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 Lifestyle Fitness Center Conference Room {5105 W. Cypress Avenue, Visalia, CA} on Thursday, August 21, 2025:

- 7:45AM 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, September 18, 2025 • Kaweah Health Lifestyle Fitness Center 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 – 7:45 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 – 7:46 AM

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

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

5. **Quality Incentive Pool (QIP) Report –** A review of current performances 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 Health Officer.*

6. **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.

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

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Agenda item intentionally omitted

OPEN Quality Council Committee
Thursday, August 21, 2025
The Lifestyle Center Conference Room

Attending: Board Members: Mike Olmos (Chair) & Dr. Dean Levitan, Board Member; Gary Herbst, CEO; Sandy Volchko, Director of Quality & Patient Safety; Dr. Paul Stefanacci, Chief Medical Officer; Schlene Peet, Chief Nursing Officer; Mark Mertz, Chief Strategy Officer; Ryan Gates, Chief Ambulatory Officer; Dr. Lamar Mack, Medical Director of Quality & Patient Safety; Scott Baker, Director of Emergency and Trauma Services; Shawn Elkin, Infection Prevention Manager; Evelyn McEntire, Director of Risk Management; Kyndra Licon – Recording.

Mike Olmos called to order at 7:30 AM.

Approval 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.

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

4. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives: **–** Reports reviewed and attached to minutes. No action taken.
    4.1 Emergency Department Quality Report

5. **Incident Management –** A review summary of the Incident Management meting process & RCAs and event scoring. Evelyn McEntire, Director of Risk Management. – Reports reviewed and attached to minutes. No action taken.

6. **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 8:48 AM.

QIP QCOMM Report

September 18, 2025

Kaweah Health

QIP Program Updates

Quality Incentive Pool (QIP) Program

What: CMS 1115 Waiver program through the Department of Health Care Services (DHCS)

Why - Goals of QIP:

- Promote access to care
- Increase organization's investment value-based payment arrangements
- Encourages collaboration with Medi-Cal managed care plans and Hospitals

How: Funding is tied to quality outcomes as defined by DHCS annually

When:

- Kaweah Health reports QIP performance annually to DHCS for prior Calendar Year (CY)
- Funding is only earned if DHCS targets are achieved.

Quality Incentive Pool (QIP) Program

Quality Measure Menu-60 measures

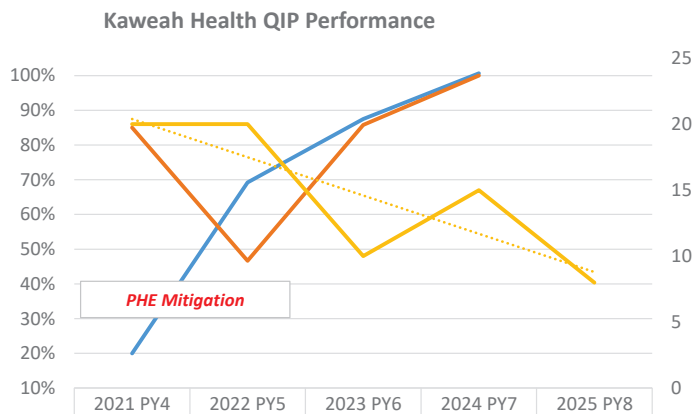
- 17 Primary Care Access and Preventative Care
- 7 Behavioral Health Care
- Care of Acute and Chronic Conditions
  - 5 Cardiovascular
  - 3 Diabetes
  - 1 HIV
  - 2 Respiratory
- 3 Care Coordination
- 2 Experience of Care
- 2 Improving Health Equity*
- 7 Maternal and Perinatal Health
- 5 Patient Safety
- 4 Overuse/Appropriateness
- 2 CalAIM Benefits- informational

Kaweah Health has strategically selected quality measures for QI and reporting that align with Primary and Preventive care to ensure high likelihood of performance.

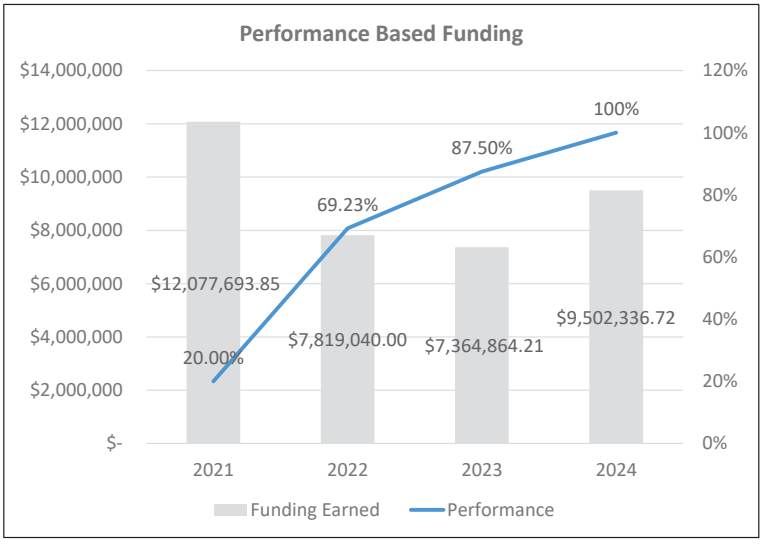
Over the last 5 years Kaweah Health has reported on up to 20 quality measures.

