December 5, 2024

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in a Quality Council Committee meeting at 7:30AM on Thursday, December 12, 2024, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

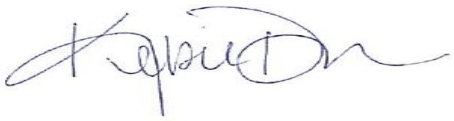
The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:31AM on December 12, 2024, 2024, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277, pursuant to Health and Safety Code 32155 & 1461.

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Quality Council Committee meeting at 8:00AM on Thursday, December 12, 2024, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

All Kaweah Delta Health Care District regular board meeting and committee meeting notices and agendas are posted 72 hours prior to meetings in the Kaweah Health Medical Center, Mineral King Wing entry corridor between the Mineral King lobby and the Emergency Department waiting room.

The disclosable public records related to agendas are available for public inspection at Kaweah Health Medical Center – Acequia Wing, Executive Offices (Administration Department) {1st floor}, 400 West Mineral King Avenue, Visalia, CA and on the Kaweah Delta Health Care District web page https://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
http://www.kaweahhealth.org

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
QUALITY COUNCIL

Thursday, December 12, 2024
5105 W. Cypress Avenue
Kaweah Health Lifestyle Fitness Center Conference Room

ATTENDING: Board Members: Michael Olmos (Chair), Dean Levitan, MD; Gary Herbst, CEO; Keri Noeske, 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 – 7:30AM

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 jurisdiction 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. **Approval of Quality Council Closed Meeting Agenda** – 7:31AM
    - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Julianne Randolph, DO, Vice Chief of Staff and Quality Committee Chair*
    - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management; Ben Cripps, Chief of Compliance and Risk Officer; Cindy Vander Schuur, RN, BSN, Patient Safety Manager.*
4. **Adjourn Open Meeting** – *Mike Olmos, Committee Chair*

CLOSED MEETING – 7:31AM

1. **Call to order** – *Mike Olmos, Committee Chair*

2. **Approval of November 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; Cindy Vander Schuur, RN, BSN, Patient Safety Manager.*

5. **Adjourn Closed Meeting** – *Mike Olmos, Committee Chair*

OPEN MEETING – 8:00AM

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. **Approval of November Quality Council Open Session Minutes –** Mike Olmos, Committee Chair; Dean Levitan, Board Member

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

    4.1. **Subacute Quality Report**

5. **Hand Hygiene Quality Report –** A review of current performance and actions focused on the clinical goal for Hand Hygiene. *Shawn Elkin, Infection Prevention Manager*

6. **Renal Services Quality Report –** A review of key performance indicators and actions associate with care of Dialysis Services. *Amy Baker, MSN RN, Director of Renal Services*

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

8. **Adjourn Open Meeting** – *Mike Olmos, Committee Chair*

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 committee meeting.

Agenda item intentionally omitted

OPEN Quality Council Committee
Thursday, November 14, 2024
The Lifestyle Center Conference Room

Attending: Board Members: Mike Olmos (Chair) & Dean Levitan, Board Member; Gary Herbst, Chief Executive Officer; Marc Mertz, Chief Strategy Officer; Sandy Volchko, Director of Quality and Patient Safety; Dr. Paul Stefanacci, Chief Medical Officer; Dr. Mack, Dr. Randolph, Vice Chief of Staff and Chair; Ben Cripps, Chief Compliance and Risk Management Officer; Evelyn McEntire, Director of Risk Management; Ryan Gates, Chief Population Health Officer; Jag Batth, Chief Operations Officer; Keri Noeske, Chief Nursing Officer; Dr Hightower, Chief of Staff; Erika Pineda, Quality Improvement Manager; Kyndra Licon, Program Coordinator – 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 8:35 am.

Mike Olmos called to order at 8:35 am.

