April 24, 2020

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Board of Directors meeting at 10:00AM on Monday, April 27, 2020 in the Kaweah Delta – Support Services Building Granite Room (4th Floor – Accessed off Mineral King Avenue) 520 West Mineral King Avenue or via *
https://www.gotomeet.me/CindyMoccio/april-kdhcd-board-of-directors-mtg or
you can also dial in using your phone (646) 749-3112 Access Code: 419-131-117

The Board of Directors of the Kaweah Delta Health Care District will meet in a closed Board of Directors meeting at 10:01AM on Monday, April 27, 2020 in the Kaweah Delta – Support Services Building Granite Room (4th Floor – Accessed off Mineral King Avenue) 520 West Mineral King Avenue pursuant to Health and Safety Code 32155 and 1461. Board members may access via GoTo meeting phone number provided to them by the Board Clerk.

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Board of Directors meeting at 10:10AM on Monday, April 27, 2020 in the Kaweah Delta – Support Services Building Granite Room (4th Floor – Accessed off Mineral King Avenue) 520 West Mineral King Avenue or via GoTo information noted 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 and on the Kaweah Delta Health Care District web page http://www.kaweahdelta.org.

KAWEAH DELTA HEALTH CARE DISTRICT
David Francis, Secretary/Treasurer

Cindy Moccio

Cindy Moccio - Board Clerk / Executive Assistant to CEO

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

KAWEAH DELTA HEALTH CARE DISTRICT
BOARD OF DIRECTORS MEETING

Kaweah Delta Medical Center / Support Services Building
520 West Mineral King – Granite Room (4th floor)

Join from your computer, tablet or smartphone
https://www.gotomeet.me/CindyMoccio/april-kdhcd-board-of-directors-mtg
or Dial In: (646) 749-3112 / Access Code: 419-131-117

Monday, April 27, 2020

OPEN MEETING AGENDA {10:00AM}

1. **CALL TO ORDER**
2. **APPROVAL OF AGENDA**
3. **PUBLIC PARTICIPATION –** Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the subject matter jurisdictions of the Board are requested to identify themselves at this time.
4. **APPROVAL OF THE CLOSED AGENDA – 10:01AM**
   - 4.1. **Approval of closed meeting minutes** – February 24, 2020, March 13, 2020, and March 23, 2020.
   - 4.2. **Credentialing** pursuant to Health and Safety Code 1461 and 32155, medical staff privileges – *Dennis Lynch, Legal Counsel*
   - 4.3. **Credentialing** - Medical Executive Committee (MEC) requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the MEC be reviewed for approval pursuant to Health and Safety Code 1461 and 32155 – *Monica Manga, MD Vice Chief of Staff*
   - 4.4. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee –– *Monica Manga, MD Vice Chief of Staff*
5. **ADJOURN**

CLOSED MEETING AGENDA {10:01AM}

Confidential GoTo Information provided to the Board of Directors

1. **CALL TO ORDER**
2. **CREDENTIALING** pursuant to Health and Safety Code 1461 and 32155, medical staff privileges

   Dennis Lynch, Legal Counsel
3. **APPROVAL OF CLOSED MEETING MINUTES** – February 24, 2020, March 13, 2020, and March 23, 2020.

   Action Requested – Approval of the closed meeting minutes – February 24, 2020, March 13, 2020, and March 23, 2020.
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

   Monica Manga, MD Vice Chief of Staff
5. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee

   Monica Manga, MD Vice Chief of Staff

ADJOURN

OPEN MEETING AGENDA {10:10AM – following closed meeting}

Join from your computer, tablet or smartphone
https://www.gotomeet.me/CindyMoccio/april-kdhcd-board-of-directors-mtg
or Dial In: (646) 749-3112 / Access Code: 419-131-117

1. **CALL TO ORDER**
2. **APPROVAL OF AGENDA**
3. **PUBLIC PARTICIPATION –** Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the subject matter jurisdictions of the Board are requested to identify themselves at this time.
4. **CLOSED SESSION ACTION TAKEN** – Report on action(s) taken in closed session.

5. **OPEN MINUTES** – Request approval of the February 24, 2020, March 13, 2020, March 23, 2020, April 14, 2020 meeting minutes.

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

   *Action Requested – Approval of the op*en meeting minutes – February 24, 2020, March 13, 2020, March 23, 2020, April 14, 2020 open *board of directors meeting minutes.*

6. **REVIEW OF ADMINISTRATIVE POLICY #182 - ALLOCATION OF SCARCE CRITICAL CARE RESOURCES DURING A PUBLIC HEALTH EMERGENCY** – Review and discussion of new Administrative Policy – reviewed and supported by the Medical Executive Committee.

   Gary Herbst, Chief Executive Officer

   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: Approval of new Administrative Policy #182 Allocation of Scarce Critical Care Resources During a Public Health Emergency.

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

   7.1. Review and approval of proposed Board Bylaws revisions. Primary changes include recommended committee name change and updated job titles.

   7.2. Approval of Resolution 2074 - a resolution ordering even-year board of director's election; consolidation of elections; and specifications of the election order for Zones 1, 3, and 5.

   7.3. Approval of the amended Kaweah Delta Health Care District "District" Conflict of Interest Code to update designated employee positions that have been added or removed to the District since adoption of the 2018 Conflict of Interest Code for the District.

   7.4. Kaweah Delta Health Care District Graduate Medical Education diplomas certifying that the Kaweah Delta Health Care District duties for each residency as noted below has been fulfilled.

   A. Emergency Medicine

   1) Lillian Hajna Batizy, MD
   2) Kevin Ryan Carpenter, MD
   3) Braxton Ray Duncan, DO
   4) Camille Angelo Enriquez, MD
   5) Niklas Erik Eriksson, MD
   6) Robert Thomas Granata, MD
   7) Matthew Henschel, DO
   8) Brian Pak-Fung Ho, MD
   9) Mark Anthony Monterroso, MD
   10) Eric Michael Patten, MD
   11) Suzanne Syeda Shah, MD
   12) Joanna Sitzmann, DO
   13) Emily Trinh, MD

B. Family Medicine
   1) Sarajinder Kaur Bansal, MD
   2) Kaur, MD Gursharnjit
   3) Kim, MD Matthew T.
   4) Macias, MD Lea A.
   5) Mann, MD Jasneet Kaur
   6) Nemetalla, MD Marina Atef
   7) Aashini H. Shah, MD

C. Transitional Year
   1) Anu Adediji, MD
   2) Garrick J. Biddle, MD
   3) Nathan Emory Drasler, DO
   4) Ryan Joseph Ferguson, DO
   5) Thomas R. Geisbush, MD
   6) Jacob Troy Gibby, MD
   7) Kyle Marcus Green, MD
   8) Jacob Daniel Hattenbach, DO
   9) Joyce Hsiao, DO
   10) Shelby Marie Potkin, MD
   11) Benjamin P. Sugar, MD
   12) Angela J. Wipf, MD

D. General Surgery
   1) Lissette Pryscilla Gomez, MD
   2) Kyle Ota, MD

E. Psychiatry
   1) Mark W Dailey, DO
   2) Aubree D Pereyra, MD
   3) Gregory Evangelatos, MD

7.5. Approval of Board of Directors Policy (BOD2) – Chief Executive Officer (CEO) Transition – Review and discussion of proposed revision to CEO Transition Board policy.

7.6. Recommendations from the Medical Executive Committee (MARCH/APRIL 2020)
   A. Privileges in Gastroenterology

8. **DESIGNATION OF APPLICANT'S AGENT RESOLUTION FOR NON-STATE AGENCIES** – Review of a resolution to approve authorized agent's to file an application with the California Governor's Office of Emergency Services for the purpose of obtaining certain federal financial assistance under Public Law 93-288 as reviewed and supported by the Finance, Property, Services, and Acquisition Committee on April 22, 2020

Malinda Tupper, VP & Chief Financial Officer

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: Approval of resolution to approve authorized agent's to file an application with the California Governor's Office of Emergency Services for the purpose of obtaining certain federal financial assistance under Public Law 93-288.

9. **FINANCIALS –** Review of the most current fiscal year 2020 financial results.

Malinda Tupper, VP & Chief Financial Officer

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

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. REPORTS

9.1. Chief of Staff – Report relative to current Medical Staff events and issues.
Monica Manga, MD, Vice Chief of Staff

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

9.3. Vice President Chief Human Resources Officer **-** Report relative to current events and issues – COVID-19 update.
Dianne Cox, VP Chief Human Resources Officer

9.4. Board President **-** Report relative to current events and issues.
Nevin House, 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 APRIL 27, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-16

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY APRIL 27, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-16

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY APRIL 27, 2020

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PAGES 7-16

KDHCD - BOARD OF DIRECTORS MEETING

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PAGES 7-16

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MONDAY APRIL 27, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-16

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY APRIL 27, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-16

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY APRIL 27, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-16

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MONDAY APRIL 27, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-16

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY APRIL 27, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-16

KDHCD - BOARD OF DIRECTORS MEETING

MONDAY APRIL 27, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 7-16

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD MONDAY FEBRUARY 24, 2020 5:30PM, IN THE KAWEAH DELTA MEDICAL CENTER MINERAL KING WING BLUE ROOM, NEVIN HOUSE PRESIDING

PRESENT: Directors Francis, Gipson, Havard Mirviss, Hawkins & House; B. Mendenhall, MD, Past Chief of Staff, M. Manga, MD, Vice Chief of Staff; G. Herbst, CEO; T. Rayner, SVP & COO; R. Sawyer, 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; D. Lynch, Legal Counsel, C. Moccio, Recording

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

Director House asked for approval of the agenda.

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

PUBLIC PARTICIPATION – none

Director House called for the approval of the closed agenda.

APPROVAL OF THE CLOSED AGENDA – 5:31PM

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

4.2. **Conference with Legal Counsel – Anticipated Litigation –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 18 Cases **–** *Ben Cripps, Chief Compliance Officer, Dennis Lynch, Legal Counsel*

4.3. **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*

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

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

ADJOURN - Meeting was adjourned at 5:31PM

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

ATTEST:

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

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD MONDAY FEBRUARY 24, 2020 6:00PM, IN THE KAWEAH DELTA MEDICAL CENTER MINERAL KING WING BLUE ROOM, NEVIN HOUSE PRESIDING

PRESENT: Directors Francis, Gipson, Havard Mirviss, Hawkins & House; B. Mendenhall, MD, Past Chief of Staff, G. Herbst, CEO; T. Rayner, SVP & COO; R. Sawyer, 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; D. Lynch, Legal Counsel, C. Moccio, Recording

The meeting was called to order at 5:30PM by Director House

Director House entertained a motion to approve the agenda.

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

PUBLIC/MEDICAL STAFF PARTICIPATION

- None.

CLOSED SESSION ACTION TAKEN: Approval of closed minutes 01.27.2020.

OPEN MINUTES – Approval of open minutes – January 27, 2020.

MMSC (Francis/Hawkins) to approve the open minutes from the January 27, 2020 open board of directors meeting. This was supported unanimously by those present. Vote: Yes – Gipson, Francis, Havard Mirviss, Hawkins, and House

Mr. Herbst introduced the new Vice Presidents:

- Jag Batth, Vice President Rehabilitation & Post Acute Services
- Ryan Gates, Vice President Population Health and CEO of the Sequoia Health and Wellness Center
- Dan Allain, Vice President Cardiac & Surgical Services
- Anu Banerjee, Vice President Chief Quality Officer

RECOGNITIONS

- Presentation of Resolution 2068 to Renee Gutierrez, Cook-Food and Nutrition Services, Service Excellence Award for January 2020.
- Presentation of Resolution 2070 to Lily Thompson, CNA, ICCU-13, Service Excellence Award for February 2020.
- Presentation of Resolution 2071 to Corazon Gaspar, RN, retiring from duty at Kaweah Delta after 34 years of service.
- Presentation of Resolution 2072 to Steve Hensley, Director of Respiratory Services, retiring from duty at Kaweah Delta after 41 years of service.

CONSENT CALENDAR – Director House entertained a motion to approve the consent calendar with the removal of the following items; 7.1D.

MMSC (Hawkins/Havard Mirviss) to approve the consent calendar with the removal of items; 7.1D (Reports: Respiratory Services). This was supported unanimously by those present. Vote: Yes – Gipson, Francis, Havard Mirviss, Hawkins, and House

7.1. REPORTS
- A. Medical Staff Recruitment
- B. Compliance
- C. Mental Health
- D. Respiratory Services
- E. Sleep Disorders Center
- F. Sequoia Surgery Center

7.2. POLICIES

A. ADMINISTRATIVE

1. Cash Control	AP146	Revised
2. Code of Ethical Behavior	AP70	Revised
3. Property Acquisition, Sales, and Leasing	AP181	New
4. Quality Improvement Plan	AP.41	Revised
5. Patient Safety Plan	AP.175	Reviewed

7.3. BOARD COMMITTEE MINUTES;
- A. Finance, Property, Services, and Acquisition Committee (01/23/2020)
- B. Marketing and Public Affairs Committee (02/05/2020)

7.4. Approval of Resolution 2073 in recognition of Pam Rosenberger, retiring from duty at Kaweah Delta after 18 years of service.

7.5. Approval of the Kaweah Delta Compliance Program Work Plan calendar year 2020 as reviewed and supported for Board approval at the February 2020 Audit and Compliance Committee meeting.

7.6. Approval of the Audit and Compliance Committee Mission and Purpose as reviewed and approved at the February 2020 Audit and Compliance Committee meeting.

7.7. Approval of the Audit Program Work Plan calendar year 2020 as reviewed and supported for Board approval at the February 2020 Audit and Compliance Committee meeting.

7.8. Kaweah Delta Health Care, Inc. Board - Request for replacement of Dr. Craig Calloway, who has resigned from the Kaweah Delta Health Care, Inc. Board with Dr. Ralph Kingsford to serve out the remainder of Dr. Calloway's term which expires on 10/31/2020.

7.9. Recommendation from the Medical Executive Committee (FEBRUARY 2020)

A. Privilege forms
- Sequoia Health and Wellness Outpatient Medicine (new)
- APP Emergency Medicine. Urgent (revised)
- Podiatry (revised)

- Emergency Medicine (revised)

B. Medical Staff Bylaws and Rules and Regulations (revised)

C. Medical Staff Policy
   - MS50 Late Career Policy (Revised)

7.1D (Reports: Respiratory Services) – Inquiry relative to the average ventilator days per patient in the 90's, why was there an increase. Mr. Hensley noted that we had more complex cases then, however we have worked hard to reduce the number of days on ventilator.

MMSC {Gipson/Havard Mirviss} to approve 7.1D (Reports: Respiratory Services). This was supported unanimously by those present. Vote: Yes – Gipson, Francis, Havard Mirviss, Hawkins, and House

QUALITY REPORT – Rapid Response Team – A review of key measures and action items associated with rapid response processes (copy attached to the original of these minutes and considered a part thereof) - Jon Knudsen, Director of Critical Care Services and Thomas Gray, M.D., Quality and Patient Safety Medical Director

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

REBRANDING – Review and discussion relative to the proposed rebranding plan for Kaweah Delta - *Gary Herbst, CEO & Marc Mertz, VP & Chief Strategy Officer*

- Review and discussion relative to the transition to "Kaweah Health" with new colors and new logo. At the recent Board Marketing Committee, following an extensive discussion, estimated cost is $600,000-700,000 (costs incurred solely because of the name change are estimated at $350,000). The cost of the rebranding will be built into the 2021 FY budget.
- Director Hawkins noted his concern about the expense of rebranding.
- Director House noted we should keep tract of the expenses for costs that we incurred solely because of the name change.

MMSC (Hawkins/Francis) to approve the rebranding plan as reviewed and approved by the Marketing and Public Affairs Committee, February 2020, to be budgeted and funded from the Fiscal Year 20/21 budget. This was supported unanimously by those present. Vote: Yes – Gipson, Francis, Havard Mirviss, Hawkins, and House

FINANCIALS – Review of the most current fiscal year 2020 financial results (copy attached to the original of these minutes and considered a part thereof) - Malinda Tupper, VP & Chief Financial Officer

- Discussion of length of stay and the current Moody's rating meeting that took place last week, we will now wait for the results with our Moody's credit rating from the current evaluation.

- Discussion relative to how much red we have at this point in the budget process, at what point do we start to make adjustment to bring us into budget.
- Discussion of what that cause of the higher supply cost was; discussion regarding acuity, census, increased costs of supplies used.
- Medical Foundation is right at budget, we are working with the Foundation to put tools in place to have in-depth analysis relative to the financial performance. Discussion of potential contract negotiations with the Foundation and the managed care and private contracts.
- Discussion regarding supplemental funding programs and forecast.
- Detailed discussion of payroll costs including contract labor.

CREDENTIALING – Byron Mendenhall, MD –Chief of Staff - Medical Executive Committee request that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the Medical Executive Committee be reviewed for approval.

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

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

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

- No report.

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

- Legislative AB5 worker independent contractor effect on Kaweah Delta relative to our CRNA's. Most of our CRNA's operate as independent contractors to Somnia.

Their contract requires they comply with all laws in CA. They have been converting from independent contractors to employees. Now California is working on amending AB5 to exempt CRNA's.

- SB758 - Overhaul of SB1953 would set aside all 2030 requirements and Kaweah could be potentially exempt because we are in a low seismic county.
- FQHC application has been submitted and formally received, now we enter into clarification mode and the scheduling of a potential site survey in April and deemed in early July (formally certified) as a FQHC.
- Town Hall meeting this Thursday at COS Ponderosa Room, Lynn Harvard Mirviss zone.
- Friday evening thee will be a cardiac reunion - cardiac patient invited to this reunion at the Visalia Convention Center at 5:30pm. Director House inquired about providing a deaf translator. Mr. Mertz noted we are having one at the town hall and we can arrange to have one at this event.

BOARD PRESIDENT REPORT – Report from Nevin House, Board President

- Director House requested that Dianne Cox look into and present to the Board Human Resources Committee the potential of employees being able to work from home – it could free up parking downtown.
- Would like us to consider getting pediatric emergency department physicians to improve patient satisfaction for pediatric care.
- Would like to have Dr. Winston give a presentation about kidney transplants at the Academic Development Committee. Director Havard Mirviss noted that Regina Tanner would be a great person to give a presentation about this to the academic committee.
- March Board meeting agenda review – no comments

Adjourn - Meeting adjourned at 8:39PM

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

ATTEST:

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

MINUTES OF THE SPECIAL OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD FRIDAY MARCH 13, 2020 2:30PM, IN THE KAWEAH DELTA MEDICAL CENTER MINERAL KING WING BLUE ROOM, NEVIN HOUSE PRESIDING

PRESENT: Directors Francis, Gipson, Havard Mirviss, Hawkins & House; G. Herbst, CEO; T. Rayner, SVP & COO; R. Sawyer, 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; K. Noeske, Director of Care Management; S. Elkin, Infection Prevention Manager; T. Boyce, Director of Medical Staff Services; J. Chahal, MD; D. Boken, MD; K. Seng, DO; R. Berglund, Legal Counsel, C. Moccio, Recording

The meeting was called to order at 2:30pm by Director House

Director House asked for approval of the agenda.

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

PUBLIC PARTICIPATION – none

Director House called for the approval of the closed agenda.

APPROVAL OF THE CLOSED AGENDA – 2:31PM

4.1. **Public Security –** Potential threat to the public's right of access to public services or public facilities pursuant to Government Code 54957(a) *– Board of Directors*

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

Adjourn - Meeting adjourned at 2:31PM

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

ATTEST:

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

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD MONDAY MARCH 23, 2020 4:00PM, IN THE KAWEAH DELTA MEDICAL CENTER SUPPORT SERVICES BUILDING EMERALD ROOM AND VIA CONFERENCE CALL 1-888-809-4012 ACCESS CODE: 6242214 (CALL IN OPTION OFFERED DUE TO STAY IN PLACE ORDER BY THE GOVENOR OF CALIFORINA) NEVIN HOUSE PRESIDING

PRESENT: G. Herbst, CEO, B. Mendenhall, MD, Chief of Staff, C. Moccio, Recording

CALL IN: Directors Francis, Gipson, Havard Mirviss, Hawkins & House; T. Rayner, SVP & COO; R. Sawyer, 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; D. Lynch, Legal Counsel

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

Director House asked for approval of the agenda.

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

PUBLIC PARTICIPATION – none

Director House called for the approval of the closed agenda.

APPROVAL OF THE CLOSED AGENDA – 5:31PM

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

4.2. **Conference with Legal Counsel – Anticipated Litigation –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 1 Cases **–** *Dennis Lynch, Legal Counsel*

4.3. **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*

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

ADJOURN - Meeting was adjourned at 4:10PM

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

ATTEST:

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

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD MONDAY MARCH 23, 2020 4:10PM, IN THE KAWEAH DELTA MEDICAL CENTER SUPPORT SERVICES BUILDING EMERALD ROOM AND VIA CONFERENCE CALL 1-888-809-4012 ACCESS CODE: 6242214 (CALL IN OPTION OFFERED DUE TO STAY IN PLACE ORDER BY THE GOVENOR OF CALIFORINA) NEVIN HOUSE PRESIDING

PRESENT: G. Herbst, CEO, B. Mendenhall, MD, Chief of Staff, C. Moccio, Recording

CALL IN: Directors Francis, Gipson, Havard Mirviss, Hawkins & House; T. Rayner, SVP & COO; R. Sawyer, 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; D. Lynch, Legal Counsel

The meeting was called to order at 4:22PM by Director House.

Director House entertained a motion to approve the agenda.

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

PUBLIC/MEDICAL STAFF PARTICIPATION

- None.

FINANCIALS – Review of the most current fiscal year 2020 financial results (copy attached to the original of these minutes and considered a part thereof) - Malinda Tupper, VP & Chief Financial Officer

- Moody's rating – we have retained our A3 rating however, it is now A3 negative. Most of the hospital industry across the nation is being downgraded to negative.
- Discussion regarding the budget process and question about how we are capturing the COVID-19 related costs. Ms. Tupper noted that we have found a way to capture the cost associated with COVID-19 and we are tracking staffing hours and other cost's associated so that we can potentially file a claim to recuperate some of our losses due to the "business interruption" such as no elective surgeries, the closure of The Lifestyle Center related to the Stay in Place order mandated by the Governor of California.
- We will continue to explore other revenues sources such as telehealth, research FEMA and disaster relief funds, change in reimbursement for IGT governmental match – it may be increased.
- Mr. Herbst noted that there is a lot of time being invested by leaders working 24 hours around the clock - these are all exempt staff.
- Mr. Herbst noted that 2 South is our designated COVID-19 unit for respiratory patients whom we are observing.
- OSHPD and CDPH have signed off on the Acequia Wing 5th and 6th floors to accelerate the opening of these two units to care for patients. We only have one in-

patient with COVID-19 at this time. We have 16 cases and 15 of the 16 are self-quarantined at home.

CREDENTIALING – Byron Mendenhall, MD –Chief of Staff - Medical Executive Committee request that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the Medical Executive Committee be reviewed for approval.

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

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

Approval of Resolution 2074 rejecting the claim of Debra Pueschel vs. Kaweah Delta Health Care District – Dennis Lynch, Legal Counsel

Public participation - No Comments

MMSC (Hawkins/Francis) to approve Resolution 2047 rejecting the claim of Debra Pueschel vs. Kaweah Delta Health Care District. This was supported unanimously by those present. Vote: Yes – Gipson, Francis, Havard Mirviss, Hawkins, and House

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

- Medical Staff maintaining, working closely with Administration doing an amazing job keeping medical staff informed, the Board should be proud. The medical staff is grateful we have kept down our numbers.

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

- COVID-19 – Our specimen Universal Transport Media (UTM) test kits are running low and these were the only medium that were being accepted for the COVID-19 test.

Our lab manager, Randy, reported to us that the county lab is accepting specimens put in a simple saline solution. We currently have 2,000 saline kits; as long as we use the county lab we should have enough testing kits. We have about 1,000 swabs, which are manufactured in Italy. We currently only have approximately 130 UTM kits which the commercial labs are requiring be used.

BOARD PRESIDENT REPORT – Report from Nevin House, Board President

- Director House entertained the discussion relative to immediate future meetings of the Board - does not envision one big meeting monthly, instead, smaller weekly meetings, could be 30 minute meetings once a week with a small consent calendar on each meeting, minimum interruption to administration.
- Director Gipson noted that he does not feel informed and he is getting questions from community members. Mr. Herbst noted that the Board is welcome to join the daily briefing for the Kaweah Delta leadership to help keep them more informed. Noted that the Board has been included on many distributions list of information that is also going to the Leadership. Director Gipson noted that he is receiving those but would appreciate being able to participate in the daily briefing call to leadership.
- Director Havard Mirviss suggested that the Board should let management focus on COVID-19.
- Director Francis inquired how we could keep the Board best informed about what is going on so if community members have questions or concerns the Board members can address them. Director Francis inquired if the Board is receiving all of the notifications going out to staff relative to COVID-19? Mr. Herbst noted that we can verify that the Board member are on the COVID-19 update email distribution list.
- Director Hawkins does not see the necessity of a weekly meeting.
- Mr. Herbst noted that we are able call a special meeting of the Board with 24-hour notice. We can keep our monthly schedule and schedule any specials meeting that are needed.
- Director Francis noted his concerned about budget planning. Mr. Herbst noted that he will keep the board apprised relative to the budget process.
- Dr. Mendenhall noted the Board members may also call him if they have questions.

Adjourn - Meeting adjourned at 5:21PM

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

ATTEST:

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

MINUTES OF THE SPECIAL OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD TUESDAY APRIL 14, 2020 9:30AM, IN THE KAWEAH DELTA MEDICAL CENTER SUPPORT SERVICES BUILDING COMPLIANCE DEPARTMENT CONFERENCE ROOM AND VIA GOTO MEETING (ELECTRONIC OPTION OFFERED DUE TO STAY IN PLACE ORDER BY THE GOVENOR OF CALIFORINA) NEVIN HOUSE PRESIDING

PRESENT: G. Herbst, CEO, R. Gates, VP Population Health; C. Moccio, Recording

CALL IN: Directors Francis, Gipson, Havard Mirviss, Hawkins & House; T. Rayner, SVP & COO; R. Sawyer, VP & CNO, M. Tupper, VP & CFO; D. Cox, VP Chief Human Resources Officer, M. Mertz, VP Chief Strategy Officer, D. Leeper, VP & CIO; A. Banerjee, VP Chief Quality Officer; D. Allain, VP Cardiac & Surgical Services; D. Lynch, Legal Counsel

The meeting was called to order at 9:45AM by Director House.

Director House entertained a motion to approve the agenda.

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

PUBLIC/MEDICAL STAFF PARTICIPATION

- None.

REVISIONS OF CO-APPLICANT AGREEMENT BY AND BETWEEN SEQUIOA HEALTH AND WELLNESS CENTERS AND KAWEAH DELTA HEALTH CARE DISTRICT – Reivew of requested revisions to the Co-Applicant Agreement by and between Sequoia Health and Wellness Centers and Kaweah Delta Health Care District (copy attached to the original of these minutes and considered a part thereof) - *Ryan Gates, PharmD, CDE, Vice President – Population Health & CEO of Sequoia Health and Wellness Center*

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

MMSC (Hawkins/Havard Mirviss) Approval of the revised Co-Applicant Agreement by and between Sequoia Health and Wellness Centers, A California Nonprofit Public Benefit Corporation and Kaweah Delta Health Care District, A California Health Care District. Authorize management to execute the revised Co-Applicant Agreement by and between Sequoia Health and Wellness Centers, A California Nonprofit Public Benefit Corporation and Kaweah Delta Health Care District, A California Health Care District and authorize management to enter into the necessary agreements and take all necessary steps for the development of a look-alike Federally Qualified Health Center (FQHC).

CHIEF OF STAFF REPORT

- Not present.

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

- COVID-19 – Mr. Herbst brief the Board relative to current events at Kaweah.
  - Last Friday Kaweah Delta was invited to join an emergency meeting with Health and Human Services Department including Kaweah Delta, Sierra View, and Adventist, Hanford and Tulare. Representatives from the State and Fresno County EMS, in addition to the Administrator of Redwood Springs Nursing Home where there is an outbreak with the number of positive cases rising exponentially. About a week ago there were 8 positive COVID-19 cases and now there are approximately 120, they have approximately 138 residents approximately 100 employees both full time and part-time. Due to a lack of staffing at Redwood (employees testing positive or symptomatic and staff refusing to come in) they were down to skeleton staffing. The County was prepared to shut them down and evacuate it, they would have evacuated to the local hospitals. Instead, the three hospitals have provided supplemental staff starting Friday evening and going forward. Twenty-three Kaweah Delta nurses and clinicians volunteered to go to Redwood Springs. Adventist and Sierra View each sent a few employees. Leaders from our command center went there Saturday morning to assess the situation. Redwood is lacking in structure and leadership, we are trying to help them set up a command center. Lisa Harrold is helping to set up a command center there, very little personal protection equipment (PPE) is there. We see how it spread so quickly through this facility.
  - We have tested all of the residents for the most part. We have about ten of their residents at Kaweah Delta, there have about 6-7 deaths.
  - We are very proud and inspired by our team , we might bring staff out of retirement to also assist.
  - Discussion of testing kits.
    - We now have eight Abbott testing devices that give us results in 15 minutes, we appear to have a steady flow of supplies - 1900 testing kits between the two platforms.
    - If the patient comes into the Emergency Department (ED) we test them in the ED and if they are positive and need to be admitted they are sent to 2S or or if they are critical they are sent to the ICU. 2S is a 29-bed inpatient unit. The staff are aware that these patients are positive and the appropriate PPE to use with these patients is provided to the staff.
    - We formally opened Zone 4 of the Emergency Department – a 9-bed unit in the ED, private rooms with doors intended to expand the capacity of the ED. Broderick unit is prepared to take patients in the event that it is need to be an intermediate ICU unit.
    - Today we hope to complete the testing for the 5th and 6th floors of the Acequia Wing and if they pass we can open them by the end of the week.
    - Director Frances inquired what is happening with Sierra View and Adventist, how many cases to they have? Mr. Herbst noted the most activity has been at Kaweah Delta mostly attributed to the situation at Redwood. We currently

have 23 positives in house on 2S, 3W, or ICU. We have a few patients who were admitted in mid-March and April 14th they are still testing positive after about 20 days.

- Mr. Herbst noted that the March financial are not going to look good due to shutting down services, we are docking staff, and furloughing staff, we will be looking to FEMA and the federal government to help with those costs associated with COVID-19 for March, April, and part of May. We received a deposit from CMS based on a calculation of our CARES Act funding; they used our Medicare payment files to determine what our share of the funds Kaweah Delta would receive to assist with our lost income.

BOARD PRESIDENT REPORT – Report from Nevin House, Board President

- No report

Adjourn - Meeting adjourned at 5:21PM

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

ATTEST:

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

Policy Number: AP182	Date Created: 04/17/2020
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Cindy Moccio (Board Clerk/Exec Assist-CEO)	

Allocation of Scarce Critical Care Resources During a Public Health Emergency

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

Executive Summary

Introduction: The purpose of this policy is to provide guidance for the triage of critically ill patients in the event that a public health emergency creates demand for critical care resources (e.g., ventilators, critical care beds) that outstrips the supply. These triage recommendations will be enacted only if: 1) critical care capacity is, or will shortly be, overwhelmed despite taking all appropriate steps to increase the surge capacity to care for critically ill patients; and 2) a regional authority has declared a public health emergency. This allocation framework is grounded in ethical obligations that include the duty to care, duty to steward resources to optimize population health, distributive and procedural justice, and transparency. It is consistent with existing recommendations for how to allocate scarce critical care resources during a public health emergency, and has been informed by extensive consultation with citizens, disaster medicine experts, and ethicists.

This policy describes: 1) the three levels of pandemic triage through which the organization will move and the thresholds and mechanism to consider when activating this policy and its accompanying algorithm; 2) the creation of triage teams to ensure consistent decision making; 3) allocation criteria for initial allocation of critical care resources; and 4) reassessment criteria to determine whether ongoing provision of scarce critical care resources are justified for individual patients.

Levels of Triage and Activation of Resource Allocation Policy: In the event of a formally-declared public health emergency, Kaweah Delta's Chief Executive Officer, in consultation with the Medical Staff's Chief of Staff, will be responsible for activating the elements of this policy and its accompanying resource allocation algorithm. The CEO will continually evaluate the severity of the emergency in the context of the following three levels of pandemic triage:

Triage Level 1 (Early in the pandemic):

- As the threat of the activation of the triage protocol increases, the hospital will cancel outpatient procedures, including elective surgeries that require a back-up option of hospital admission and ventilator support if complications arise (Note: In the event of a severe and rapidly-progressing pandemic, start with Triage Level 2).

Triage Level 2 (Worsening pandemic):

- Hospital has surged to maximum bed capacity, and emergency department is overwhelmed (defined as 95% occupancy rate across the hospital's adult medical/surgical/ICU/ICCU patient care units, including any patient care areas that have been temporarily converted to adult patient care units (e.g., pediatric unit, NICU, areas of the Emergency Department, etc.)).

- There are not enough beds to accommodate all patients needing hospital admission and not enough ventilators to accommodate all patients with respiratory failure (defined as 90% of ventilators in use).
- Hospital staff absenteeism is 20% to 30% (includes physicians, advanced practice providers, and hospital-employed staff).
- A Level 2 triage will be formally declared when any of these criteria are met and we will begin to apply the Hospital and ICU/Ventilator Admission Triage algorithm illustrated and described in Exhibit A.

Triage Level 3 (Worst-case scenario):

- A Level 2 triage is currently activated and now reflects worsening conditions.
- Hospital has implemented altered standards of care regarding nurse/patient ratios and has expanded capacity by adding patients to occupied hospital rooms.
- Hospital staff absenteeism is 30% to 40% (includes physicians, advanced practice providers, and hospital-employed staff).
- Clinicians will continue using the Hospital and ICU/Ventilator Admission Triage algorithm illustrated and described in Exhibit A.

Section 1. Creation of Triage Teams: Kaweah Delta's Chief Executive Officer, or delegate, and its Medical Staff's Chief of Staff, or delegate, will form a number of triage teams, each comprised of an acute care physician triage officer, an acute care nurse, and an administrative support person, who will apply the allocation framework described in this policy and collaborate with the attending physician to disclose triage decisions to patients and families. The creation of independent triage teams allows for the separation of the triage role from the clinical role to promote objectivity, avoid conflicts of commitments, and minimize moral distress.

Section 2. Allocation criteria for ICU admission/ventilation: This allocation framework, as described and illustrated on the attached Exhibit A—"Hospital and ICU/Ventilator Admission Triage", is based primarily on saving lives within the context of ensuring meaningful access for patients and individualized patient assessments based on objective medical knowledge. All patients who meet usual medical indications for ICU beds and services and do not meet one or more Hospital Admission Exclusion Criteria (as defined in Exhibit A hereto) will be assigned a priority score, derived from patients' likelihood of surviving to hospital discharge, assessed with an objective and validated measure of acute physiology (e.g., SOFA score). This priority score may be converted to color-coded priority groups (e.g., high, intermediate, and low priority) if needed to facilitate streamlined implementation. All scored patients will be eligible to receive critical care beds and services regardless of their priority score, but available critical care resources will be allocated according to priority score, such that the availability of these services will determine how many patients will receive critical care. Patients who are triaged to not receive ICU beds or services, including those who may be discharged home, will be offered, to the extent available, medical care, including intensive symptom management and psychosocial support.

Section 3. Reassessment for ongoing provision of critical care/ventilation: The triage team will conduct periodic reassessments of all patients receiving critical care services during times of crisis (i.e., not merely those initially triaged under the crisis standards). The timing of reassessments should be based on evolving understanding of typical disease trajectories and of the severity of the crisis. A multidimensional, individualized assessment should be used to quantify changes in patients' conditions, such as recalculation of severity of illness scores, appraisal of new complications, and treating clinicians' input. Patients

showing improvement will continue to receive critical care services until the next assessment. Patients showing substantial clinical deterioration that portends a very low chance for survival will have critical care discontinued. These patients will receive medical care, to the extent available, including intensive symptom management and psychosocial support. If such services are available, this care could be provided in other non-critical care areas of the hospital, in a designated palliative care facility(s), or the patient's home. Where available, specialist palliative care teams will provide additional support and consultation.

Introduction & Ethical Considerations

As previously stated, the purpose of this policy is to provide guidance for the triage of critically ill patients in the event that a public health emergency creates demand for critical care resources (e.g., ventilators, critical care beds) that outstrips the supply. These triage recommendations should be enacted only if: 1) critical care capacity is, or will shortly be, overwhelmed despite taking all appropriate steps to increase the surge capacity to care for critically ill patients; and 2) a regional-level authority has declared an emergency. This allocation framework is grounded in ethical obligations that include the duty to care, duty to steward resources, distributive and procedural justice, and transparency.

Ethical goals of the allocation framework: Consistent with accepted standards during public health emergencies, a goal of the allocation framework is to achieve benefit for populations of patients, often expressed as doing the greatest good for the greatest number. It should be noted that this goal is different from the traditional focus of medical ethics, which is centered on promoting the wellbeing of individual patients. In addition, the framework is designed to achieve the following:

1. To create meaningful access for all patients. Patients who would meet clinical criteria for ICU services **during ordinary circumstances** will not be excluded from receiving critical care services based on age, disabilities, or other similar factors, but they will be excluded if they present to the Hospital with one or more of the Hospital Admission Exclusion Criteria reflected in Exhibit A of this policy.
2. To ensure that all patients receive individualized assessments by clinicians, based on the best available objective medical evidence.
3. To ensure that no one is denied care based on stereotypes, assessments of quality of life, or judgments about a person's "worth" based on the presence or absence of disabilities or other factors.

The following sections of this policy describe 1) the creation of triage teams to ensure consistent decision making; 2) allocation criteria for initial allocation of critical care resources; and 3) reassessment criteria to determine whether ongoing provision of scarce critical care resources are justified for individual patients.

Section 1. Creation of triage teams

The purpose of this section is to provide guidance to create triage teams whose responsibility is to implement the allocation framework described in Sections 2 and 3. It is important to emphasize that patients' treating physicians should not make triage decisions. These decisions are grounded in public health ethics, not clinical ethics, and therefore a triage team with expertise in the allocation framework should make allocation decisions. The separation of the triage role from the clinical role is intended to enhance objectivity, avoid conflicts of commitments, and minimize moral distress.

Triage Officer

A group of triage officers should be appointed. Desirable qualities of triage officers include being a physician with established expertise in the management of critically ill patients (generally, critical care and emergency medicine physicians), strong leadership ability, and effective communication and conflict resolution skills. This individual will oversee the triage process, assess all patients, assign levels of priority, communicate with treating physicians, and direct attention to the highest-priority patients. S/he is expected to make decisions according to the allocation framework described in the attached Exhibit A, which is designed to benefit the greatest number of patients, even though these decisions may not necessarily be best for some individual patients. To optimize effective functioning in a crisis, the triage officer should ideally be well-prepared and trained in advance by means of disaster drills or exercises. The triage officer has the responsibility and authority to apply the principles and processes of this policy to make decisions about which patients will receive the highest priority for receiving critical care. S/he is also empowered to make decisions regarding reallocation of critical care resources that have previously been allocated to patients, again using the principles and processes in this policy. In making these decisions, the triage officer should not use principles or beliefs that are not included in this policy.

So that the burden is fairly distributed, triage officers will be nominated by the chairs/directors of the clinical departments that provide care to critically ill patients. The Chief Executive Officer and the Chief of Staff should approve all nominees. A roster of approved triage officers should be maintained that is large enough to ensure that triage officers will be available on short notice at all times, and that they will have sufficient rest periods between shifts.

Triage Team

In addition to the triage officer, the triage team should also consist of a nurse with acute care (e.g., critical care or emergency medicine) experience (even if no longer clinically active), and an administrative support person who will coordinate and arrange for data-gathering activities, documentation and record keeping, and assistance liaising with the Incident Command Center and bed management department. The administrative support person must be provided with appropriate computer and IT support to maintain updated databases of patient priority levels and scarce resource usage (total numbers, location, and type). The role of triage team members is to provide information to the triage officer and to help facilitate and support her/his decision-making process. A representative from hospital administration (i.e., Executive Team member(s)) should also be linked to the team, in order to supervise maintenance of accurate records of triage scores, to serve as a liaison with hospital leadership and to support the team in procuring resources, removing barriers and solving problems.

The triage officer and team members should function in shifts of twelve hours. Therefore, there should be two shifts per day to fully staff the triage function. Team decisions and supporting documentation should be reported daily to appropriate hospital leadership and incident command. A triage command center will be established in the Medical Staff Conference Room (located across the hallway from the hospital cafeteria entrance door) and will be equipped with telecommunication devices; computers; printer(s); fax machine(s); electronic dashboards to track patients, medical equipment, beds and supplies; and any other resources needed by the triage teams.

Physicians and staff assigned to triage teams will be compensated by Kaweah Delta for the shift hours they work in the triage command center (or elsewhere if deployed by the triage

officer and in active engagement with the triage team) at the hourly compensation rates they normally receive when performing their usual work duties.

Triage Mechanism
The triage officer and her/his team will use the allocation framework, as detailed in Exhibit A of this policy, to determine priority scores of all patients eligible to receive the scarce critical care resource. A decision to admit any patient to an ICU or ICCU unit will be made by the triage officer. For patients already being supported by the scarce resource, the evaluation will include reassessment to evaluate for clinical improvement or worsening at pre-specified intervals, as also detailed in Exhibit A of this policy. The triage officer will review the comprehensive list of priority scores for all patients and will communicate with the clinical teams immediately after a decision is made regarding allocation or reallocation of a critical care resource.

Communication of triage decisions to patients and families
Although the *authority* for triage decisions rests with the triage officer, there are several potential strategies to *disclose* triage decisions to patients and families. Communicating triage decisions to patients and/or their next of kin is a required component of a fair allocation process that provides respect for persons. The triage officer should first inform the affected patient's attending physician about the triage decision. Those two physicians should collaboratively determine the best approach to inform the individual patient and family. Options for who should communicate the decision include: 1) solely the attending physician; 2) solely the triage officer; or 3) a collaborative effort between the attending physician and triage officer. The best approach will depend on a variety of case-specific factors, including the dynamics of the individual doctor-patient-family relationship and the preferences of the attending physician. If the attending physician is comfortable with undertaking the disclosure, this approach is useful because the communication regarding triage will bridge naturally to a conveyance of prognosis, which is a responsibility of bedside physicians, and because it may limit the number of clinicians exposed to a circulating pathogen. The third (collaborative) approach is useful because it may lessen moral distress for individual clinicians and may augment trust in the process, but these benefits must be balanced against the risk of greater clinician exposure. Under this approach, the attending physician would first explain the severity of the patient's condition in an emotionally-supportive way, and then the triage officer would explain the implications of those facts in terms of the triage decision. The triage officer would also emphasize that the triage decision was not made by the attending physician but is instead one that arose from the extraordinary emergency circumstances, and reflects a public health decision. Regardless of who communicates the decision, it may useful to explain the medical factors that informed the decision, as well as the factors that were not relevant (e.g., race, ethnicity, gender, insurance status, perceptions of social worth, immigration status, among others). If resources permit, palliative care clinicians or social workers should be present or available to provide ongoing emotional support to the patient and family.

Appeals process for individual triage decisions
It is possible that patients, families, or clinicians will challenge individual triage decisions. Procedural fairness requires the availability of an appeals mechanism to resolve such disputes. On practical grounds, different appeals mechanisms are needed for the initial decision to allocate a scarce resource among individuals, none of whom are currently using the resource, and the decision whether to withdraw a scarce resource from a patient who is not clearly benefiting from that resource. This is because initial triage decisions for patients awaiting the critical care resource will likely be made in highly time-pressured circumstances. Therefore, an appeal will need to be adjudicated in real time to be

operationally feasible. For the initial triage decision, the only permissible appeals are those based on a claim that an error was made by the triage team in the calculation of the priority score or use/non-use of a tiebreaker (as detailed in Exhibit A). The process of evaluating the appeal should include the triage team verifying the accuracy of the priority score calculation by recalculating it. The treating clinician or triage officer should be prepared to explain the calculation to the patient, family, or other appealing individual(s) on request.

Decisions to withdraw a scarce resource such as mechanical ventilation from a patient who is already receiving it may cause heightened moral concern. Furthermore, such decisions depend on more clinical judgment than initial allocation decisions. Therefore, there should be a more robust process for appealing decisions to withdraw or reallocate critical care beds or services. Elements of this appeals process should include:

- The individuals (the patient, patient's family, patient's attending or consulting physician, or a member of the patient's care team (i.e., nurse, respiratory therapist, physician resident, etc.) appealing the triage decision should explain to the triage officer the grounds for their appeal. Appeals based in an objection to the overall allocation framework should not be granted.
- The triage team should explain the grounds for the triage decision that was made.
- Appeals based in considerations other than disagreement with the allocation framework should immediately be brought to a Triage Review Committee that is independent of the triage officer/team and of the patient's care team (see below for recommended composition of this body).
- The appeals process must occur quickly enough that the appeals process does not harm patients who are in the queue for scarce critical care resources currently being used by the patient who is the subject of the appeal.
- The decision of the Triage Review Committee will be final.
- Periodically, the Triage Review Committee should retrospectively evaluate whether the review process is consistent with effective, fair, and timely application of the allocation framework.

The Triage Review Committee should be made up of at least three individuals, recruited from the following groups or offices: Chief of Staff or designee, Chief Nursing Officer or other Nursing leadership, one or more members of Kaweah Delta's Ethics Committee, and/or an off-duty triage officer. Three committee members are needed for a quorum to render a decision, using a simple majority vote. The process can happen by telephone or in person, and the outcome will be promptly communicated to whomever brought the appeal. In certain circumstances, Kaweah Delta's outside legal counsel may be consulted by the Triage Review Committee as needed.

Section 2. Allocation process for ICU admission/ventilation

The purpose of this section is to provide a general overview of the allocation framework that should be used to make initial triage decisions for patients who present with illnesses that typically require critical care resources (i.e., illnesses that cannot be managed on a medical/surgical unit). Exhibit A—"Hospital and ICU/Ventilator Admission Triage" describes and illustrates the detail decision-making algorithm of the allocation framework and this policy. The scoring system reflected in Exhibit A applies to all patients presenting with critical illness, not merely those with the disease or disorders that have caused the public health emergency. For example, in the setting of a severe pandemic, those patients with

respiratory failure from illnesses not caused by the pandemic illness will also be subject to the allocation framework. This process involves two steps, detailed below:

1. Calculating each patient's priority score based on the multi-principle allocation framework; and,
2. Determining each day how many priority groups will receive access to critical care interventions.

First responders and bedside clinicians should perform the immediate stabilization of any patient in need of critical care, as they would under normal circumstances. Along with stabilization, temporary ventilator support may be offered to allow the triage officer or triage-trained Emergency Department physician to assess the patient for critical resource allocation. Every effort should be made to complete the initial triage assessment within 90 minutes of the recognition of the likely need for critical care resources.

STEP 1: Determine if the patient has one or more Hospital Admission Exclusion Criteria.
Patients that present to the Hospital with one or more of the Hospital Admission Exclusion Criteria described in Exhibit A hereto will be ineligible to receive critical care services and will be discharged home or transferred to a palliative care facility. While patients presenting with these exclusion criteria would be eligible for critical care services in **usual circumstances**, they will not be eligible for hospital admission during a formally-declared public health emergency. These ineligible patients will not be scored as described in Step 2.

STEP 2: Calculate each patient's priority score using an allocation framework.
The allocation framework described and illustrated in Exhibit A ensures meaningful access for all patients and individualized patient assessments based on objective medical knowledge. Patients who are more likely to survive with intensive care are prioritized over patients who are less likely to survive with intensive care. As reflected in Exhibit A, the Sequential Organ Failure Assessment (SOFA) score is used to determine patients' prognoses for hospital survival. Points are assigned according to the patient's SOFA score. Lower scores indicate higher likelihood of benefiting from critical care, and priority will be given to those with lower scores.

Other scoring considerations:
In the event one or more patients have identical SOFA scores within the Intermediate or Highest Priority Category and there is insufficient capacity to provide all of them with critical care services, consideration may be given to other criteria in deciding who receives critical care services and who does not, including:

1) Giving heightened priority to those who have had the least chance to live through life's stages (i.e., younger patients). Life-cycle considerations could be based on the following categories: age 14-40, age 41-60; age 61-75; older than age 75. The ethical justification for incorporating the life-cycle principle is that it is a valuable goal to give individuals equal opportunity to pass through the stages of life—childhood, young adulthood, middle age, and old age. The justification for this principle does not rely on considerations of one's intrinsic worth or social utility. Rather, younger individuals receive priority because they have had the least opportunity to live through life's stages. Evidence suggests that, when individuals are asked to

consider situations of absolute scarcity of life-sustaining resources, most believe younger patients should be prioritized over older ones.

2) Giving heightened priority to those who are central to the public health response (individuals who perform tasks that are vital to the public health response, including those whose work directly in supporting the provision of acute care to others). The specifics of how to operationalize this consideration will depend on the exact nature of the public health emergency. This category should be broadly construed to include those individuals who play a critical role in the chain of treating patients and maintaining social order. However, it would not be appropriate to prioritize front-line physicians and not prioritize other front-line clinicians (e.g., nurses and respiratory therapists) and other key personnel (e.g., maintenance staff that disinfect hospital rooms).

STEP 3: Make daily determinations of how many priority groups can receive the scarce resource. Hospital leaders and triage officers should make determinations twice daily, or more frequently if needed, about what priority scores will result in access to critical care services. These determinations should be based on real-time knowledge of the degree of scarcity of the critical care resources, as well as information about the predicted volume of new cases that will be presenting for care over the near-term (several days). For example, if there is clear evidence that there is imminent shortage of critical care resources (i.e., few ventilators available and large numbers of new patients daily), only patients with the highest priority should receive scarce critical care resources. As scarcity subsides, patients with progressively lower priority (higher scores) should have access to critical care interventions.

There are at least two reasonable approaches to group patients: 1) according to their raw SOFA score; and 2) by creating three priority categories based on patients' raw priority scores (e.g., high priority, intermediate priority, and low priority). Using the SOFA scale avoids creating arbitrary cut-points on what is a continuous scale and allows all the information to be used from the priority score. Using priority categories is consistent with standard practices in disaster medicine and avoids allowing marginal differences in scores on an allocation framework that has not been extensively tested to be the determinative factor in allocation decisions. Both approaches are reasonable and are permitted by this policy. The best choice depends on the specific conditions of the public health emergency and should be decided by the administrative and medical staff leaders of the institution.

Appropriate clinical care of patients who cannot receive critical care. Patients who are admitted to the hospital (did not meet one or more Hospital Admission Exclusion Criteria) but were not triaged to receive critical care/ventilation services will receive medical care that includes intensive symptom management and psychosocial support. They should be reassessed daily to determine if changes in resource availability or their clinical status warrant provision of critical care services. Where available, specialist palliative care teams will be available for consultation. Where palliative care specialists are not available, the treating clinical teams should provide primary palliative care.

Section 3. Reassessment for ongoing provision of critical care/ventilation

The purpose of this section is to describe the process the triage committee should use to conduct reassessments on patients who are receiving critical care services, in order to determine whether s/he continues with the treatment.

Ethical goal of reassessments of patients who are receiving critical care services.
The ethical justification for such reassessment is that, in a public health emergency when there are not enough critical care resources for all, the goal of maximizing population outcomes would be jeopardized if patients who were determined to be unlikely to survive were allowed indefinite use of scarce critical care services. In addition, periodic reassessments lessen the chance that arbitrary considerations, such as when an individual develops critical illness, unduly affect patients' access to treatment.

Approach to reassessment
All patients who are allocated critical care services will be allowed a therapeutic trial of a duration to be determined by the clinical characteristics of the pandemic disease. The decision about trial duration will ideally be made as early in the public health emergency as possible, when data becomes available about the natural history of the disease. Trial duration will also need to be tailored for other non-pandemic diseases and patient contexts, given the concern that patients with certain disabilities may need longer trials to determine benefit. The trial duration should be modified as appropriate if subsequent data emerge about the clinical course of the pandemic illness.

The triage committee will conduct periodic reassessments of patients receiving critical care/ventilation. A multidimensional assessment should be used to quantify changes in patients' conditions, such as recalculation of severity of illness scores, appraisal of new complications, and treating clinicians' input. Patients showing improvement will continue with critical care/ventilation until the next assessment. If there are patients in the queue for critical care services, then patients who upon reassessment show substantial clinical deterioration as evidenced by worsening SOFA scores or overall clinical judgment should have critical care withdrawn, including discontinuation of mechanical ventilation, after this decision is disclosed to the patient and/or family. Although patients should generally be given the full duration of a trial, if patients experience a precipitous decline (e.g., refractory shock and DIC) or a highly-morbid complication (e.g., massive stroke) which portends a very poor prognosis, the triage team may make a decision before the completion of the specified trial length that the patient is no longer eligible for critical care treatment

Appropriate clinical care of patients who cannot receive critical care.
Patients who are no longer eligible for critical care treatment because they now meet one or more Hospital Admission Exclusion Criteria, have a reassessed SOFA score that no longer supports hospital admission, or no longer meet ICU inclusion criteria (all of which are defined and illustrated in Exhibit A hereto), should be transferred to a medical/surgical unit within the hospital (if such resources are available), discharged home, or transferred to a palliative care facility (if one is available).

Kaweah Delta Health Care District
Allocation of Scarce Critical Care Resources
During Public Health Emergency
Exhibit A
"Hospital and ICU/Ventilator Admission Triage"

PURPOSE:

To provide a triage protocol to allocate scarce healthcare resources (intensive care services, including ventilators) to those who are most likely to benefit medically during a **pandemic respiratory crisis or other emergency situation** that has the potential to overwhelm available intensive care resources.

BASIC PREMISES:

- **Graded guidelines** should be used to control resources more tightly as the severity of a pandemic increases.
- **Priority should be given to patients for whom treatment most likely would be life-saving** and whose functional outcome most likely would improve with treatment. Such patients should be given priority over those who would likely die even with treatment and those who would likely survive without treatment.
- Under a declared state of emergency, the governor maintains the authority to supersede healthcare regulations or statutes that may come into conflict with these guidelines.

SCOPE:

- **These triage guidelines apply to all healthcare professionals, clinics, and facilities of Kaweah Delta**.
- **The guidelines apply to all patients 14 years and older.**

WHEN ACTIVATED:

Guidelines should be activated in the event the governor declares a pandemic respiratory crisis or other public health emergency that has the potential to overwhelm available intensive care resources.

HOSPITAL AND MEDICAL STAFF PLANNING:

- **Hospital should:**
  - **Establish a triage committee** for the review and support of compliance with this policy when implemented. The Committee should include the medical directors of critical care services and emergency medicine services, the Kaweah Delta CEO, CNO, Chief of Staff, a member of the hospital ethics committee, a social worker, and 1 or more independent physicians.
  - **Institute a supportive and/or palliative care team** to provide symptom management, counseling, and care coordination for patients, and support for families of patients who do not receive intensive care unit services.
- **Medical staff** should establish a method of providing peer support and expert consultation to physicians making these decisions.

Contents:

OVERVIEW OF PANDEMIC TRIAGE LEVELS

Triage Level 1
Early in the pandemic

- As the threat of the activation of the triage protocol increases, Kaweah Delta will cancel outpatient procedures, including elective surgeries that require a back-up option of hospital admission and ventilator support if complications arise.
- Note: In the event of a severe and rapidly progressing pandemic, start with Triage Level 2.

Triage Level 2
Worsening pandemic

- Hospital has surged to maximum bed capacity, and emergency department is overwhelmed.
- There are not enough beds to accommodate all patients needing hospital admission and not enough ventilators to accommodate all patients with respiratory failure. Hospital staff absenteeism is 20% to 30%.

Triage Level 3
Worst-case scenario

- Hospital has implemented altered standards of care regarding nurse/patient ratios and has expanded capacity by adding patients to occupied hospital rooms.
- Hospital staff absenteeism is 30% to 40%.

PRE-HOSPITAL SETTINGS

Initial Triage

Applies to: Patients who appear for care in physician offices or clinics, or in pre-evaluation spaces in emergency department.
Implemented by: Physicians, clinical staff, pre-screening staff
Other uses: Publish in newspapers and social media, place on Web sites for self-use by public

ALL Triage Levels: Use **INITIAL TRIAGE TOOL** (Appendix A) to provide initial triage screening, as well as instructions and directions for patients who need additional care or medical screening.

EMS, Physician Offices and Clinics

Applies to: Patients who present for care or call for guidance for where to go or how to care for ill family members.
Implemented by: Primary care staff, hospital help lines, community help lines, and health department help lines.

Triage Level 1:

1. Use **INITIAL TRIAGE TOOL** (Appendix A) to evaluate patients before sending to hospital ED or treating in an outpatient facility.

Triage Levels 2 and 3:

1. Continue to use **INITIAL TRIAGE TOOL** (Appendix A).
2. Initiate **EXCLUSION CRITERIA for Hospital Admission** (page 7) to evaluate patients. Do not send patients meeting **EXCLUSION CRITERIA** to the hospital for treatment. Send home with care instructions, including urgent consultation of palliative care or hospice agency.

Home Care, Long-term Care Facilities, and Other Institutional Facilities (e.g. mental health, correctional, handicapped)

Applies to: Patients in institutional facilities.
Implemented by: Institutional facility staff.

ALL Triage Levels:
1. Ensure that all liquid oxygen tanks are full.
2. Limit visitation to control infection.

Triage Levels 2 and 3:
1. Use **EXCLUSION CRITERIA for Hospital Admission** (page 7) to evaluate patients. Do not transfer patients meeting exclusion criteria to the hospital for treatment.
2. Give palliative and supportive care in place.

HOSPITAL SETTINGS

Hospital Administrative Roles – General

(Refer to page 15 for definitions of elective surgery categories.)

Triage Level 1:
1. **Preserve bed capacity** by:
   - Canceling all category 2 and 3 elective surgeries, and advising all category 1 elective surgery patients of the risk of infection.
   - Canceling any elective surgery that would require postoperative hospitalization.
     Note: Use standard operation and triage decision for admission to ICU because resources are adequate to accommodate the most critically-ill patients.
2. **Preserve oxygen capacity** by:
   - Phasing out all non-acute hyperbaric medicine treatments.
   - Ensure that all liquid oxygen tanks are full.
3. **Improve patient care capacity** by transitioning space in ICUs to accommodate more patients with respiratory failure
4. **Control infection** by limiting visitation (follow hospital infection control plan).

Triage Levels 2:
1. **Preserve bed capacity** by:
   - Canceling all elective surgeries unless necessary to facilitate hospital discharge.
   - Evaluating hospitalized category 1 elective surgery patients for discharge using same criteria as medical patients.
2. **Improve patient care capacity** by implementing altered standards of care regarding nurse/patient ratios and expanding capacity by adding patients to occupied hospital rooms.
3. **Institute a supportive and/or palliative care team** to provide symptom management, counseling, and care coordination for patients, and support for families of patients who do not receive intensive care unit services.

Triage Level 3:
1. **Preserve bed capacity** by limiting surgeries to patients whose clinical conditions are a serious threat to life or limb, or to patients for whom surgery may be needed to facilitate discharge from the hospital.

Emergency Department, Hospital and ICU – Clinical Triage

Use **HOSPITAL AND ICU/VENTILATOR ADMISSION TRIAGE** ALGORITHM AND TOOLS (pages 5 and 6) to determine which patients to send home for palliative care or medical management and which patients to admit or keep in the hospital or ICU. Note that the lowest priority for admission is given to patients with lowest chance of survival with or without treatment, and to patients with the highest chance of survival without treatment.

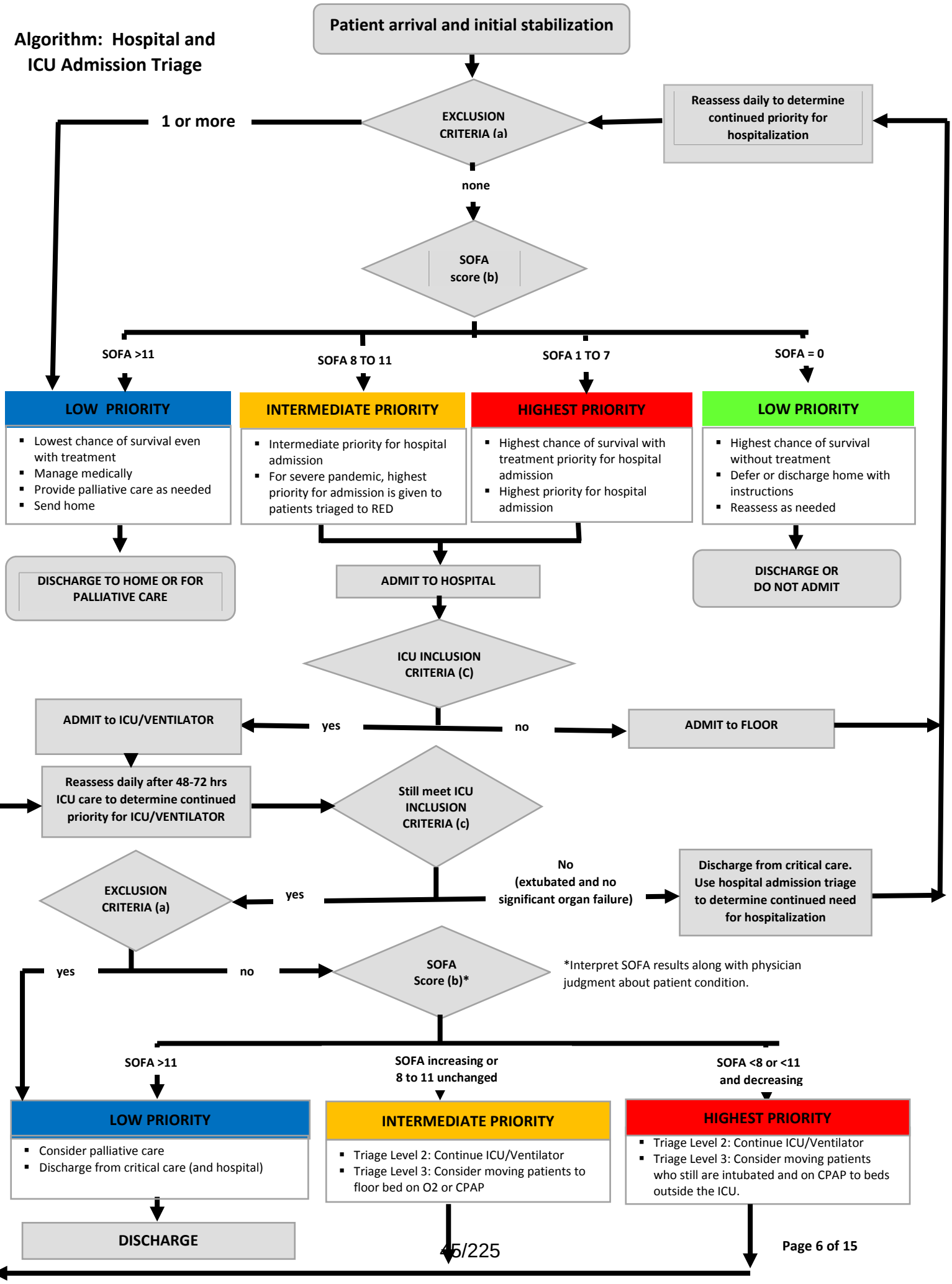
Physician judgment should be used in applying these guidelines.

Triage Level 2:

- Initiate **HOSPITAL ICU/VENTILATOR ADMISSION TRIAGE** algorithm (page 4) to determine priority for ICU admission, intubation and/or mechanical ventilation.
- Reassess need for ICU/ventilator treatment daily after 48-72 hours of ICU care.

Triage Level 3:

- Continue to use **HOSPITAL AND ICU/VENTILATOR ADMISSION TRIAGE** algorithm (page 4) to determine priority for ICU, intubation and/or mechanical ventilation.
- Triage more yellow patients to floor on oxygen or CPAP.
- Triage more red patients who are intubated and on CPAP to floor.


Algorithm: Hospital and ICU Admission Triage
Patient arrival and initial stabilization
EXCLUSION CRITERIA (a)
1 or more
Reassess daily to determine continued priority for hospitalization
none
SOFA score (b)
SOFA >11
SOFA 8 TO 11
SOFA 1 TO 7
SOFA = 0
LOW PRIORITY
Lowest chance of survival even with treatment
Manage medically
Provide palliative care as needed
Send home
INTERMEDIATE PRIORITY
Intermediate priority for hospital admission
For severe pandemic, highest priority for admission is given to patients triaged to RED
HIGHEST PRIORITY
Highest chance of survival with treatment priority for hospital admission
Highest priority for hospital admission
LOW PRIORITY
Highest chance of survival without treatment
Defer or discharge home with instructions
Reassess as needed
DISCHARGE TO HOME OR FOR PALLIATIVE CARE
ADMIT TO HOSPITAL
DISCHARGE OR DO NOT ADMIT
ICU INCLUSION CRITERIA (C)
ADMIT to ICU/VENTILATOR
yes
no
ADMIT to FLOOR
Reassess daily after 48-72 hrs ICU care to determine continued priority for ICU/VENTILATOR
Still meet ICU INCLUSION CRITERIA (c)
EXCLUSION CRITERIA (a)
yes
No (extubated and no significant organ failure)
Discharge from critical care. Use hospital admission triage to determine continued need for hospitalization
yes
no
SOFA Score (b)*
*Interpret SOFA results along with physician judgment about patient condition.
SOFA >11
SOFA increasing or 8 to 11 unchanged
SOFA <8 or <11 and decreasing
LOW PRIORITY
Consider palliative care
Discharge from critical care (and hospital)
INTERMEDIATE PRIORITY
Triage Level 2: Continue ICU/Ventilator
Triage Level 3: Consider moving patients to floor bed on O2 or CPAP
HIGHEST PRIORITY
Triage Level 2: Continue ICU/Ventilator
Triage Level 3: Consider moving patients who still are intubated and on CPAP to beds outside the ICU.
DISCHARGE

TRIAGE TOOLS AND TABLES

(a) EXCLUSION CRITERIA for Hospital Admission:
The patient is excluded from hospital admission or transfer to critical care if ANY of the following is present:

☐ **(1) Known Do Not Attempt Resuscitation (DNAR) or Out of Hospital-DNR (OOH-DNR) status.**

☐ **(2) Severe and irreversible chronic neurologic condition** with persistent coma or vegetative state.

☐ **(3) Acute severe neurologic event with minimal chance of functional neurologic recovery (physician judgment).** Includes traumatic brain injury, severe hemorrhagic stroke and intracranial hemorrhage.

☐ **(4) Traumatic injury:** Severe traumatic brain injury, hemodynamically unstable traumatic injuries requiring more than 10 units of blood transfusion, or more than one pressor, ARDS requiring high peep >15 or HFOV; Revised Trauma Score <2 [see (e)]. Revised Trauma Score:_____

☐ **(5) Severe burns with anticipated survival "Low," "Low/Expectant" or "Expectant"** as indicated by age and burn size on the Triage Decision Table for Burn Victims (f). Burns not requiring critical care resources may be cared for at the local facility.
Score ___.

☐ **(6) Cardiac arrest not responsive to ACLS interventions within 20–30 minutes.**

☐ **(7) Known severe dementia** medically treated and requiring assistance with activities of daily living (i.e., bathing, dressing, transferring, toileting and eating); **FAST** Stage 7 **(i).**

☐ **(8) Advanced untreatable neuromuscular disease** (such as ALS or end-stage MS) requiring assistance with activities of daily living or chronic ventilator support.

☐ **(9) Incurable metastatic malignant disease.**

☐ **(10) End-stage organ failure** meeting the following criteria:
- **Heart: NEW YORK HEART ASSOCIATION (NYHA) FUNCTIONAL CLASSIFICATION SYSTEM Class III or IV (g).** Class: _____
- **Lung** (any of the following):
  - Chronic Obstructive Pulmonary Disease (COPD) with Forced Expiratory Volume in one second (FEV1) <25% predicted baseline, baseline Pa02 <55 mm Hg, or severe secondary pulmonary hypertension.
  - Cystic fibrosis with post-bronchodilator FEV <30% or baseline Pa02 <55 mm Hg.
  - Pulmonary fibrosis with VC or TLC <60% predicted, baseline Pa02 <55 mm Hg, or severe secondary pulmonary hypertension.
  - Primary pulmonary hypertension with NYHA class III or IV heart failure **(g)**, right atrial pressure >10 mm Hg, or mean pulmonary arterial pressure >50 mm Hg.
- **Liver: MELD SCORE >20 or Pugh Score > 7 (h)**, when available. Includes bili, albumin, INR, ascites, encephalopathy. MELD score calculators available online. PUGH Score table on page 12.
  MELD: _____ PUGH:_____

(b) Sequential Organ Failure Assessment (SOFA) Score

SOFA scoring guidelines						
Variable	**Score 0**	**Score 1**	**Score 2**	**Score 3**	**Score 4**	**Score for each row**
$Pa0_2/Fi0_2$ or nasal cannula or mask 0_2 required to keep $Sp0_2$>90%	≥400 or room air $Sp0_2$>90%	<400 or room air $Sp0_2$>90% at 1-3 L/ min	<300 or room air $Sp0_2$>90% at 4-6 L/ min	<200 or room air $Sp0_2$>90% at 7-10 L/ min	<100 or room air $Sp0_2$>90% at >10 L/ min	
Platelets (cells/mm³)	>150,000	<150,000	<100,000	<50,000	<20,000	
Bilirubin (mg/DL)	<1.2	1.2 – 1.9	2.0 – 5.9	6.0 – 11.9	>12.0	
MAP (mm Hg) or **vasopressor**	MAP ≥70	MAP<70	DPA≤5	DPA 5.1-15	DPA>15	
Glasgow Coma Score	15	13–14	10–12	6-9	3-6	
Creatinine (mg/dL) or **urine output**	<1.2 ———	1.2–1.9 ———	2.0–3.4 ———	3.5-4.9 or urine output <500 mL in 24 hours	>5 or urine output <200 mL in 24 hours	
					SOFA score = total scores from all rows:	

$Pa0_2/Fi0_2$ = Ratio of arterial oxygen partial pressure ($Pa0_2$ in mmHg) to fractional inspired oxygen ($Fi0_2$ expressed as a fraction, not a percentage).

(c) ICU/Ventilator INCLUSION CRITERIA:

Patient must have **NO EXCLUSION CRITERIA (a)** *and* **at least one of the following INCLUSION CRITERIA**:

☐ **(1) Requirement for invasive ventilator support**

- Refractory hypoxemia (Sp02 <90% on non-rebreather mask or FIO2 >0.85)
- Respiratory acidosis (pH <7.2)
- Clinical evidence of impending respiratory failure
- Inability to protect or maintain airway.

☐ **(2) Hypotension* with clinical evidence of shock** refractory to volume resuscitation, and requiring vasopressor or inotrope support that cannot be managed in a ward setting.**

*Hypotension = Systolic BP <90 mm Hg or relative hypotension
**Clinical evidence of shock = altered level of consciousness, decreased urine output or other evidence of end-stage organ failure.

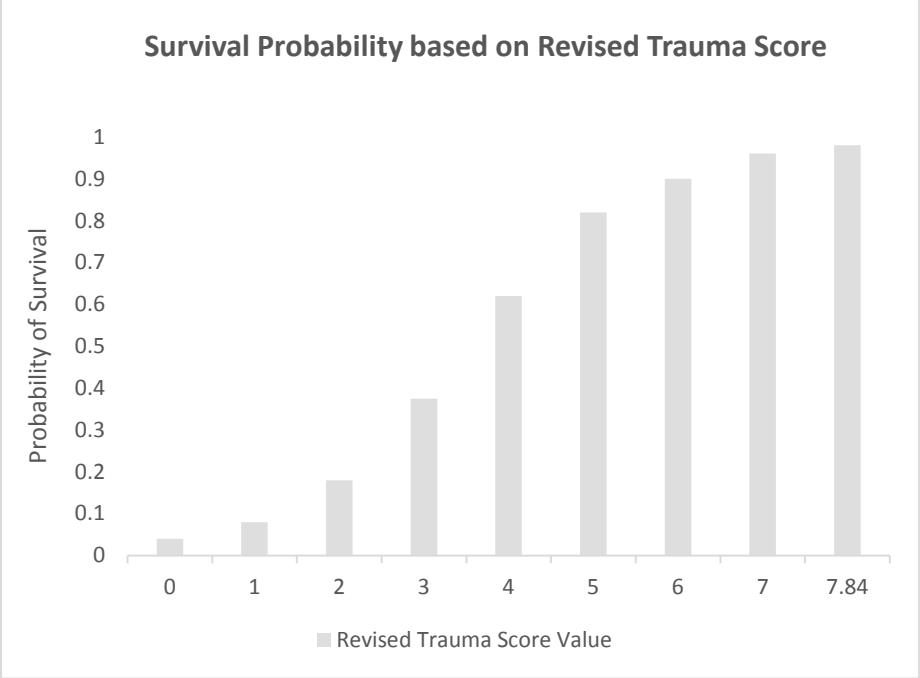
(d) GLASGOW COMA SCORE (GCS):

The GCS is used as part of the REVISED TRAUMA SCORE (RTS) in determining exclusion criteria for hospital admission in the case of pandemic respiratory crisis or other emergency situation at triage levels 2 and 3.

Glasgow Coma Scoring Criteria			
Criteria		**Score**	**Criteria Score**
Best Eye Response (4 possible points)	No eye opening	**1**	
	Eye opens to pain	**2**	
	Eye opens to verbal command	**3**	
	Eyes open spontaneously	**4**	
Best Verbal Response (5 possible points)	No verbal response	**1**	
	Incomprehensible sounds	**2**	
	Inappropriate words	**3**	
	Confused	**4**	
	Oriented	**5**	
Best Motor Response (6 possible points)	No motor response	**1**	
	Extension to pain	**2**	
	Flexion to pain	**3**	
	Withdraws from pain	**4**	
	Localizes to pain	**5**	
	Obeys commands	**6**	
Total Score (add 3 subscores; range 3 to 15):			

(e) REVISED TRAUMA SCORE (RTS):

Values for the REVISED TRAUMA SCORE (RTS) range from 0 to 7.8408. The RTS is heavily weighted toward the GLASGOW COMA SCORE (GCS) to compensate for major head injury without multisystem injury or major physiological changes. The RTS correlates well with the probability of survival. A Revised Trauma Score of <2 is an exclusion criterion for hospital admission during a pandemic respiratory crisis or other emergency situation at triage levels 2 and 3.



Revised Trauma Score Calculation				
Criteria	**Score**	**Coded value**	**Weighting**	**Adjusted Score**
Glasgow Coma Score	3	0	x 0.9368	
	4 to 5	1		
	6 to 8	2		
	9 to 12	3		
	13 to 15	4		_____
Systolic Blood Pressure (SBP)	0	0	x 0.7326	
	1 to 49	1		
	50 to 75	2		
	76 to 89	3		
	>89	4		_____
Respiratory Rate (RR) in breaths per minute (BPM)	0	0	x 0.2908	
	1 to 5	1		
	6 to 9	2		
	>29	3		
	10 to 29	4		_____
Revised Trauma Score (add 3 adjusted scores):				_____

(f) TRIAGE DECISION TABLE FOR BURN VICTIMS:

A burn score of "Low" or worse on this table is an exclusion criterion for hospital admissions in the case of pandemic respiratory crisis or other emergency situation at triage levels 2 and 3.

