Kaweah Delta
MORE THAN MEDICINE. LIFE.

January 22, 2021

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in the Lifestyle Center Conference Room {5105 W. Cypress Avenue, Visalia} on Monday January 25, 2021 beginning at 4:00PM. Due to the maximum capacity allowed in this room per CDC social distancing guidelines, members of the public are requested to attend the Board meeting via GoTo meeting - https://www.gotomeet.me/CindyMoccio/kaweahdeltaopenregularboardmeetings or you can also dial in 669-224-3412 Access Code: 468-246-165.

The Board of Directors of the Kaweah Delta Health Care District will meet in an Open Board of Directors at 4:00PM (location and GoTo information above).

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Board of Directors meeting at 4:01PM pursuant to Health and Safety Code 1461 and 32155, Government Code 54956.9(d)(1) and 54956.9(d)(2).

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

All Kaweah Delta Health Care District regular board meeting and committee meeting notices and agendas are posted 72 hours prior to meetings (special meetings are posted 24 hours prior to meetings) in the Kaweah Delta Medical Center, Mineral King Wing entry corridor between the Mineral King lobby and the Emergency Department waiting room.

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

KAWEAH DELTA HEALTH CARE DISTRICT
Garth Gipson, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
Board Clerk / Executive Assistant to CEO

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

KAWEAH DELTA HEALTH CARE DISTRICT - BOARD OF DIRECTORS MEETING

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

Join from your computer, tablet or smartphone

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

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

Monday January 25, 2021

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 subject matter jurisdictions of the Board are requested to identify themselves at this time.
4. **APPROVAL OF THE CLOSED AGENDA – 4:01PM**
   - 4.1. **Approval of closed meeting minutes** – December 21, 2020 and January 19, 2021.
   - 4.2. **Conference with Legal Counsel** – Existing Litigation – Pursuant to Government Code 54956.9(d)(1) – *Rachele Berglund, Legal Counsel, Anu Banerjee, VP & Chief Quality Officer, and Alexandra Bennett, Director of Risk Management*
     - A. Dowdy vs KDH - Case # 283475
     - B. Weaver vs KDH – Case # VCL195709
     - C. Stanger vs KDH – Case # 284760
     - D. Snow vs KDH – Case # VCU284063
     - E. Stalcup vs KDH – Case # 284918
   - 4.3. **Conference with Legal Counsel – Anticipated Litigation –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 1 Case **–** *Rachele Berglund, Legal Counsel*
   - 4.4. **Credentialing** - Medical Executive Committee (MEC) requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the MEC be reviewed for approval pursuant to Health and Safety Code 1461 and 32155 – *Byron Mendenhall, MD Chief of Staff*
   - 4.5. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee –– *Byron Mendenhall, 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 January 25, 2021 closed meeting agenda.
5. **ADJOURN**

CLOSED MEETING AGENDA {4:01PM}

1. **CALL TO ORDER**
2. **APPROVAL OF CLOSED MEETING MINUTES** – December 21, 2020.

   Recommended Action: Approval of the closed meeting minutes from December 21, 2020.
3. **CONFERENCE WITH LEGAL COUNSEL** – Existing Litigation – Pursuant to Government Code 54956.9(d)(1).

   Rachele Berglund, Legal Counsel, Anu Banerjee, VP & Chief Quality Officer, and Alexandra Bennett, Director of Risk Management

   A. Dowdy vs KDH - Case # 283475
   B. Weaver vs KDH – Case # VCL195709
   C. Stanger vs KDH – Case # 284760
   D. Snow vs KDH – Case # VCU284063
   E. Stalcup vs KDH – Case # 284918
4. **CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 1 Case

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

   Byron Mendenhall, MD Chief of Staff
6. **QUALITY ASSURANCE** - Pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee.

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

OPEN MEETING AGENDA {4:30PM}

Join from your computer, tablet or smartphone

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

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

1. **CALL TO ORDER**
2. **APPROVAL OF AGENDA**
3. **PUBLIC PARTICIPATION –** Members of the public may comment on agenda items before action is taken and after Board discussion. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the subject matter jurisdictions of the Board are requested to identify themselves at this time.

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

5. **OPEN MINUTES** – Request approval of the December 21, 2020 and January 19, 2021 open minutes.

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

   Action Requested – Approval of the open meeting minutes – December 21, 2020 and January 19, 2021 *open board of directors meeting minutes.*

6. **RECOGNITIONS** – *Garth Gipson*
   - **6.1.** Presentation of Resolution 2115 to Stephen Puerner in recognition as the Service Excellence recipient - December 2020.
   - **6.2.** Presentation of Resolution 2116 to Cora Rodgers in recognition as the Service Excellence recipient - January 2021.
   - **6.3.** Presentation of Resolution 2117 to Cathy Gage-Ivers retiring from Kaweah Delta after 35 years of service
   - **6.4.** Presentation of Resolution 2118 to Deborah Robinson retiring from Kaweah Delta after 35 years of service.

7. **BOARD EDUCATION – Kaweah Delta Medical Staff Credentialing Process –** Review and discussion relative to the Kaweah Delta Medical Staff credentialing process and the role of the Board of Directors in the credentialing process.

   Michael Boyd, DPM, Credentials Committee Chair and Teresa Boyce, MHA, CPMSM, CPCS, Director, Medical Staff Services

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

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

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

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

   Byron Mendenhall, MD, Chief of Staff

10. **QUALITY – Annual Review of Quality and Patient Safety Plans** – A review of the effectiveness of the Quality and Patient Safety Plans including key measures and actions.

    Sandra Volchko, RN, DNP, Director of Quality and Patient Safety

11. **STRATGIC PLANNING – Outstanding Health Outcomes –** Review of the Kaweah Delta strategic plan initiative – Outstanding Health Outcomes including a review of the metrics and strategies/tactics.

Anu Banerjee, Vice President – Chief Quality Officer, Tom Gray, MD, Medical Director of Quality and Patient Safety, Sandra Volchko, RN, DNP, Director of Quality and Patient Safety, and Alexandra Bennett, Director of Risk Management

12. **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 January 25, 2021 Consent Calendar.

12.1. **REPORTS**

A. Physician Recruitment
B. Sequoia Surgery Center
C. Environment of Care
D. Inpatient Medical Services
E. Medical Imaging Services
F. Risk Management

12.2. Recommendations from the Medical Executive Committee (January 2021)

A. Privileges
   1) Neurology
   2) Neurosurgery
   3) Addition to all privilege forms: (may include telehealth)

12.3. Approval of Resolution 2119 rejecting the claim of Gabriella Montes de Oca v. Kaweah Delta Health Care District.

13. **LOCAL AGENCY FORMATION COMMISSION (LAFCO) NOMINATION** – Nomination to appoint an independent special district representative to the Tulare County Redevelopment Agency Dissolution (RDA) Oversight Board.

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 – Nomination of a member of the Kaweah Delta Health Care District Board of directors for a potential appointment to service as an independent special district representative to the Tulare County Redevelopment Agency Dissolution (RDA) Oversight Board.

14. **REPORTS**

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

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

ADJOURN

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

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY JANUARY 25, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-37

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY JANUARY 25, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-37

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MONDAY JANUARY 25, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-37

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PAGES 6-37

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MONDAY JANUARY 25, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-37

KAWEAH DELTA HEALTH CARE DISTRICT

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CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-37

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PAGES 6-37

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CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-37

KAWEAH DELTA HEALTH CARE DISTRICT

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MONDAY JANUARY 25, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-37

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CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-37

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY JANUARY 25, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-37

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY JANUARY 25, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-37

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MONDAY JANUARY 25, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-37

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MONDAY JANUARY 25, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-37

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MONDAY JANUARY 25, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-37

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BOARD OF DIRECTORS MEETING

MONDAY JANUARY 25, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-37

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MONDAY JANUARY 25, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-37

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MONDAY JANUARY 25, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-37

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY JANUARY 25, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-37

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY JANUARY 25, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-37

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY JANUARY 25, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-37

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MONDAY JANUARY 25, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-37

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MONDAY JANUARY 25, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-37

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PAGES 6-37

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CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-37

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY JANUARY 25, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-37

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY JANUARY 25, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-37

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY JANUARY 25, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-37

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY JANUARY 25, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-37

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY JANUARY 25, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-37

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY JANUARY 25, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-37

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MONDAY JANUARY 25, 2021

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 6-37

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD MONDAY DECEMBER 21, 2020, AT 3:30PM, IN THE LIFESTYLE CENTER CONFERENCE ROOMS / 5105 W. CYPRESS AVENUE, VISALIA AND VIA GOTO MEETING (CALL IN OPTION DUE TO STAY IN PLACE ORDER BY GOVENOR OF CALIFORNIA), DAVID FRANCIS PRESIDING

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

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

Director Francis entertained a motion to approve the agenda.

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

PUBLIC PARTICIPATION – none

CLOSED AGENDA – 3:31PM

- **Approval of closed meeting minutes** – November 23, 2020 and December 14, 2020.
- **Credentialing** - Medical Executive Committee (MEC) requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the MEC be reviewed for approval pursuant to Health and Safety Code 1461 and 32155 – *Byron Mendenhall, MD Chief of Staff*
- **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee –– *Byron Mendenhall, MD Chief of Staff*

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

ADJOURN - Meeting was adjourned at 3:31PM

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

ATTEST:

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

The Open Board meeting minutes for the 12/21 meeting will be posted by 5:00PM 01/22/21 .

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The Open Board meeting minutes for the 12/21 meeting will be posted by 5:00PM 01/22/21

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD TUESDAY JANUARY 19, 2021, AT 3:30PM, IN THE LIFESTYLE CENTER CONFERENCE ROOMS / 5105 W. CYPRESS AVENUE, VISALIA AND VIA GOTO MEETING (CALL IN OPTION DUE TO STAY IN PLACE ORDER BY GOVENOR OF CALIFORNIA), NEVIN HOUSE PRESIDING

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

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

Director Francis entertained a motion to approvee the agenda.

MMSC (0lmos/Rodriguez) to approve the open agenda. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

PUBLIC PARTICIPATION – none

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

- Focused presentation relative to physician agreements initiatives and service line strategies. The presentation for service line strategies for population health will be presented at the February special Board meeting.
- During the review of the financials there was a discussion led by Mr. Herbst, Ms. Cox, and Ms. Tupper relative to the need for a market adjustment for bedside nurses. Discussion relative to the recent increased turnover in bedside nurses who are being heavily recruited by local hospitals in Hanford and Fresno who are offering up to $10,000 signing bonuses and increases of $3.00 or more per hour. The Board is being requested to approve an average wage increase of $2.50 per hour for bedside nurses which would impact approximately 1,300 staff and the projected financial impact to the District would be $2,000,000.

MMSC (Havard Mirvis/Rodriguez) to approve the requested wage adjustment for bedside registered nurses effective February 7th with a projected financial impact of $2,000,000. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

CHIEF EXECUTIVE OFFICER REPORT

- Review of COVID census, progress of vaccination clinics in Tulare County and the financial impact of COVID to Kaweah Delta.

BOARD PRESDIENT REPORT

- No report.

ADJOURN - Meeting was adjourned at 6:10PM

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

ATTEST:

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

Kaweah Delta
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RESOLUTION 2115

WHEREAS, the Department Heads of the KAWEAH DELTA HEALTH CARE DISTRICT are recognizing Stephen Puerner, with the Service Excellence Award for the Month of December 2020, for consistent outstanding performance, and,

WHEREAS, the Board of Directors of the KAWEAH DELTA HEALTH CARE DISTRICT is aware of his 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 Stephen Puerner for this honor and in recognition thereof, have caused this resolution to be spread upon the minutes of the meeting.

PASSED AND APPROVED this 25th day of January 2021 by a unanimous vote of those present.

President, Kaweah Delta Health Care District

ATTEST:

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

11/4/2020 Stephen Puerner spuerner@kdhcd.org Emmanuel Alvarez

Stephen is a valued member of our Patient Access Team. You will usually find him stationed in one of the lobbies of the main campus. You cannot miss him! He has this great smile (which is currently hidden under his mask) and this positive vibe, which tells you how genuinely kind and caring he is. Stephen's current job duties include greeting and screening patients and visitors at our various entrances. This is not an easy task as there are many unique scenarios that require a calm, levelheaded person to make on-the-spot decisions. Stephen works very well with the clinical team to obtain updates about patients for family and he's always making sure our patient flow at the entrances are smooth. Stephen treats everyone with respect and he is a role model for World-Class customer service through his displays of empathy and concern. Stephen is even signing up for Spanish classes at the Adult School so that he can assist the spanish-speaking patients more! The personality traits that Stephen has are critical to this role, especially in the midst of a pandemic where patients and families need it the most.

Stephen did not start out in Patient Access. His journey at Kaweah Delta began in Food Services 5 years ago. Today he is here with us and we could not be happier. Aside from Stephen's perfect attendance and prompt punctuality, he is a tremendous asset to our team in that he is reliable, flexible, caring and just an overall joy to be around. If you compliment Stephen on his great service, he will tell you the story about how he used to work for his father in a shoe store. He feels that this adventure taught him everything he needed to become a great salesperson then and a great Patient Access Specialist now.

We are so fortunate to have Stephen on our team. You will never meet anyone more humble or proud to work for Kaweah Delta. We, his leaders, tell him how great he is every chance we get. To be recognized by the entire hospital would be a dream come true and he would be well deserving of this recognition. We thank Stephen for everything he does for our patients, our team and the hospital overall.

January 2021

Nominated: Cora Rodgers crodgers@kdhcd.org 11 Years of Service

Manager: Rheta Silvas

Director: James McNulty

Cora is tireless in her efforts to ensure our skilled nursing patients receive the right medications at the right dose. She collaborates effectively with the medical staff to facilitate dose or medication adjustments when appropriate to ensure the best alignment between the patient's medications and their condition, comorbidities and age. She will spend significant time educating patients and families and confirming their understanding. During the annual CDPH skilled nursing survey, when Cora walks in with her binder detailing everything she does to manage psychotropic medications, the surveyors know immediately that all standards are being met. We have had no findings in this area since Cora became our pharmacist. Cora is an absolute joy to work with - always full of positive energy and thoughtful to all she works with. She takes such incredible ownership of her work, and she makes a difference every day for our patients and our team

Kaweah Delta
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RESOLUTION 2116

WHEREAS, the Department Heads of the KAWEAH DELTA HEALTH CARE DISTRICT are recognizing Cora Rodgers, with the Service Excellence Award - January 2021, 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 Cora Rodgers for this honor and in recognition thereof, have caused this resolution to be spread upon the minutes of the meeting.

PASSED AND APPROVED this 25th day of January 2021 by a unanimous vote of those present.

President, Kaweah Delta Health Care District

ATTEST:

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

Kaweah Delta
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RESOLUTION 2117

WHEREAS, Cathy Gage-Ivers, RN, is retiring from duty at Kaweah Delta Health Care District after 35 years of service; and,

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

NOW, THEREFORE, BE IT RESOLVED that the Board of Directors of the Kaweah Delta Health Care District, on behalf of themselves, the hospital staff, and the community they represent, hereby extend their appreciation to Cathy Gage-Ivers, RN for 35 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 25th day of January 2021 by a unanimous vote of those present.

President, Kaweah Delta Health Care District

ATTEST:

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

Kaweah Delta
MORE THAN MEDICINE. LIFE.

RESOLUTION 2118

WHEREAS, Deborah Robinson, RN, is retiring from duty at Kaweah Delta Health Care District after 35 years of service; and,

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

NOW, THEREFORE, BE IT RESOLVED that the Board of Directors of the Kaweah Delta Health Care District, on behalf of themselves, the hospital staff, and the community they represent, hereby extend their appreciation to Deborah Robinson, RN for 35 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 25th day of January 2021 by a unanimous vote of those present.

President, Kaweah Delta Health Care District

ATTEST:

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

Kaweah Delta Medical Staff Credentialing Process

Presented by

Michael Boyd, D.P.M.,

Credentials Committee Chair

Teresa Boyce, MHA, CPMSM, CPCS

Director, Medical Staff Services

Introduction

- The Board has overall responsibility for the District. ***The Buck Stops Here!***
- The Board has delegated oversight of the quality of care provided to patients to the organized Medical Staff .
- Medical Staff structure and processes are established in accordance with CMS, The Joint Commission, and California Title 22.
- The Medical Staff Bylaws, Rules & Regulations, and policies are approved by the Medical Staff and, ultimately, the Board. These documents govern the Medical Staff.

Medical Staff
Membership / Privileges

Membership Only

- **Community Affiliate:** Active practice in the community.
- **Administrative:** Contracted with Kaweah Delta for administrative duties only.
- **Honorary:** Retired, member of the Medical Staff, in good standing for 10+ years.

Privileges Only

- Telehealth Physicians
- Advanced Practice Providers

Membership & Privileges

- **Active:** Admits a minimum of 24 patients in two years; and performs privileges granted by the Board.
- **Courtesy:** Admits 6-24 patients in two years; and performs privileges granted by the Board.
- **Consulting:** In collaboration with an admitting physician performs privileges granted by the Board.

Application Process

- Provider requests an application.
- Medical Staff Office emails applicant the link and initial password to his/her online application.
- Provider completes application and uploads required documents
- Provider submits application.
- Medical Staff Office accepts completed application and begins processing.

Primary Source Verification

- Medical Staff Office conducts Primary Source Verification, including:
  - License (state & DEA)
  - Education & Training
  - Board Certification
  - American Medical Association (AMA) or American Osteopathic Association (AOA)
  - Current and previous hospital affiliations (last 5 yrs)

Primary Source Verification

- Medical Staff Office conducts Primary Source Verification, including:
  - Malpractice Insurance coverage, history, claims
  - Work History
  - Sanctions with Medicare or Medicaid (OIG)
  - National Practitioner Data Base (NPDB)
  - Reference letter (minimum of two)
  - Background check
  - Additional information as needed

Review and Recommendation

- Upon completion of primary source verification the file is forwarded to:

  Department Chair: Reviews application;*; If approved sends recommendation forward to the

  Credentials Committee: Reviews application;*; If approved sends recommendation forward to the

  Medical Executive Committee (MEC):*; If approved sends recommendation forward to the

  Governing Board

* May request additional information; Interview applicant

Kaweah Delta

Credentials Summary to the Board

- The Chief of Staff presents the Credential Summary to the Board.
- The report is transparent and identifies
  - Category One: Files with significant RED FLAGS
  - Category Two: Clean Files – no issues
- Board members can be confident that the credential files have been reviewed and any significant issues have been thoroughly investigated.

Board Approval

- Upon receipt of a recommendation from the Medical Executive Committee the Board may
  - Appoint the applicant and grant privileges as recommended; or
  - Refer the matter back to the Credentials Committee or MEC for additional research or information; or
  - Reject or modify the recommendation.

- The Board has the final authority to grant membership and privileges.

Additional Information

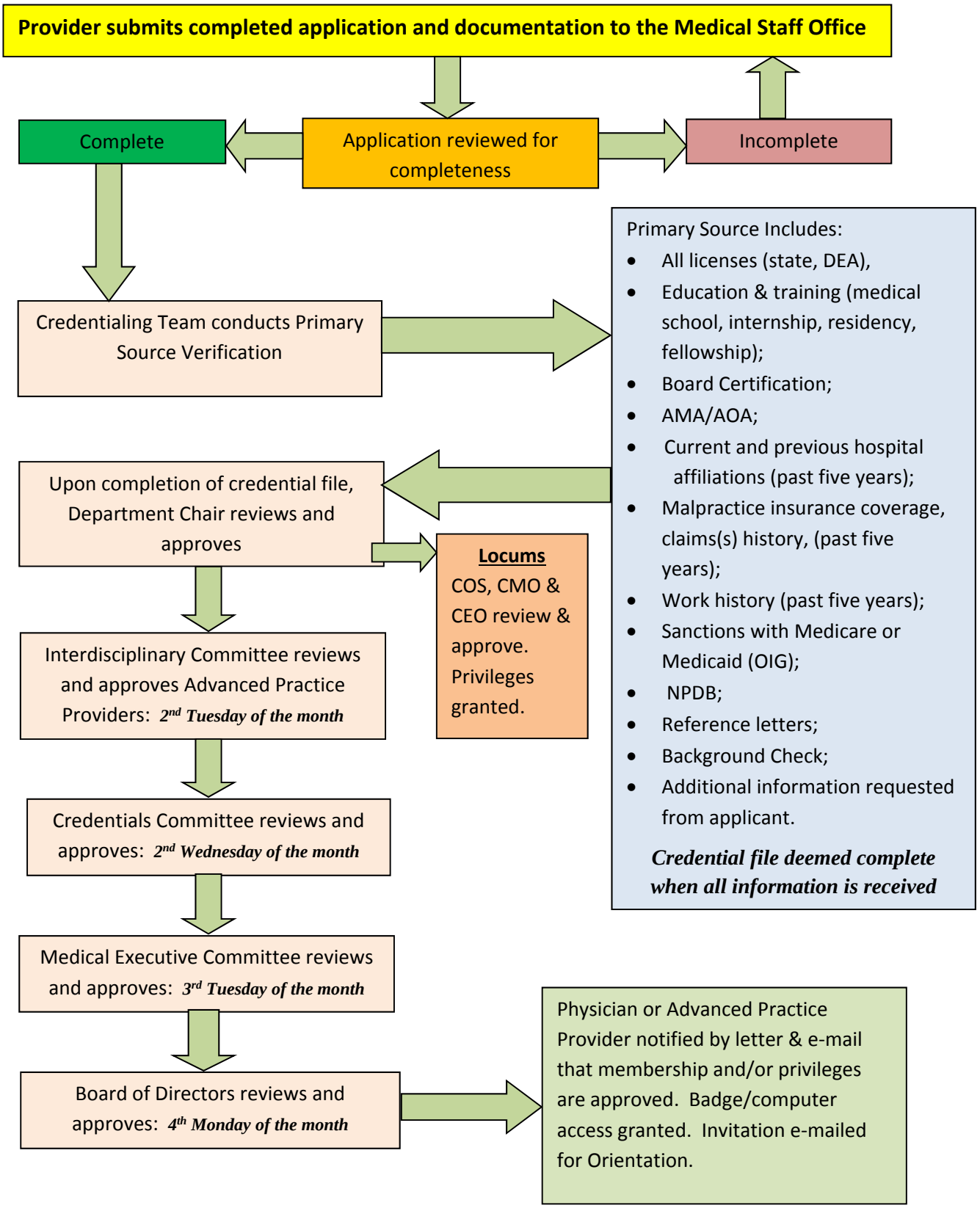
- Temporary privileges are approved by the Department Chair, Chief of Staff, and CEO on behalf of the Board.
- Privileges are considered the property right of a physician. If the application is rejected or privilege(s) are restricted or denied, the physician has a right to request a Fair Hearing.
- Denial or restriction of privileges may trigger a report to the California Medical Board or California Osteopathic Medical Board and the National Practitioners Data Base.

References

- Medical Staff Bylaws, Article 4
- MS 48 Credentialing and Privileging of Medical Staff & Advanced Practice Providers
- Regulatory Agencies
  - CMS
  - The Joint Commission
  - California Title 22

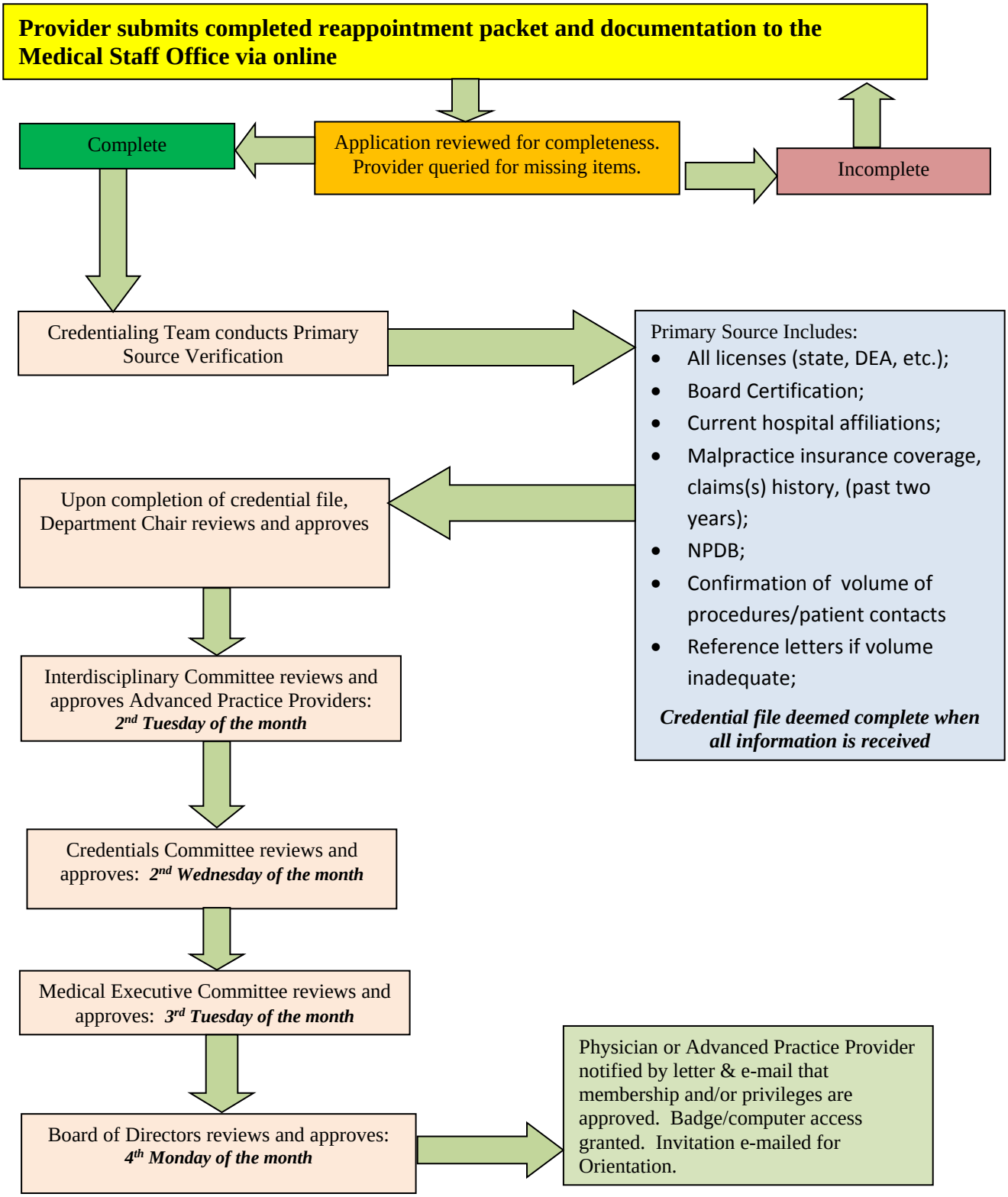
Kaweah Delta Health Care District

Medical Staff Credentialing Process



Additional information can be requested at any time during the process, sending it back to the previous step.
Medical Staff Bylaws 4.A.8 "Once an application is **deemed complete**,
it is expected to be processed within 120 days, unless it becomes incomplete."

REAPPOINTMENT PROCESS



ARTICLE 4
PROCEDURE FOR INITIAL APPOINTMENT

4.A. PROCEDURE FOR INITIAL APPOINTMENT

4.A.1 Application:

(a) Applications for appointment shall be on forms (which may be electronic) that have been approved by the Credentials Committee and the MEC.

(b) An individual seeking initial appointment shall be sent the Medical Staff Bylaws, the Rules and Regulations, and an application form.

(c) Applications may be provided to residents or fellows who are nearing the end of the completion of their training. Such applications may be processed, but final action shall not be taken until all applicable threshold eligibility criteria are satisfied.

(d) Applications may be processed and reviewed by Medical Staff leadership and approved by the Board contingent upon the applicant providing evidence that a California license, completion of residency/fellowship program, and adequate professional liability insurance have been obtained. Any grant of appointment and/or clinical privileges by the Board shall become effective only upon such demonstration.

4.A.2 Initial Review of Application:

(e) A completed application form with copies of all required documents must be returned to the Medical Staff Services Department accompanied by the application fee.

(f) As a preliminary step, the application shall be reviewed by the Medical Staff Services Department to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria. Incomplete applications shall not be processed. Individuals who fail to return completed applications or fail to meet the threshold eligibility criteria shall be notified that their applications shall not be processed. A determination of ineligibility does not entitle the individual to the hearing and appeal rights outlined in the Bylaws.

(g) The Medical Staff Services Department shall oversee the process of gathering and verifying relevant information, and confirming that all references and other information or materials deemed pertinent have been received.

4.A.3 Steps to Be Followed for All Initial Applicants:

(h) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be contained in the application, and obtained from peer references, from the same

discipline where practicable and from other available sources, including the applicant's past or current department chairs at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.

(i) An interview(s) with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview may be conducted by two or more of the following: the department chair, the Credentials Committee, a Credentials Committee representative, the MEC, an MEC representative, the CMO, and/or the Chief of Staff.

4.A.4 Department Chair Procedure:

(j) The Medical Staff Services Department shall transmit the completed application and all supporting materials to the chair of each department in which the applicant seeks clinical privileges. Each chair shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested and that includes a recommendation as to appointment, staff category, clinical privileges to be granted, and any special conditions on a form provided by the Medical Staff Services Department.

(k) The department chair shall be available to the Credentials Committee and the MEC to answer any questions that may be raised with respect to the report and findings of the chair.

4.A.5 Credentials Committee Procedure:

(l) The Credentials Committee shall review and consider the report prepared by the relevant department chair and shall make a recommendation.

(m) The Credentials Committee may use the expertise of the department chair, or any member of the service, or an outside consultant, if additional information is required regarding the applicant's qualifications.

(n) The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., personal professionalism) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, proctoring, completion of CME requirements). The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions. Unless these matters involve the specific recommendations set forth in Section 9.A.1(a) of the Bylaws, such conditions do not entitle an individual to request the procedural rights set forth in Article 9 of the Bylaws.

4.A.6 MEC Recommendation:

(o) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the MEC shall:

(1) adopt the findings and recommendation of the Credentials Committee as its own; or

(2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the MEC prior to its final recommendation; or

(3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation.

(p) If the recommendation of the MEC is to appoint, the recommendation shall be forwarded to the Board.

(q) If the recommendation of the MEC is unfavorable and would entitle the applicant to request a hearing in accordance with Section 9.A.1(a) of the Bylaws, the MEC shall send special notice to the applicant through the Chief of Staff and the application will be held until after the applicant has completed or waived a hearing and appeal.

4.A.7 Board Action:

(r) Expedited Review. The Board may delegate to a committee, consisting of at least two Board members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the Credentials Committee and the MEC and there is no evidence of any of the following:

(1) a pending or previous adverse action against the applicant's license or DEA registration;

(2) an involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other hospital or other entity; or

(3) an unusual pattern of, or an excessive number of, professional liability actions against the applicant.

Any decision reached by a Board committee to appoint shall be effective immediately and shall be forwarded to the Board for ratification at its next meeting.

(s) Full Board Review. When there has been no delegation to a Board committee, upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board may:

(1) appoint the applicant and grant clinical privileges as recommended; or

(2) refer the matter back to the Credentials Committee or MEC for additional research or information; or

(3) reject or modify the recommendation.

(t) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chair of the Credentials Committee and the Chair of the MEC. If the Board's recommendation remains unfavorable, the Ad Hoc Dispute Resolution process set forth in Section 12.F of the Bylaws shall be followed. If, following the Ad Hoc Dispute Resolution process, the Board's determination remains unfavorable to the applicant, the CEO shall promptly send special notice to the applicant that the applicant is entitled to request a hearing.

(u) Any final decision by the Board to grant, deny, revise or revoke appointment and/or clinical privileges will be disseminated to appropriate individuals and, as required, reported to appropriate entities.

4.A.8 Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within 120 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

Policy Number: MS 48	Date Created: 07/09/2019
Document Owner: April McKee (Medical Staff Coordinator)	Date Approved: 08/26/2019
Approvers: Board of Directors (Administration), Credentials Committee, Medical Executive Committee, April McKee (Medical Staff Coordinator), Cindy Moccio (Board Clerk/Exec Assist-CEO), Debbie Roeben (Medical Staff Coordinator), Teresa Boyce (Director of Medical Staff Svcs)	

Credentialing and Privileging of Medical Staff & Advanced Practice Providers

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

Policy:
All applications for appointment, reappointment and requests for clinical privileges for physicians (MD, DO, DPM, DDS, and PhD) and advanced practice providers (CRNA, CNM, NP, PA, and PharmD), will be evaluated based on current licensure, education, training or experience, current competence and ability to perform the clinical privileges requested. For Temporary Privilege see MS 53 Temporary Privileges Policy.

Procedures (See Attachment A for flow chart of application process)

I. New Applicants

Individuals requesting to be credentialed and privileged will be provided a link to the Online Application on the MD Staff website. Content of the Website will include:

1. Application including licensure information on any active or inactive licenses, DEA registration, Education History, Work History, Insurance History and complete information for Peer References
2. Attestation Questionnaire
3. Authorization to Release Information Form
4. Professional Liability Questionnaire
5. Claims Status form, to be completed for each Open or Closed Claim in the last five years
6. Health Screening Requirements (PPD, Influenza Vaccination); (Tdap, fitness for duty as required)
7. Background Release Form
8. Continuing Education Attestation form
9. Confidentiality and Conflict of Interest Statement of compliance
10. Medicare Acknowledgement Statement
11. Code of Conduct and Professional Behavior
12. Privilege Forms
13. Medical Staff Bylaws, Rules & Regulations
14. A Copy of a government issued ID
15. 2x2 photo required to be uploaded on the online application.
16. Current Curriculum Vitae (CV) documented in months and years
17. Life Support Certification (BLS, ACLS, etc.) as defined on privilege form.

II. Reappointments

Reappointment to the Medical Staff and Advanced Practice Provider Staff and requesting of clinical privileges shall occur no less often than biennially.

A link to the on line application shall be sent to providers five(5) months prior to their appointment expiration date and are expected to be completed and returned within 5 weeks.

The practitioner shall be required to submit:

1. Application including licensure information on any active or inactive licenses, DEA registration, Education History, Work History, Insurance History and complete information for Peer References
2. Attestation Questionnaire
3. Authorization to Release Information Form
4. Professional Liability Questionnaire
5. Claims Status form, to be completed for each Open or Closed Claim since last appointment
6. Health Screening Requirements (PPD, Influenza Vaccination); (Tdap, fitness for duty as required)
7. Continuing Education Attestation form
8. Confidentiality and Conflict of Interest Statement of compliance
9. Medicare Acknowledgement Statement
10. Code of Conduct and Professional Behavior
11. Privilege Forms
12. Medical Staff Bylaws, Rules & Regulations
13. Life Support Certification (BLS, ACLS, etc.) as defined on privilege form.

If the provider fails to submit a completed online application they shall be deemed to have voluntarily resigned their Medical Staff membership. The procedural rights set forth in the Medical Staff Bylaws shall not apply to a voluntary resignation.

III. Timeliness of Information

Any of the following information found to be beyond 180 days at the time the file is presented to the Credentials Committee or Interdisciplinary Practice Committee (IPC) will be re-verified prior to review by that committee:

- All on line verifications
  - CA Medical or Professional License
  - CA Furnishing License
  - DEA
  - NPDB
  - OIG
- Answers to attestation questions
- Signature and date on consent form

IV. Approval

1. The application, privilege request form and supportive documentation are made available to the appropriate Department Chair for review and recommendation to the IPC and/or Credentials Committee. Any documents of concern with be printed and flagged. The Department Chair will complete the recommendation form and note the length of appointment and any concerns, which will be forwarded to the Credentials Committee.

V. Requests for Additional Privileges

Any provider may request additional privileges at any time. These requests are processed as follows.

1. The provider must complete the appropriate privilege form and supply supporting documentation regarding training or experience, as required.
2. The following must be verified by the Medical Staff Office:
    - CA Medical or Professional License
    - CA Furnishing license, if applicable
    - DEA, if applicable
    - OIG
    - NPDB
3. The evaluation and approval for additional privilege(s) is forwarded to the IPC and/or Credentials Committee upon recommendation of the Department Chair, with final review and recommendation by the MEC and Governing Board.

VI. Provider rights to amend application and to receive updates

Providers have the right to correct erroneous information obtained throughout the credentialing process. If any submitted items differ substantially from documentation disclosed through the verification process, the provider will be asked via written request (email or certified letter) to resolve this discrepancy and will be expected to do so within 10 business days of the request. Any and all corrections should be submitted in writing to the Medical Staff Office for adequate review of current documentation. Any instance of the provision of information containing misrepresentations or omissions is forwarded to the Credentials Committee for review and action. Providers are allowed access to their credential files, with the exception of Peer Evaluations or verifications.

Providers have the right to receive updates on their application for appointment or reappointment. All such requests will be responded to within a reasonable period of time, not to exceed four business days.

VII. Processing the application

When the application for appointment or reappointment is returned, a review for completeness is performed by the Medical Staff office. If additional information is required, or if questions are left blank, the application will be returned back to the applicant for completion. Failure to submit the requested information within 90 days shall be considered a voluntary withdrawal of the application.

Information gathered on the application will be verified by the primary source, as required by The Joint Commission. Primary source may include verbal verifications, which require a dated, signed note in the credentialing file, including

the name of individual providing the information, date and time of verification. After three failed attempts to gather information from a primary source, a secondary source may be used, i.e., another hospital where the practitioner is currently credentialed.

In addition, queries will be made to the NPDB and the MBC if any verification received has adverse actions, the practitioner will be asked to provide a written explanation of the issue. Sources used for verification include:

1. California Professional License / Professional Licenses from other States

2. DEA Certification
   An online NTIS query is required for primary source verification. All providers must have a valid DEA certificate, including all schedules (2, 2N, 3, 3N, 4 and 5), with a California address. A practitioner with an out of state address on their DEA may be credentialed pending the change of address, if proof of request has been received by the Medical Staff Office.

3. Fluoroscopy Certificate
   Required for all practitioners who will be using fluoroscopy equipment.

4. Verification of Hospital Affiliations and Work History
   Written verification of five (5) years of clinical work history from hospitals or other health care organizations affiliations is required for initial appointments (2 years for reappointment). Affiliation verifications within the last five (5) years will be required for new appointments (2 years for reappointment). A minimum of five (5) affiliation verifications will be required if an applicant has more than five (5) affiliations. A request of the practitioners quality and performance profile/data may be accepted in lieu of a “good standing” letter.

   Any gaps in the past five (5) years of work history of three months or more will require written clarification from the practitioner.

   Failure to obtain verification of an affiliation after three attempts with the applicant’s assistance shall be documented in the practitioners file for the Department Chair. The file may then move through the evaluation process without this documentation.

5. Verification of Medical/Professional School and Completion of Post Graduate Programs
   Verification of education and completion of post graduate training may be obtained from the institution(s) where the training was completed, and/or an agency that is deemed primary source verification (AMA/AOA) or Background Check for Advance Practice Providers hired by HR. If unable to obtain verification from any of the above resources after three attempts, information will be obtained from a reliable secondary source such as another hospital that has a documented primary source verification of the credential. A letter of completion of residency or fellowship program will be obtained for all new graduates.

Verification for International Medical Graduates must present certification by the Education Commission for Foreign Medical Graduates (ECFMG), or successful completion of a fifth pathway (excluding Canada).

6. Board Certification
   Board Certification or active pursuit of board certification is a requirement for membership and privileges for individuals appointed after March 2016. Medical Staff Members appointed prior to March 2016 are grandfathered and governed by any board certification requirements at the time of their appointment. Verification of certification is obtained through the ABMS online database or a letter directly from the certification board. Board certification is verified at the time of initial appointment and each reappointment. In exceptional circumstances, initial applicants who are not board certified and existing Medical Staff members seeking recertification may request additional time to obtain certification or recertification for one additional period, not to exceed two years. In order to be eligible to request an extension in these situations, an individual must satisfy criteria set forth in the Medical Staff Bylaws 2.A.1.

   All Advanced Practice Practitioners are required to have National Certification at the time of hire or obtain certification within one year of completion of professional training and maintain certification by any of the following bodies:
   - American Academy of Nurse Practitioner AANP
   - American Nurses Association Credentialing Center – ANCC
   - Pediatric Nursing Certification Board – PNCB
   - National Certification Corp. for the Obstetric, Gynecologic and Neonatal Nursing Specialties – NCC
   - American Association of Critical Care Nurses – AACN
   - National Commission on Certification of Physician Assistants – NCCPA
   - National Board of Certification & Recertification for Nurse Anesthetists - NBCRNA

7. Current, Adequate Professional Liability Insurance
   The Certificate of Insurance must meet the requirements determined by the Kaweah Delta Health Care District Board. See Attachment B.

8. Professional Liability Claims History
   Verification of claims history for the immediately preceding five (5) years for new appointments and two (2) years for reappointments will be obtained from the National Practitioner Data Bank (NPDB) or directly from the Insurance Company.

9. Background Checks
   Background checks shall be performed at the time of initial appointment. Results will be stored electronically in the credentials file. Adverse information will be evaluated by the Department Chair and appropriate reviewing committees.

10. Privileging Criteria – Current Clinical Competency
    Each applicant must meet the criteria related to the privileges they are requesting on the privilege form. Clinical activity from all facilities at which the physician has been privileged to practice within the reappointment timeframe, will be included for specific privileges requested and volume requirements. At reappointment, if the practitioner does not have an adequate volume required by the department, a letter of reference may be required from a colleague who has observed the practitioner and can attest to their competency. Volumes from facilities other than Kaweah Delta do not count towards membership category assignments.

11. National Practitioner Data Bank
    The NPDB must be queried for all new and reappointments and when additional privileges are requested. Continuous Query is utilized for all privileged members. Adverse information will be evaluated by the department chair.

12. Medicare/Medicaid Sanctions
    Medicare and Medicaid Sanction verifications will be processed by obtaining a Sanctions Exclusions Report published by the OIG for each credentialed provider. In addition, ongoing monitoring for sanctions will be done on a monthly basis for all credentialed practitioners.

13. Professional References
    Three professional references are requested for new applicants and two are required for application packets to be considered complete. Peer references are required at reappointment for providers who do not have adequate volume to evaluate competency. Advanced Practice Provider's supervising physician evaluation may be utilized in lieu of a peer reference letter. The references must be from individuals who have recently worked with the applicant, have directly observed their professional performance and can provide reliable information regarding clinical ability, health status, ethical character and the ability to work with others. If the applicant has completed a residency or fellowship in the past two years, a reference from the program director shall be requested. Adverse comments or reluctance to recommend will be flagged for review. Peer references will be asked to identify the picture of the applicant is the person they are providing a reference for which will be used by the hospital to verify the practitioner requesting approval is the same practitioner identified in the credentialing documents.

    Failure to obtain a peer reference after three attempts the applicant will be asked to provide contact information for additional peer reference(s).

14. Continuing Education
    An attestation must be signed for appointment or reappointment indicating that the practitioner has met their applicable continuing professional education requirements for licensure.

