRN, Acct. #, DOB, physician, etc.) or patient label.~~

5. ~~Using a small font, center the title of the form in the footer between the areas left for the bar code and patient identification. *(This is for ease of identification while form is in patient's chart.)* Do not translate into Spanish.~~

6. ~~Place the date of revision (or creation) at the bottom, center of the page or just above the barcode.~~

7. ~~Design forms to eliminate any markings within 1/4" of the document edge.~~

8. ~~Do not use any type of shading.~~

9. ~~Allow 1/2" (one half inch) space at top of patient care forms for hole punch. The KDHCD title and the form title can be placed between the 1/4" and 1/2" area at the top of the form if necessary to fit the form on one page.~~

10. ~~Fold out forms shall be perforated on the fold lines with each page numbered in sequence and allow for patient identification and form identification on ALL separate sheets. The barcode only needs to be on the first page.~~

11. Place the barcode on the front, only, of a duplex (two-sided) form; even for English/Spanish duplex forms (English on one side; Spanish on the other).

12. All Medical Record/patient chart copies of NCR's need to be white.

13. All documentation requires lines for date, time, and signature of person documenting. All physician signatures require a date and time.

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The following guidelines will be used when formatting documents for use in the medical record. The business forms vendor and/or HIM is responsible for formatting and typesetting the document.

- All documents should be designed using one of the Documentation Standards Committee **Microsoft Word** templates.

- Form Identification:
  - KAWEAH DELTA HEALTH CARE DISTRICT must be located in upper left hand corner in the header of the document. The district logo will be placed in the header when space allows. If the form is intended to be used only in the hospital of the main campus, the Medical Center header will be used.
  - "A Division of Kaweah Delta Health Care District" in italics under the 'header line' is acceptable when more specific location identification is appropriate.
  - Form Name/Title: The name of the form must be located in two places on the form:
    - Upper right hand corner in the header of the document.
    - Centered in the footer of the document between the bar code and patient identification areas. This is for ease of identification of the form in the patient's chart while the patient is still in the facility.
  - Forms used District-wide should not have location specific names printed on the form.

- Margins:
  - Forms should be designed to eliminate any markings within ¼" of the document edge.
  - Generally a ½" side margin should be observed, if possible.
  - Allow 1.4" space at top of patient care forms for the margin, hole punch, and logo/title bar.
  - Standard forms: leave 1" at top for margin and logo/title bar.

- Footer: leave 1.25" at bottom of the page for margin/bar code and name, and patient identification (ID label). Patient name, MRN, Account Number, DOB, physician name or patient identification label will be placed here.

- Font Theme and Size:
  - For the ease of conversion into an electronic form, only the Helvetica font theme will be used.
  - Font size 14 will be used for the Authorization for Use or Disclosure of Health Information.
  - Font size 12 will be used for all material provided to patients, including consent forms and Condition of Admission (COA).
  - Font size 8 will be used for the title of the form in the footer of the document.

- Shading:
  - Do not use any type of shading when drafting form. Shading will be added when form is typeset.

- Form Number and Creation/Revision Date:
  - Located at the bottom, center of the page and/or just above the barcode.

- Multiple Page Forms:
  - A page number will be present at the footer of every page.
  - Barcode and patient identification will be placed on every page.
  - The header of the first page will contain the Kaweah Delta logo.
    - A simplified header will be placed for any subsequent pages.

- Multi-Part Forms
  - First page will be the original form in the color white.
  - Footer should state:
    - First page: Original – Medical Record
    - Additional pages should state appropriate distribution, i.e., Patient copy, Physician Office copy, etc.

- Fold out forms:
  - Will be perforated on the fold lines with each page numbered in sequence.
  - Barcode and patient identification will be placed on every page.
  - Page numbers will be placed on each sheet.

- Signature Lines:
  - Forms requiring signatures will have a standardized footer.
  - Physician: Signature/Date/Time
  - Consents/Authorizations: Signature/Date/Time
  - Patient Education Material: Signature/Date
  - Space for legal relationship to patient when the form is signed by someone other than the patient.

- Location for signatures will be standard for all forms and be located at the bottom of the document.

- Pages of forms that do not need to be scanned into the electronic medical record require the following statement in the footer:
  - "For reference only. Do not include this page in the medical record."

- Language Translation
  - Forms provided to patients will be offered in English and Spanish.
  - Spanish language forms will be translated by Interpreter Services.
  - A space for interpreter signature, printed name, or telephonic ID number will be added to all consent and education forms that require language translation.

- Reading Level
  - Forms intended for patients to read must be written at a 5th grade reading level.

REQUEST FOR NEW/REVISED FORM

Date of Request: _____/_____/_____

Form Title: _____

Requested by: _____ Phone: _____ e-mail: _____

Originated by (name of committee or person): _____

Department Head approval (signature): _____ Dept: _____

Physician's approval: _____

Name of person who will present this form at the Documentation Standardization Meeting: _____

Other Committees/Meetings that approved this form: _____

_____

Does this form contain the same information as an existing form(s)? ☐ Yes ☐ No

Is this form replacing the existing form (s)? ☐ Yes ☐ No

Name of form(s) being replaced: _____

_____

Does this form meet "Form Standardization Guidelines"? ☐ Yes ☐ No

(Contact a Documentation Standardization Committee member for a copy of the guidelines ext. 5018.)

Why is this form required? ☐ TJC ☐ CMS ☐ Other: _____

Will this form be filed in the patient's chart? ☐ Yes ☐ No

If yes, what barcode in EDM will this form be filed under? _____

How does this form feed into the electronic medical record? ☐ Cold drop ☐ Scanned

Will this form be given to the patient? ☐ Yes ☐ No

If yes, what is the reading level of the this form? _____
(It is recommended that patient forms be written at a 5th grade reading level)

Which Physicians/Departments use this information?
_____

Who will primarily record on this form?
_____

Can this form be utilized throughout the District? ☐ Yes ☐ No

Who is responsible for staff education regarding this form?
_____

Will form require translation in a language other than English? ☐ Yes ☐ No ☐ Other:
_____

Request the form to be printed by or made available through: ☐ CVBF ☐ E-Forms ☐ KDNet
☐ Other: _____

Approximate number of forms used per month (circle one): <25 25-100 101-250
251-500 >500

Comments:
_____
_____

_____ Barcode:
_____

Kaweah Delta Health Care District
400 W Mineral King ` Visalia CA 93291-6263 ` 559 624 2000

REQUEST FOR NEW/REVISED FORM

Date of Request: _____/_____/_____

Form Title: _____

Requested by : _____ Where you can be reached: _____

Originated by (name of committee or person): _____

Department Head approval (signature): _____ Dept: _____

Physician's approval: _____

Who will present this form at the Documentation Standardization Meeting? _____

Other Committees/Meetings that this form has been approved at: _____

_____

Does this form contain the same information as an existing form (s)? ☐ Yes ☐ No

Is this form replacing the existing form (s) ? ☐ Yes ☐ No

Name of form (s) being replaced: _____

_____

Does this form meet "Form Standardization Rules"? ☐ Yes ☐ No
(See a Committee Member for a copy of the rules.)

Why is this form required? ☐ JCAHO ☐ HCFA ☐ MEDICARE ☐ Other: _____

Will this form be filed in the patient's chart? ☐ Yes ☐ No

If yes, under what tab? _____

What tab in **IMNET** will this record be filed ? _____

Which Physicians/Departments use this information? _____

Who will primarily record on this form? _____

"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: AP123	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Malinda Tupper (Chief Financial Officer)	

Financial Assistance Program Full Charity and Partial Discount Programs

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

I. Purpose: Kaweah Delta Health Care District (Kaweah Health) serves all persons within its boundaries and the surrounding region. As a regional hospital provider, Kaweah Health is dedicated to providing high-quality, customer-oriented, and financially strong healthcare services that meet the needs of those we serve. Providing patients with opportunities for Financial Assistance for healthcare services is therefore an essential element of fulfilling the Kaweah Health mission. Kaweah Health is committed to providing access to Financial Assistance programs when patients are uninsured, underinsured, or may need help paying their hospital bill. These programs include government sponsored coverage programs, charity care, and partial charity care as defined herein. This policy defines the Kaweah Health Financial Assistance Program, its criteria, systems, and methods.

Kaweah Health, like all California acute care hospitals, must comply with Health & Safety Code Sections 127400 et seq., including requirements for written policies providing charity care to financially-qualified patients. Kaweah Health operates a non-profit hospital and, therefore, Kaweah Health must also comply with 26 U.S.C. § 501(r) and its implementation regulations, 26 C.F.R. § 1.501(r), et seq., including requirements related to billing and collections practices for financially-qualified patients. This policy is intended to meet such legal obligations and provides for charity care to patients who financially qualify under the terms and conditions of the Kaweah Health Financial Assistance Program.

Kaweah Health affirms and maintains its commitment to serve the community in a manner consistent with the philosophy of the Board of Directors. This philosophy emphasizes the provision of optimal health care services to aid all persons regardless of age, sex, race, creed, disability, national origin, sexual orientation, gender identity, or financial status. These beliefs have led Kaweah Health to develop a policy for providing charity care for the less fortunate.

II. Definitions:

A. Charity care is defined as health care services provided at no charge to patients who do not have or cannot obtain adequate financial resources or other means to pay for this care and who qualify for free care under the eligibility guidelines specified in this policy. Charity care is in contrast to bad debt, which is defined as a patient and/or guarantor who, having the requisite financial resources to pay for health care services, has demonstrated by his/her actions an unwillingness to comply with the obligation to resolve an account.

B. Partial Charity Care is defined as health care services provided at a reduced charge to patients who do not have adequate financial resources or other means to pay for this care and who qualify for discounted care under the eligibility guidelines specified in this policy, but do not qualify for free care.

C. Community Care Rate means the amount Kaweah Health would receive for services under its contract with Blue Cross.

D. Essential living expenses[1] means, for purposes of this policy, expenses for all of the following, as applicable to the patient's individual circumstances: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

E. Financially Qualified Patients are eligible for assistance under this policy for care covered by the policy without regard to whether the patient has applied for assistance under the policy[2] and includes any of the following:

i) Self-Pay Patients[3] are:

- Patients who do not have third party insurance, Medi-Cal, or Medicare, and who do not have a compensable injury for purposes of worker's compensation, automobile insurance, or other insurance as determined and documented by Kaweah Health.

[1] Cal. Health & Safety Code § 127400(i)
[2] 26 C.F.R. §§ 1-501(r)-1(b)(15)
[3] Cal. Health & Safety Code § 127400(f)

ii) <u>Under-insured Patients</u> include:

- Patients with high medical costs who have insurance or health coverage but have a remaining patient responsibility balance that they are unable to pay. Remaining patient responsibility balances include out-of-pocket costs, deductibles, and coinsurance that constitute high medical costs as defined below.
- Patients who are eligible for Medi-Cal, Medicare, California Children's Services and any other applicable state or local low-income programs who do not receive coverage or payment for all services or for the entire stay.
- Patients with third-party insurance whose benefits under insurance have been exhausted prior to admission or whose insurance has denied stays, denied days of care, or refused payment for medically necessary services.

iii) <u>High Medical Cost Patients</u>[4] are patients:

- Whose family income is at or below 400% of the Federal Poverty Guidelines;
- Who do not otherwise qualify for full charity care under this policy;
- Who have high medical costs as defined below.

F. <u>High medical costs</u>[5] are defined as out-of-pocket medical costs incurred by the patient that exceed 10 percent of the Patient's Family Income in the prior 12 months, or annual out-of-pocket medical expenses incurred in the prior twelve (12) months that exceed 10% of Patient's Family income.

G. <u>Patient's Family</u>[6] is defined as follows:

1. For persons 18 years of age and older, the family includes the patient's spouse, registered domestic partner, and dependent children under 21 years of age, whether living at home or not.

2. For patients under 18 years of age, the family includes the patient's parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

III. Policy and Procedures:

Kaweah Health recognizes that the need for charity is a sensitive and deeply personal issue for recipients. Confidentiality of information and individual dignity will be maintained for all who seek charitable services.

[4] Cal. Health & Safety Code § 127400(g)
[5] Cal. Health & Safety Code § 127400(g)(1) & (2)
[6] Cal. Health & Safety Code § 127400(h)

Training of staff and the selection of personnel who will implement these policies and procedures are guided by these values. Providing charity care (financial assistance) to low-income families along with other community benefit services is important evidence of Kaweah Health's mission fulfillment. It is imperative that the determination, reporting, and tracking of charity care are in concert with our not-for-profit mission and community obligation and in compliance with Assembly Bill No. 774, Assembly Bill 1020, Hospital Fair Pricing Policies and Senate Bill 1276 (Chapter 758, statutes or 2014) and applicable IRS laws and regulations.

Charity care will not be abridged on the basis of age, sex, race, creed, disability, national origin, sexual orientation, gender identity, or financial status.[7] Medically necessary available health care services, inpatient or outpatient, shall be available to all individuals under this policy. Confidentiality of information and individual dignity will be maintained for all that seek charitable services. The handling of personal health information will meet all HIPAA requirements.

Charity care will be based on income and family size as defined by Federal Poverty Income Guidelines and the attached sliding scales.[8] Kaweah Health will also actively assist an individual in pursuing alternate sources of payment from third parties. Those individuals or families who qualify for alternative programs and services within the community but refuse to take advantage of them will not be covered by this policy. These actions are intended to allow Kaweah Health to provide the maximum level of necessary charity services within the limits of respective resources.

Charity care provided by this policy are available for medically necessary care.[9] Charity is generally not available for non-medically necessary procedures. However, in certain cases an exception may be made. Exceptions require approval by administration. Specialized, high-cost services (i.e., experimental procedures, etc.) requiring charity care are also subject to the review of administration prior to the provision of service.

A. <u>Identification of Applicant</u>

Kaweah Health makes reasonable efforts to presumptively determine whether a patient is eligible for Financial Assistance based on prior eligibility for Financial Assistance or the use of third-party data to identify Financially Qualified Patients.[10]

[7] 42 U.S.C. § 18116; 45 C.F.R. §§ 92.1 *et seq.*
[8] Cal. Health & Safety Code §§ 127405(a)(1)(A), (b).
[9] 26 C.F.R. § 1-501(r)-4(b)(1)(i).
[10] 26 C.F.R. §§ 1-501(r)-1(b)(25); 1-501(r)-6(c)(2).

Any member of the medical staff, any employee, the patient or his/her family and any other responsible party may request charity care from Kaweah Health. Any member of the Patient Financial Services team, other hospital staff, or community advocates may identify possible charity recipients during any portion of the business cycle.

B. How to Apply

Patients may request an application for assistance in person from the Acequia Lobby at the corner of Floral and Acequia, 305 West Acequia Avenue in Visalia, California 93291, over the phone by calling Patient Financial Services at (559) 470-0016 or (559) 624-4200 option 5, or may obtain an application from Kaweah Health's website at kaweahdelta.org/documents/PDFs/FinancialAssistanceApp-[english].pdf. Documentation required to determine eligibility is included on the application. Kaweah Health does not require any documentation not listed on the application form.

The Kaweah Health standardized application form will be available in both English and Spanish, and any other language deemed necessary by the methods discussed in Section VIII, below, and shall be available in any Registration or Patient Accounting area, as well as on the Kaweah Health website.[11] For patients who speak a language other than English or Spanish, or who need other accessibility accommodations, Kaweah Health will provide appropriate accommodations, language assistance services, and application assistance free of charge.

C. Full Charity Care

A full write-off of all balances due from a patient, whether the patient is insured, underinsured or self-pay, shall be granted to those financially qualified patients whose family income is up to 200% of the most recent Federal Poverty Guidelines.

Kaweah Health presumes qualified for full charity care any patient who can provide proof that they are eligible for or in a public benefits program such as CalWORKS, CalFresh, SSI/SSP, Medicare Savings Program, WIC, or general assistance/general relief.

Patients who are covered by Medi-Cal are eligible for charity write-offs. This includes patients who have Medi-Cal with a Share of Cost. It also includes charges related to Medi-Cal denied stays or denied days of care, non-covered medically necessary Medi-Cal services received on a Medi-Cal remittance advice, or when otherwise required by law. Treatment Authorization Request (TAR) denials and any lack of payment

[11] 26 C.F.R. § 1-501(r)-4(b)(5)(i)(A).

for non-covered services provided to Medi-Cal patients are to be classified as charity.

D. Partial Charity Care:

Partial Charity Care will be granted to Financially Qualified Patients earning between 201% and 600% of the Federal Poverty Level based on the most recent Federal Poverty Guidelines.[12] For these patients, expected payment for services will be limited to the amount Kaweah Health would have received from Medicare or Medi-Cal, whichever is greater, and then adjusted by the percentages defined on the attached sliding scales.[13]

In determining what if any payment is due from a patient with insurance, the expected payment amount, defined as the amount equal to the Kaweah Health community rate, will be compared to the amount paid by their third-party insurance. If the amount paid by the third-party insurance is greater than the expected payment, no payment will be sought from the patient. If the expected payment is greater than the payment received from the third-party insurance, and the patient has a remaining patient responsibility amount, the difference in payment will be sought from the patient subject to a determination of eligibility for financial assistance.

E. Governmental Assistance

Kaweah Health makes all reasonable efforts to determine whether medical care would be either fully or partially paid for under other private or public health insurance. Consideration will be given to coverage offered through private health insurance, Medi-Cal, Medicare, California Children's Services, the California Health Benefit Exchange (Covered California), or other state- or county-funded programs designed to provide health coverage.[14]

Kaweah Health provides an application for the Medi-Cal program or other state- or county-funded health coverage programs to patients identified as being potentially eligible for Medi-Cal or any other third-party coverage. This application is provided prior to discharge if the patient has been admitted or to patients receiving emergency or outpatient care.[15]

If a patient applies or has a pending application or related appeal for another health coverage program, or for coverage under their health plan at the time an application for charity or discounted care is submitted, neither application shall

[12] Cal. Health & Safety Code § 127405(a)(1)(A).
[13] Cal. Health & Safety Code § 127405(d).
[14] Cal. Health & Safety Code § 127420(a).
[15] Cal. Health & Safety Code § 127420(b)(4).

preclude eligibility for the other program. Kaweah Health will hold any charity care eligibility determinations until the final disposition of the application or appeal of the health coverage program, if the patient makes a reasonable effort to communicate with Kaweah Health about the progress of any pending appeals.

IV. Eligibility Criteria:

A. General Guidelines:

1. Kaweah Health determines eligibility for financially qualified patients in accordance with this policy and applicable state and federal laws.

2. Kaweah Health will not defer, deny, or require payment before providing medically necessary care because of an individual's nonpayment of one or more bills for previously provided care covered under Kaweah Health's Financial Assistance Policy.[16]

3. Financially Qualified Patients, as defined above, or any patient who indicates the financial inability to pay a bill for a medically necessary service is screened for charity care.

4. Information obtained during the application process for financial assistance may not be used in the collection process, either by Kaweah Health, or by any collection agency engaged by Kaweah Health, except that such information, if independently obtained, may be used by Kaweah Health or any collection agency engaged by Kaweah Health independently of the eligibility process for charity care.[17]

5. A patient's status or claims with respect to worker's compensation, automobile insurance, or other insurance, including potential payments from pending litigation or third-party liens related to the incident of care, may be taken into consideration when evaluating the patient's eligibility for charity care or discount payments.

6. Emergency physicians providing emergency services in Kaweah Health are required to provide discounts to financially qualified patients whose family incomes are at or below 400 percent of the Federal Poverty Guidelines.[18] At the patient's request, Kaweah Health will advise patients to apply for charity care to the physician's billing company upon the patient's receipt of a bill for services from that billing company. This statement shall not be construed to impose any additional responsibilities upon Kaweah Health.

B. Eligibility Guidelines

The following factors are used in the determination of financially qualified recipients and the amount of charity extended.

[16] 26 C.F.R. § 1.501(r)-6(b)(1)(iii).
[17] Cal. Health & Safety Code § 127405(e)(3).
[18] Cal. Health & Safety Code § 127452(a)

1. Patient Income

The Federal Poverty Guidelines as established by Health and Human Services will be used to determine annual income guidelines and limits.[19]

To determine the patient's eligibility for financial assistance, Kaweah Health considers the patient's family size and family income. Kaweah Health considers annual family earnings and cash benefits from all sources before taxes, less payments made for alimony and child support.

Earnings for the purposes of determining eligibility will be based on the lower of either the patient's projected annual family income or the patient's family current income level at the time of application for financial assistance.[20]

The applicant may be asked to provide acceptable income verification, such as recent payroll stubs, tax returns, or other items or verification.[21] If the patient is unemployed or does not receive payroll stubs, a written statement of need must be provided by the patient or the patient's representative attesting to their income and employment status as part of their financial assistance application.

2. Patient Assets

Only certain assets and resources may be considered when determining eligibility for charity care. Retirement or deferred compensation plans qualified under the Internal Revenue Code, or nonqualified deferred compensation plans will not be considered as available resources to pay Kaweah Health bills.[22] Furthermore, the first ten thousand dollars ($10,000) of a patient's monetary assets shall not be counted in determining eligibility, nor shall 50 percent of a patient's monetary assets over the first ten thousand dollars ($10,000) be counted in determining eligibility.[23]

3. Other Sources of Payment for Services Rendered

The appropriate amount of charity care is determined in relation to the amounts due after applying all other sources of payment. Kaweah Health provides applications for other sources of payment, such as Medi-Cal, if requested by the patient, or if the patient does not indicate coverage by a third-party payor or requests a discounted price or charity care.[24]

[19] Cal. Health & Safety Code § 127405(b).
[20] *C.f.* Cal. Welf. & Inst. Code § 14005.65.
[21] Cal. Health & Safety Code § 127405(e)(1).
[22] Cal. Health & Safety Code §§ 127405(c), (e)(2)
[23] Cal. Health & Safety Code § 127405(c).
[24] Cal. Health & Safety Code § 127420(b)(4).

C. Patients without Housing

Patients without a residence, source of family income, and mailing address will be classified as charity care eligible. Consideration for charity care must also given to emergency department patients who do not provide adequate information as to their financial status. In many instances, these patients are homeless and have few resources to cover the cost of care.

D. Special Circumstances

Charity care may be granted in special circumstances to those who would not otherwise qualify for assistance under this policy. Kaweah Health will document why the decision was made and why the patient did not meet the regular criteria. Special circumstances may include:

(1) Deceased patients without an estate or third-party coverage.

(2) Patients who are in bankruptcy or recently completed bankruptcy.

(3) On rare occasions, a patient's individual circumstances may be such that while they do not meet the regular charity care criteria in this policy, they do not have the ability to pay their Kaweah Health bill. In these situations, with the approval of management (see subsection VII, below), part or all of their cost of care may be written off as charity care.

V. Timelines

A. Eligibility Period

Eligibility for charity care may be determined at any time Kaweah Health is in receipt of information regarding a patient's family income and financial situation.[25] While it is preferred that such patients be screened upon admission, they may be screened at any time, including throughout any third-party collections process.

Once granted charity care, services the patient receives in the 6-month period following that approval will also remain eligible for such charity care. However, if over the course of that 6-month period the patient's family income or insurance status changes to such an extent that the patient may be ineligible for free or discounted care, the patient has an obligation to report those changes to Kaweah Health. Such subsequent services would require a new charity care application. Any patient may be required to re-apply for charity care after their 6-month eligibility period has expired. Nothing shall limit the number of times a person may request charity care or discounted payments.

[25] Cal. Health & Safety Code § 127405(e)(4).

B. Time Requirements for Charity Care Eligibility Determination

Every effort is made to determine a patient's eligibility for charity care as soon as possible. While it is desirable to determine the amount of charity care for which the patient is eligible as close to the time of service as possible, there is no limit on the time when an application or the eligibility determination is made. A determination will be postponed while insurance or other sources of payment are still pending.

The timeframe to make a decision on an application will be extended if the patient has a pending appeal for coverage of the services, until a final determination of that appeal is made.[26] The patient shall make a reasonable effort to communicate with Kaweah Health about the progress of any pending appeals.

For purposes of this section, "pending appeal" includes any of the following:[27]

(1) A grievance or appeal against a health plan;
(2) An independent medical review;
(3) A fair hearing for a review of Medi-Cal eligibility or claims; or
(4) An appeal regarding Medicare coverage consistent with federal law and regulations.

The timeframe to make a decision on an application may also be extended if a patient is attempting to qualify for coverage under any third-party insurance, Medi-Cal, or Medicare, or if the patient has a pending claim with respect to workers' compensation, automobile insurance, or other insurance, including potential payments from pending litigation or third-party liens related to the incident of care.

In some cases, a patient eligible for charity care may not have been identified prior to initiating external collection action. Accordingly, Kaweah Health requires its collection agencies to comply fully with all pertinent state and federal laws and regulations, with this policy on charity care, and with Kaweah Health's Credit and Collection Policy.[28] This will allow the agency to report amounts that they have determined to be uncollectible due to the inability to pay in accordance with Kaweah Health's charity care eligibility guidelines.

VI. Partial Charity Care Discount Payment Plans

Kaweah Health will make available reasonable, no-interest payment plans for patients qualifying for Partial Charity Care under this policy.[29] The plan will be individually negotiated between the patient and Kaweah

[26] Cal. Health & Safety Code § 127426(a).
[27] Cal. Health & Safety Code § 127426(c).
[28] Cal. Health & Safety Code § 127425(b).
[29] Cal. Health & Safety Code § 127425(i).

Health based on the rates outlined in Section III.D. ("Partial Charity Care"), above.[30] A reasonable payment plan means monthly payments cannot exceed more than ten percent of a patient's family income for a month after deductions for essential living expenses, as defined in Section II above[31].

In the event a Financially Qualified Patient still has a remaining balance after payment has been received from third-party payers and an application for financial assistance has been processed, expected payment for services will be based on the attached sliding scales.

Any patient who inquires about a payment plan for an outstanding balance who has not already applied for assistance will be informed of the availability of financial assistance and screened for eligibility under this policy.

If a patient defaults in making regular payments, Kaweah Health makes reasonable efforts to contact the patient by phone and in writing, giving notice that the extended payment plan may become inoperative.[32] An attempt at renegotiating the payment plan will be done at the request of the patient or their guarantor. Kaweah Health initiates collection efforts only after reasonable efforts to contact the patient have failed and after 90 days of non-payment. Kaweah Health does not report adverse information to a credit-reporting bureau until the extended payment plan has been declared inoperative.

VII. Patient Finance Processes

E. Who can grant Charity Care Eligibility

Kaweah Health provides personnel who have been trained to review Financial Assistance applications for completeness and accuracy. Application reviews are completed as quickly as possible considering the patient's need for a timely response.

A Financial Assistance determination will be made only by approved Kaweah Health personnel according to the following levels of authority:

- Account Specialist, Patient Financial Services: Accounts less than $5,000
- Supervisor, Patient Financial Services: Accounts less than $25,000
- Manager, Patient Financial Services: Accounts less than $50,000
- Director of Patent Financial Services: Accounts less than $100,000

[30] Cal. Health & Safety Code § 127405(b).
[31] Cal. Health & Safety Code § 127400(i).
[32] Cal. Health & Safety Code § 127425(i).

- Chief Financial Officer: Accounts greater than $100,000

B. Review of Decision

Once a determination has been made, a notification letter will be sent to each applicant advising them of Kaweah Health's decision.

In the event of a dispute prior to an eligibility determination, a patient may seek review from the Patient Accounting Supervisor, Revenue Cycle Manager or Director of Revenue Cycle.[33]

If a patient's application for assistance is denied, the patient has the right to an appeal and review of that decision. A patient may request further review by contacting the Patient Accounting Department. The patient shall include with the appeal an explanation of the dispute and rationale for reconsideration. The patient shall also include any additional relevant documentation to support the patient's appeal.

The review process shall consist of these level of management:

1. First Level: Revenue Cycle Manager
2. Second Level: Director of Revenue Cycle

C. External Collections

Accounts will not be sent to a collection agency if the patient is in the process of applying for charity care or discounted payment. If the patient does not comply with requests for information or refuses to provide Kaweah Health with information, the account can be sent for collections no sooner than 180 days after initial billing. Prior to sending the account to collections, a notice must be provided to the patient as specified in the Kaweah Health Credit and Collection Policy.

Kaweah Health will only send patient accounts to a collection agency when the collection agency agrees to adhere to all state and federal laws pertaining to fair collection of debt, as well as to those pertaining to charity and discount care.[34] That includes the Kaweah Health Financial Assistance Policy, the Kaweah Health Credit and Collection Policy, the California Hospital Fair Pricing Act, the Rosenthal Fair Debt Collection Practices Act, the federal Fair Debt Collection Practices Act, and the tax regulations at 26 C.F.R. §§ 1.501®-1, et seq.

An account that has been placed with an outside collection agency can be considered for charity care at any time in accordance with Kaweah Health's charity care policy. When, during the collection process, a patient asserts they cannot afford to pay the debt, has failed to make

[33] Cal. Health & Safety Code § 127405(a)(1)(A).
[34] 26 C.F.R. § 1-501(r)-6(c)(10).

previously agreed upon extended payments, or is otherwise identified by the collection agency as meeting Kaweah Health's charity care eligibility criteria, the collection agency will refer the account to Kaweah Health to screen for charity care eligibility. Kaweah Health will undertake reasonable efforts to gather eligibility information from the patient. If, after such reasonable efforts, the patient fails or refuses to provide required information, the account will be referred back to the collection agency.

If a patient is approved for Financial Assistance under this policy, Kaweah Health and any collection agencies acting on its behalf shall assess the patient's financial status over the previous 8 months to determine eligibility for charity care. Kaweah Health will reimburse financially qualified patients for the amount actually paid, if any, in excess of the amount due for debt related to care received from Kaweah Health. Any payments made during the previous 8 months when the patient would have been financially eligible for full charity care shall be considered paymen“s "in excess of the amount d”e," and shall be reimbursed. If the patient is eligible for partial charity care, any outstanding balance the patient owes will be reduced according to the sliding scale terms of partial charity care. Any payments the patient made while eligible for partial charity care will be reassessed using the same sliding scale amount; any amount the patient paid in excess of the partial charity care amount due in that month shall be reimbursed. Payments made for debt related to care received from Kaweah Health at a time when the patient was not eligible for Financial Assistance shall not be reimbursed.

Kaweah Health and any collection agencies acting on its behalf shall take all reasonably available measures to reverse any extraordinary collection actions taken against the individual for debt that was 1) incurred for care received from Kaweah Health during the previous 8 months; and 2) incurred at any time at which the patient was eligible for Financial Assistance under this policy. These reasonably available measures include but are not limited to vacating any judgment, lifting any levy or lien on the patient's property, and removing any adverse information reported to any consumer reporting agency from the individual's credit report.

For further information regarding Kaweah Health's internal and external collections policies and practices, including information about actions that may be taken to obtain payment before and after referral to external collections, when and under whose authority patient debt is advanced for collection, policies and practices for the collection of debt, timelines for reporting debt to consumer credit reporting agencies, and the rights and

responsibilities of patients, Kaweah Health and external collection agencies retained by Kaweah Health, see the Kaweah Health Credit and Collection Policy.

D. Recordkeeping

Kaweah Health keeps records for 10 years relating to potential charity care patients that are readily obtainable.

E. Application of Policy

This policy only applies to charges or services provided by Kaweah Health and included in a bill from Kaweah Health for such services. Charity care and discounted payment options may or may not be available through non-employed physician groups. At the patient's request, Kaweah Health will advise patients to apply for charity care to the physician's billing company upon the patient's receipt of a bill for services from that billing company.

VIII. Public Notice and Posting

Kaweah Health widely publicizes this policy in a manner that is reasonably calculated to reach, notify and inform those patients in our communities who are most likely to require financial assistance.[35]

Kaweah Health accommodates all significant populations that have limited English proficiency (LEP)[36] by translating this policy, the application form, and the plain language summary[37] of this policy into the primary language(s) spoken by each LEP language group that constitutes the lesser of 1,000 individuals or five percent of the community served by Kaweah Health, or the population likely to be affected or encountered by Kaweah Health. Kaweah Health will make further efforts to publicize this policy in languages other than English as appropriate and consistent with requirements under the law.[38]

Public notice of the availability of assistance through this policy shall be made through the following means:

Availability of Policy and Application

1. Kaweah Health makes this policy, applications for assistance, and the plain language summary of this policy, as well as other important information about the availability of financial assistance, widely available on the Kaweah Health website.

[35] 26 C.F.R. §§ 1-501(r)-4(b)(5) - (b)(6).
[36] 26 C.F.R. § 1-501(r)-4(b)(5)(i)(D)(3)(ii).
[37] 26 C.F.R. § 1-501(r)-1(b)(24).
[38] Cal. Health & Safety Code § 127410(a).

2. Kaweah Health makes paper copies of this policy, the application for assistance under this policy, and the plain language summary of the policy available upon request and without charge, both by mail and in public locations in the hospital facility, including, at a minimum, in the emergency department, admissions areas, and billing department.

Posted Notices[39]

1. Kaweah Health posts notices in a visible manner in locations where there is a high volume of inpatient or outpatient admitting/registration, such as the emergency department, billing office, admitting office, and hospital outpatient service settings.

2. Posted notices are in English and Spanish and in a manner consistent with all applicable federal and state laws and regulations.

3. Posted notices contain the following information:

a. A plain language statement indicating that Kaweah Health has a financial assistance policy for low-income uninsured or underinsured patients who may not be able to pay their bill and that this policy provides for full or partial charity care write-off or a discount payment plan.

b. A Kaweah Health contact phone number that the patient can call to obtain more information about the policy and about how to apply for assistance.

c. The internet address for the Health Consumer Alliance (https://healthconsumer.org) and a statement there are organizations that will help the patient understand the billing and billing process.

d. A statement explaining that for patients who speak a language other than English or Spanish or who have other accessibility needs, Kaweah Health will provide language assistance services and accessibility accommodations free of charge.

4. Kaweah Health sets up conspicuous public displays[40] (or other measures reasonably calculated to attract patients' attention) that notify and inform patients about the policy in public locations in Kaweah Health facilities, including, at a minimum, the emergency department, admissions areas, billing office, and other outpatient settings.

Written Notices[41]

1. Kaweah Health provides all written notices in the language spoken by the patient, as required by applicable state and federal law.

[39] Cal. Health & Safety Code § 127410(b).
[40] 26 C.F.R. § 1-501(r)-4(b)(5)(i)(D)(3).
[41] Cal. Health & Safety Code § 127410(a).

2. Upon admission or discharge, Kaweah Health provides to every patient a written, plain language summary of the Kaweah Health Financial Assistance Policy that contains information about the availability of Kaweah Health's charity care policy, eligibility criteria, and the contact information for a Kaweah Health employee or office where the patient may apply or obtain further information about the policy. If any patient is not admitted, the written notice will be provided when patient leaves the facility. If the patient leaves the facility without receiving the written notice, Kaweah Health will mail the notice to the patient within 72 hours of providing services.[42]

3. Kaweah Health includes a conspicuous written notice on all billing statements that notifies and informs patients about the availability of financial assistance under this policy and includes the telephone number of the office or department which can provide information about the policy and application process, and the direct Web site address (or URL)[43] where copies of this policy, the application form, and the plain language summary of this policy may be obtained.[44]

4. With each billing statement sent to uninsured patients, Kaweah Health provides a clear and conspicuous notice that contains all of the following:[45]

a. A statement of charges for services rendered by Kaweah Health.

b. A request that the patient inform Kaweah Health if the patient has health insurance coverage, Medicare, Medi-Cal, or other coverage.

c. A statement that, if the patient does not have health insurance coverage, the patient may be eligible for Medicare, Healthy Families Program, Medi-Cal, coverage offered through the California Health Benefit Exchange, California Children's Services program, other state- or county-funded health coverage, or charity care.

d. A statement indicating how patients may obtain applications for the programs identified in paragraph (c) above.

e. A referral to a local consumer assistance center housed at legal services offices.[46]

f. Information regarding applications for assistance under this policy, including the following:

i. A statement that indicates that if the patient lacks, or has inadequate, insurance, and meets certain low- and moderate-income requirements, the patient may qualify for discounted payment or charity care.

[42] 26 C.F.R. § 1-501(r)-4(b)(5)(i)(D)(1), Cal. Health & Safety Code § 127410(b)
[43] 26 C.F.R. § 1-501(r)-4(b)(5).
[44] 26 C.F.R. § 1-501(r)-4(b)(5)(i)(D)(2).
[45] 26 C.F.R. § 1-501(r)-4(b)(5)(i)(D)(2).
[46] Cal Health & Safety Code § 127420(b)(4).

ii. The name and telephone number of a hospital employee or office from whom or which the patient may obtain information about the hospital's discount payment and charity care policies, and how to apply for that assistance.[47]

[47] Cal Health & Safety Code § 127420(b)(5).

Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

Policy Number: AP02	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	

Conditions of Admissions

POLICY:

The "Conditions of Admission," has two primary functions:

1. To document the patient's consent to hospitalization and routine services provided thereby;

2. To document financial responsibility for payment of hospital charges for services rendered.

The "Conditions of Admission" form also documents the relationship between the patient and the hospital with regard to several other important matters: release of information, nursing care/health care training personnel, personal belongings.

As a general rule, the form should be signed by the patient (and/or other appropriate party) upon admission, or as soon thereafter as possible. However, California law requires that emergency services and care be rendered without first questioning the patient (or any other person) as to his or her ability to pay.

PROCEDURE:

I. The Patient Access Services (PAS) Registrar shall be responsible for making every attempt to obtain consent by getting proper signatures upon presentation for services.

II. The PAS Registrar will utilize the COA (Conditions of Admission) script to describe the signing of the COA process to the patient.

III. The PAS Registrar will be responsible for explaining the document to the patient and must be prepared to answer any questions regarding signing the COA.

a) The Registrar will explain the purpose of obtaining the patient's signature on COA, which is for consent and treatment authorization and accepting financial responsibility.

b) The Registrar will inform the patient of the release of information section of the COA and obtain the patient's signature ~~initials~~ in the

appropriate section; either authorizing release of the information or to request the information not be released.

c) The Registrar will inform the patient of the assignment of insurance or health plans benefits to hospital-based physicians and obtain the patient's signature ~~initials~~ authorizing this assignment.

~~d) The Rgistrar will verify the patient's address with the patient as printed on the Conditions of Admission Form.~~

Commented [FC1]: The address is not printed on the COA. There is a label with patient name, FIN, gender, MRN and DOB but no address. We should remove 'D'.

IV. If the patient is unable to sign a written signature, the Registrar will obtain a verbal consent from the patient or family member and complete the Telephone/Verbal Consent section of the Conditions of Admission. The Registrar will sign as the witness to the verbal consent and have another hospital employee serve as the second witness to the consent and sign as such. (See PAC02 - Who May Give Consent).

V. The PAS Registrar will document that the COA was signed (in the Patient Notes section) by using the PA Notes function located in the Patient Management System.

VI. If the PAS Registrar is unable to obtain the signature, it shall be documented on the COA. The Registrar must also note this under the PA Notes function that the signature was not obtained by using the PA Notes function located in the Patient Management System.

VII. For patients whose COA remains unsigned upon arrival to the nursing unit, the nursing personnel should contact the Patient Access Services Department when the patient is able or available to sign. The Registrar will then go to the patient's room to have the document signed. The Registrar will document in PA Notes when the COA was signed.

VIII. The completed COA will be scanned by the PAS registrar into EDM for global viewing in the patient EHR.

IX. Refer to Patient Care Manual policy: Informed Consent Verification (See PR.05).

"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

Kaweah Health

Subcategories of Department Manuals not selected.

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Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration)	

Computer Security

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

POLICY: ~~KDHCD~~ Kaweah Health will maintain a secure computing environment, employing appropriate procedural and technical controls designed to safeguard information and supporting technologies.

~~KDHCD~~ Kaweah Health provides security awareness education for staff members and implement workplace practices where staff understands their responsibilities for ensuring confidentiality and where their workflow encourages protection of information.

All employees receive security awareness education during employee orientation and ~~periodic staff meetings~~on an annual basis.

The underlying rule of information protection is 'the need to know," i.e. one should only access information when access is required to fulfill one's job responsibilities or perform an authorized and assigned business function. Access to patient record is tracked and recorded ~~by the system~~.

Users who violate security, confidentiality, and/or integrity of information intentionally or through carelessness will be subject to loss or restriction of use of the computer system and/or disciplinary action up to and including termination under established ~~District~~ organization policies.

PROCEDURE:

I. ROLES

~~A. Application Steward~~

~~B.~~A. Application Administrator

~~C.~~B. Information Systems Services

~~D.~~C. Individual Users

~~E.~~D. IS Security Coordinator

II. RESPONSIBILITIES

~~A. The Steward is an individual accountable for leading activities related to a computer application and its information. The Steward is a representative of an operational business or clinical application.~~

~~1. Access Management~~

~~a) Develop information access profiles for job functions, or 'roles'.~~

~~b) Identify individuals who may use applications and information.~~

~~c) Review and approve/deny access requests which deviate from role profiles.~~

~~2. Designate a person to cover administrative responsibilities.~~

~~3. Report episodes of policy violations to Human Resources and IS Security Coordinator.~~

~~B.~~A. The Administrator is an individual accountable for managing and administering activities related to a computer system/application and its information, and receives his/her direction from the application Steward.

1. Password Management
   a) Creates and maintains the computer access codes in the application's security file.
   b) When emergency access is needed, he/she may generate the new code, or change current access, but must notify and follow-up with the Steward ~~and ISS Security Coordinator~~ as soon as possible for further direction.
   c) Add or delete user access in the information user database.
2. Coordinate backup procedures, and software/hardware upgrades with ISS.
3. Report episodes of policy violations to ~~application Steward~~compliance.

~~C.~~B. Information System Services (ISS) is responsible for ensuring the availability of data for backup and recovery processing on a continuing basis and providing tools and support for controlling access to ~~District~~ the organization's information.

1. Develop strategic directions to secure the ~~KDHCD~~ organization's ~~Network and information security~~information systems.
2. Identify security vulnerabilities and implement network technologies that secure the ~~KDHCD N~~network and information during transmission over private or public network (authentication, access control, encryption, etc).
3. Ensure physical controls are provided to prevent theft or damage to hardware and software.
4. Manage process for assigning access to ~~KDHCD Network and Desktop applications~~hardware and software.
5. Manage purchase and inventory control of ~~District~~ hardware and software.
6. Implement information ~~storage~~ systems technologies. ~~under which processing is optimized.~~
7. Implement information storage and retention procedures.
8. Develop and implement backup, recovery, and business resumption plans to ensure that the impact of any system failure or disruption is minimized.

9. Ensure the availability, and integrity of backup data.
10. Educate and support the application Stewards in identifying potential security risks to their department's computer application and information, and in determining protection requirements.
11. Document procedures that verify compliance to the ~~District~~ Kaweah Health Security Administration Policy.
12. Report episodes of policy violations to ~~Human Resources and IS Security Coordinator~~compliance.

~~D.~~C. Individual persons who access or use ~~KDHCD~~ Kaweah Health information or data are expected to fulfill certain responsibilities according to the roles they are assigned.

1. Maintain a secure work area.
2. Protect computer access and do not divulge ~~security codes~~passwords or other confidential information to unauthorized persons, even in cases where the unauthorized person is also a staff member of ~~the District~~Kaweah Health.
3. Report observed or suspected breaches of information to Management, cCompliance ~~and IS Security Coordinator~~.

~~E.~~D. ~~IS Security Coordinator~~ The Chief Information Officer/Chief Information Security Officer oversees the ~~District~~Kaweah Health Information Security Program.

1. Ensures that policies, products and systems are compliant with State and Federal laws and regulations with regard to the security and confidentiality of electronic information.
2. Develop a Security Administration Policy, standards, procedures, and guidelines.
3. Develop, implement, and monitor the information security awareness programs.
4. Partner with application Stewards to provide a ~~System Needs Assessment~~system needs assessment and Disaster Contingency Plan ~~for each application.~~
5. Monitor and maintain a current listing of all personnel who have access to information systems and their authorized functions as determined by their m~~M~~anagement.
6. Audit applications for appropriate use and report breaches and abuse to ~~Management and Human Resources~~compliance.
7. Audit application(s) for appropriate access to and use of information.

"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: AP130	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	

Community Managed Care Rate

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

PURPOSE: The purpose of this policy is to ensure that Kaweah Delta Health Care District (KDHCD) implements consistent practices for extending fair and equitable discounts to uninsured patients who do not qualify for Kaweah Health's Financial the District's charity care Assistance program. This policy also serves to define the eligibility criteria for identifying uninsured patients, determining the amount of the Community Managed Care Rate, and providing administrative and accounting guidelines for the classification and reporting of the Community Managed Care Rate.

This policy is part of Kaweah Delta Health Care District's overall goal of providing accessible and affordable health care services to the community and should be read in conjunction with the Financial Assistance Policy, AP.123.

The Community Managed Care Rate program is intended to apply to uninsured patients who do not qualify for charity careFinancial Assistance, but still may face hardships paying their medical bills. Patients who are offered charity careFinancial Assistance receive free or substantially discounted services and are not eligible to receive the Community Managed Care Rate. The Community Managed Care Rate does not apply to co-pays, deductibles, or share of cost or litigation accounts, except under the very limited circumstances set forth in section (1) of Attachment A.

REFERENCE: Financial Assistance Policy, AP.123

POLICY: It is the policy of KDHCDKAWEAH HEALTH to implement a consistent approach to extending fair and equitable discounts to "Uninsured Patients", as defined in section 'A'. Any Community Managed Care Rate, that is inconsistent with this policy, must be approved by KDHCD's Patient Financial ServicesRevenue Cycle Director or Chief Financial Officer.

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It is also the policy of KDHCDKaweah Health to ensure that uninsured patients are provided with information regarding the availability of charity careFinancial Assistance, local and state governmental programs, and the Community Managed Care Rate.

PROCEDURES:

a) **Uninsured Patient Eligibility Requirements**:

An "Uninsured Patient" is defined in this policy as a patient who is responsible to pay a District Kaweah Health bill for healthcare services received that is not covered or discounted by any type of insurance or governmental program. In order to qualify as an

"Uninsured Patient" and receive the Community ~~Managed~~Managed~~r~~ Care Rate, the patient or the patient's guarantor must verify that they are not aware of any right to insurance or governmental program benefits that would cover or discount their bill. Insurance in this case includes but is not limited to any HMO, PPO, indemnity coverage, or consumer-directed health plan.

Patients offered ~~Ccharity Ccare~~Financial Assistance receive free or substantially discounted services and are not eligible to receive the Community Managed Care Rate.

b) **Community Managed Care Rate**:

The Community Managed Care Rate is a discount applied to the patient's billed charges and is given at the time the uninsured patient is billed for ~~District~~ services rendered. The Community Managed Care Rate is equivalent to an average of the contractual fee-for-service rates received from ~~KDHCD~~Kaweah Health's~~'s~~ contracted Managed Care ~~payors~~payers. ~~as set forth in Attachment B.~~

The Community Managed Care Rate does not apply to co-pays, deductibles, ~~or~~ share of cost, or litigation accounts except under specific circumstances set forth in Attachment A.

c) **Annual Determination of Community Managed Care Rates**:

The Community Managed Care Rates will be re-evaluated, and adjusted as appropriate, at the beginning of each fiscal year (July 1) or anytime at the request of the ~~Patient Financial Services~~Revenue Cycle Director or the ~~District's~~ Chief Financial Officer.~~.~~

d) **Notification of Availability of Community Managed Care Rates and Other Financial Assistance Programs**:

As required by law, it is the ~~District's~~ Kaweah Health's responsibility to notify uninsured patients of their ~~E~~estimated ~~F~~financial ~~R~~responsibility and available ~~F~~financial ~~A~~assistance programs, if requested. Patients who the ~~District~~ Kaweah Health identifies as "uninsured" (as defined in Attachment A) will be provided with information regarding the availability of ~~charity care~~Financial Assistance, local and state governmental programs, and the Community Managed Care Rates. This information shall be provided to patients during preadmission or registration (except in the case of emergency services), or as soon thereafter as ~~practicable~~possible. ~~KDHCD~~Kaweah Health ~~—~~shall provide contact information for a ~~District~~ Kaweah Health employee or office from which the patient may obtain further information about these programs.

e) **Accounting for the Community Managed Care Rates**

To allow ~~KDHCD~~Kaweah Health to track and monitor the discounts provided to patients via the Community Managed Care Rate program, all contractual adjustments will be done using the Community Rate adjustment.~~adjusted using CDM 8040215.~~

Kaweah ~~Delta Health Care District~~ Health may not include the amount of the Community Managed Care Rate discount when reporting bad debt expense.

Attachment A

Community Managed Care Rate Guidelines

The following guidelines are intended for use in specific situations that arise in the ordinary course of business.

1. Co-pays, deductibles, ~~and~~ share of cost or litigation accounts~~.~~	These amounts should be collected from the patient. The Community Managed Care Rate should not be extended, **except where all of the following apply:** a) No portion of the patient's bill is covered by any insurance; and b) No portion of the patient's bill is subject to a discount negotiated with any insurance company; and c) No portion of the patient's bill is covered by a government program.
2. Charges not covered by insurance because patient exceeded benefit cap prior to admission.	These amounts should be collected from the patient. The ~~Charity Care~~Financial Assistance P~~p~~olicy may apply. If the patient is not eligible for ~~charity care~~Financial Assistance, the Community Managed Care Rate applies.
3. Charges not covered by insurance because patient exceeded benefit cap during patient's stay.	When a payer pays only a portion of the expected reimbursement for a patient's stay due to exhaustion of the patient's benefits during the stay, the Community Managed Care Rate applies to those dates that are patient responsibility.
4. Non-covered services and items (excluding co pays-, deductibles, and share of cost).	These amounts should be collected from the patient. The ~~Charity Care~~Financial Assistance P~~p~~olicy may apply. If the patient is not eligible for C~~charity C~~~~care~~Financial Assistance, the Community Managed Care Rate applies.
5. Services provided to ineligible members.	If coverage is denied, these amounts should be collected from the patient unless the patient's health plan is responsible for the services under the terms of the contract. The ~~Charity Care~~Financial Assistance P~~p~~olicy may apply. If the patient is not eligible for ~~charity care~~Financial Assistance, the Community Managed Care Rate applies.
6. Indemnity Insurance Company or Medicare Supplemental Plan pays member directly.	Patient ~~may~~ will be billed. ~~Charity C~~~~care~~Financial Assistance and other discounts do not apply.
7. Indemnity Insurance Company refuses to pay claiming patient has failed to cooperate by providing needed information.	Patient will~~may~~ be billed. ~~Charity Care and other discounts may apply.~~
8. Indemnity Insurance Company, PPO or non-contracted Third Party Payer underpays claiming charges are unreasonable or unsupported.	Continue to pursue amounts due from insurance. Pursuance of collections from the patient for liable amounts. The ~~Charity Care~~Financial Assistance policy may apply. If the patient is not eligible for C~~charity C~~~~care~~Financial Assistance, the Community Managed Care Rate applies.

9. Co-pays and share of cost for government programs	These amounts should be collected from the patient, unless the patient demonstrates financial need. The ~~Charity Care~~Financial Assistance Policy may apply.

COMMUNITY RATE

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Service	Codes	Rate
Inpatient		
Inpatient Per Diems	-	-
Medical	-	$3,000
Surgical	-	$5,000 1st day/LOC thereafter
ICU	-	$5,700
ICCU	-	$3,250
Trauma	-	60% Charges
Acute Rehabilitation	-	$1,600
Subacute / SNF	-	-
Level 1	-	$1,160
Level 2	-	$1,160
Level 3	-	$1,160
Level 4	-	$1,160
Transition Care Service (TCS)	-	$900
Maternity	-	-
Vaginal Delivery	-	$5,200
Vag w/ Tubal	-	$5,200
C-Section 1 day	-	$6,550
Additional Days	-	LOC
Baby	-	$550
Nursery	-	-
Rev 170 P/T B	-	$925
Rev 171 - Level I	-	$1,375
Rev 172 Level II P/T K	-	$2,500
Rev 173 Level III P/T L	-	$4,350
Rev 174 Level IV P/T I	-	$4,560
Cardiovascular	-	-
216 - 221 & 231 - 236: include all professional fees except Cardiologist, nephrologist and ERP	-	YES
215 Other Heart Assist Sys Implant	-	$43,600/7 days
216, 217 & 218 Cardiac Valve w/cath	-	$43,600/7 days
219, 220 & 221Cardiac Valve w/o Cath	-	$43,600/7 days
222 - 227 MS-DRG Cardiac Defib	-	$43,600/7 days

$5,000 first day/ LOC thereafter

228, 229, & 230 Other Vascular/Cardio Procedures	-	$43,600/7 days
231 & 232 CABG w/PTCA	-	$43,600/7 days
233 & 234 Coronary bypass	-	$43,600/7 days
235 & 236 Coronary bypass w/o CC	-	$43,600/7 days
34, 35 & 36 Carotid stent	-	$19,250/2 days
Intracardiac Ablation ICD9 Proc Code 37.34	-	$19,250/2 days
112 PTCA w/Rotoblade	-	$19,250/2 days
516/517 PTCA w/Stent, Pacemaker	-	$19,250/2 days
237& 238 Arotic Stent	-	$19,250/2 days
242, 243 & 244 Pacemaker procedures	-	$43,600/7 days
246 - 251 MS-DRG PTCA	-	$19,250/2 days
252, 253 & 254 Vascular Services	-	$19,250/2 days
258 & 259 Pacemaker replacement	-	$19,250/2 days
260, 261 & 262 Pacemaker revision	-	$19,250/2 days
Electrophysiology Studies ICD9 Proc Code 37.20, 37.26 37.27	-	$11,500
286 & 287 Cardiac Cath	-	$9,500/2 days
Add'l Days (Cardiac Surgery)	-	LOC
Add'l Days(Cardiac,PTCA & Cardiac Cath)	-	LOC
Exclusions (Inpt & Outpt)	-	-
Implants Rev code 274, 275,276,278,279	-	46% of implant charges
Outpatient Services	-	-
Emergency Room Per Visit Rates	-	-
99281	-	$250
99282	-	$500
99283	-	$1,150
99284	-	$1,800
99285	-	$1,800
ER/Observation	-	$3,000
Urgent Care (Global Tech/Pro Rates)	-	-
Level 1 EST / CPT 99211	-	$75
Level 1 NEW / CPT 99201	-	$90
Level 2 EST / CPT 99212	-	$100
Level 2 NEW / CPT 99202	-	$115
Level 3 EST / CPT 99213	-	$145
Level 3 NEW / CPT 99203	-	$175
Level 4 EST / CPT 99214	-	$205
Level 4 NEW / CPT 99204	-	$225

Level 5 EST / CPT 99215	-	$250
Level 5 NEW / CPT 99205	-	$265
School Physicals & Flu Vaccines	-	$25
Trauma	-	60% Charges
Outpatient Surgery	-	-
Group 0	-	$550
Group 1	-	$1,600
Group 2	-	$2,100
Group 3	-	$2,400
Group 4	-	$3,000
Group 5	-	$3,400
Group 6	-	$3,900
Group 7	-	$4,700
Group 8	-	$4,550
Group 9	-	$6,300
Group 10	-	-
Unlisted	-	$3,900
Multiple Procedures	-	100% / 50% / 25%
Cardiology / Cardiac Cath	-	$9,750
PTCA / Pacemaker	-	$9,750
Robotic Procedures	-	$15,000
Cardiac Ablation	-	$9,750
EP Studies	-	$9,750
Lap Band	-	$8,670
Outpatient Lab	-	300% of fee schedule
Outpatient Radiology/Diagnostic Services	-	300% of fee schedule
Hemodialysis	-	-
Hemodialysis	-	$500
CAPD	-	$250
CAPD Training	-	$250
CCPD	-	$250
CCPD Training	-	$250
Home Hemodialysis	-	$250
Radiation Therapy Clinic Visit (Tech/Room Charge)	E/M Codes	$125
Radiation Therapy	7XXXX CPT Codes	300% of fee schedule
Home Infusion Pharmacy drugs	-	fee schedule
Home Infusion Pharmacy supplies & equip	-	fee schedule
Sleep Studies	-	300% of fee schedule
Physical Therapy Visit	Rev Code 424	$120

-	Rev Code 420-423, 429	$95
Speech Therapy Visit	Rev Code 444	$120
-	Rev Code 440-443, 449	$95
Occupational Therapy Visit	Rev Code 434	$120
-	Rev Code 430-433, 439	$95
Hand Therapy DME Supplies	L3701, L3806, L3806, L3906, L3908 L3913, L3923, L3933, L3935, L3975	60%
Respiratory Therapy	-	$180
Cardiac Rehab	-	$75
Family Medicine Clinic Visit (Tech/Room Charge)	E/M Codes	$125
Wound Therapy Clinic Visit (Tech/Room Charge)	E/M Codes	$125
Hyperbaric Oxygen Chamber	First 90 minutes	-
Hyperbaric Oxygen Chamber	CPT G0277	$95
CDMC Clinic Visit (Tech/Room Charge)	E/M Codes	$125
Diabetes Education & Management	Individual- G0108	$62
-	Group - G0109	$17
Outpt Infusion Therapy per visit	96413, 96420, C8957, 96416, 96425, 96440, 96446, 96450	$327
-	96360, 96365, 96369, 96422, 96374, 96373, 96409, 96521, 96522, 96406, 96542	$210
-	96367, 96415, 96417, 96411, 96372, 96401, 96402, 96523, 96405	$64
-	96361, 96366, 96370, 96379, 96423, 96375, 96549	$41
Infusion Therapy Drugs	-	fee schedule
Cardiology Clinic Visit (Tech/Room Charge)	E/M Codes	$125
Neurosciences Center Visit (Tech/Room Charge)	E/M Codes	$125
Other outpt. services	-	60%
Professional Services/Fees	-	-

Neurosciences Center	-	-
Level 1 NEW	Cpt code 99201	$30
Level 1 EST	Cpt code 99211	$10
Level 2 NEW	Cpt code 99202	$57
Level 2 EST	Cpt code 99212	$29
Level 3 NEW	Cpt code 99203	$86
Level 3 EST	Cpt code 99213	$58
Level 4 NEW	Cpt code 99204	$146
Level 4 EST	Cpt code 99214	$89
Level 5 NEW	Cpt code 99205	$191
Level 5 EST	Cpt code 99215	$126
Inpatient Initial Consult Level 1	99251	$30.00
Inpatient Initial Consult Level 2	99252	$57.00
Inpatient Initial Consult Level 3	99253	$86.00
Inpatient Initial Consult Level 4	99254	$146.00
Inpatient Initial Consult Level 5	99255	$191.00
Inpatient Subsequent Consult Level 1	99231	$44.00
Inpatient Subsequent Consult Level 2	99232	$83.00
Inpatient Subsequent Consult Level 3	99233	$118.00
Non-Physician Practicioner Services	Modifier AS, SA	85% of rate above
Surgery/Procedures	CPT range: 10021 – 69990 & 9XXXX codes	60%
Wound Center	-	-
Level 1 NEW	Cpt code 99201	$30
Level 1 EST	Cpt code 99211	$10
Level 2 NEW	Cpt code 99202	$57
Level 2 EST	Cpt code 99212	$29
Level 3 NEW	Cpt code 99203	$86
Level 3 EST	Cpt code 99213	$58
Level 4 NEW	Cpt code 99204	$146
Level 4 EST	Cpt code 99214	$89
Level 5 NEW	Cpt code 99205	$191
Level 5 EST	Cpt code 99215	$126
Hyperbaric Oxygen Therapy	CPT 99183	$120
Tissue Debridement	11042 11047, 97597, 97598	$94
Skin Substitute/Graft Procedures	15271-15278	$107
Leg Casting	CPT 29145	$118
Incision & Drainage Procedures	10060, 10061, 10140, 10180	$165

Bone Biopsy	20220, 20240	$128
Burn Procedures	16000, 16020, 16025, 16030, 16035, 16036,	$123
All Other Procedures	29581, 97605-97608, 11100, 11101, 11720, 11721, 11730, 11732, 17250, 69210	$35
Non Physician Practicioner Services	Modifier AS, SA	85% of rate above
Chronic Disease Management Center	-	-
Level 1 NEW	Cpt code 99201	$30
Level 1 EST	Cpt code 99211	$10
Level 2 NEW	Cpt code 99202	$57
Level 2 EST	Cpt code 99212	$29
Level 3 NEW	Cpt code 99203	$86
Level 3 EST	Cpt code 99213	$58
Level 4 NEW	Cpt code 99204	$146
Level 4 EST	Cpt code 99214	$89
Level 5 NEW	Cpt code 99205	$191
Level 5 EST	Cpt code 99215	$126
Diabetes Education & Management - Ind	98960	$24
Diabetes Education & Management - Group	989619, 98962	$11
Botox Injections	64611, 64612, 64615	$129
Inpatient Initial Consult Level 1	99251	$30.00
Inpatient Initial Consult Level 2	99252	$57.00
Inpatient Initial Consult Level 3	99253	$86.00
Inpatient Initial Consult Level 4	99254	$146.00
Inpatient Initial Consult Level 5	99255	$191.00
Inpatient Subsequent Consult Level 1	99231	$44.00
Inpatient Subsequent Consult Level 2	99232	$83.00
Inpatient Subsequent Consult Level 3	99233	$118.00
Non Physician Practicioner Services	Modifier AS, SA	85% of rate above
Surgery/Procedures	9XXXX CPT Codes	60%
Cardiology Clinic	-	-
Level 1 NEW	Cpt code 99201	$30
Level 1 EST	Cpt code 99211	$10
Level 2 NEW	Cpt code 99202	$57
Level 2 EST	Cpt code 99212	$29
Level 3 NEW	Cpt code 99203	$86
Level 3 EST	Cpt code 99213	$58
Level 4 NEW	Cpt code 99204	$146

Level 4 EST	Cpt code 99214	$89
Level 5 NEW	Cpt code 99205	$191
Level 5 EST	Cpt code 99215	$126
Inpatient Initial Consult Level 1	99251	$30.00
Inpatient Initial Consult Level 2	99252	$57.00
Inpatient Initial Consult Level 3	99253	$86.00
Inpatient Initial Consult Level 4	99254	$146.00
Inpatient Initial Consult Level 5	99255	$191.00
Inpatient Subsequent Consult Level 1	99231	$44.00
Inpatient Subsequent Consult Level 2	99232	$83.00
Inpatient Subsequent Consult Level 3	99233	$118.00
Non-Physician Practicioner Services	Modifier AS, SA	85% of rate above
Surgery/Procedures	9XXXX CPT Codes	60%
Family Medicine Center	-	-
Level 1 NEW	Cpt code 99201	$30
Level 1 EST	Cpt code 99211	$10
Level 2 NEW	Cpt code 99202	$57
Level 2 EST	Cpt code 99212	$29
Level 3 NEW	Cpt code 99203	$86
Level 3 EST	Cpt code 99213	$58
Level 4 NEW	Cpt code 99204	$146
Level 4 EST	Cpt code 99214	$89
Level 5 NEW	Cpt code 99205	$191
Level 5 EST	Cpt code 99215	$126
Rural Health Clinics (Global Tech/Pro Rates)	-	-
Level 1 NEW	Cpt code 99201	$52
Level 1 EST	Cpt code 99211	$25
Level 2 NEW	Cpt code 99202	$87
Level 2 EST	Cpt code 99212	$51
Level 3 NEW	Cpt code 99203	$124
Level 3 EST	Cpt code 99213	$84
Level 4 NEW	Cpt code 99204	$188
Level 4 EST	Cpt code 99214	$124
Level 5 NEW	Cpt code 99205	$236
Level 5 EST	Cpt code 99215	$167
Non-Physician Practicioner Services	Modifier AS, SA	85% of rate above
Injections	Drug Code + CPT 96372	fee schedule
Observation Department	-	-
Observation Discharge	99217	$84
Initial Date Observation - Low Severity	99218	$113

Initial Date Observation - Mod Severity	99219	$155
Initial Date Observation - High Severity	99220	$211
Subsequent Obs Care - Stable	99224	$45
Subsequent Obs Care - Inadequate Response	99225	$83
Subsequent Obs Care - Unstable	99226	$119
Same Day Obs and Discharge - Low Severity	99234	$151
Same Day Obs and Discharge - Mod Severity	99235	$192
Same Day Obs and Discharge - High Severity	99236	$248
Non-Physician Practicioner Services	Modifier AS, SA	85% of the above rate

Inpatient Surgery (Implants are excluded see specific rates below)

Medical			$2,000.00
ICU/CCU			00
DOU/Tele			$2,200.00
Brachytherapy Services			$9,000/2days
Acute Rehabilitation			$1,200.00
Transitional Care Services (TCS)			$775.00
Subacute			$1,000.00
Lithotripsy			
	Uni-lateral	Cpt code 50590	$6,150/1day
	Bi-lateral	Cpt code 50590	$8,200/1day
	Repeat (within 30 days)	Cpt code 50590	$3,300/1day
Maternity			
Normal (includes normal newborn charges)		DRG 372 & 373	$4,100/2days
Normal w/ Tubal or OR procedure (includes normal newborn charges)		DRG 374 & 375	$4,800/2day
C-Section (includes normal newborn charges)		DRG 370 & 371	$5,250/3days
Additional Days OB			Level Of Care (LOC)
Multiple Births Case Rate per birth per case			$500.00
Boarder Baby		Rev Code 170	$630.00
	Intermediate Care Nursery		
	NICU I	Rev Code 171	$1,375.00
	NICU II	Rev Code 172	$2,500.00

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	NICU III & IV	Rev Code 173 & 174	$3,200.00
Cardiovascular			
Cardiac Valve w/Cath or w/o Cath		DRG 104, 105, 514 & 515	$36,000/7days
CABG w/PTCA		DRG 106	$42,000/7days
Coronary bypass w/Cath		DRG 547 & 548	$35,500/7days
CABG w/o Cath		DRG 549 & 550	$29,900/7days
104-106, 547, 548, 549 & 550 include all professional fees except Cardiologist, nephrologists and ERP			YES
Other Vascular/Cardiothoracic Procedures		DRG 108	$37,000/7days
114,119,479 DRG		DRG 114, 119 & 479	$15,000/4days
Circulatory System Disorders		DRG 113 & 120	$13,500/4days
Major Cardio Procedures w/o CC		DRG 111, 551, 552, 533, 534 & 554	$15,000/4days
PTCA w/Stent, Pacemaker		DRG 555 & 556	$13,000/2days
Major Cardio Procedures with CC		DRG 110 & 553	$26,000/2days
PTCA w/o stent		DRG 518	$11,000/2days
Cardiac Cath w/ or w/o Comp DX		DRG 124 & 125	$6,500/2days
PTCA w/ or w/o drug eluting stent		DRG 557 & 558	$13,000/2days
Additional Days			Level Of Care (LOC)
Outpatient Services			
Trauma Services			70% of billed charges
Emergency Services			
	Level 1	Cpt codes 99281 & 99282	$100
	Level 2	Cpt code 99283	$250
	Level 3	Cpt codes 99284 & 99285	$475
	Level 4	Cpt codes 99291	$750
Urgent Care			
	Level 1 EST	Cpt code 99211	$45
	Level 1 NEW	Cpt code 99201	$55
	Level 2 EST	Cpt code 99212	$60
	Level 2 NEW	Cpt codes 99202	$90
	Level 3 EST	Cpt code 99213	$76
	Level 3 NEW	Cpt code 99203	$130
	Level 4 EST	Cpt codes 99214	$110
	Level 4 NEW	Cpt code 99204	$180
	Level 5 EST	Cpt code 99215	$215

	Level 5 NEW	Cpt code 99205	$225
*** For services that do not have the above listed cpt codes, the discount will be 40% off total billed charges**			
Opt. Services not listed		Cpt codes	Fee Schedule
Outpatient Lab		Cpt codes	Fee Schedule
Outpatient Radiology		Cpt codes	Fee Schedule
Outpatient Infusion		Rev codes 260-269, 335	$250 per visit
Outpatient Infusion Drugs			Fee schedule
Outpatient Surgery			
	Group 1	fee schedule	$988.00
	Group 2	fee schedule	$1,248.00
	Group 3	fee schedule	$1,591.20
	Group 4	fee schedule	$2,132.00
	Group 5	fee schedule	$2,288.00
	Group 6	fee schedule	$2,392.00
	Group 7	fee schedule	$3,016.00
	Group 8	fee schedule	$3,276.00
	Group 9	fee schedule	$4,056.00
	Unlisted		60%
	Multiple Procedures	highest group reimbursed at 100%	100%, 50%, 25%
Cardiac Cath		ICD 9 procedure codes; 37.21-37.23, 88.52-88.58	$6,500.00
Lap Cholesectomy		Cpt codes 47562, 47563, 47564	$5,400.00
Lap Hysterectomy		ICD9 codes 68.31, 68.51	$4,850.00
Lap Appendectomy		ICD9 code 47.01	$4,850.00
PTCA		ICD9 procedure codes; 00.50, 00.54, 37.80-37, 36.01, 36.02, 36.05 & 36.09	$5,775.00
Hysteroscopic Sterilization		cpt code 58565	$2,500.00
Exclusions			
Hip Replacement Device		Rev codes 274, 275, 276 & 277	$4,635
Total Knee Replacement Device (per Knee)		Rev codes 274, 275, 276 & 278	$3,605
Spinal Fusion Device (Lumbar Cage)		Rev codes 274, 275, 276 & 278	$21,000
Cardiac Stent Bare Metal Implant		Rev codes 274, 275, 276 & 278	$1,500
Cardiac Drug Eluting Stent Implant		Rev codes 274, 275, 276 & 278	$2,500
Spinal Neurostimulator		Rev codes 274, 275, 276 & 278	$18,500

Infusion Pump Device	Rev codes 274, 275, 276 & 278	$9,865
Vagus Nerve Stimulator	Rev codes 274, 275, 276 & 278	$16,000
AICD Device	Rev codes 274, 275, 276 & 278	$31,000
Thoracic or Abdominal Stent Implant	Rev codes 274, 275, 276 & 278	$13,000
Pacemaker	Rev codes 274, 275, 276 & 278	$10,500
Carotid Stent Implant	Rev codes 274, 275, 276 & 278	$1,500
Outpatient Dialysis		
Hemodialysis	Cpt codes 90935, 90937, 90999	$350/visit
CAPD	Cpt codes 90945, 90947	$175/day
CAPD Training	Cpt code 91989, 90993	$175/Treatment
CCPD	Cpt codes 90945, 90947	$175/day
CCPD Training	Cpt code 90989, 90993	$175/Session
Home Hemodialysis	Cpt code 90999	$175/Treatment
Home Health		
RN Visit	HCPC code S9123	$180.00
LVN Visit	HCPC code S9124	$140.00
Home Health Aide Visit	HCPC code S9122	$120.00
Physical Therapy	HCPC code G0151	$180.00
Respiratory Therapy		$180.00
Speech therapy	HCPC code G0153	$180.00
Occupational Therapy	HCPC code G0152	$180.00
MSW Visit		$180.00
Outpatient Therapy		
Physical Therapy	Rev codes 420-424, 429	$80.00
Respiratory Therapy	Rev codes 410, 412, 419	$180.00
Speech therapy	Rev codes 440-444, 449	$80.00
Occupational Therapy	Rev codes 430-434, 439	$80.00
Cardiac Rehab		
Hospice Services		
Routine Home Care Per Date of Service		$132/day
Continuous Home Care (minimum of 8 Hours)		$32/hr
Inpatient Respite Care		$135/day
General Inpatient Care		$585/day
Home Infusion		

All Services			100% of Medicare
Kaweah Delta Mental Health			
Behavioral Health			
Acute Inpatient per diem			$800.00
CD Detox Inpatient Per Diem		HCPC codes H0008-H0011	$800.00
IOP - Intensive Outpatient Program			
	Group/Family Session	CDM 9440002 or 9440004	$100.00
	Individual Sessions	CDM 9440001	$62.50
	After Care	CDM 9440006	$25.00
Dr. Castillo/Outpatient Child Adolescent			
	First Visit	Cpt code 90801	$300.00
	Per Visit	Cpt codes 90807 & 90847	$200.00
	Per Visit	Cpt code 90805	$125.00

*** For services that do not have the above listed cpt codes, the discount will be 40% off total billed charges**

San Juan Health Center			
	Level 1 EST	Formatted Table	00
	Level 1 NEW	Cpt code 99201	$40.00
	Level 2 EST	Cpt code 99212	$60.00
	Level 2 NEW	Cpt codes 99202	$70.00
	Level 3 EST	Cpt code 99213	$90.00
	Level 3 NEW	Cpt code 99203	$100.00
	Level 4 EST	Cpt codes 99214	$120.00
	Level 4 NEW	Cpt code 99204	$130.00
	Level 5 EST	Cpt code 99215	$150.00
	Level 5 NEW	Cpt code 99205	$160.00

*** For services that do not have the above listed cpt codes, the discount will be 40% off total billed charges**

"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: AP46	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	

Commercial card expense reporting (CCER) program

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

POLICY: To improve internal controls and cost-effectiveness, Kaweah Delta Health Care District participates in the WellsOne Expense Manager Program. When obtaining goods or supplies through the normal purchasing procedure is not appropriate or practical for the given situation, authorized staff members who possess a District issued credit card (Cardholder) can make certain local purchases on a limited basis. Advantages of using this method for making smaller, local purchases include:

- Reduction of paperwork & streamlines the purchasing cycle for vendors that don't normally accept a purchase order
- Improves internal controls at the department level for point of sale transactions
- Allows for transactions to be integrated into the financial accounting system
- Reduces the number of accounts payable checks written by providing centralized billing and settlement (one monthly payment to Wells Fargo bank versus multiple vendor payments)

REFERENCES:

AP19	Travel, Per Diem and Other Employee Reimbursements
AP105	Professional and Service Club District Reimbursed Memberships
AP135	Capital Budget Purchases
AP156	Standard Procurement Practices

PROCEDURE:

I. Executive Team Responsibilities
   - A. Authorize cardholders , approve cardholder's transactions and/or reconciler, and establish original monthly and transactional spending limits for the cardholder
   - B. Authorize any modifications to Item (A) above.
   - C. Sign and approve the Procurement Card Application/Modification and Agreement form related to Items (A) and (B) above.
   - D. Ensure that all employees abide by the Procurement Card policies and procedures

II. Approver's Responsibilities

A. Must sign the cardholder agreement to acknowledge the responsibilities of the use of the procurement card and approver's responsibilities

B. Must participate in procurement card training

C. Responsibility for the control and stewardship of the procurement card lies with each department. The department is responsible for ensuring that cardholders are purchasing with competence and honesty and providing complete and reliable backup for the purchase. Any abuse or misuse of the procurement cards must be reported to the appropriate Executive Team member and the Financial Accounting Manager.

D. Review all charges billed to a cardholder's card to ensure that the charges are appropriate and reconciled to receipts. Charges must meet the requirements as set forth in District Policies, including but not limited to, AP19 (Travel, Per Diem and Other Employee Reimbursements), AP84 (Mileage Reimbursements), AP105 (Professional and Service Club District Reimbursed Memberships), AP156 (Standard Procurement Practices). Review and approval must be made on a regular basis.

E. Ensure the transaction's description, spend category and cost center coding are appropriate.

F. Ensure that original receipts are uploaded and reconciled to the corresponding transaction prior to online approval.

G. Ensure that all transactions have the required supporting documents.

H. Report any suspected fraud or negligence of this policy to an Executive Team member.

I. Failure to follow this policy may result in the relinquishment of Approver responsibilities.

III. Cardholder Responsibilities

A. Participate in a procurement card training and sign the cardholder agreement to acknowledge the responsibilities of the use of the procurement card

B. Abide by all procurement card policies and procedures when making purchases as outlined in this policy and the Purchasing Card Agreement. Failure to adhere to the procedures as outlined in this policy will result in revocation of individual Cardholder privileges and may result in disciplinary action

C. Ensure the physical security of the purchasing card and protect the account number and all other security aspects of the card. The card should be kept in a secure location. Cardholders are responsible for all transactions posted to their account. Immediately report lost or stolen cards to Wells Fargo Bank, cardholder's Approver and the Financial Accounting Manager, or designee. The cardholder may be liable for charges incurred until the card is reported lost, stolen, or misplaced.

D. The use of the card by any person other than the cardholder may result in revocation of the individual Cardholder privileges and may result in disciplinary action of the person using the card

E. Ensure the transaction's description, spend category and cost center coding are appropriate. Adjust spend category and cost center codes as appropriate within the financial accounting system.
F. Provide required documentation for each purchase in accordance with the "Required Documentation Section" of this policy
G. Any disputed transactions must be reported to Wells Fargo's customer service.
H. Transactions **MUST** be reconciled by the end of the month. If the end of the month falls on a weekend, transactions should be reconciled the next business day in order for the expense to post to the cost center for that billing period

IV. Issuance of the Procurement Card
A. The District in coordination with Wells Fargo Bank issues the procurement card.
B. The Procurement Card Application/Modification Form and the Procurement Card agreement **MUST** be completed, approved and returned to the Financial Accounting Manager prior to ordering the card.
C. Cardholders must complete training before the procurement card is issued.
D. Cardholders must pick up the card in Finance.

V. Allowable Purchases
A. The District procurement card may be used for the following:
1. Certain local purchases on a limited basis,
2. When obtaining goods, supplies or services through the normal purchasing procedure outlined in AP156 (Standard Procurement Practices) is not appropriate or practical for the given situation, or travel.
B. All purchases made with the procurement card must be for expenses associated with official District business.
C. Travel expenses must be in compliance with AP19 (Travel, Per Diem and Other Employee Reimbursements).
D. Procurement card purchases by Accounts Payable staff in lieu of check or EFT payment
E. Credit card purchases by Materials Management staff in lieu of vendor credit terms
F. Dues and memberships expenses must be in compliance with AP105 (Professional and Service Club District Reimbursed Memberships)
G. Goods and services purchased for the benefit of employees and staff appreciation accounted for under any HR program (such as Job Well Done) must have Executive Officer and HR approval before the purchase is made to confirm that the department has budgeted funds available.

VI. Prohibited Purchases, include but not limited to
A. Cash advances

B. Capital expenditures, unless prior approval is obtained by the CEO and obtaining the capital item through the normal purchasing procedure via Materials Management is not appropriate or practical.
C. Goods, supplies or services normally purchased through materials management in accordance with the District's Standard Procurement Practices (District Administrative Policy AP156)
D. Leases/rental agreements
E. Maintenance/Service Agreements
F. Software Licensing Agreements
G. Personal items as noted in AP19 (Travel, Per Diem and Other Employee Reimbursements) or HR188 (Personal Property and Valuables)
H. Office supplies (must be procured through the Office Depot website or through Materials Management)
I. Services of sole proprietorships, individuals, non incorporated businesses, or physician payments (these are 1099 reportable and generally covered by a District contractual agreement)
J. Any purchase categories blocked through the purchasing card Merchant Category Codes (MCC)
K. Payment of any type of penalty, unless approved by the CEO or Compliance Department
L. Multiple purchases to circumvent a cardholder's single purchase limit.

VII. Automatic cancelation of a cardholder's procurement card, include but not limited to
A. More than two instances of using the credit card for personal purchases
B. More than two instances of a lost card
C. More than two instances of securing purchases not allowable under this policy
D. More than two instances of being on the decline report without correction
E. More than two monthly instances of failure to reconcile transactions
F. Three (3) consecutive months with without usage

VIII. Required Documentation

A. Original receipts **MUST** be uploaded to each transaction:
1. For vendor purchases, a receipt including the vendor name, transaction amount, date, and detail of the item(s) purchased.
2. For Internet purchases, a screen print or order confirmation email.
B. In the rare and unique occurrence that a receipt cannot be located, an Executive Team member must approve the transaction via email. Upload the email approval as support for the transaction. The executive team member can require the cardholder to reimburse the District for transactions not supported by a receipt.
C. If the business purpose of the transaction is not evident upon review of the receipt, further documentation of the business purpose will be required.

D. Documentation relating to purchases and AP105 (Professional and Service Club District Reimbursed Memberships) and AP156 (Standard Procurement Practices) must be in compliance with the governing District policy.

E. If purchases relate to Job Well Done, Executive Team Member and HR approval documentation must be attached.

"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

Procurement Card Application/Modification Agreement
Kaweah Delta Healthcare District

Cardholder Information – To be completed by Cardholder

Last Name _____ First Name _____

Job Title _____ Employee ID _____

Dept. Name _____ Dept # _____

Cardholder's email _____ Business Phone _____

Card Business Purpose _____

Procurement Card Controls – must be completed by Authorizing Executive Team Member

Procurement Card Controls

Card Type	Spend Limits
Level 1	Monthly: $500.00 Single: $100.00
Level 2	Monthly: $1,000.00 Single: $500.00
Level 3	Monthly: $5,000.00 Single: $2,500.00
Level 4 (Must be director or Executive Memb	Monthly: $10,000.00 Single: $5,000.00
Accounts Payable / Facilities / Materials Management / Maintenance	Limits TBD based on job requirements

Procurement Card Agreement

If a card is lost or stolen, it is the Cardholder's responsibility to notify Wells Fargo Bank and the Financial Accounting Manager **immediately**. If notification does not take place within 24 hours, the Cardholder is responsible and will be held accountable for all charges made to the procurement card. Should a Cardholder terminate employment with Kaweah Delta Healthcare District, the Cardholder must return the procurement card to their approving director and/or Executive Team Member or the Procurement Card Program Administrator, who will then notify the bank. A Change/Cancellation Form must be submitted to the Procurement Card Program Administrator within 48 hours of employment termination.

Failure to adhere to the procedures as outlined in AP46 Procurement **CARD PROGRAM**) will result in revocation of individual Cardholder privileges and may result in disciplinary action. Use of the Procurement Card for non-District business purposes (personal purchases), prohibited purchases as outlined in AP46, or allowing the use of the card by any person other than the cardholder may result in revocation of the individual Cardholder privileges and may result in disciplinary action, up to and including dismissal from employment and may in some circumstances constitute a criminal act punishable by law.

Cardholder
As a Cardholder, I agree to accept responsibility and accountability for the protection and proper use of this Procurement Card. If non-District charges are placed on the Procurement Card and repayment is not forthcoming by reimbursement payable to the District, this will result in suspension of procurement card privileges. I understand that I must allow 4 – 6 weeks for delivery of my card.

Cardholder Signature Date

Approver
As the Approver, I take responsibility to review and reconcile purchases made by the cardholder to original receipts and ensure that all purchases are in accordance with District policies and procedures. Failure to comply with policy may result in disciplinary action.

Approver Signature Date

Cost Center Manager
As the cost center manager, I take full administrative responsibility for the issuance of the procurement card and the cardholder's transactions posted to the department's cost center.

Cost Center Manager Signature Date

Executive Team Member
As the Approving Official, I take full administrative responsibility for the action of the Cardholder and I approve the limits as set forth for this card on the Procurement Card Application.

Executive Team Member Signature Date

~~**POLICY:** To improve internal controls and cost-effectiveness, Kaweah Delta Health Care District participates in the Wells Fargo Bank Commercial Card Expense (CCER) Program. Authorized staff members who possess a District issued credit card (Cardholder) can make certain~~

local purchases on a limited basis, when obtaining goods or supplies through the normal purchasing procedure is not appropriate or practical for the given situation. Advantages of using this method for making smaller, local purchases include:

- Reduction of paperwork & streamlines the purchasing cycle for vendors that don't normally accept a purchase order
- Improves internal controls at the department level for point of sale transactions
- Allows for transactions to be automatically uploaded into the financial accounting system
- Reduces the number of accounts payable checks written by providing centralized billing and settlement (one monthly payment to Wells Fargo bank versus multiple vendor payments)

REFERENCES:

AP19 Travel, Per Diem and Other Employee Reimbursements

AP84 Mileage Reimbursements

AP105 Professional and Service Club District Reimbursed Memberships

AP135 Capital Budget Purchases

AP156 Standard Procurement Practices

PROCEDURE:

I. Executive Team Responsibilities

A. Authorize cardholders , cardholder's approver and/or reconciler, and establish original monthly and transactional spending limits for the cardholder

B. Authorize any modifications to Item (A) above.

C. Sign and approve the Purchasing Card Application/Modification and Agreement form related to Items (A) and (B) above.

D. Ensure that all employees abide by the CCER program policies and procedures

II. CCER On-line Approver's Responsibilities

A. Must be an authorized signer with a completed Purchase Authorization Sheet on file with Material Management having purchase limits that meet or exceed the purchase limits of the cardholder or OOP they are approving.

B. Must sign the cardholder agreement to acknowledge the responsibilities of the use of the purchasing card and approver's responsibilities

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C. Must request a CCER account for the cardholder through HR On-line System Authorization Request

D. Must participate in purchasing card training

E. Responsibility for the control and stewardship of the purchasing card program lies with each department. The department is responsible for ensuring that cardholders are purchasing with competence and honesty and providing complete and reliable backup for the purchase. Any abuse or misuse of the purchasing cards must be reported to the appropriate Executive Team member and the Financial Accounting Manager.

F. Review all charges billed to a cardholder's card to ensure that the charges are appropriate and reconciled to receipts. Charges must meet the requirements as set forth in District Policies, including but not limited to, AP19 (Travel, Per Diem and Other Employee Reimbursements), AP84 (Mileage Reimbursements), AP105 (Professional and Service Club District Reimbursed Memberships), AP156 (Standard Procurement Practices). Review and approval must be made on a regular basis.

G. Ensure the transaction's description, account and cost center coding are appropriate and within the guidelines of approver's signing authority. Adjust account and cost center codes as appropriate within the CCER On-line program.

H. Ensure that all original receipts are provided and reconciled to the monthly transactions prior to final on-line approval being completed.

I. Ensure that all documentation required to be submitted to Finance is complete and timely. Documentation includes the approved Purchasing Card Reconciliation form with all receipts. Documents **MUST** be submitted to Finance by the 8th of the month. If the 8th falls on a weekend, it is to be submitted by the following Monday. The required documentation may be submitted to Finance via electronic PDF format as long as the department maintains the original for the required retention period.

J. Track disputed items to ensure proper credit is received. Any discrepancies in billing must be marked as disputed charges using the on-line system.

K. Report any suspected fraud or negligence of this policy to an Executive Team member.

L. Failure to follow this policy may result in the relinquishment of Approver responsibilities.

III. Cardholder Responsibilities

A. Participate in a purchasing card training and sign the cardholder agreement to acknowledge the responsibilities of the use of the purchasing card

B. Abide by all purchasing card policies and procedures when making purchases as outlined in this policy and the Purchasing Card Agreement. Failure to adhere to the procedures as outlined in this policy will result in revocation of individual Cardholder privileges and may result in disciplinary action

C. Ensure the physical security of the purchasing card and protect the account number and all other security aspects of the card. The card should be kept in a secure location. Cardholders are responsible for all transactions posted to their account. Immediately report lost or stolen cards to Wells Fargo Bank, cardholder's CCER On-line Approver and the Financial Accounting Manager, or designee. The cardholder may be liable for charges incurred until the card is reported lost, stolen, or misplaced.

D. The use of the card by any person other than the cardholder may result in revocation of the individual Cardholder privileges and may result in disciplinary action of the person using the card

E. Ensure the transaction's description, account and cost center coding are appropriate and within the guidelines of approver's signing authority. Adjust account and cost center codes as appropriate within the CCER On-line program

F. Provide required documentation for each purchase in accordance with the "Required Documentation Section" of this policy

IV. Issuance of the Purchasing Card

A. The District in coordination with Wells Fargo Bank issues the purchasing card.

B. The Purchasing Card Application/Modification Form and the Purchasing Card agreement **MUST** be completed, approved and returned to the Financial Accounting Manager prior to the card being ordered.

C. Upon the completion and approval of the Application, the cardholder's supervisor must request that the employee be setup in the CCER program by requesting the system authorization "Commercial Card Program" through HR OnLine.

D. Cardholders must complete training before a card is issued.

E. Cardholder must pick up the card in Finance and sign the back of the card in the presence of a Finance staff member.

V. Allowable Purchases

A. The District purchasing card may be used for

1. certain local purchases on a limited basis,

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2. when obtaining goods, supplies or services through the normal purchasing procedure outlined in AP156 (Standard Procurement Practices) is not appropriate or practical for the given situation, or travel.

B. All purchases made with the purchasing card must be for expenses associated with official District business.

C. Travel expenses must be in compliance with AP19 (Travel, Per Diem and Other Employee Reimbursements).

D. Credit card purchases by Accounts Payable staff in lieu of check or ACH payment

E. Credit card purchases by Materials Management staff in lieu of vendor credit terms

F. Dues and memberships expenses must be in compliance with AP105 (Professional and Service Club District Reimbursed Memberships)

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

VI. Prohibited Purchases, include but not limited to

A. Cash advances

B. Capital expenditures, unless prior approval is obtained by the CEO and obtaining the capital item through the normal purchasing procedure via Materials Management is not appropriate or practical.

C. Goods, supplies or services normally purchased through materials management in accordance with the District's Standard Procurement Practices (District Administrative Policy AP156)

D. Leases/rental agreements

E. Maintenance/Service Agreements

F. Software Licensing Agreements

G. Personal items as noted in AP19 (Travel, Per Diem and Other Employee Reimbursements) or HR188 (Personal Property and Valuables)

H. Office supplies (must be procured through the Office Depot website or through Materials Management)

I. Services of sole proprietorships, individuals, non incorporated businesses, or physician payments (these are 1099 reportable and generally covered by a District contractual agreement)

J. Any purchase categories blocked through the purchasing card Merchant Category Codes (MCC)

K. Payment of any type of penalty, unless approved by the CEO or Compliance Department

~~L. Multiple purchases to circumvent a cardholder's single purchase limit.~~

~~VII. Automatic cancelation of a cardholder's credit card, include but not limited to~~

~~A. More than two instances of using the credit card for personal purchases~~

~~B. More than two instances of a lost card~~

~~C. More than two instances of securing purchases not allowable under this policy~~

~~D. More than two instances of being on the decline report without correction~~

~~VIII. Cardholders with Out of Pocket Expenses will be processed in accordance with AP19 and AP84. Automatic cancelation of Approver privileges, include but not limited to:~~

~~A. More than two instances of approving a cardholder's purchases having personal purchases~~

~~B. More than three instances of failure to submit monthly required documentation to Finance timely~~

~~C. More than three monthly instances of approving purchases without the required descriptions or proper account coding~~

~~IX. Required Documentation~~

~~A. Original receipts **MUST** be submitted to the approver:~~

~~1. For vendor purchases, a receipt including the vendor name, transaction amount, date, and detail of the item(s) purchased.~~

~~2. For Internet purchases, a screen print or order confirmation email~~

~~B. In the rare and unique occurrence that a receipt can not be located, an Executive Team member must sign the Purchasing Card Reconciliation form approving the missing receipt. The executive team member can require the cardholder to reimburse the District for transactions not supported by a receipt or deny the reimbursement request for the OOP user.~~

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

~~D. Documentation relating to purchases and expense reimbursements governed by a specific District policy, such as AP19 (Travel and Other Employee Reimbursements), AP84 (Mileage Reimbursements), AP105 (Professional and Service Club District Reimbursed Memberships) and~~

AP156 (Standard Procurement Practices) must be in compliance with the governing District policy.

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

F. All backup documentation (in accordance with the required documentation section of this policy) **MUST** accompany a Purchasing Card Reconciliation form. Forms must be signed and dated, and forwarded to the employee's CCER On-line approver who will be reviewing and approving the transactions. These documents **MUST** be submitted to Finance by the 8th of the month. If the 8th falls on a weekend, it is to be submitted by the following Monday. The required documentation may be submitted to Finance via electronic PDF format as long as the department maintains the original for the required retention period.

"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."

Purchasing Card Application/Modification Agreement
Kaweah Delta Healthcare District

Cardholder Information – To be completed by Cardholder

Last Name _____ First Name _____

Job Title _____ Employee ID _____

Dept Name _____ Dept # _____

Card Business Purpose _____ Cardholder's email _____

Business Phone _____

Cardholder Controls – To be completed by Authorizing Executive Team Member

CCER On-line Approver's Name _____

CCER On-line Approver's Title _____

CCER On-line Reconciler's Name, if applicable _____

CCER On-line Reconciler's Title _____

Purchasing Card Controls

~~Card Type~~		~~Executive, Travel, Maintenance, All Other~~
~~Monthly Spend Limit~~	~~$~~	~~To be determined by Authorizing Executive Team Member~~
~~Single Purchase Limit~~	~~$~~	~~Must not exceed Employee's Purchase Authorization Sheet limit on file with Material Management~~

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~~Purchasing Card Agreement~~

~~If a card is lost or stolen, it is the Cardholder's responsibility to notify Wells Fargo Bank and the Financial Accounting Manager **immediately**. If notification does not take place within 24 hours, the Cardholder is responsible and will be held accountable for all charges made to the Purchasing Card. Should a Cardholder terminate employment with Kaweah Delta Healthcare District, the Cardholder must return the Purchasing Card to their Approving Director and/or Vice President or the Purchasing Card Program Administrator, who will then notify the bank. A Change/Cancellation Form must be submitted to the Purchasing Card Program Administrator within 48 hours of employment termination.~~

~~Failure to adhere to the procedures as outlined in AP46 (**COMMERCIAL CARD EXPENSE REPORTING (CCER) PROGRAM**) will result in revocation of individual Cardholder privileges and may result in disciplinary action. Use of the Purchasing Card for non-District business purposes (personal purchases), prohibited purchases as outlined in AP46, or allowing the use of the card by any person other than the cardholder may result in revocation of the individual Cardholder privileges and may result in disciplinary action, up to and including dismissal from employment and may in some circumstances constitute a criminal act punishable by law.~~

As a Cardholder, I agree to accept responsibility and accountability for the protection and proper use of this Purchasing Card. If non-District charges are placed on the Purchasing Card and repayment is not forthcoming by direct deduction through the CCER banking system, I authorize the District to deduct any non-District business, personal, or excluded charges from my paycheck subject to the limits of garnishments. I have read the related FAQ for the CCER banking system and understand the approval cycle times. I also understand that I must allow 4 – 6 weeks for delivery of my card.

Cardholder's Signature _____ Date _____

CCER On-line Approver

As the CCER On-line Approver, I take responsibility to review and reconcile purchases made by the cardholder to original receipts and ensure that all purchases are in accordance with District policies and procedures. Original receipts and my approved Purchasing Card Reconciliation form will be forwarded to Finance within the required timeframes outlined in AP46. Failure to comply with policy will result in revocation of the CCER On-line Approving privileges and may result in disciplinary action.

CCER On-line Approver's Signature _____ Date _____

Executive Team Member

As the Approving Official, I take full administrative responsibility for the action of the Cardholder and I approve the limits as set forth for this card on the Purchasing Card Application.

Authorizing Executive Team Signature _____
Date _____

Kaweah Delta Health Care District

PURCHASING CARD RECONCILIATION

Year _____ Month _____

Purchasing Card # (last 4 digits) _____

I attest that original receipts are included and that all purchases made are in accordance with District policies and procedures.

Cardholder Name _____

Cardholder Signature _____ Date _____

I attest that the purchases have been reconciled by me or my designee and I have reviewed the purchases accordingly. Original receipts are included and all purchases are in accordance with District policies and procedures.

CCER On-line Approver's Name _____

CCER On-line Approver's Signature_____ Date _____

~~**FORWARD COVER SHEET ALONG WITH ATTACHED RECEIPTS TO ACCOUNTS PAYABLE NO LATER THAN THE 5TH OF THE MONTH. ALL RECEIPTS LESS THAN 8 ½ BY 5 ½ MUST BE TAPED TO A BLANK SHEET OF PAPER. MULTIPLE RECEIPTS MAY BE COMBINED ON ONE SHEET, BUT MAY NOT OVERLAP**~~

Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

Policy Number: AP99	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	

Abandoned Newborn: Safe Surrender

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

POLICY: The Safely Surrendered Baby Law was created to respond to the increasing number of newborn infant deaths due to abandonment in unsafe locations.

In accordance with California Health and Safety Code 1255.7, the parents or persons with lawful custody of ~~newborns~~ infants 72 hours old or younger, can voluntarily surrender the ~~child~~ infant to an employee on duty at a public or private hospital. ~~emergency room~~. This person will have immunity from criminal prosecution.

Infants older than 72-hours are not covered under the California Safe Surrender Law. Child Protective Services (CPS) would be notified of child abandonment of an infant.

DEFINITION: ~~Staff~~ Kaweah Health employees designated to accept an infant in accordance with this policy are:

I. Director/Nurse Manager/ Lead RN or designee in the Emergency Room, Labor and Delivery, Mother Baby, Neonatal Intensive Care Unit (NICU) or Pediatrics.
II. House Supervisor
III. Social Worker

PROCEDURE:

Procedures for person choosing to safely surrender ~~baby~~an infant who was born outside of Kaweah Health. ~~and baby has already been delivered outside of the hospital.~~

I. ~~Any Kaweah Delta Health Care District~~Health ~~staff member who is approached by someone wishing to give over an infant that appears 72 hours old or less, should~~ will ~~direct and help the individual and baby to the Emergency Department (ED).~~ Any Kaweah Health employee who is approached by an individual who wants to surrender an infant that appears to be 72-hours old or younger, will direct the individual and infant to the Emergency Department (ED).

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II. ~~The ED Director/Nurse Manager/Lead RN, Social Worker, or House Supervisor should be notified and will accept custody of the infant.~~ The ED Director, Nurse Manager, Lead RN, Social Worker, or House Supervisor will be notified and one of them will accept custody of the infant.

~~The person accepting the baby will contact Admitting Department.~~

III. Admitting will be notified of the surrendered infant, they will register the infant utilizing the "Doe" naming convention. Once registered, Admitting will place an identification band on the infant's ankle and a duplicate band will be placed on the individual who has lawful custody of the infant in good faith effort to facilitate reclaiming of the infant. ~~....~~

~~II. The person accepting custody of the baby will place a Newborn Identification bracelet with an Inpatient Identification number (obtained from the Admitting Department) on the infant's ankle and document the number on the Medical Record.~~

~~III.~~IV. ~~Upon surrender, the hospital personnel accepting the infant will make a good faith effort to provide the parent or other individual surrendering the infant with the unique identification number to facilitate reclaiming of the infant by the person who surrendered the infant.~~ The ED medical provider will perform a Medical Screening Exam and consult with the Pediatric Hospitalist to obtain orders to admit to the Neonatal Intensive Care Unit (NICU) or Pediatrics dependent on the infant's condition at time of surrender.

~~IV. The ED medical provider will perform a Medical Screening Exam, notify the Emergency On Call Pediatrician, obtain an order to admit to the Neonatal Intensive Care Unit (NICU) or Pediatrics, and notify NICU or the Pediatric staff of the admission.~~ Hospital personnel accepting the infant will provide and request that individual with lawful custody complete the "Safely Surrendered Baby Medical Questionnaire" (see Addendum A). The completion of the questionnaire is voluntary. ~~wh~~

V. ~~The ED staff will attempt to obtain a Newborn Family Medical History from the person surrendering the newborn, this is entirely voluntary and can be declined, (see addendum A).~~As soon as possible, but no later than 48-hours after surrender of the infant, the hospital will notify local Child Welfare Services via verbal report to the local mandated hotline and a written report. Written report shall maintain confidentiality of the person surrendering the infant.

VI. ~~As soon as possible, but no later than 48 hours after surrender of the infant, the hospital is will to notify local Child WelfareProtective Services via verbal report to local mandated hotline and written report. Written report shall maintain the confidentially of the person surrending the baby. who will file the appropriate legal actions and provide placement for the child.~~

VII. Once the infant is medically cleared and ready for discharge, Child Welfare Services will be notified so they can facilitate the discharge plan. Child Welfare Services is responsible for the completion of form VS 136 Certificate of Unknown Child or Safely Surrendered Child.

~~VI.~~ The individual with lawful custody has up to 14-days from the time of surrender to reclaim the infant. If the individual with lawful custody

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presents to reclaim the infant the hospital Social Worker must be notified immediately. They will notify Child Welfare Services immediately and verify the identification bands match on both the individual and the infant. The individual with lawful custody must work with Child Welfare Services to complete Child Welfare Services legal workflows to regain custody of the infant. The medical center does not determine whether or not the infant may reunite with individual of lawful custody.

~~The parent or person with lawful custody has up to 14 days from the time of surrender to reclaim their baby.~~

~~Procedures for person choosing to safely surrender baby and was delivered during persons hospital stay.~~Procedure for infant born at Kaweah Health who is Safely Surrendered.

I. ~~If patient informs any Kaweah Health staff member that she wants to adopt or safe surrender her baby, periardum or postpardum, . who is approached by someone wishing to give over an infant that appears 72 hours old or less, will direct the individual and baby to the Emergency Department (ED).~~ If patient informs a Kaweah Health employee that they want to safely surrender or adopt their infant who is 72-hours old or younger, the employee will notify the Unit Lead RN, Unit Nurse Manager and Social Worker. The medical team, in collaboration with patient, will determine whether infant remains with patient or moved to another location.

II. ~~The ED Director/Nurse Manager/Lead RN, Social Worker, or House Supervisor should be notified and will accept custody of the infant.~~ RN Manager, Social Worker or House Supervisor with notify Admitting. Admitting will change the infant's name in the EHR utilizing the "Doe" naming convention. A new identification band will be printed and placed on the infant's ankle and a duplicate band placed on the patient surrendering the infant to facilitate reclaiming of the infant.

~~The person accepting the baby will contact Admitting Department.~~

III. ~~Admitting will ….~~The Pediatric Hospitalist will perform a Medical Screening Exam and notify the attending Pediatrician. The Pediatric Hospitalist will determine whether the infant is to be admitted to the Neonatal Intensive Care Unit (NICU) or Pediatrics dependent on infant's condition.

~~The person accepting custody of the baby will place a Newborn Identification bracelet with an Inpatient Identification number on the infant's ankle and document the number on the Medical Record.~~

IV. ~~Upon surrender, the hospital personnel accepting the infant will make a good faith effort to provide the parent or other individual surrendering the infant with the unique identification number to facilitate reclaiming of the infant by the person who surrendered the infant.~~ The Social Worker will attempt to obtain a "Safely Surrendered Baby" Medical Questionnaire from the patient surrendering the infant, this is entirely voluntary and can be declined (See Addendum A).

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V. ~~The ED medical provider will perform a Medical Screening Exam, notify the Emergency On-Call Pediatrician, obtain an order to admit to the Neonatal Intensive Care Unit (NICU) or Pediatrics, and notify NICU or the Pediatric staff of the admission.~~ As soon as possible, but no later than 48 hours after surrender of the infant, the hospital will notify local Child Welfare Services via verbal report to the local mandated hotline and written report. The written report shall maintain the confidentiality of the patient surrendering the infant.

VI. Once the infant is medically cleared and ready for discharge, Child Welfare Services will be notified so they can facilitate the discharge plan and complete form VS 136 Certificate of Unknown Child or Safely Surrendered Child. At discharge, all of the surrendering patient's information will be removed from the infant's medical record and the link to the birth parent will be broken so the patient's medical record and the infant's medical record are no longer linked.

~~The ED staff will attempt to obtain a Newborn Family Medical History from the person surrendering the newborn, this is entirely voluntary and can be declined, (see addendum A).~~ The individual with lawful custody has up to 14-days from the time of surrender to reclaim the infant. If the individual with lawful custody presents to reclaim the infant the hospital Social Worker must notify Child Welfare Services immediately and verify the identification bands match on both the individual and the infant. The Individual with lawful custody must work with Child Welfare Services to complete Child Welfare Services legal workflows to regain custody of the infant. The medical center does not determine whether or not the baby may reunite with individual of lawful custody.

VII. ~~As soon as possible, but no later than 48 hours after surrender of the infant, the hospital will notify local Child Welfare Services via verbal report to local mandated hotline and written report. Written report shall maintain the confidentially of the person surrending the baby.~~

~~The parent or person with lawful custody has up to 14 days from the time of surrender to reclaim their baby.~~

~~VII.~~

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Reference:

Health and Safety Code, Section 1255.7

Penal Code Section 11165.13

All County Information Notice I-16-04

Assembly Bill 1048 (Chapter 567, 2010)

"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."

Addendum A

"SAFELY SURRENERED BABY"
Medical Questionnaire

THANK YOU FOR CHOOSING TO GIVE THIS BABY A SAFE AND SECURE FUTURE

NOTICE: THE BABY YOU HAVE BROUGHT IN TODAY MAY HAVE SERIOUS MEDICAL NEEDS IN THE FUTURE THAT WE DON'T KNOW ABOUT TODAY. SOME ILLNESS, INCLUDING CANCER, ARE BEST TREATED WHEN WE KNOW ABOUT FAMILY MEDICAL HISTORIES. IN ADDITION, SOMETIMES RELATIVES ARE NEEDED FOR LIFE-SAVING TREATMENTS. TO MAKE SURE THIS BABY WILL HAVE A HEALTHY FUTURE, YOUR ASSISTANCE IN COMPLETING THIS QUESTIONNAIRE FULLY IS ESSENTIAL. THANK YOU.

Please remember that these questions will allow us to provide the best supportive care possible to the baby.
If you need help answering any of the questions, please ask. If you are uncomfortable answering any of the questions, skip them and answer the rest. Any information you provide will benefit the baby.

ALL INFORMATION IS CONFIDENTIAL AND WILL BE USED ONLY TO HELP CARE FOR THE BABY

1. What were the date, time and place of the baby's birth?
   Date: _____ Time: _____ ☐ a.m. ☐ p.m. Place: _____
2. Was the baby born early (premature)? _____ Late ? _____ Unknown Due Date? _____
3. Did the baby have any trouble starting to breathe? ☐ Yes ☐ No
4. Has the baby been breast fed? ☐ Yes ☐ No
   If yes, how long? _____ When was the baby last fed? ☐ am ☐ pm
5. Has the baby been fed formula? ☐ Yes ☐ No
   If yes, how long? _____ When was the baby last fed? ☐ am ☐ pm
6. Did the birth mother see a doctor during pregnancy? ☐ Yes ☐ No
   If yes, when did she first see the doctor? _____
   How many times did she see the doctor during pregnancy? _____
7. Was the birth mother attended by a physician, midwife, nurse or other health care professional? ☐ Yes ☐ No
8. Has a doctor seen the baby since birth? ☐ Yes ☐ No
   If yes, when? _____
9. Did the birth mother smoke cigarettes during the pregnancy? ☐ Yes ☐ No
   If yes, how often? _____
10. Did the birth mother drink alcohol during the pregnancy? ☐ Yes ☐ No
    If yes, how often? _____
11. Did the birth mother take over the counter or prescription medication during the pregnancy? ☐ Yes ☐ No
    If yes, what type? _____ How often? _____
12. Did the birth mother take recreational or "street" drugs during the pregnancy? ☐ Yes ☐ No
    If yes, what type? _____ How often? _____
13. Has the birth mother been pregnant before? ☐ Yes ☐ No
    If yes, how many times? _____
14. Race/ethnicity of the baby's parents: Mother _____ Father _____
15. Does the baby have any Native American ancestry? ☐ Unknown ☐ Yes ☐ No
    If yes, what is the name of the tribe? _____ From what state? _____

Please tell us if the birth mother, birth father, or any of their relatives had or now have any of the medical conditions listed below

TYPE OF ILLNESS	RELATIONSHIP TO THE CHILD (Mother, Father, Grandparent, Aunt, Uncle) Please state if relative is mother's or father's	AGE ILLNESS BEGAN
☐ HIV OR AIDS	☐ Mother's ☐ Father's	
☐ Sexually Transmitted Disease What kind? _____	☐ Mother's ☐ Father's	
☐ Cancer What kind? _____	☐ Mother's ☐ Father's	
☐ Epilepsy	☐ Mother's ☐ Father's	
☐ Mental Illness What kind? _____	☐ Mother's ☐ Father's	
☐ High Blood Pressure	☐ Mother's ☐ Father's	
☐ Heart Disease	☐ Mother's ☐ Father's	
☐ Diabetes	☐ Mother's ☐ Father's	
☐ Cystic Fibrosis	☐ Mother's ☐ Father's	
☐ Kidney Problems What kind? _____	☐ Mother's ☐ Father's	
☐ Hearing, vision, or speech problems What kind? _____	☐ Mother's ☐ Father's	
☐ Asthma	☐ Mother's ☐ Father's	
☐ Tuberculosis	☐ Mother's ☐ Father's	
☐ Sickle Cell Disease	☐ Mother's ☐ Father's	
☐ Learning delay/special education	☐ Mother's ☐ Father's	
☐ Allergies What kind? _____	☐ Mother's ☐ Father's	
☐ Arthritis What kind? _____	☐ Mother's ☐ Father's	
☐ Other What kind? _____	☐ Mother's ☐ Father's	

Policy Number: EOC 1021	Date Created: 12/13/2012
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Manager)	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
CVL 3	60-75	30-60

Area	Temperature Range in Fahrenheit	Humidity in %
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.

STERILE PROCESSING/STORAGE:

a. Initial readings will be evaluated daily to verify spaces are within range.
b. Regardless of daily findings applicable interventions are performed by staff for spaces, equipment, and instruments prior to procedures.
c. A temporary excursion is allowed within ±10° in temperature or ±10% of humidity of the ranges identified in the table above for excursion periods of up to six (6) hours.
d. If the parameter is outside the acceptable range ***and*** continuously remains in the excursion range for greater than six (6) hours, the Facilities designee will notify the associated charge staff and/or manager of the affected area/s.
e. If humidity is high the staff will follow the Wet Packs protocol. See Wet Pack Policy for additional information.
f. If any of the areas fall outside the recommended parameters ***and*** condensation is present, departmental management, Infection Control and Facilities are notified. Facilities notification is required through the work order process.

OPERATING/PROCEDURE ROOMS:

a. Initial readings will be evaluated daily to verify spaces are within range.
b. Regardless of daily findings applicable interventions are performed by staff for spaces, equipment, and instruments prior to procedures.

c. A temporary excursion is allowed within ±10° in temperature or ±10% of humidity of the ranges identified in the table above for excursion periods of up to six (6) hours.
d. If the parameter is outside the acceptable range and continuously remains in the excursion range for greater than six (6) hours, the Facilities designee will notify the surgery charge staff and/or manager.
e. 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. This also applies to staff comfort related to temperature.
f. If the parameter cannot be met, the nurse manager or designee will notify medical staff, who shall collaboratively decide and document whether it is safe to continue current and/or future cases.
g. All corrective actions will be documented in the data base.
h. The temperature and humidity deficiency logs shall be reviewed by Facilities and Infection Prevention (IP) Department on an as needed basis.
i. Infection Prevention department will take notice of 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.
j. Measurement ranges are approved and accepted by Safety, Facilities, Infection Prevention, and Nursing Leadership.

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

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

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Policy Number: EOC 3000	Date Created: 06/01/2009
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Manager)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Security Management Plan

I. OBJECTIVES

The objectives of the Management Plan for Security at Kaweah Health (KH) are to provide a safe environment wherein intentional risks for harm or loss can be minimized. The plan will identify risk mitigation strategies for both the grounds and District premises. The plan 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 Kaweah Health and any off site areas as per Kaweah Health license.

Each off site area is required to have a unit-specific Safety Plan that addresses the unique considerations of the built environment, including directions for reaching Security or law enforcement. Kaweah Health Medical Center personnel are to dial 44 for an immediate security response within the premises and grounds. Offsite areas are required to call the local police in the event an urgent security response is required.
All areas, including off site areas are monitored for compliance with this plan during routine environmental surveillance by Environment of Care committee members. It is the responsibility of the Safety Officer to assess and document compliance with the Security Management Plan for all areas, including the offsite areas, using an environmental surveillance checklist.

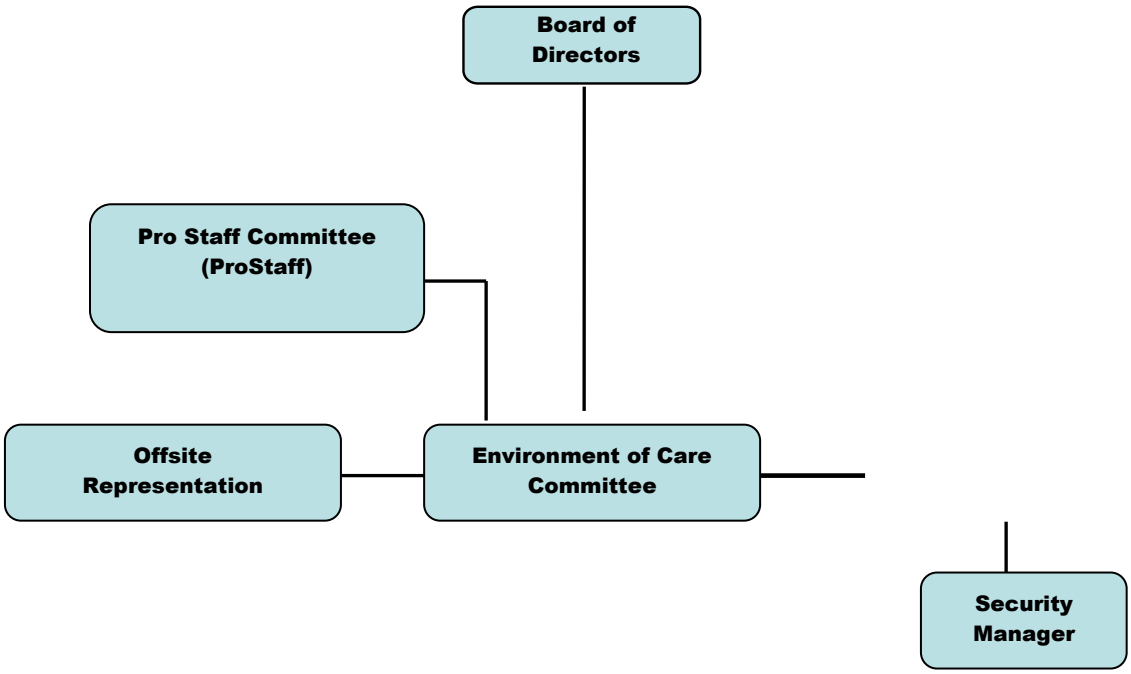
III. AUTHORITY

The authority for the Management Plan for Security is EC.01.01.01. The authority for overseeing and monitoring the Security Management Plan and program lies in the *Environment of Care* Committee, for the purpose of ensuring that security risks are identified, monitored and evaluated, and for ensuring that applicable regulatory activities are monitored and enforced as necessary.

IV. ORGANIZATION

The following represents the organization of security management at Kaweah Health .

Organization - Security Management



V. RESPONSIBILITIES

EC.01.01.01 EP 1

Leadership within (KDHCD) have varying levels of responsibility and work together in the management of risk and in the coordination of [security] risk reduction activities in the physical environment as follows:

Governing Board: The Board of Directors supports the Security Management Plan by:

- Review and feedback if applicable of the quarterly *Environment of Care* reports
- Endorsing budget support as applicable, which is needed to implement security improvements identified through the activities of the Security Management Program.

Pro Staff Committee (ProStaff): Reviews annual *Environment of Care* report from the *Environment of Care* Committee, and provides broad direction in the establishment of performance monitoring standards for security, and provides applicable feedback.

Administrative Staff: Administrative staff provides active representation on the *Environment of Care* Committee meetings and sets an expectation of accountability for compliance with the Security Management Program

Environment of Care Committee: Environment of Care Committee members review and approve the quarterly *Environment of Care* reports, which contain a Security Management component. Members also monitor and evaluate the Security Management Program **(EC.04.01.01-1)** and afford a multidisciplinary process for resolving *Environment of Care* issues relating to security. Committee members represent clinical, administrative and support services when applicable. The committee

addresses *Environment of Care* issues in a timely manner, and makes recommendations as appropriate for approval. *Environment of Care* issues are communicated to organizational leaders through quarterly and annual evaluation reports. At least annually, one Process Improvement activity is recommended to the Board of Directors, based upon the ongoing monitoring of *Environment of Care* management plans. *Environment of Care* issues are communicated to those responsible for managing the patient safety program as applicable when risks occur relating to Security that may have an impact on the safety of the patient.

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

- Reviewing and correcting deficiencies identified through the hazard surveillance process that may pose a security risk.
- Communicating security recommendations from the *Environment of Care* Committee to applicable staff in a timely manner.
- Developing education programs within each department that ensure compliance with the policies of the Security Management Program (for example education or training relating to “Code Pink” or “Code Gray” response).
- Supporting all required employee security 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 expectations.

Employees: Employees are required to participate in the Security Management Program by:

- Completing required security education.
- Calling Security, and notifying his/her manager if anything or anyone suspicious occurs in the department within which they are working.
- Participating in Code Pink/Purple drills.

Medical Staff: Medical Staff will support the Security Management Program by reporting any unusual or suspicious activity to Security staff.

VP Chief Compliance/Risk Officer: This individual has the ultimate authority over security personnel, and the Security Management Program.

MANAGEMENT OF SECURITY RISKS
EC.02-01-01 EP-1
The hospital identifies security 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.

Risk Assessment: The management of organization security risks consists of the following processes:

1 **Policy/Plan/Program Development.** Inherent in risk assessment are the development of security policies, management plan for security, and program development for security through the structure of the *Environment of Care* Committee. Regulations, accreditation or industry standards (e.g., AB 508, Title 22) provide the structure 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 security processes, which will require a plan for improvement to minimize unfavorable outcomes from the possibility of consequential risks. Accountability for assessment and improvement activities is with the *Environment of Care* committee.