Age (yrs)	Burn Size (% total body surface area)									
	0–10%	11–20%	21–30%	31–40%	41–50%	51–60%	61–70%	71–80%	81–90%	91%+
0 – 1.9	Very high	Very high	Very high	High	Medium	Medium	Medium	Low	Low	Low/ expectant
2.0 – 4.9	Outpatient	Very high	Very high	High	High	High	Medium	Medium	Low	Low
5.0 – 19.9	Outpatient	Very high	Very high	High	High	High	Medium	Medium	Medium	Low
20.0 – 29.9	Outpatient	Very high	Very high	High	High	Medium	Medium	Medium	Low	Low
30.0 – 39.9	Outpatient	Very high	Very high	High	Medium	Medium	Medium	Medium	Low	Low
40.0 – 49.9	Outpatient	Very high	Very high	Medium	Medium	Medium	Medium	Low	Low	Low
50.0 – 59.9	Outpatient	Very high	Very high	Medium	Medium	Medium	Low	Low	Low/ expectant	Low/ expectant
60.0 – 69.9	Very high	Very high	Medium	Medium	Low	Low	Low	Low/ expectant	Low/ expectant	Low/ expectant
70.0+	Very high	Medium	Medium	Low	Low	Low/ expectant	Expectant	Expectant	Expectant	Expectant

Outpatient: Survival and good outcome expected, without requiring initial admission; **Very high**: Survival and good outcome expected with limited/short-term initial admission and resource allocation (straightforward resuscitation, LOS <14–21 days, 1-2 surgical procedures); **High**: Survival and good outcome expected (survival >90%) with aggressive and comprehensive resource allocation, including aggressive fluid resuscitation, admission ≥14–21 days, multiple surgeries, prolonged rehabilitation; **Medium:** Survival 50–90% and/or aggressive care and comprehensive resource allocation required, including aggressive resuscitation, initial admission ≥14–21 days, multiple surgeries and prolonged rehabilitation; **Low**: Survival <50% even with long-term aggressive treatment and resource allocation; **Expectant**: Predicted survival <10% even with unlimited aggressive treatment.

(g) NEW YORK HEART ASSOCIATION (NYHA) FUNCTIONAL CLASSIFICATION SYSTEM

The NYHA functional classification system relates symptoms to everyday activities and the patient's quality of life. NYHA Class III or IV heart failure are exclusion criteria for hospital admission in the case of pandemic respiratory crisis or other emergency situation at triage levels 2 and 3.

NYHA Classes	
Class	**Patient Symptoms**
Class I (Mild)	No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitations or dyspnea.
Class II (Mild)	Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitations or dyspnea.
Class III (Moderate)	Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitations or dyspnea.
Class IV (Severe)	Unable to carry out physical activity without discomfort. Symptoms of cardiac insufficiency at rest. If any physical activity is under- taken, discomfort is increased.

(h) PUGH SCORE:

A total PUGH SCORE >7 is an exclusion criterion for hospital admission in the case of pandemic respiratory crisis or other emergency situation at triage levels 2 and 3.

Scoring Criteria			
Criteria	**Value**	**Points**	**Total for criteria**
Total Serum Bilirubin	<2 mg/dL	1	
	2–3 mg/dL	2	
	>3 mg/dL	3	
Serum Albumin	>3.5 g/dL	1	
	2.8–3.5 g/dL	2	
	<2.8 g/dL	3	
INR	<1.70	1	
	1.71–2.20	2	
	>2.20	3	
Ascites	None	1	
	Controlled medically	2	
	Poorly controlled	3	
Encephalopathy	None	1	
	Controlled medically	2	
	Poorly controlled	3	
		Total Pugh Score	

Score interpretation		
Total PUGH SCORE	**Class**	
5 to 6	A	Life expectancy 15–20 years Abdominal surgery perioperative mortality 10%
7 to 9	B	Liver transplant evaluation indicated Abdominal surgery perioperative mortality 30%
10 to 15	C	Life expectancy 1–3 years Abdominal surgery perioperative mortality 82%

(i) SEVERE DEMENTIA: FUNCTIONAL ASSESSMENT STAGING TEST (FAST):

The Functional Assessment Staging Test (FAST) is a scale used to describe the stages of dementia. FAST employs a seven-stage system based on one's level of functioning and ability to perform daily living activities. However, FAST focuses more on an individual's level of functioning and activities of daily living versus cognitive decline. Note: A person may be at a different stage cognitively (GDS stage) than functionally (FAST stage).

Functional Assessment Staging Test (FAST)			
Stage	**Patient Condition**	**Level of Functional Decline**	**Expected Duration of Stage**
Stage 1	Normal adult	No functional decline.	N/A
Stage 2	Normal older adult	Personal awareness of some functional decline.	Unknown
Stage 3	Early Alzheimer's disease	Noticeable deficits in demanding job situations.	Average duration of this stage is 7 years.
Stage 4	Mild Alzheimer's	Requires assistance in complicated tasks such as handling finances, traveling planning parties, etc.	Average duration of this stage is 2 years.
Stage 5	Moderate Alzheimer's	Requires assistance in choosing proper clothing.	Average duration of this stage is 1.5 years.
Stage 6	Moderately severe Alzheimer's	Requires assistance with dressing, bathing, and toileting. Experiences urinary and fecal incontinence.	Average duration of this stage is 3.5 months to 9.5 months
Stage 7	Severe Alzheimer's	Speech ability declines to about a half-dozen intelligible words. Progressive loss of ability to walk, to sit up, to smile, and to hold head up.	Average duration of this stage is 1 year to 1.5 years.

DEFINITIONS USED IN THIS DOCUMENT

- **Emergency patients:** Those patients whose clinical conditions indicate that they require admission to the hospital and/or surgery within 24 hours.
- **Elective surgery:**
  - **Category 1:** Urgent patients who require surgery within 30 days.
  - **Category 2:** Semi-urgent patients who require surgery within 90 days.
  - **Category 3:** Non-urgent patients who need surgery at some time in the future.
- **Long-term care facility:** A residential program providing 24-hour care, to include: Nursing Homes, Skilled Nursing Facilities, Assisted Living 1 and 2, Residential Care Facilities, and Intermediate Care for the Mentally Retarded (ICFMR) facilities.
- **Palliative care:** In the setting of an overwhelming medical crisis, palliative care helps improve patient symptoms such as shortness of breath, pain and anxiety. Palliative care teams also support patient and family spiritual and/or emotional pain.

District Bylaws

Article I The District and Its Mission

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

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

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

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

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

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

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

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

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

Article II The Governing Body

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2) Approve an annual audited financial statement prepared by a major accounting firm and presented directly to the Board of Directors.

3) Approve any specific expenditure in excess of $75,000, which is not included in the annual budget

4) Approve financial policies, plans, programs, and standards to ensure preservation and enhancement of the organization's assets and resources.

5) Monitor actual performance against budget projections and review and adopt ethical financial policies and guidelines.

6) Review major capital plans proposed for the organization and its subsidiaries.

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

1) Review and approve a comprehensive strategic plan and supportive policy statements.

2) Develop long term capital expenditure plans as a part of its long range strategic planning.

3) Determine whether or not the strategic plan is consistent with the mission statement.

4) Assess the extent to which plans meet the strategic goals and objectives that have been previously approved.

5) Periodically review, discuss, and amend the strategic plan to ensure its relevance for the community.

6) Regularly review progress towards meeting goals in the plan to assess the degree to which the organization is meeting its mission.

7) Annually meet with the leaders of the Medical Staff to review and analyze the health care services provided by the District and to discuss long range planning for the District.

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

1) Oversee the recruitment, employment, and regular evaluations of the performance of the Chief Executive Officer, the ~~Compliance and Privacy Officer~~Chief Compliance Officer, and the ~~Director of Internal Audit~~Director of Audit & Consulting.

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

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

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

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

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

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

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

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

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

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

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

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

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

8) Maintain an up-to-date Board policy manual, which includes specific policies covering oversight responsibilities in the area of quality performance, financial performance, strategic planning performance, and management performance.

9) Review the District's Mission, Vision & Pillar statements every two years.

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

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

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

Sections 32100.2 and 32106 of the Health and Safety Code of the State of California, as amended, indicate the attendance and quorum requirements for members of the Board of Directors of any health care district in the State of California. For general business the Board may operate under the rules of a small committee, however, upon the request of any member of the Governing Body immediate implementation of the Standard Code of Parliamentary Procedure (Roberts Rules of Order) shall be adopted for the procedure of that meeting.

Section 6 The President of the Board of Directors shall appoint the committees of the Board and shall appoint the Chairperson and designate the term of office in a consistent and systematic approach. All committees of the Governing Body shall have no more than two (2) members of the Governing Body upon the committee and both Board members shall be present prior to the Board committee meeting being called to order. All committees of the Governing Body shall serve as extensions of the Governing Body and report back to the Governing Body for action. Minutes of all committee meetings shall be distributed to all members of the Governing Body in such fashion that discussion and recommendations to the Governing Body are clearly presented.

The President of the Board of Directors may appoint, with concurrence of the Board of Directors, any special committees needed to perform special tasks and functions for the District.

Any special committee shall limit its activities to the task for which it was appointed, and shall have no power to act, except as specifically conferred by action of the Board of Directors.

The Chief of Staff shall be notified and shall facilitate Medical Staff participation in any Governing Board Committee that deliberates the discharge of Medical Staff responsibility.

The standing committees of the Governing Body are:

A. Academic Development

The members of this committee shall consist of two (2) Board members, ~~the~~ Chief Executive Officer (CEO), ~~the~~ Designated Institutional Officer (DIO), Director of Graduate Medical Education, Director of Pharmacy, and any other members designated by the Board President.

This committee will provide Board direction and leadership for the Graduate Medical Education Program, the Pharmacy Residency Program, and achievement of Kaweah Delta's foundational Pillar "Empower through education".

B. Audit and Compliance

The members of this committee shall consist of two (2) Board members (~~the~~ Board President or Secretary/Treasurer shall be a standing member of this committee), ~~the~~ CEO, Chief Financial Officer (CFO), Chief Operating Officer (COO), ~~the Director of Internal Auditor~~Director of Audit & Consulting, ~~Compliance and Privacy Officer~~Chief Compliance Officer, Compliance Specialist, legal counsel, and any other members designated by the Board President. The Committee will engage an outside auditor, meet with them pre audit and post audit, and review the audit log of the internal auditor. The Committee will examine and report on the manner in which management ensures and monitors the adequacy of the nature, extent and effectiveness of compliance, accounting and internal control systems. The Committee shall oversee the work of those involved in the financial reporting process including the internal auditors and the outside auditors, to endorse the processes and safeguards employed by each. The Committee will encourage procedures and practices that promote accountability among management, ensuring that it properly develops and adheres to a compliant and sound system of internal controls, that the internal auditor objectively assesses management's accounting practices and internal controls, and that the outside auditors, through their own review, assess management and the internal auditor's practices. This committee shall supervise all of the compliance activities of the District, ensuring that Compliance and Internal Audit departments effectively facilitate the prevention, detection and correction of violations of law, regulations, and/or District policies. The ~~Compliance~~

~~and Privacy Officer~~Chief Compliance Officer will review and forward to the full Board a written Quarterly Compliance Report.

This committee, on behalf of the Board of Directors, shall be responsible for overseeing the recruitment, employment, evaluation and dismissal of the ~~Compliance and Privacy Officer~~Chief Compliance Officer and the ~~Director of Internal Audit~~Director of Audit & Consulting. These responsibilities shall be performed primarily by the CEO and/or the CEO's designees, but final decisions on such matters shall rest with this committee, acting on behalf of the full Board.

C. Community-Based Planning

The members of this committee shall consist of two (2) Board members {Board President or Secretary/Treasurer shall be a standing member of this committee}, CEO, Facilities Planning Director and any other members designated by the Board President as they deem appropriate to the topic(s) being considered: community leaders including but not limited to City leadership, Visalia Unified School District (VUSD) leadership, College Of the Sequoias leadership, County Board of Supervisors, etc.

The membership of this committee shall meet with other community representatives to develop appropriate mechanisms to provide for efficient implementation of current and future planning of District facilities and services and to achieve mutual goals and objectives.

D. Finance / Property, Services & Acquisitions

The members of this committee shall consist of two (2) Board members - (~~the~~ Board President or Secretary/Treasurer will be a standing member of this committee), ~~the~~ CEO, ~~the~~ CFO, ~~the~~ COO, ~~VP Strategic Planning and Business Development~~Chief Strategy Officer, ~~the~~ Facilities Planning Director, and any other members designated by the Board President.

This committee will oversee the financial health of the District through careful planning, allocation and management of the District's financial resources and performance. To oversee the construction, improvement, and maintenance of District property as well as the acquisition and sale of property which is essential for the Health Care District to carry out its mission of providing high-quality, customer-oriented, and financially-strong healthcare services.

E. Governance & Legislative Affairs

The members of this committee shall consist of two (2) Board members {~~the~~ Board President or the Board Secretary/Treasurer}, ~~the~~ CEO and any other members designated by the Board President. Committee activities will include~~:~~; reviewing Board committee structure, calendar, bylaws and, planning the bi-annual Board self-evaluation, and monitor conflict of interest. Legislative activities will include~~:~~; establishing the legislative program scope & direction for the District, annually review appropriation request to be submitted by the District, effectively communicating and maintaining collegial relationships with local, state, and nationally elected officials.

F. Human Resources

The members of this committee shall consist of two (2) Board members, ~~the~~ CEO, ~~the Vice President of Human Resources~~Chief Human Resources Officer, ~~the~~ Chief Nursing Officer (CNO) and any other members designated by the Board President. This committee shall review and approve all personnel policies. This committee shall annually review and recommend changes to the Salary and Benefits Program, the Safety Program and the Workers' Compensation Program. This committee will annually review the workers compensation report, competency report & organizational development report.

G. Information Systems

The members of this committee shall consist of two (2) Board members, ~~the~~ CEO, CFO, COO, CNO, ~~the~~ Chief Information Officer (CIO), ~~the~~ Medical Director of Informatics, and any other members designated by the Board President. This committee shall supervise the Information Systems projects of the District.

H. Marketing and ~~Public Affairs~~Community Relations

The members of this committee shall consist of two (2) Board members and ~~the~~ CEO, ~~the VP of Strategic Planning and Business Development~~Chief Strategy Officer, ~~the~~ Marketing Director, and any other members designated by the Board President.

This committee shall oversee marketing and ~~public affairs~~community relations activities in the District in order to increase ~~the primary and secondary market share in all service areas~~the community's awareness of available services and to improve engagement with the population we serve. Additionally, create a brand that builds preference for Kaweah Delta in the minds of consumers and creates a public image that instills trust, confidence, and is emblematic of Kaweah Delta's mission ~~statement~~and our vision to become "world-class". Further develops and fosters a positive perception that will attract the highest caliber of employees and medical staff

I. Patient Experience

The members of this committee shall consist of two (2) Board members and ~~the Vice President of Human Resources~~Chief Human Resources Officer, Director of Patient Experience, Director of Emergency Services, and any other members designated by the Board President.

This committee will work with the patient experience team and leadership to develop a patient experience strategy to ensure that patient experiences are meeting the Mission and Vision of Kaweah Delta and its foundational Pillar "Deliver excellent service".

J. Quality Council

The members of this committee shall consist of two (2) Board members, ~~the~~ CEO or designate, ~~the~~ Chief Medical Officer (CMO), CNO, Chief Quality Officer, ~~the~~ Chief of the Medical Staff, ~~the~~ chair of the Professional Staff Quality Committee (Prostaff), ~~the~~ Medical Directors of Quality and Patient Safety, Director of Quality and Patient Safety, Director of Risk Management, and members of the Medical Staff as designated by the Board.

This committee shall review and recommend approval of the annual Quality Improvement (QI) plan and Patient Safety plans to the Board of Directors, determine priorities for improvement, monitor key outcomes related to Quality Focus Team activities, evaluate clinical quality, patient safety, and patient satisfaction, monitor and review risk management activities and outcomes, evaluate the effectiveness of the performance improvement program, foster commitment and collaboration between the District and Medical Staff for continuous improvement, and review all relevant matters related to Quality within the institution, including Performance Improvement, Peer Review, Credentialing/Privileging and Risk Management..

K. Strategic Planning

The members of this committee shall consist of two (2) Board members, ~~the~~ CEO, ~~VP of Strategic Planning and Business Development~~ Chief Strategy Officer, other Executive Team members, Medical Staff Officers, Immediate past Chief of Staff along with other members of the Medical Staff as designated by the Board and the CEO.

This committee shall review the budget plan, review the strategic plan and organize objectives, review changes or additions to service lines.

The Strategic Planning Committee will provide oversight and forward to the full Board the following reports:

1. Review of the Strategic Plan Annually
2. Strategic Plan initiatives progress and follow-up bi-monthly to full Board.

L. Independent Committees

The following independent committees may have Board member participation.

1. Cypress Company, LLC
2. Graduate Medical Education Committee (GMEC)
3. Joint Conference
4. Kaweah Delta Medical Foundation
5. Kaweah Delta Hospital Foundation
6. Quail Park {All entities}
7. Retirement Plans' Investment Committee
8. Sequoia Integrated Health, LLC
9. Sequoia Surgery Center, LLC
10. Sequoia Regional Cancer Center – Medical & Radiation, LLC
11. Tulare Kings Cancer (TKC) Development, LLC
    - The Board President shall serve as General Manager for TKC Development, LLC.
12. 202 W. Willow – Board of Owners
13. Central Valley Health Care Alliance - JPA

M. Medical Affairs

1) A member of the Board, as appointed by the President, shall also serve on the following Medical Staff Committees:
   a) Joint Conference & Planning Committee - This committee shall regularly meet to discuss current issues/concerns with Medical Staff, Board, and Administration.
   b) Credentials Committee - The Board shall participate in this committee to observe the Medical Staff process.

Section 7 The Governing Body Bylaws:

The Governing Body Bylaws and any changes thereto may be adopted at any regular or special meeting by a legally constituted quorum of the Governing Body. All portions of Governing Body Bylaws must be in compliance with applicable California Code, which is the ruling authority.

Any member of the Governing Body may request a review for possible revision of the Bylaws of the District.

The Chief Executive Officer and the Governing Body shall review the Bylaws and recommend appropriate changes every year.

Section 8 Members of the Governing Body shall annually sign a job description which outlines the duties and responsibilities of the Governing Body members including but not limited to adherence to the Board conflict of interest policy {Board of Directors policy - BOD5 – Conflict of Interest}, District confidentiality, and the Brown Act.

Section 9 Members of the Governing Body are publicly elected. The members of the Governing Body are expected to participate actively in the functions of the Governing Body and its committees and to serve the constituency who elected them. Notwithstanding any other provision of law, the term of any member of the board of directors shall expire if he or she is absent from three consecutive regular meetings, or from three of any five consecutive meetings of the board

and the board by resolution declares that a vacancy exists on the board {Health and Safety Code 32100.2}.

Section 10 The Chief Executive Officer shall provide an orientation program to all newly elected members of the Governing Body. {Board of Directors policy – BOD1 – Orientation of a New Board Member} All members of the Board of Directors shall be provided with current copies of the District Bylaws and the Medical Staff Bylaws and any revisions of these Bylaws.

Section 11 All members of the Governing Body shall be provided with a copy of the Bylaws which govern the Board of Directors, a job description for the District Governing Body and the Board President or Individual Board Member as applicable.

Article III Officers of the Board

Section 1 The offices of President, Vice President, and Secretary/Treasurer shall be selected at the first regular meeting in December of a non-election year of the District. To hold the office of President, Vice President, or Secretary/Treasurer, a Board member must have at least one year of service on the Board of Directors. These officers shall hold office for a period of two (2) years or until the successors have been duly elected (or in the case of an unfulfilled term, appointed) and qualified. The officer positions shall be by election of the Board itself.

Section 2 The duties and responsibilities of the Governing Body President are:

A. Keep the mission of the organization at the forefront and articulates it as the basis for all Board action.

B. Understand and communicate the roles and functions of the Board, committees, Medical Staff, and management.

C. Understand and communicate individual Board member, Board leader, and committee chair responsibilities and accountability.

D. Act as a liaison between the Board, management, and Medical Staff.

E. Plan agendas.

F. Preside over the meetings of the Board.

G. Preside over or attend other Board, Medical Staff, and other organization meetings.

H. Enforce Board and hospital bylaws, rules, and regulations (such as conflict of interest and confidentiality policies).

I. Appoint Board committee chairs and members in a consistent and systematic approach.

J. Act as a liaison between and among other Boards in the healthcare system.

K. Direct the committees of the Board, ensuring that the committee work plans flow from and support the hospital and Board goals, objectives, and work plans.

L. Provide orientation for new Board members and arrange continuing education for the Board.

M. Ensure effective Board self-evaluation.

N. Build cohesion among the leadership team of the Board President, CEO, and Medical Staff leaders.

O. Lead the CEO performance objective and evaluation process.

Section 3 The duties and responsibilities of the Governing Body Vice President are:

A. The Vice President shall act as President in the absence of the President or the Secretary/Treasurer in the absence of the Secretary/Treasurer, and so acting shall have all the responsibility and authority of that position.

Section 4 The Secretary/Treasurer shall act as the Secretary for the Board of Directors of Kaweah Delta Health Care District and in so doing shall:

A. maintain minutes of all meetings of the Board of Directors;

B. be responsible for the custody of all records and for maintaining records of the meetings;

C. be assured that an agenda is prepared for all meetings.

Section 5 The Secretary/Treasurer shall be custodian of all funds of Kaweah Delta Health Care District as well as the health care facilities operated by the District. The Secretary/Treasurer shall assure that administration is using proper accounting systems; that this is a true and accurate accounting of the transactions of the District; that these transactions are recorded and accurate reports are regularly reported to the Board of Directors. The Secretary/Treasurer in conjunction with the Board Audit and Compliance Committee shall see that a major accounting firm provides ongoing overview and scrutiny of the fiscal aspects of the District, and shall further assure that an annual audit is prepared by a major accounting firm and presented directly to the Board of Directors.

Article IV The Medical Staff

Section 1 The Governing Body shall appoint the Medical Staff composed of licensed physicians, surgeons, dentists, podiatrists, clinical psychologists, and all Allied Health Practitioners (including Physician Assistants, Nurse Practitioners and Nurse Midwives) duly licensed by the State of California {Health and Safety Code of the State of California, Section 32128}. The Governing Body, upon consideration of the recommendations of the Medical Staff coming from the Medical Executive Committee, through the Credentials Committee, affirms or denies appointment and privileges to the Medical Staff of Kaweah Delta Health

Care District in accordance with the procedure for appointment and reappointment of medical staff as provided by the standards of the Joint Commission on Accreditation of Healthcare Organizations {Joint Commission Standard MS.01.01.01}. The Board of Directors shall reappoint members to the Medical Staff every two (2) years, as set forth in the Medical Staff Bylaws. The Governing Body requires that an organized Medical Staff is established within the District and that the Medical Staff submits their Bylaws, Rules and Regulations and any changes thereto, to the Governing Body for approval.

Section 2 Members of the Medical Staff are eligible to run in public election for membership on the Governing Body in the same manner as other individuals.

Section 3 All public meetings of the Governing Body may be attended by members of the Medical Staff. The Chief of Staff of Kaweah Delta Health Care District shall be notified and invited to each regular monthly meeting of the Governing Body and the Chief of Staff's input shall be solicited with respect to matters affecting the Medical Staff.

Section 4 The Chief of Staff of Kaweah Delta Health Care District shall be invited to all meetings of the Governing Body at which credentialing decisions are made concerning any member of the Medical Staff of Kaweah Delta Hospital or at which quality assurance reports are given concerning the provision of patient care at Kaweah Delta Hospital. Quality assurance reports shall be made to the Board periodically. Credentialing decisions shall be scheduled on an as-needed basis. The Chief of Staff shall be encouraged to advise the Board on the content and the quality of the presentations, and to make recommendations concerning policies and procedures, the improvement of patient care and/or the provision of new services by the District.

Annually, the Governing Body shall meet with the leaders of the Medical Staff to review and analyze the health care services provided by the District and to discuss long range planning for the District as noted in Article II, Section 4, Item C7.

Section 5 **The District has an organized Medical Staff that is accountable to the Governing Body {Joint Commission Standard LD.01.05.01}.** The organized Medical Staff Executive Committee shall make recommendations directly to the Governing Body for its approval. Such recommendations shall pertain to the following:

A. the structure of the Medical Staff;
B. the mechanism used to review credentials and delineate clinical privileges;
C. individual Medical Staff membership;
D. specific clinical privileges for each eligible individual;
E. the organization of the performance improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate, and revise such activities;

F. the mechanism by which membership on the Medical Staff may be terminated;

G. the mechanism for fair hearing procedures.

Section 6 The Governing Body shall act upon recommendations concerning Medical Staff appointments, re-appointments, termination of appointments, and the granting or revision of clinical privileges within 120 days following the regular monthly meeting of the Governing Body at which the recommendations are presented through the Executive Committee of the organized Medical Staff.

Section 7 The Governing Body requires that only a member of the organized Medical Staff with admitting privileges at Kaweah Delta Hospital may admit a patient to Kaweah Delta Hospital and that such individuals may practice only within the scope of the privileges granted by the Governing Body and that each patient's general medical condition is the responsibility of a qualified physician of the Medical Staff.

Section 8 The Governing Body requires that members of the organized Medical Staff and all Allied Health Practitioners (including Physician Assistants, Nurse Practitioners and Nurse Midwives) maintain current professional liability insurance with approved carriers and in the amounts of $1,000,000/$3,000,000 (per occurrence / annual aggregate) or such other amounts as may be established by the Governing Body by resolution.

Section 9 The Governing Body holds the Medical Staff responsible for the development, adoption, and annual review of its own Medical Staff Bylaws, Rules and Regulations that are consistent with the District policy, applicable codes, and other regulatory requirements. Neither the Medical Staff nor The Governing Body may make unilateral amendments to the Medical Staff Bylaws or the Medical Staff Rules and Regulations.

The Medical Staff Bylaws and the Rules and Regulations adopted by the Medical Staff, and any amendments thereto, are subject to, and effective upon, approval of the Governing Body, such approval not to be unreasonably withheld.

Section 10 The Medical Staff is responsible for establishing the mechanism for the selection of the Medical Staff Officers, Medical Staff Department Chairpersons, and Medical Staff Committee Chairpersons.

This mechanism will be included in the Medical Staff Bylaws.

Section 11 The Governing Body requires the Medical Staff and the Management to review and revise all department policies and procedures as often as needed. Such policies and procedures must be reviewed at least every three (3) years.

In adherence with Title 22, {70203} Policies relative to medical service {those preventative, diagnostic and therapeutic measures performed by or at the request of members of the organized medical staff} shall be approved by the governing body as recommended by the Medical Staff.

In adherence with Title 22, {70213} Nursing Service Policies for patient care shall be developed, maintained and implemented by nursing services; policies which

involve the Medical Staff shall be reviewed and approved by the Medical Staff prior to implementation. The hospital administration and the governing body shall review and approve all policies that relate to nursing services every three years or more often, if necessary.

Section 12 Individuals who provide patient care services (other than District staff members), but who are not subject to the Medical Staff privilege delineation process, shall submit their credentials to the Interdisciplinary Practice Committee of the Medical Staff which shall, via the Executive Committee, transmit its recommendations to the Governing Body for approval or disapproval.

Section 13 The quality of patient care services provided by individuals who are not subject to Medical Staff privilege delineation process, shall be included as a portion of the District's Performance Improvement program.

Section 14 The Governing Body specifies that under the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA), the Medical Staff and the District are in an Organized Health Care Arrangement (OHCA). The OHCA is a clinically integrated care setting in which individuals receive heath care from more than one provider and the providers hold themselves out to the public as participating in a joint arrangement. The Medical Staff is in an OHCA with the District for care provided at District facilities. This joint arrangement is disclosed to the patients in the Notice of Privacy Practices given to patients when they access care at any of the District's facilities.

Article V Joint Committees

Section 1 The President of the Governing Body or a member of the Board appointed by the President shall participate, along with the Chief Executive Officer, in the Joint Conference Committee, which is a committee of the Medical Staff of Kaweah Delta Health Care District. This committee shall serve as a systematic mechanism for communication between members of the Governing Body, the Administration, and members of the Medical Staff of Kaweah Delta Health Care District. Specifically, issues which relate to quality of patient care shall be regularly addressed. Additionally, other matters of communication which are of importance to maintaining a sound working relationship between the Governing Body and the Medical Staff shall be discussed. These meetings shall be held at a minimum of every other month and minutes, if any, shall be kept by the organized Medical Staff under the direction of its President. The proceedings and records of this committee are protected by Section 1157 of the evidence Code.

Article VI Chief Executive Officer

Section 1 The Governing Body shall be solely responsible for appointment or dismissal of the Chief Executive Officer. {Board of Directors policy – BOD2 – Chief Executive Officer (CEO) Transition}

Section 2 The Governing Body shall assure that the Chief Executive Officer is qualified for his responsibilities through education and/or experience {Board of Directors policy – BOD3 – Chief Executive Officer (CEO) Criteria}.

Section 3 The Chief Executive Officer shall act on behalf of the Governing Body in the overall management of the District.

Section 4 In the absence of the Chief Executive Officer, a Vice President designated by the Chief Executive Officer or by the President of the Governing Body shall assume the responsibilities of this position. The Governing Body retains final authority to name the person to act during the absence or incapacity of the Chief Executive Officer.

Section 5 Annually the Governing Body shall meet in Executive session to monitor the performance of the Chief Executive Officer. The conclusions and recommendations from this performance evaluation will be transmitted to the Chief Executive Officer by the Governing Body.

Section 6 The Chief Executive Officer shall select, employ, control, and have authority to discharge any employee of the District other than any individual with the title or equivalent function of Senior Vice President, Vice President, ~~Compliance and Privacy Officer~~Chief Compliance Officer, ~~Director of Internal Audit~~Director of Audit & Consulting, or Board Clerk. Employment of new personnel shall be subject to budget authorization granted by the Board of Directors of Kaweah Delta Health Care District.

Section 7 The Chief Executive Officer shall organize, and have the authority to reorganize the administrative structure of the District, below the level of CEO, subject to the limitations set forth in in Section 6 above. The District's organizational chart shall reflect that the ~~Compliance and Privacy Officer~~Chief Compliance Officer, and the ~~Director of Internal Audit~~Director of Audit & Consulting have direct, solid-line reporting relationships to the Board (functional) and to the CEO (administrative).

Section 8 The Chief Executive Officer shall report to the Board at regular and special meetings all significant items of business of Kaweah Delta Health Care District and make recommendations concerning the disposition thereof. The Chief Executive Officer shall, directly and through the District's Vice Presidents, keep the ~~Compliance and Privacy Officer~~Chief Compliance Officer, and the ~~Director of Internal Audit~~Director of Audit & Consulting well-informed of District operations and shall promptly inform them of any matter that may expose the District to a material legal, regulatory or financial liability.

Section 9 The Chief Executive Officer shall submit regularly, in cooperation with the appropriate committee of the Board, periodic reports that may be required by the Board.

Section 10 The Chief Executive Officer shall attend all meetings of the Board when possible and shall attend meetings of the various committees of the Board when so requested by the committee chairperson.

Section 11 The Chief Executive Officer shall serve as a liaison between the Board and the Medical Staff of Kaweah Delta Hospital. The Chief Executive Officer shall cooperate with the Medical Staff and secure like cooperation on the part of all concerned with rendering professional service to the end that patients may receive the best possible care.

Section 12 The Chief Executive Officer shall make recommendations concerning the purchase of equipment and supplies and the provision of services by the District, considering the existing and developing needs of the community and the availability of financial and medical resources.

Section 13 The Chief Executive Officer shall keep abreast and be informed of new developments in the medical and administrative areas of hospital administration.

Section 14 The Chief Executive Officer shall oversee the District's physical plants and ground and keep them in a good state of repair, conferring with the appropriate committee of the Board in major matters, but carrying out routine repairs and maintenance without such consultation.

Section 15 The Chief Executive Officer shall supervise all business affairs such as the records of financial transactions, collections of accounts and purchase and issuance of supplies, and be certain that all funds are collected and expended to the best possible advantage.

Section 16 The Chief Executive Officer shall supervise the preservation of the permanent medical records of the District and act as overall custodian of these records.

Section 17 The Chief Executive Officer shall keep abreast of changes in applicable laws and regulations and shall insure that a District compliance program, appropriate educational programs, and organizational memberships are in place to carry out this responsibility.

Section 18 The Chief Executive Officer shall be responsible for assuring the organization's compliance with applicable licensure requirements, laws, rules, and regulations, and for promptly acting upon any reports and/or recommendations from authorized agencies, as applicable.

Section 19 The Chief Executive Officer will ensure that the business of the Health Care District is conducted openly and transparently, as required by law.

Section 20 The Chief Executive Officer will oversee the activities of the Health Care District's community relations committees to ensure meaningful participation of community members and communication of the input and recommendation from the committee to the Board and to KDHCD management.

Section 21 The Chief Executive Officer shall perform any special duties assigned or delegated to him by the Board.

Article VII The Health Care District Guild

Section 1 The Governing Body recognizes the Kaweah Delta Health Care District Guild in support of the staff and patients of the District.

Section 2 The Chief Executive Officer is charged with effecting proper integration of the health care district Guild within the framework of the District organization.

Section 3 The President of the Guild is encouraged to attend the meetings of the Board of Directors.

Article VIII Performance Improvement (PI)

Section 1 The Governing Body requires that the Medical Staff and the District staff implement and report on the activities and mechanisms for monitoring and evaluating the quality of patient care, for identifying and resolving problems, and for identifying opportunities to improve patient care within the District.

Section 2 The Governing Body, through the Chief Executive Officer, shall support these activities and mechanisms.

Section 3 The Governing Body shall adopt a Performance Improvement Plan and Risk Management Plan for the District and shall provide for resources and support systems to ensure that the plans can be carried out.

Section 4 The Governing Body requires that a complete and accurate medical record shall be prepared and maintained for each patient; that the medical record of the patient shall be the basis for the review and analysis of quality of care. The Governing Body holds the organized Medical Staff of the health care district responsible for self-governance with respect to the professional work performed in the hospital and for periodic meetings of the Medical Staff to review and analyze at regular intervals their clinical experience. Results of such review will be reported to the Governing body at specific intervals defined by the Board.

Section 5 The quality assurance mechanisms within any of the District's facilities shall provide for monitoring of patient care processes to assure that patients with the same health problem are receiving the same level of care within the District.

Article IX Conflict of Interest

Section 1 The Administration Policy Manual of Kaweah Delta Health Care District and the Board of Directors Policy Manual has a written Conflict of Interest Policy {Administrative Policy AP23 and Board of Directors Policy BOD5} which requires the completion and filing of a Conflict of Interest Statement disclosing financial interests that may be materially affected by official actions and provides that designated staff members must disqualify themselves from acting in their official capacity when necessary in order to avoid a conflict of interest. The requirements of this policy are additional to the provisions of Government Code §87100 and other laws pertaining to conflict of interest; and nothing herein is

intended to modify or abridge the provisions of the policies of Kaweah Delta Health Care District which apply to:

A. members of the Governing Body,
B. the executive staff of the District,
C. employees who hold designated positions identified in Exhibit "A" of the District Conflict of Interest Code.

Section 2 Each member of the Governing Body, specified executives, and designated employees must file an annual Conflict of Interest Statement as required by ~~California Code~~California Government Code – Section 87300-87313.

Section 3 The Board shall assess the adequacy of its conflict-of-interest/confidentiality policies and procedures {Board Of Directors Policy - BOD5 - and Administrative Policy 23 – Conflict of Interest} at least every two years.

Article X Indemnification of Directors, Officers, and Employees

Section 1 Actions other than by the District. The District shall have the power to indemnify any person who was or is a party, or is threatened to be made a party, to any proceeding (other than an action by or in the right of the District to procure a judgment in its favor) by reason of the fact that such person is or was a director, officer or employee of the District, against expenses, judgments, fines, settlements, and other amounts actually and reasonably incurred in connection with such proceeding if that person acted in good faith and in a manner that the person reasonably believed to be in the best interest of the District and, in the case of a criminal proceeding, had no reasonable cause to believe the conduct of that person was unlawful. The termination by any proceeding by judgment, order, settlement, conviction or upon a plea of nolo contendere or its equivalent, shall not, of itself, create a presumption that the person did not act in good faith and in the manner that the person reasonably believed to be in the best interests of the District person's conduct was unlawful.

Section 2 Actions by the District. The District shall have the power to indemnify any person who was or is a party, or is threatened to be made a party, to any threatened, pending, or completed action by or in the right of the District to procure a judgment in its favor by reason of the fact that such person is or was a director, officer, or employee of the District, against expenses actually and reasonably incurred by such person in connection with the defense or settlement of that action, if such person acted in good faith, in a manner such person believed to be in the best interest of the District and with such care, including reasonable inquiry, as an ordinarily prudent person in a like position would use under a similar circumstance.

No indemnification shall be made under this Section:

A. with respect to any claim, issue or matter as to which such person has been adjudged to be liable to the District in their performance of such person's duty to the District, unless and only to the extent that the court in

which that proceeding is or was pending shall determine upon application that, in view of all the circumstances of the case, such person is fairly and reasonably entitled to indemnity for the expenses which the court shall determine;

B. of amounts paid in settling or otherwise disposing of a threatened or pending action, with or without court approval;

C. of expenses incurred in defending a threatened or pending action that is settled or otherwise disposed of without court approval.

Section 3 Successful defense by director, officer, or employee. To the extent that a director, officer or employee of the District has been successful on the merits in defense of any proceeding referred to in Section 1 or Section 2 of this Article X, or in defense of any claim, issue or matter therein, the director, officer or employee shall be indemnified as against expenses actually and reasonably incurred by that person in connection therewith.

Section 4 Required approval. Except as provided in Section 3 of this Article, any indemnification under this Article shall be made by the District only if authorized in the specific case, upon a determination that indemnification of the officer, director or employee is proper in the circumstances because the person has met the applicable standard of conduct set forth in Sections 2 and 3 of this Article X, by one of the following:

A. a majority vote of a quorum consisting of directors who are not parties to the proceeding; or

B. the court in which the proceeding is or was pending, on application made by the District or the officer, director or employee, or the attorney or other person rendering services in connection with the defense, whether or not such other person is opposed by the District.

Section 5 Advance of expenses. Expenses incurred in defending any proceeding may be advanced by the District before the final disposition of the proceeding upon receipt of an undertaking by or on behalf of the officer, director or employee to repay the amount of the advance unless it shall be determined ultimately that the officer, director or employee is entitled to be indemnified as authorized in this Article.

Section 6 Other contractual rights. Nothing contained in this Article shall affect any right to indemnification to which persons other than directors and officers of this District may be entitled by contract or otherwise.

Section 7 Limitations. No indemnification or advance shall be made under this Article except as provided in Section 3 or Section 4, in any circumstance where it appears:

A. that it would be inconsistent with the provision of the Articles, a resolution of the Board, or an agreement in effect at the time of accrual of the alleged cause of action asserted in the proceeding in which the expenses

were incurred or other amounts were paid, which prohibits or otherwise limits indemnification; or

B. that it would be inconsistent with any condition expressly imposed by a court in approving a settlement.

Section 8 Insurance. If so desired by the Board of Directors, the District may purchase and maintain insurance on behalf of any officer, director, employee or agent of the corporation, insuring against any liability asserted against or incurred by the director, officer, employee or agent in that capacity or arising out of the person's status as such, whether or not the District would have the power to indemnify the person against that liability under the provisions of this Article.

If any article, section, sub-section, paragraph, sentence, clause or phrase of these District Bylaws is for any reason held to be in conflict with the provisions of the Health and Safety Code of the State of California, such conflict shall not affect the validity of the remaining portion of these Bylaws.

These Bylaws for Kaweah Delta Health Care District are adopted, as amended, this ~~29th~~ 27th day of ~~January, 2020~~April, 2020.

President
Kaweah Delta Health Care District

Secretary/Treasurer
Kaweah Delta Health Care District

(Adopt and file with the County Registrar of Voters
NO LATER THAN JULY 1, 2020)

BEFORE THE BOARD OF DIRECTORS OF THE

Kaweah Delta Health Care District
(Name of District)

Resolution Ordering Even-Year Board of Directors	)	
Election; Consolidation of Elections; and	)	RESOLUTION
Specifications of the Election Order	)	NO. 2074

WHEREAS, California Elections Code requires a general district election be held in each district to choose a successor for each elective officer whose term will expire on the first Friday in December following the election to be held on the first Tuesday after the first Monday in November in each even-numbered year; and

WHEREAS, other elections may be held in whole or in part of the territory of the district, and it is to the advantage of the district to consolidate pursuant to Elections Code Section 10400; and

WHEREAS, Elections Code Section 10520 requires each district involved in a general election to reimburse the county for the actual costs incurred by the county elections official in conducting the election for that district; and

WHEREAS, Elections Code Section 13307(3c) requires that before the nominating period opens, the governing body must determine whether a charge shall be levied against each candidate submitting a candidate's statement to be sent to the voters; and

WHEREAS, Elections Code Section 12112 requires the elections official of the principal county to publish a notice of the election once in a newspaper of general circulation in the district;

NOW, THEREFORE, IT IS ORDERED that an election be held within the territory included in this district on the 3rd day of November, 2020, for the purpose of electing members to the board of directors of said district in accordance with the following specifications:

SPECIFICATIONS OF THE ELECTION ORDER

1. The Election shall be held on Tuesday, the 3rd day of November 2020. The purpose of the election is to choose members of the board of directors for the following seats (list offices and terms):

Zone 1 {12/04/2020-12/06/2024}
Zone 3 {12/04/2020-12/06/2024}
Zone 5 {12/04/2020-12/06/2024}

2. This governing board hereby requests and consents to the consolidation of this election with other elections which may be held in whole or in part of the territory of the district, as provided in Elections Code 10400.

3. The district will reimburse the county for the actual cost incurred by the county elections official in conducting the general district election upon receipt of a bill stating the amount due as determined by the elections official.

4. The district has determined that the Candidate (District or Candidate) will pay for the Candidate's Statement. The Candidate's Statement will be limited to 200 words.

5. The district directs that the County Registrar of Voters of the principal county publish the notice of election in the following newspaper, which is a newspaper of general circulation that is regularly circulated in the territory: Visalia Times Delta and Fresno Bee.

THE FOREGOING RESOLUTION WAS ADOPTED upon motion of Director _____, seconded by Director _____, at a regular meeting on this 27th day of April, 2020, by the following vote:

AYES :_____

NAYS :_____

ABSENT:_____

_____
(Secretary of said District)

KAWEAH DELTA HEALTH CARE DISTRICT

CONFLICT OF INTEREST CODE

Government Code Section 87300 requires each state and local government agency to adopt and promulgate a Conflict of Interest Code. The Fair Political Practices Commission has adopted Section 18730 of Title 2 of the California Code of Regulations, which contains the terms of a model conflict of interest code (hereinafter "Standard Code") which may be adopted by reference by any state or local agency which desires to do so. For the purpose of providing a conflict of interest code for Kaweah Delta Health Care District, its Board of Directors, and its employees, the terms of the Standard Code and any amendments to it duly adopted by the Fair Political Practices Commission are hereby incorporated by reference and made a part hereof as if set forth herein at length, and, along with Exhibits A and B attached hereto, in which officials and employees are designated and disclosure categories are set forth, such Standard Code shall constitute the Conflict of Interest Code for Kaweah Delta Health Care District, its Board of Directors, and its employees. The Chief Executive Officer shall ensure that a current copy of the Standard Code is kept on file in the District's administrative office with this Conflict of Interest Code. A copy of the current version of the Standard Code is attached hereto as Exhibit C for information purposes only.

Pursuant to Section 4 of the Standard Code, designated employees shall file statements of economic interests with the Chief Executive Officer of Kaweah Delta Health Care District. Upon receipt of the statements filed by the designated employees of the department, the Chief Executive Officer shall make and retain a copy and forward the original of these statements to the code reviewing body, which in this case is the Tulare County Board of Supervisors.

Adopted by the Board of Directors of Kaweah Delta Health Care District effective ~~November 27, 2018~~April 27, 2020.

EXHIBIT "A"

KAWEAH DELTA HEALTH CARE DISTRICT

CONFLICT OF INTEREST CODE

Disclosure Categories

Designated Positions	Category of Interests Required to be Disclosed
Members of the Board of Directors	1
Employees	
Chief Executive Officer	1
Vice President, Chief Financial Officer	1
~~Senior~~ Vice President, ~~Chief Operating Officer~~Ancillary & Support Services	1
Vice President, Chief Quality Officer	1
Vice President, Chief Medical Officer	1
Vice President, Chief Nursing Officer	1
Vice President, Chief Information Officer	1
Vice President ~~of~~ Chief Human Resources Officer	1
Vice President, Chief Strategy Officer~~ of Strategic Planning & Development~~	1
Vice President, Cardiac & Surgical Services	1
Vice President, Rehabilitation and Post Acute Services	1
Vice President, Population Health & CEO Sequoia Health and Wellness Center (SHWC)	1
~~District~~ Chief Compliance ~~& Privacy~~ Officer	1
Director ~~– Internal Audit~~of Audit and Consulting	1
Director of Procurement and Logistics Material Management	1
Kaweah Delta Medical Foundation Chief Executive Officer	1
Kaweah Delta Medical Foundation Chief Financial Officer	1
Director of Risk Management	1
Director of Facilities ~~and Security~~	1
Director of Facilities Planning Services	1
All Directors of Kaweah Delta Health Care District	4B
Consultants	
Legal Counsel to the Board of Directors	1

["Consultants may be designated employees who must disclose financial interests as determined on a case-by-case basis. The District must make a written determination whether a consultant must disclose financial interests. The determination shall include a description of the consultant's duties and a statement of the extent of the disclosure requirements, if any, based upon that description. All such determinations are public records and shall be retained for public inspection with this conflict of interest code.

["Consultants can be deemed to participate in making a governmental decision when the consultant, acting within the authority of his or her position:

(1) Negotiates, without significant substantive review, with a governmental entity or private person regarding certain governmental decisions; or

(2) Advises or makes recommendations to the decision-maker either directly or without significant intervening substantive review, by:

a. Conducting research or making an investigation, which requires the exercise of judgment on the part of the person and the purpose of which is to influence a governmental decision; or

b. Preparing or presenting a report, analysis, or opinion, orally or in writing, which requires the exercise of judgment on the part of the person and the purpose of which is to influence the decision."

(From the Tulare County Counsel)

{A consultant is also subject to the disclosure requirements if he/she acts in a staff capacity (i.e., performs the same or substantially all the same duties that would otherwise be performed by an individual holding a position specified in the Code).]

EXHIBIT "B"

KAWEAH DELTA HEALTH CARE DISTRICT

CONFLICT OF INTEREST CODE

Disclosure Categories

1. **Full Disclosure:**

Designated persons in this category must report:

All interests in real property located entirely or partly within this District's jurisdiction or boundaries, or within two miles of this District's jurisdiction or boundaries or of any land owned or used by this District. Such interests include any leasehold, ownership interest or option to acquire such interest in real property.

All investments, business positions, ownership and sources of income, including gifts, loans and travel payments.

2. **Full Disclosure (excluding interests in real property):**

All investments, business positions, ownership and sources of income, including gifts, loans and travel payments.

3. **Interests in Real Property (only):**

All interests in real property located entirely or partly within this District's jurisdiction or boundaries, or within two miles of this District's jurisdiction or boundaries or of any land owned or used by this District. Such interests include any leasehold, ownership interest or option to acquire such interest in real property.

4. **General Contracting (two options):**

A. All investments, business positions, ownership and sources of income, including gifts, loans and travel payments, from sources that provide, or have provided in the last two years, leased facilities, goods, supplies, materials, equipment, vehicles, machinery, services, or the like, including training or consulting services, of the type utilized by the District.

[Intended for employees whose duties and decisions involve contracting and purchasing for the entire District.]

B. All investments, business positions, ownership and sources of income, including gifts, loans and travel payments, from sources that provide, or have provided in the last two years, leased facilities, goods, supplies, materials, equipment, vehicles, machinery, services, or

the like, including training or consulting services, of the type utilized by the employee's department or division.

[Intended for employees whose duties and decisions involve contracting and purchasing for a specific department or division of the District.]

5. **Regulatory, Permit or Licensing Duties:**

All investments, business positions, ownership and sources of income, including gifts, loans and travel payments, from sources that are subject to the regulatory, permit or licensing authority of, or have an application for a license or permit pending before, the employee's department or division, or the District.

6. **Grant/Service Providers/Departments that Oversee Programs:**

A. All investments, business positions, ownership and sources of income, including gifts, loans and travel payments, or income from a nonprofit organization, if the source is of the type to receive grants or other monies from or through a specific department or division of the District.

[Intended for employees whose duties and decision involve awards of monies or grants to organizations or individuals.]

EXHIBIT "C"

KAWEAH DELTA HEALTH CARE DISTRICT

CONFLICT OF INTEREST CODE

Standard Code

§ 18730. Provisions of Conflict of Interest Codes.

(a) Incorporation by reference of the terms of this regulation along with the designation of employees and the formulation of disclosure categories in the Appendix referred to below constitute the adoption and promulgation of a conflict of interest code within the meaning of Government Code section 87300 or the amendment of a conflict of interest code within the meaning of Government Code section 87306 if the terms of this regulation are substituted for terms of a conflict of interest code already in effect. A code so amended or adopted and promulgated requires the reporting of reportable items in a manner substantially equivalent to the requirements of article 2 of chapter 7 of the Political Reform Act, Government Code sections 81000, *et seq*. The requirements of a conflict of interest code are in addition to other requirements of the Political Reform Act, such as the general prohibition against conflicts of interest contained in Government Code section 87100, and to other state or local laws pertaining to conflicts of interest.

(b) The terms of a conflict of interest code amended or adopted and promulgated pursuant to this regulation are as follows:

(1) Section 1. Definitions.

The definitions contained in the Political Reform Act of 1974, regulations of the Fair Political Practices Commission (2 Cal. Code of Regs. sections 18100, *et seq*.), and any amendments to the Act or regulations, are incorporated by reference into this conflict of interest code.

(2) Section 2. Designated Employees.

The persons holding positions listed in the Appendix are designated employees. It has been determined that these persons make or participate in the making of decisions which may foreseeably have a material effect on economic interests.

(3) Section 3. Disclosure Categories.

This code does not establish any disclosure obligation for those designated employees who are also specified in Government Code section 87200 if they are designated in this code in that same capacity or if the geographical jurisdiction of this agency is the same as or is wholly included within the jurisdiction in which those persons must report their economic interests pursuant to article 2 of chapter 7 of the Political Reform Act, Government Code sections 87200, et seq.

In addition, this code does not establish any disclosure obligation for any designated employees who are designated in a conflict of interest code for another agency, if all of the following apply:

(A) The geographical jurisdiction of this agency is the same as or is wholly included within the jurisdiction of the other agency;

(B) The disclosure assigned in the code of the other agency is the same as that required under article 2 of chapter 7 of the Political Reform Act, Government Code section 87200; and

(C) The filing officer is the same for both agencies. [1]

Such persons are covered by this code for disqualification purposes only. With respect to all other designated employees, the disclosure categories set forth in the Appendix specify which kinds of economic interests are reportable. Such a designated employee shall disclose in his or her statement of economic interests those economic interests he or she has which are of the kind described in the disclosure categories to which he or she is assigned in the Appendix. It has been determined that the economic interests set forth in a designated employee's disclosure categories are the kinds of economic interests which he or she foreseeably can affect materially through the conduct of his or her office.

(4) Section 4. Statements of Economic Interests: Place of Filing.

The code reviewing body shall instruct all designated employees within its code to file statements of economic interests with the agency or with the code reviewing body, as provided by the code reviewing body in the agency's conflict of interest code. [2]

(5) Section 5. Statements of Economic Interests: Time of Filing.

(A) Initial Statements. All designated employees employed by the agency on the effective date of this code, as originally adopted, promulgated and approved by the code reviewing body, shall file statements within 30 days after the effective date of this code. Thereafter, each person already in a position when it is designated by an amendment to this code shall file an initial statement within 30 days after the effective date of the amendment.

(B) Assuming Office Statements. All persons assuming designated positions after the effective date of this code shall file statements within 30 days after assuming the designated positions, or if subject to State Senate confirmation, 30 days after being nominated or appointed.

(C) Annual Statements. All designated employees shall file statements no later than April 1.

(D) Leaving Office Statements. All persons who leave designated positions shall file statements within 30 days after leaving office.

(5.5) Section 5.5. Statements for Persons Who Resign Prior to Assuming Office.

Any person who resigns within 12 months of initial appointment, or within 30 days of the date

of notice provided by the filing officer to file an assuming office statement, is not deemed to have assumed office or left office, provided he or she did not make or participate in the making of, or use his or her position to influence any decision and did not receive or become entitled to receive any form of payment as a result of his or her appointment. Such persons shall not file either an assuming or leaving office statement.

(A) Any person who resigns a position within 30 days of the date of a notice from the filing officer shall do both of the following:

(1) File a written resignation with the appointing power; and

(2) File a written statement with the filing officer declaring under penalty of perjury that during the period between appointment and resignation he or she did not make, participate in the making, or use the position to influence any decision of the agency or receive, or become entitled to receive, any form of payment by virtue of being appointed to the position.

(6) Section 6. Contents of and Period Covered by Statements of Economic Interests.

(A) Contents of Initial Statements.

Initial statements shall disclose any reportable investments, interests in real property and business positions held on the effective date of the code and income received during the 12 months prior to the effective date of the code.

(B) Contents of Assuming Office Statements.

Assuming office statements shall disclose any reportable investments, interests in real property and business positions held on the date of assuming office or, if subject to State Senate confirmation or appointment, on the date of nomination, and income received during the 12 months prior to the date of assuming office or the date of being appointed or nominated, respectively.

(C) Contents of Annual Statements. Annual statements shall disclose any reportable investments, interests in real property, income and business positions held or received during the previous calendar year provided, however, that the period covered by an employee's first annual statement shall begin on the effective date of the code or the date of assuming office whichever is later, or for a board or commission member subject to Government Code section 87302.6, the day after the closing date of the most recent statement filed by the member pursuant to 2 Cal. Code Regs. section 18754.

(D) Contents of Leaving Office Statements.

Leaving office statements shall disclose reportable investments, interests in real property, income and business positions held or received during the period between the closing date of the last statement filed and the date of leaving office.

(7) Section 7. Manner of Reporting.

Statements of economic interests shall be made on forms prescribed by the Fair Political Practices Commission and supplied by the agency, and shall contain the following information:

(A) Investments and Real Property Disclosure.

When an investment or an interest in real property[3] is required to be reported,[4] the statement shall contain the following:

1. A statement of the nature of the investment or interest;

2. The name of the business entity in which each investment is held, and a general description of the business activity in which the business entity is engaged;

3. The address or other precise location of the real property;

4. A statement whether the fair market value of the investment or interest in real property equals or exceeds two thousand dollars ($2,000), exceeds ten thousand dollars ($10,000), exceeds one hundred thousand dollars ($100,000), or exceeds one million dollars ($1,000,000).

(B) Personal Income Disclosure. When personal income is required to be reported,[5] the statement shall contain:

1. The name and address of each source of income aggregating five hundred dollars ($500) or more in value, or fifty dollars ($50) or more in value if the income was a gift, and a general description of the business activity, if any, of each source;

2. A statement whether the aggregate value of income from each source, or in the case of a loan, the highest amount owed to each source, was one thousand dollars ($1,000) or less, greater than one thousand dollars ($1,000), greater than ten thousand dollars ($10,000), or greater than one hundred thousand dollars ($100,000);

3. A description of the consideration, if any, for which the income was received;

4. In the case of a gift, the name, address and business activity of the donor and any intermediary through which the gift was made; a description of the gift; the amount or value of the gift; and the date on which the gift was received;

5. In the case of a loan, the annual interest rate and the security, if any, given for the loan and the term of the loan.

(C) Business Entity Income Disclosure. When income of a business entity, including income of a sole proprietorship, is required to be reported,[6] the statement shall contain:

1. The name, address, and a general description of the business activity of the business entity;

2. The name of every person from whom the business entity received payments if the filer's pro rata share of gross receipts from such person was equal to or greater than ten thousand dollars ($10,000).

(D) Business Position Disclosure. When business positions are required to be reported, a designated employee shall list the name and address of each business entity in which he or she is a director, officer, partner, trustee, employee, or in which he or she holds any position of management, a description of the business activity in which the business entity is engaged, and the designated employee's position with the business entity.

(E) Acquisition or Disposal During Reporting Period. In the case of an annual or leaving office statement, if an investment or an interest in real property was partially or wholly acquired or disposed of during the period covered by the statement, the statement shall contain the date of acquisition or disposal.

(8) Section 8. Prohibition on Receipt of Honoraria.

(A) No member of a state board or commission, and no designated employee of a state or local government agency, shall accept any honorarium from any source, if the member or employee would be required to report the receipt of income or gifts from that source on his or her statement of economic interests. This section shall not apply to any part time member of the governing board of any public institution of higher education, unless the member is also an elected official.

Subdivisions (a), (b), and (c) of Government Code section 89501 shall apply to the prohibitions in this section.

This section shall not limit or prohibit payments, advances, or reimbursements for travel and related lodging and subsistence authorized by Government Code section 89506.

(8.1) Section 8.1 Prohibition on Receipt of Gifts in Excess of $390.

(A) No member of a state board or commission, and no designated employee of a state or local government agency, shall accept gifts with a total value of more than $390 in a calendar year from any single source, if the member or employee would be required to report the receipt of income or gifts from that source on his or her statement of economic interests. This section shall not apply to any part time member of the governing board of any public institution of higher education, unless the member is also an elected official.

Subdivisions (e), (f), and (g) of Government Code section 89503 shall apply to the prohibitions in this section.

(8.2) Section 8.2. Loans to Public Officials.

(A) No elected officer of a state or local government agency shall, from the date of his or her election to office through the date that he or she vacates office, receive a personal loan from any officer, employee, member, or consultant of the state or local government agency in which

the elected officer holds office or over which the elected officer's agency has direction and control.

(B) No public official who is exempt from the state civil service system pursuant to subdivisions (c), (d), (e), (f), and (g) of Section 4 of Article VII of the Constitution shall, while he or she holds office, receive a personal loan from any officer, employee, member, or consultant of the state or local government agency in which the public official holds office or over which the public official's agency has direction and control. This subdivision shall not apply to loans made to a public official whose duties are solely secretarial, clerical, or manual.

(C) No elected officer of a state or local government agency shall, from the date of his or her election to office through the date that he or she vacates office, receive a personal loan from any person who has a contract with the state or local government agency to which that elected officer has been elected or over which that elected officer's agency has direction and control. This subdivision shall not apply to loans made by banks or other financial institutions or to any indebtedness created as part of a retail installment or credit card transaction, if the loan is made or the indebtedness created in the lender's regular course of business on terms available to members of the public without regard to the elected officer's official status.

(D) No public official who is exempt from the state civil service system pursuant to subdivisions (c), (d), (e), (f), and (g) of Section 4 of Article VII of the Constitution shall, while he or she holds office, receive a personal loan from any person who has a contract with the state or local government agency to which that elected officer has been elected or over which that elected officer's agency has direction and control. This subdivision shall not apply to loans made by banks or other financial institutions or to any indebtedness created as part of a retail installment or credit card transaction, if the loan is made or the indebtedness created in the lender's regular course of business on terms available to members of the public without regard to the elected officer's official status. This subdivision shall not apply to loans made to a public official whose duties are solely secretarial, clerical, or manual.

(E) This section shall not apply to the following:

1. Loans made to the campaign committee of an elected officer or candidate for elective office.

2. Loans made by a public official's spouse, child, parent, grandparent, grandchild, brother, sister, parent-in-law, brother-in-law, sister-in-law, nephew, niece, aunt, uncle, or first cousin, or the spouse of any such persons, provided that the person making the loan is not acting as an agent or intermediary for any person not otherwise exempted under this section.

3. Loans from a person which, in the aggregate, do not exceed five hundred dollars ($500) at any given time.

4. Loans made, or offered in writing, before January 1, 1998.

(8.3) Section 8.3. Loan Terms.

(A) Except as set forth in subdivision (B), no elected officer of a state or local government

agency shall, from the date of his or her election to office through the date he or she vacates office, receive a personal loan of five hundred dollars ($500) or more, except when the loan is in writing and clearly states the terms of the loan, including the parties to the loan agreement, date of the loan, amount of the loan, term of the loan, date or dates when payments shall be due on the loan and the amount of the payments, and the rate of interest paid on the loan.

(B) This section shall not apply to the following types of loans:

1. Loans made to the campaign committee of the elected officer.

2. Loans made to the elected officer by his or her spouse, child, parent, grandparent, grandchild, brother, sister, parent-in-law, brother-in-law, sister-in-law, nephew, niece, aunt, uncle, or first cousin, or the spouse of any such person, provided that the person making the loan is not acting as an agent or intermediary for any person not otherwise exempted under this section.

3. Loans made, or offered in writing, before January 1, 1998.

(C) Nothing in this section shall exempt any person from any other provision of Title 9 of the Government Code.

(8.4) Section 8.4. Personal Loans.

(A) Except as set forth in subdivision (B), a personal loan received by any designated employee shall become a gift to the designated employee for the purposes of this section in the following circumstances:

1. If the loan has a defined date or dates for repayment, when the statute of limitations for filing an action for default has expired.

2. If the loan has no defined date or dates for repayment, when one year has elapsed from the later of the following:

a. The date the loan was made.

b. The date the last payment of one hundred dollars ($100) or more was made on the loan.

c. The date upon which the debtor has made payments on the loan aggregating to less than two hundred fifty dollars ($250) during the previous 12 months.

(B) This section shall not apply to the following types of loans:

1. A loan made to the campaign committee of an elected officer or a candidate for elective office.

2. A loan that would otherwise not be a gift as defined in this title.

3. A loan that would otherwise be a gift as set forth under subdivision (A), but on which the creditor has taken reasonable action to collect the balance due.

4. A loan that would otherwise be a gift as set forth under subdivision (A), but on which the creditor, based on reasonable business considerations, has not undertaken collection action. Except in a criminal action, a creditor who claims that a loan is not a gift on the basis of this paragraph has the burden of proving that the decision for not taking collection action was based on reasonable business considerations.

5. A loan made to a debtor who has filed for bankruptcy and the loan is ultimately discharged in bankruptcy.

(C) Nothing in this section shall exempt any person from any other provisions of Title 9 of the Government Code.

(9) Section 9. Disqualification.

No designated employee shall make, participate in making, or in any way attempt to use his or her official position to influence the making of any governmental decision which he or she knows or has reason to know will have a reasonably foreseeable material financial effect, distinguishable from its effect on the public generally, on the official or a member of his or her immediate family or on:

(A) Any business entity in which the designated employee has a direct or indirect investment worth two thousand dollars ($2,000) or more;

(B) Any real property in which the designated employee has a direct or indirect interest worth two thousand dollars ($2,000) or more;

(C) Any source of income, other than gifts and other than loans by a commercial lending institution in the regular course of business on terms available to the public without regard to official status, aggregating five hundred dollars ($500) or more in value provided to, received by or promised to the designated employee within 12 months prior to the time when the decision is made;

(D) Any business entity in which the designated employee is a director, officer, partner, trustee, employee, or holds any position of management; or

(E) Any donor of, or any intermediary or agent for a donor of, a gift or gifts aggregating $390 or more provided to, received by, or promised to the designated employee within 12 months prior to the time when the decision is made.

(9.3) Section 9.3. Legally Required Participation.

No designated employee shall be prevented from making or participating in the making of any decision to the extent his or her participation is legally required for the decision to be made. The fact that the vote of a designated employee who is on a voting body is needed to break a

tie does not make his or her participation legally required for purposes of this section.

(9.5) Section 9.5. Disqualification of State Officers and Employees.

In addition to the general disqualification provisions of section 9, no state administrative official shall make, participate in making, or use his or her official position to influence any governmental decision directly relating to any contract where the state administrative official knows or has reason to know that any party to the contract is a person with whom the state administrative official, or any member of his or her immediate family has, within 12 months prior to the time when the official action is to be taken:

(A) Engaged in a business transaction or transactions on terms not available to members of the public, regarding any investment or interest in real property; or

(B) Engaged in a business transaction or transactions on terms not available to members of the public regarding the rendering of goods or services totaling in value one thousand dollars ($1,000) or more.

(10) Section 10. Disclosure of Disqualifying Interest.

When a designated employee determines that he or she should not make a governmental decision because he or she has a disqualifying interest in it, the determination not to act may be accompanied by disclosure of the disqualifying interest.

(11) Section 11. Assistance of the Commission and Counsel.

Any designated employee who is unsure of his or her duties under this code may request assistance from the Fair Political Practices Commission pursuant to Government Code section 83114 and 2 Cal. Code Regs. sections 18329 and 18329.5 or from the attorney for his or her agency, provided that nothing in this section requires the attorney for the agency to issue any formal or informal opinion.

(12) Section 12. Violations.

This code has the force and effect of law. Designated employees violating any provision of this code are subject to the administrative, criminal and civil sanctions provided in the Political Reform Act, Government Code sections 81000 – 91014. In addition, a decision in relation to which a violation of the disqualification provisions of this code or of Government Code section 87100 or 87450 has occurred may be set aside as void pursuant to Government Code section 91003.

NOTE: Authority cited: Section 83112, Government Code.
Reference: Sections 87103(e), 87300-87302, 89501, 89502 and 89503, Government Code.

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[1] Designated employees who are required to file statements of economic interests under any

other agency's conflict of interest code, or under article 2 for a different jurisdiction, may expand their statement of economic interests to cover reportable interests in both jurisdictions, and file copies of this expanded statement with both entities in lieu of filing separate and distinct statements, provided that each copy of such expanded statement filed in place of an original is signed and verified by the designated employee as if it were an original. See Government Code section 81004.

[2]See Government Code section 81010 and 2 Cal. Code of Regs. section 18115 for the duties of filing officers and persons in agencies who make and retain copies of statements and forward the originals to the filing officer.

[3]For the purpose of disclosure only (not disqualification), an interest in real property does not include the principal residence of the filer.

[4]Investments and interests in real property which have a fair market value of less than $2,000 are not investments and interests in real property within the meaning of the Political Reform Act. However, investments or interests in real property of an individual include those held by the individual's spouse and dependent children as well as a pro rata share of any investment or interest in real property of any business entity or trust in which the individual, spouse and dependent children own, in the aggregate, a direct, indirect or beneficial interest of 10 percent or greater.

[5]A designated employee's income includes his or her community property interest in the income of his or her spouse but does not include salary or reimbursement for expenses received from a state, local or federal government agency.

[6]Income of a business entity is reportable if the direct, indirect or beneficial interest of the filer and the filer's spouse in the business entity aggregates a 10 percent or greater interest. In addition, the disclosure of persons who are clients or customers of a business entity is required only if the clients or customers are within one of the disclosure categories of the filer.

Policy Number: BOD2	Date Created: 09/01/2004
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	

Chief Executive Officer (CEO) Transition

PURPOSE: It is the belief of the Board of Directors of Kaweah Delta Health Care District that the continued proper functioning of the District, the maintenance of the highest quality of patient care and the preservation of the District's financial integrity require that the District have a pre-established and orderly process for replacement of the CEO, in the event of the CEO's death, disability or termination of his/her employment relationship with the District.

Accordingly the Board adopts the following policy.

POLICY:

I. **Temporary Succession of CEO when unable to perform duties.** In the event the CEO becomes unable to perform his/her duties as the result of death or the sudden onset of disability, or in the event the Board decides to immediately terminate the District's employment relationship with the CEO, the Senior Vice President/Chief Operating Officer shall immediately assume those responsibilities pending further action of the Board Of Directors. In the event the Senior Vice President/Chief Operating Officer is unable to immediately assume those responsibilities because of death, disability or vacancy in the position of Senior Vice President/Chief Operating Officer, then the ~~Senior~~ Vice President/Chief ~~Financial~~ Nursing Officer shall immediately assume those responsibilities pending further action of the Board of Directors.

II. **Death of the CEO** - In the event of the CEO's death, the Board shall immediately commence the process for hiring a new CEO.

III. **Temporary Disability of the CEO** - If the disability of the CEO is temporary, as determined by Board in the reasonable exercise of its discretion, after reviewing appropriate medical information, the CEO shall again assume the duties of CEO as soon as he/she is able.

IV. **Permanent Disability of the CEO** - If the disability of the CEO is permanent (i.e. will extend for 6 months or more) and prevents the CEO from performing his/her duties, as determined by the Board in the reasonable exercise of its discretion, after reviewing appropriate medical information, the Board may terminate the CEO's contract, in accordance with the contract provisions, and commence the process for hiring a new CEO.

V. **Voluntary termination of the CEO's employment contract** - If the CEO advises the Board of his/her intention to voluntarily end his/her employment relationship with the District, or if the Board makes a decision to terminate the CEO's contract or a decision not to renew the

CEO's contract at the expiration of its term, the Board shall commence the process for hiring a new CEO expeditiously so as to minimize, or avoid if possible, the time during which there would be no CEO under contract with the District.

VI. **Involuntary Termination of the CEO**

A. Basis. During the term of his/her contract, the CEO's employment may be terminated by the Board if the CEO fails to properly carry out the responsibilities of the CEO, if the CEO engages in conduct which reflects poorly on the District, if the CEO engages in conduct which is criminal or which involves moral turpitude, or if, for any other reason, the Board loses confidence in the CEO's ability to properly discharge the duties of CEO.

B. Interim Suspension. In the event the Board makes a preliminary determination to terminate the employment of the CEO, the Board shall have the right, in the exercise of its discretion, to immediately suspend all or any part of the responsibilities of the CEO, pending the outcome of the hearing described in Subparagraph 3 below.

C. Confirmatory Hearing. If the Board makes a decision to terminate the employment of the CEO, the CEO shall have the right, within five (5) days of being advised of the Board's decision, to request, in writing, a hearing on the Board's decision. The written request shall be delivered to the Board President. Failure to request a hearing within that time, and in the manner described, shall be deemed a waiver of the hearing.

If properly requested, the hearing shall be held within ten (10) days of the CEO's request and shall be conducted before one of the personnel hearing officers appointed by the Board to conduct personnel hearings of District employees. The purpose of the hearing will be to allow the hearing officer to review the evidence relevant to the Board's decision to terminate the employment of the CEO, and to have the hearing officer render an opinion indicating his/her agreement or disagreement with the Board's decision. Each side may be represented by counsel and may offer oral and/or documentary evidence and may cross examine the witnesses who testify. The strict rules of evidence will not apply. The hearing officer will have the discretion to admit or deny whatever evidence he/she deems appropriate and to give whatever weight he/she deems warranted to the evidence admitted. The hearing officer will render a written opinion within two (2) days of the hearing.

The decision of the hearing officer is advisory only. Nothing in this policy or in the conduct of the hearing shall be interpreted or deemed to reflect a right in the CEO to continued employment beyond the specific terms of this policy and the CEO's contract.

VII. **Hiring of a new CEO**

A. Recruitment and Search. When it becomes necessary for the Board to replace the CEO, the District will look internally as well as advertising the position widely and/or engage a consultant to assist in the search, in a manner which the Board determines at that time will be effective for attracting qualified candidates. If, however, in the Board's opinion, a qualified candidate (or candidates) are already employed by the District, the Board, at its discretion, may waive the foregoing requirements. The Board may consult with the District's Vice President for Human Resources to acquire information on processes

available for advertising the position or for engaging a consultant to assist in the search for a new CEO. At the time of the search, the Board will establish criteria for selecting its new CEO.

B. Interviews of Prospective CEO Candidates. Interviews of prospective CEO candidates will be done by the entire Board. The Board will determine in the exercise of its discretion if individuals other than elected Board members will participate in the actual CEO candidate interviews. In the course of evaluating potential candidates, the Board will consult with the President of the District's Medical Staff and ask him/her to make recommendations to the Board on the candidates under consideration.

C. CEO Contract. The CEO shall be employed for a definite period of time pursuant to a written contract which sets forth the specific terms of the CEO's employment, including the compensation and other consideration to be paid, the term of the agreement, a detailed description of the duties of the CEO, the specific criteria to be used by the Board to evaluate the CEO's performance, and the bases upon which the contract can be terminated by either the Board or the CEO. The contract shall require the CEO to provide at least six (6) months' notice of the CEO's voluntary termination of the contract.

It is the policy of the District to compensate the CEO in a manner that is appropriately competitive in the marketplace, taking into consideration, among other things, the compensation paid to CEOs of similar sized California hospitals. Accordingly, the Board will review surveys of salaries paid to CEOs of California hospitals as part of the process of setting the CEO's compensation. The Board may consult with the District's Vice President for Human Resources to acquire information on available survey information.

Privileges in Gastroenterology

Name: _____ Date: _____

Please Print

GASTROENTEROLOGY PRIVILEGES - INITIAL CRITERIA
Education: M.D. or D.O. and successful completion of an accredited residency in Internal Medicine and fellowship in Gastroenterology approved by the ACGME, AOA or the Royal College of Physician & Surgeons of Canada *(if board certified by an ABMS Board or actively pursuing ABMS Board Certification).* Board certification must be obtained within 5 years of completion of residency.
Current Clinical Experience: Documentation of inpatient or consultative services for at least 100 gastroenterology patients during the past 2 years OR Successful completion of an ACGME or AOA accredited residency or clinical fellowship within the past 12 months.
Renewal Criteria: Inpatient or consultative services for at least 100 gastroenterology patients during the past 2 years AND Maintain certification or active participation in the examination process leading to certification in Gastroenterology by the ABIM/AOBIM;
FPPE: Minimum of 1 concurrent review for Colonoscopy and EGD; 4 retrospective chart reviews

Request	GASTROENTEROLOGY CORE PRIVILEGES	Approve
☐	**Core Privileges include:** Perform Medical H&P; evaluate, diagnosis, provide consultation and treat patients with illnesses, injuries, and disorders of the stomach, intestines, and related structures, such as the esophagus, liver, gallbladder, pancreas and nutrition. Core privileges include biopsy, polypectomy, injection/coagulation for hemostasis and/or tissue ablation and percutaneous liver biopsy, pH probe and esophageal manometry, Nonvariceal hemostasis - upper and lower, snare Polypectomy, Variceal hemostasis, Esophageal dilation, Flexible sigmoidoscopy, Colonoscopy (with or without biopsy; with or without polypectomy), Diagnostic Esophagogastroduodenoscopy (EGD), PEG	☐
☐	Admitting Privileges (must request Active or Courtesy staff status)	☐

GENERAL INTERNAL MEDICINE CORE PRIVILEGES

Renewal Criteria: 25 patient contacts in the past two years AND Maintenance of Board Certification in Internal Medicine.

