March 10, 2022

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, March 17, 2022, 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 Thursday, March 17, 2022, 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, March 17, 2022, 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
Michael Olmos, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
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, March 17, 2022
5105 W. Cypress Avenue
Kaweah Health Lifestyle Fitness Center Conference Room

ATTENDING: Board Members; David Francis – Committee Chair, Michael Olmos; Gary Herbst, CEO; Keri Noeske, RN, BSW, DNP, Vice President & CNO; Monica Manga, MD, Chief of Staff; Daniel Hightower, MD, Professional Staff Quality Committee Chair; Tom Gray, MD, Quality and Patient Safety Medical Director; Sandy Volchko DNP, RN CLSSBB, Director of Quality and Patient Safety; Ben Cripps, Vice President, Chief Compliance and Risk Management Officer; Evelyn McEntire, Director of Risk Management; and Rita Pena, Recording.

OPEN MEETING – 7:30AM

1. **Call to order** – *David Francis, 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 (Cindy Moccio 559-624-2330) or cmoccio@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 – *Daniel Hightower, MD, and Professional Staff Quality Committee Chair; James McNulty*
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management and Ben Cripps, Vice President & Chief Compliance and Risk Officer.*
4. **Adjourn Open Meeting** – *David Francis, Committee Chair*

CLOSED MEETING – 7:31AM

1. **Call to order** – *David Francis, Committee Chair & Board Member*
2. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Daniel Hightower, MD, and Professional Staff Quality Committee Chair*

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

4. **Adjourn Closed Meeting** – *David Francis, Committee Chair*

OPEN MEETING – 8:00AM

1. **Call to order** – *David Francis, 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. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives:
    - 3.1. Fall Prevention Committee
    - 3.2. Infection Prevention Dashboard
    - 3.3. Maternal Child Health Quality Report including Labor & Delivery, Neonatal Intensive Care Unit, Pediatrics, and Obstetrics
    - 3.4. HAPI Quality Focus Team Report
    - 3.5. Handoff Communication Quality Focus Team Report
    - 3.6. Diversion Prevention Committee Report
    - 3.7. Best Practice Teams Quality Update

4. **CMS Star Rating** – A review of quality indicators that make up the CMS Star Rating and which initiatives impact Kaweah Health's star ratings. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety*.

5. **Update: Clinical Quality Goals** - A review of current performance and actions focused on the fiscal year 2022 clinical quality goals. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety*.

6. **Adjourn Open Meeting** – *David Francis, 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.

Unit/Department Specific Data Collection Summarization

QIC/ProStaff Committee Report

UNIT/DEPARTMENT: **Fall Prevention Committee** REPORT DATE: **September 2021**

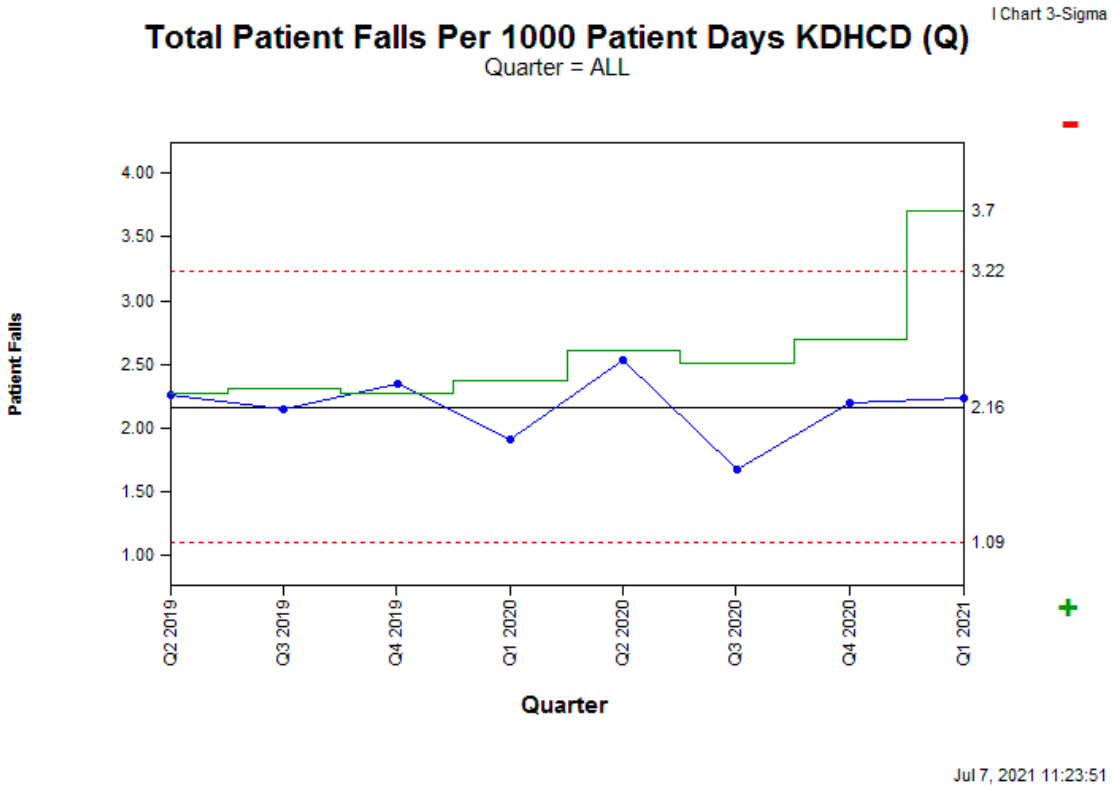
Kaweah Delta Nursing Unit Falls Data, Benchmarked Nationally:

The National Database of Nursing Quality Indicators® (NDNQI®) provides a national database of more than 2,000 U.S. hospitals that features nursing-sensitive outcome measures used to monitor relationships between quality indicators and outcomes. Participating Kaweah Delta nursing units include 2North, 2South, 3North, 3South, 3West, 4North, 4South, 4Tower, Broderick Pavilion, ICU, CV-ICU, CV-ICCU (5Tower), Mental Health, Pediatrics, and Acute Rehab.

INDICATOR #1 **Total Falls per 1000 Patient Days**

GOAL **Outperform national target metric and/or reduce fall rate by 10%**

DATE RANGE **Q4 2020 – Q1 2021**



	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021
Patient Falls	2.26	2.14	2.34	1.91	2.53	1.66	2.19	2.22
Target	2.27	2.30	2.27	2.37	2.60	2.50	2.69	3.70

ANALYSIS OF MEASURE/DATA (Include key findings, improvements, opportunities)

- ✓ **Goal met: Most recent 5 quarters outperform national target benchmark**
- ⦸ **Goal not met: Fall rate for Q1 2021 (2.22) is 1.4% higher than fall rate for Q4 2020 (2.19)**

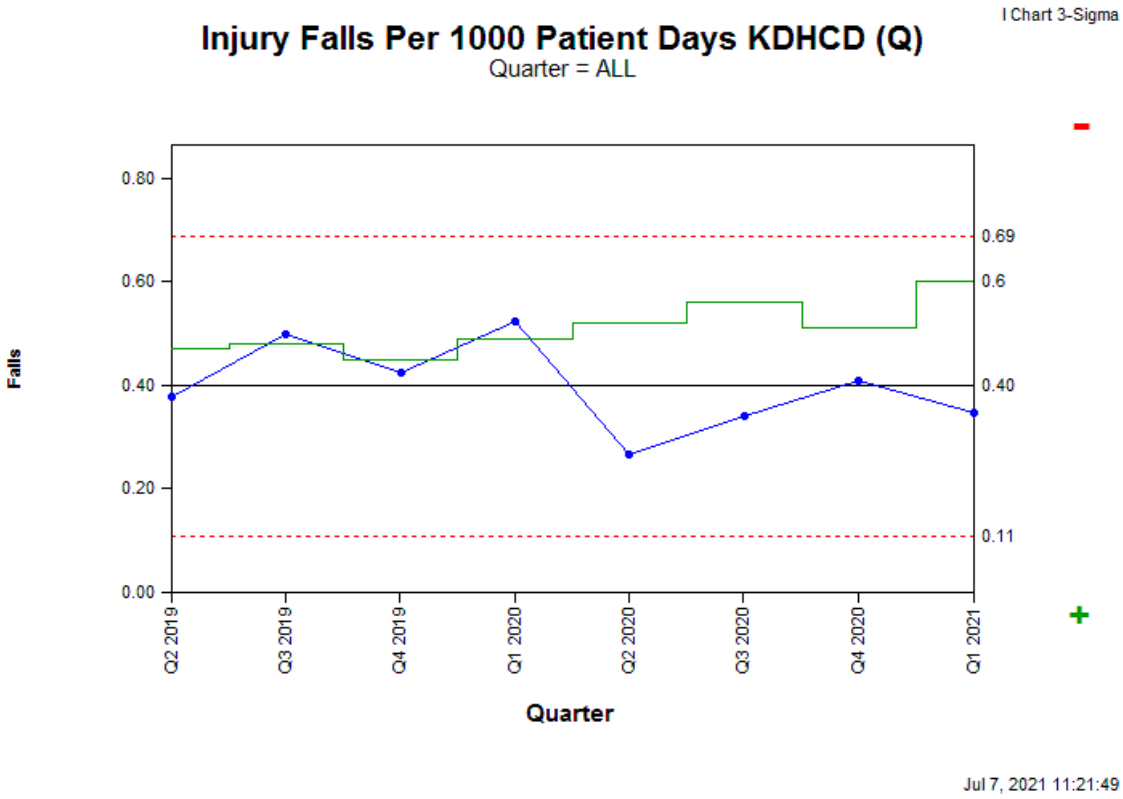
Unit/Department Specific Data Collection Summarization

