

December 18, 2020

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in the Lifestyle Center Conference Room {5105 W. Cypress Avenue, Visalia} on Monday December 21, 2020 beginning at 3:30PM. Due to the maximum capacity allowed in this room per CDC social distancing guidelines, members of the public are requested to attend the Board meeting via GoTo meeting - <https://www.gotomeet.me/CindyMoccio/kaweahdeltaopenregularboardmeetings> or you can also dial in 669-224-3412 Access Code: 468-246-165.

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

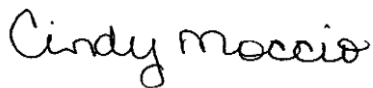
The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Board of Directors meeting at 3:31PM pursuant to Health and Safety Code 1461 and 32155.

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

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

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

KAWEAH DELTA HEALTH CARE DISTRICT
Garth Gipson, Secretary/Treasurer



Cindy Moccio
Board Clerk / Executive Assistant to CEO

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



KAWEAH DELTA HEALTH CARE DISTRICT - BOARD OF DIRECTORS MEETING

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

Join from your computer, tablet or smartphone

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

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

Monday December 21, 2020

OPEN MEETING AGENDA {3:30PM}

1. CALL TO ORDER
2. APPROVAL OF AGENDA
3. **PUBLIC PARTICIPATION** – Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the subject matter jurisdictions of the Board are requested to identify themselves at this time.
4. **APPROVAL OF THE CLOSED AGENDA – 3:31PM**
 - 4.1. **Approval of closed meeting minutes** – November 23, 2020 and December 14, 2020.
 - 4.2. **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*
 - 4.3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee — *Byron Mendenhall, MD Chief of Staff*

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

Action Requested – Approval of the December 21st 3:31pm closed meeting agenda.

5. ADJOURN

CLOSED MEETING AGENDA {3:31PM}

1. CALL TO ORDER
2. **APPROVAL OF CLOSED MEETING MINUTES** – [November 23, 2020](#) and [December 14, 2020](#).
Recommended Action: Approval of the November 23, 2020 closed meeting minutes.
3. **CREDENTIALING** - 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

Mike Olmos – Zone I
Board Member

Lynn Havard Mirviss – Zone II
Vice President

Garth Gipson – Zone III
Secretary/Treasurer

David Francis – Zone IV
President

Ambar Rodriguez – Zone V
Board Member

MISSION: *Health is our Passion. Excellence is our Focus. Compassion is our Promise.*

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

Byron Mendenhall, MD Chief of Staff

5. **ADJOURN**

OPEN MEETING AGENDA {4:00PM}

Join from your computer, tablet or smartphone

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

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

1. **CALL TO ORDER**
2. **APPROVAL OF AGENDA**
3. **PUBLIC PARTICIPATION** – Members of the public may comment on agenda items before action is taken and after Board discussion. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the subject matter jurisdictions of the Board are requested to identify themselves at this time.
4. **CLOSED SESSION ACTION TAKEN** – Report on action(s) taken in closed session.
5. **OPEN MINUTES** – Request approval of the November 23, 2020 and December 14, 2020 open meeting minutes.
Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.
Action Requested – Approval of the open meeting minutes – November 23, 2020 and December 14, 2020 open board of directors meeting minutes.
6. **RECOGNITIONS** – *Lynn Havard Mirviss*
 - 6.1. Presentation of [Resolution 2111 to Arlene Mendez](#), Patient Access Specialist, Precert/Benefit Verification retiring from Kaweah Delta after 31 years of service.
7. **QUALITY - Hospital Acquired Pressure Injury (HAPI) Quality Focus Team** - A report of key outcome measures and actions from recent Rapid Improvement Event to reduce HAPI.
Mary Laufer, DNP, RN, NE-BC
8. **KAWEAH DELTA MEDICAL FOUNDATION** – Annual report and financial review of the Kaweah Delta Medical Foundation.
Paul Schofield, Kaweah Delta Medical Foundation Chief Executive Officer & Coby LaBlue Kaweah Delta Medical Foundation Chief Financial Officer

9. [SEQUOIA HEALTH AND WELLNESS CENTERS \(SHWC\)](#) – Review and request approval of the amended Co-Applicant Agreement by and between Sequoia Health and Wellness Centers and Kaweah Delta Health Care District.

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.

Recommended Action: 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.

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

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

Action Requested – Approval of the December 21, 2020 Consent Calendar.

10.1. POLICIES

A. Administrative

- 1) [AP27](#) Use of district name and or stationery REVISED
- 2) [AP29](#) Patient Care Forms New and Revisions to Existing REVISED
- 3) [AP46](#) Commercial card expense reporting (CCER) program REVISED
- 4) [AP72](#) Litigation, Handling Medical Records REVISED
- 5) [AP123](#) Financial Assistance Program Full Charity and Partial Discount Programs REVISED
- 6) [AP147](#) Use of District Vehicle REVISED
- 7) [AP149](#) Hospital Acquired Conditions and Present on Admission Indicator REVISED
- 8) [AP150](#) Identity Theft Detection, Prevention, and Mitigation REVISED

B. Human Resources

- 1) [HR241](#) Paid Time Off (PTO) Cash Out REVISED
- 2) [HR145](#) Family Medical Leave Act (FMLA/California Family Rights Act (CFRA) Leave of Absence REVISED
- 3) [HR184](#) Attendance & Punctuality REVISED
- 4) [HR244](#) Paid Family Leave REVISED

C. Emergency Management

- 1) [DM 2109](#) Program Management Emergency Mgt Committee Revised
- 2) DM 2111 Dependent Care Plan Reviewed
- 3) DM 2120 Post Disaster Recovery- Financial Reviewed
- 4) DM 2211 Decontamination Plan Reviewed
- 5) DM 2212 Earthquake Response Reviewed
- 6) DM 2218 Anhydrous Ammonia Safety Procedures Reviewed

D. Environment of Care

- 1) [EOC 1042](#) Failure of Fire Alarm System REVISED
- 2) [EOC 3000](#) Security Management Plan REVISED
- 3) [EOC 7305](#) Utilities Management Emergency Power REVISED

Monday December 21, 2020

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Board Member

Lynn Havard Mirviss – Zone II
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Ambar Rodriguez – Zone V
Board Member

- 4) [EOC 5041](#) Department Decorations REVISED
- 5) EOC 1019 Equipment Cleaning and Low Intermediate Level Disinfection REVIEWED
- 6) EOC 4007 Compressed Gas and Oxygen Use REVIEWED
- 7) EOC 4010 RCRA Disposal of Hazardous Waste REVIEWED
- 8) EOC 1037 Disruption of Services, Sewage REVIEWED
- 9) EOC 1039 Failure of Air Conditioner REVIEWED
- 10) EOC 1035 Disruption of Service, Medical Gas REVIEWED
- 11) EOC 1044 Disruption of Services, Telephone REVIEWED

10.2. REPORTS

- A. [Physician Recruitment](#)
- B. [Sequoia Health and Wellness Centers](#)
- C. [Diabetes Education Clinic](#)
- D. [Chronic Disease Management Center](#)
- E. [Infusion Center](#)

10.3. BOARD COMMITTEE MINUTES

- A. [Quality Council](#) (November 19, 2020)
- B. [Strategic Planning](#) (December 2, 2020)

10.4. Recommendations from the Medical Executive Committee (December 2020)

- A. [Privileges in Pathology](#)
- B. [Medical Staff Bylaws & Rules and Regulations Revisions](#)
 - 1) Bylaws 5.F – Practitioners in departments subject to exclusive contracts.
 - 2) Rules and Regulations 3.1b – Medical Records, General Requirements – Medical Records Entries.
 - 3) Rules and Regulations 3.2.d – Medical Records, Content and Timeliness of Medical Record Documentation – Medical Orders.
 - 4) Rules and Regulations 4.1.a – Medical Orders, General, Order Entry.

10.5. Approval of the first amendment to the [Cardiovascular Service Line Affiliation agreement](#) effective December 21, 2020 by and between The Cleveland Clinic Foundation and Kaweah Delta Health Care District.

10.6. Approval of [Resolution 2110 to Michael Mayo](#), LCSW/LMFT, Patient Family Services, retiring from Kaweah Delta after 15 years of service.

10.7. Approval of [Resolution 2112 to Janey Parker](#), RN, Field Infection Prevention, Infection Prevention Services, retiring from Kaweah Delta after 33 years of service.

10.8. Approval of [Resolution 2113 to Carol Chavez, RN](#), Clinical Educator, Clinical In-service Education, retiring from Kaweah Delta after 29 years of service.

10.9. Approval of [Resolution 2114 to Cindra Cochran, RN](#) Clinical Educators, ACLS; Clinical In-service Education.

11. **GRADUATE MEDICAL EDUCATION** – Review of Graduate Medical Education annual institutional review academic year 2019-2020.

Lori Winston, M.D., Vice President Medical Education & Designated Institutional Officer

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

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

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

13. REPORTS

- 13.1. **Chief of Staff** – Report relative to current Medical Staff events and issues.

Byron Mendenhall, MD, Chief of Staff

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

Gary Herbst, Chief Executive Officer

- 13.3. **Board President** - Report relative to current events and issues.

David Francis, Board President

ADJOURN

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

BOARD OF DIRECTORS MEETING – CLOSED SESSION

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY DECEMBER 21, 2020

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KDHCD - BOARD OF DIRECTORS MEETING

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MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD MONDAY NOVEMBER 23, 2020, AT 3:30PM, IN THE LIFESTYLE CENTER CONFERENCE ROOMS / 5105 W. CYPRESS AVENUE, VISALIA AND VIA GOTO MEETING (CALL IN OPTION DUE TO STAY IN PLACE ORDER BY GOVERNOR OF CALIFORNIA), NEVIN HOUSE PRESIDING

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

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

Director House entertained a motion to approve the agenda.

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

PUBLIC PARTICIPATION – none

CLOSED AGENDA – 3:31PM

Approval of closed meeting minutes – September 28 and October 26, 2020.

Conference with Real Property Negotiator {Government Code 54956.8}: Property: APN's 119-85-012, 199-85-013, 119-85-014. Negotiating party: Kaweah Delta Health Care District: Marc Mertz and Sequoia Gateway, LLC – price and terms – *Marc Mertz, Vice President – Chief Strategy Office*

Conference with Real Property Negotiator {Government Code 54956.8}: Property: Intersection of Highway 99 and Caldwell Avenue (Lots 13, 14, 15, 16, 17, 18 of Sequoia Gateway Commerce Center). Negotiating party: Kaweah Delta Health Care District: Marc Mertz and Sequoia Gateway, LLC – price and terms – *Marc Mertz, Vice President – Chief Strategy Office*

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

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

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

ADJOURN - Meeting was adjourned at 3:31PM

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

ATTEST:

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

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD MONDAY NOVEMBER 23, 2020, AT 4:00PM, IN THE LIFESTYLE CENTER CONFERENCE ROOMS / 5105 W. CYPRESS AVENUE, VISALIA AND VIA GOTO MEETING (CALL IN OPTION DUE TO STAY IN PLACE ORDER BY GOVERNOR OF CALIFORNIA), NEVIN HOUSE PRESIDING

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

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

Director House asked for approval of 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 PARTICIPATION – none

CLOSED SESSION ACTION TAKEN: Approval of closed minutes September 28, 2020 and October 26, 2020.

OPEN MINUTES – Request approval of the October 26, 2020 and November 17, 2020 meeting minutes.

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

MMSC (Hawkins/Francis) Approval of the open meeting minutes – October 26, 2020 and November 17, 2020 open board of directors meeting minutes. This was supported unanimously by those present. Vote: Yes – Gipson, Francis, Havard Mirviss, Hawkins, and House

RECOGNITIONS – Director David Francis presenting

- Presentation of Resolution 2105 to Kelly Pierce, Service Excellence November 2020.
- Presentation of Resolution 2106 – Nevin House, Board of Directors – in recognition of his service on the Kaweah Delta Board from 2016-2020.

PROVIDER NEEDS ASSESSMENT – Board action requested relative to the Kaweah Delta physician recruitment annual physician recruitment plan – 2021 based on the Provider Needs Assessment for Kaweah Delta Medical Center presented at the September 28, 2020 Board of Director meeting - Marc Mertz, VP & Chief Strategy Officer and Brittany Taylor – Director of Physician Recruitment & Relations

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/Francis) Having reviewed and analyzed the Provider Needs Assessment conducted by Sg2 in 2020, which includes a specific list of the needed physician specialties for 2020 and 2021 in communities served by the District “Needed Physician Specialties,” the Board hereby finds that it will be in the best interests of the public health of the communities served by the District to have the District provide appropriate assistance in order to obtain licensed physicians and surgeons in the Needed Physician Specialties to practice in the communities served by the District. Therefore, the Board authorizes the District to provide the types of assistance authorized by Cal. Health &

Safety Code §32121.3, to obtain licensed physicians and surgeons in the Needed Physician Specialties to practice in the communities served by the District. This was supported unanimously by those present. Vote: Yes – Gipson, Francis, Havard Mirviss, Hawkins, and House

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

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

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

QUALITY – Length of Stay – Review of the revised plan to approach length of stay reduction (copy attached to the original of these minutes and considered a part thereof) - Kassie Waters, Director of Critical Care Services and Rebekah Foster, Director of Care Management

STRATEGIC PLAN – Kaweah Care Culture - Review and discussion of the metrics, strategies, and tactics of the strategic initiative; Kaweah Care Culture (copy attached to the original of these minutes and considered a part thereof) Dianne Cox, Vice President Chief Human Resources Officer

ORGANIZATIONAL REBRANDING INITIATIVE – Review and discussion of potential rebranding initiative and implementation considerations as reviewed by the Marketing and Community Relations Committee on November 17, 2020 (copy attached to the original of these minutes and considered a part thereof) Marc Mertz, Vice President and Chief Strategy Officer

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

MMSC (Hawkins/Gipson) To authorize management to proceed with the immediate planning and implementation of an organizational rebranding initiative with the \$112,000 of unbudgeted expense to be funded from cash reserves if no other funding source is available. This was supported unanimously by those present. Vote: Yes – Gipson, Francis, Havard Mirviss, Hawkins, and House

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

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

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

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

ELECTION OF OFFICERS - Request Board's consent to a special one-time waiver of the ordinary District Bylaws provisions in order to permit election of officers in this year, an election year of the District, since the President will be leaving the Board. Further, request Board's consent to a special one-time waiver of the ordinary District Bylaws provisions to permit the third most experienced remaining member of the Board to be eligible to be elected to an office, despite being one month shy of the ordinary requirement that 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. Any specially elected officers would hold office for a period of one (1) year or until their 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.

MMSC (Francis/Havard Mirviss) To approve a special one-time waiver of the ordinary District Bylaws provisions in order to permit election of officers in this year, an election year of the District, since the President will be leaving the Board. This was supported unanimously by those present. Vote: Yes – Gipson, Francis, Havard Mirviss, Hawkins, and House

MMSC (Francis/Hawkins) To consent to a special one-time waiver of the ordinary District Bylaws provisions to permit the third most experienced remaining member of the Board to be eligible to be elected to an office, despite being one month shy of the ordinary requirement that 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. This was supported unanimously by those present. Vote: Yes – Gipson, Francis, Havard Mirviss, Hawkins, and House

Mr. Lynch entertained nominations for the office of President.

- Director Hawkins nominated Director Havard Mirviss.
- Director House nominated Director Francis.
 - With no other nomination Mr. Lynch asked for a vote for Director Havard Mirviss for Board President {Hawkins & Havard Mirviss}
 - Mr. Lynch asked for a vote for Director Francis for Board President {House, Gipson & Francis}
 - Director David Francis will now serve as the Board President.
- With Director Francis now serving as the President, we must now fill the office of Secretary/Treasurer. Mr. Lynch entertained nominations for the office of
- Secretary/Treasurer.
 - Director House nominated Director Gipson.
 - With no other nomination Mr. Lynch asked for a vote for Director Gipson as the Board Secretary/Treasurer {Francis, Gipson, Hawkins, Havard Mirviss & House}
 - Director Gipson will now serve as the Board Secretary/Treasurer.

Appointment to replace Nevin House on the Sequoia Integrated Health Board of Managers effective December 4, 2020.

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

MMSC (Havard Mirviss/Hawkins) to appoint Mike Olmos to serve on the Sequoia Integrated Health Board of Managers effective December 4, 2020. 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

- First virtual general staff meeting was well attending.

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

- Status update on COVID including occupancy update, staff shortages and the status of the visitor policy.

BOARD PRESIDENT REPORT – Report from Nevin House, Board President

- Recommended that the Board should take a good look at service lines that are not profitable to determine what is causing the lack of profitability.
- Recommendation to provide better on-line tools for the Board meeting, suggested checking with local Rotary group to see what they are using.
- Recommended evaluating the relationship with Cerner and determining if this is the best service for the District.

Director House entertained a motion to approve the closed agenda.

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

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

ADJOURN - Meeting was adjourned at 7:05PM

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 DECEMBER 14, 2020, AT 3:30PM, IN THE LIFESTYLE CENTER CONFERENCE ROOMS / 5105 W. CYPRESS AVENUE, VISALIA AND VIA GOTO MEETING (CALL IN OPTION DUE TO STAY IN PLACE ORDER BY GOVERNOR OF CALIFORNIA), NEVIN HOUSE PRESIDING

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

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

Director Francis entertained a motion to approve the agenda.

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

PUBLIC PARTICIPATION – none

CLOSED AGENDA – 3:31PM

Conference with Real Property Negotiator {Government Code 54956.8}: Property: APN's 119-85-012, 199-85-013, 119-85-014. Negotiating party: Kaweah Delta Health Care District: Marc Mertz and Sequoia Gateway, LLC – price and terms – *Marc Mertz, Vice President – Chief Strategy Office*

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

ADJOURN - Meeting adjourned at 3:31PM

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

ATTEST:

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

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD MONDAY DECEMBER 14, 2020, AT 3:35PM, IN THE LIFESTYLE CENTER CONFERENCE ROOMS / 5105 W. CYPRESS AVENUE, VISALIA AND VIA GOTO MEETING (CALL IN OPTION DUE TO STAY IN PLACE ORDER BY GOVERNOR OF CALIFORNIA), NEVIN HOUSE PRESIDING

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

The meeting was called to order at 3:35PM by Director Francis.

Director Francis entertained a motion to approve the agenda.

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

PUBLIC PARTICIPATION – none

CLOSED SESSION ACTION TAKEN

11-23-2020 - The Board unanimously voted to authorize management to execute a purchase and sale agreement and open escrow on lots 10, 11, and 12 in the Sequoia Gateway Commerce and Business Park at a purchase price of \$3,000,000.00 to be funded from the proceeds of the sale of 27627 Road 140, Visalia, CA 93291 {APN's 126-130-012, 126-130-028, and 126-130-029}

12-14-2020 the Board unanimously voted to approved Resolution 2109 to validate the action by the Board on November 23, 2020 to authorization management to execute a purchase and sale agreement and open escrow on lots 10, 11, and 12 in the Sequoia Gateway Commerce and Business Park at a purchase price of \$3,000,000.00 to be funded from the proceeds of the sale of 27627 Road 140, Visalia, CA 93291 {APN's 126-130-012, 126-130-028, and 126-130-029}

2020/2021 ANNUAL OPERATING AND CAPITAL BUDGET AND FINANCIALS – Review and discussion of the budget and the current financials (copy attached to the original of these minutes and considered a part thereof) - *Malinda Tupper, VP & Chief Financial Officer*

MASTER PLANNING – Review and discussion of master planning process and options for Kaweah Delta Health Care District (copy attached to the original of these minutes and considered a part thereof) – *Julieta Moncada, Director of Facilities Planning*

CHIEF EXECUTIVE OFFICER REPORT

- No Report.

BOARD PRESIDENT REPORT

- No report.

ADJOURN - Meeting was adjourned at 7:11PM

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

ATTEST:

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



RESOLUTION 2111

WHEREAS, Arlene Mendez, is retiring from duty at Kaweah Delta Health Care District after 31 years of service; and,

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

NOW, THEREFORE, BE IT RESOLVED that the Board of Directors of the Kaweah Delta Health Care District, on behalf of themselves, the hospital staff, and the community they represent, hereby extend their appreciation to Arlene Mendez for 31 years of faithful service and, in recognition thereof, have caused this resolution to be spread upon the minutes of this meeting.

PASSED AND APPROVED this 21st day of December 2020 by a unanimous vote of those present.

President, Kaweah Delta Health Care District

ATTEST:

Vice President, Kaweah Delta Health Care District
and of the Board of Directors, thereof



Hospital-Acquired Pressure Injury Quality Focus Team Rapid Improvement Event Review

Dr. Mary Laufer NE-BC
Director of Nursing
Practice
December 21, 2020

Hospital-Acquired Pressure Injury

- HAPI – formerly known as “pressure ulcer” or “bed sore”
- Localized injury to skin and/or underlying tissue that occurs during an inpatient hospital stay
- Resulting from pressure and/or shear forces that damage tissue
- Usually over a bony prominence or related to a medical device
- Injury may present as intact skin or an open ulcer, and may be painful

HAPI Rapid Improvement Event

GOAL: focused event accomplishes objectives in short timeframe and develop participants as problem solvers

OBJECTIVES

- 100% management support and all players participate in process required
- Develop 4 improvement strategies to be continued by HAPI Quality Focus Team (HAPI QFT)
- Create solutions with existing resources (people, equipment, space)
- Facilitator guides content experts using Quality Improvement / Six Sigma Tools

Our Team!

- **Executive Sponsor:** K. Noeski, A. Banerjee
- **Content Experts:** (Wound Team) A. Gregory, K. Roepke-Brenner, E. Seechan, S. Engstrom, A. Benton
- **Team Members:** M. Laufer, J. Knudsen, A. Fajardo, T. Quintyn, A. Baker, R. Piche, D. Gamboa, A. Aguilar, E. Sotelo, K. Waters, R. Taylor, A. Bradshaw
- **Fresh Eyes:** E. Largoza
- **Facilitator:** S. Volchko, C. Vander Schuur



Lean Six Sigma

Lean Six Sigma: DMAIC



Define

Define the problem.



Measure

Quantify the problem.



Analyze

Identify the cause of the problem.



Improve

Implement and verify the solution.



Control

Maintain the solution.

Team Charter



Define

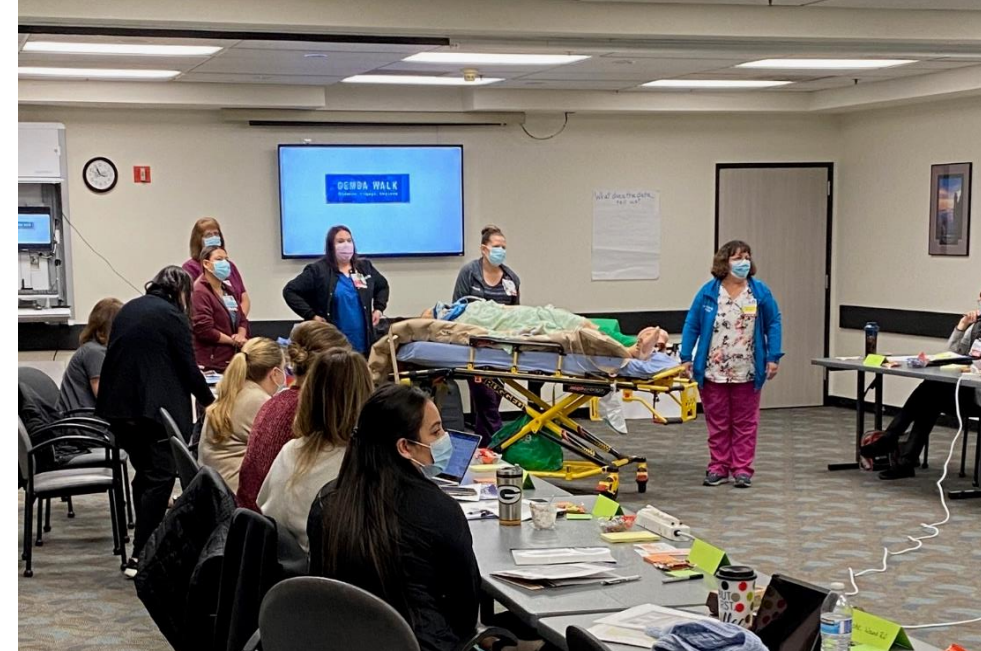
Define the problem.

CHARTER: Hospital Acquired Pressure Injury (HAPI) Rapid Improvement Event		Event Dates: Nov. 13 & 18, 2020	
Executive Sponsor	Problem Statement / Opportunity Statement:		
Keri Noeske Anu Banerjee	Patients are acquiring Hospital Acquired Pressure Injuries at KDMC. HAPI's result in poor outcomes for patients, a negative public perception of care through publically reported safety scores, and they financially impact the organization through the HAC and, starting in 2021, the VBP programs, as well as increased treatment costs and LOS. The estimated cost to KDMC is approximately \$21,000 per HAPI (2019).		
Process Owner	Aim:		
Mary Laufer, Andrea Gregory, Katie Roepke-Brenner, Eechai Seechan, Sheryl Engstrom, Annette Benton	Reduce all HAPI events; improve compliance with best practices that prevent HAPI's		
Team Members	Scope: Inpatients identified at risk for skin breakdown (Braden \leq 18) or who develop a wound \geq Stage 2 during their hospitalization at KDMC until wound heals or patient is discharged. Out of scope: Wounds that are present on admission. Stage 1. Outpatient areas. Staffing.		
Content Experts: (Wound Team) A. Gregory, K. Roepke-Brenner, E. Seechan, S. Engstrom, A. Benton Team Members: M. Laufer, J. Knudsen, A. Fajardo, T. Quintyn, A. Baker, R. Piche, D. Gamboa, A. Aguilar, E. Sotelo, K. Waters, R. Taylor, A. Bradshaw Facilitators: S. Volchko and C. Vander Schuur			
	Key Metrics	Current	Target
	Number of Stage 2+ HAPI's/1000 patient days YTD 2020	1.76	Lower is better
	NDNQI % of surveyed patients with Stage 2+ HAPI (One day survey/Qtr) Q1 & Q2 2020	2.92	Lower is better
Number of Device Associated HAPI's/1000 patient days YTD 2020	0.81	Lower is better	

Gemba Walk

Core principle: In-person observation

- Observe where the work is being done
- Interact with the people and process in a spirit of Kaizen (“change for the better”)



Process Mapping

Define process from patient admission to HAPI identification

Decision-making steps identified when constructing process map



Define

Define the problem.

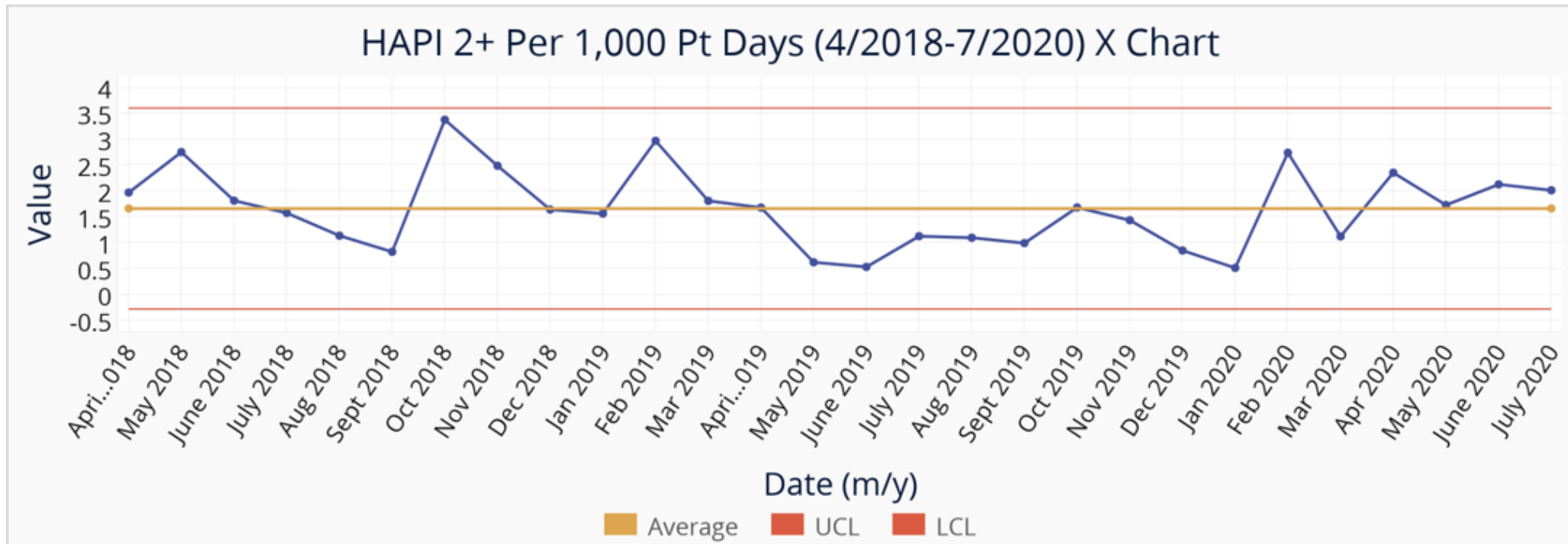
Current State Review

HAPI Stage 2+ per 1,000 Patient Days



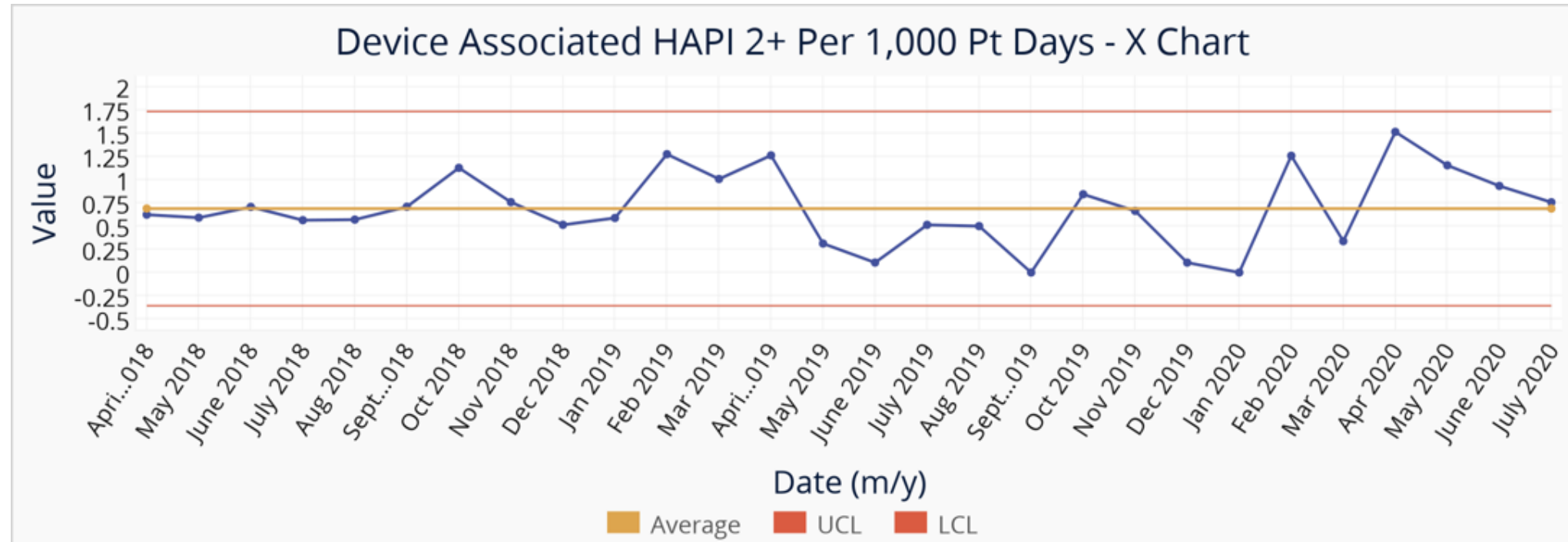
Measure

Quantify the problem.



Current State Review

Device-Related HAPI Stage 2+ per 1,000 Patient Days

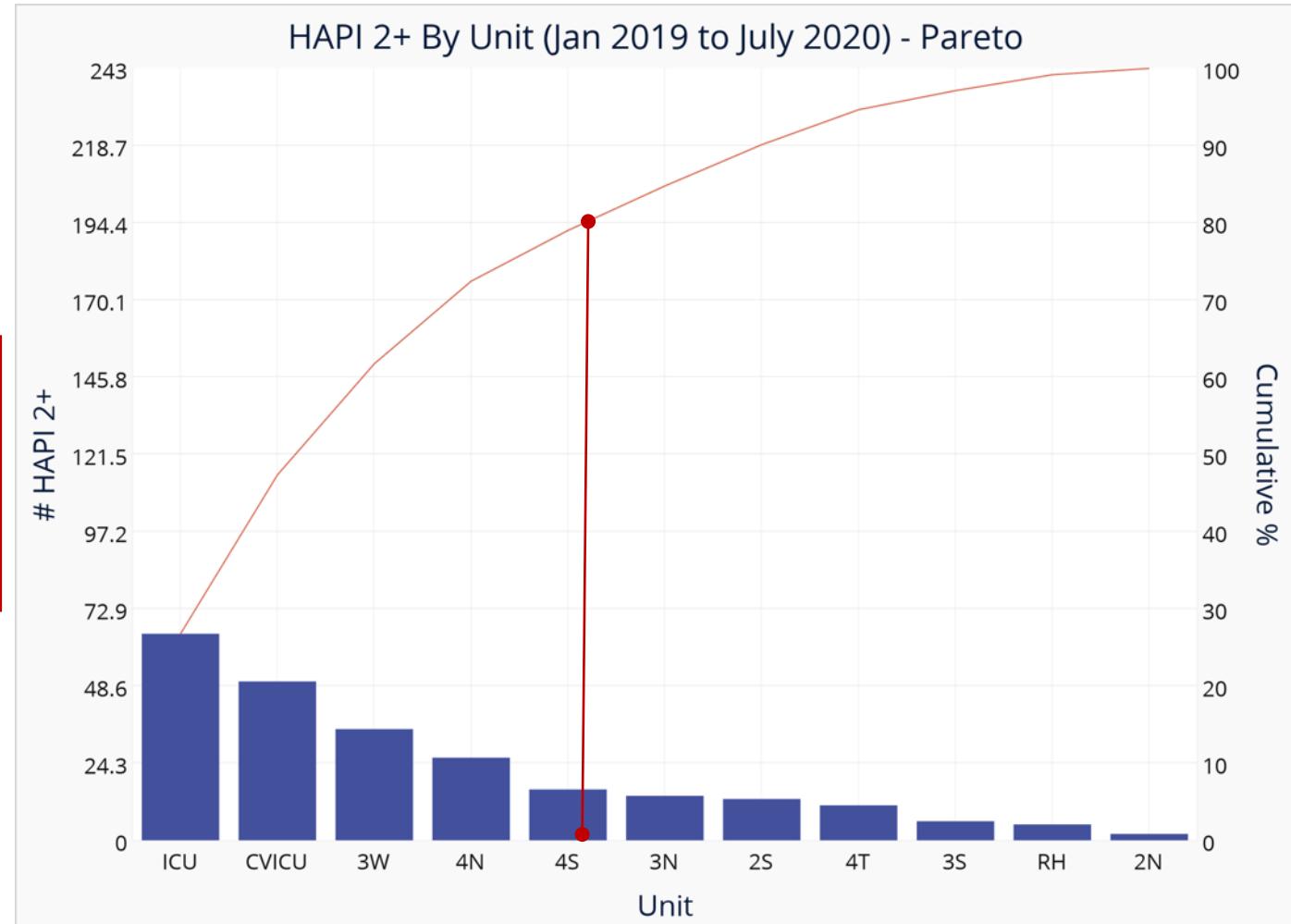


Current State Review

HAPIs are not isolated to one unit or unit type

Results

	# HAPI 2+	Cumulative # HAPI 2+	Percentage	Cum Percentage
ICU	65	65	26.75	26.75
CVICU	50	115	20.58	47.33
3W	35	150	14.4	61.73
4N	26	176	10.7	72.43
4S	16	192	6.58	79.01
3N	14	206	5.76	84.77
2S	13	219	5.35	90.12
4T	11	230	4.53	94.65
3S	6	236	2.47	97.12
RH	5	241	2.06	99.18
2N	2	243	0.82	100

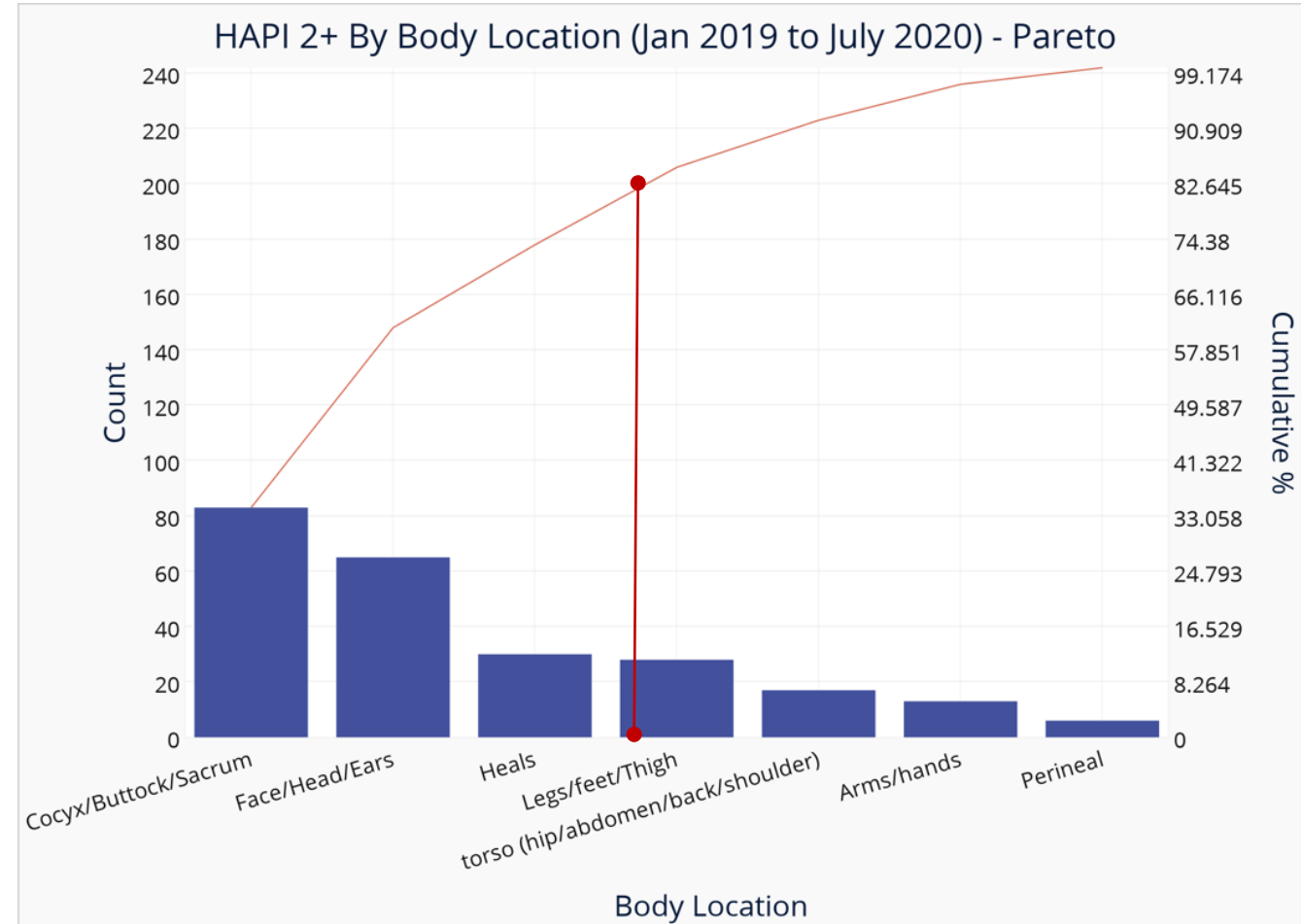


Current State Review

HAPIs are not isolated to one body part

Results

	Count	Cumulative Count	Percentage	Cum Percentage
Cocyx/Buttock/Sacrum	83	83	34.3	34.3
Face/Head/Ears	65	148	26.86	61.16
Heals	30	178	12.4	73.55
Legs/feet/Thigh	28	206	11.57	85.12
torso (hip/abdomen/back/shoulder)	17	223	7.02	92.15
Arms/hands	13	236	5.37	97.52
Perineal	6	242	2.48	100

