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, July 17, 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

Mike Olmos • Zone 1
President

Lynn Havard Mirviss • Zone 2
Vice President

Dean Levitan, MD • Zone 3
Board Member

David Francis • Zone 4
Secretary/Treasurer

Amando Murrieta • Zone 5
Board Member

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, July 17, 2025 • Kaweah Health Lifestyle Fitness Center Conference Room
Attending: Board Members: Michael Olmos (Chair), Dean Levitan, MD; Gary Herbst, CEO; Schlene Peet, Interim Chief Nursing Officer; Paul Stefanacci CMO/CQO; Julianne Randolph, OD, Vice Chief of Staff and Quality Committee Chair; LaMar Mack, MD, Quality and Patient Safety Medical Director; 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 June 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 – Julianne Randolph, DO, 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*
5. **ADJOURN CLOSED MEETING –** Mike Olmos, Committee Chair

Mike Olmos • Zone 1 President
Lynn Havard Mirviss • Zone 2 Vice President
Dean Levitan, MD • Zone 3 Board Member
David Francis • Zone 4 Secretary/Treasurer
Amando Murrieta • Zone 5 Board Member

Kaweah Delta Health Care District

Board Of Directors Committee Meeting

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

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. **Closed Meeting Report Out**
4. **Review of June 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. **Best Practice Teams**
    b. **Diabetes Committee Quality Report**
6. **Kaweah Health Chronic Dialysis Report –** A review of key performance indicators and actions associate with care of dialysis patient population. Amy Baker, MSN RN, Director of Specialty Clinics, Connie Green, Nurse Manager, Chronic Dialysis.
7. **Clinical Quality Goals Update –** A review of current performance and actions focused on the clinical quality goals for Sepsis, and Healthcare Acquired Infection. Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.
8. **ADJOURN OPEN MEETING -** Mike Olmos, Committee Chair

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Mike Olmos • Zone 1 President
Lynn Havard Mirviss • Zone 2 Vice President
Dean Levitan, MD • Zone 3 Board Member
David Francis • Zone 4 Secretary/Treasurer
Amando Murrieta • Zone 5 Board Member

Agenda item intentionally omitted

OPEN Quality Council Committee
Thursday, June 19, 2025
The Lifestyle Center Conference Room

Attending: Board Members: Mike Olmos (Chair) & Dean Levitan, Board Member; Gary Herbst, CEO; Sandy Volchko, Director of Quality & Patient Safety; Jag Batth, Chief Operating Officer, Schlene Peet, Interim Chief Nursing Officer; Mark Mertz, Chief Strategy Officer; Cindy Vander Schuur, Manager of Patient Safety; Dr. Mack, Medical Director of Quality & Patient Safety; Molly Niederreiter, Director of Rehabilitation Services; Marissa Gutierrez, Nurse Manager; Erika Pineda, Quality Improvement Manager; Kyndra Licon – Recording.

Mike Olmos called to order at 7:30 AM.

Approval of Closed Session Agenda: 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. **Approval of May Quality Council Open Session Minutes –** Mike Olmos, Committee Chair; Dean Levitan, Board Member.
    - Approval of May Quality Council Open Session Minutes by Dean Levitan and Mike Olmos.

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 Hand Hygiene Quality Report
    4.2 Subacute Quality Report

5. **Safety Culture Survey –** Results and actions associated with the 2025 Safety Culture Survey. Sandy Volchko, RN, DNP, Director of Quality Patient Safety. – Suggestion to ensure that staff who take the Safety Culture Survey are also included in Day 2 of Orientation where high reliability concepts are discussed.
6. **Clinical Quality Goals Update**- A review of current performance and actions focused on the clinical quality goals for Sepsis, and Healthcare Acquired Infections. – Reports reviewed and attached to minutes. No action taken.

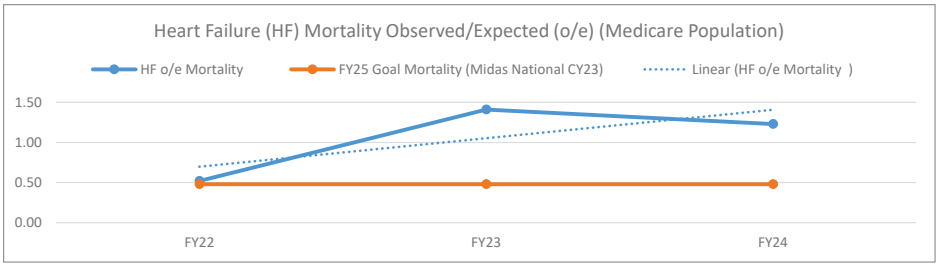
Adjourn Open Meeting – *Mike Olmos, Committee Chair*

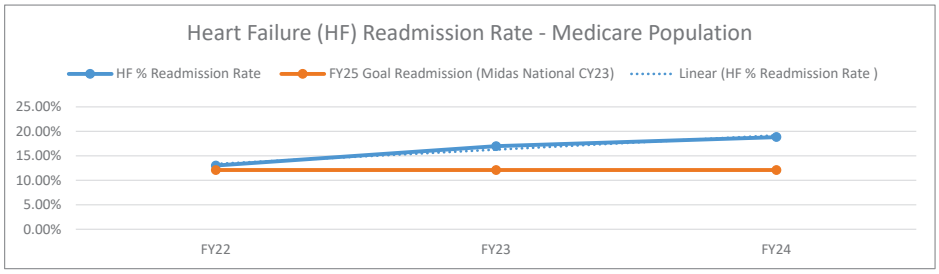
Mike Olmos adjourned the meeting at 8:55 AM.

Outstanding Health Outcomes (OHO) QUALITY & PATIENT SAFETY PRIORITY

Mortality & Readmission Reduction
Heart Failure (HF), Chronic Obstructive Pulmonary Disease (COPD) & Pneumonia (PN)
June 2025

OHO FY25 Plan: Mortality & Readmission Reduction Heart Failure – Historical Baseline





FY25 GOAL

(CMS population)

Decrease HF Hospital Readmissions to < 12.10

Decrease HF Mortality Rates to < 0.48

FY25 PLAN – Mortality & Readmissions

Heart Failure

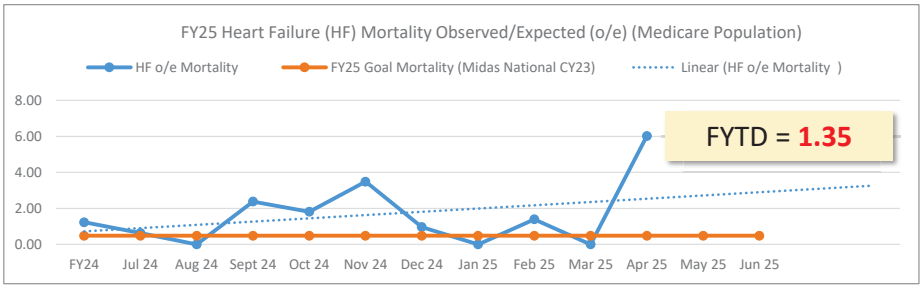
High Level Action Plan

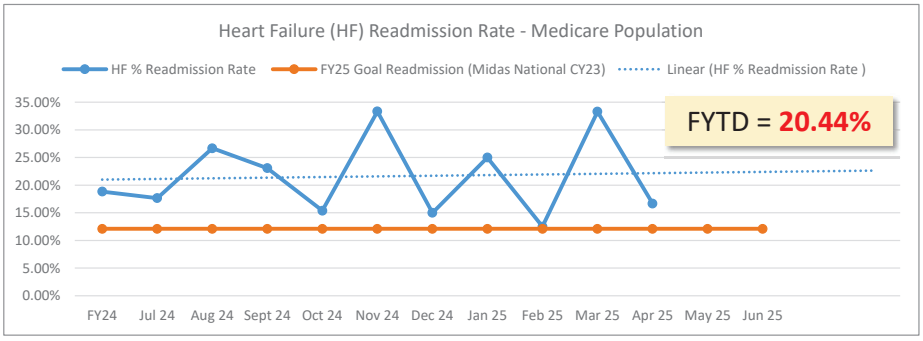
- Identify HF patients with an EF ≤ 40%
  - EMR identification of ejection fraction
- Provide Guideline Directed Medical Therapy at discharge

