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, January 15, 2026 • Kaweah Health Executive Office Conference Room
Attending: Board Members: Mike Olmos (Chair), Dean Levitan, MD; Marc Mertz, CEO; Scott Baker, Interim Chief Nursing Officer; Paul Stefanacci CMO/CQO; Jag Batth, Chief Operating Officer; Michael Tedaldi, MD, Vice Chief of Staff and Quality Committee Chair; LaMar Mack, MD, Quality and Patient Safety Medical Director; Ben Cripps, Chief Compliance and Risk Management Officer; Evelyn McEntire, Director of Risk Management; Megan Stuart, RN Clinical Care QA; and Kyndra Licon, Recording.

OPEN MEETING – 7:45 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. **ADJOURN OPEN MEETING –** Mike Olmos, Committee Chair

CLOSED MEETING – 7:46 AM

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

2. **Review of the December Quality Council Closed Session Minutes –** Mike Olmos, Committee Chair; Dean Levitan, Board Member

3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – Michael Tedaldi, MD, Vice Chief of Staff and Quality Committee Chair

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

OPEN MEETING – 8:00 AM

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

Kaweah Delta Health Care District
Board Of Directors Committee Meeting

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

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. **Close Meeting Report Out**
4. **Review of December Quality Council Open Session Minutes -** Mike Olmos, Committee Chair; Dean Levitan, Board Member
5. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives:
    a. **Maternal Child Health Quality Report**
    b. **Health Equity Quality Report**
6. **Rapid Response Team Code Blue Quality Report–** A review of key process and outcome measures related to rapid response and code blue processes. *Scott Baker, Interim Chief Nursing Officer.*
7. **Orthopedic Services Quality Report –** A review of key quality measures and actions focused on the care of the orthopedic patient population. *Kevin Bartel, PT, DPT, MTC, Director of Orthopedics, Neurosciences & Specialty Practice*
8. **Clinical Quality Goals Update –** A review of current performance and actions focused on the clinical quality goals for Healthcare Acquired Infection and Patient Safety Indicator (PSI) 90 Composite. Shawn Elkin, Infection Prevention Manager; Chris Patty, Clinical Practice Guidelines Program Manager.
9. **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 Session Minutes

OPEN Quality Council Committee
Thursday, December 11, 21025
The Executive Office Conference Room

Attending: Board Members: Dr. Dean Levitan (Standing Committee Chair), Dave Francis (Board Member); Gary Herbst, CEO; Marc Mertz, Chief Strategy Officer; Jag Batth, Chief Operation Officer; Amy Baker, MSN, RN, Director of Specialty Clinics; Connie Green, Nurse Manager, Chronic Dialysis; Chris Patty; Clinical Practice Guidelines Program Manager; Shawn Elkin, Infection Prevention Manager; Dr. Paul Stefanacci, Chief Medical Officer; Chris Patty, Clinical Practice Guidelines Program Manager; Kyndra Licon – Recording.

Dr. Dean Levitan called to order at 7:45 AM.

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

Dr. Dean Levitan adjourned the meeting at 7:46 AM.

Public Participation – None.
Dr. Dean Levitan called to order at 8:00 AM.

4. **Review of November Quality Council Open Session Minutes –** Dr. Dean Levitan, Standing Committee Chair; Dave Francis, Board Member.
    - Reviewed and acknowledged the November Quality Council Open Session Minutes by Dr. Dean Levitan and Mike Olmos. No further actions.

5. **Written Quality Reports –** a review of key quality metrics and actions associated with the following improvement initiatives: Reports reviewed and attached in minutes. No action taken.
    a. **HAPI Quality Report**
    b. **Hand Hygiene Dashboard**
    c. **Subacute Quality Report**
    d. **Diabetes Committee Report**

6. **Emergency Department Quality Report –** A review of current performance and actions focused on the clinical goals for Emergency Department. Scott Baker, RN, Director of Emergency and Trauma Services. Report reviewed and attached in minutes. No action taken.

7. **Kaweah Health Chronic Dialysis Report -** A review of key performance indicators and actin associate with care of dialysis patient population. *Amy Baker, MSN, RN, Director of Specialty Clinic; Connie Green, Nurse Manager, Chronic Dialysis.* Report reviewed and attached in minutes. No action taken.

8. **Clinical Quality Goals Update**- A review of current performance and actions focused on the clinical quality goals for Healthcare Acquired Infections and Patient Safety Indicator (PSI) 90 Composite. *Shawn Elkin, Infection Prevention Manager; Chris Patty, Clinical Practice Guidelines Program Manager.* Reports reviewed and attached to minutes. No action taken.

Adjourn Open Meeting – *Dr. Dean Levitan,* Standing *Committee Chair*

Dr. Dean Levitan adjourned the meeting at 9:17 AM.

Separator Page

Maternal Child Health Quality Report

Labor and Delivery Early Elective Delivery

Goal: The goal is to have zero early elective deliveries.	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Felicia Vaughn, Kristen Del Sesto**	**Time Period: July-September 2025**
Team Leader: Felicia Vaughn	**Team members: All OB Providers**		**Revision (date): November 2025**
PI Liaison:			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
Patients with an induction or cesarean procedure prior to labor including patients with 37/38 week deliveries, excluding those with a condition justifying an elective delivery (per The Joint Commission) or a history of prior stillbirth IF induction or cesarean performed in current delivery.

Current Condition: YTD 12.3%

- Jan –Mar 2025 = 13.8%
- April- June 2025= 8.1%
- July-September 2025 = 15.1%

Target / Goal: 0%

Problem Analysis / Root Cause, Gap:

1. There is no stop gap when a provider calls to schedule an early elective delivery.
2. There are issues with diagnostic coding.
3. Provider documentation needs to support

DO

Countermeasure / Action Plan / Solutions:
2024
07/16/24 – review of quality improvement data (all of MCH)
2025
Meeting with providers to discuss barriers & documentation
Scheduler to alert to manager to potential fall-outs
Connect with coders to correct retrospectively

CHECK

Results / Metrics:
Continue to monitor compliance.
2024
August 2024-**Goal Met** 0% early elective deliveries
Oct-Dec 2024 = 16.3%
2025
Quarterly Goal Not Met: Jan-Mar **2025** – 16.3%, April- June 2025 8.1%, July-September 2025-15.1%
YTD Goal Not Met 2025 – 12.3%

ACT / ADJUST

Follow-Up / Sustainability:
Working to correct potential issues with coding.
Continuing to monitor for compliance.
Working with MCH Scheduler to identify elective deliveries not meeting criteria at time of scheduling

Labor and Delivery Nullip Term Singleton Vertex: PC-02

Goal: The goal is to have ≤23.6% cesarean deliveries for this population.	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Felicia Vaughn, Elizabeth Bowen**	**Time Period: July-September 2025**
Team Leader: Felicia Vaughn	**Team members: All OB Providers**		**Revision (date): November 2025**
PI Liaison:			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
Working to reduce the cesarean section rate for the lowest risk patient population, the nulliparous term singleton vertex patient.

Current Condition: YTD: 31.2%
Jan-March = 30.7%
April- June= 29.9%
July-September = 33.0%
- July 2025: 38.3%
- August 2025: 32.5%
- September 2025: 28.2%

Target / Goal: To have a **≤23.6%** cesarean delivery rate for this patient population.

Problem Analysis / Root Cause, Gap:
1. Most common reason for fallout is Induced Labor (25.1%)
2. Staff need further education on the appropriate induction process and communication with providers.

DO

Countermeasure / Action Plan / Solutions:
Monthly review of quality improvement data (all of MCH) with unit specific key stakeholders.
Unit based action plan-
- Added a celebration board for staff to indicate when they have a successful NTSV vaginal delivery.
- Added a Labor Comfort Cart to provide more tools for the nurses to assist patients in achieving a vaginal delivery.
- Provided education on supporting vaginal births to licensed staff.
- Consider a Turn Campaign to promote vaginal birth

CHECK

Results / Metrics:
Continue to monitor compliance.
2024
Yearly Goal Not Met - 26.2%
July- Sep 2024 22.4% (July & Sep goal met)
Oct- Dec 2024 = 27.5%
2025
Quarterly Goal Not Met Jan-Mar 2025 – 30.7%, April- June 2025 29.9%, July-September = 33.0%

YTD Goal Not Met 2025 – 31.2%

ACT / ADJUST

Follow-Up / Sustainability:
Educator continues to meet with staff to educate them on best practices and ensure they are up to date on NSTV.

Labor and Delivery Scheduled Inductions Not Delayed

Goal: The goal is to have 95% of inductions started timely	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Felicia Vaughn, Kristen Del Sesto**	**Time Period: July-September 2025**
Team Leader: Felicia Vaughn	**Team members: All OB Providers**		**Revision (date): November 2025**
PI Liaison:			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
Scheduled inductions experiencing delay in the initiation of induction medications. Delays may result in prolonged LOS and an increase in patient census.

Current Condition: YTD 83.9%
Jan – Mar 2025 = 81.49%
Apr- June 2025= 85.75%
July-September 2025= 84.37%
- July 2025- 76.0%
- August 2025- 92.90%
- September 2025- 84.20%

Target / Goal: To have 95% of all induction medications started within 1 hour of admission.

Problem Analysis / Root Cause, Gap:
1. Delays due to provider not seeing patients and orders not placed in a timely manner.
2. Delays related to bed availability/staffing for scheduled admissions such as inductions.

DO

Countermeasure / Action Plan / Solutions:
- Triage Staff are instructed to call providers right away for admission orders
- Increased staffing for 3 Triage RNs
- Working with providers to have them come see induction patients in a timely manner.
- Onboarding new staff, open positions available, use of contract labor.

CHECK

Results / Metrics:
Continue to monitor compliance
2024
Yearly Goal not met – 81.0%
July- Sep 2024 67.7%
Oct- Dec 2024 = 68.9%
2025
YTD Goal Not Met 2025 – 83.9%
Jan – Mar 2025 = 81.49%
Apr- June 2025= 85.75%
July-September 2025= 84.37%

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to follow-up on individual fallouts with both staff and providers.

Labor and Delivery Severe Unexpected Complications in Term Newborns: PC-06.1

Goal: The goal is to have ≤5%	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Felicia Vaughn, Kristen Del Sesto**	**Time Period: July-September 2025**
Team Leader: Felicia Vaughn	**Team members: All OB Providers**		**Revision (date): November 2025**
PI Liaison:			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
Working to reduce the cesarean section rate for the lowest risk patient population, the nulliparous term singleton vertex patient.

Current Condition: YTD 5.1%
Jan – March 2025 = 3.7%
April- June 2025= 3%
July-September 2025 = 7.8%
- July 2025 – 3.3%
- August 2025-13.10%
- September 2025-7.0%

Target / Goal: To have a ≤5% severe unexpected complications in term newborns.