3. **Approval of October Quality Council Open Session Minutes –** Mike Olmos, Committee Chair; Dean Levitan, Board Member.
    - Approval of October 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:

    4.1 Cardiology Services – ACC Outstanding Health Outcomes Report – reviewed with no discussion.

5. **Emergency Department Quality Update –** a review of key quality metrics and associated action plans. Keri Noeske, Chief Nursing Officer.
    A review of care for ESI 2 patients in treatment spaces identified inconsistencies in assigning ESI 2 designations during triage assessments. These patients require close monitoring. It was determined that conducting triage training during nurse orientation is not effective. A new triage training program, specifically for triage nurses, is scheduled to begin on 11/22/2024. A clinical escalation policy for ESI 2 patients has been implemented. Any ESI 2 patient unable to be placed in a bed from triage or EMS will be escalated to the charge nurse or supervisor (if available on shift). Efforts are underway to increase RN staffing, including the onboarding of 45 travel nurses. Currently, 22 have been onboarded. Two leaders are dedicated to onboarding both permanent and temporary staff to address staffing needs.
    For moderate-to-high suicide risk patients, the expectation is 1:1 monitoring, but staffing shortages limit compliance. Additional mental health worker positions have been posted, and tele-sitter technology is being implemented to free staff for higher-risk patients. Suicide risk is assessed using the Columbia Suicide Risk Scale, with input from patients, families, or law enforcement. The hospital remains conservative in downgrading suicide risk levels. In August, 112 patients were identified as moderate to high risk for suicide, and 84% were monitored at the expected 1:1 level;

others were monitored at 1:2. Staffing challenges, including limited bed availability, have impacted 1:1 coverage. Nursing staffing improvements, including the onboarding of two interim leaders (starting November 22 and 25, respectively) and reopening Fast Track Zone 6, are expected to address challenges. Interim leadership contracts are for three months with potential extensions, focusing on process improvements and audits. Communication gaps, especially with radiology and patient turnaround times, are being addressed to reduce the length of stay (LOS). Workflow adjustments and better triage practices for ESI 2 patients aim to optimize care and resource allocation. Ongoing training for staff, scheduled for next week, will align triage practices and decision-making. Plans include reorganizing the waiting room into zones, setting clear communication protocols, and ensuring new leadership and consultants (Chartis and Greeley) are aware of current workflows.

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

Three metrics are part of our FY25 SIR goals:

- CLABSI SIR: Target <0.92
- CAUTI SIR: Target <0.341
- MRSA SIR: Target <0.434

As of September, we are meeting the goal for 1 of the 5 metrics: Central Line Utilization. Our goals align with the top 30% nationally. The CHG bathing initiative has been launched, targeting at-risk MRSA patients identified through HAI QFT nasal screening and treatment. CHG forms a protective barrier on the skin, preventing bacterial infections without systemic absorption.

Improvements were noted in hand hygiene and ATP cleaning compliance, reaching 97.3%. However, compliance with the SEP-1 bundle and sepsis mortality goals for August fell short. Antibiotic administration within 60 minutes is at 27%, against a goal of 30%. Key focus areas include timely IV fluid administration, antibiotics, and blood culture collection.

Identified barriers:

- Limited sepsis education opportunities due to GME curriculum constraints
- ED throughput issues, including space and staffing challenges
- Lack of a dedicated blood culture resource, particularly during high-severity periods with 13–16 code sepsis cases in 24 hours

Current efforts include reminders for residents to utilize the sepsis order set and awaiting enhanced ED leadership support for onboarding. These initiatives aim to improve compliance and reduce sepsis mortality rates.

Adjourn Open Meeting – *Mike Olmos, Committee Chair*

Mike Olmos adjourned the meeting at 9:33 am.

Sub Acute and Short Stay SNF Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Sub Acute and Short Stay SNF **Report Date:** October 2024

Measure Objective/Goal:

1. Falls (internal data)
2. Pressure Injuries (internal data)
3. Psychoactive medication use (MDS/Casper)

Date range of data evaluated:

Data evaluated populated from internal data as well as CASPER report period: 1/01/2024 – 6/30/2024. Data compared with Casper Report 1/1/2024 – 6/30/2024 and 1Q24 through 2Q24 for internal data.

