

Kaweah Delta Health Care District Board of Directors Meeting

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



DATE POSTED: May 15, 2026

NOTICE

Date: Thursday, May 21, 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/kaweahdeltahealthcaredistrictboardofdirectorsmeeting>

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

Armando Murrieta • Zone 5
Vice President

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

David Francis, 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:

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

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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, May 21, 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, May 21, 2026

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CLOSED SESSION – 8:01 AM

1. **CALL TO ORDER**
2. **REVIEW OF THE CLOSED MEETING MINUTES** – April 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 – *Melissa Quinonez, MSN, RN-BC, PHN, Risk Management Manager; Ben Cripps, Chief of Compliance.*
5. **ADJOURN CLOSED SESSION**

Thursday, May 21, 2026

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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 – April 16, 2026

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

5. SEPSIS QUALITY REPORT

Overview of performance and key quality outcomes related to the Sepsis Program. *Jared Cauthen, RN-Sepsis Coordinator*

6. EMERGENCY DEPARTMENT QUALITY REPORT

Overview of performance and key quality outcomes related to the emergency department quality metrics. *Cameron Beatty, Interim Director of Emergency and Trauma Services.*

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, May 21, 2026

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Agenda Posting and Public Records

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Vice President

Agenda item intentionally omitted

OPEN Quality Council Committee

Thursday, April 16, 2026

The Executive Office Conference Room

Attending: Board Members: Dr. Dean Levitan, Chair; Jonna Schengel, Board Member; Dr. Paul Stefanacci, Chief Medical Officer; Scott Baker, Interim Chief Nursing Officer; Kevin Morrison, Vice President of Support Services; Melissa Quinonez, Risk Management; Tom Boggs, Chief Ambulatory Officer; Marianne Barrinuevo, Director of Mental Health Services; Cheryl Smit, Stroke Program Manager; Shawn Elkin, Infection Prevention Manager; Megan Stuart, RN Clinical Care QA (Recording); Martha Cardenas, RN Clinical Care QA

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 March Quality Council Open Session Minutes** – Dr. Dean Levitan, Chair Board Member
 - Reviewed and acknowledged the March 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:
 - **Mental Health CMS Core Measures**
Report reviewed, accepted, and attached in minutes. No action taken.

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*
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. *Shawn Elkin, Infection Prevention Manager*; Patient Safety Indicator (PSI) 90 Composite deferred to next meeting due to time. Reports reviewed and attached to minutes.

Adjourn Open Meeting – *Dr. Dean Levitan*

Dean Levitan adjourned the meeting at 9:40 AM.

Quality and Patient Safety

Quality Council- Sepsis Report
May 21, 2026

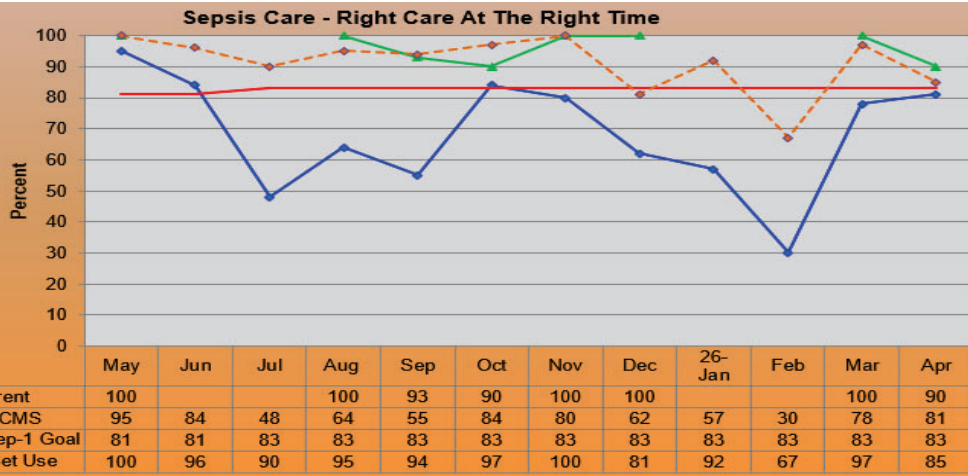
Jared Cauthen- Sepsis Coordinator



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Current Performance



Sepsis Quality Focus Dashboard

KEY >10% away from goal Within 10% of goal Within 5% of goal Outperforming/meeting goal

