June 24, 2022

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in the City of Visalia City Council Chambers {707 W. Acequia, Visalia, CA} on Wednesday June 29, 2022 beginning at 3:30PM in open session; at 3:31PM in a closed session pursuant to Health and Safety Code 1461 and 32155; at 4:00PM an open session and immediately following the 4:45PM open session, a closed meeting pursuant to Government Code 54956.9(d)(2), 54956.9(d)(2) and Health and Safety Code 1461 and 32155.

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

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

KAWEAH DELTA HEALTH CARE DISTRICT
Mike Olmos, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
Board Clerk / Executive Assistant to CEO

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

KAWEAH DELTA HEALTH CARE DISTRICT
BOARD OF DIRECTORS MEETING

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

Wednesday June 29, 2022

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 jurisdictions of the Board are requested to identify themselves at this time. For those who are unable to attend the beginning of the Board meeting during the public participation segment but would like to address the Board, please contact the Board Clerk (Cindy Moccio 559-624-2330) or cmoccio@kaweahhealth.org to make arrangements to address the Board.
4. **APPROVAL OF THE CLOSED AGENDA – 3:31PM**
   - 4.1. **Conference with Legal Counsel – Anticipated Litigation –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 8 Cases **–** *Ben Cripps, Vice President, Chief Compliance and Risk Officer and Rachele Berglund, Legal Counsel*
   - 4.2. **Conference with Legal Counsel – Anticipated Litigation –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 1 Case **–** *Rachele Berglund, Legal Counsel*
   - 4.3. **Conference with Legal Counsel – Existing Litigation**, Riaz v. Kaweah Health Medical Center, et al., Tulare County Superior Court Case 291575 – Pursuant to Government Code 54956.9(d)(1) – *Rachele Berglund, Legal Counsel*
   - 4.4. **Credentialing** - Medical Executive Committee (MEC) requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the MEC be reviewed for approval pursuant to Health and Safety Code 1461 and 32155 – *Gary Herbst, Chief Executive Officer*
   - 4.5. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee –– *Gary Herbst, Chief Executive Officer*
   - 4.6. **Approval of the closed meeting minutes** – May 25, 2022.

   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 June 29, 2022 closed meeting agenda.

5. **ADJOURN**

Mike Olmos – Zone 1 *Secretary/Treasurer* | *Lynn Havard Mirviss – Zone 2I* *Vice President* | *Garth Gipson – Zone 3* *Board Member* | *David Francis – Zone 4* *President* | *Ambar Rodriguez – Zone 5* *Board Member*

CLOSED MEETING AGENDA {3:31PM}

1. **CALL TO ORDER**
2. **CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 8 Cases

   Ben Cripps, Vice President and Chief Compliance and Risk Officer and Rachele Berglund, Legal Counsel
3. **CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 1 Case

   Rachele Berglund, Legal Counsel
4. **CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION**, Riaz v. Kaweah Health Medical Center, et al., Tulare County Superior Court Case 291575 – Pursuant to Government Code 54956.9(d)(1)

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

   Gary Herbst, Chief Executive Officer
6. **QUALITY ASSURANCE** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee.
   Gary Herbst, Chief Executive Officer
7. **APPROVAL OF THE CLOSED MEETING MINUTES** – May 25, 2022

   Action Requested – Approval of the closed meeting minutes – May 25, 2022.
8. **ADJOURN**

OPEN MEETING AGENDA {4:00PM}

1. **CALL TO ORDER**
2. **APPROVAL OF AGENDA**
3. **PUBLIC PARTICIPATION –** Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdictions of the Board are requested to identify themselves at this time. For those who are unable to attend the beginning of the Board meeting during the public participation segment but would like to address the Board, please contact the Board Clerk (Cindy Moccio 559-624-2330) or cmoccio@kaweahhealth.org to make arrangements to address the Board.

Mike Olmos – Zone I Secretary/Treasurer | *Lynn Havard Mirviss – Zone II Vice President* | *Garth Gipson – Zone III Board Member* | *David Francis – Zone IV President* | *Ambar Rodriguez – Zone V Board Member*

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

5. **OPEN MINUTES** – Request approval of the May 25 and June 15, 2022 open minutes.

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

Action Requested – Approval of the open meeting minutes May 25 and June 15, 2022 open board of directors meeting minutes.

6. **RECOGNITIONS** – *Garth Gipson*

6.1. Presentation of Resolution 2166 to Scott Ritchie, in recognition as the Kaweah Health World Class Employee of the Month recipient – June 2022.

6.2. Presentation of Resolution 2167 to Maria Hernandez retiring from Kaweah Health after 15 years of service.

7. **INTRODUCTIONS – NEW DIRECTORS**

7.1. Lori Mulliniks, Kaweah Health Medical Group Chief Financial Officer

7.2. Theresa Croushore, Director - Behavioral Health Service Line

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

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

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

9. **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 June 29, 2022 Consent Calendar.

Mike Olmos – Zone I *Secretary/Treasurer* | *Lynn Havard Mirviss – Zone II* *Vice President* | *Garth Gipson – Zone III* *Board Member* | *David Francis – Zone IV* *President* | *Ambar Rodriguez – Zone V* *Board Member*

9.1. REPORTS

A. Compliance

B. Physician Recruitment

C. Environment of Care

9.2. Approval of the amended Kaweah Delta Health Care District dba Kaweah Health Conflict of Interest Code to update designated employee positions titles.

9.3. As reviewed and approved by the Medical Executive Committee - approval of the Kaweah Delta Health Care District Medical Staff Policy: Guidelines for Privacy Violations.

9.4. Board approval to authorize Marc Mertz, Chief Strategy Officer and/or Deborah Volosin, Director of Community Engagement, to complete the County of Tulare Voter Registration and Elections application to access voter registration on the Kaweah Delta Health Care District dba Kaweah Health Board's behalf.

9.5. Approval of notice of denial of application to file late claim, in part, of Christopher Renfro v. Kaweah Delta Health Care District.

9.6. Acceptance of Application to file late claim and rejection, in part, of claim of Christopher Renfro v. Kaweah Delta Health Care District.

9.7. Approval of notice of rejection of claim of Christopher Renfro (relating to employment loss).

9.8. Medical Executive Committee (June 2022)

A. Nurse Practitioner / Physician Assistant privilege form (revised)

9.9. Compliance Policies as reviewed at the Audit and Compliance Committee meeting on June 1, 2022.

A. CP.01 – Compliance Program Administration

B. CP.03 – Physician Contracts and Relationships

C. CP.05 – Compliance and Privacy Issues Investigation and Resolution

D. CP.06 – Compliance Program Education

E. CP.07 – Excluded Individuals_Entities

F. CP.10 – Compliance Reviews and Assessments

G. CP.13 – Federal and State False Claims Act and Employee Protection Provisions

9.10. Human Resources Policies as reviewed at the Human Resources Committee on May 4, 2022.

A. Event Participation Pay {new}

B. COVID.38 Team Member COVID-19 Symptomatic Testing {new}

C. COVID.36 Team Member COVID-19 Vaccination and Asymptomatic Surveillance Testing {new}

Mike Olmos – Zone I Secretary/Treasurer | *Lynn Havard Mirviss – Zone II Vice President* | *Garth Gipson – Zone III Board Member* | *David Francis – Zone IV President* | *Ambar Rodriguez – Zone V Board Member*

Kaweah Health

D. HR.216 Progressive Discipline {revised}
E. HR.66 Payroll Deductions {reviewed}
F. HR.17 Language Resource Assistant Program {reviewed}
G. HR.242 Personal Medical Leave {reviewed}
H. HR.147 Pregnancy Disability Leave of Absence {reviwed}
I. HR.75 Differential Pay-Shift, Holiday, Weekend {reviewed}
J. HR.65 Payment of Wages {reviewed}
K. HR.74 Telecommuting {reviewed}
L. HR.236 Computer and Communication Devices and Social Media Code of Conduct {reviewed}
M. HR.148 Personal Leave of Absence {reviewed}
N. HR.243 Leave of Absence {reviwed}
O. HR.173 Employee Emergency Relief {reviewed}
P. HR.234 Extended Illness Bank (EIB) Donations {reviewed}

9.11. Environment of Care Policies

A. Safety Management Plan - EOC 1001 Revised
B. Security Management Plan - EOC 3000 Revised
C. Hazardous Materials and Waste Management Program - EOC 4001 Revised
D. Fire Prevention Management Plan - EOC 5000 Revised

9.12. Emergency Management Policies

A. Code Gray Activation - DM 2203 Revised
B. Code Purple - DM 2206 Revised
C. Water Systems Failure Disruption - DM 2216 Revised
D. Total Evacuation Plan - DM 2810 Revised

9.13. Administrative Policies

A. Use of District name and/or stationery – AP27
B. Catering Guidelines – AP39
C. Quality Improvement Plan – AP41
D. Chaplain Clergey – AP100
E. Critical Incident Stress Management – AP129
F. Messenger Model Guidelines for Managed Care Contracting for Physicians – AP164
G. Use of Medical/Allied Health Staff Personal Information – AP170
H. Bridge Policy for Federal Grants – AP179
I. Complimentary Meal Ticket –AP131 (Delete)

Mike Olmos – Zone I Secretary/Treasurer | *Lynn Havard Mirviss – Zone II Vice President* | *Garth Gipson – Zone III Board Member* | *David Francis – Zone IV President* | *Ambar Rodriguez – Zone V Board Member*

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10. **STRATEGIC PLAN** – Review and requested approved of the Strategic Plan for fiscal year 2022/2023.

Suzy Plummer, Director of Project Management and Consulting Office, Joseph Palermo, Senior Consultant, and Diana Saechao, Senior Consultant

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

Action Requested – Approval of the Strategic Plan for fiscal year 2022/2023.

11. **PATIENT THROUGHPUT PERFORMANCE** - Review of patient throughput performance improvement progress report.

Keri Noeske, Chief Nursing Officer

12. **QUALITY – ANNUAL INFECTION PREVENTION** - A review of key quality measures and improvement actions associated with care of the maternal child health population.

Shawn Elkin, MPA, BSN, RN, PHN, CIC, Kaweah Health Infection Prevention Manager

13. **2022/2023 ANNUAL OPERATING AND CAPITAL BUDGET** – Review of the annual operating and capital budget.

Malinda Tupper – Chief Financial 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.

Recommended action: Approval of the 2022/2023 Annual Operating and Capital Budget

14. REPORTS

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

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

15. 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.

Mike Olmos – Zone I Secretary/Treasurer | *Lynn Havard Mirviss – Zone II Vice President* | *Garth Gipson – Zone III Board Member* | *David Francis – Zone IV President* | *Ambar Rodriguez – Zone V Board Member*

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MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD WEDNESDAY MAY 25, 2022 AT 4:30PM, IN THE CITY OF VISALIA CITY COUNCIL CHAMBERS – 707 W. ACEQUIA, VISALIA, CA.

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

The meeting was called to order at 4:30PM by Director Francis.

Director Francis entertained a motion to approve the agenda.

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

PUBLIC PARTICIPATION – None

APPROVAL OF THE CLOSED AGENDA – 4:31PM

- **Credentialing** - Medical Executive Committee (MEC) requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the MEC be reviewed for approval pursuant to Health and Safety Code 1461 and 32155 – *Monica Manga, MD Chief of Staff*
- **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee — *Monica Manga, MD Chief of Staff*
- **Approval of the closed meeting minutes** – April 27, 2022.

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 – No public present.

MMSC (Havard Mirviss/Gipson) to approve the May 25, 2022 closed agenda. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

ADJOURN - Meeting was adjourned at 4:31PM

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

ATTEST:

Mike Olmos, 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 WEDNESDAY MAY 25, 2022 AT 4:45PM, IN THE CITY OF VISALIA CITY COUNCIL CHAMBERS – 707 W. ACEQUIA, VISALIA, CA.

PRESENT: Directors Francis, Gipson, Olmos & Rodriguez; G. Herbst, CEO; M. Manga, MD, Chief of Staff, K. Noeske, VP& CNO; M. Tupper, CFO; M. Mertz, Chief Strategy Officer; D. Leeper, Chief Information and Cybersecurity Officer & R. Gates, Chief Population Health Officer; J. Batth, Chief Operating Officer; B. Cripps, Chief Compliance Officer, L. Winston, MD, Chief Institutional Officer; R. Berglund, Legal Counsel; and K. Davis, recording

The meeting was called to order at 4:46pm by Director Francis.

Director Francis asked for approval of the agenda.

MMSC (Gipson/Havard Mirviss) 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: Approval the closed minutes from April 27, 2022.

OPEN MINUTES – Request approval of the open meeting minutes April 27 and May 17, 2022.

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 (Olmos/Havard Mirviss) to approve the open minutes from April 27 and May 17, 2022. This was supported unanimously by those present. Vote: Yes – Gipson, Olmos, Havard Mirviss, Rodriguez, and Francis.

RECOGNITIONS – Employee of the Month, Minerva Aceves. Patient Safety Heroes of the Year, Barbara Roldan and Sunny Attygalle. Directors: Melissa Quinonez, Director of Mental Health Services, and Leah Daugherty, Director of ISS Clinical Informatics.

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 Francis requested a motion for the approval of the credentials report.

MMSC (Gipson/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 – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

CHIEF OF STAFF REPORT – Report from Monica Manga, MD – Chief of Staff.

- Dr. Managa noted the Goal Committee has been established and the meetings have started. This initiative is led by Dr. Seng.

PATIENT THROUGHPUT PERFORMANCE - Review of patient throughput performance improvement progress report (copy attached to the original of these minutes and considered a part thereof) – Jag Batth, Chief Operating Officer; The Chartis Group: Martha Bailey, Mark Krivopal

CONSENT CALENDAR – Director Francis entertained a motion to approve the consent calendar (copy attached to the original of these minutes and considered a part thereof). Mr. Olmos pulled consent calendar item 11.1 D.

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 (Gipson/Havard Mirviss) to approve the consent calendar as submitted. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis.

QUALITY REPORT – Cardiac Surgery – A review of key quality measures through the Society of Thoracic Surgery, and associated action plans related to the quality of care for the cardiac surgical population (copy attached to the original of these minutes and considered a part thereof) - *Fred Mayer, MD and Tracy Salsa, Director of Cardiovascular Service Line*

QUALITY REPORT – Surgical Quality Improvement – A review of key indicators and actions related to the quality of care for the surgical population. (copy attached to the original of these minutes and considered a part thereof) - *LaMar Mack, MD and Brian Piearcy, Director of Surgical Services*

MENTAL HEALTH SERVICES GRANT – Review and discussion relative to a State grant opportunity for adult mental health services including proposed plans and financial pro forma (copy attached to the original of these minutes and considered a part thereof) - *Marc Mertz – Chief Strategy Officer*

ANNUAL INSTITUTIONAL REVIEW – Graduate Medical Education annual institutional review - (copy attached to the original of these minutes and considered a part thereof) - *Lori Winston, MD, FACEP, Chief Medical Education Officer, Designated Institutional Official*

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

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

- Mr. Herbst noted that COVID numbers are rising. We have gone from 6 to 22 patients. 21 adults and 1 child with 1 in the ICU who is not on a ventilator. We are up to 57 employees who are out on a COVID leave of absence. Our occupancy rate today is 99.4%.
- We continue to recruit for a Chief Quality Officer.
- Our Hospital Foundation is ending our Modernization Campaign and about to kick off our Modernization 2.0 Campaign which will invest in our physicians and employees work environment.

BOARD PRESIDENT REPORT – Report from David Francis, Board President

- No report.

APPROVAL OF CLOSED AGENDA AS FOLLOWS: Closed Meeting Agenda – Immediately following the 4:45PM open session

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

Conference with Labor Negotiator – Discussion with Agency Designated Representative Rachele Berglund regarding terms for Chief Executive Officer contract pursuant to Government Code 54957.6.

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/Gipson) to approve the closes session following the 4:45PM open session; CEO Evaluation and Conference with Labor Negotiator. This was supported unanimously by those present. Vote: Yes – Gipson, Olmos, Havard Mirviss, Rodriguez, and Francis.

ADJOURN - Meeting was adjourned at 7:38 PM

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

ATTEST:

Mike Olmos, 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 WEDNESDAY JUNE 15, 2022 AT 3:30PM, AT SEQUOIA REGIONAL CANCER CENTER MAYNARD FAUGHT CONFERENCE ROOM – 4945 W. CYPRESS AVENUE, VISALIA, CA.

PRESENT: Directors Francis, Havard Mirviss, Gipson, & Olmos; G. Herbst, CEO; K. Noeske, VP& CNO; M. Tupper, CFO; M. Mertz, Chief Strategy Officer; D. Leeper, Chief Information and Cybersecurity Officer & R. Gates, Chief Population Health Officer; J. Batth, Chief Operating Officer; B. Cripps, Chief Compliance Officer, R. Berglund, Legal Counsel; and K. Davis, recording

The meeting was called to order at 3:34PM by Director Francis.

Director Francis entertained a motion to approve the agenda.

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

PUBLIC PARTICIPATION – None

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

- Following the presentation, the Board consensus was that we budget for a loss and issue a press release similar to what other hospitals are doing. It was suggested that we utilize Chartis to benchmark outcomes and measure department FTE efficiencies.

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

- No Report.

BOARD PRESIDENT REPORT – Report from David Francis, Board President

- No Report.

ADJOURN - Meeting was adjourned at 5:42PM

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

ATTEST:
Mike Olmos, Secretary/Treasurer
Kaweah Delta Health Care District Board of Directors

RESOLUTION 2166

WHEREAS, the Department Heads of the KAWEAH DELTA HEALTH CARE DISTRICT dba KAWEAH HEALTH are recognizing Scott Ritchie, with the World Class Service Excellence Award for the Month of June 2022, for consistent outstanding performance, and,

WHEREAS, the Board of Directors of the KAWEAH DELTA HEALTH CARE DISTRICT is aware of his excellence in caring and service,

NOW, THEREFORE, BE IT RESOLVED that the Board of Directors of the KAWEAH DELTA HEALTH CARE DISTRICT on behalf of themselves, the hospital staff, and the community they represent, hereby extend their congratulations to Scott for this honor and in recognition thereof, have caused this resolution to be spread upon the minutes of the meeting.

PASSED AND APPROVED this 29th day of June 2022 by a unanimous vote of those present.

President, Kaweah Delta Health Care District

ATTEST:

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

Scott Ritchie, just been recognized by, Randall Kokka on 5/20/2022

Comments: Every day, behind the scenes, thousands and thousands of lab tests are performed. Throughout our organization, diagnosis and treatment decisions are dependent on timely and accurate lab results. Many do not know this, but two years ago we were in desperate need of technical leadership in our highest volume area, Clinical Chemistry. It was a daunting situation: we perform millions of tests annually in this area and we were about to embark on the most complex and challenging expansion project in the history of the Kaweah clinical laboratory. Very few people would be willing, or qualified, to take this on, but Scott Ritchie voluntarily stepped forward when we needed him most and assumed the role of Section Chief of Chemistry. He has performed beyond expectations. Scott has always been one of the most popular members of our team because of his pleasant personality and positive attitude and now we are seeing his leadership qualities grow exponentially by the day. He is intelligent, very hard-working, collaborative, highly competent technically and humble. As we progress into the next phase of our construction project, I can think of no one who is better to lead this than Scott. We are very fortunate to have him here with us. By the way, this week, Scott was recognized by the California Association for Medical Technology (our State professional organization) as the "2022 Lab Person of the Year". He obviously represents our Lab, and Kaweah Health, in the best possible way. We believe it is time to recognize him in our own organization.

RESOLUTION 2167

WHEREAS, Maria Hernandez 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 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 Maria 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 29th day of June 2022 by a unanimous vote of those present.

President, Kaweah Delta Health Care District

ATTEST:

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

Compliance Program Activity Report – Open Session

February 2022 through April 2022

Ben Cripps, Chief Compliance & Risk Officer

Education

Live Presentations

- Compliance and Patient Privacy – Management Orientation
- Operational Compliance Educational Update – Kaweah Health Medical Group
- Privacy Training – Patient and Family Services Department

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

- Compliance and Patient Privacy – New Hire 48 Hour Checklist
- Identify Theft Detection, Prevention, and Mitigation
- FairWarning
- Privacy Compliance in the Healthcare Setting
- Code of Conduct
- Guidelines for Releasing PHI to Law Enforcement
- Mandatory Annual Training (MAT) – Compliance and Privacy

Prevention & Detection
Continuous

Review and Distribution of:

- California Department of Public Health (CDPH) All Facility Letters (AFL)
- Medicare and Medi-Cal Monthly Bulletins
- Office of Inspector General (OIG) Monthly Audit Plan Updates
- California State Senate and Assembly Bill Updates
- Patient Privacy Walkthrough
- User Access Privacy Audits
- Office of Inspector General (OIG) Exclusion Attestations
- Medicare PEPPER Report Analysis

Oversight, Research & Consultation
Ongoing

- Fair Market Value (FMV) Oversight
- Medicare Recovery Audit Contractor (RAC) and Medicare Probe Audit Activity
- Licensing Applications
- KD Hub Non-Employee User Access
- COVID-19 Incident Response
- Medicare Conditions of Participation (CoP) with Discharge, Transfer Notifications
- Business Associate Agreements

Oversight, Research & Consultation

New

Record Retention: ED Call Logs – Research and consultation on retention of digital recorded information for the Transfer Center, Case Management (CM) and Patient Family Services (PFS) call logs. The California Hospital Association (CHA) Retention guidelines were reviewed and findings were provided to leadership.

Mental Health Patients in Acute Setting – Research and consultation on acute care admission and attending privileges for psychiatrists. Research confirmed that psychiatrists may admit patients to an acute care hospital and serve as the attending physician when privileges have been granted by the facility. Medical Staff confirmed Kaweah Health admitting physician and privilege forms for psychiatrists apply to all inpatient sites. Research and findings were provided to leadership and physicians.

Physician Assistant (PA) in Radiology Treating Fluoroscopy Patients – Research and consultation regarding a PA's ability to perform and bill Medicare for fluoroscopy procedures. Research confirmed that PAs may perform and bill for Fluoroscopy procedures with proper credentialling and certification. Research and findings were provided to leadership.

Oversight, Research & Consultation

New

Health and Human Services (HHS) Office of Civil Rights (OCR) Investigation – Responded to an OCR investigation alleging that Kaweah Health failed to provide a copy of medical records to a patient upon request. The investigation confirmed Kaweah Health made multiple attempts to contact the patient via phone and email and fulfilled the record request via the third-party medical records platform. An official response was sent to the OCR regional manager. On May 17, 2022, Kaweah Health received a Closure Notification Letter from the OCR citing no deficiencies.

COVID Related Matters –Research and consultation for questions related to visitor log retention and masking exemptions in outpatient settings. Research and findings were provided to leadership.

GoTo Meeting Recording Guidance – Research and consultation on the recording of virtual meetings. Leadership communications from the Compliance Office discouraged recordings citing concerns related to the Public Records Act. Research and findings were provided to the requestor.

Glucose Tolerance Test Protocols – Research of a concern regarding glucose administration for glucose lab testing. Research concluded that Kaweah Health has two policies (one for pregnant patients and one for non-pregnant patients) related to the administration of glucose tolerance tests. Following discussion with Lab Leadership and the Medical Director, the policies were combined to establish dosing consistency between the two.

Oversight, Research & Consultation

New

Superior Office Solutions – Investigated and resolved a concern regarding Kaweah Health's failure to remit payment to Superior Office Solutions for services rendered in 2017. Research concluded that Kaweah Health had not submitted payment for the services. On February 2, 2022, Kaweah Health entered into a Settlement Agreement with Superior Office Solutions, LLC. Payment was sent on February 25, 2022.

Oversight, Research & Consultation

Update

Operational Compliance Committee:

- Developed audit protocols for several departments within Kaweah Health Medical Group (KHMG) to assess regulatory compliance. Findings have indicated satisfactory compliance within focused areas. Process standardizations have been incorporated including best practices with educating staff, roll out of regulatory updates, and updating of patient forms.

- Implemented the use of a formal Education Log. Documentation of education provided to teams each month is maintained within the department dashboard for ongoing tracking.

- Enhancement to the Operational Compliance dashboard to track department policies and upcoming expiration dates. This enhancement has allowed the leaders to ensure they are proactively working on policies prior to expiration. Additionally, the Patient Accounting Department has expanded the use of the dashboard to include tracking updates for their job descriptions.

Oversight, Research & Consultation
Update

Operational Compliance Committee (Continued)

- Cross-departmental collaboration: Operational Compliance has become a conduit for encouraging cross-departmental collaboration for issues that otherwise were not being addressed.
- Proactive notification of potential issues: The Operational Compliance committee has allowed uninterrupted time between department leaders and Compliance to share concerns that may arise, preventing potential compliance issues.
- Phase II Implementation: Over the next 6 – 12 months, the following departments will be engaged to develop an Operational Compliance Committee: laboratory, diagnostic imaging, pharmacy, rural health clinics.

Auditing & Monitoring
New

- Patient Status Audit – An internal coding review of thirty-five (35) randomly selected Medicare encounters was completed to evaluate compliance with Medicare billing guidelines for Observation, Short Stay and Outpatient Surgery Patients. The audit noted an accuracy rate of 100%. The results have been shared with Case Management, Patient Access and Patient Accounting leadership.

- Medicare Secondary Payor (MSP) Claims Review – An external review of thirty (30) Medicare encounters to evaluate MSP billing compliance. The audit noted a 100% compliance rate for MSP billing. The results of the review have been shared with Patient Accounting Leadership. The results have been shared with Patient Accounting leadership.

Live with passion.

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

Physician Recruitment and Relations

Medical Staff Recruitment Report - June 2022

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

Date prepared: 6/16/2022

Central Valley Critical Care Medicine	
Intensivist	2

Delta Doctors Inc.	
OB/Gyn	1

Frederick W. Mayer MD Inc.	
Cardiothoracic Surgery	2

Kaweah Health Medical Group	
Audiology	1
Dermatology	2
Endocrinology	1
Family Medicine	3
Gastroenterology	2
Neurology	1
Orthopedic Surgery (Hand)	1
Otolaryngology	2
Pulmonology	1
Radiology - Diagnostic	1
Rheumatology	1
Urology	3

Oak Creek Anesthesia	
Anesthesia - Critical Care	1
Anesthesia - General	4
Anesthesia - Obstetrics	1
CRNA	3.5

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

Other Recruitment	
Neurology - Inpatient	1

Sequoia Cardiology Medical Group	
EP Cardiology	1

Sequoia Oncology Medical Associates Inc.	
Hematology/Oncology	1

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

Candidate Activity						
Specialty/Position	**Group**	**Last Name**	**First Name**	**Availability**	**Referral Source**	**Current Status**
Anesthesia	Oak Creek Anesthesia	Aijaz, M.D.	Tabish	08/23	Medicus Firm - 5/1/22	Currently under review
Anesthesia	Oak Creek Anesthesia	Goldenmerry, M.D.	Yoaul	10/23	Medicus Firm - 4/5/22	Site Visit: 6/24/22
Anesthesia	Oak Creek Anesthesia	Kim, D.O.	Christopher	08/23	Medicus Firm - 3/16/22	Currently under review
Anesthesia	Oak Creek Anesthesia	Olalemi, M.D.	Hafeez	08/23	Comp Health - 5/10/22	Currently under review
Anesthesia	Oak Creek Anesthesia	Sanguino, M.D.	Luis	08/23	Curative - 3/30/22	Site visit pending dates
Anesthesia	Oak Creek Anesthesia	Sinha, M.D.	Ashish	05/22	Medicus Firm - 2/16/22	Site Visit: 4/5/22; Hospital credentialing in progress
Anesthesia - Cardiac	Oak Creek Anesthesia	Nagm, M.D.	Hussam	06/22	Direct/Referral	Site Visit: 11/9/21; Tentative Start Date: 6/1/22
Cardiothoracic Surgery	Independent	Williams, M.D.	Julio	08/22	Direct - 4/19/22	Initial Screening: 4/22/22
Certified Registered Nurse Anesthetist	Oak Creek Anesthesia	Havlicak	Ashley	01/23	Direct/Referral	Offer accepted
Certified Registered Nurse Anesthetist	Oak Creek Anesthesia	Liu	Jia	03/23	Comp Health - 5/16/22	Currently under review
Certified Registered Nurse Anesthetist	Oak Creek Anesthesia	Petersen	Lucille	07/22	Direct - 6/15/22	Offer accepted
Certified Registered Nurse Anesthetist (Part-Time)	Oak Creek Anesthesia	Mendoza	Mayra	ASAP	Direct	Hospital credentialing in progress
Chief Medical Officer/Medical Director	Kaweah Health Medical Group	Quackenbush, M.D.	Todd	ASAP	Direct - 3/1/22	Interview: 3/28/22; Offer accepted; contract in process
Family Medicine	Kaweah Health Medical Group	Vanegas, M.D.	Alvin	ASAP	Direct email	Currently under review
Family Medicine Core Faculty	Kaweah Delta Faculty Medical Group	Rangel-Orozco, M.D.	Daniela	08/22	Kaweah Health Resident	Site Visit: 10/28/21; Offer accepted; Start Date: 8/1/22
Hospitalist	Valley Hospitalist Medical Group	Kaur, M.D.	Kamalmeet	08/22	Direct	Offer accepted; Tentative Start Date: August 2022
Intensivist	Central Valley Critical Care Medicine	Athale, M.D.	Janhavi	09/22	Comp Health - 1/6/22	Offer extended; contract under review
Intensivist	Central Valley Critical Care Medicine	De Freese, M.D.	Marissa	TBD	Direct/referral - 1/18/22	Site visit pending dates
Intensivist	Central Valley Critical Care Medicine	Khanuja, M.D.	Simrandeep	TBD	Comp Health - 6/2/22	Currently under review
Intensivist	Central Valley Critical Care Medicine	Sourial, M.D.	Mina	09/22	PracticeMatch - 4/11/22	Offer pending

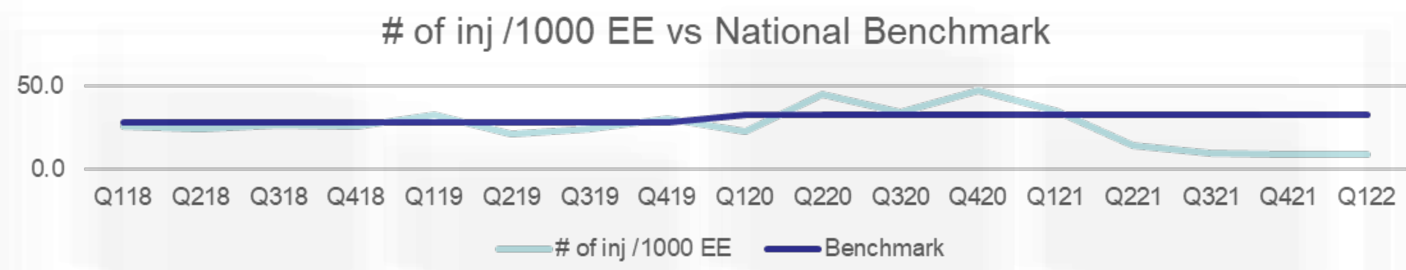
Candidate Activity						
Specialty/Position	**Group**	**Last Name**	**First Name**	**Availability**	**Referral Source**	**Current Status**
Internal Medicine	Kaweah Health Medical Group/Key Medical Associates	Virk, D.O.	Harman	09/23	Direct email	Currently under review
Interventional Radiology	Mineral King Radiology Group	Youssef Ali, M.D.	Mahmoud	09/23	PracticeLink - 6/6/22	Currently under review
Internal Medicine/Sleep Medicine	Kaweah Health Medical Group	Sarrami, M.D.	Kayvon	08/22	Direct - 11/27/21; Fiancé is current 2nd Year Anesthesia Resident at KH.	Site Visit: 1/10/22; Offer accepted; Tentative Start Date: August 2022
Medical Oncology	Sequoia Oncology Medical Associates	Mohammadi, M.D.	Oranus	08/23	PracticeMatch - 3/31/22	Site visit pending dates in September
Medical Oncology	Sequoia Oncology Medical Associates	Palla, M.D.	Amruth	08/22	Direct/referral - 1/26/22	Site visit pending dates (Nov/Dec 2022 - Tentative)
Neonatology	Valley Children's	Agrawal, M.D.	Pulak	08/23	Valley Children's - 5/14/22	Site Visit: 6/30/22
Neonatology	Valley Children's	Al Kanjo, M.D.	Mohamed	08/23	Valley Children's - 3/14/22	Site Visit: 4/7/22; Offer pending
Neonatology	Valley Children's	Nwokidu-Aderibigbe, M.D.	Uche	08/23	Valley Children's - 5/14/22	Site Visit: 6/17/22
Neonatology	Valley Children's	Sharma, M.D.	Amit	TBD	Valley Children's - 3/1/22	Site Visit: 3/29/22; Offer extended
Neonatology	Valley Children's	Singh, M.D.	Himanshu	08/22	Valley Children's - 3/31/21	Site Visit: 4/19/2021; Offer accepted. Start date 8/29/2022
Nephrology	Independent	Sourial, M.D.	Maryanne	ASAP	Direct - Dr. Mina Sourial's spouse	Site Visit: 5/13/22
Pediatric Cardiology	Valley Children's	Ozdemir, M.D.	Ege	08/22	Valley Children's - 3/1/22	Site Visit: 3/23/22; Offer extended
Pediatric Hospitalist	Valley Children's	Mittal, M.D.	Daaman	07/22	Valley Children's - 2/17/22	Site visit: 2/21/22; Offer accepted; Start Date: 8/1/22
Pediatrics	Kaweah Health Medical Group	Galindo, M.D.	Ramon	09/22	Direct/referral - 6/28/21	Site visit: 9/14/21; Offer accepted; Tentative Start Date: 08/2022
Pediatrics	Kaweah Health Medical Group	Renn, M.D.	Caitlin	05/22	LocumTenens.com	Offer accepted; Start Date: 5/23/22
Psychiatry	Precision Psychiatry	Kumar, M.D.	Rachna	07/22	Kaweah Health Resident	Offer accepted
Psychiatry	Precision Psychiatry	Sangani, M.D.	Arul	07/22	Kaweah Health Resident	Offer accepted
Radiology - Diagnostic	Kaweah Health Medical Group	Noorani, D.O.	Azeem	TBD	Staff Care - 6/13/22	Tentative Site Visit: 7/18/22

Candidate Activity						
Specialty/Position	**Group**	**Last Name**	**First Name**	**Availability**	**Referral Source**	**Current Status**
Rheumatology	Kaweah Health Medical Group	Li, M.D.	Zi Ying (Kimmie)	08/22	Direct - 11/27/21	Phone Interview: 12/15/21; Site Visit: 4/5/22; Will decide on location in November 2022.
Urology	Kaweah Health Medical Group	Aram, M.D.	Pedram	07/23	PracticeMatch - 3/1/22	Site Visit: 5/26/22
Urology	Kaweah Health Medical Group	Chopra, M.D.	Sameer	02/23	Direct Referral	Currently under review

Environment of Care
1st Quarter Report
Jan 1, 2022 through March 31, 2022
Presented by
Maribel Aguilar, Safety Officer
559-624-2381

EOC: SAFETY & QIC: SAFETY

Performance Standard: Employee Health: Challenge ourselves to reduce OSHA recordable injuries: In 2018 we had 238 injuries, 2019 - 215 injuries, 2020 - 196 injuries, and 207 total for 2021. Our goal for 2022 is 200 injuries or less.



Evaluation:

- 45 OSHA recordable injuries in Qtr 1-2022 , plus 84 Covid 19 claims
- Covid 19 vaccination began 12/18/20, boosters began Oct 2021
- Provided 14 ergo evaluations
- 2022 Sharps Exposure- Quarter 1—11 total (6 -GME)
- Influenza vaccination rate 2021-2022 80%

Type of injury	Q1	Q2	Q3	Q4	Totals 2022	Totals 2021	Per 1000 employees	Annualized # of injuries
Total Incidents	185				178	448	35.84	740
Covid 19+	84					310	16.27	336
OSHA recordable	45					207	8.72	180
Lost time cases	104					379	20.15	416
Strain/sprain	30					116	5.81	120
Sharps Exp	11					78	2.13	44
# EE end of QTR	5162				5162			

- **Plan for Improvement:**
- Continue to work with Infection Prevention to decrease Covid 19+ exposures/ claims by Health Care Workers in 2022.
- Identify employees with ≥ 3 OSHA recordable injuries in last 2 year --EHS speaks with managers directly noting any trends per employee and/or injuries.
- Same day on-site incident investigation with employee. Follow-up with manager for prevention opportunities and/or process changes and policy review. Investigation/ follow-up may include photos, video and interview of witnesses/ manager.
- Increase Sharps education in General Orientation by Infection Prevention and Manager orientation by EHS. Demo correct sharps activation in new hire physicals with all employees handling sharps.
- Utilize PTA in Employee Health for Ergo evaluations, evaluate for proper body mechanics to prevent injury, stretching exercises and equipment recommendations to ensure safety with our jobs.

OSHA recordable injuries and Illnesses are as follows:

- Fatalities (reportable)
- Hospitalizations (reportable)
- Claim with lost work day, or modified work with restrictions (recordable)
- Medical treatment other than First Aid (recordable)

Total Incidents include First Aid and Report Only,

SAFETY (Infection Prevention)

First Quarter 2022

Infection Prevention Component:	**INFECTION PREVENTION COMPREHENSIVE ROUNDS**
Performance Standard:	**Comprehensive Rounds -** Each infection prevention based element of performance and/or environment-of-care criteria meets at least 90% compliance during unit/department rounds performed twice annually. **Goal:** >90% compliance rate. **Minimum Performance Level:** 90% compliance rate.

Evaluation:

Overall compliance rate for infection prevention elements during rounds in Q1 2022: 69.4%

Eleven inpatient units, KHMG, Tulare, Exeter clinics, Lab, Food Services, and SPD were surveyed in Q1 2022.

Elements of highest performance:

Patients on transmission based precautions per Infection Prevention policy.
PPE is available, worn and stored appropriately.
Staff members can verbalize Infection Prevention principles.

Elements of lowest performance:

Environment is clean, organized, and without factors that increase risk of infection.
Patient Nutrition Area is kept in accordance with Infection Prevention principles.
Medication Room is maintained in accordance with Infection Prevention principles.

General Areas (Inpatient Areas and Clinics): Infection Prevention Element Compliance	Rate %
Staff members can verbalize Infection Prevention principles.	93.9
Adherence to Kaweah Health's Hand Hygiene policies and procedures.	78.1
PPE is available, worn and stored appropriately.	96.8
Environment is clean, organized, and without factors that increase risk of infection.	41.9
Equipment is visibly clean and in working condition.	87.5
Hospital approved cleaner/disinfectant available and properly maintained.	84.4
Clean Supply Room maintained in accordance with Infection Prevention principles.	71.9
Dirty Supply Room is maintained in accordance with Infection Prevention principles.	62.5
Linens is maintained in accordance with Infection Prevention principles.	75.0
Patient care environment maintained in accordance with Infection Prevention principles.	74.2
Patients on transmission based precautions per Infection Prevention policy.	100
Patient Nutrition Area is kept in accordance with Infection Prevention principles.	50.0
Medication Room is maintained in accordance with Infection Prevention principles.	35.5
Staff Workspace maintained in accordance with Infection Prevention principles.	78.1
Staff Kitchen/Lounge is maintained in accordance with Infection Prevention principles.	81.3
Specialty Areas: Overall Area Compliance	**Rate %**
Laboratory Areas	90.3
Food Services Areas	91.0
Sterile Processing Areas	100

Plan for Improvement:

Action plans from each area requested for items out of compliance. Leaders of the area are required to submit in writing their actions to correct the items out of compliance. Infection Prevention will follow up with manager or director as appropriate.

Collaboration continued with Emergency Department leadership and weekly rounding conducted in Q1 2022.

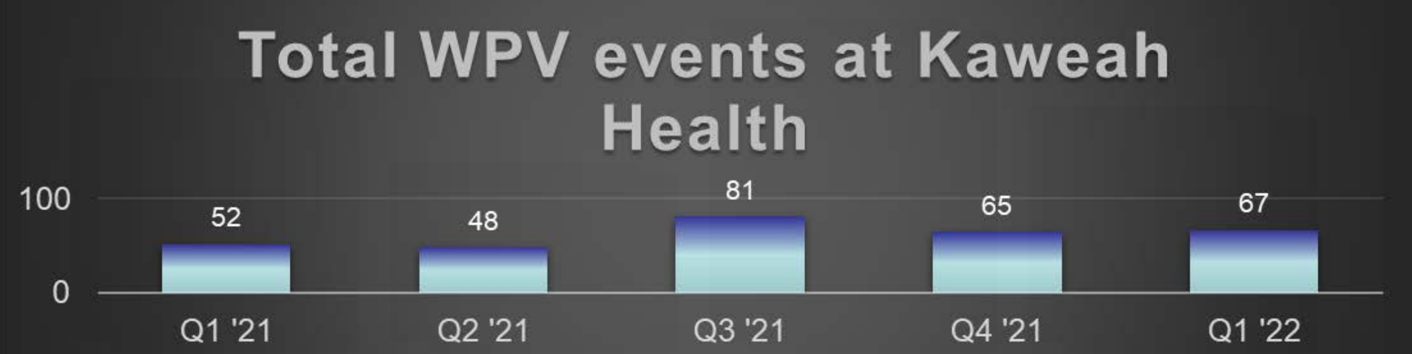
SAFETY

First Quarter 2022

Performance Standard: Reduce Workplace Violence Events (WPV)
Goal: 10% Reduction in WPV events from 2021
Sponsor: Chris Luttrell
Plan for Improvement: **(Summary)**

1. Improve WPV prevention training.
2. Implement WPV electronic flag system.
3. Increase WPV prevention and de-escalation training in off-site facilities.

Evaluation:
There was a 3% increase in the total number of WPV events organization-wide in the 1st quarter of 2022.

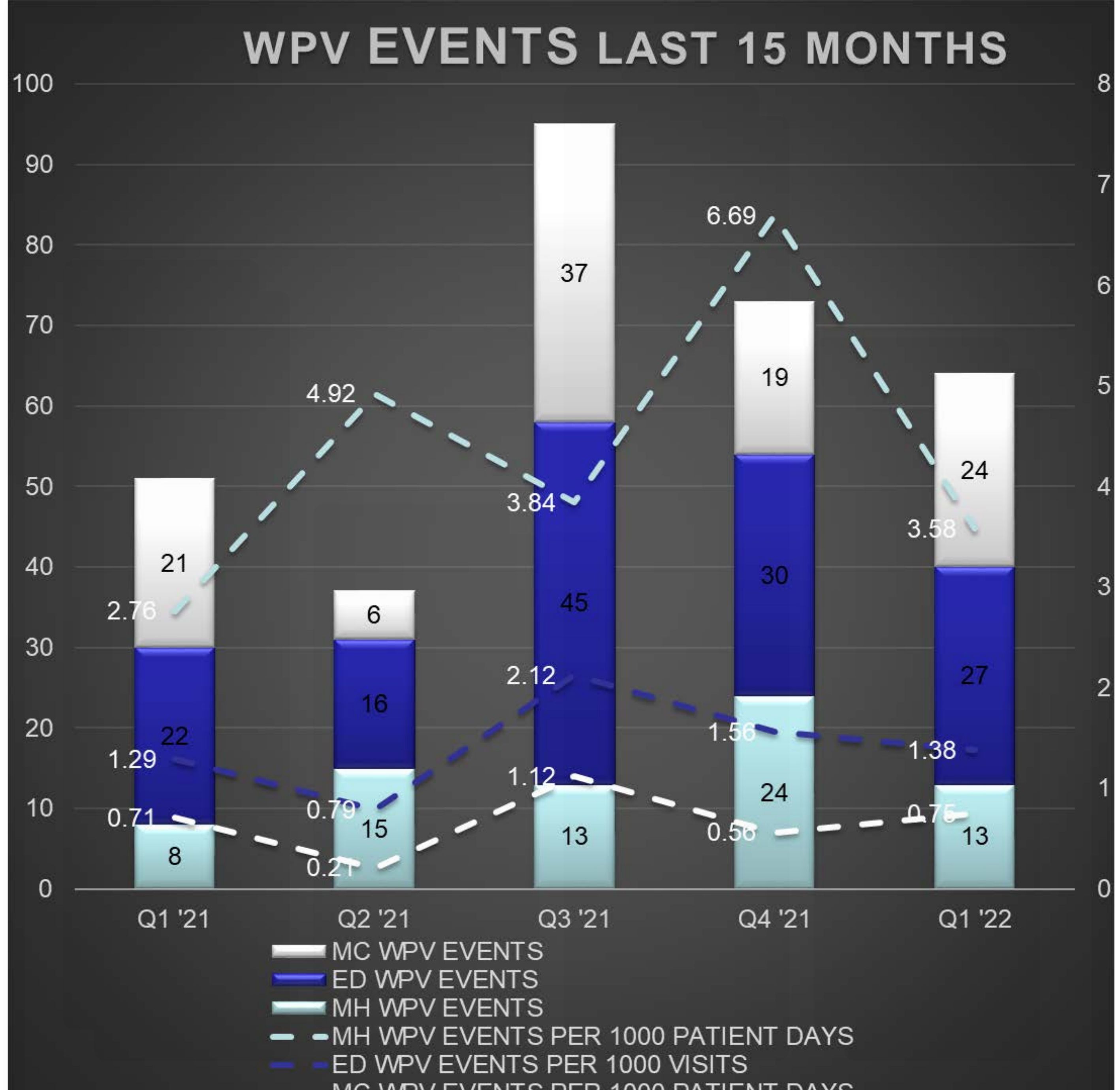


Evaluation:
There was a 22% increase in WPV events in the ED (22 to 27). There was a 26% increase in WPV events in the Medical Center (19 to 24). There was a 300% increase in WPV events in off-campus areas (0 to 3). There was a 45% decrease in WPV events at Mental Health (24 to 13).

WPV EVENTS PARETO
JANUARY - MARCH 2022

EVENTS
27
24
21
18
15
12
9
6
3
0
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
ED
MC
MH
OFF
LOCATION
COUNT
CUMMULATIVE %
80% LINE

Evaluation:
There was an increase of .19 events per 1,000 patient days in the Medical Center. There was a decrease of .18 events per 1,000 visits in the ED and decrease of 3.11 events per 1,000 patient days at Mental Health.



Detailed Plan for Improvement:
1. The WPV committee will assess which groups of staff should be CPI trained. The WPV review team will monitor results of WPV incidents in bi-weekly meetings. Safety specialist rounding to ensure processes are properly in-place.
2. Problematic patients are added to the electronic Aggressive Patient Alert system, which flags patients when they register at any Kaweah Health clinic or hospital. The Security Department provides proactive patrols and supports staff with early intervention Plan of Care and Code Gray: Combative Person response.
3. Advanced CPI training for Mental Health staff. Mock code-grays at Mental Health. Safety Specialist attending off-campus staff meetings for de-escalation training.

EOC Component: SAFETY

Performance Standard: Risk Management –Reporting of non-patient safety related injuries within 7 days will to be compliant at 100%.

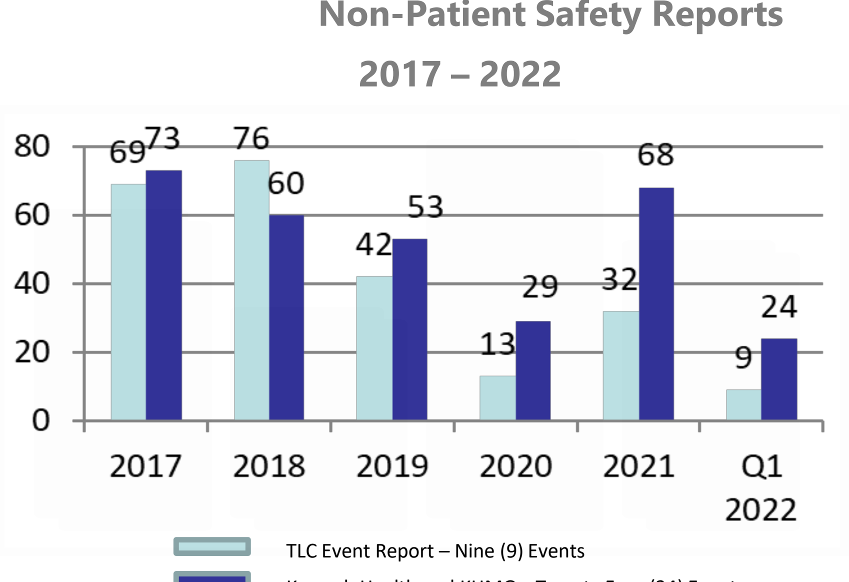
Goal: Report non-patient safety related events within 7 days

Minimum Performance Level: Report non-patient safety related events within 7 days

Evaluation:

In 1st Qtr. 2022, We identified one (1) safety risk concern which has been addressed:
TLC = Two members were engaged in a physical altercation during a basketball game. After the members exited the building, it was reported that one member pointed a gun at the other member while driving out of the parking lot. VPD & Security notified.
Member's gym membership was terminated immediately.

Minimum performance measure was met for 1st Qtr. 2022 at 100% compliance.



EMERGENCY PREPAREDNESS

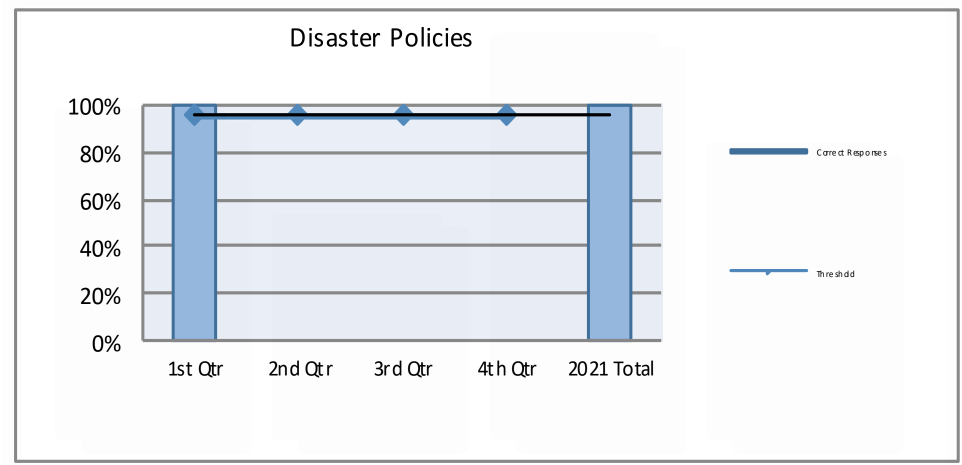
First Quarter 2022

Performance Standard: Employees able to provide correct responses related to Emergency Preparedness questions. During Hazardous Surveillance Rounds employees will be questioned regarding Code Green response.
Goal: 100% Compliance (all employees surveyed answered correctly)
Status: Goal met for 1st Quarter 2022
Sponsor: Maribel Aguilar

Evaluation:

Thirty two departments were surveyed in the 1st quarter. In all departments surveyed staff where able to verbalize Code Green response, which resulted in a 100% compliance rate.

95% minimum performance level was met for this quarter.



Detailed Plan for Improvement:
In each department visited there was knowledge of Code Green response.

UTILITIES MANAGEMENT

First Quarter 2022

Performance Standard: High Risk, Low Risk, Infection Control Preventive Maintenance to be completed on time
Goal: 100% Compliance (no missed PM's)
Status: Goal not met for 1st Quarter 2022 (2224/2240 completed on time: 99.29%)
Sponsor: Steve Gloeckler
Plan for Improvement: (Summary)
14 Patient room PM's were completed late due to census. 2 PM's assigned to Safety not complete.

Evaluation:
2224 of 2240 preventative maintenance work orders were completed on time.

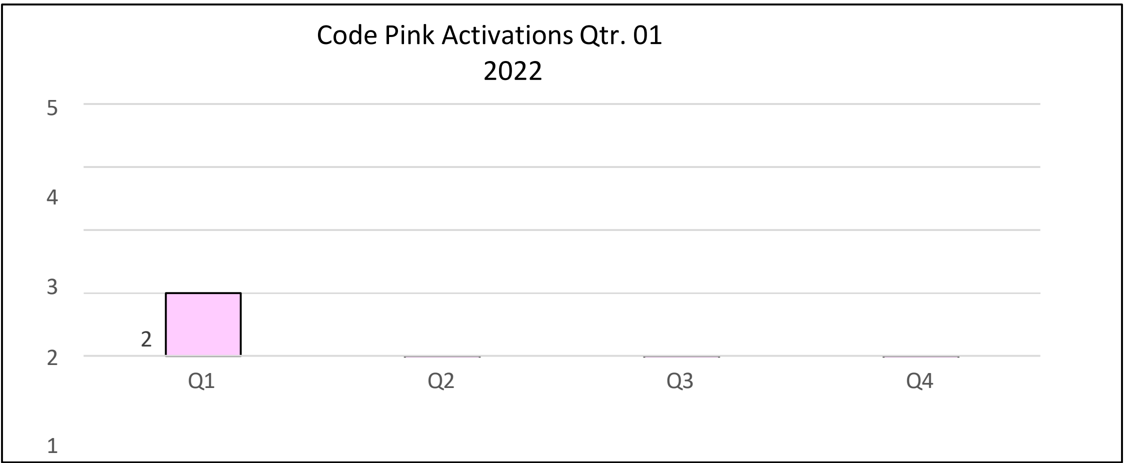
PM Completion %				
	Non-High Risk	Infection Prevention	High Risk	Q4 Summary
January	97.21%	100.00%	98.96%	97.90%
Febuary	100.00%	100.00%	100.00%	100.00%
March	100.00%	100.00%	100.00%	100.00%
Q1 Summary:	99.07%	100.00%	99.65%	99.29%

Plan for Improvement:
Will continue to work with House Supervisor and Nursing leaders for completion.

EOC Component:	**SECURITY**
Performance Standard:	**False Code Pink Activations–** Reduce ***false*** Code Pink activations. Frequent false Code Pink activations are creating alarm fatigue response from support departments and increasing our vulnerability to stop/identify an abductor in the event of a real Code Pink event. **Goal**: 100 % compliance rate **Minimum Performance Level**: <4 events per Quarter

Evaluation:
In year 2020 the Medical Center experienced 48 ***false*** Code Pink activations. In year 2021 we ended the year with 33 events, a 31% decrease. For year 2022, the goal is to decrease Code Pink false alarms by 50% of the previous year - <4 per quarter; <16 events for the year.

Goal **Met** – Two (2) Code Pink ***false*** activations reported for the 1st quarter



Plan for Improvement:
The majority of ***false*** Code Pink activations are due to staff forgetting to deactivate or to set the HUGS transmitter in transport when moving the child/newborn from the home unit to the transport unit. Unit leaders for Maternal-child Health units will work with their clinical/clerical staff to improvement system management, especially when short staffed.

Improvements completed in 2021:
- Security Department provided the Maternal-child Health leaders with a flyer to help educate unit staff.
- Floor tape (CAUTION ALARM WILL SOUND) was installed in Labor and Delivery, OB-OR and Mother- baby units on August 5, 2021 to support alarm safe boundary identification.
- TRL, the company that supports our child abduction security alarm system corrected alarm sensitivity issues in the Pediatrics and Labor and Delivery units to eliminate/mitigate false alarms.

EOC Component: Medical Equipment Preventive Maintenance Compliance

Performance Standard: **Medical Equipment – Preventive Maintenance Compliance**

#1) Non-High Risk Medical Equipment Preventive Maintenance Compliance

#2) High-Risk including Life Support Equipment (HRiLS) Preventive Maintenance Compliance
Goal: 100 % Compliance for each Group
Minimum Performance Level: 100% Compliance

Performance Standard:

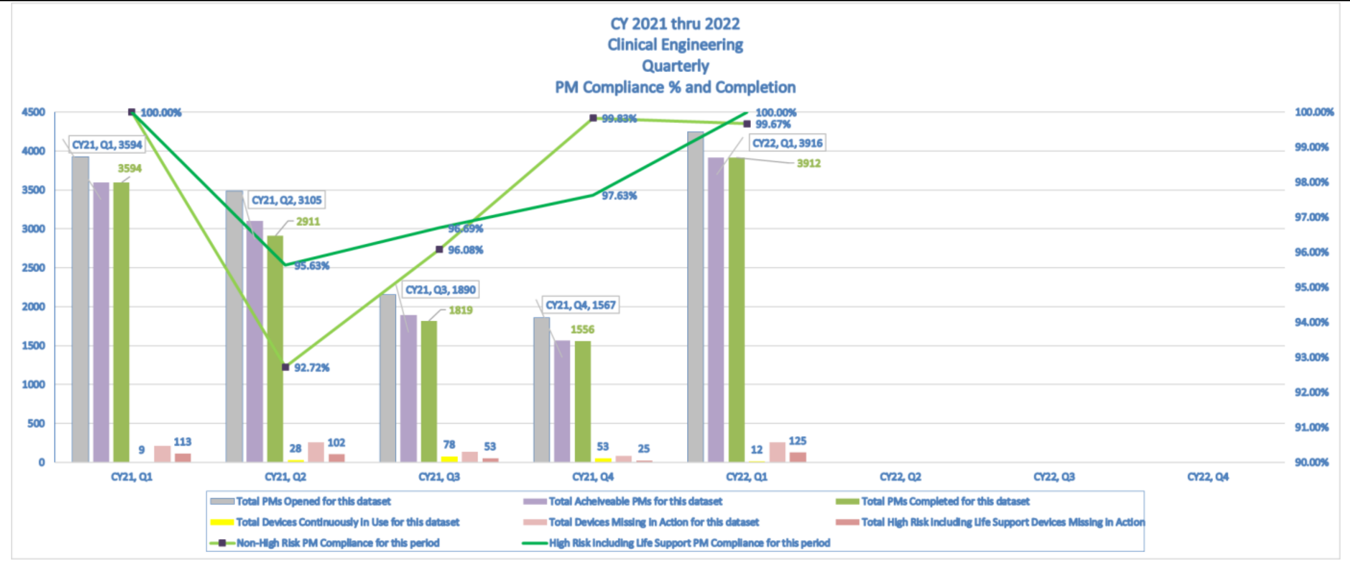
#3) High Risk (HRiLS) Missing-in-Action Devices (Not Locatable for Preventive Maintenance)

Goal: <1% of the Total HRiLS inventory is to be Missing for Preventive Maintenance during any month. 1% of the HRiLS inventory for Q1 is 40.46 devices.

Evaluation:

For the reporting quarter, CY 2022, Q1 (Jan-Mar). A count of 3916 Devices were to receive Preventive Maintenance and 3912 of those devices received Preventive Maintenance as scheduled. Four (4) devices this quarter did not receive Planned Preventive Maintenance as scheduled.

Measured Performance Metrics:
#1) PM Compliance for Non-High Risk Devices is 99.67% and **the 100% Compliance Goal** was **Not Met.**
#2) PM Compliance for High Risk Including Life Support Devices is 100.00% and **the 100% Compliance Goal Was Met.**
#3) High Risk Devices including Life Support (HRiLS) Missing for this reporting Quarter is 3.09% (125 Devices) and **the Compliance Goal of <1.0% of HRiLS Devices Missing** was **Not Met**.



Plan for Improvement:

As of March 7, 2022 all technician positions were filled! Continuing to remind Department Leaders to review medical devices in their areas to report PM stickers that are expired to Clinical Engineering so the device will receive service quickly per policy EOC-6001. Training new staff continues to increase productivity and has already contributed to improved compliance results. In February and March of Quarter 1, both #1 and #2 PM Compliance metrics were met.
Total HRiLS devices missing count increased in March. More than 1700 HRiLS devices were included for service in March 2022 and includes almost all IV Pumps at all locations, 78 were not located. Clinical Engineering has submitted for a passive location system with a goal of dropping the missing totals to near zero in FY23 Capital Budget.

KAWEAH DELTA HEALTH CARE DISTRICT
DBA KAWEAH HEALTH

CONFLICT OF INTEREST CODE

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

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

Adopted by the Board of Directors of Kaweah Delta Health Care District effective ~~October 25, 2021~~June 29, 2022.

EXHIBIT "A"

KAWEAH DELTA HEALTH CARE DISTRICT
DBA KAWEAH HEALTH

CONFLICT OF INTEREST CODE

Disclosure Categories

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

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

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

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

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

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

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

(From the Tulare County Counsel)

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

EXHIBIT "B"

KAWEAH DELTA HEALTH CARE DISTRICT
DBA KAWEAH HEALTH

CONFLICT OF INTEREST CODE

Disclosure Categories

1. **Full Disclosure:**

Designated persons in this category must report:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EXHIBIT "C"

KAWEAH DELTA HEALTH CARE DISTRICT

DBA KAWEAH HEALTH

CONFLICT OF INTEREST CODE

Standard Code

§ 18730. Provisions of Conflict of Interest Codes.

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

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

(1) Section 1. Definitions.

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

(2) Section 2. Designated Employees.

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

(3) Section 3. Disclosure Categories.

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

et seq.

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

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

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

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

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

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

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

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

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

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

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

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

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

Any person who resigns within 12 months of initial appointment, or within 30 days of the date of notice provided by the filing officer to file an assuming office statement, is not deemed to have assumed office or left office, provided he or she did not make or participate in the making of, or use his or her position to influence any decision and did not receive or become entitled to receive any form of payment as a result of his or her appointment. Such persons shall not file either an assuming or leaving office statement.

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

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

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

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

(A) Contents of Initial Statements.

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

(B) Contents of Assuming Office Statements.

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

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

(D) Contents of Leaving Office Statements.

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

(7) Section 7. Manner of Reporting.

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

(A) Investments and Real Property Disclosure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(8.2) Section 8.2. Loans to Public Officials.

(A) No elected officer of a state or local government agency shall, from the date of his or her

election to office through the date that he or she vacates office, receive a personal loan from any officer, employee, member, or consultant of the state or local government agency in which the elected officer holds office or over which the elected officer's agency has direction and control.

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

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

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

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

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

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

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

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

(8.3) Section 8.3. Loan Terms.

(A) Except as set forth in subdivision (B), no elected officer of a state or local government agency shall, from the date of his or her election to office through the date he or she vacates office, receive a personal loan of five hundred dollars ($500) or more, except when the loan is in writing and clearly states the terms of the loan, including the parties to the loan agreement, date of the loan, amount of the loan, term of the loan, date or dates when payments shall be due on the loan and the amount of the payments, and the rate of interest paid on the loan.

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

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

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

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

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

(8.4) Section 8.4. Personal Loans.

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

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

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

a. The date the loan was made.

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

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

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

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

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

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

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

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

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

(9) Section 9. Disqualification.

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

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

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

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

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

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

(9.3) Section 9.3. Legally Required Participation.

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

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

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

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

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

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

(10) Section 10. Disclosure of Disqualifying Interest.

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

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

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

(12) Section 12. Violations.

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

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

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

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

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

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

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

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

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

KAWEAH DELTA HEALTH CARE DISTRICT
Medical Staff Policy: Guidelines for Privacy Violations

PURPOSE: The Medical Staff of Kaweah Delta Health Care District (KDHCD) seeks to establish standards for the security of confidential patient health information and guidelines for appropriate disciplinary action for privacy breaches. These guidelines provide a consistent framework for the Medical Staff to identify and evaluate the seriousness of violations of state and federal privacy laws, and of privacy and security provisions set forth in the Medical Staff Bylaws, the Medical Staff Rules, and Hospital and Medical Staff policies ("KDHCD Privacy Policies").

BACKGROUND: The Medical Staff is committed to ensuring compliance with all applicable privacy and security laws, including the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH"), the California Confidentiality of Medical Information Act, the Fair Credit Reporting Act, and the regulations promulgated under these laws, and the KDHCD Privacy Policies.

All Medical Staff members are required to comply with these privacy and security laws and the KDHCD Privacy Policies and to immediately report suspected or known violations to KDHCD's VP & Chief Compliance and Risk Officer or designee. Neither the Hospital nor the Medical Staff will intimidate or retaliate against any individual who reports acts or practices by Medical Staff members or Advanced Practice Providers that are unlawful and/or violate the KDHCD Privacy Policies, provided the member believes in good faith that the practice was unlawful and/or a violation of the KDHCD Privacy Policies.

I. DEFINITIONS

a. **“**Protected Health Information (PHI)” means individually identifiable health information, including demographic information, in any form or media, whether electronic, paper, or oral, that is created or held by a health care provider, health plan, employer, or health care clearinghouse or its business associate, that relates to the past, present, or future physical or mental health or condition of an individual in his or her status as a patient, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. Examples of PHI include name, address, birth date, Social Security Number, contact information, diagnosis, medical test results, treatment information, prescription information, and medical record numbers.

b. “Access” means to view, manipulate, utilize or examine PHI.

c. “Disclosure” means the release, transfer, provision of access to, or the divulging in any manner PHI to any individual within or outside of Hospital who does not have a legitimate need to access the information or who has not been authorized in writing to access or disclose the PHI by the individual whose PHI is at issue, or the individual's representative.

d. “Hospital” means Kaweah Delta Health Care District dba Kaweah Health Medical Center and all its affiliations.

II. TYPES OF VIOLATIONS

The type of the breach of patient confidentiality, privacy, or security (hereinafter collectively referred to as "privacy breach") will be determined according to several factors: (1) the intrusiveness of the privacy breach and the extent of information accessed or disclosed; (2) whether the privacy breach was the result of human error; and (3) whether the privacy breach was an isolated incident or evidences a pattern of improper access to or disclosure of PHI. The degree of discipline warranted by the privacy breach ranges from coaching and re-education to termination of the membership and/or clinical privileges of the Medical Staff member or Advanced Practice Provider, as determined by Medical Executive Committee (and KDHCD Board of Directors, when applicable) based on the results of an investigation.

There are four general types of privacy breaches identified below as Categories 1 – 4 based on the seriousness of the privacy breach. Sanctions, set forth in Attachment A may be modified based on mitigating factors, in the discretion of the Medical Executive Committee.

Category 1: Theft or loss of device containing encrypted PHI.

Category 2: Accidental or inadvertent access or disclosure. This is an unintentional privacy breach that may be caused by carelessness or other human error.

Category 3: Unauthorized access or disclosure. This is a privacy breach resulting from unauthorized or unlawful access of/to PHI. “Unauthorized” means the inappropriate accessing of medical information without a direct need for that information for a lawful use. This includes accessing or disclosing PHI for which the individual or the recipient has no legitimate business need. This breach is often motivated by curiosity or a desire to gain information for personal use.

Category 4: Malicious violation . This is a privacy breach that involves the access or disclosure of PHI to third parties motivated by financial, personal, or commercial gain and an intent to harm patients and/or the Hospital.

Examples of each category of privacy breach and the recommended sanctions are set forth in Attachment A.

III. PROCEDURE

Hospital uses FairWarning, an analytics and insider threat detection platform, to detect suspicious activity and policy violations, including privileged user access to patient healthcare information. Any individual who is aware of or suspects that a member of the Medical Staff or an Advanced Practice Provider has violated the KDHCD Privacy Policies must immediately report the occurrence to KDHCD's VP & Chief Compliance and Risk Officer or designee. The KDHCD VP & Chief Compliance and Risk Officer or designee will notify the Chief of Staff upon receipt of the report and will conduct a timely investigation. At a minimum, the investigation will include an interview of the provider who is alleged to have violated the KDHCD Privacy Policies. Following completion of the investigation, KDHCD’s VP & Chief Compliance and Risk Officer or designee will submit a report setting forth the findings of the investigation, including the category of the privacy breach, if any, to the Chief of Staff.

When the investigation concludes a privacy breach occurred, a copy of the report and its findings will be provided to the Medical Executive Committee. At its next regularly scheduled meeting, the Medical Executive Committee will make a recommendation as to the sanction for the privacy breach. The sanction recommended by the Medical Executive Committee is separate and apart from any civil or criminal penalties that may result from the privacy breach.

If the sanction does not involve a restriction or suspension of clinical privileges, the Medical Executive Committee will issue a notice to the provider of the sanction and its terms. The notice will inform the provider of the opportunity to submit a written response, which will be maintained in the provider's confidential file.

If the Medical Executive Committee's recommended sanction involves a restriction on or suspension of clinical privileges, the subject provider will be sent notice of the recommendation and the basis therefore and an opportunity to request to meet with the Medical Executive Committee to discuss the matter. Following that meeting, or if the provider does not timely request such a meeting, the Medical Executive Committee will render its final recommendation. If the final recommendation constitutes grounds for a hearing under the Medical Staff Bylaws, the procedures set forth in Article 9 of the Medical Staff Bylaws will be followed. If the final recommendation does not constitute grounds for a hearing but involves a restriction on or suspension of clinical privileges, the Medical Executive Committee's recommendation will be forwarded to the Board of Directors for consideration and approval before implementation.

ATTACHMENT A

Incident	Sanction
Category 1: Theft or loss of device containing encrypted PHI	**Coaching and Re-Education**
Possible Scenarios: Work or personal device, not password protected and containing non-encrypted PHI, is lost or stolen.	Provider will receive coaching by Medical Staff leadership and undergo re-education and training by KDHCD's VP & Chief Compliance and/or Risk Officer. Further violations will lead to progressive disciplinary action.
Category 2: Accidental or inadvertent disclosure	**Letter of Reprimand and Re-Education**
Possible Scenarios: • Directing PHI via mail, email, fax or other method to a wrong party; or • Failing to safeguard portable device from loss or theft; or • Leaving detailed PHI on an answering machine without patient authorization; or • Transmitting PHI using an unsecured method; or • Improperly disposing of PHI; or • Failing to properly sign off from or lock computer when leaving a work-station.	Provider will be sent letter of reprimand. Mandatory re-education and training will be required. Further violation will lead to progressive disciplinary action.
Category 3: Unauthorized access or disclosure	**Suspension and Re-Education**
Possible Scenarios: • Accessing or using PHI without a legitimate need to do so, such as checking the results of a hospital employee's pregnancy test or the medical records of a relative without prior written authorization; or • Disclosing PHI to someone who has no legitimate business need to have the PHI.	Provider's clinical privileges will be suspended for a minimum of 29 days. Mandatory re-education and training will be required. Further violation will result in a recommendation to terminate Medical Staff membership and/or clinical privileges.
Category 4: Malicious violation	**Termination of Medical Staff membership and/or privileges**
Possible Scenarios: • Disclosing PHI to an unauthorized individual or entity for illegal purposes (i.e., identity theft); or • Posting PHI to social media websites; or • Selling PHI to entities for personal or financial gain; or • Disclosing an individual's PHI to the media.	Medical Executive Committee will recommend termination of Medical Staff membership and/or privileges.

COUNTY OF TULARE

VOTER REGISTRATION AND ELECTIONS

Application to Access Voter Registration Information

For Office Use Only
Date Received ______
Approved by: ______
Date Paid: ______

Name of Person Requesting Data	**Name of Organization/Committee/Candidate/Campaign**		
Title or Position	**Email Address for Electronic File Delivery**	**Phone Number**	
Address (Street Number and Name)	**City**	**State**	**Zip**
Business Address	**City**	**State**	**Zip**

USE INFORMATION: Use of voter registration files is limited.
YOU MUST COMPLETE PAGE 3 OR YOUR APPLICATION WILL BE DENIED.

What type(s) of organization(s), or committee(s) do you represent?

☐ **Election** ☐ **Candidate** ☐ **Political** ☐ **Scholarly** ☐ **Journalistic** ☐ **Other (specify)** ____________________

Your request must include the following:

Election: Information identifying the California candidate (s), California ballot measure (s), or committee (s) for/against any initiative or referendum measure for which legal publication is made.

Candidate: Information identifying federal, state, or local office.

Political: Documentation establishing affiliation with the political organization on the institution's letterhead stating that the applicant is authorized to receive data.

Scholarly: Letter from the institution (professor, administrator, etc) on the institution's letterhead stating that the applicant is authorized to receive data.

Journalistic: A clear photocopy of press pass.

Other: Permissible use as listed in the California Code of Regulations Title 2, Division 7, Article 1, § 19003.

AGREEMENT: All information furnished on this application is subject to verification.

________ *(initial here)*	Applicant and beneficiary, if applicable, hereby agree that the information set forth in the voter registration records will be used for the approved purposes, consistent with state law, as defined by California Elections Code § 2194, California Code of Regulations § 19003, and Government Code § 6254.4.
________ *(initial here)*	Applicant and beneficiary, if applicable, further agree not to sell, lease, loan, or deliver possession of the registration information, or a copy thereof, or any portion thereof, in any form or format, to any person, organization, or agency without first submitting a new application and receiving written authorization from the Secretary of State to release such registration information.
________ *(initial here)*	Applicant and beneficiary, if applicable, agree to maintain information in a secure and confidential manner and notify the Secretary of State immediately of any violation or breach.
________ *(initial here)*	Applicant and beneficiary, if applicable, understand that it is a misdemeanor for a person in possession of voter registration information to use or permit the use of all or any part of the information for any purpose other than as permitted by law. (California Elections Code § 18109)
________ *(initial here)*	Applicant and beneficiary, if applicable, agree to pay to the State of California, as compensation for any unauthorized use of each individual's registration information, an amount equal to the sum of fifty cents ($.50) multiplied by the number of times each registration record is used by the applicant and/or the beneficiary, if applicable, in an unauthorized manner. (California Code of Regulations § 19001-19009)

5951 South Mooney Blvd., Visalia, CA 93277
Phone (559) 624-7300 **Fax** (559) 737-4498 **Email** AV1@tularecounty.ca.gov **Website** www.tularecoelections.org

COUNTY OF TULARE
VOTER REGISTRATION AND ELECTIONS
Application to Access Voter Registration Information

☐VOTER REGISTRATION	Qty	Price Per File
Option 1: Data File with County of Tulare Voters (MVMJ004) ☐ Countywide ☐ District ________________ District Number________ **Would you like voter history**: Yes ☐ No ☐ **If Yes, how would you like to see the voter history?** ☐ Included with the file (one file) ☐ As a separate file (two files) **If Yes, how many elections: (Maximum of 5)** ☐ Last 5 countywide elections ☐ Specify election dates for voter history (Maximum of 5):		**Voter File Extract** $35 Per District, if District contains fewer than 20,000 registered voters $70 Per District, if the District contains more than 20,000 registered voters **Voting History File Extract** $35 Per Election, if District contains fewer than 20,000 registered voters$70 Per Election, if the District contains more than 20,000 registered voters
☐ CUSTOM DATA	**Qty**	**Price Per File**
Option 2: Customized Data File (MVMR010) ☐ **Printed Walking List** (Precinct Index) ☐ District ________________ District Number ________ ☐ Consecutive Precinct Range________________ ☐ Other Custom Report/Data Please explain: ________________		$0.50 Per 1,000 registered voters
Option 3: Customized Data File (PDMJ001 or PDMR001) **List of Precincts** ☐ Countywide ☐ District ________________ District Number________ ☐ Other Custom Report / Data Please explain:________________		$35.00 Per District
☐VOTE BY MAIL DATA	**Qty**	**Price Per File**
PLEASE NOTE: Voting Activity Status Reports must be delivered via an FTP site, reports **cannot** be emailed. Voting Activity Status Reports will contain all Vote By Mail voters who have returned a ballot within a specific date range. Clients must specfiy which dates they would like the report ran and uploaded to their FTP site.		
☐Option 1: Voting Activity Status Report Subscription (AVMJ011) 17 days ☐ Countywide ☐ District:________________ District Number________		$595.00
☐Option 3: Voting Activity Status Report (AVMJ011) 1 day(Limit 4 individual files per election) ☐Countywide ☐ District:________________ District Number ________		$35.00
All orders must be paid in full before report(s) can be created. We accept Cash or check only. Please make checks payable to: County of Tulare Registrar of Voters		
YOU MUST COMPLETE PAGE 3 OR YOUR APPLICATION WILL BE DENIED. **TOTAL**		$
IN-OFFICE VOTER INFORMATION LOOKUP ON PUBLIC TERMINAL		No Charge

5951 South Mooney Blvd., Visalia, CA 93277
Phone (559) 624-7300 **Fax** (559) 737-4498 **Email** AV1@tularecounty.ca.gov **Website** www.tularecoelections.org

COUNTY OF TULARE

VOTER REGISTRATION AND ELECTIONS

Application to Access Voter Registration Information

INTENDED USE: This section must be completed. If more space is needed, continue on another sheet of paper.

I certify under penalty of perjury, under the laws of the State of California, that the foregoing information provided by me is true and correct.

Signature of Applicant or Agent	**Date**
	Driver's License or State ID

5951 South Mooney Blvd., Visalia, CA 93277
Phone (559) 624-7300 **Fax** (559) 737-4498 **Email** AV1@tularecounty.ca.gov **Website** www.tularecoelections.org

VOTER FILE CODES AND REGULATIONS: PERMISSIBLE AND NON-PERMISSIBLE ACCESS TO VOTER REGISTRATION.

California Code of Regulations Title 2, Division 7, Chapter 1, Article 1: Access to Voter Registration Information

19002. Use of Registration Information; Limitations.
Registration information obtained by any person from a source agency shall be used solely for election and governmental purposes.