15. Ongoing Professional Practice Evaluation (OPPE)
    Quality Data for each practitioner is evaluated by the Department Chair every eight months. A two year composite of the data is provided to the chair for a comprehensive review at reappointment.

16. Training Modules
    All applicants shall be informed of any assigned educational requirements at the time of appointment or reappointment.

17. Health Screening
    All practitioners are required to comply with annual PPD and Influenza Vaccination requirements. Failure to do so will result in an administrative suspension until appropriate documentation is provided to the Medical Staff Services Department.

18. The credentialing data for all practitioners credentialed by Medical Staff Office are entered into the Medical Staff Office credentialing database (MD STAFF). Medical Staff Office utilizes this system to maintain current credentialing and privileging information, and to monitor proctoring, license, DEA, insurance renewals and reappointment activities. All information contained in the database is confidential and has restricted access. Medical Staff Office is responsible for ensuring that the information contained in the database is accurate and current. The Managed Care department has access to the information in the Medical Staff Office database that specifically pertains to information needed for credentialing with the health plans.

19. All practitioners are required to pay dues and application fees; Fees are determined by the MEC, and are non-refundable.

VIII. Category Assessment

During the processing of each reappointment, practitioner activity reports will be evaluated to confirm if they are assigned to the appropriate membership category. The following guidelines shall be used:

1. A physician currently on the Active Medical Staff, but has had less than 24 patient contacts in the last 2 years at a Kaweah Delta facility the practitioner will be reassigned to a category that appropriately reflects their activity, in accordance with the Medical Staff Bylaws.

2. A physician currently on the Active or Courtesy staff, who has had no patient contacts at a Kaweah Delta Facility during the previous two years, shall be reassigned to the Community Affiliate Category (membership only, no clinical privileges).

3. A Physician currently on the Consulting staff who has activity from other hospitals and office practice shall not be reassigned unless requested by the practitioner.

If applicable criteria indicate a membership category reassignment may be appropriate, the credentialing staff will send a letter, email, text or fax to the practitioner outlining any changes being recommended for their feedback. The complete credential file is forwarded to the Department Chair along with any additional information submitted by the provider for review and final recommendation.

IX. Expirables

The following items will be monitored as Expirables. An expired certificate or license shall result in an administrative suspension of membership/privileges, or a suspension of the privilege tied to that certificate.

- CA State license
- Furnishing License
- DEA
- Professional Liability Insurance
- Board Certification/National Certification
- Fluoroscopy Certificate
- ACLS, ATLS, BLS, NRP, PALS (as specified by privileges)
- Delinquent Health Records

Failure to provide updated documents within 60 days will result in voluntary withdrawal of membership/privileges or a voluntary withdrawal of the privilege tied to that certificate.

Practitioners will be notified by email or text approximately 45 days, 30 days, and 15 days prior to license or certificate expiration.

X. Delegated Credentialing for Telehealth Providers

Delegated Credentialing is accepted for telehealth providers under the following conditions:

1. The Distant Site is accredited by the Joint Commission
2. A contract for related services has been executed between Kaweah Delta and the Distant Site
3. Distant site provides proof of accreditation as a Medicare Provider

4. Procedure
    a. Distant Site Provides the following:
        i. Profile sheet for each practitioner participating in the telehealth services for Originating site
        ii. Current list of privileges granted to practitioner by Distant Site.
        iii. Certificate of Professional Liability
        iv. Completed attestation by the Distant Site
        v. 2” X 2” color photo
        vi. Medical Staff Fees
        vii. An updated list of providers (addendum to the contract) to Kaweah Delta Medical Staff Office upon any change of providers (additions and/or resignations).
    b. Initial Application:

i. Medical Staff enters the following information into the Medical Staff Credentialing database obtained from the Profile sheet
    1. Name
    2. DOB
    3. SS#
    4. NPI
    5. CA License number and expiration date
    6. Education
    7. Board Certification
    8. Current Professional Liability and expiration date
    9. Information forwarded for approval through the process defined in the Medical Staff Bylaws.

c. Reappointment
    i. Current list of practitioners and obtain from Distant Site
    ii. Medical Staff Office runs NPDB, OIG, Licensure
    iii. Information forwarded for approval through the process defined in the Medical Staff Bylaws.

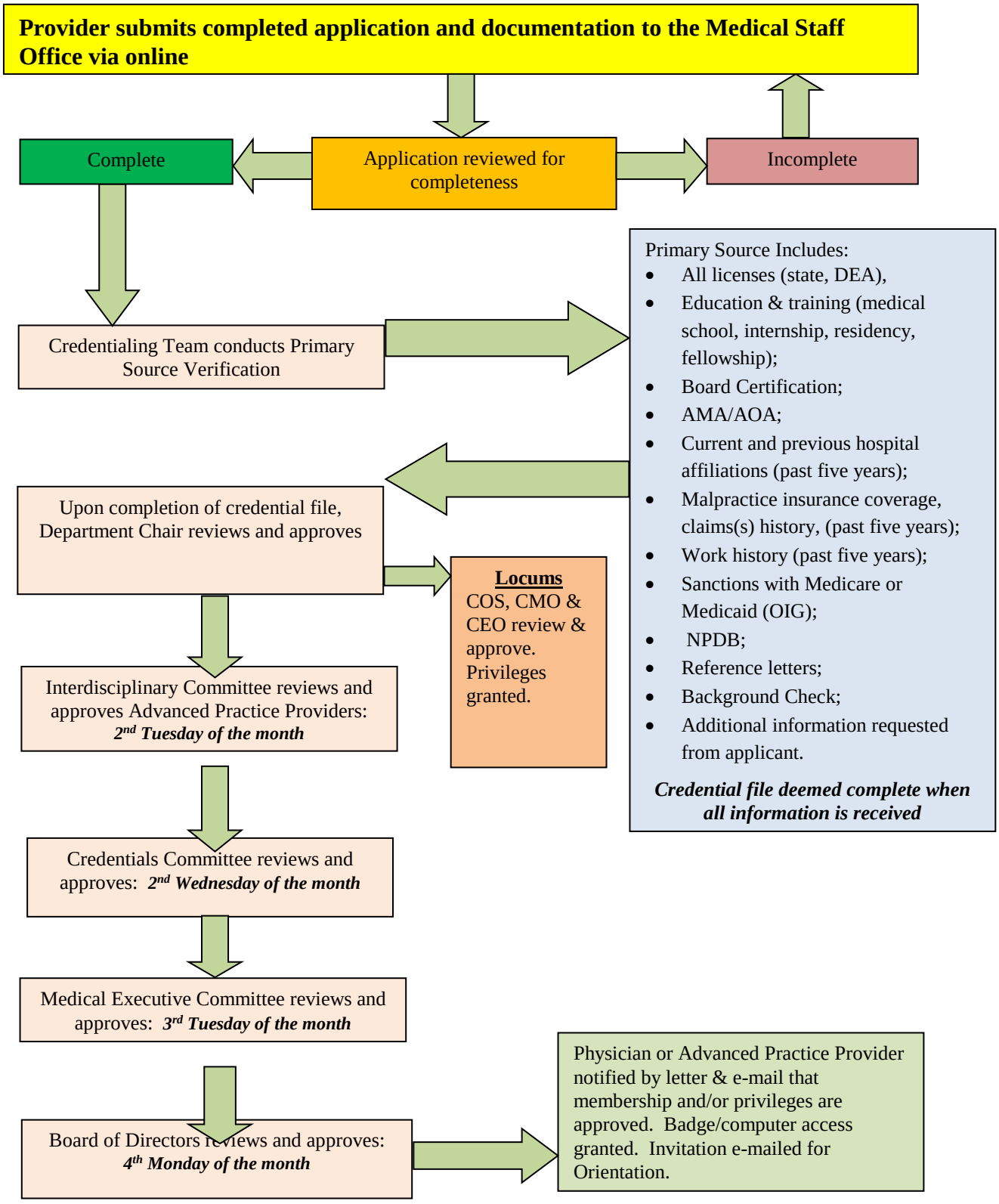
d. Expirables
    i. Medical Staff Office keeps track of the following Expirables
        1. CA Licensure
        2. Professional Liability

Related Documents:
Kaweah Delta Medical Staff Bylaws, Rules and Regulations

References:
- TJC Standards
- Title 22 Regulations

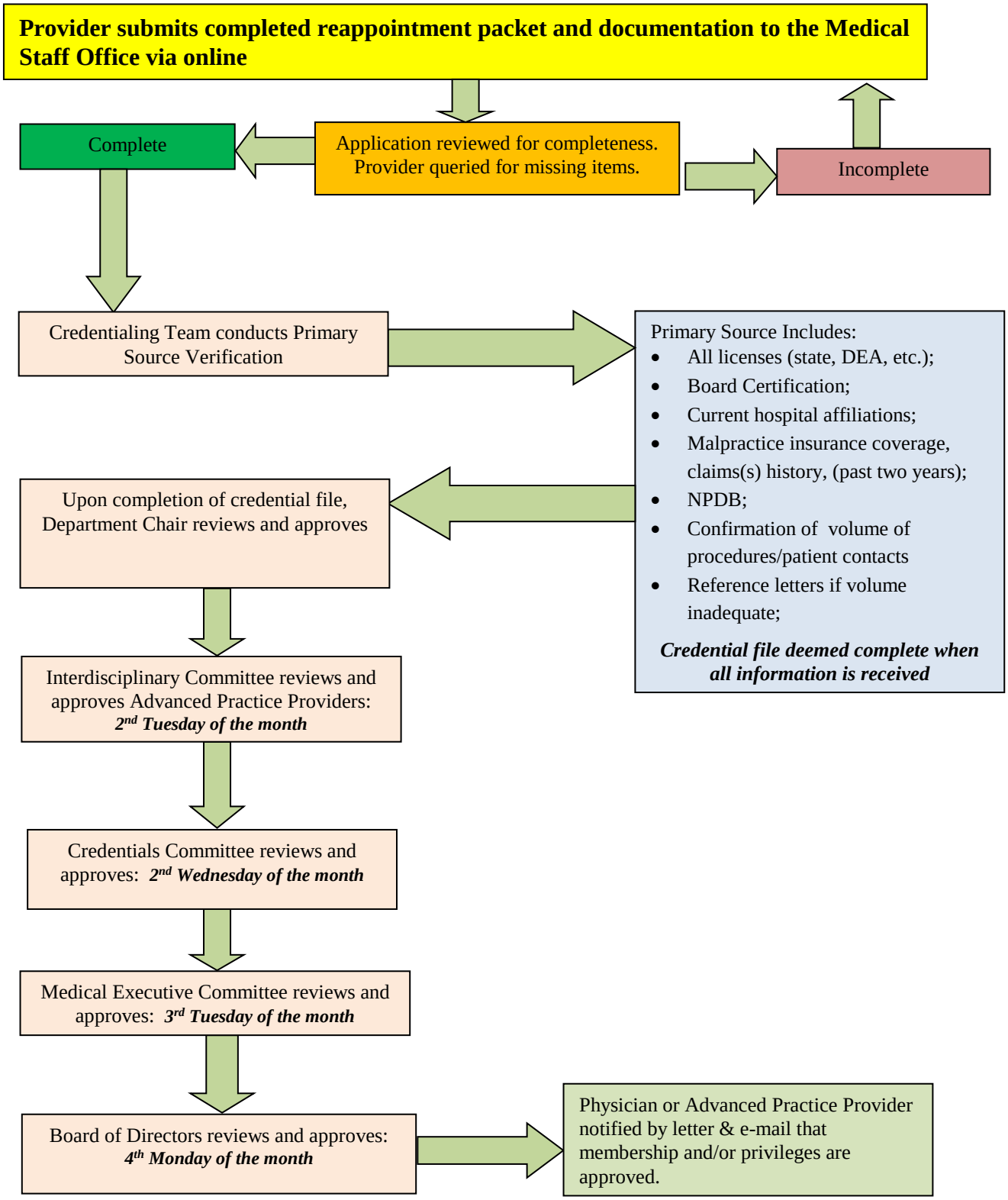
"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New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

ATTACHMENT A
INITIAL APPLICATION PROCESS



Additional information can be requested at any time during the process, sending it back to the previous step.
Medical Staff Bylaws 4.A.8 "Once an application is **deemed complete**,
it is expected to be processed within 120 days, unless it becomes incomplete."

REAPPOINTMENT PROCESS



ATTACHEMENT B

KAWEAH DELTA HEALTH CARE DISTRICT
Medical Staff Service

Certificate of Insurance Guidelines

Per Kaweah Delta Health Care District Board of Directors January 2018 Resolution and the Medical Staff Bylaws, a Medical Staff Provider's Certificate of Insurance must meet the following requirements:

1. Professional liability insurance must have a minimum coverage of $1,000,000 per occurrence/ $3,000,000 in the aggregate.
2. Deductibles or self-insurance retention can be no more than $100,000.
3. The insurance company must either be licensed to do business in California or have been issued a Certificate of Authority by the California Insurance Commissioner. For confirmation of the insurance company's status search the California Department of Insurance website for the business name at https://interactive.web.insurance.ca.gov/companyprofile/companyprofile. ***The company name MUST be an exact match***. If there is not an exact match you must provide proof the company issuing the insurance is licensed to do business in California or has been issued a Certificate of Authority.
4. The professional liability insurance company **MUST** maintain an A.M. Best rating of at least ("A") and have a financial size of at least VII ($50 million to $100 million). For determine the A.M. Best rating and financial size category, check the A.M Best website at http://www.ambest.com/home/default.aspx.
5. SURPLUS LINES: http://www.insurance.ca.gov/01-consumers/120-company/07-lasli/lasli.cfm EXACT Match and A.M. Best Rating A++ (Superior) rating and a Financial Size Category of XV ($2 Billion or greater)
6. No shared limits of liability coverage are permitted except under the following circumstances: **one** (1) Advanced Practice Provider can share limits of liability with a medical group on a group policy.
7. KDHCD will accept Cooperative of American Physicians/Mutual Protection Trust ("CAP/MPT") coverage.
8. For verification of past or current coverage, Physicians and Advanced Practice Providers who are, or have been, employed by a governmental agency (i.e., a County or State health care facility, a Prison or HRSA Health Center Program) should provide a letter of employment from that agency that confirms their employment or independent contractor status and specifies their malpractice coverage is provided by the government entity.

Quality and Patient Safety Plan Annual Review 2020

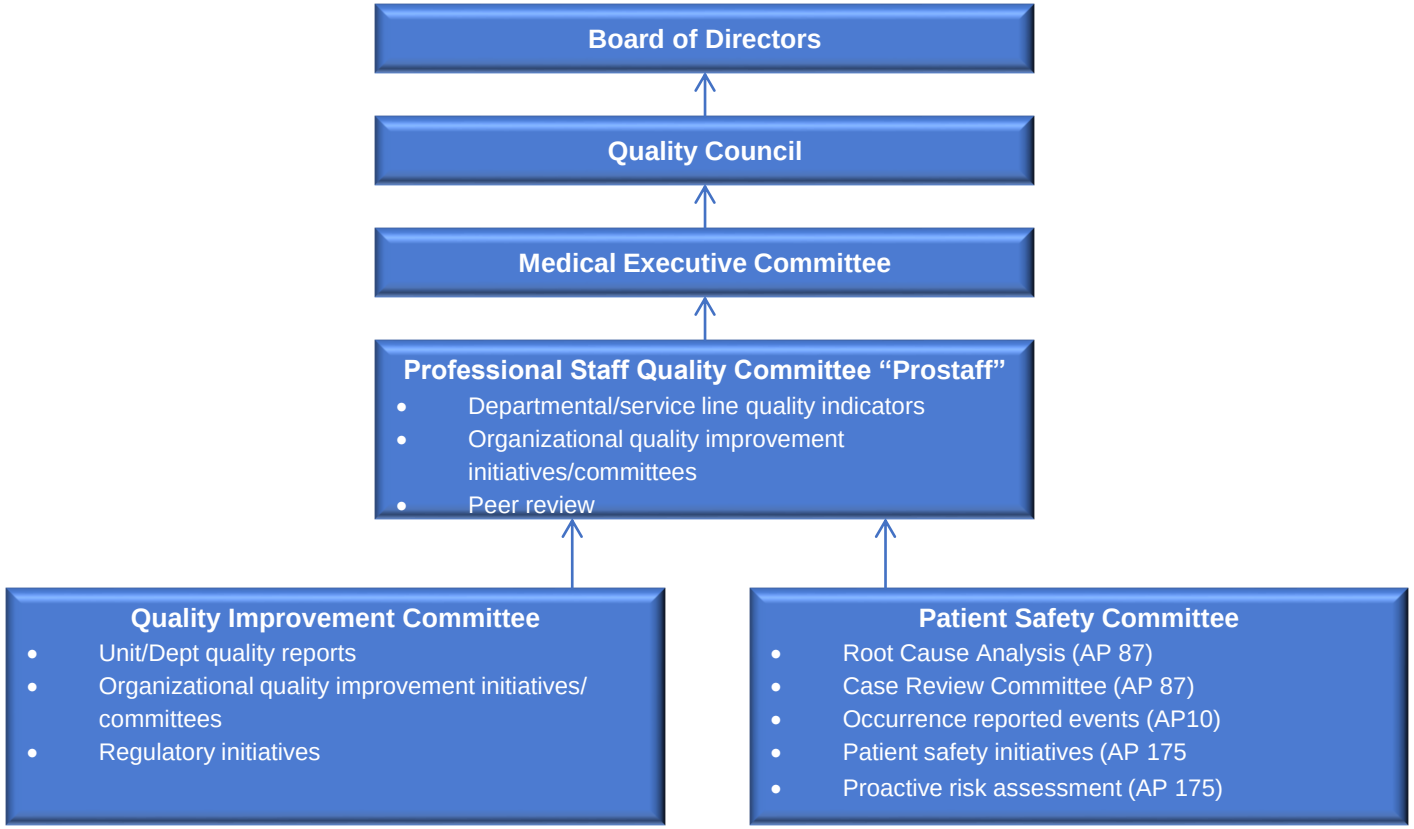
Quality Council January 2021

Abbreviations and Glossary:

Abx:	Antibiotic
AMI:	Acute Myocardial Infarction
BIBA:	Brought In By Ambulance
BC:	Blood Culture
CABG:	Coronary Artery Bypass Graft (open heart surgery)
CAUTI:	Catheter-Associated Urinary Tract Infection
CHG:	Chlorhexidine gluconate
CDI:	Clinical Documentation Improvement
CLABSI:	Central Line-Associated Bloodstream Infection
CMS:	Centers for Medicare and Medicaid Services
COPD:	Chronic Obstructive Pulmonary Disease
CPOE:	Computerized Provider Order Entry
EMR:	Electronic Medical Record
ERAS:	Enhanced Recover after Surgery
Gemba:	The location where value is created.
GME:	Graduate Medical Education
HCAHPS:	Hospital Consumer Assessment of Healthcare Providers and Systems
HIM:	Health Information Management
HF:	Heart Failure
IBW:	Ideal Body Weight
ISS:	Information Systems Services
IUC:	Indwelling Urinary Catheter
Kaizen:	Japanese term meaning “continuous improvement”
LA:	Lactic acid
MRSA:	Methicillin-Resistant Staphylococcus Aureus
NQF:	National Quality Forum
o/e:	Observed over expected
PN:	Pneumonia
PSI:	Patient Safety Indicator
QFT:	Quality Focus Team
SAQ:	Safety Attitudes Questionnaire
SSI:	Surgical Site Infection
STEMI:	ST-elevated myocardial infarction
TPN:	Total parenteral nutrition
VBP:	Value Based Purchasing

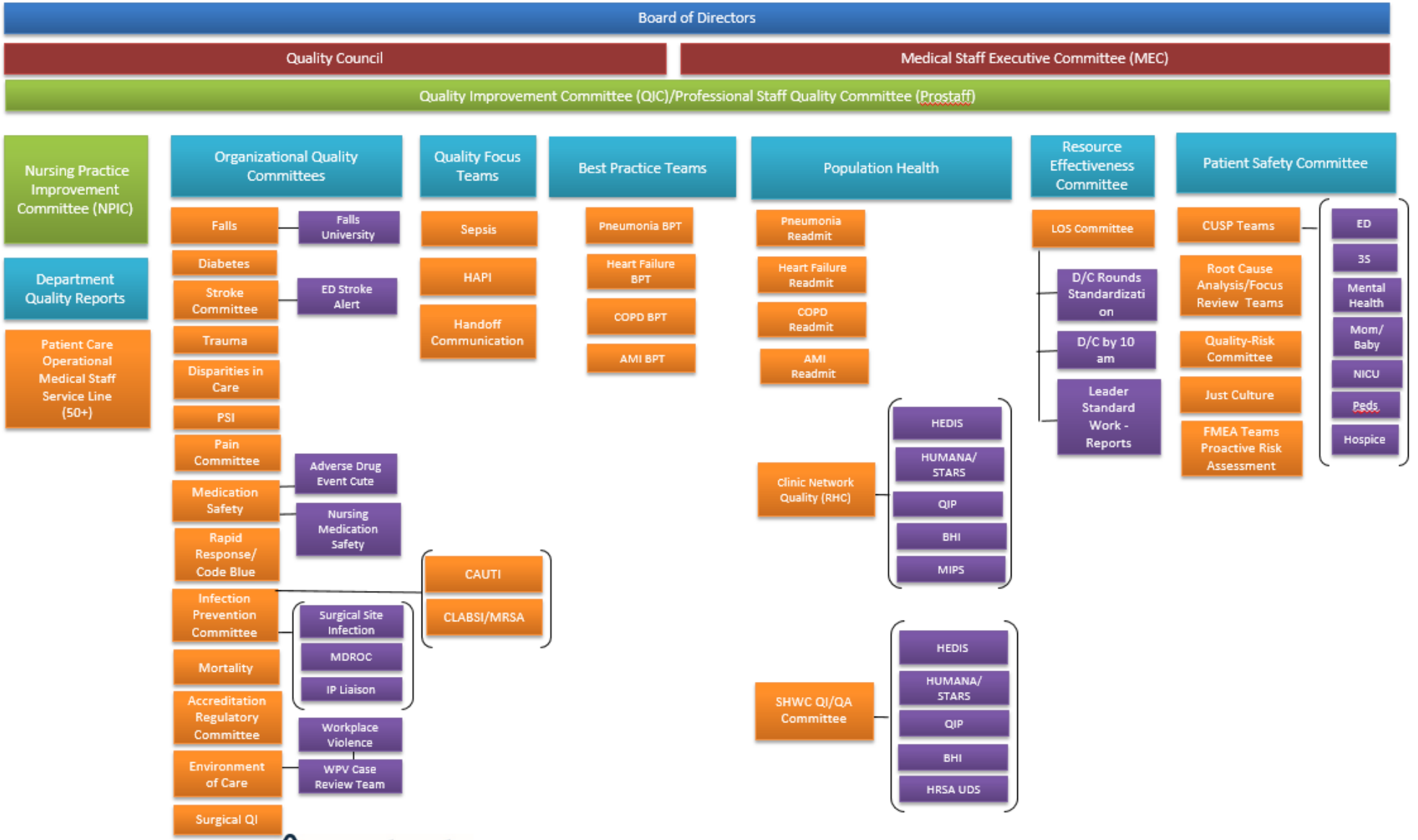
OUTSTANDING HEALTH OUTCOMES

Quality Improvement Committee Structure 2020/21
Quality Improvement & Patient Safety Plan



OUTSTANDING HEALTH OUTCOMES

Quality Improvement Committees/Teams 2020-21



Kaweah Delta Clinical Quality Improvement Committees & Teams 2020/21 (Reporting structure noted in QIC/Prostaff schedules)

OUTSTANDING HEALTH OUTCOMES

Core Measures - CY 2020 data

2020 Achievements

CMS Core Measures – Immunization / VTE / Sepsis

- Outperforming in all 3 metrics
- Zero → Hospital-acquired VTEs
- Second Sepsis Coordinator position added
- Sepsis outperforming CMS national and KD internal benchmarks for 4 of the last 6 months
- Performing in the top decile in the nation for sepsis bundle at least 4 months in 2020

HBIPS

- Newly implemented template for admission screening successful – Outperformed 6 months in the last year
- Outperforming in 9 of 16 measures

Perinatal Care

- Outperforming in 2 of 3 measures

2021 Areas of Focus

CMS Core Measures – Sepsis

- Complete the few remaining QI strategies identified during 2020 Sepsis Six Sigma project (ie. mandatory notification of sepsis alert)
- Continue to outperform national and internal benchmarks

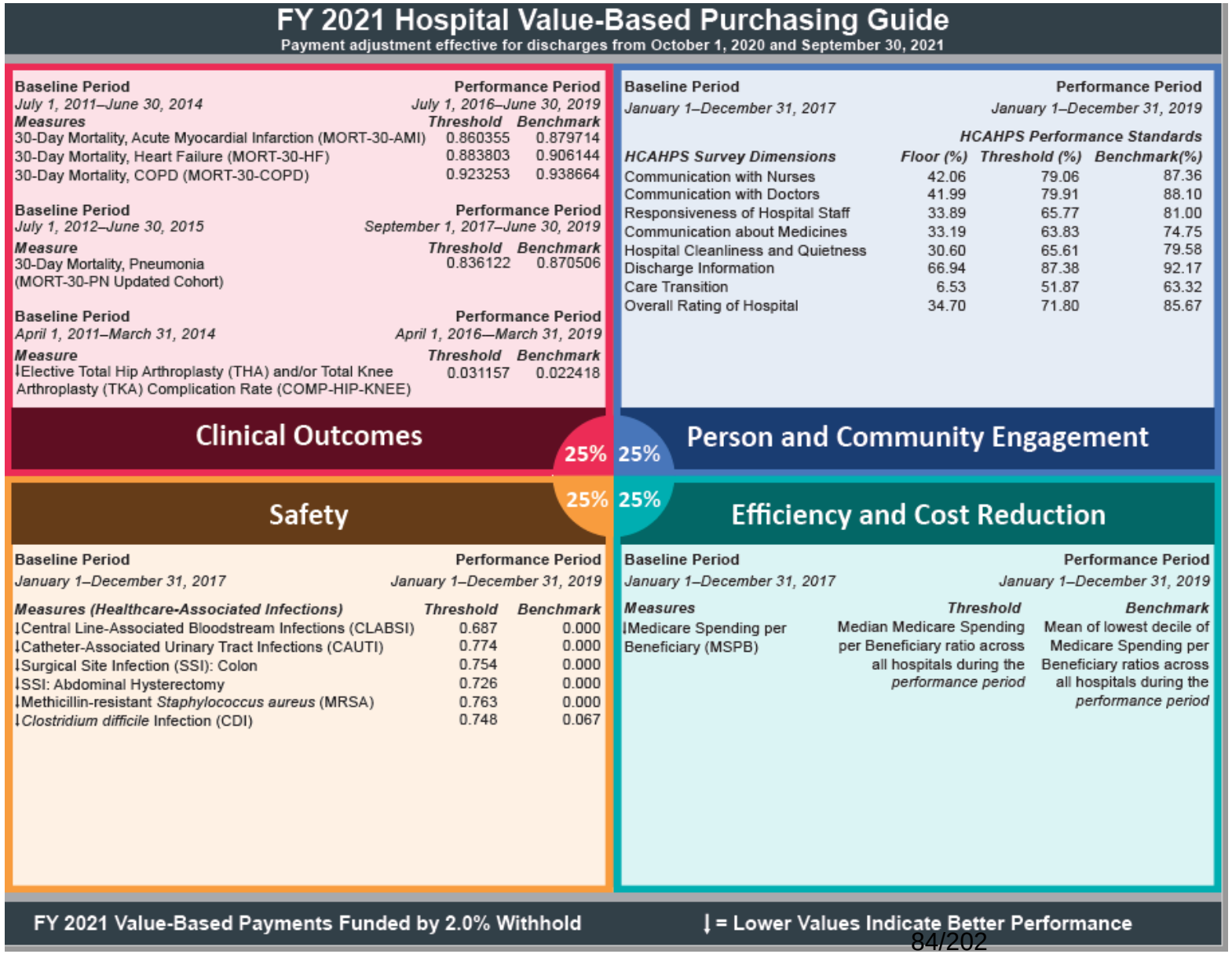
HBIPS

- HBIPS 5a - Resident QI project initiated to identify potential gaps and develop process improvements to standardize prescription of multiple anti-psychotic medications at discharge

Perinatal Care

- PCM 2a – Physician QI project initiated to identify potential gaps and develop process improvements to reduce Overall C-Section Rate

Strategic Initiative Charter: Outstanding Health Outcomes



FY 2021 Hospital Value-Based Purchasing Guide

Payment adjustment effective for discharges from October 1, 2020 and September 30, 2021

Clinical Outcomes — 25%

Baseline Period July 1, 2011–June 30, 2014 | **Performance Period** July 1, 2016–June 30, 2019

Measures	Threshold	Benchmark
30-Day Mortality, Acute Myocardial Infarction (MORT-30-AMI)	0.860355	0.879714
30-Day Mortality, Heart Failure (MORT-30-HF)	0.883803	0.906144
30-Day Mortality, COPD (MORT-30-COPD)	0.923253	0.938664

Baseline Period July 1, 2012–June 30, 2015 | **Performance Period** September 1, 2017–June 30, 2019

Measure	Threshold	Benchmark
30-Day Mortality, Pneumonia (MORT-30-PN Updated Cohort)	0.836122	0.870506

Baseline Period April 1, 2011–March 31, 2014 | **Performance Period** April 1, 2016–March 31, 2019

Measure	Threshold	Benchmark
↓Elective Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Complication Rate (COMP-HIP-KNEE)	0.031157	0.022418

Person and Community Engagement — 25%

Baseline Period January 1–December 31, 2017 | **Performance Period** January 1–December 31, 2019

HCAHPS Survey Dimensions	HCAHPS Performance Standards: Floor (%)	Threshold (%)	Benchmark(%)
Communication with Nurses	42.06	79.06	87.36
Communication with Doctors	41.99	79.91	88.10
Responsiveness of Hospital Staff	33.89	65.77	81.00
Communication about Medicines	33.19	63.83	74.75
Hospital Cleanliness and Quietness	30.60	65.61	79.58
Discharge Information	66.94	87.38	92.17
Care Transition	6.53	51.87	63.32
Overall Rating of Hospital	34.70	71.80	85.67

Safety — 25%

Baseline Period January 1–December 31, 2017 | **Performance Period** January 1–December 31, 2019

Measures (Healthcare-Associated Infections)	Threshold	Benchmark
↓Central Line-Associated Bloodstream Infections (CLABSI)	0.687	0.000
↓Catheter-Associated Urinary Tract Infections (CAUTI)	0.774	0.000
↓Surgical Site Infection (SSI): Colon	0.754	0.000
↓SSI: Abdominal Hysterectomy	0.726	0.000
↓Methicillin-resistant *Staphylococcus aureus* (MRSA)	0.763	0.000
↓*Clostridium difficile* Infection (CDI)	0.748	0.067

Efficiency and Cost Reduction — 25%

Baseline Period January 1–December 31, 2017 | **Performance Period** January 1–December 31, 2019

Measures	Threshold	Benchmark
↓Medicare Spending per Beneficiary (MSPB)	Median Medicare Spending per Beneficiary ratio across all hospitals during the *performance period*	Mean of lowest decile of Medicare Spending per Beneficiary ratios across all hospitals during the *performance period*

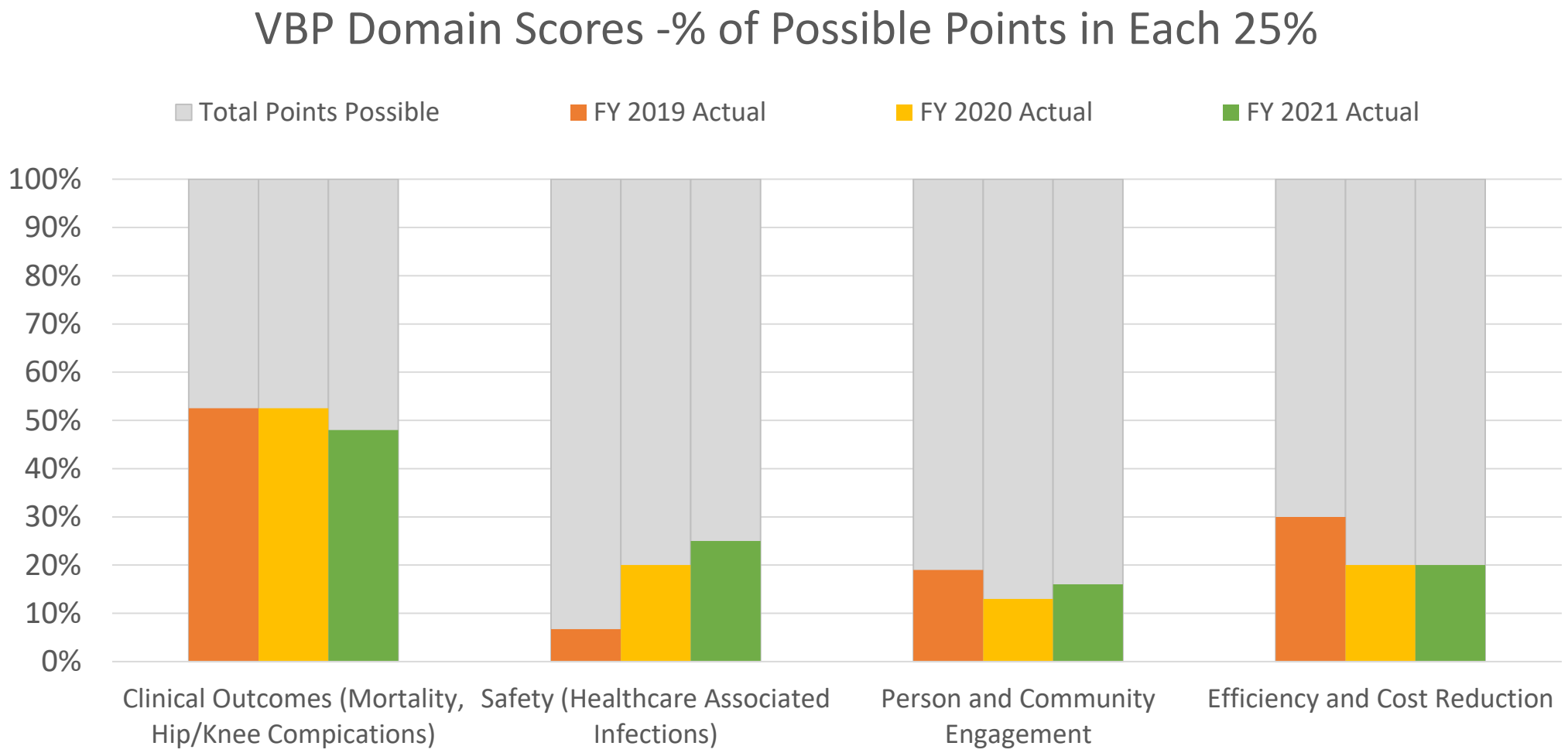
FY 2021 Value-Based Payments Funded by 2.0% Withhold

↓ = Lower Values Indicate Better Performance

Value Based Purchasing Measures Fiscal Year 2021

- Payment adjustment effective for discharges from Oct 1, 2020 and Sept 30, 2021
- For outcomes reported in CY 2019 (Safety, Efficiency and Engagement Domains) and July 1, 2016 through June 30, 2019 for Clinical Care Domain

Strategic Initiative Charter: Outstanding Health Outcomes



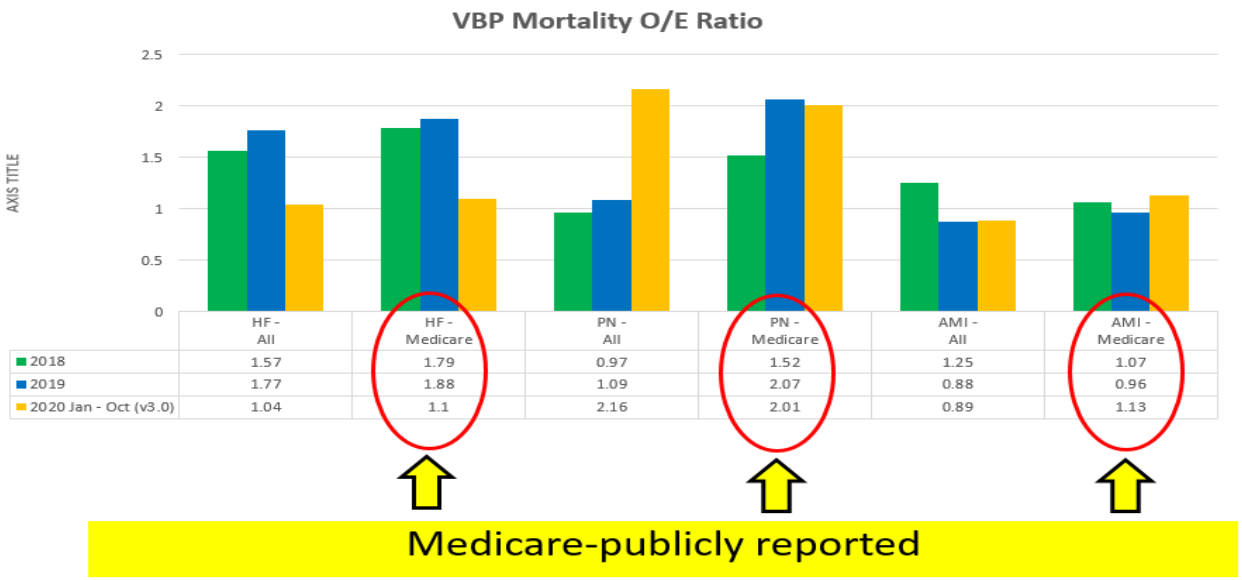
FY 2021 Actual VBP Cost	
Contribution	Payment Received
2% = $1,868,400	1.48% = $1,693,100
($175,300)	

FY 2020 Actual VBP Cost	
Contribution	Payment Received
$1,816,800	$1,345,800
($471,000)	

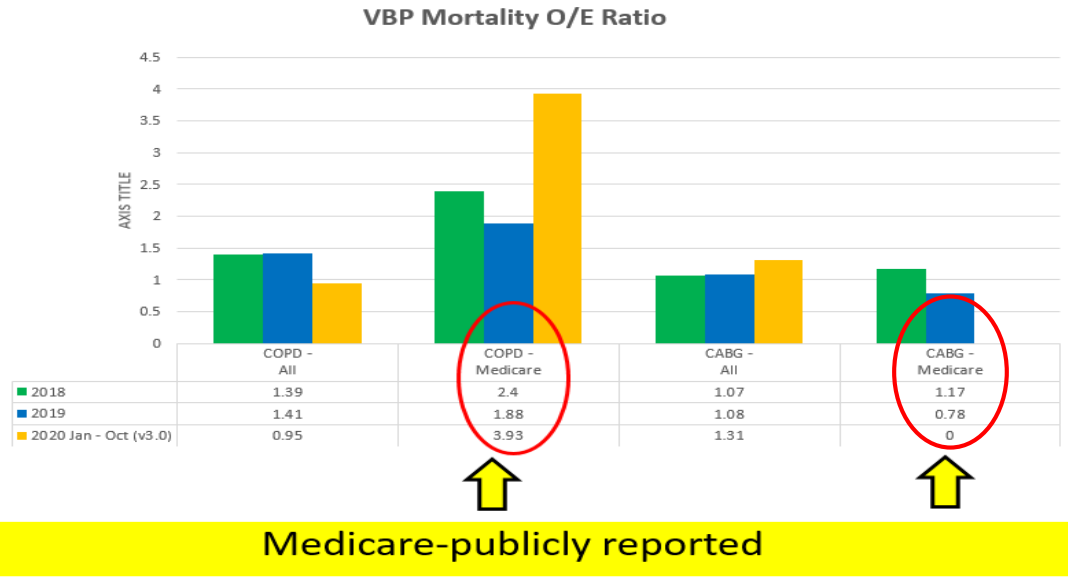
OUTSTANDING HEALTH OUTCOMES

KDHCD Mortality – Value-Based Purchasing

CY 2020 data



Medicare-publicly reported



Medicare-publicly reported

2021 VBP Achievements

- Improved performance in SSI, MRSA, HF/PN mortalities, and Hip/Knee complications
- *Total Performance Score* improved from 2020: 26.4 to 2021: 28.3
- Biovigil implementation for all inpatient units

2021 Mortality Achievements

- Performing 'same as' nationally in HF, PN, AMI, COPD, and CABG
- Restructured Mortality Review Committee to focus on greatest opportunity which is earlier Palliative Care
- Tulare Co. Public Guardian and Mortality Committee successfully developed and implemented a screening tool for conserved patients to identify goals of care and end-of-life decision-making

2021 VBP Areas of Focus

- AM Gemba rounds and PM Post Gemba rounds continue for CAUTI/CLABSI
- Bathing prioritization and central line dressing changes standardization and implementation on all units
- 'Operation Always' & Increased Leadership Rounding in Inpatient and Outpatient areas

2021 Mortality Areas of Focus

- Expand Palliative Care services at KDHCD and within community
- Increase in community referrals to KD Hospice Program
- Diagnosis-specific teams (HF, PN, AMI, COPD) for best practices

OUTSTANDING HEALTH OUTCOMES

KDHCD Patient Safety Indicators (PSI)

CY 2020 data

2020 Achievements

- PSI 3 - Hospital-Acquired Pressure Injuries
  - Nov 2020 - Kaizen conducted where root causes of HAPIs were identified and prioritized by key stakeholders
- PSI 4 – Death Rate among surgical Inpatients with Serious Treatable Conditions
  - Detailed analysis of 2020 cases conducted which revealed no concerning trends/system issues at this time
  - Downward trend noted from early 2018 through mid 2020 until COVID-19
  - Improvements in performance seen in the last 4 months; Nearing national benchmark
- PSI 5 – Retained Surgical Item
  - Zero cases in 2020
- Re-implementation of Surgical Quality Improvement Program (SQIP) post COVID-19 to provide additional oversight and input of surgical PSI performance

2021 Areas of Focus

- PSI 3 – Hospital-Acquired Pressure Injuries
  - QFT to identify and implement improvement strategies for top 4 priority opportunities resulting from Kaizen
- PSI 9 – Perioperative hemorrhage
  - Detailed analysis of 2020 cases conducted which revealed no concerning trends/system issues at this time; Continue to monitor in collaboration with SQIP
- PSI 10 – Postoperative kidney injury
  - QI project to be conducted by Surgery Medical Director to identify pre-operative opportunities for surgical patients with known decreased kidney function
- Continue interdisciplinary proactive case review to reflect accurate coding and documentation of clinical care; monitoring of 13 PSIs

OUTSTANDING HEALTH OUTCOMES

2020 CMS Star Report

Various data – CY 2016 - 2019

- Star rating measures include:
  - *Mortality* – Same as National Average
  - *Patient Safety* (ie: infection prevention, PSIs, HACs.) – Same as National Average (decreased)
  - *Readmission* – Same as National Average (increased)
  - *Patient Experience* – Below National Average
  - *Effectiveness of care* (ie: proper discharge medications, early elective delivery) – Same as National Average
  - *Timeliness of care* (ie: throughput) – Below National Average
  - *Effective use of medical imaging* – Same as National Average

- Various performance periods included from 2016 to 2019; ratings are 1-5 stars

- Beginning in CY 2021, CMS is simplifying methodology; standardizing the calculation of scores; begin to use averages of measure scores with equal weightings; and updating the reporting thresholds and peer grouping. Critical-access and VA hospitals will now be included in Overall Ratings.

