Kaweah Delta Health Care District
Board Of Directors Committee Meeting

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

NOTICE

The Quality Council Committee of the Kaweah Delta Health Care District will meet at the Kaweah Health 4T Multipurpose Room on Thursday, November 13, 2025:

- 7:30AM Closed meeting.
- 8:00AM Open meeting.

In compliance with the Americans with Disabilities Act, if you need special assistance to participate at this meeting, please contact the Board Clerk (559) 624-2330. Notification 48 hours prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to the Kaweah Delta Health Care District Board of Directors meeting.

All Kaweah Delta Health Care District regular board meeting and committee meeting notices and agendas are posted 72 hours prior to meetings (special meetings are posted 24 hours prior to meetings) in the Kaweah Health Medical Center, Mineral King Wing near the Mineral King entrance.

The disclosable public records related to agendas can be obtained by contacting the Board Clerk at Kaweah Health Medical Center – Acequia Wing, Executive Offices (Administration Department/Executive Offices) {1st floor}, 400 West Mineral King Avenue, Visalia, CA via phone 559-624-2330 or email: kedavis@kaweahhealth.org, or on the Kaweah Delta Health Care District web page http://www.kaweahhealth.org.

KAWEAH DELTA HEALTH CARE DISTRICT

David Francis, Secretary/Treasurer

Kelsie Davis

Board Clerk / Executive Assistant to CEO

DISTRIBUTION:

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

Kaweah Delta Health Care District
Board Of Directors Committee Meeting

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Kaweah Delta Health Care District Board of Directors Quality Council
Meeting held: Thursday, November 13, 2025 • Kaweah Health 4T Multipurpose Room
Attending: Board Members: Michael Olmos (Chair), Dean Levitan, MD; Gary Herbst, CEO; Schlene Peet, Chief Nursing Officer; Paul Stefanacci CMO/CQO; Jag Batth, Chief Operating Officer; Michael Tedaldi, MD, Vice Chief of Staff and Quality Committee Chair; LaMar Mack, MD, Quality and Patient Safety Medical Director; Marc Mertz, Chief Strategy Officer; Ryan Gates, Chief Ambulatory Officer; Sandy Volchko, Director of Quality and Patient Safety; Ben Cripps, Chief Compliance and Risk Management Officer; Evelyn McEntire, Director of Risk Management; Cindy Vander Schuur, Patient Safety Manager; and Kyndra Licon, Recording.

OPEN MEETING – 7:30 AM

1. **CALL TO ORDER –** Mike Olmos, Committee Chair

2. **PUBLIC / MEDICAL STAFF 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 minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdictions of the Board are requested to identify themselves at this time. For those who are unable to attend the beginning of the Board meeting during the public participation segment but would like to address the Board, please contact the Board Clerk (Kelsie Davis 559-624-2330) or kedavis@kaweahhealth.org to make arrangements to address the Board.

3. **ADJOURN OPEN MEETING –** Mike Olmos, Committee Chair

CLOSED MEETING – 7:31 AM

1. **CALL TO ORDER –** Mike Olmos, Committee Chair

2. **Review of the October Quality Council Closed Session Minutes –** Mike Olmos, Committee Chair; Dean Levitan, Board Member

3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – Michael Tedaldi, MD, Vice Chief of Staff and Quality Committee Chair; Mara Miller, PharmD, BCPS, Medication Safety Coordinator

4. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management; Ben Cripps, Chief Compliance and Risk Officer*

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5. **ADJOURN CLOSED MEETING –** Mike Olmos, Committee Chair

OPEN MEETING – 8:00 AM

1. **CALL TO ORDER -** Mike Olmos, Committee Chair

2. **PUBLIC / MEDICAL STAFF PARTICIPATION –** Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves at this time. Members of the public or the medical staff may comment on agenda items after the item has been discussed by the Committee but before a Committee recommendation is decided. In either case, each speaker will be allowed five minutes.

3. **Close Meeting Report Out**

4. **Review of October Quality Council Open Session Minutes -** Mike Olmos, Committee Chair; Dean Levitan, Board Member

5. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives:

    a. **Falls Reduction Initiative Report**
    b. **Trauma Committee Quality Report**

6. **Leapfrog Update** – A review of Kaweah Health letter grade on performance in preventing medical errors, infections, and other patient safety issues. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*

7. **Healthgrades Update –** A review of Kaweah Healthgrades methodology Star Ratings & Specialty Awards. *Chris Patty, DNP, RN, Clinical Practice Guideline Program Manager.*

8. https://us.nasdaqboardvantage.com/services/rh?resourceid=MERPREM6MDNZWEpFLTk3OEQzRjMzMjdCOTQ3ODNCQTQyRUIxQzUzRkQyQzhD**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; Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.

9. **ADJOURN OPEN MEETING -** Mike Olmos, Committee Chair

Kaweah Delta Health Care District

Board Of Directors Committee Meeting

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Agenda item intentionally omitted

OPEN Quality Council Committee
Thursday, October 16, 2025
The Executive Office Conference Room

Attending: Board Members: Mike Olmos (Chair) & Dr. Dean Levitan, Board Member; Sandy Volchko, Director of Quality & Patient Safety; Schlene Peet, Chief Nursing Officer; Dr. Julianne Rudolph, Chief of Staff and Chair; Jag Batth, Chief Operation Officer; Ryan Gates, Chief Ambulatory Officer; Shawn Elkin, Infection Prevention Manager; Martha Cardenas, RN-Clinical Care Quality Assurance; Dr. Paul Stefanacci, Chief Medical Officer; Dr. Ashok Verma, Medical Director of Cath Lab; Ayham Zoreikat, Director of Cardiovascular Service Line and Operations; Cheryl Smit, Stroke Program Manager; Leslie Archer, RN Clinical Analyst; Scott Baker, Director of Emergency and Trauma Services; Kyndra Licon – Recording.

Mike Olmos called to order at 7:30 AM.

Review of Closed Session Agenda: Dr. Dean Levitan made a motion to approve the closed agenda, there were no objections.

Mike Olmos adjourned the meeting at 7:31 AM.

Public Participation – None.
Mike Olmos called to order at 8:00 AM.

4. **Review of August Quality Council Open Session Minutes –** Mike Olmos, Committee Chair; Dr. Dean Levitan, Board Member.
    - Reviewed and acknowledged the September Quality Council Open Session Minutes by Dr. Dean Levitan and Mike Olmos. No further actions.

5. **Written Quality Reports –** a review of key quality metrics and actions associated with the following improvement initiatives: Reports reviewed and attached in minutes. No action taken.
    a. **Stroke Committee Quality Report**
    b. **Care Compare Report**
    c. **Hospice Quality Report**
    d. **Home Health Quality Report**
    e. **Health Equity Report**

6. **Cardiology Services (ACC) Quality report –** A review of current performance and actions focused on the clinical goals for Cardiology Services. – Reports reviewed and attached to minutes. No action taken.

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. – Reports reviewed and attached to minutes. No action taken.

Adjourn Open Meeting – *Mike Olmos, Committee Chair*

Mike Olmos adjourned the meeting at 8:53 AM.

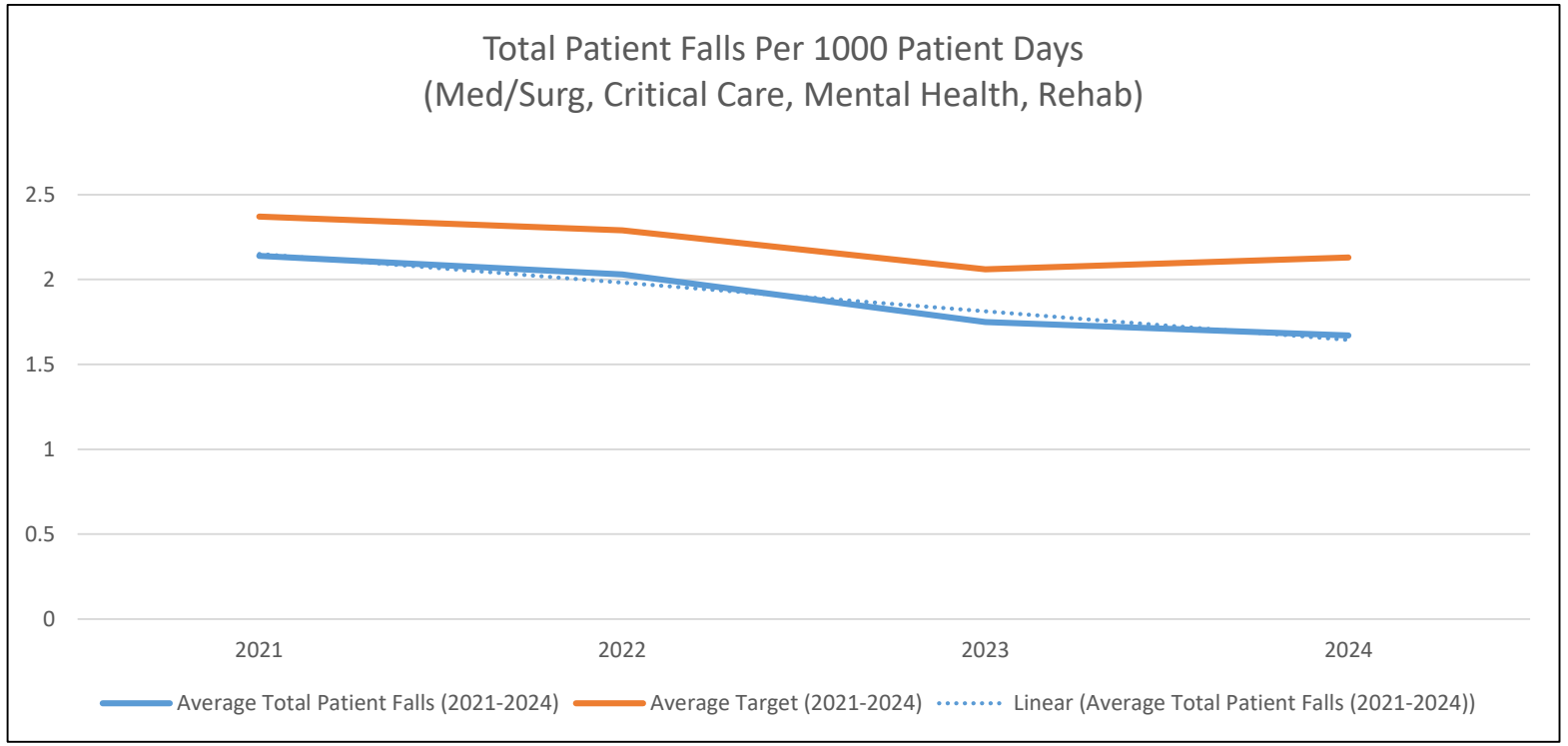
PATIENT SAFETY PRIORITY

Falls Committee: Falls Reduction Initiative

October 2025

Enriqueta Santoyo DNP, RN, APN, AGPCNP, CMSRN

Falls Reduction Annual Plan



2025 GOAL

Benchmark is 2.14 Total Falls per 1000 patient days.

Average total falls for CY2024 is 1.7 total falls per 1000 patient days.

Goal: will continue to be less than the quarterly target established by NDNQI.

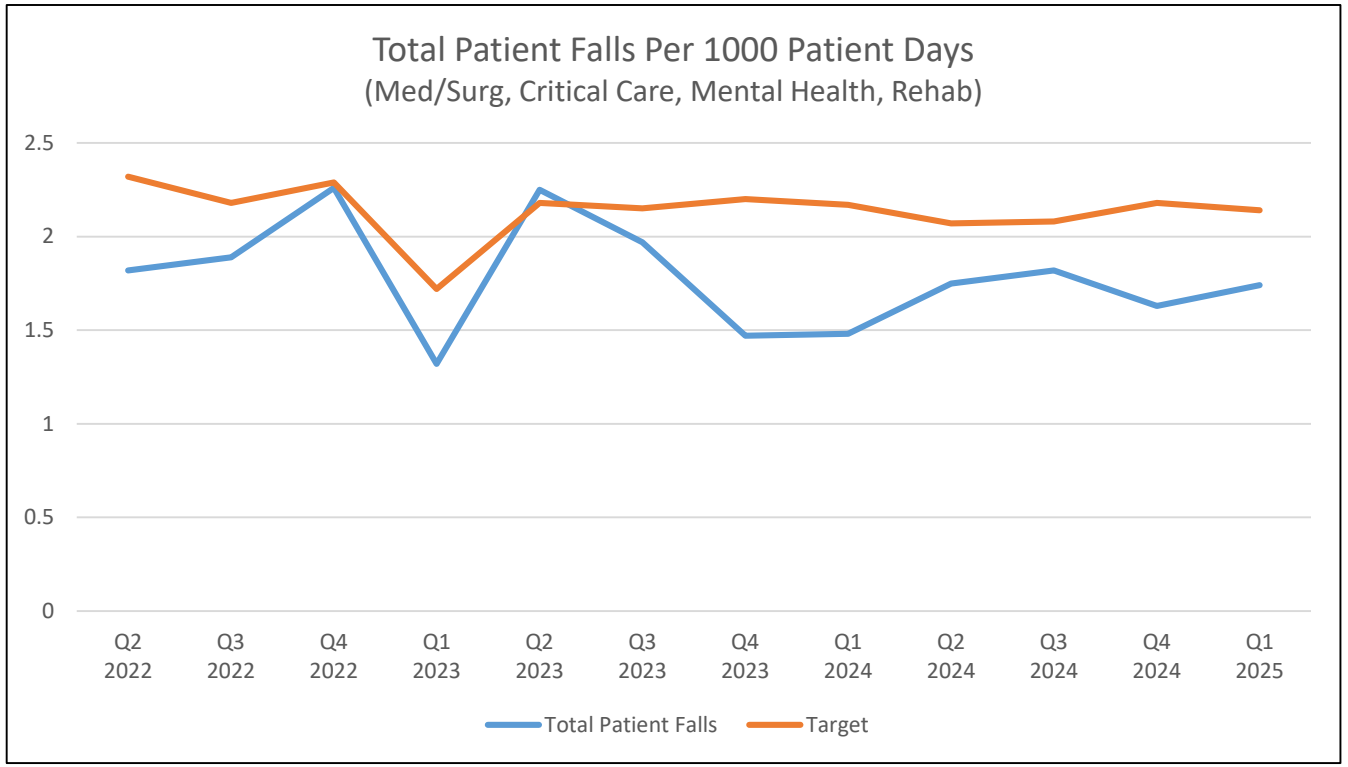
Calendar Year 2025 PLAN

High Level Action Plan

Fall preventative strategies include:

- Standardize and enculturate evidence- based prevention practices with 100% compliance:
  - Initial assessment of fall risk using the Johns Hopkins Fall Risk Assessment Tool (JHFRAT).
  - Documentation of the fall prevention plan (IPOC) for patients deemed at risk for fall.
  - All moderate or high-risk patients have a fall agreement signed (or documented refusal).
  - All moderate or high-risk patients have bed or chair alarms on(or documented refusal after use of chain of command to explain safety importance).
- Waffle cushion removed from all Umano beds effective 10/2/2025

Fall Reduction Update



2025 GOAL

Benchmark is 2.14 Total Falls per 1000 patient days.

Average total falls for CY2024 is 1.7 total falls per 1000 patient days.

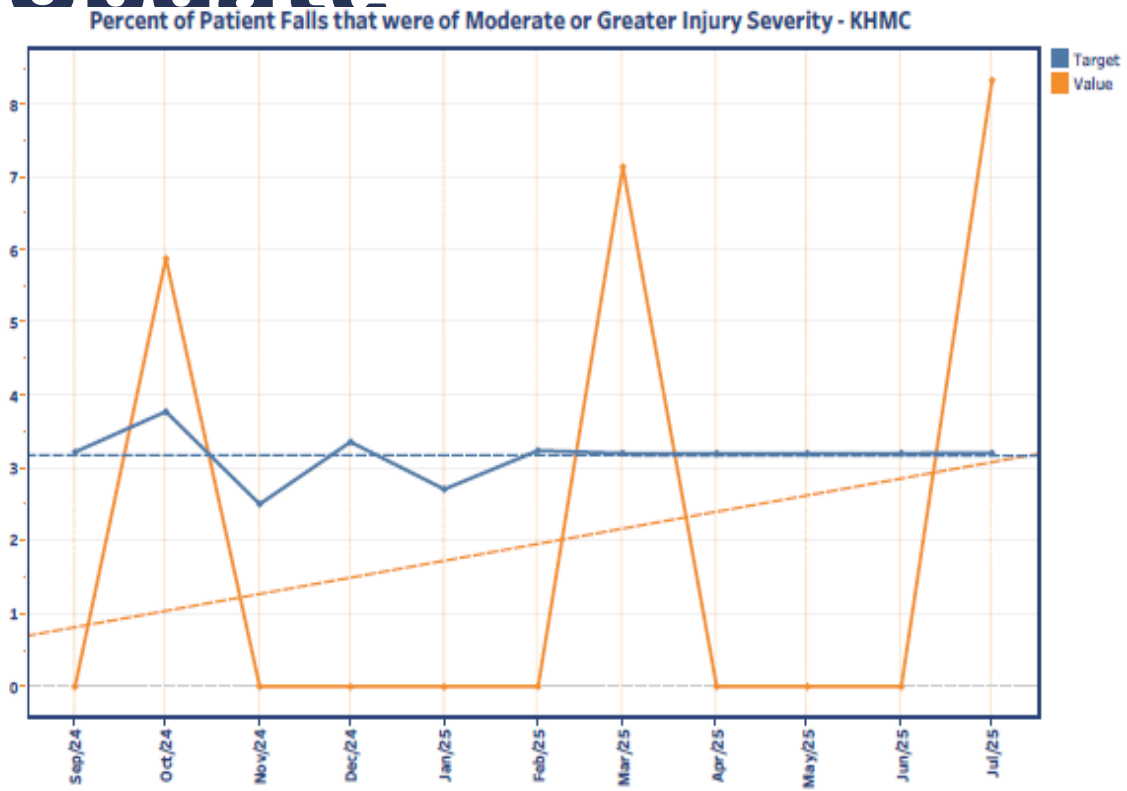
Goal: will continue to be less than the quarterly target established by NDNQI.

PROGRESS ON CY 2025 PLAN

High Level Data Plan:

- **Fall Risk Assessment (JHFRAT):Goal:** 100% completion for three consecutive months. **Actual:** 98.5%
  - **Status:** Near target; continued monitoring to sustain compliance.
- **Fall Prevention Plan Documentation (IPOC): Goal:** 100% completion for three consecutive months. **Actual:** 100% for 3 consecutive months.
- **Bed/Chair Alarm Compliance**: **Goal:** 100% compliance for three consecutive months. **August Result:** 95% compliance
- **4. Practice Change – Umano Beds (Effective 10/2/2025):** Waffle overlays discontinued.
  - Staff to follow **PC.230 Bed Algorithm** for specialty mattress/bed selection.
  - **Action:** Clinical Education distributed Practice Change flyer to leadership for dissemination and reinforcement.
- **5. Fall Prevention Education**: **Licensed Staff:** Completed during Education Excursion (May 19–26). **Non-Licensed Staff:** Completed on September 22, 2025.
  - **Outcome:** All nursing staff have received updated fall prevention training.
- **Summary:**
  Overall fall prevention performance demonstrates significant progress across multiple metrics, with strong compliance in risk assessment and bed/chair alarm use. Fall IPOC goal met.

Fall Reduction Update



2025 GOAL

Benchmark is 3.21 Percent of Patient Falls that were of Moderate or Greater Injury Severity – KHMC locations .

PROGRESS ON 2024-2025 PLAN

High Level Action Plan

Following a fall with severe injury in March 2025, a Root Cause Analysis (RCA) was conducted to identify missed opportunities and strengthen prevention measures. Several key interventions were implemented and monitored for sustained compliance.

Post-RCA Actions:

Standardized Handoff (SBAR) – Fall Risk Discussion: **Goal:** 100% inclusion of fall risk in SBAR handoffs for three consecutive months

- **Action:** Staff education completed; audits-initiated May 1: **Result:** 100% compliance sustained for three consecutive months

Fall Risk Education Documentation: **Goal:** 100% documentation for moderate- and high-risk patients for three consecutive months

- **Action:** Education completed in April; audits-initiated May 1: **September Result:** 100% compliance

Audit Oversight: Ongoing audits conducted by unit leadership to ensure continued adherence and accountability.

<u>Fall with severe injury on July 7, 2025</u>

Fall Education Enhancement: Evaluated and updated fall prevention education for permanent and traveler staff to include critical thinking and real-life scenario training. **Status:** Evaluation completed; gaps identified (9/5/2025).

- **Next Step:** Update education content in collaboration with Clinical Education for all staff (new and current). **Projected Completion:** 11/5/2025: **Current Progress:** 50%

Fall Risk Tool Evaluation: Reviewed and refined the fall risk tool to include reference guidance for high-risk medications and equipment. **Status:** Evaluation completed; EHR updates required (9/5/2025).

- **Projected Completion:** 11/5/2025: **Current Progress:** 50%

Patient Fall Agreement Process: Optimize the electronic fall agreement workflow. Evaluation completed (9/2/2025); EHR optimization request submitted. Content updates needed before Cerner build.

- **Projected Completion:** 11/5/2025: **Current Progress:** 50%

Enhanced Handoff Process: Ensure all handoffs (minimum of 78 cumulative or 100%) include discussion of fall risk assessment score for three consecutive months. **Goal:** 100% compliance

- **Bed/Chair Alarm Compliance:** Ensure bed/chair alarms are active and functional for all moderate- and high-risk patients (minimum of 77 cumulative or 100%) for three consecutive months. **Goal:** 100% compliance

The organization continues to strengthen fall prevention through targeted education, process standardization, and EHR optimization. Sustained improvement in documentation and communication demonstrates strong progress, with new initiatives underway to further reduce fall-related injuries and reinforce a culture of safety.

Fall Reduction Opportunities

Targeted Opportunities (What specifically is causing the fallouts?)

Patient Access to Personal Items

- **Issue:** Falls occurred when patients reached for items out of reach.
- **Action:** Ensure all personal items always remain within easy reach to reduce risk.

Tele-sitter Activation Delays

- **Issue:** Delayed initiation of tele-sitter monitoring for high-risk patients.
- **Action:** Perform comprehensive fall risk assessments every shift and as needed (PRN) to verify that interventions, including tele-sitter use, remain appropriate and active.

Incomplete Fall Partnership Agreements

- **Issue:** Missing or undocumented patient/family partnership agreements.
- **Action:** Reinforce education with patients and families regarding safety expectations and fall prevention strategies; ensure partnership agreements are completed and documented.

Incomplete Handoff Communication

- **Issue:** Fall risk assessment scores not consistently discussed during handoffs.
- **Action:** Standardize SBAR handoff content to include fall risk assessment scores for every patient transfer.

Bed/Chair Alarm Compliance

- **Issue:** Bed or chair alarms not consistently activated or functioning.
- **Action:** Verify alarm functionality every shift and PRN for all moderate- and high-risk patients.

Fall Reduction Action Plan

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED/ACTUAL COMPLETION DATE	BARRIERS
Initiate a multidisciplinary Falls Prevention Committee to guide evidence-based practices	9/30/2025	none
Review Falls Policy PC.88 to ensure it is evidence-based and current	11/15/2025	none
Nursing will ensure fall prevention measures are consistently implemented during hourly rounding	12/15/2025	Staff compliance
Met with CNO and director of Clinical Engineering regarding Umano beds and patients rolling over upright side rails.	9/30/2025	none
Establish a unit-based Falls Dashboard and appoint Falls Champions to support fall prevention initiatives	12/152025	none
Continue falls prevention training as part of nursing competency fairs		Nursing Competency Fair cancelled

Thank you

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Kaweah Health

Trauma Department

Sept 2025

Trauma Stats

TQIP Report

- Spring 2025 Benchmark Report
  - Data dates: Oct 2023 – Sept 2024
- All level III Trauma centers in the United States
  - 227 TQIP centers
- 115,203 patients included in this report (All patients)
  - 1,026 Kaweah Trauma patients

Hospital Registry

Year	Case Volume	% Change
2021	2,969 (4 registrars/60 days)	24.1%
2022	2,988 (4 registrars/60 days)	0.64%
2023	3,245 (5 registrars/57 days)	8.60%
2024	3,477 (5 registrars/55 days)	7.15%
2025	2,991 (6 registrars/21 days)	2% (YTD)

Trauma Registry Staffing Req. – 1 FTE per 600 registry cases

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TQIP Mortality

II. Risk-Adjusted Mortality

Expected rates are estimated based on statistical models and take into account the risk profile of patients cared for in your center. The TQIP Average column displays summaries based on data from all TQIP hospitals and can be used as a point of reference for your center-specific results.

Observed rates and expected rates shown below can only be used to approximate the odds ratio due to model factors which account for risk-factor effects, sample size, data transformations, and outcome variability.

Fall 2025	Patients	Mortality				Odds Ratio and 90% Confidence Interval				
Cohort	N	Observed Events	Observed (%)	Expected (%)	TQIP Average (%)	Odds Ratio	Lower	Upper	Outlier	Decile
All Patients	1,329	64	4.8	5.3	3.4	0.85	0.66	1.11	Average	3
Elderly	639	32	5.0	5.4	4.0	0.92	0.68	1.25	Average	4
LIFT	114	3	2.6	5.4	4.8	0.77	0.47	1.26	Average	1
IHF	184	4	2.2	2.8	3.2	0.94	0.65	1.37	Average	3

Spring 2025	Patients	Mortality				Odds Ratio and 90% Confidence Interval				
Cohort	N	Observed Events	Observed (%)	Expected (%)	TQIP Average (%)	Odds Ratio	Lower	Upper	Outlier	Decile
All Patients	1,026	80	7.8	6.3	3.5	1.49	1.14	1.93	High	10
Elderly	415	44	10.6	7.2	4.5	1.69	1.24	2.30	High	10
LIFT	102	6	5.9	6.2	5.3	0.97	0.60	1.58	Average	5
IHF	172	5	2.9	3.6	3.4	0.89	0.53	1.49	Average	4

TQIP Mortality

Opportunity

- TQIP is the Trauma Quality Improvement Program part of the American College of Surgeons. They look at the mortality rate for our patients in Four areas: all patients, > 65 years old, Low Injury Severity and Frailty in Trauma (LIFT) score, and isolated hip fractures.