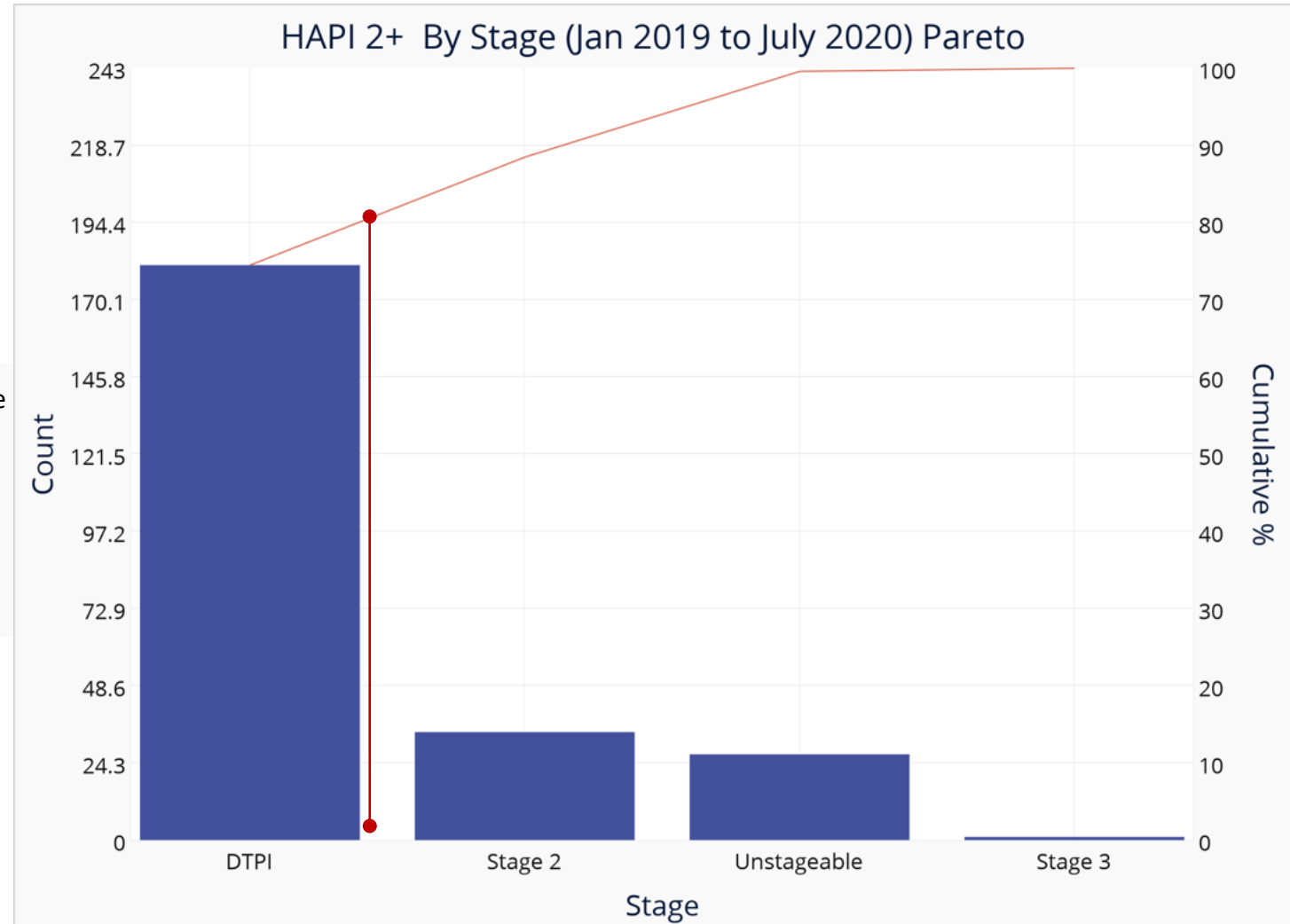


Current State Review

Deep Tissue Pressure Injuries account for 75% of our HAPIs (by stage)

Results

	Count	Cumulative Count	Percentage	Cum Percentage
DTPI	181	181	74.49	74.49
Stage 2	34	215	13.99	88.48
Unstageable	27	242	11.11	99.59
Stage 3	1	243	0.41	100

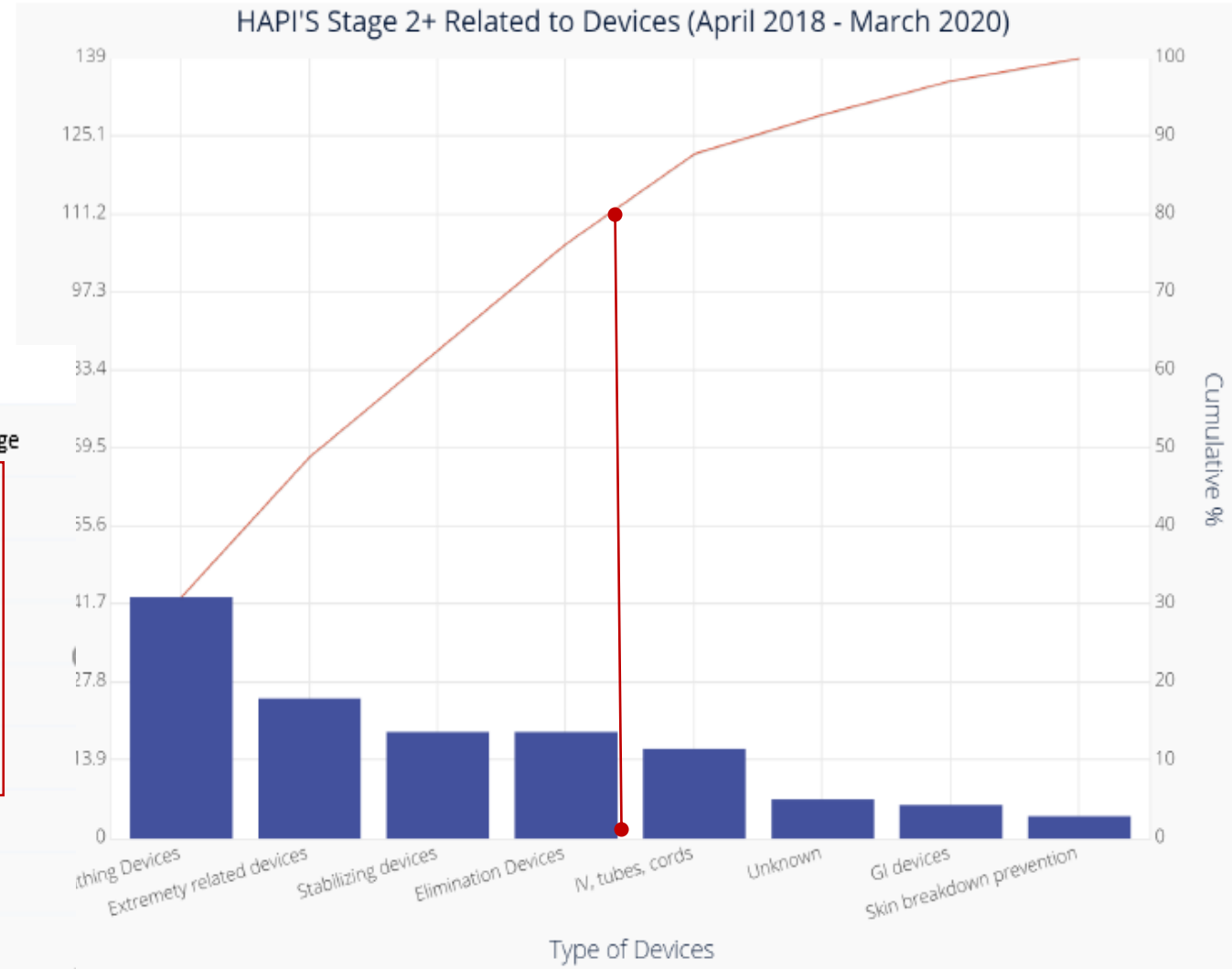


Current State Review

88% of Device-Related HAPIs are attributed to a wide-range of commonly used devices.

Results

	Totals	Cumulative Totals	Percentage	Cum Percentage
Breathing Devices	43	43	30.94	30.94
Extremety related devices	25	68	17.99	48.92
Stabilizing devices	19	87	13.67	62.59
Elimination Devices	19	106	13.67	76.26
IV, tubes, cords	16	122	11.51	87.77
Unknown	7	129	5.04	92.81
GI devices	6	135	4.32	97.12
Skin breakdown prevention	4	139	2.88	100



Outcomes



Measure

Quantify the problem.

HAPI QFT Dashboard

Measure Description	Benchmark/ Target	2019								
		Baseline	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	YTD 2020
Outcome Measures										
HAPI Stage 2+ per 1,000 pt days (all HAPIs)	1.31 (-20% from 2019)	1.64	0.60	3.08	1.26	2.35	1.73	2.13	1.38	1.76
Device Associated HAPI per 1,000 pt days	0.59 (-20% from 2019)	0.74	0.00	1.16	0.42	1.51	1.15	0.93	0.76	0.81
NDNQI % Surveyed Patients Stage 2+ (1 day prevalence per quarter)	1.96 (1Q 2020) 2.34 (2Q 2020)	2.62			2.35			3.57		2.92
PSI 3 - Claims-based HAPI Stage 3, 4, DTPI, and Unstageable per 1,000 discharges	0.6 - Hospital Compare (Q3 2017-Q2 2019) 0.35 - Midas 50th Percentile (2019)	0.79	1.98	1.03	2.25	0	0	1.35	2.16	1.33
Process Measures										
EXAMPLE 02 Device associated HAPI per 1,000 pt days										
TBD										
Unit Level	(-15% from 2019)									
4N - HAPI 2+ per 1,000 pt days	1.14	1.34	1.15	11.03	1.24	1.69	0.00	1.29	0.00	2.42
3W - HAPI 2+ per 1,000 pt days	1.92	2.26	0.00	2.58	1.30	1.70	3.96	13.13	1.77	3.08
ICU - HAPI 2+ per 1,000 pt days	6.04	7.1	1.97	12.58	4.26	9.43	12.74	10.18	1.92	7.44
CVICU - HAPI 2+ per 1,000 pt days	4.42	5.2	4.38	8.79	9.05	8.15	1.77	4.63	18.52	6.99
2N - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	0.1	0.00	0.00	1.41	0.00	0.00	0.00	0.00	0.19
2S - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	0.7	0.00	0.00	0.00	8.81	5.85	0.00	4.21	2.84
3N - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	0.86	0.00	2.07	0.00	1.28	0.00	1.17	0.00	0.63
3S - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	0.46	0.00	0.00	0.00	0.00	0.00	1.18	0.00	0.18
4S - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	1.37	1.01	0.00	0.00	0.00	0.00	0.00	0.00	0.16
4T - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	1.23	0.00	1.72	0.00	0.00	0.00	0.00	3.62	0.79
BP - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Rehab - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	0.75	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
5T - HAPI 2+ per 1,000 pt days	n/a							0.00	0.00	0.00
Other Units										
ED	n/a	4	0	2	0	0	0	0	0	2
Sub-acute	n/a	5	0	1	0	0	0	1	0	2
Surgery	n/a	6	0	0	0	0	0	0	0	0
Cath Lab	n/a	1	0	0	0	0	0	0	0	0
MA	n/a	1	0	0	0	0	0	0	0	0
TCS	n/a	1	0	0	0	0	0	0	0	0
Green	Better than Target									
Yellow	Within 10% of Target									
Red	Does not meet Target									

Current State Review

STANDARD WORK: Evidence-Based and Best Practices

- Pressure Injury Prevention Plan
- Policies, Order Sets
- Education, Training, Competency

Current State Review

LEADERSHIP STANDARD WORK: Check

- Managers review 100% HAPI events
- Wound RN participation in CVICU daily rounds
- Visual Management of outcomes

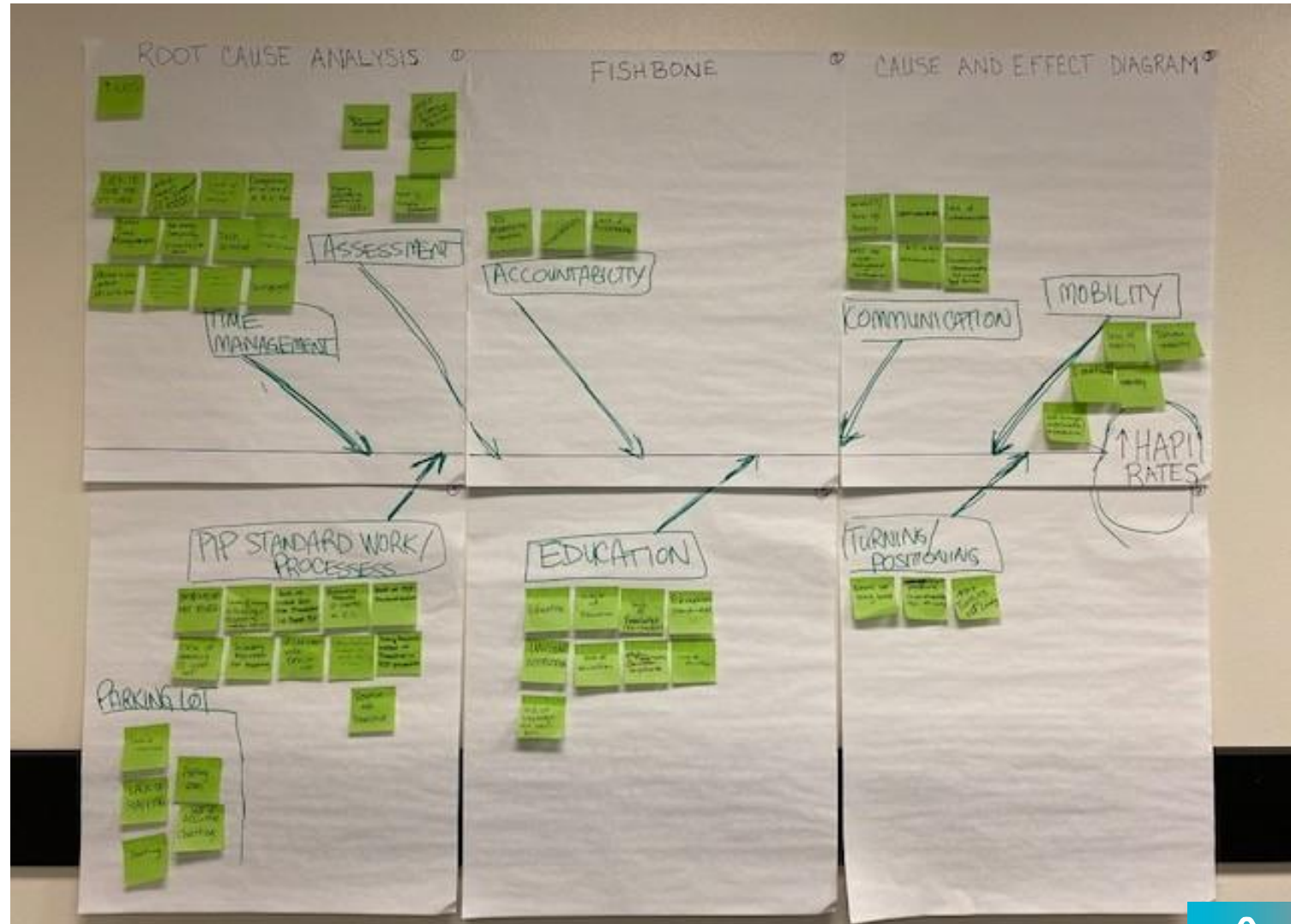


Analyze

Identify the cause of the problem.

Root Cause Analysis

1. Turning/Positioning
2. Accountability
3. Time Management
4. Communication
5. Pressure Injury Prevention Standard Work Processes
6. TIE: Mobility, Education
7. Assessment

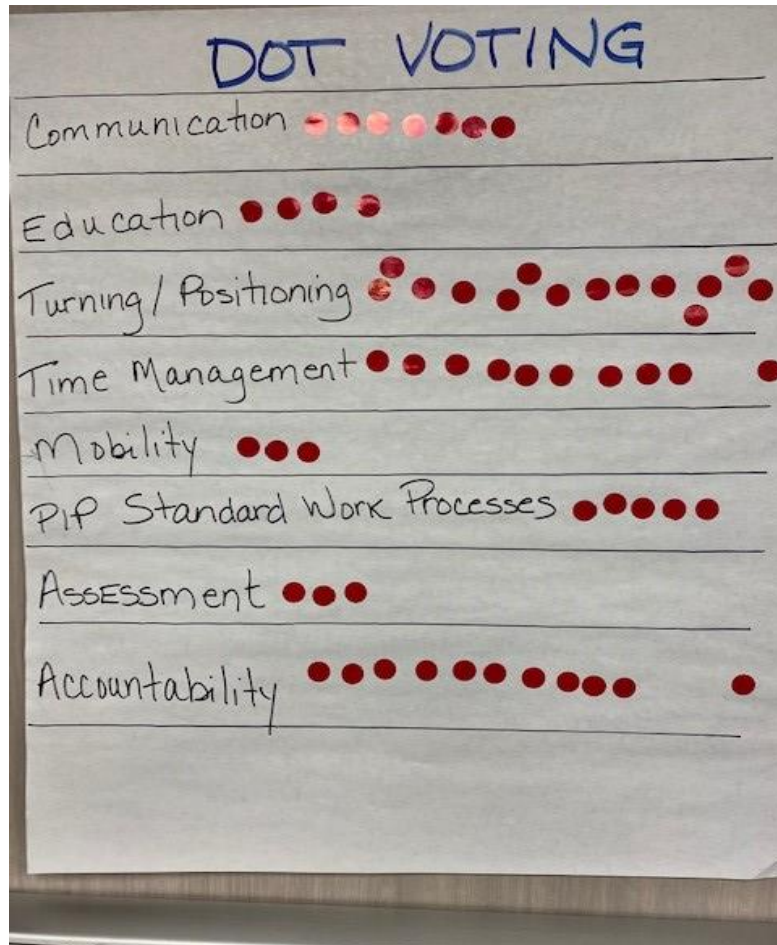


Prioritizing Solutions



Stage 1 – Identify Top Root Causes

Stage 2 – Identify Solutions



FOUR CORNER CHART: HAPI

Addresses Root Cause: Time Management



Problem / Goals & Objectives

Problem Statement: Patient's are acquiring HAPI's at KDMC. HAPI's result in poor outcomes for patients, a negative public preception of care through publically reported safety scores, and they financially impact the organizatin through the HAC and , starting in 2021, the VBP programs, as well as increased treatment costs and LOS. The estimated cost to KDMC is approximately \$21,000 per HAPI (2019)

Goals and Objectives (Quantified):

- In 6 months will have 80% compliance of skin assessment within 3 hours of admist order/start of shift.
- In 6 months will have 80% compliance of implemented Interventions based on the assessment that was done within 2 hours.

Critical Issues / Deliverables

Critical Issues (ie. Barriers):

- Clear expectations
- Roll out of education
- Culture change/change in process
- Accountability of documentation in a timely manner/real time
- Expectation of duties with less staff as staffing changes through out day

Deliverables:

- CNA task list in Cerner
- Visual cue to turn patients
- Assessment documentation done early
- Preventative interventions in place
- CM and Gemba rounds moved to a later time

Plan (brief descption of tasks, consider feedback loop, measures for success & communication plan)

#	Task	Start Date	Due Date	Who	Status R/Y/G
1	Move skin assessment to first priority at beginning of shift, with in 3 hours with interventions initiated			RN, Charge nurse, PCL, PCM	
2	Move Discharge and Gemba rounds later in am & afternoon			Management teams, PCL, PCM	
3	Cluster care : Assess skin when in room for med pass			RN, CNA	
4	Collaborate skin assessment when other tasks are being done, i.e. during bath			RN, CNA	
5	Visual aide for when bath/skincare/pericare & turning needs to be done			Clin-Ed, Management	
6	Culture change that all patients belong to unit and not just the assigned NA /RN to assist with turns/OOB/Mobility			Management, RN, Charge nurse	
7	Move med pass from 8am to 9am, 8pm to 9pm			PCL, PCM, Pharm	
8	Change standards to include preventative devices/foam			Advanced practice Director	
9	Task list / Schedule on Cerner for CNA			CNA 66/246	

Accomplishments / Next Steps

Accomplishments:

Next Steps:

FOUR CORNER CHART: HAPI

Addresses Root Cause: Pressure Injury Prevention (PIP) Processes



Problem / Goals & Objectives

Problem Statement: In 2018 and 2019 Kaweah Delta had a mean of 1.66 stage 2 + HAPIs per 1000 patient days (or a total of 243). Of the patients that had a HAPI in 2019, 14% of them were not on the correct surface, 24% of them did not have proper skin care, and 36% of them were not mobilized. These are pressure injury prevention measures.

Goals and Objectives (Quantified): 100% of RNs and CNAs can name the prevention measures included in the pressure injury prevention plan by April 2021.

Plan

(brief description of tasks, consider feedback loop, measures for success & communication plan)

#	Task	Start Date	Due Date	Who	Status R/Y/G
1	Create a CBL on pressure injury prevention.			Bekah/Tiffany	
2	The CBL on PIP will be completed for all current bedside staff (RNs/CNAs/RTs) and oncoming staff during their first 3 months of hire.			Clinical Education	
3	Print the pressure injury prevention plan on green paper and have in all floor's black boxes.			Melinda Blankenship	
4	Nurse Managers or educators will review PIP expectations and PIPP at staff meetings twice a year.			NMs/Educators	
5	How-to pictures showing what preventative supplies need to be used with which device will be placed where those devices/equipment live on each unit (or with the kit when it's made and available).			Annette/Sheryl	
6	PIPP incorporated into MD admission order sets.			ISS ?	
7	Skin "timeout" on every transfer/admission. Primary RN paired with one other team member (RN/LVN/CNA) to rapidly assess risk factors and put prevention measures into place. (K board)			Charge Nurses/ NMs 67/246	

Critical Issues / Deliverables

Critical Issues (ie. Barriers):

Long ED/1E stay times in the. PIP may not be initiated in the ED/1E. Holding/table times in the OR. Prevention interventions in Cerner are not bundled together.

Deliverables:

1. CBL
2. PIPP on green paper
3. How-to pictures

Accomplishments / Next Steps

Accomplishments:

Next Steps:

FOUR CORNER CHART: HAPI

Addresses Root Cause: Turning & Positioning



Problem / Goals & Objectives

Problem Statement: Turning/Positioning is not consistently performed as evidenced by increased HAPIs. 2019: 91 vs 2020 Jan-July: 152 defects. The magnitude of this problem is widespread on all units. The units with the highest rate of HAPIs are ICU, CVICU, 3W, 4N, 4S.

Goals and Objectives (Quantified): Turn/Position patients every 2 hours

Critical Issues / Deliverables

Critical Issues (ie. Barriers):

1. Higher priorities (preventative interventions are lower priority)
2. Staffing
3. Lack of time to complete all required tasks
4. Excuse culture, laziness
5. Higher acuity/more problematic patients draining resources.

Deliverables:

1. Modified PIP checklist posted in patient and supply rooms.
2. Escalation algorithm added to wound book and e-coach.
3. Standard work for RNs/CNAs.
4. Education

Accomplishments / Next Steps

Accomplishments:

Next Steps:

1. Perform tasks

Plan					
(brief description of tasks, consider feedback loop, measures for success & communication plan)					
#	Task	Start Date	Due Date	Who	Status R/Y/G
1	Implement Turn/Adjust Schedule. Patients will be turned/devices adjusted on even hours and together at change of shift (Days/Noc). Measure?				
2	Standardize turn Q2 and adjust interventions. Modify existing PIP Plan checklist. Display checklist in rooms.				
3	Consistent RN/CNA handoff w/ high risk patients that are difficult to turn and max assist. Print patient list. Measure?				
4	Develop Chain of command algorithm for patients that refuse. Measure?				
5	Evaluate need for tubes, lines, and drains. Include in Gemba?				
6	Communication Plan: Develop talking points, mandatory education, slides to present at meetings.				
7	Feedback loop: Get feedback from RNs/CNAs. Add to meeting agendas.				
8	Measure of success: Decrease overall rate of HAPIs by 25% within 6 months.			68/246	

FOUR CORNER CHART: HAPI

Addresses Root Cause: Communication



Problem / Goals & Objectives

Problem Statement: Poor communication leads to missed opportunities for preventing pressure injuries as evidenced by higher than benchmark of reported Stage 2 or greater HAPI's per 1000 patient days.

Goals and Objectives (Quantified): Our goal is 100% of high risk patients are known and identified to the team each shift on each unit.

Plan

(brief description of tasks, consider feedback loop, measures for success & communication plan)

#	Task	Start Date	Due Date	Who	Status R/Y/G
1	<i>Establish standard unit communication tool</i>				
2	<i>Pilot on unit</i>				
3	<i>Leader checks tool daily (During Gemba rounds) Tool completed or not. Seek to understand fallout reallocate resources, use Just Culture algorithms</i>				
4	<i>Place visual prompts to promote skin communication during shift change.</i>				
5	<i>Follow standard communication plan during shift</i>				
6	<i>Communication plan upon success of pilot will be to present at PCM, PCL.</i>				
7	<i>Establish educational rollout of new communication process.</i>				

69/246

Critical Issues / Deliverables

Critical Issues (ie. Barriers):

1. Braden Tool is subjective
2. Nightshift accountability challenge

Deliverables:

1. Communication Tool (Visual Tool) to let team know who is high risk
2. Shift Report visual prompts-

Accomplishments / Next Steps

Accomplishments:

Defined/Clarified at risk patients to standardize communication

• **Are they at risk? Y/N**

- Incontinent/Moisture
- Mobility/turns,
- Nutrition
- Device

Next Steps:

Action Plan

- Strategies brought forth by the HAPI Rapid Improvement Team are documented
 - Evaluated and prioritized by the HAPI Quality Focus Team
 - Actions implemented by priority
 - Track action items for each strategy
- How do we know we have been successful?
 - Strategies have measurable objectives (process measures)
 - Monitor the HAPI Stage 2+ and Device Associated events (outcome measures)



Control

Maintain the
solution.

Participant Evaluation

Question	Average Participant Response n=17, scale 1-10 (higher is better)
1. My knowledge of Lean/Six Sigma methods & tools improved after participating in the Rapid Improvement Event	8.29
2. The tools used during the event (to complete DMAIC) became clear and were useful in helping the team reach their goals	9.0
3. I feel confident that the strategies developed for improvement during the Rapid Improvement Event will be successful (improvement will happen)	7.8

Thank you...



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

Kaweah Delta Medical Foundation

Paul Schofield, CEO
Contact number: 559-738-7500, ext. 5545
pschofie@kdhcd.org
November 13, 2020

Summary Issue/Service Considered

1. Establishing an integrated delivery system whereby the Visalia Medical Clinic (VMC/Group) and Kaweah Delta Health Care District (KDHCD) work in unison to deliver world class healthcare services in Visalia and the surrounding region.
2. Leading the expansion of the depth and breadth of medical services provided to the community.

Analysis of financial/statistical data:

1. For the first three months of fiscal year 2021, KDHCD's net investment to fund KDMF is \$1,883,175 compared with a budgeted net investment of \$2,173,557.
2. For the first three months of fiscal year 2021, work relative value units (wRVUs) were 97,416, compared with 94,351 for the first three months of fiscal year 2020.
3. For the first three months of fiscal year 2021, total charges were \$19,262,060, compared with \$18,667,751 for the first three months of fiscal year 2020.
4. For the first three months of fiscal year 2021, total collections were \$10,606,386, compared with \$11,256,188 for the first three months of fiscal year 2020.
5. For the first three months of fiscal year 2021, patient encounters were 81,806, compared with 88,628 for the first three months of fiscal year 2020.
6. Total number of Visalia Medical Clinic physicians on November 1, 2020 is 46, compared to 47 physicians one year ago – with 2 more physicians already committed to join the clinic in 2021.
7. Total number of Visalia Medical Clinic providers on November 1, 2020 is 64, compared to 63 providers one year ago.
8. Fiscal year 2020 was heavily impacted by the COVID-19 pandemic, beginning in March 2020. KDMF was meeting its budget projections through February 2020. KDMF ended fiscal year 2020 in June with a net investment of \$10,465,079 – with a budgeted net investment for fiscal year 2020 of \$8,505,737. This variance was largely driven by lost volume and its associated revenue. At its worst point, volumes at KDMF dropped to 50% of weekly averages. By June 2020 volumes had partially recovered and were running approximately 15% below normal.

Policy, Strategic or Tactical Issues

The Kaweah Delta Medical Foundation (KDMF) was established just over 5 years ago by KDHCD to provide a mechanism for KDHCD and VMC to work collaboratively in the provision of health care services. Accordingly, both parties entered into a 10-year Professional Services Agreement (PSA), which will be renegotiated or terminated in November of 2025. Subject to California's Corporate Practice of Medicine Laws, KDMF is one of 14 medical foundations that currently exist in California. Just under two-thirds of California medical foundations are investing more annually, as a percent of the respective medical foundation's net revenue, than KDHCD is currently investing in KDMF, with Adventist Health investing the most in its medical foundation than any other medical foundation in the State.

The primary purpose of KDMF is to establish a vehicle through which KDHCD and VMC are able to work collaboratively to ensure better continuity of patient care from initial office visit, to inpatient and outpatient services – including surgery, to home health and hospice services (and everything in between). The two driving goals in forming KDMF (to strengthen physician alignment with KDHCD and to enhance physician recruitment) have not yet been fully achieved.

For the first three months of fiscal year 2021, notwithstanding the global pandemic, KDMF has accelerated improvement beyond any other period since its inception.

1. Financial performance is better than budget by \$290,382 through the first quarter of fiscal year 2021.
2. KDMF leadership has done a tremendous job of managing expenses and staff productivity throughout the COVID-19 pandemic, which has played a key role in our ability to meet our budget despite reduced volumes.
3. Hospital/physician collaboration within KDMF appears to be improving.
4. VMC has added 2 providers (and lost 2 providers), since January 1, 2020.

Hospital/Physician Collaboration

A successful strategic planning session was held August 29, 2020, at which KDMF reaffirmed its prior adoption of the new Mission, Vision, and Pillars of KDHCD. Five strategic initiatives were agreed upon: (1) Operational Efficiency, (2) Kaweah Care Culture, (3) Strategic Growth, (4) Innovation, and (5) Integration. Three strategies/tactics under each strategic initiative were identified. Champions for each of the five strategic initiatives were identified, including Malinda Tupper, KDHCD CFO; Dianne Cox, KDHCD VP Human Resources; Paul Schofield, KDMF CEO; Ralph Kingsford, M.D., Executive Director VMC; and Ben Brennan, M.D., Joint Operating Committee member. Progress continues in each of these areas.

Growth

The number of Visalia Medical Clinic providers on November 1, 2020 was 64, compared with 63 providers a year ago.

Financial Performance (see financial data section above).

Recommendations/Next Steps

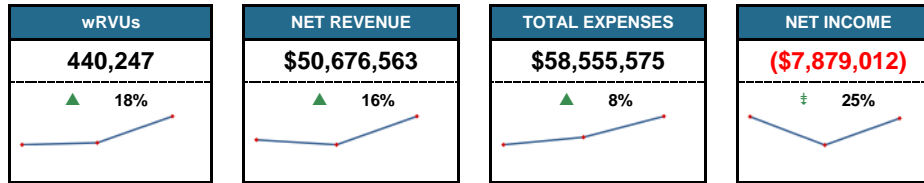
1. Continue implementation of the Strategies/Tactics identified in the 2020 Strategic Planning Process under each of the 5 Strategic Initiatives.
2. Continue implementation of the recommendations from the ECG report, as agreed to by the KDMF Board of Directors, including but not limited to the following:
 - a. Implementation of a referral management process that maximizes “in-house” referrals.
 - b. Renegotiation of commercial payer contracts to achieve rates at the 75th percentile.
 - c. Increase the efficiency of the revenue cycle by submitting clean claims, which will reduce days in accounts receivable.
 - d. Continue evaluation to better align ancillary services.
 - e. Invite other physician groups into KDMF, including hospital-based groups.
 - f. In conjunction with KDHCDC, develop an ASC joint venture opportunity.
3. Successfully adjust the physician compensation model by the end of fiscal year 2021, as outlined in the PSA.

Approvals/Conclusions

KDMF will focus on the following in the coming year:

1. Operate the Medical Foundation to exceed budget expectations.
2. Accelerate the recruitment of physicians into KDMF based on community need.
3. Look for additional opportunities for operational alignment to drive down cost in the future, as we have done this past year in the areas of Lab, IT, and management of physician benefits.
4. Focus on the implementation of Strategies/Tactics from the 5 Strategic Planning Initiatives, and the ECG recommendations.
5. Continue to support KDHCDC in its development of a Rural Health Clinic in the City of Tulare.
6. Continue to support KDHCDC Rural Health Clinics and the new FQHC by supplying specialists as needed/available.
7. Identify geographic areas outside of Visalia in which to expand.

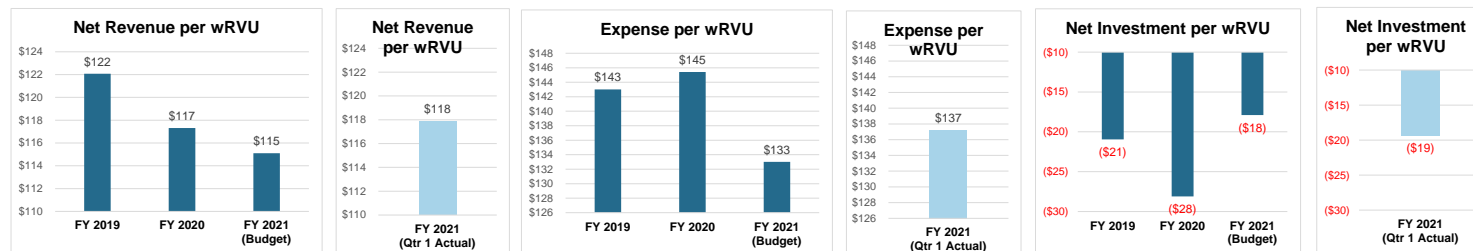
KEY METRICS - FY 2021 (BUDGET)



METRICS SUMMARY - 3 YEAR TREND

METRIC	FY 2019	FY 2020	FY 2021 (Budget)	%CHANGE FROM PRIOR YR	3 YR TREND	FY 2021 (Qtr 1 Actual)	FY 2021 (Qtr 1)	Variance
Work RVUs (wRVUs)	367,674	372,369	440,247	▲ 18%		97,417	109,248	(11,831)
Net Revenue	\$44,883,063	\$43,684,285	\$50,676,563	▲ 16%		\$11,482,997	\$12,615,885	(\$1,132,888)
Total Expenses	\$52,583,954	\$54,149,364	\$58,555,575	▲ 8%		\$13,366,172	\$14,789,442	(\$1,423,269)
Net Income (Investment)	(\$7,700,891)	(\$10,465,079)	(\$7,879,012)	‡ 25%		(\$1,883,175)	(\$2,173,557)	\$290,382
Net Revenue per wRVU	\$122	\$117	\$115	-2%		\$118	\$115	\$2
Expense per wRVU	\$143	\$145	\$133	-9%		\$137	\$135	\$2
Net Investment per wRVU	(\$21)	(\$28)	(\$18)	36%		(\$19)	(\$20)	\$1

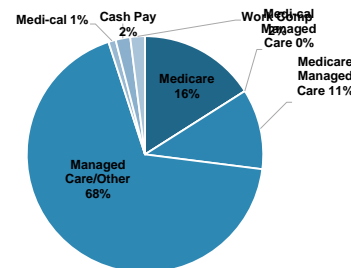
PER wRVU TRENDED GRAPHS



PAYER MIX - 3 YEAR TREND

PAYER	FY 2019	FY 2020	FY 2021-Budget
Medicare	23%	16%	16%
Medi-cal Managed Care	0%	0%	0%
Medicare Managed Care	6%	11%	11%
Managed Care/Other	68%	68%	68%
Medi-cal	0%	1%	1%
Cash Pay	1%	2%	2%
Work Comp	2%	2%	2%

FY 2021-Budget Payer Mix



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**

Original Date: April 3rd, 2019

Revision Date: December 17th, 2020

CO-APPLICANT AGREEMENT

THIS CO-APPLICANT AGREEMENT (the "Agreement") is entered into as of April 3, 2019 (the "Effective Date"), by and between KAWEAH DELTA HEALTH CARE DISTRICT, a California health care district ("District") and SEQUOIA HEALTH AND WELLNESS CENTERS, a California nonprofit, public benefit corporation ("Sequoia"). District and Sequoia shall be collectively referred to herein as the "Parties" and individually as a "Party". This Agreement is made with reference to the following facts:

RECITALS

A. "Kaweah Delta Health Care District" is a California health care district formed under The Local Health Care District Law as set forth in Section 32000, et seq., of the California Health & Safety Code ("District Law"), and that has its principal place of business at 400 W. Mineral King Avenue, Visalia, California 93291; and

B. "Sequoia Health and Wellness Centers" is a California nonprofit public benefit corporation and has its administrative office at principal place of business at 202 W. Willow Ave, Suite 502, Visalia, CA 93291; and

C. The United States Department of Health and Human Services' Health Resources and Services Administration ("HRSA") administers the Health Center program established under Section 330 of the Public Health Services Act ("Section 330"), in addition to certifying Federally Qualified Health Centers ("FQHCs") as described in in 42 U.S.C. §§ 1395x(aa)(4) and 1396d(l)(2)(B) of the Medicare and Medicaid programs, respectively; and

D. District believes that it can better address the health care needs of the medically underserved through its participation in the Section 330 program with respect to certain health center sites (collectively referred to as "Health Center"), and that the District's participation in the Section 330 program requires it to comply with the statutes, regulations and policies administered by HRSA including but not limited to 42 U.S.C. § 254b, 42 C.F.R. §§ 51c.101 – 51c.507, 2 C.F.R. Part 200, 45 C.F.R. Part 75, the HRSA "Health Center Program Compliance Manual" (Rev. 8/20/18), and the United States Department of Health and Human Services ("DHHS") "HHS Grants Policy Statement" ("Applicable Law"); and

E. District is authorized under the Local Health Care District Law to, among other things, maintain, and operate, or provide assistance in the operation of, one or more health facilities or health services, including, but not limited to, outpatient programs, services, and facilities; retirement programs, services, and facilities; chemical dependency programs, services, and facilities; or other health care programs, services, and facilities and activities at any location within or without the District for the benefit of the District and the people served by the District.

