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, June 19, 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

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

Kaweah Delta Health Care District Board of Directors Quality Council
Meeting held: Thursday, June 19, 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
    - **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

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

CLOSED MEETING – 7:31 AM

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

4. **Approval of May 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

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 May 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 Hand Hygiene Quality Report
   4.2 Subacute Quality Report

5. Safety Culture Survey – Results and actions associated with the 2025 Safety Culture Survey. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*

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.

7. **ADJOURN OPEN MEETING -** Mike Olmos, Committee Chair

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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, May 15, 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; 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; Miguel Morales, Safety Specialist; Frank Martin, Trauma Program Manager; Kevin Morrison, Director of Facilities; Erika Pineda, Quality Improvement Manager; Shawn Elkin, Infection Prevention Manager; Kyndra Licon – Recording.

Mike Olmos called to order at 7:30 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 7:31 AM.

Public Participation – None.
Mike Olmos called to order at 8:03 AM.

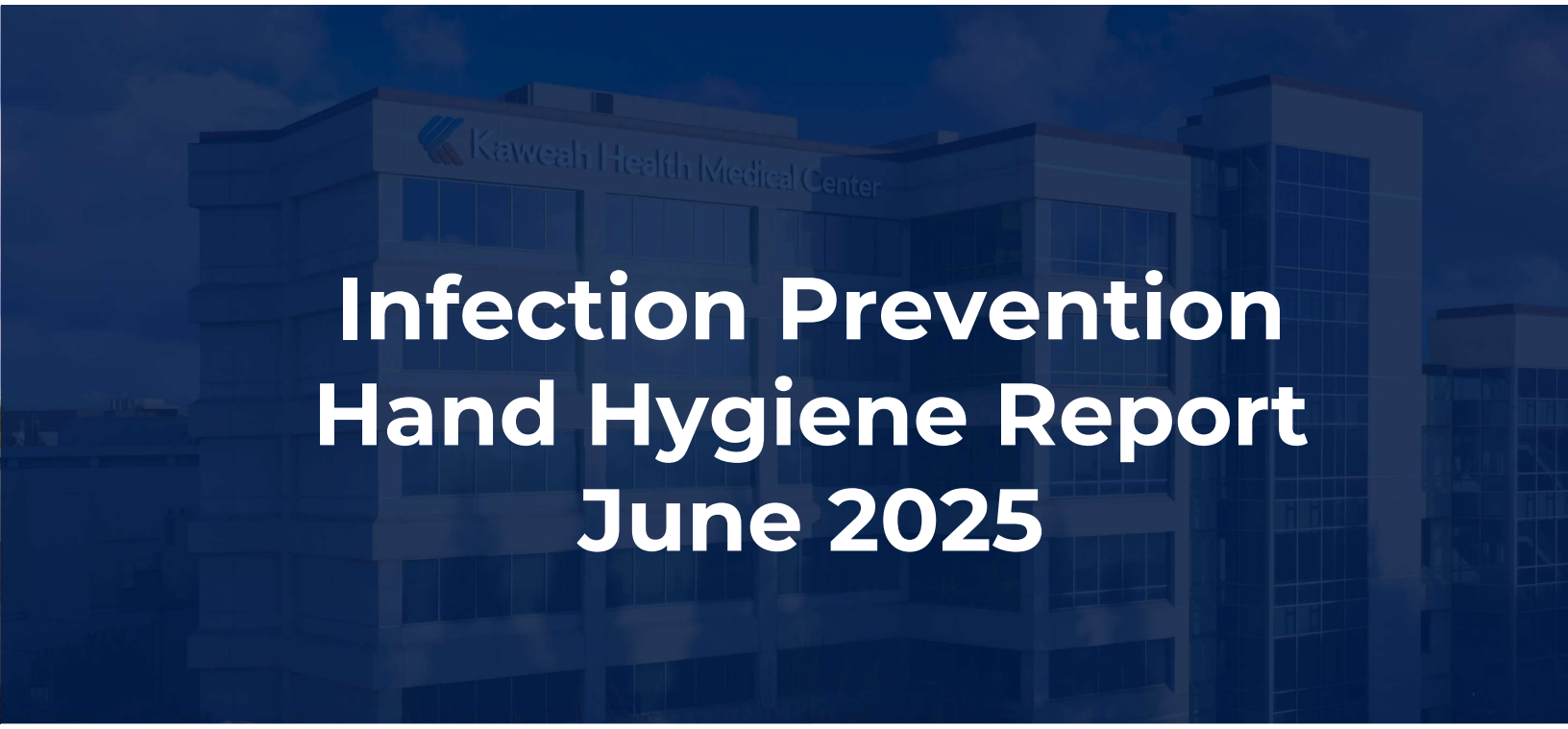
3. **Approval of April Quality Council Open Session Minutes –** Mike Olmos, Committee Chair; Dean Levitan, Board Member.
    - Approval of April Quality Council Open Session Minutes by Dean Levitan and Mike Olmos.

4. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives: **–** Reports reviewed and attached to minutes. No action taken.
    4.1 Workplace Violence Annual Quality Report
    4.2 Trauma Quality Report

5. **Leapfrog Hospital Safety Score –** A review of Kaweah Health letter grade on performance in preventing medical errors, infections, and other patient safety issues. – Reports reviewed and attached to minutes. No action taken.
6. **Clinical Quality Goals Update**- A review of current performance and actions focused on the clinical quality goals for Sepsis, and Healthcare Acquired Infections. – Reports reviewed and attached to minutes. No action taken.

Adjourn Open Meeting – *Mike Olmos, Committee Chair*

Mike Olmos adjourned the meeting at 9:28 AM.



Infection Prevention Hand Hygiene Report June 2025

BioVigil Hand Hygiene Performance

Hand Hygiene Program

1. New hire orientation:
   - Instructions on how to perform HH
   - Hand hygiene competency for new employees as part of the 48 hour orientation checklist
   - Discussion about the importance of hand hygiene, the Biovigil hand hygiene monitoring system, hand hygiene patient surveys performed in the clinics
   - Viewing the Norwegian Institute of Public Health – Gloves do not replace hand hygiene. The invisible challenge II. (Video)
2. Quarterly audits and trending HH supply processes (refill soap, paper towels, sanitizer) by EVS
3. Biovigil electronic HH reminder system in place; manual observations completed in patient care areas concurrently with electronic monitoring (over 6,000 observations FY2025).
4. Hand Hygiene compliance data disseminated to leadership for action; ready to use power points and written materials easily accessible to all staff and leaders for QI work
5. Healthcare Associated Infection Quality Focus Team working on strategies heavily focused on supporting leaders and staff in using the system to improve hand hygiene compliance.
6. Visual reminders to perform hand hygiene posted in locations throughout the hospital
7. Ad Hoc HH Campaigns

   Examples:
   - DUDE VP/CEO videos available on Kaweah Compass

BioVigil Hand Hygiene Performance

		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
Hand Hygiene Compliance Rate (BioVigil)	>95%	94%	94%	94%	94.0%	93.8%	93.9%	94.1%	94.1%	93.7%	93.5%	93.8%		94%
% of ACTVE BioVigil Users Achieving target Badge Hours (>80hrs/month)	60% (10% increase annually FY26+)	44%	50%	54%	52%	59%	56%	60%	60%	60%	59%	62%		56%
Volume of Hand Hygiene Opportunities Captured in BioVgil		1,284,687	1,295,835	1,396,251	1,353,851	1,431,137	1,544,719	1,518,568	1,440,912	1,612,073	1,628,920	1,686,149		16,193,102

Data Summary

1. Overall HH Compliance 94%, 1% below 95% goal
2. Achieving our organizational goal of at least 50% of active Biovigil users pairing to a badge ≥80 hours a month. As predicted, with a greater number of active Biovigil users (2,052) and a goal to increase paired badge time, hand hygiene compliance rates have decreased.
3. No significant difference between HH compliance rates between day/night shift or weekday/weekend shifts
4. Data analysis by role indicates opportunities for improved hand hygiene compliance exist with Certified Nursing Assistants and Licensed Vocational Nurses, followed by Registered Nurses.