FPPE: 6 retrospective chart reviews

Request	Privileges/Procedures	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.	☐

ADVANCED GASTROENTEROLOGY PRIVILEGES

Request	Procedure	Initial Criteria	Renewal Criteria	FPPE	Approve
☐	EUS	Documentation of training ~~and~~ to include 150 supervised cases ~~including:~~ 50 EUS guided FNA and 75 pancreaticobiliary cases within the last 2 years; OR Documentation of training AND 20 procedures in the last 2 years.	20 procedures in the last 2 years.	Minimum of 4 concurrent review, to include 2 FNA	☐
☐	ERCP *Prerequisite: Fluoroscopy Certificate*	Documentation of training and 25 (Includes 5 stent and 20 sphincterotomies placements) in the last 2 years	25 in the last 2 years	Minimum of 2 concurrent review	☐

ADDITIONAL PRIVILEGES

Request	Procedure	Initial Criteria	Renewal Criteria	FPPE	Approve
☐	Supervision of a technologist using fluoroscopy equipment	Current and valid CA Fluoroscopy supervisor and Operator Permit or a CA Radiology Supervisor and Operator Permit	Current and valid CA Fluoroscopy supervisor and Operator Permit or a CA Radiology Supervisor and Operator Permit AND pass KD annual safe fluoroscopy practices exam	None	☐
☐	Procedural Sedation *Prerequisite: ACLS or Airway management course*	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. Please identify: **__ Dinuba __ Exeter __Lindsay** **__ Woodlake** **__ Family Medicine Clinic** **__ Chronic Disease Mgmt Center**	Executed contract with Kaweah Delta Health Care District or KDHCD ACGME Family Medicine Program	Maintain initial criteria		☐

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:_____ Date:_____

Signature: _____ _____
Department of Internal Medicine Chairman *Date*

STATE OF CALIFORNIA
GOVERNOR'S OFFICE OF EMERGENCY SERVICES
Cal OES 130

Cal OES ID No: _____

DESIGNATION OF APPLICANT'S AGENT RESOLUTION FOR NON-STATE AGENCIES

BE IT RESOLVED BY THE Board of Directors (Governing Body) OF THE Kaweah Delta Health Care District (Name of Applicant)

THAT Gary K. Herbst, CEO (Title of Authorized Agent), OR

Malinda Tupper, CFO (Title of Authorized Agent), OR

Jennifer Stockton, Director of Finance (Title of Authorized Agent)

is hereby authorized to execute for and on behalf of the Kaweah Delta Health Care District (Name of Applicant), a public entity established under the laws of the State of California, this application and to file it with the California Governor's Office of Emergency Services for the purpose of obtaining certain federal financial assistance under Public Law 93-288 as amended by the Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1988, and/or state financial assistance under the California Disaster Assistance Act.

THAT the Kaweah Delta Health Care District (Name of Applicant), a public entity established under the laws of the State of California, hereby authorizes its agent(s) to provide to the Governor's Office of Emergency Services for all matters pertaining to such state disaster assistance the assurances and agreements required.

Please check the appropriate box below:

☐ This is a universal resolution and is effective for all open and future disasters up to three (3) years following the date of approval below.

☒ This is a disaster specific resolution and is effective for only disaster number(s) California Covid 19 (DR-4482)

Passed and approved this 27th day of April, 20 20

Nevin House, President
(Name and Title of Governing Body Representative)

Lynn Havard Mirviss, Vice President
(Name and Title of Governing Body Representative)

David Francis, Secretary Treasurer
(Name and Title of Governing Body Representative)

CERTIFICATION

I, Cindy Moccio (Name), duly appointed and Board Clerk (Title) of Kaweah Delta Health Care District (Name of Applicant), do hereby certify that the above is a true and correct copy of a Resolution passed and approved by the Board of Directors (Governing Body) of the Kaweah Delta Health Care District (Name of Applicant) on the 27th day of April, 20 20.

_____ (Signature)

_____ (Title)

99/225

Cal OES Form 130 Instructions

A Designation of Applicant's Agent Resolution for Non-State Agencies is required of all Applicants to be eligible to receive funding. A new resolution must be submitted if a previously submitted Resolution is older than three (3) years from the last date of approval, is invalid or has not been submitted.

When completing the Cal OES Form 130, Applicants should fill in the blanks on page 1. The blanks are to be filled in as follows:

Resolution Section:

Governing Body: This is the group responsible for appointing and approving the Authorized Agents.
Examples include: Board of Directors, City Council, Board of Supervisors, Board of Education, etc.

Name of Applicant: The public entity established under the laws of the State of California. Examples include: School District, Office of Education, City, County or Non-profit agency that has applied for the grant, such as: City of San Diego, Sacramento County, Burbank Unified School District, Napa County Office of Education, University Southern California.

Authorized Agent: These are the individuals that are authorized by the Governing Body to engage with the Federal Emergency Management Agency and the Governor's Office of Emergency Services regarding grants applied for by the Applicant. There are two ways of completing this section:

1. Titles Only: If the Governing Body so chooses, the titles of the Authorized Agents would be entered here, not their names. This allows the document to remain valid (for 3 years) if an Authorized Agent leaves the position and is replaced by another individual in the same title. If "Titles Only" is the chosen method, this document must be accompanied by a cover letter naming the Authorized Agents by name and title. This cover letter can be completed by any authorized person within the agency and does not require the Governing Body's signature.

2. Names and Titles: If the Governing Body so chooses, the names **and** titles of the Authorized Agents would be listed. A new Cal OES Form 130 will be required if any of the Authorized Agents are replaced, leave the position listed on the document or their title changes.

Governing Body Representative: These are the names and titles of the approving Board Members.
Examples include: Chairman of the Board, Director, Superintendent, etc. The names and titles **cannot** be one of the designated Authorized Agents, and a minimum of two or more approving board members need to be listed.

Certification Section:

Name and Title: This is the individual that was in attendance and recorded the Resolution creation and approval.
Examples include: City Clerk, Secretary to the Board of Directors, County Clerk, etc. This person **cannot** be one of the designated Authorized Agents or Approving Board Member (if a person holds two positions such as City Manager and Secretary to the Board and the City Manager is to be listed as an Authorized Agent, then the same person holding the Secretary position would sign the document as Secretary to the Board (not City Manager) to eliminate "Self Certification."

COVID-19 Financial Activity

New Funds Received and Expected

Hospital Stimulus Funds – Kaweah Delta	$11,420,930	Received 4/11/20
Hospital Stimulus Funds – KDMF	$684,104	Received 4/11/20
California Hospital Association	$25,899	Expected Receipt April 2020
Removal of 2% Medicare Sequestration	$2,100,000	Beginning May 2020
Impact to Net Revenue	**$14,230,933**	

- CARES ACT: $30B to healthcare providers stimulus – Unlike the advanced payments this funding does **not** have to be paid back. The calculation is based on our Medicare Revenue. We received a direct deposit April 10th in the amount of $11,420,930 and KDMF received $684,104.
- First Stimulus package $50M pool of funds divided among hospital associations: California Hospital Association received $4.1M from government and is allocating to the hospitals in the state by the # of licensed beds. We will be receiving $25,899.08.
- CARES ACT: CMS removal of the 2% Medicare sequestration is estimated to increase our revenue by $2.1M from May –December 2020.
- FEMA: Applied for FEMA disaster assistance 4/17/20 – Board Resolution is required for all applicants to be eligible to receive funding. CAL OES Form130
- USDA Telehealth Grants: Applied for a Rural Telehealth grant 4/9/2020 - $1,242,735
- Insurance: Applying for Business Interruption Coverage
- Discussion on extension of 1115 waiver and work to speed up supplemental payments
- CARES ACT - $70B: the Administration is working rapidly on targeted distributions that will focus on providers in areas particularly impacted by the COVID-19 outbreak, rural providers, providers of services with lower shares of Medicare reimbursement or who predominantly serve the Medicaid population, and providers requesting reimbursement for the treatment of uninsured Americans.

COVID-19 Financial Activity

Cash Flow Opportunities – Temporary Cash

Medicare Advanced Payments	$89,269,784	Received April 2020
FICA tax deferral Apr.-Dec.	$13,500,000	Deferral begins April 2020
Commercial Payers Advanced Payments		Pending further analysis
Cash Flow Impact	**$102,769,784**	

- CMS: Expansion of the accelerated and advance payment programs: In April, we received $86.3M in advanced payments (6 months of Medicare Payments) to be paid back after 120 days – spread over 1 year from the date of the accelerated payment. This represents an additional 43 days of cash on hand.

- CARES Act: Will allow the deferral of FICA payments due April –December 2020. We estimate this to be $977K/pay period - $19.4M/Total. 50% of the deferred amount would be due by 12/31/21 and the remainder due by 12/31/22

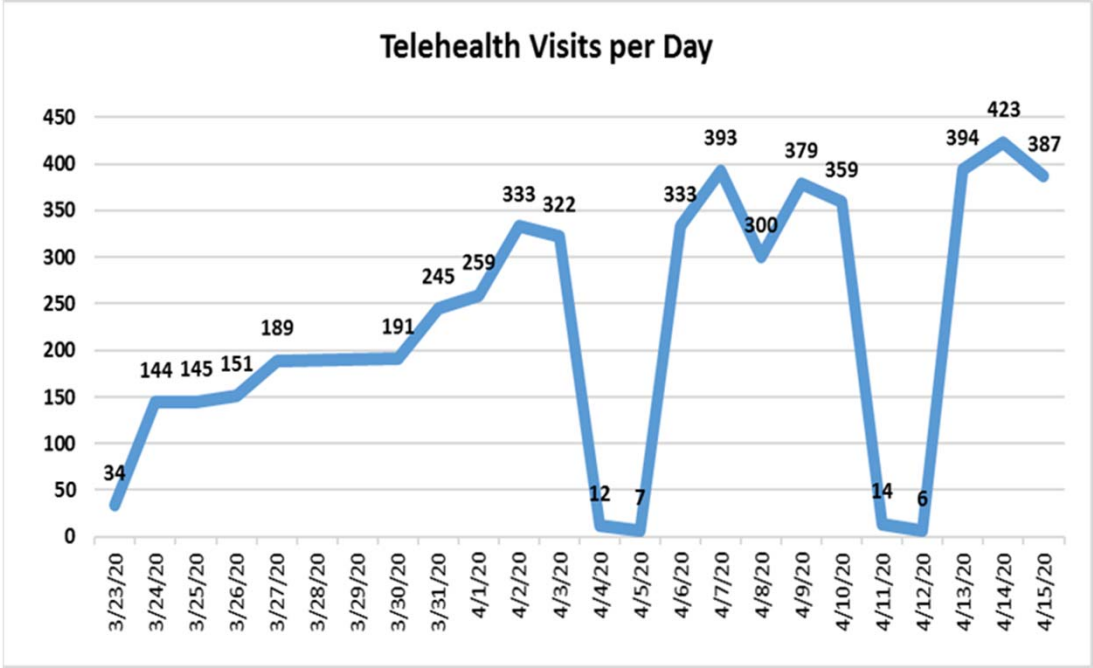
- Blue Shield California and United are also offering loans – pending additional vetting

COVID-19: Costs and Billing

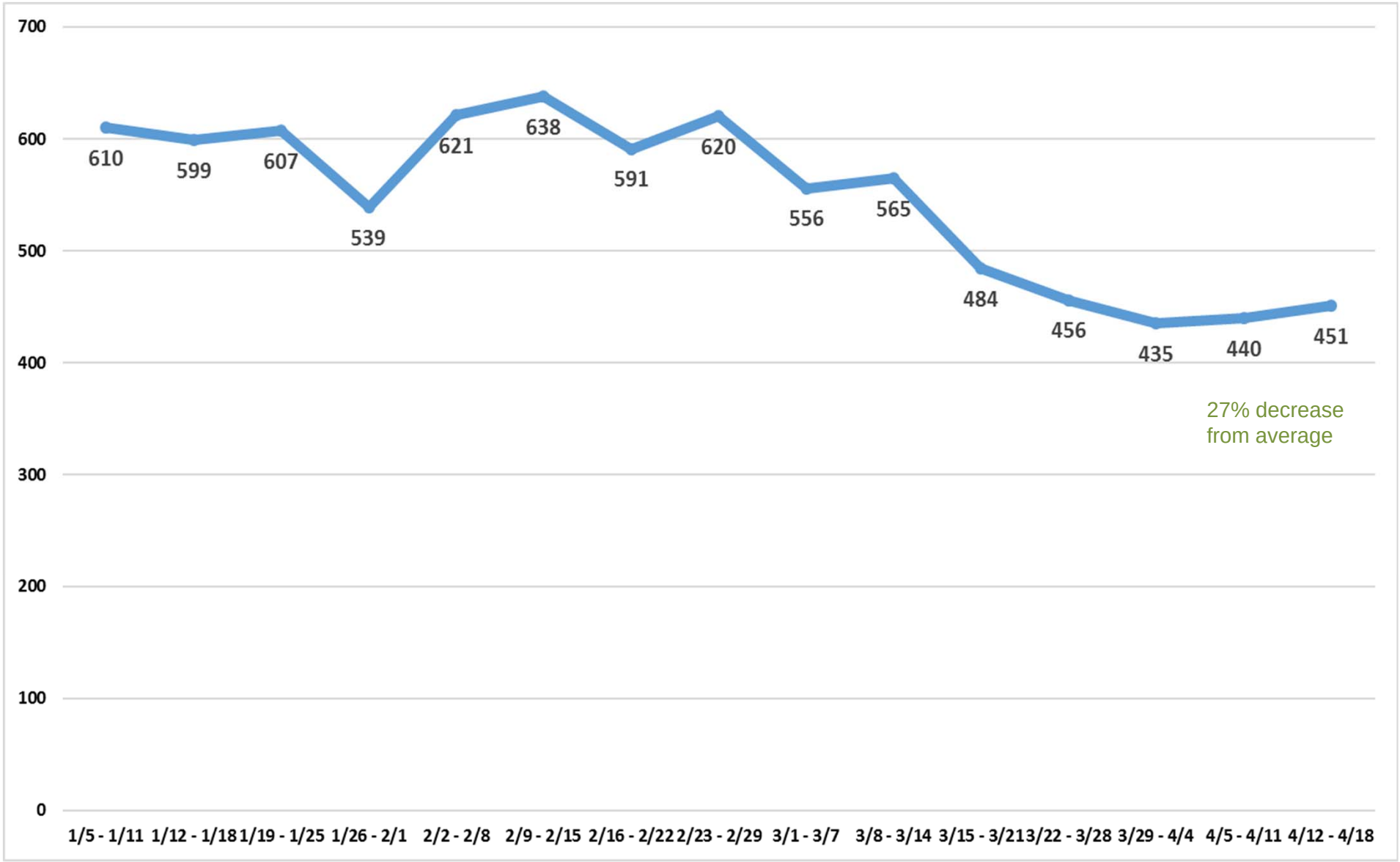
Tracking Costs: $1M in COVID labor and expenses were identified in March 2020.

Volume New Services: Telehealth new services: have ramped up to over 400 visits/day

Telehealth Registrations 03/23-04/15	
Exeter-Rural Health Center	1,916
Kaweah Delta Medical Foundation	1,224
Lindsay-Rural Health Center	683
SFM Family Medicine	263
Dinuba - Rural Health Center	255
Woodlake-Rural Health Center	185
SQ Seq Cardiology	144
SC Urgent Care	119
NS Neuro Sciences	115
CD Chronic Disease	98
SFM Medication Mgmt	13
CD Palliative Care	5
Total	**5,020**

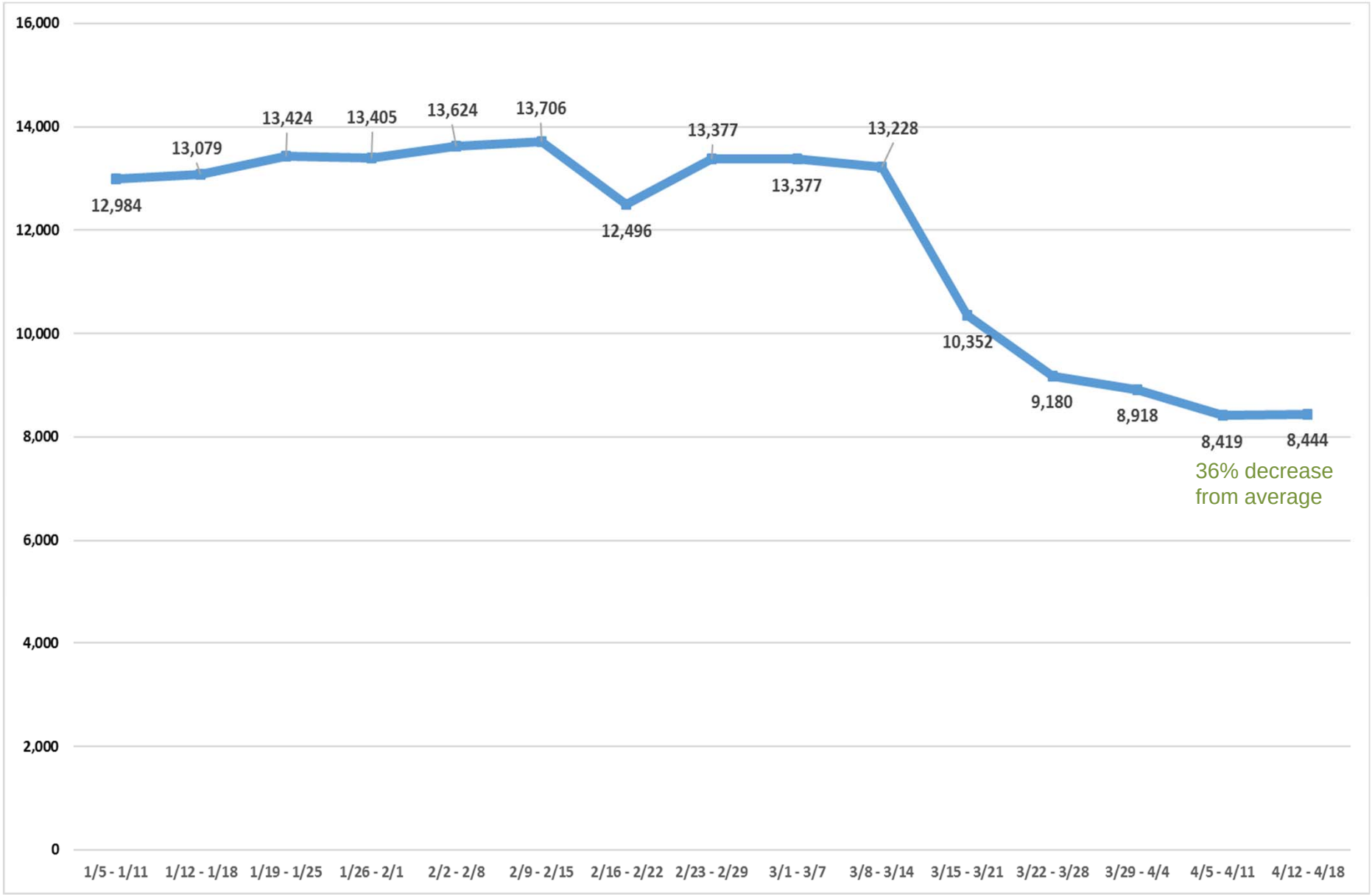


COVID-19 Weekly Impact: Inpatient Encounters



COVID-19 Weekly Impact: Outpatient Encounters

(excluding Home Health, Hospice, Home Infusions)



$100B for COVID-19 Expenses/Losses

- $100 Billion appropriated to the Public Health and Social Services Emergency Fund (PHSSEF) for providers'
  - COVID-19 health expenses
  - Lost revenue attributable to COVID-19
- Administered by HHS
  - May be pre-payment, prospective payment, or retrospective payment
  - Consider most efficient payment systems practicable
  - Application includes statement justifying need and TIN
  - Can't reimburse expenses or losses that other sources are obligated to reimburse

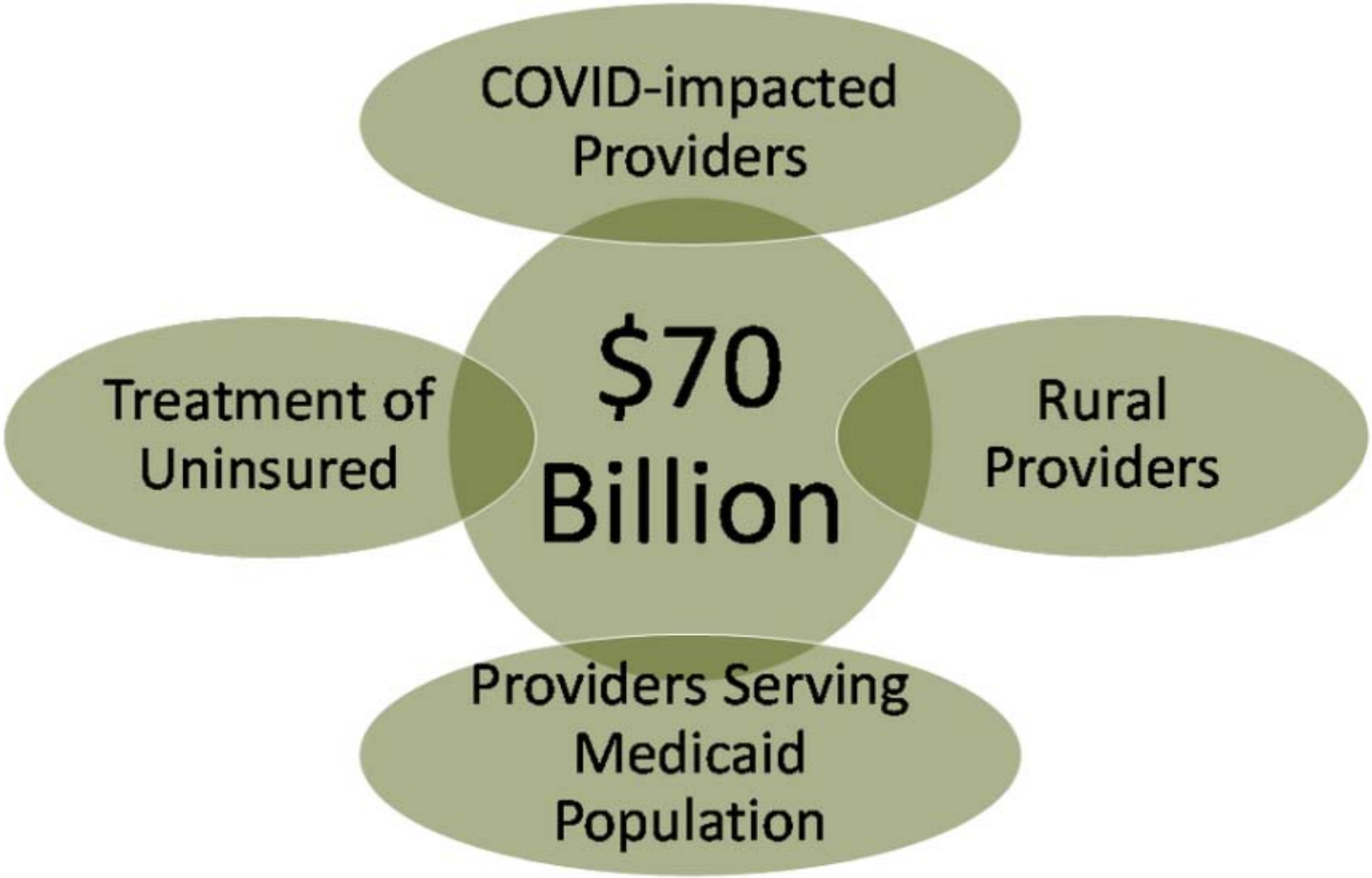
First $30 Billion

- **Timing:** Began distribution on April 10
- **Amount of payment**: Relative share of FFY 2019 Medicare Payments
- **Terms and Conditions**: Sign within 30 days
- **Uses of Funds:**
  - prevent, prepare for, and respond to coronavirus
  - health care related expenses or lost revenues that are attributable to coronavirus
  - Cannot be used for expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse
- **Record-keeping & Reporting Requirements**
- **Surprise Billing**

Eligible Providers:

- *Billed Medicare in 2019*
- *Provides diagnoses, testing, or care for individuals with possible or actual cases of COVID-19*
- *Not currently terminated or excluded from participation in a Federal health care program*
- *does not currently have Medicare billing privileges revoked*

Remaining $70 Billion



New $75B for Hospitals

On 4/21/20 Congress and White House leaders reached a deal to provide $75B for hospitals and another $25B for testing. The funding, which is expected to pass Congress this week and got an endorsement from President Trump, is part of a $484B package that would also replenish a small business loan program.

Other parts of the funding package include:

- $600 million in grants to health centers
- $225 million in additional funding for COVID-19 testing and related expenses to rural health clinics. The funding can also be used to create temporary structures to increase capacity for testing
- $1 billion for covering the cost of testing for the uninsured
- $6 billion for the Department of Health and Human Services' Office of Inspector General to use on oversight activities
- $11 billion to states and localities to purchase and administer COVID-19 tests and to scale up lab capacity

Accelerated & Advance Payments Program

Eligibility:

- Billed Medicare for claims within 180 days immediately prior to request
- Not in bankruptcy
- Not under active medical review or program integrity investigation
- No outstanding, delinquent Medicare overpayments

Application Process

- Use existing MAC applications, links available at our COVID-19 Resource page
- CMS Fact Sheet gives specific instructions: https://www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf

AMOUNT ADVANCED:

- **Hospitals: 6-months of Medicare payments**
- **Others: 3-months of Medicare Payments**

TIMING:

- **Processing: 7 days**
- **Repayment begins after 120 days**
- **Balance due after 1 year (hospitals) or 210 days (others**

Temporary Sequester Relief

Medicare Sequester:

- 2% reduction to FFS Medicare Payments
- In place since April 1, 2013

CARES Act:

- Exempts Medicare from sequestration from May 1, 2020 to December 31, 2020
- Extends sequester from 2029 to 2030

→ Consider impact on Medicare Advantage payments

Medicare IPPS Add-On Payment

- Recognition that COVID-19 inpatients are more costly than others:
  - More intensive services
  - Longer length of stay
- DRG weight increased by 20% for individuals diagnosed with COVID-19
- 20% add-on applies for discharges during the Public Health Emergency (beginning January 27, 2020)
- New COVID-19 Diagnosis Code: U07.1
- Note: Outlier Threshold for FFY 2020 is $26,473

FEMA Public Assistance (PA)

Eligible Recipients:

- State, Territorial, Tribal, local government entities (including public hospitals)
- Certain private non-profit (PNP) organizations
- For-profit entities are not eligible for direct PA, but, under certain circumstances, may contract with an eligible entity to carry out eligible emergency protective measures

No duplication of funding from other sources

Emergency protective measures may include:

- Management, control, and reduction of immediate threats to public health/safety
- Emergency medical care
- Medical sheltering

COVID-19 Testing & Payment

- **Medicare/Medicaid FFS & MA:**
  - Coverage without cost-sharing for COVID-19 testing-related service
  - Includes the E/M visit
- **Commercial Plans:**
  - Coverage without cost-sharing, prior authorization, etc. for COVID-19 testing
  - Includes items and service furnished during office, urgent care, and emergency room visits but only to the extent such items and services relate to the furnishing or administration of the test or evaluation for purposes of determining the need for such test
  - Reimbursement:
    - Negotiated rate in effect in January (if any)
    - If no negotiated rate, cash price or lower negotiated rate
  - Price Transparency:
    - Provider must publicize "cash price" for COVID-19 test on its public internet website
    - Compliance enforced through corrective action plans and then CMP of up to $300/day

Business Interruption Coverage

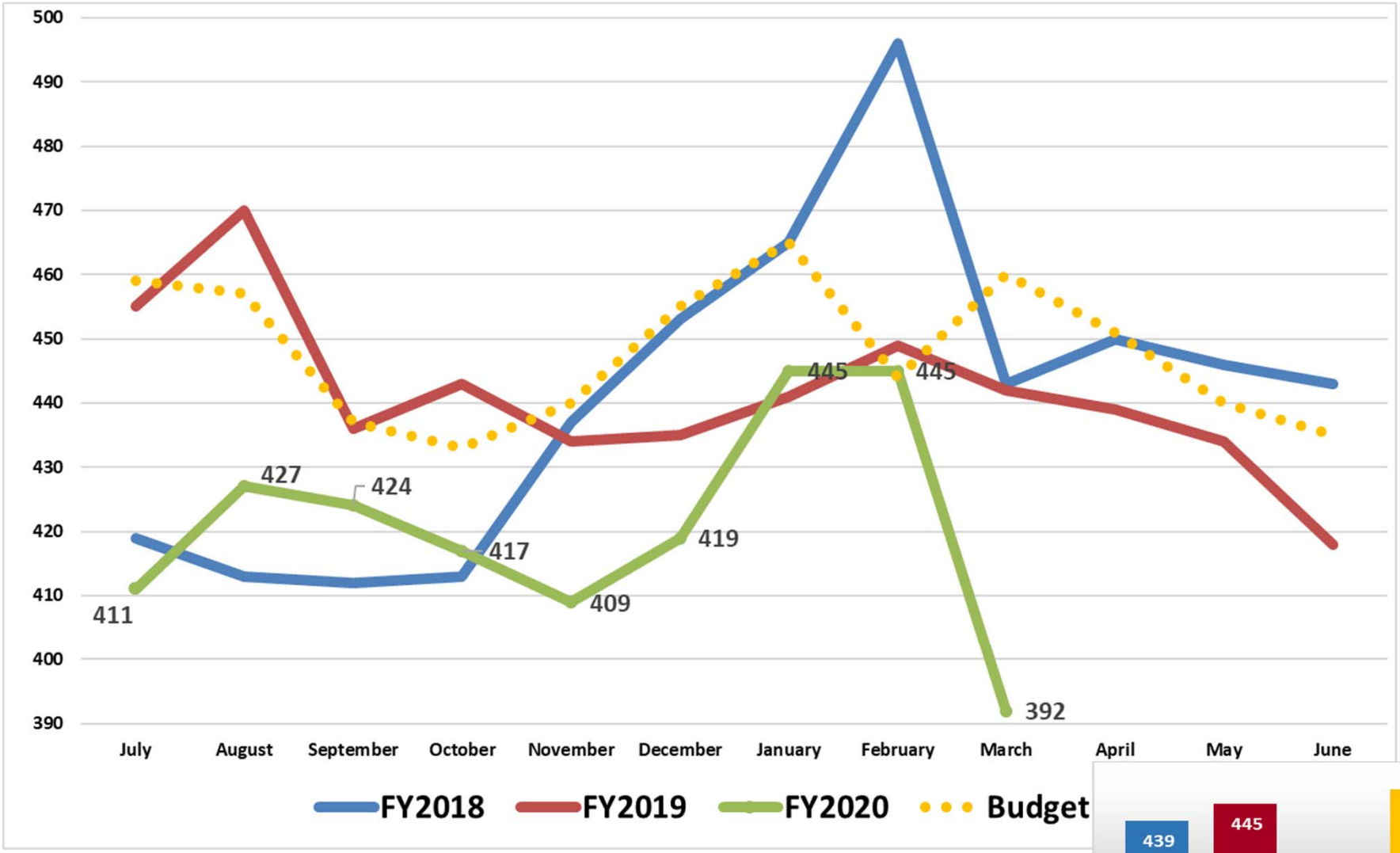
- These are huge potential losses, due to either total discontinuation of services, diminishment of services, and increased cost of operations.
- Lawsuits are already being filed. All are relying upon the States' closure orders.
- Land speed records on denials, at least so far. The carriers really have no economic choice/incentive not to fight this issue to the hilt.
- Mass claims predicted.
- Court decisions may well help whole groups of insureds.
- There also may be either a mass action (MDL) or several of such consolidated proceedings that could benefit you. These often result in a negotiated settlement, as we've seen with tobacco, opioid and the like.
- Governmental action already at work: NAIC (state insurance commissioners) is issuing guidance almost daily. 4/12: NAIC and 18 states issue guidance on BI coverage, including with respect to how COVID-19 impacts a typical BI policy; the impact of a statewide stay-at-home order affects coverage; and the stay-at-home loss costs.
- So far, state legislatures in LA, MA, NJ, NY. OH, PA and SC have introduced legislation to specifically create retroactive BI coverage explicitly for COVID-19.

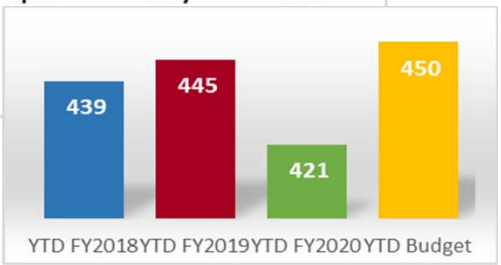
CFO Financial Report

April 27, 2020

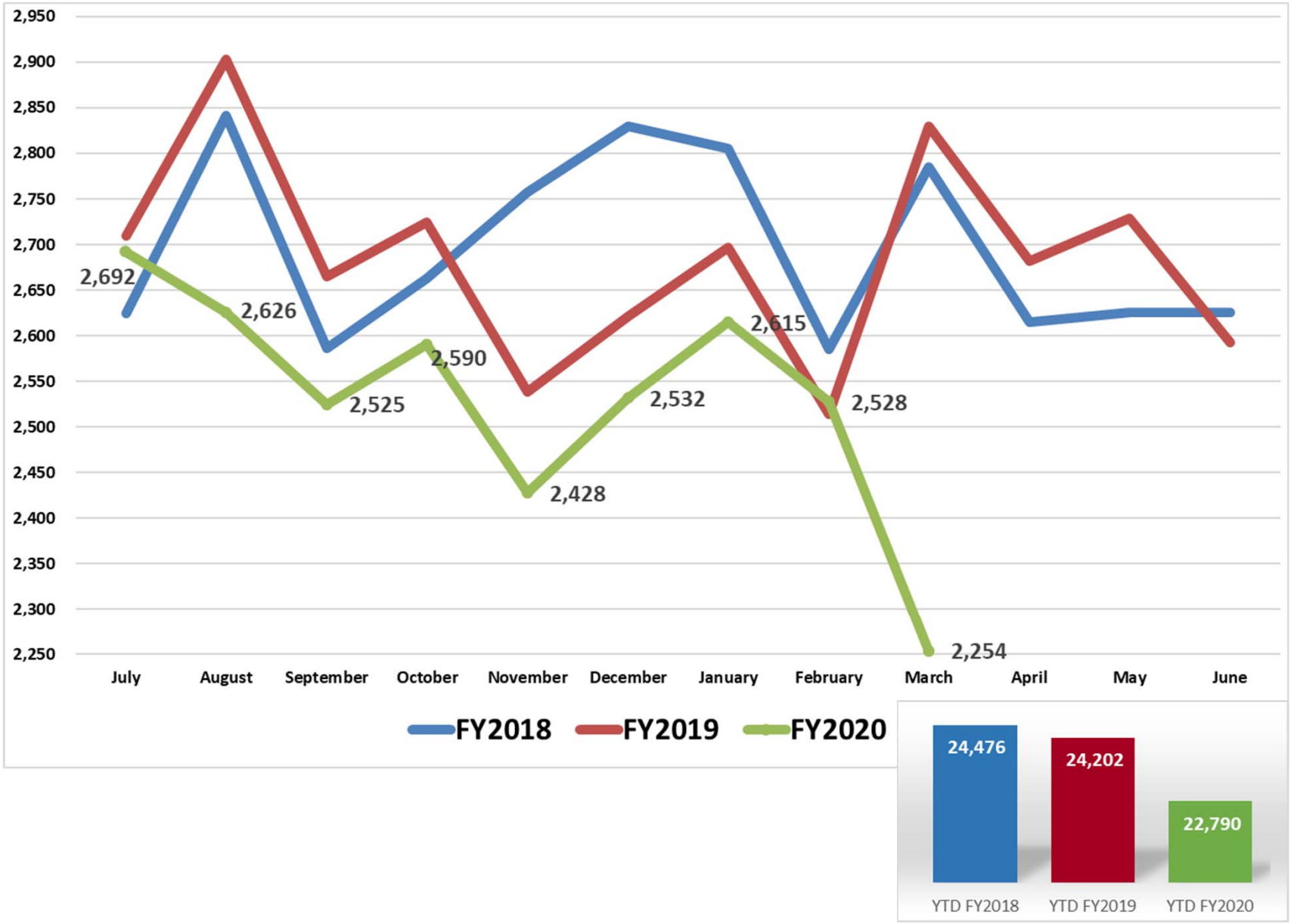
Kaweah Delta
HEALTH CARE DISTRICT

Average Daily Census





Admissions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2,550
2,500
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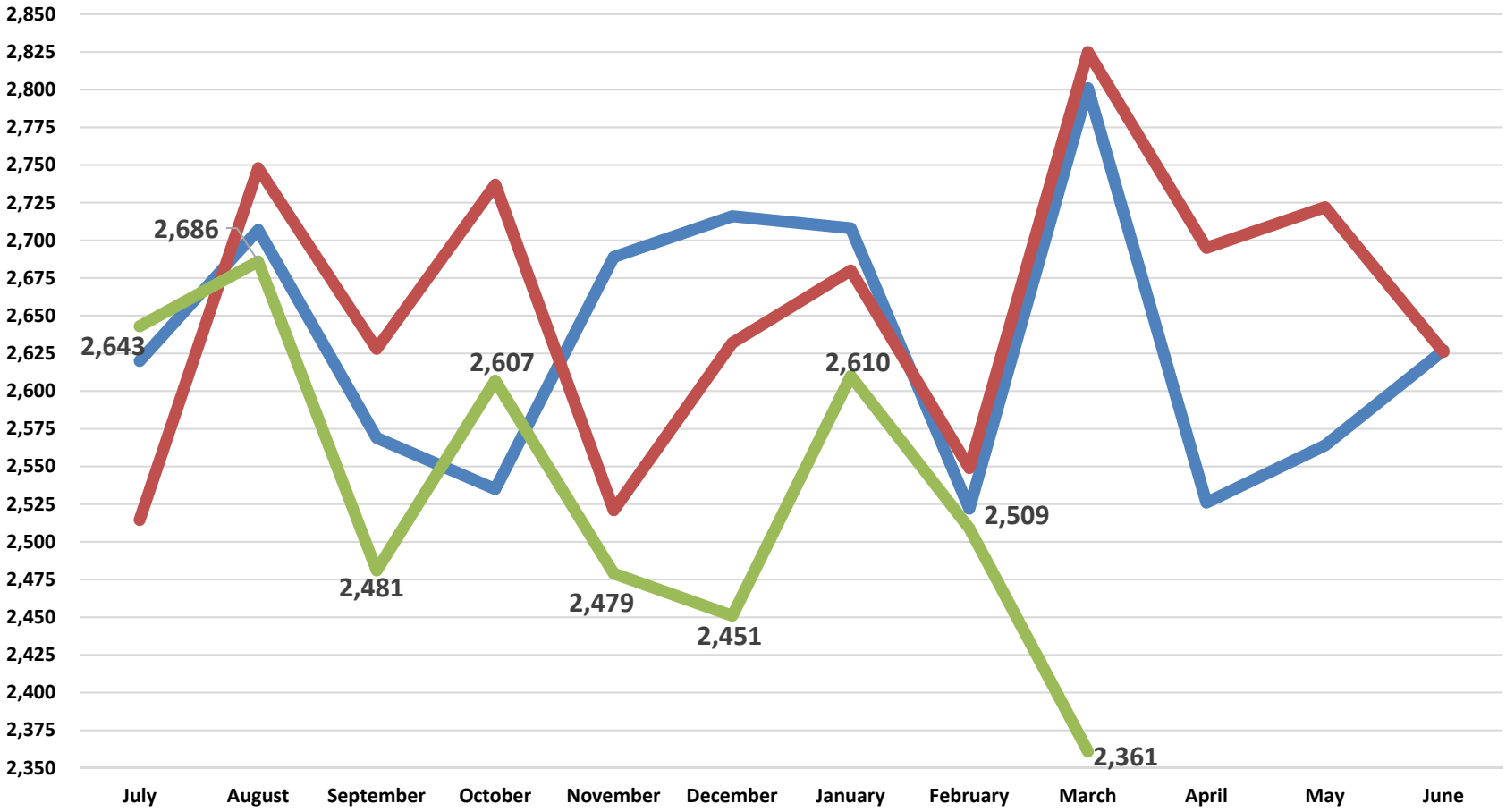
2,350
2,300
2,250
2,692
2,626
2,525
2,590
2,428
2,532
2,615
2,528
2,254
July
August
September
October
November
December
January
February
March
April
May
June
FY2018
FY2019
FY2020
24,476
24,202
22,790
YTD FY2018
YTD FY2019
YTD FY2020

Discharges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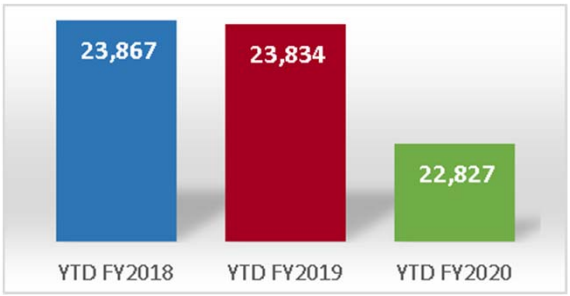
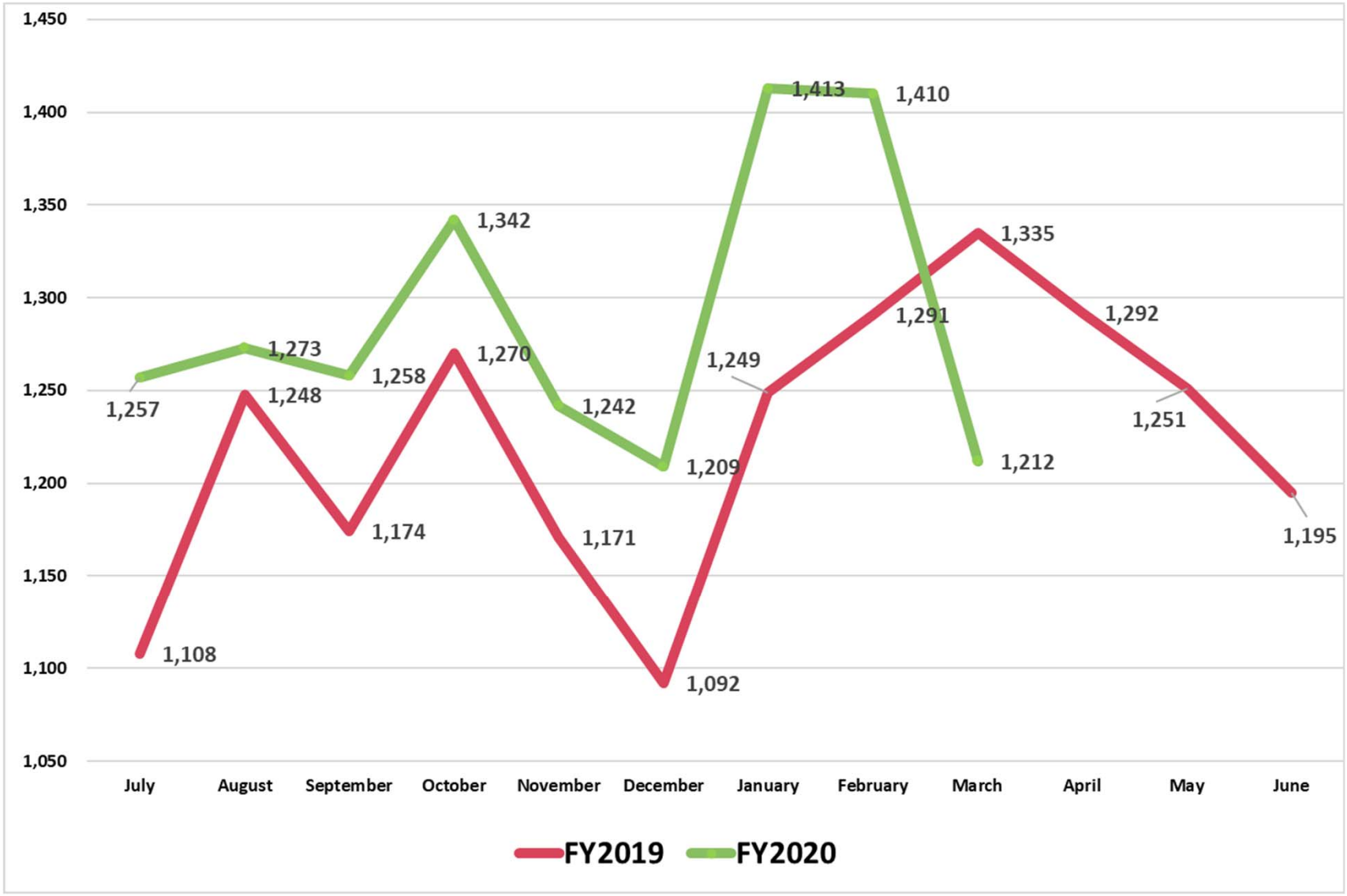
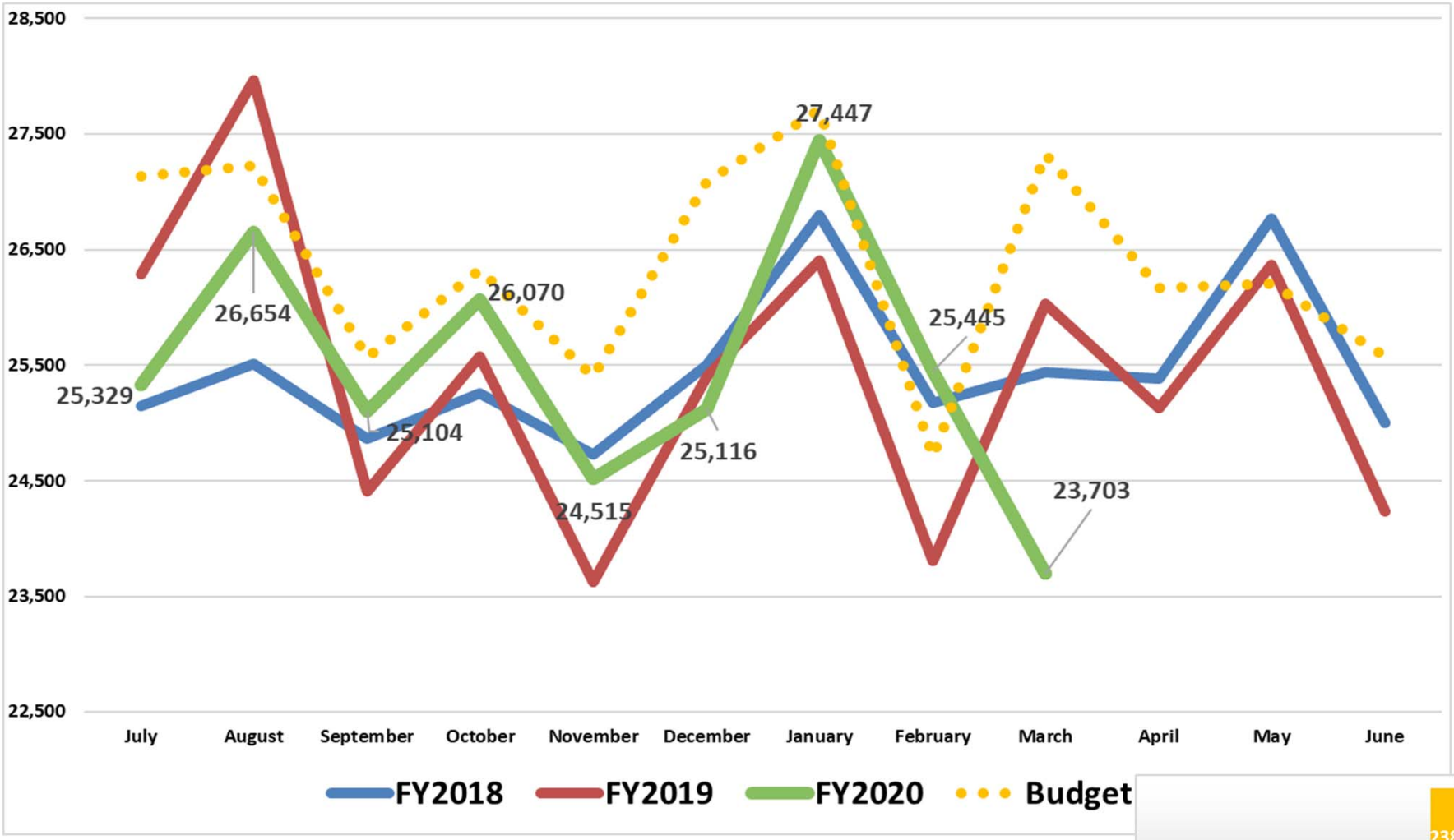
2,475
2,450
2,425
2,400
2,375
2,350
2,686
2,643
2,481
2,607
2,479
2,451
2,610
2,509
2,361
July
August
September
October
November
December
January
February
March
April
May
June
FY2018
FY2019
FY2020

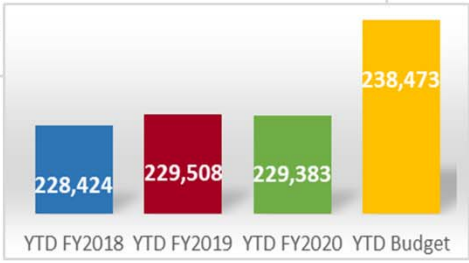

23,867
23,834
22,827
YTD FY2018
YTD FY2019
YTD FY2020

Outpatient Registrations per Day



Adjusted Patient Days





Statistical Results – Fiscal Year Comparison (March)

	Actual Results			Budget	Budget Variance	
	Mar 2019	Mar 2020	% Change	Mar 2020	Change	% Change
Average Daily Census	**442**	**392**	**(11.3%)**	**460**	**(68)**	**(14.7%)**
KDHCD Patient Days:						
Medical Center	8,727	7,754	(11.1%)	9,155	(1,401)	(15.3%)
Acute I/P Psych	1,460	1,409	(3.5%)	1,478	(69)	(4.7%)
Sub-Acute	957	945	(1.3%)	961	(16)	(1.7%)
Rehab	648	397	(38.7%)	637	(240)	(37.7%)
TCS-Ortho	439	390	(11.2%)	402	(12)	(3.0%)
TCS	555	426	(23.2%)	525	(99)	(18.9%)
NICU	335	370	10.4%	551	(181)	(32.8%)
Nursery	586	473	(19.3%)	550	(77)	(14.0%)
Total KDHCD Patient Days	**13,707**	**12,164**	**(11.3%)**	**14,259**	**(2,095)**	**(14.7%)**
Total Outpatient Volume	**41,385**	**37,572**	**(9.2%)**	**43,909**	**(6,337)**	**(14.4%)**

Statistical Results – Fiscal Year Comparison (Jul-Mar)

	Actual Results			Budget	Budget Variance	
	FYTD 2019	FYTD 2020	% Change	FYTD 2020	Change	% Change
Average Daily Census	**445**	**421**	**(5.4%)**	**450**	**(29)**	**(6.5%)**
KDHCD Patient Days:						
Medical Center	78,788	73,574	(6.6%)	79,473	(5,899)	(7.4%)
Acute I/P Psych	12,877	12,804	(0.6%)	13,031	(227)	(1.7%)
Sub-Acute	8,473	8,146	(3.9%)	8,468	(322)	(3.8%)
Rehab	4,967	4,732	(4.7%)	5,324	(592)	(11.1%)
TCS-Ortho	3,449	3,740	8.4%	3,564	176	4.9%
TCS	4,264	4,461	4.6%	4,635	(174)	(3.8%)
NICU	3,908	3,602	(7.8%)	4,050	(448)	(11.1%)
Nursery	5,207	4,686	(10.0%)	5,264	(578)	(11.0%)
Total KDHCD Patient Days	**121,933**	**115,745**	**(5.1%)**	**123,809**	**(8,064)**	**(6.5%)**
Total Outpatient Volume	**334,151**	**354,776**	**6.2%**	**354,534**	**242**	**0.1%**

Other Statistical Results – Fiscal Year Comparison (March)

	Actual Results				Budget	Budget Variance	
	Mar 2019	Mar 2020	Change	% Change	Mar 2020	Change	% Change
Adjusted Patient Days	**26,032**	**23,703**	**(2,330)**	**(8.9%)**	**27,321**	**(3,618)**	**(15.3%)**
Outpatient Visits	**41,385**	**37,572**	**(3,813)**	**(9.2%)**	**43,909**	**(6,337)**	**(16.9%)**
Home Infusion Days	10,266	12,395	2,129	**20.7%**	11,420	975	**7.9%**
GME Clinic visits	938	1,095	157	**16.7%**	1,240	(145)	**(13.2%)**
Home Health Visits	2,511	2,885	374	**14.9%**	2,800	85	**2.9%**
Hospice Days	3,422	3,874	452	**13.2%**	3,290	584	**15.1%**
KDMF RVU	30,997	33,013	2,016	**6.5%**	34,446	(1,433)	**(4.3%)**
Surgery Minutes – General & Robotic (I/P & O/P)	1,038	995	(43)	**(4.1%)**	1,125	(130)	**(13.1%)**
O/P Rehab Units	19,819	18,011	(1,808)	**(9.1%)**	21,182	(3,171)	**(17.6%)**
Radiation Oncology Treatments (I/P & O/P)	2,487	2,259	(228)	**(9.2%)**	2,035	224	**9.9%**
OB Deliveries	399	361	(38)	**(9.5%)**	426	(65)	**(18.0%)**
Urgent Care - Demaree	2,736	2,462	(274)	**(10.0%)**	2,855	(393)	**(16.0%)**
Radiology/CT/US/MRI Proc (I/P & O/P)	15,695	14,025	(1,670)	**(10.6%)**	15,343	(1,318)	**(9.4%)**
Physical & Other Therapy Units	18,942	16,778	(2,164)	**(11.4%)**	18,855	(2,077)	**(12.4%)**
Cath Lab Minutes (IP & OP)	400	348	(52)	**(13.0%)**	394	(46)	**(13.2%)**
Endoscopy Procedures (I/P & O/P)	508	441	(67)	**(13.2%)**	463	(22)	**(5.0%)**
Dialysis Treatments	2,108	1,823	(285)	**(13.5%)**	1,886	(63)	**(3.5%)**
ED Total Registered	7,805	5,955	(1,850)	**(23.7%)**	7,742	(1,787)	**(30.0%)**
Urgent Care - Court	4,845	3,179	(1,666)	**(34.4%)**	4,355	(1,176)	**(37.0%)**

Other Statistical Results – Fiscal Year Comparison (Jul-Mar)

	Actual Results				Budget	Budget Variance	
	FY 2019	FY 2020	Change	% Change	FY 2020	Change	% Change
Adjusted Patient Days	**229,543**	**229,364**	**(179)**	**(0.1%)**	**238,475**	**(9,111)**	**(3.8%)**
Outpatient Visits	**334,151**	**354,776**	**20,625**	**6.2%**	**354,534**	**242**	**0.1%**
Urgent Care - Demaree	13,988	20,877	6,889	**49.2%**	18,478	2,399	**13.0%**
Endoscopy Procedures (I/P & O/P)	4,216	5,506	1,290	**30.6%**	4,161	1,345	**32.3%**
Home Health Visits	21,472	24,426	2,954	**13.8%**	23,517	909	**3.9%**
KDMF RVU	267,561	296,431	28,870	**10.8%**	301,057	(4,626)	**(1.5%)**
Radiation Oncology Treatments (I/P & O/P)	18,104	19,471	1,367	**7.6%**	18,315	1,156	**6.3%**
Hospice Days	29,367	31,548	2,181	**7.4%**	30,278	1,270	**4.2%**
GME Clinic visits	8,768	9,337	569	**6.5%**	10,960	(1,623)	**(14.8%)**
Home Infusion Days	97,720	101,507	3,787	**3.9%**	99,666	1,841	**1.8%**
Physical & Other Therapy Units	157,843	163,679	5,836	**3.7%**	163,620	59	**0.0%**
Surgery Minutes – General & Robotic (I/P & O/P)	9,124	9,435	311	**3.4%**	10,730	(1,295)	**(12.1%)**
ED Total Registered	63,286	65,156	1,870	**3.0%**	68,981	(3,825)	**(5.5%)**
Radiology/CT/US/MRI Proc (I/P & O/P)	132,222	135,198	2,976	**2.3%**	138,072	(2,874)	**(2.1%)**
Cath Lab Minutes (IP & OP)	3,309	3,339	30	**0.9%**	3,541	(202)	**(5.7%)**
O/P Rehab Units	175,086	172,584	(2,502)	**(1.4%)**	184,096	(11,512)	**(6.3%)**
Dialysis Treatments	17,553	16,515	(1,038)	**(5.9%)**	16,364	151	**0.9%**
OB Deliveries	3,677	3,418	(259)	**(7.0%)**	3,818	(400)	**(10.5%)**
Urgent Care - Court	38,595	33,250	(5,345)	**(13.8%)**	38,566	(5,316)	**(13.8%)**

March Financial Comparison (000's)

	Actual Results			Budget	Budget Variance		
	Mar 2019	Mar 2020	% Change	Mar 2020	Change	% Change	Explanation
Operating Revenue							
Net Patient Service Revenue	**48,012**	**48,523**	**1.1%**	**51,811**	**($3,287)**	**(6.3%)**	
Supplemental Gov't Programs	9,024	7,041	(22.0%)	4,319	2,721	63.0%	*See highlights slide*
Prime Program	604	905	49.8%	905	0	0.0%	
Premium Revenue	3,739	4,218	12.8%	4,428	(210)	(4.7%)	
Management Services Revenue	2,776	2,655	(4.4%)	2,696	(42)	(1.5%)	
Other Revenue	1,928	1,515	(12.6%)	1,768	(253)	(14.3%)	
Other Operating Revenue	18,073	16,505	**(8.7%)**	14,118	2,388	16.9%	
Total Operating Revenue	**66,085**	**65,028**	**(1.6%)**	**65,928**	**(900)**	**(1.4%)**	
Operating Expenses							
Salaries & Wages	24,597	27,448	11.6%	26,097	1,351	5.2%	*See highlights slide*
Contract Labor	1,317	834	(36.6%)	335	499	149.1%	
Employee Benefits	6,316	7,313	15.8%	6,178	1,134	18.4%	*See highlights slide*
Total Employment Expenses	**32,229**	**35,596**	**10.4%**	**32,611**	**2,985**	**9.2%**	
Medical & Other Supplies	9,219	10,216	10.8%	9,427	789	8.4%	*See highlights slide*
Physician Fees	6,775	8,202	21.1%	7,919	282	3.6%	
Purchased Services	3,288	3,028	(7.9%)	3,300	(272)	(8.2%)	
Repairs & Maintenance	2,003	2,134	6.6%	2,242	(108)	(4.8%)	
Utilities	355	483	35.9%	508	(25)	(5.0%)	
Rents & Leases	505	572	13.2%	531	41	7.7%	
Depreciation & Amortization	2,568	2,492	(2.9%)	2,800	(307)	(11.0%)	
Interest Expense	461	500	8.7%	524	(23)	(4.5%)	
Other Expense	1,863	1,796	(3.6%)	1,797	(1)	(0.1%)	
Management Services Expense	2,564	2,711	5.7%	2,654	57	2.2%	
Total Other Expenses	**29,600**	**32,133**	**8.6%**	**31,701**	**432**	**1.4%**	
Total Operating Expenses	**61,830**	**67,729**	**9.5%**	**64,312**	**3,417**	**5.3%**	
Operating Margin	**$4,255**	**($2,700)**	**(163.5%)**	**$1,616**	**($4,316)**	**(267.1%)**	
Nonoperating Revenue (Loss)	3,325	1,610	(51.6%)	670	939	140.1%	
Excess Margin	**$7,580**	**($1,091)**	**(114.4%)**	**$2,286**	**($3,377)**	**(147.7%)**	

Operating Margin %	**6.4%**	**(4.2%)**		**2.5%**
Excess Margin %	**10.9%**	**(1.6%)**		**3.4%**

YTD Financial Comparison (000's)

	Actual Results FYTD Jul-Mar			Budget FYTD	Budget Variance FYTD	
	FYTD2019	FYTD2020	% Change	FYTD2020	Change	% Change
Operating Revenue						
Net Patient Service Revenue	**421,822**	**450,922**	**6.9%**	**459,675**	**(8,752)**	**(1.9%)**
Supplemental Gov't Programs	49,190	43,222	(12.1%)	38,873	4,350	11.2%
Prime Program	11,028	9,081	(17.7%)	8,146	935	11.5%
Premium Revenue	28,833	36,153	25.4%	34,273	1,880	5.5%
Management Services Revenue	23,772	24,275	2.1%	24,241	33	0.1%
Other Revenue	17,990	17,039	(5.3%)	15,845	1,193	7.5%
Other Operating Revenue	130,814	129,771	**(0.8%)**	121,378	8,392	6.9%
Total Operating Revenue	**552,636**	**580,693**	**5.1%**	**581,053**	**(360)**	**(0.1%)**
Operating Expenses						
Salaries & Wages	215,035	231,902	7.8%	228,975	2,927	1.3%
Contract Labor	11,603	8,500	(26.7%)	2,859	5,641	197.3%
Employee Benefits	56,744	58,812	3.6%	54,577	4,235	7.8%
Total Employment Expenses	**283,382**	**299,214**	**5.6%**	**286,411**	**12,803**	**4.5%**
Medical & Other Supplies	87,063	89,638	3.0%	84,104	5,534	6.6%
Physician Fees	62,358	68,968	10.6%	71,234	(2,266)	(3.2%)
Purchased Services	26,475	31,512	19.0%	26,975	4,537	16.8%
Repairs & Maintenance	19,166	19,051	(0.6%)	20,124	(1,073)	(5.3%)
Utilities	4,301	4,608	7.1%	4,490	118	2.6%
Rents & Leases	4,462	4,827	8.2%	4,780	48	1.0%
Depreciation & Amortization	22,735	22,372	(1.6%)	23,424	(1,052)	(4.5%)
Interest Expense	4,095	4,120	0.6%	4,714	(594)	(12.6%)
Other Expense	14,355	15,129	5.4%	15,881	(752)	(4.7%)
Management Services Expense	23,144	24,035	3.9%	23,856	179	0.8%
Total Other Expenses	**268,154**	**284,260**	**6.0%**	**279,581**	**4,679**	**1.7%**
Total Operating Expenses	**551,536**	**583,474**	**5.8%**	**565,992**	**17,482**	**3.1%**
Operating Margin	**$1,099**	**($2,781)**	**(353.0%)**	**$15,061**	**($17,842)**	**(118.5%)**
Nonoperating Revenue (Loss)	7,586	11,058	45.8%	5,942	5,117	86.1%
Excess Margin	**$8,685**	**$8,277**	**(4.7%)**	**$21,003**	**($12,726)**	**(60.6%)**

Operating Margin %	**0.2%**	**(0.5%)**		**2.6%**
Excess Margin %	**1.6%**	**1.4%**		**3.6%**

Kaweah Delta Medical Foundation
Fiscal Year Financial Comparison (000's)

	Actual Results FYTD March			Budget FYTD	Budget Variance FYTD	
	Jul – Mar 2019	Jul - Mar 2020	% Change	Jul – Mar 2020	Change	% Change
Operating Revenue						
Net Patient Service Revenue	**32,387**	**33,519**	**3.5%**	**35,617**	**(2,099)**	**(5.9%)**
Other Operating Revenue	473	674	42.5%	473	201	42.4%
Total Operating Revenue	**32,860**	**34,192**	**4.1%**	**36,090**	**(1,898)**	**(5.3%)**
Operating Expenses						
Salaries & Wages	8,594	8,730	1.6%	9,081	(351)	(3.9%)
Contract Labor	122	49	(60.3%)	0	49	0.0%
Employee Benefits	2,121	2,226	5.0%	2,162	64	3.0%
Total Employment Expenses	**10,838**	**11,005**	**1.5%**	**11,244**	**(239)**	**(2.1%)**
Medical & Other Supplies	4,477	4,614	3.1%	4,775	(161)	(3.4%)
Physician Fees	16,454	18,393	11.8%	19,375	(981)	(5.1%)
Purchased Services	947	860	(9.3%)	483	376	77.8%
Repairs & Maintenance	1,422	1,609	13.1%	1,966	(357)	(18.2%)
Utilities	318	290	(9.0%)	315	(25)	(7.9%)
Rents & Leases	1,991	2,077	4.4%	2,152	(74)	(3.5%)
Depreciation & Amortization	900	759	(15.7%)	792	(33)	(4.2%)
Interest Expense	17	9	(45.3%)	18	(9)	(47.3%)
Other Expense	1,198	1,264	5.5%	1,369	(106)	(7.7%)
Total Other Expenses	**27,724**	**29,874**	**7.8%**	**31,244**	**(1,370)**	**(4.4%)**
Total Operating Expenses	**38,561**	**40,879**	**6.0%**	**42,487**	**(1,609)**	**(3.8%)**
Excess Margin	**($5,702)**	**($6,686)**	**(17.3%)**	**($6,397)**	**($289)**	**(4.5%)**
Excess Margin %	**(17.4%)**	**(19.6%)**		**(17.7%)**		

March Highlights – Budget Variances

- **Cash:** Days cash on hand were lower in March primarily due to a **$10M IGT** rate range supplemental payment. We anticipate receiving the IGT amount plus the match amount ($25M) in June or possibly sooner. This reduction in cash was slightly offset by a strong month of patient services collections which were higher than usual at $52M.

- **Patient Accounts Receivable:** The AR balance is the lowest we have seen in the last 20 months due to improved collections and continued improvement on working through the backlog. Our Days in AR have decreased by 20% since last year, but we still have another 20% to go to meet the goal of 55 days by July.

- **Supplemental Income:** . On April 10th, KDMF and Kaweah received $11.4M in relief funds that were appropriated in the CARES Act. Unlike the advanced payment funds, these funds do not require repayment. However, there are very specific use and cost tracking requirements. Because relief funds relate to specific expenditures, we are recording ¼ ($2.97M) in March in our supplemental income line and the rest as deferred revenue, which will continue to be spread and recognized as income over the next three months.

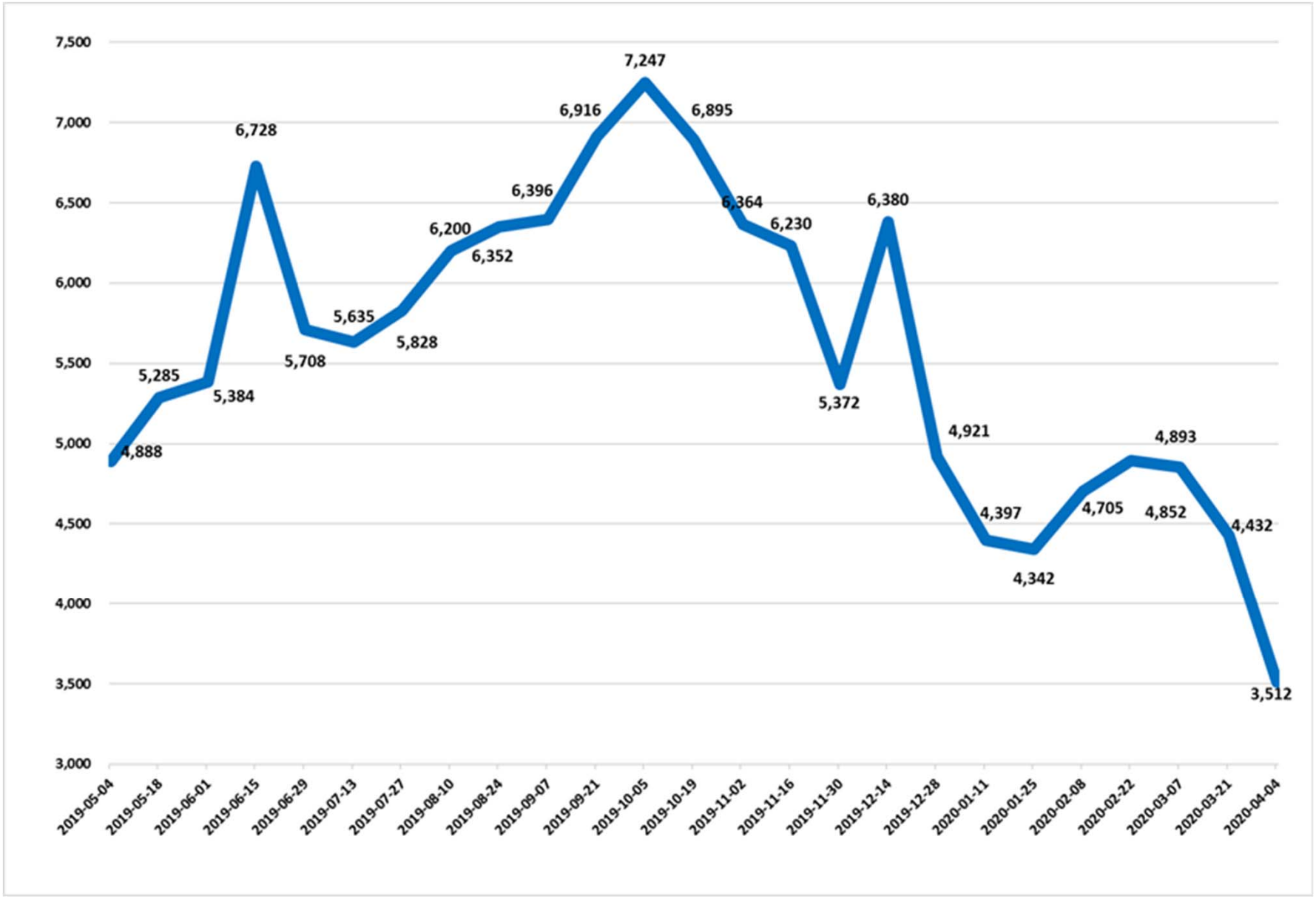
Continuation– Budget Variances

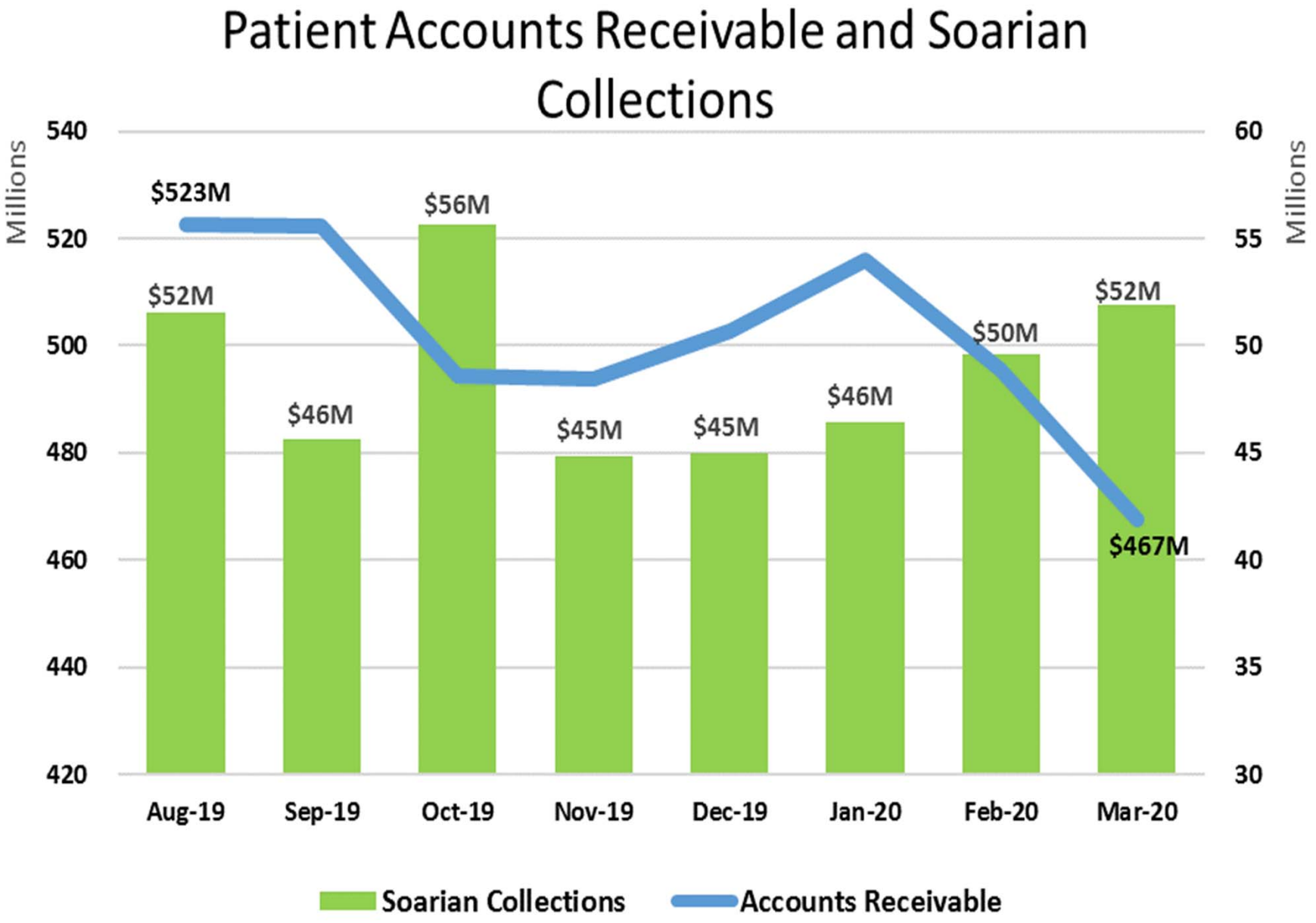
- **Salaries & Contract Labor**: The unfavorable variance of $1.9M in March is primarily related to the nursing areas which were impacted by the focused efforts on nurse to patient ratios, as well as some unfavorable departmental productivity ratio variances. In addition, there were $914K of labor costs transferred to the COVID 19 Disaster Department. March's payroll expense also includes an unbudgeted $283K accrual related to our retention program.

- **Employee Benefits:** The $1.1M unfavorable variance resulted from an increase in the PTO liability of $657K, or 18,000 hour increase, a $304K overage in employee health insurance cost, and a $252 overage in FICA expense.

