

Kaweah Delta Health Care District Board of Directors Meeting

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



DATE POSTED: April 10, 2026

NOTICE

Date: Thursday, April 16, 2026

Location: Kaweah Health Medical Center – Executive Conference Room

Address: 305 W. Acequia Avenue, Visalia, California

Please join my meeting from your computer, tablet or smartphone.

<https://meet.goto.com/KelsieD/kaweahdeltahealthcaredistrictboardofdirectorsmeet>

You can also dial in using your phone.

Access Code: 460-561-181

United States: [+1 \(646\) 749-3122](tel:+16467493122)

SCHEDULE:

- **8:00 AM** – Open Session (to approve the Closed Session agenda)
- **8:01 AM** – Closed Session
Pursuant to:
 - Health & Safety Code §§1461 and 32155 (Confidential Quality Assurance/Medical Staff Matters)
 - Health & Safety Code §§1461 and 32155 (Confidential Quality Assurance/Medical Staff Matters)
- **8:30 AM** – Open Session

AMERICANS WITH DISABILITIES ACT (ADA) NOTICE:

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

POSTING NOTICE:

All Kaweah Delta Health Care District regular Board and committee meeting notices and agendas are posted at least **72 hours** prior to the meeting (and **24 hours** prior to special meetings) in the Kaweah Health Medical Center, Mineral King Wing, near the Mineral King entrance, in accordance with Government Code §54954.2(a)(1).

Mike Olmos • Zone 1
Board Member

Jonna Schengel • Zone 2
Board Member

Dean Levitan, MD • Zone 3
Secretary/Treasurer

David Francis • Zone 4
President

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Kaweah Delta Health Care District

Board of Directors Meeting

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PUBLIC RECORDS:

Disclosable public records related to this agenda are available for public inspection at:

Kaweah Health Medical Center – Acequia Wing, Executive Offices (1st Floor)

400 West Mineral King Avenue, Visalia, CA 93291

You may also request records by contacting the Board Clerk at (559) 624-2330 or

kedavis@kaweahhealth.org, or by visiting the District’s website at www.kaweahhealth.org.

KAWEAH DELTA HEALTH CARE DISTRICT

Dean Levitan, MD, Secretary/Treasurer

Prepared by:

A handwritten signature in blue ink, appearing to read "Kelsie K. Davis".

Kelsie K. Davis

Board Clerk / Executive Assistant to the CEO

DISTRIBUTION:

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This agenda is posted in compliance with the Ralph M. Brown Act, including amendments enacted under Senate Bill 707.

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS QUALITY COUNCIL COMMITTEE MEETING

Kaweah Health Medical Center – Executive Conference Room
305 W. Acequia, Visalia, CA

Thursday, April 16, 2026 {Committee Meeting}

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OPEN SESSION (LIMITED PURPOSE – CONVENING ONLY) – 8:00 AM

1. CALL TO ORDER

2. PUBLIC COMMENT ON CLOSED SESSION ITEMS ONLY – 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 jurisdiction of the Board are requested to identify themselves at this time.

3. ADJOURN TO CLOSED SESSION

Thursday, April 16, 2026

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Board of Directors Meeting

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CLOSED SESSION – 8:01 AM

1. **CALL TO ORDER**
2. **REVIEW OF CLOSED MEETING MINUTES – [March 19, 2026](#)**
Possible reportable action – recommended for approval to the Regular Board Meeting
3. **QUALITY ASSURANCE:**
Pursuant to Health and Safety Code 32155 and 1461 – *Michael Tedaldi, MD, Vice Chief of Staff and Quality Committee Chair*
4. **QUALITY ASSURANCE:**
Pursuant to health and Safety Code 32155 and 1461 – *Melissa Quinonez, MSN, RN-BC, PHN, Risk Management Manager*
5. **ADJOURN CLOSED SESSION**

Thursday, April 16, 2026

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Kaweah Delta Health Care District

Board of Directors Meeting

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OPEN SESSION – 8:30 AM (OR IMMEDIATELY FOLLOWING CLOSED SESSION)

1. CALL TO ORDER

2. PUBLIC PARTICIPATION

Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five (5) minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdiction of the Board are requested to identify themselves at this time.

3. CLOSED SESSION ACTION TAKEN

Report on action(s) taken in closed session

4. REVIEW OF OPEN SESSION MINUTES – [March 19, 2026](#)

Possible reportable action - recommended for approval to the Regular Board Meeting

5. WRITTEN QUALITY REPORTS

A review of key quality metrics and actions associated with the following improvement initiatives:

- i. [Mental Health CMS Core Measures](#)

6. [STROKE QUALITY FOCUS TEAM:](#)

Overview of program, performance, and key quality outcomes related to the Stroke Program. *Cheryl Smit, BSN, RN Stroke Program Manager*

7. [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.*

8. ADJOURN OPEN MEETING

Thursday, April 16, 2026

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Kaweah Delta Health Care District

Board of Directors Meeting

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Vice President

Agenda item intentionally omitted

March 19, 2026

OPEN Quality Council Committee

Thursday, March 19, 2026

The Executive Office Conference Room

Attending: Board Members: Dr. Dean Levitan, Chair; David Francis, Board Member; Marc Mertz, Chief Executive Officer; Dr. Paul Stefanacci, Chief Medical Officer; Scott Baker, Interim Chief Nursing Officer; Kevin Morrison, Vice President of Support Services; Ben Cripps, Chief of Compliance & Risk Management; Tom Boggs, Chief Ambulatory Officer; Dr. LaMar Mack, Medical Staff; Sonia Duran-Aguilar, Director of Population Health; Crystal Clark, Data Reporting Manager; Shawn Elkin, Infection Prevention Manager; Chris Patty, Clinical Practice Guidelines Program Manager; Megan Stuart, RN Clinical Care QA (Recording); Martha Cardenas, RN Clinical Care QA

Closed Session:

Dr. Dean Levitan called to order at 8:18 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 8:29 AM.