  % of Patients Prescribed each of Four Medications at Discharge

  Baseline data 1/2/24-4/29/24 and n = 5
  - 60% ACE/ARB/ARNI
  - 100% Beta Blocker
  - 0% SGLT2i
  - 0% MRA
  - Goal = 100%

OHO Update: Mortality & Readmission Reduction Heart Failure – FY25





FY25 GOAL (CMS population)
Decrease HF Hospital Readmissions to < 12.10
Decrease HF Mortality Rates to < 0.48

FY25 PLAN – Mortality & Readmissions Heart Failure

High Level Action Plan

- Identify HF patients with an EF ≤ 40%
  - EMR identification of ejection fraction
  - Completed 6/2024
- Provide Guideline Directed Medical Therapy at discharge

  Data pending - Patients Prescribed each of Four Medications at Discharge

  ACE/ARB/ARNI

  Beta Blocker

  SGLT2i

  MRA

  Goal = 100%

OHO Update: Mortality & Readmission Reduction Heart Failure- FY25

The last data point did not meet goal because:

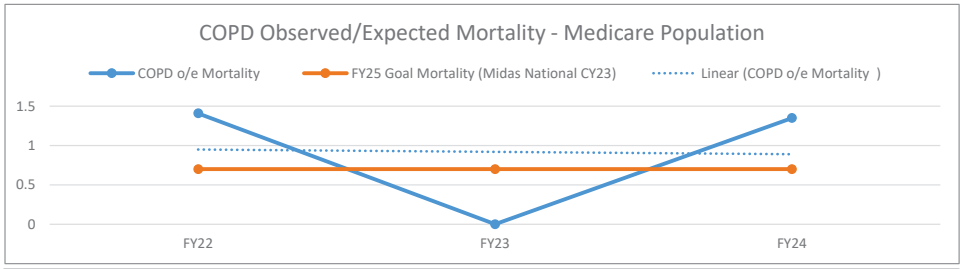
- Evidenced-based medications are not being prescribed upon discharge
  - According to the American College of Cardiology (ACC) and American Heart Association (AHA), patients with heart failure with reduced ejection fraction (HFrEF) should be treated with a combination of four medications: Angiotensin receptor/neprilysin inhibitors (ARNI), Beta blockers, Mineralocorticoid receptor antagonists (MRAs), and Sodium-glucose cotransporter-2 inhibitors (SGLT2i). These medications are sometimes called the "fantastic four". Some of these medications can help strengthen the heart muscle, lower blood pressure, and treat the heart muscle.
- Patient are not consistently seen timely post discharge by primary care provider or cardiology

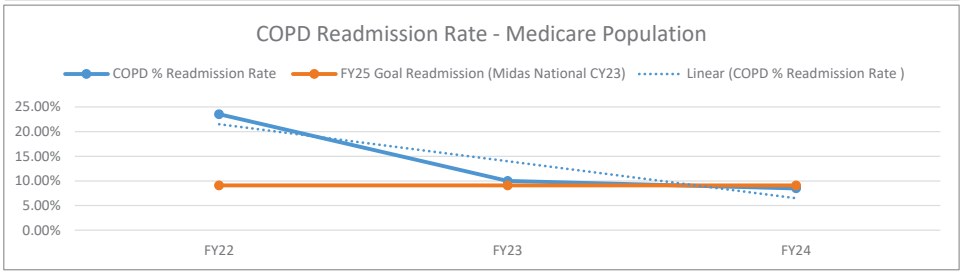
Targeted Opportunities (What specifically is causing the fallouts?)

1. Patients not consistently scheduling their post d/c appointments (increases likelihood of readmission)
2. Insurance companies not covering ARNI (Entresto) despite strongest evidence that it impacts patient outcomes
3. There are medical contraindications for why certain patients can't take these medications – need better info on how often these contraindications are happening

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

OHO FY25 Plan: Mortality & Readmission Reduction COPD - Historical Baseline





FY25 GOAL

(CMS population)

Decrease COPD Hospital Readmissions to < 9.09

Decrease COPD Mortality Rates to < 0.70

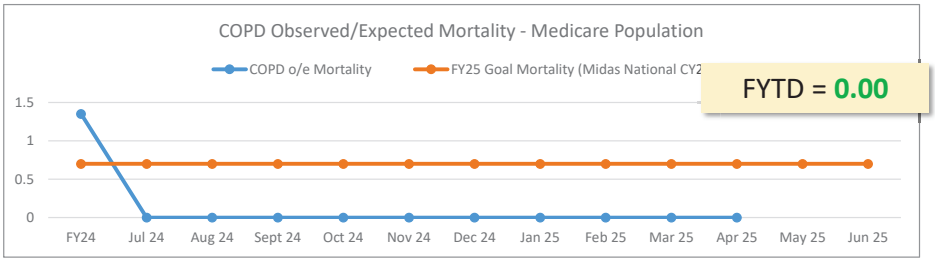
FY25 PLAN – Mortality & Readmissions

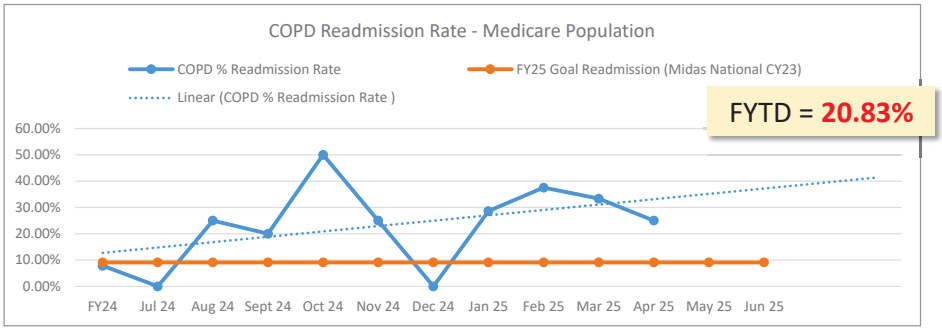
COPD

High Level Action Plan

- Provide Evidence Based steroid treatment while hospitalized - Prednisone 40mg PO daily x 5 days
  - Baseline Data – 50% of patients prescribed Prednisone during hospitalization (n=4)
  - Goal = 100%
- Provide Guideline Directed Medical Therapy at discharge - LAMA/LABA inhaler
  - Baseline Data – 50% of patients prescribed LAMA/LABA upon discharge (n=4)
  - Goal = 100%

OHO Monthly Update: Mortality & Readmission Reduction COPD – FY25





FY25 GOAL (CMS population)
Decrease COPD Hospital Readmissions to < 9.09
Decrease COPD Mortality Rates to < 0.70

FY25 PLAN – Mortality & Readmissions

COPD

High Level Action Plan

- Provide Evidence Based steroid treatment while hospitalized - Prednisone 40mg PO daily x 5 days
  - 42% (Jan – Apr 2025), **Improved** from 29% in 2024 Goal = 100%
- Provide Guideline Directed Medical Therapy at discharge - LAMA/LABA inhaler
  - 62% (Jan – Apr 2025), **Improved** from 58% in 2024; Goal=100%. Data used as an indicator of improvement; currently includes patients who have contraindications or have insurance barriers (will be excluded in future data set)

OHO Monthly Update: Mortality & Readmission Reduction COPD – FY25

The last data point did not meet goal because:

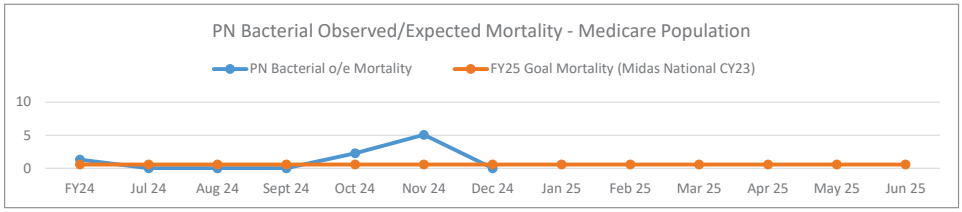
- Patients not being discharged on the evidenced-based meds that affect patient outcomes
  - Cost of inhalers – some patients revert to Advair at home because it is very inexpensive, (but not a recommended medication) compared to LAMA/LABA inhalers
- Using IV solumedrol rather than PO prednisone – high dose steroids can actually cause patient harm

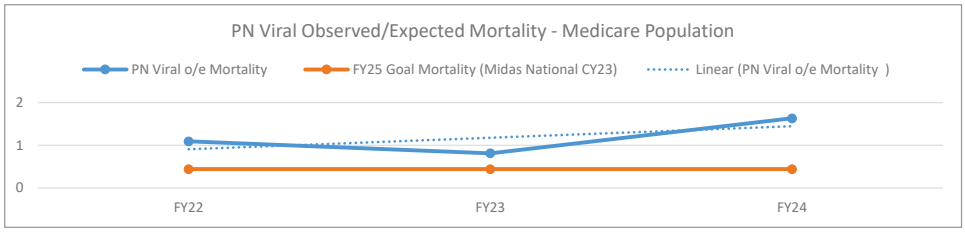
Targeted Opportunities (What specifically is causing the fallouts?)

