Kaweah Delta Health Care District
Board Of Directors Committee Meeting

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

NOTICE

The Quality Council Committee of the Kaweah Delta Health Care District will meet at the Kaweah Health Lifestyle Fitness Center Conference Room {5105 W. Cypress Avenue, Visalia, CA} on Thursday, May 15, 2025:

- 7:30AM Closed meeting.
- 8:00AM Open meeting.

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

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

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

KAWEAH DELTA HEALTH CARE DISTRICT

David Francis, Secretary/Treasurer

Kelsie Davis

Board Clerk / Executive Assistant to CEO

DISTRIBUTION:

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

Kaweah Delta Health Care District
Board Of Directors Committee Meeting

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Kaweah Delta Health Care District Board of Directors Quality Council
Meeting held: Thursday, May 15, 2025 • Kaweah Health Lifestyle Fitness Center Conference Room
Attending: Board Members: Michael Olmos (Chair), Dean Levitan, MD; Gary Herbst, CEO; Schlene Peet, Interim Chief Nursing Officer; Paul Stefanacci CMO/CQO; Julianne Randolph, OD, Vice Chief of Staff and Quality Committee Chair; LaMar Mack, MD, Quality and Patient Safety Medical Director; Sandy Volchko, Director of Quality and Patient Safety; Ben Cripps, Chief Compliance and Risk Management Officer; Evelyn McEntire, Director of Risk Management; Cindy Vander Schuur, Patient Safety Manager; and Kyndra Licon, Recording.

OPEN MEETING – 7:30 AM

1. **CALL TO ORDER –** Mike Olmos, Committee Chair

2. **PUBLIC / MEDICAL STAFF 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 (Kelsie Davis 559-624-2330) or kedavis@kaweahhealth.org to make arrangements to address the Board.

3. **Approval of Quality Council Closed Meeting Agenda – 7:31 AM**
    - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – Julianne Randolph, DO, Vice Chief of Staff and Quality Committee Chair; Mara Miller, PharmD, BCPA, Medication Safety Coordinator.

    - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – Evelyn McEntire, RN, BSN, Director of Risk Management; Ben Cripps, Chief of Compliance and Risk Officer; Cindy Vander Schuur, RN, BSN, Patient Safety Manager

4. **ADJOURN OPEN MEETING –** Mike Olmos, Committee Chair

CLOSED MEETING – 7:31 AM

3. **CALL TO ORDER –** Mike Olmos, Committee Chair

Kaweah Delta Health Care District
Board Of Directors Committee Meeting

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4. **Approval of April Quality Council Closed Session Minutes –** Mike Olmos, Committee Chair; Dean Levitan, Board Member
    - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – Julianne Randolph, DO, Vice Chief of Staff and Quality Committee Chair; Mara Miller, PharmD, BCPA, Medication Safety Coordinator.

5. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management; Ben Cripps, Chief Compliance and Risk Officer.*

6. **ADJOURN CLOSED MEETING –** Mike Olmos, Committee Chair

OPEN MEETING – 8:00 AM

1. **CALL TO ORDER -** Mike Olmos, Committee Chair

2. **PUBLIC / MEDICAL STAFF PARTICIPATION –** Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves at this time. Members of the public or the medical staff may comment on agenda items after the item has been discussed by the Committee but before a Committee recommendation is decided. In either case, each speaker will be allowed five minutes.

3. **Approval of April Quality Council Open Session Minutes -** Mike Olmos, Committee Chair; Dean Levitan, Board Member

4. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives:

    4.1 Workplace Violence Annual Quality Report
    4.2 Trauma Quality Report

5. **Leapfrog Hospital Safety Score –** A review of Kaweah Health letter grad eon performance in preventing medical errors, infections, and other patient safety issues. *Erika Pineda, RN, Quality & Patient Safety Manager.*

6. **Clinical Quality Goals Update –** A review of current performance and actions focused on the clinical quality goals for Sepsis, and Healthcare Acquired Infection. Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.

Kaweah Delta Health Care District
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7. ADJOURN OPEN MEETING - Mike Olmos, Committee Chair

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.

Agenda item intentionally omitted

OPEN Quality Council Committee
Thursday, April 17, 2025
The Lifestyle Center Conference Room

Attending: Board Members: Mike Olmos (Chair) & Dean Levitan, Board Member; Gary Herbst, CEO; Sandy Volchko, Director of Quality & Patient Safety; Cindy Vander Schuur, Patient Safety Manager; Ryan Gates, Chief Population Health Officer; Jag Batth, Chief Operating Officer, Schlene Peet, Interim Chief Nursing Officer; Mark Mertz, Chief Strategy Officer; Dr. Mack, Medical Director of Quality & Patient Safety; Evelyn McEntire, Director of Risk Management; Emma Camarena, Director of Clinical Nursing; Erika Pineda, Quality Improvement Manager; Shawn Elkin, Infection Prevention Manager; Cheryl Smit, Manager of Stroke; Sonia Duran Aguilar, Director of Population Health Manager; Tiffany Bullock, Director of Home Health & Home Care Services; Shannon Esparza, RN – OASIS Coordinator/Education; Melany Gambini, Director of Hospice Services ; Kyndra Licon – Recording.

Mike Olmos called to order at 8:33 am.

Approval of Closed Session Agenda: Dean Levitan made a motion to approve the closed agenda, there were no objections.

Mike Olmos adjourned the meeting at 8:34 am.

Mike Olmos called to order at 8:34 am.

3. **Approval of March Quality Council Open Session Minutes –** Mike Olmos, Committee Chair; Dean Levitan, Board Member.
    - Approval of March Quality Council Open Session Minutes by Dean Levitan and Mike Olmos.
4. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives: **–** reviewed, no questions. Mike commented on how well the report was completed.
    - **4.1 Quality Dashboard – Centers for Medicaid and Medicare Services**
    - **4.2 Hospice Quality Report**
    - **4.3 Home Health Quality Report**
      SHP National and State observed score. Dr Levitan asked how is the improvement in grooming assessed. It's a series of questions that are structured on how to get groomed broken down in sections. The nurses know how to look at every single element. Gary – I do see for Kaweah over all we are at 89.3% almost 3% above the state we are doing well compared to the state national benchmarks but month to month varies.
    - **4.4 Cardiology Services (ACC) Quality Report**

5. **Stroke Quality Report –** A review of key quality performances and action related to the care process in the Stroke program. *Cheryl Smit, BS, RN, Manager of Stroke*.

   The Stroke Program survey was conducted on March 14th, with a primary focus on reviewing data, clinical processes, and quality improvement efforts. The survey was well-received overall, with several positive comments. The surveyor was impressed by the inclusion of resident involvement, which is not common across all facilities. Some findings focused on opportunities

for additional staff education and training. Regarding NIH Stroke Scale evaluations, nurses currently complete recertification annually. To align with national standards, the process has been modified to complete full certification every two years, with interim skill assessments conducted in off years to ensure continued competency. A stroke risk adjustment model has been developed, and the team continues efforts to educate the community and raise awareness around stroke symptoms and care. The stroke alert response process has been refined. When symptoms are identified, staff now initiate a RRT call and involve both the attending physician and a neurologist promptly. The surveyor identified opportunities in quality improvement efforts, noting that some key metrics—door-to-CT time and thrombolytic administration time—have not shown measurable improvement. She challenged the team to reassess and strengthen the current quality improvement program. Of the six charts reviewed, two lacked the use of a stroke order set, despite overall 90% compliance. This highlights the need for greater consistency. Collaboration is ongoing with Dr. Oldroyd, ED providers, and Sound Physicians to reinforce stroke order set usage and ensure it is consistently applied in clinical workflows. A compliance gap was noted in core measure metric reporting. While data was collected for the comprehensive stroke measure, it was not submitted. This oversight has since been addressed. A high-level 2025 action plan was reviewed, with an emphasis on: Establishing regular meetings with key leaders, clarifying roles, responsibilities, and expectations for committee members, focusing efforts on three core metrics: stroke-related mortality, door-to-CT time, and thrombolytic administration time. Dr. Levitan inquired about whether the focus will remain on the ED process, prompting Cheryl to outline the stroke response protocol, including care pathways for patients arriving via EMS or walking into the ED. Patients requiring a higher level of care are transferred to CRMC, with USC as the backup facility. Rapid Staff Wire is being used to enable real-time image sharing with receiving hospitals to improve response time and continuity of care. Jag reported that currently two neurologists are covering all stroke calls, with additional candidates being interviewed. The organization is moving forward with implementing a tele-neurology platform, supported by Ben, with contract finalization in progress. This system will allow 24/7 video consultation for stroke patients, with implementation expected over the next 3–4 months. Dr. Stefanacci recognized the discussion, highlighting the importance of understanding workflow from EMS arrival through CT scan, diagnosis, treatment, and reassessment. A major area of focus will be enhancing performance in time-sensitive care delivery, especially: Door-to-CT time and Door-to-thrombolytic time. These areas will be the primary focus of the Performance Improvement project for 2025. Dr. Oldroyd is leading efforts related to order set utilization and evidence-based care, with efforts underway to elevate compliance levels toward benchmark goals. Mike extended his appreciation to the stroke team for their dedication and commitment to continuous improvement.

6. **Health Equity Quality Report –** A review of completed and planned initiatives to identify and address health equity. *Sonia Duran-Aguilar, MSN, MPH, RN, PHN, CNL, CRHCP, Director of Population Health Management; Ryan Gates, PharmD, CRHCP, Chief Population Health Officer.*

The Joint Commission now requires data collection and QI work focused on health equity, and the organization has identified pregnant female farm workers as the population of focus for addressing healthcare disparities. We have ensured that the infrastructure is in place to report on equity-related elements, and implementation of tools and workflows has already begun. A CMS Health Equity Report is due in less than a month, with a key focus on social needs screening. Assembly Bill (AB) 1204 (via HCAI) requires acute care, psychiatric, and children's hospitals to submit two equity-focused plans by September 2025. A 60-day extension may be requested up to September 30, 2025, with a $5,000 penalty for non-compliance. The three structural and core quality measures are being reviewed; the greatest compliance risk currently lies with psychiatric hospital reporting, and ISS is actively working on this. AB 3161, effective January 2026, mandates specific demographics be submitted for all CDPH-reportable events with a $5,000 fine for non-compliance.
Equity Data and Screening Tools: Our PREPARE social needs screening tool went live on December 12, 2023, supported by IT. It includes:

- 15 standardized questions plus 5 additional questions assessing essential needs.
- The tool has been rolled out in both inpatient and outpatient settings.
- It is currently required for patients aged 18+, with low initial completion rates.
- Common themes identified include housing instability (noted in 34% of respondents).
- Staff suggested using iPads for privacy to increase response rates.