- Since our last TQIP report, we have decreased in our risk adjusted Mortality rates.

Solution

- We have been reviewing all our mortalities and looking for trends.

- We are working with EMS to ensure they bring in appropriate patients. The EMS agency has a policy for their staff that states which patients should be brought to the facility and those that stay at the scene. When we find questionable cases, we send them to the EMS agency for review.

- Bi-Monthly staff education with the trauma registrars. Covering audits, NTDB definitions, and general questions.

- Autopsy reports from our coroner's office. (We have reconnected with Tulare County as they transitioned to a new group)

Measures

- We will use the bi-annual TQIP report for our data and review our mortalities monthly.

Next Steps

We will continue our monthly mortality reviews and follow up with any identified educational opportunities.

All mortalities are reviewed at our Trauma PIPS meeting every month and discussed for OFIs.

Reverification Survey

March 2025, We completed our Reverification Survey by The American College of Surgeons.
Results: We passed with a 2-year verification

Deficiencies from 2024 survey

- Trauma Registry Staffing Req. – 1 FTE per 600 registry cases – Completed
- Trauma Multidisciplinary PIPS committee Attendance – Completed
- Trauma Mortality Review PIPS meeting minutes – Completed

Next Steps

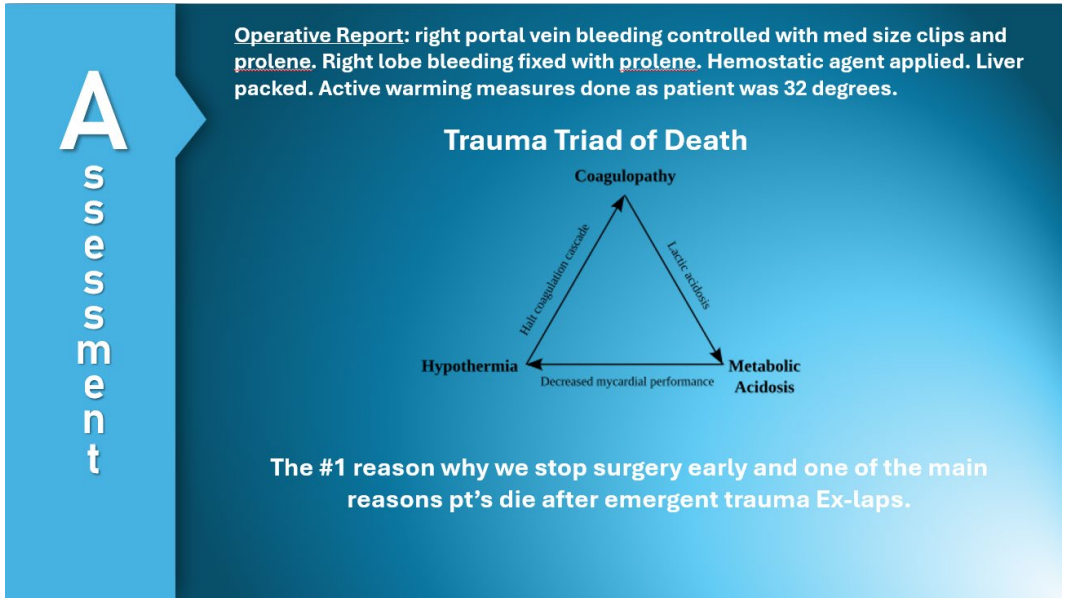
- Continue to monitor staffing levels

Reverification Survey

Weaknesses from 2024 survey

Standard	Opportunities for Improvement	Comments	Status
3.1	Operating Room Availability	The policy for OR staffing should inlcude the expectation that staffing and a room must be available within 30 min of notification in trauma cases where this is required. Currently, there is no such expectation.	Inprogress
5.1	Clinical Practice Guidelines	The practice guidelines are limited in number, with some notable absences (solid organ injury) and one outdated guideline (high frequency oscillating ventilation)	Inprogress
5.3	Levels of Trauma Activation	With only two levels for trauma activations, an unnecessary burden of minor trauma evaluation and management is allocated to trauma services.	Inprogress
3.3	Operating Room for Orthopaedic Trauma Care	There is no dedicated block time for ortho trauma cases. This leads to half of trauma ortho cases completed beyond the 24-hour goal. Rec: Create dedicated block time for ortho trauma	Completed
3.4	Blood Products	The critical nature of blood availability requires attention. Possibly another vender.	Completed
4.11	Orthopaedic Trauma Care	The ortho trauma service has a concerning low percentage of hip and femur fx operative fixation within 24 hrs.	Completed
4.35	Performance Improvement staffing req.	OFI: Standard 4.35 requires "at least" 1 FTE for trauma volumes greater than 1,000 annually. KHMC's volume of over 3,000 patients annually presents a significant challenge to their single PI nurse.	Completed
5.13	Decision to Transfer	A large number of orthopaedic patients are transferred out, many of whom were never seen by an orthopaedic surgeon.	Completed
7.3	Documented Effectiveness of the PIPS program	While some of the issues identified at PI lead to changes within the trauma program and the hospital in general, potentially important issues were frequently missed.	Completed
7.5	Physician Participation in Prehospital Performance Improvement	Provided documents include the EMS "Spinal Immobilization" protocol which was last revised nine years ago and uses terminology (spinal immobilization) which is not consistent with current nomenclature (spine motion restriction). This was evident in other protocols as well.	Completed

Trauma Team Lead Meeting



Opportunity

- Fundamental Trauma Care for nursing
  (Identified weakness through chart review with PI)
- Increase communication with nursing to better understand barriers to trauma care (Identified weakness by ED/Trauma management team)

Solution

- Extensive case reviews and Presentation from PI Trauma Nurses (Ongoing as of August 2025)
- Meeting to discuss issues and potential solutions with front line staff (Ongoing as of August 2025)

Measures

- We will utilize PI Chart review to monitor pt care of our Trauma pt's
- We will send out TTL surveys and communicate with the TTL to better serve their education needs and the departments needs.

Next steps

- Trauma PI nurses will continue to monitor cases for opportunities.

Trauma Registry
Data abstraction and Accuracy

Opportunity

- Due to the growth of the registry over the years and the new standards set by the American College of Surgeon we have had been running on the maximum allowable charts per registrar. This has made it difficult to run ahead in the registry. ACS maximum days for chart abstraction is 60 days.
- This as contributed to data quality problems as this did not give us time for audits.

Solution

- The recommendation was to add additional trauma registrar. We hired a new registrar Dec 2024; this gave us a .25 FTE over in our staffing per the recommendations by the ACS. This gave us the ability to catch up in our registry and give room for growth. We have now gone from 59 days in the registry to 12 to 15 days for complete abstraction.
- Increased minimum weekly chart completion to 13 (Completed).
- Setting the minimum chart abstraction and the adequate staff to cover those charts, we have switched our focus to quality abstraction and education. We have bi-monthly registrar meetings to discuss audit question, injury coding education, and recent education from webinars.

Measures

- Monthly reports for chart completion
- Monthly registrar chart audits

Next steps

- Increase our Chart audit score from 95% accuracy to 97%.

Orthopedic Trauma Care

2025	Benchmark	Jan	Feb	Mar	Apr	May	Jun	Jul
Femur Fixation <24 hr (avg)	24 hr.	29:01:00	9:36:00	16:31:00	12:37:00	24:56:00	9:42:00	20:41:00
Hip Fx < 24 hr	24 hr.	26:02:00	23:20:00	20:58:00	36:00:00	22:38:00	23:33:00	18:26:00
Open tib/fib <24 hr	24 hr.	15:46:00	27:38:00	11:49:00	21:08:00	n/a	11:35:00	23:51:00
Transfers		**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**
Ortho		0	1	1	3	1	2	2

Opportunity

- Decrease the amount of ortho transfers (Identified weakness)
- Increase Surgical block time for ortho injuries (Identified weakness)

Solution

- The recommendation was to recruit trauma fellowship trained surgeon (Completed Sept 2024)
- Add block time for ortho care (Completed Sept 2024)

Measures

- We utilize our trauma registry to monitor the times for ortho injuries.
- Transfer Data comes from the transfer center.

Next steps

- As of now we have made significant amount of progress with this weakness by adding Dr. Dean and the block time in the OR. We are providing data to the ortho team for review every month so they can help us pinpoint opportunities.
- We will continue to monitor these cases for opportunities.

BMI

2025	Benchmark	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
BMI	90%	83%	88%	81%	81%	81%	88%	87%	86%

Opportunity

The lack of documentation of patients' height and weight affects care in many ways. Some examples include anesthesia for surgery, antibiotics, vent settings, etc.

Solution

Education: ED education was sent out on 3/2/23 via daily huddle.

EMR: Task added to every patient that comes to the ER on 5/3/23.

Equipment: Tape measures and scales were added to the ER on 6/2023.

TTL meeting: We now discuss numbers at our monthly meetings, and we sent out emails to staff that have fallouts for reminders. 8/2025

Measures

The measurement process is through our DI registry system. Our registrars extract this information and input it into our system, which I review monthly.

Next Steps

EMR: ISS is working on pulling height from previous visits to help increase compliance. Completed 7/2024.

Trauma Flowsheet: We will add a spot on the written trauma flowsheet for height and weight. Completed 2/2025

Monitor for improvement

Community Outreach

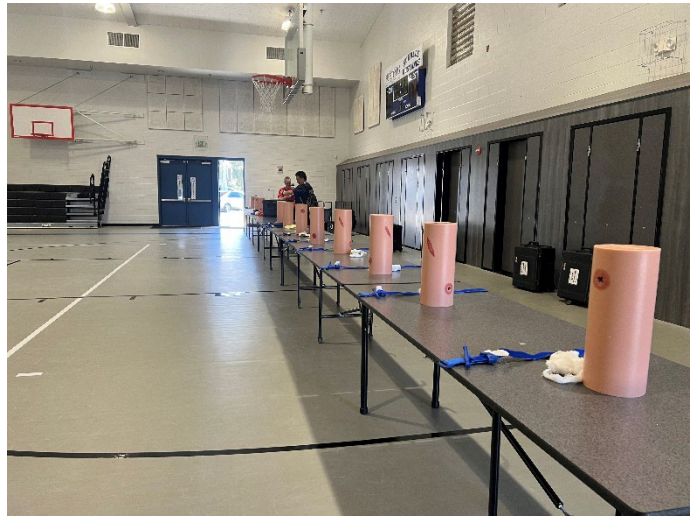
Stop the Bleed

- 2025
  - Quarterly training with the Tulare County Health and Human Services for staff.
  - Sundale School - 100 staff members in August were trained. We had the assistance of American Ambulance, Skylife, and Kaweah Trauma program to put on this training.

Hospital programs

- Falls are 50% of our mechanisms in the TQIP report
  - Our community outreach program at Kaweah puts on Tai Chi classes

		Patients	Mechanism							
Cohort	Group	N	Fall (%)	MVT Occupant and Other (%)	MVT Motorcyclist (%)	Pedestrian/ Pedal (%)	Struck by/ Against (%)	Firearm (%)	Cut/ Pierce (%)	Other (%)
All Patients	All Hospitals	70,863	71.1	12.3	2.1	3.6	3.4	1.5	1.4	4.6
	Your Hospital	1,026	50.5	25.1	3.5	6.7	2.8	4.3	2.3	4.7



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The pursuit of healthiness

Kaweah Health
MORE THAN MEDICINE. LIFE.

