Kaweah Delta Health Care District
Board of Directors Meeting

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

Kaweah Health
MORE THAN MEDICINE. LIFE.

DATE POSTED: September 10, 2026

NOTICE

Date: Thursday, September 17, 2026
Location: Kaweah Health Medical Cetner – Executive Conference Room
Address: 305 W. Acequia Avenue, Visalia, California

Please join my meeting from your computer, tablet or smartphone.
https://meet.goto.com/KelsieD/kaweahdeltahealthcaredistrictboardofdirectorsmeeti
You can also dial in using your phone.
Access Code: 460-561-181
United States: +1 (646) 749-3122

SCHEDULE:

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

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

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

PUBLIC RECORDS:
Disclosable public records related to this agenda are available for public inspection at:
Kaweah Health Medical Center – Acequia Wing, Executive Offices (1st Floor)
400 West Mineral King Avenue, Visalia, CA 93291
You may also request records by contacting the Board Clerk at (559) 624-2330 or **kedavis@kaweahhealth.org**, or by visiting the District's website at **www.kaweahhealth.org**.

KAWEAH DELTA HEALTH CARE DISTRICT
David Francis, Secretary/Treasurer

Prepared by:

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

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

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, September 17, 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**

Kaweah Delta Health Care District
Board of Directors Meeting

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CLOSED SESSION – 8:01 AM

1. **CALL TO ORDER**

2. **REVIEW OF THE CLOSED MEETING MINUTES** – August 20, 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**

Kaweah Delta Health Care District
Board of Directors Meeting

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

1. **CALL TO ORDER**

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

3. **CLOSED SESSION ACTION TAKEN**
   Report on action(s) taken in closed session

4. **REVIEW OF OPEN SESSION MINUTES** – August 20, 2026
   Possible reportable action - recommended for approval to the Regular Board Meeting

5. **LABORATORY QUALITY REPORT**
   A review of current performance and actions focused on the clinical goals for laboratory. *Randy Kokka, Director of Laboratory.*

6. **FOOD AND NUTRITION SERVICES QUALITY REPORT**
   A review of current performance, quality outcomes, and improvement initiatives focused on food and nutrition services *Lawrence Headley, Director of Food & Nutrition Services*

7. **CLINICAL QUALITY GOALS UPDATE**
   A review of outstanding health outcomes initiatives for Surgical Safety Program. Chris Patty, Clinical Practice Guidelines Program Manager.

8. **ADJOURN OPEN MEETING**

Kaweah Delta Health Care District
Board of Directors Meeting

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Thursday, September 17, 2026

Agenda item intentionally omitted

OPEN Quality Council Committee
Thursday, August 20, 2026
The Executive Office Conference Room

Attending: Board Members: Dr. Dean Levitan, Chair; Jonna Schengel, Board Member; Marc Mertz, CEO; Kevin Morrison, VP of Support Services; Jag Batth, Chief Operation Officer; Dr. Micheal Tedaldi, Vice Chief of Staff; Ben Cripps, Chief of Compliance; Max Heckhausen, VP of Strategy; Stephen Forney, Chief Financial Officer; Scott Baker, Chief Nursing Officer; Dr. Paul Stefanacci, CMO/CQO; Farid Sheikh, Director of Quality and Patient Safety; Luke Schneider, VP of Information Systems and Services; Renee Lauck, Director of Imagining and Radiation Services; Shawn Elkin, Infection Prevention Manager; Dr Verma, Medical Director of Cath Lab; Ayham Zoreikat, Director of Cardiovascular Service Line and Operations; 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 8:25 AM.

Open Session:

Public Participation – None.

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

4. **Review of July Quality Council Open Session Minutes –** Dr. Dean Levitan, Chair Board Member
    - Reviewed and acknowledged the July Quality Council Open Session Minutes by Jonna Schengel and Dr. Dean Levitan.