Grant Programs and Partnerships:
HRSA Care Coordination Grant ($1.2M over 4 years – currently in Year 2):

- Target: 40 participants
- Current: 21 enrolled, 23 active mothers
- Focus: Integration of community health workers at Lindsay Rural Health Clinic for pregnant individuals.

DHCS EPT Program ($710K over 3 years – Year 1): Kaweah is one of four participating hospitals.
MOVES Grant ($1.8M over 3 years – Year 1): Focuses on social determinants of health and reducing barriers to care for Centene members.
A Behavioral Health Mobile Clinic is under development and expected to go live by August 2025.
Population Health Home Base: 623 Willow, across from the pharmacy. Housing Efforts: The organization has housed 62 individuals experiencing homelessness. The state's direction on DEI (Diversity, Equity, and Inclusion) efforts may evolve under future administrations. However, internal leadership reaffirmed its commitment to continuing these equity efforts regardless of external changes.

7. **Clinical Quality Goals Update**- A review of current performance and actions focused on the clinical quality goals for Sepsis, and Healthcare Acquired Infections. *Shawn Elkin, Infection Prevention Manager; Erika Pineda, Quality and Patient Safety Manager.*

- 0 CAUTI, 0 MRSA events in current period.
- CAUTI SIR: 0.36, exceeding the goal of 0.34
- 2 MRSA events in current period. Increasing our SIR to 1.34, exceeding the goal of .435. one patient was admitted with MRSA, the second patient developed infection post-endocarditis diagnosis. Antibiotics response testing and patient movement may have influenced event classification.
- Key strategies in progress include Medical staff discussion or a consensus statement on removal of femoral lines, enhanced line management protocols including rounds assessing line necessity,

dressing integrity, and timeliness of removal. Regarding MRSA action plans, All SNF transferred patients are now assessed for MRSA risk and are receiving decolonization treatment

- A comprehensive initiative is being prepared, led by Schlene, focused on purposeful line rounds and early removal.
- SEP 1 has met goal for the last 5 months. Targeted opportunities are Antibiotic Administered 91% compliance and Blood Cultures Collection 93% compliance; goal is 95%. Patients with Sepsis that Received Abx within 60 Minutes of patient 1st seen by ED Provider 29.7% and Patients met 1-Hr Bundle 26.9% compliance; goal is 30%. IV Fluid Resuscitation is meeting goal of 95% compliance.

Review page 107 for meeting notes on sepsis

Adjourn Open Meeting – *Mike Olmos, Committee Chair*

Mike Olmos adjourned the meeting at 9:39am.

2024 Workplace Violence Prevention Program Annual Review

Maribel Aguilar, Safety Officer

Safety Specialists Claudia Razo and Miguel Morales

Regulatory Compliance

California Code of Regulations, Title 8, Section 3342

Violence Prevention in Health Care

- The employer shall establish, implement and maintain an effective workplace violence prevention plan (Plan) that is in effect at all times in every unit, service, and operation.
- The written shall include all of the following elements:

  (9) Assessment procedures to identify and evaluate environmental risk factors, including community-based risk factors, for each facility, unit, service, or operation. This shall include a review of all workplace violence incidents that occurred in the facility, service, or operation within the previous year, whether or not an injury occurred.
- For fixed workplaces: Procedures to identify and evaluate environmental risk factors for workplace violence in each unit and area of the establishment, including areas surrounding the facility such as employee parking areas and other outdoor areas.

Administrative Policy 161 – Workplace Violence Prevention Plan

Kaweah Health worksite analysis

Proactive efforts

- Daily safety huddle identifies the location(s) of at-risk patients based on Broset violence risk screening.
- Daily security shift pass downs identify the location(s) of high-risk areas of the hospital, and areas where violent acts have occurred in the last shift.
- The violence electronic flag system notifies staff of individuals who have had a violent incident(s) in the past, and who are present at the hospital or off-site location based on patient registration.
- The workplace violence toolkit resource was added to Kaweah Compass for ease of access.
- Weekly hazardous surveillance rounds are conducted by both security and safety to identify areas where workplace violence could occur and take steps to mitigate risk in those areas.
- The workplace violence case review team meets bi-weekly to review workplace violence incidents and establish a root cause of those events. Results are taken back to the unit for training purposes, and results are shared with the workplace violence prevention committee to better inform of workplace violence trends.
- The workplace violence prevention committee meets quarterly to discuss trends, identify areas of improvement, and formulating plans to prevent workplace violence.
- Key takeaways from case review sent to Leadership Team.
- The workplace violence prevention committee meets quarterly to discuss trends, identify areas of improvement, and formulating plans to prevent workplace violence.
- Annual mandatory trainings featuring several workplace violence prevention topics are required of all staff at Kaweah Health.
- Security Services' annual risk assessments of the environment and identification and mitigation of potential threats
- Crisis Prevention and Intervention training is conducted on an annual basis for staff, unit leaders, and non-clinical staff who work in high-risk areas or who can come in contact with workplace violence.
- Crisis Prevention and Intervention training with advanced physical skills is conducted annually with staff who work at the Mental Health Hospital.
- Ad Hoc Safety Task Force

Kaweah Health worksite analysis

Proactive analysis of the worksite - Environmental risk factors

Any employees working in locations isolated from other employees because of being assigned to work alone or in remote locations, during night or early morning hours, or where an assailant could prevent entry into the work area by responders or other employees.	No noted deficiencies
Is there a lack of physical barriers between employees and persons at risk of committing workplace violence?	No noted deficiencies
Is there poor lighting or blocked visibility of areas where possible assailants may be present?	No noted deficiencies
Is there a lack of effective escape routes?	No noted deficiencies
Panic-duress alarm systems in place and operational?	Noted deficiencies. The Emergency Department and the Mental Health Hospital are using a third-party panic-duress alarm system. The system is not working effectively at either site. Also, the project to replace the Medical Center's existing end-of-life fixed panic-duress alarm system with modern Siemens system has not been completed.
Are there obstacles and impediments that prevent staff from accessing alarm systems?	No noted deficiencies
Are authorized personnel doors/exit only doors accessible by the public or other unauthorized persons?	Deficiencies were identified at six Kaweah Health sites 1. Radiology, Hosp. 2. KH Imaging 3. NICU (AW 6th floor) 4. Medical Clinic @ Ben Maddox 5. Rehab Hospital 6. RHC, Exeter – deficiency also noted in 2023 assessment Unit leadership has been notified, and work orders have been submitted with a request to review and correct the noted deficiencies.
Is there the presence of furnishings or any objects that can be used as weapons in the areas where patient contact activities are performed?	No noted deficiencies
Storage of high-value items, currency or pharmaceuticals in place?	No noted deficiencies

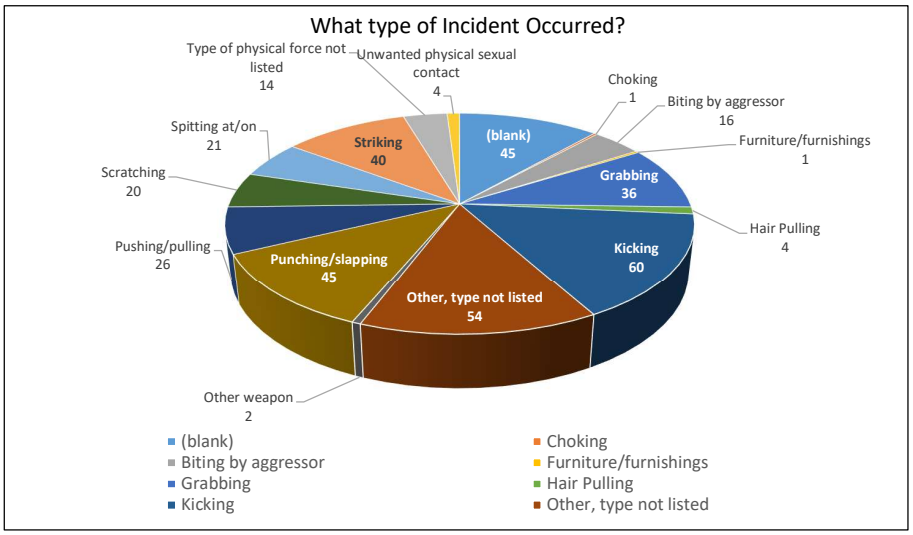
Midas System - Workplace Violence Incident Log Review

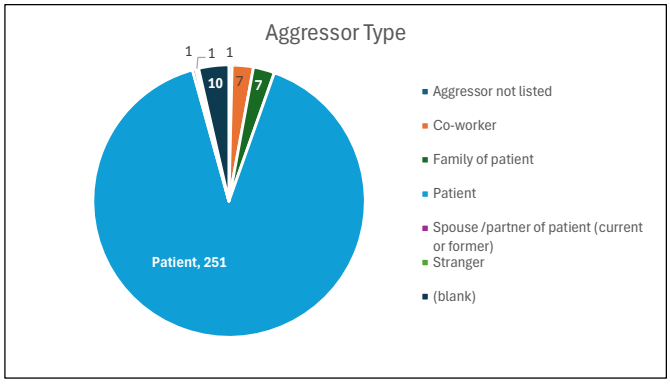
Where did the event take place?

