Kaweah Delta Health Care District
Board of Directors Meeting

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

DATE POSTED: March 13, 2026

NOTICE

Date: Thursday, March 19, 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:

- **8:15 AM** – Open Session (to approve the Closed Session agenda)
- **8:16 AM** – Closed Session
  Pursuant to:
  - 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**

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, March 19, 2026 {Committee Meeting}

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

OPEN SESSION (LIMITED PURPOSE – CONVENING ONLY) – 8:15 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**

CLOSED SESSION – 8:16 AM

---

1. **CALL TO ORDER**
2. **REVIEW OF THE CLOSED MEETING MINUTES** – February 19, 2026.

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

4. **QUALITY ASSURANCE** pursuant to health and Safety Code 32155 and 1461 – Ben Cripps, Chief Compliance and Risk Office

5. **ADJOURN CLOSED SESSION**

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 –** February 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. **Diabetes Committee**

6. **Quality Incentive Pool - Rural Health Clinics:** Overview of program, performance, and key quality outcomes for participating rural health clinics. *Sonia Duran-Aquilar, MSN, MPH, RN, PHN, CNL. Director of Population Health.*

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

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 at least 48 hours prior to the meeting.

Agenda Posting and Public Records
Agendas are posted at least 72 hours in advance of regular meetings. Disclosable public records may be obtained by contacting the Board Clerk at 400 W. Mineral King Avenue, Visalia, CA, or by email at kedavis@kaweahhealth.org, or on the District website.

Agenda item intentionally omitted

February 19, 2026

OPEN Quality Council Committee
Thursday, January 15, 2026
The Executive Office Conference Room

Attending: Board Members: Dr. Dean Levitan, Chair; Jonna Schengel, Board Member; Jag Batth, Chief Operation Officer; Dr. Paul Stefanacci, Chief Medical Officer; Scott Baker, Interim Chief Nursing Officer; Malinda Tupper, Chief Financial Officer; Evelyn McEntire, Director of Risk Management; Shawn Elkin, Infection Prevention Manager; Chris Patty, Clinical Practice Guidelines Program Manager; Ayham Zoreikat, Director of Cardiovascular Services; Megan Stuart, RN Clinical Care QA (Recording); Martha Cardenas, RN Clinical Care QA;

Dr. Dean Levitan called to order at 8:03 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 8:33 AM.

Public Participation – None.
Dr. Dean Levitan called to order at 8:35 AM.

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

5. **Written Quality Reports –** a review of key quality metrics and actions associated with the following improvement initiatives: Reports reviewed, accepted, and attached in minutes. No action taken.
    a. **Annual Review of Quality and Patient Safety Plans**

6. **Cardiac Surgery Service Line –** A review of key process and outcomes measures related to cardiac surgery service line. Ayham Zoreikat, Director of Cardiovascular Services. Report reviewed and attached in minutes. Committee requested to bring back report to revisit when the next scheduled reporting calendar.

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*
Mike Olmos adjourned the meeting at 9:12 AM.

Diabetes Committee

Outstanding Health Outcomes (OHO)
QUALITY & PATIENT SAFETY PRIORITY

Inpatient Diabetes Care – Hypoglycemia Reduction

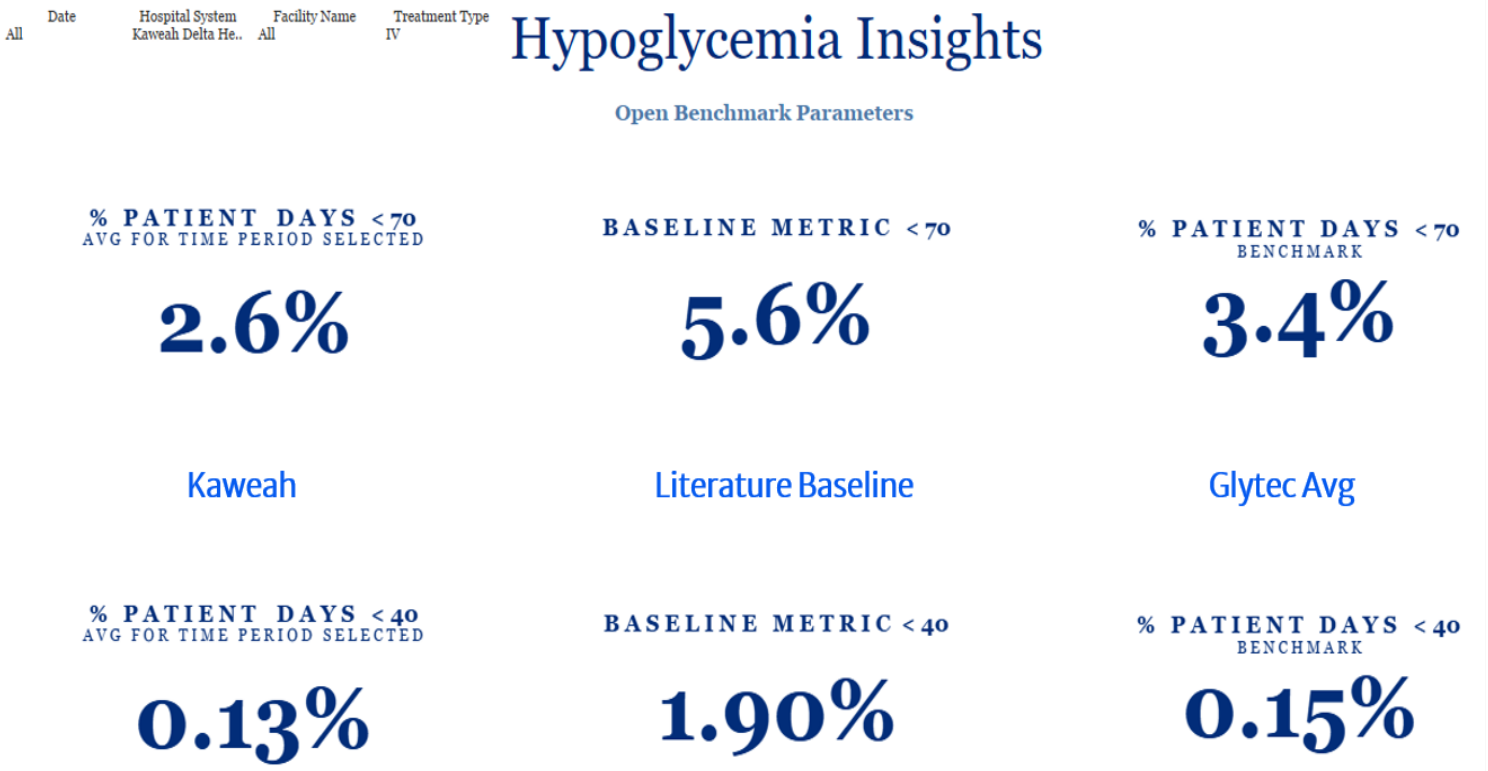
February 2026

Inpatient Diabetes Management Team Recommendation

- While Kaweah Health has several initiatives, programs and services addressing diabetes, it is the consensus of the committee that we lack specialty support and coordination with our inpatient population.
- 40% of patients admitted to Kaweah Health have diabetes as either a primary or secondary diagnosis
- **Centers for Medicare & Medicaid Services (CMS) will mandate that hospitals report electronic clinical quality measures (eCQMs) for severe hyperglycemia and hypoglycemia events**. This mandatory reporting requirement will directly impact Medicare reimbursement starting in fiscal year (FY) 2027
- The cost avoidance of preventing hypoglycemic events is $2,466,574 with a full time Inpatient Diabetes Management Provider, that performs daily glucose surveillance and interventions regarding glycemic decisions.