5. **Cardiology Services (ACC) Quality Report –** A review of current performance and actions focused on the clinical goals for Cardiology Services. *Ashok Verma, Medical Director of Cath Lab; Ayham Zoreikat, Director of Cardiovascular Services Line and Operations*. No further actions.

6. **Imaging/Radiology Quality Report -** A review of current performance, quality outcomes, and improvement initiatives focused on diagnostic imagining and radiology services. *Renee Lauck, Director of Imaging and Radiation Services.* No further actions.

7. **Clinical Quality Report –** A review of outstanding health outcomes initiatives Healthcare Acquired infection. *Shawn Elkin, Infection Prevention Manager.* No further actions.

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

Clinical Laboratory

QComm Report
September 2026

Program Overview: Clinical Laboratory CQI

The Clinical Laboratory currently performs over 7 million tests per year and services virtually every clinical area as a primary data source, i.e. up to 70% of diagnosis and treatment decisions are based on lab results.

The Kaweah Health Clinical Laboratory consists of multiple specialty areas: Microbiology, Chemistry, Immunochemistry, Hematology and Hemostasis (Coagulation), Serology, Molecular Biology and Immunohematology (Blood Bank). Each of these areas has several CQI (continuous quality improvement) metrics in order to track and document performance.

The Laboratory is expected and required to provide proof of process improvement in all three phases of operation, including: the pre-analytical phase (specimen collection and processing), the analytical phase (testing), and the post-analytical phase (result reporting/communication).

The following slides provide a snapshot of selected quality improvement initiatives.

Quality Priority: ***to provide timely, accurate and reliable laboratory services that support patient care, timely diagnosis and treatment, and improved clinical outcomes.***

Quality Initiatives:

1. **Ensure Critical Value Reporting**
2. **Minimize Blood Culture Contamination**
3. **Maximize "AM Run" throughput**

Quality Initiative #1: ensure critical values results are communicated to the provider per policy

Critical Findings Measure	Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	12 month Avg
% of critical findings communicated to primary care provider per policy	100%	100%	100%	100%	100%	100%	100%	100%	99.90%	100%	99.90%	100%	100%	100%
Total # of critical call results		3600	3766	3772	3357	4142	3685	3727	3971	3228	3565	3340	3718	43871

Current status: Goal Met

Opportunities for Improvement: in the past year there have been two delayed notifications that involved outpatient critical results to providers who were difficult to reach. In both cases, the Lab Medical Director was notified and communicated with the patient to complete the requirement. Follow up included discussions with the provider answering service or on-call process with the Lab technical staff now using the "who's on call" application.

Quality Initiative #2: to reduce the amount of blood culture contamination to 2%, or less

BLOOD CULTURE CONTAMINATION RATES 2026													
LOCATION: Month =	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	AVE.
ED bld cult contam rate (%):	3.19	2.22	2.10	3.12	3.58	4.15	3.12	2.76	3.92	3.01	3.19	3.97	3.19
Lab bld cult contam rate (%):	1.62	1.13	1.76	0.83	0.74	1.52	0.49	1.38	1.63	2.02	1.98	2.32	1.45
RN (non-ED) bld cult contam rate (%)	1.35	0.00	1.61	2.13	1.72	1.19	3.17	0.00	1.49	0.00	2.00	0.00	1.22

Current status: Goal Not Met

Opportunities for Improvement: as seen in the chart above, Lab contamination rates trended upward in the last quarter and exceeded the benchmark goal of 2% in May and July for the first time since January 2024. Extensive audits indicate the etiology stems from incomplete cleaning of the venipuncture site, including a lack of compliance with antiseptic dwell time. Lab Coordinators performed additional training in July focusing, primarily on newly hired staff, with the expectation of a return to previous performance levels.

