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 Executive Office Conference Room {Acequia Wing} on Thursday, October 16, 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

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

Kaweah Delta Health Care District Board of Directors Quality Council
Meeting held: Thursday, October 16, 2025 • Kaweah Health Executive Office Conference 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 September 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

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*

Kaweah Delta Health Care District
Board Of Directors Committee Meeting

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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 September 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. **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. *Ayham Zoreikat, Director of Cardiovascular Service Line and Operations.*

7. **Clinical Quality Goals Update –** A review of current performance and actions focused on the clinical quality goals for Healthcare Acquired Infection and Sepsis. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*

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

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will enable the District to make reasonable arrangements to ensure accessibility to the Kaweah Delta Health Care District Board of Directors meeting.

Agenda item intentionally omitted

OPEN Quality Council Committee
Thursday, September 18, 2025
The Lifestyle Center Conference Room

Attending: Board Members: Mike Olmos (Chair) & Dr. Dean Levitan, Board Member; Sandy Volchko, Director of Quality & Patient Safety; Marc Mertz, Chief Strategy Officer; Schlene Peet, Chief Nursing Officer; Dr. Julianne Rudolph, Chief of Staff and Chair; Jag Batth, Chief Operation Officer; Ryan Gates, Chief Ambulatory Officer; Dr. Lamar Mack, Medical Director of Quality & Patient Safety; Shawn Elkin, Infection Prevention Manager; Martha Cardenas, RN-Clinical Care Quality Assurance; Dr. Paul Stefanacci, Chief Medical Officer; Kyndra Licon – Recording.

Mike Olmos called to order at 7:45 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 7:46 AM.

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

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

4. **Quality Incentive pool (QIP) report –** A review of current performance and initiatives aimed at improving rural health care clinics. *Sonia Duran-Aguilar, MSN, MPH, RN, PHN, CNL, CRHCP, Director of Population health Management; Ryan Gates, PharmD, CRHCP, Chief Population Officer.* - Reports reviewed and attached to minutes. No action taken.

5. **Clinical Quality Goals Update**- A review of current performance and actions focused on the clinical quality goals for Healthcare Acquired Infections and Sepsis. – Reports reviewed and attached to minutes. No action taken.

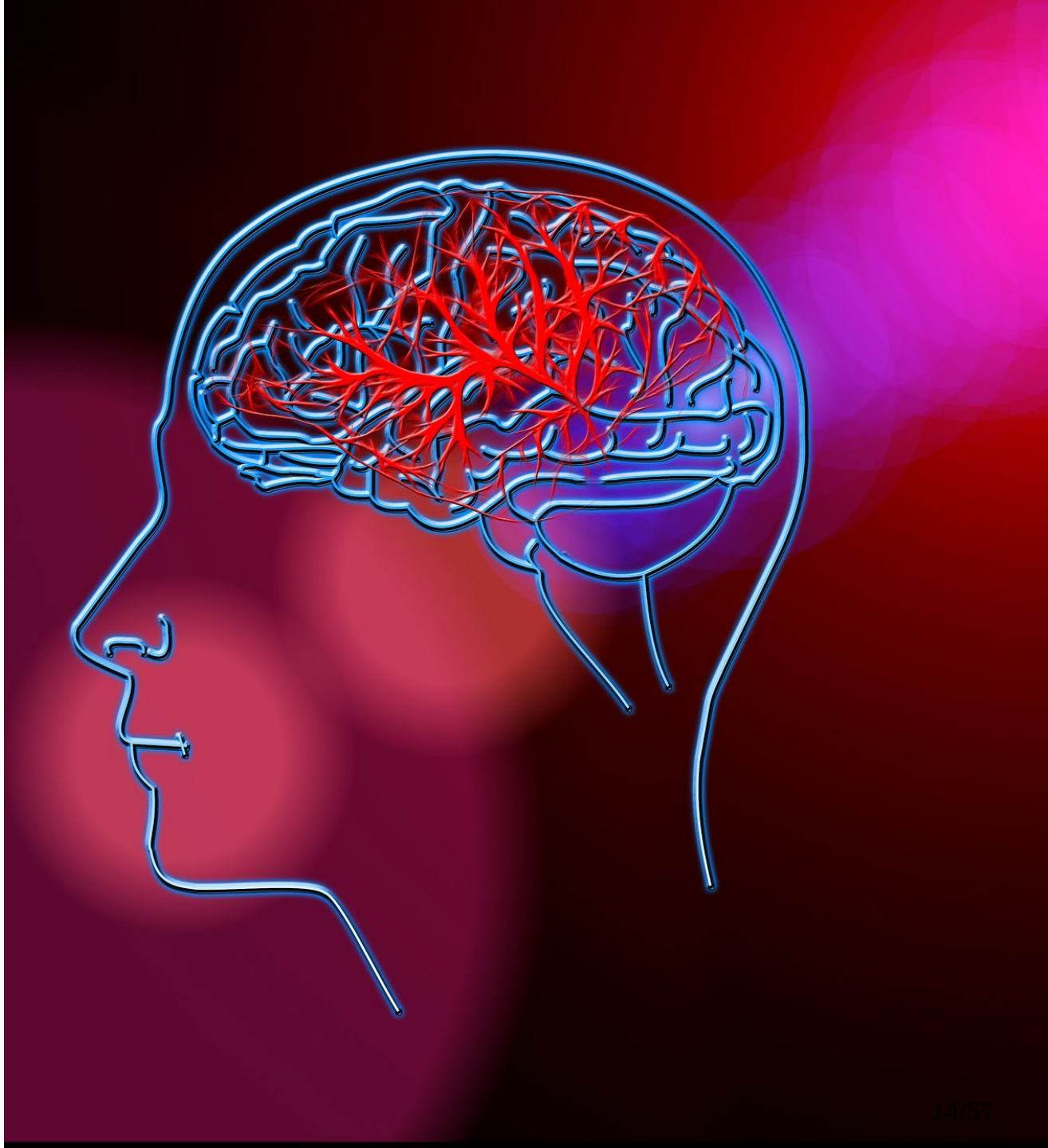
Adjourn Open Meeting – *Mike Olmos, Committee Chair*

Mike Olmos adjourned the meeting at 8:52 AM.

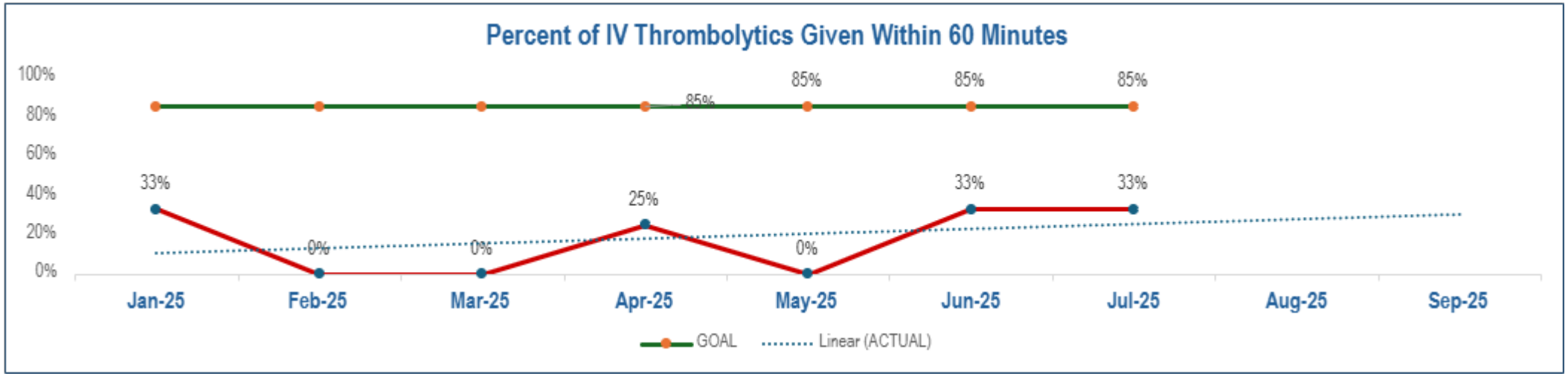
Stroke Quality Committee

August 2025

High Priority Initiatives and Action Items



IV Thrombolytics Given to Eligible Acute Ischemic Stroke Patients



Month	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Goal	85%	85%	85%	85%	85%	85%	85%
Numerator	1	0	0	1	0	1	1
Denominator	3	2	2	4	0	3	3
Average	33%	0%	0%	25%	0%	33%	33%

Barriers to Optimal Outcomes:

- Delays in initial stroke alert order and treatment initiation.
- Full provider assessment completed should only occur after CT scan.
- Inconsistent team huddle following CT results.
- Written consent required, causing delays
- Consent discussions occur late in the process.
- Inconsistent identification of Tier 1 patients.
- Blood pressure management/control prior to treatment is variable.

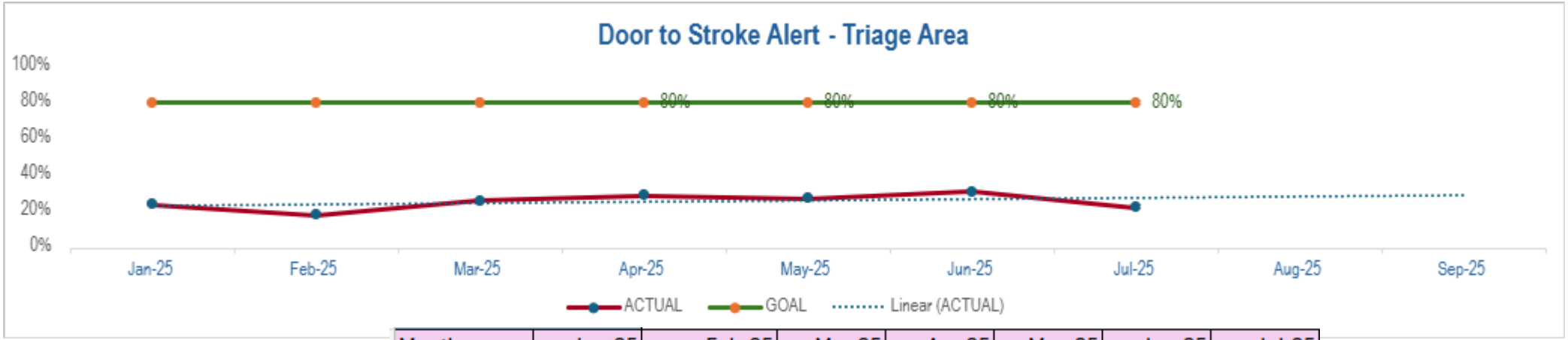
Action Items to Improve Outcomes:

- Implemented EMS Patient Information Card to aide in consent process -May 1, 2025. Working with Marketing on QR code for EMS staff.
- Reinforce nursing education on early blood pressure management for potential TNK patients. Education completed June 4, 2025
- Increase presence of Stroke Manager, ED Assistant Nurse Managers, and ED Clinical Educator during tier 1 stroke alerts.

OWNER(S): Scott Baker, Dr. Oldroyd, Dr. Tu

TARGET: < 60 minutes
MEDIAN TIME: 79 minutes

Door to Stroke Alert – Triage Area



Month	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Goal	80%	80%	80%	80%	80%	80%	80%
Numerator	10	10	13	18	16	21	17
Denominator	42	55	50	63	59	67	77
Average	24%	18%	26%	29%	27%	31%	22%

Barriers to Optimal Outcomes:

- Early patient identification by registration staff (non-medical personnel) rather than clinical providers.
- Delays in identifying Tier 1 patients.
- Prolonged time to provider evaluation.
- Unclear protocol for involving STL during alerts.
- Patients presenting with vague symptoms such as numbness, tingling, or unclear history.
- Additional steps in the triage alert process causing delays.

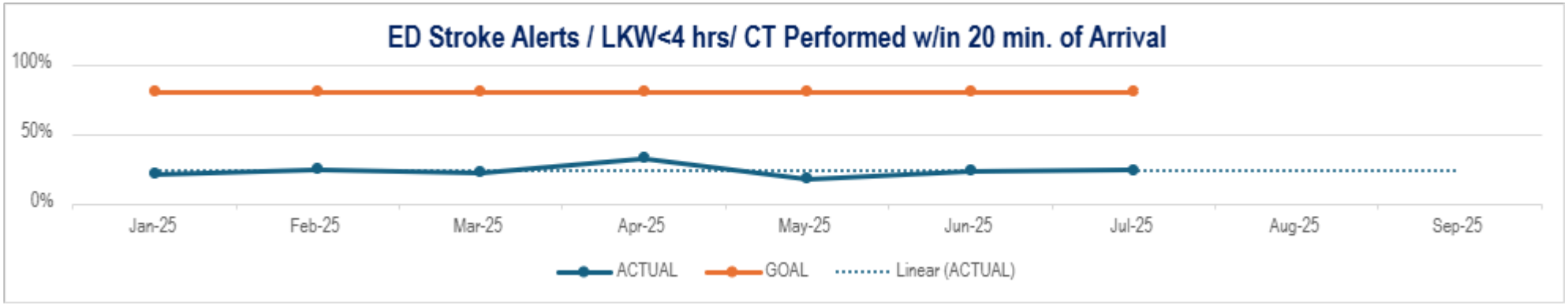
Action Items to Improve Outcomes:

- Collaborate with Registration Staff to explain the purpose of stroke alerts and identified barriers to early identification. Follow up with registration staff, identified no opportunities. **Completed**
- Continue gathering data to better understand and address identification challenges.
- Launchpad initiated in June, all triage stroke alerts are called overhead. Zone 5 provider is to come evaluate patient within 5 minutes.