Problem Analysis / Root Cause, Gap:
This measure addresses this gap and gauges adverse outcomes resulting in severe or moderate morbidity in otherwise healthy term infants without preexisting conditions. This measure also uses length of stay (LOS) modifiers to guard against over coding and under coding of diagnoses. Importantly, this

DO

Countermeasure / Action Plan / Solutions:
- Reviewed specific cases, evaluated commonalities between fallouts
- Monthly review of quality improvement data (all of MCH) with key stakeholders.
- Reviewed specific cases, seeing connections between these cases and inductions and NTSV cesarean sections

CHECK

Results / Metrics:
Continue to monitor compliance
2024
Yearly Goal = 6.75%
July- Sep 2024 = 6.8%
Oct- Dec 2024 = 3%
2025
Quarterly Goal Met April- June 2025
YTD Goal Met 2025 5.1%
Quarter 3 goal not met
July-September 2025 = 7.8%
- July 2025 – 3.3%
- August 2025-13.10%
- September 2025-7.0%

Labor and Delivery Severe Unexpected Complications in Term Newborns: PC-06.1

	metric serves as balancing measures for other maternal measures such as NTSV Cesarean rates and early elective delivery rates. The purpose of a balancing measure is to guard against any unanticipated or unintended consequences of quality improvement activities for these measures.	ACT / ADJUST	**Follow-Up / Sustainability:** Continue working and collaborating with our OB Improvement and MCH Quality Improvement Committee's to ensure case reviews and to identify areas of improvement.

Labor and Delivery Hand Hygiene

Goal: Hand hygiene compliance is 95% or greater.	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Felicia Vaughn, Kristen Del Sesto**	**Time Period: July-September 2025**
Team Leader: Felicia Vaughn	**Team members: All Staff**		**Revision (date): November 2025**
PI Liaison:			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at how many opportunities were identified by the Biovigil system for hand hygiene and how many were compliant. All staff entering a patient's room should participate in hand hygiene utilizing the Biovigil system.

Current Condition: 2025 YTD 95%
Jan-Mar 2025 = 96.4%
Apr- August 2025 94.18%
July-September 2025: 93.16%

- July 2025: 93.90%
- August 2025: 93.30%
- September 2025: 93.50%

Target / Goal: 95%

Problem Analysis / Root Cause, Gap:
Continue to ensure the team is compliant by running reports and holding staff accountable to usage.
Biovigil data is reviewed monthly with all MCH leadership, fall outs identified and addressed by each unit manager.

DO

Countermeasure / Action Plan / Solutions:
Identification of usage and compliance through reports.
8/30/2025- Issue with the amount of Biovigil badges available for staff. IP has increased the amount of badges for the unit.

CHECK

Results / Metrics:
2023
Goal Met for 2023 year to date= 97.2%
2024
Goal Met for 2024 year to date= 95.3%
July- Sep 2024= 94.9% Below goal
Oct-Dec 2024= 95.6%
2025
Quarterly Goal Met Jan-Mar 2025 met – 96.4%
July- September 2025- issue identified; shortage on Biovigil badges resulting in 93.6%
YTD Goal Met 2025 – 95%

Labor and Delivery Hand Hygiene

		ACT / ADJUST	**Follow-Up / Sustainability:** We will continue to monitor for compliance.

Labor and Delivery Barcode Medication Administration

Goal: Barcode Medication Administration compliance is 95% or greater.	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Felicia Vaughn, Kristen Del Sesto**	**Time Period: July-September 2025**
Team Leader: Felicia Vaughn	**Team members: All Staff**		**Revision (date): November 2025**
PI Liaison:			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at each time a medication was administered to verify that the medication and the patient armband were scanned each time.

Current Condition: YTD 97.3%

Jan-Mar 2025 = 97%
April- June 2025= 97.18%
July-September 2025= 97.1%

- July 2025: 96.3%
- August 2025: 97.2%
- September 2025: 97.1%

Target / Goal: 95%

Problem Analysis / Root Cause, Gap:
Continue to ensure the team is compliant by running reports and holding staff accountable to scan every medication and every patient every time.

DO

Countermeasure / Action Plan / Solutions:
Identification of compliance through reports.

CHECK

Results / Metrics:
2024
Goal Met for 2024: 97%.
July- Sep 2024 = 96.7%
Oct- Dec 2024 = 98.1%
2025
Quarterly Goal Met: July- September 97.1%
YTD Goal Met 2025 – 97.3%

Labor and Delivery Barcode Medication Administration

		ACT / ADJUST	**Follow-Up / Sustainability:** We will continue to monitor for compliance.

Neonatal Intensive Care Unit Hand Hygiene

Goal: Hand hygiene compliance is 95% or greater.	**Med Staff Champion: Dr. Dosado**	**Subject Experts: Daniel Castaneda, Mary Dieterle, Kelly Gentner**	**Time Period: July-September 2025**
Team Leader: Daniel Castaneda	**Team members: All Staff**		**Revision (date): 11.24.2025**
PI Liaison:			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at how many opportunities were identified by the Biovigil system for hand hygiene and how many were compliant. All staff entering a patient's room should participate in hand hygiene utilizing the Biovigil system.

Current Condition: Quarter Average: 99.2%

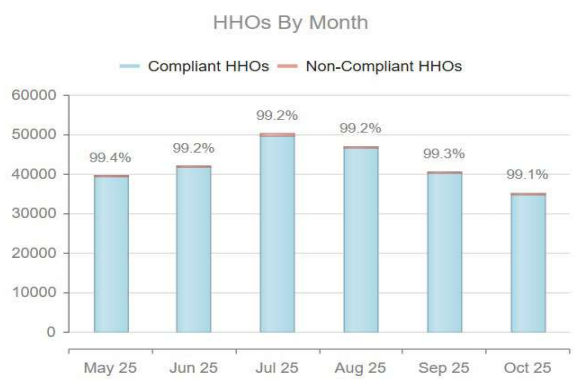
- July: 99.2%
- August: 99.2%
- September: 99.3%

Target / Goal: 95%

Problem Analysis / Root Cause, Gap:
Continue to ensure the team is compliant by running reports and holding staff accountable to usage.

DO

Countermeasure / Action Plan / Solutions:
Identification of usage and compliance through reports.



CHECK

Results / Metrics:
Goal Met

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Neonatal Intensive Care Unit (NICU)- Breast Milk for NICU Babies

Goal: 100% of qualifying NICU patients receive any/some breast milk during their hospital admission to the NICU.	**Med Staff Champion: Dr. Dosado**	**Subject Experts: Daniel Castaneda, Mary Dieterle, Kelly Gentner**	**Time Period: July-September 2025**
Team Leader: Daniel Castaneda	**Team members: All Staff**		**Revision (date): 11/21/2025**
PI Liaison:			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at the total number of qualifying patients who receive breastmilk during any point of their NICU admission.
Exclusion Criteria:
Exclusive formula preference from mother, observation admissions with less than 4 hours in the NICU, transfers out of the NICU before the first feeding and expiration of life prior to first feeding.

Current Condition: Quarter Average- 96.1%
- July -97.6%
- August- 95.5%
- September- 95.1%

Target / Goal: 100%

Problem Analysis / Root Cause, Gap:
- NICU admission challenge mothers from providing exclusive breast milk due to separation from their infant(s).

DO

Countermeasure / Action Plan / Solutions:
- Early lactation support for mothers with breastfeeding preference on admission. - Dedicated Lactation Nurse stationed in the NICU five days a week.
- Acknowledge and recognize mothers who provide expressed breast milk for their infant(s).
- Counting any breastmilk used and utilizing donor milk to patients that meet cateria.

CHECK

Results / Metrics:
- Results from quarter averaging at 96.1%
- Researching new reasonable and attainable goals to meet overall goal.

ACT / ADJUST

Follow-Up / Sustainability:
- Continue to support families that wish to provide breast milk for their infants.
- Continue to utilize donor breastmilk bank services.

Neonatal Intensive Care Unit CLABSI

Goal: Zero CLABSI in the NICU	**Med Staff Champion: Dr. Dosado**	**Subject Experts: Daniel Castaneda, Mary Dieterle, Kelly Gentner**	**Time Period: July-September 2025**
Team Leader: Daniel Castaneda	**Team members: All Staff**		**Revision (date): 11.21.2025**
PI Liaison:			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at total number of patient days and how many of those days there was a central line-associated bloodstream infection.

Current Condition: 1,161 patient days with 0% (2024-2025)
Jan-June 2024= 322 patient days with 0% CLABSI
July-Dec 2024= 370 patient days with 0% CLABSI
Jan-June 2025= 322 patient days with 0% CLABSI
July-Sep 2025= 147 patient days with 0% CLABSI

Target / Goal: 0%

Problem Analysis / Root Cause, Gap:
N/A

DO

Countermeasure / Action Plan / Solutions:
Limit the number of Vascular Access team members.
Standardize insertion techniques.
Continue sterile technique for dressing changes.
Continue to perform hand hygiene.

CHECK

Results / Metrics:
Goal Met

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Neonatal Intensive Care Unit VAP

Goal: Zero VAP in the NICU per 1000 patient days.	**Med Staff Champion: Dr. Dosado**	**Subject Experts: Daniel Castaneda, Mary Dieterle, Kelly Gentner**	**Time Period: July-September 2025**
Team Leader: Daniel Castaneda	**Team members: All Staff**		**Revision (date): 11.24.2025**
PI Liaison:			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at total number of patient days and how many of those days there was ventilator-associate pneumonia in the Neonatal Intensive Care Unit.

Current Condition: 267 patient vent days, 0% VAP 9 2024-2025)
Jan-June 2024/ 109 patient vent days, 0% ventilator associated PNA
July-Dec 2024/ 65 patient vent days, 0% ventilator associated PNA
Jan-June 2025/ 41 patient vent days, 0% ventilator associated PNA
July-Sept 2025/ 52 patient vent days, 0% ventilator associated PNA

Target / Goal: 0%

Problem Analysis / Root Cause, Gap:
N/A

DO

Countermeasure / Action Plan / Solutions:
Adhere to the NICU Ventilator Associated Pneumonia Bundle.
Continue to collaborate with respiratory department.

CHECK

Results / Metrics:
Goal Met

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Pediatrics CLABSI

Goal: Zero Central Line Associated Blood Stream Infection in the Pediatrics Unit	**Med Staff Champion: Dr. Maccali**	**Subject Experts: Danielle Grimaldi**	**Time Period: July-September 2025**
Team Leader: Danielle Grimaldi	**Team members: All Staff**		**Revision (date): 11/25/2025**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at total number of patient days and how many of those days there was a central line-associated bloodstream infection in the Pediatric Unit.

Current Condition: FY: 0%

- July 2025: 0
- August 2025: 0
- September 2025:0

Target / Goal: 0%

Problem Analysis / Root Cause, Gap:
N/A

DO

Countermeasure / Action Plan / Solutions:
Continue sterile technique for dressing changes.
Continue to perform hand hygiene.

CHECK

Results / Metrics:
Goal Met

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Pediatrics Early Warning Score

Goal: 90% compliance in documenting a Pediatric Early Warning Score.	**Med Staff Champion: Dr. Maccalli**	**Subject Experts: Danielle Grimaldi**	**Time Period: July-September 2025**
Team Leader: Danielle Grimaldi	**Team members: All Staff**		**Revision (date): 11/25/2025**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at how many pediatric patients had a Pediatric Early Warning Score documented every 4 hours.

