# Kaweah Delta Health Care District
## Board of Directors Meeting

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

Kaweah Health
MORE THAN MEDICINE. LIFE.

**DATE POSTED:** August 13, 2026

# NOTICE

**Date:** Thursday, August 20, 2026
**Location:** Kaweah Health Medical Cetner – 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/kaweahdeltahealthcaredistrictboardofdirectorsmeeti
**You can also dial in using your phone.**
Access Code: 460-561-181
United States: +1 (646) 749-3122

**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).

**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**
David Francis, Secretary/Treasurer

**Prepared by:**

Kelsie K. Davis
Board Clerk / Executive Assistant to the CEO

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

# Kaweah Delta Health Care District
Board of Directors Meeting

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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, August 20, 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**

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**CLOSED SESSION – 8:01 AM**

1. **CALL TO ORDER**

2. **REVIEW OF THE CLOSED MEETING MINUTES** – July 16, 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 – *Ben Cripps, Chief of Compliance*

5. **ADJOURN CLOSED SESSION**

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## 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** – July 16, 2026
   *Possible reportable action - recommended for approval to the Regular Board Meeting*

5. **CARDIOLOGY SERVICES (ACC) QUALITY REPORT**
   A review of current performance and actions focused on the clinical goals for Cardiology Servies. *Ashok Verma, Medical Director of Cath Lab; Ayham Zoreikat, Director of Cardiovascular Service Line and Operations.*

6. **IMAGING/RADIOLOGY QUALITY REPORT**
   A review of current performance, quality outcomes, and improvement initiatives focused on diagnostic imaging and radiology services. *Renee Lauck, Director of Imagining & Radiation Services*

7. **CLINICAL QUALITY GOALS UPDATE**
   A review of outstanding health outcomes initiatives for Healthcare Acquired Infection. Shawn Elkin, Infection Prevention Manager

8. **ADJOURN OPEN MEETING**

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# Agenda item intentionally omitted

**OPEN Quality Council Committee**
**Thursday, July 16, 2026**
**The Executive Office Conference Room**

Attending: Board Members: Dr. Dean Levitan, Chair; Jonna Schengel, Board Member; Marc Mertz, CEO; Kevin Morrison, VP of Support Services; Jag Batth, Chief Operation Officer; Ben Cripps, Chief of Compliance; Max Heckhausen, VP of Strategy; Stephen Forney, Chief Financial Officer; Dr. Paul Stefanacci, CMO/CQO; Megan, Stuart, RN Quality Improvement Coordinator – Clinical Outcomes; Cindy Vander Schuur, Patient Safety Manager; Shawn Elkin, Infection Prevention Manager; Chris Patty, Clinical Practice Guidelines Program Manager; (Recording) Kyndra Licon, Quality Project Manager

**Closed Session:**

Dr. Dean Levitan called to order at 8:00 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 8:32 AM.

**Open Session:**

**Public Participation –** None.

Dr. Dean Levitan called to order at 8:34 AM.

4. **Review of June Quality Council Open Session Minutes –** Dr. Dean Levitan, Chair Board Member
    - Reviewed and acknowledged the May Quality Council Open Session Minutes by Dr. Dean Levitan. No further actions.

5. **Orthopedic Service Line Quality Report –** A review of key quality measures and actions focused on the care of the orthopedic patient population. *Jag Batth, Chief Operating Officer.* No further actions.

6. **Clinical Quality Report –** A review of outstanding health outcomes initiatives for fiscal year 2027. *Dr. Paul Stefanacci, Chief Medical Officer and Chief Quality Officer.* Dr. Levitan requested information on the number of admission risk assessments required for Falls, Skin, and Suicide. The committee will bring this information back for review at next month's meeting.

**Adjourn Open Meeting** – *Dr. Dean Levitan*
Dean Levitan adjourned the meeting at 9:41 AM.

# Cardiology Services

## ACC Quality Report
## August 2026

# Program Overview

**Volume Trends: FY 2026 vs. FY 2025**

- AAA up 37%
- EP up 28%
- IR up 33%
- Micra new volume of 14
- PCI up 70%
- TAVR up 10%
- Watchman 146%

➢ Overall Volume up 7.3%

**New Procedure Highlights**

- Mitral Clip
- Tri Clip
- Renal Denervation
- CCM (CHF Treatment)
- Leadless Pacemaker

# Quality Priorities

**Goal:**
Reduce ST Elevated Myocardial Infarction (STEMI) Mortality below Odds Ratio of 1 by end of 2026

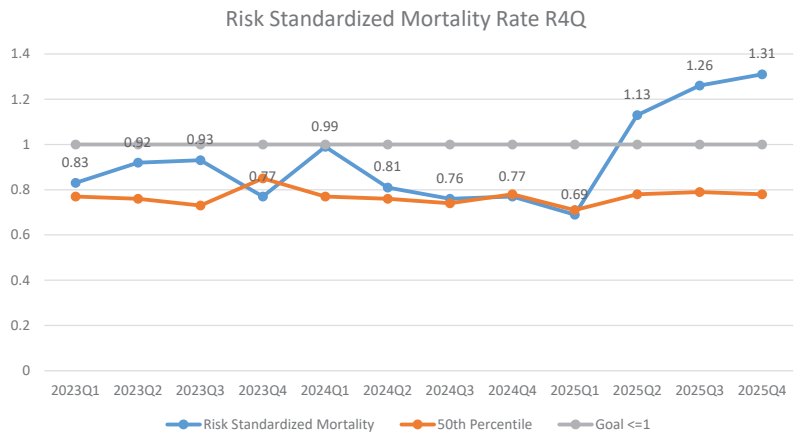
**Objectives:**
- Improve patient safety and survival
- Ensure clinical excellence by:
  - Protect vital organs
  - Speed up recovery times
  - Deliver better overall health outcomes for vulnerable patients.

