Kaweah Delta Health Care District
Board of Directors Meeting

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

Kaweah Health
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DATE POSTED: November 5, 2026

NOTICE

Date: Thursday, November 12, 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:

- **8:45 AM** – Open Session (to approve the Closed Session agenda)
- **9:15 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)
- **9:15 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	Jonna Schengel • Zone 2	Dean Levitan, MD • Zone 3	David Francis • Zone 4	Armando Murrieta • Zone 5
Board Member	Board Member	Secretary/Treasurer	President	Vice President

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, November 12, 2026 {Committee Meeting}

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OPEN SESSION (LIMITED PURPOSE – CONVENING ONLY) – 8:45 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**

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

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Board of Directors Meeting

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CLOSED SESSION – 8:46 AM

1. **CALL TO ORDER**

2. **REVIEW OF THE CLOSED MEETING MINUTES** – October 15, 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**

Mike Olmos • Zone 1 Board Member
Jonna Schengel • Zone 2 Board Member
Dean Levitan, MD • Zone 3 Secretary/Treasurer
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Kaweah Delta Health Care District
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OPEN SESSION – 9:15 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 –** October 15, 2026
   Possible reportable action - recommended for approval to the Regular Board Meeting

5. **MENTAL HEALTH QUALITY REPORT**
   A review of current performance and actions focused on the care of mental health patient population. *Melissa Quinonez, Director of Mental Services.*

6. **VALUE BASED PURCHASING**
   A review of completed and planned initiatives to identify and address Value Based Purchasing. *Farid Sheikh, Director of Quality & Patient Safety*.

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 Posting and Public Records
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Thursday, November 12, 2026

Mike Olmos • Zone 1	Jonna Schengel • Zone 2	Dean Levitan, MD • Zone 3	David Francis • Zone 4	Armando Murrieta • Zone 5
Board Member	Board Member	Secretary/Treasurer	President	Vice President

Agenda item intentionally omitted

4. 10.15.2026 Quality Council Open Session Meeting

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

Attending: Board Members: Dr. Dean Levitan, Chair; Dave Francis, 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; Jewel Crisan Calub, Chief Nursing Officer; Dr. Paul Stefanacci, CMO/CQO; Farid Sheikh, Director of Quality and Patient Safety; Luke Schneider, VP of Information Systems and Services; Christina Noel, Quality Data Abstractor I; Cheryl Smit, Stroke Manager; Amy Baker, Director of Specialty Clinics; Connie Green, Nurse Manager; Rhonda Quinones, Director of Maternal Child Health; Stephanie Genetti, Nurse Manager; Felicia Vaughn, Nurse Manager; Mara Lawson, Director of Nursing Practice Professional Development; 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 8:20 AM.

Open Session:

Public Participation – None.

Dr. Dean Levitan called to order at 8:30 AM.

4. **Review of September Quality Council Open Session Minutes –** Dr. Dean Levitan, Chair Board Member
    - Reviewed and acknowledged the September Quality Council Open Session Minutes by Dr. Dean Levitan.
5. **Maternal Child Health**
   A review of current performance and actions focused on the care of maternal child health patient population. Rhonda Quinones*, Director of Maternal Child Health; Stephanie Genetti, Nurse Manager; Daniel Castaneda, Nurse Manager; Felicia Vaughn, Nurse Manager.* Dr. Levitan has requested to discuss more on the Braden Score Criteria at next month meeting.
6. **Renal Service Quality Report**
   A review of key performance indicators and action associate with care of dialysis patient population. *Amy Baker, MSN, RN, Director of Specialty Clinics; Connie Green, Nurse Manager, Chronic Dialysis.* No actions taken.
7. **Clinical Quality Goals Update**
   A review of outstanding health outcomes initiatives for Safety in Nursing Practice and Safety Program Optimization. Mara Lawson, Director of Nursing Practice Professional Development. Cindy Vander Schuur, Patient Safety Manager. No actions taken.

Adjourn Open Meeting – *Dr. Dean Levitan*
Dean Levitan adjourned the meeting at 9:30 AM.

5. QCOMM-Mental Health-9-28-26

Mental Health Services

QComm Report
November 2026



Program Overview: Mental Health Services

- **Inpatient Operations**
- 63-bed licensed psychiatric facility
- Optimal ADC: 48–54 patients
- Serves patients with severe and complex mental health conditions
- Common diagnoses include psychosis, depression, bipolar disorder, schizophrenia, and co-occurring substance use
- **Consultation & Liaison (C&L)**
- Psychiatric coverage across the ED and acute care units
- 7 days/week | 7:00 a.m.–7:00 p.m.
- Multidisciplinary team of psychiatrists, residents, and APPs
- Provides psychiatric assessments, recommendations, and care plans

Quality Priorities

Goal:

Our goal is to elevate patient safety, safety culture, and clinical excellence by integrating trauma-informed safety practices, standardized suicide interventions, and high-impact therapeutic interactions that drive top-tier patient satisfaction.

Objectives:

Minimize Seclusion and Restraints: Implement proactive de-escalation strategies and trauma-informed care protocols to safely reduce restrictive interventions.

Standardize Suicide Prevention Protocols: Deliver targeted, evidence-based interventions and continuous monitoring for high-risk patients to ensure safety.

Exceed Patient Experience Benchmarks: Enhance clinical and therapeutic interactions to consistently surpass industry targets for the “symptoms/problems improved" metric.