Current Condition: FY: 96.3%

- July 2025: 95.8%
- August 2025: 93.0%
- September 2025: 100%
- July-September 96.3%

Target / Goal: 90%

Problem Analysis / Root Cause, Gap:
N/A

DO

Countermeasure / Action Plan / Solutions:
Continue to audit weekly and remind staff to complete the assessments.

CHECK

Results / Metrics:
Goal Met

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Pediatrics Patient Falls

Goal: Zero patient falls in the Pediatric Unit.	**Med Staff Champion: Dr. Maccalli**	**Subject Experts: Danielle Grimaldi**	**Time Period: July-September 2025**
Team Leader: Danielle Grimaldi	**Team members: All Staff**		**Revision (date): 11/25/2025**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
Calculates total number of falls per quarter.

Current Condition: YTD-0 fall
April-June 2025 = 0 patient falls
July- September 2025 = 0 patients fall

Target / Goal: 0 patient falls

Problem Analysis / Root Cause, Gap:
Parents are educated throughout their child's stay on Peds regarding falls, but are non-compliant with education instructions.

DO

Countermeasure / Action Plan / Solutions:
Staff will continue to take all measures to prevent our pediatric patients from falling during their hospital admission.

CHECK

Results / Metrics:
Goal Met

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.
We will continue to educate parents with every interaction, and place play mat in the room if patient is active and at risk for falls.

Pediatrics Bar Code Medication Administration

Goal: Barcode Medication Administration compliance is 95% or greater.	**Med Staff Champion: Dr. Maccalli**	**Subject Experts: Danielle Grimaldi**	**Time Period: July-September 2025**
Team Leader: Danielle Grimaldi	**Team members: All Staff**		**Revision (date): 11/24/2025**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at each time a medication was administered to verify that the medication and the patient armband were scanned each time.

Current Condition: FY 99.47 %

- July: 99.3%
- August:99.3%
- September: 99.8%
- July-Sep: 99.47%

Target / Goal: 95%

Problem Analysis / Root Cause, Gap:
Continue to ensure the team is compliant by running reports and holding staff accountable to usage.

DO

Countermeasure / Action Plan / Solutions:
Identification of compliance through reports.

CHECK

Results / Metrics:
Goal Met

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Pediatrics Baxter Pump IV fluids

Goal: Baxter Pump Pediatric Drug library utilized 95% of the time of every Peds fluid infusion	**Med Staff Champion: Dr. Maccalli**	**Subject Experts: Danielle Grimaldi and Irene Price**	**Time Period: July-September 2025**
Team Leader: Danielle Grimaldi	**Team members: All Staff**		**Revision (date): 11/24/2025**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at how many times Pediatric drug guardrails are utilized during all Pediatric IV fluid infusions.

Current Condition: FY: 97.5%

- July: 98.90%
- August 96.80%
- September: 96.80%
- July-September: 97.5%

Target / Goal: 95%

Problem Analysis / Root Cause, Gap:
Continue to ensure the team is compliant by running reports and holding staff accountable to usage.
Alaris Pump Pediatric Drug library converted to Baxter Pediatric Drug library at the end of March 2025.

DO

Countermeasure / Action Plan / Solutions:
Identification of usage and compliance through reports. Ensure all fluids running on the Pediatric floor is utilizing Pt Fin number. This will help to delineate which Pediatric fluids are utilized outside the drug library on Peds and in the ED. Licensed staff must enter correct FIN number to help narrow down personnel administering IV fluids outside guardrails on each unit.

CHECK

Results / Metrics:
Goal met.

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Child Life Activities

Goal: 90% compliance in documenting a Child Life Activity opportunity during each shift.	**Med Staff Champion: Dr. Maccalli**	**Subject Experts: Danielle Grimaldi and Irene Price**	**Time Period: July-September 2025**
Team Leader: Danielle Grimaldi	**Team members: All Staff**		**Revision (date): 11.24.2025**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at how many pediatric patients engaged in a Child Life Activity and it was documented each shift.

Current Condition: FY 100%

- July 2025 : 100%
- August 2025: 100%
- September 2025: 100%
- July-September: 100%

Target / Goal: 90%

Problem Analysis / Root Cause, Gap:
Continue to ensure the team is compliant by auditing minimum of thirty (30) patient charts per month and holding staff accountable to documentation.

DO

Countermeasure / Action Plan / Solutions:
Added documentation checks to daily Charge Nurse duties to address in the moment. Documentation workflow updated to increase compliance with documentation

CHECK

Results / Metrics:
Goal met.

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Pediatrics Hand Hygiene

Goal: Hand hygiene compliance is 95% or greater.	**Med Staff Champion: Dr. Maccalli**	**Subject Experts: Danielle Grimaldi**	**Time Period: July-September 2025**
Team Leader: Danielle Grimaldi	**Team members: All Staff**		**Revision (date): 11/15/2025**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at how many opportunities were identified by the Biovigil system for hand hygiene and how many were compliant. All staff entering a patient's room should participate in hand hygiene utilizing the Biovigil system.

Current Condition: FY: 96.8%

- July: 96.3%
- August: 97.1%
- September: 97.1%
- July-September: 96.8%

Target / Goal: 95%

Problem Analysis / Root Cause, Gap:
Continue to ensure the team is compliant by running reports and holding staff accountable to usage.

DO

Countermeasure / Action Plan / Solutions:
Identification of usage and compliance through reports.

CHECK

Results / Metrics:
Goal Met

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Mother Baby Bar Code Medication Administration

Goal: Bar Code Medication Administration compliance is 95% or greater.	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Stephanie Genetti, Elizabeth Bowen**	**Time Period: July- September 2025**
Team Leader: Stephanie Genetti	**Team members: All Staff**		**Revision (date): November 2025**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at how many opportunities were identified by the number of missed scan opportunities by medication and patient per month by staff and how many were compliant. All staff administering medication should use the scanning system via Medication Administration Wizard in Cerner.

Current Condition:
2024 YTD 98.5%
2025 YTD 99.2%
July-September 2025 : 99.2%

- July: 99.1%
- August: 99.5%
- September: 99.0%

Target / Goal: 95%

Problem Analysis / Root Cause, Gap:
Continue to ensure the team is compliant by running reports and holding staff accountable to usage.

DO

Countermeasure / Action Plan / Solutions:
Identification of usage and compliance through reports.

CHECK

Results / Metrics:
Goal Met for 2024. Goal Met 2025. FYTD 99.2%

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Mother Baby Bar Code Medication Administration

Mother Baby Hand Hygiene

Goal: Hand Hygiene Compliance is 95% or greater	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Stephanie Genetti, Elizabeth Bowen**	**Time Period: July- September 2025**
Team Leader: Stephanie Genetti	**Team members: All Staff**		**Revision (date): November 2025**
QI Liaison:			**Revision #:**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:

This measure looks at how many opportunities were identified by the Biovigil system for hand hygiene and how many were compliant. All staff entering a patient's room should participate in hand hygiene utilizing the Biovigil system.

Current Condition: YTD 97.1%
July-September 2025: 97.2%

- July 97.1%
- August 97.1%
- September 97.4%

Target / Goal: 95%

Problem Analysis / Root Cause, Gap:
Continue to ensure the team is compliant by running reports and holding staff accountable to usage.

DO

Countermeasure / Action Plan / Solutions:

Identification of usage and compliance through reports.

CHECK

Results / Metrics:
Goal met 2025. Goal met all quarters thus far.

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Mother Baby Hand Hygiene

Mother Baby Exclusive Breastmilk

Goal: The goal is 52.4% (The Joint Commission benchmark) or greater of single term live born newborns discharged alive from the hospital were fed breast milk only since birth.	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Stephanie Genetti, Elizabeth Bowen, Lactation Team, Staff RN's**	**Time Period: July-September 2025**
Team Leader: Stephanie Genetti	**Team members: All Staff, UBC**		**Revision (date): November 2025**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
The goal is that at least 52.4% of our single term live born newborns discharged alive from the hospital were fed breast milk exclusively since birth.

Current Condition: YTD 56.8%
July-September 2025: 59.7%

- July: 59.0%
- August: 58.0%
- September: 62.0%

Target / Goal: 52.4%

Problem Analysis / Root Cause, Gap:
Continue to enforce the breastfeeding bundle and support our patients in their feeding preferences.

DO

Countermeasure / Action Plan / Solutions:
The breast-feeding bundle has been implemented across all staff. New hires are scheduled to orient with Lactation team members and competency is established prior to staff orientation completion. In addition, staff maintain yearly competency and attend training opportunities as well. Each month a member of the Lactation team presents the exclusive breastfeeding rate to the Unit Based Council and minutes are disseminated to the team.

CHECK

Results / Metrics:
Goal Met for fiscal year 2024 and both 1st, 2nd and 3rd quarters for calendar year 2025.

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Kaweah Health

Mother Baby Exclusive Breastmilk

Mother Baby Completion of Communication Boards

Goal: Communication Boards, all fields (this unit has added additional preference line items to our communication boards, which are non-standard to the house). Completion compliance is 95% or greater.	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Stephanie Genetti, Elizebeth Bowen**	**Time Period: July- September 2025**
Team Leader: Stephanie Genetti	**Team members: All Staff**		**Revision (date): November 2025**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at all preference fields added by the mother baby staff patient communication initiative to increase positive interactions as they relate to the patient experience. Auditors look at how many opportunities were identified by the number of missed fields, documented on the communication board.

Current Condition: 91%

- July NA (didn't begin until August)
- August 92%
- September 90%

Target / Goal: 95%

Problem Analysis / Root Cause, Gap:
Continue to ensure the team is compliant by completing minimum of 50 random audits per month. .

DO

Countermeasure / Action Plan / Solutions:
LVN and Discharge Nurse complete a minimum of 50 random audits of room during activities of daily work to ensure compliance. Identification of fallouts and feedback will be provided to nursing staff who are non-compliant, and we will work to identify gaps with staff to move towards 95% or better completion. usage and compliance through reports.

CHECK

Results / Metrics:
FYTD 91%

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

MOTHER BABY EARLY URINARY CATHETER REMOVAL

Goal: Early Urinary Catheter Removal Compliance goal is 100%	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Stephanie Genetti, Elizabeth Bowen**	**Time Period: July- September 2025**
Team Leader: Stephanie Genetti	**Team members: All Staff**		**Revision (date): November 2025**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement: Early urinary catheter removal: % of elective C-section cases who have foley catheter removed within 12 hrs after delivery.

Current Condition: YTD 98.9%
2023 YTD 75.84%
2024 YTD 88.3%
2025 YTD 98.9%

July-September 2025: 99.0%
- July: 96.9%
- August:100%
- September: 100%

Target / Goal: 100%

Problem Analysis / Root Cause, Gap:
Staff are not charting the Early Catheter Removal. See the void but this is up to two hours after removal. Provider request.