TARGET: 10 minutes
MEDIAN TIME (YTD): 15 minutes

OWNER(S): Scott Baker, Dr. Oldroyd, Dr. Tu

Door to CT Perform: Tier 1 Stroke Alerts



Month	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Goal	80%	80%	80%	80%	80%	80%	80%
Numerator	10	13	11	16	11	15	14
Denominator	45	52	50	56	62	64	58
Average	22%	25%	22%	29%	18%	23%	24%

Barriers to Optimal Outcomes:

- Delays in stroke alert activation during triage.
- Stroke alert orders not placed promptly, delaying CT scan performance.
- Unclear stroke patient flow from EMS/triage to CT.
- Providers performing full evaluations before CT, causing delays.

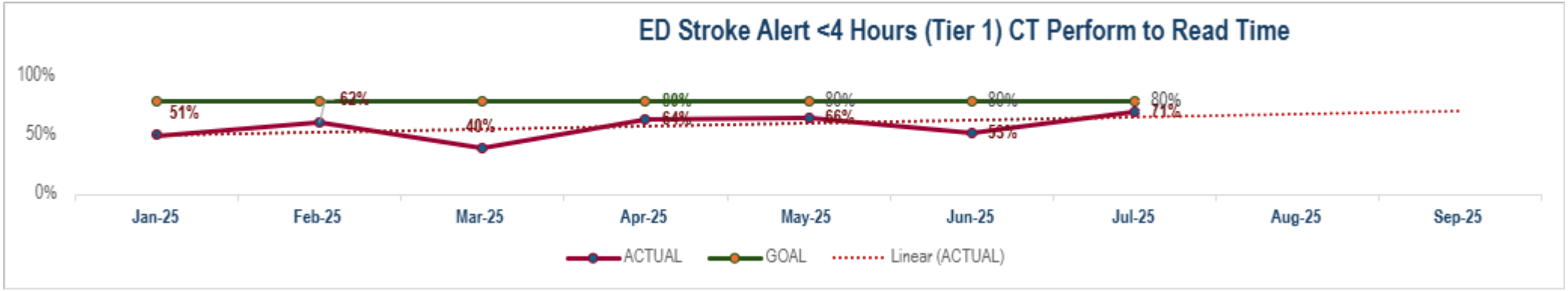
Action Items to Improve Outcomes:

- Utilize Renee's audit tool to track CT delays. Audit started June 13, 2025. Plan to review with ED Leadership.
- Clearly assign Zone 5 Team B provider to evaluate patients at Launchpad.
- Consider designating a resident as the stroke lead for each shift.

OWNER(S): Scott Baker, Dr. Oldroyd, Dr. Tu, Renee Lauck , Dr. Roper

TARGET: 80%; 20 minutes
MEDIAN TIME (YTD): 24% ; 26 minutes

CT Perform to Read Time: Tier 1 Stroke Alerts



Month	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Goal	80%	80%	80%	80%	80%	80%	80%
Numerator	23	32	20	36	41	34	41
Denominator	45	52	50	56	62	64	58
Average	51%	62%	40%	64%	66%	53%	71%

Barriers to Optimal Outcomes:

- Software issues with RAPID impacting workflow.
- Insufficient radiology resources due to high scan volume.
- Radiologists' lack of awareness regarding priority color coding on stroke alert scans.
- Inconsistent communication of imaging findings to ED providers.
- Delays in generating CT/CTA reports.

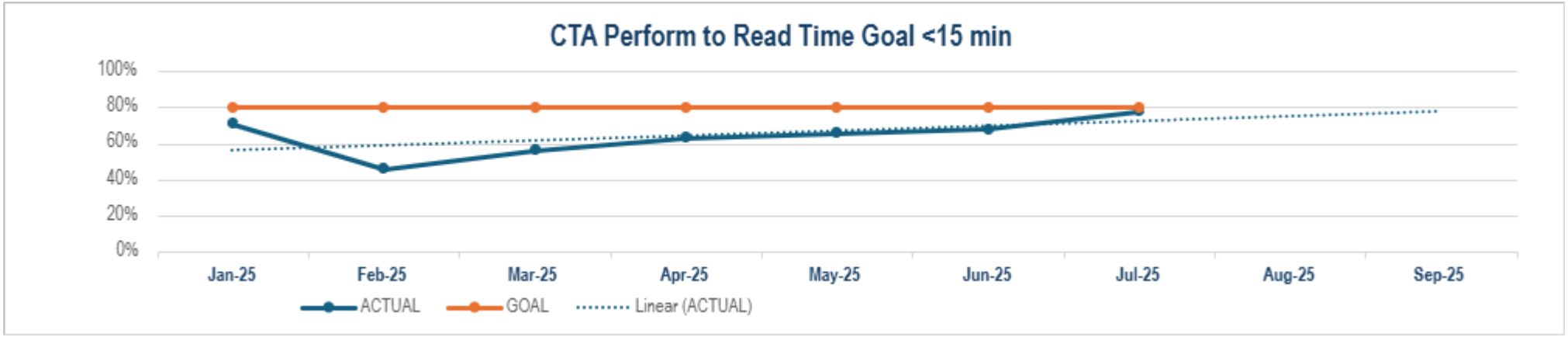
Action Items to Improve Outcomes:

- Renee has developed an audit tool to track delays. Audit started June 13, 2025
- Renee will provide education to radiologists on stroke alert prioritization. 7/7/25 Update: **Education completed.**
- Dr. Oldroyd and Cheryl have been invited to the Radiology Department meeting in August to discuss perform to read time goals

TARGET: 80%; 10 minutes
MEDIAN TIME (YTD): 58% ; 7 minutes

OWNER(S): Renee Lauck, Dr. Roper

CTA Perform to Read Time: Stroke Alerts



Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
80%	80%	80%	80%	80%	80%
50	65	71	83	91	105
108	117	113	126	133	134
46%	56%	63%	66%	68%	78%

Barriers to Optimal Outcomes:

- Software issues with RAPID impacting workflow.
- Insufficient radiology resources due to high scan volume.
- Radiologists' lack of awareness regarding priority color coding on stroke alert scans.
- Inconsistent communication of imaging findings to ED providers.
- Delays in generating CT/CTA reports.

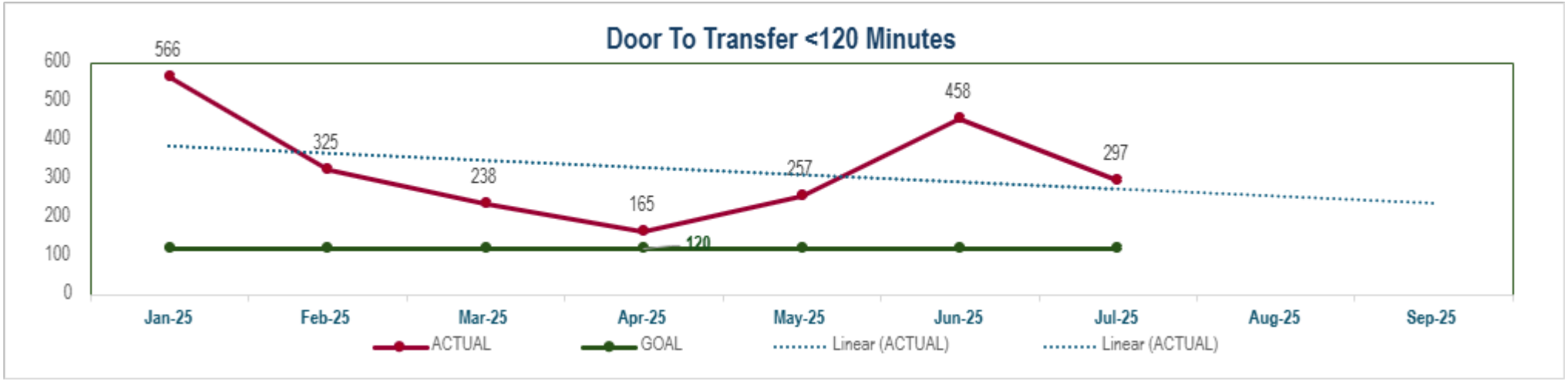
Action Items to Improve Outcomes:

- Renee has developed an audit tool to track delays. Audit started June 13, 2025
- Renee will provide education to radiologists on stroke alert prioritization. 7/7/25 Update: **Education completed.**
- Dr. Oldroyd and Cheryl have been invited to the Radiology Department meeting in August to discuss perform to read time goals

OWNER(S): Renee Lauck, Dr. Roper

TARGET: 80%; 15 minutes
MEDIAN TIME (YTD): 64% ; 12 minutes

Door to Transfer: Hemorrhagic Stroke



Barriers to Optimal Outcomes:

- No stroke alert activated for patients with symptoms lasting over 24 hours.
- At times, additional intervention needed (e.g., ET placement).
- Inadequate blood pressure control.
- Delays in transfer center notification.
- Delays in transport (Skylife) notification.
- Untimely initiation of the Ready to Fly checklist.
- Inconsistent discharge time documentation in Cerner

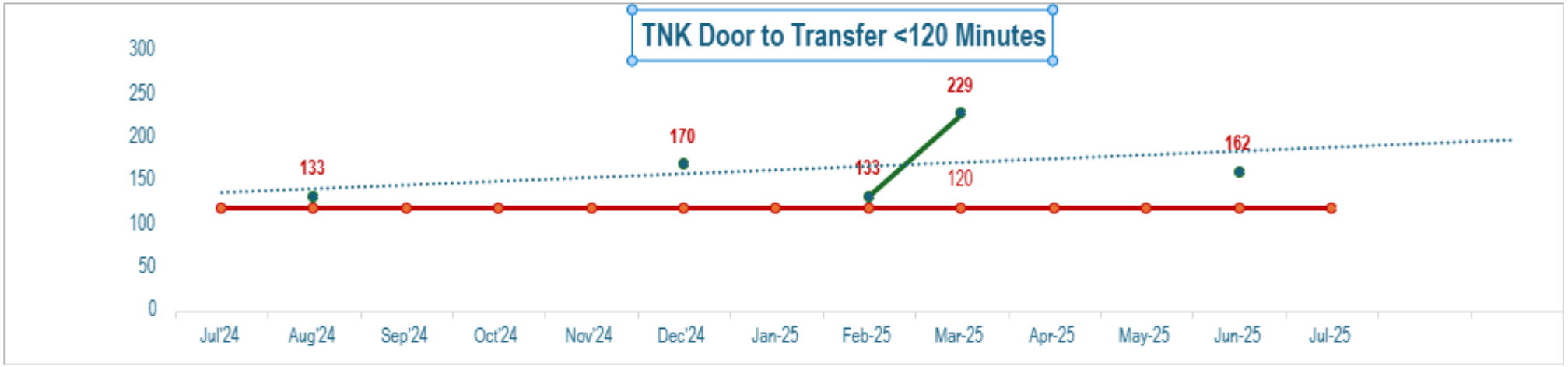
Action Items for Improved Outcomes:

- Conduct annual education sessions for ED providers and staff focused on the stroke alert process to reinforce timely and effective response.
- ED leadership to investigate the root causes of delays in discharge documentation within Cerner and develop an actionable plan to address issues.