New QI Strategies 2025

- Hand Hygiene dashboard (overall and unit level results) disseminated to leadership monthly, includes ready-to-use resources for unit leaders to use for improvement work, 1Q 2025, ongoing
- Increased vendor engagement to ensure BioVigil program is effective and efficient for all end users (ie. ensure enough badges are available and distributed for end users) – April 2025, ongoing.
- Monthly leadership sessions with BioVigil and Infection Prevention Leadership to review HH compliance data, opportunities and have open dialogue on barriers and success and improvement strategies – July 2025, ongoing

Reference Material

BioVigil Hand Hygiene Performance

Trends in Hand Hygiene

Hand Hygiene (HH) Dashboard														
Measure Description	**Benchmark/ Target**	**2022Q3**	**2022Q4**	**2023Q1**	**2023Q2**	**2023Q3**	**2023Q4**	**2024Q1**	**2024Q2**	**2024Q3**	**2024Q4**	**2025Q1**	**Apr-25**	**May-25**
PROCESS MEASURES - Patient Care Units														
Hand Hygiene By Day/time														
HH Overall Compliance - AM Shift	95%	96.84	96.56	96.52	96.12	95.88	95.16	94.66	94.70	94.35	93.6%	93.7%	93.0%	94.0%
Number of HH Audits Performed - AM Shift	n/a	1,788,791	1,537,477	1,692,071	1,581,236	2,009,845	2,231,993	2,364,156	1,860,837	1,913,533	2,876,676	2,982,305	1,763,244	1,816,582
HH Overall Compliance - PM Shift	95%	97.02	96.67	96.67	96.29	96.08	95.32	95.39	93.89	93.42	94.5%	94.4%	94.0%	94.0%
Number of HH Audits Performed - PM Shift	n/a	1,027,940	885,201	931,538	907,680	1,171,572	1,330,362	1,481,929	2,104,934	2,121,587	1,646,958	1,726,329	1,494,694	1,549,836
HH Overall Compliance - Weekdays	95%	96.90	96.53	96.52	96.14	95.91	95.19	94.94	94.32	93.84	93.8%	94.0%	93.5%	93.8%
Number of HH Audits Performed - Weekdays	n/a	2,161,631	1,831,097	2,036,012	1,896,628	2,439,272	2,729,350	2,947,875	3,022,708	3,098,453	3,469,987	3,560,529	1,265,860	1,262,134
HH Overall Compliance - Weekends	95%	96.94	96.82	96.77	96.33	96.10	95.33	94.93	94.11	93.91	94.0%	93.8%	93.4%	94.2%
Number of HH Audits Performed - Weekends	n/a	655,100	591,581	587,597	592,288	742,145	833,005	898,210	943,063	936,667	1,053,647	1,148,005	363,109	421,075

FY2025 (July 1 – June 30th) electronic hand hygiene monitoring data analysis:

- Night shift reflects 75% of the number of hand hygiene opportunities that day shift does. There is little difference between the hand hygiene compliance rate for days versus nights.
- Weekend shifts reflect 31% of the number of hand hygiene opportunities that weekdays do. There is again little difference between the hand hygiene compliance rate for weekdays versus weekends.

BioVigil Hand Hygiene Performance

Hand Hygiene (HH) Dashboard														
Measure Description	**Benchmark/ Target**	**2022Q3**	**2022Q4**	**2023Q1**	**2023Q2**	**2023Q3**	**2023Q4**	**2024Q1**	**2024Q2**	**2024Q3**	**2024Q4**	**2025Q1**	**Apr-25**	**May-25**
Hand Hygiene By Patient Care Unit Location (*biovgil data)														
2AcequiaCVC - HH Compliance	95%	95.10	95.52	94.88	95.95	94.64	88.56	90.03	91.08	91.83	92.6%	90.0%	89.2%	90.7%
2AcequiaCVC - HH Audits Performed	n/a	42,591	32,295	32,071	20,203	30,379	27,456	38,799	52,836	50,754	56,984	84,030	3,611	29,107
2NorthMedTele - HH Compliance	95%	96.22	95.87	94.52	94.09	94.69	93.47	92.82	91.95	91.81	91.5%	93.0%	93.5%	93.5%
2NorthMedTele - HH Audits Performed	n/a	301,476	291,144	320,448	288,901	258,049	218,788	228,852	248,703	273,653	310,960	344,245	129,550	108,961
2WestICU - HH Compliance	95%	97.21	97.10	97.00	97.36	96.78	96.02	94.65	94.09	92.56	92.5%	93.2%	94.2%	94.1%
2WestICU - HH Audits Performed	n/a	105,929	67,661	76,377	71,635	84,736	92,078	148,161	205,833	228,603	231,198	226,564	68,768	70,905
3AcequiaCVICU - HH Compliance	95%	95.01	93.00	92.72	92.48	94.35	92.72	91.83	92.76	91.93	91.2%	92.1%	92.2%	92.8%
3AcequiaCVICU - HH Audits Performed	n/a	124,390	102,607	103,381	92,509	115,903	173,181	163,191	202,163	204,423	242,723	230,329	73,912	66,543
3SouthOncology - HH Compliance	95%	95.25	95.40	95.44	95.35	94.12	93.44	92.49	91.91	91.84	93.3%	92.3%	92.7%	91.2%
3SouthOncology - HH Audits Performed	n/a	225,974	193,534	176,571	147,794	165,451	220,284	225,141	244,942	242,309	256,550	255,419	91,098	100,510
4SouthOrthoNeuroMedSurg - HH Compliance	95%	96.64	97.30	96.82	94.14	92.79	92.75	91.83	92.28	91.84	93.0%	93.4%	92.6%	93.1%
4SouthOrthoNeuroMedSurg - HH Audits Perfor	n/a	125,023	96,735	177,977	236,388	187,359	211,382	258,732	257,201	246,625	278,055	288,117	100,264	98,945
5AcequiaCVICCU - HH Compliance	95%	92.56	92.45	94.81	93.77	93.68	92.15	92.31	92.50	93.03	93.0%	93.4%	93.3%	93.6%
5AcequiaCVICCU - HH Audits Performed	n/a	139,610	121,686	97,962	80,545	112,133	186,268	180,019	220,258	222,680	279,200	321,992	109,002	117,083
Emergency Department - HH Compliance	95%	90.01	92.97	95.66	94.52	93.59	92.80	94.75	89.93	87.68	87.7%	89.3%	88.6%	89.8%
Emergency Department - HH Audits Performed	n/a	213,753	78,836	69,926	153,415	75,500	89,330	92,825	302,056	278,265	304,392	255,763	12,409	113,271
Mental Health - HH Compliance	95%	NULL	NULL	NULL	NULL	NULL	80.22	79.15	83.33	72.93	72.8%	70.4%	73.0%	73.8%
Mental Health - HH Audits Performed	n/a	NULL	NULL	NULL	NULL	NULL	465	2,422	10,899	6,146	3,882	1,700	2,564	5,538
WestCampusDialysis - HH Compliance	95%	96.77	96.38	96.29	96.33	96.40	96.43	95.30	94.91	94.36	93.8%	93.7%	93.1%	93.7%
WestCampusDialysis - HH Audits Performed	n/a	75,022	60,743	92,153	79,316	80,820	76,804	60,558	90,425	96,961	107,067	107,089	38,434	37,484