Nationally benchmarked quality data is collected through the MDS submissions process to CMS where data is populated into the CASPER report. CMS divides data between short-stay cases (<100 day length) and long-stay cases (>100 day length). The Skilled Nursing program client group is predominately in the short-stay category. Statistically this means that Long-Stay measures typically have a denominator of 33-34. Short-Stay measures typically have a denominator of 200+. Internal data is based on total units of service and does not differentiate based upon length of stay. There is no comparable national bench-marking of Short Stay cases for falls, and for HAPI prevalence overall. For these two indicators, we assess ourselves to internal performance goals.

FALLS

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

The total rate of falls per 1000/pt. days in both units: 1Q24 is 1.06 and 2Q24 is 1.11 falls per 1000 patient days. Facility observed percent for falls for long stay patients in the most current CASPER report is 6.7%, remaining well below national average of 44.2%, placing the program in the top 1 percentile nationally.

Falls per Unit per 1000 Pt Days per Quarter 2022-24

UNIT	1Q22	2Q22	3Q22	4Q22	T	1Q23	2Q23	3Q23	4Q23	T	1Q24	2Q24
SNF (Combined Total)	0.88	0.79	0.57	0.88	0.77	0.51	0.75	0.00	0.00	0.32	1.06	1.11
Subacute	0.00	0.00	1.14	0.00	0.29	0.36	0.70	0.00	0.00	0.27	0.72	1.16
TCS-Ortho (Short Stay)	3.06	1.83	0.91	5.00	2.74	1.70	0.87	0.00	0.00	0.68	2.00	0.98

2024 Falls per Unit per Quarter

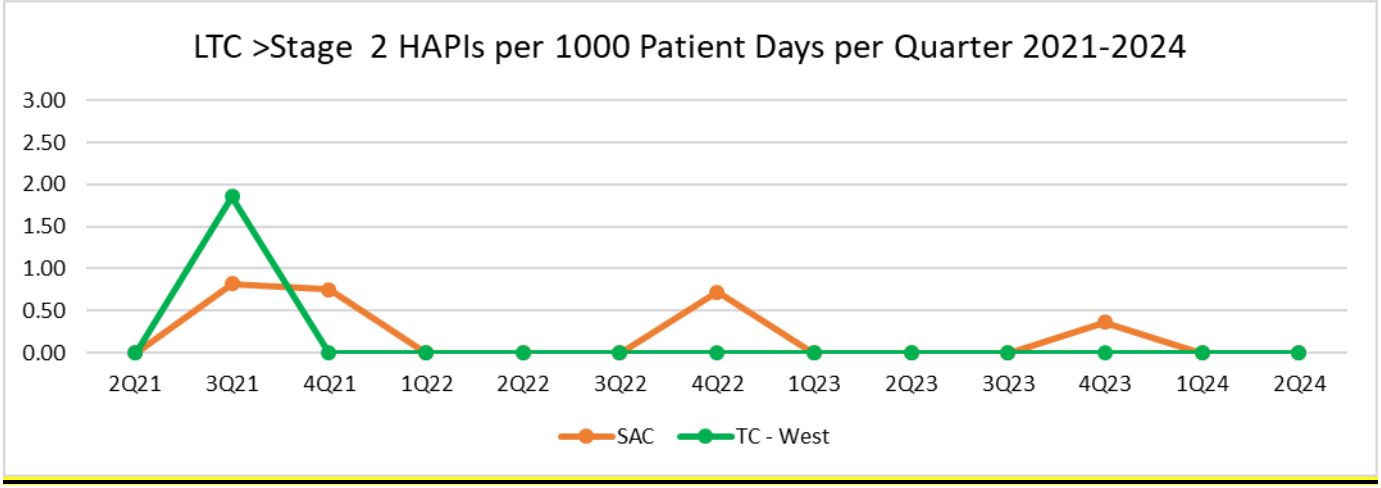
UNIT	1Q24	2Q24	3Q24	4Q24	T
SNF (Comb	4	4	0	0	8
SAC	2	3			5
TC-W	2	1			3

If improvement opportunities identified, provide action plan and expected resolution date:
Staff continues to participate in district-wide initiatives for fall prevention including Falls University to identify trends and communicate “take-aways”. Coaching and progressive discipline is applied using Just Culture. Falls occur most commonly with our short-stay population, this skilled nursing unit has many patients who participate in physical and occupational therapy sessions with varying functional levels. Therapy sessions are designed to promote mobility and independence ultimately preparing the residents to discharge home. The Short Stay unit utilizes several interventions, such as adding fall review during staff meetings for educational purposes and increasing the availability of fall prevention equipment such as tele sitters and chair alarms.