Kaweah Health QIP Reporting

Year over Year Reporting-improved quality, reduction in QM reported



	2021 PY4	2022 PY5	2023 PY6	2024 PY7	2025 PY8
Performance	20.00%	69.23%	87.50%	101%	
Quality Score	85%	46.67%	85.80%	100%	
Measures Reported	20	20	10	15	8



2024 Funding expected late 2026

Kaweah Health

DHCS QIP Reporting Updates

Funding Model Changes

- 60% Quality Measures/40% Medi-Cal Reimbursement
- 50% Quality Measures/50% Medi-Cal Reimbursement
    - Positive impact for Kaweah
    - Reduction of # Quality Measure we must perform on and report

Transition away from Performance Year (PY) to Calendar Year (CY)

Priority vs. Elective Quality Measures-Funding implications

- DHCS is focused on continuous quality improvement (preventing switching measures annually)
- 50% of total measures need to be Priority Measures
- 30% of total measures need to be reported year prior

Priority vs Elective Funding

Overperformance makes a difference!

Priority measures-potential to earn an additional $633K

Elective measures-potential to earn MAX 50% of the metric value $316K

QIP PY7 Reporting Funding Projections					
	Measure Name	Type	Metric Value	Priority AV	Elective AV
1	Cervical Cancer Screening	**Priority**	0.5	0	0
2	Breast Cancer Screening	**Priority**	1	1	0
3	HIV Screening	Elective	1	0	0.25
4	Lead Screening in Children	Elective	1	0	0.5
5	Colorectal Cancer Screening	**Priority**	1	0	0
6	W30	**Priority**	1	1	0
7	GSD (A1c Control)	**Priority**	1	1	0
8	Q-FUA	**Priority**	1	1	0
9	Q-FUI	Elective	1	0	0.5
10	Controlling Blood Pressure	**Priority**	1	1	0
11	WAC/WCC	**Elective**	0.667	0	0
12	Advance Care Planning	Elective	0	0	0
14	Child & Adolescent Well Care Visits (WCV	**Priority**	0	0	0
14	Prenatal	**Priority**	0	0	0
15	Post Partum	**Priority**	0	0	0
Total			**10.167**	**5**	**1.25**

Metric Value= $633,489.11

Total (MAX) Funding Available=$9,502,336.72

Kaweah Health

DHCS QIP Reporting Updates

"Better of MCP or QIP Entity Rate"

Limitation on use of Local Mapping to clinical events to reflect performance

RISK- If the claims or documentation to the health plans do not include the proper coding (quality codes, CPTII, LOINC) performance will be negatively impacted

Work to improve code capture remains underway

No Local Mapping to clinical events will be allowed.

Claims submission along with coding of diagnosis codes and Quality Codes will be *key to meeting performance*.

QIP Performance Year 7 (2024)

Quality Incentive Pool (QIP) Program

QIP 2024 (Performance Year 7)

- Currently undergoing Comprehensive Review
- 15 Quality Measures reported
- Each valued at $633K
- Quality score 100%
- Total funding to be earned $9,502,336.72
- Payment expected Fall 2027
- Funding disbursed by MCPs (Anthem BC and HealthNet)