Quality Initiatives:

1. Reduce Restrictive Practices
2. Enhance Suicide Prevention
3. Optimize Patient Experience by restoring mental wellness

We are committed to delivering effective programming and a therapeutic environment that ensures safe, timely, and accessible care to empower our patients on their journey to recovery

Quality Initiative #1: Reduce Restrictive Practices

Kaweah Health

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

Metrics		CMS Benchmark	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Total
HBIPS-2a	Physical Restraint-Overall Rate - (hours/days)	0.31 / 0.29*	0.89	0.25	1.33	0.88	0.46	0.53	1.28	0.48	0.52	1.01	0.48	1.33	0.79
HBIPS-3a	Seclusion-Overall Rate -(hours/days)	0.35 / 0.36*	1.20	0.38	1.57	0.83	1.22	0.89	0.81	0.72	1.46	1.46	1.24	0.31	1.03
SUB-2	Alcohol Use Intervention Provided/Offered/Not offered	58.00% / 60.00%*	100% 8/8	88.89% 8/9	100% 4/4	83.33% 5/6	80.00% 8/10	100% 4/4	100% 4/4	100% 14/14	100% 7/7	100% 7/7	100% 12/12	100% 8/8	95.70% 89/93
SUB-2A	Alcohol Use Brief Intervention refused/declined	77.00% / 76.00%*	37.5% 3/8	44.44% 4/9	75.00% 3/4	50% 3/6	70% 7/10	50% 2/4	50% 2/4	85.71% 12/14	71.43% 5/7	71.43% 5/7	91.67% 11/12	75.00% 6/8	67.74% 63/93
SUB-3	Alcohol/Other Drug Use Tx provided/offerred at D/C	71.00% / 72.00%*	100% 19/19	100% 21/21	100% 14/14	91.43% 32/35	100% 31/31	100% 21/21	100% 23/23	100% 27/27	100% 30/30	93.75% 15/16	100% 20/20	95.65% 22/23	98.21% 275/280
SUB-3A	Alcohol/Other Drug Use Disorder Tx at D/C	61.00% / 59.00%*	100% 19/19	100% 21/21	100% 14/14	91.43% 32/35	100% 31/31	100% 21/21	100% 23/23	100% 27/27	100% 30/30	93.75% 15/16	100% 20/20	95.65% 22/23	98.21% 275/280
IMM-2	Influenza Immunization-screening for immunization status	77.00% / 81.00%*	N/C	100% 61/61	100% 51/51	100% 61/61	100% 64/64	100% 54/54	100% 57/57	N/C	N/C	N/C	N/C	N/C	100% 348/348
TOB-3	Tobacco Treatment Provided/Offered at Discharge Received or refused a prescription for FDA-approved cessation medication upon discharge.	57.00% / 58.00%*	52.17% 12/23	66.67% 18/27	39.13% 9/23	67.74% 21/31	50.00% 15/30	63.16% 12/19	60.00% 12/20	81.48% 22/27	90.48% 19/21	100% 14/14	92.00% 23/25	100% 19/19	70.25% 196/279
TOB-3A	Tobacco Treatment on discharge "Referred to outpatient counseling"	16.00% / 18.00%*	8.70% 2/23	0% 0/27	4.35% 1/23	6.45% 2/31	6.67% 2/30	0% 0/19	0% 0/20	11.11% 3/27	4.76% 1/21	0% 0/14	16.00% 4/25	5.26% 1/19	5.74% 16/279
CT-2	Care Transitions w/specified elements received by discharged patients	62.00% / 63.00%*	79.25% 42/53	85.25% 52/61	86.79% 46/53	76.56% 49/64	83.33% 55/66	80.70% 46/57	83.33% 50/60	84.48% 49/58	90.57% 48/53	84.91% 45/53	77.36% 41/53	79.24% 42/53	82.60% 565/684
SMD-1	Screening for Metabolic Disorders	80.00% / 82.00%*	94.29% 33/35	97.06% 33/34	97.5% 39/40	89.65% 26/29	84.21% 32/38	78.05% 32/41	93.48% 43/46	84.78% 39/46	92.5% 37/40	92.59% 25/27	90% 27/30	81.82% 27/33	88.86% 391/440

*updated benchmark effective Jun-26

Quality Initiative #1: Reduce Restrictive Practices

Current status: Goal Not Met

Opportunities for Improvement: An analysis of the trailing 12-month restraint data reveals a critical area for quality improvement. The hospital averaged an overall restraint rate of 0.79, underperforming against the CMS benchmark of 0.29. With rates spiking as high as 1.33 and falling below the threshold only once (0.25), these metrics underscore the urgent operational need for our primary quality initiative: deploying proactive de-escalation and trauma-informed care protocols to systematically and safely stabilize these numbers.

Quality Initiative #1: Reduce Restrictive Practices

Corrective Actions

Proactive Sensory Intervention: Promote utilizing sensory room proactively to manage anxiety before it escalates to a mechanical restraint crisis.

Early Escalation Huddles: Initiate immediate clinical huddles at the first sign of distress, prioritizing verbal de-escalation and comfort choices over mechanical intervention.

Early Medication Interventions: Utilizing agitation behavioral scale to administer prn medications when early signs of escalation are observed. Ensuring Riese hearings for involuntary medication administration are petitioned immediately for patients who are refusing ordered medications.

Verbal De-escalation Mock Events: Implement regular, hands-on simulated crisis drills to help staff practice real-time verbal de-escalation techniques under pressure.