F. In order to establish a user-majority governing board that is representative of the patient population being served by the Health Center and which assumes specified responsibility as to the Health Center, consistent with Applicable Law, the Parties wish to enter into a co-applicant arrangement identifying the roles and responsibilities of District and Sequoia, and to further describe areas of shared responsibility; and

G. For the mutual benefit of the Parties and the residents of the Health Center's service area, Sequoia and the District wish to enter an agreement setting forth their rights and obligations with respect to the co-applicant board, consistent with HRSA requirements.

NOW, THEREFORE, the District and Sequoia agree as follows:

A. Establishment of Co-Applicant Board.

This Co-Applicant agreement is required by HRSA, and is intended by the Parties, to describe the delegation of authority and define roles, responsibilities, and authorities, including any shared roles and responsibilities in carrying out applicable governance functions relating to the Health Center. Sequoia is a California nonprofit, public benefit corporation which will operate the Health Center as a Co-Applicant, as that term is utilized by HRSA in connection with its administration of the Section 330 health center program, in accordance with the terms of this Agreement.

B. Sequoia's Health Center Board Composition.

1. Sequoia's health center governing board ("**Health Center Board**") shall consist of at least 9 and no more than 25 members. The specific number shall be set forth in Sequoia's corporate bylaws ("**Bylaws**").
2. The majority (at least 51 percent) of the Health Center Board members must be patients served by the health center. These health center patient board members must, as a group, represent the individuals who are served by the health center in terms of demographic factors, such as race, ethnicity, and gender. To the extent that the Health Center has filed a HRSA Uniform Data System ("**UDS**") report, the demographic factors shall be consistent with those set forth in the UDS report.
3. A "patient" of the Health Center shall be as such term is defined by HRSA. The term "patient" is currently defined by HRSA as an individual who has received at least one service in the past 24 months from the Health Center that generated a Health Center visit, where both the service and the site where the service was received are within the HRSA-approved scope of project. A legal guardian of a patient who is a dependent child or adult, a person who has legal authority to make health care decisions on behalf of a patient, or a legal sponsor of an immigrant patient may also be considered a patient of the health center for purposes of Health Center Board representation.
4. The initial patient Health Center Board members shall be patients meeting the foregoing definition as to services and sites for which HRSA approval is being sought. Non-patient Health Center Board members must be representative of the community served by the Health Center and must be selected for their expertise in relevant subject areas, such as community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community.
5. Of the non-patient Health Center Board members, no more than one-half may derive more than 10 percent of their annual income from the health care industry. The Health Center Board shall determine, within its policies, how to define "health care industry" for purposes of board composition and how to determine the percentage of annual income of each non-patient board member

derived from the health care industry.

6. A Health Center Board member may not be an employee of Sequoia or the District, or spouse or child, parent, brother or sister by blood, adoption or marriage of such an employee. An “employee” shall include an individual who would be considered a “common-law employee” or “statutory employee” according to the Internal Revenue Service criteria, as well as an individual who would be considered an employee for state or local law purposes.
7. The Project Director, as such term is utilized in the Applicable Law, shall be the Chief Executive Officer (“**CEO**”); the CEO or his/her designee shall serve as a non-voting, ex-officio member of the Health Center Board.
8. The initial voting members of the Health Center Board were nominated and appointed in accordance with California law and the Bylaws. Upon the expiration of the initial term of such directors, or earlier resignation, termination or removal from the Health Center Board, voting members shall be nominated and approved in accordance with California law and the Bylaws.
9. The Bylaws shall prescribe the process for selection and removal of all Health Center Board members. This selection process shall ensure that the Health Center Board is representative of the Health Center’s patient population as described above and consistent with the Applicable Law.

C. Sequoia’s Health Center Board’s Authority and Obligations.

As described in the Bylaws, the Health Center Board provides community-based governance and oversight of the District’s Health Center, and shall have authority and responsibility for the following activities:

1. Frequency of Board Meetings: The Health Center Board shall hold meetings no less frequently than once per month and shall ensure that a quorum is present to ensure the Board has the ability to exercise its required authorities and functions.
2. Chief Executive Officer. The Health Center Board shall have final authority to select, approve, remove, and evaluate Sequoia’s CEO, as described in Sections D and E(2) – E(3) of this Agreement;
3. Adoption of Policies. The Health Center Board shall establish or adopt policies for Sequoia’s conduct of its participation in the Section 330 program (“**Project**”) and shall update these policies when needed. These policies shall include: (i) hours of operation; (ii) health care services provided; (iii) quality-of-care audit procedures; (iv) credentialing and privileging of licensed and certified Project staff; (v) patient satisfaction evaluation and grievance resolution; (vi) sliding fee scale; (vii) Billing and Collections; (viii) Contracting and Purchasing; (ix) in the event of relocation or redevelopment of the physical plant, the locations of the Health Center sites; and (x) any other policy required by HRSA.
4. Approval of the Annual Budgets. The Health Center Board shall have final authority to approve Sequoia’s annual operating and capital budget.
5. Financial Management Protocol. Subject to, and consistent with Sections C(3) and C(4) of this Agreement, the Health Center Board shall establish or adopt written policies for the financial management practices of the Project (including a system to assure accountability for the Project’s resources, provision of an

annual audit, long-range financial planning, billing and collection policies, and accounting procedures).

6. Evaluation of the Project's Activities and Achievements. On at least an annual basis, the Health Center Board shall conduct an evaluation of Sequoia's activities and achievements and recommend, as necessary, revision of Sequoia's goals, objectives and strategic plan with respect to the Project.
7. Approval of Applications. The Health Center Board shall approve applications for annual FQHC recertification, annual Section 330 grants (as applicable), and other grant funds for the Project.
8. Compliance. The Health Center Board shall assure the Project's compliance with applicable federal, state and local laws, regulations and policies. Under the direction of the CEO in accordance with Section D(2) the District shall provide the Health Center Board with periodic reports regarding the Health Center's legal and regulatory compliance program. On at least an annual basis, the Health Center Board shall evaluate the Project's compliance activities and recommend, as necessary, the revision, restructuring, or updating of the compliance program by the District.
9. Quality Management. The Health Center Board shall have final authority to review and approve the Project's annual Quality Improvement Plan. The Health Center Board shall evaluate and monitor the quality management programs developed and recommended by Sequoia's staff in a manner and frequency according to the approved Quality Improvement Plan and Section F(5)(e)..
10. Evaluation of the Health Center Board. On at least an annual basis, the Health Center Board shall evaluate its compliance with the governance requirements and report its findings and any recommendations for corrective action to the District. Also, on at least an annual basis, the Health Center Board shall evaluate itself and its actions for effectiveness, efficiency and compliance with the authorities set forth in this Agreement consistent with the requirements of Section 330.

D. Duties and Evaluation of the Chief Executive Officer.

1. Chief Executive Officer. The CEO shall be an employee of the District and shall, on behalf of the District, coordinate with the Health Center Board to meet the obligations under this Agreement.
2. Duties. The CEO shall have responsibility for the general care, management, supervision, and direction of the Project's affairs, consistent with the priorities and policies established by the Health Center Board and by HRSA, with respect to the obligations of a Project Officer. The CEO shall report directly to the Health Center Board and shall act in accordance with the best interests of Sequoia, regardless of and notwithstanding any employment arrangement between the CEO and the District. The CEO shall have the authority to select, supervise, and discharge all Project personnel in accordance with the laws, collective bargaining agreements, if any, and personnel policies applicable to the District and/or Sequoia (as reviewed and approved by the Health Center Board in accordance with Section C(3)). The CEO shall also have the authority to direct the development of the annual operating and capital budgets, monitor and coordinate all contracts for goods and services as required for the operation of the Project, subject to the laws and policies applicable to the District's and Sequoia's

procurement and purchasing, the budget approved by the Health Center Board for the Project, and the laws and policies applicable to the District's and Sequoia's administration of contracts.

3. Evaluation. The Health Center Board shall review the CEO's performance annually based on performance evaluation criteria approved by the Health Center Board. The review shall be coordinated and conducted by a subcommittee of the Health Center Board. The report of the annual review shall be submitted to the full Health Center Board, and to the District.

E. Selection, Approval, and Removal of Chief Executive Officer.

1. Selection and Approval. The Health Center Board shall have sole authority to select and approve the CEO.
2. Removal. The Health Center Board shall have sole authority to remove the CEO. Any recommendation for the removal of the CEO shall be presented to the full Health Center Board for approval. Such removal of the CEO shall not constitute a termination of employment or preclude his/her continued employment by the District in a capacity other than Project Director/CEO of the Health Center..
3. Recruitment of Chief Executive Officer.
 - a. In the event of a vacancy in the office of the CEO the Health Center Board will collaborate with the District in the recruitment of qualified applicants.
 - b. At the direction of the Health Center Board, a search outside of the District may be conducted for a CEO.
 - c. Preliminary interviews and evaluation of candidates for the CEO position must include at least two representatives of the Health Center Board..
4. Selection and Approval. The Health Center Board shall have sole authority to select and approve the CEO from the qualified candidates presented by the District at the conclusion of the search process. Selection of the CEO shall be presented to the full Health Center Board for approval.
5. Removal. The Health Center Board shall have sole authority to remove the CEO. Any recommendation for the removal of the CEO shall be presented to the full Health Center Board for approval. Such removal of the CEO shall not constitute a termination of employment or preclude his/her continued employment by the District in a capacity other than Project Director/CEO of the Health Center..

F. Role of the District

1. The District as a Public Agency. In accordance with federal requirements, the District and Sequoia, recognize that the District as a public agency is constrained by law in the delegation of certain government functions to other entities, and is permitted to establish general policies which will be reviewed and adopted by the Health Center Board. Therefore, in support of the Health Center Project, the District as a public agency with an approved co-applicant board arrangement and under the direction of the CEO in accordance with Section D(2), shall establish the following types of general policies:
 - a. Fiscal Policies.
 - i. Internal control procedures to ensure sound financial management procedures.

- ii. Purchasing policies and standards.
 - b. Personnel Policies.
 - i. Employee selection, performance review/evaluations, and dismissal procedures.
 - ii. Employee compensation, including wage and salary scales and benefit packages.
 - iii. Position descriptions and classification.
 - iv. Employee grievance procedures.
 - v. Equal opportunity practices.
2. Notwithstanding the terms of this Agreement or the Bylaws of Sequoia and subject to the authorities shared with the Health Center, neither Party shall take any action inconsistent with the District's authority to support the management of the Project:
- a. Fiscal Controls.
 - i. Under the direction of the CEO in accordance with Section D(2), the District shall develop and shall provide preliminary recommendations for the annual operating and capital budgets of Sequoia. The District shall recommend such budgets to the Health Center Board for review and final approval. In the event that the Health Center Board does not approve the recommended budget, the District and the Health Center Board shall meet and confer to develop an appropriate budget that is satisfactory to both. If the District and the Health Center Board fail to develop a mutually agreed upon budget within thirty (30) days of the initial review, then the dispute shall be resolved in accordance with Section H(5) below. Subject to the requirements for adoption and approval of a public agency budget, the Health Center Board shall have final authority to approve the annual operating and capital budgets of the Health Center.
 - ii. Under the direction of the CEO in accordance with Section D(2), the District shall spend funds that are consistent with the budget approved by the Health Center Board. The Parties shall not materially deviate from the adopted budget except that the District, under the direction of the CEO, may propose to the Health Center Board modifications to planned fiscal activities if there is a change in available resources (e.g., levels of reimbursement, increased or diminished revenues, or adverse labor events). Under the direction of the CEO, the District shall immediately notify the Health Center Board of any proposed budgetary change that would materially modify the scope of the Project, and shall seek the necessary Health Center Board approvals of such changes.
 - iii. Under the direction of the CEO in accordance with Section D(2), the District shall be responsible for the management of the financial affairs of Sequoia, including capital and operational borrowing consistent with the budgets, policies and priorities established or adopted by the Health Center Board.

- iv. Under the direction of the CEO in accordance with Section D(2), the District shall develop and implement financial policies and controls related to Sequoia as set forth in this Agreement.
 - v. All funds received for services provided and all income otherwise generated by Sequoia, including fees, premiums, third-party reimbursements and other state and local operational funding, and Section 330 grant funds ("Project Income"), as well as all Project Income greater than the amount budgeted ("Excess Project Income"), shall be under the direction of the CEO and control of the District. Project Income and Excess Project Income shall solely be used to further the goals of the federally approved Project and consistent with the budgets, policies and priorities established or adopted by the Health Center Board.
 - vi. Under the direction of the CEO in accordance with Section D(2), the District shall have sole authority to receive, manage, allocate, and disburse, as applicable, revenues necessary for the operation of the Health Center, consistent with this Agreement.
3. Funding From Governmental and Charitable Sources. Neither Party shall take any action that would negatively impact the District's funding from federal, state, or local sources or financial support from foundations or other charitable organizations.

4. Employer-Employee Relations.

Subject to the limitation of Section C(2) of this Agreement regarding the selection, evaluation, approval and removal of Sequoia's CEO, the District shall provide human resources support to the Health Center Project for employment matters and development and approval of personnel policies and procedures, including but not limited to, the selection, discipline and dismissal, salary and benefit scales, employee grievance procedures and processes, equal employment opportunity practices, collective bargaining agreements, labor disputes and other labor and human resources issues, as well as agreements for the provision of staff who are employees of other agencies or organizations. Consistent with this Agreement, the Health Center shall review and adopt the personnel policies and procedures developed and approved by the District.

5. Operational Responsibilities. Subject to the governance responsibilities exercised by the Health Center Board, the District staff, under the direction of the CEO in accordance with Section D(2), shall conduct the day-to-day operations of the Health Center. Such operational responsibilities shall include but not be limited to:
- a. Applying for and maintaining all licenses, permits, certifications, accreditations and approvals necessary for the operation of the Health Center.
 - b. Credentialing and privileging of staff and providers, in coordination with the SHWC CMO and as delegated by the Health Center Board of Directors in accordance with the credentialing and privileging policy.

- c. Receiving, managing, and disbursing, as applicable, revenues of the Health Center consistent with the approved budget for the Health Center. The District shall not be required to disburse funds for any expenditure not authorized by the approved budget.
- d. Subject to the limitations set forth in this Agreement, employing or contracting personnel to perform all clinical, managerial, and administrative services necessary to assure the provision of high-quality healthcare services to the Health Center's patients. The CEO shall provide direction to all District personnel supporting the Health Center Project in accordance with Section D(2).
- e. Provide resources and support for the Health Center Board approved Quality Improvement Program which may include clinical services and management which are overseen by Sequoia's medical director(s), and maintaining the confidentiality of records, per 42 U.S.C. § 254b(k)(3)(C) and 42 C.F.R. § 51c.303(c)(1)-(2).
- f. Subject to the limitations set forth in this Agreement, under the direction of the CEO in accordance with Section D(2), managing and evaluating all Health Center staff and, if necessary, disciplining, terminating or removing such staff pursuant to the District's personnel policies and processes.
- g. Under the direction of the CEO in accordance with Section D(2), preparing and submitting cost reports, supporting data, and other materials required in connection with reimbursement under Medicare, Medicaid, and other third-party payment contracts and programs.
- h. Under the direction of the CEO in accordance with Section D(2), providing for the annual audit of the Health Center, which shall be undertaken in consultation with the Health Center in accordance with this Agreement, consistent with the requirements of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards (45 C.F.R. Part 75), to determine, at a minimum, the fiscal integrity of financial transactions and reports and compliance with Section 330 requirements and the fiscal policies of the District. The Health Center Board shall review and accept the annual health center audit, and shall ensure that any appropriate follow-up actions are taken.
- i. Under the direction of the CEO in accordance with Section D(2), preparing monthly financial reports, which shall be submitted to the Health Center Board, and managing financial matters related to the operation of the Health Center.
- j. Under the direction of the CEO in accordance with Section D(2), developing and managing internal control systems, in consultation with the Health Center Board as set forth in this Agreement (as applicable), in accordance with sound management procedures and Section 330 that provide for:
 - i. eligibility determinations;
 - ii. development, preparation, and safekeeping of records and books of account relating to the business and financial affairs of the Health Center;

- iii. separate maintenance of the Health Center's business and financial records from other records related to the finances of the District so as to ensure that funds of the Health Center may be properly allocated;
- iv. accounting procedures and financial controls in accordance with generally accepted accounting principles;
- v. billing and collection of payments for services rendered to individuals who are: (1) eligible for federal, state or local public assistance; (2) eligible for payment by private third-party payors and (3) underinsured or uninsured and whose earnings fit the low-income criteria;
- vi. compliance with the terms and conditions of the Section 330 Grantee designation, as applicable.
- vii. Unless otherwise stated in this Agreement, establishment of the Health Center's operational, management, and patient care policies.
- viii. Establishing ongoing quality improvement and compliance programs.
- ix. Ensuring the effective and efficient operation of the Health Center.
- k. Under the direction of the CEO in accordance with Section D(2), provide patient support services including language assistance, defined as the timely availability of professional translation (written) and interpretation (oral) services (e.g., access to bilingual providers, onsite interpreters, language telephone line) as well as auxiliary aids based on the primary language(s) spoken by a substantial number of individuals in the health center's target population and service area. These services will be provided through the employment of competent bilingual staff, staff interpreters, contracts or formal arrangements with local organizations providing interpretation or translation services, and telephonic interpretation services.

G. Mutual Obligations

1. Compliance with Laws and Regulations. The Parties shall have a mutual commitment and responsibility to work together to ensure that Sequoia provides care in compliance with all applicable federal, state and local laws, policies and regulations.
2. Financial Responsibility. Each Party agrees not to undertake expenditures in excess of the authorized budget and the available resources and to recognize the District's responsibility with respect to the Fiscal Controls and related financial matters described in this Agreement.
3. Expenses of Parties. The expenses of the District and Sequoia incurred in carrying out its respective obligations for governance and operation of the Project pursuant to this Agreement shall be considered expenses incurred on behalf of Sequoia in furtherance of the Project and thus shall be reimbursed in accordance with applicable program requirements and the fiscal policies of the District.

4. Record Keeping and Reporting.

- a. Record Keeping. Each Party shall maintain records, reports, supporting documents and all other relevant books, papers and other documents to enable the Parties to meet all Section 330-related reporting requirements. Records shall be maintained for a period of ten (10) years from the date this Agreement expires or is terminated, unless state and/or federal law requires that records be maintained for a period greater than the ten (10) year period specified herein ("the Retention Period"). If an audit, litigation, or other action involving the records is started before the end of the retention period, the Parties agree to maintain the records until the end of the Retention Period or until the audit, litigation, or other action is completed, whichever is later. The Parties shall make available to each other, DHHS and the Comptroller General of the United States, the California Department of Health Care Services, the Office of the Comptroller of the State of California or any of their duly authorized representatives, upon appropriate notice, such records, reports, books, documents, and papers as may be necessary for audit, examination, excerpt, transcription, and copy purposes, for as long as such records, reports, books, documents, and papers are retained. This right also includes timely and reasonable access to each Party's personnel for purposes of interview and discussion related to such documents.
- b. Confidentiality. Subject to the District's obligations, if any, to make public its records in accordance with applicable law, the Parties agree that all information, records, data, and data elements collected and maintained for the administration of this Agreement (in any form, including, but not limited to; written, oral, or contained on video tapes, audio tapes, computer diskettes or other storage devices) shall be treated as confidential and proprietary information. Accordingly, each Party shall take all reasonable precautions to protect such information from unauthorized disclosure; however, nothing contained herein shall be construed to prohibit any authorized Federal or other appropriate official from obtaining, reviewing, and auditing any information, record, data, and data element to which he/she is lawfully entitled. The Parties (and their directors, officers, employees, agents, and contractors) shall maintain the privacy and confidentiality of all protected health information ("PHI") of the patients receiving care provided by the Health Center, in accordance with all applicable state and federal laws and regulations, including but not limited to the Health Insurance Portability and Accountability Act ("HIPAA") and the California Confidentiality of Medical Information Act ("CMIA").
- c. Medical Records. The Parties agree that the District, as the operator of the Health Center, shall retain ownership of medical records established and maintained relating to diagnosis and treatment of patients served by the Health Center.
- d. Insurance. The District shall maintain Professional Liability Insurance, Workers' Compensation Insurance, and General Liability and Property Damage Insurance and/or self-insurance to cover Health Center activities. Such insurance may include deemed coverage under the Federal Tort Claims Act (42 U.S.C. § 233) to the extent applicable. This

Section shall survive the termination of this Agreement without regard to the cause for termination.

- e. Ownership of Property Acquired with Grant Funds. The provisions of 45 C.F.R. § 75.316, et seq., apply to tangible property acquired under this Agreement. The Parties agree that the District shall be the titleholder to all property purchased with grant funds as the non-Federal entity, within the meaning of 45 C.F.R. § 75.2.
- f. Copyrightable Material. Consistent with the requirements and limitations described in 45 C.F.R. 75.322, District shall have a copyright for any work that is subject to copyright and was developed, or for which ownership was acquired, under a Federal award. The HHS awarding agency reserves a royalty-free, nonexclusive and irrevocable right to reproduce, publish, or otherwise use the work for Federal purposes, and to authorize others to do so.

H. Governing Law.

1. Applicable Laws, Regulations, and Policies. This Agreement shall be governed and construed in accordance with applicable Federal laws, regulations, and policies, including but not limited to the Applicable Law, as defined herein. In addition, each Party covenants to comply with all applicable laws, regulations, ordinances, and policies of the State of California and all local governments in the performance of the Agreement, including all licensing standards and applicable accreditation standards, if any.
2. New HRSA Directives. Sequoia's CEO shall submit promptly to each Party any directives or policies that are received from HRSA after execution of this Agreement and are pertinent to applicable Section 330 grants, and the Parties shall comply with such additional directives/policies, as they become applicable.
3. Non-Discrimination. By signing this Agreement, Sequoia agrees to comply with the District's Equal Employment Opportunity Non-Discrimination Policy and all related personnel policies as well as all related federal requirements, including but not limited to those specified in 2 C.F.R. Part 200, Appendix II.
4. Term. This Agreement shall commence upon execution by the Parties, and shall remain in effect while either (i) one or more of the Health Center sites have been qualified by HRSA as an FQHC; or (2) the District has received a Section 330 grant award, where in either circumstance, Sequoia is the District's Co-Applicant, unless termination occurs at an earlier date in accordance with the terms of Section J of this Agreement.

I. Termination.

1. Reporting. Termination of this Agreement will be reported to HRSA within ten (10) days, or such earlier time as required by the Applicable Law. The Parties shall collaborate to minimize any risk that a termination under this Section will negatively impact either Party's compliance with the requirements of Section 330 or the FQHC status of any Health Center site.
2. For Cause Termination. Either Party may terminate this Agreement "for cause" in the event that the other Party fails to meet its material obligations under this Agreement. Such "for cause" termination shall require ninety (90) days' prior written notice of intent to terminate during which period the Party that has

allegedly failed to meet its material obligations may cure such failure or demonstrate that no such failure has occurred. Any dispute between the Parties regarding whether a breach of a material obligation has occurred, or that such a breach has been satisfactorily cured, will be resolved in accordance with this Agreement.

3. Termination by Mutual Agreement. This Agreement may be terminated upon the mutual approval of the Parties in writing provided there is HRSA approval to terminate.
4. Termination Contingent upon HRSA Approval. With the exception of a termination for cause arising from the voluntary or involuntary loss of one or more Health Center site's FQHC designation (or its Section 330 grant), either Party may terminate this agreement on one hundred twenty (120) days' prior written notice; however, such termination shall not become effective unless and until HRSA issues its written approval of such termination.
5. Dispute Resolution and Mediation. The Parties shall first attempt to resolve any dispute or impasse in decision-making arising under or relating to this Agreement by informal discussions between the District, the Chairperson of the governing board of Sequoia and the CEO. Any dispute or impasse not resolved within a reasonable time following such discussions (not to exceed thirty (30) days) shall be submitted to mediation by an experienced mediator, acceptable to both parties, who is on the panel of mediators for the Tulare County Superior Court. If the Parties are unable to resolve the dispute through mediation, either Party may pursue any remedy available at law.

J. General Provisions.

1. Notices. All notices permitted or required by this Agreement shall be deemed given when made in writing and delivered personally, sent by email, or deposited in the United States Mail, first class postage prepaid, Certified and Return Receipt Requested, addressed to the other Party at the appropriate address set forth below or such other addresses as the Party may designate in writing:

For Health Center: Chief Executive Officer
202 W. Willow Ave., Suite 205
Visalia, CA 93291

For the District: Chief Executive Officer
400 West Mineral King Avenue
Visalia, CA 93291

2. Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same Agreement, binding on both of the Parties hereto.
3. Time is of the Essence. Time is of the essence for each provision of this Agreement and each performance called for in this Agreement.
4. Entire Agreement. This Agreement, the Exhibits and Schedules, if any, and the

documents referred to herein contain the entire understanding between the Parties with respect to the transactions contemplated hereby and supersede all prior contemporaneous agreements, understandings, representations and statements, oral or written between the Parties on the subject matter hereof, which shall be of no further force or effect.

5. Headings. The section and other headings contained in this Agreement and in the Exhibits and Schedules to this Agreement, if any, are included for the purpose of convenient reference only and shall not restrict, amplify, modify or otherwise affect in any way the meaning or interpretation of this Agreement or the Exhibits and Schedules hereto.
6. No Waiver. Any term, covenant or condition of this Agreement may be waived at any time by the Party which is entitled to the benefit thereof but only by a written notice signed by the Party waiving such term or condition. The subsequent acceptance of performance hereunder by a Party shall not be deemed to be a waiver of any preceding breach by the other Party of any term, covenant or condition of this Agreement, other than the failure of such Party to perform the particular duties so accepted, regardless of such Party's knowledge of such preceding breach at the time of acceptance of such performance. The waiver of any term, covenant or condition shall not be construed as a waiver of any other term, covenant or condition of this Agreement. The rights and remedies set forth in this Agreement shall be in addition to any other rights or remedies that may be granted by law.
7. Amendment of Agreement. This Agreement may not be amended, supplemented or modified except by a written instrument duly executed by District and Sequoia.
8. Severability. If any term, provision, condition or covenant of this Agreement or the application thereof to any Party or circumstance shall be held to be invalid or unenforceable to any extent in any jurisdiction, then the remainder of this Agreement and the application of such term, provision, condition or covenant in any other jurisdiction or to persons or circumstances other than those as to whom or which it is held to be invalid or unenforceable, shall not be affected thereby, and each term, provision, condition and covenant of this Agreement shall be valid and enforceable to the fullest extent permitted by law.
9. Exhibits and Schedules. The Exhibits and Schedules attached to this Agreement, if any, shall be construed with and as an integral part of this Agreement to the same extent as if the same had been set forth verbatim herein.
10. Fair Meaning. This Agreement shall be construed according to its fair meaning and as if prepared by both Parties hereto.
11. Rules of Construction. Except as otherwise specifically provided in this Agreement, the singular of any term shall include the plural, and vice versa, the use of any term shall be equally applicable to any gender, "or" shall not be exclusive, and "including" shall not be limiting. The words "herein," "hereof," and "hereunder" and other words of similar import refer to this Agreement as a whole, including any Exhibits and Schedules hereto, as the same may from time to time be amended, modified or supplemented, and not to any particular section, subsection or clause contained in this Agreement. Any reference to a "Section," "Exhibit," or "Schedule" shall refer to the relevant Section of, or Exhibit or

Schedule to, this Agreement, unless specifically indicated to the contrary.

12. No Third-Party Beneficiary. None of the provisions herein contained are intended by the Parties, nor shall they be deemed, to confer any benefit on any person not a Party to this Agreement.
13. Anti-Kickback Laws. Nothing in this agreement or in any other written or oral agreement between District and Sequoia, nor any consideration offered or paid in connection with this agreement, contemplates or requires the admission or referral of any patient to District or Sequoia.
14. Changes in Laws. In the event there are any material changes in federal, state or local laws, rules or regulations or the interpretation or application thereof, including the laws, rules or regulations applicable to Medicare, Medi-Cal, FQHCs or other governmental health care programs, which may have a material impact on the performance of this Agreement, District or Sequoia may elect to renegotiate this Agreement by giving written notice thereof to the other. In any case where such notice is provided, both Parties shall negotiate in good faith during the thirty (30)-day period after the date of the written notice in an effort to develop a revised Agreement, which, to the extent reasonably practicable, will adequately protect the interests of both Parties in light of the changes which constituted the basis for the exercise of this provision.
15. Public Health Service Act. Sequoia and District understand and acknowledge that to the extent that Health Center is qualified by HRSA as an FQHC, it shall be subject to the provisions of Section 330 of the Public Health Service Act and implementing regulations, and any provision required to be in this Agreement by either of the above shall bind the Parties whether or not provided in this Agreement. Nothing in this Agreement shall prohibit or interfere with requirements imposed upon District and Sequoia by the Public Health Service Act and regulations. Notwithstanding the foregoing, if any such requirements materially affect the financial and other understandings between the Parties as set forth in this Agreement, the Parties shall attempt in good faith to amend this Agreement to give effect to the Parties' intentions and if no suitable compromise can be reached, either Party may terminate this Agreement for cause pursuant to Section J(2).

IN WITNESS WHEREOF, the Parties hereto have executed this Co-Applicant Agreement as of the date first above written.

KAWEAH DELTA HEALTH CARE DISTRICT, A
California Health Care District

By: _____

Its: _____

Date: _____

Address: 400 W. Mineral King Ave.
Visalia, CA 93291

SEQUOIA HEALTH AND WELLNESS CENTERS, A
California Nonprofit Public Benefit Corporation

By: _____

Its: _____

Date: _____

Address: 202 W. Willow Ave., Suite 502
Visalia, CA 93291



Policy Number: AP27	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Use of district name and/or stationery	

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

POLICY: Use of Kaweah Delta Health Care District’s name and stationery is restricted for official District business.

Use of business names for Kaweah Delta Health Care District divisions and programs is limited to the list approved by the District board on July 14, 2008 and those subsequently approved by the Executive Team. The complete list including logos, required taglines, and logo use requirements is attached to this document {Exhibit A}.

PROCEDURE:

- I. Use of Name
 - A. Unless specifically authorized to do so, staff members are not to publicly or privately present a point of view as being that of the Health Care District.
 - B. Unless specifically authorized to do so, staff members are not to speak with members of the media holding themselves out to be representatives of or speakers for the Health Care District. Any media requests should be forwarded to Kaweah Delta’s Media Relations Department.
 - C. Requests to create a social media account using a business name for a Kaweah Delta program or division requires prior approval by the Kaweah Delta Media Relations Department. The approval process is:
 - 1. Submit a request to the Media Relations Department
 - 2. Meet all of the stated Media Relations Department’s requirements for establishment of the social media account
 - 3. Agree to an annual audit to ensure that all social media accounts in are in compliance with requirements
 - D. Any and all websites that use a Kaweah Delta business name must be coordinated through the Marketing and Communications Department.
 - E. Requests to use any name other than those on the approved list will follow this procedure:
 - 1. Submit the proposed name to the Marketing and Communications Department for approval.

2. If approved Marketing will submit the proposed name to the Vice President/ Chief Strategy Office.
3. If approved the Vice President/ Chief Strategy Officer will take the proposal to the Executive Team for consideration.
4. If approved by the Executive Team the requested name may be used in Marketing and internal materials with the approved logo and required tagline(s).

When using the name of a Kaweah Delta program (i.e. Worksite Wellness) on any marketing materials, the program must contain the tagline "A program offered by Kaweah Delta Health Care District" rather than the tagline "A division of Kaweah Delta Health Care District". "A division of Kaweah Delta Health Care District" will apply to all service lines (i.e. Kaweah Delta Hospice, a division of Kaweah Delta Health Care District).

If you are unsure of the proper use of a tagline, contact the Marketing and Communications Department for assistance.

II. Use of Stationery

- A. Use of District stationery by any staff member is limited to purposes of official business within the scope of the duties and responsibilities of that individual.
- B. All correspondence addressed to government officials, particularly which indicates a point of view for or against legislation, rules, or regulation, must be approved by the Chief Executive Officer prior to mailing.
- C. No materials including, letterhead, flyers, promotional items, etc. should be sent to print without approval from the chain of command listed above.

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



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

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

POLICY:

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

PROCEDURE:

- I. All hospital personnel requesting a new or revised form shall complete the “Request for New or Revised Form” (attached), ensure form design meets form standardization rules, and obtain necessary approval prior to submission of request to the DSC. For urgent or minor changes, the Director of HIM or DSC Chair can authorize a form between Document Standardization meetings. The form can then be presented by the Director or his or her agent at the next DSC meeting.
 - A. Complete “Request for New or Revised Form” and attach a sample form designed according to standardization rules. Include original for comparison when submitting revision.
 - B. Obtain Department Head and/or physician’s approval on the request and forward these to the Forms Coordinator (Executive Assistant to the CIO)..
 - C. Completed requests for new or revised forms shall be processed within sixty (60) days.

- II. Upon receipt of completed “Request for New or Revised Form” the DSC Chair shall coordinate the preliminary review process. The form requester will present forms at the DSC meeting.
 - A. Upon receipt of the request, the DSC Chair shall log the request and complete preliminary review process.
 - B. Schedule the requester to bring new or revised form to the DSC for approval.

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

conform to the forms standardization rules.

- A. When appropriate the DSC Chair will research the master file to identify similar forms. If similar forms exist, then notify requester to:
 - 1. determine if requester can use existing form; or,
 - 2. request that requester explain and justify needed changes.
 - 3. determine if changes are significant enough to warrant a new form or whether they can be made to an existing form.

- IV. Whenever possible, patient care forms shall be “piloted” prior to submission before the final approval process.
 - A. An DSC member may assist in form development and provide “pilot” forms for use.
 - B. DSC member provided forms should be used for a minimum of thirty (30) days without revision or correction.
 - C. Revision and/or correction shall be made prior to finalizing document.
 - D. No “pilot” form will be used for a period exceeding six (6) months.

- V. Final Approval
 - A. DSC shall complete the approval process then forward the patient care form to the HIM Committee for final approval. Only those patient care forms requiring a physician’s signature go on to HIM Committee for approval.
 - 1. DSC shall return forms not approved to the requester with reason for non-approval. Form standardization rules will be attached as appropriate.
 - 2. Approved forms will receive bar code assignment.
 - 3. Method of printing and/or online location will be determined by the committee.
 - 4. Patient Care forms requiring a physician’s signature will be placed on HIM Committee agenda for approval.

 - B. If necessary the HIM Committee shall review the form at their monthly meeting within the established policy time frame of sixty (60) days.
 - 1. Forward the approved form to the appropriate individual for printing and distribution as needed.
 - 2. Return non-approved forms to the requester with reason for non-approval.
 - 3. A copy of the final version of the form will be sent to the Medical Executive Committee by the Forms Coordinator.

- C. DSC Chair will ensure printing and distribution of the new or revised form.
- D. DSC Chair to file copy final draft in Forms Binder or electronic Forms Library.

Form Standardization Guidelines

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

1. All documents should be designed using one of the Documentation Standards Committee **Microsoft Word** templates.
2. Form Identification:
 - a. KAWEAH DELTA HEALTH CARE DISTRICT must be located in upper left hand corner in the header of the document. The district logo will be placed in the header when space allows. If the form is intended to be used only in the hospital of the main campus, the Medical Center header will be used.
 - b. “A Division of Kaweah Delta Health Care District” in italics under the ‘header line’ is acceptable when more specific location identification is appropriate.
 - c. Form Name/Title: The name of the form must be located in two places on the form:
 - i. Upper right hand corner in the header of the document.
 - ii. Centered in the footer of the document between the bar code and patient identification areas. This is for ease of identification of the form in the patient’s chart while the patient is still in the facility.
 - d. Forms used District-wide should not have location specific names printed on the form.
3. Margins:
 - a. Forms should be designed to eliminate any markings within ¼” of the document edge.
 - b. Generally a ½” side margin should be observed, if possible.
 - c. Allow 1.4” space at top of patient care forms for the margin, hole punch, and logo/title bar.
 - d. Standard forms: leave 1” at top for margin and logo/title bar.
 - e. Footer: leave 1.25” at bottom of the page for margin/bar code and name, and patient identification (ID label): Patient name, MRN, Account Number, DOB, physician name or patient identification label will be placed here.
4. Font Theme and Size:
 - a. For the ease of conversion into an electronic form, only the Helvetica font theme will be used.
 - b. Font size 14 will be used for the Authorization for Use or Disclosure of Health Information.