19003. Permissible Uses.
Permissible uses of information obtained from a source agency shall include, but shall not be limited to, the following:
a) Using registration information for purposes of communicating with voters in connection with any election.
b) Sending communications, including but not limited to, mailings which campaign for or against any candidate or ballot measure in any election.
c) Sending communications, including but not limited to, mailings by or in behalf of any political party; provided however, that the content of such communications shall be devoted to news and opinions of candidates, elections, political party developments and related matters.
d) Sending communications, including but not limited to, mailings, incidental to the circulation or support of, or opposition to any recall, initiative, or referendum petition.
e) Sending of newsletters or bulletins by any elected public official, political party or candidate for public office.
f) Conducting any survey of voters in connection with any election campaign.
g) Conducting any survey of opinions of voters by any government agency, political party, elected official or political candidate for election or governmental purposes.
h) Conducting an audit of voter registration lists for the purpose of detecting voter registration fraud.
i) Soliciting contributions or services as part of any election campaign on behalf of any candidate for public office or any political party or in support of or opposition to any ballot measure.
j) Any official use by any local, state, or federal governmental agency.

19004. Non-permissible Uses.
The following uses of registration information obtained from a source agency shall be deemed other than for election and governmental purposes:
a) Any communication or other use solely or partially for any commercial purpose.
b) Solicitation of contributions or services for any purpose other than on behalf of a candidate or political party or in support of or opposition to a ballot measure.
c) Conducting any survey of opinions of voters other than those permitted by Sections 19003(f) and (g).

19005. Prior Written Authorization.
No person who obtains registration information from a source agency shall make any such information available under any terms, in any format, or for any purpose, to any person without receiving prior written authorization from the source agency. The source agency shall issue such authorization only after the person to receive such information has executed the written agreement set forth in Section 19008.

19007. Penalties.
Every person, who directly or indirectly obtains registration information from a source agency, shall be liable to the State of California, as a penalty for any use of said registration information which is not authorized by Section 607 of the Elections Code and the regulations promulgated pursuant thereto, for an amount equal to the sum of 50 ¢ multiplied by the number of registration records which such person used in an unauthorized manner. Unauthorized use by any applicant of any portion of the information obtained pursuant to this Chapter shall raise a presumption that all such information obtained by such applicant was so misused. Illustration: X Data Corp. obtains registration information from a source agency and uses this information to address a commercial mailing to 10,000 voters. Under the provision of this section, X Data Corp. is obligated to pay the State of California the sum of $5000, which constitutes the sum of 50 ¢ multiplied by 10,000, the number of registration records which were used in an unauthorized manner.

19008. Application. (Text Omitted)

19009. Submissions to Secretary of State.
The Secretary of State may require that the applicant submit to the Secretary of State a copy of all mailings conducted by the applicant pursuant to this Chapter.

California Elections Code § 2188. Application for voter registration information.
(a) Any application for voter registration information available pursuant to law and maintained by the Secretary of State or by the elections official of any county shall be made pursuant to this section.
(b) The application shall set forth all of the following:
(1) The printed or typed name of the applicant in full.
(2) The complete residence address and complete business address of the applicant, giving street and number. If no street or number exists, a postal mailing address as well as an adequate designation sufficient to readily ascertain the location.
(3) The telephone number of the applicant, if one exists.
(4) The number of the applicant's driver's license, state identification card, or other identification approved by the Secretary of State if the applicant does not have a driver's license or state identification card.
(5) The specific information requested.
(6) A statement of the intended use of the information requested.
(c) If the application is on behalf of a person other than the applicant, the applicant shall, in addition to the information required by subdivision (b), set forth all of the following:
(1) The name of the person, organization, company, committee, association, or group requesting the voter registration information, including their complete mailing address and telephone number.
(2) The name of the person authorizing or requesting the applicant to obtain the voter registration information.
(d) The elections official shall request the applicant to display his or her identification for purposes of verifying that identifying numbers of the identification document match those written by the applicant on the application form.
(e) The applicant shall certify to the truth and correctness of the content of the application, under penalty of perjury, with the signature of his or her name at length, including given name, middle name or initial, or initial and middle name. The applicant shall state the date and place of execution of the declaration.
(f) Completed applications for voter registration information shall be retained by the elections official for five years from the date of application.
(g) This section shall not apply to requests for information by elections officials for election purposes or by other public agencies for governmental purposes.
(h) The Secretary of State may prescribe additional information to be included in the application for voter registration information.
(i) A county may not provide information for any political subdivision that is not wholly or partially contained within that county.

California Elections Code § 2194. Access to voter registration information. Limited Confidentiality. (Not Full Text)
(a) Except as provided in § 2194.1, the affidavit of voter registration information identified in § 6254.4 of the Government Code:
(1) Shall be confidential and shall not appear on any computer terminal, list, affidavit, duplicate affidavit, or other medium routinely available to the public at the county elections official's office.
(2) Shall not be used for any personal, private, or commercial purpose, including, but not limited to:
(A) The harassment of any voter or voter's household.
(B) The advertising, solicitation, sale, or marketing of products or services to any voter or voter's household.
(C) Reproduction in print, broadcast visual or audio, or display on the Internet or any computer terminal unless pursuant to paragraph (3).
(3) Shall be provided with respect to any voter, subject to the provisions of Sections 2166,2166.5, 2166.7, and 2188, to any candidate for federal, state, or local office, to any committee for or against any initiative or referendum measure for which legal publication is made, and to any person for election, scholarly, journalistic, or political purposes, or for governmental purposes, as determined by the Secretary of State.

California Elections Code § 18109. Misuse of Information; Misdemeanor.
(a) It is a misdemeanor for a person in possession of information identified in Section 2138.5, or obtained pursuant to Article 5 (commencing with Section 2183) of Chapter 2 of Division 2 of this code or Section 6254.4 of the Government Code, knowingly to use or permit the use of all or any part of that information for any purpose other than as permitted by law.
(b) It is a misdemeanor for a person knowingly to acquire possession or use of voter registration information from the Secretary of State or a county elections official without first complying with Section 2188.

Government Code § 6254.4. Voter Registration Information; Confidentiality.
a) The home address, telephone number, email address, precinct number, or other number specified by the Secretary of State for voter registration purposes, and prior registration information shown on the affidavit of registration, is confidential and shall not be disclosed to any person, except pursuant to Section 2194 of the Elections Code.
(b) For purposes of this section, "home address" means street address only, and does not include an individual's city or post office address.
(c) The California driver's license number, the California identification card number, the social security number, and any other unique identifier used by the State of California for purposes of voter identification shown on an affidavit of registration, or added to the voter registration records to comply with the requirements of the federal Help America Vote Act of 2002 (42 U.S.C. Sec. 15301 et seq.), are confidential and shall not be disclosed to any person.
(d) The signature of the voter that is shown on the affidavit of registration is confidential and shall not be disclosed to any person.

June 29, 2022

Christopher Renfro
P.O. Box 495
Tipton, CA 93272

RE: <u>Notice of Denial of Application to File Late Claim, in part, of Christopher Renfro v. Kaweah Delta Health Care District</u>

NOTICE IN HEREBY GIVEN that the Application for Leave to Present Late Claim on behalf of Claimant Christopher Renfro, dated May 25, 2022, which you presented to Kaweah Health on that same date, was denied **<u>in part</u>**; specifically, that portion of your Application as it relates to medical treatment by Kaweah Health; emotional distress for failure to receive medical attention and from being released as a patient of Quickcare (formerly Sequoia Prompt Care) – was denied on June 29, 2022.

<u>WARNING</u>

If you wish to file a court action in this matter, you must first petition the appropriate court for an order relieving you from the provisions of Government Code section 945.6 (claims presentation requirement). See also Government Code section 946.6. Such petition must be filed with the court six (6) months from the date your application for leave to present a late claim was denied.

RE: <u>Acceptance of Application to File Late Claim and Rejection, in part, of Claim of Christopher Renfro v. Kaweah Delta Health Care District</u>

NOTICE IF HEREBY GIVEN that the Application for Leave to Present Late Claim on behalf of Claimant Christopher Renfro, dated May 25, 2022, which you presented to Kaweah Health on that same date, was granted **<u>in part</u>**; specifically, that portion of your Application as it relates to loss of employment, was granted on June 29, 2022.

RE: <u>Notice of Rejection of Claim of Christopher Renfro (relating to employment loss)</u>

NOTICE IS HEREBY GIVEN that the claim, which you presented to the Board of Directors of Kaweah Health on May 25, 2022, as it relates only to your loss of employment, was rejected on its merits by the Board of Directors on June 29, 2022.

WARNING

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

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

Sincerely,

Michael Olmos
Secretary/Treasurer, Board of Directors

cc: Rachele Berglund, Attorney at Law

Provider Name: ____ Date: _______________
Please Print

NURSE PRACTITIONER / PHYSICIAN ASSISTANT

Assignment: ☐ ICU ☐ ICCU ☐ Cardiac Services ☐ Through-Put ☐ OB/GYN ☐ Pediatric ☐ Psychiatry ☐ Radiology

☐ Adult Hospitalists ☐ Surgery ☐ Orthopedic ☐ Neurosurgery ☐ Family Medicine ☐ Internal Medicine ☐ Employee Health

Initial Criteria

Physician Assistant: Completion of an ARC-PA approved program; Current certification by the NCCPA (***Obtain certification within one year of completion of PA program or granting of privileges***); Current licensure to practice as a PA by the California Physician Assistant Board; **OR**

Nurse Practitioner: Completion of an advanced nursing program accredited by the Commission of Collegiate of Nursing Education (CCNE) or National League for Nursing Accrediting Commission (NLNAC) with emphasis on the NP's specialty area; current certification by the ANCC or AANP (***Obtain certification within one year of completion of advanced nursing program); AND***

Additional Certifications: BLS or ACLS and full schedule California DEA

Clinical Experience: Documentation of patient care for 50 patients in the past two years OR completion of training program within the last 12 months

Renewal Criteria: Documentation of patient care for 50 patients in the past 2 years **AND** maintenance of current certification by NCCPA, ANCC, or AANP (For PA's granted privileges prior to March 2016 that are not certified by the NCCPA: Must provide 100 CMEs within the last 2 year period, 50 of which must be category I, as defined by the NCPPA for Certification); **AND** current BLS or ACLS and full schedule California DEA

FPPE: A minimum of 5 cases by Direct Observation and Retrospective Chart Review at the supervising physician's discretion.

Request	**GENERAL CORE PRIVILEGES** Includes procedures on the following list and such other procedures that are extensions of the same techniques and skills (may include telehealth):	Approve
☐	• Apply, remove, and change dressings and bandages; Perform debridement and general care for superficial wounds and minor superficial surgical procedures • Counsel and instruct patients, families, and caregivers as appropriate • Direct care as specified by medical staff-approved protocols; Make daily rounds on hospitalized patients, as appropriate; Initiate appropriate referrals; • Implement palliative care and end-of-life care through evaluation, modification, and documentation according to the patient's response to therapy, changes in condition, and to therapeutic interventions • Implement therapeutic intervention for specific conditions when appropriate • Insert and remove nasogastric tube; provide tracheostomy care • Order and initial interpretation of diagnostic testing and therapeutic modalities; • Perform field infiltrations of anesthetic solutions; incision and drainage of superficial abscesses; • Perform History & Physical/ MSE; • Perform other emergency treatment • Prescribe & Administer medications per formulary of designated certifying board • Record progress notes; • Removal of drains, sutures, staples, & packing • Remove arterial catheters, central venous catheters, chest tubes; • Short-term and indwelling urinary bladder catheterization; venous punctures for blood sampling, cultures, and IV catheterization; superficial surgical procedures • Write Discharge Summaries and Instructions	☐
☐	Adult: Patients >18 years of age	☐
☐	Pediatric: Well newborn up to 18 years of age	☐
☐	Outpatient Services at a Kaweah Health Clinic identified below. Privileges include performance of core privileges/procedures as appropriate to an outpatient setting and may include telehealth: **__Dinuba __Exeter __Lindsay __Tulare __Woodlake __SHWC – Willow __Dialysis Clinic __Hospice __Chronic Disease Management Center __Wound Care Center __Sequoia Cardiology Clinic __Neuroscience Center**	☐

ADVANCED INPATIENT PRIVILEGES

Initial FPPE is deemed to have been satisfied based on succesful completion of a preceptorship at Kaweah Health within 6 months prior to the grant of clinical privileges

Request	Procedure	Criteria	Renewal Criteria	FPPE	Approve
☐	Bronchoscopy	20 procedures in the last 2 years	10 procedures in the last 2 years	Minimum of 5 concurrent	☐

Provider Name: ____ Date: ________________

Please Print

☐	Cerebral Spinal Fluid (CSF Shunt Tap)	2 in the last 2 years	1 in the last 2 years	2 concurrent	☐
☐	Endotracheal tube placement	10 in the last 2 years	8 in the last 2 years	Minimum of 3	☐
☐	Insertion of Arterial Lines	5 in the last 2 years	5 in the last 2 years	2 concurrent	☐
☐	Insertion & Removal of central venous access or dialysis catheters	5 in the last 2 years	5 in the last 2 years	Minimum of 2 -any site	☐
☐	Insertion of Chest Tubes	5 in the last 2 years	5 in the last 2 years	Minimum of 3	☐
☐	Laceration Repair – Complex and Layered	3 in the last 2 years	3 in the last 2 years	3 concurrent	☐
☐	Lumbar Puncture	3 in the last 2 years	3 in the last 2 years	2 concurrent	☐
☐	Myelogram	3 in the last 2 years	3 in the last 2 years	2 concurrent	☐
☐	Paracentesis	5 in the last 2 years	5 in the last 2 years	5 concurrent	☐
☐	Perform pharmacological and non-pharmacological stress tests	10 in the last 2 years	10 in the last 2 years	2 concurrent	☐
☐	Placement of External Ventricular Drainage Device	3 in the last 2 years	3 the last 2 years	2 concurrent	☐
☐	Placement of Intracranial Monitoring Devices	3 in the last 2 years	3 in the last 2 years	2 concurrent	☐
☐	Radiologic procedures of the genitourinary and gastrointestinal tracts	5 in the last 2 years	5 in the last 2 years	5 concurrent	☐
☐	Removal of Intra-Aortic Balloon Pump	5 in the last 2 years	5 in the last 2 years	5 concurrent	☐
☐	Removal of Intra-cardiac lines or temporary Epicardial Pacer Wires	2 in the last 2 years	2 in the last 2 years	2 concurrent	☐
☐	Remove & reinsert PEG tube	3 in the last 2 years	3 in the last 2 years	2 concurrent	☐
☐	Replacement of tracheostomy tubes >1 month since time of tracheostomy	5 in the last 2 years	5 in the last 2 years	5 concurrent	☐
☐	Surgical Assistant (*may not perform opening and/or closing surgical procedures at or below the fascia on a patient under anesthesia without the personal presence of a supervising physician and surgeon).*	10 in the last 2 years	10 in the last 2 years	2 concurrent	☐
☐	Thoracentesis	5 in the last 2 years	5 in the last 2 years	Minimum of 2	☐
☐	Tilt Table	5 in the last 2 years	5 in the last 2 years	2 concurrent	☐
☐	Uncomplicated Ventilator Management	5 in the last 2 years	5 in the last 2 years	2 concurrent	☐

ADVANCED OUTPATIENT PRIVILEGES

FPPE requirement waived if provider has successfully completed training (preceptorship) at Kaweah Health within the last 6 months

Request	Procedure	Criteria	Renewal Criteria	FPPE	Approve
☐	Colposcopy	Documentation of training and 10 procedures in the last 2 years.	10 procedures in the last 2 years.	A minimum of 1	☐

Provider Name: ____ Date: ___________________

Please Print

☐	Complex Wound Care (Wound debridement, application of skin substitutes, complicated management and wound biopsy) (Wound Care Center Only)	20 procedures in the last 2 years	20 procedures in the last 2 years	First 2 concurrent cases	☐
☐	Hospice: Rounding on home-bound patients enrolled in KDHCD Hospice Services	Initial Criteria for Core Privileges	20 patient contacts in the last 2 years.	2 concurrent or retrospective chart reviews.	☐
☐	Hyperbaric Oxygen Therapy Pre-requisite: Hyperbaric Course approved by the Undersea and Hyperbaric Medical Society (UHMS) or the American College of Hyperbaric Medicine (ACHM) (Wound Care Center Only)	Completion of 40 hour Hyperbaric Course **and** documentation of 20 cases in the last 2 years.	20 procedures **AND** documentation of 10 CME in wound care/hyperbaric medicine in the last 2 years	2 direct observation & 2 retrospective chart reviews	☐
☐	Joint Injection	Documentation of training and 5 procedures in the last 2 years (Use of Sim Lab acceptable for up to 2)	2 procedures in the last 2 years (Sim Lab procedures not accepted)	A minimum of 1	☐
☐	Nephrology: Changing dry weight, checking declots (Dialysis Centers Only)	Initial Criteria for Core Privileges	20 nephrology patient contacts in the last 2 years	2 concurrent or retrospective chart reviews.	☐
☐	OB Care: Prenatal and post-partum care	Documentation of training and 20 prenatal/ post-partum cases in the last 2 years.	20 prenatal/ post-partum cases in the last 2 years.	2 concurrent or retrospective chart reviews.	☐
☐	OB ultrasonography: Evaluation of fetal presentation, number, confirmation of cardiac activity, position and placental placement	Completion of Basic Obstetric Ultrasound course in limited U/S and 10 in the last 2 years.	10 in the last 2 years.	3 concurrent and/or retrospective chart reviews	☐
☐	Paragard and Mirena IUD insertion/removal	Documentation of training and 10 procedures in the last 2 years	2 in the last 2 years.	A minimum of 1	☐
☐	Nexplanon insertion	Documentation of training and 10 procedures in the last 2 years	2 in the last 2 years.	A minimum of 1	☐
☐	Pelvic examinations, including pap smears	Documentation of training and 10 procedures in the last 2 years	2 in the last 2 years.	A minimum of 1	☐
☐	Endometrial Biopsy	Documentation of training and 10 procedures in the last 2 years	2 in the last 2 years.	A minimum of 1	☐
☐	Biopsy of the cervix	Documentation of training and 10 procedures in the last 2 years	2 in the last 2 years.	A minimum of 1	☐
☐	Perform pharmacological and non-pharmacological stress tests (Chronic Disease Management Center Only)	10 procedures in the last 2 years	10 in the last 2 years	2 concurrent	☐
☐	Radiation Oncology: Assist with simulations; high dose rate brachytherapy, intravenous radioactive therapy, oral radioactive administration and atrontium beta-irradiation application	A minimum of 3-month training period with a radiation oncologist OR previous experience.	10 in the last 2 years	A minimum of 10 (including Core)	☐

ADDITIONAL PRIVILEGES

Request	Procedure	Initial Criteria	Renewal Criteria	FPPE	Approve
☐	~~Performance of Procedures under fluoroscopic guidance~~ Use of fluoroscopy equipment (or supervision of other staff using the equipment.	~~Meet Initial Criteria AND~~ Current and valid CA Fluoroscopy supervisor and Operator Permit or a CA Radiology Supervisor and Operator Permit	Current and valid CA Fluoroscopy supervisor and Operator Permit or a CA Radiology Supervisor and Operator Permit	None	☐

Provider Name: ____ Date: ________________
Please Print

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 Health 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.

____ ______________
Advanced Practice Provider Signature *Date*

____ ______________
Supervising/Collaborating Physician Signature *Date*

DEPARTMENT CHAIR SIGNATURE(S) :

____ ______________
Department of Cardiovascular Services *Date*

____ ______________
Department of Critical Care, Pulmonary & Adult Hospitalist *Date*

____ ______________
Department of Family Medicine *Date*

____ ______________
Department of Internal Medicine *Date*

____ ______________
Department of OB/GYN *Date*

____ ______________
Department of Pediatrics *Date*

____ ______________
Department of Psychiatry & Neurosciences *Date*

____ ______________
Department of Radiology *Date*

____ ______________
Department of Surgery *Date*

Policy Number: CP.01	Date Created: 03/21/2022
Document Owner: Lisa Wass (Compliance Analyst)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Compliance Committee, Amy Valero (Compliance Manager), Ben Cripps (Chief Compliance/Risk Officer)	
Compliance Program Administration	

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

Purpose:

The Kaweah Delta Health Care District ("Kaweah ~~Delta~~Health") Compliance Program was developed to:

1. Establish standards and procedures to be followed by all Kaweah ~~Delta~~ Health employees to effect compliance with applicable federal, state and local laws, regulations and ordinances, Administrative Regulations, Medical Staff Bylaws, and Kaweah ~~Delta~~ Health policies;
2. Designate the Kaweah ~~Delta~~ Health official responsible for directing the effort to enhance compliance including implementation of the Compliance Program;
3. Document compliance efforts;
4. Ensure Discretionary Authority is given to appropriate persons;
5. Provide a means for communicating to all Kaweah ~~Delta~~ Health employees the legal and ethical standards and procedures all employees are expected to follow;
6. Establish minimum standards for billing and collection activities, including a system of monitoring and oversight of billing activity to ensure adherence to the standards and procedures established;
7. Provide a means for reporting apparent illegal or unethical activity to the appropriate authorities;
8. Provide for the enforcement of ethical and legal standards;
9. Provide a mechanism to investigate any alleged violations and to prevent future violations;
10. Increase training of medical staff members and billing personnel concerning applicable billing requirements and Kaweah ~~Delta~~ Health policies;

11. Provide for regular review of overall compliance efforts to ensure that practices reflect current requirements and that other adjustments made to improve the Compliance Program;

12. Monitor provision of quality care to the patients served by Kaweah ~~Delta~~Health;

13. Promote effective communication between Kaweah ~~Delta's~~ Health's Legal Counsel, Executive Team, and Board of Directors;

14. Preserve the financial viability of Kaweah ~~Delta~~Health; and

15. Enforce consistent disciplinary mechanisms for compliance or privacy violations.

Policy:

Kaweah ~~Delta~~Health, and its affiliated health care facilities, requires all employees, agents and medical staff members to act, at all times, in an ethical and legal manner, consistent with all applicable legal, governmental, and professional standards and requirements. In order to avoid even the appearance of impropriety or conflict of interest, this Compliance Program applies to employees, agents, faculty, and medical staff within Kaweah ~~Delta~~Health, without regard to an individual's specific job duties or function. It is the policy of Kaweah ~~Delta~~ Health that all services and business transactions rendered by Kaweah ~~Delta~~ Health shall be carried out and documented in accordance with federal, state, and local laws, regulations, and interpretations. This Compliance Program is intended to enhance and further demonstrate Kaweah ~~Delta's~~ Health's commitment to honest and fair dealing by providing an effective means by which to prevent and detect illegal, unethical or abusive conduct. Kaweah ~~Delta~~ Health will exercise due diligence in its efforts to ensure that the Compliance Program is effective in its design, implementation, and enforcement. Kaweah ~~Delta~~ Health employees are expected to deal fairly and honestly with patients and their families, suppliers, third-party payors, and their professional associates. Adherence to the Compliance Program is a condition of employment at Kaweah ~~Delta~~Health. Likewise, the granting of medical staff privileges and the offer of employment at Kaweah ~~Delta~~ Health is contingent upon acceptance of and compliance with the Compliance Program.

Kaweah Health encourages transparency and honesty in an effort to encourage employees to report suspected fraud and improprieties. Kaweah ~~Delta~~ Health will not tolerate retaliation against any employee who reports suspected wrongdoing. See CP.13 ~~See~~ Federal and State False Claims Act and Employee Protection Provisions. All reported information will be investigated, tracked and remediated according to Kaweah ~~Delta~~ Health policy and shall be kept confidential to the maximum extent possible.

Process:

The Compliance Program was developed to provide oversite of compliance administrative efforts including (1) establishing operating protocol and standards; (2) designating oversight responsibilities; (3) providing employee compliance training; (4) monitoring and auditing; (5) supporting and facilitating open lines of communication and reporting; (6) following through with enforcement and disciplinary procedures; and (7) establishing response and prevention plans.

1. **Establishing Operating Protocol and Standards of Conduct** – For the purposes of preventing illegal, unethical or abusive conduct, compliance Standards of Conduct and procedures shall be implemented and followed by all employees and agents of Kaweah ~~Delta~~Health. The procedures shall include mechanisms for reporting fraud, waste, abuse, and other wrongdoing. The reporting procedures shall be set in a manner that promotes the internal discovery and reporting of wrongdoings and/or non-compliance.

~~1.~~2. **Designating Oversight Responsibilities** – The ~~VP &~~ Chief Compliance and ~~Privacy~~Risk Officer and Kaweah ~~Delta~~ Health Leadership shall oversee and enforce compliance standards and procedures. The ~~VP &~~ Chief Compliance and ~~Privacy~~Risk Officer shall have the authority to take appropriate action to assure effective implementation of compliance efforts. The ~~VP&~~ Chief Compliance and ~~Privacy~~ Risk Officer shall report directly to the Chief Executive Officer (CEO) and the Board of Directors.

   The ~~VP &~~ Chief Compliance and ~~Privacy~~Risk Officer shall have unrestricted authority and access to review all entity records, physical properties, and personnel related to compliance audit and investigative activities. Any confidential information received or reviewed shall not be used in any manner which would be contrary to law or detrimental to the interests of Kaweah ~~Delta~~Health.

   Kaweah ~~Delta~~ Health shall employ individuals whose education, training, and abilities are appropriate to perform the jobs assigned to them. Kaweah ~~Delta~~ Health shall use due care to delegate substantial discretionary authority to appropriate competent individuals and shall use due care to avoid delegation of such authority to individuals whom he or she knows, or should have known, have a propensity to engage in illegal activities.

3. **Providing Employee Compliance Training** – Kaweah ~~Delta~~Health, through its Leadership, shall effectively communicate its standards and procedures to all staff members and agents by requiring mandatory participation in compliance training programs and by disseminating publications that explain the new policies, procedures and standards. See Compliance Program Education.

~~2.~~4. **Monitoring and Auditing** – Kaweah ~~Delta~~Health, through its Leadership, shall take reasonable steps to achieve compliance with its standards by utilizing, monitoring and auditing systems including the use of legal reviews of policies and procedures, financial audits and providing all staff members access to a hotline. See Compliance Reviews and Assessments.

~~3.~~5. **Supporting and Facilitating Open Lines of Communication and Reporting** – Kaweah ~~Delta~~Health allows for anonymity and/or confidentiality, whereby ~~the organization's~~ employees and agents of Kaweah ~~Delta~~Health may report or seek guidance regarding potential or actual ~~criminal conduct~~wrong~~-~~doings or non-compliance without fear of retaliation.

~~4.~~6. **Following through with Enforcement and Disciplinary Procedures** – Kaweah ~~Delta~~Health's compliance program shall be promoted and enforced consistently throughout the organization through appropriate disciplinary measures for engaging in criminal conduct, wrongdoings, non-compliance and/or for failing to take reasonable steps to prevent or detect criminal conduct. See HR.216 Progressive Discipline.

~~5.~~7. **Establishing Response and Prevention Plans** – The standards developed under the Kaweah ~~Delta~~ Health Compliance Program shall be enforced consistently through appropriate disciplinary mechanisms including discipline of individuals responsible for failing to detect and report an offense. The Compliance Program shall take reasonable steps to investigate and respond appropriately to all reported concerns. See Compliance and Privacy Issues Investigation and Resolution.

Procedure:

Reporting and Investigative Process and Non-Retaliation

Kaweah ~~Delta~~ Health employees aware of any illegal, unethical or abusive conduct or any other wrongdoing or non-compliance shall report the concern immediately to Leadership. If the employee is uncomfortable reporting their concern to Leadership for fear of retaliation or is concerned that no action may be taken, the employee should immediately contact:

Kaweah ~~Delta~~ Health ~~VP &~~ Chief Compliance and ~~Privacy~~ Risk Officer – ~~–~~(559) 624-5006

The Anonymous Compliance Line – ~~–~~(800) 998-8050

Kaweah Health~~Delta~~'s Compliance Advocate – ~~Dennis M. Lynch~~Rachel~~l~~e Berglund – ~~–~~(559) 636-0200~~738-8100 or (559) 280-3075~~

Employees will not be subject to retaliation for reporting, in good faith, action that they feel violates Standards of Conduct, a law, and/or Kaweah ~~Delta~~ Health policy.

Any employee engaging in any action of retaliation or reprisal for good faith reporting shall be subject to disciplinary action up to, and including, termination.

Investigation of Concerns

Investigations of suspected illegal, unethical, or abusive conduct or any other wrongdoing or non-compliance will be coordinated and organized by the ~~VP &~~ Chief Compliance and ~~Privacy~~Risk Officer, the Compliance Advocate, and/or Compliance Staff.

Internal Investigations

Internal investigation and resolution of compliance issues will be managed pursuant to ~~CP.05~~ Compliance and Privacy Issues Investigation and Resolution.

All reports of suspected or actual fraud and subsequent investigations and outcomes must be reported to the ~~VP &~~ Chief Compliance and ~~Privacy~~Risk Officer. The ~~VP &~~ Chief Compliance and ~~Privacy~~Risk Officer will contact the Compliance Advocate, the Chief Executive Officer, and the Kaweah ~~Delta~~ Health Chairperson of the Board of Directors (as necessary).

A financial audit will be conducted every year in accordance with Kaweah ~~Delta~~ Health policy and under appropriate audit guidelines and standards. A financial audit provides no assurance that Kaweah ~~Delta~~ Health complies with all federal laws and regulations; rather provides an opinion as to the general strength of the internal operating controls and procedures.

External Investigations

External investigations by a regulatory agency will be managed pursuant to Unannounced Regulatory Survey Plan for Response.

"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."

Compliance Manual

Policy Number: CP.01	Date Created: 07/09/2019
Document Owner: Lisa Wass (Compliance Analyst)	Date Approved: 09/03/2019
Approvers: Board of Directors (Administration), Compliance Committee, Amy Valero (Compliance Manager), Ben Cripps (Chief Compliance/Risk Officer)	
Compliance Program Administration	

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Purpose:

The Kaweah Delta Health Care District (“Kaweah Delta”) Compliance Program was developed to:

1. Establish standards and procedures to be followed by all Kaweah Delta employees to effect compliance with applicable federal, state and local laws, regulations and ordinances, Administrative Regulations, Medical Staff Bylaws, and Kaweah Delta policies;

2. Designate the Kaweah Delta official responsible for directing the effort to enhance compliance including implementation of the Compliance Program;

3. Document compliance efforts;

4. Ensure Discretionary Authority is given to appropriate persons;

5. Provide a means for communicating to all Kaweah Delta employees the legal and ethical standards and procedures all employees are expected to follow;

6. Establish minimum standards for billing and collection activities, including a system of monitoring and oversight of billing activity to ensure adherence to the standards and procedures established;

7. Provide a means for reporting apparent illegal or unethical activity to the appropriate authorities;

8. Provide for the enforcement of ethical and legal standards;

9. Provide a mechanism to investigate any alleged violations and to prevent future violations;

10. Increase training of medical staff members and billing personnel concerning applicable billing requirements and Kaweah Delta policies;

11. Provide for regular review of overall compliance efforts to ensure that practices reflect current requirements and that other adjustments made to improve the Compliance Program;

12. Monitor provision of quality care to the patients served by Kaweah Delta;
13. Promote effective communication between Kaweah Delta's Legal Counsel, Executive Team, and Board of Directors;
14. Preserve the financial viability of Kaweah Delta; and
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Policy:

Kaweah Delta, and its affiliated health care facilities, requires all employees, agents and medical staff members to act, at all times, in an ethical and legal manner, consistent with all applicable legal, governmental, and professional standards and requirements. In order to avoid even the appearance of impropriety or conflict of interest, this Compliance Program applies to employees, agents, faculty, and medical staff within Kaweah Delta, without regard to an individual's specific job duties or function. It is the policy of Kaweah Delta that all services and business transactions rendered by Kaweah Delta shall be carried out and documented in accordance with federal, state, and local laws, regulations, and interpretations. This Compliance Program is intended to enhance and further demonstrate Kaweah Delta's commitment to honest and fair dealing by providing an effective means by which to prevent and detect illegal, unethical or abusive conduct. Kaweah Delta will exercise due diligence in its efforts to ensure that the Compliance Program is effective in its design, implementation, and enforcement. Kaweah Delta employees are expected to deal fairly and honestly with patients and their families, suppliers, third-party payors, and their professional associates. Adherence to the Compliance Program is a condition of employment at Kaweah Delta. Likewise, the granting of medical staff privileges and the offer of employment at Kaweah Delta is contingent upon acceptance of and compliance with the Compliance Program.

Kaweah encourages transparency and honesty in an effort to encourage employees to report suspected fraud and improprieties. Kaweah Delta will not tolerate retaliation against any employee who reports suspected wrongdoing. See CP.13 Federal and State False Claims Act and Employee Protection Provisions. All reported information will be investigated, tracked and remediated according to Kaweah Delta policy and shall be kept confidential to the maximum extent possible.

Process:

The Compliance Program was developed to provide oversite of compliance administrative efforts including (1) establishing operating protocol and standards; (2) designating oversight responsibilities; (3) providing employee compliance training; (4) monitoring and auditing; (5) supporting and facilitating open lines of communication and reporting; (6) following through with enforcement and disciplinary procedures; and (7) establishing response and prevention plans.

1. **Establishing Operating Protocol and Standards of Conduct** – For the purposes of preventing illegal, unethical or abusive conduct, compliance Standards of Conduct and procedures shall be implemented and followed by all employees and agents of Kaweah Delta. The procedures shall include mechanisms for reporting fraud, waste, abuse, and other wrongdoing. The reporting procedures shall be set in a manner that promotes the internal discovery and reporting of wrongdoings and/or non-compliance.

2. **Designating Oversight Responsibilities** – The Compliance and Privacy Officer and Kaweah Delta Leadership shall oversee and enforce compliance standards and procedures. The Compliance and Privacy Officer shall have the authority to take appropriate action to assure effective implementation of compliance efforts. The Compliance and Privacy Officer shall report directly to the Chief Executive Officer (CEO) and the Board of Directors.

   The Compliance and Privacy Officer shall have unrestricted authority and access to review all entity records, physical properties, and personnel related to compliance audit and investigative activities. Any confidential information received or reviewed shall not be used in any manner which would be contrary to law or detrimental to the interests of Kaweah Delta.

   Kaweah Delta shall employ individuals whose education, training, and abilities are appropriate to perform the jobs assigned to them. Kaweah Delta shall use due care to delegate substantial discretionary authority to appropriate competent individuals and shall use due care to avoid delegation of such authority to individuals whom he or she knows, or should have known, have a propensity to engage in illegal activities.

3. **Providing Employee Compliance Training** – Kaweah Delta, through its Leadership, shall effectively communicate its standards and procedures to all staff members and agents by requiring mandatory participation in compliance training programs and by disseminating publications that explain the new policies, procedures and standards. See Compliance Program Education.

4. **Monitoring and Auditing** – Kaweah Delta, through its Leadership, shall take reasonable steps to achieve compliance with its standards by utilizing, monitoring and auditing systems including the use of legal

reviews of policies and procedures, financial audits and providing all staff members access to a hotline. See Compliance Reviews and Assessments.

5. **Supporting and Facilitating Open Lines of Communication and Reporting** – Kaweah Delta allows for anonymity and/or confidentiality, whereby employees and agents of Kaweah Delta may report or seek guidance regarding potential or actual wrongdoings or non-compliance without fear of retaliation.

6. **Following through with Enforcement and Disciplinary Procedures** – Kaweah Delta's compliance program shall be promoted and enforced consistently throughout the organization through appropriate disciplinary measures for engaging in criminal conduct, wrongdoings, non-compliance and/or for failing to take reasonable steps to prevent or detect criminal conduct. See HR.216 Progressive Discipline.

7. **Establishing Response and Prevention Plans** – The standards developed under the Kaweah Delta Compliance Program shall be enforced consistently through appropriate disciplinary mechanisms including discipline of individuals responsible for failing to detect and report an offense. The Compliance Program shall take reasonable steps to investigate and respond appropriately to all reported concerns. See Compliance and Privacy Issues Investigation and Resolution.

Procedure:

Reporting and Investigative Process and Non-Retaliation

Kaweah Delta employees aware of any illegal, unethical or abusive conduct or any other wrongdoing or non-compliance shall report the concern immediately to Leadership. If the employee is uncomfortable reporting their concern to Leadership for fear of retaliation or is concerned that no action may be taken, the employee should immediately contact:

Kaweah Delta Compliance and Privacy Officer – (559) 624-5006

The Anonymous Compliance Line – (800) 998-8050

Kaweah Delta's Compliance Advocate – Dennis M. Lynch
(559) 738-8100 or (559) 280-3075

Employees will not be subject to retaliation for reporting, in good faith, action that they feel violates Standards of Conduct, a law, and/or Kaweah Delta policy. Any employee engaging in any action of retaliation or reprisal for good faith reporting shall be subject to disciplinary action up to, and including, termination.

Investigation of Concerns

Investigations of suspected illegal, unethical, or abusive conduct or any other wrongdoing or non-compliance will be coordinated and organized by the Compliance and Privacy Officer, the Compliance Advocate, and/or Compliance Staff.

Internal Investigations

Internal investigation and resolution of compliance issues will be managed pursuant to Compliance and Privacy Issues Investigation and Resolution.

All reports of suspected or actual fraud and subsequent investigations and outcomes must be reported to the Compliance and Privacy Officer. The Compliance and Privacy Officer will contact the Compliance Advocate, the Chief Executive Officer, and the Kaweah Delta Chairperson of the Board of Directors (as necessary).

A financial audit will be conducted every year in accordance with Kaweah Delta policy and under appropriate audit guidelines and standards. A financial audit provides no assurance that Kaweah Delta complies with all federal laws and regulations; rather provides an opinion as to the general strength of the internal operating controls and procedures.

External Investigations

External investigations by a regulatory agency will be managed pursuant to Unannounced Regulatory Survey Plan for Response**.**

"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: CP.03	Date Created: 04/21/2022
Document Owner: Lisa Wass (Compliance Analyst)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Compliance Committee, Ben Cripps (Chief Compliance/Risk Officer)	
Physician Contracts and Relationships	

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

Purpose:

The purpose of this Policy and Procedure is to establish guidelines for the orderly processing of negotiating, documenting, and administering contracts between Kaweah Delta Health Care District ("Kaweah Delta") and physician(s) or physician groups. This policy must be followed prior to entering into any arrangement (i) in which Kaweah Delta engages physicians to provide services or space/items to Kaweah Delta, or (ii) in which Kaweah Delta provides any services, space, staff, equipment or items to physicians.

Policy:

It is the policy of Kaweah Delta to comply with all state and federal laws. Kaweah Delta shall execute contracts with physicians and physician groups ("physician(s)") that comply with all applicable laws and regulations, including those designed to prevent the provision of improper payments, inappropriate referrals, and/or inappropriate inducements to refer. To that end, Kaweah Delta will negotiate, document, and administer Agreements that comply with the following standards:

I. The Agreement shall be set out in writing and signed by all parties. The terms of the Agreements must be commercially reasonable.

II. The arrangement must be commercially reasonable, and the compensation under the arrangement must be set in advance, established at fair market value through an arms-length transaction, and must not take into account the volume or value of referrals for an item or service reimbursable by a state or federal program or other business generated between the parties.

III. All items and services covered by an Agreement with physician(s) must address a legitimate need of Kaweah Delta, must actually be provided by the physician(s), and must be specifically described in sufficient detail in the Agreement.

IV. The Agreement shall specify the compensation terms in sufficient and measurable detail.

V. The term of the Agreement shall be for not less than twelve (12) months, or longer than thirty-six (36) months unless approved by the Chief Executive Officer (CEO) and Board in consultation with Legal Counsel and allowable under District Law. Contracts shall not automatically renew.

VI. The services performed under the Agreement shall not involve the counseling or promotion of a business arrangement or other activity that violates any state or federal law.

VII. All Agreements between Kaweah Delta and physician(s) for any purpose shall be prepared by, or in collaboration with, Kaweah Delta's Legal Counsel for signature by the parties**.**

VIII. Any payment to physician(s) shall be made only pursuant to an Agreement that has been formally executed between Kaweah Delta and the physician(s). Medical Director payments will be made only pursuant to approved time records submitted by the physicians. Likewise, payments to physician(s) will require documentation of availability and/or services rendered.

IX. Gifts and financial benefits to a physician or their office shall not exceed the annual physician non-monetary compensation threshold as established by the Federal Stark Law. Any gift or benefit provided to physician(s) or a physician's office must first be approved, documented, and tracked through the Medical Staff Office.

Procedure:

I. Fair Market Value (FMV) – State and federal law require a documented and objective determination that the payment between Kaweah Delta and physician(s) is consistent with FMV. Such determination may be evidenced by an approved vendor-written appraisal/valuation, an approved published third-party source, or as otherwise approved by Legal Counsel. The Chief Compliance Officer (CCO) (or designee) will oversee the management and administration of the FMV process.

The CCO (or designee) must be contacted before entering into negotiations of any physician Agreement to evaluate the FMV compensation needs. The negotiated rate must be reviewed and approved by the CCO (or designee) before Legal Counsel is engaged to draft or modify the Agreement. The FMV compensation process will be documented and administered in the following manner:

A. Medical Director Agreements – The Compliance Department will maintain an updated listing of all Medical Director positions by specialty and the corresponding FMV range. ~~Vice President~~Executive(s) ~~(VP)~~ (or designee) may negotiate rates up to the 50th percentile. Negotiations between the 51st and 65th percentiles require documented justification and CEO approval. Negotiations beyond the 65th percentile require Executive FMV Committee approval (CEO, Board Chair, and CCO).

B. Recruitment Agreements – The Compliance Department will maintain a listing of Board approved physician recruitment needs by specialty and the corresponding FMV range. The Chief Compliance Officer, ~~VP~~ Chief Strategy Officer, and Director of Physician Recruitment and Relations will make recommendations to the Physician Compensation Committee. The Physician Compensation Committee will approve the negotiated rates up to the 50th percentile. Negotiations between the 51st and 65th percentiles require documented justification and CEO approval. Negotiations beyond

the 65th percentile require Executive FMV Committee approval (CEO, Board Chair, and CCO).

C. Exclusive and Non-Exclusive Provider Agreements – The FMV rate must be established through an independent and external FMV assessment. The ~~VP~~ Executive (or designee) will work with the CCO (or designee) to engage Legal Counsel and a third-party valuation firm. The CCO (or designee) will facilitate the Fair Market Valuation process to ensure the data and assumptions are documented and appropriate.

1. Changes to compensation terms and/or methodologies must be reviewed by the Executive Team and formally approved by the CCO and CEO. This provision and approval process applies to all Exclusive and Non-Exclusive Provider Agreements including new or potential agreements, contract renewals, and agreements that allow for compensation changes throughout the term of the agreement.

D. Space Lease Agreement - The ~~VP~~ Executive(or designee) will work with the CCO (or designee) and Legal Counsel to establish the FMV rate. The Space Lease calculation must be reviewed by the CCO (or designee) and approved by Legal Counsel.

II. Medical Director Agreements

A. New and existing Medical Director Agreements shall be prepared and executed using the process outlined in Exhibit A.

B. The ~~VP~~Executive is responsible for ensuring the necessity of a Medical Director position and ensuring the physician satisfies any qualification or training requirements and provides required services.

C. Compliance will maintain a listing of Medical Director positions required by federal, state, or Joint Commission accreditation. Compliance must be contacted immediately of a statute, regulation, or other standard requiring a Medical Director position. If a new Medical Director position is not required, the ~~VP~~ Executive must demonstrate the necessity and/or benefit to Kaweah Delta, and present the need to the Executive Team for review and approval.

D. Semi-Annually, Compliance will provide a listing of all Medical Director positions to the Executive Team for review and evaluation. Medical Director positions not required by federal, state, or Joint Commission accreditation will be reviewed by the Executive Team to evaluate and demonstrate the necessity and/or benefit to Kaweah Delta.

E. Monthly payments to Medical Directors must be supported by approved time records as follows:

1. Physician(s) must track time spent on activities/responsibilities outlined in the Agreement.

2. Physician(s) shall record activities by date in the electronic time record system. Physician(s) may use a method other than electronic to document and submit time records when approved by the responsible ~~VP~~ Executive and by Finance Department.

3. Physician(s) time records submitted in any format must include an attestation statement signed by the physician(s) (electronic signature process is used in the electronic time record system).

4. The responsible Executive ~~VP~~ (or designee) must review and approve time records and approve the payment amount to authorize payment. Evidence of such approval must include an original or electronic signature by the ~~VP~~Executive.

5. Upon receipt of the approved time record and payment amount, Accounts Payable will process the payment for the amount approved by the Executive~~VP~~.

6. The responsible ~~VP~~Executive (or designee) will promptly meet with the Medical Director if they fail to (i) submit time records in a timely manner or (ii) provide services in the manner set forth in the Agreement. Recurring performance issues shall be immediately reported to the CCO.

III. New and existing and Exclusive and Non-Exclusive Physician Provider Agreements shall be prepared and executed using the processes outlined in Exhibits B, C, and D.

IV. Physician Lease of Space Agreements shall be negotiated by the responsible ~~VP~~ Executive (or designee).

The proposed lease rate shall be at FMV.

1. Market analysis must be documented.
2. Rate must be reviewed by the CCO (or designee) and approved by Legal Counsel.

V. Physician Recruitment Agreements shall be negotiated by the Director of Physician Recruitment and Relations or responsible ~~VP~~Executive (or designee) consistent with AP.126 – (AP126) Physician Recruitment Policy (v.2).

A. The terms of the Agreement shall follow current physician recruitment guidelines approved by the Board of Directors.

B. The proposed income guarantee shall be at FMV.

1. Market analysis must be documented.

2. Compensation arrangement must be approved by the CCO (or designee).

IV. Information on all signed Agreements will be maintained in the contract database (see AP.69 Requirement for Contracting with Outside Service Providers).

X. Modifications – In the event physician(s) requests any modifications to the Agreement language, the ~~VP~~Executvie (or designee) shall forward the requests to Legal Counsel for consideration. If the changes are agreeable, a modified Agreement or Addendum will be provided to the ~~VP~~ Executive (or designee). If changes are not agreeable, Legal Counsel will provide explanations to the ~~VP~~Executive (or designee).

XI. Board Approval – Board Approval is required as described below:

A. Medical Director Agreements – New or established Medical Director Agreements do not require review and approval by the Board if the expense has been accounted for within the current fiscal budget.

B. Non-Exclusive Providers Agreements – New or established Non-Exclusive Provider Agreements do not require review and approval by the Board if the expense has been accounted for in the current fiscal year budget.

C. Exclusive Provider Agreements – All new or unbudgeted Exclusive Provider Agreements must be submitted to the Board of Directors for review and approval.

VI. Monitoring –

A. The Compliance and/or Internal Audit Departments may complete periodic audits of Medical Directors and Physician Providers Agreements.

B. Prior to the expiration of the Agreement, the ~~VP~~Executive (or designee) is required to evaluate position duties, requirements, and hours, and to solicit input from key stakeholders including Kaweah Delta staff and/or Medical Staff as appropriate.

VII. Gifts and other financial benefits given to a physician(s) or their office staff shall be recorded by the Medical Office.

A. Any employee/department must contact the Medical Staff Office prior to giving any gifts/financial benefit.

B. The Medical Staff Office must confirm that total financial benefits to the physician(s) and their office do not exceed the annual physician non-monetary compensation threshold for the current calendar year.

C. The Medical Staff Office will log the gift/financial benefit.

D. The value of a gift given to a group of physicians shall be divided and attributed to each physician equally.

Any violators may be subject to disciplinary action for violating Kaweah Delta policy.

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EXHIBIT A

MEDICAL DIRECTOR CONTRACT CHECKLIST

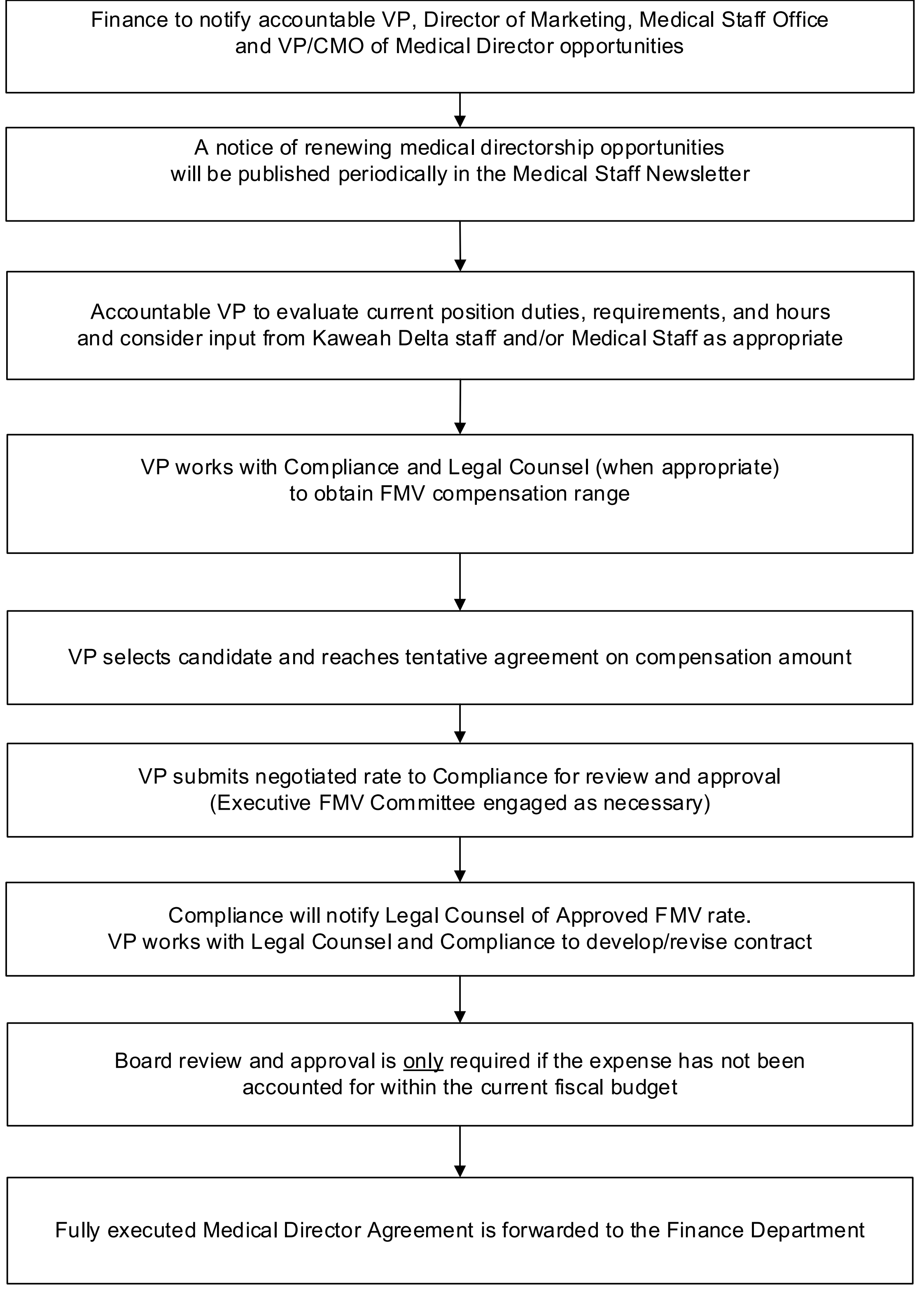

EXHIBIT B

PROVIDER CONTRACT RENEWALS

Exclusive and Non-Exclusive Provider Agreements

Finance to notify accountable VP and Medical Staff Office of upcoming Provider Contract expiration

Accountable VP to solicit input from Kaweah Delta staff on
1. Quality of performance by current provider and/or potential candidates
2. Recommendations or revisions to the current duties or requirements

Exclusive Provider Agreements

Medical Staff Officers consider input from medical staff on:
1) Quality of performance by current provider and/or new potential providers
2) Recommendations or revisions to the current duties or requirements

MEC Recommendations:
(Up to Six (6) months prior to expiration of contract)
1. Provider evaluations
2. Performance changes/revisions to the expectations/ services (Medical Staff Organizations role is completed at this time and MEC acknowledgement of opportunity to provide input into the provider's performance and into expectations/services incorporated into the agreement will be documented in MEC's minutes)

Non-Exclusive Provider Agreements

Accountable VP may solicit input from Medical Staff on
1. Quality of performance by current provider and/or potential candidates
2. Recommendations or revisions to the current duties or requirements

Formal Request for Proposal (RFP) is conducted (if appropriate)

Physician/Physician Group is selected

VP works with Compliance, Legal Counsel and FMV Consulting Firm to establish FMV range

VP and physician/physician group negotiate and reach tentative agreement on rate

Negotiated rate and FMV analysis to Compliance for Review and Approval

Compliance will notify Legal Counsel of approved FMV rate
VP works with Legal Counsel and Compliance to develop/revise contract

VP presents the new or unbudgeted Exclusive Provider Agreement to Board for review and approval
(Board approval not required for budgeted Non-Exclusive Provider Agreements)

Fully executed Exclusive / Non-Exclusive Provider Agreement is forwarded to the Finance Department

EXHIBIT C

NEW PROVIDER CONTRACT

Exclusive Provider Agreements

Vice President and Kaweah Delta Health Care District Board of Directors requests MEC to review Exclusive Provider arrangement

↓

MEC (or Subcommittee appointed by Chief of Staff) review quality of care and service implications of proposed exclusive provider contract.

Review includes evaluation from:
1. Members of applicable specialty involved
2. Members of other specialties who directly utilize or rely on the specialty under evaluation
3. Kaweah Delta Administration

↓

VP and Board receive and review MEC recommendations and make a decision to proceed with Exclusive Provider arrangement or Board Resolution

↓

Formal Request for Proposal (RFP) is conducted (if appropriate)

↓

Physician/Physician Group is selected

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VP works with Compliance, Legal Counsel and FMV Consulting Firm to establish FMV range

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VP and physician/physician group negotiate and reach tentative agreement on rate

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Negotiated rate and FMV analysis to Compliance for review and approval

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Compliance will notify Legal Counsel of approved FMV rate
VP works with Legal Counsel and Compliance to develop/revise contract

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VP presents the new Exclusive Provider Agreement to Board of Directors for review and approval

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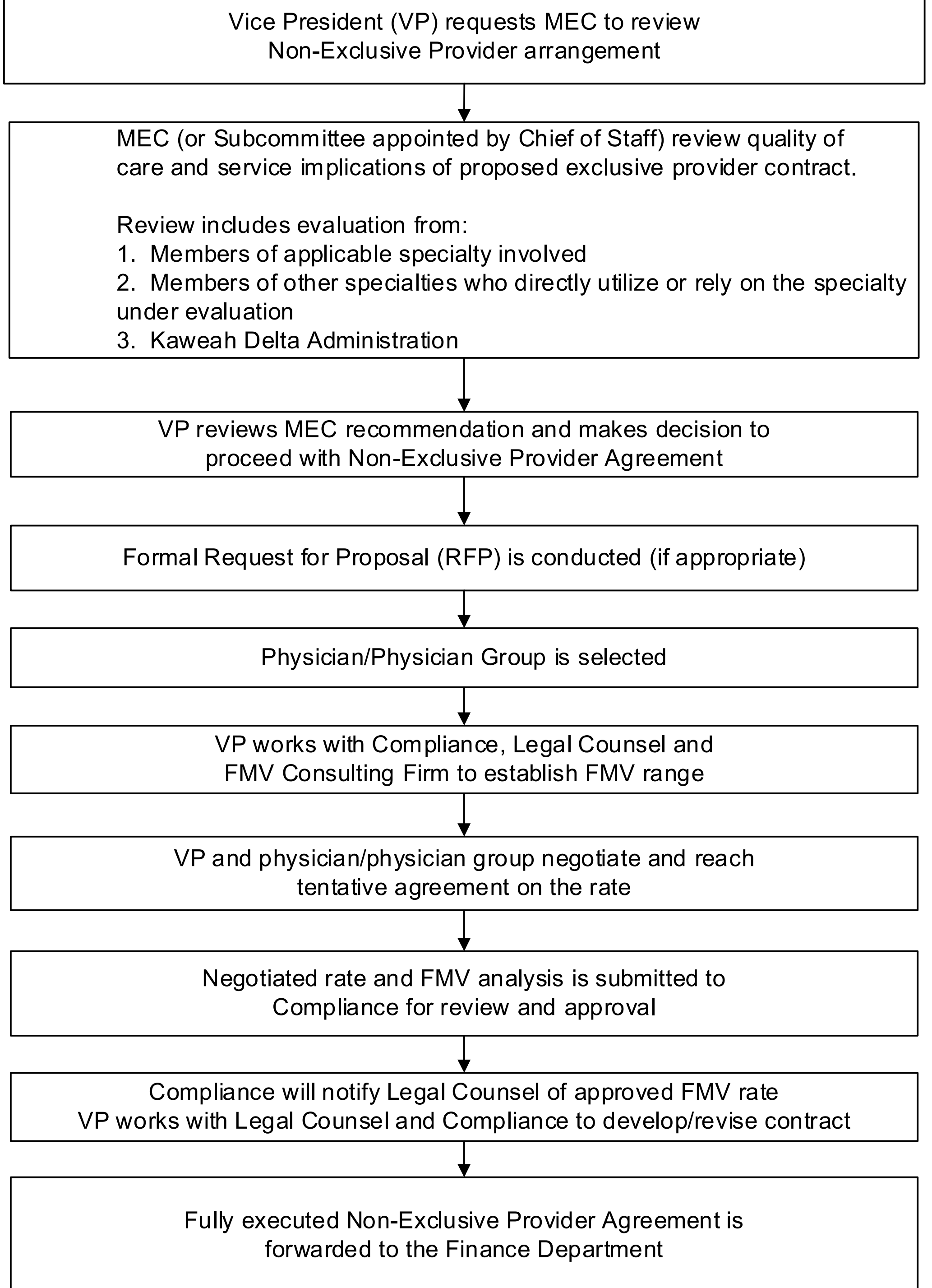
Fully executed Non-Exclusive Provider Agreement is forwarded to the Finance Department

EXHIBIT D

NEW PROVIDER CONTRACT

Non-Exclusive Provider Agreements



Policy Number: CP.03	Date Created: 07/30/2020
Document Owner: Lisa Wass (Compliance Analyst)	Date Approved: 03/08/2021
Approvers: Board of Directors (Administration), Compliance Committee, Ben Cripps (Chief Compliance/Risk Officer)	
Physician Contracts and Relationships	

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

Purpose:

The purpose of this Policy and Procedure is to establish guidelines for the orderly processing of negotiating, documenting, and administering contracts between Kaweah Delta Health Care District ("Kaweah Delta") and physician(s) or physician groups. This policy must be followed prior to entering into any arrangement (i) in which Kaweah Delta engages physicians to provide services or space/items to Kaweah Delta, or (ii) in which Kaweah Delta provides any services, space, staff, equipment or items to physicians.

Policy:

It is the policy of Kaweah Delta to comply with all state and federal laws. Kaweah Delta shall execute contracts with physicians and physician groups ("physician(s)") that comply with all applicable laws and regulations, including those designed to prevent the provision of improper payments, inappropriate referrals, and/or inappropriate inducements to refer. To that end, Kaweah Delta will negotiate, document, and administer Agreements that comply with the following standards:

I. The Agreement shall be set out in writing and signed by all parties. The terms of the Agreements must be commercially reasonable.

II. The arrangement must be commercially reasonable, and the compensation under the arrangement must be set in advance, established at fair market value through an arms-length transaction, and must not take into account the volume or value of referrals for an item or service reimbursable by a state or federal program or other business generated between the parties.

III. All items and services covered by an Agreement with physician(s) must address a legitimate need of Kaweah Delta, must actually be provided by the physician(s), and must be specifically described in sufficient detail in the Agreement.

IV. The Agreement shall specify the compensation terms in sufficient and measurable detail.

V. The term of the Agreement shall be for not less than twelve (12) months, or longer than thirty-six (36) months unless approved by the Chief Executive Officer (CEO) and Board in consultation with Legal Counsel and allowable under District Law. Contracts shall not automatically renew.

VI. The services performed under the Agreement shall not involve the counseling or promotion of a business arrangement or other activity that violates any state or federal law.

VII. All Agreements between Kaweah Delta and physician(s) for any purpose shall be prepared by, or in collaboration with, Kaweah Delta's Legal Counsel for signature by the parties**.**

VIII. Any payment to physician(s) shall be made only pursuant to an Agreement that has been formally executed between Kaweah Delta and the physician(s). Medical Director payments will be made only pursuant to approved time records submitted by the physicians. Likewise, payments to physician(s) will require documentation of availability and/or services rendered.

IX. Gifts and financial benefits to a physician or their office shall not exceed the annual physician non-monetary compensation threshold as established by the Federal Stark Law. Any gift or benefit provided to physician(s) or a physician's office must first be approved, documented, and tracked through the Medical Staff Office.

Procedure:

I. Fair Market Value (FMV) – State and federal law require a documented and objective determination that the payment between Kaweah Delta and physician(s) is consistent with FMV. Such determination may be evidenced by an approved vendor-written appraisal/valuation, an approved published third-party source, or as otherwise approved by Legal Counsel. The Chief Compliance Officer (CCO) (or designee) will oversee the management and administration of the FMV process.

The CCO (or designee) must be contacted before entering into negotiations of any physician Agreement to evaluate the FMV compensation needs. The negotiated rate must be reviewed and approved by the CCO (or designee) before Legal Counsel is engaged to draft or modify the Agreement. The FMV compensation process will be documented and administered in the following manner:

A. Medical Director Agreements – The Compliance Department will maintain an updated listing of all Medical Director positions by specialty and the corresponding FMV range. Vice President(s) (VP) (or designee) may negotiate rates up to the 50th percentile. Negotiations between the 51st and 65th percentiles require documented justification and CEO approval. Negotiations beyond the 65th percentile require Executive FMV Committee approval (CEO, Board Chair, and CCO).

B. Recruitment Agreements – The Compliance Department will maintain a listing of Board approved physician recruitment needs by specialty and the corresponding FMV range. The Chief Compliance Officer, VP Chief Strategy Officer, and Director of Physician Recruitment and Relations will make recommendations to the Physician Compensation Committee. The Physician Compensation Committee will approve the negotiated rates up to the 50th percentile. Negotiations between the 51st and 65th percentiles require documented justification and CEO approval. Negotiations beyond

the 65th percentile require Executive FMV Committee approval (CEO, Board Chair, and CCO).

C. Exclusive and Non-Exclusive Provider Agreements – The FMV rate must be established through an independent and external FMV assessment. The VP (or designee) will work with the CCO (or designee) to engage Legal Counsel and a third-party valuation firm. The CCO (or designee) will facilitate the Fair Market Valuation process to ensure the data and assumptions are documented and appropriate.

1. Changes to compensation terms and/or methodologies must be reviewed by the Executive Team and formally approved by the CCO and CEO. This provision and approval process applies to all Exclusive and Non-Exclusive Provider Agreements including new or potential agreements, contract renewals, and agreements that allow for compensation changes throughout the term of the agreement.

D. Space Lease Agreement - The VP (or designee) will work with the CCO (or designee) and Legal Counsel to establish the FMV rate. The Space Lease calculation must be reviewed by the CCO (or designee) and approved by Legal Counsel.

II. Medical Director Agreements

A. New and existing Medical Director Agreements shall be prepared and executed using the process outlined in Exhibit A.

B. The VP is responsible for ensuring the necessity of a Medical Director position and ensuring the physician satisfies any qualification or training requirements and provides required services.

C. Compliance will maintain a listing of Medical Director positions required by federal, state, or Joint Commission accreditation. Compliance must be contacted immediately of a statute, regulation, or other standard requiring a Medical Director position. If a new Medical Director position is not required, the VP must demonstrate the necessity and/or benefit to Kaweah Delta, and present the need to the Executive Team for review and approval.

D. Semi-Annually, Compliance will provide a listing of all Medical Director positions to the Executive Team for review and evaluation. Medical Director positions not required by federal, state, or Joint Commission accreditation will be reviewed by the Executive Team to evaluate and demonstrate the necessity and/or benefit to Kaweah Delta.

E. Monthly payments to Medical Directors must be supported by approved time records as follows:

1. Physician(s) must track time spent on activities/responsibilities outlined in the Agreement.

2. Physician(s) shall record activities by date in the electronic time record system. Physician(s) may use a method other than electronic to document and submit time records when approved by the responsible VP and by Finance Department.

3. Physician(s) time records submitted in any format must include an attestation statement signed by the physician(s) (electronic signature process is used in the electronic time record system).
4. The responsible VP (or designee) must review and approve time records and approve the payment amount to authorize payment. Evidence of such approval must include an original or electronic signature by the VP.
5. Upon receipt of the approved time record and payment amount, Accounts Payable will process the payment for the amount approved by the VP.
6. The responsible VP (or designee) will promptly meet with the Medical Director if they fail to (i) submit time records in a timely manner or (ii) provide services in the manner set forth in the Agreement. Recurring performance issues shall be immediately reported to the CCO.

III. New and existing and Exclusive and Non-Exclusive Physician Provider Agreements shall be prepared and executed using the processes outlined in Exhibits B, C, and D.

IV. Physician Lease of Space Agreements shall be negotiated by the responsible VP (or designee).

The proposed lease rate shall be at FMV.

1. Market analysis must be documented.
2. Rate must be reviewed by the CCO (or designee) and approved by Legal Counsel.

V. Physician Recruitment Agreements shall be negotiated by the Director of Physician Recruitment and Relations or responsible VP (or designee) consistent with AP.126 – (AP126) Physician Recruitment Policy (v.2).

A. The terms of the Agreement shall follow current physician recruitment guidelines approved by the Board of Directors.

B. The proposed income guarantee shall be at FMV.

1. Market analysis must be documented.
2. Compensation arrangement must be approved by the CCO (or designee).

IV. Information on all signed Agreements will be maintained in the contract database (see AP.69 Requirement for Contracting with Outside Service Providers).

X. Modifications – In the event physician(s) requests any modifications to the Agreement language, the VP (or designee) shall forward the requests to Legal Counsel for consideration. If the changes are agreeable, a modified Agreement or Addendum will be provided to the VP (or designee). If changes are not agreeable, Legal Counsel will provide explanations to the VP (or designee).

XI. Board Approval – Board Approval is required as described below:

A. Medical Director Agreements – New or established Medical Director Agreements do not require review and approval by the Board if the expense has been accounted for within the current fiscal budget.

B. Non-Exclusive Providers Agreements – New or established Non-Exclusive Provider Agreements do not require review and approval by the Board if the expense has been accounted for in the current fiscal year budget.

C. Exclusive Provider Agreements – All new or unbudgeted Exclusive Provider Agreements must be submitted to the Board of Directors for review and approval.

VI. Monitoring –

A. The Compliance and/or Internal Audit Departments may complete periodic audits of Medical Directors and Physician Providers Agreements.

B. Prior to the expiration of the Agreement, the VP (or designee) is required to evaluate position duties, requirements, and hours, and to solicit input from key stakeholders including Kaweah Delta staff and/or Medical Staff as appropriate.

VII. Gifts and other financial benefits given to a physician(s) or their office staff shall be recorded by the Medical Office.

A. Any employee/department must contact the Medical Staff Office prior to giving any gifts/financial benefit.

B. The Medical Staff Office must confirm that total financial benefits to the physician(s) and their office do not exceed the annual physician non-monetary compensation threshold for the current calendar year.

C. The Medical Staff Office will log the gift/financial benefit.

D. The value of a gift given to a group of physicians shall be divided and attributed to each physician equally.

Any violators may be subject to disciplinary action for violating Kaweah Delta policy.

"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."

EXHIBIT A

MEDICAL DIRECTOR CONTRACT CHECKLIST

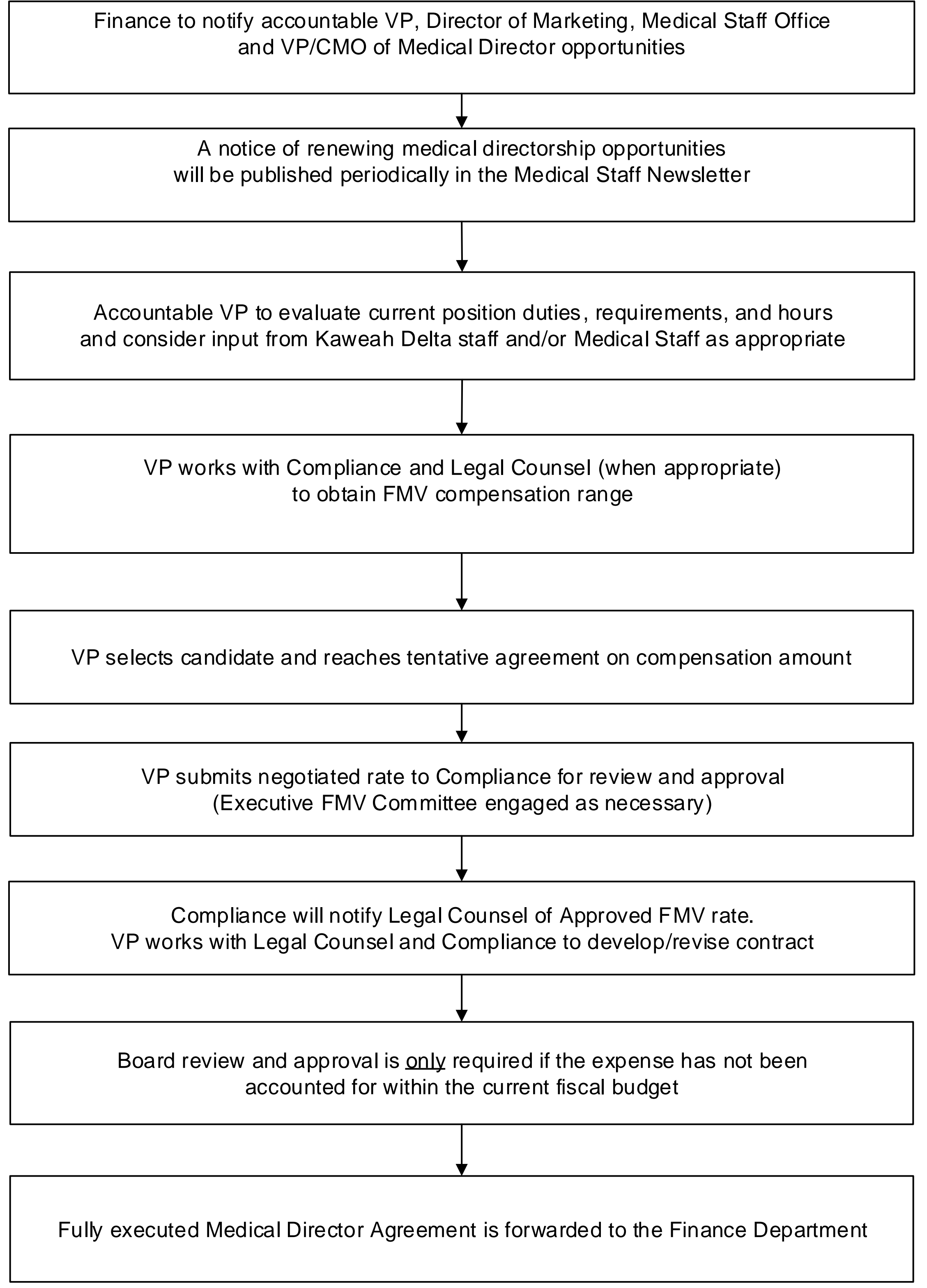


EXHIBIT B

PROVIDER CONTRACT RENEWALS

Exclusive and Non-Exclusive Provider Agreements

Finance to notify accountable VP and Medical Staff Office of upcoming Provider Contract expiration

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Accountable VP to solicit input from Kaweah Delta staff on
1. Quality of performance by current provider and/or potential candidates
2. Recommendations or revisions to the current duties or requirements

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Exclusive Provider Agreements

Medical Staff Officers consider input from medical staff on:
1) Quality of performance by current provider and/or new potential providers
2) Recommendations or revisions to the current duties or requirements

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MEC Recommendations:
(Up to Six (6) months prior to expiration of contract)
1. Provider evaluations
2. Performance changes/revisions to the expectations/ services (Medical Staff Organizations role is completed at this time and MEC acknowledgement of opportunity to provide input into the provider's performance and into expectations/services incorporated into the agreement will be documented in MEC's minutes)

Non-Exclusive Provider Agreements

Accountable VP may solicit input from Medical Staff on
1. Quality of performance by current provider and/or potential candidates
2. Recommendations or revisions to the current duties or requirements

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Formal Request for Proposal (RFP) is conducted (if appropriate)

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Physician/Physician Group is selected

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VP works with Compliance, Legal Counsel and FMV Consulting Firm to establish FMV range

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VP and physician/physician group negotiate and reach tentative agreement on rate

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Negotiated rate and FMV analysis to Compliance for Review and Approval

↓

Compliance will notify Legal Counsel of approved FMV rate
VP works with Legal Counsel and Compliance to develop/revise contract

↓

VP presents the new or unbudgeted Exclusive Provider Agreement to Board for review and approval
(Board approval not required for budgeted Non-Exclusive Provider Agreements)

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Fully executed Exclusive / Non-Exclusive Provider Agreement is forwarded to the Finance Department

EXHIBIT C

NEW PROVIDER CONTRACT

Exclusive Provider Agreements

Vice President and Kaweah Delta Health Care District Board of Directors requests MEC to review Exclusive Provider arrangement

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MEC (or Subcommittee appointed by Chief of Staff) review quality of care and service implications of proposed exclusive provider contract.

Review includes evaluation from:
1. Members of applicable specialty involved
2. Members of other specialties who directly utilize or rely on the specialty under evaluation
3. Kaweah Delta Administration

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VP and Board receive and review MEC recommendations and make a decision to proceed with Exclusive Provider arrangement or Board Resolution

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Formal Request for Proposal (RFP) is conducted (if appropriate)

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Physician/Physician Group is selected

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VP works with Compliance, Legal Counsel and FMV Consulting Firm to establish FMV range

↓

VP and physician/physician group negotiate and reach tentative agreement on rate

↓

Negotiated rate and FMV analysis to Compliance for review and approval

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Compliance will notify Legal Counsel of approved FMV rate
VP works with Legal Counsel and Compliance to develop/revise contract

↓

VP presents the new Exclusive Provider Agreement to Board of Directors for review and approval

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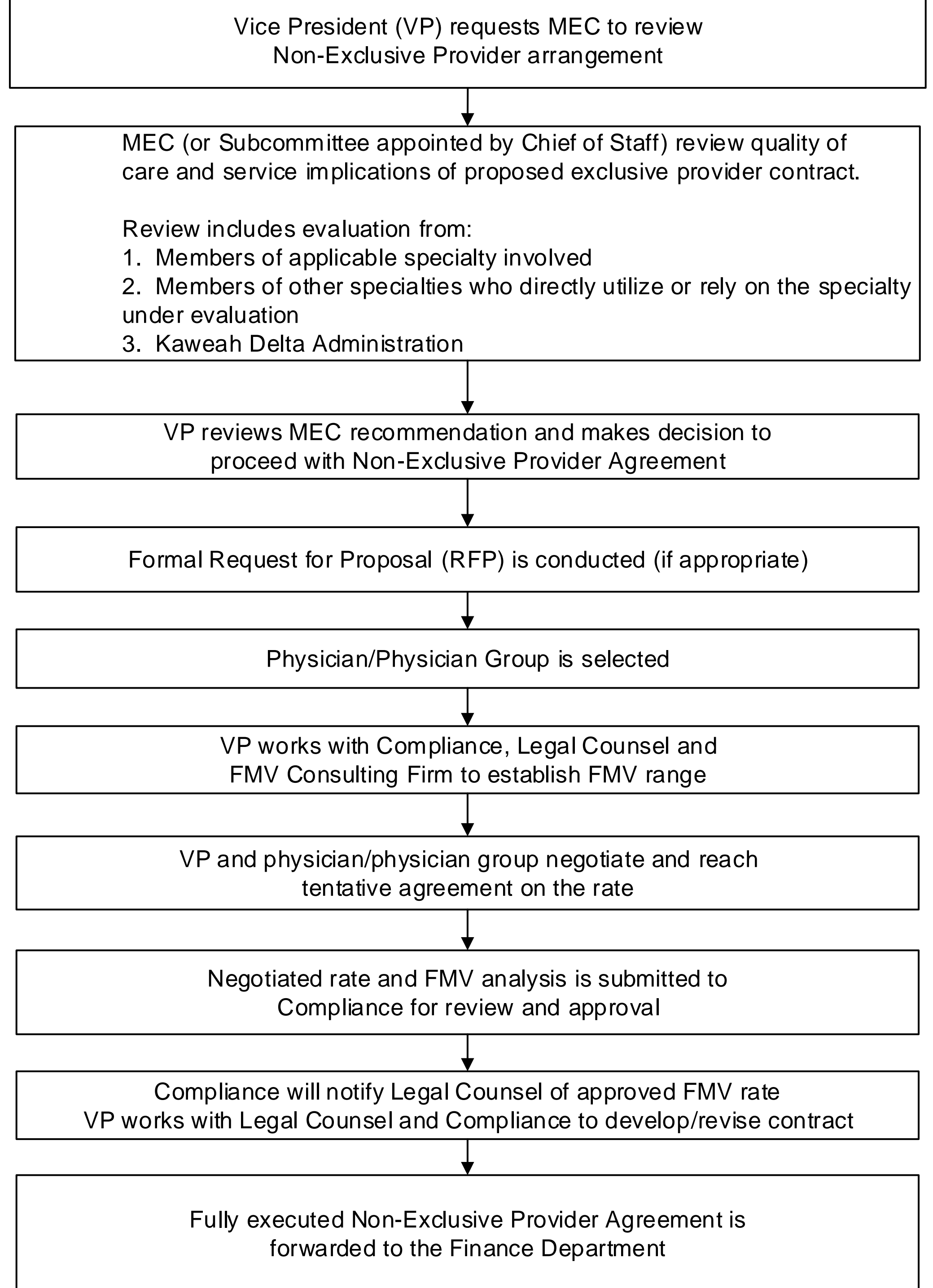
Fully executed Non-Exclusive Provider Agreement is forwarded to the Finance Department

EXHIBIT D

NEW PROVIDER CONTRACT

Non-Exclusive Provider Agreements



Policy Number: CP.05	Date Created: 04/21/2022
Document Owner: Lisa Wass (Compliance Analyst)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Compliance Committee, Amy Valero (Compliance Manager), Ben Cripps (Chief Compliance/Risk Officer)	
Compliance and Privacy Issues Investigation and Resolution	

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

Purpose: To establish a Compliance Program in which all issues are handled consistently to ensure integrity of the Program and all matters receive appropriate attention and resolution.