3 **External Sources: *Sentinel Event Alerts*, Regulatory and Insurer inspections, Audits, and Consultants. Security 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 *Environment of Care* committee.

4 **Education:** Education is implemented to provide information, and thereby mitigate risk and includes, but is not limited to:
- New Hire Orientation
- Department Specific Education
- Education for patients, staff, physicians, volunteers, and 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 infant security or disaster, constitute activities designed to inform, educate and thereby mitigate risk when areas of risk are identified during the debriefing and/or evaluation process.

6 **Reporting and Investigation of Incidents.** Complementary to risk assessment is proper reporting and investigation of security incidents. Internal processes and activities that support risk assessment include reporting and investigation mechanisms which may identify the opportunity to mitigate risk relating to property damage, thefts, vandalism, burglary, assault, battery and any violent incidents.

ACTIONS TO MINIMIZE OR ELIMINATE IDENTIFIED SECURITY RISKS
EC.02.01.01 EP-3
The hospital takes action to minimize or eliminate identified safety risks.
When risks are identified from the above processes, the *Environment of Care* Committee uses the risks identified to select and implement procedures and controls to achieve the lowest potential for adverse impact on the safety and security of patients, staff, and other persons throughout the organization. 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

In-house Security Services are provided at KH. Coverage is provided twenty-four (24) hours per day, seven (7) days a week by uniformed facility security officers at the Main, South and West Campuses, including the Acute Psych Hospital. Security provides routine patrols of the campus and parking lots, providing visual presence and identifying safety and security risk. Hospital entrance doors are secured by the security officer according to a set schedule with the exception of the Emergency Department public entrance. Employees are able to access the medical center with the use of an ID badge Key Card.

The Security Department is responsible for the following:

- Protection of persons/property
- Access control
- Parking and vehicle management
- Safety Escort service
- Loss prevention
- Patrol of buildings and grounds
- Maintaining daily activity logs
- Preparation of incident/crime reports

Additionally, the following mechanisms are in place to proactively minimize or eliminate security risks:

1. Committee Structure. The *Environment of Care* Committee is the structure through which security-related problems and issues can be identified and resolved. It should be noted that the *Environment of Care* Committee is closely integrated with patient safety functions. The purpose of the *Environment of Care* 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 hospital that reflect security issues, the *Environment of Care* Committee will participate in improving outcomes relating to security risk management.

2. Reporting and Investigation Mechanisms. A reporting and investigation process is in place that is part of the responsibilities of security staff. Security incidents are reported on an electronic reporting system, which are completed by staff involved with the incident. Violent, assaultive and/or battery type incidents are reported to the local police with a written report generated within 72 hours. Security incidents are reported on a quarterly basis to the *Environment of Care* Committee, which provides members with the opportunity to observe for trends or patterns, and make the appropriate recommendations.

3. An Identification System. An identification system is in place to identify active employees, physician staff, volunteers and business associates; and to minimize the entry of unauthorized personnel onto the premises.

4. Access Control. Access Control is in place in sensitive areas, and protected by special systems which allows only authorized personnel to enter the areas.

5. Closed Circuit TV. Closed circuit TV is in place to monitor the security sensitive areas, public entrances, lobbies and corridors, and select parking lots.

6. Panic Buttons. Panic buttons are located in high-risk areas throughout the hospital. Alarms are installed and monitored internally, provided by a third party monitoring company or combination of both. When an alarm is activated, the PBX operator notifies Security and contacts the police for assistance. A burglar-panic alarm monitoring company will notify the hospital PBX in the event of activation so that hospital Security can respond. Panic Buttons are located in the following departments:
   Administration, Admitting, Dietary, Emergency Department, Guild Gift Shop, HIM, Human Resources, ICU, Kaweah Korner Employee Store, Labor and Delivery, Mother-Baby, NICU, Patient Accounting, Pediatrics, Foundation, Pharmacy, Rehabilitation Hospital, Risk Management, and the Surgery Waiting Room.

7. Policies. Security policies and procedures are in place, providing guidelines for the prevention of risk, e.g., “Code Pink” policy, Code Gray, Code Silver, Code Purple.

8. Education – for Newly-hired Staff and Ongoing (HR.01.04.05.01 EP 1; HR.01.04.01 EP 1, 2, 3; EC.03.01.01 EP’s 1-2). Education plan is in place to promote employee awareness of risk, and to provide the phone number to call in the event security assistance is needed.
   a. New hire Education. Education relating to general security processes is given during New hire orientation, and covers introductory information, which includes the phone number to call if security is needed, as well as hospital emergency codes information.
   b. Specific Job-Related Hazards. Education is provided to new security officers relating to specific job-related competencies, which is reviewed annually.

9. Loss Prevention strategies: Doors leading to departmental work areas are controlled by keys which are restricted to department members, facilities, security personnel and environmental services. The Admitting Office and the Security Department maintains a safe for patient valuables. Hospital property is tagged with a decal which lists the hospital’s property number. Property which is being removed from the premises must be accompanied by a signed property removal pass.

Risk Reduction Strategies – When Risks Have Been Identified

When proactive security risks have been assessed, risk reduction strategies will be the responsibility of security staff in coordination with the *Environment of Care* 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 *Environment of Care* Committee, based upon the severity and type of risk identified. Risk reduction strategies for identified risks 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 reinforced.
6. Repairs/ Upgrades on Equipment. Repairs and or upgrades/modifications on security equipment, such as cameras or hand-held radios 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
EC. 02.01.01 EP 5

Kaweah Health 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 *Environment of Care* Committee personnel. Additionally, routine and varied security patrols are conducted wherein any security hazards are brought to the attention of the *Environment of Care* Committee. Building/grounds surveys with a contractor's representative are conducted when construction activities are occurring. In certain instances, Security staff may be requested to participate in a fire watch. 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.

EC.02-.01.01 EP 7
The hospital identifies individuals entering its facilities.
Identification methods used at the medical center include the following:
A. Photo Identification: All employees, members of the medical staff and volunteers are issued a photo identification badge to be worn while on hospital property.
B. Temporary Badges: Visitors are issued temporary badges in the Emergency Department, at all three main entrances (Mineral King Lobby, Surgery Center entrance and the Acequia Wing Lobby), and when visiting after hours. Vendors and Business Associates are issued temporary badges while working on the hospital campus.
C. Identification Bracelets: Patients are provided with identification bracelets.

EC.02.01.01 EP 8

The hospital controls access to and from areas it identifies as security sensitive.

Access Control: the following sensitive areas of the hospital are protected by special systems:

- CV-ICU – Badge Access
- Emergency Department – Combination Keypad, badge access and CCTV
- ICU/CCU – Combination Keypad and limited key access
- Information Systems – Limited key access, burglar alarm system and CCTV
- Labor & Delivery – Badge access, CCTV, HUGS Infant Security System, panic-duress alarms
- Materials Management – Limited key access
- Mother-Baby Unit – Badge access, HUGS Infant Security System, CCTV, and panic-duress alarms
- NICU –Badge access, HUGS Infant Security System, CCTV, and panic-duress alarms
- OB-Surgery – Badge access / CCTV / HUGS Infant Security System
- Operating Room –badge access
- Pharmacy: Dedicated key access, keypad and badge access
- Helipad – Badge access; key access for exterior staircase security fence

Vehicular Access and Traffic Control: Parking lot way finding signs assist Emergency vehicles, patients and visitors find their destination. The Emergency Department is clearly identified and when necessary, are assisted by a security officer for direction and/moving personal vehicles. Security provides traffic control in times of need with Facilities/Engineering's assistance.

Complimentary Valet Services are also provided for hospital patients and guests.

EC.02.01.01 EP 9-10

The hospital has written procedures to follow in the event of a security incident, including an infant or pediatric abduction.

In the event of a security incident, staff is directed to Dial #44 (hospital emergency number) to contact Security via the Hospital Operator/PBX. The Hospital Emergency Code(s) help to communicate the type of emergency and response by Security and hospital staff. A back-up system is in place, which involves contracting with a local security guard services company that provides additional security staff when needed. If a system failure occurs, the vp Chief Compliance/Risk Officer has the authority to contact the appropriate vendors to initiate repairs or to request security guard services. The Director of Facilities will be notified immediately, in any event, when Security systems fail or when staffing plans cannot be met as scheduled.

Infant/Pediatric Security: The prevention of infant kidnapping is addressed by a "Code Pink" policy and procedure. All OB nursing personnel are in-serviced regarding the Code Pink policy. All parents, on admission, receive information on the prevention of infant kidnapping. At least twice a year, "Code Pink" drills are conducted to assess staff response to an infant abduction. Drills are evaluated for response plan effectiveness and reported to the *Environment of Care* Committee.

Handling of situations involving VIP's or the media: VIPs, patient family members and the media will be escorted by Security personnel to a designated area for waiting. The Director of Media Relations will be responsible for any information released to any entity. Security personnel will not give any information to any family member, VIP or the media. Security staff will take all precautions necessary to protect the individual. If the VIP has his/her own security protection, Security staff will work together with that security force to assure that the VIP is protected. This may include establishing special patrols or calling in additional officers.

02.01.01 EP 17
The hospital conducts and annual worksite analysis related to its workplace violence prevention program. The hospital takes actions to mitigate or resolve the workplace violence safety and security risks based upon finding from the analysis.

INFORMATION COLLECTION SYSTEM TO MONITOR CONDITIONS IN THE ENVIRONMENT
EC.04.01.01 EP's 1,3,5-6,
The hospital establishes a process(es) for continually monitoring, internally reporting, and investigating the following:

- Security incidents involving patients, staff or others within its facilities, including those related to Workplace Violence.

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

ANNUAL EVALUATION OF THE SECURITY MANAGEMENT PLAN
EC.04.01.01 EP-15
On an annual basis *Environment of Care* Committee members evaluate the Management Plan for Security, as part of a risk assessment process. Validation of the management plan occurs to ensure contents of the plan support ongoing activities within the medical center. Based upon findings, goals and objectives will be determined for the subsequent year. The annual evaluation will include a review of the following:

- The objectives: The objective of the Security Management Plan will be evaluated to determine continued relevance for the organization (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 objectives 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 Security 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 offsite areas, and throughout the organization? Was security managed appropriately for the offsite areas?)
- Performance Standards. Specific performance standards for the Security 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.

THE DISTRICT ANALYZES IDENTIFIED *ENVIRONMENT OF CARE* ISSUES
EC.04.01.03 EP-2
Environment of care issues are identified and analyzed through the *Environment of Care* Committee with recommendations made for resolution. It is the responsibility of the *Environment of Care* Committee chairperson to establish an agenda, set the meetings, coordinate the meeting and ensure follow-up occurs where indicated. Topics that relate to overall security management are a standing agenda item for *Environment of Care* committee members to consider. Security issues are documented. Quarterly *Environment of Care* reports are communicated to Performance Improvement, the Medical Executive Committee and the Board of Directors.

PRIORITY IMPROVEMENT PROJECT
At least annually, priority Improvement activities are communicated by the *Environment of Care* Committee to the Governing Board. Each priority improvement activity is based upon ongoing performance monitoring and identified risk within the environment. The activity may be related to a security issue if the activity ranks high as a prioritized risk.

KAWEAH HEALTH TAKES ACTION ON IDENTIFIED OPPORTUNITIES TO RESOLVE ENVIRONMENTAL SAFETY ISSUES
EC.04.01.05 EP-1
Performance standards are identified, monitored and evaluated that measure effective outcomes in the area of security management. Performance standards are identified for Security, and they 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 related to security.

Patient Safety
Periodically there may be an *environment of care* issue that has impact on the safety of our patients that results from a security issue. This may be determined from a *Sentinel Event*, security incident(s), 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.

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 3007	**Date Created: 04/01/2010**
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Manager)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Emergency Department Security

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

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

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

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

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

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

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

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

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

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

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

Kaweah Health

Subcategories of Department Manuals not selected.

Policy Number: EOC 3010	**Date Created: 04/01/2010**
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Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Key Control Policy

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

POLICY:

Key control is an important facet of controlling access to Kaweah Delta Health Care District herein after referred to as Kaweah Health (KH) facilities. All buildings will have an appropriate system to ensure security to protect personnel and property.

PROCEDURE:

Keys will be issued by the Maintenance Department to the Department Director or Manager of the facility for issuance to personnel.

Department Heads or Managers will be responsible for who has keys and will also be responsible for collecting them when necessary. The Maintenance Department will only issue new keys or replacement keys upon authorization of the Department Director or Manager of the facility involved.

A Grand Master Key will be kept in the PBX at KDMC for emergency purposes. It will be kept in a glass box that can be broken under Emergency Conditions by any Manager.. A report will be filed anytime this key is used with the Director of Facilities.

All employees will normally be issued an Employee Key when employment begins at the District. The type, function, and capability of this key to open locks will be determined by the employee's manager. This key must be returned to Kaweah Health upon termination, via the Department Director or Manager.

The Pharmacy Director is responsible for all Medication Room Locks. The Pharmacy Department works with an outside contractor, who is bonded, for their locks and keys.

Changes to any combination lock or key will only be granted with the approval of the Manager or Department Director. It is the approving authority's responsibility to request new keys or combinations and give them to the appropriate parties.

All excess or old keys shall be returned to the Maintenance Department.

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

Policy Number: EOC 3014	Date Created: 04/01/2010
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Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Security Measures Involving VIP(s)

POLICY:

Whenever a VIP status person arrives to Kaweah Health (KH) as a patient, steps will be taken to address special internal security protocols, crowd control and media coverage

DEFINITION:

VIP (Very Important Person) – Examples include celebrities, heads of state/heads of government and other politicians, major employers, high-level corporate officers, other notable person who receives special treatment for any reason, or influential persons in the community

PROCEDURE:

Upon notification of the arrival or anticipated arrival of a VIP as a patient, the house supervisor will be notified. The house supervisor will determine any further notification that need to occur. :

I. ONGOING STAY:

VIP patients who are admitted shall be admitted to ICU or other patient care unit with access control security measures. Patient will be admitted by registration clerk as a "No Info". Patient name will not appear on computer screens or certain reports to prevent unauthorized viewing. The patient must be registered under the correct name for lab work and blood transfusions as risk prevention.

II. SECURITY:

The appropriate federal, state or local law enforcement, if a Government VIP, will provide internal security.

The front hospital entrance shall be used for all entrances and exits. Kaweah Health security officers shall stand by for availability as needed. External security will be coordinated between the Visalia Police Department, Hospital Security and any involved government agency law enforcement.

III. COMMUNICATION:

Any inquiry from the news media (newspapers, magazines, radio, and television) shall be directed to Administration for approval.

Inquiries from reporters to interview patients or personnel shall be referred to Administration prior to granting admittance to the hospital.

If a patient prefers not to interview, the hospital will provide the media with the routine information, which is releasable. All staff shall maintain confidentiality information by not discussing the case with anyone who does not have a need for this information.

"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."

Subcategories of Department Manuals not selected.

Policy Number: EOC 4000	**Date Created: 10/01/2009**
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Manager)	**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 Health (KH) 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 **KH**, and any off site areas, per KH 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.

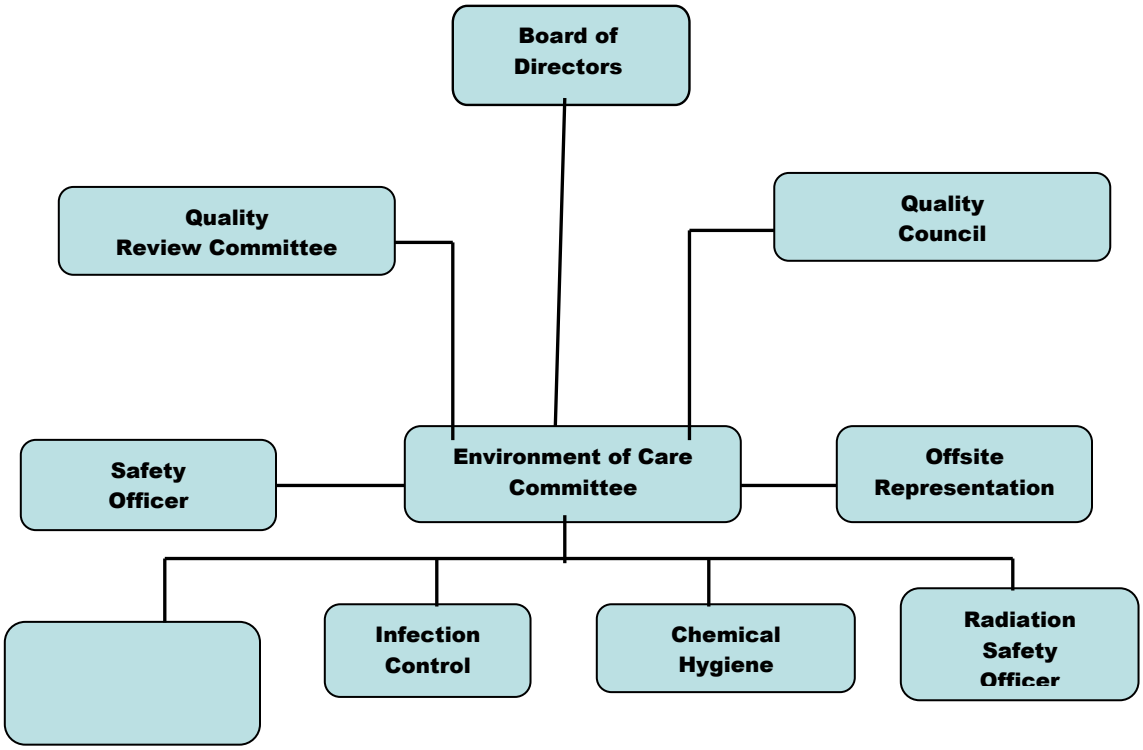
III. AUTHORITY

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 Hospital Safety Officer has the authority to oversee the hazardous materials and waste program at KH.

IV. ORGANIZATION

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

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 KDCompass:.

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

Employees. Employees of KH 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.

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 1 The 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 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. KH 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 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 Kaweah Health may be safely cleaned with the appropriate spills kit by the staff member involved in the spill.

EC.02.02.01-5 and 6
KH 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 containers. 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:

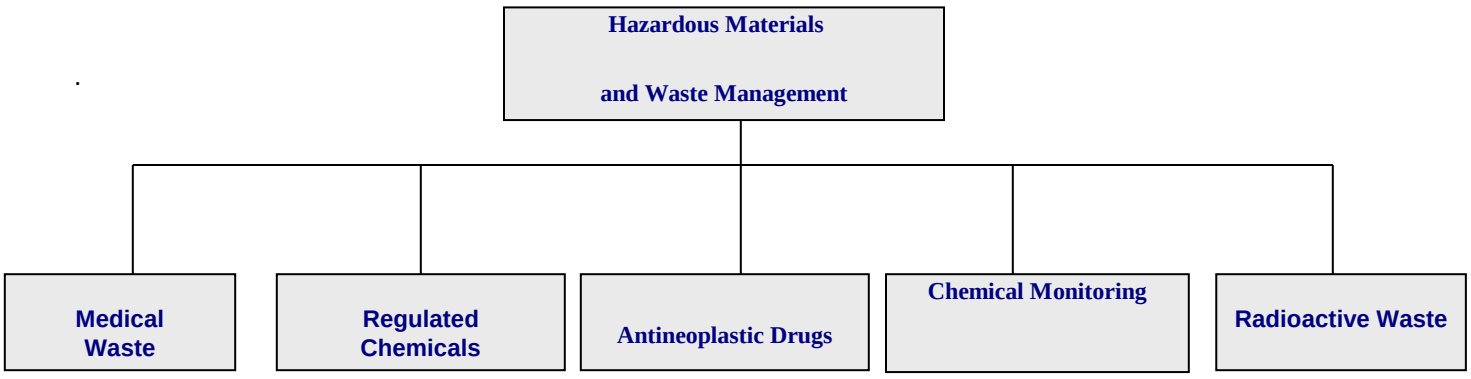
1.The chemical waste is labeled.
2. The chemical waste is placed in the appropriate container.
3. The chemical waste is removed from the area as soon as possible.
4. The chemical waste may not be stored for more than 90 days
5. The chemical waste is manifested in accordance with regulation.

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.

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 Safety and Facilities personnel to ensure the permits are current on an annual basis with the agency having jurisdiction.

EC.02.02.01-12

KH **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.

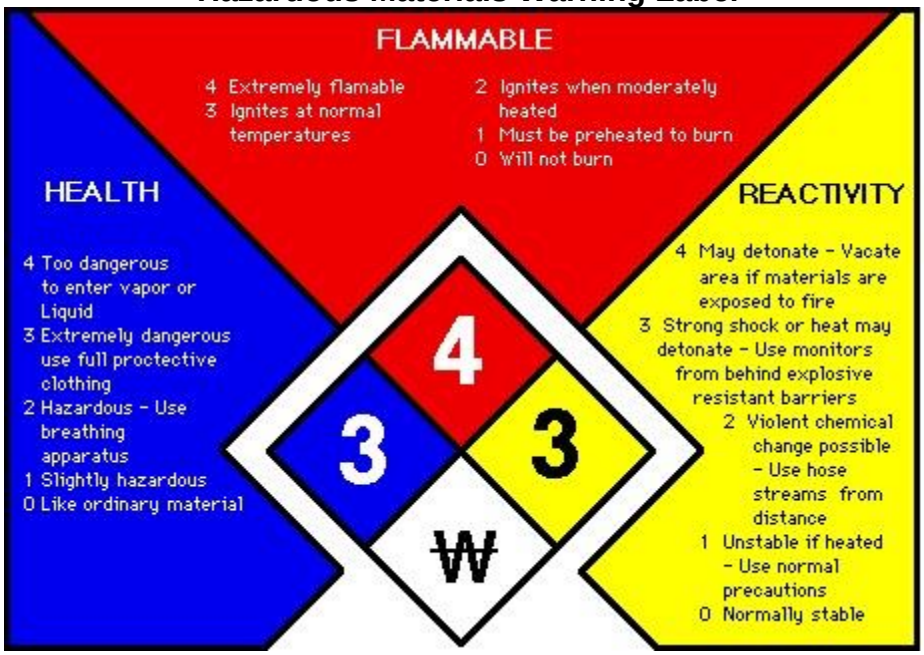
Labeling of Hazardous Materials: All hazardous materials used throughout the District must be labeled with the information that is generated from the manufacturer. If a hazardous material is transferred from the original container to a secondary container, the secondary container must have the same information 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

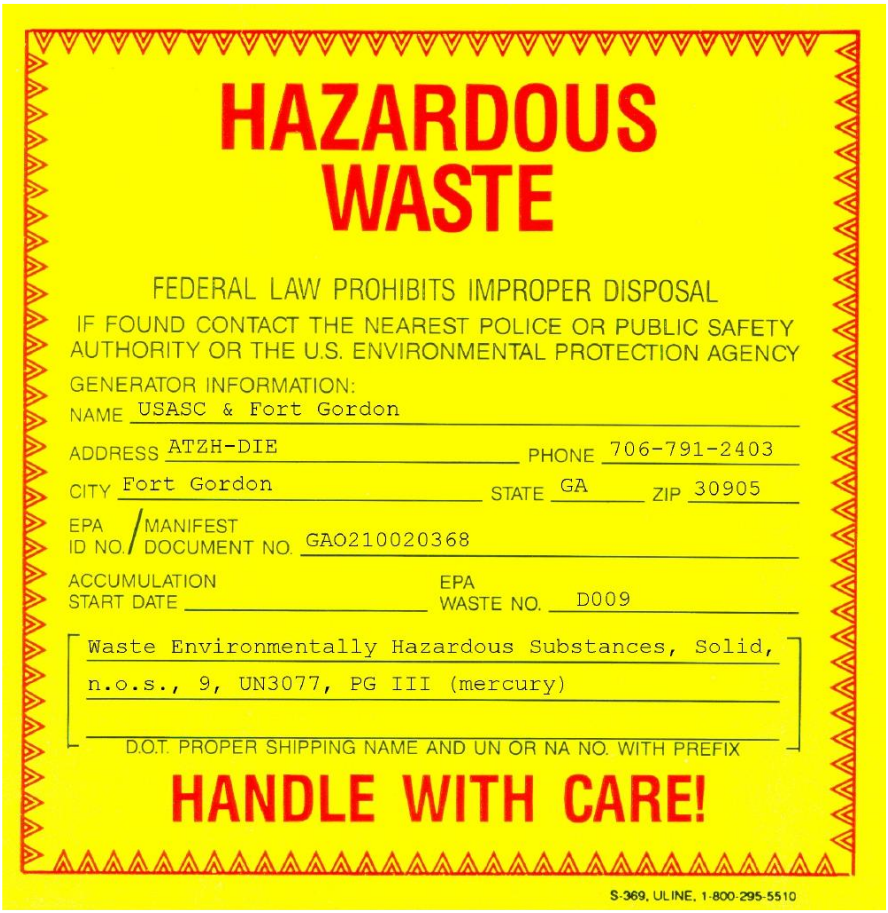


Bloodborne Pathogen Warning

.

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-
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 Health

Subcategories of Department Manuals not selected.

Policy Number: EOC 4001	**Date Created: 03/01/2006**
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Manager)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Hazardous Materials and Waste Management Program

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

TABLE OF CONTENTS

I. POLICY OVERVIEW:

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

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

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

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

PURPOSE:

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

OBJECTIVES:

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

III. DEFINITIONS:

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

IV. ROLES AND RESPONSIBILITIES:

- **KAWEAH HEALTH**

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

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

- **ALL EMPLOYEES**

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

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

- **CONTRACTORS**

  1. Follow all safety rules at this workplace

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

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

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

- **DEPARTMENT DIRECTORS**
    1. The personnel of the department shall be oriented to the Incora MAXCOM™ (SDS) Manual.
    2. Staff orientation to the Incora MAXCOM™ (SDS) Manual:
        - Existence of the Manual and contents
        - Where it is kept (It is to be available to employees at all times)

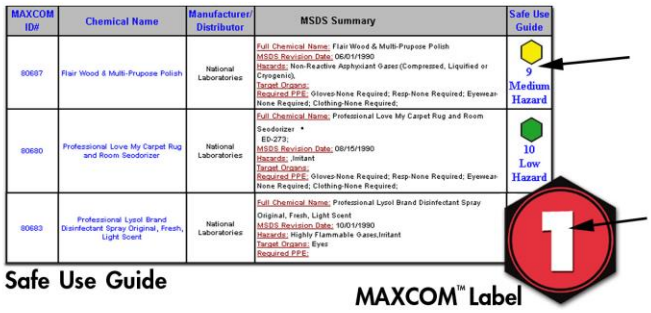
- How to utilize the Incora MAXCOM™ system (manual and online), and read a standard SDS

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

V. RESPONSE

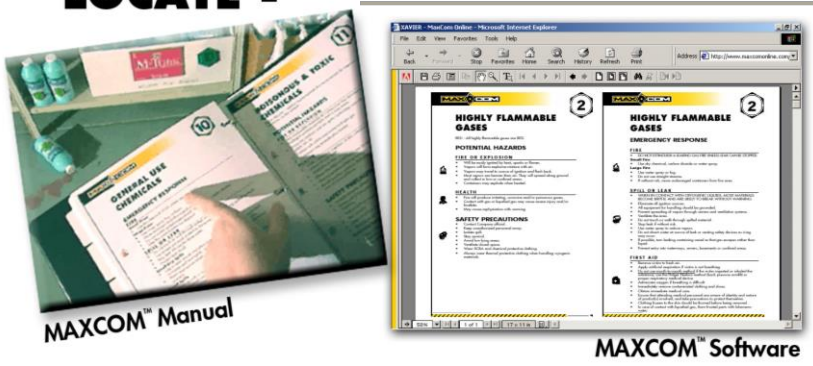
The following procedure illustrates an appropriate response to a chemical spill within the District:

IDENTIFY -



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

LOCATE -



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

RESPOND -

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

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

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

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

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

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

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

VI. LIST OF HAZARDOUS CHEMICALS

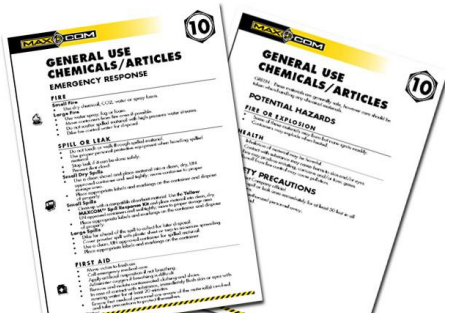
The list of hazardous chemicals is provided in Section 4 of the Incora MAXCOM™ MSDS Manual

available through Kaweah Compass

Sample MSDS Index

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

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



VII. SAFETY DATA SHEETS (SDS) AND OTHERINFORMATION

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

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

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

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

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

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

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

button onthe upper right hand side of this page.

VIII. SDS PROCEDURES

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

IX. EMPLOYEE INJURY FROM HAZARDOUS MATERIALS AND WASTE

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

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

X. PERSONAL PROTECTIVE EQUIPMENT (PPE)

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

XI. LABELS AND OTHER FORMS OF WARNING

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

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

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

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

XII. TRAINING

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

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

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

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

  All training shall be documented.

XIII. NON-ROUTINE TASKS

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

XIV. CONTRACTOR EMPLOYERS

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

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

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

XV. MATERIAL ORDERING AND RECEIVING

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

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

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

XVI. HAZMAT STORAGE

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

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

XVII. DISPOSAL OF HAZARDOUS WASTE

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

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

    - *DIETETIC DEPARTMENT/SERVICE WASTE DISPOSAL*

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

▪ *ENVIRONMENTAL SERVICES WASTE DISPOSAL*

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

XVIII. BIO-HAZARDOUS WASTE:

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

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

DEFINITION:

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

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

XIX. RADIOACTIVE WASTE

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

NOTE: WHEN HANDLING RADIONUCLIDES, WEAR RUBBER GLOVES.

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

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

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

XX. COMPRESSED GASES AND OXYGEN

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

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

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

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

XXI. Pharmaceutical Waste

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

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

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

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

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

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

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

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

XXII. PESTICIDE MANAGEMENT

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

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

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

XXIII. HAZARDOUS GAS TESTING

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

PROCEDURES:

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

PPM

- Time weighted average (TWA) 0.5

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

PPM

- Time weighted average (TWA) 50

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

PPM

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

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

PPM

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

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

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

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

XXV. SEMIANNUAL REVIEWS: (Hazard Surveillance)

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

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

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

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

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Document Owner: Maribel Aguilar (Safety Officer/Life Safety Manager)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Code Triage- Activation Plan

I. Policy

In the event of an emergency incident that has the potential to overwhelm day-to-day operations, Kaweah Delta Health Care District herein after referred as Kaweah Health (KD) will activate the Emergency Operations Plan. The decision to activate the plan will be made by the Incident Commander CEO, Administrator on Duty (until the CEO arrives), or Nursing Supervisor (until the CEO or Administrator on Duty arrives). The decision to terminate shall be made by the Incident Commander in coordination with the authority having jurisdiction and other civil or military authorities involved. The Emergency Operations Plan is flexible and can be customized to the needs of an emergency per the Hospital Incident Command System (HICS) model. The Incident Commander has ultimate responsibility and authority for decision making during Emergency Operations Plan activation.

Emergencies affecting the hospital may be:

A. Internal – Any occurrence within the District such as fire, explosion, bomb threat, hazardous materials spill/release, etc., which significantly impact normal practices and procedures and/or which overwhelm available resources. This could include injured patients and/or employees, loss of critical systems or services needed for patient care that would require partial or complete evacuation. Also, a large external disaster could overtax District resources to the point that it also becomes an internal disaster.

B. External – A major fire, flood, earthquake, explosion, air or ground vehicular accidents, hazardous materials spill/release, or any other major emergency outside of District facilities that produces multiple victims requiring timely treatment of mass casualties.

II. Procedures

A. Determining Need for Emergency Operations Plan Activation

1. Upon direction of the Incident Commander, the PBX Operator notifies the HICS team via paging system “Code Triage, Alert” (3x).
    a. When an emergency or unusual event impacts the District, the primary leaders for the Hospital Command Center (HCC) report to the HCC for an early stage Code Triage.
    b. Staff who report to the HCC include those who fill the following key roles in the **HICS model:**

1. Incident Commander:
2. Safety/Security Officer
3. Liaison Officer
4. Public Information Officer (PIO)
5. Logistics Chief
6. Planning Chief
7. Operations Chief
8. Finance Chief
9. Facility Unit Leader
10. Medical Staff Director

2. The HICS team will analyze the situation and determine the level of response.

B. Code Triage – Emergency Operations Plan Activation

1. The Incident Commander authorizes the PBX Operator to announce the Code Triage and implements HICS to the extent required.

2. Hospital-Wide Announcement

a. Incident Commander/Administrator On Call/Director On Call/CEO will determine if Code Triage needs to activated.
b. Approved list from (A.) will contact the PBX Operator x44 to make the overhead announcement: “Code Triage” (3x).
c. Approved list from (A.) will contact the ISS Help Desk x2280 to activate the Cisco phone digital display (Berbee) on all district phones and to notify leadership staff via xMatters alert system.

Example of verbiage for Cisco Phone Display (Berbee): Code Triage: ED still experiencing high volumes. Inpatient and Mental Health also with high volumes. Capacity is improved, will continue to work to move patients. Possible staffing needs tonight. More information to follow.

Example of verbiage for xMatters: Code Triage: ED still experiencing high volumes. Inpatient and Mental Health also with high volumes. Capacity is improved, will continue to work to move patients. Possible staffing needs tonight. More information to follow.

C. Response Procedure
See attached Plan Activation Checklist and flowchart (Appendix B & C).

D. Functional Areas

See attached table, “Functional Areas during Activation of the Emergency Operations Plan.” (Appendix D)

E. Emergency Supplies, Disaster Kits and MOUs

Kaweah Health will maintain a minimum stockpile of emergency supplies and ensure immediate access to critical materials including pharmaceuticals, medical supplies, food, linen, industrial and potable (drinking) waters as needed. The hospital will maintain Memos of Understanding (MOUs) with vendors to receive priority shipment of critical supplies in the event of an emergency.
See attached table, “Emergency Supplies.” (Appendix E)

F. Termination of Code Triage

1. The decision to terminate the Code Triage will be made by the Incident Commander, in coordination with the authority having jurisdiction and other involved civil or military authorities.
2. When the Code Triage is terminated, the Incident Commander notifies the PBX Operator, who makes the overhead announcement, “Code Triage, All Clear” (3x).

Note: See Appendix for form:

Department Emergency Status Report

"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."

CODE TRIAGE – PLAN ACTIVATION

INCIDENT COMMANDER CHECK LIST- House Supervisor, AOC or Designee

 Establish HCC.(Temp at MSC Auditorium or as specified by IC)
 Assess situation and activate HICS to the extent necessary to manage the incident.
 Direct PBX Operator for all overhead emergency announcements.
 Brief managers and medical staff on anticipated impact and update them on the event's status.
 Provide leadership for HICS Command Team (see Incident Commander Job Action Sheet).
 Determine when the incident has been stabilized to the point where normal hospital operations may be resumed and deactivate HICS. Authorize PBX Operator to announce "All Clear."
 Conduct an incident debriefing as soon as possible following the deactivation of Code Triage.
Note: The Incident Commander has ultimate responsibility and authority for decision-making during Emergency Operations Plan activation.

PBX OPERATOR / HELP DESK ANALYST CHECKLIST

 As directed by Incident Commander/Administrator On Call/Director On Call/CEO. PBX Operator implements "Code Triage, Alert" to summon key HICS staff to the HCC.
 PBX Operator announces: "Code Triage" (3x)
 Help Desk will send Cisco phone message (Berbee) to all digital hospital phones.
 Help Desk will send xMatters to all Leadership staff.
 Help Desk will send xMatters to all staff, if requested by Incident Commander/Administrator On Call/Director On Call/CEO.

DEPARTMENT MANAGERS CHECKLIST

 Implement hospital and department disaster-specific plan.
 Inventory personnel, supplies, equipment, victims and injuries on your *Emergency/Disaster Status Report* and send to HCC via runner.
 Report all needs and concerns via HICS Chain-of-Command.
At Code Triage:
Complete Department Status Form and fax to Incident Command Center #713-2332.
Send surplus staff to Labor Pool.
Activate staff call backlists to summon off-duty staff if requested.
Report to Incident Command Center for assignment.
 Update HCC on department status as needed or requested. Stand by for further instructions from HCC.
 Participate in incident debriefing as requested.

STAFF RESPONSE CHECKLIST

If Off-Duty:

 Secure home and family (and pets), then

 If you have a pre-assigned emergency duty through HICS, report for work automatically and do not wait for contact from Kaweah Health.

Emergency Management Manual

 If you do not have a pre-assigned emergency duty, stay tuned to television news broadcasts or the following radio stations: KMJ 580.

 Be prepared to report for an emergency assignment.

 If the broadcast message indicates, or if you do not hear a broadcast message within two hours after a major event, call the Employee Emergency Phone Line: 559-624-2008 .

 The message will specify where and when to report.

 Leave a message on the phone line giving your status and the time you will be able to arrive at the assigned work location.

 If summoned, wear ID badge and bring appropriate license.

If On-Duty:

 Follow instructions in the Emergency Management Manual.

 All unassigned or available hospital staff must report to the Labor Pool.

 Remain at hospital and perform duties as assigned. Wear your ID badge at all times.

 If you are evacuated from a building, check in at your assigned Evacuation Assembly Area.

EMERGENCY DEPARTMENT CHECKLIST

 The ED Team Leader will report all incident-related messages from StatusNet Communications system or EMS Agency Duty Officer to the Incident Commander at HCC.

 When the emergency incident/disaster involves the potential for large numbers of victims arriving to the ED, the Operations Chief will appoint a HICS Medical Care Director/Treatment Areas Supervisor to direct the activation, emergency operations and assignment of HICS Unit Leaders for functional treatment areas required during activation of the Emergency Operations Plan. The HICS Unit Leader positions will be assigned on the basis of staff availability and experience.

 Call Central Logistic to request the ED Disaster Carts.

 ED Team Leader to refer to ED specific “Disaster Cheat Sheet” for more detailed actions.

 Directions for activation (HICS Job Action Sheets) of treatment areas will be distributed to the HICS Unit Leaders by the HICS Medical Care Director/Treatment Areas Supervisor.

 Supplies for the Triage and Treatment areas are located in the ED supply room and in pre-positioned MCI Supply trailers. ED Charge Nurse/Nursing Shift Supervisor has keys.

 Treatment Areas Unit Leaders communicate staff overload issues during a Code Triage to the Treatment Areas Supervisor, who will discuss with the Medical Care Director/Operations Chief.

ALL CLEAR

At the conclusion of a disaster, the Incident Commander will notify the PBX Operator to overhead page, “Code Triage, All Clear” (3x) and notify other medical facilities and government agencies as appropriate. Return to your normal work duties, unless otherwise directed.

Note: Following the emergency incident, the Department Manager(s) of the affected area(s) shall fax an *Emergency Occurrence/Drill Critique* to the Safety Office within 24 hours: 559-713-2204.

Functional Areas during Activation of the Emergency Management Plan

Appendix D

Functional Area	Location		Essential Activity	Responsible Person
	Primary	Secondary		
Clinical Admitting	Admitting	TBD	Complete admission paperwork and locate bed assignment	Bed Control in collaboration with the Nursing Unit Leader
Decontamination Area	Emergency Department Decon Shower	N/A	For chemical and radioactive decontamination	Decon Unit Leader
Delayed Treatment Area			Care of dying and those who may be treated when time and staff permit	Delayed Treatment Unit Leader
Dependent Care Area	Kaweah Kids		Care for staff dependents who have no alternative care arrangements	Dependent Care Unit Leader
Discharged Patients Holding Area	Acequia Wing Lobby		Hold discharged patients until trans-portation is available	Discharge Unit Leader
Employee/ Physician Entrance	Admin Entrance	Lobby Entrance	Controlled access to hospital	Medical Staff Labor Pool and Labor Pool Unit Leaders
Holding Area for Patients Waiting to be Admitted	Main Lobby		Waiting area for patients awaiting inpatient beds	Immediate Treatment Unit Leader
Hospital Command Center (HCC) (GSH)	MSC Auditorium	Admin Conf Room	Command area	Incident Commander
Satellite HCC at West Campus	Rehab Charting Room		Command area	West Campus Incident Commander
Satellite HCC at South Campus	Subacute Station A			South Campus Incident Commander
Immediate Treatment Area	Emergency Department		Treatment of critical and serious patients	Immediate Treatment Unit Leader
Labor Pool – Main Campus	Cafeteria	MCS Auditorium	Organize and assign personnel	Labor Pool Unit Leader
Labor Pool – South Campus	Cafeteria	TBD	Organize and assign personnel	Labor Pool Unit Leader
Labor Pool – West Campus	Rehab Cafeteria	TBD	Organize and assign personnel	Labor Pool Unit Leader
Logistics Command Post	Blue Room	Maintenance Upstairs	Manage the provision of material/supply resources, nutritional resources and the safe environment	Logistics Chief

Functional Area	Location		Essential Activity	Responsible Person
	Primary	Secondary		
Media Area	Acequia Wing Lobby	SSB Emerald Room	Provide information to news media, coordinate all internal and external communication	Public Information Officer
Medical Staff Pool	Medical Staff Offices		Organize and assign medical staff	Medical Staff Unit Leader
Minor Treatment Area and Non-emergent First Aid	Emergency Dept Zone 6		Walking wounded and stable patients treated	Minor Treatment Unit Leader
Morgue	Morgue	Medical Waste Storage Area	Deceased victims	Morgue Unit Leader
Operations Command Post	MSC Auditorium		Manage the medical mission of the hospital, including all nursing units and supportive and ancillary units	Operations Chief
Patient Information Area	Surgery Center Waiting Room		Victims' families receive information	Patient Information Officer
Relative Waiting Area	Surgery Center Waiting Room		Victims' families receive information	Patient Information Officer
Security Command Post	Security Offices	VP Operations' Office	Monitor security cameras, assign Security Officers, answer calls	Safety/Security Officer
Staff Rest/ Nutrition Area	4th Floor Conference Room	Cafeteria	Provision of a staff rest area, food and drink, information updates and psychological support	Staff Support Unit Leader
Triage Area	Outside Emergency Department		Patients triaged	Triage Unit Leader
Visitor/Relative's Entrance	AW Lobby Entrance	Main Entrance	Controlled access to hospital	Safety & Security Officer

1.	Communication equipment: • 800 MHz handheld radios • Emergency Cell phones • Laptops, Cellular Hot Spots	PBX / ISS	
2.	Decontamination Equipment, including • Personal protective equipment (PPE) • Plastic tarps, tents, frames • Shower curtains • Privacy screens • Showers • Liquid soaps and towelettes • Water supply • Fan • Trash/laundry receptacles and bags	t Emergency Trailer located in Physician Lot and Decontamination shower outside of Emergency Department	N/A
3.	Decontamination Unit (Portable)	Emergency Trailer	N/A
4.	Disaster Kits (recommended supplies) • Heavy work gloves • Crowbar • Flashlight and batteries • Waterless soap • Duct tape • Blue tape (for sealing windows) • Super Bar (to open jammed doors or cabinets, etc.)	Onsite Maintenance	N/A
5.	Evacuation Equipment • Stryker Evac Chairs • Evacusleds	Mineral King Floors 3rd and 4th floor. Mineral King Wing beds	N/A
6.	Evacuation Maps	Onsite	N/A
7.	First Aid Supplies	Onsite	N/A
8.	Food Supplies	Kitchen/Creekside	N/A
9.	HICS vests	Hospital Command Center (HCC)	N/A
10.	Lighting • Portable emergency lighting • Extension cords • Flashlights	Plant Operations Emergency Trailer Departments	N/A
11.	Linen	Laundry	MOU
	• 1 Box 20 gauge IV Catheters • 1 Box 18 gauge IV Catheters • 1 Box 16 gauge IV Catheters • 10 boxes Exam Gloves small • 10 boxes Exam Gloves medium • 10 boxes Exam Gloves large • 2 boxes Exam Gloves extra large	Units	
12.	Pharmaceuticals • Standard emergency medications • Other specific drugs as indicated by the incident	Contact Pharmacy Director or Emergency Management Coordinator for location of cache.	N/A

14.	Incident Command Cart Code Triage- Activation Plan	Hospital Command Center (HCC)	N/A 8
13.	Water (potable): Supplemental in-tank and bottled water	• Dietary	In Progress
15.	Medical Supplies (12 Disaster Carts): 5 Adult Ambu-Bags (Bag-Valve Mask Device) 5 Pediatric Ambu-Bags (Bag-Valve Mask Device) 5 Anesthesia Bags (To provide ventilation to an infant or newborn) 10 Pediatric 02 Masks 10 Adult Non-Rebreather 02 Masks 20 Hand Held Nebulizers (for breathing treatments). Possibly stocked in Respiratory. 2 Box disposable tongue depressors. 2 IV Pumps • 20 Secondary IV Set (To hang IV Piggybacks) • 5 boxes alcohol preps • 5 Yankauer Suction Catheters • 5 Suction catheters 8 French • 5 Suction catheters 10 French • 5 Suction catheters 14 French • 5 Suction catheters 18 French • 5 Suction Connection Tubings • 5 Suction Canisters • 5 Stethoscopes • 5 Manual BP Cuffs Adult Size (Not the disposable cuffs that are designed for use on a machine) • 5 Manual BP Cuffs Pediatric Size • 40 bags IV Normal Saline 1000 mL • 10 bags IV Normal Saline 250 mL • 10 bags IV D5W/0.25% Normal Saline • 1 Box 24 gauge IV Catheters • 1 Box 22 gauge IV Catheters	Central Logistics – the three Disaster Carts would be delivered to the ED	N/A

Policy Number: DM2211	Date Created: No Date Set
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Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Decontamination Plan

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

Policy

To provide guidelines for safe and effective decontamination and control of patients who have been contaminated with hazardous materials or bioterrorism agents. When activating the Decontamination Plan, the most important element of decontamination is to do it fast. Set up of the decontamination area should be completed within 30 minutes.

II. Procedure

Background

All patients in need of decontamination due to a hazardous material, including biological material, will be decontaminated prior to entering the patient care area. The decontamination process will be carried out in a manner consistent with the following procedures for safe handling of hazardous materials to minimize the risk to staff, patients, or visitors. (In most cases, patients exposed to bioterrorism agents will not require decontamination.)

Response Plan

Job Action Sheets

Attachment

Attachment A – Decontamination PPE, Equipment and Supplies

Decontamination of Hazardous Chemicals or Biological Materials

A. Definitions

1. External Incident: Outside a Kaweah Health (KH) facility, including on the grounds of the immediate campus of the hospital.

2. Internal Incident: On the premises of Kaweah Health.

3. Exposure: In close proximity to a hazardous material – but not contaminated (no direct contact to the contaminated person or clothing worn by that person).

4. Contamination: Actual hazardous material on person, in orifices, in wounds, ingested, on clothing worn by the person. (Person has made direct contact with hazardous material.)

5. Decontamination Staff: Those individuals trained and designated to respond to the decontamination site and responsible for a specific task in the decontamination of individuals known or suspected to be contaminated with a hazardous material.

B. Activation/Notification

If more than one victim, activate the Kaweah Health /Emergency Response Plan as needed. (See attached checklist.)

C. Multi-Patient Decontamination Operations

Built in Decon shower delivers a pre-set 98 degree warm water.

For portable showers, decontamination Team will utilize water supply that is temperature controlled by use of designated HazMat faucets located in the ambulance bay or by use of designated decon portable water heaters.

All patients will have a Disaster Triage Tag applied. This tag can go through the decontamination shower. There is a tab on this tag that can be pulled off and placed with the patient belongings to assist with identification. This tag is also part of the medical record and will need to be scanned in the patient's medical record.

1. Decontamination Areas

Decontamination will be conducted in the Emergency Department Decontamination shower located adjacent to the ambulance bay or outside the Emergency Department.Ambulance bay area. The location of decontamination is determined Decontamination Team Unit Leader generally based upon the number of victims as follows:

a. ED Emergency Decontamination Shower: **up to 10 ambulatory patients or 5 non-ambulatory patients**

b. Mass decontamination using portable decon showers and/or mass decon shower: greater than 10 patients. . (Mass Decon shower is stored in Decontamination Trailer.

c. Note: The above listed numbers are just estimates and may be higher or lower based on complexity of the situation and patient condition.

Functional Area	Location		Essential Activity	Responsible Person
	Primary	Secondary		
Decontamination Area Up to 50 victims	Emergency Department Decontamination shower or Portable showers in ambulance bay area.	Designated by Decon Team Unit Leader	For chemical, biological and radioactive decontamination	Decon Team Unit Leader
Mass Decontam-ination Area Greater than 50 victims	Portable and/or Mass Decon Shower in ambulance bay area.	Designated by Decon Team Unit Leader	For chemical, biological and radioactive decontamination	Decon Team Unit Leader

c. Area for ambulatory and non-ambulatory, if volumes of patients indicate. Security-Exclusionary Zone or Contamination Reduction Corridor with entrance (contaminated) and exit (decontaminated) encompassing the following areas:

1) Refuge Area
2) Contaminated Clothing Removal Area (privacy)
3) Shower Area (privacy)
4) Decontaminated Patient dressing Area (privacy)
5) Exit – Decontaminated Patient

D. Personal Protective Equipment (PPE)

1. **Order for donning PPE** – Primary Triage Staff, then Greeters, Stripper/Bagger/Tagger, Washer/Rinser, Redresser:

a. Check Tychem 9400 chemical resistant suits for leaks and zipper integrity.

b. Using the buddy system, don chemical-resistant suit.

c. Don non-sterile latex or vinyl gloves.

d. Check power air purifying respirators (PAPRs) and cartridges FR-57.

e. Don hood, placing inside layer under the neckline of the suit.

f. Seal hood and zipper of suit with chemical-resistant tape.

g. Apply nitrile rubber gloves over outside of suit and seal with chemical resistant tape.

h. Using the buddy system recheck for proper donning of PPE.

2. ED Staff working in the clean area, i.e., cold zone, will receive patients following decontamination and will wear Tyvek coveralls and examination gloves.

3. Security Staff working in clean area will don Haz/Mat DQA Personal Protective Kit, (hooded coveralls with booties, nitrile gloves, latex-free inner gloves, pre-measured duct tape strips, goggles and surgical mask), and air purifying respirator equipped with FR-64 cartridges.

E. Safety Considerations

Decontamination will only be performed by current member of the KH Decontamination Team.

1. Decontamination Team

The safety of the hospital decontamination team is paramount. The Decon Unit Leader and the entire team are to watch team members for signs and symptoms similar to the patients and for those of dehydration. Personnel are to rotate at least every 30–45 minutes when working in protective suits and respiratory protection. Replacement personnel are needed for each position. (Each individual may only rotate into the contamination reduction corridor a total of two times. When staff come out they are reassessed medically.)

Note: If the contaminate is known, consult a standard reference such as CAMEO, DOT Emergency Response Guidebook, MSDS, Agency for toxic Substances and Disease Registry Managing Hazardous Material Incidents for specific decontamination instructions.

a. List of substances with a <u>high risk</u> for secondary contamination

- Acids, alkali and corrosives (if concentrated)
- Asbestos (large amounts, crumbling)
- Cyanide salts and related compounds (e.g., nitriles) and hydrogen cyanide
- Hydrofluoric acid solutions
- Nitrogen-containing and other oxidizers which may produce methemoglobinemia
- (aniline, aryl amines, aromatic nitro-compounds, chlorates, etc.)
- Pesticides and Nerve agents.
- Mustard agents
- PCBs (polychlorinated biphenyls)
- Phenol and phenolic compounds
- Many other oily or adherent toxic dusts and liquids

b. List of substances with a <u>low risk</u> for secondary contamination

- Most gases and vapors unless they condense in significant amounts on the clothing, skin or hair
- Weak acids, weak alkali and weak corrosives in low concentrations (excluding hydrofluoric acid)

- Weak acid or weak alkali vapors (unless clothing soaked and excluding hydrofluoric acid vapor)
- Arsine gas
- Carbon monoxide gas
- Gasoline, kerosene and related hydrocarbons
- Phosphine gas
- Smoke/combustion products (excluding chemical fires)
- Small quantities of common hydrocarbon solvents (e.g., toluene, xylene, paint thinner, ketones, chlorinated degreasers)

c. As part of its PPE for chemical decontamination, Kaweah Health uses the ILC Dover Sentinel XL CBRN System. The Sentinel XL CBRN Cap 2 Systems are the only NIOSH-approved Cap 2 CBRN PAPRs. Tested to withstand the harshest threats for decon and infectious disease such as: warfare agents, biologic, industrial chemical, and nuclear particulate.

Note: Many chemicals are highly toxic only in the high concentrations found in the immediate exposure area but pose minimal risk to persons outside the hot zone. Small amounts of some chemicals may produce minimal acute toxicity, but because they are suspected of causing cancer or other chronic disease they are considered to create a risk of secondary contamination.

2. Selection Criteria for Portable Unit Location

In the event portable units are also needed, use following criteria for site selection:

a. Outside and away from the facility doors/ventilation systems.

b. Privacy and protective barriers should not inhibit the natural ventilation from diluting gases and airborne contaminates.

c. No cross traffic; pedestrian or vehicular.

d. Accessibility to water.

e. Adequate drain off with ability to dyke and contain contaminates and/or channel runoff.

f. Minimal impact hospital operations if the Decontamination Area becomes “off limits” due to contamination issues.

g. Provide for sufficient distance and security between hospital personnel setting up decontamination area and those patients seeking or awaiting decontamination.

h. Consider rapid deployment of emergency decontamination measures for groups of patients who are awaiting the setup of a formal decontamination process.

F. Decontamination – Ambulatory

1. Clinical staff will evaluate patients for compromised airway, breathing and circulation (ABCs) throughout decontamination process and initiate emergency treatment as needed.

2. See attached Job Action Sheets for description of process.

G. Decontamination – Non-Ambulatory

Note: Evaluate patients for compromises of airway, circulation and breathing (ABCs) as these take priority over decontamination.

1. Receive patients on litters into the Refuge Area.

2. Set up Saw Horse & backboard in containment pool under a canopy if not using decon shower. Provide privacy by attaching curtains or blankets to the canopy.

3. Medically stable patients are moved to the Contaminated Patient Undressing Area where clothing is cut up the midline of limbs and chest/abdomen and rolled in a manner so as to contain as much of the contaminant as possible.

4. All removed clothing is to be placed in a large, clear plastic bag and jewelry is to be placed in a smaller, labeled clear plastic bag. All personal property is to be considered evidence. Attach a patient label & personal property identification tag from the Triage Tage.

5. Move patient into shower area and shower exposed or irritated skin and hair with plain water and mild soap for 3 to 5 minutes. Use soft sponges and brushes on all areas of the patient. Rinse and flush thoroughly. Repeat washing and flushing as necessary. DO NOT abrade or chafe the skin, especially in areas where open wounds are present.

6. Thoroughly dry and dress patient in the *Decontaminated Patient Dressing Area.*

7. Move patients to the Safe Holding-Treatment Area for re-triage into the hospital.

8. Contact Tulare County Environmental Services to determine how decontamination waste water will need to be disposed of.

Decontamination PPE, Equipment and Supplies

Quantity	Item	Location
	Personal Protective Equipment (PPE): Decontamination Staff: ILC Dover Sentinel XL CBRN System. Tychem 9400 coveralls level B suits (water impermeable, chemical resistant) • Nitrile Decontamination Utility Gloves Heavy Duty Rubber Decontamination Boots Chem Tape N-95 HEPA respirators for use in biological contamination only ED Staff assigned to Secondary Triage: Tyvex coveralls Gloves	
	Barrier tape	
	Biohazard red bags	
	Bullhorns	
	Disposable scrub brushes with soap	
	Disposable slippers/booties	
	Doff-it Personal Modesty Kits (to be used by patients for private clothing removal)	
	Sump Pump	
	Extension Cords	
	Fans	
	Flashlights	
	Heater	

Quantity	Item	Location
	Large clear plastic bags (50 gallon) (for soiled linens)	
	Laundry cart stocked with towels and bath blankets	
	Plastic bags (1 gallon)	
	Plastic bucket (1–2 gallon)	
	Portable lamps	
	Portable showers, collection pools and elevation grids. Portable shower system that can be set up to treat six patients per unit simultaneously.	
	Privacy screens	
	Nitrazine pH Test Paper	
	Raised grids for Decon showers	
	Shampoo	
	Shower water catch basins	
	Storage Bins (supplies: extra shower wands, high-pressure nozzles)	
	Wand-style wash brushes	
	Water Supply Hoses (for portable showers)	
	Waterproof pens, clipboards	
	stretchers, hazmat decon backboards	
	50-gallon plastic container	

Purpose: To provide guidelines for effective decontamination and control of patients who have been contaminated with hazardous materials or bioterrorism agents.

Note: Following the emergency incident, Decontamination Leader will e-mail the District Safety Officer with specifics regarding the incident including supplies that may need to be re-ordered or reportable conditions.

ED (OR DESIGNEE) CHECKLIST

ED Team Leader (or designee) will:

- ☐ Notify:
  - ☐ PBX to Activate Kaweah Health Decontamination via xMatters.
    Nursing Supervisor
  - ☐ Security (respond to ED to provide perimeter security)
  - ☐ District Safety Officer and District EMS Coordinator
  - ☐ ED Nurse Manager on call
    (If a Radioactive substance is involved – page the Radiation Safety Officer –# 559-679-2031_____ .
- ☐ Appoint:
  - ☐ Decon Unit Leader to oversee Decon Operations
  - ☐ Decontamination Response Staff

  .
- ☐ Direct incoming ambulance to bring victims to designated entry area at the back Emergency Department Decontamination Area.
- ☐ Initiate 911 request to report the hazardous materials incident and request a Fire Department Hazardous Incident Team (HazMat Team) to assist with Decon, as needed.
- ☐ Call in additional ED staff, as needed.
  Coordinate operations with Fire Department personnel.
- ☐ Contacts Regional Poison Control at 1-800-411-8080 for specific guidelines on medical management.
- ☐ Re-open Triage and any areas isolated, only after clearance from Visalia Fire Dept., Poison Control or Decontamination Safety Officer. After Decontamination Operation is complete: Notify Env. Services Supervisor to have Decontamination Area cleared of non-essential equipment and floors chemically washed if indicated.
- Notify Administrator on Duty (AOD).Director On Call if indicated.

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SECURITY CHECKLIST

Upon receiving notification from ED Charge Nurse, Security staff will:

- ☐ Demarcate the decontamination area(s) with warning tape and signs. Provide perimeter control.
- ☐ Place signs at all entrances directing victims to the Decon area.
- ☐ Direct ambulance traffic to a designated entry area at Emergency Department Ambulance Bay.
- ☐ Assist in directing patients, personnel, family/friends to appropriate areas.
- ☐ Contact Sheriff's Office for additional support, as needed.

FACILITIES STAFF CHECKLIST

Upon notification from Nursing Supervisor, Facilities staff will:

- ☐ Obtain Decontamination Trailer from Physician Parking Lot if needed.
- ☐ Assist with setup of decontamination equipment.

ENVIRONMENTAL SERVICES STAFF CHECKLIST

Upon notification from Nursing Supervisor, Environmental Services staff will:

- ☐ Hose down Ambulance Bay with water and/or Decon Dressing Areas with germicide.

DECONTAMINATION STAFF CHECKLIST

Assigned Decontamination Staff (Greeter, Stripper/Bagger/Tagger, Washer/Rinser, Redresser) perform duties as descripted in their Job Action Sheets. (See Attachment.)

ALL CLEAR

After "All Clear" is announced, return to your normal work duties, unless otherwise directed.

Emergency Management Manual **Decontamination –**

Functional Areas

Area	Function	Staff Responsible
Warm Zone (Contamination Reduction)	Corridor Contamination Reduction	Decontamination Group
Entrance (Contaminated Patients)	Only those individuals suspected to be contaminated or needing decontamination are permitted to enter.	Security
Refuge Area (Primary Triage Area)	Patients are triaged for emergent medical problems and provided basic life support.	Primary Triage Medical Team
Contaminated Patient Triage Area	Metered to Contaminated Clothing Removal Area. Patients metered into shower area.	Greeter

Area	Function	Staff Responsible
Refuge Area (Contaminated Clothing Removal Area)	Ambulatory patients undress and bag their clothing and valuables in clear plastic bags. Non-ambulatory patients are undressed; clothing is placed in clear plastic bag. Patient/owner identifying tags are placed into each of the two bags. Patients are metered into the shower area.	Stripper/Bagger/ Tagger
Decontamination Area/Shower Area	Private and separate showering areas for male and female ambulatory and non-ambulatory patients could be arranged. Ambulatory patients are instructed and monitored in self-cleansing. Non-ambulatory patients are rinsed, washed and rinsed again by hospital personnel. Ambulatory patients are given towels and bath blanket and are observed for remaining contamination. Any evidence of remaining contamination will require the patient to repeat the decontamination shower procedure. Properly decontaminated, asymptomatic patients are directed to the Safe Holding-Treatment Area. Non-Ambulatory patients are dried by hospital personnel with examination and observations for remaining contaminates. The decontamination shower process will be repeated if required. Decontaminated non-ambulatory patients will be moved forward to the Safe Holding-Treatment Area.	Washer/Rinser
Decontaminated Patient Dressing Area	Patients receive Tyvex coveralls and disposable slippers. Non-ambulatory patients are assisted in donning gowns.	Redresser
Exit – Decontaminated Patients to Secondary Triage (Cold Zone Area)	Designated safe exit for decontaminated patients that protects them from recontamination. Exit is monitored to prevent: a. Contamination of the area by those contaminated utilizing the wrong entrance. b. Intrusion of unauthorized individuals.	Redresser
Secondary Triage Area Holding/Transportation/ Discharge	• Patients are triaged and directed to appropriate treatment locations. • Ambulatory/non-ambulatory patients wait in area to be relocated and routed to Patient Treatment/ Discharge Area.	Secondary Triage Team
Cold Zone	Clean Area/Secondary Triage Area.	Secondary Triage Team
Security – Perimeter	Provide adequate resources and space to maintain a security zone around the Decontamination Area.	Security

DECONTAMINATION SAFETY OFFICER

Mission:

- **Provides technical consultation to Decon Unit Leader; assists in identifying contaminant; ensures proper donning of PPE.**

Assigned to: _____ (your name) _____ (date and time)

You report to: _____ (Decon Unit Leader) _____ (phone/pager)

Key contacts: _____ (ED Charge Nurse) _____ (phone/pager)

CHECKLIST OF DUTIES

Immediate:

- ☐ 1. Receive appointment from ED Charge Nurse.
- ☐ 2. Obtain PPE.
- ☐ 3. Obtain initial briefing from Decon Unit Leader.
- ☐ 4. Obtain names and phone numbers for Key Contacts.
- ☐ 5. Review hand signals with Decon Response Team.

Intermediate:

Preparation

- ☐ 6. Report to triage for baseline vital signs and recording of weight.
- ☐ 7. Hydrate with 8 to 16 ounces of water or power drink.
- ☐ 8. Remove all jewelry, wallets, and valuables and secure.
- ☐ 9. Don PPE using buddy system.

Safety Monitoring

- ☐ 10. Arrange for Environmental Services Staff to be assigned to hose down Decon Dressing Areas with germicide and Ambulance Bay with water, during any MCI requiring decontamination.
- ☐ 11. Monitor staff donning PPE to ensure gear is properly worn.
- ☐ 12. Assist Decon Unit Leader in identifying contaminate(s).
- ☐ 13. Inspect hazardous waste collection area(s) to ensure the effectiveness of containment measures.

Extended:

- ☐ 14. Observe all staff, volunteers and patients for signs of stress and inappropriate behavior. Report concerns to the Decon Unit Leader.

Note: In the unlikely event that an agent with water reactivity properties is present, adding large amounts of water to the small amount of residual chemical poses little risk of creating a serious reaction hazard. Consult Emergency DOT Response Guidebook or MSDS.

Forward completed Job Action Sheet to Decon Unit Leader.

GREETER

Mission:

- **Explains decontamination process to patient(s). Provides patient(s) with a Doff-it Kit and directs patient(s) to undressing area.**

Assigned to: _____ (your name) _____ (date and time)

You report to: _____ (Decon Unit Leader) _____ (phone/pager)

Key contacts: _____ (ED Charge Nurse) _____ (phone/pager)

CHECKLIST OF DUTIES

Immediate:

☐ 1. Receive appointment from the ED Charge Nurse.
☐ 2. Obtain Doff-it Kits, bullhorn and PPE.
☐ 3. Obtain initial briefing from Decon Unit Leader.
☐ 4. Obtain names and phone numbers for Key Contacts.
☐ 5. Review hand signals with Decon Response Team.

Intermediate:

Preparation

☐ 6. Report to triage for baseline vital signs and recording of weight.
☐ 7. Hydrate with 8 to 16 ounces of water or power drink.
☐ 8. Remove all jewelry, wallets, and valuables and secure.
☐ 9. Don PPE using buddy system.
☐ 10. Check the setting of boundary zones (Warm, Cold) security pylons, and tape. Ensure that Doff-it Kits are available and accessible to your area.

Patient Assistance

☐ 11. Make visual/verbal contact with patient(s).
☐ 12. Instruct patient in decon procedure verbally and through signage.
☐ 13. Use a bullhorn to communicate instructions and reassurance to large groups.
☐ 14. Receive patients into the Refuge Area.
☐ 15. Continue visual/verbal contact with patients to assist in maintaining patient flow through the Contamination Reduction Corridor.
☐ 16. Notify Decon Unit Leader if more Doff-it Kits are needed.
☐ 17. Maintain contact with Decon Unit Leader and Decon Staff.
☐ 18. At deactivation or fatigue rotation, report through Contamination Reduction Corridor and perform self-decontamination.
☐ 19. Report for medical monitoring prior to release or reactivation.

Extended:

☐ 20. Observe all staff for safe practices, signs of stress and inappropriate behavior. Immediately report concerns to the Decon Unit Leader.

Forward completed Job Action Sheet to Decon Unit Leader.

MEDICAL SCREENER

Mission:

- **Assures staff members, assigned to decontamination duties, complete the health screen prior to donning Level C PPE. Monitors and records decontamination staff member's initial weight, temperature, pulse and respirations and repeats the measurements at the end of each assignment rotation.**

Assigned to: _____ (your name) _____ (date and time)

You report to: _____ (Decon Unit Leader) _____ (phone/pager)

Key contacts: _____ (Treatment Areas Supervisor) _____ (phone/pager)

CHECKLIST OF DUTIES

Immediate:

- ☐ 1. Receive assignment from the ED Charge Nurse.
- ☐ 2. Obtain Scales, Strip thermometers, and Medical Screening Form.
- ☐ 3. Obtain initial briefing from Decon Unit Leader.
- ☐ 4. Obtain names and phone numbers for Key Contacts.
- ☐ 5. Review hand signals with Decon Response Team.

Intermediate:

- ☐ 6. Obtain the Medical Screening Forms for all Decontamination Staff. Assure that all decontamination staff have reported to triage for baseline vital signs and recording of weight.
- ☐ 7. Assure that all decontamination staff hydrate with 8 to 16 ounces of water or power drink.
- ☐ 8. Record the time that each staff member dons PPE.
- ☐ 9. Notify the Decon Unit Leader of the time that the first team are to be rotated out.
- ☐ 10. Monitor and record staff member's weight, temperature and pulse when they rotate out of the warm zone.
- ☐ 11. Record staff time out, hydration taken, and time of reentry, as applicable.
- ☐ 12. Report to Decon Unit Leader any staff that does not meet reentry criteria.
- ☐ 13. Maintain contact with Decon Unit Leader and Treatment Areas Supervisor.

Extended:

- ☐ 14. Observe all staff for safe practices, signs of stress and inappropriate behavior. Immediately report concerns to the Decon Unit Leader, Treatment Areas Supervisor, or Incident Commander.

Forward completed Job Action Sheet to Treatment Areas Supervisor.

PRIMARY TRIAGE STAFF

Mission:

- **Triages patients for emergent medical problems. Provides basic life support.**

Assigned to:	**(your name)**	**(date and time)**
You report to:	**(Decon Unit Leader)**	**(phone/pager)**
Key contacts:	**(ED Charge Nurse)**	**(phone/pager)**
Key contacts:	**(Secondary Triage Unit Leader)**	**(phone/pager)**

CHECKLIST OF DUTIES

Immediate:

- ☐ 1. Receive appointment from the ED Charge Nurse.
- ☐ 2. Obtain Triage Cart, Nextel Phone and PPE.
- ☐ 3. Check Triage Cart inventory; test phone.
- ☐ 4. Obtain initial briefing from Decon Unit Leader.
- ☐ 5. Obtain names and phone numbers for Key Contacts.
- ☐ 6. Review hand signals with Decon Response Team.

Intermediate:

Preparation

- ☐ 7. Report to triage for baseline vital signs and recording of weight.
- ☐ 8. Hydrate with 8 to 16 ounces of water or power drink.
- ☐ 9. Remove all jewelry, wallets, and valuables and secure.
- ☐ 10. Don PPE using buddy system.

Triage

- ☐ 11. Meet the victim(s) at the ambulance arrival zone.
- ☐ 12. Evaluate victim(s) for evidence of life threatening injuries and need for decontamination. Provide BLS as required.
- ☐ 13. Scan patient(s) for evidence of contamination such as wet/soiled clothing, condition of the skin, need for immediate medical care and appropriate signs or symptoms of chemical exposure.
- ☐ 14. Ask patient(s) if he or she has received a field wash.
- ☐ 15. Direct patient(s) needing immediate decontamination to Greeter.
- ☐ 16. Assess resources inventory and needs. Report needs to ED Charge Nurse.
- ☐ 17. Maintain contact with Decon Unit Leader.
- ☐ 18. At deactivation or fatigue rotation, report through Contamination Reduction Corridor and perform self-decontamination.
- ☐ 19. Report for medical monitoring prior to release or reactivation.

Extended:

- ☐ 20. Observe all staff for safe practices, signs of stress and inappropriate behavior. Immediately report concerns to the Decon Unit Leader.

Forward completed Job Action Sheet to Decon Unit Leader.

REDRESSER

Mission:

- **Assists decontaminated patient(s) into white Tyvex coveralls (or gowns if non ambulatory) and disposable slippers.**

SECONDARY TRIAGE STAFF

Mission:

- **Triages patients for emergent medical problems. Provides basic life support.**

Assigned to:	**(your name)**	**(date and time)**
You report to:	**(Decon Unit Leader)**	**(phone/pager)**
Key contacts:	**(ED Charge Nurse)**	**(phone/pager)**
Key contacts:	**(Secondary Triage Unit Leader)**	**(phone/pager)**

CHECKLIST OF DUTIES

Immediate:

- ☐ 1. Receive appointment from the ED Charge Nurse.
- ☐ 2. Obtain Triage Cart, Nextel Phone and PPE (Tyvex coveralls and examination gloves)
- ☐ 3. Check Triage Cart inventory; test phone.
- ☐ 4. Obtain initial briefing from Decon Unit Leader.
- ☐ 5. Obtain names and phone numbers for Key Contacts.
- ☐ 6. Review hand signals with Decon Response Team.

Intermediate:

Preparation

- ☐ 7. Report to triage for baseline vital signs and recording of weight.
- ☐ 8. Hydrate with 8 to 16 ounces of water or power drink.
- ☐ 9. Remove all jewelry, wallets, and valuables and secure.
- ☐ 10. Don PPE.

Triage

- ☐ 11. Receive patients following decontamination.
- ☐ 12. Evaluate victim(s) for evidence of life threatening injuries. Provide BLS as required.
- ☐ 13. Ensure sufficient transport equipment and personnel for Secondary Triage Area.
- ☐ 14. Ensure that the patient tracking chart and admission forms are utilized. Request documentation/clerical personnel if necessary.
- ☐ 15. Review and approve the area documenter's recordings of actions/decisions in the Secondary Triage Area. Send copy to Decon Unit Leader.
- ☐ 16. Re-triage patients and route to appropriate treatment locations or discharge area.
- ☐ 17. Ensure patients wait in Secondary Triage Area to be relocated to treatment, transfer, or discharge (and to avoid recontamination).
- ☐ 18. Assess resources inventory and needs. Report needs to ED Charge Nurse.
- ☐ 19. Maintain contact with Decon Unit Leader.
- ☐ 20. At deactivation or fatigue rotation, report through Contamination Reduction Corridor and perform self-decontamination.
- ☐ 21. Report for medical monitoring prior to release or reactivation.

Extended:

- ☐ 22. Observe all staff for safe practices, signs of stress and inappropriate behavior. Immediately report concerns to the Decon Unit Leader.

Forward completed Job Action Sheet to Decon Unit Leader.

STRIPPER/BAGGER/TAGGER

Mission:

- **Assist contaminated patients with clothing removal.**
- **Ensure patient clothing/valuables are sealed in labeled, plastic bags and stored as evidence.**

Assigned to: _____ (your name) _____ (date and time)

You report to: _____ (Decon Unit Leader) _____ (phone/pager)

Key contacts: _____ (ED Charge Nurse) _____ (phone/pager)

CHECKLIST OF DUTIES

Immediate:

- ☐ 1. Receive appointment from the ED Charge Nurse.
- ☐ 2. Obtain PPE.
- ☐ 3. Obtain initial briefing from Decon Unit Leader.
- ☐ 4. Obtain names and phone numbers for Key Contacts.
- ☐ 5. Review hand signals with Decon Response Team.

Intermediate:

Preparation

- ☐ 6. Report to triage for baseline vital signs and recording of weight.
- ☐ 7. Hydrate with 8 to 16 ounces of water or power drink.
- ☐ 8. Remove all jewelry, wallets, and valuables and secure.
- ☐ 9. Don PPE using the buddy system.

Decontamination

- ☐ 10. Make visual/verbal contact with patient(s).
- ☐ 11. Assist patient in their removal of personal items and clothing. (It may be necessary to cut off clothing to avoid removing clothing over person's head.)
- ☐ 12. Ensure that all clothing, personal property, and equipment is properly bagged and labeled.
- ☐ 13. Place bags with patient's clothing and valuables in a large bin. Ensure that all contaminated patient clothing and belongings remain in the decontamination area. These items may become legal evidence. The Decontamination Safety Officer must provide clearance before patient belongings can be removed.
- ☐ 14. Instruct patient in decon procedure verbally as well as through signage.
- ☐ 15. Continue visual/verbal contact with patients to assist in maintaining patient flow through the Contamination Reduction Corridor.
- ☐ 16. Assess resources inventory and needs. Report need to Decon Unit Leader.
- ☐ 17. Maintain contact with Decon Unit Leader.
- ☐ 18. Assist Washer/Rinser if census allows.
- ☐ 19. At deactivation or fatigue rotation, report through Contamination Reduction Corridor and perform self-decontamination. (Wash PPE off in shower. Exit into Cold Zone Staff Refuge Area to receive assistance doffing PPE. Rehydrate.)
- ☐ 20. Report for medical monitoring prior to release or reactivation.

Extended:

- ☐ 21. Observe all staff for safe practices, signs of stress and inappropriate behavior. Immediately report concerns to the Decon Unit Leader.

Forward completed Job Action Sheet to Decon Unit Leader.

WASHER/RINSER

Mission:

- **Assists individual into shower and reviews shower instructions with patient and ensures thorough decontamination of patient – assisting patient as needed. Provides clean towel/bath blanket to patient after decontamination and disposes of used scrub brush and modesty poncho.**

Assigned to: _____ (your name) _____ (date and time)

You report to: _____ (Decon Unit Leader) _____ (phone/pager)

Key contacts: _____ (ED Charge Nurse) _____ (phone/pager)

CHECKLIST OF DUTIES

Immediate:

- ☐ 1. Receive appointment from the ED Charge Nurse.
- ☐ 2. Obtain PPE.
- ☐ 3. Obtain initial briefing from Decon Unit Leader.
- ☐ 4. Obtain names and phone numbers for Key Contacts.
- ☐ 5. Review hand signals with Decon Response Team.

Intermediate:

Preparation

- ☐ 6. Report to triage for baseline vital signs and recording of weight.
- ☐ 7. Hydrate with 8 to 16 ounces of water or power drink.
- ☐ 8. Remove all jewelry, wallets, and valuables and secure.
- ☐ 9. Don PPE using buddy system.

Decontamination

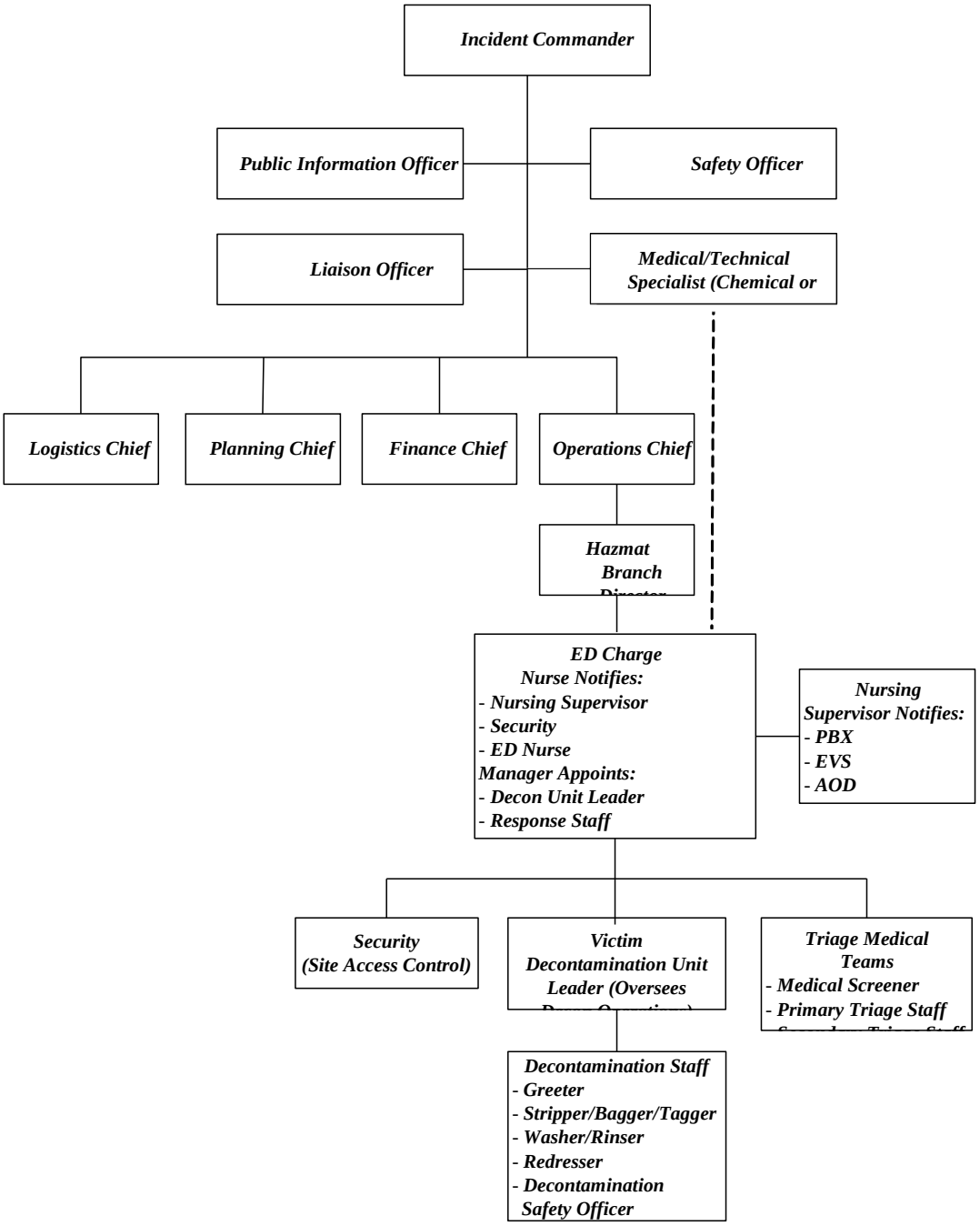
- ☐ 10. Make visual/verbal contact with patient(s).
- ☐ 11. Instruct patient in decon procedure verbally and through signage.
- ☐ 12. Flush or shower exposed or irritated skin and hair with plain water and mild soap for 3 to 5 minutes (a longer shower for concentrated, strong alkali, oily or adherent chemicals); rinse and flush thoroughly. Repeat washing and flushing as necessary. (Each shower is equipped with a timer.)
- ☐ 13. Exposed and irritated eyes should be flushed with plain water or saline for a minimum of 5 to 10 minutes. Remove contact lenses as soon as possible.
- ☐ 14. Use only soft brushes or sponges when removing oily or persistent agents. DO NOT abrade or chafe the skin.
- ☐ 15. Dispose of patient modesty poncho and scrub brush in hazardous waste garbage bin.
- ☐ 16. Provide clean towel and bath blanket to patient(s) after decontamination.
- ☐ 17. Direct patient(s) to Decontaminated Patient Dressing Area.
- ☐ 18. Continue visual/verbal contact with patients to assist in maintaining patient flow through the Contamination Reduction Corridor.
- ☐ 19. Assess resources inventory and needs. Report needs to Decon Unit Leader.
- ☐ 20. Maintain contact with Decon Unit Leader, Stripper/Bagger/Tagger, Redresser.
- ☐ 21. Assist Stripper/Bagger/Tagger if census allows.
- ☐ 22. At deactivation or fatigue rotation, report through Contamination Reduction Corridor and perform self-decontamination.
- ☐ 23. Report for medical monitoring prior to release or reactivation.

Extended:

- ☐ 24. Observe all staff for safe practices, signs of stress and inappropriate behavior. Immediately report concerns to the Decon Unit Leader.

Forward completed Job Action Sheet to Decon Unit Leader.

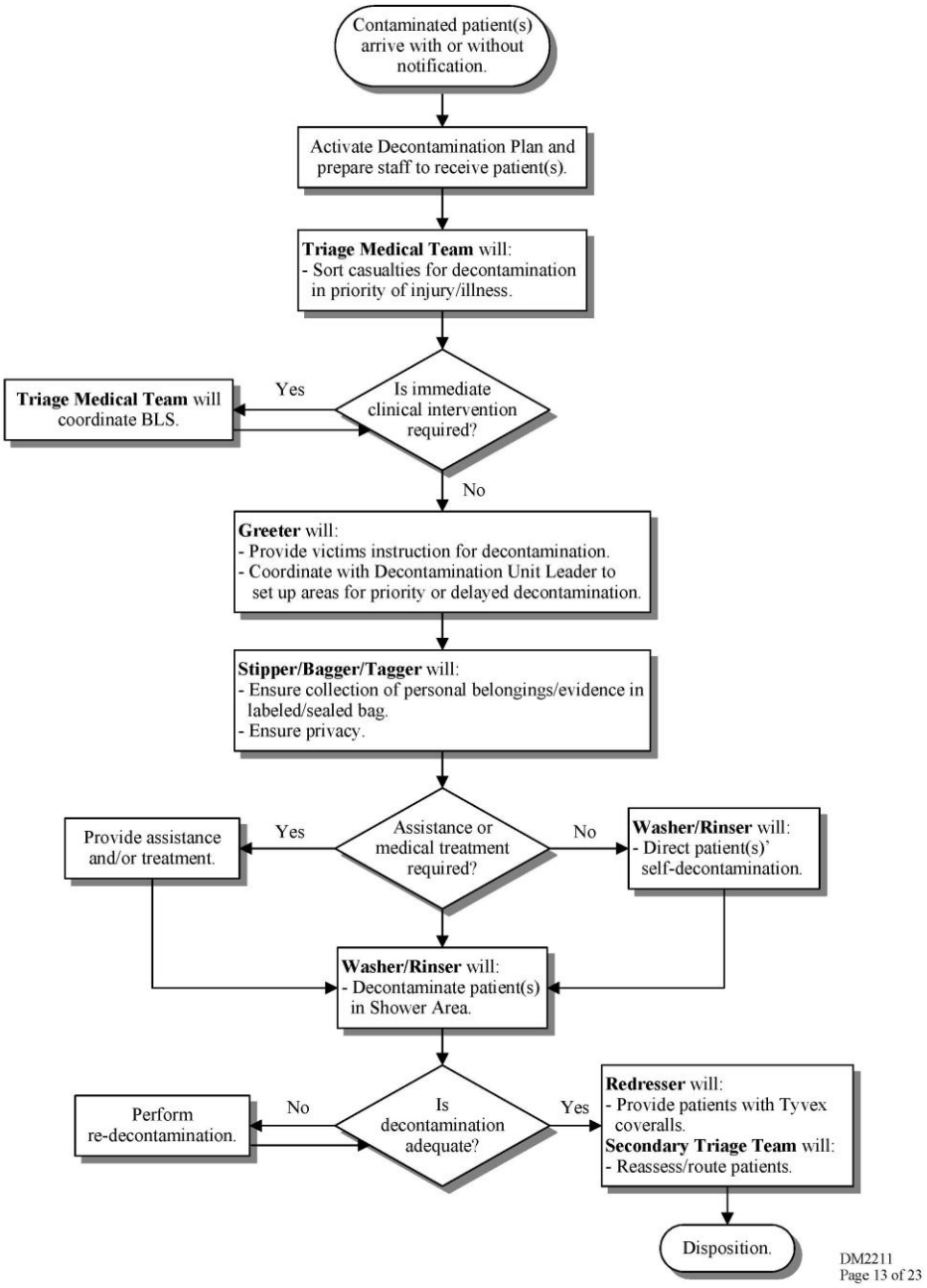
Emergency Management
Decontamination Group
Organizational Chart


Incident Commander
Public Information Officer
Safety Officer
Liaison Officer
Medical/Technical Specialist (Chemical or
Logistics Chief
Planning Chief
Finance Chief
Operations Chief
Hazmat Branch
ED Charge Nurse Notifies:
- Nursing Supervisor
- Security
- ED Nurse
Manager Appoints:
- Decon Unit Leader
- Response Staff
Nursing Supervisor Notifies:
- PBX
- EVS
- AOD
Security (Site Access Control)
Victim Decontamination Unit Leader (Oversees
Triage Medical Teams
- Medical Screener
- Primary Triage Staff
Decontamination Staff
- Greeter
- Stripper/Bagger/Tagger
- Washer/Rinser
- Redresser
- Decontamination Safety Officer

Kaweah Health

Emergency Management Manual

Decontamination Process Flowchart



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Kaweah Health
MORE THAN MEDICINE. LIFE.

Employee Health
Infection Prevention

Policy Number: EHS 01	Date Created: 09/26/2023
Document Owner: Ellason Schales (RN-Employee Health Nurse)	Date Approved: Not Approved Yet
Approvers: Dianne Cox (Chief Human Resources Officer)	

Infection Prevention Guidelines for Pregnant Healthcare Workers

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

Policy:

Pregnant women working with or exposure to certain bacteria, viruses, or other infectious agents could increase their chances of having a miscarriage, a baby with a birth defect, or other reproductive problems. ~~Certain diseases are detrimental to the development of an unborn child.~~ Therefore, pregnant women must be protected from the transmission of these diseases. The approach for the prevention of disease transmission is broad. These guidelines are based on CDC recommendations for pregnant Healthc ~~C~~are Workers (HCW).

~~Pertinent facts to G~~guide to Management of O~~o~~ccupational E~~e~~xposures ~~to infectious agents~~in Pregnant Healthcare workers

Disease	Modes of Transmission	Prevention	Comments
~~Covid 19~~ Coronavirus (Covid 19)	Respiratory secretions through droplet transmission (including contact with droplets on contaminated surfaces) ~~Respiratory secretions~~	Airborne and Droplet precautions COVID-19 vaccination is recommended for all HCWs including pregnant HCWs.	~~*Reassign pregnant HCW.*~~ *Consider limiting exposure of pregnant HCWs to patients with confirmed or suspected Covid 19, especially during high risk procedures (ex; aerosol-generating procedures). If staffing allows, reassign pregnant HCW.*
Cytomegalovirus (CMV)	Contact with infectious body fluids, such as urine, saliva, blood, tears, semen, vaginal secretions, and breast milk~~Urine, blood, vaginal secretions, semen and~~	Standard precautions	*No additional precautions for pregnant HCW.*
Ebola Virus	Ebolaviruses spread through contact (such as through broken skin or mucous membranes) with b~~: B~~lood or body fluids and through contact with objects contaminated with body fluids from of a person who is sick with or has died from Ebola disease. Ebolaviruses can remain in certain body fluids of a patient who has	Droplet and Control	*Reassign pregnant HCW.* For any suspected or known Ebola patients, notify Infection Prevention staff Immediately; after hours ask House Supervisor/PBX to contact Infection Prevention staff on call.

Disease	Modes of Transmission	Prevention	Comments
	recovered from Ebola disease. ~~Ebolaviruses also spread through .contact with an infected animal (bat or nonhuman primate)~~		
Hepatitis B	Percutaneous (puncture through skin) or mucosal contact with infectious b~~B~~lood or ~~and~~ body fluids ~~((~~blood, semen, vaginal fluid, amniotic fluid, breast milk, cerebrospinal fluid, pericardial fluid, peritoneal fluid, pleural fluid, synovial fluid, and blood visible in bodily fluids)~~vaginal~~	Standard Precautions Hepatitis B vaccine ~~strongly~~ recommended for all HCWs including pregnant HCWs. ~~Vaccine available HBIG to infant if exposure of non-immune personnel~~	*No additional precautions for pregnant HCW.* ~~Hepatitis B vaccine strongly recommended for all HCWs including pregnant HCWs.~~ Report any blood/body fluid exposure immediately to your supervisor and Employee Health~~.~~ (or House Supervisor if Employee Health is closed and follow up with Employee Health
Hepatitis C	Percutaneous (puncture through skin) or mucosal contact with infectious~~Infectious~~ b~~B~~lood or~~and~~ body fluids (blood, semen, vaginal fluid, amniotic fluid, breast milk, cerebrospinal fluid, pericardial fluid, peritoneal fluid, pleural fluid, synovial fluid, and blood visible in	Standard Precautions	*No additional precautions for pregnant HCW.* Report any blood/body fluid exposure immediately to your supervisor and Employee Health~~.~~ (or House Supervisor if Employee Health is closed and follow up with Employee Health on the following business day).
Herpes Simplex	Contact with lesion (vesicular fluid, oropharyngeal and vaginal secretions)	Standard precautions or contact precautions depending upon severity of illness	*No additional precautions for pregnant HCW.*
HIV	Percutaneous (puncture through skin) or mucosal contact with infectious b~~B~~lood or bodily fluids (blood, semen, vaginal fluid, amniotic fluid, breast milk, cerebrospinal fluid, pericardial fluid, peritoneal fluid, pleural fluid, synovial fluid~~,~~ and ~~and bodily fluid~~blood visible in bodily fluids)~~s, vaginal~~	Standard precautions	*No additional precautions for pregnant HCW.* Report any blood/body fluid exposure immediately to your supervisor and Employee Health (or House Supervisor if Employee Health is closed and follow up with Employee Health on the following business day).~~.~~
Influenza	Respiratory secretions from sneezing and coughing (droplet transmission)	Droplet precautions ~~and Standard precautions~~ Yearly ~~i~~Influenza vaccine ~~strongly~~ recommended for all HCWs including pregnant HCWs (live attenuated influenza vaccine is not contraindicated during pregnancy)	*No additional precautions for pregnant HCW.* ~~Vaccination (safe during pregnancy)~~

Disease	Modes of Transmission	Prevention	Comments
Parvovirus B19 (Fifth's Disease)	Respiratory secretions from saliva, sputum, or nasal mucus (droplet transmission) ~~(~~and ~~rarely~~blood ~~)~~or blood products	Droplet precautions ~~and Standard precautions~~	*Reassign pregnant HCW. ~~women~~*
Pertussis	Respiratory secretions from sneezing and coughing (droplet transmission)	Droplet Precautions Recommended pregnant HCWs should receive a dose of Tdap during each pregnancy irrespective of prior history of receiving Tdap	*Reassign pregnant HCWs in their 3rd trimester, if they have not received their recommended TDAP vaccination for their current pregnancy (given in the 3rd trimester with each pregnancy).*
Rubella	Respiratory secretions from nasopharyngeal secretions from coughing or sneezing (droplet transmission) or contact with droplets.	Droplet precautions Contact precautions for congenital rubella MMR vaccine is contraindicated during pregnancy.	*Reassign non-immune pregnant* HCWs. ~~*employees to avoid risk of exposure.* The non-immune HCW, pregnant or not, should not care for rubella patients until vaccination is complete. The MMR vaccine and its component vaccines should not be given to women known to be pregnant.~~
Rubeola (Measles)	Direct contact with infectious droplets or by airborne spread when an infected person breathes, coughs, or sneezes.	Airborne precautions MMR vaccine is contraindicated during pregnancy.	*Reassign non-immune pregnant* ~~*employees to avoid risk of exposure.* The non-immune HCW, pregnant or not, should not care for rubeola patients until vaccination is complete.~~*HCWs.*
Tuberculosis (Extra-pulmonary, draining lesion)	Airborne droplets from sneezing or coughing and contact with skin lesions	Airborne and contact precautions	*No additional precautions for pregnant HCW.* Report any unprotected exposure to your supervisor, employee health services, and infection prevention.~~.~~
Tuberculosis (Pulmonary or Laryngeal)	Airborne droplets from sneezing or coughing	Airborne precautions	*No additional precautions for pregnant HCW.* Report any unprotected exposure to your supervisor, employee health services, and infection prevention.~~.~~

Disease	Modes of Transmission	Prevention	Comments
Varicella (Chickenpox)	Droplet or airborne spread of vesicle fluid or secretions of the respiratory tract or by contact with vesicular lesions.	Airborne and contact precautions Varicella vaccine is contraindicated during pregnancy.	*Reassign non-immune pregnant ~~employees to avoid risk of exposure.~~HCWs.* ~~The non-immune HCW, pregnant or not, should not care for varicella patients.~~ ~~Non- immune women should be~~
Varicella Zoster (Shingles), Disseminated or localized disease in immune-compromised patient until disseminated infection is ruled out.~~d or localized in~~	Droplet or airborne spread of vesicle fluid or secretions of the respiratory tract or by contact with vesicular lesions.	Airborne and contact precautions Shingles vaccine contraindicated during pregnancy.	*Reassign non-immune pregnant ~~employees to avoid risk of exposure.~~HCWs.* ~~The non-immune HCW, pregnant or not, should not care for varicella zoster patients. Non-immune women should be evaluated for post exposure prophylaxis.~~
Varicella Zoster (Shingles), ~~localized~~Localized in patient with intact immune system with lesions that can be contained and/ or covered	Contact with vesicular lesions	Standard precautions Shingles vaccine contraindicated during pregnancy.	*Reassign non-immune pregnant ~~employees to avoid risk of exposure.~~ ~~The non-immune HCW, pregnant or not, should not care for varicella patients. Reassign to avoid risk of exposure.~~HCWs.* ~~Non- immune women should be evaluated for post exposure~~

Additional Guidelines

1. For some infectious agents, vaccines are available, and it is recommended that HCWs will become immunized before conception.
2. For some infectious agents, there is no vaccine available, and pregnant HCW must rely on Standard Precautions (as well as the specific precautions for the infectious diseases as outlined in the above table), including the appropriate use of hand hygiene, masks, gown, glove, eye protection, and respiratory protection, when exposure to potentially infectious blood and body fluids is likely. Restricting pregnant HCWs from caring for patients with certain known infections (e.g., CMV) is not recommended (APIC, 2014, 104: 3-12)
3. Pregnant health care workers may consult with Employee Health if immune status is unknown.
4. Radiation Safety: For those pregnant employees who provide a Declaration of Pregnancy, every effort will be made to provide an accommodation to not work with “I 131” patients.

Related Documents:

EHS 02: Employee Exposure to Bloodborne Pathogens Policy

IP.TBP: A Transmission Based Precautions Table Policy
~~None~~

References:

APIC Text of Infection Control and Epidemiology; June 2014, 4th Edition, Volume 3, 104: 3-12
CDC HICPAC reference: Bolyard, E., et.al., Guideline for infection control in health care personnel. Centers for Disease Control and Prevention Healthcare Infection Control Practices Advisory Committee (CDC-HICPAC), 1998, pgs. 322.

https://nccc.ucsf.edu/clinical-resources/pep-resources/pep-quick-guide-for-occupational-exposures/

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html

~~cdc.gov/coronavirus/2019/-ncov/hcp/faq.html~~

https://www.cdc.gov/coronavirus/2019-ncov/your-health/about-covid-19.html

https://www.cdc.gov/niosh/topics/repro/infectious.html

~~Cdc.gov/niosh/topics/repro/infectious.html~~

"Responsibility for the review and revision of this Policy is assigned to the Chief of Human Resources. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases. Kaweah Delta will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Delta Policies and Procedures."

Policy Number: EHS 02	**Date Created: 08/23/2016**
Document Owner: Ellason Schales (RN-Employee Health Nurse)	**Date Approved: Not Approved Yet**
Approvers: Dianne Cox (Chief Human Resources Officer)	

Employee Exposure to Bloodborne Pathogens

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

PURPOSE:

Kaweah Health ~~Care District~~ is committed to providing a safe work environment for our entire staff. In pursuit of this goal, the following Exposure Control Plan (ECP) is provided to eliminate or minimize occupational exposure to bloodborne pathogens in accordance with OSHA standard 29 CFR 1910.1030, ~~"Occupational Exposure t0~~ "Bloodborne Pathogens."

Bloodborne pathogens are infectious microorganisms in human blood that can cause disease in humans. These pathogens include, but are not limited to, Hepatitis B (HBV), Hepatitis C (HCV) and Human Immunodeficiency Virus (HIV). Needlesticks and other sharps-related injuries may expose workers to bloodborne pathogens. Also, though it is a lower risk of transmission, blood from a positive source can also be a risk when it enters the body via open wounds, cuts, and by splashing in the face, eyes, and mouth.

Because the infectious status of patients is often unknown, healthcare workers are to observe precautions when dealing with potentially infectious materials at all times. Most important is the avoidance of blood contaminated penetrating injuries from sharp needles and scalpels, etc. The use of Standard Precautions is therefore to be practiced in all circumstances.

~~The purpose of this policy is to:~~

1. ~~Establish individual responsibilities to minimize the risk for healthcare workers of acquiring bloodborne disease due to occupational exposure.~~

2. ~~Comply with OSHA Bloodborne Pathogen Standard.~~

EXPOSURE DETERMINATION:

A component of the Exposure Control Plan is a listing of all job classifications in which employee may have occupational exposure.

This exposure determination shall be made without regard to the use of personal protective equipment.

CATEGORY I: Jobs with tasks that routinely involve exposure or potential exposure to blood, body fluids or tissues.

CATEGORY II: Jobs with tasks that do not routinely involve exposure to blood, body fluids, or tissues, but exposure or potential exposure may be required as a condition of employment.

CATEGORY III: Jobs with tasks that do not routinely involve exposure to blood, body fluids or tissues, (persons in this category are not called upon to perform or assist in emergency medical aid or to be potentially exposed in any other way as a condition of employment).

Exposure Determination:

A. The following job (employee) classifications will be included as having occupational exposure:
   1. ~~All nurses,~~ RN, LVN, CNA, MA, Technicians, Aides
   2. Cardiopulmonary technicians
   3. Environmental Services and Plant Operations employees
   4. Laboratory Personnel
   5. Physicians
   6. Radiology P~~p~~ersonnel
   7. Surgery Personnel
   8. Physical Therapy Personnel
   ~~8.~~9. Emergency Personnel
   ~~9.~~10. Child Care Personnel

B. The following are examples of tasks and procedures or groups of closely related tasks and procedures in which occupational exposure may occur:
   1. Assisting in Code Blue
   2. Assisting in delivery of newborn
   3. Assisting in surgery or other diagnostic testing
   4. Cleaning blood or other infectious spills
   5. Handling of contaminated equipment
   6. Handling of contaminated sharps
   7. Handling of laboratory specimens
   8. Handling of medical waste
   9. Handling of soiled linen
   10. Performing or assisting in invasive procedures

11. Performing or assisting in treatment procedures
12. Post-mortem care

~~The District~~Kaweah Health shall:

- Provide appropriate types and supplies of protective gear, which includes gloves, goggles, masks, gowns, etc. Protective equipment shall also include ventilation devices for CPR.
- Ensure that personnel use appropriate personal protective equipment.
- Ensure that personnel, students, and volunteers affiliated with the District receive education and training in the ~~District~~ Standard Precautions and Infection Control policies and procedures that are specific to their responsibilities prior to assuming these duties on an annual basis.
- Ensure that personnel wash hands immediately or as soon as feasible after removal of gloves or other personal protective equipment.
- Monitor and document individual compliance with the practice of the ~~District~~ Standard Precautions and infection control policies and procedures in a fair and equitable manner.
- Include compliance with ~~District~~ Standard Precautions and infection control policies and procedures as part of each employee's performance review/annual competency.
- Provide appropriate retraining and progressively discipline, if necessary, individuals who fail to comply with department procedures for Standard Precautions and infection control.
- Provide lancets, needleless IV system, safety syringes to aid in reduction of blood and body fluid exposures secondary to needlesticks/sharp injuries.

Department Managers and Supervisors shall:

- Direct exposed staff member to report exposure to supervisor and then complete "Report of Work Related Injury/Illness" form, located on Kaweah Compass under Forms/ KH Work Injury Report. Exposed s~~S~~taff m~~M~~ember should then go to Employee Health Services (EHS) or if outside of EHS operating hours, report to the Nursing Supervisor for evaluation of need for emergency medical attention.
- Submit an incident report for all instances where an individual's technique is not consistent with ~~District~~ Kaweah Health's Standard Precautions and infection control policies and procedures.
- Ensure that this Policy is accessible to personnel and to the healthcare professional evaluating an employee after an exposure incident.

Each Employee shall:

- Understand the principles of standard precautions and infection control policies and procedures, with specific knowledge of the tasks that they may assume. Know what tasks to perform that may have occupational exposure.

- Routinely apply the practices of standard precautions and infection control policies and procedures to each task they perform. This includes the appropriate use of personal protective equipment.

- Report incidents to their Supervisor or Manager and Employee Health Services of actual exposure to blood or body fluid.

- Report incidents to their supervisor when other individuals are noncompliant with Standard Precautions and infection control practices.

- Complete the bloodborne pathogens educational information contained in New Hire Orientation and in MAT Module.

METHODS OF COMPLIANCE:

- **General -** ~~Standard~~ Standard Precautions are observed to prevent contact with blood or other potentially infectious materials. Under circumstances in which differentiation between body fluid types is difficult or impossible, all body fluids shall be considered potentially infectious materials

- **Engineering and Work Practice Controls -** used to eliminate or minimize employee exposure. Where occupational exposure remains after institution of these controls, personal protective equipment shall also be used.

    - Handwashing facilities ~~(or antiseptic hand cleaners and towels or antiseptic towelettes)~~, ~~which~~ are readily accessible to all employees who have potential for exposure. When handwashing facilities are not feasible, antiseptic hand cleanser in conjunction with clean cloth/paper towels or antiseptic towelettes. When antiseptic hand cleansers or towelettes are used, hands shall be washed with soap and running water as soon as feasible.
        - Employees will wash their hands immediately or as soon as feasible after removal of gloves or other personal protective equipment.
        - Employees will wash hands and any other skin with soap and water or flush mucous membranes with water immediately or as soon as feasible following contact of such body areas with blood or other potentially infectious materials.

- ~~Lancets~~

- ~~Needleless IV System~~

- ~~Safety Syringes~~

  - Contaminated needles or sharps will not be bent, recapped or removed unless there is no reasonable alternative or the action is required by specific medical procedures (i.e., following injection of radio isotopes).

    - Such bending, recapping, or needle removal must be accomplished through the use of a mechanical device or a one-handed technique.
    - Shearing or breaking of contaminated needles is prohibited.

  - Reusable sharps: Contaminated reusable sharps need to be placed immediately or as soon as possible after use in appropriate containers until properly reprocessed.

    - Containers for reusable sharps need to be puncture resistant, labeled with biohazard warning or color-coded, leakproof on the sides and bottom, and shall not be stored or processed in a manner that requires employees to reach by hand into the containers where these sharps have been placed.

  - Disposable sharps: Contaminated sharps shall be discarded immediately or as soon as feasible in containers that are closable, puncture resistant, leakproof on sides and bottom, and labeled with biohazard warning or color-coded.

    - During use, containers for contaminated sharps shall be easily accessible to personnel and located as close as is feasible to the immediate area where sharps are used or can be reasonably anticipated to be found, maintained upright throughout use, replaced routinely, and not be allowed to overfill.
    - Container should be placed in a secondary container if leakage is possible. The second container shall be closable, constructed to contain all contents and prevent leakage during handling, storage, transport, or shipping, and labeled with biohazard warning or color-coded.
    - Reusable containers shall not be opened, emptied, or cleaned manually or in any other manner which would exposure employees to the risk of percutaneous injury. ~~, the secondary container must be puncture-resistant as well. All specimen containers used for shipping will have a biohazard warning label attached.)~~
    - If the specimen can puncture the primary container the primary container shall be placed within a secondary container which is puncture resistant in addition to the above characteristics ~~Containers for contaminated disposable sharps which are puncture resistant, labeled with biohazard warning and leak-proof on sides and bottom.~~

- Regulated Waste Containment: Regulated waste shall be placed in containers that are closable, constructed to contain all contents and prevent leakage of fluids during handling, storage, transport, or shipping, labeled with biohazard warning or color-coded, closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.
  - If outside contamination of the regulated waste container occurs, it shall be placed in a second container. The second container shall be: closable, constructed to contain all contents and prevent leakage of fluids during handling, storage, transport, or shipping, labeled with biohazard warning or color-coded, and closed prior to removal to prevent spillage or protusion of contents during handling, storage, transport, or shipping.
  - Disposal of all regulated waste shall be in accordance with applicable regulations of the United States.

- Laundry: Contaminated laundry shall be handled as little as possible with a minimum of agitation and should be bagged or containerized at the location where it was used and shall not be sorted or rinsed in the location of use.
  - Employees will use standard precautions in handling of all soiled laundry.
  - Contaminated laundry shall be placed and transported in bags or containers labeled or color-coded in accordance with paragraph (g)(1)(i) of this standard.
  - Whenever contaminated laundry is wet and presents a reasonable likelihood of soak-through of or leakage from bag or container, the laundry shall be placed and transported in bags or containers which prevent soak-through and/or leakage of fluids to the exterior.
  - Employees who will have contact with contaminated laundry will be provided with protective gloves and other appropriate PPE.
- ~~Specimen containers and secondary containers are leak-proof, labeled with a biohazard warning and puncture-resistant, when necessary.~~

~~Contaminated needles or sharps are not bent, recapped or removed unless there is no reasonable alternative or the action is required by specific medical procedures (i.e., following injection of radio isotopes). If recapping or needle removal is necessary, it is accomplished through the use of a medical device or a one handed technique.~~

- Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is a reasonable likelihood of occupational exposure.

- Food and drink are not kept in refrigerators, freezers, shelves, cabinets or on counter tops or benchtops or in other storage areas where~~n~~ blood or other potentially infectious materials~~fluids~~ are present.
- ~~Suctioning of blood or other infectious materials is prohibited~~

- All procedures involving blood or other potentially infectious material shall be performed in such a manner as to minimize splashing, spraying, spattering and generation of droplets of these substances.~~materials~~

- Mouth pipetting/suctioning of blood or other potentially infectious materials is prohibited

- ~~Handwashing. Following any contact of body areas with blood or any other infectious materials, personnel shall wash their hands or any other exposed skin with soap and water as soon as possible. They shall also flush exposed mucous membranes with water.~~

- Employees will use Standard Precautions in the handling of all specimens and place specimens in containers that are recognizable as containing specimens. The container for storage, transport, or shipping shall be labeled or color-coded according to paragraph (g)(1)(i) of the OSHA standard 29 CFR 1910.1030 and closed prior to being stored, transported, or shipped if standard precautions are not used or if specimens/containers leave the facility (biohazard warning label needs to be attached).
  - During transportation of containers they shall be closed immediately prior to removal or replacement to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.
  - Equipment which may become~~s~~ contaminated with blood or other potentially infectious materials shall be~~is~~ examined prior to servicing or shipping, and shall be decontaminated~~ion~~ as necessary (unless it can be demonstrated that decontamination is not feasible).
  - A readily observable label~~n~~ in accordance with paragraph (g)(1)(i) of the OSHA standard 29 CFR 1910.1030 (appropriate biohazard warning label) ~~is~~ shall be attached to any contaminated equipment, stating which portions remain contaminated. ~~identifying the contaminated portions.~~
  - Information regarding the remaining contamination is conveyed to all affected ~~personnel~~employees, the equipment manufacturer and/or the equipment service representative as appropriate prior to handling, servicing or shipping so that the appropriate precautions will be taken.

PERSONAL PROTECTIVE EQUIPMENT (PPE):

- Personal protective equipment is specialized clothing or equipment worn by an employee for protection against a hazard. Employees will be provided PPE (at no cost to the employee) ~~-~~when there is occupational exposure. ~~is required for protection of bloodborne pathogens. Because of this, the District provides (at no cost to our employees) the personal protective equipment that they need to protect themselves against such exposure~~
- This equipment includes, but is not limited to: Gloves, gowns, laboratory coats, face shields, masks, eye protection, mouthpieces, resuscitation bags, pocket masks, shoe covers, or other ventilation devices.
  ~~Gloves~~
  ~~CPR masks~~

~~Gowns~~
~~Hoods~~
~~Face shield/masks~~
~~Shoe covers~~
~~Safety glasses~~
~~Goggles~~
~~Mouthpieces~~
~~Resuscitation bags~~

- PPE must prevent blood or other potentially infectious materials from passing through to or reaching the employee's work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of the time which the PPE will be used.

- In the rare and extraordinary circumstance that the employee's professional judgment in a specific instance determined that the PPE would have prevented the delivery of health care or public safety services or would have posed an increased hazard to the safety of the employee or co-worker, these circumstances shall be investigated and documented in order to determine whether changes can be instituted to prevent such occurrences in the future.

- Hypoallergenic gloves and similar alternatives are available to employees who are allergic to the gloves normally used.

- Any garments penetrated by blood or other infectious materials are to be removed immediately, as soon as feasible, after contamination exposure.

- All personal protective equipment is removed prior to leaving a work area and placed in an appropriately designated area or container for storage, washing, decontamination or disposal.

- In addition to patient care requirements, gloves are worn in the following circumstances:

  - Whenever ~~personnel~~ employees anticipate hand contact with blood, other potentially infectious materials, mucous membranes, and non-intact skin
  - When performing vascular access procedures except as specified in paragraph (d)(3)(ix)(D) of the OSHA standard 29 CFR 1910.1030
  - When handling or touching contaminated items or surfaces

- Disposable (single use) gloves such as surgical or examination gloves shall be replaced as soon as practical when contaminated or as soon as feasible if they are torn, punctured, or when their ability to function as a barrier is compromised.

- Utility gloves may be decontaminated for re-use if the integrity of the glove is not compromised. They will be discarded if they are cracked, peeling, torn, punctured, or exhibit other deterioration or when their ability to function as a barrier is compromised.

~~are replaced as soon as practical after contamination or if they are torn, punctured or otherwise lose their ability to function as an "exposure barrier."~~

- Masks, eye protection, and face shields: ~~and eye protection (such as goggles, face shields, etc.)~~ Masks in combination with eye protection devices such as goggles or glasses with solid side shields, or chin-length face shields, shall be worn ~~are used~~ whenever splashes, ~~or~~ spray, splatter, or droplets of blood or other potentially infectious materials may be generated and eye, nose, or mouth contamination can be reasonably anticipated. ~~s may generate droplets of infectious materials~~

- Gowns, Aprons, and other protective clothing: Appropriate p~~P~~rotective clothing ~~(~~such as, but not limited to gowns, aprons, lab coats, clinic jackets, or similar outer garments shall be ~~gowns and aprons) are~~ worn in occupational exposure situations. The type and characteristics will depend upon the task and degree of exposure anticipated.~~whenever potential exposure to potentially infectious material is anticipated.~~

- Surgical caps or ~~/~~hoods and/or shoe covers or ~~/~~boots ~~are~~ shall be worn ~~used~~ in ~~any~~ instances when~~re~~ ~~"~~gross contamination~~" is~~ can be reasonably anticipated (such as autopsies and/or orthopedic surgery).

WHEN AN EXPOSURE OCCURS:

Employee:

- Clean wound with soap and water, flush mucous membrane with cool water
- Complete Work Injury Report, found on Kaweah Compass under forms- fax to Employee Health at 559-635-6233, email Employee Health at employeehealth@kaweahhealth.org, or bring directly into Employee Health Services
- If outside of EHS hours, report incident to House Supervisor immediately
- Report to Employee Health in person. If EHS is closed, report next business day to complete Blood and Body Fluid Exposure log paperwork and go over source patient lab results as applicable.

Source Patient:

- Bedside nurse will notify source patient's physician of exposure, and have physician order source patient labs under 'ID Exposure Source Patient". These will include: Hep C ~~titre~~titer, Hep B SAG, and HIV. If source patient labs result positive for HIV or Hep C lab will run a viral load.
- If Source Patient labs are positive for HIV, Hep B, and/ or Hep C, EHS may contact UCSF PEP (Post Exposure Prophylaxis) line 888-448-4911 and/or utilize their website www.nccc.ucsf.edu, as well as the Medical Director or Infection Prevention Specialist to determine best evidence course of treatment for the exposed employee.

KAWEAH HEALTH POLICIES TO REFERENCE:

- EOC 4000 Hazard Material Management Plan
- IP 1.14 Blood/Body Fluid Disposal
- IP 1.18 Disposable Sharps Handling

- IP 1.16 Specimen Handling/Transport
- IP 1.20 Health Care Providers Infected with Bloodborne Pathogens

REFERENCE:

OSHA standard 29 CFR 1910.1030, ~~"Occupational Exposure t0~~ "Bloodborne Pathogens." https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030

"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: EHS 08	**Date Created: 05/29/2018**
Document Owner: Ellason Schales (RN-Employee Health Nurse)	**Date Approved: Not Approved Yet**
Approvers: Dianne Cox (Chief Human Resources Officer)	

Employee Health Standing Orders

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

Policy: Standing orders forand provision of employee immunizations, TB tests, Covid 19 testing and vaccination, and lab draws by Kaweah Health KDHCD Employee Health nursing staff forto Employees, Physicians, and Volunteers associated with Kaweah Health.

Procedure:

I. Vaccines: Mmay be administered by the Employee Health Nurses or qualified designees, according to CDC guidelines. Give the following doses of vaccines, as needed, according to the employee's immunization records or or titers.

1. Measles, Mumps, Rubella (MMR) Vaccine

~~1. Measles, Mumps, Rubella (MMR) Vaccine~~

   a. Route of administration: Subcutaneous
   b. Standard dose: 0.5 ml, x 2 doses

2. Hepatitis B Vaccine
   a. Route of administration: Intramuscular
   b. Standard Adult Dose: 1.0 ml, x 3 doses

3. Varicella Virus Vaccine
   a. Route of administration: Subcutaneous
   b. Standard dose: 0.5 ml, x 2 doses

4. Tdap Vaccine
   a. Route of administration: Intramuscular
   b. Standard dose: 0.5 ml

5. Flu Vaccination
   a. Route of administration: Intramuscular
   b. Standard dose: 0.5 ml x annually

~~b.~~

II. TB Testing

1. Upon Hire: T~~TB tests – t~~two step TB skin test (PPD) or Quantiferon Gold blood draw ~~on hire or Quantiferon Gold, and~~
~~6.~~2. A~~a~~nnual TB test ~~thereafter~~ per CDC, ~~and~~ CDPH, Cal OSHA, and Tulare County Public Health guidelines.
   a~~A~~. Chest x~~X~~-ray to be ordered and obtained for any positive result.
   b~~B~~. If a person has a previously documented positive TB result, a TB test need not be done, but a baseline chest x~~X~~-r~~R~~ay shall be obtained.

III. Blood draws
1. Titers~~New Hires~~
   a. ~~–~~D~~d~~raw titers for HBSAB, MMR, ~~Hep A~~ and Varicella as needed for new hire
   employees and current employees as needed.
2. Blood and Body Fluid Exposures:
   a. Draw required labs as recommended by current CDC/PEP guidelines for employees exposed to Hep B, Hep C, and HIV
   b. In the rare case that source patient labs were not able to be drawn
   and the source patient is able and willing to come to Employee
   ~~7.~~ Health Services, draw HBsAG, Hep C, and HIV

~~8. Draw HIV, HEP C, HBsAg as needed for exposures~~
~~9. Meningococcal Vaccine –~~
~~A. Meningococcal A (Menactra) -1 dose IM, then booster in 5 years~~
~~– Meningococcal B (Bexsero) – 2 doses IM one month apart~~

IV. Covid 19 testing: ~~–~~T~~t~~o be ordered by ~~E~~mployee~~Employee~~ Health~~S~~ N~~n~~urse or designee, as needed, based on symptoms reported by employee, or state regulation testing per California Department of Public Health (CDPH). Covid 19 symptom assessment shall be based on CDC guidelines.