Trauma-Informed Debriefs: Conduct formal reviews with staff and the patient within 24 hours of release to update their care plan and prevent recurrence.

Workplace Violence Committee Review: Analyze data from all mock and real events during monthly committee meetings to identify trends and uncover additional areas for quality improvement.

Optimize therapeutic group engagement: implementation of active, varied therapeutic groups that match patient needs. By scheduling high-interest activities during peak crisis hours and training staff to encourage attendance, we will keep patients safely engaged and regulated

Quality Initiative #2: Enhance Suicide Prevention

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Suicide Risk Daily Compliance Surveillance Data

*Non-compliance is corrected in the moment during daily rounds, or risk is mitigated by implementing strategies per MH 31.01

Overall-Acute Psych

Question	Goal	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
1. Columbia Full Assessment done on admission	100%	100% 36/36	100% 69/69	100% 28/28	100% 40/40	100% 75/75	100% 67/67	100% 36/36	100% 68/68	100% 77/77	100% 27/27	100% 50/50	100% 43/43
2. C-SSRS shift screen been done every shift (not required at admission)	100%	94.44% 34/36	100% 68/68	100% 26/26	100% 34/34	100% 75/75	97.5% 65/67	96.42% 27/28	98.41% 62/63	97.22% 70/72	100% 27/27	100% 50/50	100% 43/43
3. Room Sweeps completed each shift	100%	100% 36/36	100% 69/69	100% 28/28	100% 40/40	100% 75/75	100% 67/67	100% 36/36	100% 71/71	100% 77/77	100% 27/27	100% 51/51	100% 42/42
4. Pt monitored per policy (Q15 minute checks/ 1:1 if applicable)	100%	100% 35/35	100% 68/68	100% 28/28	100% 40/40	100% 75/75	100% 67/67	100% 36/36	100% 71/71	100% 77/77	100% 27/27	100% 51/51	100% 44/44
5. Order for No Sharps (no sharps located in patient room)	100%	100% 35/35	100% 69/69	100% 28/28	97.5% 39/40	100% 75/75	100% 67/67	100% 35/35	88.57% 62/70	100% 77/77	68.75% 11/16	82.14% 23/28	63.64% 28/44
6. Order for Safety Blanket (regular linen/curtains removed from room)	100%	100% 35/35	100% 69/69	100% 28/28	97.44% 38/39	100% 75/75	100% 67/67	100% 36/36	88.57% 62/70	100% 77/77	68.75% 11/16	82.14% 23/28	63.64% 28/44

Key: not meeting goal/benchmark | meeting goal/benchmark

N/C=No Cases

Current status: Goal Not Met

Opportunities for Improvement: Over the past year, staff demonstrated strong alignment with suicide prevention workflows, achieving an 98.66% average compliance rate for C-SSRS shift screenings and hitting the 100% target in seven separate months. Conversely, compliance for 'no sharps' and safety blanket orders averaged 89.97%, showing a sharp drop-off in the latter half of the year to a low of 63.64%. While screening processes are stable, standardizing the environment-of-care ordering process is a critical focus area to eliminate errors and return to a consistent 100% compliance rate."

Quality Initiative #2: Enhance Suicide Prevention

Corrective Actions

Just-in-Time Staff Counseling: Leaders conducting audit are to provide supportive leadership counseling in the moment for staff members with missed opportunity or non-compliant order to reinforce safety expectations and address knowledge gaps

Ordering Provider Reinforcement: Leaders are partnering with Medical Staff Director to conduct targeted education for physicians and advanced practice providers (APPs), reinforcing their responsibility to immediately enter required safety orders upon notification of a high/moderate-risk score.

Dual-Verification Shift Handoffs: Mandate that oncoming and outgoing nurses cross-reference the high-risk patient roster against active environment-of-care orders during every shift change.

Daily Audits & Huddle Reviews: Perform random daily safety audits on the floor, and actively review these results during staff meetings and daily huddles to transparently reinforce compliance goals.

Quality Initiative #3: Optimize Patient Experience

By Restoring Wellness

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Behavioral Health Patient Experience Dashboard

	Benchmark	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	YTD Average
Respondent n-size	TBD	57	36	38	33	25	17	66	35	38
PIX Behavioral Health Question										
Symptoms/problems have improved	73.5%	71.4%	83.30%	86.80%	84.8%	83.3%	77.8%	89.2%	83.3%	82.5%

Current status: Goal Met

Opportunities for Improvement: Over the last seven recorded months, the hospital consistently outperformed the 73.5% patient experience benchmark for the *"my symptoms/problems have improved"* metric, achieving an impressive average score of 82.2%. Aside from an initial dip in the first month (71.4%), the facility maintained strong, positive momentum, beating the target in 6 out of the 7 months and peaking at 89.2%.

Quality Initiative #3: Optimize Patient Experience By Restoring Wellness

Corrective Actions

Treatment Team Escalation: Review patients showing minimal symptom improvement during daily interdisciplinary treatment team meetings to dynamically modify care plans to patient-specific needs.

Proactive Patient Rounding: Bedside nurse hourly rounding to be completed to address patient discomforts before they escalate into negative reviews.

Daily Leader Rounding: Leaders to round on patients daily to build immediate rapport, capture live feedback, and project high-touch leadership presence.

Structured Group Therapy Implementation: Standardize and enforce consistent daily group therapy sessions designed to maximize patient engagement, reduce idle downtime, and directly train individuals in proactive self-care, symptom management, and safe coping skills.

Questions?