DO

Countermeasure / Action Plan / Solutions:
Identification of compliance through reports and auditing.
January-June 2024: The Unit-Based Council continues to audit 50 randomly selected patient charts. Findings are then reported, and the team is notified via minutes.
Staff are directed to be increasingly diligent and reminders have been added to staff huddles and weekly newsletters.
Between March and May, the Manager sent emails with an attached PowerPoint presentation for continued education to staff identified as having "fall outs." Staff were directed to respond with questions/concerns/barriers to compliance. With the manager's direct and timely follow-up with individuals, there has been an increase in overall compliance.
Ongoing: The Mother Baby leadership team has begun auditing 100% of all elective C-section cases to further identify gaps. Year-to-date findings are shared. The manager is implementing discipline conversations and utilizing case studies for additional education and reinforcement.
In 2025, we continue to make gains, with a current year-to-date (YTD) rate of 95%, up from 90% in the last reporting session. Most fallouts now are related to an underlying medical indication, such as bed rest for magnesium infusion or bladder injury.
As of 11/2025, the Team continues to monitor and make progress.

CHECK

Results / Metrics:
The goal was not met; annual competency and case study assignments have increased awareness and compliance for the 1st or 2nd quarter of calendar year 2025. Steady increase noted.

MOTHER BABY EARLY URINARY CATHETER REMOVAL

		ACT / ADJUST	**Follow-Up / Sustainability:** Mother Baby leadership is now completing 100% of all elective C-section audits to evaluate all opportunities. Will track and trend for improved compliance. Education and discipline have been initiated.

Goal: The goal is 100% of our patients who are exclusively breastfeeding will have a LATCH assessment documented at least once per shift.	**Med Staff Champion: Dr. Betre/Maccalli**	**Subject Experts: Stephanie Genetti, Elizabeth Bowen, Lactation Team, Staff Rn's**	**Time Period: July-September 2025**
Team Leader: Stephanie Genetti	**Team members: All Staff, UBC**		**Revision (date): November 2025**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
The goal is 100% of our patients who are exclusively breastfeeding will have a LATCH assessment documented at least once per shift as required per our standards of care following California Department of Public Health Model Hospital Policy, excluding any patients that are formula feeding only.

Current Condition: YTD 93.3%.
July-September 2025: 88%

- July: 90%
- August: 84%
- September: 90%

DO

Countermeasure / Action Plan / Solutions: .
Apr- June 2024: Annual Competency Validation includes nursing staff direction to provide evidence of daily work to substantiate correct scoring for accuracy and frequency.
Ongoing: Staff are now directed to remind oncoming staff during bedside report to confirm the latch score has been completed. Hold one another accountable and include lactation for tracking of trends. During the last hour of the shift, the LVN will audit charts and notify RN's if the latch score still needs to be charted. Audits identified through Annual competency notes fall out for patients who discharge early in the shift. The manager has implemented conversations with staff to address trends/gaps as a warning prior to implementing discipline.
Unit-based Council/Charge Nurse and Team Lead staff have all been included in problem-solving and compliance.
Moving forward, suggest a case review presentation from the identified "fall out" staff to present at UBC via a case review format, further discussing barriers to compliance.
2025 Breast Friends committee started; staff support was implemented with case studies and monthly UBC presentations, where gap analysis with track and trend reports was completed and provided to staff. Last quarter, we invited additional members to the committee, which meets once a month, and a sub-group that meets weekly. We have also included Dr. Maccalli in the findings.
HUC workflow modified to include verification of a LATCH score prior to early discharge time fallouts, related to the identification of early discharge time fallouts. In January, February, and March, 100% compliance was achieved.
*Cerner build includes a latch pop-up to prompt staff to document the latch when breastfeeding is documented.
*staff has been responsible to complete 10 audits for the following month if they are noted to have a fall out for the latch assessment.

CH

Results / Metrics:

	Target / Goal: 100%		Will continue to monitor compliance. Unit-Based Council is reporting the findings on a monthly basis to staff who have started to also hold one another responsible during change-of-shift reports. 50 random patient charts are evaluated monthly.
	Problem Analysis / Root Cause, Gap: Staff note that the patients do not call for every feeding, and in turn, some opportunities to assess are lost. Staff referenced further, it was not clear that this was an assessment. *Re-education has taken place and been reinforced in staff team huddles and weekly newsletter reminders.		
		ACT / ADJUST	**Follow-Up / Sustainability:** We will continue to monitor for compliance. LATCH is reported monthly to all staff via UBC minutes to establish team methods for process improvement. The lactation team is also partnering for additional reinforcement and is available for remediation should a lack of education/competency be identified as a concern.

Mother Baby RASS

Goal: Richmond Agitation Sedation Scale must be assessed within 60 minutes of giving an oral narcotic medication.	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Stephanie Genetti, Elizabeth Bowen**	**Time Period: July 2025-September 2025**
Team Leader: Stephanie Genetti	**Team members: All Staff**		**Revision (date): November 2025**
QI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at compliance of the Licensed Nurse documenting the Richmond Agitation Sedation Scale (RASS) of a patient within 60 minutes of administering an oral narcotic medication. The follow up from the Licensed Nurse must be documented using the RASS scoring 100% of the time

Current Condition: YTD: 99.3%
July-September: 99.3%

- July: 100%
- August: 100%
- September: 98%

Target / Goal: 100%

Problem Analysis / Root Cause, Gap:
Staff were not charting the RASS scoring assessment.

DO

Countermeasure / Action Plan / Solutions:
Identification of compliance through reports and auditing.

May-July 2025: Mother Baby's Unit Based Council audited 50 random charts each month and presented findings to share with the team.

Ongoing: Licensed Vocational Nurses have been effectively utilized to complete daily audits. The Nurse notifies staff Registered Nurse if there are any RASS scores that remain outstanding. A continued increase in compliance and consistency has been noted. 2023 YTD was 59.3. The team achieved 100% in 2024 and 2025. Plan to remove from QIC. The assessment has become standard practice, and staff continue to hold one another accountable. Reminders are periodically included in team huddles and weekly updates. This metric was also included in the team's Annual Competency, where evidence of daily work was substantiated by approved validators to ensure accuracy and consistency. For consecutive staff misses, the Manager is implementing discipline/conversations, and the use of a case study for additional education. In 2024, with bedside reports and tap-in staff-to-staff accountability, compliance has been significantly enhanced. The 2025 bedside report with tap-in and confirmation continues to demonstrate compliance. In November 2025, just before we were going to remove the metric, we noticed a decline in compliance, and we have elected to continue working on this metric.

CHECK

Results / Metrics:
Goal was successfully achieved for the entire last quarter score of 100%. Since then we have seen some inconsistency with a current YTD of 99.2% we continue to audit for this QIC.

ACT / ADJUST

Follow-Up / Sustainability:

We will continue to monitor and report findings via Unit Based Council minutes to the team monthly.

Separator Page

Health Equity Quality Report

DMAIC Project Summary: Health Equity Committee

Reports to: Health Equity Committee	Project Leader: Jag Batth	Start Date: March 2023
Team members/ Subject experts: Sonia Duran-Aguilar, Dr. Omar-Guzman		Revision (date): January 6, 2026
		Revision #: 5

DEFINE

Background/Committee Purpose

- Guide organization's efforts to evaluate and address health equity and ensure compliance with various State and Federal agencies as well as health plan requirements
- Identify disparities in health outcomes and their causes
- Identify opportunities and partnerships with community-based organizations to build and increase our collective capacity to address disparities
- Ensure the diversity of our workforce reflects the community we serve
- Prioritize and develop action plans to address disparities in health outcomes
- Monitor progress and modify action plans as needed
- Report to key stakeholders and leadership on at least an annual basis
- Create, oversee and guide workgroups or subcommittees as needed

Current Condition:

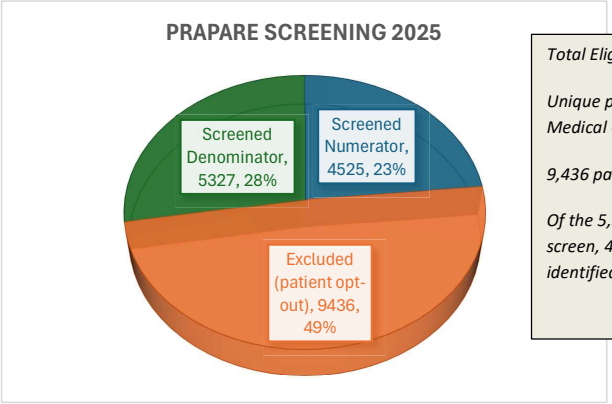
CMS recently released their IPPS rules that go into effect 1/1/2026 removing the federal requirement to collect, analyze and report health equity data for hospitals, though CA state still requires data collection and submission. Kaweah Health successfully complied with CMS 2025 requirement of submitting social determinants of health (SDoH) data. The reporting requirement deadline for California (HCAI) was September 30th, 2025, though the data required to report is far more specific and detailed than CMS requirements and data extract reports required demographic fields do not yet exist in Cerner. Kaweah Health has asked for an extension which has been granted. The penalty for not reporting is $5,000/year, but the cost to build enhancements in Cerner and reporting capabilities far exceed the penalty. Kaweah Health began collecting SDOH data in December 2023 and results have been reviewed at Health Equity Committee. There continues to be opportunities to increase the completion of the PRAPARE Screening tool upon admission to the hospital. In 2023, Kaweah Health was awarded a 4year HRSA grant to address the health disparities amongst pregnant farm workers in the rural community of Lindsay. The grant is going well and patient outcomes are being collected.

IMPROVE

Countermeasure / Action Plan / Solutions:

1. Health Equity Committee formed – March 2023
2. Health Equity Committee Charter approved
   a. Membership and leadership determined
   b. Review of regulatory health equity standards- Joint Commission, CMS and HCAI
3. Review, selection and completion of Health Equity assessment tool-HSAG's Health Equity Roadmap
4. Review, selection and implementation of SDOH patient screening tool
   a. PRAPARE Tool implemented December 2023 IP and OP
   b. Dashboard validation completed
5. Participation in completion of the Community Health Needs Assessment (CHNA)
6. Attendance to NCQA's Health Equity Summit by Health Equity Committee leadership
   a. Sonia Duran-Aguilar, Dr. Omar Guzman, Ryan Gates
7. 4-year HRSA grant awarded to address inequities amongst pregnant farm laborers
   a. Invited to present efforts in Atlanta, GA annual conference for grantees x2
8. Presenter and Break-Out Session facilitator at the Annual Women Farmworker Women's Conference – Sonia Duran-Aguilar
9. Norman Scharrer Symposium: Addressing Social Drivers of Health in the Healthcare Setting
   a. Dr. Omar Guzman, Dr. Alfredo Guerrero, Ryan Gates, Sonia Duran-Aguilar

Results / Metrics: 2025 Inpatient Data



Total Eligible Population= 14,763

Unique patients, 18+ Admitted to Medical Center

9,436 patients declined/opted out

Of the 5,327 who agreed to screen, 4,525 had at least 1 SDOH identified

Kaweah Health

DMAIC Project Summary: Health Equity Committee

A Senior Health Equity Data Analyst was hired late in 2025 to support the grant. HRSA considers Kaweah Health one of the top performers in the nation and has been asked Kaweah to present at their annual conference in Atlanta the last 2 years.