~~10. Covid 19 vaccine – To be administered per Manufacturers Guidelines.~~

References:

https://www.cdc.gov/coronavirus/2019-ncov/index.html

https://www.cdph.ca.gov

https://www.cdc.gov/vaccines/adults/rec-vac/hcw.html

"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: EHS 11	Date Created: 08/21/2018
Document Owner: Ellason Schales (RN-Employee Health Nurse)	Date Approved: Not Approved Yet
Approvers: Dianne	

Immunization Requirements for Health Care Workers

Policy:

Healthcare Personnel (HCPs) are at risk for exposure to and possible transmission of vaccine-preventable diseases because of their contact with patients or infective material from patients. The Centers for Disease Control (CDC) and Advisory Committee on Immunization Practices (ACIP) recommend the following requirements for all Healthcare Personnel Immunizations.

Procedure:

Hepatitis B Vaccine:

- Documented evidence of complete hepatitis B series and a positive hepatitis B surface antibody titer (HBSAB titer) or positive HBSAB titer alone for all healthcare personnel who have an occupational risk for exposure to blood and/or other body fluids.
- Vaccination for hepatitis B can be either a 3-dose series of Recombivax HB or Engerix-B or a 2-dose series of Heplisav-B. Doses will be provided at intervals recommended per current CDC guidelines.
- If the HCP has had the complete series already but does not have evidence of a positive/reactive HBSAB titer, draw an HBSAB titer. If the HBSAB is nonreactive, meaning no or low immunity to the hepatitis B virus, give one hepatitis B booster, then recheck HBSAB in 4-8 weeks. If the healthcare personnel's HBSAB remains nonreactive, complete the full series of hepatitis B vaccine. Retest HBSAB 4-8 weeks following the competed series.
- HCP who are non-responders should be considered susceptible to HBV and are counseled regarding precautions to prevent HBV infection.
- HCP who are exposed to Hepatitis B antigen in the workplace, EHS 02 Employee Exposure to Bloodborne Pathogens Policy will be followed.
- Administration of more than two complete hepatitis B series is generally not recommended, expect for people on hemodialysis.

Influenza Vaccine:

- One dose of influenza vaccine annually. See Policy EHS 05: Influenza Prevention.

Measles, Mumps, Rubella Vaccine (MMR):

- Proof of two documented doses of measles-and mumps-containing vaccine and 1 documented dose of rubella-containing vaccine or proof of positive titers.
- If no evidence of vaccination or positive titer, draw titer.
- For healthcare personnel who do not have serologic evidence of immunity or prior vaccination, give 2 doses of MMR (4 weeks apart). No follow up titer necessary.

- If the healthcare personnel provides proof of two documented measles-and mumps-containing vaccinations and also has a negative or equivocal titer(s) result for measles or mumps, it is not recommended that they receive an additional dose of MMR vaccine. Such people should be considered to have acceptable evidence of measles or mumps immunity; retesting is not necessary.
- If healthcare personnel (except for women of childbearing age) who have 1 documented dose of rubella-containing vaccine are tested serologically and have a negative or equivocal titer result for rubella, it is not recommended that they receive an additional dose of MMR vaccine. Such people should be considered to have acceptable evidence of rubella immunity, retesting not necessary.

Varicella Vaccine (Chicken Pox):

- Proof of two documented doses of varicella vaccine or a positive titer.
- If no evidence of vaccination or positive titer, draw titer.
- For healthcare personnel who do not have serologic evidence of immunity or prior vaccination, give 2 doses of varicella (4 weeks apart). No follow up titer necessary.
- If the healthcare personnel provides proof of two documented varicella vaccinations and has a negative or equivocal titer result for varicella, it is not recommended that they receive an additional dose of varicella vaccine (commercial assays are not sensitive enough to always detect antibodies after vaccination).

Tetanus, Diphtheria, and Pertussis Vaccine (Tdap):

- One time dose of Tdap for high risk areas. See Policy EHS 07: Tdap Policy for Healthcare Personnel.

Covid 19 vaccine:

- Two dose series or approved one dose vaccine plus one booster.

Tuberculosis testing (TB):

- A two-step TB skin test is required for all new hire healthcare personnel, or one Quantiferon Gold (QFG), and then an annual TB test thereafter.
- If the healthcare personnel provides documentation of a TB skin test within the last year, it will be counted as #1 of the two step TB skin test. If documentation is provided of a second TB skin test that was placed and read within the last 3 months prior to hire date, it will be accepted as #2 TB skin test. Otherwise the healthcare personnel will need a current TB skin test(s) placed and read to begin orientation.
- If the HCP has had a previous documented positive TB test, they will need a chest x-ray performed (proof of chest x-ray within the last year is acceptable) and annual TB symptom questionnaire completed.

Declinations of Vaccines:

- HCP's who require a vaccination will be provided the CDC Vaccine information sheets.
- If a HCP declines the MMR, Varicella, or Hepatitis B vaccines after receiving information of the benefits, they will be provided a declination form to sign for each of the vaccines they are declining. This information will be recorded in their Employee Health record.
- For HCP's declining influenza vaccine refer to policy EHS 05: Influenza Prevention for process to decline influenza vaccine
- For HCP's declining Tdap vaccine refer to EHS 07: Tdap Policy for Healthcare Personnel for process to decline Tdap vaccine

- For HCP's declining Ceovid vaccination refer to Covid 36: Team Member Covid-19 Vaccination Policy for process to decline Covid vaccine

References:

Immunization of Health Care Personnel: Recommendations of the Advisory Committee in Immunization Practices (ACIP) November 25, 2011 / 60(RR07); 1-45 (https://www.cdc.gov/mmwr/pdf/rr/rr6007.pdf)

Centers for Disease Control and Prevention Website: Recommended Vaccines for Healthcare Workers. Last Reviewed May 2, 2016. (https://www.cdc.gov/vaccines/adults/rec-vac/hcw.html)

"Responsibility for the review and revision of this Policy is assigned to the Chief of Human Resources Officer. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Health Policies and Procedures."

Policy Number: EHS 13	**Date Created: No Date Set**
Document Owner: Ellason Schales (RN-Employee Health Nurse)	**Date Approved: Not Approved Yet**
Approvers: Dianne Cox (Chief Human Resources Officer)	

Respiratory Protection Program

POLICY:

It is the policy of Kaweah Health to protect the health and safety of its employees by eliminating hazardous exposures where possible and using engineering and administrative controls to minimize hazardous exposures that cannot be eliminated. In some cases, however, such controls will not reduce exposures to safe levels and the use of respiratory protection may be required.

PURPOSE:

The purpose of this Respiratory Protection Program (RPP) is to maximize the protection afforded by respirators when they must be used. It establishes the procedures necessary to meet the regulatory requirements for use of respiratory protection including Respiratory Protection Standard (Title 8 California Code of Regulations Section 5144), and the Aerosol Transmissible Diseases Standard (8 CCR Section 5199).

This program applies to all employees who may need to wear respiratory protection due to the nature of their work at Kaweah Health.

In regards to non-employees of Kaweah Health, students will be held to their own school's RPP, but nursing registries, (travelers), temporary employees, and volunteers will follow Kaweah Health's RPP and/or their agencies RPP.

PROGRAM PROCEDURE:

I. Responsibilities:

A. Respirator Program Administrator (RPA):

1. Employee Health Services Manager has been designated as the RPA.

2. The RPA has received appropriate training and is knowledgeable about the requirements of the Cal/OSHA Respiratory Protection Standard and all elements of the Respiratory Protection Program that need to be implemented in order for it to be effective. Upper management has ultimate responsibility for all aspects of this program and has given the manager full authority to make the necessary decisions to ensure its success. This authority includes (but is not limited to) conducting a hazard assessment for selecting appropriate respiratory protection, purchasing the necessary equipment and supplies, and developing and implementing the policies and procedures in the written RPP.

3. Specifically, the RPA will:

    - Conduct a hazard assessment and select the appropriate level of respiratory protection for each task or job title with exposure and record that information in the Kaweah Health EHS 17 Aerosol Transmissible Diseases Exposure Control Plan Policy
    - Develop and monitor respirator maintenance procedures.
    - Coordinate purchase, maintenance, repair, and replacement of respirators.
    - Routinely evaluate the effectiveness of the RPP, with employee input, and make any necessary changes to the program.
    - Provide or arrange for annual training in the use and limitations of respirators in accordance with 8 CCR Section 5144.
    - Provide or arrange for annual respirator fit testing in accordance with 8 CCR Section 5144.
    - Maintain records of respirator training, medical clearance, and fit testing as required by 8 CCR Sections 5144 and 3204.
    - Maintain a copy of this written RPP and program evaluations, and ensure that they are readily accessible to anyone in the program.
    - Review the written RPP at least annually to ensure compliance with 8 CCR Section 5144.

B. Supervisors

1. Supervisors of employees included in the RPP will:

    - Participate in the hazard assessment by evaluating all potential exposures to respiratory hazards, including chemical exposures and/or aerosol transmissible diseases (ATDs), and communicating this information to the RPA.
    - Identify employees and/or tasks for which respirators may be required and communicate this information to the RPA.
    - Be responsible for ensuring that employees in their units follow the procedures outlined in the RPP. They will ensure employees attend

medical evaluations as needed, training, and fit testing and ensure that they are allowed to attend these appointments during work hours.

C. Employees in the Program

1. Employees assigned to jobs/tasks requiring the use of a respirator will:

- Complete required questionnaire for medical clearance and participate in a medical examination if necessary.
- Adhere to hospital policy on facial hair.
- Attend annual training and respirator fit testing as required in the RPP.
- Use, maintain, and dispose of respirators properly in accordance with training and the procedures in the RPP.

II. Respirator Selection

A. Hazard assessment

1. The RPA will select the types of respirators to be used by hospital staff based on the hazards to which employees may be exposed and in accordance with all Cal/OSHA regulations and CDC and/or CDPH guidelines.

2. With input from the respirator user, the RPA and supervisor will conduct a hazard assessment for each task, procedure, or work area where there are airborne contaminants.

3. The hazard assessment will include the following as needed:

- Identification of potential exposures. The most common potential exposure for employees involved in patient care will be ATDs such as tuberculosis, covid, or pandemic influenza. Maintenance and housekeeping staff may have the potential to be exposed to hazardous gases, vapors, or dusts in addition to ATDs.
- A review of work processes to determine which tasks and locations have potential exposures.
- Relative to chemical exposures, quantification or objective determination of potential exposure levels where possible.This will not be done for ATDs.

B. NIOSH Certified Equipment

1. All respiratory protective equipment shall be approved by the National Institute for Occupational Safety and Health (NIOSH) for the environment in which it is going to be used.

2. The following definitions apply to equipment that may be issued to employees under this program:

   - **Air-purifying respirator (APR)** is a respirator that removes gases, vapors, or particles, or combinations of gases, vapors, and/or particles from the air through the use of filters, cartridges, or canisters that have been tested and approved by NIOSH for use in specific types of contaminated atmospheres. This respirator does not supply oxygen and therefore cannot be used to enter an atmosphere that is oxygen-deficient.

     - **Filtering facepiece respirator (N95 for ATDs)** is a particulate air-purifying respirator in which the entire facepiece is composed of the filtering medium. These respirators are disposable and designed for a single use. An N95 has a filter efficiency of 95%

   - **Powered air-purifying respirator (PAPR)** is an air-purifying respirator that uses a blower to force ambient air through air-purifying elements to the respirator facepiece, helmet, or hood.

C. Assignment of Respirators by Task and Location

1. The RPA will use the hazard assessment to assign appropriate types of respirators for use by specific types of personnel during specific procedures or in specific areas of the hospital.

2. These assignments are listed in Kaweah Health EHS 17 Aerosol Transmissible Diseases Exposure Control Plan Policy.

D. Updating the Hazard Assessment

1. The RPA will revise and update the hazard assessment any time an employee or supervisor anticipates a new exposure.

2. Any employee who believes that respiratory protection is needed during any particular activity must contact their supervisor or the RPA. The supervisor must contact the RPA whenever respiratory protection is requested. The RPA will assess the potential hazard with the employee and supervisor. If it is determined that respiratory protection

is needed, all elements of this program will be in effect for those tasks and the program will be updated accordingly.

E. Voluntary Use of Respirators

1. When the use of a respirator is not required by a standard or hospital policies and the RPA has determined that its use is not necessary to protect the health of the employee, an employee may still request and use a respirator voluntarily.

2. Employees using respirators voluntarily will be provided with the information in Appendix D to 8 CCR Section 5144 (Appendix A of this RPP).

3. Employees must have the approval of their supervisor to be in the voluntary respirator program, because of the program cost for the initial services. These employees are welcome to attend annual training provided to those in the full respirator program, but it will not be scheduled specifically to accommodate them. If they are aware of a change that warrants review of medical clearance or repeat fit testing, they should bring that to the attention of their supervisor.

III. Medical Evaluation

A. Employees whose work activities require the use of respiratory protective equipment shall receive medical clearance prior to the use of a respirator and prior to being fit tested for a respirator.

1. Medical evaluations and clearances will be performed by a physician or other licensed health care provider (PLHCP) at Kaweah Health Employee Health Services.

2. Before being assigned to work in an area where respirators are required, each employee will complete one of the questionnaires in Appendix B of this RPP and turn it in to Kaweah Health Employee Health Services.

3. Employees may also speak directly with the PLHCP if they have questions. The PLHCP will be provided information about the type of respiratory protection to be used by employees, duration and frequency of respirator use, expected physical effort, other protective equipment worn, and any expected extremes of temperature or humidity.

B. The PLHCP will review completed questionnaires and make a medical determination as to whether the employee can wear a respirator safely. The PLHCP may make this determination based on the questionnaire alone, but may also require a physical examination of the employee and any tests, consultations, or procedures the PLHCP deems are necessary. The PLHCP will provide a clearance letter, which may clear the employee for all respirator use, or may specify restrictions or limitations on use, such as the type of respirator that may be worn or the duration that it may be worn. A copy of this written determination shall also be provided by the PLHCP to the employee.

    1. An additional medical evaluation is required when:

        - The employee reports medical signs or symptoms that are related to the ability to use a respirator.
        - A PLHCP requests re-evaluation.
        - Observations made during fit testing and/or program evaluation indicate a need for re-evaluation (e.g., the employee experiences claustrophobia or difficulty breathing during the fit test).
        - A change occurs in workplace conditions (e.g., physical work effort, protective clothing, or temperature) that may result in a substantial increase in the physiological burden placed on an employee wearing a respirator.

IV. Fit Testing

A. Before an employee is required to use any respirator with a tight-fitting facepiece (anything except a PAPR with hood or helmet that does not rely upon a tight-fitting facepiece-to-face seal), she/he will be fit tested by a trained Kaweah Health staff member or by an outside consultant with the same make, model, style, and size of respirator to be used.

B. Employees with facial hair that interferes with the facepiece-to-face seal will not be fit tested and will not be allowed to wear a respirator with a tight-fitting facepiece.

C. All employees who must wear respiratory protection shall receive medical clearance before fit testing is performed. Fit tests will be provided at the time of initial assignment and annually thereafter.

D. Additional fit tests will be provided whenever the employee experiences or the supervisor or RPA observes physical changes that could affect respirator fit. These changes include, but are not limited to, facial scarring, dental changes, cosmetic surgery, or an obvious change in body weight.

E. Employees who will be using only a PAPR with hood or helmet will not be fit tested. Any employee who cannot be successfully fit tested with a tight-fitting

facepiece respirator will be assigned a PAPR with a hood or helmet for all tasks requiring any respirator.

F. Employees will be offered a selection of several models and sizes of respirators from which they may choose the one that correctly fits and is most acceptable/comfortable as available.

G. A qualitative fit test will be used for all wearers of half-face APRs. The qualitative test will follow the protocol for saccharine solutions found in Appendix A of the Cal/OSHA Respiratory Protection Standard (8 CCR Section 5144) and in Appendix C of this RPP.

V. Training

A. Annual respirator training will be provided for all employees covered by this program. The training will be conducted by a trained Kaweah Health staff member or by an outside consultant and will include the following:

1. The general requirements of the Cal/OSHA Respiratory Protection Standard.

2. The specific circumstances under which respirators are to be used.

3. Why the respirator is necessary and how proper fit, usage, or maintenance can ensure the protective effect of the respirator.

4. The limitations and capabilities of the respirators that will be used.

5. How to effectively use the respirators.

6. How to inspect, put on, remove, use, and check the seals of the respirator (for tight-fitting respirators such as N95s).

7. The procedures outlined in this program for maintenance, storage, and cleaning or disposal of respirators. Employees who are issued PAPRs shall be instructed in procedures for charging and maintaining the batteries, and for checking the air flow rate.

8. How to recognize medical signs and symptoms that may limit or prevent the effective use of respirators.

9. How to decontaminate (or safely dispose of) a respirator that has been contaminated with chemicals or hazardous biological materials is completed in the Hazardous Drug Handling USP 800 Module training

and employees can refer to EOC 4001 “Hazardous Materials and Waste Management Program” Policy.

B. Training shall be provided at the time of initial assignment to respirator use, but before actual use, and annually thereafter.

C. Additional training will be provided when there is a change in the type of respiratory protection used, or when inadequacies in the employee's knowledge or use of the respirator indicate that he/she has not retained the requisite understanding or skill.

D. The employee will also receive additional training during the fit testing procedure that will provide him/her an opportunity to handle the respirator, have it fitted properly, test its facepiece-to-face seal, wear it in normal air for a long familiarity period, and finally to wear it in a test atmosphere. Every respirator wearer will receive fitting instructions, including demonstrations and practice in how the respirator should be worn, how to adjust it, and how to perform a user seal check according to the manufacturer’s instructions.

E. Employees will be given the opportunity during training to provide feedback on the effectiveness of the program and any suggestions they have for improvement.

VI. Respirator Use

A. Employees will use their respirators under conditions specified by this program and in accordance with the training they receive on the use of each particular model or type of respirator. The appropriate types of respirators to be used and the exposure conditions are listed in the respirator selection in Kaweah Health EHS 17 Aerosol Transmissible Diseases Exposure Control Plan Policy.

B. Respirators relying on a tight facepiece-to-face seal must not be worn when conditions prevent a good face seal. Such conditions may be a growth of beard, long moustache, sideburns, or even razor stubble as well as scars, other facial deformities, and sometimes temple pieces on glasses. In addition, the absence of one or both dentures can seriously affect the fit of a facepiece.

C. Employees and supervisors are expected to be diligent in observing policies pertaining to ensuring the safe use of respirators. To assure proper protection, the wearer will perform a user seal check in accordance with manufacturer’s instructions and the training provided at the time of fit testing, each time he/she puts on the respirator. Employees who wear corrective

glasses or other personal protective equipment must be sure that such equipment is worn in a manner that does not interfere with the facepiece seal.

D. Filtering facepiece respirators (N95 masks for ATDs) will be discarded after each use.

    1. During conventional use in patient care, a disposable respirator should be removed and discarded between patients.

E. If masking shortages or the potential for masking shortages occur due to a pandemic or other extraordinary circumstances consideration may be taken in account for extended use of N95 respirators as respiratory protection as recommended by NIOSH for conserving the supply of N95 filtering facepiece respirators is as follows:

    1. When practicing extended use of N95 respirators over the course of a shift, consider the following if able to do so:

        - The ability of the N95 respirator to retain its fit
        - Contamination concerns
        - Practical aspects (ex: meal breaks)
        - Comfort of user

    2. N95 respirators should be discarded immediately after bring removed. If removed for a meal break, the respirator should be discarded and a new respirator put on after break.

    3. N95 masks should be discarded when contaminated with blood, respiratory or nasal secretions, or other bodily fluids from patients. HCP can consider using a face shield over the respirator to reduce contamination of the respirator, especially during aerosol generating procedures or procedures that might generate splashes and sprays. A medical mask should not be placed over a respirator because it may comprise the fit of the respirator.

F. If masking shortages or the potential for masking shortages occur due to a pandemic or other extraordinary circumstances consideration may be taken in account for limited re-use of N95 respirators as respiratory protection as recommended by NIOSH for conserving the supply of N95 filtering facepiece respirators is as follows:

    1. If limited re-use is practiced on top of extended use, caution should be used to minimize self-contamination and degradation of the respirator. If no manufacturer guidance is available, a reasonable limitation should be five total donnings regardless of the number of hours the respirator is worn.

2. N95 respirators should not be re-used when caring for patients with varicella or other pathogens that can also be transmitted via contact routes, as contact transmission poses a risk to HCP who implement this practice.

3. Respirators soiled or grossly contaminated with blood, respiratory or nasal secretions, or other bodily fluids from patients should be discarded. HCP can consider using a face shield over the respirator to reduce and prevent contamination of the N95 respirator, especially during aerosol generating procedures or procedures anticipated to generate splashes and sprays. It is important to perform hand hygiene before and after the previously worn N95 respirator is donned or adjusted.

G. Employees may leave the work area to change or adjust their respirator for the following reasons:

1. To adjust their respirator if the respirator is impeding their ability to work.

2. To wash their face if the respirator is causing discomfort or rash.

3. To inspect the respirator if it stops functioning as intended, or if there is a noticeable increased resistance to breathing.

VII. Storage, Maintenance, and Care of Respirators

A. Storage

1. All respirators will be stored to protect them from damage, contamination, dust, sunlight, extreme temperatures, excessive moisture, and damaging chemicals.

2. Filtering facepiece respirators that will be used in patient care areas will be stored in storage carts/rooms on units and outside door of precaution rooms as needed. These will be discarded after each use.

3. PAPRs will be stored in the respiratory therapy department and will be provided to employees upon request for use during high hazard procedures being conducted on patients with suspected or confirmed airborne infectious disease or for use by individuals who are unable to wear a respirator with a tight-fitting facepiece.

B. Inspection, Maintenance, and Repairs

1. All respirators will be inspected by the user prior to each use. Inspections should include a check of:

    - Condition of the various parts including, but not limited to, the facepiece and head straps
    - PAPR connecting tubes or hoses, air flow, and batteries.

2. Any defective respirators shall be removed from service. Defective disposable respirators will be discarded and replaced.

3. Respiratory Therapy Department is responsible for charging and maintaining PAPR pumps and batteries when they are stored or not in use.

C. Cleaning and Disinfection

1. Reusable respirators (PAPRs) will be cleaned and disinfected according to manufacturer's guidelines.

2. Reusable respirators (PAPRs) used in fit testing and training will be cleaned after each use by the employee conducting the fit testing or training.

VIII. Program Evaluation

A. The RPA will conduct a periodic evaluation of the RPP to ensure that all aspects of the program adhere to the requirements of the Cal/OSHA Respiratory Protection Standard and that it is being implemented effectively to protect employees from respiratory hazards. This evaluation will be done annually and as needed.

B. Program evaluation will include:

1. A review of the written program.

2. Completion of a Program Evaluation Checklist based on observations of workplace practices.

3. A review of feedback obtained from employees (to include fit, use, and maintenance issues) that will be collected at the annual training session.

C. The RPP will be revised as necessary and records of revisions will be kept on file with the written program. Any procedural changes that are implemented

as a result of program evaluation will be communicated to the employees and reinforced by their supervisors.

IX. Recordkeeping

A. The RPA will ensure that the following records are maintained:

1. Personnel medical records such as medical clearance to wear a respirator shall be retained by Employee Health Services in employee's chart as part of a confidential medical record and made available in accordance with the Cal/OSHA Access to Medical Records Standard (8 CCR Section 3204), for a minimum of thirty (30) years after an employee's separation or termination.

2. Documentation of training and fit testing will be kept by Employee Health Services in employee's chart until the next training or fit test.

3. A copy of this RPP and records of program evaluations and revisions shall be made available to all affected employees, their representatives, and representatives of the Chief of the Division of Occupational Safety and Health (Cal/OSHA) upon request.

X. References

California Department of Public Health Occupational Health Branch. "Implementing Respiratory Protection Programs in Hospitals: A Guide For Respirator Program Administrators." August 2015. Website: https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/OHB/CDPH%20Document%20Library/HCResp-CARPPGuide.pdf

Title 8 California Code of Regulations Section 5144: "Respiratory Protection Standard." Website: https://www.dir.ca.gov/title8/5144.html

Title 8 California Code of Regulations Section 5199 "Aerosol Transmissible Diseases Standard." Website: https://www.dir.ca.gov/title8/5199.html

The National Institute for Occupational Safety and Health (NIOSH). "Strategies for Conserving the Supply of N95 Filtering Facepiece Respirators." Reviewed 5/20/23. Website: https://www.cdc.gov/niosh/topics/pandemic/strategies-n95.html

XI. Related Kaweah Health Policies:

EHS 17 Aerosol Transmissible Disease Exposure Control Plan

RPP Appendix A: Information for Voluntary Users

Respirators are an effective method of protection against designated hazards when properly selected and worn. Respirator use is encouraged even when exposures are below the exposure limit, to provide an additional level of comfort and protection for workers. However, if a respirator is used improperly or not kept clean, the respirator itself can become a hazard to the worker. Sometimes, workers may wear respirators to avoid exposures to hazards, even if the amount of hazardous substance does not exceed the limits set by OSHA standards. If your employer provides respirators for your voluntary use, you need to take certain precautions to be sure that the respirator itself does not present a hazard.

You should do the following:

1. Read and heed all instructions provided by the manufacturer on use, maintenance, cleaning and care, and warnings regarding the respirators limitations.

2. Use only N95 Filtering Facepiece Respirators provided by Kaweah Health.

3. Do not wear your respirator into atmospheres containing contaminants for which your respirator is not designated to protect against. For example, a respirator designed to filter dust particles will not protect you against gases, vapors or very small solid particles of fumes or smoke.

4. Keep track of your respirator so that you do not mistakenly use someone else's respirator.

RPP Appendix B: Medical Clearance Questionnaire and Fit Test Form

Please Print ***Initial and Annual N-95 MASK FIT TEST***

Last Name:	**First Name:**	**Birthdate:**
Employee ID:	**Job title:**	**Dept:**

Medical Questionnaire:This questionnaire is used in determining whether or not you have a medical condition that may affect your ability to wear a respirator (mask). We anticipate being able to approve most people for respirator fit testing based on this questionnaire alone. In some cases, we may ask for more information.

Have you ever had any of the following?

Lung Disease: Yes_____ No_____ **Asthma: Yes_____ No_____**
Heart Disease: Yes_____ No_____ **Hypertension: Yes_____ No_____**

Explain "Yes" answers:_____

Do you have a: ☐ **N/A** ☐ **Beard** ☐ **Goatee** ☐ **5 O'Clock shadow at Work**

Smoking History: ☐ **Never Smoked** ☐ **Ex-smoker** ☐ **Presently a smoker**

1. **Do you get short of breath or wheeze with exertion?** ☐ **Yes** ☐ **No**
2. **Do you ever get chest pain?** ☐ **Yes** ☐ **No**
3. **Do you have any medical problems that might interfere with the wearing of a Respirator /mask?** ☐ **Yes** ☐ **No**
4. **Do you take any medications for treatment of cardiac, respiratory, or blood Pressure problems?** ☐ **Yes** ☐ **No**
5. **Have you ever had problems wearing a respirator/mask?** ☐ **Yes** ☐ **No**

Explain "Yes" answers: _____

☐ **Provided the ATD Training form**

Employee Signature: _____ **Date:**_____

Brand & Model Number	*3M 8210*	*3M 1860*	*3M 1870*	*3M 9205+*	*Alpha Pro Tech*

					Other:

Fitting:
□Satisfactory Qualitative Saccharin Fit Test □Instructions for use reviewed □Donning and Removal
□ Training information given
□Pass
□ Fail -Explain:_____
□ Information given on PAPR
Signature of test administrator:_____ **Date:**_____

RPP Appendix C: Fit Test Protocol

Part I. OSHA-Accepted Fit Test Protocols

A. Fit Testing Procedures--General Requirements. The employer shall conduct fit testing using the following procedures.

1. The test subject is shown the respirators currently utilized at Kaweah Health.

2. The test subject is shown to put on a respirator, how it should be positioned on the face, how to set strap tension and how to determine an acceptable fit. A mirror shall be available if needed to assist the subject in evaluating the fit and positioning of the respirator.

3. Assessment of comfort shall include a review of the following points with the test subject and allowing the test subject adequate time to determine the comfort of the respirator.

(a) Position of the mask on the nose

(b) Room for eye protection

(c) Room to talk

(d) Position of mask on face and cheeks

4. The following criteria shall be used to help determine the adequacy of the respirator fit:

(a) Chin properly placed;

(b) Adequate strap tension, not overly tightened;

(c) Fit across nose bridge;

(d) Respirator of proper size to span distance from nose to chin;

(e) Tendency of respirator to slip;

(f) Self-observation in mirror to evaluate fit and respirator position.

5. The test subject shall conduct a user seal check. Before conducting the check, the subject shall be told to seat the mask on the face by moving the head from side-to-side and up and down slowly while taking in a few slow deep breaths. Another facepiece shall be selected and retested if the test subject fails the user seal check tests.

6. The test shall not be conducted if there is any hair growth between the skin and the facepiece sealing surface, such as stubble beard growth, beard, mustache or sideburns which cross the respirator sealing surface. Any type of apparel which interferes with a satisfactory fit shall be altered or removed.

7. If a test subject exhibits difficulty in breathing during the tests, she or he shall be referred to a physician or other licensed health care professional, as appropriate, to determine whether the test subject can wear a respirator while performing her or his duties.

8. If the employee finds the fit of the respirator unacceptable, the test subject shall be given the opportunity to select a different respirator and to be retested.

9. Exercise regimen. Prior to the commencement of the fit test, the test subject shall be given a description of the fit test and the test subject's responsibilities during the test procedure. The description of the process shall include a description of the test exercises that the subject will be performing. The respirator to be tested shall be worn for at least 5 minutes before the start of the fit test.

10. Test Exercises.

(a) The following test exercises are to be performed for all fit testing methods prescribed in this appendix. test subject shall perform exercises, in the test environment, in the following manner:

(1) Normal breathing. In a normal standing position, without talking, the subject shall breathe normally.

(2) Deep breathing. In a normal standing position, the subject shall breathe slowly and deeply, taking caution so as not to hyperventilate.

(3) Turning head side to side. Standing in place, the subject shall slowly turn his/her head from side to side between the extreme positions on each side. The head shall be held at each extreme momentarily so the subject can inhale at each side.

(4) Moving head up and down. Standing in place, the subject shall slowly move his/her head up and down. The subject shall be instructed to inhale in the up position (i.e., when looking toward the ceiling).

(5) Talking. The subject shall talk out loud slowly and loud enough so as to be heard clearly by the test conductor. The subject can read from a prepared text such as the Rainbow Passage, count backward from 100, or recite a memorized poem or song.

Rainbow Passage

When the sunlight strikes raindrops in the air, they act like a prism and form a rainbow. The rainbow is a division of white light into many beautiful colors. These take the shape of a long round arch, with its path high above, and its two ends apparently beyond the horizon. There is, according to legend, a boiling pot of gold at one end. People look, but no one ever finds it. When a man looks for something beyond reach, his friends say he is looking for the pot of gold at the end of the rainbow.

(7) Bending over. The test subject shall bend at the waist as if he/she were to touch his/her toes. Jogging in place shall be substituted for this exercise in those test environments such as shroud type QNFT or QLFT units that do not permit bending over at the waist.

15. Saccharin Solution Aerosol Protocol. The entire screening and testing procedure shall be explained to the test subject prior to the conduct of the screening test.

(a) Taste threshold screening. The saccharin taste threshold screening will be performed on initial testing or when reported changes in taste by employee. Threshold screening will performed without wearing a respirator and is intended to determine whether the individual being tested can detect the taste of saccharin.

(1) During threshold screening as well as during fit testing, subjects shall wear an enclosure about the head and shoulders that is approximately 12 inches in diameter by 14 inches tall with at least the front portion clear and that allows free movements of the head when a respirator is worn. An enclosure substantially similar to the 3M hood assembly, parts # FT 14 and # FT 15 combined, is adequate.

(2) The test enclosure shall have a 3/4-inch (1.9 cm) hole in front of the test subject's nose and mouth area to accommodate the nebulizer nozzle.

(3) The test subject shall don the test enclosure. Throughout the threshold screening test, the test subject shall breathe through his/her slightly open mouth with tongue extended. The subject is instructed to report when he/she detects a sweet taste.

(4) Using a DeVilbiss Model 40 Inhalation Medication Nebulizer or equivalent, the test conductor shall spray the threshold check solution into the enclosure. The nozzle is directed away from the nose and mouth of the person. This nebulizer shall be clearly marked to distinguish it from the fit test solution nebulizer.

(5) To produce the aerosol, the nebulizer bulb is firmly squeezed so that it collapses completely, then released and allowed to fully expand.

(6) Ten squeezes are repeated rapidly and then the test subject is asked whether the saccharin can be tasted. If the test subject reports tasting the sweet taste during the ten squeezes, the screening test is completed. The taste threshold is noted as ten regardless of the number of squeezes actually completed.

(7) If the first response is negative, ten more squeezes are repeated rapidly and the test subject is again asked whether the saccharin is tasted. If the test subject reports tasting the sweet taste during the second ten squeezes, the screening test is completed. The taste threshold is noted as twenty regardless of the number of squeezes actually completed.

(8) If the second response is negative, ten more squeezes are repeated rapidly and the test subject is again asked whether the saccharin is tasted. If the test subject reports tasting the sweet taste during the third set of ten squeezes, the screening test is completed. The taste threshold is noted as thirty regardless of the number of squeezes actually completed.

(9) The test conductor will take note of the number of squeezes required to solicit a taste response.

(10) If the saccharin is not tasted after 30 squeezes (step 10), the test subject is unable to taste saccharin and may not perform the saccharin fit test.

(11) If the test subject eats or drinks something sweet before the screening test, he/she may be unable to taste the weak saccharin solution.

(12) If a taste response is elicited, the test subject shall be asked to take note of the taste for reference in the fit test.

(13) Correct use of the nebulizer means that approximately 1 ml of liquid is used at a time in the nebulizer body.

(14) The nebulizer shall get thoroughly rinsed in water, shaken dry, and refilled at least each morning and afternoon or at least every four hours.

(b) Saccharin solution aerosol fit test procedure.

(1) The test subject may not eat, drink (except for plain water), smoke, or chew gum for 15 minutes before the test.

(2) The fit test uses the same enclosure described in 3. (a) above.

(3) The test subject shall don the enclosure while wearing the respirator. The respirator shall be properly adjusted as needed.

(4) A second DeVilbiss Model 40 Inhalation Medication Nebulizer or equivalent is used to spray the fit test solution into the enclosure. This nebulizer shall be clearly marked to distinguish it from the screening test solution nebulizer.

(5) The fit test solution shall be used for the fit test.

(6) As before, the test subject shall breathe through the slightly open mouth with the tongue extended, and report if he/she tastes the sweet taste of saccharin.

(7) The nebulizer is inserted into the hole in the front of the enclosure and an initial concentration of saccharin fit test solution is sprayed into the enclosure using the same number of squeezes (either 10, 20 or 30 squeezes) based on the number of squeezes required to elicit a taste response as noted during the screening test. A minimum of 10 squeezes is required.

(8) After generating the aerosol, the test subject shall be instructed to perform the exercises in section I. A. 14. of this appendix.

(9) The test subject shall indicate to the test conductor if at any time during the fit test the taste of saccharin is detected. If the test subject does not report tasting the saccharin, the test is passed.

(10) If the taste of saccharin is detected, the fit is deemed unsatisfactory and the test is failed. A different respirator shall be tried and the entire test procedure is repeated (taste threshold screening and fit testing).

(11) Since the nebulizer has a tendency to clog during use, the test operator must make periodic checks of the nebulizer to ensure that it is not clogged. If clogging is found at the end of the test session, the test is invalid.

~~**Policy: It is the policy of Kaweah Delta Health Care District to provide its employees with a safe and healthful work environment. The purpose of this program is to reduce employee exposure to infectious agents in the workplace through the proper use of respirators during an influenza pandemic or other infectious respiratory disease emergency. Respiratory protection is provided at**~~

no cost to the employees. This policy includes the implementation of this respiratory protection program as a means of providing the highest levels of protection to employees during an influenza pandemic, as defined by OSHA.2 Specific details of this guidance appear in the Appendix. Program Administration

Procedure: Responsibilities:

The following Department has ultimate total and complete responsibility for the administration of the respiratory protection program:

Name: Employee Health Services
Telephone: 1-559-624-2458

This Department has the authority to act on any and all matters relating to the operation and administration of the respiratory protection program. All employees, operating departments, and service departments will cooperate to the fullest extent. This department is referred to as the Respiratory Protection Program Administrator. This department will also be responsible for monitoring the ongoing and changing needs for respiratory protection (Pandemic Influenza Preparedness and Response Guidance for Healthcare Workers and Healthcare Employers; OSHA 3328-05, 2007).

Roles and Responsibilities:

Employee Health Services: The Respiratory Protection Program Administrator is responsible for administering the respiratory protection program. Duties of the RPPA include:

- Identify work areas, processes, or tasks that require respiratory protection. For this model program, this means identifying patient care areas and other circumstances likely to present a pandemic influenza transmission risk.
- Monitor Cal/OSHA policy and standards for changes and make changes to agency's policy
- Select respiratory protection products.
- Monitor respirator use to ensure that respirators are used in accordance with their certification.
- Distribute and ensure completion of the medical clearance questionnaire (RFT)questionnaire[SG1] (which may be completed onl
- Provide required information to the physician or other licensed health care provider who will do medical evaluations of respirator users
- Ensure that respirator users have received a medical evaluation and are medically qualified to use a respirator
- Evaluate any feedback information or surveys.
- Arrange for and/or conduct training and fit testing.
- Ensure proper storage and maintenance of respiratory protection equipment.

- Annually review the implementation of the program in consultation with employees and their representatives.

Supervisor: Employee Health Services[SG2]Directors and Managers: The RPPA may also serve as the supervisor for the respiratory protection program. Supervisors are responsible for ensuring that the respiratory protection program is implemented in their particular units. Supervisors must also ensure that the program is understood and followed by the employees under their charge. Duties of the supervisor include:

- Knowing the hazards in the area in which they work.
- Knowing types of respirators that need to be used.
- Ensuring the respirator program and worksite procedures are followed.
- Enforcing/encouraging staff to use required respirators.
- Ensuring employees receive training and medical evaluations.
- Coordinating annual retraining and/or fit testing.
- Notifying the RPA with problems with respirator use, or changes in work processes that would impact airborne contaminant levels.
- Ensure proper storage and maintenance of all respirators.

Employee: It is the responsibility of the employee to have an awareness of the respiratory protection requirements for their work areas (as explained by management). Employees are also responsible for wearing the appropriate respiratory protective equipment according to proper instructions and for maintaining the equipment in a clean and operable condition.

Employees should also:
- Participate in all training.
- Maintain equipment.
- Report malfunctions or concerns.

Program Scope and Application: This program applies to all employees who could potentially be exposed to airborne respiratory illnesses during routine work operations in the event of an influenza pandemic or other infectious respiratory disease emergency. Some of the types of work activities required to wear respirators are outlined in the table below:

Direct Patient Care: N95 / PAPR
Housekeeping: N95 / PAPR
Maintenance: N95/ PAPR

Identifying Work Hazards:

The respirators selected will be used for respiratory protection from potentially airborne infectious diseases; they do not provide protection from chemical exposure. Through normal working situations employees may be asked to have contact with patients who could be infected with a potentially airborne infectious agent such as the influenza virus.

~~Respirator Selection Only respirators approved by the National Institute for Occupational Safety and Health (NIOSH) will be selected and used.~~

~~Those in use at this facility:~~

~~‡ N95 respirators are available for patient contact/care.~~

~~‡ A powered air-purifying respirator (PAPR) is available for patient contact/care (if your facility has purchased or obtained one). A PAPR may be selected for use if:~~

~~- The N95 respirator choice(s) does not fit;~~
~~- Employee has facial hair or facial deformity that would interfere with mask-to-face seal (facial hair such as a mustache must fit within the seal of the mask);~~
~~- The N95 respirator choice(s) are unavailable; or,~~
~~- Desired for high-risk aerosol-generating procedures Respiratory Protection Equipment Respirators: Respirators differ from surgical masks. They are designed specifically to ensure the capture of particles of the size that can be inhaled into the respiratory tract, including the entire range of nasopharyngeal, tracheobronchial and alveolar-sized particles. N95 Respirators: "N95" refers to respirators designed for non-oil based respiratory hazards which have an efficiency of 95% (stopping 95% of particles).~~
~~- PAPR (Powered Air Purifying Respirator): A respirator that provides cleaned air to the inside of a light-weight hood, purifying the air by means of a battery powered blower which pulls the air through a filter cartridge. PAPRs are worn by people who do not fit test to an N95 respirator, and by anyone with facial hair (which interferes with the seal needed for an N95.~~

~~Respirator Training and Fit Testing:~~

~~Training: Workers will be trained prior to the use of a respirator, at least annually thereafter, and whenever supplemental training is deemed necessary by the Respiratory Protection Program Administrator, or when conditions in the workplace effecting respirator use change.~~

~~Training will cover:~~
~~- Identifying hazards, potential exposure to these hazards, and health effects of hazards.~~
~~- Respirator fit, improper fit, usage, limitations, and capabilities for maintenance, usage, cleaning, and storage.~~
~~- Inspecting, donning, removal, seal check and trouble shooting.~~
~~- Explaining respirator program (policies, procedures, Cal/OSHA standard, resources).~~

~~Fit Testing:~~

After the initial fit test, fit tests must be completed at least annually, or more frequently if there is a change in status of the wearer or if the employer changes model or type of respiratory protection. As of 7/1/04 the Cal/OSHA Respiratory Protection Standard 8 CCR 5144 applies to health care workers. This template will be changed to reflect the most current OSHA regulations as new information becomes available. The fit testing procedure appears in Appendix A to this program. Fit tests are conducted to determine that the respirator fits the user adequately and that a good seal can be obtained. Respirators that do not seal do not offer adequate protection. Fit testing is required for tight fitting respirators.

Fit tests will be conducted:

1. Prior to being allowed to wear any N95 respirator.
2. If the facility changes respirator product.
3. If the employee changes weight by 10% or more, or if the employee has changes in facial structure or scarring.
4. If the employee reports that a respirator that previously passed a fit-test is not providing an adequate fit
5. If the RPPA or other supervisor notices a change in employee that would require an additional fit-test as Cal/OSHA standards require. Fit testing will not be done on employees with facial hair that passes between the respirator seal and the face or interferes with valve function. Such facial hair includes stubble[SG3], beards and long sideburns.

PAPRs: If it is determined that an individual cannot obtain an adequate fit with any tight fitting respirator, a loose fitting powered air purifying respirator may be provided instead.

Medical Evaluation: Persons assigned to tasks that require respiratory protection during an influenza pandemic or other respiratory disease emergency must be physically and psychologically able to perform the tasks while wearing a respirator. Employees who are required to wear respirators during an influenza pandemic or infectious respiratory disease emergency must participate in a medical evaluation before being permitted to wear a respirator on the job. Employees are not permitted to wear respirators until receiving medical clearance according to the process identified below. A mandatory medical evaluation questionnaire (specified in Section 5144(c)) must be used and reviewed by the physician or other licensed healthcare professional (PLHCP) specified below by the employer, or a medical evaluation with the same content must be provided by a PLHCP. If the PLHCP deems it necessary, the employee will receive an examination. The purpose of the medical evaluation is to determine if the employee is physically and psychologically able to perform the assigned work while wearing the respiratory protective equipment. Medical clearance should occur prior to fit testing. The medical evaluation may be kept with the PLHCP or with the employee's medical record. It should not be kept in an employee's personnel file.

Those employees that require further screening will be evaluated in person at Employee Health Services. Medical reevaluation will occur annually. A medical evaluation

questionnaire[SG41] questionnaire (RFT) is provided in Appendix B for use by Employee Health Services. The medical evaluation procedures are as follows:

- The medical evaluation will be conducted using the questionnaire provided in Appendix B. The Program Administrator will provide a copy of this questionnaire to all employees requiring medical evaluations.
- To the extent feasible, the facility will assist employees who are unable to read the questionnaire by providing the questionnaire in alternate languages. When this is not possible, the employee will be sent directly to the medical practitioner for medical evaluation.
- All affected employees will be given a copy of the medical questionnaire to fill out. Employees will be permitted to fill out the questionnaire on company time.
- Follow-up medical exams will be granted to employees as required by this program, and/or as deemed necessary by the medical practitioner.
- All employees will be granted the opportunity to speak with the medical practitioner about their medical evaluation, if they so request.

Re-evaluation will be conducted under these circumstances:

- Employee reports physical symptoms that are related to the ability to use a respirator, (e.g., wheezing, shortness of breath, chest pain, etc.)
- It is identified that an employee is having a medical problem during respirator use.
- The healthcare professional performing the evaluation determines an employee needs to be reevaluated.
- A change occurs in the workplace conditions that may result in an increased physiological burden on the employee. All examinations and questionnaires are to remain confidential between the employee and Employee Health Services. Medical reevaluation will occur every year.

Proper Respirator Use:

General Use: Employees will use their respirators under conditions specified by this program, and in accordance with the training they receive on the use of the selected model(s). In addition, the respirator shall not be used in a manner for which it is not certified by the National Institute for Occupational Safety and Health (NIOSH) or by its manufacturer. All employees shall conduct positive and negative pressure user seal checks each time they wear a respirator. All employees shall leave a potentially contaminated work area to clean (PAPR) or change (N95 - disposable) their respirator if the respirator is impeding their ability to work. This means employees shall leave the contaminated area:

- If increased breathing resistance of the respirator is noted.
- If severe discomfort in wearing the respirator is detected.
- Upon illness of the respirator wearer, including: sensation of dizziness, nausea, weakness, breathing difficulty, coughing, sneezing, vomiting, fever and chills.

- To wash face to prevent skin irritation.

Additionally, employees will be required to immediately leave the contaminated or infected area:

- Upon malfunction of the respirator such as a reduction in air flow of a PAPR.
- Upon detection of leakage of contaminant into the respirator.
- Breathing through the respirator becomes more difficult.

Cleaning and Disinfecting N95 – disposable: Discard after use.

Discard if soiled, if breathing becomes more difficult, or if structural integrity is compromised. If patient is under Contact Precautions (e.g., MRSA, VRE, smallpox), discard the respirator after use with that patient.

PAPRs – Cleaning and disinfection differ based on brand and manufacturer. Clean according to the manufacturer's instructions. Wipe down with QT3 spray or Super Sani Purple wipes after each use. See Appendix C.

Respirator Reuse Disposable N95 respirators are not designed for reuse. However, concern about potential shortages of N95s during a pandemic has forced consideration of respirator reuse. Studying the issue, and in particular reference to N95s for healthcare worker use during a pandemic, the National Academy of Sciences offers this recommendation: Despite these findings about the constraints of reuse, the committee makes a recommendation for extending the life of disposable N95 respirators for individual users. This recommendation is consistent with the Centers for Disease Control and Prevention's Interim Domestic Guidance on the Use of Respirators to Prevent Transmission of SARS (CDC, 2003).

Recommendation 1: Avoiding Contamination Will Allow for Limited Reuse. If an individual user needs to reuse his or her own disposable N95 respirator, the committee recommends that it be done in the following manner:

- Protect the respirator from external surface contamination when there is a high risk of exposure to influenza (i.e., by placing a medical mask or cleanable face shield over the respirator so as to prevent surface contamination but not compromise the device's fit).
- Use and store the respirator in such a way that the physical integrity and efficacy of the respirator will not be compromised.
- Practice appropriate hand hygiene before and after removal of the respirator and, if necessary and possible, appropriately disinfect the object used to shield it.

Respirator Inspection, Maintenance, and Storage: Inspection: All types of respirators should be inspected prior to use.

N95 – disposable:

1. Examine the face piece of the disposable respirator to determine if it has structural integrity. Discard if there are nicks, abrasions, cuts, or creases in seal area or if the filter material is physically damaged or soiled.

2. Check the respirator straps to be sure they are not cut or otherwise damaged.

3. Make sure the metal nose clip is in place and functions properly (if applicable).

4. Disposable respirators are not to be stored after use. They are to be discarded.

PAPR:

1. Check battery level.

2. Inspect the breathing tube and body of the respirator, including the High Efficiency Particulate Air (HEPA) filter, if visible, for damage.

3. Examine the hood for physical damage (if parts are damaged, contact the Respiratory Protection Program Administrator[SG5]Administrator or the Respiratory Therapy Department).

4. Check for airflow prior to use.

5. Follow manufacturer's recommendations on maintenance, including battery recharging.

Repair: During cleaning and maintenance, respirators that do not pass inspection will be removed from service and will be discarded or repaired. Repair of the respirator must be done with parts designed for the respirator in accordance with the manufacturer's instructions before reuse. No attempt will be made to replace components or make adjustments, modifications or repairs beyond the manufacturer's recommendation.

Storage: Respirators not discarded after one shift use will be stored in a location where they are protected from sunlight, dust, heat, cold, moisture, and damaging chemicals.

Evaluating and Updating the Program: The Respiratory Protection Program Administrator will complete an annual evaluation of the respiratory protection program. They will:

- Evaluate any feedback from employees.
- Review any new hazards, case definitions, or other pandemic influenza guidance from public health agencies, or changes in policy that would require respirator use.
- Make recommendations for any changes needed in the respiratory protection program.

~~Related Documents:~~

~~References:~~

~~https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/OHB/Pages/RespStd.aspx~~

~~https://www.dir.ca.gov/title8/5144a.html~~

~~http://www.cahf.org/Portals/29/DisasterPreparedness/pandemic/CAHF_MRPP.pdf~~

~~*"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."*~~

APPENDIX A:

Fit Test Procedure Fit test procedures should be consistent with the fit testing equipment being used. Employee Health Services provides the 3M Qualitative Fit Test Instructions for Use. If equipment other than the 3M FT-10 or FT-30 apparatus is being used, please consult the manufacturer's instructions for fit test procedures. Fit testing equipment is usually sold in kits, with the ability to purchase individual components of the kit as specific supplies dwindle. Components typically include:

- A harmless chemical, used to allow each respirator's wearer to test the seal of their respirator;
- A means of dispensing or vaporizing a mist of that chemical; and,
- A hood in which the fit test can be performed. Fit test kits are sold by occupational health and safety companies such as 3M.

Qualitative Fit Test (QLFT)

A qualitative fit test (QLFT) may only be used to fit-test:

- Negative-pressure, air-purifying respirators, as long as they'll only be used in atmospheres where the hazard is at less than 10 times the permissible exposure limit (PEL).
- Tight fitting facepieces used with powered and atmosphere-supplying respirators.

QLFT is pass/fail and relies on the user's senses using one of four OSHA-accepted test agents:

- Isoamyl acetate (banana smell); only for testing respirators with organic vapor cartridges.
- Saccharin (sweet taste); can test respirators with a particulate filter of any class.
- Bitrex® (bitter taste); can also test respirators with particulate filters of any class.
- Irritant smoke (involuntary cough reflex); only for testing respirators with level 100 particulate filters.

Each QLFT method uses seven exercises performed for 1 minute each:

- Normal breathing.
- Deep breathing.
- Moving head side to side.
- Moving head up and down.
- Bending over (or jogging in place if fit test unit doesn't permit bending at the waist).
- Talking.
- Normal breathing again.

APPENDIX B

KAWEAH DELTA HEALTH CARE DISTRICT

EMPLOYEE HEALTH SERVICES

Initial and Annual N-95 MASK FIT TEST

Please Print

Last Name:	First Name:	Birthdate:
Emp ID:	Job title:	Dept:

Medical Questionnaire:

This questionnaire is used in determining whether or not you have a medical condition that may affect your ability to wear a respirator (mask). We anticipate being able to approve most people for respirator fit testing based on this questionnaire alone. In some cases, we may ask for more information.

Have you ever had any of the following?

Lung Disease: Yes_____ No_____ Asthma: Yes_____ No_____
Heart Disease: Yes_____ No_____ Hypertension: Yes_____ No_____

Explain "Yes" answers: _____

Do you have a: ☐ Beard ☐ Goatee ☐ 5 O'Clock shadow at Work

Smoking History: ☐ Never Smoked ☐ Ex-smoker ☐ Presently a smoker

1. Do you get short of breath or wheeze with exertion? ☐ Yes ☐ No
2. Do you ever get chest pain? ☐ Yes ☐ No
5. Do you have any medical problems that might interfere with the wearing of a Respirator /mask? ☐ Yes ☐ No
6. Do you take any medications for treatment of cardiac, respiratory, or blood Pressure problems? ☐ Yes ☐ No

5. Have you ever had problems wearing a respirator/mask? ☐ Yes ☐ No

Explain "Yes" answers: _____

Employee Signature: _____ Date: 11/ /2020

Brand & Model Number	*3M 1860S*	*3M 1860*	*3M 1870*	*3M 9205+*	*Other:*

Fitting:

☐Satisfactory Qualitative Saccharin Fit Test ☐Instructions for use reviewed ☐Donning and Removal

☐Pass

☐ Fail Explain: _____

☐ Information given on PAPR

Signature of test administrator: _____ Date: 11/ /2020

Rvsd:11/1/20 vw

~~Appendix C - to Section 5144: Respirator Cleaning Procedures (Mandatory)~~

~~These procedures are provided for employer use when cleaning respirators. They are general in nature, and the employer as an alternative may use the cleaning recommendations provided by the manufacturer of the respirators used by their employees, provided such procedures are as effective as those listed here in Appendix B-2. Equivalent effectiveness simply means that the procedures used must accomplish the objectives set forth in Appendix B-2, i.e., must ensure that the respirator is properly cleaned and disinfected in a manner that prevents damage to the respirator and does not cause harm to the user.~~

~~I. Procedures for Cleaning Respirators.~~

~~A. Remove filters, cartridges, or canisters. Disassemble facepieces by removing speaking diaphragms, demand and pressure-demand valve assemblies, hoses, or any components recommended by the manufacturer. Discard or repair any defective parts.~~

~~B. Wash components in warm (43 deg. C [110 deg. F] maximum) water with a mild detergent or with a cleaner recommended by the manufacturer. A stiff bristle (not wire) brush may be used to facilitate the removal of dirt.~~

~~C. Rinse components thoroughly in clean, warm (43 deg. C [110 deg. F] maximum), preferably running water. Drain.~~

~~D. When the cleaner used does not contain a disinfecting agent, respirator components should be immersed for two minutes in one of the following:~~

~~1. Hypochlorite solution (50 ppm of chlorine) made by adding approximately one milliliter of laundry bleach to one liter of water at 43 deg. C (110 deg. F); or,~~

~~2. Aqueous solution of iodine (50 ppm iodine) made by adding approximately 0.8 milliliters of tincture of iodine (6-8 grams ammonium and/or potassium iodide/100 cc of 45% alcohol) to one liter of water at 43 deg. C (110 deg. F); or,~~

~~3. Other commercially available cleansers of equivalent disinfectant quality when used as directed, if their use is recommended or approved by the respirator manufacturer.~~

~~E. Rinse components thoroughly in clean, warm (43 deg. C [110 deg. F] maximum), preferably running water. Drain. The importance of thorough rinsing cannot be overemphasized. Detergents or disinfectants that dry on facepieces may result in dermatitis. In addition, some disinfectants may cause deterioration of rubber or corrosion of metal parts if not completely removed.~~

~~F. Components should be hand-dried with a clean lint-free cloth or air-dried.~~

~~G. Reassemble facepiece, replacing filters, cartridges, and canisters where necessary.~~

~~H. Test the respirator to ensure that all components work properly.~~

~~NOTE~~

~~Authority cited: Section 142.3, Labor Code. Reference: Section 142.3, Labor Code.~~

Policy Number: HR.03	Date Created: 11/19/2019
Document Owner: Dianne Cox (Chief Human Resources Officer)	Date Approved: 05/24/2021
Approvers: Not Assigned	

Just Culture Commitment

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

Purpose:

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

Policy:

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

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

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

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

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

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

"Responsibility for the review and revision of this Policy is assigned to the Chief Human Resources Officer. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Health Policies and Procedures."

Policy Number: HR.04	Date Created:12/19/2019
Document Owner: Dianne Cox (Chief Human Resources Officer)	Date Approved:
Approvers: Board of Directors (Human Resources)	

Special Pay Practices

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

Designated departments may have special pay practices which provide for competitive compensation and/or incentives for employees to work varying shifts or additional shifts. All special pay practices are approved by the Hospital and are subject to change at any time.

In all cases, Wage and Hour Law will apply.

Pay Practices:

Other Hours- Base rate of pay for additional hours or shifts worked.

Eligible Job Codes:

- Pharmacy: 0360, 0972, 1940
  2094, 2093 (hours)
- RN-Nurse Practitioner: 1541 (shift)
- Nurse Practitioner Manager 1833 (shift)
- MICN: $1.50 for active MICN certification. Effective upon submission/validation of certification to Human Resources.
- TNCC: $1.50 for active TNCC certification. Effective upon submission/validation of certification to Human Resources. Eligible job codes include:
  - RN: 2217 2247 in ED
  - Charge Nurse: 2277 in ED
  - Assistant Nurse Manager: 2187/2188 in ED

Sleep Pay

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

Private Home Care Holiday

Rate is based on where the employee travels.

Holiday differential is received for Kaweah Health observed holidays, in addition to Mother's Day and Easter.

Private Home Care On-Call

Eligible Job Codes:

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

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Policy Number: HR.36	**Date Created: 06/01/2007**
Document Owner: Dianne Cox (Chief Human Resources Officer)	**Date Approved: 08/23/2023**
Approvers: Board of Directors (Administration)	

New Hire Processing

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

POLICY:

All applicants who have accepted an offer of employment with Kaweah Health will be required to successfully complete all steps of the new hire process prior to their first day of work, including background check, post offer/pre-employment medical exam, drug screen, and new hire paperwork. This process maintains compliance with The Joint Commission, Title XXII, OSHA requirements, The Americans with Disabilities Act, and all Federal, State and Local regulations. Applicants who refuse any part of the medical exam, drug screen or new hire processing will not be hired.

PROCEDURE:

I. Background Check Results

After the contingent job offer is extended and accepted, applicants are asked to disclose information to Human Resources concerning criminal conviction history. Analysis of criminal convictions will be individually assessed by Human Resources based on the nature and gravity of the offense or conduct, the time that has passed since the offense, conduct and/or completion of the sentence, and the nature of the job held or sought.

Following acceptance of the contingent job offer, a third-party background check is initiated for completion. Applicants are then provided with an electronic email link from the background vendor providing their legal rights concerning consumer reports (background check), and submit authorization allowing Kaweah Health to run background check.

When background results are returned to Human Resources, they are reviewed for consistency with the information disclosed by applicant within the disclosure form and employment application. If results are consistent with what was disclosed and if the criminal history results are not relevant to employment at Kaweah Health, Human Resources will clear the background check and continue with the new hire process.

When background results are not consistent with what was disclosed by applicant, or if the report contains information that raises concern regarding work performance, an assessment will be undertaken by Human Resources. If

the results of the assessment determine that the offer may be withdrawn, the adverse action process may be initiated.

II. Adverse Action Process

The third-party vendor completing the background check is considered a consumer reporting agency. As such, per the federal Fair Credit Reporting Act, before taking an adverse action based on information contained in a consumer report (background check), Human Resources will:

1. Provide the subject of the report a “Pre-Adverse Action” notice, a copy of the report, and a copy of the document “A Summary of Your Rights Under the Fair Credit Reporting Act” and any applicable state law notices.
2. Allow ten (10) days for the applicant to review the report and contact the third-party background company to dispute any information the consumer believes to be inaccurate or incomplete.
3. If the applicant does not file a dispute (or based on the results of a dispute investigation), Human Resources may take adverse action. The applicant will be provided with a “Final Adverse Action” Notice, a copy of the report, and a copy of the document “A Summary of Your Rights Under the Fair Credit Reporting Act”. Adverse action will result in the withdrawal or rescission of the job offer.

III. Medical Exam and Drug Screen

Upon clearance of the background check, prospective new hires will be scheduled
for a post-offer/pre-employment medical examination at Employee Health Services within 60 days of start date.

The exam is performed utilizing the physical requirements outlined in the job description. The exam will include but not be limited to: drug screen, TB skin test (PPD), diagnostic lab work and immunizations if determined to be necessary by the position to be hired for and the examining practitioner. (See Policy EHS 11- Immunization Requirements for Health Care Workers.)
In the event that Employee Health receives a report indicating temporary or permanent work restrictions or presence of a communicable disease, the Employee Health Services Manager, with Medical Director guidance, will make the decision as to whether or not the individual is cleared to be hired for the position offered. If the applicant is deemed to be unable to perform his/her job duties, the applicant will be given the opportunity to request a reasonable accommodation that would allow the new hire with a qualified disability to perform the essential functions of the job, unless the accommodation would create an undue hardship for the organization. (Please refer to HR.16 Reasonable Accommodation & Medical Fitness for Work.)

Employee Health Services notifies Human Resources of clearance or non-clearance results after completion of the post-offer/pre-employment medical

examination and drug screen. Prospective new hires will receive notification from Human Resources if it is determined that they are not fit for employment as a result of the medical exam and/or drug screen.

IV. New Hire Processing

Upon clearance of the background check, prospective new hires will be scheduled for a processing meeting in Human Resources. New hires will be required to show proof of their right to work in the United States, provide social security card (for payroll and tax purposes only), as well as original licenses, certifications or registrations required for their job.

Electronic new hire paperwork will become available for the new hire to complete in Workday in advance of their start date and is expected to be completed no later than day one of employment.

V. Rescinded Job Offers

Job offers may be withdrawn or rescinded due to reasons including results of the background report or drug screen, failure to verify ability to work in the United States, failure to fulfill all components of the employment process in a timely professional manner, and in some cases, the results of the post-offer/pre-employment medical examination (per HR.16- Reasonable Accommodation & Medical Fitness for Work).

VI. Proof of right to work in the United States

Kaweah Health will comply with the Immigration Reform and Control Act of 1986 which prohibits the employment of unauthorized aliens and requires all employers to implement an employment verification system.

VII. E-Verify

Kaweah Health participates in E-Verify (effective 7/10/2023) and will provide the federal government with Form I-9 information from each new hire to confirm work authorization.

"Responsibility for the review and revision of this Policy is assigned to the Chief Human Resources Officer. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Health Policies and Procedures."

Policy Number: HR.46	**Date Created: 06/01/2007**
Document Owner: Dianne Cox (Chief Human Resources Officer)	**Date Approved: 01/29/2019**
Approvers: Board of Directors (Administration), Cindy Moccio (Board Clerk/Exec Assist-CEO)	

Orientation of Kaweah Health Personnel

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

POLICY:

Kaweah Health will conduct a structured General Orientation program for all new employees to ensure employees are knowledgeable of important topics and to assist them in adjusting to their new work environment. All newly hired and rehired employees of Kaweah Health are required to attend General Orientation as their first day of employment and to complete any additional Kaweah Health orientation requirements (Patient Care, Nursing Services, RN orientations, etc.) within thirty (30) days of their initial day of employment.

Exceptions may be allowed based on staffing needs and must be approved by Human Resources.

All rehires must comply with the above mandated Kaweah Health orientation requirements, with the exception of employees who have had a break in service equaling less than 12 months and have also completed Orientation or Annual Training/Competencies for the job they are being hired into within the 12 months preceding their rehire date. General Orientation is organized by Human Resources and the Organizational Development Department and is offered routinely. Additional Kaweah Health orientation for clinical staff is organized by the Clinical Education Department.

Each department will conduct a department specific orientation for all personnel joining their department. (This includes new hires, re-hires, transfers, forensic staff, contracted/temporary agency staff, volunteers and clinical students).

Management of the department will also provide a specific orientation for personnel new to management/leadership positions.

All non-employee categories, including but not limited to Temporary staff, Travelers, Registry, Volunteers, Students, Agency and Contracted Staff are required to be oriented to Kaweah Health and department. Refer to HR Policy 233 Non-Employees for further detail.

PROCEDURE:

Scheduling

Scheduling of employees in General Orientation will be coordinated by Human Resources and attendance monitored by Organizational Development. Managers and supervisors will be responsible for ensuring that all employees attend the orientation as scheduled.

Orientation Compensation

All orientation programs for employees will be considered as regular hours. Such hours will be included in computing hours worked and overtime, as well as hours toward qualification for benefit accruals.

Department Orientation Checklist

Within forty-eight (48) hours of the first day of work at their assigned location, each staff member will complete, have signed, and submit to Human Resources electronically through Workday, the original copy of the *Kaweah Health Department Orientation Checklist* ("48 hour checklist").

New Leader Orientation Checklist

Each staff member new to a management role will work with their direct supervisor to plan their management orientation using the New Leader Orientation Checklist Journey assigned to them within Workday. The Journey must be fully completed within 90 days of the date of assuming the management role.

Non-Employee Orientation Requirements

As required by Joint Commission all personnel completing work on Kaweah Health premises are required to be oriented to Kaweah Health and department. These Orientation packets are available in Human Resources and should be completed prior to the start of their work assignment.

Clinical Student Interns/Externs Orientation Requirements

All student interns seeking clinical experience with Kaweah Health must have a fully executed student affiliation agreement contract on file in Human Resources. As required by Joint Commission and DHS, all interns must be oriented to Kaweah Health and department. Department management is responsible to ensure Orientation occurs. Clinical Student Orientation packets and badges are available in Human Resources.

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Policy Number: HR.47	Date Created: 06/01/2007
Document Owner: Dianne Cox (Chief Human Resources Officer)	Date Approved:
Approvers: Board of Directors (Administration)	

Professional Licensure and Certification

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

POLICY:

To ensure appropriate licensure and certification on all employees and contracted staff (not subject to the medical staff privilege process, e.g., Allied Health Professionals) in compliance with appropriate licensing agencies. Employee Health requirements for immunizations and PPD are available for Licensed Independent Practitioners and Physicians who practice at Kaweah Health.

It is the policy of Kaweah Health to employ only those individuals and/or to utilize contract services staff that meet all job requirements (TB Screening/PPD testing, etc.) and have proper licensure, certification or registration by the appropriate licensing agency in those jobs requiring such status. Current employees and contract staff who provide direct patient care will have a CPR (Heartsaver-AED or BLS) card on file with Human Resources (or in the nursing office or applicable department if Contract Staff). Employees and Contract Staff working in positions with a requirement for ACLS, NRP, and PALS, etc., will also provide proof of certification. Employees driving their own vehicles for ongoing business will be required to produce proof of current California Driver's License.

All job requirements and current status of documentation shall be maintained by the employee/contract staff member. The employee will furnish proof of this status with original documents before employment or service begins. At each time the status requires updating and/or renewal, the employee will provide further documentation to Human Resources as proof of update and/or renewal.

For employees on a Leave of Absence, Kaweah Health may hold in abeyance the requirement to complete job requirement documentation (i.e., updated competencies, TB testing, etc.) until the employee returns from leave. The employee must complete all outstanding job requirements and documentation (licensure, CPR, ACLS, NRP, PALS, TB Testing, as applicable) prior to returning to work. Competency-related documentation must be completed within two weeks of the employee's return to work.

Current job requirement documentation will be retained by Human Resources and Manager is responsible in ensuring staff are compliant. Failure on the part of the employee to provide such documentation or proof of current status, or failure to meet any job requirement will result in Progressive Discipline, up to and including, termination of employment.

PROCEDURE:

I. Definitions

Licensure/Certification: Refers to any license/certifications required for an employee's job from the time of hire going forward. Examples include: CA RN License, Clinical Dietitian Registration, and Radiology Tech Certification. Basic Life Support (BLS) , Heartsaver CPR AED (. Licensure/Certification requirements are listed in job descriptions, and employee offer letters, and also can be found in Workday.

Primary Source Verification (PSV): refers to the required process of confirming with the issuing board/agency that an individual possesses a valid license, certification or registration to practice a profession when required by law or regulation. PSV must include the date the verification was conducted, and must take place prior to placing employee in job. Simply presenting a copy of a license in lieu of evidence that PSV was completed does not meet the intent of the requirement. Methods for conducting PSV most often include secure online verification from the licensing board, but can also include direct correspondence, documented telephone verification, or reports from credentials verification organizations.

II. Verification Licensure/Certification at Time of Hire/Transfer/Renewal

It is the responsibility of the Human Resources Department to validate the PSV prior to hire/transfer date. Renewals of Licensure/Certifications will be tracked, verified and documented by the Human Resources Department prior to the expiration date. Employees and Managers can upload the primary source verification (PSV) of licensure/certification through Workday for electronic review and approval by Human Resources.

a. Human Resources will process the hire/transfer/renewal of an employee to a job that requires valid licensure/certification only after obtaining PSV from the appropriate licensing board. Primary source verification applies only to licensure/certifications required to practice a profession. It is not required for organizational requirements such as advanced cardiac life support (ACLS) or pediatric advanced life support (PALS) or clinical certification such as peripherally inserted catheter (PICC) line certification.

b. Any employee that allows their required licensure/certification to lapse for any reason will be given a Disciplinary Action and removed from the schedule. Exceptions:

1. MICN Certification: If regional EMS agency cancels MICN certification class, the employee will be permitted to work without updated certification and no disciplinary action. Employee will be required to attend the next scheduled regional MICN class.
2. TNCC Certification: If TNCC class is cancelled, and as a result, the employee is unable to obtain initial/renewal TNCC certification, employee will be permitted to work without updated certification and no disciplinary action. Employee will be required to attend the next scheduled TNCC class.

c. Employees may return to work once they have shown proof of renewed licensure/certification from a primary source.

III. Cardiopulmonary Resuscitation (CPR) Courses

A. Only the American Heart Association (AHA) or American Red Cross (ARC) certification programs will be acceptable for employment or renewal. Acceptable courses must contain an in-person, hands-on skills component and cannot be completed solely online. Kaweah Health has established appropriate paid time for hourly employees, upon approval of your supervisor. Classes taken outside of Kaweah Health must be AHA or ARC courses and documentation of completion must include the following:

1. Course completion card (or eCard) from AHA or ARC training center/site

OR

2. Temporary Certificate of Completion paperwork from the AHA or ARC training center stating the following:
    i. Student's name
    ii. Type of course
        1. AHA Heartsaver CPR AED
        2. AHA BLS for Health Care Providers
        3. ARC CPR/AED adult, child & infant
        4. ARC CPR for the Professional Rescuer or CPR for the health care provider
    iii. Date of Course
    iv. Successful Completion
    v. Name of Training Center
    vi. Signature of training center representative

For option 2 above, the provider course card (or eCard) must be submitted to Human Resources within 30 days of course completion to avoid suspension and disciplinary action.

IV. Kaweah Health Offered Courses

A. Employees are to give advanced notice for cancellation of any class or program in which they are enrolled, whether voluntary or mandatory. Advanced notice for cancellation defined as the following:

1. If class is on Tuesday through Friday, cancel the day before by 8:00am. EXAMPLE: Class is Wednesday at noon- must cancel before Tuesday 8:00 am.
2. If class is on Monday, cancel prior to 23:59 on Saturday
3. Classes need to be cancelled through our Learning Management System (LMS)
4. If the employee cannot cancel in our LMS or they are past the defined time for advanced notice, the employee must contact their manager via phone or email letting them know they cannot attend.

B. Kaweah Health completed courses will be documented in Workday as a completed learning course and added as a validated certification for job

requirements. Employees and Managers do not have to provide documentation to Human Resources for courses completed at Kaweah Health.

C. Classes offered at Kaweah Health are at no charge, and classes taken outside of Kaweah Health are not eligible for reimbursement.

III. Manager's Responsibilities

A. Management is responsible for ensuring that all licensed/certified staff has current licensure at all times while working and is not working if license/certification has expired. Upon expiration, the manager will place the employee on a personal leave of absence and the employee is subject to termination.

B. Managers and Directors may also be subjected to Disciplinary Action, including suspension and possible termination should licensed/certified employees within their responsibility be working without proper licensure/certification.

IV. Employee's Responsibilities

Employees who have failed to renew their required license or certification, by the expiration date will not be permitted to work. In addition, upon expiration, the employee will be placed on a personal leave of absence for a maximum of 12 weeks and is subject to termination. Employees who allow required licensure/certification to expire will be given a Level Disciplinary Action. Refer to Progressive Discipline policy HR 216.

V. Interim Permit or Temporary License Processing

Employees must obtain licensure in accordance with the requirements of the applicable licensing board. Employees whose temporary license or interim permit expires, or is otherwise invalidated will be placed on a personal leave of absence for a maximum of 12- weeks. During the 12-weeks period, if licensure is obtained, current employees may apply for a transfer to an open position. If licensure and/or transfer to an eligible position is not obtained, employment will be terminated at the end of the 12-week leave of absence.

VI. Employees on Leave of Absence

Employees on a Kaweah Health approved Leave of Absence are responsible for being in compliance with all license/certification requirements prior to their return to work. As it pertains to CPI, employees returning from leave will have 60 days from return to complete Kaweah Health offered CPI course.

VII. Display of License/Certification

As required by law, some licensure/certifications must be displayed in the department.

Related Documents:
Human Resources policy, HR.216 Progressive Discipline

“Responsibility for the review and revision of this Policy is assigned to the Chief Human Resources Officer. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee’s responsibility to review and understand all Kaweah Health Policies and Procedures.”."

Policy Number: HR.49	**Date Created: 06/01/2007**
Document Owner: Dianne Cox (Chief Human Resources Officer)	**Date Approved: 08/23/2023**
Approvers: Board of Directors (Administration), Dianne Cox (VP Human Resources)	

Education Assistance

- **Tuition, Books and Fees Reimbursement or Loan Repayment**
- **Educational Programs and Compensation**
- **Continuing Education and Conferences**
- **Professional Certification Fee Reimbursement and Awards**

POLICY:

Kaweah Health recognizes the importance of growth and development of all employees to improve work performance and increase job knowledge and skill. As an employee benefit and in support of the recruitment and retention of qualified employees, Kaweah Health offers a number of programs and opportunities as described in this policy.

Certain amounts reimbursed up to $5,250 in a calendar year received under this Educational Assistance program are excluded from wages and other compensation. Monies are reimbursed without being subject to taxes. These programs include reimbursement for tuition, books and fees and for fees related to obtaining certifications. Loan Repayment is currently excluded from wages through 12/31/2025 due to the CARES Act. Employees are responsible to ensure their annual tax withholdings and disclosures are appropriate.

Education Assistance - Tuition, Books and Fees Reimbursement or Loan Repayment

Full-time and part-time employees may apply for reimbursement of tuition, books and fees or loan repayment for educational programs applicable to positions at Kaweah Health. An employee must have completed 2080 hours (1872 hours for 12-hour shift employees) of active employment and have received at least one performance evaluation before submitting a request for Tuition, Books, and Fees or Loan Repayment. Employees who have received a performance evaluation below an overall “Successful” rating or a Level II or III Performance Correction Notice within the prior 12 months are not eligible for that year, even if they had been previously eligible. If performance in a subsequent year meets expectations and there are no Performance Correction Notices, the employee is eligible again for reimbursement or loan repayment. No retroactive payments will be made; the lifetime amounts remain the same as long as eligibility and all requirements are met.

Lifetime maximum amounts for reimbursement or outstanding student loan repayments combined for each degree:

- Up to $2,500 for Associates Degree or educational programs leading to a certification required for a position at Kaweah Health.
- Up to $10,000 for a Baccalaureate Degrees, limited to $2,500 per calendar year. Payments are made over four or more years if employee remains employed in an active full-time or part-time-benefitted status.
- Up to $15,000 for a Masters' Degree, limited to $5,000 per calendar year. Payments are made over three or more years if employee remains employed in an active full-time or part-time-benefited status. If receiving reimbursement for a Baccalaureate Degree, reimbursable monies for a Master's Degree will begin once the Baccalaureate Degree reimbursement is completed.
- Up to $20,000 for Doctoral Degree (Pharmacy, Physical Therapy and Nursing Director or Manager, DNP or PhD in Nursing, or RN with BSN in a program for Nurse Practitioner that requires DNP), limited to $5,000 per calendar year. Payments are made over four years if employee remains employed in an active full-time or part-time-benefited status.

If receiving reimbursement for a Bachelors' or Masters' Degree, reimbursable monies for a Doctoral Degree will begin once the Masters' Degree reimbursement is completed.

For all reimbursements or loan repayments, employees are required to exhaust all school, program, federal or state grant, scholarship and loan repayment opportunities offered prior to submitting a Reimbursement Form or Loan Repayment Form to Kaweah Health. These include, but are not limited to:

- Nurse Corps
- Health Professions Education Foundation
- CSLRP Loan Repayment Program only applicable to certain approved specialites and must be Primary Care
- Public Service Loan Forgiveness

In no case will an employee receive more than $5,000 in a calendar year.

An employee may request pre-approval for the Tuition Reimbursement portion of this policy. If so, the employee must submit the form two weeks prior to the beginning of class or the program. A letter of approval/disapproval will be sent to the employee. If pre-approval is granted, all conditions of successful completion of the class or program must still be achieved to remain eligible for reimbursement.

Reimbursement or Loan Repayment Forms are due upon course completion or annually each year following the successful completion of the performance evaluation.

The Reimbursement Form and original receipts as well as grades verifying course completion must be submitted to Human Resources. A grade of C or better in graded courses and/or a grade of "Credit" in a Credit/No Credit course indicates successful completion. For loan repayment, a current outstanding educational loan statement must be attached to the application. If prior loan repayments have been issued, at least 2/3 of the

monies received from Kaweah Health must show as a credit on the statement for the prior period. If not, there is no payment for the current year. The employee may reapply in future years providing evidence of loan payments.

All signatures on applications are required to be obtained prior to submitting the application to Human Resources, including the employee's Director or Chief Officer for Directors submitting for reimbursement, and the designated Human Resources Director.

Kaweah Health Sponsored Programs

Kaweah Health has partnership agreements in place with several school programs for difficult to fill positions. Kaweah Health employees selected for sponsorship are subject to the details of the applicable program agreement.

Terms and Conditions

Nothing in this policy shall be construed to bind either Kaweah Health or the employee to any period of employment with the other. Each party recognizes that employment is terminable at the will of either party.

Class attendance and completion of study assignments will be accomplished outside of the employee's regularly scheduled working hours. It is expected that educational activities will not interfere with the employee's work.

EDUCATIONAL PROGRAMS AND COMPENSATION

Kaweah Health provides various educational programs and opportunities for employees including but not limited to formal hospital/departmental/unit specific orientation, annual requirements, in-services related to new equipment or procedures, maintenance of certifications as required for identified positions, and staff meetings. Appropriate compensation will be provided in accordance with regulatory and Kaweah Health established guidelines.

Mandatory Education

- Programs may be designed as mandatory by Kaweah Health, a Chief Officer, a Director or a Manager. These programs may be offered during scheduled working hours or outside of scheduled working hours.

- Mandatory programs such as meetings, courses, and orientations will be compensated by Kaweah Health. Education hours will be considered productive time and as such will be paid in compliance with applicable wage and labor regulations and policy and are subject to adherence to the policies and procedures that govern productive time, i.e. – dress code, attendance, etc. (Refer to Policies HR.184—Attendance and Punctuality, HR.197 Dress Code - Professional Appearance Guidelines.)

- Courses may consist of instructor led training, computer based learning/testing, or blended learning defined as computer based learning followed by instructor led discussion or skills testing.

- With the exception of illness, approved absence or scheduled vacation, all employees must attend mandatory meetings. Reasonable notice is to be provided to employees of upcoming mandatory meetings. If the employee is unable to attend, he/she should request an absence. An employee who is unable to attend may be required to read and initial the meeting minutes or attend an additional meeting or program.

- Employees are to give advanced notice for cancellation of any class or program in which they are enrolled, whether voluntary or mandatory. Advanced notice for cancellation is defined as the following:
    - 1. If class is on Tuesday through Friday, cancel the day before by 8:00am. EXAMPLE: Class is Wednesday at noon- must cancel before Tuesday 8:00 am.
    - 2. If class is on Monday, cancel prior to 23:59 on Saturday Attendance & Punctuality
    - 3. Classes need to be cancelled through our Learning Management System (LMS)
    - 4. If the employee cannot cancel in our LMS or they are past the defined time for advanced notice, the employee must contact their manager via phone or email letting them know they cannot attend.
    - 5.Employees must be on time.
    - 6. Failure to give advance notice may count as an occurrence under the Attendance Policy HR.184. Refer to Progressive Discipline policy HR 216.

- Assignment to attend during regular work hours will be made at the discretion of the department leader. Any deviations from mandatory attendance will be made at the discretion of the department leader.

COMPENSATION FOR KAWEAH HEALTH ASSIGNED JOB REQUIREMENTS

Employees who participate in courses will be paid for such time if the course is required for their position or they have obtained manager approval prior to participating in the course.

- Courses should be scheduled on non-work days and overtime should be avoided to the extent possible.

- If the course is offered at Kaweah Health, no reimbursement will be provided for programs taken elsewhere unless manager approval is obtained prior to attending an outside course.

- Instructor led training will be paid for actual time spent in the classroom. Staff who arrive late or unprepared will not be allowed to participate in the course and will not be paid for the attempt to participate.

- Computer based courses/testing completed onsite will be paid for actual time spent completing the course/test. Computer based courses/testing completed off-site will be paid based on a predetermined amount of time. Fees charged to access online courses will not be reimbursed unless management approval is obtained prior to purchasing the course.

- Time spent by employees attending training programs, lectures and meetings are not counted as hours worked if attendance is voluntary on the part of the employee or the course is not related to the employee's job.

Employees must use the current time keeping system to record actual time for instructor led training and previously established hours for online training in order to receive compensation for education hours.

Established compensation for successful completion of online training includes but is not limited to the following:

Online Training	**Hours Paid**
HeartCode BLS	3
ACLS/PALS required pre-course self-assessment	2
NRP	4
STABLE	2
NDNQI Pressure Ulcer Training	1 (per module/max 4 modules)
NIHSS Stroke Certification	4
Off Duty completion of performance evaluation – self evaluation	1
Off Duty completion of NetLearning Modules/Testing	Variable based on module length, TBD prior to module release
Completion of Peer Evaluations	Not eligible – Must be done on duty

CONTINUING EDUCATION AND CONFERENCES

With the assistance of Human Resources and Clinical Education, department leaders plan, develop, and present educational offerings to Kaweah Health employees on a continuous and on-going basis. Continuing education includes all forms of job-related training, whether offered by Kaweah Health or by an outside organization.

Many different methods are utilized for staff education such as formal continuing education classes, in-services, web-based education, one-on-one instruction, teleconferences, self- learning modules, and conferences. Reference materials for staff education are available within their respective

departments, Kaweah Health Library, KDCentral and/or KDNet and resources online.

Types of educational offerings are determined as a result of Performance Improvement and Risk Management activities, new and changing technology, therapeutic and pharmacological intervention, regulatory and accreditation bodies, and identified or stated learning needs of employees.

Continuing education events may be required by Kaweah Health and if mandatory, the costs and time for attendance will be paid. If a program is voluntary, any payment or reimbursement of expenses and time for attendance will be determined by the department leader.

Conferences

A department may budget for short-term conference or seminar-type trainings for employees. It is the responsibility of the employee to complete the Travel Reimbursement Form and secure approval in advance of the training for all anticipated expenses, including approval for the hours to attend and whether hours in attendance will be paid. Conferences may be required by Kaweah Health and if mandatory, the costs and time for attendance will be paid.

Refer to AP19 Travel, Per Diem and Other Employee Reimbursements

PROFESSIONAL CERTIFICATION FEE REIMBURSEMENT AND AWARDS

As determined by the area Chief Officer, pre-approved professional certification fees are available to full-time and part-time employees attaining and/or maintaining professional certification(s) in their vocational area.

Employees must have successfully completed six months of employment to be eligible for this reimbursement or awards.

Professional Certification Criteria: To be reimbursed for examination fees and to qualify for the monetary award, the professional certification attained by the employee must:

- Not be a requirement for the staff members job code;
- Be sponsored by a national professional organization
- Involve an initial written examination that is available nationally and tests a professional body of knowledge (i.e., not technical such as ACLS, BCLS, etc.);
- Specify a defined recertification interval

Professional Certification Exclusions: Certification necessary as a condition of employment or as a minimum requirement for the position in which the employee is employed with Kaweah Health is not eligible under this program.

Employees may request reimbursement for exam and renewal fees associated with the examination up to a maximum of $250; the maximum an employee may receive for all exam and renewal fees under this program is $250 per calendar year. These fees are not taxable as long as the annual maximum received in reimbursement for tuition, books and fees and Loan Repayment is under $5,250. Expenses which are not eligible for reimbursement, include but are not limited to travel, food, and lodging. The continuing education costs themselves and renewal fees without an exam or continuing education requirement are not eligible. Reimbursements must be submitted to Human Resources within 30 days of obtaining certification.
Reimbursement monies will be included on the employee's next paycheck.

Employees receiving an initial certification or renewal are eligible for a monetary award in recognition of their accomplishment. Full-time and part-time employees will receive an award of $500. The maximum amount of award per calendar year is $500. Award monies are taxable in accordance with employee exemptions on file.

Employees requesting reimbursement for examination or renewal fees and/or a monetary award may request the appropriate form through Human Resources.

All signatures on applications are required to be obtained prior to submitting the application to Human Resources, including the employee's Director or Chief Officer for Directors submitting for reimbursement, and the Director of Human Resources.

Any exceptions to this policy must be approved by the Chief Human Resources Officer.

"Responsibility for the review and revision of this Policy is assigned to the Chief Human Resources Officer. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Health Policies and Procedures."

Policy Number: HR.66	**Date Created: 06/01/2007**
Document Owner: Dianne Cox (Chief Human Resources Officer)	**Date Approved:**
Approvers: Board of Directors (Administration)	

Payroll Deductions

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

POLICY:

To inform employees of the requirements regarding the different categories of payroll deductions and our responsibilities as an employer.

As required by law, there are deductions that employers are required to withhold from employees' wages.

I. Statutory Payroll Deductions

1. Federal Income Tax - (Determined by employee's W-4 Form and current Federal Tax Tables)
2. F.I.C.A. - Social Security and Medicare - Determined by Current Year federal rates.
3. S.D.I.- California State Disability Insurance - Determined by Current Year CA rate.
4. S.I.T. - State Income Tax – (Determined by employee's W-4 Form or DE 4 Form and current CA Tax Tables)

Wage Garnishments / Earnings Withholding / Tax Levies / Child & Spousal Support Orders:
As an employer, Kaweah Health must comply with all written notices received according to instructions issued by the respective agency. The employee will be mailed a copy of the notice received and it is their responsibility to act quickly if they wish to obtain a release, modification, or termination of the withholding order. Kaweah Health cannot stop an order to withhold prematurely unless the issuing agency instructs us to do so in writing. Voluntary wage assignments will not be honored by Kaweah Health.

II. Voluntary Payroll Deductions
Voluntary payroll deductions include:

Retirement benefits such as 401k and 457b, medical, dental, vision, FSA, life, short term and long term disability and other benefits offered by employer usually during open enrollment, when there is a change in family status, or for new hired staff. Some of these deductions may change when there is a change in family status, or for newly hired staff. Some of these deductions may be taken pre-tax and some after-tax.

Other voluntary payroll deductions include: cafeteria, pharmacy, Kaweah Korner, Gift Shop, TLC membership and purchases, as well as Kaweah Health Foundation donations.

Any balance owed to Kaweah Health will be deducted from the final paycheck. Deductions taken from an employee's final paycheck must be pre-authorized in writing by the employee.

III. If an employee believes an improper deduction was withheld from their pay, or has questions regarding payroll deductions, they should contact the payroll department.

"Responsibility for the review and revision of this Policy is assigned to the Chief of Human Resources Officer. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Health Policies and Procedures."

Policy Number: HR.75	Date Created: 06/01/2007
Document Owner: Dianne Cox (Chief Human Resources Officer)	Date Approved:
Approvers: Board of Directors (Administration)	

Differential Pay-Shift, Holidays, and Weekend

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

POLICY:
Differentials will be paid to eligible employees who are scheduled for and work non-business-hour shifts.

PROCEDURE:

I. Employee Eligibility

Employees with qualifying job codes are eligible for differential pay. Job codes with M-F 8:00 am - 5:00 pm (or approximate) schedules are not eligible for any differentials, unless needed to work by leadership.

II. Shift Differential Eligible Hours

Evening: 10% of the minimum of the range will be paid to non-exempt eligible job codes. A differential will be paid if the majority (i.e., more than 50%) of hours worked fall between 3:00 p.m. and 11:00 p.m.

Nights: 15% of the minimum of the range will be paid to non-exempt eligible job codes. A differential will be paid if the majority (i.e., more than 50%) of hours worked fall between 11:01 p.m. and 6:30 a.m.

Weekends: 10% of the minimum of the grade will be paid to all eligible licensed clinical job codes. This differential will be paid only for hours worked between 6:00 p.m.
Friday and 6:30 p.m. Sunday; and the employee must work more than one hour within that time period.

Exception:
Pharmacists are eligible for all shift differentials.

III. Holiday Differential

25% of the minimum of the range will be paid to employees who are required to work on the following holidays.

For New Years, Memorial Day, Labor Day, Thanksgiving and Christmas: Differential will only be paid for hours worked between 6:00 p.m. the night before the holiday until 6:30 p.m. the night of the holiday.

For Independence Day, the differential will only be paid for hours worked from 6:00 a.m. on July 4th through 6:30 a.m. July 5th.

Exception:
Private Home Care will receive a different hourly holiday differential based on where they travel. The differential will be paid for Mother's Day and Easter, in addition to all Kaweah Health recognized holidays.

"Responsibility for the review and revision of this Policy is assigned to the Chief of Human Resources Officer. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Health Policies and Procedures."

Policy Number: HR.80	**Date Created: 06/01/2007**
Document Owner: Dianne Cox (Chief Human Resources Officer)	**Date Approved:**
Approvers: Board of Directors (Administration)	

Docking Staff

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

POLICY:
The fluctuating workload and census inherent in hospitals and health care may occasionally cause the need for a reduced workforce. When this situation occurs, non-exempt personnel may have their hours reduced in accordance with this policy. Exempt staff are not normally included in the docking rotation. Each department's management will be responsible for recommending and implementing sound staffing decisions in accordance with Kaweah Health's goals for effective resource management. Employees who report to work, are not provided any work, and are subsequently docked are guaranteed one (1) hour of pay.

PROCEDURE:
At times the workload or census may require that employees who are scheduled to work but indicated to dock be put on Standby. In these cases employees will stay on Standby until called back into work or subsequently docked until their shift ends. Employees will not have the right to refuse Standby for regularly scheduled shifts. Pay for Standby and Callback will be in accordance with policy entitled STANDBY AND CALLBACK PAY (HR. 72). Additionally, docked time will be documented in the timekeeping system to allow appropriate application of hours.

Each department establishes a plan for docking that sets out the criteria by which decisions for docking are made, utilizing the prioritization noted below. When docking is indicated, the determination of which employees will be scheduled for docking will be made by the department leader or designee.

II. Mandatory dock time will be applied in the following order
   A. Overtime shifts
   B. Employees who volunteer to be docked
   C. Per Diem
   D. Part-Time Staff
   E. Full-Time Staff

Docking Staff

Prior to mandatory docking employees, leaders may ask if any employee wishes to take time off rather than work the shift or remainder of the shift.

If no employee desires time off, then leaders will apply the mandatory dock time as it meets the functional needs of the department.

To ensure fairness, each department will rotate their employees through docking procedures as appropriate to their staffing needs.

Timekeeping

Timekeeping is noted as PTO Mandatory Dock or Mandatory Dock/No Pay.

Dock hours are applied to:

A. Hours required to maintain employee benefits eligibility.
B. Accruals earned each pay period,
C. Qualified service hours used to compute what level Paid Time Off accrual is earned.

Department management who routinely dock employees will review staffing needs. Those who are actively recruiting to fill vacancies within their department will analyze the need for extra staff and, when not justified, will notify Human Resources if it is determined that a current vacancy should not be posted or if a full-time opening should be changed to part-time or per-diem.

Policy Number: HR.128	**Date Created: 06/01/2007**
Document Owner: Dianne Cox (Chief Human Resources Officer)	**Date Approved:**
Approvers: Board of Directors (Administration)	

Employee Benefits Overview

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

POLICY:

Eligible Kaweah Health Employees are provided a wide range of employee benefits. A number of the programs, such as Social Security, Workers' Compensation, and Unemployment Insurance, cover all employees in the manner prescribed by Federal or State law. Hospital-sponsored benefits eligibility is dependent upon a variety of factors, including employee classification. Human Resources maintains a listing of current benefits available. The controlling terms and conditions of all benefits are contained within the plan documents which define each benefits plan. In the event of discrepancies between other printed material and formal plan provisions describing Kaweah Health employee benefits programs, the official plan documents and instruments provisions govern.

Employees will be responsible for paying their insurance premiums and those for their enrolled dependents based on status and the date of eligibility. Enrollment in most plans must be completed within 30 days of the date of eligibility for the plan. Benefit eligible employees may also apply for offered benefits during Open Enrollment, normally offered in fall of each year for a January 1st effective date. If a full time employee does not elect or waive medical coverage, their coverage will default to the High Deductible Medical Plan Employee Only. Please review Summary Plan Documents for each plan for complete information.

PROCEDURE:

General:

1. Insurance premiums for medical, dental, vision, supplemental life, dependent life, etc., are deducted each pay period (24 per calendar year) from paychecks.

2. Eligible employees may opt to cover eligible dependents with timely enrollment and financial responsibility for any dependent coverage. If a spouse or registered domestic partner has coverage available through their own outside employer (not KH); the KH plan will pay only as secondary insurance.

3. If an event occurs which will change the amount of premium the employee pays, the employee will either be required to pay back premiums or will receive reimbursement for premiums already deducted, depending on the nature of the event.

4. All premium contributions for medical, dental and vision are deducted on pre-tax basis. The conditions of Internal Revenue Service Code, Section 125, specifically prohibit employees from changing their insurance benefit coverage until an Open Enrollment period is offered or unless there is a major life change or qualifying event. Certain qualifying events may permit an employee to apply for late enrollment or changes in the employee's enrolled dependents.

Normal Waiting Period:

1. Coverage for health benefits begin the first of the month following a status change to a benefit eligible position.

Status Change:

1. The department head will submit a Job Change in Workday when an employee changes employment status. The effective date of the status change is the first day of the pay period in which the status change occurs.

2. Human Resources will notify the employee of changes in eligibility and/or applicable premium levels for eligible benefits. If a full time employee does not elect or waive medical coverage, their coverage will default to the High Deductible Medical Plan Employee Only.

3. The premiums to be deducted are dependent on the date of the status change and may apply to the portion of the premium covering the employee as well as the dependent coverage.

4. If a Per Diem employee with coverage converts to Benefitted status, premiums deducted will be appropriately adjusted.

5. A newly eligible employee, i.e., one who converts from Part Time No Benefits or Per Diem (because of a qualifying event) to Benefitted or benefits eligible status, who has already satisfied the waiting period will not have to satisfy an additional waiting period.

6. An employee who was previously eligible and enrolled in the insurance plans and subsequently changed to a non-benefit eligible status, who has now converted to a benefits eligible status will not be subject to the waiting period.

7. An eligible employee who was eligible for, and declined benefits because of other coverage and then loses the other coverage is eligible to enroll in benefits with no waiting period under the Health Insurance Portability and

Accountability Act of 1996 (HIPAA). The employee must enroll within 30 days of the loss of other coverage and provide a Certificate of Creditable Coverage from the other plan.

8. An employee who loses medical, vision, dental coverage or a medical spending account due to conversion to an ineligible status or termination of employment will be offered continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), except in the case of discharge for gross misconduct. Eligibility, payment of premiums, and length of available coverage are determined by COBRA regulations.

9. In the case of a Leave of Absence, if an employee is on paid status (utilizing PTO/EIB), the employee may continue their normal premiums through payroll deduction. If on unpaid status, he/she is required to pay Kaweah Health his/her portion of the premiums bi-weekly/monthly while on a leave of absence for a total of four months combined within a rolling 12 months. After four months, employees will be offered COBRA Continuation Coverage for applicable benefits. Group medical, dental and vision insurance coverage will cease on the last day of the month in which an employee reaches four months of leave or employment ends except that continuation is allowed under COBRA regulations if applicable to the plan. In the case where Pregnancy Disability Leave (FMLA) combined with CFRA bonding leave applies, if an employee is on paid status (utilizing PTO/EIB), the employee may continue her normal premiums through payroll deduction. If on unpaid status, she is required to pay Kaweah Health her portion of the premiums monthly while on a leave of absence for a total of up to seven months; COBRA rules then apply.

<u>Procedures for COBRA:</u>

a. At the time of the qualifying event, Human Resources or the COBRA Administrator will forward the Employee Notice and Election Form to the employee via US mail.

   COBRA qualifiers: Death of a covered employee, divorce or legal separation, a covered employee becoming eligible for Medicare, or a covered dependent child who is no longer eligible for coverage under the group plan.

b. The employee, the separated or divorced spouse, or covered dependent will have no more than 60 days from the date of receipt of the COBRA letter to apply for continuance of medical, dental, or vision coverage. Notification is accomplished by completing the Employee Notice and Election form. If the employee, separated or divorced spouse, or covered dependent wishes to continue with medical, dental, or vision coverage, the initial premium payment to the COBRA Administrator must be received within 45 days of the date the employee signs the Employee Notice and Election Form and must be paid in full, back to the date of COBRA coverage.

c. Upon receipt of the initial payment, the COBRA Administrator will begin the COBRA coverage and will expect future premiums due. The employee or eligible dependent must continue payments each month in order to continue coverage. COBRA coverage will be terminated if payments are not made within the guidelines set forth.

"Responsibility for the review and revision of this Policy is assigned to the Chief Human Resources Officer. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Health Policies and Procedures."

Policy Number: HR.147	Date Created: 06/01/2007
Document Owner: Dianne Cox (Chief Human Resources Officer)	Date Approved:
Approvers: Board of Directors (Administration)	

Pregnancy Disability Leave of Absence

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

POLICY:

To allow time off to employees who have no other recourse than to be away from work for 17 1/3 weeks. To establish a system to continue to receive compensation through accessible benefits, such as Extended Illness Bank (EIB), Paid Time Off (PTO), State Disability Insurance. To advise employees of their rights and responsibilities.

To comply with applicable laws ensuring equal employment opportunities to qualified individuals with a disability, Kaweah HealthKaweah Health will make reasonable accommodations for known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or an employee, unless undue hardship would result. A leave of absence may be considered as a type of reasonable accommodation. Any applicant or employee who requires an accommodation in order to perform the essential functions of the job should contact their supervisor, department head, or Human Resources and make a request to participate in a timely interactive process to explore reasonable accommodations. The individual with the disability is invited to identify what accommodation he or she needs to perform the job. Kaweah Health will take steps to identify the barriers that make it difficult for the applicant or employee to perform his or her job, and will identify possible accommodations, if any, that will enable the individual to perform the essential functions of his or her job. If the accommodation is reasonable and will not impose an undue hardship, Kaweah Health will meet the request.

NOTE: Due to coordination of information between departments and outside agencies, and the requirement that certain records be maintained to demonstrate compliance with state and federal law, it is important that paperwork and documentation be completed and submitted to Human Resources in a timely manner by Department Heads and employees.

PROCEDURE:

1. Reason for Leave

   Kaweah Health will grant an unpaid pregnancy disability leave to employees disabled due to their pregnancy, child birth, or related medical conditions. This can include an employee who is unable to perform any one or more of the essential functions of her job or to perform them without undue risk to herself, to her pregnancy's successful completion, or to other persons; the employee is suffering from severe morning sickness; and/or the employee needs to take time off for prenatal or postnatal care, bed rest, gestational diabetes, pregnancy-induced hypertension, preeclampsia, post-part depression, childbirth, loss or end of pregnancy, or recovery from childbirth, loss or end of pregnancy.

2. Leave Available

   a. An employee disabled due to pregnancy, childbirth, or a related medical condition may take up to a maximum of four (4) months leave. As an alternative, Kaweah Health may transfer the employee to a less strenuous or hazardous position if the employee so requests, with the advice of her physician, if the transfer can be reasonably accommodated.

   b. Refer to FMLA Intermittent Leave.

   c. Leave taken under the pregnancy disability policy runs concurrently with the Family and Medical Leave Act (FMLA) under Federal law, but not Family and Medical Leave under the California Family Rights Act (CFRA).

3. Notice and Certification Requirement

   a. Notice:
   Employees planning to take a pregnancy disability leave must provide Kaweah Health with reasonable advance notice.

   b. Certification of Disability:

   Kaweah Health requires a written statement from a physician or other licensed health-care practitioner which must include the following:

      i. That the employee is unable to perform the essential job duties or that the employee is unable to perform these duties without undue risk to herself or other persons;
      ii. The date on which the disability commenced; and
      iii. The expected date of the employee's ability to return to work.

   c. Periodic Reports:

During a leave, an employee must provide periodic reports regarding the employee's status to the department head and Human Resources, including any change in the employee's plans to return to work. Failure to provide updates may cause Kaweah Health to apply a voluntary resignation from employment.

4. Compensation During Leave:

   Refer to the pamphlet from the Employment Development Department (EDD) entitled "For Your Benefit California's Program for the Unemployed" for more information.

   a. For a medical leave of absence longer than seven days which is to be coordinated with State Disability Insurance (SDI), or a Workers' Compensation leave of absence, accrued EIB hours are paid after 24 hours off. The initial three (3) days are paid through accrued PTO, if available, at the employee's discretion. In the circumstance of an immediate hospitalization or surgery, an employee may be paid from accrued EIB from their first full day off. EIB must be used for coordination with SDI or Workers' Compensation Temporary Disability Payments; PTO time may be used only after all Extended Illness Bank (EIB) has been exhausted. Coordinated amounts will not exceed the regular amount of pay normally earned by the employee.

   b. It is the employee's responsibility to notify Payroll of the amount they receive from SDI or Workers' Compensation to ensure the correct amount of EIB coordination.

5. Benefit Accrual:

   The employee will continue to accrue PTO as long as he/she is being paid PTO by Kaweah Health (receiving a paycheck).

6. Merit Review Date:

   The merit review date will not change due to the leave of absence.

7. Benefits During Leave:

   a. An employee taking leave will continue to receive coverage under Kaweah Health's employee benefit plans for up to a maximum of four (4) months per 12-month period at the level and under the conditions of coverage as if the employee had continued in employment continuously for the duration of such leave. Kaweah Health will continue to make the same premium contribution as if the employee had continued working.

   b. Insurance premiums (health, vision, dental, life, etc.) are to be paid by the employee and the Hospital, under the same conditions as existed

prior to the leave, for a maximum period of four (4) months in a 12-month period.

c. If on paid status (utilizing PTO/EIB), an employee may continue his/her normal premiums through payroll deduction. If on unpaid status, he/she is required to pay Kaweah Health his/her portion of the premiums while on a leave of absence for a total of four months. After four months, employees will be offered COBRA Continuation Coverage for applicable benefits.

d. See FMLA HR.145 #d, page 9 of 7.

e. An employee whose insurance is canceled due to nonpayment of premiums will have to satisfy a new waiting period after returning to work and will be considered a “new employee” for insurance purposes and as such, the employee may have to provide proof of insurability and will be subject to the pre-existing rules which apply at the time of the leave.

f. An employee may cancel his/her insurance(s) at the end of any given month during the leave. Cancellation must be done in writing to the Human Resources Department. The employee may reinstate coverage within 30 days of his/her return from work.

g. Group medical, dental, vision insurance coverage and the medical spending account will cease on the last day of the month in which an employee reaches four months, or seven months when PDL combines with CFRA, of leave or employment ends except that continuation is allowed under COBRA regulations if applicable to the plan.

h. If the employee fails to return to work at the expiration of the leave, he/she must repay any health insurance premiums paid by Kaweah Health while on leave, unless failure to return to work is due to a continuation of his/her own serious health condition or other reasons beyond his/her control.

8. Reinstatement

A doctor’s release and a clearance with Employee Health Services will be required when an employee is returning from a Pregnancy Disability leave of absence.

Upon the submission of a medical certification from a health care provider that an employee is able to return to work, the employee will, in most circumstances, be offered the same position held a the time of the leave or an equivalent. However, an employee returning from a Pregnancy Disability Leave has no greater right to reinstatement that if the employee had been continuously employed rather than on leave. For example, if an employee on Pregnancy Disability Leave would have been laid off had he/she not gone on leave, or if and employee’s position is eliminated during the leave, then the

employee would not be entitled to reinstatement. Similarly, if the employee's position has been filled in order to avoid undermining Kaweah Health's ability to operate safely and efficiently while the employee was on leave, and there is no equivalent position available, then the reinstatement would be denied.

Otherwise, Kaweah Health will comply with the agreed upon date of reinstatement. If no date was agreed or there is a change in the reinstatement date, Kaweah Health will reinstate the employee within two business days, or as soon as reasonably possible.

9. The employee must complete all outstanding job requirements and documentation (licensure, CPR, ACLS, NRP, PALS, and TB Testing, as applicable) prior to return to work. Competency-related documentation must be completed within 2 weeks of the employee's return. Requesting or receiving a leave of absence in no way relieves an employee of his or her obligation while on the job to perform his or her job responsibilities and to observe all District policies, rules and procedures.

"Responsibility for the review and revision of this Policy is assigned to the Chief of Human Resources Officer. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Health Policies and Procedures."

Policy Number: HR.200	**Date Created: 06/01/2007**
Document Owner: Dianne Cox (Chief Human Resources Officer)	**Date Approved:**
Approvers: Board of Directors (Administration)	

Drug Free Work Place and Drug/Alcohol Testing

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

POLICY:

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

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

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

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

DEFINITIONS:

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

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

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

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

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

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

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

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

ALCOHOL USE PROHIBITIONS:

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

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

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

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

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

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

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

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

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

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

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

DRUG USE PROHIBITIONS:

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

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

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

3. Prescription drugs or non-prescription drugs may also affect the safety of the employee or fellow employees or members of the public. Therefore, any

employee who is taking any prescription or, non-prescription drug which might impair safety, performance, or any motor, cognitive functions must advise his/her supervisor or department head before reporting to work under such medication. Employees will not be required to identify such medications or the underlying illnesses. If Kaweah Health determines that such use does not pose a safety risk, the employee will be permitted to work.

TESTING:

1. Testing of Applicants

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

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

2. Testing of Current Employees

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

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

3. Actions to be taken by Management

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

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

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

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

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

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

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

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

DRUG-FREE CONTRACT AND FOLLOW-UP TESTING:

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

1. <u>Additional Testing</u>

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

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

TESTING PROCEDURE:

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

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

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

4. Testing Laboratory

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

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

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

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

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

7. Kaweah Health will pay the cost of initial and confirmation drug tests required of employees and job applicants. An employee or job applicant will pay the cost of

any additional drug tests not required by Kaweah Health.

TEST RESULTS:

1. Reporting Results

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

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

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

2. Medical Review Officer (MRO)

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

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

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

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

   e. Additionally, the MRO shall outline the rights and procedures for a retest of

the original specimen and process any employee or job applicant requests for retest of the original specimen within one hundred, eighty (180) days of notice of the positive test result in another licensed laboratory selected by the employee or job applicant. The employee or job applicant requesting the additional test shall be required to pay for the cost of the retest, including handling and shipping expense. The MRO shall contact the original testing laboratory to initiate the retest.

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

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

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

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

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

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

3. <u>Kaweah Health Notification of Test Results</u>

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

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

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

4. Challenges to Test Results

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

5. Employee and Job Applicant Protection

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

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

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

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

INVESTIGATION:

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

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

3. Searches of an employee's personal property (purses, pockets, etc.) will take place only in the employee's presence, to the extent possible. All searches under this policy will occur with the utmost discretion and consideration for the employee involved.

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

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

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

ARREST OR CONVICTION FOR DRUG-RELATED CRIME:

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

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

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

    c. Because of the seriousness of such situations, Kaweah Health reserves the right to alter or change its policy or decisions on a given situation

depending upon its investigation and the totality of the circumstances.

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

CONFIDENTIALITY:

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

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Policy Number: HR.216	Date Created: 06/01/2007
Document Owner: Dianne Cox (Chief Human Resources Officer)	Date Approved:
Approvers: Board of Directors (Administration)	

Progressive Discipline

POLICY:

Kaweah Health uses positive measures and a process of progressive discipline to address employee performance and/or behavioral problems. Kaweah Health recognizes that the circumstances of each situation must be evaluated individually to determine whether to discipline progressively or to impose more advanced discipline immediately. This policy applies to all Kaweah Health employees, except residents enrolled in Kaweah Health's Graduate Medical Education (GME) program. Disciplinary actions related to residents in the GME program are handled by the Office of the GME as described in the Resident Handbook.

The primary purpose of Disciplinary Action is to assure compliance with policies, procedures and/or Behavioral Standards of Performance of Kaweah Health. Orderly and efficient operation of Kaweah Health requires that employees maintain appropriate standards of conduct and service excellence. Maintaining proper standards of conduct is necessary to protect the health and safety of all patients, employees, and visitors, to maintain uninterrupted operations, and to protect Kaweah Health's goodwill and property. Because the purpose of disciplinary action is to address performance issues, it should be administered as soon after the incident(s) as possible. Therefore, depending on the seriousness of the offense and all pertinent facts and circumstances, disciplinary action will be administered promptly.

Certain violations are considered major and require more immediate and severe action such as suspension and/or termination. Lesser violations will generally be subject to Progressive Discipline.

Any employee who is in Progressive Discipline is eligible for transfer or promotion within Kaweah Health with review and approval by the hiring manager and Human Resources.

Progressive Discipline shall be the application of corrective measures by increasing degrees, designed to assist the employee to understand and comply with the required expectations of performance. All performance of an employee will be considered when applying Progressive Discipline.

In its sole discretion, Kaweah Health reserves the right to deviate from Progressive Discipline or act without Progressive Discipline whenever it determines that the circumstances warrant.

PROCEDURE:

I. The process of Progressive Discipline may include the following, depending on the seriousness of the offense and all pertinent facts and circumstances:

A. Warnings

1. Verbal Warning:
A Verbal Warning explains why the employee's conduct/performance is unacceptable and what is necessary to correct the conduct/performance.

B. Written Warning:

A Written Warning provides the nature of the issue and outlines the expectations of performance/conduct or what is necessary to correct the situation. This Warning becomes part of the employee's personnel file, along with any pertinent back-up documentation available, and will inform the employee that failure to meet the job standards/requirements of the Warning will necessitate further disciplinary action, up to and including termination.

The department management, in concert with Human Resources, determines the level of corrective disciplinary action that will take place based upon the seriousness of the offense, the existence of any prior disciplinary actions and the entirety of the employee's work record.

1. Level I
Any employee who receives a Level I is subject to further Written Warnings as stated in this policy.

2. Level II
Any employee who receives a Level II is subject to further Written Warnings as stated in this policy.

3. Level III
A Level III is considered Final Written Warning to the employee involved, and includes a written explanation of what is necessary to meet the expectation of performance. A Level III Warning may be accompanied by a suspension. A suspension may be without pay and is generally up to five days or forty hours.

C. Administrative Leave

In the discretion of Kaweah Health, an employee may be placed on Administrative Leave at any time to give Kaweah Health time to conduct an investigation or for other circumstances considered appropriate. Management may impose an Administrative Leave at any time for an employee(s) if they believe there is a risk to employee or patient safety. Management will notify Human Resources immediately if an Administrative Leave is enforced. When an employee is placed on Administrative Leave, Kaweah Health will make every effort to complete the investigation of the matter within five business days. If Kaweah Health is unable to complete an investigation of the matter within five days the Administrative Leave may be extended.

After the investigation has been completed, the employee may be returned to work and, in the discretion of Kaweah Health and depending on the circumstances, may be reimbursed for all or part of the period of the leave. If it is determined that the employee should be terminated, compensation may, in the discretion of Kaweah Health, be paid until the Post Determination Review process has been completed. (See policy HR.218).

D. Dismissal Without Prior Disciplinary History

As noted, Kaweah Health may determine, in its sole discretion, that the employee's conduct or performance may warrant dismissal without prior Progressive Discipline. Examples of conduct that may warrant immediate dismissal, suspension or demotion include acts that endanger others, job abandonment, and misappropriation of Kaweah Health resources. This is not an exclusive list and other types of misconduct/poor performance, may also result in immediate dismissal, suspension or demotion. See Employee Conduct below.

E. Employee Conduct

This list of prohibited conduct is illustrative only; other types of conduct injurious to security, personal safety, employee welfare or Kaweah Health's operations may also be prohibited. This includes behavior or behaviors that undermine a culture of safety. Employee conduct that will be subject to Progressive Discipline up to and including immediate involuntary termination of employment includes but is not limited to:.

1. Falsifying or altering of any record (e.g., employment application, medical history form, work records, time cards, business or patient records and/or charts).

2. Giving false or misleading information during a Human Resources investigation;

3. Theft of property or inappropriate removal from premises or unauthorized possession of property that belongs to Kaweah Health, employees, patients, or their families or visitors;

4. Damaging or defacing materials or property of the Kaweah Health, employees, patients, or their families or visitors;

5. Possession, distribution, sale, diversion, or use of alcohol or any unlawful drug while on duty or while on Kaweah Health premises, or reporting to work or operating a company vehicle under the influence of alcohol or any unlawful drug;

6. Fighting, initiating a fight, threats, abusive or vulgar language, intimidation or coercion or attempting bodily injury to another person on Kaweah Health property or while on duty. Reference policy AP161 Workplace Violence Prevention Program;

7. Workplace bullying which can adversely affect an employee's work or work environment, Reference policy HR.13 Anti- Harassment and Abusive Conduct.

8. Bringing or possessing firearms, weapons, or any other hazardous or dangerous devices on Kaweah Health property without proper authorization;

9. Endangering the life, safety, or health of others;

10. Intentional violation of patients' rights (e.g., as stated in Title XXII);

11. Insubordination and/or refusal to carry out a reasonable directive issued by an employee's manager (inappropriate communication as to content, tone, and/or language)

12. Communicating confidential Kaweah Health or Medical Staff information, except as required to fulfill job duties;

13. Sleeping or giving the appearance of sleeping while on duty;

14. An act of sexual harassment as defined in the policy entitled Anti-Harassment and Abusive Conduct HR.13;

15. Improper or unauthorized use of Kaweah Health property or facilities;

16. Improper access to or use of the computer system or breach of password security;

17. Improper access, communication, disclosure, or other use of patient information. Accessing medical records with no business need is a violation of state and federal law and as such is considered a terminable offense by Kaweah Health.

18. Unreliable attendance (See Attendance and Punctuality HR.184)

19. Violations of Kaweah Health Behavioral Standards of Performance.

20. Unintentional breaches and/or disclosures of patient information may be a violation of patient privacy laws. Unintentional breaches and/or disclosures include misdirecting patient information to the wrong intended party via fax transmission, mailing or by face-to-face interactions.

21. Access to personal or family PHI is prohibited.

22. Refusing to care for patients in the event mandated staffing ratios are exceeded due to a healthcare emergency.

23. Working off the clock at any time. However, employees are not permitted to work until their scheduled start time.

24. .

25. Use of personal cell phones while on duty if, unrelated to job duties anywhere in Kaweah Health. This includes wearing earbuds for the purpose of listening to music from your personal cell phone, unless authorized by department leadership.

26. Excessive or inappropriate use of the telephone, cell phones, computer systems, email, internet or intranet.

27. Any criminal conduct off the job that reflects adversely on Kaweah Health.

28. Making entries on another employee's time record or allowing someone else to misuse Kaweah Health's timekeeping system.

29. Bringing children to work, or leaving children

unattended on Kaweah Health premises during the work time of the employee.

30. Immoral or inappropriate conduct on Kaweah Health property.

31. Unprofessional, rude, intimidating, condescending, or abrupt verbal communication or body language.

32. Unsatisfactory job performance.

33. Horseplay or any other action that disrupts work,

34. Smoking within Kaweah Health and/or in violation of the policy.

35. Failure to report an accident involving a patient, visitor or employee.

36. Absence from work without proper notification or adequate explanation, leaving the assigned work area without permission from the supervisor, or absence of three or more days without notice or authorization.

37. Unauthorized gambling on Kaweah Health premises.

38. Failure to detect or report to Kaweah Health conduct by an employee that a reasonable person should know is improper or criminal.

39. Providing materially false information to Kaweah Health or a government agency, patient, insurer or the like.

40. Spreading gossip or rumors which cause a hostile work environment for the target of the rumor.

41. Impersonating a licensed provider.

42. Obtaining employment based on false or misleading information, falsifying information or making material omissions on documents or records.

43. Violation of Professional Appearance Guidelines

44. Being in areas not open to the general public during non- working hours without the permission of the supervisor or interfering with the work of employees.

45. Failure to complete all job related mandatory

requirements as noted on the job description and as issued throughout a year (i.e. Mandatory Annual Training, TB/Flu, etc.).

46. Mandatory utilization of BioVigil.

47. Failure to use two (2) patient identifiers in the course of patient care.

Further information regarding this policy is available through your department manager or the Human Resources Department.

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Kaweah Health
MORE THAN MEDICINE. LIFE.