2024 Performance

Legend
- Not reported
- Not Performing
- Performing
- Partial Performance

Kaweah Health QIP Performance Scorecard	QIP Performance				
Quality Measure	**2021**	**2022**	**2023**	**2024**	**Improvement 23-24**
Q-FUA Follow Up After ED Visit for Alcohol and Other Drug Abuse of Dependence (FUA) 30 Days ***(MCP reported rate 2025 for both 2023 & 2024)***	6.38%	11.11%	38.35%	44.03%	5.68%
Q-FUA Follow Up After ED Visit for Alcohol and Other Drug Abuse of Dependence (FUA) 7 Days ***(MCP reported rate 2025 for both 2023 & 2024)- informational only***	14.89%	5.56%	26.52%	15.67%	-10.84%
Q-FUI-Follow Up After High-Intensity Care for Substance Use Disorder (FUI) 30 Days ***(MCP reported rate 2025 for both 2023 & 2024)***			42.11%	58.76%	16.66%
Q-FUI-Follow Up After High-Intensity Care for Substance Use Disorder (FUI) 7 Days ***(MCP reported rate 2025 for both 2023 & 2024)- informational only***			15.79%	32.99%	17.20%
Q-CMS52 Preventive Care and Screening: Screening for Depression and Follow Up Plan (CDF) ***(Trending Break) (Transitioned to HEDIS Measure for 7)- Q DSF-E 2 rates Depression Screening & Follow Up on Positive Screen***	48.53%	47.78%	56.10%	45.46%	-10.64%
Q-CBP Controlling High BP	75.47%	64.65%	68.79%	66.76%	-2.03%
Q- CDC-H9 Comprehensive DM Poor Care HbA1c Poor Control (>9%) * ↓ ***(lower rate is better)***	34.92%	30.33%	31.26%		
Q-GSD Glycemic Status Assessment for patients with Diabetes (GSD)				23.08%	8.17%
Q-QPP47 Advance Care Plan	72.24%	64.61%	54.21%	52.76%	-1.45%
Q-CMS130 Colorectal Cancer Screening (1) ***(Trending Breack PY5, new Population 45-75)***		30.14%	27.32%	40.71%	13.39%
Q-CMS349 HIV Screening	26.16%	33.54%	40.11%	45.32%	5.21%
Q-W30: Well-Child Visits in the First 15 Months	63.00%	70.12%	80.83%	77.60%	-3.23%
Q-W30: Well-Child Visits in the First 30 Months of Life 15-30 Months	68.51%	79.27%	75.37%	76.11%	0.74%
Q-WCC Weight Assessment & Counseling (3-17 year olds) BMI (WAC)	66.97%	71.06%	82.48%	82.39%	-0.09%
Q-WCC Weight Assessment & Counseling (3-17 year olds) Counseling for Physical Activity (WAC)	30.30%	35.84%	67.90%	71.49%	3.59%
Q-WCC Weight Assessment & Counseling (3-17 year olds) Counseling for Nutrition (WAC)	31.74%	34.76%	67.45%	70.99%	3.54%
Q-WCV: Child and Adolescent Well-Care (WCV) ***(New in PY5)***	60.61%	40.16%	39.80%	42.07%	2.27%
Q-LSC- Lead Screening in Children (2) ***(New in PY6)***	-	41.08%	56.21%	81.19%	24.98%
Q-PPC-PRE Prenatal Care	82.07%	84.78%	88.10%	87.19%	-0.91%
Q-PPC-PST Post Natal Care	84.06%	82.61%	78.91%	77.50%	-1.41%
Q-BCS Breast Cancer Screening	51.06%	49.36%	48.63%	56.60%	7.98%
Q-CCS Cervical Cancer Screening (3)	54.45%	52.84%	55.10%	55.82%	0.72%

QIP Performance Year 8 (2025)

QIP PY8 2025 Quality Measure Focus

Strategy to monitor more than 8 measures.

Funding available ~$7,992,399

1. Controlling High BP - *Q-CBP* **(Priority)**
2. Glycemic Status Assessment for patients with Diabetes - *Q-GSD* **(Priority)**
3. Breast Cancer Screening - *Q-BCS* **(Priority)**
4. Cervical Cancer Screening - *Q-CCS* **(Priority)**
5. Chlamydia Screening - *Q-CHL* **(Priority)**
6. Post Natal Care - *Q-PPC-PST* **(Priority)**
7. Prenatal Care - *Q-PPC-PRE* **(Priority)**
8. Lead Screening in Children - *Q-LSC-* **(Elective)**
9. Colorectal Cancer Screening - *Q-CMS130* **(Elective)**
10. HIV Screening - *Q-CMS349* **(Elective)**
11. Preventative Care and Screening: Tobacco Use-Screening and Cessation Intervention Rate 1, Rate 2, & Rate 3 - *Q-CMS138* **(Priority)**

Informational

1. Number of Members enrolled in Enhanced Care Management (ECM) - *Q-ECM*
2. Number of and Percentage of Eligible Members Receiving Community Supports (COMS) and Number of Unique COMS received by members - *Q-COMS*
3. Percentage of Acute Hospital Stay Discharges Which Had Follow-Up Ambulatory Visits W/in 7 days Post Hospital Discharge- *Q-FUAH*