- c. Font size 12 will be used for all material provided to patients, including consent forms and Condition of Admission (COA).
 - d. Font size 8 will be used for the title of the form in the footer of the document.
5. Shading:
 - a. Do not use any type of shading when drafting form. Shading will be added when form is typeset.
6. Form Number and Creation/Revision Date:
 - a. Located at the bottom, center of the page and/or just above the barcode.
7. Multiple Page Forms:
 - a. A page number will be present at the footer of every page.
 - b. Barcode and patient identification will be placed on every page.
 - c. The header of the first page will contain the Kaweah Delta logo.
 - i. A simplified header will be placed for any subsequent pages.
8. Multi-Part Forms
 - a. First page will be the original form in the color white.
 - b. Footer should state:
 - i. First page: Original – Medical Record
 - ii. Additional pages should state appropriate distribution, i.e., Patient copy, Physician Office copy, etc.
9. Fold out forms:
 - a. Will be perforated on the fold lines with each page numbered in sequence.
 - b. Barcode and patient identification will be placed on every page.
 - c. Page numbers will be placed on each sheet.
10. Signature Lines:
 - a. Forms requiring signatures will have a standardized footer.
 - b. Physician: Signature/Date/Time
 - c. Consents/Authorizations: Signature/Date/Time
 - d. Patient Education Material: Signature/Date
 - e. Space for legal relationship to patient when the form is signed by someone other than the patient.
 - f. Location for signatures will be standard for all forms and be located at the bottom of the document.
11. Pages of forms that do not need to be scanned into the electronic medical record require the following statement in the footer:
 - a. “For reference only. Do not include this page in the medical record.”
12. Language Translation
 - a. Forms provided to patients will be offered in English and Spanish.

- b. Spanish language forms will be translated by Interpreter Services.
- c. A space for interpreter signature, printed name, or telephonic ID number will be added to all consent and education forms that require language translation.

13. Reading Level

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

REQUEST FOR NEW/REVISED FORM

Date of Request:

_____/_____/_____

Form Title:

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

Originated by (name of committee or person):

Department Head approval (signature): _____ Dept: _____

Physician's approval:

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

Other Committees/Meetings that approved this form:

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

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

Name of form(s) being replaced:

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

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

Patient Care Forms – New and Revisions to Existing

7

Why is this form required? TJC CMS Other:

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

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

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

Will this form be given to the patient? Yes No

If yes, what is the reading level of the this form?

(It is recommended that patient forms be written at a 5th grade reading level)

Which Physicians/Departments use this information?

Who will primarily record on this form?

Can this form be utilized throughout the District? Yes No

Who is responsible for staff education regarding this form?

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

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

Other: _____

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

Comments:

Barcode:

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



Policy Number: AP46	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Commercial card expense reporting (CCER) program	

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

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

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

REFERENCES:

- AP19 Travel, Per Diem and Other Employee Reimbursements
- AP84 Mileage Reimbursements
- AP105 Professional and Service Club District Reimbursed Memberships
- AP135 Capital Budget Purchases
- AP156 Standard Procurement Practices

PROCEDURE:

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

- A. Must be an authorized signer with a completed Purchase Authorization Sheet on file with Material Management having purchase limits that meet or exceed the purchase limits of the cardholder or OOP they are approving.
 - B. Must sign the cardholder agreement to acknowledge the responsibilities of the use of the purchasing card and approver's responsibilities
 - C. Must request a CCER account for the cardholder through HR On-line System Authorization Request
 - D. Must participate in purchasing card training
 - E. Responsibility for the control and stewardship of the purchasing card program lies with each department. The department is responsible for ensuring that cardholders are purchasing with competence and honesty and providing complete and reliable backup for the purchase. Any abuse or misuse of the purchasing cards must be reported to the appropriate Executive Team member and the Financial Accounting Manager.
 - F. Review all charges billed to a cardholder's card to ensure that the charges are appropriate and reconciled to receipts. Charges must meet the requirements as set forth in District Policies, including but not limited to, AP19 (Travel, Per Diem and Other Employee Reimbursements), AP84 (Mileage Reimbursements), AP105 (Professional and Service Club District Reimbursed Memberships), AP156 (Standard Procurement Practices). Review and approval must be made on a regular basis.
 - G. Ensure the transaction's description, account and cost center coding are appropriate and within the guidelines of approver's signing authority. Adjust account and cost center codes as appropriate within the CCER On-line program.
 - H. Ensure that all original receipts are provided and reconciled to the monthly transactions prior to final on-line approval being completed.
 - I. Ensure that all documentation required to be submitted to Finance is complete and timely. Documentation includes the approved Purchasing Card Reconciliation form with all receipts. Documents **MUST** be submitted to Finance by the 8th of the month. If the 8th falls on a weekend, it is to be submitted by the following Monday. The required documentation may be submitted to Finance via electronic PDF format as long as the department maintains the original for the required retention period.
 - J. Track disputed items to ensure proper credit is received. Any discrepancies in billing must be marked as disputed charges using the on-line system.
 - K. Report any suspected fraud or negligence of this policy to an Executive Team member.
 - L. Failure to follow this policy may result in the relinquishment of Approver responsibilities.
- III. Cardholder Responsibilities

- A. Participate in a purchasing card training and sign the cardholder agreement to acknowledge the responsibilities of the use of the purchasing card
 - B. Abide by all purchasing card policies and procedures when making purchases as outlined in this policy and the Purchasing Card Agreement. Failure to adhere to the procedures as outlined in this policy will result in revocation of individual Cardholder privileges and may result in disciplinary action
 - C. Ensure the physical security of the purchasing card and protect the account number and all other security aspects of the card. The card should be kept in a secure location. Cardholders are responsible for all transactions posted to their account. Immediately report lost or stolen cards to Wells Fargo Bank, cardholder's CCER On-line Approver and the Financial Accounting Manager, or designee. The cardholder may be liable for charges incurred until the card is reported lost, stolen, or misplaced.
 - D. The use of the card by any person other than the cardholder may result in revocation of the individual Cardholder privileges and may result in disciplinary action of the person using the card
 - E. Ensure the transaction's description, account and cost center coding are appropriate and within the guidelines of approver's signing authority. Adjust account and cost center codes as appropriate within the CCER On-line program
 - F. Provide required documentation for each purchase in accordance with the "Required Documentation Section" of this policy
- IV. Issuance of the Purchasing Card
- A. The District in coordination with Wells Fargo Bank issues the purchasing card.
 - B. The Purchasing Card Application/Modification Form and the Purchasing Card agreement **MUST** be completed, approved and returned to the Financial Accounting Manager prior to the card being ordered.
 - C. Upon the completion and approval of the Application, the cardholder's supervisor must request that the employee be setup in the CCER program by requesting the system authorization "Commercial Card Program" through HR OnLine.
 - D. Cardholders must complete training before a card is issued.
 - E. Cardholder must pick up the card in Finance and sign the back of the card in the presence of a Finance staff member.
- V. Allowable Purchases
- A. The District purchasing card may be used for
 - 1. certain local purchases on a limited basis,
 - 2. when obtaining goods, supplies or services through the normal purchasing procedure outlined in AP156 (Standard Procurement Practices) is not appropriate or practical for the given situation, or travel.

- B. All purchases made with the purchasing card must be for expenses associated with official District business.
 - C. Travel expenses must be in compliance with AP19 (Travel, Per Diem and Other Employee Reimbursements).
 - D. Credit card purchases by Accounts Payable staff in lieu of check or ACH payment
 - E. Credit card purchases by Materials Management staff in lieu of vendor credit terms
 - F. Dues and memberships expenses must be in compliance with AP105 (Professional and Service Club District Reimbursed Memberships)
 - G. Goods and services purchased for the benefit of employees and staff appreciation accounted for under any HR program (such as Job Well Done) must have VP and HR approval before the purchase is made to confirm that the department has budgeted funds available.
- VI. Prohibited Purchases, include but not limited to
- A. Cash advances
 - B. Capital expenditures, unless prior approval is obtained by the CEO and obtaining the capital item through the normal purchasing procedure via Materials Management is not appropriate or practical.
 - C. Goods, supplies or services normally purchased through materials management in accordance with the District's Standard Procurement Practices (District Administrative Policy AP156)
 - D. Leases/rental agreements
 - E. Maintenance/Service Agreements
 - F. Software Licensing Agreements
 - G. Personal items as noted in AP19 (Travel, Per Diem and Other Employee Reimbursements) or HR188 (Personal Property and Valuables)
 - H. Office supplies (must be procured through the Office Depot website or through Materials Management)
 - I. Services of sole proprietorships, individuals, non incorporated businesses, or physician payments (these are 1099 reportable and generally covered by a District contractual agreement)
 - J. Any purchase categories blocked through the purchasing card Merchant Category Codes (MCC)
 - K. Payment of any type of penalty, unless approved by the CEO or Compliance Department
 - L. Multiple purchases to circumvent a cardholder's single purchase limit.
- VII. Automatic cancelation of a cardholder's credit card, include but not limited to
- A. More than two instances of using the credit card for personal purchases
 - B. More than two instances of a lost card
 - C. More than two instances of securing purchases not allowable under this policy
 - D. More than two instances of being on the decline report without correction

- VIII. Cardholders with Out of Pocket Expenses will be processed in accordance with AP19 and AP84. Automatic cancelation of Approver privileges, include but not limited to:
- A. More than two instances of approving a cardholder's purchases having personal purchases
 - B. More than three instances of failure to submit monthly required documentation to Finance timely
 - C. More than three monthly instances of approving purchases without the required descriptions or proper account coding
- IX. Required Documentation
- A. Original receipts **MUST** be submitted to the approver:
 - 1. For vendor purchases, a receipt including the vendor name, transaction amount, date, and detail of the item(s) purchased.
 - 2. For Internet purchases, a screen print or order confirmation email
 - B. In the rare and unique occurrence that a receipt can not be located, an Executive Team member must sign the Purchasing Card Reconciliation form approving the missing receipt. The executive team member can require the cardholder to reimburse the District for transactions not supported by a receipt or deny the reimbursement request for the OOP user.
 - C. If the business purpose of the transaction is not evident upon review of the receipt, further documentation of the business purpose is required.
 - D. Documentation relating to purchases and expense reimbursements governed by a specific District policy, such as AP19 (Travel and Other Employee Reimbursements), AP84 (Mileage Reimbursements), AP105 (Professional and Service Club District Reimbursed Memberships) and AP156 (Standard Procurement Practices) must be in compliance with the governing District policy.
 - E. All receipts and/or invoices less than 8 ½ by 5 ½ inches must be taped to a plain white sheet of paper. Multiple receipts may be included on the same sheet of paper, but they may not overlap.
 - F. All backup documentation (in accordance with the required documentation section of this policy) **MUST** accompany a Purchasing Card Reconciliation form. Forms must be signed and dated, and forwarded to the employee's CCER On-line approver who will be reviewing and approving the transactions. These documents **MUST** be submitted to Finance by the 8th of the month. If the 8th falls on a weekend, it is to be submitted by the following Monday. The required documentation may be submitted to Finance via electronic PDF format as long as the department maintains the original for the required retention period.

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

medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

Purchasing Card Application/Modification Agreement Kaweah Delta Healthcare District

Cardholder Information – To be completed by Cardholder

Last Name _____ First Name _____

Job Title _____ Employee ID _____

Dept Name _____ Dept # _____

Card Business Purpose _____ Cardholder's email _____

Business Phone _____

Cardholder Controls – To be completed by Authorizing Executive Team Member

CCER On-line Approver's Name _____

CCER On-line Approver's Title _____

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

CCER On-line Reconciler's Title _____

Purchasing Card Controls

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

Purchasing Card Agreement

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

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

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

Cardholder's Signature _____ Date _____

CCER On-line Approver

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

CCER On-line Approver's Signature _____ Date _____

Executive Team Member

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

Authorizing Executive Team Signature _____ Date _____



**Kaweah Delta
Health Care District**
PURCHASING CARD RECONCILIATION

Year _____

Month _____

Purchasing Card # (last 4 digits) _____

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

Cardholder Name _____

Cardholder Signature _____ Date _____

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

CCER On-line Approver's Name _____

CCER On-line Approver's Signature _____ Date _____

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



Policy Number: AP72	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Litigation, Handling Medical Records	

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

POLICY:

- I. Risk Management (RM) will maintain an ongoing database of records in active litigation
- II. Receipt of Subpoena for Medical Records will trigger Health Information Management (HIM) clerk recording original medical records to retain a master copy of records for ongoing litigation needs
- III. The Director/Manager of RM or the RM Coordinator shall be notified of all requests for information from litigated medical records.

PROCEDURE:

- I. Risk Management receives lawsuit
- II. Risk Management Coordinator, Administrative Assistant, Manager, or Director will notify HIM Manager, Lead, and designated Tech by email including patient name and medical record number within one business day.
- III. HIM will complete archiving of the records for response to subpoena within three business days
- IV. Risk Management Coordinator, Manager, and Director will be notified of any records requests for the held record



**Kaweah Delta
Health Care District**
The Best of Health

PATIENT NAME: _____
MEDICAL RECORD NUMBER: _____

GLOBAL CIRCULATING FILE

**PLEASE NOTIFY THE RISK MANAGEMENT COORDINATOR IN RISK
MANAGEMENT AT KAWEAH DELTA HEALTH CARE DISTRICT AT 624-5284
PRIOR TO RELEASE OF ANY MEDICAL RECORDS ON THIS PATIENT.**

THIS IS A LOCKED FILE.

**THE ORIGINAL MEDICAL RECORD IS LOCATED IN THE KDHCD HEALTH
INFORMATION DEPARTMENT.**

**PLEASE NOTE: IF ADDITIONAL RECORDS ARE ADDED AFTER THE DATE
BELOW, PLEASE GIVE THE ORIGINAL TO THE RISK MANAGEMENT
DEPARTMENT.**

SIGNATURE

DATE

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



Policy Number: AP123	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Financial Assistance Program Full Charity and Partial Discount Programs	

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

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

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

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

Definitions: **A. Charity care** is defined as health care services provided at no charge to patients who do not have or cannot obtain adequate financial

resources or other means to pay for this care and who qualify for free care under the eligibility guidelines specified in this policy. Charity care is in contrast to bad debt, which is defined as a patient and/or guarantor who, having the requisite financial resources to pay for health care services, has demonstrated by his/her actions an unwillingness to comply with the obligation to resolve an account.

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

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

D. Essential living expenses¹ means, for purposes of this policy, expenses for all of the following, as applicable to the patient's individual circumstances: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

E. Financially Qualified Patients are eligible for assistance under this policy for care covered by the policy without regard to whether the patient has applied for assistance under the policy² and includes any of the following:

i) Self-Pay Patients³ are:

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

ii) Under-insured Patients include:

- Patients with high medical cost who have insurance or health coverage but have a remaining patient responsibility balance that they are unable to pay. Remaining patient responsibility balances include out-of-pocket costs, deductibles, and coinsurance that constitute high medical costs as defined below.
- Patients who are eligible for Medi-Cal, Medicare, California Children's Services and any other applicable state or local low-income programs who do not receive coverage or payment for all services or for the entire stay.

¹ Cal. Health & Safety Code § 127400(i)

² 26 C.F.R. §§ 1-501(r)-1(b)(15)

³ Cal. Health & Safety Code § 127400(f)

- Patients with third-party insurance whose benefits under insurance have been exhausted prior to admission or whose insurance has denied stays, denied days of care, or refused payment for medically necessary services.

iii) High Medical Cost Patients⁴ are patients:

- Whose family income is at or below 350% of the Federal Poverty Guidelines;
- Who do not otherwise qualify for full charity care under this policy;
- Who have high medical costs as defined below.

F. High medical costs⁵ are defined as out-of-pocket medical costs incurred by the patient that exceed 10 percent of the Patient's Family Income in the prior 12 months, or annual out-of-pocket medical expenses incurred in the prior twelve (12) months that exceed 10% of Patient's Family income.

G. Patient's Family⁶ is defined as follows:

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

Policy and Procedures:

KDHCD recognizes that the need for charity is a sensitive and deeply personal issue for recipients. Confidentiality of information and individual dignity will be maintained for all who seek charitable services. Training of staff and the selection of personnel who will implement these policies and procedures are guided by these values. Providing charity care (financial assistance) to low-income families along with other community benefit services are important evidence of KDHCD's mission fulfillment. It is imperative that the determination, reporting, and tracking of charity care are in concert with our not-for-profit mission and community obligation and in compliance with Assembly Bill No. 774, Hospital Fair Pricing Policies and Senate Bill 1276 (Chapter 758, statutes or 2014) and applicable IRS laws and regulations.

⁴ Cal. Health & Safety Code § 127400(g)

⁵ Cal. Health & Safety Code § 127400(g)(1) & (2)

⁶ Cal. Health & Safety Code § 127400(h)

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

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

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

A. Identification of Applicant

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

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

B. How to Apply

Patients may request an application for assistance in person from the Acequia Lobby at the corner of Floral and Acequia, 305 West Acequia Avenue in Visalia, California 93291, over the phone by calling Patient

⁷ 42 U.S.C. § 18116; 45 C.F.R. §§ 92.1 *et seq.*

⁸ Cal. Health & Safety Code §§ 127405(a)(1)(A), (b).

⁹ 26 C.F.R. § 1-501(r)-4(b)(1)(i).

¹⁰ 26 C.F.R. §§ 1-501(r)-1(b)(25); 1-501(r)-6(c)(2).

Financial Services at (559) 470-0016 or (559) 624-4200 option 5, or may obtain an application from KDHCDC's website at [kaweahdelta.org/documents/PDFs/FinancialAssistanceApp-\[english\].pdf](http://kaweahdelta.org/documents/PDFs/FinancialAssistanceApp-[english].pdf). Documentation required to determine eligibility is included on the application. KDHCDC does not require any documentation not listed on the application form.

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

C. Full Charity Care

A full write-off of all balances due from a patient, whether the patient is insured, underinsured or self-pay, shall be granted to those financially qualified patients whose family income is up to 200% of the most recent Federal Poverty Guidelines.¹²

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

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

D. Partial Charity Care:

Partial Charity Care will be granted to Financially Qualified Patients earning between 201% and 600% of the Federal Poverty Level based on the most recent Federal Poverty Guidelines.¹³ For these patients, expected payment for services will be limited to the amount KDHCDC would have received from Medicare and then adjusted by the percentages defined on the attached sliding scales.¹⁴

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

¹² Cal. Health & Safety Code § 127405(c).

¹³ Cal. Health & Safety Code § 127405(a)(1)(A).

¹⁴ Cal. Health & Safety Code § 127405(d).

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

E. Governmental Assistance

KDHCDC makes all reasonable efforts to determine whether medical care would be either fully or partially paid for under other private or public health insurance. Consideration will be given to coverage offered through private health insurance, Medi-Cal, Medicare, California Children's Services, the California Health Benefit Exchange (Covered California), or other state- or county-funded programs designed to provide health coverage.¹⁵

KDHCDC provides an application for the Medi-Cal program or other state- or county-funded health coverage programs to patients identified as being potentially eligible for Medi-Cal or any other third party coverage. This application is provided prior to discharge if the patient has been admitted or to patients receiving emergency or outpatient care.¹⁶

If a patient applies or has a pending application or related appeal for another health coverage program, or for coverage under their health plan at the time an application for charity or discounted care is submitted, neither application shall preclude eligibility for the other program. KDHCDC will hold any charity care eligibility determinations until the final disposition of the application or appeal of the health coverage program, if the patient makes a reasonable effort to communicate with KDHCDC about the progress of any pending appeals.

Eligibility Criteria:

A. General Guidelines:

1. KDHCDC determines eligibility for financially qualified patients in accordance with this policy and applicable state and federal laws.
2. KDHCDC will not defer, deny, or require payment before providing medically necessary care because of an individual's nonpayment of one or more bills for previously provided care covered under KDHCDC's Financial Assistance Policy.¹⁹

¹⁵ Cal. Health & Safety Code § 127420(a).

¹⁶ Cal. Health & Safety Code § 127420(b)(4).

¹⁹ 26 C.F.R. § 1.501(r)-6(b)(1)(iii).

3. Financially Qualified Patients, as defined above, or any patient who indicates the financial inability to pay a bill for a medically necessary service is screened for charity care.
4. Information obtained during the application process for financial assistance may not be used in the collection process, either by KDHCD, or by any collection agency engaged by KDHCD, except that such information, if independently obtained, may be used by KDHCD or any collection agency engaged by KDHCD independently of the eligibility process for charity care.²⁰
5. A patient's status or claims with respect to worker's compensation, automobile insurance, or other insurance, including potential payments from pending litigation or third party liens related to the incident of care, may be taken into consideration when evaluating the patient's eligibility for charity care or discount payments.
6. Emergency physicians providing emergency services in KDHCD are required to provide discounts to financially qualified patients whose family incomes are at or below 350 percent of the Federal Poverty Guidelines. ²¹ At the patient's request, KDHCD will advise patients to apply for charity care to the physician's billing company upon the patient's receipt of a bill for services from that billing company. This statement shall not be construed to impose any additional responsibilities upon KDHCD.

B. Eligibility Guidelines

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

1. Patient Income

The Federal Poverty Guidelines as established by Health and Human Services will be used to determine annual income guidelines and limits.²²

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

Earnings for the purposes of determining eligibility will be based on the lower of either the patient's projected annual family income or the patient's family current income level at the time of application for financial assistance.²³

²⁰ Cal. Health & Safety Code § 127405(e)(3).

²¹ Cal. Health & Safety Code § 127452(a)

²² Cal. Health & Safety Code § 127405(b).

²³ *C.f.* Cal. Welf. & Inst. Code § 14005.65.

The applicant may be asked to provide acceptable income verification, such as recent payroll stubs, tax returns, or other items or verification.²⁴ If the patient is unemployed or does not receive payroll stubs, a written statement of need must be provided by the patient or the patient's representative attesting to their income and employment status as part of their financial assistance application.

2. Patient Assets

Only certain assets and resources may be considered when determining eligibility for charity care. Retirement or deferred compensation plans qualified under the Internal Revenue Code, or nonqualified deferred compensation plans will not be considered as available resources to pay KDHCD bills.²⁵ Furthermore, the first ten thousand dollars (\$10,000) of a patient's monetary assets shall not be counted in determining eligibility, nor shall 50 percent of a patient's monetary assets over the first ten thousand dollars (\$10,000) be counted in determining eligibility.²⁶

3. Other Sources of Payment for Services Rendered

The appropriate amount of charity care is determined in relation to the amounts due after applying all other sources of payment. KDHCD provides applications for other sources of payment, such as Medi-Cal, if requested by the patient, or if the patient does not indicate coverage by a third-party payor or requests a discounted price or charity care.²⁷

C. Homeless Patients

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

D. Special Circumstances

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

²⁴ Cal. Health & Safety Code § 127405(e)(1).

²⁵ Cal. Health & Safety Code §§ 127405(c), (e)(2)

²⁶ Cal. Health & Safety Code § 127405(c).²⁶ Cal. Health & Safety Code § 127405(a)(1)(A).

²⁶ Cal. Health & Safety Code § 127405(d).

²⁶ Cal. Health & Safety Code § 127420(a).

²⁶ Cal. Health & Safety Code § 127420(b)(4).

²⁷ Cal. Health & Safety Code § 127420(b)(4).

1. Deceased patients without an estate or third party coverage.
2. Patients who are in bankruptcy or recently completed bankruptcy.
3. On rare occasions, a patient's individual circumstances may be such that while they do not meet the regular charity care criteria in this policy, they do not have the ability to pay their KDHCDC bill. In these situations, with the approval of management (see subsection VII, below), part or all of their cost of care may be written off as charity care.

Timelines

A. Eligibility Period

Eligibility for charity care may be determined at any time KDHCDC is in receipt of information regarding a patient's family income and financial situation.²⁸ While it is preferred that such patients be screened upon admission, they may be screened at any time, including throughout any third-party collections process.

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

B. Time Requirements for Charity Care Eligibility Determination

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

The timeframe to make a decision on an application will be extended if the patient has a pending appeal for coverage of the services, until a final determination of that appeal is made.²⁹ The patient shall make a reasonable effort to communicate with KDHCDC about the progress of any pending appeals.

²⁸ Cal. Health & Safety Code § 127405(e)(4).

²⁹ Cal. Health & Safety Code § 127426(a).

For purposes of this section, “pending appeal” includes any of the following:³⁰

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

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

In some cases, a patient eligible for charity care may not have been identified prior to initiating external collection action. Accordingly, KDHCD requires its collection agencies to comply fully with all pertinent state and federal laws and regulations, with this policy on charity care, and with KDHCD’s Credit and Collection Policy.³¹ This will allow the agency to report amounts that they have determined to be uncollectible due to the inability to pay in accordance with KDHCD’s charity care eligibility guidelines.

Partial Charity Care Discount Payment Plans

KDHCD will make available reasonable, no-interest payment plans for patients qualifying for Partial Charity Care under this policy.³² The plan will be individually negotiated between the patient and KDHCD based on the rates outlined in Section III.D. (“Partial Charity Care”), above.³³ A reasonable payment plan means monthly payments cannot exceed more than ten percent of a patient’s family income for a month after deductions for essential living expenses, as defined in Section II above.

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

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

³⁰ Cal. Health & Safety Code § 127426(b).

³¹ Cal. Health & Safety Code § 127425(b).

³² Cal. Health & Safety Code § 127425(g).

³³ Cal. Health & Safety Code § 127405(b).

If a patient defaults making regular payments, KDHCD makes reasonable efforts to contact the patient by phone and in writing, giving notice that the extended payment plan may become inoperative.³⁴ An attempt at renegotiating the payment plan will be done at the request of the patient or their guarantor. KDHCD initiates collection efforts only after reasonable efforts to contact the patient have failed and after 90 days of non-payment. KDHCD does not report adverse information to a credit-reporting bureau until the extended payment plan has been declared inoperative.

Patient Finance Processes

A. Who can grant Charity Care Eligibility

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

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

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

B. Review of Decision

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

In the event of a dispute prior to an eligibility determination, a patient may seek review from the Patient Accounting Supervisor, Revenue Cycle Manager or Director of Revenue Cycle.³⁵

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

³⁴ Cal. Health & Safety Code § 127425(g).

³⁵ Cal. Health & Safety Code § 127405(a)(1)(A).

The review process shall consist of these level of management:

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

C. External Collections

Accounts will not be sent to a collection agency if the patient is in the process of applying for charity care or discounted payment. If the patient does not comply with requests for information or refuses to provide KDHCD with information, the account can be sent for collections no sooner than 150 days after initial billing. Prior to sending the account to collections, a notice must be provided to the patient as specified in the KDHCD Credit and Collection Policy.

KDHCD will only send patient accounts to a collection agency when the collection agency agrees to adhere to all state and federal laws pertaining to fair collection of debt, as well as to those pertaining to charity and discount care.³⁶ That includes the KDHCD Financial Assistance Policy, the KDHCD Credit and Collection Policy, the California Hospital Fair Pricing Act, the Rosenthal Fair Debt Collection Practices Act, the federal Fair Debt Collection Practices Act, and the tax regulations at 26 C.F.R. §§ 1.501(r)-1, et seq.

An account that has been placed with an outside collection agency can be considered for charity care at any time in accordance with KDHCD's charity care policy. When, during the collection process, a patient asserts they cannot afford to pay the debt, has failed to make previously agreed upon extended payments, or is otherwise identified by the collection agency as meeting KDHCD's charity care eligibility criteria, the collection agency will refer the account to KDHCD to screen for charity care eligibility. KDHCD will undertake reasonable efforts to gather eligibility information from the patient. If, after such reasonable efforts, the patient fails or refuses to provide required information, the account will be referred back to the collection agency.

If a patient is approved for Financial Assistance under this policy, KDHCD and any collection agencies acting on its behalf shall assess the patient's financial status over the previous 8 months to determine eligibility for charity care. KDHCD will reimburse financially qualified patients for the amount actually paid, if any, in excess of the amount due for debt related to care received from KDHCD. Any payments made during the previous 8 months when the patient would have been financially eligible for full charity care shall be considered payments "in excess of the amount due," and shall be reimbursed. If the patient is eligible for partial charity care, any outstanding balance the patient owes

³⁶ 26 C.F.R. § 1-501(r)-6(c)(10).

will be reduced according to the sliding scale terms of partial charity care. Any payments the patient made while eligible for partial charity care will be reassessed using the same sliding scale amount; any amount the patient paid in excess of the partial charity care amount due in that month shall be reimbursed. Payments made for debt related to care received from KDHCDC at a time when the patient was not eligible for Financial Assistance shall not be reimbursed.

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

For further information regarding KDHCDC's internal and external collections policies and practices, including information about actions that may be taken to obtain payment before and after referral to external collections, when and under whose authority patient debt is advanced for collection, policies and practices for the collection of debt, timelines for reporting debt to consumer credit reporting agencies, and the rights and responsibilities of patients, KDHCDC and external collection agencies retained by KDHCDC, see the KDHCDC Credit and Collection Policy.

D. Recordkeeping

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

E. Application of Policy

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

Public Notice and Posting

KDHCDC widely publicizes this policy in a manner that is reasonably calculated to reach, notify and inform those patients in our communities who are most likely to require financial assistance.³⁷

³⁷ 26 C.F.R. §§ 1-501(r)-4(b)(5) - (b)(6).

KDHCD accommodates all significant populations that have limited English proficiency (LEP)³⁸ by translating this policy, the application form, and the plain language summary³⁹ of this policy into the primary language(s) spoken by each LEP language group that constitutes the lesser of 1,000 individuals or five percent of the community served by KDHCD, or the population likely to be affected or encountered by KDHCD. KDHCD will make further efforts to publicize this policy in languages other than English as appropriate and consistent with requirements under the law.⁴⁰

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

Availability of Policy and Application

1. KDHCD makes this policy, applications for assistance, and the plain language summary of this policy, as well as other important information about the availability of financial assistance, widely available on the KDHCD website.
2. KDHCD makes paper copies of this policy, the application for assistance under this policy, and the plain language summary of the policy available upon request and without charge, both by mail and in public locations in the hospital facility, including, at a minimum, in the emergency department, admissions areas, and billing department.

Posted Notices⁴¹

1. KDHCD posts notices in a visible manner in locations where there is a high volume of inpatient or outpatient admitting/registration, such as the emergency department, billing office, admitting office, and hospital outpatient service settings.
2. Posted notices are in English and Spanish and in a manner consistent with all applicable federal and state laws and regulations.
3. Posted notices contain the following information:
 - a. A plain language statement indicating that KDHCD has a financial assistance policy for low-income uninsured or underinsured patients who may not be able to pay their bill and that this policy provides for full or partial charity care write-off or a discount payment plan.
 - b. A KDHCD contact phone number that the patient can call to obtain more information about the policy and about how to apply for assistance.
 - c. A statement explaining that for patients who speak a language other than English or Spanish or who have other accessibility needs,

³⁸ 26 C.F.R. § 1-501(r)-4(b)(5)(i)(D)(3)(ii).

³⁹ 26 C.F.R. § 1-501(r)-1(b)(24).

⁴⁰ Cal. Health & Safety Code § 127410(a).

⁴¹ Cal. Health & Safety Code § 127410(b).

KDHCD will provide language assistance services and accessibility accommodations free of charge.

4. KDHCD sets up conspicuous public displays⁴² (or other measures reasonably calculated to attract patients' attention) that notify and inform patients about the policy in public locations in KDHCD facilities, including, at a minimum, the emergency department, admissions areas, billing office, and other outpatient settings.

Written Notices⁴³

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

2. Upon admission or discharge, KDHCD provides to every patient a written, plain language summary of the KDHCD Financial Assistance Policy that contains information about the availability of KDHCD's charity care policy, eligibility criteria, and the contact information for a KDHCD employee or office where the patient may apply or obtain further information about the policy.⁴⁴

3. KDHCD includes a conspicuous written notice on all billing statements that notifies and informs patients about the availability of financial assistance under this policy and includes the telephone number of the office or department which can provide information about the policy and application process, and the direct Web site address (or URL)⁴⁵ where copies of this policy, the application form, and the plain language summary of this policy may be obtained. ⁴⁶

4. With each billing statement sent to uninsured patients, KDHCD provides a clear and conspicuous notice that contains all of the following:⁴⁷

- a. A statement of charges for services rendered by KDHCD.
- b. A request that the patient inform KDHCD if the patient has health insurance coverage, Medicare, Medi-Cal, or other coverage.
- c. A statement that, if the patient does not have health insurance coverage, the patient may be eligible for Medicare, Healthy Families Program, Medi-Cal, coverage offered through the California Health Benefit Exchange, California Children's Services program, other state- or county-funded health coverage, or charity care.
- d. A statement indicating how patients may obtain applications for the programs identified in paragraph (c) above.
- e. A referral to a local consumer assistance center housed at legal services offices.⁴⁸

⁴² 26 C.F.R. § 1-501(r)-4(b)(5)(i)(D)(3).

⁴³ Cal. Health & Safety Code § 127410(a).

⁴⁴ 26 C.F.R. § 1-501(r)-4(b)(5)(i)(D)(1).

⁴⁵ 26 C.F.R. § 1-501(r)-4(b)(5).

⁴⁶ 26 C.F.R. § 1-501(r)-4(b)(5)(i)(D)(2).

⁴⁷ 26 C.F.R. § 1-501(r)-4(b)(5)(i)(D)(2).

⁴⁸ Cal Health & Safety Code § 127420(b)(4).

- f. Information regarding applications for assistance under this policy, including the following:
 - i. A statement that indicates that if the patient lacks, or has inadequate, insurance, and meets certain low- and moderate-income requirements, the patient may qualify for discounted payment or charity care.
 - ii. The name and telephone number of a hospital employee or office from whom or which the patient may obtain information about the hospital's discount payment and charity care policies, and how to apply for that assistance.⁴⁹

⁴⁹ Cal Health & Safety Code § 127420(b)(5).



Policy Number: AP147	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Use of District Vehicle	

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

Purpose: To describe the authorization process for allowing District employees to use the District vehicle for travel.

POLICY: The District provides a vehicle to employees for travel after proper authorization.

Only those individuals properly authorized by their department manager and approved through the Risk Management Department may use the District vehicle.

Authorized employees will be allowed to use the hospital vehicle provided it is available.

District employees using the District vehicle will return the vehicle with a full tank of gas..

PROCEDURE:

- I. District Vehicle must be reserved at a minimum of 48 hour in advance.
- II. The following must be completed 24 hours before any District employee drives the District Vehicle:
 - a) The employee will complete the Kaweah Delta Health Care District Driver Attestation Form and submit to the Risk Management Department. (Attachment 1) (Form may be faxed to 635-4064)
 - b. Risk management staff will give access via HR online for staff member to use vehicle. Risk management will send request to ISS for approved employee to allow access to van scheduling calendar.
 - The District employee will contact the finance department to be issued a pin number to use gas card.

- IV. The hospital vehicle must be picked up on the day it is needed, and returned when the employee returns to town.
- V. No one other than the authorized employee is allowed to drive the vehicle.
- VI. The hospital vehicle may not be kept overnight at an employee's home.
- VII. PBX staff will maintain a check-in/check-out log in the department.

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ATTACHEMENT 1



**Kaweah Delta
Health Care District**

KAWEAH DELTA HEALTH CARE DISTRICT DRIVER ATTESTATION FORM

- 1. I am 21 years old or older.
- 2. My date of birth is _____.
- 3. My California Driver's license is current – expiration date: _____.
- 4. My California Driver's license number is _____.
- 5. My California Driver's license is not suspended.
- 6. I have had 2 years experience as a licensed driver in the United States.

7. I have not had more than TWO major violations in the past three years.
8. I have not had more than TWO chargeable accidents in the past three years.
9. I have never had a driving under the influence, narcotic, drug or felony conviction.
10. I hereby authorize KDHCDC to procure Motor Vehicle Records and additional reports about me from time to time, as it deems appropriate, to evaluate my insurability or for other permissible purposes

Date

Employee's Signature

PRINT Employee's Name

Vehicle/Gas Card Log – PBX

Month Submitted to Finance _____

Date	OPR Initials	Name of Person	Department	Cost Center	Departure time	Return time	Gas card taken Y/N	Gas card returned Y/N	Receipt Received Y/N	Receipt amount



Policy Number: AP149	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Hospital Acquired Conditions and Present on Admission Indicator	

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

Policy: Kaweah Delta Health Care District will appropriately follow CMS’s guidelines in identifying and billing events considered not **Present on Admission** (POA) and/or **Hospital Acquired Conditions** (HAC). As required by CMS, a POA indicator will be placed on all claims involving inpatient admissions.

Reference: <http://www.cms.hhs.gov/HospitalAcqCond/>

Procedure:

I. Hospital Acquired Conditions

- a. If an event is determined to be not present on admission the Medicare Administrative Contractor (MAC) will process the claim as though the selected condition(s) was not present on admission and/or a Hospital Acquired Condition and may adjust the payment DRG.
 - i. POA is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered POA.
- b. Hospital Acquired Conditions are proposed and communicated via IPPS Proposed and Final rules each year.
 - i. Additional Hospital Acquired Conditions will be outlined in future IPPS Proposed Rules

II. Coding

- a. The POA Indicator will be assigned during the coding process by Health Information Management (HIM) to the principal and secondary diagnoses.
- b. If a condition would not be coded and reported based on Uniform Hospital Discharge Data Set definitions and current official coding guidelines, then the POA Indicator would not be reported.
- c. HIM will conduct periodic second level reviews.

III. Billing

- a. The POA indicator, as entered by HIM will be placed on the bill by the billing system when the bill is created.
- b. The Patient Accounting Department will not modify, add, or delete the POA indicator.

- c. The Patient Accounting Department will bill all services in compliance with CMS rules and regulations to the assigned Medicare Administrative Contractor (MAC).

IV. Monitoring of Hospital Acquired Conditions

A report will be generated to track and report cases.

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a

Policy Number: AP150	Date Created: No Date Set
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Approvers: Board of Directors (Administration)	
Identity Theft Detection, Prevention, and Mitigation	

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

POLICY: Kaweah Delta Health Care District (“Kaweah Delta”) will maintain appropriate protocols to detect, prevent, and mitigate possible occurrences of identity theft.

REFERENCE: Fair Credit Reporting Act (FCRA, 15 U.S.C. 1681 et seq.)

PROCEDURE:

Protocols to Prevent Identity Theft

a. Registration

i. Kaweah Delta Registration personnel will verify a patient’s identity by using a government issued identification card or other acceptable forms of photo identification.

1. In emergent situations, basic registration information may be obtained prior to the medical screening examination as long as it does NOT delay the medical screening examination or emergency treatment.