Human Resources

Policy Number: HR.234	**Date Created: 06/01/2007**
Document Owner: Dianne Cox (Chief Human Resources Officer)	**Date Approved:**
Approvers: Board of Directors (Administration)	

Paid Time Off (PTO), Extended Illness Bank (EIB) and Healthy Workplace, Healthy Families Act of 2014

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

POLICY:

Paid Time Off (PTO), Extended Illness Bank (EIB) and Healthy Workplace, Healthy Families Workplace Act of 2014 – Paid Sick Leave (PSL) benefits are offered to all employees as defined in this policy. PTO is offered to full-time and part-time benefit eligible employees for leisure, celebration of holidays, short-term illness and other personal needs. EIB is offered to full-time and part-time benefit eligible employees for extended illness and Kin Care. Private Home Care staff, temporary staff/interims and Per Diem staff are not eligible for PTO or EIB but are eligible for Paid Sick Leave (PSL) as defined in this policy. Excessive occurrences of unapproved time off may result in disciplinary action. See Policy HR.184 Attendance and Punctuality.

This policy does not apply to Graduate Medical Education

PROCEDURE:

Eligibility and Accrual for PTO and EIB

Full-time and part-time benefited employees are eligible to receive PTO and EIB as of the first pay period of eligibility (date of hire or transfer). If an eligible employee is changed to a non-eligible status, the PTO and EIB time accrual will cease. The employee will receive a lump-sum payment for all accrued PTO paid at 100% of their hourly rate of pay prior to the status change. During the non-eligible status, the employee will accrue PSL.

If a non-eligible employee is changed to an eligible status, the employee begins accruing PTO and EIB as of the first pay period in which the status change became effective; PSL accrual will cease. At no time will an employee accrue PTO and EIB as well as PSL. An employee accrues either PTO and EIB or PSL.

EIB accrual will be reinstated for employees who leave Kaweah Health and are rehired as follows:

a. If left as non-benefited and rehired as a non-benefited, we will reinstate the ending available EIB balance into a reserve bucket. These hours are available for use.
b. If terminated as a benefited and rehired as benefited, we will reinstate the ending EIB balance.

c. If terminated as non-benefited and rehired as benefited, we will reinstate the ending available EIB balance from the reserved EIB balance (if any).

d. If terminated as a benefited and rehired as non-benefited, we will reinstate the ending available EIB balance up to the 80-hour maximum, placing the excess EIB balance into a reserve bucket. These hours are not available for use.

The rate of PTO and EIB accrual received is based on years of service. Employees receive accruals on up to 80 eligible hours, per pay period. The bi-weekly pay period starts at 12 AM on a Sunday, and ends at 11:59 PM on the last Saturday of the pay period. Qualified service hours which count towards a year of service for the accrual rate include the following: regular hours worked (non-overtime), Flex Time Off, PTO FMLA, PTO unscheduled, PTO/PSL, PTO Sick/Pregnancy, PTO/Workers Compensation, Sitter Pay, Sleep Pay, PTO hours, bereavement hours, jury duty hours, training/workshop hours, orientation hours, and mandatory dock hours. Neither EIB nor PTO accruals will be earned while employees are being paid EIB hours.

All Other Employees					Directors					Chiefs				
Beg Years	End Years	PTO Max Hrly Accrual Rate (Up to 80 elg hrs)	Max Hours accrued per pay period	PTO Days per year	Beg Years	End Years	PTO Max Hrly Accrual Rate (Up to 80 elg hrs)	Max Hours accrued per pay period	PTO Days per year	Beg Years	End Years	PTO Max Hrly Accrual Rate (Up to 80 elg hrs)	Max Hours Accrued per pay period	PTO Days per year
0.0	4.9	0.084625	6.77	22	0.0	4.9	0.103875	8.3	27	0.0	1.0	0.103875	8.3	27
5.0	9.9	0.103875	8.31	27	5.0	9.9	0.123000	9.8	32	1.1	4.0	0.123000	9.8	32
10.0	14.9	0.123000	9.84	32	10.0	14.9	0.142250	11.4	37	4.1	9.0	0.142250	11.4	37
15	19.9	0.126875	10.15	33	15	19.9	0.146125	11.7	38	9.1	13.5	0.146125	11.7	38
20	24.9	0.130750	10.46	34	20	24.9	0.150000	12.0	39	13.6	18.0	0.150000	12.0	39
25	26.9	0.134625	10.77	35	25	26.9	0.153875	12.3	40	18.1	22.5	0.153875	12.3	40
27	28.9	0.138500	11.08	36	27	28.9	0.157750	12.6	41	22.6	27.0	0.157750	12.6	41
29+		0.142375	11.39	37	29+		0.161625	12.9	42	27.1		0.161625	12.9	42

Eligibility and Accrual for PSL

PSL eligible employees include Per-Diem, Private Home Care, and Part-Time non-benefit eligible employees. PSL eligible employees will accrue at the rate of one hour per every 30 hours worked (.033333 per hour); accrual begins as of the first pay period.

To qualify for sick leave (PSL), an employee must:

- Must be employed for 30-days;
- May use beginning at 90-days of employment;
- Will be paid to the extent of an employee's accrued hours only.

Employees are limited to use up to 40 hours or five (5) days which ever is greater of accrued time in each calendar year. PSL will carry over to the following calendar year not to exceed 60 hours of accrual in any calendar year.

Maximum Accruals

The maximum PTO accrual allowed is 400 hours. The accrual will cease once the maximum accrual is reached until PTO hours are used or cashed out. The maximum EIB accrual is 2000 hours; the maximum PSL accrual is 120 hours in a calendar year. No payment is made for accrued EIB or PSL time when employment with Kaweah Health ends for any reason.

Requesting, Scheduling, and Access to PTO, EIB and PSL

Employees are required to use accrued PTO for time off for illness or unexpected absence occurrences.

Routine unpaid time off is not allowed. Any requests for unpaid time should be considered only on a case-by-case basis taking into consideration the need for additional staffing to replace the employee and other departmental impacts. It is the responsibility of management to monitor compliance. Employees should be aware that unpaid time off could potentially affect their eligibility for benefits.

Any planned request for PTO time, whether for traditional holiday, for vacation time or otherwise must be approved in advance by management. Management will consider the employee's request as well as the needs of the department. In unusual circumstances, management may need to change the PTO requests of employees based upon the business and operational needs of Kaweah Health. In such situations, Kaweah Health is not responsible for costs employees may incur as a result of a change in their scheduled PTO time.

AB 1522 Healthy Workplace Healthy Families Act of 2014

An employee may utilize up to five (5) days or 40 hours 40 hours, whichever is greater, of PTO or PSL in a calendar year (January-December). For example:

- For employees who work 12-hour shifts, the employee will be entitled to use up to 60 hours of paid sick leave (5 days x 12 hours).
- An employee who works 10-hour shifts will be entitled to use up to 50 hours (5 days x 10 hours).
- An employee who works 8-hour shifts will be entitled to use up to 40 hours (5 days x 8 hours).
- Alternatively, if an employee works only 6 hours a day and takes five days of paid sick leave, for a total of 30 hours, the employee will still have 10 hours remaining.

Employee may use PTO or PSL for the following purposes:

a) Diagnosis, care, or treatment of an existing health condition, or preventative care for an employee or an employee's designated person, family member, as defined as employee's parent, child, spouse, registered domestic partner, grandparent, grandchild, and siblings.

b) "Family Member" means any of the following:

i. A child, which for purposes of this policy means a biological, adopted or foster child, stepchild, legal ward, or a child to whom the employee stands in loco parentis; this definition of child is applicable regardless of age or dependency status.
ii. A biological, adoptive, or foster parent, stepparent, or legal guardian of an employee or the employee's spouse or registered domestic partner, or a person who stood in loco parentis when the employee was a minor child.
iii. Spouse
iv. Registered domestic partner
v. Grandparent
vi. Grandchild
vii. Sibling

c) Designated Person means the following:
i. Under the California Family Rights Act (CFRA) and California Healthy Workplaces Health Families Act (HWHFA) an employee will be able to identify a designated person for whom they want to use leave when they request unpaid CFRA or paid HWHFA.

d) For an employee who is a victim of domestic violence, sexual assault or stalking, as specified.

There is no cash out provision for the PSL accrual, including upon termination of employment or with a status change to a benefit eligible position. However, if an employee separates from Kaweah Health and is rehired within one year, previously accrued and unused PSL will be reinstated.

PSL and PTO time shall be utilized at a minimum of 1-hour increments and no more than the length of the employee's shift.

PTO and PSL time taken under this section is not subject to the Progressive Discipline Policy HR.216.

Time Off Due To Extended Illness

Employees who are absent due to illness for more than three (3) consecutive work days should notify their manager and contact the Human Resources Department to determine if they are eligible for a leave of absence. Accrued EIB can be utilized for an approved continuous leave of absence beyond three (3) days and if admitted to a hospital or have a medical procedure under anesthesia. However, in instances when an employee has been issued Disciplinary Action and directed to provide a doctor's note for all sick days, then an employee may need to submit a doctor's note. If applying for a continuous leave of absence, PTO-PSL may be applied for the first three calendar days at the employee's regular shift length, if leave is for your own medical condition.

Employees who are absent due to illness for more than seven (7) consecutive days should file a claim for California State Disability Insurance. Claim forms are available in Human Resources. State Disability payments will be

supplemented with any accrued EIB time by the Payroll Department and PTO at the employee's request.

Employees who are absent with an Intermittent Leave under FMLA/CFRA are required to use accrued PTO for their absences, at no less than one hour and no more than the regular length of the shift.

Time Off Due to Kin Care

Kin Care allows eligible employees to use up to one-half (1/2) of the Extended Illness Bank (EIB) that they accrue annually in a calendar year to take time off to care for a sick family member. Only employees who accrue EIB are eligible for Kin Care. No more than one-half of an employee's EIB accrual in a calendar year period can be counted as Kin Care. An employee who has exhausted their EIB and then is absent to care for a sick family member cannot claim that absence under Kin Care.

Kin Care can be used to care for a sick family member, to include a spouse or registered domestic partner, child of an employee, "child" means a biological, foster, or adopted child, a stepchild, a legal ward, a child of a domestic partner, or a child or a person standing in loco parentis, parents, parents- in-law, siblings, grandchildren and grandparents.

EIB time taken under this section to care for an immediate family member is not subject to the Progressive Discipline Policy HR.216.

Holidays

Kaweah Health observes 72 holiday hours each year. Eligible employees may be scheduled a day off and will be paid provided adequate accrual exists within their PTO bank account for each observed holiday. Time off for the observance of holidays will always be in accordance Kaweah Health needs.

1. New Year's Day (January 1st)
2. President's Day (Third Monday in February)
3. Memorial Day (Last Monday in May)
4. Independence Day (July 4th)
5. Labor Day (First Monday in September)
6. Thanksgiving Day (Fourth Thursday in November)
7. Day after Thanksgiving Day (Friday following Thanksgiving)
8. Christmas Day (December 25th)
9. Personal Day

Business departments and/or non-patient care areas will typically be closed in observance of the noted holidays. Where this is the case, employees assigned to and working in these departments will be scheduled for a day off on the day the department is closed. Employees affected by department closures for holidays should maintain an adequate number of hours within their PTO banks to ensure that time off is with pay.

In business departments and/or non-patient care areas, holidays, which fall on Saturday, will typically be observed on the Friday preceding the actual holiday

and holidays, which fall on Sunday, will be observed on the Monday following the actual holiday.

Employees who work hours on some of these holidays may be eligible for holiday differential. For more information of eligibility, see policy HR.75 Differential Pay- Shift, Holiday, and Weekend.

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Policy Number: HR.242	**Date Created: 02/10/2016**
Document Owner: Dianne Cox (Chief Human Resources Officer)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration), HR Advisory Committee, Blanca Bedolla (Employee Relations Coordinator), Cindy Moccio (Board Clerk/Exec Assist-CEO), Dianne Cox (Chief Human Resources Officer)	

Personal Medical Leave

Policy:

To allow time off to employees who have no other recourse than to be away from work for up to one (1) year of medical leave. To establish a system to continue to receive compensation through accessible benefits, such as Extended Illness Bank (EIB), Paid Time Off (PTO), State Disability Insurance (SDI), and Workers' Compensation. To advise employees of their rights and responsibilities.

NOTE: Due to coordination of information between departments and outside agencies, and the requirement that certain records be maintained to demonstrate compliance with state and federal law, it is important that paperwork and documentation be completed and submitted to Human Resources in a timely manner by Department Heads and employees.

Procedure:

This policy on medical leaves applies if an employee does not qualify under a legislated leave, such as the California Family Rights Act, as amended in 1993 (CFRA), and the Federal Family and Medical Leave Act of 1993 (FMLA), and/or a Workers' Compensation Leave.

I. Reason for Leave

Kaweah Health offers employees the opportunity to take an unpaid leave of absence because of a non-work-related serious health condition that makes the employee unable to perform the functions of the employee's job (other than pregnancy, childbirth and related medical conditions).

a. A "serious health condition" is an illness, injury, impairment or physical or mental condition which involves:
   i. Inpatient care (i.e., an overnight stay) in a medical care facility; or
   ii. Continuing treatment by a health care provider for a condition that either prevents the qualified family member from participating in school or other daily activities.
   iii. The continuing treatment may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two

visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may qualify.

II. Leave Available

An employee may take up to one (1) year of medical leave during a 12-month period begins on the date of an employee's first use of medical leave. Successive 12-month periods commence on the date of an employee's first use of such leave after the preceding 12-month period has ended.

III. Notice, Certification and Reporting Requirements

a. Timing:

i. If the need for the leave is foreseeable, an employee must provide 30 days written notice prior to the requested start of the leave. When 30 days is not possible, the employee must provide notice as soon as practicable and generally must comply with Kaweah Health's normal call-in procedures.

ii. If the need for the leave is foreseeable due to a planned medical treatment or supervision, the employee must make a reasonable effort to schedule the treatment or supervision in order to avoid disruption to the operations of Kaweah Health.

b. Employee Periodic Reports:

During a leave, an employee must provide periodic reports regarding the employee's status to the department head and Human Resources, including any change in the employee's plan to return to work. Failure to provide updates may cause Kaweah Health to apply a voluntary resignation from employment.

c. Department Heads:

Department heads may not contact the employee's health care provider to obtain information on a leave. They are to refer any questions to Human Resources or Employee Health who may contact the provider.

IV. Compensation During Leave:

Refer to the pamphlet from the Employment Development Department (EDD) entitled "For Your Benefit: California's Program for the Unemployed" for more information.

a. For a medical leave of absence longer than seven (7) days which is to be coordinated with State Disability Insurance (SDI), or a Workers' Compensation leave of absence, accrued Extended Illness Bank (EIB) hours are paid after 24 hours off. The initial three (3) 24 hours are paid through accrued PTO, if available, at the employee's discretion. In the

circumstance of an immediate hospitalization or surgery, an employee may be paid from accrued EIB from their first full day off. EIB must be used for coordination with SDI or Workers' Compensation Temporary Disability Payments; PTO time may be used only after EIB has been exhausted. Coordinated amounts will not exceed the regular amount of pay normally earned by the employee.

b. It is the employee's responsibility to notify Payroll of the amount they receive from SDI or Workers' Compensation to ensure the correct amount of EIB hours.

V. Benefit Accrual:

The employee will continue to accrue PTO as long as they are being paid by Kaweah Health (receiving a paycheck) during integration of benefits on continuous leave of absence.

VI. Merit Review Date:

The merit review date will not change during a leave of absence.

VII. Benefits During Leave:

a. An employee taking leave will continue to receive coverage under Kaweah Health's employee benefit plans for up to a maximum of four (4) months per 12-month period at the level and under the conditions of coverage as if the employee had continued in employment continuously for the duration of such leave. Kaweah Health will continue to make the same premium contribution as if the employee had continued working.

b. Insurance premiums (health, vision, dental, life, etc.) are to be paid by the employee and Kaweah Health, under the same conditions as existed prior to the leave, for a maximum period of four (4) months in a 12-month period.

c. If on paid status (utilizing PTO/EIB), an employee may continue his/her normal premiums through payroll deduction. If on unpaid status, he/she is required to pay Kaweah Health his/her portion of the premiums while on a leave of absence for a total of four months. After four (4) months, employees will be offered COBRA Continuation Coverage for applicable benefits.

d. An employee whose insurance is canceled due to nonpayment of premiums will have to satisfy a new waiting period after returning to work and will be considered a "new employee" for insurance purposes and as such, the employee may have to provide proof of insurability.

e. An employee may cancel his/her insurance within 30 days of the end of his/her paid leave and will be re-enrolled upon return without a waiting period. Cancellation must be done in writing to the Human Resources Department. The employee must reinstate coverage within 30 days of his/her return from work.

f. Group medical, dental and vision insurance coverage will cease on the last day of the month in which an employee reaches four months of leave or employment ends except that continuation is allowed under COBRA regulations if applicable to the plan.

g. If the employee fails to return to work at the expiration of the leave, he/she must repay any health insurance premiums paid by Kaweah Health while on leave, unless failure to return to work is due to a continuation of his/her own serious health condition or other reasons beyond his/her control.

VIII. Reinstatement:

If returning from a non-work-related medical leave, Kaweah Health will meet with the employee to review the interest and abilities to return to work with or without a reasonable accommodation. There are no guarantees of reinstatement and the employee's return will depend on their qualifications for existing openings.

A doctor's release and a clearance with Employee Health Services will be required when an employee is returning from a medical leave of absence.

The employee must complete all outstanding job requirements and documentation (licensure, CPR, ACLS, NRP, PALS, and TB testing, as applicable) prior to a return to work. Competency-related documentation must be completed within two weeks of the employee's return.

The employee must complete all outstanding job requirements and documentation (licensure, CPR, ACLS, NRP, PALS, and TB Testing, as applicable) prior to return to work. Competency-related documentation must be completed within two weeks of the employee's return. Requesting or receiving a leave of absence in no way relieves an employee of his or her obligation while on the job to perform his or her job responsibilities and to observe all Kaweah Health policies, rules and procedures.

"Responsibility for the review and revision of this Policy is assigned to the Chief of Human Resources Officer. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Health will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Health Policies and Procedures."

February 28, 2024

Miracle Mile Law Group, LLP
11835 W. Olympic Blvd, Suite 870E
Los Angeles, California 90064

RE: Notice of Rejection of Claim of Adrianna Burton 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 February 20, 2024, was rejected on its merits by the Board of Directors on February 28, 2024.

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,

Dave Francis
Secretary/Treasurer, Board of Directors

PC: Rachele Berglund, Attorney at Law
Herr Pedersen Berglund, Attorneys At Law LLP

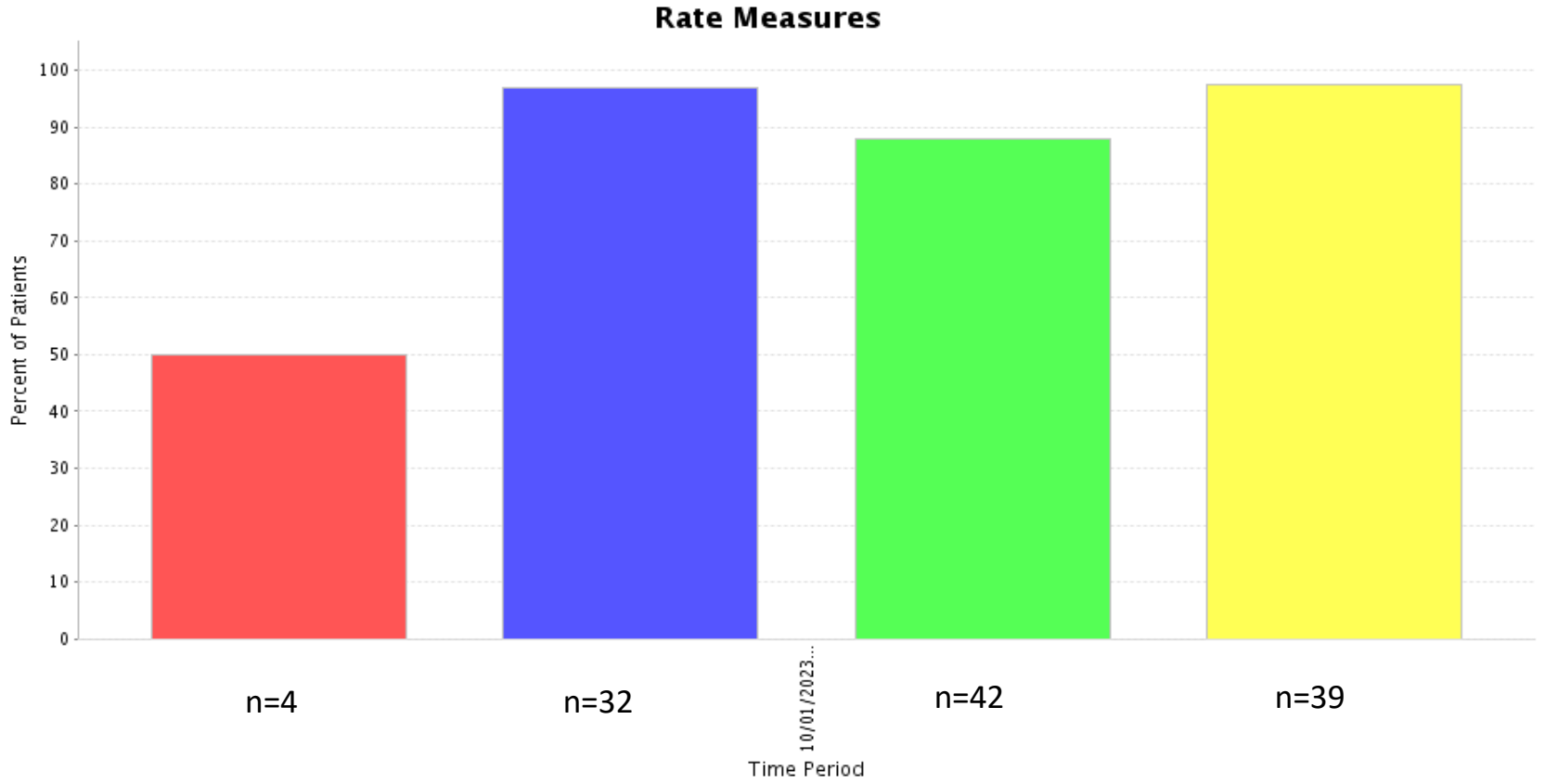
RRT/Code Blue Board Report

Shannon Cauthen- January 2024

kaweahhealth.org

Kaweah Health
MORE THAN MEDICINE. LIFE.

Get With the Guidelines



Q3 2023 (July-September)

RRT and Resuscitation Scorecard

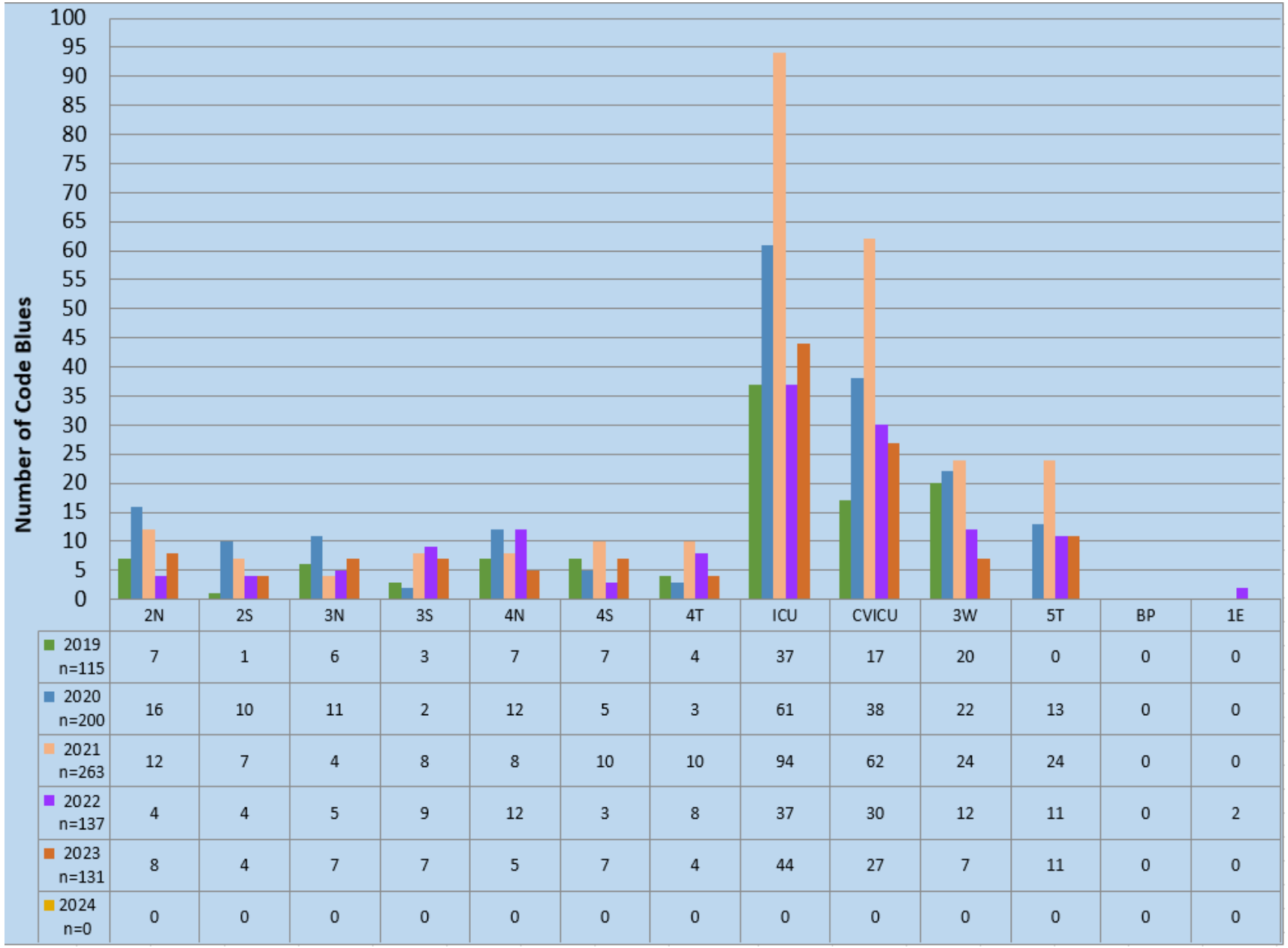
Kaweah Health
MORE THAN MEDICINE. LIFE.

RRT Resuscitation Quality Scorecard

	Hospitals (External Benchmark) ALL GWTG	CY 2022 Baseline Mean	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Mean (Rolling 12 months)
Code Blue Data															
Total Code Blues (Med/Surg/ICCU/CC)		12	14	14	13	9	2	14	7	9	9	7	11	21	11
Total COVID-19 Positive Code Blues		2	4	1	0	0	0	0	0	0	0	0	0	0	0
Code Blues per 1000 Discharges Med Surg/ICCU		5	3	4	7	3	0	6	3	2	3	4	3	9	4
Code Blues per 1000 Discharges Critical Care		4	8	9	3	5	2	6	2	5	4	2	5	7	5
Percent of Codes in Critical Care	66% (↑ is better)	49%	71%	71%	29%	67%	100%	50%	43%	67%	56%	29%	64%	43%	58%
Event Survival Rates			57%	71%	43%	33%	100%	79%	71%	44%	56%	57%	73%	67%	63%
Code Blue: Survival to Discharge	20% (↑ is better)	22%	14%	0%	14%	0%	100%	21%	14%	33%	56%	14%	9%	10%	24%
Deaths from Cardiac Arrest (expired during event)		4	8	4	8	6	0	3	2	5	4	3	3	7	4
Overall Hospital Mortality Rate		2.87	3.54	3.2	2.29	2.84	2.47	2.85	1.9	1.79	2.69	2.45	3.09	3.25	2.70
RRT Data			**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Mean**
Total RRTS		108	121	96	133	104	102	90	125	103	87	115	119	128	110
RRTs per 1000 Patient Discharge Days		86	98	87	100	88	81	71	98	79	71	100	93	99	89
RRT Mortality	21% (↓ is better)	19%	22% n=27	17% n=16	17% n=22	16% n=17	15% n=15	24% n=22	13% n=16	17% n=17	13% n=11	23% n=25	22% n=23	24% n=29	19%
RRTs Within 24 hours of Arriving to Inpatient Unit	15% (↓ is better)	21%	26% n=31	24% n=23	26% n=35	24% n=25	28% n=29	36% n=32	26% n=32	30% n=31	25% n=22	26% n=30	23% n=27	25% n=32	27%
RRT- Med-Surg to Intermediate Critical Care Transfers	*9%	17%	14% n=17	24% n=23	23% n=30	27% n=28	18% n=18	22% n=20	22% n=27	22% n=23	20% n=17	23% n=26	13% n=16	21% n=27	21%
RRT- Med-Surg to Critical Care Transfers	*29%	10%	9% n=11	1% n=1	10% n=13	7% n=7	17% n=17	10% n=9	12% n=15	9% n=9	11% n=10	7% n=8	11% n=13	6% n=8	9%
RRT-Intermediate Critical Care Transfers to Critical Care	*32%	7%	10% n=12	8% n=8	9% n=12	5% n=5	10% n=10	6% n=5	6% n=8	9% n=9	14% n=12	12% n=14	6% n=7	9% n=12	9%

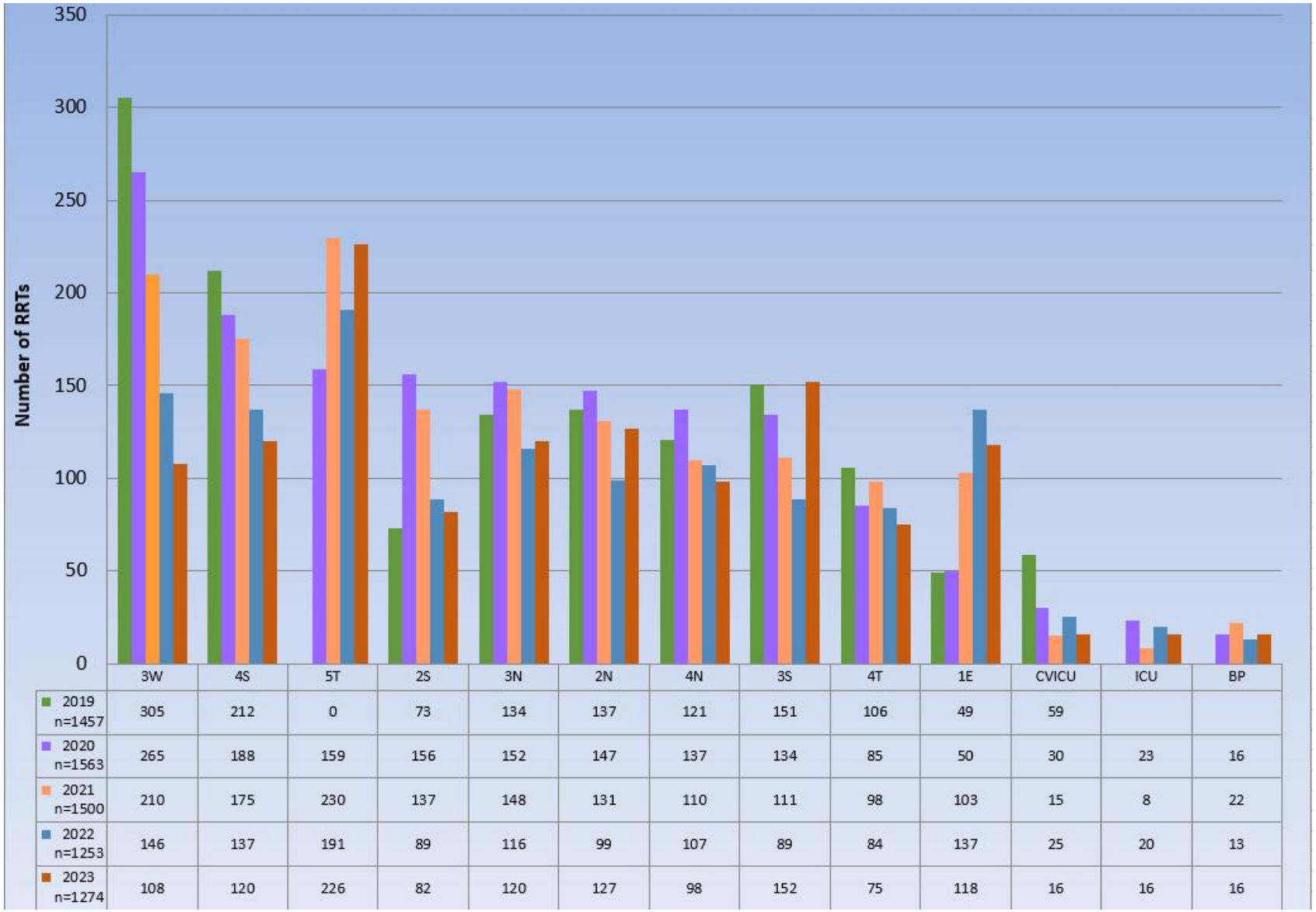
Better than Target
Does not meet Target
*Target Goal not Being Established

Code Blues by Location



	2N	2S	3N	3S	4N	4S	4T	ICU	CVICU	3W	5T	BP	1E
2019 n=115	7	1	6	3	7	7	4	37	17	20	0	0	0
2020 n=200	16	10	11	2	12	5	3	61	38	22	13	0	0
2021 n=263	12	7	4	8	8	10	10	94	62	24	24	0	0
2022 n=137	4	4	5	9	12	3	8	37	30	12	11	0	2
2023 n=131	8	4	7	7	5	7	4	44	27	7	11	0	0
2024 n=0	0	0	0	0	0	0	0	0	0	0	0	0	0

RRTs by Location



	3W	4S	5T	2S	3N	2N	4N	3S	4T	1E	CVICU	ICU	BP
2019 n=1457	305	212	0	73	134	137	121	151	106	49	59		
2020 n=1563	265	188	159	156	152	147	137	134	85	50	30	23	16
2021 n=1500	210	175	230	137	148	131	110	111	98	103	15	8	22
2022 n=1253	146	137	191	89	116	99	107	89	84	137	25	20	13
2023 n=1274	108	120	226	82	120	127	98	152	75	118	16	16	16

2023 Projects

- Sidewalk CPR (June 2023)
- LUCAS (CPR Device) Implementation (August 2023)
- Mock Code Blue Program (October 2023)

American Heart Association.

2023 GET WITH THE GUIDELINES.

SILVER

RESUSCITATION

2023 Projects

2023 Projects

2024 Next Steps

- Foster relationship building between new RRT nurses and floor staff
- Mentor and educate novice nurses in clinical settings
- Revise ICCU Admission Criteria- vetting by Medical Staff
- Continue Mock Code Blue program- growth dependent on resources.
- Continue community engagement and education
- Await eligibility confirmation for Gold Award from AHA
- Improve patient outcomes

Abby, daughter of ICU BSM, after attending Sidewalk CPR

The pursuit of healthiness

Kaweah Health
MORE THAN MEDICINE. LIFE.

FY 2024 Strategic Plan

Patient Experience and Community Engagement

February 28, 2024

World-Class Service Champion: Keri Noeske

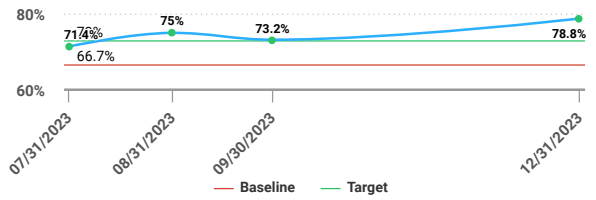
Objective: *Develop strategies that provide our health care team the tools they need to deliver a world-class health care experience.*

Plan

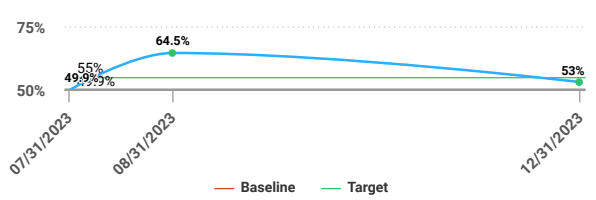
#	Level	Name	Start Date	Due Date	Assigned To	Status	Last Comment
6.1.5	Outcome	Achieve Patient Feedback Score Goal on ED Survey	07/01/2023	06/30/2024	Keri Noeske	Off Track	Team is making good progress on the goal and maintaining improvements related to patient flow, communication, and compassion. Goal for FY24 is a stretch goal.
6.1.8	Outcome	Achieve overall Organization Net Promoter Score of 83.2 (October 2023 - June 2024)	07/01/2023	06/30/2024	Keri Noeske	Off Track	Lower scores continue - attributed primarily to communication and long wait times in clinic and ED settings. Communication training being developed, plan to roll out organization wide in May. Throughput improvements in ED in place, monitoring changes. Leaders implementing service alert response processes by 3/1/24 if not sooner.
6.1	Strategy	Highlight World-Class Service/Outcomes (Hospitality Focus)	07/01/2023	06/30/2024	Keri Noeske	On Track	HCAHPS Data: For FY24 will be 30 days behind d/t HCAHPS surveying timelines. Data for July 2023 will be updated in September 2023. ED Score: Value below baseline. ED Operations team to assess feedback and recommend an action plan to Patient Experience Committee to address decrease.
6.1.1	Objective	Provide trainings & tools to team members on how to deliver world-class service.	07/01/2023	06/30/2024	Keri Noeske	On Track	Story-telling tactic initiated in January. Sharing patient experience stories in all departments of the organization to enhance compassion and empathy around the patient experience. Training module being developed for roll out with spring mandatory training modules and in orientation starting in May 2024.
6.1.2	Objective	Enhance patient navigation across the health care continuum.	07/01/2023	06/30/2024	Deborah Volosin	On Track	Project assigned to Jacob Kennedy to initiate review and plans for patient navigation across continuum. Assessment of opportunities, development of interventions and implementation of changes planned over next 12 months.
6.1.3	Objective	Patient Wayfinding	07/01/2023	06/30/2024	Deborah Volosin	On Track	A community wayfinding exercise took place at the main campus during the month of August, 2023. "Secret shoppers" were assigned destinations (or units) and asked to answer questions during that assignment on various areas of focus. (Facilities, cleanliness, directions, friendliness of staff, website, parking, etc.) The results of the exercise were presented to the Board of Directors at the October, 2023 Board of Directors meeting. The Board has asked that the same participants be brought back to the main campus for a follow-up tour after some of their feedback has been implemented and upgrades have been completed.
6.1.4	Outcome	Achieve the 60th Percentile in Overall Rating Goal on HCAHPS Survey	07/01/2023	06/30/2024	Keri Noeske	On Track	Individual departments focusing on areas of concern. Organization specifically focusing on compassionate communication, responsiveness of staff, cleanliness and care transitions. First quarter score was 70.8%.
6.1.6	Outcome	Achieve the 75th Percentile in HCAHPS Care Transitions Score	07/01/2023	06/30/2024	Keri Noeske	On Track	Care transitions and patient navigation plans to be reviewed at February 2024 patient experience steering committee.
6.1.7	Outcome	Improve Net Promoter Score (NPS) Clinics - Would Recommend Provider	07/01/2023	06/30/2024	Keri Noeske	On Track	Clinic leadership following up on service alerts, interacting with patients and visitors, explaining care and connecting patients with resources.

World-Class Service Champion: Keri Noeske

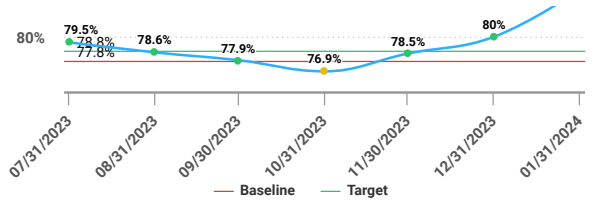
Achieve the 60th Percentile in Overall Rating Goal on HCAHPS Survey



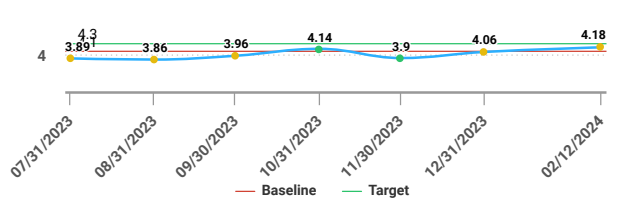
Achieve the 75th Percentile in HCAHPS Care Transitions



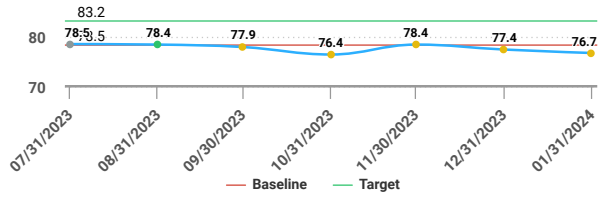
Improve Net Promoter Score Clinics - Would Recommend Provider



Achieve 4.3 Patient Feedback Score Goal on ED Survey



Achieve overall Organization Net Promoter Score of 83.2 (October 2023 - June 2024)



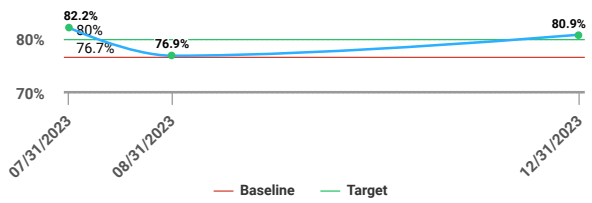
Increase Compassionate Communication Champions: Keri Noeske

Objective: *Improve physician and nursing communication and responsiveness of staff.*

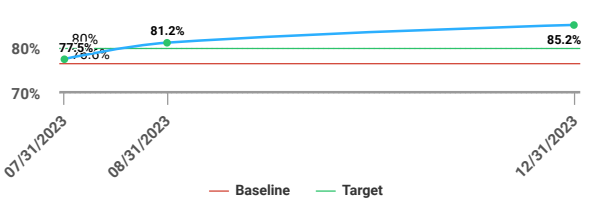
Plan

#	Level	Name	Start Date	Due Date	Assigned To	Status	Last Comment
6.2.1	Objective	Develop an expectation for best practice provider and team communication (training and coaching)	07/01/2023	06/30/2024	Keri Noeske	Not Started	Supporting medical staff office with identifying resources and developing a plan for training and coaching.
6.2.2	Objective	Bedside Rounds - Health Care Team Rounds Implemented in all Med Surg and Critical Care areas	07/01/2023	06/30/2024	Keri Noeske	Achieved	Implemented in critical care. All targeted adult patient care areas performing multidisciplinary rounds to review plan of care with patient and/or family.
6.2.3	Outcome	Achieve the 60th Percentile in Physician Communication Score	07/01/2023	06/30/2024	Keri Noeske	On Track	Continued improvements in this area, on track. Collaborating with medical staff office team for communication to medical staff about progress and continued sustained improvement.
6.2.4	Outcome	Achieve the 60th Percentile in Nursing Communication Score	07/01/2023	06/30/2024	Keri Noeske	On Track	Improvements noted, continued work at the direct patient care level to sustain the changes.
6.2.5	Outcome	Achieve the 70th Percentile in Responsiveness of Staff to Patients and Among Internal Teams	07/01/2023	06/30/2024	Keri Noeske	On Track	Improvements made and noted. Continued work to maintain improvements through measures such as Smile and Greet, Gratitude and ownership of interactions for all team members.

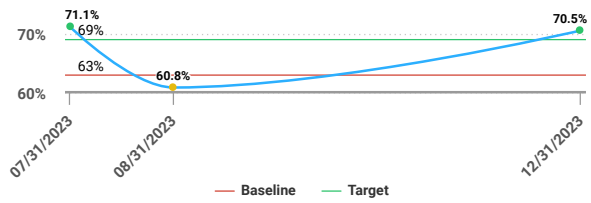
Achieve the 60th Percentile on Physician Communication Scores



Achieve the 60th Percentile on Nursing Communication Scores



Achieve the 70th Percentile in Responsiveness of Staff to Patients and Internal Teams

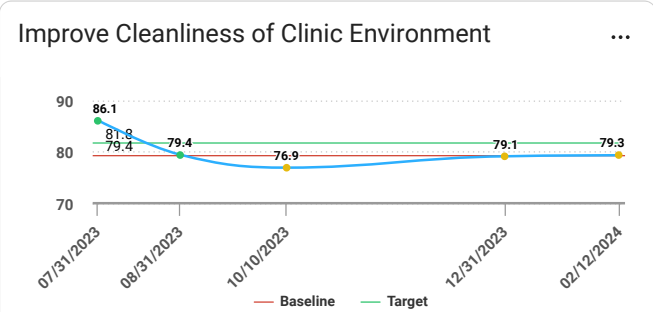


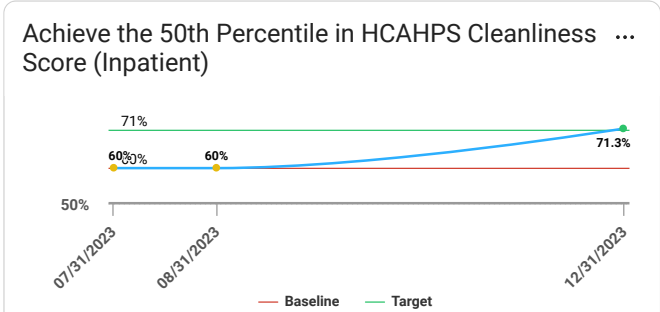
Enhancement of Environment Champion: Deborah Volosin

Objective: *To create a secure, warm and welcoming environment for patients and the community.*

Plan

#	Level	Name	Start Date	Due Date	Assigned To	Status	Last Comment
6.3.1	Objective	Environmental Rounds: Identify and Respond to Environmental Needs	07/01/2023	06/30/2024	Deborah Volosin	On Track	Marc Mertz, Dianne Cox, Kevin Morrison and Tendai Zinyemba have started monthly rounds at the main campus identifying things that need to be fixed or updated. As a result of these rounds changes have been or are going to be made to the following areas: 3 West, Acequia Wing main hallway, 4 South nurse station, and 4 Center restroom. The Green Committee met in June and brainstormed ideas for making Kaweah a more environmentally friendly organization. Ideas included refillable water bottle stations, composting food waste, drought tolerant landscaping, recycling program, biodegradable silverware, and battery recycling. These ideas are being vetted at the Director level to determine if they are financially feasible.
6.3.2	Outcome	Reunite 75% of Lost Belongings with Owners	07/01/2023	06/30/2024	Keri Noeske	At Risk	Challenging to measure improvements - values are not reliable with two different reporting systems. We have implemented alerts going to individual departments and engaging Admin Assts in tracking of communications and retrieval of items. Moved ownership of lost belongings to department level. Next steps with Patient Exp Steering Committee to implement new lost belongings prevention program with departments.
6.3.3	Outcome	Improve the Cleanliness of Clinic Environment	07/01/2023	06/30/2024	Keri Noeske	Off Track	Year to date average of all clinic scores still at baseline or just below. Fallouts primarily in rural health clinics. Leaders working with EVS and contracted agencies to improve cleanliness and appearance of the spaces. Strong improvements in the specialty clinics (score is 85.3).
6.3.4	Outcome	Achieve the 50th Percentile in HCAHPS Cleanliness Survey Score (Inpatient)	07/01/2023	06/30/2024	Keri Noeske	On Track	Enhanced team focus on first impressions, responsiveness to needs and thoroughness of completion. EVS has heightened focus on public areas, waiting rooms and ED spaces for highest traffic.





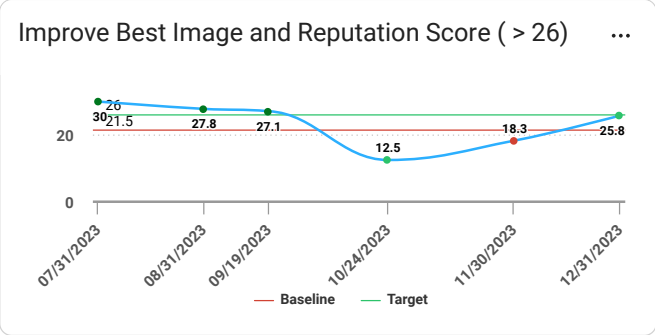
Community Engagement Champion: Deborah Volosin and Keri Noeske

Objective: *To provide an environment where community members and patients are able to assist staff in co-designing safe, high quality, and world-class care and services.*

Plan

#	Level	Name	Start Date	Due Date	Assigned To	Status	Last Comment
6.4.1	Objective	Report on Community Engagement Activities	07/01/2023	06/30/2024	Deborah Volosin	On Track	We continue to meet monthly with the five advisory councils and the employee ambassador group. The December meetings were cancelled due to the Community Town Hall. . As a part of our community engagement we did a District-Wide holiday giving initiative. Our employees donated toys, food, blankets, socks, coats and we donated them to six local non-profits. We sponsored 21community events and continue to participate monthly in the VEDC, Industrial Park Roundtable, Tulare Kings Hispanic Chamber of Commerce Ambassador Roundtable, and Visalia Chamber of Commerce Ambassador roundtable. We have 14 leaders in local community service clubs and one of our Kaweah Health representatives from our Tulare Clinic was Volunteer of the Year with Tulare Chamber of Commerce.
6.4.2	Objective	Continue to meet with Community Advisory Councils and Ambassador groups to gain community and employee insights and support	07/01/2023	06/30/2024	Deborah Volosin	On Track	Diversity/Comm Relations is working on a reboot of the Patient Guide and has edited a Health Equity Survey that is going out to the community in the next few weeks. H4TT received presentations from the Physician Recruitment Director and the Mental Health Hospital leadership. PFAC met and reviewed patient feedback and the Strategic Plan initiatives. EDAC is focusing on the ED dashboard.
6.4.3	Objective	Explore ways to collaborate on modernization efforts with other health care districts, Central Valley Healthcare Alliance, and the County of Tulare	07/01/2023	06/30/2024	Deborah Volosin	On Track	Leaders from Kaweah Health and Sierra View have been meeting to discuss and prioritize opportunities to revitalize CVHA, including operational and clinical opportunities. These efforts have taken on new importance given SB525.
6.4.4	Objective	Promote Community Engagement program with new membership, new Councils, and a new onboarding program	07/01/2023	06/30/2024	Deborah Volosin	On Track	CE is working with Marketing to do an annual campaign for new members on the community advisory councils. We will also be kicking off a new membership drive for the employee ambassador group.
6.4.5	Objective	Continue to promote Speakers Bureau	07/01/2023	06/30/2024	Deborah Volosin	On Track	In the last quarter of 2023, we had four community speaking engagements for our leaders. Dr. Winston spoke at Downtown Rotary and County Center Rotary, Marc Mertz spoke at the Visalia Noon Kiwanis, Gary Herbst spoke at Downtown Rotary, and Deborah Volosin spoke at Leadership Visalia. In January, 2024, Gary spoke at County Center Rotary. In February, Tracy Salsa will be speaking at the Exeter Women's Club and Networking for Women. Deborah has also been working with the leaders at the Mental Health hospital on a community presentation on Kaweah Health's mental health services. They have been practicing their presentation in front of the community advisory councils in preparation for going out into the community.
6.4.6	Objective	Continue to monitor legislation around seismic regulations and financial implications related to replacing the Mineral King Wing and keep the community engagement participants informed of the legislative updates. If needed, plan community webinars, town halls, social media posts, and other communicative methods if these updates are concerning or have a significant impact to Kaweah Health.	07/01/2023	06/30/2024	Deborah Volosin	On Track	We are continuing to talk to lawmakers about the seismic regulations and the potential financial impact to the hospital. We are looking into doing a community forum with hospital leaders, local politicians, and hospital partners to highlight the efforts and partnerships.
6.4.7	Objective	Kick off a new Foundation fundraising campaign	07/01/2023	06/30/2024	Deborah Volosin	On Track	The Kaweah Health Foundation's current campaign, Caring for our Caregivers, will run through June of 2024. They are doing an update to capture employees who are a part of the Hour Club. This will update the donations to reflect their current hourly rate.
6.4.8	Outcome	Improve Best Image and Reputation Score (26)	07/01/2023	06/30/2024	Deborah Volosin	On Track	The rolling 12 is 29.1

Community Engagement Champion: Deborah Volosin and Keri Noeske



Health Equity at Kaweah Health

February 28, 2024

kaweahhealth.org

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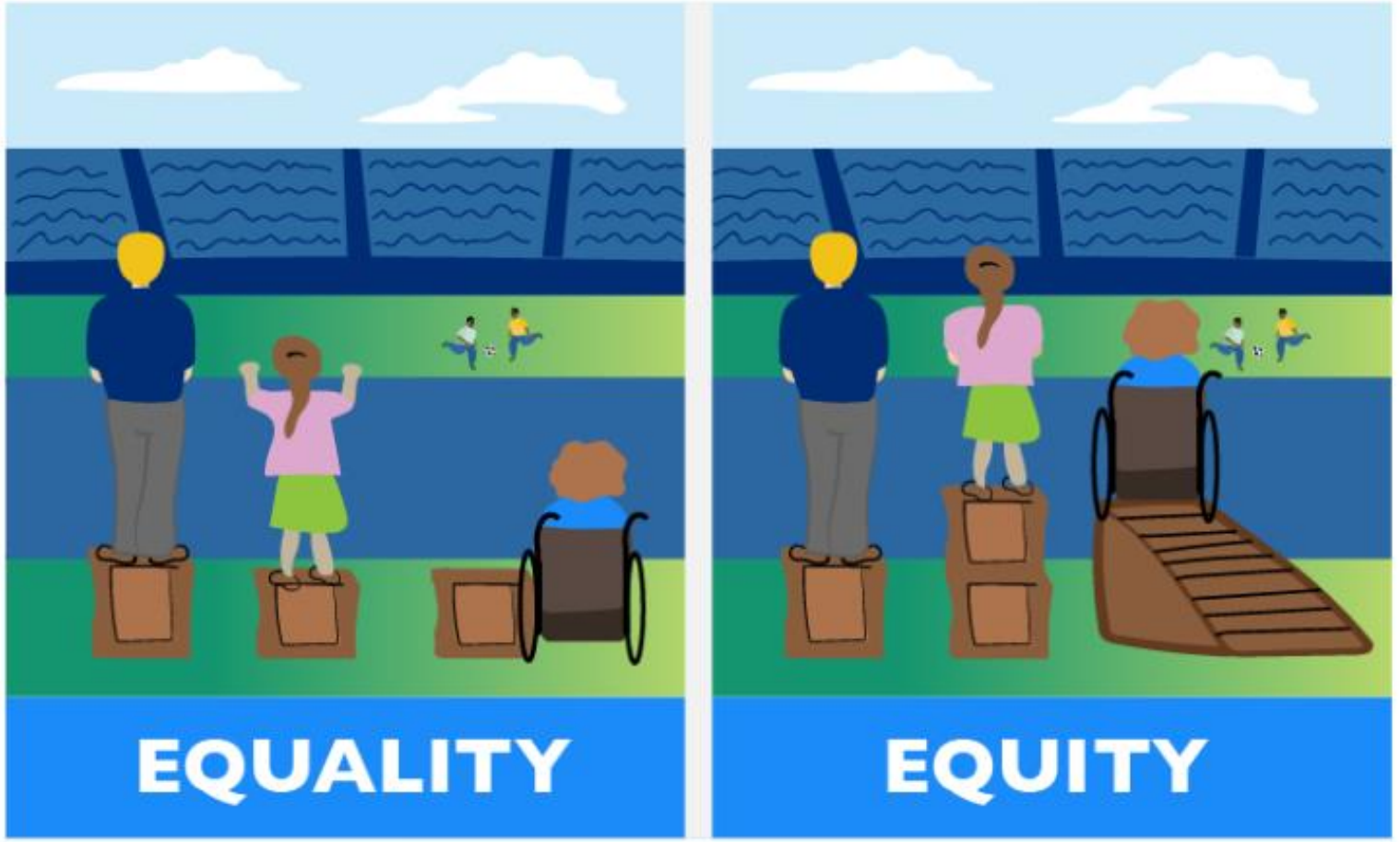
Health Equity at Kaweah Health

- What is Health Equity?
- Growing regulatory requirements
- Health Equity Committee
- PRAPARE Tool
- Programs at Kaweah Health that address health equity
- Grants bringing resources to directly address health equity

What is Health Equity?

Health equity is the **state in which everyone has a fair and just opportunity to attain** their highest level of health



https://www.cdc.gov/healthequity/whatis/index.html

https://www.hopkinsacg.org/health-equity-equality-and-disparities/

Health Disparities are preventable differences in health outcomes that are experienced by distinct populations.

Identifying and addressing the root causes of disparities is the work of **Health Equity**.

https://www.cdc.gov/healthequity/whatis/index.html

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Regulatory Requirements in Health Equity

CMS - Health Equity 2022-2023

- **Priority 1:** Expand the Collection, Reporting, & Analysis of Standardized Data
  - Screening for Social Drivers of Health *(process measure)*
  - Screen Positivity Rate for Social Drivers of Health *(process measure)*
    - **Required reporting period: January 1, 2024 - December 31, 2024. Submission deadline: May 15, 2025**
- **Priority 2:** Assess Causes of Disparities Within CMS Programs & Address Inequities in Policies & Operations to Close Gaps
- **Priority 3:** Build Capacity of Health Care Organizations & the Workforce to Reduce Health & Health Care Disparities
- **Priority 4:** Advance Language Access, Health Literacy, & the Provision of Culturally Tailored Services
- **Priority 5:** Increase All Forms of Accessibility to Health Care Services & Coverage

https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf

Joint Commission - NPSG 16.01.01:

"Improving health care equity for the organization's patients is a quality and safety priority"

1. Identify an individual to lead activities to improve health care equity
2. Assess the patient's health-related social needs
3. Analyze quality and safety data to identify disparities
4. Develop an action plan to improve health care equity
5. Take action when the organization does not meet the goals in its action plan
6. Inform key stakeholders about progress to improve health care equity

https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_npsg-16.pdf?db=web&hash=F4FA36C38D4D4146D38956F0392272DE

Health Care Access and Information (HCAI)

- Assembly Bill 1204 requires the Department of Health Care Access and Information (HCAI) to develop and administer a hospital equity report program to collect and post hospital equity reports

- These annual reports are required to include measures on patient access, quality, and outcomes by race, ethnicity, language, disability status, sexual orientation, gender identity, and payor as recommended by the newly created Hospital Equity Measures Advisory Committee

Kaweah's Health Equity Committee

Kaweah Health's - Health Equity Committee

- ✓ Identify an individual to lead activities to improve health care equity
- ✓ Assess the patient's health-related social needs
- ❑ Analyze quality and safety data to identify disparities
- ❑ Develop an action plan to improve health care equity
- ❑ Take action when the organization does not meet the goals in its action plan
- ❑ Inform key stakeholders about progress to improve health care equity

https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_npsg-16.pdf?db=web&hash=F4FA36C38D4D4146D38956F0392272DE

Assessing Patient Health-Related Social Needs

PRAPARE Screening Tool

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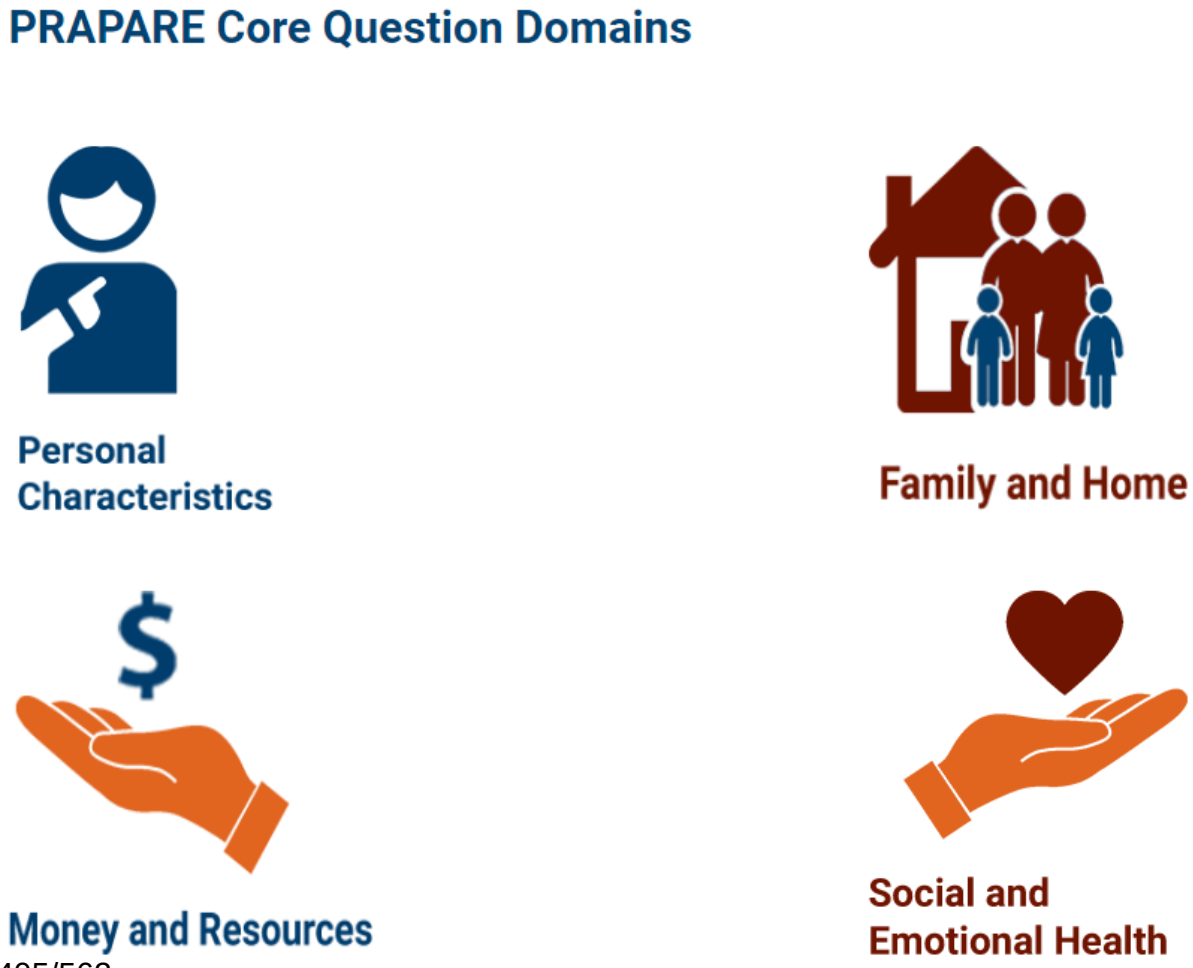
PRAPARE Screening Tool

Protocol for Responding to and Assessing Patient's Assets, Risks and Experience

- National standardized patient risk assessment tool
- Designed to engage patients in assessing & addressing Social Determinants of Health
- Standardized across ICD-10, LOINC, and SNOMED codes



https://prapare.org/what-is-prapare/

Programs at Kaweah Health that address health equity

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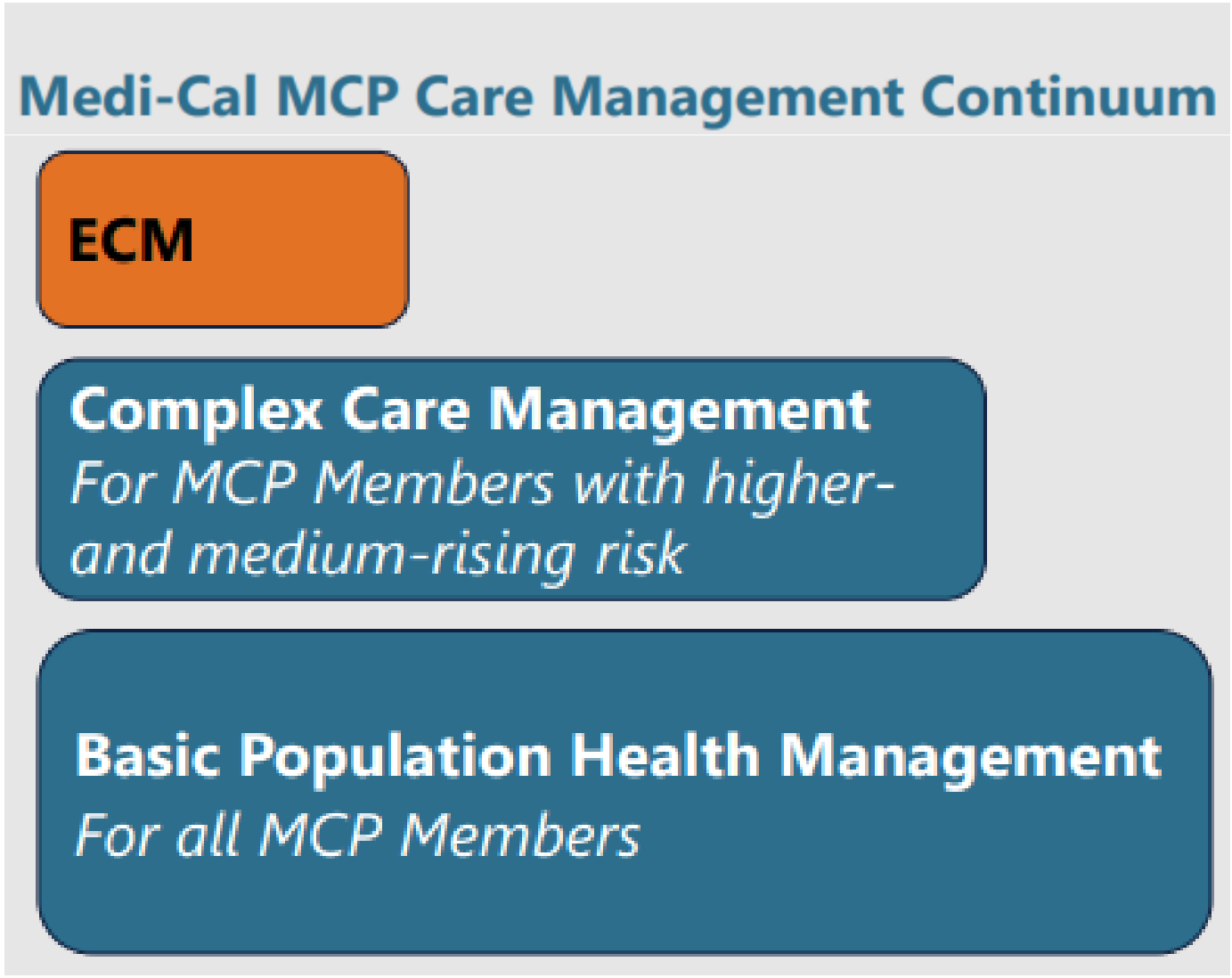
Cal AIM - Enhanced Care Management

- DHCS' vision for ECM is to **coordinate all care for eligible Members**, including **across the physical, behavioral, and dental health delivery systems**.
- ECM is interdisciplinary, high-touch, person-centered, and **provided primarily through in-person interactions** with Members where they live, seek care, or prefer to access services.
- ECM is the **highest tier of care management** for Medi-Cal MCP Members.

kaweahhealth.org



Cal AIM – Community Supports

Housing Support	Post-Acute Care Placement	Home-Based Services	Additional Services
• Housing Transition Navigation Services	• Short-Term Post-Hospitalization Housing	• Respite Services	• Day Habilitation Programs
• Housing Deposits	• Recuperative Care (Medical Respite)	• Community Transition Services/Nursing Facility Transition to a Home	• Sobering Centers
• Housing Tenancy and Sustaining Services	• Nursing Facility Transition/ Diversion to Assisted Living Facilities	• Personal Care and Homemaker Services	• Asthma Remediation
		• Environmental Accessibility Adaptations (Home Modifications)	
		• Meals/Medically Tailored Meals or Medically-Supportive Foods	

Source: California Department of Health Care Services (DHCS)

Making a Difference:
Population Health Team

2023 Journal

Monica and Joey. Unhoused for five years. Dealing with social and health-related obstacles. Veronica requires regular dialysis. Jeffrey battles depression. We were able to secure social security cards and identification for them. Placed first in a transitional housing facility (Eden House) — later to a more permanent solution at The Lofts.

Alisha. Living in a toxic environment at a room and board facility. The Kaweah Health Client Services (CS) team helped her find suitable housing. With assistance, she was able to secure her own apartment in Woodlake.

Sandra. Living on the streets. Successfully transitioned into a one-bedroom apartment. Housing opportunity was made possible through The Housing Choice Voucher program. Her new home was fully furnished through the No Place Like Home program (NPLH). Thank you NPLH!

Richard, his significant other, and two daughters — Unhoused and living in an abandoned trailer. The CS team assisted the family in securing a house and other health services. Richard and his family are now in stable housing and no longer in distress.

Jeanette, mother of four. Residing in a shelter when met by the CS team. Heather and her children are now comfortable and safe in a three-bedroom, two-bathroom apartment, fully furnished through NPLH.

Annie. Residing in her car, on a friend's couch, and in motels with her two sons. The CS team is actively working on finding housing for her. The home will be furnished by Community Services Employment Training (C-SET).

Isabel and her two daughters. At one time living in their vehicle and motels, they are now in a stable housing arrangement. Their three-bedroom, two-bathroom apartment was furnished through the support of C-SET.

Street Medicine

kaweahhealth.org

HRSA Rural Care Coordination Grant

Maternal Health- Lindsay, CA

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Award Details

- Kaweah Health is one of 10 recipients nation wide

- $1.2 million grant
  - 4 year term- $299,771 per year
    - Funds 3 FTEs (Patient Access Specialist, Community Health Worker & Data Analyst)
  - Year 1 planning

- Partnering with local organizations
  - Tulare County Women, Infants and Children (WIC)
  - Lindsay – Family Resource Center

Goals

- **Expand access** to quality and equitable care coordination to rural communities
- **Utilize innovative evidence-based**, promising practice, and/or value-based care models known or demonstrate strong evidence to improve health outcomes, and the planning and delivery of patient-centered health care services
- **Increase collaboration** among multi-sector and multidisciplinary network partnerships to address the underlying factors related to social determinants of health
- **Develop** deliberate and **sustainable strategies** of care coordination into policies, procedures, staffing, services and communication systems sustainability

Focus Area

- **Lindsay community and surrounding area**
- **Primary focus on farmworker population**

Lindsay, CA	
Population	12,000
Latino Population	86.1% (1,033)
Poverty Rate	32.6%
Little to no English speaking	2/3 of population

Health Disparities

- **Maternal Health Statistics- Farmworkers**

	Farmworker	Non-Farmworker
Miscarriage	22%	15-20%
Pre-term Birth	14%	8.8%
Low Birth Weight	15%	7%
Birth Defects	5.4%	3%

https://clc.ucmerced.edu/farmworker-health-study

Impact

Goals – Improve:

- Adherence to perinatal visits
- Identification and treatment of issues (before & after birth)
- Identification of social determinants of health (SDoH)
- Partnering to address SDoH's

Outcomes:

- Healthier moms and babies
  - Shorter hospital stays
  - Reduced NICU time
  - Decreased fetal and maternal morbidity & mortality
  - Reduced prenatal and postpartum depression
  - Reduce primary C-section rate

- Convince DHCS to add Pregnant Farmworker Women to ECM

Equity Practice Transformation (EPT) Program

DHCS

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DHCS's Equity and Practice Transformation (EPT) Program

What is it?

- One-time $700 million funding opportunity over 5 years to help primary care practices invest in care transformation programs to *"advance health equity and reduce COVID-19-driven care disparities"*
- Level of funding is directly determined by:
  - Number of assigned Medi-Cal primary care lives
  - Number of categories organization commits to completing over 5 years
- EPT categories have defined milestones
- Total eligible funding is evenly divided by number of categories and number of milestones
- When milestone is completed, funding amount is drawn down bi-annually
- DHCS has delegated administration of the program to the MCP's (HealthNet is our administrator)

DHCS's Equity and Practice Transformation (EPT) Program

- Over 700 organizations applied and only 200 were awarded
- Kaweah Health was notified on 1/11/2024 that we were awarded
- We applied to participate in all 8 EPT categories (3 required, 5 optional)
  - *All of which we are already doing or wanting to do*
- Population of Focus = Maternal Health
- We are eligible for $3.75M based on our assigned lives, we requested $4M
- We have 5 years (ends 12/31/2028) to close milestones and draw down funding

DHCS's Equity and Practice Transformation (EPT) Program

EPT Funding Limits Based on Medi-Cal Assigned Lives

- Maximum payment based on total assigned lives (across all Medi-Cal payor contracts) at the time of application
- Includes Medi-Medi/ Duals assigned lives

100,000+ Assigned Lives: $10,000,000 Maximum Payment
80,001-100,000 Assigned Lives: $9,000,000 Maximum Payment
60,001-80,000 Assigned Lives: $7,000,000 Maximum Payment
40,001-60,000 Assigned Lives : $5,000,000 Maximum Payment
20,001-40,000 Assigned Lives : $3,750,000 Maximum Payment
10,001-20,000 Assigned Lives: $2,250,000 Maximum Payment
5,001-10,000 Assigned Lives: $1,500,000 Maximum Payment
2,001-5,000 Assigned Lives : $1,000,000 Maximum Payment
1,001-2,000 Assigned Lives: $600,000 Maximum Payment
500-1,000 Assigned Lives: $375,000 Maximum Payment

EPT Program Categories

Required Categories

- Empanelment & Access
- Technology & Data
- Patient-Centered, Population-Based Care

Optional Categories

- Evidence-Based Models of Care
- Leadership and Culture
- Behavioral Health
- Social Health
- Value-Based Care & Alternative Payment Methodologies

The pursuit of healthiness

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CFO Financial Report

Month Ending January 2024

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Moody's Outlook Boost

On February 12th, Moody's changed our outlook from negative to stable based on our financials and stabilization of cash. While we are still at a Ba1 rating, we are encouraged that the next review we will see our outlook changed to positive and then back into investment grade ratings.

The Bond Buyer publication "*Improved financials at Kaweah Health spur Moody's rating outlook boost. Beleaguered Kaweah Health Care District in central California had its rating outlook revised to stable from negative by Moody's Investors Service, which cited significant traction by management on its financial turnaround plans.* 5 days ago"

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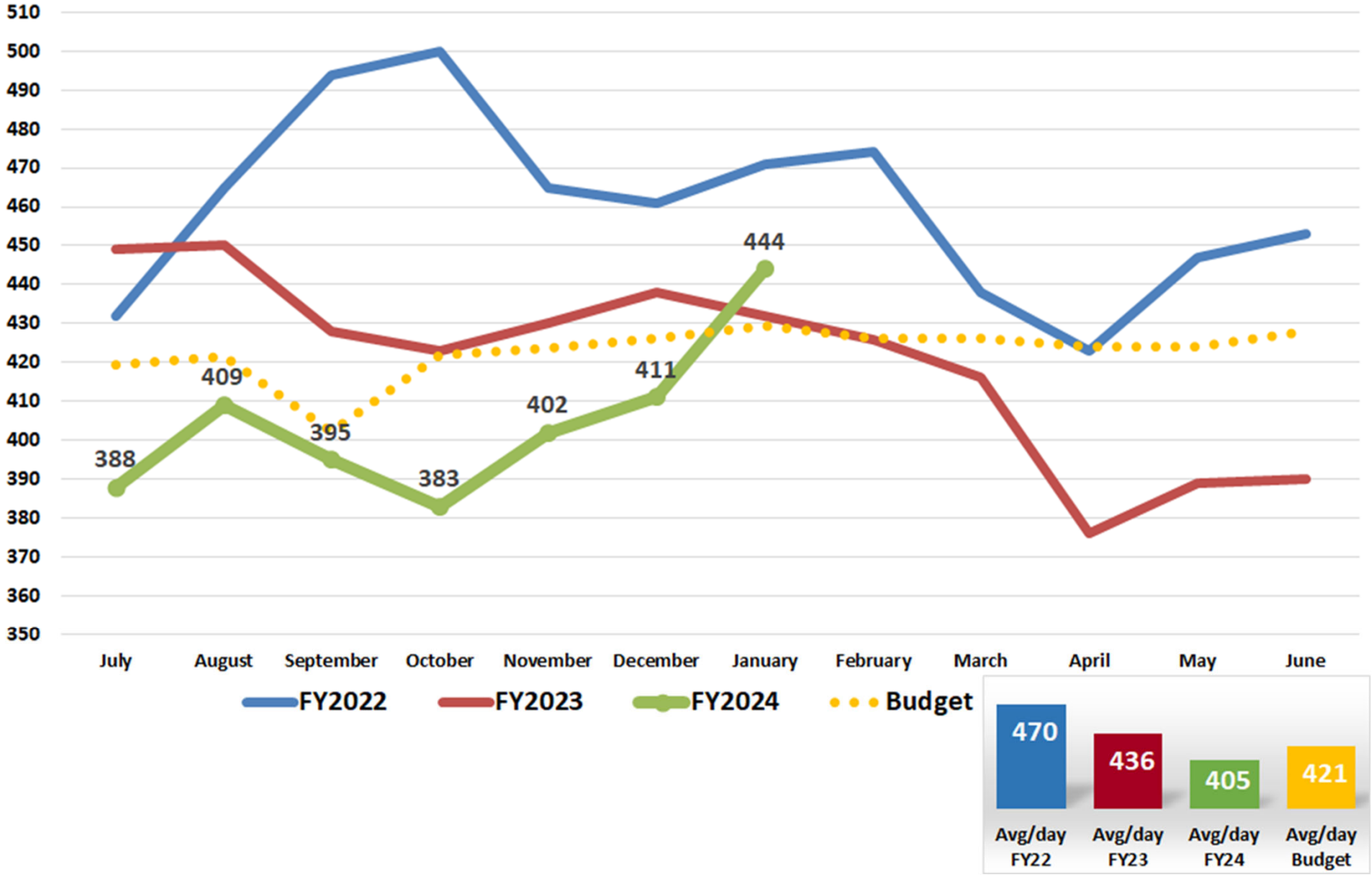
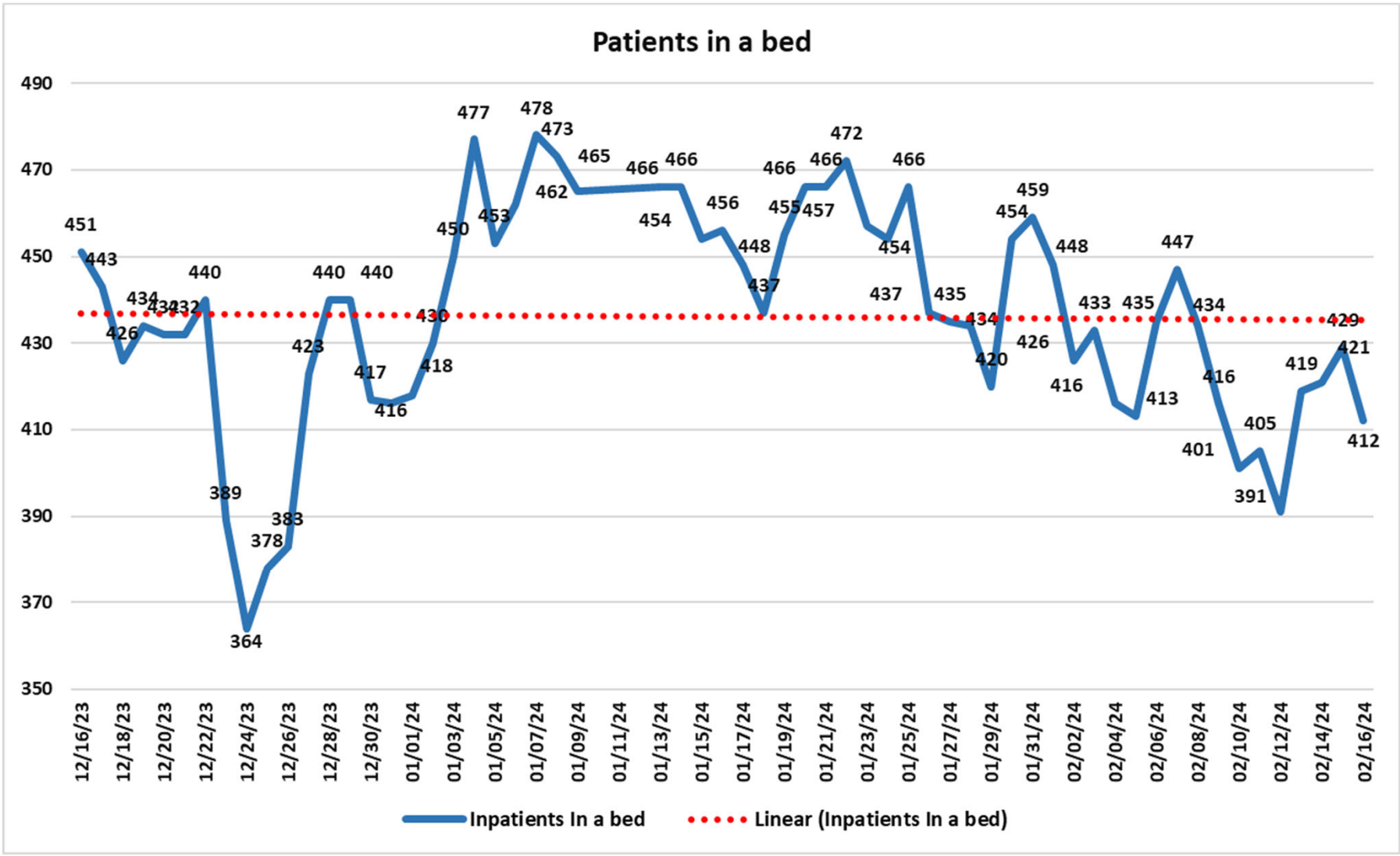
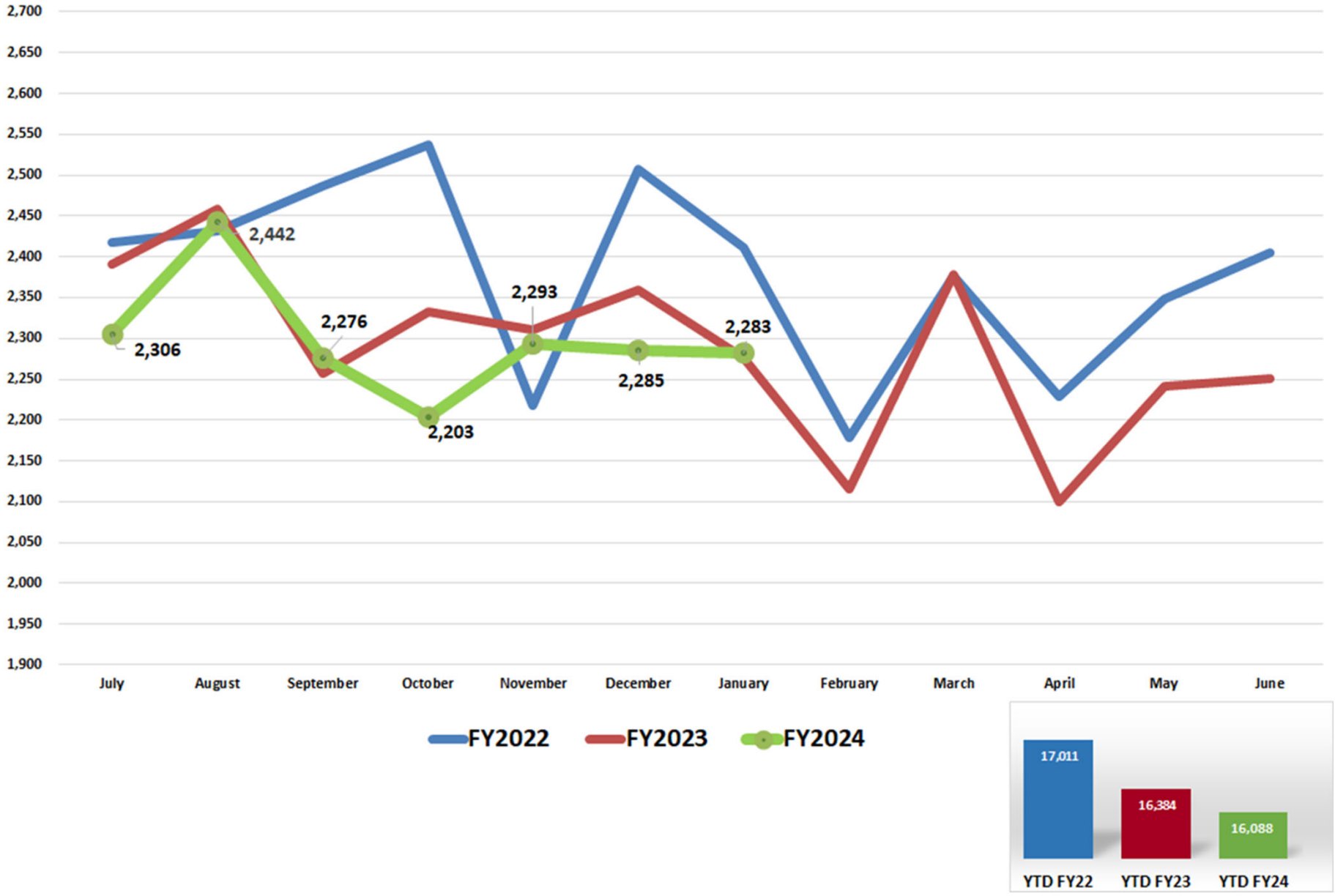
Average Daily Census



Daily Trend of Patients in a Bed



Discharges


2,700
2,650
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2,400
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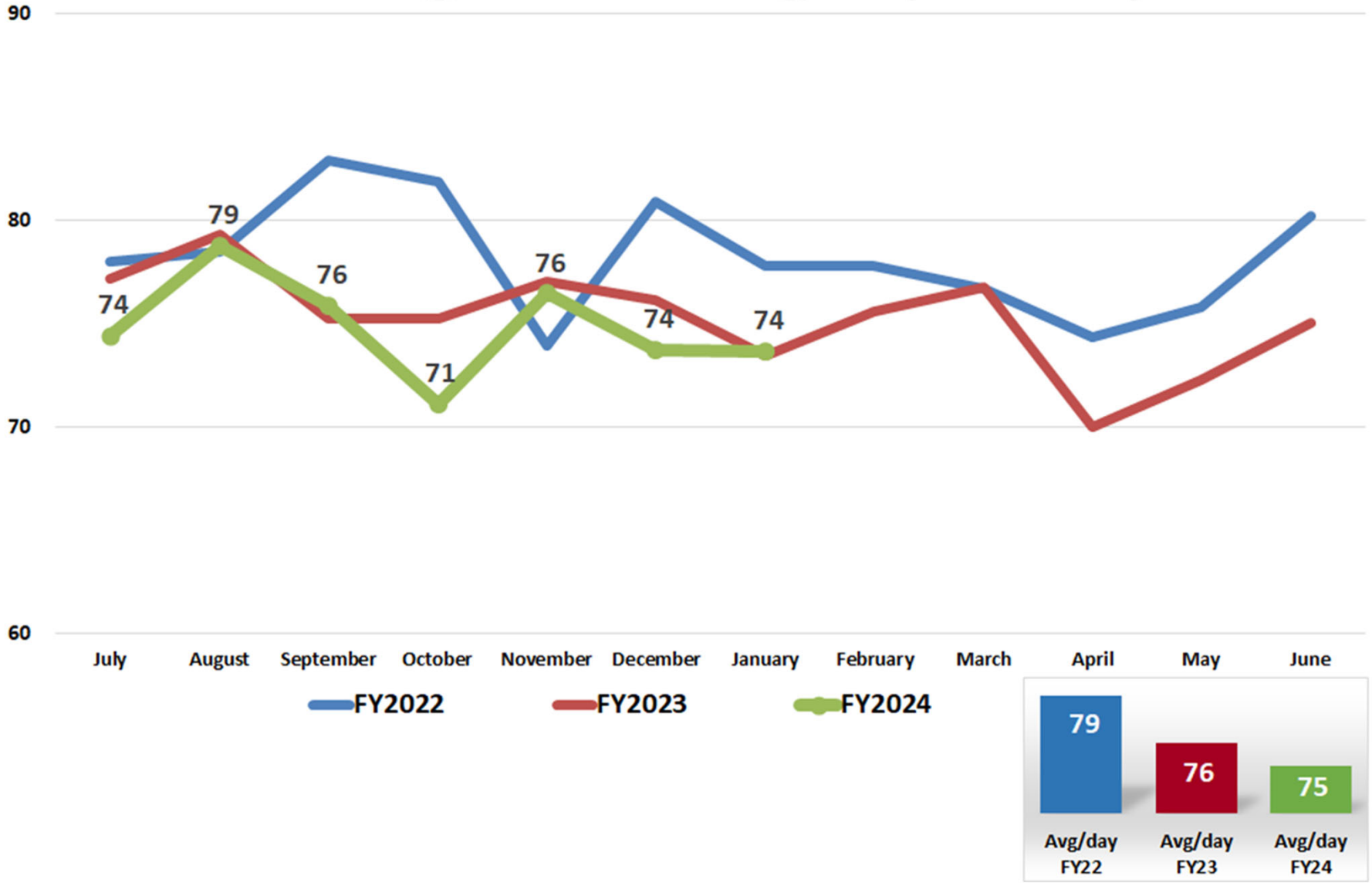
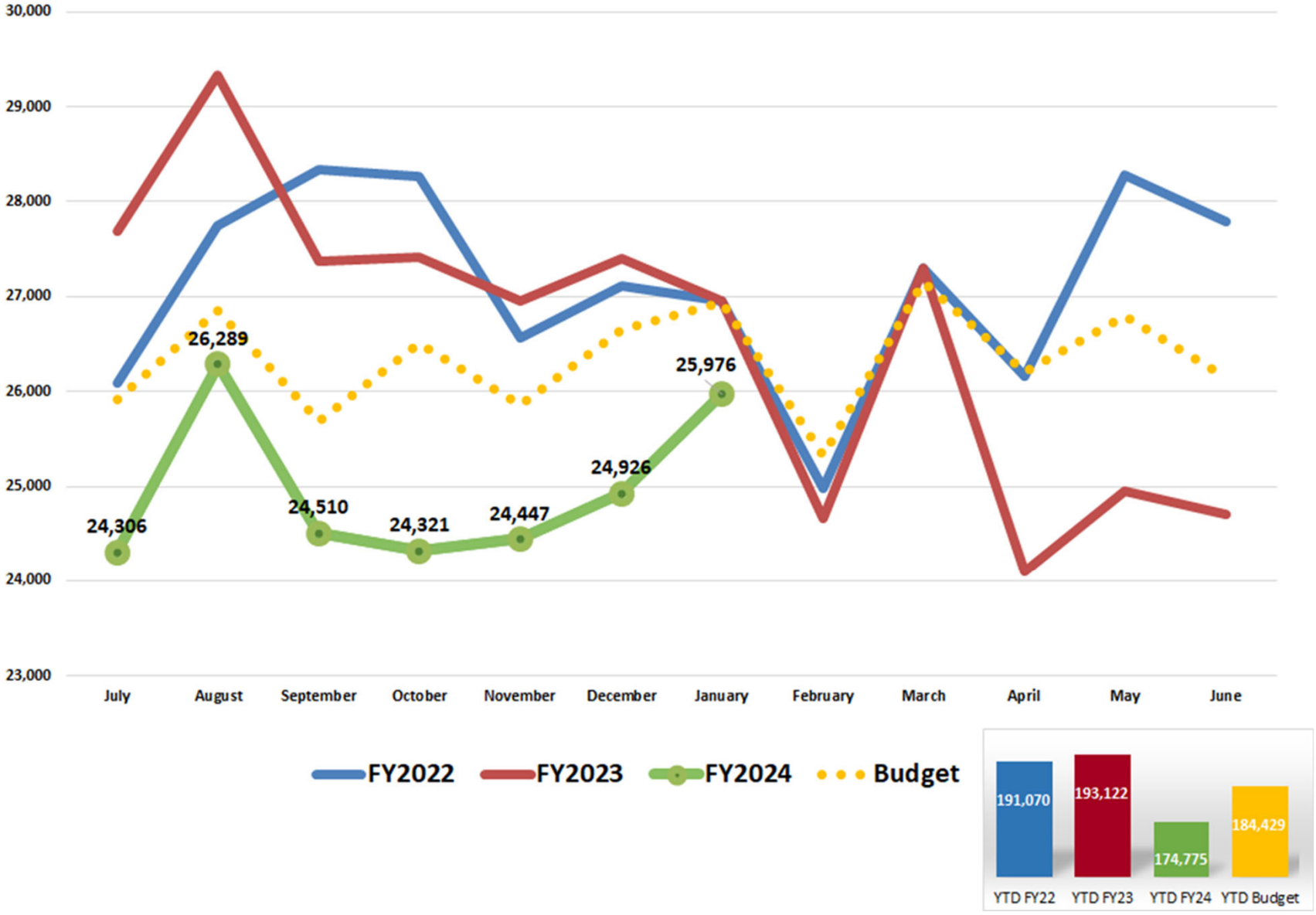
2,200
2,150
2,100
2,050
2,000
1,950
1,900
2,442
2,306
2,276
2,203
2,293
2,285
2,283
July
August
September
October
November
December
January
February
March
April
May
June
FY2022
FY2023
FY2024
17,011
16,384
16,088
YTD FY22
YTD FY23
YTD FY24

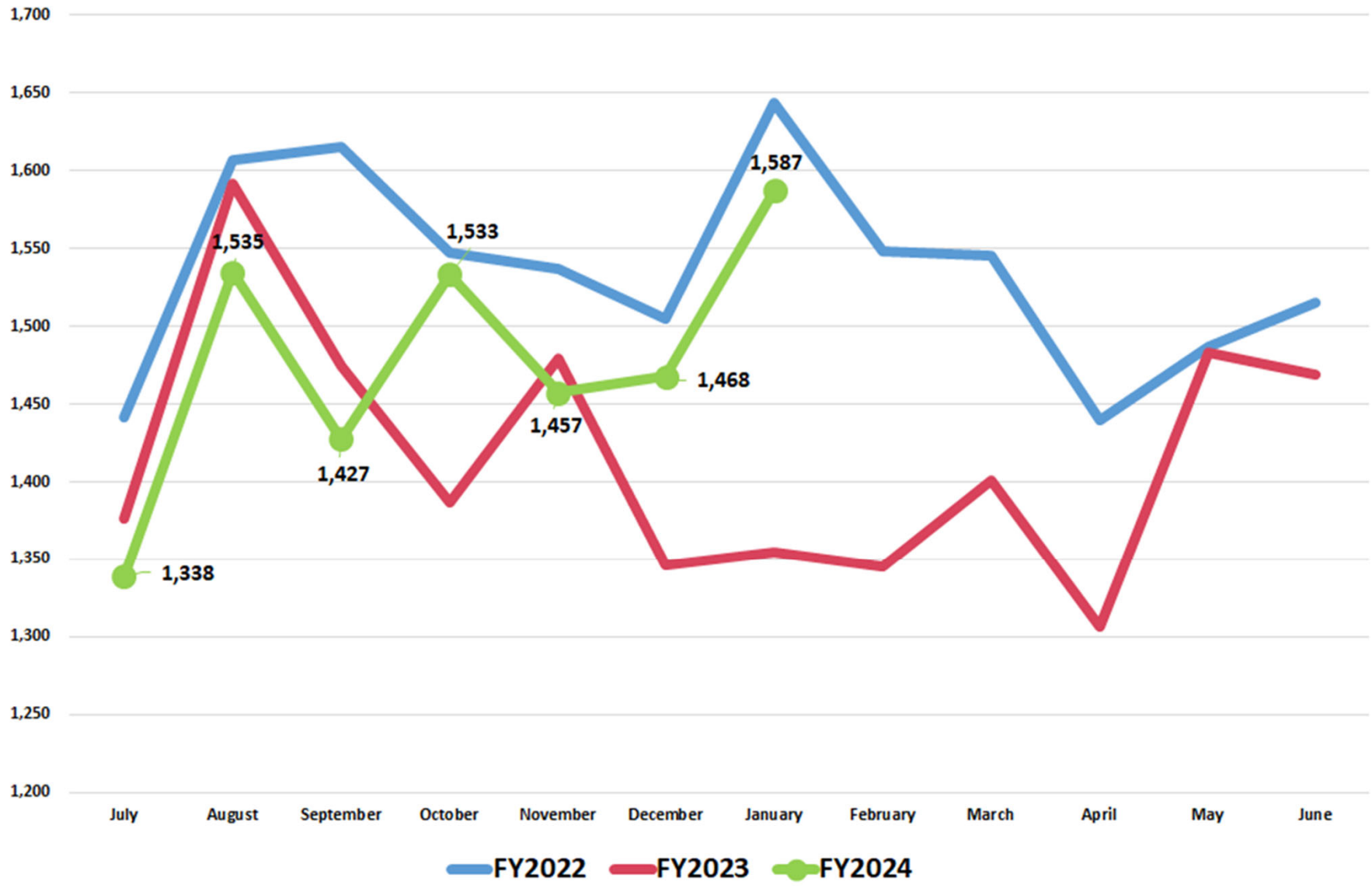
Average Discharges per day



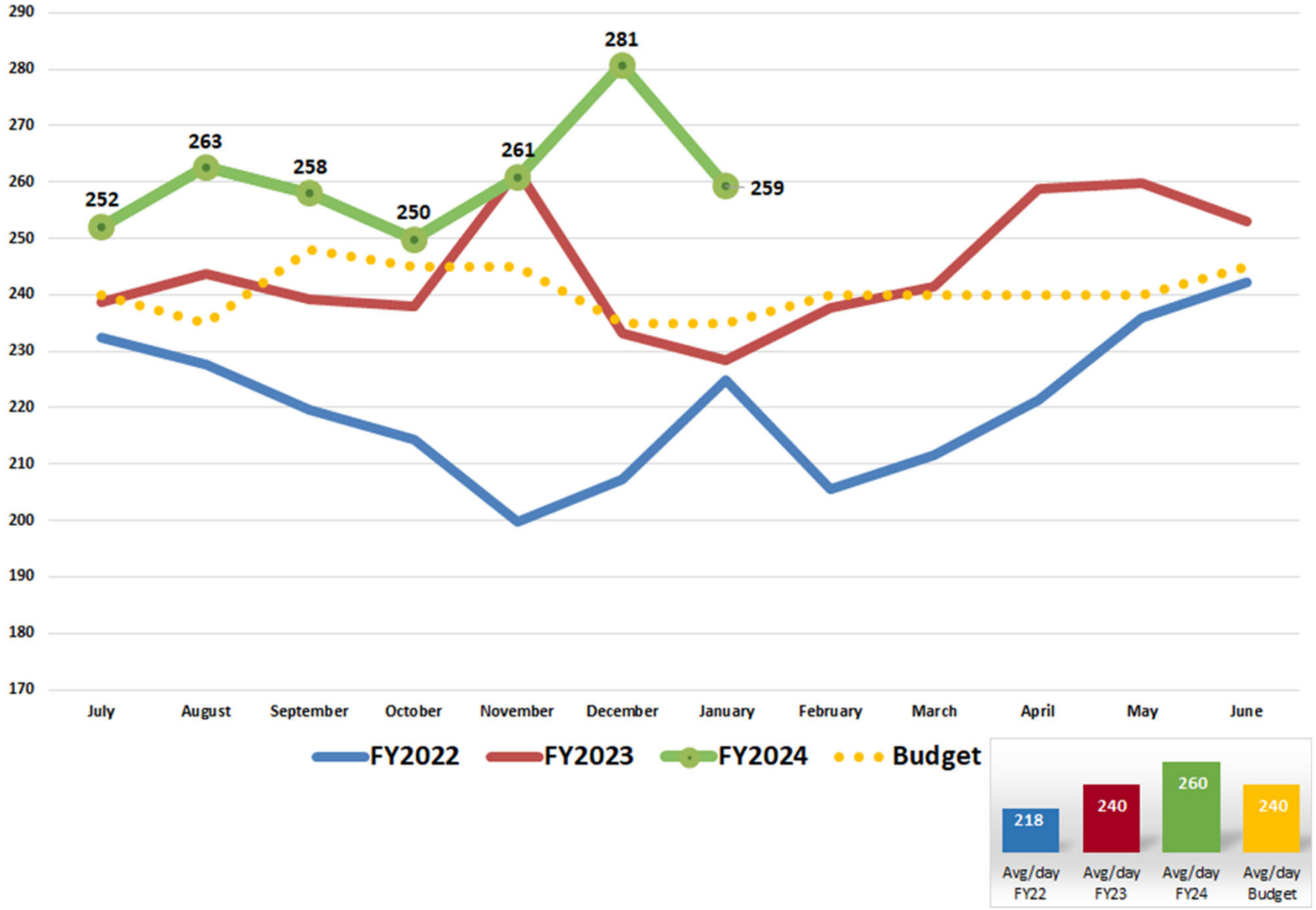
Adjusted Patient Days



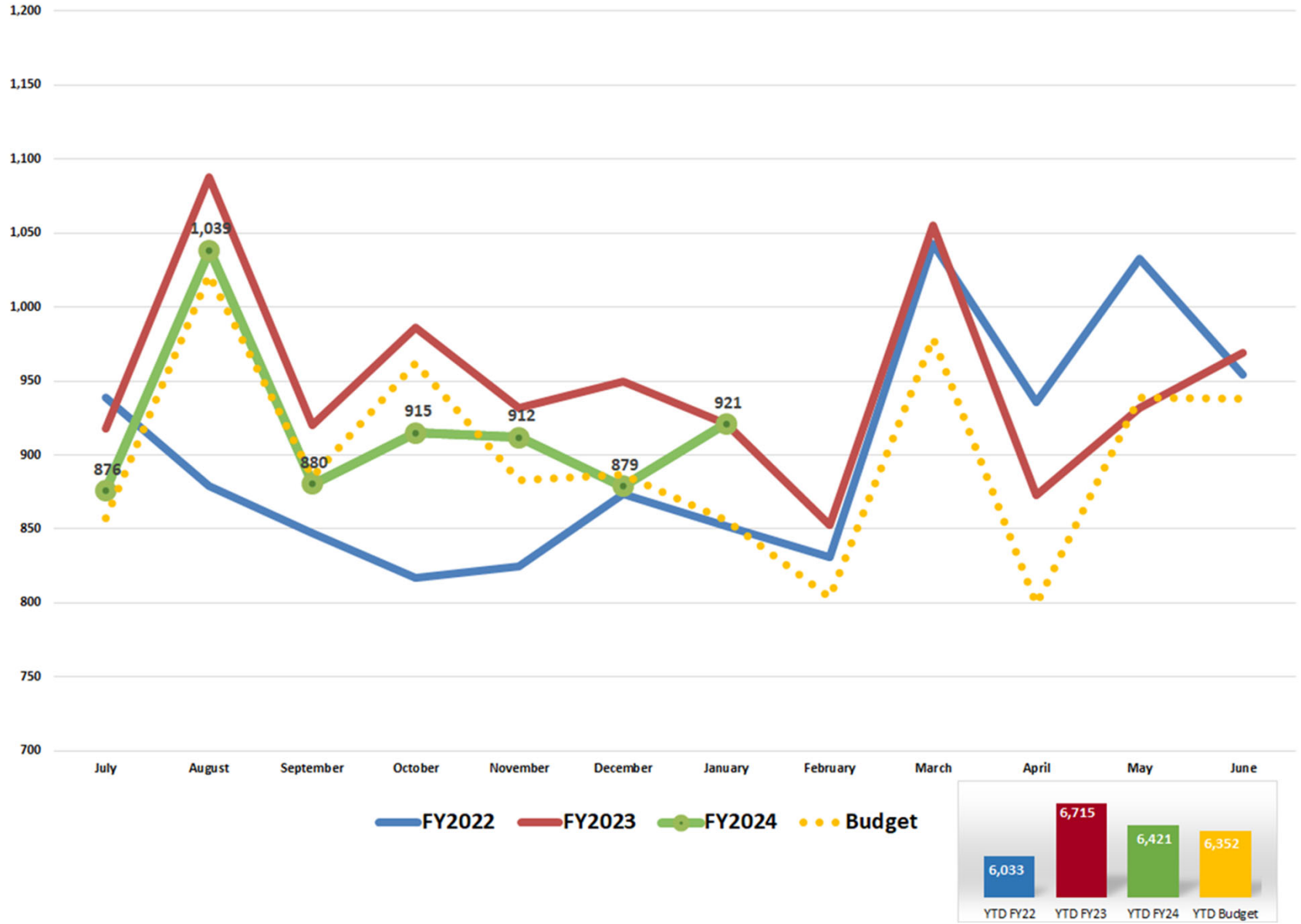
Outpatient Registrations Per Day



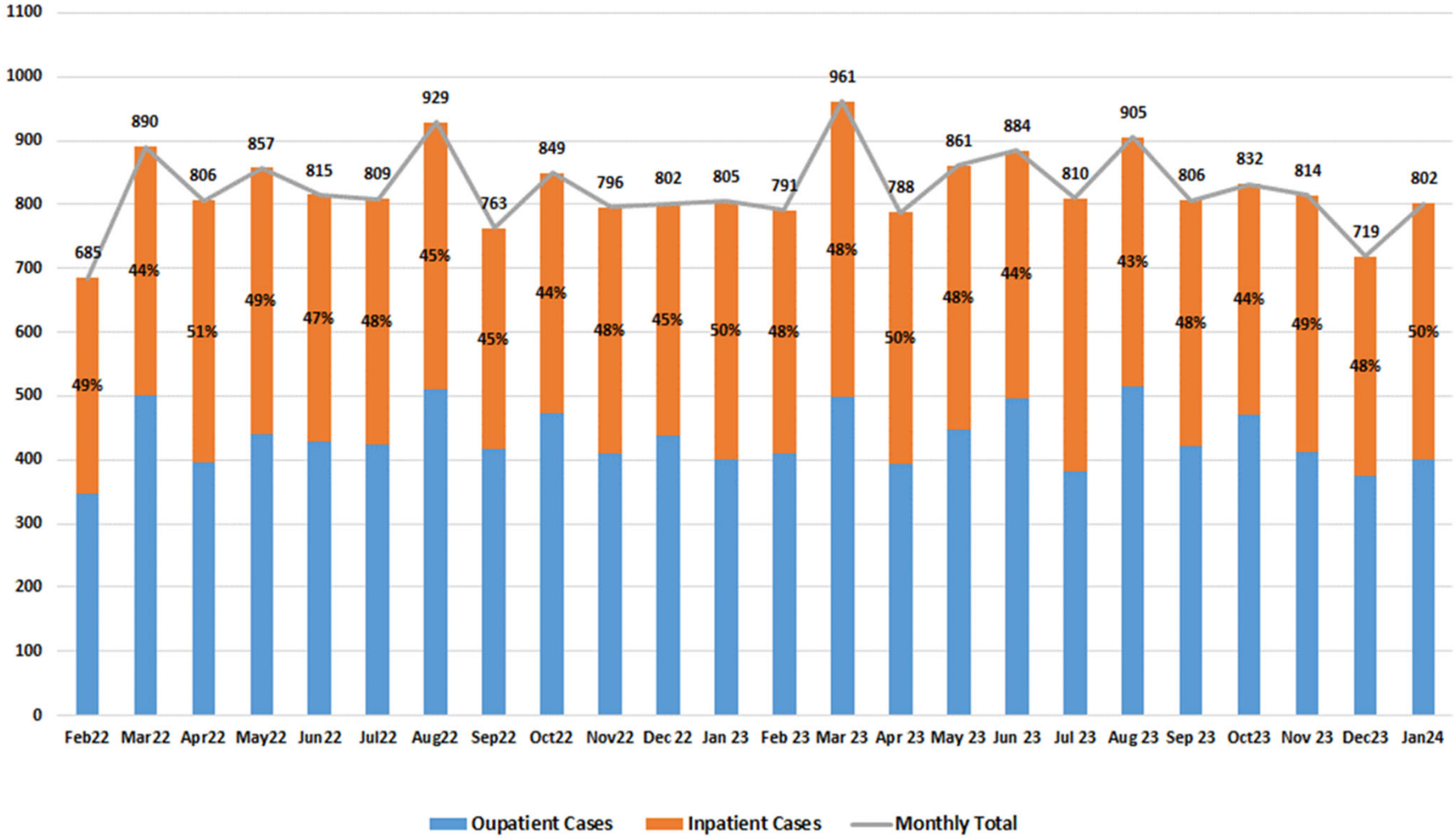
ED - Avg Treated Per Day



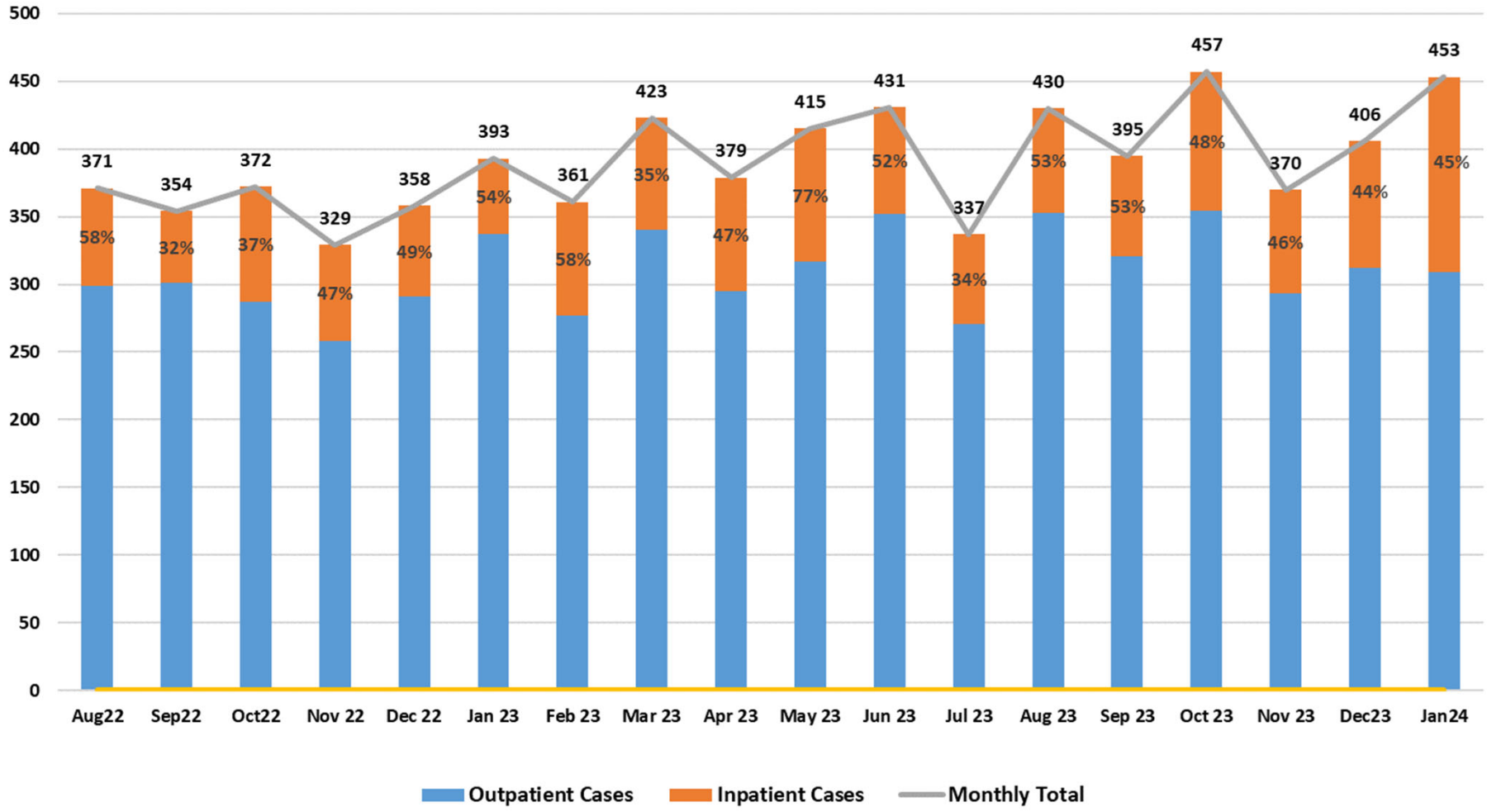
Surgery (IP & OP) – 100 Min Units



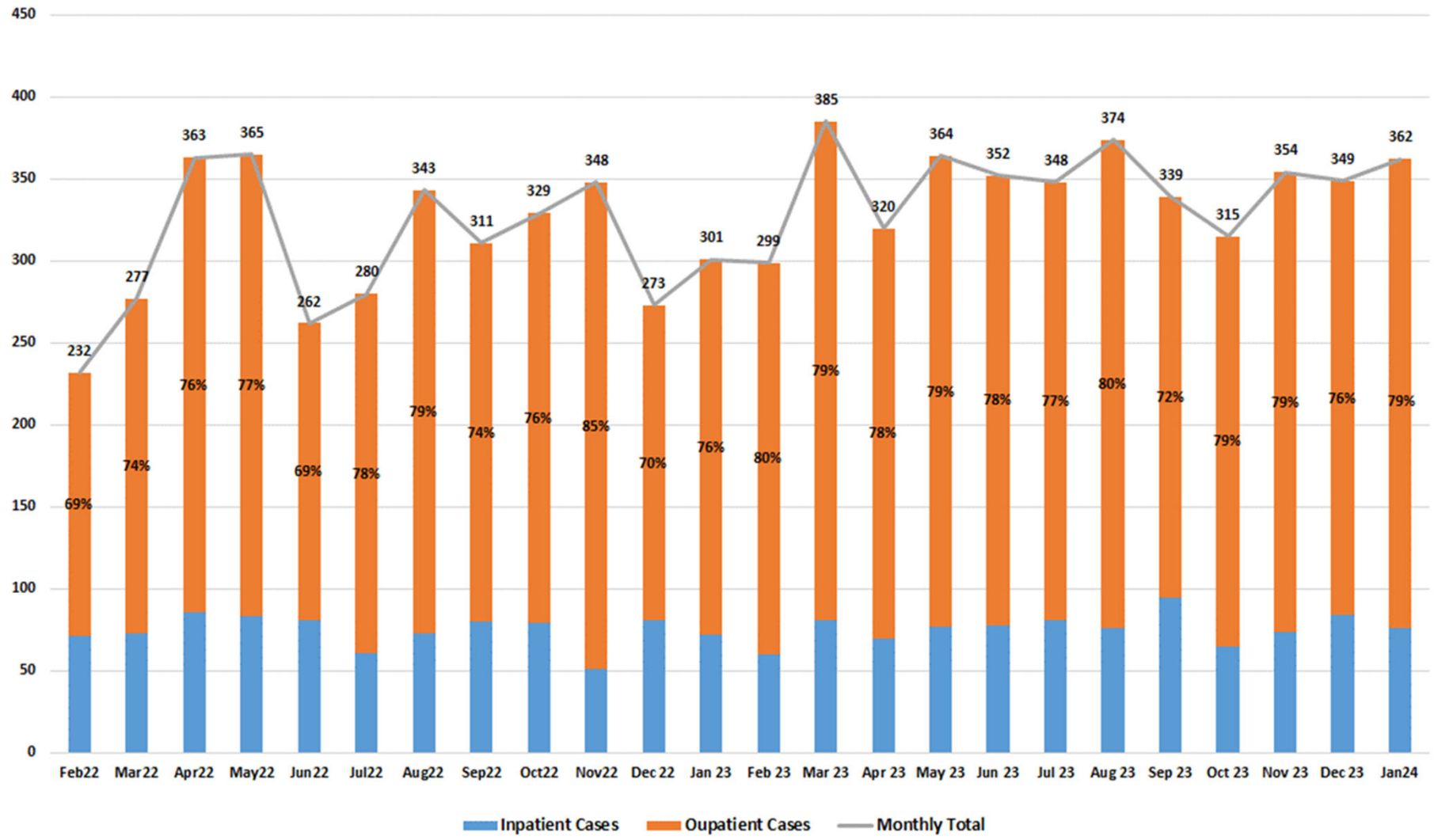
Surgery Cases (IP & OP)