Open Session:

Public Participation – None.

Dr. Dean Levitan called to order at 8:32 AM.

- 4. Review of February Quality Council Open Session Minutes** – Dr. Dean Levitan, Board Member
 - Reviewed and acknowledged the February Quality Council Open Session Minutes by Dr. Dean Levitan. Corrections made to reflect correct date and location on the February closed meeting minutes. No further actions.
- 5. Written Quality Reports** – a review of key quality metrics and actions associated with the following improvement initiatives:
 - a. **Diabetes Committee**
Report reviewed, accepted, and attached in minutes. No action taken.
- 6. Quality Incentive Pool – Rural Health Clinics** – Overview of program, performance, and key quality outcomes for participating rural health clinics. *Sonia Duran-Aguilar, MSN, MPH, RN HN, CNL. Director of Population Health.* Report reviewed and attached in minutes. Committee requested to bring back report to revisit when the next scheduled reporting calendar occurs.
- 7. 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

Dean Levitan adjourned the meeting at 9:32 AM.

Mental Health CMS Core Measures

Mental Health Services

Quality Council Report
April 08, 2026



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Current Quality Priorities

- HBIPS
- Workplace Violence
- Suicide Prevention

HBIPS Performance Indicator



Hospital-Bases Inpatient Psychiatric Services Measures: (Care Compare)
Mental Health Services

Metrics		CMS Benchmark	Mar-25	Apr-25	May-25	Jun-25*	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Total
HBIPS-2a	Physical Restraint-Overall Rate - (hours/days)	0.32 / 0.31*	0.50	1.25	1.78	0.44	0.16	0.41	0.89	0.25	1.33	0.88	0.46	0.53	0.74
HBIPS-3a	Seclusion-Overall Rate -(hours/days)	0.35 / 0.36*	0.98	0.68	2.15	2.17	1.35	0.74	1.20	0.38	1.57	0.83	1.22	0.89	1.18
SUB-2	Alcohol Use Intervention Provided/Offered/Not offered	60.00% / 58.00%*	100% 5/5	100.0% 9/9	100% 4/4	100% 5/5	91.67% 11/12	100% 9/9	100% 8/8	88.89% 8/9	100% 4/4	83.33% 5/6	80.00% 8/10	100% 4/4	94.12% 80/85
SUB-2A	Alcohol Use Brief Intervention refused/declined	77.00% / 76.00%*	60% 3/5	44.44% 4/9	25% 1/4	60% 3/5	58.33% 7/12	44.44% 4/9	37.5% 3/8	44.44% 4/9	75.00% 3/4	50% 3/6	70% 7/10	50% 2/4	51.77% 44/85
SUB-3	Alcohol/Other Drug Use Tx provided/offered at D/C	72.00% / 71.00%*	93.33% 14/55	100% 21/21	100% 30/30	100% 19/19	100% 32/32	100% 20/20	100% 19/19	100% 21/21	100% 14/14	91.43% 32/35	100% 31/31	100% 21/21	98.56% 274/278
SUB-3A	Alcohol/Other Drug Use Disorder Tx at D/C	61.00% / 59.00%*	93.33% 14/15	100% 21/21	100% 30/30	100% 19/19	100% 32/32	100% 20/20	100% 19/19	100% 21/21	100% 14/14	91.43% 32/35	100% 31/31	100% 21/21	98.56% 274/278
IMM-2	Influenza Immunization-screening for immunization status	77.00% / 81.00%*	100% 52/52	N/C	N/C	N/C	N/C	N/C	N/C	100% 61/61	100% 51/51	100% 61/61	100% 64/64	100% 54/54	100% 343/343
TOB-3	Tobacco Treatment Provided/Offered at Discharge Received or refused a prescription for FDA-approved cessation medication upon discharge.	58.00% / 57.00%*	43.48% 10/23	68.18% 15/22	72% 18/25	42.11% 8/19	70.83% 17/24	57.14% 8/14	52.17% 12/23	66.67% 18/27	39.13% 9/23	67.74% 21/31	50.00% 15/30	63.16% 12/19	58.21% 163/280
TOB-3A	Tobacco Treatment on discharge "Referred to outpatient counseling"	18.00% / 16.00%*	8.70% 2/23	4.55% 1/22	8% 2/25	0% 0/19	4.17% 1/24	0% 0/14	8.70% 2/23	0% 0/27	4.35% 1/23	6.45% 2/31	6.67% 2/30	0% 0/19	4.64% 13/280
CT-2	Care Transitions w/specified elements received by discharged patients	62.00% / 63.00%*	77.36% 41/53	79.03% 49/62	76.19% 48/63	81.48% 44/54	87.30% 55/63	92.45% 49/53	79.25% 42/53	85.25% 52/61	86.79% 46/53	76.56% 49/64	83.33% 55/66	80.70% 46/57	82.05% 576/702
SMD-1	Screening for Metabolic Disorders	79.00% / 80.00%*	96.43% 27/28	94.74% 36/38	88.89% 40/45	90.63% 29/32	88.46% 46/52	94.29% 33/35	97.06% 33/34	97.5% 39/40	89.65% 26/29	84.21% 32/38	78.05% 32/41	93.48% 43/46	90.83% 416/458