OUTSTANDING HEALTH OUTCOMES

Actions to Improve VBP and Star Rating 2021

Measures	Strategy
Mortality	• Establish best practice teams 4/1/21 for AMI (non-STEMI), COPD, HF & Pneumonia and select best practice guideline. • Identification of key performance indicators (KPIs), dashboard development & initial QI work on KPIs • Development of care pathways
Readmissions	• Readmission teams for AMI (non-STEMI), COPD, HF & Pneumonia • COPD and HF established in 2020, Prioritized and staggered in 2021
Patient Experience	• Leader rounding • Operation always

Healthcare Acquired Infections (HAIs)	• Continue with heightened focus through Quality Focus Teams
	• Provider focused task force to address:
	  • Culture of culturing
	  • Vascular access team

Timeliness of Care (throughput)	• LOS Committee – 3 task forces: Discharge rounds; discharge by 10 am, and leadership standard work (report-based action at the unit-level)

OUTSTANDING HEALTH OUTCOMES

Healthgrades

Healthgrades Methodology

- Ratings based on 3 years of Medicare claims data (2017 – 2019)
- Measures risk-adjusted mortality (inpatient and 30 day) or surgical complications in 30 different diagnoses or procedures
- Star ratings are presented as:
  - “better” – 5 stars (top 15%)
  - “as expected” – 3 stars (middle 70%)
  - “worse” – 1 star (bottom 15%)

2021 Specialty Excellence Awards

Kaweah Delta Medical Center

Top 5% in the Nation
4 years in a row
(2017 – 2021)

Top 5% in the Nation
2 years in a row
(2020 – 2021)

Top 5% in the Nation
3 years in a row
(2019 – 2021)

Top 5% in the Nation
8 years in a row
(2014 – 2021)

Top 5% in the Nation
2 years in a row
(2020 – 2021)

OUTSTANDING HEALTH OUTCOMES

Healthgrades Achievements

2021 Quality Awards & Achievements – KDMC

Hospital Wide
Recipient of Healthgrades® 'America's 250 Best Hospitals' Award™ for 3 Years in a Row (2019-2021)
Best Specialty
One of Healthgrades America's 50 Best Hospitals for Cardiac Surgery™ for 4 Years in a Row (2018-2021)
One of Healthgrades America's 100 Best Hospitals for Stroke Care™ in 2021
One of Healthgrades America's 100 Best Hospitals for Pulmonary Care™ in 2021
One of Healthgrades America's 100 Best Hospitals for Critical Care™ in 2021
Cardiac
Recipient of the Healthgrades Cardiac Surgery Excellence Award™ for 5 Years in a Row (2017-2021)
Named Among the Top 5% in the Nation for Cardiac Surgery for 4 Years in a Row (2018-2021)
Named Among the Top 10% in the Nation for Cardiac Surgery for 5 Years in a Row (2017-2021)
Five-Star Recipient for Coronary Bypass Surgery for 5 Years in a Row (2017-2021)
Five-Star Recipient for Valve Surgery in 2021
Five-Star Recipient for Treatment of Heart Failure in 2021

OUTSTANDING HEALTH OUTCOMES

Healthgrades Achievements

Neurosciences
Recipient of the Healthgrades Neurosciences Excellence Award™ for 2 Years in a Row (2020-2021)
Recipient of the Healthgrades Stroke Care Excellence Award™ for 3 Years in a Row (2019-2021)
Named Among the Top 5% in the Nation for Treatment of Stroke for 3 Years in a Row (2019-2021)
Named Among the Top 10% in the Nation for Neurosciences for 2 Years in a Row (2020-2021)
Named Among the Top 10% in the Nation for Treatment of Stroke for 3 Years in a Row (2019-2021)
Five-Star Recipient for Treatment of Stroke for 7 Years in a Row (2015-2021)
Pulmonary
Recipient of the Healthgrades Pulmonary Care Excellence Award™ for 8 Years in a Row (2014-2021)
Named Among the Top 5% in the Nation for Overall Pulmonary Services in 2021
Named Among the Top 10% in the Nation for Overall Pulmonary Services for 8 Years in a Row (2014-2021)
Five-Star Recipient for Treatment of Chronic Obstructive Pulmonary Disease in 2021
Five-Star Recipient for Treatment of Pneumonia for 8 Years in a Row (2014-2021)
Gastrointestinal
Five-Star Recipient for Gallbladder Removal Surgery in 2021
Critical Care
Recipient of the Healthgrades Critical Care Excellence Award™ for 2 Years in a Row (2020-2021)
Named Among the Top 5% in the Nation for Critical Care in 2021
Named Among the Top 10% in the Nation for Critical Care for 2 Years in a Row (2020-2021)
Five-Star Recipient for Treatment of Sepsis for 9 Years in a Row (2013-2021)
Five-Star Recipient for Treatment of Respiratory Failure for 3 Years in a Row (2019-2021)

OUTSTANDING HEALTH OUTCOMES

Leapfrog Hospital Safety Score Dec 2020

KDHCD Hospital Safety Score Dec 2020 = 2.9833

Date	Grade
Dec 2020	B
May 2020	C
Oct 2019	C
May 2019	C
Oct 2018	C
May 2018	A

Letter Grade Key:

A = >3.133

B = >2.964

C = >2.476

D = >2.047

OUTSTANDING HEALTH OUTCOMES

Components of the Leapfrog Hospital Safety Score

- **PSIs/Healthcare Acquired Infections (HAIs) and Healthcare Acquired Conditions (HACs)**
- **Patient Experience**
- **3 Sections of the Leapfrog Survey:**
    - ICU physician Staffing
    - Computerized Provider Order Entry (CPOE)
    - Safe Practice Score

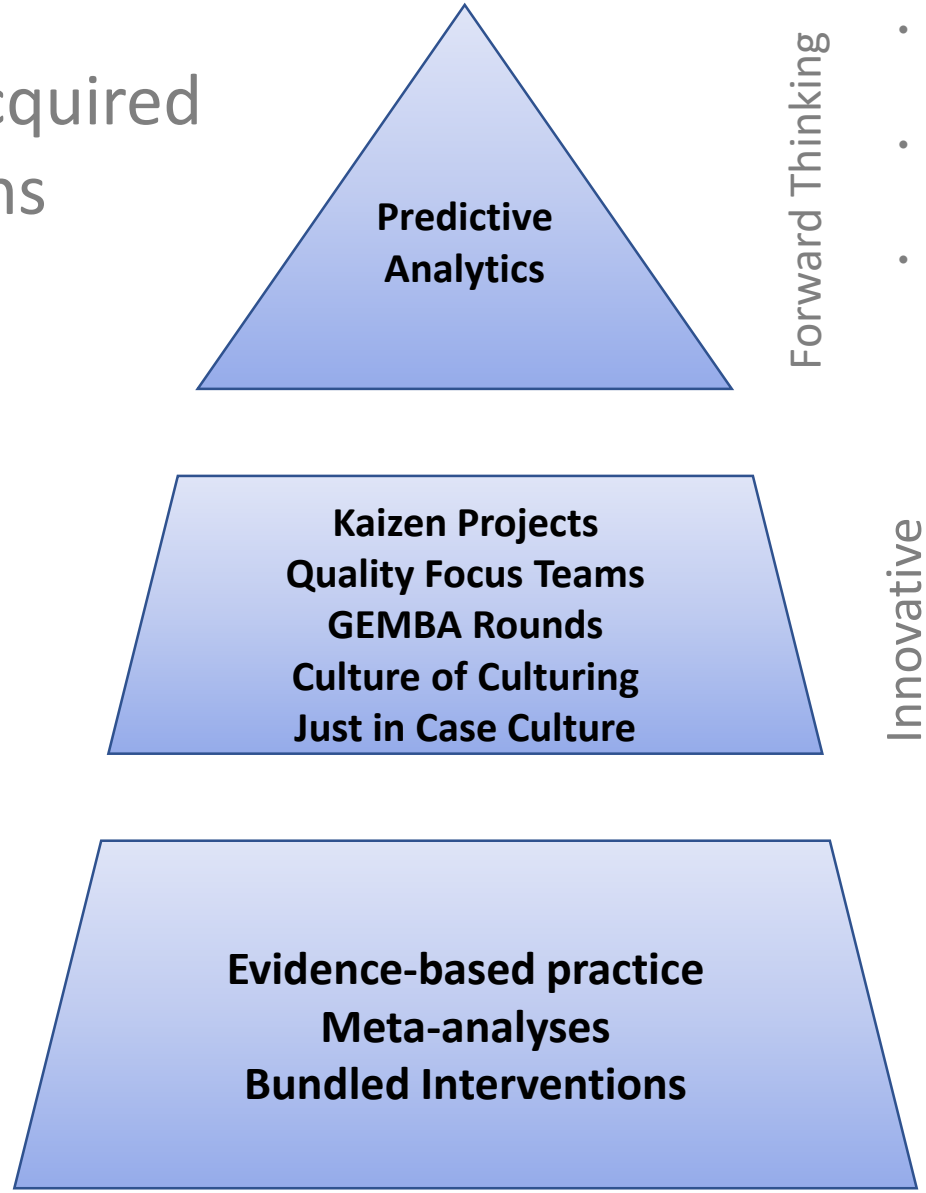
OUTSTANDING HEALTH OUTCOMES

Leapfrog Hospital Safety Score – Actionable Steps to Achieve "A"

- Continue with 100% Safe Practices
  - Commitment from Board and leadership to quality and safety culture improvement
  - Compliance with approx. 75 evidenced based safe practices focused on: Culture of leadership structures/systems, safety culture measurement & feedback, nursing workforce (events & nurse staffing), hand hygiene and medication safety
- Continue improvement in Patient Experience
  - New vendor JL Morgan
  - Operation always
  - Leader rounding
- Continue optimizing CPOE
- Continue focused improvement efforts on:
  - Healthcare acquired Infections—Achieve ZERO events
  - PSIs—Achieve ZERO events

Reducing Healthcare Acquired Infections - Interventions

What are we doing to prevent health care associated infections?



Forward Thinking

- Review of variables leading up to previously identified HAI.
- Statistical analyses of these variables to determine risks/odds of occurrence.
- Technology based alerts for events before they happen.

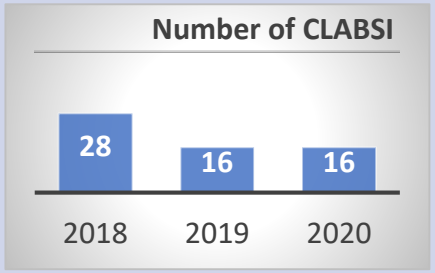
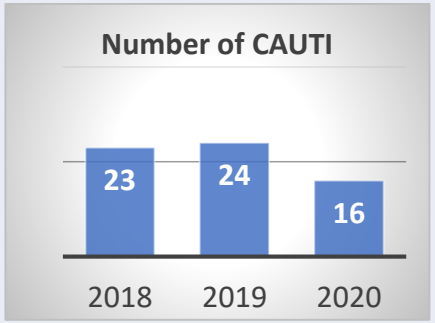
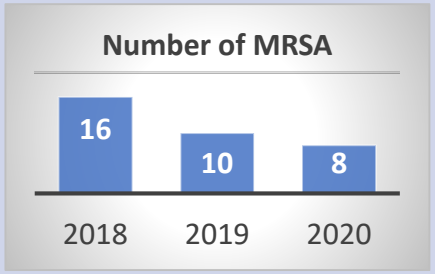
Innovative

- Retrospective review and analysis of healthcare districts HAI's.
- Deep dive into the "Why and How" for reported events.
- Collaborative action plans/stakeholder involvement.

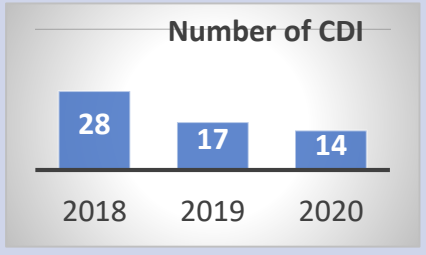
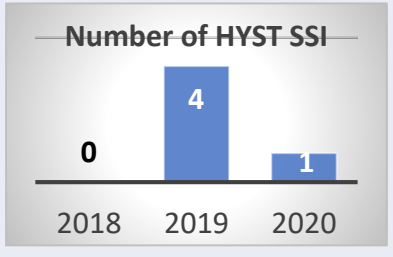
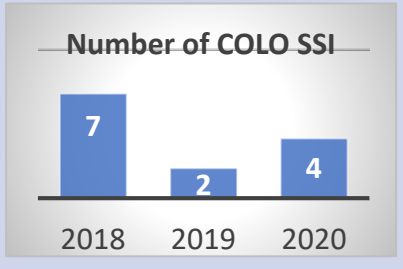
Evidence-Based

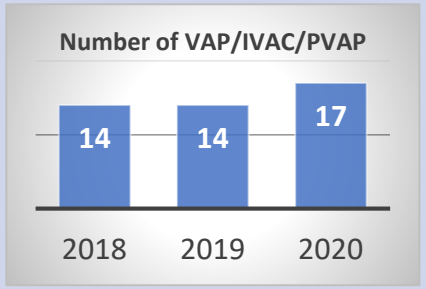
- CDC – HICPAC Guidelines for Reduction of Healthcare Associated Infections
- AHRQ – Toolkits for Reducing HAI
- CDC – STRIVE Infection Control Interventions

OUTSTANDING HEALTH OUTCOMES

HAI	# Infections	Above or Below	Team	Key Strategies
Central Line Associated Bloodstream Infection		12.5% reduction in events compared to 2019 50% reduction in events compared to 2018	• CLABSI Prevention Quality Focus Team • Operation Stomp-Out CLABSI Committee • HAI Case Review Committee	• "GEMBA" Unit-based rounds to de-escalate/remove central lines. • Blood Culture Order Alert • Midlines as an alternative • TPN/Abdominal Surgery & Candidemia Scoring
Catheter Associated Urinary Tract Infection		34.7% reduction in events compared to 2019 37.5% reduction in events compared to 2018	• CAUTI Prevention Quality Focus Team • HAI Case Review Committee	• "GEMBA" Unit-based rounds to remove indwelling urinary catheters or advocate for an alternative non-invasive device. • Urinary Retention Management • Urine Culture Algorithm (PowerPlan)
Healthcare Onset Methicillin Resistant Staphylococcus aureus Bloodstream Infection		20% reduction in events compared to 2019 50% reduction in events compared to 2018	• MDRO Prevention Committee • HAI Case Review Committee	• Biovigil Hand Hygiene Electronic Surveillance System • D.U.D.E. Hand Hygiene Campaign • Blood Culture Order Alert

OUTSTANDING HEALTH OUTCOMES

HAI	# Infections	Above or Below	Team	Key Strategies
Healthcare Onset Clostridium difficile Infection (CDI)		23.5% reduction in events compared to 2019 53% reduction in events compared to 2018	MDRO Prevention Committee	• Antimicrobial Stewardship • Reminders to avoid testing when on bowel regimen, tube feedings, receiving Lactulose • Policy PC.255 C. difficile Testing Criteria
Total Abdominal Hysterectomy Surgical Site Infection		25% reduction in events compared to 2019 100% increase in events compared to 2018	Surgical Site Infection Prevention Committee	• Reinforcing the use of clean-closure technique • Pre/Post operative blood glucose management
Colorectal Surgical Site Infection		100% increase in events compared to 2019 42.9% reduction in events compared to 2018	Surgical Site Infection Prevention Committee	• Reinforcing the use of clean-closure technique • Pre/Post operative blood glucose management

HAI	# Infections	Above or Below	Team	Strategy
Ventilator Associated Events (includes: Ventilator Associated Condition; Ventilator Infection Associated Condition; Probable Ventilator Associated Pneumonia)		7% Increase in events compared to 2019 No increase/decrease in events compared to 2018	VAP Prevention Committee	• Peridex Oral Solution Rinse • Elevate head-of-bed • Avoidance of PPIs • Sedation Vacation • Mobility

Primary Stroke Certification through The Joint Commission (TJC)

- **2020 TJC Recertification survey has been postponed due to COVID 19**
- 2 year certification cycle
- Initial accreditation March 9, 2018
  100% compliant with all Standards; No plans for improvement requested
- 20 Process and outcome measures are monitored on a monthly basis to maintain certification and award status for AHA Get with the Guidelines
  - 17 measures have performed above the goals set in 2020
  - 3 measures have performed at or below the goals set in 2020

Stroke Program
Performance Improvement Initiatives
Fiscal Year 2021

Door to Alteplase <60 minutes.

Continue this metric since it is a TJC and GWTG measure. KDH goal is now <45 minutes.

Follow-Up Calls/Perception of Care

Continue TJC requirement that we monitor perception of care.

Dysphagia screening process

Continue to monitor/track.

TIA work-up/admission

New measure. The goal of this project is to reduce TIA length of stay by using a visible LOS time tracker for physicians which may improve the length of stay, this would be similar to how the ED tracks their patients.

Transfer Process

New measure. Goal is to reduce door to transfer time to <120 minutes. Task Force has been established to address issue.

Stroke Program
Performance Improvement Initiatives
Fiscal Year 2021

Patient Education

New measure. This project was initiated by our GME TY resident during the previous year and will be continued for the upcoming year. Goal is to improve patient education metric in GWTG and improve 30 day readmission and mortality rates by physician engagement in stroke education, primarily in lifestyle modification.

Admission guideline criteria

New measure. KDH has historically had admission guidelines but a task force has recently reconvened to review admission guidelines.

New guidelines developed and implemented in May 2020.

Post Alteplase Monitoring

Continue to monitor/track.

Kaweah Delta
Primary Stroke Certification through The Joint Commission (TJC)

OUTSTANDING HEALTH OUTCOMES

Proactive Risk Assessment of High Risk Processes:
Failure Modes Effects Analysis (FMEA) 2020/21

- Heparin Infusion FMEA & Action Team
  - FMEA Completed 2019
  - 2020 Action team to address identified potential high risk failure modes:
    - Evaluated required pharmacist documentation for all therapeutic anticoagulants
    - Worked toward a weight rule in Cerner to fire an alert when an outlier weight is entered
    - Heparin bolus vials are no longer available as an 'override' in Pyxis on 4 North
    - PTT/PTTh Education sent out as an Essential Information/Bundle
    - Hold time of "0" included in the character function of Heparin Infusions
    - Double Check (IDC) challenges; Pharmacy Resident created IDC sticker to be attached to every Heparin bag.
  - 2021 - Finalize, pilot on unit, and education

- Radiation Dosing FMEA 2020/21
  - 2020 process defined, failure modes identified
  - 2021 risk mitigation strategies developed & implemented to address potential failure modes

OUTSTANDING HEALTH OUTCOMES

Safety Culture

Components of Safety Culture Program:

- Safety Attitudes Questionnaire (SAQ)
- Event Reporting
- Just Culture
- Team/Safety Culture Training
- CUSP – Comprehensive Unit-Based Safety Program
- Event Review (Root Cause Analysis/Focused Review)
- Recognition Programs

2018 KDHCD SAQ Domain Scores & Organizational Initiatives

2020/21 SAQ currently in progress, survey closes 2/1/21

- 5 categories below the 50th percentile, 1 above and 1 equal
- 3 domains have improved from 2016, 2 have decreased and 2 are unchanged

Score change is % change from KDHCD's 2016 SAQ survey

JOB SATISFACTION

70% | -1% Score Change | 71% Industry Med.

View Dashboard

Below Median

ORG INITIATIVE 2018 - 2021

- Employee engagement initiatives
- Unit-Level SAQ action plans

TEAMWORK CLIMATE

63% | 0% Score Change | 66% Industry Med.

Below Median

- TeamSTEPPS
- CUSP Program

STRESS RECOGNITION

55% | 6% Score Change | 47% Industry Med.

Above Median

- Stress Recognition modules for all new hires and ad hoc

PERCEPTIONS OF SENIOR MANAGEMENT

41% | 1% Score Change | 46% Industry Med.

Below Median

- CUSP ET Sponsors
- Leader rounding
- Just Culture

SAFETY CLIMATE

69% | -2% Score Change | 73% Industry Med.

Below Median

ORG INITIATIVE 2018 - 2021

- Just Culture
- Midas system revisions
- Good catch/Hero
- CUSP/IP Liaison
- CUS mandatory new hire module
- Daily safety huddle

PERCEPTIONS OF LOCAL MANAGEMENT

62% | 3% Score Change | 67% Industry Med.

Below Median

- CUSP
- Leader rounding
- Just Culture

WORKING CONDITIONS

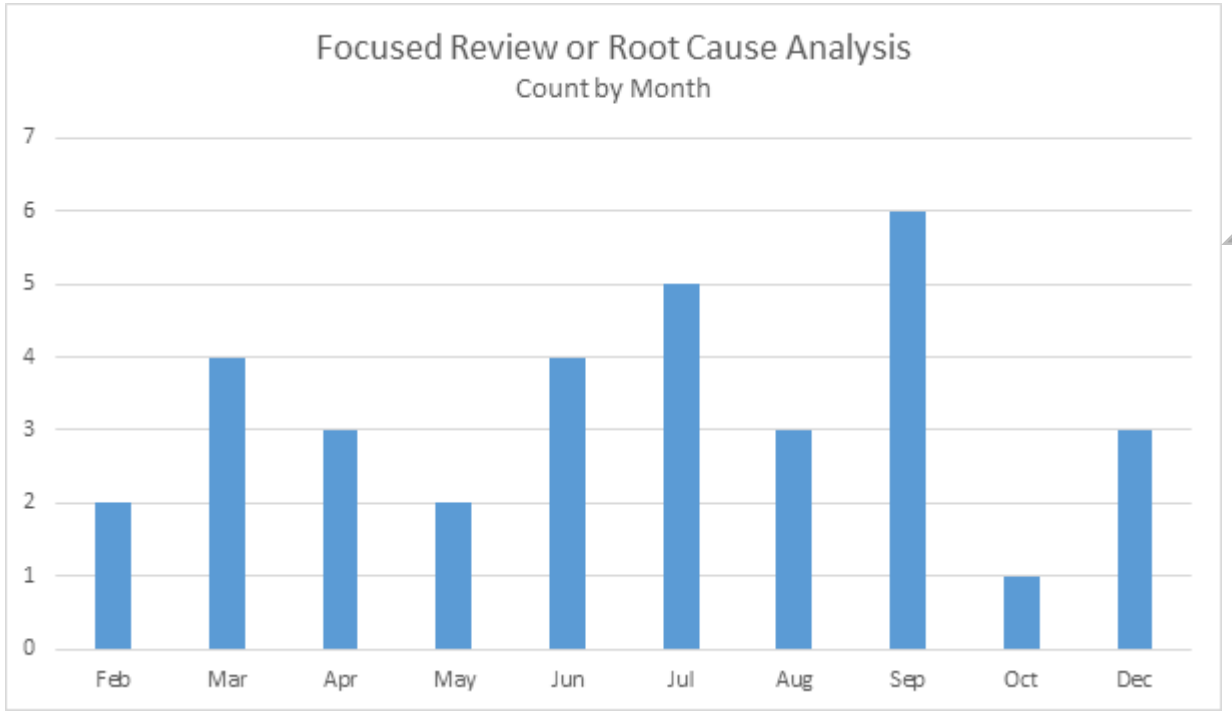
55% | 0% Score Change | 55% Industry Med.

Equal to Median

- Employee engagement initiatives
- Unit-Level SAQ action plans

OUTSTANDING HEALTH OUTCOMES

Safety Culture/Patient Safety Root Cause Analysis (RCA) & Focused Reviews (FR)



Effectiveness

Actions Taken by Category - Implemented for RCA/FRs

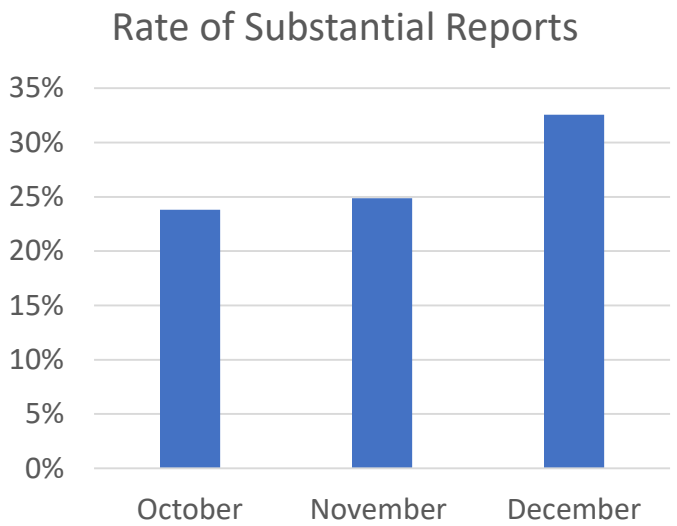
Error Proofing Strategy	Number Implemented 2019	Number Implemented 2020
Forcing Functions	0	1
Automation & Computerization	3	4
Standardization & Protocols	13	4
Rules & Policies	8	2
Education/Information	37	10
"Be more vigilant"	0	4
Number of RCAs/FRs	17	33

Goal is to increase systematic event review to:

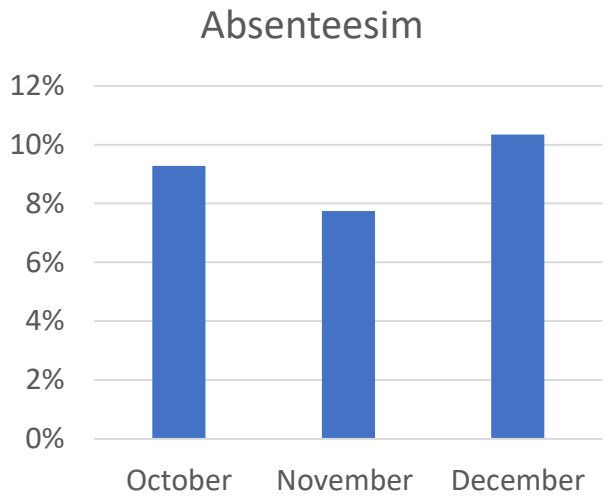
- Engage with leaders to proactively address issues or patterns of events
- Collaborate with teams to address opportunities

Daily Enterprise Safety Huddles

- The Daily Enterprise Safety Huddle is a short, 15-minute meeting at 8:45 every morning to share any concerns that occurred in the last 24 hours, review the steps taken to resolve those matters, and anticipate challenges or safety issues in the next 24 hours.
- Includes all departments of Kaweah Delta; Manager or Director present and listen to safety topics
- Summary of reports is sent out by email to hospital and medical staff leaders within 30 minutes daily to support proactive risk mitigation and communication across the enterprise
- Rollout began October 1, 2020; more departments and campuses were added each month. On January 4, 2021 Enterprise Safety Huddle went live with every department in the organization!



"Substantial Reports" are those departments that are present and contribute information or safety concerns beyond a report of "safe", and is reflective of engagement and active participation



Absenteeism is the number of absent reporting departments out of the total reporting opportunities. Follow-up on expectations occurs with frequently absent individuals

Kaweah Delta

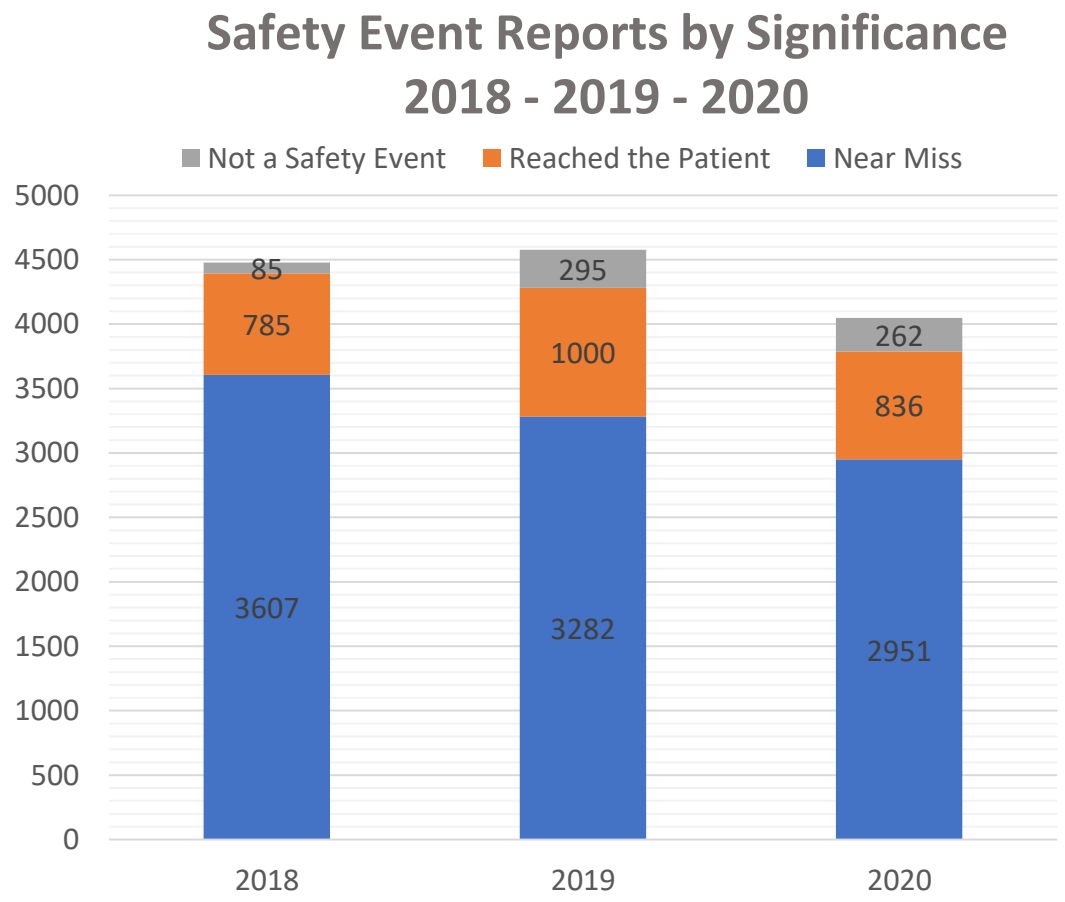
OUTSTANDING HEALTH OUTCOMES

Safety Culture/Patient Safety Root Cause Analysis (RCA) & Focused Reviews (FR)

Summary

- 12% decrease in overall events submitted from 2019 to 2020
- Proportion of events reported that reached the patient has increased since 2018 (18%) to 2020 (21%)
  - Pro: Staff comfortable to report (just culture will be utilized)
  - Con: more events reported reached patient (does not indicate harm occurred)
- Possible reductions related to decrease in census in 2020

	2019	2020	% Change
Acute Care Patient Days	130,740	128,668	1.6% ↓
Emergency Dept Visits	86,918	73,132	15.8%↓



OUTSTANDING HEALTH OUTCOMES

Safety Culture – Organizational Initiatives – 2020/21

Just Culture Steering Committee

- Plan for Just Culture staff awareness campaign early/mid 2021
- In 2020 Additions of Just Culture questions to event follow up in Midas
- Including the Just Culture focused questions in the 2020/21 SAQ (compare to 2018 baseline) to measure improvement
- 2021 Ongoing manager training to Just Culture and the Marx Algorithm

Team Training

TeamSTEPPS Leadership (Medical Team Training)

- 30 Kaweah leaders participated in training March 2020.
- Evaluation indicated the training accomplished goals: participants felt it was useful to their role/work, and learning occurred: 49% improvement in the understanding of TeamSTEPPS from before and after training
- 15 medical team tools implemented in 11 Kaweah locations
- 2Q 2021 3rd leadership cohort

TeamSTEPPS Staff

- All new hires in patient care roles complete CUS (I am concerned, uncomfortable, this is a safety situation) training; achieved training goals (>90% correct response rate) from 2017-2020 (2020 n=698). Post test indicates 100% correct response rate for each question. 100% of staff indicate ability to use CUS during a patient safety situation
- 2nd TeamSTEPPS tool approved by patient safety Committee for broad implementation in 2021; "Say it again, Sam" (2 challenge rule); 2Q 2021 Staff version of TeamSTEPPS simulation

Safety Culture Training

Stress Recognition Training

- 2017-2020 All new hires in patient care/support roles (2020 n=692)
- Post test indicates goal achieved (>90%) with >93% correct/ desirable responses

SAQ

- Unit level Action plans June 2021
- Broad dissemination

Recognitions

- 12 Good Catch awards (staff and providers) in 2020
- Hero of the Year awarded in 2020

Event Reporting/ Event Review

- New mandatory training module process implemented for staff involved in 2 identifier events
- Daily safety huddle implemented 2020
- Just Culture Algorithm added to Manager Investigation Tab (Medical Director documentation in development)
- Education on Just Culture Event Response to Managers and Directors
- Education through Medical Staff departments on Just Culture response to event
- Link to Event Reporting in KD Compass

CUSP (Unit Safety Teams)

- 6 teams in 2020; greatly affected by COVID-19
- Program under evaluation, enhancements planned for March 2021

Questions?

January 25, 2021

FY 2021 Strategic Plan: Outstanding Health Outcomes

Anu Banerjee, VP/ CQO
Tom Gray, M.D. Medical Director of Quality & Patient Safety
Sandy Volchko, Director of Quality & Patient Safety
Alexandra Bennett, Director of Risk Management

Abbreviations and Glossary:

Abx:	Antibiotic
AMI:	Acute Myocardial Infarction
BIBA:	Brought In By Ambulance
BC:	Blood Culture
CABG:	Coronary Artery Bypass Graft (open heart surgery)
CAUTI:	Catheter-Associated Urinary Tract Infection
CHG:	Chlorhexidine gluconate
CDI:	Clinical Documentation Improvement
CLABSI:	Central Line-Associated Bloodstream Infection
CMS:	Centers for Medicare and Medicaid Services
COPD:	Chronic Obstructive Pulmonary Disease
CPOE:	Computerized Provider Order Entry
DVT:	Deep vein thrombosis
EMR:	Electronic Medical Record
ERAS:	Enhanced Recovery after Surgery
Gemba:	The location where value is created.
GME:	Graduate Medical Education
HCAHPS:	Hospital Consumer Assessment of Healthcare Providers and Systems
HIM:	Health Information Management
HF:	Heart Failure
IBW:	Ideal Body Weight
ISS:	Information Systems Services
IUC:	Indwelling Urinary Catheter
Kaizen:	Japanese term meaning “continuous improvement”
LA:	Lactic acid
MRSA:	Methicillin-Resistant Staphylococcus Aureus
NQF:	National Quality Forum
o/e:	Observed over expected
PE:	Pulmonary Embolism
PN:	Pneumonia
PSI:	Patient Safety Indicator
QFT:	Quality Focus Team
SAQ:	Safety Attitudes Questionnaire
SSI:	Surgical Site Infection
STEMI:	ST-elevated myocardial infarction
TPN:	Total parenteral nutrition
VBP:	Value Based Purchasing

Kaweah Delta Strategic Plan Framework 2020-2021

Our Mission
(*The reason we exist*)

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

Our Vision
(*What we aspire to be*)

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

Our Pillars

Achieve ***outstanding community health***

Deliver ***excellent service***

Provide an ***ideal work environment***

Empower through ***education***

Maintain ***financial strength***

Strategic Initiative	Metrics	Strategies/ Tactics
Organizational Efficiency and Effectiveness ***Increase the efficiency and the effectiveness of the organization*** *to reduce costs, lower length of stay, and improve outcomes.*	• **ALOS within 0.75 days of GMLOS** • Drug/supply/testing utilization or spend- TBD • Surgical implant standardization- TBD • Staffing metrics- TBD • OR patient-out-patient-in within 30 minutes or less • Spending per beneficiary score < 0.97	• Utilize the updated Resource Effectiveness Committee (REC) structure to improve patient flow, population management, and cost savings. • Better align staffing levels with patient volumes/units of service. • Assess utilization of diagnostic testing, lab testing, and use of medications and make reductions, as appropriate. • Standardize supplies and medical implants • Improve OR efficiency and block utilization
Kaweah Care Culture ***Recruit, develop, and retain the best staff and physicians*** *to create an ideal work environment and ensure that patients receive excellent compassionate care.*	• **Pulse Survey - Improve ≥50% Tier 3 Teams to Tier 2 or higher** • EE Engagement survey - 4.19 engagement score (65th ptile) • Physician Engagement survey – 3.68 alignment score • SAQ Teamwork: 66%; Safety 73% • **HCAHPS Overall Rating: 76.5% 9s and 10s during FY21** • **ED Patient experience: Overall Rating: 70% during FY21**	• Pulse & Employee Engagement Survey and action planning • Leadership Development programs • Just Culture Commitment – Staff awareness • GME faculty and Medical Staff Leader Development • Physician Engagement Committee work • Operation Always - Patient engagement • Safety attitudes questionnaire (SAQ) and action planning • Increase Kaweah Care recognitions and celebrations • Develop performance scorecards for leaders, physicians, medical directors and department chairs
Outstanding Health Outcomes ***Demonstrate that we are a high-quality provider*** *so that patients and payers choose Kaweah Delta.*	• Leapfrog B • **CAUTI ≤ 0.727** • **CLABSI ≤ 0.633** • **MRSA ≤ 0.748** • **Sepsis bundle ≥70%** • 100% of Leapfrog/NQF Safe Practices points • Zero Defect performance- 100%	• Quality focus teams • Daily catheter and central line Gemba rounds • Improve compliance with sepsis bundle • Create diagnosis-specific committees to address mortality and readmissions • Infection prevention hand hygiene program • Expand adoption and compliance with Cleveland Clinic quality metrics and best practices
Strategic Growth and Innovation ***Grow intelligently*** *by expanding existing services, adding new services, and serving new communities.*	• 2% growth in market share (FPSA) • 11.2% increase in IP surgical volume • Net 30 increase in the number of physicians in the market • Retain 11 KD residents (40%) in the Central Valley • Two new ambulatory locations • TBD % increase in total OR capacity (available hours/minutes) • Launch telehealth services • Introduce new branding	• Develop a comprehensive and coordinated ambulatory network strategy • Better monitor and manage patient referrals to ensure continuity of care • Enhance physician relations capabilities to improve recruitment, onboarding, and retention of physicians • Promote key service lines to a broader geographic market (e.g. Fresno and Kern Counties) • Continue work with community advisory groups and use public perception data to improve community relations • Refresh of organization branding and naming strategy • Complete master facility plan to modernize and expand facilities
High Performing OP Delivery Network ***Improve the performance of our ambulatory services*** *to provide greater access to care and keep people healthy.*	• Employee engagement ≥ 50th percentile • OP patient satisfaction score ≥ 50th percentile • OP Outcome measures (A1c < 9), blood pressure, depression screening, flu vaccine) • Clinic visits ≥ 100% of budget • Net income ≥ 100% of budget • Labor productivity ≥ 100% of budget • Provider deficiencies 0% • RAF score of TBD, resulting in $750,000 increase in revenue	• People: Leadership rounding with staff and physicians • Service: Leadership rounding with patients • Population health: Improve documentation/coding/billing processes for clinical documentation • Growth: Develop existing provider productivity/opportunity reports and identify new primary/specialty care opportunities • Finance: Monthly accountability meetings around operational measures

Note: **Blue bolded** font indicates organizational goals; red font indicates draft/pending information

Strategic Initiative Charter: Outstanding Health Outcomes

AGENDA

1. Organizational Data Review
    a) Strategic plan measures, current performance vs goals
    b) CMS Star Report – 3 year comparison
    c) CMS Value-Based Purchasing – 3 year comparison
    d) Leapfrog Hospital Safety Score – 3 year comparison

2. NEW 2021 QI Initiatives
    a) CAUTI
    b) CLABSI/MRSA
    c) Patient Safety Indicators (PSIs)
    d) Sepsis Bundle Compliance
    e) Mortality & Readmissions
    f) Best Practice Teams
    g) Leapfrog/National Quality Forum Safe Practices
    h) Never Events