**Quality Initiatives:**
1. **Improve Door to Reperfusion Time**
2. **Reduce Acute Kidney Injury**
3. **Reduce Bleeding Events**

*Improvement in these **Quality Initiatives** Reduces downstream risk of morbidity and mortality*

# Current Performance

## Quality Goal #1: STEMI mortality to be at or below Standardized Risk of 1




**Current status: Goal Not Met**

**Opportunities for Improvement**

1. Improve Door to Reperfusion Time
2. Reduce Acute Kidney Injury
3. Reduce Bleeding Events

**Corrective Actions**

- M&M review of all mortalities with Cleveland Clinic review model to identify targeted opportunities for improvement
- Implement Defined Quality Initiatives

**Goals**

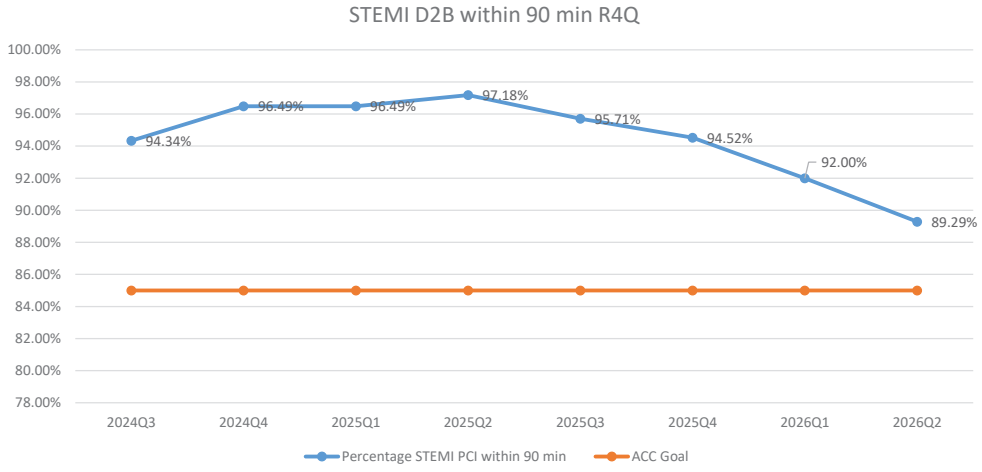
1. R4Q STEMI D2B <= 90 mins 85% of the time
2. Acute Kidney Injury below the risk standardized rate of 1
3. Bleeding rate below the risk standardized rate of 1

# Quality Initiative #1: Door-to-Balloon Time

- **Definition:**
  - Time from STEMI patient arrival to balloon inflation during PCI to restore coronary blood flow
- **“Time is Muscle”**
  - Longer ischemia causes irreversible myocardial cell death and larger infarcts
- **Preserving Heart Function**
  - Rapid reperfusion helps maintain left ventricular ejection fraction & reduces cardiogenic shock and life-threatening arrythmias
- **Mortality Link**
  - D2B time < 90 minutes are associated with better 30-day & long-term outcomes
  - Mortality increases with treatment delays
  - every 20 minute delay = 4-5% increase in mortality risk for

# Current Performance

## Initiative #1: R4Q Door to Balloon times should ≤ to 90 minutes 85% of the time




**Current status: Goal Met**

- Continue to monitor downward trend

Improvement Driven by:

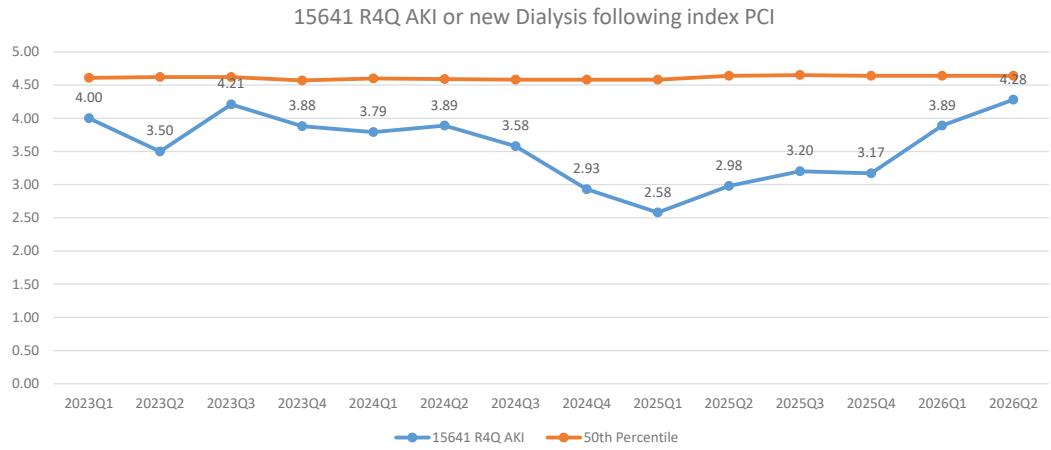
- Cath Lab activation targets of 30 minutes
- Real time feedback loops
- Pre-hospital 12 lead transmission from EMS and transferring hospitals