2. If a patient is unable to present an acceptable form of identification, the Registration personnel will document that photo identification was not verified

a. Registration personnel will use other patient identifiers when photo identification is not available, some examples are Social Security Number and Date of Birth

3. Registration personnel will create a new medical record, if they are unable to verify and confirm the patient’s identity.

b. Confidentiality and Security of protected medical information

i. As outlined in the *Confidentiality, Security, and Integrity of Information* policy (AP. 64 [Confidentiality Security and Integrity of Health Information](#)) Kaweah Delta will ensure that individually identifiable health information is kept confidential and is only

- accessed and/or released in accordance with Kaweah Delta policy, State, and/or Federal laws governing release of information.
- ii. If there is a reasonable suspicion that the confidentiality of patient information is compromised, the Kaweah Delta Compliance & Privacy Officer or designee will be notified immediately.
- iii. AP 107 [Patient Privacy Use and Disclosure of Patient Information](#)
- iv. AP 108 [Patient Privacy Administrative and Compliance Requirements](#)

Protocols to Detect and Monitor for Identity Theft

- a. The Patient Accounting Department will monitor for potential instances of identity theft by Social Security Number (SSN) and/or patient address.
 - i. a. If a SSN is reported as being misused by a patient, the Patient Accounting Specialist will review the patient's account to determine if potential identity theft has occurred..
 - 1. If potential identity theft is believed to have occurred, the *Potential Identity Theft* form will be completed.
- b. The Federal Trade Commission (FTC) has suggested 26 "Red Flags" that are possible indicators of identity theft across the multitude of financial institutions affected by the Fair Credit Reporting Act. The FTC has allowed each individual entity to monitor the "Red Flags" that apply to their entity's business practices.
 - i. A summary of the "Red Flags" considered relevant to Kaweah Delta's business practices are have been identified (Attachment A).
 - 1. If there is an occurrence of an issue relevant to one of the FTC's "Red Flags", the *Potential Identity Theft* form will be completed.

Investigation Process

- a. The *Potential Identity Theft* form will be completed in any instance where there is a reasonable suspicion that identity theft has occurred or where a patient has notified Kaweah Delta of identity theft. When reported to Patient Accounting, Customer Service or Registration personnel, they will make a reasonable effort to review the account(s) for validation.
- b. If a patient reports a concern of identity theft, the patient must file a police report with the appropriate Law Enforcement Agency. A copy of the police report must be provided to Kaweah Delta and the police report number documented on the *Potential Identity Theft* form.
- c. The completed *Potential Identity Theft* form is forwarded to the Compliance Department for further investigation.
- d. Once the information has been received in the Compliance Department, the potential identity theft incident will be reviewed and researched in accordance with District Policy CP.05 [Compliance and Privacy Issues Investigation and Resolution](#).

Identity Theft Mitigation

- a. If Identity Theft is confirmed the following will occur:

- i. Incorrect medical record entries will be moved from the victim's medical record.
- ii. Any erroneous payments received, will be refunded accordingly.
- iii. .
- iv. The victim of the identity theft will be notified of the identity theft if they are not already aware by the Compliance department.
- v. Kaweah Delta may offer credit protection monitoring for the affected individual for a period of one year at Kaweah Delta expense.

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

Attachment A

FTC Red Flags

1. Documents provided for identification appear to have been altered or forged.
2. The photograph or physical description on the identification is not consistent with the appearance of the applicant or customer presenting the identification.
3. Other information on the identification is not consistent with readily accessible information that is on file with the financial institution or creditor, such as a signature card or a recent check.
4. Personal identifying information provided is inconsistent when compared against external information sources used by the financial institution or creditor.
5. Personal identifying information provided by the customer is not consistent with other personal identifying information provided by the customer. For example, there is a lack of correlation between the SSN range and date of birth.
6. Personal identifying information provided is associated with known fraudulent activity as indicated by internal or third-party sources used by the financial institution or creditor.
7. Personal identifying information provided is of a type commonly associated with fraudulent activity as indicated by internal or third-party sources used by the financial institution or creditor.
8. The SSN provided is the same as that submitted by other persons opening an account or other customers.
9. The address or telephone number provided is the same as or similar to the account number or telephone number submitted by an unusually large number of other persons opening accounts or other customers.
10. The person opening the covered account or the customer fails to provide all required personal identifying information on an application or in response to notification that the application is incomplete.
11. Personal identifying information provided is not consistent with personal identifying information that is on file with the financial institution or creditor.
12. For financial institutions and creditors that use challenge questions, the person opening the covered account or the customer cannot provide authenticating information beyond that which generally would be available from a wallet or consumer report.
13. Mail sent to the customer is returned repeatedly as undeliverable although transactions continue to be conducted in connection with the customer's covered account.
14. The financial institution or creditor is notified that the customer is not receiving paper account statements.
15. The financial institution or creditor is notified of unauthorized charges or transactions in connection with a customer's covered account.
16. The financial institution or creditor is notified by a customer, a victim or identity theft, a law enforcement authority, or any other person that is has opened a fraudulent account for a person engaged in identity theft.



Attachment B

POTENTIAL IDENTITY THEFT FORM

Today's Date: _____ Police Report # _____

Name of person making complaint: _____

Name of person whose Private Data has been used or disclosed (if different from above): _____

Account # _____ Medical Record # _____

Date of Birth: _____ Last 4 digits of SS#: XXX-XX-_____

I can be reached at: _____ or _____
Phone Number Alternate Phone Number

Address: Street City State Zip

The best time of day to reach me is: _____

Type of Private Data involved: Health Information Personal Identifying Information

I feel that the privacy rights of the above-named person have been violated in the following way:

This is what I want done to resolve this violation:

Signature: _____

Thank you for the opportunity to improve our services. We want to assist you in any way we reasonably can. Please keep a copy of this form and mail or fax to (559) 735-3006 or if you choose to deliver to the Compliance Department located at 520 W. Mineral King, Visalia CA 93291 4th Floor Support Services Building. A representative will contact you to discuss your concerns.

Mail to: 400 W. Mineral King Ave, Visalia, CA 93291 Attention: Compliance Department Fax: 559-735-3006



Policy Number: HR.241	Date Created: 06/20/2019
Document Owner: Dianne Cox (VP Chief HR Officer)	Date Approved: 06/24/2019
Approvers: Board of Directors (Administration), Cindy Moccio (Board Clerk/Exec Assist-CEO)	
Paid Time Off (PTO) Cash Out	

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

Policy:

Kaweah Delta encourages employees to take vacation time; however, Kaweah Delta recognizes that, in a 24-hour setting, employees may not take the amount of Paid Time Off (PTO) they are generally granted yearly, thus accruing maximum amounts in their PTO bank.

Procedure:

Employees who meet eligibility requirements have the option of cashing out a portion of their PTO. However, to meet Internal Revenue Service regulations, calendar year PTO cash-out elections are made during a special Open Enrollment in the December preceding each calendar year.

- I. All hours are cashed-out at the employee’s base rate of pay.
- II. During the Open Enrollment, the employee must complete an irrevocable PTO Cash-Out Election in HROnline.
- III. The maximum cash-out for the calendar year is 40 hours. There are three dates available for cash-outs and any amount of hours may be requested so long as the minimum and maximum rules are met. PTO cash-outs are paid to the employee with their regular paycheck on the dates indicated in HROnline. Kaweah Delta requires that an employee keep available a “minimum utilization” of 40 hours of PTO in his/her accrual bank at the time of the cash-out, and cash-outs will be modified if 40 hours are not available.

“Responsibility for the review and revision of this Policy is assigned to the Vice President of Human Resources. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Delta will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee’s responsibility to review and understand all Kaweah Delta Policies and Procedures.”



**Kaweah Delta
Health Care District**

Policy Number: HR.145	Date Created: 06/01/2007
Document Owner: Dianne Cox (VP Chief HR Officer)	Date Approved: 05/08/2019
Approvers: Board of Directors (Administration)	
Family Medical Leave Act (FMLA) / California Family Rights Act (CFRA) Leave of Absence	

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

POLICY:

To allow time off to eligible employees. To establish a system to continue to receive compensation through accessible benefits, such as Extended Illness Bank (EIB), Paid Time Off (PTO), State Disability Insurance, and Workers' Compensation. To advise employees of their rights and responsibilities.

To comply with applicable laws ensuring equal employment opportunities to qualified individuals with a disability, Kaweah Delta will make reasonable accommodations for known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or an employee, unless undue hardship would result. A leave of absence may be considered as a type of reasonable accommodation. Any applicant or employee who requires an accommodation in order to perform the essential functions of the job should contact their supervisor, department head, or Human Resources and make a request to participate in a timely interactive process to explore reasonable accommodations. The individual with the disability is invited to identify what accommodation he or she needs to perform the job. Kaweah Delta will take steps to identify the barriers that make it difficult for the applicant or employee to perform his or her job, and will identify possible accommodations, if any, that will enable the individual to perform the essential functions of his or her job. If the accommodation is reasonable and will not impose an undue hardship, Kaweah Delta will meet the request.

NOTE: Due to coordination of information between departments and outside agencies, and the requirement that certain records be maintained to demonstrate compliance with State and Federal law, it is important that paperwork and documentation be completed and submitted to Human Resources in a timely manner by department heads and employees.

PROCEDURE:

This policy is based on the California Family Rights Act, as amended in 1993 (CFRA), and the Federal Family and Medical Leave Act of 1993 (FMLA), and is intended to provide eligible employees with all of the benefits mandated by these laws. However, in the event that these laws or the regulations implementing these laws are hereafter amended or modified, this policy may be amended or modified to conform with any change or clarification in the law.

1. Reason for Leave

Family leaves are subject to the eligibility requirements and rules set forth in this policy statement, and as provided by State and Federal regulations.

- a. FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:
 - i. For incapacity due to pregnancy, prenatal medical care or childbirth;
 - ii. Leave taken for the birth, adoption or placement of a child for foster care must be concluded within 12 months immediately following the birth, adoption or placement. The minimum duration for such leave is two (2) weeks. However, leave for less than two (2) weeks can be taken on two occasions only. Kaweah Delta has the right to approve intermittent leave. Under CFRA, bonding leave may be taken at the end of Pregnancy Disability Leave for up to 12 weeks, and concluded within 12 months immediately following the birth.
 - iii. To care for the employee's spouse, son or daughter, or parent, who has a serious health condition, including a son or daughter 18 years of age or older if the adult son or daughter has a disability as defined by the Americans with Disability Act (ADA); or
 - iv. For a serious health condition that makes the employee unable to perform the employee's job.
 - v. Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status deployed to a foreign country may use Leave to prepare for short-notice deployment, attend military events, arrange for childcare, address financial and legal arrangements, attend counseling sessions, and allow for rest, recuperation and post-deployment activities, among other events.
 - vi. A special leave entitlement is available that permits eligible employees to take up to 26 weeks of leave to care for a covered service member who is the spouse, son, daughter, parent, or next of kin. Certain conditions apply.
- b. CFRA: In addition to the protections listed above, CFRA allows an employee to take up to 12 workweeks of unpaid protected leave during any 12-month period to bond with a new child of the employee or to care for themselves or a child, parent, grandparent, grandchild, sibling, spouse, or domestic partner. If Kaweah Delta employs both of the parents of a child, both are covered by this policy if eligibility requirements are met. Kaweah Delta will grant a request by an eligible employee to take up to 12 workweeks of unpaid protected leave during any 12-month period due to a qualifying exigency related to the covered active duty or call to covered active duty of an employee's spouse, domestic partner, child, or parent in the Armed Forces of the United States. Leaves for this reason are, for the most part, covered under the FMLA, so these leaves may run concurrently with leave under the FMLA if the leave qualifies for protection under both laws.

- c. A “serious health condition” is an illness, injury, impairment or physical or mental condition which involves:
 - i. inpatient care (i.e., an overnight stay) in a medical care facility; or
 - ii. continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee’s job, or prevents the qualified family member from participating in school or other daily activities.
 - iii. The continuing treatment may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may qualify.

2. Employee Eligibility

Family leave is available to employees who have worked at least 12 months for Kaweah Delta and have worked more than 1,250 hours during the previous 12 months.

3. Leave Available

An employee may take up to twelve (12) weeks of leave during a 12-month period. A 12- month period begins on the date of an employee’s first use of FMLA/CFRA leave. Successive 12- month periods commence on the date of an employee’s first use of such leave after the preceding 12-month period has ended. FMLA and CFRA counts against the amount of Medical Leave available and vice versa.

- a. If certified to be medically necessary, leave to care for a family member’s serious health condition may be taken intermittently or the employee may request a reduced work schedule. See below for more information.
- b. Leave taken for the birth, adoption or placement of a child for foster care must be concluded within 12 months immediately following the birth, adoption or placement. The minimum duration for such leave is two (2) weeks. However, leave for less than two (2) weeks can be taken on two occasions only. Kaweah Delta has the right to approve intermittent leave. Under CFRA, bonding leave may be taken at the end of Pregnancy Disability Leave for up to 12 weeks, and concluded within 12 months immediately following the birth.
- c. Employees with pregnancy-related disabilities may have the right to take a Pregnancy Disability Leave in addition to a Family Leave.

4. Intermittent or Reduced Leave Schedule:

- a. If certified to be medically necessary, leave to care for a family member’s serious health condition may be taken intermittently or the employee may request a reduced work schedule.
- b. Employees requesting intermittent leave or a reduced work schedule may be requested to transfer to an alternate job position. Such a transfer will be to a job position better able to accommodate recurring periods of absence but which provides equivalent compensation and benefits.

- c. In any case, employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations.
- d. Leaves to care for a newborn child or a child placed for adoption of foster care may not be taken intermittently or on a reduced leave schedule under FMLA/CFRA.
- e. Exempt employees taking an intermittent or reduced leave will be paid for all hours actually worked. For example: An exempt employee is restricted to working three hours a day. The employee will be paid for three hours of productive time and five hours of PTO without impacting their exempt status. If the employee doesn't have PTO, the five hours will be unpaid.
- f. Accrued PTO hours are required to be used for intermittent leaves.

5. Notice, Certification and Reporting Requirements

a. Timing:

- i. If the need for the leave is foreseeable, an employee must provide 30 days written notice prior to the requested start of the leave. When 30 days is not possible, the employee must provide notice as soon as practicable and generally must comply with Kaweah Delta's normal call-in procedures.
- ii. If the need for the leave is foreseeable due to a planned medical treatment or supervision, the employee must make a reasonable effort to schedule the treatment or supervision in order to avoid disruption to the operations of Kaweah Delta.

b. Certification:

- i. An employee requesting leave to care for a family member with a serious health condition must provide a health-care provider's certification that it is medically necessary for the employee to assist in caring for the family member with the serious health condition. The certification must include the following:
 - 1. The date on which the serious health condition commenced;
 - 2. The probable duration of the condition;
 - 3. An estimate of the amount of time that the health care provider believes the employee needs to care for the individual requiring the care; and
 - 4. A statement that the serious health condition warrants the participation of a family member to provide care during a period of the treatment or supervision of the individual requiring care.
- ii. Upon expiration of the time estimated by the health-care provider needed for the leave, Kaweah Delta may require the employee to obtain recertification in accordance with the above requirements as

certifications expire.

- iii. In addition, an employee requesting an Intermittent Leave or reduced work schedule must provide a health-care provider's certification stating the following:
 1. The date on which the treatment is expected to be given and the duration of the treatment.
 2. That the employee's Intermittent Leave or reduced work schedule is necessary for the care of a spouse, child or parent with a serious health condition or that such leave will assist in the individual's recovery; and
 3. The expected duration of the need for an Intermittent Leave or reduced work schedule.
- iv. Department heads may not contact the employee's health care provider to obtain information on a leave. They are to refer any questions to Human Resources or Employee Health Services who may contact the provider.

c. Employee Periodic Reports:

During a leave, an employee must provide periodic reports regarding the employee's status to the department head and Human Resources, including any change in the employee's plans to return to work. Failure to provide updates may cause Kaweah Delta to apply a voluntary resignation from employment.

During an approved Intermittent Leave, the employee must call their department head or designee and Human Resources each day or partial day that is requested as Intermittent Leave time.

6. Compensation During Leave:

Refer to the pamphlet from the Employment Development Department (EDD) entitled "For Your Benefit: California's Program for the Unemployed" for more information. Also refer to the Paid Family Leave policy in the manual.

- a. For a medical leave of absence longer than seven days which is to be coordinated with State Disability Insurance (SDI), or a Workers' Compensation leave of absence, accrued EIB hours are paid after 24 hours off. The initial three 24 hours are paid through accrued PTO, if available, at the employee's discretion. In the circumstance of an immediate hospitalization or surgery, an employee may be paid from accrued EIB from their first full day off. EIB must be used for coordination with SDI or Workers' Compensation Temporary Disability Payments; PTO time may be used only after all Extended Illness Bank (EIB) has been exhausted. Coordinated amounts will not exceed the regular amount of pay normally earned by the employee.
- b. It is the employee's responsibility to notify Payroll of the amount they receive from SDI or Workers' Compensation to ensure the correct amount of EIB coordination.

- c. Applying the EIB utilization guidelines, EIB may be used to attend to the illness of a child, parent, spouse, or registered domestic partner. Up to 50% of the annual EIB accrual can be used if the employee has worked a full 12 months; otherwise the utilization will be limited to 50% of the employee's accrued EIB. A maximum of 50% of accrued hours in a 12-month period may be utilized.

7. Benefit Accrual:

The employee will continue to accrue PTO and EIB as long as he/she is being paid by Kaweah Delta (receiving a paycheck).

8. Merit Review Date:

The merit review date will be adjusted by the number of days of paid and/or unpaid leave of absence over eighty-four (84) days.

9. Benefits During Leave:

- a. An employee taking leave will continue to receive coverage under Kaweah Delta's employee benefit plans for up to a maximum of four (4) months per 12-month period at the level and under the conditions of coverage as if the employee had continued in employment continuously for the duration of such leave. Kaweah Delta will continue to make the same premium contribution as if the employee had continued working.
- b. Insurance premiums (health, vision, dental, life, etc.) are to be paid by the employee and Kaweah Delta, under the same conditions as existed prior to the leave, for a maximum period of four (4) months in a 12-month period.
- c. If on paid status (utilizing PTO/EIB), an employee may continue his/her normal premiums through payroll deduction. If on unpaid status, he/she is required to pay Kaweah Delta his/her portion of the premiums while on a leave of absence for a total of four months. After four months, employees will be offered COBRA Continuation Coverage for applicable benefits.
- d. In the case where Pregnancy Disability Leave (FMLA) combined with CFRA bonding leave applies, if an employee is on paid status (utilizing PTO/EIB), the employee may continue her normal premiums through payroll deduction. If on unpaid status, she is required to pay Kaweah Delta her portion of the premiums monthly while on a leave of absence for a total of up to seven months; COBRA rules then apply.
- e. An employee whose insurance is canceled due to nonpayment of premiums will have to satisfy a new waiting period after returning to work and will be considered a "new employee" for insurance purposes and as such, the employee may have to provide proof of insurability and will be subject to the pre-existing rules which apply at the time of the leave.
- f. An employee may cancel his/her insurance(s) within 30 days of the end of his/her paid leave and will be re-enrolled upon return without a waiting period. Cancellation must be done in writing to the Human Resources Department. The employee must reinstate coverage within 30 days of his/her return from work.

- g. Group medical, dental, vision insurance coverage and the medical spending account will cease on the last day of the month in which an employee reaches four months of leave or employment ends except that continuation is allowed under COBRA regulations if applicable to the plan.
- h. If the employee fails to return to work at the expiration of the leave, he/she must repay any health insurance premiums paid by Kaweah Delta while on leave, unless failure to return to work is due to a continuation of his/her own serious health condition or other reasons beyond his/her control.

10. Reinstatement:

- a. A doctor's release and a clearance with Employee Health Services will be required when an employee is returning from a medical leave of absence. The employee must complete all outstanding job requirements and documentation (licensure, CPR, ACLS, NRP, PALS, and TB testing, as applicable) prior to a return to work. Competency-related documentation must be completed within 2 weeks of the employee's return. Requesting or receiving a leave of absence in no way relieves an employee of his or her obligation while on the job to perform his or her job responsibilities and to observe all District policies, rules and procedures.
- b. Under most circumstances, upon return from Family or Medical Leave, an employee will be reinstated to his or her previous position, or to an equivalent job with equivalent pay, benefits, and other employment terms and conditions. However, an employee returning from a Family or Medical Leave has no greater right to reinstatement than if the employee had been continuously employed rather than on leave. For example, if an employee on Family and Medical Leave would have been laid off had he/she not gone on leave, or if an employee's position is eliminated during the leave, then the employee would not be entitled to reinstatement.
- c. An employee's use of Family and Medical Leave will not result in the loss of any employment benefit that the employee earned or was entitled to before using Family or Medical Leave.
- d. The employee must complete all outstanding job requirements and documentation (licensure, CPR, ACLS, NRP, PALS, and TB testing, as applicable) prior to a return to work. Competency-related documentation must be completed within 2 weeks of the employee's return. Requesting or receiving a leave of absence in no way relieves an employee of his or her obligation while on the job to perform his or her job responsibilities and to observe all District policies, rules and procedures.

"Responsibility for the review and revision of this Policy is assigned to the Vice President of Human Resources. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Delta will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Delta Policies and Procedures."



Policy Number: HR.184	Date Created: Not Set
Document Owner: Dianne Cox (VP Chief HR Officer)	Date Approved: 05/31/2018
Approvers: Board of Directors (Administration)	
Attendance & Punctuality	

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

POLICY:

Attendance and punctuality is important to Kaweah Delta’s mission to deliver high quality service to our patients and the community. It is each employee’s responsibility to maintain a good attendance record. Employees with excessive absenteeism may be subject to Progressive Discipline.

Regular attendance and promptness are considered part of an employee's essential job functions. Employees with disabilities may be granted reasonable accommodation to assist them in meeting essential functions under any provision in this policy. In cases of disability, appropriate documentation from a healthcare provider in compliance with Kaweah Delta Leave Policies. A Leave of Absence may be considered as a reasonable accommodation. Please refer to Leave of Absence and the Reasonable Accommodation Policy for more information.

All absences will be recorded on an attendance record (timecard or timekeeping, utilizing specific comments in the KRONOS system), which will be used to identify acceptable or unacceptable attendance patterns. The focus of this policy is on the frequency of absences and is to ensure reliability of employees to their work schedule and/or work requirements.

All employees are expected to maintain good attendance with minimal absenteeism. Employees are also expected to report to work punctually at the beginning of the scheduled shift and when returning from meals and breaks. An employee who misrepresents any reason for taking time off may be subject to disciplinary action up to and including termination of employment. See HR.216 Progressive Discipline.

PROCEDURE:

Absenteeism is not being at work or at a Kaweah Delta paid class when scheduled unless the absence is protected by law.

The following number of occurrences, including full shift absences, tardies and leaving early, will be considered excessive and will be grounds for counseling and disciplinary action up to and including termination. During the new hire introductory period (see HR.37 Introductory Period), unacceptable attendance may result in the employee being

placed in an advanced step of disciplinary action up to and including termination of employment.

Occurrence:

- An occurrence is defined as a full day or consecutive days of unscheduled, unapproved, unprotected time off. If makeup time is authorized on the same day or within the week of the occurrence, the absence is still counted as an occurrence.
- For the purpose of this policy, a "tardy" results when an employee fails to report to their work area ready for work at the start of their shift or fails to return from lunch or break at the appropriate time.
- Two tardies or leaving early that have not been pre-approved count as one occurrence. One tardy and one time leaving early can also count as one occurrence, as well as two unscheduled events of leaving early will count as one occurrence.
- An employee is required to call in absences at least two hours prior to the start of their scheduled shift.
- Please note that attendance and punctuality is considered an important factor of overall performance and will be considered in performance evaluations and disciplinary actions. As such, if an employee has or is to receive disciplinary actions other than attendance, the levels as noted below will escalate. The entire performance of an employee is considered when establishing levels and Kaweah Delta may apply any level or immediate termination if warranted due to the circumstance.

Number of Occurrences in a Rolling 12-Month Period

<i>Counseling</i>	<i>Occurrences</i>	<i>Introductory Period</i>
<i>Verbal Warning</i>	<i>4</i>	<i>4</i>
<i>Level I Written Warning</i>	<i>5</i>	<i>NA</i>
<i>Level II Written Warning</i>	<i>6</i>	
<i>Level III Written Warning</i>	<i>7</i>	
<i>Termination</i>	<i>8</i>	<i>5</i>

Pattern Absenteeism:

Employees will be considered to have a pattern of unscheduled absences if their absences tend to occur immediately before or after scheduled days off, before or after holidays or weekends, occur at regular intervals or on consistent days, occur immediately following disciplinary action, or occur on days that the employee requested off but were denied such request. Patterned absences will be considered misconduct and will be grounds for Progressive Discipline.

Absences not to be considered under this policy are noted below. Reasonable notice of these absences is requested and in some cases required. Progressive Discipline

may apply where reasonable notice or requested proof of time off documentation is not provided.

- a. Work-related accident/illness.
- b. Pre-scheduled Paid Time Off (PTO).
- c. Pre-scheduled personal time.
- d. Time off to vote or for duty as an election official. This provision will be limited to federal and statewide elections exclusively and shall not be extended to include local, city or county elections. Employees requesting time off to vote will submit the request in writing. The request should state specifically why the employee is not able to vote during non-working hours. Unless otherwise agreed, this time must be taken at the beginning or ending of the employee's shift to minimize the time away from work.
- e. Time off for adult literacy programs.
- f. Time off if a victim of a crime, or if a family member is the victim of a crime, when they take time off following the crime. Protections are for an employee who is a victim of domestic violence, sexual assault, or stalking for taking time off from work for any specified purpose, including seeking medical attention, for injuries caused by the domestic violence, assault, or stalking and appearing in court pursuant to a subpoena. In addition, protections include taking time off from work to obtain or attempt to obtain any relief. Relief includes, but is not limited to, a temporary restraining order, restraining order, obtaining psychological counseling, engaging in safety planning, seeking other injunctive relief, and to help ensure the health, safety or welfare of the victim or their child. Furthermore, protections include if the employee provides certification that they were receiving services for injuries relating to the crime or abuse or if the employee was a victim advocate.
- g. Time off to attend judicial proceedings as a victim of a crime, the family member, registered domestic partner or child of a registered domestic partner who is a victim of a crime. Victim means any person who suffers direct or threatened physical, psychological, or financial harm as a result of the commission or attempted commission of specified crime or their spouse, parent, child, sibling, or guardian.
- h. Employees who enter uniformed military service of the Armed Forces of the United States for active duty or training.
- i. Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation.
- j. Time off of up to fourteen (14) days per calendar year for volunteer firefighter, reserve peace officer, or emergency rescue personnel training or duties.
- k. Time off to attend school or child care activities for their children, grandchildren

or guardians (limited to 40 hours per year not exceeding eight hours in any calendar month). Applies to children in grades 1 through 12 or in a licensed child care facility. Additional protections apply for required appearances after suspension of a child from school. Effective January 1, 2016, employees may take time off from work to find a school or a licensed child care provider and to enroll or re-enroll a child, and time off to address child care provider or school emergencies.

- l. Bereavement time related to Policy.
- m. Jury Duty or Witness Duty.
- n. Leaves pursuant to legislative requirements Family and Medical Leave Act of 1993 (FMLA); California Family Rights Act of 1991 (CFRA); Pregnancy Disability Leave (PDL); Organ and Bone Marrow Donation Leave; and Workers' Compensation (WC).
- o. Kin Care: Kin Care authorizes eligible employees to use up to one-half ($\frac{1}{2}$) of the Extended Illness Bank (EIB) that they accrue annually, in a rolling 12 months, to take time off to care for a sick family member. Employees who accrue EIB are eligible for Kin Care. Employees who are not eligible for EIB are not eligible for Kin Care. No more than one-half of an employee's EIB accrual in a rolling 12-month period can be counted as Kin Care. For example, for full-time employees this would mean no more than 24 hours can be utilized as Kin Care in a rolling 12-month period. An employee must have EIB available to use on the day of the absence for that absence to be covered under Kin Care. An employee who has exhausted his/her EIB and then is absent to care for a sick family member cannot claim that absence under Kin Care. Kin Care can be used to care for a sick family member, to include a spouse or registered domestic partner, child of an employee, parents, parents-in-law, siblings, grandchildren and grandparents. A Leave of Absence form does not need to be submitted unless the employee will be absent and use sick leave for more than three continuous workdays. In addition, an employee taking Kin Care does not need to submit a doctor's note or medical certification. However, in instances when an employee has been issued Disciplinary Action and directed to provide a doctor's note for all sick days, then an employee may need to submit a doctor's note.

Absence for Religious Observation

Kaweah Delta will attempt to accommodate employees requesting absence for religious observation, however, in certain circumstances accommodation may not be possible or reasonable.

Notification of Late Arrival

An employee is required to call in absences at least two hours prior to the start of their scheduled shift.

Schedules

- a. Employees are scheduled to work during specified hours. Unless approved by management, those hours may not be adjusted to accommodate early or late arrival or departure.

- b. Employees who arrive for work early may not leave before the end of their scheduled work period unless authorized to do so by their management. Employees may be subject to discipline for incurring unauthorized overtime by reporting to work prior to their scheduled start time. Employees who arrive for work late may not remain on duty beyond the regular scheduled work time to make up the lost time unless authorized to do so by their management. Employees who are absent without approval but are allowed to makeup time will continue to be subject to disciplinary action for lack of reliability.
- c. Employees are only paid for actual hours worked.
- d. Employees may not shorten the normal workday by not taking or by combining full meal periods and rest break periods and may not leave before the end of their scheduled shift without the authorization of a supervisor.
- e. Any employee who leaves Kaweah Delta premises during work hours must notify and obtain approval from management and/or their designee prior to departure. Employees must clock out and in for their absence.
- f. Employees are to give 48 hours' notice for cancellation of any class or program in which they are enrolled, whether voluntary or mandatory. Employees must be on time.
- g. Failure to give advance notice may count as an occurrence under the Attendance Policy HR.184. Refer to Progressive Discipline policy HR 216.
- h. Employees who are absent from work for three days and have not contacted their department manager or supervisor will be assumed to have voluntarily terminated their employment. Employees who are absent from work without authorization and without providing proper notification to management may be considered to have abandoned their job and will be terminated from employment.
- i. Weekend Makeup Policy – Employees who call in on weekends may be required to make up weekend shifts missed.^{1[1]} Weekend shifts will be scheduled for makeup on a successive schedule at the discretion of the scheduling coordinator/supervisor per staffing needs.
- j. Holiday Makeup Policy – Employees who call in on a ^{2[2]}holiday will be required to work another holiday or an extra weekend shift at the discretion of the scheduling coordinator/supervisor per staffing needs.

Loitering

Kaweah Delta employees may not arrive to work greater than thirty (30) minutes prior to the start of their shift and may not remain within Kaweah Delta facilities greater than thirty (30) minutes beyond the end of their shift without specific purpose and/or authorization to do so.

Clocking

Employees should not clock in, may not begin work before the start of their scheduled shift and must discontinue work and clock out at the conclusion of their scheduled shift, unless instructed otherwise by their management. Employees may not work off-the-

clock, including use of electronic communication.

Further information regarding this policy is available through your department manager or the Human Resources Department

¹⁽¹⁾ Weekend shift starts Fridays at 1800 and ends Mondays at 0600.

²⁽²⁾ Holiday is from 1800 the day before the holiday and ends 0600 the morning after the holiday.

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Policy Number: HR.244	Date Created: Not Set
Document Owner: Dianne Cox (VP Chief HR Officer)	Date Approved: 06/29/20
Approvers: Board of Directors (Administration), Cindy Moccio (Board Clerk/Exec Assist-CEO)	
Paid Family Leave	

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

Policy:

Paid Family Leave (PFL) is a type of unemployment compensation paid to employees who have a wage loss when they take time off from work for up to eight (8) weeks to care for a seriously ill family member, bond with a new child or for a qualifying exigency related to the covered active duty or call to covered active duty of an individual’s specified family member in the Armed Forces of the United States. To be eligible for California PFL benefits for bonding, employees must have welcomed a new child into the family in the past 12 months either through birth, adoption, or foster care placement. Specified family members qualifying for the exigency related to active duty are: the individual’s spouse, domestic partner, child, or parent in the Armed Forces of the United States. This benefit provides compensation through accrued Paid Time Off (PTO), Extended Illness Bank (EIB) and California sponsored Paid Family Leave (PFL).

NOTE: Due to coordination of information between departments and outside agencies, and the requirement that certain records be maintained to demonstrate compliance with State and Federal law, it is important that paperwork and documentation be completed and submitted to Human Resources in a timely manner by department leadership and employees.

Procedure:

This policy is based on the California Paid Family Leave (PFL) and is intended to provide eligible employees with all of the benefits mandated by the State of California Employment Development Department. However, in the event that these laws or the regulations implementing these laws are hereafter amended or modified, this policy may be amended or modified to conform with any change or clarification in the law.

1. Reason for Leave:

May be eligible under FMLA and CFRA please refer to the Family Medical Leave of Absence Policy.

2. Employee Eligibility:

- a) Have paid into State Disability Insurance, (noted as “CASDI” on paystubs) in the past 5 to 18 months.

b) This benefit applies to all employees regardless of length of service. If an employee does not also qualify for a leave under the FMLA or CFRA guidelines, a Personal Leave of Absence may apply upon the manager's discretion. Please review HR.148 Personal Leave Policy.

3. Compensation Available:

Refer to the Notice to Employees from the Employment Development Department (EDD) for more information.

- a. Employees may use 24 hours of EIB/KIN (see b.) and/or PTO starting day one at integration with State Disability Insurance or Paid Family Leave.
- b. Applying the Extended Illness Bank (EIB) utilization guidelines, EIB/Kin may be used to attend to the illness of a child, parent, spouse, grandparent, grandchild, sibling, registered domestic partner or parent-in-law. Up to 50% of the annual EIB accrual can be used if the employee has worked a full 12 months; otherwise the utilization will be limited to 50% of the employee's annual accrued EIB. A maximum of 50% of accrued hours in a 12-month period may be utilized. This is referred to as "Kin Care."
- c. An employee may be paid up to eight (8) weeks of leave during a 12-month period. A 12-month period begins on the date of an employee's first use of PFL leave. Successive 12-month periods commence on the date of an employee's first use of such compensation after the preceding 12-month period has ended. If eligible, PFL runs concurrent with FMLA and CFRA Leaves of Absence.

4. Certification:

Refer to the Family Medical Leave of Absence Policy in the Manual.

5. Periodic Reports:

Refer to the Family Medical Leave of Absence Policy in the Manual.

6. Benefits During Leave:

Refer to the Family Medical Leave of Absence Policy in the Manual.

7. Reinstatement:

Refer to the Family Medical Leave of Absence Policy in the Manual.

"Responsibility for the review and revision of this Policy is assigned to the Vice President of Human Resources. In some cases, such as Employee Benefits Policies, Summary Plan Descriptions and Plan Documents prevail over a policy. In all cases, Kaweah Delta will follow Federal and State Law, as applicable, as well as Regulatory requirements. Policies are subject to change as approved by the Governing Board and will be communicated as approved after each Board Meeting. It is the employee's responsibility to review and understand all Kaweah Delta Policies and Procedures."



Policy Number: DM 2109	Date Created: 09/01/2008
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	
Program Management- Emergency Management Committee	

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

I. Policy

The Emergency Management Committee is a subcommittee of the Kaweah Delta Health Care District (KDHCD) Environment of Care Committee. Under this oversight, it is charged with developing and maintaining the District’s Emergency Operations Plan. This shall be done through planning, implementation and evaluation of all elements of the program. The Emergency Management Committee ensures compliance with Federal, State, and other accreditation boards that control regulations regarding emergency management activities.

II. Procedure

A. Responsibility

1. The Emergency Management Committee is responsible for development and maintenance of the Emergency Management Manual, planning and implementation of training exercises, review of all Hospital Incident Command System (HICS) activations, and communication of applicable Emergency Management information to the Environment of Care Committee.
2. Department Managers are responsible for ensuring that all employees within their department are familiar with the main components of the Emergency Operations Plan.

B. Membership of the Committee

1. The Emergency Management Committee is chaired by the District Safety Officer or designee.
2. The Emergency Management Committee is composed of representatives from:
 - Emergency Department (Physician and RN)
 - Risk Management
 - Security
 - Maintenance
 - Infection Control
 - Nutrition Services
 - Communications
 - Human Resources
 - Information Systems
 - Nursing
 - Marketing
 - Environmental Services
 - Imaging

Additional KDHCD staff is invited to attend committee meetings as needed to share information and receive updates.

3. The District Safety Officer will be a member of the Environment of Care Committee and act as a liaison between the two committees.

C. Duties of the Emergency Management Committee.

1. Meeting Attendance

Members attend regularly scheduled meetings.

2. Drill Requirements – The Joint Commission

Ensures that the District conducts at least two drills per year (unless there are actual events that would meet our Joint Commission and CMS requirements for Emergency Preparedness). One includes an influx of volunteer or simulated patients. One includes a community wide drill relevant to the priority emergencies identified in the District's Hazard Vulnerability Analysis (HVA) and that assesses communication, coordination, and the effectiveness of the hospital's and the community's command structure. The Emergency Management Committee also performs a post-exercise critique, and ensures written reports evaluate performance per The Joint Commission requirements.

3. Drill Requirements – Title 22 Department of Public Health Services (DPHS) Assures that emergency management drills are performed in compliance with Title 22 requirements (at least once per shift per quarter). Contributes to written reports of all plan activations, including drills or actual events. The report outlines deficiencies, recommends plans of correction or improvement, identify person(s) or department(s) responsible for corrections.

4. Quality Improvement

Approves and acts upon changes recommended as a result of post-exercise critiques. Monitors outcome at its regular meetings.

5. Annual Plan Review

Reviews the Emergency Operations Plan annually, revises as needed, and submits a written report to the Environment of Care Committee.

6. Training

Ensures that all personnel are instructed in the Emergency Operations plan to the degree necessary to assume their role in implementing the Plan.

7. Quarterly Reports

Reports to the Environment of Care Committee, quarterly, all deficiencies and performance improvements.

D. Emergency Management Committee Chair

Liaisons with other community Emergency Operations Planning groups and reports back to the Emergency Management Committee.

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Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	
Failure of Fire Alarm System	

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

Procedure

In the event that the Fire Alarm System fails, follow the procedure listed.

PBX will immediately notify maintenance.