OWNER(S): Scott Baker, Dr. Oldroyd, Denise Cabaje

TARGET: 120 minutes
MEDIAN TIME (YTD): 297 minutes

Door to Transfer: Large Vessel Occlusion w/ TNK



Barriers to Optimal Outcomes:

- Limited EMS resources
- Delays in transfer center notification
- Delays in transport (Skylife) notification
- Untimely initiation of the Ready to Fly checklist
- Inconsistent discharge time documentation in Cerner

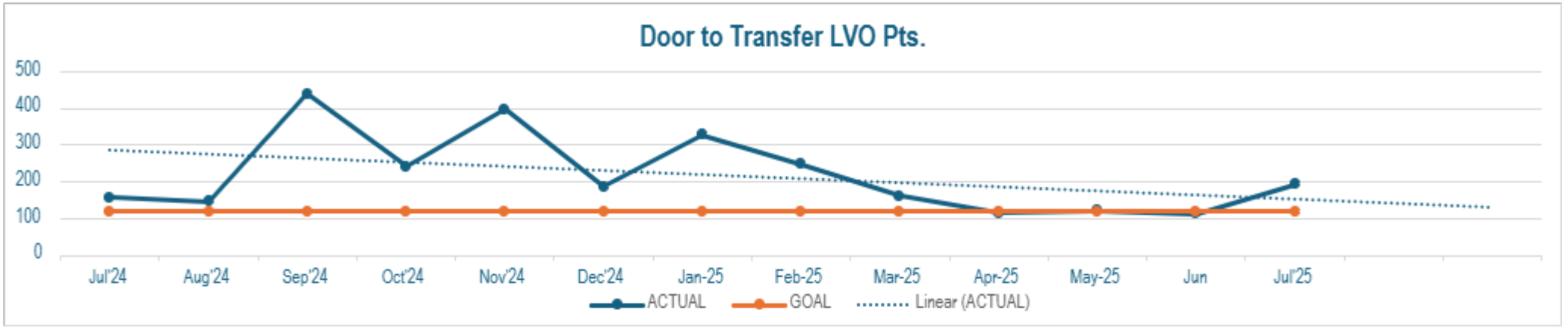
Action Items for Improved Outcomes:

- Conduct annual education sessions for ED providers and staff focused on the stroke alert process to reinforce timely and effective response.
- ED leadership to investigate the root causes of delays in discharge documentation within Cerner and develop an actionable plan to address issues.

OWNER(S): Sean Oldroyd, Scott Baker, Denise Caboje

TARGET: 120 minutes
MEDIAN TIME (YTD): 162 minutes

Door to Transfer: Large Vessel Occlusion



Barriers to Optimal Outcomes:

- Limited EMS resources causing transfer delays.
- Inconsistent discharge documentation in Cerner during transfers.
- Lack of perceived urgency due to unclear or extended timeframes.
- Post-scan, patients with Large Vessel Occlusions (LVOs) are occasionally moved to locations other than Zone 2, delaying appropriate intervention.
- Delays in notifying the transfer center, leading to downstream coordination issues.
- Delays in notifying transfer center and transport teams (e.g., Skylife).
- Discrepancies in how and when discharge time is entered into Cerner, causing documented delay in transfer time.

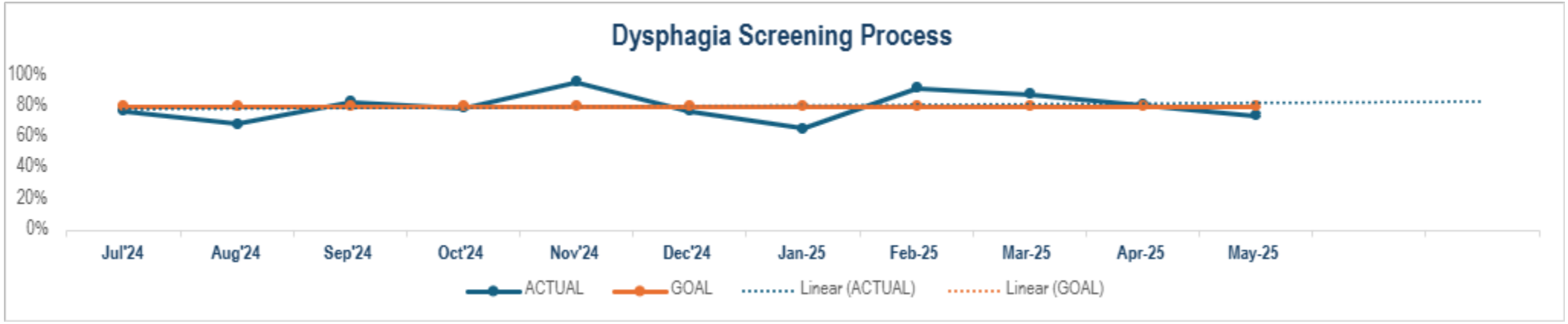
Action Items for Improved Outcomes:

- Conduct annual education sessions for ED providers and staff focused on the stroke alert process to reinforce timely and effective response.
- ED leadership to investigate the root causes of delays in discharge documentation within Cerner and develop an actionable plan to address issues.

OWNER(S): Sean Oldroyd, Scott Baker, Denise Caboje

TARGET: 120 minutes
MEDIAN TIME (YTD): 161 minutes

Dysphagia Screening Process



Barriers to Optimal Outcomes

•**Inconsistent dysphagia screening before PO intake** – Unclear if screen completed before patient receives food or meds.
•**Inconsistent use of stroke PowerPlans** – ED/admitting providers not always using stroke-specific order sets.
•**Providers unaware of screening outcome** – Risk of inappropriate PO orders or duplicate screening.
•**Triage communication gap** – RN and LVN/RN not consistently sharing dysphagia screen status.

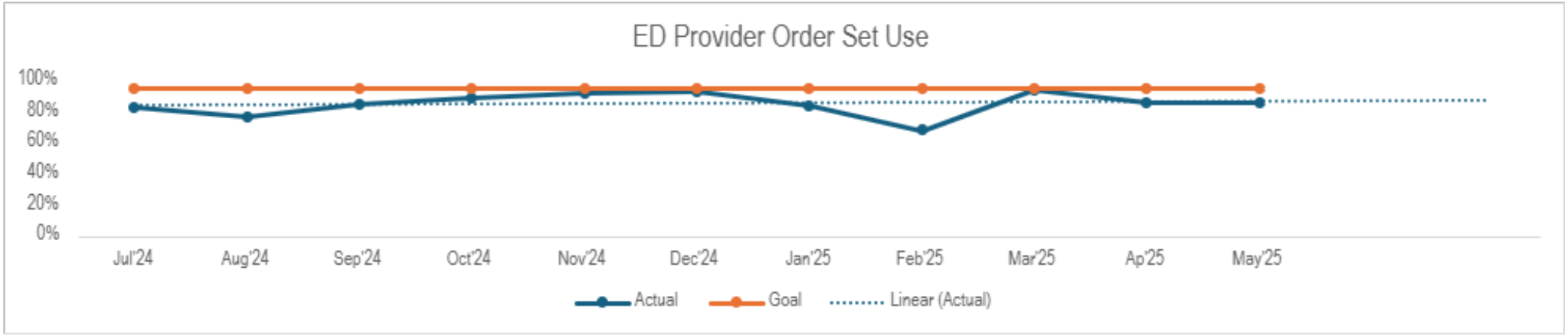
Action Items for Improved Outcomes:

- ED nursing leadership will follow up with involved staff as close to the event date as possible to provide timely feedback and support process improvement

OWNER(S): Scott Baker, Dr. Oldroyd, Dr. Tu

TARGET: 80%
AVE COMPLIANCE (YTD): 80%

Provider: ED Stroke Related PowerPlan Usage



Barriers to Optimal Outcomes

- Patients often present to the Emergency Department (ED) with vague or nonspecific symptoms, or with an extended time since they were last known well, which can delay diagnosis and treatment decisions.
- A key barrier has been identified in hemorrhagic stroke patients transferred to KH from outside facilities: there is inconsistent utilization of the ED hemorrhagic stroke order set at the transferring institutions, which may contribute to suboptimal care coordination and delays in initiating appropriate treatment upon arrival.

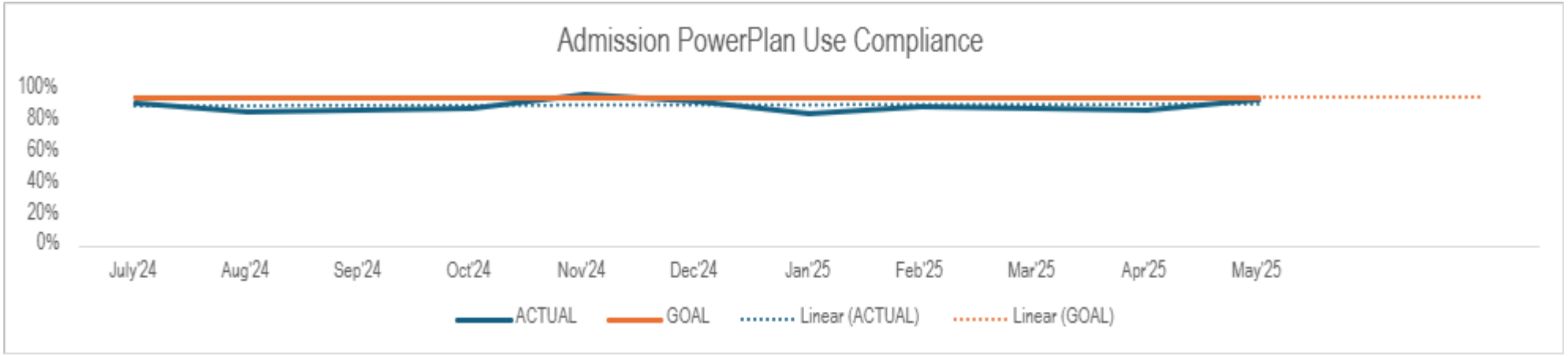
Action Items for Improved Outcomes:

- Implemented annual education for ED providers and staff focused on the stroke alert process and protocol adherence.
- Distribute weekly memos from the Stroke Medical Director to providers who have not utilized the appropriate stroke-related PowerPlan, reinforcing best practices.
- Provide quarterly updates and presentations at the Emergency Medicine Department meeting to review trends, reinforce protocols, and address ongoing challenges.

OWNER(S): Sean Oldroyd, DO, Khoa Tu, MD

TARGET: 95%
MEDIAN TIME (YTD): 86%

Provider: Admission Stroke PowerPlan Usage



Barriers to Optimal Outcomes

- **Limited Awareness Among New Providers**
  Newly credentialed providers may be unaware of the existing stroke PowerPlan and its importance in standardized stroke care
- **Infrequent Admitting Providers**
  Providers who seldom admit patients to KH may lack familiarity with the stroke PowerPlan or its location within the system.
- **No Dedicated PowerPlan for In-House Stroke Identification**
  When a stroke is identified in-house (not at admission), there is currently no specific PowerPlan available to guide timely and standardized treatment.

Action Items for Improved Stroke Outcomes:

- **Weekly Compliance Memos**
  The Stroke Medical Director will send weekly memos to providers who have not utilized the appropriate stroke-related PowerPlan.
- **Quarterly Department Presentations**
  Present stroke care updates and metrics quarterly at the Hospitalist/Intensivist Medical Staff Department meetings.
- **Annual Stroke Education Program**
  Develop and implement an annual stroke education initiative for all adult care providers.
- **In-House Stroke PowerPlan Development**
  Create and implement a standardized, in-house Stroke PowerPlan tailored to our institution's protocols.

OWNER(S): Dr. Oldroyd, Dr. Tedaldi, Dr. Hammond

TARGET: 95%
MEDIAN TIME (YTD): 88%

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department:
Hospice

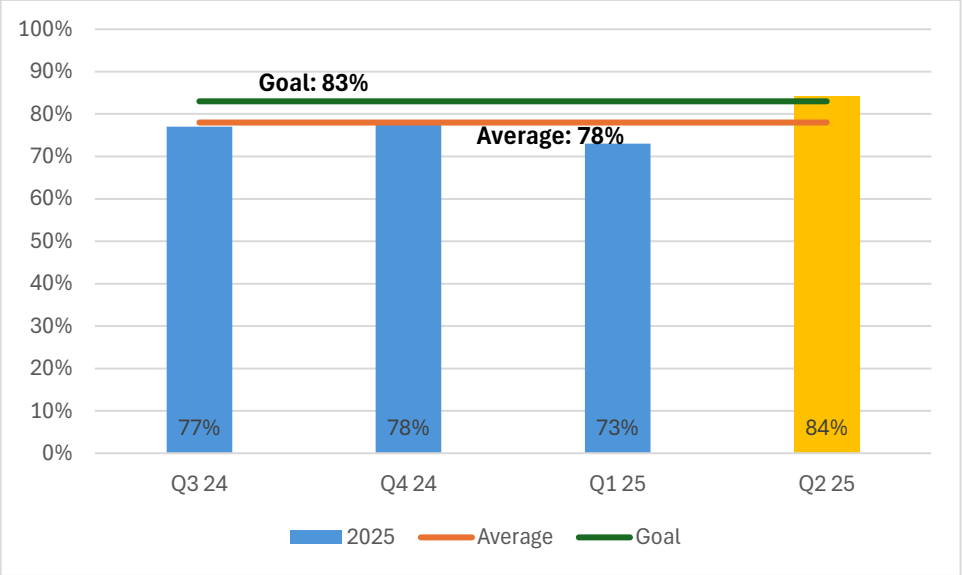
Date submitted:
August 2025

Kaweah Health Hospice utilizes NRC, a CMS approved third party vendor for distribution of satisfaction surveys and reporting of results. When calculating, an average for the last 4 quarters was used. By utilizing this data, the results have more current, relevant and detailed data than that reported by CMS on Hospice Compare. This information from NRC will eventually be submitted to CMS and will be publicly reported.