QIP PY8 2025 Quality Measure Focus

Meeting 4 QM
Target 8 QM

Caveat-claims data

Quality Measures Cozeva	Mar-25	Apr-25	May-25	Jun-25	Jul-25			Trends
	Aggregate Performance March	Aggregate Performance April	Aggregate Performance May	Aggregate Performance June	Aggregate Performance July	Target	Delta	
Q-CBP Controlling High BP	25.90%	43.23%	53.16%	54.55%	50.31%	67.36%	17.05%	
Q-GSD Diabetes|Glycemic Status Assessment for Patients With Diabetes (Glycemic Status <=9.0%)	14.65%	23.87%	34.56%	42.76%	49.56%	27.01%	-22.55%	
Q-QPP47 Advance Care Plan								
Q-CMS130 Colorectal Cancer Screening (1) (Trending Break PY5, new Population	26.90%	30.09%	28.86%	30.95%	33.11%	42.44%	9.33%	
Q-CMS138 Preventative Care and Screening: Tobacco Use-Screening and Cessation Intervention Rate 1, Rate 2, & Rate 3								
Q-CMS349 HIV Screening								
Q-W30: Well-Child Visits in the First 15 Months	17.19%	20.40%	20.90%	31.38%	36.44%	69.67%	33.23%	
Q-W30: Well-Child Visits in the First 30 Months of Life 15-30 Months	51.42%	55.87%	57.03%	62.47%	63.76%	76.49%	12.73%	
Q-WCC Prevention and Screening|Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile	71.14%	75.06%	70.95%	73.39%	76.22%	83.28%	7.06%	
Q-WCC Prevention and Screening|Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	7.40%	7.90%	9.61%	15.58%	12.52%	72.33%	59.81%	
Q-WCC Prevention and Screening|Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	7.40%	7.90%	9.53%	9.73%	12.52%	72.56%	60.04%	
Q-IMA: Immunizations for Adolescents	18.02%	19.16%	19.34%	22.82%	21.59%	31.36%	9.77%	
Q-CIS10-Immunizations|Childhood Immunization Status COMBO-10	5.09%	5.19%	5.23%	4.24%	2.07%	22.87%	20.80%	
Q-LSC- Lead Screening in Children	68.98%	70.84%	72.25%	75.42%	77.44%	79.51%	2.07%	
Q-PPC-PRE Prenatal Care	91.37%	90.97%	89.88%	87.55%	88.03%	84.50%	-3.53%	
Q-PPC-PST Post Natal Care	58.99%	63.87%	80.36%	68.27%	79.29%	78.41%	-0.88%	
Q-BCS Breast Cancer Screening	53.53%	54.03%	55.82%	49.13%	52.58%	57.29%	4.71%	
Q-CCS Cervical Cancer Screening	51.14%	51.59%	52.80%	54.64%	58.37%	56.98%	-1.39%	
Q-CHL Chlamydia Screening	25.76%	28.57%	30.92%	39.81%	44.72%	49.65%	4.93%	
Q-WCV: Child and Adolescent Well-Care	4.81%	8.05%	9.38%	20.10%	23.11%	46.57%	23.46%	
Q-AMR Asthma Medication Ratio (AMR)	95.12%	92.54%	90.72%	82.96%	82.50%	76.65%	-5.85%	

QIP PY8 2025 Quality Measure Focus

QM	Priority/Elective	Target	Delta	QI efforts
Q-CBP Controlling High BP	Priority	67.36%	17.05%	Amb Pharmacy/Community Outreach/ HABO worklist/Cozeva GIC
Q-GSD A1c (<9%)	Priority	27.01%	22.55%	Amb Pharmacy/Community Outreach/HABO worklist/Cozeva GIC
Q-BSC Breast Cancer	Priority	57.29%	4.71%	Cozeva GIC
Q-CCS Cervical Cancer Screening	Priority	56.98%	-1.39%	Cozeva GIC/HABO worklist
Q-CHL Chlamydia Screening	Priority	49.65%	4.93%	Cozeva GIC
Q-PPC PST	Priority	78.41%	-0.88%	Cozeva GIC/HABO worklist
Q-PPC PRE	Priority	84.50%	-3.53%	Cozeva GIC/HABO worklist
Q-LSC Lead Screening	Elective	79.51%	2.07%	Cozeva GIC
Q-CMS349 HIV Screening	Elective	48.01%	**UNK**	HABO worklist/Patient Advisory
Q-CMS138 Tobacco	Priority	78.76%	**UNK**	Amb Pharmacy/2 Sub-rates; using Target for Rate 3

Quality Improvement Initiatives

1. **Supplemental Data Uploads:** Ongoing by Gaps in Care (GIC) team & Pop Health in Cozeva from Cerner MILN (18 measures)
2. **Supplemental Flat File Submission:** Captures values not submitted on claims; sent monthly by ISS Business Development
3. **CPTII Data Coding:** Population Health Data Team & Partnering with HIM (3 measures)
4. **External Document Scanning:** QA external document type scans project HIM & Population Health (3 measures)
5. **Cologuard HL7 Interface with Cerner:** go live August 2025
6. **Targeted QI Efforts**
   a. **Community Outreach Events:** Immunizations, Colorectal CA Screening, Diabetes Management, Medi-Cal Enrollment
   b. **Colorectal Cancer Screening:** Kits shipped to patients' home w/ Well App text messaging & phone reminders

Quality Improvement Initiatives, continued

7. Communication Strategies

Sharing performance & targeted QI efforts Monthly Population Health Steering Committee, Clinic lead, RHC Manager, Medical Director & Provider Meetings; Quarterly Population Health Quality Meeting

8. IT Build

a. Diabetic QuickVisits

b. Real Time QM Performance Dashboard (5 QM)

1. Controlling High Blood Pressure
2. Tobacco Screening and Cessation
3. Glycemic Status Assessments for Patients with Diabetes (GSD) A1c <9%
4. Influenza
5. HIV

c. Patient Advisories (Long Term)

Monthly Quality Meetings: Managed Care Plans (Anthem BC and HealthNet)