3. Summary & Questions

4. 2020 QI Initiatives

Strategic Initiative Charter: Outstanding Health Outcomes

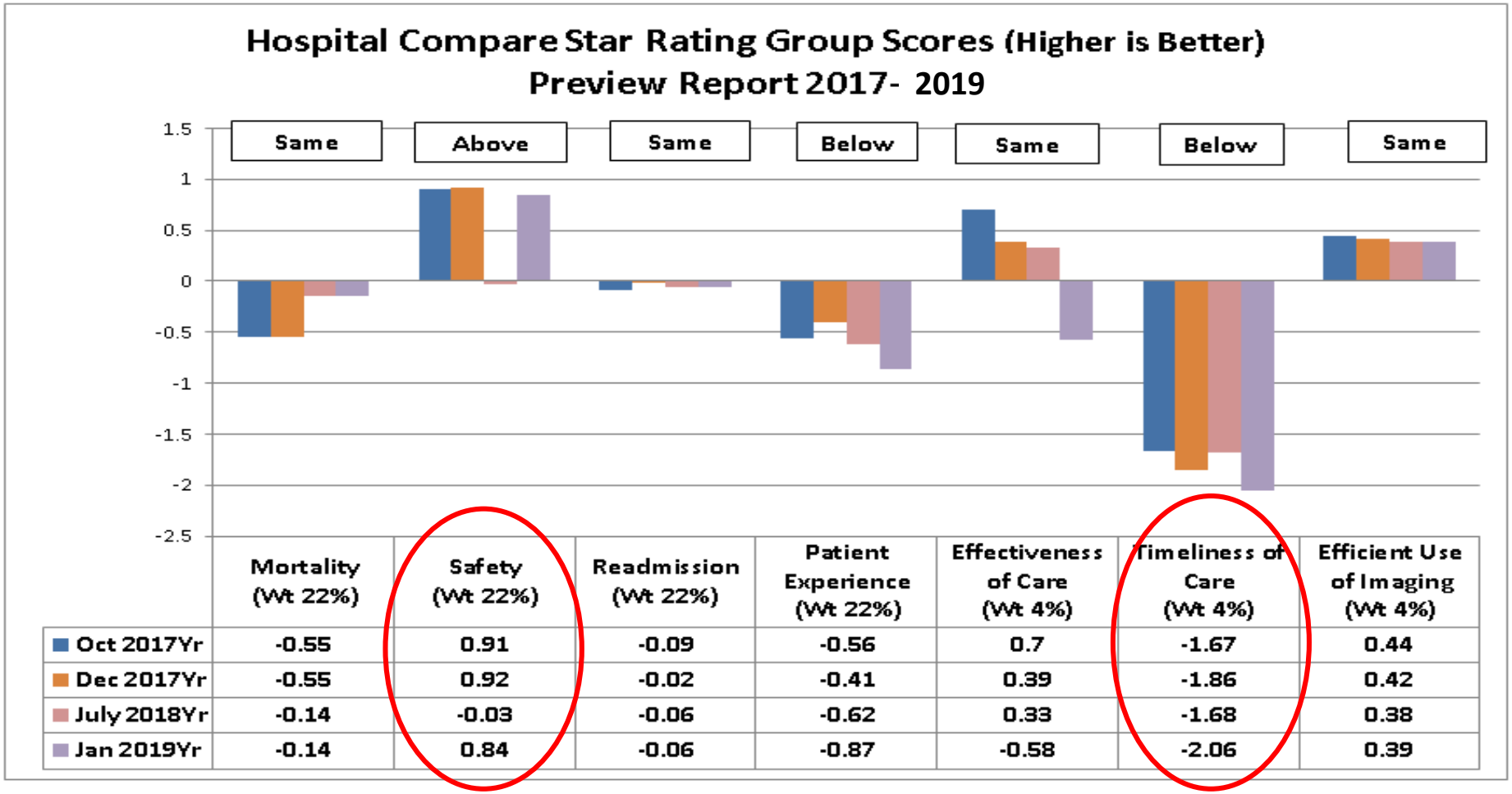
Performance Measure	Baseline FYTD	FY21 Goal	2021 FYTD (Jul-Dec 2020)	FY22 Goal	FY23 Goal
Healthcare Acquired Infections (HAI) (CMS population only)	CAUTI 1.03 CLABSI 0.74 MRSA 1.00	CAUTI ≤ 0.727* CLABSI ≤ 0.633* MRSA ≤ 0.748*	CAUTI 1.04 CLABSI 1.20 MRSA 1.29 (July – Nov 2020)*ALL PAYOR	CAUTI ≤ 0.690 (-5%) CLABSI ≤ 0.601 (-5%) MRSA ≤ 0.710 (-5%)	CAUTI ≤ 0.656 (-5%) CLABSI ≤ 0.570 (-5%) MRSA ≤ 0.675 (-5%)
Patient Safety Indicators (PSI90)**	0.925 (7/1/19-6/30/20)	≤ 0.64	1.09	≤ 0.61 (-5%)	≤ 0.58 (-5%)
Sepsis Bundle Compliance (SEP-1)	TBD end of FY20	≥70%	76% (July-Oct)	≥75% (+7%)	≥80% (+7%)
COPD Mortality o/e	2.5 (7/1/19-3/31/20)	2.25 (-10%)	6.10 (1/0.16)	2.02 (-10%)	1.82 (-10%)
AMI 30 Day Readmission	12.61%	11.98% (-5%)	6.52%	11.98% (-5%)	11.98% (-5%)
CABG 30 Day Readmission	9.09%	8.64% (-5%)	8.7%	8.64%	8.64%
Heart Failure 30 Day Readmission	18.71%	16.84% (-10%)	17.24%	15.00%(-5%)	14.25%(-5%)
COPD 30 Day Readmission	11.11%	10.00% (-10%)	31.6% (6/19)	9.5% (-5%)	9.05% (-5%)
Pneumonia 30 Day Readmission	17.02%	15.38%	14.7%	14.61% (-5%)	13.88% (-5%)
Hip/Knee 30 Day Readmission	1.72%	0	0	0	0
Leapfrog/NQF Safe Practices	100% of points	100% of points	100% of points	100% of points	100% of points
Leapfrog	C	B	B	A	A
Zero Defects Goal • Retained Foreign Object after surgery • Wrong site/wrong procedure on wrong patient	 0 0	 0 0	 0 0 117/202	 0 0	 0 0

*2022 VBP thresholds
**Included in 2023 VBP

PSI90 Benchmarks:
Midas (7/1/19-6/31/20): All Payor – 0.66, Medicare 0.64
CMS: 1.0 (2018)

Readmission benchmarks:
CMS: 15.3% (Q317 - Q218)
Midas: 8.92% (Pacific Nw), 9.46 National

Strategic Initiative Charter: Outstanding Health Outcomes



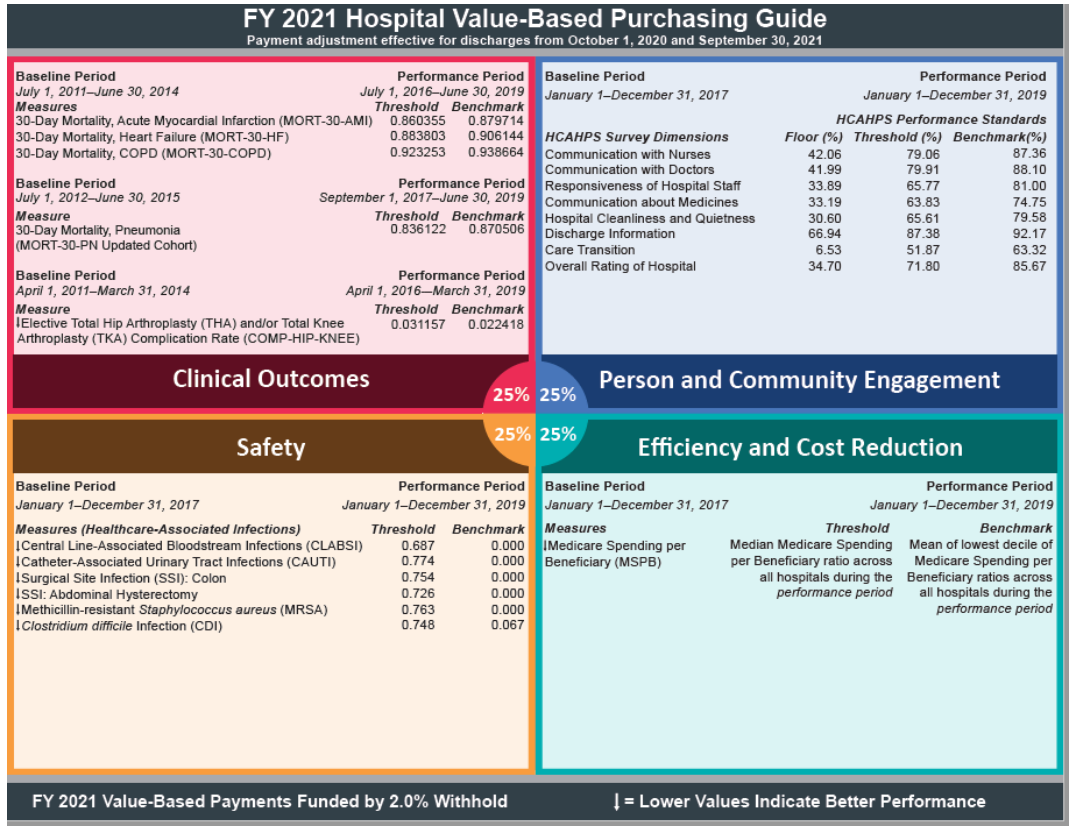
	Mortality (Wt 22%)	Safety (Wt 22%)	Readmission (Wt 22%)	Patient Experience (Wt 22%)	Effectiveness of Care (Wt 4%)	Timeliness of Care (Wt 4%)	Efficient Use of Imaging (Wt 4%)
Oct 2017Yr	-0.55	0.91	-0.09	-0.56	0.7	-1.67	0.44
Dec 2017Yr	-0.55	0.92	-0.02	-0.41	0.39	-1.86	0.42
July 2018Yr	-0.14	-0.03	-0.06	-0.62	0.33	-1.68	0.38
Jan 2019Yr	-0.14	0.84	-0.06	-0.87	-0.58	-2.06	0.39

Safety: HAI and PSI

Timeliness of Care: ED throughput

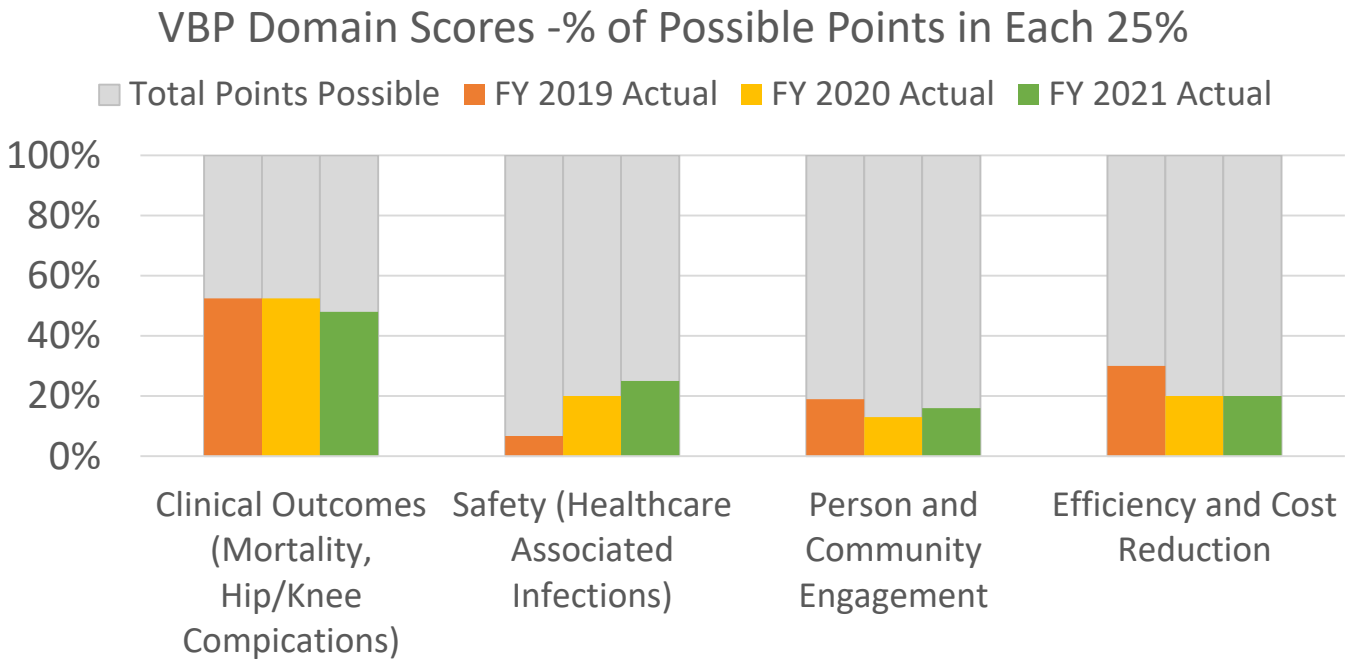
Effectiveness of Care: EED, PE/DVT, Flu Vaccine & Endoscopy measures

Strategic Initiative Charter: FY 2021 Value Based Purchasing



Value Based Purchasing Measures Fiscal Year 2021

- Payment adjustment effective for discharges from Oct 1, 2020 and Sept 30, 2021
- For outcomes reported in CY 2019 (Safety, Efficiency and Engagement Domains) and July 1, 2016 through June 30, 2019 for Clinical Care Domain



FY 2020 Actual VBP Cost	
Contribution	**Payment Received**
$1,816,800	**$1,345,800**
($471,000)	

FY 2021 Actual VBP Cost	
Contribution	**Payment Received**
2% = $1,868,400	**1.48% = $1,693,100**
($175,300)	

Leapfrog Hospital Safety Score 2018-2020

Outcome Measures (lower is better)	Data Source	Apr/May 2018	Sept/Oct 2019	Apr/May 2020	Dec 2020	Mean Dec 2020	Data Date Range Dec 2020
Letter Grade		A	C	C	B		
Overall Score		3.1966	2.8426	2.7773	2.9833		
Foreign Object Retained	CMS	0	0.135	0.135	0.065	0.02	07/01/17-06/30/19
Air Embolism	CMS	0	0	0	0	0.000	07/01/17-06/30/19
Falls and Trauma	CMS	0.347	0.472	0.472	0.327	0.43	07/01/17-06/30/19
CLABSI	CMS	0.91	1.277	1.927	1.071	0.67	10/01/2018-09/30/2019
CAUTI	CMS	0.649	1.052	1.756	1.627	0.72	10/01/2018-09/30/2019
SSI: Colon	CMS	0.725	0.797	0.982	0.498	0.81	10/01/2018-09/30/2019
MRSA	CMS	1.966	2.169	1.744	1.454	0.79	10/01/2018-09/30/2019
C. Diff.	CMS	1.538	0.585	0.343	0.291	0.58	10/01/2018-09/30/2019
PSI 3: Pressure Ulcer Rate	CMS	0.05	0.65	0.65	0.41	0.58	07/01/2017-06/30/2019
PSI 4: Death Rate, Surg. Inpatients w/ Serious Treatable Complications	CMS	174.56	212.08	212.08	168.71	164.47	07/01/2017-06/30/2019
PSI 6: Iatrogenic Pneumothorax Rate	CMS	0.26	0.26	0.26	0.3	0.25	07/01/2017-06/30/2019
PSI 11: Postoperative Respiratory Failure Rate	CMS	12.6	6.62	6.62	6.66	6.36	07/01/2017-06/30/2019
PSI 12: Perioperative PE/DVT Rate	CMS	2.34	3.8	3.8	2.94	3.74	07/01/2017-06/30/2019
PSI 14: Postoperative Wound Dehiscence Rate	CMS	1.98	0.82	0.82	0.98	0.91	07/01/2017-06/30/2019
PSI 15: Abdominopelvic Accidental Puncture/Laceration Rate	CMS	0.79	1.31	1.31	1.27	1.26	07/01/2017-06/30/2019

Process Measures (higher is better)	Data Source	Apr/May 2018	Sept/Oct 2019	Apr/May 2020	Dec 2020	Mean Dec 2020	Data Date Range Dec 2020
Computerized Physician Order Entry (CPOE)	Leapfrog Survey	100	100	100	100	83.53	2020
Bar Code Medication Administration (BCMA)	Leapfrog Survey	n/a	100	100	100	83.41	2020
ICU Physician Staffing (IPS)	Leapfrog Survey	100	100	100	100	60.18	2020
SP 1: Culture of Safety Leadership, Structures & Systems	Leapfrog Survey	120	120	120	120	117.26	2020
SP 2: Culture Measurement, Feedback, & Intervention	Leapfrog Survey	120	120	120	120	116.86	2020
SP 4: Identification & Mitigation of Risks & Hazards	Leapfrog Survey	100	100	100	n/a	n/a	n/a
SP 9: Nursing Workforce	Leapfrog Survey	100	100	100	100	98.39	2020
SP 19: Hand Hygiene	Leapfrog Survey	60	60	60	60	59.10	2020
H-COMP-1: Nurse Communication	CMS	91	89	90	90	91.05	10/01/2018-09/30/2019
H-COMP-2: Doctor Communication	CMS	91	88	88	89	90.94	10/01/2018-09/30/2019
H-COMP-3: Staff Responsiveness	CMS	84	84	84	85	84.28	10/01/2018-09/30/2019
H-COMP-5: Communication about Medicines	CMS	78	76	77	76	77.74	10/01/2018-09/30/2019
H-COMP-6: Discharge Information	CMS	86	85	85	85	86.50	10/01/2018-09/30/2019

Letter Grade Key: A = >3.133 B= >2.964 C= >2.476 D= >2.047

Strategic Initiative Charter: Outstanding Health Outcomes Summary

Strategies (Tactics)	Net Annual Impact ($)*
Infection Prevention Measure Bundle: 1. CAUTI, CLABSI/MRSA Quality Focus Teams 2. Daily catheter and central line Gemba rounds 3. Enhanced daily huddles, education/awareness, culture of culturing 4. Vascular access team, TPN utilization	2% Medicare reimbursement per beneficiary (star rating); CMS HAC & VBP Program penalties
Patient Safety Indicators (PSI): 1. PSI Committee; timely review of PSI from CDI, HIM, Surgeon Champion and Quality & P/S; clinical system enhancements 2. Enhanced recovery after surgery (ERAS) program	CMS HAC and VBP Program penalties
Sepsis Bundle Compliance 1. Multidisciplinary Quality Focus Team 2. Sepsis Coordinators 3. Focus Six Sigma QI Strategies to address root causes of bundle non-compliance	Reduction to length of stay
Mortality/Readmissions 1. Enhanced diagnostic specific workgroups/committees	Readmission Reduction Program & VBP
Leapfrog/NQF Safe Practice 1. Med Safety Initiatives, SAQ administration, dissemination & QI, nursing staffing/adverse events, CPOE	No financial impact
Zero Defects 1. Achieve zero defects, or “never events”	

2021 Strategies Summary for: CAUTI

Outcomes	FY21	FY22	FY23
CAUTI	≤ 0.727	≤ 0.690	≤ 0.656

Initiative	Person Responsible	Timeline
Place all IUC order resources on eCoach GOAL- Increase IUC appropriateness/ prompt removal, bundle compliance (improving ease of access for providers and nursing staff)	Lacey Jensen	1Q21
Develop Urine Culture only powerplan to replace single orderable. GOAL- Reduce CAUTI events related to culture ordering by guiding intentional use of this risky order. seek ORC approval to make changes to existing powerplans and replace with this new urine culture only powerplan	Kari Knudsen/Sarah Brown	1Q21
Powerchart changes- IUC dynamic group for POA include on arrival from OR/ED, other GOAL: capture device list for lines already in place	KK/ SB	1Q21
Add 3-way catheter as trigger to device list GOAL: accurate collection of device count	KK/SB	1Q21
Create alert when patient has IUC in place and documented loose stools GOAL: inspire intervention to prevent risk of CAUTI with loose stool and IUC	KK/SB	Jan 2021
Evaluate reasons for IUC insertion orders GOAL: Reduce IUC utilization/appropriate indications for IUC	Dr. Gray	Jan/Feb 2021
Safety Summit (CAUTI education for new hires) relaunch post-COVID GOAL – Improve/sustain RN bundle compliance	Shawn Elkin	1Q21
Epithelial cells count GOAL: Stop UA processing based on a determined threshold of squamous cells in the sample	Alisha, Ben, Kari	1Q21
Bladder training order and education	KK	2Q21
Changes to the discontinue order- develop electronic prompts/orders for retention management power plan upon discharging an IUC. GOAL- provides orders for nursing to manage post IUC DC retention	KK/SB	1Q21
Culture of Culturing committee for urine specimens – appropriate culture ordering based on symptoms (e. fever). This is a separate task force but will report back to CAUTI QFT.	SE	
Adding sticker to IUC GOAL: Visual cue for staff, reminder to change IUC before specimen collections	KK	Feb 2021

2021 Strategies Summary for: CLABSI/MRSA

Initiative	Person Responsible	Date/Time
TPN Utilization - Formulary flexibility, PowerPlan creation, Enteral Feeding algorithm, Candidemia scoring GOAL: Reduce events related to TPN use	Shawn Elkin	3/30/2021
CHG Bathing - Licensed vs. non-licensed staff and bathing GOAL: increase recommended practice of CHG bathing for central line patients	Keri Noeske/Anu Banerjee	3/30/2021
Just-In-Case-Culture – GOAL: Develop interventions that hone ordering practices for cultures to when they are indicated.	SE	3/30/2021
Central Line Dressing Kits – GOAL: improve best practices related to central line dressings	Amy Baker/Shawn Elkin	2/30/2021
Staff/Provider Education relaunch - Nursing Safety Summit, GME Residency HAI Summit GOAL: staff are 100% knowledgeable on best practice bundles	SE	2/30/2021
Stopping Labs after Dispatch –patient with hospice status change. GOAL: reduce unnecessary orders	Randy Kokka/Shawn Elkin	3/30/2021
Fever algorithm - Fever as a trigger for blood culture (BC) orders. GOAL: increase appropriate ordering of BC for central line patients	Cody Erickson	3/30/2021
Midlines as an alternative - Staff/Provider Education GOAL: Reduce unnecessary central lines	SE	5/30/2021
Midlines as an alternative - Incorporation into a vascular access team GOAL: Reduce unnecessary central lines	SE	9/30/2021
Vascular Access Team - Determining resources GOAL: Standardization of insertion, appropriateness and monitoring of best practice application	SE	3/30/2021
Vascular Access Team - Educational Plan and Budgeting GOAL: Standardization of insertion, appropriateness and monitoring of best practice application	SE	5/30/2021
Vascular Access Team - Development of quality indicator metrics and creation of reporting mechanisms GOAL: Standardization of insertion, appropriateness and monitoring of best practice application	SE	8/30/2021

Outcomes	FY21	FY22	FY23
CLABSI	≤ 0.633 123/202	≤ 0.601	≤ 0.570

2021 Strategies Summary for: Patient Safety Indicators (PSIs)

Initiative	Person Responsible	Date/Time
PSI 3 Pressure Ulcer Rate. Unit-Level communication strategies. GOAL: 100% of high risk patients are known and identified to the team each shift on each unit	Mary Laufer	2Q21
PSI 3 Pressure Ulcer Rate. Pressure injury prevention (education, setting expectations, visual cues, skin time out on transfers) GOAL: 100% of RNs and CNAs can name the prevention measures included in the pressure injury prevention plan by April 2021	ML	2Q21
PSI 3 Pressure Ulcer Rate. Time management (clustering care, adjusting time of activities, task lists and visual aides). GOAL: In 6 months will have 80% compliance of implemented Interventions based on the assessment that was done within 2 hours	ML	2Q21
PSI 3 Pressure Ulcer Rate. Standardization of turning/repositioning. GOAL: Turn/Position patients every 2 hours	ML	2Q21
PSI 7 Central Venous Catheter Related Blood Stream Infection Rate (CLABSI)	See CLABSI	See CLABSI
PSI 13 Postoperative Sepsis rate	See Sepsis	See Sepsis
Enhanced Recovering After Surgery (ERAS) expansion to orthopedic and OB/GYN patients GOAL: Reduce complications and length of stay, improve patient outcomes	Brian Piercy/Megan Goddard, Tracie Plunkett	Feb/March 2021

Outcomes	FY21	FY22	FY23
PSI90	≤ 0.64	≤ 0.61 (-5%)	≤ 0.58

2021 Strategies Summary for (SEP-1) Sepsis Bundle Compliance

Initiative	Person Responsible	Date/Time
Revised new hire and annual Sepsis training/competence GOAL: Ensure RNs are knowledgeable and competent on sepsis best practices	Evelyn McEntire	March 2021
Make form revisions to "provider notification"; provide prompts for critical thinking and order set initiation, and title it differently to eliminate confusion GOAL: Early identification and treatment of septic patients, increase bundle compliance	EM	June 2021
Hand off sheet/pathway checklist - Similar to existing workflow with MRI safety form, belonging forms "ad hoc" forms. Ideally it populate, and reminder to complete. GOAL: ensure communication of bundle element completion is handed off	EM	June 2021
Required for RN to fill out "provider notification form" after sepsis alert fires – alerts suppressed for 48hrs, so RNs do not receive multiple alerts. THIS IS DEPENDENT ON FORM REVISIONS ABOVE. GOAL: Early identification and treatment of septic patients, increase bundle compliance	EM	June 2021
Reflex alert, when Abx ordered (specific list of Abx) provider gets alert "do you want Blood culture" GOAL: Improve compliance with requirement to obtain a blood culture before Adx administered	EM	April 2021
Evaluate BC labeling process; set up meeting with ED and Lab and ISS/Bridge to determine if there is a process where the actual time the labs were drawn (via generic label) can be used when "real" label is printed after provider order is obtained GOAL: improve compliance with blood culture timing	EM	3Q21
Evaluate what clin Ed provides to new RNs about sepsis alerts and how to respond? Ideally hands on training upon hire, look at alerted patient and walk through documentation. GOAL: Ensure RN training is achieving desired objectives	EM	3Q21
ED Techs input height and weight in EMR; RN input for BIBA patients; THEN IBW automated in fluid order when height and weight are documented GOAL: improve compliance with fluid requirements of bundle	EM	May 2021

Outcomes	FY21	FY22	FY23
SEP-1	≥70%	≥75%	≥80%

125/202

2021 Strategies Summary for: CMS Mortality and Readmissions

Initiative	Person Responsible	Date/Time
Tulare County Public Guardian (TCPG) Sub-Committee Purpose: To collaboratively identify and correct gaps in system processes among KDHCD and TCPG Developed TCPG Guide for Managing Serious and Chronic Medical Conditions Disseminated KD Hospice Reference Guide to TCPG team	Dr. Gray	2Q21
Best Practice Teams (AMI (non-STEMI), COPD, PN, HF) • Team established, best practice guideline selection • Key performance indicators selected, dashboard development, initial QI work to standardize key clinical best practices • Clinical pathway development GOAL: Standardization of care, reductions in mortality, complications, and LOS	Q&P/S	2Q21
Readmission Teams (AMI (non-STEMI), PN, HF) • 6 Sigma Process with Kaizen Events GOAL: Reduction of readmissions	Q&P/S	2Q21 (staggered, 1 per quarter)

Outcomes	FY21	FY22	FY23
COPD Mortality o/e	-10%	-5%	-5%
AMI 30 Day Readmission	11.98% (-5%)	11.98% (-5%)	11.98% (-5%)
CABG 30 Day Readmission	8.64% (-5%)	8.64%	8.64%
Heart Failure 30 Day Readmission	16.84% (-10%)	15.00%(-5%)	14.25%(-5%)
COPD 30 Day Readmission	10.00% (-10%)	9.5% (-5%)	9.05% (-5%)
Pneumonia 30 Day Readmission	15.38%	14.61% (-5%)	13.88% (-5%)
Hip/Knee 30 Day Readmission	0	0	0

2021 Strategies Summary: Best Practice Teams

AMI (non-STEMI), COPD, Heart Failure & Pneumonia

Initiation

- Prioritized & staggered
- Team identification: Q&P/S Facilitator, MD Champion, RN Director, process stakeholders
- Best Practice Guideline selection

Goal: Identify clinical processes that will yield optimal patient outcomes

Phase I

- Clinical KPIs Selection
- Measures defined
- Dashboard developed
- Initial QI work (ie. power plan optimization/ work flow) to achieve targets

Goal: Identify KPIs that will reduce mortality o/e & complications (2° LOS & Readmission)

Phase II

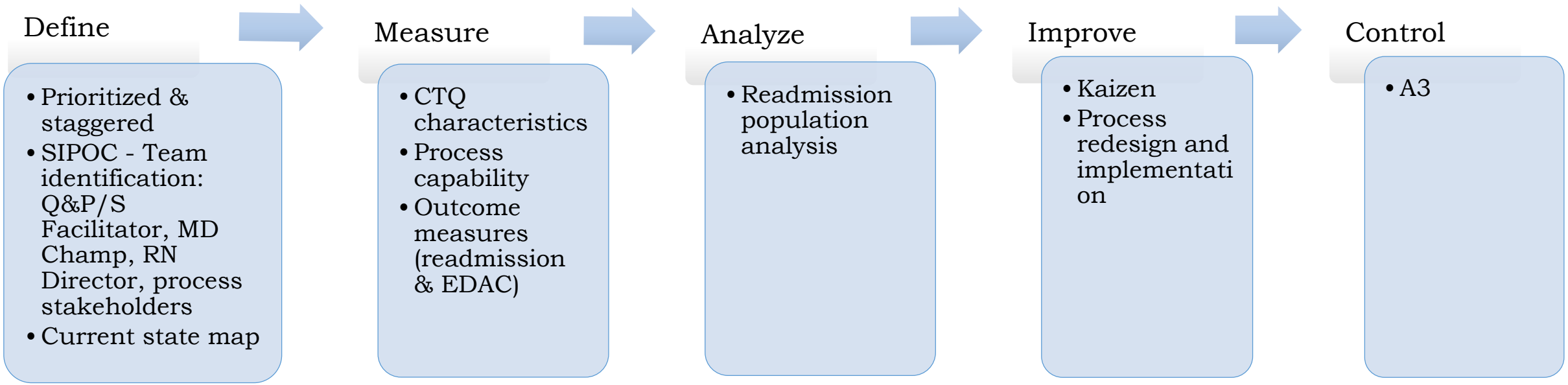
- Care Pathway developed
- Integrated into Cerner power plans & workflow
- QI Measures added to dashboard
- QI work to achieve targets

Goal: Improve efficiency and further reductions in LOS, mortality o/e & readmission

2021 Strategies Summary: Best Practice READMISSION Teams

AMI (non-STEMI), COPD, Heart Failure & Pneumonia

Six Sigma Approach with Kaizen/Rapid Improvement Event



2021 Strategies Summary for: Leapfrog/NQF Safe Practices

Initiative	Person Responsible	Date/Time
Safety Attitudes Questionnaire (SAQ) Administration GOAL: obtain data using a scientifically validated tool to measure safety culture at the unit and organizational level.	Sandy Volchko	Feb 2021
Safety Attitudes Questionnaire (SAQ) Results Dissemination GOAL: Analysis of SAQ results by location, role, safety culture category to identify trends and measure previous QI strategies and target new QI strategies	SV	Apr-May 2021
SAQ Unit/Dept Action Plans GOAL: To develop meaningful unit level action plans based on SAQ data and input solicit from staff during debrief sessions	Unit Leaders	June 2021
TeamSTEPPS Leadership Cohort #3 (medical team training) GOAL: Provide evidenced-based tools for leadership to implement in their work settings to improve teamwork climate and patient safety	SV	2Q21
TeamSTEPPS Staff Simulation Training offering (medical team training) GOAL: Provide evidenced-based tools for staff to use in their daily work to improve teamwork climate and patient safety	SV	2Q21
Just culture staff awareness campaign GOAL: To increase safety climate by use of just culture	Laura Goddard	March 2020
CUSP program enhancements GOAL: Improve safety and teamwork climate and adverse events at the unit level with highly effective unit-level safety teams	SV	2Q21

Outcomes	FY21	FY22	FY23
Leapfrog/NQF Safe Practice Score	100% of points	100% of points	100% of points

Risk Management Strategic Development

Implement and maintain organization-wide Risk Control strategies and programs to support high quality, customer-oriented, and financially strong healthcare services that meet the needs of those we serve

- Improve engagement and transparency in established event review forums
- Develop Leadership skills through Just Culture and Error Reduction techniques and training
- Proactive Risk Assessments to prevent losses
- "Zero Defect and Zero Harm" initiatives
- Develop Best Practices in Health care Risk Mitigation: Enterprise Risk Management

Key Current Initiatives:

Initiative	Person Responsible	Date
RCA2 (Root Cause Analysis and Action)	Alexandra Bennett/Mia Bonvie	June 2021
Risk Assessment	Alexandra Bennett/Enriqueta Santoyo	May 2021
Clinical Risk Management Dashboard	Alexandra Bennett	March 2021
Risk Control Survey of Walkways	Alexandra Bennett/Laree Irving	February 2021
Leadership Development for Risk Mitigation	Alexandra Bennett/Enriqueta Santoyo	July 2021
Occurrence Reporting System Process Update	Alexandra Bennett	January 2021
Risk Management Staff Lean Six Sigma Training	Alexandra Bennett	December 2021

Strategy Summary for: Risk Control

Strategic Initiative: Outstanding Health Outcomes

Achieve ZERO DEFECTS and ZERO PATIENT HARM events: Wrong side/Wrong Patient/Wrong Procedure

Key Components

Initiative	Person Responsible	Date/Time
2 ID Mandatory Education	Alexandra Bennett	Completed Oct 2020
Armband check at all perioperative transitions of care	Brian Piearcy	February 2021
“Get it RIGHT” Campaign	Renee Lauck	Completed October 2020

Achieve ZERO DEFECTS and ZERO PATIENT HARM events: Safe Management of Patients At Risk for Suicide

Key Components

Initiative	Person Responsible	Date/Time
Suicide Risk Assessment in ED	Alexandra Bennett/Brad Danby	In Progress
“Hands And Head Visible” Education	Kari Knudsen	Completed January 2021
Utilization of Sitters in ED-Communicating Patient Safety Needs	Billy Walker/Brad Danby	Completed December 2020

Strategic Goals: ZERO DEFECTS / ZERO PATIENT HARM

Strategic Initiative: Outstanding Health Outcomes

Objective:

Over the next 2-3 years, achieve a ZERO DEFECTS for NEVER Events through improved engagement, high reliability interventions, reducing variation across clinical practices.

Priority Defects:
• Wrong side/Wrong Patient/Wrong Procedure
• Unintended Retention of Foreign Object (RFO)
• Medication Errors resulting in patient harm
• Mislabeled Lab Specimens
• Failure to provide safe handling of tissues, organs and parts to another facility
• Failure to provide Safe Management of Patients At Risk for Suicide
• Patient Death/Disability associated with Patient Elopement
• Blood Transfusion Errors

Questions?

Reference Slides
2020 Quality Initiatives

2020 Strategies Summary for: CAUTI

Initiative	Person Responsible	Date/Time
Morning Gemba: GOAL - Go to where the work is done to ensure best practices are applied consistently	Unit Managers	March 2020, daily
Addition of CAUTI prevention bundle to daily unit safety huddle	Unit Managers	March 2020
CAUTI Dashboards. GOAL - quantify best practice compliance (overall and unit level) and identify trends, disseminate broadly	Sandy Volchko	April 2020, monthly
Afternoon Gemba (Resident & Q&P/S) GOAL – follow up on am Gemba items to ensure best practices are applied daily	SV	Oct 2020, daily
Create change IUC task at 30 days following documented insertion GOAL- trigger nursing staff to change chronically retained IUC	Kari Knudsen/Sarah Brown	Dec 2020
Hide single Insert IUC orderable for downtown campus and Rehab GOAL: Improve bundle compliance by driving use of the insert IUC Powerplan which contains needed maintenance elements	KK/SB	Oct 2020
Kaizen strategy: evaluate option for time clock for line info GOAL- Improve prompt removal, visual reminder of how long the line has been in place	KK/SB	Nov 2020
CAUTI Case Reviews Lessons Learned GOAL – Reduce CAUTI by ensuring identified opportunities are addressed globally	Kari Knudsen/ Shawn Elkin	Monthly

Outcomes	FY21	FY22	FY23
CAUTI	≤ 0.727	≤ 0.690	≤ 0.656

2020 Strategies Summary for: CAUTI

Initiative	Person Responsible	Date/Time
Bathing Prioritization (in collaboration with CLABSI Committee) GOAL – Improve bathing/peri-care of IUC patients	Amy Baker	Oct 2020 .
Add 'restricted use' to the urine culture only orderable GOAL- reduce use of culture only order in defined populations without accompanying UA	Kari Knudsen/Sarah Brown	July 2020
Develop insert IUC Powerplan to include important maintenance elements: straight cath option prior to IUC insertion, change IUC prior to specimen collection, change IUC at 30 days GOAL- Create and bundle essential orders for IUC maintenance	KK/SB	Aug 2020
Develop provider update/education related to current CAUTI status and how to order IUC/Culturing awareness GOAL- create awareness	KK	Sept 2020
Changes to discontinue IUC orderable- alerts RN to dc the insert IUC Powerplan and related maintain order GOAL- assist with order clean up	KK/SB	Aug 2020
Develop orders for Adult Urinary Retention management GOAL- orders for retention management currently exist as one off options, bundling them together for ease of ordering increases use	KK/SB	Sept 2020

Outcomes	FY21	FY22	FY23
CAUTI	≤ 0.727	≤ 0.690	≤ 0.656

2020 Strategies Summary for: CLABSI/MRSA

Initiative	Person Responsible	Date/Time
Morning Gemba: GOAL - Go to where the work is done to ensure best practices are applied consistently	Unit Managers	March 2020, daily
CLABSI Dashboards. GOAL - quantify best practice compliance (overall and unit level) and identify trends, disseminate broadly	Sandy Volchko	April 2020, monthly
Appropriate TPN Utilization: Design evidence based TPN Utilization Guide GOAL: reduce events related to TPN use	Emma Camarena	Feb 2020
Afternoon Gemba (Resident & Q&P/S) GOAL – follow up on am Gemba items to ensure best practices are applied daily	Sandy Volchko	Oct 2020, daily
Non vent pnuemonia Oral Care Relaunch GOAL: Reduce healthcare acquired pneumonia (r/t MRSA)	Alisha Sandidge	Nov 2020
Biovigil Hand Hygiene (HH) Program GOAL: increase volume of HH observations, HH compliance. Enhance program monitoring through data analysis	Jon Knudsen/Shawn Elkin	Sept 2020

Outcomes	FY21	FY22	FY23
CAUTI	≤ 0.727	≤ 0.690	≤ 0.656

2020 Strategies Summary for: Patient Safety Indicators (PSIs)

Initiative	Person Responsible	Date/Time
PSI Multidisciplinary Committee (MD, HIM, CDI & Q&P/S); peer review and system changes when indicated. GOAL: Multidisciplinary oversight, trend identification and timely follow up	Evelyn McEntire/ Dr. Gray	Ongoing, monthly
Proactive CDI Review, Surgeon champion and Q& P/S review of 13 PSIs GOAL: Timely identification & follow up to coding, care concerns or opportunities for palliative care opportunities	CDI/ Q&P/S	Ongoing, case reviews weekly
Review and analysis of PSI4 - Death Rate among Surgical inpatients with serious treatable conditions GOAL: Trend identification	Evelyn McEntire/ Dr. Gray	October 2020
Rapid Improvement Event: PSI 3 Pressure Ulcer Rate. Developed 4 comprehensive QI strategies GOAL: Reduction in hospital acquired pressure injuries through data-driven QI strategies.	Mary Laufer	November 2020
PSI 7 Central Venous Catheter Related Blood Stream Infection Rate (CLABSI)	See CLABSI	See CLABSI
PSI 13 Postoperative Sepsis rate	See Sepsis	See Sepsis

Outcomes	FY21	FY22	FY23
PSI90	≤ 0.64	≤ 0.61 (-5%)	≤ 0.58

2020 Strategies Summary for (SEP-1) Sepsis Bundle Compliance

Initiative	Person Responsible	Date/Time
2nd Sepsis Coordinator GOAL: Improve bundle compliance and front-line staff/provider education	Q&P/S	May 2020
Sepsis QFT Six Sigma Event GOAL: Improve bundle compliance through org QI strategies developed by subject matter experts	Q&P/S	March 2020
ED - Build and utilize SEP-1A "Catch Up" order set so all bundle components can be ordered GOAL: Reduce bundle fall outs when patient's presentation is not clearly sepsis (ED order set not initially utilized)	Q&P/S & ISS	May 2020
Build dot phrase - If it's not Sepsis, document it GOAL: Reduce bundle fallouts where patients condition did not require bundle elements	Q&P/S	May 2020
Schedule ED and GME regular education/awareness of bundle, and order set usage GOAL: improve physician knowledge of sepsis bundle	Q&P/S	July-Nov 2020
Obtain safety summit compliance rates to validate if new staff are getting instructions upon hire of requirements GOAL: Verify staff receiving appropriate training upon hire	Q&P/S	May 2020
126ml/hr option added to ED AND INPATIENT ADULT SEPSIS order sets GOAL: improve compliance with fluid component of bundle	Q&P/S	May 2020
Admit to CC/3W Orders: Short list of orders… if this not done… for each piece of bundle, this is like a continuation of initial sepsis orders or active "hold" orders to keep the ball rolling. GOAL: Reduce fallouts related to missed bundle elements	Q&P/S	Sept 2020
Dot phrase for when Abx are urgent and BC cannot be drawn beforehand, so provider documentation is in EMR (..sepsis bc) GOAL: Reduce bundle fallouts related to timing of blood cultures	Q&P/S	May 2020
Standardized documentation of attending reassessment (Dr. Malli's phrase) GOAL: Improve compliance with provider reassessment component of bundle	Q&P/S	Aug 2020
Add to ED AND INPATIENT order set Reflex LA order when previous LA >2 GOAL: Improve compliance with lactic acid component of bundle	Q&P/S	April 2020

2020 Strategies Summary for: CMS Mortality and Readmissions

Initiative	Person Responsible	Date/Time
Tulare County Public Guardian (TCPG) Sub-Committee established	Dr Gray	March 2020
CDI Case Review (identification of coding, care concerns, palliative care opportunities)	CDI	Ongoing, completed per case
Provider Letters sent for potential palliative care opportunities	Mortality Committee	Ongoing, completed per case
COPD Readmission team: redesigned discharge and post discharge processes	Sandy Volchko/Dr. Manga	October 2020
HF Readmission Current State Review	Sandy Volchko	October 2020

Outcomes	FY21	FY22	FY23
COPD Mortality o/e	-10%	-5%	-5%
AMI 30 Day Readmission	11.98% (-5%)	11.98% (-5%)	11.98% (-5%)
CABG 30 Day Readmission	8.64% (-5%)	8.64%	8.64%
Heart Failure 30 Day Readmission	16.84% (-10%)	15.00%(-5%)	14.25%(-5%)
COPD 30 Day Readmission	10.00% (-10%)	9.5% (-5%)	9.05% (-5%)
Pneumonia 30 Day Readmission	15.38%	14.61% (-5%)	13.88% (-5%)
Hip/Knee 30 Day Readmission	0	0	0

2020 Strategies Summary for: Leapfrog/NQF Safe Practices

Initiative	Person Responsible	Date/Time
TeamSTEPPS Leadership Training (Medical Team Training) GOAL: Improve teamwork climate SAQ scores	Sandy Volchko	March 2020
Just culture prompts added to manager event follow up GOAL: Improve safety climate SAQ scores	Alexandra Bennett	Nov 2020
Daily Org Safety Huddle GOAL: Improve safety climate SAQ scores	AB	Oct 2020
Medication Safety workgroups addressing bar code scanning GOAL: Achieve and sustain >95% bar code scanning rates in targeted locations	Mary Laufer/Med Safety	Aug 2020, ongoing
Workgroups addressing clinical decision support in CPOE GOAL: Implement evidenced-based clinical decision support that reduced med events	Lacey Jensen	Aug 2020, ongoing
Workgroup addressing safe practices in maternal child health GOAL: Monitor and sustain best practices	Tracie Plunkett	Aug 2020, ongoing
Biovigil hand hygiene program GOAL: increase volume of HH observations, HH compliance. Enhance program monitoring through data analysis	Jon Knudsen/Shawn Elkin	Sept 2020, ongoing
Leader hand hygiene QI tools & resources developed & available on all KD desktops GOAL: increase HH compliance by providing resources to leadership for QI work	SV	Aug 2020
Workgroup addressing nurse staffing and adverse events GOAL: Sustain the collection, analysis and education on events and nurse staffing	Mary Laufer	Aug 2020, ongoing

Outcomes	FY21	FY22	FY23
Leapfrog/NQF Safe Practice Score	100% of points 141/202	100% of points	100% of points

Kaweah Delta Physician Recruitment and Relations
Medical Staff Recruitment Report - January 2021

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

Date prepared: 1/20/2021

Central Valley Critical Care Medicine	
Intensivist	1

Delta Doctors Inc.	
OB/Gyn	1

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

Key Medical Associates	
Internal Medicine/Family Medicine	2

Other Recruitment	
Palliative Medicine	1
Neurology	1
Orthopedic Surgery (Trauma)	1

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

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

Candidate Activity						
Specialty/Position	**Group**	**Last Name**	**First Name**	**Availability**	**Referral Source**	**Current Status**
Colorectal Surgery	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Ota, M.D.	Kyle	08/21	Current KD General Surgery resident	Offer accepted; Contract signed
Dermatology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Totoraitis, M.D.	Kristin	08/21	Direct - 1/12/21	Initial phone call: 1/22/21 at 11AM
Family Medicine	Visalia Family Practice	Suleymanova, M.D.	Violetta	04/21	Direct -4/21/20 UCSF Fresno Career Fair	Offer pending
Family Medicine - Associate Program Director	Kaweah Delta Faculty Medical Group	Ramirez, M.D.	Magda	ASAP	Current Core Faculty with Kaweah Delta Faculty Medical Group	Interview pending dates
Family Medicine Core Faculty	Kaweah Delta Faculty Medical Group	Bassali, M.D.	Mariam	08/21	Referred by Dr. Martinez - 10/14/20	Site visit pending dates
Family Medicine Core Faculty	Kaweah Delta Faculty Medical Group	Mohamed, M.D.	Hashem	ASAP	Direct Referral - Dr. Ahmed Amari	Site visit pending dates
Family Medicine Core Faculty	Kaweah Delta Faculty Medical Group	Mora-Roman Jr., MD	Ruben	08/21	Direct Referral - Dr. Rafael Martinez	Site visit pending dates
Family Medicine Core Faculty	Kaweah Delta Faculty Medical Group	Reed, M.D.	Jennifer	08/21	Vista Staffing - 1/18/21	Currently under review
Family Medicine Core Faculty	Kaweah Delta Faculty Medical Group	Sandoval, M.D.	Omar	08/21	Referred by Dr. Martinez - 8/14/20	Site Visit: 11/24/20
Gastroenterology (Hospitalist)	Valley Hospitalist Medical Group	Bharadwaj, M.D.	Shishira	TBD	Direct email - 12/30/20	Currently under review
Hospitalist	Central Valley Critical Care Medicine	Day, M.D.	Eric	09/21	Direct referral - Dr. Diana Moers	Virtual Interview: 1/4/20
Hospitalist	Central Valley Critical Care Medicine	Malhasian, M.D.	Armen	09/21	Direct referral - Dr. Liza Diramerian	Virtual Interview: 1/19/20
Hospitalist	Central Valley Critical Care Medicine	Malik, M.D.	Sara	08/21	Direct - Dr. Umer Hayyat's spouse	Site Visit: 10/7/20; Offer accepted
Intensivist	Central Valley Critical Care Medicine	John, D.O.	Avinaj	08/21	Vista Staffing - 10/25/19	Site visit: 12/13/19; Offer accepted
Intensivist	Central Valley Critical Care Medicine	Akinjero, M.D.	Akintunde	08/21	Vista Staffing - 10/20/20	Virtual Interview: 11/30/20 Offer accepted

Candidate Activity						
Specialty/Position	**Group**	**Last Name**	**First Name**	**Availability**	**Referral Source**	**Current Status**
Intensivist	Central Valley Critical Care Medicine	Alperstein, M.D.	Adam	08/21	Vista Staffing - 9/21/20	Site visit: 12/11/20; Reviewing draft contract
Intensivist	Central Valley Critical Care Medicine	Fischer, M.D.	Brian	TBD	Comp Health - 11/4/20	Currently under review
Intensivist	Central Valley Critical Care Medicine	Leger, M.D.	Kathleen	08/21	Comp Health - 8/24/20	Virtual Interview pending dates
Intensivist	Central Valley Critical Care Medicine	Shaikh, M.D.	Mohammed	ASAP	Direct - 12/24/20	Offer extended for part-time
Maternal Fetal Medicine	Valley Children's Health Care	Behl, D.O.	Esha	04/21	Valley Children's Health Care	Site visit: 12/4/20; Offer extended
Orthopedic Surgery - Hand	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Tomooka, D.O.	Beren	08/21	Direct referral	Phone Interview: 12/2/20; Site visit pending dates (Tentative - 2/19/21)
Orthopedic Surgery - Total Joint	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Amin, M.D.	Raj	08/20	Direct referral	Currently under review
Otolaryngology APP	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Pascillas	Amanda	ASAP	Indeed posting	Interview: 12/11/20
Palliative Medicine	Independent	Grandhe, M.D.	Sundeep	08/21	Direct -12/7/20	Virtual Interview: 12/28/20; Offer extended
Radiation Oncology	Sequoia Radiation Oncology Services, Inc.	Ly, M.D.	David	02/21	Direct referral	Offer accepted; Start date: 2/1/21
Urology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Patel, M.D.	Neil	TBD	Los Angeles Career MD Fair 9/14/19	Site Visit: 9/25/20; Offer extended

Kaweah Delta Health Care District
Report to the Board of Directors

Sequoia Surgery Center
January 2021

Gary Herbst, CEO
624-2330

Summary Issue/Service Considered

Sequoia Surgery Center (SSC), a California limited liability company (LLC), was formed on August 1, 2010 upon the merger of Cypress Surgery Center (CSC) and the Center for Ambulatory Medicine & Surgery (CAMS). SSC operates a four-suite ambulatory surgery center where they performed approximately 5,600 outpatient surgeries and endoscopic procedures during 2019 but finished 2020 down more than 9% due to the coronavirus pandemic. Surgery services include orthopedics, general, gynecological, urological, plastic, podiatric, pain management and ENT. SSC gastroenterologists also perform a significant number of endoscopic procedures at the Center, primarily colonoscopies, which accounted for approximately 28% and 22% of SSC's annual case volume in 2019 and 2020, respectively.