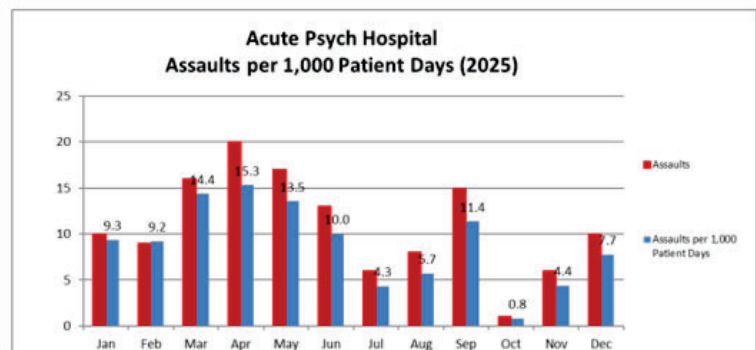
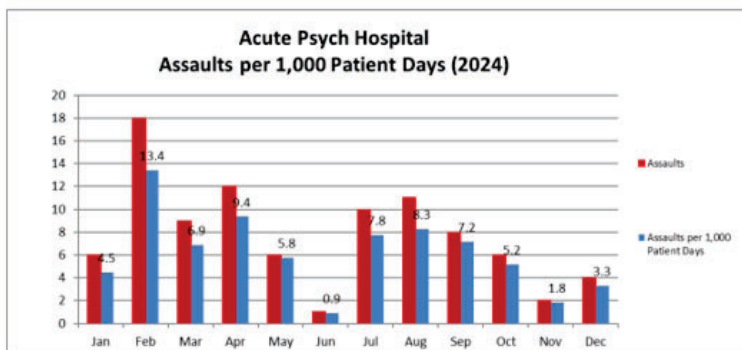
*updated benchmark effective Jun-25

Kaweah Health workplace violence incidents

Mental Health: Assaults per 1,000 Patient Days

YR 2025	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Patient Days	1,073	981	1,114	1,306	1,255	1,299	1,402	1,399	1,321	1,297	1,375	1,292
Assaults	10	9	16	20	17	13	6	8	15	1	6	10
Assaults per 1,000 Patient Days	9.3	9.2	14.4	15.3	13.5	10.0	4.3	5.7	11.4	0.8	4.4	7.7

Data collected from Security Services' incident reporting system and Finance Department census reports for the period from 01/01/2025 to 12/31/2025



Data collected from Security Services' incident reporting system and Finance Dept patient days data for the period from 01/01/2025 to 12/31/2025

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Suicide Prevention

Question	Overall Acute Psych													
	Goal	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
1. Columbia Full Assessment done on admission	100%	100% 34/34	100% 56/56	100% 21/21	100% 37/37	96.88% 62/64	100% 66/66	100% 55/55	100% 46/46	100% 28/28	100% 38/38	100% 23/23	100% 67/67	100% 36/36
2. C-SSRS shift screen been done every shift (not required at admission)	100%	93.94% 31/33	96.43% 54/56	100% 19/19	100% 37/37	100% 64/64	98% 65/66	98% 54/55	98% 44/45	100% 27/27	100% 32/32	100% 23/23	97% 56/58	100% 31/31
3. Room Sweeps completed each shift	100%	100% 33/33	100% 56/56	100% 22/22	100% 36/36	100% 63/63	100% 66/66	100% 55/55	100% 46/46	100% 28/28	100% 38/38	100% 23/23	100% 67/67	100% 36/36
4. Pt monitored per policy (Q15 minute checks/ 1:1 if applicable)	100%	100% 34/34	100% 56/56	100% 22/22	100% 34/34	100% 63/63	100% 66/66	100% 55/55	100% 46/46	100% 28/28	100% 38/38	100% 23/23	100% 67/67	100% 36/36
5. Order for No Sharps (no sharps located in patient room)	100%	91.18% 31/34	100% 54/54	100% 22/22	100% 34/34	100% 64/64	100% 66/66	31% 17/55	100% 46/46	100% 28/28	100% 38/38	100% 23/23	100% 67/67	100% 36/36
6. Order for Safety Blanket (regular linen/curtains removed from room)	100%	91.91% 30/33	100% 56/56	100% 22/22	100% 35/35	100% 62/62	100% 66/66	31% 17/55	100% 46/46	100% 28/28	100% 38/38	100% 23/23	100% 67/67	100% 36/36

Key

* updated Feb 2026

Opportunities for Improvement

Seclusion & Restraints

Opportunities

- Physical restraints and seclusion continues to be below CMS benchmark.
- Newer nursing staff needs to be more proactive in early assessments and early interventions to prevent escalating aggressive behaviors of patients.
- Hourly nursing documentation has taken nursing away from the floor.
- Nursing staff to communicate patient behaviors and need medication management to physicians before a code happens.

Action Plan

- Nursing staff refresher trainings with real scenarios.
- Set staff expectation to actively engage with patients on the floor to quickly assess any changes in patient behaviors, provide appropriate interventions and prevent crisis.
- Work with ISS and informatics to reduce hourly nursing documentation to once a shift and PRN.
- Discussion with Precision Medical Group regarding assertive medication management.

Opportunities for Improvement

HBIPS – SUB 2A

Opportunities

- SUB 2A Alcohol use brief intervention refused/declined continues to be below CMS benchmark.
- Select staff continue to document patient refusal of alcohol use brief intervention although all patients are offered treatment information.