Locations with ≥5 quarter of performance below 95% hand hygiene compliance are:

CVU (Cardiac Cath Holding), 2 North, ICU, CVICU, 3 South Oncology, 4 South, 5T CVICCU, Emergency Department Mental Health Chronic Dialysis Clinic

BioVigil Hand Hygiene Performance

Hand Hygiene by Role (>10 observations in one quarter, does not inlcude biovigil)															
Measure Description	**Benchmark /Target**	**2022Q3**	**2022Q4**	**2023Q1**	**2023Q2**	**2023Q3**	**2023Q4**	**2024Q1**	**2024Q2**	**2024Q3**	**2024Q4**	**2025Q1**	**Apr-25**	**May-25**	**Jun-25**
Aide - HH Compliance	95%	96.59	97.46	96.44	95.94	95.72	95.66	95.51	93.58	94.17	95.7%	96.3%	97.0%	97.3%	97.3%
Aide - HH Audits Performed	n/a	32,989	24,288	22,916	26,422	14,670	16,992	19,035	16,738	18,074	17,106	14,123	5,015	441	338
C.N.A. - HH Compliance	95%	96.00	95.61	95.53	93.79	94.00	93.06	92.73	92.59	92.15	92.2%	92.3%	93.1%	93.1%	93.5%
C.N.A. - HH Audits Performed	n/a	712,329	579,885	668,698	617,169	648,793	746,829	767,452	739,455	723,766	852,569	982,392	356,108	381,557	25,679
EVS - HH Compliance	95%	96.38	96.51	96.60	97.47	95.77	95.58	93.18	92.78	93.45	96.9%	97.0%	96.3%	96.1%	95.7%
EVS - HH Audits Performed	n/a	140,698	140,719	223,114	276,919	280,969	320,456	335,387	315,541	341,963	387,777	384,618	124,132	124,105	7,522
LVN/Tech - HH Compliance	95%	96.46	96.79	96.92	95.76	95.28	94.25	95.40	94.31	93.61	94.0%	93.5%	92.9%	92.0%	92.1%
LVN/Tech - HH Audits Performed	n/a	295,512	236,036	254,785	289,104	185,829	211,115	232,407	218,284	230,443	251,686	218,597	74,301	69,570	4,662
Nurse - HH Compliance	95%	96.17	96.31	96.44	96.32	96.47	95.53	95.44	95.46	95.60	95.2%	94.0%	92.9%	93.2%	92.0%
Nurse - HH Audits Performed	n/a	1,601,691	1,264,992	1,261,601	1,134,105	1,289,821	1,361,250	1,532,603	910,634	619,729	687,886	666,268	222,818	254,319	16,061

Opportunities for improved hand hygiene compliance exist with Certified Nursing Assistants and Licensed Vocational Nurses, followed by Registered Nurses.

Other ancillary healthcare personnel have exceeded hand hygiene compliance rates by a minimum of 96%, this includes Environmental Services, Rehab Aides, and Respiratory Therapy.


Live with passion.
Health is our passion. Excellence is our focus. Compassion is our promise.
Kaweah Health

Sub Acute and Short Stay SNF Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Sub Acute and Short Stay SNF **Report Date:** **April 2025**

Measure Objective/Goal:

1. Falls (internal data)
2. Pressure Injuries (internal data)
3. Psychoactive medication use (MDS/Casper)

Date range of data evaluated:

Data evaluated populated from internal data as well as CASPER report period: 10/01/2024 – 12/21/2024. Data compared with Casper Report and 3Q24 through 4Q24 for internal data.

Nationally benchmarked quality data is collected through the MDS submissions process to CMS where data is populated into the CASPER report. CMS divides data between short-stay cases (<100 day length) and long-stay cases (>100 day length). The Skilled Nursing program client group is predominately in the short-stay category. Statistically this means that Long-Stay measures typically have a denominator of 33-34. Short-Stay measures typically have a denominator of 200+. Internal data is based on total units of service and does not differentiate based upon length of stay. There is no comparable national bench-marking of Short Stay cases for falls, and for HAPI prevalence overall. For these two indicators, we assess ourselves to internal performance goals.

FALLS

Analysis of all measures/data: (Include key findings, improvements, opportunities)

The total rate of falls per 1000/pt. days in both units: 3Q24 is 0.81 and 4Q24 is 0.25 falls per 1000 patient days. Facility observed 0.8% for falls for long stay patients in the most current CASPER report is 3.6%, remaining well below national average of 43.7%, placing the program in the top 1 percentile nationally.

Falls per Unit per 1000 Pt Days per Quarter 2022-24															
UNIT	1Q22	2Q22	3Q22	4Q22	T	1Q23	2Q23	3Q23	4Q23	T	1Q24	2Q24	3Q24	4Q24	T
SNF (Combined Total)	0.88	0.79	0.57	0.88	0.77	0.51	0.75	0.00	0.00	0.32	1.06	1.11	0.81	0.25	0.80
Subacute	0.00	0.00	1.14	0.00	0.29	0.36	0.70	0.00	0.00	0.27	0.72	1.16	0.74	0.35	0.74
TCS-Ortho (Short Stay)	3.06	1.83	0.91	5.00	2.74	1.70	0.87	0.00	0.00	0.68	2.00	0.98	1.02	0.00	0.96

2024 Falls per Unit per Quarter					
UNIT	1Q24	2Q24	3Q24	4Q24	T
SNF (Combined Total)	4	4	3	1	12
Subacute	2	3	2	1	8
TCS-Ortho (Short Stay)	2	1	1	0	4

If improvement opportunities identified, provide action plan and expected resolution date:
Staff continues to participate in district-wide initiatives for fall prevention including Falls University to identify trends and communicate "take-aways". Coaching and progressive discipline is applied using Just Culture. Falls occur most commonly with our short-stay population, this skilled nursing unit has many patients who participate in physical and occupational therapy sessions with varying functional levels. Therapy sessions are designed to promote mobility and independence ultimately preparing the residents to discharge home. The Short Stay unit utilizes several interventions, such as adding fall review during staff meetings for educational purposes and increasing the availability of fall prevention equipment such as tele sitters and chair alarms.

PRESSURE INJURIES
Analysis of all measures/data: (Include key findings, improvements, opportunities)
Incidence of new or worsening pressure ulcers for short stay patients, which would include Sub Acute patients with a length of stay under 100 days, as reported on the Casper report is 0.7 % with the national average of 2.7%.

Patients at high risk for pressure ulcers (long stay residents, defined as high risk, who have > stage II pressure ulcers) is 13.3%. This is a slight decrease from 16.7% in the last report. The definition for this long stay quality measure asks if a wound is present, not if acquired in the facility. This is particularly challenging in a program that preferentially admits cases with pressure ulcers for ongoing treatment. The measure triggers a flag until the wound completely heals (and through the 6-month period). Very large wounds that have healed down to very small, chronic wounds will continue to trigger this measure. Thus, it is common to see a delay in improvement on the CASPER report, while seeing improvement more immediately in our internal data.

Overall, the total wound rate for both SNF units per 1000/pt. days for Q3 was 2 and Q4 2024 was 3. This is greater than the previous report of 0. Both SNF units participate in Kaweah health Clinical Skin Institute when pressure injuries are discovered on the unit, staff capture skin injuries during routine assessments and preventative measures are implemented early leading to better patient outcomes.