Quality Initiative #3: to complete 83% of "AM run" daily test orders by 0730

Total Ave =	85	86	87	88	86	84	83	84	85	87	85	87
Wkend Ave =	86	86	85	89	83	79	82	83	81	87	85	86
Month =	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26

Current status: Goal Met

Opportunities for Improvement: "AM Run Throughput" is the most important daily measure of Lab operational integrity and is an important length of stay component. Over 95% of the time, Lab performance to metric goal is determined via staffing integrity in the specimen collection group (CPT). This is closely monitored and a variety of interventions are being actively deployed, including: advanced training of Team Lead personnel, acquisition of additional per diem CPT staff, up-staffing of morning run scheduled personnel, etc.

Questions?

Food & Nutrition Services

Quality Report
August 2026

Department Purpose Statement

Food & Nutrition Services supports the health, healing, and quality of life of patients and residents by delivering safe, nutritious, high-quality, and clinically appropriate food and nutrition services. Through meal service and clinical nutrition care, the department promotes adequate intake, identifies and addresses nutrition risk, provides individualized interventions and education, and maintains food safety, sanitation, regulatory compliance, meal accuracy, and a positive patient experience. As an integral member of the health care team, FNS contributes to improved clinical outcomes, recovery, and overall well-being.

Department Overview: Food & Nutrition Services

4 Facilities

- **KHMC** Kaweah Health Medical Center
- **KHUC** Kaweah Health Urgent Care
- **KHRH** Kaweah Health Rehabilitation Hospital
- **KHMH** Kaweah Health Mental Health Hospital

12 Service Lines

- Medical Center Patient Care
- North Fork Café
- Ambrosia Café
- Wishing Well Gift Shop
- Medical Staff Food Supply (Six Locations)
- Kaweah Kids Food Supply
- Urgent Care Subacute Patient Care
- Cousteau's Café
- Short Stay & Rehab Patient Care
- Mental Health Patient Care
- South Campus Cafeteria
- Youth Crisis Stabilization Center

Department Overview June 25 and June 26

	Fiscal Year 2025	Fiscal Year 2026	
Scope of Services	Volume	Volume	
Patient Trays Served	455,478	438,026	
Supplemental Meal Services Guest Trays, Patient Snacks, etc.	46,833	88,626	
Catered Meals Medical Staff Lounges/Kaweah Kids	62,137	62,903	
Clinical Nutrition Encounters	24,406	34,230	
Retail Services Transactions | Net Revenue	699,194 | $5.01M	723,895 | $6.54M	
Food Purchasing Volume Cases Purchased	117,136 Cases	122,130 Cases	
Total Meal Equivalents *(Annual)*	**Fiscal Year 25: 1,736,435**	**Fiscal Year 26: 2,474,900**	**42.5% Increase**

Quality Improvement Overview

Three priority initiatives were selected to address measurable opportunities in regulatory compliance, clinical nutrition performance, and patient safety.

Quality Initiatives:

1. Labeling and Dating Compliance
2. Registered Dietitian Assessment Timeliness
3. HAPI-Related RD Assessment Timeliness

Objectives:

- **Labeling and Dating Compliance** — Improve consistency and reduce food safety risk.
- **RD Assessment Timeliness** — Increase on-time completion of qualifying nutrition assessments.
- **HAPI-Related RD Assessment Timeliness**— Sustain reductions through targeted corrective action.