Policy: Investigations of suspected illegal, unethical, abusive conduct, wrongdoing, or non-compliance with laws, regulations, accreditation requirements and/or Kaweah Health policies and procedures shall be conducted by the appropriate person as determined by the ~~Vice President &~~ Chief Compliance and Risk ~~and Privacy~~ Officer (~~VP~~CCRO) ~~(CPO)~~ and the Kaweah Health Compliance Advocate.

Process:

I. Issues shall be investigated when one or more of the following criteria are met:

A. Non-routine subpoena or search warrant received from a governmental or regulatory agency.

B. Outside regulatory site visit or audit resulting in deficiencies and/or citations, not including routine responses to the California Department of Health Care Services (CDPH).

C. Correspondence received from a governmental entity or government contractor regarding actual or potential billing errors or quality of care issues.

D. Allegation or indication from any source (including the Anonymous Information Line) that a regulation or policy has been violated.

E. Indication from any source that overpayments have been received by Kaweah Health.

F. Indication from any source that current procedures or processes may result in a violation, or create a compliance risk due to ineffectiveness or lack of controls.

G. Ineffective processes that create actual or potential billing errors or other compliance risks.

H. Concern raised regarding potential breaches of patient privacy, medical record security, or identity theft.

I. Request made by a member of the Leadership and/or Executive Team.

J. Request made by the Audit and Compliance Committee, Compliance Advocate, or a Board member.

K. Any other concern of suspected illegal, unethical, abusive conduct, wrongdoing, or non-compliance with laws, regulations, accreditation requirements and/or Kaweah Health policies and procedures not otherwise identified above.

II. The following steps shall be used in an internal investigation when a concern is identified or reported:

A. The ~~VP~~CCRO~~PO~~ (or designee) will investigate the concern to determine how the potential problem was identified and designate the person who will oversee the investigation. When necessary, the appropriate Leadership and/or Executive Team members shall be notified of the potential concern.

1. Issues that are strictly operational in nature shall be referred back to the appropriate Leadership and Executive Team members for review and investigation. Once complete, the Leadership and Executive Team member shall provide a summary of the resolution to the ~~CPO~~ ~~VP~~CCRO (or designee).

2. Safety issues shall be referred to the Safety Officer with notification to the appropriate Executive Team member. Once complete, the Safety Officer shall provide a summary of the resolution to the ~~CPO~~~~VP~~CCRO (or designee).

3. Personnel issues shall be referred to Human Resources with notification to the appropriate Executive Team member. Once complete, the Human Resources representative shall provide a summary of the resolution to the ~~CPO~~ ~~VP~~CCRO (or designee).

4. Quality of care issues shall be referred to Patient Safety and Quality Department with notification to the appropriate Executive Team member. Once complete, the Patient Safety and Quality representative shall provide a summary of the resolution to the ~~CPO~~~~VP~~CCRO (or designee).

5. Risk Management issues shall be referred to the Risk Management Department. Once complete, the Risk Management representative shall provide a summary of the resolution to the CCRO (or designee).

6. Other issues shall be investigated by the ~~CPO~~~~VP~~CCRO (or designee) with notification to the appropriate Executive Team member.

B. The ~~CPO~~~~VP~~CCRO (or designee) will contact the Kaweah Health Compliance Advocate to invoke attorney-client privilege, as appropriate, in situations where a potential violation has been identified which could result in governmental intervention, self-reporting and/or re-payments to a third-party payer. In situations where the Kaweah Health Compliance Advocate invokes attorney-client privilege for investigation of an issue, all meetings, discussions and investigation activities related to that issue shall take

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place in the presence of, or under the direction of, the Kaweah Health Compliance Advocate or ~~CPO~~~~VP~~CCRO.

C. When necessary, the ~~CPO~~ ~~VP~~CCRO (or designee) will place the issue on the Compliance Issue Log reviewed quarterly by the Audit and Compliance Committee and the Board. If the matter is a privacy concern or other compliance matter not requiring inclusion on the Compliance Issue Log, the ~~CPO~~ ~~VP~~CCRO (or designee) will document and log the concern for tracking and reporting purposes.

D. The ~~CPO~~ ~~VP~~CCRO (or designee) will determine the appropriate steps to investigate the issue and initiate these steps as soon as possible. The ~~CPO~~ ~~VP~~CCRO (or designee) will ensure Leadership places an immediate stop to any practice violating any federal or state law or regulation and/or accreditation standard; specifically those impacting billing or coding processes.

E. The ~~CPO~~ ~~VP~~CCRO (or designee) will discuss the issue with the appropriate Leadership and/or Executive Team members.

F. When appropriate, the ~~CPO~~ ~~VP~~CCRO (or designee) will retain outside opinions, other experts, or consultants~~,~~ to evaluate the information and provide guidance or recommendations.

G. The ~~CPO~~ ~~VP~~CCRO (or designee) will initiate specific steps to review the issue. These may include, but are not limited to:

1. Review relevant policies and procedures.
2. Identify and interview staff who may have knowledge of the problem. Analyze past history relevant to the problem.
3. Research applicable laws.
4. Review claims/medical records in question.
5. Review relevant documents and files.
6. Complete audits of patient records and system access.

H. The ~~CPO~~ ~~VP~~CCRO (or designee) will document all steps taken in the investigation and resolution of the issue, including interview/meeting notes, summaries of reviews, completed copies of policies, or other relevant documents and other pertinent information related to the issue.

I. The ~~CPO~~ ~~VP~~CCRO (or designee) will determine the appropriate course of action:

1. Refer concerns about performance actions of specific individuals to Leadership and Human Resources.
2. Work with appropriate Leadership and/or Executive Team members to implement new processes, policies and procedures, education, or other steps to ensure the problem does not persist or reoccur.
3. Confirm the re-billing or repayment of any specific claims where a billing/payment error has been identified. If it is determined that an overpayment has been received from Medicare, the overpayment must be reported and returned to the appropriate agency within 60 days

after the date on which the overpayment amount is identified, or the date any corresponding cost report is due, if applicable. Failure to submit a timely report and return the overpayment may lead to False Claims Act liability. See CP.13 Federal and State False Claims Act and Employee Protection Provisions for additional information.

4. Determine if self-disclosure and restitution is necessary and, if so, work with the Kaweah Health Compliance Advocate and appropriate Executive Team member to make prompt restitution to the appropriate health care program/third-party payer.
5. Schedule future monitoring and review activity to mitigate any future reoccurrence. The final resolution of the issue will be reported to the appropriate Executive Team member, the Audit and Compliance Committee, the Chief Executive Officer (CEO), and Board (when appropriate). The length of the investigation and final resolution will vary depending on the complexity and risk associated with the issue.

III. When an investigation is initiated based upon a report of a problem by an employee, the ~~CCPO~~ ~~VP~~CCRO (or designee) will provide a summary of the final resolution to that employee. If the employee still has concerns, the following steps will be used:

A. The ~~CPO~~ ~~VP~~CCRO will report the continuing concern to the Audit and Compliance Committee.

B. The ~~CPO~~ ~~VP~~CCRO or Compliance Advocate will contact the employee to request a written statement of their ongoing concerns.

C. The ~~CPO~~ ~~VP~~CCRO will prepare a written response to the employees concerns.

D. The Audit and Compliance Committee will review the written statement and respond and instruct the ~~CPO~~ ~~VP~~CCRO whether to continue or to close the investigation.

E. A letter will be sent from the Compliance Advocate on behalf of the Audit and Compliance Committee to the employee stating the final decision of the Audit and Compliance Committee.

IV. When an investigation is initiated concerning a potential breach of patient confidentiality or inappropriate access to medical records the ~~CPO~~ ~~VP~~CCRO (or designee) will follow Kaweah Health Administrative Policy AP.108 Patient Privacy Administrative and Compliance Requirements.

A. When required by Federal and State law, the Compliance Department will make the necessary notifications to the patient and Federal/State agencies.

Exceptions:

Notification may be delayed if it would impede a criminal investigation, cause damage to national security, or cause harm to the patient.

"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: CP.05	Date Created: 07/06/2021
Document Owner: Lisa Wass (Compliance Analyst)	Date Approved: 02/14/2022
Approvers: Board of Directors (Administration), Compliance Committee, Amy Valero (Compliance Manager), Ben Cripps (Chief Compliance/Risk Officer)	
Compliance and Privacy Issues Investigation and Resolution	

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

Purpose: To establish a Compliance Program in which all issues are handled consistently to ensure integrity of the Program and all matters receive appropriate attention and resolution.

Policy: Investigations of suspected illegal, unethical, abusive conduct, wrongdoing, or non-compliance with laws, regulations, accreditation requirements and/or Kaweah Health policies and procedures shall be conducted by the appropriate person as determined by the Vice President & Chief Compliance and Risk Officer (VPCCRO) and the Kaweah Health Compliance Advocate.

Process:

I. Issues shall be investigated when one or more of the following criteria are met:

A. Non-routine subpoena or search warrant received from a governmental or regulatory agency.

B. Outside regulatory site visit or audit resulting in deficiencies and/or citations, not including routine responses to the California Department of Health Care Services (CDPH).

C. Correspondence received from a governmental entity or government contractor regarding actual or potential billing errors or quality of care issues.

D. Allegation or indication from any source (including the Anonymous Information Line) that a regulation or policy has been violated.

E. Indication from any source that overpayments have been received by Kaweah Health.

F. Indication from any source that current procedures or processes may result in a violation, or create a compliance risk due to ineffectiveness or lack of controls.

G. Ineffective processes that create actual or potential billing errors or other compliance risks.

H. Concern raised regarding potential breaches of patient privacy, medical record security, or identity theft.

I. Request made by a member of the Leadership and/or Executive Team.

J. Request made by the Audit and Compliance Committee, Compliance Advocate, or a Board member.

K. Any other concern of suspected illegal, unethical, abusive conduct, wrongdoing, or non-compliance with laws, regulations, accreditation requirements and/or Kaweah Health policies and procedures not otherwise identified above.

II. The following steps shall be used in an internal investigation when a concern is identified or reported:

A. The VPCCRO (or designee) will investigate the concern to determine how the potential problem was identified and designate the person who will oversee the investigation. When necessary, the appropriate Leadership and/or Executive Team members shall be notified of the potential concern.

1. Issues that are strictly operational in nature shall be referred back to the appropriate Leadership and Executive Team members for review and investigation. Once complete, the Leadership and Executive Team member shall provide a summary of the resolution to the VPCCRO (or designee).
2. Safety issues shall be referred to the Safety Officer with notification to the appropriate Executive Team member. Once complete, the Safety Officer shall provide a summary of the resolution to the VPCCRO (or designee).
3. Personnel issues shall be referred to Human Resources with notification to the appropriate Executive Team member. Once complete, the Human Resources representative shall provide a summary of the resolution to the VPCCRO (or designee).
4. Quality of care issues shall be referred to Patient Safety and Quality Department with notification to the appropriate Executive Team member. Once complete, the Patient Safety and Quality representative shall provide a summary of the resolution to the VPCCRO (or designee).
5. Risk Management issues shall be referred to the Risk Management Department. Once complete, the Risk Management representative shall provide a summary of the resolution to the VPCCRO (or designee).
6. Other issues shall be investigated by the VPCCRO (or designee) with notification to the appropriate Executive Team member.

B. The VPCCRO (or designee) will contact the Kaweah Health Compliance Advocate to invoke attorney-client privilege, as appropriate, in situations where a potential violation has been identified which could result in governmental intervention, self-reporting and/or re-payments to a third-party payer. In situations where the Kaweah Health Compliance Advocate invokes attorney-client privilege for investigation of an issue, all meetings, discussions and investigation activities related to that issue shall take

place in the presence of, or under the direction of, the Kaweah Health Compliance Advocate or VPCCRO.

C. When necessary, the VPCCRO (or designee) will place the issue on the Compliance Issue Log reviewed quarterly by the Audit and Compliance Committee and the Board. If the matter is a privacy concernor other compliance matter not requiring inclusion on the Compliance Issue Log, the VPCCRO (or designee) will document and log the concern for tracking and reporting purposes.

D. The VPCCRO (or designee) will determine the appropriate steps to investigate the issue and initiate these steps as soon as possible. The VPCCRO (or designee) will ensure Leadership places an immediate stop to any practice violating any federal or state law or regulation and/or accreditation standard; specifically those impacting billing or coding processes.

E. The VPCCRO (or designee) will discuss the issue with the appropriate Leadership and/or Executive Team members.

F. When appropriate, the VPCCRO (or designee) will retain outside opinions, other experts, or consultants to evaluate the information and provide guidance or recommendations.

G. The VPCCRO (or designee) will initiate specific steps to review the issue. These may include, but are not limited to:

1. Review relevant policies and procedures.
2. Identify and interview staff who may have knowledge of the problem. Analyze past history relevant to the problem.
3. Research applicable laws.
4. Review claims/medical records in question.
5. Review relevant documents and files.
6. Complete audits of patient records and system access.

H. The VPCCRO (or designee) will document all steps taken in the investigation and resolution of the issue, including interview/meeting notes, summaries of reviews, completed copies of policies, or other relevant documents and other pertinent information related to the issue.

I. The VPCCRO (or designee) will determine the appropriate course of action:

1. Refer concerns about performance actions of specific individuals to Leadership and Human Resources.
2. Work with appropriate Leadership and/or Executive Team members to implement new processes, policies and procedures, education, or other steps to ensure the problem does not persist or reoccur.
3. Confirm the re-billing or repayment of any specific claims where a billing/payment error has been identified. If it is determined that an overpayment has been received from Medicare, the overpayment must be reported and returned to the appropriate agency within 60 days

after the date on which the overpayment amount is identified, or the date any corresponding cost report is due, if applicable. Failure to submit a timely report and return the overpayment may lead to False Claims Act liability. See CP.13 Federal and State False Claims Act and Employee Protection Provisions for additional information.

4. Determine if self-disclosure and restitution is necessary and, if so, work with the Kaweah Health Compliance Advocate and appropriate Executive Team member to make prompt restitution to the appropriate health care program/third-party payer.
5. Schedule future monitoring and review activity to mitigate any future reoccurrence. The final resolution of the issue will be reported to the appropriate Executive Team member, the Audit and Compliance Committee, the Chief Executive Officer (CEO), and Board (when appropriate). The length of the investigation and final resolution will vary depending on the complexity and risk associated with the issue.

III. When an investigation is initiated based upon a report of a problem by an employee, the VPCCRO (or designee) will provide a summary of the final resolution to that employee. If the employee still has concerns, the following steps will be used:

A. The VPCCRO will report the continuing concern to the Audit and Compliance Committee.

B. The VPCCRO or Compliance Advocate will contact the employee to request a written statement of their ongoing concerns.

C. The VPCCRO will prepare a written response to the employees concerns.

D. The Audit and Compliance Committee will review the written statement and respond and instruct the VPCCRO whether to continue or to close the investigation.

E. A letter will be sent from the Compliance Advocate on behalf of the Audit and Compliance Committee to the employee stating the final decision of the Audit and Compliance Committee.

IV. When an investigation is initiated concerning a potential breach of patient confidentiality or inappropriate access to medical records the VPCCRO (or designee) will follow Kaweah Health Administrative Policy AP.108 Patient Privacy Administrative and Compliance Requirements.

A. When required by Federal and State law, the Compliance Department will make the necessary notifications to the patient and Federal/State agencies.

Exceptions:

Notification may be delayed if it would impede a criminal investigation, cause damage to national security, or cause harm to the patient.

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Compliance Manual

Policy Number: CP.06	**Date Created: 04/21/2022**
Document Owner: Lisa Wass (Compliance Analyst)	**Date Approved: Not Approved Yet**
Approvers: Board of Directors (Administration), Compliance Committee, Amy Valero (Compliance Manager), Ben Cripps (Chief Compliance/Risk Officer)	
Compliance Program Education	

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

Purpose: To educate employees and physicians on the medical staff about the Kaweah Health Compliance Program on topics including, but not limited to, Code of Conduct, Patient Privacy regulations, False Claims Act (FCA), Anti-Kickback Statute (AKS), STARK, Criminal Health Care Fraud Statute, Federal Exclusion Statute, and Civil Monetary Penalties (CMP) Laws.

Policy: All employees shall receive mandatory Compliance and Privacy training upon hire, and annually thereafter. All employees and Medical Staff physicians will receive ongoing education on relevant compliance and Patient Privacy topics. Employees working within the Revenue Cycle shall receive additional focused education related to their function and responsibility.

Process:

I. **New Employee Orientation** – The ~~Vice President & ~~Chief Compliance ~~and Privacy ~~and Risk Officer (~~VP~~CCRO) (or designee) will provide live, in-person training to all new employees at New Employee General Orientation. Training content shall include an overview of the Kaweah Health Compliance Program, Code of Conduct, Patient Privacy regulations, FCA, AKS, STARK, Criminal Health Care Fraud Statute, Exclusion Statute, CMP Laws, and other topics as deemed necessary.

II. **Medical Staff Orientation –** New Medical Staff physicians will be oriented to the Kaweah Health Compliance Program through the Medical Staff Orientation Process. Training content shall include an overview of the Kaweah Health Compliance Program, Code of Conduct, Patient Privacy regulations, FCA, AKS, STARK, Criminal Health Care Fraud Statute, Exclusion Statute, CMP Laws, and other topics as deemed necessary.

III. **New Manager Orientation –** New managers shall meet with the ~~VP~~CCRO ~~Chief Compliance and Privacy Officer~~ (or designee) to receive a more detailed understanding of the Kaweah Health Compliance Program. The training will also include a review of the manager's responsibility for compliance education and reporting.

IV. **New Board Member Orientation –** New Board Members will meet with the ~~VP~~CCRO ~~Chief Compliance and Privacy Officer~~ to receive a comprehensive

overview of the Kaweah ~~Delta~~ Health Compliance Program. The training will also include a review of the Board member's responsibility for compliance.

V. **Continuing Education** - All employees shall receive on-going education about relevant compliance topics including updates to the Compliance Program, Code of Conduct, new laws and regulations, or new Compliance and Privacy policies and procedures. The ways in which information and education shall be provided include:

A. Compliance and Privacy Mandatory Annual Training (MAT) shall be completed by all employees. Failure to complete MAT will result in disciplinary action pursuant to Kaweah Health's Human Resources Policy HR.216 Progressive Discipline.

B. Relevant compliance topics included periodically via the Kaweah Health Communication Boards, all staff e-mail communications, the employee newsletter, and the Medical Staff newsletter.

C. Periodically, Compliance staff may attend department staff meetings to present relevant compliance and privacy topics as required by law, the ~~VP~~CCRO ~~Compliance and Privacy Officer~~, or at the request of Department Management.

D. Each department/area will identify a representative to serve as their Area Compliance Expert (ACE). These individuals will help support their management by providing compliance and privacy related education on an on-going basis at their department/area staff meetings. Relevant topics will include identified high-risk areas for compliance or information on new laws or regulations.

VI. **Focused Education** - Employees working in Patient Access, Patient Accounting, Health Information Management, Clinical Documentation Improvement, and Case Management participate in the development and ongoing management of Operational Compliance Committee, focused on the discussion of regulations, policies, auditing and monitoring, and educational efforts within the departments; including the development and implementation of dashboards designed to develop focused goals and measure effectiveness of each committee.

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Policy Number: CP.06	Date Created: 02/02/2021
Document Owner: Lisa Wass (Compliance Analyst)	Date Approved: 02/14/2022
Approvers: Board of Directors (Administration), Compliance Committee, Amy Valero (Compliance Manager), Ben Cripps (Chief Compliance/Risk Officer)	
Compliance Program Education	

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Purpose: To educate employees and physicians on the medical staff about the Kaweah Health Compliance Program on topics including, but not limited to, Code of Conduct, Patient Privacy regulations, False Claims Act (FCA), Anti-Kickback Statute (AKS), STARK, Criminal Health Care Fraud Statute, Federal Exclusion Statute, and Civil Monetary Penalties (CMP) Laws.

Policy: All employees shall receive mandatory Compliance and Privacy training upon hire, and annually thereafter. All employees and Medical Staff physicians will receive ongoing education on relevant compliance and Patient Privacy topics. Employees working within the Revenue Cycle shall receive additional focused education related to their function and responsibility.

Process:

I. **New Employee Orientation** – The Vice President & Chief Compliance and Risk Officer (VPCCRO) (or designee) will provide live, in-person training to all new employees at New Employee General Orientation. Training content shall include an overview of the Kaweah Health Compliance Program, Code of Conduct, Patient Privacy regulations, FCA, AKS, STARK, Criminal Health Care Fraud Statute, Exclusion Statute, CMP Laws, and other topics as deemed necessary.

II. **Medical Staff Orientation –** New Medical Staff physicians will be oriented to the Kaweah Health Compliance Program through the Medical Staff Orientation Process. Training content shall include an overview of the Kaweah Health Compliance Program, Code of Conduct, Patient Privacy regulations, FCA, AKS, STARK, Criminal Health Care Fraud Statute, Exclusion Statute, CMP Laws, and other topics as deemed necessary.

III. **New Manager Orientation –** New managers shall meet with the VPCCRO (or designee) to receive a more detailed understanding of the Kaweah Health Compliance Program. The training will also include a review of the manager's responsibility for compliance education and reporting.

IV. **New Board Member Orientation –** New Board Members will meet with the VPCCRO to receive a comprehensive overview of the Kaweah Health

Compliance Program. The training will also include a review of the Board member's responsibility for compliance.

V. **Continuing Education** - All employees shall receive on-going education about relevant compliance topics including updates to the Compliance Program, Code of Conduct, new laws and regulations, or new Compliance and Privacy policies and procedures. The ways in which information and education shall be provided include:

A. Compliance and Privacy Mandatory Annual Training (MAT) shall be completed by all employees. Failure to complete MAT will result in disciplinary action pursuant to Kaweah Health's Human Resources Policy HR.216 Progressive Discipline.

B. Relevant compliance topics included periodically via the Kaweah Health Communication Boards, all staff e-mail communications, the employee newsletter, and the Medical Staff newsletter.

C. Periodically, Compliance staff may attend department staff meetings to present relevant compliance and privacy topics as required by law, the VPCCRO , or at the request of Department Management.

D. Each department/area will identify a representative to serve as their Area Compliance Expert (ACE). These individuals will help support their management by providing compliance and privacy related education on an on-going basis at their department/area staff meetings. Relevant topics will include identified high-risk areas for compliance or information on new laws or regulations.

VI. **Focused Education** - Employees working in Patient Access, Patient Accounting, Health Information Management, Clinical Documentation Improvement, and Case Management participate in the development and ongoing management of Operational Compliance Committee, focused on the discussion of regulations, policies, auditing and monitoring, and educational efforts within the departments; including the development and implementation of dashboards designed to develop focused goals and measure effectiveness of each committee.

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Policy Number: CP.07	Date Created: 04/21/2022
Document Owner: Lisa Wass (Compliance Analyst)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Compliance Committee, Amy Valero (Compliance Manager), Ben Cripps (Chief Compliance/Risk Officer)	
Excluded Individuals/Entities Office of Inspector General/Department of Health and Human Services	

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

Purpose: To establish procedures to prevent Kaweah Delta Health Care District (herein after referred to as Kaweah Health) hiring, employing, contracting with and/or the provision of Medical Staff privileges to anyone excluded from participation in a Federal or State Health Care Program.

Policy: All current and prospective new employees, independent contractors, vendors, suppliers, consultants, and Medical Staff members shall be searched against the Department of Health and Human Services/Office of Inspector General's List of Excluded Individuals/Entities (OIG) and the General Systems Administration (GSA) list of Excluded Individuals/Entities based on the frequency outlined in this policy.

Definition of an Excluded Person:

An excluded person can be an employee, independent contractor, vendor, supplier, consultant, Medical Staff members, or entity who has been identified by the Federal or State government as committing an act that excludes the individual/entity from participating in a Federal or State health care program, or Federal/State procurement. The exclusion applies regardless of who submits the claims and applies to all administrative and management services furnished by the excluded person.

Procedure:

I. Vendors/Suppliers/Contracted Services

A. Before entering into a contract or agreement, the person responsible for executing or renewing the contract shall ensure that the proposed vendor or supplier is not an Excluded Person/Entity. If the vendor or supplier is excluded from participation in a Federal or State Health Care Program, a contract shall not be executed.

All new or renewed contracts shallcontain a clause, requiring the vendor to immediately notify Kaweah Health should they become ineligible / excluded from participating in a Federal or State Health Care Program. The contract shall also specify Kaweah Health's authority to immediately terminate the agreement in the event the vendor becomes excluded. See AP69 Requirement for Contracting with Outside Service Providers. All executed agreements shall be retained in the Contract Management System.

B. The Director of Finance (or designee) shall search the OIG/GSA List quarterly to ensure that any Kaweah Health vendor/supplier is not an Excluded Person/Entity. Any vendor found to be excluded shall be immediately notified and their contract with Kaweah Health terminated.

C. Any providers not credentialed with Kaweah Health, but whose patients utilize Kaweah Health for the fulfillment of services (Laboratory, Imaging, etc.) will be searched for on the OIG list to validate exclusion status. A third-party vendor will maintain the monthly monitoring of non-credentialed providers. Orders for non-credentialed providers who are found to be excluded will not be accepted at Kaweah Health for the fulfillment of medical services.

Documentation of the review shall be forwarded to the Compliance Department and may be in the format in Exhibit A or other such format as agreed to by the ~~Vice President &~~ Chief Compliance and Risk~~and Privacy~~ Officer (~~VP~~CCRO) or designee.

II. Medical Staff /Allied Health Staff

A. Before approving a physician for Medical Staff privileges or authorizing an allied health staff person to provide services, the Medical Staff Director (or designee) shall ensure that the individual is not an Excluded Person. If a physician or allied health professional is identified on the OIG/GSA Exclusion Lists, Medical Staff privileges/authorization to provide services shall not be granted. Any physician or Allied Health Professional with a change in status, such as an exclusion from Federal or State Health Care participation, shall immediately report such change to the Kaweah ~~Delta~~ Health (~~VP~~CCRO)~~Compliance Officer~~ and Medical Staff Office.

B. The Director of the Medical Staff Office (or designee) shall search the OIG/GSA list monthly to ensure that any Kaweah Health Medical Staff or Allied Health Professional is not an Excluded Person. In the event a physician or Allied Health Professional is on the OIG/GSA Exclusion List, Medical Staff privileges/authorization to provide services shall be immediately revoked.

Documentation of the review shall be forwarded quarterly to the ~~VP~~CCRO~~Chief Compliance and Privacy Officer~~r (or designee) and may be in the format in Exhibit A or other such format as agreed to by the ~~VP~~CCRO~~Compliance and Privacy Officer~~.

III. Employment Applicants

A. Prior to making an offer of employment or contract, Human Resources staff shall search the OIG/GSA List to ensure that the applicant is not an Excluded Person. In the event the applicant is on the OIG/ GSA List, no offer of employment or contract shall be made.

IV. Kaweah Health Employees

A. The OIG/GSA and State Exclusion Lists shall be searched monthly to determine if a Kaweah Health employee has been identified as an Excluded Person. The review will also evaluate any published legal or license activity that might affect a person's status for their California licensure. Human Resources will be immediately notified of any potential situations that require further review and evaluation.

B. In the event an employee is identified as an Excluded Person, the ~~Vice President of~~Chief Human Resources Officer will review the finding and report the outcome of the review to the ~~VP~~CCRO~~Compliance and Privacy Officer~~. Confirmation of the "excluded" status is cause for immediate termination of employment with Kaweah Health.

V. Investigations of Excluded Person(s)

A. In the event that an Excluded Person/party is identified, the Compliance Department will conduct an investigation following CP.05 Compliance and Privacy Issues Investigation and Resolution.

B. In the event that an Excluded Person/party is identified, Insurance Plan Sponsors and/or Payor will be notified (when appropriate).

EXHIBIT A

Verification of review of OIG and GSA List of Excluded Individuals/Entities

Review completed for: ____

Vendors, Medical and Allied Health Staff, Consultants, Staff)

Review completed on: ____

(Date)

I certify that this review has been completed and no Excluded Individuals/Entities were found.

Signature: ________________________________

Print Name: ______________________________

I certify that this review has been completed and the following Individuals/Entities were found:

____________________________________ ______________________________________

____________________________________ ______________________________________

Signature: ________________________________

Print Name: ______________________________

Please forward the completed form to the ~~VP~~CCRO~~Compliance and Privacy Officer~~ or designee

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Policy Number: CP.07	Date Created: 02/02/2021
Document Owner: Lisa Wass (Compliance Analyst)	Date Approved: 02/14/2022
Approvers: Board of Directors (Administration), Compliance Committee, Amy Valero (Compliance Manager), Ben Cripps (Chief Compliance/Risk Officer)	
Excluded Individuals/Entities Office of Inspector General/Department of Health and Human Services	

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

Purpose: To establish procedures to prevent Kaweah Delta Health Care District (herein after referred to as Kaweah Health) hiring, employing, contracting with and/or the provision of Medical Staff privileges to anyone excluded from participation in a Federal or State Health Care Program.

Policy: All current and prospective new employees, independent contractors, vendors, suppliers, consultants, and Medical Staff members shall be searched against the Department of Health and Human Services/Office of Inspector General's List of Excluded Individuals/Entities (OIG) and the General Systems Administration (GSA) list of Excluded Individuals/Entities based on the frequency outlined in this policy.

Definition of an Excluded Person:

An excluded person can be an employee, independent contractor, vendor, supplier, consultant, Medical Staff members, or entity who has been identified by the Federal or State government as committing an act that excludes the individual/entity from participating in a Federal or State health care program, or Federal/State procurement. The exclusion applies regardless of who submits the claims and applies to all administrative and management services furnished by the excluded person.

Procedure:

I. Vendors/Suppliers/Contracted Services

A. Before entering into a contract or agreement, the person responsible for executing or renewing the contract shall ensure that the proposed vendor or supplier is not an Excluded Person/Entity. If the vendor or supplier is excluded from participation in a Federal or State Health Care Program, a contract shall not be executed.

All new or renewed contracts shallcontain a clause, requiring the vendor to immediately notify Kaweah Health should they become ineligible / excluded from participating in a Federal or State Health Care Program. The contract shall also specify Kaweah Health's authority to immediately terminate the agreement in the event the vendor becomes excluded. See AP69 Requirement for Contracting with Outside Service Providers. All executed agreements shall be retained in the Contract Management System.

B. The Director of Finance (or designee) shall search the OIG/GSA List quarterly to ensure that any Kaweah Health vendor/supplier is not an Excluded Person/Entity. Any vendor found to be excluded shall be immediately notified and their contract with Kaweah Health terminated.

C. Any providers not credentialed with Kaweah Health, but whose patients utilize Kaweah Health for the fulfillment of services (Laboratory, Imaging, etc.) will be searched for on the OIG list to validate exclusion status. A third-party vendor will maintain the monthly monitoring of non-credentialed providers. Orders for non-credentialed providers who are found to be excluded will not be accepted at Kaweah Health for the fulfillment of medical services.

Documentation of the review shall be forwarded to the Compliance Department and may be in the format in Exhibit A or other such format as agreed to by the Vice President & Chief Compliance and Risk Officer (VPCCRO) or designee.

II. Medical Staff /Allied Health Staff

A. Before approving a physician for Medical Staff privileges or authorizing an allied health staff person to provide services, the Medical Staff Director (or designee) shall ensure that the individual is not an Excluded Person. If a physician or allied health professional is identified on the OIG/GSA Exclusion Lists, Medical Staff privileges/authorization to provide services shall not be granted. Any physician or Allied Health Professional with a change in status, such as an exclusion from Federal or State Health Care participation, shall immediately report such change to the Kaweah Health VPCCRO and Medical Staff Office.

B. The Director of the Medical Staff Office (or designee) shall search the OIG/GSA list monthly to ensure that any Kaweah Health Medical Staff or Allied Health Professional is not an Excluded Person. In the event a physician or Allied Health Professional is on the OIG/GSA Exclusion List, Medical Staff privileges/authorization to provide services shall be immediately revoked.

Documentation of the review shall be forwarded quarterly to the VPCCRO (or designee) and may be in the format in Exhibit A or other such format as agreed to by the VPCCRO.

III. Employment Applicants

A. Prior to making an offer of employment or contract, Human Resources staff shall search the OIG/GSA List to ensure that the applicant is not an Excluded Person. In the event the applicant is on the OIG/ GSA List, no offer of employment or contract shall be made.

IV. Kaweah Health Employees

A. The OIG/GSA and State Exclusion Lists shall be searched monthly to determine if a Kaweah Health employee has been identified as an Excluded Person. The review will also evaluate any published legal or license activity that might affect a person's status for their California licensure. Human Resources will be immediately notified of any potential situations that require further review and evaluation.

B. In the event an employee is identified as an Excluded Person, the Vice President Chief Human Resources Officer will review the finding and report the outcome of the review to the VPCCRO. Confirmation of the "excluded" status is cause for immediate termination of employment with Kaweah Health.

V. Investigations of Excluded Person(s)

A. In the event that an Excluded Person/party is identified, the Compliance Department will conduct an investigation following CP.05 Compliance and Privacy Issues Investigation and Resolution.

B. In the event that an Excluded Person/party is identified, Insurance Plan Sponsors and/or Payor will be notified (when appropriate).

EXHIBIT A

Verification of review of OIG and GSA List of Excluded Individuals/Entities

Review completed for: ___________________________________
Vendors, Medical and Allied Health Staff, Consultants, Staff)

Review completed on: ___________________________________
(Date)

I certify that this review has been completed and no Excluded Individuals/Entities were found.

Signature: ____________________________

Print Name: ___________________________

I certify that this review has been completed and the following Individuals/Entities were found:

________________________________ __________________________________

________________________________ __________________________________

Signature: ____________________________

Print Name: ___________________________

Please forward the completed form to the VPCCRO or designee

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Compliance Manual

Policy Number: CP.10	Date Created: 04/21/2022
Document Owner: Lisa Wass (Compliance Analyst)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Compliance Committee, Amy Valero (Compliance Manager), Ben Cripps (Chief Compliance/Risk Officer)	
Compliance Reviews and Assessments	

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

Purpose: To outline and evaluate the process of performing audits and/or monitoring to measure compliance and assist in process improvement.

Policy: Kaweah Delta Health Care District (herein after referred to as Kaweah Health) acknowledges its responsibility to detect and prevent illegal, unethical, and abusive conduct. The Kaweah Health Compliance Program shall complete auditing and monitoring activities on a regular basis to evaluate compliance with specific laws, regulations, accreditation requirements and/or Kaweah Health policies and procedures. The Compliance Program shall evaluate and assess compliance risk through ongoing risk assessment process. The Compliance Program shall also audit and/or monitor high-risk areas and changing government standards or industry practices on a regular basis.

Process:

I. **Closed Compliance Issues** – Risk areas identified for closed compliance issues will be evaluated and prioritized. Auditing and monitoring activities will be completed periodically based on the recommendation of the ~~Vice President &~~ Chief Compliance and Risk ~~and Privacy~~ Officer (~~VP~~CCRO) to the Audit and Compliance Committee. Follow-up audits or monitoring activity will be completed by Compliance staff or may be referred to Internal Audit. Reviews requiring independent detailed claim or record reviews will be completed by Compliance staff or contracted external audit firm.

II. **Risk Prevention and Identification** – The ~~Chief Compliance Officer~~~~VP~~CCRO (or designee) will review risk areas identified by the Office of Inspector General (OIG), Centers for Medicare and Medicaid Services (CMS), Medi-Cal, California Department of Public Health (CDPH), and other government agencies and audit contractors. Particular focus will be given to risk areas involving complex processes and to those areas new to Kaweah ~~Delta~~Health operations.

III. **Billing and Coding Reviews** – Billing, coding and medical record reviews will be completed periodically as outlined in CP.02 Review of Billing Practices . The results of these reviews shall be monitored by the ~~Chief Compliance and Privacy Officer~~~~VP~~CCRO (or designee) and reported to the Audit and Compliance Committee.

IV. **Corrective Action Monitoring –** The Compliance and/or Internal Audit staff shall also audit and monitor processes in risk areas where compliance investigations have been completed and corrective actions implemented. Periodic monitoring of these risk areas will be used to validate the effectiveness of corrective actions and continued compliance.

V. **Suspected Wrongdoing** – When an assessment identifies suspected wrongdoing, possible fraud and abuse, or non-compliance with laws, regulations, accreditation requirements and/or Kaweah ~~Delta~~Health policies and procedures, a ~~more~~ thorough investigation will be initiated pursuant to Compliance Policy Compliance and Privacy Issues Investigation and Resolution.

VI. **Recommended Audit and Monitoring Procedures** – Assignments of audit staff will be based on the particular expertise required to fully audit the specific area or standard being evaluated. All analysis and documentation related to each unscheduled audit shall be compiled at the direction of the ~~Chief Compliance and Privacy Officer~~~~VP~~CCRO and/or legal counsel and shall be treated as attorney-client work product (when appropriate).

All audit reports shall be completed in a timely fashion, reported to the Audit and Compliance Committee, and at a minimum include the following information:

(1) Audit objectives and scope;
(2) Audit procedures employed;
(3) Results obtained;
(4) Conclusions concerning accomplishment of the audit objectives;
(5) Details concerning any deficiencies noted; and
(6) Recommendations for corrective action or improvement.

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Compliance Manual

Policy Number: CP.10	Date Created: 02/02/2021
Document Owner: Lisa Wass (Compliance Analyst)	Date Approved: 02/14/2022
Approvers: Board of Directors (Administration), Compliance Committee, Amy Valero (Compliance Manager), Ben Cripps (Chief Compliance/Risk Officer)	
Compliance Reviews and Assessments	

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

Purpose: To outline and evaluate the process of performing audits and/or monitoring to measure compliance and assist in process improvement.

Policy: Kaweah Delta Health Care District (herein after referred to as Kaweah Health) acknowledges its responsibility to detect and prevent illegal, unethical, and abusive conduct. The Kaweah Health Compliance Program shall complete auditing and monitoring activities on a regular basis to evaluate compliance with specific laws, regulations, accreditation requirements and/or Kaweah Health policies and procedures. The Compliance Program shall evaluate and assess compliance risk through ongoing risk assessment process. The Compliance Program shall also audit and/or monitor high-risk areas and changing government standards or industry practices on a regular basis.

Process:

I. **Closed Compliance Issues** – Risk areas identified for closed compliance issues will be evaluated and prioritized. Auditing and monitoring activities will be completed periodically based on the recommendation of the Vice President & Chief Compliance and Risk Officer (VPCCRO) to the Audit and Compliance Committee. Follow-up audits or monitoring activity will be completed by Compliance staff or may be referred to Internal Audit. Reviews requiring independent detailed claim or record reviews will be completed by Compliance staff or contracted external audit firm.

II. **Risk Prevention and Identification** – The VPCCRO (or designee) will review risk areas identified by the Office of Inspector General (OIG), Centers for Medicare and Medicaid Services (CMS), Medi-Cal, California Department of Public Health (CDPH), and other government agencies and audit contractors. Particular focus will be given to risk areas involving complex processes and to those areas new to Kaweah Health operations.

III. **Billing and Coding Reviews** – Billing, coding and medical record reviews will be completed periodically as outlined in CP.02 Review of Billing Practices . The

results of these reviews shall be monitored by the VPCCRO (or designee) and reported to the Audit and Compliance Committee.

IV. **Corrective Action Monitoring –** The Compliance and/or Internal Audit staff shall also audit and monitor processes in risk areas where compliance investigations have been completed and corrective actions implemented. Periodic monitoring of these risk areas will be used to validate the effectiveness of corrective actions and continued compliance.

V. **Suspected Wrongdoing** – When an assessment identifies suspected wrongdoing, possible fraud and abuse, or non-compliance with laws, regulations, accreditation requirements and/or Kaweah Health policies and procedures, a thorough investigation will be initiated pursuant to Compliance Policy Compliance and Privacy Issues Investigation and Resolution.

VI. **Recommended Audit and Monitoring Procedures** – Assignments of audit staff will be based on the particular expertise required to fully audit the specific area or standard being evaluated. All analysis and documentation related to each unscheduled audit shall be compiled at the direction of the VPCCRO and/or legal counsel and shall be treated as attorney-client work product (when appropriate).

All audit reports shall be completed in a timely fashion, reported to the Audit and Compliance Committee, and at a minimum include the following information:

(1) Audit objectives and scope;
(2) Audit procedures employed;
(3) Results obtained;
(4) Conclusions concerning accomplishment of the audit objectives;
(5) Details concerning any deficiencies noted; and
(6) Recommendations for corrective action or improvement.

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Policy Number: CP.13	Date Created: 03/21/2022
Document Owner: Lisa Wass (Compliance Analyst)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Compliance Committee, Amy Valero (Compliance Manager), Ben Cripps (Chief Compliance/Risk Officer)	
Federal and State False Claims Act and Employee Protection Provisions	

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

Purpose: Kaweah Delta Health Care District ("Kaweah ~~Delta~~Health") (herein after known as Kaweah Health) acknowledges its responsibilities to establish policies and procedures under the Federal Deficit Reduction Act to provide information and education to its employees, agents and contracted work force regarding the federal False Claims Act, the Federal Whistleblower's Act as well California law on these subjects. The following policy is established in order to help our employees, agents and contractors understand the provisions of the federal and state laws regarding submitting false claims for reimbursement, as well as to further inform our employees of their right to report violations at the state and federal levels as well as to their supervisor or through Kaweah ~~Delta's~~ Health's Compliance structure.

Policy: Detailed information regarding both state and federal false claims laws and whistleblower laws will be distributed to employees via this policy as well as through the various educational courses and orientation programs ongoing throughout the system. Employees are strongly encouraged to report any observations they might make regarding potential violations to their supervisor, the Kaweah ~~Delta~~ Health ~~VP &~~ Chief Compliance and ~~Privacy~~Risk Officer, or through the Kaweah ~~Delta~~ Health Confidential Compliance Hotline (1-800-998-8050). Every concern will be investigated in accordance with policy CP.05 Compliance and Privacy Issues Investigation and Resolution.

Federal False Claims Act - The False Claims Act (FCA) is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid (Medi-Cal) programs. The Act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U. S. Government for payment.

The term "knowingly" is defined to mean that a person, with respect to information:

- Has actual knowledge of falsity of information in the claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a claim; or
- Acts in reckless disregard of the truth or falsity of the information in a claim

The Act does not require proof of a specific intent to defraud the United States Government. Instead health care providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the Government, such as knowingly making false statements, falsifying records, or otherwise causing ~~a~~ false claims to be submitted.

Claim - For purposes of the False Claims Act, a “claim” includes any request or demand for money that is submitted to the U.S. Government or its contractors.

Liability - Health care providers and suppliers (persons and organizations) who violate the False Claims Act can be subject to civil monetary penalties from $~~10,957~~11,803 and $~~21,916~~23,607 for each false claim submitted. In addition to this civil penalty, providers and suppliers can be required to pay three (3) times the amount of damages sustained by the U.S. Government (See 31 USC §3729(a)). If a provider or supplier is convicted of a False Claims Act violation, the Office of Inspector General (OIG) may seek to exclude the provider or supplier from participation in federal health care programs.

California False Claims Act - –The California FCA, enacted in 1987, is a state statute that covers fraud involving state funded contracts or programs, including Medi-Cal. The act establishes liability for any person who knowingly presents or causes to be presented a false claim for payment or approval or causes to be made or used a false statement to get a false claim paid or approved.

The California FCA closely mirrors the structure and content of the Federal False Claims Act. However, the California FCA does contain some provisions that differ from the federal statute. For example, the California FCA imposes liability upon a provider for an inadvertent submission of a false claim when the provider subsequently discovers the falsity but fails to disclose it within a reasonable period of time after the discovery of the false claim. Further, the California FCA states that liability is triggered if a provider conspires to defraud by getting a false claim allowed or paid.

The term “knowingly” for the California FCA is ~~the~~ identical to the federal False Claims Act. As with the federal statute, proof of specific intent to defraud is not required.

Damages for the California FCA are similar to its federal counterpart. Any provider who violates the California FCA is liable to the state for three (3) times the amount of damages. Such a provider is also responsible for the costs of a civil action to recover the penalties and damages. Finally, any provider who violates the state statute may be liable for a civil penalty for each false claim. A “claim” is defined as any request or demand for money or services.

***Employee Protection - Qui Tam* “Whistleblower” Provision -** To encourage individuals to come forward and report misconduct involving false claims, both the federal False Claims Act and the California FCA include “qui tam” or whistleblower provisions. These provisions allow a person who is the “original source” to file a *qui tam* action and the party bringing the action is known as the “relator.” “Original source” is defined as direct and independent knowledge of the information on which

the allegations are based and has voluntarily provided the information to the Government before filing a lawsuit on behalf of the U.S. Government or State of California. There are many different types of health care fraud that can be the basis of a qui tam action. These include, but are not limited to: add-on services, up-coding and unbundling, kickbacks, false certification and information, lack of medical necessity, fraudulent cost reports, grant or program fraud, and billing for inadequate patient care.

Kaweah ~~Delta~~Health staff have the right to request the presence of their supervisor, the Director of Risk Management, and/or the Compliance and Privacy Officer during an interview with a government investigator/inspector. Additionally, employees, or an employee's representative, have the right to discuss possible regulatory violations and/or patient safety concerns with the California Department of Public Health's (CDPH) inspector(s) privately during the course of an investigation or inspection. (See AP.91 Unannounced Regulatory Survey Plan for Response).

The False Claims Act is an increasingly significant enforcement tool due to the whistleblower provisions which entitle relators to recover a percentage of the penalty imposed. Law enforcement officials are using these acts and the whistleblower protections to pursue high penalty fraud allegations against hospitals, physicians, and other health care providers. However, individuals seeking whistleblower status must meet several criteria (e.g. "original source") to prevail as outlined below.

Health Insurance Portability and Accountability Act (HIPAA) Exception – Section 164.502(j)(1) of HIPAA permits a member of a covered entity's workforce or a business associate to disclose PHI with a Government Agency and/or Attorney due to the workforce member or business associate's belief in good faith that the covered entity has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or that the care, services, or conditions provided by the covered entity potentially endangers one or more patients, workers, or the public.

***Qui Tam* Procedure -** The relator must file his or her lawsuit on behalf of the Government in a federal district court or for the State of California in the name of California if state funds are involved. The lawsuit will be filed "under seal," meaning that the lawsuit is kept confidential while the state and/or federal Government reviews and investigates the allegations contained in the lawsuit and decides how to proceed.

Rights of Parties to *Qui Tam* Actions - If the Government determines that the lawsuit has merit and decides to intervene, the prosecution of the lawsuit will be directed by the U.S. Department of Justice. If the state proceeds with the action, it shall have the responsibility for prosecuting the action. If the federal government or state decides not to intervene, the whistleblower can continue with the lawsuit on his or her own.

Award to *Qui Tam* Whistleblowers - If the federal and/or state lawsuit is successful, and provided certain legal requirements are met, the relator may receive a percentage award of the total amount recovered or settlement made. If the federal and/or state does not proceed with the action and the *qui tam* plaintiff proceeds with

the action, the relator may receive a percentage award of the penalties and damages. The whistleblower may also be entitled to reasonable expenses including attorney's fees and costs for bringing the lawsuit. All such expenses, fees and costs will be awarded against the defendant and in no circumstances will they be the responsibility of the federal government or state.

No Retaliation - In addition to a financial award, the False Claims Act entitles whistleblowers to additional relief, including employment reinstatement, back pay, and any other compensation arising from retaliatory conduct against a whistleblower for filing an action under the False Claims Act or committing other lawful acts, such as investigating a false claim or providing testimony for, or assistance in, a False Claims Act action. Additionally, non-retaliation and whistleblower protections are afforded to county patients' rights advocates who are contracted individuals or entities.

Reporting a Concern – Employees are required to report any concerns of suspected non-compliance pursuant to Compliance Policy Compliance Program Administration. Concerns should be reported immediately to Kaweah ~~Delta~~ Health Leadership, the ~~VP &~~ Chief Compliance and ~~Privacy~~Risk Officer, the Compliance Hotline at 1(800) 998-8050, or the Kaweah ~~Delta~~ Health Compliance Advocate at (559) ~~738-8100~~636-0200.

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Policy Number: CP.13	Date Created: 11/15/2019
Document Owner: Lisa Wass (Compliance Analyst)	Date Approved: 12/19/2019
Approvers: Board of Directors (Administration), Compliance Committee, Amy Valero (Compliance Manager), Ben Cripps (Chief Compliance/Risk Officer)	
Federal and State False Claims Act and Employee Protection Provisions	

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

Purpose: Kaweah Delta Health Care District ("Kaweah Delta") acknowledges its responsibilities to establish policies and procedures under the Federal Deficit Reduction Act to provide information and education to its employees, agents and contracted work force regarding the federal False Claims Act, the Federal Whistleblower's Act as well California law on these subjects. The following policy is established in order to help our employees, agents and contractors understand the provisions of the federal and state laws regarding submitting false claims for reimbursement, as well as to further inform our employees of their right to report violations at the state and federal levels as well as to their supervisor or through Kaweah Delta's Compliance structure.

Policy: Detailed information regarding both state and federal false claims laws and whistleblower laws will be distributed to employees via this policy as well as through the various educational courses and orientation programs ongoing throughout the system. Employees are strongly encouraged to report any observations they might make regarding potential violations to their supervisor, the Kaweah Delta Compliance and Privacy Officer, or through the Kaweah Delta Confidential Compliance Hotline (1-800-998-8050). Every concern will be investigated in accordance with policy CP.05 Compliance and Privacy Issues Investigation and Resolution.

Federal False Claims Act - The False Claims Act (FCA) is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid (Medi-Cal) programs. The Act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U. S. Government for payment.

The term "knowingly" is defined to mean that a person, with respect to information:

- Has actual knowledge of falsity of information in the claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a claim; or
- Acts in reckless disregard of the truth or falsity of the information in a claim

The Act does not require proof of a specific intent to defraud the United States Government. Instead health care providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the Government, such as knowingly making false statements, falsifying records, or otherwise causing a false claims to be submitted.

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***Qui Tam* Procedure -** The relator must file his or her lawsuit on behalf of the Government in a federal district court or for the State of California in the name of California if state funds are involved. The lawsuit will be filed "under seal," meaning that the lawsuit is kept confidential while the state and/or federal Government reviews and investigates the allegations contained in the lawsuit and decides how to proceed.

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Policy Number:	Date Created:
Document Owner:	Date Approved:
Approvers:	
Event Participation Pay	

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

POLICY:
Kaweah Health recognizes the value of having leaders at community events and fairs. All leaders are encouraged to participate and, in order to ensure coverage, Kaweah Health will compensate employees for the time. Hourly employees will be compensated with pay (hours over 40 in one week causing overtime should be avoided if possible; hourly employees may be able to flex as leaders allow) and exempt employees may flex time and/or may be paid their exempt rate.

PROCEDURE:
The Community Engagement Department will keep a list of employees who are available to represent Kaweah Health at community events. These events can include health and community fairs, job fairs, and other community events that offer booth space and are outside of the employee's regular work hours. Once an event date has been established and the logistics of the event are understood, the Community Engagement team will reach out to employees to review roles and expectations and schedule them for timeslots.

I. Pay will be based on the following:

- For hourly employees:
  - a) They will receive their hourly rate from Cost Center 8612.
  - b) If their pay falls into overtime, Cost Center 8612 will pick up the additional cost.
- For exempt employees:
  - a) A flexible schedule to accommodate the event may be authorized.
  - b) If approved by the leader, an employee will be paid their regular base rate through "Other Hours" from Cost Center 8612.
- For GME Residents:
  - a) Residents will be paid their hourly rate through "Other Hours" from Cost Center 8612. The Designated Institutional Officer will need to approve all moonlighting by Residents.

II. Requirements to participate:

- Must be in good standing with their directors. Manager must be aware of the event and approve employee's participation.
- This policy does not apply to employees who are representing Kaweah Health at galas or dinners.

III. Behavioral Expectations:

If employees are representing Kaweah Health at an event, during their regularly scheduled work hours, where alcohol is served, they are not allowed to partake.

Policy Number: COVID.38	Date Created: No Date Set
Document Owner: Emma Mozier (Director of Medical/Surgical)	Date Approved: Not Approved Yet
Approvers: Emma Mozier (Director of Medical/Surgical), Keri Noeske (Chief Nursing Officer)	
Team Member COVID-19 Symptomatic Testing	

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

DEFINITIONS:

Team Member: Kaweah Health staff, licensed independent practitioners (LIP), or contracted staff.

Symptomatic: A team member reporting any of the following symptoms: fever greater than 100.4, dry cough, fatigue, congestion, runny nose, aches and pains, sore throat, diarrhea, headache, loss of taste and smell, or other symptoms possibly related to COVID-19.

PURPOSE:

I. To facilitate and provide COVID-19 testing to the Kaweah Health team member per Centers of Disease Control (CDC) guidance.

II. Identify COVID-19 positive (+) team members and remove from the work setting in order to protect the health of these workers, co-workers, and patients.

POLICY:

I. COVID-19 Testing
   A. Team members that are symptomatic for COVID-19 should be prioritized for viral testing with nucleic acid, polymerase chain reaction (PCR), or antigen detection assays; ensure that SARS-CoV-2 testing is performed with a test that is capable of detecting SARS-CoV-2 even with currently circulating variants in the United States.

II. Symptomatic Team Member Testing During Business Hours
   A. A symptomatic team member is to isolate, including leaving work if on duty, call Employee Health (EHS) to report symptoms, and be screened by phone for COVID-19 testing. They must also report symptoms to their direct supervisor.
      1. If a team member has tested positive for COVID-19 in the last 90 days, they will be evaluated by the EHS nurse and may not be tested for COVID-19.

2. If the team member is required to test for COVID-19 based on the EHS nurse's evaluation of the team member, they are to isolate at home while waiting for results.

B. Once lab results are available, the EHS nurse will call the team member and provide instruction.
  1. If positive, the investigative questionnaire is completed and shared with Infection Prevention (IP) for contact tracing.
  2. If negative, the team member is not further evaluated by EHS and follows up with their direct supervisor if they feel unwell to come to work.
     a. If they continue to be symptomatic and have an exposure or another reason they require testing again, they are to contact EHS again.
  3. Team member is instructed to quarantine for a specific number of days per current CDC guidelines/recommendations. Onset of symptoms is considered day "0".
  4. The team member is to call EHS on the date provided by the EHS staff member to be evaluated for return to work. If they remain symptomatic as their day to return to work approaches, they are instructed to call EHS and speak with the EHS nurse. They are also instructed to notify their direct supervisor of their required time away from work. EHS will notify the Leave of Absence (LOA) team in Human Resources (HR) of the extended time off.
  5. EHS records and tracks positive staff members.
  6. HR notifies all potential COVID-19 team member exposures by unit. The information is emailed out within 1 business day once exposure is confirmed or known.

III. Weekend/Holiday Testing Process:
  A. A symptomatic team member is to isolate, including leaving work if on duty, call EHS and is directed by voicemail to present to Urgent Care on Court Street for COVID-19 testing. They must also report symptoms to their direct supervisor and notify EHS of the results after testing.
  B. The following business day, EHS contacts the team member and follows the 'Symptomatic Team Member Testing During Business Hours' process as listed above.

IV. Exposure Process
  A. Team members who have been identified by IP or the positive employee as having been possibly exposed will receive an email from EHS to watch for symptoms for 14 days from last exposure.

V. Return to Work Process
  A. Team members with improved symptoms, are fever free (less than 100.4 without fever reducing medication) and/or new onset diarrhea free for a least 24 hours following their COVID-19 quarantine will present to EHS on

the day prior to their return to work date for an evaluation of symptoms and return to work status. A determination by an EHS Nurse on return to work clearance will be made and communicated to the LOA team via email.

VI. Records maintained in EHS
   A. Phone call logs with identifying information, date/time, symptoms, whether tested or not, and results.
   B. COVID Positive team member spreadsheet
   C. COVID Absence Spreadsheet with dates off work due to COVID
   D. Investigative questionnaires
   E. Workers Compensation documents when exposure is deemed work related and employee files a worker’s compensation claim.

Related Documents:
None

References: https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html

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Policy Number: COVID.36	Date Created: No Date Set
Document Owner: Emma Mozier (Director of Medical/Surgical)	Date Approved: Not Approved Yet
Approvers: Emma Mozier (Director of Medical/Surgical), Keri Noeske (Chief Nursing Officer)	
Team Member COVID-19 Vaccination and Asymptomatic Surveillance Testing	

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

DEFINITIONS:

Team Member: a Kaweah Health (KH) employee, licensed independent practitioners (LIP), contract staff, and volunteers.

Fully Vaccinated: Received a single dose of Johnson and Johnson/Janssen COVID vaccine and if eligible received a booster dose after initial vaccination OR received both doses of the Moderna or Pfizer COVID vaccine and if eligible received a booster dose after initial vaccination. Beginning 3/1/22, booster doses must be received within 15 days of booster eligibility (Johnson and Johnson/Janssen is at 2 months from initial vaccination, Moderna or Pfizer is 6 months from 2nd dose of initial vaccination).

Not Fully Vaccinated: An individual that has received no or partial doses of the COVID vaccine. An individual that has received the initial full dose(s) of the COVID vaccine but now is eligible for the booster but has not received it.

PURPOSE: To comply with state and federal COVID-19 vaccination mandates.

POLICY:

I. COVID Vaccinations

A. All team members are to be fully vaccinated for COVID-19. This includes a booster dose if eligible per manufacturer and Food and Drug Administration (FDA) regulations and timelines. Vaccination records are provided to the organization upon hire and receipt of any subsequent vaccinations. Booster dose's must be received within 15 days of eligibility. If a team member became COVID-19 positive or received Monoclonal Antibody (mAB) treatment, they are not required to get the vaccine or booster dose until 105 days (90 + 15) after the date of their positive COVID test. They may receive the vaccine earlier depending on guidance of their primary care providers.

B. If an employee declines to be fully vaccinated, they must complete a declination form indicating that they are declining for a sincerely held religious belief or based on a medical exemption. A declination form is to be signed and submitted. A declination for medical reasons must include

a written statement signed by a LIP. If a team member received the initial vaccine series but is now declining the booster dose for the above reasons, a booster dose declination must be completed and submitted.

C. Failure to be fully vaccinated or failure to submit a signed declination form, including a written statement signed by a LIP for a medical exemption, may result in termination of employment in accordance with state and federal mandates making COVID-19 vaccination a condition of employment.

II. COVID Testing for those not fully vaccinated

A. All team members who meet the definition of not fully vaccinated and work in a location listed below, must routinely test for COVID-19. Frequency of testing is determined by the employee's weekly schedule and location:

Twice Weekly Testing	**Once a Week Testing**	**PRN/Per Diem**
- Two or More Shifts/ Week at Main Hospital, Acute Rehab, Skilled Nursing Facility (SNF) - Recommend testing on Monday or Tuesday AND Wednesday or Thursday.	- Works 1 Shift/ Week at Main Hospital, Acute Rehab, SNF or Works in Other Direct Patient Care Areas (Dialysis Center, Acute Psychiatric Hospital, Clinics, Rehabilitation Clinics, Hospice, Home Health, Outpatient Retail Pharmacy and Therapy) - Recommend testing Monday, Tuesday, Wednesday, or Thursday.	- Works Less than 1 Shift Per Week - Testing to take place within 48 hours of scheduled shift.

B. Testing kits or a location for testing will be provided to team members required to undergo testing. If a team member undergoes testing for COVID-19 at another facility, they may provide proof of negative tests (copy of test result) per the required interval to KH in lieu of testing at KH.

C. Test results will be logged through an electronic or paper record indicating the team member name, date of test, and result.

D. If a team member became COVID-19 positive, they are not required to test until the 91st day after the positivity date.

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III. Record of Vaccinations and Declinations

A. Employee Health Services (EHS) will maintain all vaccine records and declination forms (initial and booster).

IV. Personal Protective Equipment (PPE) for team members not fully vaccinated

A. KH PPE practices for patient care are created regardless of vaccination status and implemented equally.

B. Refer to the “COVID-19 PPE Grid” for full outline of PPE practices related to COVID-19.

C. Team members not fully vaccinated have respirators available to them for use. Respirators are discarded daily and when moist, concerned about contamination, or damaged or contaminated with blood, respiratory or nasal secretions, or other bodily fluids. Also discard after contact with a patient in droplet or airborne isolation.

Related Documents:
None

References:
https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-34.aspx

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COVID Serial Asymptomatic Testing Requirements
IF SYMPTOMATIC OR KNOWN EXPOSURE CALL EMPLOYEE HEALTH 624-2458

Action Item	Twice Weekly Testing (Two or More Shifts/ Week at Main Hospital, Acute Rehab, SNF)*	Once a Week Testing (Works 1 Shift/ Week at Main Hospital, Acute Rehab, SNF or Works in Other Direct Patient Care Areas**)	PRN/Per Diem (Works Less than 1 Shift Per Week) Within 48 hours of scheduled shift
How will I test?	Depends by location. Some individuals will be testing at home, some will be testing within their department and some will be testing at a centralized location. The testing location is indicated on the weekly unvaccinated employee report from ISS.	Depends by location. Some individuals will be testing at home, some will be testing within their department and some will be testing at a centralized location. The testing location is indicated on the weekly unvaccinated employee report from ISS.	Depends by location. Some individuals will be testing at home, some will be testing within their department and some will be testing at a centralized location. The testing location is indicated on the weekly unvaccinated employee report from ISS.
When do I test?	You will need to complete testing two times per week. Suggest by the end of the day on Tuesday (can test Monday or Tuesday) and Thursday (can test Wednesday or Thursday).	You will need to complete testing one time per week. Suggest by the end of the day on Thursday (can test any day Monday-Thursday).	You will need to test **within** 48 hours of your scheduled shift.
How do I report my results? How will my results be documented and monitored?	Most individuals will be self reporting their results via Kaweah Compass. Results for those assigned to a centralized testing location will be documented in NAVICA. Leadership will access reports in HR Online to monitor compliance with testing requirements for their staff. ISS has provided job aides and education on how to do this.	Most individuals will be self reporting their results via Kaweah Compass. Results for those assigned to a centralized testing location will be documented in NAVICA. Leadership will access reports in HR Online to monitor compliance with testing requirements for their staff. ISS has provided job aides and education on how to do this.	Most individuals will be self reporting their results via Kaweah Compass. Results for those assigned to a centralized testing location will be documented in NAVICA. Leadership will access reports in HR Online to monitor compliance with testing requirements for their staff. ISS has provided job aides and education on how to do this.
What if I test positive?	Contact Employee Health at 559-624-2458 for direction. A confirmatory PCR test will be completed. You will not be subject to testing for 90 days after a positive COVID test.	Contact Employee Health at 559-624-2458 for direction. A confirmatory PCR test will be completed. You will not be subject to testing for 90 days after a positive COVID test.	Contact Employee Health at 559-624-2458 for direction. A confirmatory PCR test will be completed. You will not be subject to testing for 90 days after a positive COVID test.
What if I refuse to test or do not complete and document the required testing?	Testing of unvaccinated employees is required by State Mandate. If you refuse to complete the required testing, Kaweah Health would consider that a voluntary resignation. For those who do not complete and document the required testing, progress discipline will occur.	Testing of unvaccinated employees is required by State Mandate. If you refuse to complete the required testing, Kaweah Health would consider that a voluntary resignation. For those who do not complete and document the required testing, progress discipline will occur.	Testing of unvaccinated employees is required by State Mandate. If you refuse to complete the required testing, Kaweah Health would consider that a voluntary resignation. For those who do not complete and document the required testing, progress discipline will occur.

***For employees that do not provide direct patient care, but who work in areas where direct patient care is provided, your Manager or Director will notify you of the required testing frequency.**

****Other Direct Patient Care Areas Dialysis Center, Acute Psychiatric Hospital, Clinics, Rehabilitation Clinics, Hospice, Home Health, Outpatient Retail Pharmacy and Therapy, and other direct patient care areas.**

*****Employees who have had a positive COVID test are exempt from testing for 90-days. Unvaccinated employees must resume COVID testing after the 90th day of a positive test.**

Human Resources

Policy Number: HR.216	Date Created: 06/01/2007
Document Owner: Dianne Cox (Chief Human Resources Officer)	Date Approved: 06/28/2021
Approvers: Board of Directors (Administration)	
Progressive Discipline	

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POLICY:

Kaweah Health uses positive measures and a process of progressive discipline to address employee performance and/or behavioral problems. Kaweah Health recognizes that the circumstances of each situation must be evaluated individually to determine whether to discipline progressively or to impose more advanced discipline immediately. This policy applies to all Kaweah Health employees, except residents enrolled in the Kaweah Health's Graduate Medical Education (GME) program. Disciplinary actions related to residents in the GME program are handled by the Office of the GME as described in the Resident Handbook.

The primary purpose of Disciplinary Action is to assure compliance with policies, procedures and/or Behavioral Standards of Performance of Kaweah Health. Orderly and efficient operation of Kaweah Health requires that employees maintain appropriate standards of conduct and service excellence. Maintaining proper standards of conduct is necessary to protect the health and safety of all patients, employees, and visitors, to maintain uninterrupted operations, and to protect Kaweah Health's goodwill and property. Because the purpose of disciplinary action is to address performance issues, it should be administered as soon after the incident(s) as possible. Therefore, depending on the seriousness of the offense and all pertinent facts and circumstances, disciplinary action will be administered promptly.

Certain violations are considered major and require more immediate and severe action such as suspension and/or termination. Lesser violations will generally be subject to Progressive Discipline.

Any employee who is in Progressive Discipline is not eligible for transfer or promotion within Kaweah Health without review and approval by the hiring manager and Human Resources.

Progressive Discipline shall be the application of corrective measures by increasing degrees, designed to assist the employee to understand and comply with the required expectations of performance. All performance of an employee will be considered when applying Progressive Discipline.

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In its sole discretion, Kaweah Health reserves the right to deviate from Progressive Discipline or act without Progressive Discipline whenever it determines that the circumstances warrant.

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PROCEDURE:

I. The process of Progressive Discipline may include the following, depending on the seriousness of the offense and all pertinent facts and circumstances:

A. Warnings

1. Verbal Warning:

A Verbal Warning explains why the employee's conduct/performance is unacceptable and what is necessary to correct the conduct/performance. This written record of the verbal warning typically remains in the department manager's/supervisors confidential files unless more serious discipline follows.

B. Written Warning:

A Written Warning provides the nature of the issue and outlines the expectations of performance/conduct or what is necessary to correct the situation. This Warning becomes part of the employee's personnel file, along with any pertinent back-up documentation available, and will inform the employee that failure to meet the job standards/requirements of the Warning will necessitate further disciplinary action, up to and including termination.

The department management, in concert with Human Resources, determines the level of corrective disciplinary action that will take place based upon the seriousness of the offense, the existence of any prior disciplinary actions and the entirety of the employee's work record.

1. Level I
Any employee who receives a Level I is subject to further Written Warnings as stated in this policy.

2. Level II
Any employee who receives a Level II is subject to further Written Warnings as stated in this policy.

3. Level III

A Level III is considered Final Written Warning to the employee involved, and includes a written explanation of what is necessary to meet the expectation of performance. A Level III Warning may be accompanied by a suspension. A suspension may be without pay and is generally up to five days or forty hours.

C. Administrative Leave

In the discretion of Kaweah Health, an employee may be placed on Administrative Leave with or without pay at any time to give Kaweah Health time to conduct an investigation or for other circumstances considered appropriate by Kaweah Health. Management may impose an Administrative Leave at any time for an employee(s) if they believe there is a risk to employee or patient safety. Management will notify Human Resources immediately if an Administrative Leave is enforced. When an employee is placed on Administrative Leave, Kaweah Health will make every effort to complete the investigation of the matter within five business days. If Kaweah Health is unable to complete an investigation of the matter within five days the Administrative Leave may be extended.

After the investigation has been completed, the employee may be returned to work and, in the discretion of Kaweah Health and depending on the circumstances, may be reimbursed for all or part of the period of the leave. If it is determined that the employee should be terminated, compensation may, in the discretion of Kaweah Health, be paid until the Post Determination Review process has been completed. (See policy HR.218).

D. Dismissal Without Prior Disciplinary History

As noted, Kaweah Health may determine, in its sole discretion, that the employee's conduct or performance may warrant dismissal without prior Progressive Discipline. Examples of conduct that may warrant immediate dismissal, suspension or demotion include acts that endanger others, job abandonment, and misappropriation of Kaweah Health resources. This is not an exclusive list and other types of misconduct/poor performance, may also result in immediate dismissal, suspension or demotion. See Employee Conduct below. .

E. Employee Conduct

This list of prohibited conduct is illustrative only; other types of conduct injurious to security, personal safety, employee welfare or Kaweah Health's operations may also be prohibited. This includes behavior or behaviors that undermine a culture of safety. Employee conduct that will

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be subject to Progressive Discipline up to and including immediate involuntary termination of employment includes but is not limited to:.

1. Falsifying or altering of any record (e.g., employment application, medical history form, work records, time cards, business or patient records and/or charts).

2. Giving false or misleading information during a Human Resources investigation;

3. Theft of property or inappropriate removal from premises or unauthorized possession of property that belongs to Kaweah Health, employees, patients, or their families or visitors;

4. Damaging or defacing materials or property of Kaweah Health, employees, patients, or their families or visitors;

5. Possession, distribution, sale, diversion, or use of alcohol or any unlawful drug while on duty or while on Kaweah Health premises, or reporting to work or operating a company vehicle under the influence of alcohol or any unlawful drug;

6. Fighting, initiating a fight, threats, abusive or vulgar language, intimidation or coercion or attempting bodily injury to another person on Kaweah Health property or while on duty. Reference policy AP161 Workplace Violence Prevention Program;

7. Workplace bullying which can adversely affect an employee's work or work environment, Reference policy HR.13 Anti-Harassment and Abusive Conduct.

8. Bringing or possessing firearms, weapons, or any other hazardous or dangerous devices on Kaweah Health property without proper authorization;

9. Endangering the life, safety, or health of others;

10. Intentional violation of patients' rights (e.g., as stated in Title XXII);

11. Insubordination and/or refusal to carry out a reasonable directive issued by an employee's manager (inappropriate communication as to content, tone, and/or language)

12. Communicating confidential Kaweah Health or Medical Staff information, except as required to fulfill job duties;

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13. Sleeping or giving the appearance of sleeping while on duty;

14. An act of sexual harassment as defined in the policy entitled Anti-Harassment and Abusive Conduct HR.13;

15. Improper or unauthorized use of Kaweah Health property or facilities;

16. Improper access to or use of the computer system or breach of password security;

17. Improper access, communication, disclosure, or other use of patient information. Accessing medical records with no business need is a violation of state and federal law and as such is considered a terminable offense by KDHCD.

18. Unreliable attendance (See Attendance and Punctuality HR.184)

19. Violations of Kaweah Health Behavioral Standards of Performance.

20. Unintentional breaches and/or disclosures of patient information may be a violation of patient privacy laws. Unintentional breaches and/or disclosures include misdirecting patient information to the wrong intended party via fax transmission, mailing or by face-to-face interactions.

21. Access to personal or family PHI is prohibited.

22. Refusing to care for patients in the event mandated staffing ratios are exceeded due to a healthcare emergency.

23. Working off the clock at any time. For the convenience of the employees, Kaweah Health allows staff to clock in before their start time. However, employees are not permitted to work until their scheduled start time.

24. Failure to work overtime.

25. Use of personal cell phones while on duty if unrelated to job duties anywhere in Kaweah Health.

26. Excessive or inappropriate use of the telephone, cell phones, computer systems, email, internet or intranet.

27. Any criminal conduct off the job that reflects adversely on Kaweah Health.

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28. Making entries on another employee's time record or allowing someone else to misuse Kaweah Health's timekeeping system.

29. Bringing children to work, or leaving children unattended on Kaweah Health premises during the work time of the employee.

30. Immoral or inappropriate conduct on Kaweah Health property.

31. Unprofessional, rude, intimidating, condescending, or abrupt verbal communication or body language.

32. Unsatisfactory job performance.

33. Horseplay or any other action that disrupts work,

34. Smoking within Kaweah Health and/or in violation of the policy.

35. Failure to report an accident involving a patient, visitor or employee.

36. Absence from work without proper notification or adequate explanation, leaving the assigned work area without permission from the supervisor, or absence of three or more days without notice or authorization.

37. Unauthorized gambling on Kaweah Health premises.

38. Failure to detect or report to Kaweah Health conduct by an employee that a reasonable person should know is improper or criminal.

39. Providing materially false information to Kaweah Health, or a government agency, patient, insurer or the like.

40. Spreading gossip or rumors which cause a hostile work environment for the target of the rumor.

41. Impersonating a licensed provider.

42. Obtaining employment based on false or misleading information, falsifying information or making material omissions on documents or records.

43. Violation of Professional Appearance Guidelines

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44. Being in areas not open to the general public during non-working hours without the permission of the supervisor or interfering with the work of employees.

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

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

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Subcategories of Department Manuals not selected.

Policy Number: EOC 1001	Date Created: 06/01/2009
Document Owner: Maribel Aguilar (Safety Officer/Life Safety Mgr)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Board of Directors (EOC/Emergency Preparedness)	

Safety Management Plan

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

I. OBJECTIVES

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

II. SCOPE

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

III. AUTHORITY

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

IV. ORGANIZATION

The following represents the organization of safety management at ~~KDHCD~~KH:

Organization - Safety Management

Board of Directors

Pro Staff Committee (ProStaff)

Emergency Management Committee

Environment of Care Committee

Safety Officer

V. RESPONSIBILITIES

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

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

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

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

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

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

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

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

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

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

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

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

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

SAFETY OFFICER AUTHORITY

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

MANAGEMENT OF SAFETY RISKS

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

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

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

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

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

ACTIONS TO MINIMIZE OR ELIMINATE IDENTIFIED SAFETY RISKS

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

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

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

Risk Reduction Strategies-Proactive

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

1. **Worker Safety Program with Safety Officer Role**. The *Environment of Care* Committee outlines the broad objectives of the safety program for (~~KDHCD~~KH), and implements various activities to ensure the program is viable, as well as defines, through

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

2. **Committees.** The EOC Committee is the structure through which safety-related problems and issues can be identified and resolved. It should be noted that the EOC Committee is closely integrated with patient safety functions. The purpose of the EOC Committee with respect to the Patient Safety standards is to remain aware of sentinel event alert information from the Joint Commission and to assess organizational practices against current information relating to patient safety. Additionally, when recommendations are made for hospitals, each recommendation is critically reviewed, with a plan of action established. If sentinel events occur within the District setting that reflect *environment of care* issues, the EOC Committee will participate in improving outcomes relating to patient safety.
   The Radiation Safety Committee impacts worker safety as it oversees the radiation safety program and issues relating to the safety of the worker and radiation exposures. The Emergency Management Subcommittee convenes for the purpose of minimizing risks associated with unforeseen emergent situations that have the potential for consequential or adverse events.

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

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

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

   a) **Area Specific Safety**. Area specific safety is covered for new employees and contracted workers on each department within (~~KDHCD~~KH) and is the responsibility of the department manager and is documented. Information may include, but not be limited to location of the department's fire alarms, fire extinguishers, exits, evacuation plans; and location of unit- specific policies and procedures.
   b) **Specific Job-Related Hazards**. Education relating to specific job-related hazards may be part of the new employee's competencies, and part of the competency reorientation process. Examples of this may include job-related hazards related to the use of chemotherapy for nurses, "lock-out-tag out" for engineering staff, or use of certain cutting materials in the kitchen. Education for specific job-related hazards is the responsibility of the department manager and is documented.