Action Plan

- Staff training on how to complete HBIPS data and reminders in monthly staff meetings.
- 1:1 discussion with identified staff
- Implement disciplinary action for staff who continuously miss completion of SUB 2A.

Opportunities for Improvement

HBIPS – SUB 3A

Opportunities

- TOB-3A Tobacco treatment on discharge referred to outpatient counseling continues to be below CMS benchmark.
- Select staff continues to document patient refusal of tobacco treatment on discharge.

Action Plan

- Staff trainings on how to complete HBIPS data and reminders in staff meetings and huddles
- ISS to add smoking cessation in physician order set.

Accomplishments - HBIPS

	CMS Benchmark	KH Mental Health Hospital
SUB-2	58.00%	94.62%
SUB-3	71.00%	98.23%
SUB-3A	59.00%	96.23%
IMM-2	81.00%	100%
CT-2	63.00%	82.52%
SMD-1	80.00%	90.85%
TOB -3	57.00%	58.66%

Questions?



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STROKE QUALITY FOCUS TEAM:

Stroke Quality Focus Team Report

Quality Council Report
April 16, 2026

Cheryl Smit, BSN, RN, Stroke Program Manager
Sean Oldroyd, DO Stroke Program Medical Director



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Primary Stroke Re-certification Survey March 14, 2025

Survey Summary:

Strengths and Best Practices:

- The education assessment is excellent! Including Residents in the process is a great practice that many organizations overlook
- The NIH validation process with a super user every two years is commendable—many organizations do not implement this.
- Strong community awareness efforts and stroke community assessments are notable achievements. Not many organizations emphasize these initiatives, so well done!
- The recent changes to the inpatient RRT process for in-house stroke alerts are impressive, and the response times look great.

Findings and Opportunities for Improvement:

- Quality Improvement Initiatives (Low/Pattern): While progress has been made, door-to-needle and CT performance times are not consistently meeting targets. Strengthening ongoing quality improvement efforts may help optimize these metrics.
- Order Set Usage & Evidence-Based Care Delivery (Moderate/Pattern): A review of patient charts identified some areas where adherence to evidence-based care protocols can be strengthened, particularly in physician order set usage. Addressing these gaps can further enhance patient care.
- Core Measure Metric Reporting (Low/Widespread): Expanding data entry efforts to ensure full alignment between GWTG and the TJC system will enhance the completeness and accuracy of reporting.

Restructure of the Oversight Stroke Quality Committee

Requirements of Improvement Quality Improvement Initiatives

Indicator	Benchmark	Jan'25	Feb'25	Mar'25	Apr'25	May'25	Jun'25	Jul'25	Aug'25	Sep'25	Oct'25	Nov'25	Dec'25
Core Measures													
STK-1 VTE (GWTG, TJC)	85% or greater	88%	91%	100%	100%	93%	97%	97%	100%	92%	95%	93%	98%
STK-2 Discharged on Antithrombotic (GWTG, TJC)	85% or greater	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
STK-3 Anticoag for afib/flutter ordered at Dc (GWTG, TJC)	85% or greater	100%	100%	75%	88%	100%	100%	100%	100%	100%	100%	100%	100%
STK-4 Thrombolytics arrive 2hrs treat 3hrs (GWTG, TJC)	85% or greater	100%	100%	100%	100%	NA	100%	100%	100%	100%	100%	100%	100%
STK-5 Early Antithrombotics by end of day 2 (GWTG, TJC)	85% or greater	100%	100%	100%	100%	97%	100%	98%	100%	100%	100%	100%	98%
STK-6 Discharged on Intensive Statin (GWTG, TJC)	85% or greater	94%	93%	96%	85%	91%	79%	97%	89%	96%	94%	97%	97%
STK-8 Stroke Education (GWTG, TJC)	75% or greater	100%	93%	92%	86%	92%	92%	96%	100%	92%	97%	92%	89%
STK-10 Assessed for Rehab (GWTG, TIC)	75% or greater	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

2025 GOAL

Build and maintain a structured approach to stroke quality improvement that enhances team collaboration, supports performance tracking, and drives measurable improvements in care processes and outcomes.

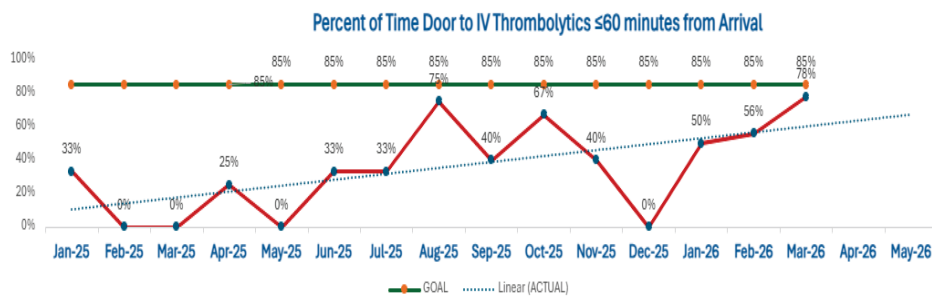
2025-2026 PLAN

High Level Action Plan

- Develop standard guidelines on roles and responsibilities of performance improvement work at the committee level (April 21, 2025)
- Review and restructure Stroke Committee membership and expectations (May 2025)
- Prioritize meaningful, data-driven improvement efforts. Implement root cause analysis (RCA) method to select and prioritize stroke quality improvement project focused on guideline adherence and outcome improvement (May 2025)
 - Door to IV thrombolytic timeliness
 - Door to CT read timeliness
 - Order Set Usage and evidence based care delivery
- Leadership engagement has improved since the implementation of these action items.