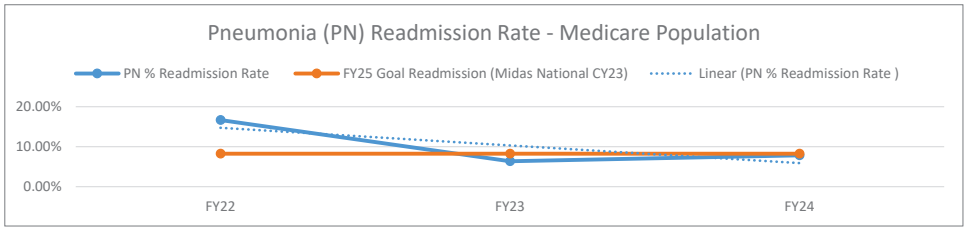
1. Because of limited pulmonology, the decision of discharge medications fall more to discharging hospitalists. Hospitalists prescribe nebulizers for COPD inpatients, not inhalers that are used in the outpatient setting. Therefore they have understandably less knowledge on what insurance companies cover which inhalers supplied by community pharmacies
2. Provider "inertia" in using IV solumedrol – i.e. physicians have always done this and continue to do it

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

OHO FY25 Plan: Mortality & Readmission Reduction Pneumonia - Historical Baseline







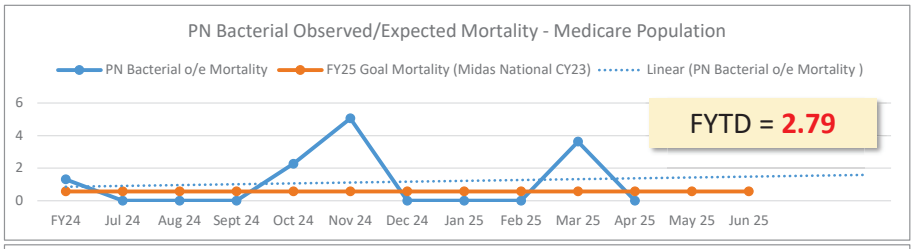
FY25 PLAN – Mortality & Readmissions Pneumonia

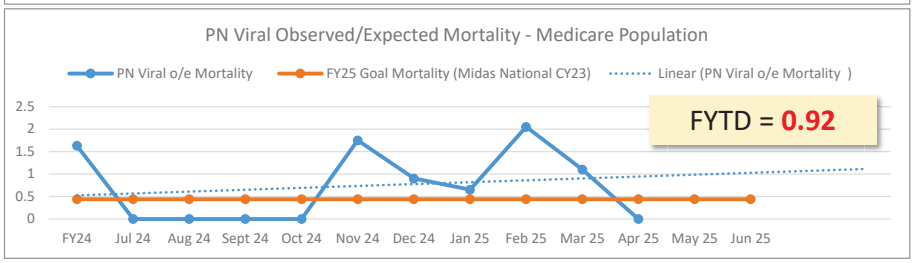
High Level Action Plan

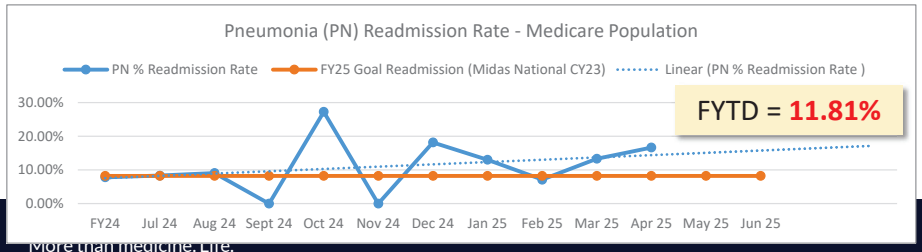
- Utilize Evidence-based order set for patients admitted with Community Acquired Pneumonia
  - Baseline Data – 50% of bacterial PN patients, and 71% of viral PN pt's with order set in place (n=13)
  - Goal = 100%
- Order the appropriate antibiotics upon admission for patients with Community Acquired Pneumonia
  - 69% Utilize preferred empirical antibiotic treatment
  - Goal = 100%

FY25 GOAL (CMS population)
Decrease PN Viral/Bacterial Hospital Readmissions to <8.24
Decrease PN Bacterial Mortality Rates to < 0.57
Decrease PN Viral Mortality Rates to < 0.43

OHO Monthly Update: Mortality & Readmission Reduction Pneumonia – FY25







FY25 PLAN – Mortality & Readmissions Pneumonia

High Level Action Plan

- Utilize Evidence-based order set for patients admitted with Community Acquired Pneumonia

  29% (Jan – Apr 2025), **decreased** from 46% in 2024 Goal = 100%

- Order the appropriate antibiotics upon admission for patients with Community Acquired Pneumonia

  81% (Jan – Apr 2025), **Improved** from 64% in 2024 Goal = 100%

FY25 GOAL (CMS population)
Decrease PN Viral/Bacterial Hospital Readmissions to <8.24
Decrease PN Bacterial Mortality Rates to < 0.57
Decrease PN Viral Mortality Rates to < 0.43

OHO Monthly Update: Mortality & Readmission Reduction Pneumonia (PN) – FY25

The last data point did not meet goal because:

- Order set usage down, but the Antibiotics (Abx) section of the PN order set placed in other diagnoses and the general admission order sets
- Competing Diagnosis, ie. Heart failure on admit, but by end of hospitalization determined it is pneumonia as work up gets completed
- Community Acquired Order Set not being used
- PN patients not on the correct evidenced based antibiotic (Abx) type

Targeted Opportunities (What specifically is causing the fallouts?)

1. PN order set not being used when there is a competing diagnosis
2. Suboptimal EMR workflows that make it challenging for providers to order Evidenced based Antibiotics
3. Abx Stewardship

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
Order set integration of PN Abx "Sub Phase" into other power plans	Feb 2025	None
Dr. Tedaldi attends monthly Hospitalist meeting to encourage utilization of admission power plans.	On going	None
Pilot handshake (3 hospitalists and ID pharmacist) rounds to improve antibiotic stewardship. Plan to expand participation among providers.	Began May 2025, On going	None

Thank you

Live with passion.