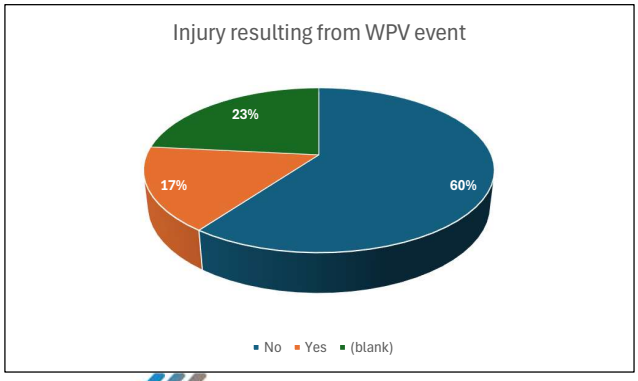
Department-Unit	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
1E (ED Admit Hold)												1	1
2 East (Labor & Delivery)	1					1							2
2 North	2	1					1	2	2	1			9
2 South	1	1	2	1								1	6
3 North	2		1		1		1	1				2	8
3 South	1	4	2				1				1		9
3 West (ICCU)				1					1				2
4 North (Renal)	1		1		1		2				1	1	7
4 South (Ortho/Observation)		1	5									1	7
4T Med Surg / Telemetry		1				2	1						4
5T Cardiovascular (ICCU)			1										1
Acute Psych East	13	15	11	8	10	5	9	19	16	7	5	6	124
Acute Psych West	7	2	6	6				1		14	31	9	76
Cardiovascular ICU							1		1				2
Emergency Department	1		1					2	2	1		1	8
Intensive Care Unit (ICU)							1					1	2
KH Medical Center							1			2			3
Mother/ Baby (Obstetrics)					1								1
Outpatient Visit							1						1
PACU- Post Anesthesia Care Unit (Flex Care)												1	1
Subacute					2								2
Therapy Outpatient (Rehab Hospital)						1							1
Visalia Dialysis							1						1
(blank)													
Grand Total	29	25	30	16	15	9	20	25	22	25	38	24	278

Data collected from Midas occurrence reporting system (WPV events) for the period from 01/01/2024 to 12/31/2024

WPV Incident Log Review

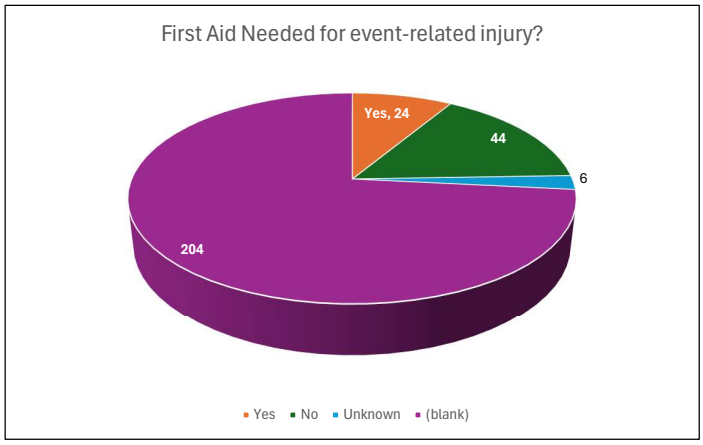


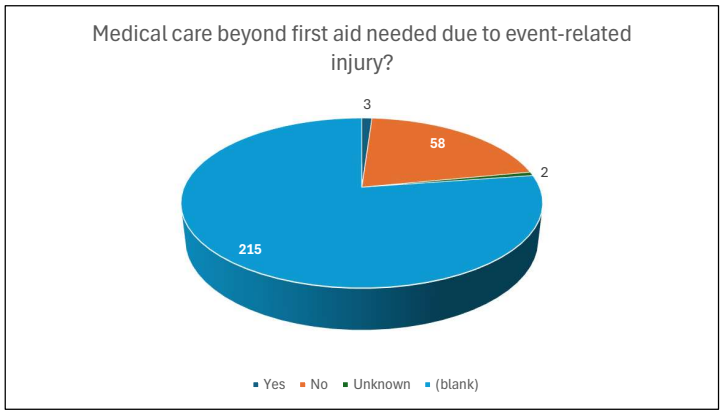


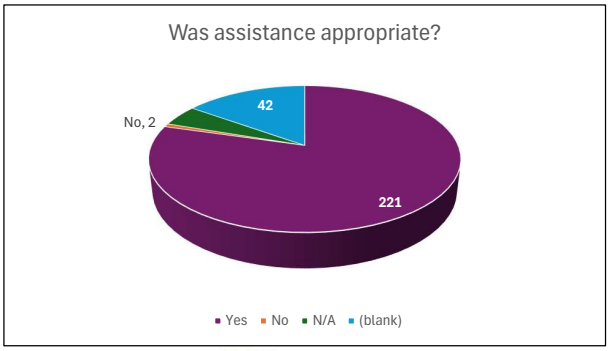


Data collected from Midas occurrence reporting system (WPV events) for the period from 01/01/2024 to 12/31/2024

WPV Incident Log Review







Data collected from Midas occurrence reporting system (WPV events) for the period from 01/01/2024 to 12/31/2024

Kaweah Health workplace violence incidents

Workplace Violence Events recorded by Security Services

	2024					2023
Location	Qtr01	Qtr02	Qtr03	Qtr04	Total	Total
2 North	1	1	6	4	12	12
2 South	5	1	3	3	12	2
2 West-ICU	1	0	3	0	4	2
3 North	0	4	2	5	11	10
3 South	6	5	5	6	22	9
3 Tower-CV ICU	0	0	0	1	1	5
3 West	1	0	5	0	6	3
4 North	9	2	1	9	21	10
4 South	3	10	6	7	26	14
4 Tower	3	4	4	0	11	11
5 Tower	0	1	0	1	2	8
ASC	0	0	0	0	0	0
Acequia Lobby	0	0	0	0	0	4
CT	0	0	0	0	0	1
Emergency Department	28	20	28	34	110	151
Exeter Clinic	0	0	0	0	0	0
Finance Bldg	0	0	0	0	0	0
Hospice	0	0	0	0	0	0
Kaweah Kids Center	0	0	0	0	0	0
Labor & Delivery	1	0	0	0	1	1
Lindsay Clinic	0	0	0	0	0	0

	2024					2023
Location	Qtr01	Qtr02	Qtr03	Qtr04	Total	Total
Mental Health	44	26	29	56	155	213
MK Lobby	0	0	0	0	0	1
Mother-baby	0	0	0	1	1	1
MRI	0	0	0	0	0	2
PACU	0	0	0	0	0	0
PBX-Operator	0	0	0	0	0	2
Parking Lot	1	2	0	0	3	5
Pediatrics	0	0	0	0	0	0
Public Area	0	0	0	0	0	0
Rehab Hospital	0	0	0	0	0	2
Respitory	0	0	0	0	0	0
SSB	0	0	1	0	1	0
Specialty Clinic	0	0	1	0	1	0
Sub-Acute, S. Campus	0	0	0	0	0	0
TLC	0	0	0	0	0	0
UCC, S. Court	0	0	0	0	0	1
Visalia Dialysis	0	0	0	0	0	0
Visalia SRCC	0	0	0	0	0	0
West Campus	0	0	0	0	0	1
X-Ray	0	0	0	0	0	0

Data collected from Security Services' incident reporting system for the period from 01/01/2024 to 12/31/2024

Kaweah Health workplace violence incidents

Occurrence Reporting: WPV Case Review Debriefs

	2024 – 68 cases												
Dept-Unit	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Grand Total**
ED	1		1					2	3	2		1	10
1 ED Admit Hold												1	1
2 North	2	1					1	2	2	1			9
2 East L&D	1					1							2
2 South	1	1	2	1									5
2 West							1						1
3 North	2		1				1	1					5
3 West	0	0	0	1									1
3 South	1	4	2				1				1		9
4 North	1		1				1				1	1	5
4 South		1	5									1	7
4 Tower		1				1	1						3
5 Tower			1										1
ICU		2											2
CVICU							1						1
Mother/Baby					1								1
Pop Health							1						1
OR												1	1
Visalia Dialysis							1						1
Subacute					2								2
Grand Total	**9**	**10**	**13**	**2**	**3**	**2**	**9**	**5**	**5**	**3**	**2**	**5**	**68**

← 62 total in 2023

Elements Reviewed

- Was the intended process flow followed?
- Was the WPV event related to human factors?
- Was the WPV event related to equipment failure?
- Was the WPV event related to environment failure?
- Was the WPV event related to staffing?
- Would training and/or education have prevented the WPV event?
- Was the WPV event related to failure in communication?

Data collected from Midas occurrence reporting system (WPV events) for the period from 01/01/2024 to 12/31/2024

The pursuit of healthiness

Kaweah Health
MORE THAN MEDICINE. LIFE.

Trauma Department

March 2025

Summary Information

TQIP Report

- Fall 2024 Benchmark Report
  - Data dates: April 2023 – March 2024
- All level III Trauma centers in the United States
  - 213 TQIP centers
- 105,811 patients included in this report (All patients)
  - 1,414 Kaweah Trauma patients

Hospital Registry

Year	Case Volume	% Change
2021	2,969	24.1%
2022	2,988	0.64%
2023	3,245	8.60%
2024	3,477	7.15%
2025	761	4% (YTD)

Reverification Survey

May 2024, We completed our Reverification Survey by The American College of Surgeons.

Results: We passed with a 1-year verification with corrective action.

Opportunities

- Trauma Registry Staffing Req. – 1 FTE per 600 registry cases
- Trauma Multidisciplinary PIPS committee Attendance
- Trauma Mortality Review

Solution

- Staffing: We have hired another registrar and currently have a Performance improvement nurse posted.
- Attendance: We currently have >80% attendance from our committee members. We now email and send out reminders via text the day before and day of the meeting.
- Mortality: All mortalities are fully reviewed at every meeting no matter if no opportunity for improvement is found during primary and secondary review.

Next Steps

- Corrective action documentation has been turned in 3 months early. We are waiting to hear back from them.

Door to Transfer

	Patients	Average Time to Transfer (minutes)			Difference from TQIP Average (minutes) and 95% Confidence Interval				
Cohort	N	Observed	Expected	TQIP Average	Difference	Lower	Upper	Outlier	Decile
Early Transfer	205	143	131	146	12	0	25	Average	7

Opportunity
Transferring Trauma patients for a higher level of care on average for our facility is observed to be 12 min on average longer than TQIP expects to transfer a patient. (Previous TQIP report we were observed 22 min on average longer, 10 min improvement)

Solution
Completed items: Early Recognition, Transfer Algorithm, and Monthly Dashboard

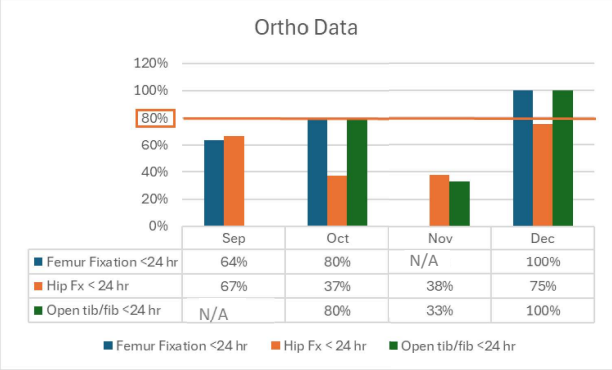
Transfer destination list: Creating a comprehensive transfer destination list and ranking trauma centers in California from closest to furthest is a significant step. This tool empowers our transfer center nurses with a clear roadmap for efficient patient transfers.

Transfer guidelines: Transfer center leadership is finalizing transfer call center guidelines so that staff understand patient transfer expectations.