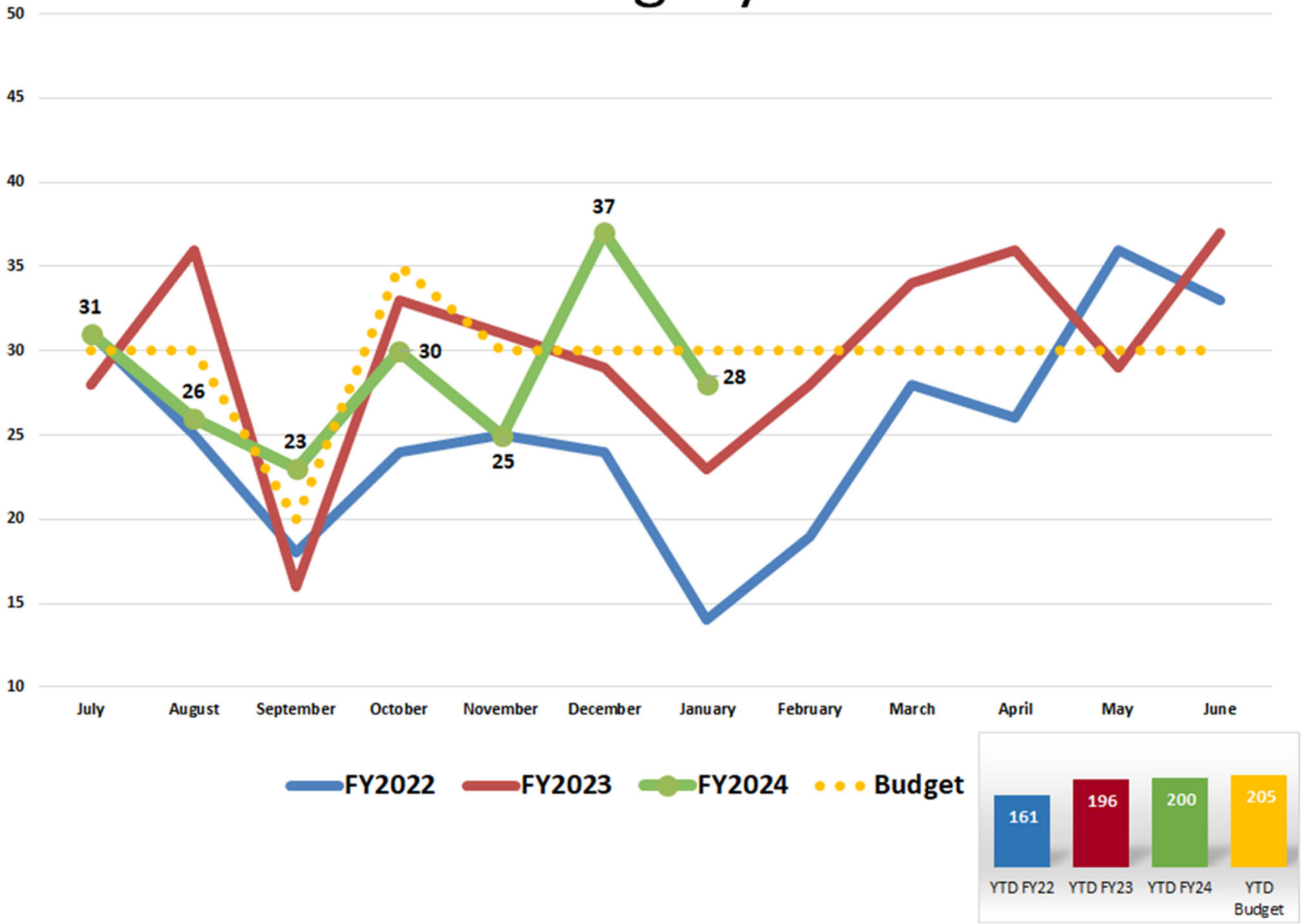
Cath Lab Patients (IP & OP) REVISED



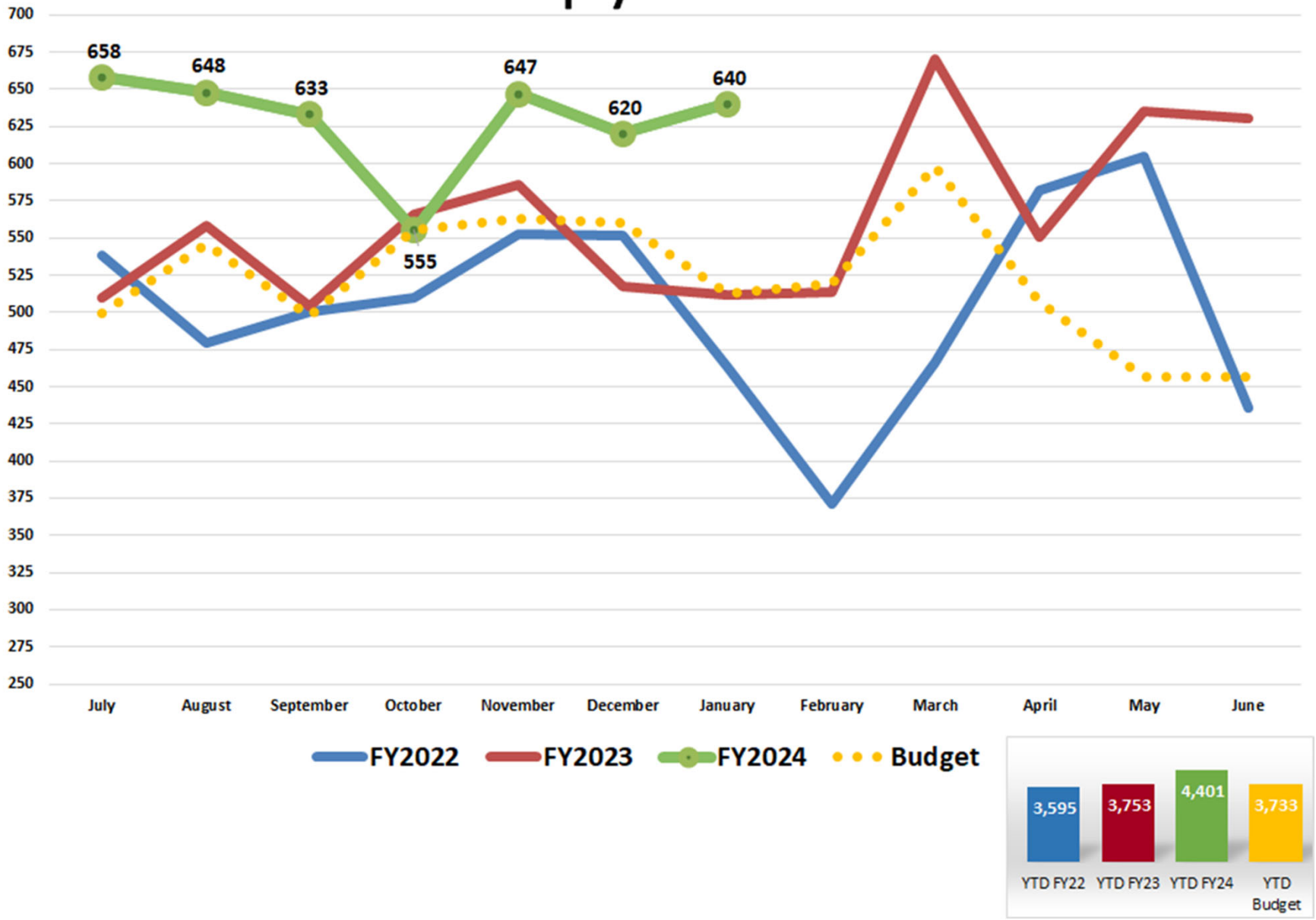
Endo Cases (Endo Suites)



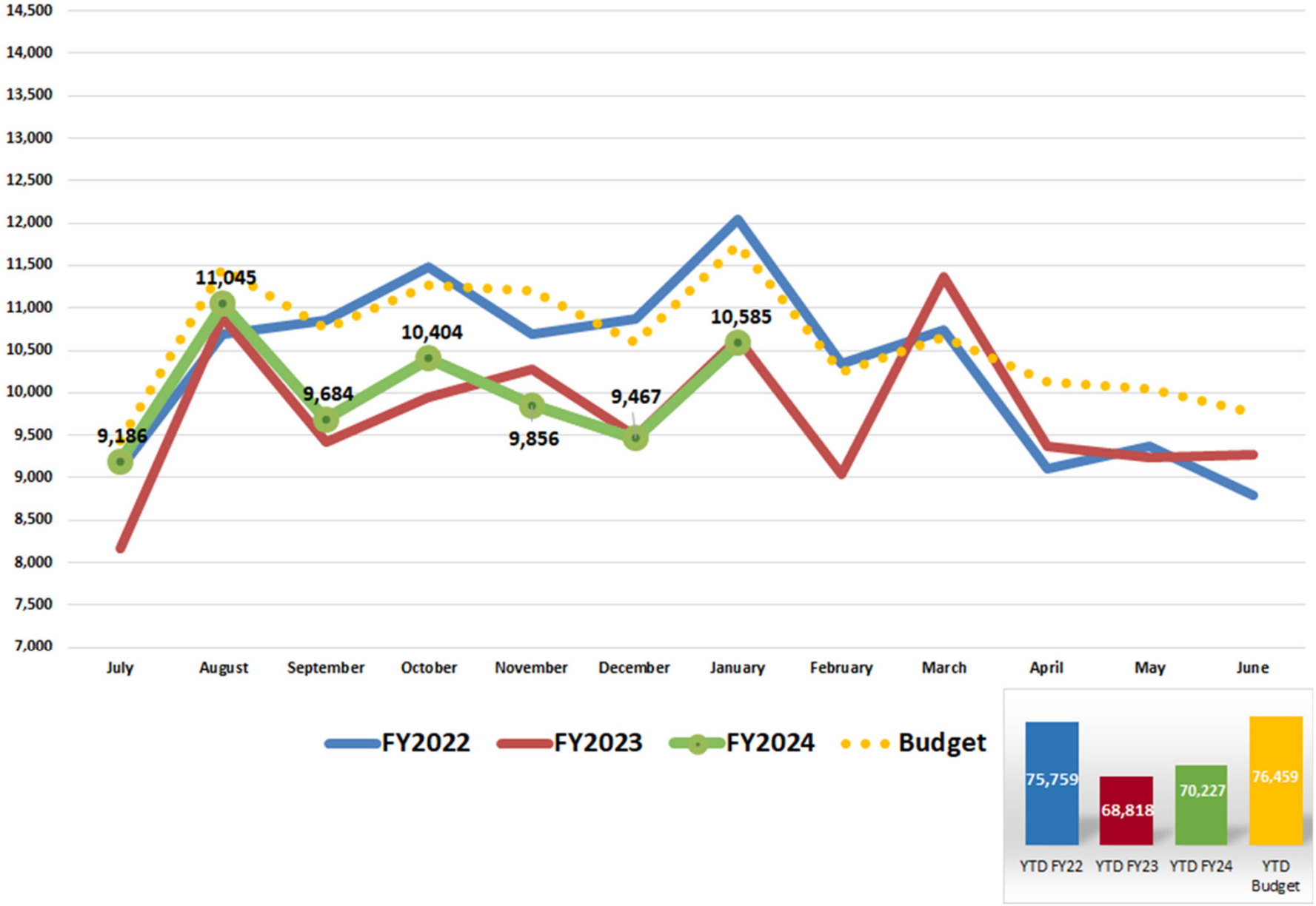
Cardiac Surgery Cases

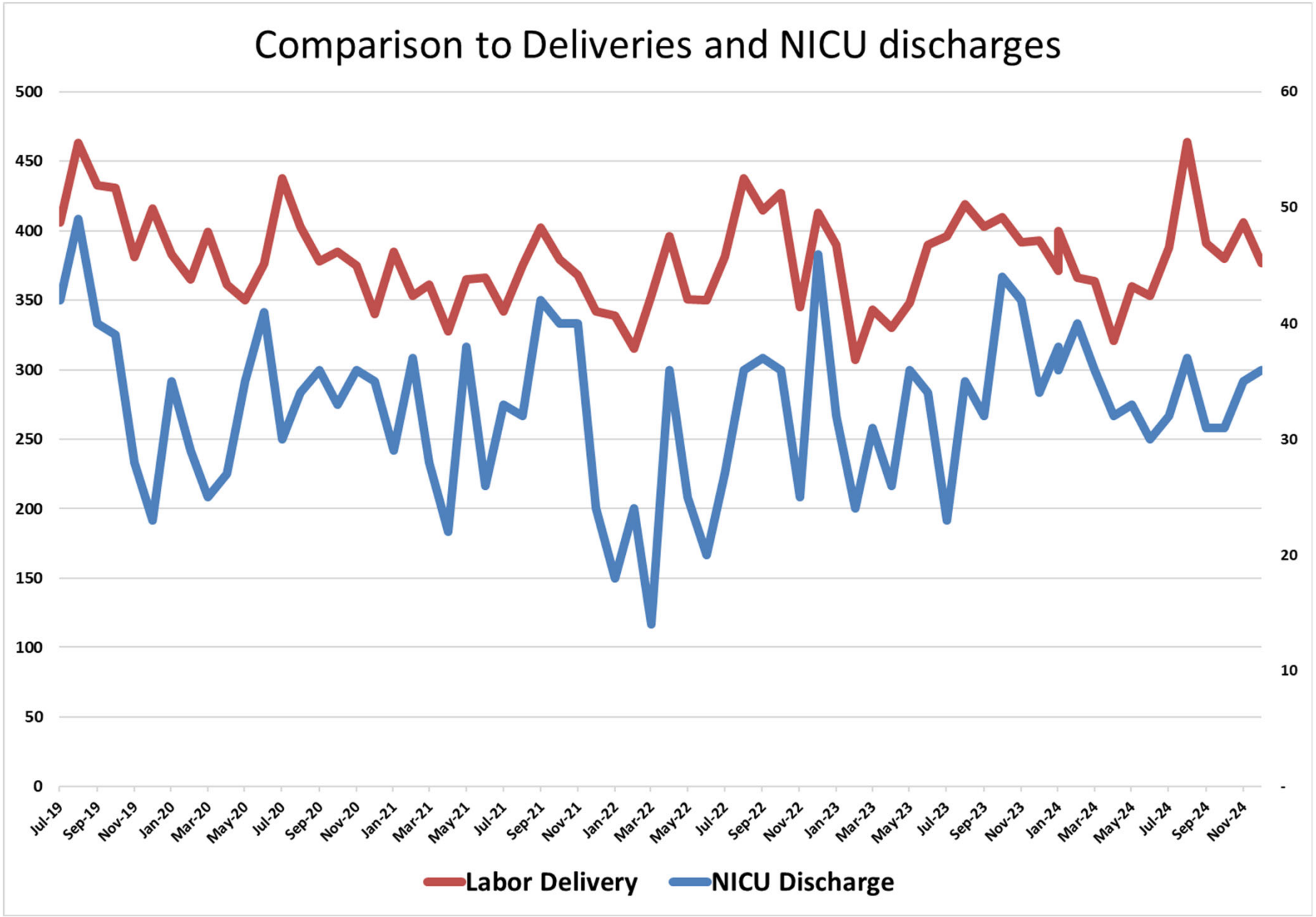


Endoscopy Procedures



Rural Health Clinics Registrations




Comparison to Deliveries and NICU discharges
500
450
400
350
300
250
200
150
100
50
0
60
50
40
30
20
10
-
Jul-19
Sep-19
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Nov-22
Jan-23
Mar-23
May-23
Jul-23
Sep-23
Nov-23
Jan-24
Mar-24
May-24
Jul-24
Sep-24
Nov-24
Labor Delivery
NICU Discharge

Statistical Results – Fiscal Year Comparison (Jan)

	Actual Results			Budget	Budget Variance	
	Jan 2023	Jan 2024	% Change	Jan 2024	Change	% Change
Average Daily Census	**432**	**444**	**2.7%**	**429**	**15**	**3.4%**
KDHCD Patient Days:						
Medical Center	9,227	9,650	4.6%	9,079	571	6.3%
Acute I/P Psych	1,339	1,340	0.1%	1,395	(55)	(3.9%)
Sub-Acute	925	945	2.2%	955	(10)	(1.0%)
Rehab	526	631	20.0%	532	99	18.6%
TCS-Ortho (Short Stay Rehab)	398	313	(21.4%)	415	(102)	(24.6%)
NICU	532	373	(29.9%)	461	(88)	(19.1%)
Nursery	449	512	14.0%	477	35	7.3%
Total KDHCD Patient Days	**13,396**	**13,764**	**2.7%**	**13,314**	**450**	**3.4%**
Total Outpatient Volume	**42,005**	**49,197**	**17.1%**	**42,641**	**6,556**	**15.4%**

Statistical Results – Fiscal Year Comparison (Jul-Jan)

	Actual Results			Budget	Budget Variance	
	FYTD 2023	FYTD 2024	% Change	FYTD 2024	Change	% Change
Average Daily Census	**435**	**405**	**(7.0%)**	**423**	**(18)**	**(4.2%)**
KDHCD Patient Days:						
Medical Center	62,550	58,610	(6.3%)	60,932	(2,322)	(3.8%)
Acute I/P Psych	9,170	9,174	0.0%	9,720	(546)	(5.6%)
Sub-Acute	6,325	6,553	3.6%	6,248	305	4.9%
Rehab	3,771	3,771	0.0%	4,122	(351)	(8.5%)
TCS-Ortho (Short Stay Rehab)	2,703	2,399	(11.2%)	2,864	(465)	(16.2%)
TCS	2,115	0	(100.0%)	0	0	0.0%
NICU	3,313	2,941	(11.2%)	3,324	(383)	(11.5%)
Nursery	3,602	3,568	(0.9%)	3,649	(81)	(2.2%)
Total KDHCD Patient Days	**93,549**	**87,016**	**(7.0%)**	**90,859**	**(3,843)**	**(4.2%)**
Total Outpatient Volume	**307,356**	**317,811**	**3.4%**	**295,734**	**22,077**	**7.5%**

Other Statistical Results – Fiscal Year Comparison (Jan)

	Actual Results				Budget	Budget Variance	
	Jan 2023	Jan 2024	Change	% Change	Jan 2024	Change	% Change
Adjusted Patient Days	**27,042**	**25,976**	**(1,066)**	**(3.9%)**	**26,938**	**(962)**	**(3.6%)**
Outpatient Visits	**42,005**	**49,197**	**7,192**	**17.1%**	**42,641**	**6,556**	**15.4%**
Endoscopy Procedures (I/P & O/P)	512	640	128	**25.0%**	513	127	**24.8%**
ED Total Registered	7,142	8,200	1,058	**14.8%**	7,284	916	**12.6%**
Radiology/CT/US/MRI Proc (I/P & O/P)	16,433	18,640	2,207	**13.4%**	16,683	1,957	**11.7%**
Infusion Center	387	425	38	**9.8%**	475	(50)	**(10.5%)**
Radiation Oncology Treatments (I/P & O/P)	1,731	1,880	149	**8.6%**	2,022	(142)	**(7.0%)**
OB Deliveries	371	400	29	**7.8%**	380	20	**5.3%**
Urgent Care - Court	3,184	3,315	131	**4.1%**	4,130	(815)	**(19.7%)**
Physical & Other Therapy Units	17,989	18,590	601	**3.3%**	19,313	(723)	**(3.7%)**
O/P Rehab Units	19,391	19,945	554	**2.9%**	20,542	(597)	**(2.9%)**
Surgery Minutes-General & Robotic (I/P & O/P)	933	945	12	**1.3%**	935	10	**1.1%**
RHC Registrations	10,643	10,585	(58)	**(0.5%)**	11,745	(1,160)	**(9.9%)**
Urgent Care - Demaree	2,484	2,428	(56)	**(2.3%)**	2,684	(256)	**(9.5%)**
Cath Lab Minutes (IP & OP)	333	312	(21)	**(6.3%)**	374	(62)	**(16.6%)**
Home Health Visits	3,256	3,032	(224)	**(6.9%)**	3,215	(183)	**(5.7%)**
Hospice Days	3,617	3,258	(359)	**(9.9%)**	3,796	(538)	**(14.2%)**
Dialysis Treatments	1,764	1,567	(197)	**(11.2%)**	1,550	17	**1.1%**

Other Statistical Results – Fiscal Year Comparison (Jul-Jan)

	Actual Results				Budget	Budget Variance	
	FY 2023	FY 2024	Change	% Change	FY 2024	Change	% Change
Adjusted Patient Days	**193,292**	**174,775**	**(18,517)**	**(9.6%)**	**184,429**	**(9,654)**	**(5.2%)**
Outpatient Visits	**307,356**	**317,811**	**10,455**	**3.4%**	**295,734**	**22,077**	**7.5%**
Endoscopy Procedures (I/P & O/P)	3,753	4,401	648	**17.3%**	3,733	668	**17.9%**
Infusion Center	2,325	2,719	394	**16.9%**	2,771	(52)	**(1.9%)**
ED Total Registered	52,295	56,759	4,464	**8.5%**	51,679	5,080	**9.8%**
Radiology/CT/US/MRI Proc (I/P & O/P)	115,757	122,610	6,853	**5.9%**	116,339	6,271	**5.4%**
O/P Rehab Units	130,634	137,538	6,904	**5.3%**	136,587	951	**0.7%**
Home Health Visits	20,894	21,604	710	**3.4%**	21,788	(184)	**(0.8%)**
RHC Registrations	68,818	70,227	1,409	**2.0%**	76,459	(6,232)	**(8.2%)**
OB Deliveries	2,784	2,806	22	**0.8%**	2,798	8	**0.3%**
Hospice Days	25,620	25,645	25	**0.1%**	26,332	(687)	**(2.6%)**
Dialysis Treatments	10,611	10,611	0	**0.0%**	10,850	(239)	**(2.2%)**
Cath Lab Minutes (IP & OP)	2,194	2,167	(27)	**(1.2%)**	2,472	(305)	**(12.3%)**
Physical & Other Therapy Units	124,258	119,938	(4,320)	**(3.5%)**	133,135	(13,197)	**(9.9%)**
Radiation Oncology Treatments (I/P & O/P)	12,778	12,119	(659)	**(5.2%)**	14,714	(2,595)	**(17.6%)**
Surgery Minutes-General & Robotic (I/P & O/P)	7,475	6,758	(717)	**(9.6%)**	6,884	(126)	**(1.8%)**
Urgent Care - Demaree	20,592	15,389	(5,203)	**(25.3%)**	19,592	(4,203)	**(21.5%)**
Urgent Care - Court	31,092	22,397	(8,695)	**(28.0%)**	30,336	(7,939)	**(26.2%)**

January Financial Comparison without KHMG (000's)

	Without KHMG Comparison to Budget - Month of January				Without KHMG Comparison to Prior Year - Month of January			
	Budget Jan-2024	Actual Jan-2024	$ Change	% Change	Jan-2023	Jan-24	$ Change	% Change
Operating Revenue								
Net Patient Service Revenue	**$50,618**	**$49,472**	**($1,145)**	**-2.3%**	**$47,029**	**$49,472**	**$2,444**	**4.9%**
Supplemental Gov't Programs	$6,483	$8,780	$2,297	26.2%	$6,060	$8,780	$2,720	31.0%
Prime Program	$835	$2,459	$1,624	66.0%	$743	$2,459	$1,717	69.8%
Premium Revenue	$7,931	$6,754	($1,177)	-17.4%	$6,336	$6,754	$417	6.2%
Management Services Revenue	$3,439	$3,756	$317	8.4%	$3,294	$3,756	$462	12.3%
Other Revenue	$2,489	$2,630	$141	5.4%	$3,256	$2,630	($626)	-23.8%
Other Operating Revenue	$21,176	$24,379	$3,203	13.1%	$19,689	$24,379	$4,690	19.2%
Total Operating Revenue	**$71,794**	**$73,851**	**$2,057**	**2.8%**	**$66,717**	**$73,851**	**$7,134**	**9.7%**
Operating Expenses								
Salaries & Wages	$29,480	$29,705	$225	0.8%	$27,275	$29,705	$2,430	8.2%
Contract Labor	$1,373	$1,780	$407	22.9%	$2,215	$1,780	($434)	-24.4%
Employee Benefits	$6,815	$6,160	($655)	-10.6%	$6,423	$6,160	($263)	-4.3%
Total Employment Expenses	**$37,669**	**$37,645**	**($23)**	**-0.1%**	**$35,912**	**$37,645**	**$1,733**	**4.6%**
Medical & Other Supplies	$13,270	$14,980	$1,710	11.4%	$12,621	$14,980	$2,358	15.7%
Physician Fees	$6,665	$7,558	$893	11.8%	$6,254	$7,558	$1,305	17.3%
Purchased Services	$1,519	$1,709	$190	11.1%	$1,471	$1,709	$239	14.0%
Repairs & Maintenance	$2,371	$2,964	$593	20.0%	$2,150	$2,964	$815	27.5%
Utilities	$893	$831	($62)	-7.5%	$806	$831	$25	3.0%
Rents & Leases	$165	$140	($25)	-18.0%	$120	$140	$20	14.2%
Depreciation & Amortization	$2,914	$2,890	($23)	-0.8%	$2,922	$2,890	($31)	-1.1%
Interest Expense	$587	$603	$16	2.6%	$607	$603	($4)	-0.7%
Other Expense	$2,187	$1,315	($872)	-66.3%	$1,890	$1,315	($575)	-43.7%
Humana Cap Plan Expenses	$3,701	$2,751	($950)	-34.5%	$3,674	$2,751	($922)	-33.5%
Total Other Expenses	**$34,273**	**$35,742**	**$1,469**	**4.1%**	**$32,514**	**$35,742**	**$3,228**	**9.0%**
Total Operating Expenses	**$71,942**	**$73,388**	**$1,446**	**2.0%**	**$68,426**	**$73,388**	**$4,961**	**6.8%**
Operating Margin	**($148)**	**$464**	**$611**		**($1,709)**	**$464**	**$2,172**	
Stimulus/FEMA	**$1,610**	**$0**	**($1,610)**		**$190**	**$0**	**($190)**	
Operating Margin after Stimulus/FEMA	**$1,462**	**$464**	**($998)**		**($1,519)**	**$464**	**$1,982**	
Nonoperating Revenue (Loss)	$484	$969	$484		$1,350	$969	($381)	
Excess Margin	**$1,946**	**$1,432**	**($514)**		**($169)**	**$1,432**	**$1,601**	

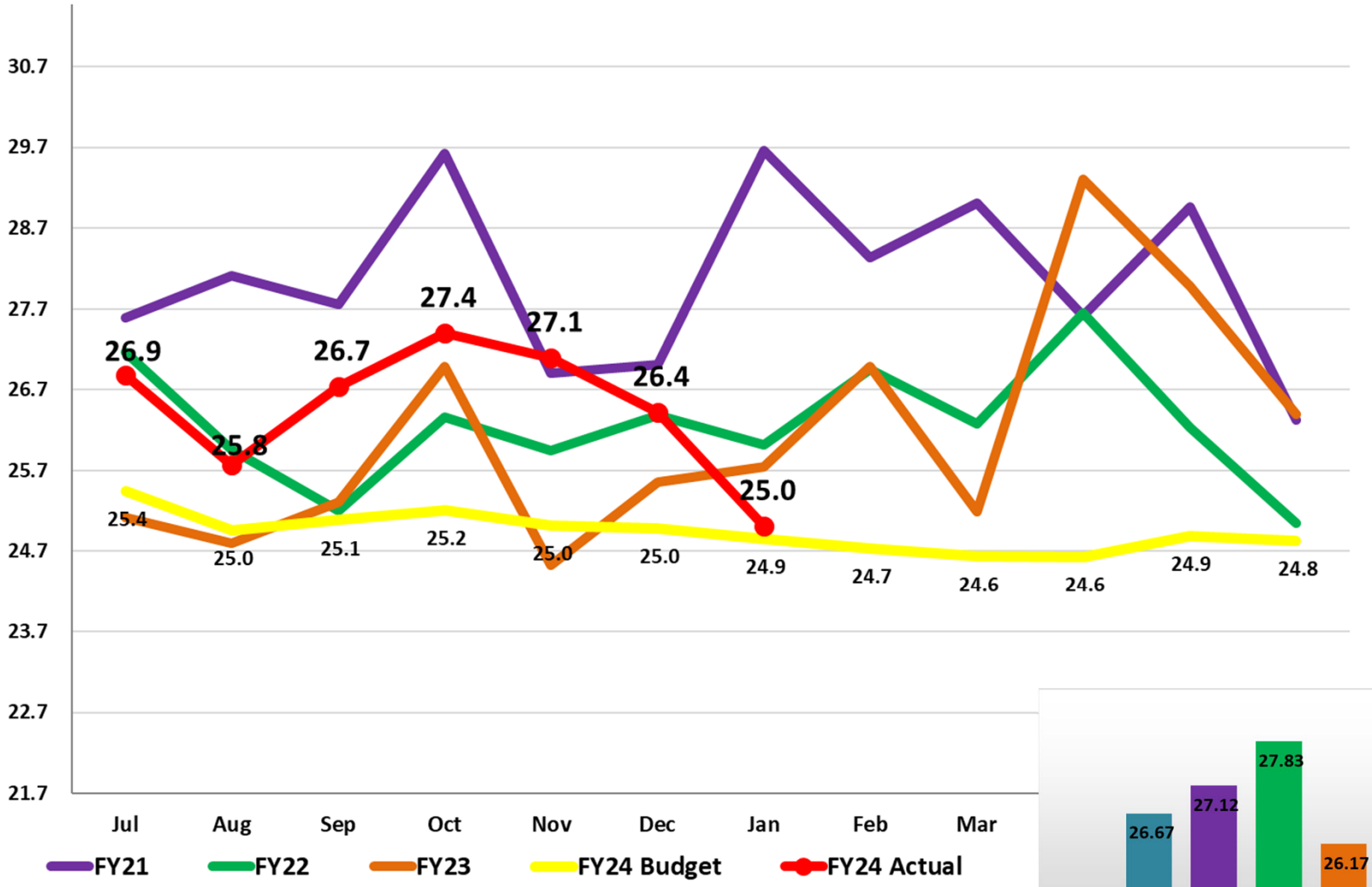
FYTD July-Jan: Financial Comparison without KHMG (000's)

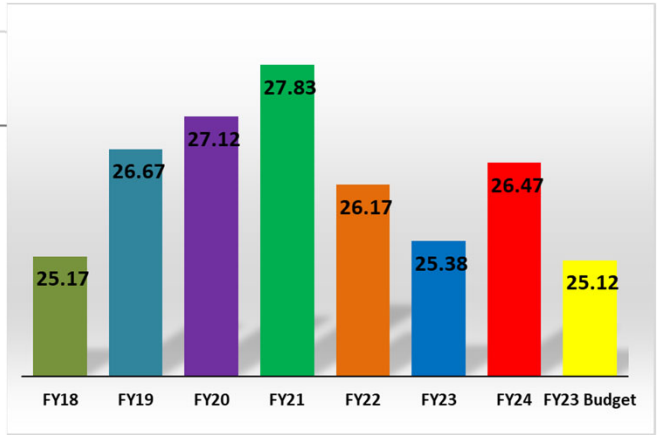
	Without KHMG Comparison to Budget - YTD January				Without KHMG Comparison to Prior Year - YTD January			
	Budget Jan-2024	Actual Jan-2024	$ Change	% Change	Jan-2023	Jan-2024	$ Change	% Change
Operating Revenue								
Net Patient Service Revenue	**$340,739**	**$336,033**	**($4,705)**	**-1.4%**	**$343,225**	**$336,033**	**($7,191)**	**-2.1%**
Supplemental Gov't Programs	$44,960	$47,897	$2,938	6.1%	$36,616	$47,897	$11,281	23.6%
Prime Program	$5,792	$7,389	$1,597	21.6%	$5,198	$7,389	$2,191	29.7%
Premium Revenue	$55,003	$51,968	($3,035)	-5.8%	$42,643	$51,968	$9,325	17.9%
Management Services Revenue	$23,852	$23,113	($739)	-3.2%	$22,905	$23,113	$208	0.9%
Other Revenue	$17,356	$22,837	$5,482	24.0%	$18,073	$22,837	$4,764	20.9%
Other Operating Revenue	$146,961	$153,205	$6,243	4.1%	$125,435	$153,205	$27,769	18.1%
Total Operating Revenue	**$487,700**	**$489,238**	**$1,538**	**0.3%**	**$468,660**	**$489,238**	**$20,578**	**4.2%**
Operating Expenses								
Salaries & Wages	$203,646	$199,631	($4,015)	-2.0%	$194,390	$199,631	$5,241	2.6%
Contract Labor	$11,234	$13,280	$2,046	15.4%	$36,201	$13,280	($22,922)	-172.6%
Employee Benefits	$47,075	$46,934	($141)	-0.3%	$37,113	$46,934	$9,822	20.9%
Total Employment Expenses	**$261,955**	**$259,846**	**($2,109)**	**-0.8%**	**$267,704**	**$259,846**	**($7,859)**	**-3.0%**
Medical & Other Supplies	$94,094	$92,407	($1,687)	-1.8%	$92,906	$92,407	($499)	-0.5%
Physician Fees	$46,656	$46,438	($217)	-0.5%	$47,521	$46,438	($1,083)	-2.3%
Purchased Services	$10,536	$11,213	$677	6.0%	$11,131	$11,213	$82	0.7%
Repairs & Maintenance	$16,577	$16,278	($300)	-1.8%	$15,529	$16,278	$749	4.6%
Utilities	$6,713	$6,294	($419)	-6.7%	$5,980	$6,294	$314	5.0%
Rents & Leases	$1,156	$1,061	($95)	-8.9%	$974	$1,061	$87	8.2%
Depreciation & Amortization	$20,396	$19,760	($637)	-3.2%	$19,652	$19,760	$108	0.5%
Interest Expense	$4,074	$4,209	$135	3.2%	$4,341	$4,209	($133)	-3.2%
Other Expense	$15,171	$13,301	($1,870)	-14.1%	$11,954	$13,301	$1,347	10.1%
Humana Cap Plan Expenses	$25,910	$24,108	($1,803)	-7.5%	$25,191	$24,108	($1,084)	-4.5%
Total Other Expenses	**$241,283**	**$235,068**	**($6,215)**	**-2.6%**	**$235,179**	**$235,068**	**($111)**	**0.0%**
Total Operating Expenses	**$503,238**	**$494,914**	**($8,324)**	**-1.7%**	**$502,883**	**$494,914**	**($7,970)**	**-1.6%**
Operating Margin	**($15,538)**	**($5,675)**	**$9,862**		**($34,224)**	**($5,675)**	**$28,548**	
Stimulus/FEMA	**$11,164**	**$3,220**	**($7,944)**		**$287**	**$3,220**	**$2,933**	
Operating Margin after Stimulus/FEM	**($4,374)**	**($2,455)**	**$1,918**		**($33,937)**	**($2,455)**	**$31,481**	
Nonoperating Revenue (Loss)	$3,352	$9,115	$5,763		$1,733	$9,115	$7,381	
Excess Margin	**($1,022)**	**$6,659**	**$7,681**		**($32,203)**	**$6,659**	**$38,862**	

FYTD July-January : Trended Financial Information (000's)

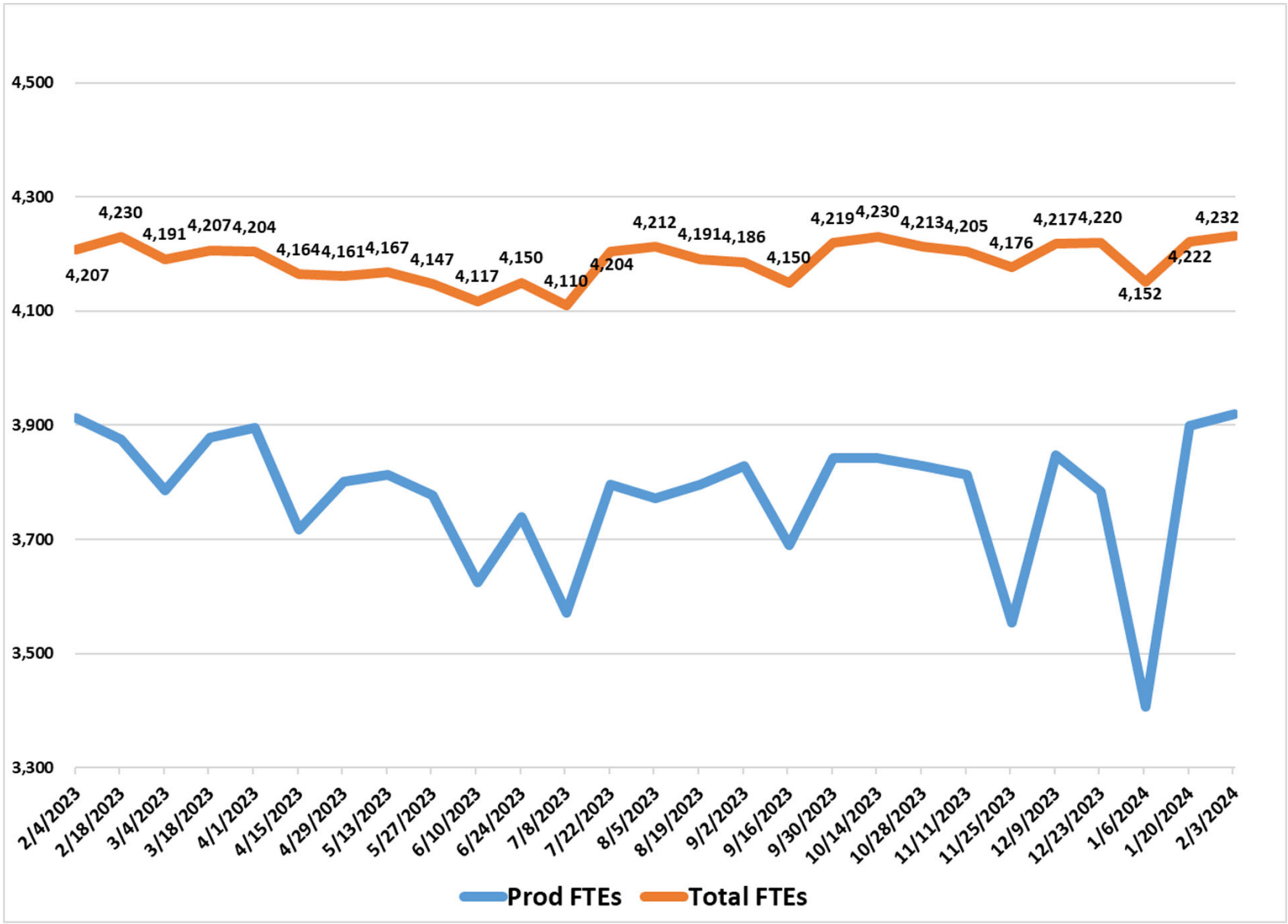
Income Statement	FY 2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	FYTD 2024	
Patient Service Revenue	$611,350	$45,479	$49,531	$47,195	$47,502	$48,225	$48,629	$49,472	$336,033	
Other Revenue	$240,615	$21,161	$22,458	$21,039	$21,928	$21,261	$20,979	$24,379	$153,205	
Total Operating Revenue	$851,965	$66,640	$71,989	$68,234	$69,431	$69,486	$69,608	$73,851	$489,238	
Employee Expense	$462,214	$36,176	$37,019	$35,180	$38,961	$37,597	$37,268	$37,645	$259,847	
Other Operating Expense	$448,205	$33,478	$34,922	$33,204	$31,579	$33,162	$32,981	$35,742	$235,067	
Total Operating Expenses	$910,418	$69,654	$71,941	$68,384	$70,540	$70,759	$70,249	$73,388	$494,914	
Net Operating Margin	($58,453)	($3,014)	$48	($150)	($1,110)	($1,273)	($641)	$464	($5,676)	
Stimulus/FEMA	$609	$1,610	$1,610	$0	$0	$0	$0	$0	$3,220	
NonOperating Income	$10,627	$617	$602	$626	$665	$578	$5,057	$969	$9,115	
Excess Margin	($47,218)	($787)	$2,259	$477	($444)	($695)	$4,416	$1,433	$6,659	
Profitability										Moody's A
Operating Margin %	(6.9%)	(4.5%)	0.1%	(0.2%)	(1.6%)	(1.8%)	(0.9%)	0.6%	(1.2%)	0.1%
Operating Margin %excl. Interest	(6.0%)	(3.6%)	0.9%	0.7%	(0.7%)	(1.0%)	(0.1%)	1.4%	(0.3%)	
Operating EBIDA	($11,318)	$395	$3,493	$3,265	$2,340	$2,111	$2,732	$3,957	$18,292	
Operating EBIDA Margin	(1.3%)	0.6%	4.9%	4.8%	3.4%	3.0%	3.9%	5.4%	3.7%	5.6%
Liquidity Indicators										
Day's Cash on Hand	78.3	84.2	84.7	83.3	83.7	81.1	83.5	81.4	81.4	206.5
Day's in Accounts Receiveable	72.5	72.6	74.6	76.6	79.1	78.4	77.6	72.5	72.5	48.0
Surplus/Unrestricted Funds (000's)	$186,803	$181,339	$185,762	$182,518	$183,138	$178,653	$183,624	$179,987	$179,987	
Capital Expenditures (000's)	$23,394	$301	$816	$563	$621	$1,399	$1,706	$1,725	$7,130	$14,000
Debt & Other Indicators										
Debt Service Coverage (MADS)	(0.1)	1.63	2.57	2.54	2.37	2.23	2.67	2.71	2.71	3.80
Discharges (Monthly)	2,289	2,306	2,442	2,276	2,203	2,293	2,285	2,283	2,298	
Adj Discharges (Case mix adj)	7,600	7,504	7,884	7,580	7,417	7,743	7,344	7,228	7,520	
Adjusted patient Days (Mo.)	26,609	24,306	26,289	24,516	24,321	24,447	24,965	25,976	24,974	
Cost/Adj Discharge	$10.0	$9.3	$9.1	$9.0	$9.5	$9.1	$9.6	$10.2	$9.4	
Compensation Ratio	76%	80%	75%	75%	82%	78%	77%	76%	77%	

Productivity: Worked Hours/Adjusted Patient Days

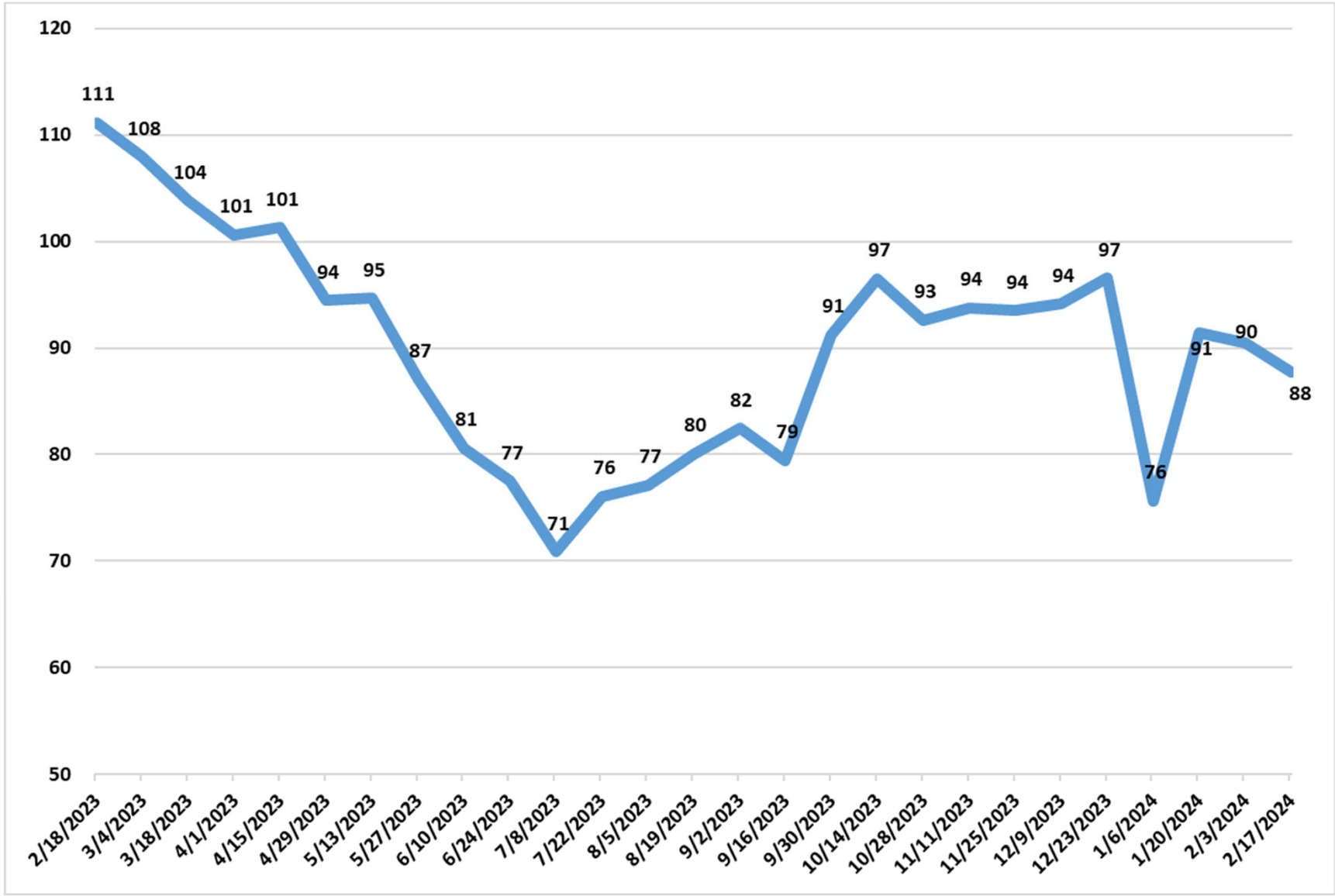




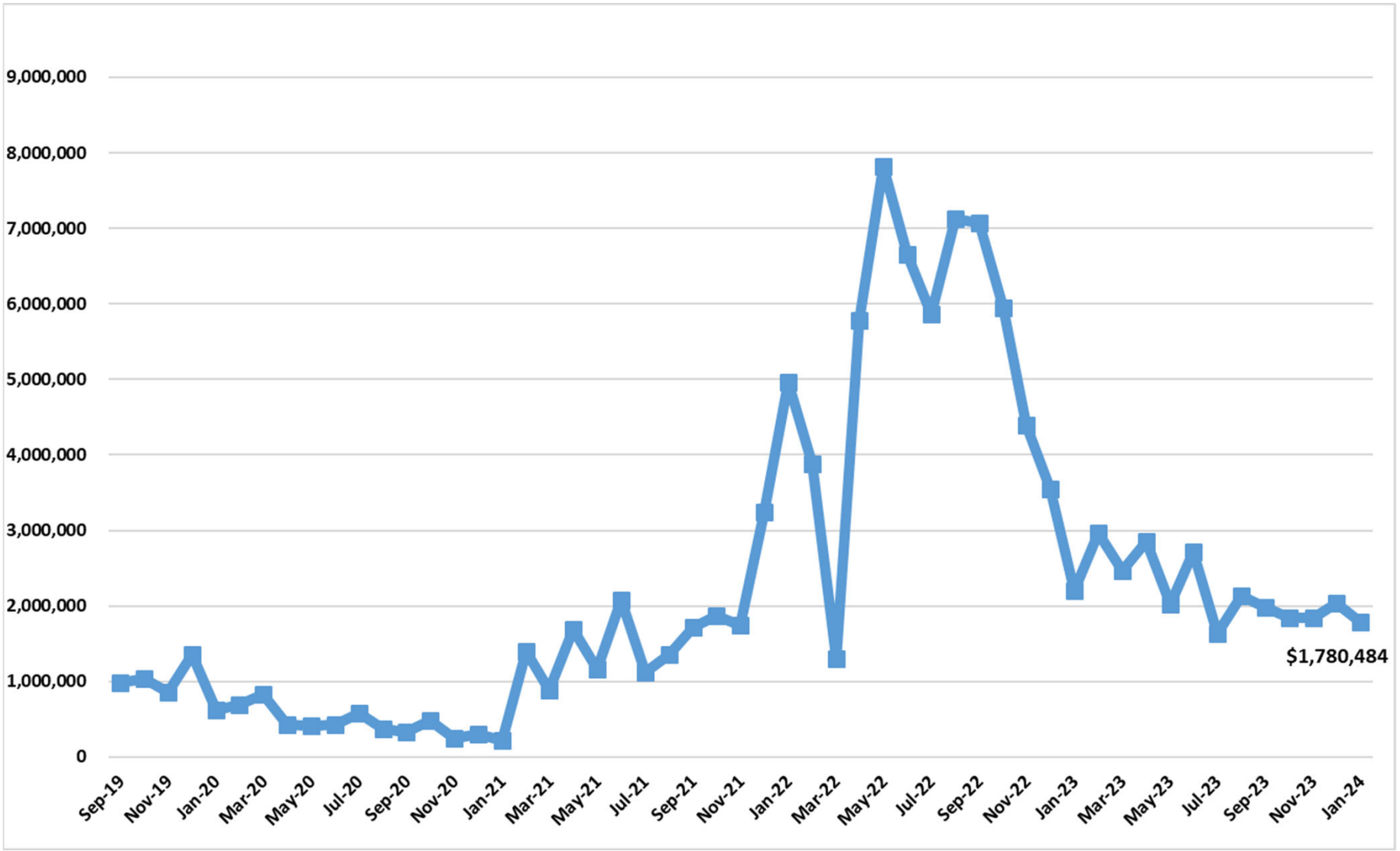
Productive and Total FTEs without KHMG



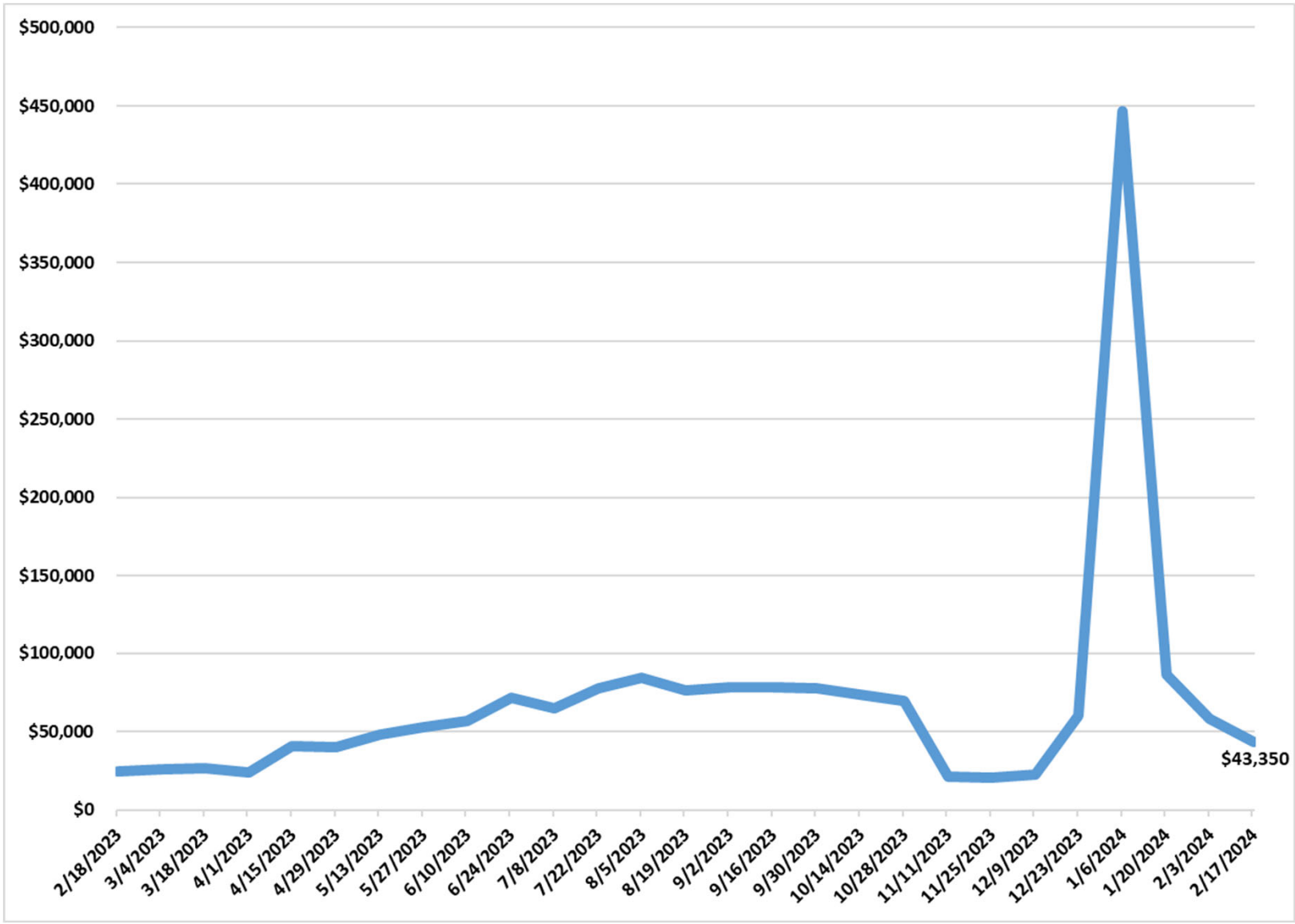
Contract Labor Full Time Equivalents (FTEs)



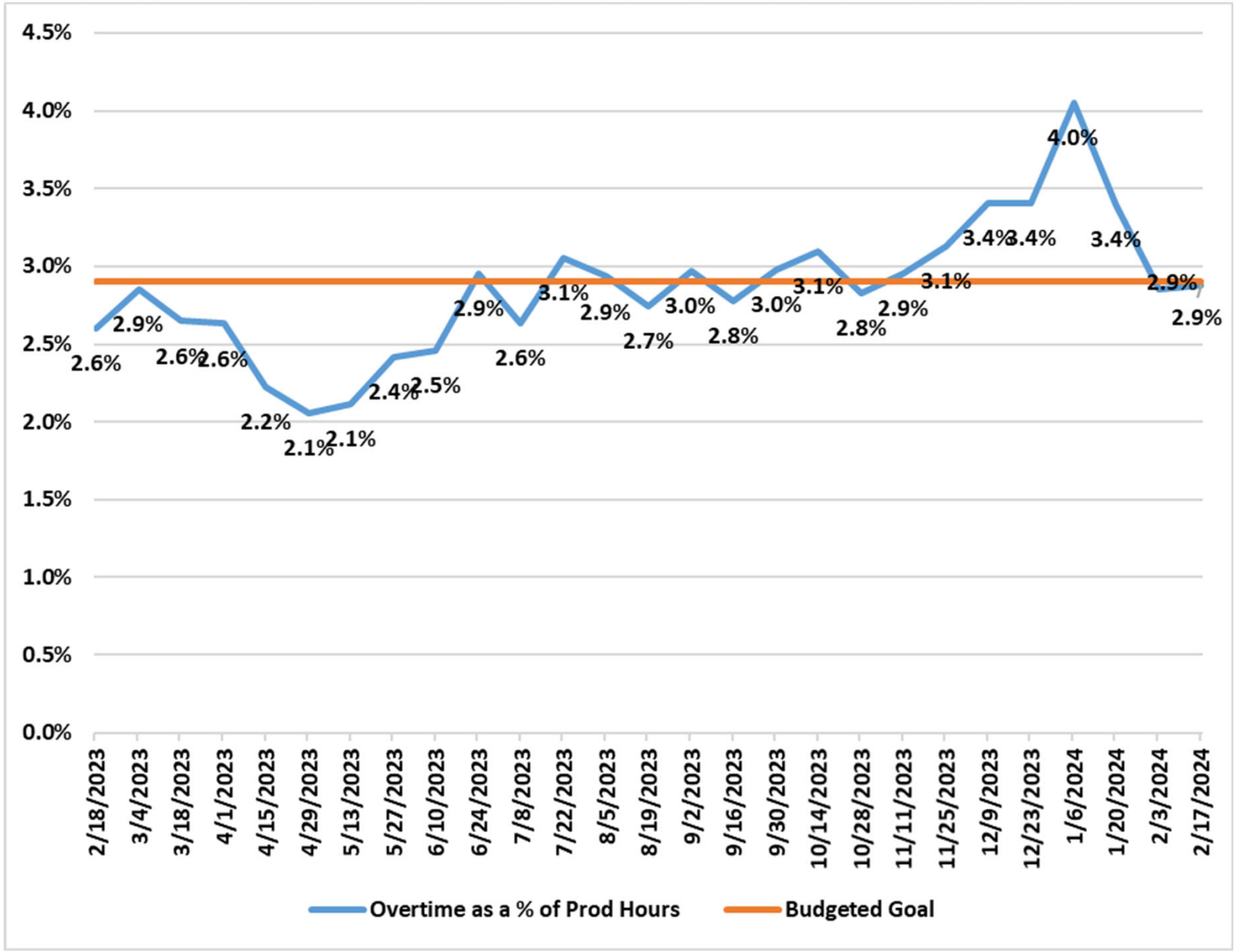
Contract Labor Expense

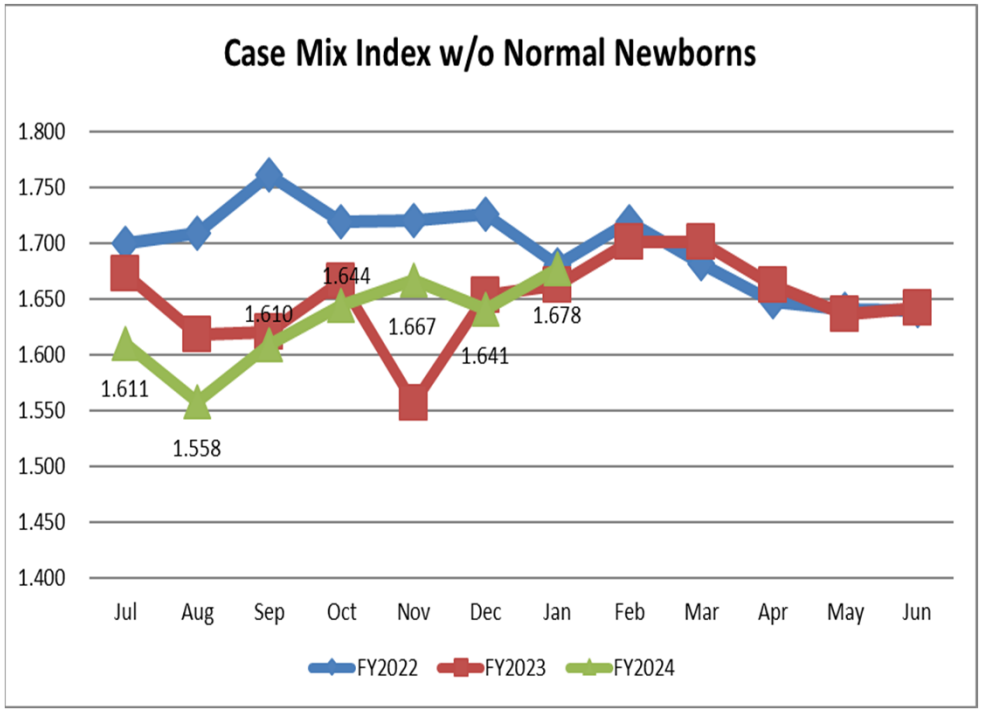


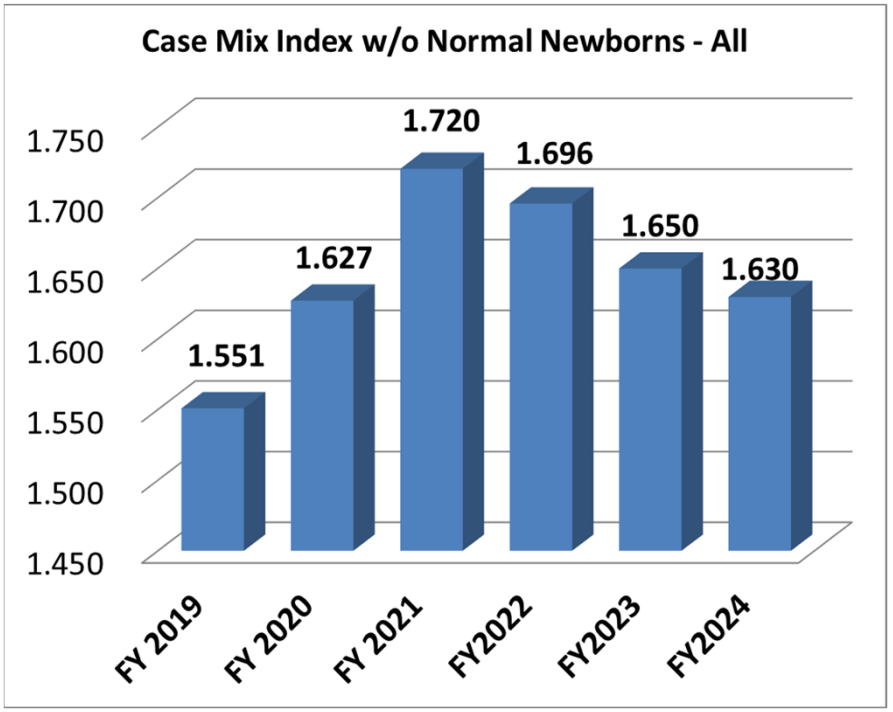
Shift Bonus Expense

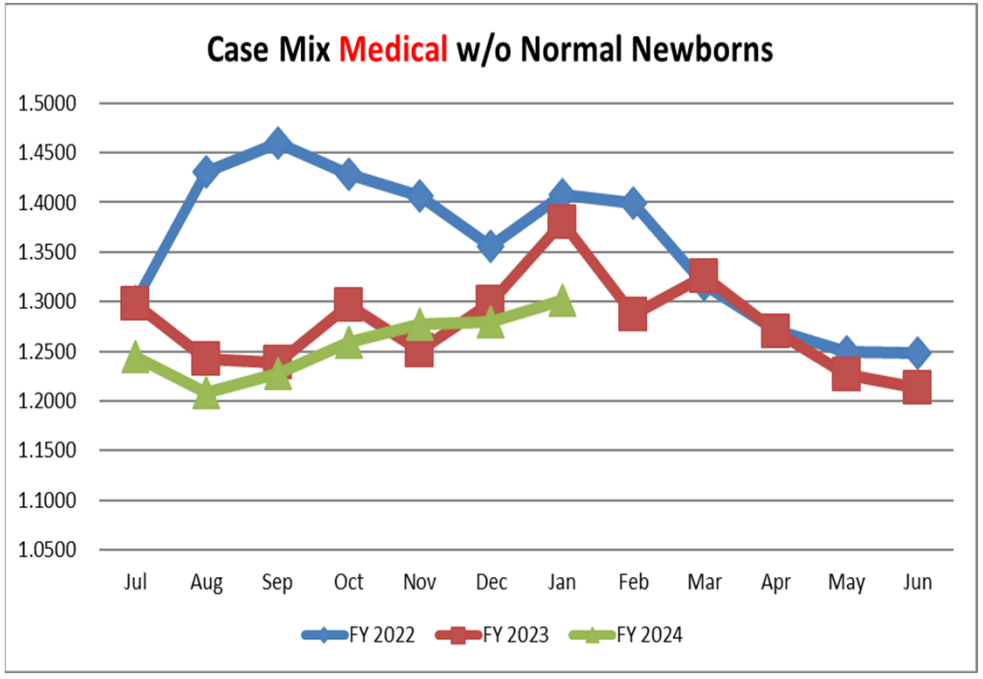


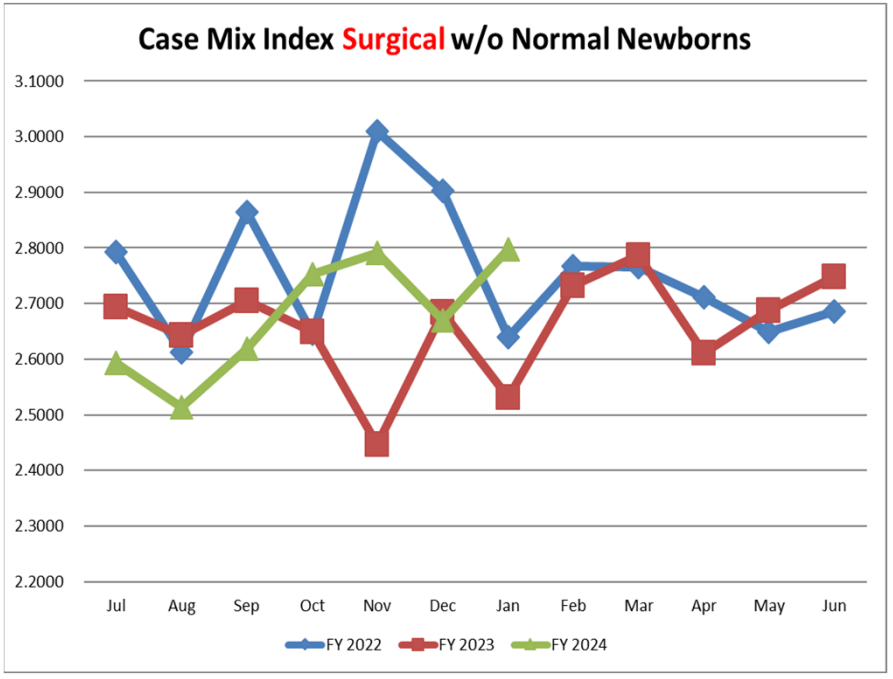
Overtime as a % of Productive Hours



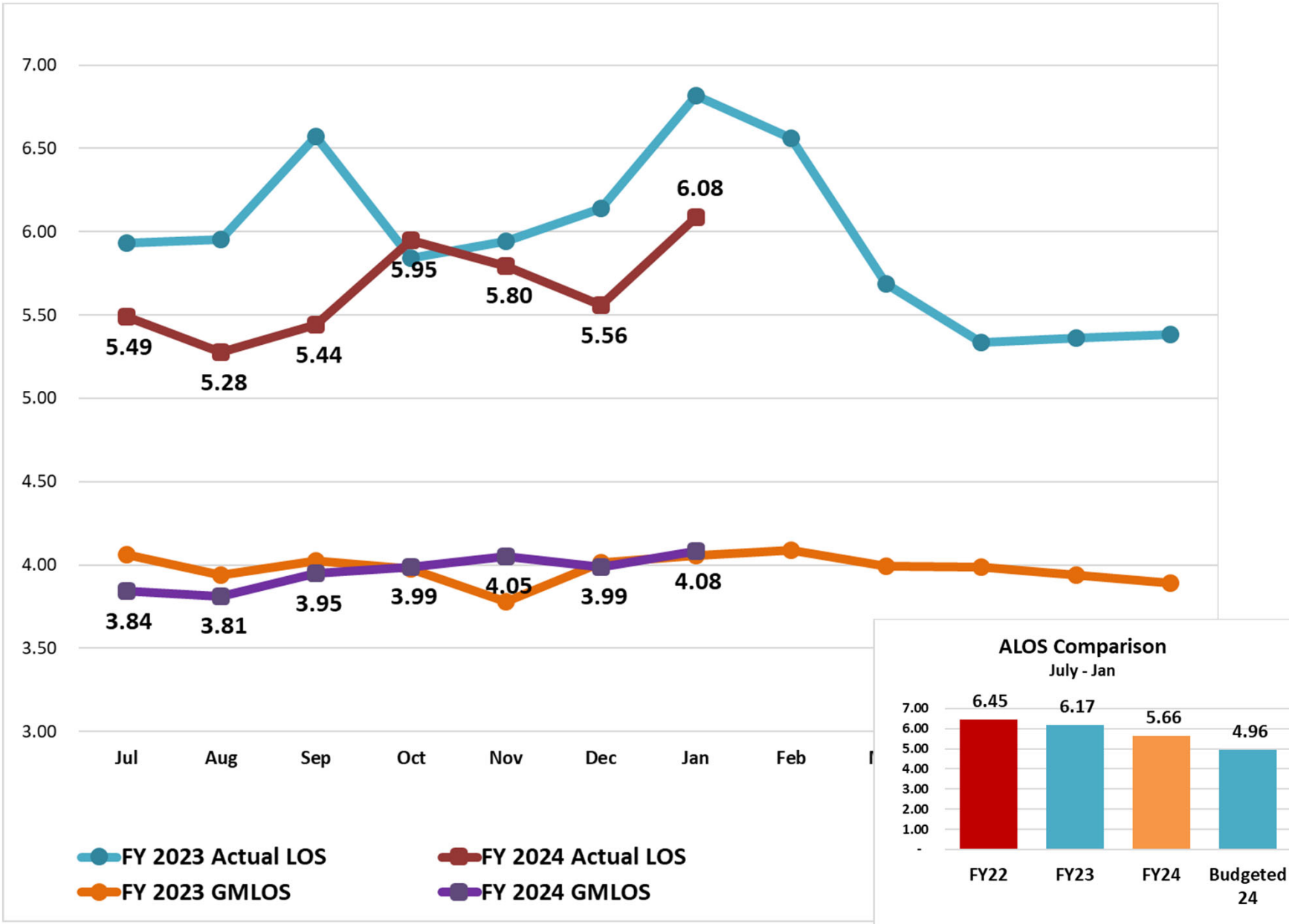

Case Mix Index w/o Normal Newborns
1.800
1.750
1.700
1.650
1.600
1.550
1.500
1.450
1.400
1.611
1.558
1.610
1.644
1.667
1.641
1.678
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY2022
FY2023
FY2024


Case Mix Index w/o Normal Newborns - All
1.750
1.700
1.650
1.600
1.550
1.500
1.450
1.551
1.627
1.720
1.696
1.650
1.630
FY 2019
FY 2020
FY 2021
FY2022
FY2023
FY2024


Case Mix Medical w/o Normal Newborns
1.5000
1.4500
1.4000
1.3500
1.3000
1.2500
1.2000
1.1500
1.1000
1.0500
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY 2022
FY 2023
FY 2024


Case Mix Index Surgical w/o Normal Newborns
3.1000
3.0000
2.9000
2.8000
2.7000
2.6000
2.5000
2.4000
2.3000
2.2000
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY 2022
FY 2023
FY 2024

Average Length of Stay versus National Average (GMLOS)

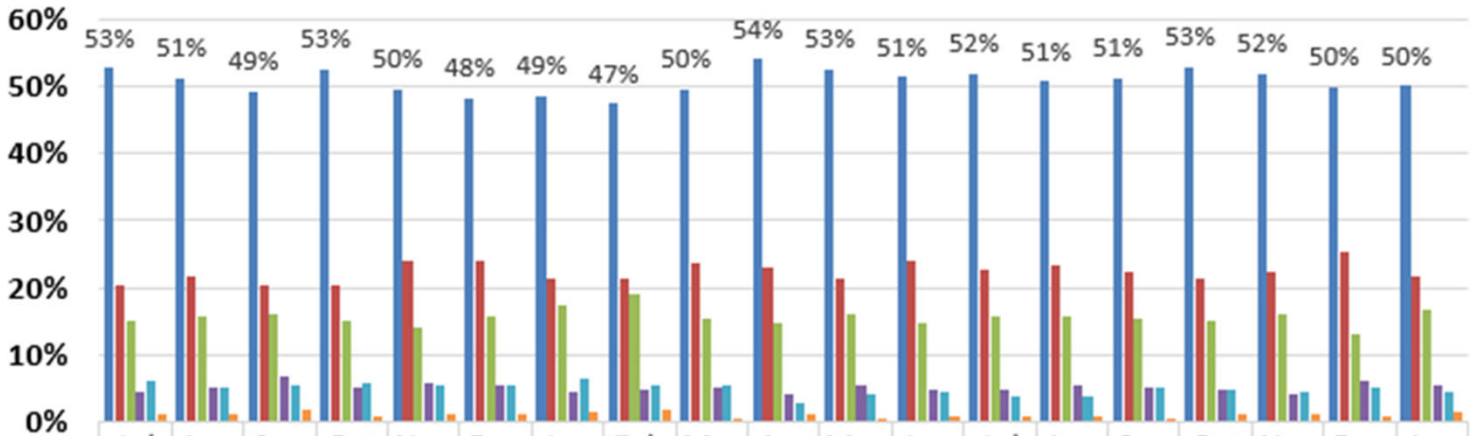


Average Length of Stay versus National Average (GMLOS)

	Including COVID Patients			Excluding COVID Patients		
	ALOS	GMLOS	GAP	ALOS	GMLOS	GAP
Jan-22	6.09	4.26	1.83	5.97	3.97	2.00
Feb-22	6.61	4.23	2.38	5.86	3.83	2.03
Mar-22	6.60	4.02	2.58	5.86	3.89	1.97
Apr-22	5.79	3.99	1.80	5.67	3.98	1.69
May-22	5.98	3.94	2.04	5.61	3.88	1.73
Jun-22	6.11	3.97	2.14	5.63	3.88	1.75
Jul-22	5.93	4.06	1.87	5.66	3.90	1.76
Aug-22	5.95	3.94	2.01	5.62	3.82	1.80
Sep-22	6.57	4.02	2.55	6.32	3.95	2.37
Oct-22	5.83	3.98	1.85	5.63	3.91	1.72
Nov-22	5.94	3.78	2.16	5.88	3.74	2.14
Dec-22	6.14	4.01	2.13	5.69	3.92	1.77
Jan-23	6.82	4.06	2.76	6.30	3.95	2.35
Feb-23	6.56	4.09	2.47	6.36	4.04	2.32
Mar-23	5.69	3.99	1.70	5.56	3.93	1.63
Apr-23	5.34	3.99	1.35	5.05	3.94	1.11
May-23	5.36	3.94	1.42	5.14	3.91	1.23
Jun-23	5.38	3.89	1.49	5.32	3.86	1.46
Jul-23	5.49	3.84	1.65	5.47	3.82	1.65
Aug-23	5.28	3.81	1.47	5.22	3.77	1.45
Sep-23	5.44	3.95	1.49	5.39	3.91	1.48
Oct-23	5.95	3.99	1.96	5.90	3.97	1.93
Nov-23	5.80	4.05	1.75	5.60	4.02	1.58
Dec-23	5.56	3.99	1.57	5.54	3.96	1.58
Jan-24	6.08	4.08	2.00	5.94	4.07	1.87
Average	**5.97**	**4.00**	**1.96**	**5.70**	**3.92**	**1.79**

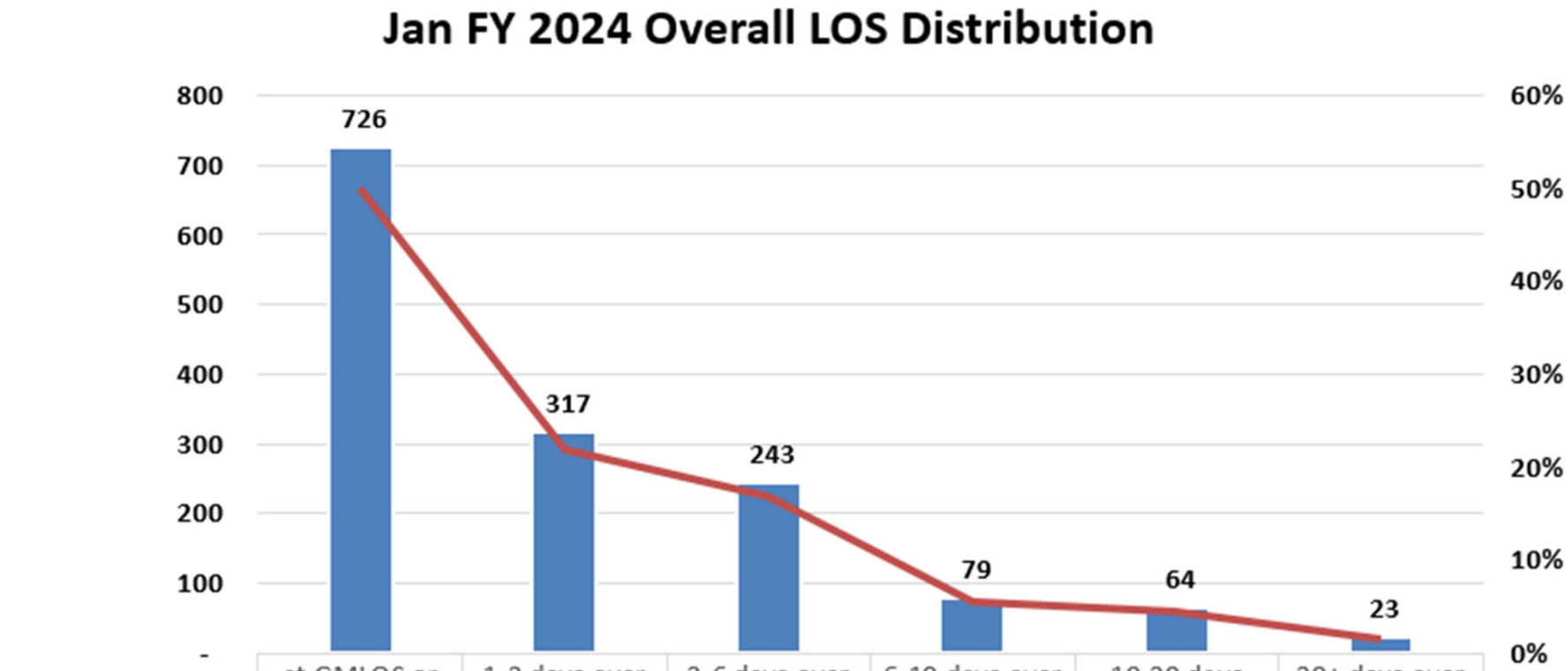
Average Length of Stay Distribution

Overall



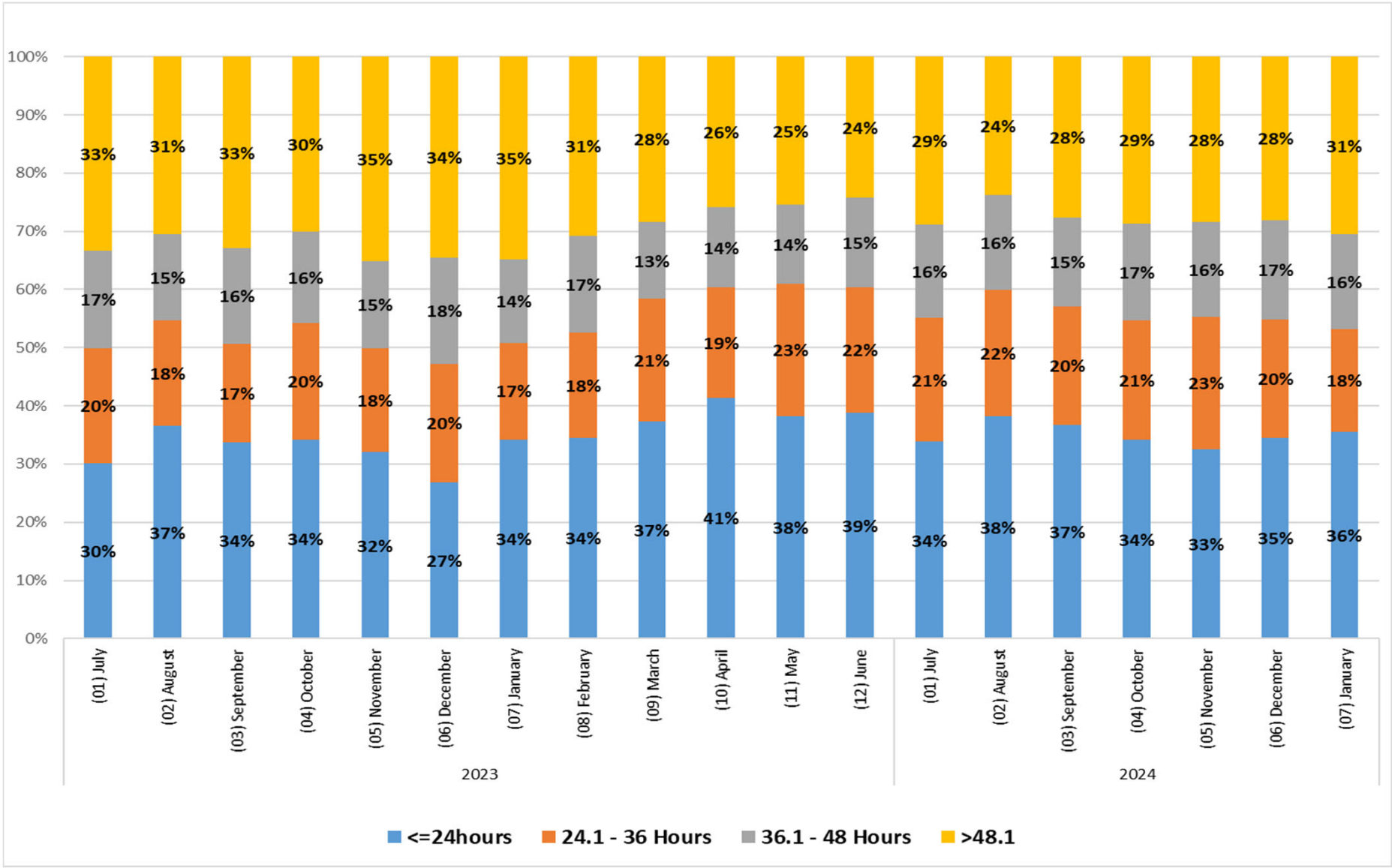
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
at GMLOS or Better	53%	51%	49%	53%	50%	48%	49%	47%	50%	54%	53%	51%	52%	51%	51%	53%	52%	50%	50%
1-2 days over GMLOS	20%	22%	20%	20%	24%	24%	21%	21%	24%	23%	21%	24%	23%	23%	22%	21%	22%	25%	22%
2-6 days over GMLOS	15%	16%	16%	15%	14%	16%	17%	19%	16%	15%	16%	15%	16%	16%	15%	15%	16%	13%	17%
6-10 days over GMLOS	5%	5%	7%	5%	6%	5%	5%	5%	5%	4%	6%	5%	5%	6%	5%	5%	4%	6%	5%
10-30 days over GMLOS	6%	5%	6%	6%	5%	6%	7%	5%	6%	3%	4%	5%	4%	4%	5%	5%	4%	5%	4%
30+ days over GMLOS	1.2%	1.2%	1.7%	1.0%	1.2%	1.1%	1.6%	1.9%	0.5%	1.2%	0.5%	0.8%	0.9%	0.8%	0.6%	1.2%	1.2%	0.7%	1.6%

Average Length of Stay Distribution

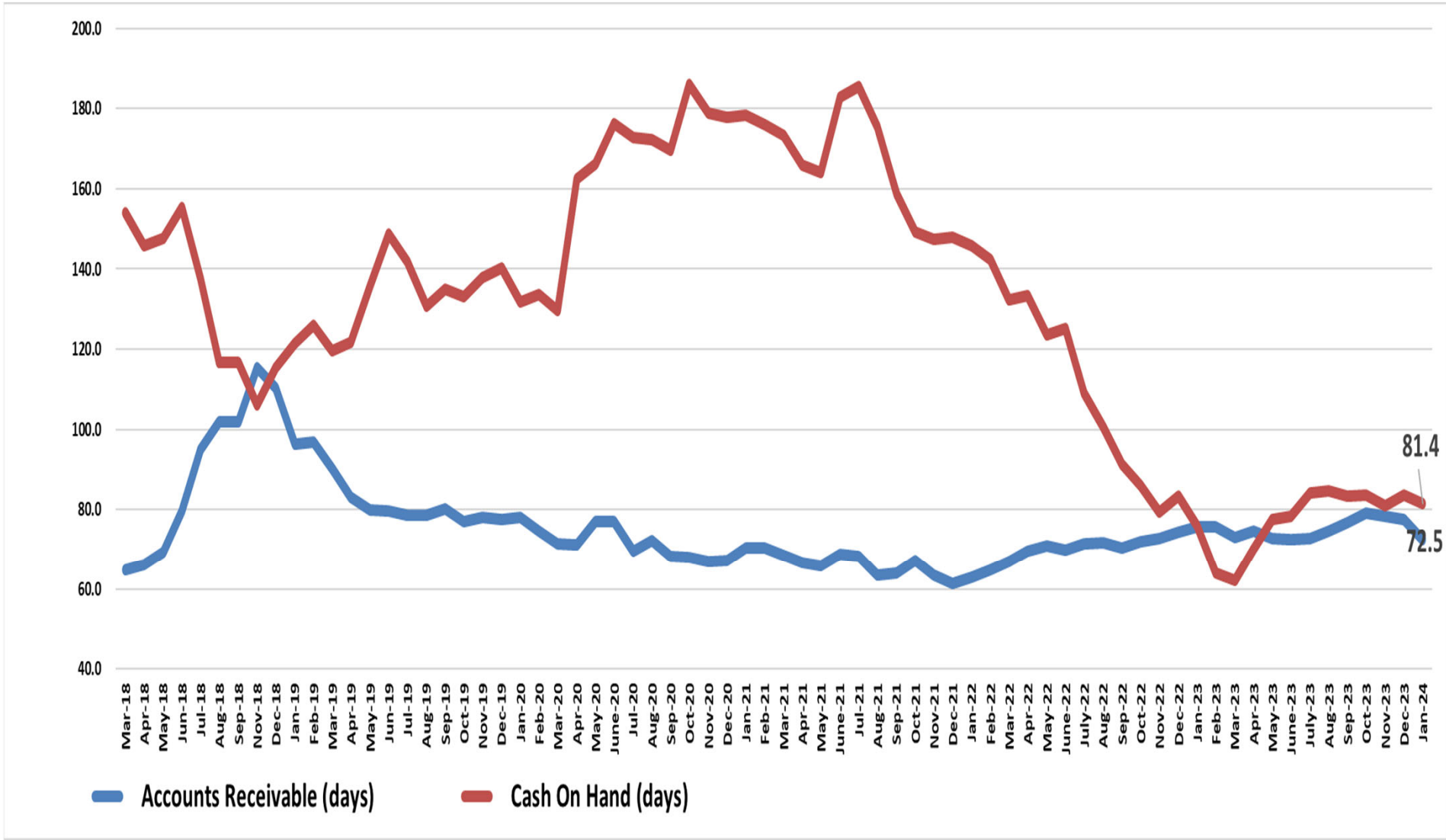


	at GMLOS or Better	1-2 days over GMLOS	2-6 days over GMLOS	6-10 days over GMLOS	10-30 days over GMLOS	30+ days over GMLOS
Count of Visits	726	317	243	79	64	23
% of Visits	50%	22%	17%	5%	4%	2%

Monthly Discharges of Observation Patients by their Length of Stay



Trended Liquidity Ratios



Ratio Analysis Report

	Jan FY24 Value	Dec FY24 Value	June 30, 2023 Audited Value	2022 Moody's Median Benchmark Aa	A	Baa
LIQUIDITY RATIOS						
Current Ratio (x)	3.0	2.9	2.7	1.5	**1.8**	1.7
Accounts Receivable (days)	72.5	77.6	72.5	48.7	**48**	43.8
Cash On Hand (days)	81.4	83.5	78.3	276.5	**206.5**	157.6
Cushion Ratio (x)	9.9	10.1	10.3	44.3	**24.9**	17.3
Average Payment Period (days)	47.8	48.4	44.7	79	**66.7**	68.1
CAPITAL STRUCTURE RATIOS						
Cash-to-Debt	81.6%	83.3%	84.7%	259.9%	**173.7%**	128.6%
Debt-To-Capitalization	35.3%	35.0%	35.2%	23.4%	**31.8%**	37.5%
Debt-to-Cash Flow (x)	4.5	4.5	(128.9)	2.8	**3.6**	5
Debt Service Coverage	2.7	2.7	(0.1)	6.1	**4.5**	2.8
Maximum Annual Debt Service Coverage (x)	2.7	2.7	(0.1)	5.9	**3.8**	2.4
Age Of Plant (years)	14.9	14.8	12.2	11.4	**12.8**	13.7
PROFITABILITY RATIOS						
Operating Margin	(1.2%)	(1.5%)	(6.9%)	1.5%	**0.1%**	(2.1%)
Excess Margin	1.3%	1.2%	(5.5%)	4.8%	**2.7%**	(.3%)
Operating Cash Flow Margin	3.7%	3.5%	(1.3%)	6.1%	**5.6%**	3.6%
Return on Assets	1.3%	1.2%	(5.7%)	3.3%	**1.9%**	(.3%)

Consolidated Statements of Net Position (000's)

	Jan-24	Dec-23	Change	% Change	Jun-23 (Audited)
ASSETS AND DEFERRED OUTFLOWS					
CURRENT ASSETS					
Cash and cash equivalents	$ 3,884	$ 447	$ 3,437	768.16%	$ 4,127
Current Portion of Board designated and trusted assets	20,111	17,161	2,951	17.19%	14,978
Accounts receivable:					
Net patient accounts	133,047	138,691	(5,644)	-4.07%	132,621
Other receivables	30,794	30,169	625	2.07%	27,475
	163,840	168,859	(5,019)	-2.97%	160,096
Inventories	14,245	14,748	(503)	-3.41%	13,117
Medicare and Medi-Cal settlements	104,898	95,745	9,153	9.56%	81,412
Prepaid expenses	9,566	8,752	814	9.30%	9,037
Total current assets	316,545	305,712	10,833	3.54%	282,767
NON-CURRENT CASH AND INVESTMENTS -					
less current portion					
Board designated cash and assets	168,342	175,416	(7,074)	-4.03%	174,916
Revenue bond assets held in trust	19,166	19,279	(114)	-0.59%	18,605
Assets in self-insurance trust fund	516	514	2	0.41%	956
Total non-current cash and investments	188,024	195,210	(7,185)	-3.68%	194,477
INTANGIBLE RIGHT TO USE LEASE, net of accumulated amortization	11,685	11,933	(248)	-2.08%	11,249
INTANGIBLE RIGHT TO USE SBITA, net of accumulated amortization	8,418	8,418	-	0.00%	8,417
CAPITAL ASSETS					
Land	20,544	20,544	-	0.00%	17,542
Buildings and improvements	428,039	427,164	875	0.20%	427,105
Equipment	330,662	329,371	1,290	0.39%	328,663
Construction in progress	21,854	22,295	(441)	-1.98%	25,413
	801,099	799,375	1,725	0.22%	798,723
Less accumulated depreciation	499,737	496,622	3,115	0.63%	486,537
	301,362	302,752	(1,390)	-0.46%	312,186
OTHER ASSETS					
Property not used in operations	1,503	1,896	(393)	-20.71%	1,533
Health-related investments	2,188	2,195	(7)	-0.33%	2,841
Other	14,298	13,976	322	2.30%	13,350
Total other assets	17,989	18,067	(78)	-0.43%	17,724
Total assets	844,022	842,091	1,931	0.23%	826,820
DEFERRED OUTFLOWS	23,853	23,886	(33)	-0.14%	24,083
Total assets and deferred outflows	**$ 867,876**	**$ 865,977**	**$ 1,898**	**0.22%**	**$ 850,903**

Consolidated Statements of Net Position (000's)

	Jan-24	Dec-23	Change	% Change	Jun-23
LIABILITIES AND NET ASSETS					
CURRENT LIABILITIES					
Accounts payable and accrued expenses	$ 27,337	$ 27,399	$ (62)	-0.23%	$ 30,636
Accrued payroll and related liabilities	55,022	55,714	(692)	-1.24%	50,478
SBITA liability, current portion	2,734	2,734	-	0.00%	2,734
Lease liabiilty, current portion	2,614	2,614	-	0.00%	2,614
Bonds payable, current portion	10,105	10,105	-	0.00%	12,159
Notes payable, current portion	7,895	7,895	-	0.00%	7,895
Total current liabilities	105,707	106,461	(754)	-0.71%	106,516
LEASE LIABILITY, net of current portion	9,312	9,547	(236)	-2.47%	8,741
SBITA LIABILITY, net of current portion	4,425	4,425	-	0.00%	4,426
LONG-TERM DEBT, less current portion					
Bonds payable	227,332	227,338	(7)	0.00%	227,378
Notes payable	9,850	9,850	-	0.00%	9,850
Total long-term debt	237,181	237,188	(7)	0.00%	237,228
NET PENSION LIABILITY	49,429	48,505	924	1.90%	42,961
OTHER LONG-TERM LIABILITIES	34,732	34,023	709	2.08%	30,984
Total liabilities	440,786	440,150	637	0.14%	426,430
NET ASSETS					
Invested in capital assets, net of related debt	63,925	65,423	(1,497)	-2.29%	75,776
Restricted	56,640	51,341	5,298	10.32%	50,013
	306,524	309,064	(2,539)	-0.82%	294,258
Total net position	427,089	425,828	1,262	0.30%	420,047
Total liabilities and net position	**$ 867,876**	**$ 865,977**	**$ 1,898**	**0.22%**	**$ 850,903**

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
Jan 31, 2024

Board designated funds	Maturity Date	Yield	Investment Type	G/L Account	Amount	Total
LAIF		4.03	Various		10,324,324	
CAMP		5.54	CAMP		29,438,133	
Allspring		4.97	Money market		3,421,771	
PFM		4.97	Money market		1,237	
Allspring	2-Feb-24	0.35	MTN-C	Paccar Financial Mtn	1,000,000	
Allspring	8-Feb-24	0.35	MTN-C	National Rural	1,400,000	
Allspring	18-Mar-24	0.75	MTN-C	Schwab Charles	1,625,000	
PFM	18-Mar-24	0.75	MTN-C	Schwab Charles	90,000	
Allspring	22-Mar-24	0.75	MTN-C	Verizon	730,000	
PFM	25-Mar-24	3.35	U.S. Govt Agency	FNMA	81,741	
Bank of Marin - CDARS	31-Mar-24	4.50	CD	Bank of Marin	236,500	
Blue Ridge Bank - CDARS	31-Mar-24	4.50	CD	Blue Ridge Bank	236,500	
BOKF National Association - CDARS	31-Mar-24	4.50	CD	BOKF National Association	236,500	
BOM Bank - CDARS	31-Mar-24	4.50	CD	BOM Bank	236,500	
Cattlemens Bank - CDARS	31-Mar-24	4.50	CD	Cattlemens Bank	236,500	
East West Bank - CDARS	31-Mar-24	4.50	CD	East West Bank	236,500	
First Northern Bank of Dixon - CDARS	31-Mar-24	4.50	CD	First Northern Bank of Dixon	236,500	
First Republic Bank - CDARS	31-Mar-24	4.50	CD	First Republic Bank	236,500	
Live Oak Banking Company - CDARS	31-Mar-24	4.50	CD	Live Oak Banking company	236,500	
SouthEast Bank - CDARS	31-Mar-24	4.50	CD	SouthEast Bank	94,138	
SpiritBank - CDARS	31-Mar-24	4.50	CD	SpiritBank	236,500	
Springs Valley Bank & Trust Company - C	31-Mar-24	4.50	CD	Springs Valley Bank & Trust Company	54,362	
The Bank of Commerce - CDARS	31-Mar-24	4.50	CD	The Bank of Commerce	236,500	
Western Alliance - CDARS	31-Mar-24	4.50	CD	Western Alliance	250,000	
Allspring	26-Apr-24	0.50	MTN-C	Bank of Ny Mtn	1,000,000	
Allspring	1-May-24	0.36	Municipal	Wisconsin ST	1,320,000	
Allspring	1-May-24	0.43	Municipal	Wisconsin ST	500,000	
Allspring	12-May-24	0.45	MTN-C	Amazon Com Inc	875,000	
Allspring	15-May-24	0.58	Municipal	University Ca	1,000,000	
Allspring	1-Jun-24	0.59	Municipal	Orange Ca	500,000	
Allspring	1-Jun-24	0.64	Municipal	Torrance Ca	1,450,000	
Allspring	15-Jun-24	0.52	Municipal	Louisiana ST	500,000	
Allspring	1-Jul-24	0.63	Municipal	El Segundo Ca	510,000	
Allspring	1-Jul-24	5.00	Municipal	Los Angeles Calif Ca	1,500,000	
PFM	30-Jul-24	2.40	MTN-C	US Bancorp	415,000	
PFM	1-Aug-24	0.70	Municipal	San Juan Ca	195,000	
Allspring	16-Aug-24	2.02	MTN-C	Exxon Mobil	1,320,000	
Allspring	13-Sep-24	0.60	MTN-C	Caterpillar Finl Mtn	500,000	
PFM	24-Oct-24	2.10	MTN-C	Bank of NY	150,000	
PFM	25-Oct-24	0.85	MTN-C	Bank of Ny Mtn	390,000	
Allspring	31-Oct-24	1.50	U.S. Govt Agency	US Treasury Bill	650,000	
PFM	1-Nov-24	0.57	Municipal	Mississippi ST	300,000	
Allspring	8-Nov-24	2.15	MTN-C	Caterpillar Finl Mtn	600,000	
Allspring	6-Dec-24	2.15	MTN-C	Branch Banking Trust	1,300,000	
Allspring	15-Dec-24	1.00	U.S. Govt Agency	US Treasury Bill	550,000	
Allspring	31-Dec-24	1.75	U.S. Govt Agency	US Treasury Bill	1,000,000	
PFM	7-Jan-25	1.63	U.S. Govt Agency	FNMA	1,010,000	
Allspring	9-Jan-25	2.05	MTN-C	John Deere Mtn	500,000	
Allspring	15-Jan-25	1.13	U.S. Govt Agency	US Treasury Bill	3,300,000	
Allspring	21-Jan-25	2.05	MTN-C	US Bank NA	1,400,000	
PFM	7-Feb-25	1.88	MTN-C	National Rural Mtn	125,000	
PFM	12-Feb-25	1.50	U.S. Govt Agency	FHLMC	1,000,000	
PFM	13-Feb-25	1.80	MTN-C	Toyota Motor	420,000	
PFM	14-Feb-25	1.75	MTN-C	Novartis Capital	425,000	
Allspring	7-Mar-25	2.13	MTN-C	Deere John Mtn	550,000	
PFM	10-Mar-25	2.13	MTN-C	Roche Holding Inc	730,000	
Allspring	1-Apr-25	0.88	Municipal	Bay Area Toll	250,000	
PFM	1-Apr-25	3.25	MTN-C	General Dynamics	395,000	
PFM	14-Apr-25	0.50	U.S. Govt Agency	FHLB	1,340,000	
PFM	15-Apr-25	2.70	MTN-C	Home Depot Inc	65,000	
PFM	22-Apr-25	0.63	U.S. Govt Agency	FNMA	1,530,000	
Allspring	1-May-25	0.74	Municipal	San Diego County	300,000	
PFM	1-May-25	0.98	MTN-C	Citigroup Inc	440,000	
PFM	11-May-25	1.13	MTN-C	Apple, Inc	655,000	
Allspring	15-May-25	2.75	U.S. Govt Agency	US Treasury Bill	980,000	
PFM	15-May-25	0.93	Municipal	University Calf Ca	185,000	
PFM	25-May-25	3.33	U.S. Govt Agency	FHLMC	855,000	
Allspring	1-Jun-25	0.92	Municipal	Connecticut ST	400,000	
PFM	1-Jun-25	1.35	MTN-C	Honeywell	400,000	
PFM	1-Jun-25	3.15	MTN-C	Emerson Electric Co	265,000	
PFM	1-Jun-25	0.82	MTN-C	JP Morgan	1,000,000	
PFM	3-Jun-25	0.80	MTN-C	Amazon Com Inc	445,000	
Allspring	17-Jun-25	0.50	U.S. Govt Agency	FNMA	2,000,000	
Allspring	30-Jun-25	0.25	U.S. Govt Agency	US Treasury Bill	350,000	
PFM	1-Jul-25	1.26	Municipal	Florida ST	600,000	
PFM	1-Jul-25	0.77	Municipal	Wisconsin ST	440,000	
Allspring	21-Jul-25	0.38	U.S. Govt Agency	FHLMC	1,500,000	
PFM	21-Jul-25	0.50	ABS	GM Financial	54,216	

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
Jan 31, 2024

Allspring	1-Aug-25	2.17	Municipal	Santa Cruz Ca	400,000
PFM	1-Aug-25	0.77	Municipal	Los Angeles Ca	335,000
PFM	1-Aug-25	0.85	Municipal	San Juan Ca	190,000
PFM	15-Aug-25	0.78	ABS	Carmax Auto Owner	29,543
PFM	15-Aug-25	0.62	ABS	Kubota Credit	84,497
Allspring	25-Aug-25	0.38	U.S. Govt Agency	FNMA	1,500,000
PFM	25-Aug-25	3.75	U.S. Govt Agency	FHLMC	278,028
Allspring	4-Sep-25	0.38	U.S. Govt Agency	FHLB	525,000
Allspring	15-Sep-25	0.36	ABS	John Deere Owner	166,683
PFM	15-Sep-25	0.00	ABS	Hyundai Auto	46,451
PFM	15-Sep-25	3.88	MTN-C	Abbott Laboratories	195,000
Allspring	23-Sep-25	0.00	U.S. Govt Agency	FHLMC	750,000
Allspring	25-Sep-25	0.98	MTN-C	Bk of America	1,300,000
Allspring	29-Oct-25	0.55	MTN-C	Procter Gamble Co	1,300,000
Allspring	31-Oct-25	0.25	U.S. Govt Agency	US Treasury Bill	770,000
PFM	17-Nov-25	0.56	ABS	Kubota Credit	97,885
Allspring	30-Nov-25	0.38	U.S. Govt Agency	US Treasury Bill	2,550,000
PFM	15-Dec-25	0.00	ABS	Carmax Auto Owner	33,392
PFM	31-Dec-25	0.38	U.S. Govt Agency	US Treasury Bill	1,395,000
PFM	31-Jan-26	0.38	U.S. Govt Agency	US Treasury Bill	1,000,000
Allspring	6-Feb-26	1.75	MTN-C	State Street Corp	1,000,000
PFM	12-Feb-26	0.86	MTN-C	Goldman Sachs	205,000
PFM	15-Feb-26	1.63	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	17-Feb-26	0.00	ABS	Carmax Auto Owner	102,634
PFM	28-Feb-26	2.50	U.S. Govt Agency	US Treasury Bill	500,000
PFM	28-Feb-26	0.50	U.S. Govt Agency	US Treasury Bill	1,500,000
PFM	30-Mar-26	2.90	MTN-C	State Street Corp	420,000
Allspring	31-Mar-26	0.75	U.S. Govt Agency	US Treasury Bill	675,000
PFM	31-Mar-26	0.38	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	2-Apr-26	3.38	MTN-C	Bank of America	250,000
PFM	19-Apr-26	3.50	MTN-C	Bank of America	295,000
Allspring	25-Apr-26	3.91	MTN-C	Wells Fargo co	800,000
PFM	30-Apr-26	0.75	U.S. Govt Agency	US Treasury Bill	1,435,000
PFM	15-May-26	3.30	MTN-C	IBM Corp	410,000
PFM	28-May-26	1.20	MTN-C	Astrazeneca LP	265,000
PFM	31-May-26	0.75	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	31-May-26	2.13	U.S. Govt Agency	US Treasury Bill	1,200,000
PFM	15-Jun-26	0.00	ABS	Carmax Auto Owner	298,585
Allspring	18-Jun-26	1.13	MTN-C	Toyota Motor	1,400,000
Allspring	30-Jun-26	0.88	U.S. Govt Agency	US Treasury Bill	1,850,000
PFM	30-Jun-26	0.88	U.S. Govt Agency	US Treasury Bill	990,000
Allspring	1-Jul-26	1.89	Municipal	Anaheim Ca Pub	1,000,000
PFM	1-Jul-26	1.46	Municipal	Los Angeles Ca	270,000
PFM	7-Jul-26	5.25	ABS	American Honda Mtn	145,000
PFM	8-Jul-26	3.05	MTN-C	Walmart INC	205,000
PFM	17-Jul-26	5.08	MTN-C	Cooperatieve CD	400,000
PFM	20-Jul-26	0.00	ABS	Honda Auto Rec Own	130,000
PFM	31-Jul-26	0.63	U.S. Govt Agency	US Treasury Bill	880,000
PFM	7-Aug-26	5.45	MTN-C	Wells Fargo Bank Na	545,000
PFM	31-Aug-26	0.75	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	14-Sep-26	1.15	MTN-C	Caterpillar Finl Mtn	220,000
PFM	18-Sep-26	5.61	MTN-C	Natixis Ny	405,000
Allspring	30-Sep-26	0.88	U.S. Govt Agency	US Treasury Bill	2,210,000
PFM	30-Sep-26	0.88	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	1-Oct-26	2.95	MTN-C	JP Morgan	415,000
Allspring	31-Oct-26	1.13	U.S. Govt Agency	US Treasury Bill	800,000
PFM	1-Nov-26	4.76	Municipal	California St Univ	125,000
PFM	4-Nov-26	0.02	MTN-C	American Express Co	445,000
PFM	13-Nov-26	5.60	MTN-C	National Rural Mtn	160,000
PFM	15-Nov-26	3.55	MTN-C	Lockheed Martin	203,000
Allspring	30-Nov-26	1.13	U.S. Govt Agency	US Treasury Bill	2,000,000
PFM	11-Jan-27	1.70	MTN-C	Deere John Mtn	220,000
Allspring	15-Jan-27	1.95	MTN-C	Target Corp	900,000
PFM	15-Jan-27	1.95	MTN-C	Target Corp	330,000
PFM	15-Mar-27	6.03	MTN-C	Daimler Trucks	325,000
PFM	25-Mar-27	3.22	U.S. Govt Agency	FHLMC	575,000
PFM	15-Apr-27	0.00	ABS	Carmax Auto Owner	600,000
PFM	15-Apr-27	2.50	MTN-C	Home Depot Inc	220,000
Allspring	30-Apr-27	2.88	U.S. Govt Agency	US Treasury Bill	970,000
PFM	30-Apr-27	0.50	U.S. Govt Agency	US Treasury Bill	250,000
PFM	30-Apr-27	2.88	U.S. Govt Agency	US Treasury Bill	800,000
PFM	15-May-27	2.38	U.S. Govt Agency	US Treasury Bill	925,000

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
Jan 31, 2024

PFM	15-May-27	1.70	MTN-C	IBM Corp	230,000
PFM	15-May-27	3.70	MTN-C	Unitedhealth Group	85,000
PFM	17-May-27	4.14	ABS	Capital One Prime	265,000
PFM	17-May-27	2.39	MTN-C	American Express Co	655,000
PFM	17-May-27	0.00	MTN-C	Discover Card Exe	305,000
Allspring	15-Jul-27	3.68	Municipal	Massachusetts St	1,000,000
Allspring	1-Aug-27	3.46	Municipal	Alameda Cnty Ca	500,000
PFM	15-Aug-27	2.25	U.S. Govt Agency	US Treasury Bill	500,000
PFM	31-Aug-27	0.50	U.S. Govt Agency	US Treasury Bill	1,500,000
PFM	15-Nov-27	4.51	ABS	Mercedes Benz Auto	200,000
PFM	18-Feb-28	5.41	ABS	Honda Auto	350,000
PFM	25-Feb-28	0.00	ABS	BMW Vehicle Owner	95,000
PFM	29-Feb-28	1.13	U.S. Govt Agency	US Treasury Bill	1,500,000
PFM	17-Apr-28	0.00	ABS	Hyundai Auto	115,000
PFM	17-Apr-28	5.00	MTN-C	Bank of America	525,000
PFM	30-Apr-28	1.25	U.S. Govt Agency	US Treasury Bill	600,000
PFM	15-May-28	0.00	ABS	Ally Auto Rec	195,000
PFM	15-May-28	4.87	MTN-C	American Express Co	150,000
PFM	15-May-28	4.79	MTN-C	Bank of America	180,000
PFM	15-May-28	5.23	MTN-C	Ford CR Auto Owner	160,000
PFM	16-Jun-28	5.59	ABS	GM Finl con Auto Rec	110,000
PFM	25-Jun-28	0.00	U.S. Govt Agency	FHLMC	530,000
PFM	25-Jun-28	0.00	U.S. Govt Agency	FHLMC	438,589
PFM	14-Jul-28	4.95	MTN-C	John Deere Mtn	120,000
PFM	25-Jul-28	4.19	U.S. Govt Agency	FNMA	540,000
PFM	15-Aug-28	5.69	MTN-C	Harley Davidson	500,000
PFM	15-Aug-28	5.90	ABS	Fifth Third Auto	385,000
PFM	25-Aug-28	0.00	U.S. Govt Agency	FHLMC	545,000
PFM	25-Aug-28	4.65	U.S. Govt Agency	FHLMC	545,000
PFM	15-Sep-28	5.23	MTN-C	American Express	445,000
PFM	15-Sep-28	5.16	MTN-C	Chase Issuance Trust	435,000
PFM	25-Sep-28	4.85	U.S. Govt Agency	FHLMC	410,000
PFM	25-Sep-28	0.00	U.S. Govt Agency	FHLMC	535,000
PFM	29-Sep-28	5.80	MTN-C	Citibank N A	535,000
PFM	30-Sep-28	4.63	U.S. Govt Agency	US Treasury Bill	500,000
PFM	25-Oct-28	0.00	U.S. Govt Agency	FHLMC	200,000
PFM	25-Oct-28	4.86	U.S. Govt Agency	FHLMC	300,000
PFM	31-Oct-28	1.38	U.S. Govt Agency	US Treasury Bill	1,500,000
PFM	31-Oct-28	1.38	U.S. Govt Agency	US Treasury Bill	1,200,000
PFM	25-Nov-28	0.00	U.S. Govt Agency	FHLMC	280,000
PFM	25-Dec-28	0.00	U.S. Govt Agency	FHLMC	315,000
PFM	31-Dec-28	1.38	U.S. Govt Agency	US Treasury Bill	500,000
PFM	16-Jan-29	4.60	MTN-C	Chase Issuance Trust	490,000
PFM	31-Jan-29	4.60	MTN-C	Paccar Financial Mtn	160,000
PFM	1-Nov-25	0.38	U.S. Govt Agency	US Treasury Bill	500,000
					$ 160,890,710

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
Jan 31, 2024

	Maturity Date	Yield	Investment Type		G/L Account	Amount	Total
Self-insurance trust							
Wells Fargo Bank			Money market		110900	1,312,186	
Wells Fargo Bank			Fixed income - L/T		152300	600,957	
							1,913,143
2015A revenue bonds							
US Bank			Principal/Interest payment fund		142110	243,930	
							243,930
2015B revenue bonds							
US Bank			Principal/Interest payment fund		142110	711,475	
							711,475
2017C revenue bonds							
US Bank			Principal/Interest payment fund		142110	5,588,558	
							5,588,558
2020 revenue bonds							
US Bank			Principal/Interest payment fund		142110	774,457	
							774,457
2022 revenue bonds							
US Bank			Principal/Interest payment fund		142110	752,213	
							752,213
2014 general obligation bonds							
CAMP			Interest Payment fund		142110	2,968,278	
							2,968,278
Master Reserve fund							
US Bank					142102	(1,220,625)	
US Bank					142103	20,386,233	
							19,165,608
Operations							
Wells Fargo Bank		0.16	Checking	100100	100100	(1,667,412)	
Wells Fargo Bank		0.16	Checking	100500	100500	2,223,049	
						555,637	
Payroll							
Wells Fargo Bank		0.16	Checking		100200	(77,951)	
Wells Fargo Bank		0.16	Checking	Flexible Spending	100300	919,671	
Wells Fargo Bank		0.16	Checking	HSA	100300	(39,510)	
Wells Fargo Bank			Checking	Resident Fund	100300	1,537	
Bancorp			Checking	Bancorp	100300	517,180	
						1,320,927	
							1,876,563
					Total investments		**$ 194,884,935**

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
Jan 31, 2024

Kaweah Delta Medical Foundation

Wells Fargo Bank	Checking	100100		**$ 241,867**

Sequoia Regional Cancer Center

Wells Fargo Bank	Checking	100500	1,186,659	
				$ 1,186,659

Kaweah Delta Hospital Foundation

Central Valley Community Checking	Investments	100100	562,007	
Various	S/T Investments	142200	4,293,386	
Various	L/T Investments	142300	12,653,048	
Various	Unrealized G/L	142400	2,606,646	
				$ 20,115,088

Summary of board designated funds:

Plant fund:

Uncommitted plant funds		$ 113,397,636	142100	
Committed for capital		15,636,729	142100	
		129,034,365		
GO Bond reserve - L/T		1,992,658	142100	
401k Matching		5,408,392	142100	
Cost report settlement - current	2,135,384		142104	
Cost report settlement - L/T	1,312,727		142100	
		3,448,111		
Development fund/Memorial fund		104,184	112300	
Workers compensation - current	5,625,000		112900	
Workers compensation - L/T	15,278,000		113900	
		20,903,000		
		$ 160,890,710		

Investment summary by institution:

	Total Investments	%	Trust Accounts	Surplus Funds	%
Bancorp	$ 517,180	0.3%		517,180	0.3%
CAMP	29,438,133	15.1%		29,438,133	18.1%
Local Agency Investment Fund (LAIF)	10,324,324	5.3%		10,324,324	6.3%
CAMP - GOB Tax Rev	2,968,278	1.5%	2,968,278	-	0.0%
Allspring	59,148,454	30.4%	1,913,143	57,235,310	35.2%
PFM	58,979,799	30.3%		58,979,799	36.2%
Western Alliance	250,000			250,000	0.2%
Bank of Marin	236,500			236,500	0.1%
Blue Ridge Bank	236,500			236,500	0.1%
BOKF National Association	236,500			236,500	0.1%
BOM Bank	236,500			236,500	0.1%
Cattlemens Bank	236,500			236,500	0.1%
East West Bank	236,500			236,500	0.1%
First Northern Bank of Dixon	236,500			236,500	0.1%
First Republic Bank	236,500			236,500	0.1%
Live Oak Banking Company	236,500			236,500	0.1%
SouthEast Bank	94,138			94,138	0.1%
SpiritBank	236,500			236,500	0.1%
Springs Valley Bank & Trust Company	54,362			54,362	0.0%
The Bank of Commerce	236,500			236,500	0.1%
Wells Fargo Bank	3,272,527	1.7%		3,272,527	2.0%
US Bank	27,236,241	14.0%	27,236,241	-	0.0%
Total investments	$ 194,884,935	100.0%	$ 32,117,662	162,767,273	100.0%

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
Jan 31, 2024

Investment summary of surplus funds by type:			**Investment Limitations**	
Negotiable and other certificates of deposit	$	3,000,000	48,830,000	(30%)
Checking accounts		1,876,563		
Local Agency Investment Fund (LAIF)		10,324,324	75,000,000	
CAMP		29,438,133		
Medium-term notes (corporate) (MTN-C)		37,018,000	48,830,000	(30%)
U.S. government agency		60,413,358		
Municipal securities		13,770,000		
Money market accounts		3,423,008	32,553,000	(20%)
Commercial paper		-	40,692,000	(25%)
Asset Backed Securties		3,503,887	32,553,000	(20%)
Supra-National Agency		-	48,830,000	(30%)
	$	162,767,273		

Return on investment:

Current month	**2.91%**
Year-to-date	**2.08%**
Prospective	**2.54%**
LAIF (year-to-date)	**3.68%**
Budget	**1.65%**

Fair market value disclosure for the quarter ended December 31, 2023 (District only):	**Quarter-to-date**	**Year-to-date**
Difference between fair value of investments and amortized cost (balance sheet effect)	N/A	(4,126,972)
Change in unrealized gain (loss) on investments (income statement effect)	$ 3,057,656	3,704,387

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
Jan 31, 2024

Investment summary of CDs:

Western Alliance	$	250,000
Bank of Marin		236,500
Blue Ridge Bank		236,500
BOKF National Association		236,500
BOM Bank		236,500
Cattlemens Bank		236,500
East West Bank		236,500
First Northern Bank of Dixon		236,500
First Republic Bank		236,500
Live Oak Banking company		236,500
SouthEast Bank		94,138
SpiritBank		236,500
Springs Valley Bank & Trust Company		54,362
The Bank of Commerce		236,500
	$	3,000,000

Investment summary of asset backed securities:

Ally Auto Rec	$	195,000
American Honda Mtn		145,000
BMW Vehicle Owner		95,000
Fifth Third Auto		385,000
Capital One Prime		265,000
Carmax Auto Owner		1,064,154
GM Finl con Auto Rec		110,000
Gm Financial		54,216
Honda Auto		350,000
Honda Auto Rec Own		130,000
Hyundai Auto		161,451
John Deere Owner		166,683
Kubota Credit		182,383
Mercedes Benz Auto		200,000
	$	3,503,887

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
Jan 31, 2024

Investment summary of medium-term notes (corporate):

Abbott Laboratories	$	195,000
Amazon Com Inc		1,320,000
American Express		445,000
American Express Co		1,250,000
Apple, Inc		655,000
Astrazeneca LP		265,000
Bank of America		1,250,000
Bank of NY		150,000
Bank of NY Mtn		1,390,000
Bk of America		1,300,000
Branch Banking Trust		1,300,000
Chase Issuance Trust		925,000
Caterpillar Finl Mtn		1,320,000
Citibank N A		535,000
Citigroup Inc		440,000
Cooperatieve CD		400,000
Daimler Trucks		325,000
Deere John Mtn		770,000
Discover Card Exe		305,000
Emerson Electric Co		265,000
Exxon Mobil		1,320,000
Ford CR Auto Owner		160,000
General Dynamics		395,000
Goldman Sachs		205,000
Harley Davidson		500,000
Home Depot Inc		285,000
Honeywell		400,000
IBM Corp		640,000
John Deere Mtn		620,000
JP Morgan		1,415,000
Lockheed Martin		203,000
National Rural		1,400,000
National Rural Mtn		285,000
Natixis Ny		405,000
Novartis Capital		425,000
Paccar Financial Mtn		1,160,000
Procter Gamble Co		1,300,000
Roche Holding Inc		730,000
Schwab Charles		1,715,000
State Street Corp		1,420,000
Target Corp		1,230,000
Toyota Motor		1,820,000
Unitedhealth Group		85,000
US Bancorp		415,000
US Bank NA		1,400,000
Verizon		730,000
Walmart INC		205,000
Wells Fargo Bank Na		545,000
Wells Fargo co		800,000
	$	37,018,000

Investment summary of U.S. government agency:

Federal National Mortgage Association (FNMA)	$	6,661,741
Federal Home Loan Bank (FHLB)		1,865,000
Federal Home Loan Mortgage Corp (FHLMC)		9,056,617
US Treasury Bill		42,830,000
	$	60,413,358

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
Jan 31, 2024

Investment summary of municipal securities:

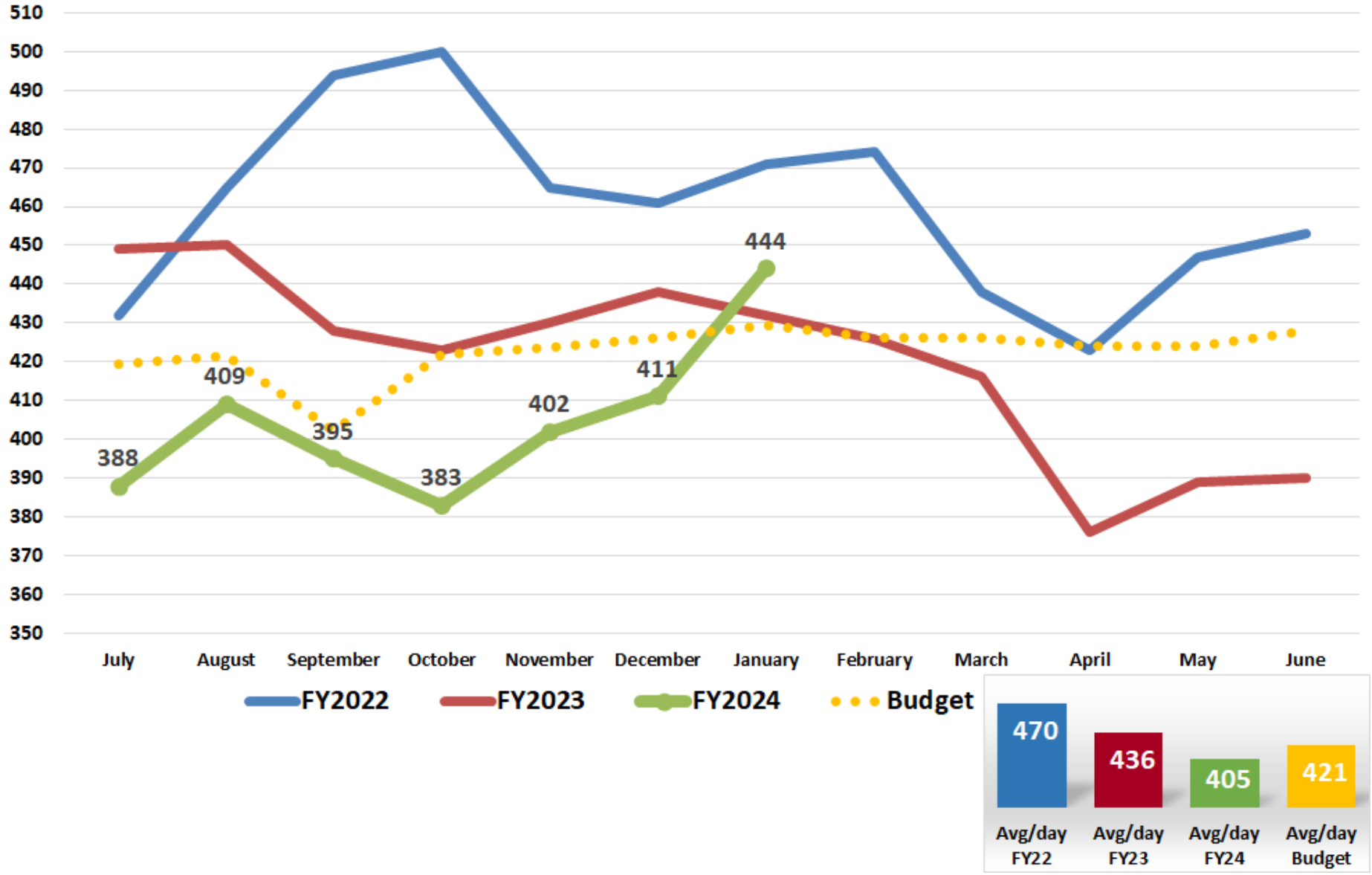
Alameda Cnty Ca	$	500,000
Anaheim Ca Pub		1,000,000
Bay Area Toll		250,000
California St Univ		125,000
Connecticut ST		400,000
El Segundo Ca		510,000
Florida ST		600,000
Los Angeles Ca		605,000
Los Angeles Calif Ca		1,500,000
Louisiana ST		500,000
Massachusetts St		1,000,000
Mississippi ST		300,000
Orange Ca		500,000
San Diego County		300,000
San Juan Ca		385,000
Santa Cruz Ca		400,000
Torrance Ca		1,450,000
University Ca		1,000,000
University Calf Ca		185,000
Wisconsin ST		2,260,000
	$	13,770,000

Investment summary of Supra-National Agency:

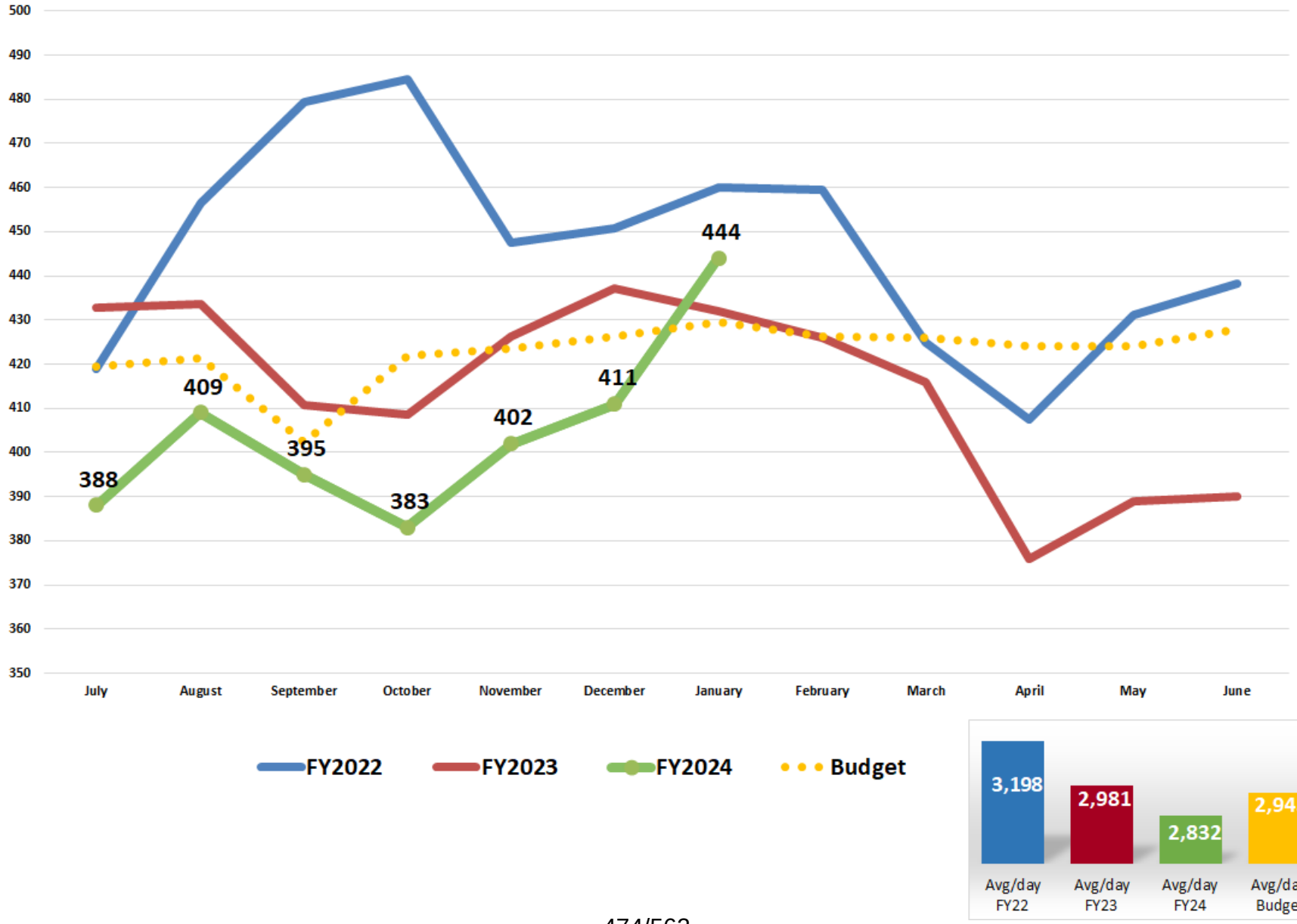
Cooperatieve	$	-
Inter Amer Bk		-
	$	-

Statistical Report
January 2024

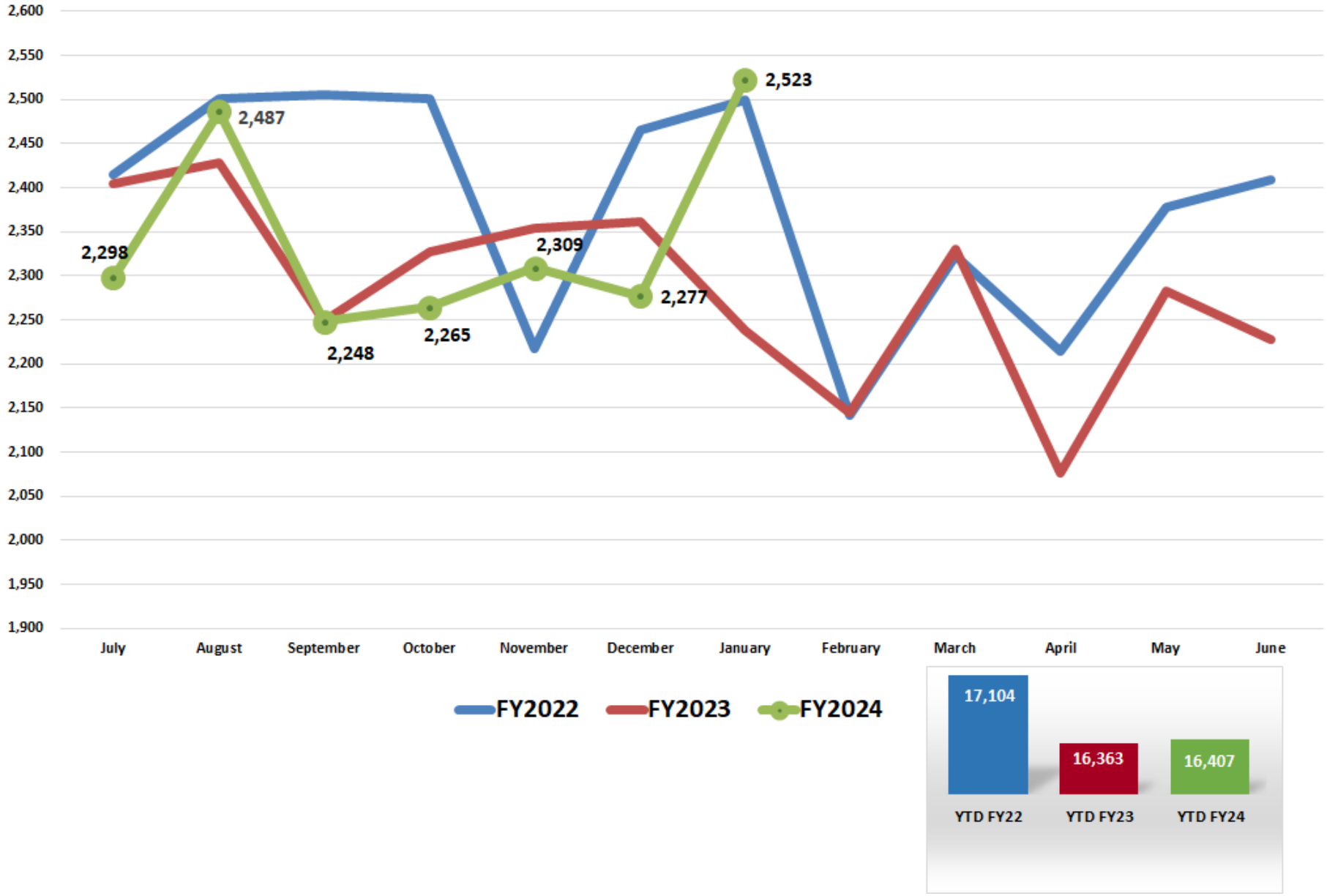
Average Daily Census



Average Daily Census w/o TCS



Admissions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2,500
2,450
2,400
2,350
2,300
2,250
2,200
2,150
2,100
2,050
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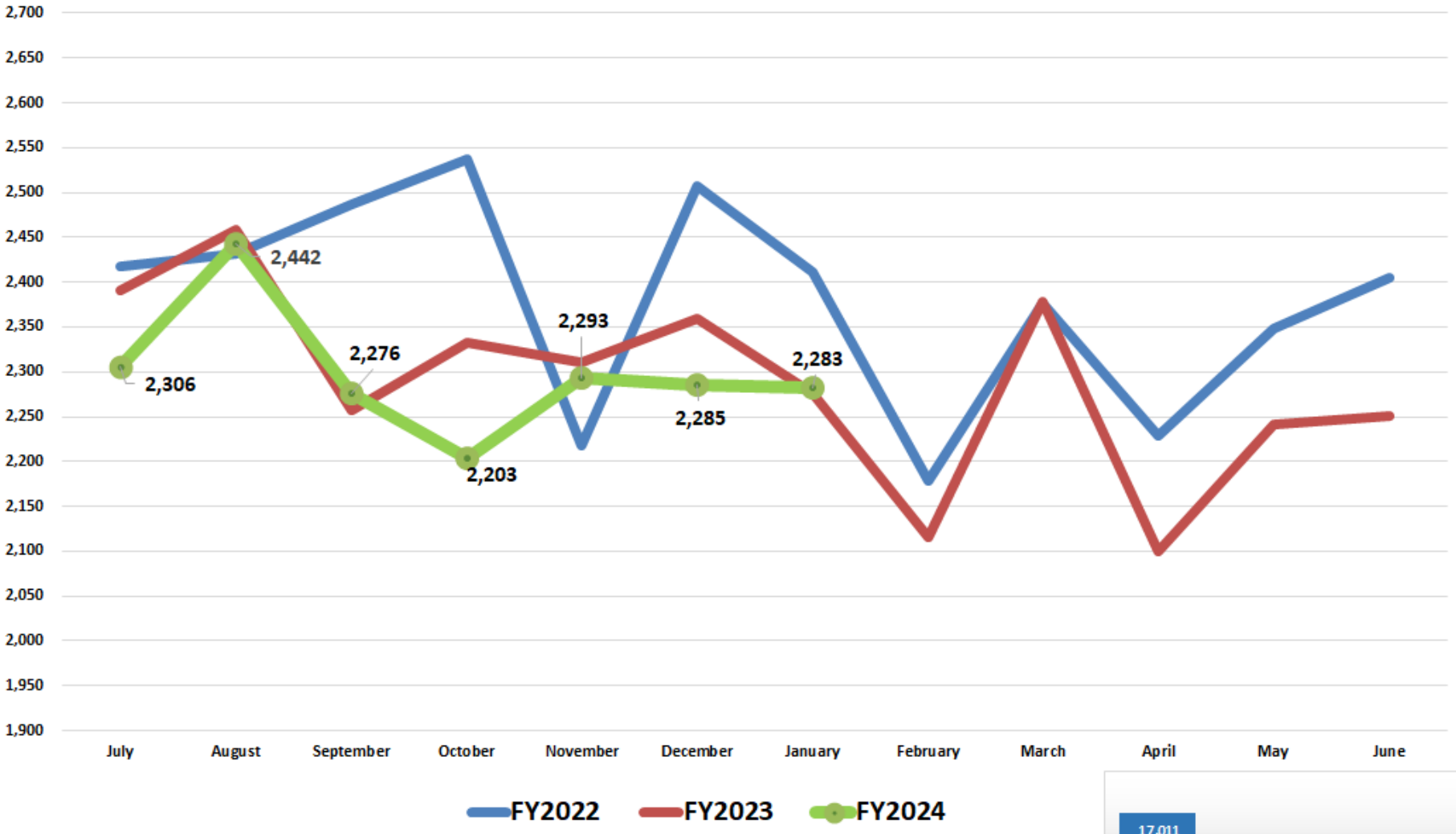
1,950
1,900
2,298
2,487
2,248
2,265
2,309
2,277
2,523
July
August
September
October
November
December
January
February
March
April
May
June
FY2022
FY2023
FY2024
17,104
16,363
16,407
YTD FY22
YTD FY23
YTD FY24

Discharges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2,350
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2,250
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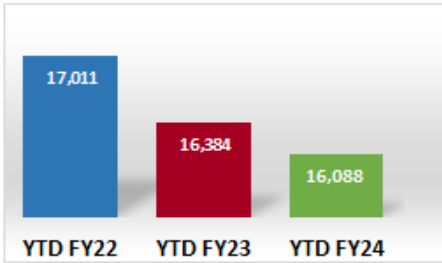
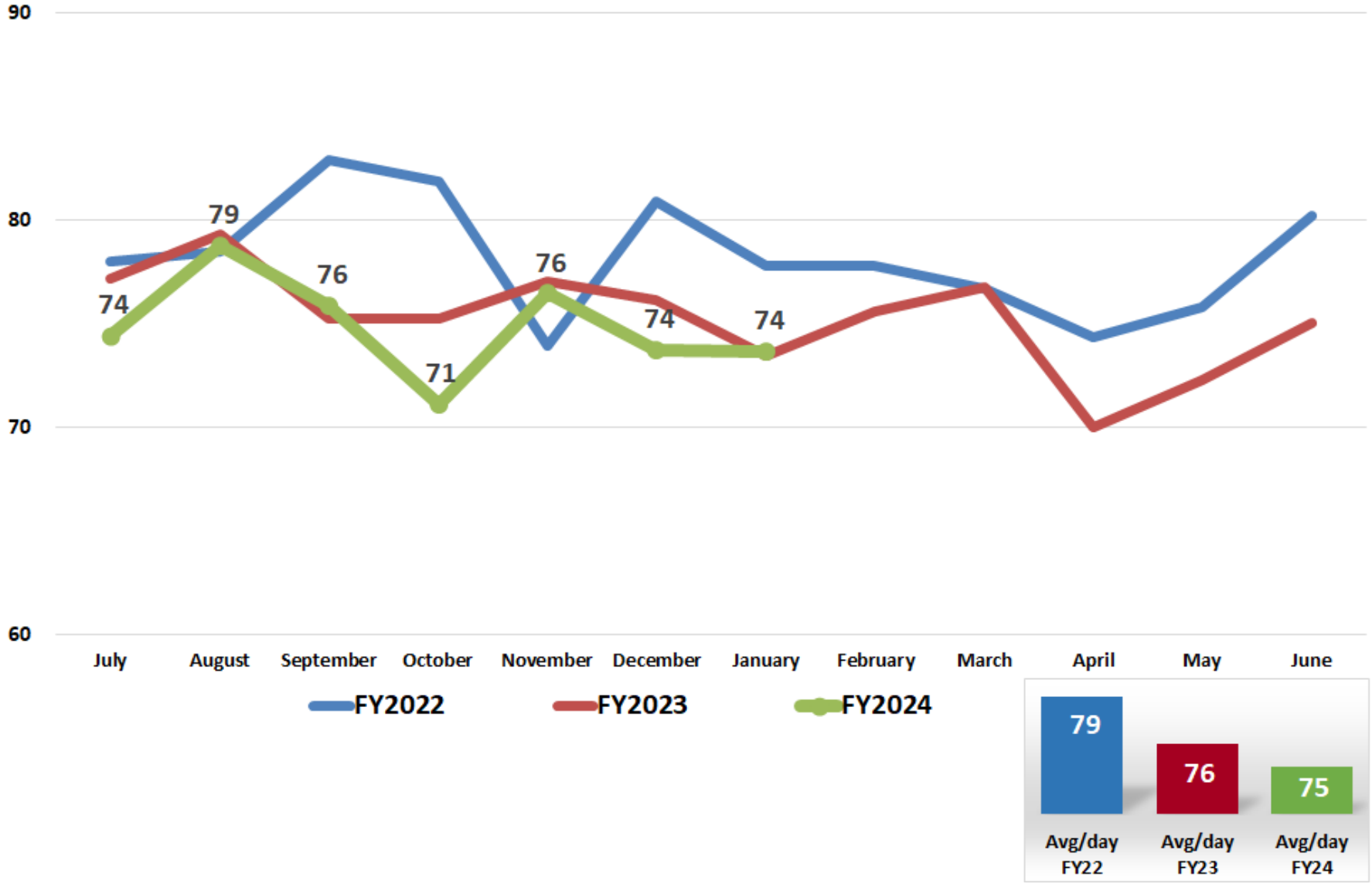
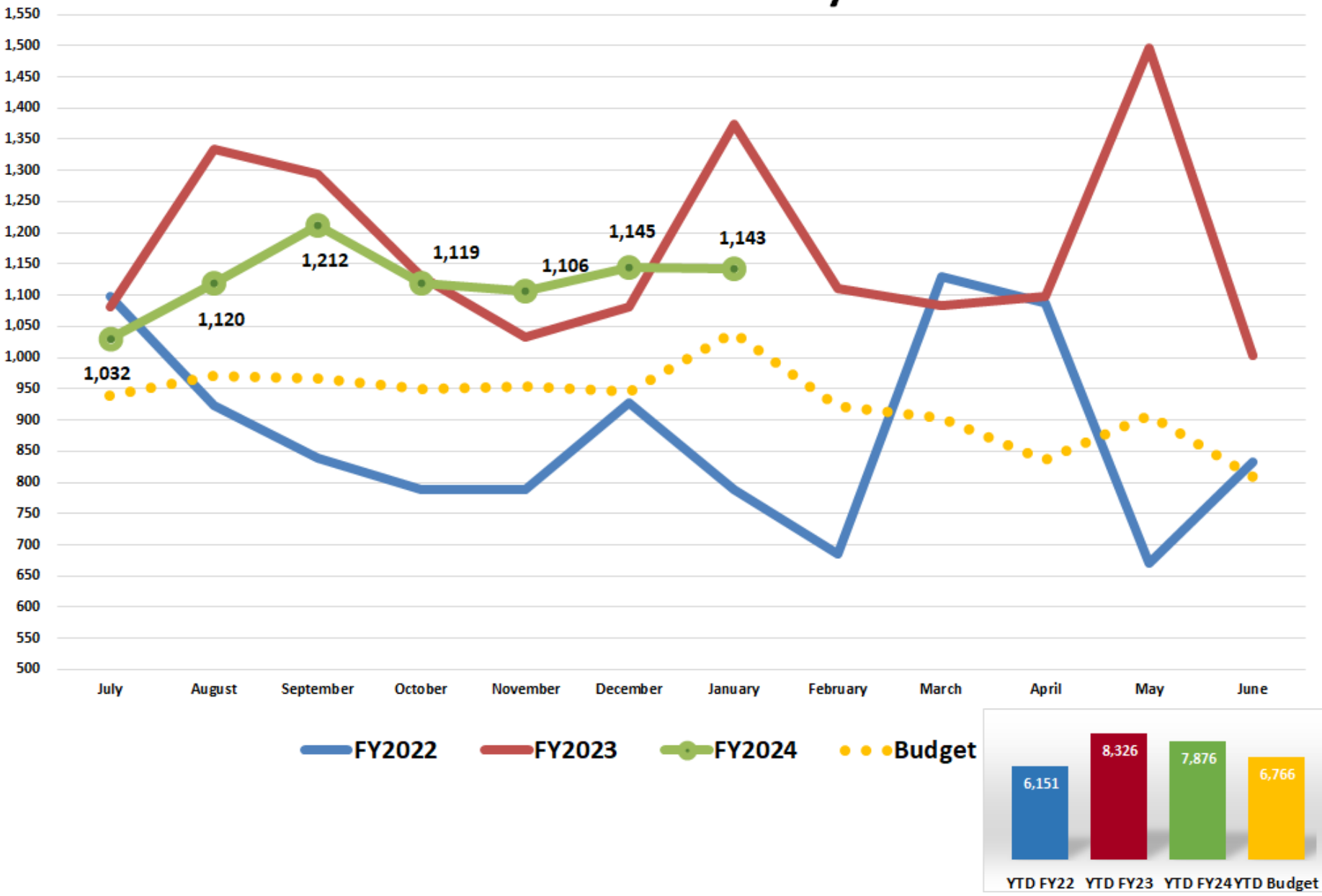
2,050
2,000
1,950
1,900
2,306
2,442
2,276
2,203
2,293
2,285
2,283
July
August
September
October
November
December
January
February
March
April
May
June
FY2022
FY2023
FY2024


17,011
16,384
16,088
YTD FY22
YTD FY23
YTD FY24

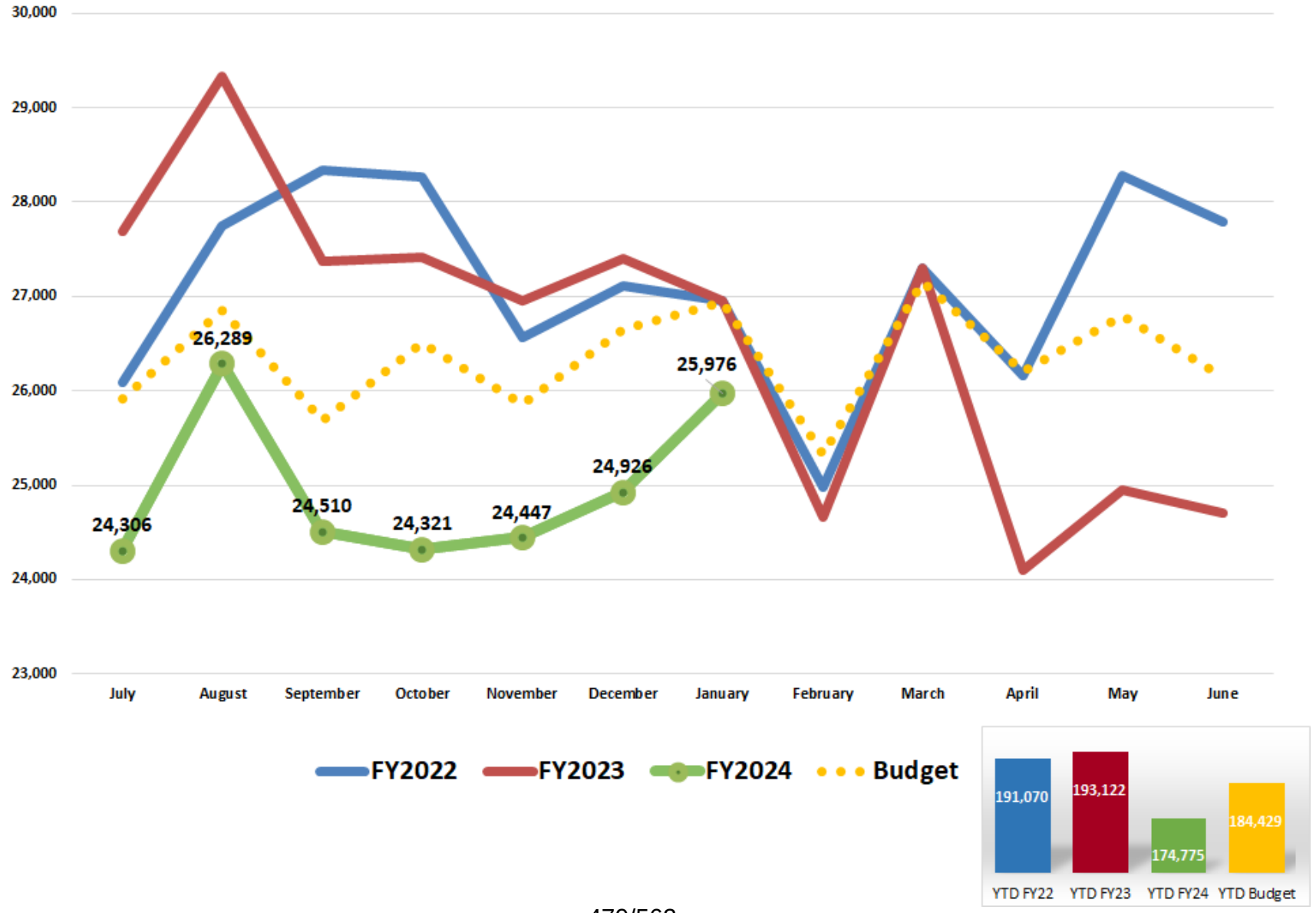
Average Discharges per day



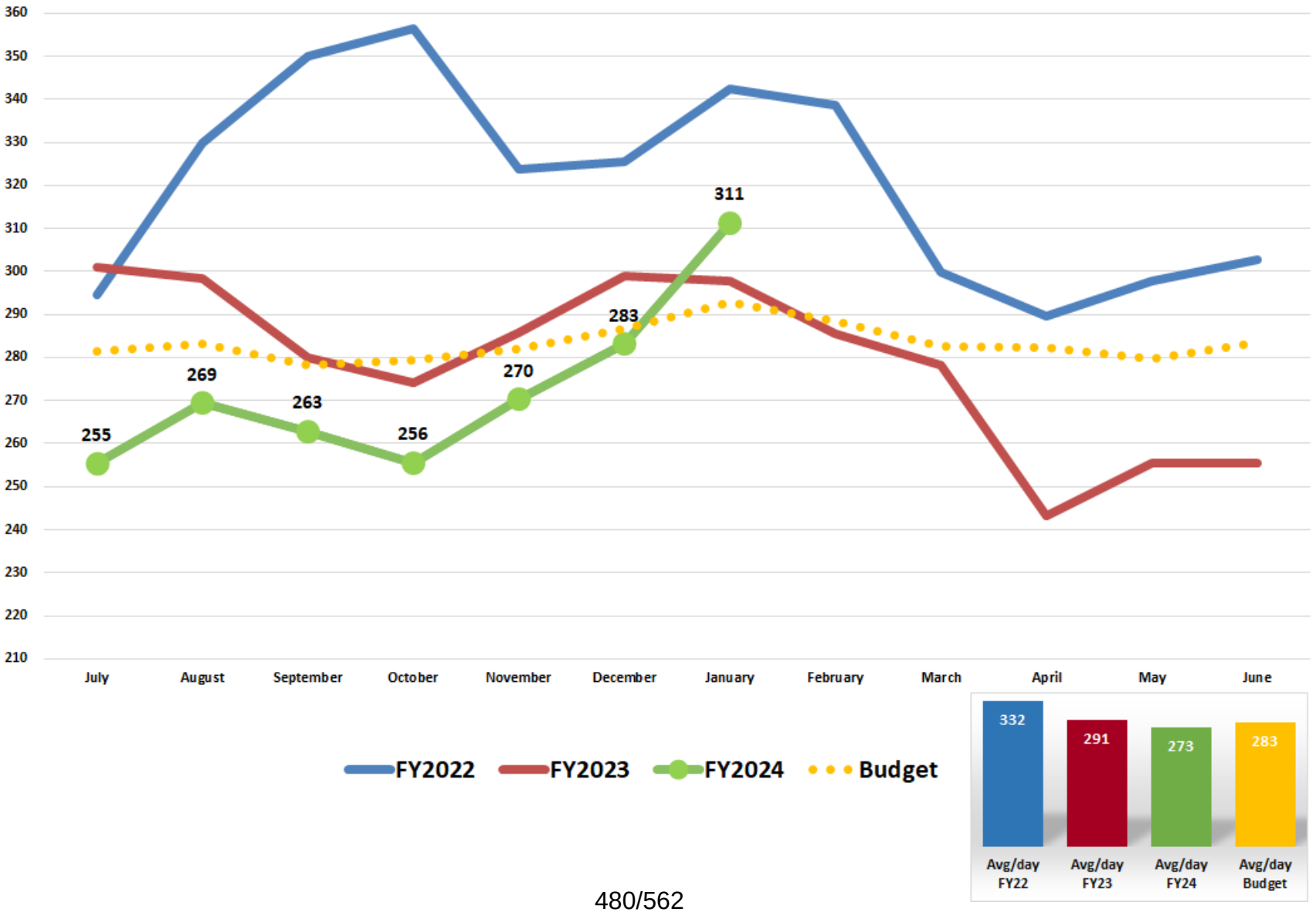
Observation Days



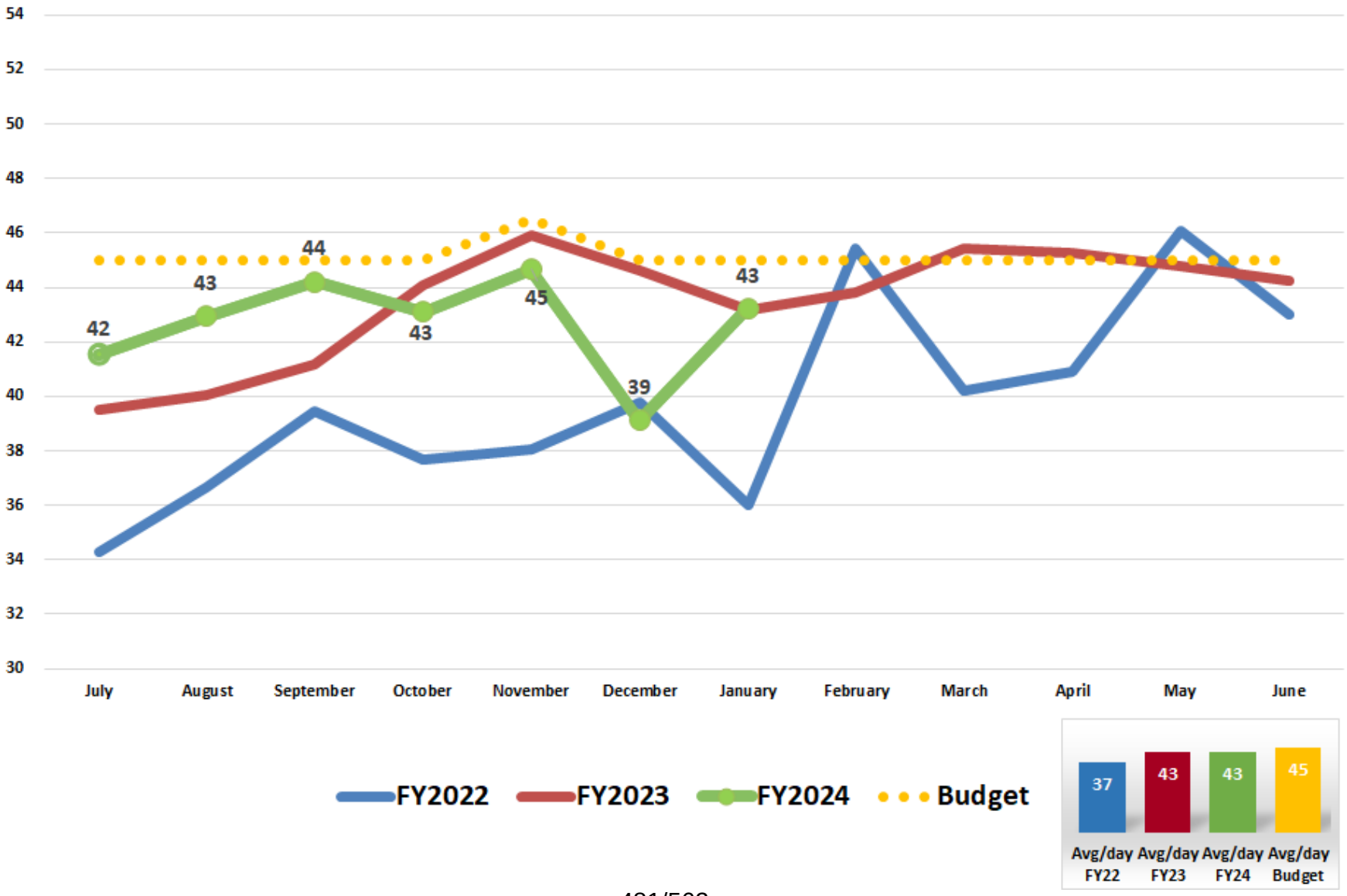
Adjusted Patient Days



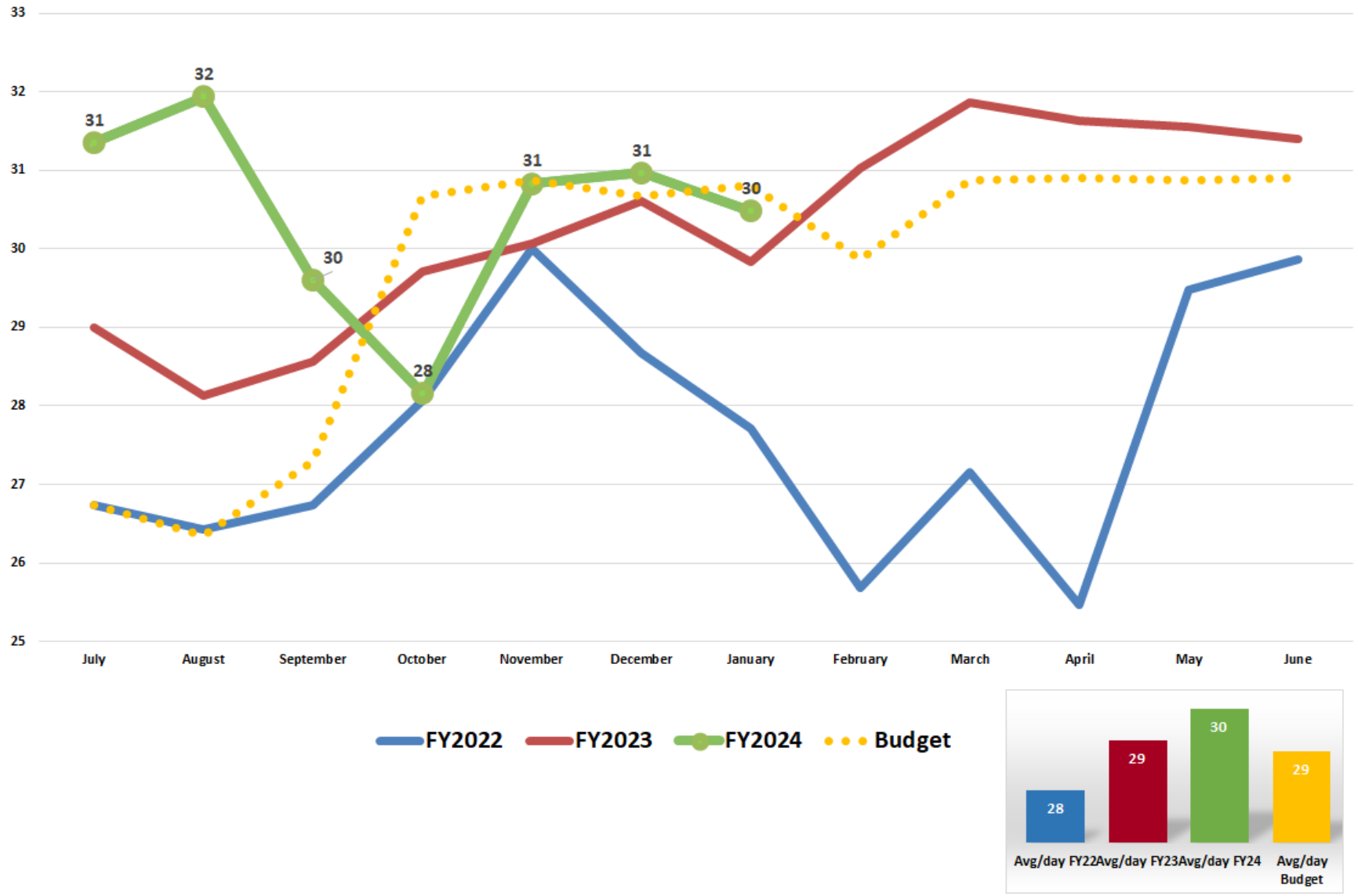
Medical Center (Avg Patients Per Day)



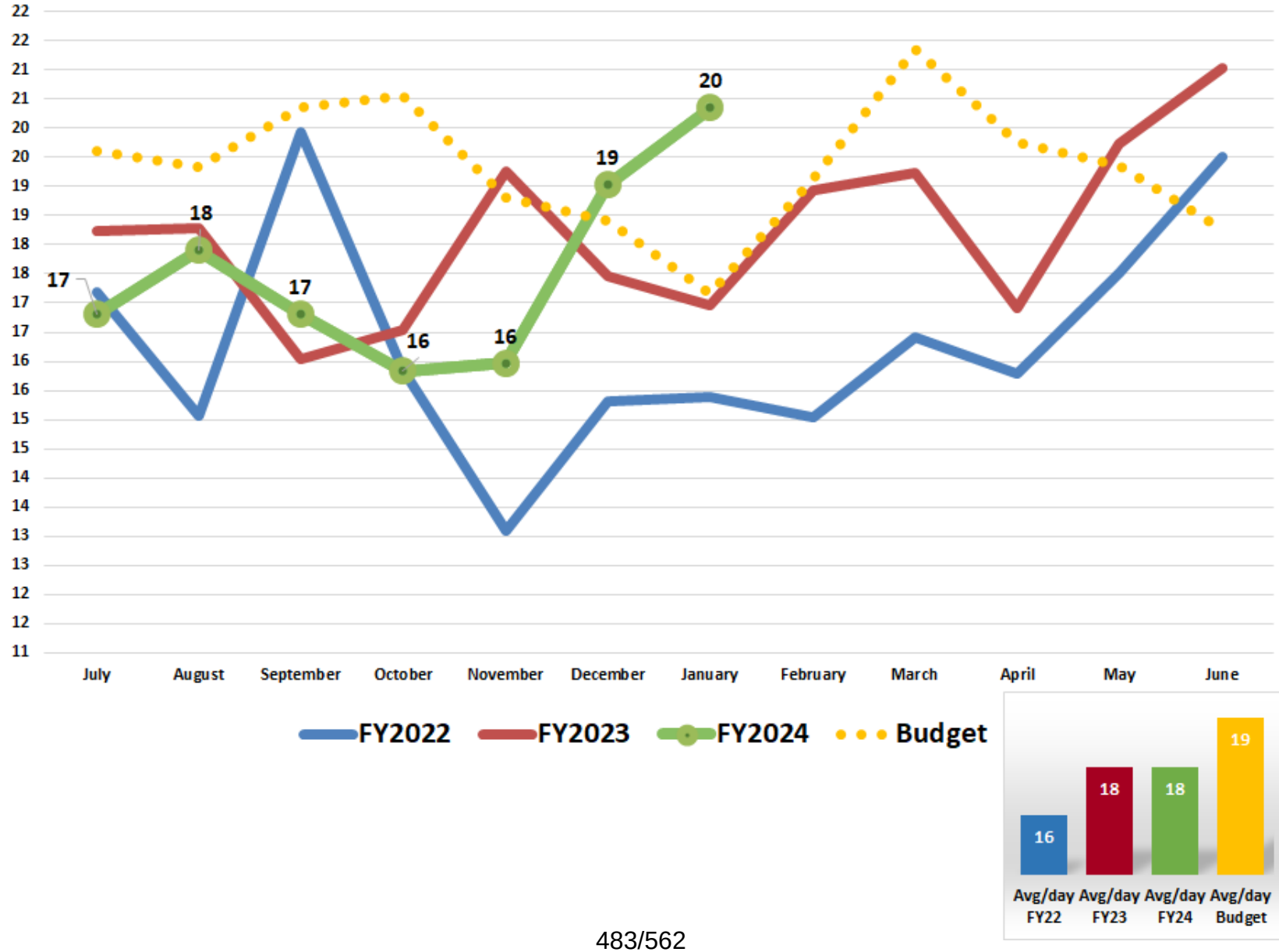
Acute I/P Psych (Avg Patients Per Day)



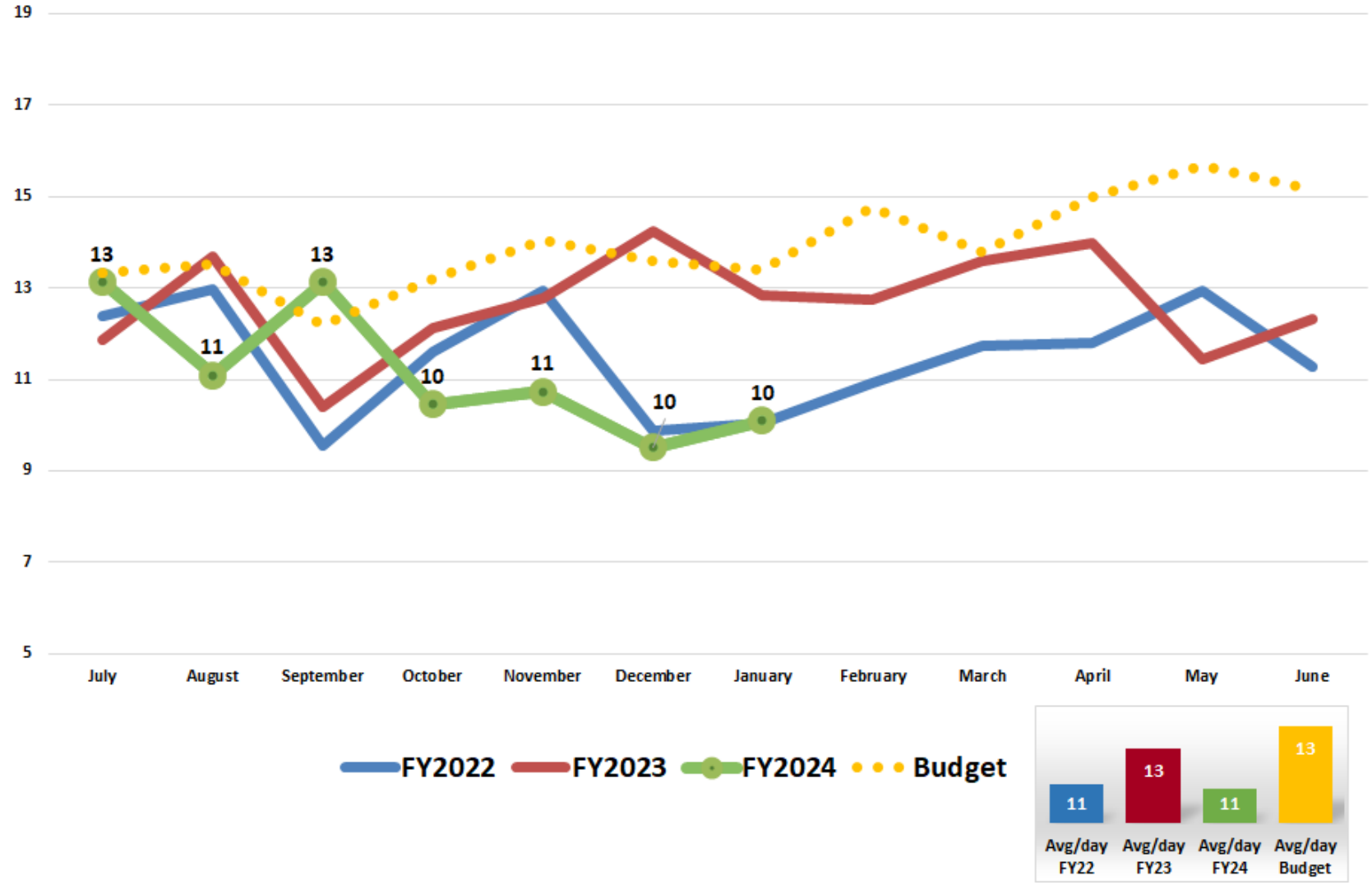
Sub-Acute - Avg Patients Per Day



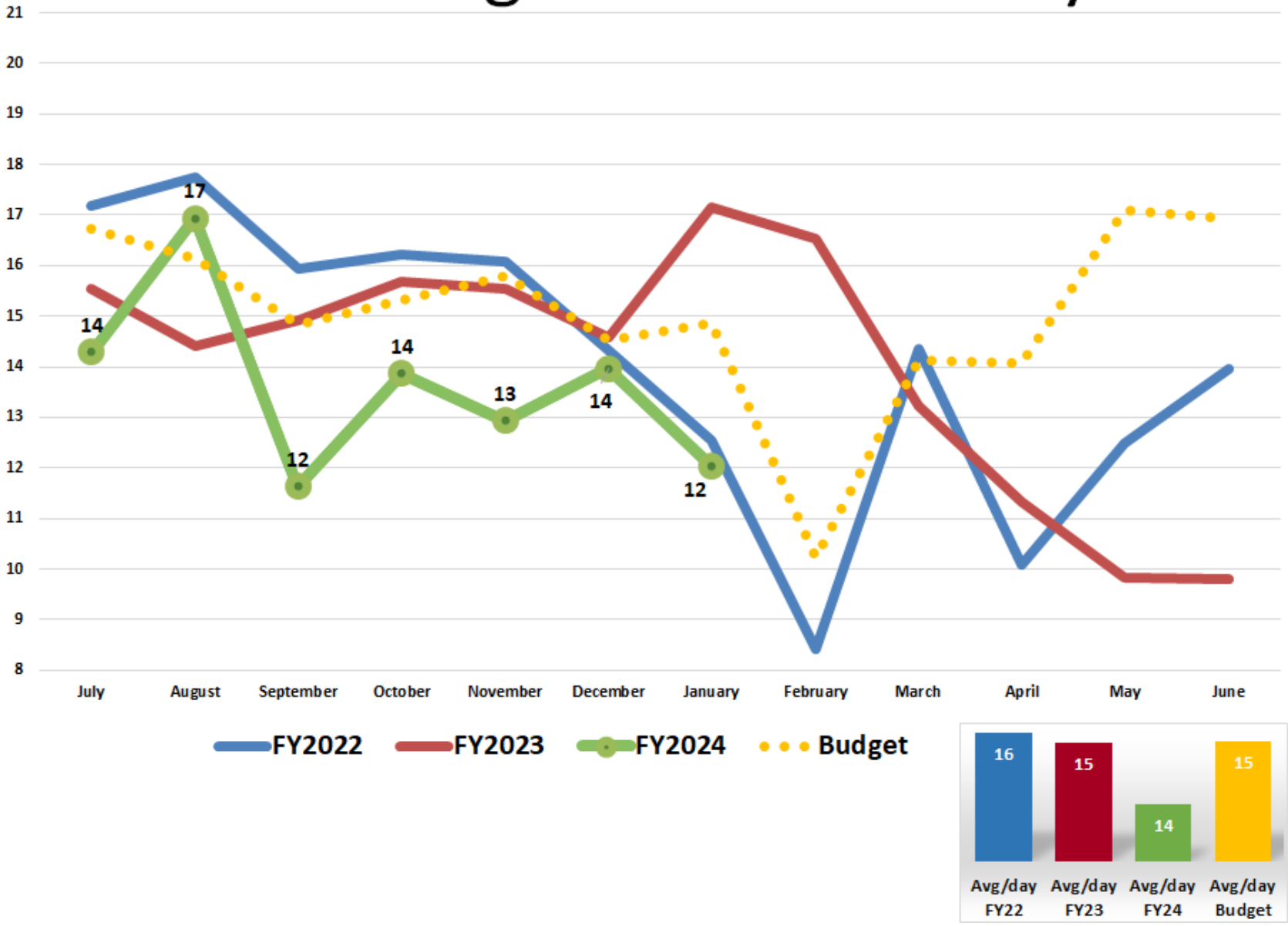
Rehabilitation Hospital - Avg Patients Per Day



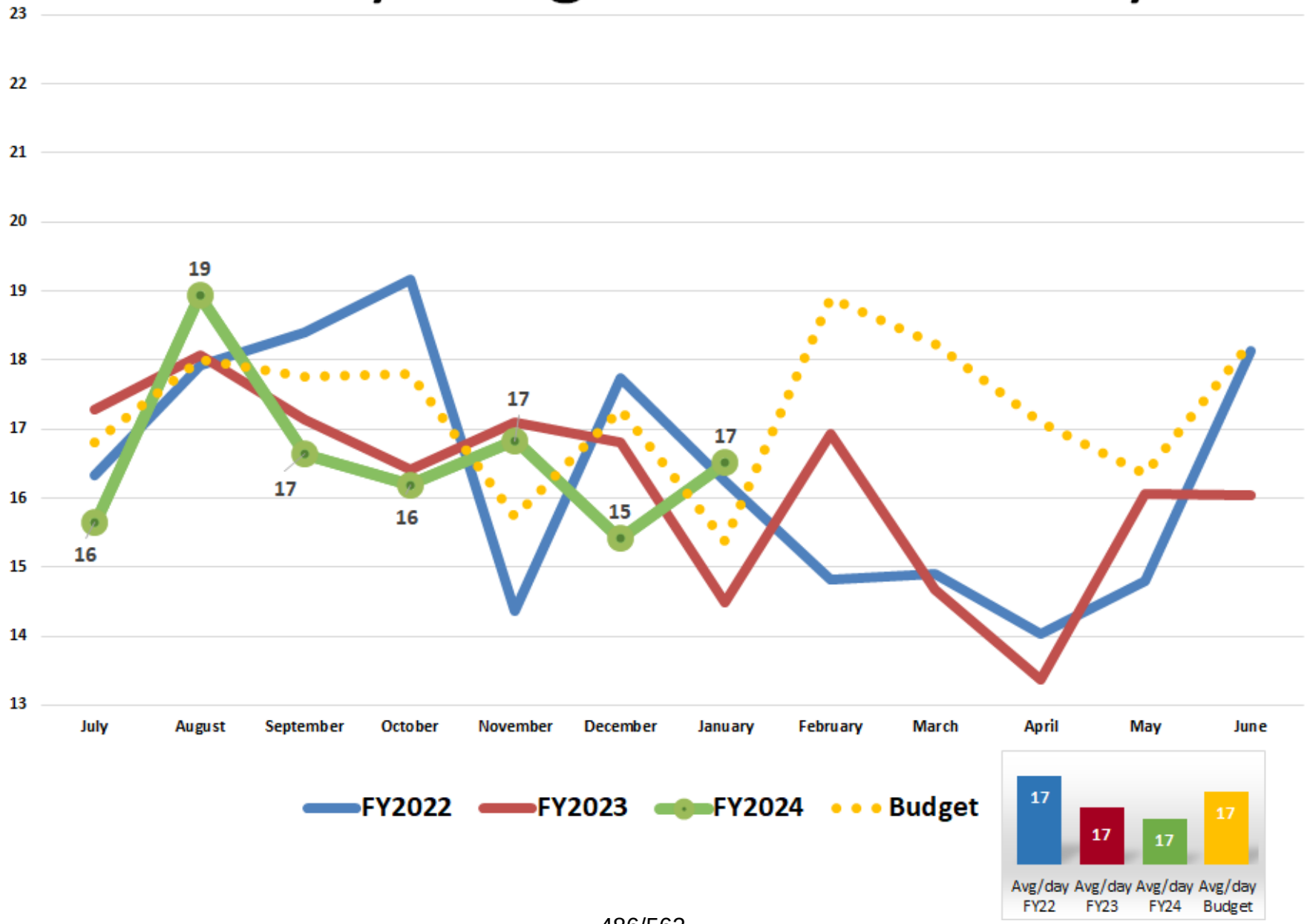
TCS Ortho - Avg Patients Per Day



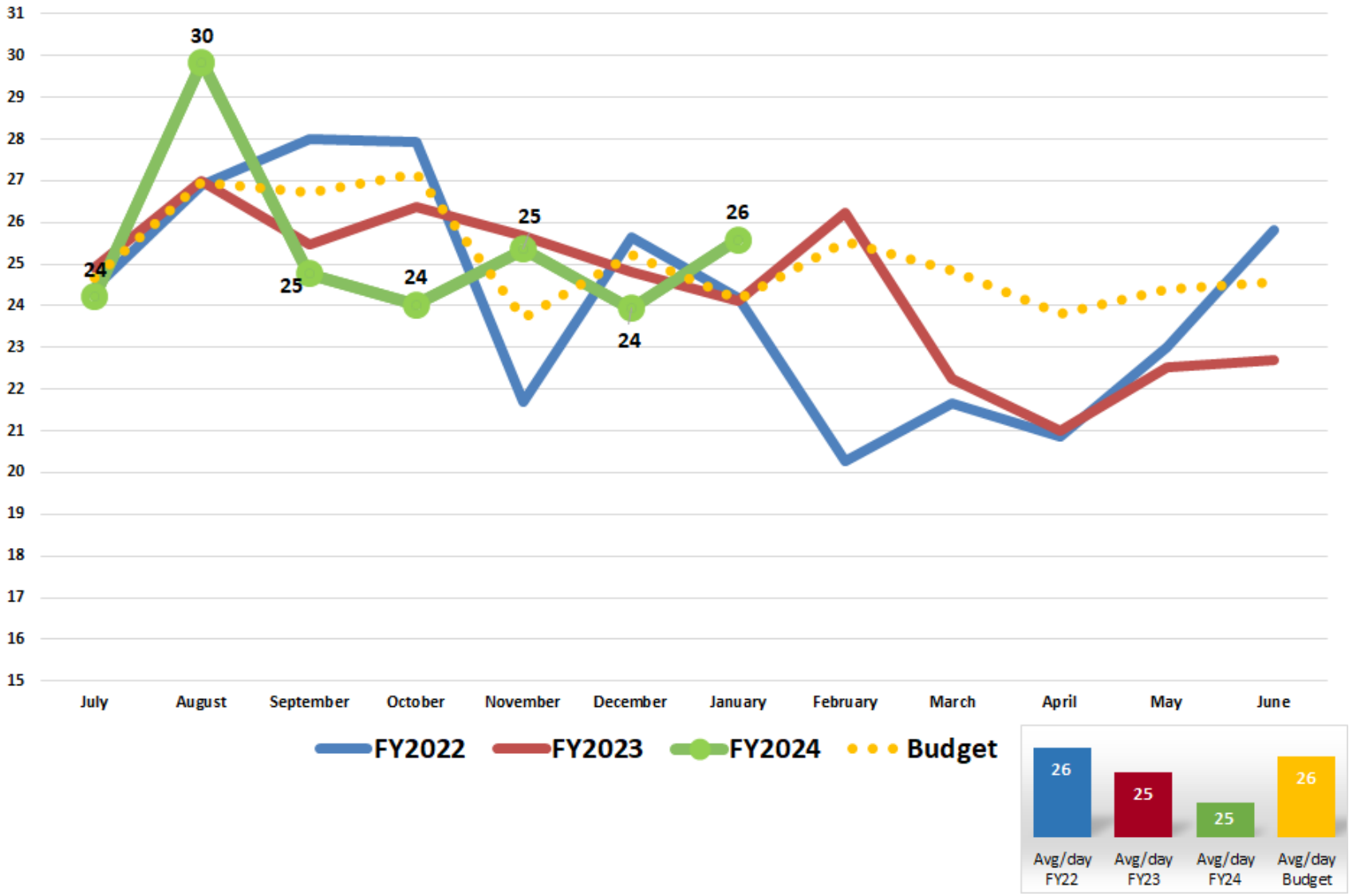
NICU - Avg Patients Per Day



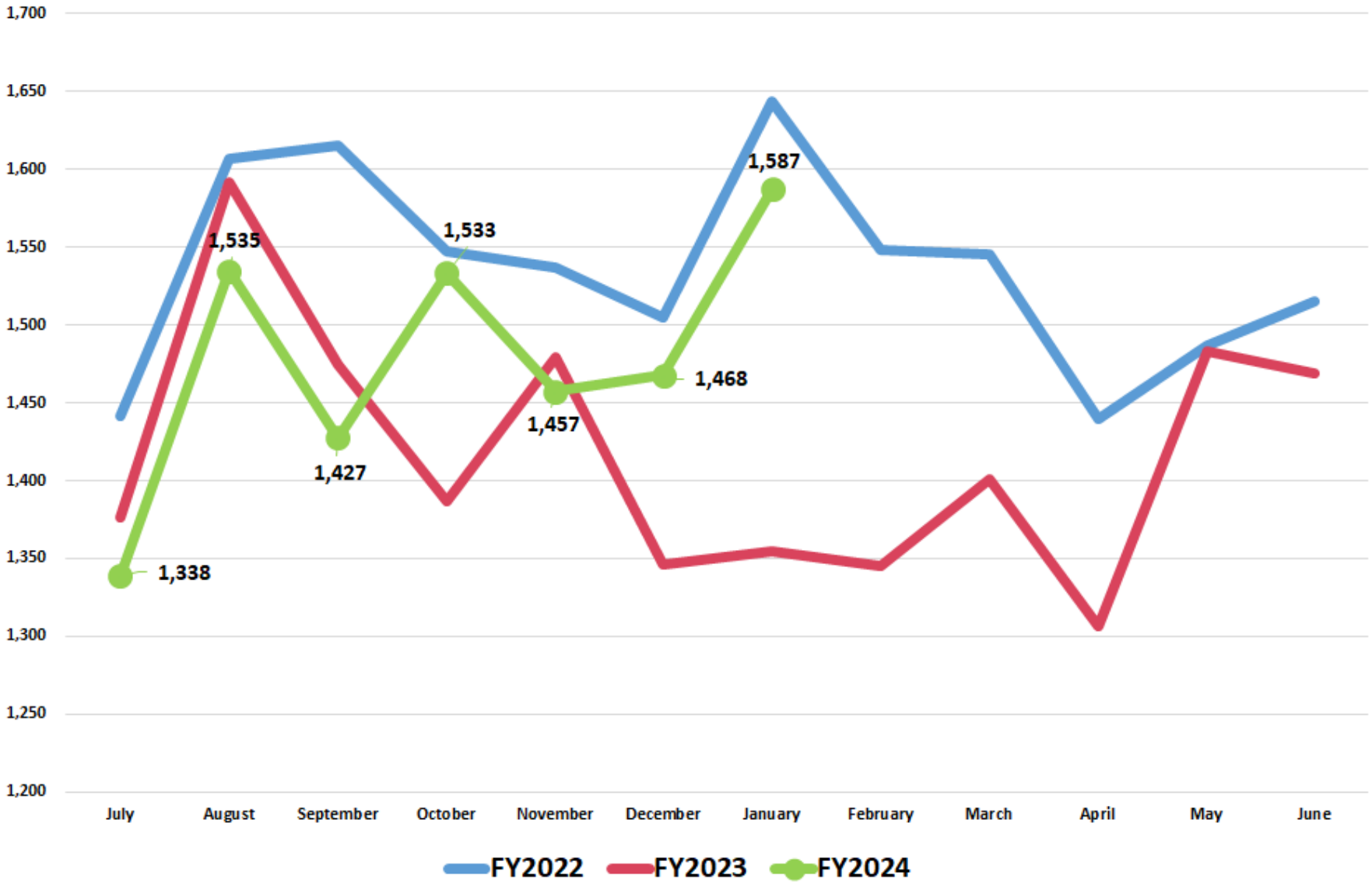
Nursery - Avg Patients Per Day



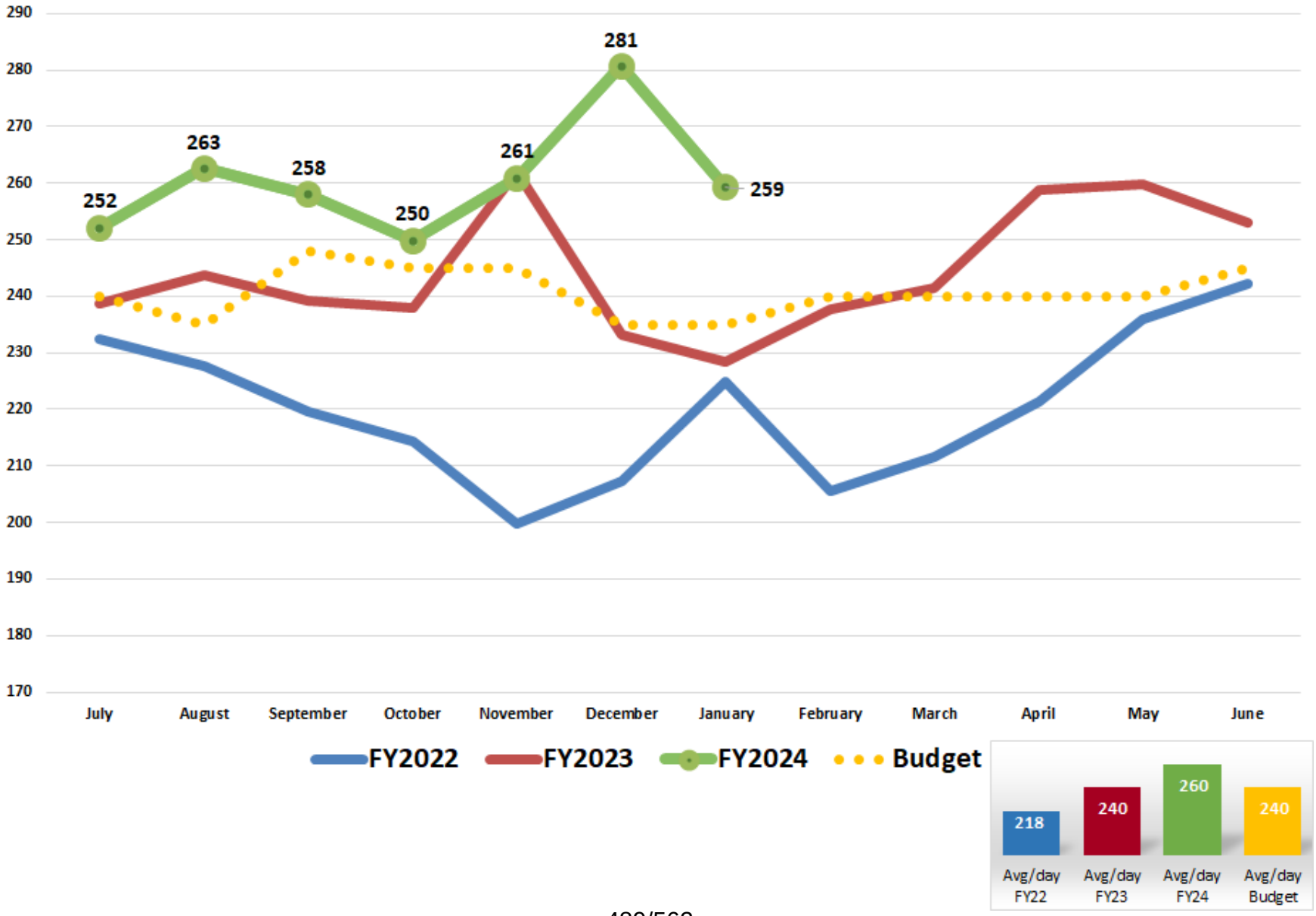
Obstetrics - Avg Patients Per Day



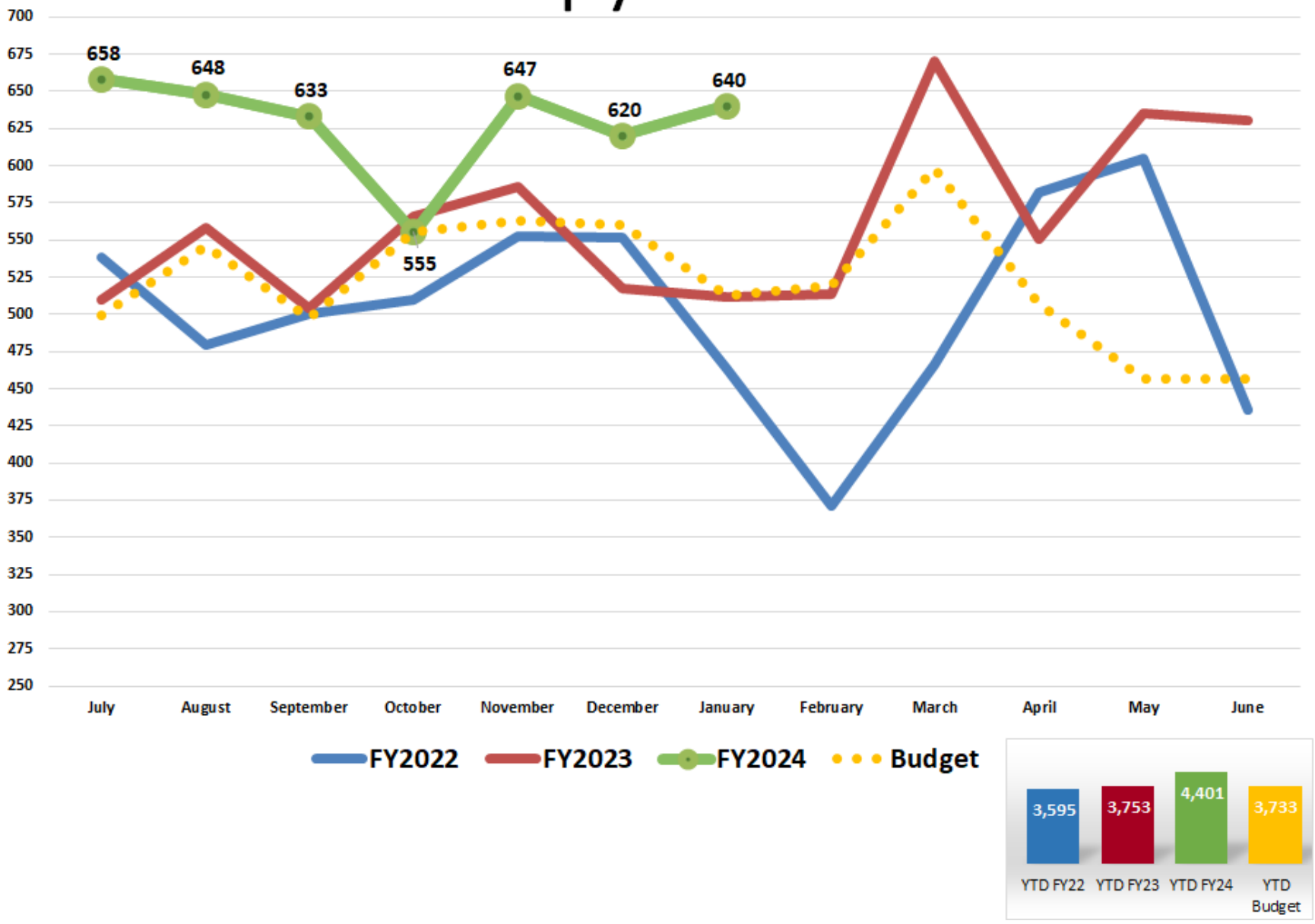
Outpatient Registrations Per Day



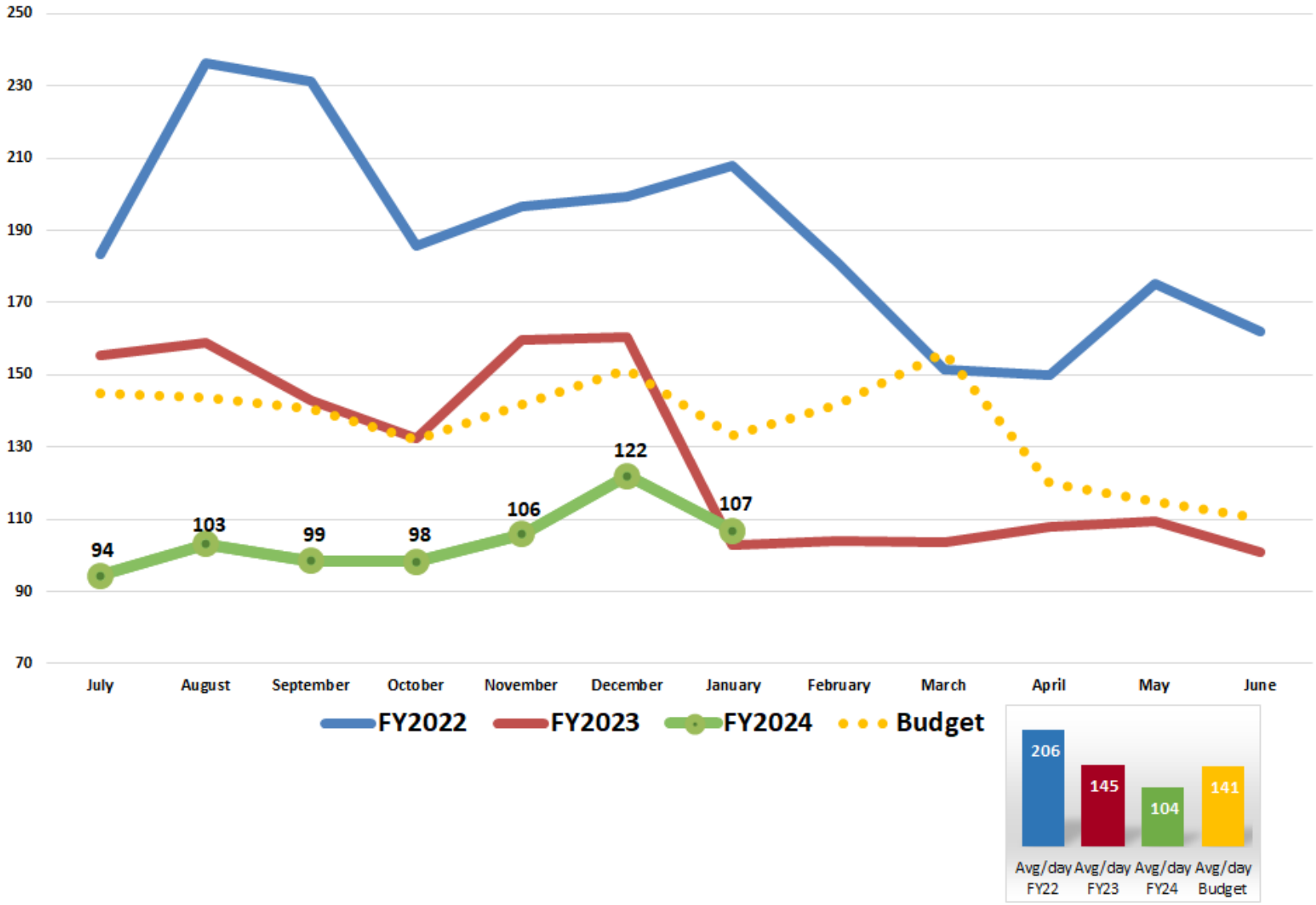
ED - Avg Treated Per Day



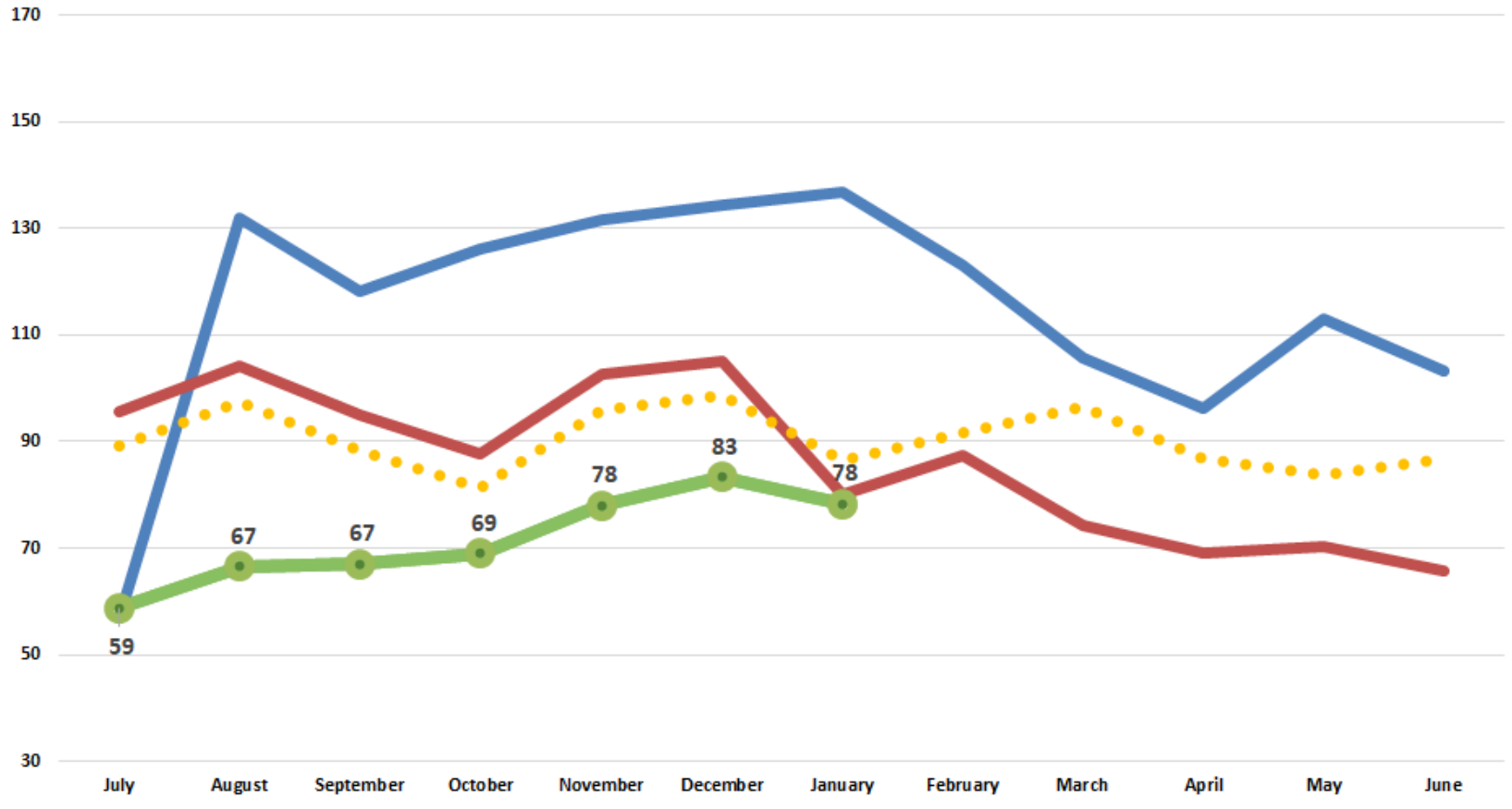
Endoscopy Procedures

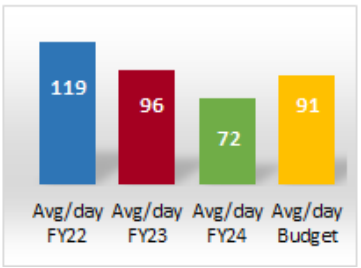


Urgent Care – Court Avg Visits Per Day

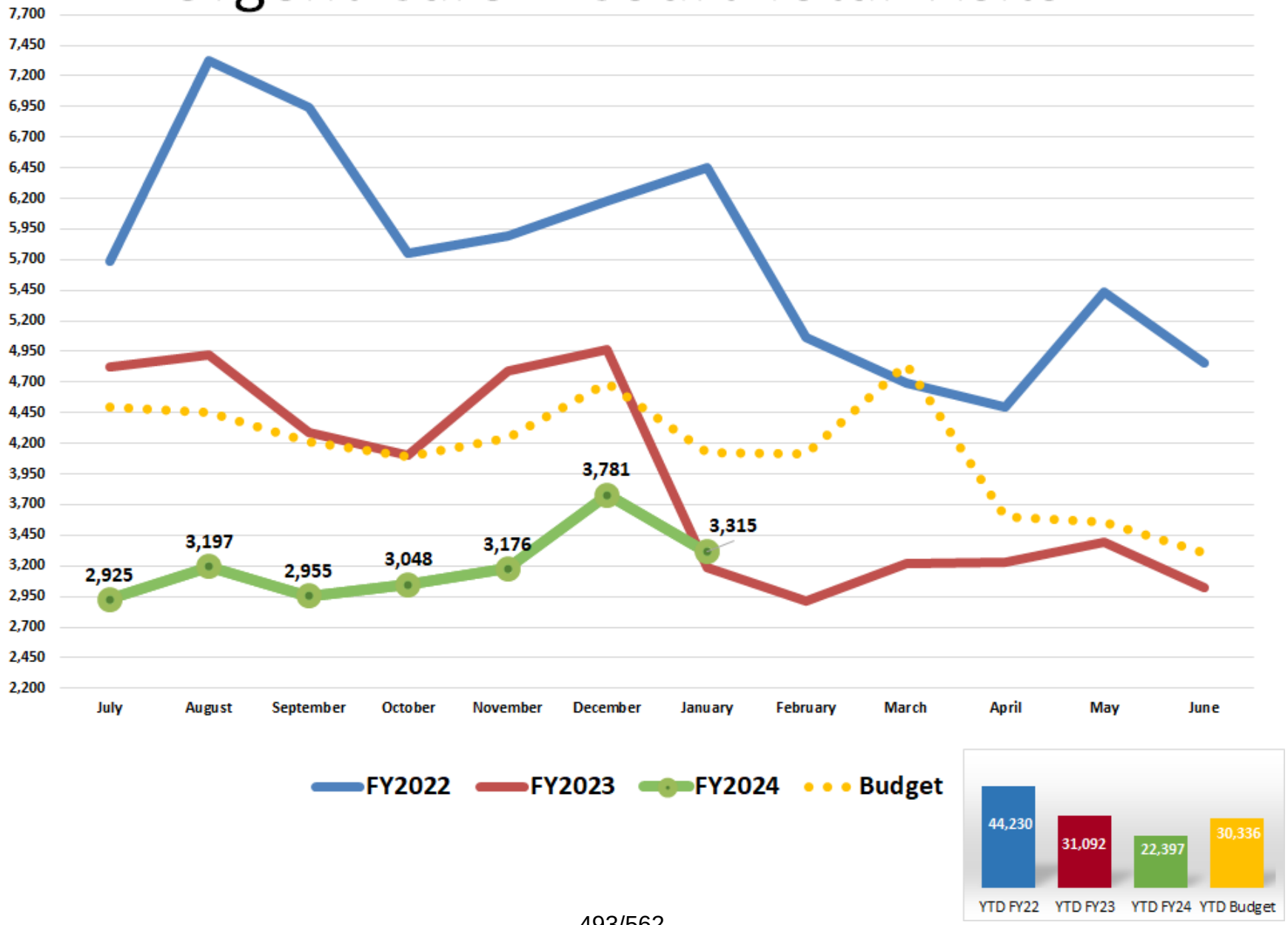


Urgent Care – Demaree Avg Visits Per Day

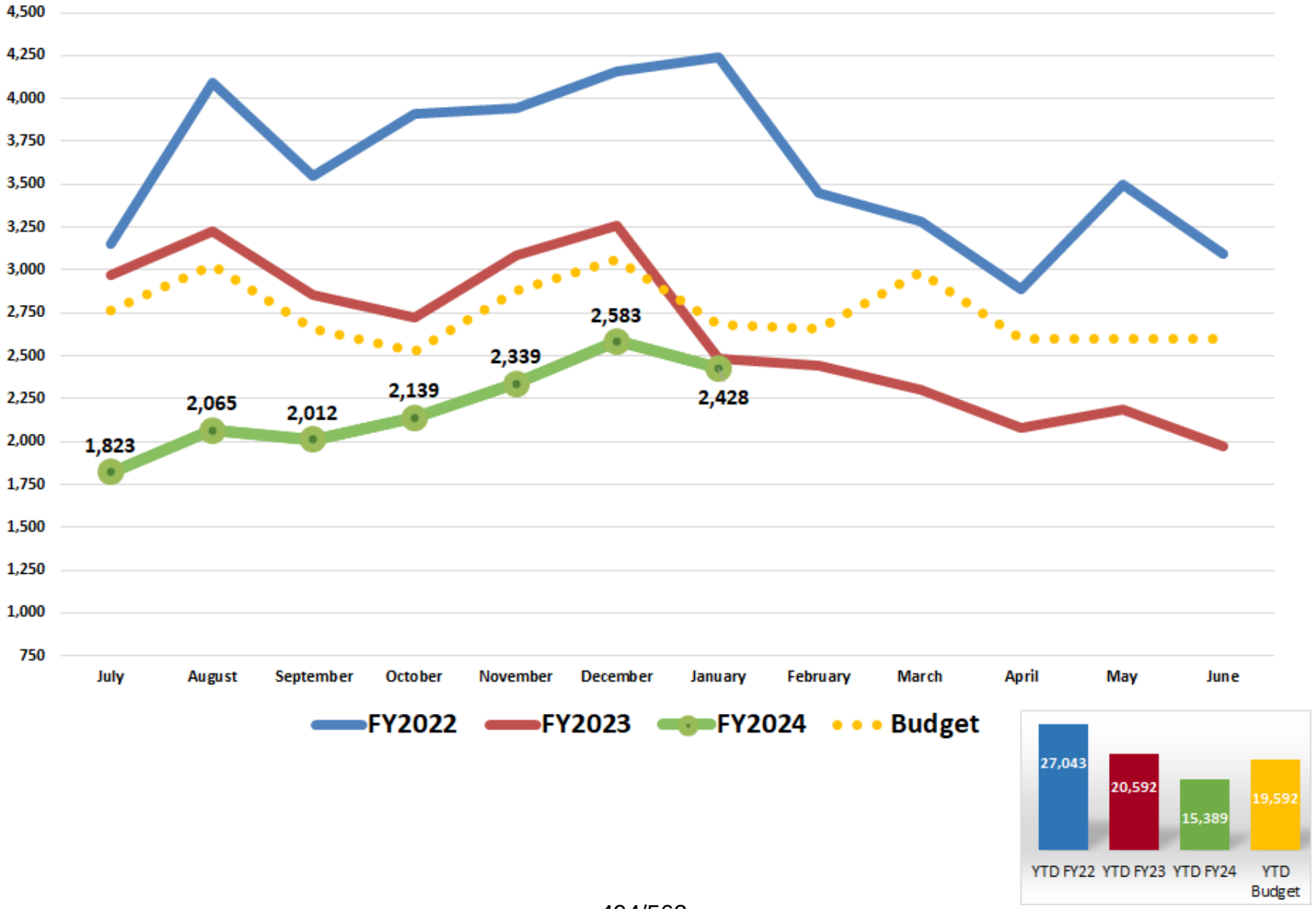




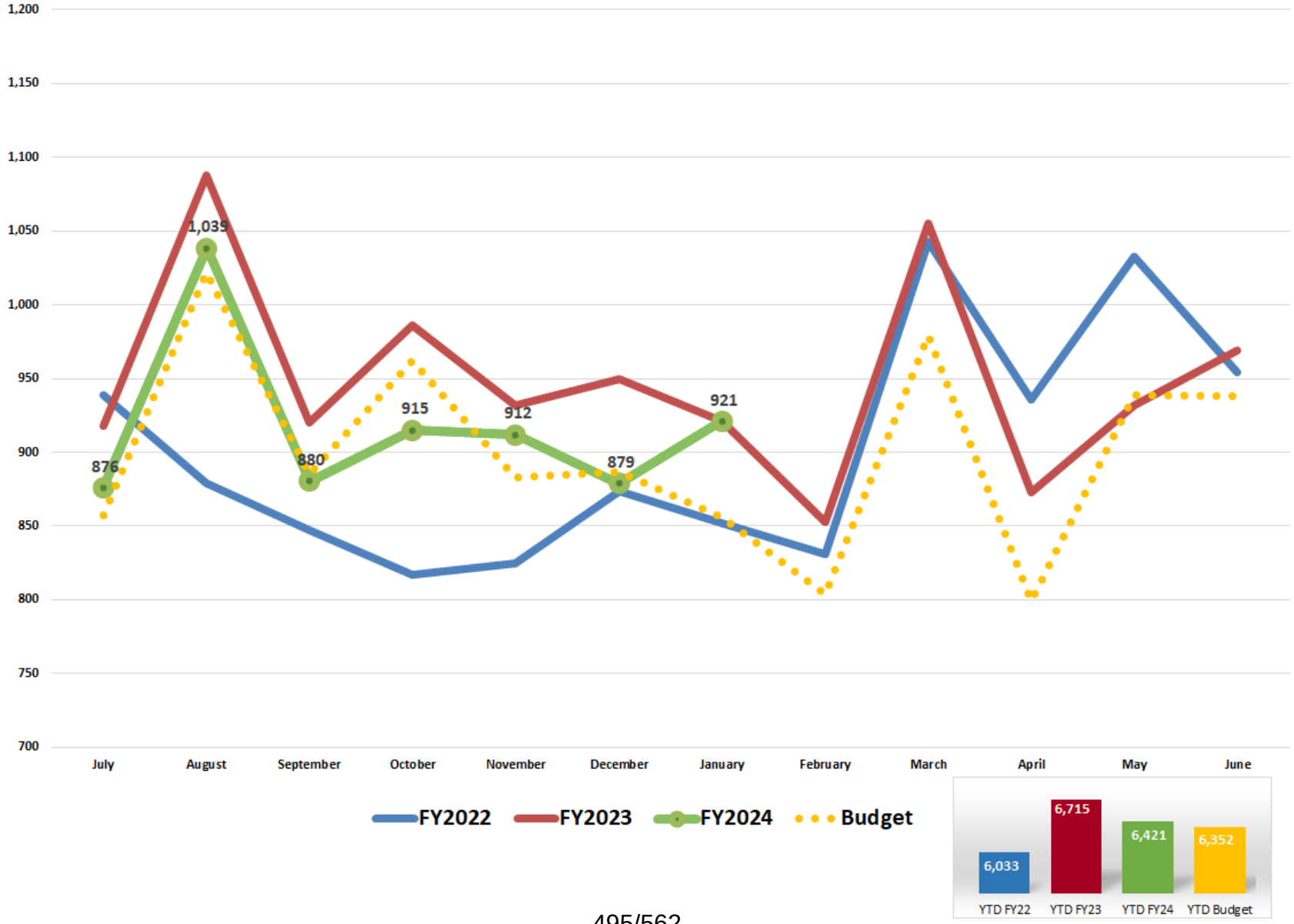
Urgent Care – Court Total Visits



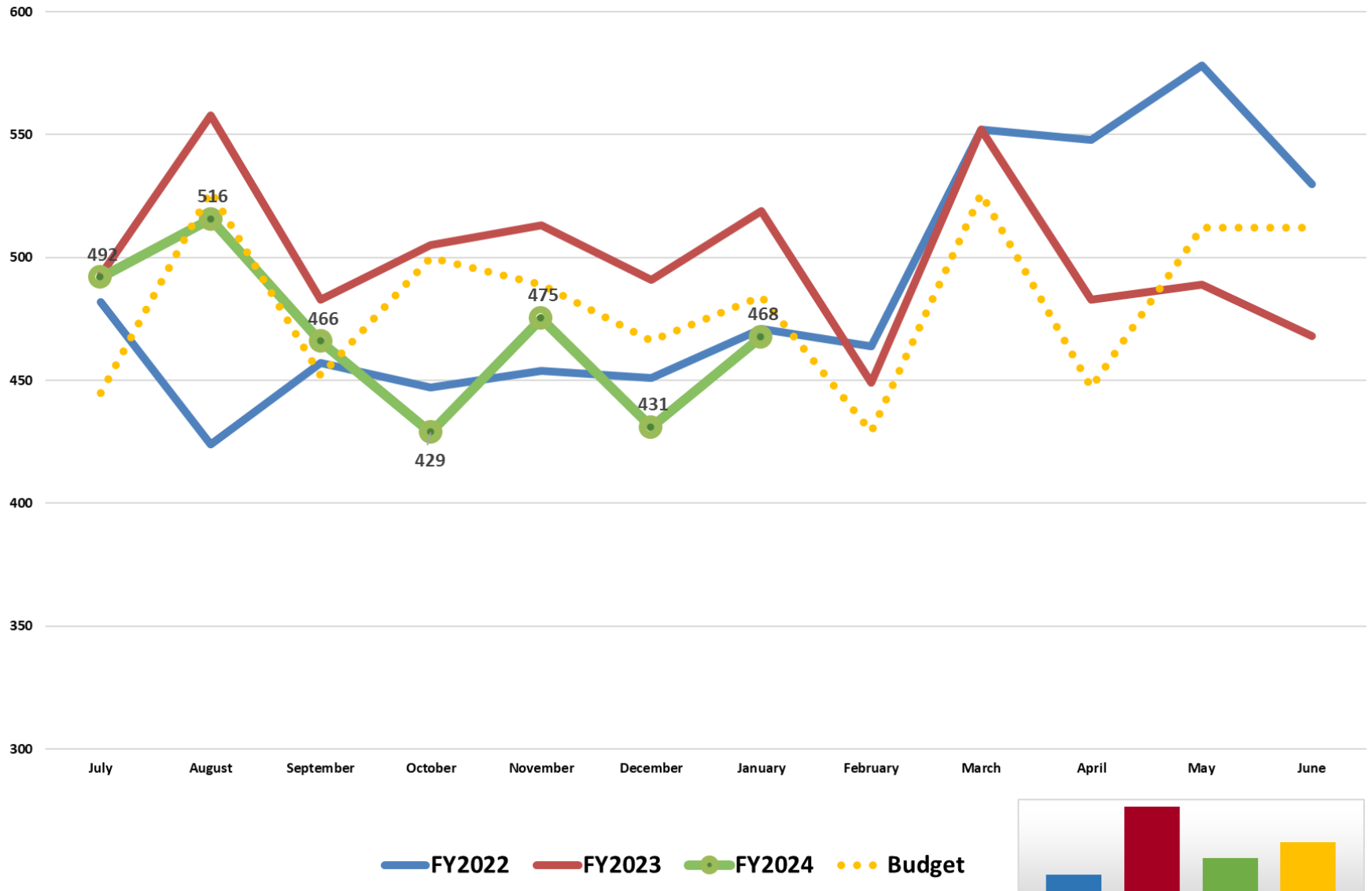
Urgent Care – Demaree Total Visits



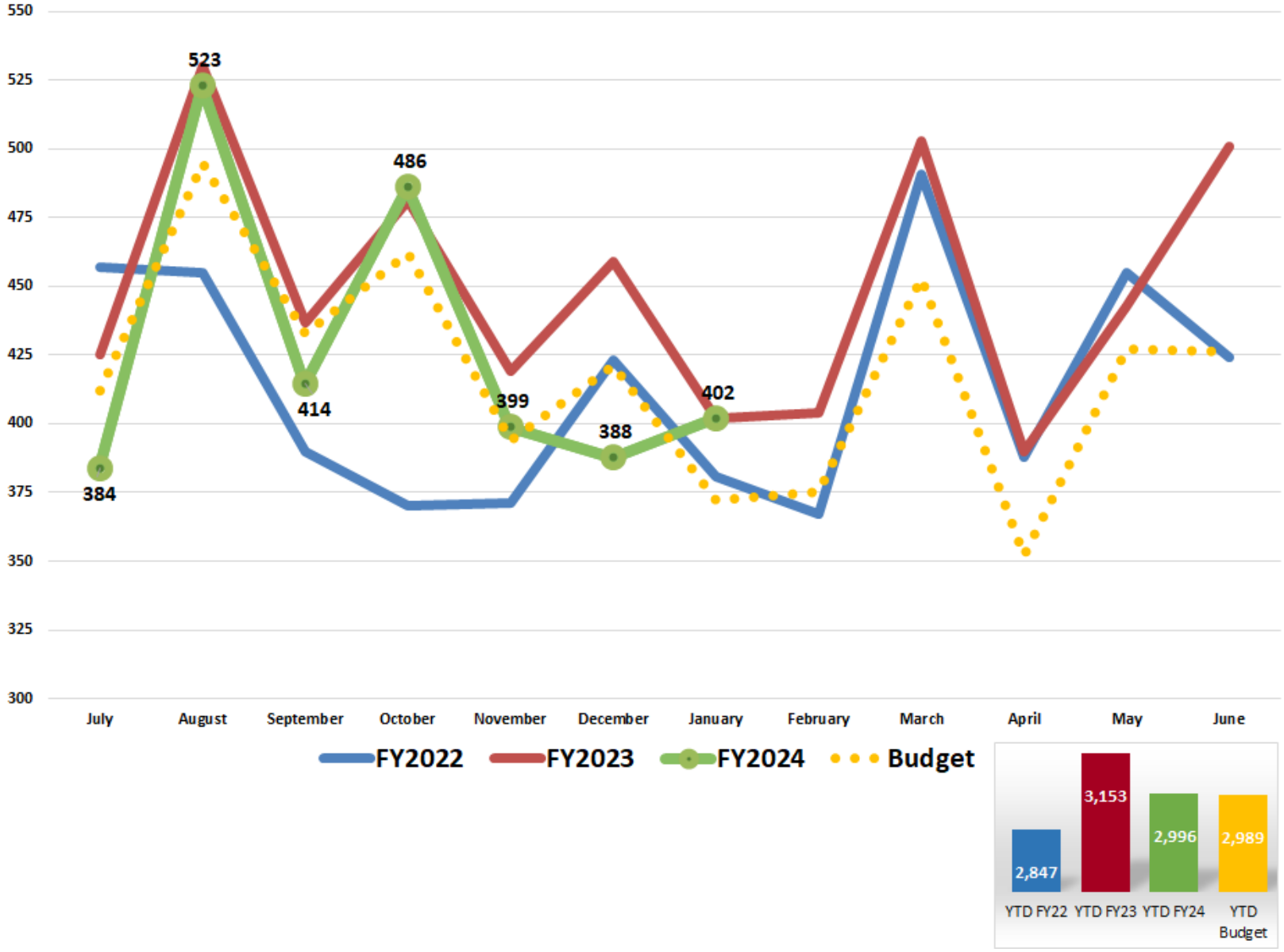
Surgery (IP & OP) – 100 Min Units



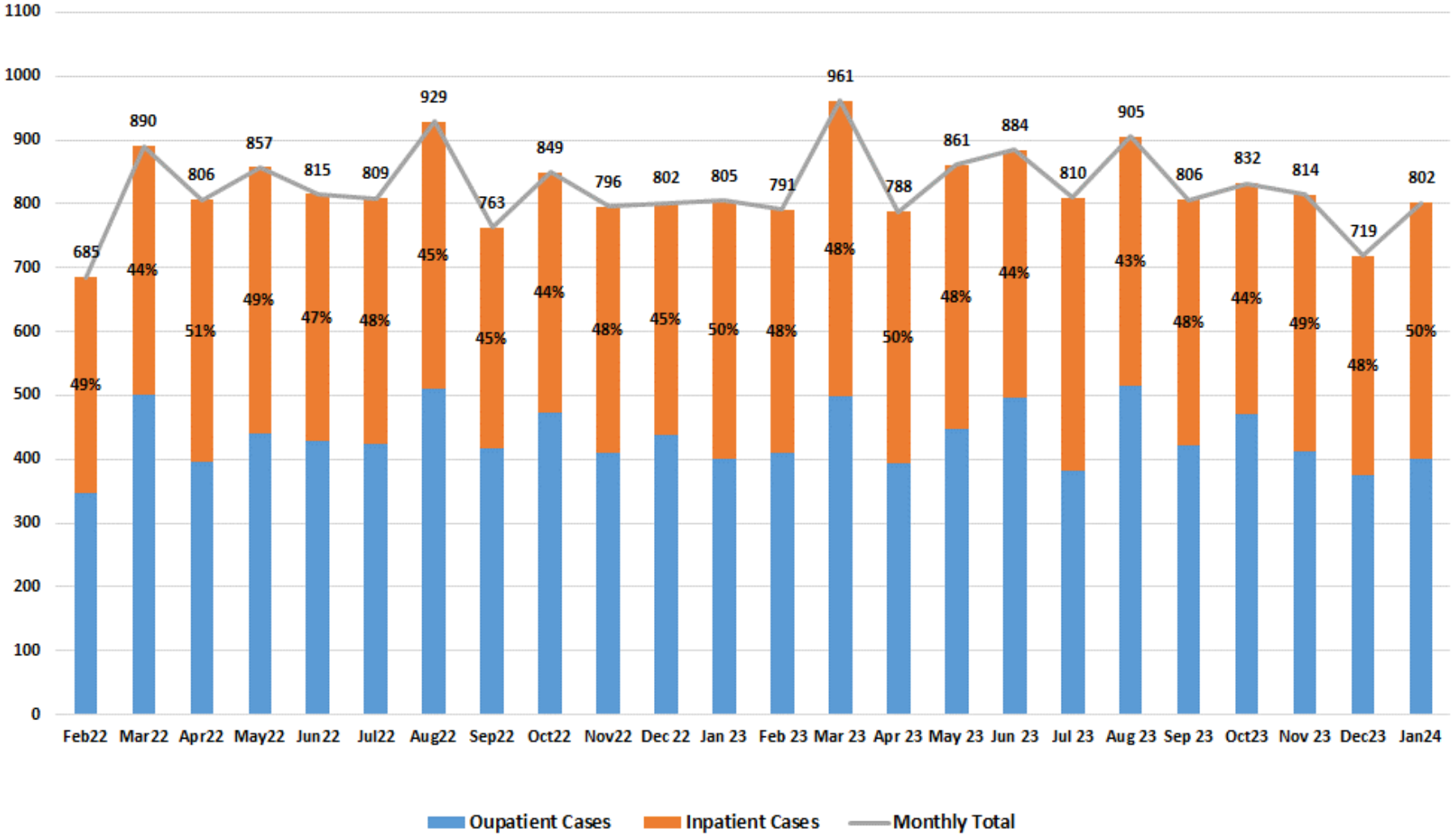
Surgery (IP Only) - 100 Min Unit



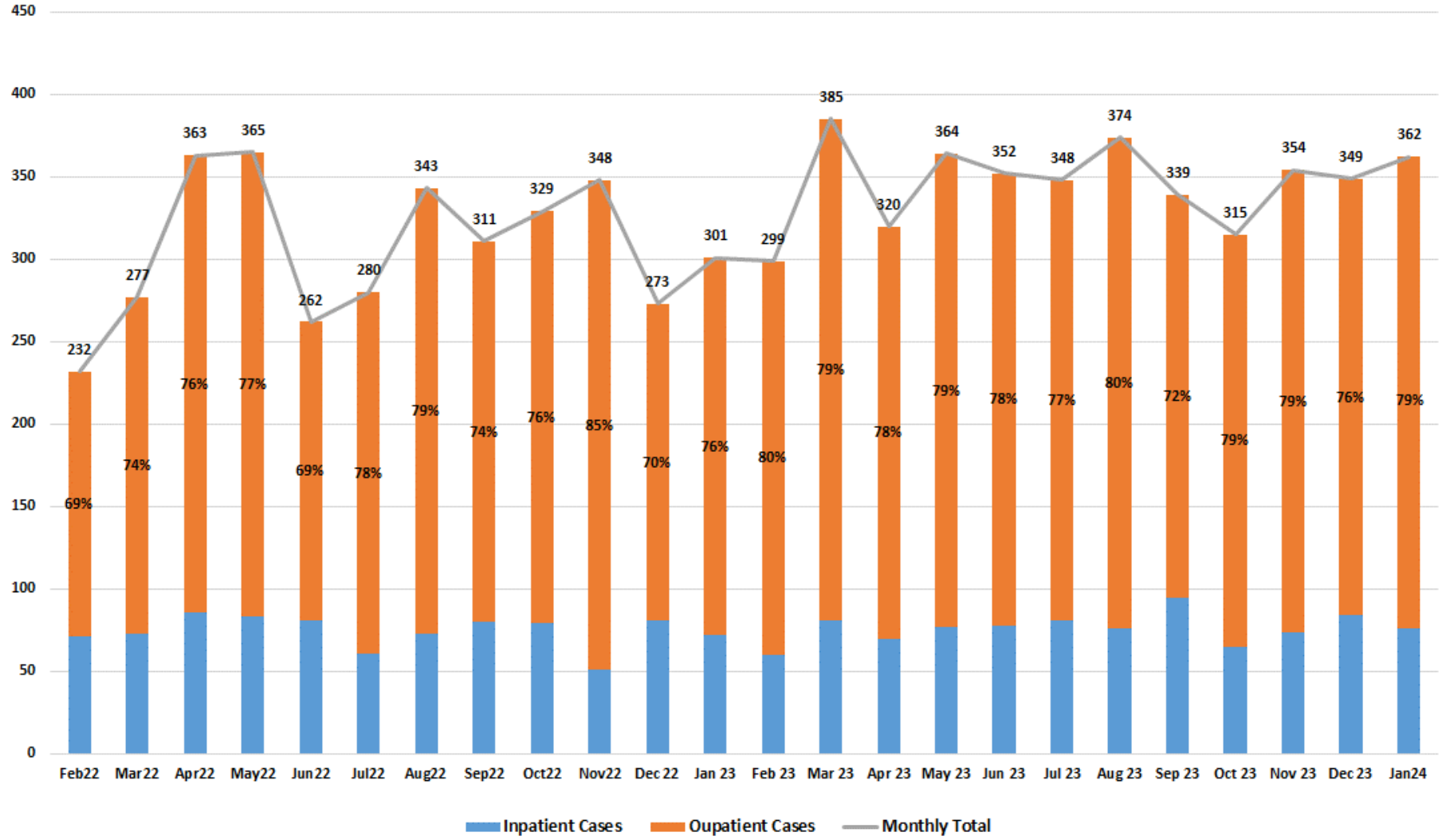
Surgery (OP Only) - 100 Min Units



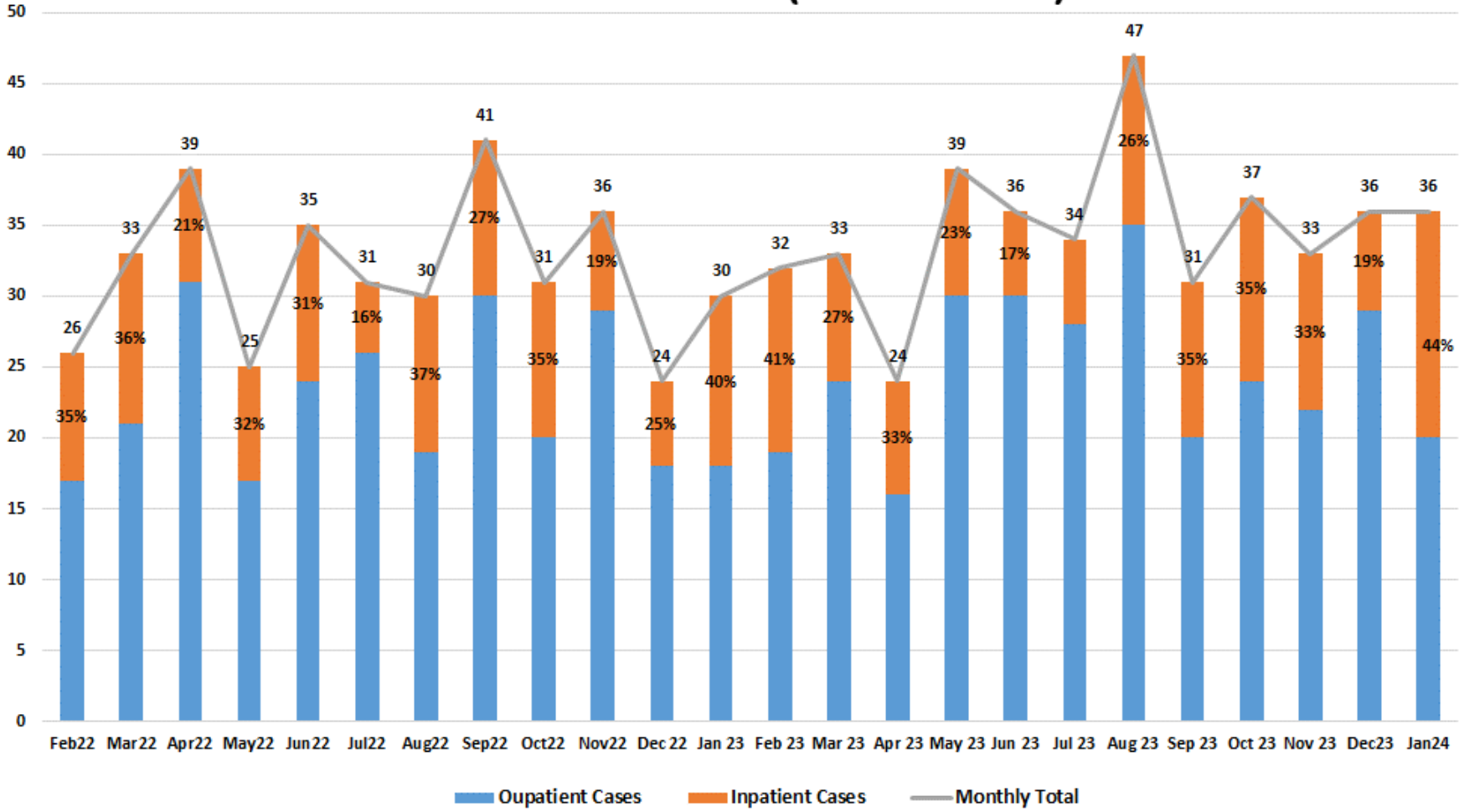
Surgery Cases (IP & OP)



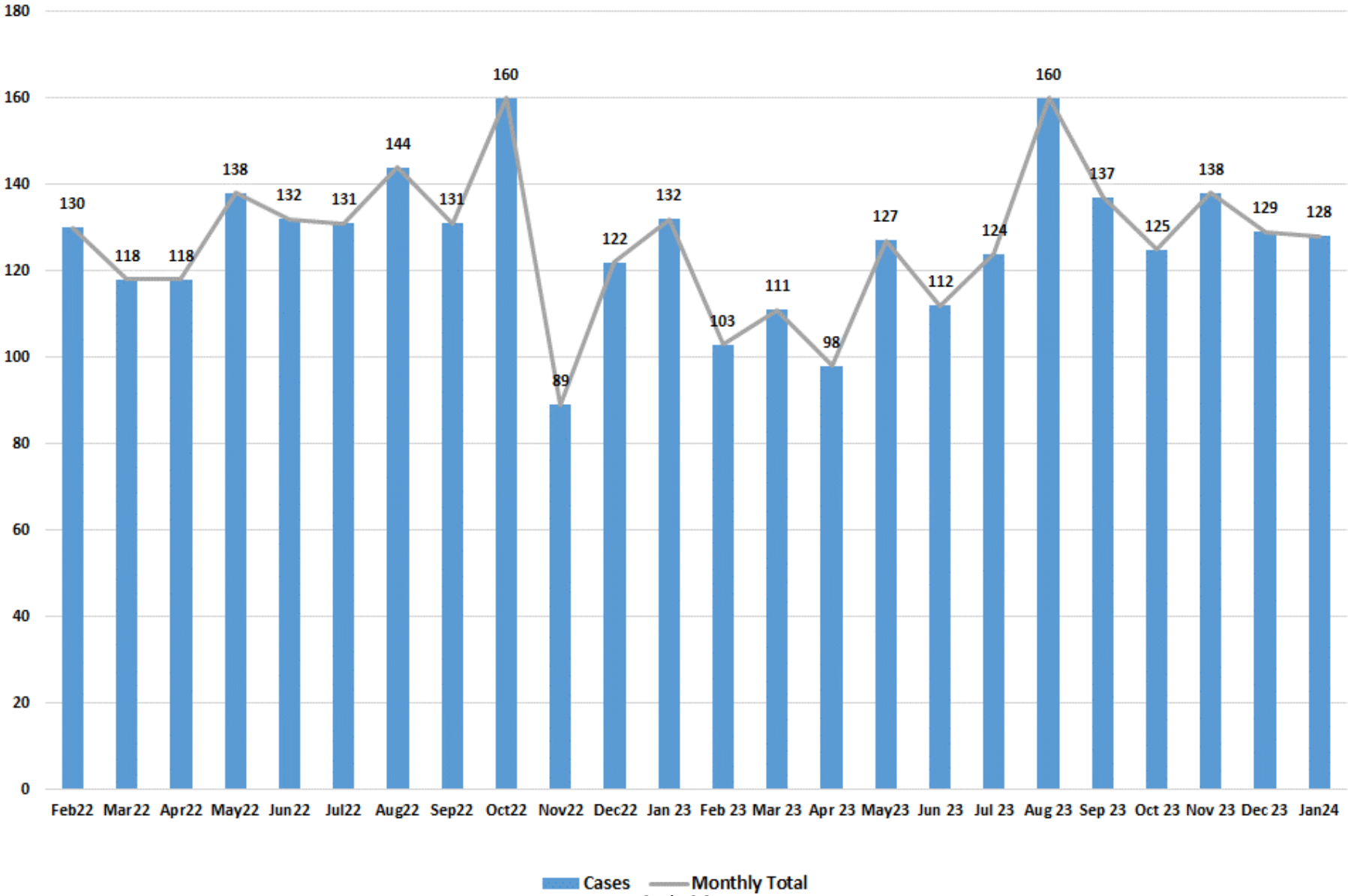
Endo Cases (Endo Suites)



Robotic Cases (IP & OP)



OB Cases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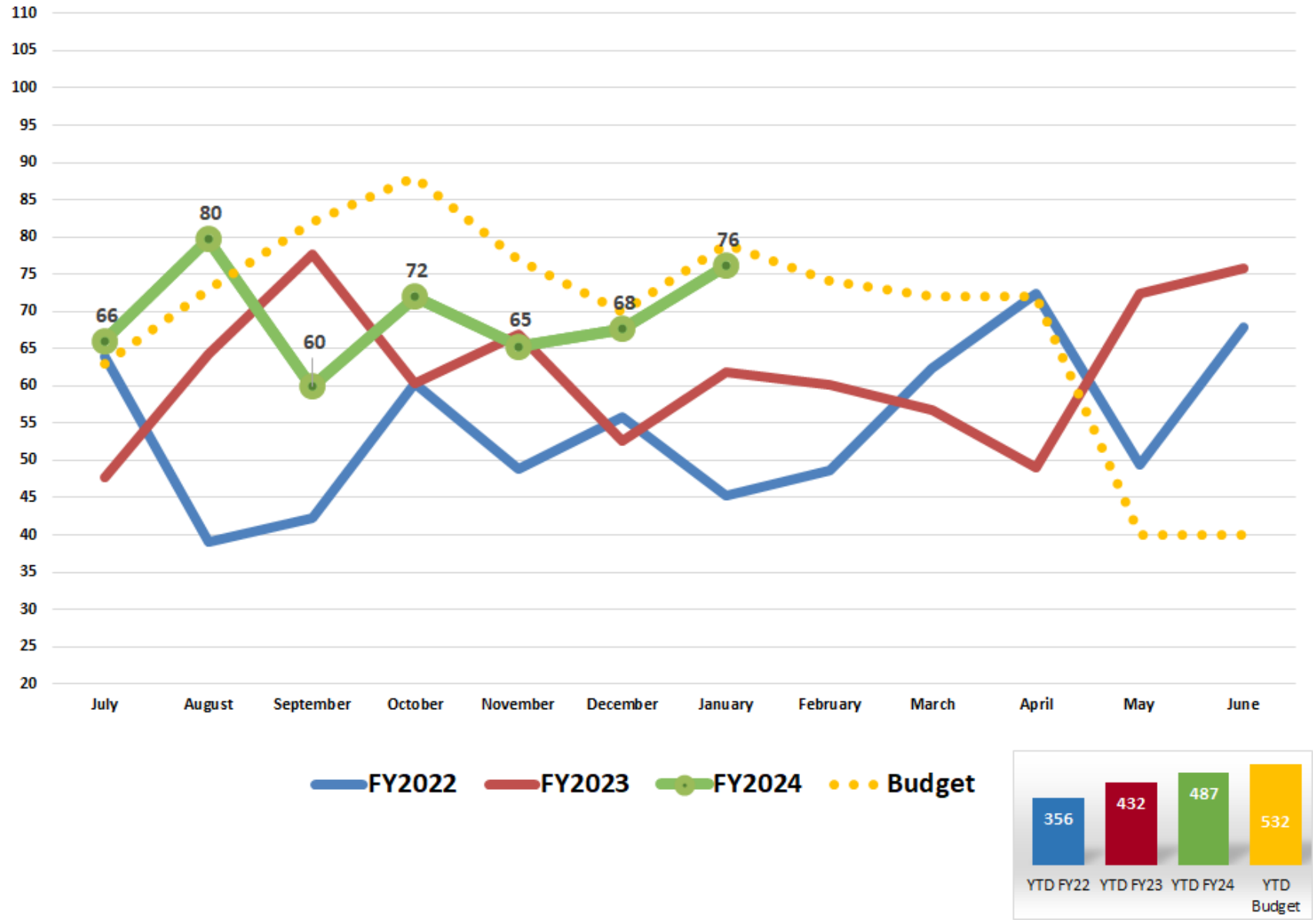
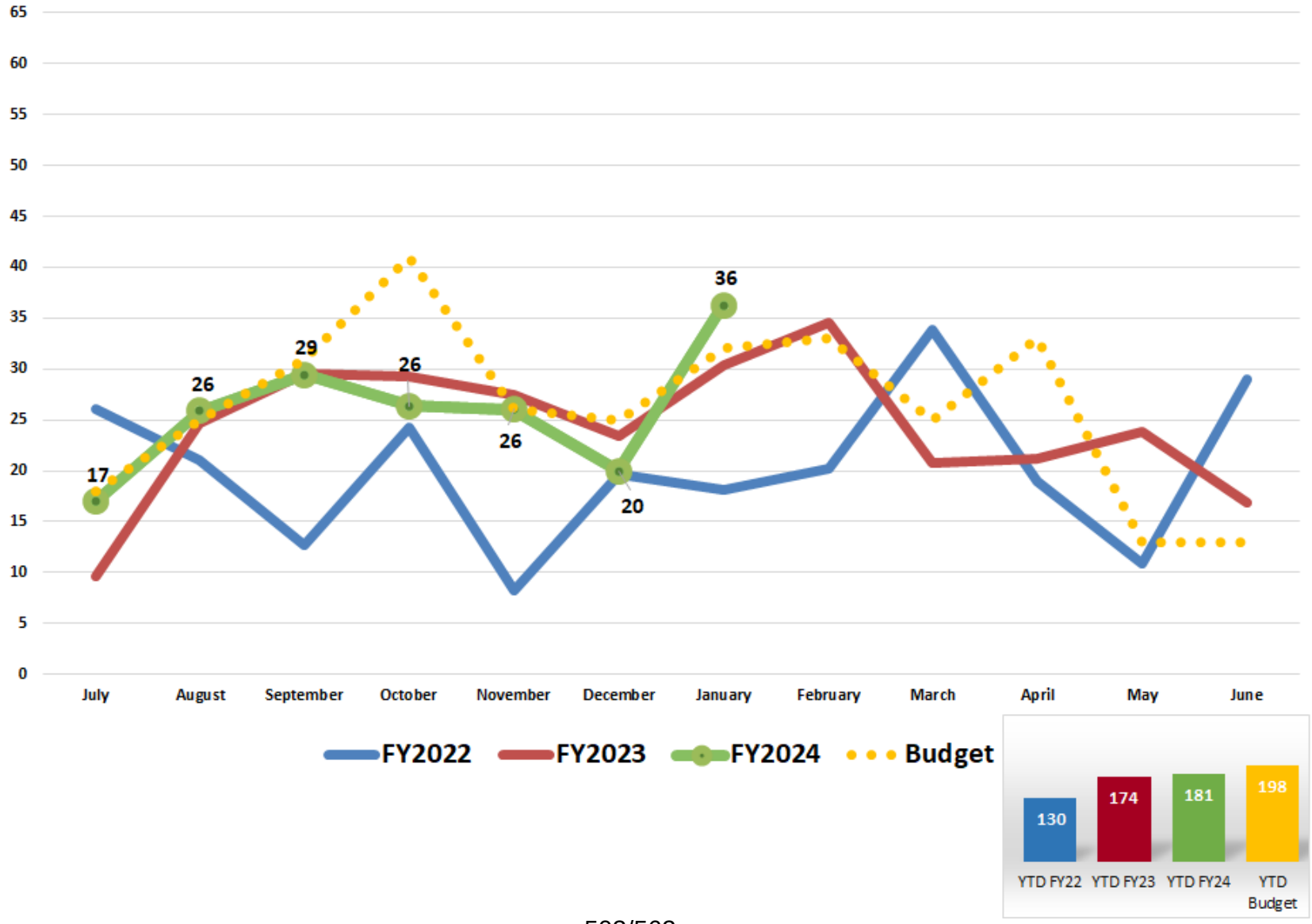
111
98
127
112
124
160
137
125
138
129
128
Feb22
Mar22
Apr22
May22
Jun22
Jul22
Aug22
Sep22
Oct22
Nov22
Dec22
Jan 23
Feb 23
Mar 23
Apr 23
May23
Jun 23
Jul 23
Aug 23
Sep 23
Oct 23
Nov 23
Dec 23
Jan24
Cases
Monthly Total