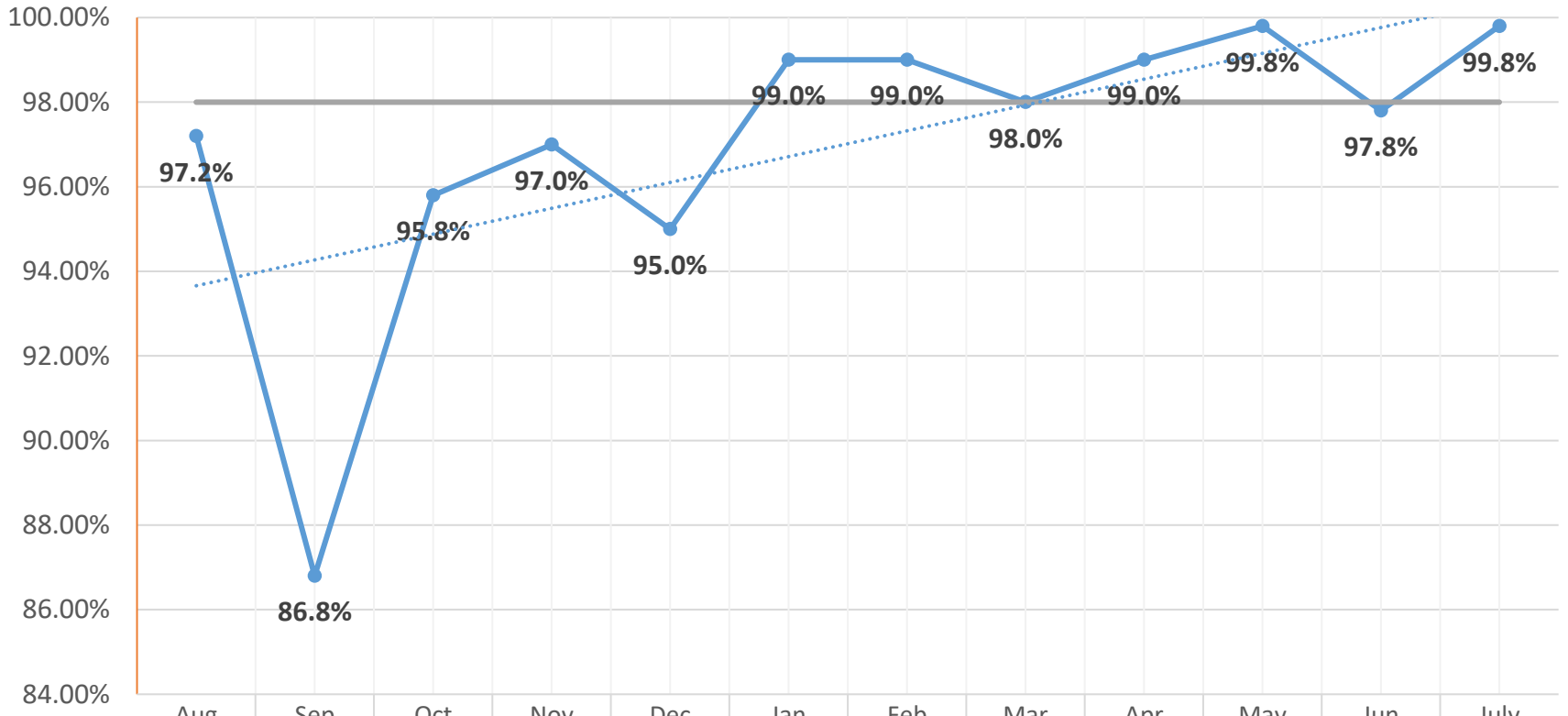
Approach:

Compare baseline to current performance, identify gaps, implement interventions, and measure progress toward defined targets.

Quality Initiative #1: Labeling and Dating Compliance

Background and Measure Definition

Labeling and dating compliance protects patients from foodborne illness. Compliance is measured through daily random audits of food storage areas. Corrective actions are focused on closing identified gaps and sustaining performance.



	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July
Last 12 Months	97.2%	86.8%	95.8%	97.0%	95.0%	99.0%	99.0%	98.0%	99.0%	99.8%	97.8%	99.8%
# of Items Checked	5267	5147	8213	8213	5196	5152	5000	5500	5000	5500	6084	9746
Goal	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%

Quality Initiative #1: Labeling and Dating Compliance

Primary Findings

A non-compliant finding may include an item that is **unlabeled, incorrectly identified, missing a preparation date, missing a use-by date, or expired**. Each finding requires documented corrective action; when corrective action is not completed, it is recorded as an additional non-compliant finding.

Walk-in Freezers **#26 and #27 at the Medical Center** had the highest concentration of labeling and dating findings and were therefore identified as priority areas for improvement.