Hospital Preparedness of CMS Mandatory Reporting		
• Implementing robust data collection and analysis systems to track the required eCQMs accurately.		
• Establishing glycemic committees and developing evidence-based policies for managing blood glucose levels.		
• Inpatient diabetes management teams are specialized, interdisciplinary groups—typically comprising endocrinologists, nurse practitioners, diabetes educators, pharmacists, and dietitians—that manage hyperglycemia/hypoglycemia, improve glycemic control, and reduce length of stay for hospitalized patients. These teams often utilize active bedside consultation or virtual surveillance to optimize insulin regimens, provide staff education, and ensure safe transitions to post-hospital care.		

OHO Annual Plan: Inpatient Diabetes Care
Hypoglycemia Reduction in Critical Care (CC) Locations



FY25 GOAL

Achieve < 4.3% benchmark performance for hypoglycemia in Critical Care (CC) patient population, defined as percent patient days with blood glucose (BG) <70

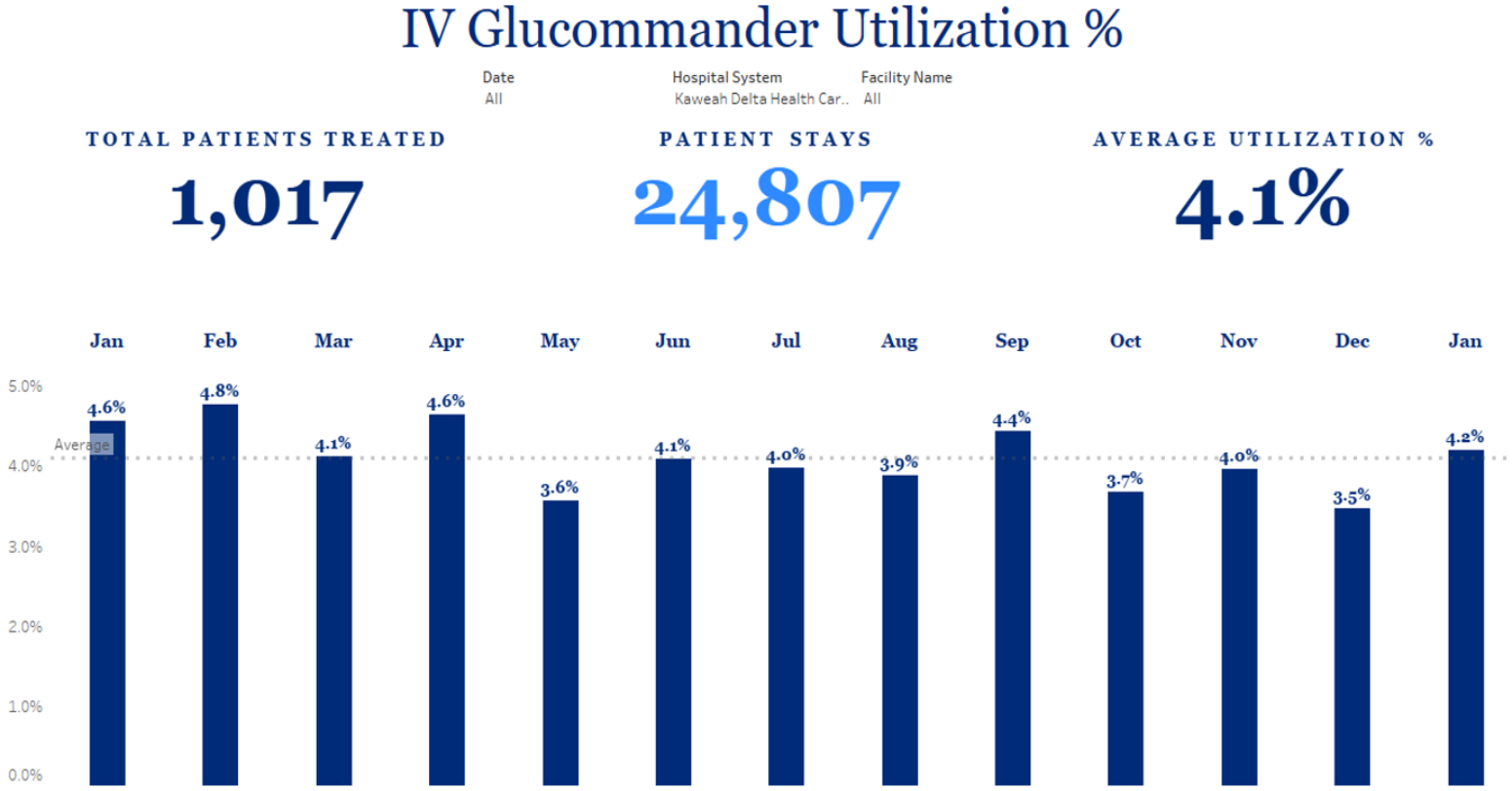
FY25 PLAN – Hypoglycemia Reduction

High Level Action Plan

- Increase IV insulin usage upon arrival to MICU from 170 to 187 (10% increase) by June 30, 2025. Currently on target for goal.
- APN will round 3 times per week to encourage use of IV Insulin usage providing rational and education to GME residents as needed.
- APN will monitor patients in the MICU using Glucometrics utilizing set parameters to avoid hypoglycemia or recurrent hypoglycemia (BG < 90 mg/dL)

OHO Annual Plan: Inpatient Diabetes Care

Hypoglycemia Reduction in Critical Care Locations



FY25 GOAL

Achieve < 4.3% benchmark performance for hypoglycemia in Critical Care (CC) patient population, defined as percent patient days with blood glucose (BG) <70

FY25 PLAN – Hypoglycemia Reduction

High Level Action Plan

- The metrics on this slide include both IV and SQ insulin in all critical care areas (MICU, CVICU, ICCU and CVICCU)
- Increase APN rounding in the MICU to encourage the use of IV Insulin for critically ill patients who are intubated and hemodynamically unstable. DM NP to met with Dr. Javed to establish a process. Dr. Javed will bring information forward with Sound group. DM NP to monitor for usage.