Kaweah Health Leapfrog Quality & Patient Safety Rating FALL 2025

Quality & Patient Safety

November 2025

Leapfrog Scorecard Overview: FALL 2025 & YTD

Measure Domain	Measure	Kaweah Health Most Recent Data	Data Date Range (most recent data)	KH's Fall 2025 Score	Reporting Period	Fall 2025 National Mean	Final Weight (N/A redistributes)
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	100	2025	100	2025	82.24	6.13%
	Bar Code Medication Administration (BCMA)	100	2025	100	2025	85.15	5.94%
	ICU Physician Staffing (IPS)	100	2025	100	2025	67.85	6.82%
	Safe Practice 1: Culture of Leadership Structures and Systems	120	2025	120.00	2025	117.59	3.09%
	Safe Practice 2: Culture Measurement, Feedback, & Intervention	120	2025	120.00	2025	117.26	3.19%
	Total Nursing Care Hours per Patient Day	100	2025	100	01/01/2024 - 12/31/2024	79.07	4.72%
	Hand Hygiene	100	2025	100	2025	76.75	4.87%
	H-COMP-1: Nurse Communication	84%	Oct 2024-Sept 2025	89	10/01/2023 - 09/30/2024	90.37	3.02%
	H-COMP-2: Doctor Communication	83%	Oct 2024-Sept 2025	89	10/01/2023 - 09/30/2024	89.99	3.02%
	H-COMP-3: Staff Responsiveness	68%	Oct 2024-Sept 2025	82	10/01/2023 - 09/30/2024	81.81	3.07%
	H-COMP-5: Communication about Medicines	73%	Oct 2024-Sept 2025	76	10/01/2023 - 09/30/2024	74.64	3.07%
	H-COMP-6: Discharge Information	91%	Oct 2024-Sept 2025	86	10/01/2023 - 09/30/2024	85.48	3.05%
Outcome Measures	Foreign Object Retained	0	Oct 2024-Sept 2025	0.000	07/01/2022 - 06/30/2024	0.011	4.20%
	Air Embolism	0	Oct 2024-Sept 2025	0.000	07/01/2022 - 06/30/2024	0.001	2.40%
	Falls and Trauma	0.246	Oct 2024-Sept 2025	0.099	07/01/2022 - 06/30/2024	0.339	4.96%
	CLABSI	0.9	Oct 2024-Sept 2025	0.691	01/01/2024 - 12/31/2024	0.585	4.54%
	CAUTI	0.68	Oct 2024-Sept 2025	0.450	01/01/2024 - 12/31/2024	0.521	4.66%
	SSI: Colon	0.44	Sept 2024-Oct 2025	0.798	01/01/2024 - 12/31/2024	0.856	3.37%
	MRSA	1.33	Oct 2024-Sept 2025	0.582	01/01/2024 - 12/31/2024	0.688	4.47%
	C. Diff.	1.116	Oct 2024-Sept 2025	0.346	01/01/2024 - 12/31/2024	0.369	4.48%
	PSI 4: Death rate among surgical inpatients with serious treatable conditions	232.26*	Aug 2024- Sept 2025	208.94	07/01/2021 - 06/30/2023	177.42	1.96%
	CMS Medicare PSI 90: Patient safety and adverse events composite	1.569*	Aug 2024- Sept 2025	1.05	07/01/2021 - 06/30/2023	1.00	14.95%
Process Measure Domain Score:				0.1836			
Outcome Measure Domain Score:				-0.0051			
Process/Outcome Domains - Combined Score:				0.1785			
Normalized Numerical Score:		2.3247		3.1785			
Hospital Safety Grade (Letter Grade):				**B**			

* Data source: Midas (similar risk adjustment methodology as CMS)
*All payer (HCAHPS surveys a random sample of adult inpatients, regardless of insurance type)

Safety Letter Grade Criteria: A = > 3.202 > B= > 2.991 C= > 2.464 D= > 1.938 F= > 1.640

Leapfrog Scorecard Overview: FALL 2025 & YTD

YTD Performance (Compared to Leapfrog Fall 2025 Mean)

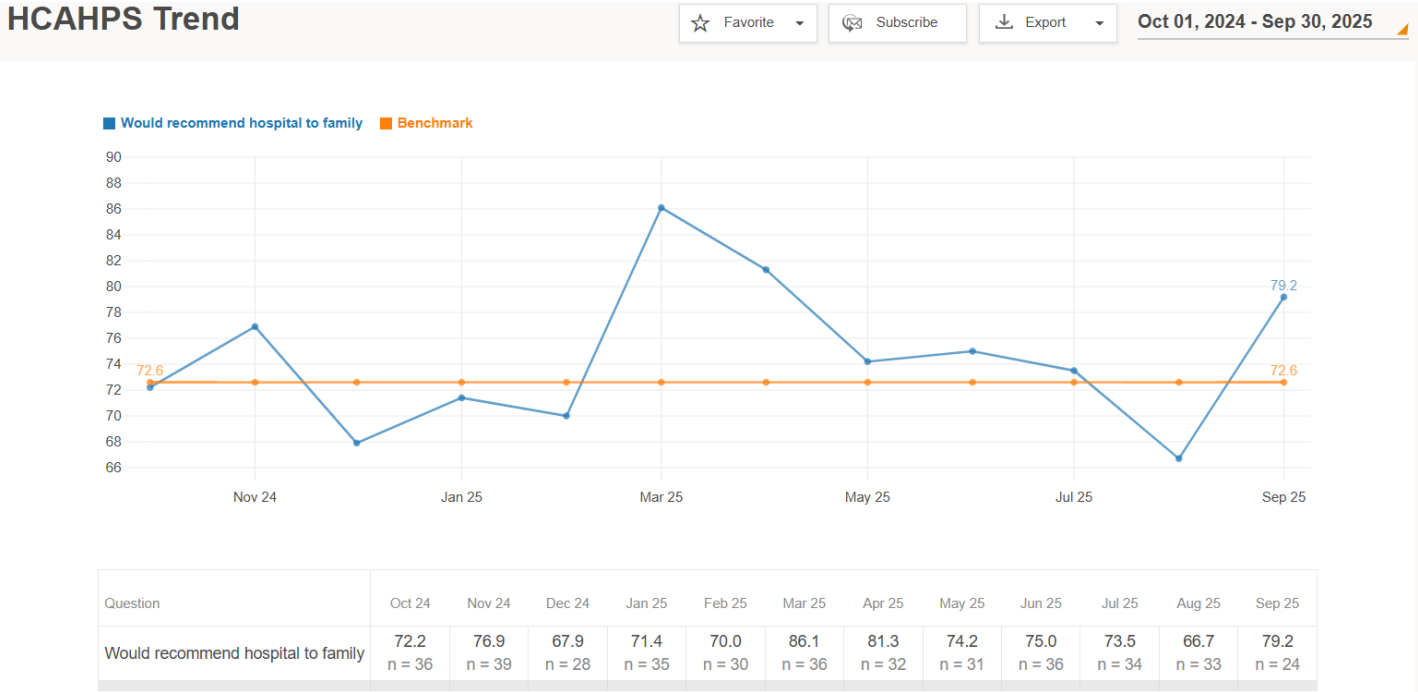
- Outperforming Areas:
  - ✓ **Hand Hygiene**
  - ✓ Computerized Physician Order Entry (CPOE)
  - ✓ Bar Code Medication Administration (BCMA)
  - ✓ ICU Physician Staffing (IPS)
  - ✓ Safe Practice 1: Culture of Leadership Structures and Systems
  - ✓ Safe Practice 2: Culture Measurement, Feedback, & Intervention
  - ✓ Total Nursing care Hours per Patient Day
  - ✓ HACs: Air Embolism, Foreign body left during procedure, Falls and Trauma
  - ✓ Hospital Acquired Conditions (HAIs): Catheter-Associated Urinary Tract Infection (CAUTI), Surgical Site Infection – Colon (SSI Colon)

- Underperforming Areas
  - ✓ Patient Experience
  - ✓ HAIs: Methicillin-Resistant Staphylococcus aureus (MRSA), Central Line-Associated Bloodstream Infection (CLABSI) & Catheter Associated Urinary Catheter Infection (CAUTI), Clostridium difficile (C. diff)
  - ✓ PSI 4 - PSI 4: Death rate among surgical inpatients with serious treatable conditions*
  - ✓ PSI 90 - CMS Medicare PSI 90: Patient safety and adverse events composite*

*Midas data is used for this comparison as a best guess which does not mirror CMS values

Safety Letter Grade Criteria: A = > 3.202 > B= > 2.991 C= > 2.464 D= > 1.938 F= > 1.640

Kaweah Health YTD Patient Experience Performance and Action Plan



Question	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25
Would recommend hospital to family	72.2 n = 36	76.9 n = 39	67.9 n = 28	71.4 n = 35	70.0 n = 30	86.1 n = 36	81.3 n = 32	74.2 n = 31	75.0 n = 36	73.5 n = 34	66.7 n = 33	79.2 n = 24

Action: Continue to push data to the units, keeping them informed of their scores and the priorities around the improvements needed.

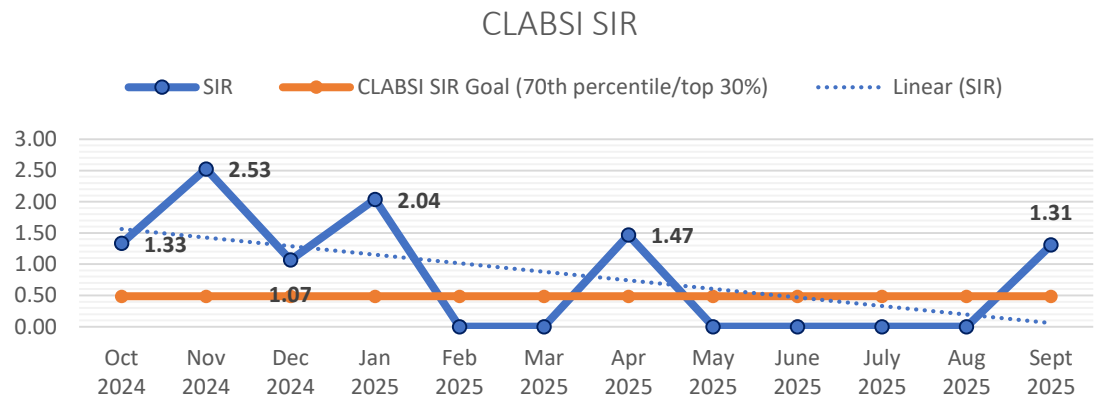
- **Nurse Communication**: PX sends monthly reports to nursing units. Additional education has been rolled out at the world-class education events (licensed, unlicensed staff).
- **Doctor Communication**: Education provided to the GME residents during Orientation to inform them of the metrics they are scored on. Provided training to Med Staff on running reports and will be educating GME staff soon.
- **Care Coordination/Care Transitions/Discharge**: We sent trends to CNO and Director of Case Management highlighting areas where case managers/social workers have opportunities.
- **Executive Rounding** with facilities, PX & EVS for environment.
- **Executive Rounding** with PX with patients and families.
- **Unit** specific training on compassionate communication.
- **New employee orientation** training on compassion and service recovery.

Kaweah Health YTD HAI Performance & Action Plan

Outcomes Measures not achieving at least national mean in YTD Performance Period (lower scores = better outcomes)

❖ CLABSI Targeted opportunities:

- Reduced central line utilization, less lines less opportunity for infection to occur.
- Reduced use of femoral line access site.

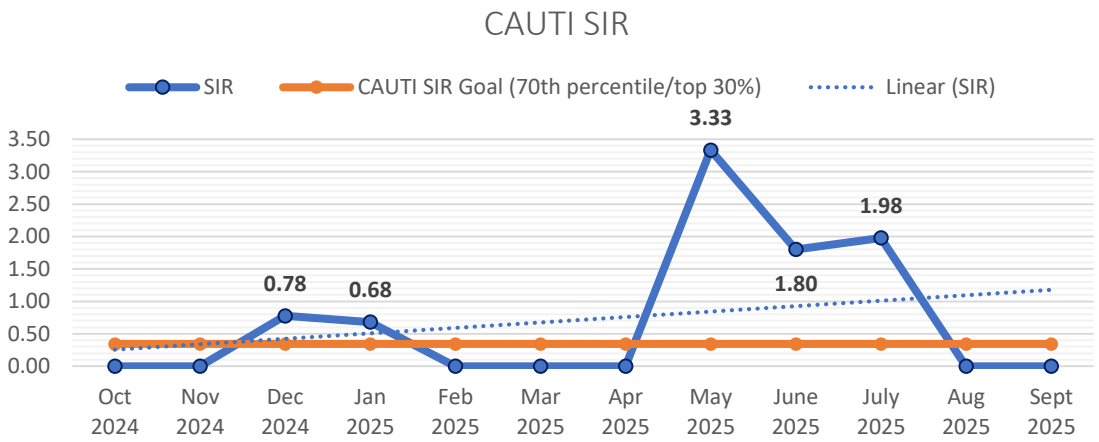


Action: Continue targeted work through Healthcare Acquired Infection – HAI Quality Focus Team

- Daily Device Rounds (May 2025) – to improve consistency with best practice prevention strategies for line utilization and care
- Nurse Skills Fair (May 2025) – emphasizing best practice prevention bundles for line maintenance
- Evaluating NEW central line CHG impregnated Tegaderm dressing
- Evaluating universal CHG bathing & bath refusal escalating process

❖ CAUTI Targeted opportunities:

- Timely removal of indwelling urinary catheters
- Medical and nursing interventions to address acute urinary retention
- Development of an IUC avoidance protocol



Action: Continue work through Healthcare Acquired Infection – HAI Quality Focus Team

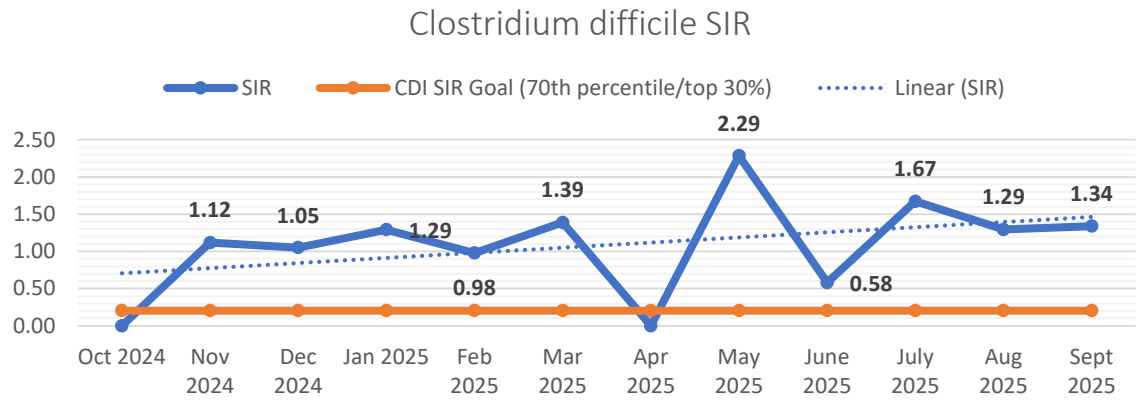
- Charge nurse escalation process for removal of indwelling urinary catheters.
- Increase utilization of external urinary devices (if indicated).