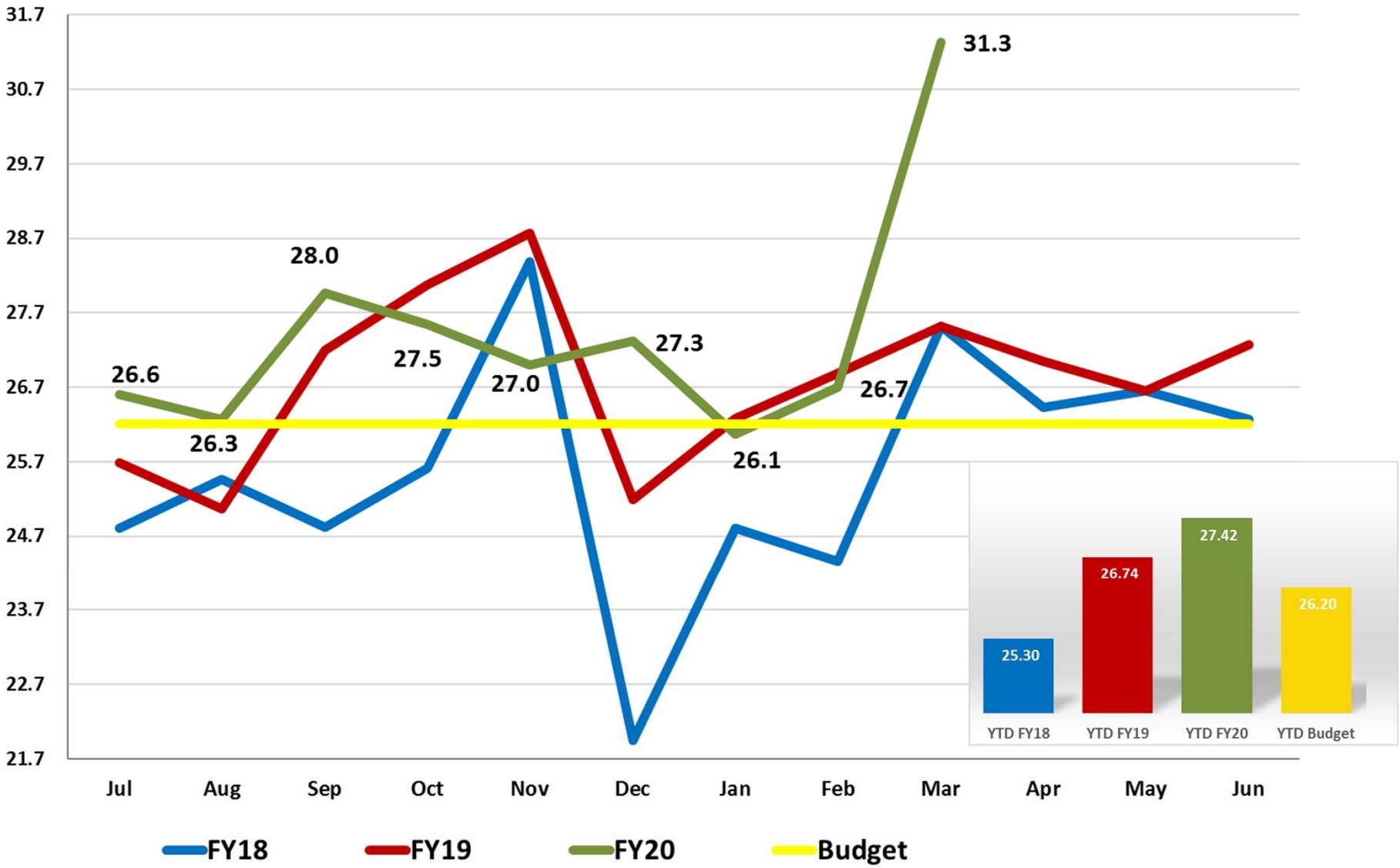
- **Medical & Other Supplies:** The $789K unfavorable variance is primarily due to an increase in medical/surgical supplies. These variances are mainly in the surgery, laboratory, prompt care and urgent care areas.

Contract Labor Hours

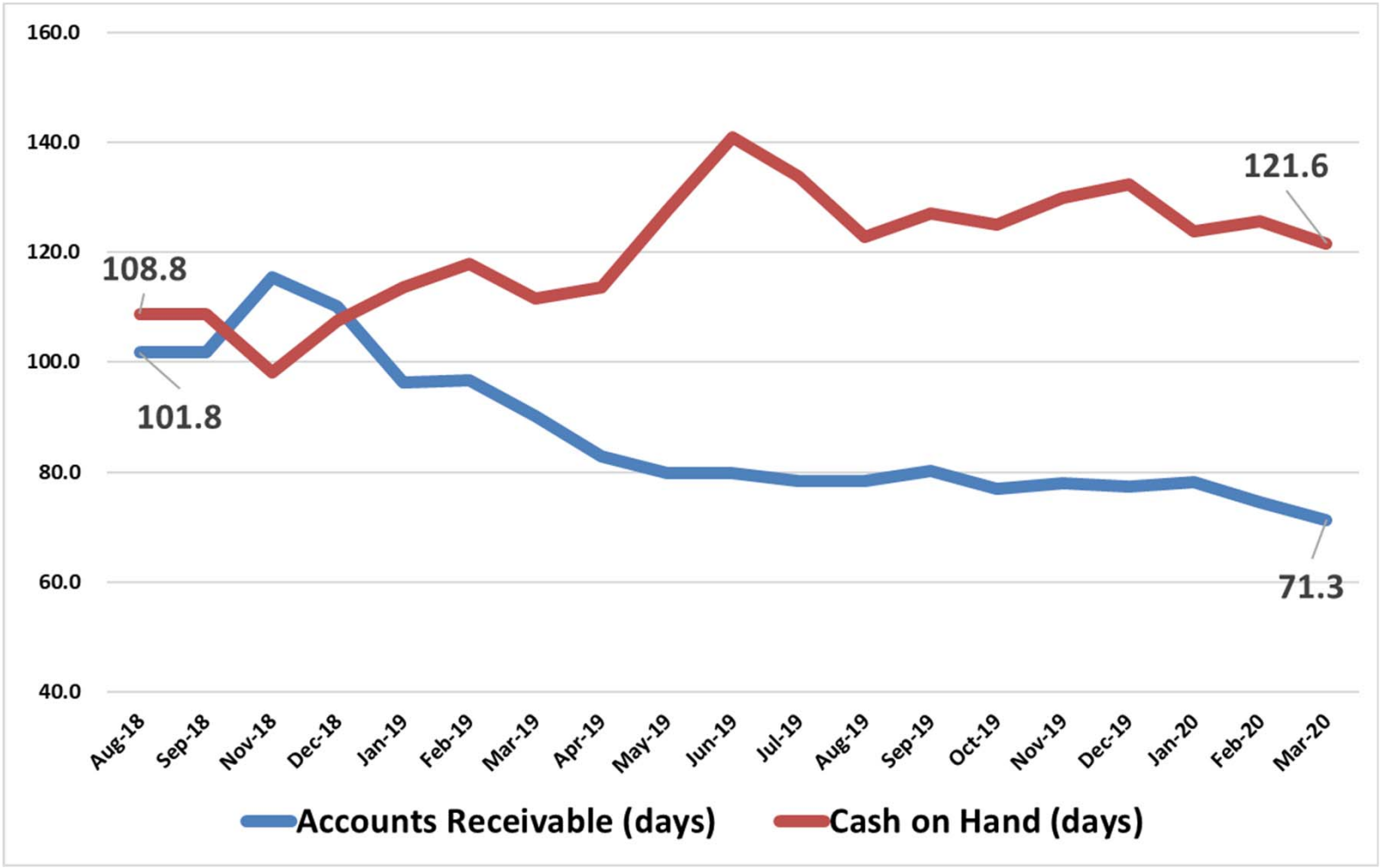



Patient Accounts Receivable and Soarian Collections
Millions
540
520
500
480
460
440
420
60
55
50
45
40
35
30
Millions
$523M
$56M
$52M
$52M
$50M
$46M
$46M
$45M
$45M
$467M
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Soarian Collections
Accounts Receivable

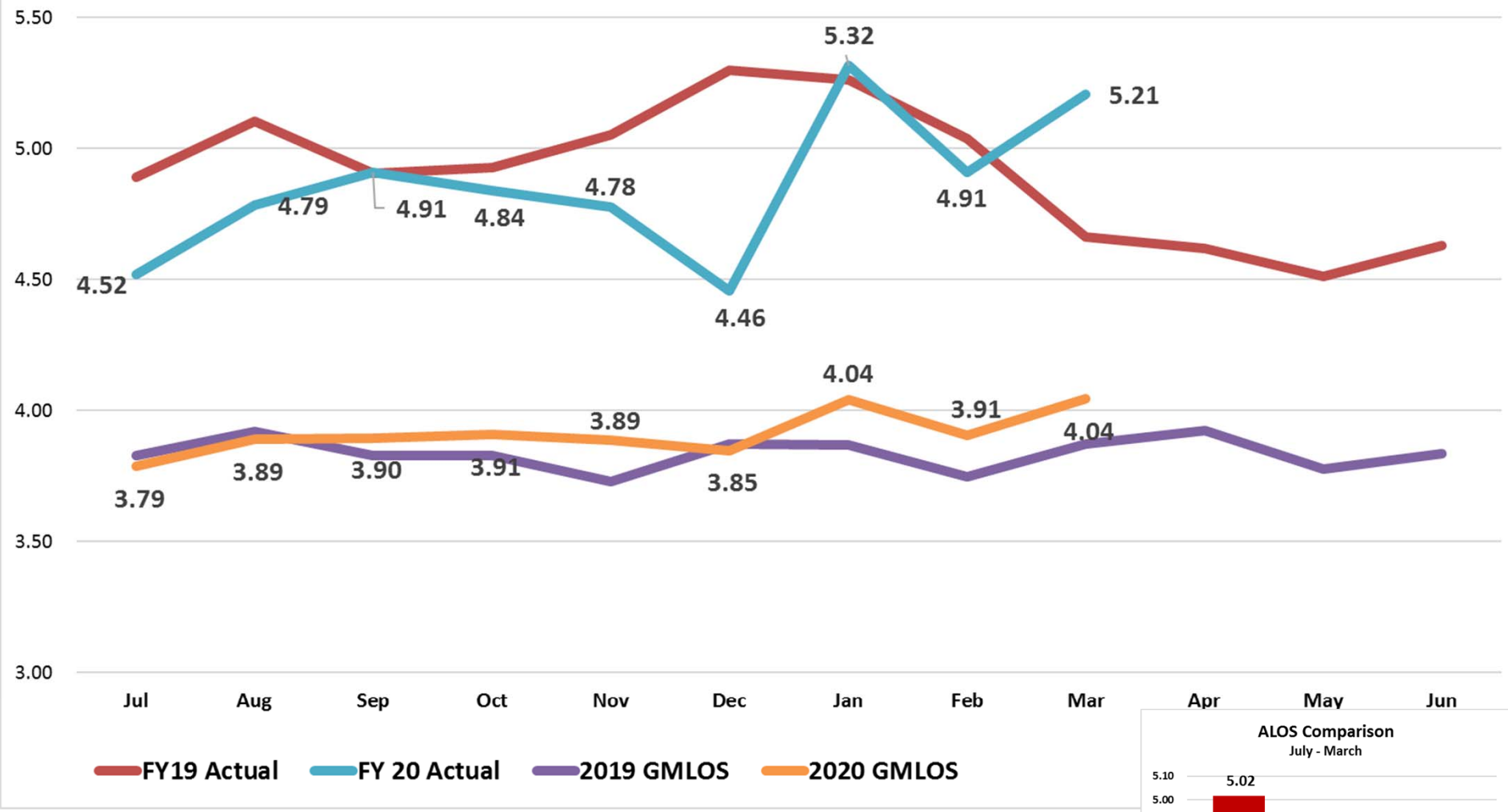
Productivity: Worked Hours/Adjusted Patient Days

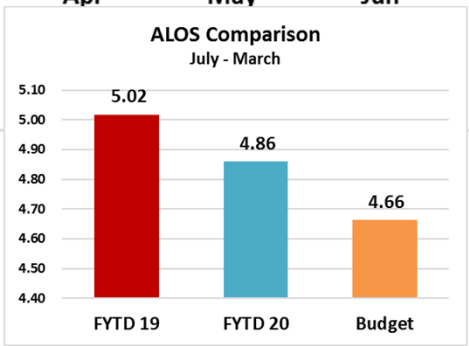


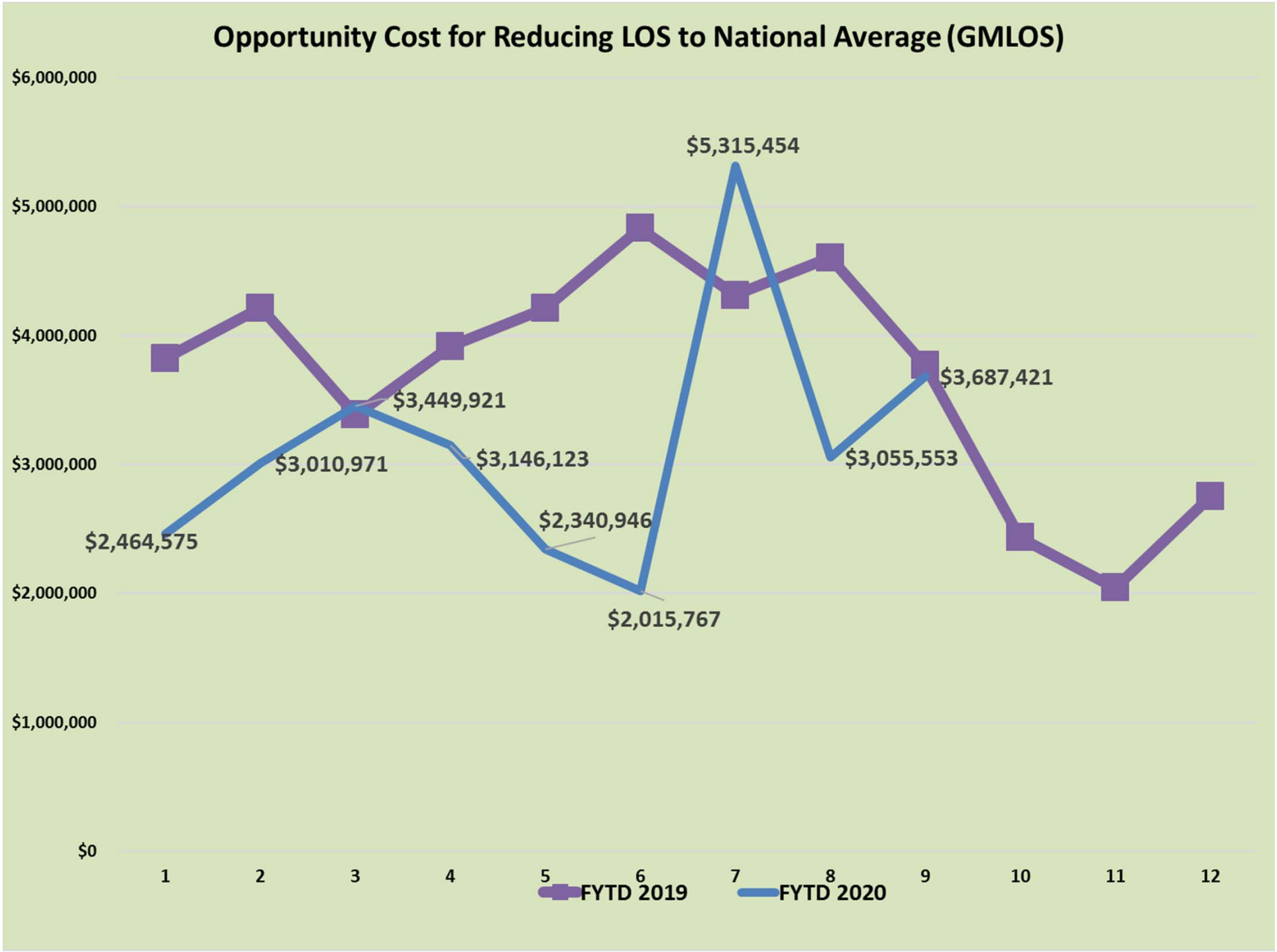
Trended Liquidity Ratios

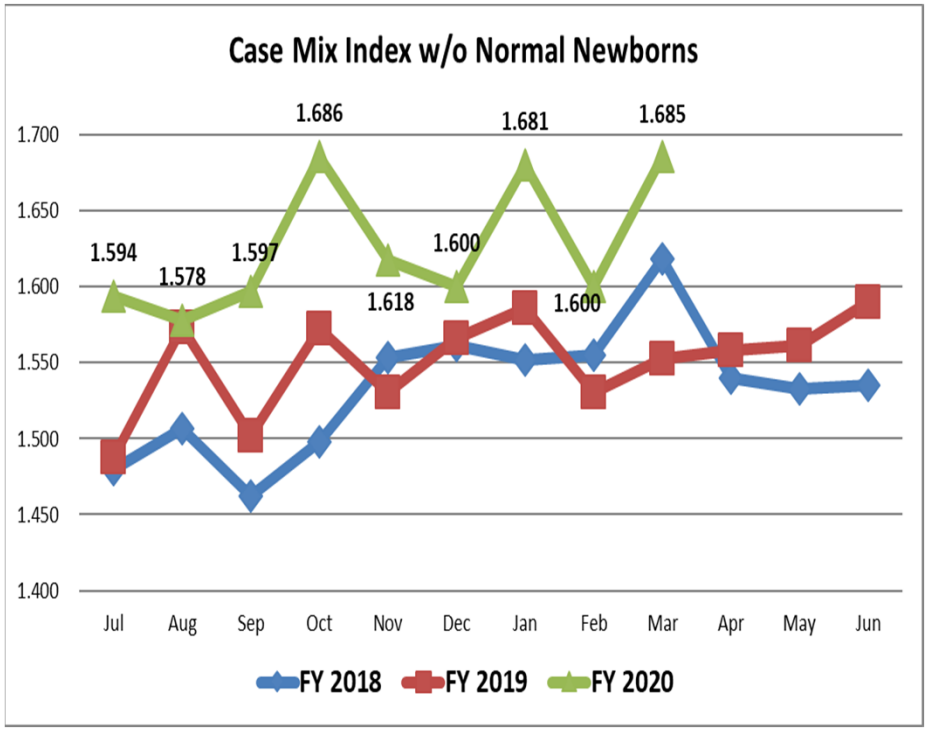


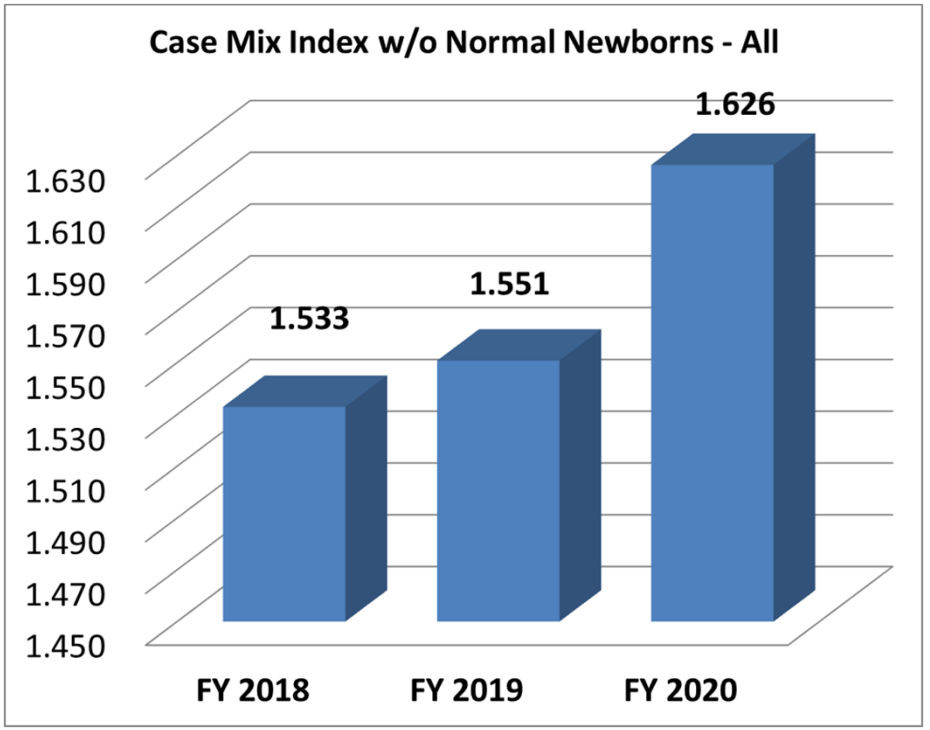
Average Length of Stay versus National Average (GMLOS)

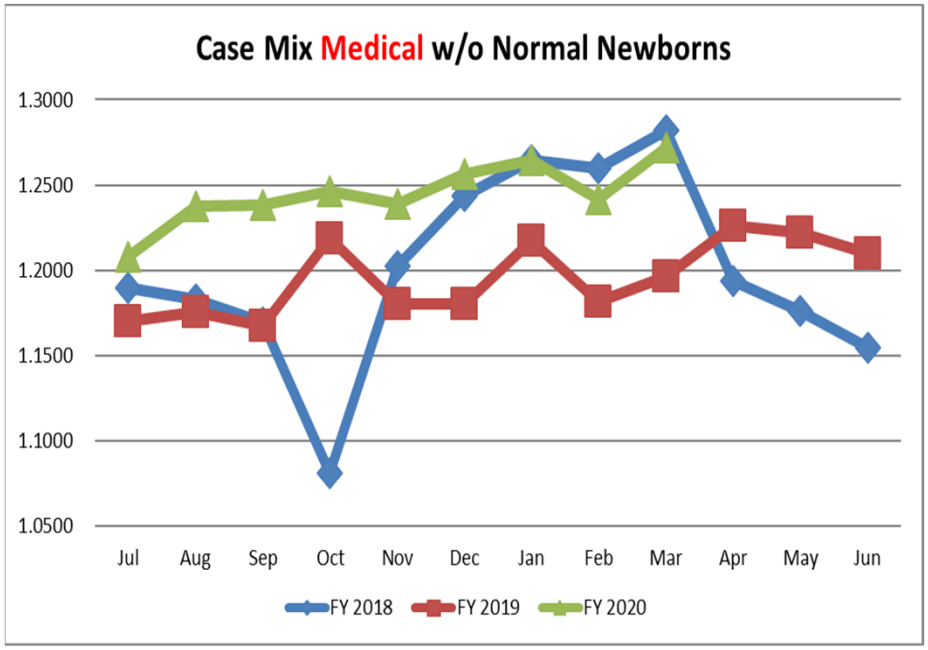


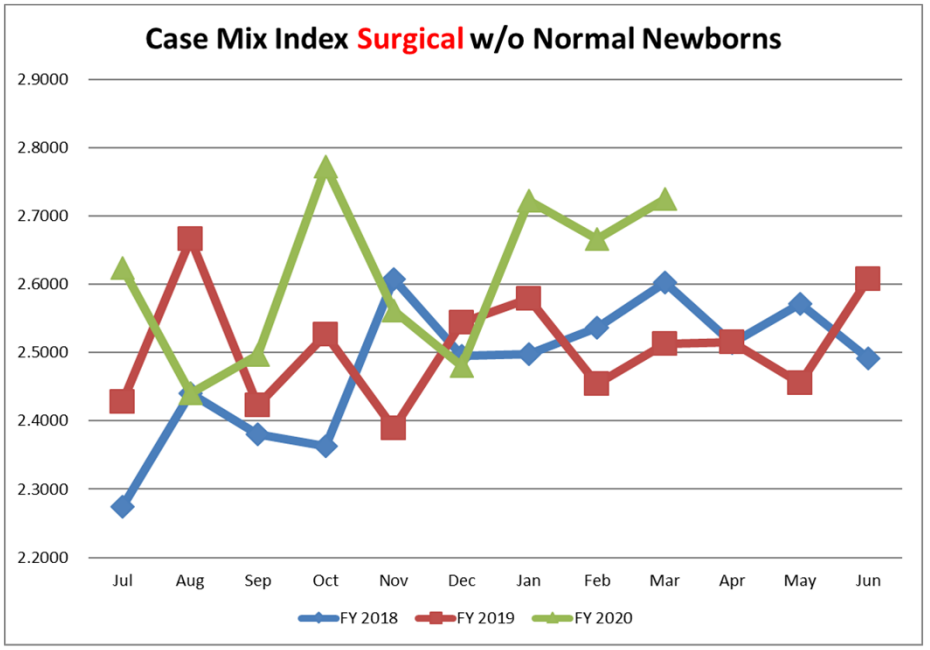



Opportunity Cost for Reducing LOS to National Average (GMLOS)
$6,000,000
$5,000,000
$4,000,000
$3,000,000
$2,000,000
$1,000,000
$0
$5,315,454
$3,687,421
$3,449,921
$3,010,971
$3,146,123
$3,055,553
$2,340,946
$2,464,575
$2,015,767
1
2
3
4
5
6
7
8
9
10
11
12
FYTD 2019
FYTD 2020


Case Mix Index w/o Normal Newborns
1.700
1.650
1.600
1.550
1.500
1.450
1.400
1.594
1.578
1.597
1.686
1.618
1.600
1.600
1.681
1.685
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY 2018
FY 2019
FY 2020


Case Mix Index w/o Normal Newborns - All
1.630
1.610
1.590
1.570
1.550
1.530
1.510
1.490
1.470
1.450
1.533
1.551
1.626
FY 2018
FY 2019
FY 2020


Case Mix Medical w/o Normal Newborns
1.3000
1.2500
1.2000
1.1500
1.1000
1.0500
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY 2018
FY 2019
FY 2020


Case Mix Index Surgical w/o Normal Newborns
2.9000
2.8000
2.7000
2.6000
2.5000
2.4000
2.3000
2.2000
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY 2018
FY 2019
FY 2020

KAWEAH DELTA HEALTH CARE DISTRICT

CONSOLIDATED INCOME STATEMENT (000's)

FISCAL YEAR 2019 & 2020

	Operating Revenue			Operating Expenses									
Fiscal Year	Net Patient Revenue	Other Operating Revenue	Operating Revenue Total	Personnel Expense	Physician Fees	Supplies Expense	Other Operating Expense	Operating Expenses Total	Operating Income	Non-Operating Income	Net Income	Operating Margin %	Excess Margin
2019													
Jul-18	49,124	11,390	60,514	30,147	6,300	9,585	12,701	58,733	1,781	434	2,215	2.9%	3.6%
Aug-18	52,124	11,439	63,563	31,602	7,668	10,624	12,980	62,874	689	482	1,171	1.1%	1.8%
Sep-18	46,634	11,659	58,293	29,835	6,524	8,862	13,361	58,582	(289)	912	624	(0.5%)	1.1%
Oct-18	48,769	11,644	60,413	32,849	7,145	9,867	13,066	62,927	(2,514)	345	(2,169)	(4.2%)	(3.6%)
Nov-18	43,870	18,365	62,235	31,066	7,310	10,195	13,900	62,470	(235)	449	214	(0.4%)	0.3%
Dec-18	43,717	14,732	58,449	31,115	7,023	10,329	12,736	61,202	(2,754)	614	(2,140)	(4.7%)	(3.6%)
Jan-19	44,312	18,178	62,489	34,290	6,624	8,909	13,104	62,927	(438)	460	22	(0.7%)	0.0%
Feb-19	45,261	15,334	60,595	30,249	6,989	9,473	13,280	59,991	604	565	1,169	1.0%	1.9%
Mar-19	48,012	18,073	66,085	32,229	6,775	9,219	13,606	61,830	4,255	3,325	7,580	6.4%	10.9%
Apr-19	45,828	17,318	63,146	31,272	7,105	9,209	15,748	63,334	(188)	604	416	(0.3%)	0.7%
May-19	47,078	18,515	65,594	32,104	8,403	9,728	13,265	63,501	2,093	585	2,678	3.2%	4.0%
Jun-19	47,183	24,376	71,558	29,357	7,655	6,865	15,114	58,992	12,566	3,562	16,128	17.6%	21.5%
2019 FY Total	**$ 561,911**	**$ 191,023**	**$ 752,933**	**$ 376,115**	**$ 85,521**	**$ 112,866**	**$ 162,861**	**$ 737,363**	**$ 15,570**	**$ 12,337**	**$ 27,907**	**2.1%**	**3.6%**
2020													
Jul-19	51,799	13,802	65,601	32,948	7,266	8,683	13,597	62,494	3,107	744	3,852	4.7%	5.8%
Aug-19	50,243	13,937	64,181	33,307	7,284	9,986	14,583	65,160	(980)	662	(318)	(1.5%)	(0.5%)
Sep-19	48,185	13,994	62,179	31,582	7,486	8,571	14,182	61,822	356	4,429	4,785	0.6%	7.2%
Oct-19	52,165	13,896	66,061	33,546	8,287	10,551	14,477	66,862	(801)	774	(27)	(1.2%)	(0.0%)
Nov-19	49,354	12,823	62,177	31,690	6,974	9,635	13,616	61,916	261	699	960	0.4%	1.5%
Dec-19	51,458	13,542	65,001	32,939	7,113	10,521	13,476	64,049	951	726	1,678	1.5%	2.6%
Jan-20	52,382	15,305	67,687	34,899	7,653	11,127	14,469	68,148	(461)	682	221	(0.7%)	0.3%
Feb-20	46,813	15,966	62,778	32,707	8,702	10,347	13,539	65,295	(2,516)	733	(1,783)	(4.0%)	(2.8%)
Mar-20	48,523	16,505	65,028	35,596	8,202	10,216	13,716	67,729	(2,700)	1,610	(1,091)	(4.2%)	(1.7%)
2020 FY Total	**$ 450,922**	**$ 129,771**	**$ 580,693**	**$ 299,214**	**$ 68,968**	**$ 89,638**	**$ 125,654**	**$ 583,474**	**$ (2,781)**	**$ 11,058**	**$ 8,277**	**(0.5%)**	**1.4%**
FYTD Budget	**459,675**	**121,378**	**581,053**	**286,411**	**71,234**	**84,104**	**124,244**	**565,992**	**15,061**	**5,942**	**21,003**	**2.6%**	**3.6%**
Variance	**$ (8,752)**	**$ 8,392**	**$ (360)**	**$ 12,803**	**$ (2,266)**	**$ 5,534**	**$ 1,411**	**$ 17,482**	**$ (17,842)**	**$ 5,117**	**$ (12,726)**		
Current Month Analysis													
Mar-20	**$ 48,523**	**$ 16,505**	**$ 65,028**	**$ 35,596**	**$ 8,202**	**$ 10,216**	**$ 13,716**	**$ 67,729**	**$ (2,700)**	**$ 1,610**	**$ (1,091)**	**(4.2%)**	**(1.6%)**
Budget	**51,811**	**14,118**	**65,928**	**32,611**	**7,919**	**9,427**	**14,355**	**64,312**	**1,616**	**670**	**2,286**	**2.5%**	**3.4%**
Variance	**$ (3,287)**	**$ 2,388**	**$ (900)**	**$ 2,985**	**$ 282**	**$ 789**	**$ (639)**	**$ 3,417**	**$ (4,316)**	**$ 939**	**(3,377)**		

KAWEAH DELTA HEALTH CARE DISTRICT

FISCAL YEAR 2019 & 2020

Fiscal Year	Patient Days	ADC	Adjusted Patient Days	I/P Revenue %	DFR & Bad Debt %	Net Patient Revenue/ Ajusted Patient Day	Personnel Expense/ Ajusted Patient Day	Physician Fees/ Ajusted Patient Day	Supply Expense/ Ajusted Patient Day	Total Operating Expense/ Ajusted Patient Day	Personnel Expense/ Net Patient Revenue	Physician Fees/ Net Patient Revenue	Supply Expense/ Net Patient Revenue	Total Operating Expense/ Net Patient Revenue
2019														
Jul-18	14,096	455	26,287	53.6%	72.4%	1,869	1,147	240	365	2,234	61.4%	12.8%	19.5%	119.6%
Aug-18	14,569	470	28,016	52.0%	76.0%	1,861	1,128	274	379	2,244	60.6%	14.7%	20.4%	120.6%
Sep-18	13,052	435	24,371	53.6%	73.5%	1,914	1,224	268	364	2,404	64.0%	14.0%	19.0%	125.6%
Oct-18	13,744	443	25,579	53.7%	73.5%	1,907	1,284	279	386	2,460	67.4%	14.7%	20.2%	129.0%
Nov-18	13,013	434	23,625	55.1%	74.9%	1,857	1,315	309	432	2,644	70.8%	16.7%	23.2%	142.4%
Dec-18	13,497	435	25,399	53.1%	76.2%	1,721	1,225	277	407	2,410	71.2%	16.1%	23.6%	140.0%
Jan-19	13,671	441	26,407	51.8%	76.9%	1,678	1,299	251	337	2,383	77.4%	14.9%	20.1%	142.0%
Feb-19	12,584	449	23,811	52.8%	75.9%	1,901	1,270	294	398	2,519	66.8%	15.4%	20.9%	132.5%
Mar-19	13,707	442	26,032	52.7%	76.9%	1,844	1,238	260	354	2,375	67.1%	14.1%	19.2%	128.8%
Apr-19	13,162	439	25,125	52.4%	76.9%	1,824	1,245	283	367	2,521	68.2%	15.5%	20.1%	138.2%
May-19	13,440	434	26,367	51.0%	75.3%	1,785	1,218	319	369	2,408	68.2%	17.8%	20.7%	134.9%
Jun-19	12,547	418	24,234	51.8%	75.6%	1,947	1,211	316	283	2,434	62.2%	16.2%	14.6%	125.0%
2019 FY Total	**161,082**	**441**	**305,353**	**52.8%**	**75.4%**	**1,840**	**1,232**	**280**	**370**	**2,415**	**66.9%**	**15.2%**	**20.1%**	**131.2%**
2020														
Jul-19	12,744	411	25,329	50.3%	73.8%	2,045	1,301	287	343	2,467	63.6%	14.0%	16.8%	120.6%
Aug-19	13,240	427	26,654	49.7%	74.8%	1,885	1,250	273	375	2,445	66.3%	14.5%	19.9%	129.7%
Sep-19	12,712	424	25,104	50.6%	74.1%	1,919	1,258	298	341	2,463	65.5%	15.5%	17.8%	128.3%
Oct-19	12,924	417	26,070	49.6%	74.6%	2,001	1,287	318	405	2,565	64.3%	15.9%	20.2%	128.2%
Nov-19	12,260	409	24,515	50.0%	74.4%	2,013	1,293	285	393	2,526	64.2%	14.1%	19.5%	125.5%
Dec-19	12,993	419	25,116	51.7%	73.8%	2,049	1,311	283	419	2,550	64.0%	13.8%	20.4%	124.5%
Jan-20	13,799	445	27,447	50.3%	75.3%	1,908	1,271	279	405	2,483	66.6%	14.6%	21.2%	130.1%
Feb-20	12,909	445	25,445	50.7%	76.9%	1,840	1,285	342	407	2,566	69.9%	18.6%	22.1%	139.5%
Mar-20	12,164	392	23,703	51.3%	74.1%	2,047	1,502	346	431	2,857	73.4%	16.9%	21.1%	139.6%
2020 FY Total	**115,745**	**421**	**229,364**	**50.5%**	**74.7%**	**1,966**	**1,305**	**301**	**391**	**2,544**	**66.4%**	**15.3%**	**19.9%**	**129.4%**
FYTD Budget	**123,809**	**450**	**238,475**	**51.9%**	**74.3%**	**1,928**	**1,201**	**299**	**353**	**2,468**	**62.3%**	**15.5%**	**18.3%**	**123.1%**
Variance	**(8,064)**	**(29)**	**(9,111)**	**(1.5%)**	**0.4%**	**38**	**104**	**2**	**38**	**76**	**4.0%**	**(0.2%)**	**1.6%**	**6.3%**
Current Month Analysis														
Mar-20	**12,164**	**392**	**23,703**	**51.3%**	**74.1%**	**2,047**	**1,502**	**346**	**431**	**2,857**	**73.4%**	**16.9%**	**21.1%**	**139.6%**
Budget	**14,259**	**460**	**27,321**	**52.2%**	**74.3%**	**1,896**	**1,194**	**290**	**345**	**2,713**	**62.9%**	**15.3%**	**18.2%**	**124.1%**
Variance	**(2,095)**	**(68)**	**(3,618)**	**(0.9%)**	**(0.2%)**	**151**	**308**	**56**	**86**	**144**	**10.4%**	**1.6%**	**2.9%**	**15.5%**

KAWEAH DELTA HEALTH CARE DISTRICT

RATIO ANALYSIS REPORT

MARCH 31, 2020

	Current Month Value	Prior Month Value	June 30, 2019 Audited Value	2018 Moody's Median Benchmark		
				Aa	A	Baa
LIQUIDITY RATIOS						
Current Ratio (x)	2.9	2.8	2.2	1.6	**1.9**	2.1
Accounts Receivable (days)	71.3	74.5	79.8	47.6	**45.9**	44.4
Cash On Hand (days)	121.6	125.6	140.8	257.6	**215.1**	158.0
Cushion Ratio (x)	15.7	16.2	18.5	36.2	**22.5**	14.4
Average Payment Period (days)	44.4	44.6	51.0	73.1	**59.2**	59.2
CAPITAL STRUCTURE RATIOS						
Cash-to-Debt	103.8%	106.6%	120.5%	228.8%	**167.7%**	119.7%
Debt-To-Capitalization	32.6%	32.6%	31.5%	26.9%	**32.2%**	40.4%
Debt-to-Cash Flow (x)	5.3	5.0	3.6	2.3	**2.9**	3.8
Debt Service Coverage	2.7	3.0	4.0	6.6	**5.2**	3.3
Maximum Annual Debt Service Coverage (x)	2.8	2.8	4.0	6.6	**4.7**	3.2
Age Of Plant (years)	13.2	13.1	12.1	10.3	**11.8**	12.1
PROFITABILITY RATIOS						
Operating Margin	(0.5%)	(.0%)	2.0%	3.2%	**2.2%**	0.7%
Excess Margin	1.4%	1.8%	3.6%	7.0%	**5.0%**	2.6%
Operating Cash Flow Margin	4.1%	4.5%	6.8%	9.1%	**8.5%**	6.8%
Return on Assets	1.2%	1.5%	3.0%	5.0%	**3.9%**	2.6%

KAWEAH DELTA HEALTH CARE DISTRICT
CONSOLIDATED STATEMENTS OF NET POSITION (000's)

	Mar-20	Feb-20	Change	% Change	Jun-19 (Audited)
ASSETS AND DEFERRED OUTFLOWS					
CURRENT ASSETS					
Cash and cash equivalents	$ 11,860	$ 10,959	$ 901	8.22%	$ 4,220
Current Portion of Board designated and trusted assets	16,504	15,361	1,143	7.44%	12,577
Accounts receivable:					
Net patient accounts	129,748	135,628	(5,880)	-4.34%	146,605
Other receivables	23,062	13,515	9,547	70.64%	13,907
	152,809	149,143	3,667	2.46%	160,512
Inventories	10,365	10,642	(277)	-2.60%	10,479
Medicare and Medi-Cal settlements	60,789	55,626	5,163	9.28%	30,759
Prepaid expenses	9,558	11,220	(1,663)	-14.82%	11,510
Total current assets	261,886	252,951	8,934	3.53%	230,057
NON-CURRENT CASH AND INVESTMENTS -					
less current portion					
Board designated cash and assets	245,373	255,710	(10,337)	-4.04%	278,883
Revenue bond assets held in trust	39,603	39,582	22	0.05%	33,569
Assets in self-insurance trust fund	4,282	4,275	8	0.18%	4,209
Total non-current cash and investments	289,258	299,566	(10,308)	-3.44%	316,662
CAPITAL ASSETS					
Land	17,542	17,542	-	0.00%	16,137
Buildings and improvements	360,727	360,724	3	0.00%	356,887
Equipment	277,582	277,368	214	0.08%	275,513
Construction in progress	58,774	56,519	2,255	3.99%	42,299
	714,626	712,153	2,472	0.35%	690,836
Less accumulated depreciation	376,130	373,811	2,319	0.62%	357,681
	338,495	338,342	153	0.05%	333,155
Property under capital leases -					
less accumulated amortization	2,770	2,851	(80)	-2.82%	3,204
Total capital assets	341,266	341,193	73	0.02%	336,359
OTHER ASSETS					
Property not used in operations	1,699	1,703	(4)	-0.25%	3,724
Health-related investments	7,550	7,590	(40)	-0.52%	7,537
Other	10,583	10,602	(20)	-0.18%	9,706
Total other assets	19,832	19,895	(64)	-0.32%	20,967
Total assets	912,241	913,606	(1,364)	-0.15%	904,045
DEFERRED OUTFLOWS	(2,648)	(2,610)	(38)	1.47%	(2,340)
Total assets and deferred outflows	**$ 909,593**	**$ 910,996**	**$ (1,403)**	**-0.15%**	**$ 901,705**

KAWEAH DELTA HEALTH CARE DISTRICT

CONSOLIDATED STATEMENTS OF NET POSITION (000's)

	Mar-20	Feb-20	Change	% Change	Jun-19
					(Audited)
LIABILITIES AND NET ASSETS					
CURRENT LIABILITIES					
Accounts payable and accrued expenses	$ 27,968	$ 28,059	$ (90)	(0.32%)	$ 35,319
Accrued payroll and related liabilities	53,927	53,792	134	0.25%	59,163
Long-term debt, current portion	8,631	8,825	(194)	(2.19%)	9,360
Total current liabilities	90,527	90,676	(149)	(0.16%)	103,842
LONG-TERM DEBT, less current portion					
Bonds payable	270,544	270,601	(57)	(0.02%)	258,553
Capital leases	183	205	(21)	(10.49%)	174
Total long-term debt	270,727	270,806	(78)	(0.03%)	258,727
NET PENSION LIABILITY	27,338	27,773	(435)	(1.56%)	31,249
OTHER LONG-TERM LIABILITIES	32,784	32,477	307	0.94%	28,647
Total liabilities	421,375	421,731	(356)	(0.08%)	422,465
NET ASSETS					
Invested in capital assets, net of related debt	104,795	104,462	333	0.32%	105,427
Restricted	33,198	33,778	(580)	(1.72%)	30,090
Unrestricted	350,224	351,024	(800)	(0.23%)	343,722
Total net position	488,218	489,265	(1,047)	(0.21%)	479,239
Total liabilities and net position	**$ 909,593**	**$ 910,996**	**$ (1,403)**	**(0.15%)**	**$ 901,704**

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
March 31, 2020

Board designated funds	S	Maturity Date	Yield	Investment Type		G/L Account	Amount	Total
LAIF			1.91	Various			54,679,426	
CAMP			1.50	CAMP			372,798	
PFM		31846V203	0.04	Money market			262,045	
Wells Cap		31846V203	0.04	Money market			246,234	
Torrey Pines Bank		5-Sep-21	1.11	CD	Torrey Pines Bank		3,000,000	
PFM		16-Oct-20	3.39	CD	Sumito MTSU		805,000	
PFM		16-Nov-20	2.27	CD	Swedbank		1,800,000	
PFM		20-Jan-21	1.80	MTN-C	IBM		900,000	
PFM		16-Feb-21	1.73	ABS	Toyota Auto Recvs		8,201	
Wells Cap		23-Feb-21	2.25	MTN-C	Apple, Inc		615,000	
PFM		12-Mar-21	2.75	MTN-C	Texas Instruments		180,000	
Wells Cap		12-Mar-21	2.75	MTN-C	Texas Instruments		630,000	
Wells Cap		15-Mar-21	1.71	ABS	Smart Trust		184,023	
PFM		1-Apr-21	2.80	Municipal	California ST		530,000	
Wells Cap		1-Apr-21	2.63	Municipal	California ST High		1,250,000	
Wells Cap		1-Apr-21	3.54	Municipal	Sacramento Ca Public		1,200,000	
PFM		2-Apr-21	2.83	CD	Credit Agricole CD		825,000	
Wells Cap		13-Apr-21	2.95	MTN-C	Toyota Motor		350,000	
Wells Cap		13-Apr-21	2.95	MTN-C	Toyota Motor		600,000	
PFM		15-Apr-21	2.50	MTN-C	Bank of NY		900,000	
Wells Cap		19-Apr-21	2.63	MTN-C	Bank of America		435,000	
Wells Cap		19-Apr-21	2.63	MTN-C	Bank of America		600,000	
PFM		21-Apr-21	2.50	MTN-C	Morgan Stanley		450,000	
PFM		21-Apr-21	2.50	MTN-C	Morgan Stanley		450,000	
Wells Cap		21-Apr-21	2.50	MTN-C	Morgan Stanley		750,000	
Wells Cap		29-Apr-21	2.15	MTN-C	PNC Bank		525,000	
Wells Cap		29-Apr-21	2.15	MTN-C	PNC Bank		400,000	
PFM		5-May-21	2.25	MTN-C	American Express		450,000	
PFM		10-May-21	2.05	MTN-C	BB T Corp		450,000	
Wells Cap		17-May-21	2.65	MTN-C	Caterpillar Finl Mtn		700,000	
PFM		19-May-21	1.95	MTN-C	State Street Corp		245,000	
Wells Cap		21-May-21	3.25	MTN-C	Charles Schwab Corp		1,300,000	
PFM		24-May-21	4.13	MTN-C	US Bancorp		900,000	
Wells Cap		14-Jun-21	2.25	MTN-C	Fifth Third Bank		800,000	
PFM		15-Jun-21	1.67	ABS	Ford Credit Auto		31,111	
Wells Cap		1-Jul-21	2.39	Municipal	San Francisco		935,000	
PFM		14-Jul-21	1.13	U.S. Govt Agency	FHLB		950,000	
PFM		23-Jul-21	2.75	Supra-National Age	Intl Bk		1,800,000	
PFM		31-Jul-21	1.75	U.S. Govt Agency	US Treasury Bill		1,000,000	
Wells Cap		1-Aug-21	1.94	Municipal	San Diego Ca Community		500,000	
PFM		16-Aug-21	1.76	ABS	Hyundai Auto		81,075	
PFM		15-Sep-21	1.90	MTN-C	Oracle Corp		900,000	
PFM		20-Sep-21	1.85	MTN-C	Cisco Systems Inc		800,000	
Wells Cap		25-Sep-21	2.99	ABS	FHLMC		1,292,001	

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
March 31, 2020

PFM		6-Oct-21	1.70	MTN-C	Pepsico Inc	1,320,000
PFM		15-Oct-21	1.82	ABS	John Deere	92,622
PFM		31-Oct-21	1.25	U.S. Govt Agency	US Treasury Bill	290,000
PFM		31-Oct-21	2.00	U.S. Govt Agency	US Treasury Bill	1,520,000
PFM		15-Nov-21	2.00	ABS	Toyota Auto Recvs	125,149
PFM		30-Nov-21	1.88	U.S. Govt Agency	US Treasury Bill	1,200,000
PFM		30-Nov-21	1.75	U.S. Govt Agency	US Treasury Bill	2,000,000
PFM		15-Dec-21	1.75	ABS	Ally Auto	127,559
PFM		31-Dec-21	2.13	U.S. Govt Agency	US Treasury Bill	3,600,000
PFM		15-Jan-22	1.63	MTN-C	Comcast Corp	450,000
Wells Cap		24-Jan-22	4.50	MTN-C	JP Morgan	1,300,000
Wells Cap		25-Jan-22	2.79	ABS	FHLMC	1,583,381
Wells Cap		7-Feb-22	2.60	MTN-C	Bank of NY	1,000,000
PFM		12-Feb-22	2.38	MTN-C	Microsoft Corp	450,000
PFM		14-Feb-22	1.80	CD	Societe Generale CD	865,000
Wells Cap		19-Feb-22	3.17	MTN-C	Citibank	500,000
PFM		8-Mar-22	3.30	MTN-C	PNC Funding Corp	494,000
PFM		1-Apr-22	2.75	MTN-C	BB T Corp	450,000
Wells Cap		1-Apr-22	1.70	Municipal	Bay Area Ca	1,000,000
Wells Cap		5-Apr-22	1.88	U.S. Govt Agency	FNMA	920,000
Wells Cap		15-Apr-22	2.25	U.S. Govt Agency	US Treasury Bill	1,795,000
PFM		25-Apr-22	2.75	MTN-C	Citigroup	1,000,000
Wells Cap		25-Apr-22	2.40	MTN-C	National Rural	950,000
Wells Cap		26-Apr-22	3.00	MTN-C	Goldman Sachs	440,000
PFM		15-May-22	1.75	U.S. Govt Agency	US Treasury Bill	2,300,000
Wells Cap		15-May-22	3.28	Municipal	Univ Of CA	400,000
PFM		16-May-22	2.35	MTN-C	United Parcel	450,000
PFM		17-May-22	3.50	MTN-C	Bank of America	300,000
Wells Cap		18-May-22	2.30	MTN-C	Costco Wholesale	1,000,000
Wells Cap		23-May-22	2.65	MTN-C	US Bank NA	1,300,000
Wells Cap		25-May-22	2.20	MTN-C	Coca Cola Co	500,000
PFM		1-Jun-22	3.38	MTN-C	Blackrock Inc.	395,000
Wells Cap		14-Jun-22	1.88	U.S. Govt Agency	FFCB	2,600,000
Wells Cap		30-Jun-22	1.75	U.S. Govt Agency	US Treasury Bill	630,000
PFM		15-Jul-22	1.75	U.S. Govt Agency	US Treasury Bill	2,100,000
Wells Cap		15-Jul-22	1.75	U.S. Govt Agency	US Treasury Bill	900,000
Wells Cap		1-Aug-22	1.93	Municipal	Ohlone Ca Cmnty	800,000
Wells Cap		1-Aug-22	2.30	Municipal	Poway Ca Unif Sch	565,000
Wells Cap		15-Aug-22	1.50	U.S. Govt Agency	US Treasury Bill	580,000
PFM		25-Aug-22	2.31	ABS	FHLMC	390,000
PFM		26-Aug-22	1.85	CD	Nordea Bk Abb Ny CD	860,000
PFM		26-Aug-22	1.86	CD	Skandin Ens CD	845,000
PFM		31-Aug-22	1.88	U.S. Govt Agency	US Treasury Bill	1,280,000
Wells Cap		31-Aug-22	1.75	U.S. Govt Agency	US Treasury Bill	590,000
PFM		8-Sep-22	2.15	MTN-C	Toyota Motor	450,000
Wells Cap		9-Sep-22	2.00	U.S. Govt Agency	FHLB	300,000
Wells Cap		11-Sep-22	1.92	ABS	BMW Vehicle Owner	1,120,000
Wells Cap		11-Sep-22	1.70	MTN-C	Apple, Inc	600,000
Wells Cap		26-Sep-22	2.00	MTN-C	Paccar Financial Mtn	375,000
PFM		30-Sep-22	1.88	U.S. Govt Agency	US Treasury Bill	750,000
Wells Cap		5-Oct-22	2.00	U.S. Govt Agency	FNMA	950,000
Wells Cap		27-Oct-22	2.70	MTN-C	Citigroup	750,000
Wells Cap		31-Oct-22	2.00	U.S. Govt Agency	US Treasury Bill	3,150,000
Wells Cap		1-Nov-22	1.71	Municipal	Oregon ST	1,000,000
PFM		15-Nov-22	1.63	U.S. Govt Agency	US Treasury Bill	1,000,000
Wells Cap		15-Nov-22	1.63	U.S. Govt Agency	US Treasury Bill	700,000
Wells Cap		21-Nov-22	1.99	ABS	Volkswagon Auto	710,000
Wells Cap		30-Nov-22	2.00	U.S. Govt Agency	US Treasury Bill	2,770,000
PFM		2-Dec-22	2.04	CD	Dnb Bank Asa Ny CD	630,000
PFM		15-Dec-22	3.02	ABS	Toyota Auto	915,000
PFM		15-Dec-22	2.70	MTN-C	Intel Corp	415,000
Wells Cap		15-Dec-22	1.84	ABS	Mercedes Benz Auto	750,000
PFM		27-Dec-22	2.28	U.S. Govt Agency	FNMA	567,012
PFM		31-Dec-22	2.13	U.S. Govt Agency	US Treasury Bill	1,180,000
Wells Cap		10-Jan-23	2.05	MTN-C	American Honda Mtn	1,000,000
PFM		17-Jan-23	3.03	ABS	Mercedes Benz Auto	565,000
Wells Cap		20-Jan-23	2.49	ABS	Citibank Credit	1,700,000
PFM		31-Jan-23	1.75	U.S. Govt Agency	US Treasury Bill	1,200,000
Wells Cap		31-Jan-23	2.38	U.S. Govt Agency	US Treasury Bill	350,000
Wells Cap		28-Feb-23	2.63	U.S. Govt Agency	US Treasury Bill	2,100,000
PFM		15-Mar-23	2.25	MTN-C	3M Company	540,000
PFM		15-Mar-23	2.75	MTN-C	Berkshire Hathaway	370,000
Wells Cap		15-Mar-23	3.06	ABS	Nissan Auto	1,515,976
Wells Cap		15-Mar-23	3.18	ABS	Toyota Auto	1,400,000
Wells Cap		20-Mar-23	2.83	ABS	Honda Auto	1,135,000

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
March 31, 2020

Wells Cap		1-Apr-23	1.85	Municipal	San Diego County	1,275,000
Wells Cap		20-Apr-23	3.38	ABS	Verizon Owner Trust	600,000
PFM		24-Apr-23	2.88	MTN-C	Bank of America	640,000
PFM		15-May-23	1.75	U.S. Govt Agency	US Treasury Bill	630,000
PFM		15-May-23	1.75	U.S. Govt Agency	US Treasury Bill	1,100,000
PFM		15-May-23	1.75	U.S. Govt Agency	US Treasury Bill	1,000,000

PFM	3	16-May-23	3.02	ABS	GM Financial	415,000
PFM	4	18-May-23	2.70	MTN-C	JP Morgan	1,000,000
PFM	9	26-Jun-23	3.40	MTN-C	Walmart Inc.	800,000
Wells Cap	7	1-Jul-23	1.89	Municipal	San Francisco	1,070,000
Wells Cap	4	17-Jul-23	2.91	ABS	John Deere	400,000
PFM	3	24-Jul-23	2.91	MTN-C	Goldman Sachs	900,000
PFM	3	25-Jul-23	3.20	ABS	FHLMC	228,949
PFM	1	1-Aug-23	2.00	Municipal	Chaffey Ca	265,000
PFM	7	1-Aug-23	2.00	Municipal	San Diego Ca Community	165,000
PFM	8	1-Aug-23	1.97	Municipal	Tamalpais Ca Union	370,000
Wells Cap	9	31-Aug-23	2.75	U.S. Govt Agency	US Treasury Bill	1,240,000
PFM	7	1-Sep-23	2.13	Municipal	San Jose Ca Ref	765,000
PFM	8	20-Sep-23	3.45	MTN-C	Toyota Motor	550,000
PFM	9	30-Sep-23	1.38	U.S. Govt Agency	US Treasury Bill	1,150,000
PFM	0	10-Oct-23	3.63	MTN-C	American Honda Mtn	395,000
PFM	9	31-Oct-23	1.63	U.S. Govt Agency	US Treasury Bill	4,280,000
Wells Cap	9	31-Oct-23	3.00	U.S. Govt Agency	US Treasury Bill	550,000
PFM	1	15-Nov-23	2.51	ABS	Capital One Prime	480,000
Wells Cap	1	15-Nov-23	2.51	ABS	Capital One Prime	900,000
Wells Cap	9	30-Nov-23	2.13	U.S. Govt Agency	US Treasury Bill	835,000
Wells Cap	9	30-Nov-23	2.13	U.S. Govt Agency	US Treasury Bill	700,000
Wells Cap	0	15-Dec-23	2.99	ABS	American Express	1,410,000
Wells Cap	9	20-Dec-23	2.33	ABS	Verizon Owner Trust	600,000
PFM	9	31-Dec-23	2.25	U.S. Govt Agency	US Treasury Bill	2,195,000
Wells Cap	6	1-Jan-24	2.12	Municipal	New York ST	585,000
PFM	6	23-Jan-24	3.50	MTN-C	PNC Financial	395,000
Wells Cap	9	31-Jan-24	2.50	U.S. Govt Agency	US Treasury Bill	3,575,000
PFM	3	5-Feb-24	2.50	U.S. Govt Agency	FNMA	1,110,000
PFM	5	6-Feb-24	2.88	MTN-C	Microsoft Corp	410,000
PFM	3	13-Feb-24	2.50	U.S. Govt Agency	FHLB	1,220,000
PFM	9	29-Feb-24	2.38	U.S. Govt Agency	US Treasury Bill	2,110,000
Wells Cap	9	29-Feb-24	2.38	U.S. Govt Agency	US Treasury Bill	2,825,000
PFM	5	7-Mar-24	2.90	MTN-C	Merck Co Inc.	405,000
PFM	7	15-Mar-24	2.95	MTN-C	Pfizer Inc.	465,000
Wells Cap	5	15-Mar-24	1.94	ABS	Mercedes Benz Auto	810,000
PFM	3	25-Mar-24	3.35	U.S. Govt Agency	FNMA	460,000
PFM	5	1-Apr-24	3.38	MTN-C	Mastercard Inc.	395,000
PFM	9	30-Apr-24	2.00	U.S. Govt Agency	US Treasury Bill	1,285,000
Wells Cap	9	30-Apr-24	2.25	U.S. Govt Agency	US Treasury Bill	500,000
PFM	9	15-May-24	2.50	U.S. Govt Agency	US Treasury Bill	425,000
PFM	9	15-May-24	2.50	U.S. Govt Agency	US Treasury Bill	950,000
Wells Cap	9	31-May-24	2.00	U.S. Govt Agency	US Treasury Bill	4,350,000
Wells Cap	9	31-May-24	2.00	U.S. Govt Agency	US Treasury Bill	500,000
Wells Cap	9	30-Jun-24	1.75	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	0	1-Jul-24	1.96	Municipal	Arizona ST	675,000
PFM	9	30-Jul-24	2.40	MTN-C	US Bancorp	415,000
Wells Cap	9	31-Jul-24	1.75	U.S. Govt Agency	US Treasury Bill	1,850,000
PFM	7	1-Aug-24	2.05	Municipal	San Diego Ca Community	80,000
PFM	8	1-Aug-24	2.02	Municipal	Tamalpais Ca Union	305,000
PFM	1	15-Aug-24	1.72	ABS	Capital One Multi	1,600,000
Wells Cap	3	16-Aug-24	2.02	MTN-C	Exxon Mobil	1,320,000
PFM	2	30-Aug-24	1.75	MTN-C	Walt Disney Co	780,000
PFM	1	6-Sep-24	1.75	MTN-C	Coca Cola Co	425,000
PFM	2	15-Oct-24	1.89	MTN-C	Discover Card	615,000
PFM	0	24-Oct-24	2.10	MTN-C	Bank of NY	150,000
PFM	9	31-Oct-24	1.50	U.S. Govt Agency	US Treasury Bill	1,500,000
Wells Cap	9	31-Oct-24	1.50	U.S. Govt Agency	US Treasury Bill	650,000
PFM	1	8-Nov-24	2.15	MTN-C	Caterpillar Finl Mtn	850,000
Wells Cap	1	8-Nov-24	2.15	MTN-C	Caterpillar Finl Mtn	600,000
Wells Cap	1	15-Nov-24	1.60	ABS	Capital One Prime	1,000,000
PFM	9	30-Nov-24	1.50	U.S. Govt Agency	US Treasury Bill	1,000,000
Wells Cap	9	30-Nov-24	1.50	U.S. Govt Agency	US Treasury Bill	700,000
Wells Cap	0	6-Dec-24	2.15	MTN-C	Branch Banking Trust	1,300,000
Wells Cap	9	31-Dec-24	1.75	U.S. Govt Agency	US Treasury Bill	1,000,000
PFM	3	7-Jan-25	1.63	U.S. Govt Agency	FNMA	1,510,000
Wells Cap	2	9-Jan-25	2.05	ABS	John Deere	500,000
PFM	3	12-Feb-25	1.50	U.S. Govt Agency	FHLMC	1,000,000
PFM	8	13-Feb-25	1.80	MTN-C	Toyota Motor	420,000
						$ 230,226,562

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
March 31, 2020

	Maturity Date	Yield	Investment Type		G/L Account	Amount	Total
Self-insurance trust							
Wells Cap			Money market		110900	594,742	
Wells Cap			Fixed income - L/T		152300	4,191,611	
							4,786,353
2012 revenue bonds							
US Bank			Principal/Interest payment fund		142112	3,185,610	
							3,185,610
2015A revenue bonds							
US Bank			Principal/Interest payment fund		142115	1,143,172	
							1,143,172
2015B revenue bonds							
US Bank			Principal/Interest payment fund		142116	1,385,394	
US Bank			Project Fund		152442	28,791,637	
							30,177,032
2017A/B revenue bonds							
US Bank			Principal/Interest payment fund		142117	735,870	
							735,870
2017C revenue bonds							
US Bank			Principal/Interest payment fund		142118	1,072,982	
							1,072,982
2020 revenue bonds							
Signature Bank			Project Fund		152446	10,936,105	
							10,936,105
2014 general obligation bonds							
LAIF			Interest Payment fund		152440	861,152	
							861,152
Operations							
Wells Fargo Bank	(Checking)	0.50	Checking		100000	(1,182,616)	
Wells Fargo Bank	(Savings)	0.50	Checking		100500	8,456,830	
						7,274,213	
Payroll							
Wells Fargo Bank	(Checking)	0.50	Checking		100100	(23,306)	
Wells Fargo Bank	(Checking)	0.50	Checking	Benesyst	100201	89,419	
Wells Fargo Bank			Checking	Resident Fund	100205	3,684	
Bancorp	(Checking)		Checking		100202	18,015	
						87,813	
							7,362,026
					Total investments		**$ 290,486,863**

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
March 31, 2020

Kaweah Delta Medical Foundation

Wells Fargo Bank		Checking	100050		**$ 2,935,029**

Sequoia Regional Cancer Center

Wells Fargo Bank	(Medical)	Checking	100535	$ 335,851	
Wells Fargo Bank	(Radiation)	Checking	100530	-	
					$ 335,851

Kaweah Delta Hospital Foundation

VCB Checking		Investments	100501	$ 319,329	
Various		S/T Investments	142200	5,650,200	
Various		L/T Investments	142300	10,869,176	
Various		Unrealized G/L	142400	(221,730)	
					$ 16,616,975

Summary of board designated funds:

Plant fund:

Uncommitted plant funds		$ 173,157,275	142100
Committed for capital		20,389,658	142100
		193,546,933	
GO Bond reserve - L/T		2,055,720	142100
401k Matching		11,057,613	142100
Cost report settlement - current	2,135,384		142104
Cost report settlement - L/T	1,312,727		142100
		3,448,111	
Development fund/Memorial fund		104,184	112300
Workers compensation - current	5,390,000		112900
Workers compensation - L/T	14,624,000		113900
		20,014,000	
		$ 230,226,562	

Investment summary by institution:

	Total Investments	%	Trust Accounts	Surplus Funds	%
Bancorp	$ 18,015	0.0%		18,015	0.0%
CAMP	372,798	0.1%		372,798	0.2%
Local Agency Investment Fund (LAIF)	54,679,426	18.8%		54,679,426	23.0%
Local Agency Investment Fund (LAIF) - GOB Tax Rev	861,152	0.3%	861,152	-	0.0%
Wells Cap	92,472,968	31.8%	4,786,353	87,686,615	36.9%
PFM	84,487,723	29.1%		84,487,723	35.6%
Torrey Pines Bank	3,000,000	1.0%		3,000,000	1.3%
Wells Fargo Bank	7,344,011	2.5%		7,344,011	3.1%
Signature Bank	10,936,105	3.8%	10,936,105		0.0%
US Bank	36,314,666	12.5%	36,314,666		0.0%
Total investments	$ 290,486,863	100.0%	$ 52,898,276	$ 237,588,588	100.0%

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
March 31, 2020

Investment summary of surplus funds by type:			**Investment Limitations**	
Negotiable and other certificates of deposit	$	9,630,000	$ 71,277,000	(30%)
Checking accounts		7,362,026		
Local Agency Investment Fund (LAIF)		54,679,426	65,000,000	
CAMP		372,798		
Medium-term notes (corporate) (MTN-C)		44,359,000	71,277,000	(30%)
U.S. government agency		82,472,012		
Municipal securities		13,735,000		
Money market accounts		508,279	47,518,000	(20%)
Asset Backed Securties		22,670,047	47,518,000	(20%)
Supra-National Agency		1,800,000	71,277,000	(30%)
	$	237,588,588		

Return on investment:

Current month	**1.95%**
Year-to-date	**2.30%**
Prospective	**2.08%**
LAIF (year-to-date)	**2.11%**
Budget	**2.28%**

Fair market value disclosure for the quarter ended March 31, 2020 (District only):	**Quarter-to-date**	**Year-to-date**
Difference between fair value of investments and amortized cost (balance sheet effect)	N/A	$ 3,312,369
Change in unrealized gain (loss) on investments (income statement effect)	$ (2,892,898)	$ (3,316,683)

Investment summary of CDs:

Credit Agricole CD	$	825,000
Dnb Bank Asa Ny CD		630,000
Nordea Bk Abb Ny CD		860,000
Societe Generale CD		865,000
Skandin Ens CD		845,000
Sumito Mtsu		805,000
Swedbank		1,800,000
Torrey Pines Bank		3,000,000
	$	9,630,000

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
March 31, 2020

Investment summary of asset backed securities:

Ally Auto	$	127,559
American Express		1,410,000
BMW Vehicle Owner		1,120,000
Capital One Multi		1,600,000
Capital One Prime		2,380,000
Citibank Credit		1,700,000
FHLMC		3,494,331
Ford Credit Auto		31,111
GM Financial		415,000
Honda Auto		1,135,000
Hyundai Auto		81,075
John Deere		992,622
Mercedes Benz Auto		2,125,000
Nissan Auto		1,515,976
Smart Trust		184,023
Toyota Auto		2,315,000
Toyota Auto Recvs		133,350
Verizon Owner Trust		1,200,000
Volkswagon Auto		710,000
	$	22,670,047

Investment summary of medium-term notes (corporate):

3M Company	$	540,000.00
American Express		450,000
American Honda Mtn		1,395,000
Apple, Inc		1,215,000
Bank of America		1,975,000
Bank of NY		2,050,000
BB T Corp		900,000
Berkshire Hathaway		370,000
Blackrock Inc.		395,000
Branch Banking Trust		1,300,000
Caterpillar Finl Mtn		2,150,000
Charles Schwab Corp		1,300,000
Cisco Systems Inc		800,000
Citibank		500,000
Citigroup		1,750,000
Coca Cola Co		925,000
Comcast Corp		450,000
Costco Wholesale		1,000,000
Discover Card		615,000
Exxon Mobil		1,320,000
Fifth Third Bank		800,000
Goldman Sachs		1,340,000
IBM		900,000
Intel Corp		415,000
JP Morgan		2,300,000
Mastercard Inc.		395,000
Merck Co Inc.		405,000
Microsoft Corp		860,000
Morgan Stanley		1,650,000
National Rural		950,000
Oracle Corp		900,000
Paccar Financial Mtn		375,000
Pepsico Inc		1,320,000
Pfizer Inc.		465,000
PNC Bank		925,000
PNC Financial		395,000
PNC Funding Corp		494,000
State Street Corp		245,000
Texas Instruments		810,000
Toyota Motor		2,370,000
United Parcel		450,000
US Bancorp		1,315,000
US Bank NA		1,300,000
Walmart Inc.		800,000
Walt Disney Co		780,000
	$	44,359,000

KAWEAH DELTA HEALTH CARE DISTRICT
SUMMARY OF FUNDS
March 31, 2020

Investment summary of U.S. government agency:

Federal National Mortgage Association (FNMA)	$	5,517,012
Federal Home Loan Bank (FHLB)		2,470,000
Federal Farmers Credit Bank (FFCB)		2,600,000
Federal Home Loan Mortgage Corp (FHLMC)		1,000,000
US Treasury Bill		70,885,000
	$	82,472,012

Investment summary of municipal securities:

Bay Area Ca	$	1,000,000.00
Arizona ST		675,000
California ST		530,000
California ST High		1,250,000
Chaffey Ca		265,000
New York ST		585,000
Ohlone Ca Cmnty		800,000
Oregon ST		1,000,000
Poway Ca Unif Sch		565,000
Sacramento Ca Public		1,200,000
San Diego Ca Community		745,000
San Diego County		1,275,000
San Francisco		2,005,000
San Jose Ca Ref		765,000
Tamalpais Ca Union		675,000
Univ Of CA		400,000
	$	13,735,000

Investment summary of Supra-National Agency:

Intl Bk	$	1,800,000
	$	1,800,000

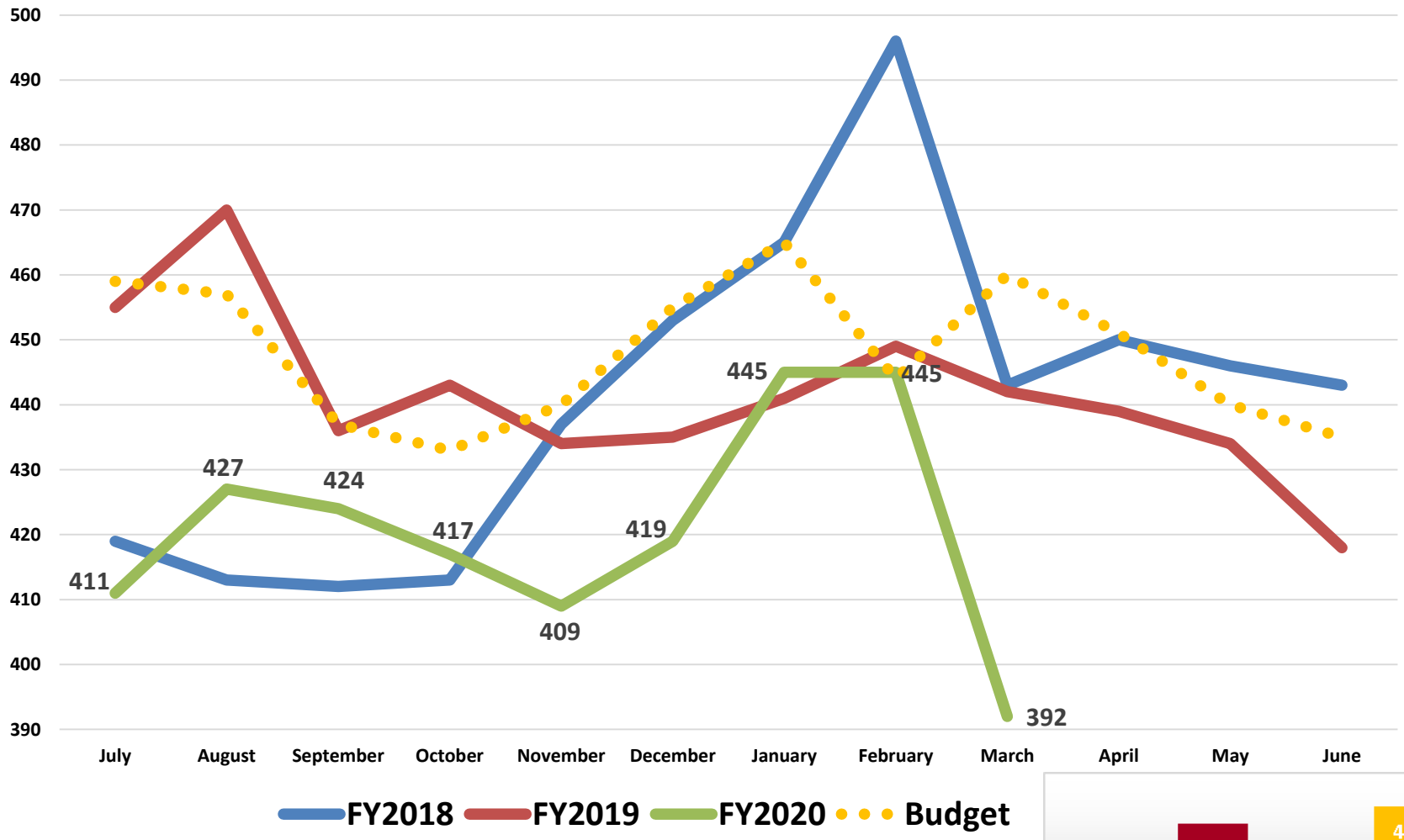
MORE THAN MEDICINE. LIFE.