# Quality Initiative #2: Acute Kidney Injury

- **Nephrotoxic risk**
  - PCI requires the use of radiocontrast dye, which can be harmful, particularly in the elderly, diabetics, and those with preexisting kidney disease
- **Beyond the Kidneys**
  - AKI triggers systemic inflammation, dangerous electrolyte imbalances, and volume overload putting immense stress on an already compromised cardiovascular system.
- **The Chronic Disease Cascade**
  - Even mild cases of AKI can accelerate chronic kidney disease and lead to dialysis
- **Mortality Link**
  - Development of AKI is independent predictor of major adverse cardiovascular events (MACE) and mortality.
  - Monitoring AKI rates forces adoption of protective protocols (pre-procedural hydration and limiting contrast volume)

# Current Performance

Initiative #2: Contrast Induced (CI) induced Acute Kidney Injury (AKI) ≤ 50th percentile




**Current status: Goal Met**

**Achieved by:**

- Use of iso osmolar contrast
- Automated contrast delivery systems
- Physiological guided rehydration
- Staged PCI

# Quality Initiative #3: Bleeding Events

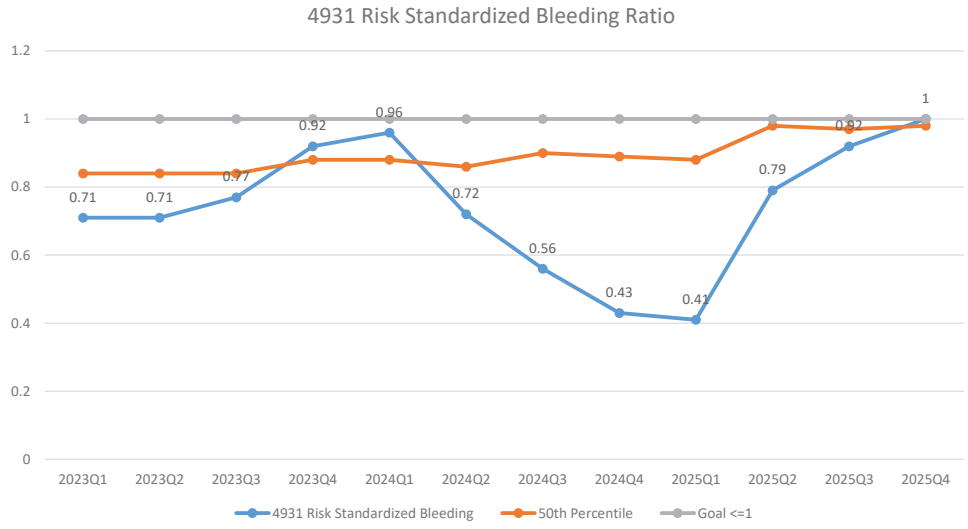
- **Avoiding the Hemorrhagic Cascade**
  - PCI involves placement of a foreign object (stent) requires patients to receive aggressive dual antiplatelet therapy (DAPT) and anticoagulants to prevent the stent from clotting, which inherently increases the risk of bleeding
- **Access Site and Systemic Risks:**
  - Bleeding can occur at the catheter insertion site (especially femoral access) or internally (such as gastrointestinal bleeding)
- **The Danger of Transfusions:**
  - Blood transfusion may cause immune-mediated responses and further strain on the heart, which are linked to higher mortality

# Quality Initiative #3: Bleeding Events

- **Mortality Link (The Stent Thrombosis Paradox):**
  - A bleeding event may force doctors to prematurely stop life-saving antiplatelet medications
  - Stopping these drugs early drastically increases the risk of acute stent thrombosis (the stent clotting shut), which often causes a massive, fatal secondary heart attack
  - Tracking bleeding metrics drives safer procedural choices, such as prioritizing radial (wrist) access, which has been proven to lower mortality by reducing bleeding complications.

# Current Performance

## Initiative #3: Reduce Bleeding Events ≤ 1




**Current status: Goal Met**

**Improvement Driven by:**

- Radial first approach
- US guided access
- Limited use of Glycoprotein Iib/IIIa inhibitors for clot burden
- Weight adjusted dosing and ACT monitoring during procedure
- Use of vascular closure devices

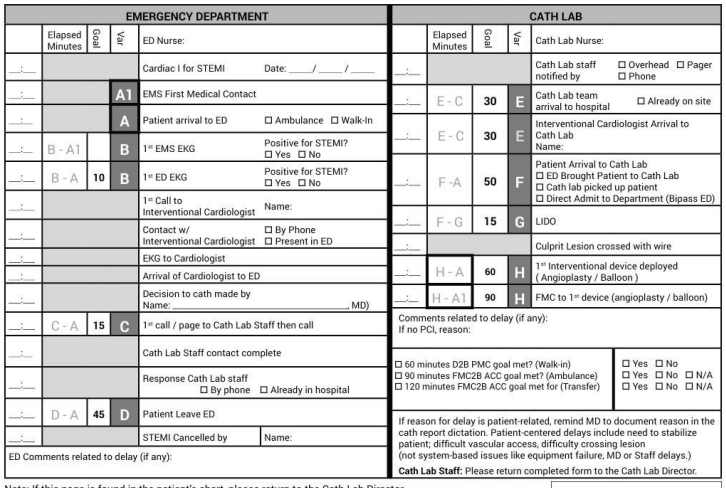
# Continuous Improvement

There are downward trends in each area that combined with the mortality rate show we need to continually monitor and consider additional interventions:

- Use of MACD (Maximum allowable contrast dose) during timeout
  - MACD is calculated as 3.7 x eGFR for the targeted contrast limit

- STEMI Time tracking sheet
  - Implementing a STEMI time tracking sheet, can show us where opportunities for improving D2B
  - Every 20 minutes shaved from D2B time decreases 1 year mortality risk by 5%