Kaweah Health YTD HAI Performance & Action Plan

Outcomes Measures not achieving at least national mean in YTD Performance Period (lower scores = better outcomes)

❖ Clostridium difficile Targeted opportunities:

- Compliance with using the Kaweah Health Clostridium difficile testing algorithm.

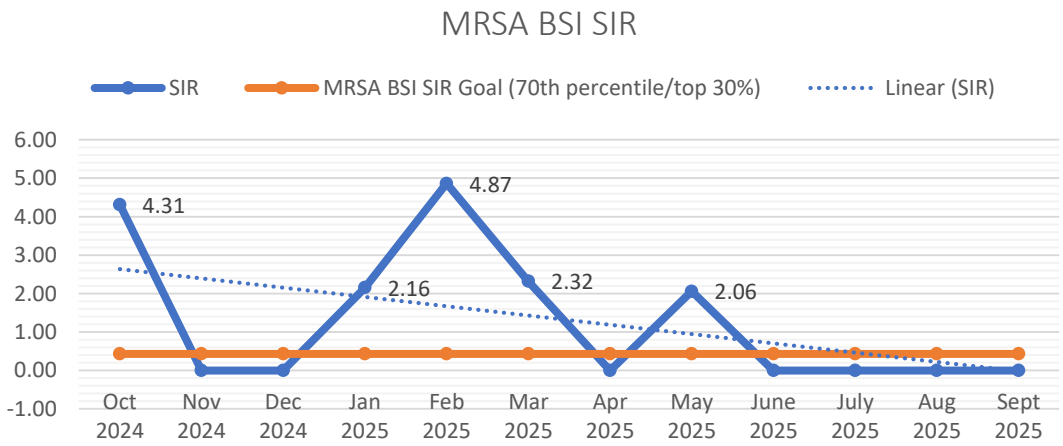


Action: Continue targeted work through Healthcare Acquired Infection – HAI Quality Focus Team

- Adherence to the Kaweah Health Clostridium difficile testing algorithm.
- Infection Prevention (IP) and Antimicrobial Stewardship Pharmacy(ASP) collaboratively working to address provider/staff knowledge deficit related to the KH C. difficile testing algorithm.
- IP/ASP reinforcement of using the KH C. difficile testing algorithm.

❖ MRSA Targeted opportunities:

- MRSA - increasing nasal and skin decolonization through focused work on identification of at-risk patients upon admission.



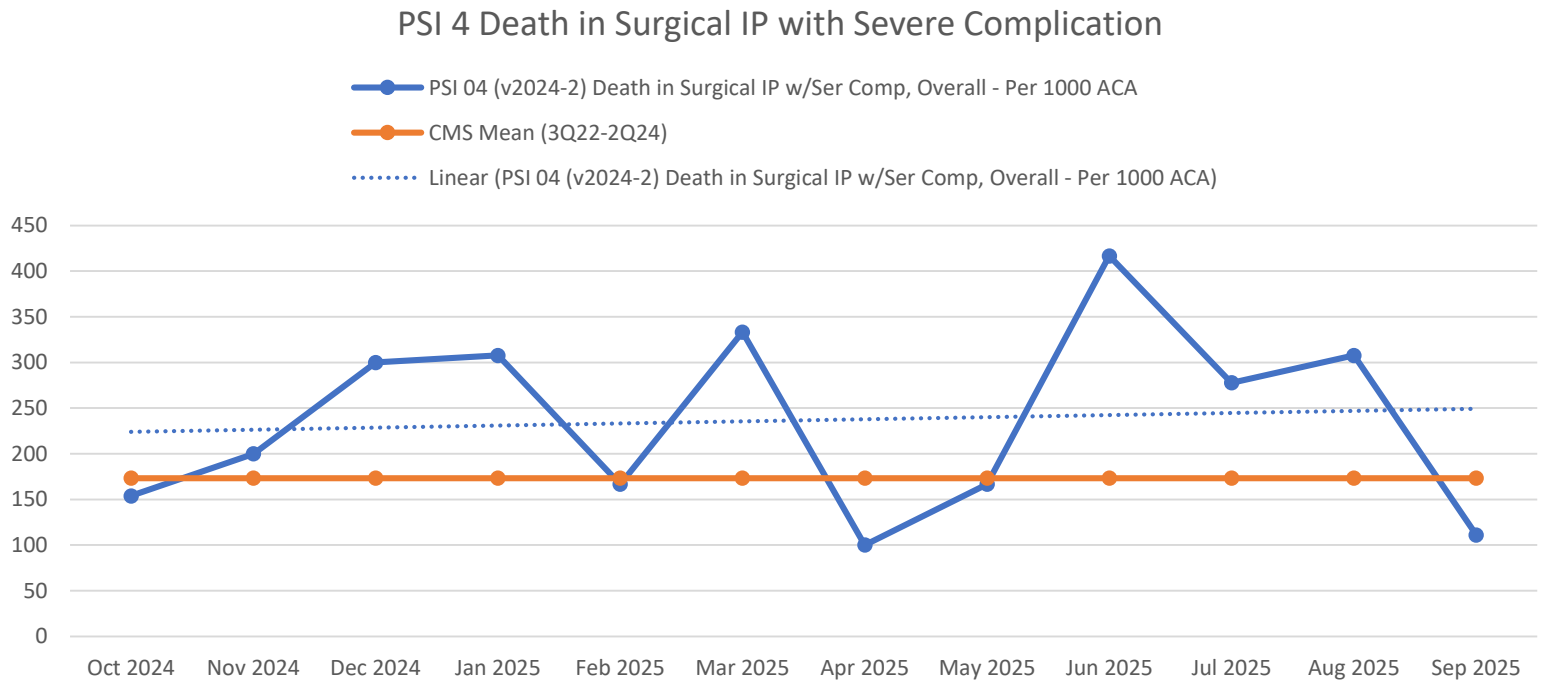
Action: Continue work through Healthcare Acquired Infection – HAI Quality Focus Team

- Reestablishing expectations to improve hand hygiene (HH) through increased use of BioVigil electronic HH monitoring system.
- Targeted decolonization of high-risk patients.
- Universal CHG bathing & bath refusal escalating process.
- Environmental Cleaning.

Kaweah Health YTD PSI Performance and Action Plan

Outcome Measures not achieving at least national mean in Fall 2025 & YTD performance (lower scores = better outcomes)

- PSI 4
  - PSI 4 Fall 2025 & YTD performance are above the leapfrog national mean
  - CMS has replaced PSI 4 with a new measure & leapfrog will be evaluating the new measure & likely replacing it in 2027
  - Additional focus through Sepsis committee for expired patients



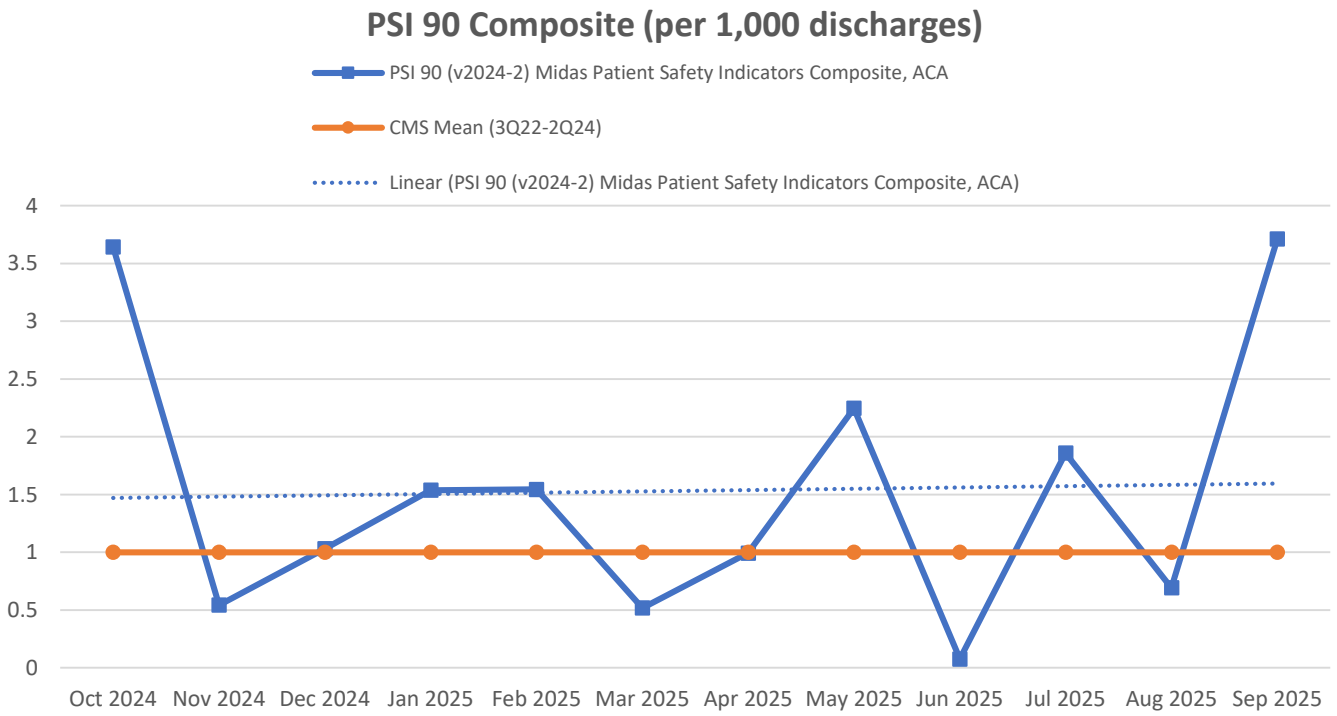
Action: Continue PSI 4 work through PSI committee & SQIP Committee

- Concurrent or close to real time review of events through 3M system. Quality, CDI and Coding in the moment collaboration when a case qualifies in 3M as a PSI
- Ongoing case review for documentation, coding and clinical opportunities through monthly PSI committee
- If applicable cases forwarded for further review through Mortality committee and/or other care team for appropriate follow up. All physician driven metrics are sent to Physician Peer Review Manager.
- Ongoing collaboration with Medical Director of Quality & Patient Safety, and Surgical Quality to enhance or improve processes

Kaweah Health YTD PSI Performance and Action Plan

Outcome Measures not achieving at least national mean in Fall 2025 & YTD performance (lower scores = better outcomes)

- PSI 90
  - PSI 90 YTD is above the leapfrog national mean
  - PSI 90 is heavily weighted **15%** of the overall weight for leapfrog letter grade
  - PSI 90 is composed of 10 individual PSI indicators
  - Ongoing focus on PSI 11 Post Op Respiratory Failure



Action: Continue PSI 90 work through weekly Harm meetings, PSI committee & SQIP Committee

- Concurrent or close to real time review of events through 3M system
- Ongoing case review for documentation, coding and clinical opportunities through monthly PSI committee
- **If applicable cases forwarded for further review through Mortality committee and/or other care team for appropriate follow up. All physician driven metrics are sent to Physician Peer Review Manager.**
- PSI 11 – deep dives into cases to evaluate opportunities in evidence-based practices such as ventilator weaning

Leapfrog Hospital Safety Score Regional Comparison Spring 2025 - (Fall grades not yet released)

Hospitals within 100 Miles	Spring 2025 Grade
Adventist Health – Tulare	A
Adventist Health - Hanford	A
Adventist Health - Selma	A
Sierra View Medical Center	B
Community Regional Medical Center	C
Clovis Community Medical Center	C
Saint Agnes Medical Center	C
Kaiser Permanente Medical Center - Fresno	A
Adventist Health - Delano	B
Adventist Health – Bakersfield	B
Bakersfield Heart Hospital	C

Hospitals within 100 Miles	Spring 2025 Grade
Mercy Hospital – Bakersfield Downtown	B
Bakersfield Memorial Hospital	A
Kern Medical Center	B
Mercy Hospital - Bakersfield Southwest	A
Other Facilities	
Cleveland Clinic – Euclid Hospital	B
University of California Ronald Reagan UCLA Medical Center	A
Los Angeles County - Harbor UCLA Medical Center	C
Los Angeles General Medical Center – LA County Hospital	A

Timeframe	KH Grade
5/2025	B
10/2024	C
5/2024	C
10/2023	C
5/2023	B
10/2022	A
5/2022	A
10/2021	A
5/2021	B
12/2020	B
5/2020	C
10/2019	C