Educational sources

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

a) **Environmental surveillance trends**. Through trending of surveillance results, it may be determined that staff need additional education. The survey process itself may be an educational tool for staff. For example,

when staff are asked specific questions relating to fire or disaster roles, or location of SDS, or relating to their responsibilities with respect to defective equipment.

b) **Fire and Disaster drills**. When staff performance is evaluated during fire and disaster drills, educational topics may be developed if a knowledge deficit exists or if staff performance was not at the expected level.

c) **Changes in Operational Practices**. Whenever changes occur within (KDHCD) that requires additional safety education, the education will be determined by the EOC committee.

d) **Needs Assessment**. Another source of education is determined from periodic needs assessment tools. These can be gathered from educational evaluations wherein the staff may be asked, “What other types of educational topics would you like to see?” Or it may be done at the unit level, for example, with the use of medical equipment when user errors occur.

e) **Illness and Injury Trends**. When illness and injury trends demonstrate an increase, the increase may be the catalyst for further education. Increasing back or needle stick injuries, or falls are examples of using injury trends to substantiate the need for additional education.

f) **Consequential Events or Risk of Consequential Events**. An incident may occur that results in an adverse patient, visitor or employee injury. This will warrant investigation~~,~~ and the possibility of additional education.

g) ***Environment of Care* Committee**. The EOC Committee may impose education upon staff due to various regulatory and/or accreditation agencies that require updating.

h) **Risk Assessment Activities**. When risks have been identified, the risks will serve as a source of education for staff, based upon the severity and type of risk assessed.

Risk Reduction Strategies – When Risks Have Been Identified

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

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

MAINTENANCE OF GROUNDS AND EQUIPMENT

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

Environmental surveys are done routinely by EOC Committee personnel. Additionally, routine and varied security patrols are conducted wherein any safety hazards are brought to the attention of the EOC Committee. Routine building/grounds surveys with a contractor’s representative are conducted when construction activities are occurring. Special investigations by the Safety Officer and other

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

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

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

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

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

For MRI Equipment:

- A least annually a diagnostic medical physicist or MRI scientist conducts a performance evaluation of all MRI imaging equipment. The evaluation, along with any

recommendations, are documented. The evaluation includes the use of phantoms to assess the following: image uniformity for all radiofrequency coils used clinically, slice position accuracy, alignment light accuracy, high and low contrast resolution, geometric or distance accuracy, magnetic field homogeneity, and artifact evaluation.

FOR CT Equipment:

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

FOR Nuclear Medicine Equipment:

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

FOR PET Imaging:

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

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

Product Notices and Recalls

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

Pharmacy Safety: In support of safe and sterile conditions within the Pharmacy during compounding or admixing, sterility of packaging is present with "event shelf life" or dated products. Infection Control surveillance observes for sterility of packaging, and Pharmacy implements quality control by observing for sterility prior to the use of a product. The only exception is in an urgent situation in which a delay could harm the patient or when the product's stability is short. (~~KDHCD~~KH) is constructed to allow for clean, uncluttered and functionally separate areas for product preparation, and pharmacy staff is trained to use clean or sterile techniques. During preparation of pharmaceutical drugs and solutions, pharmacy staff is trained to visually inspect the medications for particulates, discoloration or other loss of integrity, and to remove the product from usage, and report the information to the vendor. To support pharmaceutical safety, (~~KDHCD~~KH) has a laminar airflow hood for the preparation of intravenous admixtures or any other sterile product. The laminar airflow receives preventive maintenance in accordance with the manufacturer's recommendations.

Prohibition of Smoking

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

Information Collection System to monitor conditions in the Environment

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

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

Environmental Tours

(~~KDHCD~~KH) conducts environmental tours to identify deficiencies, hazards and unsafe practices.

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

Annual Evaluation of the Safety Management

On an annual basis EOC Committee members evaluate the Management Plan for Safety, as part of a risk assessment process. Validation of the management plan occurs to ensure contents of each plan support ongoing activities within KDHCD. Based upon findings, goals and objectives will be determined for the subsequent year. A report will be written and forwarded to the Governing Board. The annual evaluation will include a review of the following:

- The objectives: The objective of the Safety Management plan will be evaluated to determine continued relevance for Kaweah Delta Health Care District (i.e., the following questions will be asked; was the objective completed? Did activities support the objective of the plan? If not, why not? What is the continuing plan? Will this objective be included in the following year? Will new objective(s) be identified? Will specific goals be developed to support the identified objective?).
- The scope. The following indicator will be used to evaluate the effectiveness of the scope of the safety management plan: the targeted population for the management plan will be

evaluated (e.g., did the scope of the plan reach employee populations in the off-site areas, and throughout ~~KDHCD~~KH?)

- Performance Standards. Specific performance standards for the Safety Management plan will be evaluated, with plans for improvement identified. Performance standards will be monitored for achievement. Thresholds will be set for the performance standard identified. If a threshold is not met an analysis will occur to determine the reasons, and actions will be identified to reach the identified threshold in the subsequent quarter.
- Effectiveness. The overall effectiveness of the objectives, scope and performance standards will be evaluated with recommendations made to continue monitoring, add new indicators if applicable or take specific actions for ongoing review.

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

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

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

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

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

Subcategories of Department Manuals not selected.

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 (KH) 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.

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II. SCOPE

The scope of this management plan applies to Kaweah Health (KDHCD)Kaweah Delta Health Care District, and any off site areas as per KDHCD Kaweah Health license.

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The following is a list of the areas:

- Kaweah Delta Medical Center, 400 West Mineral King, Visalia, CA.
- Kaweah Delta Visalia Dialysis, 5040 West Tulare Ave., Visalia, CA.
- Kaweah Delta Exeter Health Clinic, 1014 San Juan Avenue, Exeter, CA.
- Kaweah Delta Hospice, 900 West Oak, Visalia, CA.
- Kaweah Delta Home Health, 403 West Main, Visalia, CA.
- Kaweah Delta Infusion Pharmacy, 602 Willow, Visalia, CA.
- Kaweah Delta Mental Health, 1100 South Akers, Visalia, CA.
- Kaweah Delta Porterville Dialysis, 385 North Pearson, Porterville, CA.
- Kaweah Delta Rehab Hospital, 840 South Akers, Visalia, CA.
- Kaweah Delta Skilled Nursing, 1633 South Court Street, Visalia, CA.
- Kaweah Delta Urgent Care, 1633 South Court Street, Visalia, CA.
- Sequoia Regional Radiation Oncology Center, 4945 West Cypress Ave., Visalia, CA.
- Sequoia Regional Radiation Oncology – Hanford, 1443 West 7th Street, Hanford, CA.
- Kaweah Delta Lindsay Health Clinic, 839 North Sequoia Ave., Lindsay, CA.
- Sequoia Prompt Care Center, 1110 S. Ben Maddox Way, Visalia, CA.
- Outpatient Therapy Services – Lovers Lane, 1337 So. Lovers Lane, Visalia, CA.
- Kaweah Delta Woodlake health Clinic, 180 East Antelope Ave., Woodlake, CA.
- Kaweah Delta Wound Center, 840 South Akers Rd., Visalia, CA.

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- ~~Kaweah Delta Sleep Center, 126 S. Floral, Visalia, CA.~~
- ~~Therapy Specialists,820 South Akers, Visalia, CAa 93291~~
- ~~Kaweah Delta Family Medicine Center, 202 W. Willow Suite 502, Visalia, CaA 93291~~
- ~~Kaweah Delta Dinuba Health Clinic, 355 Monte Vista Drive, Suite A, Dinuba, CAa 93618~~
- ~~Kaweah Delta Imaging Center, 4949 West Cypress Ave, Visalia, CAa 93277~~
- ~~Kaweah Delta Exeter Therapy Specialists, 1131 Visalia Road, Exeter, CAa 93221~~
- ~~Sequoia Prompt Care Center, 820 S. Akers Suite 100, Visalia, CAa 93277~~

Each off site area is required to have a unit-specific Safety Plan that addresses the unique considerations of the built environment, including directions for reaching Security or law enforcement. Kaweah Health~~Delta~~ Medical Center personnel are to dial 44 for an immediate security response within the premises and grounds. ~~Off site~~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 ~~off site~~offsite areas, using an environmental surveillance checklist.

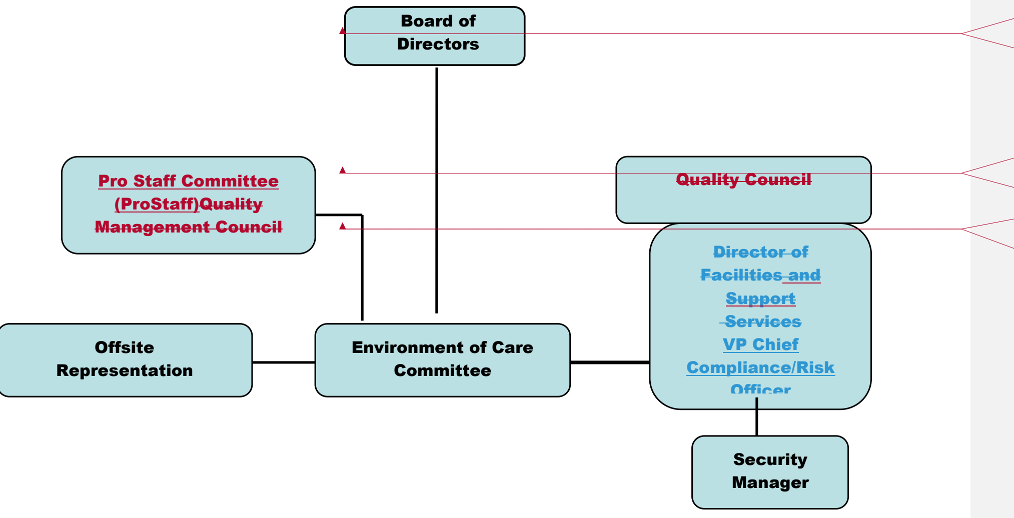
III. AUTHORITY

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

IV. ORGANIZATION

The following represents the organization of security management at Kaweah Health (KDHCD)~~Kaweah Delta Health Care District~~.

Organization - Security Management



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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:

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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.

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~~**Quality Management Council:** Reviews annual *Environment of Care* report from the *Environment of Care* Committee, providing feedback if applicable.~~

Pro Staff Committee (ProStaff)~~Quality Council~~: 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.

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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 ~~the Ddistrict's~~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.

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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.

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

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

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

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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 ~~within the District~~ 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 ~~people coming to the District~~persons throughout the organization. Moreover the identified

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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 ~~(KD~~HC~~D)~~~~Kaweah Delta Health Care District~~. Coverage is provided twenty-four (24) hours per day, seven (7) days a week by uniformed facility security officers at the Main, South, and West Campuses, including the Acute Psych Hospital. ~~South Campus is provided with 16 hours security coverage Mon-Fri (3:30 PM – 7:30 AM) and 24/7 coverage on weekends.~~ 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 ~~which is locked but able to be entered~~ with the use of an~~the~~ 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. ~~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.

~~7~~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

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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.

~~8~~

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

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

5. Closed Circuit TV. Closed circuit TV is in place to monitor the security sensitive areas, public entrances, lobbies and corridors, and select parking lots.~~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.
~~Emergency Department, Administration, Human Resources, ICU, Kaweah Korner, Labor and Delivery, Pharmacy, Admitting, Mother-Baby, Surgery Waiting Room, NICU, Patient Accounting, Pediatrics, Foundation, Risk Management, HIM, Dietary, Rehabilitation Hospital and the Guild Gift Shop.~~

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

~~7.~~Education – for Newly-hired Staff and Ongoing (HR.01.04.05.01 EP 1; HR.01.04.01 EP 1, 2, 3;

8. EC.03.01.01- EP's 1-~~3~~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.

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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.

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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

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~~(KDHCD)Kaweah Delta Health Care District~~ Kaweah Health manages risks associated with the grounds and equipment in order to minimize consequential events or adverse outcomes related to accidents.

Environmental surveys are done routinely by *Environment of Care* Committee personnel. Additionally, routine and varied security patrols are conducted wherein any security hazards are brought to the attention of the *Environment of Care* Committee. ~~Weekly~~

~~building~~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 ~~/ Badge Access~~
- ICU/CCU – Combination Keypad and~~/~~ ~~L~~limited key access
- Information Systems – Limited key access, ~~/ B~~burglar ~~a~~Alarm ~~s~~System and ~~/~~CCTV
- Labor & Delivery – Badge ~~A~~access, ~~/~~ CCTV, ~~/~~ HUGS Infant Security System, ~~/ P~~panic-~~d~~Duress ~~a~~Alarms
- Materials Management – Limited key access
- Mother-Baby Unit – Badge ~~A~~access, ~~/~~ HUGS Infant Security System, ~~/~~ CCTV, and ~~P~~panic-~~D~~duress ~~A~~alarms
- NICU –Badge ~~a~~Access, ~~/~~ HUGS Infant Security System, ~~/~~ CCTV, and ~~/P~~panic-~~D~~duress ~~A~~alarms
- OB-Surgery – Badge access / CCTV / HUGS Infant Security System
- Operating Room – ~~Signage / Restricted access signage~~badge access~~.~~
- Pharmacy: Dedicated key access, keypad and ~~/ B~~badge ~~a~~Access
- Helipad – Badge access; key access for exterior staircase security fence

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

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

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EC.-02.01.01 EP 9-1001.01.01-9

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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 Ssecurity Gguard Sservices Ccompany that provides additional security staff as when needed. If a system failure occurs, the Director of Facilitiesvp Chief Compliance/Risk Officer has the authority to contact the appropriate vendors to initiate repairs or to request Ssecurity Gguard 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.

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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 Marketing Director of Media RelationsDepartment will be responsible for any information released to any entity. Security personnel will not give any information to any family member, VIP or the media. Security staff will take all precautions necessary to protect the individual. If the VIP has his/her own security protection, Security staff will work together with that security force to assure that the VIP is protected. This may include establishing special patrols or calling in additional officers.

02.01.01 EP 17

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

INFORMATION COLLECTION SYSTEM TO MONITOR CONDITIONS IN THE ENVIRONMENT

EC.04.01.01- EP’s 1,3,5-6-11,

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

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

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

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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. ~~A report will be written and forwarded to the Governing Board.~~ The annual evaluation will include a review of the following:

- The objectives: The objective of the Security Management Plan will be evaluated to determine continued relevance for the ~~District~~ organization (i.e., the following questions will be asked:~~;~~ ~~w~~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 ~~District~~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-~~-1-~~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 ~~EC.04.01.03-EP-3~~

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

KAWEAH HEALTH~~DELTA HEALTH CAR~~ ~~IMPROVES ITS ENVIRONMENT OF CARE~~TAKES ACTION ON IDENTIFIED OPPORTUNITIES TO RESOLVE ~~ENVIORNMENTAL~~ENVIRONMENTAL SAFETY ISSUES
EC.04.01.05~~-~~ EP~~-~~1
~~-3~~

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.

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

Subcategories of Department Manuals not selected.

Policy Number: EOC 4001	Date Created: 03/01/2006
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)	
Hazardous Materials and Waste Management Program	

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

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I. POLICY OVERVIEW:

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

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

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

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

PURPOSE:

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

OBJECTIVES:

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

III. DEFINITIONS:

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

IV. ROLES AND RESPONSIBILITIES:

- **KAWEAH ~~DELTA~~ HEALTH ~~CARE DISTRICT (KDHCD)~~**
  -The following will be provided to each employee by ~~KDHCD~~KD:
  1. A written hazard communication plan
  2. A List of hazardous chemicals at this facility or in each work area
  3. SDS for each hazardous chemical
  4. Assure all chemicals are labeled
  5. "Effective" training and information for all hazardous chemicals at this facility

- **ALL EMPLOYEES**
  -As an employee you must read this written hazard communication plan and:
  1. Follow all safety instructions provided by this plan and your employer
  2. Complete hazard communication training annually
  3. Obtain a SDS for any new chemical you may be required to purchase, and ensure that a SDS has been received prior to using any new product.
  4. Forward new SDSs to the District Safety Officer to facilitate updating the plan
  5. Label containers that are used for the transfer of chemicals (secondary or portable containers), and ensure that each chemical container has the appropriate labels.
  6. Read safe use guide information and chemical labels prior to working with a chemical
  7. Always wear personal protective equipment specific to each chemical
  8. Immediately report any damaged containers or spills

- **CONTRACTORS**
  1. Follow all safety rules at this workplace
  2. Always wear personal protective equipment for each hazardous chemical
  3. Contractors and their employees must read this plan and provide the following information to the District Safety Officer:

- A list of hazardous chemicals they will use while at this workplace
- A SDS for each hazardous chemical being used by contractor

- **DISTRICT SAFETY OFFICER:**
  1. Review and update the Incora HazCom program, as necessary
  ~~2.~~ Submit new or revised SDSs to Incora MAXCOM™ ~~via fax (800-254-0800), posting or email (to be coordinated with department Safety Leaders and SDS Contacts).~~
  ~~3.~~2. Print new updated SDS Index and place into the Incora MAXCOM™ (~~M~~SDS) Manual (to be coordinated with department Safety Leaders and ~~M~~SDS Contacts)
  ~~4.~~3. Update Incora MAXCOM™ (SDS) Manual as needed
  ~~5.~~4. Remove chemicals from service until a SDS is made available (to be coordinated with department Safety Leaders and SDS Contacts)
  ~~6.~~5. Ensure that all hazardous chemicals are properly labeled (to be coordinated with department Safety Leaders and SDS Contacts)
  ~~7.~~6. Remove any chemical from service that has a missing or damaged label (to be coordinated with department Safety Leaders and SDS Contacts)
  ~~8.~~7. Label all portable secondary containers with appropriate information (to be coordinated with department Safety Leaders and SDS Contacts)
     a. The pharmacist shall be consulted on proper methods for repackaging and labeling of bulk cleaning agents, solvents, chemicals and poisons used throughout the hospital.
  ~~9.~~8. Make certain employees wear personal protective equipment for hazardous chemicals (to be coordinated with department Safety Leaders and SDS Contacts)
  ~~10.~~9. Perform an annual inventory of on-hand chemicals to ensure an accurate database for employee access (to be coordinated with department Safety Leaders and SDS Contacts)
  ~~11.~~10. Implement and over-see employee training

- **ENGINEERING AND ENVIRONMENTAL SERVICES (EVS) DEPARTMENTS**
  1. Both departments will support all internal responses to the activation of ***Code Orange***.
  2. EVS shall send trained personnel with spill kits (where these kits are maintained) to the designated location.
  3. The Spill Kits will be routinely checked to see that all required materials are present and in usable condition.

- **DEPARTMENT DIRECTORS**
  1. The personnel of the department shall be oriented to the Incora MAXCOM™ (~~M~~SDS) Manual.
  2. Staff orientation to the Incora MAXCOM™ (SDS) Manual:
     - Existence of the Manual and contents
     - Where it is kept (It is to be available to employees at all times)
     - How to utilize the Incora MAXCOM™ system (manual and online), and read a standard SDS
  3. Ensure that all departments utilizing hazardous materials have access to a manual
  4. Assign and support a departmental SDS contact to assist the District Safety Officer in the coordination of each department's HAZMAT activities (see responsibilities for District Safety Officer)
  5. Conduct accident investigations for all accidental exposures of employees

V. RESPONSE

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

IDENTIFY -

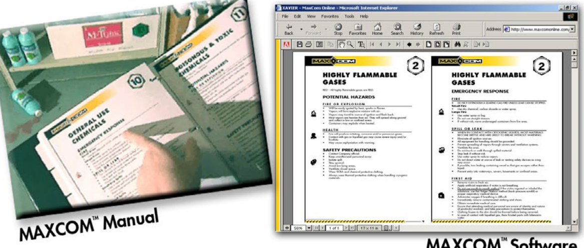
MAXCOM ID#	Chemical Name	Manufacturer/ Distributor	MSDS Summary	Safe Use Guide
80687	Flair Wood & Multi-Prupose Polish	National Laboratories	Full Chemical Name: Flair Wood & Multi-Prupose Polish MSDS Revision Date: 06/01/1990 Hazards: Non-Reactive Asphyxiant Gases (Compressed, Liquified or Cryogenic), Target Organs: Required PPE: Gloves-None Required; Resp-None Required; Eyewear-None Required; Clothing-None Required;	9 Medium Hazard
80680	Professional Love My Carpet Rug and Room Seodorizer	National Laboratories	Full Chemical Name: Professional Love My Carpet Rug and Room Seodorizer • ED-273; MSDS Revision Date: 08/15/1990 Hazards: ,Irritant Target Organs: Required PPE: Gloves-None Required; Resp-None Required; Eyewear-None Required; Clothing-None Required;	10 Low Hazard
80683	Professional Lysol Brand Disinfectant Spray Original, Fresh, Light Scent	National Laboratories	Full Chemical Name: Professional Lysol Brand Disinfectant Spray Original, Fresh, Light Scent MSDS Revision Date: 10/01/1990 Hazards: Highly Flammable Gases,Irritant Target Organs: Eyes Required PPE:	

Safe Use Guide

MAXCOM™ Label

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

LOCATE -



MAXCOM™ Manual

MAXCOM™ Software

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

RESPOND -

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

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

2. **MAJOR:** A major spill has occurred under the following conditions:
   - A life threatening condition exists, or there is an immediate danger posed to staff, patients or visitors.
   - You are not able to manage the spill on your own, and the condition requires the assistance of emergency personnel
   - The condition requires the immediate evacuation of all employees from the area or the building.
   - The spill is of a large enough quantity that additional assistance is required (threshold quantities will vary based on the chemical and can be verified on Safe Use Guides or MSDSs, but is generally greater than 2.0 liters)
   - The contents of the spilled material is unknown
   - The spilled material is highly toxic
   - You feel physical symptoms of exposure
   - The chemical is biohazardous, radioactive or flammable

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

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

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

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

VI. LIST OF HAZARDOUS CHEMICALS

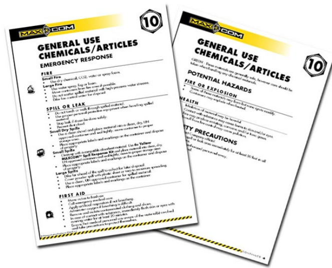
The list of hazardous chemicals is provided in Section 4 of the Incora MAXCOM™ MSDS)

Manual and it is also available on designated computers.

Sample MSDS Index

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

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



VII. SAFETY DATA SHEETS (SDS) AND OTHER INFORMATION

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

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

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

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

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

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

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

button onthe upper right hand side of this page.

VIII. SDS PROCEDURES

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

IX. EMPLOYEE INJURY FROM HAZARDOUS MATERIALS AND WASTE

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

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

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X. PERSONAL PROTECTIVE EQUIPMENT (PPE)

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

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XI. LABELS AND OTHER FORMS OF WARNING

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

If chemicals are transferred from a labeled container to a portable container, the container will be labeled with the chemical name, manufacturer and primary hazard of the chemical. Labels for each chemical can be printed on ~~Office Depot brand (Item #612-281)~~label sheets directly from the Incora MAXCOM™ System web tools.

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

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

XII. TRAINING

Employees who work with or are potentially exposed to hazardous chemicals will receive training on the physical and health hazards of each group of hazardous chemicals located at this facility. These groups of hazardous chemicals are Flammable, Corrosive, Reactive, and Toxic Chemicals. Training will be conducted through the departmental SDS contacts or department Safety Leaders. This training shall be conducted during monthly safety training sessions. It will be facilitated utilizing verbal instruction, demonstration, handouts, training videos, and reinforced using the Incora MAXCOM™ Manual. A test will be given to insure competency of each employee being trained.

- Training will emphasize the following items:

- The requirements of the OSHA "Employee Right-to-Know" Hazard Communication Standard
- How to identify a chemical release or exposure
- Physical and Health Hazards of each group of chemical used at this facility.
- How to locate an SDS for each chemical at this facility
- Procedures to protect against chemical hazards such as personal protective equipment work practices or methods to ensure appropriate use and handling of chemicals, and emergency response procedures.

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

Training records will be kept at the department level for employee's review.

XIII. NON-ROUTINE TASKS

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

XIV. CONTRACTOR EMPLOYERS

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

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

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

XV. MATERIAL ORDERING AND RECEIVING

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

- The Materials Management Department is responsible for ordering products for District use. Hazardous materials will be ordered in accordance with this department's policies and procedures.

- Buyers in the Materials Management Department, and any department performing their own procurement of hazardous materials, will be responsible for identifying whether a product to be purchased is hazardous or not. When a product is classified as hazardous, a SDS will then be requested from the vendor prior to delivery.
- User departments will be responsible for ensuring that each product has a SDS prior to using it within the District. If there is no SDS, that department is then responsible for acquiring one to be entered into the District's system.
- Any damaged products received shall be returned according to department policy.
- The vendor/manufacturer shall be notified of any deficiency and corrective action will be requested.
- The end-user department shall be responsible for ensuring that appropriate labeling is provided by the manufacturer.
- Any department that stores bulk quantities of hazardous items will routinely review inventory levels of all hazardous materials. This will be done to assess the appropriateness as a part of the overall inventory management program of the hospital.
- When any department receives a new SDS for the Hospital the following steps will be followed:
  - Verify that the product is indeed not in the database.
  - Send a copy of the SDS to the District Safety Officer. The sheets will then be sent to Incora MAXCOM™ to be entered into the database. The following routes may be used for submission:
    - **Standard mail addressed to:**
      - **~~MC Technologies, LLC~~Incora**
        ~~206 Line Rd.~~840 W. Carver Rd, Suite 104
        ~~Kennett Square, PA 19348~~Tempe, AZ 85284
        Att: Incora Hazcom Team
    - **~~Fax to: (610)444-6461~~**
    - **Email an electronic copy to: addmsds@maxcomonline.com**
  - A complete, District-wide chemical inventory will be requested from Incora MAXCOM yearly and will be maintained as the District's backup if there is a failure of the online database. The backup shall be maintained in accordance with Section VII, Subsection 3 of this policy.

XVI. HAZMAT STORAGE

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

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

XVII. DISPOSAL OF HAZARDOUS WASTE

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

- The following are department specific hazardous waste disposal guidelines:
  - *ENGINEERING DEPARTMENT WASTE DISPOSAL*
    - Light Bulb, Fluorescent Tubes, Sharps, Metal Filing: Disposed of in the trash compactor.
    - Used fluorescent tubes must be disposed in quantities of 24 or less.
    - Sawdust, Paper and Trash are collected separately in designated non-flammable basket and disposed of in the trash compactor.

- Used Paint Thinner and Cleaning Solvents: stored in a non-flammable container, which is stored in designated flammables cabinets. When the container is full, it is disposed of using an outside pick-up service. A manifest for each pick-up is required and must be kept on file.

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

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

XVIII. BIO-HAZARDOUS WASTE:

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

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

DEFINITION:

- Biohazard: Infectious or etiological (disease causing) agents, potentially infectious materials, certain toxins and other hazardous biological materials that are potentially hazardous to humans, animals and/or plants.
- Sharps**:** Objects capable of puncturing the skin, such as hypodermic needles, blades and suture needles.
- To prevent cross-contamination; the following preventative measures are to be followed:
  - When providing patient care:
    - Personnel must always utilize the Universal Precaution System.
    - Personnel must wear gowns, gloves, and masks as indicated when in contact with infectious patients.

  - Patient's linens shall be discarded in designated linen and trash receptacles.
  - Biohazard wastes will be discarded in designated receptacles labeled as biohazard.
  - Personnel shall wash hands before leaving patient rooms.
  - Red impervious containers appropriately labeled with "**BIOHAZARD"** signage will be used to collect sharps generated. These containers will be placed in biohazard waste containers in the soiled utility room
  - **DISPOSAL:**
    - Environmental Services transports "BIOHAZARDOUS" waste off of Nursing Units using designated routes to an on-site storage facility.

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

XIX. RADIOACTIVE WASTE

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

NOTE: WHEN HANDLING RADIONUCLIDES, WEAR RUBBER GLOVES.

- Remove all expired radionuclides from the active storage area to the radioactive decay vault.
- Enter into the indicated log book the date of transfer, the activity transferred, the volume transferred and initial the entry.
- Place all radioactive waste materials; such as: used syringes, needles, test tubes and other contaminated items into containers labeled for such waste.
- Daily remove and seal the plastic bags, which contain the radioactive waste from the containers and place in the decay vault.
- Dispose of the radioactive waste materials in accordance with the instructions given in the Nuclear Regulatory Commission, State of California regulations.
- Enter into the designated log book details showing radioactive materials disposed of, the date of disposal and the radioactivity present at the time of disposal.
- Perform the final disposal of all radioactive materials in accordance with the prescribed methods given by the Nuclear Regulatory Commission, State of California regulations.
- Enter into the designated logbook showing all disposals of radioactive materials, date of disposal, exposure level reading and the method used for disposal.
- ***LOG MAINTAINED BY RADIATION SAFETY OFFICER***
  ENTER IN LOG THE FOLLOWING:
  - Date
  - Radionuclide
  - Activity
  - Volume disposed of by sewage.
- Mo-99 / Tc-99m generators will be returned to the manufacturer for disposal.
- ***LIQUID WASTE:***
  - Liquid waste will be disposed of in the sanitary sewer system only in accordance with Section 20.303 of 10 Code of Federal Regulation part 20.
  - All unused radioactive liquids will be transported and stored in lead wells located in Radiology, until safe for disposal.
  - All liquid waste will be monitored with Lab Monitor or Dose Calibrator. If any radioactivity remains:
    - Determine amount of activity.
- Remove all radioactive labels and wash containers after liquid has been disposed of.

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

XX. COMPRESSED GASES AND OXYGEN

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

- General Procedures:
  - All personnel involved with the use and transport of compressed gas shall be trained in the proper handling of cylinders, cylinder trucks and supports, and cylinder-valve protection caps.
  - All cylinder storage areas, outside and inside, shall be protected from extremes of heat and cold and from access by unauthorized individuals.
  - Cylinders must be secured at all times so they cannot fall.
  - Be sure cylinders are secure on rack and never hang anything on cylinder.
  - Valve safety covers shall be left on until pressure regulators are attached.
  - Containers must be marked clearly with the name of the contents.
    - Tanks with wired on tags or color code only shall not be accepted.
  - Hand trucks or dollies must be used when moving cylinders. E-tanks may be carried by hand (one per staff member at a time).
  - Do not roll or drag cylinders.
  - The use of oil, grease or lubricants on valves, regulators or fittings is prohibited.
  - Do not attempt to repair damaged cylinders or to force frozen cylinder valves.
  - ***FLAMMABLE GASES***:
    - Special care must be used when gases are utilized in confined spaces.
    - No more than two cylinders shall be connected by a manifold; however, several instruments or outlets are permitted for a single cylinder.
  - ***PRESSURE REGULATORS AND NEEDLE VALVES***:
    Needle valves and regulators are designed specifically for different families of gases. Use only the properly designed fittings.
  - Throats and surfaces must be clean and tightly fitting. *Do not lubricate*.
  - Tighten regulators and valves firmly with the proper sized wrench. Do not use adjustable wrenches or pliers. Do not force tight fits.
  - Open valves slowly.
  - Do not stand directly in front of gauges (the gauge face may blow out).
  - Do not force valves that stick.
  - Check for leaks at connections. Leaks are usually due to damaged faces at connections or improper fittings. Do not attempt to force an improper fit. (It may only damage a previously undamaged connection and compound the problem).
  - Valve handles must be left attached to the cylinders.
  - The high-pressure valve on the cylinder shall set the maximum rate of flow. Fine-tuning of flow shall be regulated by the needle valve.
  - Shut off cylinder when not in use.
  - *LEAK TESTING:*
    - "Snoop" or a soap solution shall be used to test cylinders and connections. First test the cylinders before regulators are attached, and test again after the regulators or gauges are attached.
  - *EMPTY CYLINDERS:*

- Once a cylinder is empty, it must be marked accordingly. The letters '**MT**' may be written on the cylinder to indicate that it is empty.
- Cylinder valves must be turned off and valve safety caps replaced before securing.
- All empty cylinders must be secured properly (similar to those that are not empty).
- Empty or unused cylinders must be returned promptly to their designated holding area.

- *Oxygen Cylinders:*
  - Crack valves to clear them before bringing tank into Patient's room.
  - Read labels, tags and color code before administering any compressed gas.
  - Oxygen and other gases are potentially dangerous. Special safety precautions shall be followed at all times while using or storing oxygen.
    - Do not use wool or nylon inside patient tents - they may cause sparks.
    - Check oxygen supply regularly.
    - Store oxygen cylinders upright and secured.

XXI. Pharmaceutical Waste

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

Non-hazardous Pharmaceutical Waste includes all pharmaceuticals that are not a listed or characteristic RCRA waste, not a NIOSH hazardous drug, and not an investigative chemotherapy agent. Non-hazardous waste includes liquid, solid, paste and aerosol pharmaceuticals. Non-hazardous Pharmaceutical waste does not include unused and intact non-hazardous pharmaceuticals in their original packaging directed for resale and reuse for its original intended purpose. Non-hazardous Pharmaceutical Waste shall be discarded in the blue and white Pharmaceutical Waste container located in each unit.

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

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

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

- Hazardous Drugs are capable of causing toxicity to personnel and others who come in contact with them. Hazardous drugs pose a potential health risk to personnel who prepare, handle, administer and dispose of these drugs.
- Drugs may be classified as hazardous when they possess any one of the following characteristics: Genotoxicity, Charcinogenicity, Teratogenicity, Reproductive toxicity, Organ toxicity at low doses.
    - *LIQUID OR POURABLE* cytotoxic waste must be disposed of by a registered hazardous water transporter with the use of a hazardous waste manifest. Personnel must follow the transporters procedures for disposing such waste.

RCRA Hazardous Waste should be placed in the black RCRA containers located in the designated areas.

XXII. STERILE PROCESSING DEPARTMENT

PROCEDURE: KDHCD uses 100% EO. Sterile Processing Department stores a day's usage in the metal gas cabinet.
A leaking cartridge should not be placed in the aerator cabinet. The NFPA classifies 100% EO as a **CLASS 1 FLAMMABLE LIQUID**. As such, disposal must be carried out by **KNOWLEDGEABLE INDIVIDUALS**.

- Should there be concern about a unit-dose cartridge and it is determined that the cartridge has a leak, which is normally evidenced by spurting or very rapidly dripping liquid EO, THE FOLLOWING IS RECOMMENDED:
    - Avoid direct contact with liquid EO.
    - Evacuate personnel from the immediate area.
    - Immediately contact the appropriate fire or health Safety personnel, including the District Safety Officer.
    - If contact with liquid EO or excessive Inhalation has occurred, follow the procedure outlined for first aid, and direct the exposed staff to the Employee Health Department, or the Emergency Department.
    - Re-enter the department only after qualified fire or health safety personnel have determined that re-entry can be done safely.
    - Dispose of empty unit-dose cartridges in non-incinerated waste.
    - Contact the cartridge manufacturer.
    - If the spill is associated with the sterilizer, contact the sterilizer manufacturer's representative.
- **DO NOT INCINERATE CARTRIDGES**. This precaution applies to empty as well as full cartridges.
- Used empty unit-dose canisters or cartridges should be placed in the aerator and aerated under the same conditions as sterilized medical items.
    - This procedure will safely eliminate the small amount of vaporous EO that may remain in the cartridge at completion of sterilization cycle.
- Used, empty unit-dose cartridges should be disposed of in non-incinerated hospital waste.
- **FIRST AID:**
- READ YOUR SAFETY DATA SHEET (SDS)

    - EYE EXPOSURE: If EO gets into eyes, wash your eyes immediately with large amounts of water, lifting the lower and upper eye lids. Get medical

attention immediately. Contact lenses should not be worn when working with this chemical.

- SKIN EXPOSURE: If EO get on skin, immediately wash the contaminated skin with water. If EO wets your clothing, including your shoes, remove clothing immediately and wash the skin with water using an Emergency DELUGE shower. Get medical attention immediately. Thoroughly wash contaminated clothing before reusing. Contaminated leather shoes or other leather articles should not be reused and should be discarded.

- INHALATION: If large amounts of EO are inhaled, the exposed person must be moved to fresh air at once. If breathing has stopped, perform cardio-pulmonary resuscitation (CPR). Keep the effected person warm and at rest. Get immediate medical attention.

- SWALLOWING: When EO has been swallowed, give the person large quantities of water immediately. After the water has been swallowed, try to get the person to vomit by having him/her touch the back of the throat with his/her finger. Do not make an unconscious person vomit. Get medical attention immediately.

- RESCUE: Move the effected person from the hazardous exposure. If the exposed person has been overcome, attempt rescue only after notifying at least one other person of the emergency and putting into effect established emergency procedures. Do not become a casualty yourself. Understand your emergency rescue procedures and know the location of the emergency equipment before the need arises.

- Procedure for reporting/communicating an EO leak:
  - When an employee calls to report a major leak of Ethylene Oxide Gas, be sure to **write down the following information:**
    - Exact location of the leak
    - Whether or not there are any injured personnel
    - Whether or not there is a risk of fire
    - Name of the caller
    - Location and extension from which the caller has contacted you
  - Instruct the (first caller) to wait for personnel from the Security office (or the Engineering department) so that he/she can help identify and cordon off the area.
  - IF A FIRE RISK WAS REPORTED, **CALL** THE VISALIA FIRE DEPARTMENT AND WARN THEM OF THE INCIDENT.
  - **CALL** Security or Engineering, advise them of the need to cordon off the area. Give them Instructions on where to meet the caller.
  - If there was a report of injuries, **CALL** the EMERGENCY DEPARTMENT and warn them of the incident.

XXIII. PESTICIDE MANAGEMENT

- EPA considers sterilizing agents and disinfectants pesticides. Although, these chemicals are used to kill microorganisms in healthcare facilities. The use of these chemicals plays an important role for infection control and the continued use of these anti-microbial agents are essential. Insect sprays also fall into this category and their use is limited to the Engineering Department only. In general, the hazardous materials program will also apply to pesticides. Additional information can be obtained through the California Department of Pesticide Regulation (CDPR).
- The pesticide label shall reflect the overall toxicity and hazards of the mixture.
- Signal words provide general information about injury potential.
- Training must be given before any staff uses the chemical. Training must also include common systems of poisoning, regulations, label requirements and immediate decontamination.

XXIV. HAZARDOUS GAS TESTING

POLICY: KDHCD will sample test on a described basis, potentially hazardous gases and chemicals. The gases/chemicals to be sample tested in ambient air are **GASES: Ethylene Oxide and Nitrous Oxide. CHEMICALS: Glutaraldehyde (Cidex) and Formaldehyde.**
PROCEDURES:

- Periodic sample testing of gases and chemicals will be conducted pursuant to Title 8 by a qualified agency. Testing periods will be increased when sample tests are confirmed to be over permissible levels. The following is the protocol for each identified gas or chemical to be tested:
  - ***ETHYLENE OXIDE***: Sterile processing's ETO sterilizer located at the west end of the facility (outside Distribution) will be tested **Annually.** The testing shall be conducted in accordance with Title 8.

	PPM
Time weighted average (TWA)	0.5

  - ***NITROUS OXIDE***: Surgery and Family Birth Center will be tested **ANNUALLY.** The testing shall be conducted in accordance with Cal/OSHA. Personnel exposed to Nitrous Oxide will be tested **ANNUALLY**. Utilizing the same PPM.

	PPM
Time weighted average (TWA)	50

  - ***GLUTARALDEHYDE***: Surgery, Respiratory Therapy and Endoscopy will be tested **ANNUALLY.** The testing shall be conducted in accordance with Cal/OSHA.

	PPM
Short term exposure limit (STEL)	.2
Time weighted average (TWA)	N/A

  - ***FORMALDEHYDE***: Surgery, Laboratory, Chronic Dialysis, CAPD, Porterville Dialysis and Kaweah Dialysis Center will be tested **annually**. Dialysis will monitor on a monthly basis to comply with other regulatory standards. The testing shall be conducted in accordance with Title 8

	PPM
Short term exposure limit (STEL)	2

- Time weighted average (TWA) .75

All results will be reported annually to the Environment of Care Committee. Any results over the limits will be **IMMEDIATELY** reported to the Safety Officer for corrective action and follow-up testing.

XXV. MAINTENANCE OF POLICIES AND PROCEDURES RELATING TO CHEMICAL AND PHYSICAL HAZARDS

Policies and procedures relating to chemical and physical hazards shall be reviewed by the District Safety Officer, and by the Infection Prevention Committee for infectious hazards on an annual basis. Recommendations, conclusions and actions will be reported to the Environment of Care Committee at least annually, and as needed to address/review situations as they arise.

XXVI. SEMIANNUAL REVIEWS: (Hazard Surveillance)

Semiannual reviews shall be conducted by the departmental MSDS contacts. Reviews will be conducted within their respective departments to check management techniques of hazardous materials for labeling, isolation, ventilation and possible substitution of less hazardous agents.

XVII. TRIENNIAL EVALUATION OF THE EFFECTIVENESS OF THE HAZARDOUS MATERIALS AND WASTE MANAGEMENT PROGRAM

Every three years an evaluation of the Hazardous Materials and Waste Management Program. The EOC Committee shall conduct this evaluation.

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

Subcategories of Department Manuals not selected.

Policy Number: EOC 5000	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)	
Fire Prevention 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 Fire Prevention Life Safety at Kaweah Delta Health Care District (KDHCD) herein after referred to as Kaweah Health (KH) are to provide an environment wherein patient care can be safely administered~~,~~ to provide a fire safe *environment of care* to protect patients, personnel, visitors and property from fire and the products of combustion, and to provide for the safe construction and use of building and grounds in accordance with applicable codes and regulations for the State of California.

II. SCOPE

The scope of this management plan applies to **all buildings within ~~KDHCD~~Kaweah Health**

Each off site area is required to have a unit-specific fire plan that addresses the unique considerations of the environment, including, but not limited to, building evacuation requirements. Off-site areas are monitored for compliance with this plan during routine environmental surveillance by Environment of Care (EOC) committee members.

It is the responsibility of the Safety Officer to assess and document compliance with the Fire Prevention Plan for the off-site areas, using an environmental surveillance checklist.

III. AUTHORITY

The authority for overseeing and monitoring the fire prevention management plan and program lies with the *Environment of Care* Committee, whose members will ensure that fire prevention activities are identified, monitored and evaluated, and will also ensure that regulatory activities are monitored and enforced, as necessary.

IV. RESPONSIBILITIES

~~KDHCD~~ KH Leadership have varying levels of responsibility and work together in the management of fire risks as identified below:

Board of Directors: The Board of Directors supports the Fire Prevention Management Plan through review and feedback, if applicable, of the quarterly and annual *Environment of Care* reports and endorsing budget support.

Professional Staff Quality Committee/PROSTAFF: Reviews the annual *Environment of Care* report from the *Environment of Care* Committee, providing feedback, if necessary.

Quality Council: Reviews annual *Environment of Care* report from the *Environment of Care* Committee and provides broad direction in the establishment of performance monitoring standards relating to fire prevention and fire risks.

Administrative Staff: Administrative staff provides active representation during the *Environment of Care* Committee meetings and sets an expectation of accountability for compliance with the Fire Prevention Program.

Environment of Care Committee: *Environment of Care* Committee members review and approve the quarterly *Environment of Care* reports, which contain a Fire Prevention component and oversee any issues relating to the overall fire prevention program.

Directors and Department Managers: Support the Fire Prevention Management Program by:

1. Reviewing and correcting deficiencies identified through the hazard surveillance process that relate to fire risks
2. Communicating recommendations from the Environment of Care Committee to affected staff in a timely manner.
3. Developing education programs within each department that ensure compliance with the policies of the Fire Prevention Management Program.
4. Supporting all required employee fire prevention education and training to include a disciplinary policy for employees who fail to meet the expectations.
5. Serving as a resource for staff on matters of fire prevention.

Employees: Employees of ~~KDHCD~~ KH are required to participate in the Fire Prevention Life Safety Management program by:

1. Completing required fire prevention education.
2. Participating in fire drills
3. Reporting any observed or suspected unsafe conditions to his or her department manager as soon as possible after identification that may pose a fire risk.

Medical Staff: Medical Staff will support the Fire Prevention Management Program by abiding by the District's policies and procedures relating to fire prevention and Life Safety.

V. MANAGEMENT OF FIRE RISKS

~~KDHCD~~ KH has multiple processes in place that minimize the potential for harm from fire, smoke and other products of combustion, they include, but are not limited to:

1. This written plan serves to identify the overall components of the *Management Plan for Fire Prevention and Life Safety*.
2. Life Safety policies and procedures, which include an overall fire response plan for all staff
3. Fire Drills: Fire drills are performed per code to test staff response relating to the overall fire plan and to keep staff trained through rehearsal.
4. Procedures for testing, inspection and maintenance: Procedures are in place to ensure fire equipment testing and suppression equipment are properly tested, inspected and maintained.

5. Risk Assessment: Risk assessment for life safety includes ongoing hazard surveillance, *the Interim Life Safety Assessment* process, loss audits, regulatory, insurer and accreditation surveys.
6. Performance Standards: Performance standards are in place, based upon risk to the medical center, and monitored quarterly.
7. Education: Education and training of staff, physicians, temporary workers, students and volunteers is in place.
8. Testing, Inspection and maintenance: Testing, inspection and maintenance of fire extinguishing and suppression equipment, and fire alarm systems is in place.
9. *Statement of Conditions*: A Statement of Conditions is in place and is current. The deemed responsibility for the Statement of Conditions lies, jointly, with the Safety Office and the Facilities Director.

Reviewing Proposed Acquisitions:

To minimize the risks associated with flammable products brought into ~~KDHCD~~KH, a process is in place for the review of proposed acquisitions of bedding, window draperies, furnishings, decorations, wastebaskets and other equipment and materials. ~~KDHCD~~ KH has all "requests for purchases" submitted to Facilities for review. The materials are acquired or approved through Facilities and Purchasing, and ensures:

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1. Product(s) meets smoke and flame-resistant standards
2. Waste baskets are of noncombustible materials, or other approved material
3. Flame resistant coating and covering are maintained to retain their effectiveness
4. Attention is given to heat-generating combustible material and placement of equipment close to heat sources.

Staff will acquire samples and/or specification to assure that they have Class A rating (flame spread 0-25 and smoke development of 0-450) or rating such as Plenum, Fire rated per material. Staff will proceed with acquisition only when approved specifications are met, and are responsible for maintaining the specifications on file for each acquisition. Furniture purchased for the hospital meets state technical bulletin requirements, which requires a rating tag be attached to each article of furniture.

All materials within the hospital shall meet federal, state and local requirements for system construction, and treating and testing by approved testing agencies. Records of all materials shall be maintained on the hospital premises in the form of independent test laboratory reports, i.e., tags, or construction documentation.

These items include, but are not limited to:

Item	Verification
Finish materials	Independent Test Report
Low Voltage Wire	UL Smoke Rating/Independent Test
Construction Materials	Approved As-Builts
Furniture (State bulletins)	Test Report/Tags
Bedding/Curtains	Test report/Tags/Treat
Decorations	Test report/Tags/Treat
Holiday Trees	Office of State Fire Marshal Tag/Treat
Waste Baskets (similar items)	Location/Material/Approved

Contractors:

All contractors, before starting work at ~~KDHCD~~KH, are responsible for adhering to the following criteria.

1. All equipment installed in the facility (high and low voltage) will be listed and approved by an independent testing lab (approved by the State of California).
2. All components will be hospital grade.
3. Modifications to existing equipment cannot be made without written approval of the ~~KDHCD~~ KH (re-certification may be required).
4. All finish material will be approved and meet code requirements.
5. All furniture will meet state bulletin requirements for sprinkled and non-sprinkled areas.
6. All construction will meet federal/state and local requirements.
7. Contractors will become familiar with ~~KDHCD's~~ KH's Fire Procedures.
8. Contractors are to act in a professional manner, and to maintain proper identification and demonstrate respect for patient privacy and confidentiality.

Before initiation of a construction project, interim life safety measures (ILSM) will be assessed by the ~~safety~~safety ~~department~~department, and an Infection Control permit will be issued. Ongoing ILSM's are the responsibility of the Safety Officer. A policy is in place that identifies in detail the ILSM process, including individuals who are responsible for implementation.

Newly constructed and existing environments of care are designed and maintained to comply with the *Life Safety Code.*

To minimize the potential for harm from fire, when newly constructed and existing environment of care are designed, only licensed architects are used, who oversee the process of subcontractors, who are independently licensed and bonded. Local, state and federal regulations are followed.

Exceptions to this are made on an case by case basis, by the Facilities Department, in conjunction with authorized personnel ensuring that all applicable regulations, codes and standards are followed.~~.~~

Other Methods in Place to minimize the potential for harm from Fire, Smoke and other Products of Combustion include the following:

1. Fire/Smoke Doors: All doors are held open only by approved devices, i.e. electromagnetic or electromechanical. At NO TIME may doors be propped open with doorstops or other devices not connected to the fire alarm system.

2. General Environment: All areas of ~~KDHCD~~ KH are kept clean and orderly. Trash is removed regularly from designated holding areas.

3. Portable Electric Equipment: All plugs must be grounded. Extension cords must comply with the extension cord policy. Equipment must be in good operating condition.

4. Smoking: "No Smoking" regulations are strictly enforced, policy HR.193.

5. Ventilation Hoods: Ventilation hoods are cleaned on a regular basis, to code, to prevent buildup. The automatic fire extinguishing systems are properly charged and inspected and all nozzles securely fastened.

6. Storage Areas: Every attempt is made to arrange stock in an orderly fashion, with a minimum of eighteen (18) inches below the sprinkler heads and a minimum of twenty four (24) inches below the ceiling in non-sprinkled areas.

7. Aisles: Aisles between storage shelves are at least three feet apart. No storage is permitted within thirty-six (36) inches in front of electrical panels. Combustible materials shall not be stored in electrical rooms.

8. Space Heaters: Portable space heating devices shall be prohibited in all District areas, with the following exception: Approved portable space heating devices may be allowed in **non-patient care areas** as long as they conform to the following:
   - Heating elements of such devices do not exceed 212 degrees Fahrenheit (NFPA 101©, 2000 Edition, §19.7.8)
   - Required for medical or extreme necessity
   - Approval of the Director of Facilities, Clinical Engineering and Chief Operating Officer
   - The heating device must be equipped with a tip over shut off
   - The heater shall not be plugged into a surge protector or extension cord

9. Flammable Liquids: (Such as acetone, alcohol, benzene, and ether) limit the amount on hand to a minimum working supply. If possible, keep in metal container. Where safety cabinets or storage rooms are available, keep these materials in them and maintain the door to such storage in the closed position. No smoking, open flame or sparking device shall be allowed around flammable liquids or compressed gas. Oxygen and nitrous oxide shall not be stored with flammable gases, such as cyclopropane and ethylene, or with flammable liquids.

10. Electrical Hazards: Report promptly any frayed, broken or overheated extension cords or electrical equipment. Do not operate light switches, or connect or disconnect equipment where any part of your body is in contact with metal fixtures or is in water. Specially built equipment is in use in the operating and delivery rooms to eliminate electric sparks, and to control static electricity.

11. Acids: All concentrated or corrosive acids must be handled with extreme care. Avoid storing these materials on high shelves, or in locations where they are likely to be spilled or the containers broken. Organic acids and inorganic acids shall not be stored together. Any spillage shall be immediately diluted or neutralized and cleaned up.

Minimization of risk to patients who smoke:

See policy HR.193 “Tobacco Free Campus.”

Maintaining free and unobstructed access to all exits:

Surveillance activities allow *Environment of Care* Committee members to monitor compliance with *Life Safety Code* requirements, including maintaining free and unobstructed access to all exits. Should an exit need to be obstructed for some reason (i.e. construction, renovation, etc.) an ILSM assessment will be made before the exit path is impeded and Interim Life Safety Measures will be put into place.

The District has a written fire response plan:

See policy EOC.5002 "Fire Response Plan."

Specific roles and responsibilities of Staff, Licensed Independent Practitioners (LIPs) and Volunteers in preparing for building evacuation:

Specific roles and responsibilities of staff, LIPs and volunteers in preparing for building evacuation are integrated into new-hire orientation and annual safety training, the information is also discussed during fire drills.

The District conducts fire drills:

1. Fire drills are conducted quarterly on all shifts in each building defined by the *Life Safety Code* as the following:
   - Ambulatory Health Care Occupancy
   - Health Care Occupancy

2. Fire drills are conducted annually in all free standing buildings classified as a business occupancy as defined by the *Life Safety Code*.

3. At least 50% of fire drills are unannounced at ~~KDHCD~~ KH facilities.

4. Staff and who work in buildings where patients are housed or treated participate in fire drills

   Note: Staff participate in fire drills in all areas of the hospital, with the exception of those who cannot leave patient care during the time of a drill.

5. ~~KDHCD~~ KH critiques fire drills to evaluate fire safety equipment, fire safety-building features, and staff response to fire.
   - The evaluation is documented and reported to the *Environment of Care* on a quarterly basis.
   - Fire drills are critiqued post drill to identify deficiencies and opportunities for improvement.

The District maintains fire safety equipment and fire safety building features:
The following types of equipment or features exist within the District, with the following maintenance, testing and inspection requirements in place. All tests and/or inspections are documented and maintained in the Facilities Department.

1. At least quarterly, ~~KDHCD~~ KH tests supervisory signal devices (except valve tamper switches).
   a. Note: Supervisor signals include the following: control valves; pressure supervisor; pressure tank, pressure supervisory for a dry pipe, steam pressure; water level supervisor signal initiating device; water temperature supervisory; and room temperature supervisory.

2. Every six months, ~~KDHCD~~ KH tests valve tamper switches and water flow devices.

3. Every 12 months, ~~KDHCD~~ KH tests duct detectors, , heat detectors, manual fire alarm boxes and smoke detectors.

4. Every 12 months, ~~KDHCD~~ KH tests visual and audible fire alarms, including speakers and door releasing devices on the inventory.

5. Every quarter, ~~KDHCD~~ KH tests fire alarm equipment for notifying off-site fire responders.

6. Every week, ~~KDHCD~~ KH tests diesel fire pumps under no-flow conditions.

~~7.~~

~~8.~~7. Every week, ~~KDHCD~~ KH inspects electric motor driven fire pumps under no-flow conditions.

~~9.~~8. Every month, ~~KDHCD~~ KH tests electric motor driven fire pumps under no-flow conditions.

~~10.~~9. Every 12 months ~~KDHCD~~ KH tests main drains at system low point or at all system risers.

~~11.~~10. Every quarter, ~~KDHCD~~ KH inspects all fire department water supply connections.

~~12.~~11. Every 12 months, ~~KDHCD~~ KH tests fire pumps under flow conditions.

~~13.~~12. Every 5 years, ~~KDHCD~~ KH conducts water-flow tests for standpipe systems.

~~14.~~13. Every 6 months, ~~KDHCD~~ KH inspects any automatic fire-extinguishing systems in a kitchen.

~~15.~~14. Every 12 months, ~~KDHCD~~ KH tests carbon dioxide and other gaseous automatic fire-extinguishing systems.

~~16.~~15. At least monthly, ~~KDHCD~~ KH inspects portable fire extinguishers.

~~17.~~16. Every 12 months, ~~KDHCD~~ KH performs maintenance on portable fire extinguishers.

~~18.~~17. ~~KDHCD~~ KH operates fire and smoke dampers one year after installation and then at least every 6 years to verify that they fully close.

~~19.~~18. Every 12 months, ~~KDHCD~~ KH tests automatic smoke-detection shutdown devices for air-handling equipment.

~~20.~~19. Every 12 months, ~~KDHCD~~ KH tests sliding and rolling fire doors for proper operation and full closure.

20. Every 12 months, ~~KDHCD~~ KH tests and inspects door assemblies.

21. Every month, ~~KDHCD~~ KH tests elevators with fire fighters' emergency ~~operations.~~.operations.

~~22.~~

~~23.~~22. Every month, KDHCD inspects fire sprinkler gauges and valve tamper switches.

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Monitoring Conditions in the Environment:

~~The District~~Kaweah ~~establishes~~Health establishes a process for continually monitoring, internally reporting, and investigating fire safety management problems, deficiencies and failures.

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

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

Annual Evaluation of the Fire Prevention Management Plan:

On an annual basis *Environment of Care* Committee members evaluate the Fire Prevention Life Safety Management Plan, as part of a risk assessment process. Validation of the plan occurs to ensure contents of each plan support ongoing activities within the District.

Based upon findings, goals and objectives will be determined for the subsequent year.

A report will be written and forwarded to the Board of Directors.

The annual evaluation will include a review of the following:

1. Objectives: The objective of the Fire Prevention Management plan will be evaluated to determine continued relevance for the District (i.e., the following questions will be asked; was the objective completed? Did activities support the objective of the plan? If not, why not? What is the continuing plan? Will this objective be included in the following year? Will new objective(s) be identified? Will specific goals be developed to support the identified objective?)

2. The scope: The following indicator will be used to evaluate the effectiveness of the scope of the Fire Prevention Life Safety Management Plan: the targeted population for the management plan will be evaluated (e.g., did the scope of the plan reach employee populations in throughout the entire District?)

3. Performance Standards: Specific performance standards for the Fire Prevention Life Safety Management Plan will be evaluated, with plans for improvement identified as needed.

   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.

4. 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 1-2~~
Environment of care issues relating to Life Safety and/or fire prevention 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.

Quarterly *Environment of Care* reports are communicated to Performance Improvement, PROSTAFF and the Board of Directors.

Priority Improvement Project:

At least annually, a performance improvement project is selected by the Environment *of Care* Committee members. The priority improvement activity is based upon ongoing performance monitoring and identified risk within the environment. Based upon risk assessment, a priority improvement project may be related to Life Safety or Fire Prevention issues.

Improvement of the Environment of Care:

~~EC.04.01.05 EP1-3~~
Performance standards are identified monitored and evaluated that measure effective outcomes in the area of fire prevention management.

Performance standards are also identified for Safety, Security, Hazardous Materials, Emergency Management, Medical Equipment management and Utilities management.

The standards are approved and monitored by the *Environment of Care* Committee with appropriate actions and recommendations made. Whenever possible, the *environment of care* is changed in a positive direction by the ongoing monitoring and changes in actions that promote an improved performance.

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

Subcategories of Department Manuals not selected.

Policy Number: DM 2203	Date Created: 07/01/2011
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)	

Code Gray- Activation Plan

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

POLICY

Code Gray is designed to show a coordinated team response to protect our employees and others from any potential aggressor. The hospital has "zero tolerance" for violence.

In situations where hospital staff, physicians, or visitors ~~are in a situation where they~~ are not comfortable due to persons becoming aggressive, abusive, or threatening in any manner, a CODE GRAY may be called. This will initiate help, first from any personnel in the immediate area, and secondly from a follow-up team as described below. The intent of declaring a CODE GRAY will be to immediately have additional personnel show up, not necessarily to intervene directly, but to demonstrate a presence of other people in the area. The person calling the CODE GRAY will have the opportunity to request additional help or to dismiss staff responding.

Extremely violent situations will require a different approach. This area should be considered OFF LIMITS by initiating a Code Silver (See Policy #2204 Code Silver). Calling additional staff members to the scene puts additional people at risk. Calling an area OFF LIMITS will signal a STAT page to security and the Nursing Supervisor. The Visalia Police Department would be notified immediately when any person reports that an individual is threatening violence with a weapon.

Procedure

A. Response

See attached checklist and flowchart.

B. Supporting Information

1. Combative or abusive behavior can be displayed by anyone; a patient, a patient's family member, staff, staff family members, or acquaintances of employees and patients. Combative or abusive behavior can escalate into a more violent episode. A comprehensive workplace violence prevention policy should include procedures and responsibilities to be taken in the event of a violent incident in the workplace

2. Recognize early warning signs. The following are examples of warning signs but are not all inclusive.

    a. Direct or verbal threats of harm.
    b. Intimidation of others by words and or actions.
    c. Refusing to follow policies.
    d. Hypersensitivity or extreme suspiciousness.
    e. Extreme moral righteousness.
    f. Inability to take criticism of job performance.
    g. Holding a grudge, especially against supervisor.
    h. Often verbalizing hope for something to happen to the other person against whom the individual has the grudge.
    i. Expression of extreme desperation over recent problems.
    j. Intentional disregard for the safety of others.
    k. Destruction of property.

Emergency Management Manual

CODE GRAY – ABUSIVE/ASSAULTIVE BEHAVIOR

Purpose: To provide a safe and secure healthcare environment for patients, visitors, volunteers, physicians and employees. Also, to assist employees in managing and/or de-escalating the situation by a show of ~~force~~support, to gain the cooperation of the abusive or assaultive person, or to subdue and restrain the individual if necessary.

Note: If the situation involves a weapon, immediately notify PBX of “Code Silver and location.”

The Hospital Incident Command System (HICS) is not activated for a Code Gray unless the incident disrupts day-to-day hospital operations.

STAFF RESPONSE CHECKLIST

In the event a situation with an angry, belligerent or threatening person has escalated or has the potential to escalate; or, in the event of imminent danger where there is a potential for a violent or criminal act to occur; or, when a violent or criminal act is in progress:

☐ Dial the District operator at Ext. 44. Provide the operator with the following:
☐ Where you are and where the incident is occurring
☐ Description and number of person(s) involved. Do not hang up until the operator has all your information.

Verbal Abuse:
☐ Use a calm voice and attempt to verbally de-escalate the situation.
☐ If verbal abuse continues, call a second person to assist you.
☐ Move patients away from the hostile person, if safe to do so.
☐ Step back from person and try to get a barrier between you and the person.
☐ Direct others away from the area.

Physical Battery:
☐ Protect yourself and others from blows, attempt to get away from the person/area and defend
yourself as necessary for personal safety.
☐ Put distance and/or barrier between the parties involved – only when safe to do so. Do not attempt
to confront the person(s).
☐ Remove patients, staff and visitors from the immediate area. Remain calm and reassure those around you.
☐ Provide assistance and medical help for all injured persons when safe to do so.

Documentation to Complete:
☐ Per normal procedures, if employee is injured:
☐ Employee completes Incident Report and submits to supervisor, who completes, signs and forwards report to Risk Management

If you hear a “Code Gray” announcement ~~for a distant location~~:
☐ Trained available personnel respond to the Code and take direction from Nursing Supervisor, charge staff or Security Officer.
☐ Stand by for further instructions.
☐ Provide assistance as requested.

If you are at an off campus site: In the event a situation has escalated and a violent or criminal act occurs call 9-911.

PBX CHECKLIST

☐ When notified of a violent or potentially violent situation, immediately overhead page "Code Gray and location" (~~3x~~2x).
☐ Notify Security via radio.

~~☐ Notify Nursing Supervisor. (And notify police if instructed to do so by Nursing Supervisor by dialing 9-911.)~~
~~☐ At conclusion of incident and only when instructed by Nursing Supervisor or Security, announce by overhead page, "Code Gray, All Clear."~~

~~PBX~~ CHECKLIST-SOUTH CAMPUS

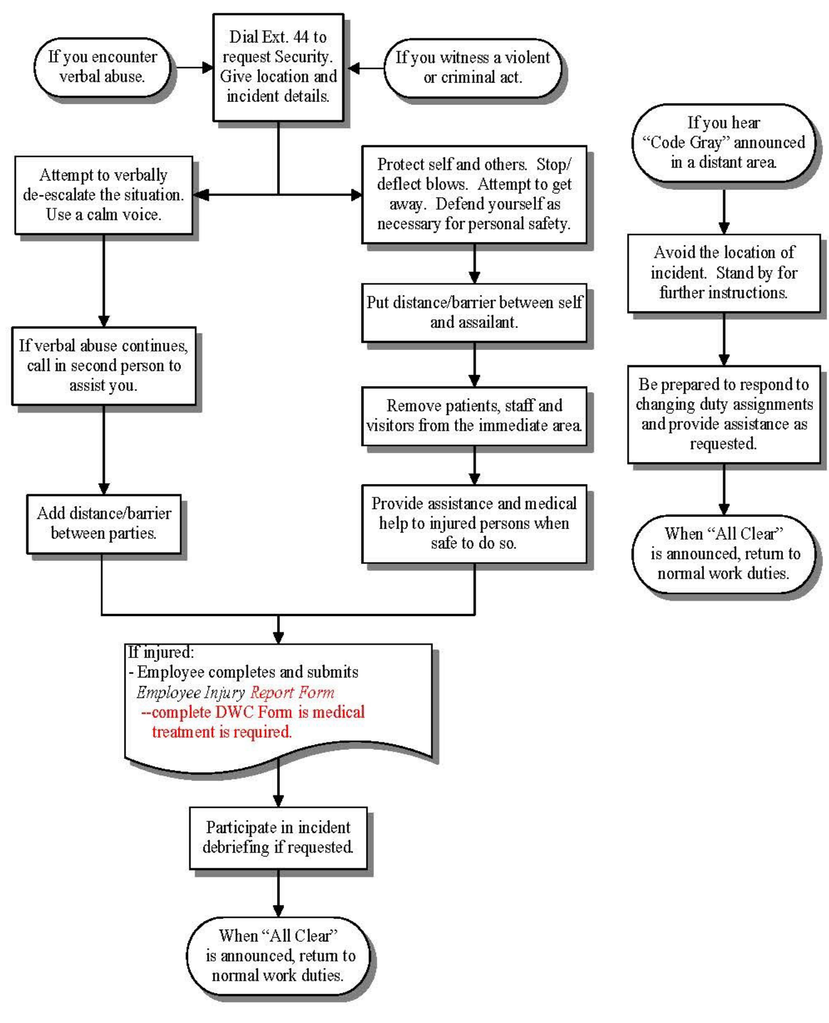
When notified of a violent or potentially violent situation, immediately overhead page to South Campus "Code Gray and location" (2~~3~~x).
Send out a Berbee page and Berbee message to South Campus.
Notify Security via radio.
Notify Nursing Supervisor. (And notify police if instructed to do so by Nursing Supervisor by dialing 9-911.)
~~At conclusion of incident and only when instructed by Nursing Supervisor Nurse Manager, Lead Nurse or Security, announce by overhead page, "Code Gray, All Clear."~~

SECURITY CHECKLIST

Upon notification of the potential for or actual occurrence of a violent or criminal act:
~~dispatch~~ Dispatch Security personnel to the location as appropriate.
☐ ~~Security when~~ When responding to the scene and approach with caution. When using force, Security will use only the minimum amount of physical force necessary to restrain or protect the individual from self-injury and/or from injuring others.
If situation has potential to disrupt hospital operations:
☐ Notify Nursing Supervisor.
☐ Direct PBX to announce by overhead page "Code Gray, location."
☐ Monitor and coordinate incident per department procedures. Control crowds and provide direction at the scene.
☐ Request help from the police department if necessary or call in extra Security staff for long-term incidents.
~~☐ At the conclusion of the incident and when authorized by the Nursing Supervisor or Security, direct PBX to announce by overhead page "Code Gray, All Clear."~~
☐ If warranted, the Security Officer will file an Incident Report. Officers will determine if a report should be filed with law enforcement.

ALL CLEAR

~~After "Code Gray, All Clear" is announced:~~
~~☐ Participate in incident debriefing if requested.~~
~~☐ Return to your normal work duties, unless otherwise directed.~~



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Subcategories of Department Manuals not selected.

Policy Number: DM 2206	Date Created: 03/14/2008
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)	
Code Purple - Child Abduction	

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

Policy

This policy is designed to provide a coordinated and effective response by a trained team of professionals to child abduction.

II. Procedure

A. Background

In the event of a removal of a child from Kaweah ~~Delta~~ Health Hospital by unauthorized persons, Kaweah Delta Health Care District herein after referred to as Kaweah Health will activate its Code Purple procedure (See Administrative Policy #AP.140). Assigned staff must respond immediately to their assigned exits of the hospital. Other hospital staff should remain in their areas, stay alert and report any suspicious persons to the PBX Operator at Ext. 44.

B. Response

See attached checklist and flowchart.

CODE PURPLE – CHILD ABDUCTION

Purpose: To protect children from removal by unauthorized persons and to define healthcare facility response to child abduction

Children are discharged from the hospital in a wheelchair and accompanied by parent or guardian.

STAFF RESPONSE CHECKLIST

☐ ~~Hospital~~ Medical Center staff must respond immediately to the exits of the ~~hospital~~ medical center as follows:

Name of Exit or Area	Department To Respond
First Floor Doors:	
1. Mineral King Main Lobby~~South Side of hospital on Mineral King~~	Patient Access after 2100 hr Emergency Department~~Maintenance staff~~
2. Ambrosia Exit~~East Wing stairwell~~	Food & Nutrition Services~~Patient Access~~
3. Nurse Supervisor /Bed Coordinator Office~~Flex care entrance after hours~~	Bed Coordinator~~Patient Access~~
4. Endoscopy Hallway~~Cafeteria exit on Mineral King~~	Respiratory~~Dietary~~
5. Surgery Center Exit~~Western Conference Room corridor~~	Surgery Waiting Patient Access after 1700 Pharmacy~~Endoscopy Staff~~
6. Acequia West Staircase Exit~~Western Conference Room corridor **after 1700**~~	~~Help Desk~~~~Respiratory~~EVS
7. Acequia West Employee Entrance/Exit by Visitor Elevators~~Exit next to Patient Access office on Mineral King~~	Patient Access after 2100 hr CVICU~~Patient Access~~
8. Acequia Wing Lobby~~Flexcare Courtyard~~	Patient Access after 2100 hr 4-Tower~~Flexcare~~
9. Acequia East Employee Entrance/Exit~~Flexcare Courtyard **after 1700**~~	EVS~~EVS~~
10. ED Zone 2	ED
Acequia Zone A - Outside by Ambulance Bay with clear view of East Stairwell exit, EMS Door, Ambulance Door, and Emergency Department Stairwell exit.~~Flexcare exit to Physician's parking~~	Emergency Department~~Flexcare~~
Acequia Zone B – East Stairwell Exit~~Flexcare exit to Physician's parking **after 1700**~~	Emergency Department~~EVS~~
Acequia Zone C – Northeast Employee Entrance/ Exit~~Physician/Administration exit~~	Patient Access after 1700 hr CV ~~Administration~~
Acequia Zone D – Acequia Main Stairwell & Exit Door – northeast side~~Physician/Administration exit **after 1700**~~	Patient Access after 1700 hr 4Tower~~EVS~~
Acequia Zone E – Acequia Main Entrance~~Loading Dock Exit~~	Patient Access after 1700 hr Emergency Department. ~~Central Logistics~~
Acequia Zone F – Northwest exit & stairwell	Environmental Services
~~Main Entrance – including Ambrosia exit~~	~~Patient Access/Security~~
Acequia Zone G - Acequia Southwest Exit with clear view of west stairwell, , recessed exit,	Environmental Services

Name of Exit or Area	Department To Respond
Mineral King Zone H – Surgery Center Pre-Op West Exit door with view of courtyard walkway, back surgery door. ~~Emergency Department Entrance~~	Laundry Department~~Emergency Department~~
Mineral King Zone I – Surgery Center Main Entrance ~~Transport Team Exit (Old Ambulance Door)~~	Surgery Patient Access after 1700 hr Pharmacy ~~Emergency Department~~
Mineral King Zone J – Loading Dock	Shipping and Receiving after 1500 hr Maintenance
Mineral King Zone K – Food & Nutrition Services~~Die~~ Exit Door	Food & Nutrition Services
Mineral King Zone L – Ambrosia Exit	Ambrosia Staff after 2000 hr Security
Mineral King Zone M – Mineral King Main Entrance	Patient Access after 2100 hr Security
Mineral King Zone N – Emergency Department Main Entrance	Security
Second Floor Doors:	
ICU patio exit and back stairwell to their unit	ICU
2 North stairwell	2 North
2 North stairwell next to nurse manager's office	2 North
Third Floor Doors:	
3 West Patio exit and back stairwell to their unit	3 West
3 North back stairwell	3 North
3 North central stairwell	3 North
3 South back stairwell	3 South
3 South visitor and utility elevators & patio	3 South
Fourth Floor Doors:	
4 North back stairwell	4 North
4 North central stairwell, employee elevators	4 North
4 South back stairwell	4 South
4 South Visitor and utility elevators	4 South
*After 1700 an outside perimeter will be established by Maintenance/Security with Maintenance covering the outside south side exits. Security will cover outside the ambulance bay and the main entrance and the exit at the Ambrosia Café.	
~~Acequia Zone A - Outside by Ambulance Bay with clear view of East Stairwell exit, EMS Door, Ambulance Door, and Emergency Department Stairwell exit.~~	~~Emergency Department~~

- ☐ Other ~~hospital staff~~medical center staff, not specifically assigned to respond, should remain in their areas, stay alert, and report any suspicious persons to the PBX Operator at Ext. 44.
- ☐ Redirect all **exiting** visitors to Main Lobby exit without impeding entry to facility. (Script, "I'm sorry, you'll have to exit through the Main Lobby, thank you.")
- ☐ If a person runs, do not attempt to apprehend them. Without losing the person, ask for someone to call Security. Take special note of their appearance, what they are

wearing (style, color, etc.), how they leave the ~~hospital~~ medical center grounds, and note their car's make, color and license plate number.

- ☐ Immediately report above information to Security.
- ☐ Should the person abandon the child and escape, keep the child with you and report above information to Security.
- ☐ Do not leave exit until you hear "All Clear."

AFFECTED AREA CHECKLIST

- ☐ Dial Ext. 44 and instruct the operator to initiate "Code Purple" and give PBX Operator the description, age and gender of missing child. Identify the department, floor and room.
- ☐ Instruct available staff to start a room-to-room search of the floor areas.

Charge Nurse will:

- ☐ Initiate a search on 2 East, Pediatrics, Broderick. Notify ~~hospital~~ medical center operator and Hospital Command Center (HCC) of results.
- ☐ The search includes areas not limited to: Patient rooms, Corridors, Nourishment Center, Waiting Room/Classrooms, Conference Rooms, Elevator/Stairways, Storage Rooms, Restrooms, Housekeeping/Utility closets, dietary/housekeeping carts, Offices.
- ☐ Contact the attending physician to relay information regarding the incident and request that they respond to the ~~hospital.~~medical center
- ☐ Protect the area where the abduction occurred; close the door to the room. DO NOT TOUCH OR MOVE ANYTHING.
- ☐ Assign a staff member and social worker to the mother/parent/caregiver and who will accompany the family at all times for immediate crises assistance, obtain an interpreter is required.
- ☐ Arrange for additional staffing on the unit if necessary.
- ☐ Gather all relevant information in preparation for the arrival of the police department.
- ☐ Complete an *Incident Report* at the conclusion of the event and submit to Risk Management.

PBX CHECKLIST

- ☐ ~~Upon notification, announce "Attention please, Code Purple Alert Age _____ (3x) over the public address system.~~

IF HUGS Alarm:

- Security
- Immediately overhead page "Code Purple and location

In the event of a HUGS Alarm Unit Staff or Security can authorize a "Code Purple, All Clear"

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Confirmed Child Abduction-Call:

- Visalia Police Department (911)
- ~~Security~~
- ~~Nursing Coordinator to initiate Disaster Plan~~Call House Supervisor
- ~~Administration Representative~~
- ~~Social Worker~~
- Risk Management
- ~~Marketing~~
- ~~Critical Stress Management Team~~

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- ☐ ~~Notify the following upon notification by the lead in charge of the abducted child's floor or by Security that a baby has been abducted:~~
  - ~~Visalia Police Department (911)~~
  - ~~Security~~
  - ~~Nursing Coordinator to initiate Disaster Plan~~
  - ~~Administration Representative~~
  - ~~Social Worker~~
  - ~~Risk Management~~
  - ~~Marketing Coordinator~~
  - ~~Critical Stress Management Team~~
- ☐ Initiate a "No Information" status for this patient.
- ☐ In the event of a child abduction, only Security or Visalia Police Department will have the authority to announce a "Code Purple, All Clear".

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SECURITY CHECKLIST

- ☐ Immediately respond to the location of the possible abduction. Secure the scene by stopping the flow of traffic out of the unit.
- ☐ Attempt to get information on possible description of suspected abductor.
- ☐ Greet police with description and any known information.
- ☐ Escort police to location of incident.
- ☐ The police will assume leadership in an internal search of the ~~hospital~~ medical center with assistance of Maintenance and/or Nursing Supervisor.
- ☐ Following the "All Clear," notify other local hospitals of any attempted child abduction.