# Opportunities for Improvement



**EMERGENCY DEPARTMENT**

| | Elapsed Minutes | Goal | Var | |
|---|---|---|---|---|
| __:__ | | | | ED Nurse: |
| __:__ | | | | Cardiac I for STEMI Date: ____/ ____/ ____ |
| __:__ | | | A1 | EMS First Medical Contact |
| __:__ | | | A | Patient arrival to ED ☐ Ambulance ☐ Walk-In |
| __:__ | B - A1 | | B | 1st EMS EKG Positive for STEMI? ☐ Yes ☐ No |
| __:__ | B - A | 10 | B | 1st ED EKG Positive for STEMI? ☐ Yes ☐ No |
| __:__ | | | | 1st Call to Interventional Cardiologist Name: |
| __:__ | | | | Contact w/ Interventional Cardiologist ☐ By Phone ☐ Present in ED |
| __:__ | | | | EKG to Cardiologist |
| __:__ | | | | Arrival of Cardiologist to ED |
| __:__ | | | | Decision to cath made by Name: _____, MD) |
| __:__ | C - A | 15 | C | 1st call / page to Cath Lab Staff then call |
| __:__ | | | | Cath Lab Staff contact complete |
| __:__ | | | | Response Cath Lab staff ☐ By phone ☐ Already in hospital |
| __:__ | D - A | 45 | D | Patient Leave ED |
| __:__ | | | | STEMI Cancelled by Name: |

ED Comments related to delay (if any):

**CATH LAB**

| | Elapsed Minutes | Goal | Var | |
|---|---|---|---|---|
| __:__ | | | | Cath Lab Nurse: |
| __:__ | | | | Cath Lab staff notified by ☐ Overhead ☐ Pager ☐ Phone |
| __:__ | E - C | 30 | E | Cath Lab team arrival to hospital ☐ Already on site |
| __:__ | E - C | 30 | E | Interventional Cardiologist Arrival to Cath Lab Name: |
| __:__ | F -A | 50 | F | Patient Arrival to Cath Lab ☐ ED Brought Patient to Cath Lab ☐ Cath lab picked up patient ☐ Direct Admit to Department (Bipass ED) |
| __:__ | F - G | 15 | G | LIDO |
| __:__ | | | | Culprit Lesion crossed with wire |
| __:__ | H - A | 60 | H | 1st Interventional device deployed ( Angioplasty / Balloon ) |
| __:__ | H - A1 | 90 | H | FMC to 1st device (angioplasty / balloon) |

Comments related to delay (if any):
If no PCI, reason:

| | |
|---|---|
| ☐ 60 minutes D2B PMC goal met? (Walk-in) | ☐ Yes ☐ No |
| ☐ 90 minutes FMC2B ACC goal met? (Ambulance) | ☐ Yes ☐ No ☐ N/A |
| ☐ 120 minutes FMC2B ACC goal met for (Transfer) | ☐ Yes ☐ No ☐ N/A |

If reason for delay is patient-related, remind MD to document reason in the cath report dictation. Patient-centered delays include need to stabilize patient; difficult vascular access, difficulty crossing lesion (not system-based issues like equipment failure, MD or Staff delays.)

**Cath Lab Staff:** Please return completed form to the Cath Lab Director.

Note: If this page is found in the patient's chart, please return to the Cath Lab Director.
**This is not a permanent part of the Medical Record and is for Quality Assurance purposed only.**

CODE STEMI TIME STUDY
Page 1 of 1

PATIENT LABEL

# Questions?

# IMAGING

## Quality Report
## AUGUST 2026

# Department Overview: Imaging Scope of Service

**6 Campuses**

- **KHMC** Kaweah Health Medical Center
- **KHDC** Kaweah Health Diagnostic Center
- **KHIC** Kaweah Health Imaging & Breast Center
- **KH Diagnostic** Imaging – South Campus Pre-Admission/Urgent Care/TCU
- **KH Diagnostic** Imaging – Demaree Urgent Care
- **KH Diagnostic** Imaging – Plaza Clinic Imaging (September 2026)

**7 Modalities**

- **CT** – All CT, procedures, Cryo and Microablations, Biopsies, IR
- **Diagnostic** – including procedures, fluoroscopy, surgery coverage, IR
- **IR** – Cath Lab – reports through Cath Lab
- **Mammography** – including breast biopsies
- **MRI** – Including Breast MRI
- **Nuclear Medicine** – Spect CT & PET/CT
- **Ultrasound (US)** – including biopsies/Venous US

# Department Overview June 25 and June 26

***Increase in volume – All Modalities, with the exception of NM-Spect CT*

| | June 2025 | June 2026 | |
|---|---|---|---|
| Scope of Services | Volume – Exams/Reads | Volume | |
| Breast/Mammo | 1,636 (includes 2D/3D) | 2,226 | |
| CT | 5,126 | 5,626 | |
| DIAGNOSTIC XR | 11,258 | 11,662 | |
| IR (Cath Lab) | 106 | 142 | |
| MRI | 945 | 1,044 | |
| NM Spect/PET | 296 | 315 | |
| US | 3,756 | 3,943 | |
| **Reads Combined** | **23,122** | **June 26 24,958** | **8% Increase** |
| **Total UOS FY 25** | **352,355** | **FY26 390,731** | **10% Increase** |

# Quality Priorities

**Goal:**
Provide critical results and quality reports in a timely manner.

**Objectives:**
- Improve care coordination & patient safety
- Ensure clinical excellence by:
  - Assure the critical finding is communicated to the ordering physician
  - Assure the radiologist authored impression is accurately documented in the report/chart.