Acronyms

- HAI – Hospital Acquired Condition
- CAUTI - Catheter-Associated Urinary Tract Infection
- C Diff - Clostridium difficile Infection
- CLABSI - Central Line-Associated Bloodstream Infection
- SSI – Surgical Site Infection
- MRSA - Methicillin-Resistant Staphylococcus aureus
- CPOE - Computerized Provider Order Entry
- HAC - Healthcare Acquired Condition
- PSI - Patient Safety Indicator
- PSI 4 - Death rate among surgical inpatients with serious treatable conditions
- PSI 90 - Patient safety and adverse events composite
- SP – Safe Practice
- H-Comp - Refers to composite score that combines multiple questions for a specific topic area within the Hospital Consumer Assessment of Healthcare Providers Survey
- HH - Hand Hygiene
- Tegaderm™ CHG - Chlorhexidine Gluconate
- ICU – Intensive Care Unit
- PSI Committee: Patient Safety Indicator Committee
- SQIP – Surgical Quality Improvement Committee
- Post Op - Post Operative
- PE/DVT – Pulmonary Embolism/Deep Vein thrombosis (blood clots)
- EMR – Electronic Medical Record
- SCD – Sequential Compression Devices (medical device to prevent blood clots)
- ALPs - Sequential Compression Device pumps used in OR (medical device to prevent blood clots)

Reference Materials

Patient Safety Indicator (PSI) 4: Death in Surgical Inpatients with Serious Treatable Complications

PSI 4 YTD Overall Rate: 382.35

PSI 4 Spring 2025 Mean: 177.42

PSI 4 Individual Stratum Feb 2024 - Jan 2025 (Stratums are not publically reported)	Actual Events Medicare Population (N/D)	Medicare Risk Adjusted Rate	Actual Events ALL Payer (N/D)	ALL Payer Risk Adjusted Rate
PSI 04c Death in Surgical IP w/Ser Comp, Sepsis - Per 1000 Medicare	**2/2**	**1000**	6/10	600
PSI 04d Death in Surgical IP w/Ser Comp, Shock - Per 1000 Medicare	**7/10**	**700**	18/43	418.61
PSI 04e Death in Surgical IP w/Ser Comp, GI - Per 1000 Medicare	**0/2**	**0**	2/18	111.11
PSI 04b Death in Surgical IP w/Ser Comp, Pneumonia - Per 1000 Medicare	**3/16**	**187.5**	12/74	162.16
PSI 04a Death in Surgical IP w/Ser Comp, PE/DVT - Per 1000 Medicare	**1/4**	**250**	1/11	90.91

- PSI 4 Sepsis & Shock are the PSI 4 stratums driving the PSI 4 overall rate
- Overall rate is publically reported for PSI 4
- **PSI 4 will be replaced by a new updated and improved measure: Failure to Rescue 30 day Mortality, that will exclude a case if the complication was present on admission**

Patient Safety Indicator (PSI) 90 Individual Components Performance

PSI 90 Individual Component Feb 2024 - Jan 2025	Actual Events Medicare Population (N/D)	Medicare Risk Adjusted Rate Publically Reported	Actual Events ALL Payer (N/D)	ALL Payer Risk Adjusted Rate Internal Tracking	Spring 2025 leapfrog mean individual Component (not used in grade scoring)
PSI 03 Pressure Ulcer [i]	2/2241	0.89	6/10579	0.57	0.20
PSI 06 Iatrogenic Pneumothorax	1/2955	0.39	3/14046	0.21	0.21
PSI 08 In-Hospital Fall-Associated Fracture	0/2952	0	0/14406	0	0.24
PSI 09 Postoperative Hemorrhage or Hematoma	1/674	1.48	7/3305	2.12	1.84
*PSI 10 Postop Acute Kidney Injury Requiring Dialysis	2/225	8.89	3/828	3.62	2.65
*PSI 11 Postoperative Respiratory Failure [i]	5/231	21.65	11/813	11.78	10.76
PSI 12 Perioperative Pulmonary Embolism or DVT[i]	1/684	1.46	7/3306	2.12	5.58
*PSI 13 Postoperative Sepsis [i]	0/215	0	2/793	2.52	7.17
PSI 14 Postoperative Wound Dehiscence	0/123	0	1/715	1.40	1.65
PSI 15 Accidental Puncture or Laceration	1/444	0	1/2705	0.37	1.58

- PSI 90 Composite YTD Rate: 1.82**
- PSI 90 Composite score Spring 2025 Mean: 1.00
- PSI 12 Perioperative PE/DVT improving based on past performance
- Highest weighted PSIs driving YTD PSI 90 Rate: PSI 3, PSI 10, PSI 11

[i] Highest weighted PSIs (risk adjusted based on volume & potential for pt. harm)
*Elective procedures
** The weighted average of the observed-to-expected ratios for the PSI 90 component indicators (PSI 90 is composed of 10 individual components: PSI 3,6,8,9,10,11,12, 13, 14, & 15)
Midas software data is an estimate utilizing the same software CMS uses however it is not apples to apples comparison

Thank you

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

Kaweah Health

Outstanding Health Outcomes (OHO)

Healthgrades 2026 Ratings & Specialty Awards Annual Update

October 2025

Healthgrades Methodology

2026 Healthgrades Methodology Star Ratings & Specialty Awards

Key Take-Away Messages

- **Clear numeric targets:** e.g., 1–5 fewer deaths or a few fewer complications to move each condition out of the 1-star tier.
- **Cross-cutting risk factors:** Renal failure, respiratory failure, acidosis, and palliative-care patients recur across conditions.
- **Strategic focus areas:**
  - Optimize risk-stratification and early intervention for these factors.
  - Strengthen care-planning and transitions for high-risk/palliative patients.

Notes:

- Report encompasses three years of Medicare patient data (2022-2024)
- Only 1-star ratings are summarized
- All COVID-19 patients are removed

★★★★★ Outcomes **better** than expected ~ 15%

★★★ Outcomes **as expected** ~ 70%

★ Outcomes **worse** than expected ~ 15%

Mortality Rates

Did patients die during or after their care?

Complication Rates

Did patients experience unexpected issues during their hospital stay?

Healthgrades 2026 Specialty Awards & Ratings

2026 Specialty Awards & Ratings

Kaweah Health

Recipient of the Healthgrades 2025 Patient Safety Excellence Award™
Named Among the Top 5% in the Nation for Patient Safety in 2025

Best Specialty
One of Healthgrades America's 100 Best Hospitals for Spine Surgery™ for 3 Years in a Row (2024-2026)
Orthopedics
Recipient of the Healthgrades Spine Surgery Excellence Award™ for 2 Years in a Row (2025-2026)
Named Among the Top 10% in the Nation for Spine Surgery for 2 Years in a Row (2025-2026)
Five-Star Recipient for Spinal Fusion Surgery for 4 Years in a Row (2023-2026)
Vascular
Five-Star Recipient for Carotid Procedures in 2026
Outpatient
Five-Star Recipient for Outpatient Total Knee Replacement for 2 Years in a Row (2025-2026)

Healthgrades Heart Attack (AMI) Mortality: 1-Star Rating

Kaweah Health Medical Center	In-hospital Mortality		
	Cases	Actual	Predicted
Acute Myocardial Infarction (Angioplasty/Stent available)			
Kaweah Health Medical Center, Visalia, CA	554	9.93%	8.40%
Three-Star Requirement	554	9.77%	8.40%
National Average	408	5.82%	5.82%

FY25 Goal

- Decrease AMI Mortality O:E ratio </= 1.09
- (Current 12-month rolling AVG O:E ratio = 1.12

Gap to 3-Star Care: 1 fewer mortality - Adverse outcome rate of 9.77% or lower

CURRENT IMPROVEMENT ACTIVITIES	COMPLETION DATE	BARRIERS
Review fall outs with Cath Lab medical director	On-going	Data for provider level detail is not available through NCDR; manual chart review has to be done
Review ACC metric appropriate use criteria (AUC) with cardiologists with fall outs	12/31/2025	Requires individual meetings – time constraints
Cath Lab medical director to assist with the above – meet with peers regarding AUC	12/31/2025	As above
Engage with transferring facilities about D2B	12/31/25	Scheduling for outside facilities ED directors, nursing leaders, Medical Director of KH Cath Lab, etc.

Healthgrades Heart Failure Mortality: 1-Star Rating

Kaweah Health Medical Center	In-hospital Mortality		
	Cases	Actual	Predicted
Heart Failure			
Kaweah Health Medical Center, Visalia, CA	1178	5.35%	4.18%
Three-Star Requirement	1178	4.93%	4.18%
National Average	602	3.12%	3.14%

FY25 Goal

- Decrease Heart Failure Mortality O:E ratio to <0.48
- (Current 12-month rolling AVG O:E ratio = 0.93

Gap to 3-Star Care: 5 fewer mortality - Adverse outcome rate of 4.9% or lower

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
Refer patients to Sequoia Cardiology for post discharge follow up for 2N patients as part of a pilot program. Plan to evaluate ability to execute house-wide.	Completed May 2025	Insurance related and the requirement for new referrals to cardiology to go through PCPs for some patients
Reviewing provider level data, posting provider level results and celebrating providers who are ordering evidenced based medications when not contraindicated, continue quarterly	June 2026	
Develop workflow in Cerner (mirrors Stroke patient discharge workflow, which successfully ensures stroke patients are discharge on correct medications) which uses a discharge power form to remind providers to prescribe the evidenced based medications, or if contraindication to select the contraindication from a list (measures can be accurate and exclude patients with contraindications).	Live June 18, 2025	
Analyze data generated from discharge power form (live June 18, 2025) to understand reasons for not prescribing medications.	30-60 days following d/c power form go live June 18, 2025	

Healthgrades COPD Mortality: 1-Star Rating

Kaweah Health Medical Center	In-hospital Mortality		
	Cases	Actual	Predicted
Chronic Obstructive Pulmonary Disease (COPD)			
Kaweah Health Medical Center, Visalia, CA	375	3.47%	2.16%
Three-Star Requirement	375	3.24%	2.16%
National Average	174	1.41%	1.45%

FY25 Goal

- Decrease mortality O:E ratio to <0.70
- (Current 12-month rolling AVG O:E ratio = 1.41)

Gap to 3-Star Care: 1 fewer mortality - Adverse outcome rate of 3.2% or lower

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
Dr. Gribben, new Pulmonologist, is available to assist in managing inpatient COPD. Predict reduction in prednisone usage and encourage greater provider adoption of LABA/LAMA prescriptions.	May 5, 2025, On going	None
Discharge power form reminding providers to order LAMA/LABA or list reason why no ordered	May 27, 2025	None
When pop up occurs workflow developed in Cerner were provider will indicate why medications are not ordered. Report to be built so opportunities can be identified to address	30-60 days following power form go live	ISS resources
Celebrating providers who are ordering meds (provider level data), continue quarterly	June 2026	None

Healthgrades Sepsis Mortality: 1-Star Rating

Kaweah Health Medical Center	In-hospital Mortality		
	Cases	Actual	Predicted
Sepsis			
Kaweah Health Medical Center, Visalia, CA	1016	25.79%	25.25%
Five-Star Requirement	1016	23.62%	25.25%
National Average	964	12.89%	12.91%

FY25 Goal

- Sepsis mortality O:E ratio ≤ 0.61
- (Current 12-month rolling AVG O:E = 0.84)
- 5 fewer deaths (1 year)

Gap to 3-Star Care: 22 fewer mortality (3years) - Adverse outcome rate of 23.6% or lower

CURRENT IMPROVEMENT ACTIVITIES	COMPLETION DATE	BARRIERS
Ongoing collaboration with HIM/Coding to improve physician coding practices for accurate organism-linked sepsis diagnosis	Ongoing	Low physician responsiveness to coder queries
Annual and PRN targeted training for all new EM residents; Annual March SIM session; Workflow training at onboarding and reinforced in weekly didactics	Ongoing	Competing clinical priorities and variable provider attendance
In-the-moment education for staff and providers on non-compliance with CMS sepsis bundle documentation and interventions	Ongoing	Resistance to workflow change and alert fatigue

HealthgradesTotal Hip Complications: 1-Star Rating

Kaweah Health Medical Center	In-hospital Complication		
	Cases	Actual	Predicted
Total Hip Replacement			
Kaweah Health Medical Center, Visalia, CA	59	13.56%	6.62%
Three-Star Requirement	59	11.84%	6.62%
National Average	118	6.20%	6.63%

FY26 Goal

- Decrease complication rate from 76th percentile to 45th percentile

Gap to 3-Star Care: 2 fewer complications – Complication rate of 11.8% or lower

CURRENT IMPROVEMENT ACTIVITIES	COMPLETION DATE	BARRIERS
Collaborate with therapy leadership and orthopedic surgeons to initiate outpatient therapy within 1 week post-op to enhance wound monitoring, education, and rehab start.	6/30/2026	Need consensus and workflow changes across therapy and surgical teams
Integrate Ortho NP daily rounding for routine assessment and coordination; review complication cases in SQIP and co-management meetings.	On-going	Balancing NP workload and consistent participation
Continue Ortho NP daily email updates with Case Management and Post-Acute Liaisons to streamline discharge planning and rehab placement.	On-going	Maintaining timely communication and addressing patient-specific rehab barriers
Refine Joint Camp education workflows with orthopedic offices to improve pre-op education access and assess functional/social barriers early.	12/31/2025	Variable engagement from provider offices and patient adherence