ADMITTING STAFF CHECKLIST

Admitting staff stationed at Main Lobby:

- ☐ Ask individuals with children to wait to exit. If individual does not wish to cooperate, immediately report their description to the HCC. Get description of vehicle and license plate number.
- ☐ **DO NOT PROVIDE ANY INFORMATION REGARDING A POSSIBLE ABDUCTION.**

INCIDENT COMMANDER CHECKLIST

- ☐ Maintain radio contact with Security and PBX at all times.
- ☐ Serve as liaison with the police department personnel.
- ☐ Provide decision-making authority and commit ~~hospital~~ medical center resources as appropriate in support of the plan response activities and needs.
- ☐ ~~Authorize Safety & Security Officer to implement Bomb Search Procedure (see attached).~~
- ☐ Request that police set up a traffic stop at the entrance/exit.
- ☐ As soon as possible, dispatch additional personnel to assist Security with control of the hospital's perimeter.

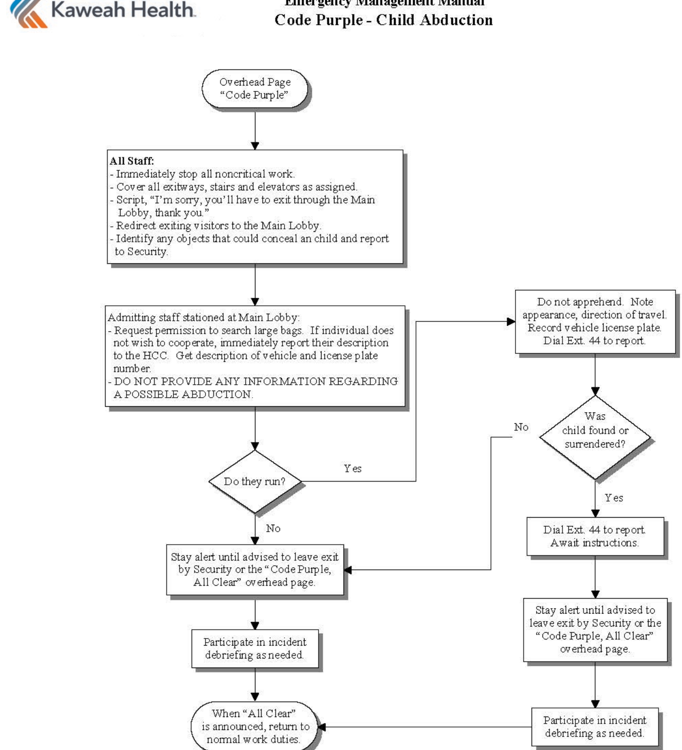
MARKETING

- ☐ Arrange for a communication center and supply the media with regular briefings. Information released to the media will only be done by the Nursing Supervisor, Administration Representative, or Marketing Director.

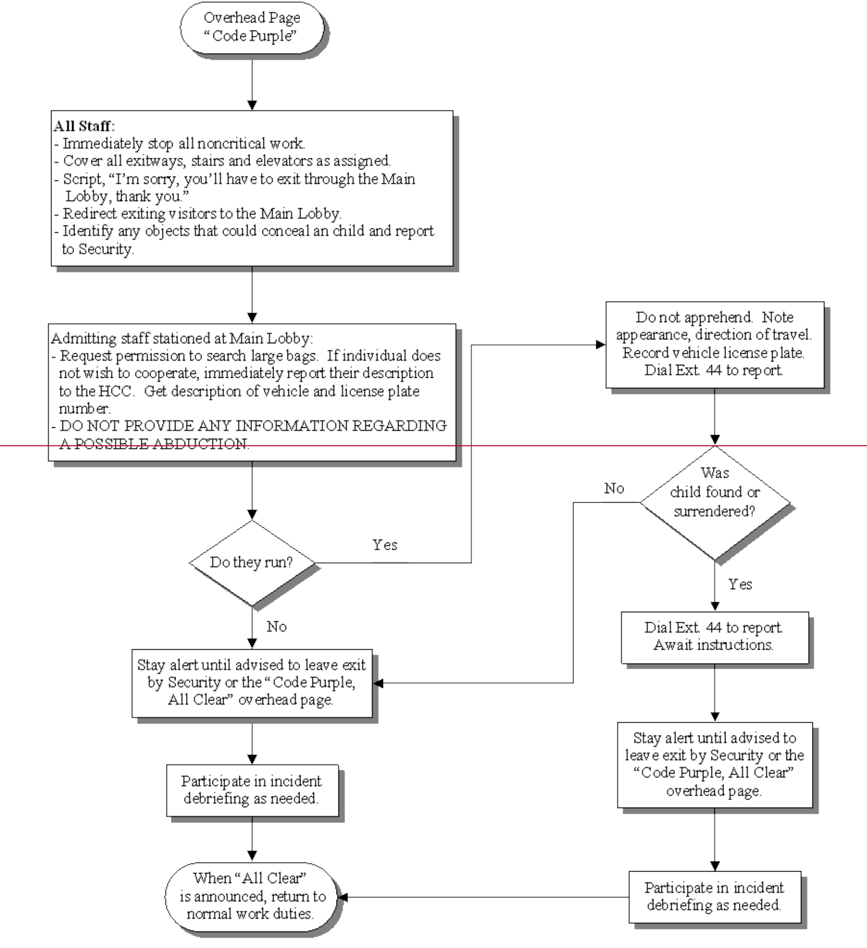
ALL CLEAR

Only the AOD (Incident Commander) can authorize the PBX to page "Code Purple, All Clear" when operations may return to normal.

Note: Following the emergency incident, the Department Manager(s) of the affected area(s) shall complete an Incident Report and submit to Risk Management.


Kaweah Health
Emergency Management Manual
Code Purple - Child Abduction
Overhead Page "Code Purple"
All Staff:
- Immediately stop all noncritical work.
- Cover all exitways, stairs and elevators as assigned.
- Script, "I'm sorry, you'll have to exit through the Main Lobby, thank you."
- Redirect exiting visitors to the Main Lobby.
- Identify any objects that could conceal an child and report to Security.
Admitting staff stationed at Main Lobby:
- Request permission to search large bags. If individual does not wish to cooperate, immediately report their description to the HCC. Get description of vehicle and license plate number.
- DO NOT PROVIDE ANY INFORMATION REGARDING A POSSIBLE ABDUCTION.
Do they run?
Yes
No
Do not apprehend. Note appearance, direction of travel. Record vehicle license plate. Dial Ext. 44 to report.
Was child found or surrendered?
No
Yes
Stay alert until advised to leave exit by Security or the "Code Purple, All Clear" overhead page.
Dial Ext. 44 to report. Await instructions.
Stay alert until advised to leave exit by Security or the "Code Purple, All Clear" overhead page.
Participate in incident debriefing as needed.
Participate in incident debriefing as needed.
When "All Clear" is announced, return to normal work duties.

Emergency Management Manual
Code Purple - Child Abduction



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

Subcategories of Department Manuals not selected.

Policy Number: DM 2216	Date Created: 07/01/2011
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)	
Water Systems Failure/Disruption	

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

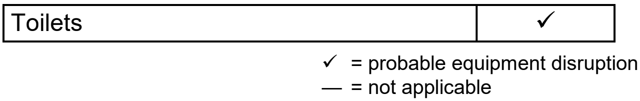
I. Policy

In the event of a water systems failure, Kaweah Delta Health Care District (KDHCD) herein after referred to as Kaweah Health will activate its Water Systems Failure/Disruption procedure. There is built-in redundancy.

II. Procedure

A. The following equipment may be disrupted due to a water systems failure in the affected building:

Equipment	Disrupted
Air Conditioning and Heating	✓
Dialysis	✓
Diesel Generators	—
Dietary Dishwasher	✓
~~Dietary~~Food & Nutrition Services Steam Operated Equipment	✓
Fire Sprinklers	✓
Laundry Equipment	✓
Hand Washing (sinks)	✓
Linear Accelerator/CT/MRI	✓
Medical Air	—
Medical Vacuum	—
Other High-Tech Heat-Generating Equipment	✓
Radiology Film Developer	—
Sanitary Waste Disposal	✓
Some Refrigerators/Freezers	✓
Steam Sterilizers	✓



Toilets	✓

✓ = probable equipment disruption
— = not applicable

B. In the event that the water service is interrupted for reasons other than a shut down for repairs, the following steps will be taken.

The Maintenance Department will immediately be notified. Each department will be notified to limit the use of water.

CALL: CALIFORNIA WATER SERVICE 559-624-1600

Ask for an estimate of the time that service will be interrupted.

C. IF WATER IS CUT OFF TO THE HOSPITAL:

1. Pressure will drop until water is exhausted.

2. Boilers will be turned off. There will be no heat or sterilization.

3. Food Services will utilize single service dishes and utensils instead of china. Meal preparation will be adjusted to utilize cold food preparation techniques.

4. Laundry Department will implement downtime procedure (Send all Soiled Linen to Mission Linen – Fresno Plant)

~~3.~~5. Hemodialysis will be terminated due to no water.

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D. During a water outage everyone should take precautions to conserve as much as possible. Patient baths, toilet flushing, and washing procedures should be kept to a minimum.

Maintenance is responsible for the distribution of emergency water supplies. Food services will distribute water for hydration via patient meal trays.

III. Emergency Water Supplies:

Main Campus:
In the event of an emergency, water supplies would be needed for approximately 1,000 people for 96 hours. One gallon per person per day totals 4,000 gallons.

Potable water contained in hot water tanks:
3,000 gallon tank located in Mineral King Wing building
5,000 gallon tank located in Mineral King building serving ED Zone 5
4,000 gallons tank located in two 2,000 gallon tanks in Acequia Wing building
6537 gallons of water for hydration and r~~d~~ehydration of Meals For All.
Total: 147,708020 185,537gallons potable water available at main campus.

In addition, there are 5 pallets of bottled water located at the downtown campus. There is a total of 1,673 gallons of bottled water available for all campuses.

South Campus:
In the event of an emergency, water supplies would be needed for approximately 200 people for 96 hours. One gallon per person per day would total 800 gallons.

55 gallons of water in kitchen ice machines
65 gallons of water in hot water tank outside kitchen
1,000 gallons of water in hot water tank
112 gallons of water from bottled water

Total: 1,232 gallons of potable water available at South Campus

West Campus
In the event of an emergency, water supplies would be needed for approximately 300 people for 96 hours. One gallon per person per day would total 1,200 gallons of water.

650 gallons of water in the Rehab hot water tank
600 gallons of water in the Lifestyles hot water tank
440 gallons of water in the Mental Health hot water tank
150 gallons of water in the SRCC hot water tank
600 gallons of water in the Dialysis hot water tank
44 gallons of water in kitchen ice machines
80 gallons of water in bottles available & kept in storage

Total: 2,564 gallons of potable water available at West Campus

In case of a county disaster that disrupts the ~~KDHCD~~ Kaweah Health water system, the Tulare County Office of Emergency Planning will be handling certain aspects of supplying services and can be called upon for service. (559-686-3461)

OTHER SOURCES OF WATER AND TRANSPORTATION OF WATER IN CASES OF EMERGENCY ARE:

Kraft Foods-Tulare (Knudsen Dairy)	559-685-0790
California National Guard	559-733-3062
Major-Sysco	1-800-877-4194
Pepsi-Cola	1-800-932-0966
	559-485-5050
Alhambra -Sierra Springs	1-800-453-0293
Culligan / Lindsay-office	559-562-6361

Culligan Personnel to contact:

Cary Miller	559-359-8650
Alex Blackwell	559-361-3686
Sepp Becker	559-359-5320
Nancy Becker	559-359-3287

WATER SYSTEMS FAILURE/DISRUPTION

Purpose: In the event of a partial or total disruption of the water supply, the hospital will provide specific procedures for staff to follow.

Note: A large-scale incident may develop into a Code Triage.

STAFF RESPONSE CHECKLIST

- ☐ Notify Maintenance by calling PBX at Ext. 44.
- ☐ **Immediately cease use of water** and check with Department Manager or designee for department procedures.
- ☐ To wash hands, use hand gel sanitizer. Soap and water should be used as sparingly as needed if hands are visibly soiled. .
- ☐ To use "dry toilets" tape a red plastic bag over the 2 red bags already taped to the toilet. Remove the single bag after use, tie the bag, and dispose in a covered large, double-lined, leak-proof container.
- ☐ Steam and water required sterilization devices will not function. Use alternate cold sterilizing methods.

If given advance notice, take the following steps:

- ☐ Fill all available sinks, basins, etc., with water.
- ☐ Have patients bathed prior to shut down.
- ☐ Obtain waterless hand washing product from storeroom for hand washing. (Should be on all units.)
- ☐ In surgery and Emergency Department (ED), obtain bottled water for surgical scrubs.
- ☐ Line toilets with red bags.
- ☐ Maintenance to obtain water tanker for on site.
- ☐ Ensure public toilets are closed.

DEPARTMENT CHECKLIST

Implement Water Systems Failure/Disruption procedures in the department.

- ☐ Establish adequate inventory of hand gel sanitizer in department. Direct that the use of bathing facilities be immediately discontinued.
- ☐ Obtain water supply for hand hygiene when sanitizer is not appropriate.
- ☐ If loss of services is for an extended period of time, as determined by the Incident Commander, consider dismissal of non-patient-related employees.
- ☐ Have employees report to Labor Pool for assistance in patient care areas if needed.
- ☐ Do not dispose of any waste in drains during utility failure until service has been restored.
- ☐ Identify procedures which require water that can be delayed or canceled.
- ☐ Assess and report department status to the Incident Commander on the *Emergency/Disaster Status Report* regarding the following items:
- ☐ Calculate the amount of water needed by determining the number of patients and staff on duty in the department. (A minimum of 1 gallon of water per person per 24-hour period is needed.)
- ☐ Determine other patient fluid requirements or special department needs for the next 24 hours.
- ☐ Inventory available potable water and non-potable water in the department (i.e., potable drinking water, canned drinks, IV fluids, distilled water, non-potable water in tubs, mop buckets, etc.).
- ☐ Identify critical areas of impact within the department. (Refer to the grid on page 1 of this policy.)

ENVIRONMENTAL SERVICES CHECKLIST

- ☐ Ensure that water for cleaning is restricted to whatever non-potable water is available.
- ☐ Determine the number and location of “dry toilets” and which toilets may be locked (in consultation with Maintenance).
- ☐ Check germicidal wipe availability in patient care areas.
- ☐ Restrict use of toilets and sinks and post “Do Not Use” signs.
- ☐ Provide red plastic bags and large double-lined leak-proof containers to designated bathrooms that remain in use.
- ☐ Assist in waste collection.
- ☐ Make necessary cleaning adjustments to conserve water use.
- ☐ Schedule additional rounds for picking up waste from nursing units.
- ☐ Obtain extra containers for waste and deliver to floors.
- ☐ Do not dispose of any waste in drains during utility failure until service has been restored.

MAINTENANCE CHECKLIST

- ☐ Maintenance will assess the water disruption and inform Administration and affected departments of the expected duration.
- ☐ Based on assessment, Engineering will activate the “Water Systems Failure/Disruption” procedure.
- ☐ Implement Engineering Department water disruption/failure plan.
- ☐ Institute Fire Watch as necessary.
- ☐ Order portable toilets with hand washing facility for each hospital entrance.
- ☐ Complete *Utility Failure Report* detailing the circumstances surrounding the utility loss and corrective action taken.

FOOD SERVICES CHECKLIST

- ☐ Go to disposable service and implement other water-saving measures.
- ☐ Use foods that do not require use of water for preparation. Use non-steam-operated equipment.
- ☐ Close cafeteria and have food catered, if necessary.
- ☐ Do not dispose of any waste in drains during utility failure until service has been restored.

SURGERY CHECKLIST

- ☐ Cancel all elective procedures, if necessary.
- ☐ Use bottled water already in the department (sterile and distilled).
- ☐ Use instruments sterilized prior to water outage. Borrow instruments from another facility, if necessary.
- ☐ Use waterless hand washing product for hand washing supplied on each unit and from the storeroom.
- ☐ Line hoppers with red bags.
- ☐ Do not dispose of any waste in drains during utility failure until services has been restored.
- ☐ Steam and water required sterilization equipment will not function.

NURSING AREAS CHECKLIST

- ☐ Do not use disposable wipes for cleaning patients, only use product designed for skin cleaning.
- ☐ Use hand sanitizer for hand washing supplied on each unit and from the storeroom.
- ☐ Line toilets with red bags.
- ☐ Discharge as many patients as possible (if needed).
- ☐ Use bedside commodes/bedpans and dispose of waste in red “hazardous waste” bags.
- ☐ Do not dispose of any waste in drains during utility failure until service has been restored.

DIALYSIS **AREAS CHECKLIST**

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NOTIFY NEPHROLOGISTS OF WATER DISTRUPTION
NOTIFY PATIENTS OF WATER DISTRIPTION AND TO NOT COME TO SCHEDULED APPOINTMENTS

LABORATORY CHECKLIST

- ☐ Drain liquid instrument waste into spill-proof, leak-proof, hazardous waste containers supplied by Environmental Services.
- ☐ Do not dispose of any waste in drains during utility failure until service has been restored.

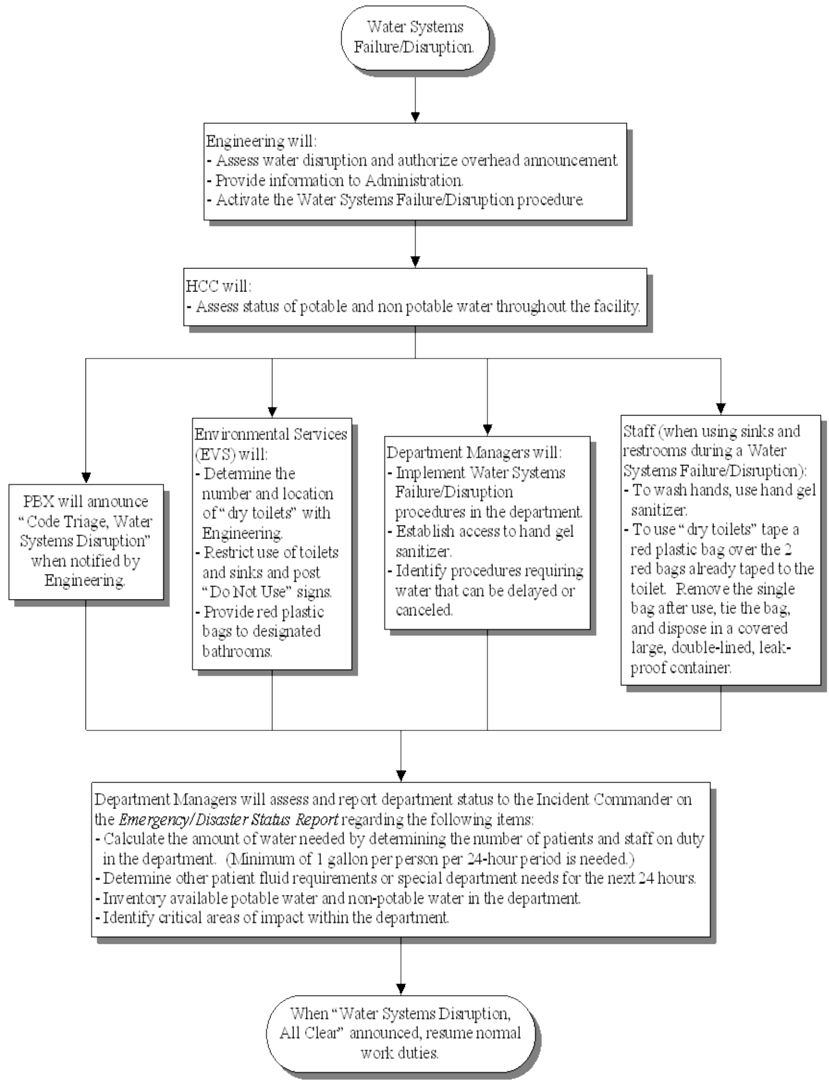
SECURITY CHECKLIST

- ☐ Conduct fire watch throughout the hospital, if directed.
- ☐ Assist in ensuring public toilets are not used by putting up signs and tape on doors.
- ☐ Do not dispose of any waste in drains during utility failure until service has been restored.

ALL CLEAR

When “Water Systems Disruption, All Clear” is announced, return to your normal work duties unless otherwise directed.

Emergency Management Manual
Water Systems Failure/Disruption



DM2216
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Subcategories of Department Manuals not selected.

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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)	
Total Evacuation Plan	

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

TOTAL EVACUATION PLAN

I. Policy:

The Total Evacuation Plan is activated only as a last resort and upon the order of the Hospital Incident Commander or designee and/or the responding Incident Commander from Visalia Fire Department. In the event of a total facility evacuation, a Joint Incident Command (Kaweah Health/Visalia Fire Department) would be used. The Fire Chief would assume the role of primary Incident Commander in the event of a fire.

II. Scope:

This is an organization-wide plan that incorporates all services and sites of care provided by Kaweah Delta Health Care District herein after referred to as Kaweah Health (KH) (in patient offsite areas listed below). This plan applies to staff, licensed independent practitioners, contract workers, and volunteers.

The following is a list of KDHCD in-patient off site areas:

o Kaweah Delta Health Mental Health, 1100 South Akers, Visalia, CA.
o Kaweah Delta Health Rehab Hospital, 840 South Akers, Visalia, CA.
o Kaweah Delta Health Skilled Nursing, 1633 South Court Street, Visalia, CA.

Each off site area is required to have a unit-specific Fire Safety plan that addresses the unique considerations of each area in the case of evacuation.

III. Procedure Response Plan

I. Activation/Notification
A. Emergency Notification Procedures 3
B. Census Saturation Plan .... (Administrative Policy #114)
C. Total Evacuation Procedure
• Checklist – All Staff 4
− Patient Carry Methods 6
• Flowchart 7
• Checklist – Nursing Care Guidelines for Special Situations 8

D. Notification- External
1. California Department of Public Health.

II. HICS – Evaluation Incident Management Team and Response Team
A. Organization Chart 9
B. Evacuation Coordinator JAS 10
C. Deputy Evacuation Coordinator JAS 11
D. Elevator Operator JAS 12
E. Floor Monitor JAS 13
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• Evacuation Routes (see Evacuation Routes posted on each floor)
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• Kaweah Delta Health Care Rehab Hospital Map 19
• Kaweah Delta Health Care Mental Health Hospital………………………………………………….. 20
• Kaweah Delta Health Care South Campus Map………………………………………………….. 21

V. Alternate Treatment Locations 22

Attachments
A. Floor Monitor Assignment Roster……………………………………………………..………………24
B. Patient Evacuation Tracking Log …………………………………………………………………….25

I. ACTIVATION/NOTIFICATION

A. Evacuation Criteria

1. The decision to evacuate is the responsibility of the Hospital Command Center (HCC) staff, led by the Incident Commander and in consultation with local authority having jurisdiction (e.g., Visalia Fire, Visalia Police, Central California EMS Agency).

2. The factors upon which a decision to evacuate include but are not limited to:
   a. Structural integrity of the building.

   b. Emergency (life threatening) conditions such as fire and chemical spills.

   c. Impending disaster, which is expected to compromise the hospital (i.e., imminent flood).

B. Activation It is anticipated that the event resulting in the need for total facility evacuation will have resulted in activation of Code Triage and use of the Hospital Incident Command System (HICS). The HCC will be established to coordinate and direct the emergency response.

C. Notification – Internal In the event of a major emergency triggering facility-wide evacuation response, PBX will announce "Code Triage" (2x). Upon instruction from Administrator on Call /Incident Commander, PBX will announce "Code Triage, Evacuate the Building."

If main hospital patients will need to be transported offsite for continuation of care the Emergency Department Team Leader will be immediately notified of possible evacuation. If evacuating patients from offsite campuses, Hospital Command Center will ensure 911
has been called for EMS Disaster response.

D. Notification – External

The Incident Commander will instruct the Liaison Officer to notify:
1. California Department of Public Health (DHS) at 408-277-1784
(Monday–Friday, 8 a.m.–5 p.m.) or OES (Office of Emergency Services) at 916-845-8911 (after hours/weekends).
2. Tulare County Department of Public Health
Public Health Officer – Dr. Karen Haught
559-624-7499 ext 4 or 559-471-7092 after hours
3. Complete the Hospital Status Report Form (see Appendix) and send to the –Tulare County Department of Emergency Operations Center (DEOC). If the DEOC is not activated, send the Hospital Status Report Form by fax to the Operational Area EOC.

E. Total Evacuation Procedure – All Staff Checklist

EVACUATION, TOTAL

Purpose: To safely remove all individuals from all floors of the hospital to designated outside areas.

Background: Total evacuation means removing all individuals from the dangerous structure to an area outside the structure which offers safety and is free from danger. **Evacuation is done only as a last resort and only upon the order of the Incident Commander (IC) or local authority having jurisdiction (fire department).**

Note: Elevators will be used for evacuation only when authorized and supervised by Fire Department or Maintenance Department staff.

ED TEAM LEADER OR MICN DESIGNEE CHECKLIST

- ☐ Notify TCCAD (Tulare County Consolidated Ambulance Dispatch) of possible hospital evacuation and request disaster response.
- ☐ Notify CCEMSA (Central California EMS Agency) Coordinator On-Call of possible hospital evacuation and request them to respond.
- ☐ Notify area hospitals of possible evacuation. Initial notifications will be to all CCEMSA EMS Base Hospital MICN Hotlines. Secondary notifications will be to all other area hospitals.
- ☐ Have EMS Medical Group Supervisor and CCEMSA Coordinator report to the ED Team Leader (or designee) for briefing with the Hospital Command Center.
- ☐ Work with Security and Visalia Police Department to establish ambulance staging area & patient staging areas.
- ☐ Hospital Evacuation Coordinator (or designee) will work EMS Medical Group Supervisor and EMS Transportation Officer to assign ambulance transport destinations for evacuated patients.
- ☐ Request Closed Status Ambulance Diversion from CCEMSA if main hospital is to be evacuated. Refer to KDHCD Policy CP85.

STAFF RESPONSE CHECKLIST

Immediately upon receiving orders to evacuate:

- ☐ Evacuate to the evacuation assembly area in this order:
  (**Note:** If 48-hour advance planning time, reverse this order.)
  - ☐ **Ambulatory patients** closest to danger (if visibility is reduced, form chain by holding hands and lead to safety). Travel down nearest stairwell according to posted Evacuation Maps or direction from the IC.
  - ☐ **Wheelchair patients** by elevator, if cleared for use, or down nearest stairwell using evacuation equipment.
  - ☐ **Non-ambulatory patients** in their beds by elevator (if operational), or down nearest stairwell using evacuation equipment. (Nursing will determine whether patient care equipment and/or traction can be discontinued and assign sufficient number of staff to move patients.) If wheelchair is needed for further evacuation, remove patient from wheelchair and make comfortable. Take wheelchair to remove additional patients.
  - ☐ **Critical Care/Ventilator-Dependent Patients** are the last to be moved. Move entire bed if necessary.
- ☐ Evacuation Monitor will make a final room check to determine the area is completely empty, doors are closed and marked with a large “X” to signify that the room has been checked and is empty.
- ☐ Take patient’s hard chart or paper record charts medications and associate staffing assignment sheet when relocating. Ensure patients being removed from Respiratory Precautions wear a mask. (See page 8, Checklist – Nursing Care Guidelines for Special Situations.)
- ☐ During total hospital evacuation, charge personnel will direct patients, visitors and staff to the department-specific evacuation route and convene in the appropriate evacuation assembly area, outside the building.
- ☐ Once evacuated to the evacuation assembly areas, charge personnel will:
  - ☐ Conduct a patient/staff headcount and assessment for injuries and report this information to the Hospital Command Center (HCC).
  - ☐ Keep medical records, medications, assistive devices and personal belongings with patient.
  - ☐ Continue to observe patients. Report any problems or injuries, or staff injuries to charge personnel.
  - ☐ Stand by for specific instructions and prepare to assist, as instructed by charge personnel.

  Note: Patients may need to be transferred to other facilities for continued care or may be evaluated by a physician for immediate discharge home.

  Note: See Evacuation Assembly Areas identified on site map

MAINTENANCE CHECKLIST

- ☐ Clear roadways.
- ☐ Man the elevators (or cordon off if not authorized for use).
- ☐ Secure building mechanical/electrical systems, begin shutdown procedures. (See Maintenance Department Manual.)
- ☐ Relocate evacuation equipment to priority areas.
- ☐ Rotate and change radio batteries.
- ☐ Help Clinical Engineering load any medical equipment onto trucks.
- ☐ Provide extension cords to evacuation assembly/staging areas for medical equipment.
- ☐ Provide lighting at evacuation assembly/staging areas.

SECURITY CHECKLIST

- ☐ Secure area to prevent persons from entering evacuated area (including staff, patients, visitors, and possible intruders/vandals). Direct vehicular traffic to and around three staging areas. Stage/prioritize vehicles.

ALL CLEAR

Do not return to the building until cleared by fire department and Incident Commander and instructed by the Floor Monitor. When "All Clear" is announced, return to your normal work duties, unless otherwise directed.

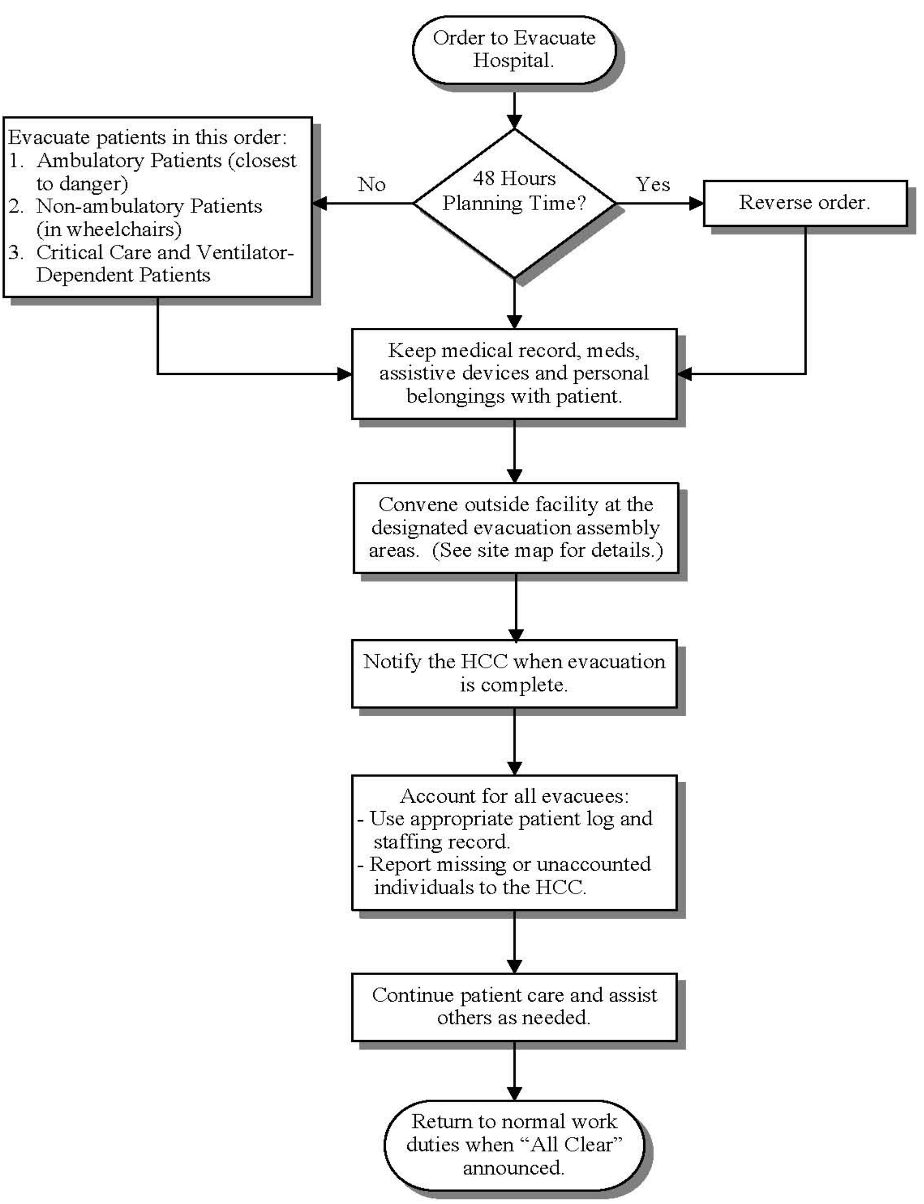
TOTAL EVACUATION PLAN

Equipment/ Carry Type	Staff Needed	Instructions
1. One-Person Assist (semi-ambulatory)	1	If patient can walk, accompany patient to area of refuge. If patient requires assistance to walk: 1. Stand next to patient and place his/her nearest arm around your waist. 2. Reach behind and around patient's waist and grasp his/her other arm. 3. "Hug from behind" and walk side by side in step – grasping your wrist. 4. When items 1, 2 and 3 have been accomplished, in order, walk the patient to the area of refuge. (If elevators are not functional, use evacuation equipment as needed to transport the patient down the stairs.)
2. Stryker Evacuation Chair	2	1. Unfold chair, place on floor. Set up following the instructions on back of seat. 2. Transport patient to chair. 3. Place restraints (for lap, chest and ankles) according to guidelines on chair. Fit should be firm but comfortable. 4. Transporters face forward in the direction of carry. The strongest person(s) should always be on the down side when ascending or descending stairs. 5. Evacuation chairs should be rolled, not carried, on all even surfaces.

Equipment/ Carry Type	**Staff Needed**	**Instructions**
3. Evacusled	1	1. Clear evacuation route, angle bed, lower bed and lock bed brakes when deploying Evacusled from bed deck. 2. Reassure patient, cocoon patient with bed linen and put IV/charts etc. in with patient. Note: Deployment can also be directly from floor position. 3. At head end of bed pull the orange cord straight up with a quick tug, over patient's head, ease white cords around mattress corners. Repeat at foot end. Velcro together. 4. Pull down to tighten cords at 4 self-locking cleats, secure patient and mattress. Tighten toggles. 5. With palms up grasp 2 carry handles below cleats. Shift your body weight to pull foot end of mattress to floor at a 45 degree angle, then guide head end gently to the floor. 6. Go to foot end of the mattress and pull out orange towing cord. Pull/roll feet first. Roll down hallway with foot end raised so sled is rolling on wheels. Make wide turns. 7. At stairwell, double check that cleats are secure. Walk down a few steps until underside wheels begin to roll downstairs. Always keep at least 2 steps between yourself and the foot end of sled. Wheels and gravity are doing the work as you guide the Evacusled down the stairs. 8. Speed of Evacusled is easily controlled with simple braking system on underside. Simply lower foot end of sled against stairs and /or press hand into sled at foot end. Pass off to next rescuer and return to get next patient.
4. Litter/Stretcher • Cervical Traction Board • Back Board		1. Place patient on stretcher. 2. Transporters should walk out of step (person in front should walk, start walking with left foot while person in back should walk right foot first). 3. Patient should be carried feet first if possible.
5. Blanket Drag		To be used as a last resort. 1. Unfold blanket. 2. Place patient face up diagonally on blanket. 3. Lift corner of blanket nearest to patient's head. 4. Drag patient, head first, to place of safety. 5. Mattress may be used in stairwells to assist with patients' evacuation.
6. Swing Method		1. Place patient in sitting position. 2. With a nurse on each side, both nurses pass one arm under the patient's arm and cross the patient's back. Each nurse should secure a firm grip on each other's shoulders. 3. The nurse's free arm is then passed under the patient's knees. One nurse keeps her palm up and the other nurse keeps her palm down, grasping each other's wrist. 4. Lift patient with arms and shoulders and remove to safety.

Total Evacuation Plan

All Staff Flowchart



Checklist – Nursing Care Guidelines for Special Situations

Mode of Hospitalized Patient Transportation	
Patient Type	**Mode of Transportation to Stairwell**
Ambulatory	Walking
Sitting patients or patients who get out of bed easily	Wheelchair
Bedridden patients	Bed or Gurney
Babies	In Arms, Cribs, or Aprons
Toddlers	In Arms or Cribs

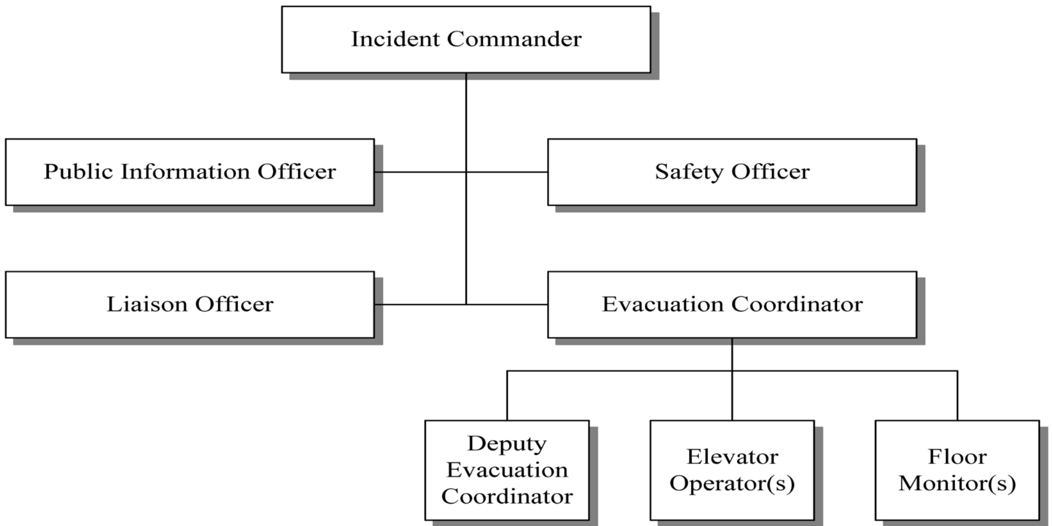
Protocol to Follow When the Hospitalized Patient is Attached to Special Equipment		
Equipment	**Procedure**	**Mode of Transportation***
Traction	Stabilize limbs – gently place weights on bed	In Bed
Stryker Bed	Transfer patient to gurney	Gurney
Central Venous Lines	All central lines must be maintained	Wheelchair or Gurney
Oxygen	Continue use with portable tank. If not available, then stop oxygen; shut off and remove flowmeter from wall, restart as soon as possible.	Walking, Wheelchair, Gurney or Bed
Precaution/Isolation Patients	Continue precautionary measures	Wheelchair or Gurney
Monitors/Telemetry	Disconnect and re-establish as soon as possible.	Wheelchair, Gurney or Bed
Ventilator Patients	Use Transport Ventilator. If not available then disconnect ventilators; connect manual resuscitator; manually ventilate patient	Gurney or Bed
Note: A nurse or respiratory therapist or physician must ventilate during transport, unless a transport ventilator is being utilized.		
Arterial Lines Central Venous Lines	Disconnect from monitor and maintain continuous flush pressure system/ all central lines must be maintained	Gurney or Bed
Intra-Aortic Balloon Pump	• If elevators approved for use: maintain IABP using internal battery If elevators are not usable: Disconnect IAB from pump. Maintain Artline as noted above. Hand inflate the balloon every 5 minutes with half its total volume. Clamp off drain during egress from unit and unclamp as soon as possible	Gurney or Bed

Hemodialysis Patients on Dialysis	• Emergently return blood to patient. • Flush lines • Clamp and disconnect	Gurney or Bed	
Vasoactive medications	• Continue via battery powered pump if possible	Gurney or Bed	
Swan-Ganz Catheter	• Continue monitoring & infusions with portable monitor and battery powered pumps if possible. • Consult with physician to see if patient is a candidate to have Swan-Ganz Catheter removed.	Gurney or Bed	
Special handling for patients who have received Radiopharmaceuticals (Muga Scan, Bone Scan, Brain Scan): Ambulatory Patients – flush toilet two times after voiding. Bedridden Patients (with Foley catheters) – wrap catheter in linen while in transport. Incontinent Patients – wrap patients in linen. **Note:** Follow decision of the HCC depending on results of assessment of situation.			Continue via battery powered pump if possible

Total Evacuation Plan

II. HICS – EVACUATION INCIDENT MANAGEMENT TEAM

A. Organization Chart



EVACUATION COORDINATOR

Mission:

Coordinate evacuation with Floor Monitors and keep Incident Commander updated on efforts. Work with Deputy Evacuation Coordinator to confirm arrival of evacuees at Evacuation Assembly Area.

Assigned to:	______________________ (your name)	__________ (date and time)
You report to:	______________________ (Incident Commander)	__________ (phone/pager)
Key contacts:	______________________ (Basement)	__________ (phone/pager)
	______________________ (Floor Monitor/Building)	__________ (phone/pager)
	______________________ (Floor Monitor/Building)	__________ (phone/pager)
	______________________ (Floor Monitor/Building)	__________ (phone/pager)
	______________________ (Floor Monitor/Building)	__________ (phone/pager)
	______________________ (Floor Monitor/Building)	__________ (phone/pager)
	______________________ (Floor Monitor/Building)	__________ (phone/pager)

CHECKLIST OF DUTIES

Immediate:

- ☐ 1. Receive appointment from the Incident Commander (IC).
- ☐ 2. Obtain Clipboard with Job Action Sheet, Identification Vest, megaphone and forms.
- ☐ 3. Read this entire Job Action Sheet and review the organizational chart on the clipboard.
- ☐ 4. Obtain handheld radio from the Safety Officer/HCC.
- ☐ 5. Obtain a situation briefing from the Incident Commander.
- ☐ 6. Activate Deputy Evacuation Coordinator (station at Evacuation Assembly Area).
- ☐ 7. Serve as a liaison with emergency responders (e.g., fire department, police department, etc.).
- ☐ 8. Meet responders upon their arrival and convey specific information about hazards in the building, access, locations of persons with special needs, etc.
- ☐ 9. Maintain communication with Floor Monitors regarding the status of the evacuation their floor.

Intermediate:

- ☐ 10. Keep Floor Monitors updated on incident status as necessary. Relay pertinent information from Floor Monitors to the HCC.
- ☐ 11. Document activities on the HICS Activity Log.
- ☐ 12. Obtain progress reports from Floor Monitors as appropriate.
- ☐ 13. Assist Public Information Officer in preparing information updates for hospital staff as needed.

Note: Report to the HCC for battery replacement for handheld radio as needed.

Forward completed Job Action Sheet to Incident Commander after the All Clear.

DEPUTY EVACUATION COORDINATOR

Mission:

Coordinate evacuation with Floor Monitors and keep Evacuation Coordinator updated on efforts. Work with Evacuation Coordinator to confirm arrival of evacuees at Evacuation Assembly Area.

Assigned to: ______________________________ ______________
(your name) (date and time)

You report to: ______________________________ ______________
(Incident Commander) (phone/pager)

Key contacts: ______________________________ ______________
(Basement) (phone/pager)

______________________________ ______________
(Floor Monitor/Building – (phone/pager)

______________________________ ______________
(Floor Monitor/Building) (phone/pager)

______________________________ ______________
(Floor Monitor/Building (phone/pager)

______________________________ ______________
(Floor Monitor/Building (phone/pager)

______________________________ ______________
(Floor Monitor/Building (phone/pager)

______________________________ ______________
(Floor Monitor/Building (phone/pager)

______________________________ ______________
(Floor Monitor/Building – Roof) (phone/pager)

CHECKLIST OF DUTIES

Immediate:

- ☐ 1. Receive appointment from the Evacuation Coordinator.
- ☐ 2. Obtain Clipboard with Job Action Sheet, Identification Vest, megaphone and forms.
- ☐ 3. Read this entire Job Action Sheet and review the organizational chart on the clipboard.
- ☐ 4. Obtain handheld radio from the Safety Officer/HCC.
- ☐ 5. Obtain a situation briefing from the Evacuation Coordinator.
- ☐ 6. Report to Evacuation Assembly Area.
- ☐ 7. Maintain communication with Floor Monitors regarding the status of the evacuation on their floor.

Intermediate:

- ☐ 8. Keep Evacuation Coordinator updated on status as necessary. Relay pertinent information from Evacuation Assembly Area to the HCC.
- ☐ 9. Document activities on the HICS Activity Log.
- ☐ 10. Obtain progress reports from Floor Monitors as appropriate.
- ☐ 11. Assist HICS Human Services Director (see JAS in Chapter 9) in preparing information updates for hospital staff as needed.

Note: Report to the HCC for battery replacement for handheld radio as needed.

Forward completed Job Action Sheet to Incident Commander after the All Clear.

ELEVATOR OPERATOR

Mission:

Operate designated elevator, if authorized, during an evacuation.
[Note: Elevators will be used for evacuation only when authorized and supervised by Fire Department or Engineering Department staff.]

Assigned to:	(your name)	(date and time)
You report to:	(Incident Commander)	(phone/pager)
Key contacts:	(Basement)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)
	(Floor Monitor/Building)	(phone/pager)

CHECKLIST OF DUTIES

Immediate:

- ☐ 1. Receive appointment from the Evacuation Coordinator.
- ☐ 2. Obtain Clipboard with Job Action Sheet, Identification Vest and forms.
- ☐ 3. Read this entire Job Action Sheet and review the organizational chart on the clipboard.
- ☐ 4. Use handheld radio for communication with Evacuation Coordinator.
- ☐ 5. Obtain a situation briefing from the Evacuation Coordinator.
- ☐ 6. Use elevator override key to efficiently transport non-ambulatory patients.
- ☐ 7. Evacuate patients in the order directed by the Evacuation Coordinator.

Note: Report to Engineering Department for battery replacement for handheld radio as needed.

Forward completed Job Action Sheet to Incident Commander after the All Clear.

FLOOR MONITOR

Mission:
Coordinate evacuation of floor to external Evacuation Assembly Area.

Assigned to:	______________________ (your name)	__________ (date and time)
You report to:	______________________ (Evacuation Coordinator)	__________ (phone/pager)
Key contacts:	______________________ (Deputy Evacuation Coordinator)	__________ (phone/pager)

CHECKLIST OF DUTIES

Immediate:

- ☐ 1. Receive appointment from the Evacuation Coordinator.
- ☐ 2. Obtain Clipboard with Job Action Sheet, Identification Vest and forms.
- ☐ 3. Read this entire Job Action Sheet and review the organizational chart on the clipboard.
- ☐ 4. Obtain handheld radio from the Safety Officer/HCC.
- ☐ 5. Obtain a situation briefing from the Evacuation Coordinator.
- ☐ 6. Ensure that all floor occupants are aware of the emergency and the need to evacuate. (Use megaphone.)
- ☐ 7. Be aware of patients/staff with special needs who may need assistance during an evacuation (e.g., hearing- or sight-impaired, on crutches, in a wheelchair, etc.).
- ☐ 8. Rank order patients to be moved. Prioritize. Write order on *Patient Evacuation Log*. (Contains name plus list of items accompanying patient.)
- ☐ 9. Assign designee to get equipment to evacuate/transport patients.
- ☐ 10. Assign trained staff to do various types of transport.
- ☐ 11. Assign runner if communications down.
- ☐ 12. Send information/status sheet to the HCC on available evacuation equipment/supplies.
- ☐ 13. Call Ext. 44 whenever a situation could pose immediate danger to people, property, or processes in the building.
- ☐ 14. Direct staff, patients and visitors to appropriate Evacuation Assembly Area.
- ☐ 15. Verify arrival of evacuees at Evacuation Assembly Area and note on *Patient Evacuation Log*.

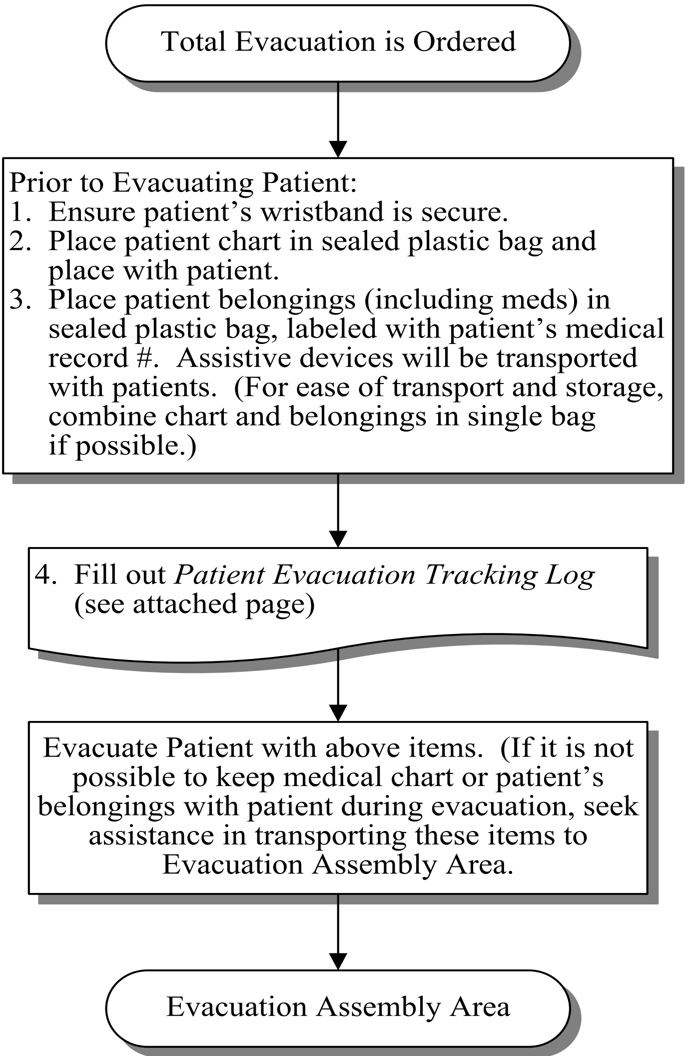
Note: Report to the HCC for battery replacement for handheld radio as needed.

Forward completed Job Action Sheet to Incident Commander after the All Clear.

III. PATIENT TRACKING METHOD

A. Patient Tracking Process

In the event of total facility evacuation, Kaweah ~~Delta Health Care District~~Health may implement its disaster patient tracking process. This tracking system will ensure that all patients may be readily located at all times. The Patient Tracking Officer will receive all information about patient movement and be the resource for patient location. Patients will be documented as described in the following procedural steps:



IV. EVACUATION ASSEMBLY AREAS

Once occupants are out of the building, they must be directed to a safe area away from the building. The following site map highlights evacuation assembly areas for each floor. These areas are where head counts will be completed. Employees should gather in these areas so that additional information can be provided easily.

Employees must be accounted for after an evacuation so that we can determine if people are missing. Floor monitors confirm that all patients and staff are out of the building or identify who is missing. This information is provided to the Hospital Command Center and local authorities when they arrive.

A. Designated Evacuation Assembly Areas:

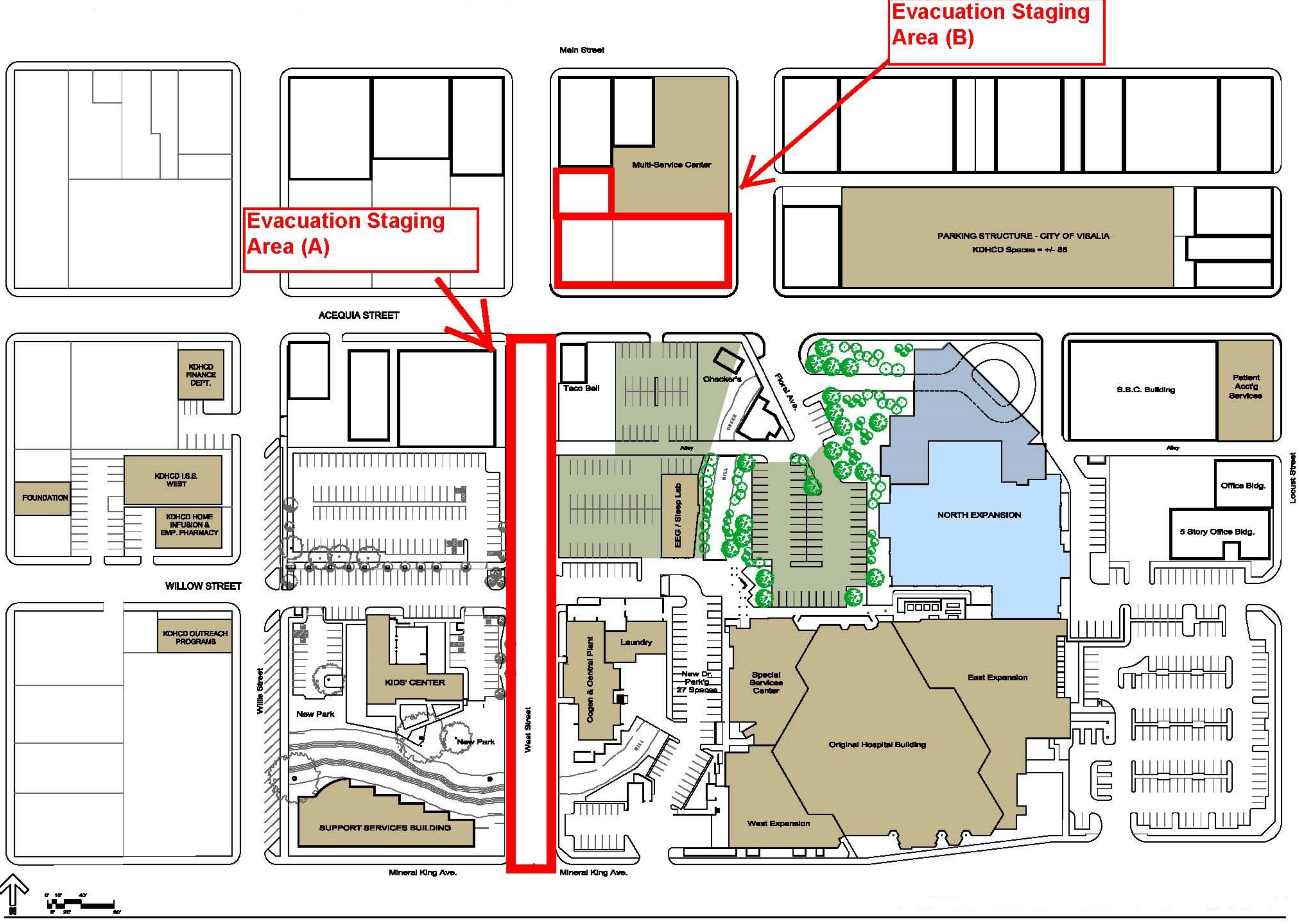
• Go to nearest Evacuation Assembly Point (see attached Evacuation Assembly Site Map).

B. Location of Exterior Assembly Points

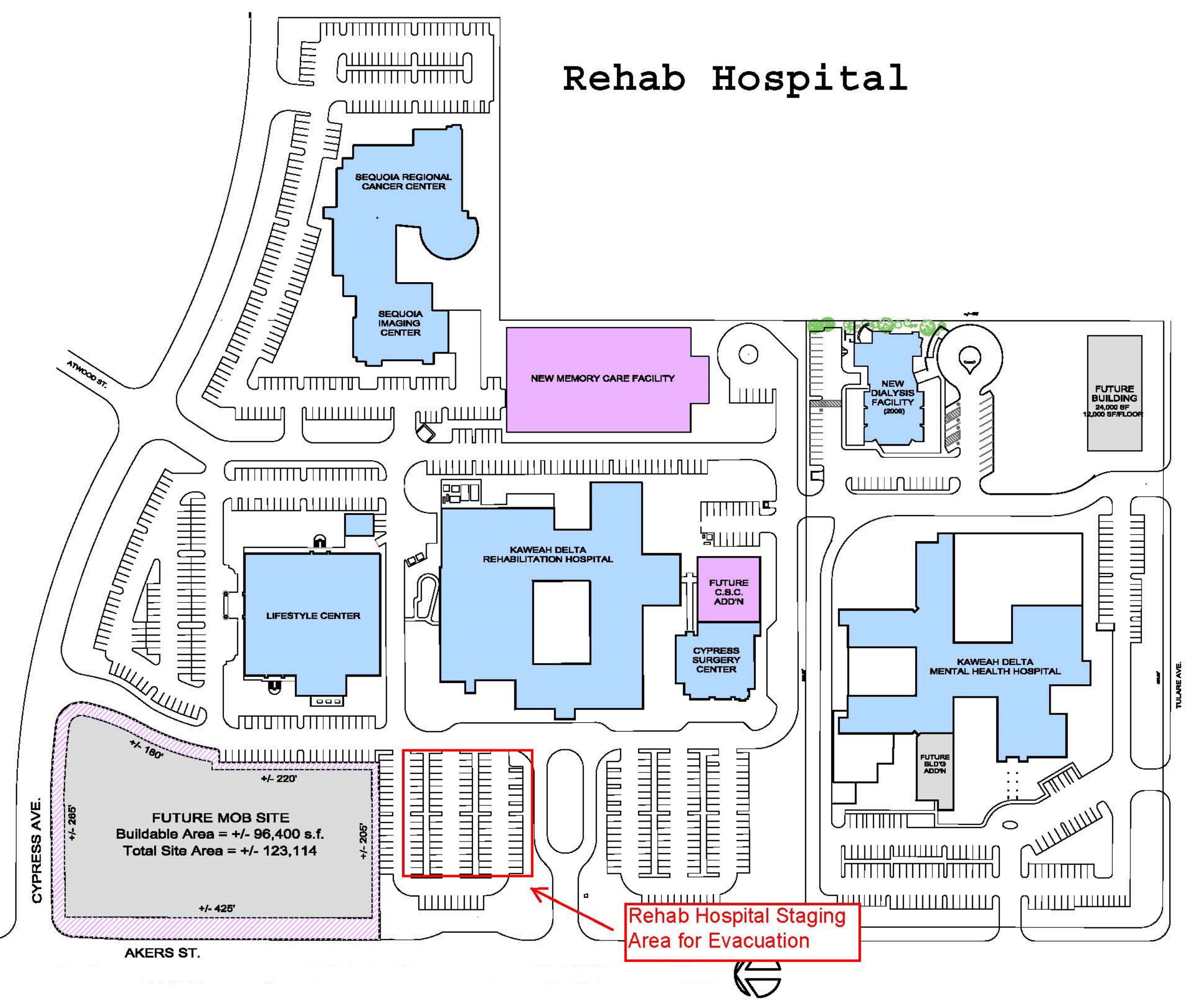
1. Kaweah ~~Delta~~ Health Medical Center
• Primary: West Street between Acequia & Mineral King
• Secondary: Multiservice Center parking lot.
2. Kaweah ~~Delta~~ Health Mental Health
• Primary: Main parking lot west of hospital
• Secondary: Rehab Hospital Main Lot
3. Kaweah ~~Delta~~ Health Rehab Hospital
• Primary: Main parking lot west of hospital
• Secondary: Mental Health Hospital Main Lot
4. Kaweah ~~Delta~~ Health – South Campus
• Primary: Main parking lot south of hospital
Secondary: North Paradise House area

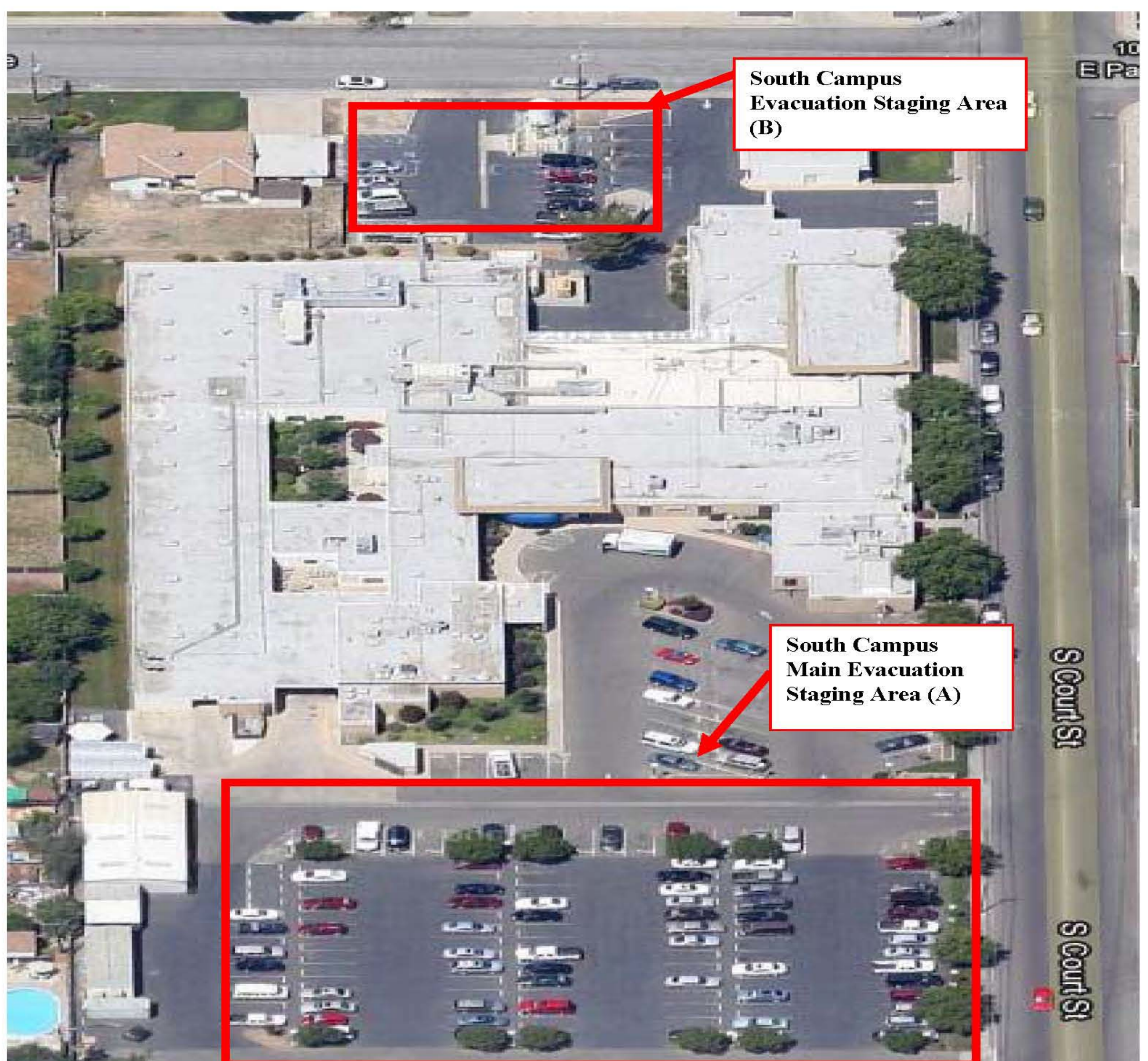
NOTE: If designating alternate evacuation assembly areas, these assembly areas should be far enough from the building to ensure the safety of personnel and should not block access for emergency responders. Plans should include an alternate assembly area in case the primary area is affected by the emergency. Include visitors, outside contractors and vendors, and employees from other sites. A system should be in place to monitor the arrival and departure of all people in the facility.

Kaweah Health Medical Center

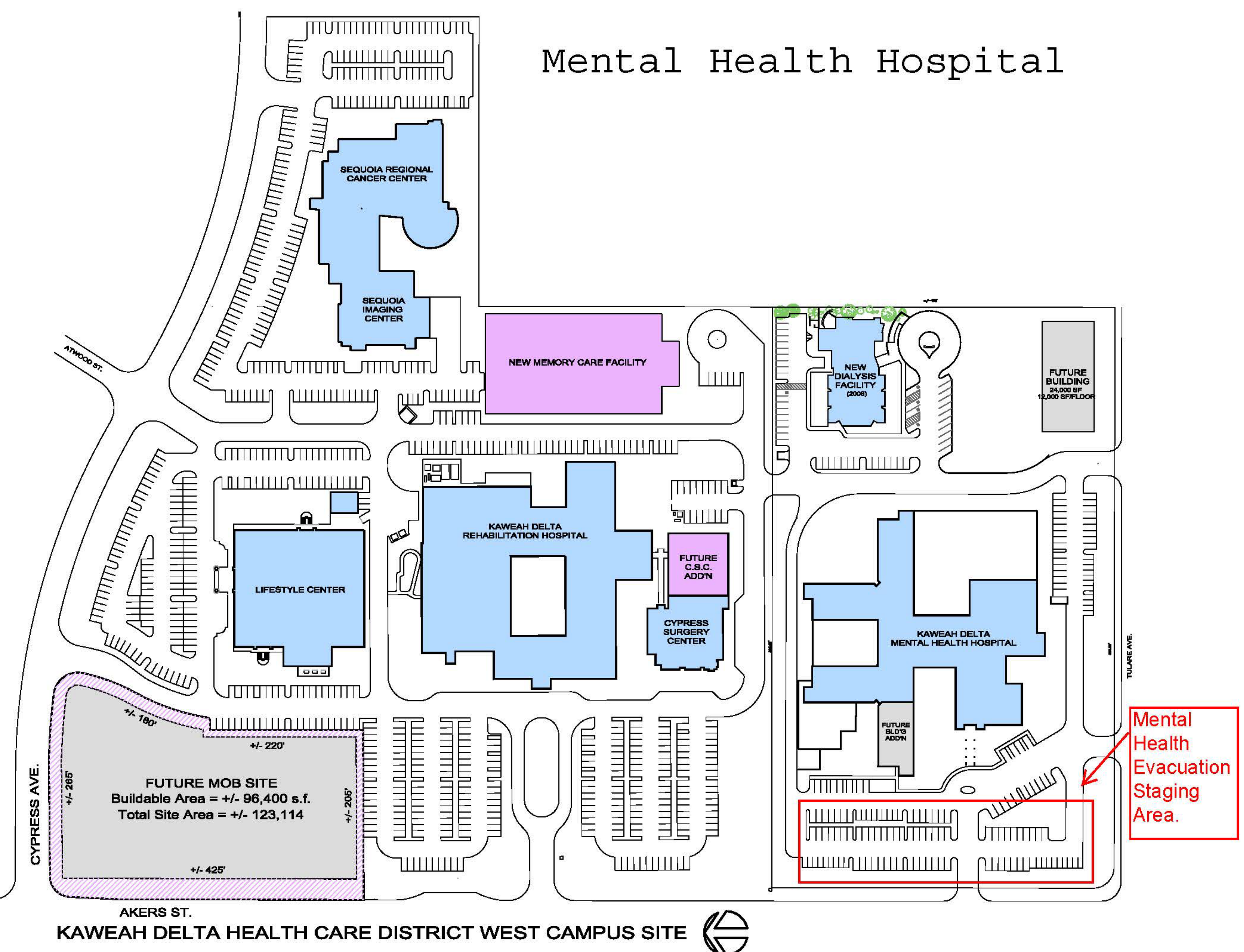


Rehab Hospital





South Campus Facility


Mental Health Hospital
SEQUOIA REGIONAL CANCER CENTER
SEQUOIA IMAGING CENTER
ATWOOD ST.
NEW MEMORY CARE FACILITY
NEW DIALYSIS FACILITY (2006)
FUTURE BUILDING 24,000 SF 12,000 SF/FLOOR
KAWEAH DELTA REHABILITATION HOSPITAL
FUTURE C.S.C. ADD'N
CYPRESS SURGERY CENTER
LIFESTYLE CENTER
KAWEAH DELTA MENTAL HEALTH HOSPITAL
FUTURE BLD'G ADD'N
TULARE AVE.
Mental Health Evacuation Staging Area.
+/- 180'
+/- 220'
+/- 265'
+/- 205'
FUTURE MOB SITE
Buildable Area = +/- 96,400 s.f.
Total Site Area = +/- 123,114
+/- 425'
CYPRESS AVE.
AKERS ST.
KAWEAH DELTA HEALTH CARE DISTRICT WEST CAMPUS SITE

ALTERNATE TREATMENT LOCATIONS

A. Overview

Kaweah ~~Delta~~ Health ~~Care District~~ will transfer patients and arriving casualties to identified alternate care sites when the hospital environment cannot support adequate patient care. The Alternate Care Site(s) Plan is a tool that establishes a process for managing patients during emergencies including activation/notifications, modification or discontinuation of services, control of patient information and patient transportation. It is anticipated that the event resulting in the need for alternate care site(s) will have resulted in an activation of Code Triage and the use of the Hospital Incident Command System (HICS).

B. Activation/Notification

1. Tulare Department of Public Health- Department Emergency Operations Center (DEOC) – Incident Commander, or designee, will notify the DEOC of the need to evacuate patients and provide information as to the number of patients and types of specialty care required.
2. California Department of Public Health (CDPH) – Incident Commander, or designee will notify DHS of the need to utilize alternate care site(s) for patient care.

C. Emergency Transfer of Patients

1. Discharge or transfer procedures in an emergency situation:
   a. Discharge
      The Medical Staff Director, as requested by the Incident Commander, will initiate the Emergency Rapid Discharge Plan. (See Section I.)
   b. Transfers

      The Kaweah ~~Delta Health Care District~~Health Incident Commander will request that Public Health activate the DEOC, via County Communications. The DEOC will survey hospitals in the county for their bed status to determine their ability to receive transferred patients. The DEOC will instruct Kaweah Delta Health Care District as to the number of patients to be transferred to each facility. Arrangements with receiving facilities will be coordinated through the Nursing Unit Leader and Medical Staff Director. Staff will ensure that medical records and personal belongings accompany each patient. The Nursing Unit Leader will maintain a record of patient transfers and destination.

   c. Transportation

      Arrangements will be made to transport patients from the hospital by the Transportation Unit Leader in collaboration with the Nursing Unit Leader and the Tulare County Emergency Medical Services (EMS

2. Alternate Care Site(s) – Acute Care Facilities
   Acute care hospitals in the CCMSA five county MOU plan. C~~c~~ounties may be able to accept Kaweah ~~Delta~~ Health ~~Care District~~ patients, depending upon the circumstances of the disaster. The Tulare County DEOC assists in locating hospitals with beds appropriate for placement of patients at alternate care sites.

If necessary, a request for National Disaster Medical System (NDMS) assistance would be made through the DEOC to the Governor. The NDMS is a federally coordinated system that augments the nation's emergency medical response capability to ensure resources are available to provide medical services following a disaster that overwhelms the local health care resources.

3. Interim Alternate Care Site(s)

In the event that evacuated patients and incoming casualties cannot be transferred to other acute care facilities, they will be routed to interim alternate care sites. These non-sterile, "hostile" environments may need to be maintained for hours or days, depending upon the circumstances of the disaster. Therefore, the HCC will:

a. Select buildings on the hospital campus to be used and/or utilize tents for staff and patients and set up in the hospital parking lot.

b. Coordinate available staff, equipment and supplies, water, power/lighting, shelter, ~~dietary~~ Food & Water resources, security, recordkeeping, and other needs to support interim care sites.

"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: AP27	Date Created: Not Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Set
Approvers: Board of Directors (Administration)	
Use of district name, logo 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, logo and stationery is restricted for official District business.

Use of business names for Kaweah Delta Health Care District (doing business as Kaweah Health) 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 Kaweah Health.

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. 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 Kaweah Health. Any media requests should be forwarded to Kaweah Health's Media Relations Department.

E. Requests to create a social media account using a business name for a Kaweah Health program or division requires prior approval by the Kaweah Health 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

F. Any and all websites that use a Kaweah Health business name must be coordinated through the Marketing and Communications Department.

G. 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 t/ Chief Strategy Office.
3. If approved, the 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).

USE OF KAWEAH HEALTH BRANDING/LOGO, DEPARTMENT AND SERVICE LINE LOGOS, AND USE OF STATIONERY

Use of Logo

One of Kaweah Health's primary strengths is its orchestrated approach to meeting the health care needs of our communities. While we are a structurally complex organization with many departments, service lines and locations, all entities are united by a common mission, a shared vision, and the same five pillars.

It is important that we:

- Guide the public perception that we are a unified body working in harmony for their benefit.
- Maintain a readily recognized brand.

approval

Having various logomarks, symbols, fonts, logotypes, naming, and divergent graphic styles for various entities undermine these objectives. This is true for any organization. The most basic principles of branding teach us that consistency is the foundation of a solid brand, and that individual preferences are cracks in that foundation. The Journey to World Class demands that we, at the very least, follow the most basic tenets of professional branding.

Kaweah Health not permit departments and/or service lines to have their own unique logomarks or wordmarks.

The Solution
While Kaweah Health does not allow hospital departments and service lines to represent themselves with their own unique logomarks or wordmarks, the Kaweah Health logo may be combined with the name of a secondary entity (as shown in the examples below) for specific uses.

These logo-plus-entity name treatments are only allowed on:

- Signage
- Promotional merchandise
- Apparel, such as pens, bags, jackets, non-workwear polo shirts, T-shirts and other giveaway items.

Important
Creation of these logo/name lockups is to be handled through the Kaweah Health Marketing Department. Generating identities from within individual departments is strictly prohibited.

For more information or additional samples, please go to KaweahHealthBrand.org/other resources

Stationery

II. Use of Stationery

A. Use of Kaweah Health 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 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.

There is only one approved version of the Kaweah Health letterhead and envelope. Stationery systems do not use service line lockups. Instead, these applications use the service line designation in text, as shown in the sample below.

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.

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Subcategories of Department Manuals not selected.

Policy Number: AP39	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Executive Team A	

Catering Guidelines

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

Policy: The primary purpose of the Catering Department within the District is to provide catering service to the staff of ~~Kaweah Delta Health Care District~~Kaweah Health. Non-profit groups may schedule an event as space and services are available.

Procedure: The Food & Nutrition Service Departments of ~~the District~~Kaweh Health will provide full catering for meetings of the ~~District~~ Kaweah Health Board, Administration, Medical Executive Committee and Foundation without ~~Vice President (VP)~~Executive Team ~~-~~authorization. In addition Medical Staff committee meetings and Human Resource meetings do not require ~~VP~~ Executive Team authorization. All other request for catering exceptions must be approved by the ~~VP~~ Executive Team member who oversees~~of~~ the requesting department.

Commented [HL1]: VP's have not been approving. Can be designated to be approved in Catertrax system.

All requests for ~~room reservations and catering for~~ standing meetings are to be completed using Catertrax Online. Standing meeting can be made Via CaterTrax online up to 12 months in advance. ~~HR Online by November 15th for the following year. Confirmations will be sent automatically by HR Online~~. ~~The on-line catering system is set-up to have 15 minute increments in-between catering events to allow staff time for clean-up, and set-up of catering events~~.

All catering events are charged to departments or areas using the service. Hospital District representatives will utilize in-house catering unless ~~a VP~~an Executive Team member authorizes otherwise or unless outside catering is more cost effective. Charges are based on the number of guests ordered not the number of guests who were serviced. When rooms are reserved with no food ordered, the group is responsible for returning the room to its original condition. ~~If the room is not left clean and orderly, the group will be charged a fee of $30.00 per room~~. N. A minimum charge of $25 will be assessed for orders not meeting the minimum amount of $25 unless approved by the Vice President.

Commented [HL2]: We don't charge a fee from FNS

Commented [HL3]: We

A catering menu is available online via CaterTrax. ~~HR Online. At the Downtown Campus, all~~ All catering requests must be received within the Food & Nutrition Service Department no less than 48 Hours prior to the actual occurrence of the event or meeting.

Full meal service will be limited to meetings held in any of the district facilities;~~ d~~downtownMedical Center campus, south campus and west campus. Please call 624-~~5081 ~~2727 for pre-approval of other sites.

PROCEDURE:

I. Catering Requests~~ Forms~~

Catering Requests can only be made using CaterTrax. Access to Catertrax will be granted to authorized personnel by calling The food service department at ext. 2781.~~ forms are available on the KDNet via HR Online~~ . The on-line request form must be completed appropriately providing all necessary information and must be received by food services~~ Catering Reservations~~ 48 hours prior to the ~~for~~ event.~~s~~ Any changes to the original order must be done prior to 24 hours of the event.

II. Food & Nutrition Service requires 24 -hour notice for cancellation of a scheduled catering event. Failure to provide 24 -hour notice will result in the ordering department being charged for food cost of the event. The department/individual that ordered the event is responsible for canceling the event online using CaterTrax Online.~~ using HR Online~~.

III. Completion of Catering Request~~ Forms~~

A. The On-line Catering Request~~ form~~ must contain all of the information requested including:

1. Name, telephone number, and department of individual requesting service;
2. Name, date, day, time, and location of event;
3. Number of individuals expected to attend; and,
4. Menu items requested.

B. If after the catering request form has been completed and submitted via ~~HR Online~~ and the information provided requires revision, i.e., number of individuals attending changes, it is the responsibility of the requester to immediately notify Catering Reservations at (559) 624-2292 with updated information.

Commented [HL4]: Catertrax

~~III. Catering Menu- call 2727 or 2292~~

IV. Cost Accounting
Department catering cost reports are available from CaterTrax Online.~~A monthly summary of costs associated with catering will be prepared and forwarded to the Manager of departments utilizing catering services~~. A monthly summary of the catering costs will be forwarded to t~~T~~he Finance Department~~ will transfer~~ and these costs will be transferred to the requesting departments cost center.~~.~~

V. Catering Guidelines for Service

Catering Guidelines for service Catering Guidelines
Type of Food Service Available

Hospital Committees	Menus developed with the Executive Chef
Board Committees	Menus developed with the Executive Chef
Dept Meetings < 2 hrs	Call 624-2727~~5081~~
Dept Meetings > 2 hrs	Call 624-~~5081~~2727
Open House	Menu to be developed with Food and Nutrition Service
Educational Events	
Lamaze Class	Beverage Service Only
Staff Member Class	Beverage Service Only
Community Class	Beverage/Muffins or Cookies
Student Tours	Juice and Cookies
Special Events	Special Requests require ~~VP~~ Executive Team member Signature
Outside Groups	Special Requests require ~~VP~~ Executive Team member Signature

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Policy Number: AP41	Date Created: Not Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: 05/25/2021
Approvers: Board of Directors (Administration)	
Quality Improvement Plan	

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

I. Purpose

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

II. Scope

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

III. Structure and Accountability

Board of Directors

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

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

Quality Council

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

improvement and patient safety activities will be evaluated and reported to the Quality Council.