SSC is owned by seventeen (17) surgeons and Kaweah Delta Health Care District. SSC is owned 69.4% by physicians and 30.6% by the District. SSC is governed and managed by a formal Board of LLC members, including the District, elected to the Board by the LLC members, and is jointly chaired by Drs. Alex Lechtman and Burton Redd. Director Garth Gibson serves as the District representative on the SSC Board of Members. Anesthesiology services are provided by independent anesthesiologists. Dr. Burton Redd, orthopedic surgeon, serves as SSC's Medical Director, and Tricia Vetter, a former charge nurse with Kaweah Delta Health Care District, serves as the Center's Administrator.

In conjunction with the merger of CSC and CAMS, CSC created a separate limited liability company, Cypress Company, LLC (CyCo), to which it transferred all real estate assets (land and building), along with the associated mortgage debt, as well as cash, accounts receivable and certain debt incurred with the buy-out of partner interests. CyCo leases the surgery facility to SCC under a long-term operating lease. CyCo is owned by ten (10) surgeons (all former members of CSC) and Kaweah Delta Health Care District. CyCo is owned 60.0% by physicians and 40.0% by the District.

Financial/Statistical Information
January 1 to December 31 (Compiled Financial Statements):

Year	Case Volume	Net Revenue	Operating Costs	Net Income
2020	4,777	$11,143,860	$10,167,830	$976,030
2019	5,583	11,995,271	10,178,721	1,816,550
2018	5,004	10,684,620	9,352,295	1,332,325

Note: 2020 results have been annualized based on actual year-to-date results through the ten-months ended October 31, 2020. Case volume and net income was significantly impacted by the arrival of the coronavirus pandemic which caused many outpatient surgeries and procedures to be cancelled by physicians and/or patients. The biggest drop in cases occurred in the months of April, May and June but began to return to historical levels later in the summer and fall. Not included in the 2020 results above is approximately $711,000 in Payroll Protection Program (PPP) funds received by SSC from the federal government in the summer of 2020. Given that SSC has fully satisfied all of the use and reporting requirements of the PPP program, SSC is entitled to retain all of these funds and record it as income to help offset payroll costs that continued to be incurred throughout the pandemic, despite the significant decline in patient volumes. With the PPP funds, adjusted net income for 2020 is projected to come in close to $1.7 million.

Quality/Performance Improvement Data
1. SSC is fully accredited by the Accreditation Association for Ambulatory Health Care (AAAHC). AAAHC awards three-year accreditations similar to the JCAHO. SSC was just recently surveyed by AAAHC in December 2020, and is anxiously awaiting their accreditation survey results; SSC management expects to receive full accreditation based on the preliminary observations and comments made by the surveyors during the exit conference.

Policy, Strategic or Tactical Issues
1. SSC's primary competition for outpatient surgery includes the District, Sierra Pacific Orthopedic Center (Fresno), and private physician offices.

2. SSC's primary strategy for growing and retaining its business is to selectively offer ownership interests to active, community surgeons with an interest in actively managing and using the Center. Additionally, SSC management and physician leaders actively reach out to new physicians that enter the marketplace, offering SSC as an alternative to Kaweah Delta and other surgical facilities. During 2019, SSC sold ownership interests to the following physicians: Seth Criner, orthopedic surgeon; Jason Mihalcin, orthopedic surgeon; Kyle Potts, general surgeon; and Kazi Rahman podiatrist. Dr. Jim Guadagni and Dr. Don Schengel, orthopedic surgeons, sold their ownership interests back to SSC in connection with their retirements.

3. During 2019, SSC discovered the presence of significant water damage to its facility's roof, walls and internal infrastructure, apparently caused by flaws in the original design and construction of the facility, and engaged Seals Construction to complete the

necessary repairs and renovations. At a total cost of approximately $1.0 million, the work has been fully completed. Citizens' Business Bank financed the project with a line of credit secured by the real estate and personal guarantees of the physician owners of CyCo. CyCo was solely responsible for the cost of these repairs.

4. In conjunction with item #3, SSC and CyCo have also been evaluating the physical expansion of its facility to create a dedicated comprehensive outpatient GI center. This interest and opportunity was solidified by Kaweah Delta's decision to not build a free-standing GI Center on the west side of its downtown hospital campus but rather to pursue a joint-venture expansion with SSC and CyCo. After considerable study and analysis, the SSC and CyCo owners subsequently agreed to modify their original plans for a new endoscopy center and alternatively construct a new 4-suite ambulatory surgical center to be located approximately 30 feet from the current SSC facility. After more than two years of planning, financial analysis and consideration of multiple iterative design options, this facility is now projected to cost approximately $15.5 million and will add 18,856 square feet to the SSC/CyCo campus. Citizen's Business Bank had previously agreed to provide both the construction and permanent financing but that was before the final above-referenced iteration and cost estimates were developed.

   When last presented to the SSC and CyCo partners, it appeared likely that the physician owners would invest a minimum of $800,000 in the project and would look to Kaweah Delta to fund the remaining $1.8 million of equity investment required by the Bank, thereby increasing Kaweah Delta's ownership stake above its current 40%. However, with the revised project design, cost and associated equity expectation of the Bank, Kaweah Delta would be required to invest as much as $2.3 million (and own 64.0% of the equity) if the physicians hold tight with their $800,000 commitment.

   After all said, another joint meeting of the SSC and CyCo owners was held on Wednesday, December 9th, at which in-depth discussion occurred relative to a "go, no-go" decision on moving forward with the proposed expansion project. After extensive discussion and debate, a super-majority of the members present voted to defer the project for an indefinite period of time. It was felt that given the current pandemic environment, the great uncertainty associated with it, and the existence of excess surgical capacity within the current SSC facility, this was not the time to take on a major construction project and the debt that comes with it.

Recommendations/Next Steps/Approvals/Conclusions

SSC will continue to emphasize high-quality, customer-oriented, and personal outpatient surgery services to physicians and patients of Visalia with the objective of differentiating itself from the more institutional feel of a large hospital system. It will actively evaluate opportunities to recruit new physicians to its Center and offer membership ownership opportunities when appropriate. It will continue to evaluate low margin services and replace them with high margin services. It will continue to evaluate opportunities to reduce supply costs through consolidation or change of vendors and more efficient utilization and it will focus on improving overall economies of scale made possible by the merger of CSC and CAMS.

Kaweah Delta
HEALTH CARE DISTRICT

Environment of Care
3rd Quarter Report
July 1, 2020 through September 30, 2020

Presented by
Maribel Aguilar, Safety Officer
559-624-2381

Kaweah Delta Healthcare District
Performance Monitoring 3rd Quarter 2020

EOC Component: SAFETY

Performance Standard:

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

Evaluation:

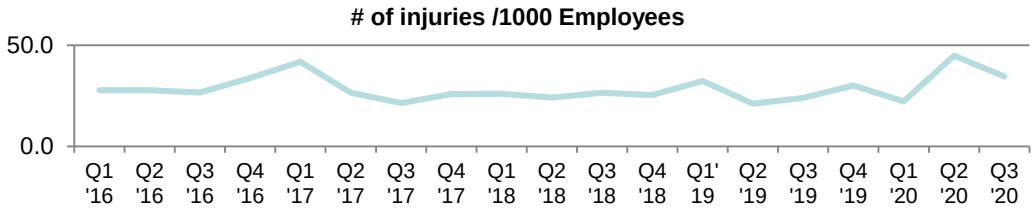
There were 121 Occupational Safety & Health Administration (OSHA) reportable injuries during the 3rd quarter 2020.

Provided 6 ergonomic evaluations in 3rd quarter to prevent cumulative trauma injuries/claims.

We had 33 sharps exposures during 3rd quarter 2020.

There were 63 Covid19+ cases in 3rd Qtr. All of which were OSHA recordable, therefore without Covid19+ 3rd Qtr. OSHA recordable cases goal would be met.

Goal for 3rd quarter was not met.



Type of injury	Q1	Q2	Q3	Q4	Totals 2020	Annual % chg	Totals 2019	Per 1000 employees
Total Incidents	112	226	177		515	30.3%	527	34.54
OSHA recordable	43	117	121		281	74.3%	215	23.61
Lost time cases	20	99	96		215	100.5%	143	18.73
Strain/sprain	27	26	21		74	-7.8%	107	4.10
Bruise/ Contusion	6	5	2		13	-51.9%	36	0.39
Cum Trauma	1	1	0		2	-46.7%	5	0.00
Sharps Exp	21	13	22		56	-6.7%	80	4.29
Covid 19+	4	71	63		138	n/a	0	12.29
BBF Splash	5	0	4		9	-36.8%	19	0.78
# EE end of QTR	5037	5036	5125					

Plan for Improvement:

- Identify employees with ≥ 3 OSHA recordable injuries in last 2 year. This number has been very minimal, we will continue to evaluate monthly. Identify trends and educational opportunities. Detail will be sent to Managers/Directors to determine prevention opportunities, re-education and/or re-training.
- Departments with 3 or more OSHA recordable injuries Qtr. 3- NONE. Same day on-site incident investigation with employee. Follow-up with manager for prevention opportunities and/or process changes and policy review. Investigation/ follow-up may include photos, video and interview of witnesses/ manager.
- Increase sharps education in general orientation by Infection Prevention and Manager orientation by EHS. Demo correct sharps activation in new hire physicals with all Employee handling sharps.
- Utilize physical therapy assistant in Employee Health for Ergonomigs evaluations, evaluate for proper body mechanics to prevent injury, stretching exercises and equipment recommendations to ensure safety with our jobs.

OSHA recordable injuries and Illnesses are as follows:
- Fatalities (reportable)
- Hospitalizations (reportable)
- Claim with lost work day, or modified work with restrictions (recordable)
- Medical treatment other than First Aid (recordable)

EOC Component: EMERGENCY PREPAREDNESS

Performance Standard:

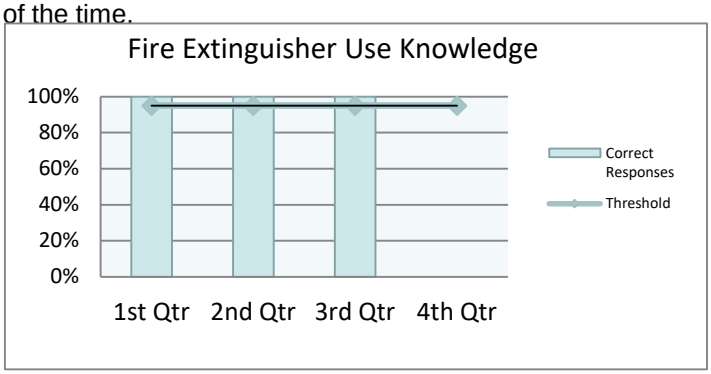
During routine hazard surveillance rounds employees will be queried on proper use of a fire extinguisher
Goal: 100% Compliance.

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

Evaluation:

Ten departments were surveyed in the 3rd quarter. In all departments surveyed staff were able to verbalize proper use of the fire extinguisher, which resulted in a 100% compliance rate.

Goal for 3rd quarter was met.



Plan for Improvement:

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

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

EOC Component: SAFETY

Performance Standard:

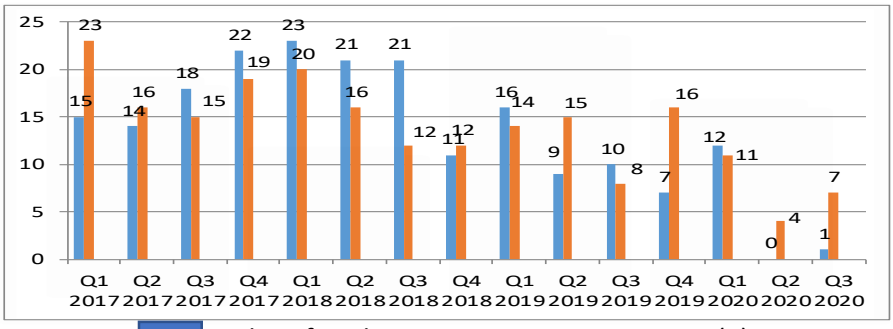
Risk Management: Non-patient injuries will be monitored to ensure reports are made within 7 days of events.
Goal: 100% of non-patient safety related events reported within 7 days
Minimum Performance Level: 90% of events reported within 7 days.

Evaluation:

There were 7 non-patient safety reports filed during the 3rd quarter 2020, all were received within 7 days of event.

Goal for 3rd quarter was met.

Risk Management – Non-Patient Safety Reports Filed



The Lifestyle Center Event Report – One (1) Event
District Except TLC – Seven (7) Events

Plan for Improvement:

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

Handrails were installed in the parking lot near the entrance of the Chronic Disease Clinic to prevent patient trips/falls.

EOC Component: SECURITY

Performance Standard:

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

Goal: 90% compliance with Code Grey event outcomes.

Evaluation:

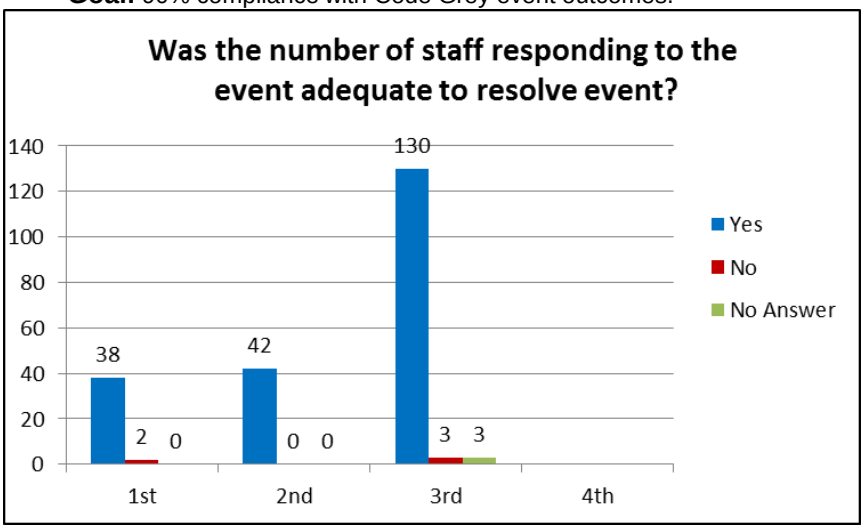
- Item 1: There were 136 recorded code gray events in the Medical Center in the Third Quarter. Out of 136 Code Gray events, 130 events had an appropriate staffing response. Goal for 3rd quarter was met.
- Item 2: Of the 136 reported Code Gray events, 95% of the events resulted in effective role delegation with responding CPI (Crisis Prevention Institute) trained personnel. Goal for 3rd quarter was met.
- Item 3: Of the 136 reported events, 76% of the events resulted in group debriefing after the event.

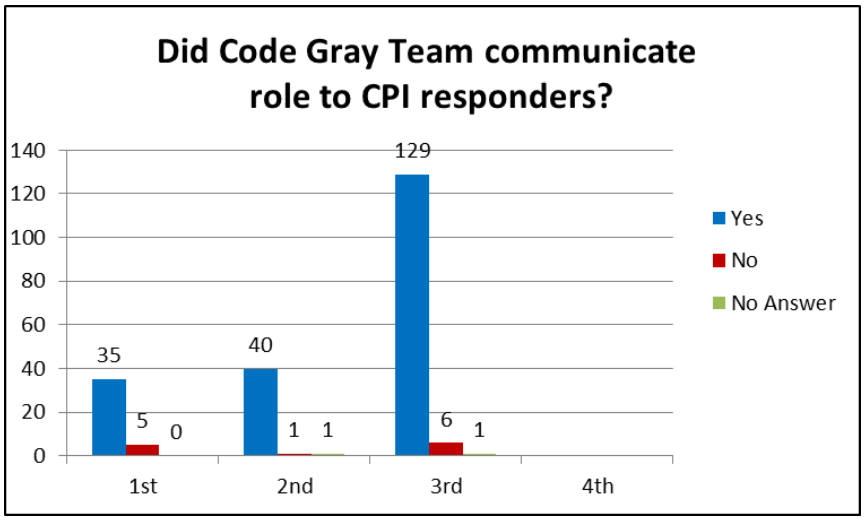
Goal for 3rd quarter was not met.

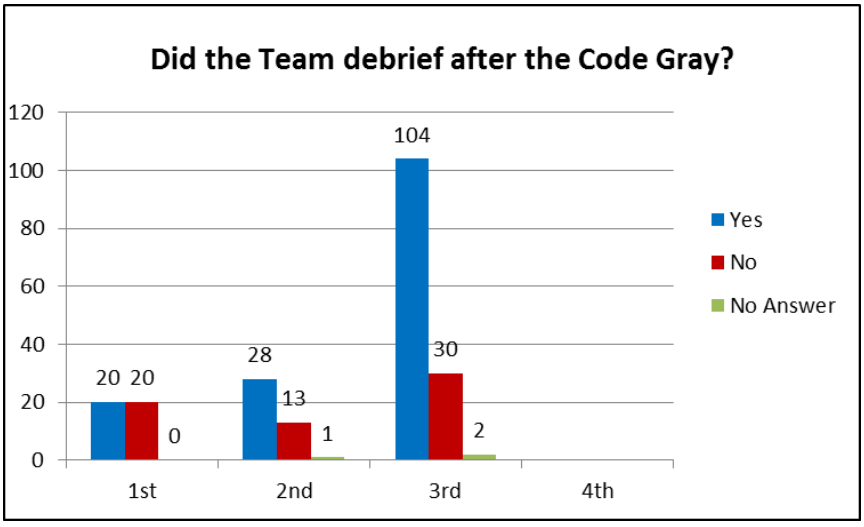
Plan for Improvement:

Code Gray events in the Medical Center increased by 224% from the previous quarter. Security manager is working with Workplace Violence first responders to identify the reason why debriefing is not occurring after every Code Gray event.

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







EOC Component: SAFETY

Performance Standard:

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

Evaluation:

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

Goal for 3rd quarter was met.

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

Plan for Improvement:

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

Continue to monitor.

EOC Component: UTILITIES MANAGEMENT

Performance Standard:

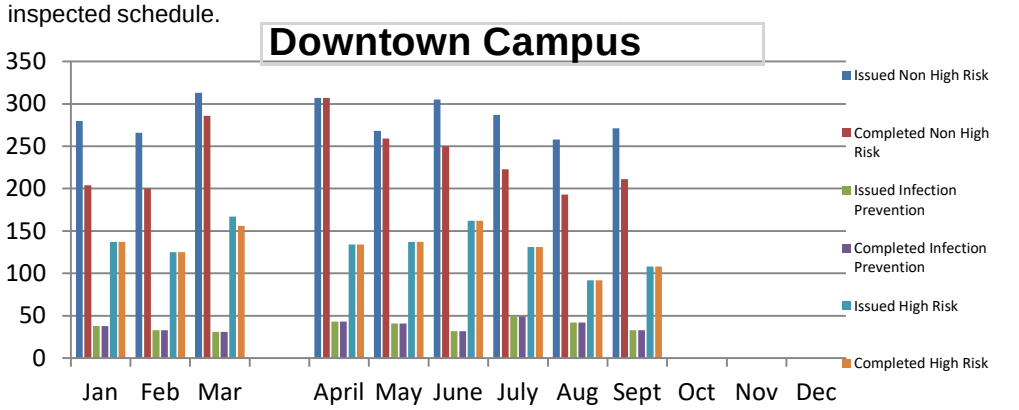
High Risk, Non-High Risk and Infection Control systems preventive maintenance will be performed on a regular basis.
Goal: 100% of **High Risk, Non-High Risk and Infection Control** systems will be serviced and/or inspected on schedule.
Minimum Performance Level: 100% of critical utility systems will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

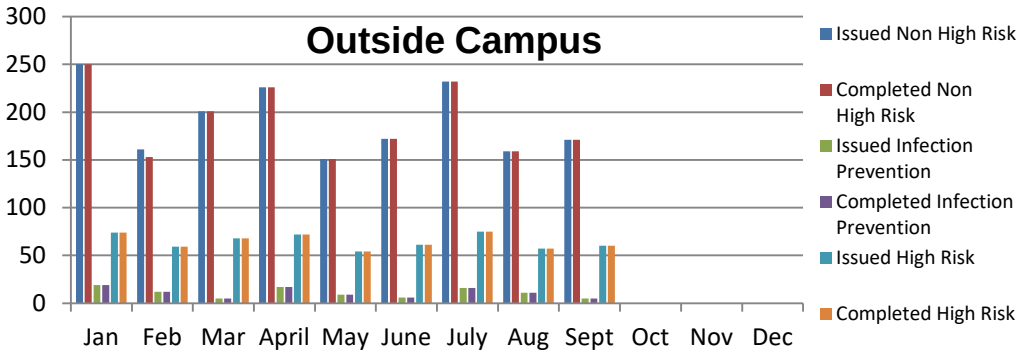
Evaluation:

For the downtown campus there were 687/816 Non-high risk, 124/124 Infection prevention and 331/331 High-risk preventative maintenance work orders completed, an average 85% completion rate. The non-high risk work orders were all related to HVAC in patient rooms, due to census were unable to gain access.

For the outside campus there were 562/562 Non-high risk, 32/32 Infection prevention and 192/192 High-risk preventative maintenance work orders completed, 100% completion rate.

Goal for 3rd quarter was not met.





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

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

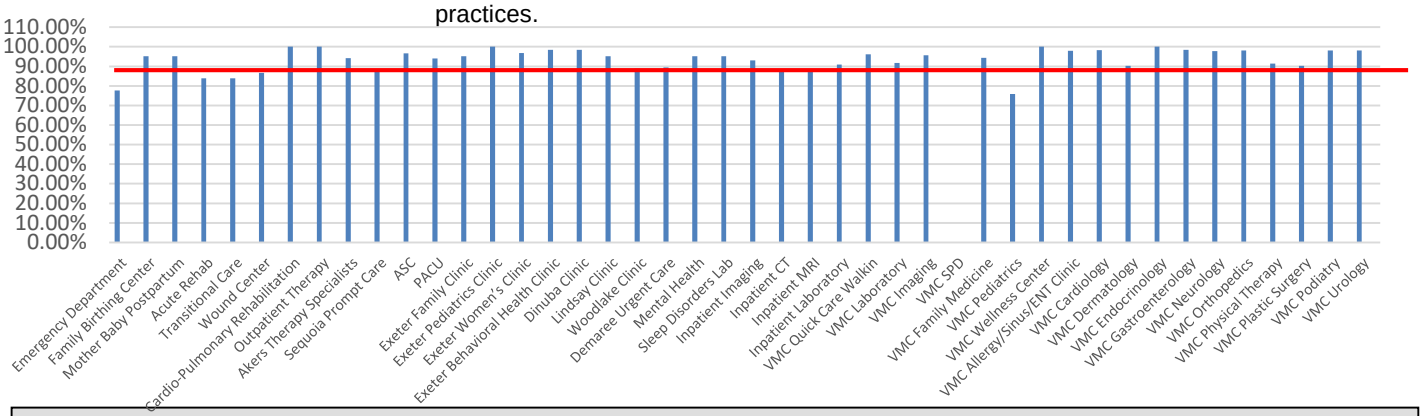
EOC Component: SAFETY

Performance Standard:

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

Goal: Units will demonstrate 100% compliance with IP best practices

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



Evaluation:

During the 3rd quarter many locations achieved 90% or greater compliance with infection prevention practices. Only fallouts were Emergency Department, Acute Rehab, Transitional Care, Wound Care, Sequoia Prompt Care, Woodlake Clinic, Demaree Urgent Care, CT, MRI, VMC Pediatrics, VMC Sequoia Prompt Care.

Goal for 3rd quarter was not met.

Plan for Improvement:

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

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

EOC Component: FIRE PREVENTION/LIFE SAFETY

Performance Standard:

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

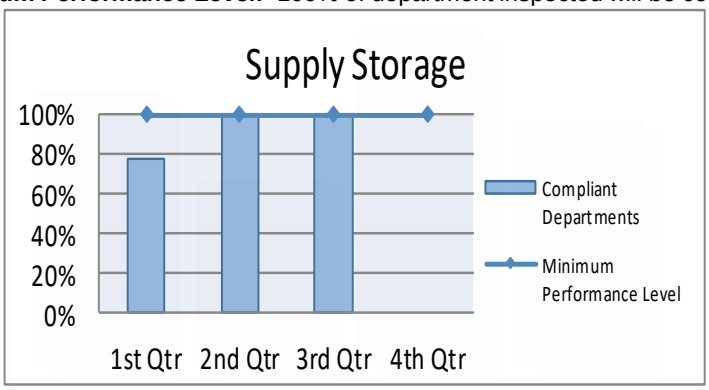
Goal: 100% of departments inspected will be compliant.

Minimum Performance Level: 100% of department inspected will be compliant.

Evaluation:

Ten departments were surveyed in the 3rd quarter. Of all surveyed departments, none were found to have supplies stored too close to the ceiling (18" clearance required). This resulted in an 100% compliance rate.

Goal for 3rd quarter was met



Plan for Improvement:

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

Continue to monitor through rounding during hazard surveillance.

EOC Component:

CLINICAL ENGINEERING 3rd Quarter CY 2020

Performance Standard:

1% of

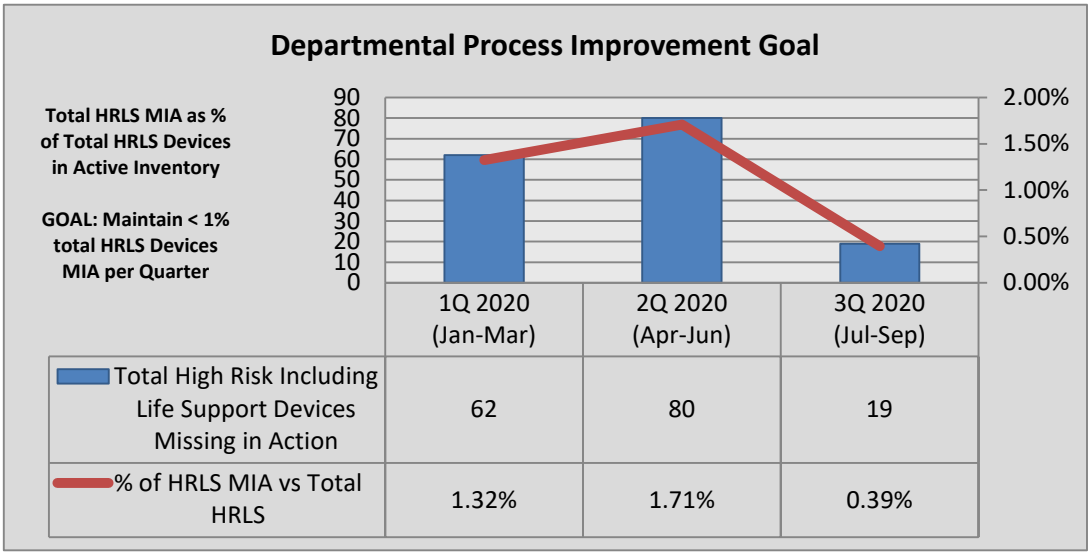
To ensure preventative maintenance completion of High Risk including Life Support Devices is managed effectively; Keep number of missing high risk devices less than total. High Risk Inventory measured quarterly.
Goal: Attain <1% Missing in Action Count on High Risk devices Quarterly.
Minimum Performance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

Evaluation:

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

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

Goal for 3rd quarter was met.



Plan for Improvement:
The data will be reviewed, inventory corrections will be identified and made and the final list of devices officially "Missing in Action" will be distributed to the departments that own the equipment. The department manager will be expected to report on the status of the equipment and make it available for maintenance completion ASAP. Clinical Engineering will continue to search for the device until removed from active inventory.

EOC Component:

CLINICAL ENGINEERING 3rd Quarter CY 2020

Performance Standard:

The Clinical Engineering Department will complete preventative maintenance for 12,184 assigned preventive maintenance tasks as required per policy EOC 6001.
Goal: 100% Compliance **Minimum Performance Level: 100**% Compliance

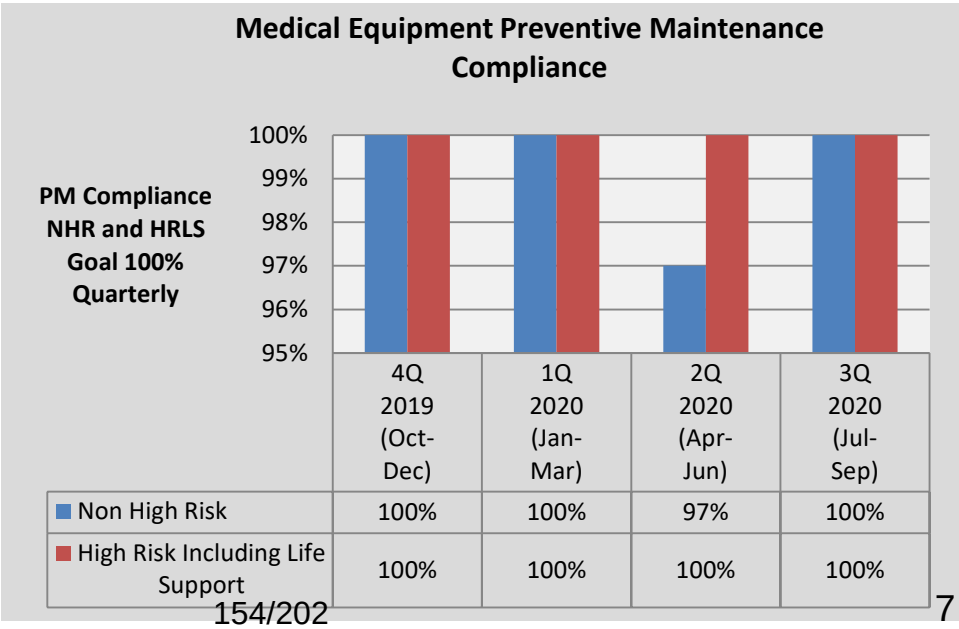
Evaluation:
PM Compliance:

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

3rd Qtr. Compliance 100%
Goal for 3rd quarter was met.

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

3rd Qtr. Compliance: 100%
Goal for 3rd quarter was met.



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

REPORT TO THE BOARD OF DIRECTORS

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

Emma Mozier, MSN, RN, CNML
Director of Medical Surgical Services
559-624-2825
January 25, 2021

Summary Issue/Service Considered

- Case type examples for included medical services:
  - General Medicine: Septicemia, Poisoning & toxic effects of drugs
  - Gastroenterology: G.I. hemorrhage, Cirrhosis & alcoholic hepatitis, Disorders of pancreas & liver, GI Obstruction
  - Neurology: Intracranial hemorrhage or cerebral infarction, Transient ischemia, Seizures
  - Endocrine: Nutritional & misc metabolic disorders, Diabetes, Endocrine Disorders
  - Nephrology: Renal failure, Kidney & urinary tract infections
  - MST: Multiple Significant Trauma, Major Chest Trauma, Traumatic Injury
  - Dermatology: Cellulitis, Trauma to the skin, subcutaneous tissue & breast, Skin Ulcers
  - Urology: Urinary stones w/o lithotripsy w/o MCC, Inflammation of Reproductive System
- Volumes are typically stable for these services, however COVID had a negative impact on the business. Specific Fiscal Year (FY) volume trends:
  - General Medicine, Gastroenterology, Endocrine, MST: stable
  - Neurology, Nephrology, Dermatology, Urology: down more than others
- One of our main trends for FY 2020 is volumes down approx. 9%, while expense trend is increasing on the nursing units
- Length of stay (LOS) opportunity runs approximately 1 day, representing possible savings of $13.6 million annually.
- Contribution margin for the included inpatient medical services is $22.2 million for FY 2020, with $10.8 million provided by supplemental funding.
- Quality initiatives continue to be a focus for our inpatient units: Catheter Associated Urinary Tract Infections-CAUTI, Central Line Associated Blood Stream Infections-CLABSI, Falls, Hospital Acquired Pressure Injuries- HAPI, Surgical Site Infections- SSI.
- Nursing recruitment and retention continue to be a high priority for both nursing leadership as well as our Human Resources department.

Quality/Performance Improvement Data

CLINICAL QUALITY	Organization Wide			
	2Q19	3Q19	4Q19	1Q20
Central line associated blood stream infection (CLABSI)	0.97	1.265	1.821	0.519
Target	0.784	0.784	0.784	0.784
Catheter associated urinary tract infection (CAUTI)	1.33	2.526	0.253	0.659
Target	0.828	0.828	0.828	0.828
Falls/1000 pt days	2.26	2.14	2.34	1.91
Target	2.27	2.3	2.27	2.37
Injury Falls/1000 pt days	0.38	0.5	0.42	0.52
Target	0.47	0.48	0.45	0.49
% pts. Stage 2+HAPI - 1 Day PREVALENCE *Hospital Acquired Pressure Injury				
NDNQI Mean	2.36	1.16	1.65	2.35
	1.87	1.74	1.71	1.96

Quality Focus Teams (QFT) for CLABSI, CAUTI, and HAPI still actively working on quality of care improvements. Each group is working on initiatives related to their focus. Significant changes made in practice around hygiene care, documentation, and necessity of indwelling catheters or central lines. QFT related to HAPI was delayed due to timing of COVID pandemic response, but it was initiated in the last quarter and interventions being developed based on input from team and identified opportunities as presented in quality updates from the team.

Policy, Strategic or Tactical Issues

- All units monitor clinical and LOS performance. As barriers and themes are identified the leaders work with the respective committee groups for support. Our LOS committee is making improvements related to documentation of medical necessity, eliminating barriers related to discharge, improving efficiency of access to care while inpatient and increasing access to consultations. Unit based councils also discuss and brainstorm at the unit level to improve discharge processes, times and follow-up. Interdisciplinary approach is in place to ensure collaboration in the inpatient process for patients receiving timely access to procedures, tests and decisions.
- These particular medical services are often in addition to other reasons for hospitalization. The care for these services is sometimes secondary to another diagnosis and the response for this care can be delayed. Opportunity to ensure length of stay does not end up extendingdue to patients waiting for secondary services that can be followed up in the outpatient settings.
- COVID challenges/barriers: much of the unit or operational leader's ability to put in concentrated work on LOS and quality or other initiatives have been challenged by the overwhelming work to adapt to our COVID pandemic. Entire departments are now dedicated to COVID patient care. At this time, 104 of our medical surgical beds have been converted to strictly COVID patient care and are occupied. This includes all of 2N, 2S, 3N and 4 rooms on 4N. This does not including ICCU and ICU areas that are also dedicated to COVID related care. The focus of the leadership has been on implementing new care standards with changes to universal precautions, support to team members as they cope with the conditions created by caring for patients safely in the pandemic, onboarding to replace open positions, creating staffing plan to changes to ensure care

can be delivered safely with fewer patient care staff, communicating more with families of patients who cannot be at the bedside, and coordinating orientation and education to teams to ensure they understand the frequent changes.

Recommendations/Next Steps

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

Approvals/Conclusions

- Strive for overall quality outcomes and set goals to continue to improve. We still have opportunities to improve LOS as well as quality goals related to CAUTI, CLABSI and HAPI. These are still a primary focus.
- Leadership remains vigilant, reviewing budget reports and striving for financial strength within each department. This includes monitoring staff pay practices, supply management, and LOS.
- Leadership continues to work through employee engagement opportunities and provide support to frontline care staff. We value the team members and want to ensure they have the best environment to care for their patients.