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

Kaweah Health

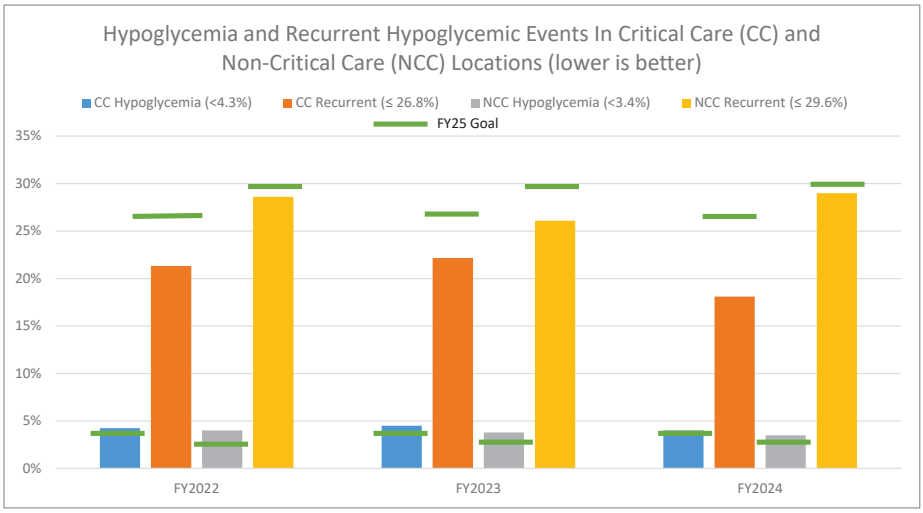
Outstanding Health Outcomes (OHO) QUALITY & PATIENT SAFETY PRIORITY

Inpatient Diabetes Care – Hypoglycemia Reduction

May 2025

OHO Annual Plan: Inpatient Diabetes Care

Hypoglycemia Reduction in Critical Care (CC) and Non-Critical Care (NCC) Locations



FY25 GOAL

Achieve < 4.3% benchmark performance for hypoglycemia in Critical Care (CC) patient population, defined as percent patient days with blood glucose (BG) <70

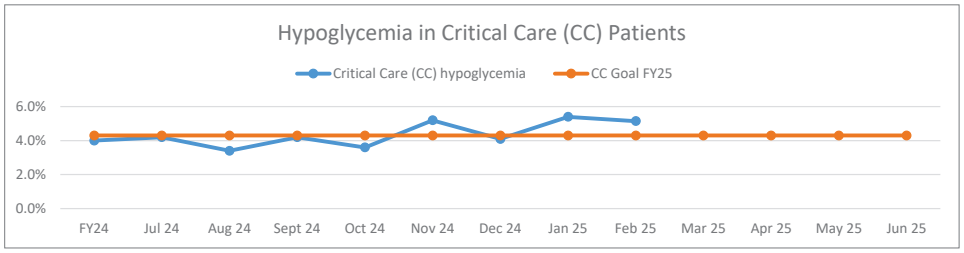
FY25 PLAN – Hypoglycemia Reduction

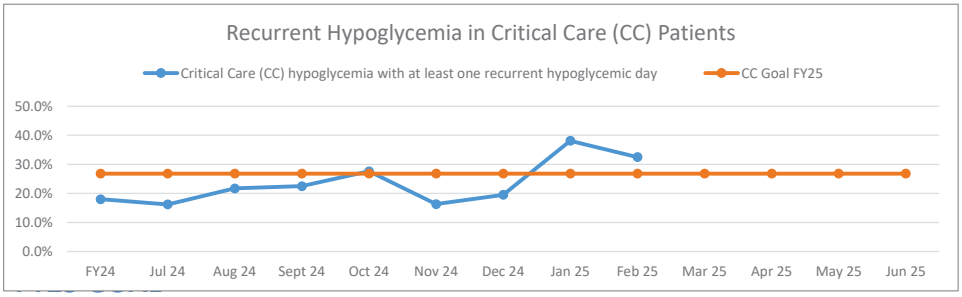
High Level Action Plan

- Increase IV insulin usage upon arrival to MICU from 170 to 187 (10% increase) by June 30, 2025. Currently on target for goal.
- APN will round 3 times per week to encourage use of IV Insulin usage providing rational and education to GME residents as needed.
- APN will monitor patients in the MICU using Glucometrics utilizing set parameters to avoid hypoglycemia or recurrent hypoglycemia (BG < 90 mg/dL)

OHO Annual Plan: Inpatient Diabetes Care

Hypoglycemia Reduction in Critical Care Locations





Achieve < 4.3% benchmark performance for hypoglycemia in Critical Care (CC) patient population, defined as percent patient days with blood glucose (BG) <70

FY25 PLAN – Hypoglycemia Reduction

High Level Action Plan

- The metrics on this slide include both IV and SQ insulin in all critical care areas (MICU, CVICU, ICCU and CVICCU)
- For the Jan & Feb 2025, the hypoglycemia and recurrent hypoglycemia rates underperformed the benchmark. The team will continue to monitor.
- Increase APN rounding in the MICU to encourage the use of IV Insulin for critically ill patients who are intubated and hemodynamically unstable. DM NP to met with Dr. Javed to establish a process. Dr. Javed will bring information forward with Sound group. DM NP to monitor for usage.

OHO Annual Plan: Inpatient Diabetes Care

Hypoglycemia Reduction in Critical Care Locations

The last data point did not meet goal because:

- Over usage of subcutaneous insulin, need more Iv insulin use(American Diabetes Association recommended practice) IV is first line therapy
- Why? Education Gap Intensivists & hospitalists (MICU, 3W & 5T)
- Residents order 70% of insulin in MICU

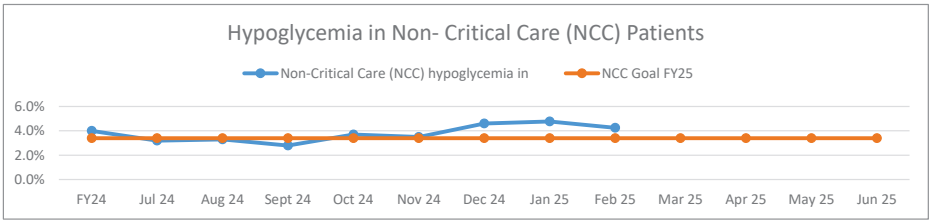
• Targeted Opportunities (What specifically is causing the fallouts?)

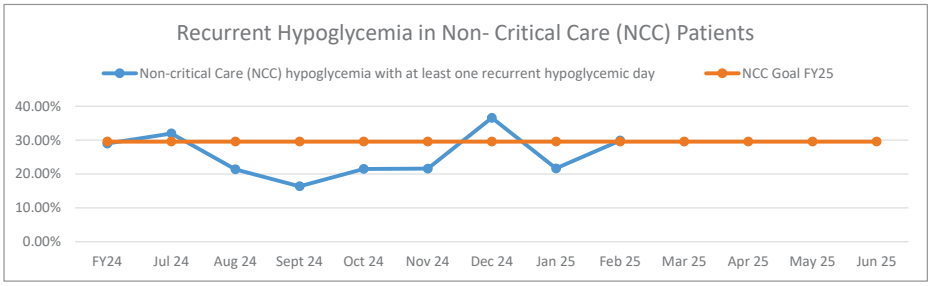
1. Intensivist/GME managing patients in MICU has most opportunity as there is a higher volume of patients who require IV insulin
2. MICU Workflow ordering, nursing influence (labor intensive to manage a patient on IV insulin)

CURRENT IMPROVEMENT ACTIVITIES	COMPLETION DATE	BARRIERS
Glytec to help review hypoglycemic patient chart review to determine which patients are not treated according to best practice guidelines (started on SQ rather than IV insulin	Ongoing	
Upgrade in May assisted in EMR issues in transcribing diabetes management orders	May 2024	
Communicating inability to adjust basal insulin at anytime, currently have to wait for morning BG to be input in GM by the nurse	TBD	1. Glytec upgrade in 2026 2. Nurses not inputting BG into GM in a timely manner
Improve knowledge and skillset of nursing, pharmacist and medical staff through education, training, consultative services.	ongoing	

OHO Annual Plan: Inpatient Diabetes Care

Hypoglycemia Reduction in MED/SURG Locations





FY25 GOAL

Achieve < 3.4% benchmark performance for hypoglycemia in Non-Critical Care (NCC) patient population, defined as percent patient days with blood glucose (BG) <70

FY25 PLAN – Hypoglycemia Reduction

High Level Action Plan

- Optimize the difficult to manage patients (i.e. Renal, recurrent hypoglycemia, insulin resistant, steroid-induced hyperglycemia) using a non-GM power plan
- Continue to work with Glytec to improve glycemic control through product improvement recommendations: adjust basal dose prior to morning BG input into GM
- For January & February 2025, the hypoglycemia rate underperformed the identified SHM benchmark for NCC. The recurrent hypoglycemia rates for the same time period outperformed or equaled the benchmark. We will continue to monitor and develop improvement strategies in the upcoming Diabetes Management meetings.