6. VBP 10.2026 QC Slide Deck FINAL

Value Based Purchasing

QComm Report
November 2026



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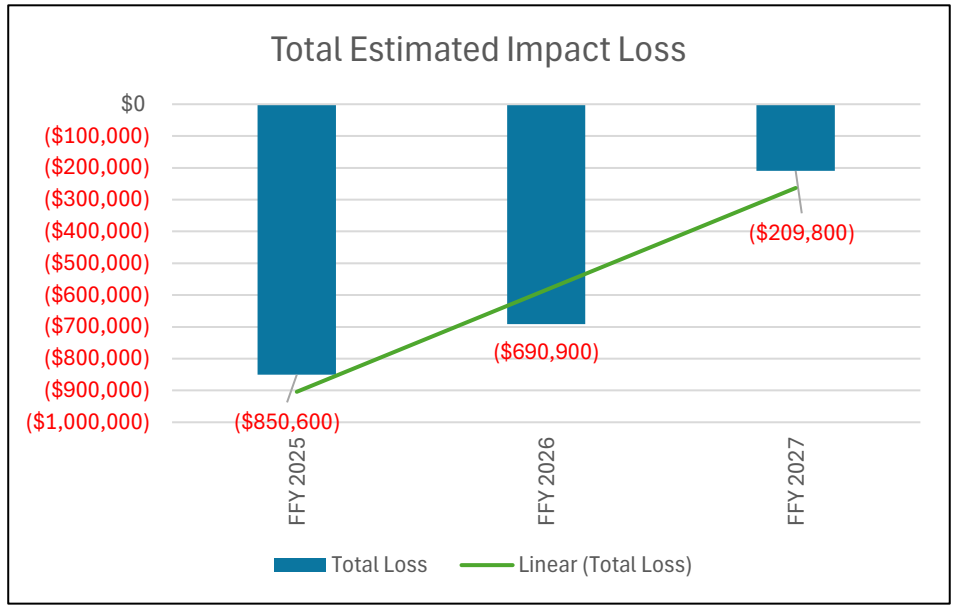
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CMS Hospital Value-Based Purchasing (VBP) Estimated Financial Impact – Kaweah Health

FY 2025 and FY 2026 Compared to Estimated FY 2027 Performance

Domain (25% weight each)	FY 2025 Impact	FY 2026 Impact	FY 2027 Estimated Impact
Person & Community Engagement HCAHPS and communication measures	($185,700)	($169,200)	($140,500)
Clinical Outcomes Mortality, complications, readmissions	($221,600)	($197,400)	($146,700)
Safety HAIs, CAUTI, CDI, CLABSI, MRSA, SSI	($42,100)	$84,600	$199,400
Efficiency Medicare spending per beneficiary (MSPB)	($401,200)	($408,900)	($122,000)
Total Estimated Impact	($850,600)	($690,900)	($209,800)

- Overall performance trends upward across most domains, particularly Safety
- Financial penalties decrease over time, especially in Engagement and Clinical Outcomes.
- Efficiency remains the largest driver of negative impact



Federal Fiscal Year 2027: Oct. 1, 2026 to Sept. 30, 2027
Federal Fiscal Year 2026: Oct. 1, 2025 to Sept. 30, 2026
Federal Fiscal Year 2025: Oct. 1, 2024 to Sept. 30, 2025

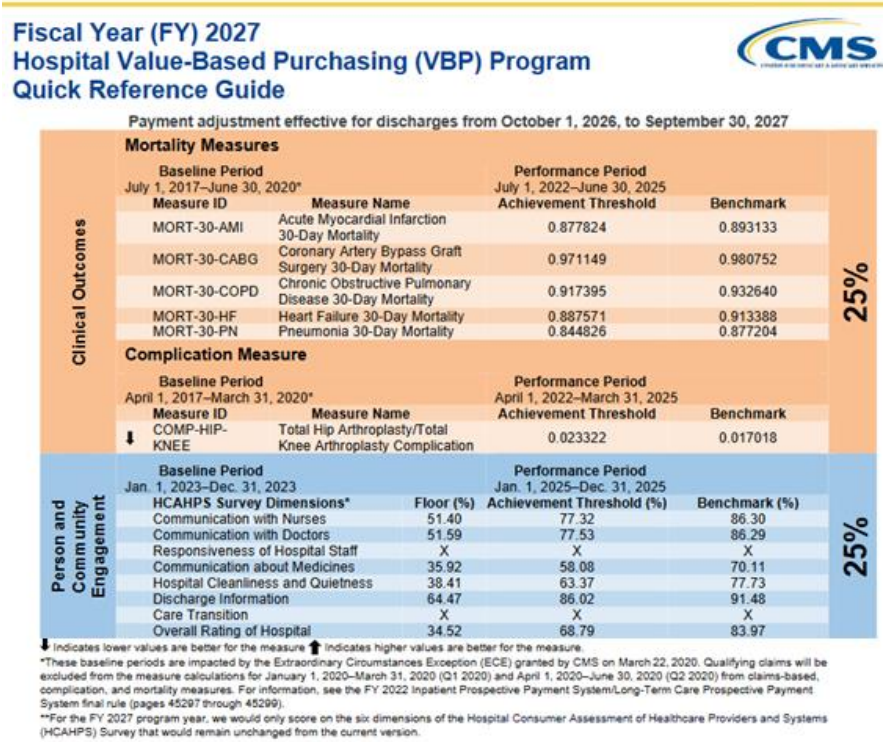
This analysis is intended to provide hospitals with a preview of the potential impact of the FFY 2027 Medicare inpatient hospital VBP program based on currently available quality data and program rules established by CMS.