If improvement opportunities identified, provide action plan and expected resolution date:
We will continue to work within the high standards of the District, with close management of our fragile, chronic wound cases, collaborating closely with the Kaweah Health wound nurses and utilizing the standardized treatment sets available to us.

UBC teams for South Campus nursing are reviewing clinical cases using a Peer review methodology to assess for and remediate practice concerns.

# of Newly Acquired Pressure Ulcers ≥ Stage 2	1Q22	2Q22	3Q22	4Q22	1Q23	2Q23	3Q23	4Q23	1Q24	2Q24	3Q24	4Q24	Total 2024	Total 2023	Total 2022	Total 2021	Total 2020	Total 2019
Subacute	0	0	0	2	0	0	0	1	0	0	1	**1**	**2**	1	2	4	6	7
TCS-Ortho (Short Stay)	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**	0	0	3	1	0
TC - South (closed)	0	0	0	0	0	0	0	0						0	0	2	1	2
LTC Total	0	0	0	2	0	0	0	1	0	0	2	**1**	**3**	1	2	9	8	9

During the first two weeks of admission to the Subacute unit, patients at high risk for developing pressure ulcers are discussed with the IDT and treatment teams and preventative options are implemented.

Any wounds that are present and worsening wounds or pressure ulcer are discussed shift to shift during safety huddles for all SNF units. Weekly summaries are done for patients to identify high risk patients for developing pressure sores. Wound nurse consults are obtained for complex wounds that require additional oversight from nursing experts.

PSYCHOACTIVE MEDICATION USE

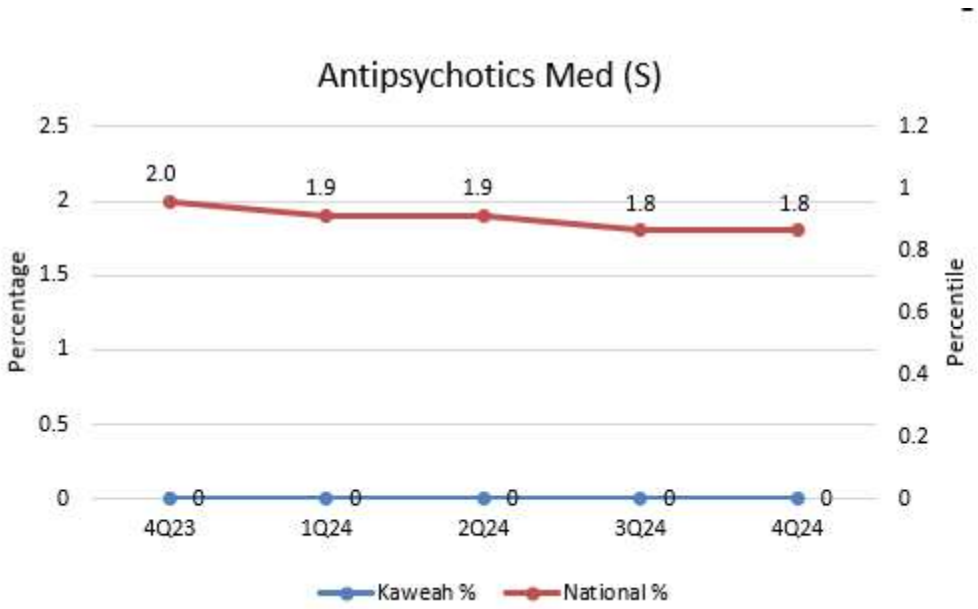
Definitions/Assumptions:

This measure is collected through the Minimum Data Sets that are completed and submitted to CMS at the defined intervals by the program. The data includes only the information regarding prescribed medications by drug category (not by intended use or indication). Therefore, for instance, a practice change in the use of anxiolytics like lorazepam to antipsychotics like quetiapine for ventilator management would affect this data directly

Increased use of medications in the antipsychotic drug-class for management of depression is also impacting our results in these measures. Antianxiety and hypnotic medication use is not reported as a quality measure for the short-stay population. The data is collected through the MDS, but is not included in the measures that make up our quality ranking. All values are expressed in percentile rankings.

Analysis of all measures/data: (Include key findings, improvements, opportunities)

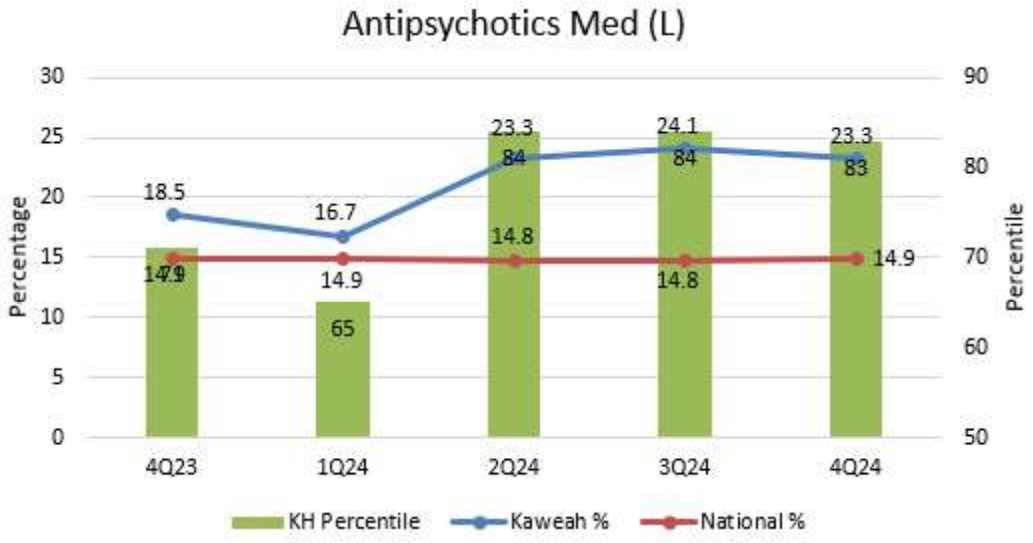
Short Stay residents (<100 days) Antipsychotic medication use for short stay patients is below the national average, which measures only cases with newly prescribed antipsychotics. The short stay patients who begin a new anti-psychotic during their stay is 0% for both 3Q24 and 4Q24, compared to the national average of 1.8%



Long Stay residents.