OHO Annual Plan: Inpatient Diabetes Care

Hypoglycemia Reduction in MED/SURG Locations

The last data point did not meet goal because:

- 4N Patients, renal patients are complex as they lack renal system to metabolize insulin
- ADA guidelines indicate best practice to manage this population you need to ensuring Lantus (longer acting) is not 50% of insulin, and need close monitoring/management to successfully avoid hypoglycemia

• Targeted Opportunities (What specifically is causing the fallouts?)

1. Are there best practice guidelines for managing diabetes for renal insufficiency patients?
2. Need very focused resources to closely manage patients who have renal insufficiency, very complex population, very dynamic with their glucose levels (factors include: timing of dialysis, times for eating, amount eaten, renal function)

CURRENT IMPROVEMENT ACTIVITIES	COMPLETION DATE	BARRIERS
Review patients with BG less than 90 mg/dL and adjust insulin as needed to avoid hypoglycemia or prevent recurrent hypoglycemia	Ongoing	Lack of time for CC APN to review all patients
Monitor patients on the non-GM power plan to ensure they are receiving correct dose of insulin. Discern report is used to identify patients on the non-GM power plan.	Ongoing	
Demonstrate return on investment (ROI) through improved throughput, decreased length of stay to increase time APN spends monitoring and caring for patients with diabetes.	12/27/2024	
Improve knowledge and skillset of nursing, pharmacist and medical staff through education, training, consultative services.	Ongoing	
Meeting with Dr. Javed from Sound Intensivist group to discuss underuse of insulin infusions.	3/11/2025	Practitioner practice may not change. Nursing staff may still push for SQ insulin when patients are not medically ready for transition to SQ insulin

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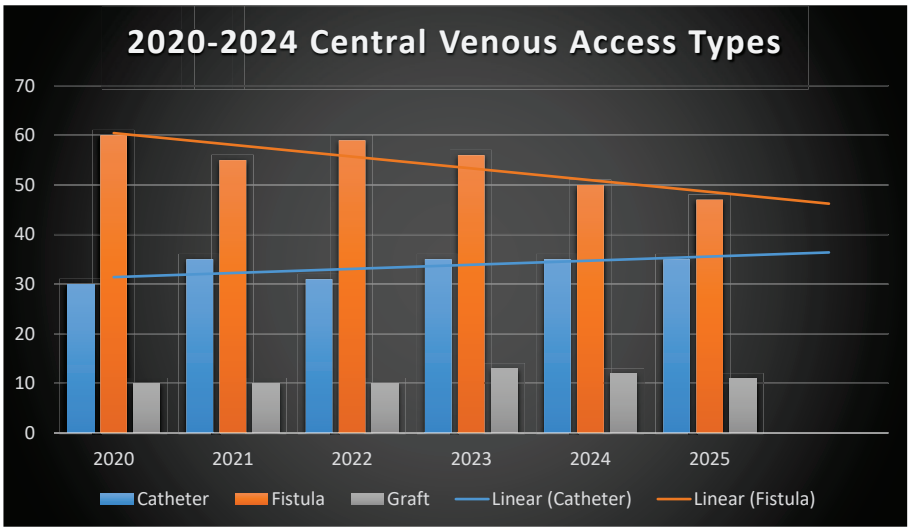
QUALITY & PATIENT SAFETY PRIORITY

Renal Services Quality Report

Quality Committee Report

March 2025

Renal Services Quality Report: Central Venous Access Management



Central Venous Access Management

High Level Action Plan CY 2025

- Increase number of patients with arteriovenous fistula 70%
- Decrease the number of patients with central venous catheter (CVC)
- Decrease number of patients with CVC greater than 90 days- Goal: 10.7%

Patients who use an arteriovenous fistula (AVF) have an increased median life expectancy. These patients have a life expectancy that exceeds the secondary patency of arteriovenous grafts and central venous catheters. In this subset of patients, AVF remains the best hemodialysis option.

Arteriovenous Fistula Remains the Best Hemodialysis Access Choice for Some Elderly Patients, Pastor, M. Chris et al. Journal of Vascular Surgery, Volume 68, Issue 3e82. September 2018

Renal Services Quality Report: Central Venous Access Management

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KH Dialysis Central Venous Access Management

	Target	Mar 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Rolling 12M Av
Percent of patients with CVC		29.7	33.1	37.85	36.7	38.36	37	37.6	39.5	40.4	43.2	40.6	41.8	37.98
Percent of patients with AV Fistula	70%	52.8	49.24	50	49.2	49.6	51.6	51.1	49.2	48.8	45.4	48.4	47.3	49.38
Percent of patients with CVC >90 days	10%	29	25.75	25.3	27.6	27.9	31.4	33	33.3	30.2	30.3	32	32.5	29.85

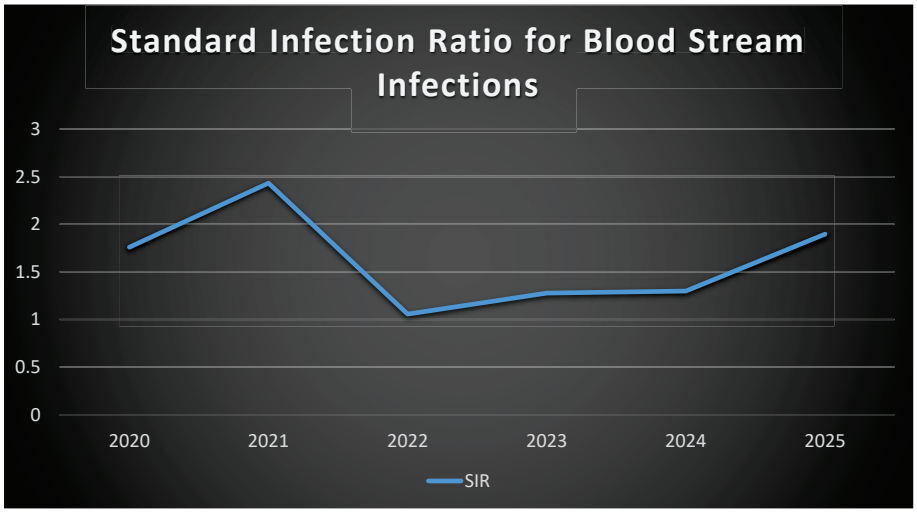
Targeted Opportunities (why goal not achieved in most recent month)

1. Lack of appointment availability for vascular access providers
2. Lack of Interventional Radiology availability for vascular providers
3. Patient refusal, which is multifactorial, can be related to knowledge deficit

Renal Services Quality Report: Central Venous Access Management

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS/UPDATES
Efficient referral process - The clinical coordinator/ access manager has established an efficient workflow to speed up the vascular access referral process. New patients are referred immediately upon admission to Kaweah Health Dialysis Clinic.	December 2025	This process generally takes longer than 90 days due to high volume of patients seeing vascular surgeons.
Patient Education on the benefits of AVF Providing education to the patient with regard to the many advantages of an AVF or AVG as opposed to a CVC. We are currently exploring new methods of providing patient education such as educational videos that play throughout the day on the dialysis center televisions.	Ongoing	Access education included in admission process. Additional education provided by staff during clinic visits/ treatment, and by Renal CoordinatorWorking with Marketing department to create content of video.

Renal Services Quality Report: Central Venous Access Management



Blood Stream Infection Reduction
High Level Action Plan CY 2025

- Goal of zero bloodstream infections

Preventing bloodstream infections in outpatient hemodialysis ensures patient safety. Closely monitoring infection trends allows us to identify areas of improvement and implement interventions to reduce infection rates. This helps improve patient outcomes and maintain compliance with regulatory standards and quality care.

Renal Services Quality Report: Central Venous Access Management

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KH Dialysis Central Venous Access Management

	Target	Mar 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Rolling 12M Av
NHSN Blood Stream Infection Ratio	0	0	0	0.836	2.489	1.886	0	3.888	2.805	0.8063	3.572	2.283	0.902	1.622
Actual Number of Blood Stream Infections	0	0	0	1	3	2	0	4	3	1	4	3	1	1.833

Targeted Opportunities (why goal not achieved in most recent month)

1. Biovigil Compliance
2. Staff Accountability to following standards of care

Renal Services Quality Report: Central Venous Access Management

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS/UPDATES
Biovigil Compliance: The nurse manager reviews Biovigil reports with staff as needed to address missed opportunities, low participation, and/or high exception rates.	December 2025	Staff reports lack of consistency in device triggering a fallout. Working with vendor to ensure devices working appropriately.
Infection Prevention Audit: Monthly observations of vascular access care. The charge nurses and nurse manager will make every attempt to address fallouts immediately as education in the moment helps to provide added insight with regard to process fallouts.	December 2025	Staff continue to skip key elements of best practice standards.