PRESSURE INJURIES
Analysis of all measures/data: (Include key findings, improvements, opportunities)
Incidence of new or worsening pressure ulcers for short stay patients, which would include Sub Acute patients with a length of stay under 100 days, as reported on the Casper report is 0.6 %, below the national average of 2.7 %.

Patients at high risk for pressure ulcers (long stay residents, defined as high risk, who have > stage II pressure ulcers) is 16.7%. This is a slight increase from 16.1% in the last report. The definition for this long stay quality measure asks if a wound is present, not if acquired in the facility. This is particularly challenging in a program that preferentially admits cases with pressure ulcers for ongoing treatment. The measure triggers a flag until the wound completely heals (and through the 6-month period). Very large wounds that have healed down to very small, chronic wounds will continue to trigger this measure. Thus, it is common to see a delay in improvement on the CASPER report, while seeing improvement more immediately in our internal data.

Overall, the total wound rate for both SNF units per 1000/pt. days for Q1 and Q2 2024 was 0. This is equal to the last report of 0. Both SNF units participate in Kaweah health Clinical Skin Institute when pressure injuries are discovered on the unit, staff capture skin injuries during routine assessments and preventative measures are implemented early leading to better patient outcomes.



If improvement opportunities identified, provide action plan and expected resolution date:
We will continue to work within the high standards of the District, with close management of our fragile, chronic wound cases, collaborating closely with the Kaweah Health wound nurses and utilizing the standardized treatment sets available to us.

UBC teams for South Campus nursing are reviewing clinical cases using a Peer review methodology to assess for and remediate practice concerns.

During the first two weeks of admission to the Subacute unit, patients at high risk for developing pressure ulcers are discussed with the IDT and treatment teams and preventative options are implemented.

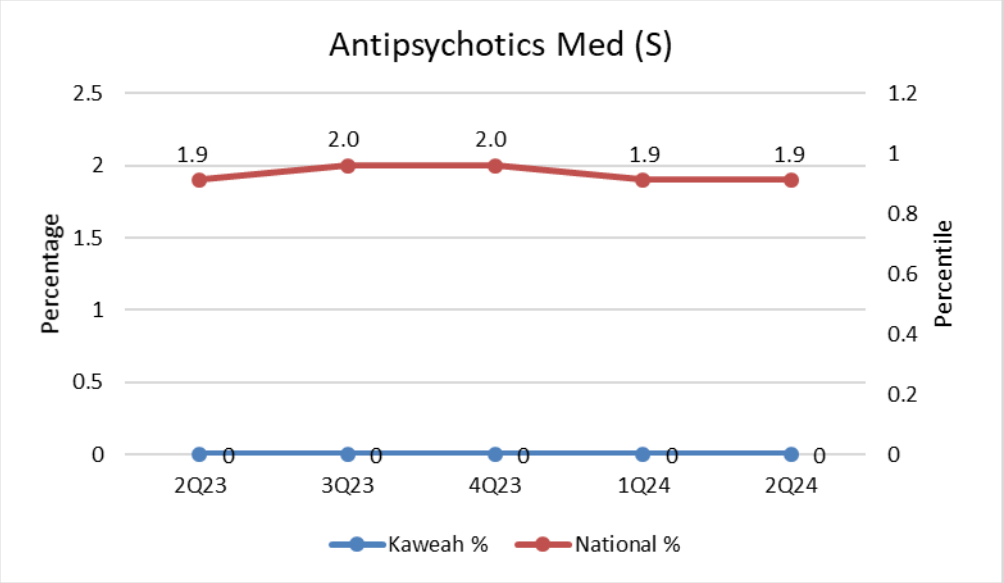
Any wounds that are present and worsening wounds or pressure ulcer are discussed shift to shift during safety huddles for all SNF units. Weekly summaries are done for patients to identify high risk patients for developing pressure sores.