OHO Annual Plan: Inpatient Diabetes Care
Hypoglycemia Reduction in Critical Care Locations

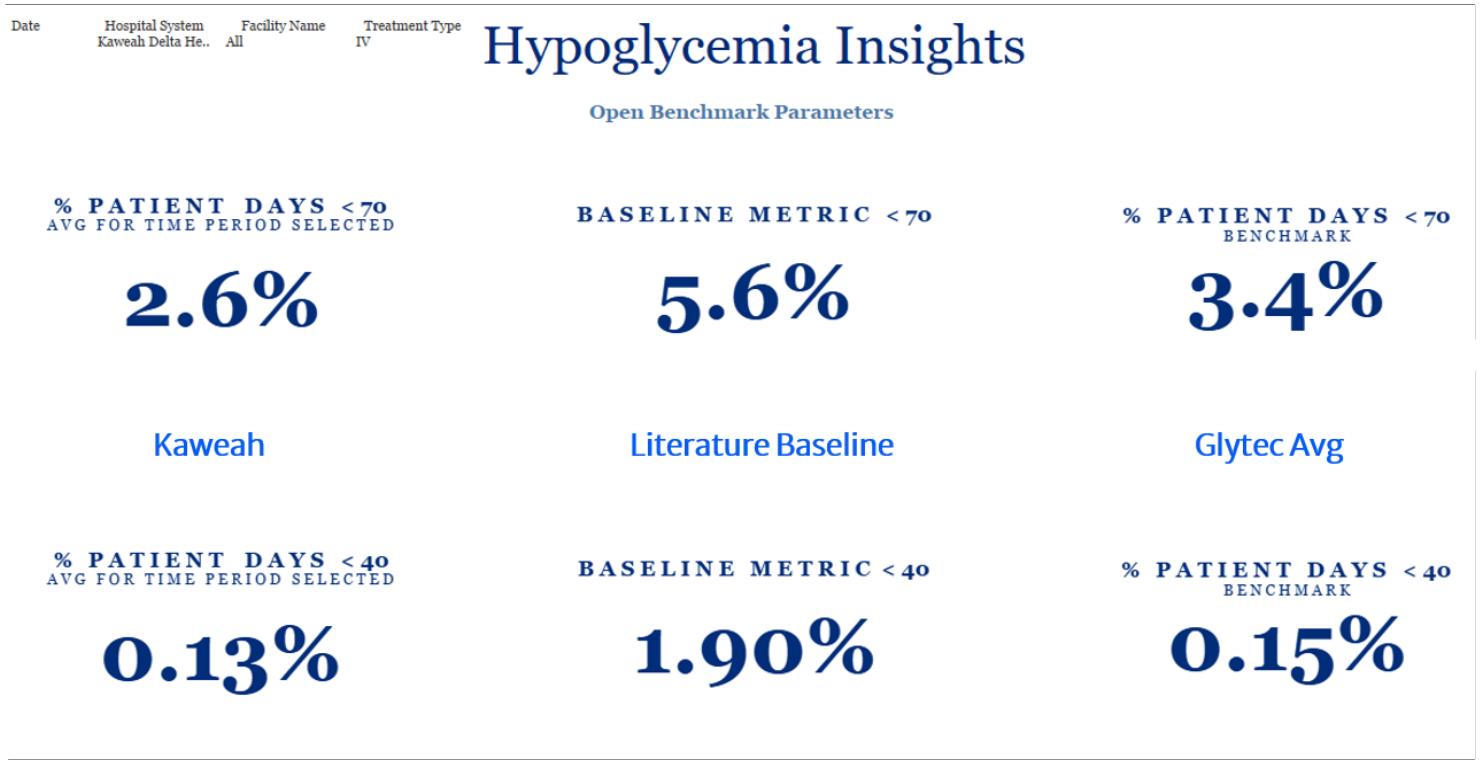
The last data point meet goal because:

- Great usage of subcutaneous/ IV insulin, continued support of IV insulin use in Critical Care(American Diabetes Association recommended practice) IV is first line therapy in Critical Care
- **Targeted Opportunities (What specifically is causing the fallouts?)**

1. Intensivist/GME managing patients in MICU has most opportunity as there is a higher volume of patients who require IV insulin
2. MICU Workflow ordering, nursing influence (labor intensive to manage a patient on IV insulin)

CURRENT IMPROVEMENT ACTIVITIES	COMPLETION DATE	BARRIERS
Glytec to help review hypoglycemic patient chart review to determine which patients are not treated according to best practice guidelines (started on SQ rather than IV insulin)	Ongoing	-New Sound TeleHealth Providers with education gaps
Upgrade in May assisted in EMR issues in transcribing diabetes management orders	May 2024	
Communicating inability to adjust basal insulin at anytime, currently have to wait for morning BG to be input in GM by the nurse	Spring 2026	1. Glytec upgrade in 2026 2. Nurses not inputting BG into GM in a timely manner
Improve knowledge and skillset of nursing, pharmacist and medical staff through education, training, consultative services.	Ongoing	

OHO Annual Plan: Inpatient Diabetes Care
Hypoglycemia Reduction in MED/SURG Locations



FY25 PLAN – Hypoglycemia Reduction

High Level Action Plan

- Optimize the difficult to manage patients (i.e. Renal, recurrent hypoglycemia, insulin resistant, steroid-induced hyperglycemia) using a non-GM power plan
- Continue to work with Glytec to improve glycemic control through product improvement recommendations: adjust basal dose prior to morning BG input into GM

FY25 GOAL

Achieve < 3.4% benchmark performance for hypoglycemia in Non-Critical Care (NCC) patient population, defined as percent patient days with blood glucose (BG) <70

OHO Annual Plan: Inpatient Diabetes Care

Hypoglycemia Reduction Inpatient

Continued struggles:

- 4N Patients, renal patients are complex as they lack renal system to metabolize insulin
- ADA guidelines indicate best practice to manage this population you need to ensuring Lantus (longer acting) is not 50% of insulin, and need close monitoring/management to successfully avoid hypoglycemia
- **Targeted Opportunities (What specifically is causing the fallouts?)**

1. Are there best practice guidelines for managing diabetes for renal insufficiency patients? Yes we are following best practice
2. Need very focused resources to closely manage patients who have renal insufficiency, very complex population, very dynamic with their glucose levels (factors include: timing of dialysis, times for eating, amount eaten, renal function)

CURRENT IMPROVEMENT ACTIVITIES	COMPLETION DATE	BARRIERS
Review patients with BG less than 90 mg/dL and adjust insulin as needed to avoid hypoglycemia or prevent recurrent hypoglycemia	Ongoing	No Inpatient Diabetes/Glycemic Management Support
Monitor patients on the non-GM power plan to ensure they are receiving correct dose of insulin. Discern report is used to identify patients on the non-GM power plan.	Ongoing	
Demonstrate return on investment (ROI) through improved throughput, decreased length of stay to increase time APN spends monitoring and caring for patients with diabetes.	12/27/2024	Denial of Inpatient Diabetes Management Team
Improve knowledge and skillset of nursing, pharmacist and medical staff through education, training, consultative services.	Ongoing	
Meeting with Dr. Javed from Sound Intensivist group to discuss underuse of insulin infusions.	3/11/2025	Practitioner practice difficult to change. Nursing staff still push for SQ insulin when patients are not medically ready for transition to SQ insulin.