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VBP Initiatives: Clinical Outcomes and Person and Community Engagement

Measure	Initiatives
Clinical Outcomes *25% of TPS* MORT-30: AMI, HF, CABG, COPD, PN COMP-HIP-KNEE (elective THA/TKA)	**Cardiology Mortality and Morbidity Committee (MORT-30-AMI, HF, CABG)** • Medical Directors review cases; the physician involved presents the case to the committee. • Committee identifies opportunities for improvement and evaluates process changes to improve care and outcomes. • Committee partners with service lines to implement improvements and standardize best practices. **Sepsis care (MORT-30-PN)** • The pneumonia mortality cohort includes patients with a principal diagnosis of sepsis (not severe sepsis) and pneumonia present on admission; ED Code Sepsis work (see Safety) supports this measure.
Person and Community Engagement *25% of TPS* HCAHPS (inpatient survey) Staff Responsiveness and Care Transition not scored FY27 to FY29	• Leaders are trained to access and interpret NRC feedback to support service recovery, identify trends, and drive improvement. • Patient Experience partners with leaders to strengthen inpatient rounding: guidance on effective practices, quality of each round, and validation and reporting to administration. • Education on Consistent Compassionate Communication using AIDET and HEARD. • Five Community Engagement groups meet monthly, bringing community members and hospital leaders together to co-design care and services.



Fiscal Year (FY) 2027
Hospital Value-Based Purchasing (VBP) Program
Quick Reference Guide

CMS

Payment adjustment effective for discharges from October 1, 2026, to September 30, 2027

Clinical Outcomes — 25%

Mortality Measures

Baseline Period: July 1, 2017–June 30, 2020*		Performance Period: July 1, 2022–June 30, 2025	
Measure ID	Measure Name	Achievement Threshold	Benchmark
MORT-30-AMI	Acute Myocardial Infarction 30-Day Mortality	0.877824	0.893133
MORT-30-CABG	Coronary Artery Bypass Graft Surgery 30-Day Mortality	0.971149	0.980752
MORT-30-COPD	Chronic Obstructive Pulmonary Disease 30-Day Mortality	0.917395	0.932640
MORT-30-HF	Heart Failure 30-Day Mortality	0.887571	0.913388
MORT-30-PN	Pneumonia 30-Day Mortality	0.844826	0.877204

Complication Measure

Baseline Period: April 1, 2017–March 31, 2020*		Performance Period: April 1, 2022–March 31, 2025	
Measure ID	Measure Name	Achievement Threshold	Benchmark
⬇ COMP-HIP-KNEE	Total Hip Arthroplasty/Total Knee Arthroplasty Complication	0.023322	0.017018

Person and Community Engagement — 25%

Baseline Period: Jan. 1, 2023–Dec. 31, 2023		Performance Period: Jan. 1, 2025–Dec. 31, 2025	
HCAHPS Survey Dimensions*	Floor (%)	Achievement Threshold (%)	Benchmark (%)
Communication with Nurses	51.40	77.32	86.30
Communication with Doctors	51.59	77.53	86.29
Responsiveness of Hospital Staff	X	X	X
Communication about Medicines	35.92	58.08	70.11
Hospital Cleanliness and Quietness	38.41	63.37	77.73
Discharge Information	64.47	86.02	91.48
Care Transition	X	X	X
Overall Rating of Hospital	34.52	68.79	83.97

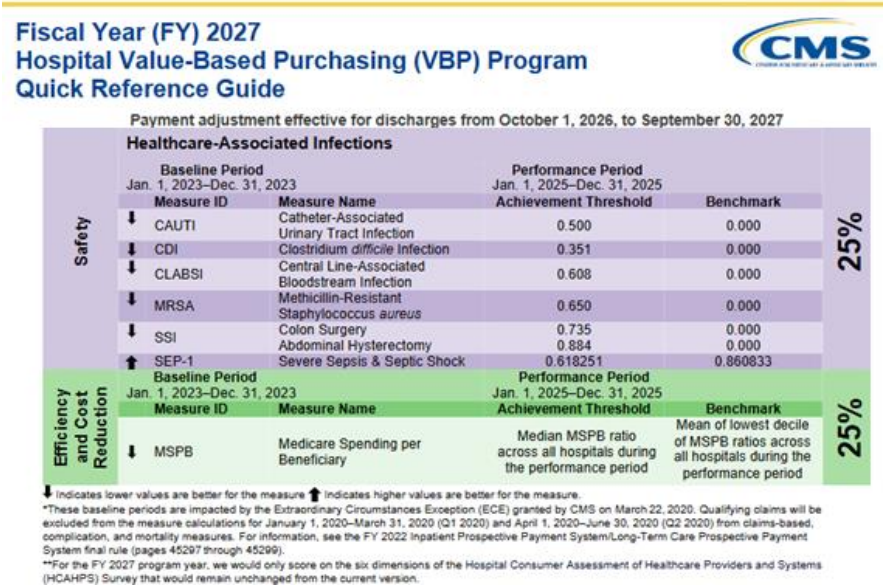
⬇ Indicates lower values are better for the measure ⬆ Indicates higher values are better for the measure.