Maintenance will initiate troubleshooting to determine cause. If beyond the capabilities of staff call vendor for immediate repair.

Notify all departments affected

California Department of Public Health will be notified if the failure exceeds 4 hours. In the event the Director of Maintenance is not present, the house supervisor may substitute

Security will be responsible to conduct a fire-watch if the failure exceeds 4 hours. All areas will be monitored each hour. Security will maintain documentation of the firewatch.

The Nursing Supervisor shall decide if Code Triage or Code Triage Alert needs to be called, if patients and/or building occupants need to be relocated.

Notify all affected departments upon service restoration.

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

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

I. OBJECTIVES

The objectives of the Management Plan for Security at Kaweah Delta Health Care District (KDHCD) are to provide a safe environment wherein intentional risks for harm or loss can be minimized. The plan will identify risk mitigation strategies for both the grounds and District premises. The plan is an accreditation/ standards-based and regulatory driven program, which is assessed for effectiveness during the annual evaluation process.

II. SCOPE

The scope of this management plan applies to **(KDHCD)** and any off site areas as per KDHCD license.

Each off site area is required to have a unit-specific Safety Plan that addresses the unique considerations of the built environment, including directions for reaching Security or law enforcement. Kaweah Delta Medical Center personnel are to dial 44 for an immediate security response within the premises and grounds. Offsite areas are required to call the local police in the event an urgent security response is required.

All areas, including off site areas are monitored for compliance with this plan during routine environmental surveillance by Environment of Care committee members. It is the responsibility of the Safety Officer to assess and document compliance with the Security Management Plan for all areas, including the offsite areas, using an environmental surveillance checklist.

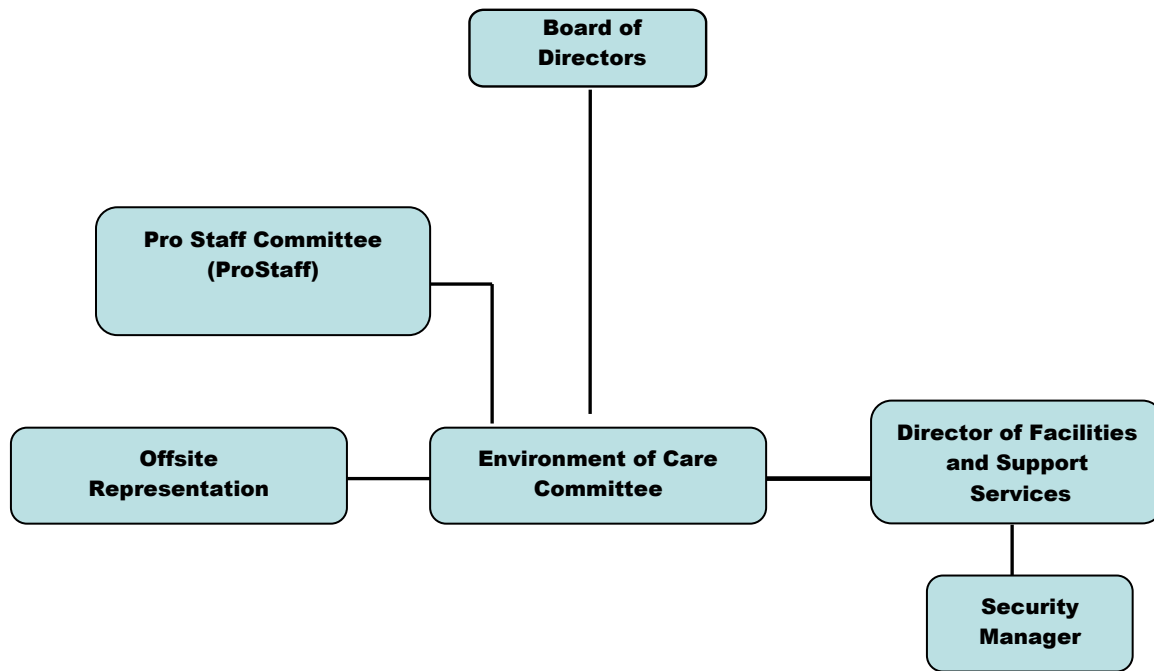
III. AUTHORITY

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

IV. ORGANIZATION

The following represents the organization of security management at (KDHCD).

Organization - Security Management



V. RESPONSIBILITIES

EC.01.01.01 EP 1

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

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

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

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

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

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

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

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

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

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

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

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

Director of Facilities and Security: This individual has the ultimate authority over security personnel, and the Security Management Program.

MANAGEMENT OF SECURITY RISKS

EC.02-01-01 EP-1

The hospital identifies security risks associated with the environment of care. Risks are identified from internal sources such as ongoing monitoring of the environment, results of root-cause analyses, results of annual proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts.

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

- 1 **Policy/Plan/Program Development.** Inherent in risk assessment are the development of security policies, management plan for security, and program development for security through the structure of the *Environment of Care* Committee. Regulations, accreditation or industry standards (e.g., AB 508, Title 22) provide the structure for policy/plan and program development.

- 2 **Environmental Surveillance, Results of Root-Cause Analyses, Pro-active Risk Assessment of high-risk processes.** Included in risk assessment are findings during environmental surveillance that reflect risk identification, and findings from root-cause analyses that require follow-up and improvement actions. During the annual evaluation process, risk identification may occur from a retrospective analysis of performance monitoring of high-risk security processes, which will require a plan for improvement to minimize unfavorable outcomes from the possibility of consequential risks. Accountability for assessment and improvement activities is with the *Environment of Care* committee.
- 3 **External Sources: Sentinel Event Alerts, Regulatory and Insurer inspections, Audits, and Consultants.** Security risk assessment may occur as a result of findings or recommendations generated from external sources, such as *Sentinel Event Alerts, Regulatory and/or Insurer surveys, or audits conducted by recruited consultants.* Accountability for assessment and improvement activities is with the *Environment of Care* committee.
- 4 **Education:** Education is implemented to provide information, and thereby mitigate risk and includes, but is not limited to:
 - New Hire Orientation
 - Department Specific Education
 - Education for patients, staff, physicians, volunteers, and students
 - Education based upon a needs assessment for any specific population. Education based upon risk assessment or the results of surveys, inspections or audits.
- 5 **Drills – Planned Exercises:** Conducting drills such as infant security or disaster, constitute activities designed to inform, educate and thereby mitigate risk when areas of risk are identified during the debriefing and/or evaluation process.
- 6 **Reporting and Investigation of Incidents.** Complementary to risk assessment is proper reporting and investigation of security incidents. Internal processes and activities that support risk assessment include reporting and investigation mechanisms which may identify the opportunity to mitigate risk relating to property damage, thefts, vandalism, burglary, assault, battery and any violent incidents.

ACTIONS TO MINIMIZE OR ELIMINATE IDENTIFIED SECURITY RISKS

EC.02.01.01 EP-3

The hospital takes action to minimize or eliminate identified safety risks.

When risks are identified from the above processes, the *Environment of Care* Committee uses the risks identified to select and implement procedures and controls to achieve the lowest potential for adverse impact on the safety and security of patients, staff, and other persons throughout the organization. Moreover the identified risks may serve as the basis for the selection of performance standards, with the criteria identified as follows:

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

- The performance standard represents an activity or finding that needs improvement due to the possibility of adverse outcomes.

Risk Reduction Strategies-Proactive

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

The Security Department is responsible for the following:

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

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

1. **Committee Structure.** The *Environment of Care* Committee is the structure through which security-related problems and issues can be identified and resolved. It should be noted that the *Environment of Care* Committee is closely integrated with patient safety functions. The purpose of the *Environment of Care* Committee with respect to the Patient Safety standards is to remain aware of sentinel event alert information from the Joint Commission and to assess organizational practices against current information relating to patient safety. Additionally, when recommendations are made for hospitals, each recommendation is critically reviewed, with a plan of action established. If sentinel events occur within the hospital that reflect security issues, the *Environment of Care* Committee will participate in improving outcomes relating to security risk management.
2. **Reporting and Investigation Mechanisms.** A reporting and investigation process is in place that is part of the responsibilities of security staff. Security incidents are reported on an electronic reporting system, which are completed by staff involved with the incident. Violent, assaultive and/or battery type incidents are reported to the local police with a written report generated within 72 hours. Security incidents are reported on a quarterly basis to the *Environment of Care* Committee, which provides members with the opportunity to observe for trends or patterns, and make the appropriate recommendations.
3. **An Identification System.** An identification system is in place to minimize the entry of unauthorized personnel onto the premises.

4. Access Control. Access Control is in place in sensitive areas, and protected by special systems which allows only authorized personnel to enter the areas.
5. Closed Circuit TV. Closed circuit TV is in place to monitor the security sensitive areas, which allows observation to occur in areas where increased risk exists.
6. Panic Buttons. Panic buttons are located in high-risk areas throughout the hospital. Alarms are installed and monitored internally, provided by a third party monitoring company or combination of both. When an alarm is activated, the PBX operator notifies Security and contacts the police for assistance. A burglar-panic alarm monitoring company will notify the hospital PBX in the event of activation so that hospital Security can respond. Panic Buttons are located in the following departments:
Administration, Admitting, Dietary, Emergency Department, Guild Gift Shop, HIM, Human Resources, ICU, Kaweah Korner Employee Store, Labor and Delivery, Mother-Baby, NICU, Patient Accounting, Pediatrics, Foundation, Pharmacy, Rehabilitation Hospital, Risk Management, and the Surgery Waiting Room.
7. Policies. Security policies and procedures are in place, providing guidelines for the prevention of risk, e.g., "Code Pink" policy, Code Gray, Code Silver, Code Purple.
8. Education – for Newly-hired Staff and Ongoing (HR.01.04.05.01 EP 1; HR.01.04.01 EP 1, 2, 3; EC.03.01.01 EP's 1-2). Education plan is in place to promote employee awareness of risk, and to provide the phone number to call in the event security assistance is needed.
 - a. New hire Education. Education relating to general security processes is given during New hire orientation, and covers introductory information, which includes the phone number to call if security is needed, as well as hospital emergency codes information.
 - b. Specific Job-Related Hazards. Education is provided to new security officers relating to specific job-related competencies, which is reviewed annually.
9. Loss Prevention strategies: Doors leading to departmental work areas are controlled by keys which are restricted to department members, facilities, security personnel and environmental services. The Admitting Office and the Security Department maintains a safe for patient valuables. Hospital property is tagged with a decal which lists the hospital's property number. Property which is being removed from the premises must be accompanied by a signed property removal pass.

Risk Reduction Strategies – When Risks Have Been Identified

When proactive security risks have been assessed, risk reduction strategies will be the responsibility of security staff in coordination with the *Environment of Care* committee, unless the risk poses the potential for serious consequential events (i.e., death, serious injury or building threat). In this instance, the individual who has assessed the risk will notify the Safety Officer and Risk Management leadership who will then assume responsibility for reduction of the risk threat. Risk reduction strategies for the possibility of non-serious or non-imminent consequential events may be addressed through the

Sentinel Event Review or *Intensive Assessment Processes*, or *Environment of Care* Committee, based upon the severity and type of risk identified. Risk reduction strategies for identified risks include, but are not limited to the following:

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

MAINTENANCE OF GROUNDS AND EQUIPMENT

EC. 02.01.01 EP 5

(KDHCD) manages risks associated with the grounds and equipment in order to minimize consequential events or adverse outcomes related to accidents.

Environmental surveys are done routinely by *Environment of Care* Committee personnel. Additionally, routine and varied security patrols are conducted wherein any security hazards are brought to the attention of the *Environment of Care* Committee. Building/grounds surveys with a contractor's representative are conducted when construction activities are occurring. In certain instances, Security staff may be requested to participate in a fire watch. Additionally, Risk Management reviews data from reported incidents that may identify patterns, trends and opportunities for improvements. The data involves all patient and visitor incidents related to accidents or other unusual events, which are not consistent with routine patient care and treatment. Incidents that involve patients or visitors, wherein some aspect of the building/grounds plays a consequential role, the Safety Officer will be notified so the hazard may be investigated and corrected as necessary. All of these activities contribute to an overall monitoring plan for the grounds and safety-related equipment.

EC.02-.01.01 EP 7

The hospital identifies individuals entering its facilities.

Identification methods used at the medical center include the following:

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

EC.02.01.01 EP 8

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

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

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

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

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

EC.01.01.01-9

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

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

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

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

INFORMATION COLLECTION SYSTEM TO MONITOR CONDITIONS IN THE ENVIRONMENT

EC.04.01.01 EP's 1,3,5-6,

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

- Security incidents involving patients, staff or others within its facilities

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

ANNUAL EVALUATION OF THE SECURITY MANAGEMENT PLAN

EC.04.01.01 EP-15

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

- The objectives: The objective of the Security Management Plan will be evaluated to determine continued relevance for the organization (i.e., the following questions will be asked: Was the objective completed? Did activities support the objective of the plan? If not, why not? What is the continuing plan? Will this objective be included in the following year? Will new objectives be identified? Will specific goals be developed to support the identified objective?).
- The scope. The following indicator will be used to evaluate the effectiveness of the scope of the Security Management Plan: the targeted population for the management plan will be evaluated (e.g., did the scope of the plan reach employee populations in the off site areas, and throughout the organization? Was security managed appropriately for the off site areas?)
- Performance Standards. Specific performance standards for the Security Management Plan will be evaluated, with plans for improvement identified. Performance standards will be monitored for achievement. Thresholds will be set for the performance standard identified. If a threshold is not met an analysis will occur to determine the reasons, and actions will be identified to reach the identified threshold in the subsequent quarter.
- Effectiveness. The overall effectiveness of the objectives, scope and performance standards will be evaluated with recommendations made to continue monitoring, add new indicators if applicable or take specific actions for ongoing review.

THE DISTRICT ANALYZES IDENTIFIED *ENVIRONMENT OF CARE* ISSUES

EC.04.01.03 EP-2

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

PRIORITY IMPROVEMENT PROJECT

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

KAWEAH DELTA HEALTH CARE DISTRICT TAKES ACTION ON IDENTIFIED OPPORTUNITIES TO RESOLVE ENVIRONMENTAL SAFETY ISSUES

EC.04.01.05 EP-1

Performance standards are identified, monitored and evaluated that measure effective outcomes in the area of security management. Performance standards are identified for Security, and they are approved and monitored by the *Environment of Care* Committee with appropriate actions and recommendations made. Whenever possible, the *environment of care* is changed in a positive direction by the ongoing monitoring, and changes in actions that promote an improved performance related to security.

Patient Safety

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

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Policy Number: EOC 7402	Date Created: 04/01/2010
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Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	
Utilities Management Emergency Power	

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

POLICY:

Kaweah Delta Health Care District shall provide and maintain a reliable, adequate emergency power system to provide electricity to designated areas during interruption of normal utility power.

Areas supplied by emergency power include, but are not limited to:

- All Alarm Systems
- Blood, Bone and Tissue Storage Units
- Egress Illumination and Exit Signs
- Elevator (at least one in patient care areas)
- Communication Systems (PBX and Paging System)
- Medical Air and Medical and Surgical Vacuum Systems
- Operating Rooms and Recovery Room
- Special Care Units - ICU, CCU, SNF, Emergency Department
- Steam Delivery System (at least one boiler)
- Delivery Rooms
- Newborn Nurseries
- Generator Locations

When operating on Emergency Power, the following status will occur:

1. White Electrical Plugs - OFF Red Electrical Plugs - ON
2. Main Phone Switch ON
3. Elevators *

Mineral King Wing

- | | |
|-------------------------------|------------------------------|
| 1. Otis Main Visitor OFF | 6. Fresno Employee ON |
| 2. Otis Main Visitor OFF | 7. Fresno Employee OFF |
| 3. Otis Surgery ON | 8. US East Expansion ON |
| 9. US East Expansion ON | |
| 5. Schindler ON | |

Acequia Wing

- | | |
|----------------------------------|---------------------------------|
| 1. Thyssenkrupp Employee ON | 5. Thyssenkrupp Employee ON |
| 2. Thyssenkrupp Employee OFF | 6. Thyssenkrupp Employee OFF |
| 3. Thyssenkrupp Visitor ON | 7. Thyssenkrupp Surgery ON |
| 4. Thyssenkrupp Visitor OFF | 8. Thyssenkrupp Surgery ON |

4. Medical Air, Oxygen, Nitrous, Nitrogen Gases*	ON
5. Medical Vacuum*	ON
6. Water Pumps*	ON
7. Air Conditioning	OFF
8. Computers availability of Red Plugs.	ON – terminals on pending
9. Kronos	OFF
10. Dietary*	Cold Food Only
11. Tube System*	OFF

* If applicable to the campus

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Policy Number: EOC 5041	Date Created: 04/01/2010
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	
Department Decorations	

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

POLICY:

To promote the highest standard of Fire Prevention as well as to comply with all State and Local Fire Regulations, please observe the following departmental decorating guidelines:

1. Holiday decorations, including quilts, blankets and tapestries may never be placed in any KDHCD EXIT corridor. Decorations may only be used in KDHCD facilities provided they have been treated with a California State Fire Marshal rated flame resistant product. **Proof of fire resistance must remain with the decorations or in the department.**
2. Do not hang anything from the ceiling sprinkler heads. Any decorations hung from the ceiling must hang at least 18” below ceiling height to prevent interference with the sprinkler system. Please ensure that hanging decorations do not impede walk-through traffic
3. Christmas lights and/or candles, of any variety or type, are prohibited in patient care areas.
4. UL Listed/Approved lights may be utilized in non-patient care areas.
5. Decorations must not block corridors or exits, or interfere with patient care.
6. Please use masking tape when necessary. Do not use scotch tape or thumb tacks on the walls.
7. Candles are prohibited. The Flameless Candles will generally be allowed in ALL Patient Treatment areas with the exception of Electrically Sensitive Patient Areas, such as ICU, CVICU, CVOR, CVC, and specific areas of 3 West where patient monitoring is on-going. These items **MUST** have the UL Listed or CSA Stamp of approval affixed to them
8. Live Christmas Trees may only be used in KDHCD facilities provided that they have been treated with an approved California State Fire Marshal rated flame resistant product. Live trees may never be placed in/or immediately adjacent to an EXIT corridor. Live Christmas trees may not be used in patient care

areas. Live Christmas tree usage and placement within the District must have prior approval from the District Safety Officer.

A non-lighted, artificial tree may be used within KDHCD facilities provided that it has been treated by a California State Fire Marshal rated flame resistant product.

Proof of fire resistance must remain with the decorations or in the department.

NOTE: Anything that impedes the complete closure of the fire doors must be removed.

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

Kaweah Delta Physician Recruitment and Relations Medical Staff Recruitment Report - December 2020

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

Date prepared: 12/17/2020

Central Valley Critical Care Medicine	
Intensivist	2

Oak Creek Anesthesia Services, Inc.	
Anesthesiology - General	1

Delta Doctors Inc.	
OB/Gyn	1

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

Key Medical Associates	
Internal Medicine/Family Medicine	2

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

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

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

Candidate Activity

Specialty/Position	Group	Last Name	First Name	Availability	Referral Source	Current Status
Anesthesia - General	Oak Creek Anesthesia Services, Inc.	Barkley, M.D.	Kevin	08/21	Comp Health - 12/8/20	Currently under review
Anesthesia - Chronic Pain	Oak Creek Anesthesia Services, Inc./ Dr. Brandon Sorensen	Truong, M.D.	Khoa	08/21	Spouse of Dr. Jessica Hong, GI	Site Visit Pending dates
Colorectal Surgery	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Ota, M.D.	Kyle	08/21	Current KD General Surgery resident	Offer accepted; Contract pending
Family Medicine	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Patty, M.D.	Christina	08/20	Direct - Local Candidate	Site Visit: 2/5/19; Offer accepted; Start Date: 1/11/21
Family Medicine - Associate Program Director	Kaweah Delta Faculty Medical Group	Ramirez, M.D.	Magda	ASAP	Current Core Faculty with Kaweah Delta Faculty Medical Group	Interview pending dates
Family Medicine Core Faculty	Kaweah Delta Faculty Medical Group	Al-Tai, M.D.	Zeena	08/21	Pacific Companies - 7/13/20	Currently under review
Family Medicine Core Faculty	Kaweah Delta Faculty Medical Group	Bassali, M.D.	Mariam	08/21	Referred by Dr. Martinez - 10/14/20	Site visit pending dates
Family Medicine Core Faculty	Kaweah Delta Faculty Medical Group	Gutierrez, M.D.	Mario	TBD	Referred by Dr. Martinez - 8/14/20	Site visit pending dates
Family Medicine Core Faculty	Kaweah Delta Faculty Medical Group	Mohamed, M.D.	Hashem	ASAP	Direct Referral - Dr. Ahmed Amari	Site visit pending dates
Family Medicine Core Faculty	Kaweah Delta Faculty Medical Group	Sandoval, M.D.	Omar	08/21	Referred by Dr. Martinez - 8/14/20	Site Visit: 11/24/20
Gastroenterology	Valley Hospitalist Medical Group	Aita, M.D.	John	ASAP	Carson Kolb - 8/4/20	Interested in part-time; Site visit pending dates
Gastroenterology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Singh, M.D.	Marvin	ASAP	Physician Empire - 12/2/20	Currently under review
Gastroenterology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Hong, M.D.	Jessica	09/21	Direct Referral (Spouse of Dr. Khoa Truong, Pain Anesthesia)	Site Visit: 10/21/20; Offer extended
Hospitalist	Central Valley Critical Care Medicine	Malik, M.D.	Sara	08/21	Direct - Dr. Umer Hayyat's spouse	Site Visit: 10/7/20; Offer accepted
Intensivist	Central Valley Critical Care Medicine	John, D.O.	Avinaj	08/21	Vista Staffing - 10/25/19	Site visit: 12/13/19; Offer accepted

Candidate Activity

Specialty/Position	Group	Last Name	First Name	Availability	Referral Source	Current Status
Intensivist	Central Valley Critical Care Medicine	Akinjero, M.D.	Akintunde	08/21	Vista Staffing - 10/20/20	Virtual Interview: 11/30/20 Offer extended, contract under review
Intensivist	Central Valley Critical Care Medicine	Alperstein, M.D.	Adam	08/21	Vista Staffing - 9/21/20	Site visit: 12/11/20; Reviewing draft contract
Intensivist	Central Valley Critical Care Medicine	Fischer, M.D.	Brian	TBD	Comp Health - 11/4/20	Currently under review
Intensivist	Central Valley Critical Care Medicine	Leger, M.D.	Kathleen	08/21	Comp Health - 8/24/20	Virtual Interview pending dates
Maternal Fetal Medicine	Valley Children's Health Care	Behl, D.O.	Esha	04/21	Valley Children's Health Care	Site visit: 12/4/20
Orthopedic Surgery - Hand	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Tomooka, D.O.	Beren	08/21	Direct referral	Phone Interview: 12/2/20; Site visit pending dates
Orthopedic Surgery - Total Joint	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Amin, M.D.	Raj	08/20	Direct referral	Currently under review
Otolaryngology APP	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Hultin	Michael	ASAP	Direct referral	Interview: 12/11/20; Offer extended
Otolaryngology APP	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Pascillas	Amanda	ASAP	Indeed posting	Interview: 12/11/20
Otolaryngology APP	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Wessel	Talina	ASAP	Indeed posting	Interview: 12/11/20
Palliative Medicine	Independent	Arafa-Price, M.D.	Ala	08/21	Fidelis - 11/17/20	Currently under review
Palliative Medicine	Independent	Grandhe, M.D.	Sundeep	08/21	Direct -12/7/20	Virtual Interview pending dates
Palliative Medicine	Independent	Hernandez, M.D.	Sarah	08/21	PracticeMatch Email Blast	Site Visit Pending dates
Radiation Oncology	Sequoia Radiation Oncology Services, Inc.	Ly, M.D.	David	02/21	Direct referral	Offer accepted; Start date: 2/1/21
Urology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Patel, M.D.	Neil	TBD	Los Angeles Career MD Fair 9/14/19	Site Visit: 9/25/20; Offer extended

Candidate Activity

Specialty/Position	Group	Last Name	First Name	Availability	Referral Source	Current Status
Urology	Visalia Medical Clinic (Kaweah Delta Medical Foundation)	Sohlberg, M.D.	Ericka	08/21	MDStaffers - 8/21/20	Site Visit: 11/16/20; Offer extended

REPORT TO THE BOARD OF DIRECTORS

Service Name Here

Jessica Rodriguez, Director- Outpatient Clinic Network, 559-624-2838
December 21, 2020

Summary Issue/Service Considered

Overview:

Sequoia Health and Wellness Centers is located on the 5th floor of the 202 West Willow building in Visalia. They offer primary and specialty care services emphasizing prevention, wellness, individual dignity and cultural sensitivity.

The services offered at this clinic include Family Medicine, OB/GYN, Behavioral Health, Pharmacy Services, and Community Outreach.

The above service lines currently include a total of 21 family medicine residents, 8 GME faculty members (part-time and full-time), 1 advanced practice provider, and a psychologist.

New Accomplishments:

*Graduated 7 Family Residents from the Family Medicine Graduate Medical Education Program (June 2019) with 6 of 7 staying in the Central Valley and 5 of 7 in Tulare County

*New Clinic Leadership (Jan 2020)

*Tele-health Implementation (March 2020)

*New GME Program Director/Medical Director (April 2020)

*HRSA application submission to become an designated Federally Qualified Health Center (June 2020)

*Completion of HRSA On-Site-Visit (OSV) with only 4 potential findings (average is 10-15)

Financial Analysis:

- Sequoia Health and Wellness Centers had a contribution loss of -\$642,000 in FY20
 - Loss was a four year low
 - Continued improvement already showing in FY 21
- Year-To-Date (YTD) clinic volume up 5% from FY 2020
- Direct cost per visit has declined over the last three years

- COVID Impact
 - COVID had an initial negative impact to the clinics from a volume perspective. Rapid action to bring up the Tele-health and targeted outreach, however, quickly stabilized visits and contribution margin while maintaining critical access for our patients

- Tele-health impact
 - FY20: Tele-health accounted for 9% of visits (1,141 visits)
 - Tele-health findings:
 - Slightly lower contribution margin per case, as compared to non-tele-health visits

Quality/Performance Improvement Data

Sequoia Health and Wellness Centers is committed to improving the clinical quality, patient experience and reducing costs. Management is developing an infrastructure to improve the outcomes of current and future patient populations.

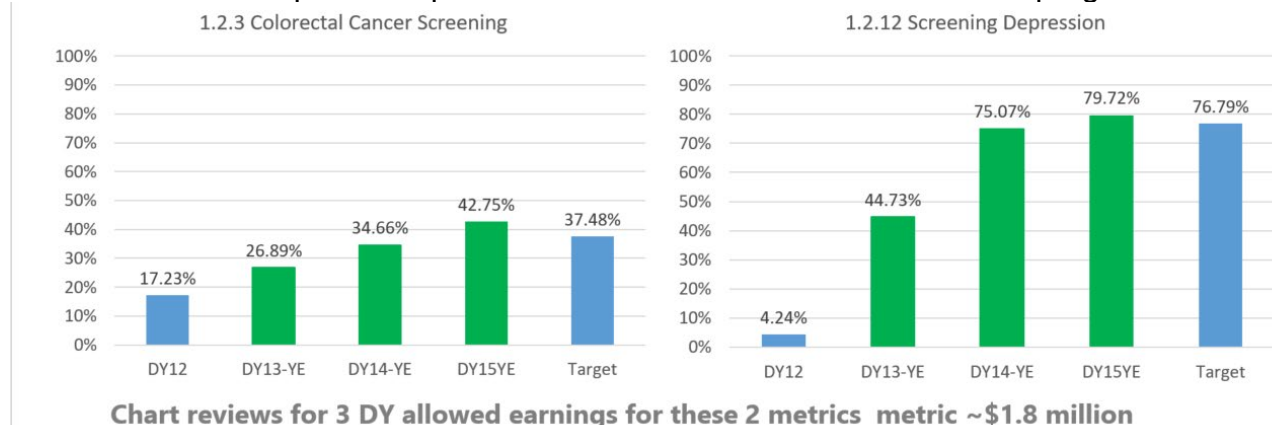
Governmental (i.e. Medicare and Medi-Cal) and health plan (i.e. Humana, HealthNet, Anthem, etc.) payers continued to drive the healthcare industry away from “fee-for-service” (FFS) towards “fee-for-value” (i.e. value based payments/risk bearing contracts).

While this clinic has and continues to participate in grants and health plan incentive programs, the single largest program the clinics have participated in is CMS 1115 waiver titled “Public hospital Redesign and Incentives in Medicaid (PRIME). Since the PRIME program began in 2015, KDHC has earned over \$70,000,000 through improving outcomes of Medi-Cal beneficiaries across 40+ outcomes measures. The majority of these outcomes are achieved through the care provided in our clinic system

Examples of PRIME outcome metrics include:

- Alcohol and Drug Misuse (SBIRT)
- CG-CAHPS-Overall Provider Rating
- Colorectal Cancer Screening
- Comprehensive Diabetes Care: HbA1c Poor Control (>9.0)
- Ischemic Vascular Disease (IVD)
- Use of Aspirin or another Antithrombotic
- Screening for Clinical Depression and follow-up
- Tobacco Assessment and Counseling

See below for examples of improved outcomes over time for the PRIME program.



Because of our location on the hospital campus and deep collaboration, we are extremely proud to share about our strong relationship with the hospital discharge team. We have seen a substantial reduction in acute care utilization in patients that have established at this clinic since January 2020.

60%
REDUCTION IN
EMERGENCY DEPARTMENT VISITS

77%
REDUCTION IN
URGENT CARE VISITS

70%
REDUCTION IN
HOSPITALIZATIONS

Policy, Strategic or Tactical Issues

The clinic network is essential infrastructure for KDHC to fulfill its mission to our community and for it to participate in programs like PRIME, its transition to Quality Incentive Program (QIP), Behavioral Health Integration (BHI), etc. to transform care delivery in the US health care system.

As Tele-health becomes a welcome and fixed component of care delivery in a post-COVID world, substantial known and potential challenges are presented in the way of reimbursement and closure of quality gaps as they are measured and defined today.

Recommendations/Next Steps

- Conversion of being a hospital-based licensed clinic to become a **federally qualified health center** (February 2021 - expected)
- Further development of **Tele-health** Platform
- **Behavioral Health Integration** (BHI) program Implementation (start Nov 2020)
- Transition PRIME to **Quality Incentive Program (QIP)**
- Continue to grow **Health Homes Program** (Medi-Cal population management program)

Approvals/Conclusions

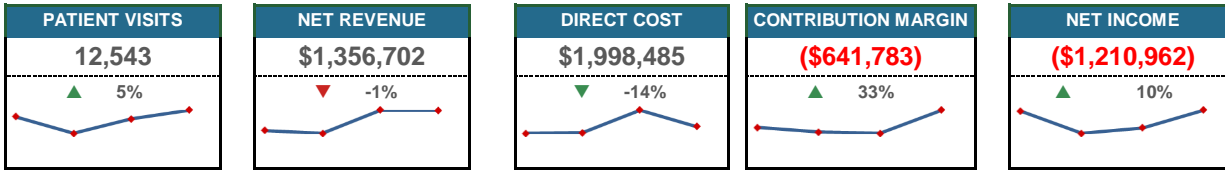
No additional approvals needed at this time. Sequoia Health and Wellness Centers, as a service line, continue to be highly impactful for the Kaweah Delta; providing outstanding primary and specialty care services to the community it serves.

KDHCD ANNUAL BOARD REPORT

FAMILY MEDICINE CENTER

FY2020

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

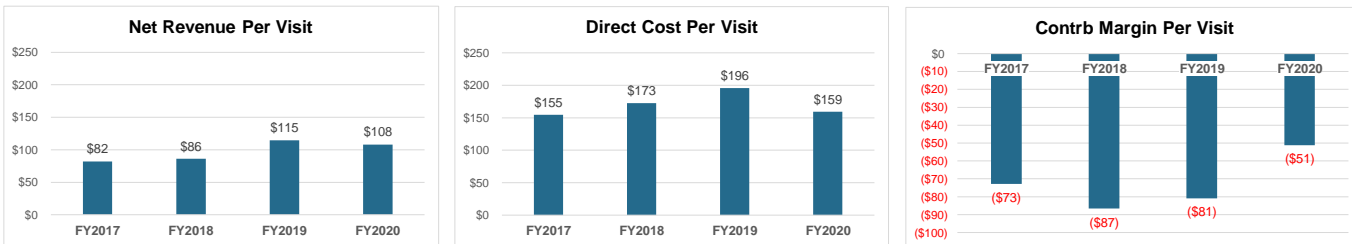


*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	4 YR TREND	Pre-COVID Ann. Jul. 19 - Feb. 20
Patient Visits	12,062	10,860	11,898	12,543	▲ 5%		12,668
Net Revenue	\$985,997	\$934,441	\$1,364,974	\$1,356,702	▼ -1%		\$1,387,437
Direct Cost	\$1,864,072	\$1,875,608	\$2,327,024	\$1,998,485	▼ -14%		\$2,135,576
Contribution Margin	(\$878,075)	(\$941,167)	(\$962,050)	(\$641,783)	▲ 33%		(\$748,139)
Indirect Cost	\$341,056	\$455,235	\$389,381	\$569,179	▲ 46%		\$499,779
Net Income	(\$1,219,131)	(\$1,396,402)	(\$1,351,431)	(\$1,210,962)	▲ 10%		(\$1,247,918)
Net Revenue Per Visit	\$82	\$86	\$115	\$108	▼ -6%		\$110
Direct Cost Per Visit	\$155	\$173	\$196	\$159	▼ -19%		\$169
Contrb Margin Per Visit	(\$73)	(\$87)	(\$81)	(\$51)	▲ 37%		(\$59)

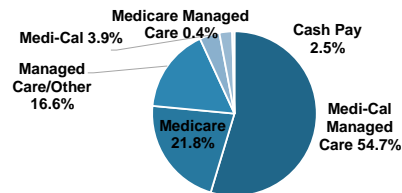
PER CASE TRENDED GRAPHS



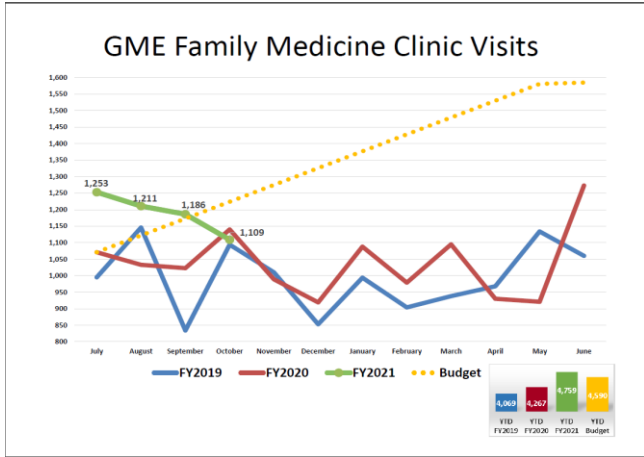
PAYER MIX - 4 YEAR TREND (VISITS)

PAYER	FY2017	FY2018	FY2019	FY2020
Medi-Cal Managed Care	51.6%	55.8%	56.8%	54.7%
Medicare	19.6%	21.3%	22.0%	21.8%
Managed Care/Other	20.1%	15.9%	15.0%	16.6%
Medi-Cal	6.4%	4.5%	4.5%	3.9%
Cash Pay	2.0%	1.3%	1.5%	2.5%
Medicare Managed Care	0.4%	1.2%	0.1%	0.4%

FY 2020 Payer Mix



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



Notes:
 Source: Outpatient Service Line Reports
 Criteria: Outpatient Service Line is Family Medicine Clinic

REPORT TO THE BOARD OF DIRECTORS

Diabetes Education Clinic

Tracy M. Salsa RN, Director of Clinical Operations
Contact Number: 559-624-4084 (office) or 909-226-3621 (mobile)

Board Meeting: December 21, 2020

Summary Issue/Service Considered

The outpatient Diabetes Education Clinic provides must needed diabetes education to our community. This clinic has been in operation at KDHCD for over 30 years. Given the high prevalence of diabetes in our community, (Tulare County ranks #1 in CA), this is a much-needed service despite a history of financial loss. Cost avoidance such as decreased hospitalizations and/or decreased length of stay, as well as potential avoidance of post-surgical complications must be considered when assessing this service line. The Diabetes Education Clinic has maintained its ADA and Sweet Success certifications. Our Sweet Success program provides gestational diabetes education and management to gestational diabetics and post-delivery care. Insulin dosing, insulin pump dosing and education is also provided at this clinic. Our educators also provide diabetes education presentations to various community events.

Quality/Performance Improvement Data

The Diabetes Education team is currently working on several key initiatives:

- *Maintaining ADA certification which involves several quality metrics (foot checks, daily blood sugar log completion, quality of life assessment score [pre/post first and last education visit], behavior changes, diet adherence, patient satisfaction)
- *Above metrics exceeded baseline – all over 90% compliance except for patient satisfaction which is 100% (for the 4th year in a row)
- *Maintaining Sweet Success certification (quality metrics include post-delivery baby weight, daily blood sugar log completion)
- *Above metrics exceeded baseline – all over 92% compliance
- *Referral processed within 5 days (PRIME metric) exceeded baseline at 93% resulting in increased PRIME funding to KDHCD

Policy, Strategic or Tactical Issues

Several key points:

- *CM consistent with prior years; FY21 volumes trending up but CM loss growing
- *Average CM loss \$243K (CM loss higher pre-COVID)

*Expense trend helped improve CM loss with a 27.4% decline in performance expenses in FY20

*Total expenses down but direct cost per visit is up due to volume, which impacts expense spread

*Part-time Diabetes Educator position eliminated in this FY due to volume decline

*Very slight improvement in reimbursement/visit; historically averaged \$60/visit prior to FY17; FY20 now at \$72/visit

*Drop in Medi-cal & Managed Care Medi-cal due to FHCN starting their own gestational diabetes service line; FHCN used to refer all these patients to KD

*Community endocrinologist has start-up online/virtual diabetes education program with several payors reimbursing for these visits (Medicare, KMG); no big impact seen yet but predict shift towards this program vs. in-person visits

*Implemented telehealth visits which Medicare and now other payors reimburse for this virtual visit; originally only telehealth visits done by a Registered Dietician were included for reimbursement but that has since changed to include Registered Nurses who perform diabetes education on a HIPAA compliant/secure web platform)

Recommendations/Next Steps

*Volume remains biggest definer of this service line; historically this service line has a high no show rate (at approximately 25%; have reduced to 15% pre-COVID)

*Develop and implement appointment reminder system; currently using staff to make a phone call for appointment reminder as well as using automated calls; enlist in ISS assistance for another option

*Continue offering telehealth visits to patients who prefer this type of visit vs. in-person

*Possible staff changes to decrease costs

*Partner with marketing to develop/implement comprehensive marketing plan to community physicians about this service line; initial marketing efforts/partnership at with VMC providers completed – move towards another round of marketing efforts mid-FY21 depending on pandemic and ability to visit physicians face-to-face

*Engage ISS team to develop online virtual care platform that surpasses the competition

Approvals/Conclusions

This service line is essential to our community. Our challenge is to increase volume to help offset financial loss. This service line has three staff – two educators and one coordinator. This clinic has maximized its operations and runs as efficiently as possible. We must adapt to our changing environment (i.e. telehealth visits) for a service line, that uses food portion models and other hands-on teaching tools. Mismanagement of diabetes results in hospitalizations, many health complications such as amputations, heart disease requiring costly stent placement and/or open-heart surgery, infections, etc. It is the value this service line brings to our patients and community to prevent these complications. The key is managing the costs associated with this service, adapt to a changing virtual environment, decrease no show rate, and increase volume.