QIC/ProStaff Committee Report

INDICATOR #2 **Injury Falls per 1000 Patient Days**

GOAL **Outperform national target metric and/or reduce injury fall rate by 10%**

DATE RANGE **Q4 2020 – Q1 2021**



	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021
Falls	0.38	0.50	0.42	0.52	0.27	0.34	0.41	0.35
Target	0.47	0.48	0.45	0.49	0.52	0.56	0.51	0.60

ANALYSIS OF MEASURE/DATA (Include key findings, improvements, opportunities)

- ✓ **Goal met: Most recent 2 quarters outperform national target benchmark**
- ✓ **Goal met: Injury fall rate for Q1 2021 (0.35) is 14.6% lower than injury fall rate reported for Q4 2020 (0.41)**

Unit/Department Specific Data Collection Summarization

QIC/ProStaff Committee Report

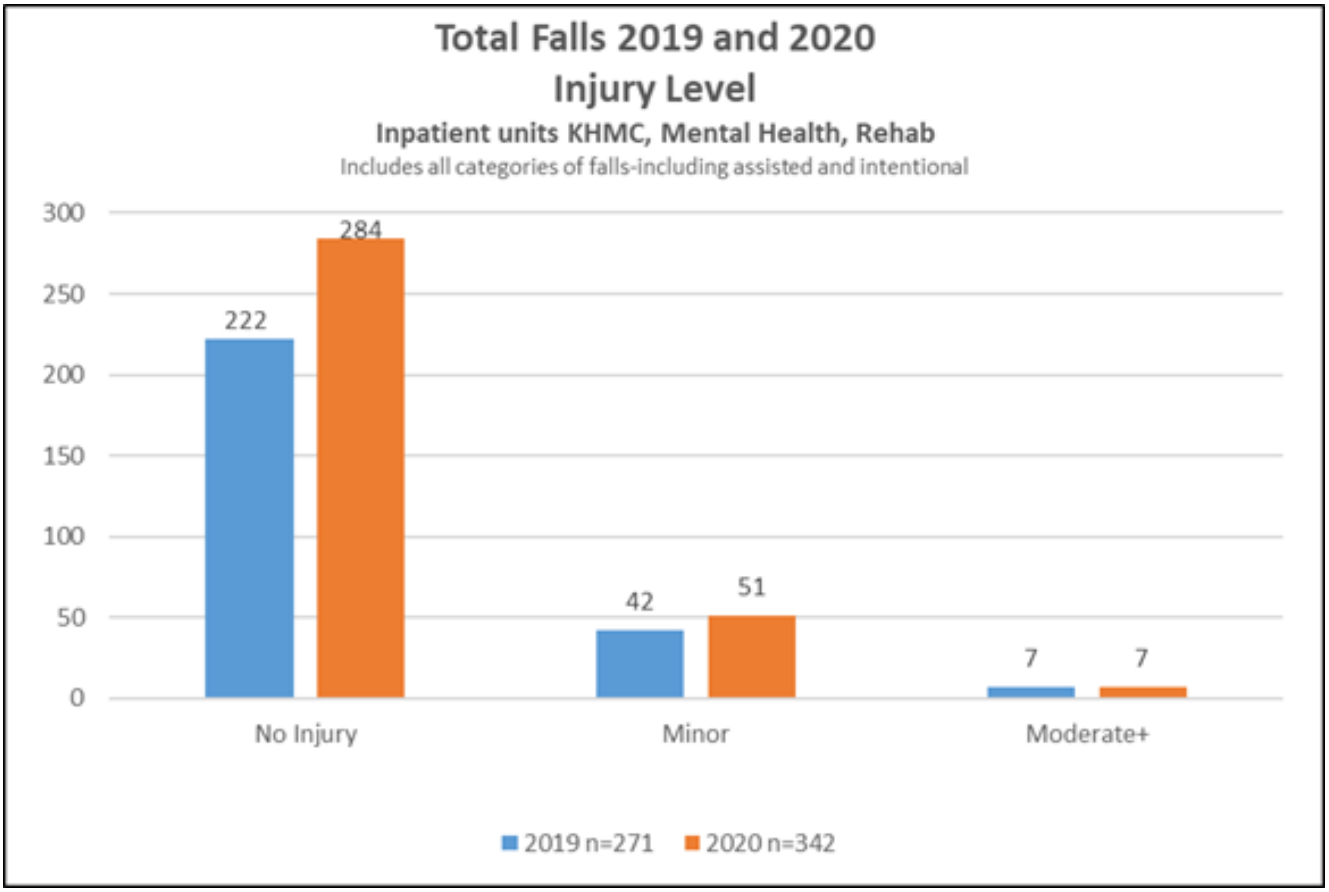
INDICATOR #3 **Total Falls – Injury Level**