The pursuit of healthiness

Outstanding Health Outcomes (OHO) QUALITY & PATIENT SAFETY PRIORITY

Healthcare Acquired Infection (HAI) Reduction

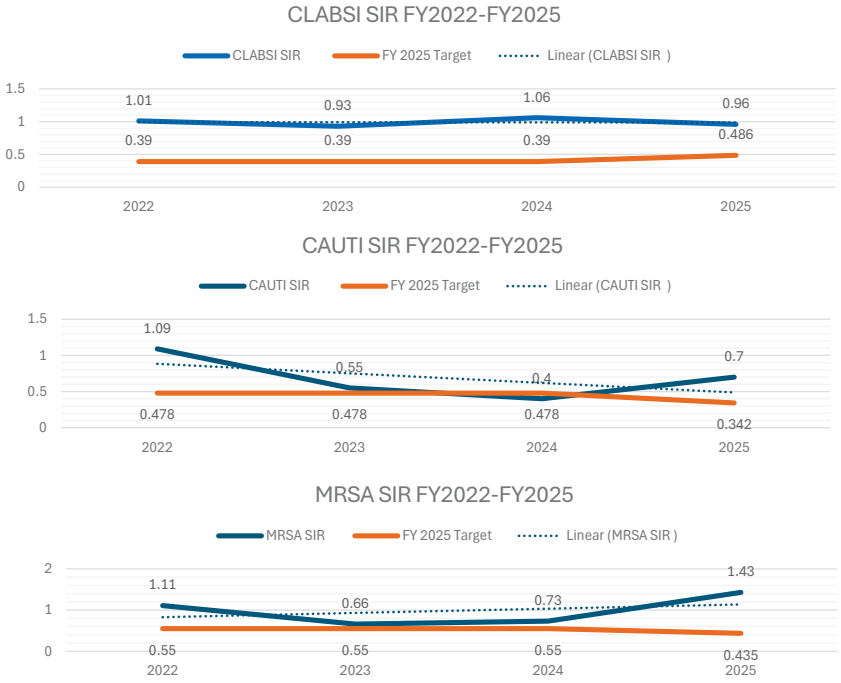
September 2025

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)

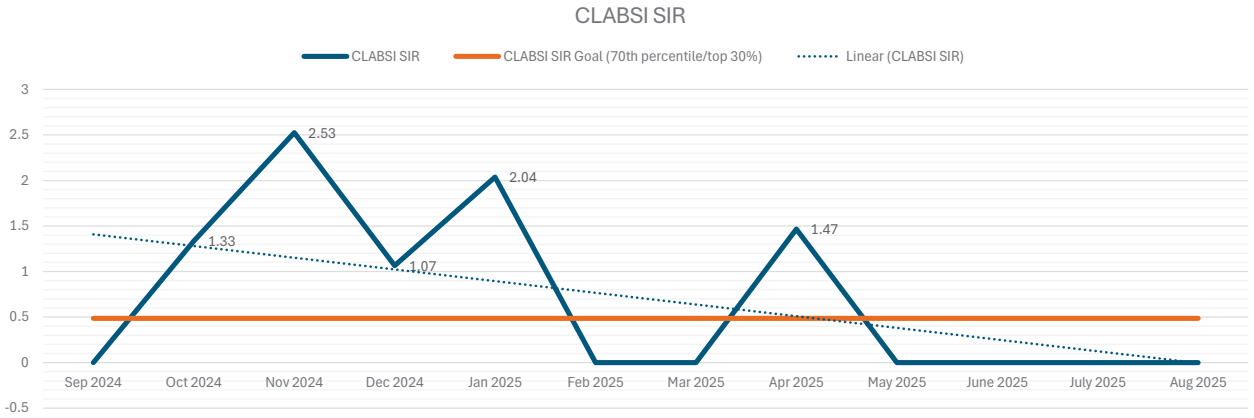
FY25 GOAL

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

Kaweah Health

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

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



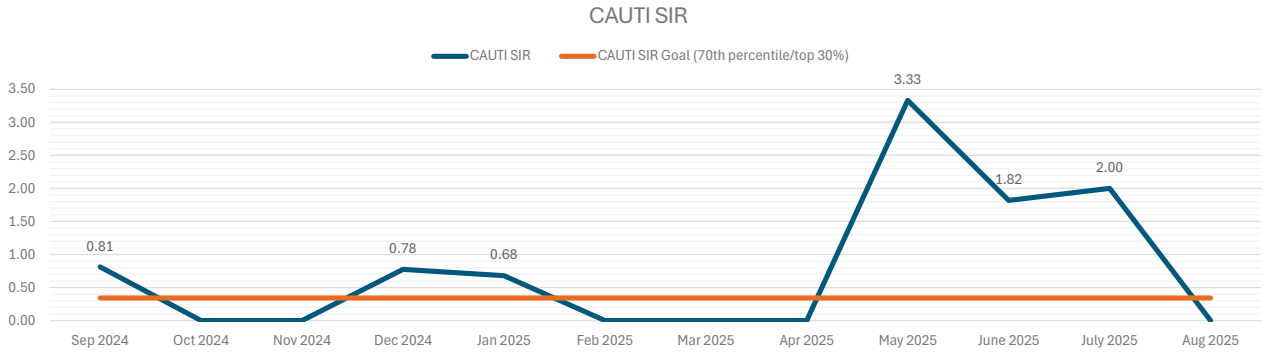
	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	June 2025	July 2025	Aug 2025	Total
CLABSI EVENTS	0	1	2	1	2	0	0	1	0	0	0	0	7
CLABSI Predicted	0.832	0.75	0.792	0.938	0.982	0.64	0.739	0.682	0.656	0.713	0.605	0.58	8.91
CLABSI SIR	0	1.33	2.53	1.07	2.04	0.00	0.00	1.47	0.00	0.00	0.00	0.00	0.79
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
Estimated Costs for Actual Event	$0	$48,108	$96,216	$48,108	$96,216	$0	$0	$48,108	$0	$0	$0	$0	$336,756
Near Miss Events	5	6	7	5	7	0	4	2	1	2	10	1	50
Estimated Costs for Near Miss Event	$240,540	$288,648	$336,756	$240,540	$336,756	0	$192,432	$96,216	$48,108	$96,216	$481,080	$48,108	$2,405,400
Estimated Near Miss Mortality	0.75 deaths	0.9 deaths	1.1 deaths	0.75 deaths	1.1 deaths	0	0.6 deaths	0.3 deaths	0.15 deaths	0.3 deaths	1.5 deaths	0.15 deaths	7.5 deaths