Thank you

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Kaweah Health

Outstanding Health Outcomes (OHO)
QUALITY & PATIENT SAFETY PRIORITY

Healthcare Acquired Infection (HAI) Reduction

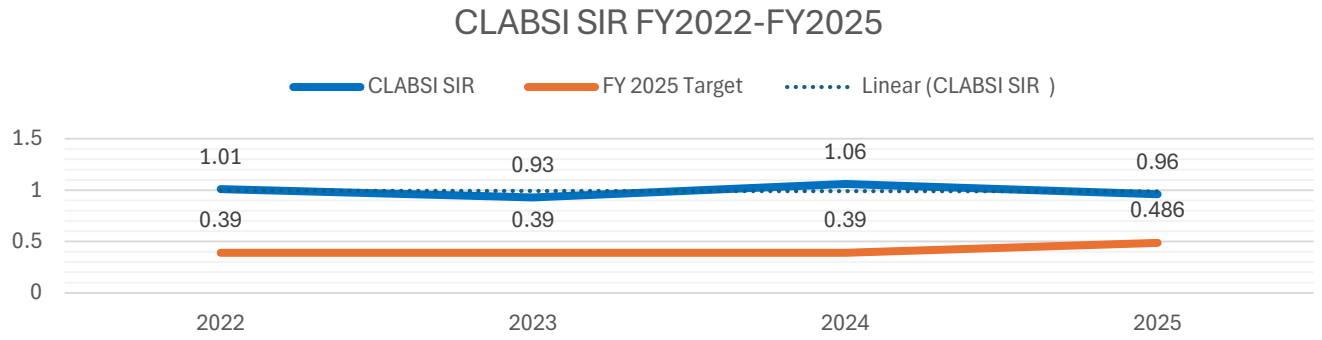
November 2025

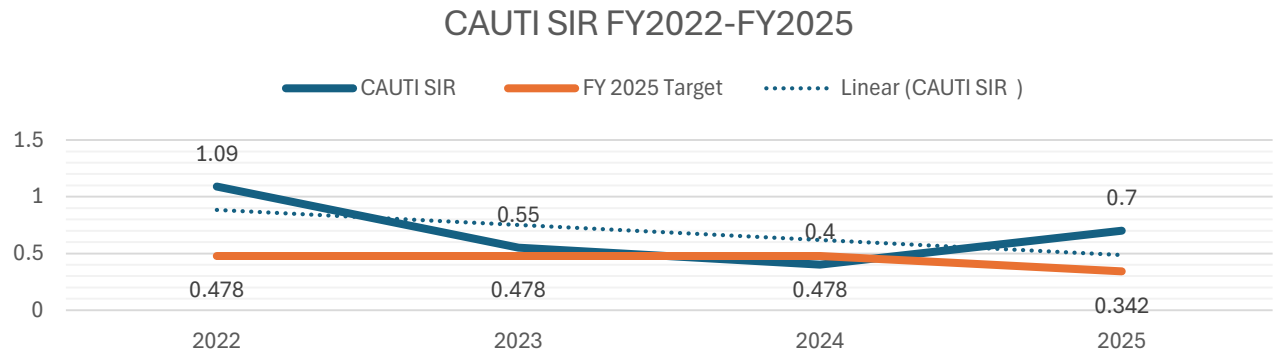
OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

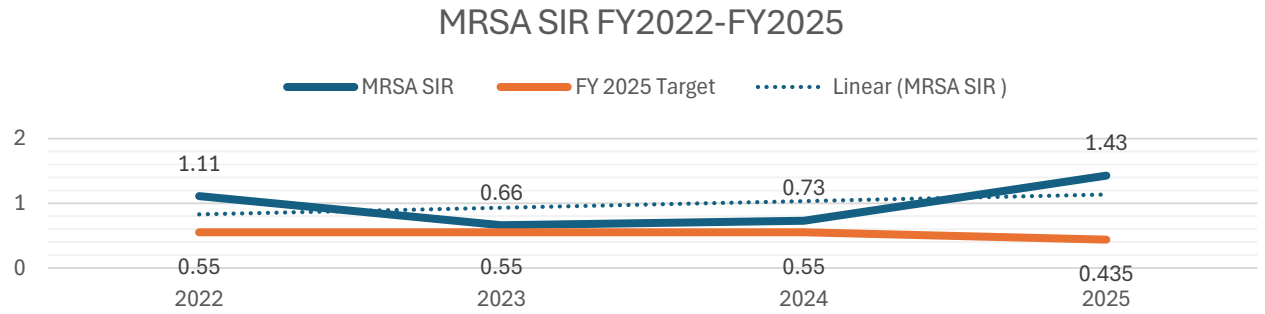
(number of actual infections/number of predicted infections by CMS)

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

Historical Baseline







FY25 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)

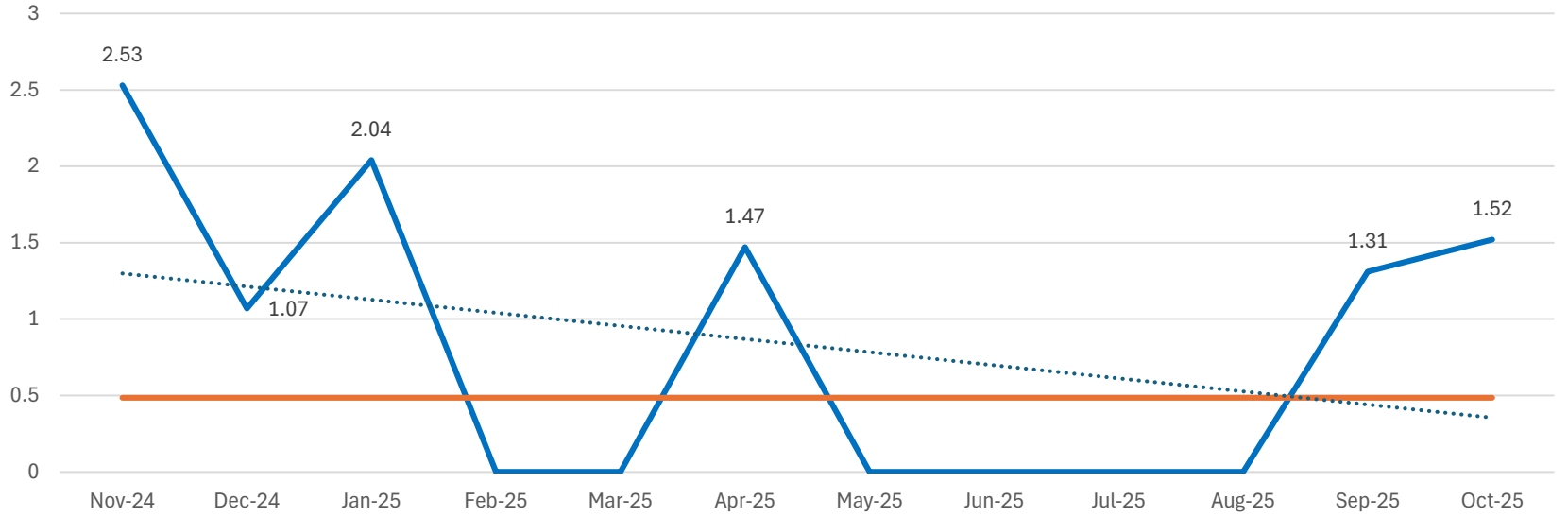
FY25 GOAL

Decrease: CLABSI SIR to <0.486; CAUTI SIR to < 0.342; MRSA <0.435

OHO FY25 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

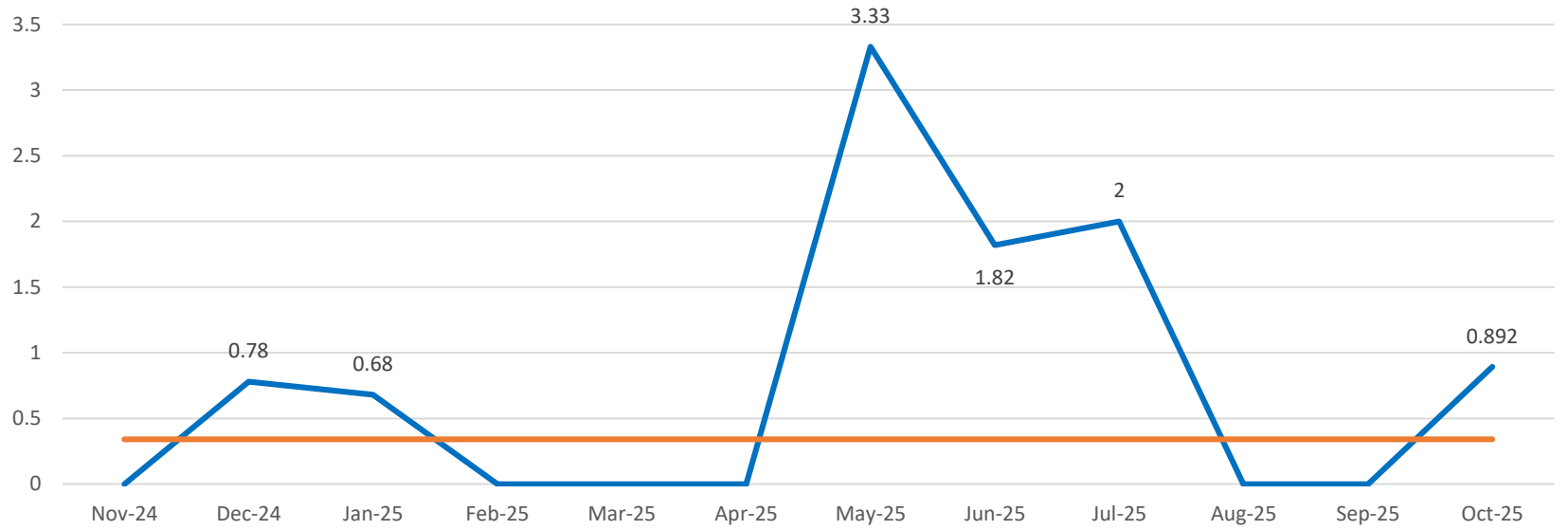


	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Total
CLABSI EVENTS	2	1	2	0	0	1	0	0	0	0	1	1	8
CLABSI Predicted	0.792	0.938	0.982	0.64	0.739	0.682	0.656	0.713	0.605	0.58	0.765	0.656	8.748
CLABSI SIR	2.53	1.07	2.04	0	0	1.47	0	0	0	0	1.31	1.52	0.91
CLABSI SIR Goal (70th 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 FY25 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
- Nurse Driven Protocol – IUC removal
- Hand Hygiene monitoring

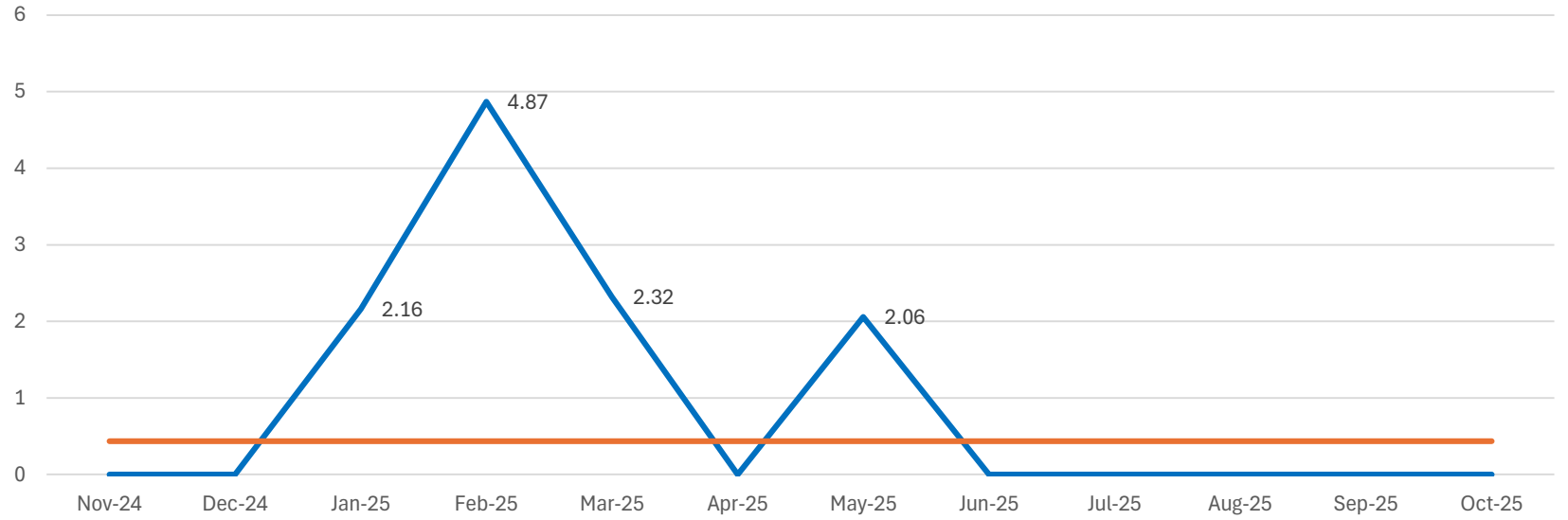


	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Total
CAUTI EVENTS	0	1	1	0	0	0	3	2	2	0	0	1	10
CAUTI Predicted	1.1	1.29	1.47	1	1.23	1.05	0.9	1.1	1	0.9	1.04	1.12	13.2
CAUTI SIR	0	0.78	0.68	0	0	0	3.33	1.82	2	0	0	0.892	0.76
CAUTI SIR Goal (70th percentile /top 30%)	0.342	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 FY25 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