GOAL *new* **100% injury falls classified either no injury or minor injury**

DATE RANGE **CY 2019 – 2020**

NDNQI Defined Injury Levels

- *None* — *Resulted in no signs or symptoms of injury as determined by post-fall evaluation (which may include x-ray or CT scan)*
- *Minor* — *Resulted in application of ice or dressing, cleaning of a wound, limb elevation, topical medication, pain, bruise or abrasion*
- *Moderate* — *Resulted in suturing, application of steri-strips or skin glue, splinting, or muscle/joint strain*
- *Major* — *Resulted in surgery, casting, traction, required consultation for neurological (e.g., basilar skull fracture, small subdural hematoma) or internal injury (e.g., rib fracture, small liver laceration), or patients with any type of fracture regardless of treatment, or patients who have coagulopathy who receive blood products as a result of a fall*
- *Death* — *The patient died as a result of injuries sustained form the fall (not from physiologic events causing the fall)*



ANALYSIS OF MEASURE/DATA (Include key findings, improvements, opportunities)

⦸ **Goal not met:**

- **While total number of falls increased in 2020, injury level improved slightly with 98% classified as either no injury or minor injury (97% in 2019)**
- **Moderate injuries accounted for 2% of falls in 2020, compared to 3% in 2019**

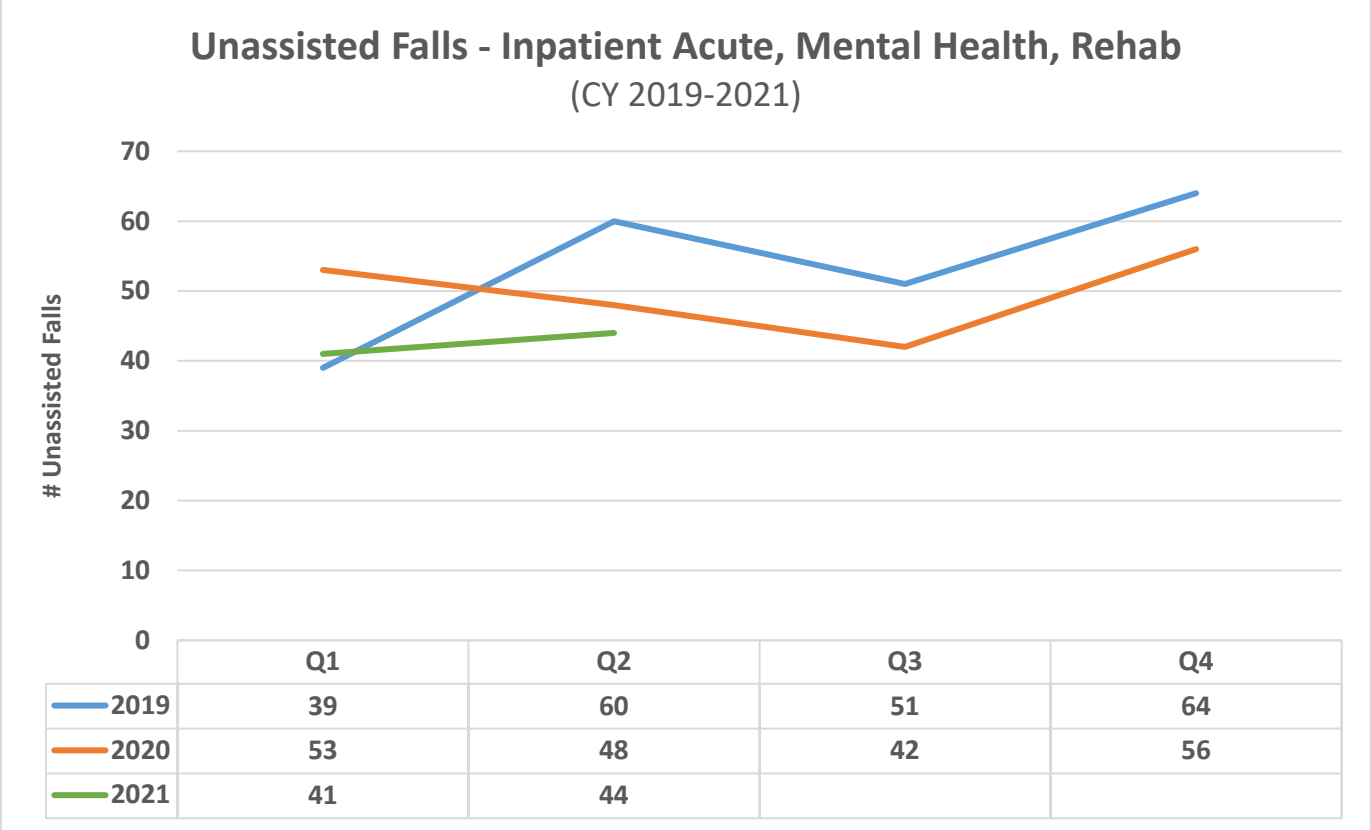
Unit/Department Specific Data Collection Summarization

QIC/ProStaff Committee Report

INDICATOR #4 **Unassisted Falls**

GOAL **Reduce unassisted falls by 10%**

DATE RANGE **Q1 – Q2 2021**



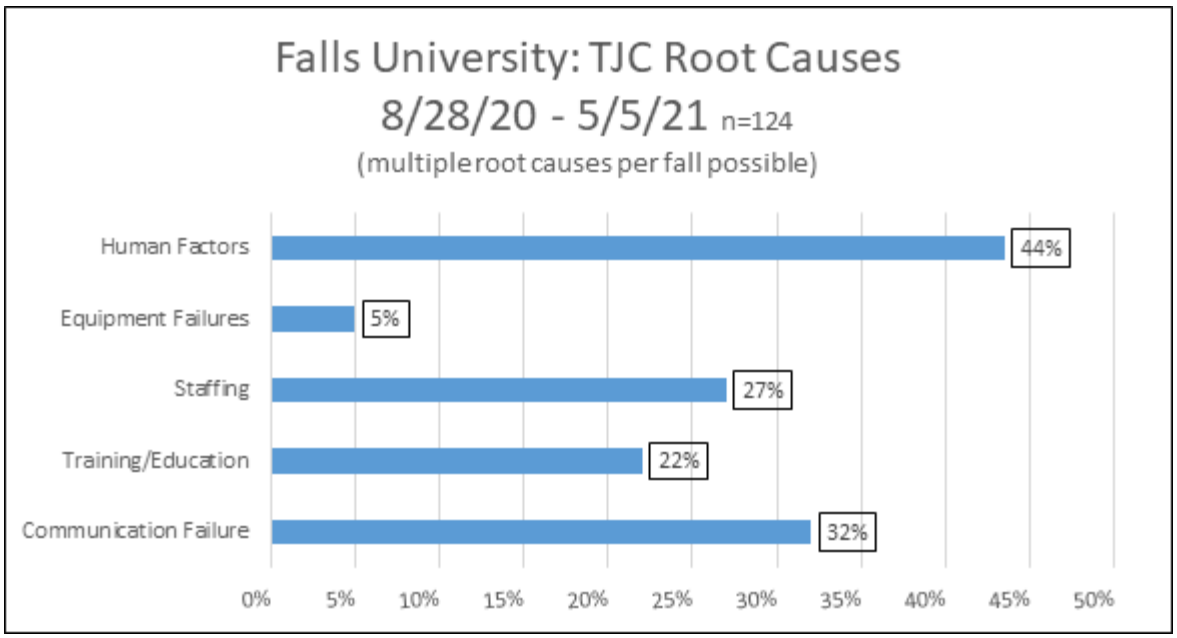
	Q1	Q2	Q3	Q4
2019	39	60	51	64
2020	53	48	42	56
2021	41	44		