Current Performance: Door to IV thrombolytic

Requirements of Improvement Quality Improvement Initiatives



2025 GOAL

The median time for IV thrombolytic administration will be given within 60 minutes on eligible patients with stretch goal of 45 minutes

The decision to administer IV thrombolytics must be made quickly and is based on timely communication with family members

2025-2026 PLAN

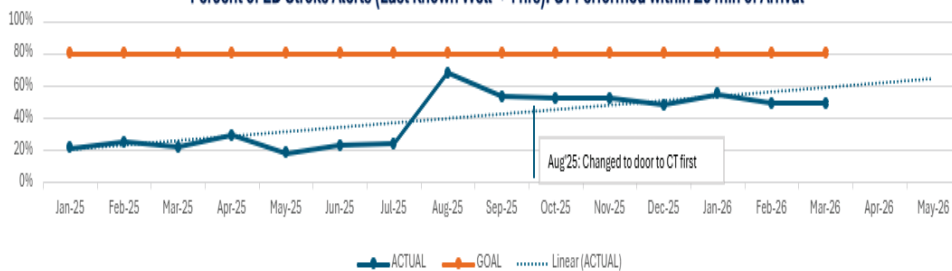
High Level Action Plan

- Developed EMS info card for timely family communication when administering IV thrombolytics (May 1, 2025)
- Mandatory ED Provider and Staff Education on the stroke alert process. (April/May 2025)
- Feedback loop: Provide ED stroke alert data to key stakeholders (ED leadership, radiology and laboratory) on a regular basis.
- Eliminated the IV thrombolytic written consent process.
- ED Stroke Alert Committee reviews each case to evaluate effectiveness of QI strategies and identify process and care gaps (ongoing)
- Collaborate with radiology to identify opportunities for improving turnaround times for stroke alert imaging. (May 2025)
- Mock stroke alert training for ED staff and Stroke Team Leads (ongoing)
- TeleSpecialists consultations on all ED and Inpatient Stroke Alert (January 6, 2026)

Current Performance: Door to CT Perform Timing

Requirement for Improvement: Quality improvement initiatives
Improving door to CT and perform times

Percent of ED Stroke Alerts (Last Known Well < 4 hrs): CT Performed within 20 min of Arrival



2025 GOAL

Achieve a door-to-CT completion time of 20 minutes

The decision to administer IV thrombolytics must be made quickly and is based on timely communication with family members

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2025-2026 PLAN

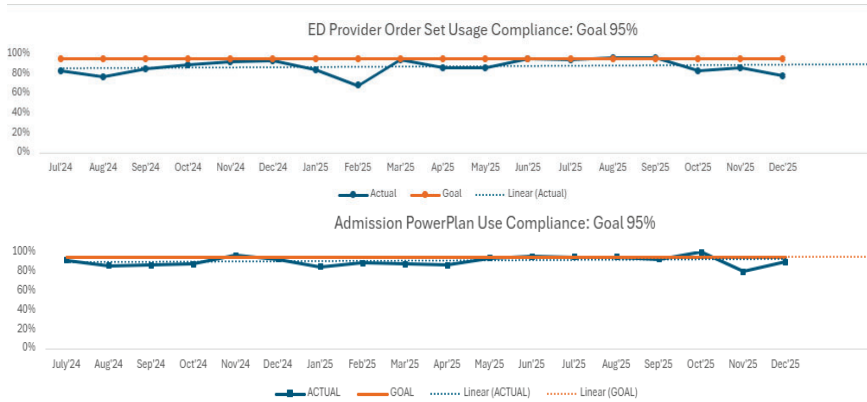
High Level Action Plan

- Collaborate with radiology to identify opportunities for improving turnaround times for stroke alert imaging. (May 2025)
- Feedback loop: Provide ED stroke alert data to key stakeholders (ED leadership, radiology and laboratory) on a regular basis.
- ED Stroke Alert Committee reviews each case to evaluate effectiveness of QI strategies and identify process and care gaps (ongoing)
- CT Perform Time definition updated to reflect the time of the first CT image obtained rather than scan completion, aligning with Joint Commission definitions (Aug 2025)
- TeleSpecialists consultations on all ED and Inpatient Stroke Alert (January 6, 2026)



Order Set Usage and Evidence-Based Care Delivery

Requirement for Improvement: Order Set Usage & Evidence-Based Care Delivery



2025 GOAL

Achieve at least 95% utilization of the ED/Hemorrhagic and Admission PowerPlans for eligible patients in both Emergency Department and inpatient admissions for three consecutive months

Usage of the Stroke related PowerPlans promote evidence-based care and reduce variability in clinical practice.

2025 PLAN

High Level Action Plan

- Provider education: PowerPlan usage to be highlighted in the Annual ED Stroke Alert Education (March 28, 2025) and in the All Adult Acute Care Provider Stroke Education module(April 2025)
- EMR optimization: Modification of the ED Hemorrhagic PowerPlan to ensure timely and accurate care of this subset of patients (March 2025)
- Feedback loop: Provide quarterly and real time feedback to providers/departments on usage rates. (April 2025)
- Accountability and Reinforcement: Partner with physician leadership to align PowerPlan usage with performance/QI metrics. (TBD)
- Empower nursing and pharmacy to advocate for appropriate PowerPlan usage when applicable. (May 2025)

Stroke Program Key Accomplishments 2025-2026

Teleneurology Implementation

- Successfully launched TeleSpecialists tele-neurology program on January 6, 2026, expanding access to neurologist expertise 24/7
- Implemented new stroke alert workflows integrating tele-neurology consultation with ED and In-House Stroke Alerts