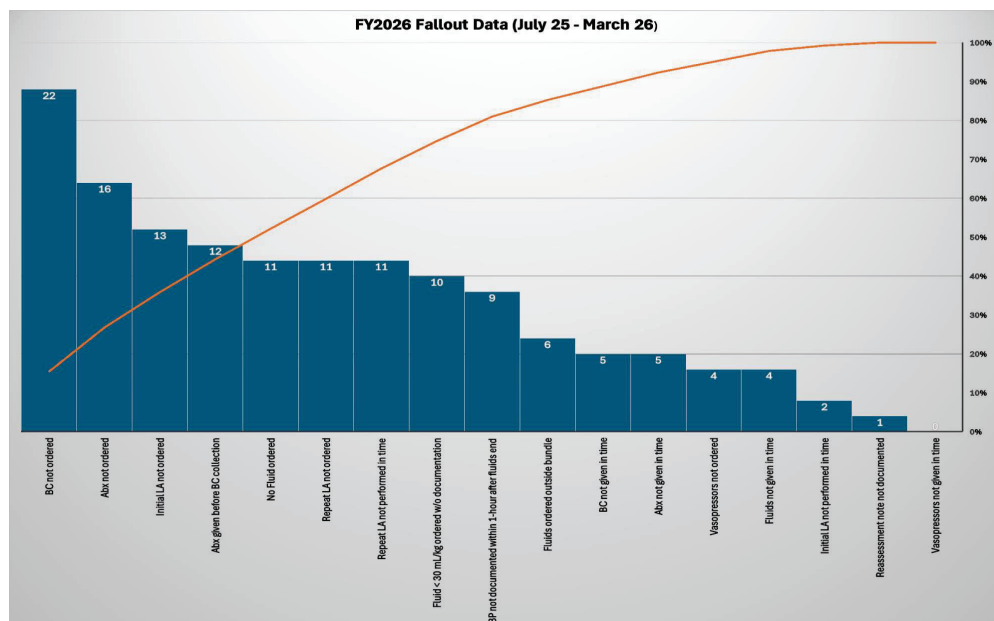
Goal	FY2023	FY2024	FY2025	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	YTD	
SEP-1 Bundle Elements															
3 hr SEP-1 Bundle % Compliance	95%	79%	79%	85%	52%	84%	68%	91%	80%	69%	59%	37%	81%	81%	70%
3hr SEP-1 Bundle Total Patients abstracted (d)	n/a	334	301	274	25	25	19	32	15	26	37	27	32	26	264
% Antibiotics administered	95%	94%	92%	93%	88%	96%	89%	97%	93%	92%	89%	74%	100%	92%	91%
% Blood Cultures drawn	95%	94%	93%	95%	77%	96%	82%	97%	86%	75%	88%	75%	94%	92%	86%
% Lactic Acid drawn	95%	98%	99%	99%	100%	91%	100%	100%	100%	100%	100%	93%	97%	100%	98%
% Fluid Resuscitation completed	95%	84%	91%	95%	69%	100%	90%	96%	100%	100%	64%	63%	67%	91%	84%
6 hr bundle % Compliance	95%	91%	91%	95%	85%	88%	80%	91%	100%	78%	95%	75%	93%	100%	88%
6hr SEP-1 Bundle Total Patients abstracted (d)	n/a	204	184	166	13	16	10	23	6	9	21	8	15	13	134
% Repeat LA drawn	95%	92%	95%	96%	92%	100%	80%	91%	100%	89%	95%	75%	93%	100%	92%
% Reassessment completed	95%	99%	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
% Vasopressors initiated when indicated	95%	100%	97%	100%	83%	82%	100%	100%	100%	89%	75%	100%	100%	100%	93%

25/53

Opportunities for Improvement

- **Top 80% of Fallouts (Greatest to Least)**

- 1) BC Not Ordered
- 2) Abx Not Ordered
- 3) Initial LA Not Ordered
- 4) Abx Administered Before BC Collection
- 5) Fluid Not Ordered
- 6) Repeat LA Not Ordered
- 7) Repeat LA Not Drawn In Timeframe
- 8) Fluid <30mL/kg Ordered w/o Documentation
- 9) BP Not Documented Within 1-Hour From Fluid End Time