KDHCD ANNUAL BOARD REPORT

FY2020

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

KEY METRICS - FY 2020 Twelve Months Ended June 30, 2020

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
6,854	$82,579,505	$60,403,888	$22,175,617	$1,179,333
▼ -11%	▼ -6%	▲ 1%	▼ -21%	▼ -82%

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

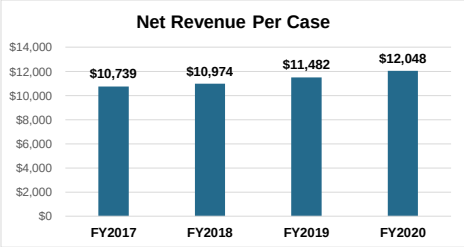
METRICS BY SERVICE LINE - FY 2020

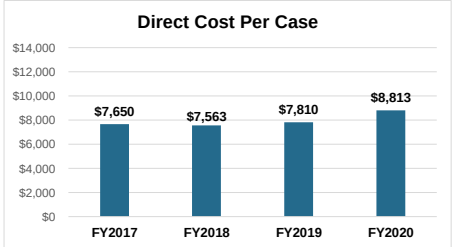
SERVICE LINE	PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
GENERAL MEDICINE	1,886	$29,166,984	$22,162,519	$7,004,465	($506,452)
GASTROENTEROLOGY	1,691	$18,655,872	$13,352,706	$5,303,166	$663,235
NEUROLOGY	1,240	$14,924,602	$10,620,665	$4,303,937	$486,569
ENDOCRINE	828	$7,642,003	$5,371,377	$2,270,626	$361,318
NEPHROLOGY	775	$7,465,335	$5,682,889	$1,782,446	($200,263)
IP MEDICAL TRAUMA	106	$1,849,491	$1,000,670	$848,821	$488,549
DERMATOLOGY	303	$2,660,056	$2,092,690	$567,366	($165,513)
UROLOGY	25	$215,162	$120,372	$94,790	$51,890
IP MEDICAL SERVICES TOTAL	6,854	$82,579,505	$60,403,888	$22,175,617	$1,179,333

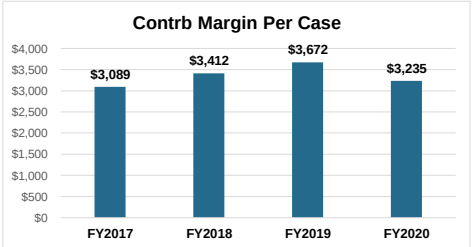
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND	Pre-COVID Ann. Jul. 19 - Feb. 20
Patient Cases	6,816	7,442	7,692	6,854	▼ -11%		7,323
Patient Days	33,361	36,007	35,834	32,330	▼ -10%		33,615
Net Revenue	$73,200,151	$81,671,398	$88,318,532	$82,579,505	▼ -6%		$85,689,118
Direct Cost	$52,144,233	$56,281,930	$60,072,150	$60,403,888	▲ 1%		$62,809,359
Contribution Margin	$21,055,918	$25,389,468	$28,246,382	$22,175,617	▼ -21%		$22,879,759
Indirect Cost	$15,768,490	$20,467,572	$21,589,739	$20,996,284	▼ -3%		$21,884,237
Net Income	$5,287,428	$4,921,896	$6,656,643	$1,179,333	▼ -82%		$995,522
Net Revenue Per Case	$10,739	$10,974	$11,482	$12,048	▲ 5%		$11,701
Direct Cost Per Case	$7,650	$7,563	$7,810	$8,813	▲ 13%		$8,577
Contrb Margin Per Case	$3,089	$3,412	$3,672	$3,235	▼ -12%		$3,124

GRAPHS







Notes:
Source: Inpatient Service Line Reports
Criteria: Inpatient Miscellaneous Medical Services
Criteria: Service Name Kaweah Delta Medical Center

KDHCD ANNUAL BOARD REPORT

FY2020

Inpatient Medical Service Lines - General Medicine

KEY METRICS - FY 2020 Twelve Months Ended June 30, 2020

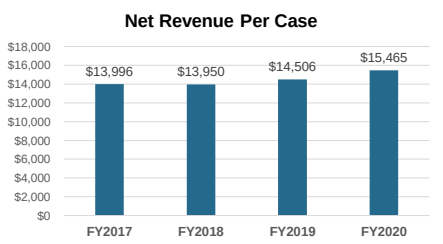
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
1,886	$29,166,984	$22,162,519	$7,004,465	($506,452)
▼ -5%	▲ 1%	▲ 6%	▼ -13%	▼ -163%

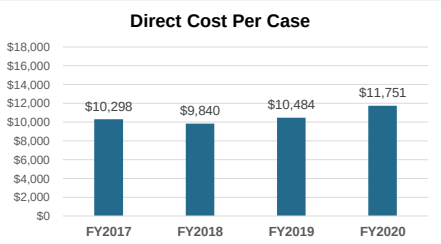
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

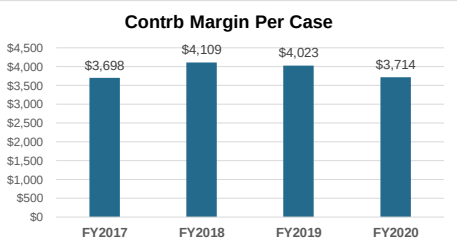
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND	Pre-COVID Ann. Jul. 19 - Feb. 20
Patient Cases	1,620	1,923	1,994	1,886	▼ -5%		1,928
Patient Days	10,029	11,543	11,412	11,078	▼ -3%		10,761
ALOS	6.19	6.00	5.72	5.87	▲ 3%		5.58
GM LOS	4.45	4.40	4.33	4.40	▲ 2%		4.35
Net Revenue	$22,673,032	$26,825,458	$28,925,784	$29,166,984	▲ 1%		$28,372,637
Direct Cost	$16,682,595	$18,922,937	$20,904,525	$22,162,519	▲ 6%		$21,504,428
Contribution Margin	$5,990,437	$7,902,521	$8,021,259	$7,004,465	▼ -13%		$6,868,209
Indirect Cost	$4,975,273	$6,687,867	$7,211,734	$7,510,917	▲ 4%		$7,295,673
Net Income	$1,015,164	$1,214,654	$809,525	($506,452)	▼ -163%		($427,464)
Net Revenue Per Case	$13,996	$13,950	$14,506	$15,465	▲ 7%		$14,720
Direct Cost Per Case	$10,298	$9,840	$10,484	$11,751	▲ 12%		$11,157
Contrb Margin Per Case	$3,698	$4,109	$4,023	$3,714	▼ -8%		$3,563
Opportunity Days	1.74	1.6	1.39	1.47			1.23

PER CASE TRENDED GRAPHS

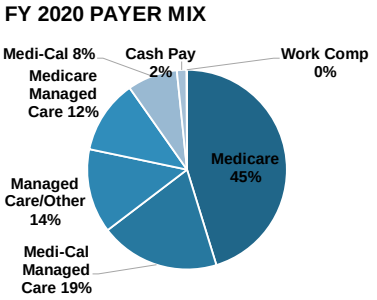






PAYER MIX - 4 YEAR TREND (GROSS CHARGES)

PAYER	FY2017	FY2018	FY2019	FY2020
Medicare	49%	49%	51%	45%
Medi-Cal Managed Care	22%	23%	20%	19%
Managed Care/Other	11%	11%	13%	14%
Medicare Managed Care	10%	10%	10%	12%
Medi-Cal	6%	6%	5%	8%
Cash Pay	1%	0%	1%	2%
Work Comp	0%	0%	0%	0%

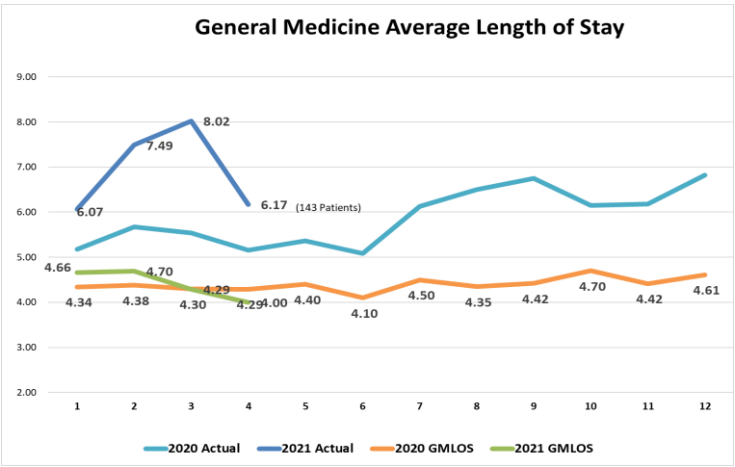


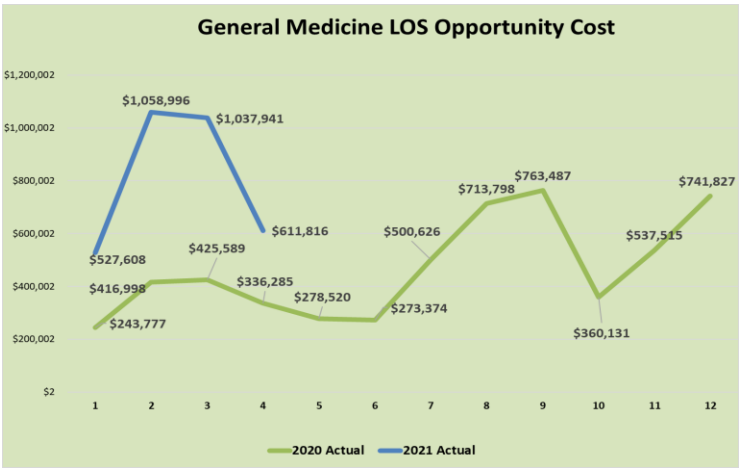
KDHCD ANNUAL BOARD REPORT

FY2020

Inpatient Medical Service Lines - General Medicine

KEY METRICS - FY 2020 Twelve Months Ended June 30, 2020





Notes:
Source: Inpatient Service Line Report
Criteria: Service Name Kaweah Delta Medical Center
Service Line is General Medicine

KDHCD ANNUAL BOARD REPORT

FY2020

Inpatient Medical Service Lines - Gastroenterology

KEY METRICS - FY 2020 Twelve Months Ended June 30, 2020

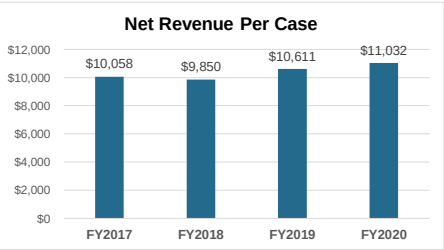
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
1,691	$18,655,872	$13,352,706	$5,303,166	$663,235
▼ -9%	▼ -6%	▲ 5%	▼ -26%	▼ -74%

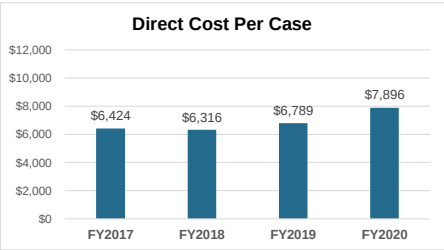
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

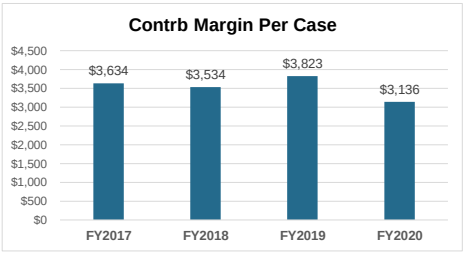
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND	Pre-COVID Ann. Jul. 19 - Feb. 20
Patient Cases	1,824	1,900	1,866	1,691	▼ -9%		1,814
Patient Days	7,882	7,885	7,917	7,107	▼ -10%		7,590
ALOS	4.32	4.15	4.24	4.20	▼ -1%		4.19
GM LOS	3.53	3.49	3.44	3.42	▼ -1%		3.40
Net Revenue	$18,345,768	$18,714,659	$19,800,872	$18,655,872	▼ -6%		$19,568,604
Direct Cost	$11,716,466	$12,000,526	$12,667,364	$13,352,706	▲ 5%		$14,269,737
Contribution Margin	$6,629,302	$6,714,133	$7,133,508	$5,303,166	▼ -26%		$5,298,867
Indirect Cost	$3,614,988	$4,492,315	$4,602,949	$4,639,931	▲ 1%		$4,964,120
Net Income	$3,014,314	$2,221,818	$2,530,559	$663,235	▼ -74%		$334,748
Net Revenue Per Case	$10,058	$9,850	$10,611	$11,032	▲ 4%		$10,791
Direct Cost Per Case	$6,424	$6,316	$6,789	$7,896	▲ 16%		$7,869
Contrb Margin Per Case	$3,634	$3,534	$3,823	$3,136	▼ -18%		$2,922

PER CASE TRENDED GRAPHS

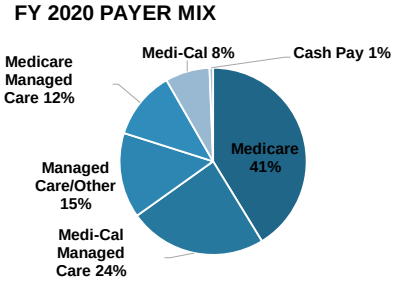






PAYER MIX - 4 YEAR TREND (GROSS CHARGES)

PAYER	FY2017	FY2018	FY2019	FY2020
Medicare	48%	45%	41%	41%
Medi-Cal Managed Care	21%	24%	25%	24%
Managed Care/Other	18%	15%	15%	15%
Medicare Managed Care	5%	8%	9%	12%
Medi-Cal	5%	7%	8%	8%
Cash Pay	0%	1%	1%	1%

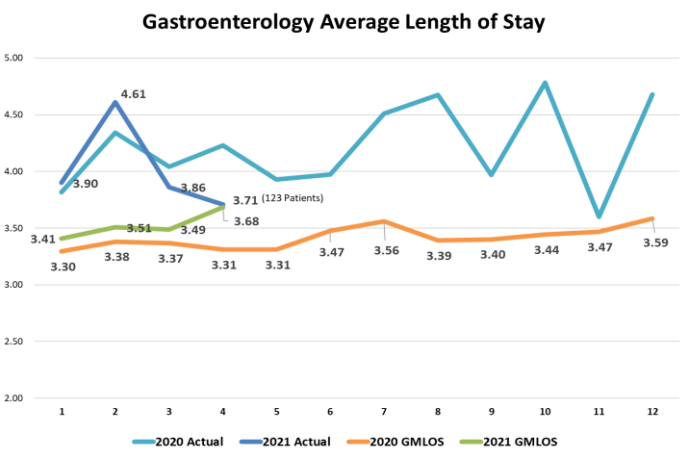


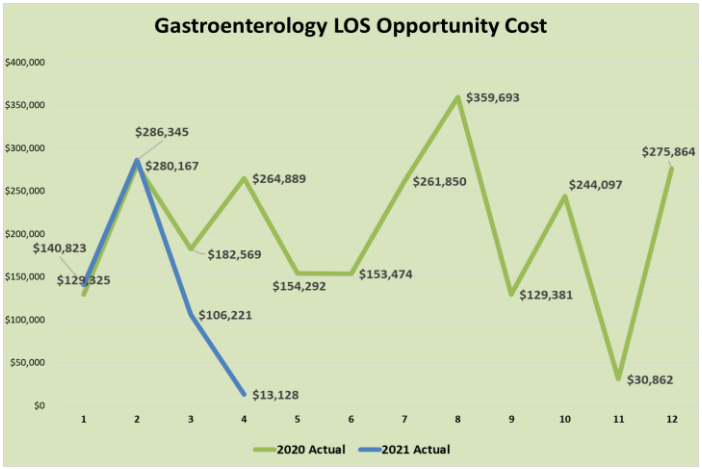
KDHCD ANNUAL BOARD REPORT

FY2020

Inpatient Medical Service Lines - Gastroenterology

KEY METRICS - FY 2020 Twelve Months Ended June 30, 2020





Notes:
Source: Inpatient Service Line Report
Criteria: Service Name Kaweah Delta Medical Center
Service Line is Gastroenterology and account type is medical

KDHCD ANNUAL BOARD REPORT

FY2020

Inpatient Medical Service Lines - Neurology

KEY METRICS - FY 2020 Twelve Months Ended June 30, 2020

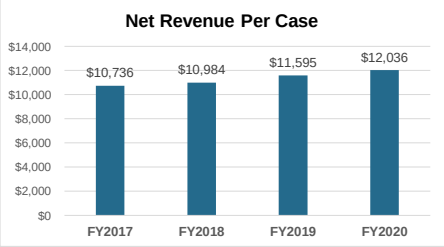
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
1,240	$14,924,602	$10,620,665	$4,303,937	$486,569
▼ -18%	▼ -15%	▼ -9%	▼ -28%	▼ -71%

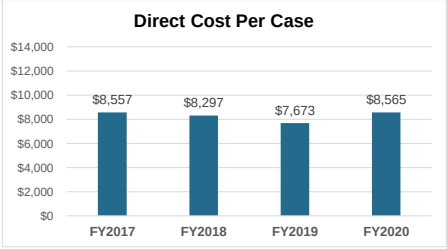
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

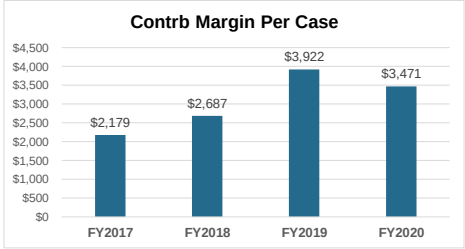
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND	Pre-COVID Ann. Jul. 19 - Feb. 20
Patient Cases	1,130	1,317	1,517	1,240	▼ -18%		1,368
Patient Days	5,436	6,364	6,874	5,913	▼ -14%		6,390
ALOS	4.81	4.83	4.53	4.77	▲ 5%		4.67
GM LOS	3.44	3.41	3.33	3.33	▶ 0%		3.32
Net Revenue	$12,131,600	$14,466,118	$17,589,624	$14,924,602	▼ -15%		$16,221,593
Direct Cost	$9,669,105	$10,927,354	$11,640,446	$10,620,665	▼ -9%		$11,526,888
Contribution Margin	$2,462,495	$3,538,764	$5,949,178	$4,303,937	▼ -28%		$4,694,705
Indirect Cost	$2,784,126	$3,870,245	$4,278,073	$3,817,368	▼ -11%		$4,157,949
Net Income	($321,631)	($331,481)	$1,671,105	$486,569	▼ -71%		$536,756
Net Revenue Per Case	$10,736	$10,984	$11,595	$12,036	▲ 4%		$11,858
Direct Cost Per Case	$8,557	$8,297	$7,673	$8,565	▲ 12%		$8,426
Contrb Margin Per Case	$2,179	$2,687	$3,922	$3,471	▼ -11%		$3,432

PER CASE TRENDED GRAPHS



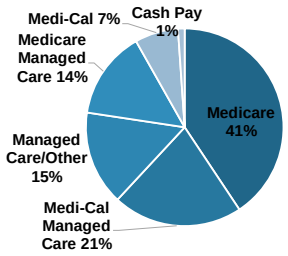




PAYER MIX - 4 YEAR TREND (GROSS CHARGES)

PAYER	FY2017	FY2018	FY2019	FY2020
Medicare	49%	49%	46%	41%
Medi-Cal Managed Care	19%	19%	20%	21%
Managed Care/Other	13%	13%	14%	15%
Medicare Managed Care	10%	10%	12%	14%
Medi-Cal	6%	6%	7%	7%
Cash Pay	1%	1%	1%	1%

FY 2020 PAYER MIX



Notes:
Source: Inpatient Service Line Report
Criteria: Service Name Kaweah Delta Medical Center
Service Line is Neurology and account type is medical

KDHCD ANNUAL BOARD REPORT

FY2020

Inpatient Medical Service Lines - Endocrine

KEY METRICS - FY 2020 Twelve Months Ended June 30, 2020

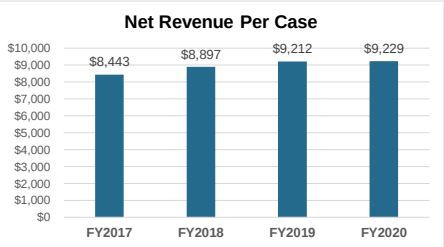
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
828	$7,642,003	$5,371,377	$2,270,626	$361,318
▼ -3%	▼ -3%	▶ 0%	▼ -10%	▼ -35%

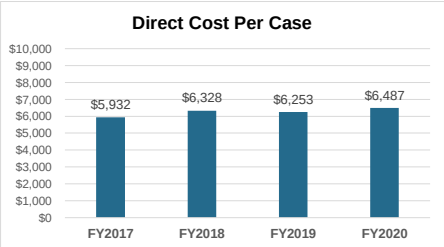
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

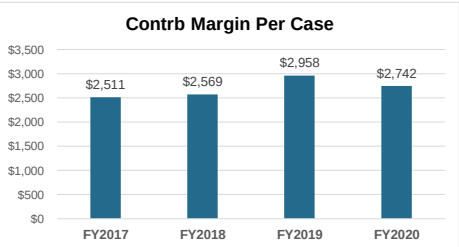
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND	Pre-COVID Ann. Jul. 19 - Feb. 20
Patient Cases	829	898	855	828	▼ -3%		887
Patient Days	3,353	3,798	3,272	2,951	▼ -10%		3,216
ALOS	4.04	4.23	3.83	3.56	▼ -7%		3.63
GM LOS	3.12	3.09	3.04	3.05	▶ 0%		3.06
Net Revenue	$6,999,167	$7,989,627	$7,875,970	$7,642,003	▼ -3%		$8,154,699
Direct Cost	$4,917,304	$5,682,558	$5,346,697	$5,371,377	▶ 0%		$5,864,624
Contribution Margin	$2,081,863	$2,307,069	$2,529,273	$2,270,626	▼ -10%		$2,290,076
Indirect Cost	$1,549,595	$2,122,095	$1,972,174	$1,909,308	▼ -3%		$2,072,298
Net Income	$532,268	$184,974	$557,099	$361,318	▼ -35%		$217,778
Net Revenue Per Case	$8,443	$8,897	$9,212	$9,229	▶ 0%		$9,199
Direct Cost Per Case	$5,932	$6,328	$6,253	$6,487	▲ 4%		$6,615
Contrb Margin Per Case	$2,511	$2,569	$2,958	$2,742	▼ -7%		$2,583

PER CASE TRENDED GRAPHS



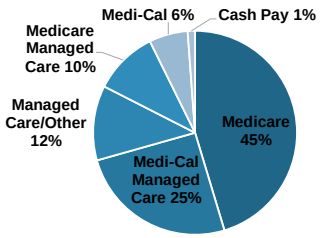




PAYER MIX - 4 YEAR TREND (GROSS CHARGES)

PAYER	FY2017	FY2018	FY2019	FY2020
Medicare	43%	46%	43%	45%
Medi-Cal Managed Care	26%	28%	27%	25%
Managed Care/Other	15%	11%	14%	12%
Medicare Managed Care	8%	7%	9%	10%
Medi-Cal	7%	6%	7%	6%
Cash Pay	0%	1%	1%	1%

FY 2020 PAYER MIX

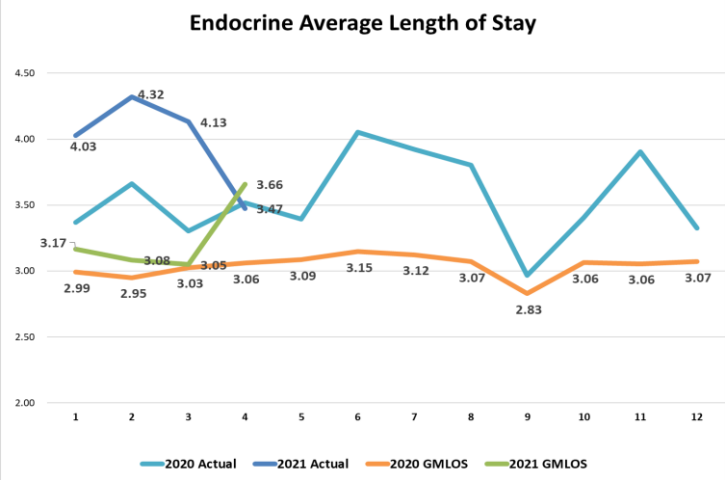


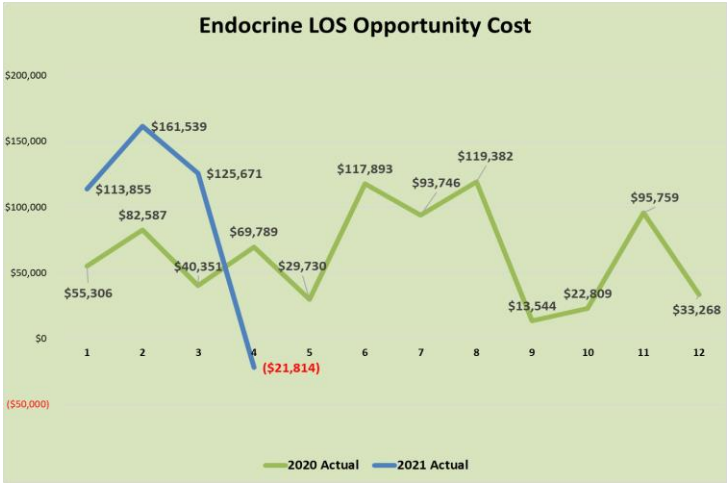
KDHCD ANNUAL BOARD REPORT

FY2020

Inpatient Medical Service Lines - Endocrine

KEY METRICS - FY 2020 Twelve Months Ended June 30, 2020





Notes:
Source: Inpatient Service Line Report
Criteria: Service Name Kaweah Delta Medical Center
Service Line is Endocrine and account type is medical

KDHCD ANNUAL BOARD REPORT

FY2020

Inpatient Medical Service Lines - Nephrology

KEY METRICS - FY 2020 Twelve Months Ended June 30, 2020

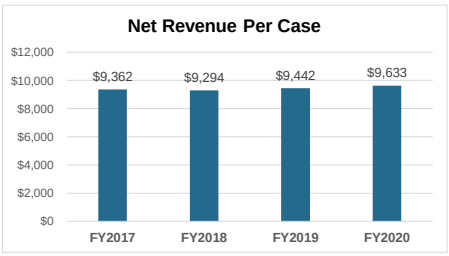
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
775	$7,465,335	$5,682,889	$1,782,446	($200,263)
▼ -13%	▼ -11%	▼ -5%	▼ -26%	▼ -208%

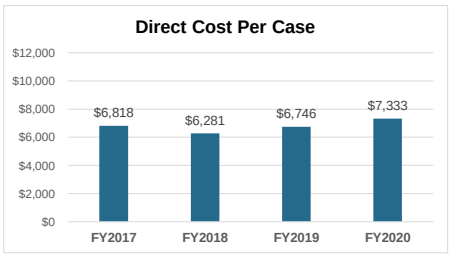
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

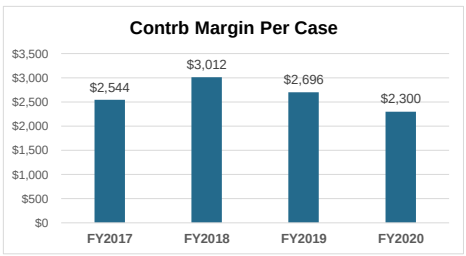
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND	Pre-COVID Ann. Jul. 19 - Feb. 20
Patient Cases	850	813	888	775	▼ -13%		858
Patient Days	4,226	3,863	4,008	3,357	▼ -16%		3,626
ALOS	4.97	4.75	4.51	4.33	▼ -4%		4.23
GM LOS	3.75	3.62	3.57	3.61	▲ 1%		3.63
Net Revenue	$7,957,396	$7,555,968	$8,384,816	$7,465,335	▼ -11%		$8,320,289
Direct Cost	$5,795,299	$5,106,820	$5,990,365	$5,682,889	▼ -5%		$6,241,596
Contribution Margin	$2,162,097	$2,449,148	$2,394,451	$1,782,446	▼ -26%		$2,078,693
Indirect Cost	$1,800,273	$1,948,720	$2,208,822	$1,982,709	▼ -10%		$2,190,156
Net Income	$361,824	$500,428	$185,629	($200,263)	▼ -208%		($111,464)
Net Revenue Per Case	$9,362	$9,294	$9,442	$9,633	▲ 2%		$9,697
Direct Cost Per Case	$6,818	$6,281	$6,746	$7,333	▲ 9%		$7,275
Contrb Margin Per Case	$2,544	$3,012	$2,696	$2,300	▼ -15%		$2,423

PER CASE TRENDED GRAPHS



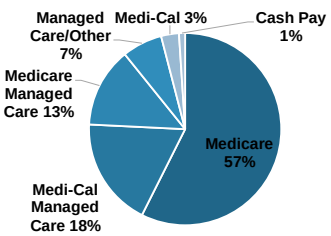




PAYER MIX - 4 YEAR TREND (GROSS CHARGES)

PAYER	FY2017	FY2018	FY2019	FY2020
Medicare	59%	51%	57%	57%
Medi-Cal Managed Care	17%	22%	16%	18%
Medicare Managed Care	7%	10%	11%	13%
Managed Care/Other	10%	9%	9%	7%
Medi-Cal	6%	6%	7%	3%
Cash Pay	0%	1%	0%	1%

FY 2020 PAYER MIX

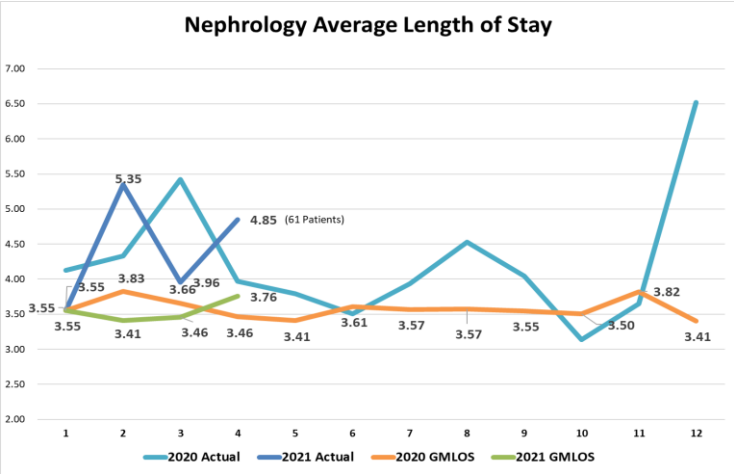


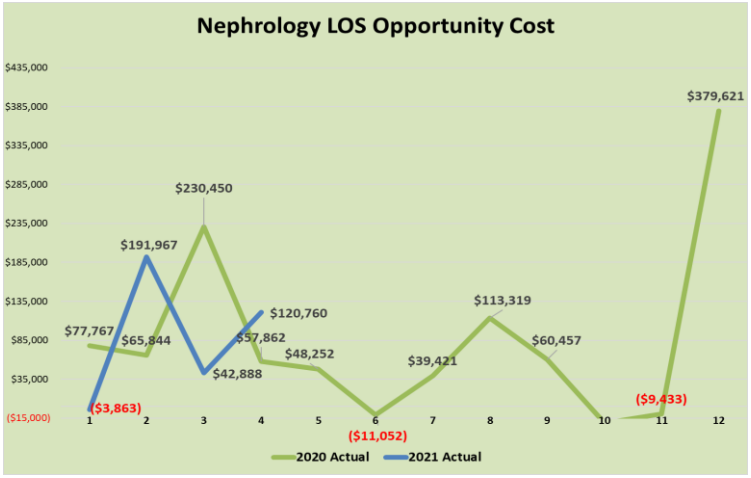
KDHCD ANNUAL BOARD REPORT

FY2020

Inpatient Medical Service Lines - Nephrology

KEY METRICS - FY 2020 Twelve Months Ended June 30, 2020





Notes:
Source: Inpatient Service Line Report
Criteria: Service Name Kaweah Delta Medical Center
Service Line is Nephrology and account type is medical

KDHCD ANNUAL BOARD REPORT

FY2020

Inpatient Medical Service Lines - Multiple Significant Trauma

KEY METRICS - FY 2020 Twelve Months Ended June 30, 2020

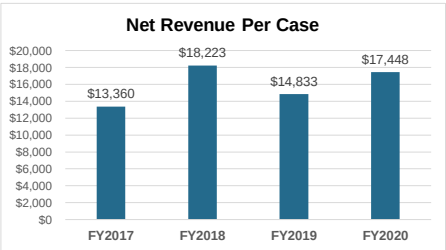
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
106	$1,849,491	$1,000,670	$848,821	$488,549
▼ -13%	▲ 2%	▲ 4%	▶ 0%	▲ 2%

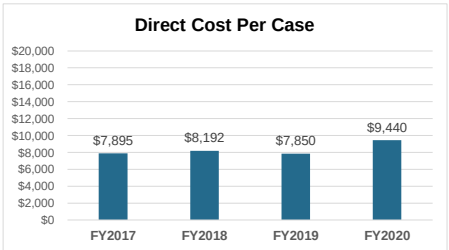
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

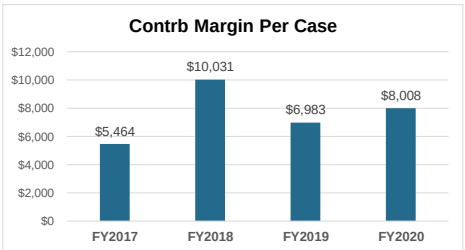
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND	Pre-COVID Ann. Jul. 19 - Feb. 20
Patient Cases	113	87	122	106	▼ -13%		111
Patient Days	515	374	601	535	▼ -11%		582
ALOS	4.56	4.30	4.93	5.05	▲ 2%		5.24
GM LOS	3.79	3.66	3.72	3.74	▲ 1%		3.80
Net Revenue	$1,509,662	$1,585,413	$1,809,615	$1,849,491	▲ 2%		$2,059,494
Direct Cost	$892,188	$712,714	$957,685	$1,000,670	▲ 4%		$1,072,515
Contribution Margin	$617,474	$872,699	$851,930	$848,821	▶ 0%		$986,979
Indirect Cost	$284,882	$262,407	$370,978	$360,272	▼ -3%		$383,939
Net Income	$332,592	$610,292	$480,952	$488,549	▲ 2%		$603,041
Net Revenue Per Case	$13,360	$18,223	$14,833	$17,448	▲ 18%		$18,554
Direct Cost Per Case	$7,895	$8,192	$7,850	$9,440	▲ 20%		$9,662
Contrb Margin Per Case	$5,464	$10,031	$6,983	$8,008	▲ 15%		$8,892
Opportunity Days	0.77	0.64	1.21	1.31			1.44

PER CASE TRENDED GRAPHS



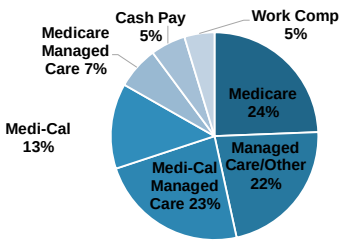




PAYER MIX - 4 YEAR TREND (GROSS CHARGES)

PAYER	FY2017	FY2018	FY2019	FY2020
Medicare	22%	14%	28%	24%
Managed Care/Other	20%	31%	16%	22%
Medi-Cal Managed Care	19%	28%	22%	23%
Medi-Cal	29%	14%	21%	13%
Medicare Managed Care	5%	2%	5%	7%
Cash Pay	0%	6%	5%	5%
Work Comp	3%	4%	4%	5%

FY 2020 PAYER MIX



Notes:
Source: Inpatient Service Line Report
Criteria: Service Name Kaweah Delta Medical Center
Service Line is Trauma and account type is medical

KDHCD ANNUAL BOARD REPORT

Inpatient Medical Service Lines - Dermatology

FY2020

KEY METRICS - FY 2020 Twelve Months Ended June 30, 2020

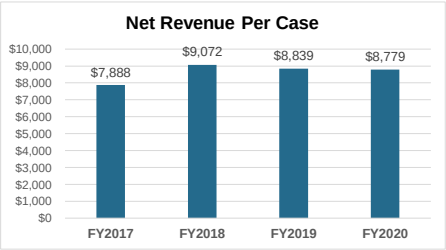
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
303	$2,660,056	$2,092,690	$567,366	($165,513)
▼ -23%	▼ -23%	▼ -10%	▼ -51%	▼ -156%

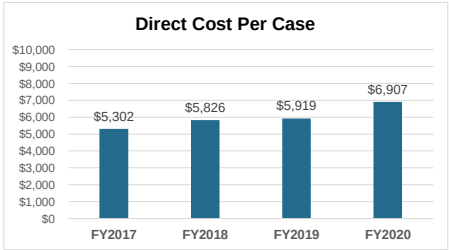
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

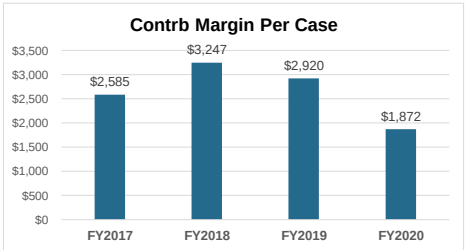
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND	Pre-COVID Ann. Jul. 19 - Feb. 20
Patient Cases	370	429	393	303	▼ -23%		327
Patient Days	1,542	1,896	1,607	1,310	▼ -18%		1,347
ALOS	4.17	4.42	4.09	4.32	▲ 6%		4.12
GM LOS	3.57	3.53	3.40	3.46	▲ 2%		3.40
Net Revenue	$2,918,384	$3,892,093	$3,473,804	$2,660,056	▼ -23%		$2,726,316
Direct Cost	$1,961,859	$2,499,259	$2,326,341	$2,092,690	▼ -10%		$2,175,650
Contribution Margin	$956,525	$1,392,834	$1,147,463	$567,366	▼ -51%		$550,667
Indirect Cost	$602,196	$918,634	$852,558	$732,879	▼ -14%		$765,369
Net Income	$354,329	$474,200	$294,905	($165,513)	▼ -156%		($214,703)
Net Revenue Per Case	$7,888	$9,072	$8,839	$8,779	▼ -1%		$8,337
Direct Cost Per Case	$5,302	$5,826	$5,919	$6,907	▲ 17%		$6,653
Contrb Margin Per Case	$2,585	$3,247	$2,920	$1,872	▼ -36%		$1,684

PER CASE TRENDED GRAPHS

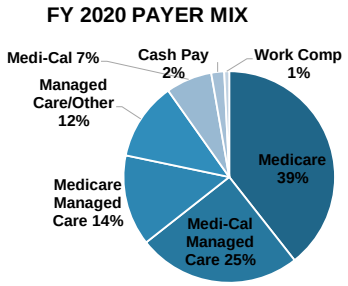






PAYER MIX - 4 YEAR TREND (GROSS CHARGES)

PAYER	FY2017	FY2018	FY2019	FY2020
Medicare	18%	33%	39%	39%
Medi-Cal Managed Care	4%	29%	33%	25%
Medicare Managed Care	19%	9%	8%	14%
Managed Care/Other	2%	13%	10%	12%
Medi-Cal	1%	13%	8%	7%
Cash Pay	50%	1%	0%	2%
Work Comp	0%	1%	1%	1%



Notes:
Source: Inpatient Service Line Report
Criteria: Service Name Kaweah Delta Medical Center
Service Line is Dermatology and account type is medical

KDHCD ANNUAL BOARD REPORT

Inpatient Medical Service Lines - Urology

FY2020

KEY METRICS - FY 2020 Twelve Months Ended June 30, 2020

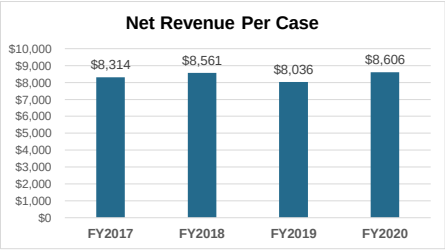
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
25	$215,162	$120,372	$94,790	$51,890
▼ -56%	▼ -53%	▼ -50%	▼ -57%	▼ -59%

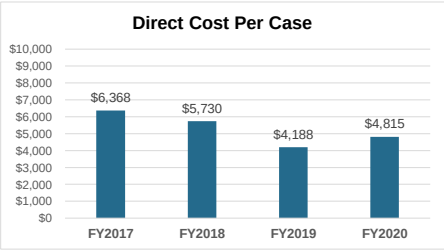
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

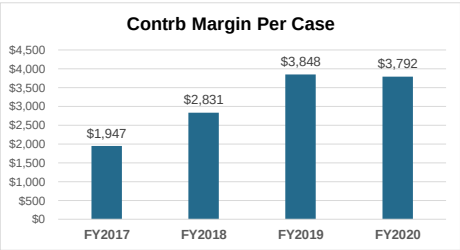
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND	Pre-COVID Ann. Jul. 19 - Feb. 20
Patient Cases	80	75	57	25	▼ -56%		32
Patient Days	378	284	143	79	▼ -45%		104
ALOS	4.73	3.79	2.51	3.16	▲ 26%		3.29
GM LOS	2.52	2.60	2.54	2.53	▶ 0%		2.52
Net Revenue	$665,142	$642,062	$458,047	$215,162	▼ -53%		$265,488
Direct Cost	$509,417	$429,762	$238,727	$120,372	▼ -50%		$153,923
Contribution Margin	$155,725	$212,300	$219,320	$94,790	▼ -57%		$111,566
Indirect Cost	$157,157	$165,289	$92,451	$42,900	▼ -54%		$54,732
Net Income	($1,432)	$47,011	$126,869	$51,890	▼ -59%		$56,834
Net Revenue Per Case	$8,314	$8,561	$8,036	$8,606	▲ 7%		$8,428
Direct Cost Per Case	$6,368	$5,730	$4,188	$4,815	▲ 15%		$4,886
Contrb Margin Per Case	$1,947	$2,831	$3,848	$3,792	▼ -1%		$3,542

PER CASE TRENDED GRAPHS

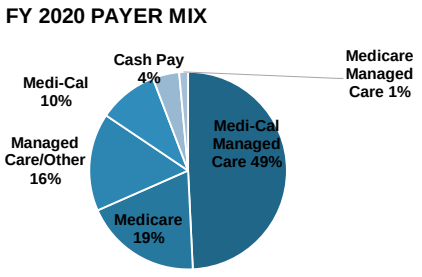






PAYER MIX - 4 YEAR TREND (GROSS CHARGES)

PAYER	FY2017	FY2018	FY2019	FY2020
Medi-Cal Managed Care	21%	37%	39%	49%
Medicare	34%	37%	28%	19%
Managed Care/Other	28%	14%	16%	16%
Medi-Cal	8%	5%	10%	10%
Cash Pay	1%	1%	3%	4%
Medicare Managed Care	6%	7%	5%	1%



Notes:
Source: Inpatient Service Line Report
Criteria: Service Name Kaweah Delta Medical Center
Service Line is Neurology and account type is medical

Kaweah Delta Health Care District
Annual Report to the Board of Directors 2019-2020
Projected FY 2021

Imaging Services

Renee Lauck, Director (559) 624-2345
January 25, 2021

Summary Issue/Service Considered

Financial Summary

Summary – Report includes 13 outpatient-imaging services located across the district. Outpatient imaging services had a contribution margin of $7.8 million in FY 2020. COVID definitely affected the business with an approximate 3,300 lost patient visits and an estimated $464,000 in lost contribution margin.

Top 3 services in terms of contribution margin are MRI Kaweah Delta Imaging Center (KDIC), Breast Center KDIC, and CT scan KDIC, providing $5 million or 64% of the total contribution margin. Financial results are consistent over the last 4 full fiscal years, with the same trend apparent in FY 2021.

- As of FY 2020, our patient cases remained flat, although 3,291 lower than projected budget.
- Combined patient visits average between 42,000 and 43,000 visits annually, although our pre-covid estimate shows we were on track to see more than 46,000 visits.
- Net Revenue per visit is $307, with consistent payer mix for FY 2019- FY 2021.
- Direct cost per visit remains stable.
- Contribution margin per visit is consistent although total contribution margin is down approximately $466k due to covid.

    - Top contributors to net income:
        - **MRI** Volumes up by 9%, slightly under pre-covid estimate.
        - **Breast Center** volumes declined due to covid as the department shut down for screening exams Mid-March to Mid May of 2020, providing only necessary diagnostic services per guidelines. Net revenue per visit remains consistent. Direct costs per visit were up 8% due to decline in volume along with set service contracts.
        - **CT** visits are up by 5% in FY 2020 with net revenue per visit up 5% as well.

Regulatory and Accreditation

- Final phases for previously reported move from Computed Radiography (**CR)** to Digital Radiography (**DR**) will be completed by the end of FY 2021. Kaweah Delta Imaging Center is completely DR, with south campus DR installs taking place in March – June of 2021.This mandate was part of the Consolidated Appropriations Act of 2016 by Centers for Medicare & Medicaid Services (**CMS**). This act accounts for a 7% reduction in reimbursements for any outpatient facility utilizing CR versus DR. The reduction increases to 10% in 2023.
- American College of Radiology (**ACR**) accreditation awarded for CAT Scan (**CT**), Ultrasound (**US**), & Magnetic Resonance Imaging (**MRI**) at all campuses in FY 2020. Plans to obtain Nuclear Medicine ACR in July/August 2021.
- CMS has pushed out the mandate for implementation of appropriate use criteria, also known as clinical decision support software, to late 2021. As a result, the tool was temporarily disabled as our organization focuses on issues related to the pandemic.