Renal Services Quality Report: Social Determinants of Health (SDOH) Integration

➢Objectives:

- Identify equity gaps in care
- Inform targeted interventions

➢Actions:

- Conduct SDOH screening (PREPARE tool)
- Stratify Key Performance Indicators by SDOH data
- Use insights to guide care and resource planning

➢Goal:

Advance health equity through data-informed decisions

➢ Current Status: For 2025 we have completed 28 screenings. 20% complete with goal to be 100% complete by 07/01/2025.

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Outstanding Health Outcomes (OHO) QUALITY & PATIENT SAFETY PRIORITY

Healthcare Acquired Infection (HAI) Reduction

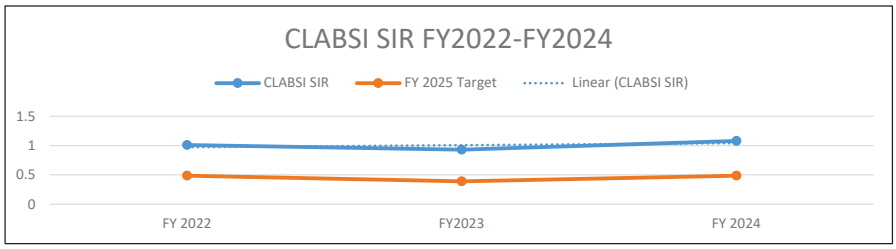
July 2025

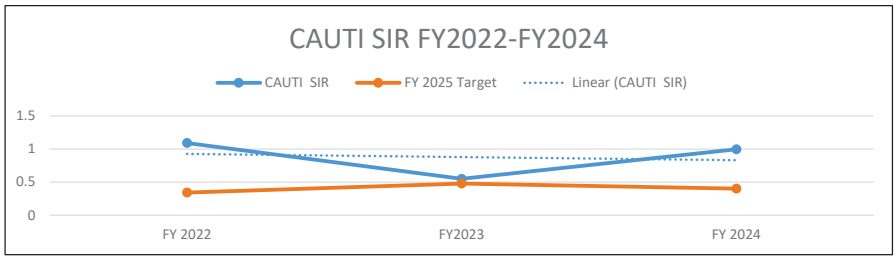
OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

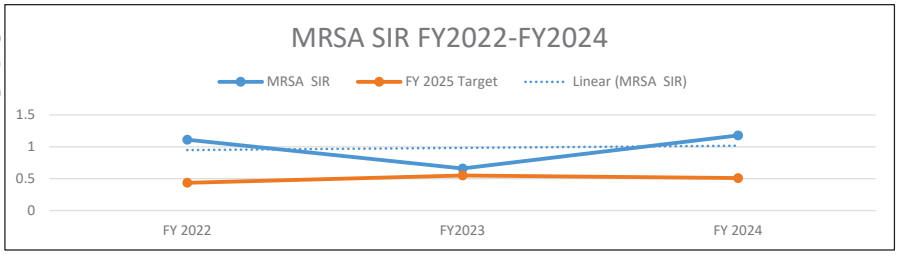
(number of actual infections/number of predicted infections by CMS)

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

Historical Baseline







FY25 PLAN – HAI Reduction CLABSI, CAUTI & MRSA SIR

High Level Action Plan

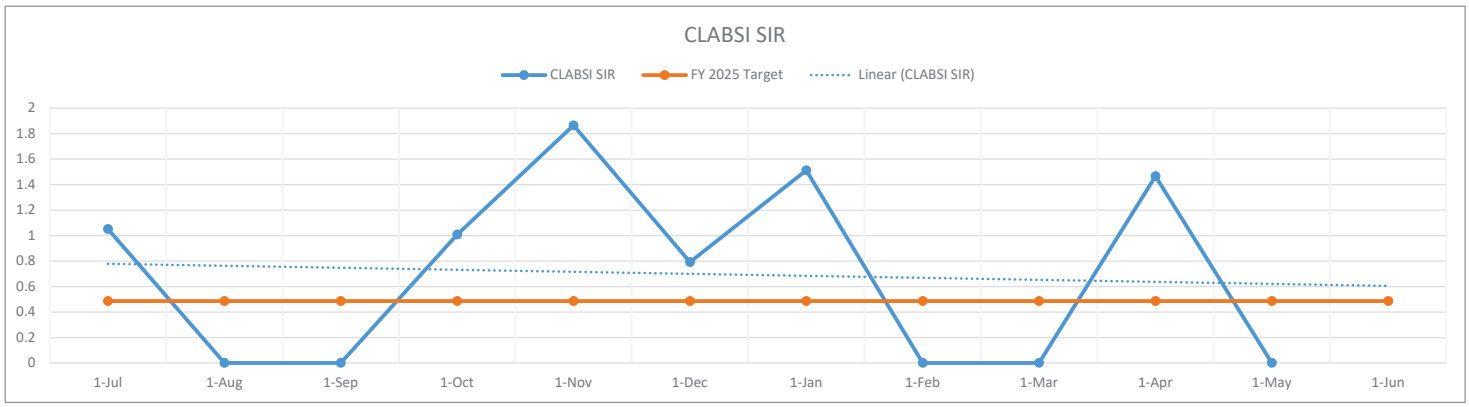
- Reduce line utilization; less lines, less opportunity for infections to occur
  - Goal: reduce central line utilization ratio to <0.66
  - Goal: reduce urinary catheter utilization ratio to <0.64
- MRSA nasal and skin decolonization for patients with lines.
  - Goal: 100% of at risk patients nasally decolonized
  - Goal: 100% of patients with lines have a CHG bath
- Improve hand hygiene (HH) through increased use of BioVigil electronic HH monitoring system
  - Goal: 60% of staff are active users of BioVigil
  - Goal: 95% compliance with hand hygiene
- Improve environmental cleaning effectiveness for high risk areas
  - Goal: 90% of areas in high risk areas are cleaned effectively the first time (all area not passing are re-cleaned immediately)

FY25 GOAL

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

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

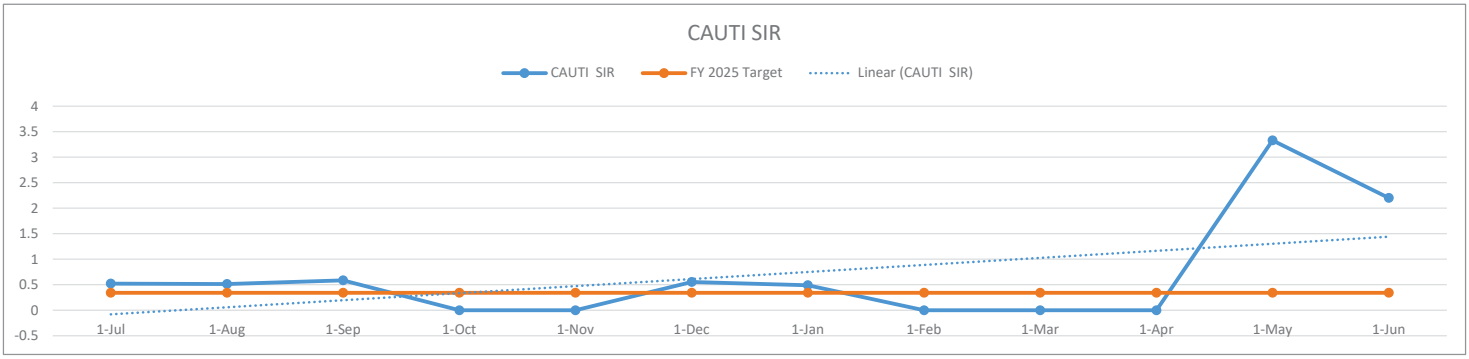
(number of actual infections/number of predicted infections by CMS)