Medical Staff

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

Quality Improvement Committee (QIC)

QIC has responsibility for oversight of organizational performance improvement. Membership includes key organizational leaders including the Medical Director of Quality and Patient Safety or Chief Quality Officer, Chief Operating Officer, Chief Nursing Officer, Assistant Chief Nursing Officer, Directors of Quality and Patient Safety, Nursing Practice, and Risk Management; Manager of Quality and Patient Safety and Manager of Infection Prevention. This committee reports to Prostaff and the Quality Council.

The QIC shall have primary responsibility for the following functions:

1. **Health Outcomes:** The QIC shall assure that there is measureable improvement in indicators with a demonstrated link to improved health outcomes. Such indicators include but are not limited to measures reported to the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC), and other quality indicators, as appropriate.

2. **Quality Indicators:**
   a. The QIC shall oversee measurement, and shall analyze and track quality indicators and other aspects of performance. These indicators shall measure the effectiveness and safety of services and quality of care.
   b. The QIC shall approve the specific indicators used for these purposes along with the frequency and detail of data collection.
   c. The Board shall ratify the indicators and the frequency and detail of data collection used by the program.

3. **Prioritization:** The QIC shall prioritize quality improvement activities to assure that they are focused on high- risk, high- volume, or problem-prone areas. It shall focus on issues of known frequency, prevalence or severity and shall give precedence to issues that affect health

outcomes, quality of care and patient safety. The QIC is responsible to establish organizational Quality Focus Teams who:

a. Are focused on enterprise-wide high priority, high risk, problem prone QI issues
b. May require elevation, escalation and focus from senior leadership
c. Have an executive team sponsor
d. Are chaired by a Director or Vice President
e. May have higher frequency of meetings as necessary to focus work and create sense of urgency.
f. Report quarterly into the QAPI program

4. **Improvement:** The QIC shall use the analysis of the data to identify opportunities for improvement and changes that will lead to improvement. The QIC will also oversee implementation of actions aimed at improving performance.

5. **Follow- Up:** The QIC shall assure that steps are taken to improve performance and enhance safety are appropriately implemented, measured and tracked to determine that the steps have achieved and sustained the intended effect.

6. **Performance Improvement Projects:** The QIC shall oversee quality improvement projects, the number and scope of which shall be proportional to the scope and complexity of the hospital's services and operations. The QIC must also ensure there is documentation of what quality improvement projects are being conducted, the reasons for conducting those projects, and the measureable progress achieved on the projects.

Medical Executive Committee

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

Nursing Practice Improvement Council

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

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

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

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

Methodologies:

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

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

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

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

    - **<u>Plan:</u>**

        - Objective and statistically valid performance measures are identified for monitoring and assessing processes and outcomes of care including those affecting a large percentage of patients, and/or place patients at serious risk if not performed well, or performed when not indicated, or not performed when indicated; and/or have been or likely to be problem prone.

        - Performance measures are based on current knowledge and clinical experience and are structured to represent cross-departmental, interdisciplinary processes, as appropriate.

- **Do:**
  - Data is collected to determine:
    - Whether design specifications for new processes were met
    - The level of performance and stability of existing processes
    - Priorities for possible improvement of existing processes
- **Check:**
  - Assess care when benchmarks or thresholds are reached in order to identify opportunities to improve performance or resolve problem areas
- **Act:**
  - Take actions to correct identified problem areas or improve performance
  - Evaluate the effectiveness of the actions taken and document the improvement in care
  - Communicate the results of the monitoring, assessment and evaluation process to relevant individuals, departments or services

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

- **Define** the problem, improvement activity, opportunity for improvement, the project goals, and customer (internal and external) requirements. QI tools that may be used in this step include:
  - Project charter to define the focus, scope, direction, and motivation for the improvement team
  - Process mapping to provide an overview of an entire process, starting and finishing at the customer, and analyzing what is required to meet customer needs
- **Measure** process performance.
  - Run/trend charts, histograms, control charts
  - Pareto chart to analyze the frequency of problems or causes
- **Analyze** the process to determine root causes of variation and poor performance (defects).
  - Root cause analysis (RCA) to uncover causes
  - Failure mode and effects analysis (FMEA) for identifying possible product, service, and process failures

- **Improve** process performance by addressing and eliminating the root causes.
  - Pilot improvements and small tests of change to solve problems from complex processes or systems where there are many factors influencing the outcome
  - Kaizen event to introduce rapid change by focusing on a narrow project and using the ideas and motivation of the people who do the work
- **Control** the improved process and future process performance.
  - Quality control plan to document what is needed to keep an improved process at its current level. Statistical process control (SPC) for monitoring process behavior
  - Mistake proofing (poka-yoke) to make errors impossible or immediately detectable

IV. Confidentiality

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

V. Annual Evaluation

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

VI. Attachments

Components of the Quality Improvement and Patient Safety Plan:

Attachment 1: Quality Improvement Committee Structure
Attachment 2: KDHCD- Prostaff Reporting Documents
Attachment 3: Quality and Patient Safety Priorities, Outstanding Health Outcomes Strategic Plan

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Subcategories of Department Manuals not selected.

Policy Number: AP100	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Chaplain / Clergy Policy	

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POLICY: Chaplaincy Service is available to all patients, families and staff of Kaweah Delta Health Care District regardless of race, religion, gender, age or faith perspective.

Chaplain Services strives to meet the needs of people by serving as a conduit between an individual's spiritual perspective and their personal clergy. The Chaplain does not proselytize or bring their own personal belief system to the patient but seeks to bring a sense of relief or comfort in stressful situations.

Kaweah Delta Chaplains welcome and encourage leaders from community faith groups to visit and will facilitate ministry with patients of their specific faith whenever possible.

1. Patients are given the opportunity to specifically request the chaplain visit during hospitalization as well as refusing a chaplain visit.

   Chaplains visit patients at the request of patient, or family, or the patient care team.

2. Community faith leaders are encouraged to visit patients of their own congregation and District Chaplains support their efforts to visit patients.
3. Chaplains respond to code blue, code white and traumas whenever possible.
4. Chaplains are available to support patients, families and staff 24 hours a day, 7 days through the District Operator.

~~5.~~ Chaplains support staff at the conclusion of critical events including 1:1 support or group support as needed. ~~The Chaplains work in collaboration with the Employee Assistance Program.~~

6. Chaplains serve on the District Bio-Ethics Committee and other committees appropriate to their role in the District.
7. Chaplains may provide support at patient family conferences at the request of the primary physician, patient care team, patient or family or the Bio-Ethics Committee chair.

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8. Continuous Quality Improvement – Chaplains seek and create opportunities to enhance the quality of chaplaincy care practice.

9. Research – Chaplains practice *evidence-based care including* ongoing evaluation of new practices and when appropriate contribute to or conduct research.

10. Knowledge and Continuing Education – Chaplains assume responsibility for continued professional development and demonstrate a working and current knowledge of current theory and practice and integrates such information into their practice.

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Subcategories of Department Manuals not selected.

Policy Number: AP129	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Critical Incident Stress Management	

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PURPOSE: The purpose of Critical Incident Stress Management (CISM) is to provide timely, effective assistance to employees involved in a critical incident and to reduce and control the harmful aspects of critical incident stress among staff at Kaweah Delta Health Care District (KDHCD.) The goal of CISM is to return personnel to their pre-incident level of functioning as soon as humanly possible and to retain valuable employees exposed to distressing situations.

POLICY: KDHCD has adopted the International Critical Incident Stress Foundation (ICISF) model of crisis intervention. This is a peer driven system with social service and mental health collaboration. ~~The CISM program will be coordinated by the Employee Assistance Program (EAP) at KDHCD. EAP will be responsible for responding to critical incidents, for managing the operational and administrative components of the CISM process, and for providing guidance to team members.~~

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The CISM team will minimally consist of a chaplain, one social worker and one peer. The peer will be a KDHCD employee that does not work in the area the incident occurred. Group defusing/debriefings will be conducted to assist staff in dealing with the stress and psychological aspects of the crisis. Follow-up recommendations will be made by the CISM team if needed.

CISM is available to KDHCD staff involved in critical incidents. Critical Incidents may include but are not limited to:

1. suicide/death of a co-worker
2. providing care to a patient who is a relative or close friend who is dying or in serious condition
3. death of a child or newborn
4. patients with gruesome, disfiguring, or dismembering injuries
5. major disasters
6. personally threatening events
7. events with media exposure
8. dealing with hysterical family members
9. death of a patient after prolonged efforts at resuscitation
10. multiple casualties at the same time

PROCEDURE:

Requests for a CISM evaluation may be initiated by any staff member, manager or designee, or administrator on-call by contacting the House Supervisor on the Main Campus.

The House Supervisor will contact ~~EAP~~ Chaplain Services ~~Monday through Friday, 0800 to 1700~~ to activate the on-call team.

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~~After hours, the House Supervisor will call the EAP CISM Coordinator/designee to activate the on-call team.~~

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Defusings or debriefings will be organized with the approval of the involved Manager/Director/Supervisor. (Individual sessions do not require manger approval.)

A *defusing* is provided within 8 to 12 hours and a *debriefing* is provided between 12 and 96 hours.

IV. In some incidents, the CISM team may be need to do an *on-scene* assessment o while the incident is occurring to give advice to the supervisory staff. Brief (under 5 minute) one-on-one sessions with individuals may occur. Group sessions will not occur until after the crisis ends.

V. The CISM team is committed to maintain confidentiality of all who receive their services. If an individual gives the CISM team permission to relate information (if there is an indication that there is a clear and present danger if the situation is not corrected), the CISM team will report the situation to the supervisor with authority to correct the situation. Individuals receiving CISM services shall not be revealed without explicit permission.

The policy book explaining procedures and guidelines for how the CISM team conducts themselves and group sessions, resides in EAP.

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Policy Number: AP164	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Messenger Model Guidelines for Managed Care Contracting for Physicians	

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POLICY: Kaweah Delta Health Care District ("District") will use a messenger model to assist physicians and medical groups ("Physicians") that have existing business relationships with the District but that do not compete or potentially compete with the District in negotiating health plan contracts ("Contracting Services"). The District will designate one or more District employees ("Messenger") in the Managed Care Department to provide Contracting Services and convey contract proposals between Physicians and health plans as to contract proposals.

The messenger model ensures that each Physician is solely responsible for determining the rates or other terms he/she will negotiate and accept for health plan services. The Messenger will not bargain or negotiate on behalf of any Physicians or determine prices or rates as the best prices or rates for any Physician. The Messenger will not share any information or data regarding the contracts, positions, opinions, views, or decisions of a Physician with any other Physician for which the Messenger performs Contracting Services

PROCEDURE:

I. **Role of the Messenger**

A. The Messenger will not provide Contracting Services for any Physician with respect to services that compete or potentially compete with the District.

B. The Messenger will act as a conduit of information between individual Physicians and health plans so that each Physician can make his/her own decision as to whether it will accept or reject an offer by a health plan.

C. The Messenger may collect information from a Physician regarding the prices or other terms that he/she will accept from health plans, including a minimum price; however, the Messenger will not use information from individual Physicians to determine an average price or other calculation to set a collective price to demand from health plans. The Messenger may

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provide this information to the health plans, but he/she may not disclose the information to any other Physician.

D. The Messenger will not negotiate or bargain with health plans for fees, rates, or any competitively sensitive terms, including rates, fees, or other prices, on on behalf of any Physicians or two or more Physicians collectively.

E. The Messenger will convey all health plan proposals to each individual Physician, including contract proposals that may fall below the minimum price levels authorized by the Physician.

F. Each Physician will decide whether to accept the proposed contract terms; the Messenger will also convey counter-offers from Physicians to the health plans.

G. The Messenger may assist a Physician in understanding the terms of a particular contract proposal by providing objective or empirical information about the terms of the offer, including comparisons to that Physician's other contracts; however, the Messenger will not recommend that a Physician accept or reject a particular health plan offer or otherwise express his/her own views or opinions to the Physician regarding the desirability or acceptability of the offers or contract terms.

II. Contracting Process

A. The Messenger will not offer Contracting Services to a Physician on an exclusive basis.

B. A Physician will not be prevented from contracting independently or directly with the health plans, either permanently or during the time which the Messenger is communicating with health plans.

C. Each Physician will be responsible to determine the rates he/she will accept from health plans and to decide whether to accept or reject a contract proposal and execute the contract.

D. The Messenger will not coordinate a collective response by any Physicians to any contract proposals from a health plan.

E. The Messenger will not refuse to transmit any offers to a Physician that are below the Physician's authorized levels.

F. The Messenger will not encourage or suggest in any way that any Physician refuse to negotiate or deal, or terminate his/her agreements with any health plan that does not raise its rates or otherwise meet the demands of the Physician.

III. Communications with Physicians

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A. The Messenger may share any public, non-confidential information with Physicians.

B. The Messenger will not share fees, other contract rate terms requested or received by a Physician, any competitively sensitive terms or information, or the contracting decisions of Physicians, with any other Physician.

C. The Messenger may provide aggregated information to Physicians; however, the information will be sufficiently aggregated so that it does not suggest or otherwise signal a price level that a Physician should select or how a Physician should act with respect to any contract proposal.

D. The Messenger will not poll the Physicians to obtain the prices that they are willing to accept from health plans, provide collective price information to the Physicians or use the Physicians' collective price information as a basis for determining which of the health plan offers the Messenger will transmit to Physicians or to negotiate price or other competitive terms with the health plans.

IV. Administration of Services

A. Each Physician will sign an Agreement authorizing the District to provide Contracting Services for the Physician.

B. The fees for Contracting Services will be priced at fair market value, and billed to the Physicians. As to a Physician receiving an income guarantee under a professional services or recruitment agreement, the fees are included in the fair market value of the compensation or recruitment assistant provided to the Physicians.

C. Each Physician is responsible for his/her billing and collection of professional fees for his/her medical services.

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Policy Number: AP170	Date Created: No Date Set
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Approvers: Board of Directors (Administration)	

Use of Medical/Allied Health Staff Personal Information

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

POLICY: The information on the Kaweah Health Physician Directory (online or Cisco phone) is intended for internal patient care and business use by Kaweah Health staff and medical/advanced practice providers only. Any personal medical/advanced practice provider contact information such as cell phone number, pager number, etc., is NOT to be given out or provided to any outside parties, including patients and families. Only exception: unless explicitly directed to do so by the medical/advanced practice provider member.

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Administrative Manual

Policy Number: AP179	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers:Board of Directors (Administration)	
Bridge Policy for Federal Grants and Awards Management	

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

Policy: Kaweah Delta Health Care District may receive Federal Grant Awards. Therefore, the District's accounting system shall operate in accordance with OMB Uniform Guidance when applicable to grant funded programs supported by Federal Awards. The Director of Development, the Grants Coordinator and the Director/and or Manager responsible for the department operating the Federal Grant are responsible for the education of, the monitoring of, and compliance with this policy.

The District's Administrative and Department Policy manuals contain various policies relating to internal controls. The policy and procedures outlined below are intended to supplement those policies, and will override as to Federal Awards should there be a conflict.

Administrative Policy **AP.148** *Grants* outlines the overall process for applying for, administering and managing grants in general.

In addition, Grants involving Federal Awards are subject to the following financial management policies and procedures:

1. **Cash Management**

   Kaweah Delta requests funds on a reimbursement basis from the Payment Management System (PMS). This ensures that funds requested are the minimum amounts necessary to cover allowable project costs, that they are in alignment with actual cash expenditures related to the project and that they do not cover future expenses. The following process should be followed when requesting fund drawdowns:

   a. Using the departmental performance report for the grant cost center, the Development Coordinator will compile all invoices and receipts that support the draw down request into a packet.
   b. Submit the packet and the draw down request form to the Department Director and/or Manager operating the grant cost center, the Director of Development and the Grants Coordinator for approval.
   c. Once approved the packet will be provided to the Finance Department to initiate the draw down request. Allow 3-4 days for the draw down to be processed.
   d. All supporting documentation related to draw downs will be maintained in the Grant Department and the Finance Department.

2. Annual Audits

A financial statement audit is conducted by independent external auditors annually for Kaweah Delta Health Care District. As part of the annual audit process, the Schedule of Expenditures of Federal Awards (SEFA) is prepared to determine whether a Single Audit is triggered, based on expenditures of federal awards in the amount of $750,000 or more. The results of the Annual Financial Statement audit and any triggered Single Audits are presented to and reviewed by the Audit Committee and the Board of Kaweah Delta Health Care District.

Selection of the independent external auditors is completed by the Audit and Compliance Committee of the Board of Directors and is governed by Administrative Policy **AP.167** *Quote and Proposal Guidelines* which governs the selection of service providers.
If a Single Audit is required, the audit package and the data collection form shall be submitted to the Federal Audit Clearinghouse 30 days after receipt of the auditor's report, or 9 months after the fiscal year end, whichever comes first.

3. Accounting System

Grant funding is accounted for in the District's financial records by assigning a cost center, referred to as an accounting unit in the accounting software system, to the grant to account for all incoming funding and outgoing expenditures. Monthly financial performance reports are generated that are provided to the Grant Manager for review. These processes are further outlined in Administrative Policy **AP.153** *Annual Operating and Capital Budget Development and Monitoring* .
Finance Department Policies **FDP.21** *General Ledger Chart of Accounts* and **FPD.41** *Guidelines for Natural Classification of Expense* govern the maintenance of the chart of accounts. Each accounting unit (cost center) in the accounting system has designated posting accounts. Each grant award will be designated a specific accounting unit number in the chart and will be assigned posting accounts and natural classes of expenditures, based upon the types of expenditures that are allowed by the grant. Any payment related to the grant will be coded to this accounting unit and correct account, or natural classification. Source documents are retained electronically in most cases in accordance with Finance Department Policy **FDP.39** *Record Retention* . This policy applies to grant source document for paid expenditures including authorization, bank statements and financial statements. These documents are housed in the Finance scanning system as well as in the Finance G: drive. Draw down reimbursement packages including authorization and all source documentation for expenditures, copies of federal awards, and copies of financial reports such as the SF 425 and FFR reports are retained electronically in the G: drive Grant folder online. In addition, the Development Department retains a complete grant file for each award including the electronic tracking of project budgets and comparison to actual expenditures, awards, obligations and unobligated balances.

4. Bank Statements

Finance Department Policy **FDP.25** *Account Reconciliation Procedure* requires all general ledger balances, including bank account balances, to be reconciled within a timely manner. A timely manner is considered to be within 30 days of month end. Administrative Policy **AP.146** *Cash Control* Also requires bank reconciliation and audit as applicable.

The Sr. Financial Analyst assigned to Treasury functions completes the monthly reconciliation process and reviews the statements. Monthly reconciliations, along with statements, are to be reviewed by the Finance GL Manager. In addition, the Finance Director completes a quarterly review and approval of all cash and investments reconciliations, including a review of statements. The Director of Finance does not process AP payments; they are released by the Finance AP Manager and processed by AP staff.

Bank Statements are obtained electronically from the Commercial Banking Online Portal. The Chief Executive Officer, Chief Financial Officer and Board treasurer are the only individuals listed as authorized signers on bank accounts and are authorized to approve the system administrator, the Director of Finance, of the Online Portal. The authorized signers are not users of the Online portal. The Sr. Analyst assigned to Treasury who performs the bank account reconciliation does not have authority to process payments and is not an authorized bank signer. All checks are signed electronically and include the signature of the CEO and Board Treasurer. Only Accounts Payable staff authorized to process checks in the AP system are allowed access to the MHC system that generates checks.

5. Disbursements/Procurement

Kaweah Delta maintains all documentation related to expenditures of grant funds as outlined above in Cash Management. The following process should be followed when requesting fund drawdowns:

a. Using the departmental performance report for the grant cost center, the Development Coordinator will compile all invoices and receipts that support the draw down request into a packet.
b. Submit the packet and the draw down request form to the Department Director and/or Manager operating the grant cost center, the Director of Development and the Grants Coordinator for approval.
c. Once approved the packet will be provided to the Finance Department to initiate the draw down request. Allow 3-4 days for the draw down to be processed.
d. **All supporting documentation** related to draw downs will be maintained in the Grant Department and the Finance Department.

Grant expenditures adhere to Kaweah Delta's Administrative Policies, **AP.156** *Standard Procurement Practices* , **AP.166** Competitive Bidding on Contracts and **AP.167** *Quote and Proposal Guidelines* to ensure appropriate and reasonable use of grant funds.

Expenditures area also in accordance with Kaweah Delta's purchase authorization process, whereby purchasing authority is granted by Directors and Vice Presidents related to both the types of purchases allowed, as well as the purchasing limits. These authorization forms are kept on file in the Finance Department as required by Materials Management Policy **MM.12** *Purchase Authorization* . Purchase orders and non PO invoices require pre-approval by those with purchasing authority as outlined in Finance Department Policy **FDP.09** *Accounts Payable Invoice Processing* as well as Materials Management Policies **MM.12** Purchase Authorization and **MM.17** *Non-Stock Item Purchase* .

All checks are processed electronically and therefore there are no blank checks. Checks are also signed electronically as outlined above. The Accounts Payable Manager reviews and electronically releases all invoice batches and reviews supporting documents prior to the processing of checks. The batch release process is required by the AP system for payment of an invoice by check or ACH. Those authorized to enter Purchase Orders and Invoices are not authorized to release invoice batches for payment. Invoices will only be processed if applicable purchase authorization is verified upon invoice or PO entry as described above.

FDP.44 *Accounts Payable Trade Vendor Maintenan*ce outlines the process for setting up new vendors in the AP system. The Finance AP Manager reviews all vendor setup and the Administrative Assistant enters new vendor information into the system. Those who process payments (AP Staff) do not have the authority to setup new vendors in the system. The Finance AP Manager reviews the AP vendor maintenance forms and releases batches, but now have system authority to enter invoices and does not process checks and ACH payments. The Administrative Assistant enters the vendors into the system.

FDP .47 *Accounts Payable Check Runs* outlines the process for processing check and ACH payments. Invoices batches are entered by AP staff. Only the Finance Manager can release batches to be paid. Once they are released, the AP staff authorized can generate the check or ACH file. The Administrative Assistant assures check or ACH copies are matched to invoice documentation and scans into the electronic filing system. Wire transfer templates can only be approved by the CEO system administrator.

6. Matching or Cost Sharing

For all Federal awards, any shared costs or matching funds and all contributions, including cash and third party in-kind contributions, are accepted as part of Kaweah Delta's Cost Sharing or Matching when the following criteria are met:

a. The costs are verifiable from Kaweah Delta's records;

b. The costs are not included as contributions for any other Federally assisted project or program;

c. The costs are necessary and reasonable for proper and efficient accomplishment of project or program objectives;

d. The costs are not paid by the Federal Government under another award, except where the Federal statute authorizing a program specifically provides that Federal funds made available for such program can be applied to matching or cost sharing requirements of other Federal programs; and

e. The costs are allowable and provided for in the approved budget.

7. Consultants and Contractors

Kaweah Delta's Administrative Policies, **AP.69** *Contracting with Outside Service Providers*, **AP.166**, *Competitive Bidding on Contract*s and **AP.167**, *Quote and Proposal Guidelines* should be followed related to the hiring or engagement of consultants and contractors. Further requirements must be satisfied related to Federal Awards*:*

a. Internal capabilities must be assessed related to the proposed consultant or contractor work to be performed prior to obtaining this assistance outside of Kaweah Delta. This assessment will be documented by the Grants Manager and retained in the Grant File.

b. To avoid unfair advantages, contractors who provide services to develop or draft grant applications, contract specifications, requirements, statements of work, invitations for bids and/or requests for proposal are excluded from competing for such opportunities.

c. Prior to selecting a new consultant or contractor, the Excluded Parties List System, within the System for Award Management at https://www.samlgove/portal/public/SAM should be reviewed to ensure that the party is not excluded from receiving federal funds.

8. Expenditure Analysis

Grant funding is accounted for in the District's financial records by assigning a cost center (department), called an accounting unit, to the grant to account for all incoming funding and outgoing expenditures. Monthly financial performance reports including budgeted and actual expenditures are generated that are provided to the Development Coordinator and Grant Coordinator for review. These budget monitoring processes are further outlined in Administrative Policy **AP.153** *Annual Operating and Capital Budget Development and Monitoring*. This policy requires those responsible to perform the analysis, understand reason for variance and make a plan for correction if applicable. **AP.148** *Grants* outlines this process as well.

Specific to federal grant funds, the Department Director responsible for the grant, the Grant Coordinator and the Development Coordinator monitor variances between budget estimates and actual expenditures in a separate spreadsheet in addition to departmental performance reports. These spreadsheets, that track budget, expenses and remaining balances are also submitted as support to the reimbursement package.

9. Indirect Costs

For Federal grants, the only current indirect cost rate being utilized is the fixed 8% rate allowed for training grants.
The indirect rate is applied to applicable expenditures and included in the draw down package submitted to be reimbursed. The Grants Coordinator, Development Coordinator, Department Director responsible for the Grant operation approve the package for reimbursement.
Applicable support for the indirect rate calculation is to be retained with the Grant file.

10. Credit Cards

Federal Awards will follow Kaweah Delta's Administrative Policy, **AP.46**, *Commercial Card Expense Reporting Program* which governs the controls related to District issued credit cards through the CCER program.

11. Timekeeping

Kaweah Delta's Human Resources Policy **HR. 63** *Timekeeping of Payroll Hours*, should be followed related to Timekeeping controls and practices. In addition, Federal Awards must adhere to the following practices:

a. The Grants Manager and Department Director must monitor the hours and dollars charged to the grant on a regular basis to ensure that the amounts allocated to and supported by the grant are in accordance with the federal award. This will ensure that the hours and dollars charged to the grant are based on actual recorded and approved hours and include the total activity for which employees were compensated. Salaries and wages will not be based on budget estimates, but on actual hours recorded and approved in the timekeeping system.

12. Travel

Kaweah Delta's Administrative Policies, **AP.19** *Travel, Per Diem and Other Employee Reimbursements* and **AP.84** *Mileage Reimbursement* should be followed related to travel expenses reimbursed by Federal Award dollars.

In addition, any travel related to federal awards should be budgeted and monitored and any specific restrictions of the award shall apply. There are to be no exceptions to rates published in the Federal Travel Regulations, unless otherwise justified.

13. Not applicable

14. Conflict of Interest

Administrative Policy **AP.23** *Conflict of Interest* covers certain District employees that are required to file a Statement of Economic Interest on an annual Basis. In addition, those administering Federal Grant Awards will adhere to the following conflict of Interest procedures:

Conflict of Interest: Any official action or any decision or recommendation by an individual acting in a capacity related to a grant-funded project, the effect of which would appear to or actually result in financial benefit to that individual or a member of the individual's household or a business with which the individual or a member of the individual's household is associated.

Family Member: The following relationships to an individual affiliated with a grant-funded project are defined as a family member: spouse or domestic partner, spouse's and domestic partner's parents, children, children's spouses or domestic partners, parents, parent's spouses or domestic partners, siblings, siblings spouses or domestic partners, grandparents, grandparent's spouses or domestic partners, grandchildren, grandchildren's spouses or domestic partners

Financial Interest: Anything of monetary value received or held by any member of Kaweah Delta Health Care District or Kaweah Delta Hospital Foundation or a member of his/her family, whether or not the value is readily ascertainable, including, but not limited to: salary or other payments for services (e.g., consulting fees, honoraria, or paid authorships for other than scholarly works); any equity interests (e.g., stocks, stock options, or other ownership interests); and the value of intellectual property rights and interests (e.g., patents, trademarks, service marks, and copyrights) and royalties or other income received from any such intellectual property.

Kaweah Delta Health Care District and Kaweah Delta Hospital Foundation ("The Organizations") encourage and support outside interactions of its staff with federal, state, and local governments, community organizations, non-profit groups, and business and industry as important parts of their daily work and community engagement activities. However, maintenance of the public's

trust is critical to the mission and reputation of The Organizations. As such, it is critical that all members of The Organizations demonstrate that they hold themselves to the highest ethical standards, including the disclosure of their participation in any activity that will result in financial, professional, or personal benefit and that results in, or gives the appearance of, a Conflict of Interest.

The Organization's approach to identifying, evaluating and managing potential Conflicts of Interest, does not attempt to illustrate all possible situations that require disclosure. All persons related to grant funded projects are expected to be vigilant and ethical in all dealings in order to ensure any potential conflicts are addressed quickly and appropriately.

A Conflict of Interest would arise when an employee, Board Member, agent, or any member of his or her immediate family, has a financial or other interest in or may receive a tangible personal benefit from a firm considered for a contract. The standard against which this should be measured is whether a reasonable person with knowledge of the situation would question the impartiality of those involved. As such the following are restrictions apply:

- No employee, Board Member, or agent of The Organizations may participate in the selection, award, or administration of a contract supported by a federal award if he or she has a real or apparent Conflict of Interest.
- No employee, Board Member, agent or any member of his or her immediate family may solicit or accept gratuities, favors or anything of monetary value from contractors or parties to subcontracts.

Employees are expected to comply with any applicable requirements pertaining to Conflicts of Interest in their grant funded activities.
In cases where grant funding is given to sub recipients to conduct grant activities, including sub awards under 45 CFR §75.351, the sub recipient will be required to adhere to this Conflict of Interest Policy in its entirety and this requirement will be included in any agreements or contracts. When actual or perceived conflicts of interest are identified by the sub recipient, Kaweah Delta, the grant recipient, must be notified immediately upon identification.

Those participating in grant funded activities are required to certify that they have appropriately disclosed any Conflict of Interest related to the grant, which would reasonably appear to create a conflict. This certification is required by all grant participants on the attached Conflict of Interest Disclosure Form.
The Grant Manager will report the existence of any Conflict of Interest, financial or other, to the granting agency contact prior to the expenditure of any sponsor funds, and provide assurance that the conflict has been managed, reduced or

eliminated within 30 days of discovery. If a conflict is identified after this initial report, another disclosure must be made to the Grant Manager within thirty (30) days of that identification, and such conflict must also be managed, reduced or eliminated within thirty (30) days of that identification. If required by the granting agency, a supplemental report detailing this conflict and its management will be provided.
If it is determined that a Conflict of Interest, financial or other, cannot be satisfactorily managed, the Grant Manager will notify in writing the appropriate granting agency contact.
Any disclosed grant-related Conflict of Interest, financial or other, will be reviewed promptly by the Grants Committee for a determination of whether it constitutes a Conflict of Interest. Notification will be provided to the sponsor of identified conflicts, including action taken to manage the Conflict, including the reduction or elimination of the conflict, as appropriate. This will be reported in accordance with 42 CFR § 75.112.

In addition, if it is determined that a Conflict of Interest was not identified or managed in a timely manner, a retrospective review of the activities funded by the grant will be conducted to determine if activities were impacted. This will be completed by the Grant Manager. Notification will be provided to the granting agency within 30 days of discovery, including how the conflict was managed.
The Grant Manager will administer this policy to the extent that a Conflict of Interest, financial or other, is grant- related, and maintain records of all filed disclosure forms and associated documents, including, but not limited to, documentation of actions taken by The Organizations to eliminate, reduce and/or manage Conflicts of Interest. All such records will be retained for a period of three years following completion of the grant.

Failure to comply with this policy may subject an Employee to corrective action up to and including dismissal. Violations of this policy must be reported to the Grants Manager and the Compliance and Privacy Officer.

Conflict of Interest Disclosure Form

Conflict of Interest: Any official action or any decision or recommendation by an individual acting in a capacity related to a grant-funded project, the effect of which would appear to or actually result in financial benefit to that individual or a member of the individual's household or a business with which the individual or a member of the individual's household is associated.

Family Member: The following relationships to an individual affiliated with a grant-funded project are defined as a family member: spouse or domestic partner, spouse's and domestic partner's parents, children, children's spouses or domestic partners, parents, parent's spouses or domestic partners, siblings, siblings spouses or domestic partners, grandparents, grandparent's spouses or domestic partners,

grandchildren, grandchildren's spouses or domestic partners

Financial Interest: Anything of monetary value received or held by any member of Kaweah Delta Health Care District or Kaweah Delta Hospital Foundation or a member of his/her family, whether or not the value is readily ascertainable, including, but not limited to: salary or other payments for services (e.g., consulting fees, honoraria, or paid authorships for other than scholarly works); any equity interests (e.g., stocks, stock options, or other ownership interests); and the value of intellectual property rights and interests (e.g., patents, trademarks, service marks, and copyrights) and royalties or other income received from any such intellectual property.

A potential or actual conflict of interest exists when commitments and obligations are likely to be compromised by the nominator(s)'other material interests, or relationships (especially economic), particularly if those interests or commitments are not disclosed.
This Conflict of Interest Form should indicate whether the individual participating in grant activities, funded by federal award dollars, has an economic interest in, or acts as an officer or a director of, any outside entity whose financial interests would reasonably appear to be affected by participation in grant activities. The individual participating should also disclose any personal, business, or volunteer affiliations that may give rise to a real or apparent conflict of interest. Relevant Federally and organizationally established regulations and guidelines in financial conflicts must be abided by. Conflicts should be disclosed and actions taken to manage or eliminate the real or apparent conflict.

Name: ______________________________________ Date: _________________

Position: ____

Grant/Federal Award to which this disclosure applies:
____

Please describe below any relationships, transactions, positions you hold (volunteer or otherwise), or circumstances that you believe could contribute to a conflict of interest:

_____ I have no conflict of interest to report.

_____ I have the following conflict of interest to report (please specify other nonprofit and for-profit boards you (and your spouse) sit on, any for-profit businesses for which you or an immediate family member are an officer or director, or a majority shareholder, and the name of your employer and any businesses you or a family member own:

1. ____

2. ____

3. ____

I hereby certify that the information set forth above is true and complete to the best of my knowledge.

Signature: ____

Date: ____

15. Mandatory Disclosures

Kaweah Delta will timely disclose, in writing to the granting agency, all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the award.

See **Appendix A** of this policy for other Standard Terms of the NOA that are incorporated into this policy.

Administrative Policy **AP.53** *Patients' Rights and Responsibilities, and Non-Discrimination* purpose is to comply with applicable State and Federal civil rights laws regarding non-discrimination and ensure patients' rights regardless of race,

color, national origin, age, disability, religion, or sex. The policy outlines the process to file an internal grievance and to file an external complaint. It also provides for free language services to people whose primary language is not English.

As related to Federal awards, under terms of Section 106 (g) of the Trafficking Victims Protection Act of 2000, as amended by (22 USC 7104):

Trafficking in persons.

1. As a recipient, Kaweah Delta, its employees, sub recipients of federal awards, and sub recipients' employees may not –

a. Engage in severe forms of trafficking in persons during the period of time the award is in effect;

b. Procure a commercial sex act during the period of time that the federal award is in effect; or

c. Use forced labor in the performance of the award or sub awards under the award.

Kaweah Delta will inform HRSA immediately of any information we receive from any source alleging a violation of a prohibition of 1 a, b and c above of this award term.

Kaweah Delta will include the requirements in 1 a, b and c above of this award term related to Trafficking in any sub award made to a private entity.

See **Appendix C** for full text of this award term.

16. Legislative Mandates

Kaweah Delta will adhere to all HRSA grant Legislative Mandates that could impact or limit the use of federal award dollars and include those as updates to these procedures. See **Appendix B** of this policy for the most current Grants Policy Bulletin related to Legislative Mandates.

In addition, on an annual basis, the Legislative Mandates for the coming year will be reviewed, assessed and incorporated into the policies and practices as appropriate.

17. Allowability of costs

There are two types of costs related to grants: direct cost and indirect costs. Direct costs are expenses that are specifically associated with a particular

sponsored project and can be directly assigned to such activities easily with a high degree of accuracy. Indirect costs are expenses that cannot be identified specifically with a particular project of activity. They are expenses that benefit more than one activity.

To be considered an allowable cost, the following criteria must be met:

- The cost must be reasonable. The cost is determined to be reasonable if a normal person, aware of the facts, would be willing to spend the same amount in similar circumstances.
- The cost must be allocable to the project and must benefit the grant programs or projects.
- The cost must be properly documented within the accounting system with source documentation as support.
- The costs must conform to all limitations and exclusions as set forth in the Notice of Award
- The costs must be treated consistently. A cost may not be attributed to one Federal Award as a direct cost when the same cost is attributed to another Federal Award as an indirect cost.

"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."

Proposed Strategic Plan

Fiscal Year 2023

kaweahhealth.org

FY23 Organizational Efficiency and Effectiveness

Strategic Initiative Charter: Organizational Efficiency & Effectiveness

Objective	Chair	ET Sponsor	Board Member
Increase the efficiency and the effectiveness of the organization to reduce costs, lower length of stay, and improve processes.	Kassie Waters	Jag Batth	Mike Olmos

Performance Measure	Baseline	FY23 Goal	FY24 Goal	FY25 Goal
Reduce Inpatient Observed to Expected Length of Stay	1.48	1.32	TBD	TBD
Increase Overall Operating Room Utilization	52%	63%	TBD	TBD
Establishment of an ongoing cost saving/revenue enhancement process	N/A	$2,540,000	TBD	TBD

Strategies (Tactics)	Net Annual Impact ($)*
Partner with the Chartis Group to implement new workflows, practices and patient flow processes that result in improved patient throughput and a reduction of the overall LOS.	$8,600,000
Utilize the work of the Operating Room (OR) Efficiency and the OR Governance Committees to improve OR Room Utilization and achievement of defined OR metrics.	$3,834,205
Establish a process to identify waste, revenue and cost savings opportunities across Kaweah Health.	$2,540,000
Total	$14,974,205

Strategy Summary for: Patient Throughput and Length of Stay

Strategic Initiative: Organizational Efficiency & Effectiveness

Objective

Implement patient flow processes that are effective and efficient to improve patient throughput and lower the overall Length of Stay.

Key Components

The Chartis Group has been hired to partner with Kaweah Health on various projects to redesign processes and practices to improve patient throughput and lower overall length of stay. A number of subcommittees have been established and the metrics and goals for this initiative will be aligned with those established mutually by Kaweah Health and Chartis.

Outcomes	Baseline	FY23	FY24	FY25
Reduce Inpatient Observed to Expected Length of Stay	1.48	1.32	TBD	TBD
Average Length of Stay-Emergency Department Patients-Inpatients (minutes)	720	612	TBD	TBD
Average Length of Stay-Observation Patients (hours)	42.1	37.9	TBD	TBD

Financial Impact	FY23	FY24	FY25
Capital Requirements		TBD	TBD
Revenue/Cost Savings		TBD	TBD
Expenses			
Labor		TBD	TBD
Supplies		TBD	TBD
Other		TBD	TBD
Total Costs		TBD	TBD
Contribution Margin	$8,600,000	TBD	TBD

Individual/Department Responsible for Execution

Jag Batth, Keri Noeske, Kassie Waters, Rebekah Foster

Strategy Summary for: Operating Room Efficiency/Capacity

Strategic Initiative: Organizational Efficiency & Effectiveness

Objective

Improve Operating Room Efficiency, Capacity and Utilization to meet surgery volume needs.

Key Components

- Increase OR capacity with focused efforts on increasing Overall OR Utilization
- Work with OR governance committee to reallocate block times to increase utilization and to provide more surgeons with necessary block time
- Work with physicians to improve the percentage of on-time start times for the first OR cases of the day; increase physician accountability
- Process improvement projects to reduce physician wait times between cases

Outcomes	Baseline	FY23	FY24	FY25
Improve Overall OR Utilization	52%	63%	TBD	TBD
Improve OR Block Utilization	44%	55%	TBD	TBD
Reduction in daily average first case delay minutes	35.11/day	Reduce by 10 minutes per day beginning 1/1/23	TBD	TBD
Reduce Physician wait time between cases defined as surgery stop time in previous case to start time of the next case	76.4 minutes	73 minutes	TBD	TBD

Financial Impact	FY23	FY24	FY25
Capital Requirements	$0	TBD	TBD
Revenue/Cost Savings	$3,900,000 (additional CM)	TBD	TBD
Expenses			
Labor	In Process	TBD	TBD
Supplies	In Process	TBD	TBD
Tagnos-Subscription	$65,795	TBD	TBD
Total Costs	In Process	TBD	TBD
Contribution Margin	$3,834,205	TBD	TBD

Individual/Department Responsible for Execution

Jag Batth, Brian Piearcy, Amanda Tercero, OR Efficiency and OR Governance

Strategy Summary for: Supply Management and Standardization

Strategic Initiative: Organizational Efficiency & Effectiveness

Objective

Establish a process to identify revenue and cost savings opportunities across Kaweah Health.

Key Components

- Review the Supply and Implant costs and contracts to identify potential savings
- Review purchased services across the organization to identify opportunities to consolidate vendors and improve pricing
- Establish an ongoing cost saving/revenue enhancement process

Outcomes	Baseline	FY23	FY24	FY25
Completion of focused purchased services review (IT, Facilities, and Clinical Engineering)	None	$600,000	TBD	TBD
Established and implement a process to identify cost savings/revenue opportunities across the organization	None	$2,000,000	TBD	TBD

Financial Impact	FY23	FY24	FY25
Capital Requirements	$0	TBD	TBD
Revenue/Cost Savings	$2,600,000	TBD	TBD
Expenses			
Labor	$0	TBD	TBD
Supplies	$0	TBD	TBD
Other-Vendor contract review	$40,000	TBD	TBD
Total Costs	$0	TBD	TBD
Contribution Margin	$2,560,000	TBD	TBD

Individual/Department Responsible for Execution

Steve Bajari, Jennifer Stockton, Materials Management

FY23 Outstanding Health Outcomes

Strategic Initiative Charter: Outstanding Health Outcomes

Objective	Chair	ET Sponsor	Board Member
To consistently deliver high quality care across the health care continuum	Sonia Duran-Aguilar	Doug Leeper	Dave Francis

Performance Measure	Baseline	FY23 Goal	FY24 Goal	FY25 Goal
Standardized Infection Ratio (SIR) CAUTI, CLABSI, MRSA (CMS Data)	CAUTI 0.84 CLABSI 1.33 MRSA 2.53	TBD	TBD	TBD
Percent Sepsis Bundle Compliance (SEP-1) (CMS Data)	75% (July-Dec2020)	TBD	TBD	TBD
Hospital Readmissions (%)	(FY2019) AMI – 12.34 COPD – 16.09 HF – 18.22 PN Viral/Bacterial – 14.13	TBD	TBD	TBD
Decrease Mortality Observed/Expected Rates	AMI - 0.75 COPD – 2.40 HF – 1.78 PN Bacterial – 1.85 PN Viral – 1.34	TBD	TBD	TBD
Team Round Implementation	Rolled out to Hospitalist patients only in Med Surge units.	Roll out to Primary Care physician groups and Acute Care Trauma and Surgical Services (ACTSS) on med surge units.	Roll out into the critical care spaces. Achieve 80% Adherence for all units and participating physician groups.	TBD

Strategic Initiative Charter: Outstanding Health Outcomes

Objective	Chair	ET Sponsor	Board Member
To consistently deliver high quality care across the health care continuum	Sonia Duran-Aguilar	Doug Leeper	Dave Francis

Performance Measure	Baseline	FY23 Goal	FY24 Goal	FY25 Goal
Meet QIP measure performance	N/A (Available end of FY22)	100% (20 of 20 measures)	100% (20 of 20 measures)	100% (20 of 20 measures)
Humana % PAF Completion/ HCC reassessment in RHCs, SHWC and KHMG	80.4%	≥80%	≥85%	≥85%
Medicare Advantage STAR Rating for Humana lives	4.0	4.0	4.0	4.0
Improve Time to Target	N/A	Establish baseline data	TBD	TBD
Reduce Hypoglycemic events	N/A	Establish baseline data	TBD	TBD

Strategic Initiative Charter: Outstanding Health Outcomes

Objective	Chair	ET Sponsor	Board Member
To consistently deliver high quality care across the health care continuum	Sonia Duran-Aguilar	Doug Leeper	Dave Francis

Strategies (Tactics)	Net Annual Impact ($)*
Standardized Infection Ratio (SIR) CAUTI, CLABSI, MRSA: • CAUTI, CLABSI/MRSA Quality Focus Teams • Daily catheter and central line Gemba rounds • Enhanced daily huddles, education/awareness, culture of culturing • TPN Utilization, Bio-Vigil, MRSA Decolonization	2% Medicare reimbursement per beneficiary (star rating); CMS HAC & VBP Program penalties
Sepsis Bundle Compliance (SEP-1) • SEPSIS Coordinators • SEPSIS Alerts-Required MD notifications • Quality Focus Team-RCAs/Fall out review	Reduction to length of stay
Mortality/Readmissions • Enhanced diagnosis specific workgroups/committees • Standardized care based on evidence • Expand palliative medicine	Readmission Reduction Program & VBP
Team Round Implementation • Multidisciplinary rounding • Develop as a Quality Improvement project to measure metrics for the unit including patient satisfaction, length of stay, adverse events, etc. • Develop brief documentation of the daily event • Identify expansion plan to more patient care units and physician groups	Reduction to length of stay Improve patient care and experience

Strategic Initiative Charter: Outstanding Health Outcomes

Objective	Chair	ET Sponsor	Board Member
To consistently deliver high quality care across the health care continuum	Sonia Duran-Aguilar	Doug Leeper	Dave Francis

Strategies (Tactics)	Net Annual Impact ($)*
QIP • Create Population Health Quality Data Coder Team • 2 Net New FTE (3 requested, 2 approved) • Identify Key Stakeholders for Quality Improvement Documentation & Coding Workgroup • Prioritize QDCs required for 20 QIP measures • Collaborate with CDI and HIM • Completion of HealtheAnalytics Fall Out Worklists for 20 QIP Measures • Development of HealtheAnalytics Performance Dashboards	$8,775,108
Humana Medicare Advantage (MA) CMS Start Score • Complete Annual Practitioner Assessment Form (PAF) • Close identified quality and HCC gaps	TBD
Diabetes Management • Review IP Diabetes Management data (AMION) • Monitor ongoing LOS data to explore potential impact of IP DM Management team on DM LOS	TBD

Strategy Summary for: Standardized Infection Ratio (SIR)

Strategic Initiative: Outstanding Health Outcomes

Objective

Over the next 3 years, achieve an “A” Leapfrog Safety Score and a CMS 5 Star Rating through the consistent application of best practices and innovative strategies.

Key Components

- CAUTI, CLABSI/MRSA Quality Focus Teams
- Daily catheter and central line Gemba rounds
- Enhanced daily huddles, education/awareness, culture of culturing
- TPN Utilization
- Bio-Vigil
- MRSA Decolonization

Outcomes	Baseline	FY23	FY24	FY25
Standardized Infection Ratio (SIR) CAUTI, CLABSI, MRSA (CMS data) [1]	CAUTI 0.84 CLABSI 1.33 MRSA 2.53	TBD	TBD	TBD

[1] CMS updated the new Value-Based Purchasing benchmarks in April 2021.
[2] Over $1M opportunity in quality adjustments. Tracked by finance.

Financial Impact	FY2023	FY2024	FY2025
Estimated Cost Avoidance	TBD	TBD	TBD
Revenue (VBP/HAC Penalty) [2]	Impacted by FY21 Performance	TBD	TBD
Expenses			
Labor	$0	$0	$0
Supplies	$0	$0	$0
Other	$0	$0	$0
Net Annual Impact	TBD	TBD	TBD

Individual/Department Responsible for Execution

Sandy Volchko, Shawn Elkin, Kari Knudsen, Amy Baker, Dr. T Gray

Strategy Summary for: Sepsis Bundle Compliance (SEP-1)

Strategic Initiative: Outstanding Health Outcomes

Objective

Over the next 3 years, achieve an "A" Leapfrog Safety Score and a CMS 5 Star Rating through the consistent application of best practices and innovative strategies

Key Components

- SEPSIS Coordinators
- SEPSIS Alerts-Required MD notifications
- Quality Focus Team-RCAs/Fall out review

Outcomes	Baseline	FY23	FY24	FY25
Sepsis Bundle Compliance (SEP-1) %	75% (July-Dec2020)	TBD	TBD	TBD

Financial Impact	FY2023	FY2024	FY2025
Capital Requirements	$0	$0	$0
Revenue (VBP)	TBD	TBD	TBD
Expenses			
Labor	$0	$0	$0
Supplies	$0	$0	$0
Other	TBD	TBD	TBD
Net Annual Impact	TBD	TBD	TBD

Individual/Department Responsible for Execution

Sandy Volchko, Dr. Thomas Gray, Ryan Smith, Jared Cauthen

Strategy Summary for: Mortality and Readmissions

Strategic Initiative: Outstanding Health Outcomes

Objective

Over the next 3 years, achieve an "A" Leapfrog Safety Score and a CMS 5 Star Rating through the consistent application of best practices and innovative strategies

Key Components

- Enhanced diagnosis specific workgroups/committees
- Standardized care based on evidence
- Expand palliative medicine

Outcomes	Baseline	FY23	FY24	FY25
Hospital Readmissions % (CMS data)	(FY2019) AMI – 12.34 COPD – 16.09 HF – 18.22 PN Viral/Bacterial – 14.13	TBD	TBD	TBD
Decrease Mortality Rates	AMI - 0.75 COPD – 2.40 HF – 1.78 PN Bacterial – 1.85 PN Viral – 1.34	TBD	TBD	TBD

Financial Impact	FY2023	FY2024	FY2025
Capital Requirements	$0	$0	$0
Revenue (VBP)	TBD	TBD	TBD
Expenses			
Labor	$0	$0	$0
Supplies	$0	$0	$0
Other (Penalty)	Pending Info	Pending Info	Pending Info
Net Annual Impact	TBD	TBD	TBD

Individual/Department Responsible for Execution

Dr. M. Tedaldi, Dr. Thomas Gray, Sandy Volchko, Emma Mozier, Molly Niederreiter, Wendy Jones, Christine Aleman

Strategy Summary for: Team Round Implementation

Strategic Initiative: Outstanding Health Outcomes

Objective

Enhance coordination of care and culture among the health care team

Key Components

- Multidisciplinary rounding
  - Use of “Team Rounds Checklist”
- Explore the opportunity to develop as a Quality Improvement project to measure metrics for the unit including patient satisfaction, length of stay, adverse events, etc.
- Develop brief documentation of the daily event
- Identify expansion plan to more patient care units and physician groups

Outcomes	Baseline	FY23	FY24	FY25
Team Round Implementation	Rolled out to Hospitalist patients only in Med Surge units.	Roll out to Primary Care physician groups and Acute Care Trauma and Surgical Services (ACTSS) on med surge units.	Roll out into the critical care spaces. Achieve 80% Adherence for all units and participating physician groups.	TBD

Financial Impact	FY2023	FY2024	FY2025
Cost Avoidance/Savings	$0	TBD	TBD
Revenue	$0	$0	$0
Expenses			
Labor	$0	$0	$0
Supplies	$0	$0	$0
Other	$0	$0	$0
Net Annual Impact	$0	TBD	TBD

Individual/Department Responsible for Execution

Dr. Lori Winston, Shawn Elkin, Keri Noeske, Sandy Volchko, Rebekah Foster, Dr. Onsy Said, Dr. Mario Martinez, Emma Mozier

Strategy Summary for: Quality Improvement Program (QIP) Reporting

Strategic Initiative: Outstanding Health Outcomes

Objective

Develop a comprehensive strategy to improve capture of quality data codes and improve QIP performance.

Key Components

- Create Population Health Quality Data Coder Team
  - 2 Net New FTE (3 requested, 2 approved)
- Identify Key Stakeholders for Quality Improvement Documentation & Coding Workgroup
- Prioritize QDCs required for 20 QIP measures
- Collaborate with CDI to educate MD/APP re: documentation requirements
- Collaborate with HIM, Revenue Integrity, ISS to increase QDC capture
- Completion of HealtheAnalytics Fall Out Worklists for 20 QIP Measures
- Development of HealtheAnalytics Performance Dashboards

Outcomes	Baseline	FY23	FY24	FY25
Meet QIP measure performance	30% (6 of 20) (Available end of FY22)	100% (20 of 20 measures)	100% (20 of 20 measures)	100% (20 of 20 measures)

Financial Impact	FY2023	FY2024	FY2025
Cost Avoidance/Savings	TBD	TBD	TBD
Revenue	$8,911,042	$10,801,263	$10,801,263
Expenses			
Labor	($135,934)	($4,078)	($4,200)
Supplies	$0	$0	$0
Other	$0	$0	$0
Net Annual Impact	$8,775,108	$10,797,185	$10,797,063

Individual/Department Responsible for Execution

Ryan Gates, Sonia Duran-Aguilar, ISS, HIM, Compliance, Clinical Education, Revenue Integrity, Population Health

Strategy Summary for: HUMANA Medicare Advantage (MA)

Strategic Initiative: Outstanding Health Outcomes

Objective

Maintain a 4 STAR Medicare Advantage Rating and $\geq$ 80% HCC reassessment/PAF visit completion rate for HUMANA MA Lives assigned to Kaweah Health Rural Health Clinics, SHWC and KHMG

Key Components:

Improve annual assessment of Hierarchical Chronic Conditions (HCCs) and closing quality gaps through:

- Completion of Provider Assessment Forms (PAFs) via dedicated MA & NP teams
- Integration of Juxly Vault software and Population Health Navigators at KHMG
- Clinical Review by Gaps In Care team and data upload into Cozeva Population Health Platform
- Proactive patient outreach via Well App
- Increased enrollment of high-risk members into comprehensive care clinic and co-management programs at KHMG

Outcomes	Baseline[2]	FY23	FY24	FY25
Humana % PAF Completion/ HCC reassessment in RHCs, SHWC and KHMG	80.4%[1]	$\geq$80%	$\geq$85%	$\geq$85%
Medicare Advantage STAR Rating for Humana lives [1]	4.0	4.0	4.0	4.0

[1] Quarterly estimates will be provided via Cozeva Platform
[2] As of 4/26/2022 (n=1,398 lives at RHCs and SHWC; n=2,368 lives at KHMG)

Financial Impact	FY2023	FY2024	FY2025
Cost Avoidance/Savings	$0	$0	$0
Revenue	TBD	TBD	TBD
Expenses	$0	$0	$0
Labor	$0	$0	$0
Supplies	$0	$0	$0
Other	$0	$0	$0
Net Annual Impact	TBD	TBD	TBD

Individual/Department Responsible for Execution

Ryan Gates, Sonia Duran-Aguilar, Crystal Ortiz, Ivan Jara, Jacob Kennedy, Mary Jo Dyck

Strategy Summary for: Diabetes Management

Strategic Initiative: Outstanding Health Outcomes

Objective

Optimize inpatient glycemic management

Key Components

- Review IP Diabetes Management data (AMION)
  - Discuss/explore financial impact of IP Diabetes Management Team
  - Evaluate the addition of 3 FTEs to develop an inpatient Diabetes Management team: Clinical Nurse Specialist, Nurse Practitioner, Certified Diabetes Educator
- Identify IP metrics
- Identify benchmarks for Time to Target
- Identify benchmarks Hypoglycemic Events
- Monitor ongoing LOS data to explore potential impact of IP DM Management team on DM LOS

Outcomes	Baseline	FY23	FY24	FY25
Improve Time to Target	N/A	Establish baseline data	TBD	TBD
Reduce Hypoglycemic events	N/A	Establish baseline data	TBD	TBD
Validate cost savings	N/A	N/A	N/A	N/A
Identify key responsibilities of DM team	N/A	N/A	N/A	N/A

Financial Impact	FY2023	FY2024	FY2025
Cost Avoidance/Savings	TBD	TBD	TBD
Revenue	$0	$0	$0
Expenses			
Labor	$0	$0	$0
Supplies	$0	$0	$0
Other	$0	$0	$0
Net Annual Impact	TBD	TBD	TBD

Individual/Department Responsible for Execution

Emma Camarena, Cody Ericson NP, Dr. Thomas Gray, Keri Noeske

FY23 Patient and Community Experience

Strategic Initiative Charter: Patient and Community Experience

Objective	Chair	ET Sponsor	Board Member
Develop and implement strategies that provide our health care team the tools they need to deliver a world-class health care experience.	Ed Largoza	Keri Noeske	Dave Francis

Performance Measure	Baseline	FY23 Goal	FY24 Goal	FY25 Goal
Achieve Overall Rating Goal on HCAHPS Survey	71.3%	76.5%	TBD	TBD
Achieve Patient Feedback Score Goal on ED Survey	3.6	4.0	TBD	TBD
Achieve the 50th percentile on physician communication scores	76.8%	80%, 50th Percentile	TBD	TBD
Achieve the 50th percentile on nursing communication scores	76.9%	79%, 50th Percentile	TBD	TBD
System enhancements	N/A	Implement Well Health	Implement Patient Education Platform	TBD
Decrease lost belongings by 25%	7/21 to 4/22 - 93	75	TBD	TBD

[1] The Press Ganey Patient Feedback Score (PFS) is now being used to assess satisfaction for all ED patients. The scale is 0-5. A good performance score is considered to be 3.7 or better.

Strategic Initiative Charter: Patient and Community Experience

Objective	Chair	ET Sponsor	Board Member
Develop and implement strategies that provide our health care team the tools they need to deliver a world-class health care experience.	Ed Largoza	Keri Noeske	Dave Francis

Strategies (Tactics)	Net Annual Impact ($)
World-Class Service • Provide trainings & tools to team members on how to deliver world-class service. • Enhance patient navigation across the health care continuum. • Relaunch a Patient & Family Advisory Council.	TBD – Impacted by Performance
Physician Communication • Implement Patient Experience Simulation course to enhance provider communication • Provide training on enhancing provider communication with patients • Give direct coaching for providers performing under expectations in doctor communication. • Pilot 'Sit for a bit' program to encourage providers to get eye-level with patients and establish a positive rapport.	TBD – Impacted by LOS
Nursing Communication • Develop an expectation for use of best practices • Enhance Leader Rounding on Patients • Hardwire Use of Communication Whiteboards • Review and planning for development of communications skills to include narrating the care, handling conflicts and consistency in communications • Bedside Rounds – Health Care Team • Employee Rounds – 1:1 Leader with Employee • Role Specific Training – Back to Basics	TBD – Impacted by LOS/VBP
Enhancements of Systems and Environment • EMR/Technology enhancements • Improve internal & external wayfinding • Improve environment • Continue to adjust the management of belongings to further reduce the volume of lost items	TBD

Strategy Summary for: World-Class Service

Strategic Initiative: Patient and Community Experience

Objective

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

Key Components

- Provide trainings & tools to team members on how to deliver world-class service.
  - Roll out World-Class Vision and Kaweah Care Service Standards
- Enhance patient navigation across the health care continuum.
- Relaunch a Patient & Family Advisory Council.

Outcomes	Baseline	FY23	FY24	FY25
Achieve Overall Rating Goal on HCAHPS Survey	71.3%	76.5%	TBD	TBD
Achieve Patient Feedback Score Goal on ED Survey[1]	3.6	4.0	TBD	TBD

[1] The Press Ganey Patient Feedback Score (PFS) is now being used to assess satisfaction for all ED patients. The scale is 0-5. A good performance score is considered to be 3.7 or better.

Financial Impact	FY2023	FY2024	FY2025
Cost Avoidance	$0	TBD	TBD
Revenue (HCAHPS)	$0	TBD	TBD
Expenses			
Labor	$0	TBD	TBD
Supplies	$0	TBD	TBD
Other	$0	TBD	TBD
Total Costs	$0	TBD	TBD
Net Annual Impact	$0	TBD	TBD

Individual/Department Responsible for Execution

Executive Team, Dave Francis, Dr. Seng, Dr. Manga, Raleen Larez, Deb Volosin, Jacob Kennedy and Ed Largoza

Strategy Summary for: Physician Communication

Strategic Initiative: Patient and Community Experience

Objective

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

Key Components

- Implement Patient Experience Scripting course to enhance provider communication
- Provide training on enhancing provider communication with patients
- Give direct coaching for providers performing under expectations in doctor communication.
- Pilot 'Sit for a bit' program to encourage providers to get eye-level with patients and establish a positive rapport.

Outcomes	Baseline	FY23	FY24	FY25
Achieve the 50th percentile on physician communication scores	76.8%	80%, 50th Percentile	TBD	TBD

Financial Impact	FY2023	FY2024	FY2025
Cost Avoidance	LOS/Quality Improvements	LOS/Quality Improvements	LOS/Quality Improvements
Revenue	VBP	VBP	VBP
Expenses			
Labor	$0	$0	$0
Supplies	$0	$0	$0
Other	$0	$0	$0
Total Costs	$0	$0	$0
Net Annual Impact	TBD	TBD	TBD

Individual/Department Responsible for Execution

Dr. Carstens, Teresa Boyce, Dianne Cox, Dr. Manga, Keri Noeske, Dr. Winston, Dr. Said, Dr. Patel, and Ed Largoza

Strategy Summary for: Nursing Communication

Strategic Initiative: Patient and Community Experience

Objective

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

Key Components

- Develop an expectation for use of best practices
  - Trending department-level data
  - Use NRC resources to identify best practices
  - Use the unit-based council structure to implement changes
- Enhance Leader Rounding on Patients
- Continue Use of Communication Whiteboards
- Review and planning for development of communications skills to include narrating the care, handling conflicts and consistency in communications
- Bedside Rounds – Health Care Team
- Employee Rounds – 1:1 Leader with Employee
- Role Specific Training – Back to Basics

Financial Impact	FY2023	FY2024	FY2025
Cost Avoidance	$0	$0	$0
Revenue	VBP	VBP	VBP
Expenses			
Labor	$0	$0	$0
Supplies	$0	$0	$0
Other	$0	$0	$0
Total Costs	$0	$0	$0
Net Annual Impact	TBD	TBD	TBD

Outcomes	Baseline	FY23	FY24	FY25
Achieve the 50th percentile on nursing communication scores	76.9%	79%, 50th Percentile	TBD	TBD

Individual/Department Responsible for Execution

Keri Noeske, Emma Mozier, Kassie Waters, Shannon Cauthen, Kari Knudsen, Amy Baker, Rebekah Piche, Hannah Mitchell, Jag Batth, Michelle Peterson, and Ed Largoza

Strategy Summary for: Enhancement of Systems and Environment

Strategic Initiative: Patient and Community Experience

Objective

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

Key Components

- **EMR/Technology enhancements**
  - Launch texting communication with patients related to appointments
  - Hold stakeholder demos (patient portal & patient education videos)
  - Select, implement and educate on technology enhancements
- **Improve internal & external wayfinding**
  - Complete internal wayfinding/branding signage at downtown campus
  - Provide color/number coding to parking areas for improved external wayfinding
  - Assess KHMG, West Campus, & South Campus for wayfinding opportunities
- **Improve environment**
  - Update older areas of the organization
  - Add trash receptacles to support a clean environment
  - Consider new internal wall paint color within the downtown campus
  - Create a 'Comfort cart'
- **Continue to adjust the management of belongings to further reduce the volume of lost items**

Outcomes	Baseline	FY23	FY24	FY25
Implementation of New Systems	N/A	Implement Well Health	Implement Patient Education Platform	TBD
Decrease lost belongings by 25%	7/21 to 4/22 - 93	75	TBD	TBD

Financial Impact	FY2023	FY2024	FY2025
Capital Request	$0	$0	$0
Revenue	$0	$0	$0
Expenses			
Labor	2.5 Navigators x 2080 x $20/hr = ($104,000)	$0	$0
Supplies		$0	$0
Other	$0	$0	$0
Cost Avoidance	$0	$0	$0
Net Annual Impact	($104,000)	$0	$0

Individual/Department Responsible for Execution

Luke Schneider, Tendai Zinyemba, Alicia Rodriguez, Kevin Morrison, Ed Largoza

FY23 Empower Through Education

Strategic Initiative Charter: Empower Through Education

Objective	ET Sponsor	Leader	Board Member
Implement initiatives to develop the healthcare team and attract and retain the very best talent in support of our mission.	Dr. Winston	Lacey Jensen	Ambar Rodriguez

Performance Measure	Baseline	FY23 Goal	FY24 Goal	FY25 Goal
Faculty Development Compliance	60%	80%	85%	90%
Interdisciplinary Educational Opportunities	0 Departments	2 Departments	3 Departments	3 Departments
Quarterly Schwartz Rounds	0	4	4	4
Launch Just Culture Certificate Program	Development	Launch	Ongoing	Ongoing
Medical Staff Leadership Training (GOLD)	None	Implementation	Ongoing	Ongoing
Mentorship Program	Started for Leaders	Expand to Staff	Ongoing	Ongoing
Succession Planning Program	None	N/A	Framework/Pilot	Go Live
Increase Nursing Cohorts by 2	1	3	5	4
Expand SNA Seats	TBD	TBD	TBD	TBD
Present Neurology Plan for Approval	Prepare pro forma	Board Approval		
Funded Resident Slots	129	133	TBD	TBD

Strategies (Tactics)	Net Annual Impact ($)*
Expand Educational Opportunities	*($177,535.40) - $25k for Director of Sim Lab (unbudgeted), remainder for Lippincott (budgeted)
Interdisciplinary Educational Opportunities	Included in education hours
Mentorship Program	Included in exempt hours
Succession Planning Program	Included in exempt hours
Funded Resident Slots	Annual impact to be determined upon completion of pro forma

Strategy Summary for: Expand Educational Offerings

Strategic Initiative: Empower Through Education

Objective

Increase the expectations and participation of educational opportunities. Improve quality metrics through interdisciplinary educational opportunities.

Key Components

- Achievement of faculty development for compliance with ACGME-Slack
- Interdisciplinary educational opportunities (L&D, PeriOp)
- Lippincott solutions implemented and adopted

Outcomes	Baseline	FY23	FY24
Faculty Development Compliance	60%	80%	85%
Interdisciplinary educational opportunities	0 Departments	2 Departments	3 Departments

Financial Impact	FY23	FY24	FY25
Capital Requirements	0	0	0
Revenue	0	0	0
Expenses			
Labor	**$25,000	0	0
Supplies	0	0	0
Other	*$152,535.40	$158,331.75	$164,348.35
Total Costs	*$152,535.40	$158,331.75	$164,348.35
Contribution Margin	*($177,535.40)	($158,331.75)	($164,348.35)

*Costs for Lippincott included in FY23 budget

**Budgeted cost for Director of Sim Lab

Individual/Department Responsible for Execution

Faculty Development Subcommittee, Dr. Sokol, Lacey Jensen

Strategy Summary for: Improve Resiliency of the Kaweah Health Team

Strategic Initiative: Empower Through Education

Objective

Increase caregiver emotional support and promote wellness.

Key Components

- Quarterly Schwartz Rounds
- Identify Measurements for success/identify metrics that demonstrate the effectiveness of Schwartz Rounds

Financial Impact	FY23	FY24	FY25
Capital Requirements	0	TBD	TBD
Revenue	0	TBD	TBD
Expenses			
Labor	0	TBD	TBD
Supplies	0	TBD	TBD
Other	0	TBD	TBD
Total Costs	0	TBD	TBD
Contribution Margin	0	TBD	TBD

Number are included in budget for GME

Outcomes	Baseline	FY23	FY24	FY25
Quarterly Schwartz Rounds	0	4	4	4

Individual/Department Responsible for Execution

Schwartz Rounds Committee, Wellness Subcommittee of GMEC

Strategy Summary for: Increase and Improve Leadership Education

Strategic Initiative: Empower Through Education

Objective

To increase the effectiveness of leadership, Kaweah Health will increase the number of mandatory and non-mandatory trainings, programs, and classes for leaders.

Key Components

- Charge nurse development program
- KH version of LEAD Academy
- DMAIC Trainings
- Executive Leadership Education
- Launch Just Culture Certificate Program
- 9 month Leadership Development program using computer-based learning
- Guided Organizational Leadership Development (GOLD) Medical Staff Leadership Training

Outcomes	Baseline	FY23	FY24
Continue DMAIC trainings	Ongoing	Ongoing	Ongoing
Launch Just Culture Certificate Program	Development	Launch	Ongoing
Medical Staff Leadership Training (GOLD)	Development	Launch	Ongoing

Financial Impact	FY23	FY24	FY25
Capital Requirements	0	TBD	TBD
Revenue	0	TBD	TBD
Expenses			
Labor	0	TBD	TBD
Supplies	0	TBD	TBD
Other	0	TBD	TBD
Total Costs	0	TBD	TBD
Contribution Margin	0	TBD	TBD

Individual/Department Responsible for Execution

Organizational Development, Dr. Seng, Quality, Dianne Cox

Strategy Summary for: Mentorship and Succession Planning

Strategic Initiative: Empower Through Education

Objective

Develop consistent and sustainable succession planning and mentorship programs throughout Kaweah Health.
Improve employee satisfaction through career ladder development.

Key Components

- Develop and deploy Kaweah Health mentorship program
- Develop Kaweah Health succession planning pilot program

Outcomes	Baseline	FY23	FY24	FY25
Mentorship Program	Started for Leaders	Expand to Staff	Ongoing	Ongoing
Succession Program	None	N/A	Pilot	Implement

Financial Impact	FY23	FY24	FY25
Capital Requirements	0	TBD	TBD
Revenue	0	TBD	TBD
Expenses			
Labor	0	TBD	TBD
Supplies	0	TBD	TBD
Other	0	TBD	TBD
Total Costs	0	TBD	TBD
Contribution Margin	0	TBD	TBD

Individual/Department Responsible for Execution

Dianne Cox, Hannah Mitchell, Succession Planning Subcommittee

Strategy Summary for: Increase Nursing Cohort Seats

Strategic Initiative: Empower Through Education

Objective

Kaweah Health has grown larger and faster than the local educational organizations. More opportunities, need expansion starting with RN seats in our local schools.

Key Components

- Two cohorts up to 25 in each
- Expand SNA/SNI seats by working with South Valley Schools

Outcomes	Baseline	FY23	FY24	FY25
2 Cohorts	1	3	5	4
Expand SNI seats	TBD	TBD	TBD	TBD

Financial Impact	FY23	FY24	FY25
Capital Requirements	0	TBD	TBD
Revenue	0	TBD	TBD
Expenses			
Labor	0	TBD	TBD
Supplies	0	TBD	TBD
Other	0	TBD	TBD
Total Costs	0	TBD	TBD
Contribution Margin	0	TBD	TBD

Individual/Department Responsible for Execution

Human Resources

Strategy Summary for: Expand GME

Strategic Initiative: Empower Through Education

Objective

Take advantage of available resources to allow for growth. Partner with Sierra View to expand GME services.

Key Components

- Determine feasibility of neurology residency
- Leverage JPA
- Pursue additional CMS resident slot funding

Outcomes	Baseline	FY23
Present Neurology plan for approval	Prepare pro forma	Board Approval
Funded resident slots	129	133

Financial Impact	FY23	FY24	FY25
Projected Labor Value	0	TBD	TBD
Revenue	0	TBD	TBD
Expenses			
Labor	0	TBD	TBD
Supplies	0	TBD	TBD
Other	0	TBD	TBD
Total Costs	0	TBD	TBD
Contribution Margin	0	TBD	TBD

Individual/Department Responsible for Execution

GME

FY23 Ideal Work Environment

Strategic Initiative Summary: Ideal Work Environment

Objective	ET Sponsor	Leader	Board Member
Foster and support healthy and desirable working environments for our Kaweah Health Teams	Dianne Cox	Raleen Larez	Lynn Havard Mirviss

Performance Measure	Baseline	FY23 Goal	FY24 Goal	FY25 Goal
Decrease overall turnover rate	20%	17%	15%	13%
Decrease nursing turnover rate	28%	25%	22%	19%
Decrease new hire turnover rate	25%	15%	12%	9%
EE/PE/Resident Survey – Different units/departments work well together	3.64	3.66	3.68	3.70
Expand Volunteer Programs	178	250	300	350

Strategies (Tactics)	Net Annual Impact ($)*
Decrease new hire/nursing/overall turnover	Approx. $500,000 savings for FY23 if goal is met
The Kaweah Health Team works well together	Labor to develop and deploy pulse survey, analyze results, then create action plan included in exempt hours
Expand volunteer programs	Volunteer equivalent of labor expectation is $3,500,000
TBD	n/a
TBD	n/a

Strategy Summary for: Employee Retention

Strategic Initiative: Ideal Work Environment

Objective

Kaweah Health is facing the same challenges as many employers in the labor market and must make retention a top priority.

Key Components

- Lifecycle surveys
- VPs sending anniversary cards
- Sign-on bonuses
- Cascading information
- On time performance evaluations
- Just Culture Champions
- Service standards and World Class definition
- Recommendations for Leadership Committee

Outcomes	Baseline	FY23	FY24	FY25
Decrease overall KH turnover rate	20%	17%	15%	13%
Decrease nursing turnover rate	28%	25%	22%	19%
Decrease new hire turnover rate	25%	15%	12%	9%

Financial Impact	FY23	FY24	FY25
Capital Requirements	0	0	0
Revenue	0	0	0
Expenses			
Reduce Overall Turnover	$650,000	$425,000	$425,000
Reduce Nursing Turnover	$600,000	$600,000	$600,000
Sign on Bonus	($750,000)	($750,000)	($750,000)
Contribution Margin	$500,000	$275,000	$275,000

Individual/Department Responsible for Execution

Human Resources

Strategy Summary for: Kaweah Health Team Works Well Together

Strategic Initiative: Ideal Work Environment

Objective

There is a need to continue to align the efforts of all Kaweah Health teams to ensure world class service.

Key Components

- Engage focus groups
- Lifecycle survey
- Employee Relations classes

Outcomes	Baseline	FY23	FY24	FY25
EE Survey – Different units/departments work well together	3.57	3.59	3.61	3.63
EE Survey – Communication between units/departments is effective	3.64	3.66	3.68	3.70
EE – The physicians at this organization respect the clinical staff's knowledge and abilities	3.73	3.75	3.77	3.79
EE – Physicians and staff work well together	3.71	3.73	3.75	3.77
PE – Different departments work well together at Kaweah Health	3.93	3.95	3.97	3.99

Financial Impact	FY23	FY24	FY25
Capital Requirements	0	TBD	TBD
Revenue	0	TBD	TBD
Expenses			
Labor	0	TBD	TBD
Supplies	0	TBD	TBD
Other	0	TBD	TBD
Total Costs	0	TBD	TBD
Contribution Margin	0	TBD	TBD

Individual/Department Responsible for Execution

Human Resources

Strategy Summary for: Expand Volunteer Programs

Strategic Initiative: Ideal Work Environment

Objective

Volunteer engagement has declined with the pandemic. Kaweah Health relies on a strong volunteer program to continue to spark career path engagement and to provide world class service.

Key Components

- Increase student and adult volunteers at KH

Outcomes	Baseline	FY23	FY24	FY25
Active Volunteers	178	250	300	350

Financial Impact	FY23	FY24	FY25
Capital Requirements	0	TBD	TBD
Revenue	0	TBD	TBD
Expenses			
Labor	*$3,500,000	TBD	TBD
Supplies	0	TBD	TBD
Other	0	TBD	TBD
Total Costs	0	TBD	TBD
Contribution Margin	*$3,500,000	TBD	TBD

* Volunteer equivalent of labor

Individual/Department Responsible for Execution

Kent Mishler, Kelly Pierce

Strategy Summary for: TBD

Strategic Initiative: Ideal Work Environment

Objective

Pending evaluation Lifecycyle Work Environment Survey

Key Components

Outcomes	Baseline	FY22	FY23	FY24

Financial Impact	FY22	FY23	FY24
Capital Requirements	TBD	TBD	TBD
Revenue	TBD	TBD	TBD
Expenses			
Labor	TBD	TBD	TBD
Supplies	TBD	TBD	TBD
Other	TBD	TBD	TBD
Total Costs	TBD	TBD	TBD
Contribution Margin	TBD	TBD	TBD

Individual/Department Responsible for Execution

Strategic Growth and Innovation

Strategic Initiative Charter: Strategic Growth and Innovation

Objective	ET Sponsor	Leader	Board Member
Grow intelligently by expanding existing services, adding new services, and serving new communities. Find new ways to do things to **improve efficiency and effectiveness**.	Marc Mertz	Ivan Jara	Garth Gipson

Performance Measure	Baseline	FY23 Goal	FY24 Goal	FY25 Goal
Inpatient Market Share (FPSA)[1]	58.3%	60.0%	TBD	TBD
Annual Ambulatory Visits	609,688	631,605	TBD	TBD
New physicians in the market	15	20	TBD	TBD
Best Image and Reputation Score (via NRC Health)	24.5	26.0	28.5	30.0

[1] Based on OSHPD data CY2020; FPSA is the facility planning service area

Strategies (Tactics)	Net Annual Impact ($)
Provider Recruitment and Retention	
Inpatient Growth	
Outpatient Growth	
Facility Modernization	Included in Budget
Improve Community Engagement	
Innovation	
Health Plan & Community Partnerships	

Strategy Summary for: Provider Recruitment and Retention

Strategic Initiative: Strategic Growth and Innovation

Objective

Recruit and retain the best physicians and providers to address unmet community needs and to support Kaweah Health's growth.