*These baseline periods are impacted by the Extraordinary Circumstances Exception (ECE) granted by CMS on March 22, 2020. Qualifying claims will be excluded from the measure calculations for January 1, 2020–March 31, 2020 (Q1 2020) and April 1, 2020–June 30, 2020 (Q2 2020) from claims-based, complication, and mortality measures. For information, see the FY 2022 Inpatient Prospective Payment System/Long-Term Care Prospective Payment System final rule (pages 45297 through 45299).

**For the FY 2027 program year, we would only score on the six dimensions of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey that would remain unchanged from the current version.

VBP Initiatives: Safety and Efficiency and Cost Reduction

Measure	Initiatives
Safety *25% of TPS* CAUTI CDI CLABSI MRSA SSI (colon, abdominal hysterectomy) SEP-1	**Sepsis (SEP-1)** • Completed ED Code Sepsis Project with a dedicated two-bed sepsis room (ED Zone 5, Room 45). • Physician leadership for sepsis oversight established with Dr. Tu and the ED Chief Resident. **CAUTI** • Nurse-driven protocol and bladder management policies updated to narrow indwelling catheter indications. • Daily review of indwelling urinary catheters on inpatient units, with a goal of prompt removal. **CLABSI** • ICU/CVICU pilot of a central line insertion bundle: direct observation of insertion and completion of the CLIP document. • IV Safety Team (launched November): evidence-based insertion, management, and removal of vascular devices. **CDI (hospital-onset: hospital day 4 and beyond)** • Pursuing a required Infectious Disease consult for all C. difficile testing on hospital day 4 and beyond. • Moving testing from the GDH/EIA-NAAT algorithm to NAAT followed by toxin EIA, to better separate colonization from active infection. **SSI (colon and abdominal hysterectomy)** • Ensuring prophylactic antimicrobials are administered timely before incision. • Auditing sterilization and high-level disinfection so surgical instruments and equipment are safely reprocessed.
Efficiency and Cost Reduction *25% of TPS* Medicare Spending per Beneficiary (MSPB-1) Episode: 3 days before admission through 30 days after discharge	**Four levers within our control; evidence is strongest for structured transition models and for moving appropriate patients to lower-intensity settings.** • **Discharge destination:** Largest lever. Risk stratification, early discharge planning, patient and caregiver education, home health when safe; strict criteria-based placement into rehab or SNF. • **Referral patterns:** Preferred SNF network selected on length of stay, readmission rate, and cost per episode, with active hospital-SNF coordination. • **Transitions of care:** Transition coach support and continued patient contact after discharge. • **Follow-up access:** Follow-up appointment scheduled before discharge (within 7 days for high-risk patients, 14 days otherwise); missed appointments trigger same-day outreach.



Fiscal Year (FY) 2027
Hospital Value-Based Purchasing (VBP) Program
Quick Reference Guide

CMS

Payment adjustment effective for discharges from October 1, 2026, to September 30, 2027

Healthcare-Associated Infections — 25%

Safety

	Measure ID	Measure Name	Achievement Threshold	Benchmark
⬇	CAUTI	Catheter-Associated Urinary Tract Infection	0.500	0.000
⬇	CDI	Clostridium *difficile* Infection	0.351	0.000
⬇	CLABSI	Central Line-Associated Bloodstream Infection	0.608	0.000
⬇	MRSA	Methicillin-Resistant Staphylococcus *aureus*	0.650	0.000
⬇	SSI	Colon Surgery Abdominal Hysterectomy	0.735 0.884	0.000 0.000
⬆	SEP-1	Severe Sepsis & Septic Shock	0.618251	0.860833

Baseline Period: Jan. 1, 2023–Dec. 31, 2023 — Performance Period: Jan. 1, 2025–Dec. 31, 2025

Efficiency and Cost Reduction — 25%

	Measure ID	Measure Name	Achievement Threshold	Benchmark
⬇	MSPB	Medicare Spending per Beneficiary	Median MSPB ratio across all hospitals during the performance period	Mean of lowest decile of MSPB ratios across all hospitals during the performance period

Baseline Period: Jan. 1, 2023–Dec. 31, 2023 — Performance Period: Jan. 1, 2025–Dec. 31, 2025

⬇ Indicates lower values are better for the measure ⬆ Indicates higher values are better for the measure.

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Questions?



7. HAI OHO Quality Council

Outstanding Health Outcomes

Healthcare Acquired Infection

September 2026

Kaweah Health

MORE THAN MEDICINE. LIFE.

OHO FY2027

Reduce Hospital Acquired Infections / Champion: Shawn Elkin

Metric Description	Baseline	FYTD27	FY27 Goal
CLABSI SIR	FY 2026 – 1.64	1.43 (2 cases)	≤0.486 (NHSN 30th Percentile 2022)
C. diff SIR	FY 2026 – 1.34	0.564 (5 cases)	≤0.170 (NHSN 30th Percentile 2024)

Quality Initiatives:

1. CLABSI: 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

2. C. diff: 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

CLABSI and C. diff: FY2027 Key Actions

Central line-associated bloodstream infections (CLABSI) and Clostridioides difficile infections (C. diff)

Initiative 1

Reduce CLABSI

Complete

Review line necessity
IP reviews every central line twice weekly for appropriateness; above-median use flagged at the daily Safety Huddle

Limit femoral lines
Tracked daily until removal; units prompted to remove or replace for quicker transition to a safer access site

Standardize insertion
Residents trained on the insertion bundle in July; checklists tracked monthly and reviewed for every infection

Dedicated line care
IV Safety Team for dressing changes, PICCs, midlines and removal of unneeded lines; closed blood sampling in critical care