**Quality Initiatives:**
1. **Critical Findings**
2. **Radiologist Authored Impression**

*We are committed to upholding our promise to provide quality care and to achieve the Joint Commission standard for providing safe and accurate imaging services.*

# Quality Initiative #1: CRITICAL FINDINGS

Notification of Critical Findings Dashboard IMAGING SERVICES

| Critical Findings Measure | Target | May 2025 | Jun 2025 | July 2025 | Aug 2025 | Sept 2025 | Oct 2025 | Nov 2025 | Dec 2025 | Jan 2026 | Feb 2026 | March 2026 | April 2026 | May 2026 | June 2026 | Rolling 12M Av |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Imaging Services - % of critical findings communicated to primary care provider per policy | 100% | 97% | 100% | 92% | 95% | 92% | 97% | 97% | 90% | 85% | 96% | 79% | 77% | 76% | 85% | 90% |
| Imaging Services - # of critical findings communicated to primary care provider per policy | | 32/33 | 21/21 | 24/26 | 52/55 | 33/36 | 29/30 | 36/37 | 27/30 | 29/34 | 28/29 | 22/28 | 33/43 | 34/45 | 41/48 | 441/495 |

## Current status: Goal Not Met

Ongoing review of all critical findings to identify targeted opportunities for improvement

- Out of 437 tagged studies. 48 studies had critical findings identified that required communication.
  - 7 Opportunities for Improvement in critical finding communication/documentation.

**Opportunities for Improvement**

- Emergency Room Ordered Studies: 4 of 30 ED order exams had Opportunities for Improvement
- Exam Types: CT Pulmonary - PE and MRI Brain - Hemorrhage had Opportunities for Improvement
- Individual Radiologist Events: Same provider, no communication of critical findings mentioned.
- Inconsistent Communication of Critical Findings Process: Teleradiologists
  - Connect messenger works well only when radiologists use it properly.

# Quality Initiative #1: CRITICAL FINDINGS

## Corrective Actions

Dr. Julia Talley has been appointed to oversee quality, safety and informatics for Mineral King Radiology group.

- Leadership to share fall outs from critical findings review with SQI officer and MKR leadership
- SQI officer to update KH leadership and KH medical staff with action plan.

**New Critical Finding Communication Process:** Rolled out on 7/1/26

Optimize communication between radiologist and ordering physician.

- Educating all radiologists to use Connect Messenger.
- Radiologists will send the critical finding message to front office staff who will then push that message to the ordering physician.
- The radiologist and front office staff both document in the report and powerchart respectively regarding completed communication to ordering physician.
- Workflow established for TeleRadiologists

Review of critical findings audits and opportunities for improvement shared with radiologists involved.

- Targeted education to TeleRadiologists

# Quality Initiative #2: RADIOLOGIST IMPRESSION

| METRIC | JUNE | JULY | AUGUST |
|---|---|---|---|
| **Audit of 10 Procedures per week performed by APP will include RADIOLOGIST AUTHORED IMPRESSION in report.** | **100% COMPLIANT** | | |

**Current status: 100% compliant for 1 month (June)**

**Goal: 100% compliance for 3 months**

**Opportunities for Improvement**

- Inconsistent Physician Documentation practices
- Reliance on APP documentation

**Corrective Actions**

- Updated report templates in Powerscribe1 to eliminate the possibility for an APP to write an impression
- Dictation software has templates designed to eliminate the ability for the APP to write the impression in the report.

# Questions?

# Outstanding Health Outcomes

Healthcare Acquired Infection

August 2026

Kaweah Health

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# OHO FY2027

## Reduce Hospital Acquired Infections / Champion: Shawn Elkin

| Metric Description | Baseline | FY27 Goal |
|---|---|---|
| **CLABSI SIR** | FY 2026<br>1.64 | ≤0.486 (NHSN 30th Percentile 2022) |
| **C Diff SIR** | FY 2026<br>1.34 | ≤0.170 (NHSN 30th Percentile 2024) |

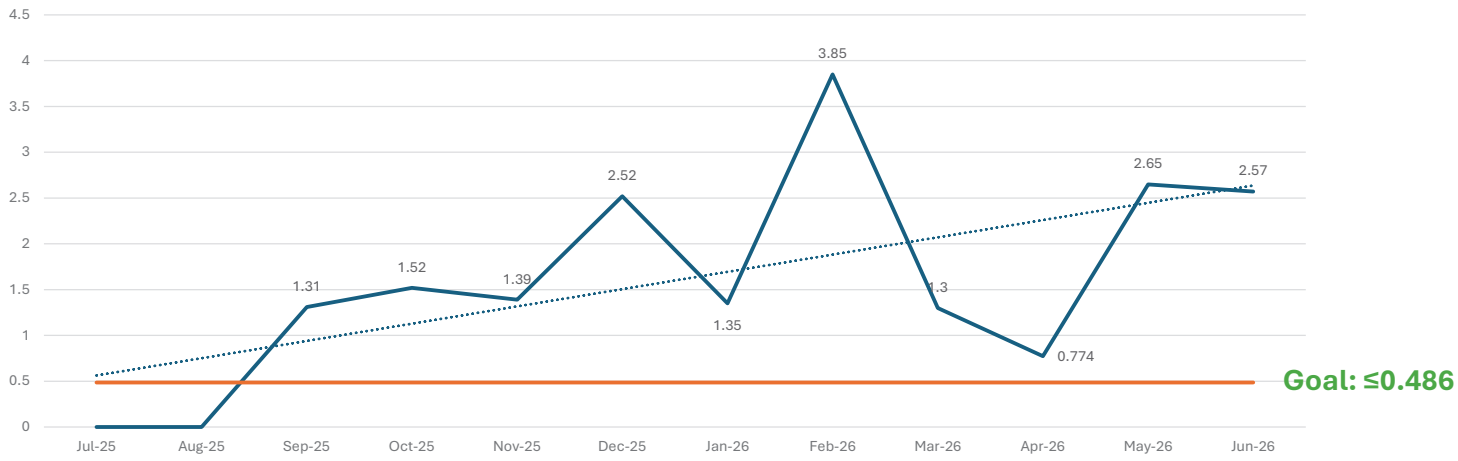
**Initiative:** Ensure Appropriate Use and Management of Central Lines