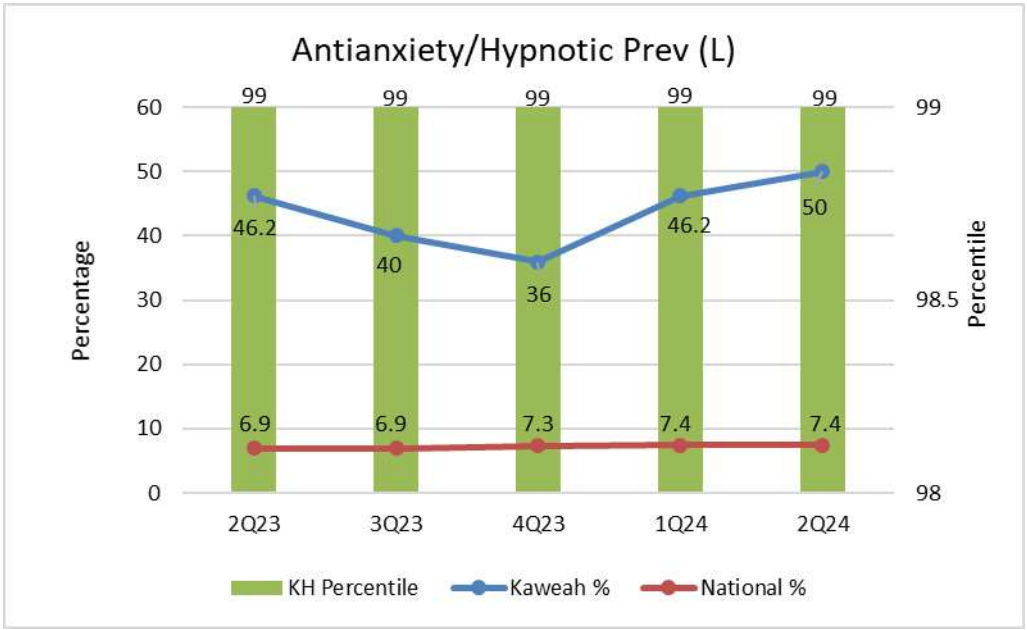
The facility percent for antipsychotic use in long stay residents for 3Q24 24.17% (84th percentile) and 4Q24 is 23.3% (83rd percentile) compared to the national average of 14.8% and 14.9%. The increase in 3Q24 and 4Q24 is associated with one patient where psychiatry was involved in treating severe agitation and combative behavior. It was determined the patient needed a higher level of care and was transferred back to the Medical Center but did return. Unlike the short stay measure, which only includes newly prescribed antipsychotics, the long stay measure includes all patients on the medication for any portion of the time (even if it was a home medication). Included in this measure are medications like quetiapine, used for depression or for ventilator management cases. There is another instance where our target client group for long-term care (Sub Acute program) is the primary driver of our performance.

SNF leadership has been working closely with the medical team, pharmacy and our MDS nurses to ensure that appropriate psychiatric diagnoses are captured in the medical record whenever possible. A small number of these diagnoses are excluded from this quality measure.



Long Stay residents.

Antianxiety/Hypnotic Medication use for long stay residents has remained high at the 99th percentile for 3Q24 and 4Q24, consistent throughout the year. This is reflective of the use of these meds for our ventilated patients in the subacute unit. There are no exclusions for medical diagnosis for this measure.



If improvement opportunities identified, provide action plan and expected resolution date:

Psychotropic medications are under constant scrutiny by CMS. Concerns around these medications are primarily founded in two concepts:

1. Inappropriate or excessive use of medications
2. Using psychotropic medications to control behaviors (as a chemical restraint) or for more convenient management of difficult patients.
3. Informed consent for psychotherapeutic drugs including recent update associated with AB 1309.

While the majority of our client group has clear and compelling indications for these agents, we continue to monitor the medications very closely. Our LTC pharmacist plays an important role in helping us ensure we track these medications closely during the transition process. Our primary focus is unnecessary medications, like prn hypnotics, hence we also monitor for the potential to reduction when possible.

All residents receive a monthly medication regimen review and physician consultation by our LTC pharmacist and Medical Director. This close partnership has helped reduce psychoactive medication used generally, including dose reduction practices.

There have been no findings around inappropriate use of psychotropic mediations in any of our programs, including the most recent CMS recertification survey in March 2024.

Submitted by Name:
Kari Moreno

Date Submitted:
April 2025

2025 Safety Culture Survey

Board of Directors Report
June 2025

Kaweah Health vs. Benchmarks (all respondents)

Response Rate: 55% (2,085/3,804)

Dates of Survey Administration – Feb 24 – Mar 16, 2025

PressGaney

Kaweah Health: 2,085 respondents

Total Safety Culture
(all questions)
3.91
0.00 vs. 2023
51st %tile vs. Nat'l Healthcare >400 Beds Avg

Prevention & Reporting
(8 questions)
4.16
+0.01 vs. 2023
77th %tile vs. benchmark

Pride & Reputation
(4 questions)
3.92
***-0.05** vs. 2023*
34th %tile vs. benchmark

Resources & Teamwork
(7 questions)
3.64
+0.02 vs. 2023
56th %tile vs. benchmark

Custom Questions
(7 questions)
4.13
***+0.09** vs. 2023*
N/A vs. benchmark

PressGaney

*Statistically significant difference represented by bold **red**/**green**.*

Safety Culture Program Results

Results Summary

- No change in overall score
- Slight score improvement in “Change Prevention & Reporting” and “Resources & Teamwork” domains
- Slight decrease in “Pride & Reputation” domain
- Significant improvement in custom Just culture focused questions

2024 Safety Program Highlights

- “High Reliability” in-person education during new employee orientation
- Daily Safety Huddle
- Foundational team training for all new employees and annually
- Robust Just Culture Program
- Unit/dept level “Stop Light” reports focused on unit/dept opportunities

Custom Questions Focused on Just Culture

Items	Response Distribution (Unfavorable / Neutral / Favorable)	Mean Score	vs. Nat'l Healthcare >400 Bed Avg 2025	vs. Historical (2023 Results)
I make Kaweah Health a safer place for patients by entering event reports.	2% / 10% / 88%	4.28	-	+0.08
I enter reports about events in which I was involved.		4.21	-	+0.06
Nurses/staff support a culture of patient safety in this unit/department.	2% / 12% / 86%	4.17	-	+0.02
The manager supports and leads a culture of safety in my unit/department.	3% / 13% / 84%	4.17	-	0.00
The unit/department Director supports and leads a culture of safety in my unit/department.	5% / 13% / 82%	4.14	-	+0.02
Physicians support a culture of patient safety in my unit/department.	4% / 16% / 80%	3.98	-	+0.05
The Midas event reporting system is easy to use.	5% / 20% / 75%	3.58	-	+0.09

Top Performing Items

These items help you identify some of the top performing items for your team based on their percentile rank compared to the selected benchmark. Use this item list to identify things that are going relatively well for your team compared to other items for your team.

Items	Response Distribution (Unfavorable / Neutral / Favorable)	Mean Score	vs. Nat'l Healthcare >400 Bed Avg 2025	vs. Historical Historical (2023 Results)
In my unit/department, we discuss ways to prevent errors from happening again.	3% 9% 89%	4.34	+0.19	+0.02
I can report patient safety mistakes without fear of punishment.	5% 9% 86%	4.30	+0.17	+0.01
We are actively doing things to improve patient safety.	3% 10% 87%	4.32	+0.16	+0.04
My unit/department works well together.	4% 10% 85%	4.30	+0.15	+0.05
Employees will freely speak up if they see something that may negatively affect patient care.	5% 10% 85%	4.23	+0.17	+0.04

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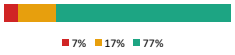
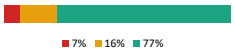
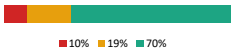
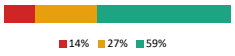
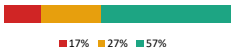
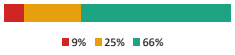
Key Drivers of Safety Culture Pride & Reputation

Key Drivers help you identify items that you should consider focusing on first to improve Safety Culture Pride and Reputation within your team. Have a discussion with your team on where you want to focus and what you can do together to improve these areas. It's important to get input from your team to make sure you are addressing the right opportunity in the right way.