In progress

ICU trial of the CLIP form
Developing a Central Line Insertion Practices (CLIP) form to ensure standardized adherence to best-practice insertion techniques

Initiative 2

Reduce C. diff

Complete

Test early
Cultures and C. diff testing encouraged before hospital day 3, while infection still counts as present on admission

In progress

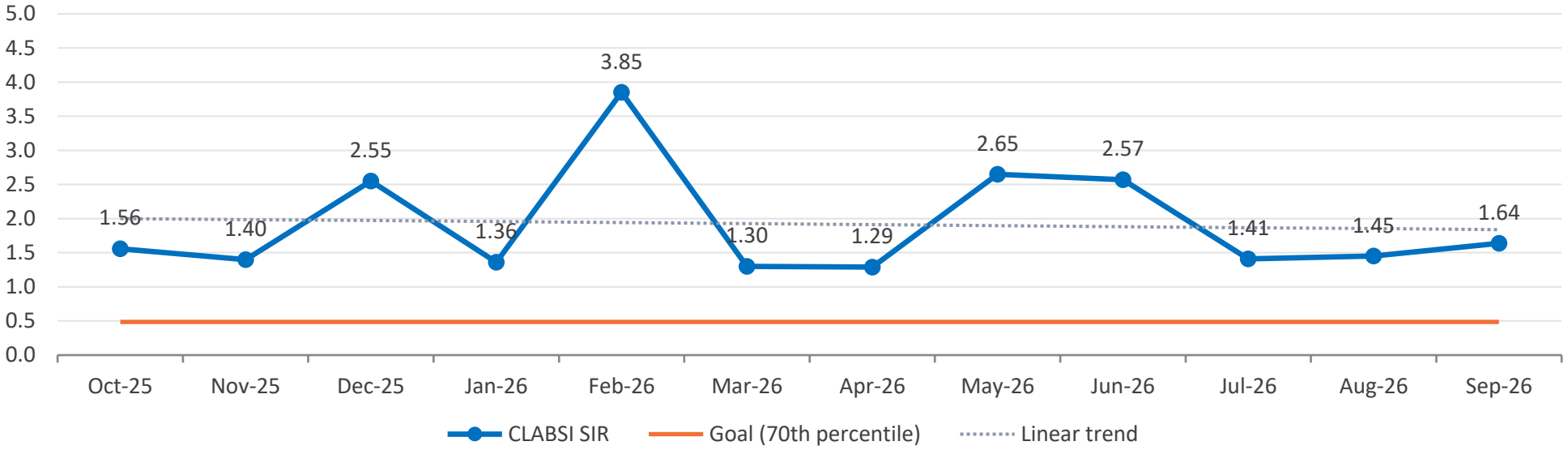
Test the right patients
Developing a workflow to require an Infectious Disease consult for C. diff testing on hospital day 4 or later

Two-step testing
Evaluating NAAT first, then toxin, to separate colonization from true infection

Antibiotic stewardship
Infection Prevention working with the ID physician and ID pharmacist on culturing and testing practices

CLABSI Events – Rolling 12-months

Hospital-wide standardized infection ratio (SIR), Oct 2025 to Sep 2026. Source: NHSN.



Rolling 12-month SIR

1.95

17 events / 8.739 predicted

Goal (70th percentile)

0.486

	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Total
CLABSI events	1	1	2	1	3	1	1	2	2	1	1	1	**17**
CLABSI predicted	0.640	0.712	0.785	0.736	0.779	0.769	0.774	0.755	0.778	0.711	0.689	0.611	**8.739**
CLABSI SIR	**1.56**	**1.40**	**2.55**	**1.36**	**3.85**	**1.30**	**1.29**	**2.65**	**2.57**	**1.41**	**1.45**	**1.64**	**1.95**

CLABSI

OHO FY27 Plan: Reduction of CLABSI

Opportunities for improvement identified in CLABSI case reviews

Insertion practices

- Skin antiseptic not allowed to dry before the procedure (2 events)
- Incomplete provider documentation, including undocumented multiple insertion attempts (3 events)
- Central line placed during a Code Blue, increasing contamination risk

Care and maintenance

- Hand hygiene deficiencies (5 events)
- CHG bath not documented or performed (4 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