PSYCHOACTIVE MEDICATION USE

Definitions/Assumptions:
This measure is collected through the Minimum Data Sets that are completed and submitted to CMS at the defined intervals by the program. The data includes only the information regarding prescribed medications by drug category (not by intended use or indication). Therefore, for instance, a practice change in the use of anxiolytics like lorazepam to antipsychotics like quetiapine for ventilator management would affect this data directly

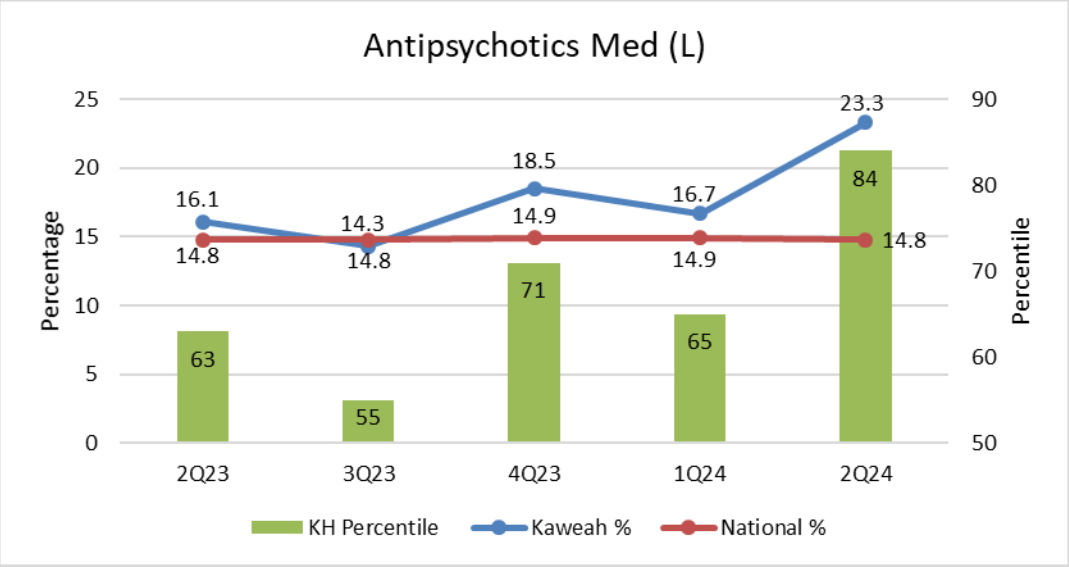
Increased use of medications in the antipsychotic drug-class for management of depression is also impacting our results in these measures. Antianxiety and hypnotic medication use is not reported as a quality measure for the short-stay population. The data is collected through the MDS, but is not included in the measures that make up our quality ranking. All values are expressed in percentile rankings.

Analysis of all measures/data: (Include key findings, improvements, opportunities)
Short Stay residents (<100 days) Antipsychotic medication use for short stay patients is below the national average, which measures only cases with newly prescribed antipsychotics. The short stay patients who begin a new anti-psychotic during their stay is 0% for both 1Q24 and 2Q24, compared to the national average of 1.9%