Thank you

Live with passion.

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

Kaweah Health

Rural Health Clinics:

QIP QCOMM Report

March 19, 2026

Kaweah Health

QIP Program Updates

Kaweah Health

Quality Incentive Pool (QIP) Program

What: CMS 1115 Waiver program through the Department of Health Care Services (DHCS)

Why - Goals of QIP:

- Promote access to care
- Increase organization's investment value-based payment arrangements
- Encourages collaboration with Medi-Cal managed care plans and Hospitals

How: Funding is tied to quality outcomes as defined by DHCS annually

When:

- Kaweah Health reports QIP performance annually to DHCS for prior Calendar Year (CY)
- Funding is only earned if DHCS targets are achieved.
- Funding changes year after year along with targets.

QIP Reporting Highlights

CY 2025 Report Underway due 6/15/2026

Currently in CY 2026 Performance Period (1/1/2026-12/31/2026)

- Plan to report on 7 Quality Measures and perform on 7 Quality Measures ~ $12.7M ($1.8M/quality measure)

Funding Model Updated to 60% Medi-Cal Reimbursement/40% Quality Measures

Priority vs. Elective Quality Measures-Funding implications

- Pushes ***continuous quality improvement*** (preventing switching measures annually)
- 50% of total measures need to be Priority Measures
- 30% of total measures need to be reported year prior

Kaweah Health has strategically selected quality measures for QI and reporting that align with Primary and Preventive care to ensure high likelihood of performance.

RHC workflows impact performance for 100% of quality measures selected.

Kaweah Health

Quality Measures Cozeva Performance Year 2025	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26			Trends
	Aggregate Performance August	Aggregate Performance September	Aggregate Performance October	Aggregate Performance November	Aggregate Performance December	Aggregate Performance January	Target	Delta	
Q-CBP Controlling High BP	52.72%	62.90%	66.25%	66.70%	68.99%	71.67%	67.36%	-4.31%	
Q-GSD Diabetes|Glycemic Status Assessment for Patients With Diabetes (Glycemic Status <=9.0%)	42.04%	48.82%	56.04%	56.30%	61.84%	58.51%	72.99%	14.48%	
Q-CMS130 Colorectal Cancer Screening (1) (Trending Break PY5, new Population 45-75)	35.55%	35.71%	36.66%	38.34%	39.17%	40.79%	42.44%	1.65%	
Q-W30: Well-Child Visits in the First 15 Months	48.93%	50.21%	51.06%	54.35%	55.90%	56.44%	69.67%	13.23%	
Q-W30: Well-Child Visits in the First 30 Months of Life 15-30 Months	66.58%	68.21%	69.21%	70.34%	69.15%	69.36%	76.49%	7.13%	
Q-WCC Prevention and Screening|Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile	78.54%	89.99%	91.79%	89.70%	91.04%	91.27%	83.28%	-7.99%	
Q-WCC Prevention and Screening|Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	49.68%	55.09%	61.02%	67.29%	69.60%	70.92%	72.33%	1.41%	
Q-WCC Prevention and Screening|Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	52.73%	57.70%	63.01%	69.12%	71.19%	72.24%	72.56%	0.32%	
Q-IMA: Immunizations for Adolescents		21.51%	25.59%	25.78%	25.12%	25.12%	31.36%	6.24%	
Q-CIS10-Immunizations|Childhood Immunization Status COMBO-10		6.43%	6.19%	6.61%	6.76%	6.61%	22.87%	16.26%	
Q-LSC- Lead Screening in Children	77.03%	77.55%	78.53%	79.04%	78.89%	78.44%	79.51%	1.07%	
Q-PPC-PRE Prenatal Care	86.36%	89.04%	89.98%	88.52%	89.25%	88.97%	87.66%	-1.31%	
Q-PPC-PST Post Natal Care	76.36%	72.05%	82.15%	88.52%	89.49%	89.44%	78.41%	-11.03%	
Q-BCS Breast Cancer Screening	52.17%	52.70%	53.97%	55.68%	56.68%	56.65%	57.29%	0.64%	
Q-CCS Cervical Cancer Screening	58.24%	59.06%	59.20%	61.01%	62.18%	62.45%	56.98%	-5.47%	
Q-CHL Chlamydia Screening	47.13%	48.11%	37.75%	55.48%	57.05%	58.44%	49.65%	-8.79%	
Q-WCV: Child and Adolescent Well-Care	33.64%	34.17%	38.85%	45.34%	47.73%	49.40%	46.57%	-2.83%	

QIP Proxy Performance

Meeting 6.3 QM
Target 8 QM

Caveat-claims data

Kaweah Health

DHCS QIP Reporting Updates

"Better of MCP or QIP Entity Rate"

Limitation on use of Local Mapping to clinical events to reflect performance

RISK- If the claims or documentation to the health plans do not include the proper coding (quality codes, CPTII, LOINC) performance will be negatively impacted

Work to improve code capture remains underway

No Local Mapping to clinical events will be allowed.

Claims submission along with coding of diagnosis codes and Quality Codes will be *key to meeting performance*.

Kaweah Health

QIP Performance Year 9 (2026)

Kaweah Health

QIP PY9 2026 Quality Measure Focus

1. Controlling High BP - *Q-CBP* **(Priority)**
2. Glycemic Status Assessment for patients with Diabetes - *Q-GSD* **(Priority)**
3. Colorectal Cancer Screening - *Q-CMS130* **(Elective)**
4. Lead Screening in Children - *Q-LSC-* **(Elective)**
5. HIV Screening - *Q-CMS349* **(Elective)**
6. Cervical Cancer Screening - *Q-CCS* **(Priority)**
7. Breast Cancer Screening - *Q-BCS* **(Priority)**

Strategy to monitor more than 7 measures.