Items	Response Distribution (Unfavorable / Neutral / Favorable)	Mean Score	vs. Nat'l Healthcare >400 Bed Avg 2025	vs. (2023 Results)
This organization provides high-quality care and service.		3.98	-0.08	-0.04
This organization makes every effort to deliver safe, error-free care to patients.		3.98	-0.04	-0.05
Senior management provides a work climate that promotes patient safety.		3.83	-0.03	-0.06
Communication between physicians, nurses, and other medical personnel is good in this organization.		3.59	-0.02	+0.03
Communication between units/departments is effective in this organization.		3.54	+0.03	-0.03
There is effective teamwork between physicians and nurses at this hospital.		3.76	-0.01	+0.03

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Completed Actions

Unit/Department/GME Program level:

- Unit/Dept Level report dissemination (April 29, 2025)
- Org results dissemination to Leadership, leadership education on effective debriefing and action planning (April 29 & May 1)
- Unit/Dept staff debriefs to identify focused opportunities for improvement (May 1 – June 20, 2025)
- Unit/Dept level action plan ("stop light reports") submitted by each unit/department (June 20, 2025)

Medical Staff

- Results cross-walked with 2024 Physician Engagement Survey results, objectives identified

Safety Program:

- Revised daily in-person operational safety huddle
- Incident management
- Redesign of Cause Analysis (training completed June X, 2025)

In-Process Actions

Unit/Department/GME Program level:

- Implementing action plans
- Pulse survey to check on effectiveness 1 quarter 2026

Medical Staff & GME:

- Results and objectives reviewed at Department meetings & GMEC, including discussion on issues and concerns
- Action plan development “Stop Light Report” and follow up

Safety Program:

- Further analysis of the Org Safety Culture Survey results to identify trends in the Key Drivers and safety culture by role by August 4, 2025
- Identify and enhance key elements that impact the culture of patient safety, reporting out of action plans by September 30, 2025
- Chief-lead staff sessions focused on survey results and seeking employee suggestions for improvement (completed by June 30, 2025)
- Executing revised cause analysis processes (date TBD)
- Relaunch of Kaweah Health “Good Catch Program” (completed by August 4, 2025)

QUESTIONS?

The pursuit of healthiness

Kaweah Health
MORE THAN MEDICINE. LIFE.

Outstanding Health Outcomes (OHO) QUALITY & PATIENT SAFETY PRIORITY

Healthcare Acquired Infection (HAI) Reduction

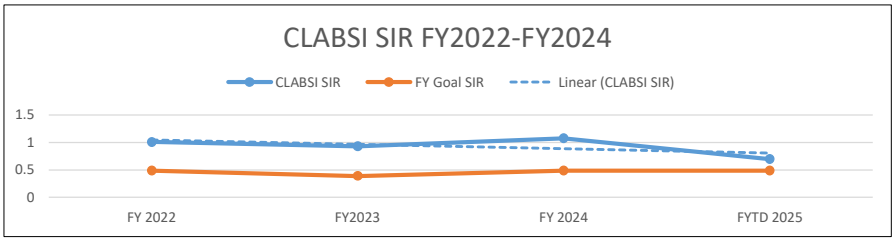
April 2025

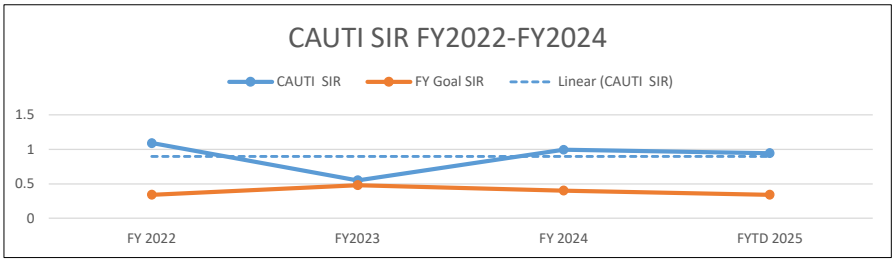
OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

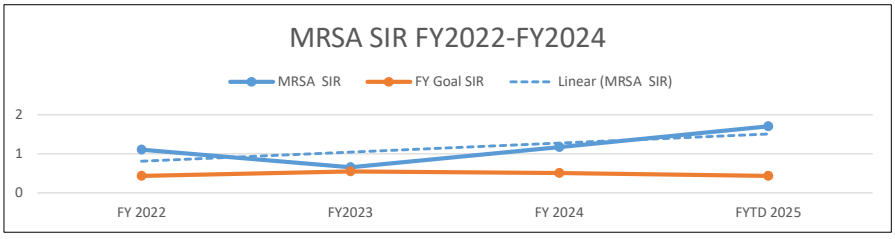
(number of actual infections/number of predicted infections by CMS)

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

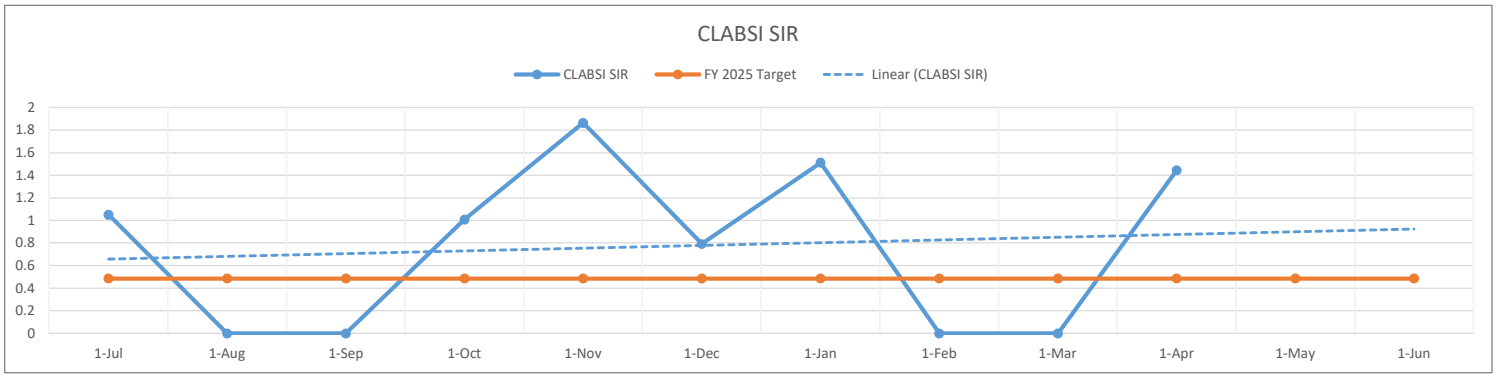
- Reduce line utilization; less lines, less opportunity for infections to occur
  - Goal: reduce central line utilization ratio to <0.66
  - Goal: reduce urinary catheter utilization ratio to <0.64
- MRSA nasal and skin decolonization for patients with lines.
  - Goal: 100% of at risk patients nasally 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