	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Total
MRSA EVENTS	0	0	1	2	1	0	1	0	0	0	0	0	5
MRSA Predicted	0.45	0.47	0.46	0.41	0.43	0.47	0.49	0.48	0.4	0.39	0.36	0.253	5.063
MRSA SIR	0	0	2.16	4.87	2.32	0	2.06	0	0	0	0	0	0.99
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

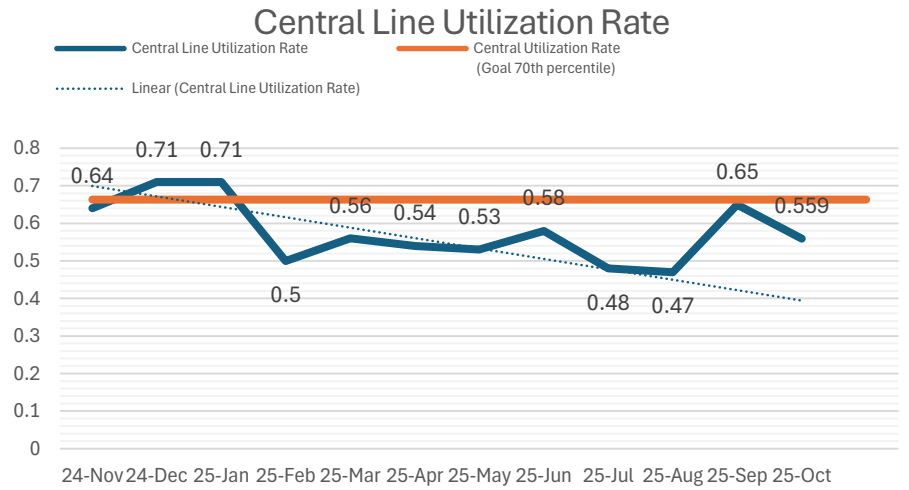
OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

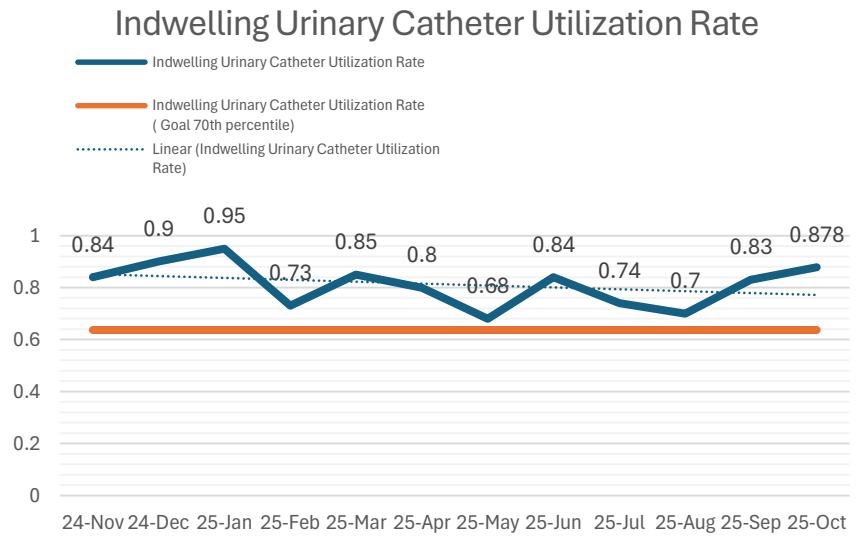
The last data point did not meet goal because:

- Evidenced-based prevention strategies to reduce HAIs are not occurring

Targeted Opportunities

- Reduce line utilization; less lines, less opportunity for infections to occur
  - Goal: reduce central line utilization ratio to <0.663
  - Nov 2024 – Oct 2025 (SUR = 0.581)
  - Goal: reduce urinary catheter ratio to <0.64
  - Nov 2024 – Oct 2025 (SUR = 0.811)
- MRSA nasal and skin decolonization for patients with lines.
  - Goal: 100% of at-risk patients nasally decolonized
  - July 2025 – Oct 2025 100% of screen patients nasally decolonized
  - Data under evaluation, case reviews indicated that all SNF patients are being screened upon admission (Mar- Oct 2025)
  - Jul 2024 - Goal: 100% of line patients have CHG bathing
- Improve hand hygiene (HH) through increased use of BioVigil electronic HH monitoring system
  - Goal: 60% of staff are active users of BioVigil
  - FY2025 56% August 2025 to October 2025 61% of staff are active users
  - HH Compliance rate overall 94.3%
  - 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





OHO FY25 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-1 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

Thank you

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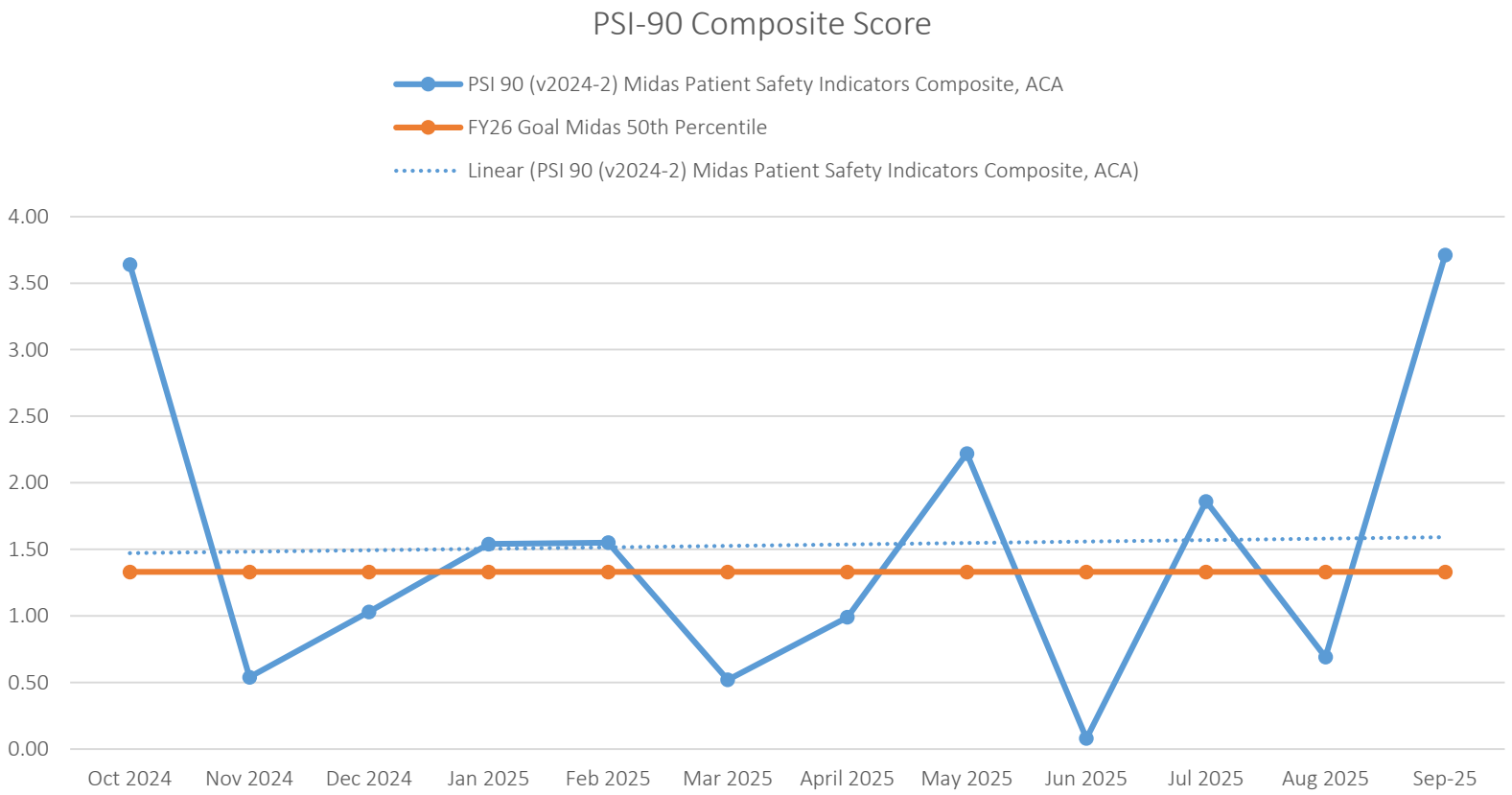
PATIENT SAFETY INDICATOR (PSI) 90 COMPOSITE

November 2025

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 = 1.41
- Goal Midas National 50th percentile = 1.33

- **FYTD 2026 = 2.23 (July-Sept. 2025)**

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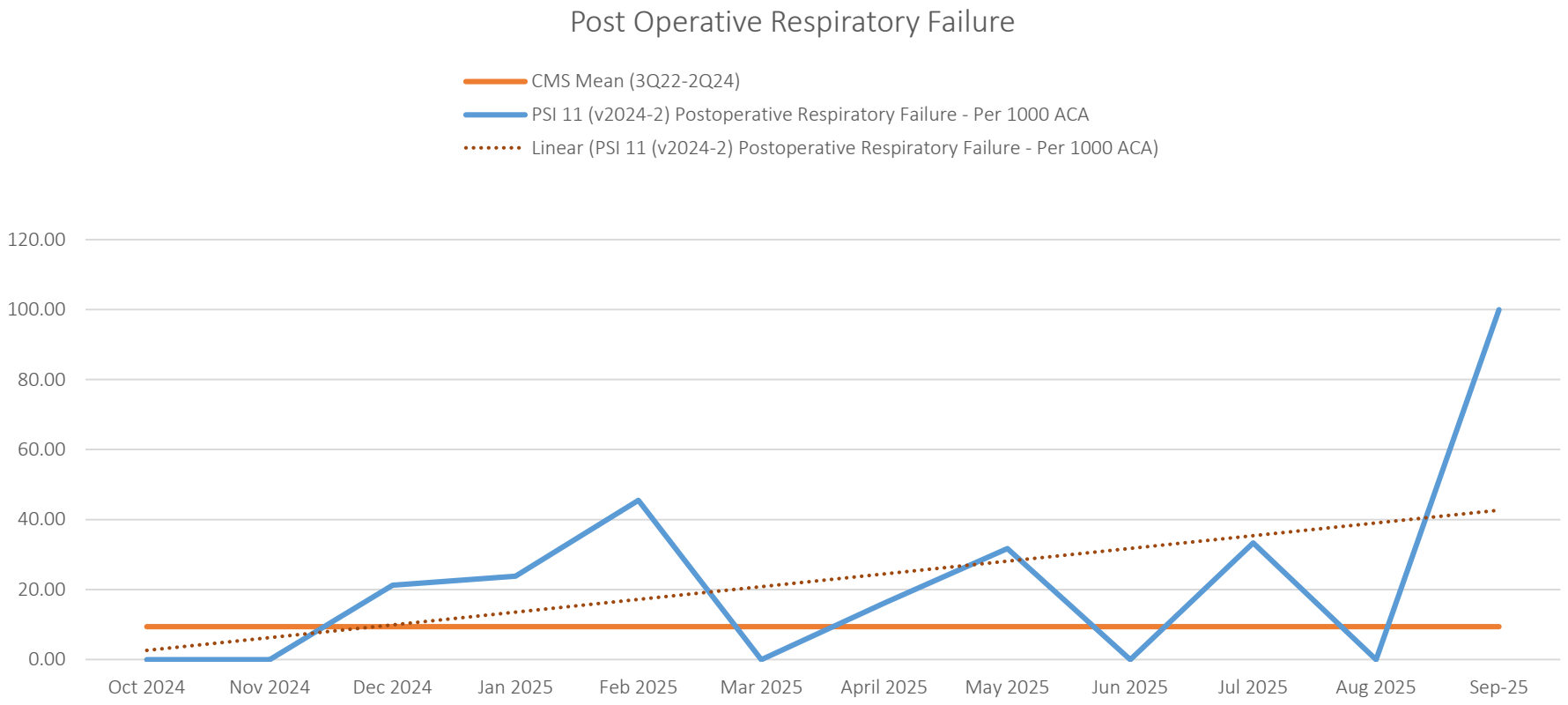
OHO FY26: Patient Safety Indicator (PSI) 11



FY25 PSI 11 rate = 15.52

Goal Midas National 50th percentile = 9.42

FYTD 2026 = 38.22 (July-Sept 2025 (n=6)

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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

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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 publically reported measure on CMS's Care Compare website and is a component in the CMS Star Rating, Leapfrog Safety Grade and also includes many coded complications used in Healthgrades star ratings

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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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