	FY 2025 Target	FY 2024	24-Jul	24-Aug	24-Sep	24-Oct	24-Nov	24-Dec	25-Jan	25-Feb	25-Mar	25-Apr	25-May	25-Jun	FYTD 25
CLABSI Events		17	2	0	0	1	1	1	2	0	0	1	0		8
CLABSI Predicted Events		16.06	1.051	1.117	0.121	1.008	1.072	1.262	1.323	0.848	0.989	0.682	0.656		11.13
CLABSI SIR	<0.486	1.06	1.903	0	0	0.992	1.865	0.792	1.512	0	0	1.446	0		0.72

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

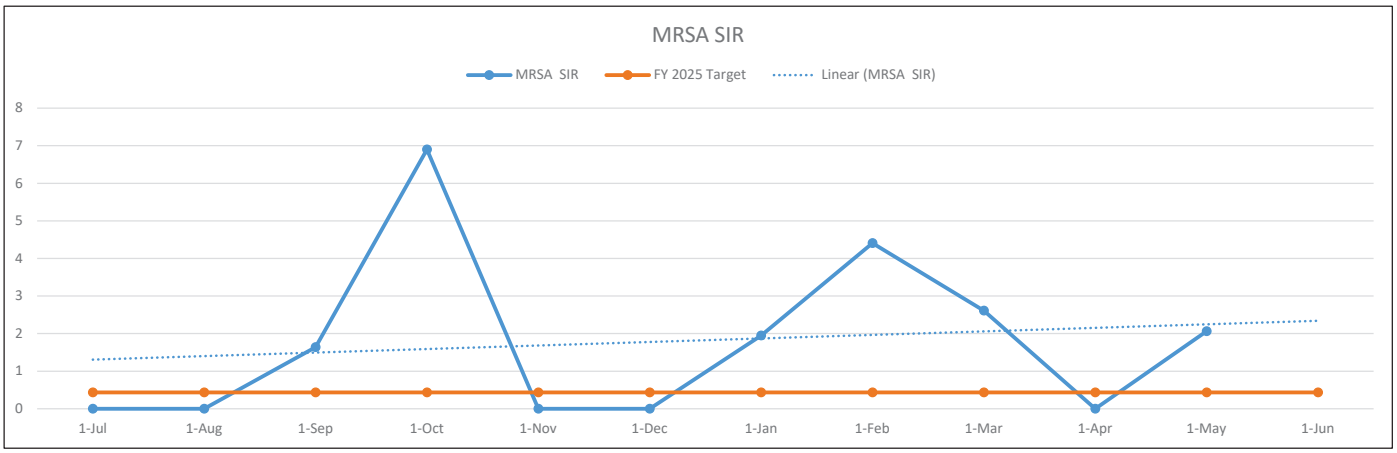
(number of actual infections/number of predicted infections by CMS)



	FY 2025 Target	FY 2024	24-Jul	24-Aug	24-Sep	24-Oct	24-Nov	24-Dec	25-Jan	25-Feb	25-Mar	25-Apr	25-May	25-Jun	FYTD 25
CAUTI Events		9	1	1	1	0	0	1	1	0	0	0	3	2	10
CAUTI Predicted Events		22.58	1.917	1.94	1.707	1.577	1.54	1.801	2.05	1.404	1.716	1.053	0.9	0.909	18.51
CAUTI SIR	<0.342	0.4	0.522	0.515	0.586	0.00	0	0.555	0.488	0	0	0	3.33	2.2	0.54

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

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



	FY 2025 Target	FY 2024	24-Jul	24-Aug	24-Sep	24-Oct	24-Nov	24-Dec	25-Jan	25-Feb	25-Mar	25-Apr	25-May	25-Jun	FYTD 25
MRSA Events		7	0	0	1	2	0	0	1	2	1	0	1		8
MRSA Predicted Events		9.62	0.501	0.482	0.485	0.290	0.451	4.74	0.512	0.454	0.383	0.465	0.485		5.824
MRSA SIR	<0.435	0.73	0	0	1.64	6.9	0	0	1.95	4.41	2.61	0	2.06		1.37

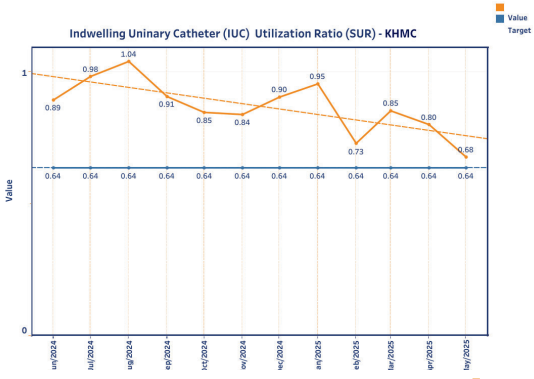
OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

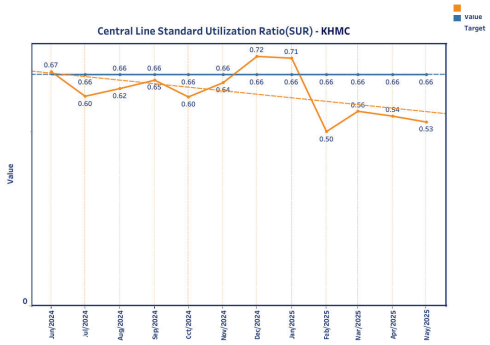
The last data point did not meet goal because:

- 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
  - July 2024 - May 2025 0.61
  - Goal: reduce urinary catheter ratio to <0.64
  - July 2024 - May 2025 0.866
- MRSA nasal and skin decolonization for patients with lines.
  - Goal: 100% of at risk patients nasally decolonized
  - Jul 2024 - Feb 2025 100% of screen patients nasally decolonized
  - Data under evaluation, case reviews indicated that all SNF patients are being screened upon admission (Mar- Apr 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
  - Jul 2024- June 2025 56% of staff are active users (Jan-June 2025 increased to **60%**)
  - HH Compliance rate overall 94% July 2024- June 2025 (goal 95%) – decreasing trend noted over 3 quarters
- 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)
  - July 2024 – May 2025 Pass cleanliness effectiveness testing **90%** of the time in high risk areas





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	Buy in from physician stakeholders
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	Time to establish Cerner workflows
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 (increase 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	None
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	None, Feb 2025 bed rail 100% cleanliness effectiveness testing
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

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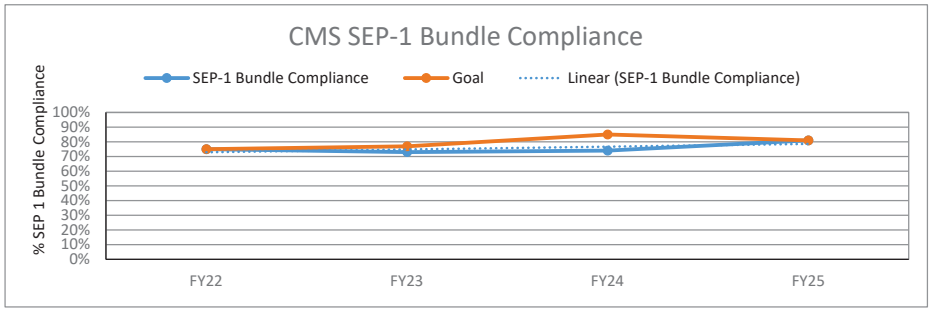
SEPSIS COMMITTEE REPORT
QUALITY & PATIENT SAFETY

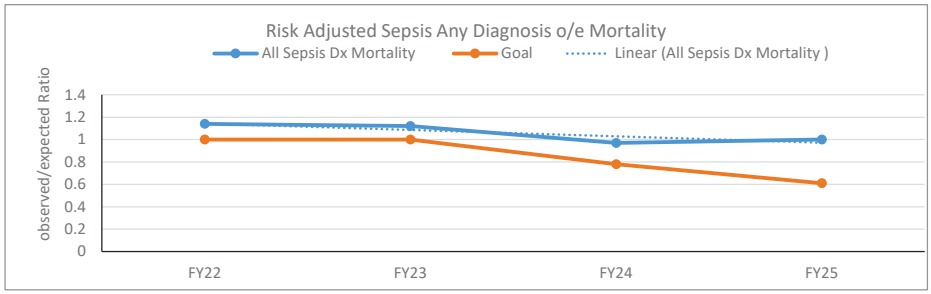
Sepsis CMS SEP-1 & Sepsis Mortality

July 2025

OHO FY25 Plan: CMS SEP 1 and Mortality (observed/expected)