Improved Acute Stroke Treatment

- Significant improvement in thrombolytic treatment timeliness, with IV thrombolytic (TNK) administered within 60 minutes increasing from 33% in 2025 to 56% in Jan-Mar 2026
- Approximate 10% improvement in transfer times for Large Vessel Occlusions (LVO) compared with 2025
- Redesigned ED triage workflow to enable earlier stroke recognition and faster activation of stroke alerts
- Continued performance monitoring of key stroke metrics including door to CT, CT to Read, and Door to Treatment times to drive ongoing process improvement

Stroke Alert Process Improvement

- Led redesign of ED and in-house stroke alert processes to improve response times and coordination
- Strengthened collaboration among ED, ICU, Neurology, Radiology, and Pharmacy teams during stroke emergencies

Stroke Program Impact 2025-2026

Performance & Quality Improvement

- Implemented high priority stroke dashboard to assist in identifying delays and drive improvement
- Maintained oversight of stroke core measure compliance and treatment documentation
- Restructure of the Oversight Stroke Quality Committee, greater involvement of key stakeholders

Education & Staff Engagement

- Delivered annual stroke education for clinical staff including updates from the 2026 AHA Acute Ischemic Stroke Guidelines
- Reinforced key practices including dysphagia screening, VTE prophylaxis, and stroke education for patients

Patient & Community Awareness

- Ensured stroke education materials are available across all acute care units
- Continued efforts to improve patient understanding of stroke symptoms, risk factors, and prevention
- Updates are being made to the patient stroke education booklets
- Collaboration with Marketing to ensure community awareness especially in our underserved populations

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Questions?



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Abbreviations Used During this Presentation

TJC = The Joint Commission
AHA/ASA = American Heart Association; American Stroke Association
GWTG = Get with the Guidelines
EMS = Emergency Medical Services
ED = Emergency Department
ICU = Intensive Care Unit
TIA = Transient Ischemic Attack
Dc = Discharge
TNK or Tenecteplase = thrombolytic therapy “clot busting medication”
CT/CTA = Computed tomography scan/computed tomography angiography
LVO = Large vessel occlusion
CMS = Centers for Medicare and Medicaid Services
VTE = Venous thromboembolism
NIHSS = National Institutes of Health Stroke Scale
RRT = Rapid Response Team
STL = Stroke Team Lead
EMR = Electronic Medical Record

CLINICAL QUALITY GOALS UPDATE

Outstanding Health Outcomes (OHO) QUALITY & PATIENT SAFETY PRIORITY

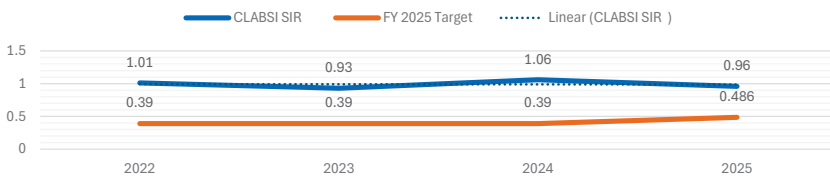
Healthcare Acquired Infection (HAI) Reduction

March 2026

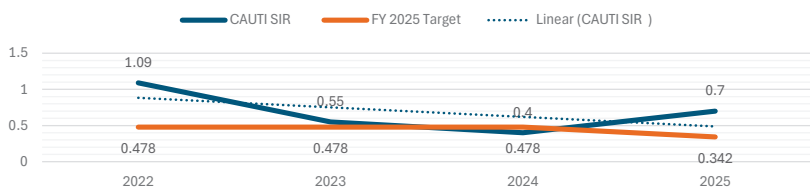
OHO FY26 Plan: HAI Reduction of Standardized Infection Ratio (SIR) (number of actual infections/number of predicted infections by CMS)

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

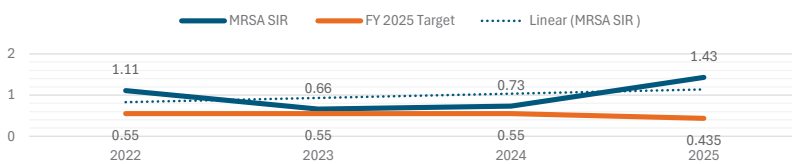
CLABSI SIR FY2022-FY2025



CAUTI SIR FY2022-FY2025



MRSA SIR FY2022-FY2025



FY26 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)