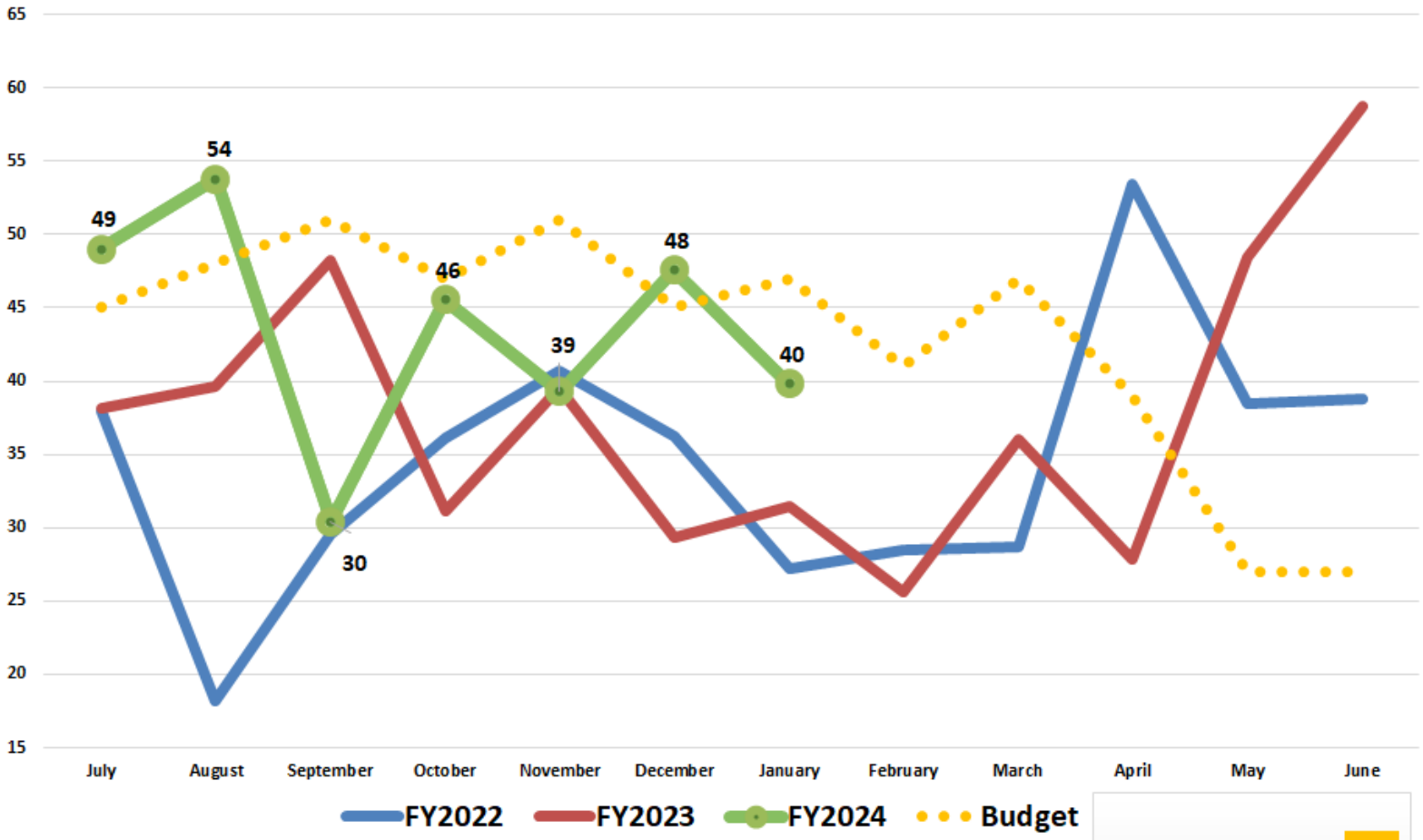
Robotic Surgery (IP & OP) - 100 Min Units

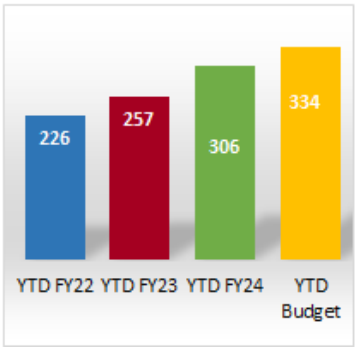


Robotic Surgery Minutes (IP Only)

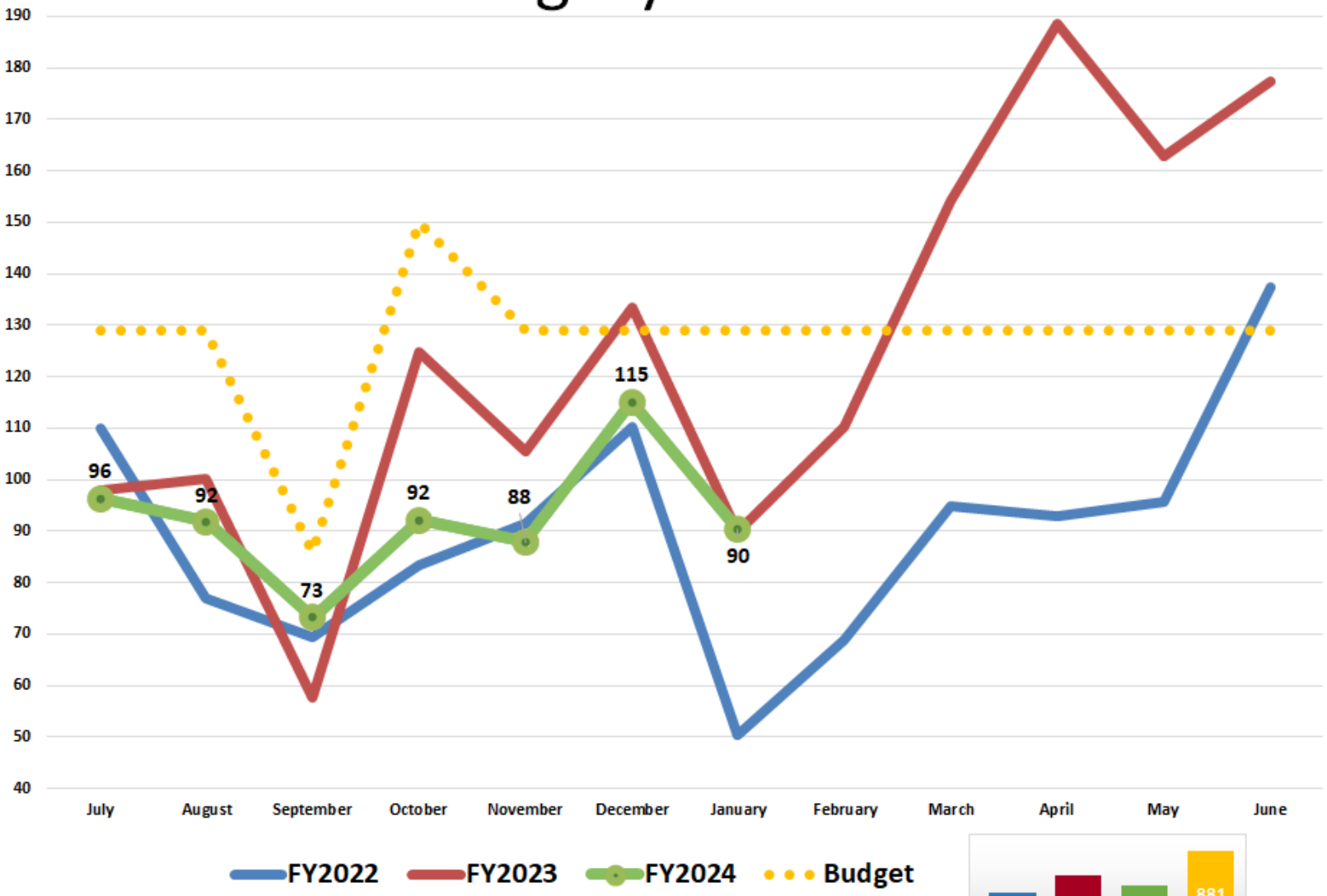


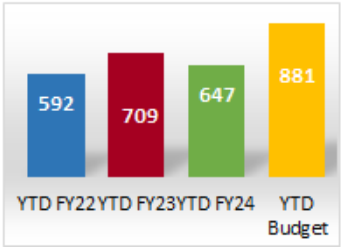
Robotic Surgery Minutes (OP Only)



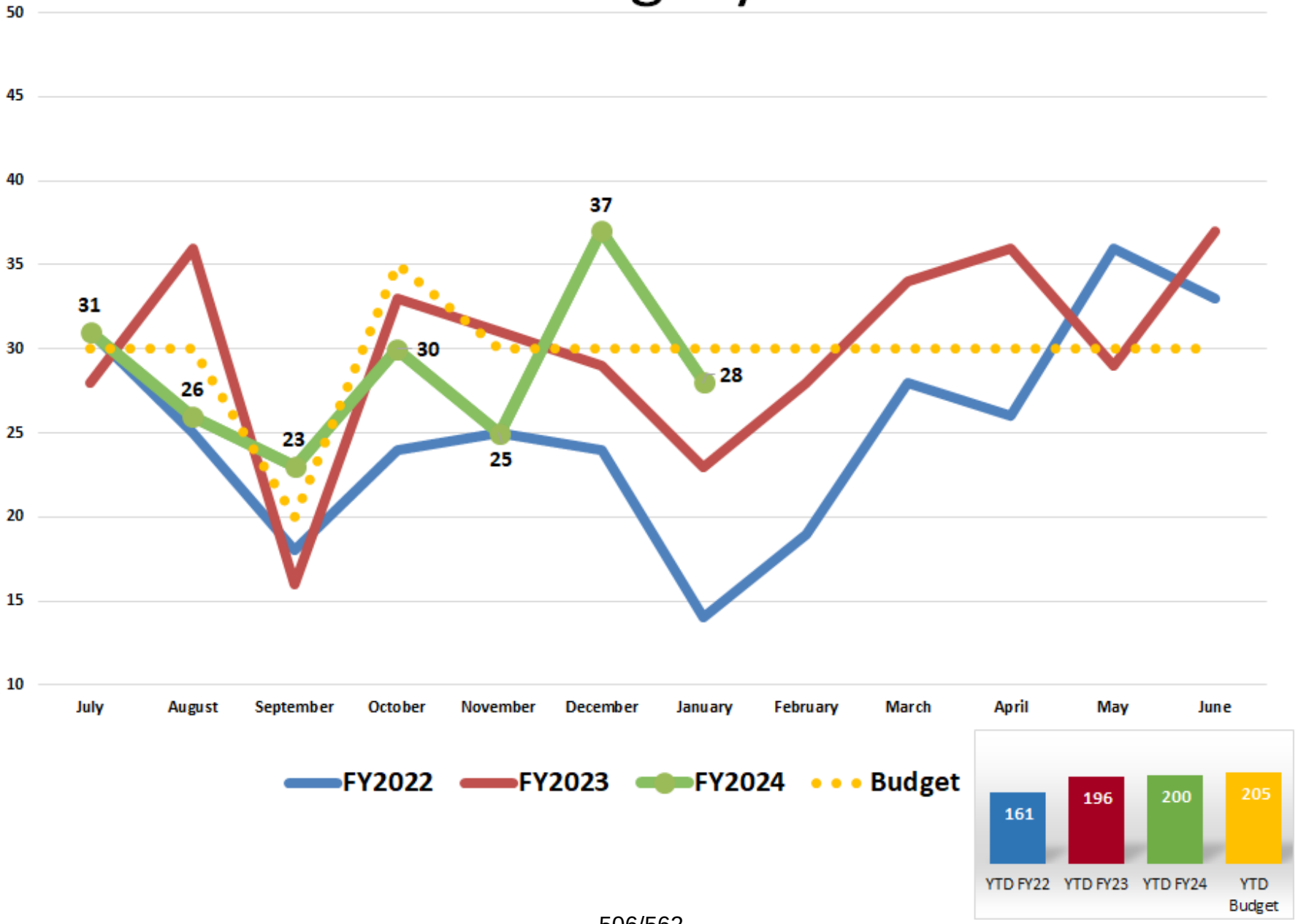


Cardiac Surgery - 100 Min Units

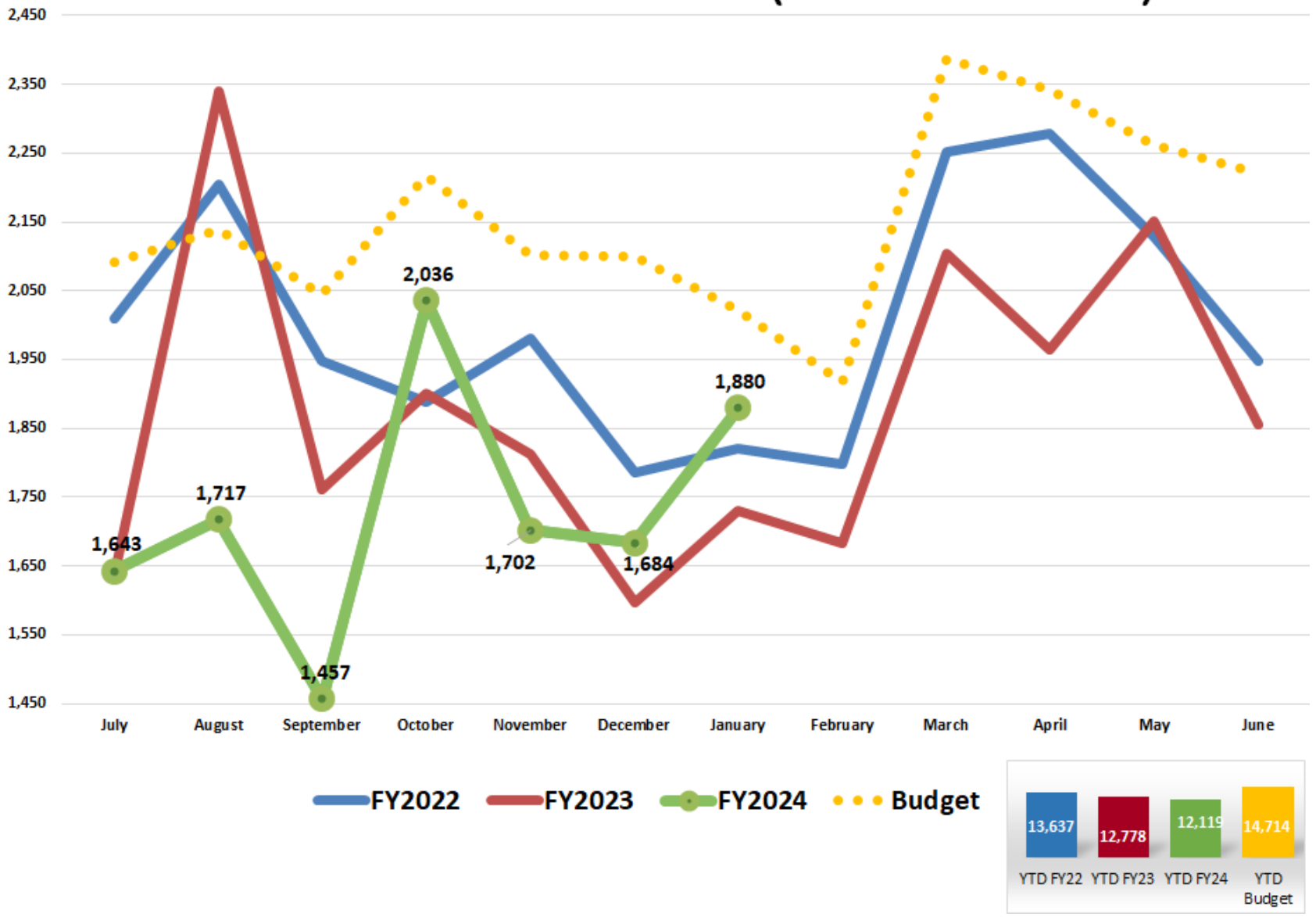




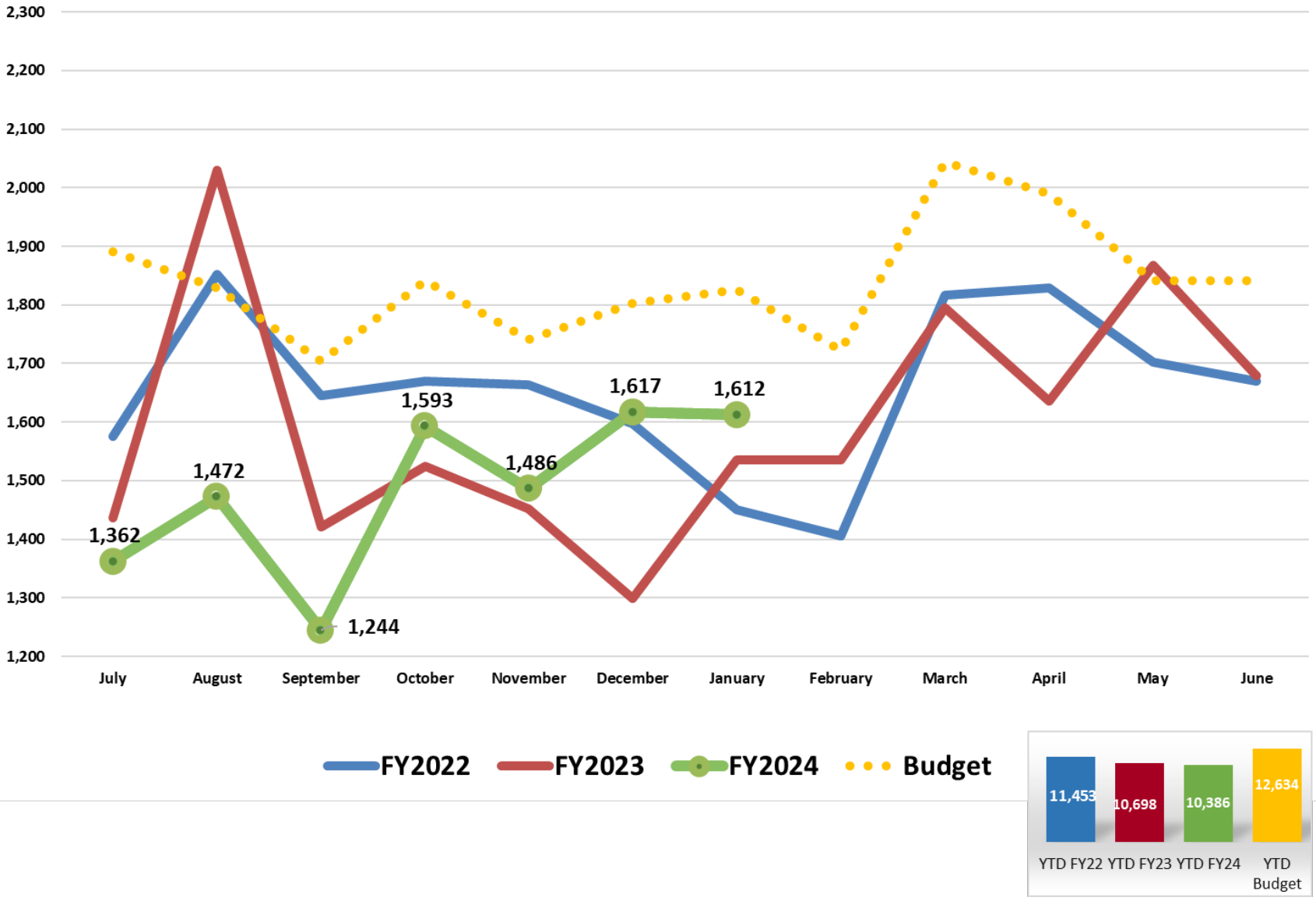
Cardiac Surgery Cases



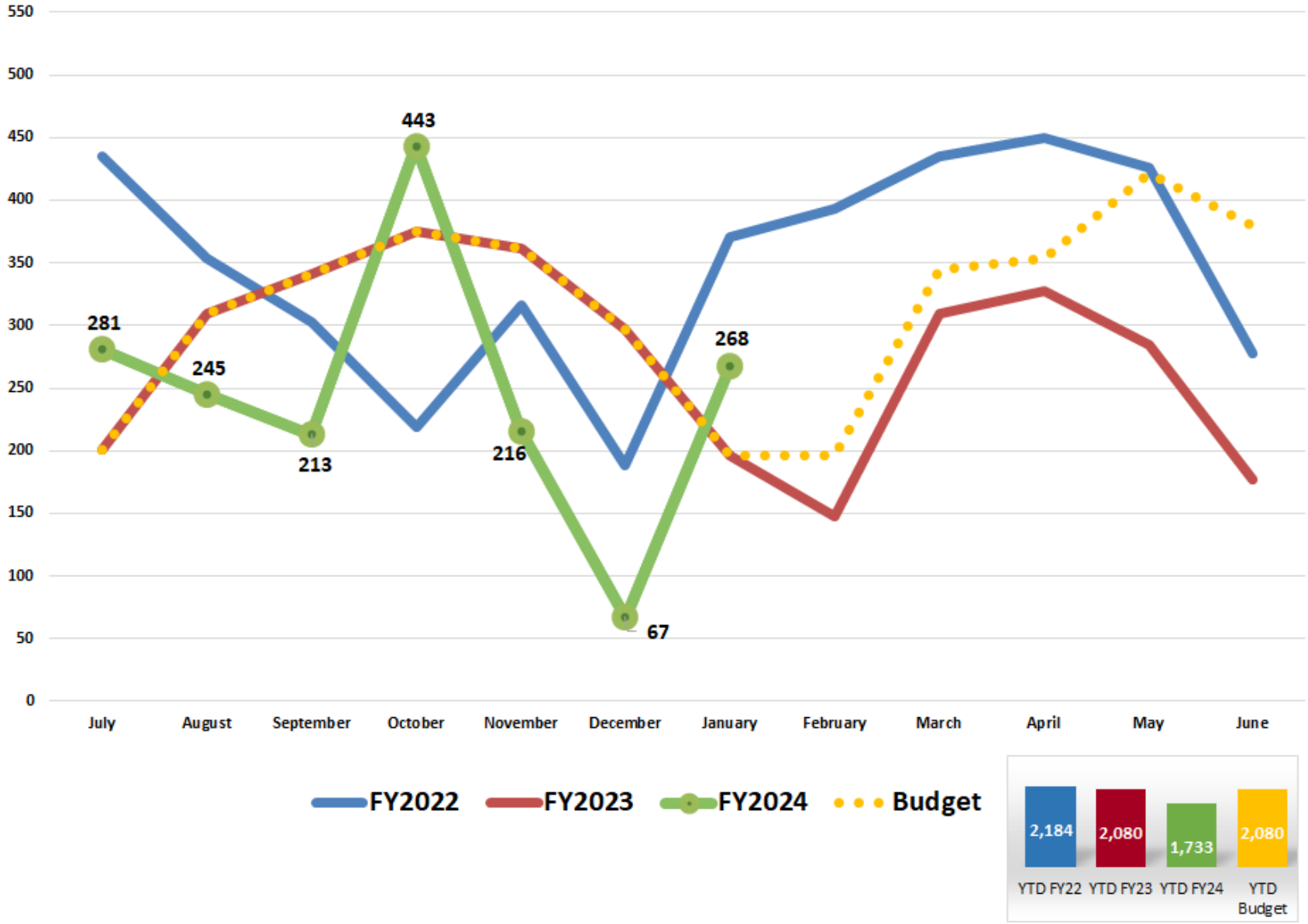
Rad Onc Treatments (Vis. & Hanf.)



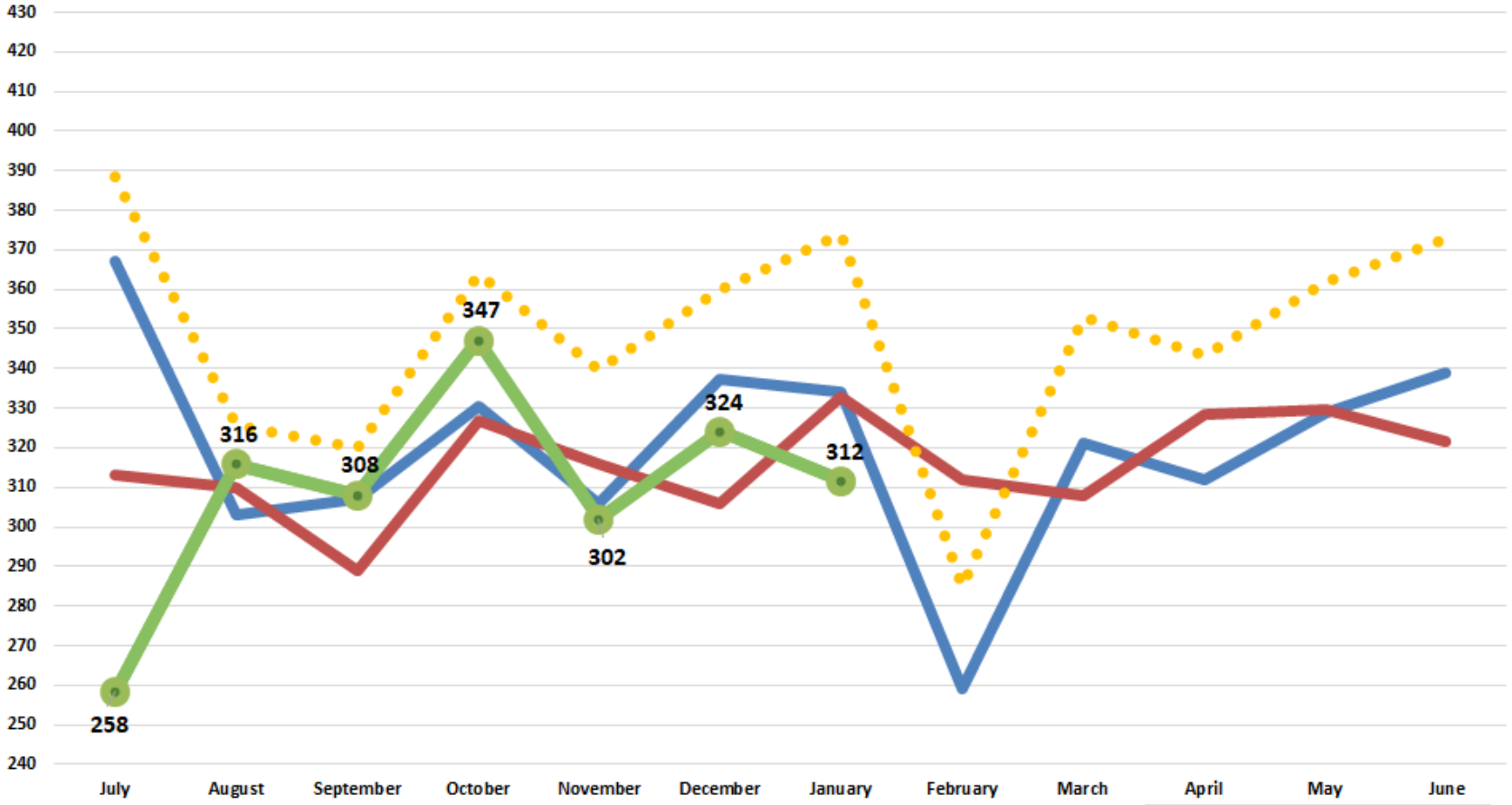
Rad Onc Visalia

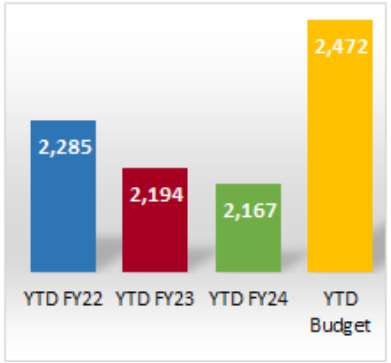


Rad Onc Hanford

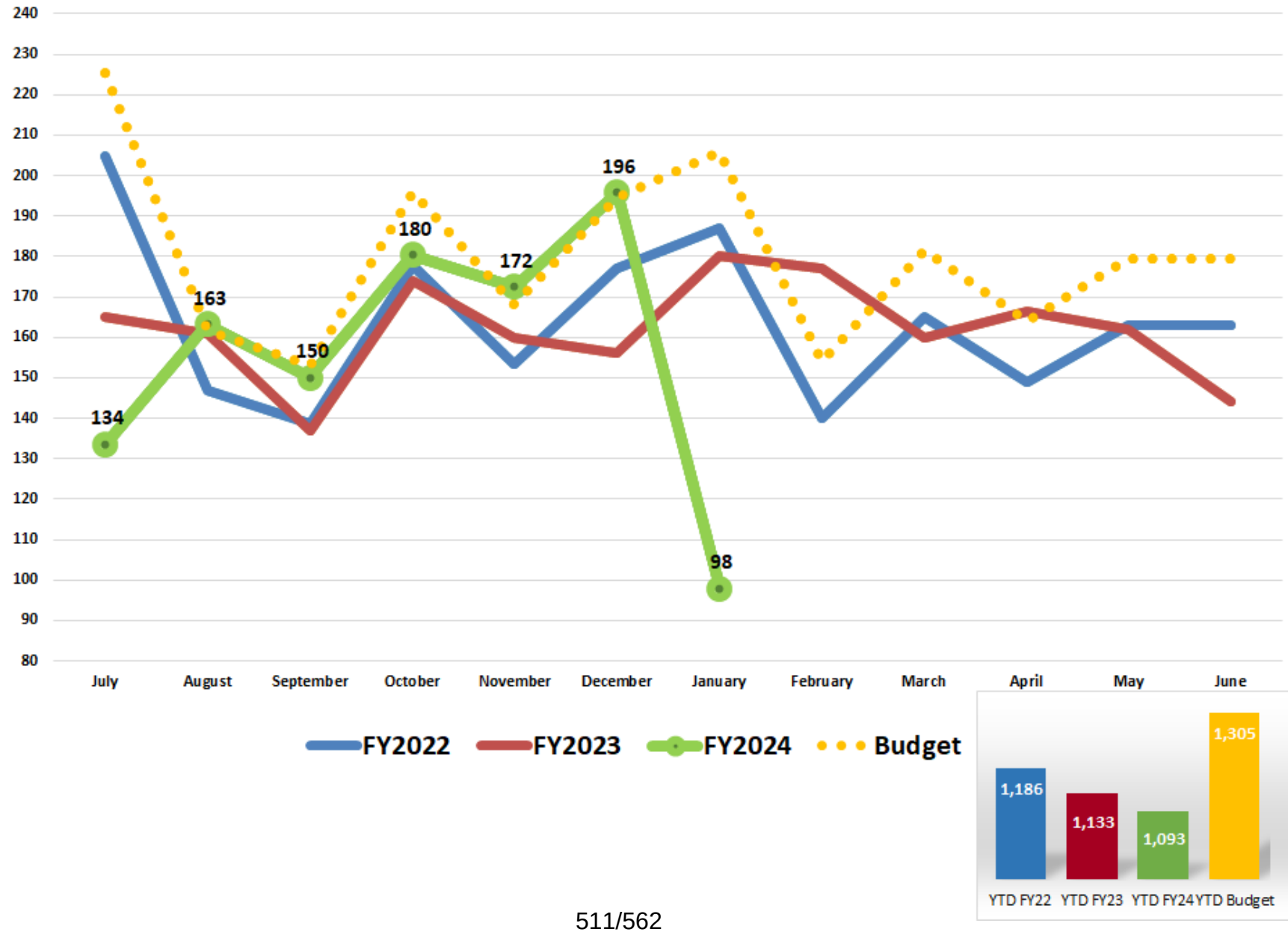


Cath Lab (IP & OP) – 100 Min Units

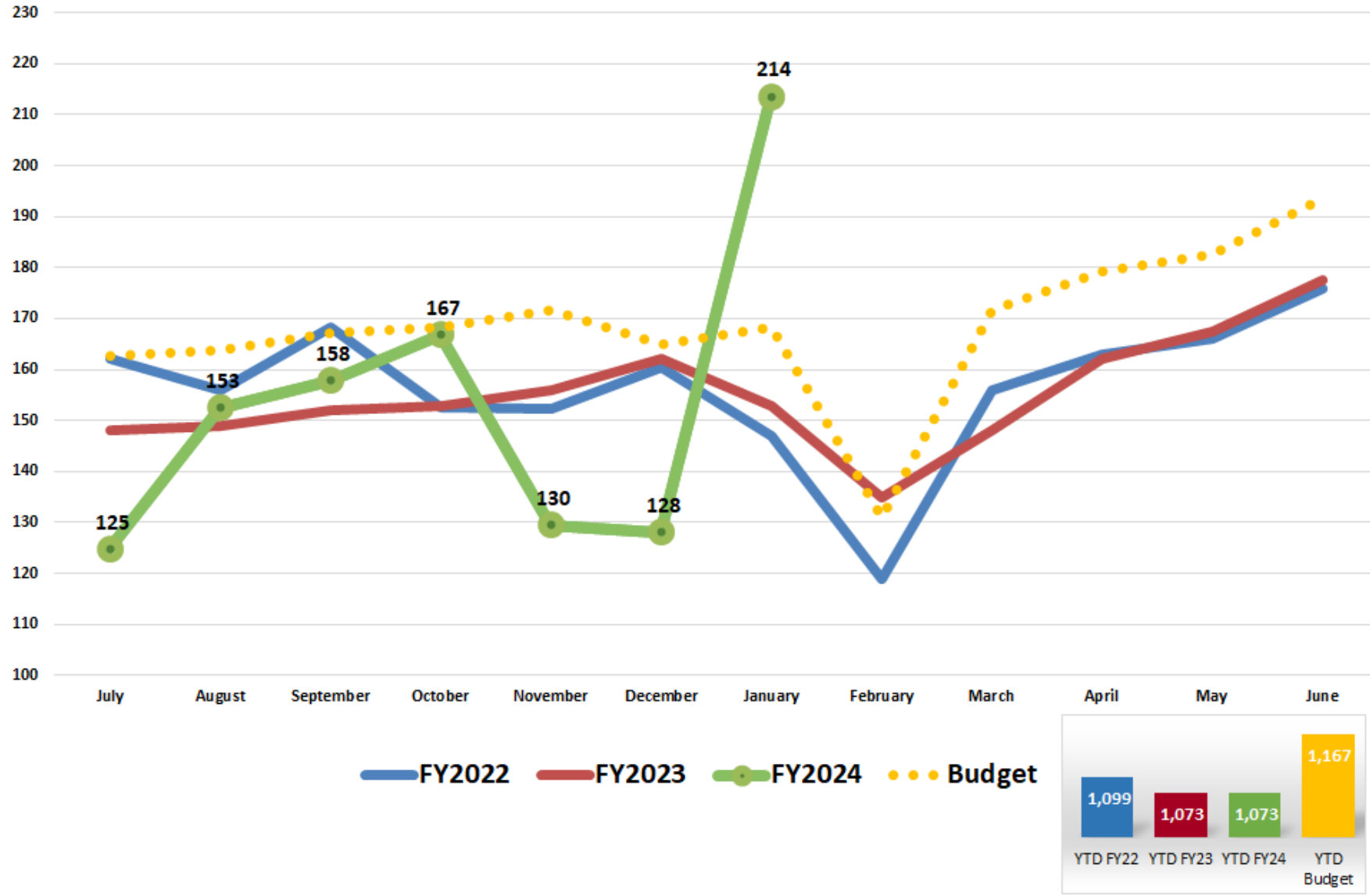




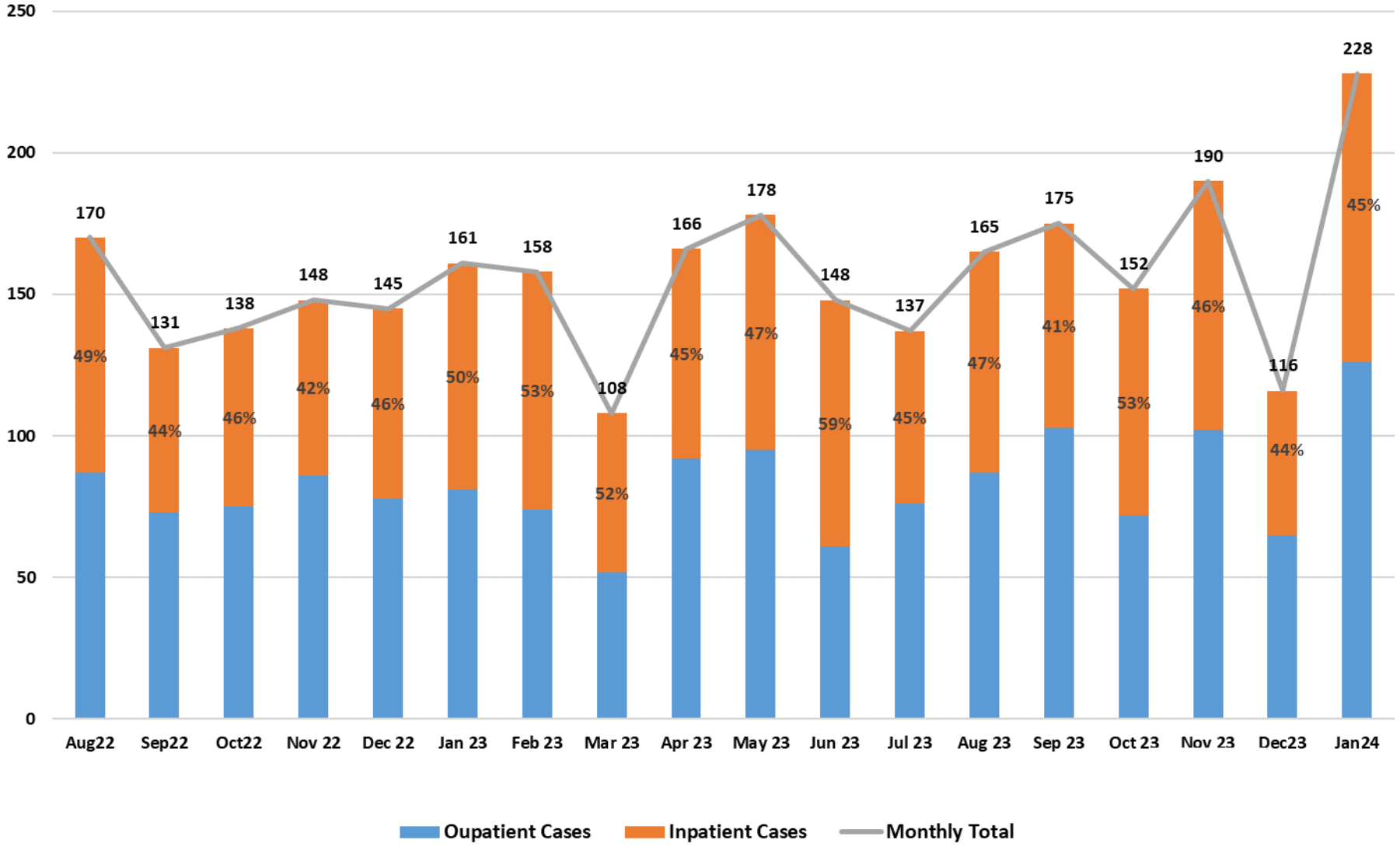
Cath Lab (IP Only) – 100 Min Units



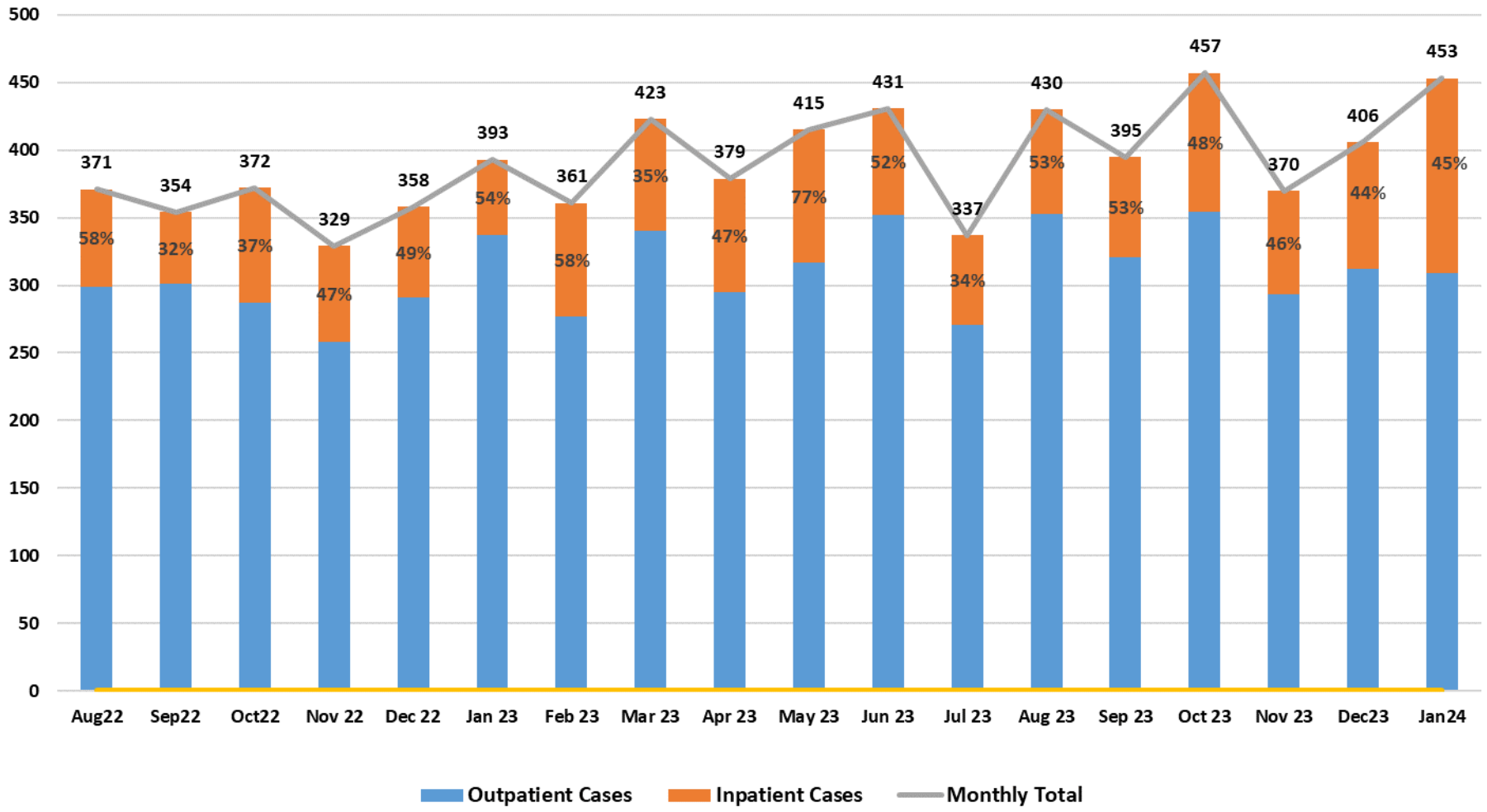
Cath Lab (OP Only) – 100 Min Units



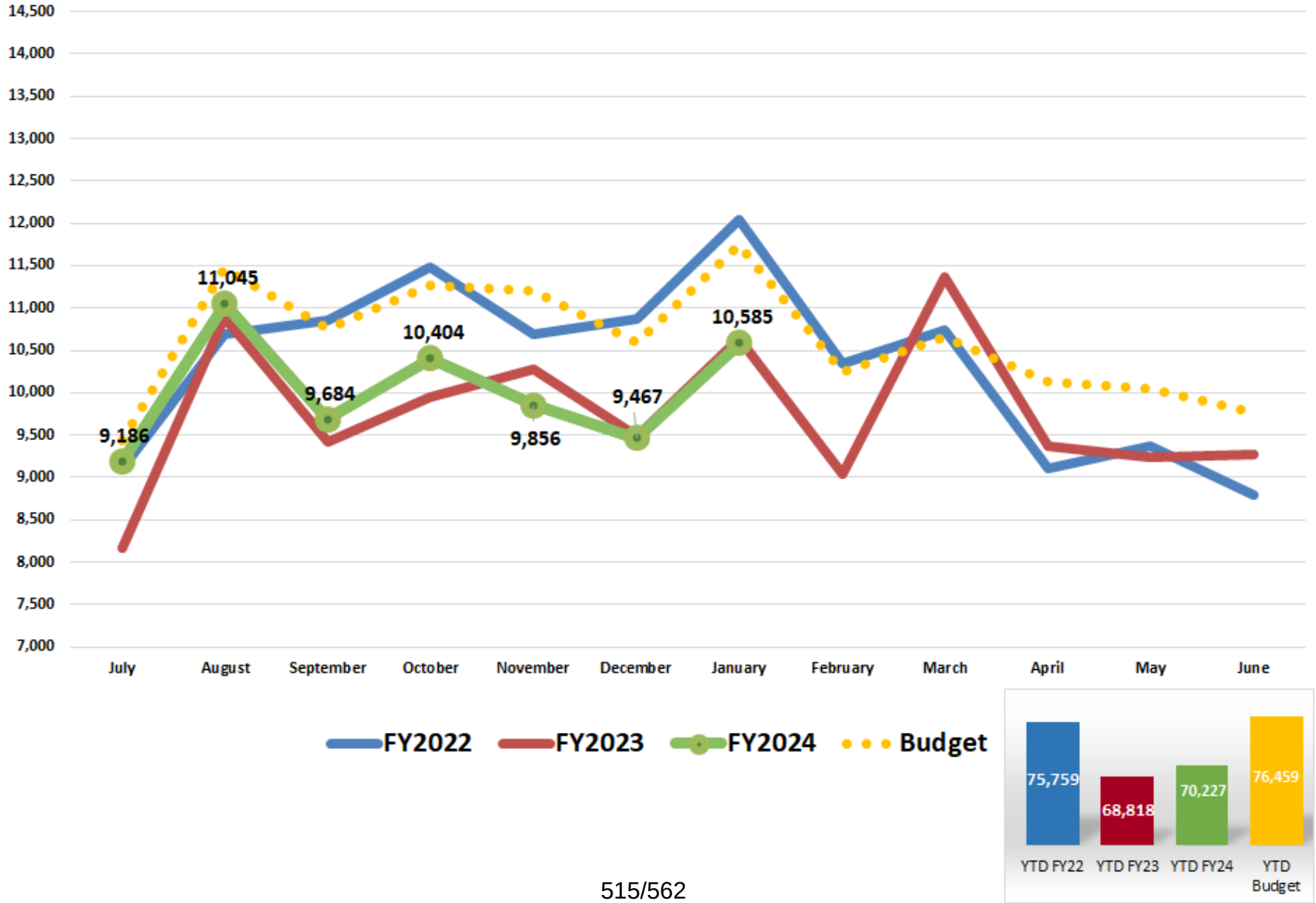
Cath Lab Patients (IP & OP)



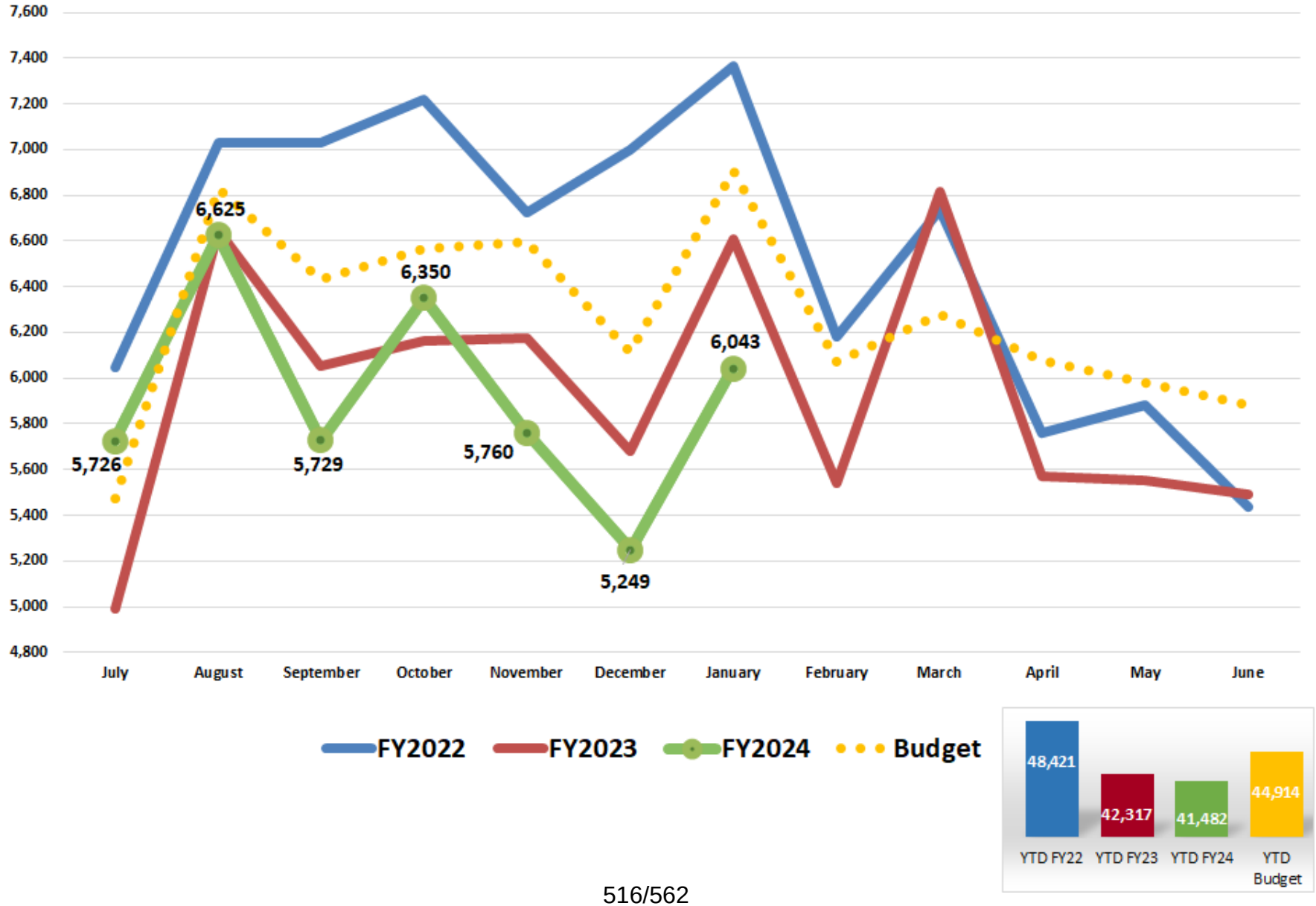
Cath Lab Patients (IP & OP) REVISED



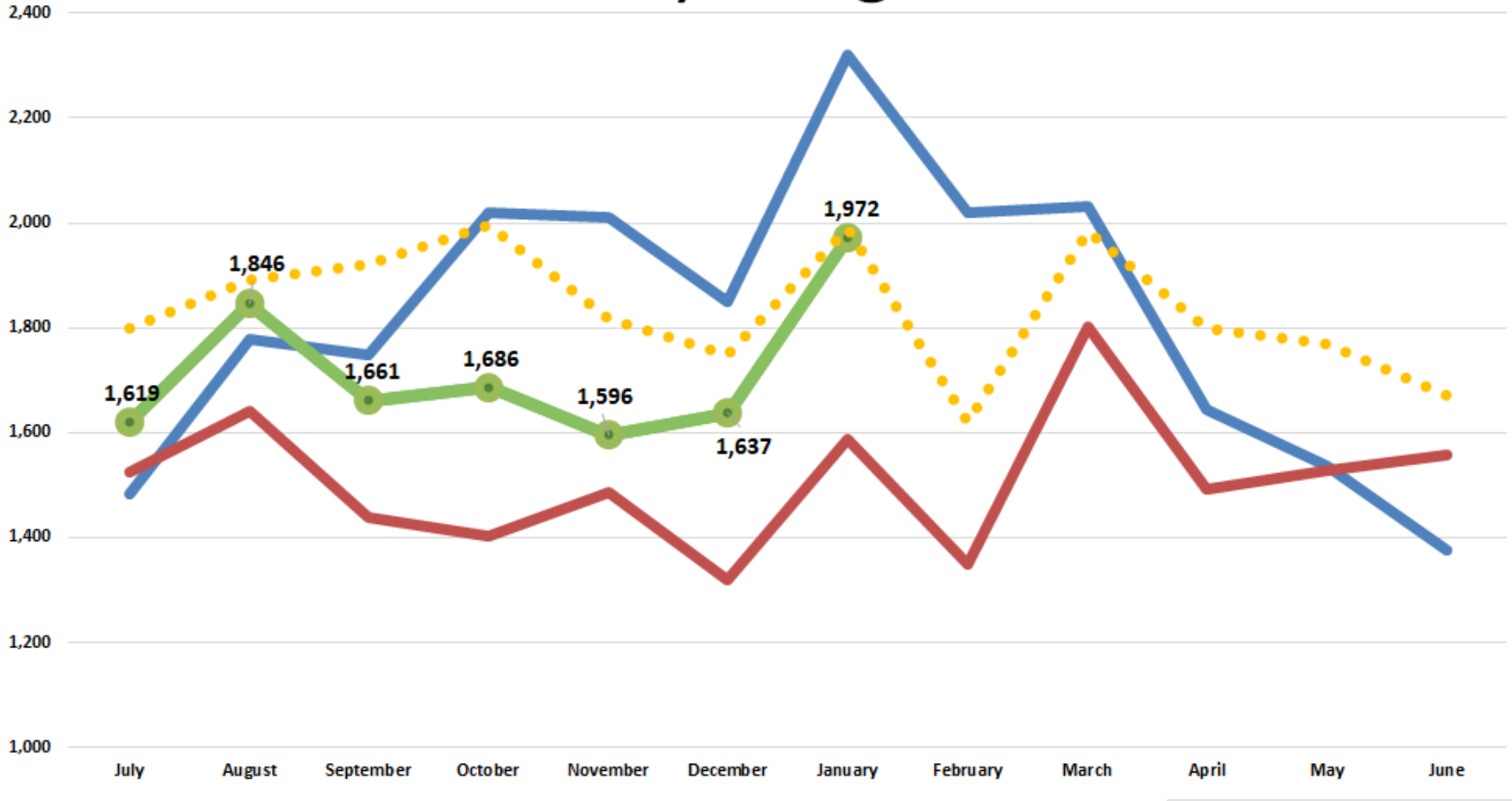
Rural Health Clinics Registrations

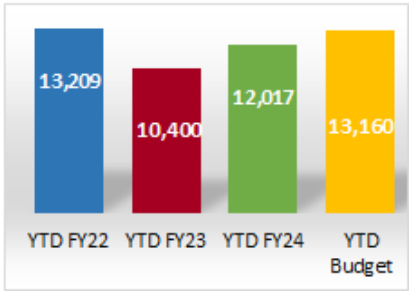


RHC Exeter - Registrations

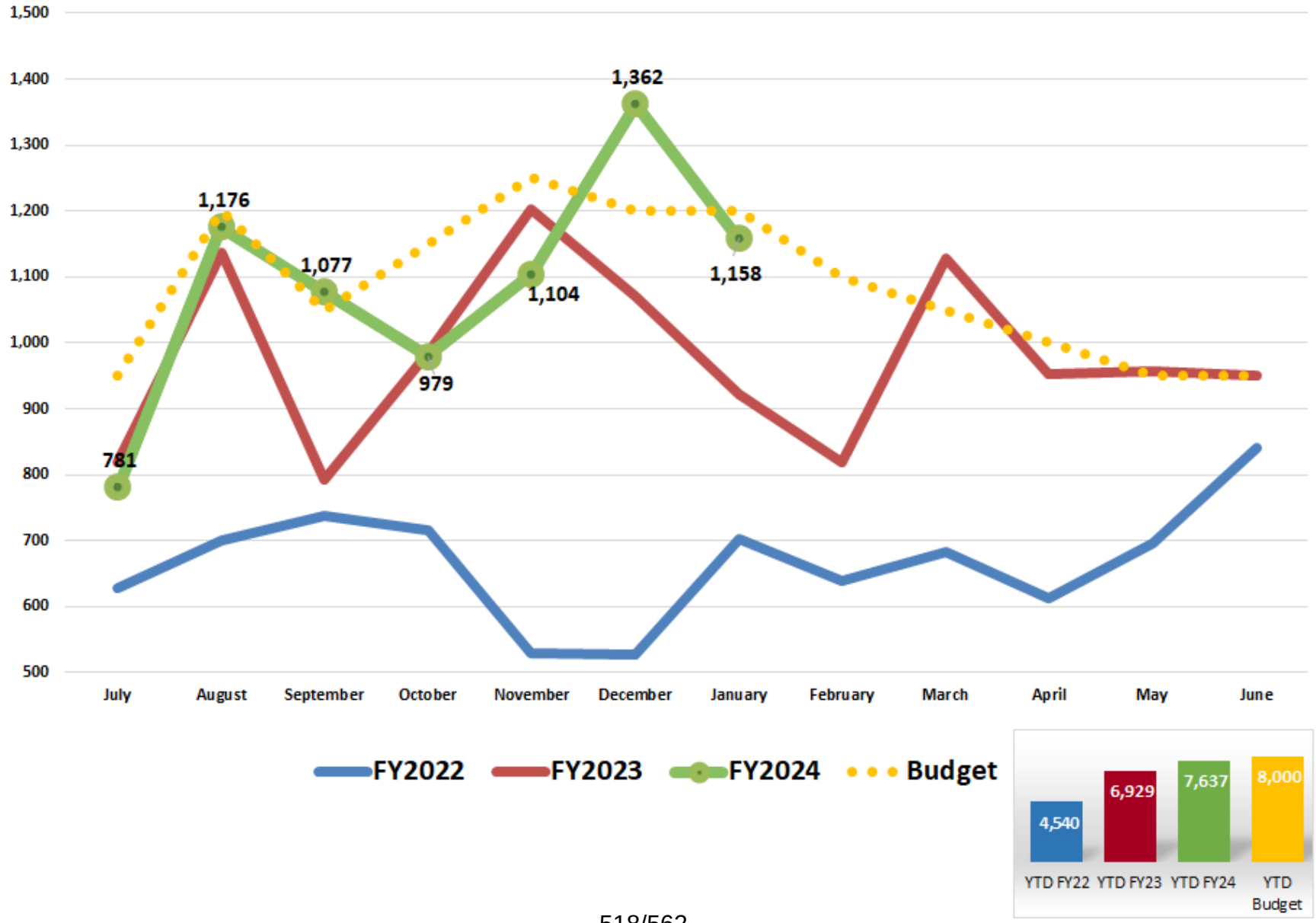


RHC Lindsay - Registrations

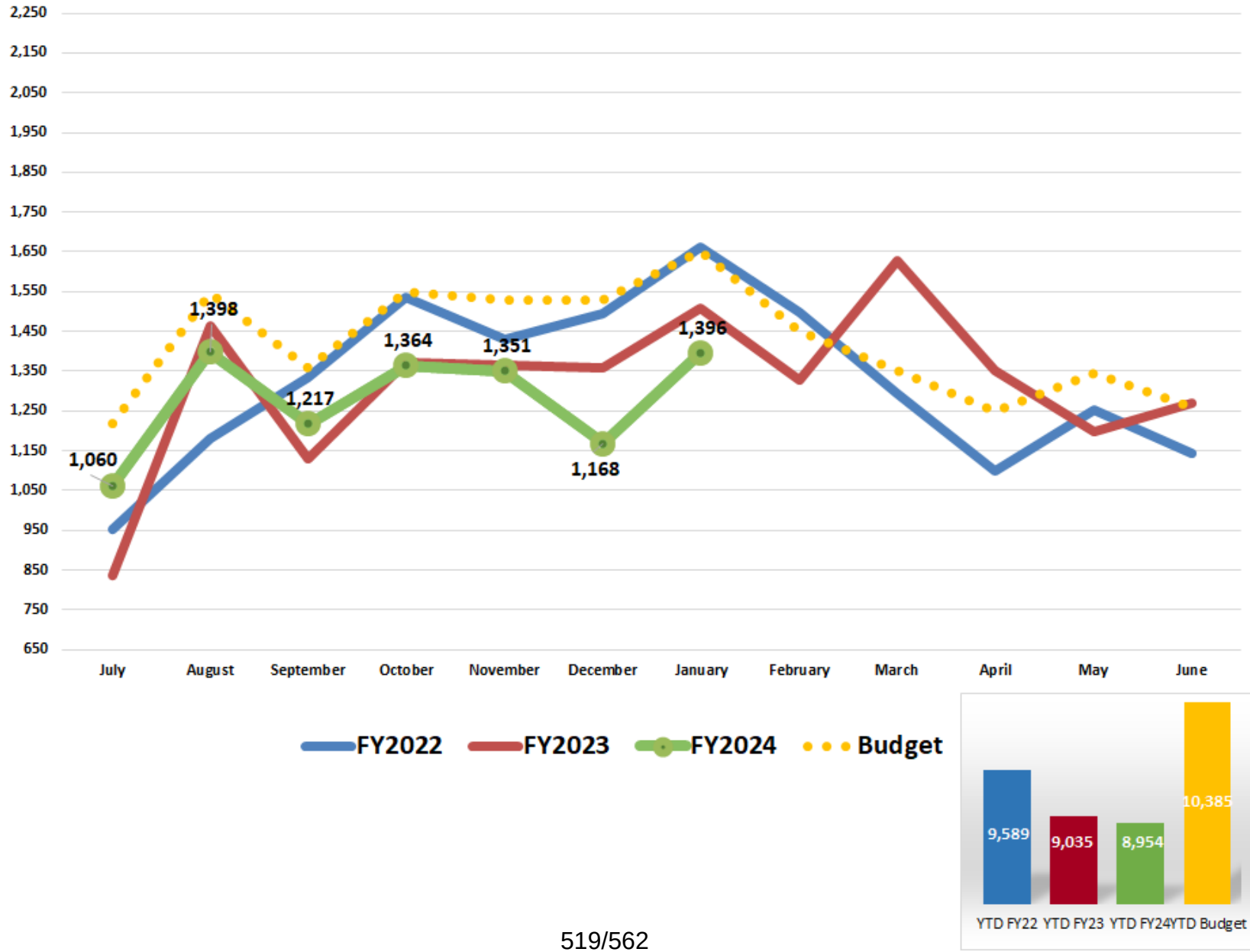




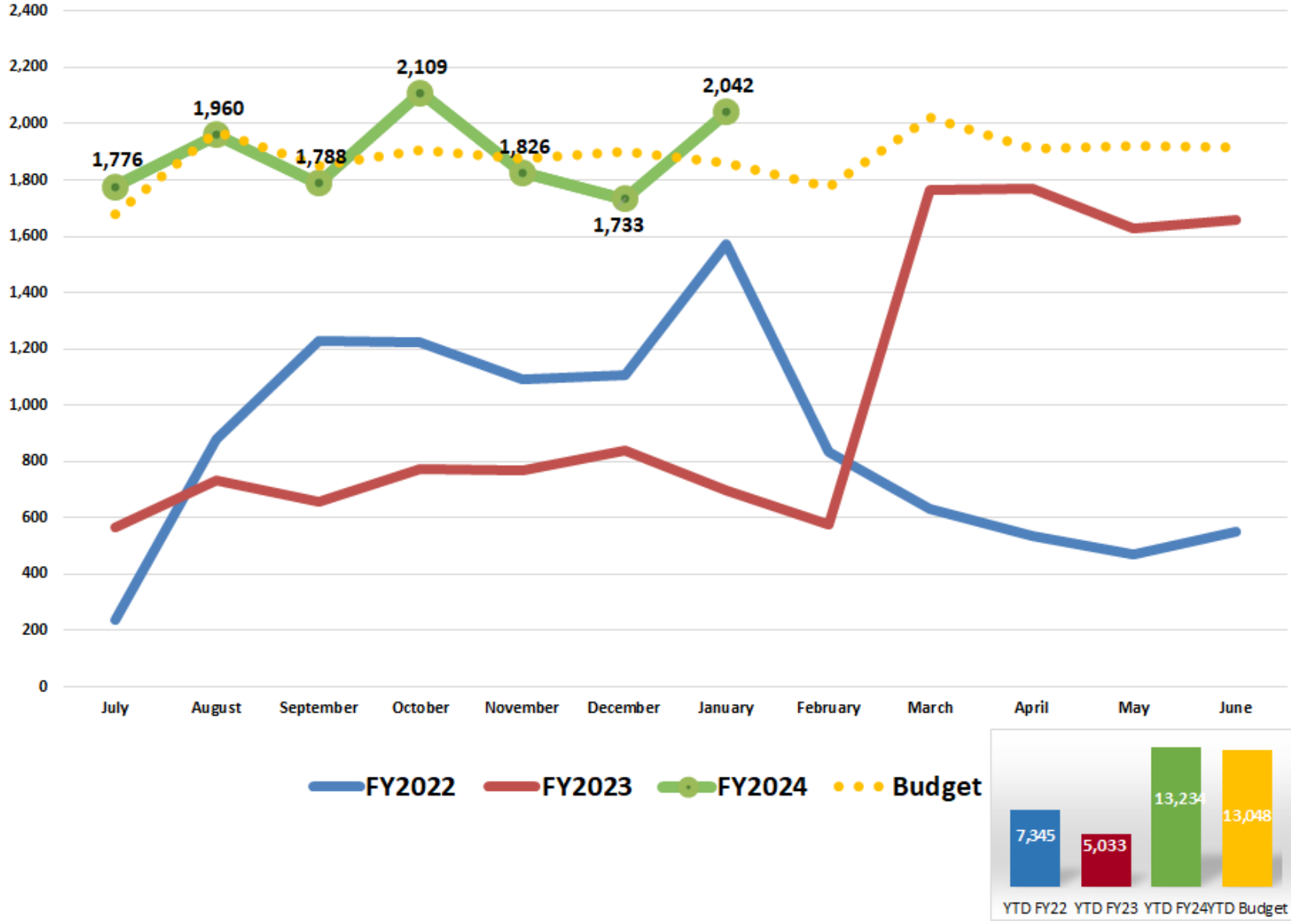
RHC Woodlake - Registrations



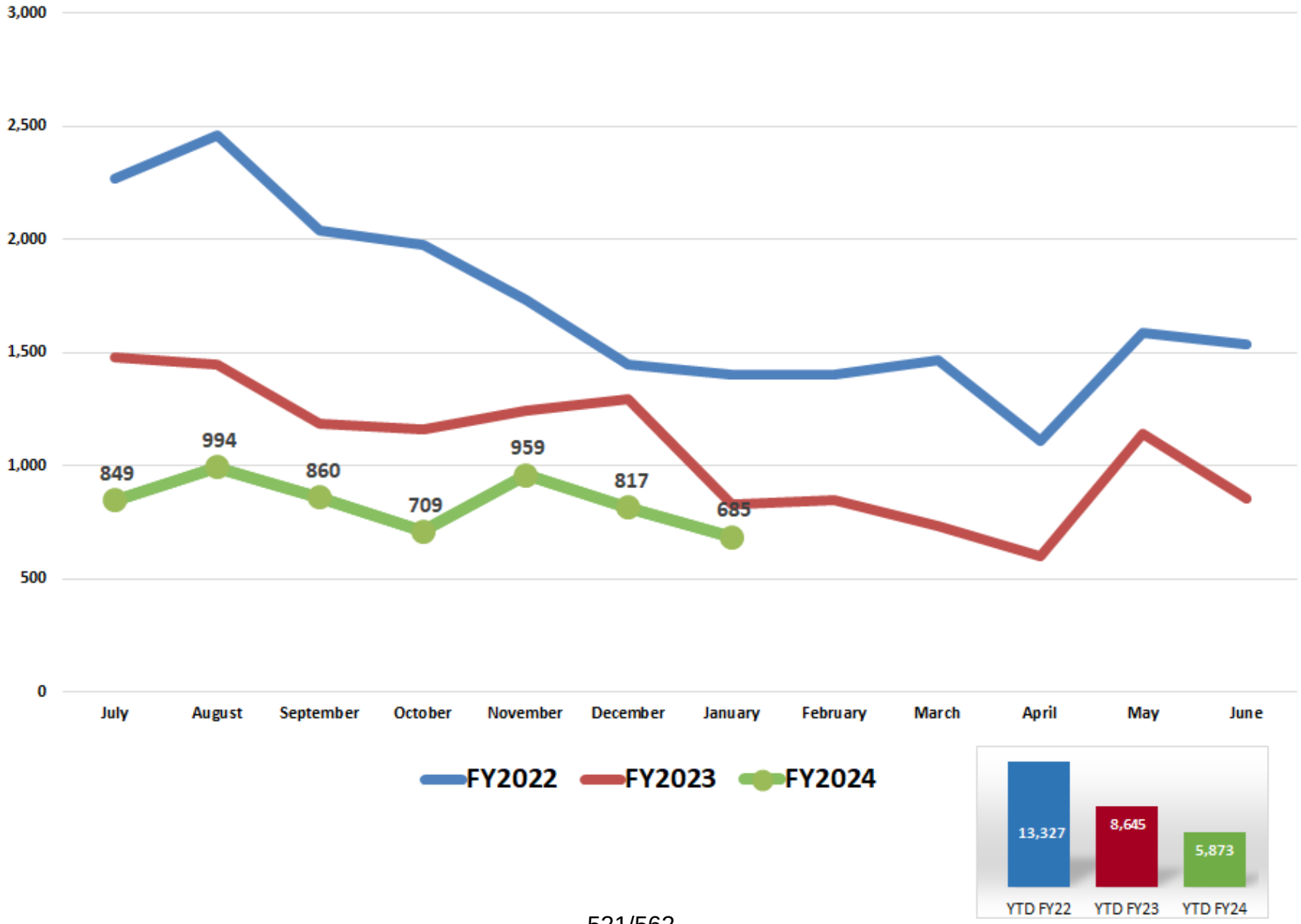
RHC Dinuba - Registrations



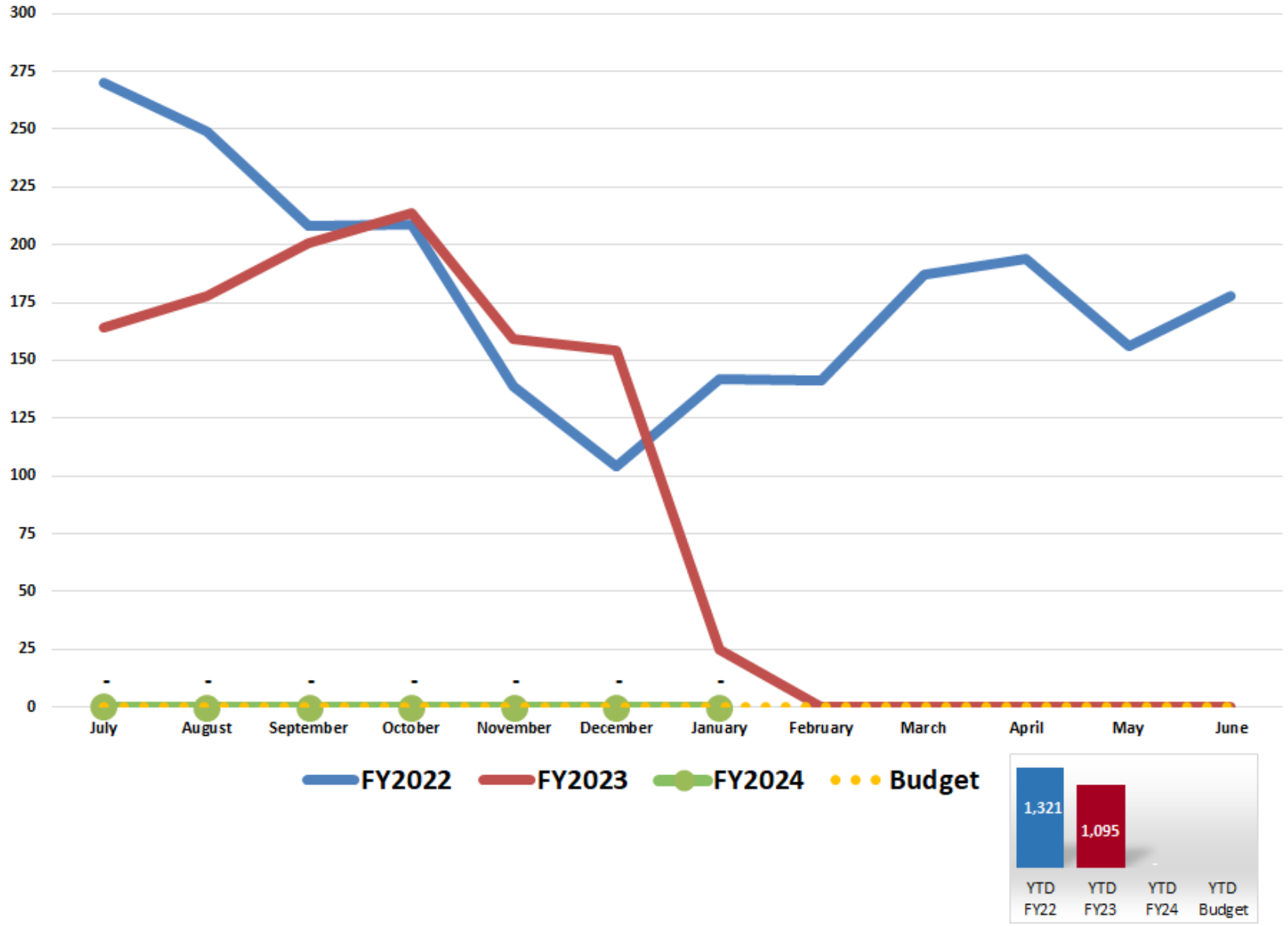
RHC Tulare - Registrations



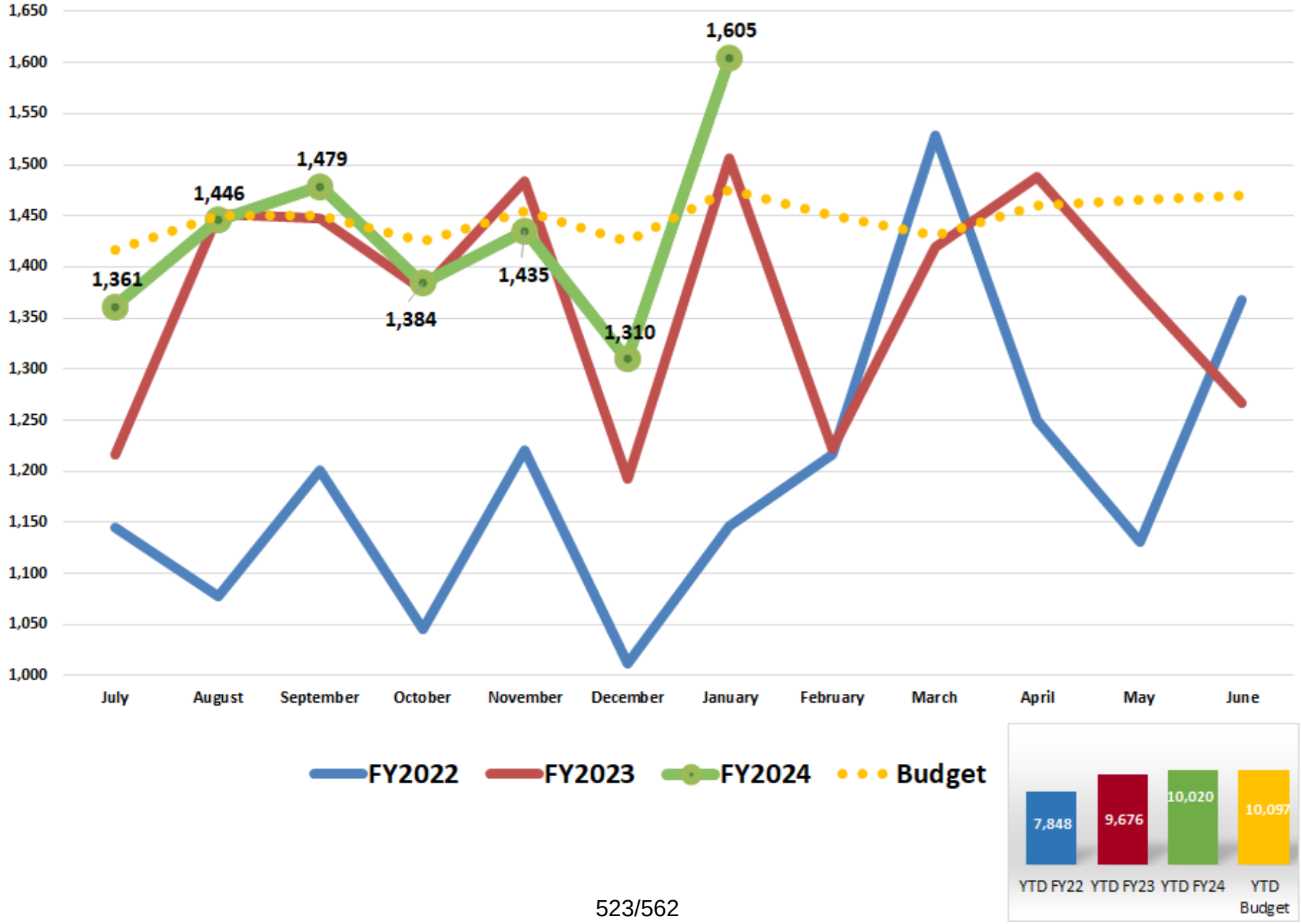
Neurosurgery Clinic - wRVU's



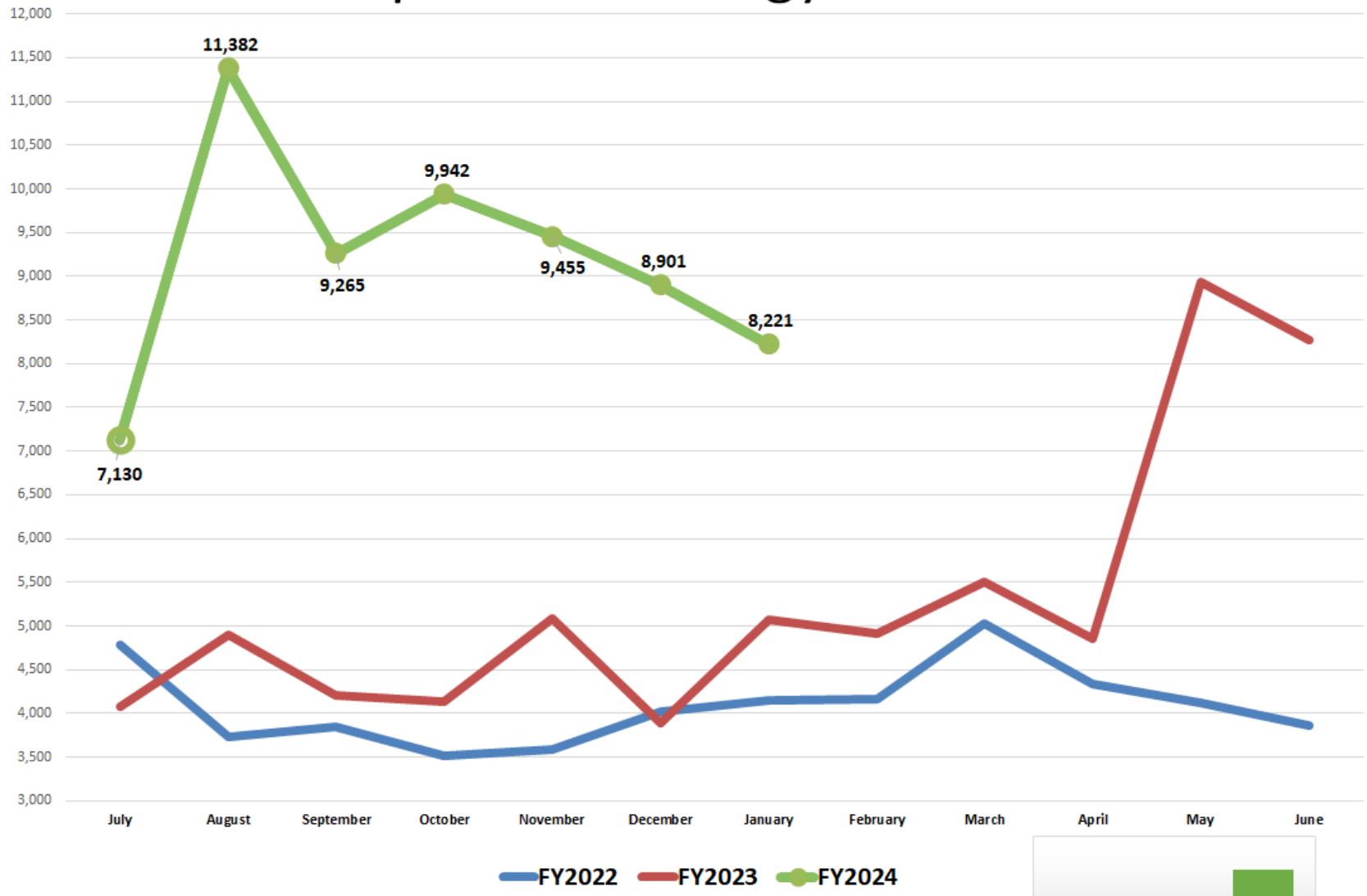
Neurosurgery Clinic Registrations

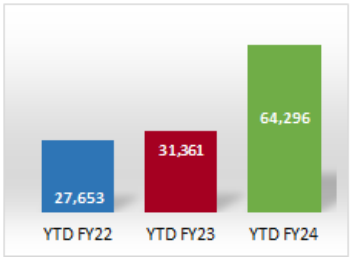


Sequoia Cardiology Registrations



Sequoia Cardiology - wRVU's





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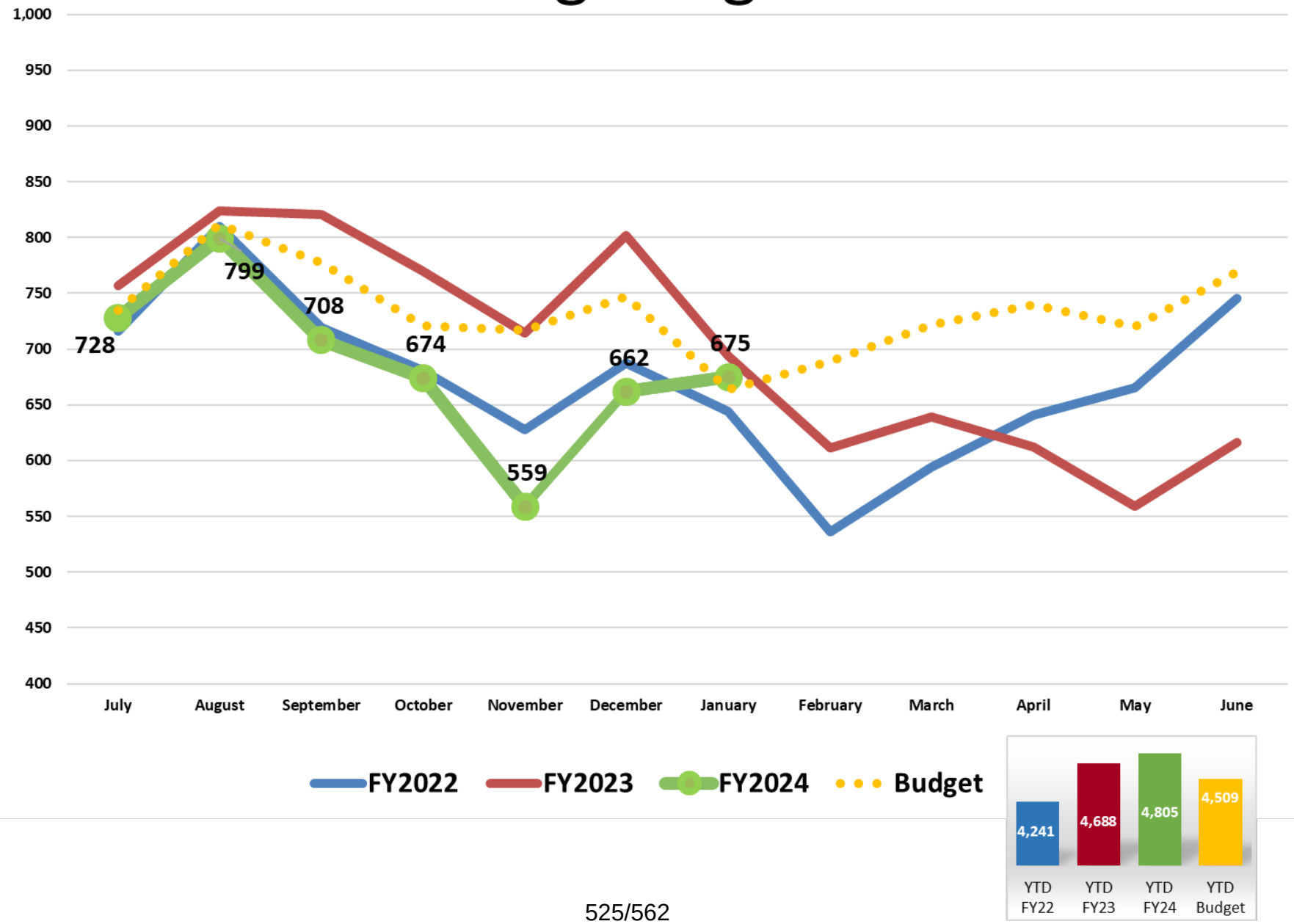

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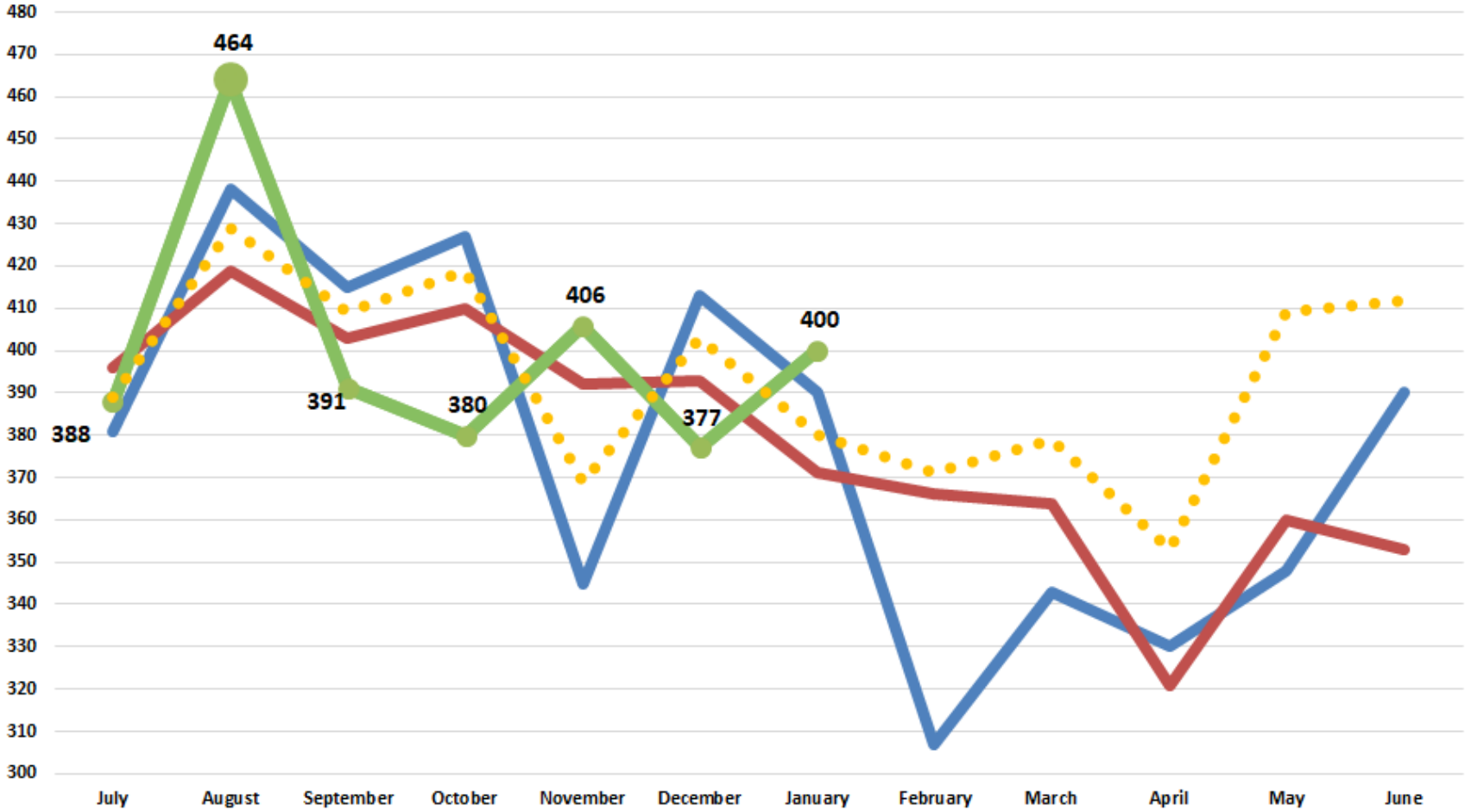
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September
October
November
December
January
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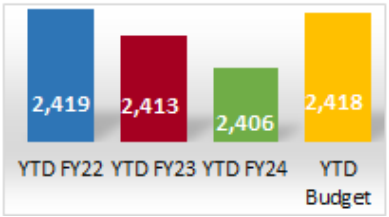
May
June
FY2022
FY2023
FY2024
Budget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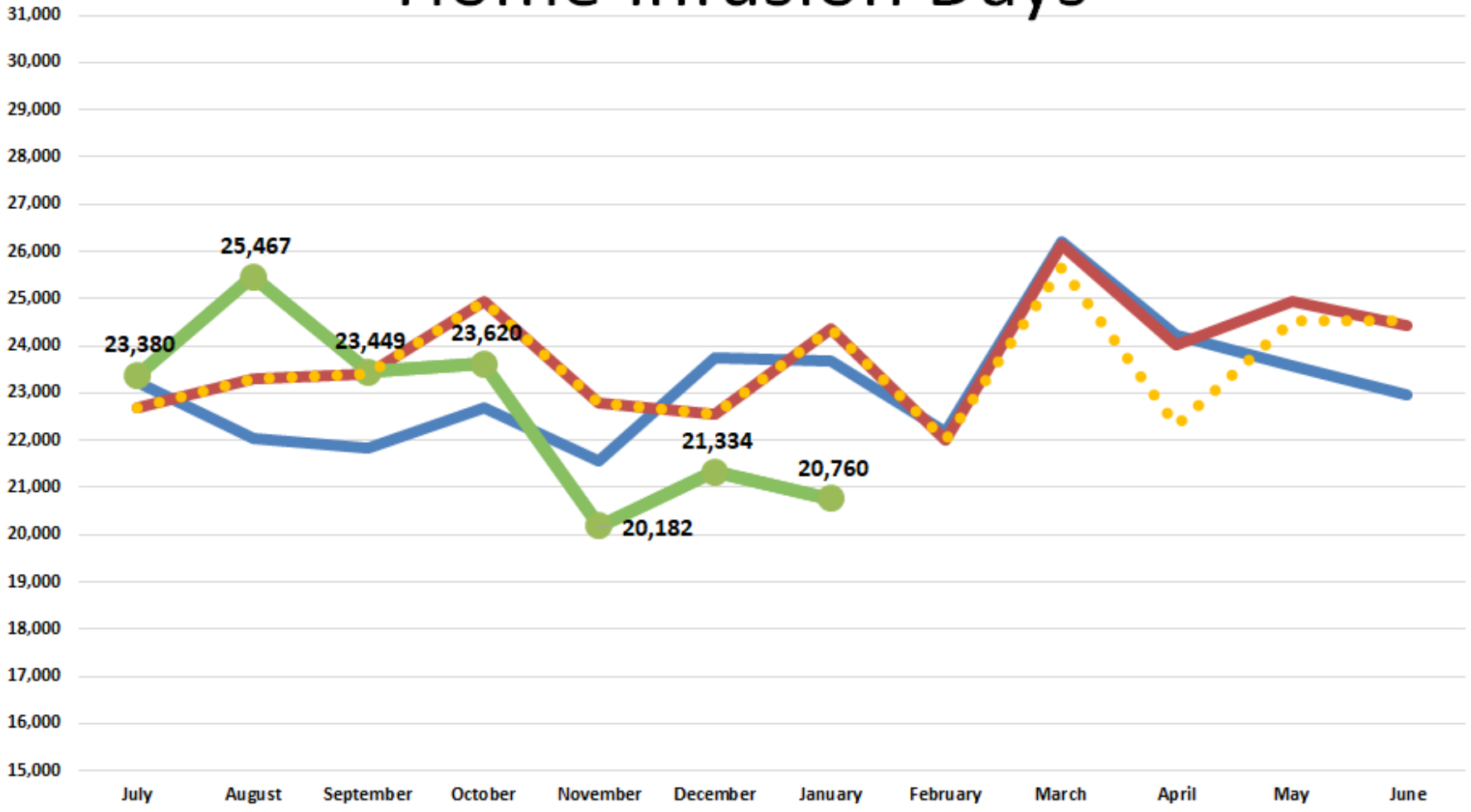
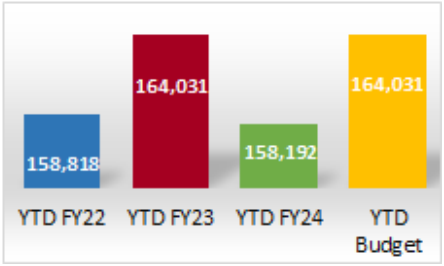
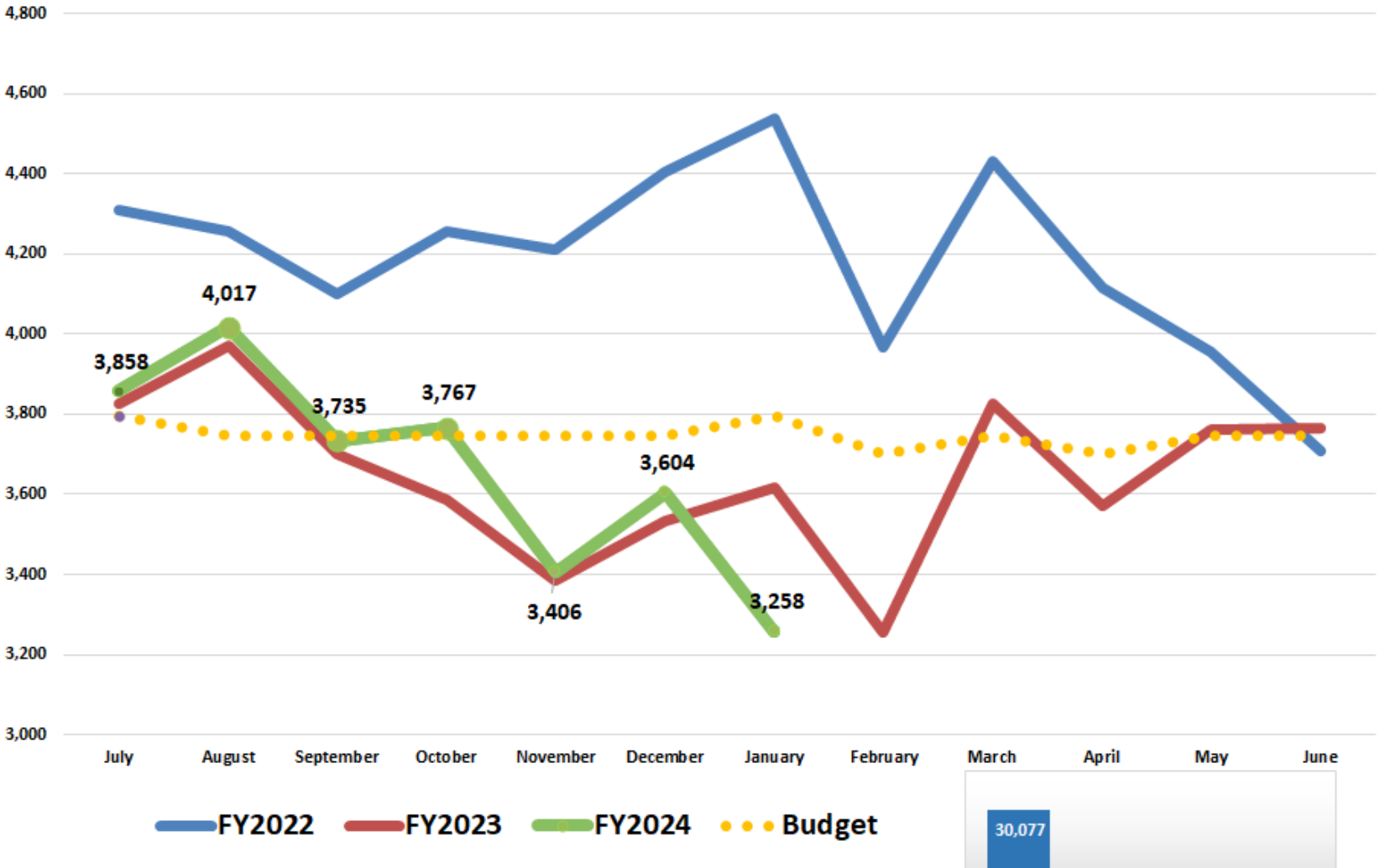
YTD FY24
YTD Budget