Historical Baseline





FY25 PLAN – CMS SEP-1

High Level Action Plan

- Provide Early Goal Directed Therapy (Sepsis work up and Treatment)

  % of Patients provided top 3 most frequently missed Sepsis bundle elements

  Goal FY 25 95%

  - IV Fluid Resuscitation
  - Antibiotic Administered
  - Blood Cultures Drawn
- Provide Early Goal Directed Therapy (Sepsis Treatment)

  Goal FY 25 = 30%

  - Pts with Sepsis that Received Abx within 60 Minutes of Pt 1st Seen
  - Pts Met 1- Hr Bundle

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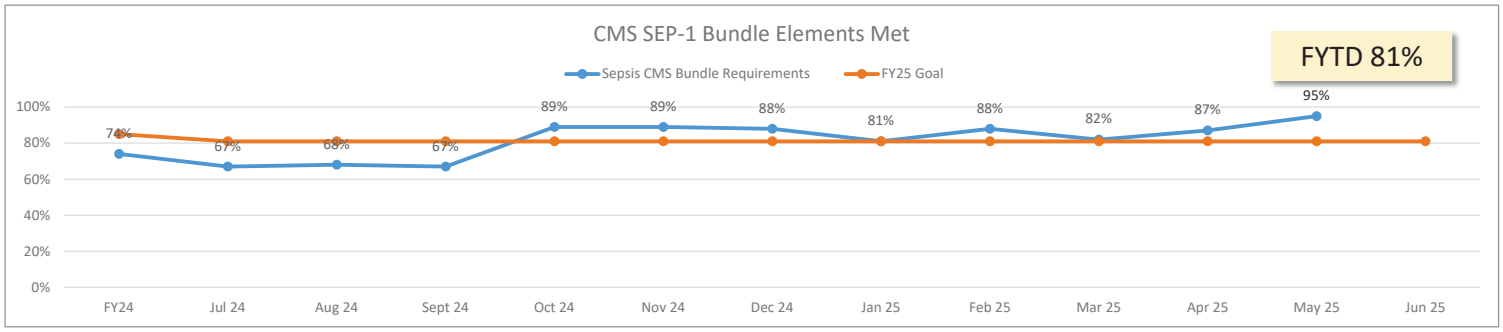
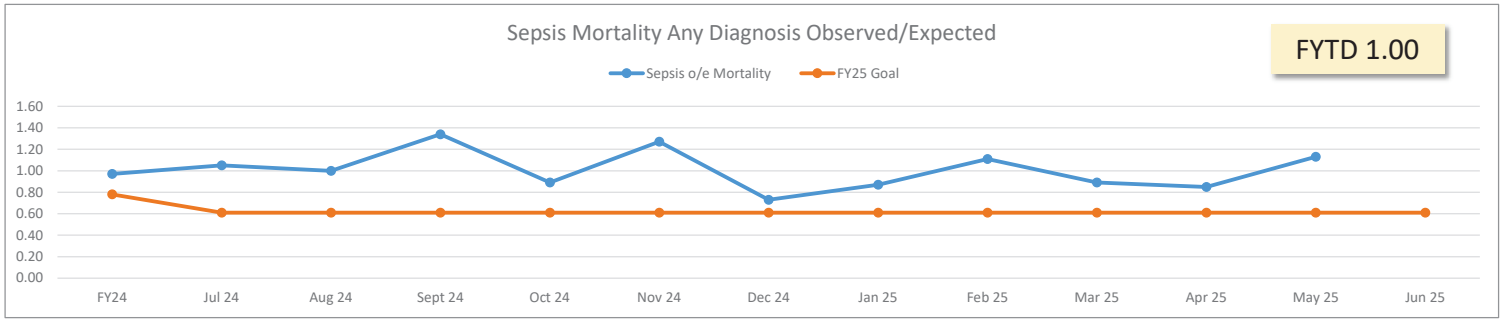
OHO FY25 Monthly Update: CMS SEP-1 & Mortality





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OHO FY25 Monthly Update: CMS SEP-1 & Mortality

The last data point did not meet goal because (Goal has been met for the last 8 months for SEP 1):

- Diagnosis of infections are not being treated with Sepsis interventions or are not being refuted when Sepsis is no longer entertained
- Sepsis bundle ordered but not as intended (i.e. Lactated Ringers ordered outside of the bundle which does not contain the required CMS verbiage for lesser fluid documentation)
- One (1) fall out only for May; Abx, Lactic acid, BC not ordered within 3 hours of Sepsis Time Zero
- Deep Dive into Sepsis mortality revealed opportunity in fluid resuscitation & linking organism to specify Sepsis documentation (Deep dive ongoing)

Targeted Opportunities

- Provide Early Goal Directed Therapy (Sepsis work up and Treatment)

  FY25

  - % of Patients provided top 3 most frequently missed Sepsis bundle elements at KH (Higher performance = Better care)
  - IV Fluid Resuscitation 95%
  - Antibiotic Administered 93%
  - Blood Cultures collection 95%

  Goal = 95%

- Provide Early Goal Directed Therapy (Sepsis Treatment)

  FY25

  - Pts with Sepsis that Received Abx within 60 Minutes of Pt 1st Seen by ED Provider 29%
  - Pts Met 1- Hr Bundle 27%

  Goal = 30%

OHO FY25 Monthly Update: CMS SEP-1 & Mortality

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
1. GME Resident engagement and ongoing education throughout the year, not just during yearly orientation o Ongoing Strong collaboration with Chief ED Residents (FY25/FY26) (Currently transitioning to new ED chiefs) ✓ Ongoing education during weekly didactic o 2 Resident project focus on Sepsis power plan utilization awareness & ED Provider pop-up to declare or refute sepsis prior to inpatient transfer o Collaboration with Dr. Stanley for engaging educational material o ***Engaged with Surgery (ACTS), Family Medicine (FM) team for ongoing Sepsis education*** o Incrementally engage Transitional Year & Psych Residents o Educational letters sent to providers (Resident & Attending) involved in opportunity case from Sepsis committee	Surgery 7/15/25 FM 6/4/25 GME yearly orientation 6/25	
2. Code Sepsis in ED (workgroup in progress)	Discussion to continue with CNO 7/1	

OHO FY25 Monthly Update: CMS SEP-1 & Mortality

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
3. Mortality summary reviews presented to Sepsis committee workgroup for Sepsis 1-hour bundle success review, analysis & improvement strategies (Intensivist, Hospitalist group engaged) o Deep dive ongoing with multidisciplinary collaboration and engagement	Ongoing	
4. Improve Severe Sepsis Alert Specificity (EMR optimization) o Collaborate with ISS team and Cerner EMR resources to optimize Sepsis alert o Decrease lookback window (for labs and vital signs) from Cerner 36 hours to **8 hrs.** for more meaningful alerts o Explore use of AI tool (s) for Sepsis alert	TBD	Limitations within Cerner cloud Concerns with disrupting existing algorithm Cerner has not yet released Sepsis AI tool, no ETA
5. Sepsis documentation improvement project o Reviewing Sepsis cases for appropriateness of Physician documentation & coding to ensure clinical picture is reflected on the medical record (including Physician linking organism & procedures performed to Sepsis population for a more descriptive clinical picture of the patient)	Ongoing	

OHO FY25 Monthly Update: CMS SEP-1 & Mortality

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
6. RN Sepsis Coordinator position posted o New Interim RN Sepsis Coordinator live 7/14/25	Ongoing	
7. Dr. Tu Educational Sepsis event to existing and incoming providers	7/15	
8. 1:1 ED Staff coaching for individual ED Sepsis fall outs	Ongoing	
9. Continue to focus on increase of order set usage	Ongoing	
10. ED leadership team shift huddle education to ED staff	Ongoing	
11. Sepsis team Sepsis refresher to ED staff during staff meetings	Ongoing	

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