Corrective Actions

- Increased Monitoring Frequency
- Assigned Area Ownership
- Implemented Electronic Labeling System
- Improved Traceability
- Ongoing Performance Review

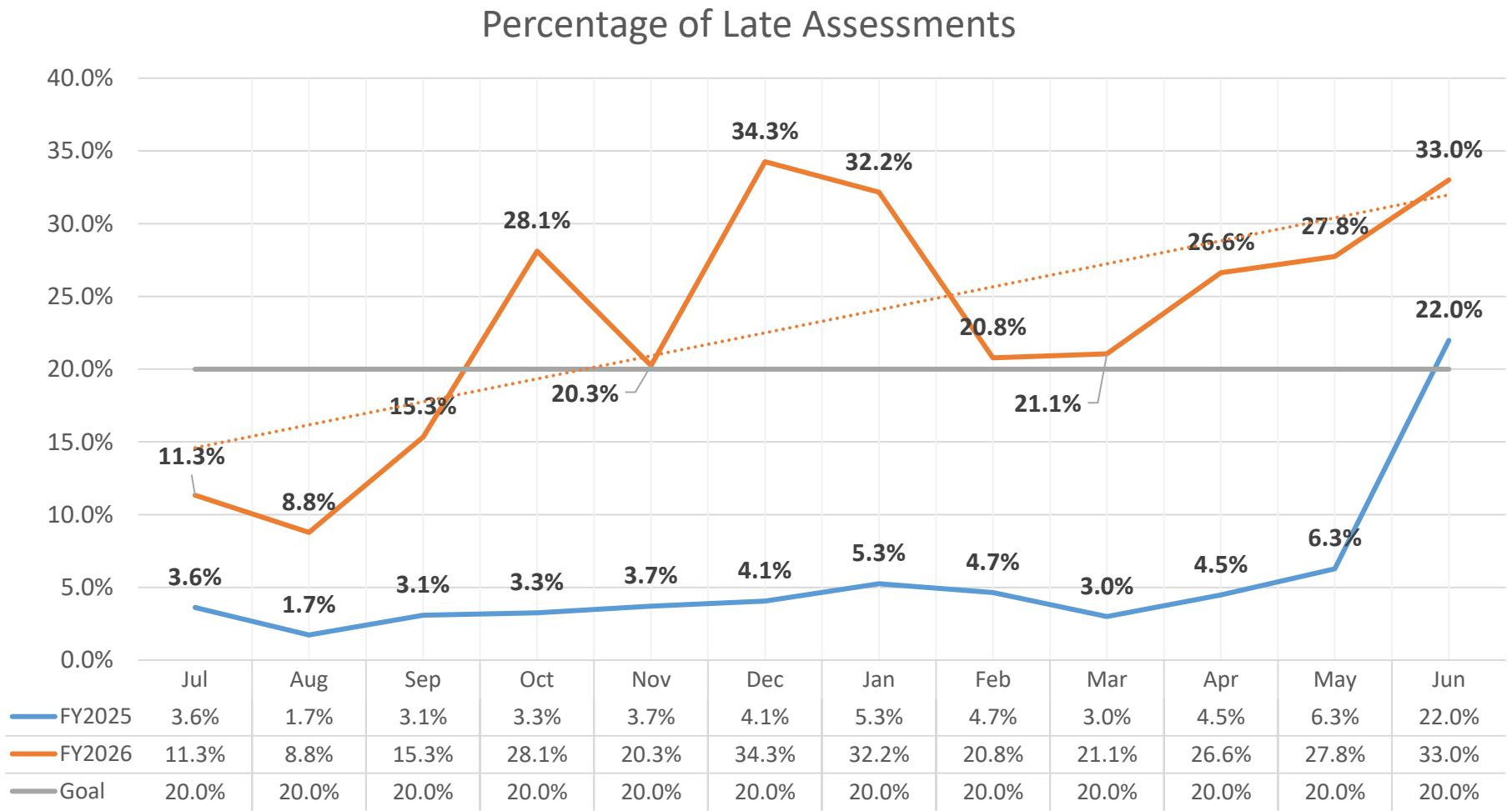
Goal

Achieve and sustain **at least 98% labeling and dating compliance across all food storage areas** through daily audits, monthly performance reviews, and targeted follow-up.