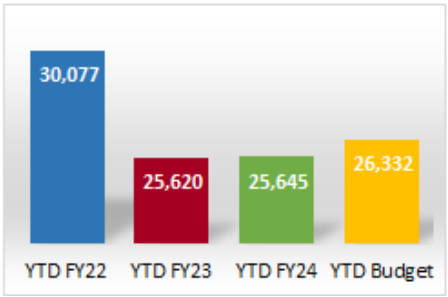
Home Infusion Days



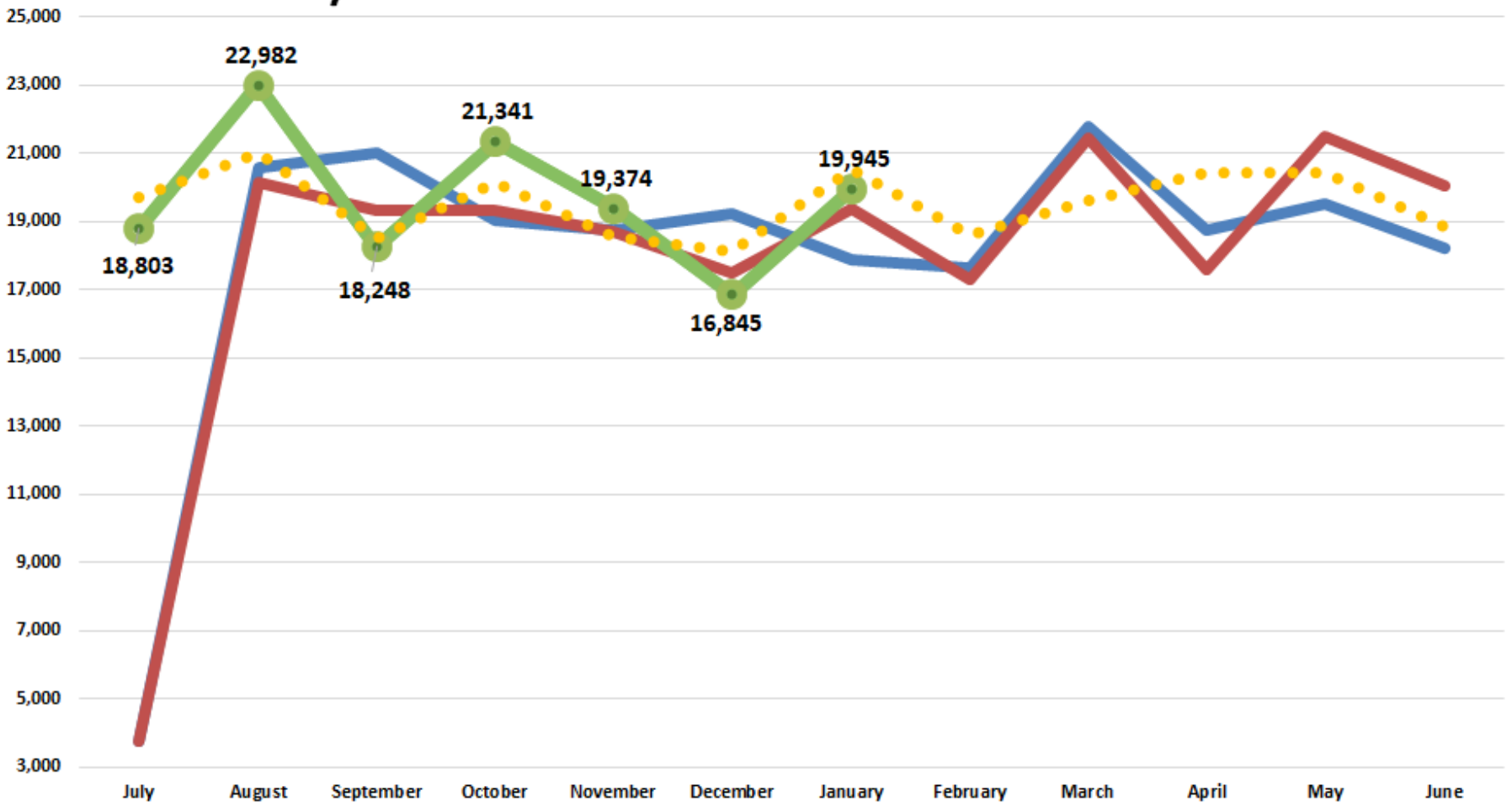


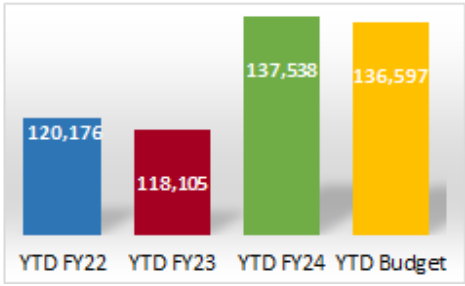
Hospice Days



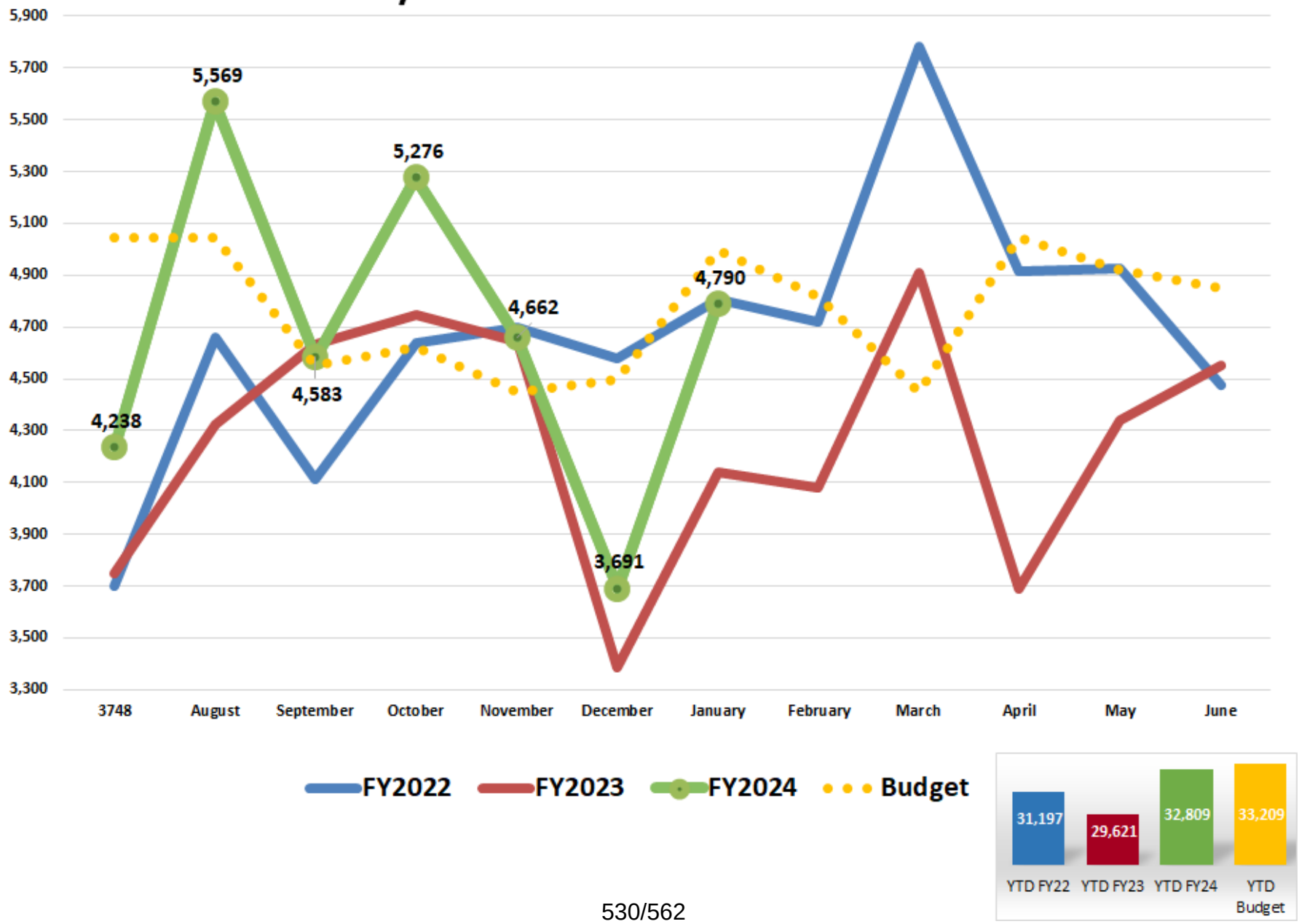


All O/P Rehab Svcs Across District

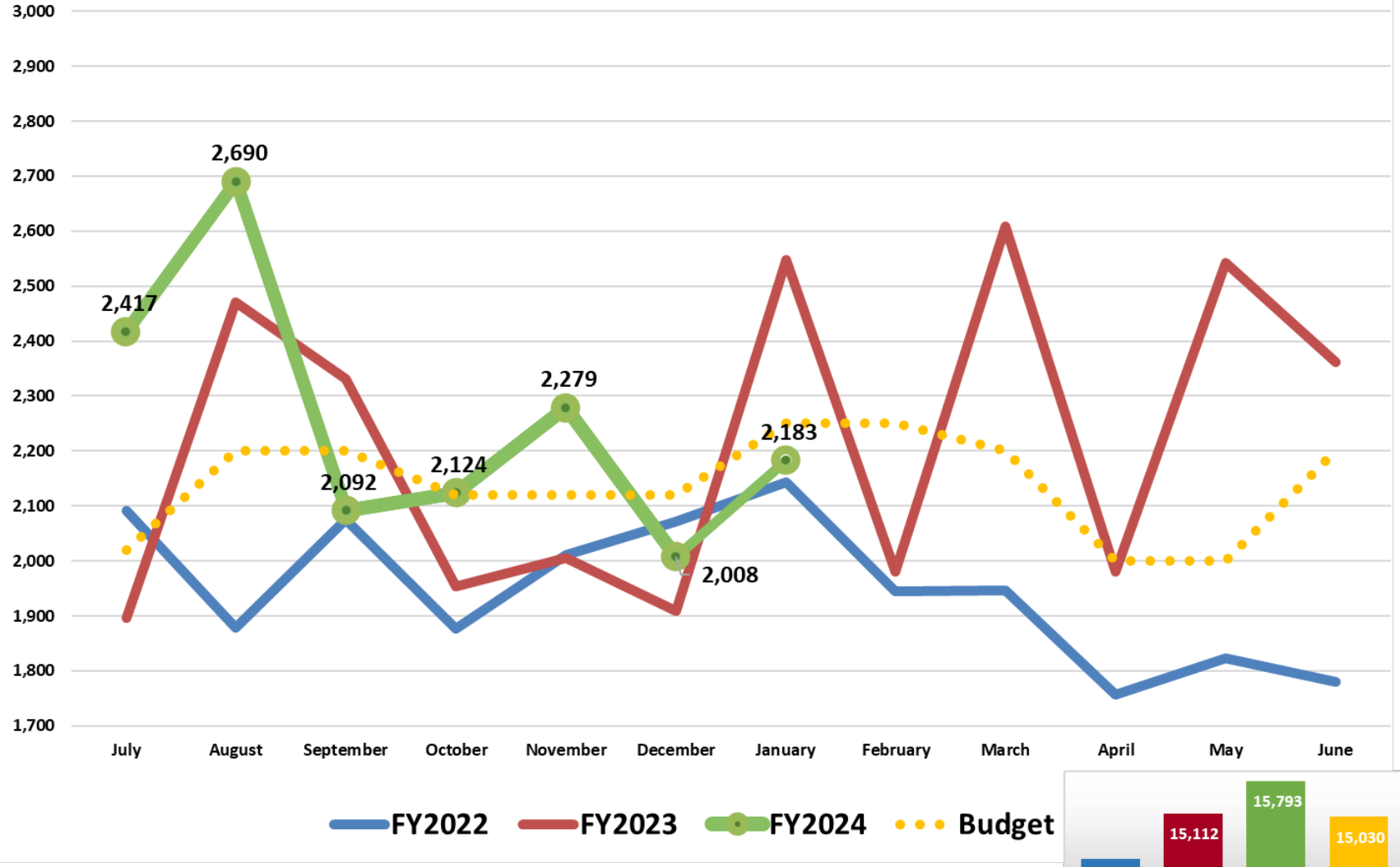


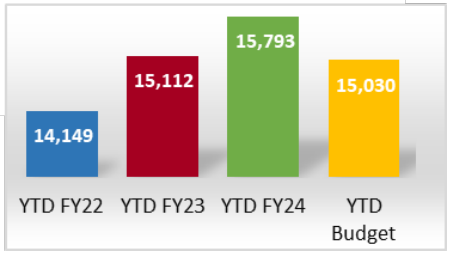


O/P Rehab Services

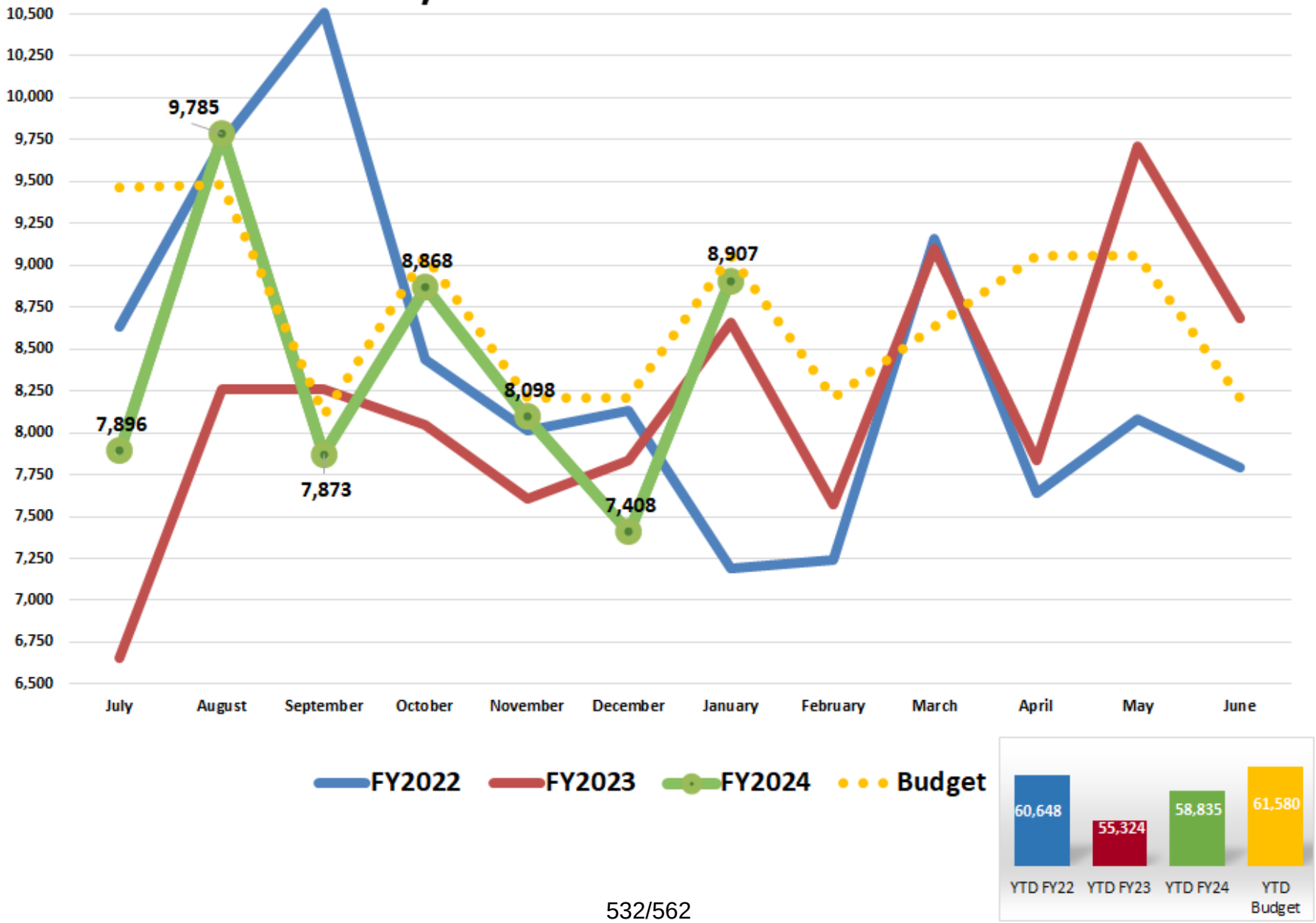


O/P Rehab - Exeter

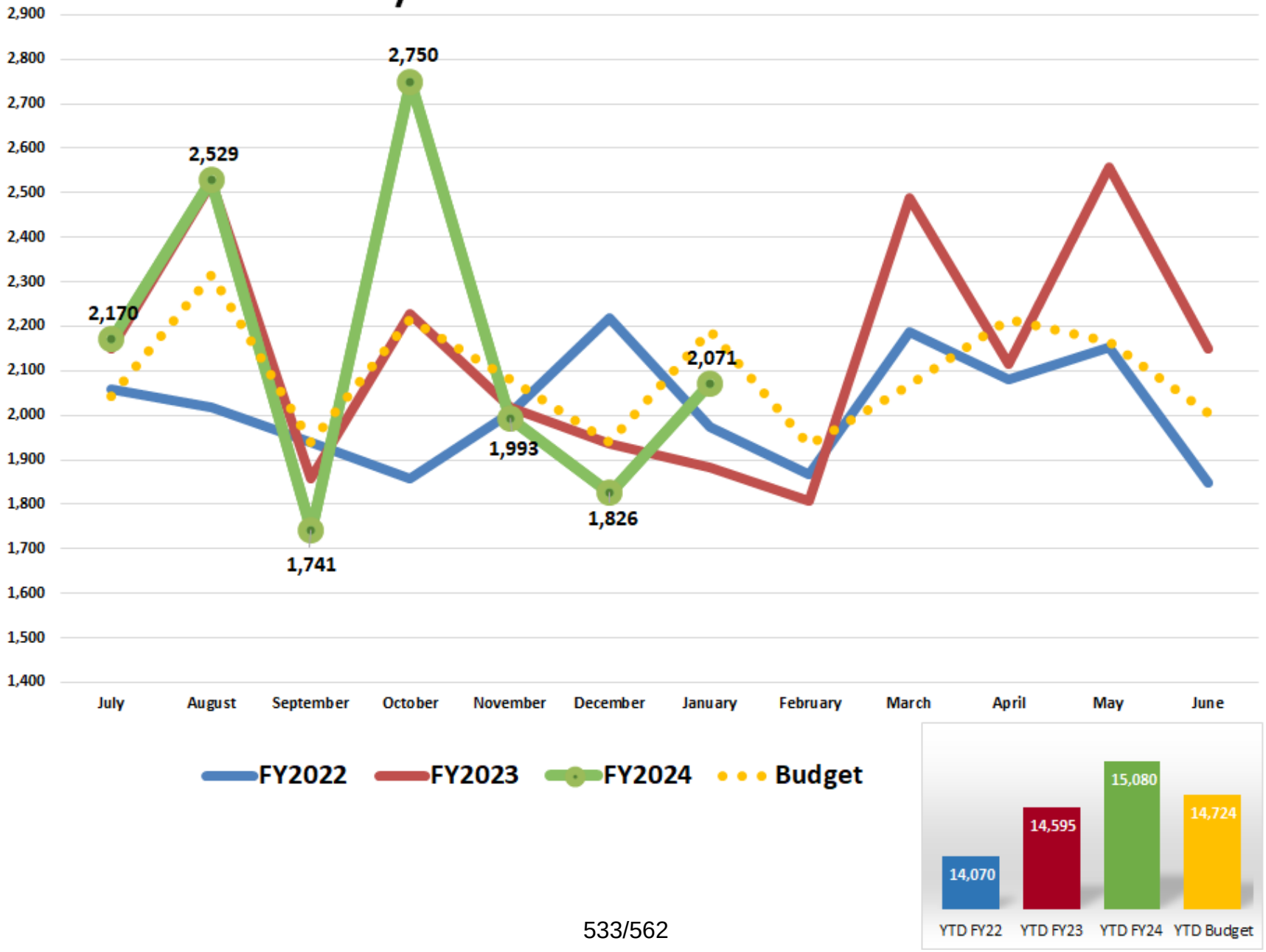




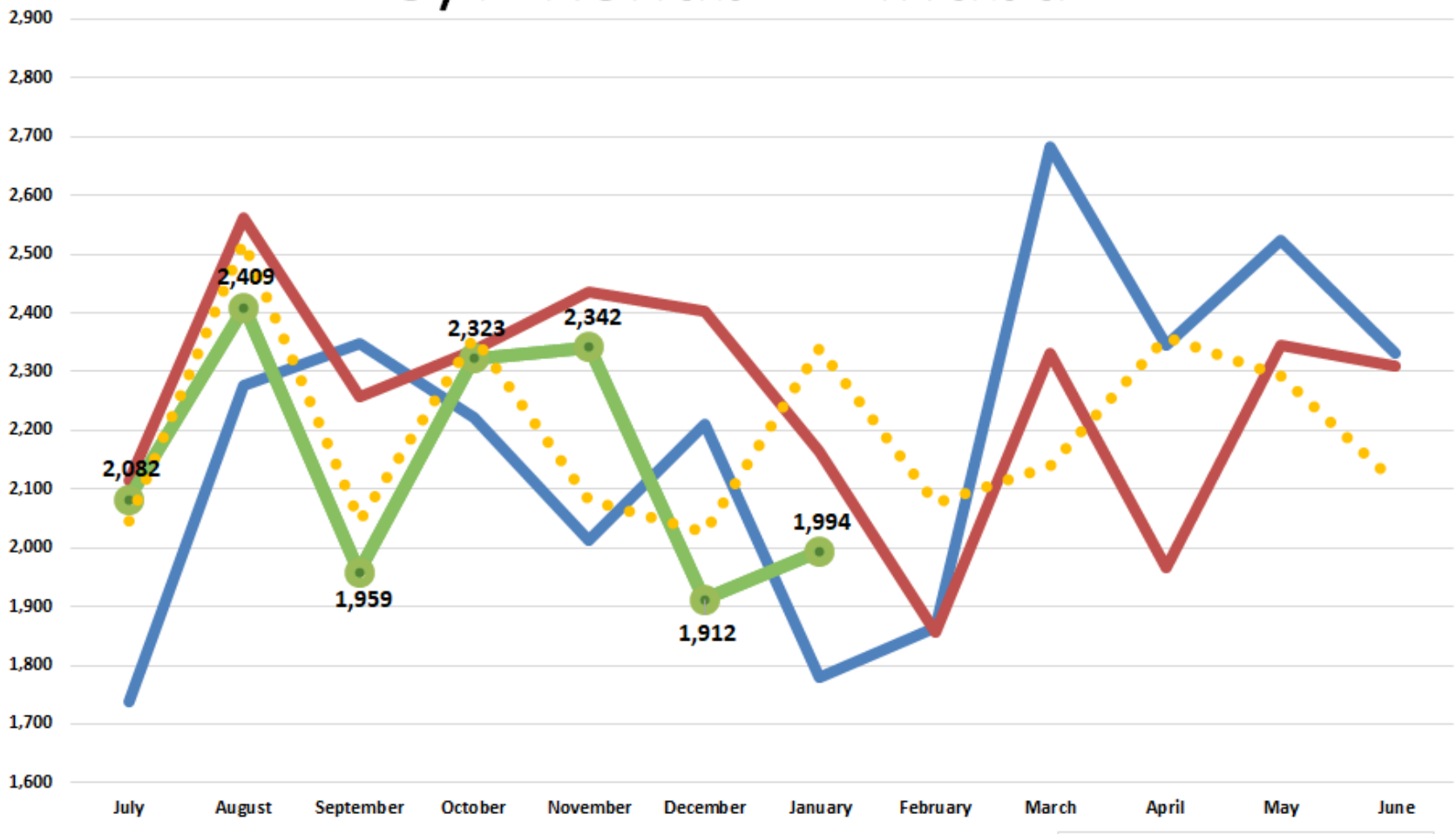
O/P Rehab - Akers

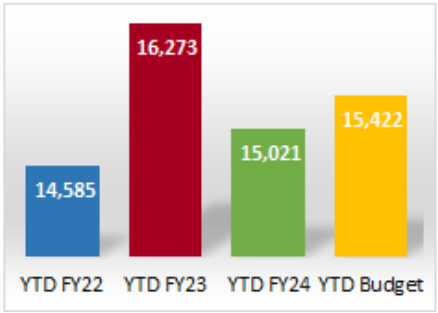


O/P Rehab - LLOPT

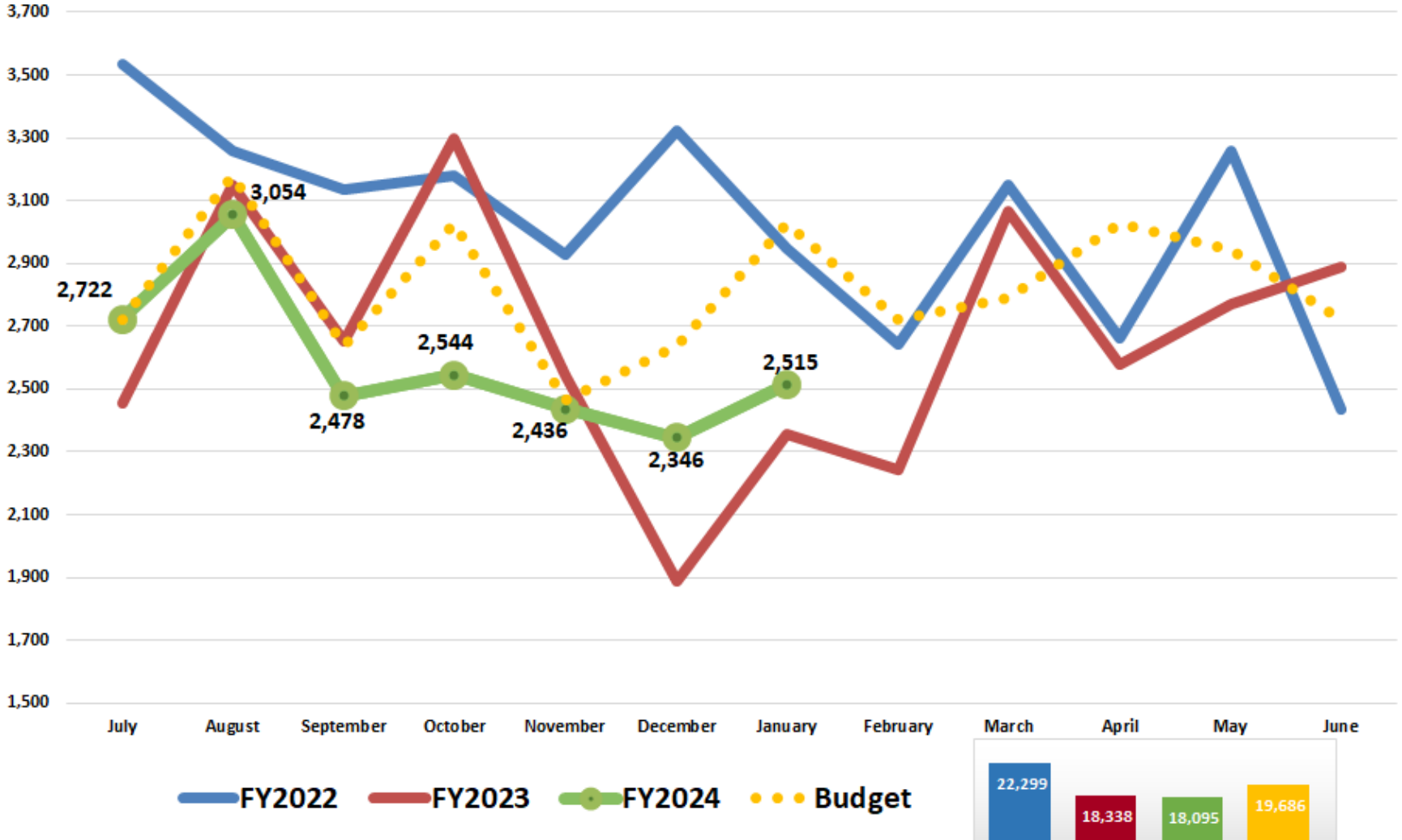


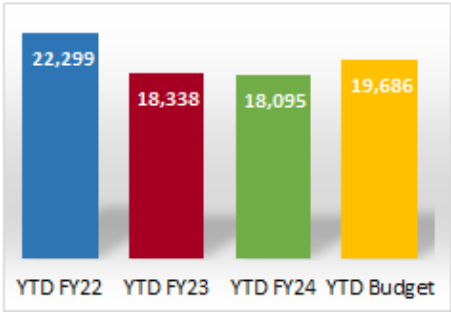
O/P Rehab - Dinuba



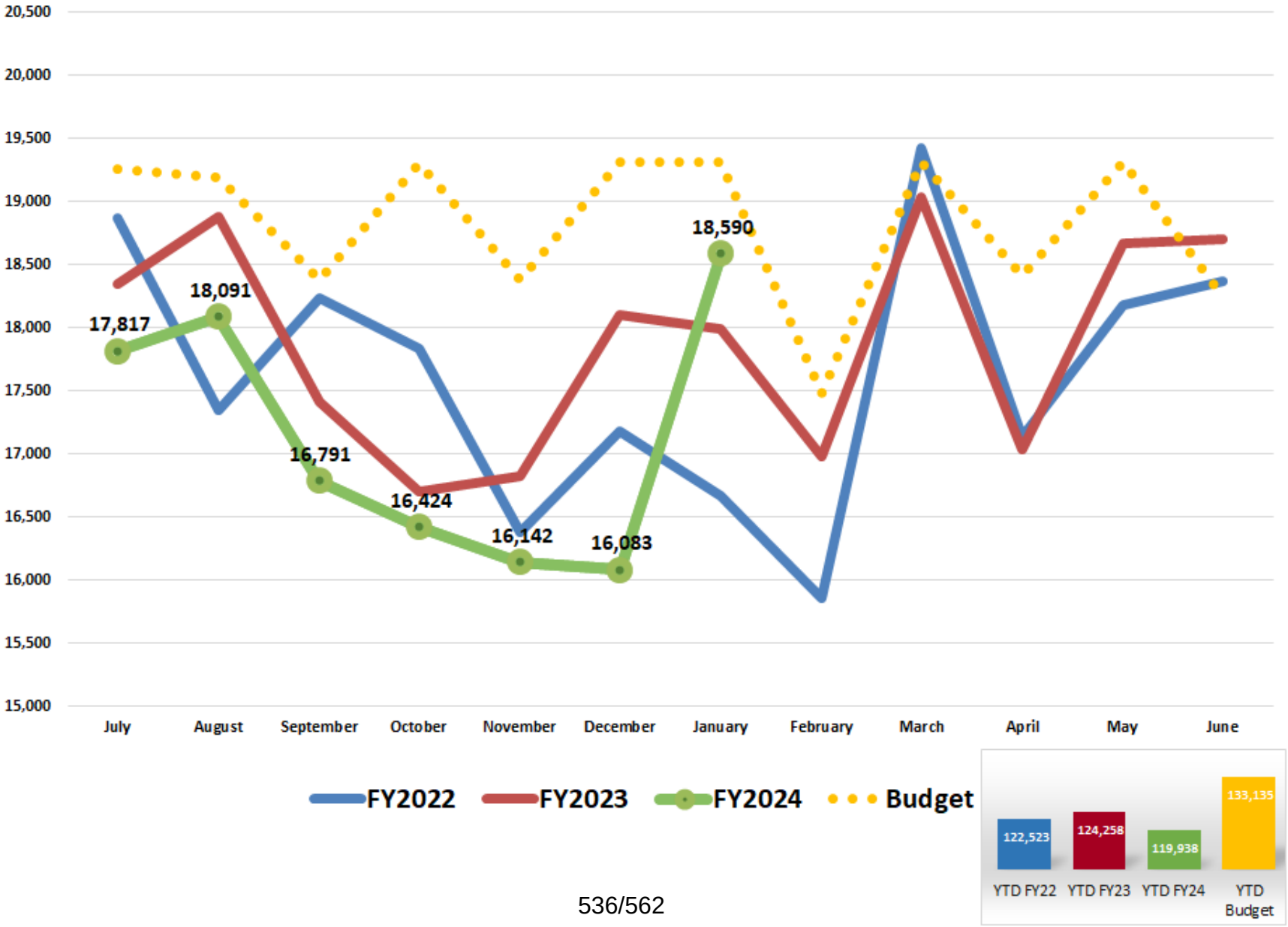


Therapy - Cypress Hand Center



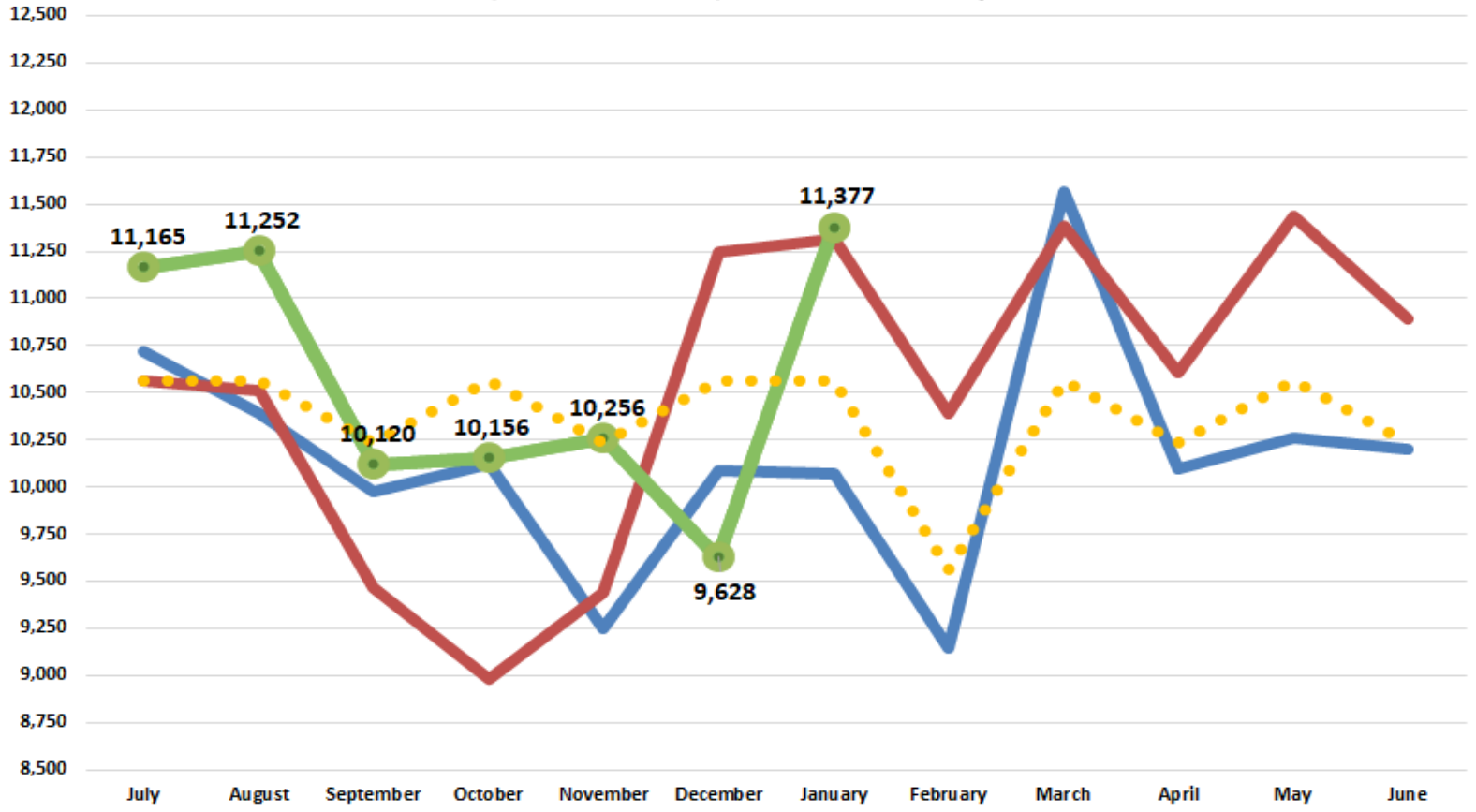


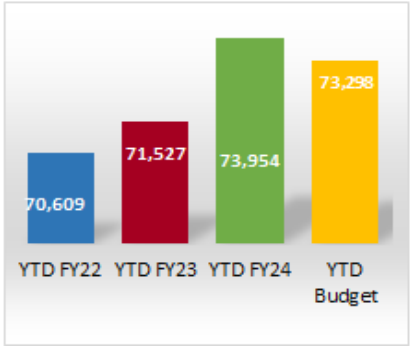
Physical & Other Therapy Units (I/P & O/P)



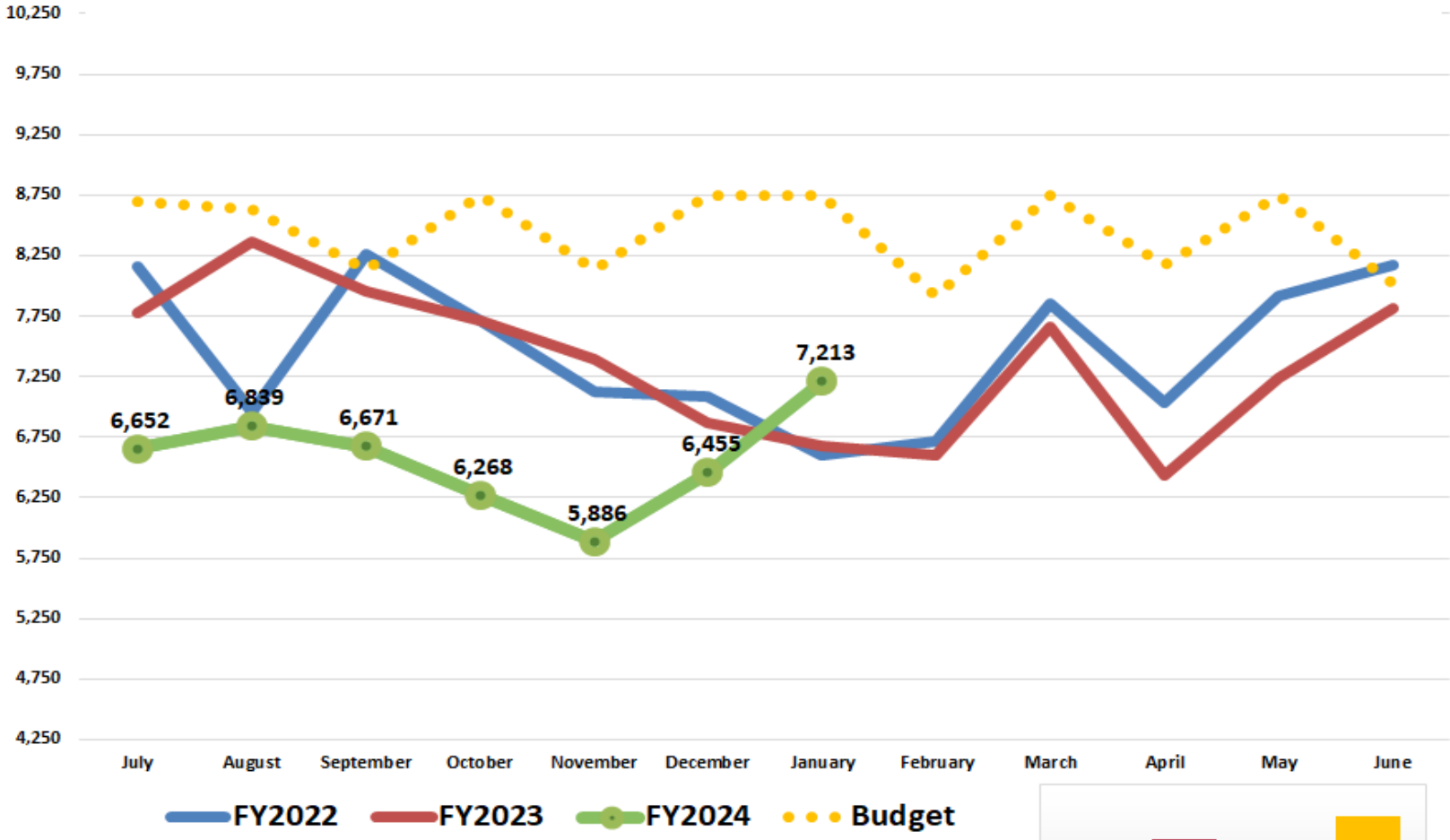
Physical & Other Therapy Units

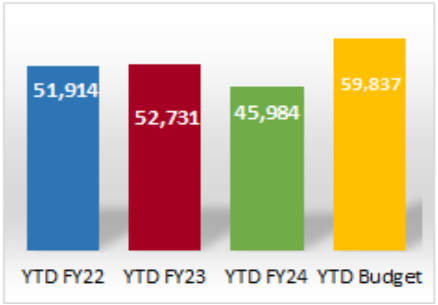
(I/P & O/P)-Main Campus



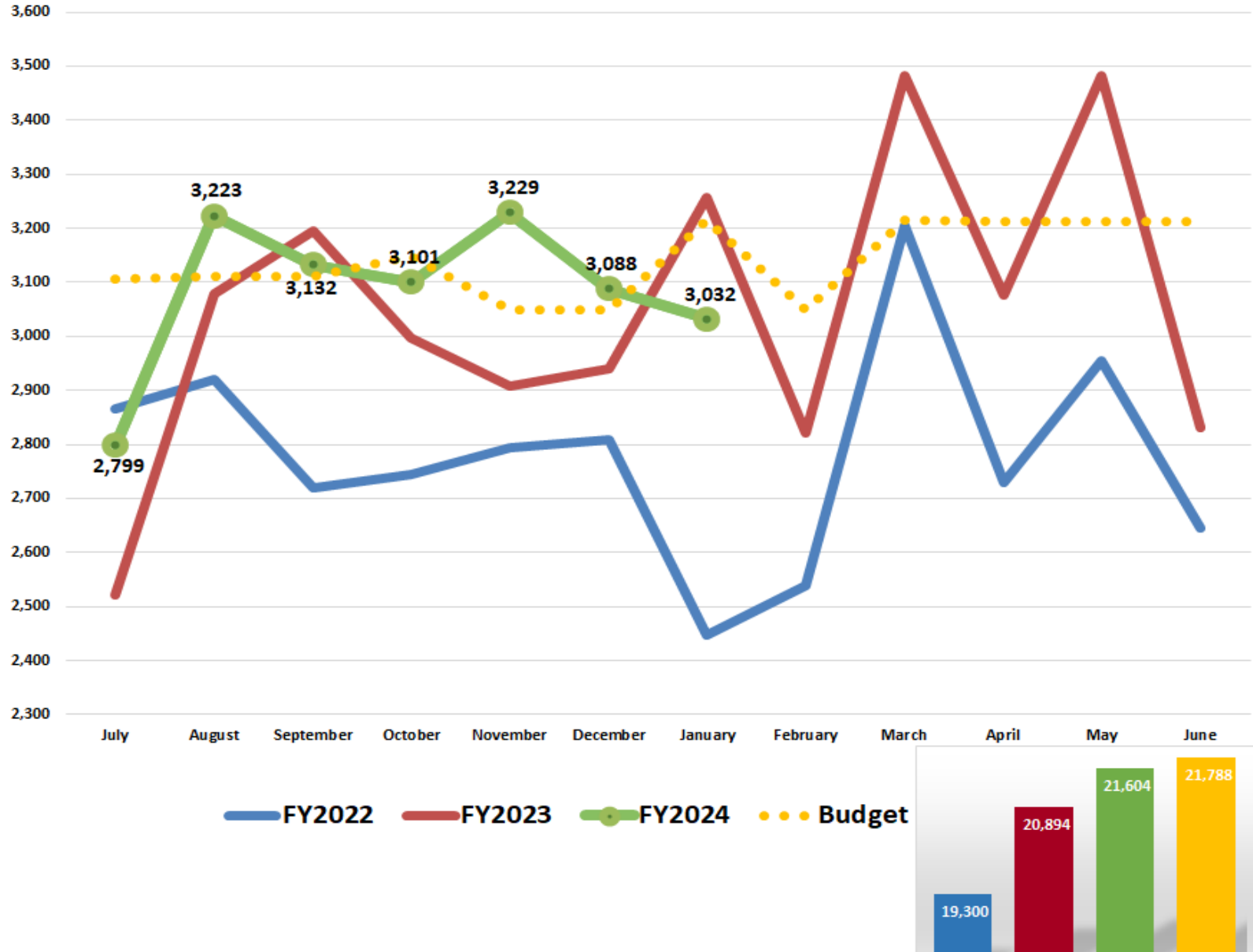


Physical & Other Therapy Units (I/P & O/P)- KDRH & South Campus

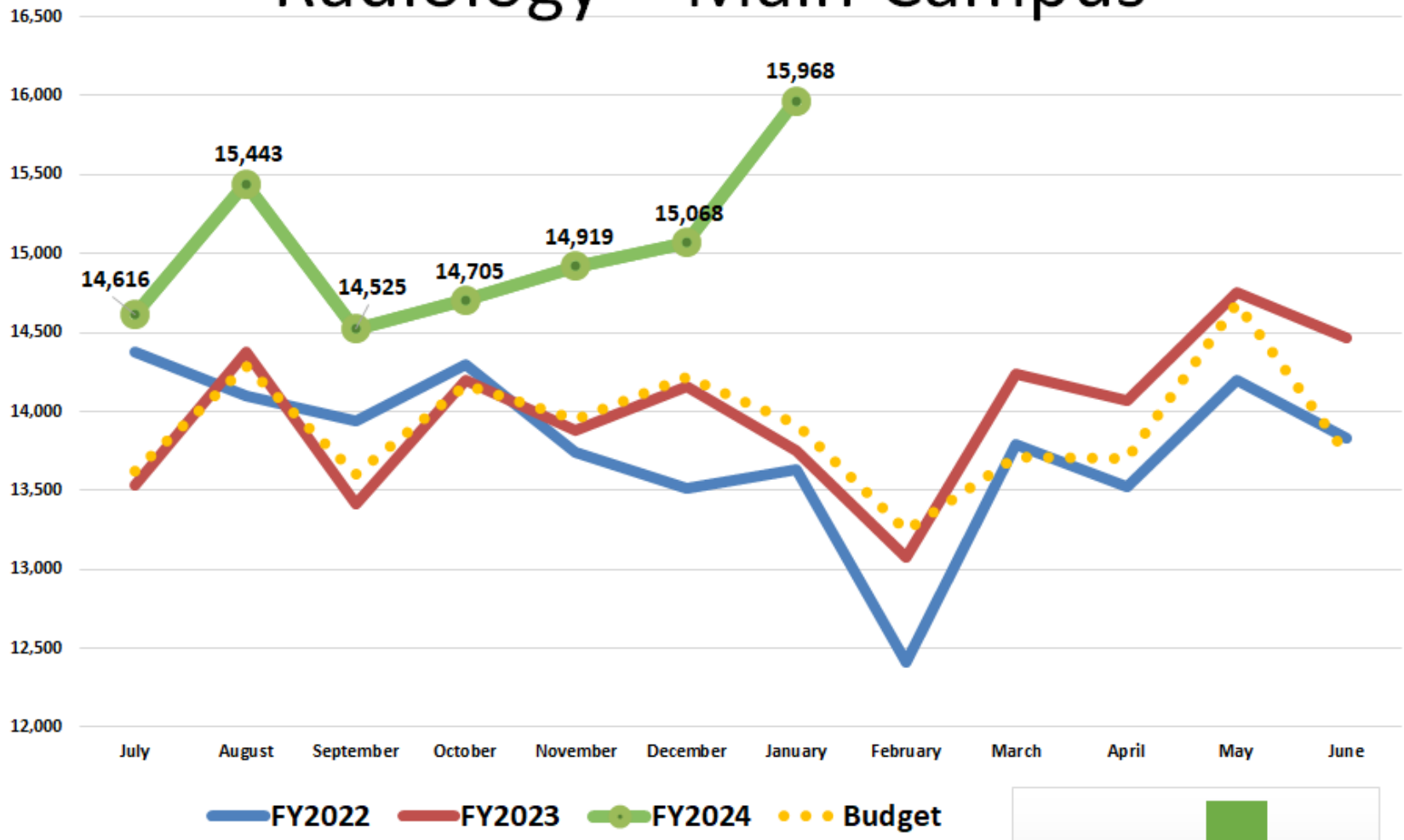


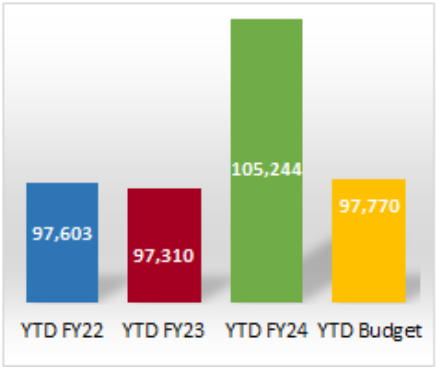


Home Health Visits

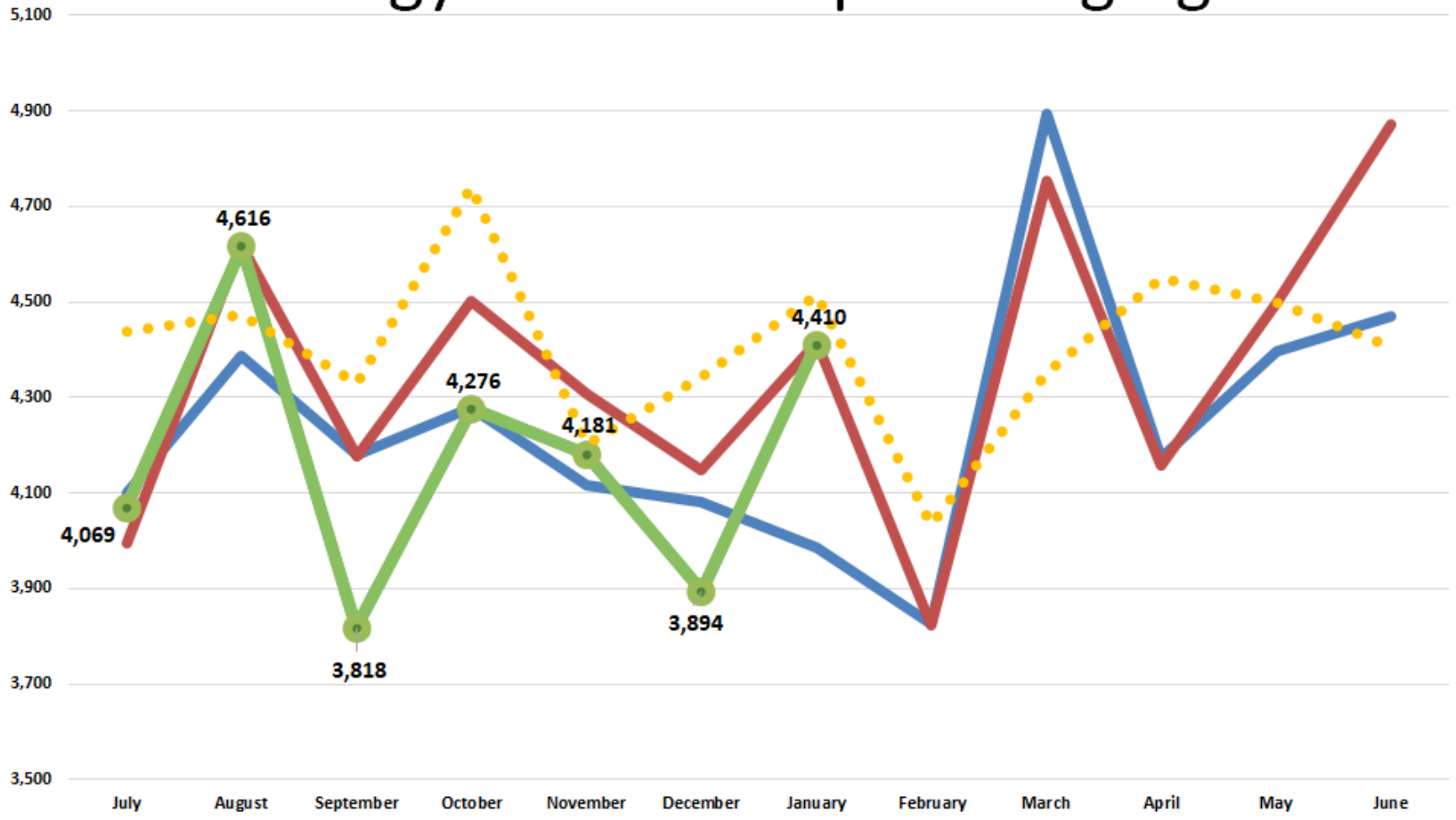


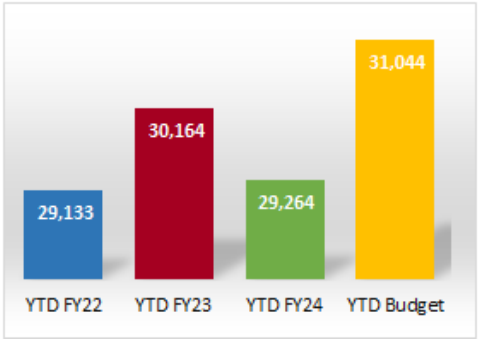
Radiology – Main Campus



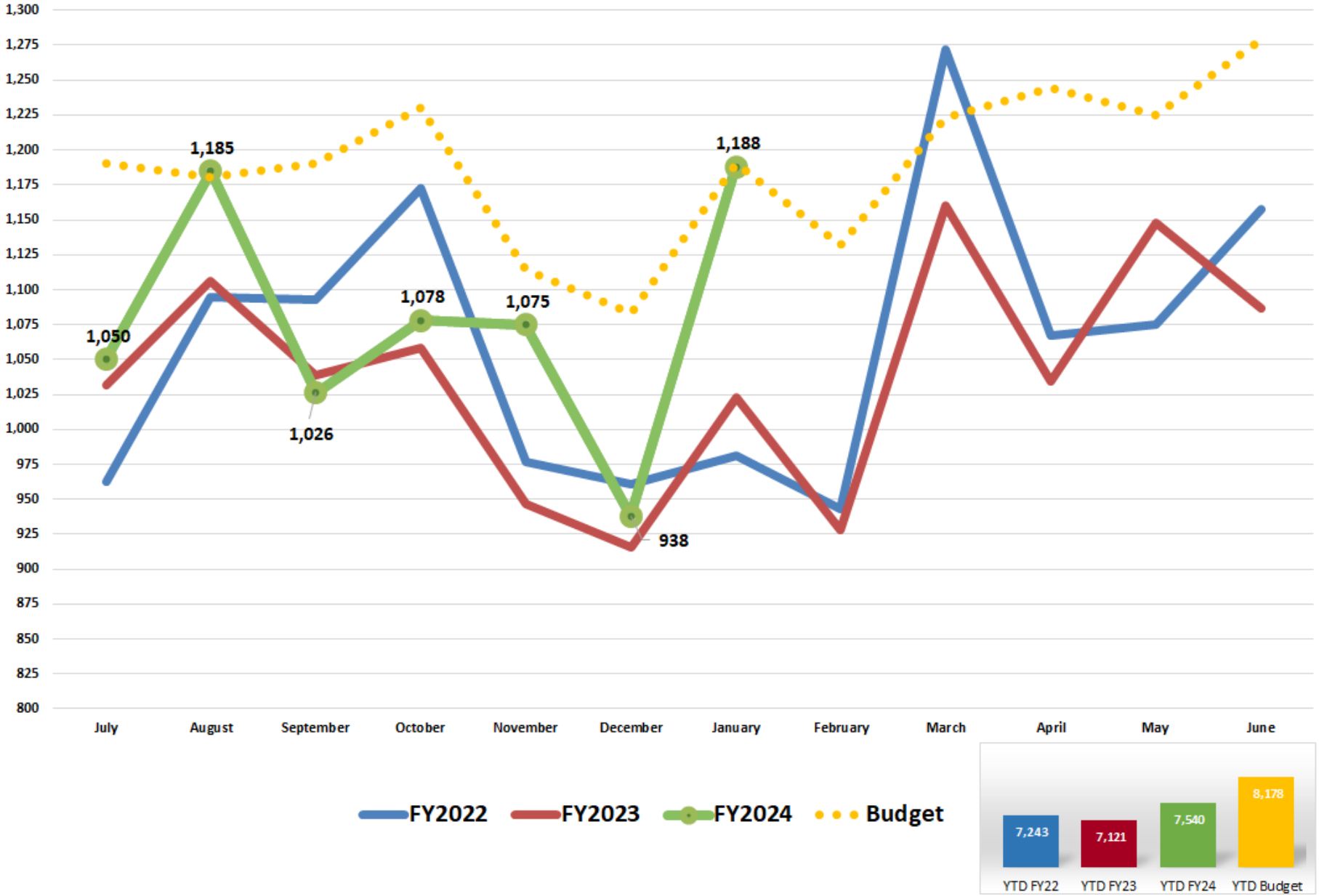


Radiology - West Campus Imaging

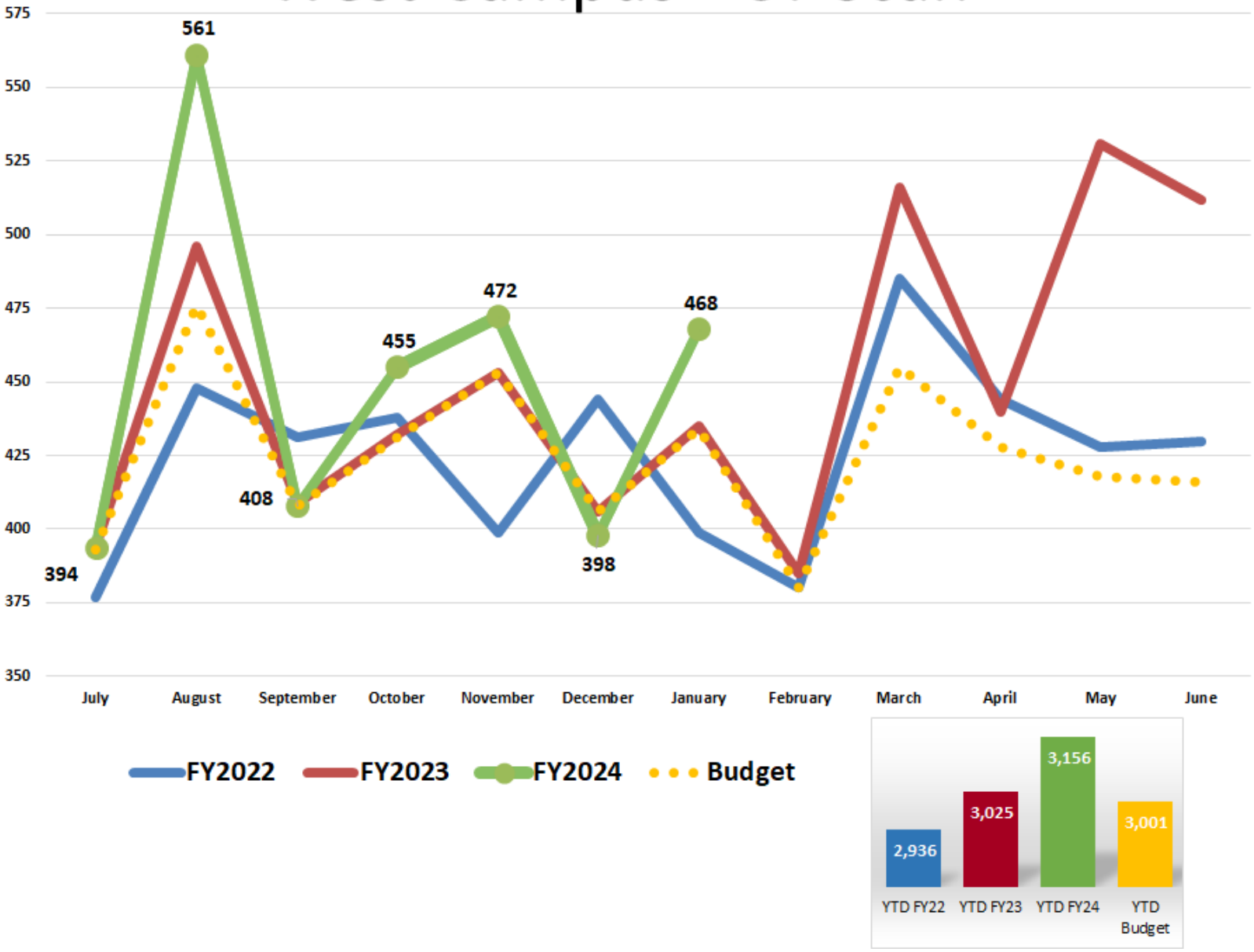




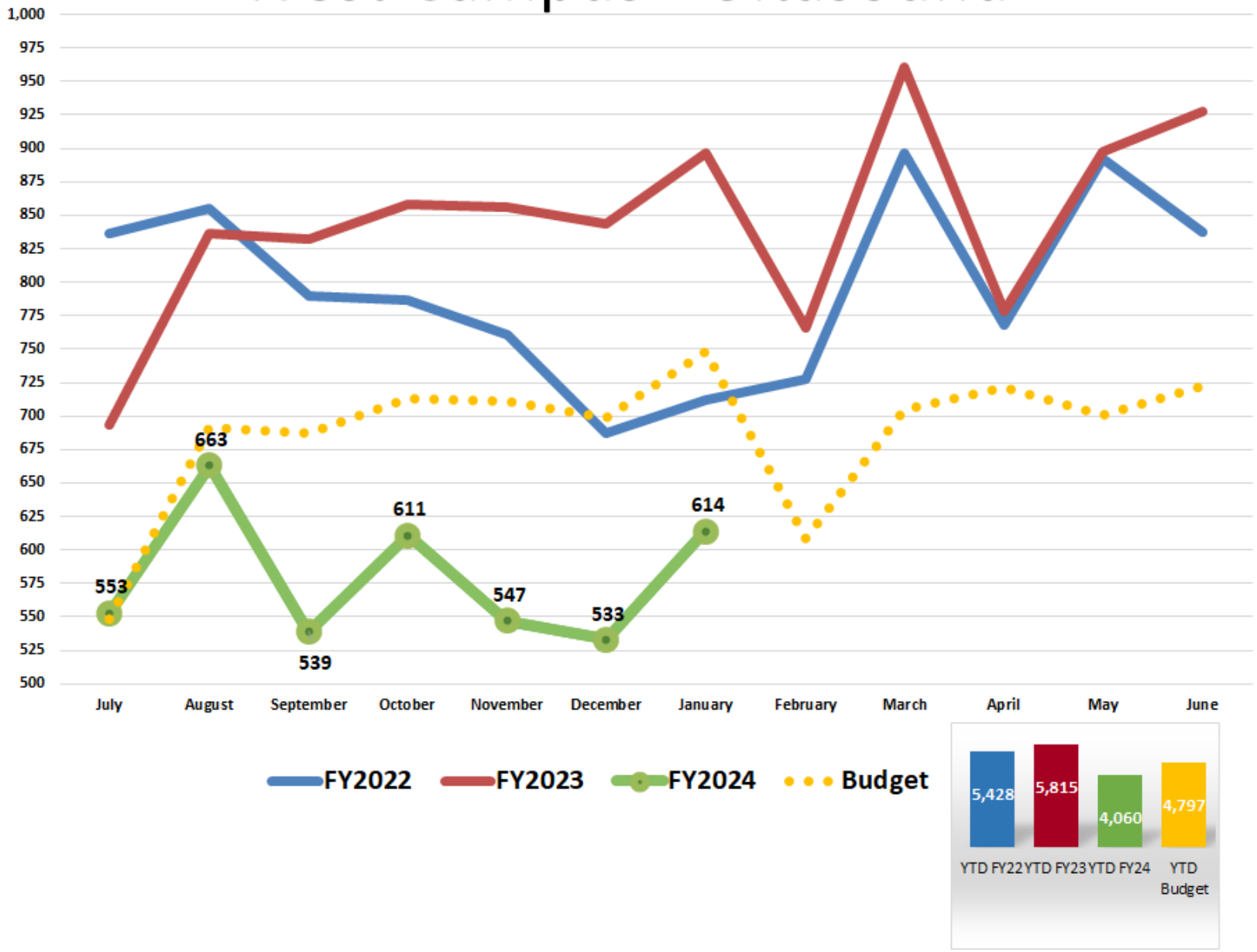
West Campus - Diagnostic Radiology



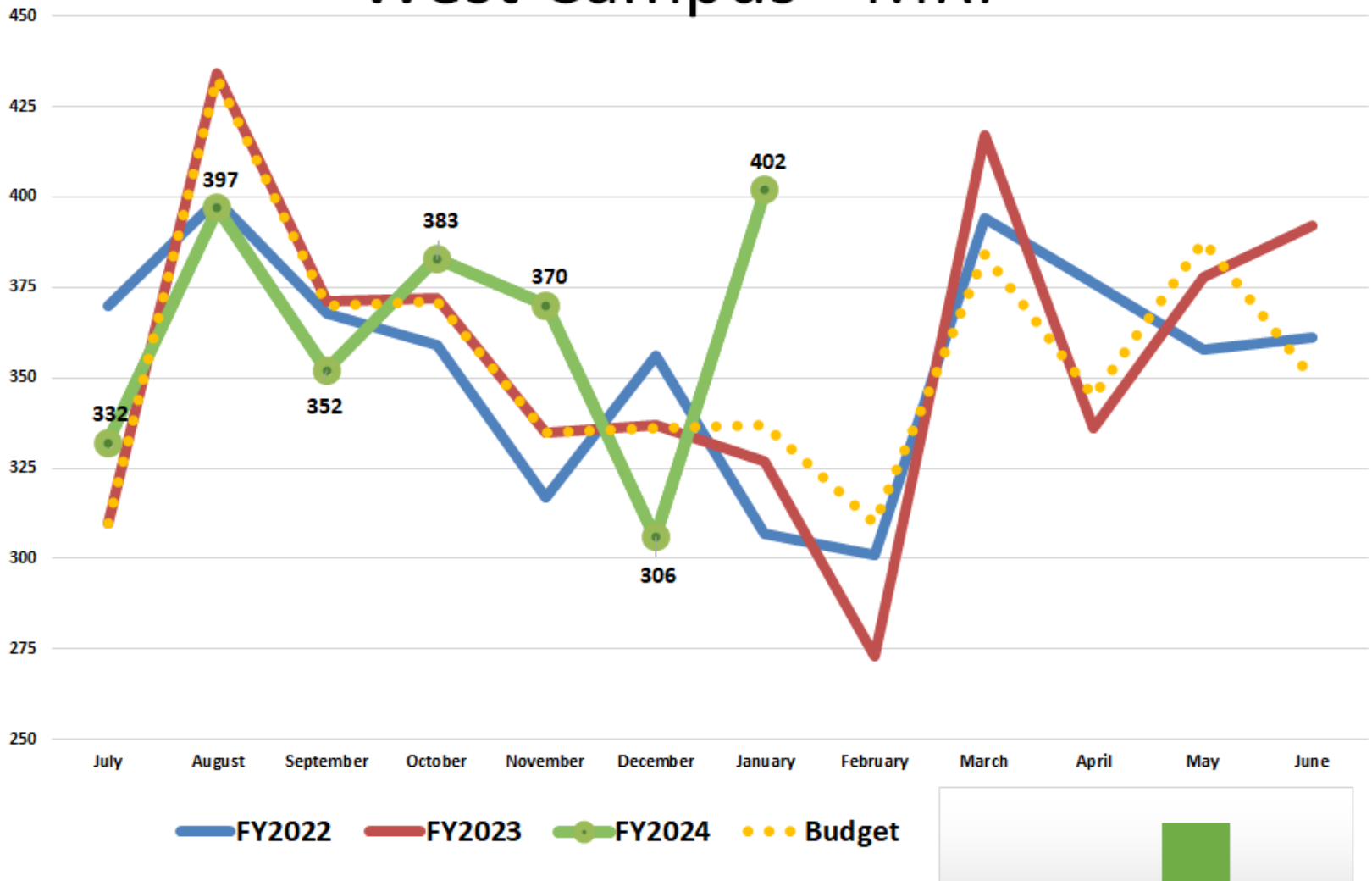
West Campus - CT Scan

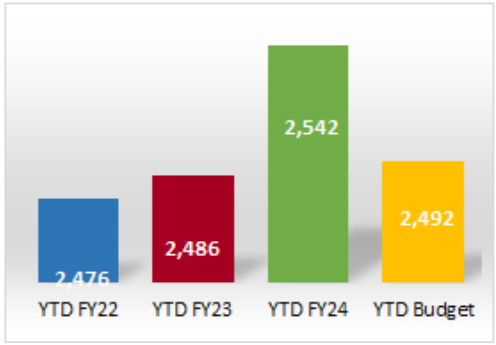


West Campus - Ultasound

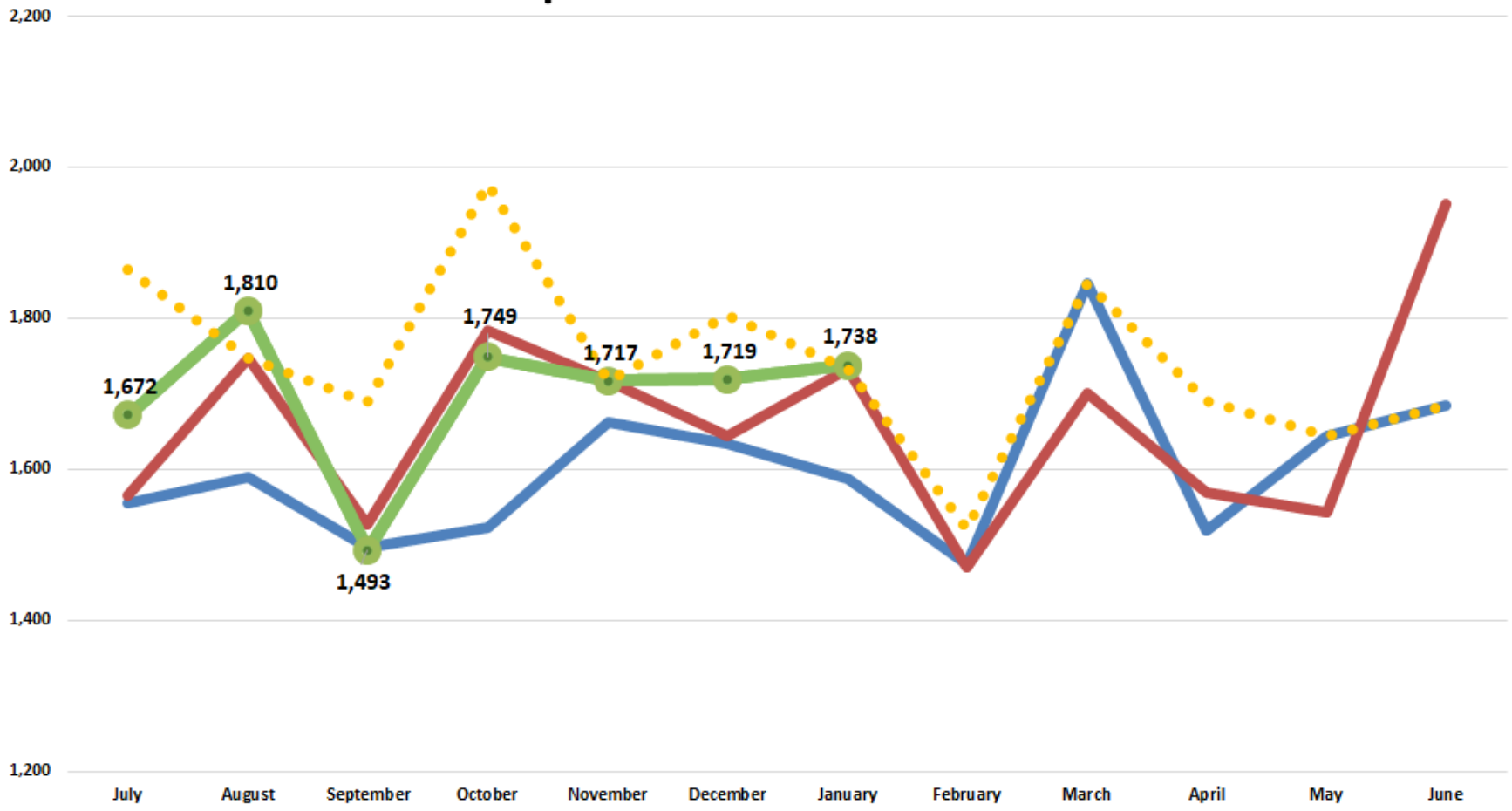


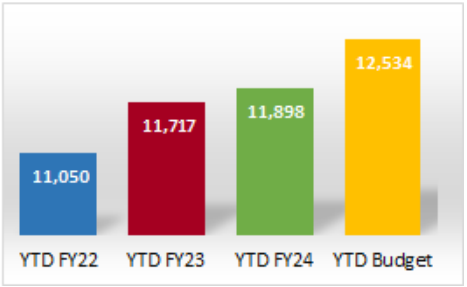
West Campus - MRI



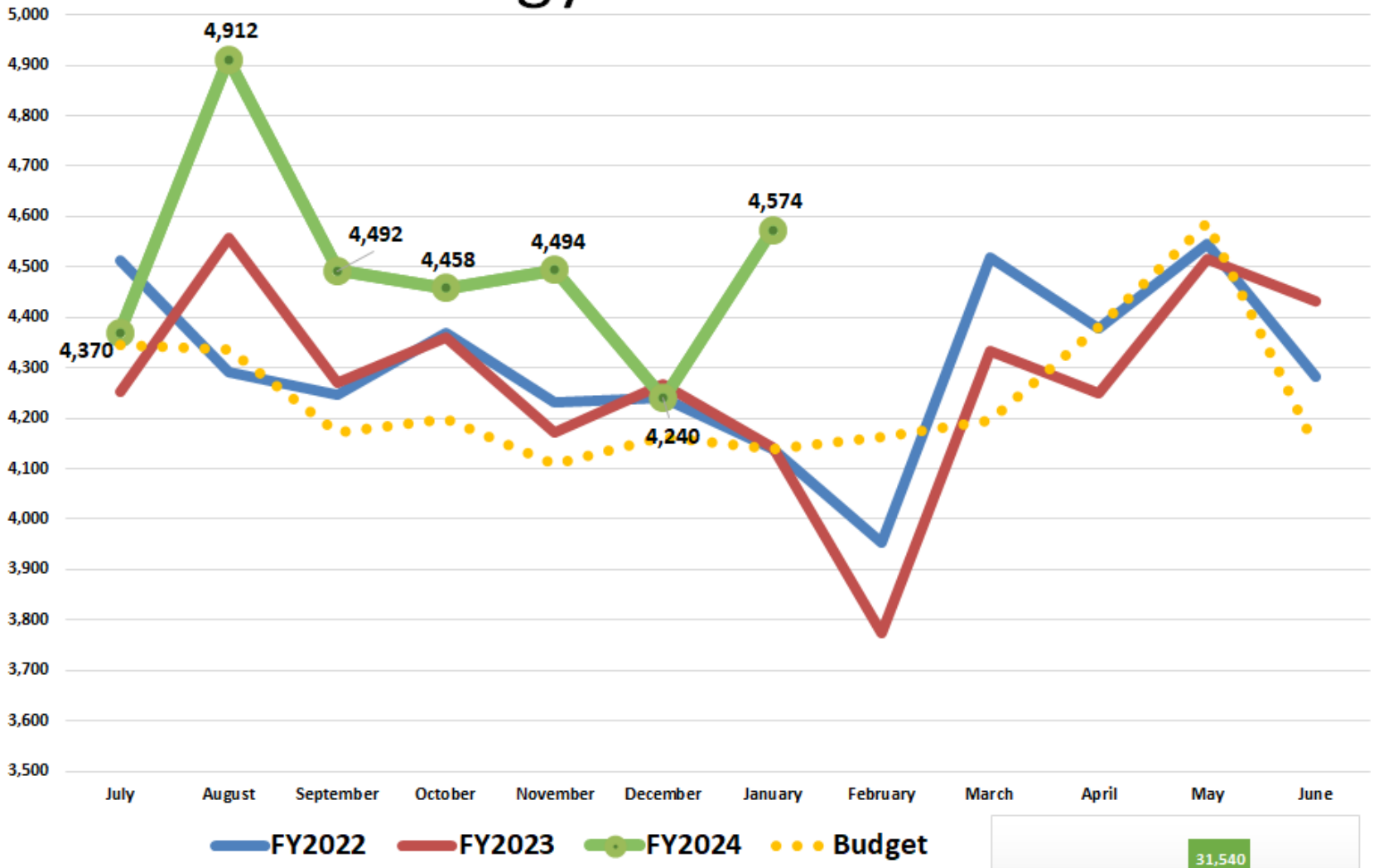


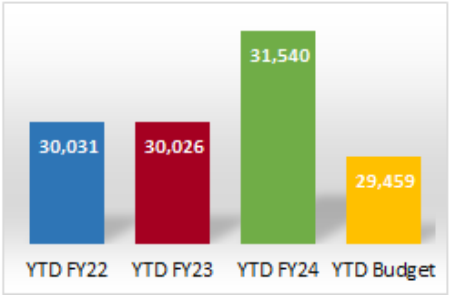
West Campus - Breast Center



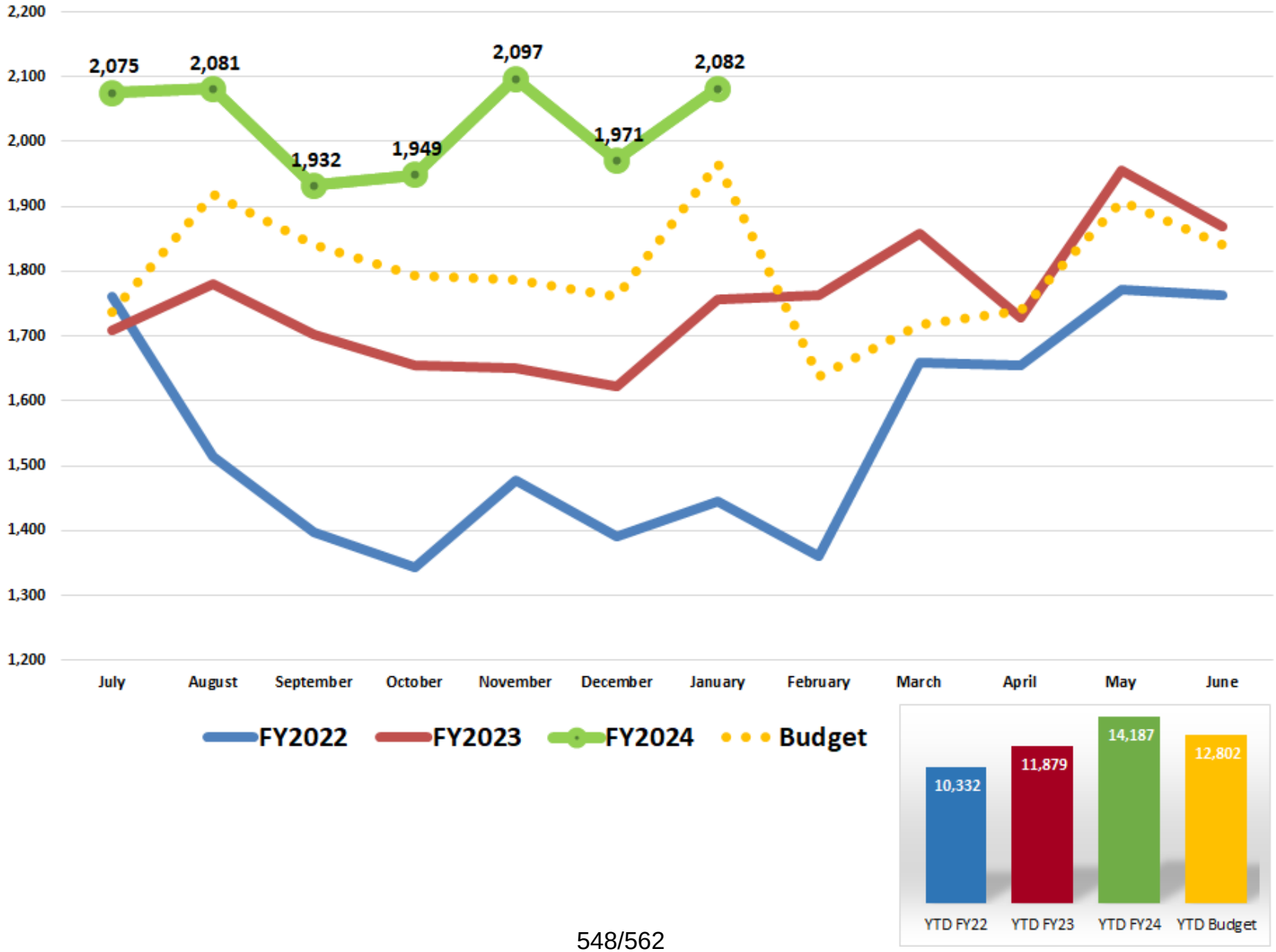


Radiology - CT - All Areas

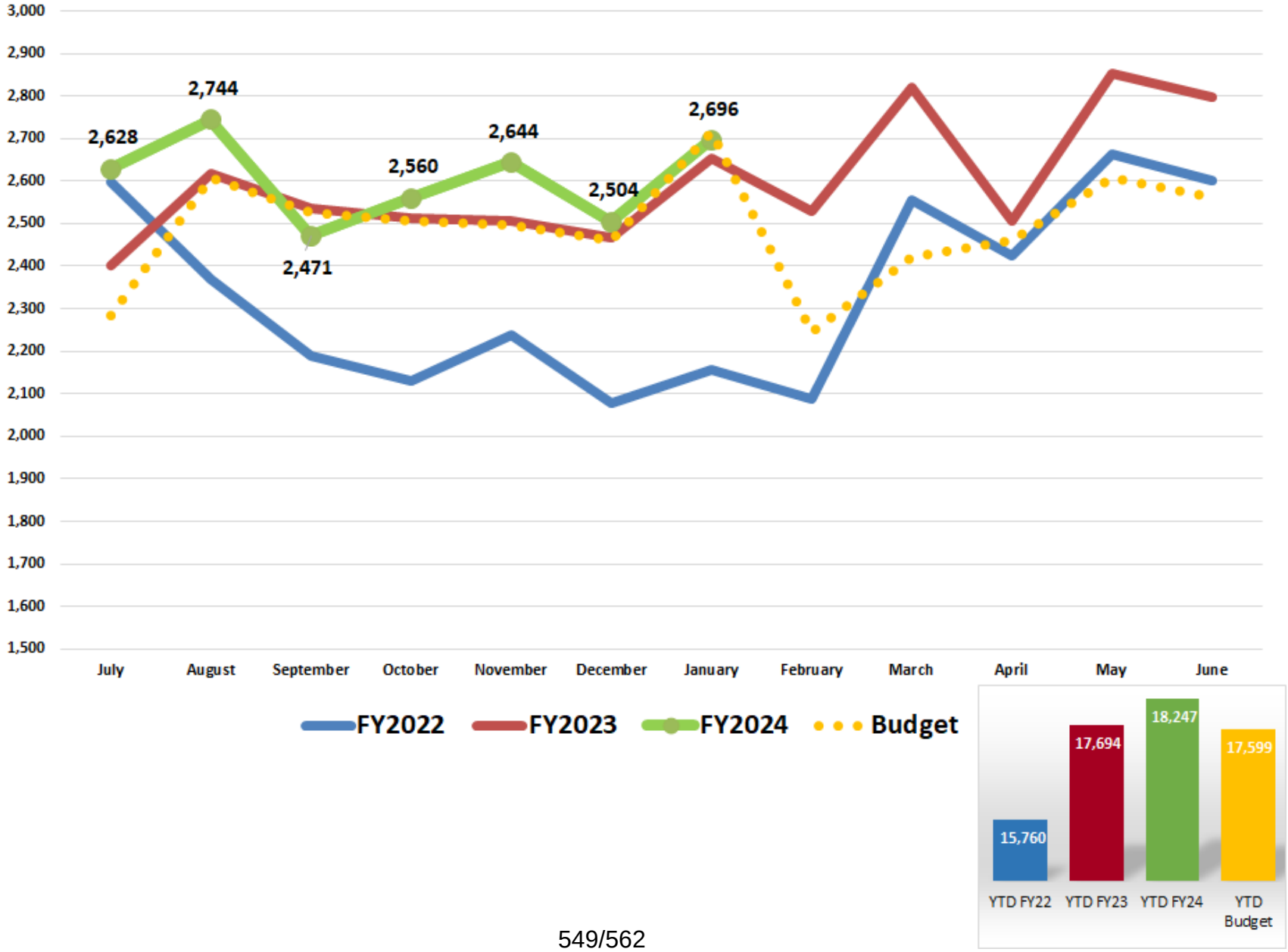




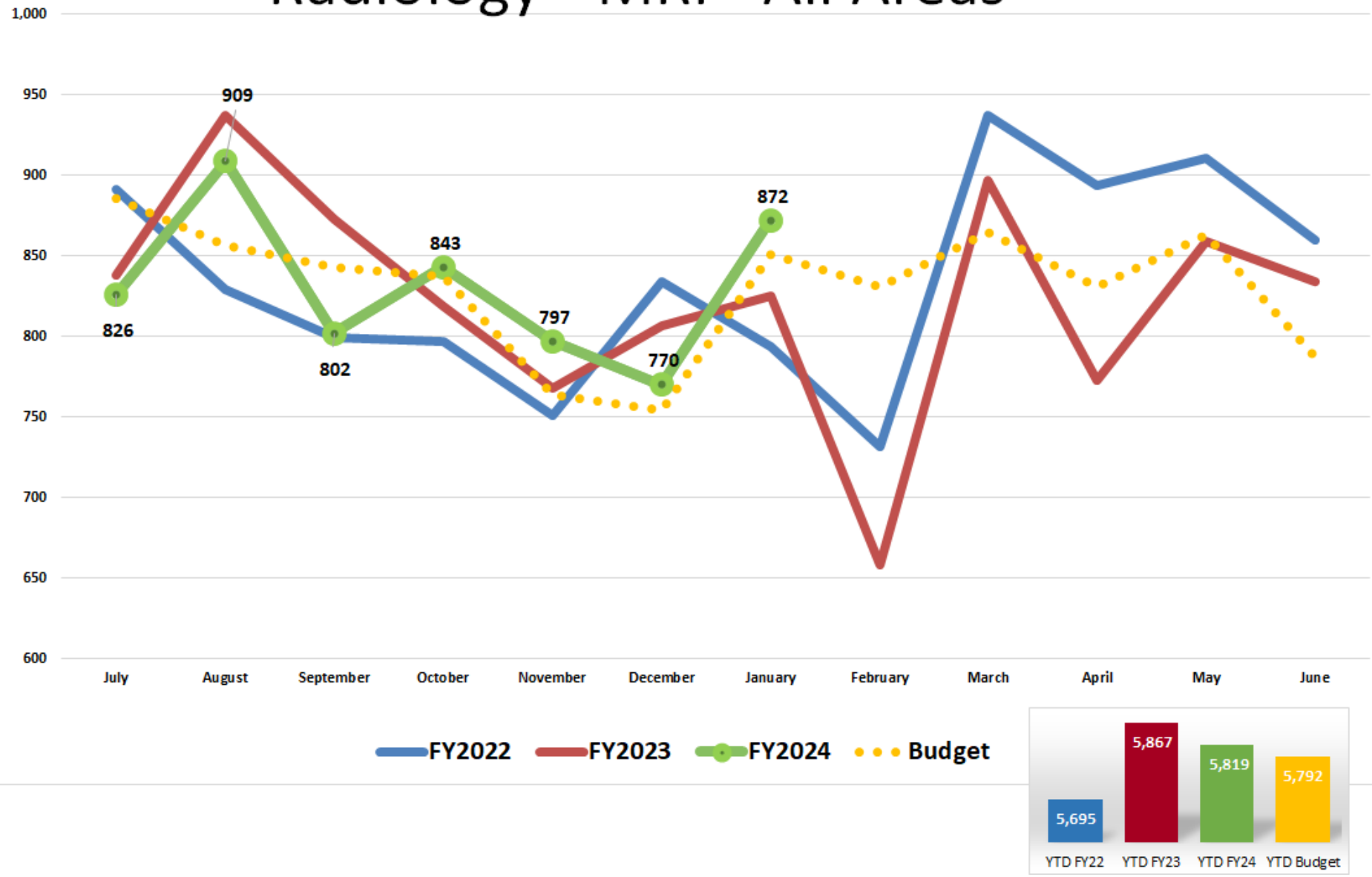
Radiology - Ultrasound - Main Campus



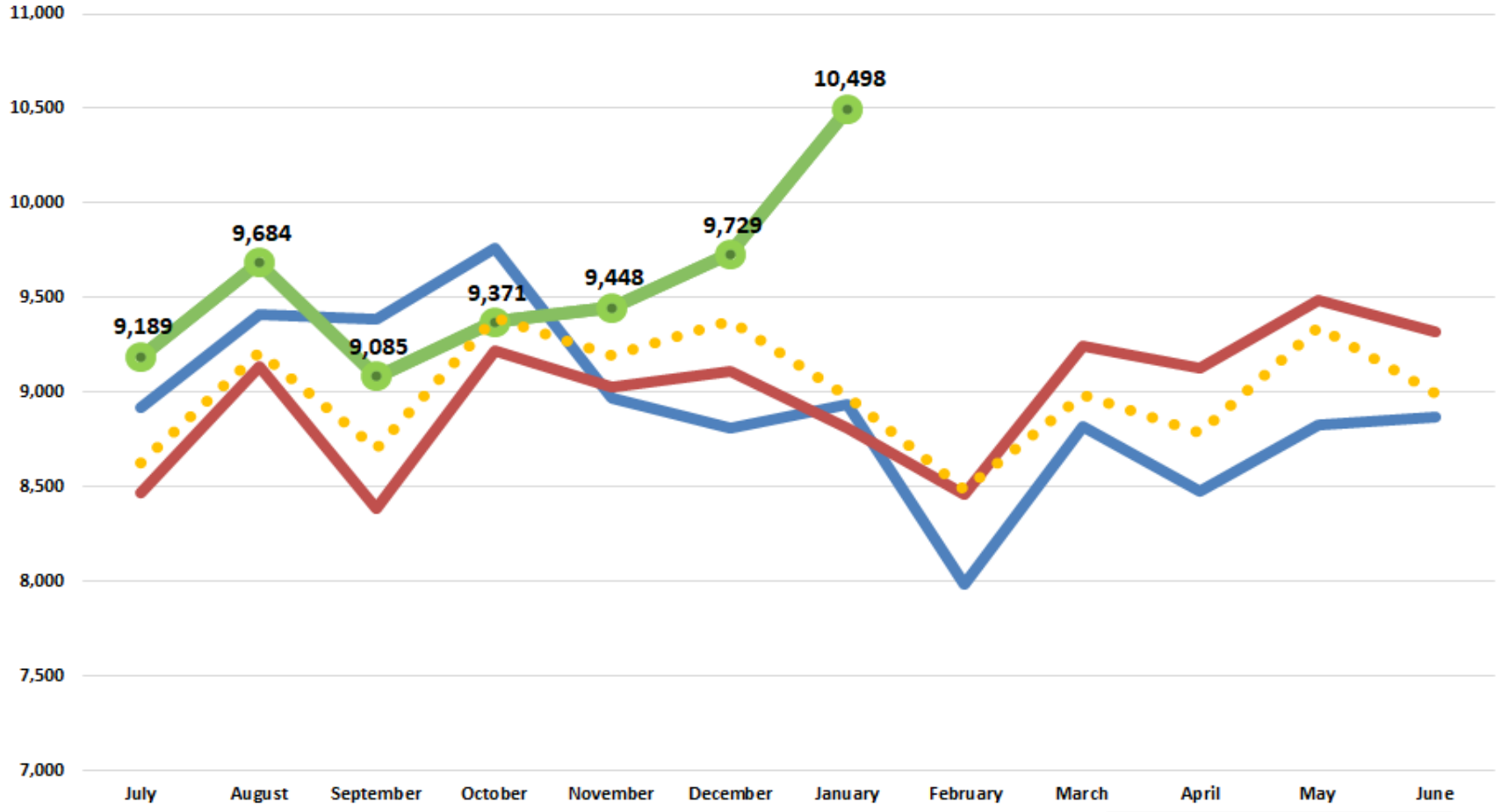
Radiology - Ultrasound - All Areas

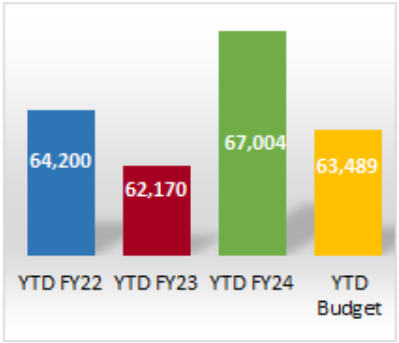


Radiology - MRI - All Areas

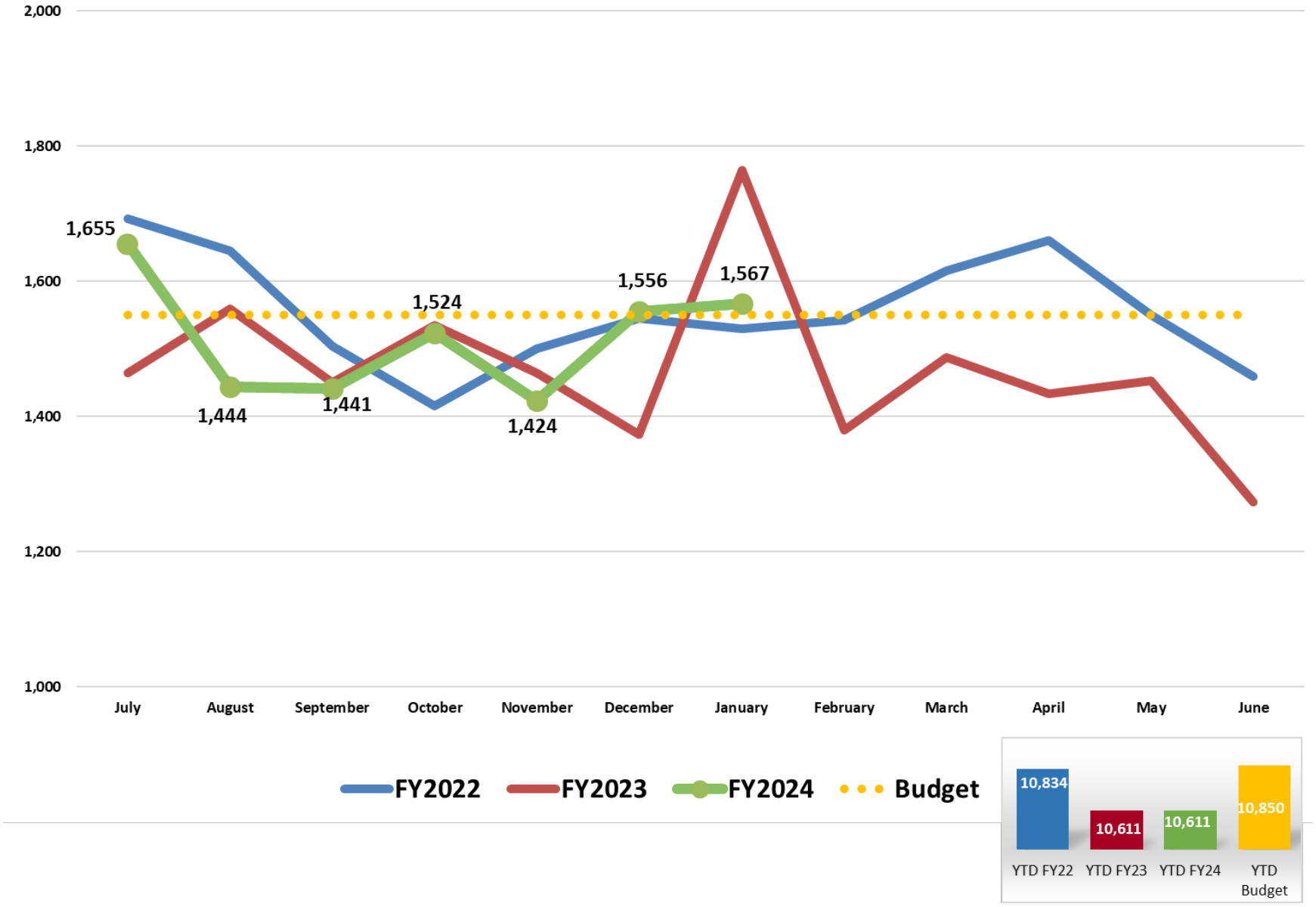


Radiology Modality - Diagnostic

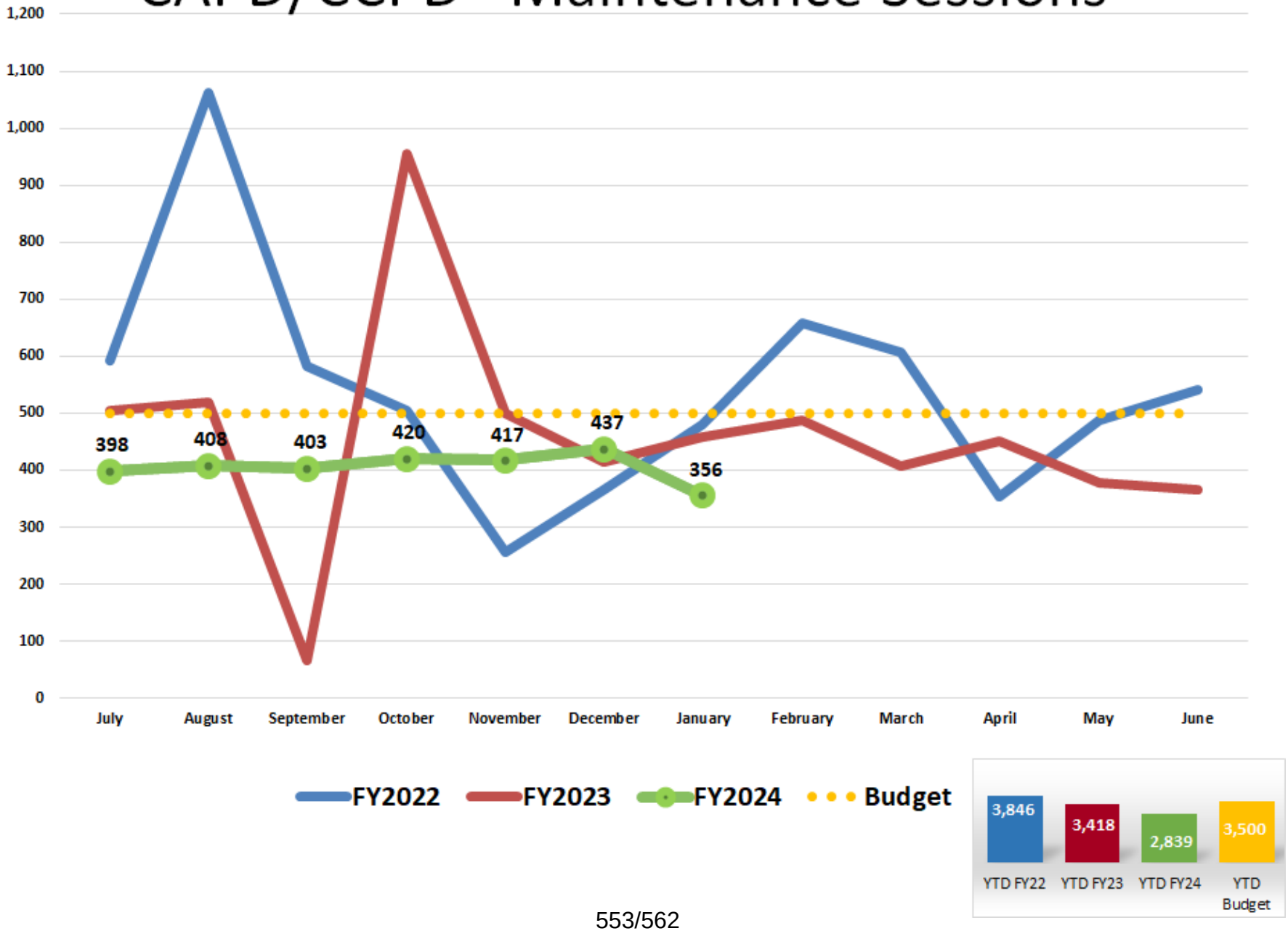




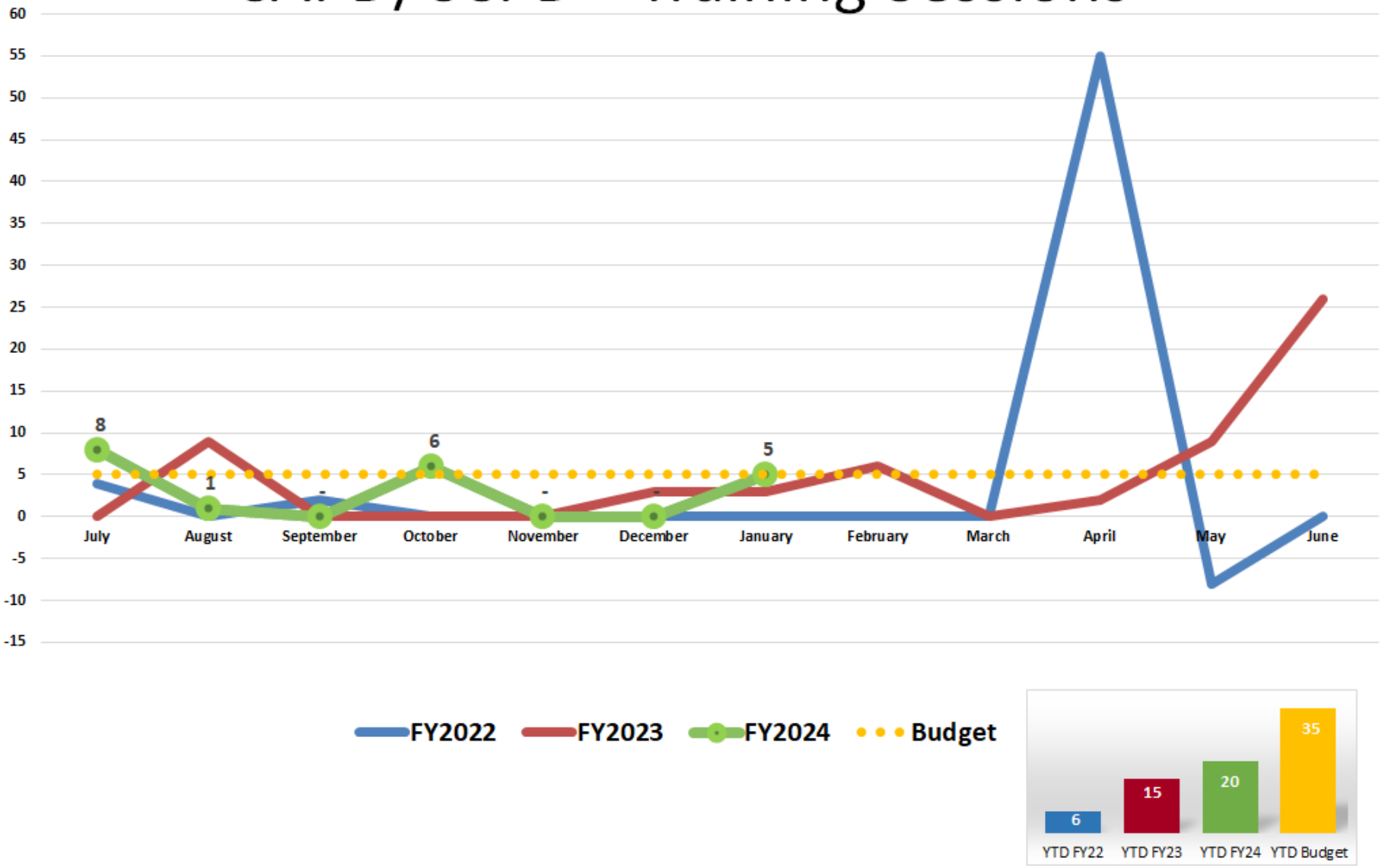
Chronic Dialysis - Visalia



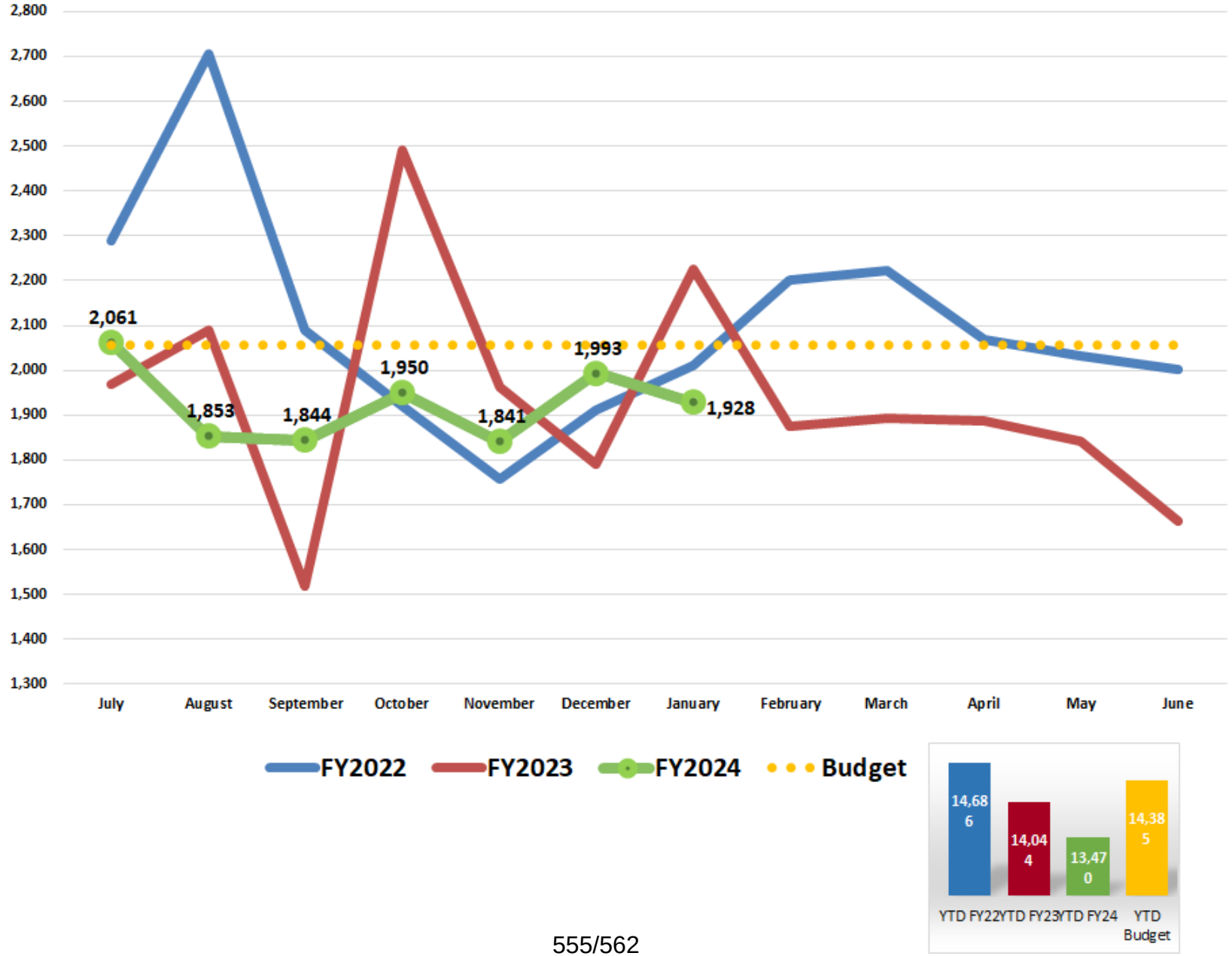
CAPD/CCPD - Maintenance Sessions



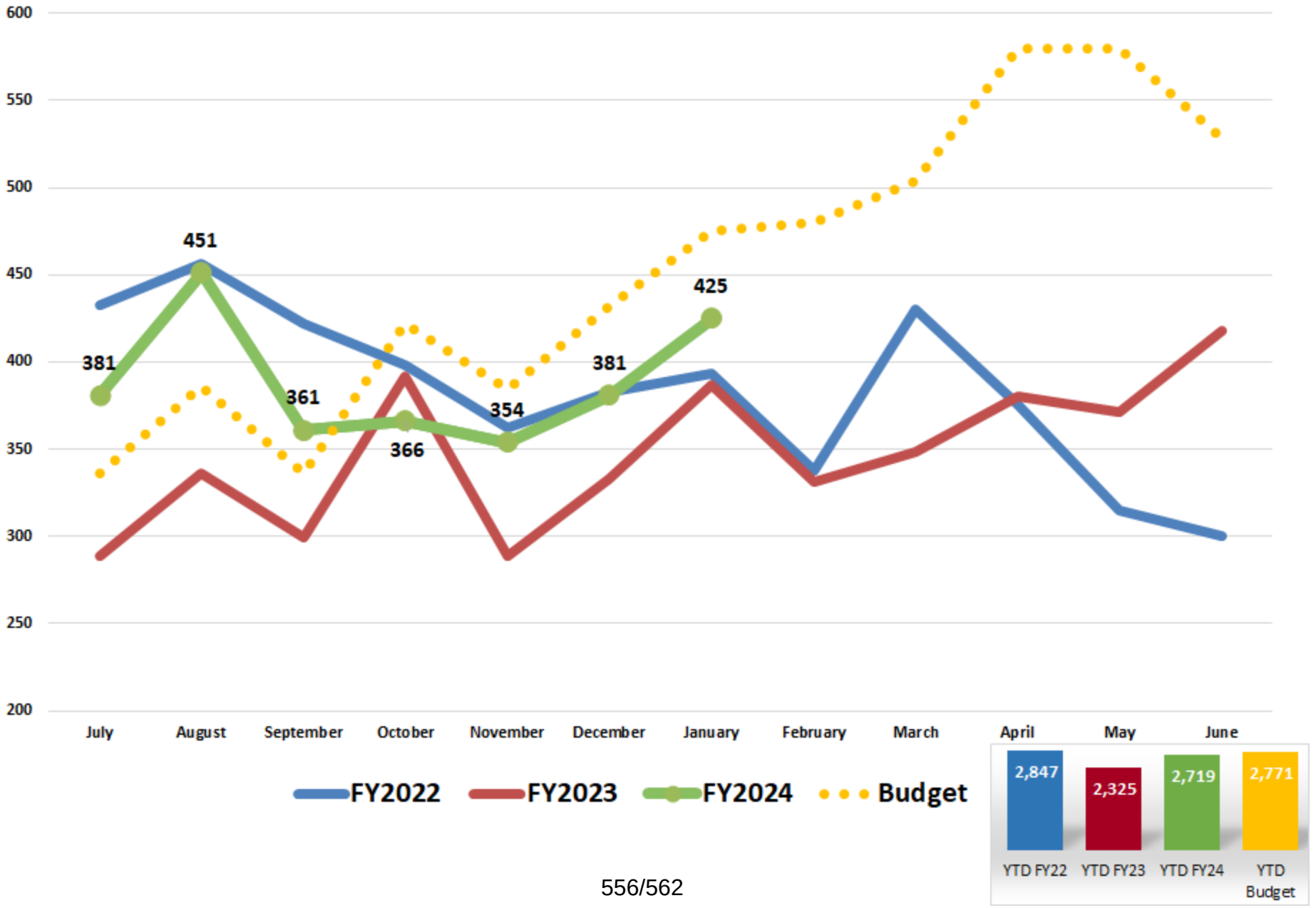
CAPD/CCPD - Training Sessions



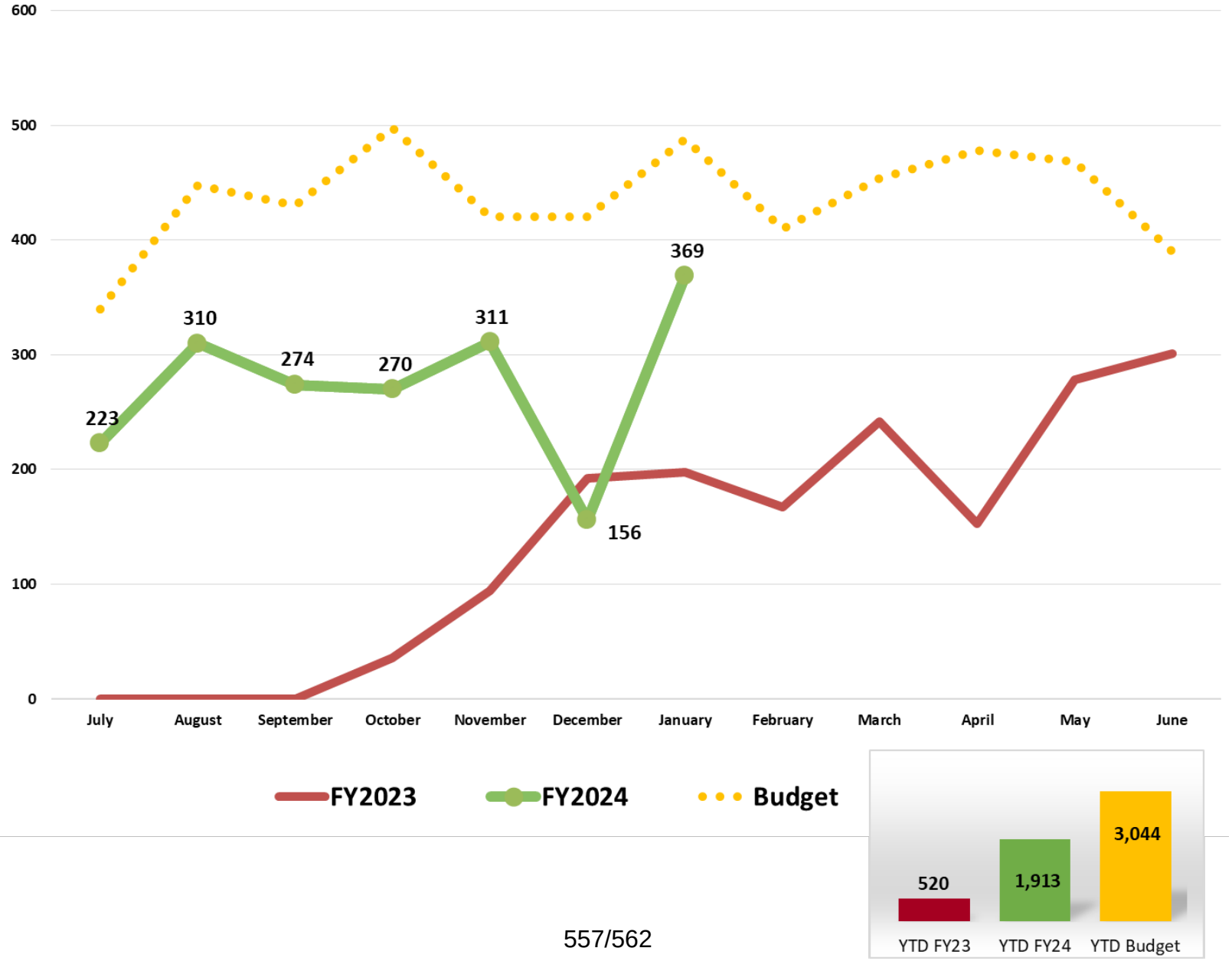
All CAPD & CCPD



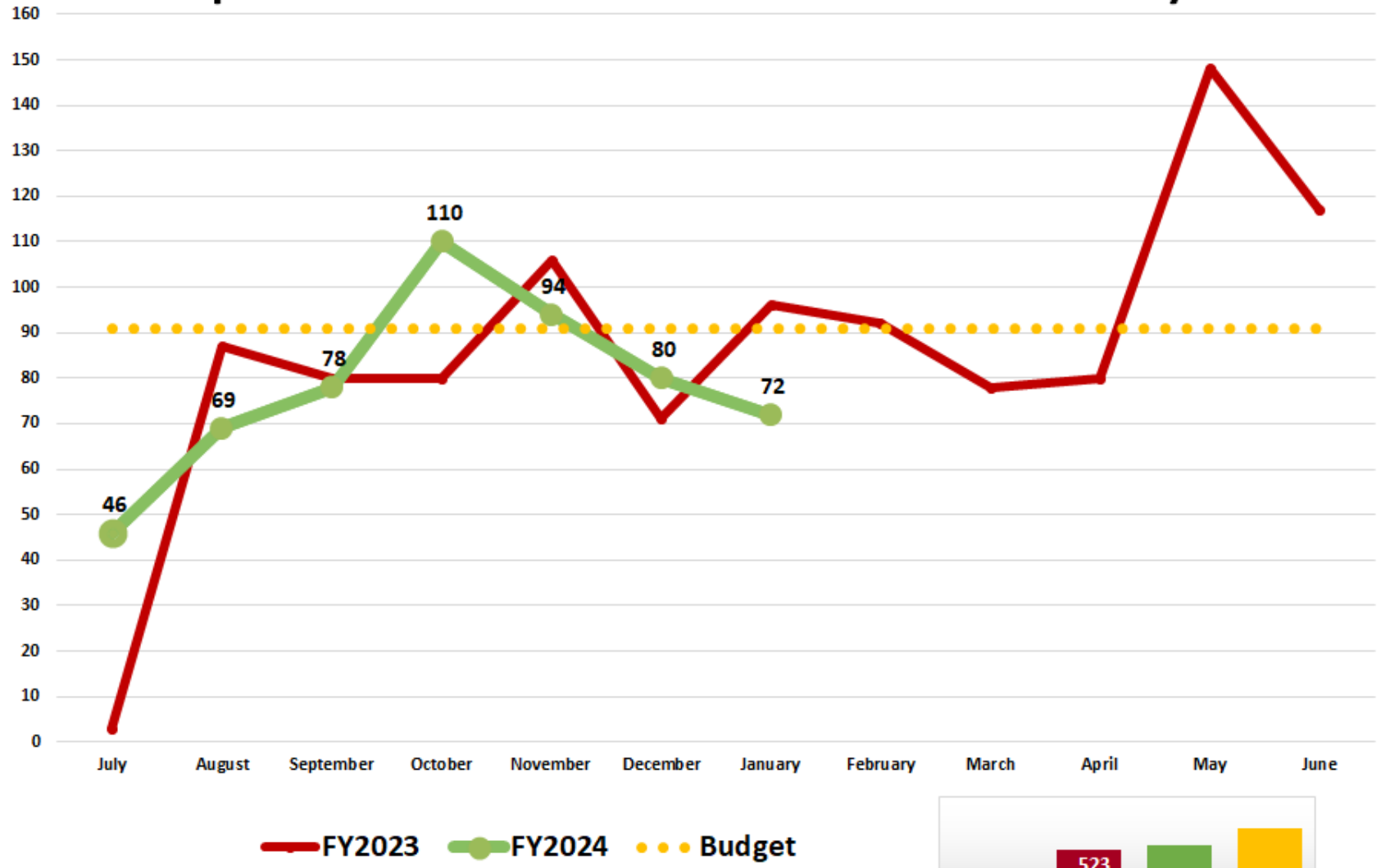
Infusion Center - Outpatient Visits

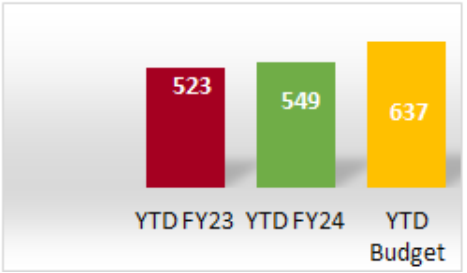


Urology Clinic Visits

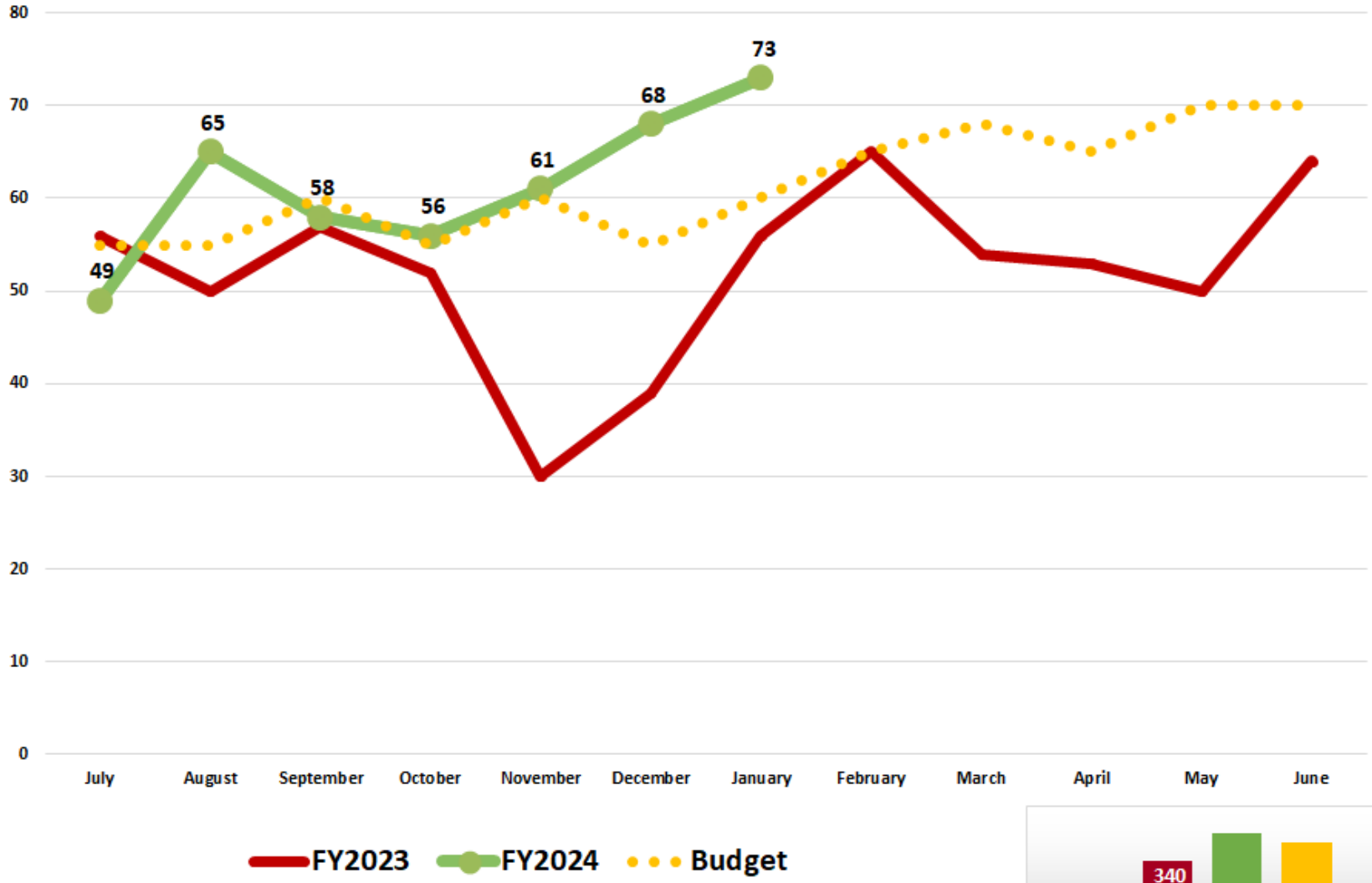


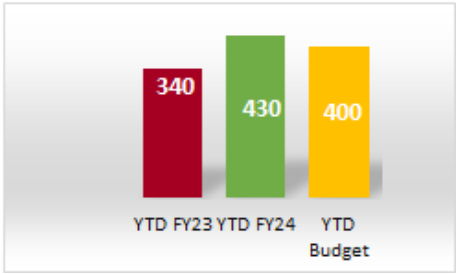
Open Arms House - Patient Days



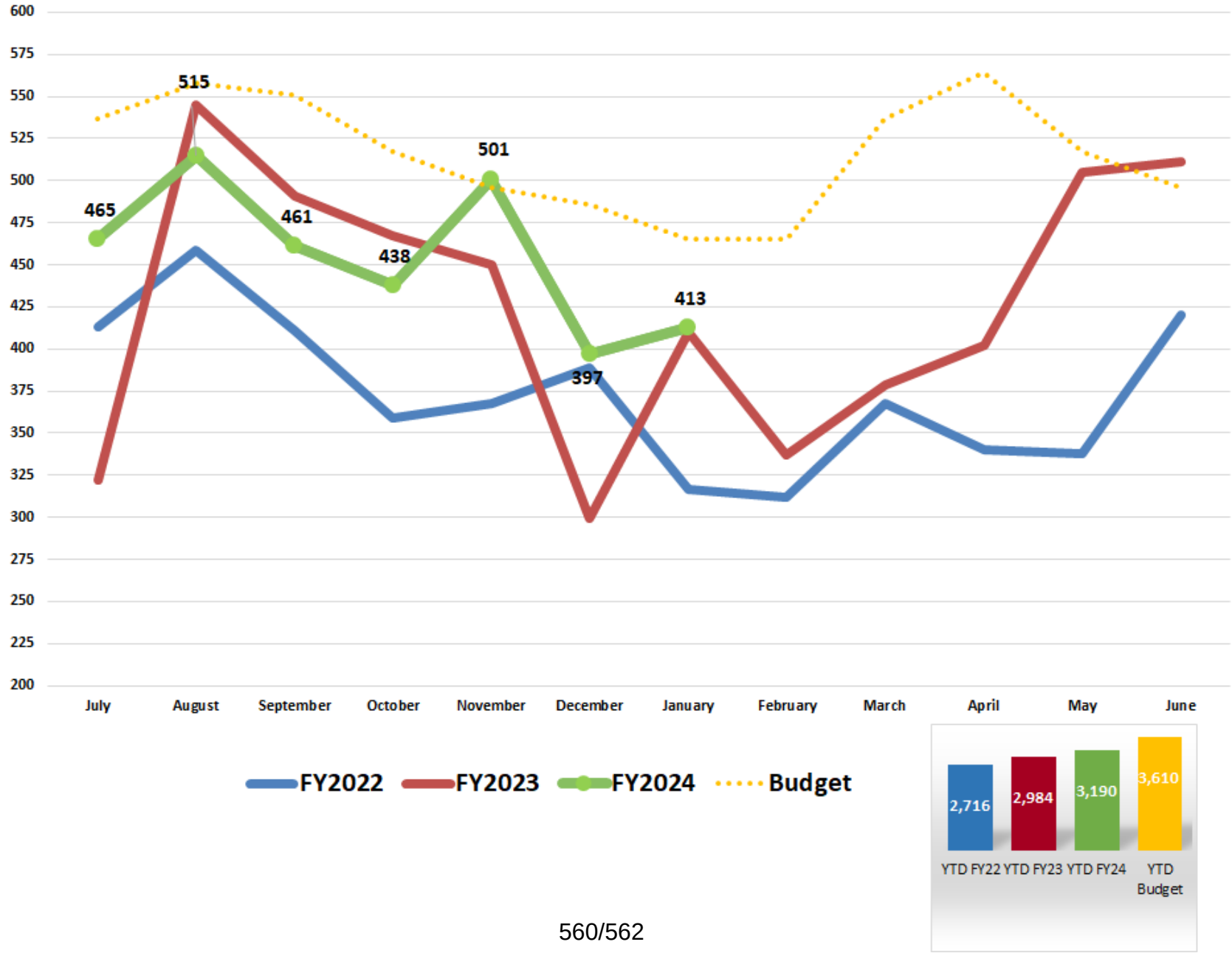


Cardiothoracic Surgery Clinic - Visits

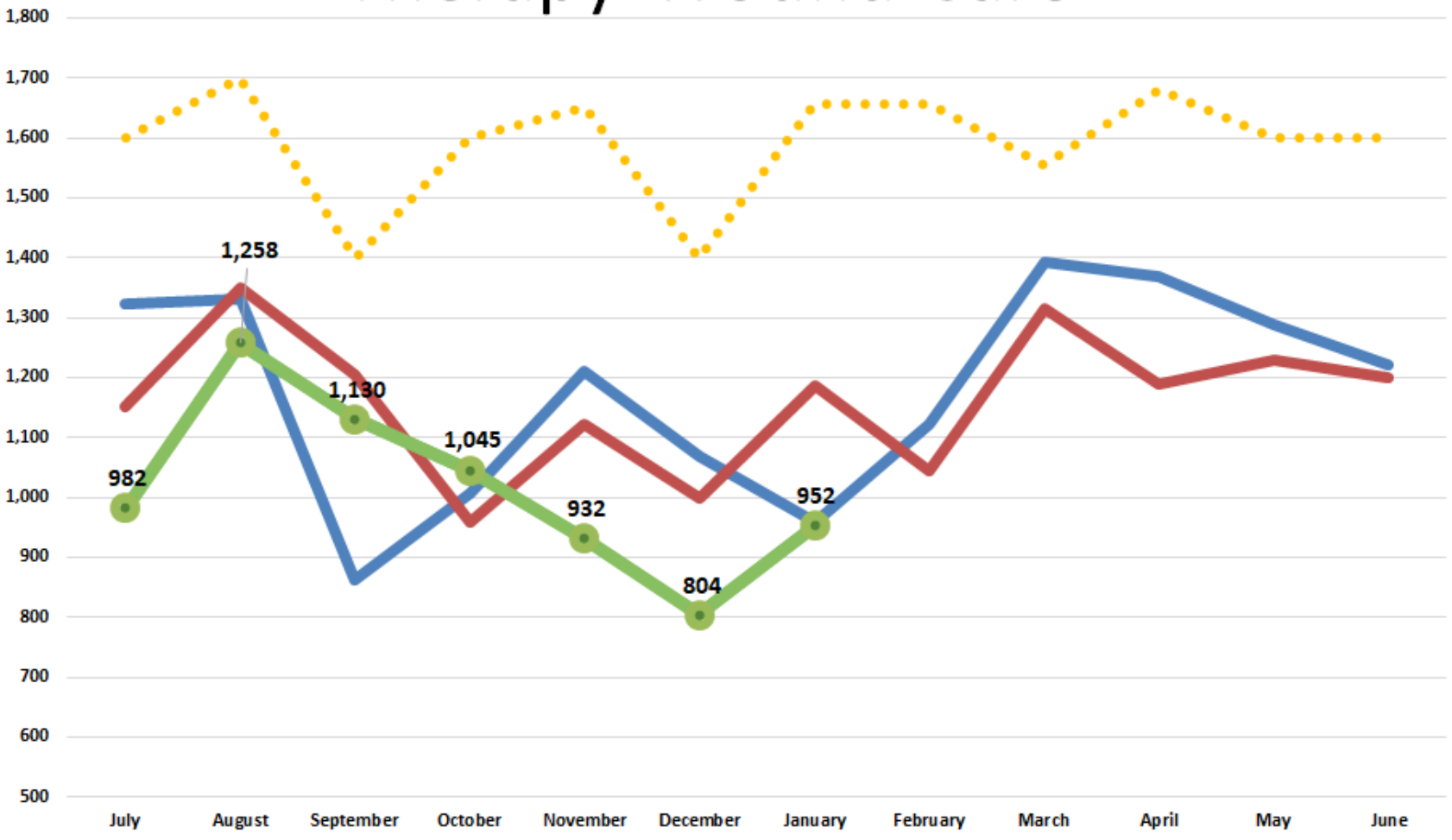


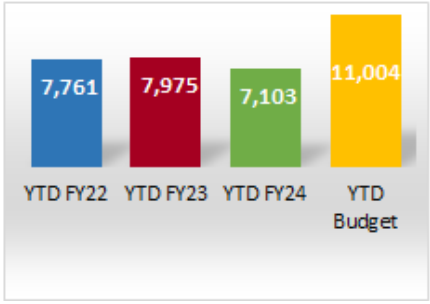


Cardiac Rehabilitation



Therapy-Wound Care





Kaweah Health

Executive Summary

Outsourcing Outpatient Wound Care Services Proposal

The Outpatient Wound Center at the Rehabilitation Hospital has operated for several years, serving 1000+ patient cases annually for both wound and hyperbaric treatment. The wound center employs approximately 4 to 5 employees, including a nurse practitioner provider. The wound center has struggled to break even and has experienced contribution losses for the past three years. In response, Kaweah has been actively exploring options and came across Healogics, who took over operations at Sierra View Medical Center's outpatient wound center.

Healogics emerges as a promising candidate, boasting a vast network of over 600 Wound Care Centers nationwide and over 20 years of experience in the field. With a workforce of 3000 employees and headquartered in Jacksonville, Florida, Healogics presents a robust partnership opportunity. We have been meeting with Healogics' principals for the last few months to evaluate proposals.

Healogics offers two management service options. The first model entails management oversight of operations, while the second includes both management and staffing by Healogics. We are leaning toward the second option. Both models encompass training, marketing strategies, leveraging technology advancements, and optimizing supply costs to enhance the overall financial performance of the clinic. The program director is hands-on, with daily oversight of both operations and staff, with the main focus on marketing and outreach. Under both models, the wound center would remain on our license, and services would be billed by our Patient Accounting Department.

The potential collaboration between Healogics and Kaweah Health will elevate clinical outcomes, operational efficiency, and financial performance. Financial projections indicate a contribution margin of approximately $200,000 based on current volumes plus downstream revenue generation through ancillary services. These are conservative volume numbers, underscoring the potential benefits of this partnership. As reflected in the financial pro forma, Healogics is paid a fee by Kaweah Health to cover the cost of staff and generate a profit for them.

In conclusion, partnering with Healogics presents an opportunity for the Wound Center at the Rehabilitation Hospital to improve profitability. Through leveraging Healogics' expertise, resources, and nationwide network, the hospital stands poised to enhance its wound care services and drive financial sustainability.

At this time, we are aiming to obtain approval from the Finance, Property, Services, & Acquisitions Committee, with subsequent review by the full Board later this month.