Resource for cost breakdown comes from AHRQ - Estimating the Additional Hospital Inpatient Cost and Mortality Associated with Selected Hospital -Acquired Conditions https://www.ahrq.gov/hai/pfp/haccost2017-results.html

*note predicted values updated mid-FY25

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

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



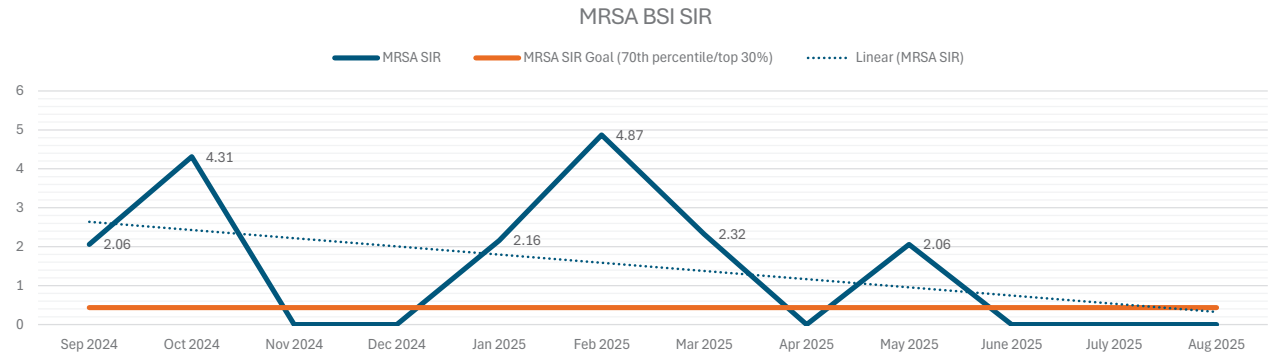
	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	June 2025	July 2025	Aug 2025	Total
CAUTI EVENTS	1	0	0	1	1	0	0	0	3	2	2	0	10
CAUTI Predicted	1.23	1.14	1.1	1.29	1.47	1	1.23	1.05	0.9	1.1	1	0.9	13.44
CAUTI SIR	0.81	0.00	0.00	0.78	0.68	0.00	0.00	0.00	3.33	1.82	2.00	0.00	0.74
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
Estimated Costs for Actual Event	$13,793	$0	$0	$13,793	$13,793	$0	$0	$0	$41,379	$27,786	$27,786	$0	$137,930
Near Miss Events	8	2	4	4	6	4	7	5	4	3	4	5	56
Estimated Costs for Near Miss Event	$110,344	$27,586	$55,172	$55,172	$82,758	$55,172	$96,551	$68,965	$55,172	$41,379	$55,172	$68,965	$772,408
Estimated Near Miss Mortality	0.29 deaths	0.08 deaths	0.14 deaths	0.14 deaths	0.22 deaths	0.14 deaths	0.25 deaths	0.18 deaths	0.14 deaths	0.108 deaths	0.14 deaths	0.18 deaths	2 deaths

Resource for cost breakdown comes from AHRQ - Estimating the Additional Hospital Inpatient Cost and Mortality Associated with Selected Hospital -Acquired Conditions https://www.ahrq.gov/hai/pfp/haccost2017-results.html

*note predicted values updated mid-FY25

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

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



	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	June 2025	July 2025	Aug 2025	Total
MRSA EVENTS	1	2	0	0	1	2	1	0	1	0	0	0	8
MRSA Predicted	0.49	0.46	0.45	0.47	0.46	0.41	0.43	0.47	0.49	0.48	0.4	0.39	5.39
MRSA SIR	2.06	4.31	0	0	2.16	4.87	2.32	0	2.06	0	0	0	1.48
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
Estimated Costs for Actual Event	$14,000	$28,000	$0	$0	$14,000	$28,000	$14,000	$0	$14,000	$0	$0	$0	$ 112,000

Resource for cost breakdown comes <https://hcup-us.ahrq.gov/reports/statbriefs/sb212-MRSA-Hospital-Stays-California-2013.jsp>