Measures
We utilize our trauma registry program to measure the time from the patient's arrival to departure. We are required by the ACS to monitor all transfers out of our facility.

Next Steps
We will continue to monitor our transfer through chart review. We have no other identified opportunities for improvement outside of individual follow-up.

Orthopedic Trauma Care



	Sep	Oct	Nov	Dec
Femur Fixation <24 hr	64%	80%	N/A	100%
Hip Fx < 24 hr	67%	37%	38%	75%
Open tib/fib <24 hr	N/A	80%	33%	100%

	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
Total	6	6	12	12	10	10	5	4	0	0	2	2

Opportunity

- Decrease the amount of ortho transfers (Identified weakness)
- Increase Surgical block time for ortho injuries (Identified weakness)

Solution

- The recommendation was to recruit trauma fellowship trained surgeon (Completed Sept 2024)
- Add block time for ortho care (Completed Sept 2024)

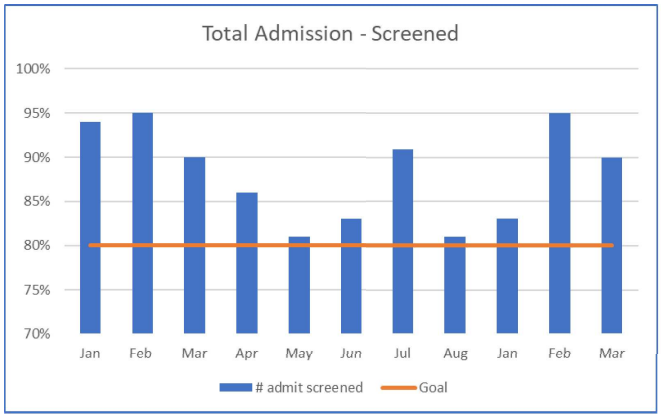
Measures

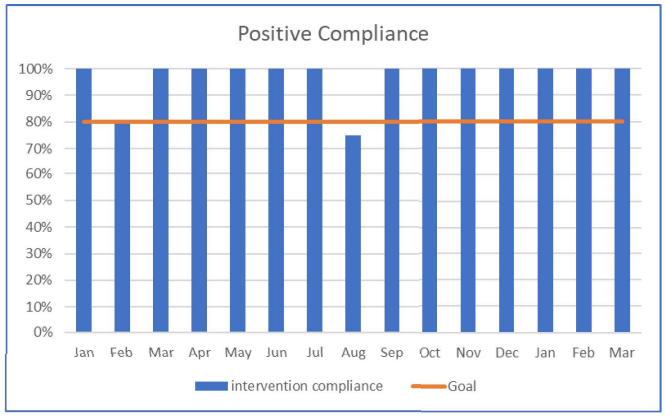
- We utilize our trauma registry to monitor the times for ortho injuries.
- Transfer Data comes from the transfer center.

Next steps

- As of now we have made significant amount of progress with this weakness by adding Dr. Dean and the block time in the OR. We are providing data to the ortho team for review every month so they can help us pinpoint opportunities.
- We will continue to monitor these cases for opportunities.

SBIRT





SBIRT is the process of screening patients for alcohol abuse utilizing our CAGE questionnaire and providing them with referrals for treatment in the event they have positive screen results.

SBIRT

Opportunity

During our last review, it was identified that we did not have a process for identifying patients who suffer from alcohol abuse and referral for treatment when they are identified.

Solution

EMR: The CAGE questionnaire triggers a task for PFS to provide a referral for treatment. (Completed)

Education: Registrar education on where to find alcohol screening in the inpatient units. (Completed)

Measures

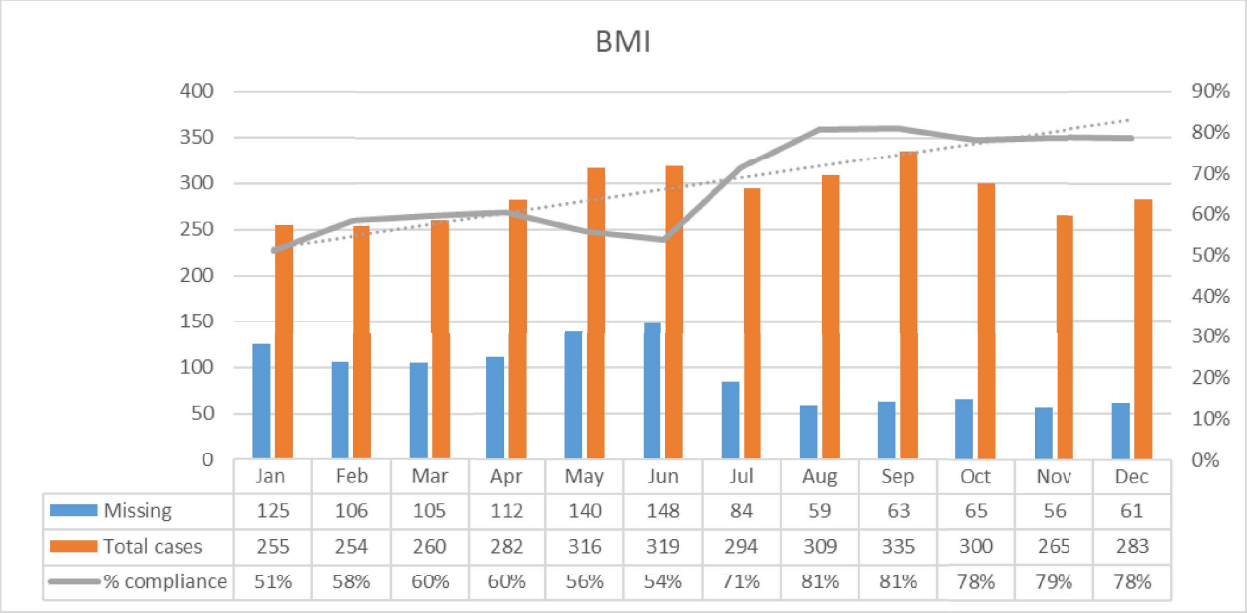
The process for measurement occurs through our DI registry system. Our registrars extract this information and input it into our system, which I review on a monthly basis.

Next Steps

As we continue to see compliance with interventions and the changes that were made early on, we identified another potential opportunity to increase our compliance with the screening.

We are working to identify a solution to capture those patients at this time.

BMI



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Missing	125	106	105	112	140	148	84	59	63	65	56	61
Total cases	255	254	260	282	316	319	294	309	335	300	265	283
% compliance	51%	58%	60%	60%	56%	54%	71%	81%	81%	78%	79%	78%

BMI

Opportunity

The lack of documentation of patients' height and weight affects care in many ways. Some examples include anesthesia for surgery, antibiotics, vent settings, etc.

Solution

Education: ED education was sent out on 3/2/23 via daily huddle.

EMR: Task added to every patient that comes to the ER on 5/3/23.

Equipment: Tape measures and scales were added to the ER on 6/2023.

Measures

The measurement process is through our DI registry system. Our registrars extract this information and input it into our system, which I review monthly.

Next Steps

EMR: ISS is working on pulling height from previous visits to help increase compliance. Completed 7/2024.

Trauma Flowsheet: We will add a spot on the written trauma flowsheet for height and weight. Completed 2/2025

Monitor for improvement

Community Outreach

Stop the Bleed

- Our goal this year is to train 500 community members this year
- 2025
  - Quarterly training with the Tulare County Health and Human Services for staff.
  - Sundale School at least 100 staff members in August

Back to School

- TBD on what education will be provided at this event (past: water safety, pedestrian safety)

STOP THE BLEED®

The pursuit of healthiness

Kaweah Health
MORE THAN MEDICINE. LIFE.

Kaweah Health Leapfrog Quality & Patient Safety Rating SPRING 2025

Quality & Patient Safety

May 2025

Leapfrog Scorecard Overview: SPRING 2025 & YTD

Measure Domain	Measure	Kaweah Health Score (Most Recent YTD)	Most Recent Timeperiod (Most Recent YTD)	Kaweah Health SPRING 2025 Score	SPRING 2025 Score Timeperiod	Leapfrog SPRING 2025 Mean	Final Weight (N/A redistributes)
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	100	2024	**100**	2024	80.21	**6.2%**
	Bar Code Medication Administration (BCMA)	100	2024	**100**	2024	81.84	**6.0%**
	ICU Physician Staffing (IPS)	100	2024	**100**	2024	65.13	**6.9%**
	Safe Practice 1: Culture of Leadership Structures and Systems	120	2024	**120**	2024	117.49	3.1%
	Safe Practice 2: Culture Measurement, Feedback, & Intervention	120	2024	**120**	2024	116.86	3.2%
	Total Nursing Care Hours per Patient Day	100	1/1/2023 - 12/31/2023	**100**	01/01/2023 - 12/31/2023	77.08	4.7%
	Hand Hygiene	40	2024	**40**	2024	74.38	4.9%
	H-COMP-1: Nurse Communication	82.10	2/2024-1/2025	**89.00**	01/01/2023 - 12/31/2023	90.19	3.0%
	H-COMP-2: Doctor Communication	80.70	2/2024-1/2025	**89.00**	01/01/2023 - 12/31/2023	89.91	3.0%
	H-COMP-3: Staff Responsiveness	67.40	2/2024-1/2025	**82.00**	01/01/2023 - 12/31/2023	81.63	3.0%
	H-COMP-5: Communication about Medicines	66.80	2/2024-1/2025	**78.00**	01/01/2023 - 12/31/2023	74.43	3.1%
	H-COMP-6: Discharge Information	92	2/2024-1/2025	**85.00**	01/01/2023 - 12/31/2023	85.25	3.0%
Outcome Measures	Foreign Object Retained	0.000	3/2024-2/2025	**0.000**	07/01/2021 - 06/30/2023	0.014	4.2%
	Air Embolism	0.000	3/2024-2/2025	**0.000**	07/01/2021 - 06/30/2023	0.002	2.4%
	Falls and Trauma	0.301	3/2024-2/2025	**0.293**	07/01/2021 - 06/30/2023	0.384	4.9%
	CLABSI	0.799	3/2024-2/2025	**1.07**	07/01/2023 - 06/30/2024	0.651	4.5%
	CAUTI	0.382	3/2024-2/2025	**0.503**	07/01/2023 - 06/30/2024	0.539	4.7%
	SSI: Colon	0.592	3/2024-2/2025	**1.001**	07/01/2023 - 06/30/2024	0.830	3.4%
	MRSA	0.93	3/2024-2/2025	**0.854**	07/01/2023 - 06/30/2024	0.719	4.5%
	C. Diff.	0.302	3/2024-2/2025	**0.542**	07/01/2023 - 06/30/2024	0.401	4.5%
	PSI 4: Death rate among surgical inpatients with serious treatable conditions	271.429	2/2024-1/2025	**208.940**	07/01/2021 - 06/30/2023	177.42	2.0%
	CMS Medicare PSI 90: Patient safety and adverse events composite	1.818	2/2024-1/2025	**1.050**	07/01/2021 - 06/30/2023	1.00	**15.0%**
Process Measure Domain Score:				**0.1345**		0.000	
Outcome Measure Domain Score:				**-0.1078**		0.000	
Process/Outcome Domains - Combined Score:				**0.0267**		0.000	
Normalized Numerical Score:				**3.0267**		3.00	
Hospital Safety Grade (Letter Grade):				**B**		B	