- Align insertion & maintenance bundles with evidence-based practices
- Embed daily interdisciplinary line necessity assessments into workflow
- Implement strict criteria limiting femoral access to emergent or last-resort

**Initiative:** Strengthen Commitment to Infection Prevention Practices

- Implement a Structured Culture Optimization Protocol
- Optimize Antibiotic Stewardship
- Embed all infection prevention protocols into the EHR with real-time alerts, order sets, and decision pathways

# OHO FY27 Plan: Reduction of CLABSI
# Central Line Associated Bloodstream Infection
## (number of actual infections/number of predicted infections by CMS)



# OHO FY27 Plan: Reduction of CLABSI

| | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Apr-26 | May-26 | Jun-26 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CLABSI EVENTS | 0 | 0 | 1 | 1 | 1 | 2 | 1 | 3 | 1 | 1 | 2 | 2 | 15 |
| CLABSI Predicted | 0.58 | 0.765 | 0.656 | 0.721 | 0.721 | 0.795 | 0.736 | 0.779 | 0.769 | 1.39 | 0.755 | 0.778 | 9.445 |
| CLABSI SIR | 0 | 0 | 1.31 | 1.52 | 1.39 | 2.52 | 1.35 | 3.85 | 1.3 | 0.774 | 2.65 | 2.57 | 1.59 |

## Opportunities for Improvement

**Insertion Practices**

- Skin antiseptic not allowed to dry before the procedure (**2 events**).
- Incomplete provider documentation, including undocumented multiple insertion attempts (**2 events**).
- Central line placed during a Code Blue, increasing contamination risk.

**Care & Maintenance**

- Hand hygiene deficiencies (**4 events**).
- CHG bath not documented/performed (**3 events**).
- Central line dressing not occlusive; reinforced multiple times.
- Right IV tubing changes not documented.

**Culturing Practices**

- Pneumonia present; blood cultures obtained without respiratory cultures.
- Blood cultures obtained while family considered transition to comfort care (**2 events**).
- Intra-abdominal abscess present; blood cultures obtained without abscess cultures.
- Blood specimens drawn from the central line, increasing contamination risk.

**Femoral line Utilization**

- Femoral Swan-Ganz catheter and intra-aortic balloon pump; left femoral Trialysis (temporary dialysis) catheter.

# HAI Reduction Initiatives

| Ensure Appropriate Use and Management of Central Lines | Actions | Process Metric | Status |
|---|---|---|---|
| • Align insertion & maintenance bundles with evidence-based practices | 7/8/2026: Met with nursing leadership to discuss the launch of the IV Safety Team, which will review vascular access devices, perform dressing changes, assist with difficult IV access, insert midlines/PICCs, and reduce unnecessary vascular access. Also discussed pursuing a Safety Summit and separate Safety Education events focused on EBP and maintenance bundles. | IV Safety team statistics:<br># of hard stick IV starts<br># of PICCs<br># of Midlines<br># of devices removed (device not indicated)<br># of dressings requiring replacement | In Progress |
| | 7/14–7/16/2026: A total of 64 GME residents and faculty from Emergency Medicine, Third Year, Surgery, and Anesthesia attended the Teleflex CVC Academy Training addressing: (1) compliance (sterility, Seldinger technique, catheter insertion, and dressing); (2) RACEVA blood vessel assessment; (3) dynamic needling; and (4) complication management. | Attendee logs with the number and names of residents who completed the training. | Complete |
| | | Verification of completed CLIP forms for all central lines via email to IP Team. | In Progress |
| • Embed daily interdisciplinary line necessity assessments into workflow | 7/6/2026: Completed the LTD with Indication report build – *Validation: LTD All Active Devices with Indication*. Nursing is pursuing a commentary section being added to the report prior to go-live. | Clinical leaders sharing the number of devices removed at each safety huddle. | Complete |
| | | Monitoring daily device utilization against monthly mean. | Complete |
| • Implement strict criteria limiting femoral access to emergent or last-resort scenarios | 7/14-7/16/2026: The Teleflex CVC Academy Training covered preferential cannulation of the internal jugular and subclavian vein versus the femoral vein. | Monitor number of femoral central line access daily, share information with unit leadership and Infectious Disease as part of the Daily Safety Huddle. Track device to removal. | In Progress |

## HAI Reduction Initiatives

| Ensure Appropriate Use and Management of Central Lines | Actions | Process Metric | Status |
|---|---|---|---|
| • Diagnostic Stewardship | Standardized documentation for site of culture collection (e.g., hand, antecubital, etc.). | ISS/BI review of 'Bridge' integration with Cerner Millenium. | In Progress |
| | Blood draws from central lines:<br>• Phlebotomy being trained NOT to prompt nursing to draw from central lines | Phlebotomy Manager and Coordinator trained phlebotomists not to prompt nurses for blood culture specimen collected from lines. | Complete |
| | • Critical Care Director procuring V.A.M.P. connection kits for all non-blood culture specimen collections from a central line to decrease line manipulation and contamination. | Critical Care nurses aware to avoid blood specimen collection from lines. V.A.M.P. procurement underway. | In Progress |
| | ID Consultations:<br>• Requiring ID consultation for Staph bacteremia, candidemia, osteomyelitis & endocarditis with suspected septicemia | Review Power Plans and working with ID physician on building automatic ID consult requirements | In Progress |
| • Hand Hygiene | Monthly Biovigil data presentations<br>Monthly top/bottom 5 hand hygiene performers<br>Monthly HH updates to QSOC<br>Safety Huddle Updates regarding HH performance | Presentation slide deck.<br>Slide with top/bottom 5 HH performers.<br>QSOC agenda and slide deck.<br>Ad hoc updates regarding HH performance | Complete<br>Complete<br>Complete<br>Complete |
| • Device Utilization | Broader IV-to-PO medication conversion recommendations | ID Pharmacy/Physician Antimicrobial Stewardship rounds - Conversions by month: May 48, June 58, July 51 (3-month total 157). | Ongoing |