Measure Objective/Goal:
Communication with Family

Question: Kept Informed on Condition

- **Average of Quarters: Quarter 3 2024 (July 24) to Quarter 2 2025 (June 25) 78%**



Date range of data evaluated:
July 1, 2024 thru June 30, 2025

Data is gathered from the surveys administered by a third-party vendor, as part of the Hospice CAHPS survey. Hospices are required to participate in these surveys, which measure caregiver satisfaction. Information is then submitted to CMS by the third-party vendor.

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Analysis of all measures/data: (Include key findings, improvements, opportunities)

The current average score for "Kept Informed on Condition" over the past four quarters is 78%, which is below the NRC benchmark of 83% by 5%.
In 2024, the team was 2% below the benchmark, indicating a persistent performance gap.
This measure is a subset of the broader "Communication with Family" initiative, highlighting an ongoing opportunity for improvement.
The consistent shortfall underscores the need for targeted strategies to enhance communication effectiveness.

Improvements:
Recognition of the importance of this measure has prompted efforts to improve communication practices.
The focus on documenting family contacts and understanding levels has laid a foundation for data-driven improvements.
The acknowledgment that providing disease-specific educational materials can help families better understand the patient's condition represents a proactive step toward improvement.

Opportunities:
Enhance Post-Visit Follow-up: Instituting structured calls and documentation to ensure families are consistently informed.
Educational Outreach: Developing and distributing tailored written materials to prepare families for disease progression.
Staff Training: Strengthening communication skills through ongoing education and role-playing.
Utilize Technology: Leveraging digital tools to maintain regular, accessible communication channels.
Monitor and Feedback: Implementing regular reviews of communication logs and family feedback to identify gaps and tailor interventions.
Dedicated Family Liaison: Assigning a specific team member to coordinate and personalize communication efforts.

Conclusion:
While progress has been made, the data clearly indicates the need for focused, systematic improvements to meet and surpass the NRC benchmark. Enhancing communication strategies will not only improve scores but also strengthen caregiver and family satisfaction, ultimately supporting higher-quality hospice care.

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Next Steps/Recommendations/Outcomes:

Implement Improvement Strategies:
Establish standardized post-visit family call protocols, documentation processes, and distribution of disease-specific educational materials.
Provide ongoing staff training to enhance communication skills and ensure consistent messaging.

Monitor Progress Continuously:
Collect and review family communication data regularly, including documentation of calls and family feedback.
Use this data to identify areas for further improvement and to ensure adherence to new protocols.

Data Analysis Timeline:
Recognize that due to reporting lag (approximately 6 months), the impact of these initiatives will be observable after at least 4 quarters.
Continue to evaluate vendor and internal data quarterly to track progress toward goals.

Performance Goal:
Aim to reach and maintain a score of 85% on the "Kept Informed on Condition" measure within the next year, reflecting substantial improvement over current levels.

Outcome Expectations:
Improved communication will enhance family satisfaction, trust, and understanding of the patient's condition.
Meeting or exceeding the 85% target will demonstrate the effectiveness of the implemented strategies and support ongoing quality improvement efforts.

Submitted by Name:
Melany Gambini, Director
Kaweah Health Hospice

Date Submitted:
August 2025

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department:
Hospice

Date submitted:
August 2025

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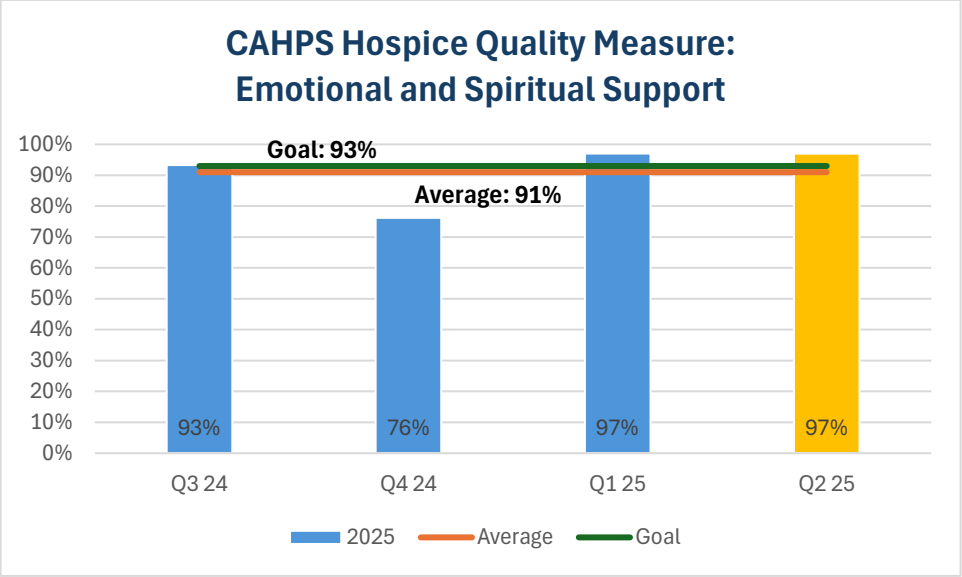
Measure Objective/Goal:
Emotional and Spiritual Support

- **Average of Quarters: Quarter 3 2024 (July 24) to Quarter 2 2025 (June 25)**



Date range of data evaluated:
July 1, 2024 thru June 30, 2025

Data is gathered from the surveys administered by a third-party vendor, as part of the Hospice CAHPS survey. Hospices are required to participate in these surveys, which measure caregiver satisfaction. Information is then submitted to CMS by the third-party vendor.

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Analysis of all measures/data: (Include key findings, improvements, opportunities)

Acknowledge Current Performance: Current data shows a strong average score of 91% on the initiative, exceeding the 93% NRC benchmark in the first three quarters. However, a significant drop occurred in Quarter 4, necessitating further investigation.

Identify Root Cause Analysis:
Focus on the three subset questions: The three subset questions (Emotional support after family member died, Emotional support from the hospice team, and religious support from hospice team) need to be analyzed to determine the specific reason(s) for the Quarter 4 decline. Qualitative data (e.g., staff feedback, family comments) should be collected in addition to quantitative data.

Training and Education:
2025-2026 Focus: The planned 2025-2026 education and training focusing on end-of-life support is a positive step. However, a more immediate, targeted training program is needed to address the identified deficiencies revealed in the Quarter 4 data.

Specific Recommendations:
Identify areas needing improvement: Are specific aspects of emotional or spiritual support lacking? Are staff members comfortable addressing these needs? Are communication protocols clear?
Implement corrective actions: Develop a plan for implementing specific training modules, materials, and tools to address the deficiencies. This could include role-playing exercises, case studies, or additional resources for staff.
Improved Communication Protocols: Review and potentially revise communication protocols to ensure families' needs are clearly identified and addressed.
Gather Feedback: Actively solicit feedback from staff and families to understand their experiences and identify areas for improvement in communication, training, and resources.

Monitoring and Evaluation:
Ongoing Tracking: Continue monitoring the initiative's performance on the three subset questions, tracking improvements in each quarter. Establish a baseline for the subset questions.
Benchmarking: Consider benchmarking against other successful hospice organizations to identify best practices and areas for improvement.

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Long-Term Strategy:
2025-2026 Plan Integration: Ensure the 2025-2026 end-of-life support training incorporates the learnings from this analysis to prevent future declines and enhance overall performance.

Outcome Goal: Return to and maintain the 93% NRC benchmark, demonstrating a strong commitment to the emotional and spiritual well-being of patients and families.

If improvement opportunities are identified, provide action plan and expected resolution date:
There is opportunity for improvement in this area. The following plan of action shall be implemented/continued:
Allowing adequate time for staff to provide the time needed to meet the emotional and spiritual needs of patients and their families.
Developing appropriate care plans at the start of care that addresses the needs. The goals, interventions and outcomes are obtainable and measurable.
identify care expectations and goals with the patient and family and ensure that we provide an emotionally safe environment.
Ensuring our bereavement support is extended to the family through phone calls and mailers the preceding year after the loved one has passed.
Ensuring our staff has the correct contact information and phone numbers at admission so that bereavement contact is available.

Current data from the date range shows an average score on this initiative of 91%. The NRC benchmark goal is 93%. The previous year's score was 93.9%. Emotional and Spiritual Support has 3 subset questions which include: Emotional support after family member died. Emotional support from the hospice team. Religious support from hospice team. Ensuring we are meeting the emotional and spiritual needs of our patients and families is the foundation of Hospice care. End of life support will be the focus of Kaweah Hospice 2025-2026 education and training for staff. This education includes anticipatory grief and bereavement support and postmortem support. Providing an emotionally safe space for staff and our patients is essential to our hospice care.

<u>If improvement opportunities are identified, provide action plan and expected resolution date:</u>
There is opportunity for improvement in this area. The following plan of action shall be implemented/continued:
Allowing adequate time for staff to provide the time needed to meet the emotional and spiritual needs of patients and their families.

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Developing appropriate care plans at the start of care that addresses the needs. The goals, interventions and outcomes are obtainable and measurable.
Identify care expectations and goals with the patient and family and ensure that we provide an emotionally safe environment.
Ensuring our bereavement support is extended to the family thru phone calls and mailers the preceding year after the loved one has passed.
Ensuring our staff has the correct contact information and phone numbers at admission so that bereavement contact is available.

Next Steps/Recommendations/Outcomes:

Once initiatives are implemented, we shall continue to monitor and analyze vendor data over the next 4 quarters. Due to the lag time in these reports (approximately 6 months), it may take at least 4 quarters before results of the above-outlined plan are shown. The goal will be 95%.

Submitted by Name:
Melany Gambini, Director
Kaweah Health Hospice

Date Submitted:
August 2025

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department:
Home Health

ProStaff/QIC Report Date:
August 2025

Data for this report was obtained from two sources; the first is the *Star Report* on the *Care Compare* website, the Centers for Medicare & Medicaid Services (CMS) platform for publicly reporting home health quality measure outcomes. Currently, the *Care Compare* website reflects data from October 1, 2023 to September 30, 2024. Kaweah Health Home Health has an overall 3.5 star-rating, out of a 5 star-rating system.

In order to review *real-time data* for analysis that reflects the outcomes of the current interventions in place, Strategic Healthcare Programs (SHP), a web-based program that analyzes the Outcome and Assessment Information Set (OASIS*) data submitted to CMS monthly, was evaluated as the second source of data.

> ***OASIS is a data collection tool that all Medicare-certified home health agencies are required to collect and transmit to CMS for all patients whose care is reimbursed by Medicare and Medicaid.***

Measure Description:

"How often patients' breathing improved"

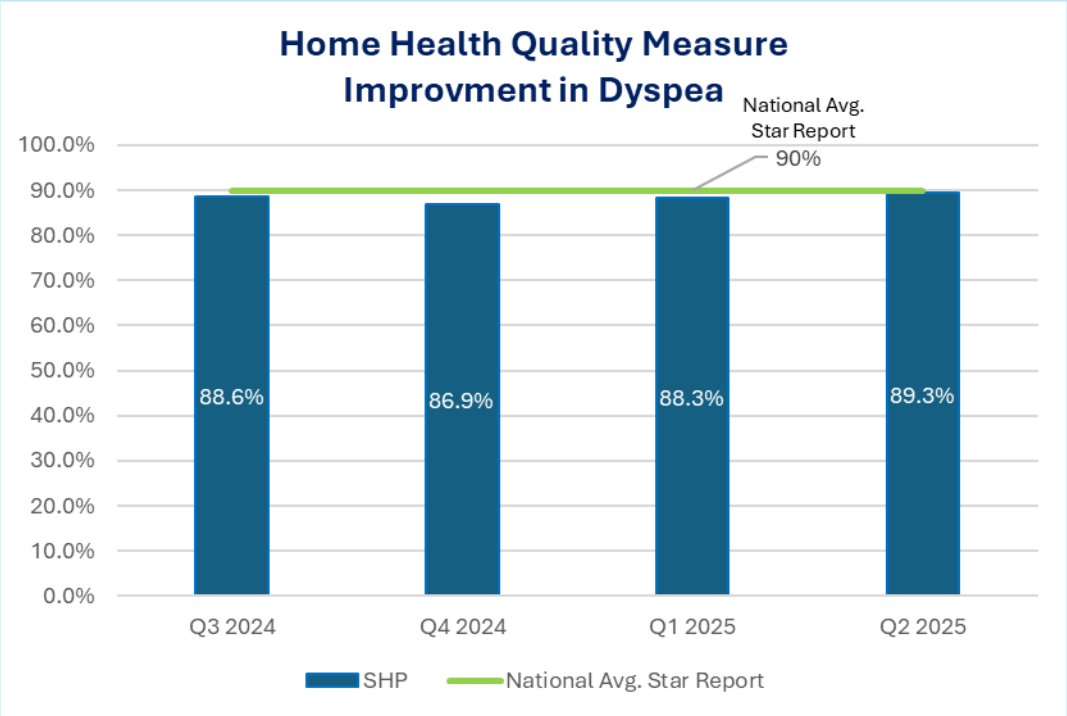
Percentage of home health quality episodes during which the patient demonstrated reduced shortness of breath (dyspnea) by the time of discharge from home health services.