*All payer (HCAHPS surveys a random sample of adult inpatients, regardless of insurance type)

Safety Letter Grade Criteria: A = > 3.202 > B= > 2.991 C= > 2.464 D= > 1.938 F= > 1.640

Leapfrog Scorecard Overview: SPRING 2025 & YTD

YTD Performance (Compared to Leapfrog Spring 2025 Mean)

- Outperforming Areas:
  - ✓ Computerized Physician Order Entry (CPOE)
  - ✓ Bar Code Medication Administration (BCMA)
  - ✓ ICU Physician Staffing (IPS)
  - ✓ Safe Practice 1: Culture of Leadership Structures and Systems
  - ✓ Safe Practice 2: Culture Measurement, Feedback, & Intervention
  - ✓ Total Nursing care Hours per Patient Day
  - ✓ HACs: Air Embolism, Foreign body left during procedure, Falls and Trauma
  - ✓ Hospital Acquired Conditions (HAIs): Catheter-Associated Urinary Tract Infection (CAUTI), Surgical Site Infection – Colon (SSI Colon)

- Underperforming Areas
  - ✓ Hand Hygiene
  - ✓ Patient Experience
  - ✓ HAIs: Methicillin-Resistant Staphylococcus aureus (MRSA), Central Line-Associated Bloodstream Infection (CLABSI)
  - ✓ PSI 4 - PSI 4: Death rate among surgical inpatients with serious treatable conditions
  - ✓ PSI 90 - CMS Medicare PSI 90: Patient safety and adverse events composite

Safety Letter Grade Criteria: A = > 3.202 > B= > 2.991 C= > 2.464 D= > 1.938 F= > 1.640

Kaweah Health YTD Performance

Process items that we did not achieve full points in Spring 2025 & YTD performance:

- Hand Hygiene (current score 40/100)

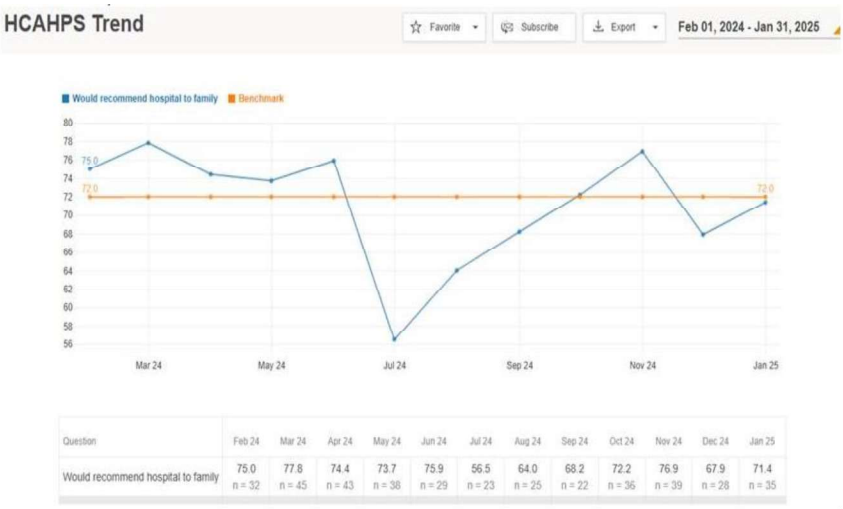
The Leapfrog "Safe Practice #6d" Hand Hygiene (HH) section focuses on monitoring and program processes, not on compliance rates.
KH is on track for 100 points in the 2025 data submission period for Leapfrog Survey.
Past gaps include:

- 200 HH electronic observations (Bio vigil) per Patient Care Area: Required for all defined Leapfrog areas.
  - Action 2024: Evaluated locations, installed BioVigil in targeted areas.
- 20 HH visual observations (in person) per pt. care location per quarter - required through direct observation by trained HH observers
  - Action 2024: Trained manual observers in targeted areas to meet Leapfrog's audit volume, reports sent to Infection Prevention.
- 2024 actions will result in achievement in full points in 2025 Leapfrog Survey

Kaweah Health YTD Patient Experience Performance and Action Plan

Process items that we did not achieve full points in Spring 2025 & YTD performance (Higher scores = Better Performance)

- Patient Experience is underperforming for the Spring 2025 grade in all measures **except** Staff responsiveness & Communication about medicines. In addition Patient Experience is underperforming in all measures except Discharge Information for YTD performance



Question	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25
Would recommend hospital to family	75.0 n = 32	77.8 n = 45	74.4 n = 43	73.7 n = 38	75.9 n = 29	56.5 n = 23	64.0 n = 25	68.2 n = 22	72.2 n = 36	76.9 n = 39	67.9 n = 28	71.4 n = 35

Action: Continue work through the new Patient Experience Team & Patient Experience Steering Committee

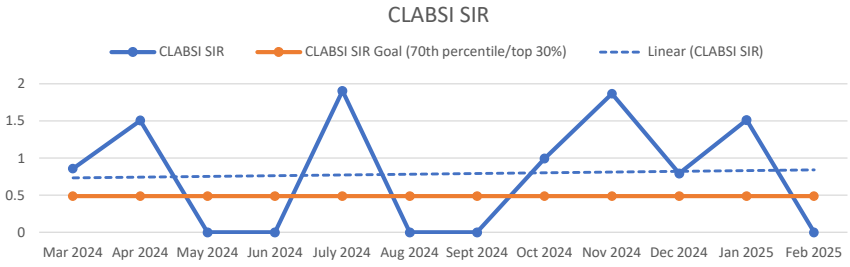
- Nurse Communication: Patient experience score reports to nursing so they are aware of how they are doing & are looking at the Priority Matrix of each of their areas. Education focused on Service Recovery at the Charge Nurse conference
- Doctor Communication: Education provided to the GME residents in March 2025 with focus on narrating the care, empathy, & communication accommodation.
- Care Coordination/Care Transitions/Discharge: Education to Case Management team focus on these areas presented at their weekly huddles.
- Executive rounding with facilities, patient experience & EVS

Kaweah Health YTD HAI Performance & Action Plan

Outcomes Measures not achieving at least national mean in YTD Performance Period (lower scores = better outcomes)

❖ CLABSI Targeted opportunities:

- Reduced central line utilization, less lines less opportunity for infection to occur
- Reduced use of femoral line access site

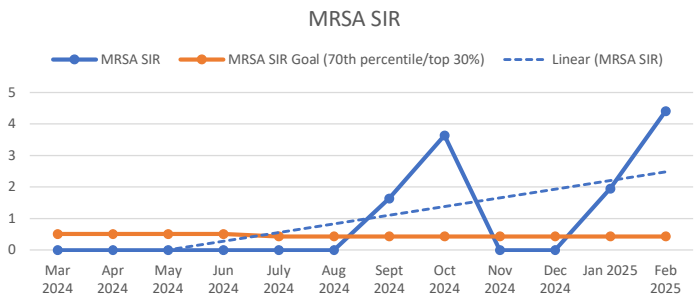


Action: Continue targeted work through Healthcare Acquired Infection – HAI Quality Focus Team

- Reestablishing expectations to improve hand hygiene (HH) through increased use of BioVigil electronic HH monitoring system
- Evaluating NEW central line CHG impregnated tegaderm dressing
- Evaluating universal CHG bathing & bath refusal escalating process
- ICU Multidisciplinary Line rounds

❖ MRSA Targeted opportunities:

- MRSA - increasing nasal and skin decolonization through focused work on identification of at risk patients upon admission



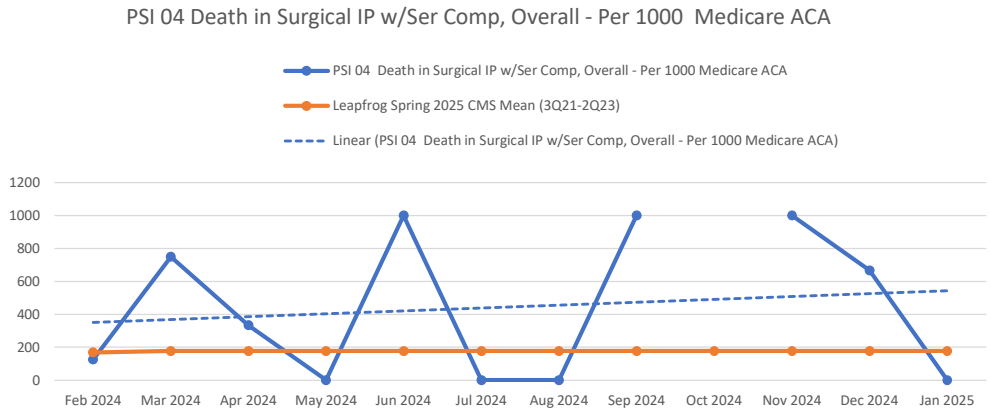
Action: Continue work through Healthcare Acquired Infection – HAI Quality Focus Team

- Reestablishing expectations to improve hand hygiene (HH) through increased use of BioVigil electronic HH monitoring system
- Universal CHG bathing & bath refusal escalating process

Kaweah Health YTD PSI Performance and Action Plan

Outcome Measures not achieving at least national mean in Spring 2025 & YTD performance (lower scores = better outcomes)

- PSI 4 (CMS has not released performance that will be used in Fall 2025 grade)
  - PSI 4 Spring 2025 & YTD performance are above the leapfrog national mean
  - CMS has replaced PSI 4 with a new measure & leapfrog will be evaluating the new measure & likely replacing it in 2026 or 2027
  - Additional focus through Sepsis committee for expired patients