Funding available ~$12.7M

Contingency Plan

1. Prenatal Care - *Q-PPC-PRE* **(Priority)**
2. Post Natal Care - *Q-PPC-PST* **(Priority)**
3. Chlamydia Screening - *Q-CHL* **(Priority)**
4. Preventative Care and Screening: Tobacco Use-Screening and Cessation Intervention Rate 1, Rate 2, & Rate 3 - *Q-CMS138* **(Priority)**

Informational

1. Number of Members enrolled in Enhanced Care Management (ECM) - *Q-ECM*
2. Number of and Percentage of Eligible Members Receiving Community Supports (COMS) and Number of Unique COMS received by members - *Q-COMS*
3. Percentage of Acute Hospital Stay Discharges Which Had Follow-Up Ambulatory Visits W/in 7 days Post Hospital Discharge- *Q-FUAH*

Kaweah Health

Quality is a Team Sport

Physicians & APPs

Health Plans/Payors

Pharmacists

HIM

Digital Health/IT

Registrars &
Medical Assistants

Nurses & Care Managers

Data & Analytics Teams

Community Health Workers

Population Health Team

Kaweah Health

Quality Improvement Initiatives

1. **Supplemental Data Uploads:** Ongoing by Gaps in Care (GIC) team & Pop Health in Cozeva from Cerner MILN (18 measures)
2. **Supplemental Flat File Submission:** Captures values not submitted on claims; sent monthly by ISS Business Development
3. **CPTII Data Coding:** Population Health Data Team & Partnering with HIM (3 measures)
4. **External Document Scanning:** QA external document type scans project HIM & Population Health (3 measures)
5. **Cologuard HL7 Interface with Cerner:** go live August 2025
6. **Targeted QI Efforts**
   a. **Community Outreach Events:** Immunizations, Colorectal CA Screening, Diabetes Management, Medi-Cal Enrollment

   b. **Colorectal Cancer Screening:** Kits shipped to patients' home w/ Well App text messaging & phone reminders

Quality Improvement Initiatives

7. Communication Strategies

Sharing performance & targeted QI efforts Monthly Population Health Steering Committee, Clinic lead, RHC Manager, Medical Director & Provider Meetings; Quarterly Population Health Quality Meeting

8. IT Build Pending

a. Diabetic QuickVisits

b. Real Time QM Performance Dashboard (5 QM)

1. Controlling High Blood Pressure
2. Tobacco Screening and Cessation
3. Glycemic Status Assessments for Patients with Diabetes (GSD) A1c <9%
4. Influenza
5. HIV

c. Patient Advisories (Long Term)

Monthly Quality Meetings: Managed Care Plans (Anthem BC and HealthNet)

The pursuit of healthiness

CLINICAL QUALITY

Outstanding Health Outcomes (OHO)
QUALITY & PATIENT SAFETY PRIORITY

Healthcare Acquired Infection (HAI) Reduction

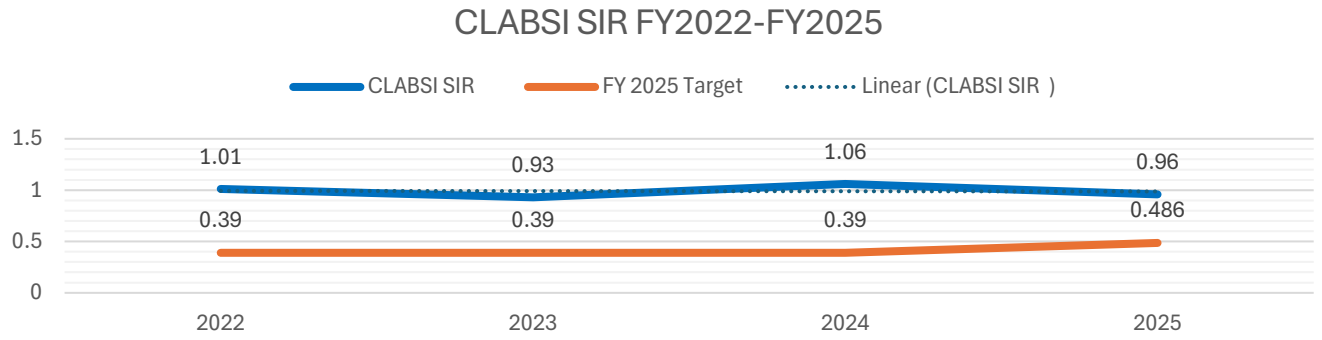
February 2026

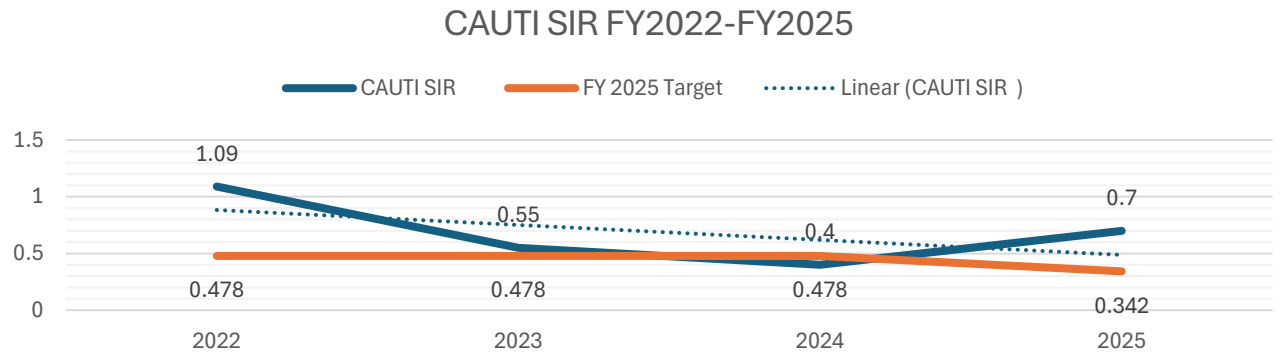
OHO FY26 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

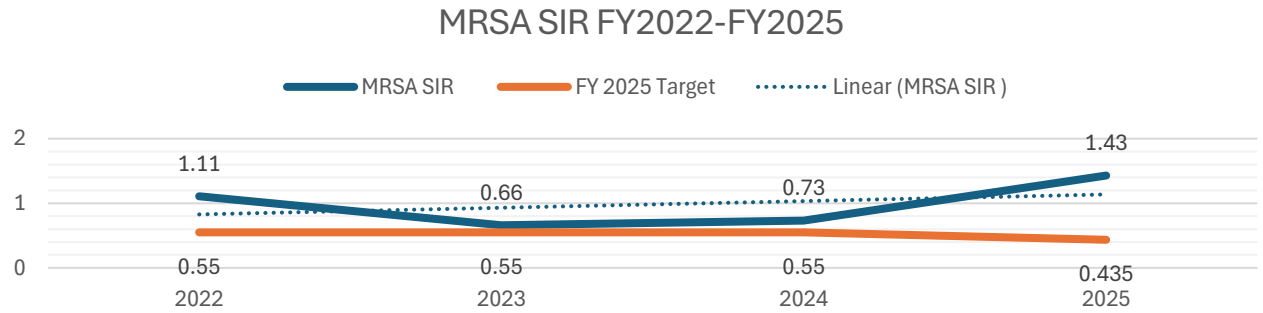
(number of actual infections/number of predicted infections by CMS)

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

Historical Baseline







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)