Measure Objective/Goal:
Improvement in Dyspnea

-- Patients are assessed upon admission to home health services and again at discharge to determine what level of exertion/activity results in shortness of breath (dyspnea).

A four-point scale ranging in severity from *0 to 4,* 4 representing the most severe level indicating a critical impairment in respiratory function at rest, is used to assess what activity level results in the patient experiencing shortness of breath:

- ***0-*** **patient *does not experience* shortness of breath**
- ***1-*** **when walking more than 20 feet, or climbing stairs**
- ***2-*** ***with moderate exertion*** **i.e. dressing, using a commode/bedpan, walking distances less than 20 feet**
- ***3-*** ***with minimal exertion*** **i.e. while eating, talking, performing other ADLs or when agitated**
- ***4-*** ***at rest***



**Higher percentages are better for this measure. Graph depicts the most recent data in individual quarters to accurately assess response to most recent performance improvement interventions and guide upcoming action plans.*

Date range of data evaluated: *(indicated in graph above)*

- **Star Report: October 1, 2023 to September 30, 2024; National Average 90%**
- **SHP data; July 1, 2024 to June 30, 2025; KH Average 88.3%**

Analysis of all measures/data: (Include key findings, improvements, opportunities)

--This measure was selected due to early identification of low performance scores during HH quality measure monitoring and OASIS audits.
--Current SHP real-time data indicates an average of 88% for this measure over the last 4 quarters, which is under the *Star Report* national average of 90%
--Flu season is approaching and there is an increased risk for patients to experience respiratory changes while on service. Epidemiologists monitor Australia to determine the seasonal influenza cycle for the Western Hemisphere. Kathy Wittman, KH Infection Prevention, reported a particularly severe flu season in Australia. Ongoing monitoring is paramount to ensure our goal has been met.
--Accurate assessment by Home Health (HH) clinical staff of patient's respiratory status upon admission is crucial. Early identification of respiratory needs reduces re-hospitalization due to respiratory disease or compromise and results in better outcomes for patients.

If improvement opportunities identified, provide action plan and expected resolution date:

Opportunity for ongoing improvement for this quality measure exists. The following plan of action will be implemented to ensure an upward trend:

--HH educator will accompany clinical staff on field visits for observational learning and collaboration to determine any barriers to accurate assessment of this measure upon admission to HH.
--Targeted training to clinical staff on recognizing and accurately documenting dyspnea severity according to OASIS guidelines.
--HH RN auditor and educator will provide immediate feedback to clinical staff with inconsistencies between documentation and OASIS scoring.
--RN educator will identify any trends in OASIS dyspnea outcome reports to ensure measures are in place to provide clinicians with the appropriate knowledge and tools to capture an accurate assessment.
--To maintain continuous staff engagement, updates on the performance and trends for this measure will be regularly communicated at staff meetings.

Next Steps/Recommendations/Outcomes:

HH educator will report the results of this quality measure monthly to the Home Health Manager and Director. Interventions will be modified as needed to ensure this measure meets or exceeds the national average for 4 or more quarters.

Accurate capture of a patient's respiratory status upon admission and the opportunity to provide the resources needed for *improvement in dyspnea* by discharge will promote optimal patient outcomes and a higher quality rating for this measure. KHHH delivers patient-centered care to promote and achieve optimal health outcomes within the community, consistent with the Kaweah Health District Pillar promoting *Outstanding Community Health.*

Submitted by Name:	**Date Submitted:**
Shannon Esparza, RN	**August 2025**

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

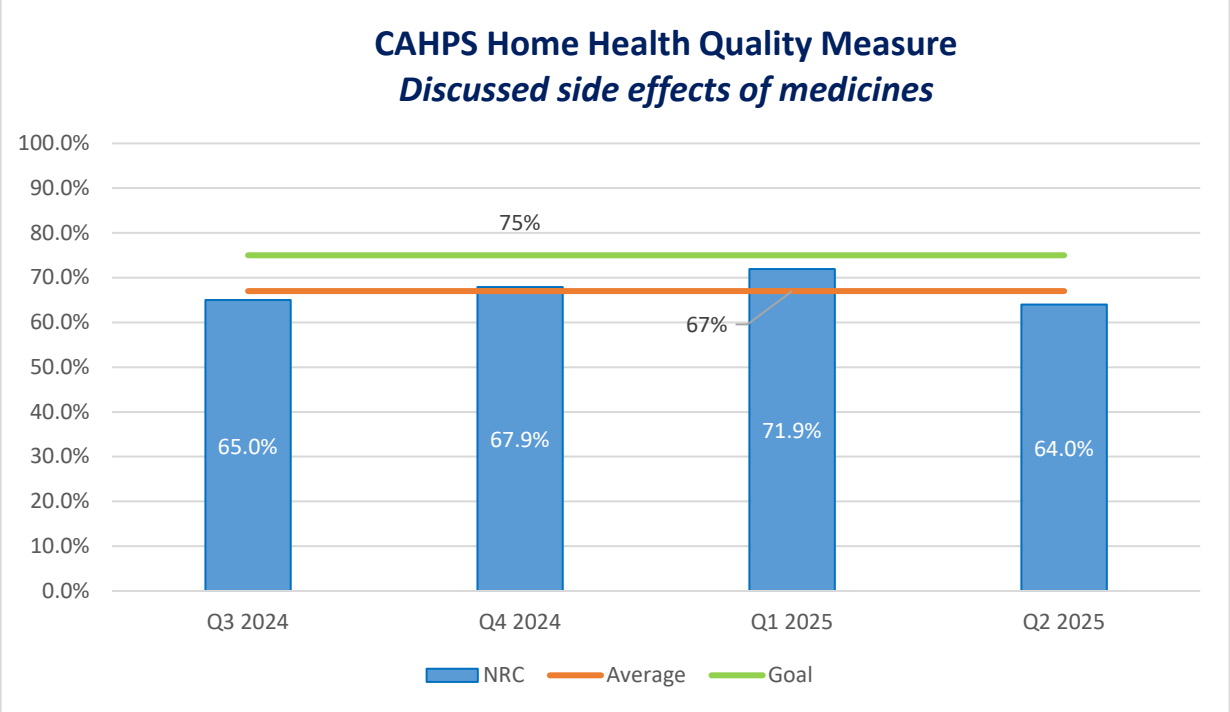
Unit/Department:
Home Health

ProStaff/QIC Report Date:
August 2025

Kaweah Health Home Health utilizes NRC, a CMS approved third-party vendor for distribution of satisfaction surveys and reporting of results. When calculating data, an average of the last 4 quarters was used. By utilizing this data, the results have more current, relevant and detailed data than that reported by CMS on Home Health Care Compare website. This information from NRC will eventually be submitted to CMS and will be publicly reported on the CMS Care Compare website.

Measure Objective/Goal:
Discussed side effects of medicines

- **July 1, 2024 - June 30, 2025 avg. 67%, Goal 75%**



**Higher percentages are better for this measure. Graph depicts the most recent data in individual quarters to accurately assess response to most recent performance improvement interventions and guide upcoming action plans.*

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Date range of data evaluated:

- **July 1, 2024 -June 30, 2025**

--Data is gathered from the surveys administered by a third-party vendor, as part of the Home Health CAHPS survey. Home Health Agencies are required to participate in these surveys, which measures caregiver satisfaction. Information is then submitted to CMS by the third-party vendor.

Analysis of all measures/data: (Include key findings, improvements, opportunities)
The surveys reflect patient responses to questions regarding their experience while on service with home health. This measure is part of a group of questions on the survey related to *Specific Care Issues*.
--Our overall performance for *Specific Care Issues* exceeds the national benchmark quarterly, but the specific question "Discussed side effects of medicines" is underperforming for this quality measure.
--It is important to focus on this area to identify any process inconsistencies or workflow issues to ensure overall improvement in this measure and maintain positive patient outcomes.
--Review of data reflected a decline in a positive response to this survey question during Q2 2025. It should be noted, fewer patients responded to this question on recent patient surveys than on previous surveys, 46% less in Q2 2025 than in Q1 2025. The smaller response size makes negative responses have more weighted significance which could disproportionately affect the overall score. Due to challenges with increasing responses, it becomes even more prudent that this measure has all responses be positive.

If improvement opportunities identified, provide action plan and expected resolution date:
There is opportunity for improvement in this area and the following plan of action will be implemented:

--Clinical staff updated on the current scores at the July staff meeting on this initiative, and feedback requested to ensure understanding and ongoing improvement.
--Discharge paperwork education reinforcement at the August discipline meetings to ensure side effects are being reviewed one final time with patients at discharge. Ensuring patients understand their resources for medication after discharge from home health services; i.e. their pharmacist and primary care doctor.
--Medication side effects teaching or issuance of medication teaching sheets that list medication side effects will continue to be documented on the patient medication profile throughout the patient episode within home health and audited during admission OASIS audits.

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

--Reinforcement of these initiatives to all staff will take place monthly.

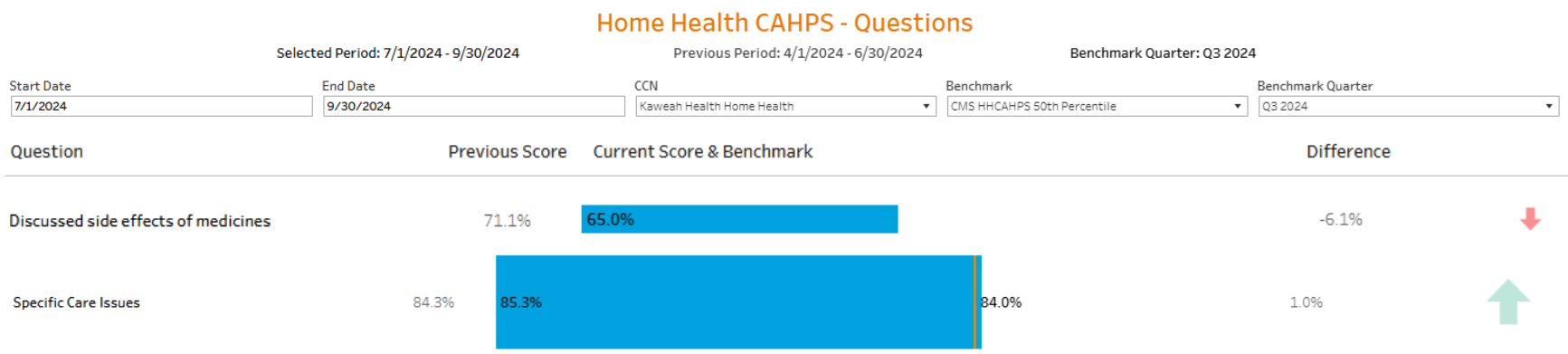
Next Steps/Recommendations/Outcomes:
With the interventions implemented as outlined above, we shall continue to monitor and analyze NRC data. Due to the delay in reports to the NRC website (approximately 6 months), it may take at least 4 quarters before we can be assured these interventions will result in longevity of sustaining the results as outlined above.