*note predicted values updated mid-FY25

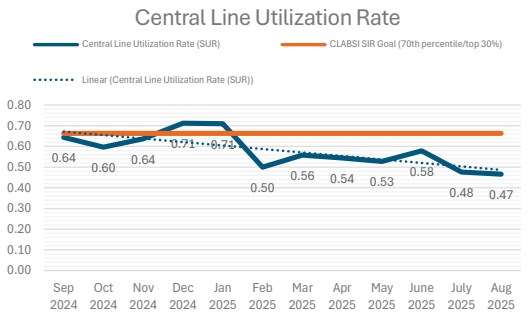
OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

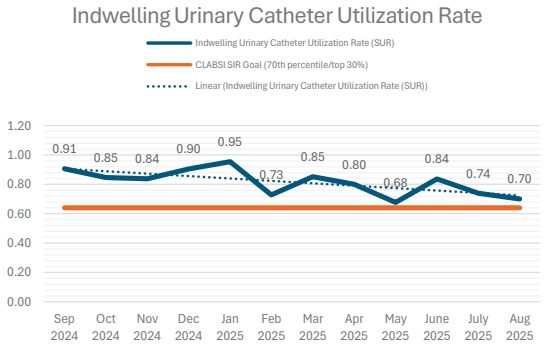
The last data point did not meet goal because:

- 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
  - Sept 2024 – Aug 2025 (SUR = 0.58)
  - Goal: reduce urinary catheter ratio to <0.64
  - Sept 2024 – Aug 2025 (SUR = 0.82)
- MRSA nasal and skin decolonization for patients with lines.
  - Goal: 100% of at-risk patients nasally decolonized
  - July 2025 – Aug 2025 100% of screen patients nasally decolonized
  - Data under evaluation, case reviews indicated that all SNF patients are being screened upon admission (Mar- Jun 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% July 2025 to Aug 2025 61% of staff are active users
  - HH Compliance rate overall 93.5%– decreasing trend noted over 6 quarters
- 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
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

September, 2025

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.**

The components are:

1. **PSI 03** – Pressure Ulcer Rate
2. **PSI 06** – Iatrogenic Pneumothorax Rate
3. **PSI 08** – In-Hospital Fall-Associated Fracture Rate
4. **PSI 09** – Postoperative Hemorrhage or Hematoma Rate
5. **PSI 10** – Postoperative Acute Kidney Injury Requiring Dialysis Rate
6. **PSI 11** – Postoperative Respiratory Failure Rate
7. **PSI 12** – Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate
8. **PSI 13** – Postoperative Sepsis Rate
9. **PSI 14** – Postoperative Wound Dehiscence Rate
10. **PSI 15** – Abdominopelvic Accidental Puncture or Laceration Rate

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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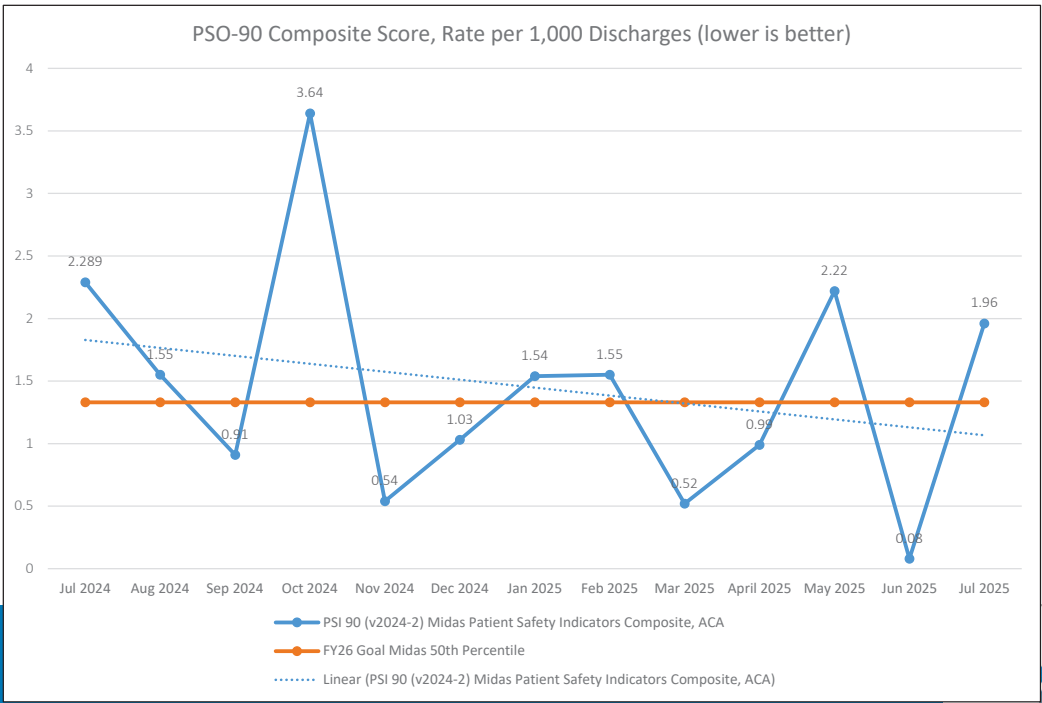
OHO FY26 Plan: Patient Safety Indicator (PSI) 90 Composite Measure
Historical Baseline