MEASURE

SDOH Measure:

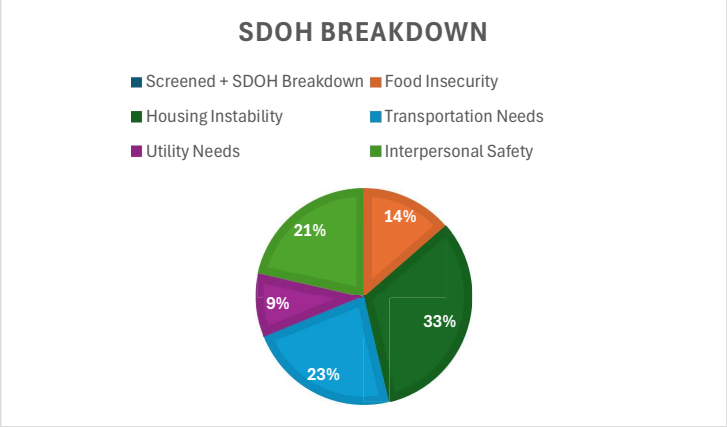
- Achieve 75%-80% PRAPARE Tool collection in Inpatient & Outpatient settings within 1 year of implementation (by 12/31/2024).
    - *Target/Goal not met with 30% of patients screened in 2024 and 28% screened in 2025.*

HRSA Pregnant Farmworker Grant Outcomes *(baselines and benchmarks to be set)*:

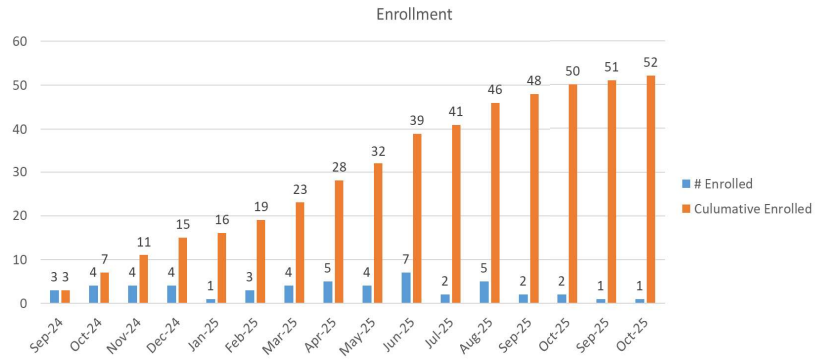
- Enrollment of 40 **MET**
- Referrals to Community Health Worker and external partners for SDOH's
- CHW encounters with patients
- Prenatal Visits
- Postpartum Visits
- No-Show Rates
- Postpartum Depression Screening
- Maternal Outcomes: Live deliveries, mortality
- NICU Admissions
- Preterm Deliveries

ANALYZE

Problem Analysis / Root Cause, Gap: As health disparities and inequities are identified through the work of the Health Equity Committee, various subcommittees will be created and problem analysis will be done for individual projects involving health equity efforts and will be reported on using specific metrics to display results.



HRSA Care Coordination Data Updates- Target 40 patients in 3 years, goal achieved.



CONTROL

Follow-Up / Sustainability:
The Health Equity Committee is scheduled to meet quarterly to discuss projects and provide oversite for subcommittees and focused projects.

Separator Page

Rapid Response Team Code Blue Quality Report–

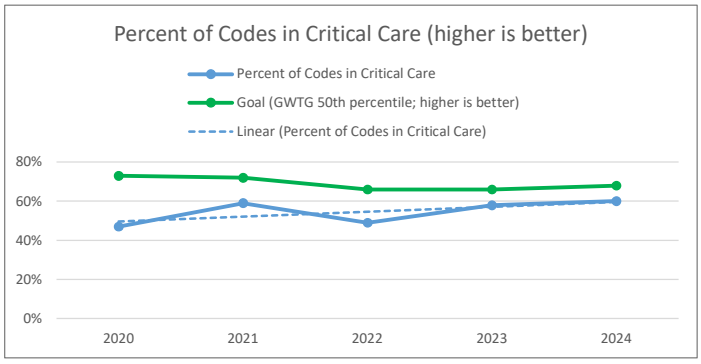
QUALITY COMMITTEE REPORT

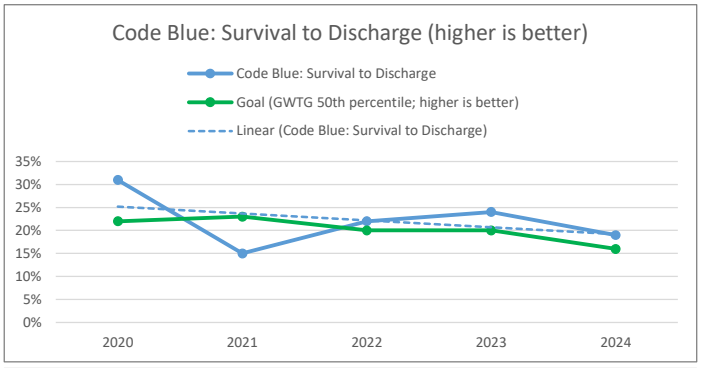
RRT/Code Blue Quality Report

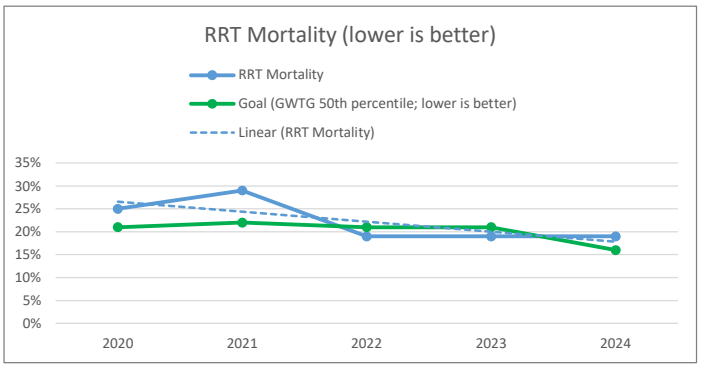
Remy Pipkin, Clinical Operations Manager

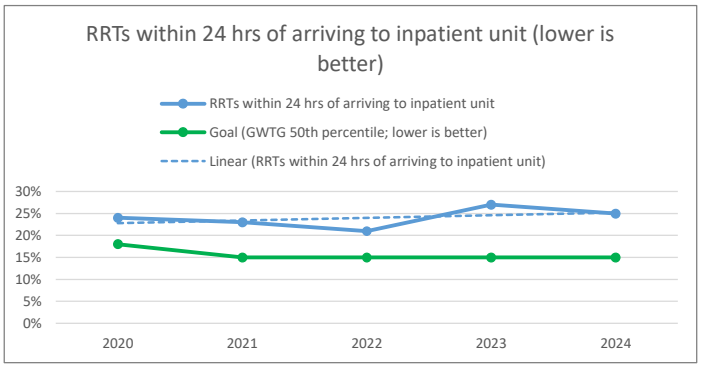
January 2026

Code Blue/RRT HISTORICAL PERFORMANCE- Key Metrics

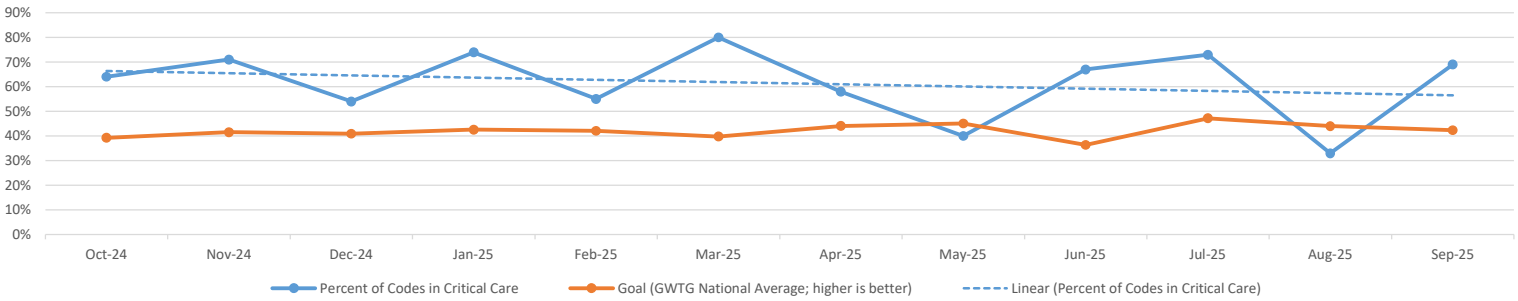








Code Blue/RRT - Percent of Codes in Critical Care

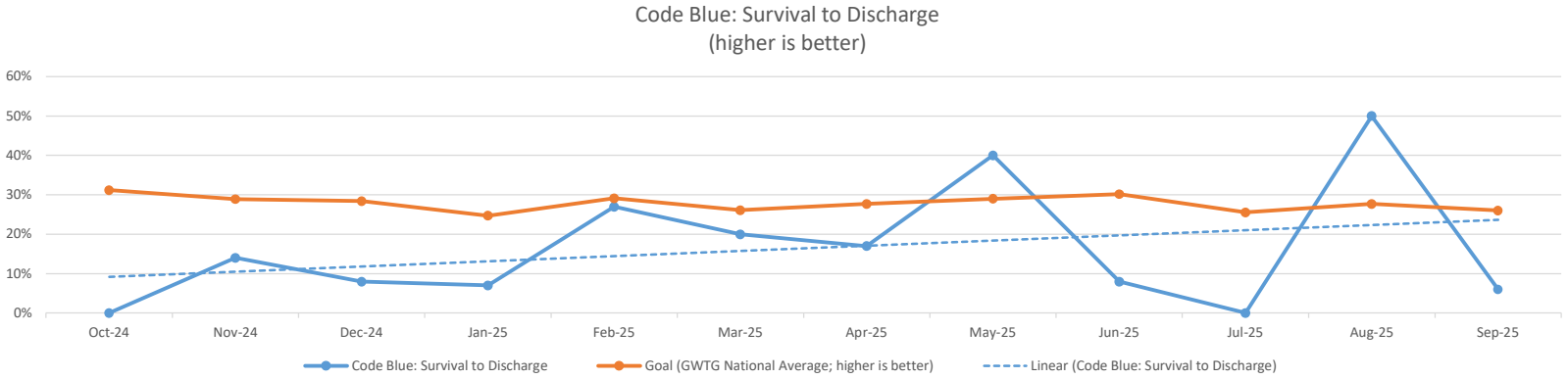


Targeted Opportunities (why goal not achieved in most recent month)

1. Get With The Guidelines does not consider our ICCUs as Critical Care
2. Delay in recognition of patient deterioration by bedside staff.