Oct 2024: No cases qualified for the measure

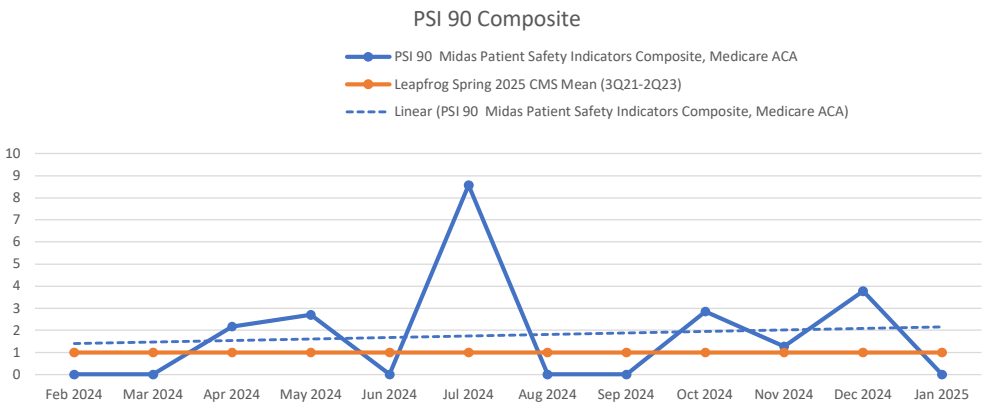
Action: Continue PSI 4 work through weekly Harm meeting/PSI committee & SQIP Committee

- Concurrent or close to real time review of events through 3M system
- Ongoing case review for documentation, coding and clinical opportunities trough weekly harm meeting and monthly PSI committee
- If applicable cases forwarded for further review trough Mortality committee, Physician Peer review and/or other care team for appropriate follow up
- Ongoing collaboration with department of surgery chair to enhance or improve processes
- Additional case review for death of patients under PSI 4 Sepsis stratum

Kaweah Health YTD PSI Performance and Action Plan

<u>Outcome</u> Measures not achieving at least national mean in Spring 2025 & YTD performance (lower scores = better outcomes)

- PSI 90 (CMS has not released performance that will be used in Fall 2025 grade)
- PSI 90 YTD is above the leapfrog national mean
- PSI 90 is heavily weighted **15%** of the overall weight for leapfrog letter grade
- PSI 90 is composed of 10 individual PSI indicators
- Ongoing SQIP focus on PSI 12 Post Op PE/DVT



Action: Continue PSI 90 work through weekly Harm meetings, PSI committee & SQIP Committee

- Concurrent or close to real time review of events through 3M system
- Ongoing case review for documentation, coding and clinical opportunities trough weekly harm meeting and monthly PSI committee
- If applicable cases forwarded for further review trough Mortality committee, Physician Peer review and/or other care team for appropriate follow up
- PSI 12 prevention focused on EMR PE/DVT risk assessment, ALPs and SCD timely placement & partnering with Trauma team to review trauma related PE/DVTs

Leapfrog Hospital Safety Score Regional Comparison Spring 2025

Hospitals within 100 Miles	Spring 2025 Grade
Adventist Health – Tulare	A
Adventist Health - Hanford	A
Adventist Health - Selma	A
Sierra View Medical Center	B
Community Regional Medical Center	C
Clovis Community Medical Center	C
Saint Agnes Medical Center	C
Kaiser Permanente Medical Center - Fresno	A
Adventist Health - Delano	B
Adventist Health – Bakersfield	B
Bakersfield Heart Hospital	C

Hospitals within 100 Miles	Spring 2025 Grade
Mercy Hospital – Bakersfield Downtown	B
Bakersfield Memorial Hospital	A
Kern Medical Center	B
Mercy Hospital - Bakersfield Southwest	A
Other Facilities	
Cleveland Clinic – Euclid Hospital	B
University of California Ronald Reagan UCLA Medical Center	A
Los Angeles County - Harbor UCLA Medical Center	C
Los Angeles General Medical Center – LA County Hospital	A

Timeframe	KH Grade
5/2025	B
10/2024	C
5/2024	C
10/2023	C
5/2023	B
10/2022	A
5/2022	A
10/2021	A
5/2021	B
12/2020	B
5/2020	C
10/2019	C

Reference Materials

Patient Safety Indicator (PSI) 4: Death in Surgical Inpatients with Serious Treatable Complications

PSI 4 YTD Overall Rate: 382.35

PSI 4 Spring 2025 Mean: 177.42

PSI 4 Individual Stratum Feb 2024 - Jan 2025 (Stratums are not publically reported)	Actual Events Medicare Population (N/D)	Medicare Risk Adjusted Rate	Actual Events ALL Payer (N/D)	ALL Payer Risk Adjusted Rate
PSI 04c Death in Surgical IP w/Ser Comp, Sepsis - Per 1000 Medicare	**2/2**	**1000**	6/10	600
PSI 04d Death in Surgical IP w/Ser Comp, Shock - Per 1000 Medicare	**7/10**	**700**	18/43	418.61
PSI 04e Death in Surgical IP w/Ser Comp, GI - Per 1000 Medicare	**0/2**	**0**	2/18	111.11
PSI 04b Death in Surgical IP w/Ser Comp, Pneumonia - Per 1000 Medicare	**3/16**	**187.5**	12/74	162.16
PSI 04a Death in Surgical IP w/Ser Comp, PE/DVT - Per 1000 Medicare	**1/4**	**250**	1/11	90.91

- PSI 4 Sepsis & Shock are the PSI 4 stratums driving the PSI 4 overall rate
- Overall rate is publically reported for PSI 4
- **PSI 4 will be replaced by a new updated and improved measure: Failure to Rescue 30 day Mortality, that will exclude a case if the complication was present on admission**

Patient Safety Indicator (PSI) 90 Individual Components Performance

PSI 90 Individual Component Feb 2024 - Jan 2025	Actual Events Medicare Population (N/D)	Medicare Risk Adjusted Rate Publically Reported	Actual Events ALL Payer (N/D)	ALL Payer Risk Adjusted Rate Internal Tracking	Spring 2025 leapfrog mean individual Component (not used in grade scoring)
PSI 03 Pressure Ulcer ǂ	2/2241	0.89	6/10579	0.57	0.20
PSI 06 Iatrogenic Pneumothorax	1/2955	0.39	3/14046	0.21	0.21
PSI 08 In-Hospital Fall-Associated Fracture	0/2952	0	0/14406	0	0.24
PSI 09 Postoperative Hemorrhage or Hematoma	1/674	1.48	7/3305	2.12	1.84
*PSI 10 Postop Acute Kidney Injury Requiring Dialysis	2/225	8.89	3/828	3.62	2.65
*PSI 11 Postoperative Respiratory Failure ǂ	5/231	21.65	11/813	11.78	10.76
PSI 12 Perioperative Pulmonary Embolism or DVTǂ	1/684	1.46	7/3306	2.12	5.58
*PSI 13 Postoperative Sepsis ǂ	0/215	0	2/793	2.52	7.17
PSI 14 Postoperative Wound Dehiscence	0/123	0	1/715	1.40	1.65
PSI 15 Accidental Puncture or Laceration	1/444	0	1/2705	0.37	1.58

- PSI 90 Composite YTD Rate: 1.82**
- PSI 90 Composite score Spring 2025 Mean: 1.00
- PSI 12 Perioperative PE/DVT improving based on past performance
- Highest weighted PSIs driving YTD PSI 90 Rate: PSI 3, PSI 10, PSI 11

ǂ Highest weighted PSIs (risk adjusted based on volume & potential for pt. harm)
*Elective procedures
** The weighted average of the observed-to-expected ratios for the PSI 90 component indicators (PSI 90 is composed of 10 individual components: PSI 3,6,8,9,10,11,12, 13, 14, & 15)
Midas software data is an estimate utilizing the same software CMS uses however it is not apples to apples comparison

Thank you

Live with passion.

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

Kaweah Health

Outstanding Health Outcomes (OHO) QUALITY & PATIENT SAFETY PRIORITY

Healthcare Acquired Infection (HAI) Reduction

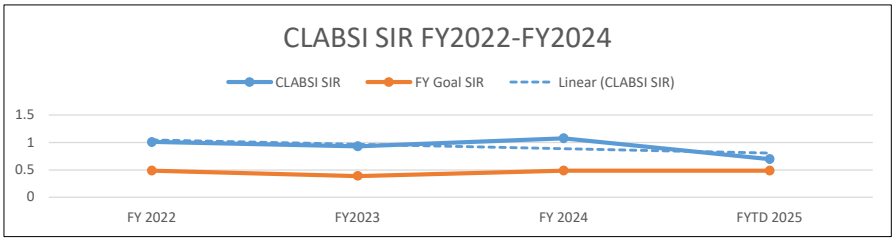
April 2025

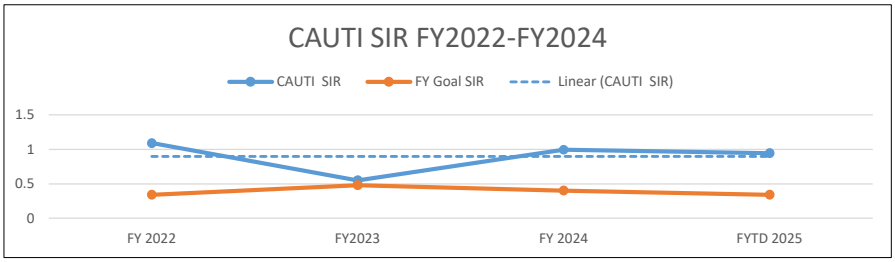
OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

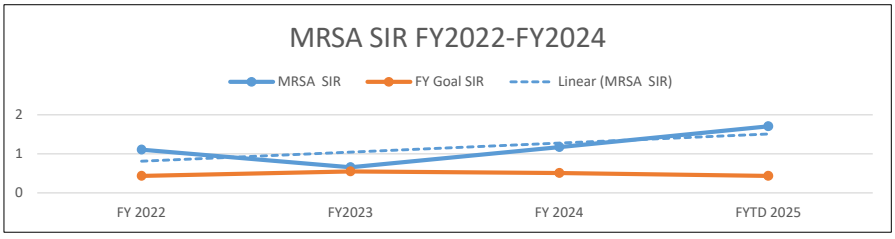
(number of actual infections/number of predicted infections by CMS)

CLABSI - Central Line-Associated Bloodstream Infection; CAUTI - Catheter-Associated Urinary Tract Infection; MRSA - Methicillin-Resistant Staphylococcus Aureus