Submitted by Name:	**Date Submitted:**
Shannon Esparza, RN	**August 2025**

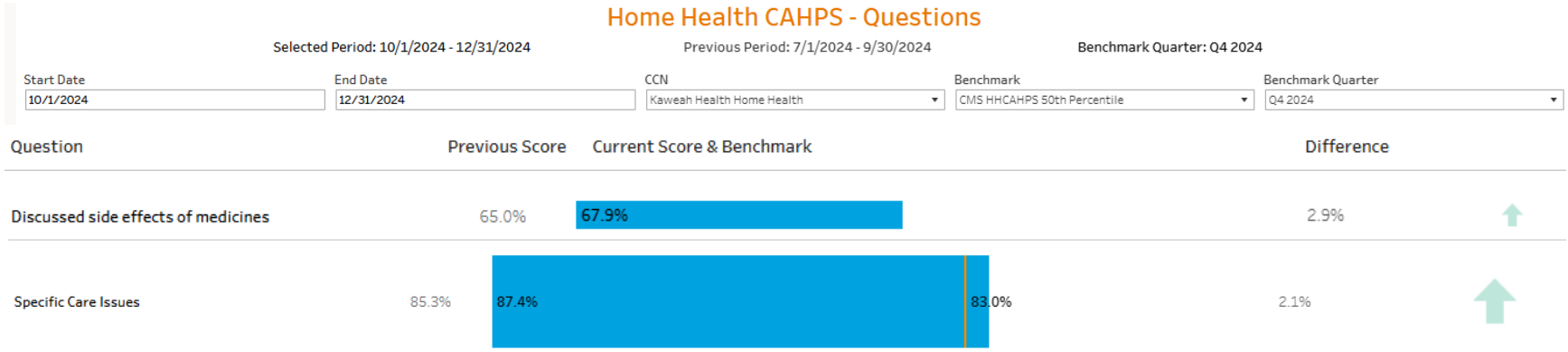
Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Quality Measure “Discussed side effects of medicines”

Q3 2024 NRC Data

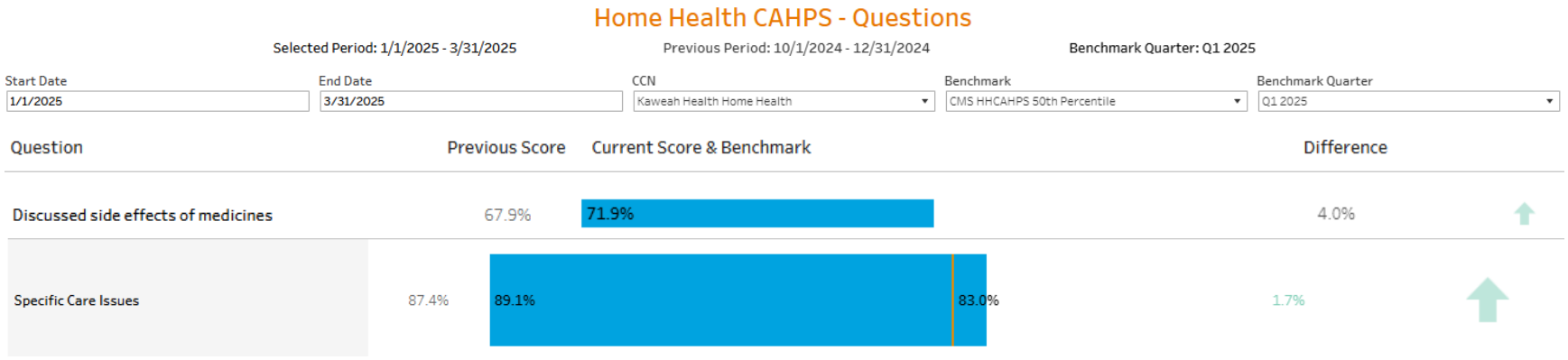


Q4 2024 NRC Data

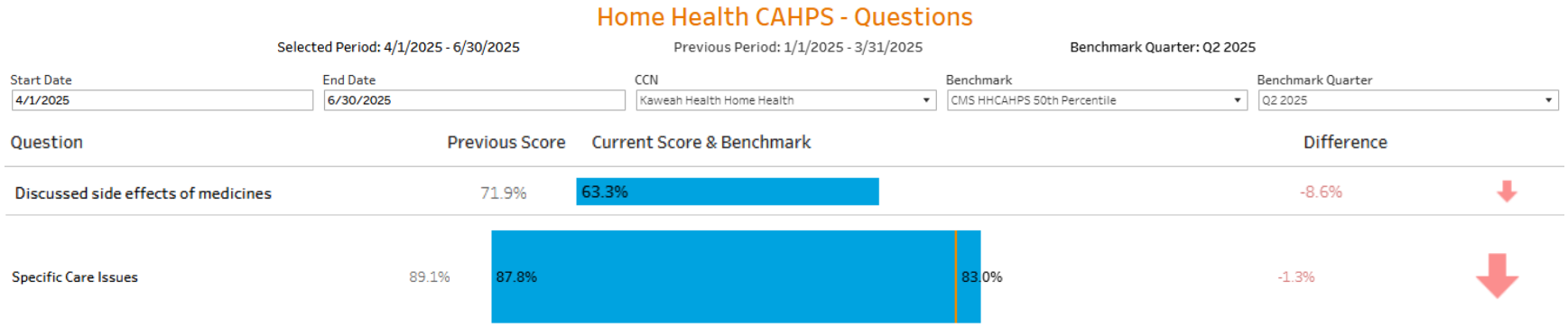


Quality Measure “Discussed side effects of medicines”

Q1 2025 NRC Data



Q2 2025 NRC Data



Measure “Improvement in Dyspnea”

Q2 2025

Outcome Analyzer
Kaweah Health Home Health

04/01/2025 - 06/30/2025
Report Date: 8/27/2025

Outcome	Group By	Eligible Episodes	Count	Observed Score
Improvement in Dyspnea	Kaweah Health Home Health	336	300	89.3%

Q1 2025

Outcome Analyzer
Kaweah Health Home Health

01/01/2025 - 03/31/2025
Report Date: 8/27/2025

Outcome	Group By	Eligible Episodes	Count	Observed Score
Improvement in Dyspnea	Kaweah Health Home Health	230	203	88.3%

Measure “Improvement in Dyspnea”

Q4 2024

Outcome Analyzer
Kaweah Health Home Health

10/01/2024 - 12/31/2024
Report Date: 8/27/2025

Outcome	Group By	Eligible Episodes	Count	Observed Score
Improvement in Dyspnea	Kaweah Health Home Health	282	245	86.9%

Q3 2024

Outcome Analyzer
Kaweah Health Home Health

07/01/2024 - 09/30/2024
Report Date: 8/27/2025

Outcome	Group By	Eligible Episodes	Count	Observed Score
Improvement in Dyspnea	Kaweah Health Home Health	246	218	88.6%

Measure “Improvement in Dyspnea”

Average of all 4 quarters, Q3 2024 thru Q2 2025

SHP **Outcome Analyzer**

Kaweah Health Home Health

07/01/2024 - 06/30/2025

Report Date: 8/27/2025

Outcome	Group By	Eligible Episodes	Count	Observed Score
Improvement in Dyspnea	Kaweah Health Home Health	1,094	966	88.3%

DMAIC Project Summary: Health Equity Committee

Reports to: Health Equity Committee	Project Leader: Ryan Gates	Start Date: March 2023
Team members/ Subject experts: Ryan Gates, Sonia Duran-Aguilar, Sandy Volchko, Dr. Omar-Guzman		Revision (date): August 18, 2025
		Revision #: 3

DEFINE

Background/Committee Purpose

- Guide organization's efforts to evaluate and address health equity and ensure compliance with various State and Federal agencies as well as health plan requirements
- Identify disparities in health outcomes and their causes
- Identify opportunities and partnerships with community-based organizations to build and increase our collective capacity to address disparities
- Ensure the diversity of our workforce reflects the community we serve
- Prioritize and develop action plans to address disparities in health outcomes
- Monitor progress and modify action plans as needed
- Report to key stakeholders and leadership on at least an annual basis
- Create, oversee and guide workgroups or subcommittees as needed

Current Condition:

CMS recently released their IPPS rules that go into effect 1/1/2026 removing the federal requirement to collect, analyze and report health equity data for hospitals, though CA state still requires data collection and submission. Kaweah Health successfully complied with CMS 2025 requirement of submitting social determinants of health (SDoH) data. The reporting requirement deadline for California (HCAI) is September 30th, 2025, though the data required to report is far more specific and detailed than CMS requirements and data extract reports required demographic fields do not yet exist in Cerner. Kaweah Health has asked for an extension which has been granted. The penalty for not reporting is $5,000/year, but the cost to build enhancements in Cerner and reporting capabilities far exceed the penalty.

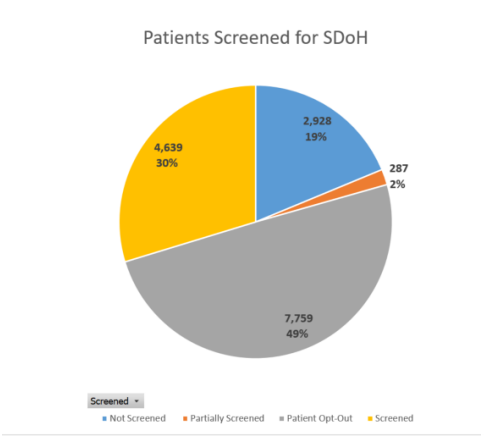
Kaweah Health began collecting SDOH data in December 2023 and results have been reviewed at Health Equity Committee. There continues to be opportunities to increase the completion of the PRAPARE Screening tool upon admission to the hospital. The Population Health division has submitted a PATH CITED Round 4 grant to bring additional resources to help improve SDOH data collection, analysis and reporting. Kawea Health will learn if we were successfully awarded $1.5M on 9/30/2025.

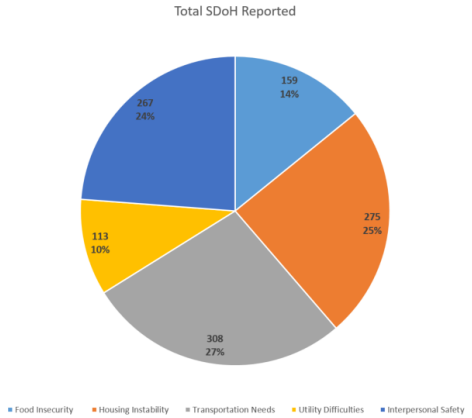
IMPROVE

Countermeasure / Action Plan / Solutions:

1. Health Equity Committee formed – March 2023
2. Health Equity Committee Charter approved
    a. Membership and leadership determined
    b. Review of regulatory health equity standards- Joint Commission, CMS and HCAI
3. Review, selection and completion of Health Equity assessment tool-HSAG's Health Equity Roadmap
4. Review, selection and implementation of SDOH patient screening tool
    a. PRAPARE Tool implemented December 2023 IP and OP
    b. Dashboard validation completed
5. Participation in completion of the Community Health Needs Assessment (CHNA)
6. Attendance to NCQA's Health Equity Summit by Health Equity Committee leadership
    a. Sonia Duran-Aguilar, Dr. Omar Guzman, Ryan Gates
7. 4-year HRSA grant awarded to address inequities amongst pregnant farm laborers
    a. Invited to present efforts in Atlanta, GA annual conference for grantees x2
8. Presenter and Break-Out Session facilitator at the Annual Women Farmworker Women's Conference – Sonia Duran-Aguilar
9. Norman Scharrer Symposium: Addressing Social Drivers of Health in the Healthcare Setting
    a. Dr. Omar Guzman, Dr. Alfredo Guerrero, Ryan Gates, Sonia Duran-Aguilar

Results / Metrics: 2024 Data





DMAIC Project Summary: Health Equity Committee

In 2023, Kaweah Health was awarded a 4year HRSA grant to address the health disparities amongst pregnant farm workers in the rural community of Lindsay. The grant is going well and patient outcomes are being collected. The grant funds afforded for the hiring of a Senior Health Equity Data Analyst which we have been recruiting for the last 2 years without success. HRSA considers Kaweah Health one of the top performers in the nation and has asked Kaweah to present at their annual conference in Atlanta that last 2 years.

MEASURE

SDOH Measure:

- Achieve 75%-80% PRAPARE Tool collection in Inpatient & Outpatient settings within 1 year of implementation (by 12/31/2024).
    - *Target/Goal not met with 30% of patients screened.*

HRSA Pregnant Farmworker Grant Outcomes *(baselines and benchmarks to be set)*:

- Referrals to Community Health Worker and external partners for SDOH's
- CHW encounters with patients
- Prenatal Visits
- Postpartum Visits
- No-Show Rates
- Postpartum Depression Screening
- Maternal Outcomes: Live deliveries, mortality
- NICU Admissions
- Preterm Deliveries

ANALYZE

Problem Analysis / Root Cause, Gap: As health disparities and inequities are identified through, the work of the Health Equity Committee various subcommittees will be created, and problem analysis will be done for individual projects involving health equity efforts and will be reported on using specific metrics to display results.

CONTROL

Follow-Up / Sustainability:

The Health Equity Committee is scheduled to meet quarterly to discuss projects and provide oversite for subcommittees and focused projects.