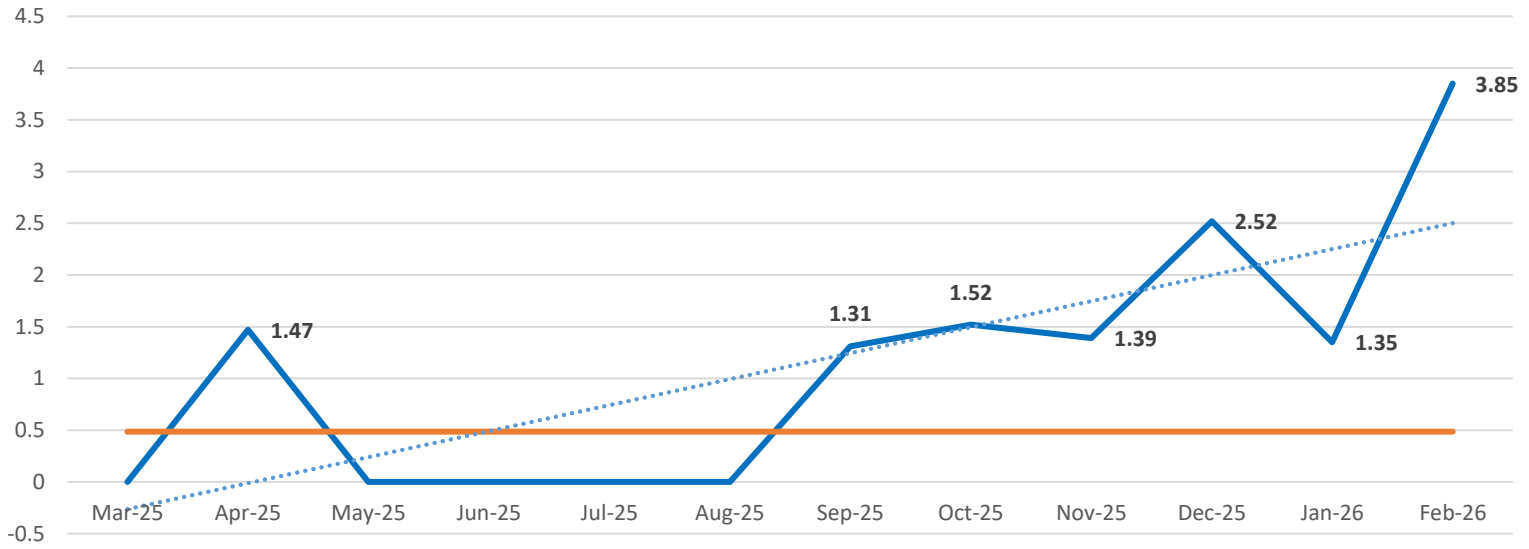
FY26 GOAL

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

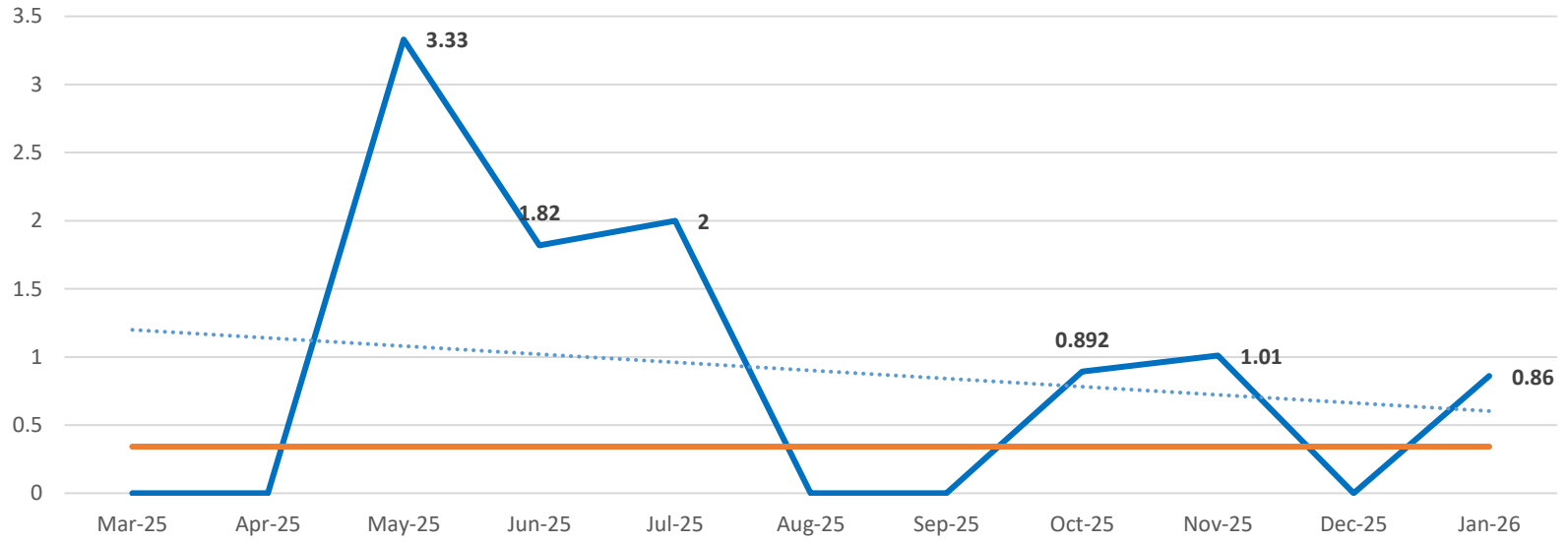


	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Total
CLABSI EVENTS	0	1	0	0	0	0	1	1	1	2	1	3	10
CLABSI Predicted	0.682	0.656	0.713	0.605	0.58	0.765	0.656	0.721	0.721	0.795	0.736	0.779	8.409
CLABSI SIR	0	1.47	0	0	0	0	1.31	1.52	1.39	2.52	1.35	3.85	1.19
CLABSI SIR Goal (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