Key Components

- Emphasize recruitment of key specialties consistent with the Board-approved recruitment plan (not a complete list):
  - Cardiothoracic surgeons
  - Urology physicians
  - Gastroenterology physicians
  - Pulmonary outpatient physicians
  - Women's health clinic/program physicians
  - Neurology
- Open the Kaweah Health/USC Urology clinic and services
- Monitor the market for opportunities to acquire medical practices that support unmet community needs or the organization's growth strategy, including working with health plans to identify practices needing support
- Work with Community Advisory Committees to launch resident host family program and resident welcome reception
- Engage our residents early on regarding career opportunities in our community
- Launch the enhanced physician onboarding program

Financial Impact	FY23	FY24	FY25
Capital Requirements	$0	$0	$0
Revenue			
Expenses			
Labor			
Supplies			
Other			
Total Costs			
Contribution Margin			

Included in Budget

Outcomes	Baseline	FY23	FY24	FY25
Number of new primary care physicians under contract	5	5	5	TBD
Number of new specialty physicians under contract	15	15	15	TBD
Percentage of KH graduating residents staying in the Valley	42%	45%	50%	50%

Individuals/Departments Responsible for Execution

Physician Recruitment & Relations, Community Engagement, and KHMG

Strategy Summary for: Inpatient Growth

Strategic Initiative: Strategic Growth and Innovation

Objective

Grow our inpatient volumes, particularly the surgical cases, with an emphasis on key service lines and our expanded service area.

Key Components

- Reopen two ORs on the 2nd floor of Mineral King
- Increase surgical volumes through promotion of services and physicians via marketing, social media, and physician liaisons
- Growth in key service lines (e.g. cardiac surgery, orthopedics, vascular, general surgery, urology, women's health, and more.)
- Add new services (e.g. bariatrics, electrophysiology, etc.)
- Conduct feasibility analysis and design process for conversion of inpatient rehab beds to skilled nursing beds
- Expand urology services and ED call coverage
- Expand endoscopy access
- Collaborate with Valley Children's Hospital on opportunities to increase KH pediatric volumes
- Enhance the mother/baby experience with concierge-level services

Outcomes	Baseline	FY23	FY24	FY25
Cardiac surgery cases	277	300	350	400
IP Market share in secondary service area	26.1%	27.5%	29.0%	30.5%
IP Market share in primary service area	77.0%	78.5%	80.0%	81.0%
Annual IP Surgical Cases [1]	4,223	4,749	TBD	TBD

Financial Impact	FY23	FY24	FY25
Capital Requirements			
Revenue			
Expenses			
Labor			
Supplies			
Other			
Total Costs			
Contribution Margin			

Included in Budget

Individuals/Departments Responsible for Execution

Ryan Gates, Jag Batth, Marc Mertz, Media Relations, Marketing & Communications, Physician Recruitment & Relations, Facilities

Strategy Summary for: Outpatient Growth

Strategic Initiative: Strategic Growth and Innovation

Objective

Increase access to outpatient care in locations that are convenient to our community.

Key Components

- Execute the ambulatory growth strategy, including site prioritization and financial planning. Strategies include:
  - Open the KHMG Industrial Park clinic location (primary care and walk-in care)
  - Develop an outpatient psychiatry clinic for pediatric and adult patients
  - Develop the crisis stabilization unit (CSU) in partnership with the Tulare County
  - Review 2020 Census data, when available, to identify underserved rural communities
- Expansion of SRCC services and equipment (2nd TrueBeam w/ BrainLab) and the growth of oncology market share in Tulare and Kings Counties
- Comprehensive marketing and promotion campaigns for our locations and services
- Finalize the Sequoia Gateway development plan, including facilities, services, funding, timing, and partnerships
- Behavioral health expansion, including adding providers in RHC, launch of the new child and adolescent fellowship, development of pediatric crisis stabilization unit (CSU), expansion of tele-psych, and application for grant funds to develop an adult CSU
- Evaluate the feasibility of expanding outpatient pharmacy services, to potentially include additional retail locations, home delivery, delivery to clinics, and support of telehealth encounters

Outcomes	Baseline	FY23	FY24	FY25
Additional ambulatory locations	1	2	1	TBD
Total ambulatory visits	609,688	631,605	TBD	TBD
OP Surgery Cases	5,421	6,198	TBD	TBD
SRCC Units of Service (Visalia + Hanford)	23,960	28,244	TBD	TBD

Financial Impact

Financial Impact	FY23	FY24	FY25
Capital Requirements			
Revenue			
Expenses			
Labor			
Supplies			
Other			
Total Costs			
Contribution Margin			

Included in Budget

Individuals/Departments Responsible for Execution

Ryan Gates, Paul Schofield, Marc Mertz, Facilities Planning, Marketing & Communications, Media Relations

Strategy Summary for: Modernization of our Facilities

Strategic Initiative: Strategic Growth and Innovation

Objective

Update our facilities to create a better patient experience and to provide our employees and medical staff with a better work environment.

Key Components

- Complete master facility plan for replacement of Mineral King wing, including conceptual design, cost estimates, and financing strategy. Engage employees, the medical staff, and the community throughout the process
- Continue advocacy efforts to improve SB1533 and other laws, as well as to seek support or relief regarding Kaweah Health's facility needs and challenges
- Develop long-term modernization plan for outpatient facilities, including KHMG, Court Street, Exeter, Woodlake, and Lindsay
- Add conference rooms space to downtown campus- Acequia Wing and Support Services Building
- Renovate Mineral King lobby and café
- Evaluate solar, recycling, and other alternative energy opportunities
- Launch a new Foundation campaign to support work environment modernization projects across the organization.

Outcomes	Baseline	FY23	FY24	FY25
Complete hospital modernization plans and financing strategy; Launch community engagement	n/a	Sept 2022	TBD	TBD
Open additional conference rooms downtown	n/a	Jan 2023	TBD	TBD
Approve development plan for Sequoia Gateway	n/a	Dec 2022	TBD	TBD

Financial Impact	FY23	FY24	FY25
Capital Requirements			
Revenue			
Expenses			
Labor			
Supplies			
Other			
Total Costs			
Contribution Margin			

Included in Budget

Individuals/Departments Responsible for Execution

Gary Herbst, Marc Mertz, Kevin Morrison, Deborah Volosin

Strategy Summary for: Improve Community Engagement

Strategic Initiative: Strategic Growth and Innovation

Objective

Continue and expand our efforts to engage our community so that we can better serve their health and wellness needs, and to gain the community's insights and support regarding our initiatives. Seek ways to expand our current reach and gain more widespread feedback and outreach.

Key Components

- Continue to meet with Community Advisory Councils and Ambassador groups to gain community and employee insights and support
- Revitalize Community Engagement program with new membership, new Councils, and a new onboarding program
- Launch comprehensive community engagement campaign regarding the need to replace the Mineral King wing through focus groups, town halls, the website, social media, and other media to gain support
- Explore ways to collaborate on modernization efforts with other health care districts, Central Valley Healthcare Alliance, and the County of Tulare
- Form a new community leadership group to focus on advocating for the hospital modernization effort
- Restart Speakers Bureau
- Kick off a new Foundation fundraising campaign

Outcomes	Baseline	FY23	FY24	FY25
Best Image and Reputation Score (via NRC Health)	24.9	26.0	28.5	30.0
Add new members to Community Engagement Program	n/a	75	TBD	TBD
Public support for bond- survey results	n/a	TBD	TBD	TBD

Financial Impact	FY23	FY24	FY25
Capital Requirements			
Revenue			
Expenses			
Labor			
Supplies			
Other			
Total Costs			
Contribution Margin			

Included in Budget

Individuals/Departments Responsible for Execution

Gary Herbst, Marc Mertz, Deborah Volosin, Liz Wynn, Media Relations, Marketing & Communication

Strategy Summary for: Innovation

Strategic Initiative: Strategic Growth and Innovation

Objective

Create, develop, and implement new processes, systems, or services, with the aim of improving efficiency, effectiveness, or competitive advantage.

Key Components

- Form a committee to explore the organization's enhanced data analytic needs and capabilities and provide the ET and BOD with recommendations regarding technology, software, staffing, and process needs.
- Continue the analysis and planning for a hospital-at-home service
- Launch comprehensive telehealth services, including the American Well platform. Provide telehealth services directly to patients, to employers, and to schools
- The newly formed Patient Navigation Steering Committee to initiate a multi-year process to develop a central patient navigation center for scheduling all services across the organization (via web, phone, email, text, etc.) including patient navigator positions to coordinate patient appointments and to respond to referring physicians' requests/referrals.
- Closely monitor changes in the ambulatory care market and develop strategies to compete, or partner, with market disruptors such as Amazon, Wal-Mart, CVS, Walgreens, telehealth providers, and others
- Explore alternative funding opportunities to enable Kaweah Health to provide community health services such as increasing access to healthy grocery options and stable housing

Outcomes	Baseline	FY23	FY24	FY25
Number of annual telehealth visits	131,051	106,912	TBD	TBD
ET/Board approved patient access center plan	n/a	Fall 2023	TBD	TBD

Financial Impact	FY23	FY24	FY25
Capital Requirements			
Revenue			
Expenses			
Labor			
Supplies			
Other			
Total Costs			
Contribution Margin			

Individuals/Departments Responsible for Execution

Doug Leeper/ISS, Keri Noeske, Malinda Tupper/patient access, Marc Mertz, Ryan Gates, ambulatory clinic leaders

Strategy Summary for: Health Plan & Community Partnerships

Strategic Initiative: Strategic Growth and Innovation

Objective

Improve and strengthen relationships with health plans, community partners, and participate in local/state/federal programs and funding opportunities to improve access, quality, and outcomes for the community.

Key Components

- **Humana/SIH**
  - Increase membership through joint marketing
  - Grow and expand programs that facilitate the annual assessment of Hierarchical Chronic Conditions (HCC) and closing quality gaps
  - Invest in technology and resources that improve the accuracy of annual coding, assessment and documentation to improve quality, generate savings and increase capitated revenue
- **CalAIM**
  - Expand Enhanced Care Management (ECM) enrollment and integration through strategic placement of Community Care Coordinators
  - Work with health plans to identify additional services and/or facilities that will benefit the community and increase access to needed care
  - Incentive Payment Program (IPP) Funding – Identify sustainable program opportunities aligned with strategic goals and seek IPP funding to support implementation
- **Anthem/Health Net**
  - Quality/Innovation Programs - Continue to work on quality and innovation programs to improve outcomes for the Medi-Cal population
- **Tulare County**
  - Behavioral Health – Crises Stabilization Unit
  - Housing/Homelessness initiatives

Outcomes	Baseline	FY23	FY24	FY25
Humana MA Membership	13,000	14,300	15,730	17,303
Annual Assessment of Humana MA open HCC's	80%	≥85%	≥85%	≥85%
Enhanced Care Management (% growth)	-	≥10%	≥10%	≥10%

Individuals/Departments Responsible for Execution

Ryan Gates, Paul Schofield, Marc Mertz, Sonia Duran-Aguilar, Facilities Planning, Marketing & Communications, Media Relations

Live with passion.

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

Patient Throughput Initiative Update

Board of Directors

June 29th, 2022

Agenda

1. May Performance Scorecard & Benefit Realization
2. Patient Throughput Steering Committee Next Steps
3. Transition Planning
4. What's Planned for July

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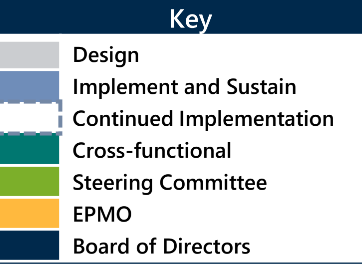

Implementation Timeline

Programs & Projects		Dec	Jan (4)	Feb (7)	Mar (9)	Apr (10)	May (11)	Jun (6)
Throughput & Patient Progression								
1.A Patient Progression								
1.B Long Stay Committee								
1.C Post-Acute Network[1]								
Demand Management								
2.A ED to Inpatient Admission Process								
2.B ED Care Model, Workflow Redesign / ED RN Staffing Optimization[2]								
2.C Transfer Center Operations								
Capacity Management								
3.A Patient Placement Infrastructure / Observation Program[1,2]								
3.B Hospitalist Deployment & Scheduling								
Foundational								
4.A Patient Throughput Dashboard[3]								
4.B Physician Leadership Structure[3]								
4.C EMR & Technology Optimization								
EPMO		EPMO Launch	PM Check-in					
Steering Committee		Steer Co Mtg						
Board of Directors								

Notes: [1]Accelerated project timeline, [2]Consolidated projects, [3]Accelerated project kickoff

We Are Here

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May Performance Scorecard

Leading Performance Metrics – Inpatient & Observation

Metric	Patient Type	Definition	Goal	Current Performance Compared to Baseline: Jan - Nov '21 Baseline (Monthly Average or Median)	Dec '21	Jan '22	Feb '22	Mar '22	Apr '22	May '22
Observation Average Length of Stay (Obs ALOS) *(Lower is better)*	**Overall**	Average length of stay (hours) for observation patients	**37.4**	**44.0**	53.3	57.5	44.8	45.7	56.4	49.4
Inpatient Average Length of Stay (IP ALOS) *(Lower is better)*	**Overall**	Average length of stay (days) for inpatient discharges	**5.64**	**6.31**	7.03	6.11	6.54	6.59	5.87	6.01
	Non-COVID		**N/A**	**5.62**	6.31	5.71	5.78	5.72	5.74	5.71
	COVID		**N/A**	**10.63**	13.77	6.27	9.19	20.32	15.33	17.60
Inpatient Observed-to-Expected Length of Stay *(Lower is better)*	**Overall**	ALOS / geometric mean length of stay for inpatient discharges	**1.32**	**1.48**	1.65	1.48	1.56	1.67	1.48	1.55*
% of Discharges Before 12 PM *(Higher is better)*	**Overall**	% of inpatients discharged before 12 PM	**35%**	**11.5%**	15.1%	11.9%	12.7%	10.9%	11.4%	13.6%
Surgical Backfill Volume *(Higher is better)*	**Overall**	Incremental inpatient elective surgical cases over baseline; pending established baseline	**TBD**	**TBD**	TBD	TBD	TBD	TBD	TBD	TBD
Discharges	**Overall**	Count of IP & observation discharges	**N/A**	**1,769**	1,600	1,579	1,475	1,656	1,685	1,709
	Inpatient-Non-COVID	Count of non-COVID IP discharges	**N/A**	**1,264**	1,218	1,092	984	1,280	1,291	1,317
	Inpatient-COVID	Count of COVID IP discharges	**N/A**	**197**	130	299	282	81	18	35
	Observation	Count of observation discharges	**N/A**	**308**	252	188	209	295	376	357

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

Source: Encounter Data Excludes: Mother/Baby, Behavioral Health, and Pediatrics

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May Performance Scorecard

Leading Performance Metrics – Emergency Department

Metric	Patient Type	Definition	Goal	Current Performance Compared to Baseline: Jan - Nov '21 Baseline (Monthly Average or Median)	Dec '21	Jan '22	Feb '22	Mar '22	Apr '22*	May '22
ED Boarding Time *(Lower is better)*	**Overall**	Median time (minutes) for admission order written to check out for inpatients and observation patients	**286**	**336**	727	998	1,085	375	332	457
	Inpatients	Median time (minutes) for admission order written to check out for admitted patients	**287**	**338**	721	983	1,070	375	330	427
	Observation Patients	Median time (minutes) for admission order written to check out for observation patients	**259**	**304**	1,110	1,284	1,295	444	416	616
ED Admit Hold Volume *(Lower is better)*	**Overall >4 Hours**	Count of patients (volume) with ED boarding time ≥ 4 hours	**N/A**	**640**	902	1,061	951	750	727	778
ED Average Length of Stay (ED ALOS) *(Lower is better)*	**Overall**	Median ED length of stay (minutes) for admitted and discharged patients	**N/A**	**347**	352	362	422	359	357	372
	Discharged Patients	Median ED length of stay (minutes) for discharged patients	**214**	**268**	264	276	310	277	277	294
	Inpatients	Median ED length of stay (minutes) for admitted inpatients	**612**	**720**	1,127	1,449	1,538	738	704	832
	Observation Patients	Median ED length of stay (minutes) for observation patients	**577**	**679**	1,272	1,524	1,569	839	801	1,086
ED Visits	**Overall**	Count of ED visits	**N/A**	**5,596**	5,339	5,975	4,956	5,513	5,584	5,940
	Discharged	Count of ED visits for discharged patients	**N/A**	**3,998**	3,801	4,431	3,546	3,971	4,056	4,338
	Inpatients	Count of ED Visits for admitted patients	**N/A**	**1,216**	1,229	1,312	1,129	1,165	1,144	1,081
	Observation Patients	Count of ED Visits for observation patients	**N/A**	**380**	313	231	278	377	384	372

*Previous month to be updated for admitted patients to align with exclusion criteria

Source: ED Encounter Data Excludes: Mother/Baby, Behavioral Health, and Pediatrics

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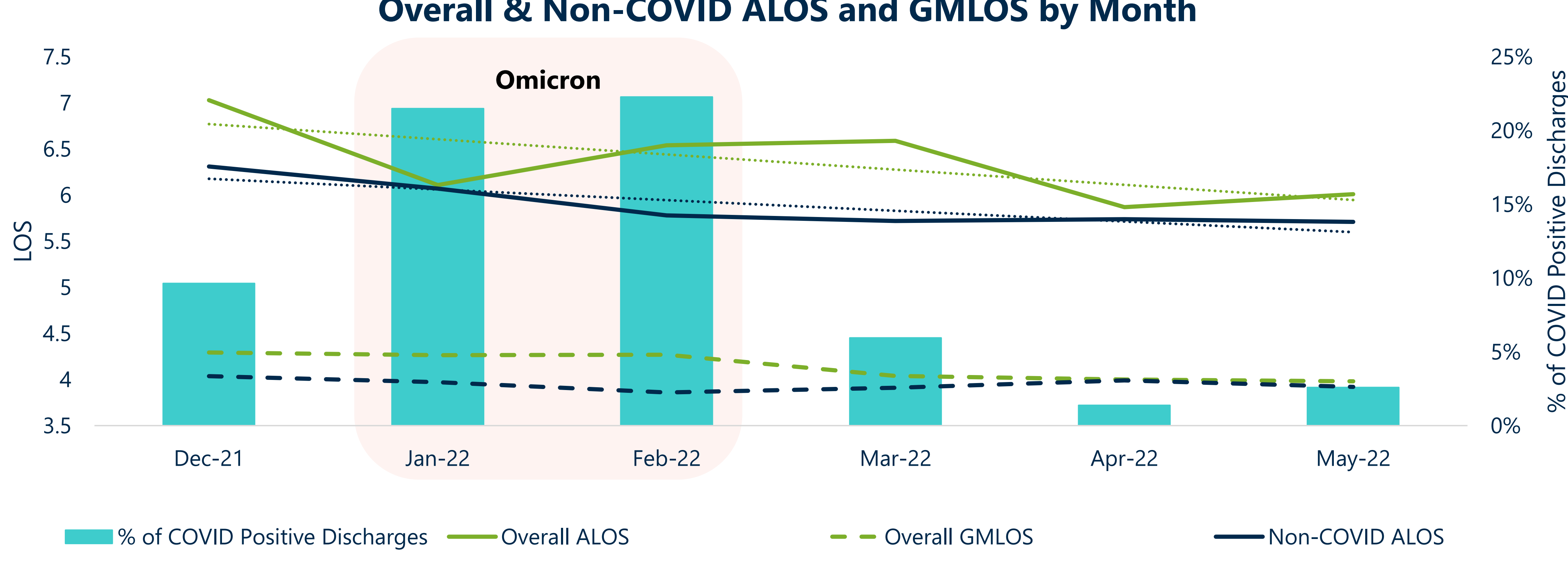
Benefit Realization Progress to Date

ALOS & GMLOS Trends for Varying Patient Populations

The two COVID waves caused a divergence between the overall ALOS and the non-COVID ALOS. The divergence between the two ALOS metrics in March and May is largely due to discharging long stay patients.



Source: Encounter Data Dec 2021 - May 2022 Excludes: Mother/Baby, Behavioral Health, and Pediatrics

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Benefit Realization Progress to Date

ALOS & GMLOS Trends for Varying Patient Populations w/LOS < 30 Days

Similarly for patients with LOS less than 30 days, the overall average length of stay (ALOS) and the Non-COVID ALOS are trending down. The difference between overall ALOS and Non-COVID ALOS in February was due to discharging COVID patients from the Omicron wave.

Month

Omicron

LOS

6
5.5
5
4.5
4
3.5

% of COVID Positive Discharges

25%
20%
15%
10%
5%
0%

Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22

% of COVID Positive Discharges
Overall ALOS
Overall GMLOS
Non-COVID ALOS
Non-COVID GMLOS
Overall ALOS Trend
Non-COVID ALOS Trend

Source: Encounter Data Dec 2021-May 2022 Excludes: Mother/Baby, Behavioral Health, and Pediatrics; Patients with a Length of Stay Greater than 30 Days

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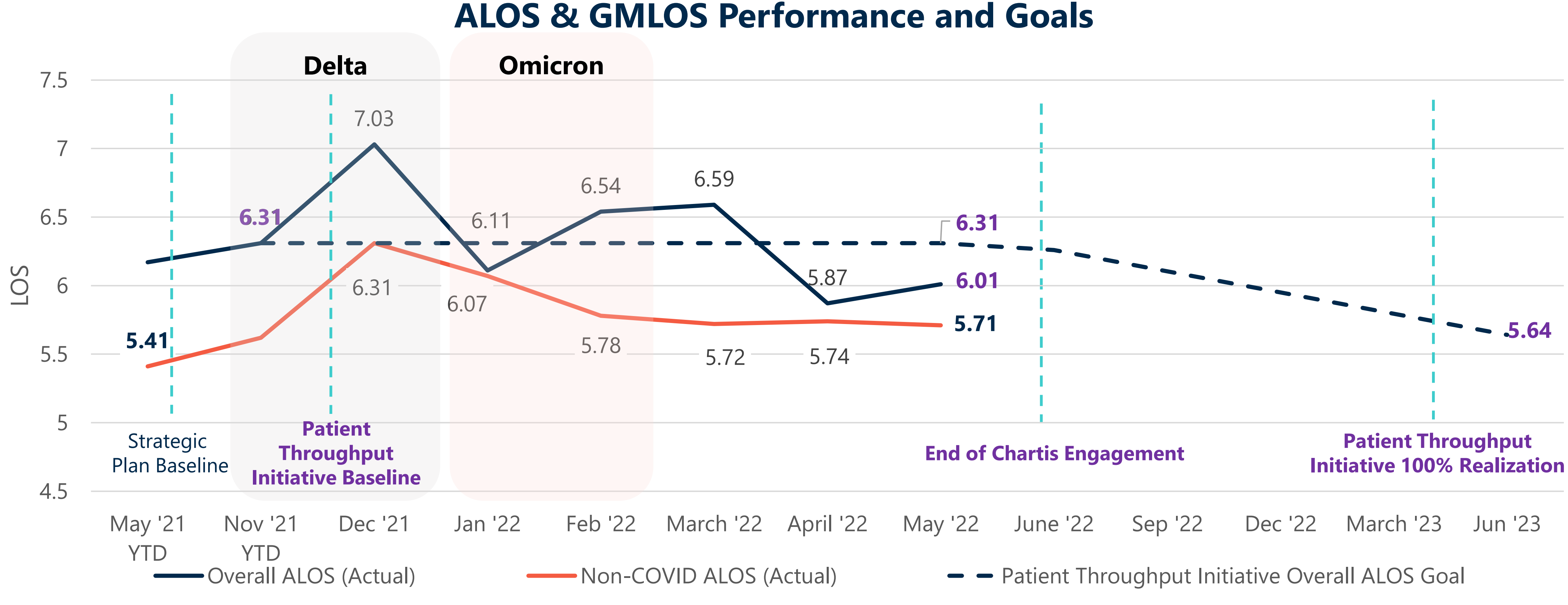
Benefit Realization Progress to Date

ALOS & GMLOS Performance to Goal

The Patient Throughput Initiative outlined a benefit realization schedule in February. As of May 2022, the Patient Throughput Initiative is ahead of the expected benefit realization timeline.



Assumptions: Utilized May '21 YTD Non-COVID LOS Patient Throughput exclusion criteria of 5.41. Strategic Plan highlighted May 2021 Non-COVID GMLOS variance within 1.25 days, pending further review with Strategy leadership. Patient Throughput initiative utilized current draft benefit realization schedule. Nov '21 YTD Overall and Non-COVID GMLOS were projected outward at current levels.

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Unit-Level Performance

% of Discharges Before Noon (DBN)

Key
<10%
10%-14%
>14%

The Patient Progression team established a discharge before noon goal of 35%. The project team rolled out team rounds on each of the Med / Surg units over the first half of 2021 (go-live months circled below with comparison of CY21 vs. CY22 YTD performance indicated by arrows).

Type	Unit	CY21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	CY22 YTD	Avg. DC / Month	June 22* (through 06/21)
Med / Surg	1 East	28.1%	21.2%	26.0%	10.7%	25.0%	26.9%	22.3% ↓	33	
	2 North	8.7%	7.7%	11.5%	12.4%	13.2%	11.3%	11.1% ↑	174	13.1%
	2 South	8.1%	11.7%	9.5%	6.7%	8.9%	14.0%	10.1% ↑	111	13.2%
	3 North	11.8%	9.2%	9.9%	13.5%	8.5%	14.7%	11.1% –	170	9.7%
	3 South	13.3%	11.5%	15.8%	6.6%	9.6%	8.7%	10.3% ↓	170	12.2%
	4 North	6.7%	7.8%	6.3%	3.6%	6.3%	6.7%	6.0% –	128	4.0%
	4 South	9.0%	4.2%	8.3%	6.9%	6.2%	11.1%	6.3% ↓	155	11.8%
	4T Tele	7.1%	6.6%	5.2%	6.3%	10.4%	8.1%	7.4% –	132	1.1%
	BP	16.6%	18.1%	22.6%	20.4%	16.5%	27.6%	21.0% ↑	74	30.0%
	Peds	15.6%	0.0%	12.5%	60.0%	N/A	33.3%	17.1% ↑	16	
ICU	3W ICCU	17.9%	18.9%	35.3%	10.8%	21.4%	21.7%	21.4% ↑	32	
	ICCU	15.4%	17.5%	9.1%	21.3%	18.9%	8.2%	14.8% –	61	
	CVICU	20.6%	35.9%	13.5%	10.0%	10.3%	23.1%	19.5% ↓	28	
	ICU	28.6%	24.3%	22.9%	27.3%	29.0%	23.1%	25.1% ↓	34	
Overall / Total		11.5%	11.6%	12.7%	10.7%	11.4%	13.6%	11.6% –	1,318	11.0%

*June numbers from Completed Discharges Dashboard through 6/21/22. Does not include exclusion criteria

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Unit-Level Performance

Observed-to-Expected Length of Stay (O/E LOS)

Key
>1.7
1.32 -1.7
<1.32

Similarly, for 2021 go-live months for team rounds are circled below with comparison of CY21 vs. CY22 YTD performance indicated by arrows. Of note, in May 2022, local skilled nurse facilities reverted to stricter COVID testing and vaccination requirements.

Type	Unit	CY21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	CY22 YTD		Avg. DC / Month
Med / Surg	1 East	0.43	0.36	0.37	0.34	0.31	0.34	0.36	↓	33
	2 North	1.49	1.69	1.72	1.82	1.48	1.95	1.73	↑	174
	2 South	1.43	1.23	1.36	1.59	1.35	1.49	1.41	–	111
	3 North	1.47	1.14	1.38	1.68	1.69	1.48	1.48	–	170
	3 South	1.73	1.91	2.02	1.88	1.64	1.88	1.86	↑	170
	4 North	1.53	1.67	2.01	1.85	1.44	1.65	1.72	↑	128
	4 South	1.75	2.16	1.98	2.03	1.80	1.68	1.92	↑	155
	4T Tele	1.42	1.51	1.71	1.66	1.44	1.29	1.52	↑	132
	BP	0.97	1.26	1.06	0.95	0.90	0.89	1.04	–	74
	Peds	1.05	1.00	1.18	1.09	0.45	0.66	1.12	–	16
ICU	3W ICCU	1.72	1.13	1.75	1.14	1.34	1.89	1.51	↓	32
	ICCU	1.39	1.37	1.47	1.62	1.18	1.30	1.38	–	61
	CVICU	1.23	1.60	1.18	1.25	1.47	1.29	1.37	↑	28
	ICU	1.52	1.46	1.35	1.69	1.11	1.21	1.37	↓	34
Overall / Total		1.50	1.49	1.56	1.67	1.48	1.55	1.55	↑	1,318

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Benefit Realization Progress to Date

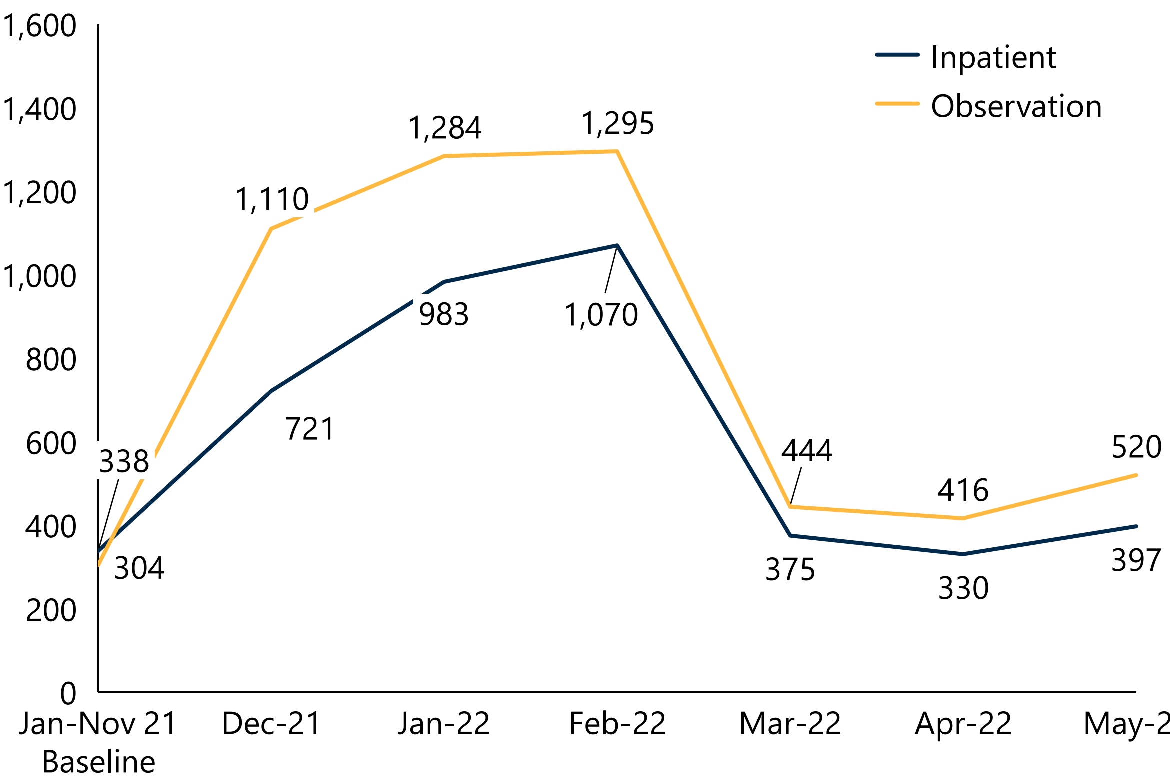
ED Average Length of Stay & Boarding Time

Key ED metrics rose significantly during the end of 2021 / beginning of 2022; however, in March 2022, ED throughput improved significantly.

Median ED LOS by Disposition Patient Type

	Jan-Nov 21 Baseline	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Inpatient	720	1,127	1,449	1,538	738	704	792
Observation	679	1,272	1,524	1,569	839	801	881

Median ED Boarding Time by Disposition Patient Type



Source: KH ED Throughput Data January 2021 - May 2022 Excludes: Mother/Baby, Behavioral Health, and Pediatrics

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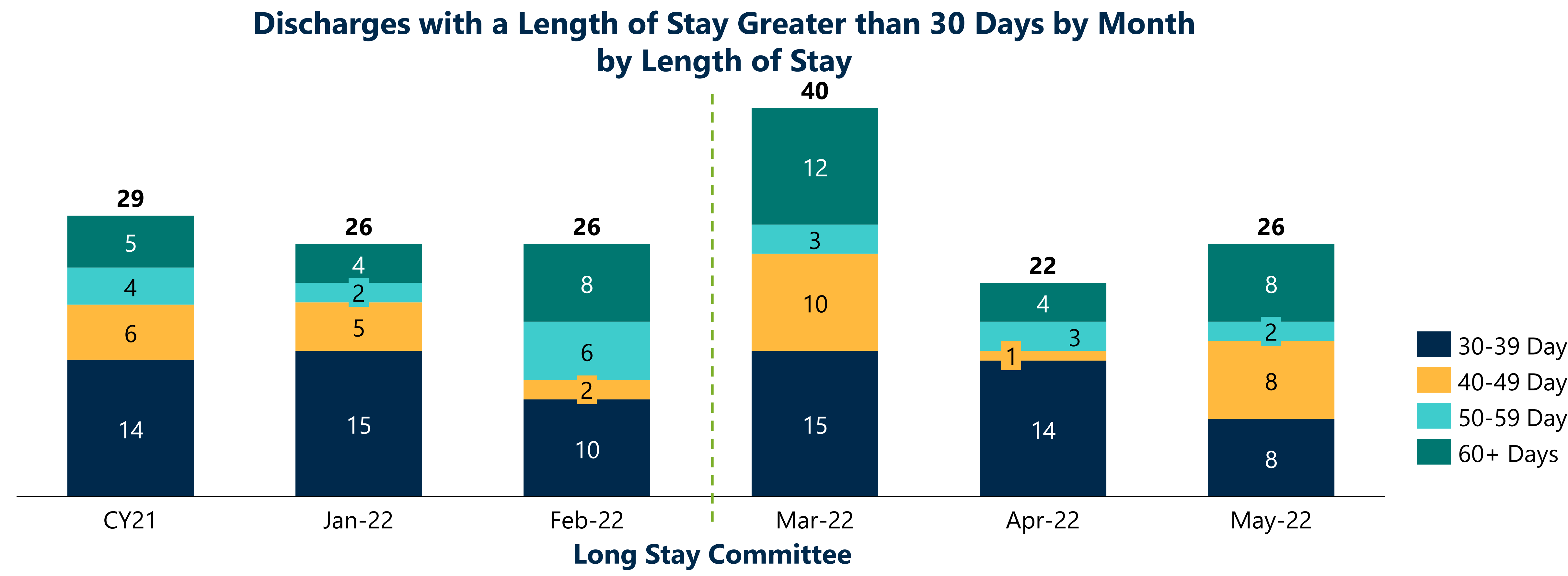
Project-Level Metrics

Long Stay Patients Discharged with LOS Greater than 30 Days

Following the Long Stay Committee kick-off, Kaweah Health discharged 40 patients with a length of stay greater than 30 days. Those 40 patients accounted for 2,142 patient days compared to an average of 1,392 patient days per month for the same group in 2021.



Source: Encounter Data January 2021 - May 2022 Excludes: Mother/Baby, Behavioral Health, and Pediatrics; Patients with a Length of Stay less than 30 Days

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Transition Planning

Program	Project	Status	Transition Date	KH Team Lead(s)	Other Key Stakeholders	PM Support	Notes
0. Alignment on Vision	**0.A Patient Throughput Steering Committee**	✓ Transitioned	4th Week of June	Keri & Jag		JC	
1. Throughput and Patient Progression	**1.A Patient Progression**	✓ Transitioned	4th Week of June	Rebekah & Dee	Emma	Diana	
1. Throughput and Patient Progression	**1.B Long Stay Committee**	✓ Transitioned	2nd Week of March	Rebekah & Kim	Malinda	Suzy	Coordination w/ Post-Acute Network
1. Throughput and Patient Progression	**1.C Post-Acute Network**	✓ Transitioned	4th Week of May	Tiffany & Elisa	Rebekah & Kim	Diana	Coordination w/ Long Stay Committee
2. Demand Mgmt	**2.A ED to Inpatient Admission Process**	✓ Transitioned	4th Week of June	Michelle & Rebekah	Dr. Seng	JC	
2. Demand Mgmt	**2.B ED RN Staffing Optimization**	✓ Transitioned	4th Week of April	Michelle		JC	
2. Demand Mgmt	**2.B ED Care Model Redesign**	✓ Transitioned	4th Week of June	Dr. Seng & Michelle		JC	Coordination w/ ED Remediation Plan
2. Demand Mgmt	**2.C Transfer Center Operations**	✓ Transitioned	4th Week of June	Dee & Dr. Kahwaji	Rebekah	JC	
3. Capacity Mgmt	**3.A Patient Placement Infrastructure (PPI)**	✓ Transitioned	4th Week of June	Kari & Kassie	Emma & Dee	Diana	Pending Observation Program
3. Capacity Mgmt	**3.A Observation Program**	✓ Transitioned	4th Week of June	Keri & Jag	Emma	Diana	
3. Capacity Mgmt	**3.A Hospitalist Deployment / Scheduling**	✓ Transitioned	4th Week of June	Dr. Said & Dr. Patel	Emma	Diana	Pending PPI
4. Foundational	**4.A Patient Throughput Dashboard**	✓ Transitioned	2nd Week of June	Julie & Jerry	Malinda & Doug	JC	
4. Foundational	**4.B Physician Leadership Structure**	❖ Ongoing	Ongoing	Gary & Dr. Manga			

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0.A Patient Throughput Steering Committee

Next Steps

Objectives

- Review/provide input to Design & Implementation projects' proposed solution sets
- Ensure solutions maintain “system mindset” perspective
- Role model transparency and communicate broadly and effectively
- Champion the project and engage colleagues
- Leverage strategic planning process and Patient Throughput Steering Committee as clearing house for ongoing areas of opportunity
- Align existing or new patient-throughput related committees to Patient Throughput Steering Committee:
  - ATEC
  - ED Operations
  - Long Stay Committee
  - Post-Acute Care Network
  - EMR Optimization

Cadence & Structure

- **Meeting Cadence:** Monthly
- **Duration:** 90 minutes
- **Proposed Day:** 4th Wednesday
- **Time:** 2:30 – 4 PM

Members

Member	Role
Keri Noeske	Co-Chair; VP, Chief Nursing Officer
Jag Batth	Co-Chair; VP, Ancillary & Post Acute Services
Malinda Tupper	VP, Chief Financial Officer
Dr. Niraj Patel	Hospitalist Medical Director
Dr. Onsy Said	Hospitalist Medical Director
Doug Leeper	Chief Information Officer
Rebekah Foster	Director, Throughput & Specialty Care
Kassie Waters	Director, Cardiac Critical Care Services
Dr. Monica Manga	Chief of Staff
Dr. Sakona Seng	ED Medical Director
Emma Mozier	Director, Med/Surg Services
Michelle Peterson	Director, Emergency Services
Marc Mertz*	VP, Chief Strategy Officer

*Ad Hoc committee member

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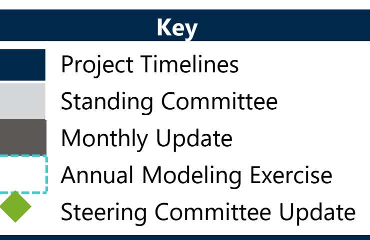
0.A Patient Throughput Steering Committee

Project Report Out & Standing Committee Update Schedule



Various projects and standing committees will report out monthly. Many of the projects will transition to standing committees as their initial work is completed. Each group will report out every other month, except the Performance Scorecard, which will be reviewed monthly.

Activity	Jul	Aug	Sep	Oct	Nov	Dec
Project Report Out						
Patient Progression						
Patient Placement Infrastructure*						
ED to Inpatient Admission Process**						
ED Care Model Redesign**						
Observation Program						
Standing Committee Updates						
ATEC						
ED Operations						
Long Stay Committee						
Post-Acute Care Network						
EMR Optimization						
Performance Scorecard						

* PPI will need to report out to the Steering Committee annually when the team updates the PASS Analytics. They do not need to be a standing committee or report out every 2 months

**Instead of creating a new committee, ED Projects will report out through the ED Operations committee once the project phase is over.

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0.A Patient Throughput Steering Committee

Agendas Through End of Year

Each of the projects and standing committees will report out to the Steering Committee every other month.

Date	July 27th	August 24th	September 28th
Agenda	**Project Report-Outs** • Patient Progression • Patient Placement Infrastructure • Observation Program **Standing Committee Updates** • Post-Acute Care Network • EMR Optimization • Performance Scorecard • ATEC	**Project Report-Outs** • ED Care Model Redesign • ED to Inpatient Admission Process **Standing Committee Updates** • Long Stay Committee • Performance Scorecard • ED Operations	**Project Report-Outs** • Patient Placement Infrastructure • ED to Inpatient Admission Process **Standing Committee Updates** • Post-Acute Care Network • EMR Optimization • Performance Scorecard • ATEC

Date	October 26th	November 16th	December 21st
Agenda	**Project Report-Outs** • Patient Progression • Observation Program **Standing Committee Update** • Long Stay Committee • Performance Scorecard • ED Operations	**Standing Committee Updates** • Post-Acute Care Network • EMR Optimization • Performance Scorecard • ATEC **Annual Modeling Exercise** • Patient Placement Infrastructure	**Standing Committee Updates** • Patient Progression • Observation Program • Long Stay Committee • Performance Scorecard • ED Operations

Patient Throughput: Chartis Perspective

Alignment on Vision
Clinical and Administrative leadership actively demonstrate alignment on the throughput goals and support for improvements

Throughput and Patient Progression
Core inpatient workflows and roles are designed to promote the multidisciplinary collaboration required to safely and efficiently progress a patient through an acute care episode

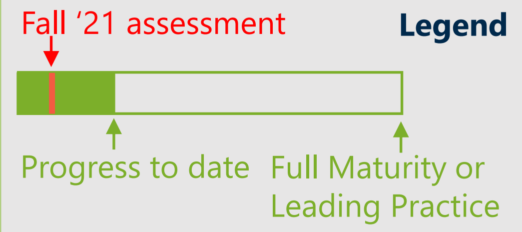
Demand Management
Processes and protocols in place to ensure patients receive the right care in the right place at the right time

Capacity Management
Acute care resources are optimally managed to meet patient demand

Performance Monitoring
Data, analytics and actionable business intelligence to enable understanding of progress, accountability for execution and continuous performance improvement

Technology Enablers
Technology deployed to optimize communication and transparency across the care team and functional areas to promote efficiency and performance

ALIGNMENT ON VISION
PERFORMANCE MONITORING
TECHNOLOGY ENABLERS
Throughput & Patient Progression
Demand Management
Capacity Management



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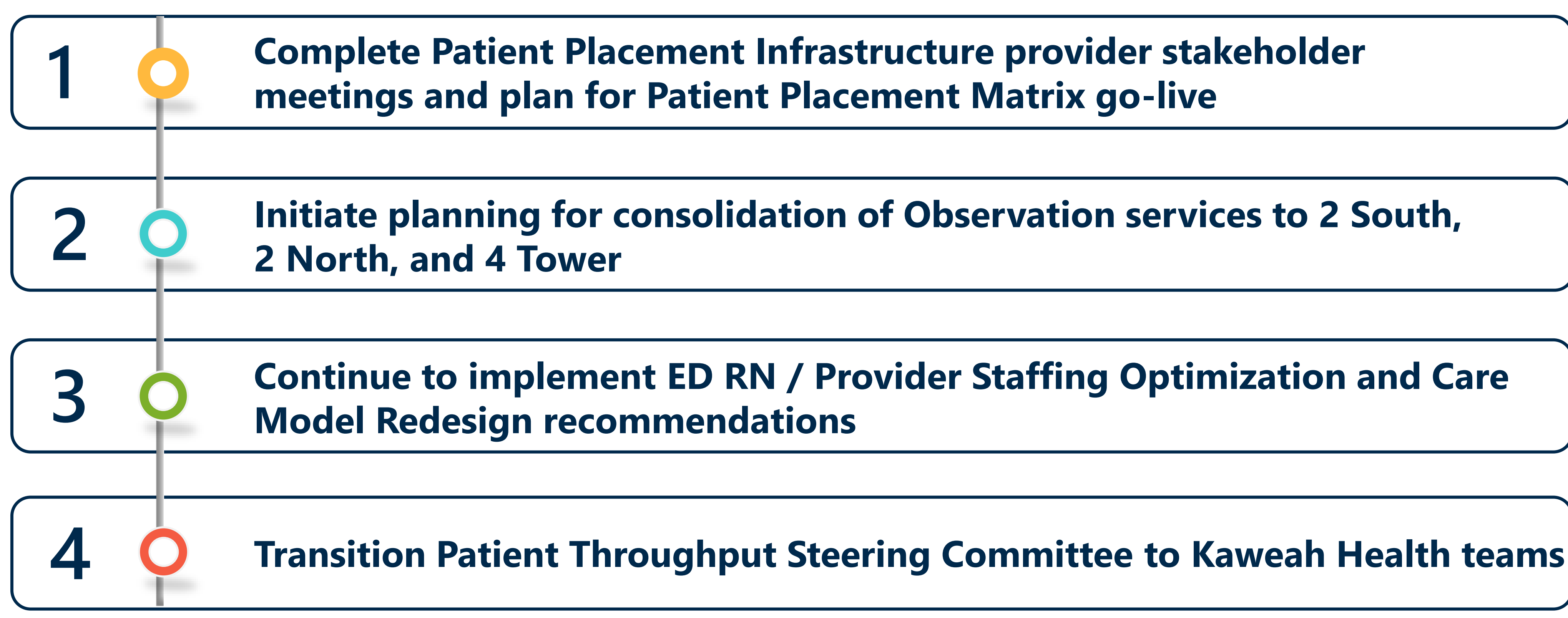
What's Planned for July



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Appendix

Updated Performance Scorecard Goal

Observation Average Length of Stay

Considering new exclusion criteria, the baseline goal increased from 42.1 to 44.0 hours. Below are updated conservative / moderate / optimistic goals for discussion and inclusion in monthly Performance Scorecard. Leadership selected the optimistic goal of 37.4 hours.

Original Goal Setting Discussion

Metric	Patient Type	Definition	Jan - Nov '21 Baseline	Conservative	Moderate	Optimistic
Observation Average Length of Stay (Obs ALOS) *(Lower is better)*	**Overall**	Average length of stay (hours) for observation patients	**42.1**	**40.0 (5%)**	**37.9 (10%)**	**35.8 (15%)**

Updated Goal Setting Discussion

Metric	Patient Type	Definition	Jan - Nov '21 Baseline	Conservative	Moderate	Optimistic
Observation Average Length of Stay (Obs ALOS) *(Lower is better)*	**Overall**	Average length of stay (hours) for observation patients	**44.0**	**41.8 (5%)**	**39.6 (10%)**	**37.4 (15%)**

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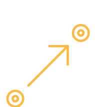
Project-level Transition Plans

1.A Patient Progression



1.A Patient Progression

Continue to clarify care team roles and responsibilities; streamline and standardized multidisciplinary huddles to support advanced discharge planning and discharge before noon goal

Work Completed to Date

- Launched **daily team rounds** for all Valley Hospitalist patients **on all Med / Surg units**
- Developed **scripts and training materials** to facilitate care team adoption
- Designed Care Management and Social Work **roles and responsibilities**
- Developed Team Rounds **Process Metrics Dashboard**

Recommended Areas of Focus – Short Term (3-6 Months)

- **Incorporate FHCN and ACTSS** into team rounds
- As new Patient Placement Matrix is implemented, **maintain close pulse-check** on team rounds, **adjusting timing** to align with changes to hospitalist deployment; **refresh communications** and **celebrate achievements** as team rounds continue to evolve

Recommended Areas of Focus – Long Term (6-18 Months)

- Hold **re-fresh training** on purpose and scripting for team rounds periodically, re-emphasizing importance and value of the daily rounds and anticipated discharge date (ADD)
- Continue to iterate on best ways **to incorporate ancillary services** into team rounds

Requirements for Success

- Participant engagement and continued usage of ADD to improve throughput across Physicians, APPs, Nurses, and Case Management teams

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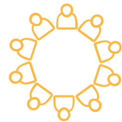
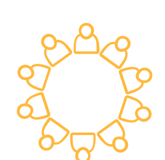


1.B-C Long Stay Committee & Post-Acute Care Network



1.B-C Long Stay Committee & Post Acute Care Network

Develop formal Long Stay Committee structure and supporting processes, including standardized report outs and escalation pathways; Evaluate need for post-acute network; assess current post-acute transition processes

Work Completed to Date

- Defined **Long Stay Committee structure, responsibilities, workflow, processes and metrics**
- **Launched Long Stay Committee** for patients with 10+ day LOS and expanded to patients with a LOS of 5+ days
- Developed **training materials to support Case Management** and reduce barriers to discharges
- **Reengaged local SNF partners** to understand their barriers and needs; developed **plan to relaunch quarterly SNF/Kaweah meeting**

Recommended Areas of Focus – Short Term

- **Launch quarterly meeting** with local SNF partners
- Continue to **refine Long Stay Committee process** and usage of TRT tool
- **Refine analytics process** to track progress to throughput goals

Recommended Areas of Focus – Long Term

- Strengthen **connections with community partners** to continue to reduce barriers to discharge
- Hold regular Case Management / Social Work training to reduce barriers to discharge

Requirements for Success

- Broad, organizational commitment to addressing long LOS barriers as a hospital-wide effort, with recognition that change does not solely land on the Case Management team

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2.A ED to Inpatient Admission Process

2.A ED to Inpatient Admission Process

Optimize hospitalist identification and admission process; identify opportunities for parallel processes in ED admission process (i.e., hospitalist acceptance patient transport request, nurse-to-nurse handover, etc.)

Work Completed to Date

- Drafted workflow to **enable ED Case Management & ED Provider collaboration**
- Identified **Provider Directory as source of truth** for ED providers to PCP provider group affiliation
- Developed **bed assign/clean to bed occupy metric definition and goal of 1 hour** (stretch goal of 45 minutes) to streamline ED patient progression
- Outlined **RN-to-RN handoff guiding principles** to decrease bed assign/clean to bed occupy time

Recommended Areas of Focus – Short Term

- Continue to identify, address and monitor **ED to inpatient admission process improvement opportunities** during ED Operations
- **Hire 3rd ED CM** to support appropriate patient class identification and ED discharge planning
- **Educate ED providers** (Attendings, Residents & Physician Assistants) on **ED CM roles & responsibilities**

Recommended Areas of Focus – Long Term

- Identify **appropriate Cerner field for provider group affiliation data** to enable streamlined hospitalist identification and admission process as well as patient placement

Requirements for Success

- Regular **review of process metrics** (e.g., bed assign/clean to bed occupy, etc.) by interdisciplinary leaders

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2.B ED Care Model Redesign & ED RN / Provider Staffing Optimization

2.B ED Care Model Redesign & ED RN / Provider Staffing Optimization

Streamline ED workflows to enable improved throughput / reduced LOS for treat & release patients; optimize triage processes to decrease number of patients in waiting room; align nurse and provider staffing to demand

Work Completed to Date

- Developed and began implementation of **ED RN Staffing Optimization** 30-60-90-day plan
- Developed **ED Provider Staffing Optimization** 30-60-90-day plan
- Reviewed **ED Care Model Redesign recommended tactics** with ED nursing and physician leadership for feedback and further alignment with other internal inflight initiatives
- Outlined **recommended approach for ED Care Model Redesign**

Recommended Areas of Focus – Short Term

- Determine **implementation approach for ED Care Model Redesign** recommended tactics
- **Optimize current ED interdisciplinary leadership infrastructure** and performance management
- Integrate **staffing to demand analytics into day-to-day operations**

Recommended Areas of Focus – Long Term

- As ED length of stay decreases, continue to **refine workflows to support enhanced patient, physician, resident and staff experience**

Requirements for Success

- **Ongoing evaluation of ED RN & Provider staffing-to-demand** opportunities

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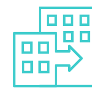
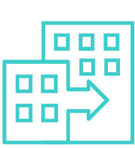


2.C Transfer Center Operations



2.C Transfer Center Operations

Develop clinical prioritization algorithm for transfer requests, escalation process for transfer requests not accepted due to bed availability, and method to track / quantify financial impact of lost or cancelled transfers

Work Completed to Date

- Drafted **clinical prioritization categories, definitions and corresponding escalation processes** in alignment with Kaweah Health's existing policies and procedures
- Developed transfer request **metric definitions and quantified financial impact** of cancelled / lost transfers
- Identified **gap in current contracting for on-call providers** for external transfer requests to inpatient setting
- Cross-walked **current operations to leading practice**

Recommended Areas of Focus – Short Term

- Implement new clinical prioritization categories, including **communication and education to all key stakeholders**
- Launch **retrospective clinical review of cancelled / lost transfers** to support financial impact tracking and ongoing process improvement

Recommended Areas of Focus – Long Term

- Leverage **leading practice comparison to prioritize focus areas** of opportunity for remainder of calendar year and beyond

Requirements for Success

- Leverage **existing ATEC infrastructure and new Transfer Center Operations meetings** for ongoing process improvement

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3.A Patient Placement Infrastructure

3.A Patient Placement Infrastructure

Align bed allocations with patient populations and develop prioritization algorithms to support enhanced patient placement and progression

Work Completed to Date

- **Developed Patient Placement Matrix** based on PASS analytics
- Outlined process and trained team **to review PASS analytics** on a regular basis
- Developed recommendations for **Observation patient cohorting** based on analytics
- Developed **Patient Placement dashboard** to track progress to goals

Recommended Areas of Focus – Short Term

- **Implement Patient Placement Matrix** across Kaweah
- Develop and implement plan to **cohort Observation patients**
- **Update provider workflows** as needed based on matrix

Recommended Areas of Focus – Long Term

- Implement **standard review of PASS analytics**
- **Refine Observation cohorting** based on updated data
- **Update patient placement matrix** as needed based on updated analytics

Requirements for Success

- **Inpatient census at steady state** to allow for bandwidth from leadership and bed management team to implement
- **Physician engagement and buy-in** of future state model

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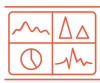
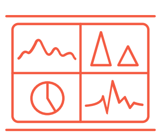


4.A Patient Throughput Dashboard



4.A Patient Throughput Dashboard

Design and launch an all-encompassing patient throughput dashboard (including process and outcome metrics) and corresponding communication / education plan

Work Completed to Date

- **Developed performance scorecard metrics** for Steering Committee and Board of Directors and **project level metrics** to track progress to goals
- Worked with ISS/DS **to build out dashboards** in Tableau and HealtheAnalytics to track progress moving forward
- Developed **standardized definitions and approaches for key metrics** to ensure alignment across teams including incorporating provider group affiliation

Recommended Areas of Focus – Short Term

- Continue to **develop and refine Patient Throughput dashboard** based on team needs and feedback
- Develop standardized way to **incorporate provider group affiliation**

Recommended Areas of Focus – Long Term

- Automate data flows where possible
- Develop **strong partnership between ISS and Operational leads** to ensure alignment and address needs

Requirements for Success

- **Continuous communication and alignment of goals** between ISS, DS, and Operational Leads

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Infection Prevention Annual Review 2022

kaweahDelta.org

Reducing Healthcare Acquired Infections - Interventions

What are we doing to prevent health care associated infections?

Predictive Analytics

Forward Thinking

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

Kaizen Projects
Quality Focus Teams
GEMBA Rounds
Culture of Culturing
Just in Case Culture

Innovative

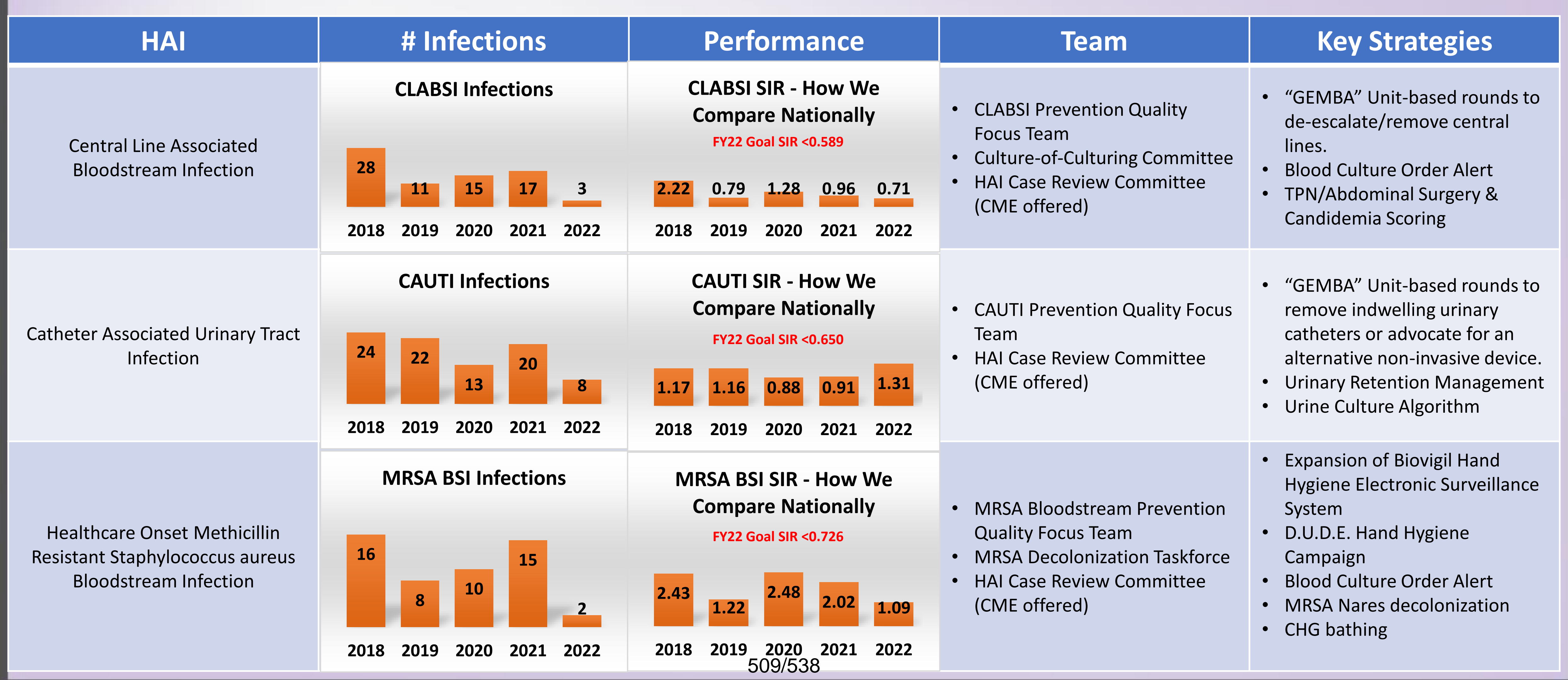
- Retrospective review and analysis of healthcare districts HAI's.
- Deep dive into the "Why and How" for reported events.
- Collaborative action plans/stakeholder involvement.

Evidence-based practice
Meta-analyses
Bundled Interventions

Evidence-Based

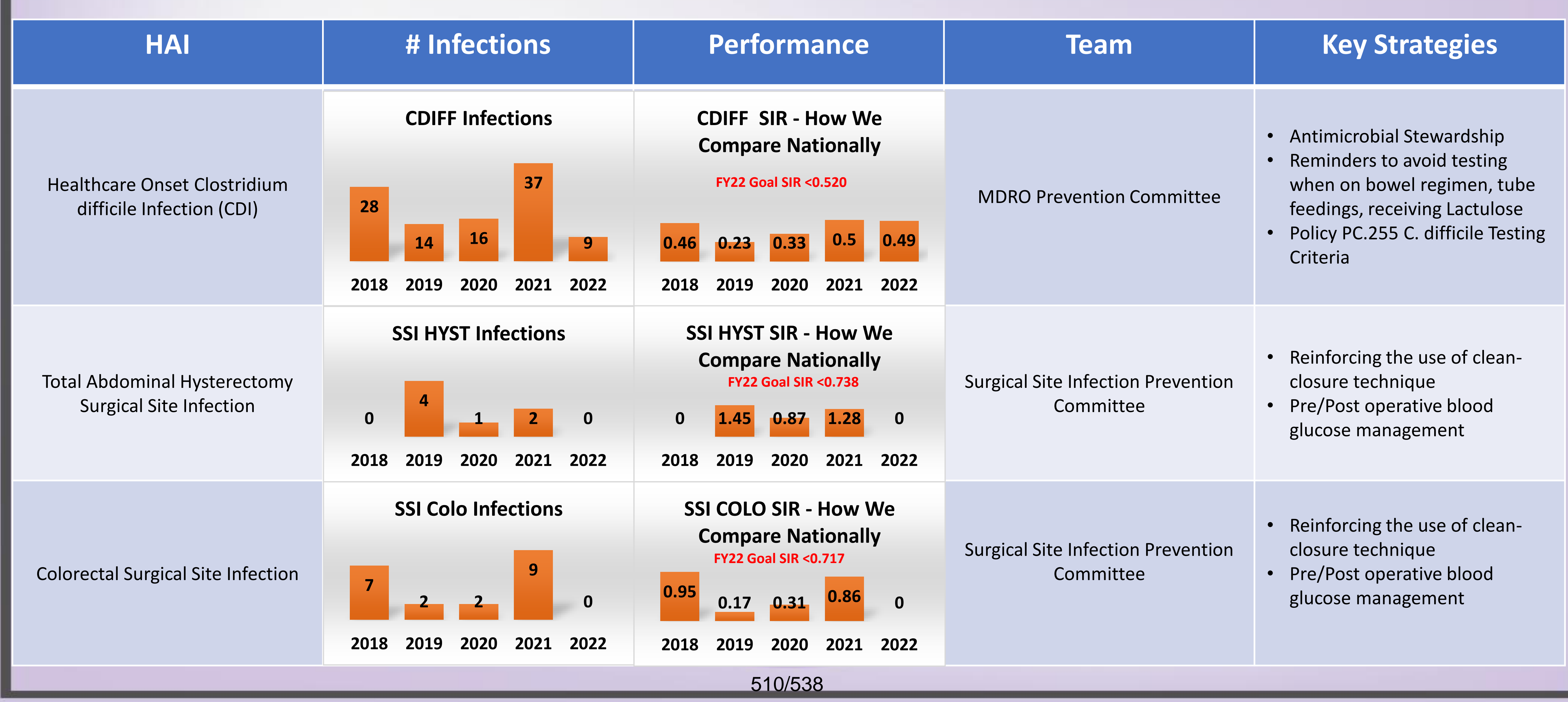
- CDC – HICPAC Guidelines for Reduction of Healthcare Associated Infections
- AHRQ – Toolkits for Reducing HAI
- CDC – STRIVE Infection Control Interventions

OUTSTANDING HEALTH OUTCOMES



HAI	# Infections	Performance	Team	Key Strategies
Central Line Associated Bloodstream Infection	**CLABSI Infections** 2018: 28; 2019: 11; 2020: 15; 2021: 17; 2022: 3	**CLABSI SIR - How We Compare Nationally** FY22 Goal SIR <0.589 2018: 2.22; 2019: 0.79; 2020: 1.28; 2021: 0.96; 2022: 0.71	• CLABSI Prevention Quality Focus Team • Culture-of-Culturing Committee • HAI Case Review Committee (CME offered)	• “GEMBA” Unit-based rounds to de-escalate/remove central lines. • Blood Culture Order Alert • TPN/Abdominal Surgery & Candidemia Scoring
Catheter Associated Urinary Tract Infection	**CAUTI Infections** 2018: 24; 2019: 22; 2020: 13; 2021: 20; 2022: 8	**CAUTI SIR - How We Compare Nationally** FY22 Goal SIR <0.650 2018: 1.17; 2019: 1.16; 2020: 0.88; 2021: 0.91; 2022: 1.31	• CAUTI Prevention Quality Focus Team • HAI Case Review Committee (CME offered)	• “GEMBA” Unit-based rounds to remove indwelling urinary catheters or advocate for an alternative non-invasive device. • Urinary Retention Management • Urine Culture Algorithm
Healthcare Onset Methicillin Resistant Staphylococcus aureus Bloodstream Infection	**MRSA BSI Infections** 2018: 16; 2019: 8; 2020: 10; 2021: 15; 2022: 2	**MRSA BSI SIR - How We Compare Nationally** FY22 Goal SIR <0.726 2018: 2.43; 2019: 1.22; 2020: 2.48; 2021: 2.02; 2022: 1.09	• MRSA Bloodstream Prevention Quality Focus Team • MRSA Decolonization Taskforce • HAI Case Review Committee (CME offered)	• Expansion of Biovigil Hand Hygiene Electronic Surveillance System • D.U.D.E. Hand Hygiene Campaign • Blood Culture Order Alert • MRSA Nares decolonization • CHG bathing

OUTSTANDING HEALTH OUTCOMES



HAI	# Infections	Performance	Team	Key Strategies
Healthcare Onset Clostridium difficile Infection (CDI)	**CDIFF Infections** 2018: 28 2019: 14 2020: 16 2021: 37 2022: 9	**CDIFF SIR - How We Compare Nationally** FY22 Goal SIR <0.520 2018: 0.46 2019: 0.23 2020: 0.33 2021: 0.5 2022: 0.49	MDRO Prevention Committee	• Antimicrobial Stewardship • Reminders to avoid testing when on bowel regimen, tube feedings, receiving Lactulose • Policy PC.255 C. difficile Testing Criteria
Total Abdominal Hysterectomy Surgical Site Infection	**SSI HYST Infections** 2018: 0 2019: 4 2020: 1 2021: 2 2022: 0	**SSI HYST SIR - How We Compare Nationally** FY22 Goal SIR <0.738 2018: 0 2019: 1.45 2020: 0.87 2021: 1.28 2022: 0	Surgical Site Infection Prevention Committee	• Reinforcing the use of clean-closure technique • Pre/Post operative blood glucose management
Colorectal Surgical Site Infection	**SSI Colo Infections** 2018: 7 2019: 2 2020: 2 2021: 9 2022: 0	**SSI COLO SIR - How We Compare Nationally** FY22 Goal SIR <0.717 2018: 0.95 2019: 0.17 2020: 0.31 2021: 0.86 2022: 0	Surgical Site Infection Prevention Committee	• Reinforcing the use of clean-closure technique • Pre/Post operative blood glucose management

HAI	# Infections	Performance	Team	Strategy
Ventilator Associated Events (includes: Ventilator Associated Condition; Ventilator Infection Associated Condition; Probable Ventilator Associated Pneumonia)	**VAE Infections** 2018: 5 2019: 7 2020: 3 2021: 7 2022: 1	**VAE SIR - How We Compare Nationally** FY21 Goal SIR <1.00 2018: 0.76 2019: 1.04 2020: 0.31 2021: 0.48 2022: 0.32	VAE Prevention Committee	• Peridex Oral Solution Rinse • Elevate head-of-bed • Avoidance of PPIs • Sedation Vacation • Mobility

BioVigil Hand Hygiene Performance

Key:	% Compliance	Volume of HHO
	Bad	Bad
	Good	Good
		Neutral

Patient care units with a hand hygiene compliance rate of <95%, submit an action plan to Quality Improvement Committee describing how performance will improve.

Hand Hygiene (HH) Dashboard

Measure Description	Benchmark /Target	2019Q4	2020Q1	2020Q2	2020Q3	2020Q4	2021Q1	2021Q2	2021Q3	2021Q4	2022Q1	2022Q2	sparklines
OUTCOME MEASURES													
HH Overall Compliance	95%	98.97	98.98	98.91	98.16	97.61	97.17	97.42	97.23	97.25	97.11	97.28	
Number of HH Audits Performed	n/a	86,487	552,670	312,205	1,798,574	3,320,010	2,794,940	2,343,324	2,317,980	2,446,234	2,277,805	2,535,346	
HH Overall Compliance - Patient Care Areas	95%	98.97	98.98	98.91	98.16	97.61	97.17	97.42	97.23	97.25	97.14	97.45	
Number of HH Audits Performed - Patient Care Areas	n/a	86,487	552,670	312,205	1,798,574	3,320,010	2,794,940	2,343,324	2,317,980	2,446,234	2,220,755	2,129,888	
PROCESS MEASURES - Patient Care Units													
Hand Hygiene By Day/time													
HH Overall Compliance - AM Shift	95%	99.17	99.16	98.83	98.14	97.48	97.24	97.33	97.10	97.16	97.19	97.57	
Number of HH Audits Performed - AM Shift	n/a	49,649	320,577	182,697	1,112,948	2,045,788	1,724,773	1,430,330	1,441,623	1,523,544	1,406,447	1,363,355	
HH Overall Compliance - PM Shift	95%	98.69	98.72	99.03	98.20	97.82	97.05	97.58	97.43	97.40	97.06	97.25	
Number of HH Audits Performed - PM Shift	n/a	36,838	232,093	129,508	685,626	1,274,222	1,070,167	912,994	876,357	922,690	814,308	766,533	
HH Overall Compliance - Weekdays	95%	98.94	98.99	98.90	98.17	97.65	97.21	97.39	97.22	97.21	97.10	97.47	
Number of HH Audits Performed - Weekdays	n/a	61,728	417,725	239,942	1,354,547	2,509,237	2,129,002	1,790,145	1,773,710	1,856,204	1,683,359	1,605,552	
HH Overall Compliance - Weekends	95%	99.05	98.94	98.96	98.13	97.49	97.03	97.53	97.26	97.39	97.27	97.39	
Number of HH Audits Performed - Weekends	n/a	24,759	134,945	72,263	444,027	810,773	665,938	553,179	544,270	590,030	537,396	524,336	

BioVigil Hand Hygiene Performance

Number of HH Audits Performed - Weekends	n/a	24,759	134,945	72,263	444,027	810,773	665,938	553,179	544,270	590,030	537,396	524,336	
Hand Hygiene By Patient Care Unit Location (*biovgil data)													
2AcequiaCVC - HH Compliance	95%	88.00	94.00	88.00	99.00	100.00	100.00	100.00	100.00	93.00	95.00	96.70	
2AcequiaCVC - HH Audits Performed	n/a	41	52	25	198	21	404	502	302	530	10,844	53,371	
2EastLabor&Delivery - HH Compliance	95%	86.00	80.00	65.00	97.24	97.33	97.64	97.51	97.24	97.97	97.82	97.55	
2EastLabor&Delivery - HH Audits Performed	n/a	80	76	46	70,276	148,020	129,732	131,498	149,119	145,080	129,564	88,627	
2NorthMedTele - HH Compliance	95%	79.00	61.00	81.00	97.23	96.92	97.36	97.62	97.26	97.09	96.29	96.57	
2NorthMedTele - HH Audits Performed	n/a	82	127	110	140,554	234,410	221,218	167,286	199,907	269,698	264,047	189,213	
2SouthObservation - HH Compliance	95%	89.00	50.00	83.00	98.43	98.08	98.02	98.51	97.82	98.31	98.16	98.29	
2SouthObservation - HH Audits Performed	n/a	28	90	102	67,987	157,102	133,157	131,810	108,888	138,197	162,681	131,994	
2WestICU - HH Compliance	95%	98.50	98.44	97.12	96.90	97.34	96.33	97.37	96.93	97.45	97.98	97.47	
2WestICU - HH Audits Performed	n/a	33,348	203,637	29,058	108,729	144,031	95,348	123,559	113,931	138,509	121,395	86,007	
3AcequiaCVICU - HH Compliance	95%	100.00	90.40	NULL	97.69	97.43	96.91	96.07	93.35	95.40	95.68	94.91	
3AcequiaCVICU - HH Audits Performed	n/a	122	63	NULL	91,774	157,004	120,389	131,750	136,066	119,300	100,240	99,668	
3AcequiaMotherBaby - HH Compliance	95%	99.00	99.00	100.00	98.18	97.74	97.81	97.93	97.03	97.79	97.92	97.84	
3AcequiaMotherBaby - HH Audits Performed	n/a	152	152	66	81,760	145,315	122,579	101,757	97,097	103,873	98,568	73,338	
3EastPediatrics - HH Compliance	95%	96.00	90.90	100.00	98.76	98.30	98.13	98.17	98.00	97.35	97.35	97.75	
3EastPediatrics - HH Audits Performed	n/a	51	33	18	5,498	21,187	14,734	22,950	24,640	25,754	21,844	15,880	
3EastPostSurgery - HH Compliance	95%	98.00	NULL	NULL	97.85	98.21	98.18	98.46	99.04	98.93	98.79	99.19	
3EastPostSurgery - HH Audits Performed	n/a	40	NULL	NULL	36,195	86,475	77,833	66,474	58,299	53,267	49,782	37,488	
3NorthMedSurg - HH Compliance	95%	84.00	80.00	75.00	98.69	98.38	98.23	98.25	98.32	98.31	98.19	97.96	
3NorthMedSurg - HH Audits Performed	n/a	64	105	63	157,106	306,844	271,518	208,799	187,554	201,745	176,546	169,860	
3SouthOncology - HH Compliance	95%	76.00	81.00	85.00	98.59	97.98	97.76	97.66	96.82	96.86	96.72	96.22	
3SouthOncology - HH Audits Performed	n/a	71	84	67	170,917	357,067	328,071	268,062	216,920	238,207	248,334	170,462	
3WestICCU - HH Compliance	95%	98.00	89.00	100.00	96.99	97.02	95.59	96.72	96.33	94.34	95.52	96.23	
3WestICCU - HH Audits Performed	n/a	63	71	61	84,081	157,893	131,983	114,691	124,755	131,411	135,100	100,603	
4AcequiaMedicalTelemetry - HH Compliance	95%	97.00	100.00	100.00	98.60	97.91	97.40	97.80	97.30	97.14	97.24	97.47	
4AcequiaMedicalTelemetry - HH Audits Performed	n/a	32	70	17	103,470	251,186	187,526	149,809	121,763	91,726	69,421	47,450	
4NorthRenalMedSurg - HH Compliance	95%	99.26	99.29	99.10	98.77	98.17	98.06	98.01	97.67	97.58	97.16	97.63	
4NorthRenalMedSurg - HH Audits Performed	n/a	53,139	349,033	283,147	335,897	379,797	348,343	316,657	330,358	302,329	262,742	232,306	
4SouthOrthoNeuroMedSurg - HH Compliance	95%	97.00	66.00	31.00	98.84	98.03	97.43	97.18	98.28	98.02	96.97	97.30	
4SouthOrthoNeuroMedSurg - HH Audits Performed	n/a	113	32	13	149,209	292,764	243,596	103,355	178,163	194,597	137,594	127,900	
5AcequiaCVICCU - HH Compliance	95%	NULL	NULL	NULL	97.30	95.25	93.47	93.84	95.38	94.19	94.83	94.90	
5AcequiaCVICCU - HH Audits Performed	n/a	NULL	NULL	NULL	127,579	351,393	302,510	203,322	139,949	148,872	121,624	116,897	
6AcequiaNICU - HH Compliance	95%	89.00	74.00	85.00	99.14	99.51	99.38	99.59	99.47	99.47	99.59	99.63	
6AcequiaNICU - HH Audits Performed	n/a	90	90	89	67,542	129,522	66,403	101,545	130,571	143,669	107,434	82,183	
ASC - HH Compliance	95%	98.00	100.00	48.00	[illegible]	75.00	100.00	100.00	100.00	77.00	98.60	98.82	
ASC - HH Audits Performed	n/a	114	131	118	65	91	552	628	512	60	5,358	35,699	

BioVigil Hand Hygiene Performance

Emergency Department - HH Compliance	95%	61.00	72.00	52.00	47.00	NULL	92.00	90.00	90.00	63.00	88.00	94.74
Emergency Department - HH Audits Performed	n/a	66	68	140	155	NULL	636	207	647	252	31,244	200,632
Endoscopy - HH Compliance	95%	100.00	92.00	100.00	100.00	100.00	100.00	0.00	0.00	0.00	99.42	99.19
Endoscopy - HH Audits Performed	n/a	29	24	12	27	30	10	0	0	0	3,116	19,680
Infusion - HH Compliance	95%	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	98.21	97.87
Infusion - HH Audits Performed	n/a	30	36	20	30	30	30	40	30	20	2,293	10,399
SouthCampusSubAcuteCare - HH Compliance	95%	100.00	71.40	100.00	100.00	100.00	97.00	0.00	100.00	100.00	98.55	99.19
SouthCampusSubAcuteCare - HH Audits Performed	n/a	102	84	47	93	101	124	0	86	64	4,471	143,717
SouthCampusTCS - HH Compliance	95%	100.00	50.00	100.00	100.00	97.00	100.00	100.00	0.00	0.00	99.42	99.47
SouthCampusTCS - HH Audits Performed	n/a	30	10	42	88	66	90	60	0	0	4,495	82,780
WestCampusAcuteCareRehab/ShortStay - HH Compliance	95%	100.00	89.00	88.00	93.00	NULL	93.00	94.00	94.00	94.00	97.04	98.43
WestCampusAcuteCareRehab/ShortStay - HH Audits Performed	n/a	30	71	82	75	NULL	639	634	1,050	659	5,074	133,515
WestCampusDialysis - HH Compliance	95%	100.00	97.00	100.00	100.00	100.00	100.00	100.00	96.00	95.00	97.33	97.98
WestCampusDialysis - HH Audits Performed	n/a	93	87	90	102	82	90	130	142	40	5,250	75,823
WestCampusWoundCare - HH Compliance	95%	NULL	NULL	NULL	NULL	NULL	NULL	NULL	NULL	NULL	95.90	98.50
WestCampusWoundCare - HH Audits Performed	n/a	NULL	NULL	NULL	NULL	NULL	NULL	NULL	NULL	NULL	658	9,854
Hand Hygiene by Role (>10 observations in one quarter, does not inlcude biovigil)												
Aide - HH Compliance	95%	94.00	NULL	85.00	98.50	98.68	97.78	98.30	98.34	97.72	97.85	98.16
Aide - HH Audits Performed	n/a	678	NULL	542	9,201	19,202	15,794	15,254	15,415	16,515	17,855	24,146
C.N.A. - HH Compliance	95%	99.53	99.19	99.44	97.95	96.77	96.09	96.53	95.84	95.94	96.40	96.84
C.N.A. - HH Audits Performed	n/a	15,486	102,302	69,129	415,866	831,386	684,279	522,495	489,887	572,524	532,047	558,962
EVS - HH Compliance	95%	97.58	97.41	82.00	97.45	96.60	95.53	95.09	92.70	95.81	95.49	95.86
EVS - HH Audits Performed	n/a	1,732	6,613	562	90,866	138,281	106,399	79,822	40,426	34,340	81,413	105,847
LVN/Tech - HH Compliance	95%	91.00	99.62	99.49	98.80	98.04	98.50	97.33	97.70	97.80	97.34	97.57
LVN/Tech - HH Audits Performed	n/a	161	11,837	17,672	58,774	120,366	102,193	88,326	105,878	129,757	136,711	215,381
Nurse - HH Compliance	95%	98.86	98.92	98.60	98.10	97.85	97.41	97.61	97.64	97.56	97.26	97.15
Nurse - HH Audits Performed	n/a	65,915	414,014	217,313	1,011,075	1,797,130	1,399,290	1,176,981	1,279,551	1,322,449	1,153,755	1,254,547
Other - HH Compliance	95%	99.22	99.36	99.82	98.75	98.53	98.13	98.36	98.01	98.31	98.02	98.58
Other - HH Audits Performed	n/a	3,217	16,689	8,528	162,090	302,052	322,758	303,172	265,952	264,691	260,518	280,419
Physician - HH Compliance	95%	98.54	97.53	92.80	92.00	95.22	94.88	97.78	90.60	98.61	95.72	98.35
Physician - HH Audits Performed	n/a	137	1,215	780	1,256	11,727	10,866	3,825	234	72	187	363
Respiratory - HH Compliance	95%	90.00	NULL	91.00	98.30	98.17	97.86	98.37	97.61	97.14	97.80	98.45
Respiratory - HH Audits Performed	n/a	396	NULL	282	45,719	82,248	88,040	97,902	86,616	70,921	66,678	72,302
Student - HH Compliance	95%	91.00	NULL	100.00	[illegible]	99.11	98.57	98.28	97.78	98.27	97.57	97.79
Student - HH Audits Performed	n/a	32	NULL	11	7,464	17,618	65,321	55,547	34,021	34,965	28,641	23,379

Questions?