Historical Baseline







FY25 PLAN – HAI Reduction CLABSI, CAUTI & MRSA SIR

High Level Action Plan

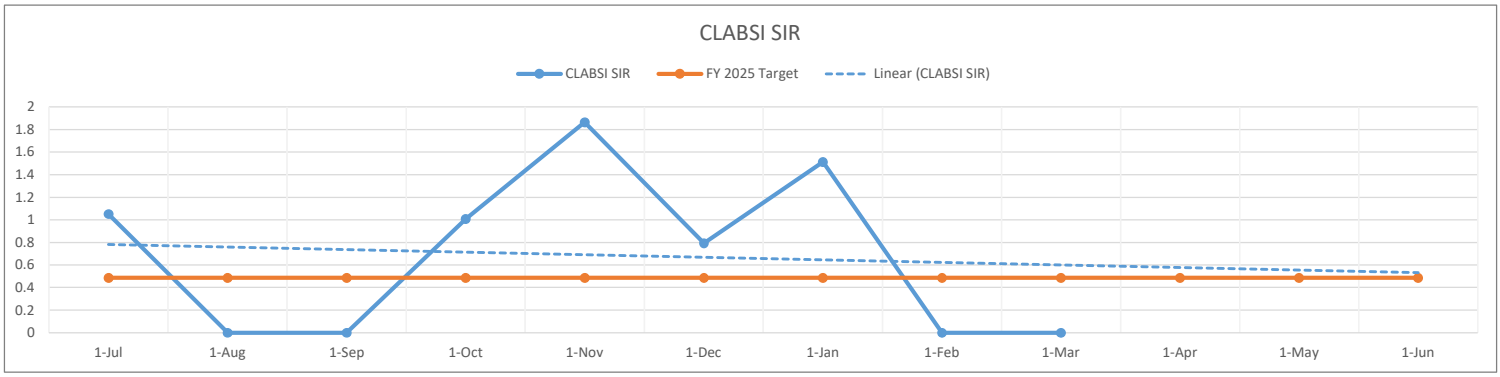
- Reduce line utilization; less lines, less opportunity for infections to occur
  - Goal: reduce central line utilization ratio to <0.66
  - Goal: reduce urinary catheter utilization ratio to <0.64
- MRSA nasal and skin decolonization for patients with lines.
  - Goal: 100% of at risk patients nasally decolonized
  - Goal: 100% of patients with lines have a CHG bath
- Improve hand hygiene (HH) through increased use of BioVigil electronic HH monitoring system
  - Goal: 60% of staff are active users of BioVigil
  - Goal: 95% compliance with hand hygiene
- Improve environmental cleaning effectiveness for high risk areas
  - Goal: 90% of areas in high risk areas are cleaned effectively the first time (all area not passing are re-cleaned immediately)

FY25 GOAL

Decrease: CLABSI SIR to <0.486; CAUTI SIR to < 0.342; MRSA <0.435

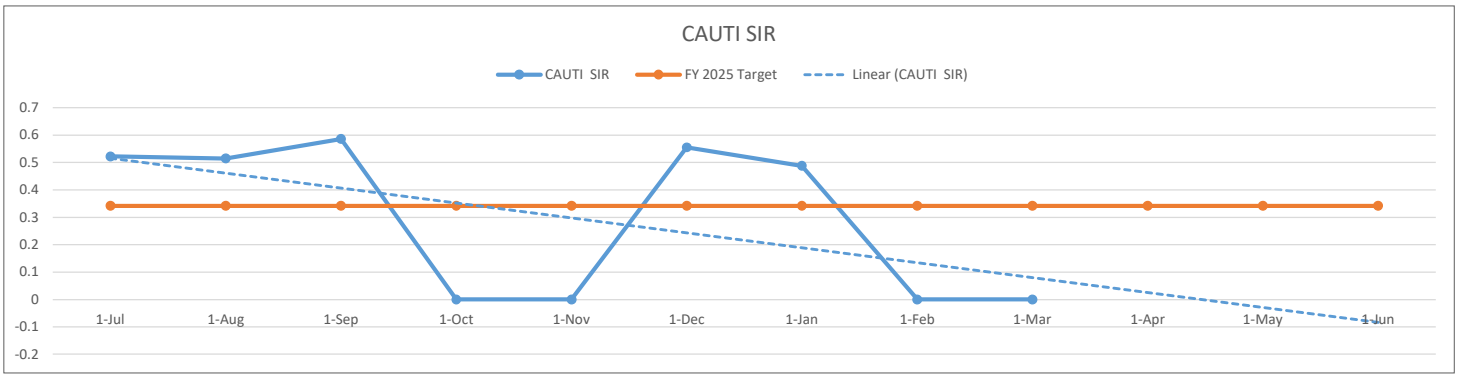
Kaweah Health

OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)
(number of actual infections/number of predicted infections by CMS)



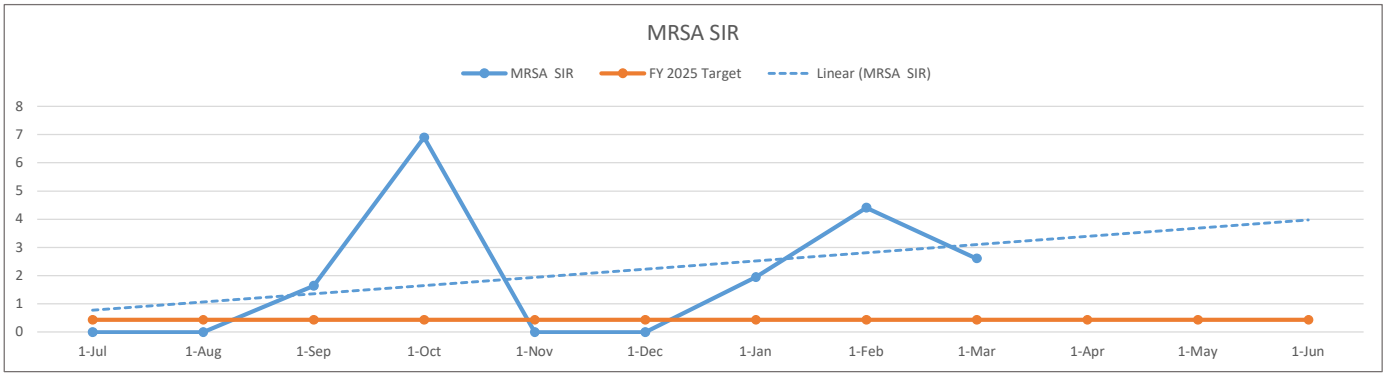
	FY 2025 Target	FY 2024	24-Jul	24-Aug	24-Sep	24-Oct	24-Nov	24-Dec	25-Jan	25-Feb	25-Mar	25-Apr	25-May	25-Jun	FYTD 25
CLABSI Events		17	2	0	0	1	1	1	2	0	0				7
CLABSI Predicted Events		16.06	1.051	1.117	0.121	1.008	1.072	1.262	1.323	0.848	0.989				9.791
CLABSI SIR	<0.486	1.06	1.903	0	0	0.992	1.865	0.792	1.512	0	0				0.71

OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)
(number of actual infections/number of predicted infections by CMS)



	FY 2025 Target	FY 2024	24-Jul	24-Aug	24-Sep	24-Oct	24-Nov	24-Dec	25-Jan	25-Feb	25-Mar	25-Apr	25-May	25-Jun	FYTD 25
CAUTI Events		9	1	1	1	0	0	1	1	0	0				5
CAUTI Predicted Events		22.58	1.917	1.94	1.707	1.577	1.54	1.801	2.05	1.404	1.716				13.936
CAUTI SIR	<0.342	0.4	0.522	0.515	0.586	0.00	0	0.555	0.488	0	0				0.32

OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)
(number of actual infections/number of predicted infections by CMS)



	FY 2025 Target	FY 2024	24-Jul	24-Aug	24-Sep	24-Oct	24-Nov	24-Dec	25-Jan	25-Feb	25-Mar	25-Apr	25-May	25-Jun	FYTD 25
MRSA Events		7	0	0	1	2	0	0	1	2	1				7
MRSA Predicted Events		9.62	0.501	0.482	0.485	0.290	0.451	4.74	0.512	0.454	0.383				4.874
MRSA SIR	<0.435	0.73	0	0	1.64	6.9	0	0	1.95	4.41	2.61				1.44

OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

The last data point did not meet goal because:

- Evidenced-based prevention strategies to reduce HAIs are not occurring

Targeted Opportunities

- Reduce line utilization; less lines, less opportunity for infections to occur
  - Goal: reduce central line utilization ratio to <0.663
  - July 2024 - Mar 2025 0.64
  - Goal: reduce urinary catheter ratio to <0.64
  - July 2024 - Mar 2025 0.89
- MRSA nasal and skin decolonization for patients with lines.
  - Goal: 100% of at risk patients nasally decolonized
  - Jul 2024 - Feb 2025 100% of screen patients nasally decolonized
  - Data under evaluation, case reviews indicated that all SNF patients are being screened upon admission (Mar- Apr 2025)
  - Jul 2024 - Goal: 100% of line patients have CHG bathing
  - Will provide update following process implementation, delayed from 10/8 to 11/19 due to Cerner upgrade processes
- Improve hand hygiene (HH) through increased use of BioVigil electronic HH monitoring system
  - Goal: 60% of staff are active users of BioVigil
  - Jul 2024- Feb 2025 55% of staff are active users (Jan-Apr 2025 increased to **60%**)
  - HH Compliance rate overall 94% July 2024- Apr 2025 (goal 95%) – decreasing trend noted over 3 quarters
- Improve environmental cleaning effectiveness for high risk areas
  - Goal: >90% of areas in high risk areas are cleaned effectively the first time (all area not passing are re-cleaned immediately)
  - July 2024 – April 2025 Pass cleanliness effectiveness testing **91%** of the time in high risk areas

OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
Expand Multidisciplinary rounds to include other stakeholders to reduce line use; NEW device rounds with Charge RN and Infection Prevention started May 1, 2025 on all inpatient units	5/30/25	Buy in from physician stakeholders
Explore consensus statement on duration of femoral lines with medical staff	5/30/25	Buy in from physician stakeholders
Skin decolonization for all line patients through CHG bathing training for CNAs and implementation to all units Next Steps: Skin decolonization of MRSA at risk patients through workflow enhancements	11/19/24 6/30/25	Time to establish Cerner workflows
MRSA screening form workflow changes to ensure patients who reside at a SNF and/or have been readmitted in past 30 days are automatically MRSA decolonized for a positive nasal swab result	3/31/25	Completed
Hand Hygiene compliance dashboard disseminated monthly to leadership (increase awareness and accountability). QI resources disseminated to leadership to use for unit/dept level improvement work	12/2/24 and ongoing	None
Communication with managers of units that are not achieving goal to review their staff level HH compliance reports and follow up with staff. "D.U.D.E, your red" campaign (peer to peer accountability when BioVigil shows need for HH)	3/17/25	None
Effective cleaning – Post staff competency, identify targeted equipment/surfaces for focused QI work. Bedrails most frequently failing testing. EVS leadership coaching consistently in staff huddles. Also evaluating different cleaning products with faster kill times that pass testing more often	3/31/25	None, Feb 2025 bed rail 100% cleanliness effectiveness testing
Daily safety huddles to include device management-Device type, date of insertion medical necessity, ordering physician	4/14/25	None
Nursing Competency Camp – plan to include MRSA screening information	5/19/25	None