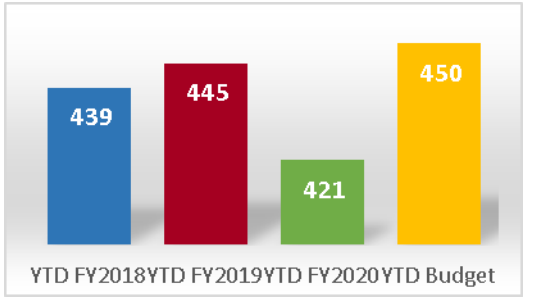
Statistical Report

April 27, 2020

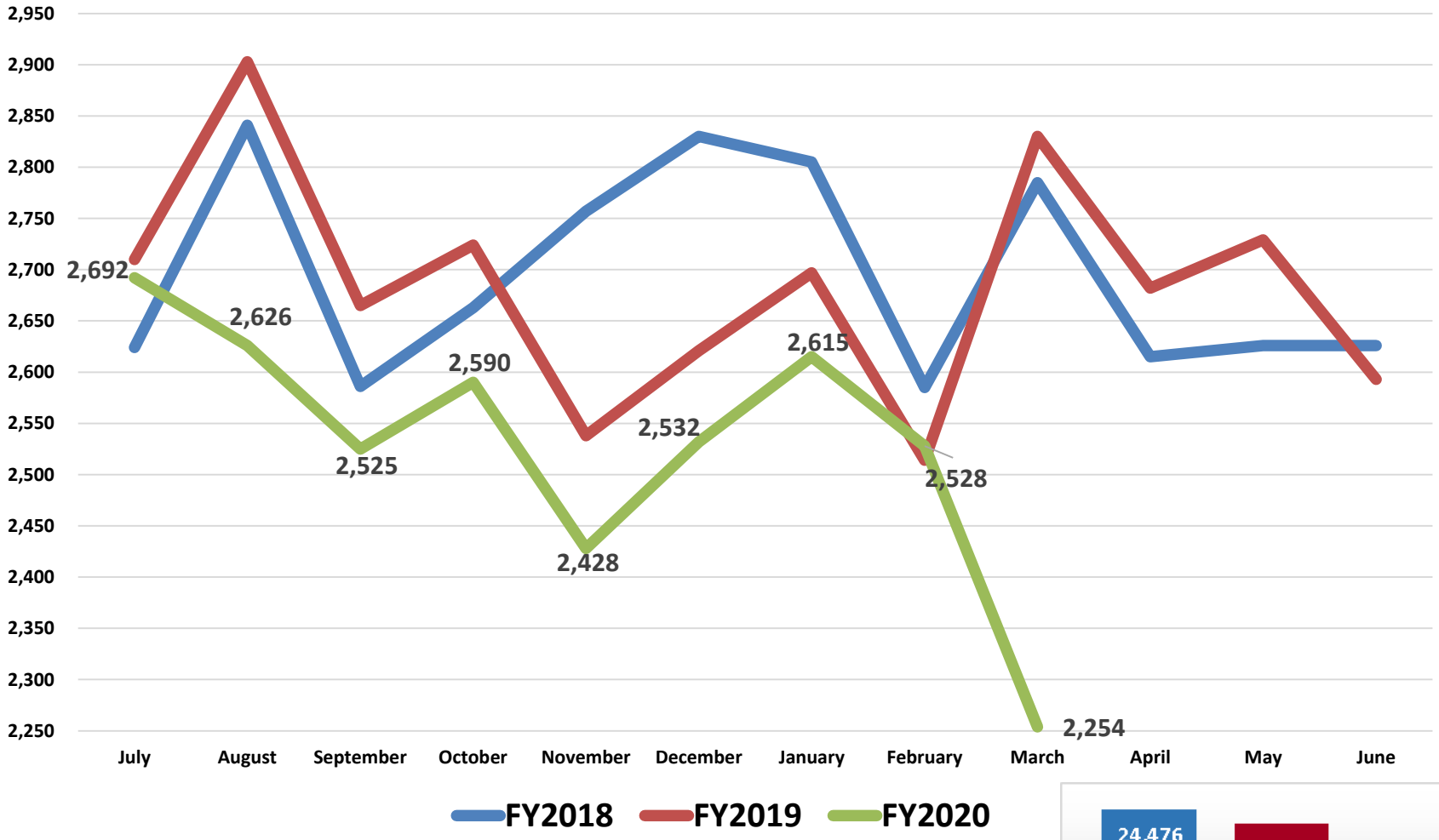
Kaweah Delta
HEALTH CARE DISTRICT

Average Daily Census





Admissions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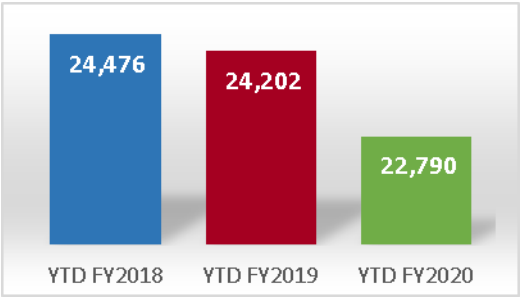
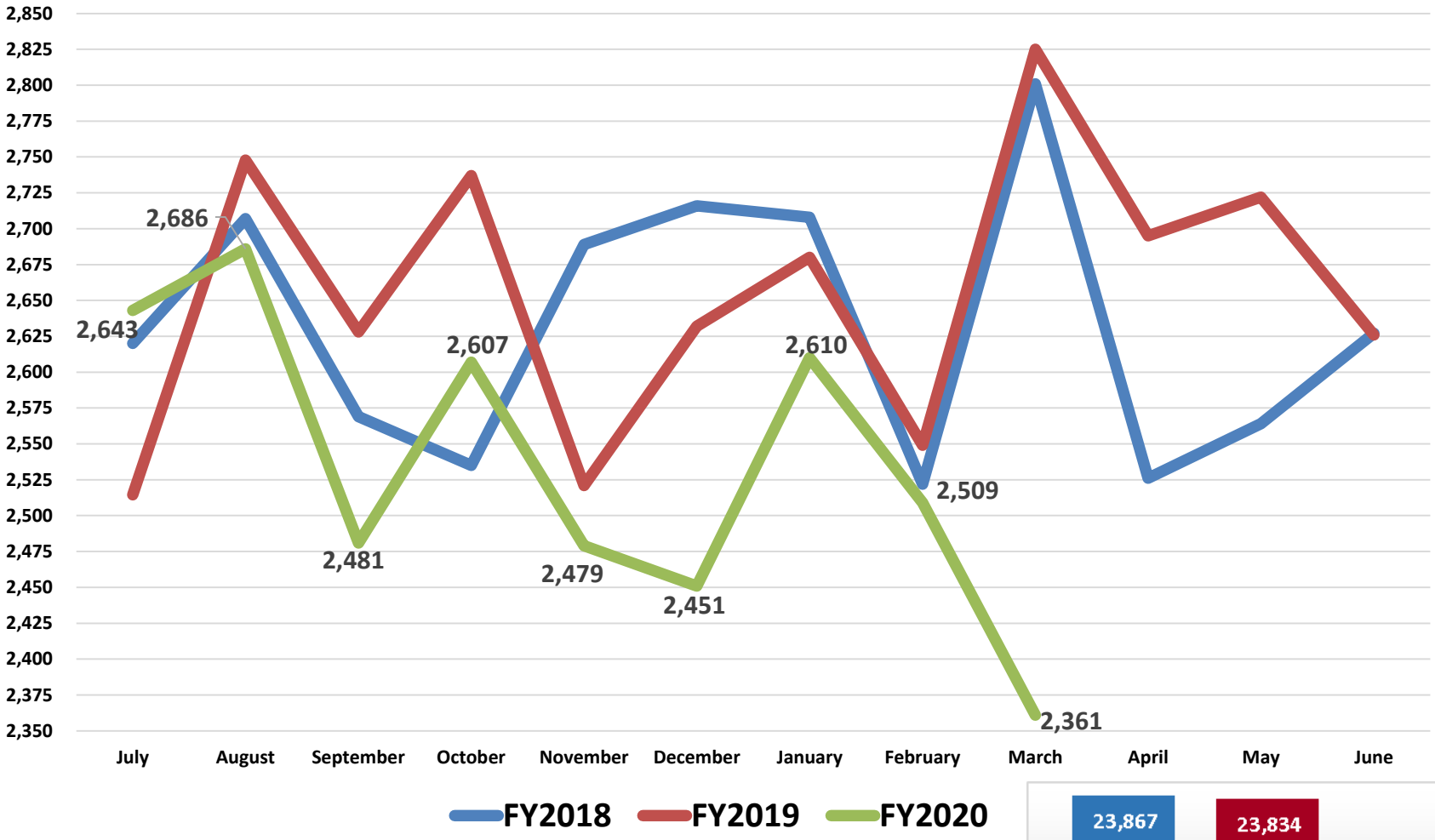
2,350
2,300
2,250
2,692
2,626
2,525
2,590
2,428
2,532
2,615
2,528
2,254
July
August
September
October
November
December
January
February
March
April
May
June
FY2018
FY2019
FY2020


24,476
24,202
22,790
YTD FY2018
YTD FY2019
YTD FY2020

Discharges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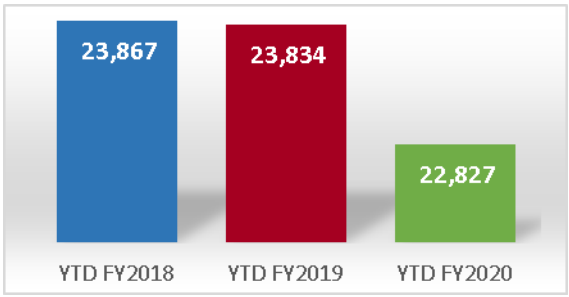
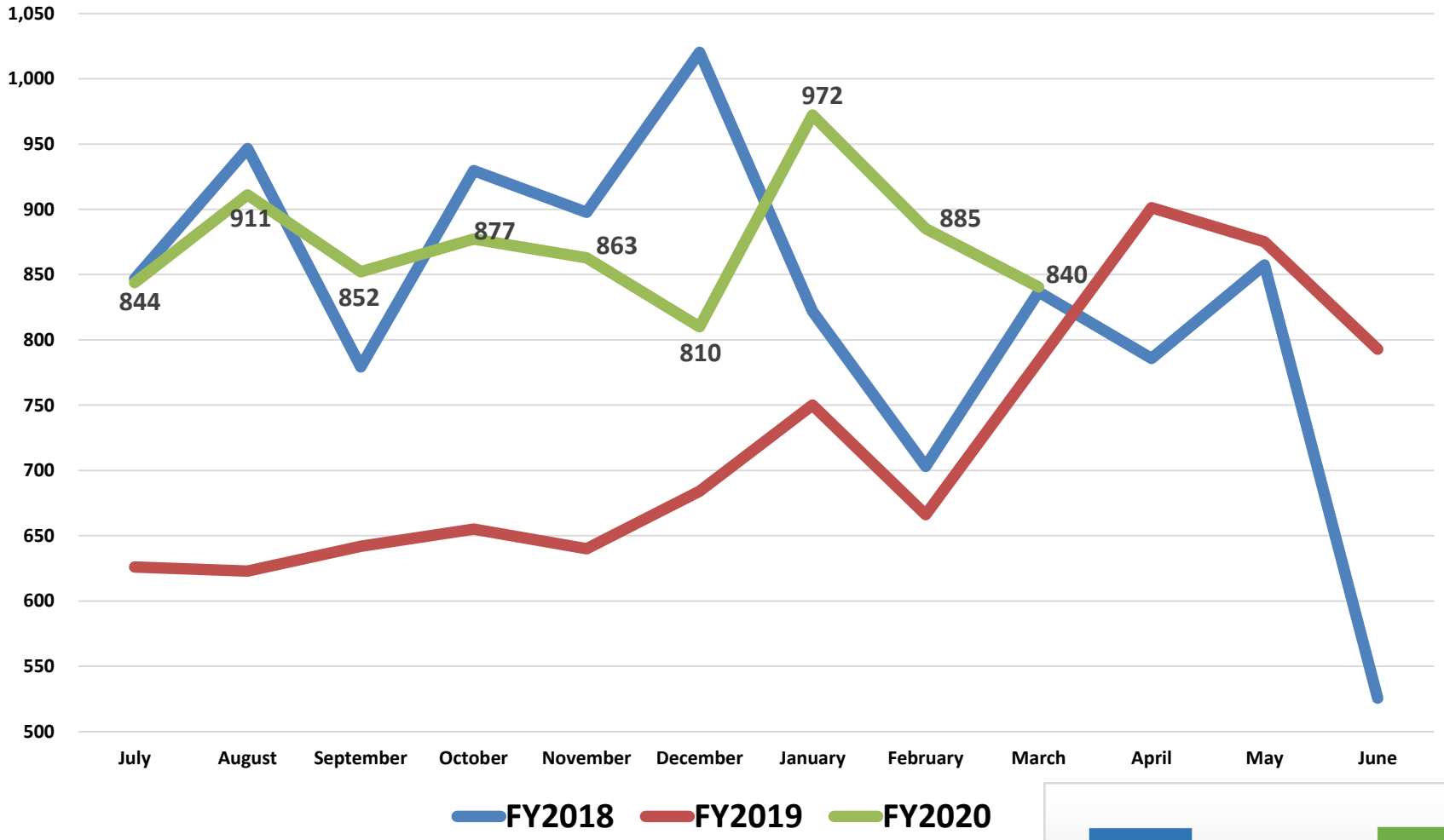
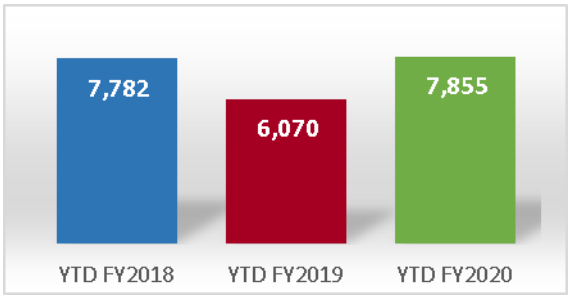
2,400
2,375
2,350
2,686
2,643
2,481
2,607
2,479
2,451
2,610
2,509
2,361
July
August
September
October
November
December
January
February
March
April
May
June
FY2018
FY2019
FY2020

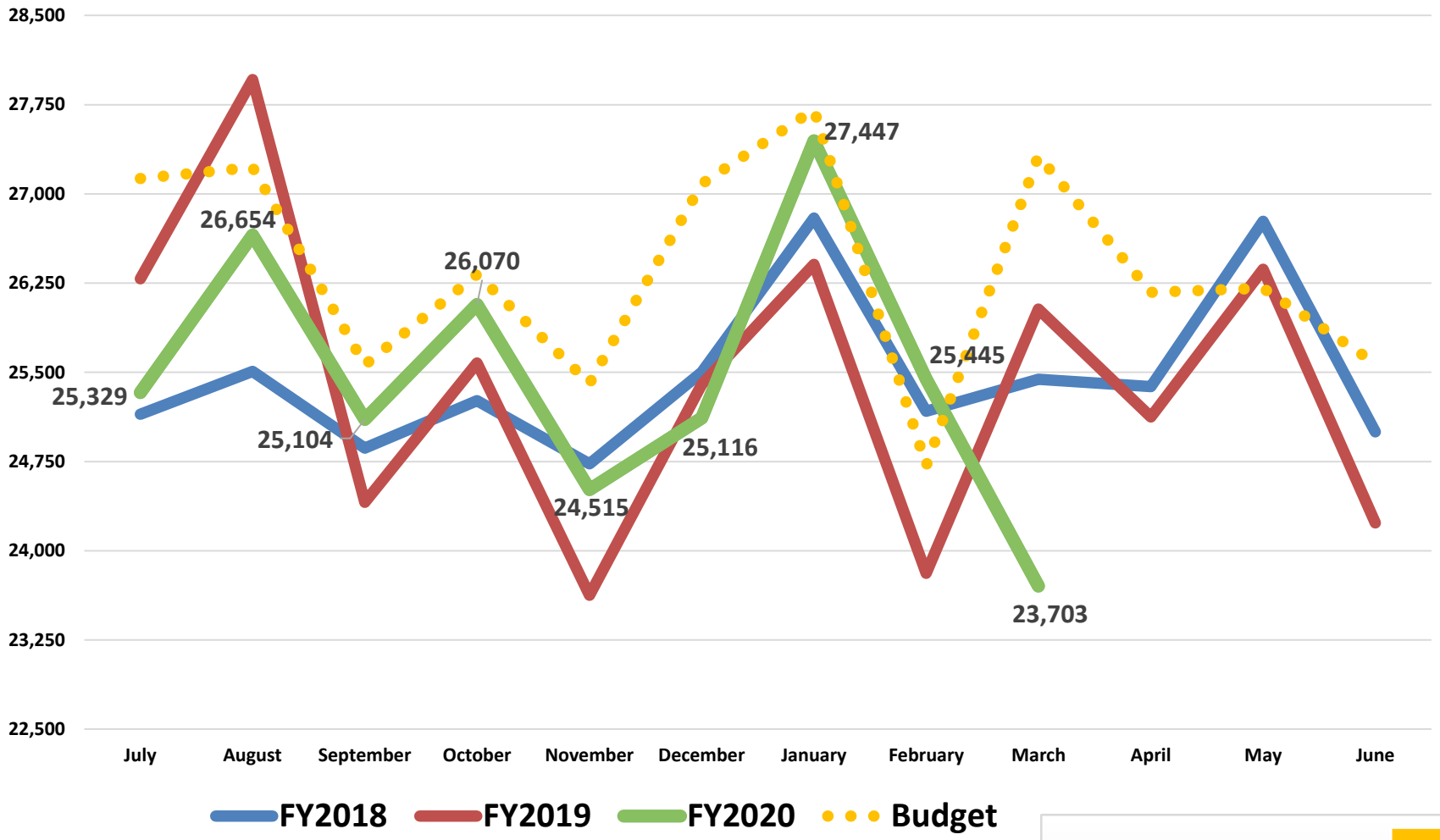

23,867
23,834
22,827
YTD FY2018
YTD FY2019
YTD FY2020

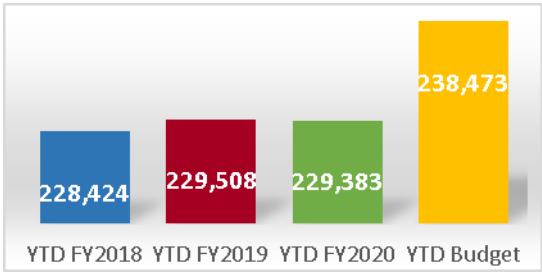
Observation Days



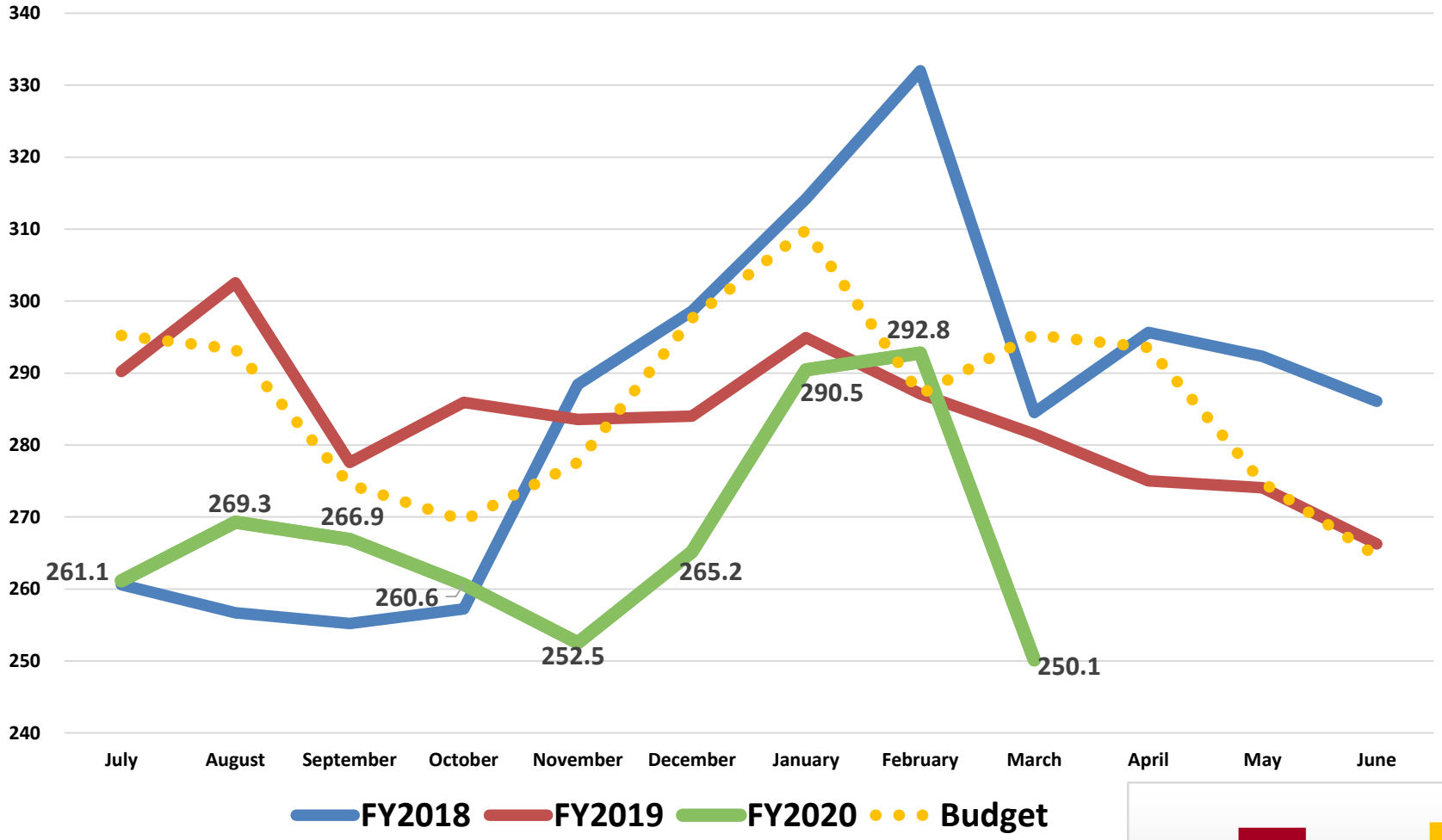


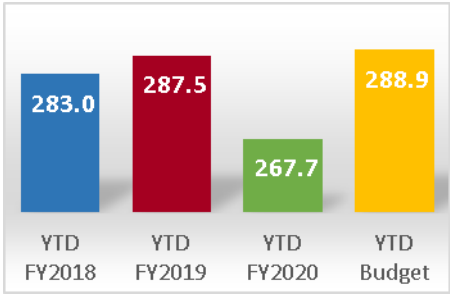
Adjusted Patient Days



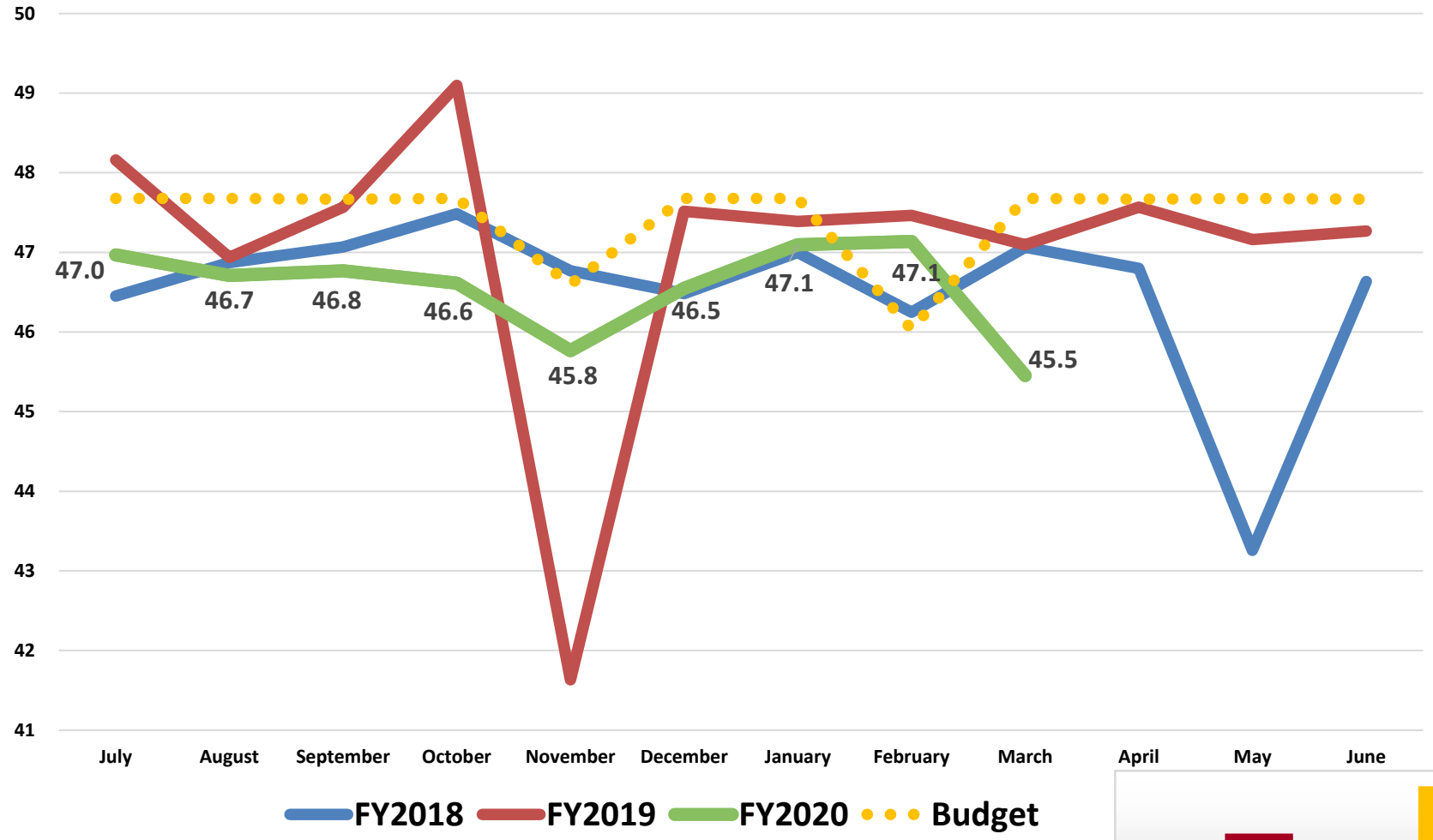


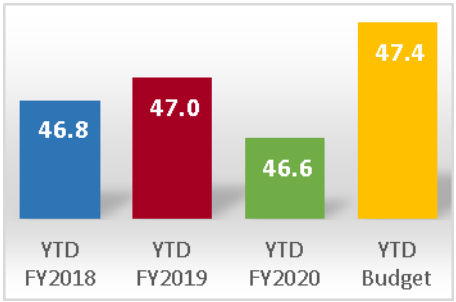
Medical Center – Avg. Patients Per Day



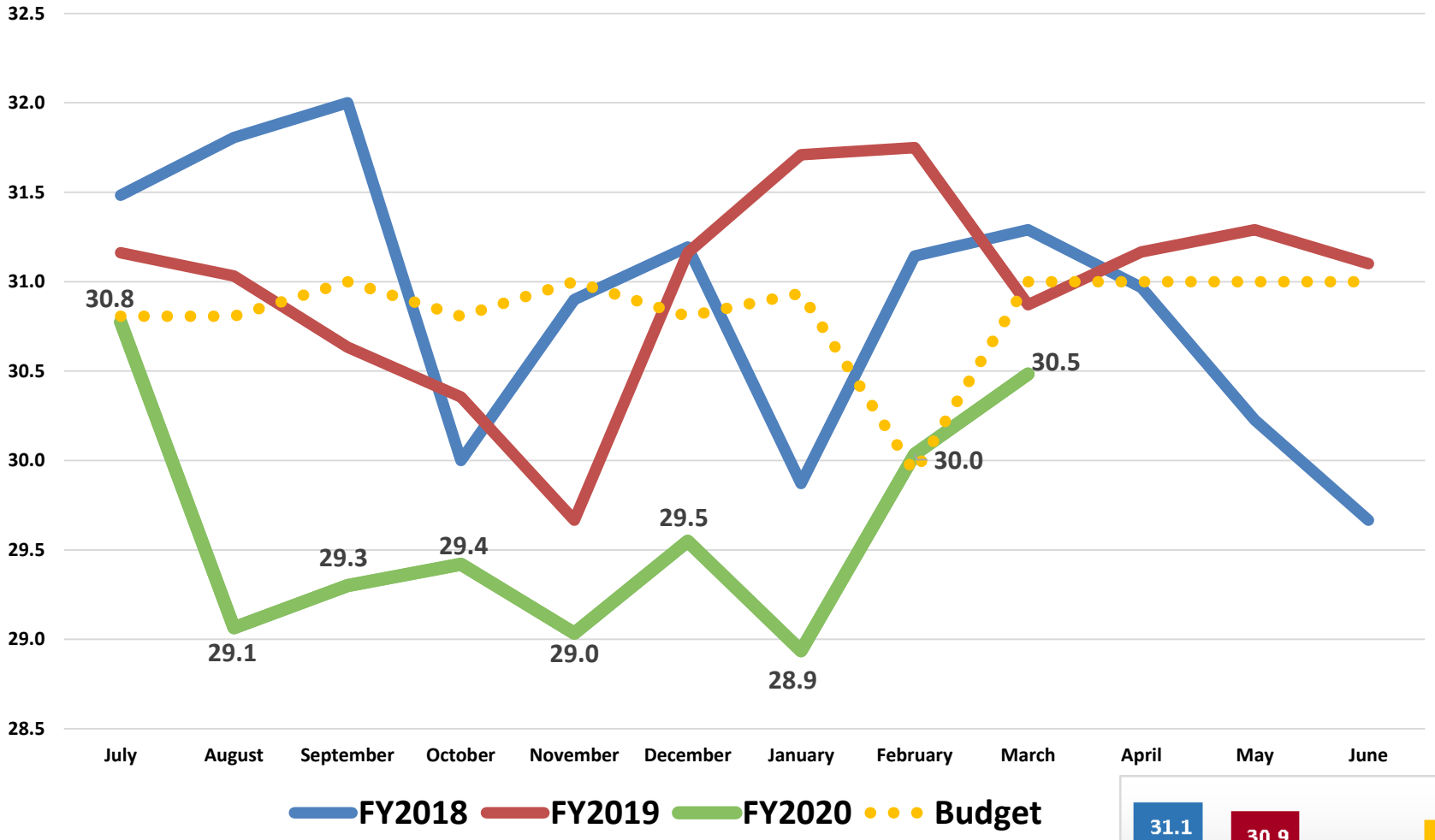


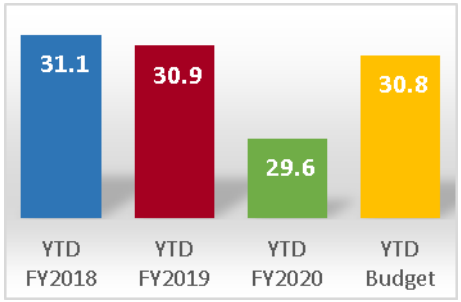
Acute I/P Psych - Avg. Patients Per Day



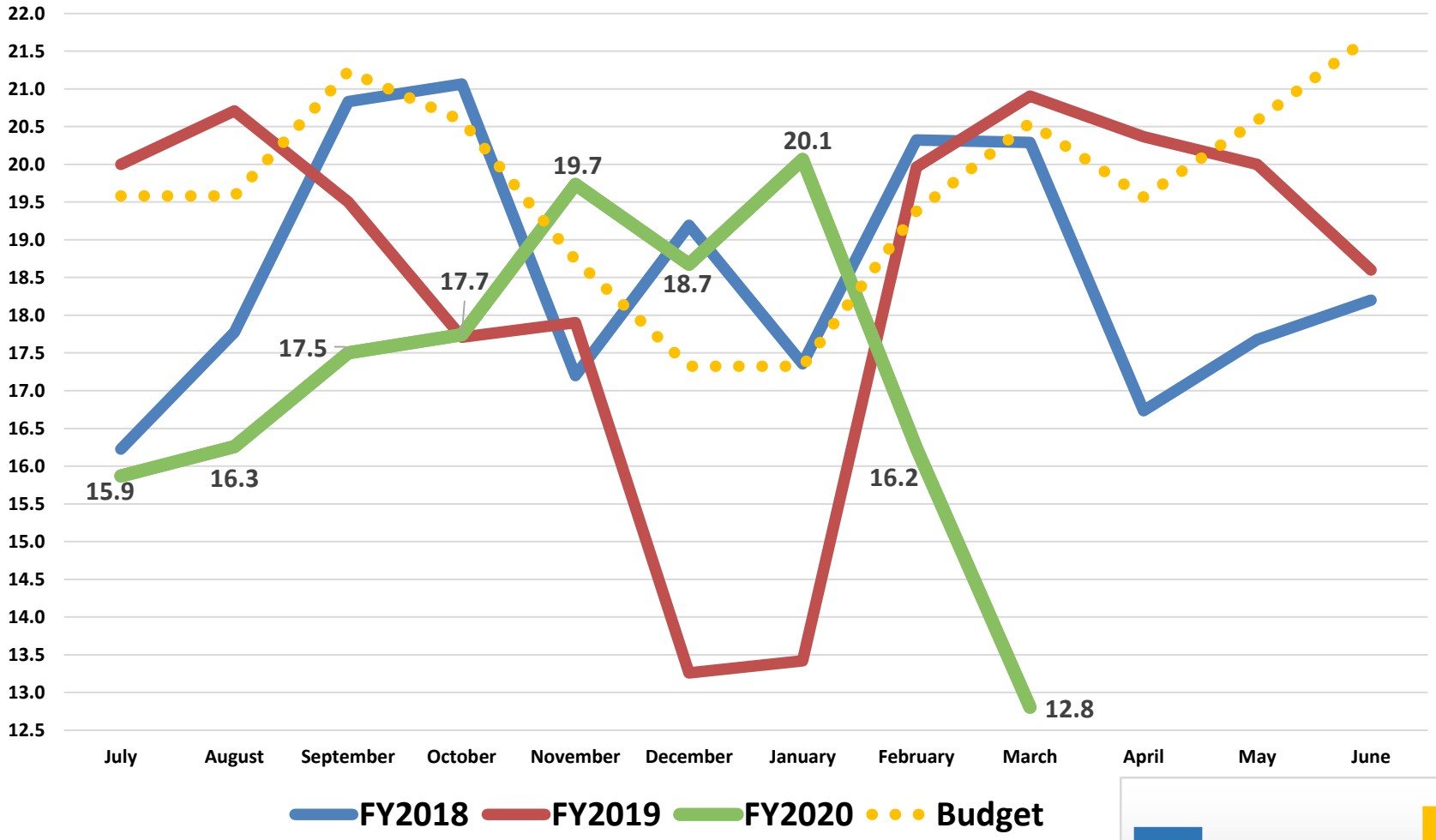


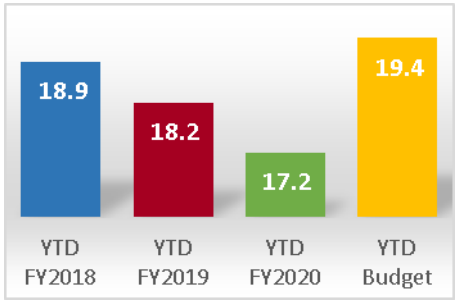
Sub-Acute - Avg. Patients Per Day



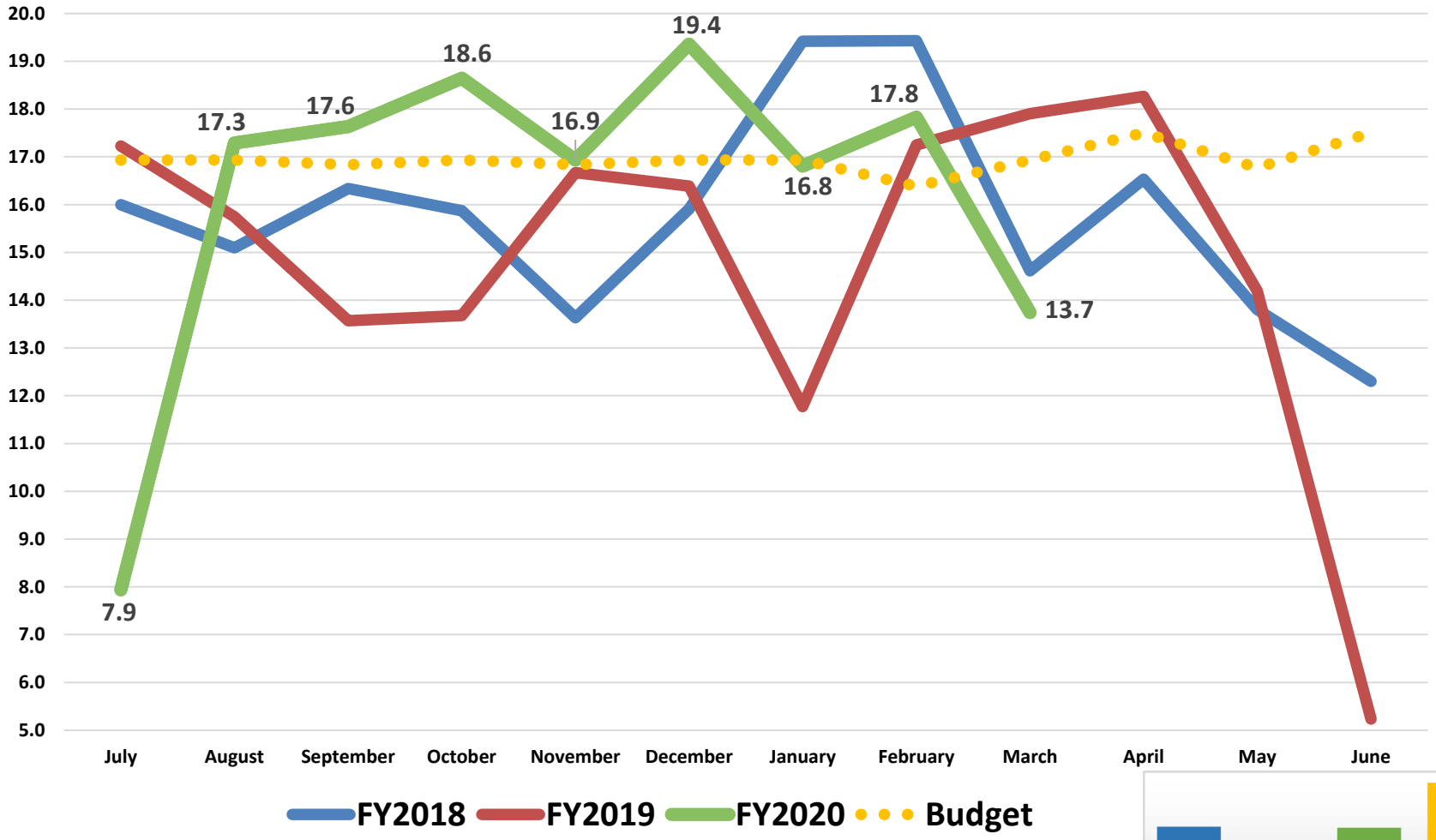


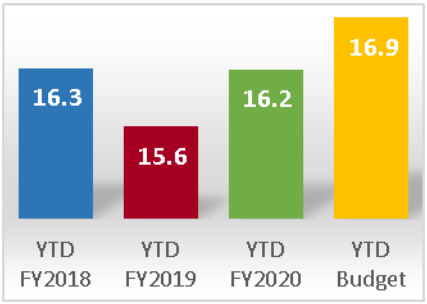
Rehabilitation Hospital - Avg. Patients Per Day



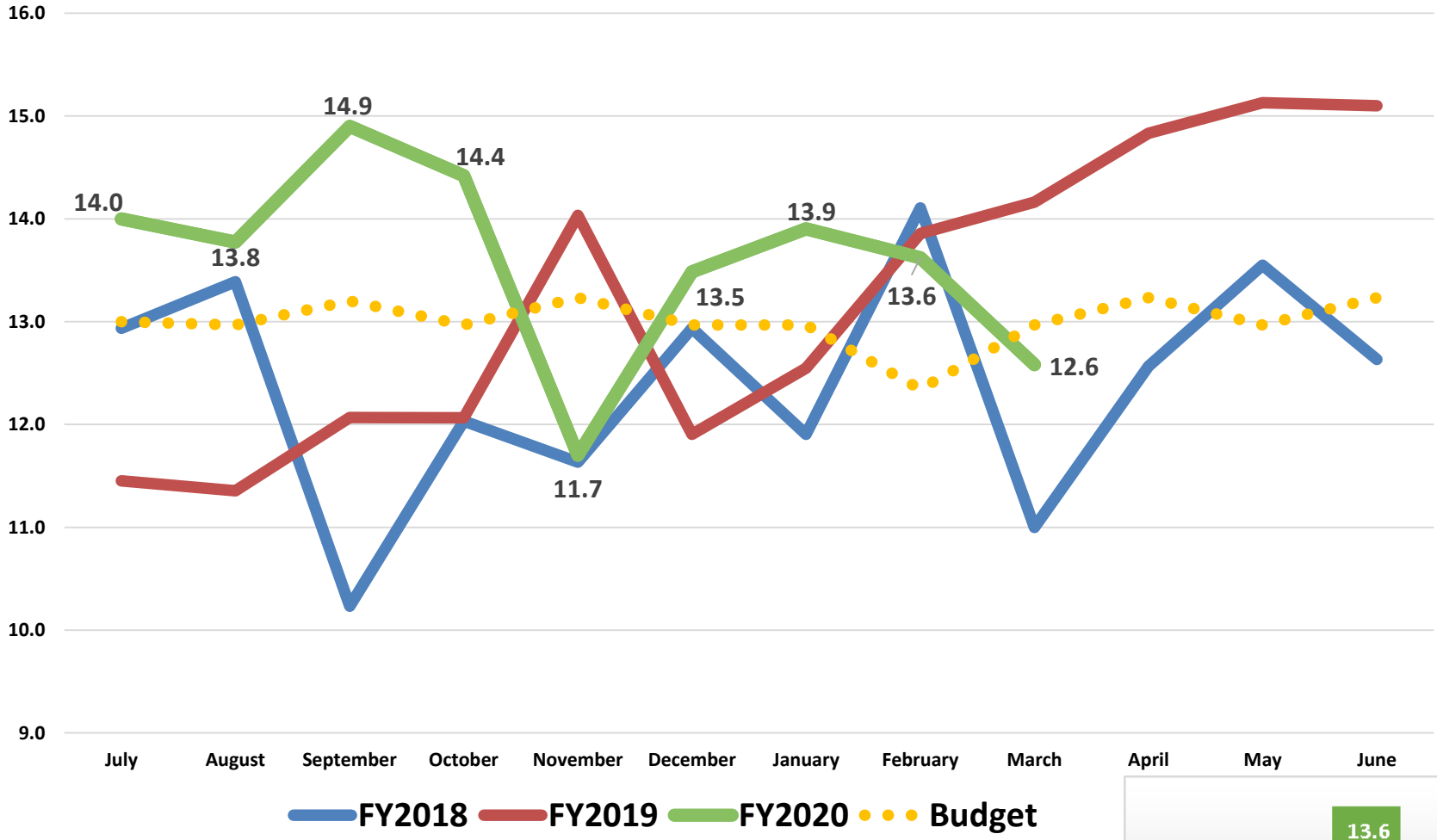


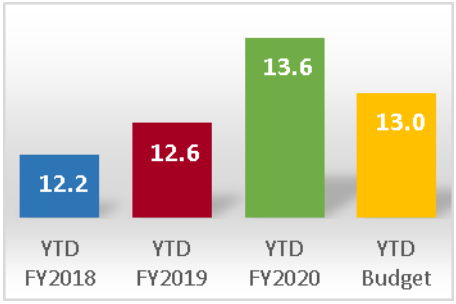
Transitional Care Services (TCS) - Avg. Patients Per Day



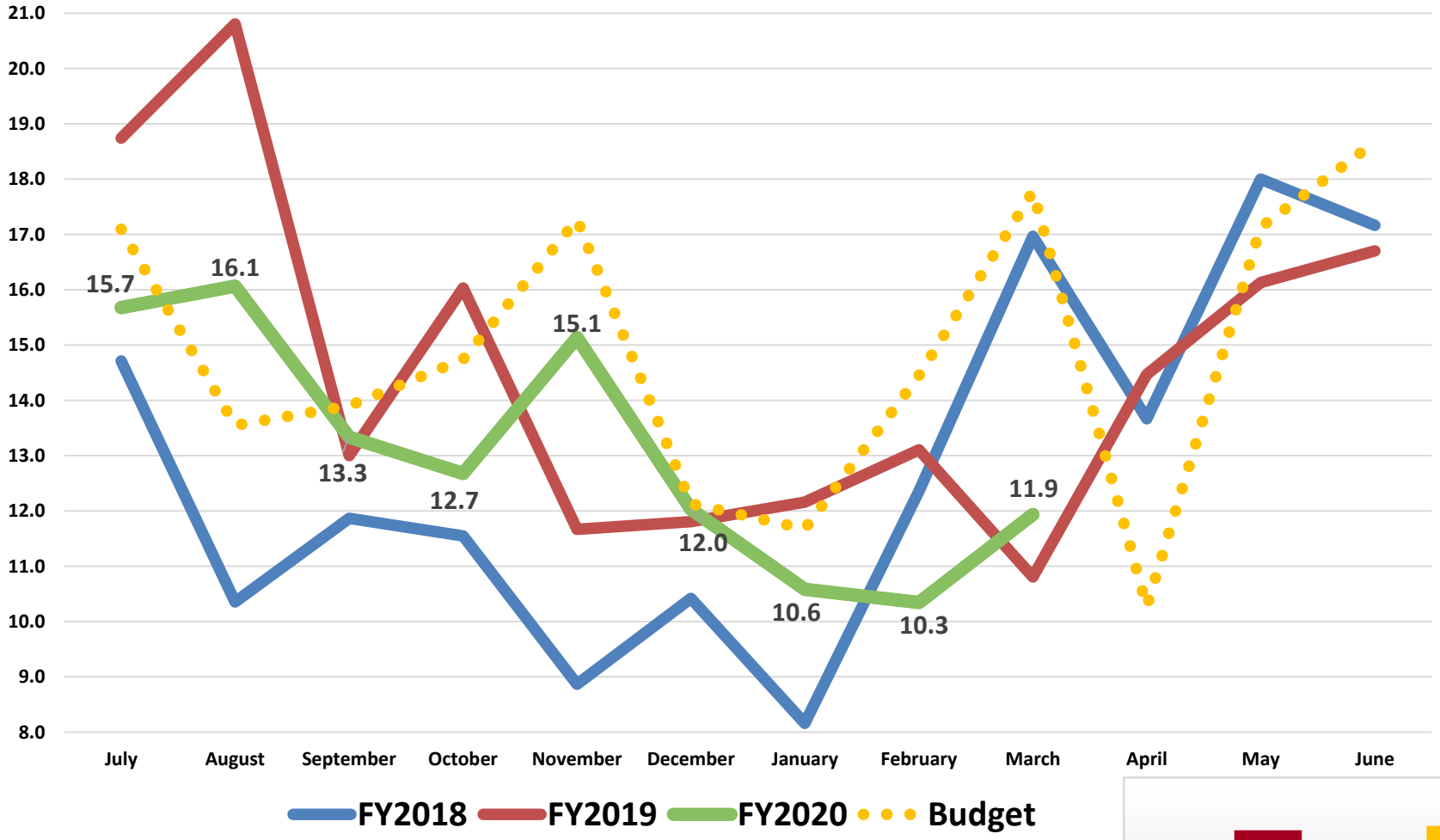


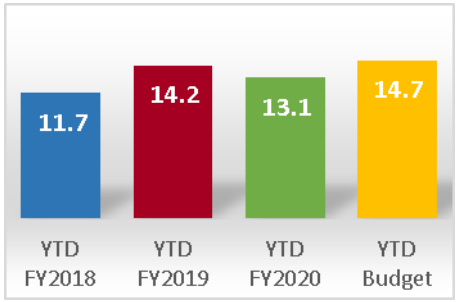
TCS Ortho - Avg. Patients Per Day



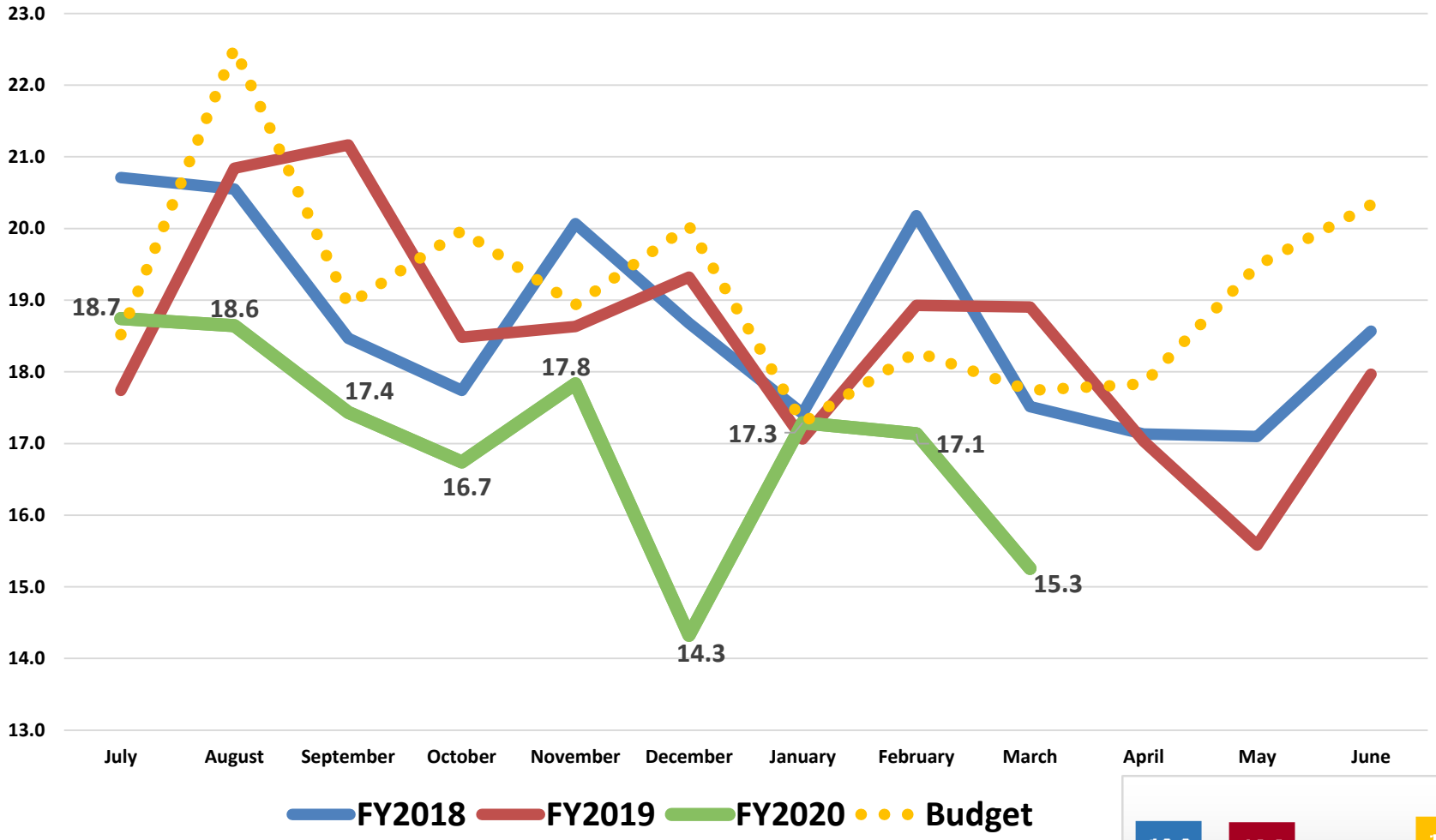


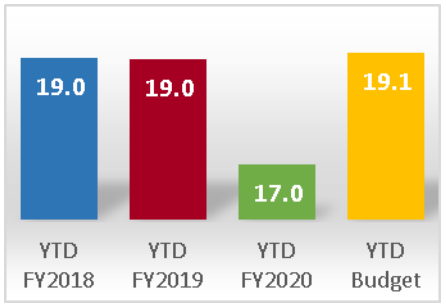
NICU - Avg. Patients Per Day



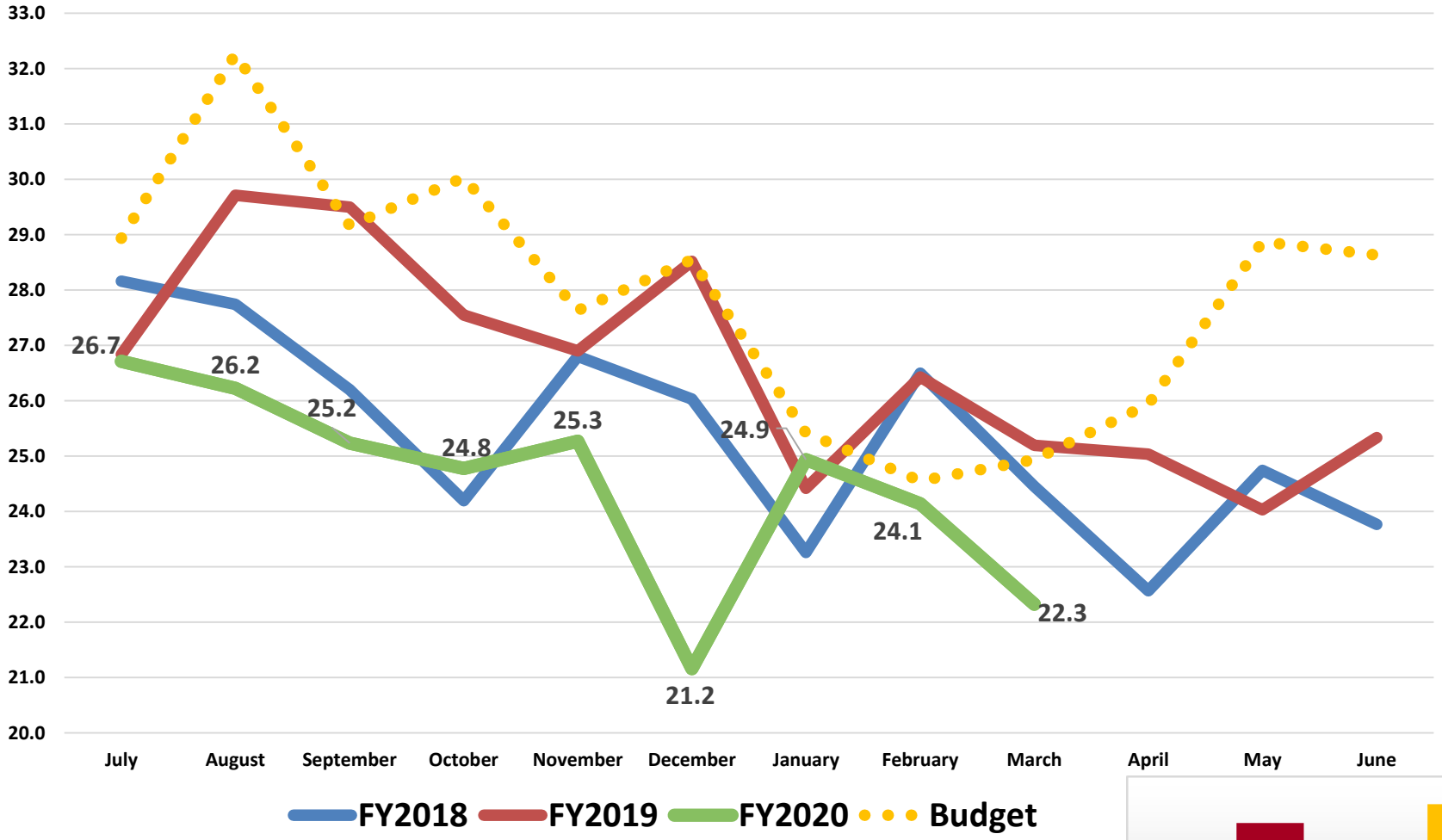


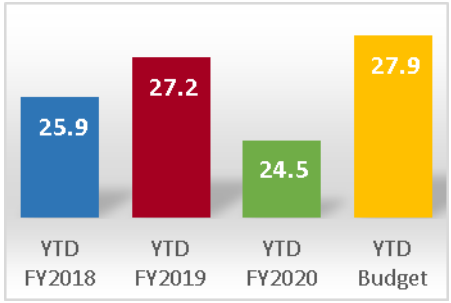
Nursery - Avg. Patients Per Day



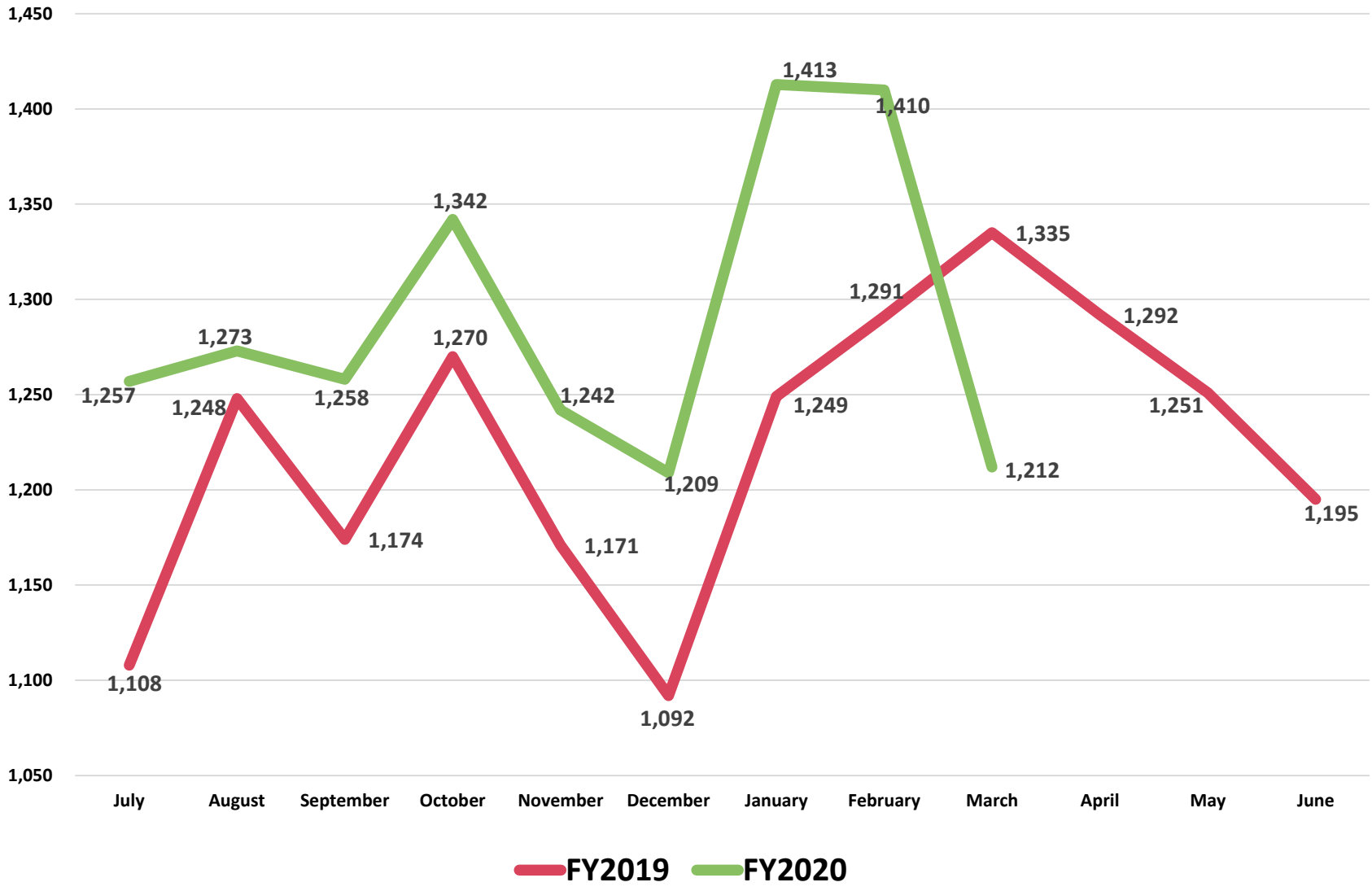


Obstetrics - Avg. Patients Per Day

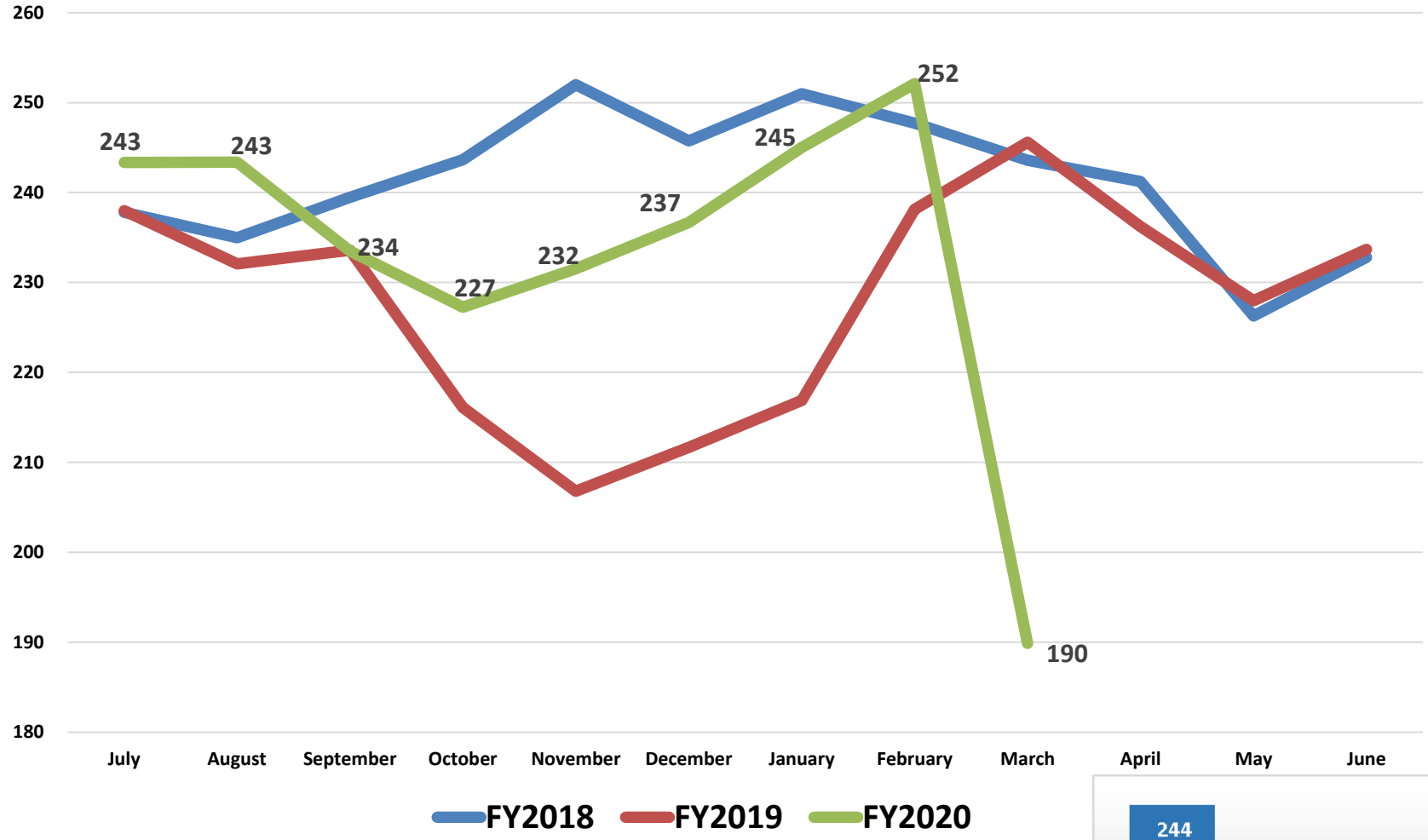


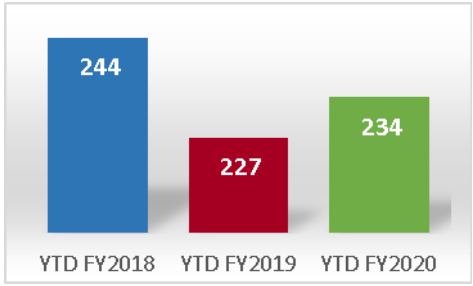


Outpatient Registrations per Day

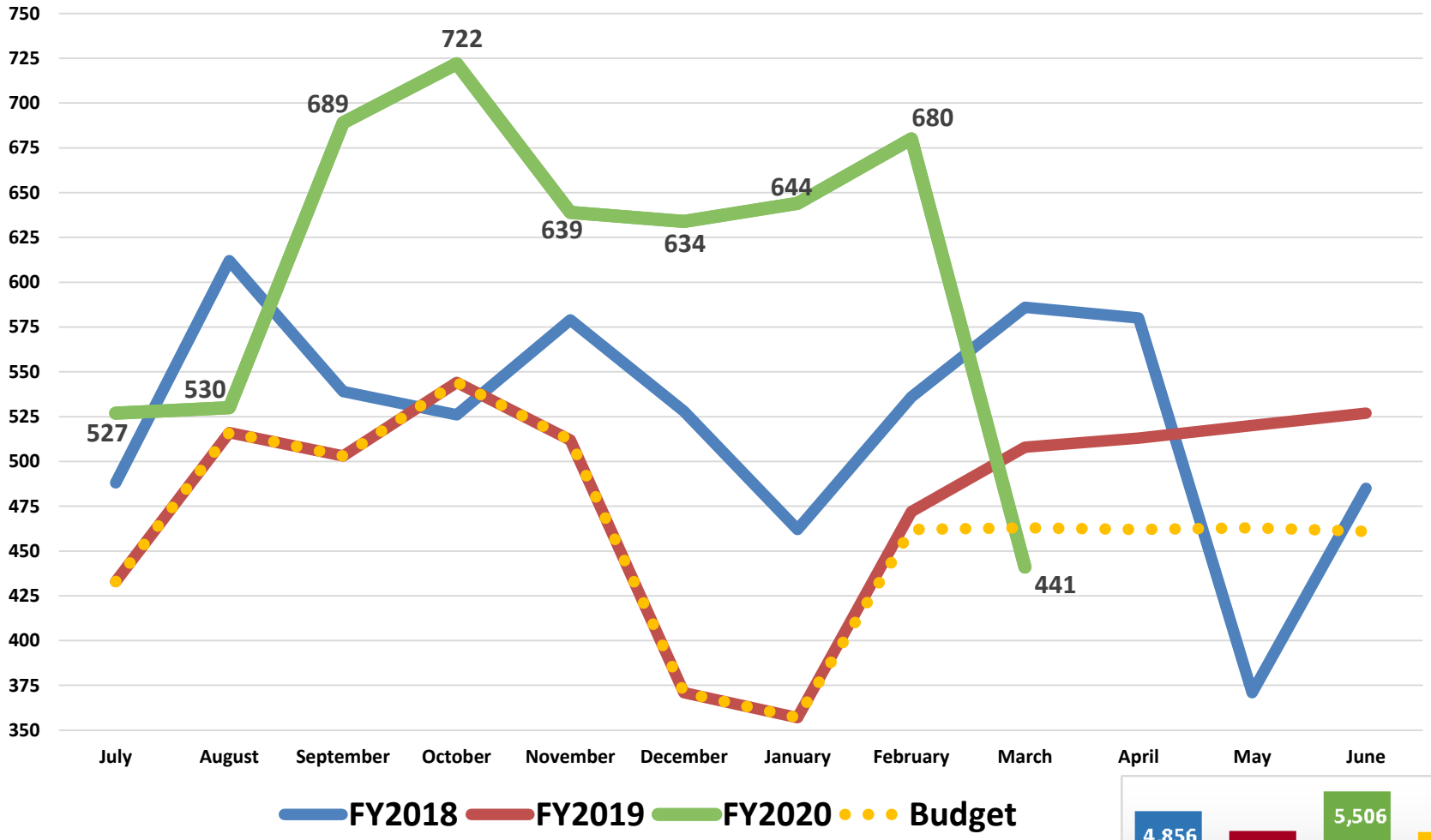


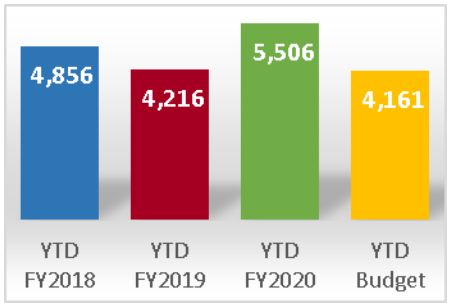
Emergency Dept – Avg Treated Per Day



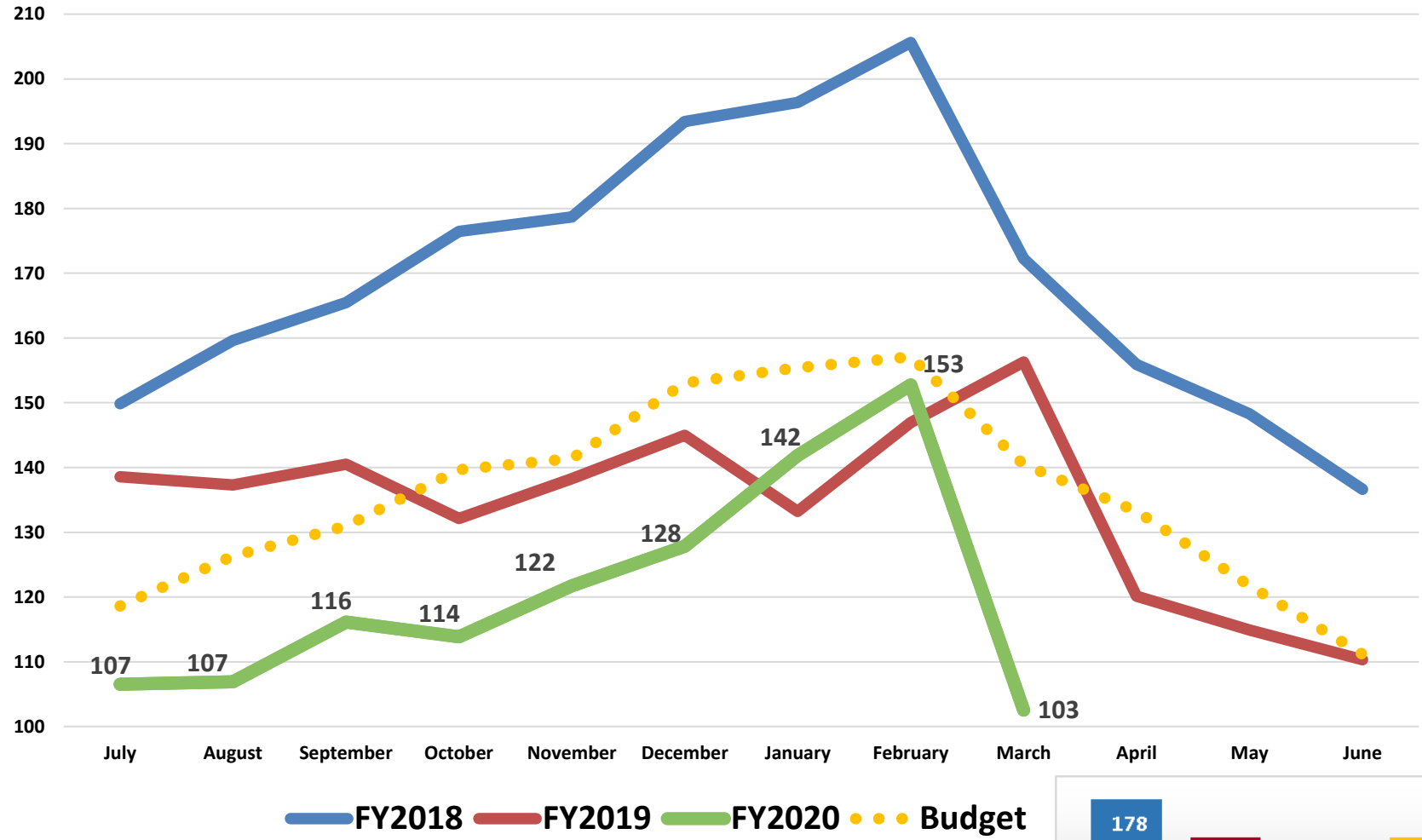


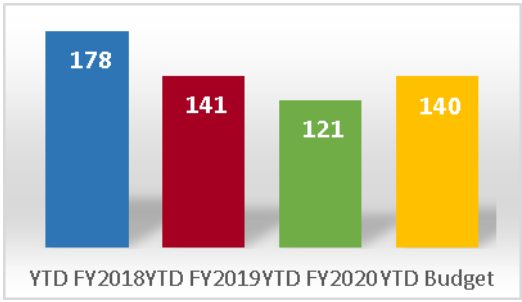
Endoscopy Procedures



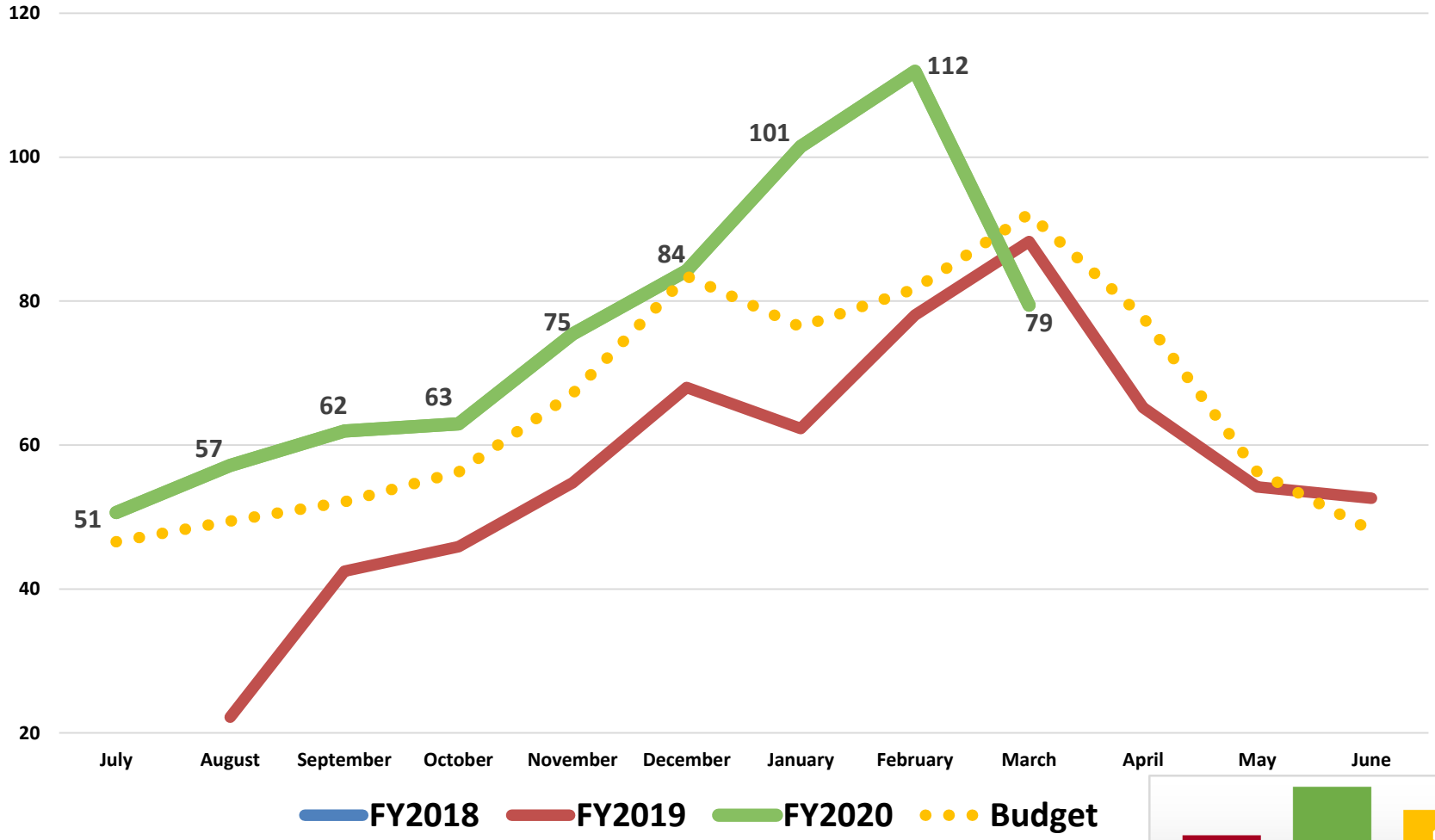


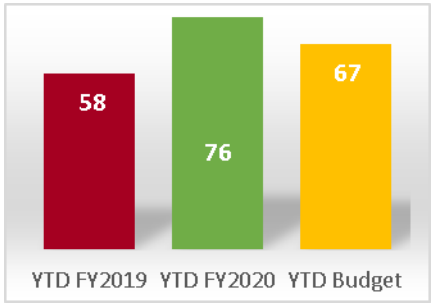
Urgent Care – Court Average Visits Per Day