KDHCD ANNUAL BOARD REPORT

Diabetes Clinic

FY2020

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



*Note: Arrows represent the change from prior year and the lines represent the 3-year trend

METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020	% CHANGE FROM PRIOR YR	3 YR TREND	Pre-COVID Ann. Jul. 19 - Feb. 20
Visits	2,852	3,130	2,892	2,001	▼ -31%		2,237
Net Revenue	\$206,927	\$181,644	\$193,909	\$143,199	▼ -26%		\$164,157
Direct Cost	\$438,608	\$531,734	\$542,580	\$402,400	▼ -26%		\$451,796
Contribution Margin	(\$231,681)	(\$350,090)	(\$348,671)	(\$259,201)	▲ 26%		(\$287,639)
Indirect Cost	\$458,946	\$531,793	\$488,889	\$202,961	▼ -58%		\$227,724
Net Income	(\$690,627)	(\$881,883)	(\$837,561)	(\$462,162)	▲ 45%		(\$515,363)
Net Revenue Per Visit	\$73	\$58	\$67	\$72	▲ 7%		\$73
Direct Cost Per Visit	\$154	\$170	\$188	\$201	▲ 7%		\$202
Contrb Margin Per Visit	(\$81)	(\$112)	(\$121)	(\$130)	▼ -7%		(\$129)

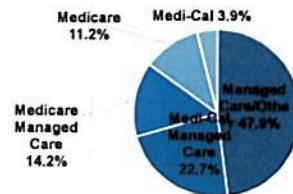
Per Visit TRENDED GRAPHS



PAYER MIX - 4 YEAR TREND (VISITS)

PAYER	FY2017	FY2018	FY2019	FY2020
Managed Care/Other	43.5%	43.7%	37.8%	47.9%
Medi-Cal Managed Care	20.5%	20.3%	31.0%	22.7%
Medicare Managed Care	10.6%	11.6%	8.1%	14.2%
Medicare	14.9%	13.1%	10.8%	11.2%
Medi-Cal	10.3%	11.1%	12.3%	3.9%

FY 2020 Payer Mix - Based on Visits



Notes:
Source: Outpatient Service Line Reports
Criteria: Outpatient Service Line is Diabetes Clinic

REPORT TO THE BOARD OF DIRECTORS

Chronic Disease Management Center (CDMC)

Tracy M. Salsa RN, Director of Clinical Operations
Contact Number: 559-624-4084 (office) or 909-226-3621 (mobile)
Dr. Monica Manga, Medical Director

Board Meeting: December 21, 2020

Summary Issue/Service Considered

The Chronic Disease Management Center (CDMC) focuses on chronic conditions such as diabetes, heart failure and COPD. Our clinic is not volume based – it is quality based with a focus on preventing emergency room visits and hospitalizations. A multi-disciplinary team consisting of a physician, physician assistant, pharmacists, a licensed vocational nurse, medical assistants, diabetes educators, pharmacy technicians, and community outreach specialists work together to provide medical care, education and home support to meet the patients' needs. We partner with Key Medical Group (KMG) to care for our most vulnerable and fragile patients within the community – people with gaps in care impacting Medicare reimbursement. Our novel programs provided to Humana Medicare Advantage patients have resulted in an accurate risk adjusted factor (RAF) which equates to Medicare reimbursement to care for these patients. Focus on gaps in care and quality/star metrics have resulted in saved health care dollars. The CDMC also manages the Foundation diabetes program for our employees and dependents, which results in KDHCD dollars saved on prescriptions. Other specialty programs provided at the CDMC include: a pharmacist led coagulation clinic, a pharmacist led pain management program (reducing ER visits for patients seeking medication), Med Assist which helps patients afford their medications and/or to avoid the gap in coverage (or donut hole) thus preventing lapse in medication compliance which could lead to hospitalization), specialty medication program (specific patient population by diagnosis of HIV, Hepatitis C and rheumatoid arthritis –must be a patient of Dr. Boken or Dr. Boniske) and Transition of Care visits (one time visit for patients discharged from the hospital but cannot see their own PCP within 7 days).

Quality/Performance Improvement Data

The CDMC team is currently working on several key initiatives:

*Outpatient referral processing time under 5 calendar days – this metric has been met 99.2% this past year; >90% new patients are scheduled within 2 weeks of completed referral; outpatient clinic volume has increased 24% (2,497 to 3,009 visits) from previous year.

*COPD program implemented Air X platform resulting in avoiding hospitalizations for two patients (Air X utilizes a telephonic platform contacting participating patients on a daily basis, ranking their risk and then treatment regime instituted)

*Focus on gap closures and accurate RAF scoring to improve financial reimbursement

*Population Health Management of patients through outreach programs aimed at reducing ER visits and hospitalizations; this includes proactive outreach to Humana/KMG patients with A1c > 8, heart failure and/or COPD diagnosis

*Patient Assessment Form (PAF) program with outreach activities by Physician Assistant and Medical Assistant to visit skilled nursing home residents for RAF assessment and gap closures for this fragile and complex patient population (historically underfunded due to no PCP visit due to living in a SNF)

Policy, Strategic or Tactical Issues

Several key points:

*CDMC has historically operated at a loss but our services measured in cost avoidance and improved Medicare funding based on avoidance of hospitalization/hospital utilization; with this in mind, contribution margin loss dramatically improved from \$897K FY19 to &186K FY20 due to staffing changes/staffing reduction and restricting of clinic operations

*Volume has improved by 24% in this quality-focused clinic with FY21 already showing a 5.8% increase in visits; referrals rely solely on PCP engagement

*Direct cost/visit substantially declined over prior year & continue to decline in FY21

*CDMC building to be future site of urology clinic, performing procedures which in a hospital-based clinic have good reimbursement to off-set payor mix; also frees OR space for complex surgeries; investigating ROI of bariatric clinic in this space

*Pharmacist led pain management program met all PRIME metrics (such as Opioid Agreement/Urine Tox screen, SBIRT completion, prescription monitoring program (CURES), depression screen); one major accomplishment → 44% overall reduction in opioid burden; total MRP cost avoided = \$358K

*Employee/dependent program (diabetes, high dollar medications for Dr. Boniske's and Dr. Boken's patients) resulted in \$1.3 million in savings to the District

Recommendations/Next Steps

*Continued focus on clinic operations – flexing staff schedule to match patient volume and maximize provider time when in clinic

*Continued partnership with Key Medical Group to increase referrals from KMG PCPs in the community – proven record of accomplishment of multi-disciplinary team's interventions resulting 88% reduction in A1c values for participating patients

*Future construction on general-purpose room to be two distinct procedure rooms for urology service line; new service lines will also maximize use of existing staff to reduce costs/maximize CM

Approvals/Conclusions

Our continued partnership with KMG & Humana has proved soft dollar savings to KDHC, improved the quality and quantity of patient lives as well as increased enrollment in Humana Medicare Advantage program. This care model has proved a

reduction in ER visits, hospitalizations, worsening co-morbidities, and high pharmacy costs. Population Health is the entire management of the patient, including socio-economic factors that significantly contribute to a patient's overall health. Proactive assessment and treatment for these vulnerable patients with multi-diagnoses results in positive results for the community. Future service lines for this clinic will provide much needed access to care (urology) and avoidance of care/procedures leaving this area for Fresno, Bakersfield, the Bay area and Southern CA. Plan for the remaining half of this FY is continued focus on quality metrics, daily assessment of clinic productivity reports to improve efficiency in the outpatient setting, and marketing strategies to increase community awareness of our unique and robust programs at the CDMC.

KDHCD ANNUAL BOARD REPORT

Chronic Disease Management Clinic

FY2020

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



*Note: Arrows represent the change from prior year and the lines represent the 3-year trend

METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020	%CHANGE FROM PRIOR YR	3 YR TREND	Pre-COVID Ann. Jul. 19 Feb. 20
Visits	1,163	2,698	2,497	3,099	▲ 24%		2,997
Net Revenue	\$154,502	\$338,636	\$314,007	\$388,484	▲ 24%		\$381,944
Direct Cost	\$1,042,209	\$787,090	\$1,120,952	\$574,875	▼ -49%		\$572,939
Contribution Margin	(\$887,707)	(\$448,454)	(\$806,945)	(\$186,391)	▲ 77%		(\$190,995)
Indirect Cost	\$948,062	\$1,045,492	\$1,113,946	\$1,291,054	▲ 16%		\$1,240,734
Net Income	(\$1,835,769)	(\$1,493,946)	(\$1,920,891)	(\$1,477,445)	▲ 23%		(\$1,431,729)
Net Revenue Per Visit	\$133	\$126	\$126	\$125	▶ 0%		\$127
Direct Cost Per Visit	\$896	\$292	\$449	\$186	▼ -59%		\$191
Contrb Margin Per Visit	(\$763)	(\$166)	(\$323)	(\$60)	▲ 81%		(\$64)

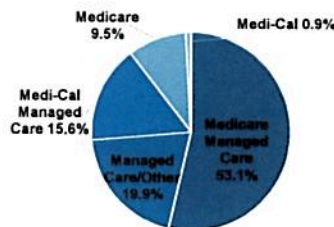
Per Visit TRENDED GRAPHS



PAYER MIX - 4 YEAR TREND (VISITS)

PAYER	FY2017	FY2018	FY2019	FY2020
Medicare Managed Care	41.2%	39.3%	41.1%	53.1%
Managed Care/Other	8.3%	10.0%	20.6%	19.9%
Medi-Cal Managed Care	24.1%	29.8%	21.6%	15.6%
Medicare	20.2%	18.4%	14.0%	9.5%
Medi-Cal	4.5%	1.9%	1.8%	0.9%

FY 2020 Payer Mix - Based on Visits



Notes:
 Source: Outpatient Service Line Reports
 Criteria: Outpatient Service Line is CDM Clinic

REPORT TO THE BOARD OF DIRECTORS

Infusion Center

Tracy M. Salsa RN, Director of Clinical Operations
Contact Number: 559-624-4084 (office) or 909-226-3621 (mobile)

Board Meeting: December 21, 2020

Summary Issue/Service Considered

Our outpatient Infusion Center remains an integral part of KDHC, providing all infused medications, central line care, and central line lab draws. The infusion center has a large chronic patient population that requires regularly infusions for a variety of diagnoses. Blood transfusions, hydration, and antibiotic infusions make up the rest of our patient population. The infusion center provides some chemotherapeutic classed medications that meet specific criteria since the infusion center is not licensed to administer full chemotherapeutic agents nor is our staff chemo certified, both requirements to administer chemotherapeutic agents.

Quality/Performance Improvement Data

The infusion center team is currently working on several key initiatives:

- *Implemented the PHQ2/9 depression screening tool this FY; achieved 100% completion since implementation
- *Implemented complete medication profile in Power Chart (Cerner); achieved 100% completion since implementation
- *Blood Transfusion Record – continued vigilance remains a focus as with previous years; 99% completed transfusion record for the FY
- *Implemented new medication ordering/tracking workflow to prevent delays in care and/or wasted medications due to no shows
- *Implemented new workflow for new medication referral received; this has decreased time from referral received to infusion date as well as fiscal oversight for new medication administered and 340b compliance

Policy, Strategic or Tactical Issues

Several key points:

- *Infusion center has historically operated at a positive CM; this FY is no different → CM is up from FY19 by 57% - equates to \$2.6 million which is highest CM in past 4 years
- *CM per visit increased by 60% from previous FY

*Drug costs increased this FY however net revenue increased by 28% from \$7.6 million to \$9.7 million

*Net Revenue per visit increased with three top payors (Medicare, Managed Care and Managed Medi-cal)

*Infusion center remains closed on weekends due to mostly to low demand, especially during pandemic however, this remains a focus for FY21 to provide hours of operation on at least Saturday to help with "outpatient in a bed" process for weekend infusions

*Volumes down by one-third this FY mostly due to pandemic

*Key Medical Group has moved a few high dollar patients to receive services at Dr. Havard's office/infusion center due to KMG being at risk for these patients (Blue Shield, Humana) thus not at risk when infused at physician-based infusion center/practice; will continue to see this shift

*Recently signed executive order, Most Favored Nation (MFN), will have fiscal implications for infusion center; effective 1/1/2021, MFN is comprised of a list of 50 medications (mostly biologics), with more to be added over time, that brings total reimbursement lower; this are high dollar therapies for patients with mostly chronic conditions needing this medication on a regular basis (usually monthly); KD workgroup currently assessing fiscal impact on the infusion center (as well as the hospital overall)

Recommendations/Next Steps

*Assess fiscal impact of MFN on service line

*Preliminary discussion of expanding number of chairs which requires construction and OSHPD approval; MFN may influence decision of moving forward with this expansion

*Adding per diem RN staff to move towards opening on weekends

*Develop pathway for Emergency Room (ER) patients requiring blood transfusions to receive in the IC vs. utilizing space in the ER or inpatient bed

*Continue with current workflow established to help eliminate drug wastage due to no shows

*Continue to update policies and procedures to include evidence-based infusion nursing standards of care

*Asses pharmacy labor standard/cost applied to this service to have accurate fiscal representation including all labor costs associated with care; currently no pharmacy staff costs are applied to this cost center

*Step-up marketing efforts to increase awareness and volume; director to collaborate with marketing department to develop and implement a comprehensive marketing plan

Approvals/Conclusions

The Infusion Center remains a much-needed service to the community, especially during the pandemic so patients do not have to be in the hospital to receive their infused medication. Despite lower volumes in the second half of FY20 and entering FY21, this service line remains profitable with a strong CM. Marketing efforts should help improve volume as well as being on the forefront of providing newly approved FDA medications.

KDHCD ANNUAL BOARD REPORT

Infusion Center

FY2020

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



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

METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2017	FY2018	FY2019	FY2020	% CHANGE FROM PRIOR YR	3 YR TREND	Pre-COVID Ann. Jul. 19 - Feb. 20
Visits	2,977	3,290	2,091	2,047	▼ -2%		2,031
Net Revenue	\$5,430,139	\$5,702,178	\$7,579,875	\$9,681,283	▲ 28%		\$8,499,417
Direct Cost	\$2,981,779	\$3,374,027	\$5,917,674	\$7,076,681	▲ 20%		\$6,492,620
Contribution Margin	\$2,448,360	\$2,328,151	\$1,662,201	\$2,604,602	▲ 57%		\$2,006,798
Indirect Cost	\$221,245	\$275,042	\$697,467	\$1,421,795	▲ 104%		\$1,275,207
Net Income	\$2,227,115	\$2,053,109	\$964,734	\$1,182,807	▲ 23%		\$731,591
Net Revenue Per Visit	\$1,824	\$1,733	\$3,625	\$4,729	▲ 30%		\$4,185
Direct Cost Per Visit	\$1,002	\$1,026	\$2,830	\$3,457	▲ 22%		\$3,197
Contrb Margin Per Visit	\$822	\$708	\$795	\$1,272	▲ 60%		\$988

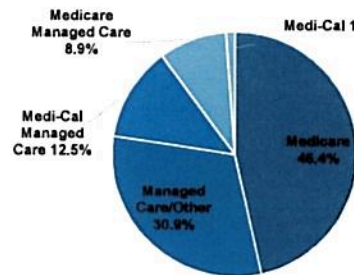
Per Visit TRENDED GRAPHS



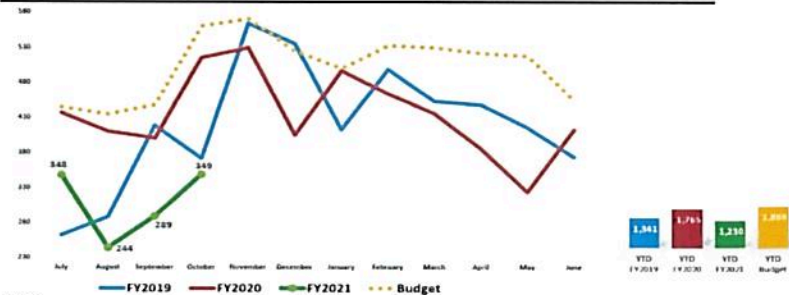
PAYER MIX - 4 YEAR TREND (VISITS)

PAYER	FY2017	FY2018	FY2019	FY2020
Medicare	40.6%	43.5%	46.5%	46.4%
Managed Care/Other	33.3%	27.7%	26.7%	30.9%
Medi-Cal Managed Care	16.1%	13.1%	15.0%	12.5%
Medicare Managed Care	7.6%	11.4%	9.6%	8.9%
Medi-Cal	1.7%	3.7%	1.9%	1.2%

FY 2020 Payer Mix - Based on Visits



GRAPH - INFUSION CENTER - OUTPATIENT VISITS



Notes:
Source: Outpatient Service Line Reports
Criteria: Outpatient Service Line Is Infusion Center

Quality Council Open Session

Thursday, November 19, 2020

8:00am – 9:00am

The Lifestyle Center/GoToMeeting

Attendees: Board Members: Nevin House, David Francis; Anu Banerjee, PhD, VP & CQO; Sandy Volchko, Director of Quality & Patient Safety; Jag Batth, VP Rehab & Post Acute Services; Gary Herbst, CEO; Tom Gray, M.D., Medical Director of Quality & Patient Safety; Melinda Tupper, CFO; Doug Leeper, CIO; Ryan Gates, VP Population Health; Dan Allain, VP Cardiac & Surgical Services; Ben Cripps, Chief Compliance Officer; Monica Manga, M.D., Professional Staff Quality Committee Chair; Byron Mendenhall, Chief of Staff; Dianne Cox, VP & Chief Human Resources Officer; Kassie Waters; Rebekah Foster; Evelyn McEntire; Shawn Elkin; Amy Baker; Michelle Adams, Recording.

Call to order: 8:05am

TOPICS	LEADER	FOLLOW-UP
<p>Written Quality Reports</p> <ul style="list-style-type: none"> • <u>3.1 Healthgrades</u> – Back surgery was a one star. The committee asked, “how come it stays at one star?” One or two cases will bring it down quite a bit. A bad case falls under the column complications: readmission, we document complications. Healthgrades sticks with us for three years; it is looking at cases that happened three years ago. • <u>3.2 Central Line Associated Blood Stream Infection (CLABSI)/MRSA Quality Focus Team</u> – Looking at documentation. Need to go back to physicians, is there a test we can go back to order another test, repeat blood culture to see who we can rule out from the first one? Organism could be existing somewhere else. We do not want to be dinged for something that was not our fault. <ul style="list-style-type: none"> - We have set a target to be at the 50th percentile. It is easier for the staff when you give them a whole number. Goal is perfect care, zero harm. We achieved almost a 30 percent reduction in the rate of CLABSI; our volume has been going up. Bundle has to be 100% implemented, 100% of the time. We investigate every HAI. We are going well beyond what CDPH recommends to prevent CLABSIs. We have identified some knowledge gaps, many culture issues. The way we document or failing to document the origin of the infection can give us false positives. Looking at other factors to identify the source of the infection. 		<p>Will bring Healthgrades as a follow up item next month.</p>

<p>Follow Up from Previous Meetings</p> <ul style="list-style-type: none"> • Handoff Quality Focus Team – There is a handoff tool that exists in Cerner. Performed a gap analysis what the nurses see as safety data information and electronic tool. Looking at what can be removed and what can be added. Make sure we have the correct information from the pilot tool we are using so the change is on the EMR. Working to make the tool shorter for the staff so there is one tool that everyone can look at. • CAUTI May Case reviews – There were five CAUTI events in one month. Urinary retention was an issue. Looked at how much urine is still in the bladder using an ultrasound to see if the patient is utilizing their bladder effectively. Need to make sure everyone knows what to do. One fever and urine is enough to do a culture. We do not want to take a urine culture form a catheter that has been in for several days because we could be culturing the biofilm. Need to remove the catheter, take the specimen, and then replace the catheter. Taking the catheter in and out is much safer and less risk for infection. Need to get away from keeping a device in. <p>Centers for Medicare and Medicaid Services (CMS) Incentive-Based Quality Improvement Programs</p> <ul style="list-style-type: none"> • Fiscal year 2021 is looking at calendar year 2019 data. We were performing better in 2019. Most of it is related to CLABSI, CAUTI and MRSA. If you make the cut, you are not penalized. COVID times will be reflected in fiscal year 2023. We are also asking for third quarter exemption because we know COVID is our priority. Waiting to hear if they are going to allow us exemption <p>Roundtable – Nevin thanked the committee for all the hard work they have done the past three years. He has enjoyed working alongside the committee and is thankful for everything they do for our patients.</p>	<p>Kassie Waters</p> <p>Shawn Elkin</p> <p>Evelyn McEntire</p>	
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Adjourned: 9:25am

Approved By: COMMITTEE MINUTES WERE APPROVED FOR DISTRIBUTION TO THE BOARD BY THE COMMITTEE CHAIR ON November 30, 2020.

Strategic Planning Committee Meeting
Wednesday, December 3, 2020
Kaweah Delta Medical Center – 402 W Acequia Avenue
Kaweah Delta Mutli Service Center
Auditorium

ATTENDING: Lynn Havard Mirviss (Chair) and Garth Gipson; Gary Herbst, CEO; Marc Mertz, Vice President of Strategic Planning & Business Development; Executive Team, Medical Staff Officers, all Members of the KDHC Medical Staff; and Kelsie Davis, recording.

Called to order at 5:32pm

Public/Medical Staff Participation- None.

Kaweah Delta Strategic Plan- *Marc Mertz, VP/Chief Strategy Officer*

- Mr. Mertz reviewed the current FY2021 strategic Plan.
- Mr. Mertz reviewed the FY2022 Strategic Planning Process.
- Mr. Mertz discussed potential strategic initiatives for the FY2022 Strategic Plan. The top Six initiatives were discussed and are noted below:
 - Outstanding Health Outcomes
 - Patient and Customer experience
 - Strategic Growth and Innovation
 - Ideal Work Environment
 - Organizational Efficiency and Effectiveness
 - Empower through Education

Adjourned- 7:05pm

Lynn Havard Mirviss, Chair

Privileges in Pathology

Name: _____

Please Print

Pathology Privileges – Initial Criteria		
Education: M.D. or D.O. and successful completion of an ACGME or AOA accredited residency in clinical and anatomic pathology with or without a subspecialty of pathology AND Current certification or active participation in the examination process leading to certification in clinical and anatomic pathology by the American Board of Pathology or the American Osteopathic Board of Pathology, with certification obtained within 5 years of completion of residency.		
ANATOMIC CORE PRIVILEGES		
Initial Clinical Experience: 300 cases in 2 years OR successful completion of an ACGME or AOA accredited residency within the past 12 months		
Renewal Criteria: Maintain current certification or active participation in the examination process leading to certification in clinical and anatomic pathology by the American Board of Pathology or the American Osteopathic Board of Pathology AND Minimum of 300 cases in 2 years		
FPPE: Successful completion of the following observations: 1 Autopsy , 10 Pap smear interpretations, 6 GI cases and 2 hepatic cases (to include at least 1 hollow viscus resection or major partial resection) , 5-3 Frozen sections, 4 Breast biopsies, 4 Thyroid, 4 Lung, 2 Gynecologic surgical cases (hysterectomy with/without adnexae), 2 Neurosurgery, 2 Head & neck, 2 Infection disease cases, Minimum of 25 broad mix of cases to include: GI (biopsies & resections); Breast (biopsies & mastectomies); Thyroid; Lung; Gynecologic surgical case; Neurosurgery; Head & Neck; Infections Disease; routine general surgical cases to include hernias, appendectomies and cholecystectomies		
Request	Procedure	Approve
<input type="checkbox"/>	Anatomic Core Privileges include: the ability to perform patient diagnosis, ordering, consultation, and laboratory medical direction in the following disciplines: surgical pathology (including intraoperative consultations), cytopathology, autopsy pathology, molecular pathology, and associated ancillary studies	<input type="checkbox"/>
CLINICAL PATHOLOGY CORE PRIVILEGES		
Initial Clinical Experience: 20-10 cases in 2 years OR successful completion of an ACGME or AOA accredited residency within the past 12 months		
Renewal Clinical Experience: Maintain current certification or active participation in the examination process leading to certification in clinical and anatomic pathology by the American Board of Pathology or the American Osteopathic Board of Pathology AND Minimum of 20-10 cases in 2 years		
FPPE: Successful discussion and evaluation of at least minimum of 51 patients with abnormal laboratory tests, chosen by the proctor.		
Request	Procedure	Approve
<input type="checkbox"/>	Clinical Pathology Core Privileges include: the ability to perform patient diagnosis, ordering, consultation, and laboratory medical direction in the following clinical pathology disciplines: hematology and coagulation, blood bank and immunohematology, microbiology, serology, molecular pathology, clinical chemistry (including the subdivisions of special chemistry, automated chemistry, endocrinology, radioimmunoassay, toxicology, and electrophoresis), clinical microscopy, and other routine clinical pathology functions	<input type="checkbox"/>

Acknowledgment of Practitioner:

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

- (a) In exercising any clinical privileges granted, I am constrained by any Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.
- (b) I may participate in the Kaweah Delta Street Medicine Program, as determined by Hospital policy and Volunteer Services guidelines. As a volunteer of the program, Medical Mal Practice Insurance coverage is my responsibility.
- (c) **Emergency Privileges** – In case of an emergency, any member of the medical staff, to the degree permitted by his/her license and regardless of department, staff status, or privileges, shall be permitted to do everything reasonably possible to save the life of a patient from serious harm.

 Signature: _____ *Applicant* _____ *Date*

 Signature: _____ *Department of Pathology Chairman* _____ *Date*

December 14, 2020

Attached are the Medical Staff Approved Proposed Bylaws & Rules and Regulations Revisions forwarded to the Board of Directors

Vote Statistics:

Sent to Active Medical Staff Members (386)

Bylaws 5.F

Approve	95.70 %	(89)
Not Approve	4.30%	(4)

Rules & Regulations 3.1.b

Approve	97.73%	(86)
Not Approve	2.27%	(2)

Rules & Regulations 3.2.d

Approve	96.59%	(85)
Not Approve	3.41%	(3)

Rules & Regulations 4.1.a

Approve	94.38%	(84)
Not Approve	5.62%	(5)

5.F. PRACTITIONERS IN DEPARTMENTS SUBJECT TO EXCLUSIVE CONTRACTS

In order to exercise clinical privileges in any service or department that is subject to an exclusive contract with the District, a practitioner must be a member of the Medical Staff ~~(with the exception of Advanced Practice Providers and/or physicians working in a locums capacity for the contracted entity group)~~, hold the applicable clinical privileges, and be an employee, partner, contractor, or associate (hereinafter "affiliate") of the group, individual, or entity that holds the exclusive contract (hereinafter "contracted entity"). Upon (1) the departure of the affiliate from the contracted entity, (2) notice from the contracted entity that a practitioner will no longer provide services at the District, or (3) the termination of the exclusive contract with the District, whichever occurs first, when all of the affiliate's clinical privileges are encompassed by the exclusive contract, the affiliate shall be deemed to have voluntarily resigned from the Medical Staff and to have voluntarily relinquished his or her clinical privileges, except when an affiliate qualifies for Honorary Staff under Section 3.E.1(a) of the Bylaws and the Medical Executive Committee, in its discretion, approves a transfer to that staff category. Such a resignation and relinquishment shall not entitle the practitioner to the procedural rights described in Article 9 of the Bylaws. To the extent the practitioner holds clinical privileges beyond those encompassed by the exclusive contract, his or her departure from the contracted entity or the termination of the exclusive contract will not result in the practitioner's voluntary resignation from the Medical Staff and the practitioner's remaining clinical privileges will remain intact.

~~It is the prerogative of the Medical Executive Committee to extend an invitation to physicians concluding their exclusive contract with the hospital or an exclusive group and who have been members in good standing/served on the medical staff for more than 10 years to request a change to Honorary Staff Category.~~

Rationale: 1) APP's and Locums do not have membership. This revision addresses that issue. 2) Allows for a MEC to extend an invitation to join the honorary staff for a retiring member of a contracted group that meets the criteria for honorary membership.

ARTICLE III

MEDICAL RECORDS

3.1. General Requirements:

- (b) Medical Record Entries: Only authorized individuals may make entries in the medical record. Electronic entries will be entered through the electronic medical record. ~~In emergency situations or when the electronic medical record is not available, handwritten entries will be legibly recorded, preferably in black ink. Legible handwritten orders~~ entries will be accepted/entered into the electronic medical record ONLY in an emergent situation or during downtime procedures. Any such written or paper-based entries will be recorded in the English language, scanned and incorporated into the patient's electronic medical record. ~~All entries shall be recorded in the English language.~~

3.2. Content and Timeliness of Medical Record Documentation:

- (d) Medical Orders:
- (1) Orders will be entered directly into the electronic medical record by the ordering practitioner utilizing CPOE. ~~Written or paper based orders should be documented on appropriate forms as approved by the District and reserved for computer downtimes, emergency situations, and unusual situations only.~~ Legible handwritten orders will be accepted/entered into the electronic medical record ONLY in an emergent situation or during downtime procedures. Any such written or paper-based orders will be recorded in the English language, scanned and entered into the patient's electronic medical record.

ARTICLE IV

MEDICAL ORDERS

4.1. General:

- (a) Orders will be entered directly into the electronic medical record by the ordering practitioner utilizing CPOE. ~~Written or paper based orders should be documented on appropriate forms as approved by the District and reserved for computer downtimes, emergency situations, and unusual situations only.~~ Legible handwritten orders will be accepted/entered into the electronic medical record ONLY in an emergent situation or during downtime procedures. Any such written or paper-based orders will be recorded in the English language, scanned and entered into the patient's electronic medical record.

**FIRST AMENDMENT
TO THE
CARDIOVASCULAR SERVICE LINE AFFILIATION AGREEMENT**

This First Amendment to the Cardiovascular Service Line Affiliation Agreement (the “**Amendment**”) is entered into this 21st day of December 2020 (the “**Amendment Effective Date**”) by and between The Cleveland Clinic Foundation (“**CCF**”) and Kaweah Delta Health Care District (“**KDHCD**”).

WHEREAS, CCF and KDHCD are Parties to the Cardiovascular Service Line Affiliation Agreement effective January 21, 2019, (the “**Agreement**”);

WHEREAS, CCF and KDHCD now wish to amend the Agreement as set forth below;

NOW, THEREFORE, in consideration of the above, the mutual covenants and agreements of the Parties hereto, and other good and valuable consideration, the receipt and sufficiency of which is acknowledged, CCF and KDHCD agree as follows:

1. **16. Billing and Compensation.** Section 16 is hereby deleted in its entirety and replaced with the following:

As full payment for the full range of affiliation, professional and administrative services to be provided by CCF hereunder, including those set forth in Exhibit A and the use of CCF’s name, KDHCD shall pay to CCF the amount of eight hundred thirty-three thousand, three hundred and thirty four dollars (\$833,334.00) in Year 1 of the affiliation, one million dollars (\$1,000,000.00) in Year 2 of the affiliation and thereafter the annual sum of eight hundred fifty thousand dollars (\$850,000.00) for each year of any Renewal Term as described in Section 17(a) (the “**Services Fee**”), prorated for any partial years hereof, payable in equal monthly installments as of the first day of each month commencing on the Effective Date (as defined herein), which amount reflects fair market value for services rendered. Payments of the Services Fee shall commence on the Effective Date.

2. **17(a). Initial and Renewal Terms.** Section 17(a) is hereby deleted in its entirety and replaced with the following:

This Agreement shall, unless earlier terminated as provided herein, have an initial term of six (6) years (the “**Initial Term**”), it shall commence as of January 21, 2019 and shall expire on January 20, 2025, after which it will automatically renew for additional three (3) year terms (each a “**Renewal Term**”). Either Party may elect to have this Agreement terminated upon the expiration of the Initial Term or a Renewal Term by providing the other Party with written notice twelve (12) months prior to the expiration of the applicable term. The Parties acknowledge and agree that the remaining provisions of Section 17 of

the Agreement are unchanged by the extension of the Term and remain in full force in effect.

All terms and conditions of the Agreement not specifically amended, modified or replaced as set forth above shall remain in full force and effect. Any capitalized terms or abbreviations not defined herein shall have the same meaning as set forth in the Agreement, as amended.

IN WITNESS HEREOF, the Parties have executed this First Amendment as of the Amendment Effective Date.

The Cleveland Clinic Foundation

Kaweah Delta HealthCare District

By: _____

By: _____

Daniel L. Allain, NP-C

Its: _____

Its: Vice President Cardiac and Surgical Services

Date: _____

Date: December 21, 2020

KAWEAH DELTA HEALTH CARE DISTRICT

MEMO

To: Kaweah Delta Board of Directors
From: Daniel L. Allain, NP-C, 624-2536
Subject: Cleveland Clinic Foundation Affiliation
Date: December 21, 2020

Kaweah Delta (KD), the Department of Cardiovascular Services (CVS), and the Cleveland Clinic (CC) entered into our initial affiliation agreement on July 2016. At this time we engaged CC to complete a comprehensive assessment of the CV service line and make recommendations for improvement, which was conclude on February 28, 2017. There were findings in the following areas: service line structure and leadership, physician alignment, quality infrastructure, quality metrics improvement, accreditation, practice standardization, and overall continuous improvement. At the conclusion of assessment engagement, we moved forward with an improvement plan to address these items with the assistance of CC. On February 1 2019, we entered into our 3-year affiliation with CC, only the second healthcare facility in California to do so. The annual fees under the agreement are approximately \$1.3 million per year. Faced with the financial strains of COVID, we negotiated a considerable price concession with the Cleveland Clinic, in exchange for an extension of the agreement for three additional years beyond the currently scheduled expiration date of January 31, 2022. In exchange for the contract extension, the current year's fee of \$1.3 million for the contract period February 1, 2020 to January 31, 2021 will be retroactively reduced to \$1.0 million and all future years' annual fee will be reduced to \$850,000.

As a result of our partnership with CC, the following are some of our achievements:

- Improved extubation protocols for Cardiovascular Intensive Care Unit (CVICU).
- Developed protocols for Left Ventricular contrast utilization.
- Began journey for (ASE) American Society of Echocardiography Lab accreditation.
- Decreased door to balloon time (D2B) – 54 minutes.
- Reduction of acute kidney injury (AKI) post percutaneous cardiac intervention (PCI) – 5.6%.
- Added and hired a Cardiovascular Service (CVSL) Director – 6/4/2018.
- Increased Radial Approach for catheterizations at 40%; results in decreased bleeding complications.
- Implemented same day discharge of elective Percutaneous Coronary Intervention (PCI), currently at 44% of cases,
- Reduced Post-PCI length of stay (LOS), for AMI, to 1.8 days.
- Cath Lab turnover time reduced to 30 minutes from 71 minutes.
- Implemented “Thoughtful Pause” – Patient selection criteria for cardiac alerts

thereby decreasing mortality. This involves an inter-professional approach including emergency medicine, critical care intensivists, cardiologists, and nursing.

- Non- acute coronary syndrome (ACS): Implemented appropriate use criteria (AUC), inappropriate intervention reduced to 10%.
- Increased staffing & education for Data Analysts.
- Created a Director of Cardiovascular (CV) Operations and CV Assistant Nurse Manager through realignment of nursing leadership roles and responsibilities.
- Provided in-depth education for leaders, staff, and physicians.
- Improved compliance with CMS core measures on appropriate use of medications at discharge for cardiac patients to 99%.
- Launched successful trans-catheter aortic valve repair/replacement (TAVR) and on November 3 we performed our 100th TAVR procedure.
- Implemented staffing plan for all services utilizing cath lab and CV surgery.
- Initiated PCI Appropriateness meetings, ECHO quality assurance meetings, and PCI mortality review committee.
- We have sent 10 staff members and 7 physicians for training and education at CC.
- Successfully opened a hospital-based cardiology clinic, Sequoia Cardiology Clinic.

We still have more opportunity to improve, but have great momentum in this regard. KD leadership and the Department of CVS would like the opportunity to continue the affiliation with the CC. CC affiliation will continue to improve our CV service line and present new opportunities for growth and market share.

Contract Benefits

- Co-branding on website, signs, and materials for cardiovascular services. We will be an affiliate of the CC Heart and Vascular Institute (HVI).
- Using the Affiliation with CC our purchasing department was successful in leveraging a \$1.5 million dollar annual reduction in implants, devices and supply cost.
- CC completed an intensive assessment of the cath lab/CT surgery operations to provide suggestions on how to become more efficient for the cardiologists, surgeons staff, and patients.
 - Assessment includes block schedule/utilization, on time starts, staff scheduling to meet the requirements that are needed to run efficiently
 - Utilize non-clinical systems engineers for this evaluation.
 - We will have access to on-site LEAN managers for any project related to CV services.
- Marketing: CC's marketing team will work with KD's team to develop co-marketing strategies.
- Recruitment: Access to CC recruitment network for physician's and staff of all specialties.
- Assistance with the development of a strategic plan for CV Services. CC co-lead a strategic planning summit for the CV service line.

- Access to quality, peer review, and case review services.
- Access to clinical documentation improvement assessments and staff.
- Access by all physicians to Second Opinion Program to determine next steps for patients.
- Access to all conferences and CME activities at or sponsored by CC.
- Access to all educational and grand rounds webinars.
- Ongoing Staff, Leader, and Physician education and training.
- Assistance with launching new services, such as our TAVR program. Considering Left Ventricular Assist Device (LVAD), Mitral Clip, and Watchman programs.
- Access to best practice tools, clinical pathways, order sets and processes.
- Ability to visit all CC and Affiliate sites for learning opportunities.
- Ability to develop co-owned best practice tools.
- Access to the newest research available for CV services.
- CC will provide project leaders as requested to assist us in achieving goals.