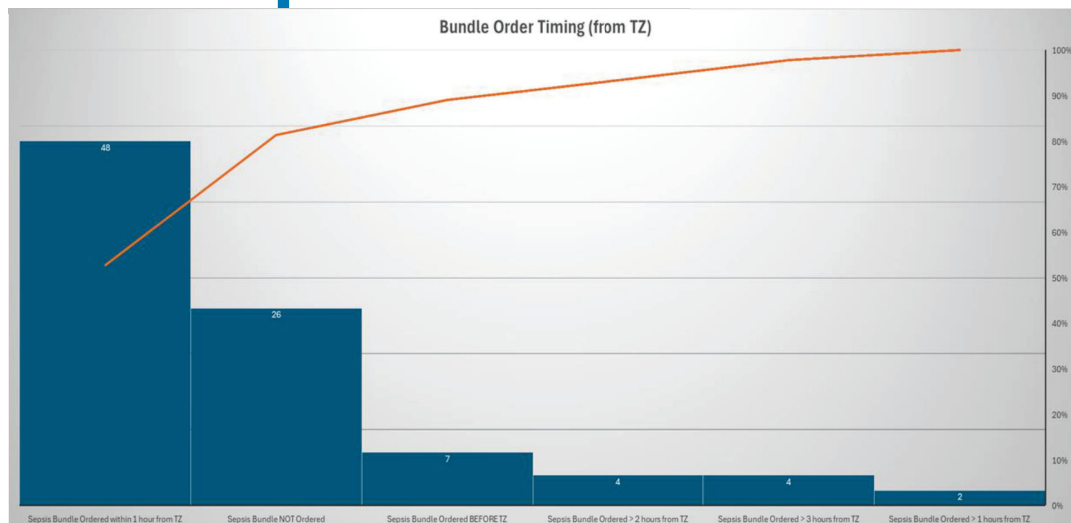
Opportunities for Improvement

Top 80% of Fallouts (Greatest to Least)

- 1) Sepsis Bundle Ordered Within 1-Hour From Time Zero (TZ)
- 2) Sepsis Bundle Not Ordered

Bottom 20% of Fallouts (Greatest to Least)

- 1) Sepsis Bundle Ordered Before TZ
- 2) Sepsis Bundle Ordered >2 Hours From TZ
- 3) Sepsis Bundle Ordered >3 Hours From TZ
- 4) Sepsis Bundle Ordered >1 Hour From TZ



Sepsis Quality Focus Dashboard

Order Set Usage

Total number of ED cases abstracted (CMS cases)	21	22	17	29	15	22	36	27	30	22	241			
Number of ED patients with sepsis order set use	19	21	16	29	15	19	33	18	29	22	221			
% of ED patients with order set used	85%		90%	90%	95%	94%	100%	100%	86%	92%	67%	97%	100%	92%
Total number of Inpatient cases abstracted	2	3	3	2	0	4	1	0	2	4	21			
Number of Inpatient cases with sepsis order set	1	1	1	1	0	2	1	0	2	0	9			
% of inpatient with order set used	50%	33%	33%	50%	0%	50%	100%	0%	100%	0%	43%			

Goal	FY2023	FY2024	FY2025	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	YTD
Total number of ED cases abstracted (CMS cases)				21	22	17	29	15	22	36	27	30	22	241
Number of ED patients with sepsis order set use				19	21	16	29	15	19	33	18	29	22	221
% of ED patients with order set used	85%		90%	90%	95%	94%	100%	100%	86%	92%	67%	97%	100%	92%
Total number of Inpatient cases abstracted				2	3	3	2	0	4	1	0	2	4	21
Number of Inpatient cases with sepsis order set				1	1	1	1	0	2	1	0	2	0	9
% of inpatient with order set used				50%	33%	33%	50%	0%	50%	100%	0%	100%	0%	43%

KEY	>10% away from goal	Within 10% of goal	Within 5% of goal	Outperforming/meeting goal
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Action Plan

Provider/Resident Focus

- GME Resident Education in March (and quarterly)
- March meeting with Chief Residents discussing Jan/Feb performance
- Handoff Plan for new Chief resident expectations scheduled week before graduation
- Improve Resident oversight (ED & Inpatient) with Vituity, FHCN, and Valley Hospitalists
- Improve inpatient Provider buy-in with Dr. Said

Order Set Focus

- Reduce deviation from order set
- ISS: Create flagged sections
- Fluid resuscitation: Change default order to 1L bolus
- ED Provider alert to declare or refute sepsis prior to inpatient transfer

ED Code Sepsis Project

- Dedicated room(s) to treat septic patients to ensure timely completion
- Overhead page to alert all providers/staff and room location
- Expand RRT Team to respond to ED sepsis alerts
- Nurse task list priority for septic patients
- Scan order for blood cultures and antibiotics