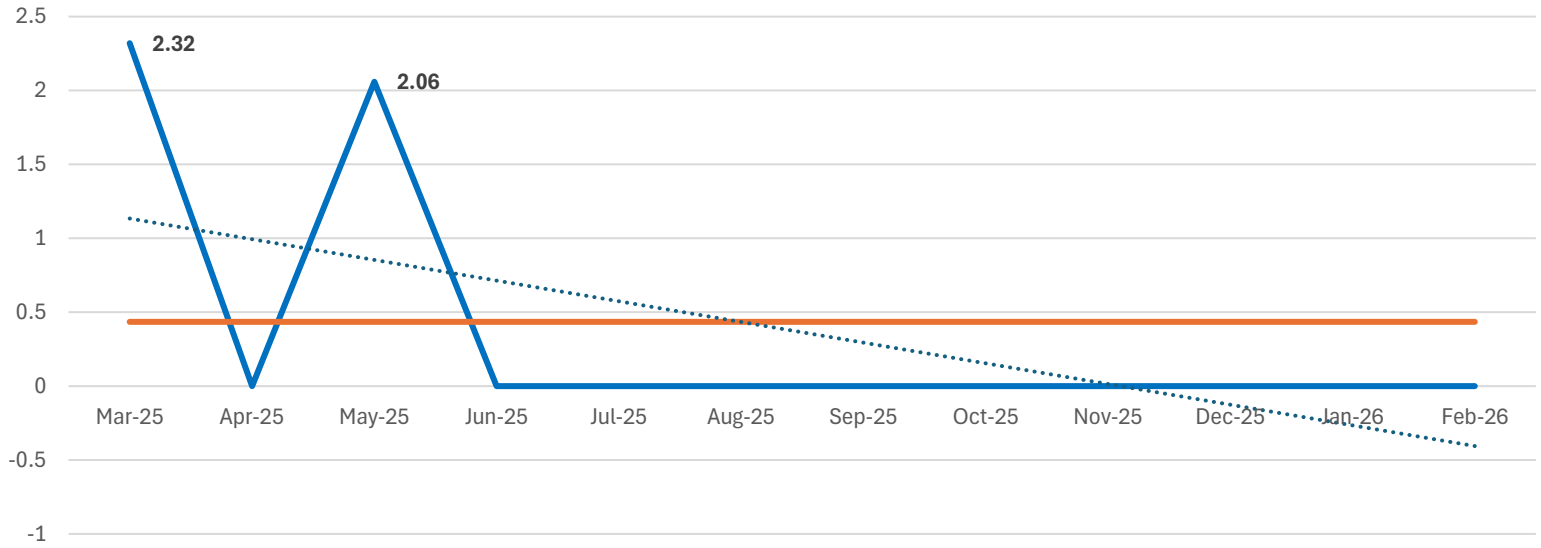


	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Total
CAUTI EVENTS	0	0	3	2	2	0	0	1	1	0	1	0	10
CAUTI Predicted	1.23	1.05	0.9	1.1	1	0.9	1.04	1.12	0.99	1.21	1.16	1.032	12.732
CAUTI SIR	0	0	3.33	1.82	2	0	0	0.892	1.01	0	0.86	0	0.79
CAUTI SIR Goal (70th percentile /top 30%)	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



	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
MRSA EVENTS	1	0	1	0	0	0	0	0	0	0	0	0	2
MRSA Predicted	0.43	0.47	0.49	0.48	0.4	0.39	0.36	0.253	0.26	0.286	0.302	0.302	4.423
MRSA SIR	2.32	0	2.06	0	0	0	0	0	0	0	0	0	0.45
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

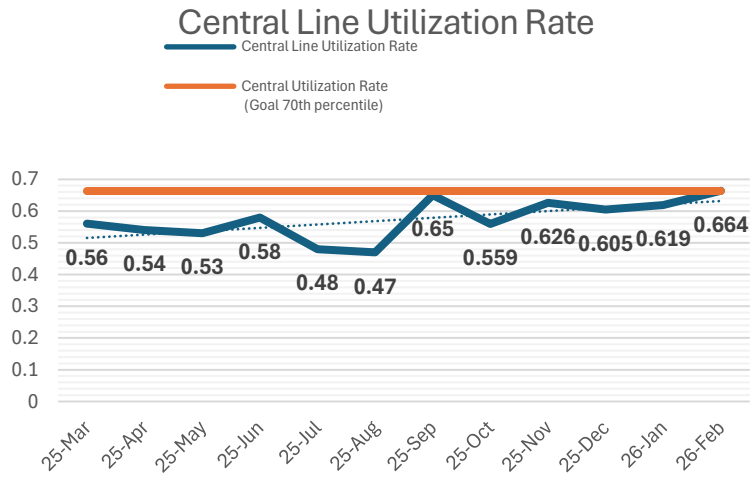
OHO FY26 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

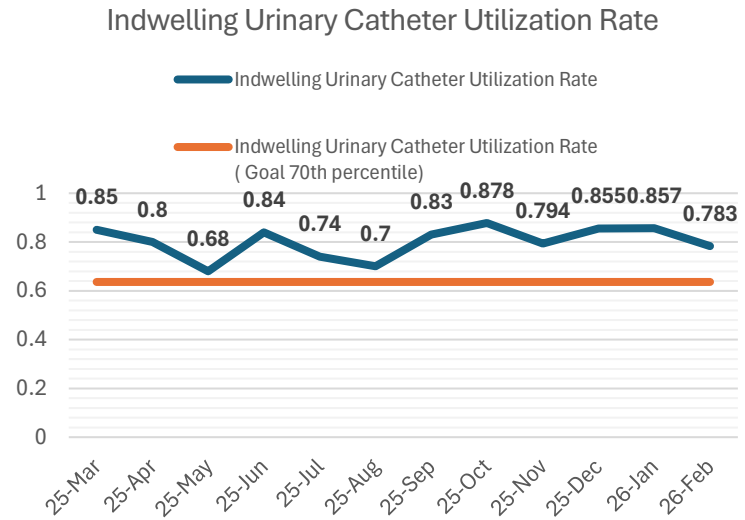
FY26 goals not met because:

- 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
  - Mar 2025 – Feb 2026 (SUR = 0.57)
  - Goal: reduce urinary catheter ratio to <0.64
  - Mar 2025 – Feb 2026 (SUR = 0.80)
- MRSA nasal and skin decolonization for patients with lines.
  - Goal: 100% of at-risk patients nasally decolonized
  - Mar 2025– Feb 2026 100% *(216 patients)* of screened patients nasally decolonized
  - Feb 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% Feb 2025 to Jan 2026 63% of staff are active users
  - HH Compliance rate overall 94.7%
  - 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 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

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 meting.
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

Live with passion.