2022-2023 Annual Budget Review

June 29, 2022

2022-2023 Annual Budget Review

- Key Volume Projections and Ratios
- FY2023 Budget Income Statement Comparison
- Financial Ratios
- Projected Cash Flow
- Defined Benefit Update
- FY2023 Capital Budget
- Volume Slides

Note: The FY22 Projected amounts are based on 11 months of actual (July 2021-May 2022) plus a projected month for June 2022.

Key Statistical Indicators | Average Daily Census

5.3% over FY22 Projection
9.5% over FY22 Budget

	Average Daily Census
2019 Actual	441
2020 Actual	413
2021 Actual	430
2022 Projected	460
2022 Budget	442
2023 Budget	484

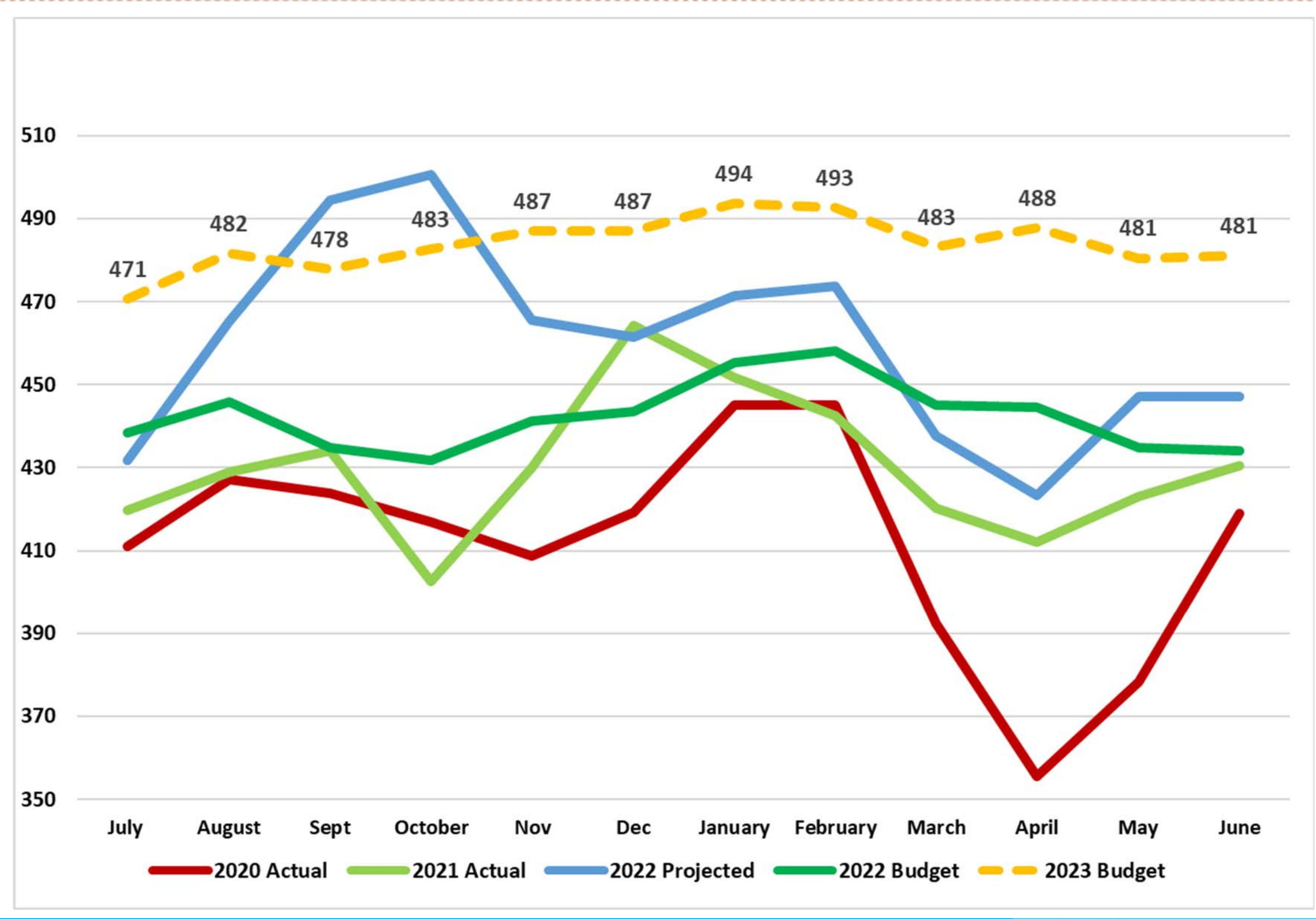
Key Statistical Indicators | Average Daily Census

	FY 22 Projected	FY 22 Budget	FY 23 Budget	Change Budget FY23-Projected FY22	% Change from FY22 Projected
Average Daily Census	**460**	**442**	**484**	**24**	**5%**

Patient Days

	FY 22 Projected	FY 22 Budget	FY 23 Budget	Change Budget FY23-Projected FY22	% Change from FY22 Projected
Medical Center	116,963	103,896	117,240	277	0%
Acute I/P Psych	14,597	17,092	18,680	4,083	28%
Sub-Acute	10,092	11,245	10,882	790	8%
Rehab	5,907	6,733	6,733	826	14%
TCS-Ortho	4,251	5,110	5,110	859	20%
TCS	5,019	6,031	6,031	1,012	20%
NICU	5,125	4,800	5,500	375	7%
Nursery	5,894	6,509	6,509	615	10%
Total Patient Days	**167,848**	**161,416**	**176,685**	**8,837**	**5%**

Key Statistical Indicators | Average Daily Census



Key Statistical Indicators | Adjusted Patient Days

	Adjusted Patient Days
2019 Actual	305,252
2020 Actual	295,442
2021 Actual	293,722
2022 Projected	325,134
2022 Budget	319,585
2023 Budget	338,259

4.0% over FY22 Projection
5.8% over FY22 Budget

Key Statistical Indicators | Volume

	FY 19 Actual	FY 22 Actual (projected ..)	FY 22 Budget	FY 23 Budget	Change Budget FY23-Budget FY22	% Change from FY22 Budget	% Change from FY19 Actual
Inpatient Days	161,082	167,848	161,416	176,685	15,269	9.5%	9.7%
Emergency Department Visits	84,834	81,118	83,950	83,950	0	0.0%	(1.0%)
Surgery Minutes	11,788	11,484	15,278	12,943	(2,335)	(15.3%)	9.8%
Cath Lab Minutes	4,403	3,830	4,786	4,786	0	0.0%	8.7%
Deliveries	4,764	4,534	4,603	4,700	97	2.1%	(1.3%)
Rural Health Clinic Visits	97,806	124,286	114,973	124,970	9,997	8.7%	27.8%
Rural Health Clinic-Tulare Visits	-	10,737	14,175	15,648	1,473	10.4%	0.0%
Urgent Care - Court	49,071	67,222	47,323	47,678	355	0.8%	(2.8%)
Urgent Care - Demaree	19,202	42,254	28,600	29,230	630	2.2%	52.2%
SWHC Family Medicine GME	11,930	13,288	14,240	14,467	227	1.6%	21.3%
Sequoia Cardiology Clinic	11,101	21,364	19,698	25,020	5,322	27.0%	125.4%
Neuroscience Center	4,125	4,276	4,684	4,242	(442)	(9.4%)	2.8%
Outpatient Rehabilitation Units	9,664	14,947	15,027	15,027	0	0.0%	55.5%
Physical & Other Therapy Units	274,912	270,485	269,361	274,661	5,300	2.0%	(0.1%)
Home Health Visits	28,794	33,426	34,765	36,160	1,395	4.0%	25.6%
Hospice	39,947	50,786	50,975	51,180	205	0.4%	28.1%
Radiation Oncology	25,031	24,045	28,504	28,244	(260)	(0.9%)	12.8%
Radiology Xray	117,573	159,654	146,922	154,595	7,673	5.2%	31.5%
Radiology CT	49,111	51,765	50,709	52,948	2,239	4.4%	7.8%
Radiology MRI	9,199	9,989	9,981	10,065	84	0.8%	9.4%
Radiology US	26,756	27,817	26,156	28,549	2,393	9.1%	6.7%

FY23 Budget Comparison to Budget (000's)

	For Comparison to Budget FY23							
	FY 19 Actual	FY 22 Actual	FY 22 Budget	FY 23 Budget	Variance Budget FY23-Actual FY22		Variance Budget FY23-Budget FY22	
Operating Revenue								
Net Patient Service Revenue	**$561,911**	**$639,253**	**$634,620**	**$671,652**	**$32,399**	**5.1%**	**$37,032**	**5.8%**
Supplemental Gov't Programs	76,471	70,220	53,106	61,903	(8,317)	(11.8%)	8,797	16.6%
Prime Program	17,717	15,850	8,000	8,911	(6,939)	(43.8%)	911	11.4%
Premium Revenue	40,871	69,496	66,017	79,636	10,140	14.6%	13,619	20.6%
Management Services Revenue	31,751	35,869	36,290	40,949	5,080	14.2%	4,659	12.8%
Other Revenue	24,245	27,625	24,560	28,943	1,318	4.8%	4,383	17.8%
Other Operating Revenue	191,056	219,060	187,973	220,342	1,282	0.6%	32,369	17.2%
Total Operating Revenue	**752,967**	**858,313**	**822,593**	**891,994**	**33,681**	**3.9%**	**69,401**	**8.4%**
Operating Expenses								
Salaries & Wages	287,902	348,599	330,396	354,621	6,022	1.7%	24,225	7.3%
Contract Labor	14,997	42,392	6,204	28,647	(13,745)	(32.4%)	22,443	361.8%
Employee Benefits	73,216	62,227	53,922	72,811	10,583	17.0%	18,889	35.0%
Total Employment Expenses	**376,115**	**453,218**	**390,522**	**456,079**	**2,860**	**0.6%**	**65,557**	**16.8%**
Medical & Other Supplies	112,866	134,355	125,503	126,655	(7,700)	(5.7%)	1,152	0.9%
Physician Fees	85,521	107,847	99,783	110,105	2,258	2.1%	10,322	10.3%
Purchased Services	21,151	18,332	15,866	19,770	1,438	7.8%	3,904	24.6%
Repairs & Maintenance	25,878	28,373	28,699	30,636	2,263	8.0%	1,937	6.7%
Utilities	5,642	8,967	7,308	8,695	(272)	(3.0%)	1,387	19.0%
Rents & Leases	6,119	6,244	6,169	7,187	943	15.1%	1,018	16.5%
Depreciation & Amortization	30,851	31,907	33,552	34,003	2,096	6.6%	451	1.3%
Interest Expense	5,453	7,469	7,234	7,190	(279)	(3.7%)	(44)	(0.6%)
Other Expense	17,260	21,979	22,630	25,436	3,457	15.7%	2,806	12.4%
Humana Cap Plan Expenses	19,151	39,823	36,254	39,994	171	0.4%	3,740	10.3%
Management Services Expense	31,359	34,657	35,899	40,457	5,800	16.7%	4,558	12.7%
Total Other Expenses	**361,250**	**439,953**	**418,897**	**450,128**	**10,175**	**2.3%**	**31,231**	**7.5%**
Total Operating Expenses	**737,366**	**893,171**	**809,419**	**906,207**	**13,036**	**1.5%**	**96,788**	**12.0%**
Operating Margin	**15,601**	**(34,858)**	**13,174**	**(14,213)**	**20,646**		**(27,387)**	
Stimulus Funds	0	17,867	1,195	3,000	(14,867)		1,805	
Operating Margin after Stimulus	**15,601**	**(16,991)**	**14,369**	**(11,213)**	**5,779**		**(25,582)**	
Nonoperating Revenue (Loss)	12,306	(5,637)	4,568	2,357	7,994		(2,211)	
Excess Margin	**$27,907**	**($22,628)**	**$18,937**	**($8,856)**	**$13,772**		**($27,793)**	

Financial Highlights (000's)

Consolidated District:

Ratio/Statistic	Moody's A (1)	2020	2021	2022 Projected	2023 Bdgt
Operating Income (3)	$619	($24,626)	$4,954	($18,625)	($11,213)
Operating Cash Flow	$67,826	$11,938	$43,370	$20,751	$29,980
Net Income	$35,038	($7,651)	$12,414	($25,929)	($8,856)
Unrestricted Cash	$519,145	$358,842	$387,773	$313,476	$279,072
Operating Margin	0.1%	(3.3%)	0.6%	(2.2%)	(1.3%)
Excess Margin	2.8%	(0.9%)	1.5%	(3.0%)	(1.0%)
Operating Cash Flow Margin	6.7%	1.6%	5.4%	2.4%	3.4%
Maximum Debt Service Coverage x	3.4	1.6	2.9	0.8 (2)	1.8
Days Cash on Hand	**232.8**	**176.1**	**182.9**	**132.71**	**116.8**

(1) Represents 2020 median ratios for all non-profit hospitals rated "A3" by Moody's Investor Services.
Must budget 1.75x MADS and have 1.35x MADS and 90 days cash on hand at 6/30 per bond covenants
(2) If unrealized losses on bond portfolio excluded, the MADS x coverage is 1.2.
(3) All operating income includes stimulus funds as measured by Moody's.

2022-2023 Surplus Cash Flows (000's)

Excess Margin	($8,856)
<u>Additional Sources (Uses) of Cash:</u>	
Capital Expenditures:	
Annual Recurring	($16,000)
General Capital Contingency Fund	($340)
Depreciation/Amortization (Non-Cash)	$34,003
Capitalized Employment Expense	($991)
No Defined Benefit Plan Funding	($1,319)
Unrealized Losses on Surplus Funds (Non-Cash)	$1,910
Debt Service Payments (Principal)	($9,899)
Total Additional Net Sources of Cash	**$7,364**
Projected Surplus Cash Flow (Deficit)	**($1,492)**

General Fund Cash Reserves (000's)

District without Kaweah Delta Hospital Foundation:

Projected Balance at July 1, 2022	$292,722
Medicare accelerated payment recoupment	(27,015)
Deferral of employer social security tax repayment	(5,898)
Cash Flow from 2022-2023 Operations	(1,492)
Balance at June 30, 2023	$258,317

Defined Benefit Plan – Pension FY22 and FY23

Discussion:

- Original: Recommend not funding pension plan in FY23 as actuarial recommended contribution is assumed to be zero as of 3/31/22 estimate due to assumption that the plan is fully funded at the 7.5% discount rate - $11.4M cash impact from prior year.
- Update: The Plan's market value further declined since the 3/31/22 valuation and therefore may not be 100% funded at 6/30/22 or 6/30/23. Our recommendation remains to freeze the contribution for FY23 due to Plan's status as we have overfunded for the most recent seven years as shown below.
- Recommend holding the pension discount rate at 7.5% versus 7.25% and resume glide path reduction in FY24. FY22 income statement $4.6M impact, FY23 income statement $2.9M impact.

Year Ended June 30	Actuarial Determined Contribution	Actual Contribution	Contribution Excess
2021	$4,414	$11,400	$6,986
2020	$3,466	$11,400	$7,934
2019	$4,533	$11,400	$6,867
2018	$5,818	$11,400	$5,582
2017	$6,879	$9,000	$2,121
2016	$3,224	$5,000	$1,776
2015	$2,673	$3,720	$1,047
2014	$3,972	$4,058	$86
2013	$4,093	$4,095	$2
2012	$2,233	$2,235	$2

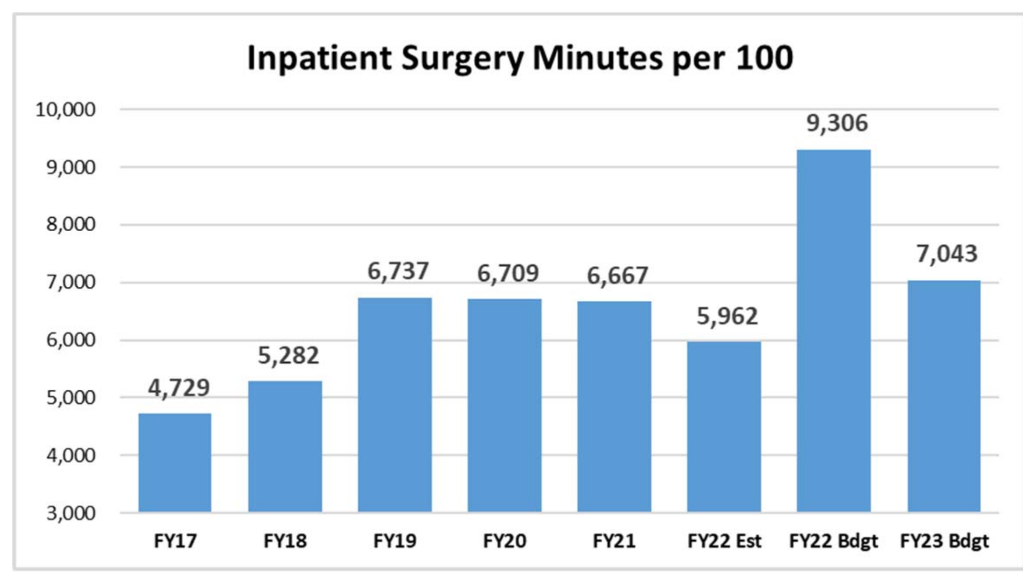
Actuary projection as of 3/31/22:

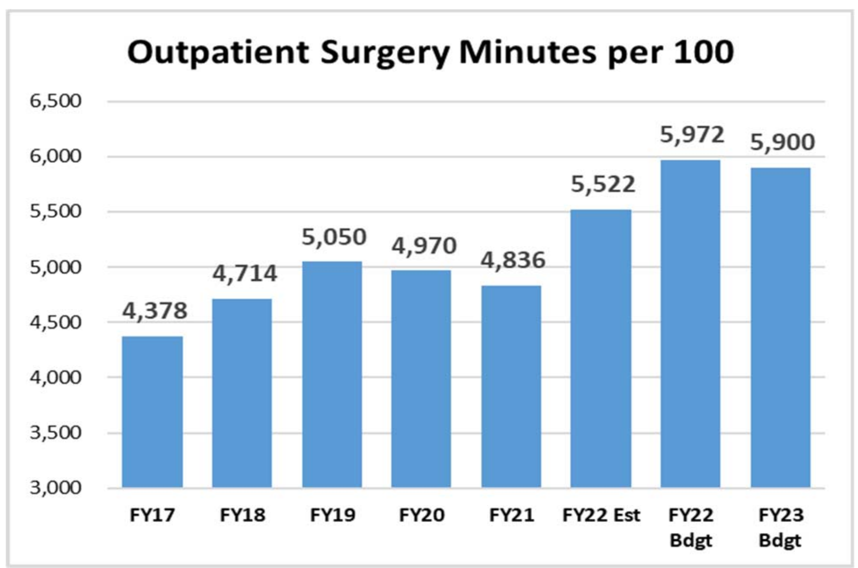
Fiscal Year Ending	6/30/2022	6/30/2023
Measurement Date	6/30/2021	6/30/2022
Valuation Date	6/30/2020	6/30/2020
Plan Fiduciary Net Position		
Total Pension Liability (TPL)	297,774,486	303,391,000
Market Value of Assets (MVA)	320,047,417	312,407,000
Net Pension Liability (NPL)	(22,272,931)	(9,016,000)
Funded Ratio	107.48%	102.97%

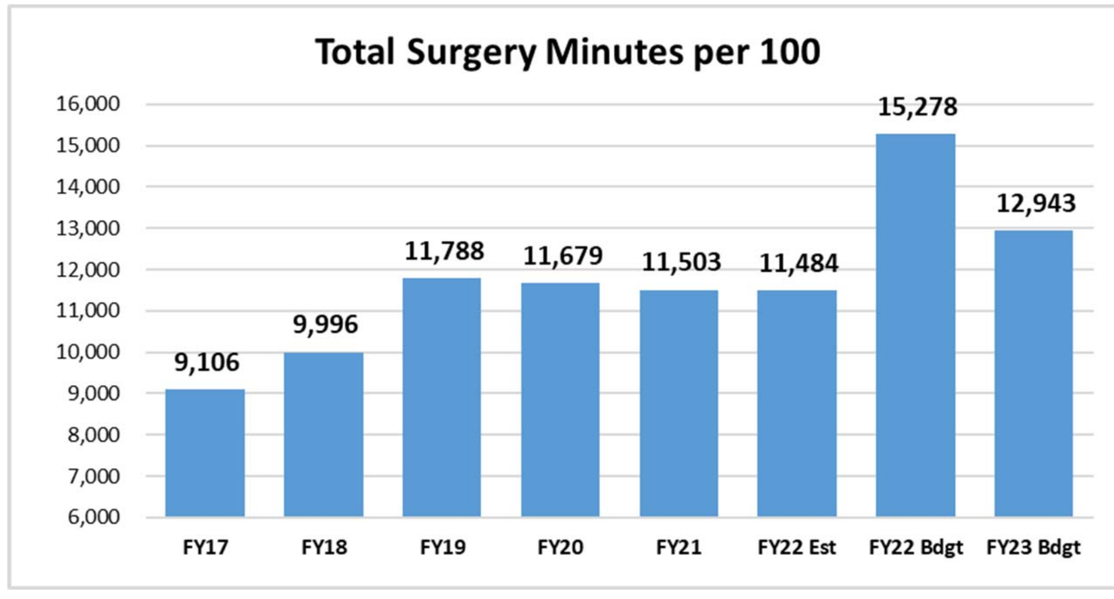
FY2023 | Capital Budget (000's)

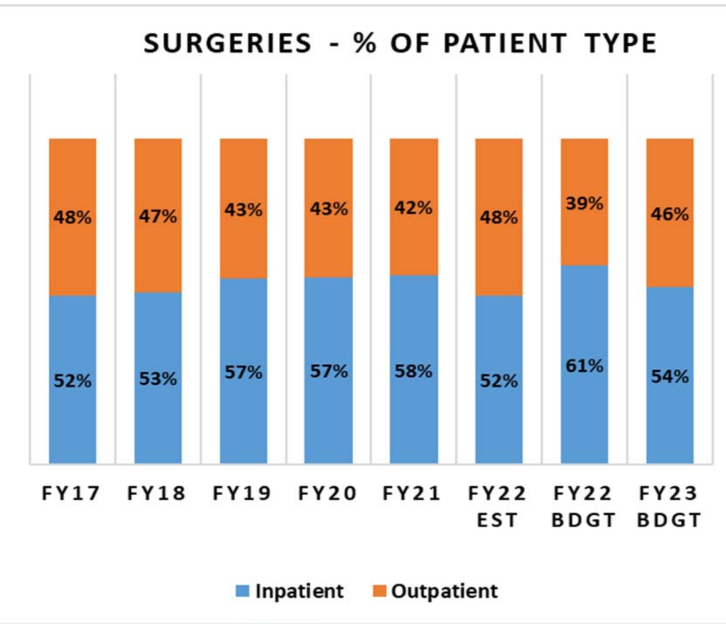
Total Capital Requests	**$22,122**
Total Rejected/Deferred	**($6,122)**
Total	**$16,000**
Breakdown of Items in Review	
Infrastructure Maintenance	$2,776
Facilities Construction Projects & Planning	$1,212
Information Services (ISS)	$2,199
Director Requests	$9,813
In Review	**$16,000**
Funding Sources	
Capital FY23	$16,000
General Contingency Capital	$340
FY 2023 Capital Budget	**$16,340**

FY23 Trended Budget Volume Graphs

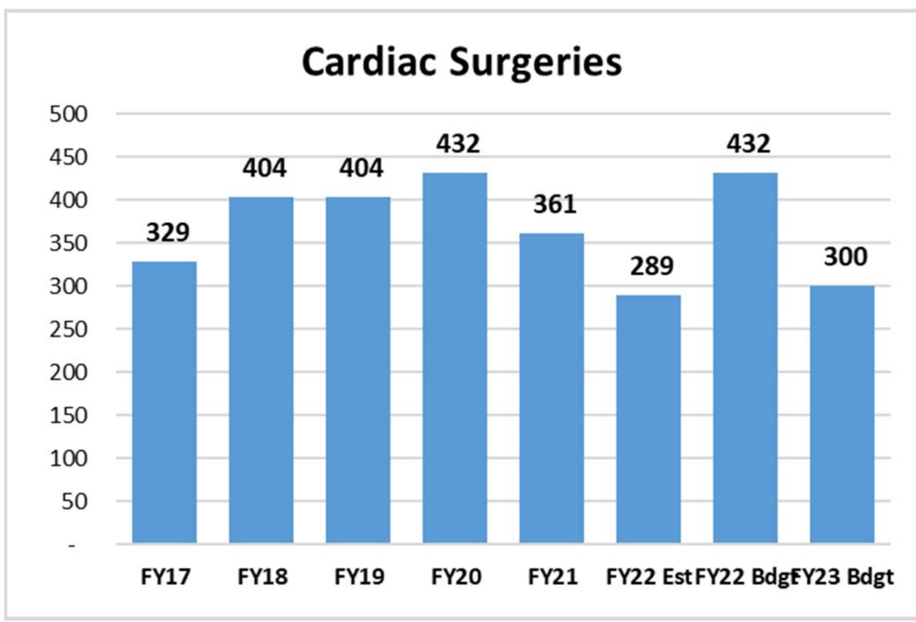


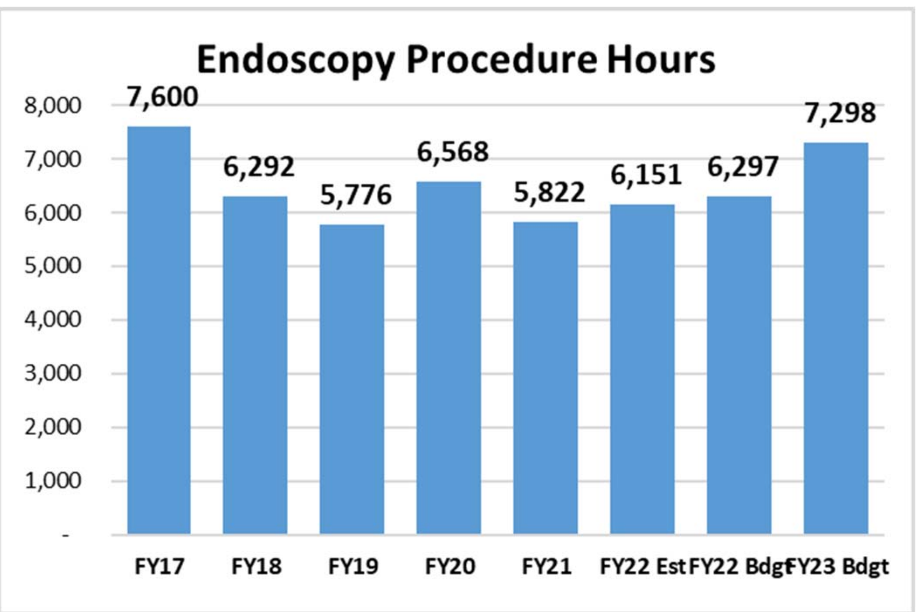


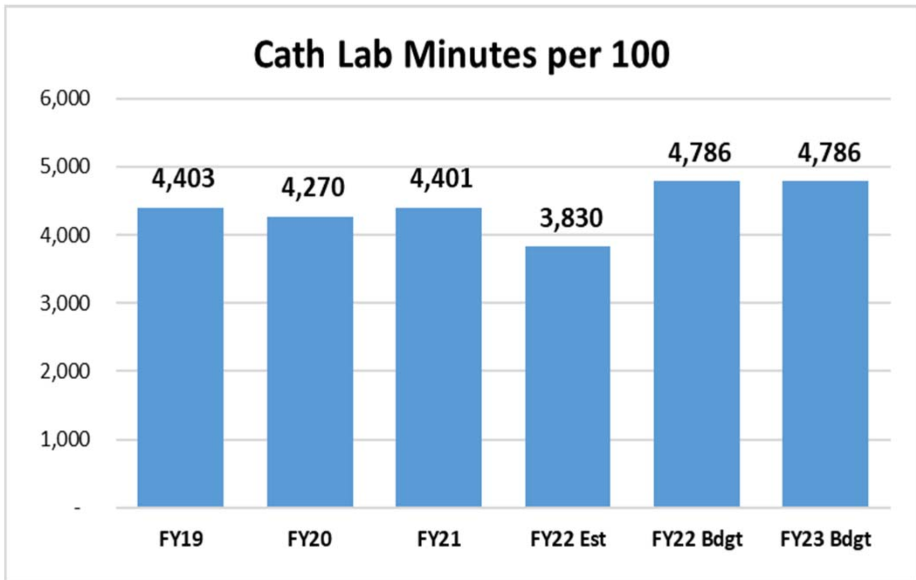


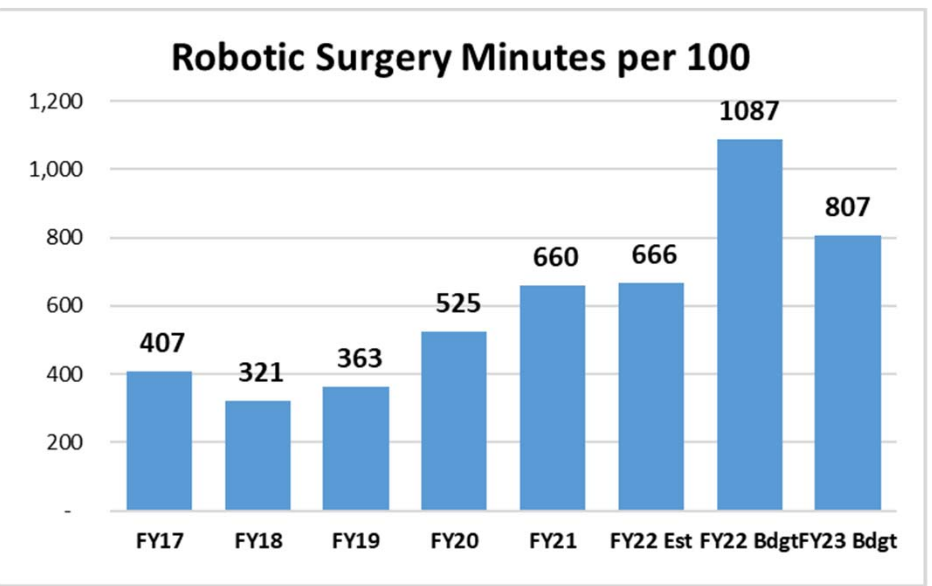


FY23 Trended Budget Volume Graphs









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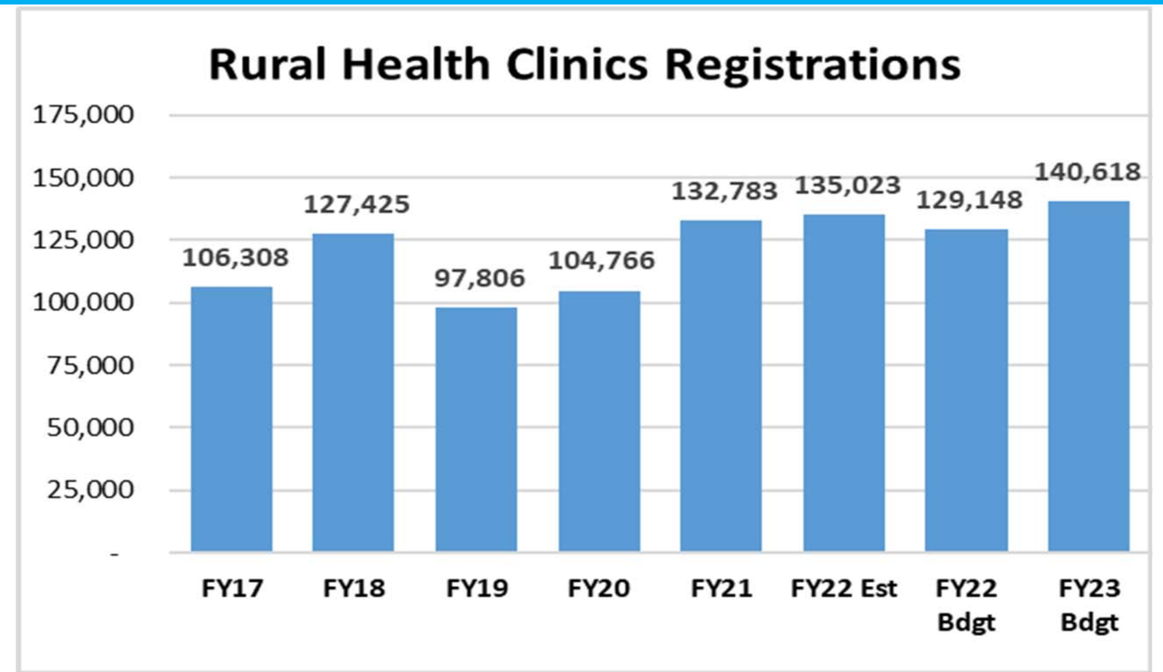

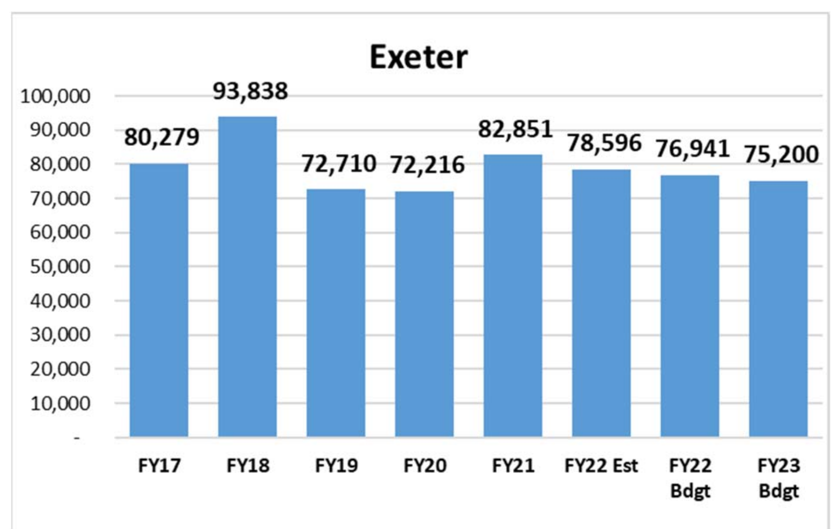

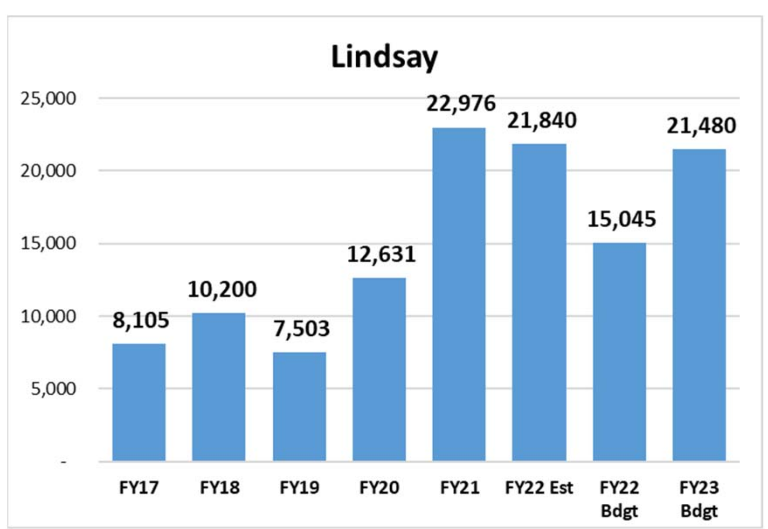

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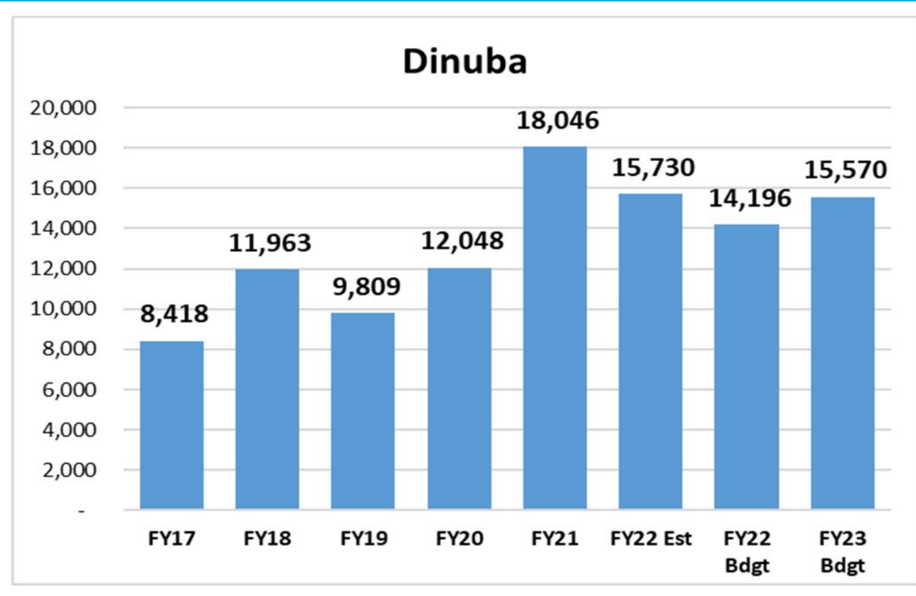

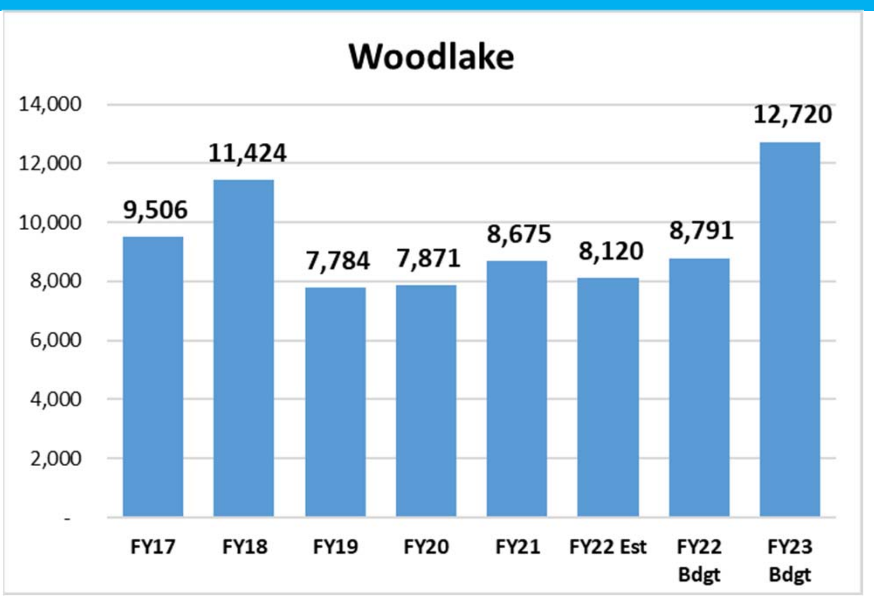

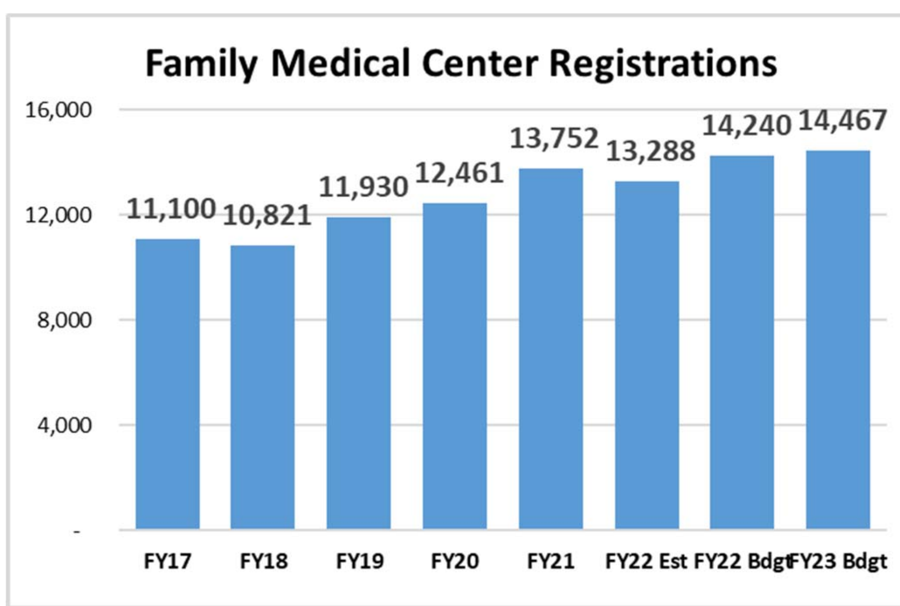

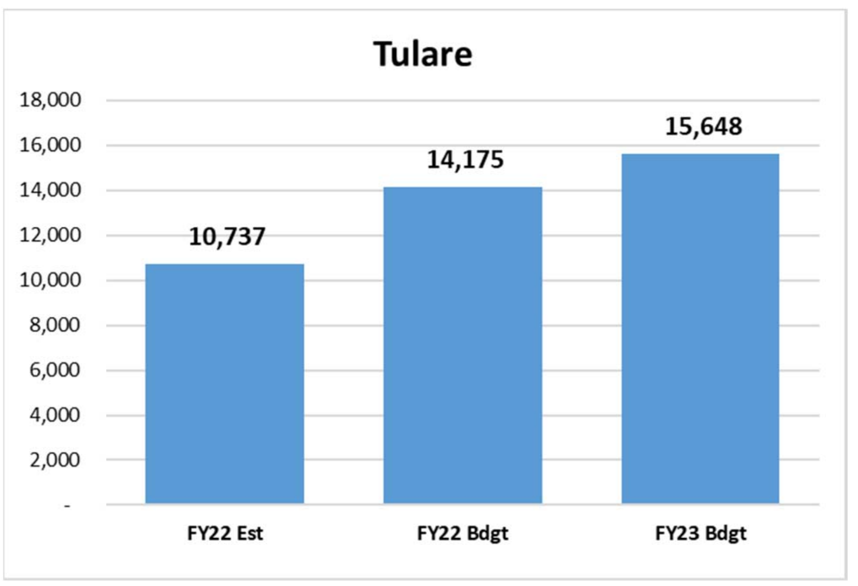

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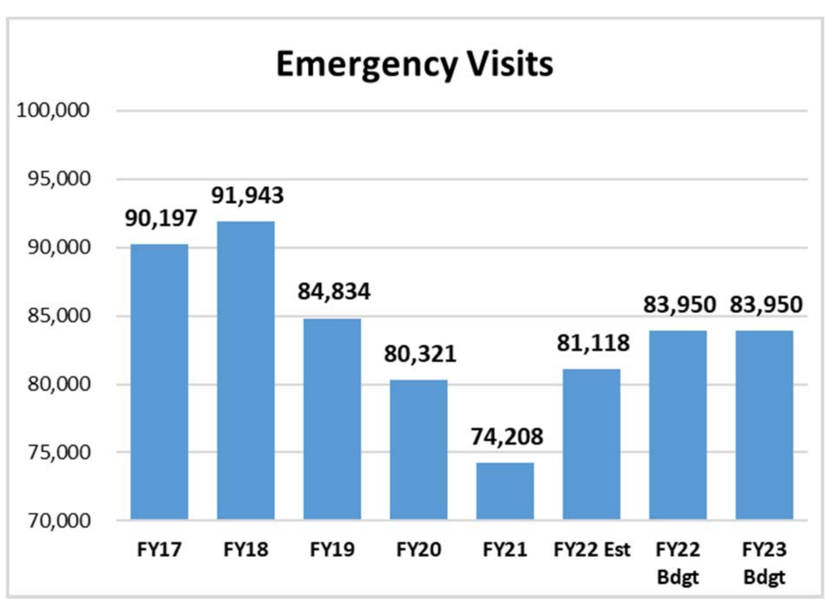

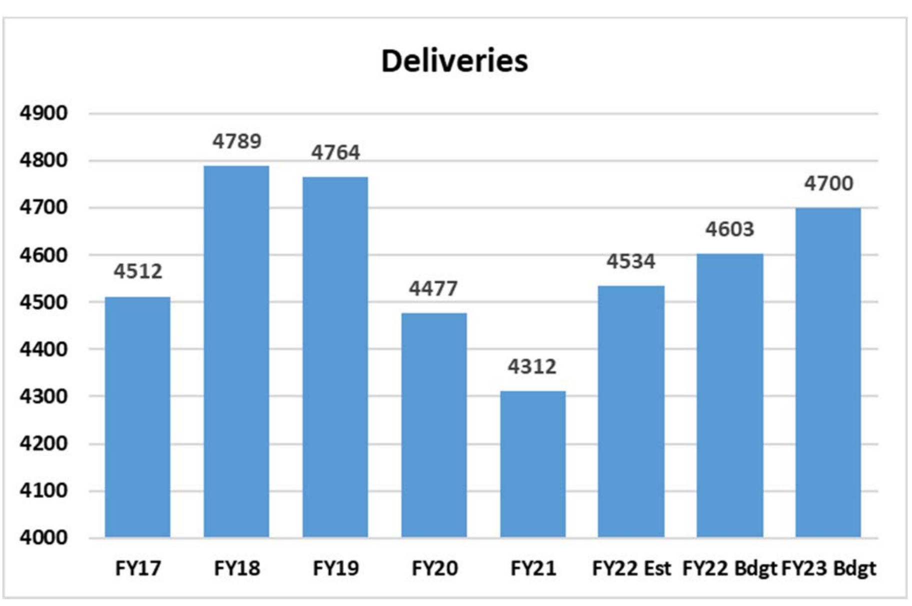

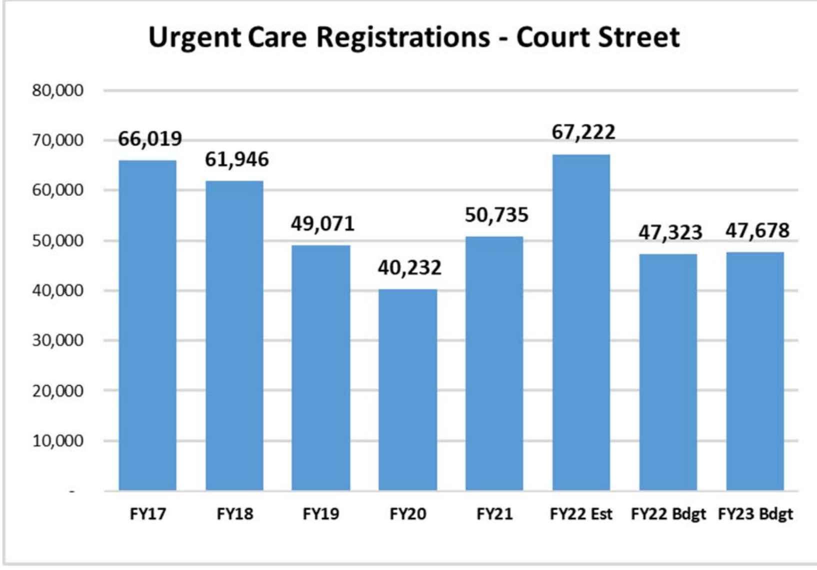

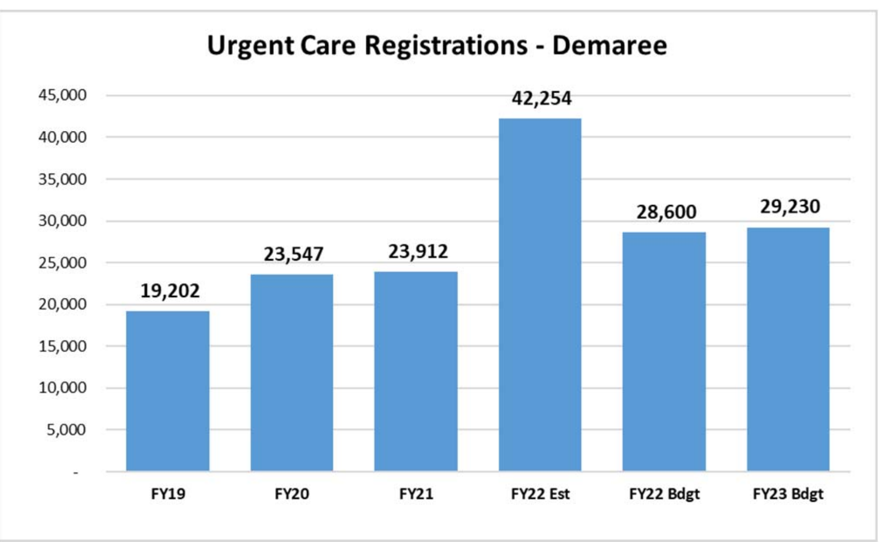

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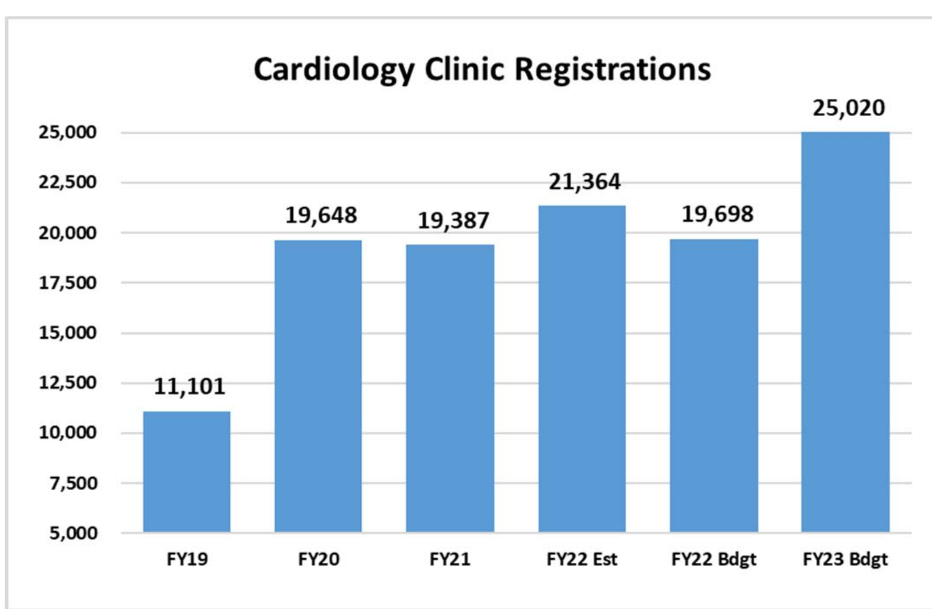

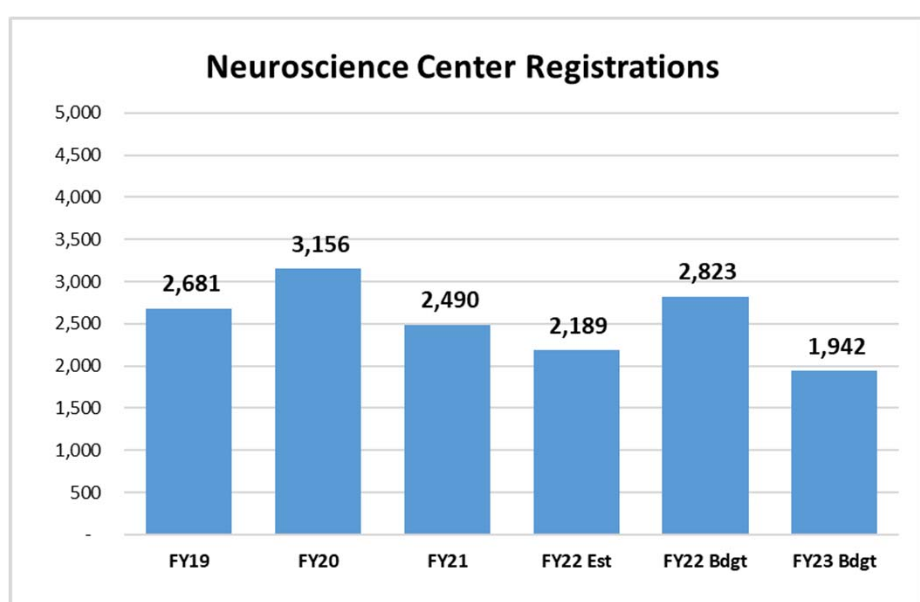

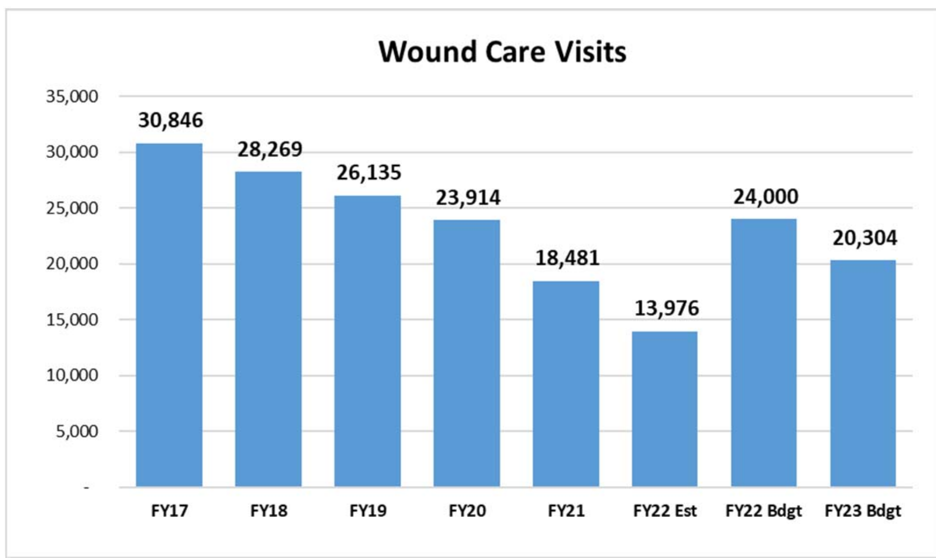

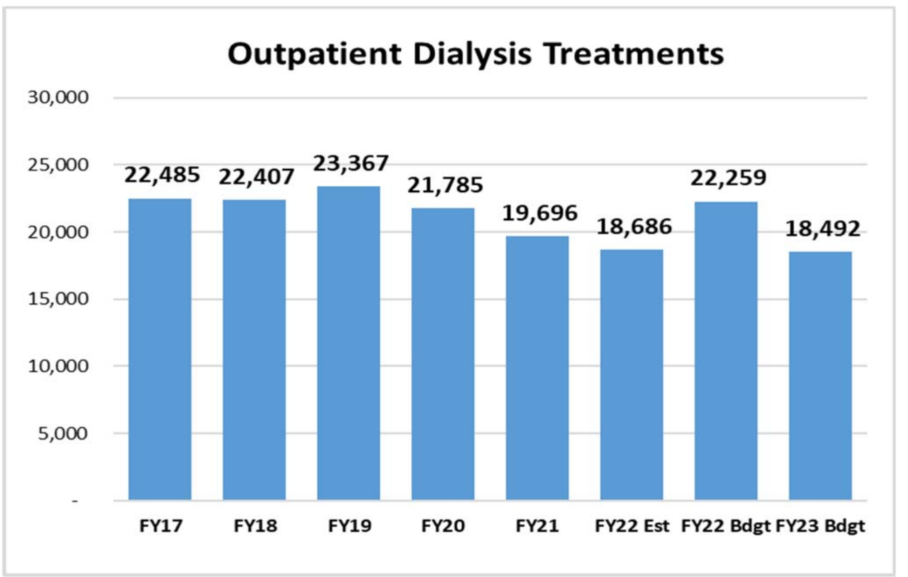

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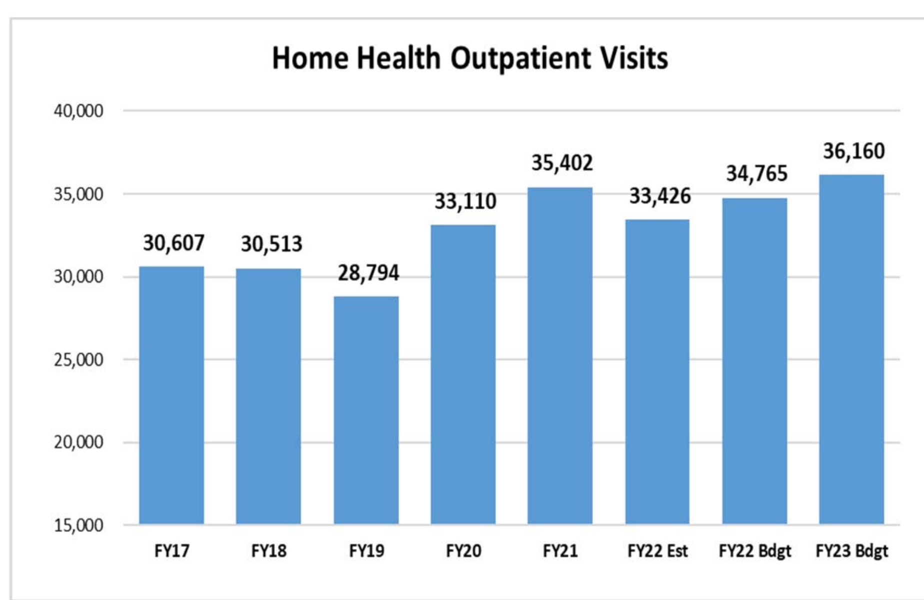

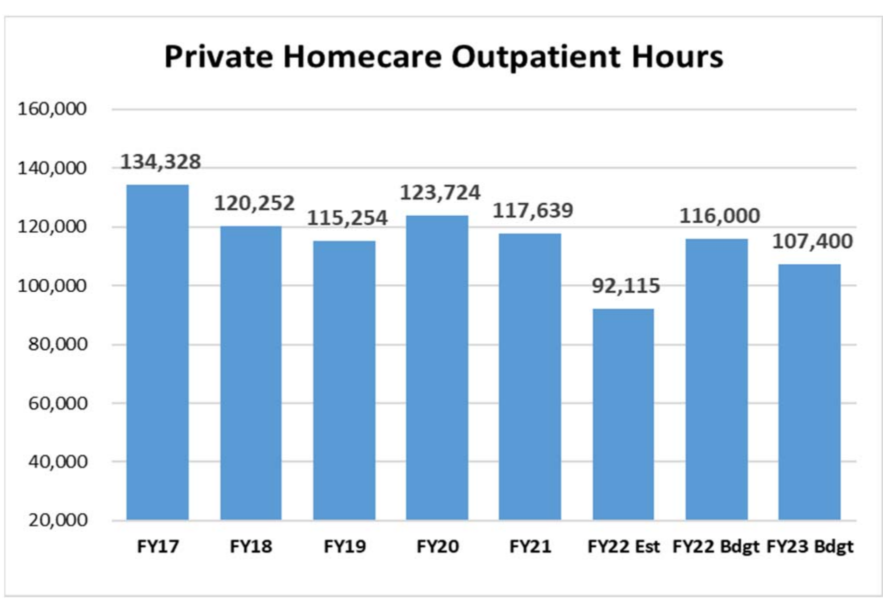

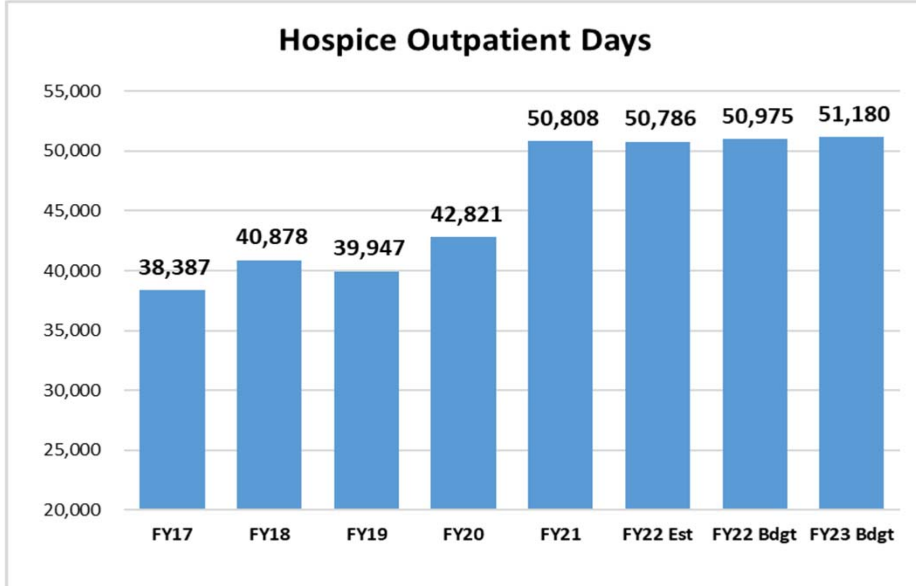

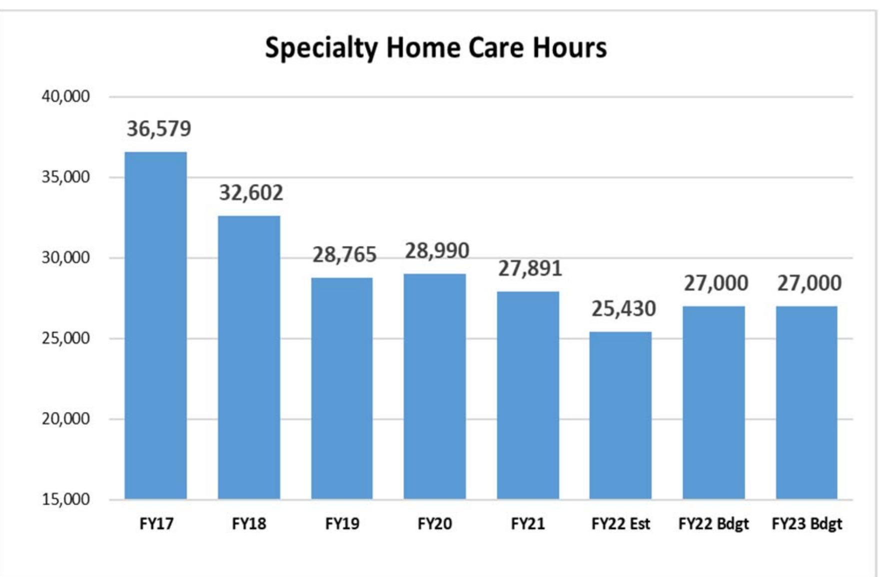

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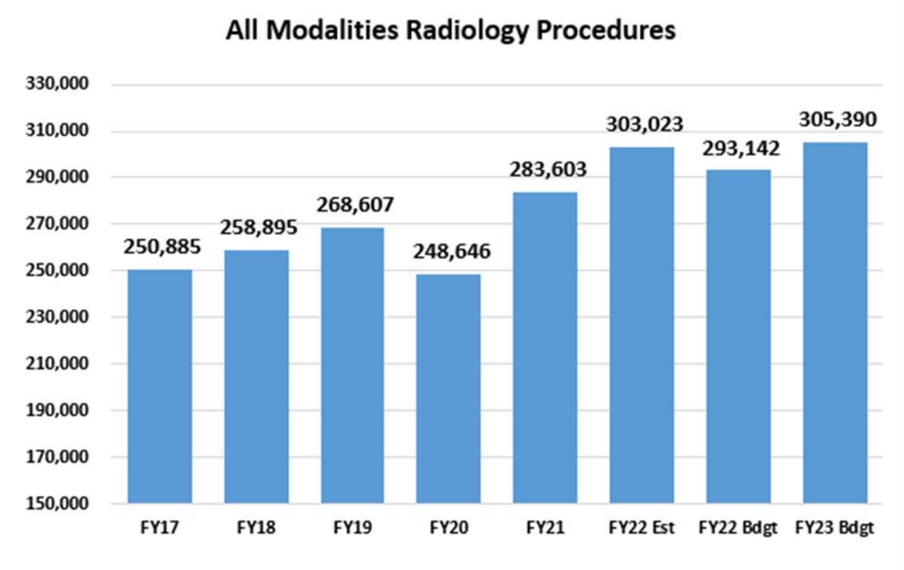

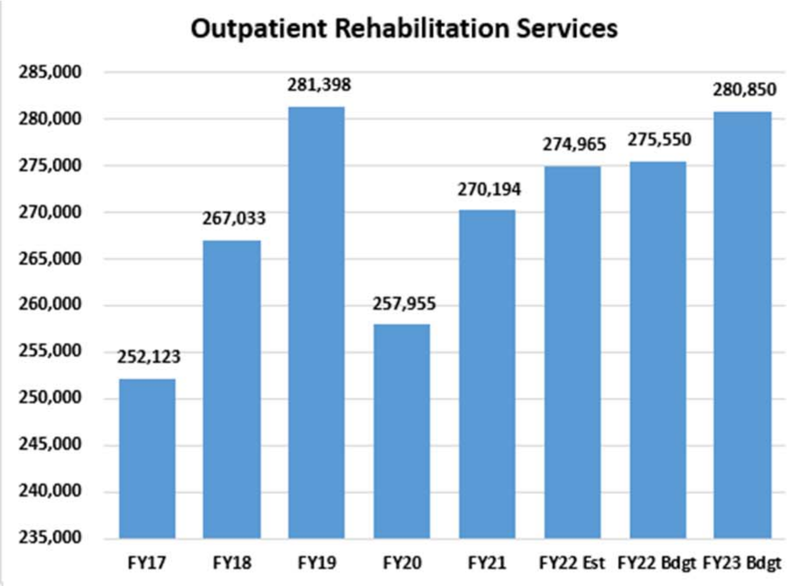

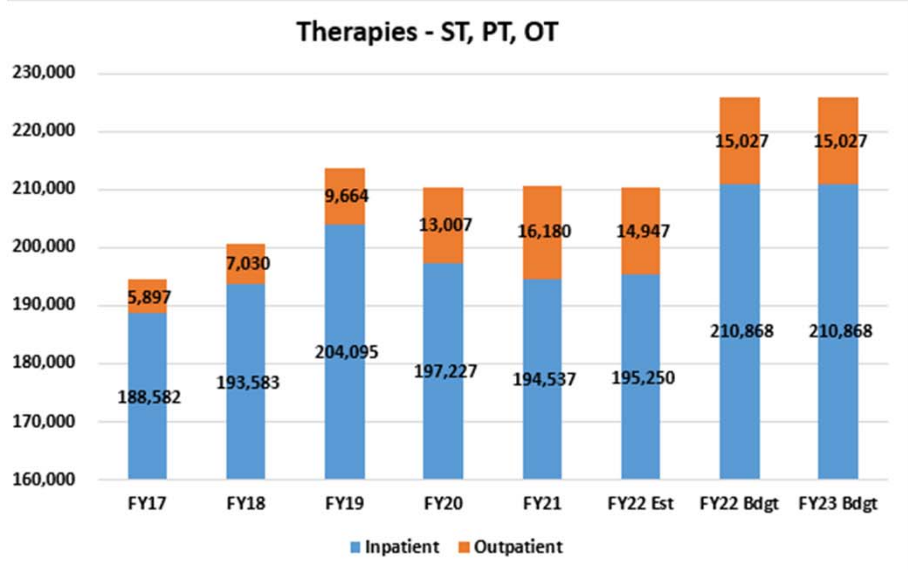

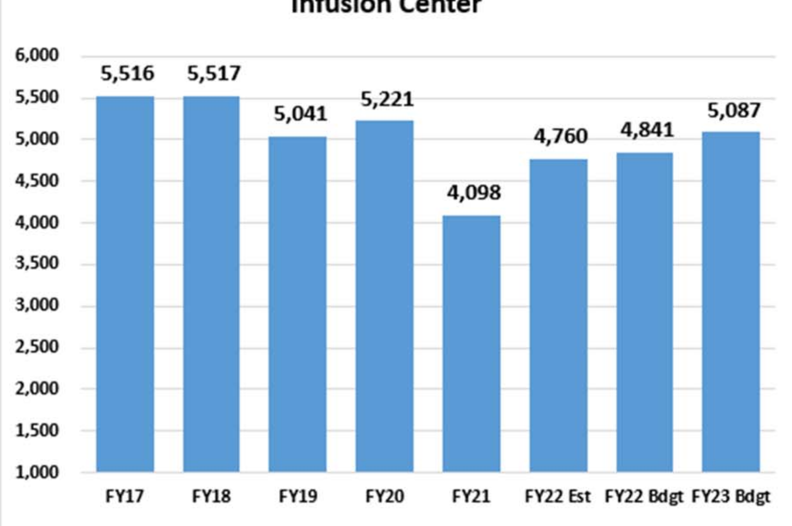

FY23 Capital Detail related to Infrastructure $6,187,053

Requested Item	Dept	Amount
Server farm	ISS	574,261
New Telesitter Solution Avasure	ISS	549,254
Network switches...	ISS	469,182
District Wide: Roofing Repair & Replacement	Maintenance	400,000
Medical Center: Nurse Call System Replacement	Maintenance	350,000
Medical Center: CoGen Turbine Refurbishment	Maintenance	290,760
District Wide: HVAC Repair & Replacement	Maintenance	252,500
Medical Center: Exterior Maintenance	Maintenance	225,000
TLC: Locker Rooms - Locker Replacement	Maintenance	225,000
West Expansion Fire Alarm Modernizations	Facilities	195,500
Medical Center: Interiors	Maintenance	181,000
Parking Lot Maintenance	Maintenance	170,000
Passive Distributed Antenna System	ISS	153,256
Additional Scope for Master Plan (CIP260)	Facilities	152,714
Medical Center: Laundry Air Compliance Project	Maintenance	150,000
Dialysis Clinic Improvements	Facilities	145,000
TLC: Pool-Pak HVAC Unit	Maintenance	140,000
KHMH Facility Improvement: Replace Nurse Stations	Facilities	125,000
CEHRT Cures Act Compliance	ISS	106,498
Convert Old MK NICU to New Prep/Holding Space	Facilities	105,000
Kaweah Care District Refurbish	Facilities	100,000
Misc. Moves/Furnishings	Facilities	100,000
Small Projects Contingency	Facilities	100,000
Medical Center: East Electrical Yard Power Upgrade	Maintenance	88,000
KHMH Maintenance Items: Door & Door Hardware	Maintenance	85,000
Surgeon Lounge and Locker Facility Modernization	Facilities	84,000

Requested Item	Dept	Amount
Medical Center: Boiler Replacement	Maintenance	75,000
AUC Codes in KD Hub and on patient bills - regulatory	ISS	68,452
Radiology: Misc costs for OSHPD approvals	Facilities	50,000
Cloverleaf Upgrade	ISS	47,939
Crescendo EMR for Hospice	ISS	47,614
PCQC Interface from KD Hub	ISS	45,851
Tracemaster Data Archival	ISS	40,330
Lovers Lane Therapy Specialists Clinic: New flooring	Maintenance	39,900
Rehab: Phase 8 Refurbishment	Maintenance	35,000
Exeter Campus: flooring work needed.	Maintenance	27,745
TLC: Duct Cleaning	Maintenance	25,000
KHMH Facility Projects: Extend Wall in Courtyard	Facilities	24,500
High-speed batch document scanner for HIM	ISS	19,090
UiPOC Upgrade	ISS	15,871
MRI Vitals Signs Monitor Integration with KD Hub	ISS	15,278
KHMG RIS Platform upgrade	ISS	14,061
Physician Parking Lot Charging Stations	Facilities	12,600
KHMH Facility Projects: Additional 3 Patient Phones	Facilities	12,000
eCase Reporting	ISS	10,900
Crescendo EMR for Private Home Care	ISS	7,663
Nihon Kohden Test System	ISS	7,521
KHMH Facility Projects: Replace Admissions Desk	Facilities	7,500
Hand Therapy Specialist: replacment of flooring	Maintenance	7,360
TLC: Circulation Pump/Motor for Pool/Spa	Maintenance	6,500
Additional POC Interface to KD Hub	ISS	6,453

FY23 Capital Detail related to Director Requests $9.8M

Department	Amount	Department	Amount
ISS Applications Services	3,611,622	Lynn Havard Mirviss Educ Ctr	44,948
MRI-KDIC	2,500,000	Emergency-ED	40,237
Intensive Care-ICU-2W	1,040,978	Food & Nutrition Svcs-West	38,662
Cardiac Cath Lab	1,000,000	OB Postpartum	36,680
ISS Technical Services	1,000,000	Pharmacy-Primary Operations	31,842
Clinical Engineering	845,871	Noninvasive Cardiology	29,038
Surgery	836,673	Sterile Processing	19,576
Radiology-KDMC	651,000	Subacute	16,902
Endoscopy	619,796	CT Scan-KDMC	16,000
Urology Clinic	600,000	M/S Cardiac-2N	14,941
Labor Delivery	408,070	Environmental Svcs-KDMC	10,000
Maintenance-KDMC	263,880	Acute Psych	9,629
Security Services	240,743	Acute Rehab	8,853
Facilities Planning	212,220	Laundry	6,000
Noninvasive Cardiology-KDDC	209,793		
Anesthesiology	182,564		
Respiratory Therapy	149,262	KHMG Radiology	304,714
Surgery Center-Ambulatory	107,582	KHMG Cardiology	247,801
Lifestyle Fitness Center	104,500	KHMG Laboratory	126,966
Dialysis-Acute	95,071	KHMG Sterile Processing	123,515
Pulmonary Function	59,565	KHMG Quick Care	8,669
Food & Nutrition Svcs-KDMC	53,833	KHMG Physical Therapy	6,571