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS/UPDATES
Working to create admission criteria for each Level of Service	TBD	Pending MEC approval
Consideration of reclassifying 5 Tower as a third ICU	TBD	Plan to be determined by Executives, will require Staff Education/Competencies
Working with ISS to create new RRT activation screening tool	TBD	Staff Education, Implementation and adoption to practice
Working with ED and Bed Allocation to expedite ICU admissions (goal time <1 hour from admission to arrival in ICU)	Ongoing	Staff education/ compliance with initiative

Code Blue/RRT - Code Blue: Survival to Discharge

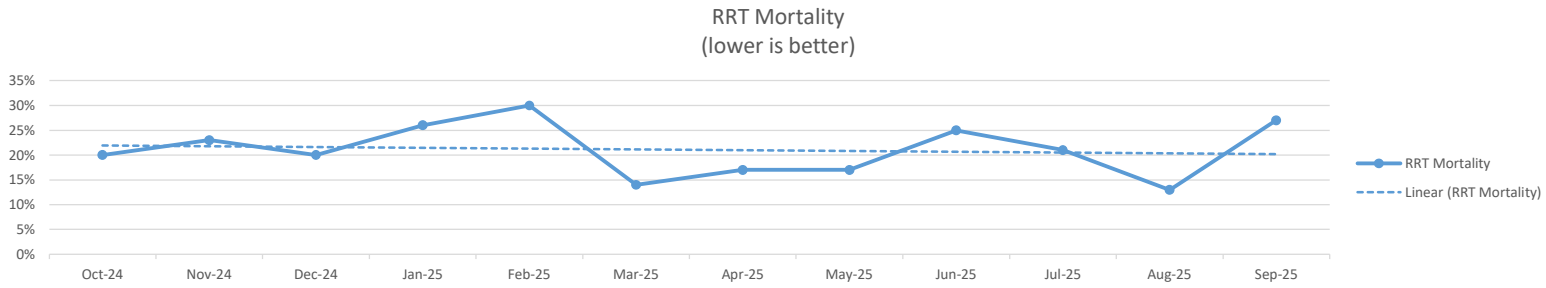


Targeted Opportunities (why goal not achieved in most recent month)

1. Central Valley is one of the poorest Socioeconomic regions in the country causing high incidence of Heart disease, Diabetes, Renal Failure, etc.
2. Very sick patients due to above factors.
3. Improving on this metric.

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS/UPDATES
Initiation of Code Blue/Critical Care Committee to perform case review and RCA	Q4 2025	Need to schedule case reviews and RCA
Active Plan of Correction on reporting any delays in RRT/Code Blue activation via MIDAS	Ongoing	Need 3 months of data with all delays reported

Code Blue/RRT - RRT Mortality

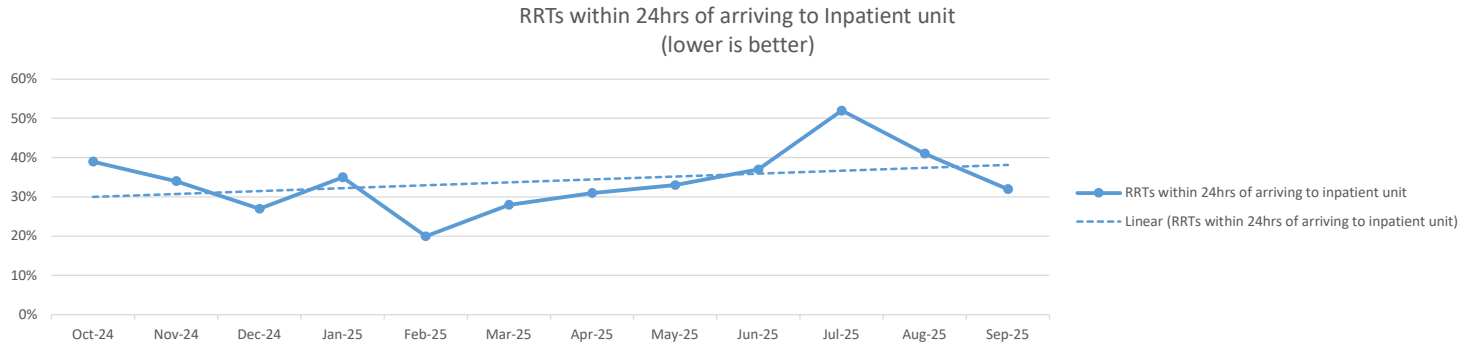


Targeted Opportunities (why goal not achieved in most recent month)

1. Central Valley is one of the poorest Socioeconomic regions in the country causing high incidence of Heart disease, Diabetes, Renal Failure, etc.
2. Very sick patients due to above factors.
3. Delay in RRT activation by bedside staff.

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS/UPDATES
Working with ISS to create new RRT activation screening tool	TBD	Staff Education, Implementation and adoption to practice
Working with ED and Bed Allocation to expedite ICU admissions (goal time <1 hour from admission to arrival in ICU)	Ongoing	Staff education/ compliance with initiative
Adding new role, Clinical Shift Supervisor, who will work elbow-to-elbow with bedside staff to educate, support and increase compliance with expected standards of care	Ongoing	New Job description, will require implementation, and experienced candidates to meet knowledge resource expectation
Active Plan of Correction on reporting any delays in RRT/Code Blue activation via MIDAS	Ongoing	Need 3 months of data with all delays reported

Code Blue/RRT - RRTs within 24 hrs of arriving to unit



Targeted Opportunities (why goal not achieved in most recent month)

1. Inappropriate level of care Admissions.
2. Delay in RRT activation by bedside staff.

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS/UPDATES
Working to create admission criteria for each Level of Service	TBD	Pending MEC approval
Working with ISS to create new RRT activation screening tool	TBD	Staff Education, Implementation and adoption to practice

Code Blue/RRT - WINS!

AHA – Get with the Guidelines Gold award for 2 consecutive years of meeting all four Resuscitation measures.
Awarded Kaweah Team of the Month for November 2025.

Questions?

Live with passion.

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

Kaweah Health

Separator Page

Orthopedic Services Quality Report

Orthopedic Service Line

Quality Council Report

January 2026

Kevin Bartel, Director of Surgical Service Lines

Surgical Site Infection July 1, 2024 – June 30, 2025 (12 months)

Type of SSI	Total # of Procedures	Actual # of infections	Predicted # of Infections	Kaweah Health Standardized Infection Ratio
KPRO	167	0	1.277	0
HPRO	182	0	2.748	0
FUSN	349	3	5.885	0.51
FX	402	4	4.168	0.96
Total	1,100	7	14.078	0.498

KPRO – Total Knee Arthroplasty
HPRO – Total Hip Arthroplasty
FUSN – Spinal Fusion
FX – Hip fracture

Goal: measure the standardized infection ration (SIR) of these orthopedic procedure types for patients who experienced a surgical site infection within 90 days after surgery

Review/Analysis

- SIR for all four procedure types were below the predicted number of infections
- Total number of hip fracture cases increased 81% from prior year
- All three Spinal Fusion cases were elective with surgeon commonality, involving patients with known comorbidities that increased risk of poor tissue healing and reduced post-operative mobilization ability
- All four hip fracture cases were emergent with surgeon commonality

Surgical Site Infection July 1, 2024 – June 30, 2025 (12 months)

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS/UPDATES
Retrospective SSI review- Review of identified SSIs in a timely manner by Director and Orthopedic Nurse Practitioners that support the service to identify trends in care provision/education that can be discussed both at SQIP and directly with the surgeon and surgery teams at the monthly orthopedic co-management meetings as appropriate.	Ongoing	IP team to send notification of SSI to Director to initiate review.
Review of SPD processes and workflows – Through review of the spinal fusion SSI cases identified during this reporting period, there was a determination that opportunity existed to audit our SPD workflows and processes to verify necessary equipment sterility and process adaptation. External company selected to perform SPD audit in November 2025.	November 2025	Surgery leadership team will collaborate with audit company to ensure any gaps identified from the audit are addressed

Complication Rate

July 1, 2024 – June 30, 2025 (12 months)

All Payers

Overall complication rate: **1.23%** (7 complications from 567 total cases)

Percentile: 28th percentile (lower is better)

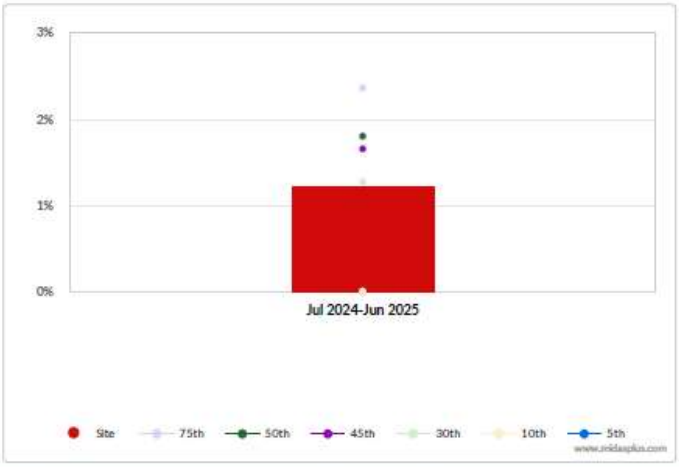
Kaweah goal: 30th percentile (1.27% complication rate)

GOAL MET

KAWEAH DELTA MEDICAL CENTER

CMS CJR Hip/Knee Arthroplasty - Complication Rate, Same Facility

Compared with 400+ beds



Period	Site Value	Site Percentile	Num	Den	Category	5th	10th	30th	45th	50th	75th	# Sites
Jul 2024-Jun 2025	1.23%	28th	7	567	400+ beds	0.00	0.00	1.27	1.66	1.80	2.36	82

Complication Rate

July 1, 2024 – June 30, 2025 (12 months)

Medicare only

Overall complication rate: **2.48%** (4 complications from 161 total cases)

Percentile: 68th percentile (lower is better)

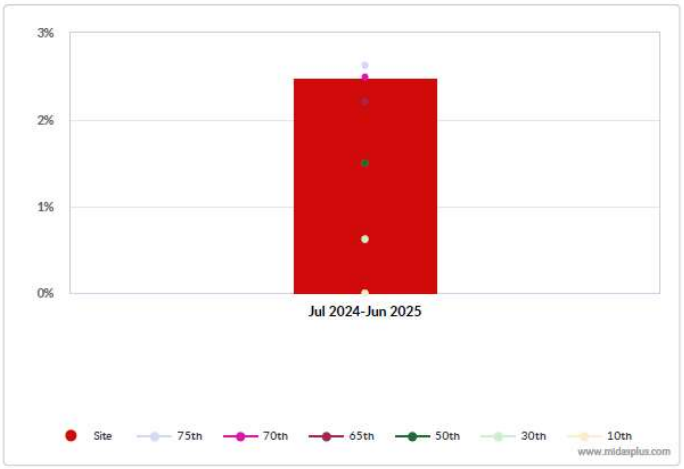
Kaweah goal: 45th percentile (1.22% complication rate)

GOAL NOT MET

KAWEAH DELTA MEDICAL CENTER

CMS CJR Hip/Knee Arthroplasty - Complication Rate, Same Facility, Medicare

Compared with 400+ beds



Period	Site Value	Site Percentile	Num	Den	Category	10th	30th	50th	65th	70th	75th	# Sites
Jul 2024-Jun 2025	2.48%	68th	4	161	400+ beds	0.00	0.63	1.49	2.21	2.50	2.63	80

Complication Rate

July 1, 2024 – June 30, 2025 (12 months)

	Primary Proc Type	Primary Proc Date	Complication Type
Q3 2024	THA	7/1/2024	mechanical complication
	TKA	7/11/2024	pneumonia
	TKA	7/22/2024	acute MI (NSTEMI)
	THA	7/23/2024	mechanical complication
Q4 2024	THA	10/1/2024	infection
	THA	10/28/2024	mechanical complication
Q1 2025			
Q2 2025	THA	5/15/2025	death within 30 days

Medicare

- 6 of the 7 total complications were discharged to home after their initial procedure with discharge orders for 2 week OP follow up with their surgeon and subsequent OP physical therapy.
- 1 of the 7 complications was discharged to Skilled Nursing Facility secondary to challenges with mobility following surgery.