ANALYSIS OF MEASURE/DATA (Include key findings, improvements, opportunities)

∅ **Goal not met: Unassisted falls increased by 7% from Q1 to Q2 2021**
NOTE: Overall unassisted falls in most recent two quarters (n=85) are 13.3% lower than previously reported quarters Q3-Q4 2020 (n=98). Comparison of same reporting period (Q1-Q2) for past two years illustrates unassisted falls in 2021 to be 14.1% lower compared to 2019 (n= 99) and 15.8% lower than 2020 (n=101)

IMPROVEMENT OPPORTUNITIES / ACTION PLANS / NEXT STEPS, RECOMMENDATIONS, OUTCOMES:

- **Continue weekly review of falls at *Falls University*, facilitating real-time discussion of events and opportunities for utilization of prevention strategies. Participation of direct care nurses is encouraged and facilitated by front-line leadership.**
  - **Falls University, briefly suspended in response to pandemic surge, resumed weekly sessions February 5, 2020**
  - **Utilize The Joint Commission's framework for Root Cause Analysis to explore impact of performance, resources, knowledge/skill-set, and communication on patient outcome (see attribution information below)**



- **Email communication to nurses at all levels includes key "Take-Aways" from Falls University event review**

- **<u>Work in Progress</u> (WIP) – summary of collaborative efforts led by Alisha Sandidge (APN Team), in partnership with clinical informatics and nursing leaders:**
  - **Post-Fall Orderset**
    - **In review, especially regarding attention to need for neurological assessment and protection of head and neck post-fall**
    - **Optimize post-fall iPOC to include alerts/task prompts to drive interventions**
  - **Prevention and Intervention Strategies**
    - **Partner with unit staff and leaders, clinical educators, quality and patient safety partners, marketing department and others to develop updated "*SPLAT Campaign*" to address frequently cited human factors (e.g., alarms, slip/trip hazards) as root causes for falls.**

- **Documentation**
  - **Combine current Falling Star [paper process] and iView documentation into PowerForm to improve workflow and standardize information capture**
- **Falling Star Notification**
  - **Redesign system based on "need to know" and conservation of resources (i.e., Transport Team responds only when required)**
- **Policy**
  - **Revise to reflect updated prevention, intervention, workflow, and documentation per WIP listed above**
- **Education and Training**
  - **Related to practice, workflow and documentation changes impacted by all WIP listed above.**

SUBMITTED BY:
Mary Laufer, DNP, RN, NE-BC
Director of Clinical Practice & Education