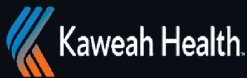
Accomplishments

FY2025 Year-End Accomplishments:

- Sepsis compliance at KH has successfully surpassed its improvement threshold compared to FY2023.
- All patients with a principal/secondary sepsis diagnosis received an antibiotic during their LOS.
- 27% of ED septic patients received full treatment within 1-hour of first suspicion (top 10%).
- 30% of ED septic patients received an antibiotic within 1-hour of first suspicion (top 20%).
- Met FY goal of 81% for CMS Sep-1 compliance (82%).
- **5 lives saved**

FY2026 Accomplishments (July 25-Current):

- All patients with a principal/secondary sepsis diagnosis received an antibiotic during their LOS.
- 3x increase in GME education involvement
- 56% of ED septic patients received full treatment within 1-hour of first suspicion (top 1%).
- 65% of ED septic patients received an antibiotic within 1-hour of first suspicion (top 1%).
- **16 lives saved**



Sepsis Quality Focus Team Dashboard

	FY26 Goal	FY2023	FY2024	FY2025	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	YTD
Sepsis Any Diagnosis - Observed/Expeded (o/e) Ratio	≤0.61	1.12	0.97	0.96	0.77	0.67	0.80	0.92	0.90	1.23	0.71	0.96	0.84		0.84
Number of Observed Mortality (N)	n/a	140	137	126	8	7	9	11	9	7	11	10	15		87
Total number Expeded Mortality (D)	n/a	125	140.63	131.17	10.44	10.37	11.26	11.98	10.01	5.69	15.52	10.40	17.7609		103.44
Sepsis Any Diagnosis - Volume	n/a	657	530	514	37	34	38	50	34	34	48	40	44		359
KEY		>30% away from goal				Within 20% of goal			Within 10% of goal				Outperforming/meeting goal		

Questions?



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QUALITY COMMITTEE REPORT

Emergency Department Quality Report

Cameron M. Beatty, DNP, MBA, RN, NEA-BC, CEN
Interim Director of Emergency, Trauma, and Obs Services

May 2026

Refer to ED SBAR Reports, ED Kaizen Reports in QComm, and Patient Safety Committee Reports for detailed historical project information Pre Oct 2024.

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ED Quality Report: Monitoring of Moderate/High Risk for Suicide

Kaweah Health MORE THAN MEDICINE. LIFE.		Suicide Risk Daily Compliance Surveillance Data											
		*Non-compliance is corrected in the moment during daily rounds, or risk is mitigated by implementing strategies per PC.26											
		ED											
Question	Goal	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
1. All: initial C-SSRS done per policy	100%	100% 35/35	100% 11/11	100% 24/24	100% 10/10	100% 11/11	100% 23/23	100% 1/1	** see footnote	100% 6/6	no data	100% 23/23	
2. All: C-SSR done each shift	100%	100% 35/35	100% 11/11	100% 24/24	100% 11/11	100% 11/11	100% 23/23	100% 1/1	** see footnote	100% 6/6	no data	100% 23/23	
3. All: Patient has teal armband on	100%	100% 35/35	100% 11/11	100% 24/24	100% 11/11	90.90% 10/11	100% 23/23	100% 1/1	** see footnote	100% 6/6	no data	100% 22/22	
4a. Mod/High: Patient monitored per policy (Mod-tele sitter, High-1:1 sitter)	100%	100% 35/35	100% 11/11	100% 24/24	100% 11/11	100% 11/11	100% 23/23	100% 1/1	** see footnote	100% 6/6	no data	100% 23/23	
4b. Mod/High: Patients without a Sitter- volume													
5. High: 1:1 sitter has panic alarm	100%	100% 35/35	90.90% 10/11	100% 24/24	100% 11/11	81.82% 9/11	100% 23/23	100% 1/1	** see footnote	100% 6/6	no data	100% 23/23	
6. High: 1:1 sitter is within appropriate distance to patient and actively observing, not distracted	100%	100% 35/35	100% 11/11	100% 24/24	100% 11/11	100% 11/11	100% 23/23	100% 1/1	** see footnote	100% 6/6	no data	100% 23/23	
7. High: Sitter is aware of patient's hands and heal at all times	100%	100% 35/35	100% 11/11	100% 24/24	100% 11/11	100% 11/11	100% 23/23	100% 1/1	** see footnote	100% 6/6	no data	100% 23/23	
Key		not meeting goal/benchmark		meeting goal/benchmark									
		N/C=No Cases											