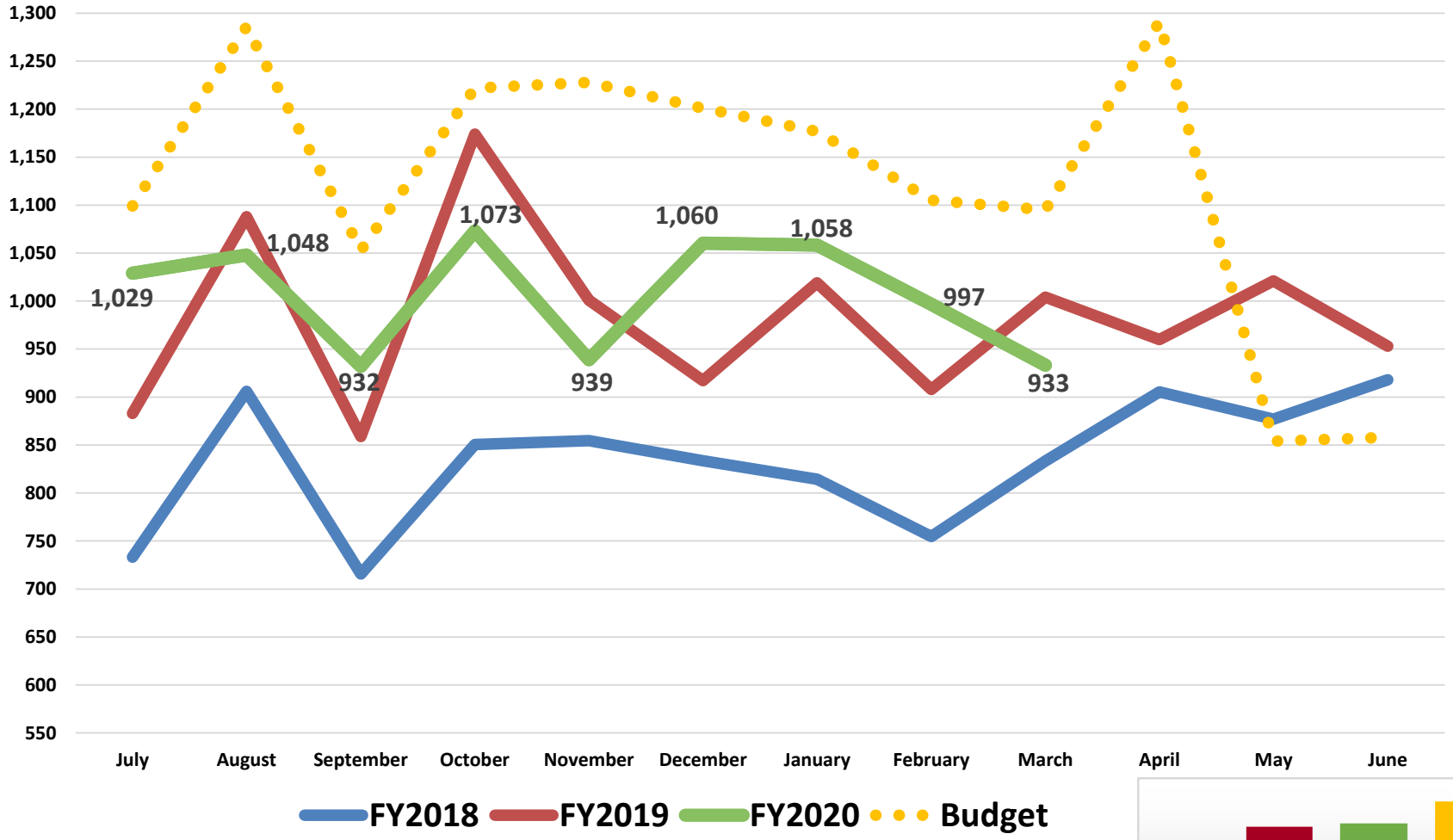


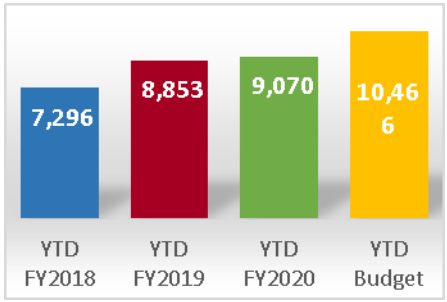
Urgent Care – Demaree Average Visits Per Day



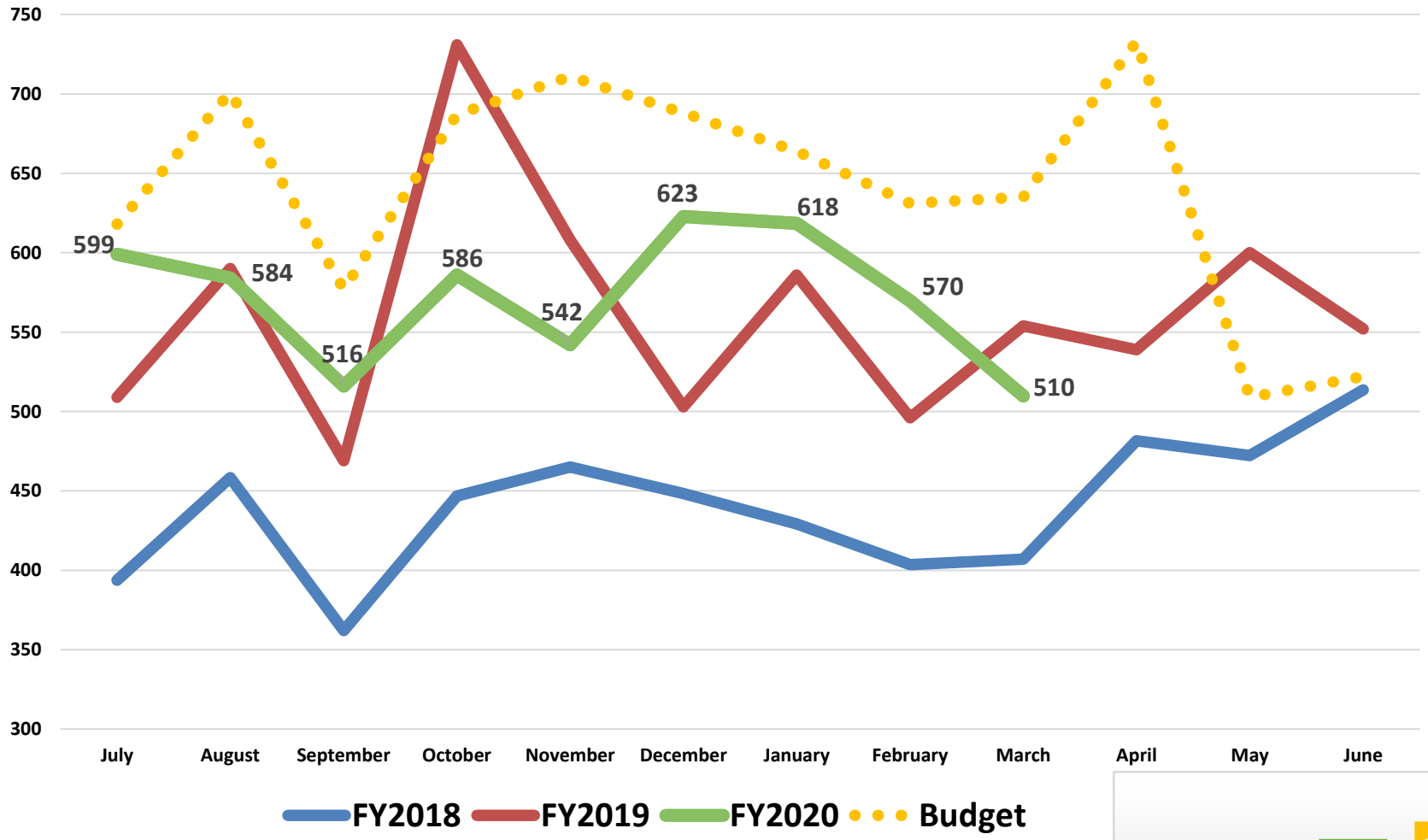


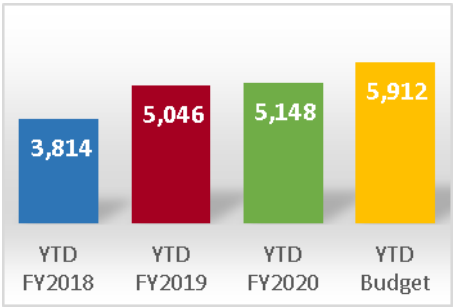
Surgery (IP & OP) – 100 Min Units



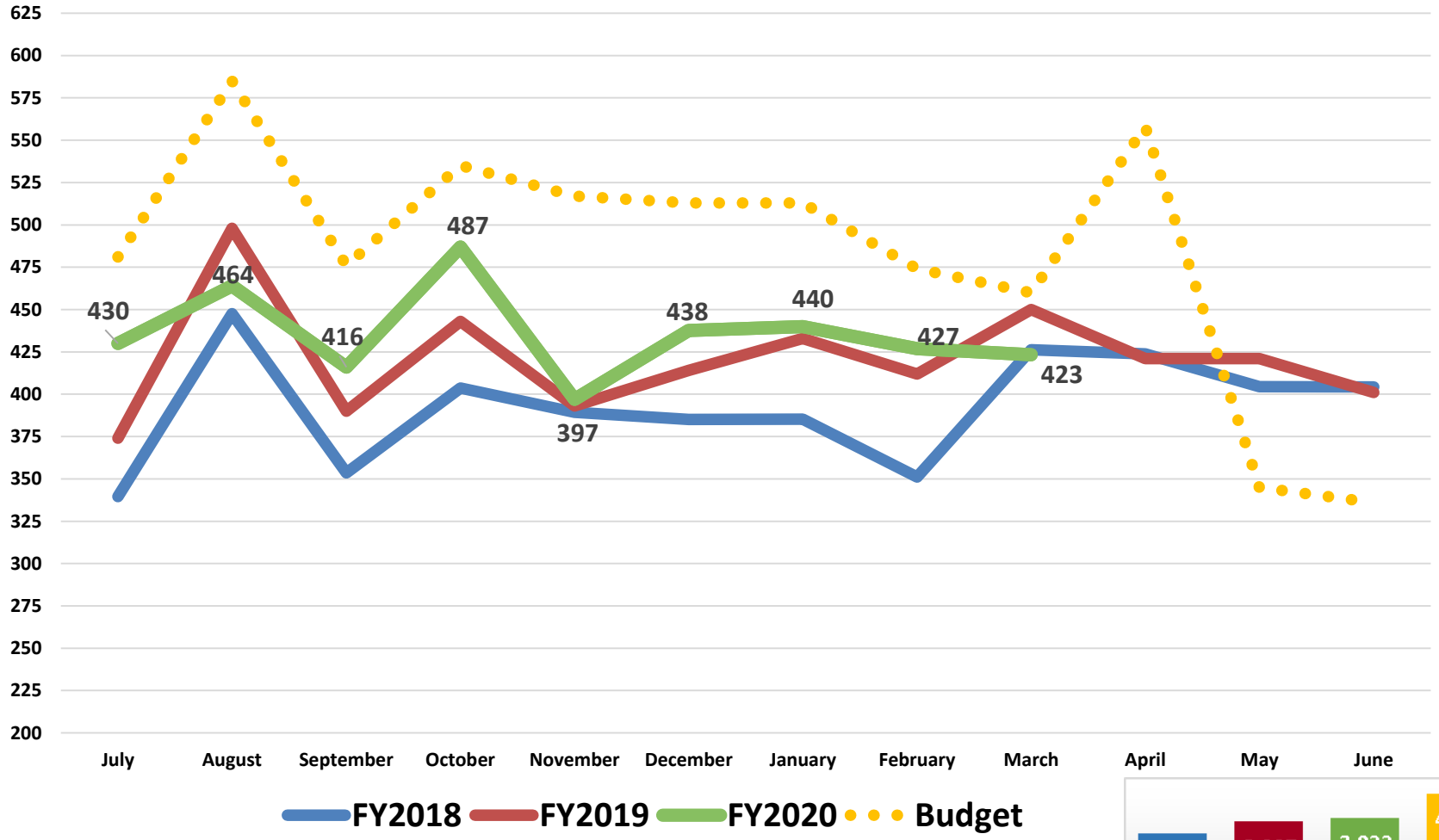


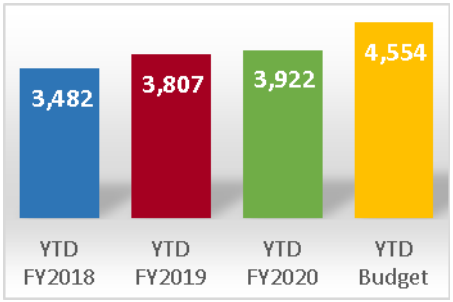
Surgery (IP Only) – 100 Min Units



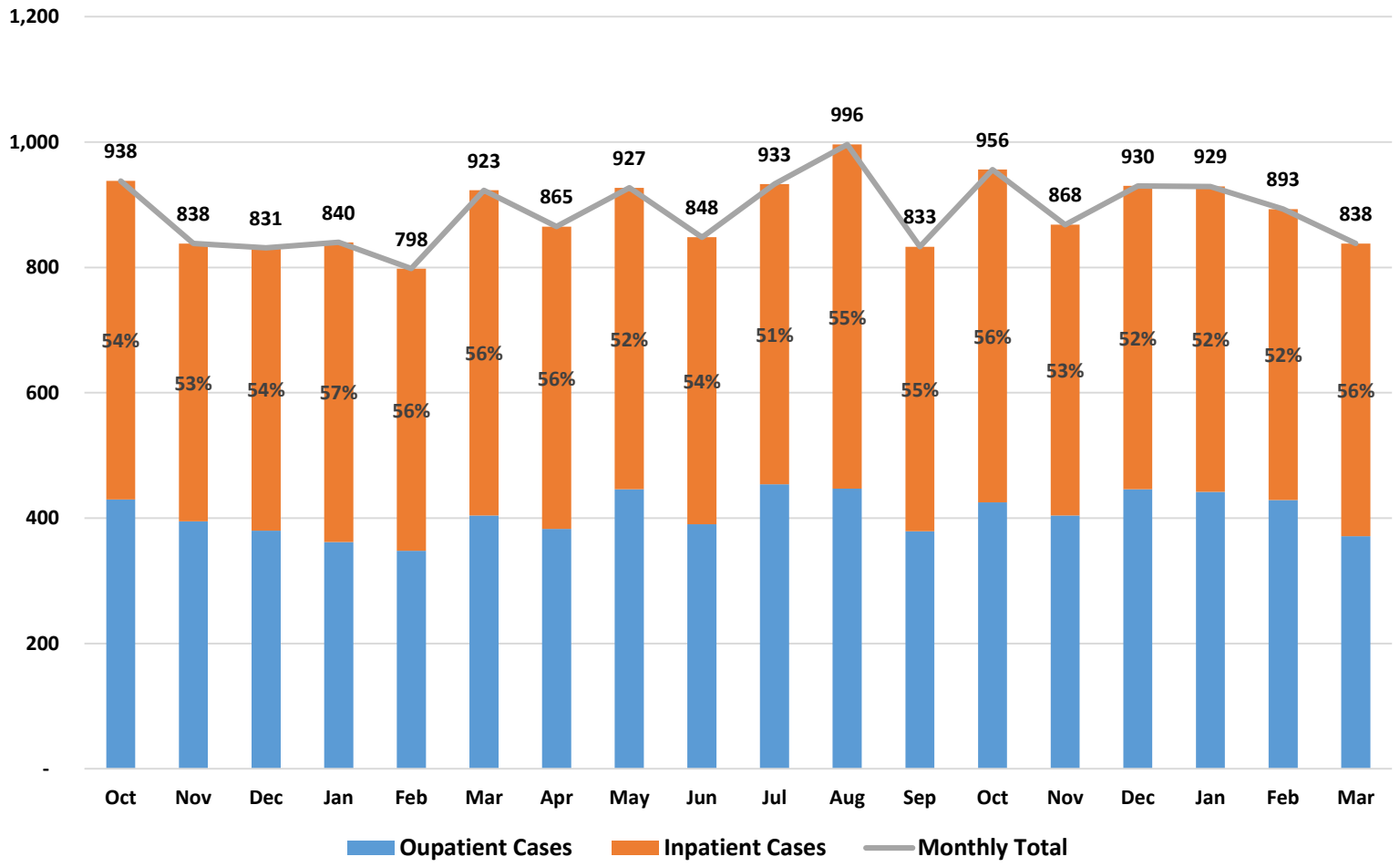


Surgery (OP Only) – 100 Min Units

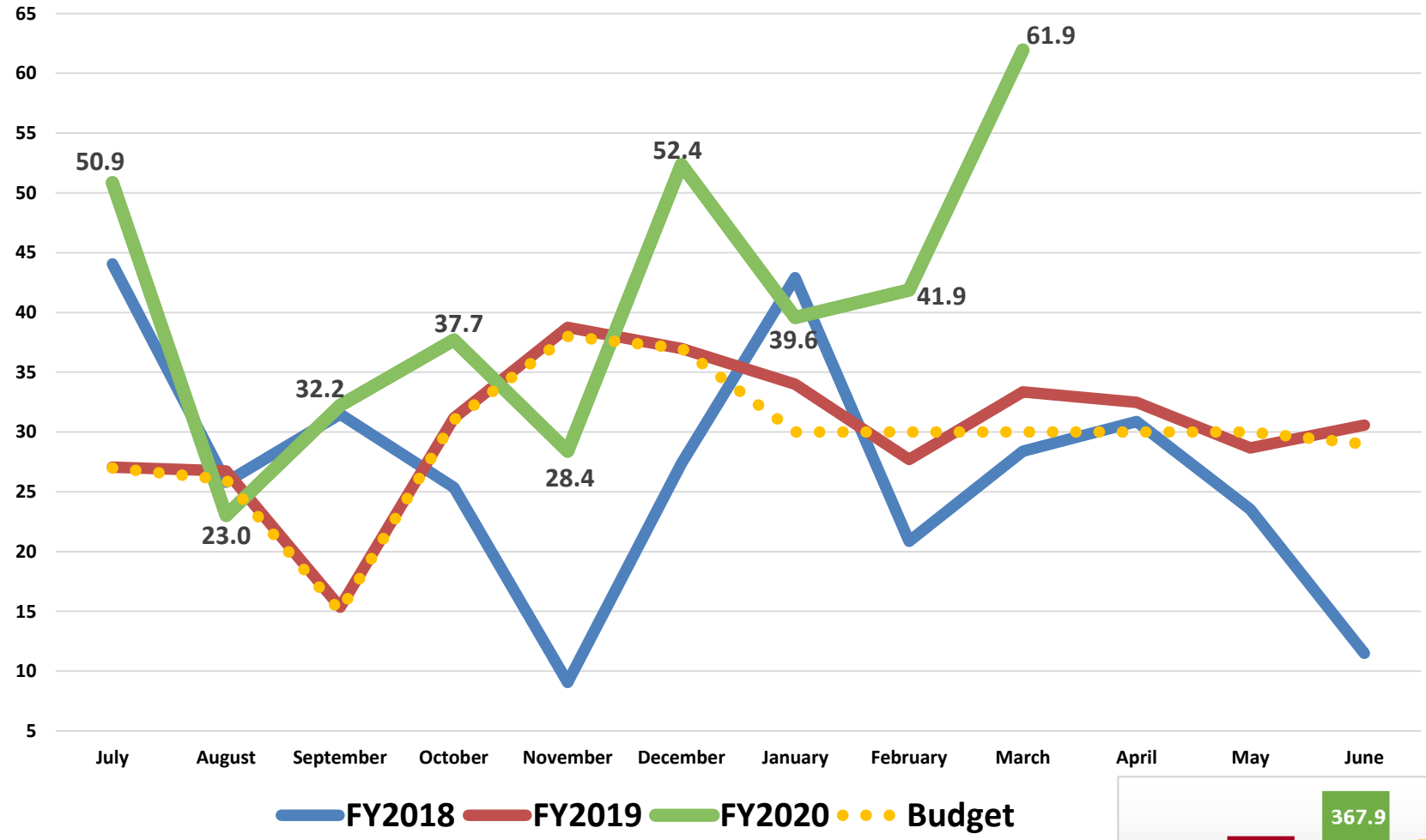


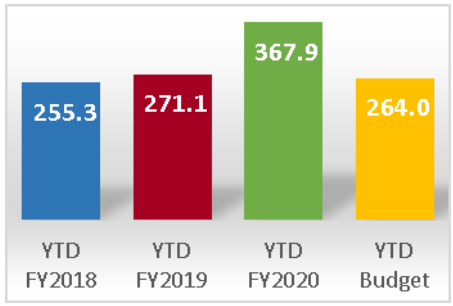


Surgery (IP & OP) - Cases

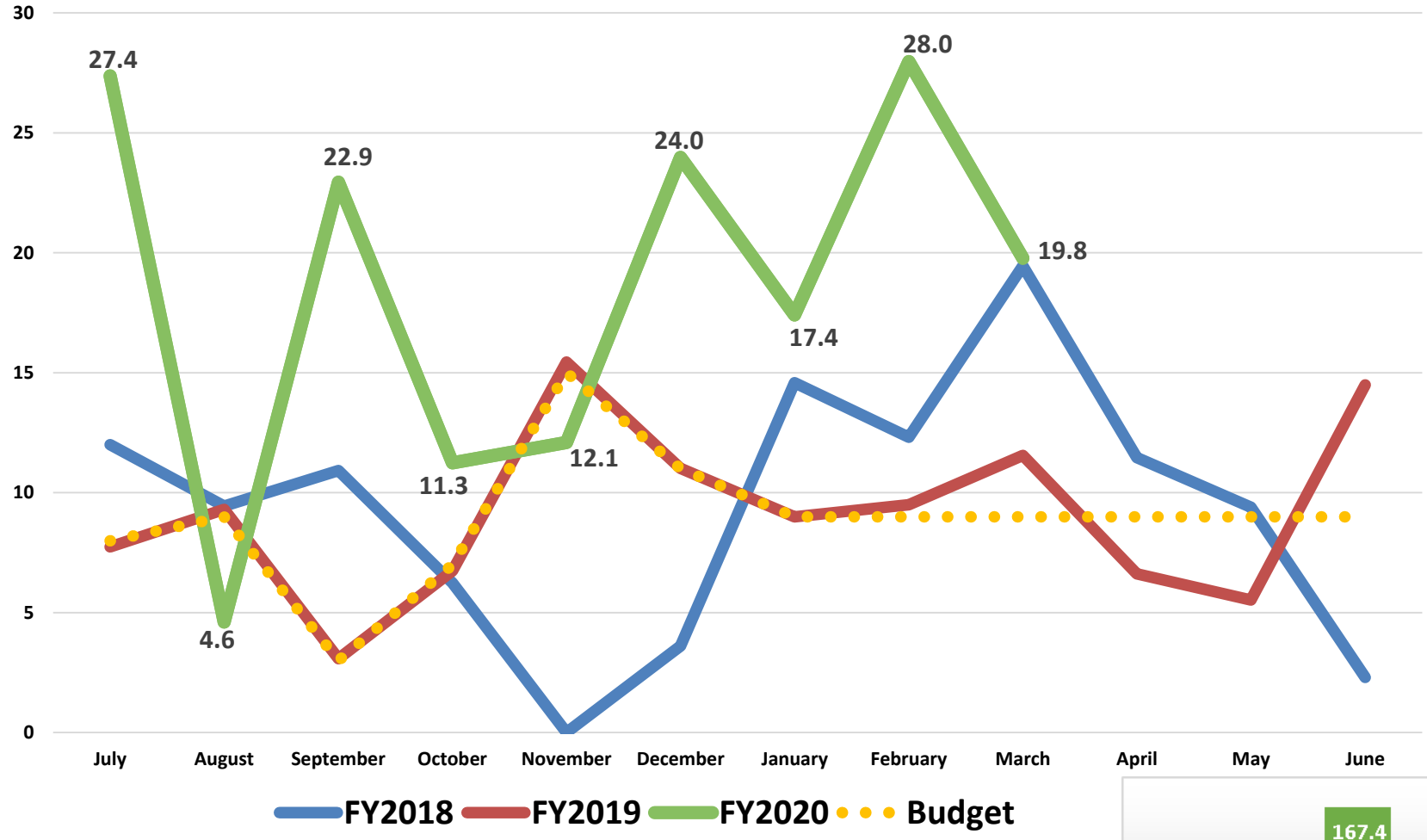


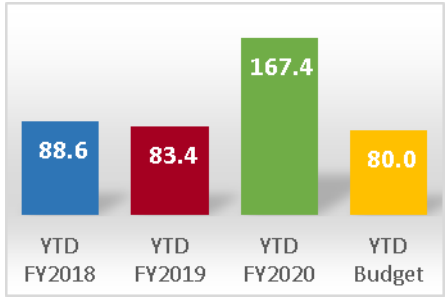
Robotic Surgery (IP & OP) – 100 Min Units



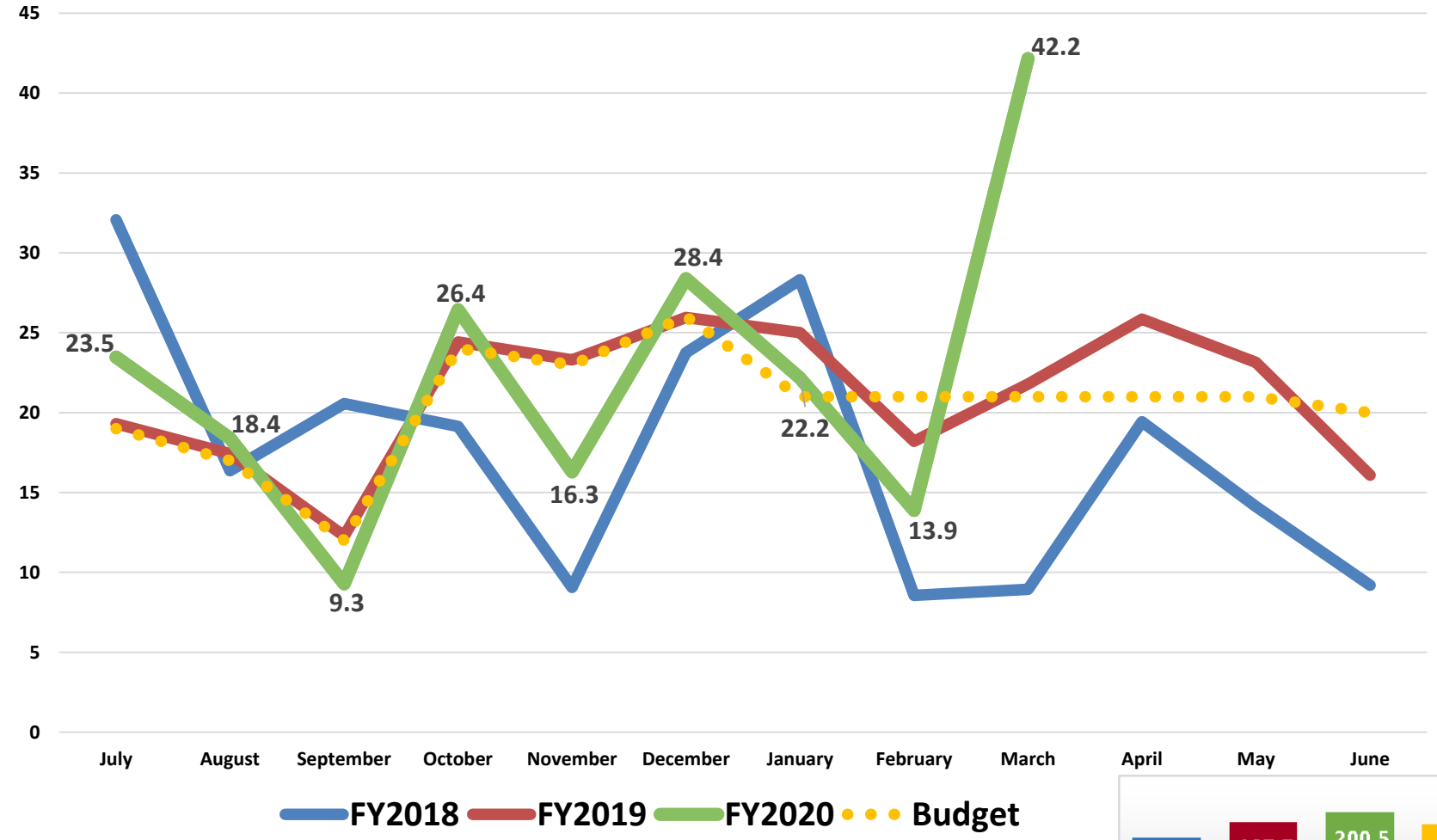


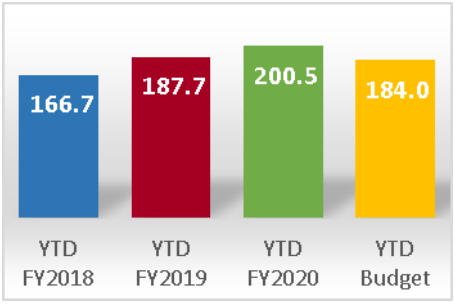
Robotic Surgery (IP Only) – 100 Min Units



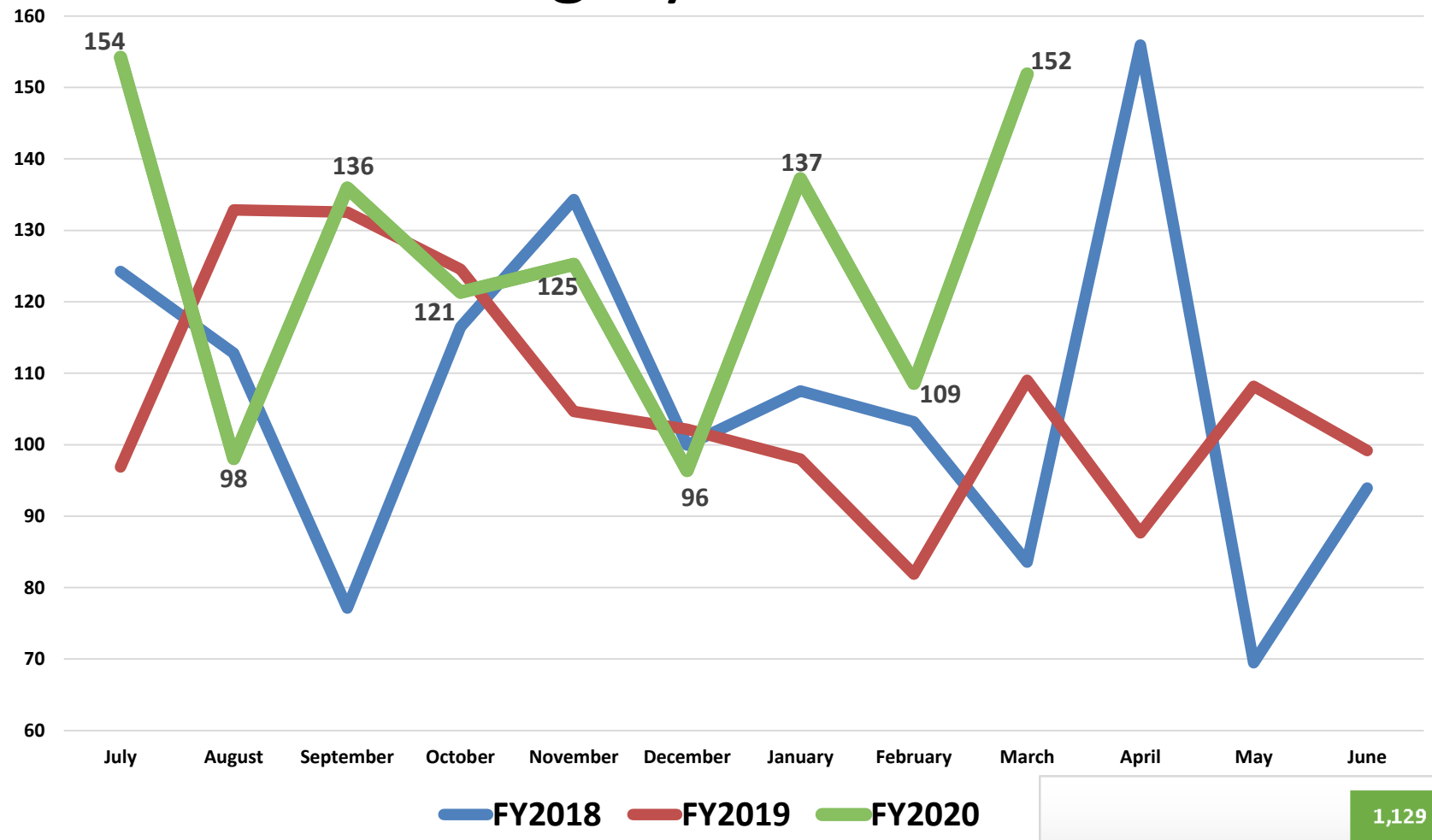


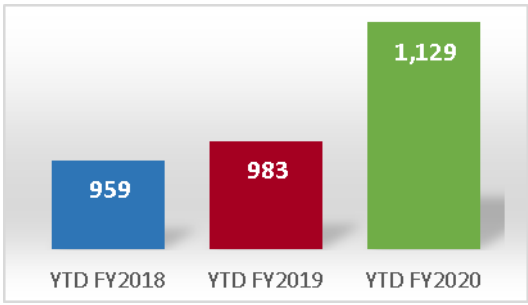
Robotic Surgery (OP Only) – 100 Min Units