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

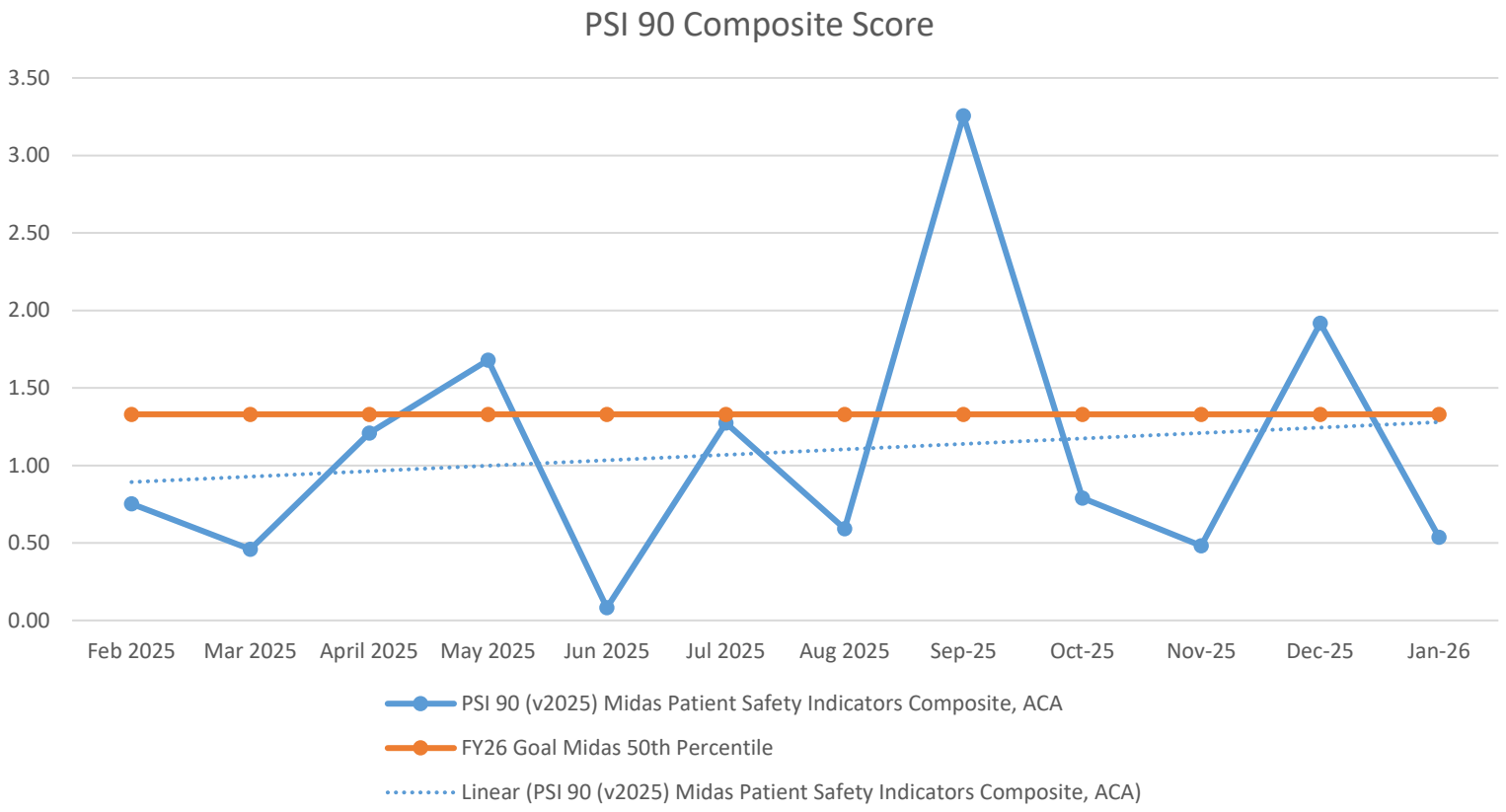
Kaweah Health

GOALS UPDATE

PATIENT SAFETY INDICATOR (PSI) 90 COMPOSITE

March 2026

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



FY26 PLAN – PSI 90

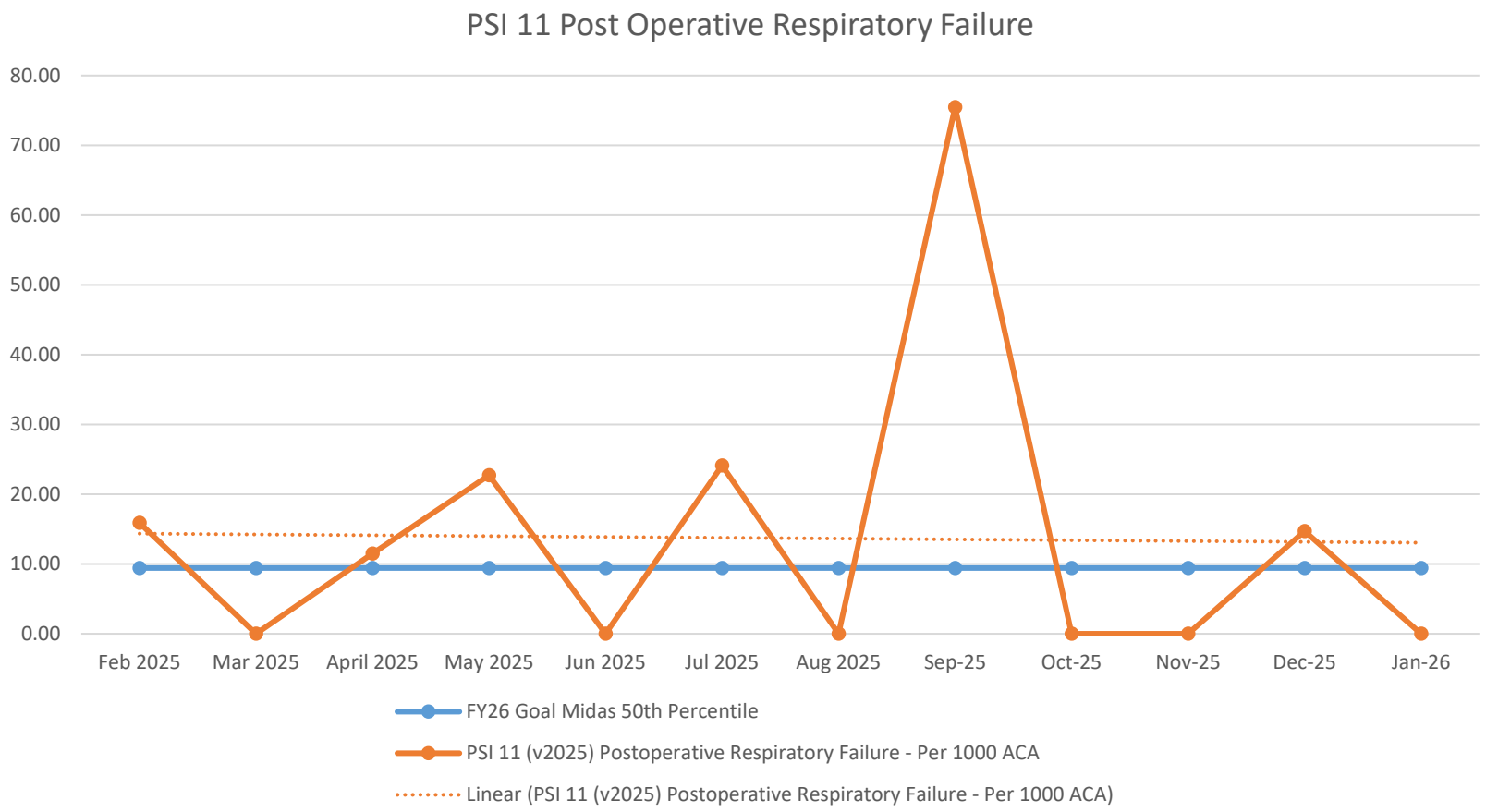
High Level Action Plan

- 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 = 1.316 (July 25 - Jan 26)**

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 = 13.807, July 25 – Jan 26 (n=7)

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

Kaweah Health
MORE THAN MEDICINE. LIFE.

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 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

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.