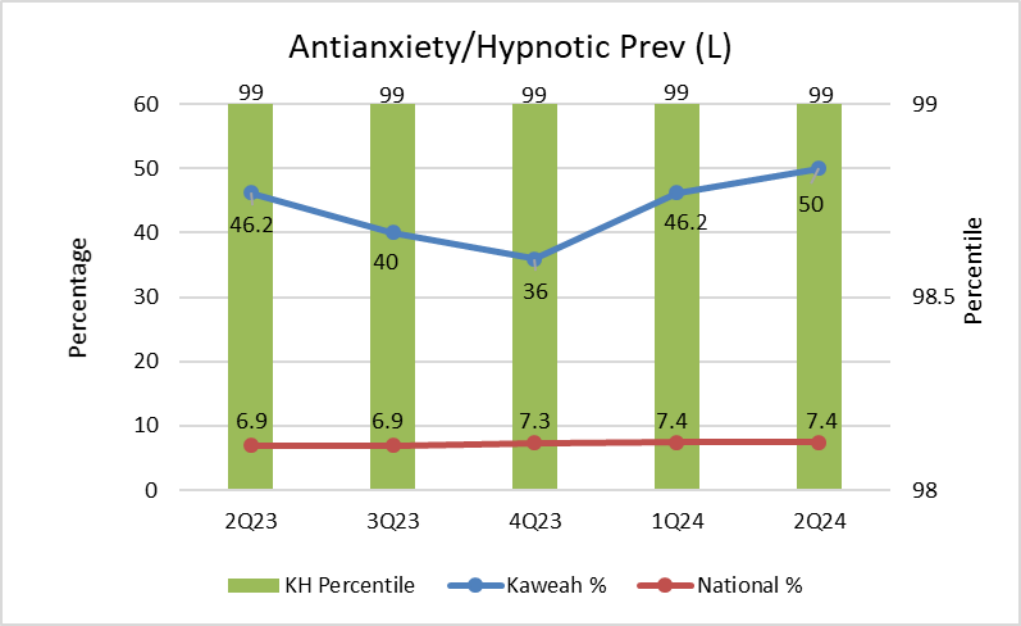
Long Stay residents.
The facility percent for antipsychotic use in long stay residents for 1Q24 16.7% (65th percentile) and 2Q24 is 23.3% (84th percentile) compared to the national average of 14.9% and 14.8%. The spike in 2Q24 is associated with one patient where psychiatry was involved in treating severe agitation and combative behavior. It was determined the patient needed a higher level of care and was transferred back to the Medical Center. Unlike the short stay measure, which only includes newly prescribed antipsychotics, the long stay measure includes all patients on the medication for any portion of the time (even if it was a home medication). Included in this measure are medications like quetiapine, used for depression or for ventilator management cases. There is another instance where our target client group for long-term care (Sub Acute program) is the primary driver of our performance.

SNF leadership has been working closely with the medical team, pharmacy and our MDS nurses to ensure that appropriate psychiatric diagnoses are captured in the medical record whenever possible. A small number of these diagnoses are excluded from this quality measure.



Long Stay residents.

Antianxiety/Hypnotic Medication use for long stay residents has remained high at the 99th percentile for 1Q24 and 2Q24, consistent throughout the year. This is reflective of the use of these meds for our ventilated patients in the subacute unit. There are no exclusions for medical diagnosis for this measure.



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

Psychotropic medications are under constant scrutiny by CMS. Concerns around these medications are primarily founded in two concepts:

1. Inappropriate or excessive use of medications
2. Using psychotropic medications to control behaviors (as a chemical restraint) or for more convenient management of difficult patients.
3. Informed consent for psychotherapeutic drugs including recent update associated with AB 1309.

While the majority of our client group has clear and compelling indications for these agents, we continue to monitor the medications very closely. Our LTC pharmacist plays an important role in helping us ensure we track these medications closely during the transition process. Our primary focus is unnecessary medications, like prn hypnotics, hence we also monitor for the potential to reduction when possible.

All residents receive a monthly medication regimen review and physician consultation by our LTC pharmacist and Medical Director. This close partnership has helped reduce psychoactive medication used generally, including dose reduction practices.

There have been no findings around inappropriate use of psychotropic mediations in any of our programs, including the most recent CMS recertification survey in March 2024.