Contract Terms

- Contract term is a three year extension to the existing agreement set to expire January 31, 2022..
- KD must maintain a cardiothoracic surgery program.
- KD must report all American College of Cardiology (ACC) and Society of Thoracic Surgeons (STS) data to CC.
- Improve and maintain benchmarks for all reported data.
- Sustain a monthly joint quality and operational meeting.
- Annual cost renegotiated from \$1.3M in year 1, \$1M in year 2 and thereafter \$850,000 for each year of any renewal term. Includes all CC travel, personnel, and related expenses. KD will pay for all KD staff and physician travel.
- Exclusivity: Inclusion of an additional clause for first right of refusal for Fresno and Madera counties if Sequoia Hospital were to not renew their affiliation.
- CC Affiliate Expectations:
 - Hospital and Medical Staff alignment toward common goals.
 - Continued pursuit of Quality Improvement by all.
 - Patient-Centered Care.
 - Same clinical expectations as ACC and STS.
- We may not affiliate with another entity for Cardiovascular medicine or surgery under the terms of the agreement.

RECOMMENDATION:

Extend the formal affiliation with Cleveland Clinic Heart and Vascular Institute (HVI) for additional 3-years.

Process	Points to Note	Use of Cleveland Clinic, (CC)	Estimated Value/Savings
Same Day Admit - Open Heart Patients	<ul style="list-style-type: none"> Go Live July 1, 2020: 5 pts in July, 11 pts in Aug, 6 pts in Sep. Process is going smoothly with minimal delays Burden on ED Throughput alleviated More time for ED to care for ED pts LOS Reduction 	<ul style="list-style-type: none"> Use of Education Materials supplied by CC Use of CC Protocols to develop KDH protocols Collaboration and advice to operationalize 	<ul style="list-style-type: none"> \$1,868/day/pt. - savings \$41,096 savings since July 2020
Radial Artery Approach	<ul style="list-style-type: none"> Started at 0.9% usage prior to affiliation 55.2% utilization as of Aug 2020 Utilization continues to trend Upward Increase of Pt Satisfaction Decreased risk of complications post procedure 	<ul style="list-style-type: none"> Use of CC Protocols to develop KDH protocols Use of CC Order Sets modified to KDH processes Facilitated Physician peer communication between Dr. Bajzer and Dr. Ashok Verma 	<ul style="list-style-type: none"> Easier to initiate Same Day Discharge because pts are ready to go home sooner Contributes to LOS reduction
Vendor Price Negotiations	<ul style="list-style-type: none"> Renegotiation of Vendor Contracts using CC pricing as leverage to save on KDH supply 	<ul style="list-style-type: none"> Able to keep control of vendor selection/products by leveraging affiliation with CC 	<ul style="list-style-type: none"> \$1.5 million in savings over 12-months through price breaks and rebates. Used the potential switch to CC as leverage and then requested the RFP, two year contracts. Validate with S. Bajari.
Same Day Discharge	<ul style="list-style-type: none"> In 2018: 11 pts SDD (entire year) SDD Go Live in June 2019 29 pts SDD June - Dec 2019 179 pts SDD YTD 2020 	<ul style="list-style-type: none"> Use of CC Protocols to develop KDH protocols Peer Physician Collaboration between Dr. Bajzer and Dr. Ashok Verma Flow Charts supplied for KDH Reference CC Order sets and Education Materials utilized to build KDH Process 	<ul style="list-style-type: none"> LOS Reduction \$334,372 estimated savings YTD 2020.
Block Schedule Adjustment	<ul style="list-style-type: none"> Early opportunity identification New Block Schedule effective as of Aug 2019 Increased access to Cath Lab Decreased after-hours cases Decrease of Staff Call Hours Decreased LOS for In-house pts Available Cath Lab Time Daily to accommodate In-house Pts Increase of staff retention and staff satisfaction Average 10% decrease of call back hours 	<ul style="list-style-type: none"> Christine Aleman worked with CC affiliates to evaluate overall workflow and to implement changes that would work for KDH KDH Leadership Team traveled to CC for onsite evaluation of the CC workflow to gain insights. 	<ul style="list-style-type: none"> Staff Retention saves estimated \$100,000 per year to train a new employee In 2019 we averaged 5 Travelers per pay period - Est \$25,500 per pay period FY19 - \$1.2 million spend on Contract Labor for Cath Lab Since 2020 - zero Travelers have been utilized
Mortality Morbidity review	<p>Mortality cases are sent for review to CC with recommendations for improvement, PCI's and CT surgery are sent.</p>	<p>Recommendations are shared with the cardiology medical director.</p>	<ul style="list-style-type: none"> Anu has valued this service at \$400,000 based on his previous contracts for cardiology review, if we are not using Cleveland Clinic we would still need to have an external review relationship.
Strategic Planning	<ul style="list-style-type: none"> Set a clear path for work to be accomplished Increased collaboration between MDs 	<ul style="list-style-type: none"> CC assigned dedicated affiliate team members to help drive deadlines to initiatives identified by KDH MDs Increased collaboration between physicians, administration, and CC. 	<ul style="list-style-type: none"> Total Estimated Savings since affiliation \$2.7 Million,
Strategic Planning	<p>Document is reviewed on monthly basis, incrementally with the respective Cardiac Surgery, Non-invasive and General Cardiology, EP and PCI</p>	<ul style="list-style-type: none"> CC reviews with the respective nursing and medical staffleaders with the open opportunities 	



RESOLUTION 2110

WHEREAS, Michael Mayo, is retiring from duty at Kaweah Delta Health Care District after 15 years of service; and,

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

NOW, THEREFORE, BE IT RESOLVED that the Board of Directors of the Kaweah Delta Health Care District, on behalf of themselves, the hospital staff, and the community they represent, hereby extend their appreciation to Michael Mayo for 15 years of faithful service and, in recognition thereof, have caused this resolution to be spread upon the minutes of this meeting.

PASSED AND APPROVED this 21st day of December 2020 by a unanimous vote of those present.

President, Kaweah Delta Health Care District

ATTEST:

Vice President, Kaweah Delta Health Care District
and of the Board of Directors, thereof



RESOLUTION 2112

WHEREAS, Janey Parker, is retiring from duty at Kaweah Delta Health Care District after 33 years of service; and,

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

NOW, THEREFORE, BE IT RESOLVED that the Board of Directors of the Kaweah Delta Health Care District, on behalf of themselves, the hospital staff, and the community they represent, hereby extend their appreciation to Janey Parker for 33 years of faithful service and, in recognition thereof, have caused this resolution to be spread upon the minutes of this meeting.

PASSED AND APPROVED this 21st day of December 2020 by a unanimous vote of those present.

President, Kaweah Delta Health Care District

ATTEST:

Vice President, Kaweah Delta Health Care District
and of the Board of Directors, thereof



RESOLUTION 2113

WHEREAS, Carol Chavez, is retiring from duty at Kaweah Delta Health Care District after 29 years of service; and,

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

NOW, THEREFORE, BE IT RESOLVED that the Board of Directors of the Kaweah Delta Health Care District, on behalf of themselves, the hospital staff, and the community they represent, hereby extend their appreciation to Carol Chavez for 29 years of faithful service and, in recognition thereof, have caused this resolution to be spread upon the minutes of this meeting.

PASSED AND APPROVED this 21st day of December 2020 by a unanimous vote of those present.

President, Kaweah Delta Health Care District

ATTEST:

Vice President, Kaweah Delta Health Care District
and of the Board of Directors, thereof



RESOLUTION 2114

WHEREAS, Cindra Cochran, is retiring from duty at Kaweah Delta Health Care District after 26 years of service; and,

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

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

PASSED AND APPROVED this 21st day of December 2020 by a unanimous vote of those present.

President, Kaweah Delta Health Care District

ATTEST:

Vice President, Kaweah Delta Health Care District
and of the Board of Directors, thereof



GRADUATE MEDICAL EDUCATION ANNUAL INSTITUTIONAL REVIEW

Academic Year 2019-2020

GOALS



RETENTION RATE - 45%

**FAMILY
MEDICINE**

47%

**GENERAL
SURGERY**

50%

**EMERGENCY
MEDICINE**

42%

TRANSITIONAL YEAR

8.3%

PSYCHIATRY

57%



PIPELINES

- **DOCTORS ACADEMY**

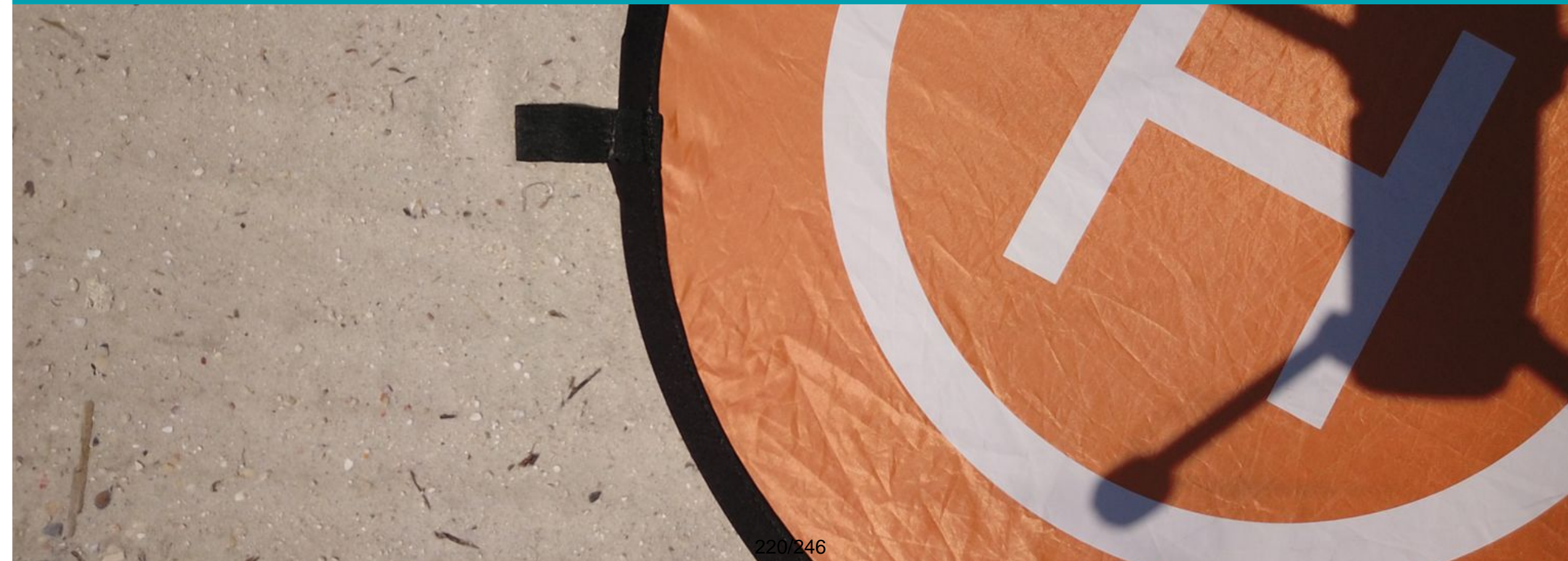
Local Community

- **NO COLLEGE RELATIONSHIP**

- **USC AFFILIATION - UNDERGRADUATE MEDICAL EDUCATION**

Street Medicine

KAWEAH LANDING PAD



GME 2013





222/246

GME 2020



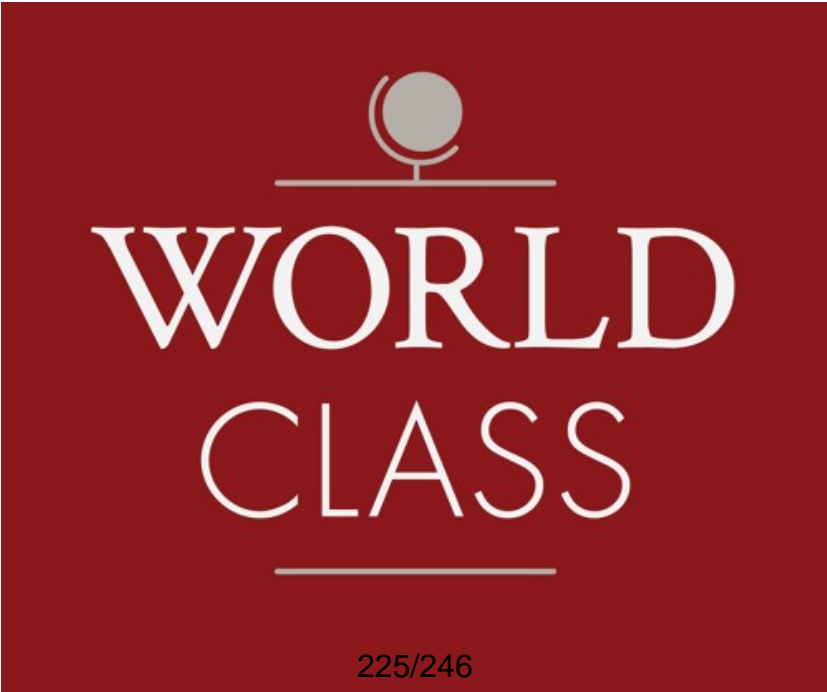
INTEGRATE MORE THOUGHTOUT THE INSTITUTION



FACULTY DEVELOPMENT OF OURSELVES

INTEGRATING & BREAKING DOWN SILOS





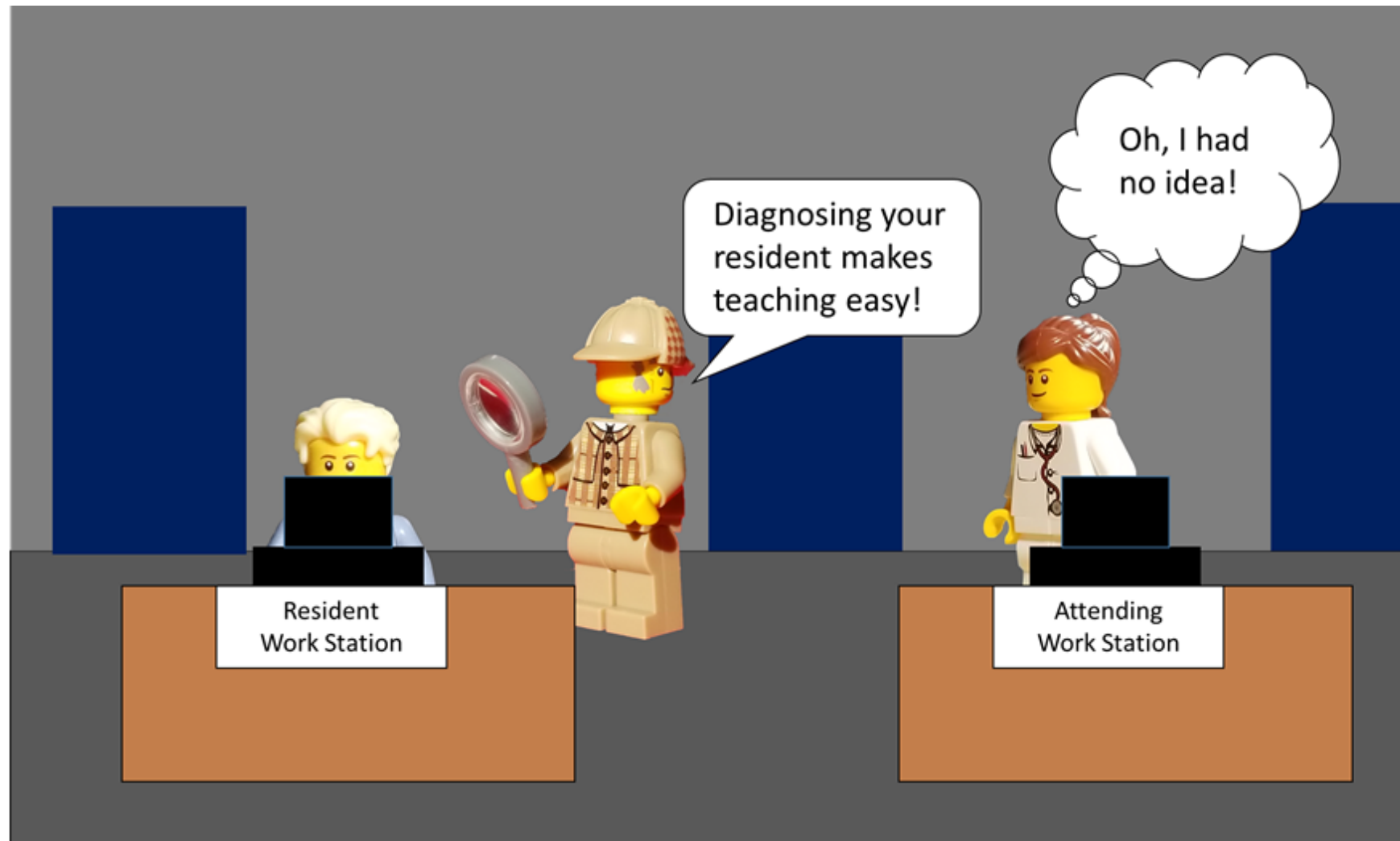
ANTIFRAGILITY



FACULTY DEVELOPMENT



MAKING BETTER PHYSICIAN EDUCATORS



Diagnosing the learner is the second part of “setting the table for teaching” (from the 3T teaching blueprint). It is important to diagnose your learners strengths, weaknesses, wants, and needs. Determining these things allows you to tailor your teaching which facilitates efficient high quality teaching with minimal effort. See supplemental info for more detail.



*“PLEASE GIVE
US FEEDBACK!”*



Attendings please provide verbal feedback to your Residents
(Remember feedback is needed for learning)

OFFICE OF RESEARCH



RESEARCH ADMINISTRATION

IRB & Compliance for all investigators



EDUCATION

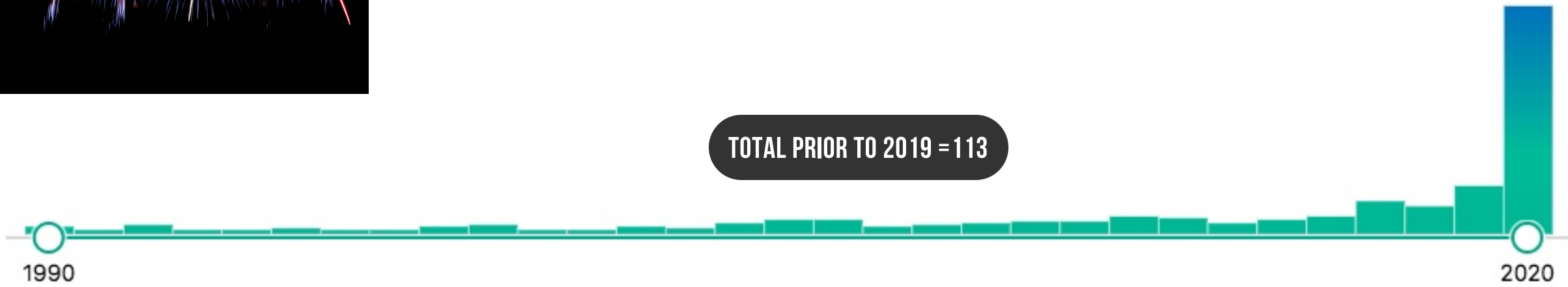
GME



LIBRARY

>300 PUBLICATIONS UNDER KAWEAH'S BELT

NUMBER OF KAWEAH PUBLICATIONS PER YEAR



TOTAL PRIOR TO 2019 = 113

2019-2020 TOTAL = 158

KAWEAH DELTA HAS DONE SOMETHING AMAZING



**Creating New Graduate Medical Education Programs
in California's Agricultural Heartland: Initial Investment Yields Rich Harvest**
Case Study of Kaweah Delta Medical Center

A photograph of several small green seedlings growing in a brown peat tray. The seedlings are in various stages of growth, with some having two leaves and others just starting to emerge. The background is a soft, out-of-focus green.

WE ARE STILL GROWING

CHILD & ADOLESCENT PSYCHIATRY FELLOWSHIP

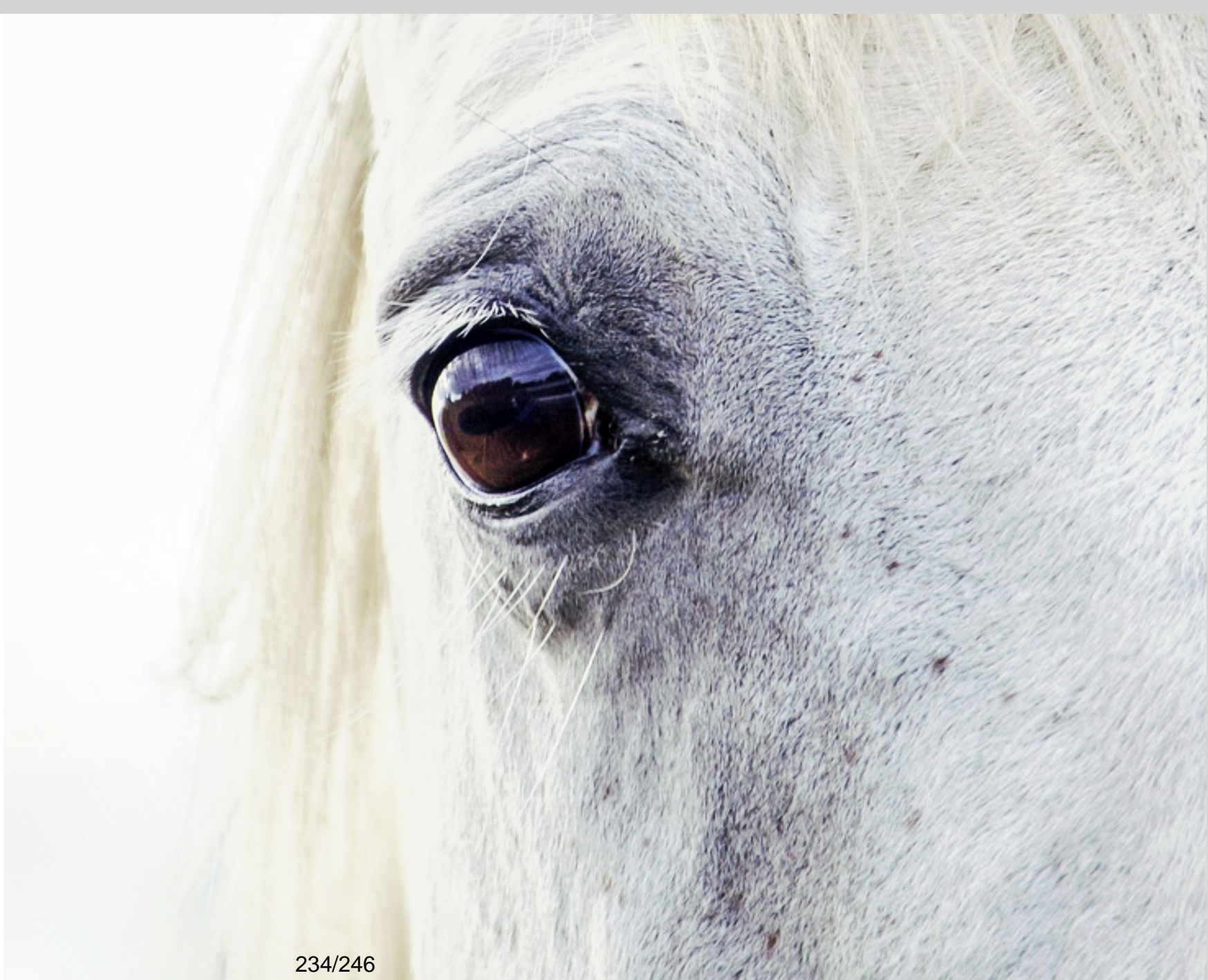
GRANTS

NEUROLOGY

INTERNAL MEDICINE RESIDENCY

DIVERSITY & INCLUSION STRATEGIES

**THANK YOU
FOR ALL
OF YOUR
SUPPORT**





QUESTIONS?

KAWEAH DELTA HEALTH CARE DISTRICT

Annual Institutional Review: Executive Summary

Academic Year 2019-2020

Presented by:

Lori Winston, MD
Vice President of Medical Education
ACGME Designated Institutional Official

GME Committee presentation December 1, 2020
Board of Directors & Executive Team presentation on December 21, 2020

Annual Institutional Review: Executive Summary

Oversight of the Graduate Medical Education programs is under the authority of the Kaweah Delta Health Care District's Graduate Medical Education Committee (GMEC) and the Office of Graduate Medical Education under the direct supervision of the Vice President of Medical Education/Designated Institutional Office, Dr. Lori Winston. The Annual Institutional Review Executive Summary is presented to the Board of Directors annually.

I.B.5.b) The DIO must annually submit a written executive summary of the AIR to the Sponsoring Institution's Governing Body. The written executive summary must include:

I.B.5.b).(1) a summary of institutional performance on indicators for the AIR; and,

I.B.5.b).(2) action plans and performance monitoring procedures resulting from the AIR.

The current status of each KDHC program, as of December 2020, is as follows:

ACCREDITED

▪ Kaweah Delta Health Care District (Institution)		Continued Accreditation
▪ Anesthesiology	15 residents	Initial Accreditation w/Warning
▪ Emergency Medicine	39 residents	Continued Accreditation
▪ Family Medicine	21 residents	Continued Accreditation
▪ Psychiatry	25 residents	Continued Accreditation
▪ Surgery	18 residents	Continued Accreditation
▪ Transitional Year	12 residents	Continued Accreditation

In accordance with ACGME requirements, each year the Program Directors submit an Annual Program Evaluation (APE). The APE is reviewed by the Vice President and Director of Graduate Medical Education. Their review consists of monitoring the criteria established in the Special Review Policy. This policy establishes criteria for identifying underperformance in the programs.

- Programs who fall below a certain threshold participate in the **Special Review Committee (SRC)** process. The Committee, appointed by the Vice President, consists of at least a Program Director, a Resident from another program and the Vice President.
- Programs who meet the criteria, but are in jeopardy of not achieving it, are assigned a **Progress Report (PR)**. The Progress Report is completed by the Program Director.

The attached spreadsheet, includes the details of each program's Progress Reports and Special Review Committees. As noted on the spreadsheet, each item has an assigned due date and is monitored by the Vice President as well as the GME Committee.

I.B.6. The GMEC must demonstrate effective oversight of underperforming program(s) through a Special Review process.

I.B.6.a) The Special Review process must include a protocol that:

I.B.6.a).(1) establishes criteria for identifying underperformance; and,

I.B.6.a).(2) results in a report that describes the quality improvement goals, the corrective actions, and the process for GMEC monitoring of outcomes.

THE FUTURE

Establishment of three institutional goals related to education for 2020-2021.

- a. Implementation of an ATLS Course.
- b. Achieve continued accreditation with no citations for all residency programs.
- c. Feasibility study for an Internal Medicine Residency.

PR

Trigger	Action plan	Timeline
Faculty survey: residents prepared for unsupervised practice	Provide faculty training on the question, which is asking "are residents prepared to to onto the next level of training	Sep-20

SRC

Trigger	Action Plan	Timeline
Resident Survey: Instruction on minimizing effects of sleep deprivation	Provide a lecture on sleep deprivation, fatigue mitigation and strategic napping to all residents, including interns. Clearly state that the lecture is being provided as part of the required curriculum of the ACGME. Going forward incorporate these types of lectures into the conference schedule, outside of the typical wellness days.	Dec-20
	Focus on developing relationships with the interns early in the program. Develop a system to incorporate the interns into the education sessions related to ACGME requirements. Create activities where the interns check in with the PD and Faculty, as well as each other.	Feb-21
	Update program orientation schedule to include lectures and sessions on ACGME requirements including sleep deprivation, wellness and fatigue mitigation. Clearly state that the lectures are being provided as part of the required curriculum of the ACGME.	Jun-21
Faculty Survey: Know how to report safety events	Provide faculty training upon hire	as needed
Faculty Survey: Process for confidential reporting of unprofessional behavior	Provide faculty training upon hire	as needed

PR

Trigger	Action plan	Timeline
Resident survey: Process in place for confidential reporting of unprofessional behavior	Department wide education on the MIDAS system. Introduce MIDAS to the residents, CRNA's, and Physicians at our Bi-Monthly meetings. Due to the volume of back-logged agenda items from COVID	Jan-21
Resident survey: Participate in adverse event analysis	Dr. Tang and Dr. Winston will work on assigning anesthesiology residents in systematic manner to be included on root cause analysis meetings (1 year and on going).	On going
Resident survey: Opportunity to evaluation program	In order to formalize the evaluation process, in addition to meeting with the program director, we will send a monthly survey-monkey to residents so that they can write their concerns as well as address them in our meetings.	Monthly starting Nov 2020

Anesthesia

Resident survey: 4 or more days free in 28 day period	All anesthesiology residents including interns must have 24 hours off/free in a 7 day period. In other words, grouping together of days off may result in violations if a resident were to group certain days off in the beginning of a rotation and subsequently group days off toward the end of the following rotation. In that sense, they may not receive 4 days off in the 28 day stretch that is the latter 2 weeks of 1 rotation and the beginning of the next rotation. Program leadership will monitor schedules.	Monthly starting Nov 2020
Faculty Survey: Satisfied with professional development and education	Dr. Stanley will attending our monthly faculty meetings and provide us with faculty development	Monthly starting Nov 2020

Trigger	Action plan	Timeline
Resident survey: Able to raise concerns without fear or intimidation	We will re-state and continue to affirm that there is no "blacklist" in this residency program and that our goal is for residents to succeed while here and to find a fulfilling job in the location of their choice upon graduation.	Oct-20
Resident survey: Satisfied with process for dealing with problems and concerns	We will go over the ACGME duty hour requirements again with the residents to ensure they understand that time off between shifts is based on <i>scheduled hours</i> while they are rotating in the emergency department. As there is concern about not logging hours they spend charting after the shift, we will encourage them to log those hours as well – if they wish – as "other rotation hours" with a comment to specify what they are doing during that time.	Oct-20
	The program evaluation committee meets quarterly and is attended by a peer-elected resident. At these meetings we discuss feedback from rotation evaluations and make plans for changes if they are indicated. The resident on the committee reports back to the other residents and a summary email is sent to all the residents with all the rotation evaluations that the committee reviewed, the PEC committee's minutes and plans following this meeting. Will label all e-mails covering in the future stating, "To close the loop on your feedback."	ongoing
	Once per block, during small groups sessions on conference days, each group will have a session meeting with the program director, where residents can ask questions, information can be disseminated, and follow-up can be made regarding issues or concerns that need to be addressed	monthly
	if residents would like another method to follow up on concerns, the program remains open to ideas and will query the residents for their thoughts on this.	Oct-20
	We have well-established mentoring/advising relationships, pairing each resident with a specific faculty member. We will pass along the feedback from residents that they would appreciate more frequent "checking in" from their faculty mentors and encourage the faculty to do so.	Oct-20
	We will add a link to the program website which will allow a resident to log an anonymous concern to be sent to the chief residents or program leadership.	Oct-20
	All residents have the ability to report through Midas anonymously and on the Compliance telephone number. The Compliance telephone number has been added to the opening page of New Innovations so that the residents can find it easily. The program plans to prep the residents before the next ACGME survey as to the multiple ways that anonymous feedback can be given.	21-Jan
Resident survey: Faculty effectively creates an environment of inquiry	Will ask the chiefs to debrief the residents in this area.	Nov-20
	Will include in the preparation before the next ACGME survey examples of faculty performance.	Jan-21

Resident survey: program fosters inclusive work environment	The reason for the score in this area is unclear. After discussing with Laura Goddard in human resources. The ACGME provides a set of slides to prep the residents for the meanings on the survey. It was decided to obtain the slides and provide information in this area prior to the next survey.	Jan-21
Resident survey: Diverse resident recruitment and retention	Program faculty and residents are participating in virtual residency fairs	Nov-20
	The program director has registered with the National medical student association (black medical student organization) to participate in a residency fair.	Nov-20
	Dr. Guzman and Dr. Herman are having the medical student presentation to cover http://tour4diversity.org/ . Hoping that some of the residents of cultural diverse groups will volunteer to be mentors.	Sep-20
	Dr. Donn, Dr. Dr. Liu and Dr. Bacon are hosting a question and answer session for medical students about our program including specific ones to underrepresented minority medical students	Oct-20
	Dr. Bacon is reaching out to Howard University's EMIG (Emergency Medicine Interest Group) to make plans to do a residency presentation. Will host a presentation to Howard University.	Nov-20
	The PD and APD will read the materials in the AAMC publication; Diversity and Inclusion Strategic Planning Toolkit	Nov-20
	The efforts of the EM administration will be shared with the residents prior to the next ACGME survey.	Jan-21
Faculty Survey: Faculty members act unprofessionally	Before sending out next survey, clarify questions regarding faculty members are for faculty in emergency medicine specifically. If there are issues with other services' faculty, these can be brought up in other areas.	Jan-21
	Specific incident brought up regarding an off-service faculty member. HR and the Program conducted an investigation. A meeting was held with the faculty member. Program will continue to monitor and survey residents in 6 months.	Apr-21
	Will continue to monitor EM faculty anonymous resident evaluations and feedback from colleagues regarding unprofessional activities or behaviors for concrete examples of EM specific unprofessionalism going forward. Will also monitor weekly conference evaluations during teaching sessions	Monthly

SRC

Trigger	Action plan	Timeline
Resident Survey: Instruction on minimizing effects of sleep deprivation	Work on addressing resident behavior to develop a culture of transitioning care when they are fatigued.	on going
	Ensure that off-service schedules provide at least 10 hours of time between scheduled duty periods with special consideration for continuity clinics	Dec-20
	Deliver didactic instruction on minimizing effects of sleep deprivation with a focus on system-based solutions.	Feb-21
	Have the EM program communicate better the number of shift expectations for EM and ICU. Also reinforce the 72hrs after a schedule has been published for the residents to highlight and bring forth concerns before the schedule is finalized.	Dec-20

Resident Survey: Able to raise concerns without fear or intimidation	FM program to provide evaluation of faculty members annually including a compilation of evaluations from residents and to include mutually agreed upon goals for the upcoming year.	Mar-21
	Begin to hold Quarterly town hall meetings (or the equivalent) to build trust between the program and the residents. And with this, empower chiefs to communicate and lead.	Jan-21
	A suggestion box was added in the FMC to serve as an additional avenue to raise concerns and serves as good strategic redundancy.	Oct-20
	Bring back Winning Wednesdays in some virtual way.	Jan-21
	Faculty development subcommittee to take message back to MEC for the non-core faculty a reminder on the importance of timely and specific feedback to residents. Assign LIFTs to noncore faculty in the FM program.	Jan-21
	Faculty indicated a need to improve work/life balance for both residents and faculty. As a proven method to accomplish this, the committee suggests the program hire at least one full-time core faculty before the end of the current academic year.	Jun-21

PR

Trigger	Action plan	Timeline
Resident survey: Able to attend personal appointments	Will discuss/encourage personal appointments during Wellness Days.	Nov-20
Resident survey: Process in place for confidential reporting of unprofessional behavior	Locked comment box will be placed in FMC.	Sep-20
Resident survey: Satisfied with process for dealing with problems and concerns	Locked comment box will be placed in FMC.	Sep-20
Resident survey: Process to transition care when fatigued	Program will survey residents about process to transition care when fatigued during annual Program Evaluation	Spring 2021
Resident survey: Diverse resident recruitment and retention	Chief residents to facilitate resident conversation seeking clarification	Sep-20

PR		
Trigger	Action plan	Timeline
Resident Survey: Education in assessing patient goals e.g. end of life care	Develop palliative care elective rotation for Psychiatry residents with Dr. Howard.	October-20
	Develop and provide lecture series on End of Life care to be given annually to PGy2 residents.	February-21
	First resident rotating on elective palliative care rotation.	February-21
	Re-survey residents to see if there has been in an improvement in their education for assessing patient goals (ie end of life care) and if gaps or concerns remain, we will develop a SIM session to address these gaps	May-21

SRC		
Trigger	Action plan	Timeline
Major resident concern regarding faculty	Dr. Anu Banerjee to meet privately with surgical residents during Tuesday conference to discuss patient safety, program concerns and confidentiality.	Dec-20
	Dr. Banerjee and Dr. Winston to discuss with Dr. Cassaro how to boost resident morale, increase trust and decrease feelings of hopelessness. Update on identified solutions will be provided to GMEC with timelines once action items on this are established	Dec-20
	Implement faculty development sessions and trainings every other month	Jan-21
	Consider Stoplight report or some other mechanism to communicate to the residents all program efforts that have been made regarding their concerns.	Jan-21
	Solicit improvement opportunities from residents regarding VA rotation and report to GMEC action items and estimated completion dates once identified.	Dec-20
	Discuss limitations with faculty about when it is appropriate to contact residents on their personal/off time.	Dec-20
	The surgery program is required to document annual evaluations of the core faculty. These documents have not been produced and this is not in compliance with ACGME requirements. Program must complete & document annual evaluations of all faculty and provide them to the Office of GME	Dec-20
	Complete a mock site visit to highlight other areas of potential ACGME noncompliance	Mar-21
	Place involved faculty member on probation with limited residency involvement until KDHC HR module on Harassment & Discrimination Prevention are completed and one AAMC course on Transforming Conflict into Collaboration or Being a Resilient Leader are completed.	Dec-20
	Review/consideration of appropriate faculty appointments based on performance evaluation and feedback	Jan-21
Average PGY3 resident ITE score is less than one standard deviation below the national average.	Family medicine program to explore creating consult team for medical management of the surgical patient. Dr. Martinez to discuss with Dr. Cassaro how to create space on FM service for the surgical patients needing medicine management.	Dec-20
	Organize faculty to deliver lectures on the rare conditions that are tested on the ABSITE.	Jan-21
	Implement consult structure similar to how ICU teams handle late/end of shift consults	Dec-20
	More oversight of nonclinical GME work production by faculty consistent with other GME faculty contracts (Completion with next ACTSS contract execution)	Jan-21
	More expectations/setting high standards discussion at orientation	Jun-21
	Faculty development regularly for all core faculty in the areas of QIPS, how to be a better educator, how to be a better surgeon and Wellness which is an ACGME common program requirement. (All faculty to complete at least one session in each area by the end of the AY June 2021)	Jun-21
PR		
Trigger	Action Plan	Timeline
Resident survey: Appropriate level of supervision	Identified one faculty member not providing appropriate supervision. Faculty member will be removed from first call roster.	Nov-20