Thank you

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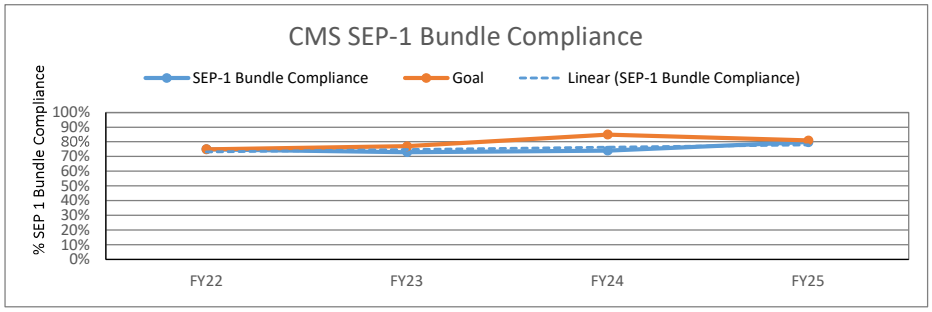
Kaweah Health

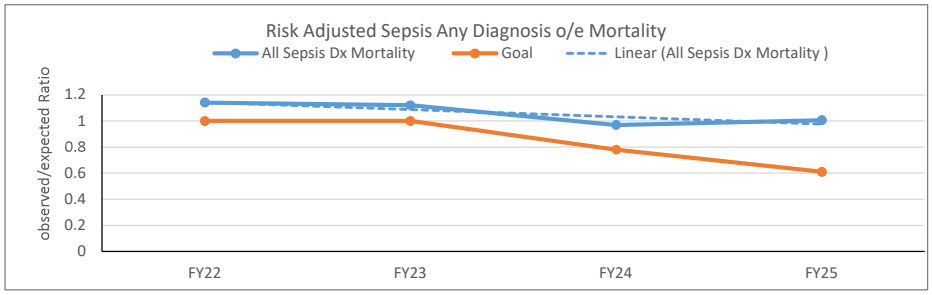
Outstanding Health Outcomes (OHO) QUALITY & PATIENT SAFETY PRIORITY

Sepsis CMS SEP-1 & Sepsis Mortality

May 2025

OHO FY25 Plan: CMS SEP 1 and Mortality (observed/expected)
Historical Baseline





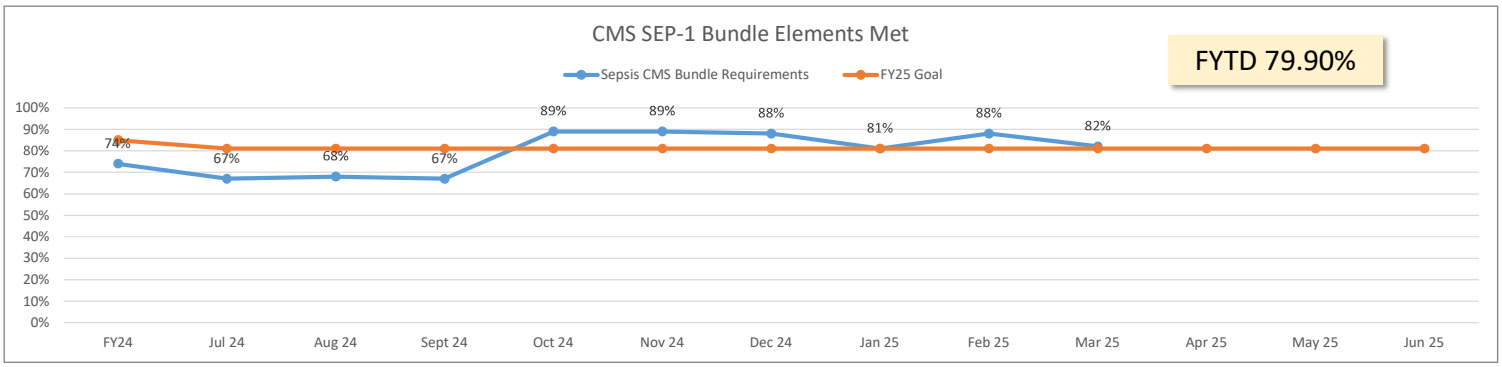
FY25 GOAL
Increase SEP-1 Bundle Compliance ≥ 81%
Decrease Sepsis any diagnosis Mortality ≤ 0.61

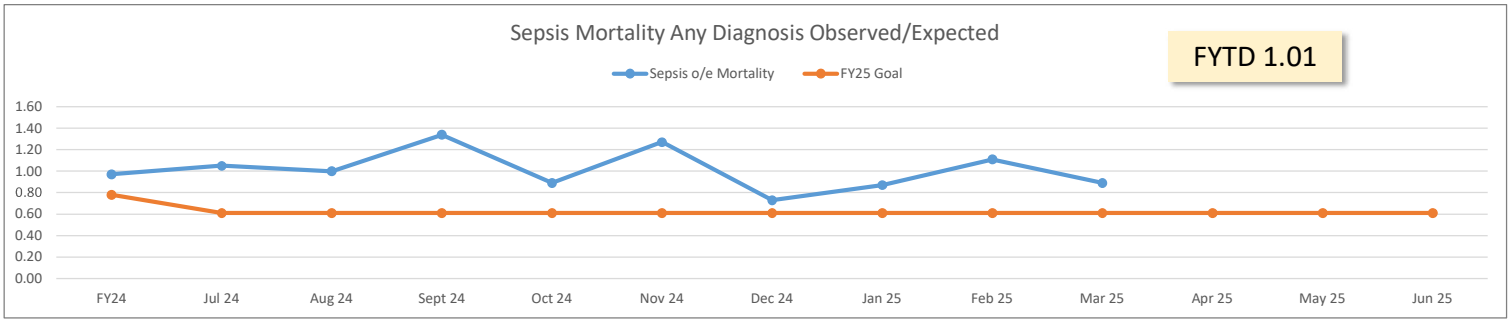
FY25 PLAN – CMS SEP-1

High Level Action Plan

- Provide Early Goal Directed Therapy (Sepsis work up and Treatment)
  - % of Patients provided top 3 most frequently missed Sepsis bundle elements
  - Goal FY 25 95%
    - IV Fluid Resuscitation
    - Antibiotic Administered
    - Blood Cultures Drawn
- Provide Early Goal Directed Therapy (Sepsis Treatment)
  - Goal FY 25 = 30%
    - Pts with Sepsis that Received Abx within 60 Minutes of Pt 1st Seen
    - Pts Met 1- Hr Bundle

OHO FY25 Monthly Update: CMS SEP-1 & Mortality





OHO FY25 Monthly Update: CMS SEP-1 & Mortality

The last data point did not meet goal because (Goal has been met for the last 6 months for SEP 1):

- Differential diagnosis of infections are not being treated with Sepsis interventions or are not being refuted when Sepsis is no longer entertained (i.e. Thrombocytopenia documented in ED Provider note)
- 1 (One) Abx not administered within 3 hours of TZ. 1 (One) Abx, BC, Repeat LA not ordered timely by ED provider (counts as 1 fall out only). 1 (One) Initial lactic acid not ordered. 1 (One) < 30 mL/kg fluids ordered. No documentation for lesser fluid reason documented by ED Provider.
- Deep Dive into Sepsis mortality revealed opportunity in fluid resuscitation & linking organism to specify Sepsis documentation

Targeted Opportunities

- Provide Early Goal Directed Therapy (Sepsis work up and Treatment)
  FY25
  - % of Patients provided top 3 most frequently missed Sepsis bundle elements at KH (Higher performance = Better care)
  - IV Fluid Resuscitation 94%
  - Antibiotic Administered 92%
  - Blood Cultures collection 95%

  Goal = 95%
- Provide Early Goal Directed Therapy (Sepsis Treatment)
  FY25
  - Pts with Sepsis that Received Abx within 60 Minutes of Pt 1st Seen by ED Provider 28.1%
  - Pts Met 1- Hr Bundle 25.6%

  Goal = 30%

OHO FY25 Monthly Update: CMS SEP-1 & Mortality

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
1. GME Resident engagement and ongoing education throughout the year, not just during yearly orientation ○ Ongoing Strong collaboration with Chief ED Residents ✓ Ongoing education during weekly didactic ○ 2 Resident project focus on Sepsis power plan utilization awareness & ED Provider pop-up to declare or refute sepsis prior to inpatient transfer ○ Collaboration with Dr. Stanley for engaging educational material ○ ***Engaged with ACTS, FM team for ongoing Sepsis education to surgical residents-upcoming meeting during didactic session*** ○ Incrementally engage Transitional Year & Psych residents	Ongoing	
2. Code Sepsis in ED (workgroup in progress)	Discussion to continue once ED Throughput project advanced	
3. Sepsis multidisciplinary collaboration with SIM (Simulation in Medical Science) Lab Planned for Spring 2025 (possible in situ SIM)	May 13, 2025	

OHO FY25 Monthly Update: CMS SEP-1 & Mortality

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
4. Mortality summary reviews presented to Sepsis committee workgroup for Sepsis 1-hour bundle success review, analysis & improvement strategies	Ongoing	Limited to no engagement from Sound Intensivist group
5. Improve Severe Sepsis Alert Specificity (EMR optimization) ○ Collaborate with ISS team and Cerner EMR resources to optimize Sepsis alert ○ Decrease lookback window (for labs and vital signs) from Cerner 36 hours to **8 hrs.** for more meaningful alerts	TBD	Limitations within Cerner cloud Concerns with disrupting existing algorithm
6. Sepsis documentation improvement project ○ Trialing reviewing All Sepsis cases for appropriateness of Physician documentation & coding to ensure clinical picture is reflected on the medical record (including Physician linking organism to Sepsis for a more descriptive ICD 10 diagnosis code) ○ Targeting Intensivist documentation opportunity (most Sepsis patients admitted to ICU) ○ Dr. Javed working on recruiting intensivist for representation in sepsis committee for ICU ongoing representation	Ongoing	Limited to non engagement from Sound intensivist group

Thank you

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