Submitted by Name:
Molly Niederreiter

Date Submitted:
October 2024

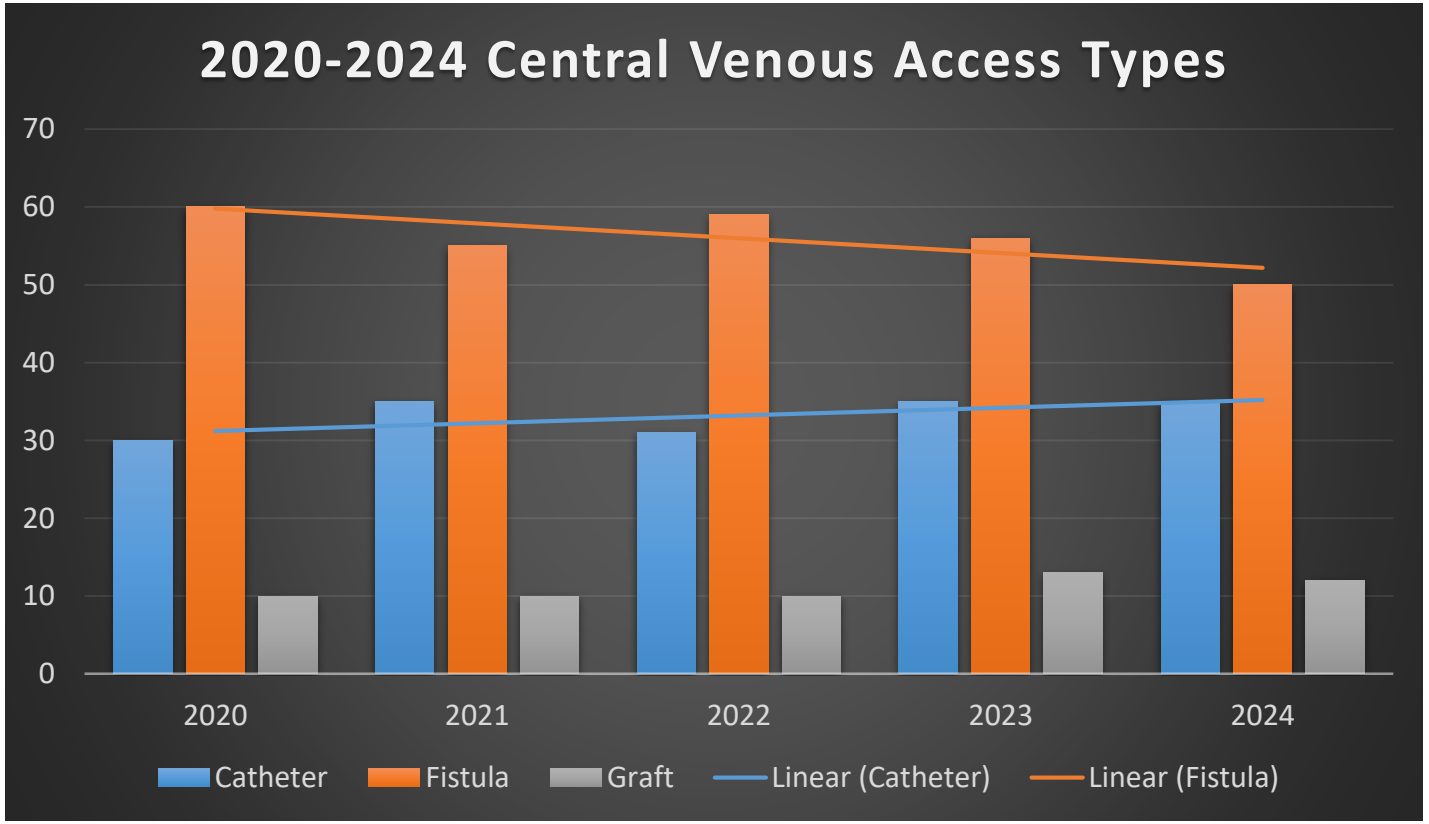
QUALITY & PATIENT SAFETY PRIORITY

Renal Services Quality Report

Quality Committee Report

December 2024

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

Kaweah Health
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KH Dialysis Central Venous Access Management

	Target	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Mar 2024	May2024	Jun 2024	Jul 2024	Aug 2024	Sept 2024	Oct 2024	Rolling 12M Av
Percent of patients with CVC		32.24	33.1	33.31	34.2	35.8	29.7	33.1	37.85	36.7	38.36	37	37.6	34.91
Percent of patients with AV Fistula	70%	54.83	53.5	53.17	52.4	51.9	52.8	49.24	50	49.2	49.6	51.6	51.1	51.61
Percent of patients with CVC >90 days	10%	23.38	23.62	23.8	27.8	30.5	29	25.75	25.3	27.6	27.9	31.4	33	27.42