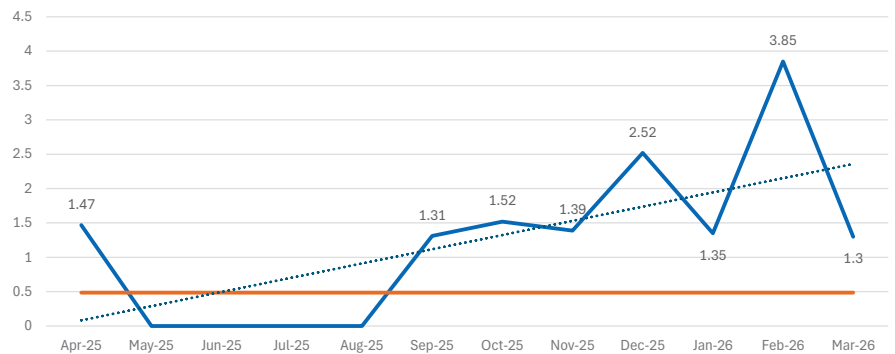
FY26 GOAL

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

OHO FY26 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

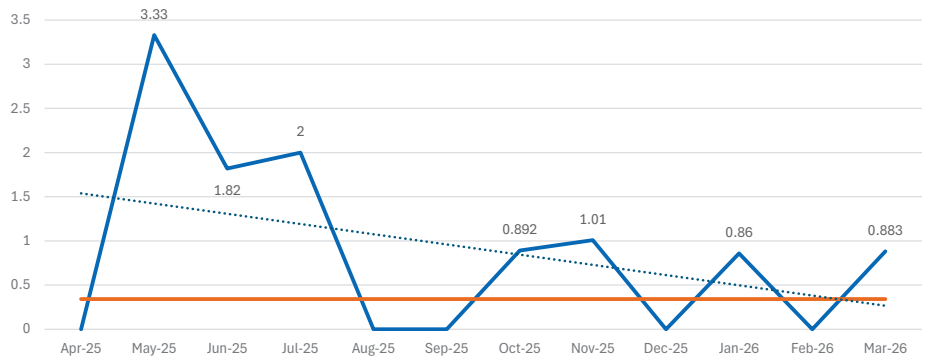


	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
CLABSI EVENTS	1	0	0	0	0	1	1	1	2	1	3	1	11
CLABSI Predicted	0.656	0.713	0.605	0.58	0.765	0.656	0.721	0.721	0.795	0.736	0.779	0.769	8.496
CLABSI SIR	1.47	0	0	0	0	1.31	1.52	1.39	2.52	1.35	3.85	1.3	1.29
CLABSI SIR Goal (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 FY26 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
- Emphasizing interventions used to avoid inserting an indwelling urinary catheter
- Revising the Nurse Driven Protocol – IUC removal
- Hand Hygiene monitoring

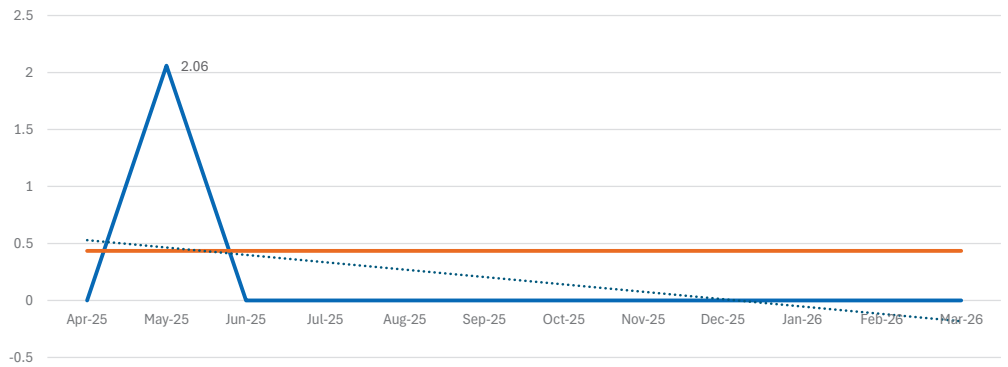


	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
CAUTI EVENTS	0	3	2	2	0	0	1	1	0	1	0	1	11
CAUTI Predicted	1.05	0.9	1.1	1	0.9	1.04	1.12	0.99	1.21	1.16	1.032	1.133	12.635
CAUTI SIR	0	3.33	1.82	2	0	0	0.892	1.01	0	0.86	0	0.883	0.87
CAUTI SIR Goal (70th percentile /top 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 FY26 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



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
MRSA EVENTS	0	1	0	0	0	0	0	0	0	0	0	0	1
MRSA Predicted	0.47	0.49	0.48	0.4	0.39	0.36	0.253	0.26	0.286	0.302	0.302	0.29	4.283
MRSA SIR	0	2.06	0	0	0	0	0	0	0	0	0	0	0.23
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

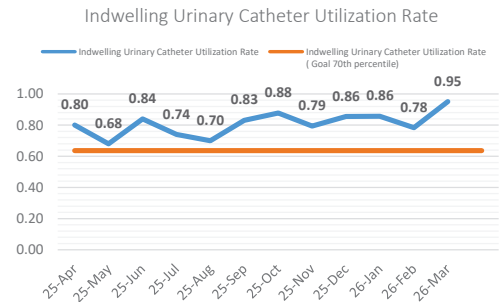
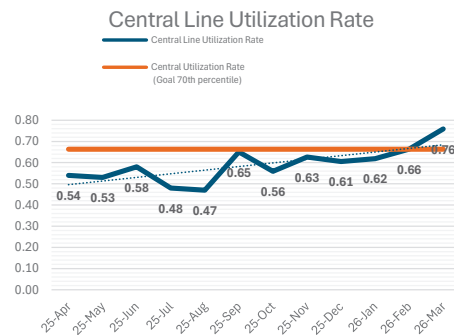
OHO FY26 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

FY26 goals not met because:

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

Targeted Opportunities

- Reduce indwelling urinary catheter utilization; less devices, less opportunity for infections to occur
 - Goal: reduce central line utilization ratio to <0.663
 - Apr 2025 – Mar 2026 (SUR = **0.77**)
 - Goal: reduce urinary catheter ratio to <0.64
 - Apr 2025 – Mar 2026 (SUR = **0.98**)
- MRSA nasal and skin decolonization for patients with lines.
 - Goal: 100% of at-risk patients nasally decolonized
 - Apr 2025– Mar 2026 **100%** (229 patients) of screened patients nasally decolonized
 - Mar 2026 - Goal: 100% of line patients have CHG bathing
- Improve hand hygiene (HH) through increased use of BioVigil electronic HH monitoring system
 - Goal: 61% of staff are active users of BioVigil
 - FY2025 **56%** Apr 2025 to Mar 2026 **61%** of staff are active users
 - HH Compliance rate overall **94.9%**
 - 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 2026 **93%** Pass rate.