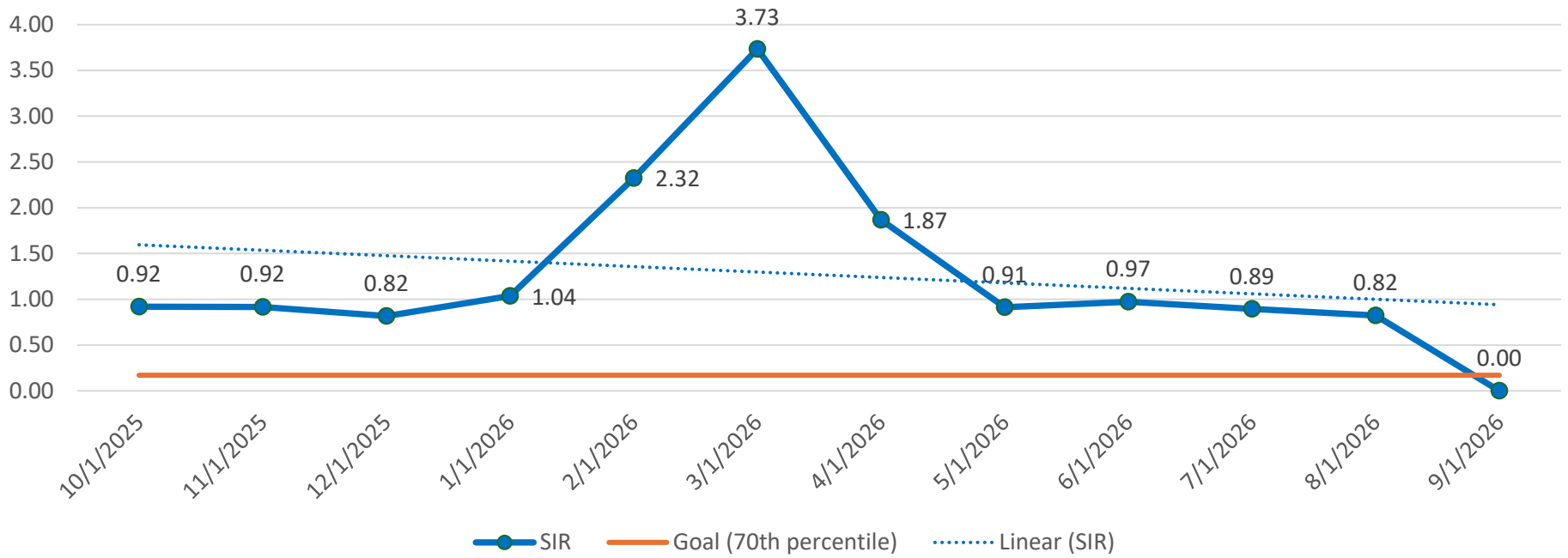
Reduction Initiatives for Central Line Associated Bloodstream Infections

Infection Prevention Improvement Initiatives = Gannt Chart

#	Improvement Initiative	Actions / Interventions	Start Date	Target Date	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27	Status
1	VAMP	Implement VAMP	Sept 2026	Oct 2026							Active
2	Blood culture line draws	No phlebotomy prompting nursing line draws for cultures.	Aug 2026	Aug 2026							Completed
3	BCID	Implement BCID	Aug 2026	End of Oct 2026							On Track
4	IV Safety Team CL/PIV review	Conduct IV Safety Team CL/PIV review	July 2026	Nov 2026							On Track
5	Hand Hygiene - montly top/bottom 5 performer reporting	Monthly QSOC meeting. Online Biovigil leadership meeting.	Mar 2026	Mar 2026							On Track
6	Careview vs CLO	Evaluate Careview vs. Clinical Leader Organizer	Oct 2026	Dec 2026							On Track
7	LTD w indication - IP driven	Implement LTD with indication (IP driven)	July 2026	Aug 2026							Completed
8	Unit based device review	Nursing leadership led unit rounds	Oct 2026	Nov 2026							On Track
9	CL Carts	Ensure efficiency through fully equiped line kits available in the line cart.	Oct 2026	Dec 2026							On Track
10	CLIP form - Nursing	Educate and enforce completion of CLIP form by nursing for CL insertions.	Oct 2026	Nov 2026							On Track
11	≤2-3 staff during CL insertion	Providers, Nursing, Allied Health Staff limited access to room during CL insertion.	Oct 2026	Nov 2026							On Track

C.diff Events – Rolling 12 months

Hospital-wide standardized infection ratio (SIR), Nov 2025 to Sep 2026. Source: NHSN



Rolling 12-month SIR

1.23

29 events / 23.63 predicted

Goal (70th percentile)

0.171

	25-Nov	25-Dec	26-Jan	26-Feb	26-Mar	26-Apr	26-May	26-Jun	26-Jul	26-Aug	26-Sep	Total
HO CDIFF events	2	2	4	7	4	2	2	2	2	2	0	**29**
HO CDIFF predicted	2.18	2.45	1.93	1.72	1.87	2.14	2.19	2.05	2.24	2.43	2.43	**23.63**
HO CDIFF SIR	**0.92**	**0.82**	**1.04**	**2.32**	**3.73**	**1.87**	**0.91**	**0.97**	**0.89**	**0.82**	**0**	**1.23**

C. DIFF

OHO FY27 Plan: Reduction of C. diff

Opportunities for improvement in testing practices identified in C. diff case reviews

4
events
Unnecessary or inappropriate C. difficile testing

4
events
Specimens collected late, 4 to 19 days after admission

3
events
Bowel regimen in place at time of testing

2
events
Post-operative tube feedings in place at time of testing

2
events
Testing ordered by Emergency Medicine and Surgical residents

Stool frequency before testing

Recorded bowel movements ranged from 2 stools over a 4-day period to 4 stools in one day.

Antibiotic exposure before testing

Patients received antimicrobial treatment for 0 to 14 days before C. difficile testing; poly-antimicrobial therapy was rare.

C. DIFF

Reduction Initiatives for Hospital-Onset C. diff

Culture optimization and antibiotic stewardship roadmap | Phase 2 is proposed

1 — 2

Complete

July 7, 2026

Initial planning completed

IP, ID physician, and ID pharmacist met to discuss culture optimization and antibiotic stewardship.

Proposed

October to November 2026

Implementation phase

- **Require ID consultation** and oversight for all C. difficile testing on hospital day 4 and beyond
- **Transition C. difficile testing** from the GDH-EIA-NAAT algorithm to NAAT followed by toxin EIA, to better separate colonization from active infection
- **Update the NHSN Annual Survey** to reflect the revised testing method