Project Plans for 2020-2021

- **KDMC CT –** Architects began design plans for a third CT, which includes an intake and recovery area, as well as radiologist reading room, if possible. This project includes the re-location of our patient access team currently in the area as well as the re-location of the Acequia Wing Conference room.
- **KDMC Diagnostic Radiology** – Completion of fluoroscopy room 2 install is set for January 25, 2021, with Room 5 to follow in June.
- **South Campus Radiology** – Construction will begin on DR xray replacements for rooms 1 and 2 in January. These rooms service our urgent care, South Campus inpatients and pre-admission testing facility.

Staffing/Operations 2020-2021

- **KDMC CT:**
    - While volumes are slightly lower in CT at KDMC, the amount of time it takes to care for our COVID patients is significant. Staffing continues to remain strong in this area.
- **KDMC Ultrasound:**
    - Licensed staffing has stabilized over the last year. Volumes are lower in Ultrasound at the main campus and we have temporarily eliminated a part time position until volume returns. We believe ED physicians to be providing more ultrasound at bedside.
- **KDMC MRI:**
    - MRI at KDMC volumes remain strong. While we have been challenged to find a replacement for a MRI technologist who left last year, we have been able to manage by covering the shift with a locum. We believe one of our students may take the job once licensed in early spring 2021, a positive factor of our active involvement with several colleges.
- **KDMC Nuclear Medicine:**
    - Nuclear Medicine volumes for both in/out patients remains much lower since COVID. We have 1.5 FTE on hold at this time and will not replace unless Volume returns. Plan to start working with marketing to review needs and enhance volume or possibly look to consolidate outpatient nuclear medicine needs with other nuclear medicine areas in the district.

Quality/Performance Improvement Data

Employee Engagement

- Engagement Challenges - While we have experienced challenges since the start of the pandemic in regards to morale, we believe the majority of our staff are satisfied and have not seen a significant loss in terms of people leaving except for moves out of the area. Managers and Director continue to address concerns over eliminating the 401 k contribution match and the freeze in salaries.
- Staffing – Posting and filling positions timely is something our managers focus on to reduce staff burnout. Managers look at staffing daily to review needs and have come up with creative ways to schedule to assure responsible and thoughtful adherence to the budget.

Monthly Performance Improvement

- Procedure complication rates
- Emergency Department (ED) Imaging discrepancies
- Incidental Findings
- Turn-around order to completion
- Turn-around time completion of exam to radiologist final read
- Mammography recall rates
- Stroke alert compliance rates.
- Duplicate Impression reporting errors

Organization, Safety and Quality (SAQ) Patient and Employee Safety Initiatives

- Accurate Tests and Treatments – Imaging Services implemented the “Get it Right” campaign in 2020. The initiative included all areas within imaging services. Staff are required to complete online education as we continue to focus on patient safety and assuring staff take the time to assure they have;
    i. the right patient
    ii. the right exam
    iii. the right side/site
    iv. the right dose according to ALARA (As low as reasonably achievable).
- Rapid Response training for ancillary staff began with a focus on education to staff. MyNetLearning module to follow soon. Assure all staff realize anyone can call a rapid response when they feel a patient is declining or having difficulties. Focus education plan to include Aides and Technologists in each modality.
- While our CUSP meetings are currently on hold, we continue to discuss safety concerns daily.
- Patient fall prevention & education remains a strong priority.
- Unit Based Council (UBC) – Our UBC remains strong and is an active foundation for our staff to share items of concerns and thoughts for improvements.

Policy, Strategic or Tactical Issues

- Implementation of Imaging Services policy committee at the end of FY 20. Project involves revamping current policy manual. Staff from each modality and Imaging medical director collaborate to assure policies are meaningful and easy to understand, while combining several policies in new manual for ease of review.
- FY 21 will include final steps for previously mentioned, replacement of Diagnostic X-ray equipment to meet CMS regulations for DR technology. This includes two replacement (R/F) Radiography and Fluoroscopy rooms at KDMC and two DR portables as well as two DR X-RAY rooms at south campus.
- American College of Radiology (ACR) accreditation for KD imaging modalities is at 95% completion.
- Met need for expanding surgery demands with purchase of additional vascular C-arm in FY 2020. C-arms are portable radiographic units that get their name from the C shaped arm that is used to fit under gurneys or surgical beds. As FY 21 approaches, we continue to review possible staffing and equipment needs for surgery coverage. Will continue to review needs as surgery volume returns, post Covid surge.

Recommendations/Next Steps

- Pursue replacement of existing CT units after third CT install. Consider high-end cardiac CT units as we move into the future.
- Explore adding radiologist reading rooms as part of new expansion
- Explore possibility of combining outpatient Nuclear Medicine needs with outpatient cardiology needs to create one outpatient area for all Nuclear Medicine Services with inpatient area being overflow. This will enable staffing efficiencies with cross coverage for nuclear medicine and PET/CT, as well as enhance patient satisfaction for our outpatients.

Approvals/Conclusions

Future in Imaging Services

- Reductions in reimbursement for imaging services will continue to impact profitability. We are currently seeing this in all areas with bundling of exams that formerly billed separately.
- Continue to assess opportunities to improve turnaround times to support ED and inpatient length of stay. Third CT should help address many of the issues as well as our work to replace older units, which break down frequently.
- Continue to access opportunities to combine various imaging services in order to reduce duplicative services throughout district.
- Review ability to work with community physicians and patients to service needs in the area.
- Aggressively market services as we continue to expand and plan for growth and new technology.

KDHCD ANNUAL BOARD REPORT

Outpatient Radiology Services - Summary

FY2020

KEY METRICS - FY 2020 BASED ON THE TWELVE MONTHS ENDED JUNE 30, 2020

Patient Visits	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
43,292	$13,277,428	$5,459,621	$7,817,807	$4,865,311
▶ 0%	▼ -2%	▶ 0%	▼ -3%	▼ -22%

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

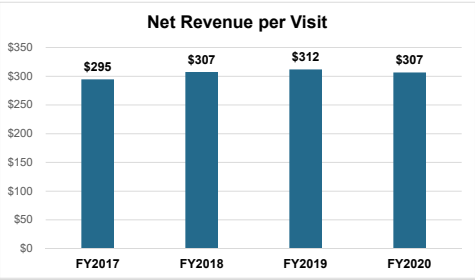
METRICS BY SERVICE LINE - FY 2020

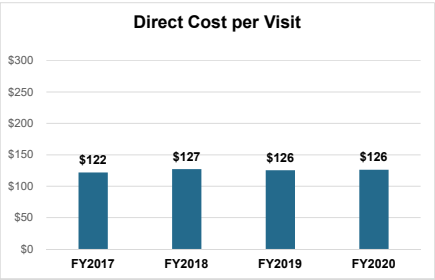
SERVICE LINE	Patient Visits	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME	CONTRB MARGIN per VISIT
MRI Kaweah Delta Img Ctr	3,668	$2,685,681	$440,864	$2,244,817	$1,836,742	$612
Breast Center Kaweah Delta Img Ctr	8,791	$2,662,707	$1,230,497	$1,432,210	$827,059	$163
CT Scan Kaweah Delta Img Ctr	3,629	$1,873,889	$537,871	$1,336,017	$891,373	$368
Ultrasound Kaweah Delta Img Ctr	5,498	$1,196,661	$390,213	$806,448	$582,967	$147
PET Scan Kaweah Delta Img Ctr	834	$1,503,090	$803,033	$700,057	$579,840	$839
Diag Imaging Kaweah Delta Img Ctr	9,166	$1,180,468	$712,876	$467,592	($59,370)	$51
Ultrasound Downtown Campus	1,681	$386,466	$149,674	$236,792	$168,242	$141
Diag Imaging South Campus	8,034	$638,458	$430,426	$208,032	($3,945)	$26
Nuclear Medicine Downtown Campus	907	$649,964	$503,323	$146,640	($83,890)	$162
CT Scan Downtown Campus	193	$186,578	$55,786	$130,792	$104,126	$678
MRI Downtown Campus	136	$121,497	$33,605	$87,892	$65,036	$646
Diagnostic Imaging Downtown Campus	309	$156,125	$127,564	$28,561	($19,664)	$92
Diag Img UCC Demaree Walk-in	446	$35,846	$43,889	($8,043)	($23,205)	($18)
Radiology Services Total	43,292	$13,277,428	$5,459,621	$7,817,807	$4,865,311	$181

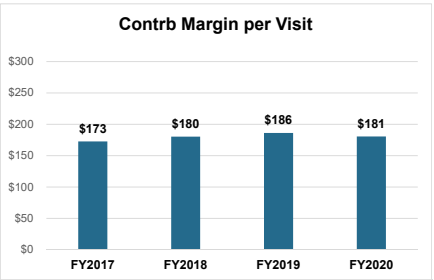
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND	Pre-Covid Ann. Jul. 19-Feb.20
Patient Visits	43,097	42,748	43,433	43,292	▶ 0%		46,583
Net Revenue	$12,704,747	$13,143,509	$13,543,897	$13,277,428	▼ -2%		$14,112,502
Direct Cost	$5,256,969	$5,434,430	$5,454,381	$5,459,621	▶ 0%		$5,830,395
Contribution Margin	$7,447,779	$7,709,078	$8,089,516	$7,817,807	▼ -3%		$8,282,107
Indirect Cost	$1,727,792	$2,089,623	$1,868,774	$2,952,497	▲ 58%		$3,134,288
Net Income	$5,719,986	$5,619,455	$6,220,742	$4,865,311	▼ -22%		$5,147,818
Net Revenue per Visit	$295	$307	$312	$307	▼ -2%		$303
Direct Cost per Visit	$122	$127	$126	$126	▶ 0%		$125
Contrb Margin per Visit	$173	$180	$186	$181	▼ -3%		$178

GRAPHS







KDHCD ANNUAL BOARD REPORT

Outpatient Radiology Services - Summary

FY2020

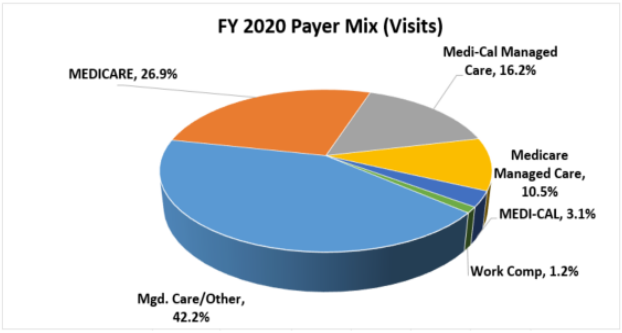
PAYER MIX (VISITS) FY 2019 - FYTD 2021

EncTypeMne: OP
ServiceLine1Mne: Radiol / Services SORT July - November

	FY 2019			FY 2020			FY 2021				
	Volume	Net Rev Per Case	Contrib Marg Per Case	Volume	Net Rev Per Case	Contrib Marg Per Case	Volume	Net Rev Per Case	Contrib Marg Per Case	NR % Chg. 19 to 20	NR % Chg. 20 to 21
Mgd. Care/Other	18,495	$451	$329	18,102	$443	$323	7,730	$444	$329	-2%	0%
MEDICARE	12,233	$235	$90	11,539	$243	$96	4,555	$257	$113	4%	6%
Medi-Cal Managed Care	6,689	$182	$75	6,954	$180	$70	2,800	$172	$73	-2%	-4%
Medicare Managed Care	3,908	$179	$52	4,485	$167	$34	2,037	$163	$43	-7%	-2%
MEDI-CAL	1,416	$213	$116	1,324	$251	$138	358	$272	$171	18%	8%
Work Comp	390	$96	$8	507	$117	$39	193	$71	$11	22%	-39%
Grand Total	**43,131**	**$312**	**$187**	**42,911**	**$308**	**$182**	**17,673**	**$313**	**$193**	**-1%**	**2%**

Payer	FY 2019 Payer Mix	FY 2020 Payer Mix	FY 2021 Payer Mix
Mgd. Care/Other	42.9%	42.2%	43.7%
MEDICARE	28.4%	26.9%	25.8%
Medi-Cal Managed Care	15.5%	16.2%	15.8%
Medicare Managed Care	9.1%	10.5%	11.5%
MEDI-CAL	3.3%	3.1%	2.0%
Work Comp	0.9%	1.2%	1.1%

37.3% Medicare Combined
19.3% Medi-Cal Combined



Note: All visits with a primary service of Radiology. This excludes visits with Radiology services performed as a part of another outpatient service line (eg. Urgent Care, Emergency Department).

KDHCD ANNUAL BOARD REPORT

Outpatient Radiology Services - MRI Kaweah Delta Imaging Center

FY2020

KEY METRICS - FY 2020 BASED ON THE TWELVE MONTHS ENDED JUNE 30, 2020

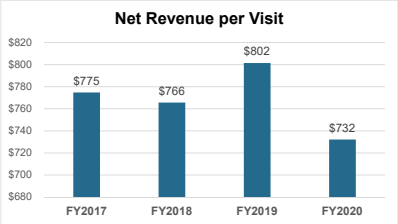
Patient Visits	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
3,668	$2,685,681	$440,864	$2,244,817	$1,836,742
▲ 9%	▶ 0%	▼ -8%	▲ 1%	▼ -7%

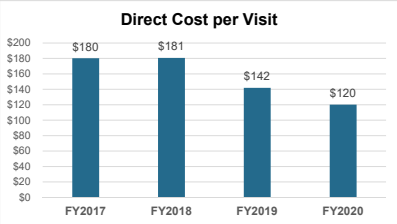
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

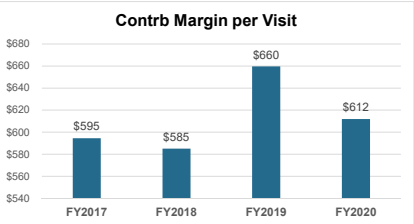
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND	Pre-Covid Ann. Jul. 19-Feb.20
Patient Visits	3,326	3,031	3,366	3,668	▲ 9%		3,822
Net Revenue	$2,576,852	$2,320,750	$2,697,884	$2,685,681	▶ 0%		$2,788,831
Direct Cost	$599,378	$547,495	$477,459	$440,864	▼ -8%		$460,051
Contribution Margin	$1,977,473	$1,773,255	$2,220,425	$2,244,817	▲ 1%		$2,328,779
Indirect Cost	$250,450	$324,426	$241,450	$408,075	▲ 69%		$424,570
Net Income	$1,727,023	$1,448,829	$1,978,975	$1,836,742	▼ -7%		$1,904,210
Net Revenue per Visit	$775	$766	$802	$732	▼ -9%		$730
Direct Cost per Visit	$180	$181	$142	$120	▼ -15%		$120
Contrb Margin per Visit	$595	$585	$660	$612	▼ -7%		$609

TRENDED GRAPHS

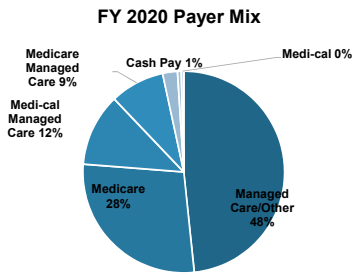


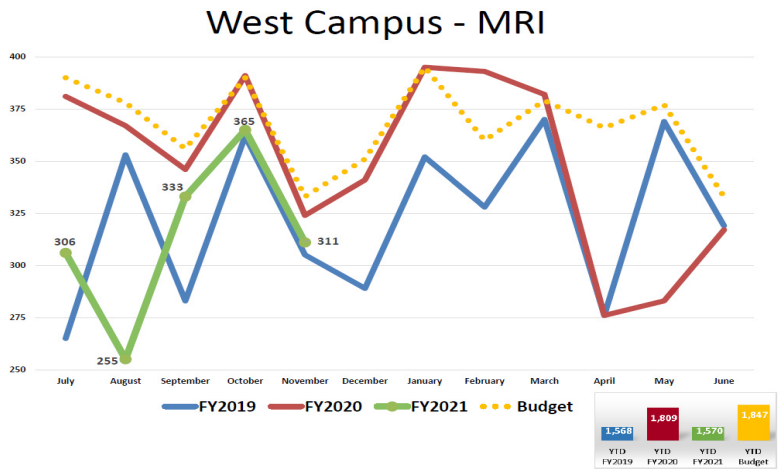




PAYER MIX - 4 YEAR TREND (VISIT VOLUME)

PAYER	FY2017	FY2018	FY2019	FY2020
Managed Care/Other	49%	46%	51%	48%
Medicare	29%	30%	26%	28%
Medi-cal Managed Care	13%	12%	9%	12%
Medicare Managed Care	6%	8%	10%	9%
Work Comp	3%	2%	3%	2%
Cash Pay	0%	1%	0%	1%
Medi-cal	1%	1%	0%	0%
Tulare County	0%	0%	0%	0%





Note: All visits with a primary service of Radiology. This excludes visits with Radiology services performed as a part of another outpatient service line (eg. Urgent Care, Emergency Department).

KDHCD ANNUAL BOARD REPORT

Outpatient Radiology Services - Breast Center Kaweah Delta Imaging

FY2020

KEY METRICS - FY 2020 BASED ON THE TWELVE MONTHS ENDED JUNE 30, 2020

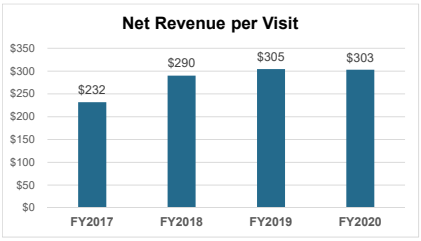
Patient Visits	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
8,791	$2,662,707	$1,230,497	$1,432,210	$827,059
▼ -12%	▼ -12%	▼ -5%	▼ -18%	▼ -39%

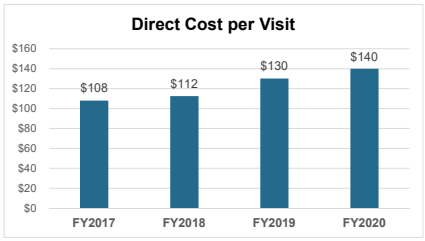
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

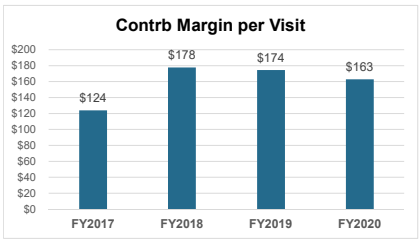
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND	Pre-Covid Ann. Jul. 19-Feb.20
Patient Visits	10,678	10,615	9,960	8,791	▼ -12%		10,445
Net Revenue	$2,476,511	$3,080,533	$3,034,147	$2,662,707	▼ -12%		$3,143,288
Direct Cost	$1,152,641	$1,193,703	$1,296,238	$1,230,497	▼ -5%		$1,433,284
Contribution Margin	$1,323,871	$1,886,829	$1,737,910	$1,432,210	▼ -18%		$1,710,003
Indirect Cost	$361,233	$443,084	$374,696	$605,151	▲ 62%		$702,019
Net Income	$962,638	$1,443,745	$1,363,214	$827,059	▼ -39%		$1,007,985
Net Revenue per Visit	$232	$290	$305	$303	▼ -1%		$301
Direct Cost per Visit	$108	$112	$130	$140	▲ 8%		$137
Contrb Margin per Visit	$124	$178	$174	$163	▼ -7%		$164

TRENDED GRAPHS

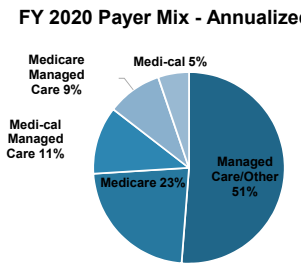


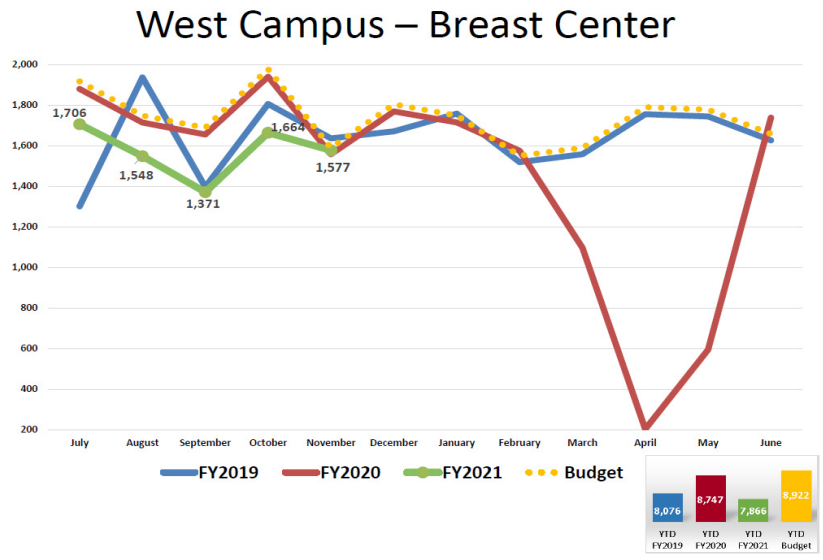




PAYER MIX - 4 YEAR TREND (VISIT VOLUME)

PAYER	FY2017	FY2018	FY2019	FY2020
Managed Care/Other	45%	49%	51%	51%
Medicare	20%	22%	23%	23%
Medi-cal Managed Care	21%	16%	13%	11%
Medicare Managed Care	5%	6%	7%	9%
Medi-cal	8%	6%	5%	5%





Note: All visits with a primary service of Radiology. This excludes visits with Radiology services performed as a part of another outpatient service line (eg. Urgent Care, Emergency Department).

KDHCD ANNUAL BOARD REPORT

Outpatient Radiology Services - CT Scan Kaweah Delta Imaging Center

FY2020

KEY METRICS - FY 2020 BASED ON THE TWELVE MONTHS ENDED JUNE 30, 2020

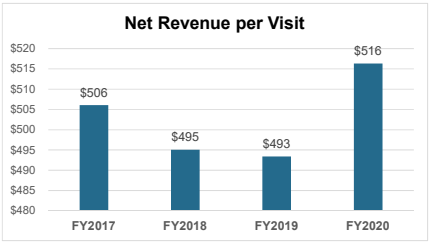
Patient Visits	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
3,629	$1,873,889	$537,871	$1,336,017	$891,373
▲ 5%	▲ 10%	▼ -1%	▲ 15%	▲ 1%

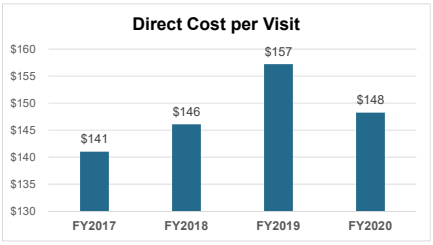
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

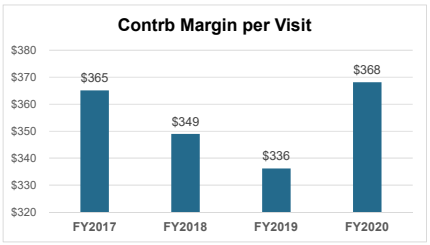
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND	Pre-Covid Ann. Jul. 19-Feb.20
Patient Visits	3,221	2,921	3,463	3,629	▲ 5%		3,660
Net Revenue	$1,630,056	$1,446,016	$1,708,594	$1,873,889	▲ 10%		$1,851,209
Direct Cost	$454,169	$426,661	$544,474	$537,871	▼ -1%		$534,223
Contribution Margin	$1,175,887	$1,019,355	$1,164,120	$1,336,017	▲ 15%		$1,316,986
Indirect Cost	$225,639	$243,028	$282,043	$444,645	▲ 58%		$442,632
Net Income	$950,248	$776,328	$882,077	$891,373	▲ 1%		$874,354
Net Revenue per Visit	$506	$495	$493	$516	▲ 5%		$506
Direct Cost per Visit	$141	$146	$157	$148	▼ -6%		$146
Contrb Margin per Visit	$365	$349	$336	$368	▲ 10%		$360

TRENDED GRAPHS

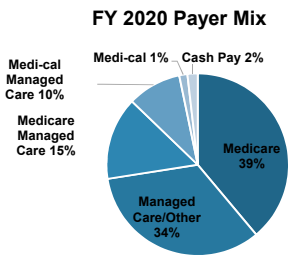


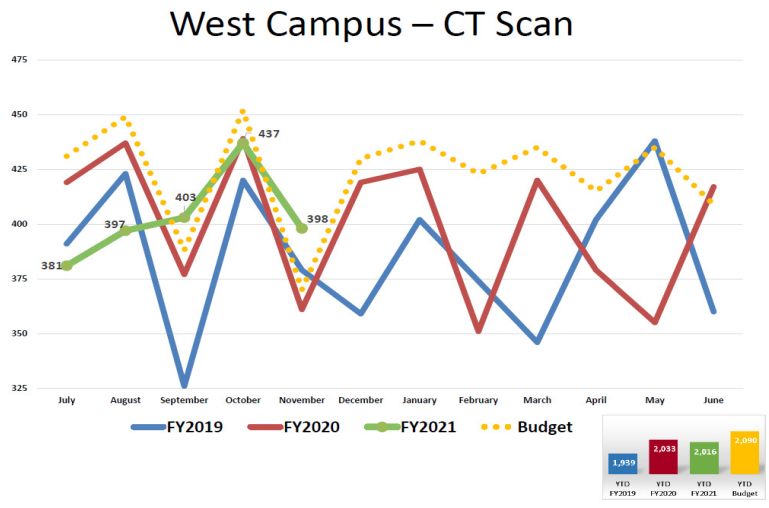




PAYER MIX - 4 YEAR TREND (VISIT VOLUME)

PAYER	FY2017	FY2018	FY2019	FY2020
Medicare	43%	41%	43%	39%
Managed Care/Other	36%	36%	34%	34%
Medicare Managed Care	8%	10%	13%	15%
Medi-cal Managed Care	11%	11%	8%	10%
Medi-cal	1%	1%	1%	1%
Cash Pay	1%	0%	1%	2%





Note: All visits with a primary service of Radiology. This excludes visits with Radiology services performed as a part of another outpatient service line (eg. Urgent Care, Emergency Department).

KDHCD ANNUAL BOARD REPORT

FY2020

Outpatient Radiology Services - Ultrasound Kaweah Delta Imaging Center

KEY METRICS - FY 2020 BASED ON THE TWELVE MONTHS ENDED JUNE 30, 2020

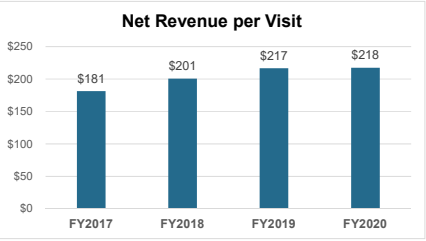
Patient Visits	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
5,498	$1,196,661	$390,213	$806,448	$582,967
▲ 3%	▲ 3%	▲ 3%	▲ 3%	▼ -9%

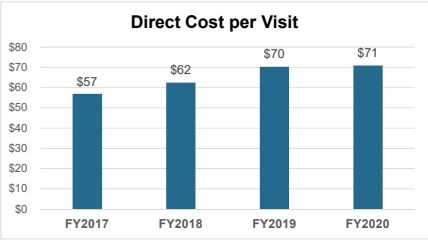
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

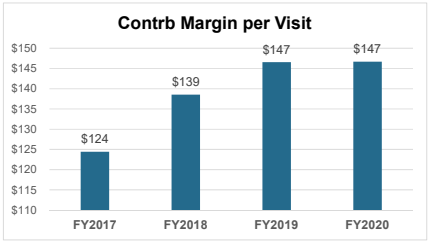
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND	Pre-Covid Ann. Jul. 19-Feb.20
Patient Visits	5,724	5,495	5,362	5,498	▲ 3%		5,718
Net Revenue	$1,037,827	$1,104,244	$1,163,070	$1,196,661	▲ 3%		$1,262,079
Direct Cost	$325,744	$343,118	$377,135	$390,213	▲ 3%		$405,526
Contribution Margin	$712,083	$761,126	$785,935	$806,448	▲ 3%		$856,553
Indirect Cost	$119,255	$144,664	$146,949	$223,482	▲ 52%		$231,380
Net Income	$592,827	$616,461	$638,987	$582,967	▼ -9%		$625,173
Net Revenue per Visit	$181	$201	$217	$218	▶ 0%		$221
Direct Cost per Visit	$57	$62	$70	$71	▲ 1%		$71
Contrb Margin per Visit	$124	$139	$147	$147	▶ 0%		$150

TRENDED GRAPHS

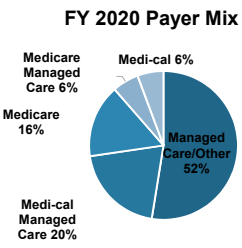


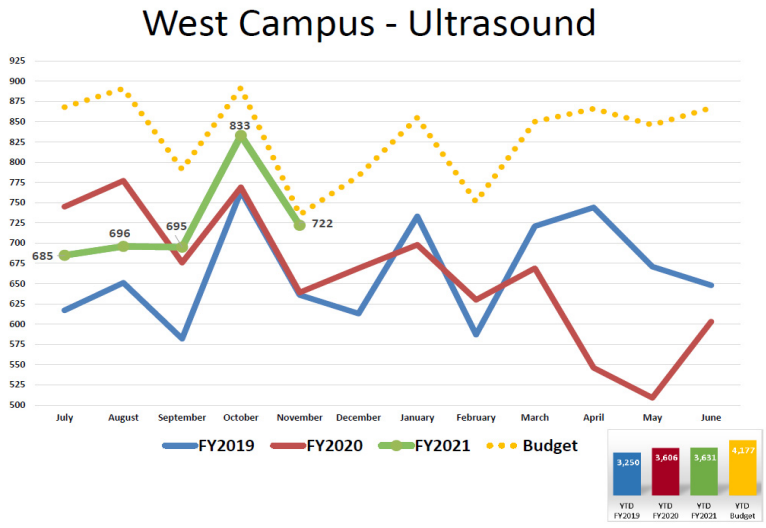




PAYER MIX - 4 YEAR TREND (VISIT VOLUME)

PAYER	FY2017	FY2018	FY2019	FY2020
Managed Care/Other	45%	50%	53%	52%
Medi-cal Managed Care	26%	21%	18%	20%
Medicare	16%	15%	16%	16%
Medicare Managed Care	4%	5%	5%	6%
Medi-cal	8%	8%	7%	6%





Note: All visits with a primary service of Radiology. This excludes visits with Radiology services performed as a part of another outpatient service line (eg. Urgent Care, Emergency Department).

KDHCD ANNUAL BOARD REPORT

FY2020

Outpatient Radiology Services - PET Scan Kaweah Delta Imaging Center

KEY METRICS - FY 2020 BASED ON THE TWELVE MONTHS ENDED JUNE 30, 2020

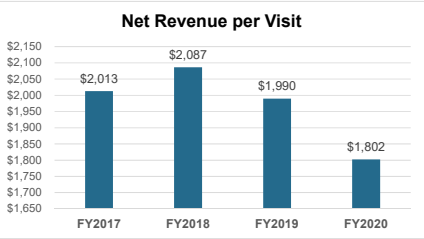
Patient Visits	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
834	$1,503,090	$803,033	$700,057	$579,840
▶ 0%	▼ -10%	▲ 4%	▼ -22%	▼ -30%

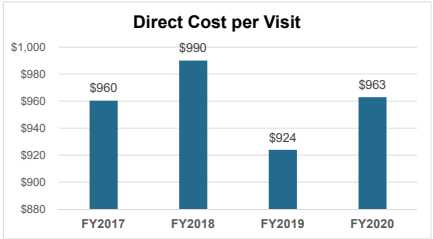
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

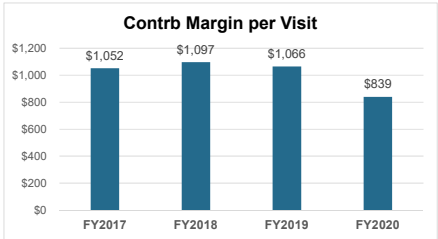
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND	Pre-Covid Ann. Jul. 19-Feb.20
Patient Visits	808	784	837	834	▶ 0%		842
Net Revenue	$1,626,194	$1,636,128	$1,665,486	$1,503,090	▼ -10%		$1,524,248
Direct Cost	$775,891	$776,208	$773,280	$803,033	▲ 4%		$809,584
Contribution Margin	$850,304	$859,920	$892,207	$700,057	▼ -22%		$714,664
Indirect Cost	$59,976	$73,154	$62,906	$120,216	▲ 91%		$120,932
Net Income	$790,328	$786,766	$829,301	$579,840	▼ -30%		$593,732
Net Revenue per Visit	$2,013	$2,087	$1,990	$1,802	▼ -9%		$1,811
Direct Cost per Visit	$960	$990	$924	$963	▲ 4%		$962
Contrb Margin per Visit	$1,052	$1,097	$1,066	$839	▼ -21%		$849

TRENDED GRAPHS

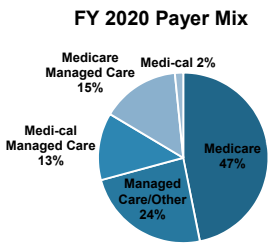






PAYER MIX - 4 YEAR TREND (VISIT VOLUME)

PAYER	FY2017	FY2018	FY2019	FY2020
Medicare	48%	50%	49%	47%
Managed Care/Other	27%	24%	25%	24%
Medi-cal Managed Care	16%	16%	14%	13%
Medicare Managed Care	8%	8%	11%	15%
Medi-cal	1%	1%	1%	2%



Note: All visits with a primary service of Radiology. This excludes visits with Radiology services performed as a part of another outpatient service line (eg. Urgent Care, Emergency Department).

KDHCD ANNUAL BOARD REPORT

FY2020

Outpatient Radiology Services - Diagnostic Imaging Kaweah Delta Imaging Center

KEY METRICS - FY 2020 BASED ON THE TWELVE MONTHS ENDED JUNE 30, 2020

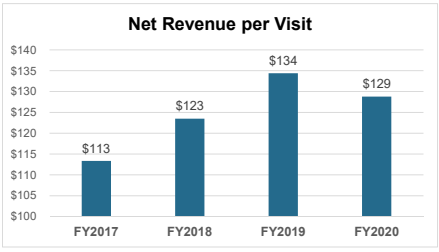
Patient Visits	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
9,166	$1,180,468	$712,876	$467,592	($59,370)
▶ 0%	▼ -4%	▼ -13%	▲ 13%	▼ -155%

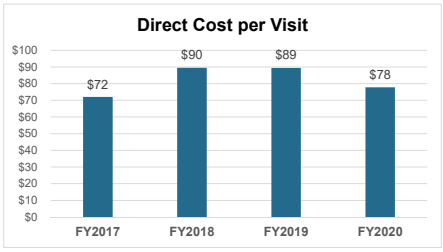
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

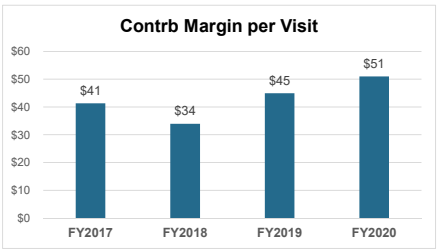
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND	Pre-Covid Ann. Jul. 19-Feb.20
Patient Visits	9,294	9,685	9,185	9,166	▶ 0%		9,458
Net Revenue	$1,053,339	$1,196,067	$1,234,281	$1,180,468	▼ -4%		$1,224,508
Direct Cost	$669,630	$867,311	$821,629	$712,876	▼ -13%		$737,468
Contribution Margin	$383,709	$328,756	$412,652	$467,592	▲ 13%		$487,040
Indirect Cost	$266,059	$322,836	$305,512	$526,962	▲ 72%		$543,347
Net Income	$117,650	$5,920	$107,140	($59,370)	▼ -155%		($56,307)
Net Revenue per Visit	$113	$123	$134	$129	▼ -4%		$129
Direct Cost per Visit	$72	$90	$89	$78	▼ -13%		$78
Contrb Margin per Visit	$41	$34	$45	$51	▲ 14%		$51

TRENDED GRAPHS

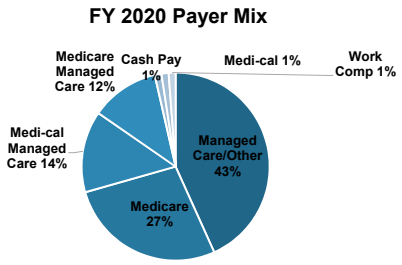






PAYER MIX - 4 YEAR TREND (VISIT VOLUME)

PAYER	FY2017	FY2018	FY2019	FY2020
Managed Care/Other	43%	42%	44%	43%
Medicare	28%	28%	29%	27%
Medi-cal Managed Care	19%	18%	14%	14%
Medicare Managed Care	6%	9%	10%	12%
Medi-cal	2%	1%	1%	1%
Cash Pay	1%	1%	1%	1%
Work Comp	1%	1%	1%	1%



Note: All visits with a primary service of Radiology. This excludes visits with Radiology services performed as a part of another outpatient service line (eg. Urgent Care, Emergency Department).

KDHCD ANNUAL BOARD REPORT

Outpatient Radiology Services - Ultrasound Downtown Campus

FY2020

KEY METRICS - FY 2020 BASED ON THE TWELVE MONTHS ENDED JUNE 30, 2020

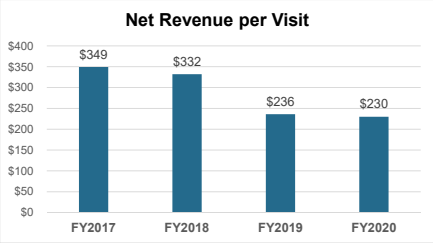
Patient Visits	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
1,681	$386,466	$149,674	$236,792	$168,242
▲ 15%	▲ 12%	▲ 41%	▶ 0%	▼ -4%

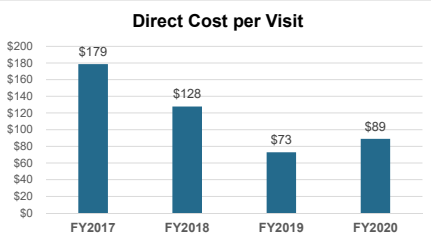
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

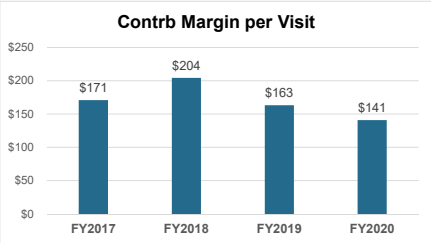
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND	Pre-Covid Ann. Jul. 19-Feb.20
Patient Visits	325	392	1,457	1,681	▲ 15%		1,731
Net Revenue	$113,570	$130,153	$343,838	$386,466	▲ 12%		$397,031
Direct Cost	$58,035	$50,061	$106,077	$149,674	▲ 41%		$157,209
Contribution Margin	$55,535	$80,092	$237,761	$236,792	▶ 0%		$239,821
Indirect Cost	$31,084	$29,734	$61,951	$68,550	▲ 11%		$70,944
Net Income	$24,451	$50,358	$175,810	$168,242	▼ -4%		$168,877
Net Revenue per Visit	$349	$332	$236	$230	▼ -3%		$229
Direct Cost per Visit	$179	$128	$73	$89	▲ 22%		$91
Contrb Margin per Visit	$171	$204	$163	$141	▼ -14%		$139

TRENDED GRAPHS

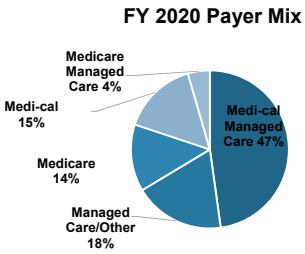






PAYER MIX - 4 YEAR TREND (VISIT VOLUME)

PAYER	FY2017	FY2018	FY2019	FY2020
Medi-cal Managed Care	27%	33%	47%	47%
Managed Care/Other	40%	30%	19%	18%
Medicare	14%	17%	18%	14%
Medi-cal	9%	12%	13%	15%
Medicare Managed Care	2%	1%	2%	4%
Cash Pay	1%	2%	1%	1%



Note: All visits with a primary service of Radiology. This excludes visits with Radiology services performed as a part of another outpatient service line (eg. Urgent Care, Emergency Department).

KDHCD ANNUAL BOARD REPORT

Outpatient Radiology Services - Diag Imaging South Campus

FY2020

KEY METRICS - FY 2020 BASED ON THE TWELVE MONTHS ENDED JUNE 30, 2020

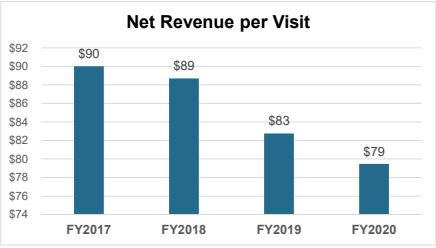
Patient Visits	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
8,034	$638,458	$430,426	$208,032	($3,945)
▼ -2%	▼ -6%	▼ -3%	▼ -11%	▼ -109%

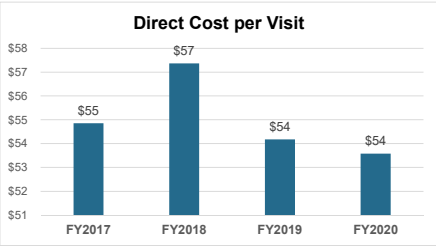
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

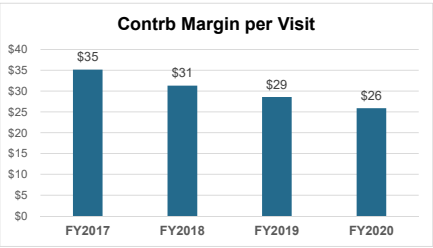
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND	Pre-Covid Ann. Jul. 19-Feb.20
Patient Visits	7,161	7,072	8,184	8,034	▼ -2%		8,745
Net Revenue	$644,610	$627,234	$677,276	$638,458	▼ -6%		$677,418
Direct Cost	$392,800	$405,695	$443,358	$430,426	▼ -3%		$468,561
Contribution Margin	$251,810	$221,539	$233,918	$208,032	▼ -11%		$208,857
Indirect Cost	$147,117	$186,187	$191,389	$211,976	▲ 11%		$231,184
Net Income	$104,694	$35,351	$42,529	($3,945)	▼ -109%		($22,327)
Net Revenue per Visit	$90	$89	$83	$79	▼ -4%		$77
Direct Cost per Visit	$55	$57	$54	$54	▼ -1%		$54
Contrb Margin per Visit	$35	$31	$29	$26	▼ -9%		$24

TRENDED GRAPHS

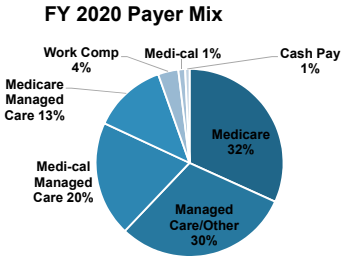






PAYER MIX - 4 YEAR TREND (VISIT VOLUME)

PAYER	FY2017	FY2018	FY2019	FY2020
Medicare	31%	33%	34%	32%
Managed Care/Other	43%	38%	30%	30%
Medi-cal Managed Care	10%	13%	20%	20%
Medicare Managed Care	9%	10%	12%	13%
Work Comp	5%	4%	2%	4%
Medi-cal	1%	1%	1%	1%
Cash Pay	1%	1%	1%	1%



Note: All visits with a primary service of Radiology. This excludes visits with Radiology services performed as a part of another outpatient service line (eg. Urgent Care, Emergency Department).