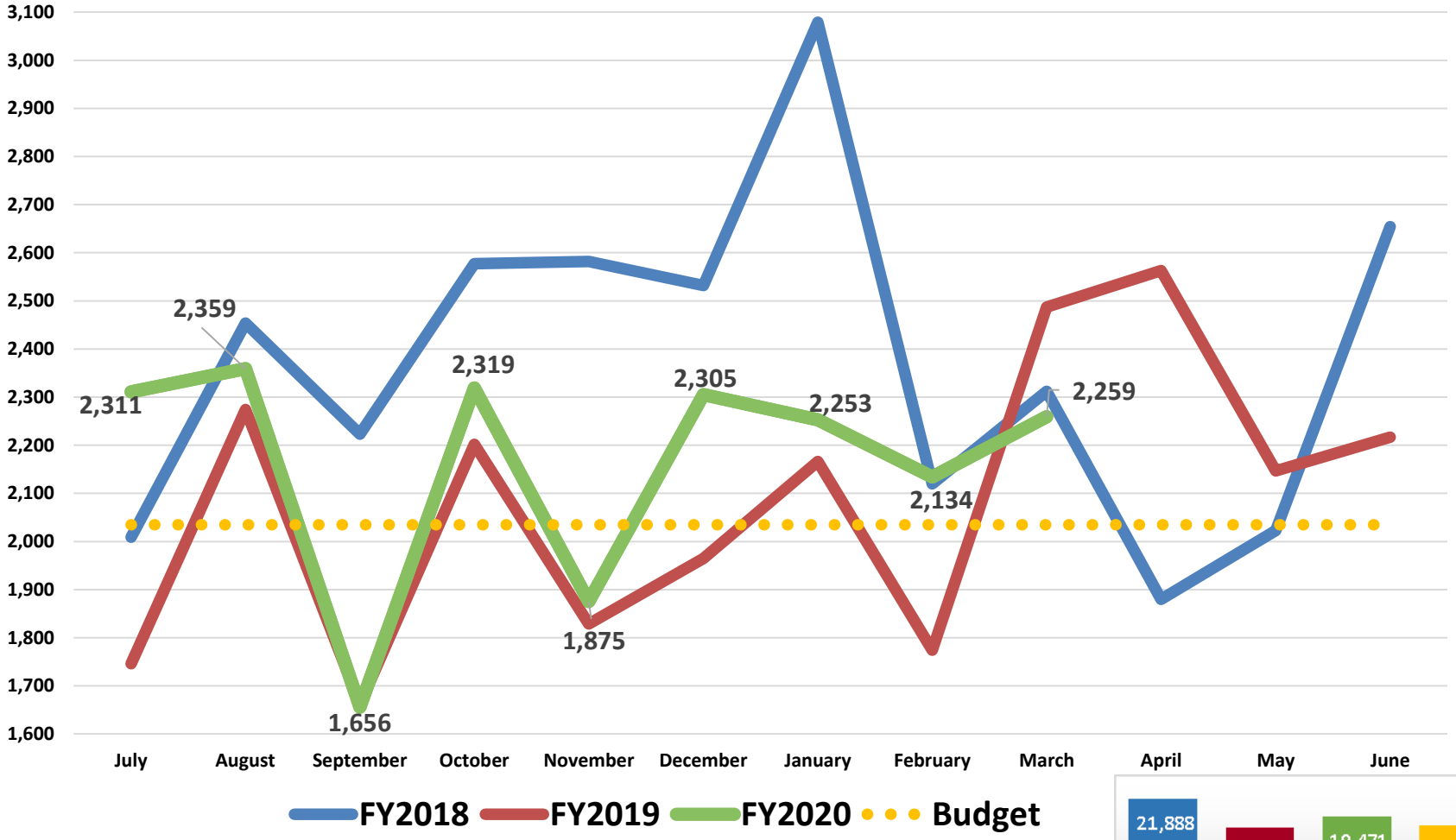
Cardiac Surgery – 100 Min Units

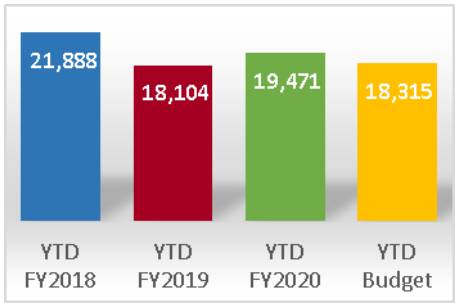




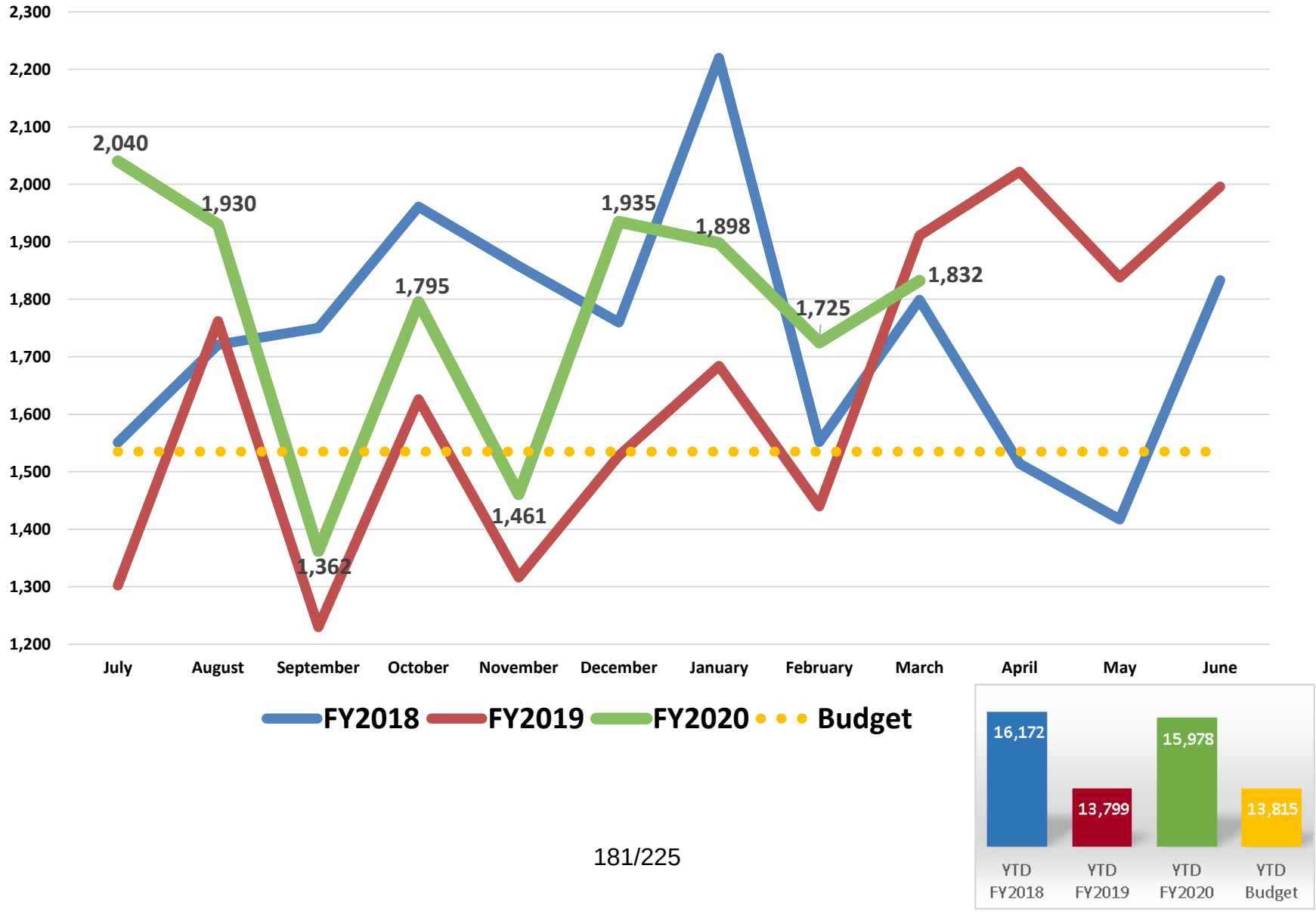
Radiation Oncology Treatments

Hanford and Visalia

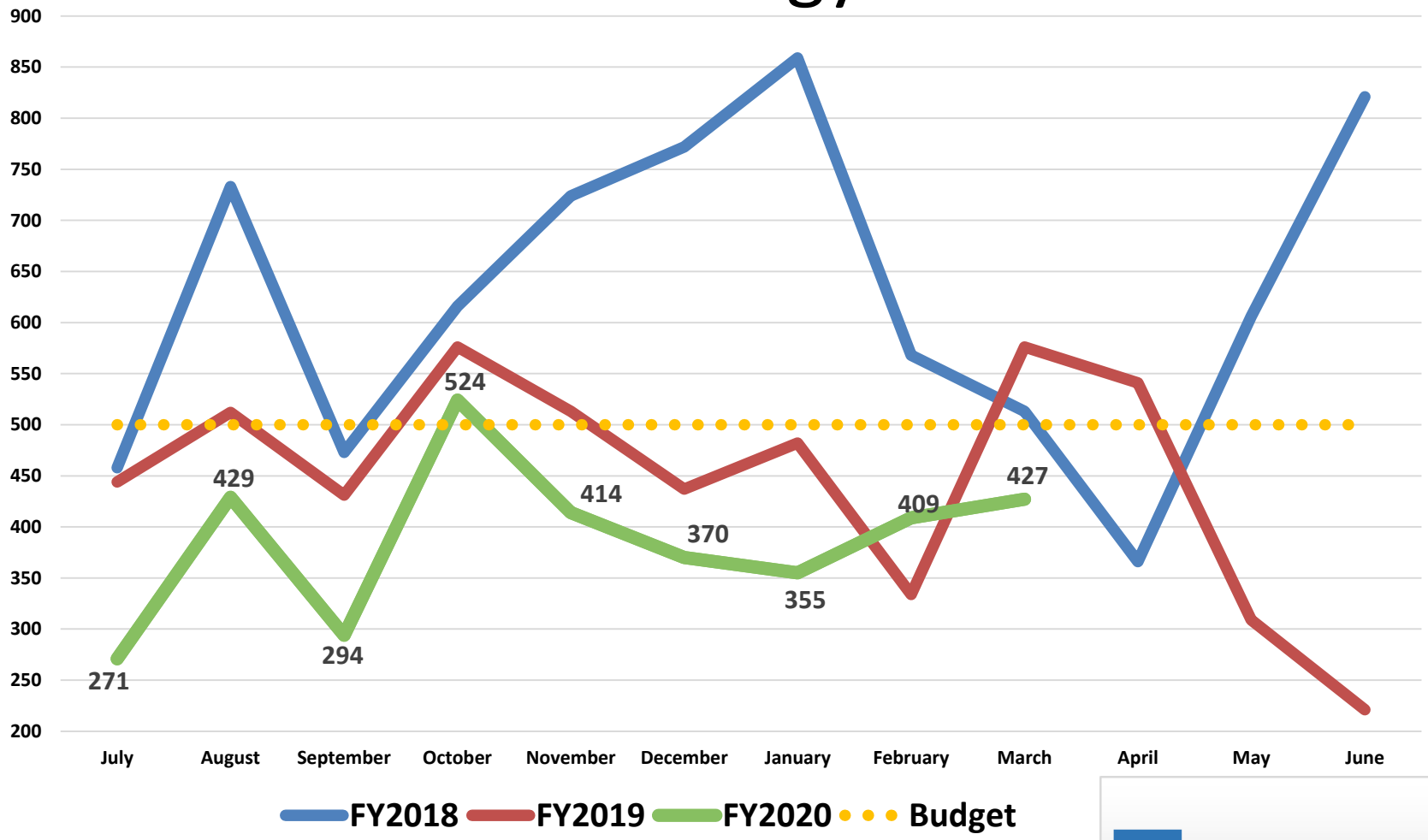


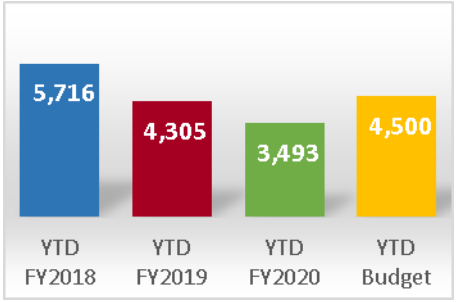


Radiation Oncology - Visalia

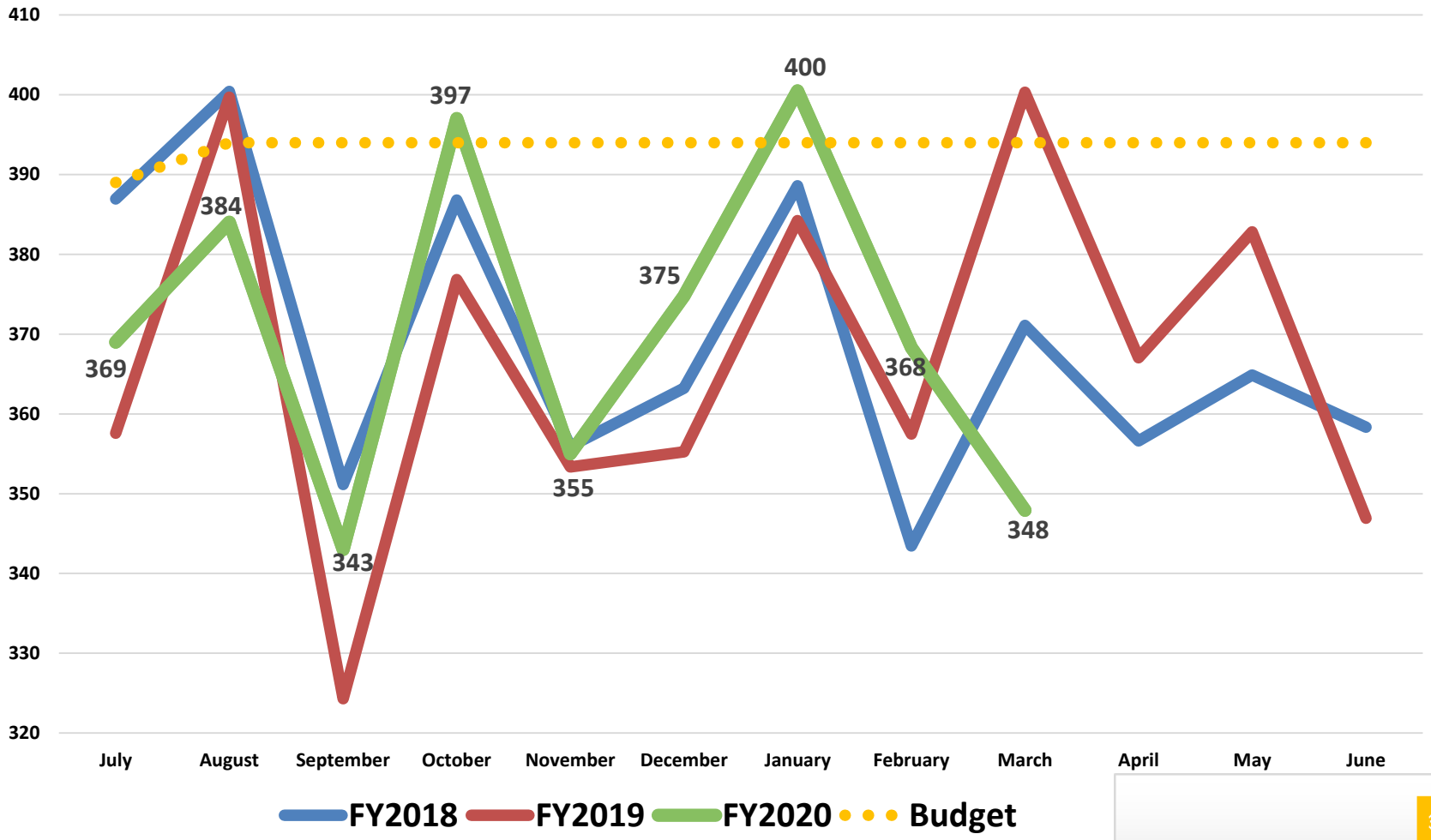


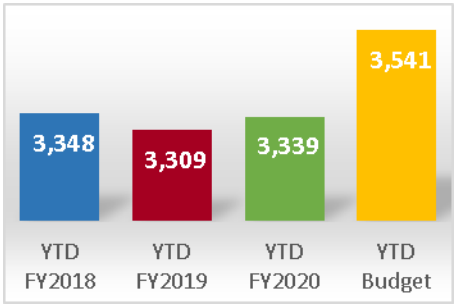
Radiation Oncology - Hanford



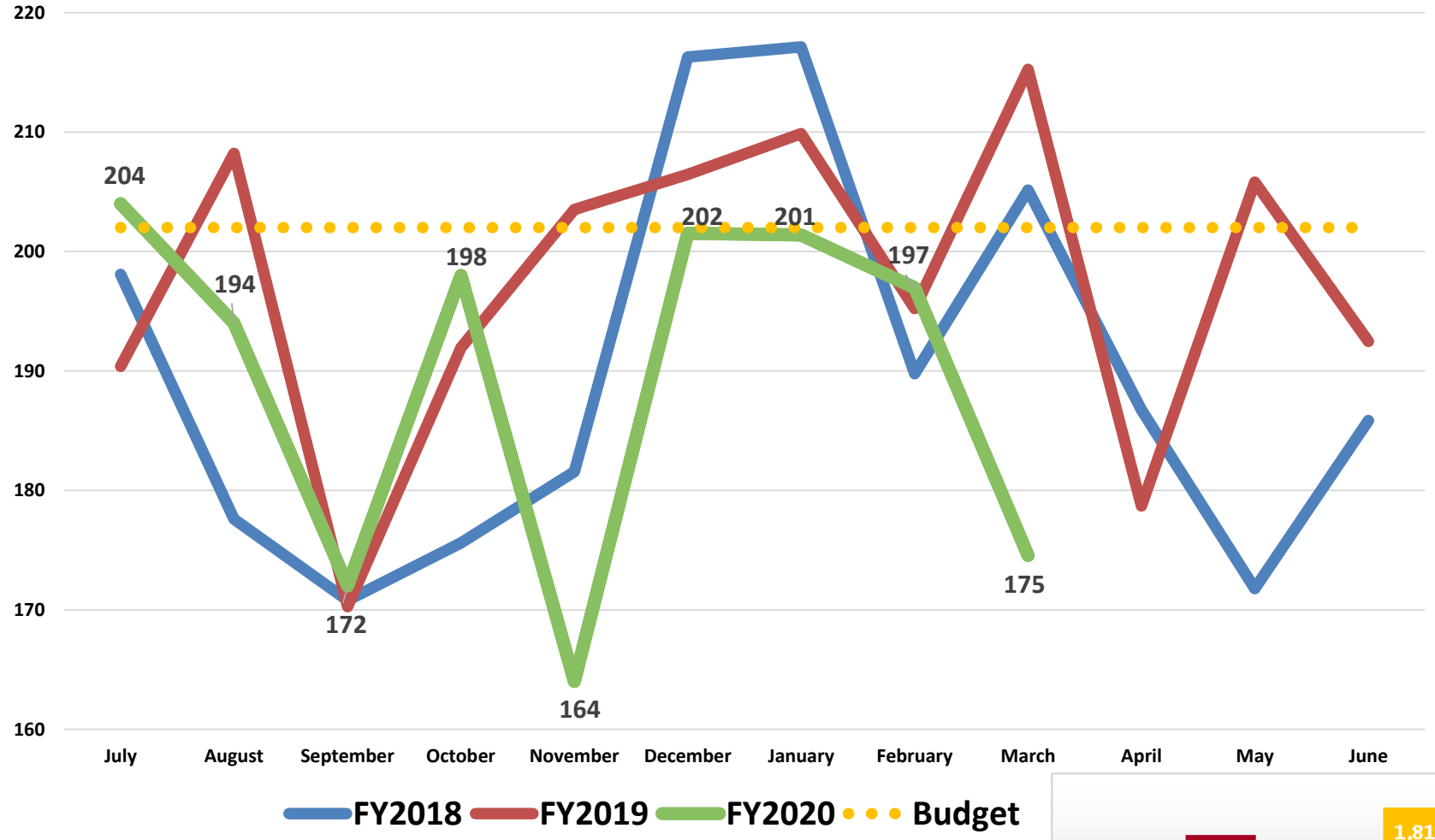


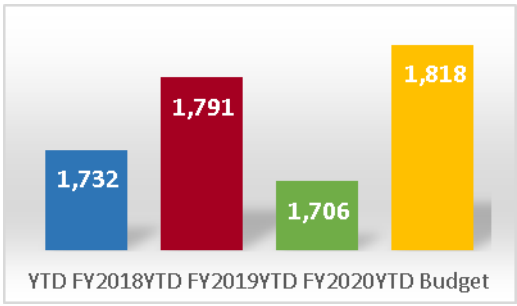
Cath Lab (IP & OP) – 100 Min Units



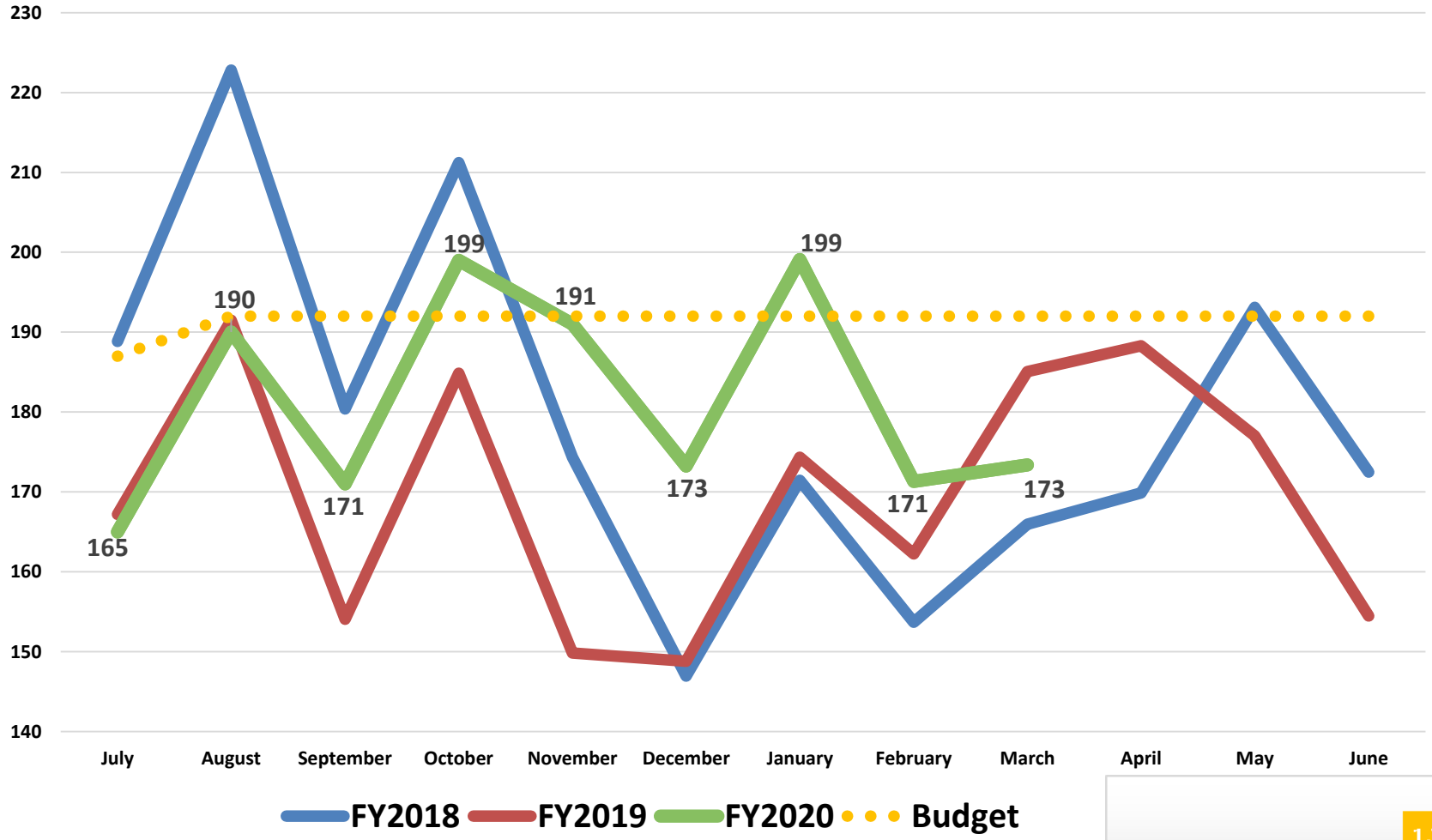


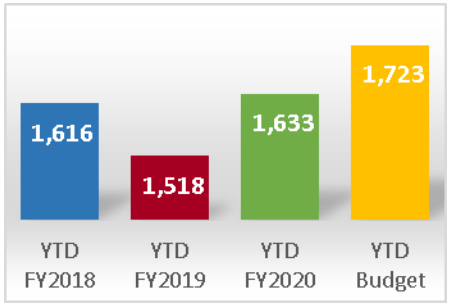
Cath Lab (IP Only) – 100 Min Units



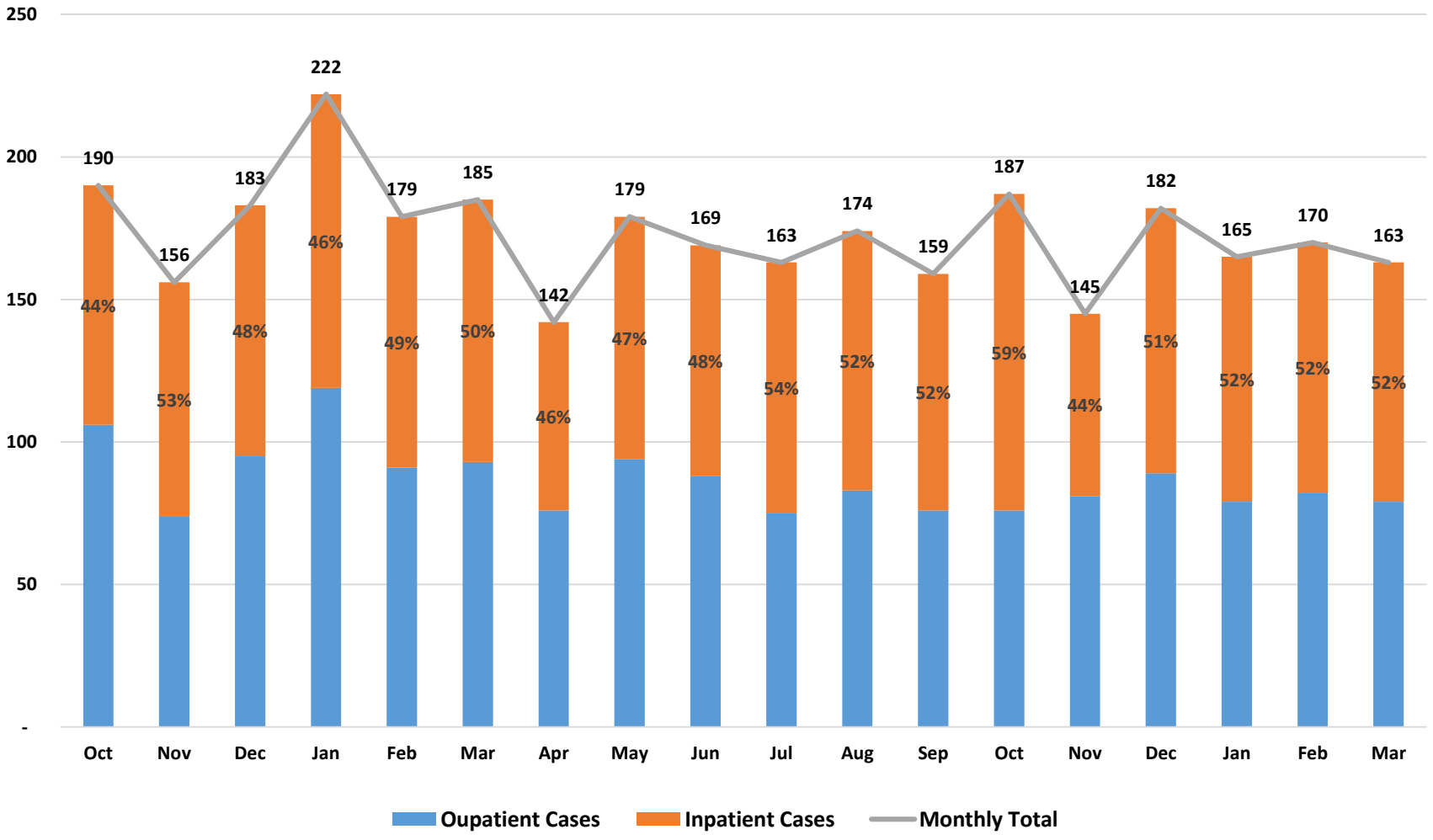


Cath Lab (OP Only) – 100 Min Units

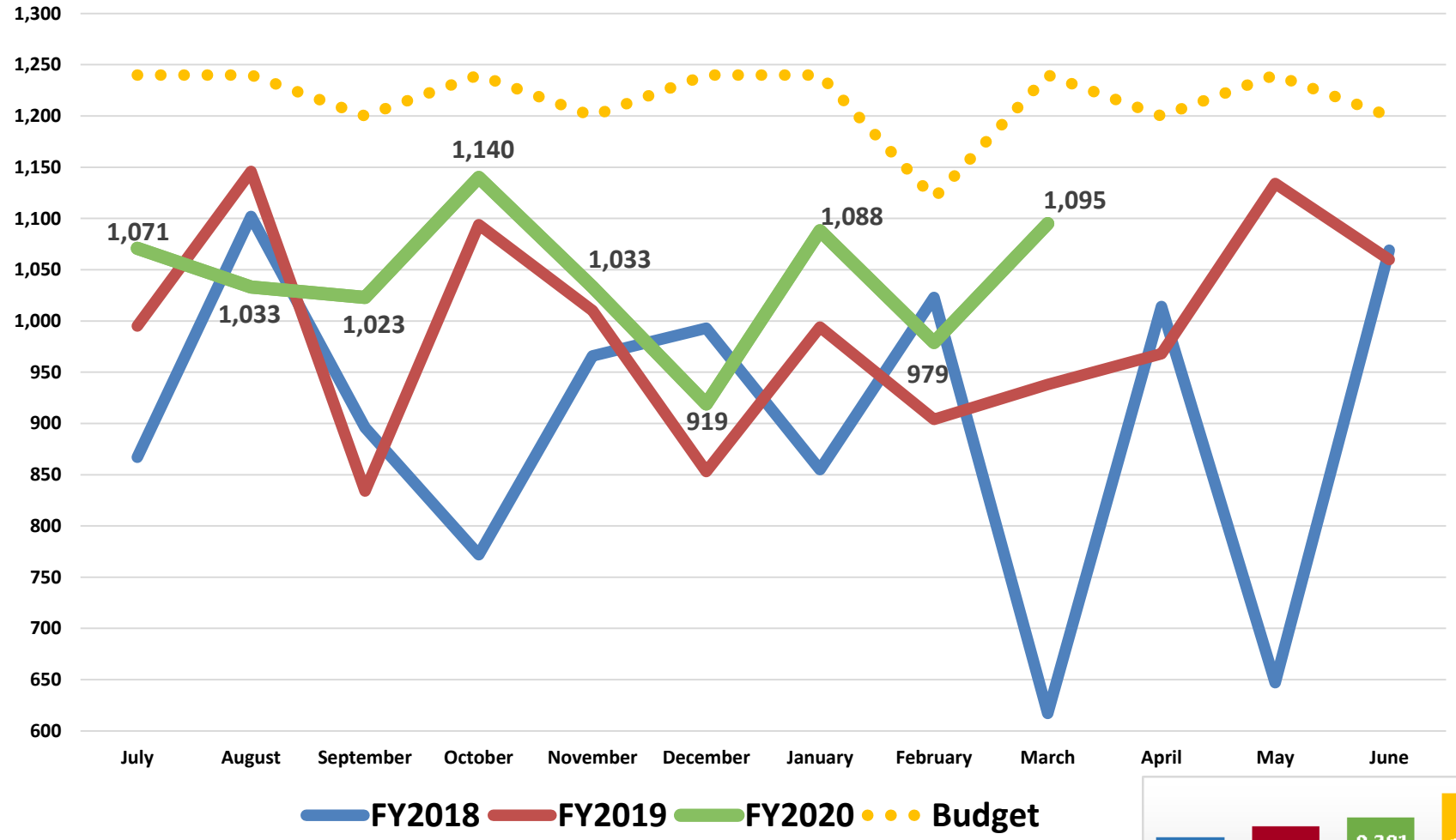


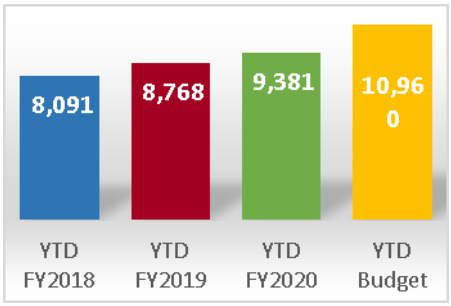


Cath Lab (IP & OP) - Patients

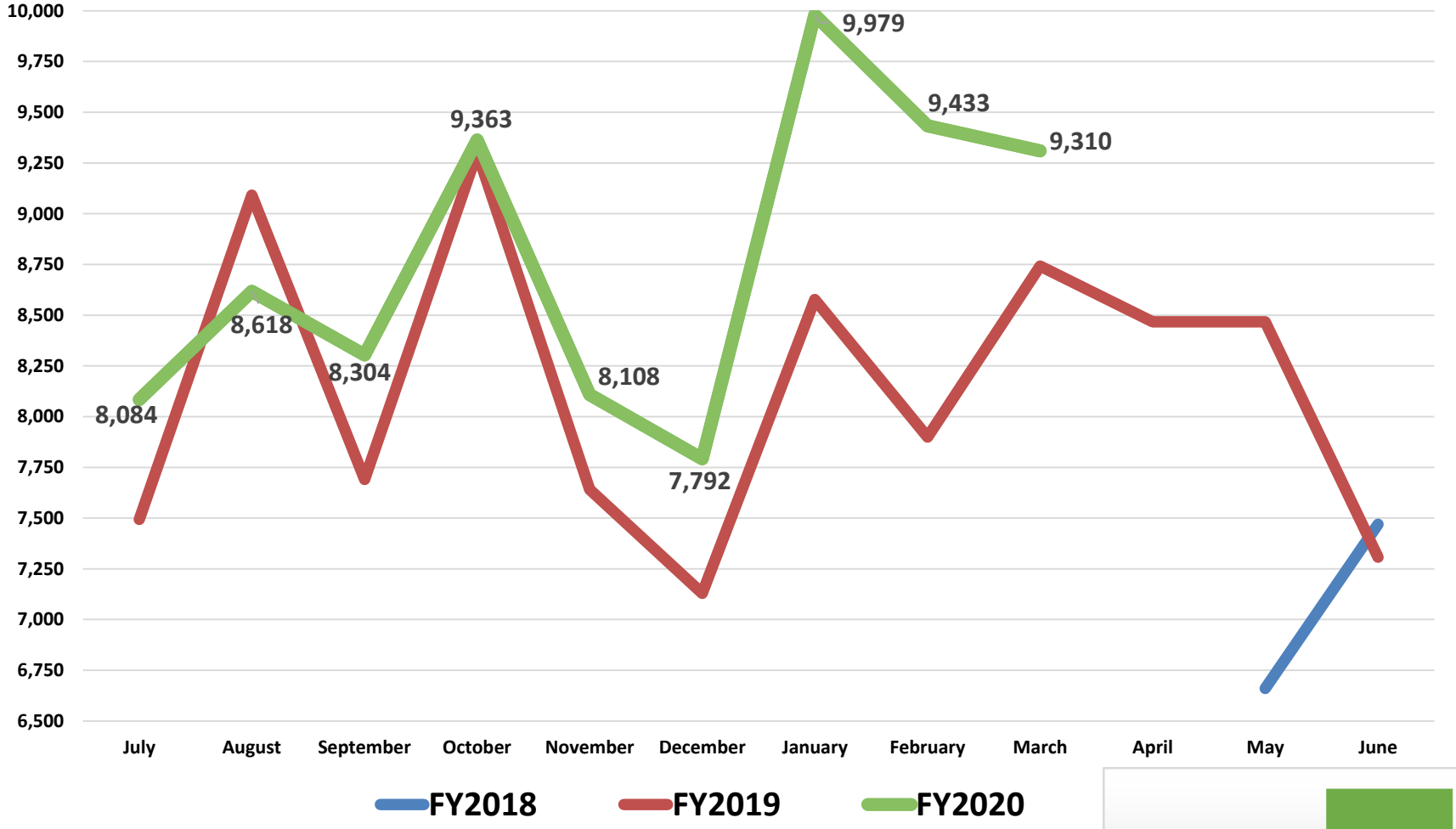


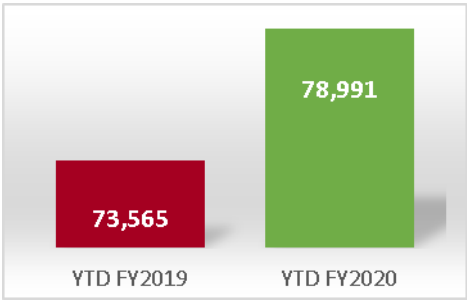
GME Family Medicine Clinic Visits



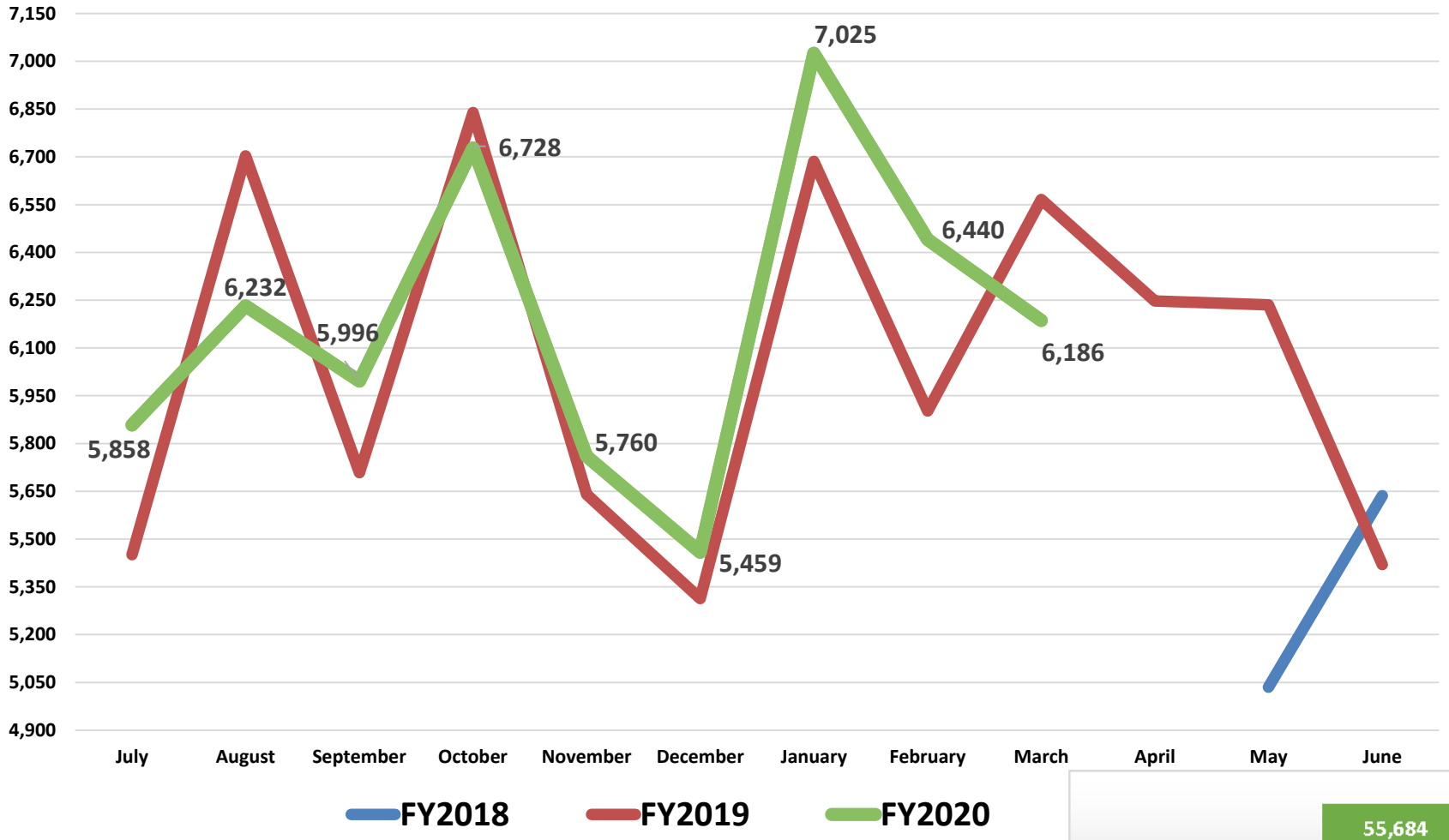


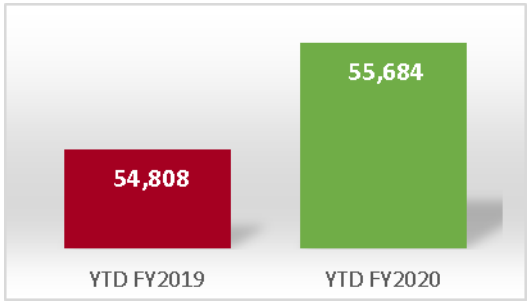
Rural Health Clinic Registrations



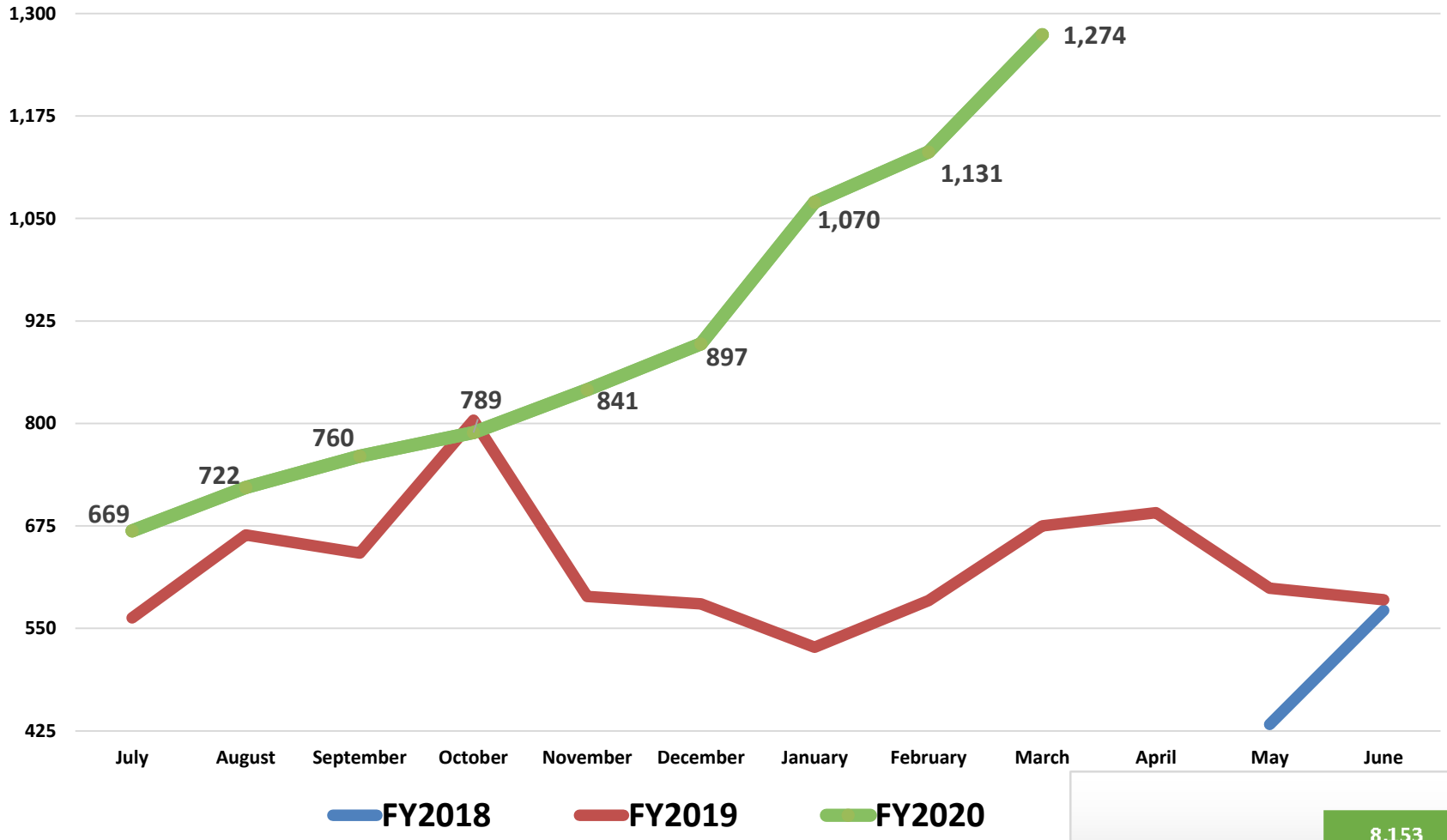


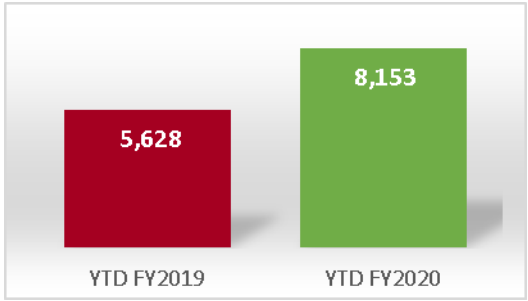
Exeter RHC - Registrations



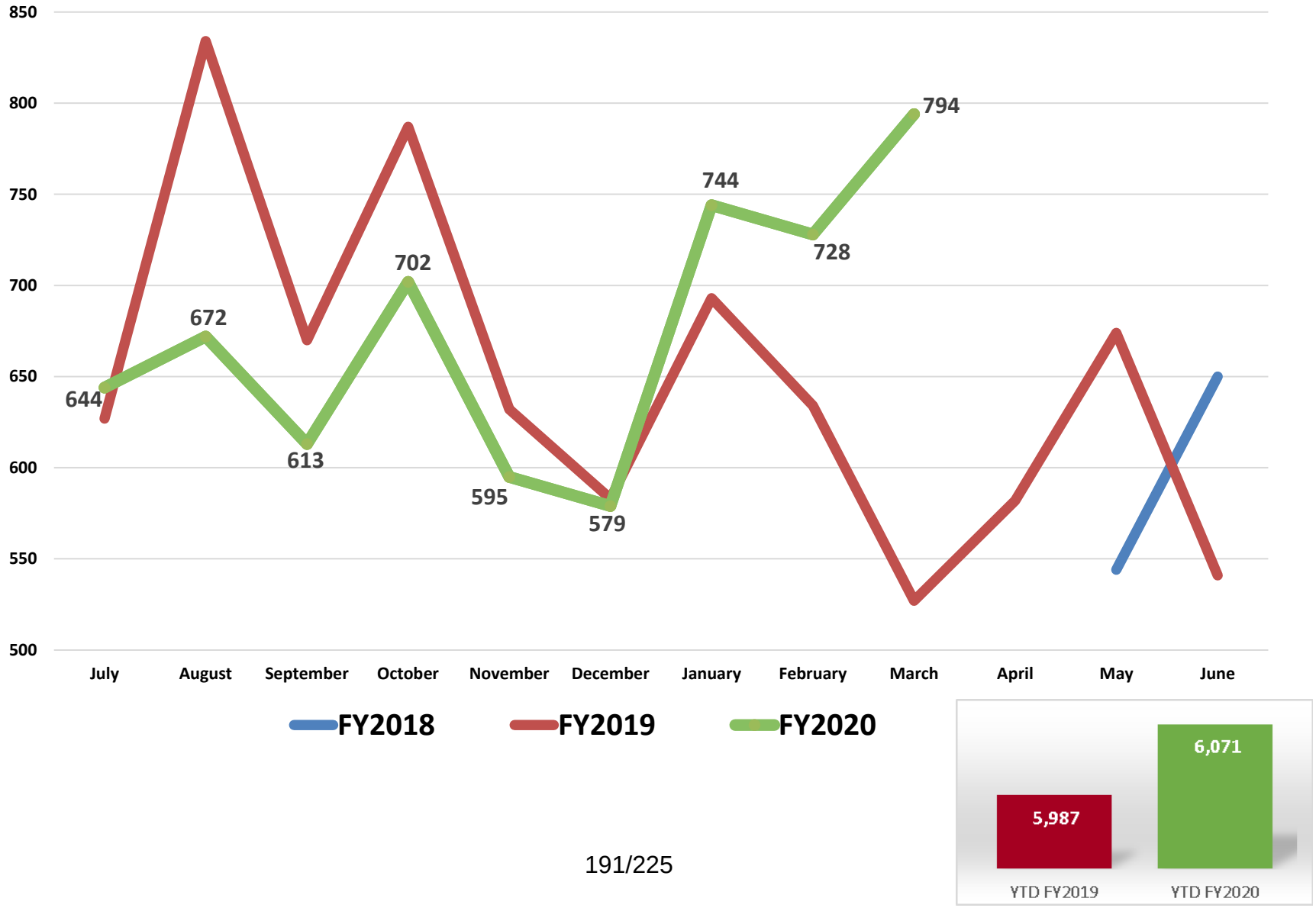


Lindsay RHC - Registrations

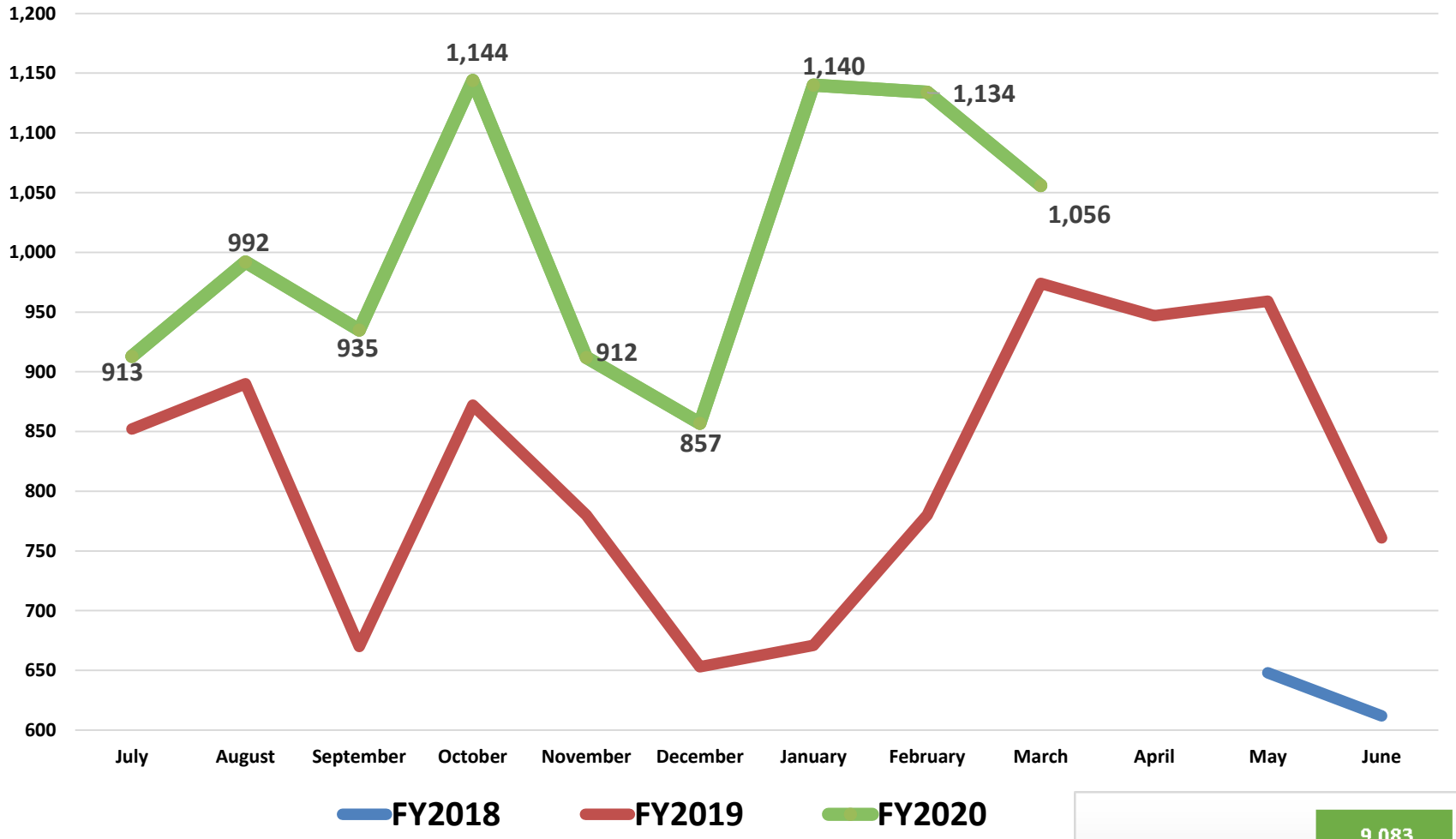


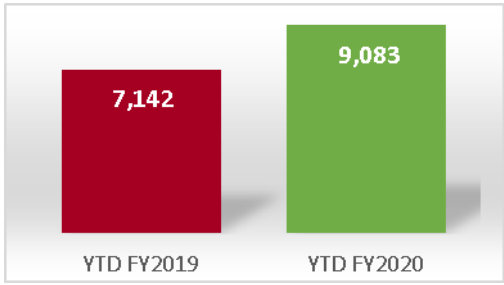


Woodlake RHC - Registrations

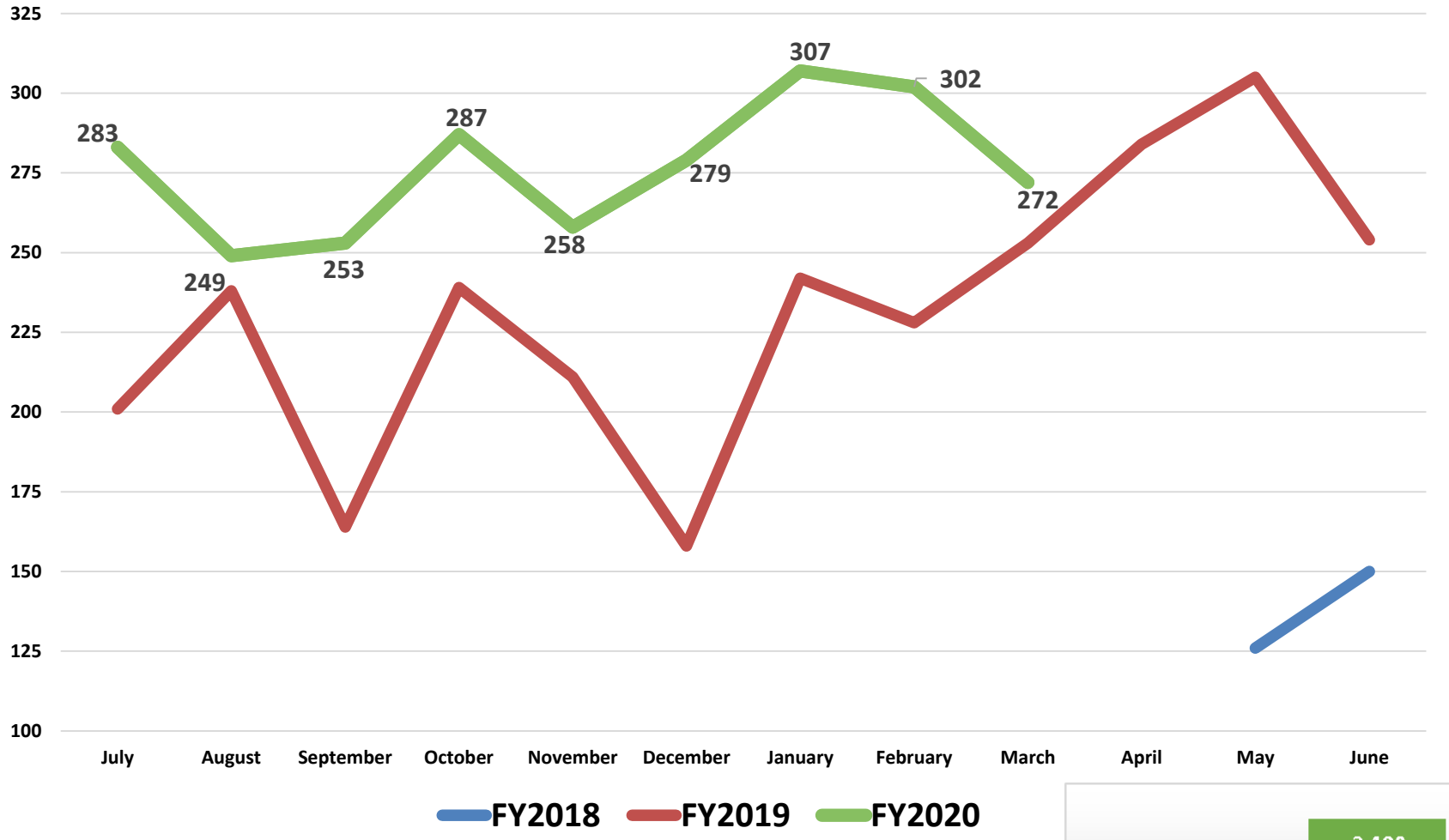


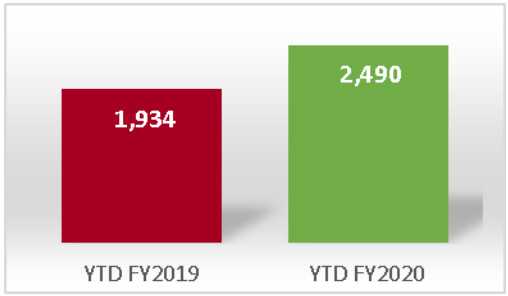
Dinuba RHC - Registrations



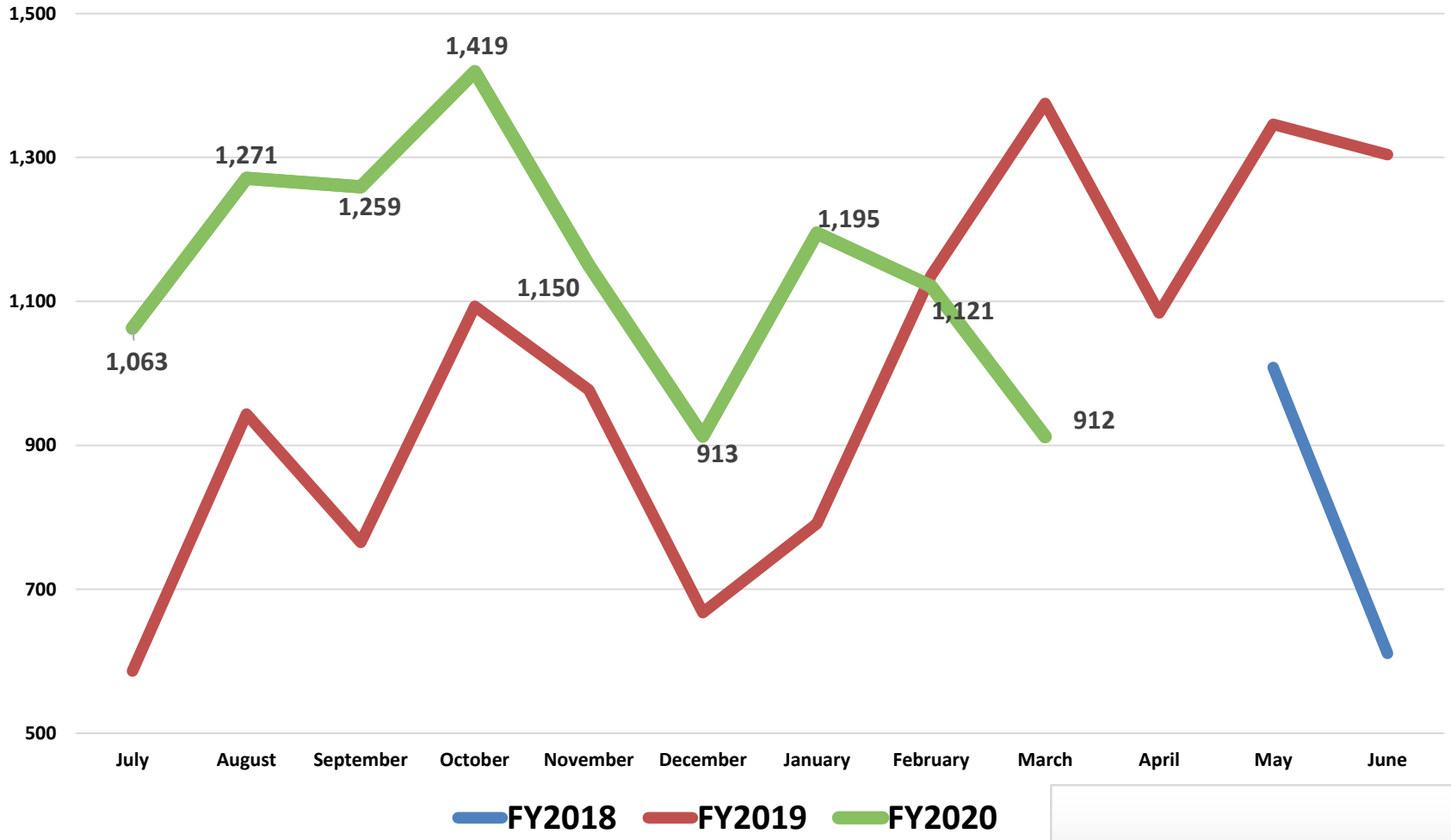


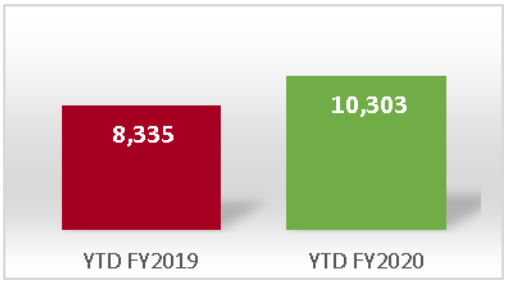
Neurosurgery Clinic - Registrations



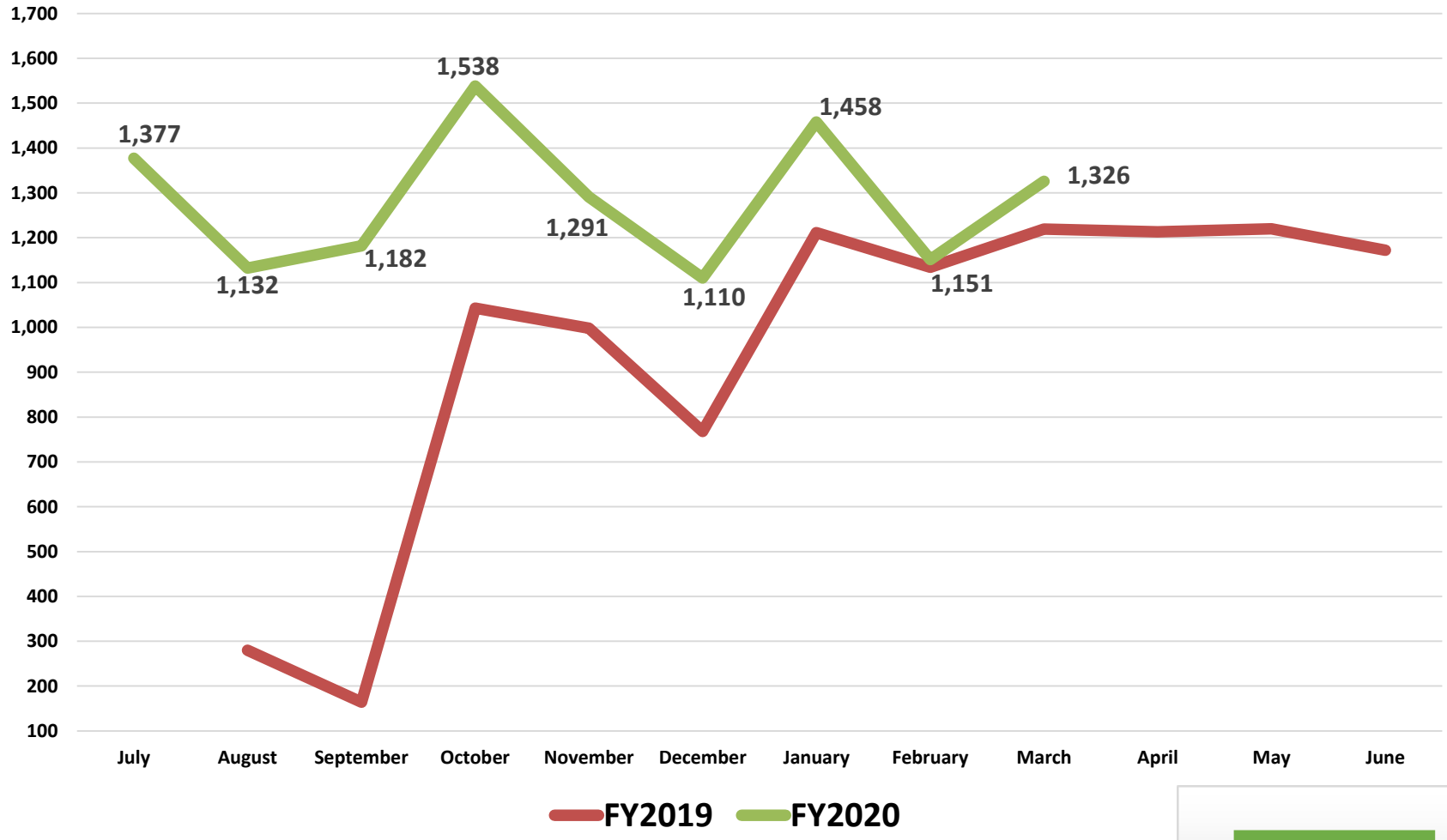


Neurosurgery Clinic - wRVU's

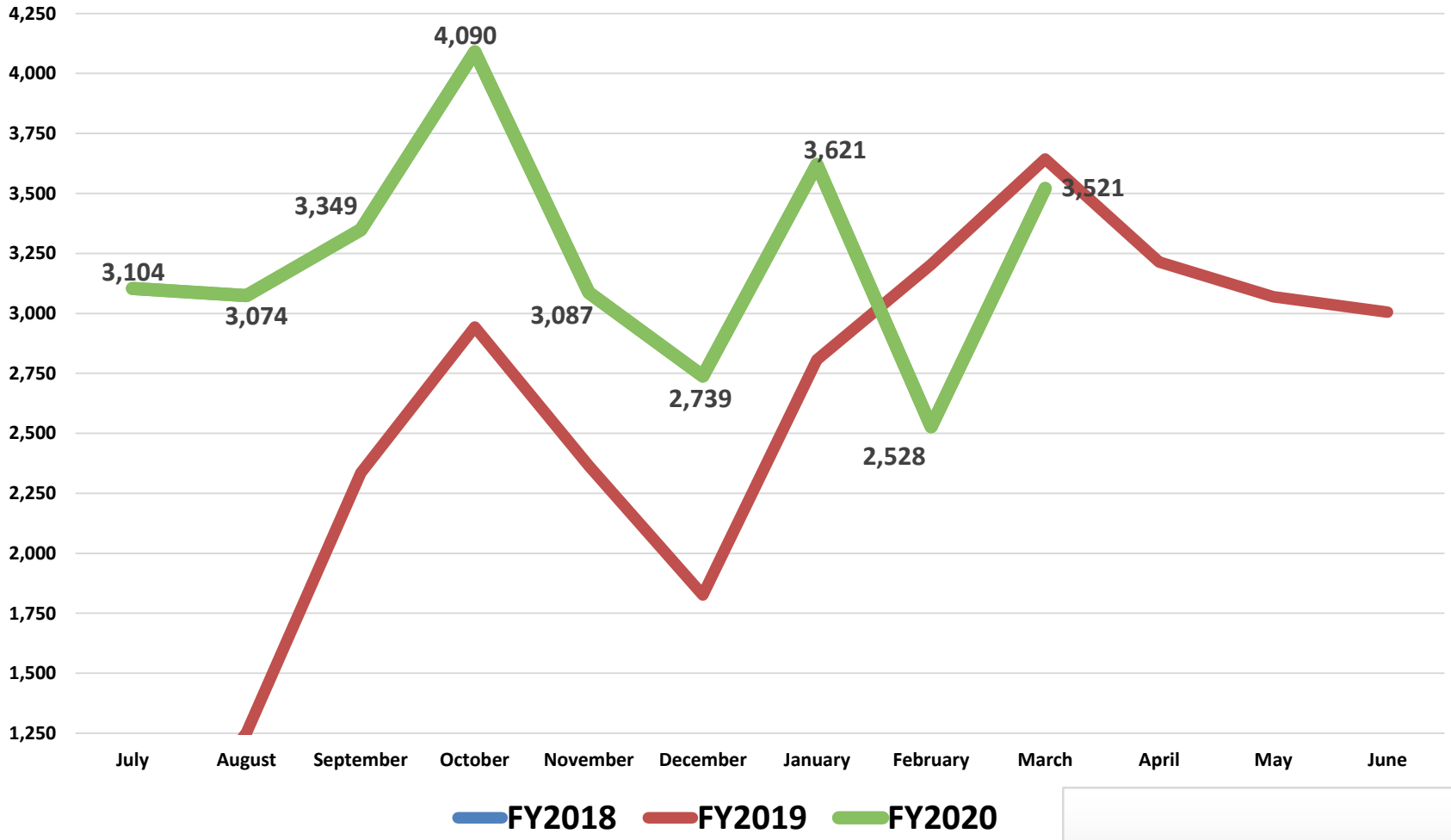


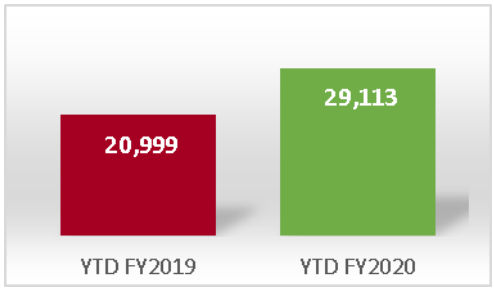


Sequoia Cardiology - Registrations

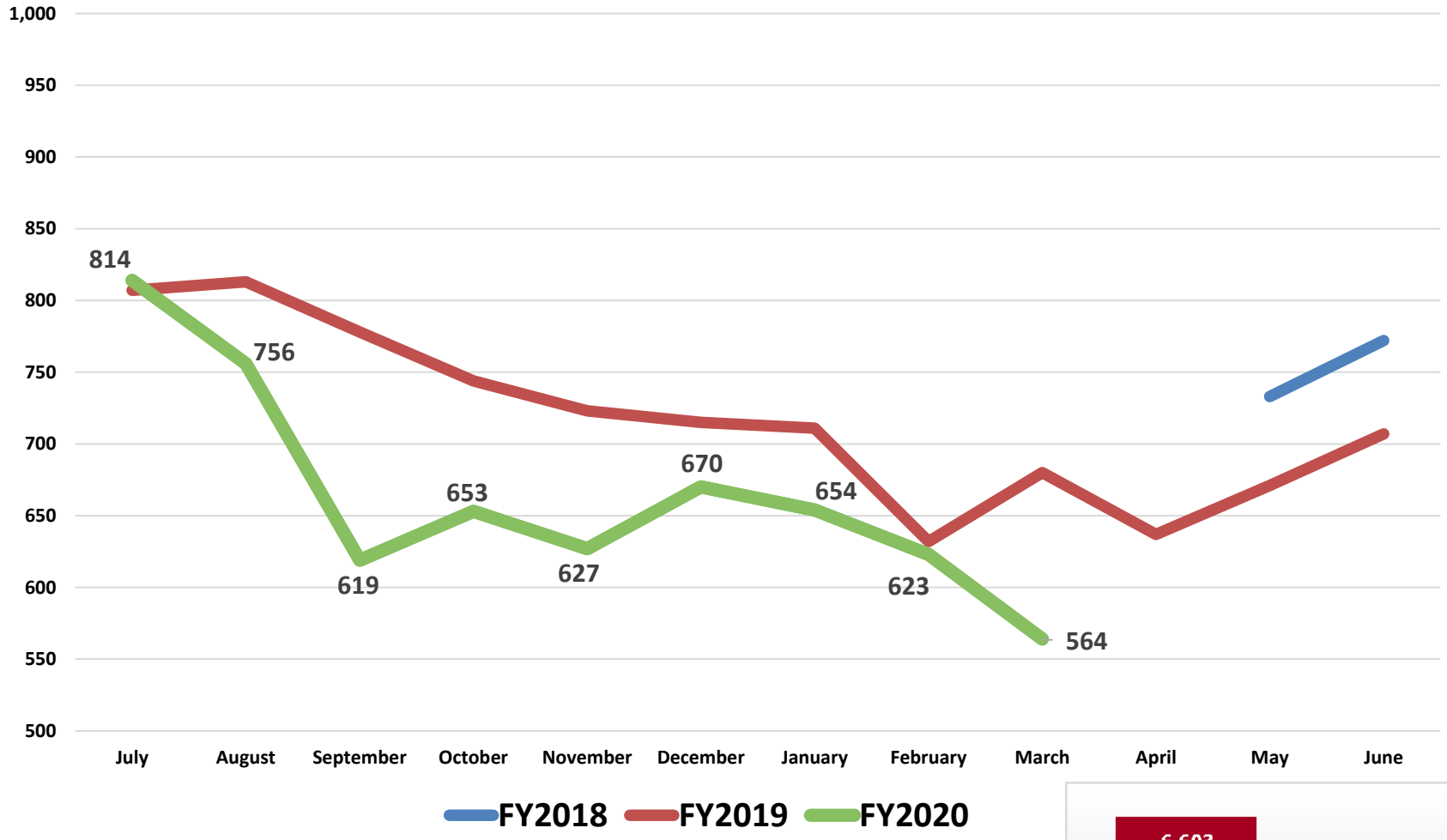


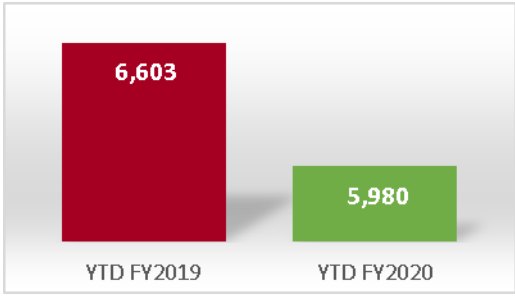
Sequoia Cardiology – wRVU's



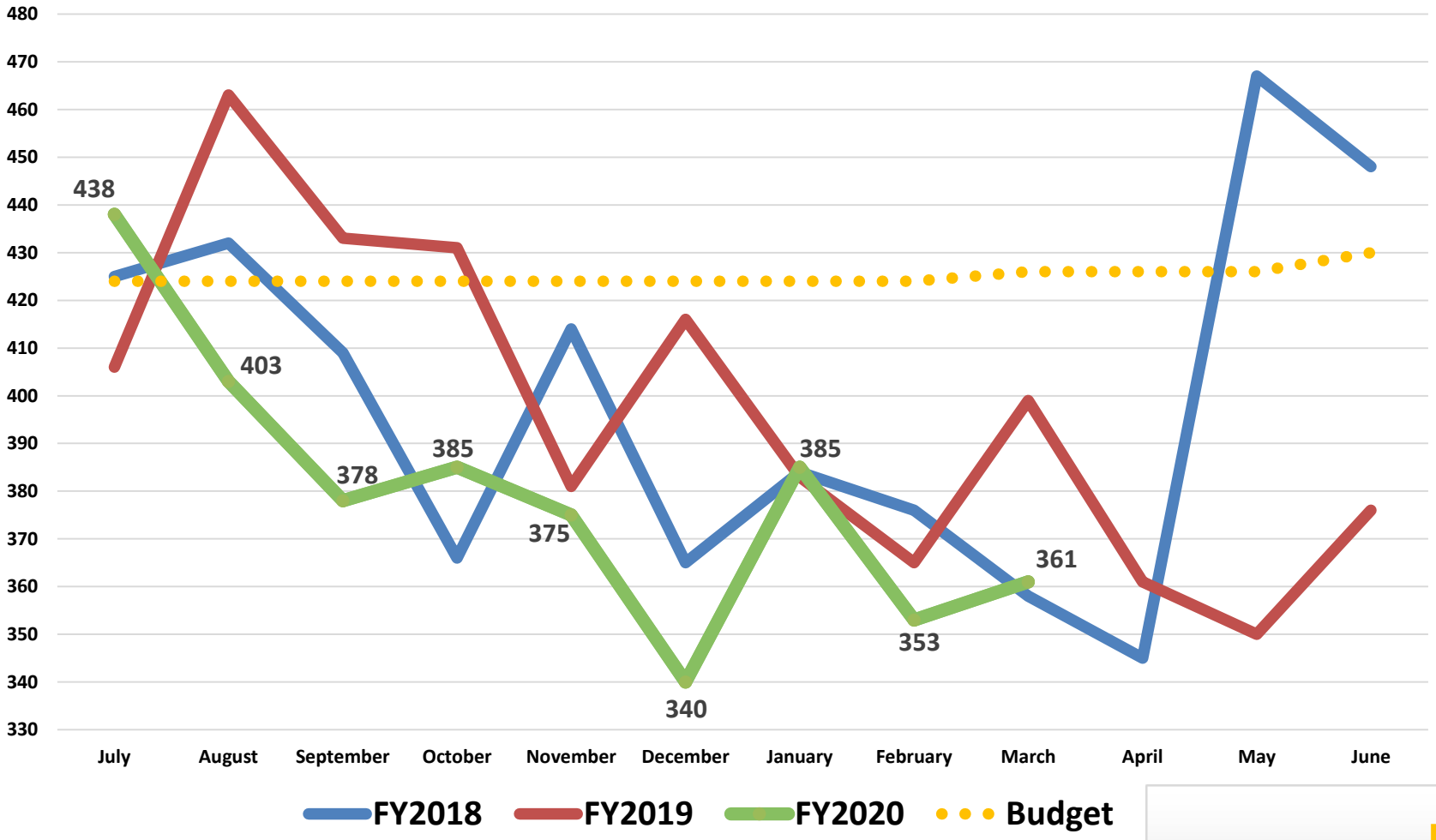


Labor Triage Registrations





Deliveries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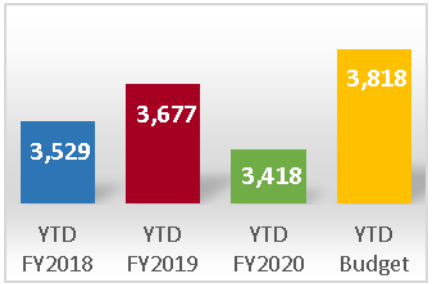
July
August
September
October
November
December
January
February
March
April
May
June
FY2018
FY2019
FY2020
Budget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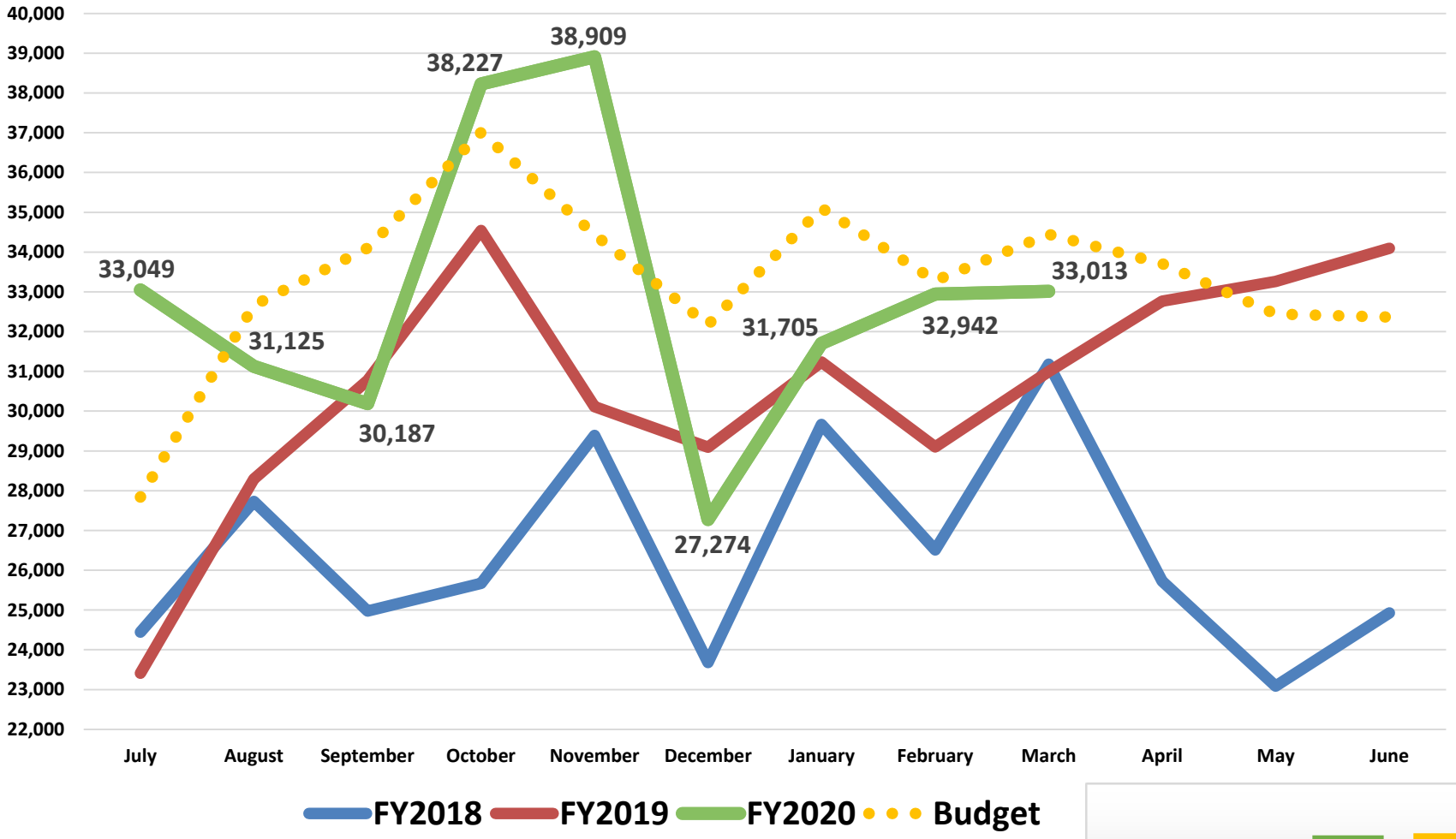
YTD FY2019
YTD FY2020
YTD Budget

KDMF RVU's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37,000
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32,000
31,000
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23,000
22,000
July
August
September
October
November
December
January
February
March
April
May
June
33,049
31,125
30,187
38,227
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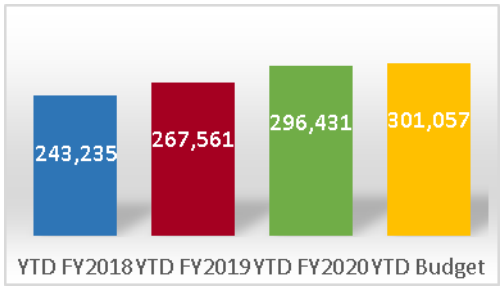
27,274
31,705
32,942
33,013
FY2018
FY2019
FY2020
Budget


243,235
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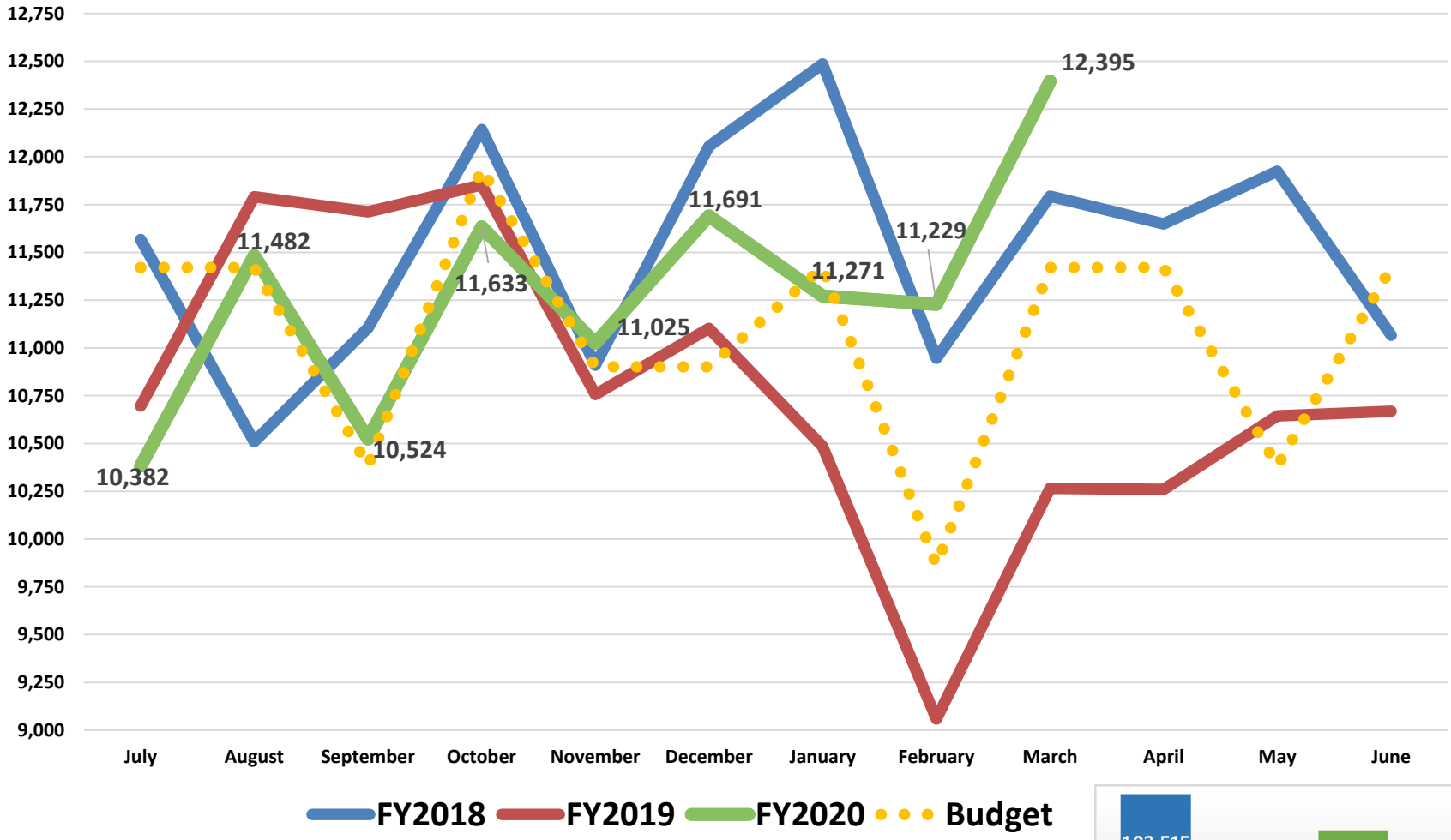
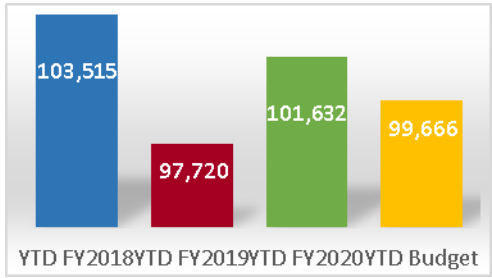
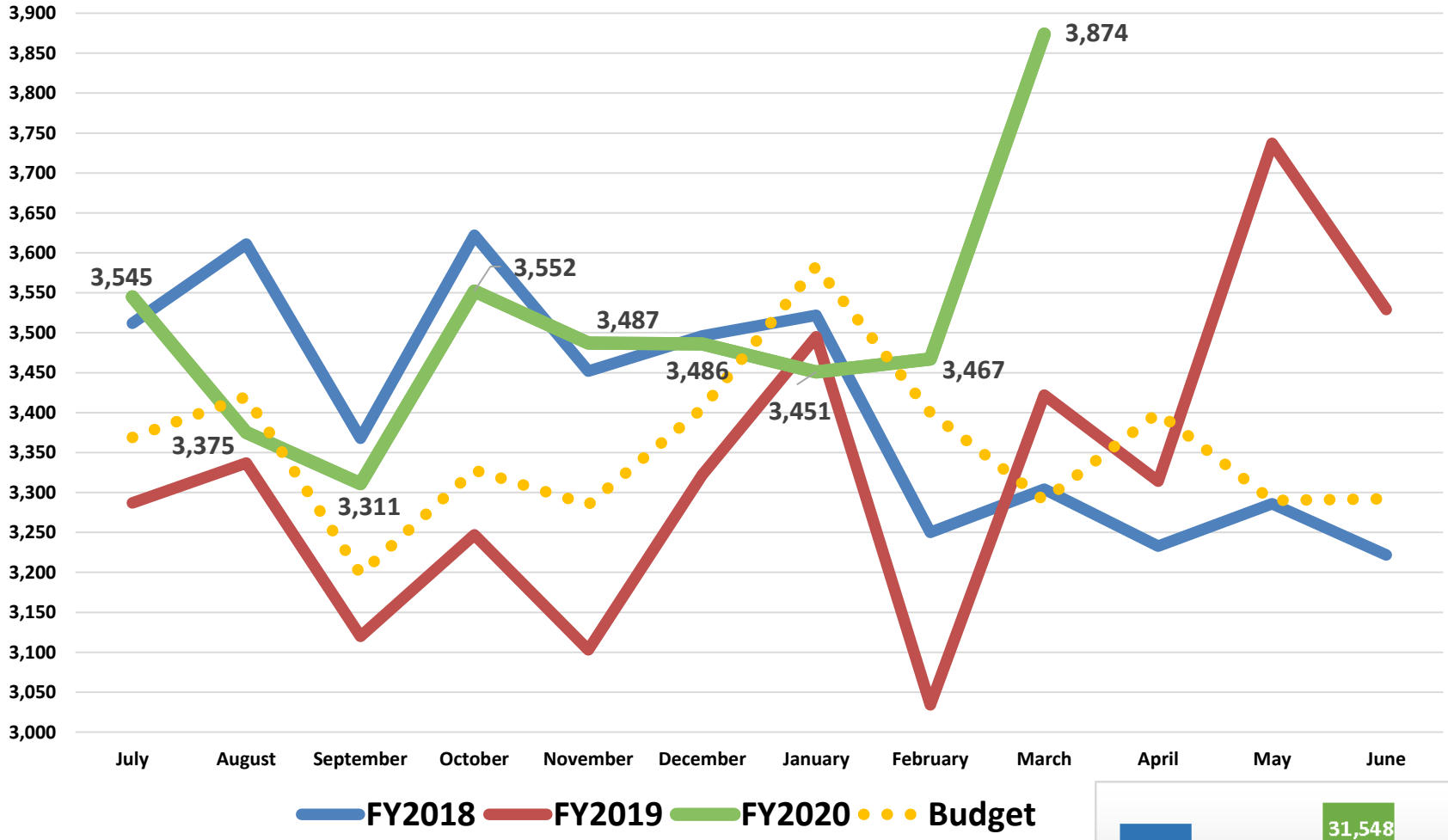
YTD FY2018
YTD FY2019
YTD FY2020
YTD Budget

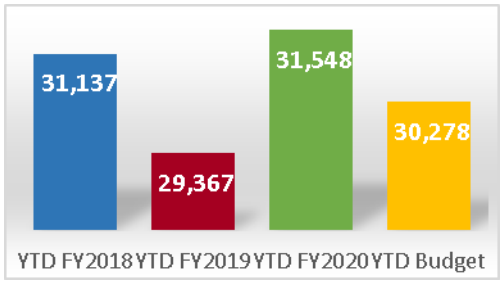
Home Infusion Days



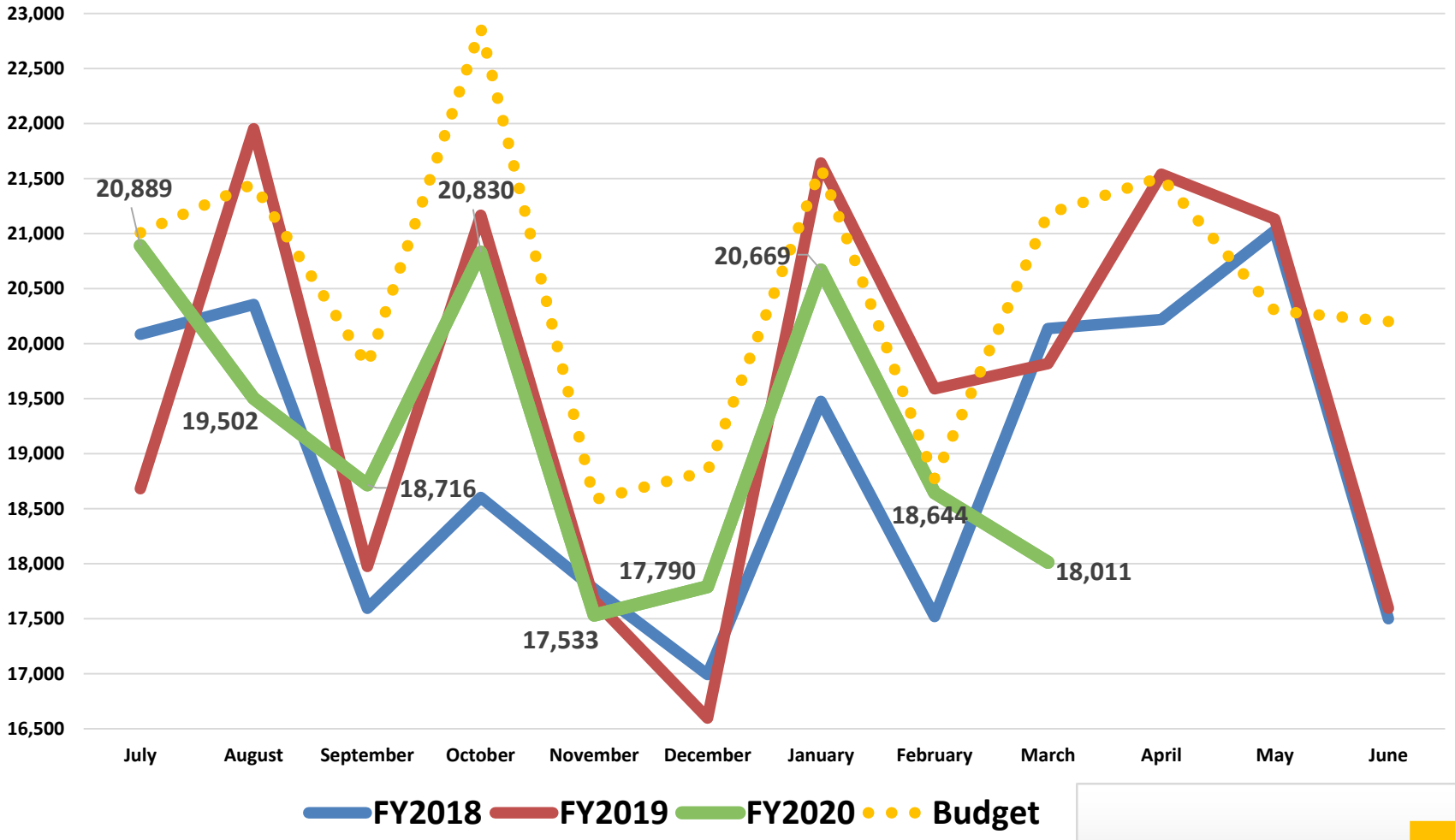


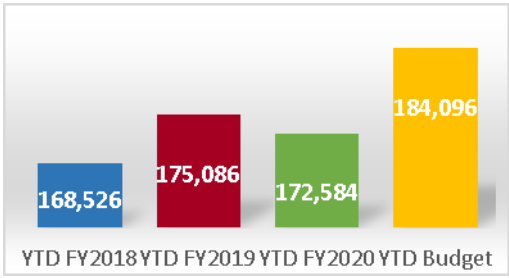
Hospice Days



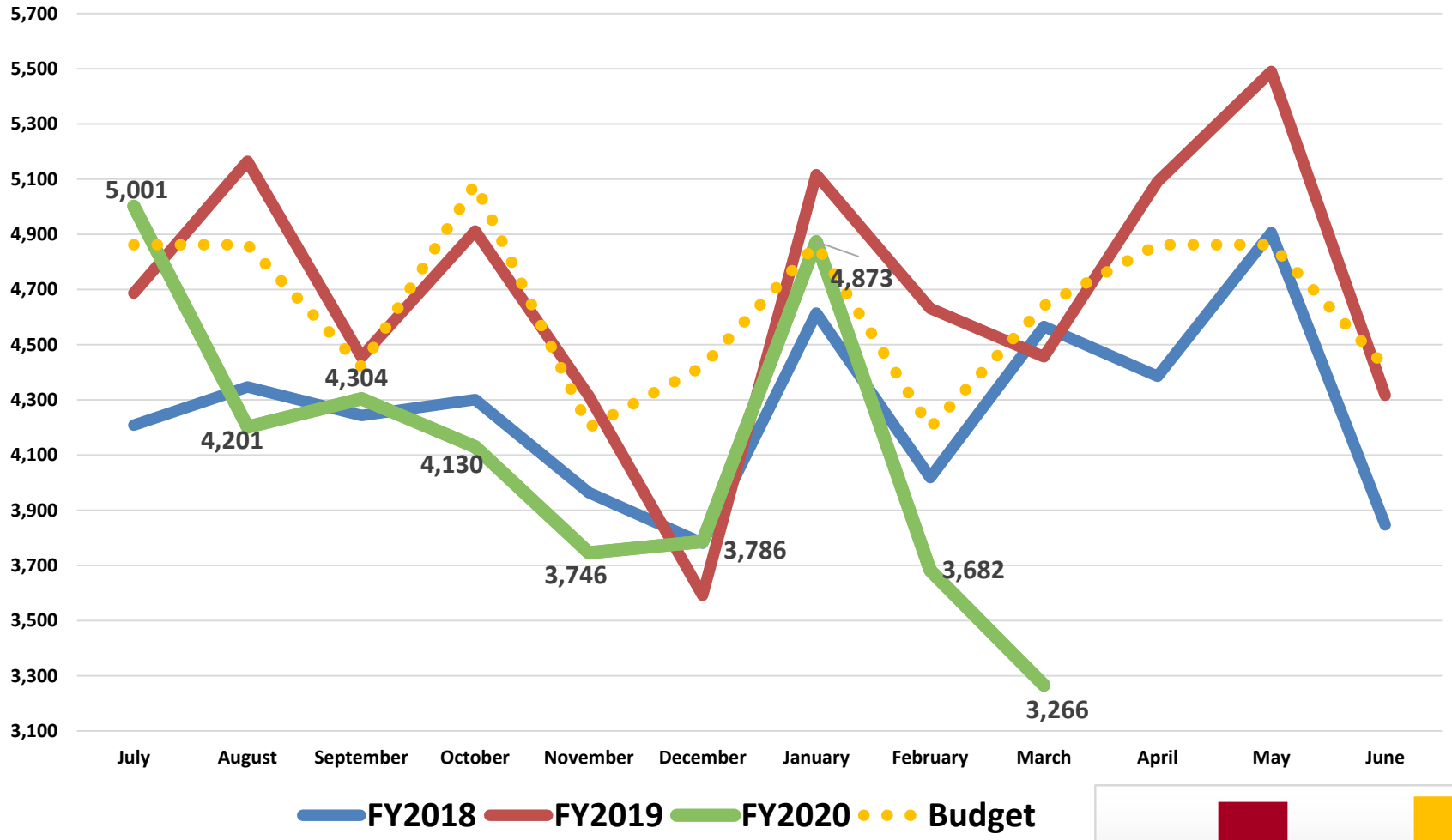


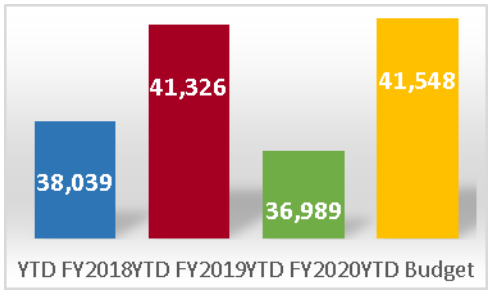
All O/P Rehab Services Across District



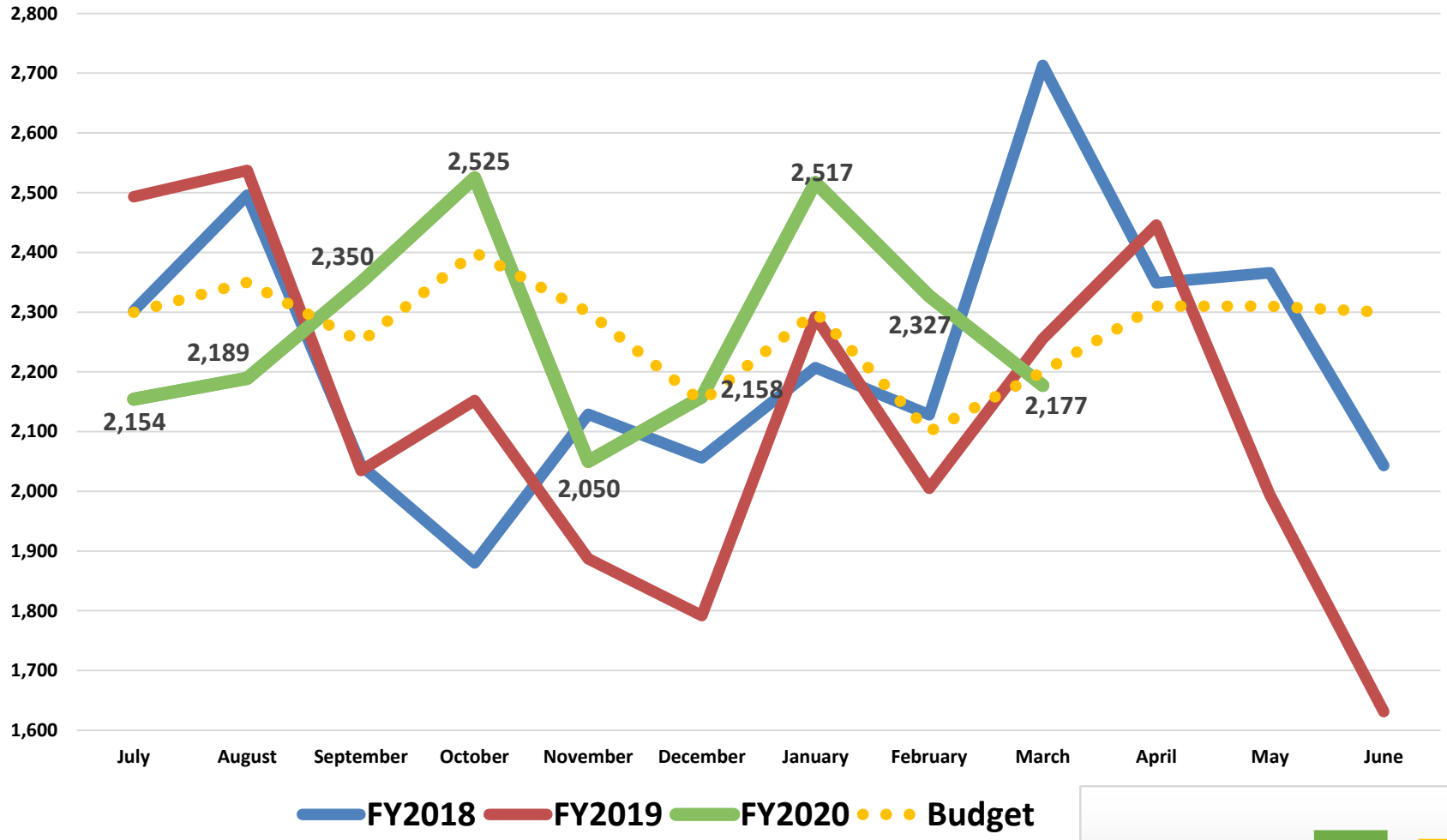


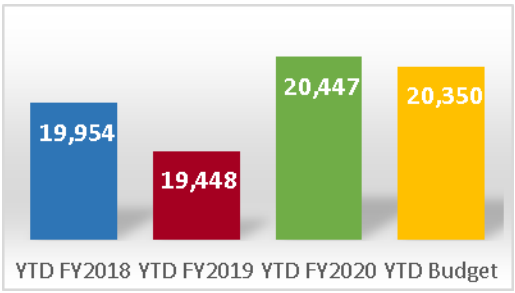
O/P Rehab Services



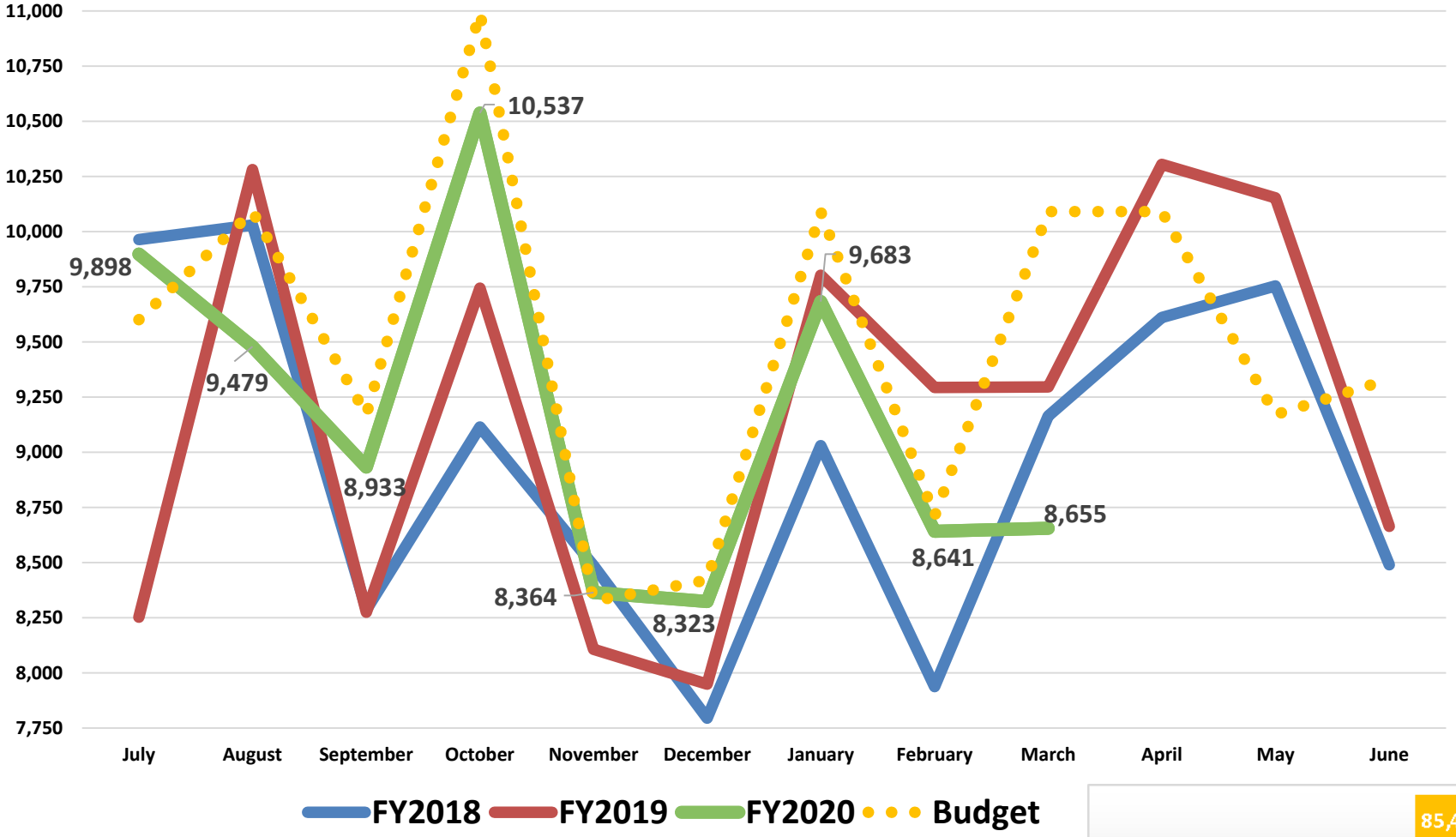


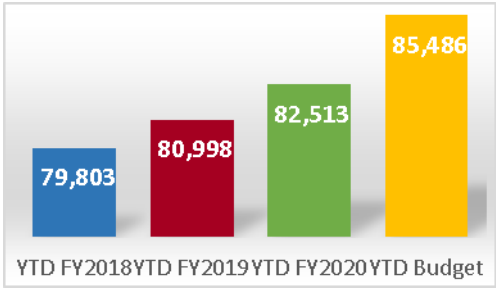
O/P Rehab - Exeter



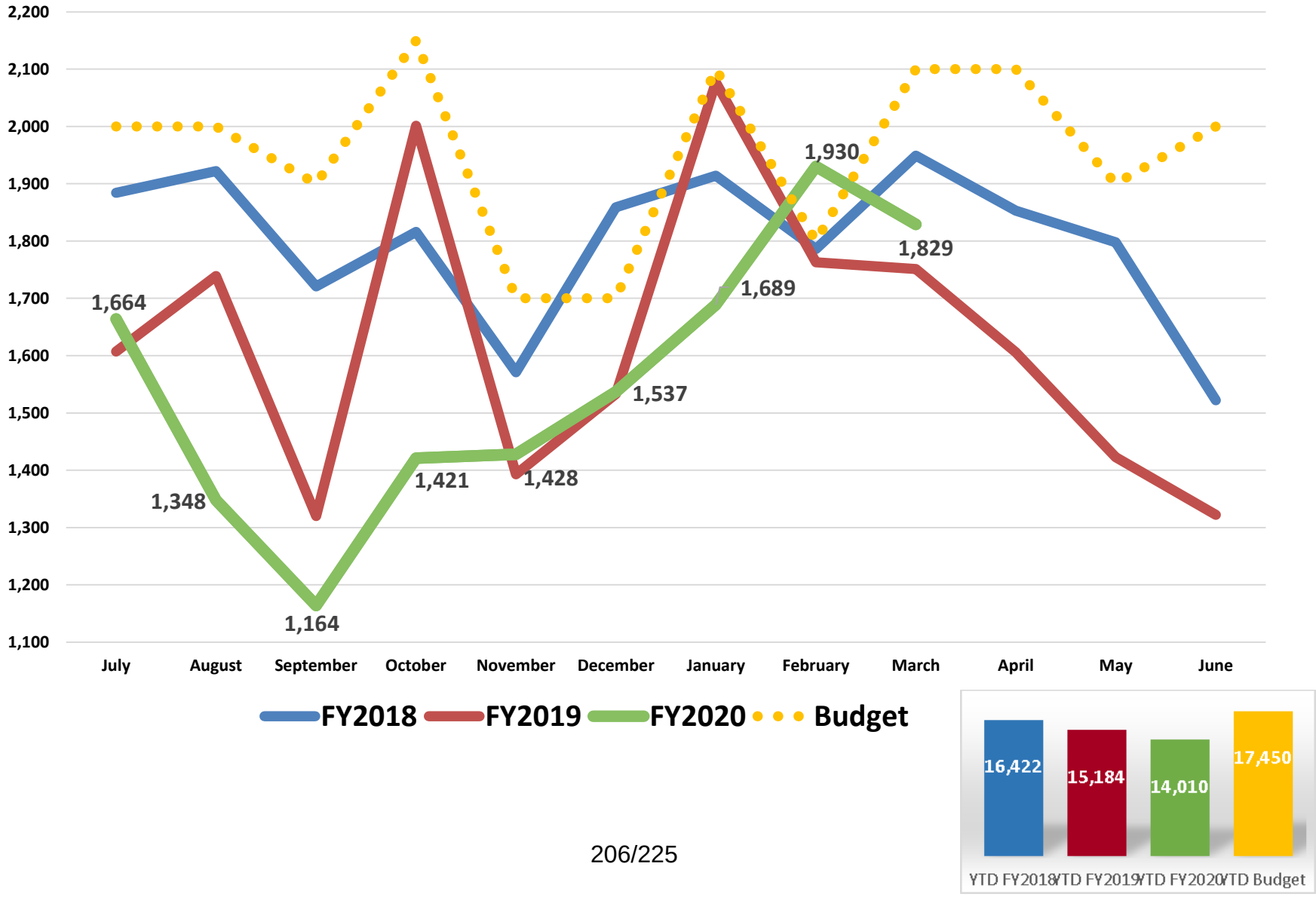


O/P Rehab - Akers

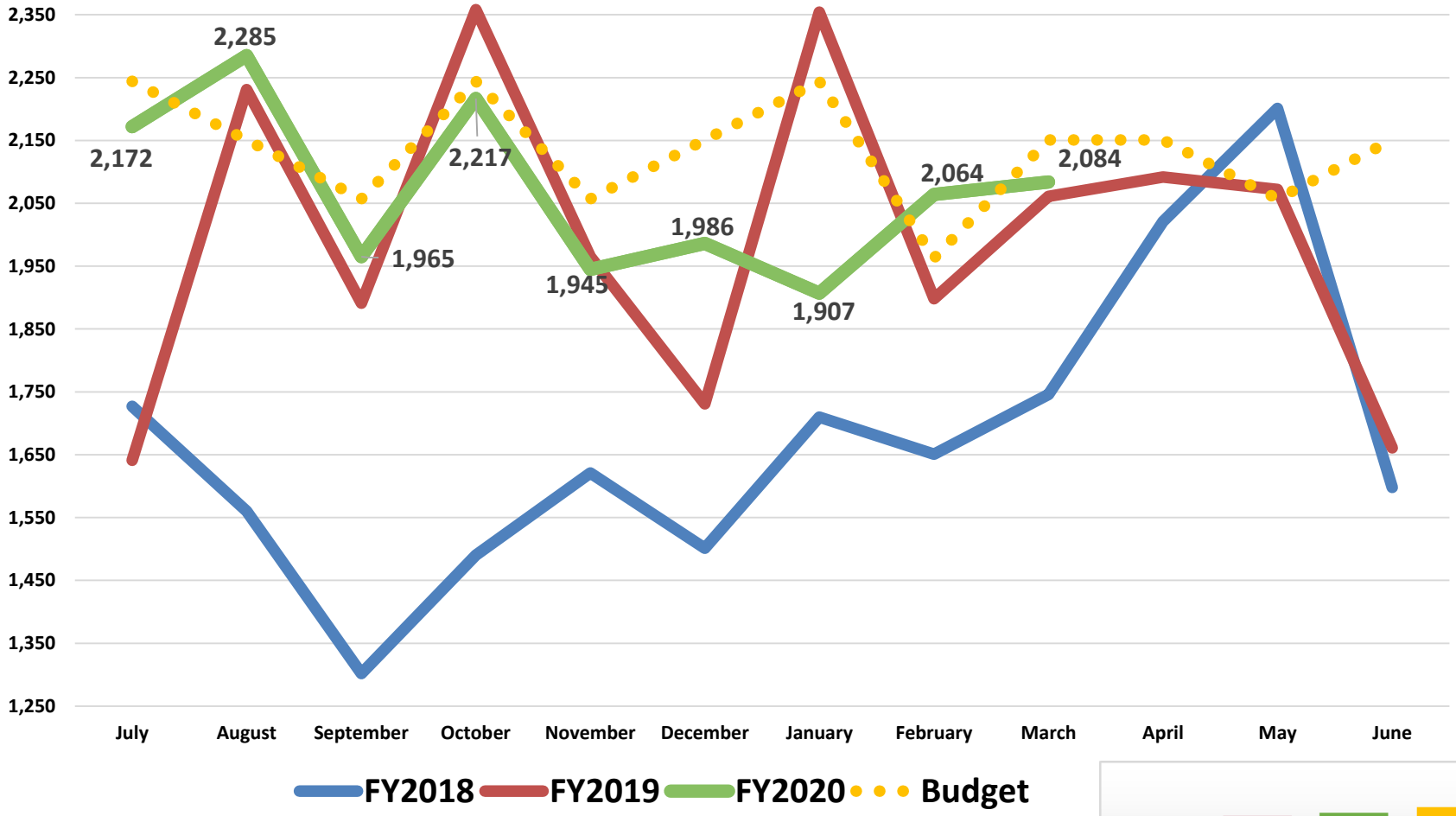


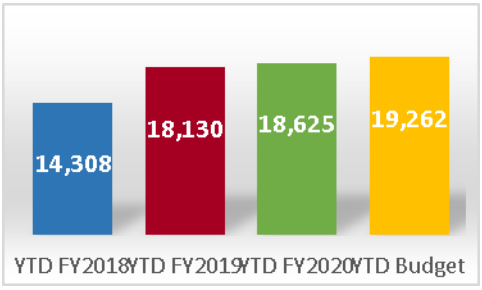


O/P Rehab - LLOPT

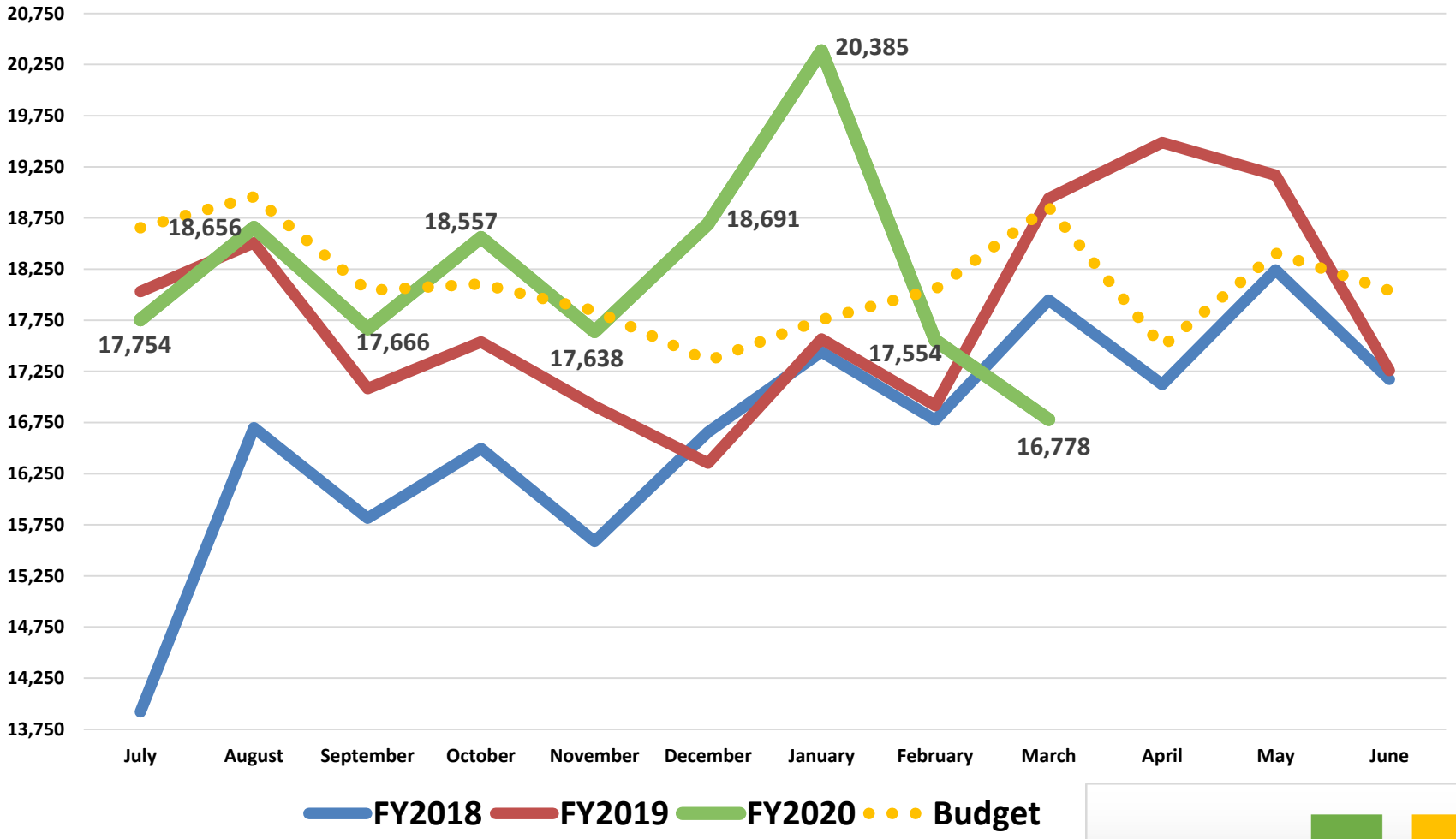


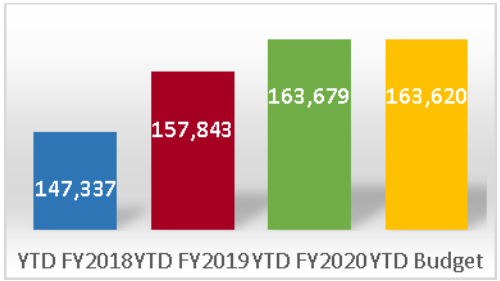
O/P Rehab - Dinuba



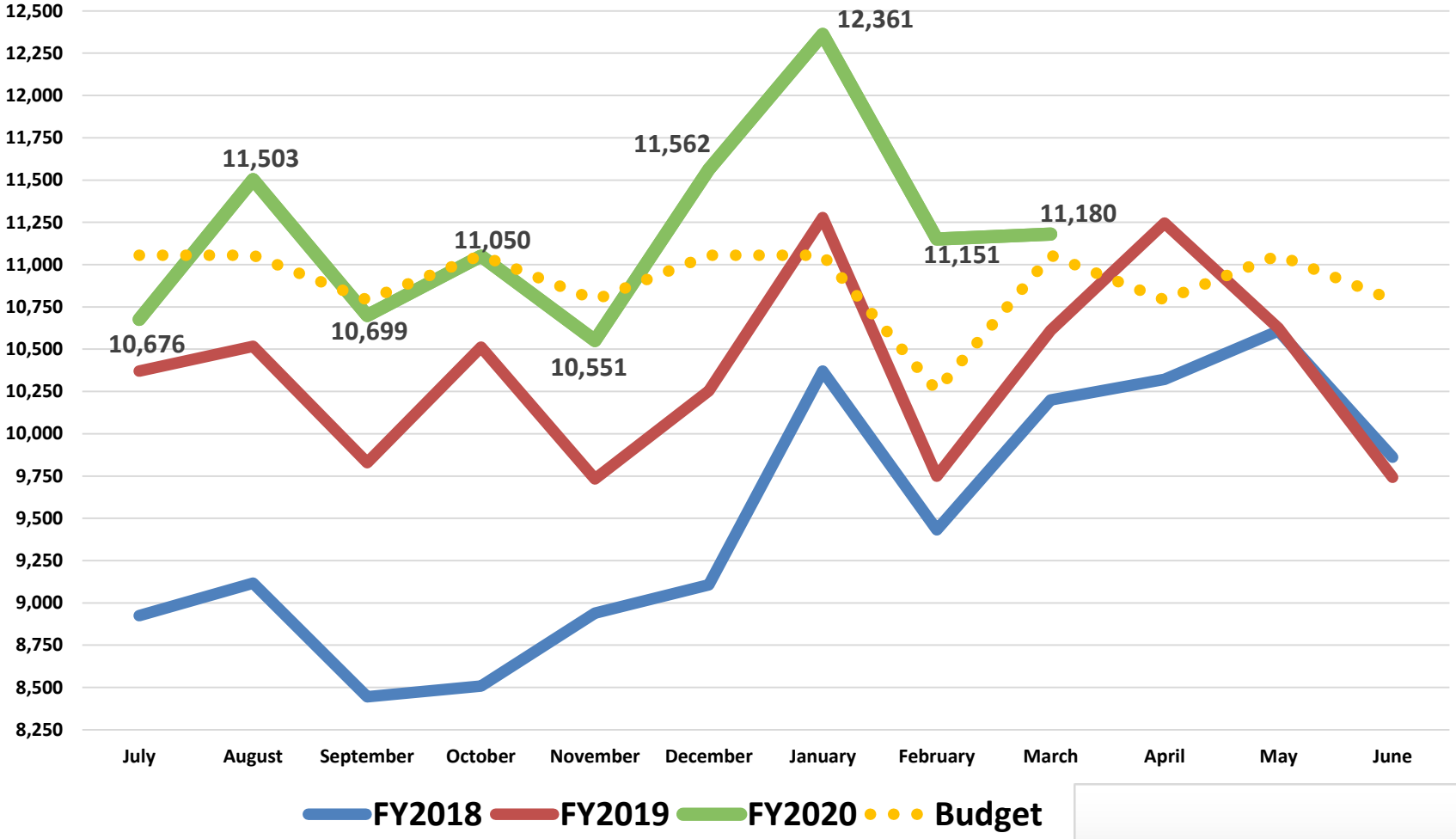


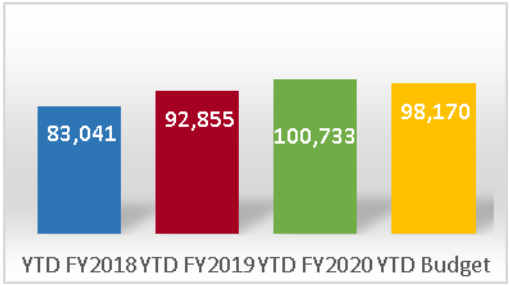
Physical & Other Therapy Units (I/P & O/P)