** Footnote: "An interruption in the data aggregation and analysis process related to suicide risk monitoring was identified. The change in nursing leadership responsible for this oversight experience disruption. Importantly, suicide screening and management workflows remained generally in place clinically and our initial review has not identified patient harm. We have reassigned accountability, resumed data collection, and initiated focused analysis of fallouts" **

ED Quality Report: Monitoring of Moderate/High Risk for Suicide

- **Current Status**
 - April 2026 data collection and aggregation now stable and reliable
 - 20+ audits completed in April with high compliance observed
- **Goal**
 - Achieve and sustain 100% compliance for all moderate/high-risk suicide patients by June 2026
- **Corrective Actions Implemented**
 - Audit process added to daily ED leader standard work (Apr. 2026)
 - Daily audits initiated to improve capture and compliance monitoring
 - Immediate 1:1 coaching provided for identified fallouts

ED Quality Report: OB Chart Audits

- **Deficiency Identified**
 - CMS citation related to incomplete ED documentation of bleeding and pain assessments for OB patients
- **Key Opportunities**
 - Improve consistency of documentation practices during triage and reassessment workflows
 - Non-compliance attributed to individual practice and/or lack of understanding
- **Corrective Actions**
 - Retrospective audits initiated 2/10/26 per accepted Plan of Correction
 - Goal established for 60 audits/month or 100% of qualifying cases
 - Re-education completed for ED nursing staff
 - Individual feedback/coaching provided for identified documentation fallouts

	Total Charts Audited	Compliant	Not Compliant	Percentage
Feb 26'	35	32	3	91.4%
Mar 26'	60	49	11	81.7%
Apr 26'	39	36	3	92.3%

ED Quality Report: ESI 2 Patient Vital Sign (VS) Monitoring

- **Background**
 - ESI level-2 patients are high acuity and require timely reassessment and vital sign monitoring.
- **Key Findings**
 - Respiratory rate documentation is the most common fallout
 - BP and HR compliance averaging 70–80%
 - Improvement noted in March following focused interventions
- **Corrective Actions**
 - Policy revised to align with national standards
 - Expectations reinforced during shift huddles
 - Real-time coaching implemented for identified fallouts
 - Ongoing audits focused on reassessment compliance
- **Goal**
 - Achieve $\geq 75\%$ compliance by July 2026

Date	Charts Audited	Charts Compliant	Charts Not-Compliant	Percentage of Compliant Charts
Jan. 26'	50	22	28	44%
Feb. 26'	50	19	31	38%
Mar. 26'	50	35	15	70%
Q1 26'	150	76	74	49%

ED Quality Report: Suicide/Self-harm assessment on all patients 12yr<

- **Background**

- Universal suicide/self-harm screening for patients age 12 and older is required and supports patient safety and accreditation standards.

- **Current State**

- Screening compliance remains consistently high across audited charts
- Limited fallouts identified, primarily related to individual documentation practice

- **Corrective Actions**

- Continued audit and monitoring process
- Real-time coaching for identified fallouts
- Reinforcement of triage screening expectations and workflow accountability

- **Goal**

- Sustain 100% screening compliance at triage

Month	# of charts audited	# of compliant charts	# of non-compliant charts	Successful
Jan 26'	67	66	1	98.5%
Feb 26'	50	46	4	92.0%
Mar 26'	50	49	1	98.0%
Q1 26'	167	161	6	96.4%

Other Ongoing ED Quality Initiatives

OTHER ONGOING IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
Left During Treatment (LDT) / AMA Rates: These also decreased to an all-time low of only 3% and 1% , respectively.	On-Going	Continue monitoring rates along with LWBS rates.
Development of an internal Standard Metrics Scorecard	June 26'	Creating an internal scorecard that doesn't currently exist with the metrics that matter
Improve TAT-D turnaround times from 290 min to 240 min median.	On-Going	New flow and process with discharge patients.