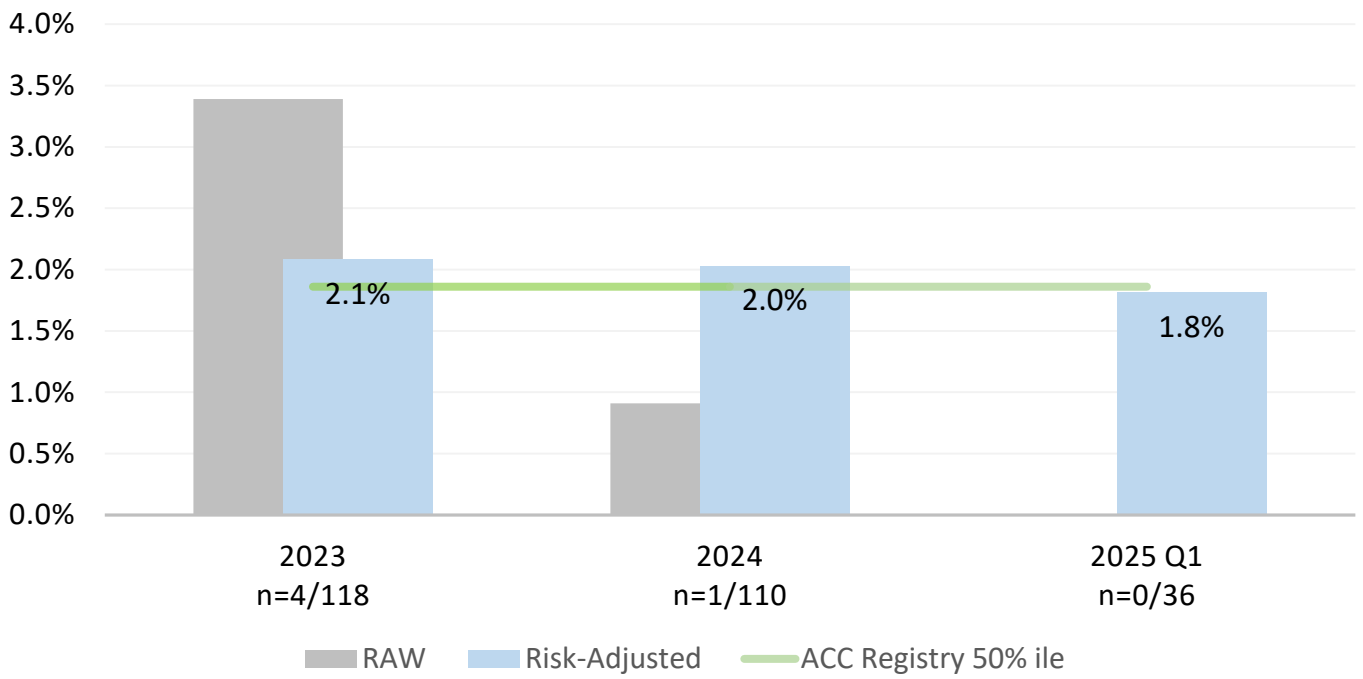
Outstanding Health Outcomes (OHO)
QUALITY & PATIENT SAFETY PRIORITY

Acute Myocardial Infarction (AMI) STEMI
Mortality & Processes of Care

August 2025

OHO Monthly Update: AMI STEMI Mort & Processes

STEMI Mortality Reduction



FY25 PLAN – Mortality Reduction

High Level Action Plan

- Thoughtful Pause initiative
  - Thoughtful Pause documented 50% by 12/31/2025
- Improve door to balloon time from outside facilities by Q4 2025
  - Baseline July 2024 – Dec 2024 = 156 minutes
  - Goal: 110 minutes (Reduce by 46 minutes) by 12/31/25

FY25 GOAL

Decrease PCI In-Hospital Risk-Standardized Mortality Rate – STEMI Patients to </= 1.86% (ACC goal is national mean from Q1 2025)

OHO Monthly Update: AMI STEMI Mort & Processes

STEMI Mortality Reduction

The last data point did not meet goal because:

- Case selection
- Appropriateness of PCI

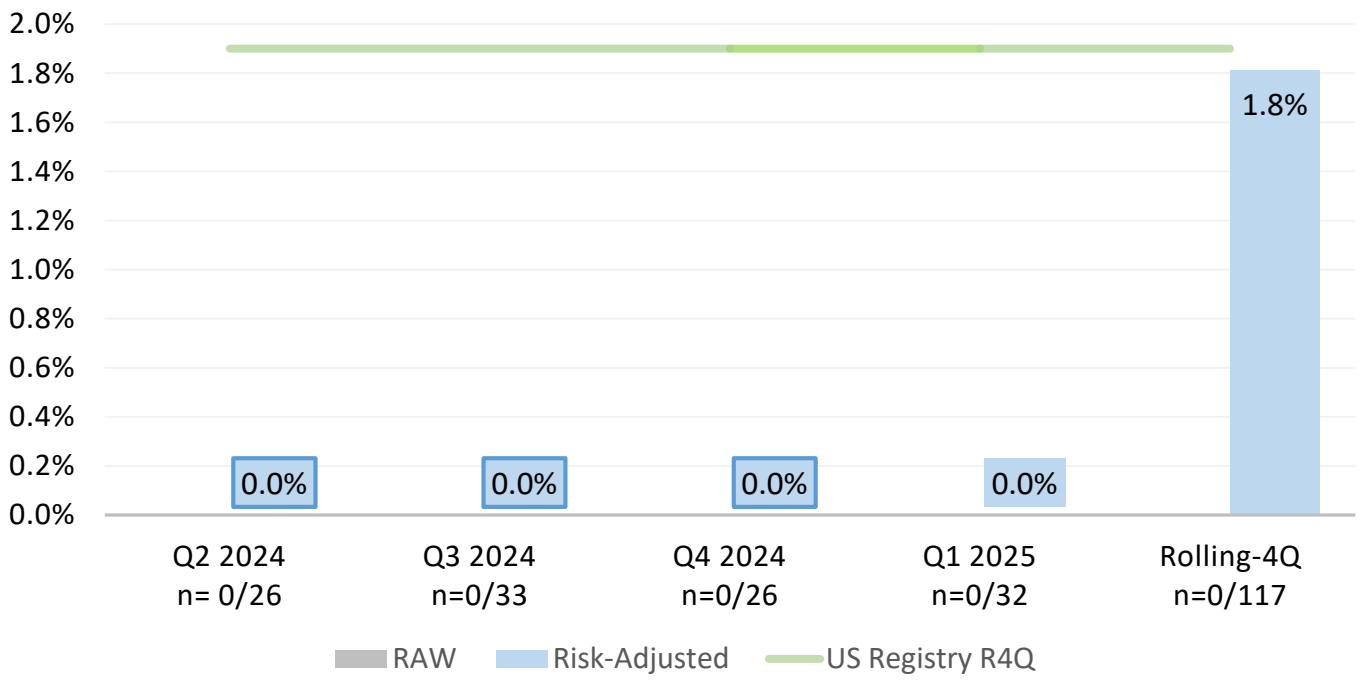
Targeted Opportunities (What specifically is causing the fallouts?)

1. Inconsistent use of “Thoughtful Pause”
2. Monthly M&M poorly attended. Limited discussion about cases due to low peer involvement. Results in limited learning opportunity, not likely to change behaviors)
3. Physician engagement low
4. Improve D2B time for transfers (currently 157 mins – goal is 110 mins), coordinating transport

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.

OHO Monthly Update: AMI STEMI Mort & Processes

STEMI Mortality Reduction



FY25 GOAL

Decrease PCI In-Hospital Risk-Standardized Mortality Rate – STEMI Patients w/o shock or Cardiac arrest to </= 1.86% (ACC goal is national mean from Q1 2025)

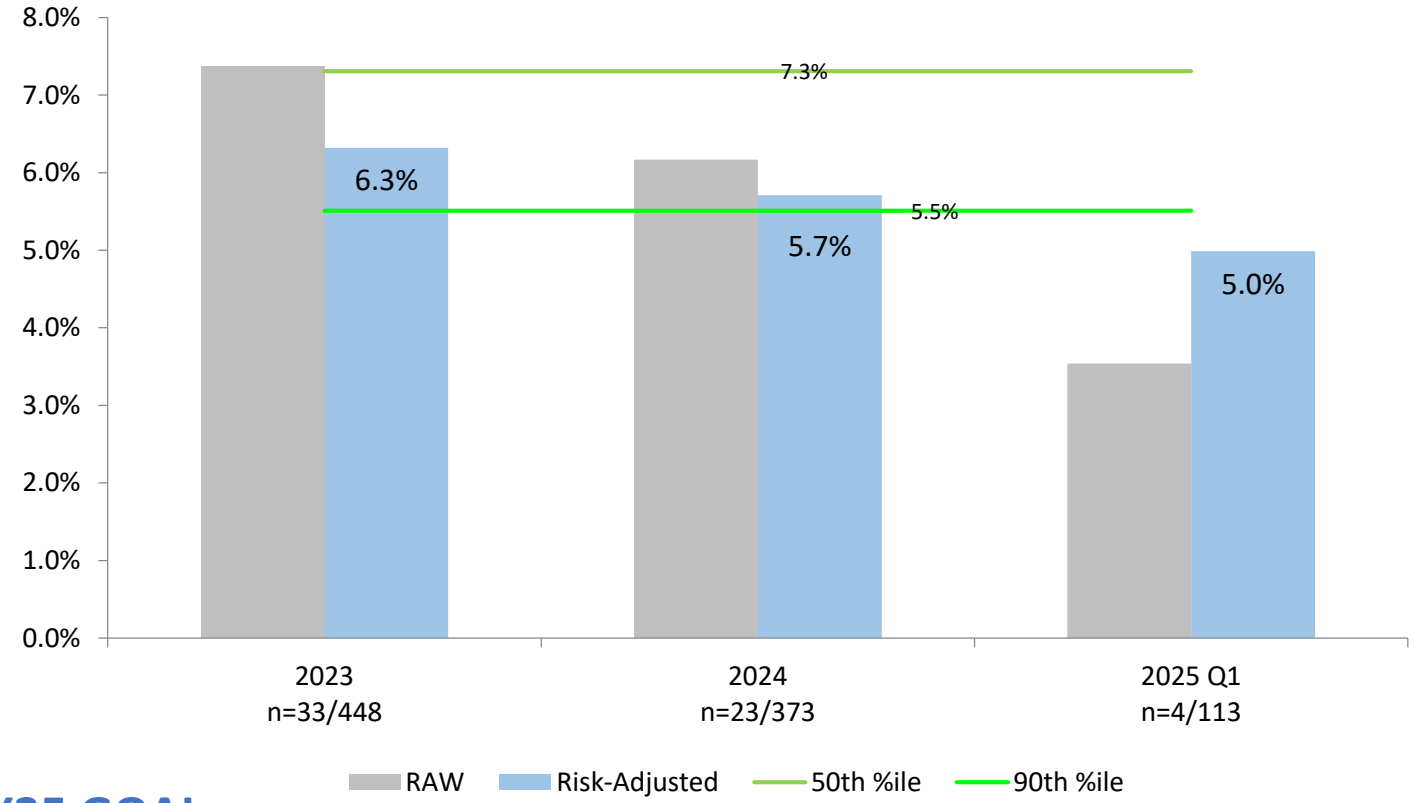
FY25 PLAN – Mortality Reduction

High Level Action Plan

- Thoughtful Pause initiative
  - Thoughtful Pause documented 100% by 12/31/2025
  - 30% thoughtful pause documented on STEMI Mar 2025-June 2025; Improved from 0% FY24
- Improve door to balloon time from outside facilities by Q4 2025
  - January – June 2025 = 164 minutes; increased by 8 minutes from baseline
  - Goal: 110 minutes (Reduce by 54 minutes) by 12/31/25

OHO Monthly Update: AMI STEMI Mort & Processes

Acute Kidney Injury (AKI) Reduction



FY25 GOAL

Decrease Risk-Standardized Acute Kidney Injury Post PCI to ≤ 5.5% (ACC goal is 90th percentile from Q1 2025)

FY25 PLAN – Acute Kidney Injury (AKI) Reduction

High Level Action Plan

- Medical Director engagement with high contrast users
  - Reduce contrast use by 10%
  - Baseline July 2024 – Dec 2024 average contrast use: 164ml
  - Goal: 150ml by 12/31/2025

OHO Monthly Update: AMI STEMI Mort & Processes

Acute Kidney Injury (AKI) Reduction

The last data point did not meet goal because:

- N/A data point met goal.