KDHCD ANNUAL BOARD REPORT

FY2020

Outpatient Radiology Services - Nuclear Medicine Downtown Campus

KEY METRICS - FY 2020 BASED ON THE TWELVE MONTHS ENDED JUNE 30, 2020

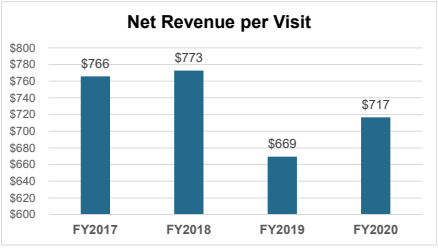
Patient Visits	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
907	$649,964	$503,323	$146,640	($83,890)
▼ -2%	▲ 5%	▲ 12%	▼ -13%	▼ -314%

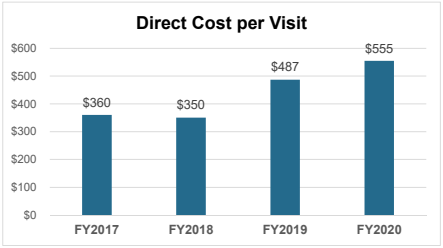
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

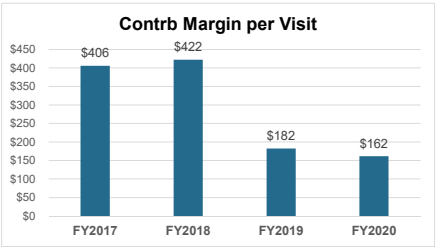
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND	Pre-Covid Ann. Jul. 19-Feb.20
Patient Visits	1,122	1,053	921	907	▼ -2%		983
Net Revenue	$859,320	$813,741	$616,558	$649,964	▲ 5%		$697,301
Direct Cost	$404,082	$369,012	$448,505	$503,323	▲ 12%		$543,796
Contribution Margin	$455,238	$444,729	$168,053	$146,640	▼ -13%		$153,505
Indirect Cost	$104,072	$120,705	$128,805	$230,530	▲ 79%		$246,016
Net Income	$351,167	$324,024	$39,249	($83,890)	▼ -314%		($92,511)
Net Revenue per Visit	$766	$773	$669	$717	▲ 7%		$710
Direct Cost per Visit	$360	$350	$487	$555	▲ 14%		$553
Contrb Margin per Visit	$406	$422	$182	$162	▼ -11%		$156

TRENDED GRAPHS

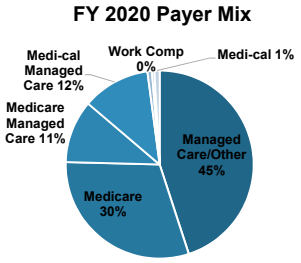






PAYER MIX - 4 YEAR TREND (VISIT VOLUME)

PAYER	FY2017	FY2018	FY2019	FY2020
Managed Care/Other	46%	47%	44%	45%
Medicare	33%	30%	35%	30%
Medicare Managed Care	6%	7%	7%	11%
Medi-cal Managed Care	13%	14%	11%	12%
Cash Pay	1%	1%	1%	1%
Work Comp	0%	0%	1%	0%
Medi-cal	1%	1%	1%	1%



Note: All visits with a primary service of Radiology. This excludes visits with Radiology services performed as a part of another outpatient service line (eg. Urgent Care, Emergency Department).

KDHCD ANNUAL BOARD REPORT

Outpatient Radiology Services - CT Scan Downtown Campus

FY2020

KEY METRICS - FY 2020 BASED ON THE TWELVE MONTHS ENDED JUNE 30, 2020

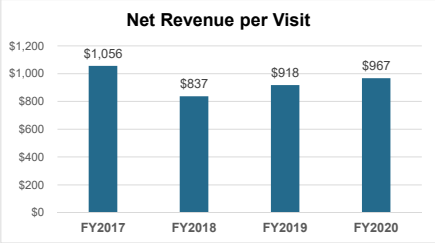
Patient Visits	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
193	$186,578	$55,786	$130,792	$104,126
▲ 12%	▲ 18%	▲ 16%	▲ 18%	▲ 18%

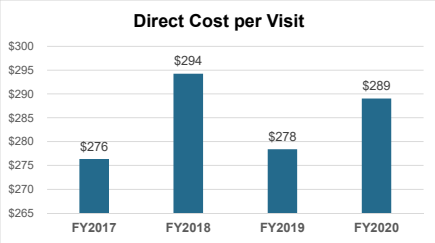
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

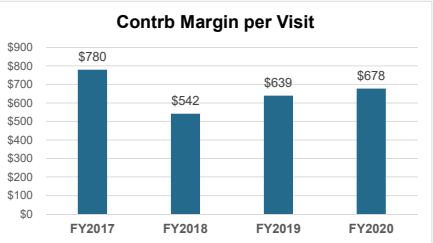
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND	Pre-Covid Ann. Jul. 19-Feb.20
Patient Visits	266	554	173	193	▲ 12%		206
Net Revenue	$280,950	$463,430	$158,755	$186,578	▲ 18%		$206,094
Direct Cost	$73,503	$163,017	$48,161	$55,786	▲ 16%		$57,270
Contribution Margin	$207,447	$300,414	$110,593	$130,792	▲ 18%		$148,825
Indirect Cost	$35,194	$93,990	$22,275	$26,666	▲ 20%		$27,749
Net Income	$172,253	$206,423	$88,318	$104,126	▲ 18%		$121,076
Net Revenue per Visit	$1,056	$837	$918	$967	▲ 5%		$1,003
Direct Cost per Visit	$276	$294	$278	$289	▲ 4%		$279
Contrb Margin per Visit	$780	$542	$639	$678	▲ 6%		$724

TRENDED GRAPHS

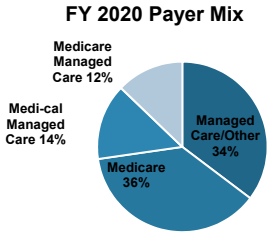






PAYER MIX - 4 YEAR TREND (VISIT VOLUME)

PAYER	FY2017	FY2018	FY2019	FY2020
Managed Care/Other	27%	29%	34%	34%
Medicare	35%	44%	41%	36%
Medi-cal Managed Care	19%	14%	16%	14%
Medicare Managed Care	12%	9%	4%	12%
Medi-cal	2%	2%	2%	2%
Cash Pay	1%	1%	2%	1%



Note: All visits with a primary service of Radiology. This excludes visits with Radiology services performed as a part of another outpatient service line (eg. Urgent Care, Emergency Department).

KDHCD ANNUAL BOARD REPORT

Outpatient Radiology Services - MRI Downtown Campus

FY2020

KEY METRICS - FY 2020 BASED ON THE TWELVE MONTHS ENDED JUNE 30, 2020

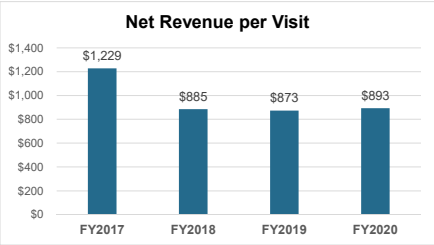
Patient Visits	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
136	$121,497	$33,605	$87,892	$65,036
▲ 36%	▲ 39%	▲ 42%	▲ 38%	▲ 39%

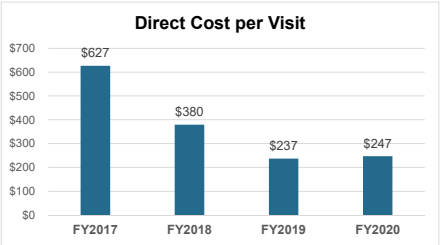
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

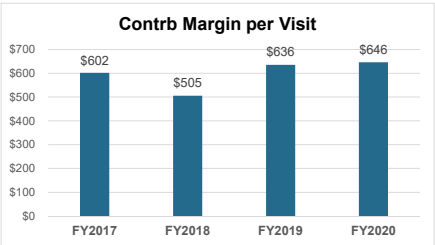
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND	Pre-Covid Ann. Jul. 19-Feb.20
Patient Visits	108	82	100	136	▲ 36%		156
Net Revenue	$132,688	$72,549	$87,276	$121,497	▲ 39%		$139,627
Direct Cost	$67,706	$31,120	$23,714	$33,605	▲ 42%		$38,940
Contribution Margin	$64,983	$41,429	$63,562	$87,892	▲ 38%		$100,687
Indirect Cost	$30,809	$18,957	$16,614	$22,856	▲ 38%		$26,528
Net Income	$34,173	$22,472	$46,948	$65,036	▲ 39%		$74,159
Net Revenue per Visit	$1,229	$885	$873	$893	▲ 2%		$895
Direct Cost per Visit	$627	$380	$237	$247	▲ 4%		$250
Contrb Margin per Visit	$602	$505	$636	$646	▲ 2%		$645

TRENDED GRAPHS

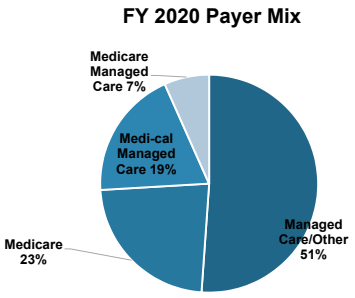






PAYER MIX - 4 YEAR TREND (VISIT VOLUME)

PAYER	FY2017	FY2018	FY2019	FY2020
Managed Care/Other	54%	51%	55%	51%
Medicare	23%	24%	27%	23%
Medi-cal Managed Care	14%	16%	9%	19%
Medicare Managed Care	5%	5%	6%	7%
Medi-cal	2%	1%	0%	0%
Cash Pay	0%	0%	0%	0%
Work Comp	3%	1%	3%	1%
Tulare County	0%	1%	0%	0%



Note: All visits with a primary service of Radiology. This excludes visits with Radiology services performed as a part of another outpatient service line (eg. Urgent Care, Emergency Department).

KDHCD ANNUAL BOARD REPORT

FY2020

Outpatient Radiology Services - Diagnostic Imaging Downtown Campus

KEY METRICS - FY 2020 BASED ON THE TWELVE MONTHS ENDED JUNE 30, 2020

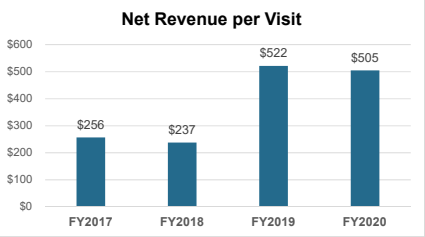
Patient Visits	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
309	$156,125	$127,564	$28,561	($19,664)
▲ 12%	▲ 9%	▲ 64%	▼ -57%	▼ -152%

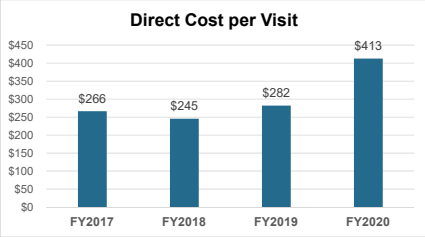
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

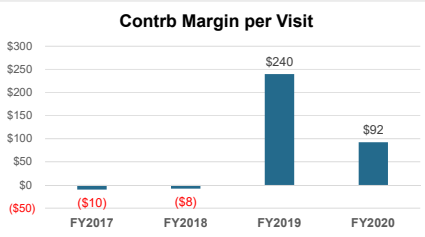
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND	Pre-Covid Ann. Jul. 19-Feb.20
Patient Visits	1,064	1,064	275	309	▲ 12%		339
Net Revenue	$272,830	$252,664	$143,524	$156,125	▲ 9%		$163,329
Direct Cost	$283,391	$261,029	$77,570	$127,564	▲ 64%		$137,659
Contribution Margin	($10,561)	($8,365)	$65,954	$28,561	▼ -57%		$25,670
Indirect Cost	$96,905	$88,857	$28,371	$48,225	▲ 70%		$51,084
Net Income	($107,466)	($97,222)	$37,583	($19,664)	▼ -152%		($25,415)
Net Revenue per Visit	$256	$237	$522	$505	▼ -3%		$482
Direct Cost per Visit	$266	$245	$282	$413	▲ 46%		$406
Contrb Margin per Visit	($10)	($8)	$240	$92	▼ -61%		$76

TRENDED GRAPHS

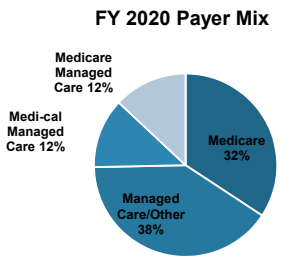






PAYER MIX - 4 YEAR TREND (VISIT VOLUME)

PAYER	FY2017	FY2018	FY2019	FY2020
Medicare	40%	39%	36%	32%
Managed Care/Other	37%	34%	41%	38%
Medi-cal Managed Care	8%	10%	9%	12%
Medicare Managed Care	11%	12%	11%	12%
Medi-cal	1%	1%	2%	1%
Cash Pay	0%	1%	0%	2%
Work Comp	2%	3%	1%	2%



Note: All visits with a primary service of Radiology. This excludes visits with Radiology services performed as a part of another outpatient service line (eg. Urgent Care, Emergency Department).

KDHCD ANNUAL BOARD REPORT

FY2020

Outpatient Radiology Services - Diagnostic Imaging UCC Demaree (Walk-in Radiology)

KEY METRICS - FY 2020 BASED ON THE TWELVE MONTHS ENDED JUNE 30, 2020

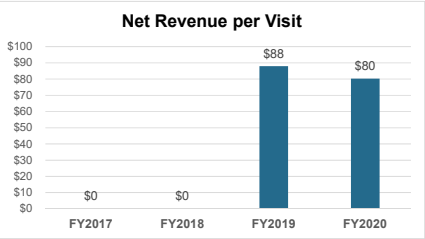
Patient Visits	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
446	$35,846	$43,889	($8,043)	($23,205)
▲ 197%	▲ 171%	▲ 162%	▼ -125%	▼ -147%

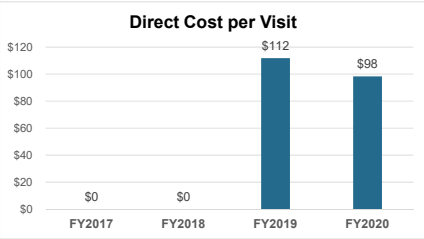
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

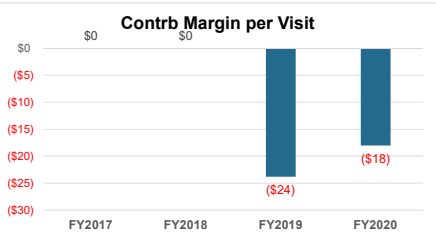
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND	Pre-Covid Ann. Jul. 19-Feb.20
Patient Visits	0	0	150	446	▲ 197%		480
Net Revenue	$0	$0	$13,208	$35,846	▲ 171%		$37,539
Direct Cost	$0	$0	$16,782	$43,889	▲ 162%		$46,823
Contribution Margin	$0	$0	($3,574)	($8,043)	▼ -125%		($9,284)
Indirect Cost	$0	$0	$5,814	$15,162	▲ 161%		$15,903
Net Income	$0	$0	($9,388)	($23,205)	▼ -147%		($25,187)
Net Revenue per Visit	$0	$0	$88	$80	▼ -9%		$78
Direct Cost per Visit	$0	$0	$112	$98	▼ -12%		$98
Contrb Margin per Visit	$0	$0	($24)	($18)	▲ 24%		($19)

TRENDED GRAPHS

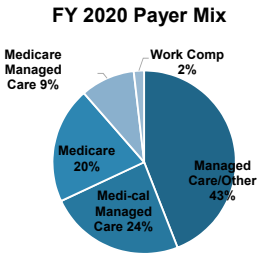






PAYER MIX - 4 YEAR TREND (VISIT VOLUME)

PAYER	FY2017	FY2018	FY2019	FY2020
Managed Care/Other	0%	0%	47%	43%
Medi-cal Managed Care	0%	0%	21%	24%
Medicare	0%	0%	24%	20%
Medicare Managed Care	0%	0%	5%	9%
Work Comp	0%	0%	1%	2%
Cash Pay	0%	0%	0%	0%
Work Comp	0%	0%	1%	2%



Note: All visits with a primary service of Radiology. This excludes visits with Radiology services performed as a part of another outpatient service line (eg. Urgent Care, Emergency Department).

Risk Management Report - Open
3rd & 4th Quarters 2020
January 25, 2021

Anu Banerjee
Vice President Chief Quality Officer
Alexandra Bennett
Director of Risk Management

More than medicine. Life.

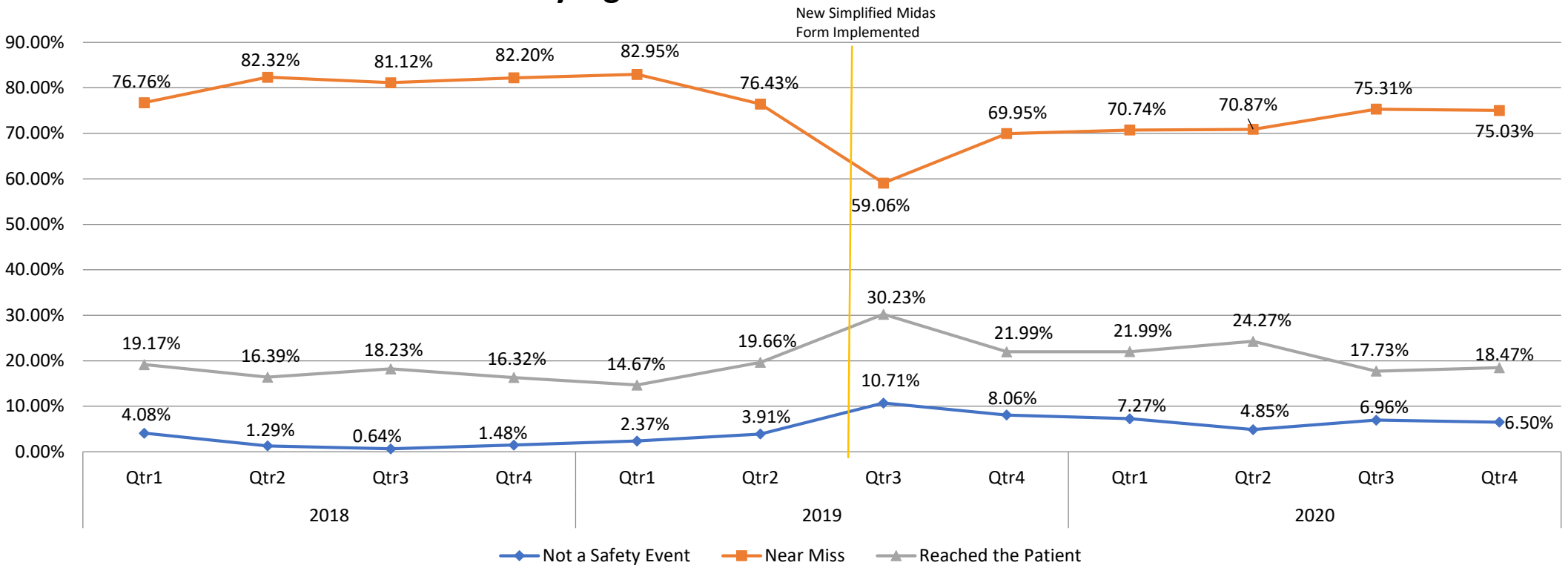
Risk Management Goals

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

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

3. Reduce frequency and severity of claims.

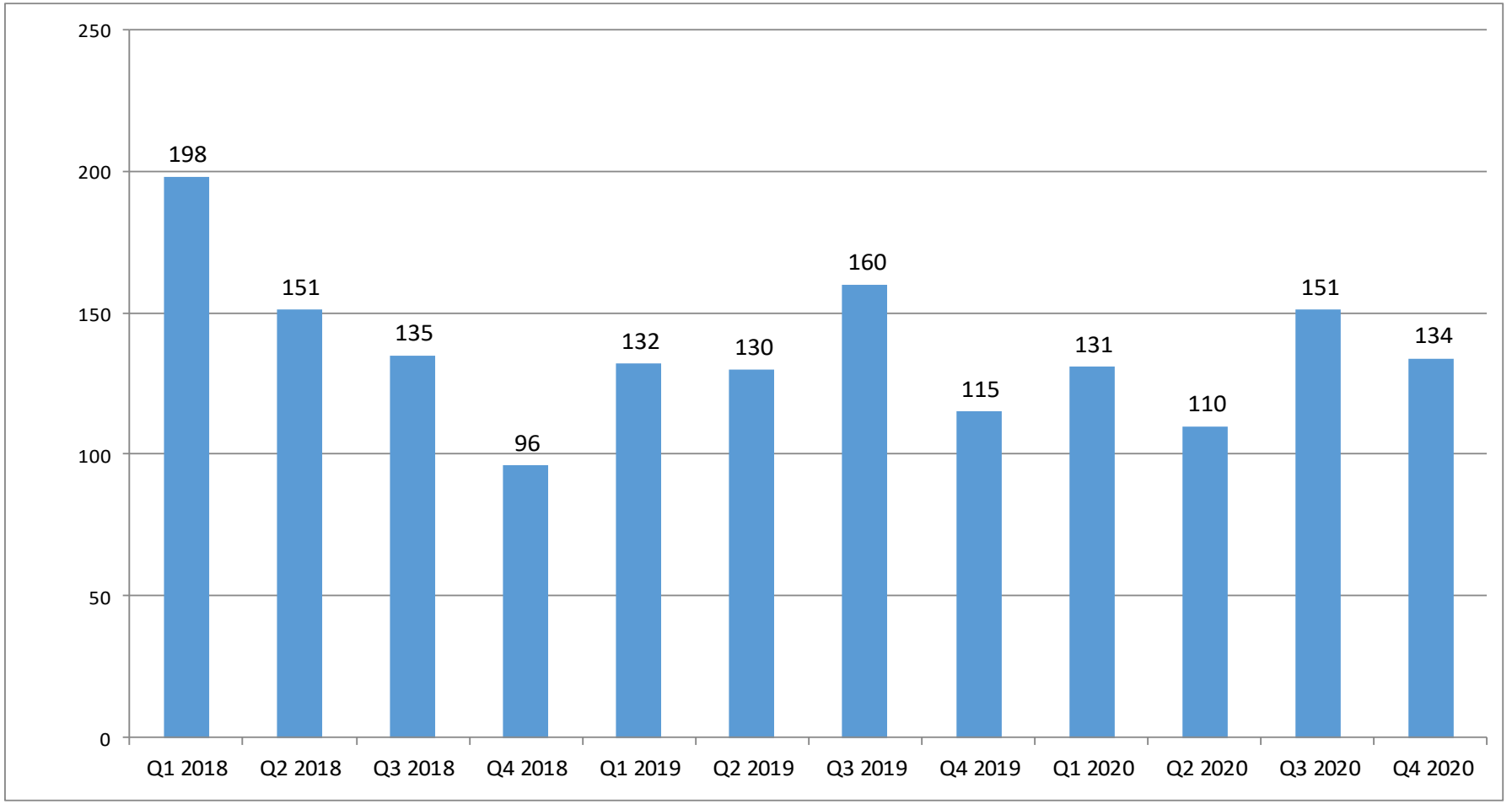
Midas Risk Events - Rate by Significance



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

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

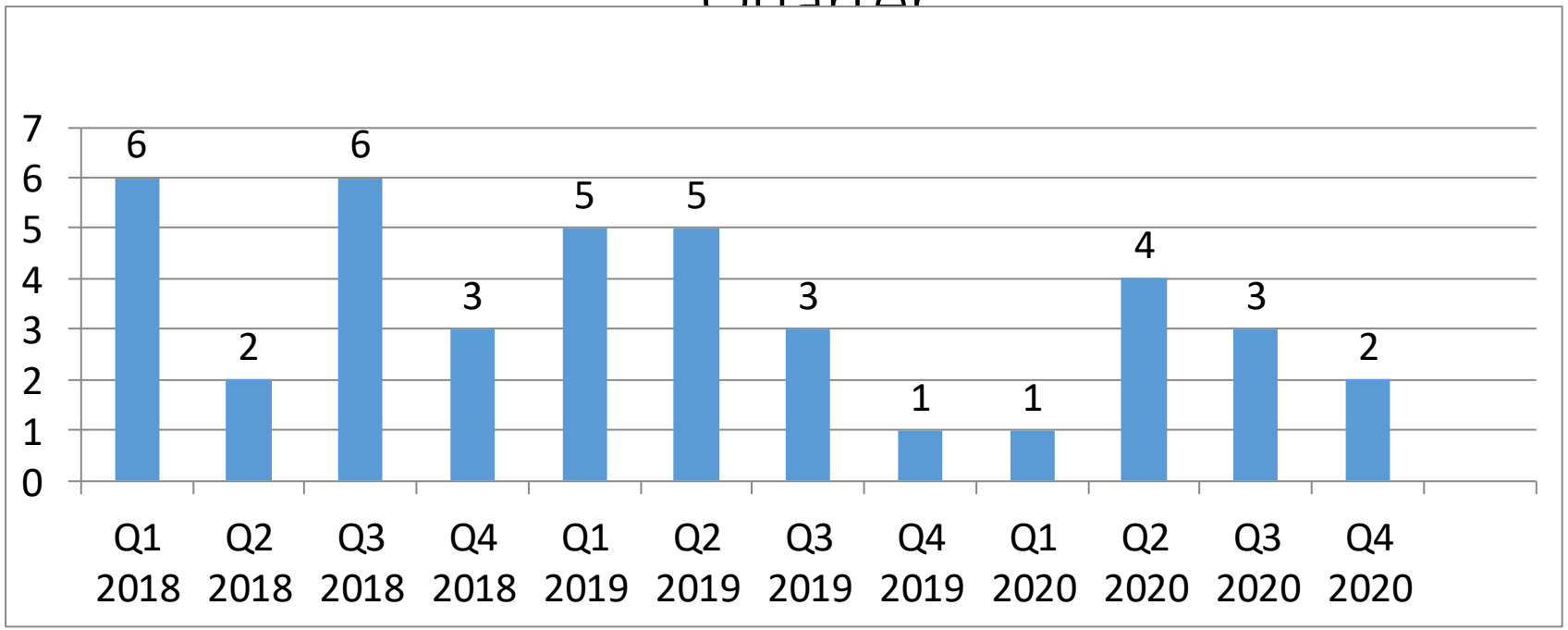
Complaints & Grievances



Most Common Complaints:

- Lost Belongings
- Nursing Care
- Physician Care

Claims Frequency
January 2018- December 2020
Number of Claims Received per Quarter



Total cases closed during 3rd Quarter 2020 – (3) Three
Total cases closed during 4th Quarter 2020 – (4) Four

Privileges in Neurology

Name: _____ Date: _____

Please Print

NEUROLOGY

Education & Training: M.D. or D.O. and successful completion of an accredited residency/fellowship in Internal Medicine or a subspecialty in Psychiatry & Neurology approved by the ACGME, AOA or by the Royal College of Physician & Surgeons of Canada *(if board certified by an ABPN or AOPN Board or actively pursuing ABPN or AOBPN Board Certification)* AND Current certification or active participation in the examination process leading to certification in Neurology by the American Board of Psychiatry Neurology or American Osteopathic Board of Neurology, with certification obtained within 5 years of completion of residency.

Initial Criteria for Sleep Studies/Polysomnography: Completion of a clinical fellowship approved by the American Academy of Sleep Medicine (AASM) or ACGME AND Board Certification or active participation in the examination process leading to certification in Sleep Medicine by the AASM or ACGME; AND 5 hours CME per year as pertains to sleep studies.

Initial Clinical Experience: Provision of care to at least 25 patient contacts in the past 2 years or successful completion of an ACGME or AOA accredited residency or clinical fellowship within the past 12 months.

Renewal Criteria: ~~10~~12 patient contacts in the past two years; AND a minimum of 24 EEG interpretation in the past two years AND Maintenance of Board Certification in Neurology.

FPPE: 6 concurrent or retrospective chart reviews representative of privileges requested.

Request	NEUROLOGY CORE PRIVILEGES	Approve
☐	Perform H&P evaluate, diagnose, treat and provide consultation to patients 16 years and older with diseases, disorders, or impaired function of the brain, spinal cord, peripheral nerves, muscles, autonomic nervous system and blood vessels that relate to these structures, including, but not limited to: • Performance and Interpretation of EEG and EMG and nerve conduction studies • Lumbar Puncture • Sleep studies/Polysomnography • Transcranial Doppler (TCD) ultrasonography • Botulinum toxin injection	☐
☐	Admitting Privileges (must request Active or Courtesy staff status)	☐
☐	Interpretation **ONLY** of neurological tests (i.e., EEG, EMG)	☐
☐	TeleHealth: Provide interpretative, diagnostic or treatment services by means of telemedicine devices (including interactive audio, video or data communications)	☐

GENERAL INTERNAL MEDICINE CORE PRIVILEGES

Request	Privileges/Procedures	Renewal Criteria	FPPE	Approve
☐	Perform H&P, evaluate, diagnose, treat and provide consultation to adolescent and adult patients with common and complex illnesses, diseases and functional disorders of the circulatory, respiratory, endocrine, metabolic, musculoskeletal, hematopoietic, gastroenteric and genitourinary systems.	Maintenance of Board Certification in Internal Medicine.	6 concurrent or retrospective chart reviews	☐

ADDITIONAL PRIVILEGES

Request	Procedure	Initial Criteria	Renewal Criteria	FPPE	Approve
☐	Procedural Sedation	Completion of KD Procedural Sedation Exam	Completion of KD Procedural Sedation Exam	None	☐
☐	Outpatient Services at a Kaweah Delta Health Care District Outpatient Clinics identified below. Privileges include performance of core privileges/procedures as appropriate to an outpatient setting and may include telehealth: **__ Dinuba __ Exeter __Lindsay__ Woodlake** **___Family Medicine Clinic __Dialysis Clinic** **__ Chronic Disease Management Clinic**	Executed contract with Kaweah Delta Health Care District or KDHCD ACGME Family Medicine Program	Maintain initial criteria	None	☐

Acknowledgment of Practitioner:

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

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

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

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

Applicant Signature:_____ Date:_____

Signature: _____ Date:_____

Privileges in Neurosurgery

Name: _____

Please Print

Neurosurgery Privileges – Initial Criteria
Education/Training: MD or DO; AND successful completion of at least 1year general surgery internship and a 5year residency in neurological surgery approved by the Accreditation Council for ACGME, by the AOA or by the Royal College of Physicians & Surgeons of Canada if board certified by and ABMS board or actively pursuing board certification by and ABMS board; AND Current certification or active participation in the examination process leading to certification in neurological surgery by the American Board of Neurological Surgery or the American Osteopathic Board of Surgery (Must obtain certification within 5 years of graduation from residency program.) **Additional Qualifications:** Applicant agrees to restrict device usage (e.g., nerve stimulators, etc.) to only those devices (models) and applications for which they have received device-specific orientation and training.

NEUROSURGERY – ~~CEREBROVASCULAR~~ CRANIAL NEUROSURGERY CORE

Initial Clinical Experience: A minimum of 15 procedures in the past 2 years or successful completion of residency/fellowship in the past 12 months

Renewal Clinical Experience: A minimum of 15 procedures in the past 2 years

FPPE: Concurrent proctoring and chart review of the first 2 ~~CEREBROVASCULAR~~ Cranial neurosurgery procedures.

Request	Procedure	Approve
☐	Admit, evaluate, diagnose, consult, and treat patients with surgically addressable pathologies of the brain, spinal cord and its coverings,~~cerebrovascular diseases, including ischemic and hemorrhagic stroke, and other diseases and malformations of intracranial, extracranial and spinal vasculature~~ including, but not limited to the following procedures, and such other procedures that are extensions of the same techniques and skills to include: • Twist drill holes, burr holes, and trephine for ventricular puncture, pressure recording device placement, and evacuation and/or drainage of hematoma, brain abscess, or cyst • Elevation of depressed skull fracture • Cranioplasty for skull defect • Ventriculocisternostomy • Creation of shunt, ventriculo-atrial, -jugular, -auricular, -peritoneal, -pleural, or other terminus • Craniectomy and craniotomy for evacuation of hematoma, excision or drainage of intracranial abscess, excision and resection of tumor in skull or infected bone, excision of foreign body from brain, repair of dural/cerebrospinal fluid leak, and repair of encephalocele • Craniectomy and craniotomy for microvascular decompression • Craniectomy and craniotomy for intra-axial tumors involving region of brainstem, sella, suprasellar region, or third or fourth ventricle, and for extra-axial tumors involving CP angle (including vestibular schwannomas and meningiomas), skull base, sella or suprasellar, or clival region • Craniotomy for aneurysms or arteriovenous malformations including resection of arteriovenous malformations • Anastomosis of extracranial to intracranial vessels • Neuroendoscopy, intracranial, with dissection of adhesions, fenestration, placement of catheters, retrieval of foreign body, and excision of tumors including transseptal/ transphenoidal resection of pituitary lesions • Repair of syringomyelia and syringhydromyelia • Repair of meningocele and meningomyelocele • Implantation of brain intracavitary chemotherapy agent • Implantation and management of vagus nerve stimulator • Stereotactic biopsy or aspiration of intracranial lesion • Stereotactic computer assisted navigational procedure where the practitioner is a current privilege holder in the corresponding minimally invasive or open procedure • Stereotactic-Guided Radiation Therapy (in conjunction with Radiation Oncologist at SRCC)	☐

SPINAL NEUROSURGERY CORE

Initial Clinical Experience: A minimum of 15 procedures in the past 2 years or successful completion of residency/fellowship in the past 12 months
Renewal Clinical Experience: A minimum of 15 procedures in the past 2 years
FPPE: Concurrent proctoring and chart review of the first 2 SPINAL neurosurgery procedures.

Request	Procedure	Approve
☐	Admit, evaluate, diagnose, consult, and treat patients with disorders of the spine, its connecting ligaments, the spinal cord, the cauda equine, and the spinal roots including, but not limited to the following procedures, and such other procedures that are extensions of the same techniques and skills to include: • Posterior epidural laminotomy and laminectomy for decompression of neural elements and excision of disc, with and without fusion/instrumentation, including posterior segmental and non-segmental spinal instrumentation • Placement of sublaminar wires, lateral mass screws, and lower cervical/upper thoracic pedicle screws • Transpedicular and costovertebral approach for posterolateral extradural decompression, with and without fusion/instrumentation • Anterior, anteriolateral, and lateral lumbar and cervical spine for extradural decompression, with and without fusion/instrumentation • Kyphoplasty and percutaneous vertebroplasty • Degenerative adult scoliosis correction with fusion/instrumentation • Implantation of artificial disc • Lumbar, cervical, and thoracic complete corpectomy with fusion/instrumentation • Iliac crest instrumentation • Occipito-cervical fusion/instrumentation • Transoral approach to skull base, brainstem, and upper spinal cord biopsy • Exposure for lateral, trans-psoas approach to lumbar spine with fusion/instrumentation • Lumbar pedicle subtraction osteotomy with fusion/instrumentation • Resection and biopsy of extradural, intradural, intra-axial, and extra-axial spinal cord lesions • Resection of spinal arteriovenous malformation • Cordotomy • Release of tethered cord • Intrathecal and epidural drug infusion pump implantation and management • Implantation and management of spinal cord stimulator • Endoscopic technique in a procedure where the applicant is a concurrent privilege holder • Lumbar puncture and/or drain • Spinal radiosurgery/sterotactic body radiotherapy (in conjunction with Radiation Oncologist at SRCC)	☐

ADDITIONAL PRIVILEGES

Use of Laser as an Adjunct to a Privileged Procedure

Education/Training: If training occurred during the previous 24 months, the applicant must provide documentation of completion of a basic training program devoted to the principles of lasers, their instrumentation and physiological effects, and safety requirements. The initial program should include clinical applications of various wavelengths in the particular specialty field and hands-on practical sessions with lasers and their appropriate surgical or therapeutic delivery systems. Such training may have occurred in a residency or fellowship program or in a post-graduate course. Such training must be followed by documentation of the performance of cases on human subjects under the supervision of a qualified preceptor.
Initial Clinical Experience: A minimum of 4 procedures in the past 2 years or successful completion of residency/fellowship in the past 12 months
Renewal Clinical Experience: A minimum of 4 procedures in the past 2 years
FPPE: Concurrent proctoring of first 2 cases

Request	Procedure	Approve
☐	Use of laser as an adjunct to a privileged procedure	☐

Request	Procedure	Initial Criteria	Renewal Criteria	FPPE	Approve
☐	Surgical Assist Only	Meet Initial Criteria	Maintain Initial Criteria	None	☐
☐	Procedural Sedation	Successful completion of KD Procedural Sedation Exam	Successful completion of KD Procedural Sedation Exam	None	☐
☐	Outpatient Services at a Kaweah Delta Health Care District Outpatient Clinics identified below. Privileges include performance of core privileges/procedures as appropriate to an outpatient setting and may include telehealth: **__ Dinuba __ Exeter __Lindsay** **__ Woodlake ___Family Medicine Clinic** **___Chronic Disease Management Center** **___Sequoia Regional Cancer Center**	Executed contract with Kaweah Delta Health Care District or KDHCD ACGME For Outpatient Only: Executed Contract AND meet Education/Training Requirements for Neurosurgery Privileges AND **50** patient contacts in past 2 years	Maintain initial criteria For Outpatient Only: Maintain Initial Criteria AND **50** patient contacts in past 2 years	None For outpatient Only: Minimum of 1 Concurrently or Retrospective	☐
☐	Supervision of a technologist using fluoroscopy equipment	Current and valid CA Fluoroscopy supervisor and Operator Permit or a	Current and valid CA Fluoroscopy supervisor and Operator Permit or	None	☐

		CA Radiology Supervisor and Operator Permit	a CA Radiology Supervisor and Operator Permit		
☐	Insertion, management, and removal of percutaneous arterial catheters, percutaneous central venous catheters, percutaneous pulmonary artery catheters, percutaneous venous catheters for dialysis (does NOT include arteriovenous fistulas or arteriovenous grafts), and subcutaneous IV ports with and without image guidance.	Documentation of 5 in the previous 24 months	Minimum of 5 in the last two years.		☐

Acknowledgment of Practitioner:

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

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

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

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

Name: _____
Print

Signature: _____ _____
Applicant *Date*

Signature: _____ _____
Department of Psychiatry & Neurosciences Chair *Date*

Privilege Form Revision Request:

Due to the ever changing health care needs, I would like to add to every privilege form in the core privileges section that telehealth may be a mode used for consultations. I know that we recommended adding it to all privileges a few months ago and it was not accepted, but with the onset of this pandemic there is a greater need to use it. For example, it is being used extensively in the outpatient setting and now ED wants to utilize it for patients that aren't admitted but need continued assessment.

Would you be in agreement to add to all privilege forms:

Core Privileges include: Perform an H&P, evaluate, diagnose, treat, and provide consultation **(may include telehealth)** …

Teresa Boyce, MHA, CPMSM, CPCS
Director of Medical Staff Services

RESOLUTION 2119

WHEREAS, a claim on behalf of Gabriella Montes de Oca has been presented on December 30, 2020 to the Board of Directors of the Kaweah Delta Health Care District,

IT IS HEREBY RESOLVED AS FOLLOWS:

1. The aforementioned claim is hereby rejected.

2. In accordance with Government Code Section 913, the Secretary of the Board of Directors is hereby directed to give notice of rejection of said claim to Nicole K. Ricotta, Esq. of Anticouni & Associates in Santa Barbara, California, in the following form:

"Notice is hereby given that the claim which you presented to the Board of Directors of the Kaweah Delta Health Care District on December 30, 2020, was rejected by the Board of Directors on January 25, 2021."

WARNING

"Subject to certain exceptions, you have only six (6) months from the date this notice was personally delivered or deposited in the mail to file a court action on this claim. See Government Code Section 945.6.

You may seek the advice of an attorney of your choice in connection with this matter. If you desire to consult an attorney, you should do so immediately."

PASSED AND ADOPTED by unanimous vote of those present at a regular meeting of the Board of Directors of the Kaweah Delta Health Care District on January 25, 2021.

_____
President, Kaweah Delta Health Care District

ATTEST:

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

/cm

LAFCO

TULARE COUNTY
LOCAL AGENCY FORMATION COMMISSION

210 N. Church St., Suite B, Visalia, CA 93291 Phone: (559) 623-0450 FAX: (559) 733-6720

12/7/2020

CALL FOR NOMINATIONS TO APPOINT AN INDEPENDENT SPECIAL DISTRICT REPRESENTATIVE TO THE COUNTYWIDE RDA OVERSIGHT BOARD

Background

On July 1, 2018, all of the redevelopment agency (RDA) oversight boards in Tulare County were consolidated into one oversight board. Our county's Independent Special District Selection Committee ("Committee") was granted the authority to appoint one special district representative to our County's oversight board.

In 2018, the Committee elected Daniel Smith of the Sierra View Health Care District as the board member and Leo Gonzalez of the Orosi Memorial District as the alternate board member for the Tulare County RDA Oversight Board. Daniel Smith is no longer on the Sierra View HCD board so a new Special District representative needs to be chosen.

Eligibility Requirements

Committee participation is limited to independent special districts that receive property tax residual from the Redevelopment Property Tax Trust Fund (Health and Safety Code section 34179(j)(3)). There are 39 independent special districts (listed on the following page) that are eligible to participate on the committee. Committee action, such as the request addressed in this memo, may be conducted via mail pursuant to Government Code section 56332(f).

Your district's representative on the committee is the presiding officer of the legislative body of the district (generally the board chairperson). If the presiding officer is unable to participate, your board may appoint one of its members instead.

The representative to the RDA oversight board appointed by the committee shall be an elected or appointed member of the legislative body of an eligible independent special district residing in Tulare County but shall not be a member of the legislative body of a city or county.

INDEPENDENT SPECIAL DISTRICT REPRESENTATIVE NOMINATION FORM TO APPOINT AN INDEPENDENT SPECIAL DISTRICT REPRESENTATIVE TO THE TULARE COUNTY REDEVELOPMENT AGENCY (RDA) OVERSIGHT BOARD

By: _____
Name of Special District making the nomination

Nomination: _____
Nominee's name and Special District they represent

Party making the nomination: _____
Signature

_____
Print Name

I attest that I am the
[ ] presiding officer, or
[ ] alternate as designated by the governing body

Date: _____

This nomination form must be returned to Tulare LAFCO
210 N. Church St., Suite B, Visalia CA 93291 by January 29, 2020
Or scanned and e-mailed to akane@tularecog.org

LAFCO use only:

Date nomination form received: *By:*