Thank you

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Outstanding Health Outcomes (OHO) QUALITY & PATIENT SAFETY PRIORITY

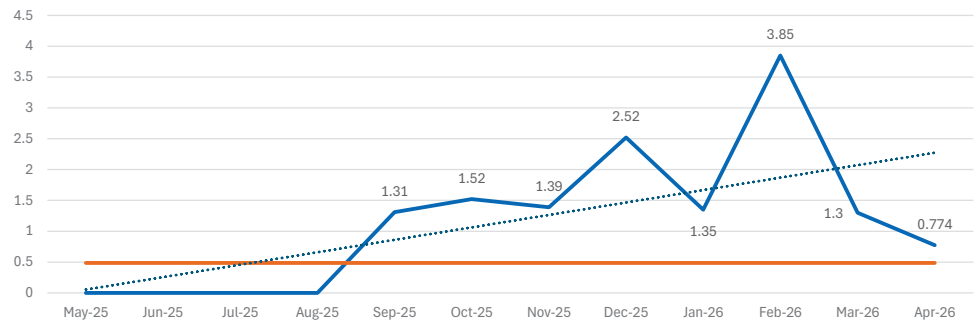
Healthcare Acquired Infection (HAI) Reduction

April 2026

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

CLABSI Prevention Interventions:

- Providers made aware of avoiding femoral vessel cannulation (formalizing process)
- CHG bathing for patients with central lines
- Hand Hygiene monitoring
- Developing a structured algorithm for ordering blood cultures (e.g., repeat/serial cultures, ID consultation, limiting panculture).
- Limiting 'open system' blood specimen collection from central lines
- Revisiting central line insertion procedure with third party oversight

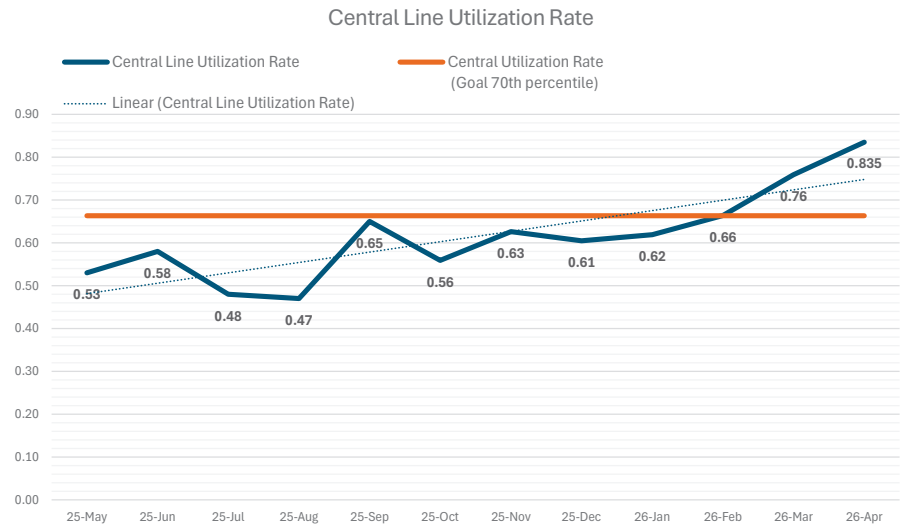


	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	Total
CLABSI EVENTS	0	0	0	0	1	1	1	2	1	3	1	1	11
CLABSI Predicted	0.713	0.605	0.58	0.765	0.656	0.721	0.721	0.795	0.736	0.779	0.769	1.39	9.23
CLABSI SIR	0	0	0	0	1.31	1.52	1.39	2.52	1.35	3.85	1.3	0.774	1.19
CLABSI SIR Goal (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)

Reduction in Central Line Utilization Interventions:

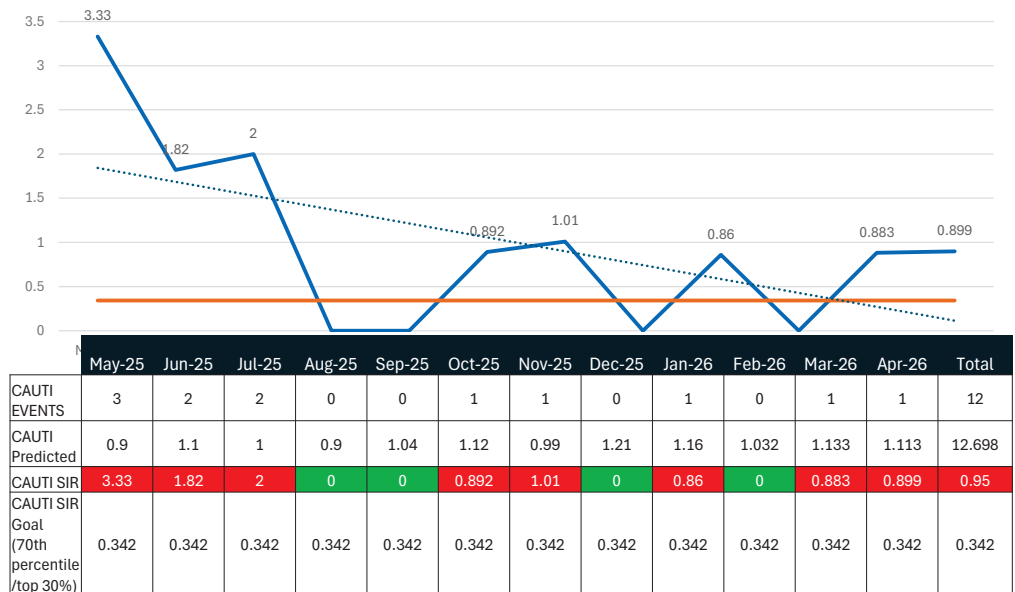
- Device rounds performed by Charge Nurses and Infection Prevention to determine device indication and emphasize removal (dynamic report under development).
- Emphasizing use of the proper central venous catheter device for the given indication
- Encouraging removal of central venous catheters prior to transfer to a medical/surgical unit