Quality Initiative #2: RD Assessment Timeliness

Background and Measure Definition

In 2025, CMS required a change from a standard 5-day follow-up to a 3-day follow-up for high-risk patients. Also, all therapeutic diet orders and any identified food or latex allergy requires an RDN screen order. These changes significantly increased the number of orders due daily.



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY2025	3.6%	1.7%	3.1%	3.3%	3.7%	4.1%	5.3%	4.7%	3.0%	4.5%	6.3%	22.0%
FY2026	11.3%	8.8%	15.3%	28.1%	20.3%	34.3%	32.2%	20.8%	21.1%	26.6%	27.8%	33.0%
Goal	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%

Quality Initiative #2: RD Assessment Timeliness

Primary Opportunity

Reduce avoidable RD workload by refining non-required automatic consults and improving therapeutic diet-ordering practices, while maintaining all CMS-required screening and clinically indicated referrals.

Potential Corrective Actions

Revise the Stroke Order Set

Promote Least Restrictive Diet Orders

Differentiate Between Food Preference and Food Allergies

- Revise the stroke order set to have an option for an RD consult but not automatically ordered for all potential stroke or TIA patients.
- Educate providers regarding the use of the least restrictive diet upon admission to address the acute reason for admission (rather than past medical history).
- Educate nursing staff to document food dislikes as dietary preferences rather than food allergies.

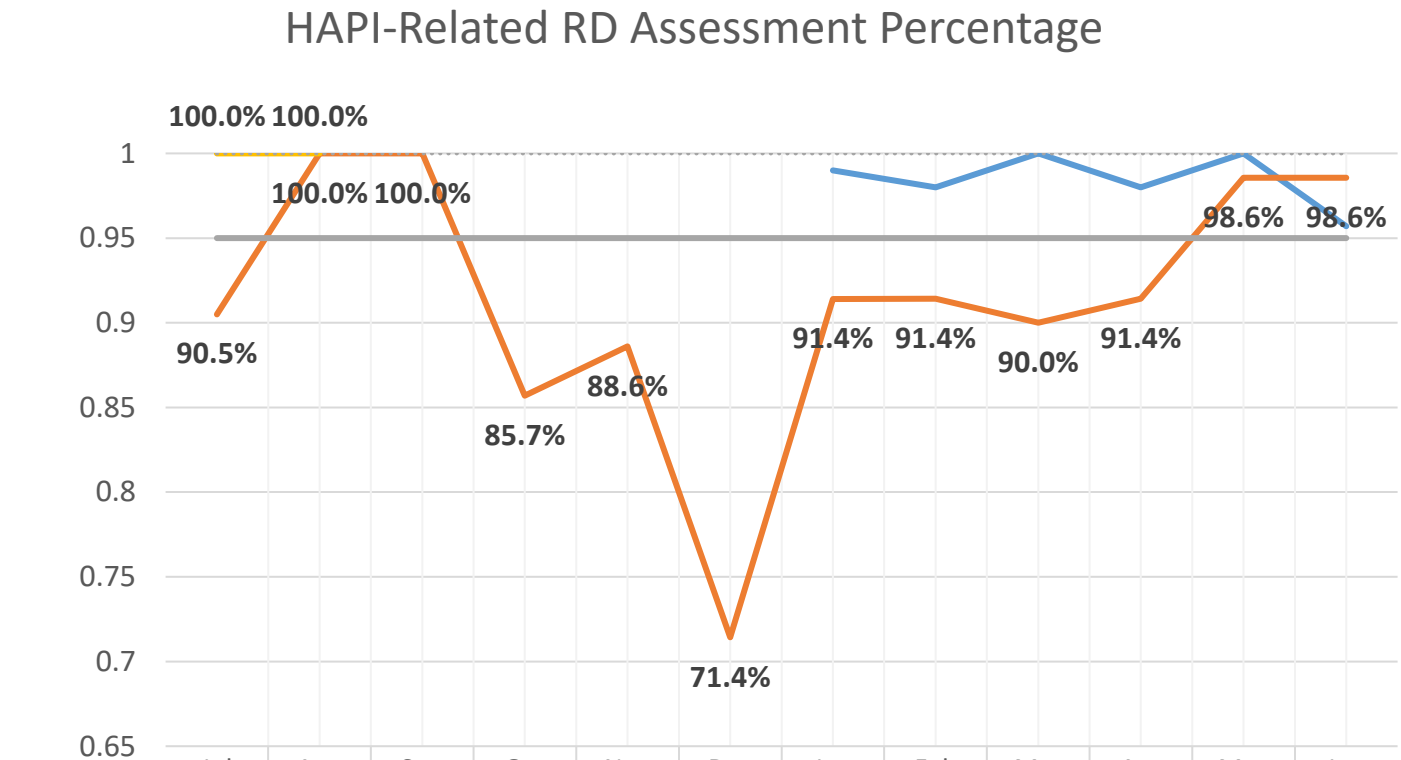
Goal: Reduce the late-assessment rate from 33% to below 20% by March 2027.