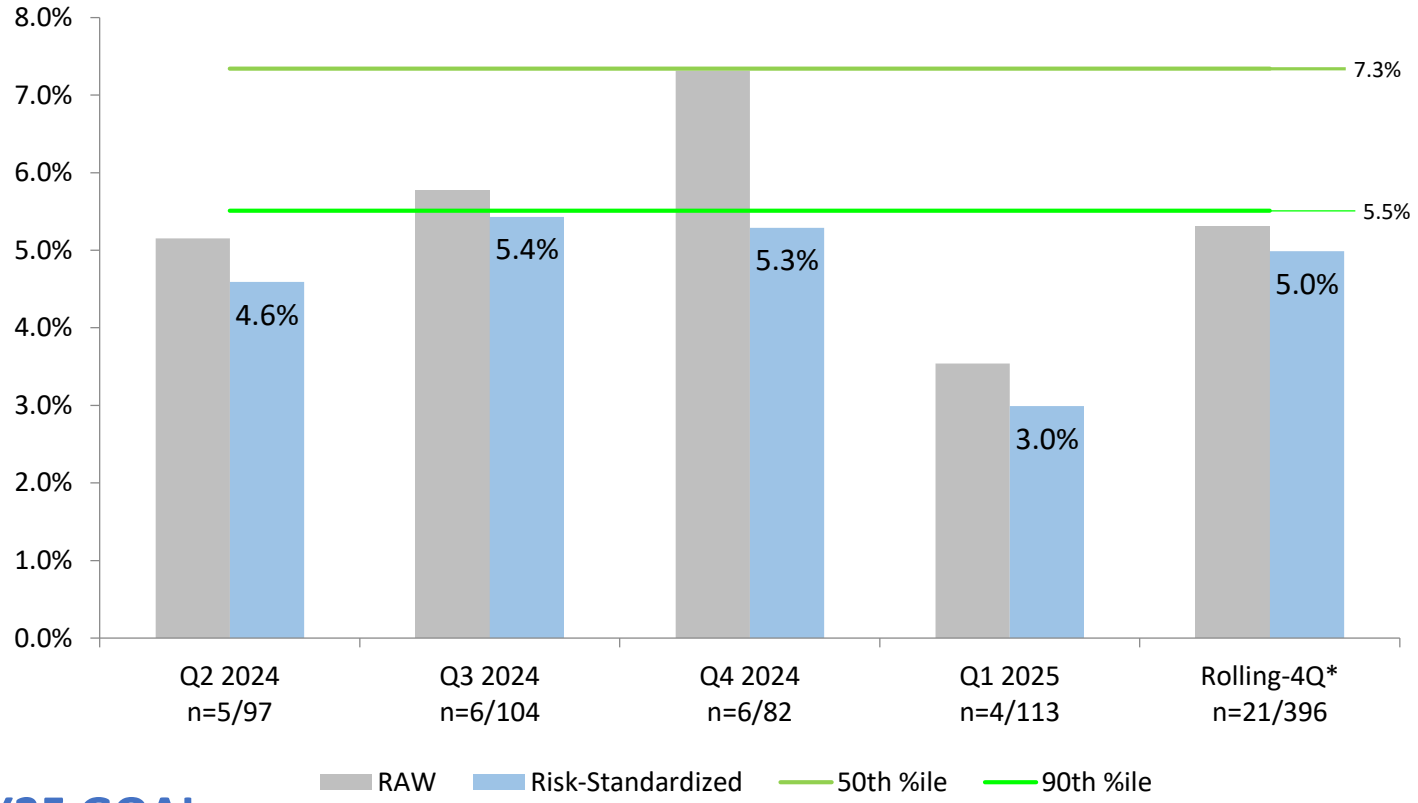
Targeted Opportunities (What specifically is causing the fallouts?)

1. Patients receiving pre-hydration but not full ordered amount per protocol (500 ml) due to cardiologist ready for the patient to be on table, or CV unit late to start IV/pre-hydration (IV access issue, patient late for check-in)
2. Reluctance of cardiologist to order full hydration amount due to patient history (i.e. heart failure)

CURRENT IMPROVEMENT ACTIVITIES	COMPLETION DATE	BARRIERS
Data review at physician level; address outliers	On-going	NA
Audit for physician compliance in using standardized order set (that includes pre-hydration order)	On-going	Manual process; need to enlist ISS help for automated report, if possible
Audit contract usage by cardiologist; Cath Lab medical director addresses with high contrast using cardiologists	On-going	Change in practice difficult for physicians
Top 5 cardiologists with lowest AKI rate & lowest contrast use posted in MD lounge (blinded)	On-going	NA

OHO Monthly Update: AMI STEMI Mort & Processes

Acute Kidney Injury (AKI) Reduction



FY25 GOAL

Decrease Risk-Standardized Acute Kidney Injury Post PCI to ≤ 5.5% (ACC goal is 90th percentile from Q1 2025)

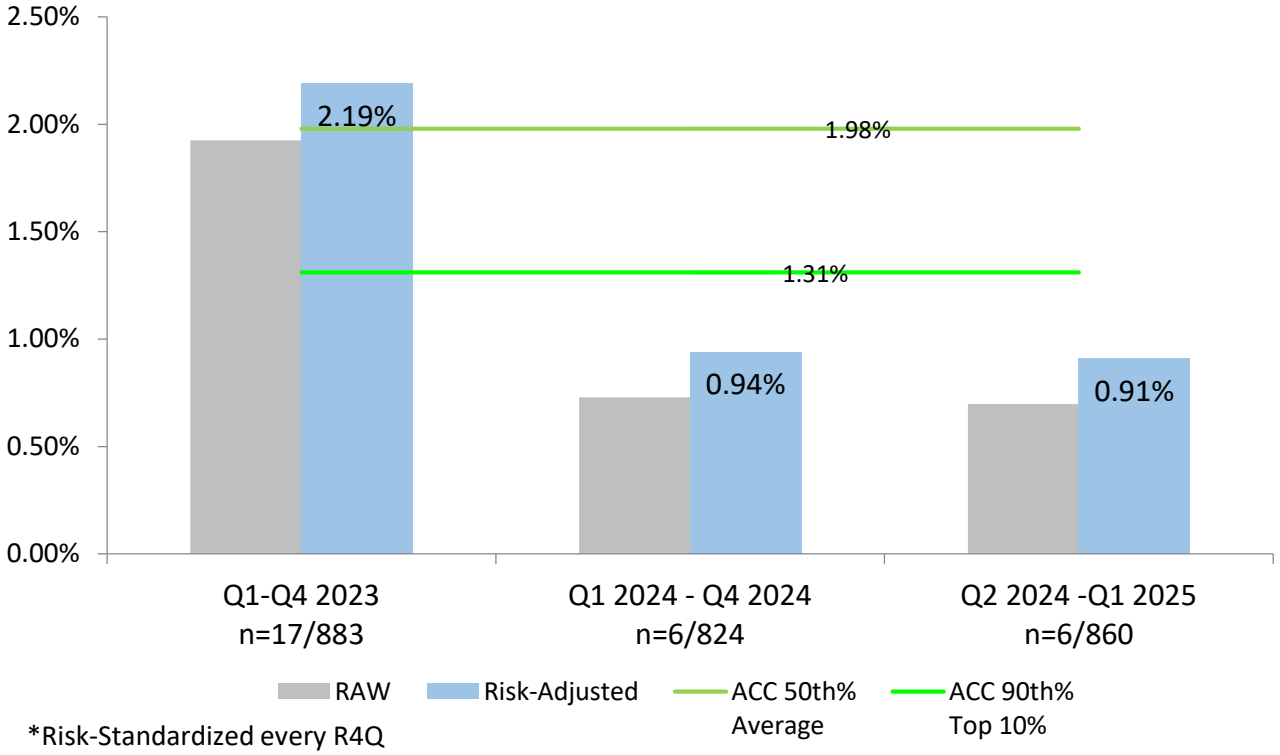
FY25 PLAN – Acute Kidney Injury (AKI) Reduction

High Level Action Plan

- Medical Director engagement with high contrast users
  - Reduce contrast use by 10%
  - January – July 2025 average contrast use = 168 ml. 4ml increase from baseline.
  - Goal by 12/31/2025 = 150ml

OHO Monthly Update: AMI STEMI Mort & Processes

Bleeding Rate Reduction



FY25 GOAL

Decrease Risk Standardized Bleeding Rate to </= 1.31% (ACC goal is 90th percentile from Q1 2025)

FY25 PLAN – Bleeding Rate Reduction

High Level Action Plan

- Medical Director 1:1s with cardiologists to increase radial usage
  - Baseline July 2024 – Dec 2024 radial access usage =49%
  - Goal = 66%
- Identify trends with bleeds unrelated to radial usage
  - Case study for each fall out completed by 12/31/2025

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Bleeding Rate Reduction

The last data point did not meet goal because:

- NA - Data point met goal

Targeted Opportunities (What specifically is causing the fallouts?)

1. Nursing education identified as an opportunity for improvement; re-education conducted; also added to mandatory RN annual competency
2. Manual audit of fall outs continues; Cath Lab medical director meeting with individual cardiologists with fall outs

CURRENT IMPROVEMENT ACTIVITIES	COMPLETION DATE	BARRIERS
Sharing provider level radial access rates to encourage increased utilization; top 5 cardiologists using radial access posted in MD lounge; Cath Lab medical director encouraging radial use/offering assistance to individual cardiologists to increase radial usage	On-going	Low radial usage mostly attributed to seasoned cardiologists so low change of a change in practice
Audit of each bleed to determine trend, if any	12/31/25	Manual audit; resources to complete this
If trend identified with the above, develop plan to address (i.e. staff education for appropriate sheath pull & hold, diligent vascular access site & pain assessment, etc.)		
Manual sheath removal & vascular sealant device education is now RN annual mandatory competency	On-going	Ensuring compliance for multiple nursing units (4T, 2N, 3W, CVICU, ICU & CVICCU)

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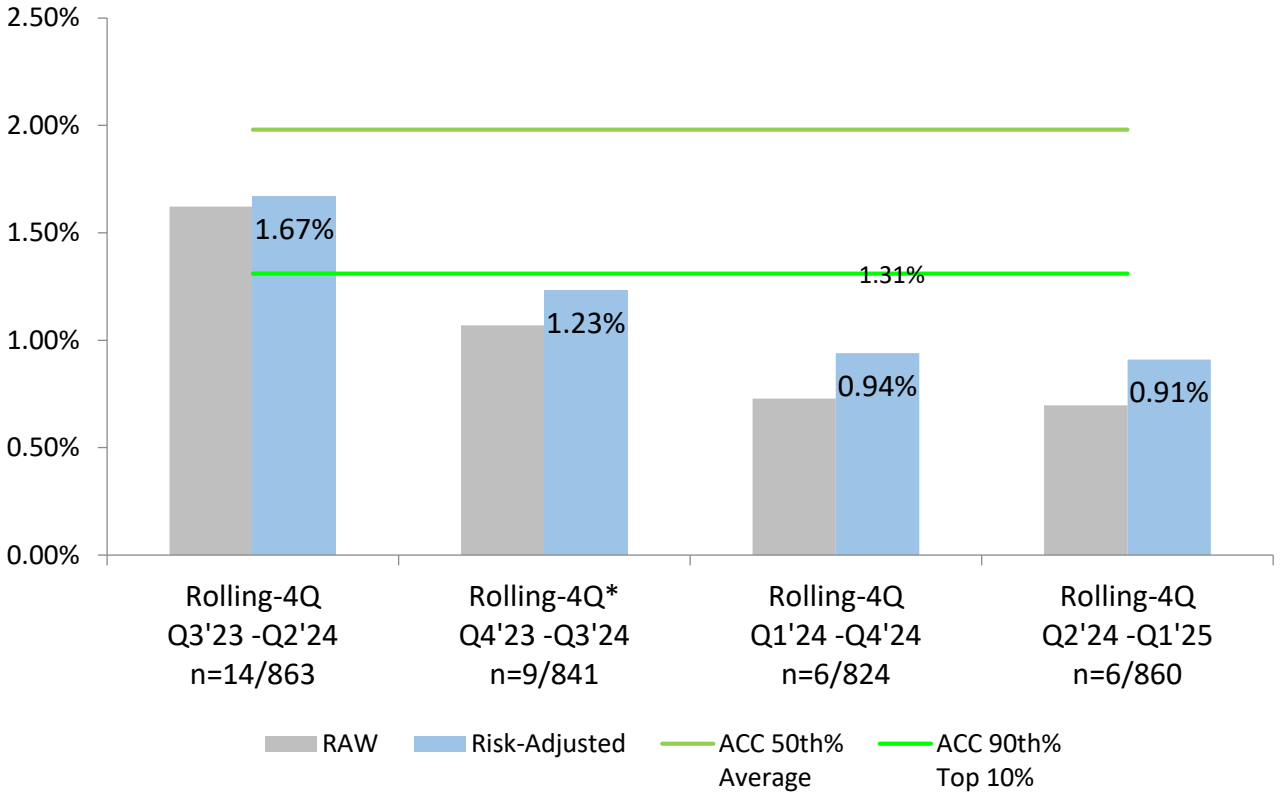

FY25 GOAL

Decrease Risk Standardized Bleeding Rate to </= 1.31% (ACC goal is 90th percentile from Q1 2025)

FY25 PLAN – Bleeding Rate Reduction

High Level Action Plan

- Medical Director 1:1s with cardiologists to increase radial usage
  - January - June 2025 radial access usage = 57.7%, Improved by 8.7% from baseline
  - Goal = 66%
- Identify trends with bleeds unrelated to radial usage
  - Case Studies completed for 100% of fallouts

Thank you

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

Kaweah Health