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

CAUTI Prevention Interventions:

- Developing a structured algorithm for ordering urine cultures, including specimen collection practices.
- Developing protocols for nursing, emphasizing interventions used to avoid inserting an indwelling urinary catheter (e.g., hydration, mobility, bladder training with I&O cath)
- Working with ISS to modify EMR enabling accurate documentation of straight cath and bladder scanning interventions
- Ensuring that nursing competency for indwelling urinary catheter insertion is performed upon hire and as needed when improper insertion practice is determined to be the source of a CAUTI event
- Hand Hygiene monitoring

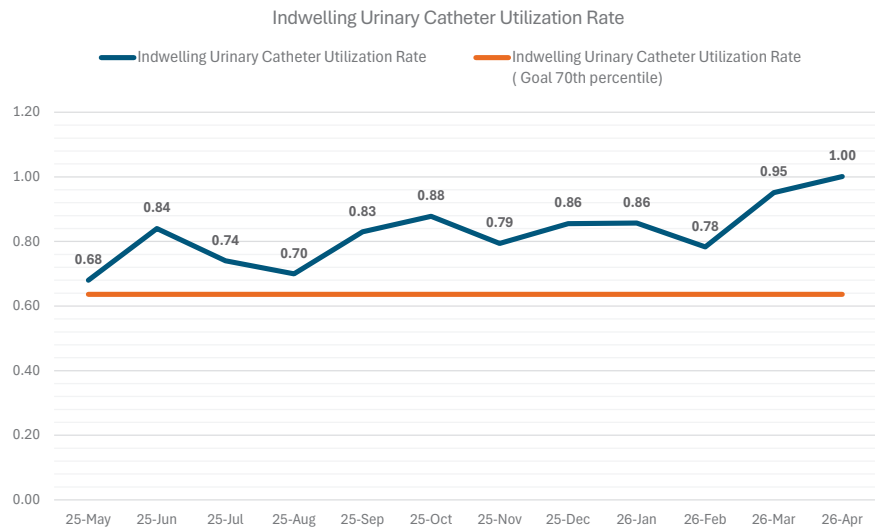


	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	Total
CAUTI EVENTS	3	2	2	0	0	1	1	0	1	0	1	1	12
CAUTI Predicted	0.9	1.1	1	0.9	1.04	1.12	0.99	1.21	1.16	1.032	1.133	1.113	12.698
CAUTI SIR	3.33	1.82	2	0	0	0.892	1.01	0	0.86	0	0.883	0.899	0.95
CAUTI SIR Goal (70th percentile /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)

Reduction in Indwelling Urinary Catheter Utilization Interventions:

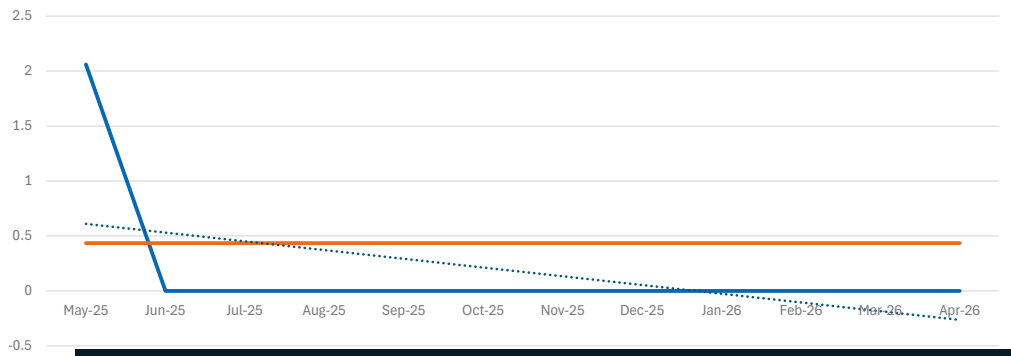
- Device rounds performed by Charge Nurses and Infection Prevention to determine device indication and emphasize removal (dynamic report under development)
- Devising PowerPlan(s) that emphasize alternatives to indwelling urinary catheters (e.g., external urinary collection devices)
- Developing protocols for nursing emphasizing Nurse Driven Protocol, Bladder Management, inclusion/exclusion criteria, Straight Cath procedure, and other elements of urinary system management, in the process of complete revision with the goal to limit indwelling urinary catheter utilization.