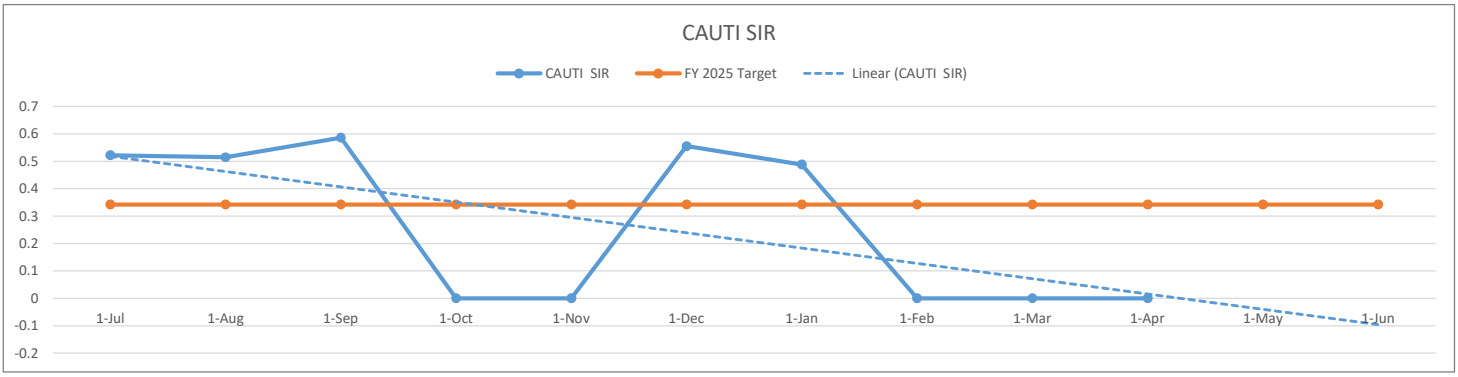
Kaweah Health

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



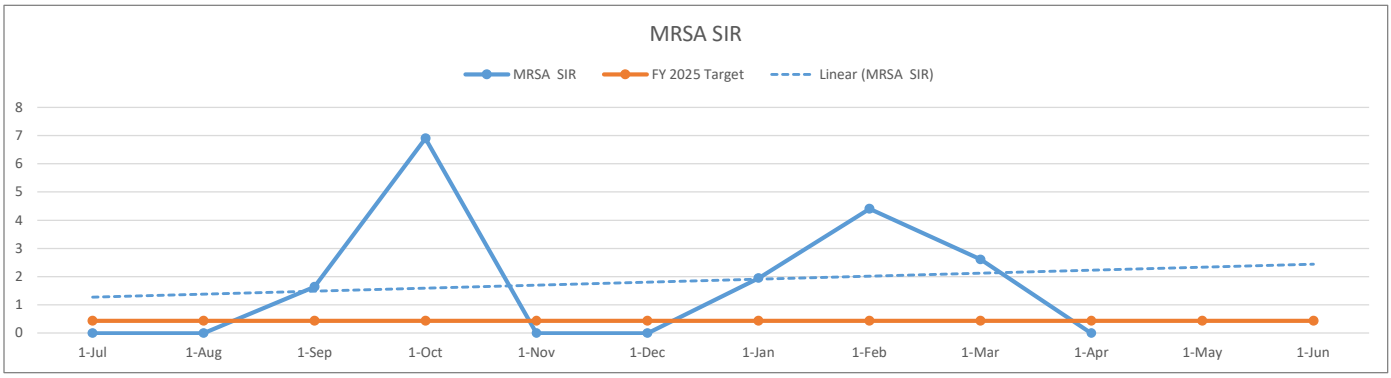
	FY 2025 Target	FY 2024	24-Jul	24-Aug	24-Sep	24-Oct	24-Nov	24-Dec	25-Jan	25-Feb	25-Mar	25-Apr	25-May	25-Jun	FYTD 25
CLABSI Events		17	2	0	0	1	1	1	2	0	0	1			8
CLABSI Predicted Events		16.06	1.051	1.117	0.121	1.008	1.072	1.262	1.323	0.848	0.989	0.682			10.473
CLABSI SIR	<0.486	1.06	1.903	0	0	0.992	1.865	0.792	1.512	0	0	1.446			0.76

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	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	1.053			16.705
CAUTI SIR	<0.342	0.4	0.522	0.515	0.586	0.00	0	0.555	0.488	0	0	0			0.30

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	0			7
MRSA Predicted Events		9.62	0.501	0.482	0.485	0.290	0.451	4.74	0.512	0.454	0.383	0.465			5.339
MRSA SIR	<0.435	0.73	0	0	1.64	6.9	0	0	1.95	4.41	2.61	0			1.31

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 - April 2025 0.64
  - Goal: reduce urinary catheter ratio to <0.64
  - July 2024 - April 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
- 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 56% 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 – May 2025 Pass cleanliness effectiveness testing **90%** of the time in high risk areas

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

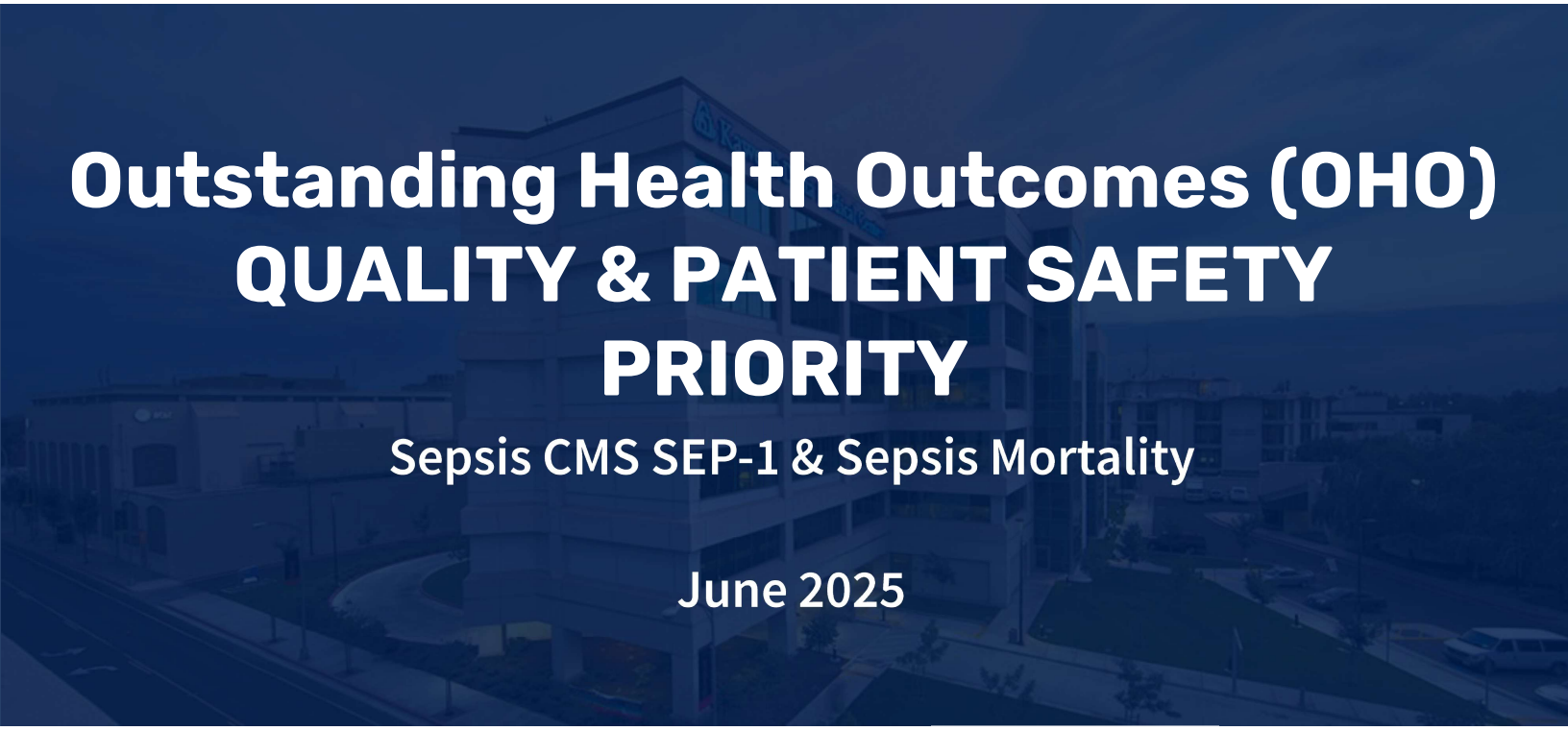
CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
Expand Multidisciplinary rounds to include other stakeholders to reduce line use; NEW device rounds with Charge RN and Infection Prevention started May 1, 2025 on all inpatient units	5/1/25	Buy in from physician stakeholders
Explore consensus statement on duration of femoral lines with medical staff	7/30/25	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 7/30/25	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	Completed, ongoing
Nursing Competency Camp – plan to include MRSA screening information	5/19/25	Completed

Thank you

Live with passion.