Complication Rate

July 1, 2024 – June 30, 2025 (12 months)

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS/UPDATES
Joint surgery patient education- Providing consistent and standardized education for our joint surgery patients is critical to optimize expectations and outcomes. KH Joint Surgery books are provided to local offices to disburse to patients pre-operatively, a joint surgery educational video on the KH website is promoted to scheduled surgery patients, and information from patients is gathered pre-operatively (functional and social status) by our orthopedic NPs to consider optimal discharge disposition in advance.	Ongoing	Relying on various local orthopedic offices to disperse joint surgery educational books and promote educational video is challenging, as their workflows vary.
Coordinated therapy pre/post op 86% of complications reported were discharged from hospital to home, with surgeon follow up approximately 2 weeks post-operatively, after which time OP therapy is referred to begin rehab efforts. There may be benefit with scheduling these patients with a session of therapy pre-operatively, and/or coordinating therapy to begin within a week of surgery, so that a licensed PT can play a role in wound inspection, inflammation reduction modalities, patient education on healing, and guiding light exercises.	4/30/26	Will initiate this workflow consideration with Dr. Kim in collaboration with therapy leadership
Optimize patient discharge disposition: Coordinated communication between our KH orthopedic NPs and KH case managers/post-acute liaisons to spotlight priority patients coordinate appropriate level of rehab/therapy indicated for their condition (i.e. transfer to inpatient rehab, short stay, SNF, home health as appropriate) in order to optimize patient access to recovery and education.	Ongoing	We continue to experience scenarios where patients have been told by their surgeon that they can go to rehab after their surgery, which isn't always allowed (per payer guidelines).

Thank you

Live with passion.

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

Kaweah Health

Separator Page

Clinical Quality Goals Update

Outstanding Health Outcomes (OHO) QUALITY & PATIENT SAFETY PRIORITY

Healthcare Acquired Infection (HAI) Reduction

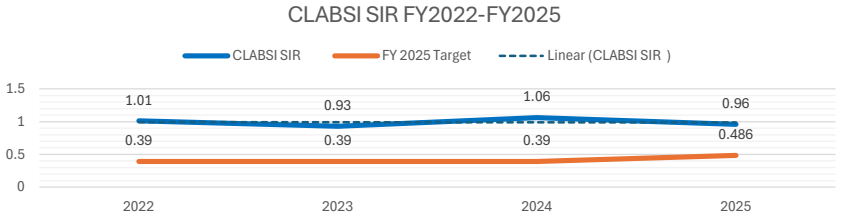
December 2025

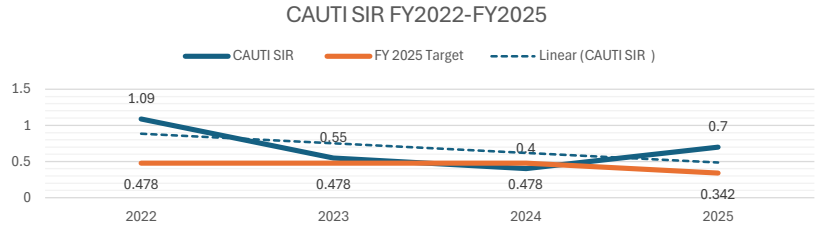
OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

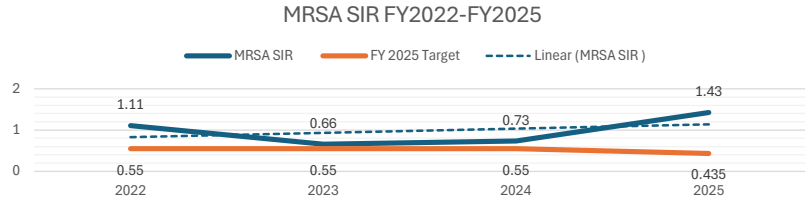
(number of actual infections/number of predicted infections by CMS)

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

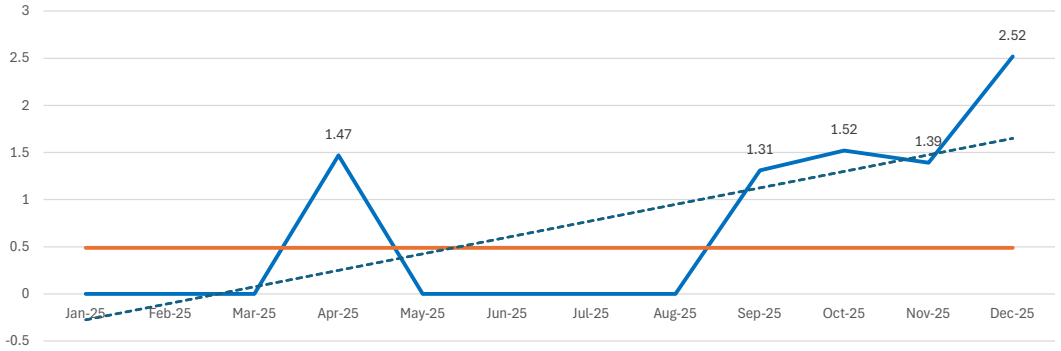
Kaweah Health

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

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

Interventions:

- Device rounds performed by Charge Nurses and Infection Prevention
- New central line management kit
- CHG bathing for patients with central lines
- Hand Hygiene monitoring
- ATP testing post disinfection of the environment
- Avoiding femoral vessel cannulation



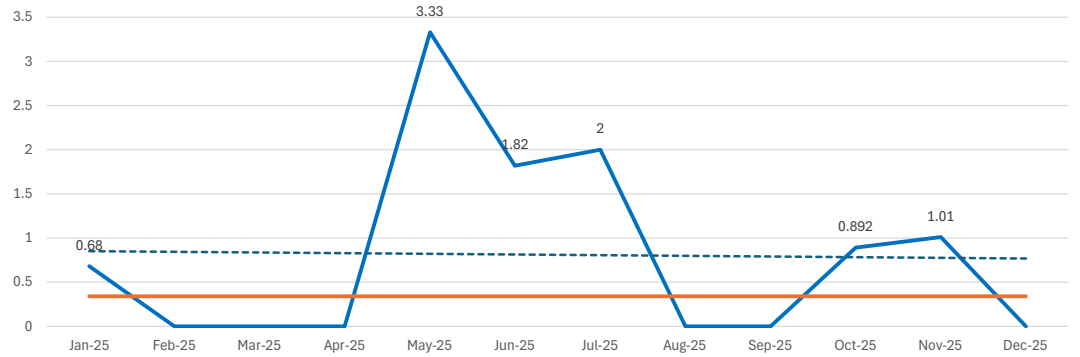
	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Total
CLABSI EVENTS	2	0	0	1	0	0	0	0	1	1	1	2	8
CLABSI Predicted	0.64	0.739	0.682	0.656	0.713	0.605	0.58	0.765	0.656	0.721	0.721	0.795	8.273
CLABSI SIR	0	0	0	1.47	0	0	0	0	1.31	1.52	1.39	2.52	0.97
CLABSI SIR Goal (70th percentile/ top 30%)	0.486	0.486	0.486	0.486	0.486	0.486	0.486	0.486	0.486	0.486	0.486	0.486	0.486

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

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

Interventions:

- Device rounds performed by Charge Nurses and Infection Prevention
- Piloting new alternatives to indwelling urinary catheters
- Nurse Driven Protocol – IUC removal
- Hand Hygiene monitoring



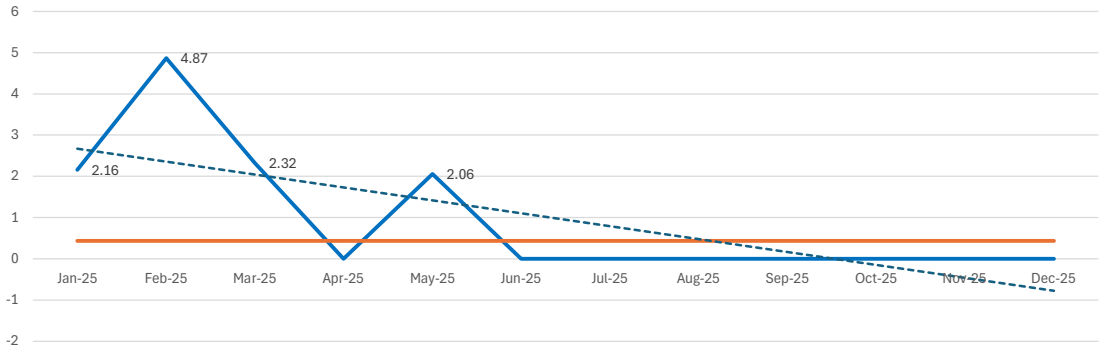
	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Total
CAUTI EVENTS	1	0	0	0	3	2	2	0	0	1	1	0	10
CAUTI Predicted	1.47	1	1.23	1.05	0.9	1.1	1	0.9	1.04	1.12	0.99	1.21	13.01
CAUTI SIR	0.68	0	0	0	3.33	1.82	2	0	0	0.892	1.01	0	0.77
CAUTI SIR Goal (70th percentile/ top 30%)	0.342	0.342	0.342	0.342	0.342	0.342	0.342	0.342	0.342	0.342	0.342	0.342	0.342

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

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

Interventions:

- MRSA nasal colonization testing for target patient populations
- Nasal decolonization for patients testing positive for MRSA in nares
- Hand hygiene monitoring
- ATP testing post disinfection of the environment



	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Total
MRSA EVENTS	1	2	1	0	1	0	0	0	0	0	0	0	5
MRSA Predicted	0.46	0.41	0.43	0.47	0.49	0.48	0.4	0.39	0.36	0.253	0.26	0.286	4.689
MRSA SIR	2.16	4.87	2.32	0	2.06	0	0	0	0	0	0	0	1.07
MRSA SIR Goal (70th percentile/ top 30%)	0.435	0.435	0.435	0.435	0.435	0.435	0.435	0.435	0.435	0.435	0.435	0.435	0.435