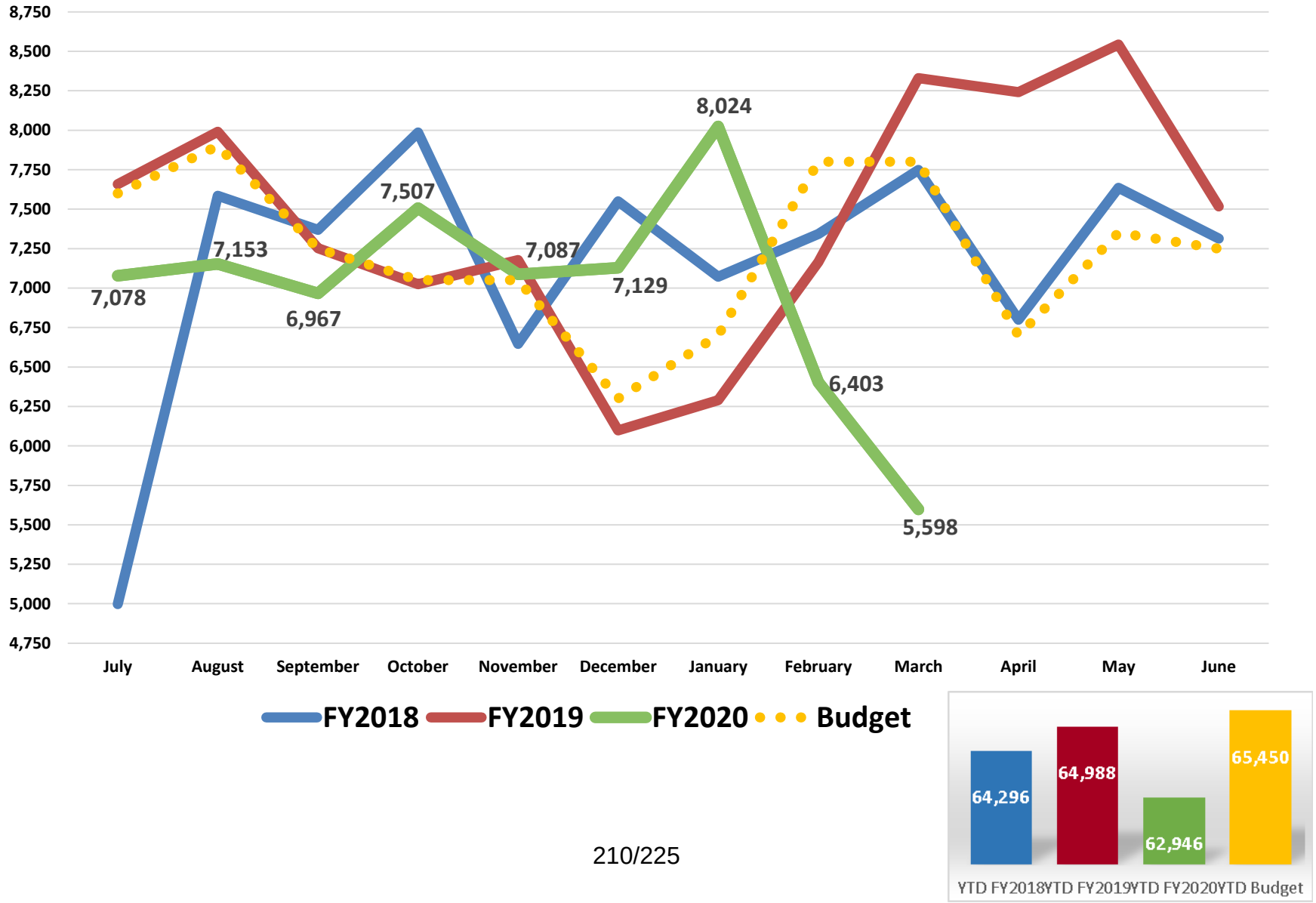


Physical & Other Therapy Units (I/P & O/P)-Main Campus

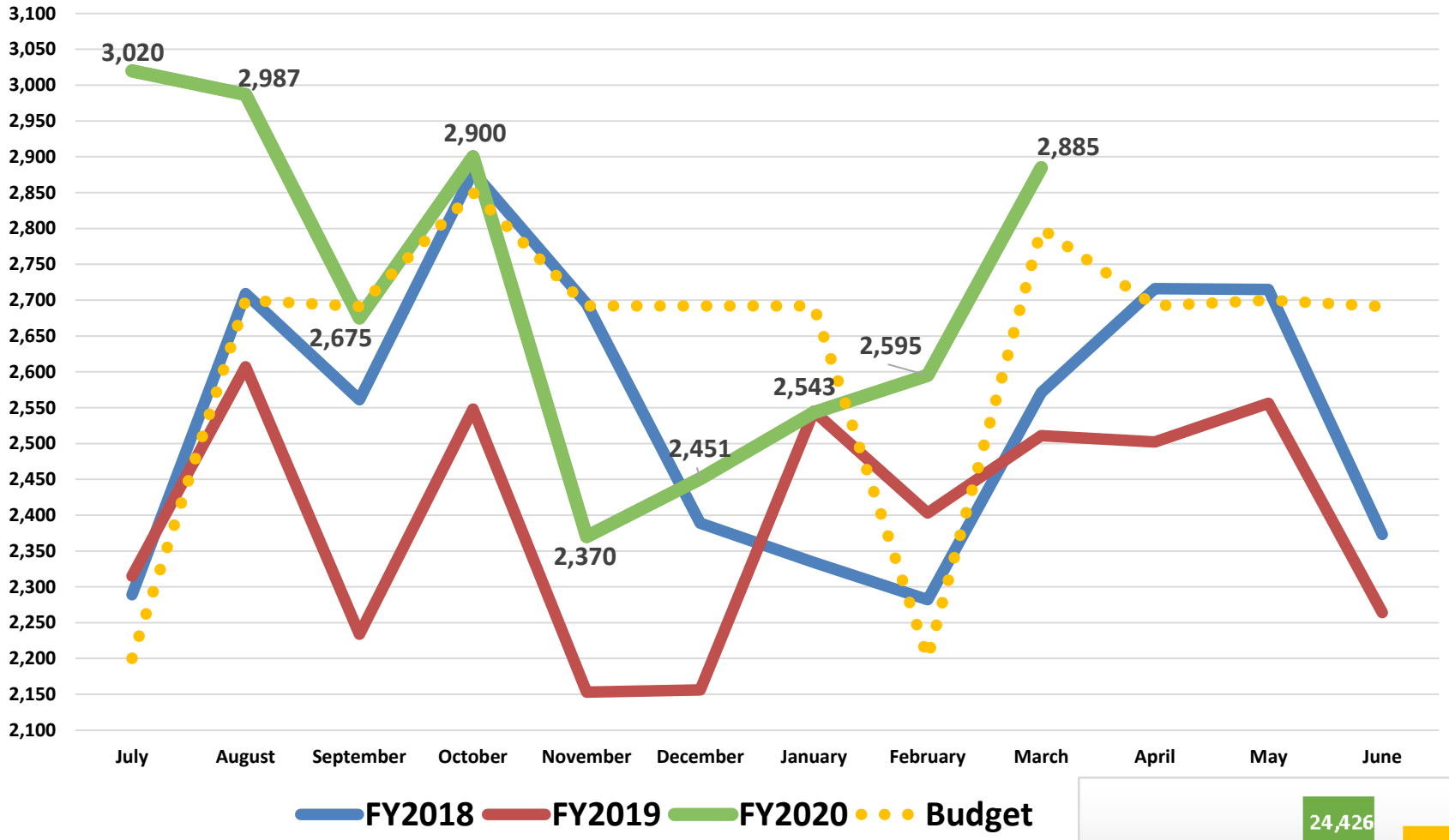


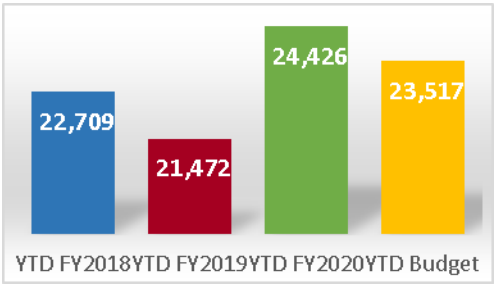


Physical & Other Therapy Units (I/P & O/P)-KDRH & South Campus

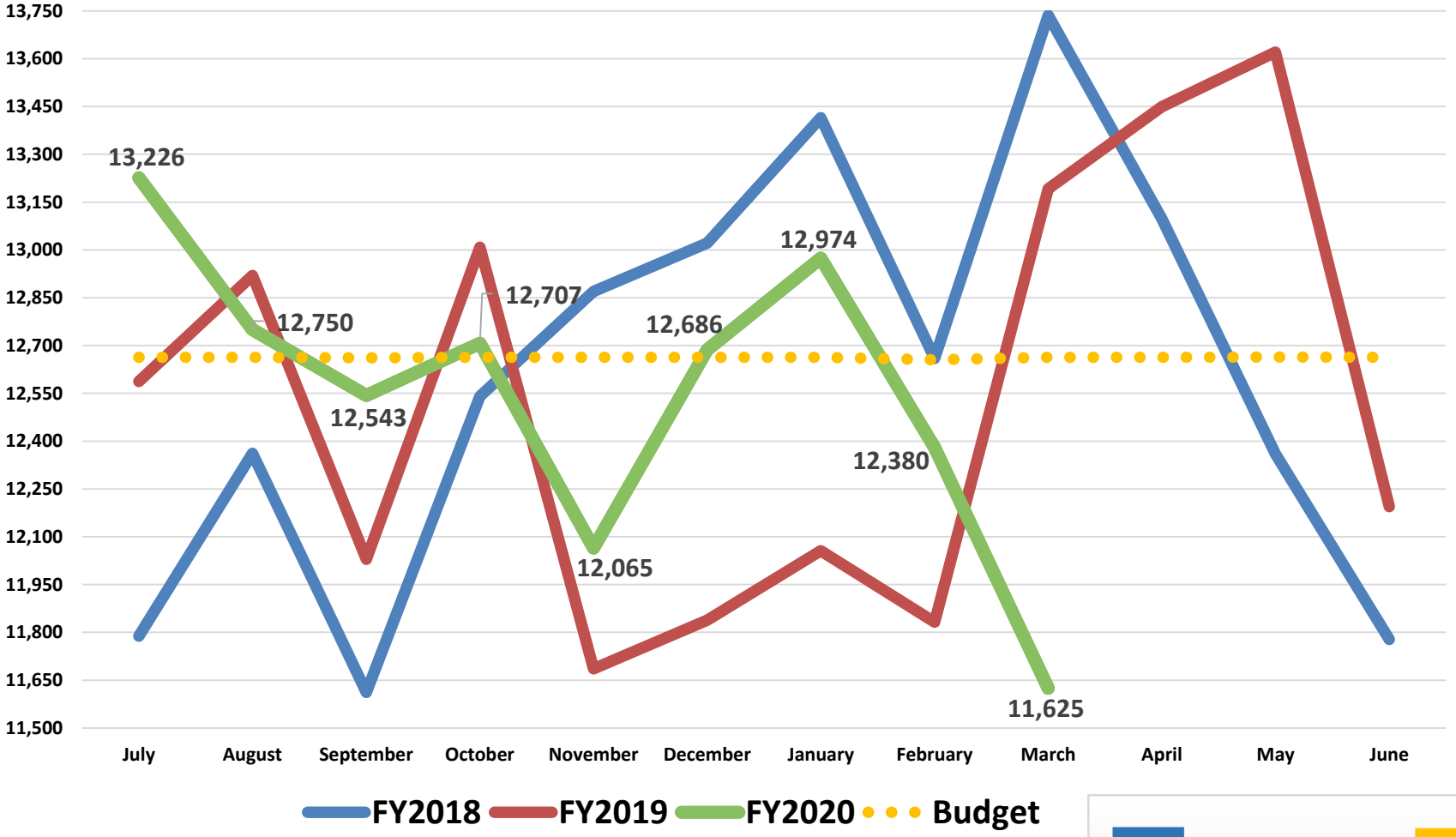


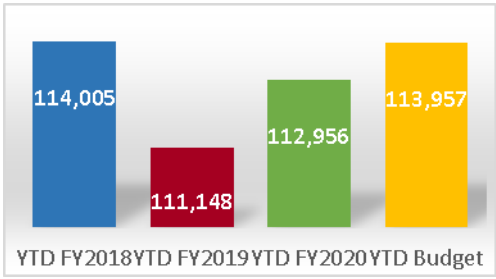
Home Health Visits



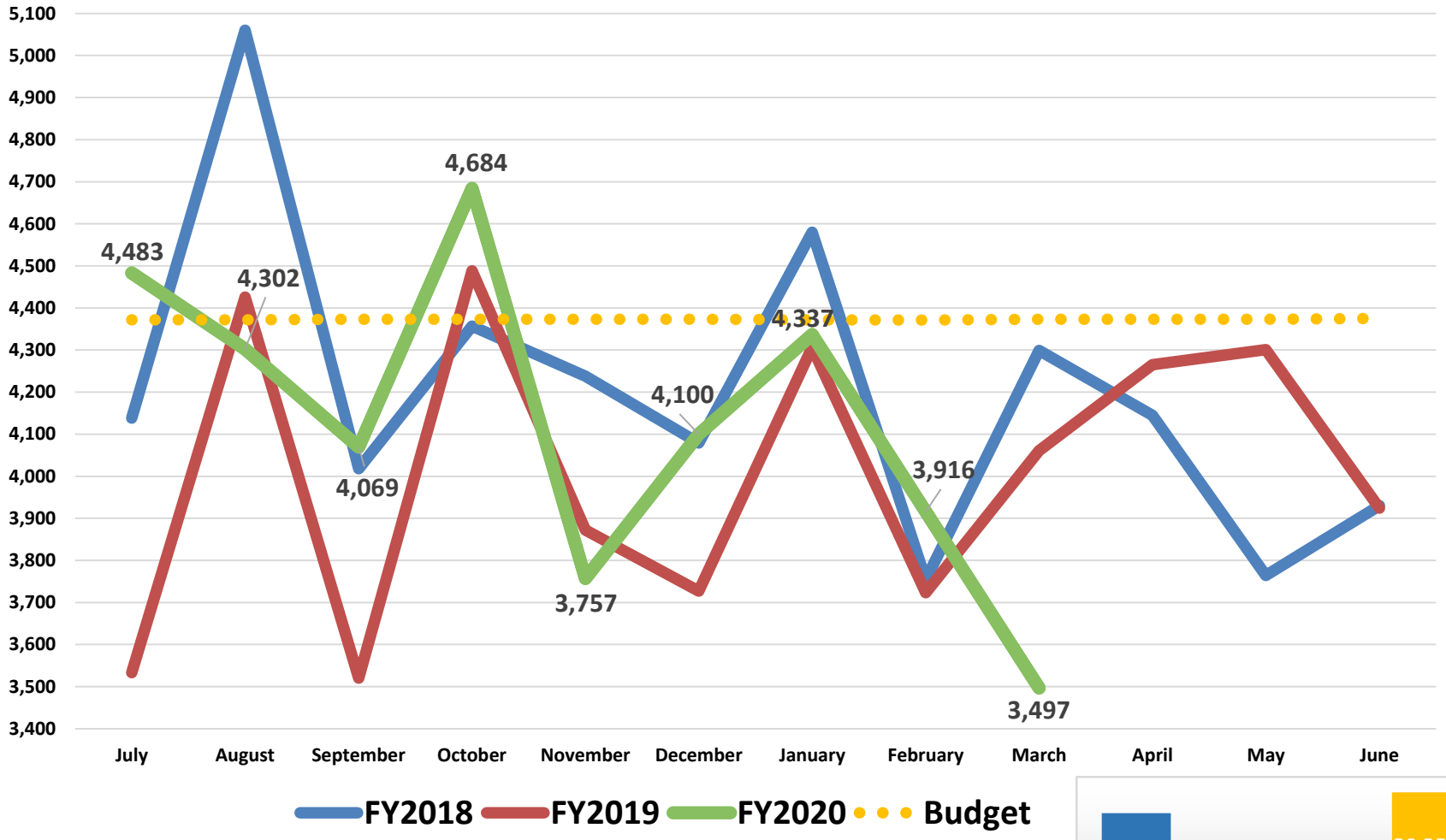


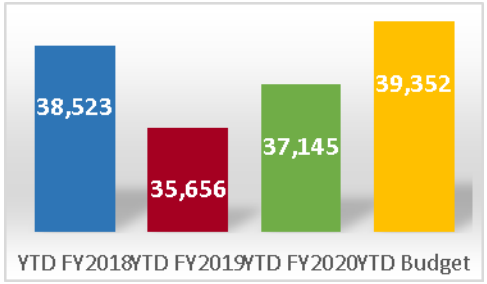
Radiology – Main Campus



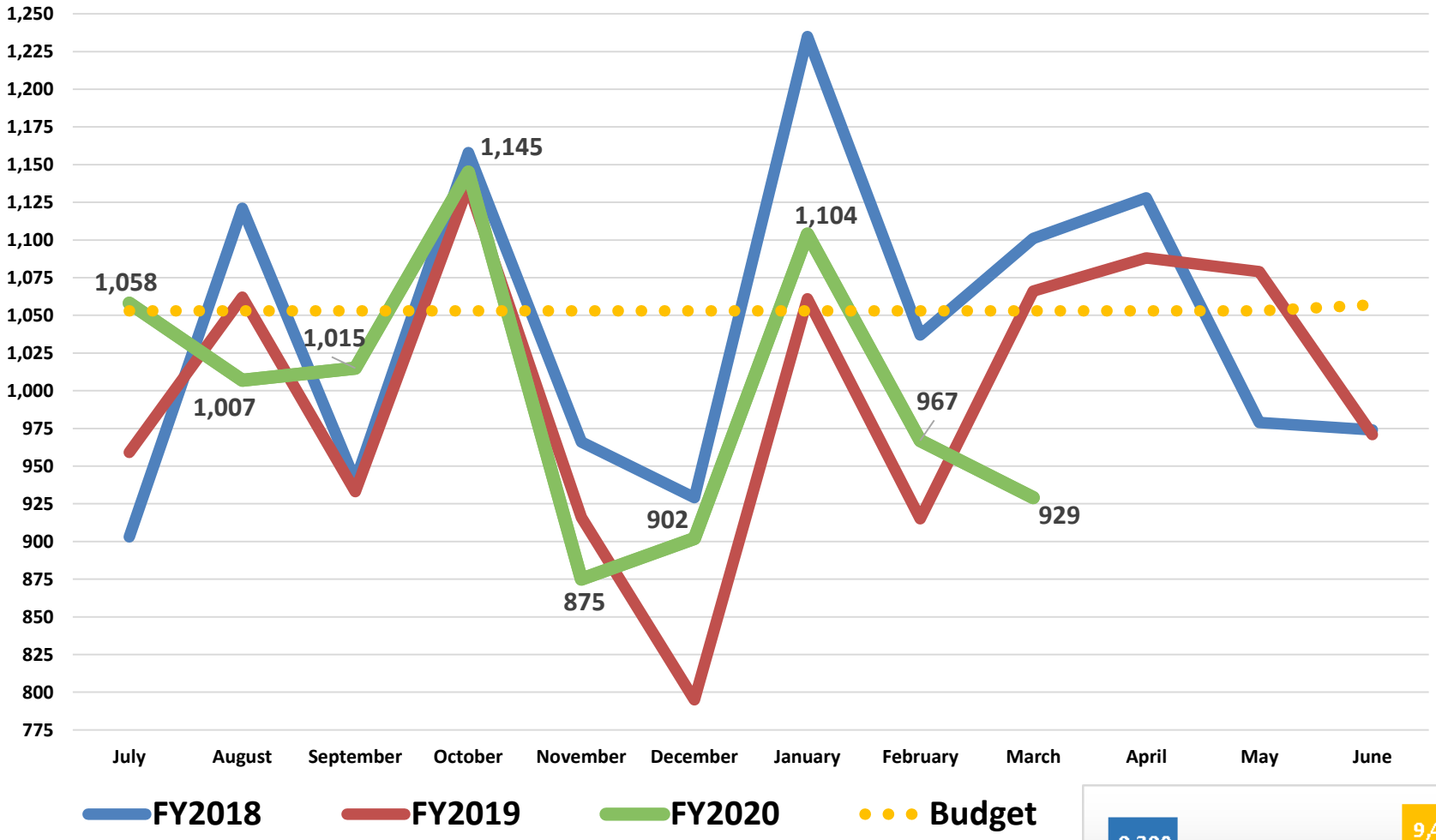


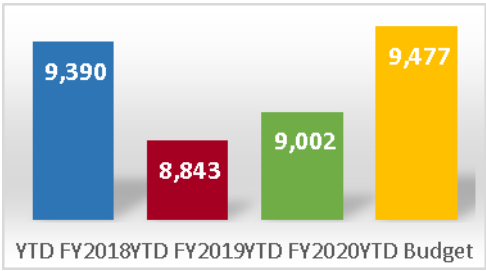
Radiology – West Campus Imaging



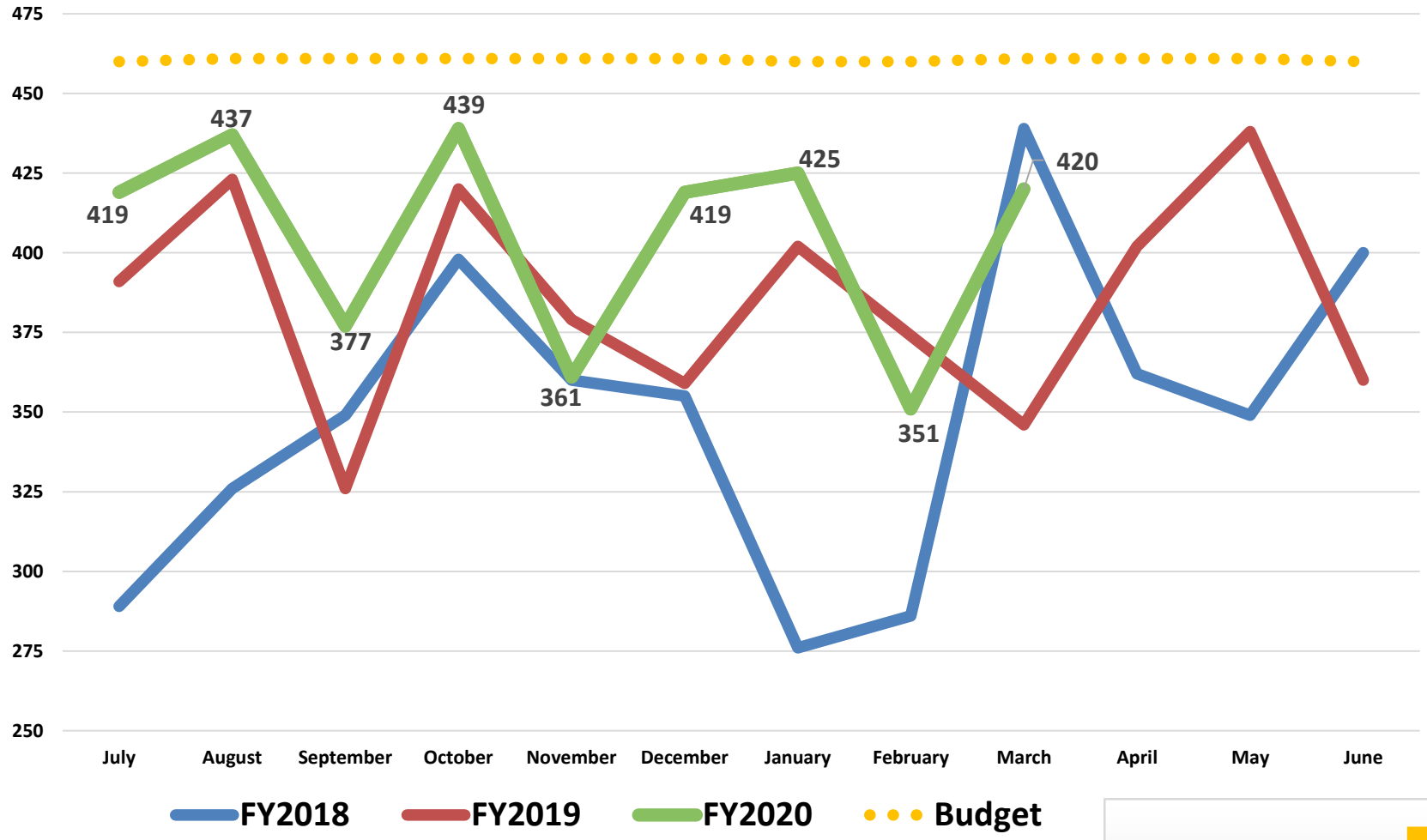


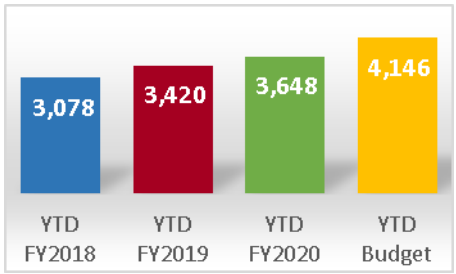
West Campus – Diagnostic Radiology



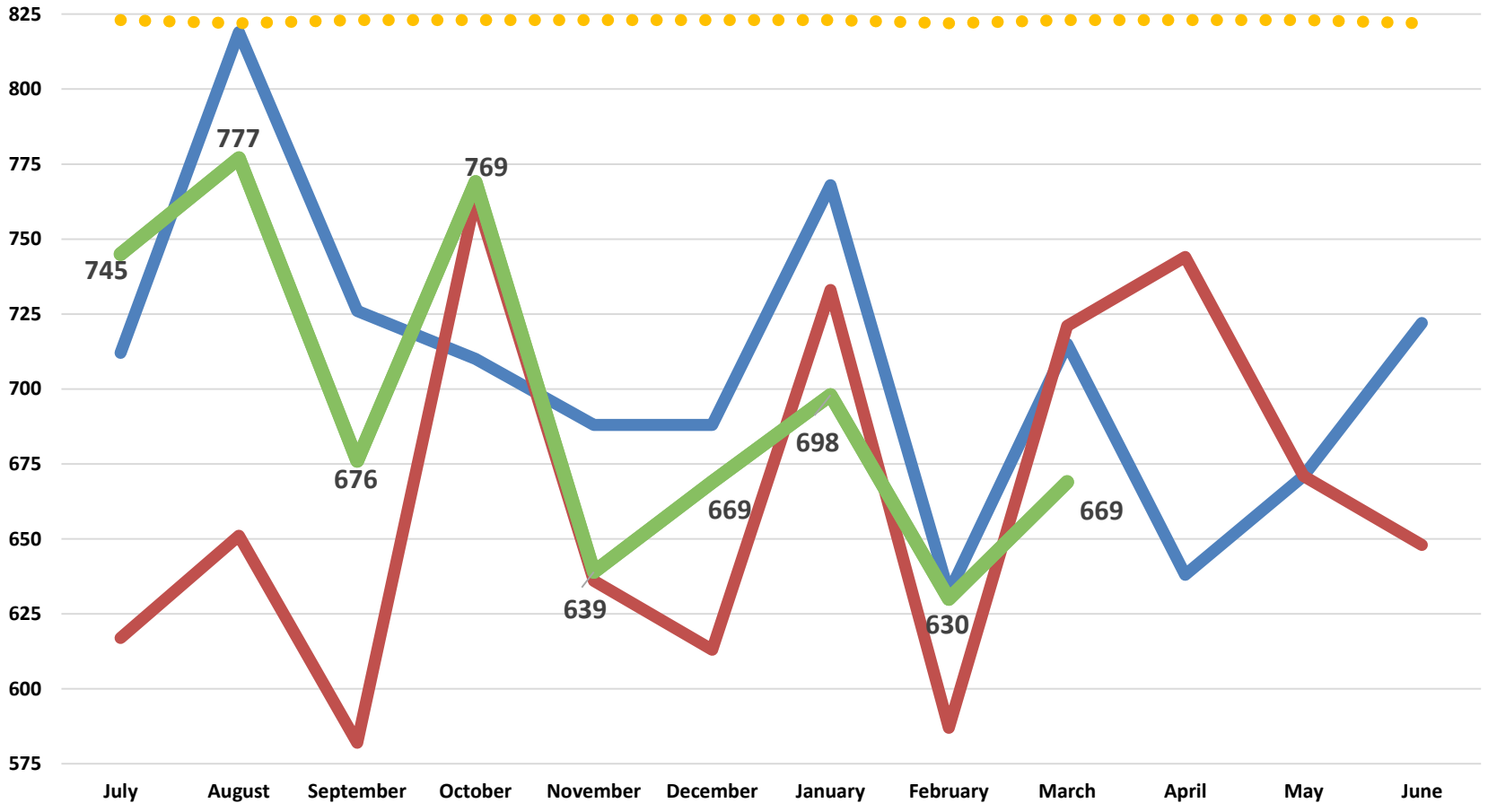


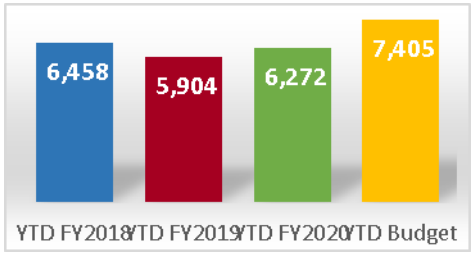
West Campus – CT Scan



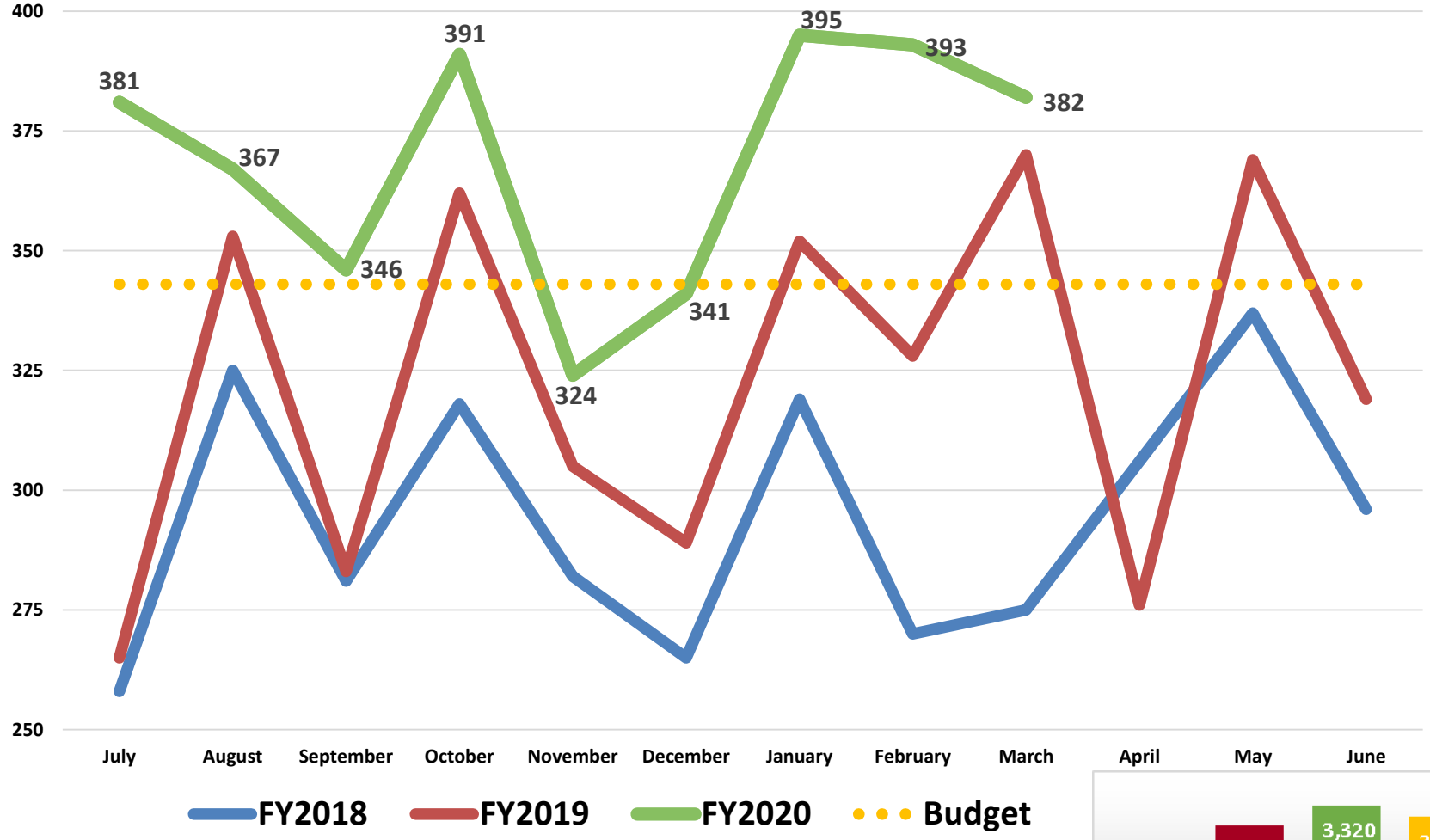


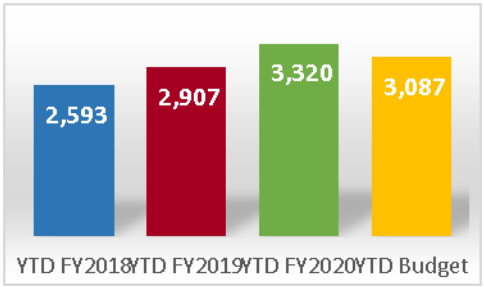
West Campus - Ultrasound



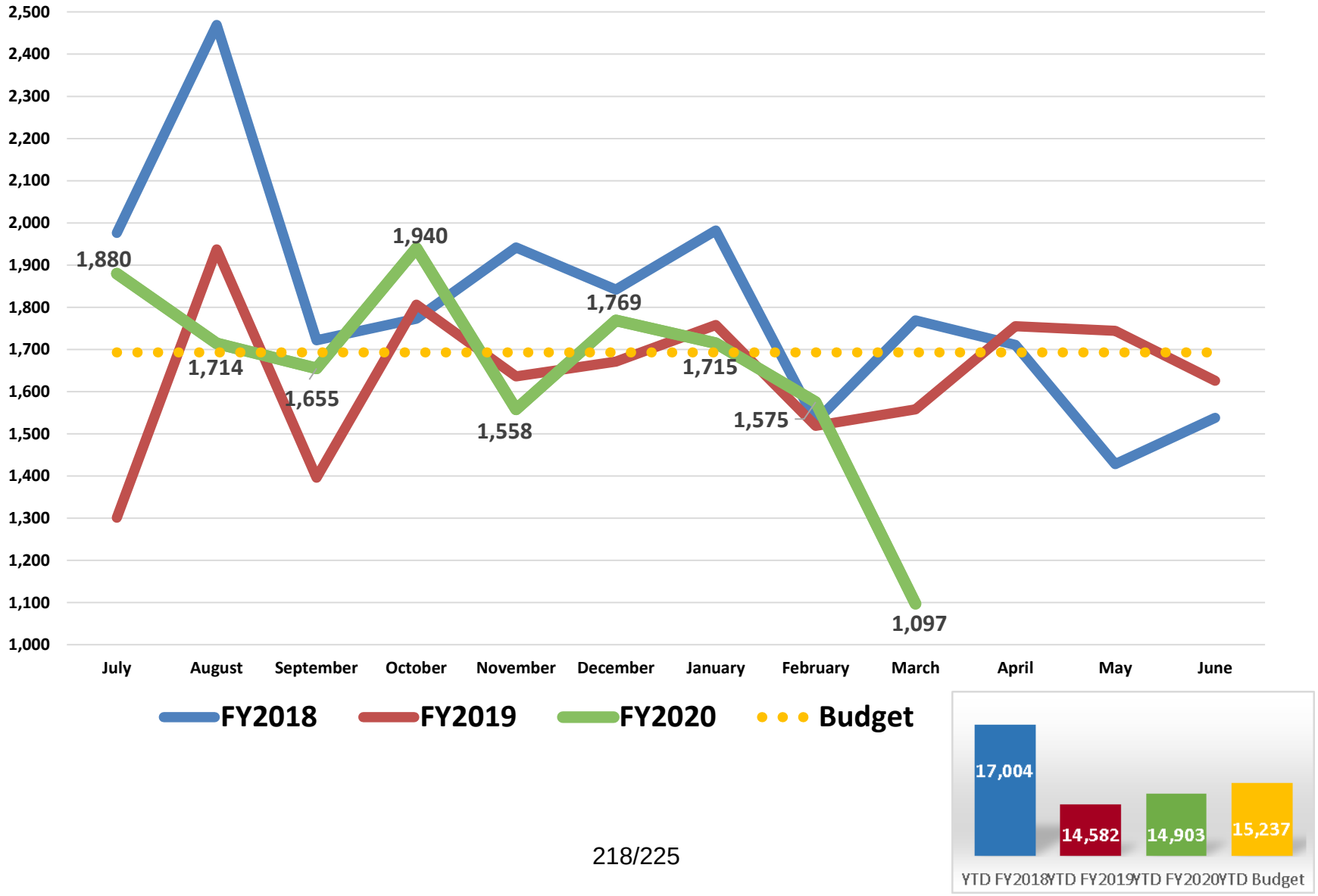


West Campus - MRI

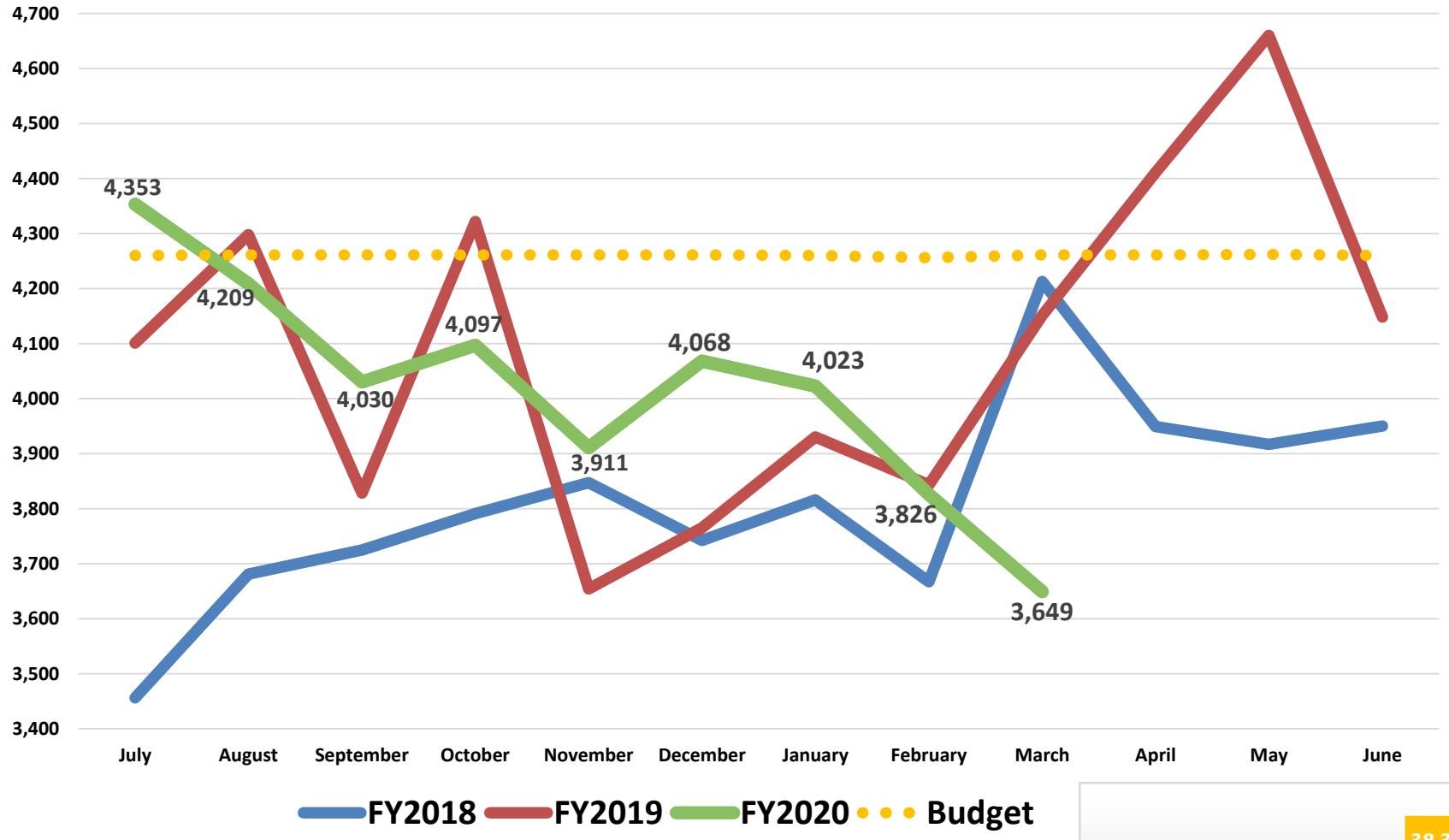


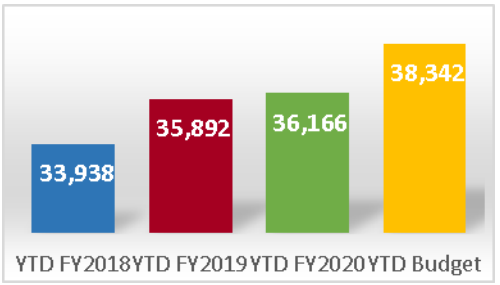


West Campus – Breast Center

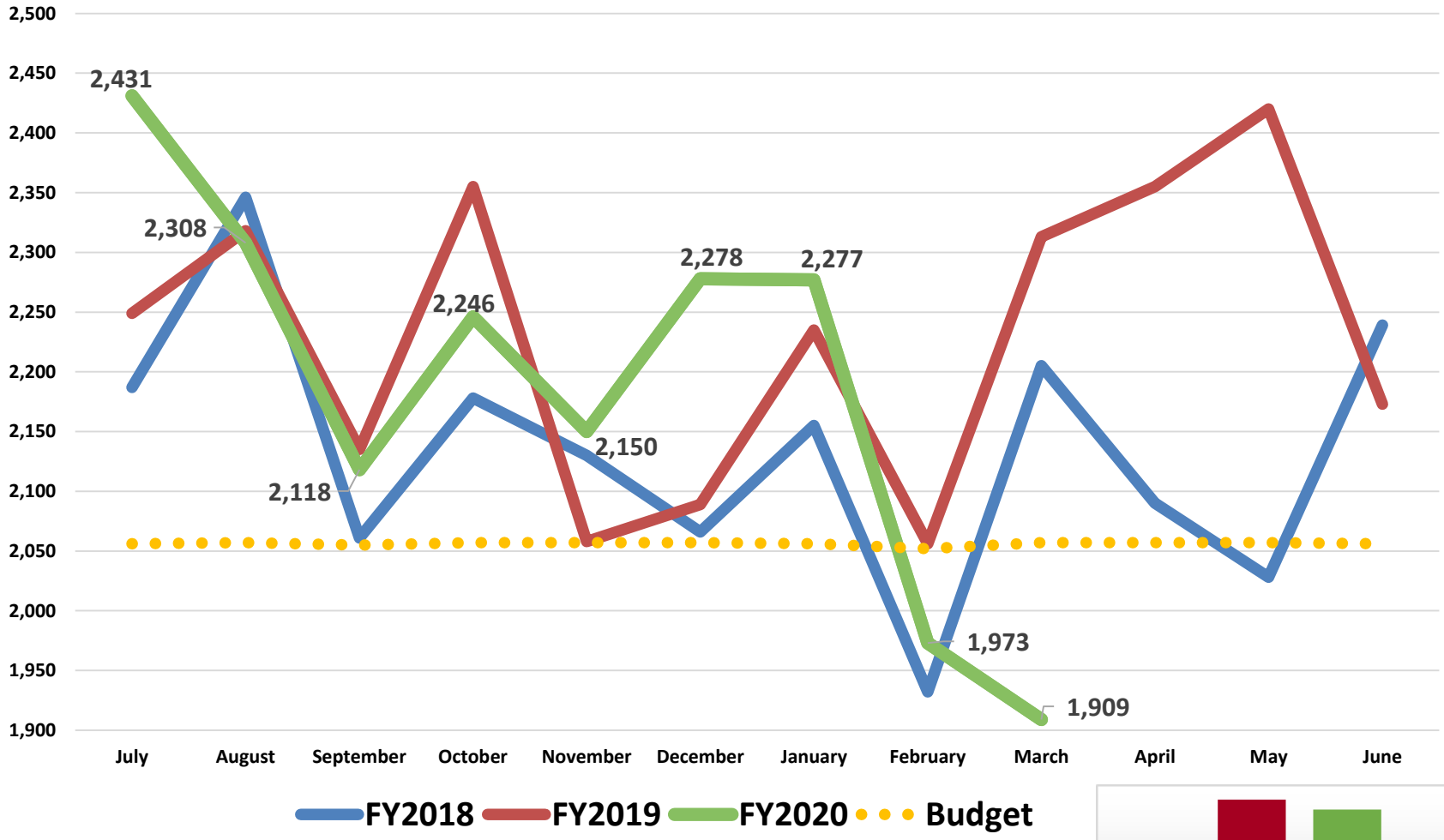


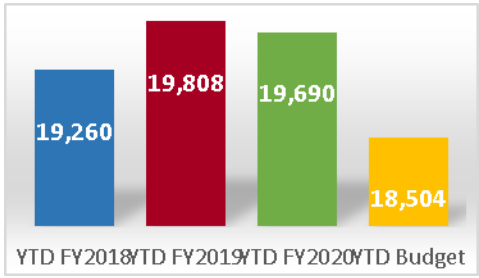
Radiology all areas – CT



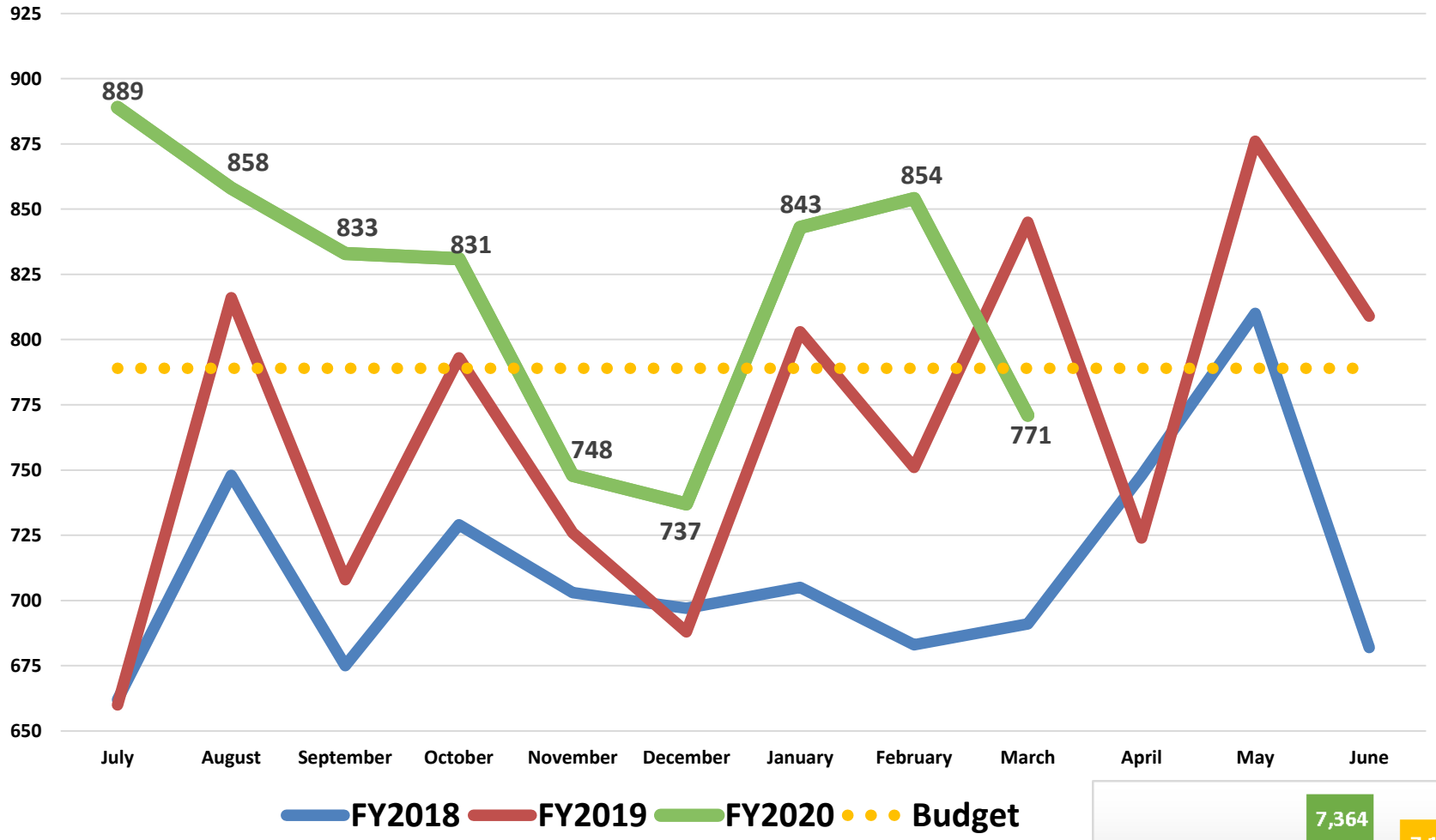


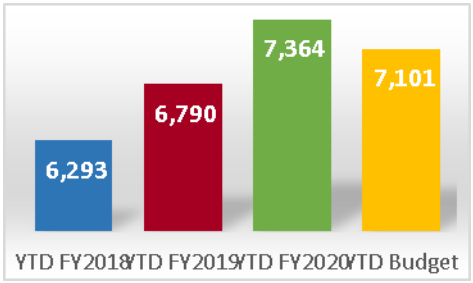
Radiology all areas – Ultrasound



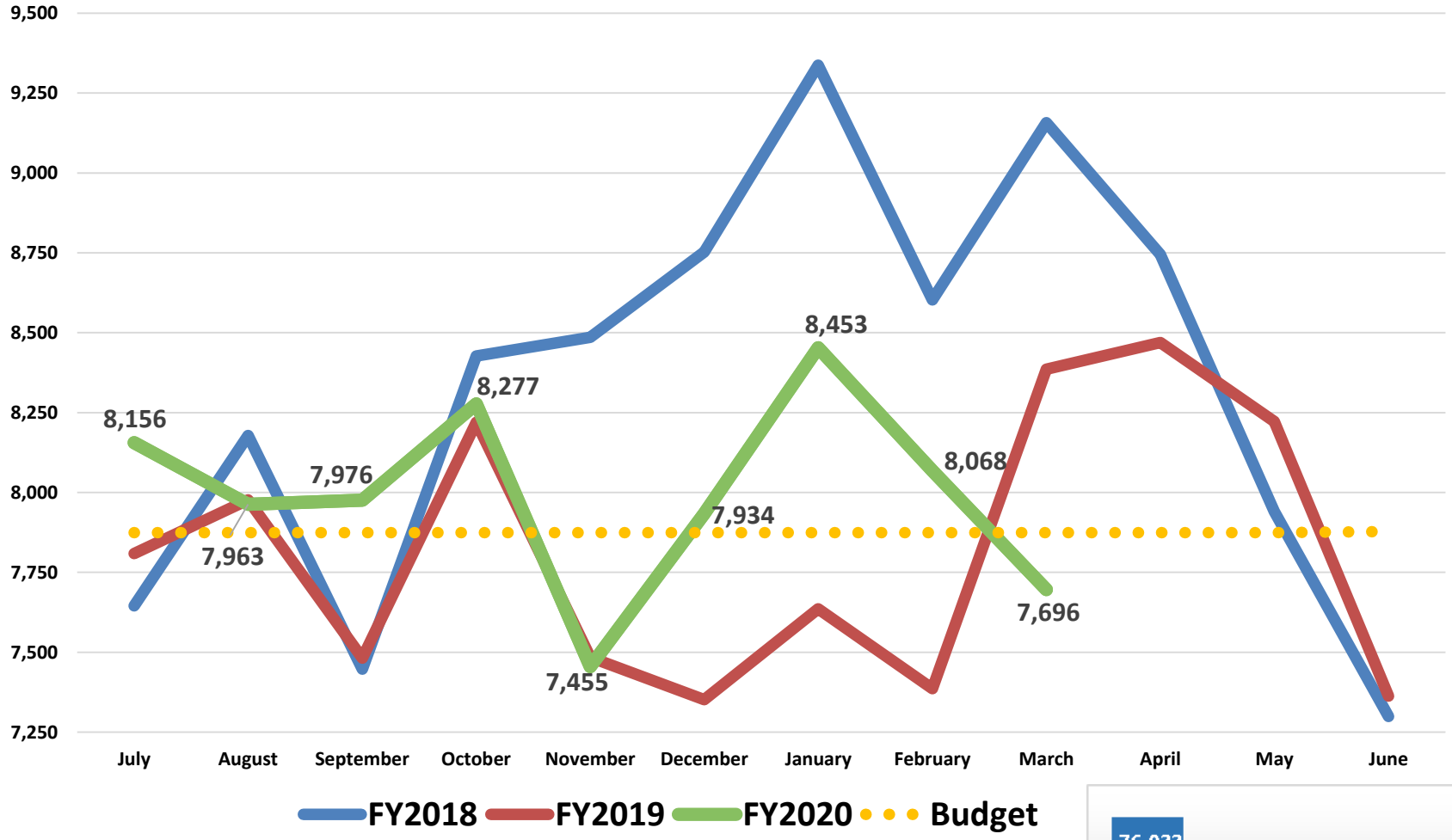


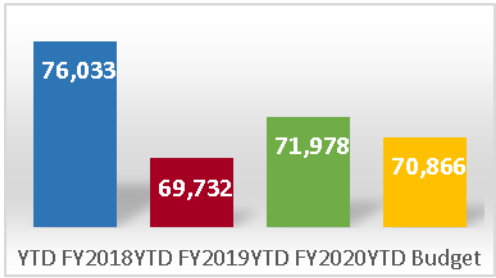
Radiology all areas – MRI



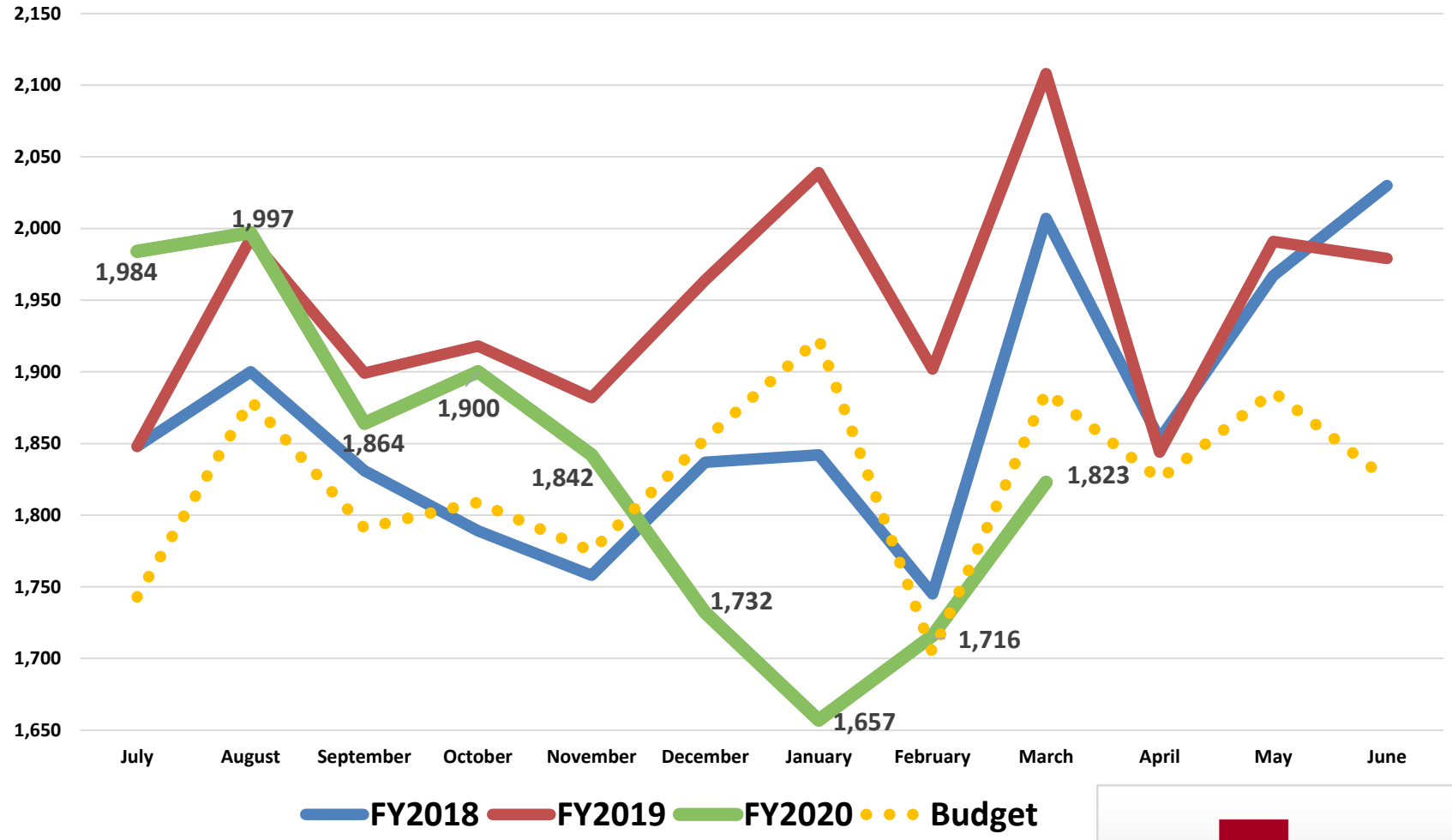


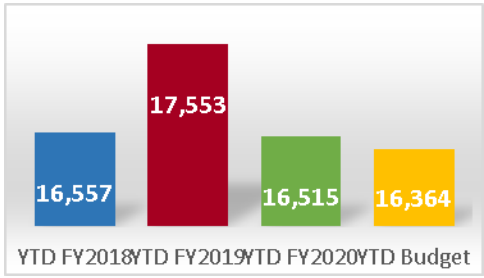
Radiology Modality – Diagnostic Radiology





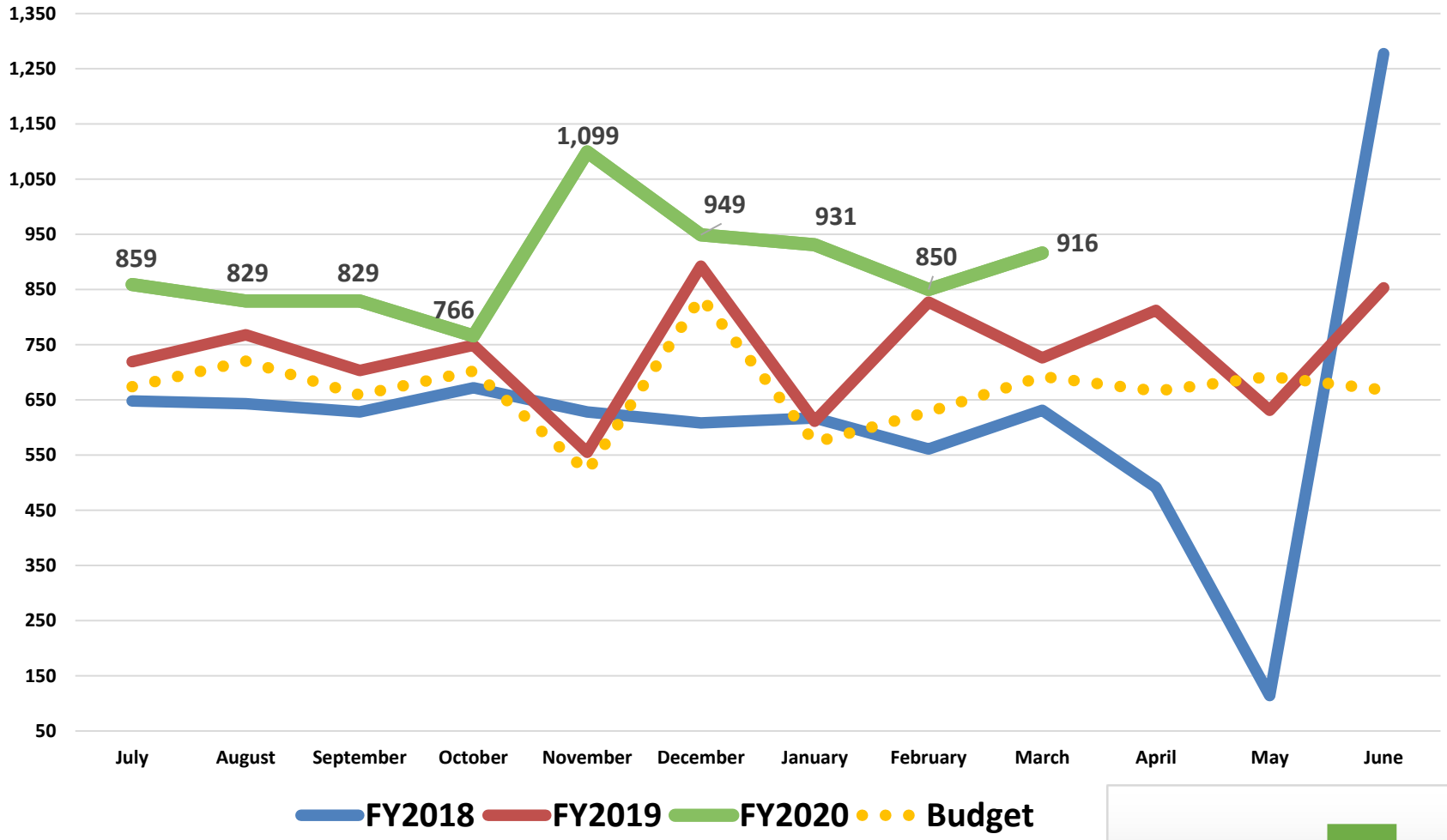
Chronic Dialysis - Visalia

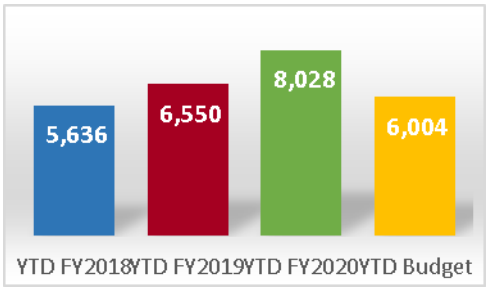




CAPD/CCPD – Maintenance Sessions

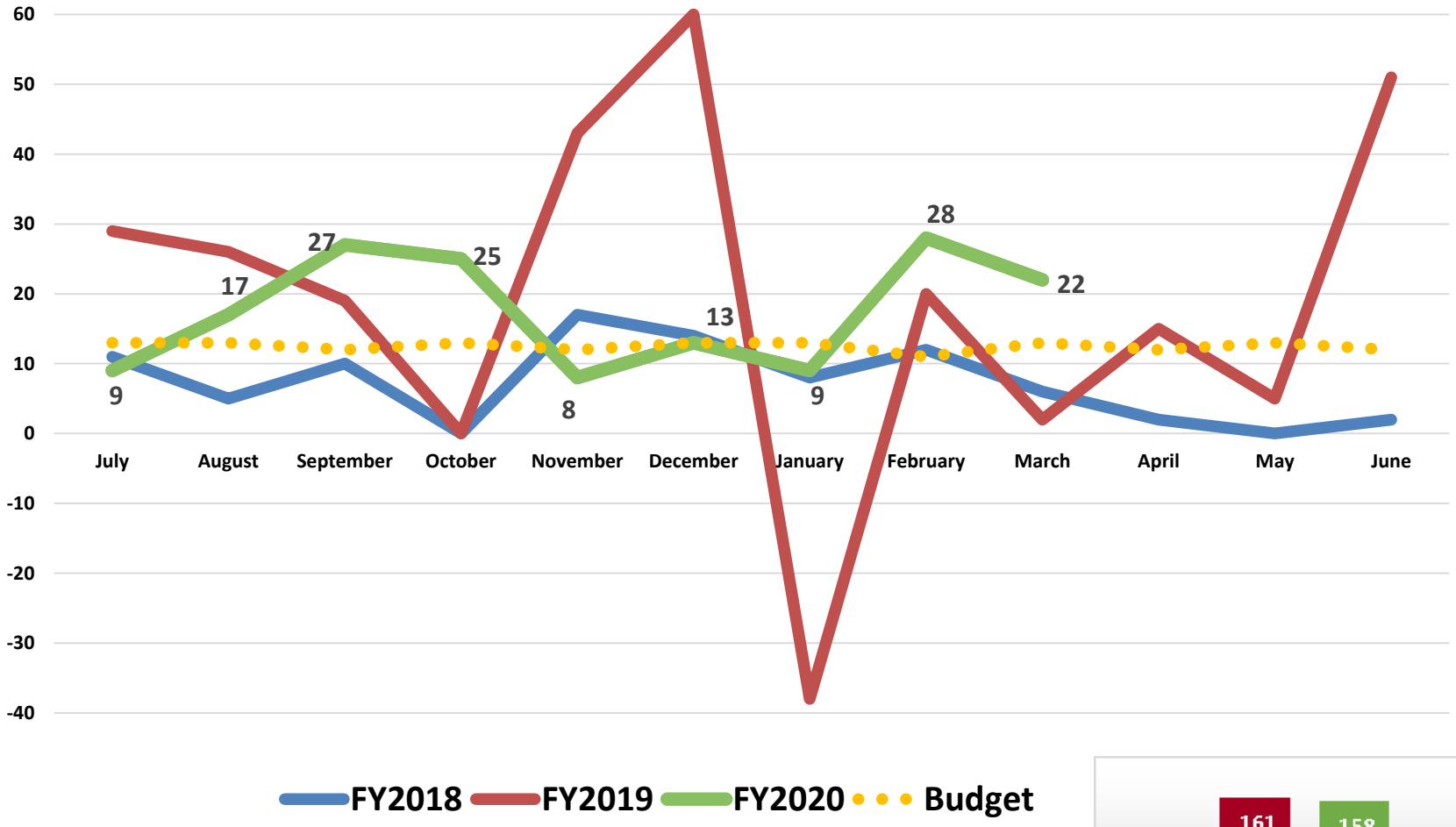
(Continuous peritoneal dialysis)

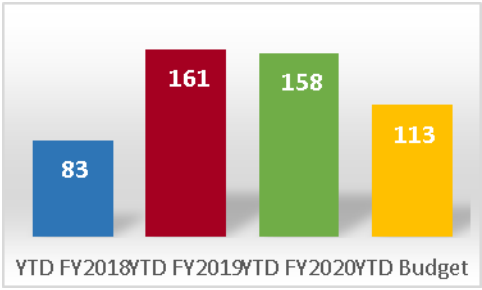




CAPD/CCPD – Training Sessions

(Continuous peritoneal dialysis)





225/225