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

Kaweah Health



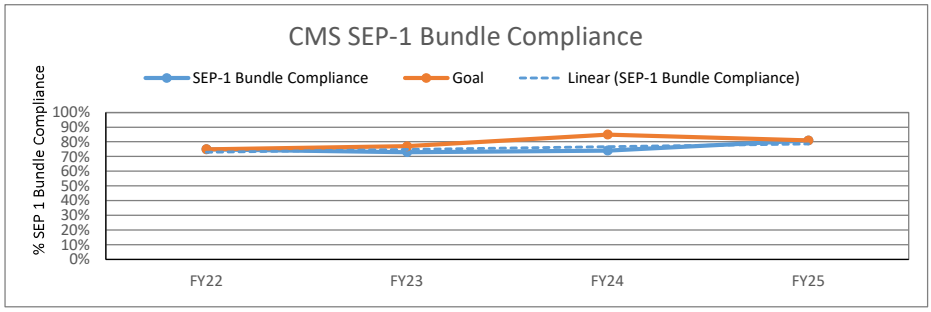
Outstanding Health Outcomes (OHO) QUALITY & PATIENT SAFETY PRIORITY

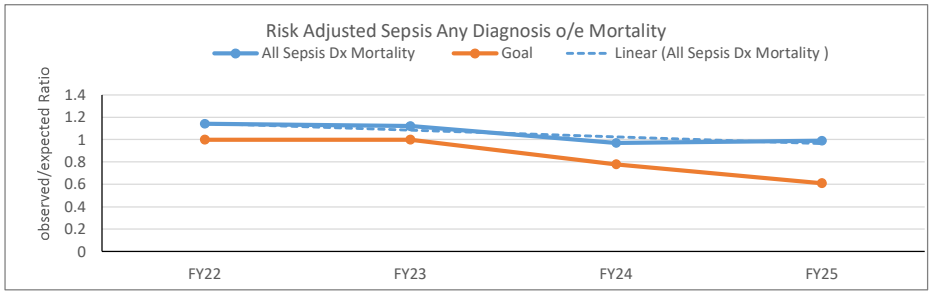
Sepsis CMS SEP-1 & Sepsis Mortality

June 2025

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

Historical Baseline





FY25 GOAL

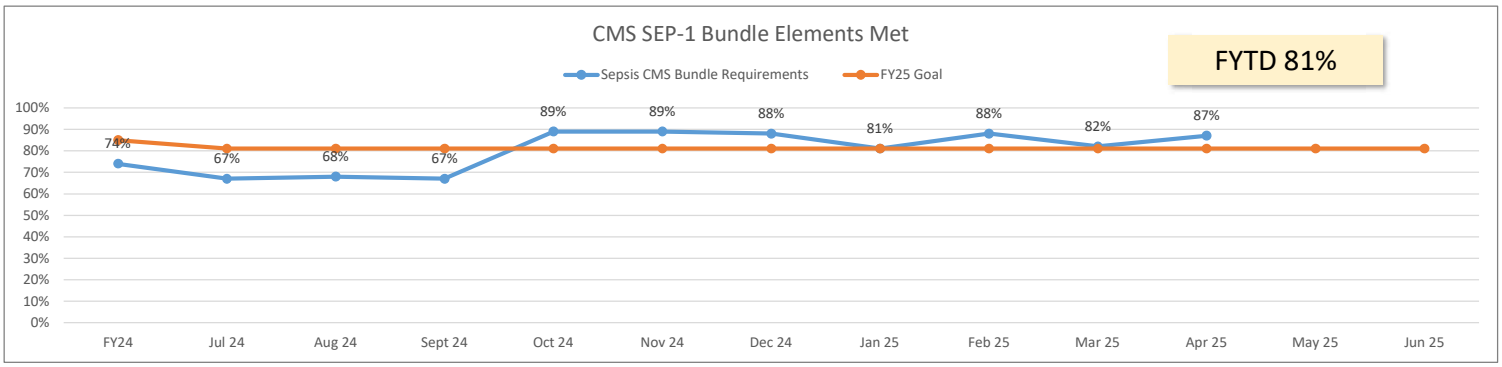
Increase SEP-1 Bundle Compliance ≥ 81%
Decrease Sepsis any diagnosis Mortality ≤ 0.61

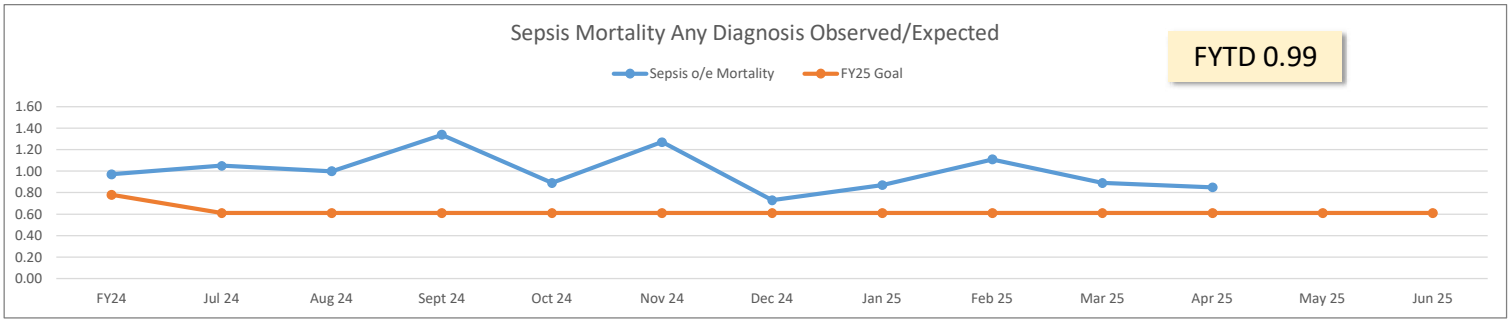
FY25 PLAN – CMS SEP-1

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 7 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) BC not ordered by Intensivist. 1(One) Abx, BC, not ordered timely by ED provider (counts as 1 fall out only). 1 (One) < 30 mL/kg fluids ordered, No documentation for lesser fluid reason documented by ED Provider; Vasopressor not ordered for persistent hypotension by ED Provided (counts as 1 fall out only).
- 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 93%
  - 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 30.5%
  - Pts Met 1- Hr Bundle 28%

  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 (FY25/FY26) ✓ 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 Surgery (ACTS), Family Medicine (FM) team for ongoing Sepsis education*** ○ Incrementally engage Transitional Year & Psych residents	Surgery 7/15/25 FM 6/4/25	
2. Code Sepsis in ED (workgroup in progress)	Discussion to continue with CNO	
3. Sepsis SIM (Simulation in Medical Science) Lab Planned for Spring 2025 (possible in situ SIM) Audience: Nursing Staff	Completed May 12, 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 (Intensivist, Hospitalist group engaged)	Ongoing	
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 ○ Explore use of AI tool (s) for Sepsis alert	TBD	Limitations within Cerner cloud Concerns with disrupting existing algorithm Cerner has not yet released Sepsis AI tool
6. Sepsis documentation improvement project ○ Reviewing 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)	Ongoing	
7. Continue to focus on increase of order set usage		
8. 1:1 ED Staff coaching for ED Sepsis fall outs		
9. RN Sepsis Coordinator position posted ○ New Interim RN Sepsis Coordinator coming soon	Ongoing	

Thank you

Live with passion.

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