# Device Utilization Reduction

## Daily Device Utilization - June

MEDICAL CENTER

| | 6/1 | 6/2 | 6/3 | 6/4 | 6/5 | 6/8 | 6/9 | 6/10 | 6/11 | 6/12 | 6/15 | 6/16 | 6/17 | 6/18 | 6/19 | 6/22 | 6/23 | 6/24 | 6/25 | 6/26 | 6/29 | 6/30 | MEDIAN |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Census | 313 | 315 | 307 | 343 | 324 | 346 | 356 | 360 | 345 | 331 | 332 | 330 | 364 | 341 | 270 | 349 | 347 | 344 | 344 | 310 | 304 | 318 | 337 |
| # isolation | 16 | 12 | 12 | 11 | 16 | 15 | 20 | 28 | 29 | 30 | 32 | 21 | 23 | 16 | 20 | 24 | 21 | 22 | 13 | 16 | 11 | 11 | 18 |
| #CL | 51 | 51 | 41 | 39 | 36 | 40 | 41 | 43 | 45 | 42 | 17 | 29 | 36 | 36 | 34 | 43 | 33 | 30 | 34 | 30 | 33 | 39 | 38 |
| # Femoral | 4 | 2 | 3 | 4 | 3 | 4 | 4 | 5 | 5 | 5 | 3 | 7 | 6 | 6 | 2 | 1 | 0 | 0 | 0 | 0 | 1 | 2 | 3 |
| # IUC | 42 | 45 | 42 | 39 | 40 | 40 | 39 | 33 | 31 | 28 | 36 | 45 | 47 | 43 | 40 | 56 | 44 | 37 | 39 | 40 | 28 | 33 | 40 |
| # External | 6 | 4 | 3 | 6 | 7 | 9 | 9 | 13 | 13 | 14 | 13 | 13 | 14 | 7 | 5 | 13 | 12 | 15 | 10 | 11 | 7 | 12 | 11 |
| #PIV | 313 | 316 | 305 | 330 | 311 | 314 | 328 | 339 | 344 | 343 | 340 | 286 | 378 | 283 | 259 | 348 | 314 | 296 | 258 | 254 | 288 | 304 | 314 |
| # Midline | 16 | 18 | 18 | 15 | 13 | 12 | 14 | 11 | 10 | 9 | 15 | 16 | 19 | 24 | 21 | 16 | 15 | 15 | 17 | 18 | 12 | 15 | 15 |
| IP Staffing | 67% | 83% | 83% | 83% | 67% | 83% | 83% | 83% | 83% | 33% | 33% | 33% | 33% | 33% | 33% | 50% | 67% | 67% | 67% | 67% | 67% | 67% | 67% |