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

MRSA Bloodstream Infection and Nasal Colonization Interventions:

- MRSA nasal and skin decolonization for patients with lines.
 - May 2025– April 2026 **100%** (223 patients) screened and treated for nasal colonization
 - Mar 2026 - Goal: **100%** of line patients have CHG bathing
- Hand Hygiene (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%**



	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	Total
MRSA EVENTS	1	0	0	0	0	0	0	0	0	0	0	0	1
MRSA Predicted	0.49	0.48	0.4	0.39	0.36	0.253	0.26	0.286	0.302	0.302	0.29	0.276	4.089
MRSA SIR	2.06	0	0	0	0	0	0	0	0	0	0	0	0.24
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

Thank you

Live with passion.

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



PATIENT SAFETY INDICATOR (PSI) 90 COMPOSITE

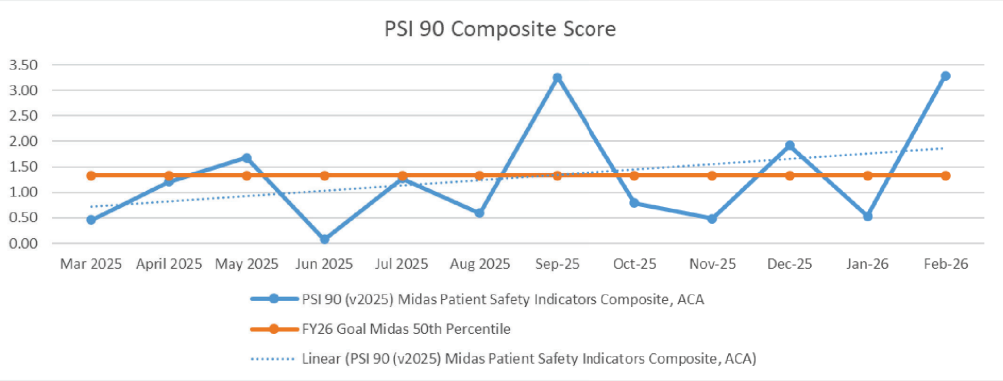
April 2026



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



FY26 PLAN – PSI 90

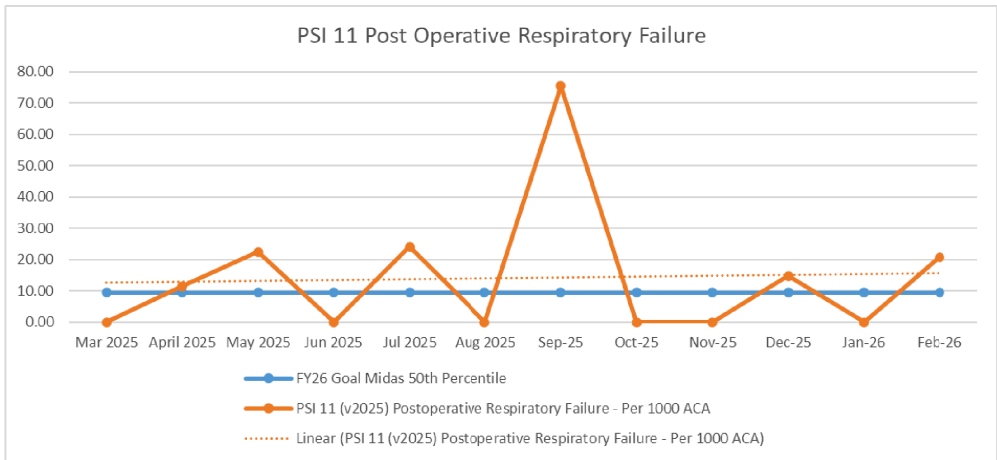
High Level Action Plan

- 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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