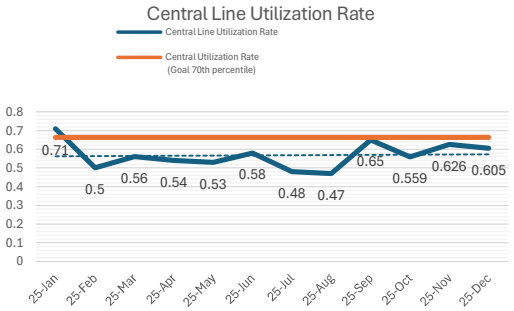
OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

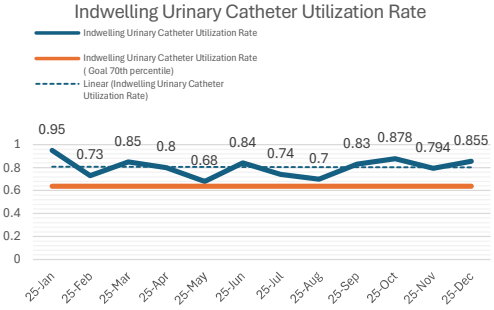
The last data point did not meet goal because:

- 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
  - Jan 2024 – Dec 2025 (SUR = 0.633)
  - Goal: reduce urinary catheter ratio to <0.64
  - Jan 2024 – Dec 2025 (SUR = 0.877)
- MRSA nasal and skin decolonization for patients with lines.
  - Goal: 100% of at-risk patients nasally decolonized
  - July 2024 – Dec 2025 100% of screen patients nasally decolonized
  - 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
  - FY2025 56% August 2025 to December 2025 61% of staff are active users
  - HH Compliance rate overall 94.3%
  - Improve environmental cleaning effectiveness for high-risk areas
  - Goal: >90% of areas in high-risk areas are cleaned effectively the first time (all areas not passing are re-cleaned immediately)
  - FY2025 88% Pass cleanliness effectiveness testing. December 2025 92% Pass rate.





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	Completed, ongoing
Explore consensus statement on duration of femoral lines with medical staff	9/30/25	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 10/30/25	Completed Cost analysis performed
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 (increased awareness and accountability). New BioVigil monthly leadership meetings start 7/16/25. Communication with managers of units that are not achieving goal to review their staff level HH compliance reports and follow up with staff.	7/16/25 and ongoing	Completed
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	In Progress (transitioning to Oxivir-364 with shorter dwell time)
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.

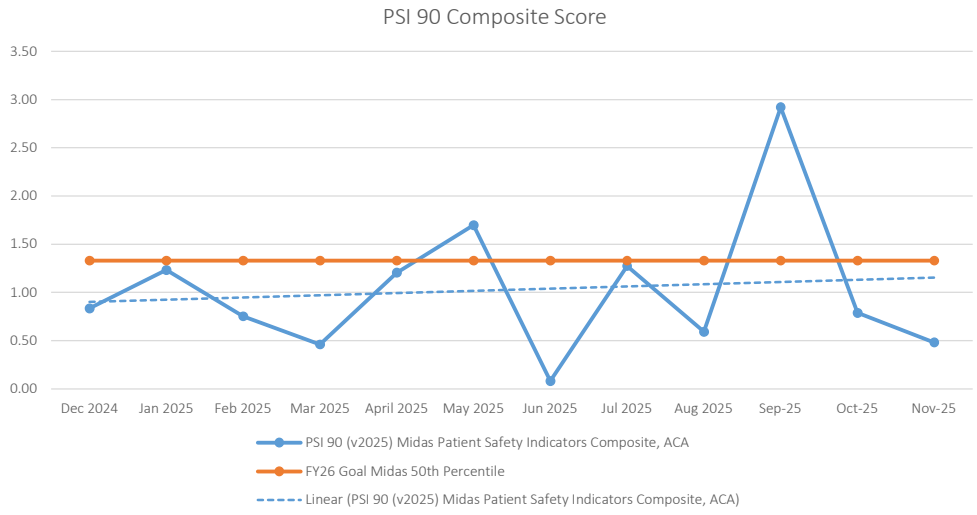
Health is our passion. Excellence is our focus. Compassion is our promise.

Kaweah Health

PATIENT SAFETY INDICATOR (PSI) 90 COMPOSITE

January 2026

OHO FY26 Monthly Update: Patient Safety Indicator (PSI) 90 Composite Score



FY26 PLAN – PSI 90

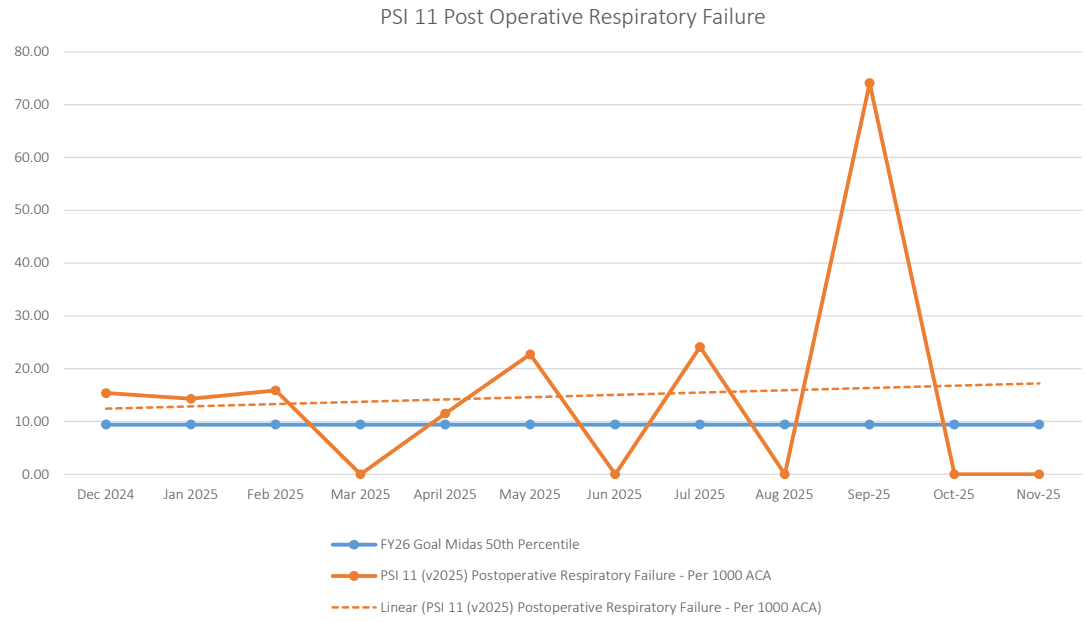
High Level Action Plan

- Concurrent case reviews and multi-departmental efforts to identify and act to address opportunities in documentation, coding and clinical care
- Analyze data to measure level to determine focused opportunity
- Timely case reviews for applicable application of evidenced-based practices
- FY25 PSI 90 rate = 1.20
- Goal Midas National 50th percentile = 1.33

- **FYTD 2026 = 1.302 (July-Nov 2025)**

Kaweah Health
MORE THAN MEDICINE. LIFE.

OHO FY26: Patient Safety Indicator (PSI) 11



FY25 PSI 11 rate = 11.03

Goal Midas National 50th percentile = 9.42

FYTD 2026 = 15.71, July-Nov 2025 (n=6)

Kaweah Health
MORE THAN MEDICINE. LIFE.

OHO FY25 Monthly Update: Patient Safety Indicator (PSI) 90

Targeted Opportunities

- Timely identification of new trends in any PSI 90 component
- Focus on PSI 11 – Respiratory failure (PSI 11 is the highest weighted PSI within the PSI 90 composite score)
- Emphasis on cardiovascular surgical population (5/11 cases during evaluation period)
- CMS counts any re-intubation as PSI 11, but ~50% of cases were for airway protection, not true respiratory failure, possibly inflating rates
- Evaluating evidence-based practices for PSI 11 including such as early warning of deterioration processes, ventilation management

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
Concurrent PSI case reviews to identify and ACT on opportunities and emerging trends in documentation, coding and clinical opportunity	Ongoing	Transitions of Quality & Patient Safety Resources
Collaboration with physician champion to further evaluate initial case reviews and evidence-based opportunities for PSI 11	11/28/25	Transitions of Quality & Patient Safety Resources
Discussion with HIM and finance to explore opportunities for adjustment in coding	11/28/25	Transitions of Quality & Patient Safety Resources

REFERENCE SLIDES

OHO FY26 Plan: Patient Safety Indicator (PSI) 90 Composite Measure

Summary

The PSI-90 composite score (Patient Safety and Adverse Events Composite) is a claims-based hospital safety measure that combines 10 preventable complications—such as blood clots after surgery, collapsed lungs from procedures, infections, and pressure ulcers—into a single rating, with a lower score meaning fewer problems and a higher score meaning more. **Each of these "patient safety indicators" is weighted and rolled into one score.**

PSI 90 Individual Components	Component Weight
*PSI 11 Postoperative Respiratory Failure	0.2152
PSI 12 Perioperative Pulmonary Embolism or DVT	0.1611
*PSI 10 Postop Acute Kidney Injury Requiring Dialysis	0.0507
PSI 09 Postoperative Hemorrhage or Hematoma	0.0338
PSI 03 Pressure Ulcer	0.2186
PSI 06 Iatrogenic Pneumothorax	0.0352
PSI 08 In-Hospital Fall-Associated Fracture	0.0506
*PSI 13 Postoperative Sepsis	0.1915
PSI 14 Postoperative Wound Dehiscence	0.0169
PSI 15 Accidental Puncture or Laceration	0.0263
PSI-90 Composite	1.00

PSI 90 is a publically reported measure on CMS's Care Compare website and is a component in the CMS Star Rating, Leapfrog Safety Grade and also includes many coded complications used in Healthgrades star ratings

Kaweah Health
MORE THAN MEDICINE. LIFE.

OHO FY26 Plan: Patient Safety Indicator (PSI) 90 Composite Measure
Historical Baseline

How Many PSI's Are Relevant to Surgical Patients?
Of the 10 PSIs:
•**7** are *surgical-only* (they include "postoperative," "perioperative," or surgical complications). These are:
PSI 09, PSI 10, PSI 11, PSI 12, PSI 13, PSI 14, and PSI 15.
•**3** apply to *all inpatients* (both medical and surgical):
PSI 03 (pressure ulcers), PSI 06 (iatrogenic pneumothorax), and PSI 08 (falls with hip fracture)

How Many PSIs Restricted to Elective Surgeries vs Any Surgery?
Some surgical component indicators are **limited to elective procedures**, while others apply broadly to all surgeries.
Based on specifications:
•**Elective-surgery-only** indicators (limited to elective admission or elective surgery discharges):

- **PSI 10** – Postoperative Acute Kidney Injury Requiring Dialysis
- **PSI 11** – Postoperative Respiratory Failure (for elective surgical discharges with specified criteria)
- **PSI 13** – Postoperative Sepsis (excludes non-elective admissions and certain infections present on admission)

The pursuit of healthiness

Kaweah Health
MORE THAN MEDICINE. LIFE.