**Intervention**
**June 19**
Femoral line Utilization shared at Safety Huddle

## Daily Device Utilization - July

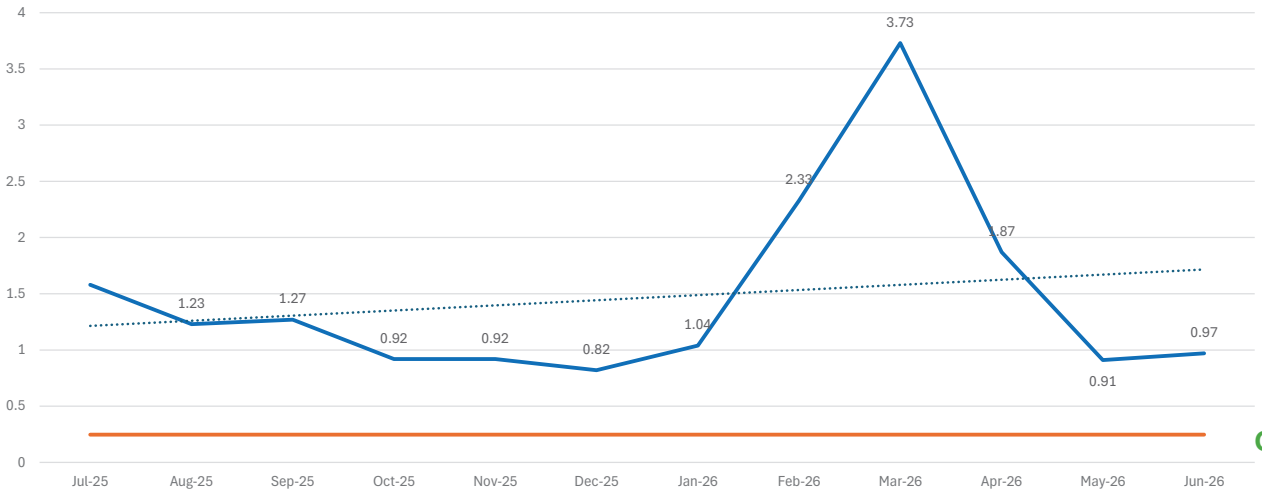
MEDICAL CENTER

| | 7/1 | 7/2 | 7/3 | 7/6 | 7/7 | 7/8 | 7/9 | 7/10 | 7/13 | 7/14 | 7/15 | 7/16 | 7/17 | 7/20 | 7/21 | 7/22 | 7/23 | 7/24 | 7/27 | 7/28 | 7/29 | 7/30 | 7/31 | MEDIAN |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Census | 338 | 336 | 325 | 307 | 331 | 336 | 329 | 343 | 345 | 333 | 349 | 355 | 355 | 349 | 330 | 342 | 358 | 341 | 337 | 370 | | | | 340 |
| # isolation | 10 | 13 | 13 | 23 | 17 | 20 | 23 | 22 | 20 | 9 | 15 | 14 | 10 | 15 | 16 | 11 | 15 | 15 | 18 | 13 | | | | 15 |
| #CL | 38 | 41 | 40 | 34 | 31 | 32 | 36 | 39 | 33 | 37 | 39 | 35 | | 29 | 30 | 32 | 33 | 32 | 29 | 38 | | | | 34 |
| # Femoral | 1 | 3 | 2 | 1 | 1 | 1 | 2 | 2 | 3 | 3 | 1 | 1 | | 3 | 2 | 0 | 0 | 0 | 0 | 1 | | | | 1 |
| # IUC | 39 | 38 | 39 | 36 | 26 | 38 | 40 | 35 | 36 | 37 | 39 | 44 | | 40 | 43 | 53 | 47 | 48 | 54 | 56 | | | | 39 |
| # External | 10 | 9 | 4 | 4 | 7 | 7 | 10 | 11 | 11 | 15 | 12 | 10 | | 16 | 12 | 9 | 11 | 15 | 13 | 16 | | | | 11 |
| #PIV | 335 | 339 | 325 | 306 | 258 | 332 | 325 | 343 | 329 | 320 | 341 | 356 | | 329 | 307 | 315 | 334 | 329 | 338 | 358 | | | | 329 |
| # Midline | 15 | 18 | 17 | 20 | 19 | 22 | 25 | 23 | 26 | 27 | 28 | 27 | | 25 | 24 | 25 | 21 | 18 | 20 | 18 | | | | 22 |
| IP Staffing | 67% | 67% | 33% | 83% | 67% | 83% | 67% | 50% | 67% | 83% | 83% | 83% | 83% | 83% | 83% | 83% | 83% | 83% | 67% | 83% | | | | 83% |

**Intervention**
**July 14 - 16**
Central Line Insertion Training for Residents

# OHO FY27 Plan: Reduction of CDIFF Healthcare Onset Clostridium difficile Infection

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



# OHO FY27 Plan: Reduction of CDIFF

| | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Apr-26 | May-26 | Jun-26 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CDIFF EVENTS | 4 | 3 | 3 | 2 | 2 | 2 | 2 | 4 | 7 | 4 | 2 | 2 | 37 |
| CDIFF Predicted | 2.526 | 2.448 | 2.366 | 2.176 | 2.183 | 2.452 | 1.978 | 1.978 | 1.875 | 2.14 | 2.19 | 2.05 | 26.362 |
| CDIFF SIR | 1.58 | 1.23 | 1.27 | 0.92 | 0.92 | 0.82 | 1.04 | 2.33 | 3.73 | 1.87 | 0.91 | 0.97 | 1.40 |

## Opportunities for Improvement

**Testing Practices**

- Unnecessary/Inappropriate C. difficile Testing (**4 events**).
- Specimens Collected Late 4 to 19 days post admission (**4 events**).
- Post-operative tube feedings associated with (**2 events**).
- Bowel regimen associated with (**3 events**).
- Recorded bowel movements range from 2 stools over a 4-day period to 4 stools in one day.
- Patients received antimicrobial treatment prior to C. difficile testing for a range of 0 to 14-days, rarely poly-antimicrobial therapy.
- Resident Ordered: Emergency Medicine and Surgical Resident ordered testing (**2 events**).

## HAI Reduction Initiatives

| Strengthen Commitment to Infection Prevention Practices | Actions | Process Metric | Status |
|---|---|---|---|
| • Implement a Structured Culture Optimization Protocol | 7/7/2026: IP met with ID physician and ID pharmacist discussed optimizing current culture protocols.<br>• Encourage early culture practices performed prior to hospital admission day 3.<br>• Hard stop to C. difficile testing on day 4 and beyond. | Will encourage early testing for C. difficile when suspected.<br>Will monitor the # of ID consults for C. difficile testing. | In Progress<br>In Progress |
| • Optimize Antibiotic Stewardship | 7/7/2026: IP met with ID physician and ID pharmacist discussed optimizing antibiotic stewardship.<br>• Hard stop to order Meropenem (approval by ID required)<br>• Pursue oral antimicrobial dosing and reduce IV administration when acceptable. | Will monitor overall Carbapenem class antimicrobial ordering each month with goal of seeing a downward trend. | In Progress |
| • Embed all infection prevention protocols into the EHR with real-time alerts, order sets, and decision pathways | Will work with ISS to develop order sets that:<br>• Require ID consult for C. difficile testing on day 4 and beyond.<br>Will encourage Hospitalists Groups and GME Residents to adhere to the C. difficile policy and testing algorithm. | Will track the progress of the C. difficile testing Power Plan to completion.<br>Will monitor the # of ID consults for C. difficile testing<br>Will meet with Hospitalists Groups and GME Residents to discuss trends in C. difficile testing and encourage adherence to the C. difficile policy and testing algorithm. | In Progress<br>In Progress<br>In Progress |