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)

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 = 1.96 (July 2025)

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Patient Safety Indicator (PSI) 90 Individual Components

PSI 90 Individual Components	Component Weight	Actual Events ALL Payer (N/D) Aug 2024-July 2025	ALL Payer Risk Adjusted Rate Aug 2024-July 2025	National Rate July 2022-June 2024
*PSI 11 Postoperative Respiratory Failure	0.2152	11/691	15.92	9.42
PSI 12 Perioperative Pulmonary Embolism or DVT	0.1611	4/3294	1.21	3.52
*PSI 10 Postop Acute Kidney Injury Requiring Dialysis	0.0507	2/671	2.98	1.67
PSI 09 Postoperative Hemorrhage or Hematoma	0.0338	7/3273	2.14	2.34
PSI 03 Pressure Ulcer	0.2186	4/10291	0.39	0.63
PSI 06 Iatrogenic Pneumothorax	0.0352	1/13988	0.07	0.21
PSI 08 In-Hospital Fall-Associated Fracture	0.0506	1/14291	0.07	0.27
*PSI 13 Postoperative Sepsis	0.1915	1/641	1.56	5.27
PSI 14 Postoperative Wound Dehiscence	0.0169	0/702	0.00	1.77
PSI 15 Accidental Puncture or Laceration	0.0263	1/2576	0.39	1.06
PSI-90 Composite	1.00	32	1.37	1.00

Targeted Opportunity:

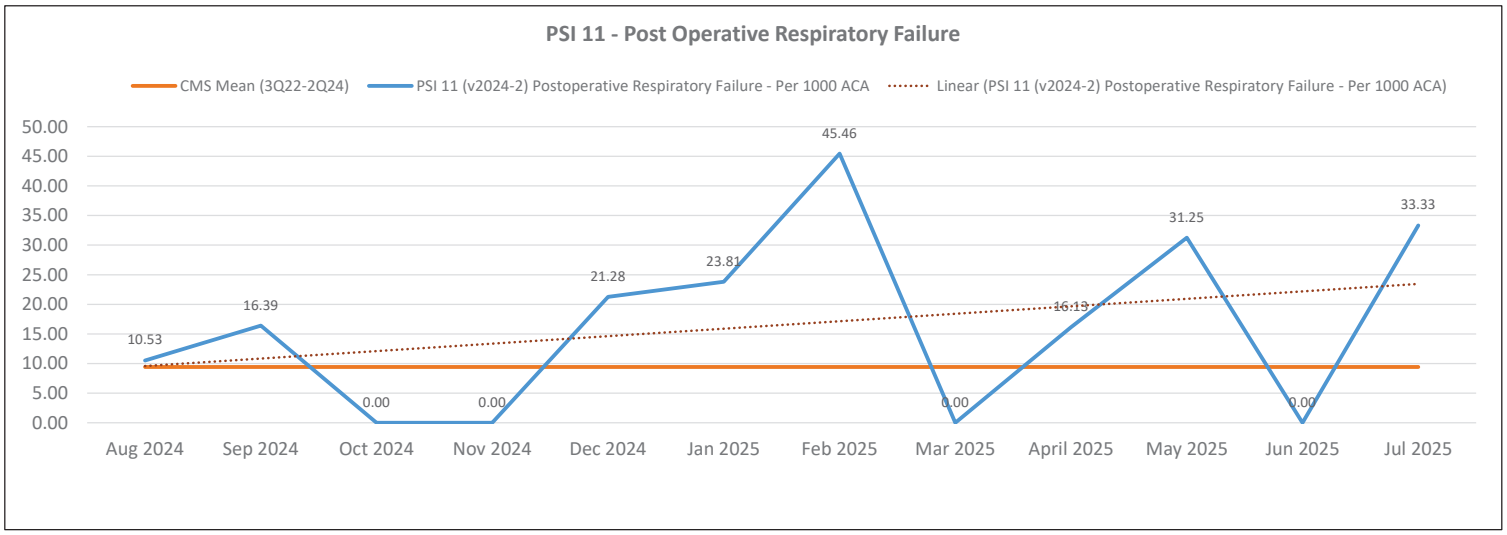
- PSI 11 Postoperative Respiratory Failure Rate: 15.92 per 1,000 Elective Surgical Discharges (11 events out of 691 patients)
- PSI 11 is the **highest** weighted PSI within the PSI 90 composite score

Other Considerations:

- PSI 10 Postop Acute Kidney Injury Requiring Dialysis Rate 2.98 per 1,000 Surgical Discharges (2 events out of 671 cases)
- While PSI 10 rate is higher than the national, it is a low volume indicator

*Elective procedures
** The weighted average of the observed-to-expected ratios for the PSI 90 component indicators (PSI 3,6,8,9,10,11,12, 13, 14, & 15)

OHO FY26: Patient Safety Indicator (PSI) 11



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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
- 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	10/31/25	Transitions of Quality & Patient Safety Resources
Discussion with HIM and finance to explore opportunities for adjustment in coding	10/31/25	Transitions of Quality & Patient Safety Resources

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