OHO FY26 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	11/19/24	Completed
Next Steps: Skin decolonization of MRSA at risk patients through workflow enhancements	10/30/25	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

OHO FY26 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
HAI Quality Focus Team dissolved	12/8/2025	Several leadership changes and lack of membership attendance prevented intervention implementation.
CAUTI & CLABSI Committee developed by Scott Baker, CNO. Committee replaced the HAI QFT committee. Purpose of new CAUTI & CLABSI Committee is to reduce the incidence of CLABSI and CAUTI by coordinating evidence-based practices, monitoring compliance and outcomes, and driving continuous improvement in device use, maintenance, and timely removal across the organization.	2/10/2026	Interest in expanding committee membership to include at least two physicians along with key clinical stakeholders. Currently committee comprises of, 2 APNs, 1 Nurse Director, Executive – CNO, 2 Nurse Managers, IP Manager and 3 IPs
Development of standardized shared document for joint IP and Clinical review of CLABSI/CAUTI events.	2/12/26	Committee approved a centralized documentation system to share and store HAI event data along with lessons learned.
Full committee review of all current evidence-based literature regarding prevention of CAUTI & CLABSI events, presented by IP Manager	3/10/26	This will occur during the April CAUTI/CLABSI Committee meeting.
Significant revisions to current Nurse Driven Protocol for Indwelling Urinary Catheter Removal, to include a simple acronym to remember indications for an IUC. Modifications will be made to orders requiring an indwelling urinary catheter so that time limits are set requiring physician review of indication for device with emphasis for device removal. Consensus document regarding femoral central venous access to be reviewed and presented to MEC for approval.	3/10/26	An APN was assigned to modify the Nurse Driven Protocol. Other aspects of Bladder Management have been assigned to separate taskforces within the committee to establish streamline algorithms addressing interventions to pursue in advance of inserting an indwelling urinary catheter.

Thank you

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(PSI) 90 Composite.

PATIENT SAFETY INDICATOR (PSI) 90 COMPOSITE

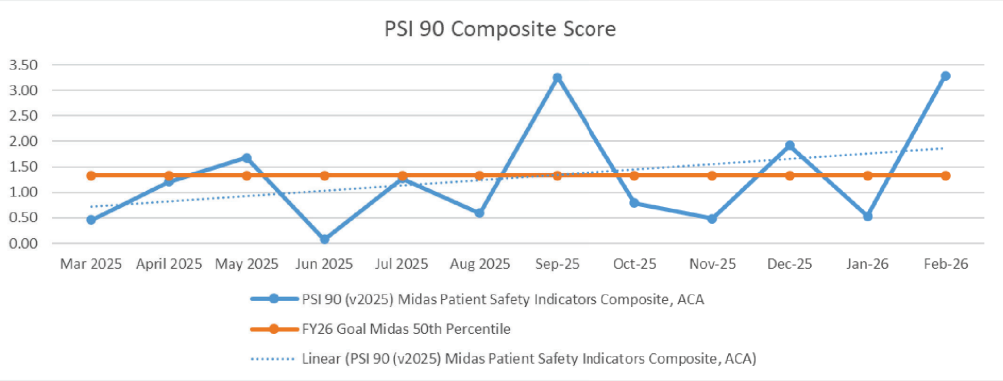
April 2026



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



FY26 PLAN – PSI 90

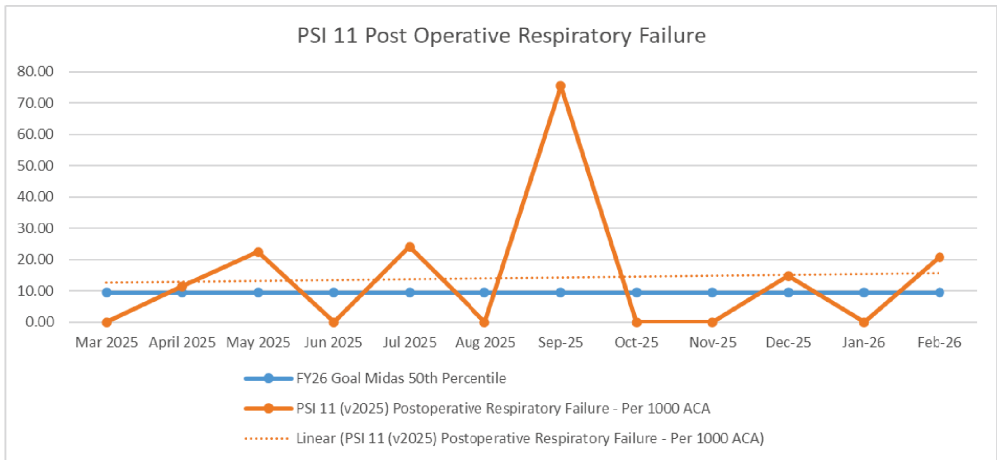
High Level Action Plan

- 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 = 1.404 (July 25 - Feb 26)**



OHO FY26: Patient Safety Indicator (PSI) 11



FY25 PSI 11 rate = 11.03
 Goal Midas National 50th percentile = 9.42
FYTD 2026 = 14.205, July 25 – Feb 26 (n=10)

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



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



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)



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