Quality Initiative #3: HAPI-Related RD Assessment Timeliness

Background and Measure Definition

Following a late-2024 4T HAPI root-cause analysis, an automatic RDN Screen order was implemented for patients with a Braden score of **≤18** to support early identification of skin-breakdown risk. The trigger was later revised to **≤14** to align with nursing risk criteria, reduce the volume of lower-risk consults, and prioritize higher-risk patients.

Compliance is measured through a monthly retrospective audit of **70 patients with documented poor PO intake** across critical care, step-down, medical/surgical, and acute rehabilitation units, based on timely completion of the RD consult per **Policy FNS.801**.



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY2025							99.0%	98.0%	100.0%	98.0%	100.0%	95.7%
FY2026	90.5%	100.0%	100.0%	85.7%	88.6%	71.4%	91.4%	91.4%	90.0%	91.4%	98.6%	98.6%
FY2027	100.0%	100.0%										
Goal	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Quality Initiative #3: HAPI-Related RD Assessment Timeliness

Primary Opportunity

Better align RD consult volume with actual nutrition and skin-breakdown risk so limited clinical capacity is directed to the highest-risk patients.

Corrective Actions

- Revise the Braden Trigger
- Strengthen RD Triage
- Protect RD Clinical Capacity
- Monitor Missed and Late Consults

Sustainment Measures

- Evaluate Patient-Safety Impact
- Improve Change Accountability

Going forward, we will sustain the revised Braden score trigger of ≤14, continue enhanced RD triage, protect RD assessment time through staffing and workflow support, and review the monthly audit to identify delays and adjust processes as needed.

Goal: Achieve **three consecutive months at 100% timely RD consult compliance**, then sustain performance at **95% or higher** while prioritizing patients at greatest nutrition and HAPI risk.

Quality Improvement Scorecard

Current performance, target status, and next milestones for the department's three priority initiatives.

Initiative	Current	Goal	Status	Next Milestone
Labeling and Dating	97.0% (Rolling 12 mos. Avg)	≥98%	Near Target	Monthly Review
RD Assessment Timeliness	23.3% Late (FY26 Avg)	<20% Late	Improvement Needed	March 2027
HAPI-Related Timeliness	100% (July 2026) 100% (August 2026)	100% × 3 months, then ≥95%	On Track	Complete Third Month

Current performance reflects the latest available reporting period for each initiative.

Questions