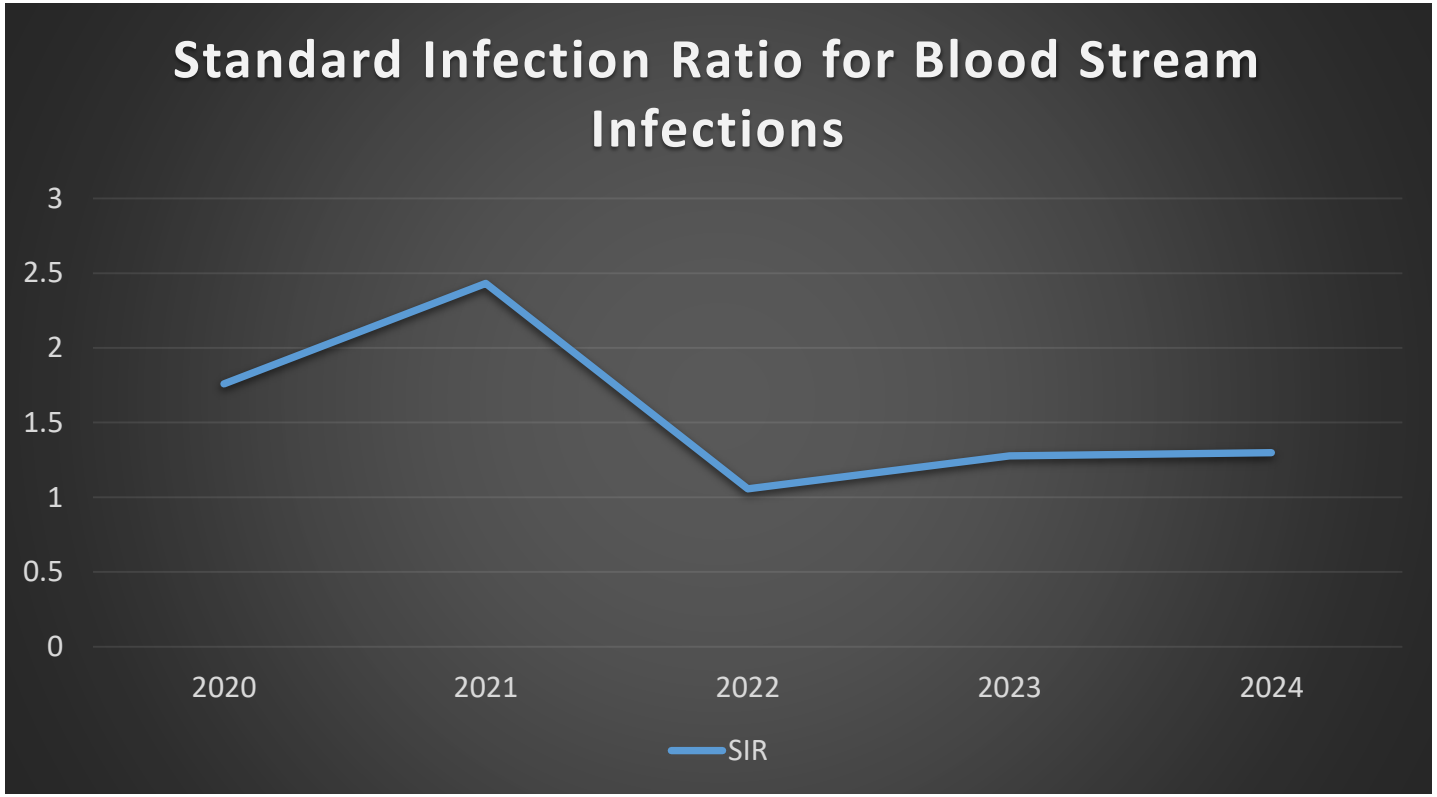
Targeted Opportunities (why goal not achieved in most recent month)

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.	May 2025	Working 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

Kaweah Health
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KH Dialysis Central Venous Access Management

	Target	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Mar 2024	May2024	Jun 2024	Jul 2024	Aug 2024	Sept 2024	Oct 2024	Rolling 12M Av
NHSN Blood Stream Infection Ratio	0	2.303	2.026	2.039	0	0	0	0	0.836	2.489	1.886	0	3.888	1.28
Actual Number of Blood Stream Infections	0	2	2	2	0	0	0	0	1	3	2	0	4	1.3

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.

Thank you

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

Kaweah Health