DATE SUBMITTED: **July 8, 2021**

Infection Prevention Dashboard March 2022

Shawn Elkin – Infection Prevention Manager

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2021							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
I. Environmental Surveillance							
A. Sterilization and High Level Disinfection Quality Control	Goal <2%						
Goal <2% Immediate Use Steam Sterilization		1.20%	2.1%	1.22			**1st QTR:** SPD saw a 0.5% decrease in IUSS events compared to the 1st QTR 2020 and has done well in sustaining limited IUSS. **2nd QTR:** Goal not met. Both April and especially June exceeded 2% IUSS threshold. SPD has requested purchase of additional surgical instruments to offset future needs and reduce IUSS. **3rd QTR:** Goal met. 3rd QTR IUSS remained below 2% each month.
B. Dialysis Water/Dialysate Quality Control (AAMI RD52:2004) (% of machines that did not exceed limits)	Goal 100%						
RO Water [Target: <200cfu] [Action: > or = 50cfu]		100%	100%	100%			**1st QTR:** 6 Reverse Osmosis & 5 Dialysis Machine samples tested all passed with no action required. **2nd QTR: (Outpatient Dialysis)** 6 Reverse Osmosis & 8 Dialysis Machine samples tested all passed with no action required. **(Acute Dialysis)** 51 Reverse Osmosis & 12 Dialysis Machine samples tested all passed with no action required. **3rd QTR:** 6 Reverse Osmosis & 7 Dialysis Machine samples tested all passed with no action required.
Endospore [Target: <2EU] [Action: > or = 1EU]		100%	100%	100%			**1st QTR:** 6 Reverse Osmosis & 5 Dialysis Machine samples tested all passed with no action required. **2nd QTR: (Outpatient Dialysis)** 8 Dialysis machines tested for bacteria and endotoxins all passed with no action required. **(Acute Dialysis)** 51 Reverse Osmosis samples were tested for bacteria and endotoxins all passed with no action required. **3rd QTR: (Acute Dialysis**) 6 Dialysis Machine samples & 51 Reverse Osmosis samples tested for Bacteria and Endospores, all passed with no action required.
C. Environmental Cleaning (ATP testing surfaces)							
Pass/Fail based on a threshold of ATP score of <200. Multiple high-touch surfaces tested each month.	Goal 100%	67%	43.1%	90.7%			**1st QTR:** A total of 103 surfaces were tested and 69 passed the first time. **2nd QTR:** A total of 65 surfaces were tested and 28 passed the first time. There has been a lower rate of surfaces tested **3rd QTR:** A total of 54 surfaces were tested and 49 passed the first time.
II. Antimicrobial Stewardship Measures							

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2021							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
Number of antibiotic IV to PO conversion interventions		185	273	281			**1st QTR:** CVICU has seen the greatest number of IV to PO conversion as there are greater opportunities for conversions due to the selections of medications often used on the unit. **2nd QTR:** CVICU remains the unit with the highest IV to PO conversion rate. However, 3N, 3S, and ICU demonstrated substantial increases in IV-to-PO conversion. This is very helpful in reducing the need for IV access that increases risk for bloodstream infection. **3rd QTR:** CVICU (50), ICU (33), 3S (32), 3N (31) accounted for the greatest volume of IV-to-PO interventions during 3rd quarter. Quarter-to-Quarter date is trending-up with the onboarding of our new ABS Pharmacist.
Average Days of Therapy per 1,000 patient days - Fluoroquinolones	Goal <7.87	**5.84**	**7.63**	NA			**1st QTR:** Data received late. Goal achieved. **2nd QTR:** An uptick in use by almost 2 points. Barely achieved goal. Will continue to monitor for increase use and rationales. **3rd QTR:** Information not available.
Average Days of Therapy per 1,000 patient days - Carbapenems	Goal <19.72	**15.45**	**16.41**	NA			**1st QTR:** Data received late. Goal achieved. **2nd QTR:** An uptick in use by almost 1 point, but well within goal. **3rd QTR:** Information not available.
III. Employee Health							
A. Needlestick Injuries							
Number of sharps/needle stick reports		23	17	16			**1st QTR:** There were 23 needle stick exposures (5 in January, 8 in February, 10 in March). A total of 9 of the needle stick exposures involved a SQ needle (Lovenox, Insulin, Heparin, Epoetin). There were 8 needle sticks that occurred during disposal of a needle before activating the safety mechanism and a remaining 4 needle stick injuries that occurred before activating the safety mechanism involving a different action such as obtaining a specimen, giving medications, and performing patient care. Employee Health developed an educational flyer about appropriate handling of sharps that has been shared twice at the new Safety Liaison Committee. **2nd QTR:** There was a 74% reduction in Sharps exposures comparing 1st to 2nd QTR rates. A combination of same day on-site investigation with employee and follow-up with manager, along with Sharps education provided to new employees as part of orientation appears to be helping decrease Sharps exposure events. **3rd QTR:**
B. Blood/Body Fluid Exposures							
Number of blood/body fluid exposures		1	0	0			**1st QTR:** There was one blood/body fluid exposures during this quarter. Splashes are no longer required reporting per OSHA and are only internally monitored. **2nd QTR:** No blood/body fluid exposures during 2nd QTR. **3rd QTR:**
IV. Healthcare Associated Infection Measures							
I. Overall Surgical Site Infections (SSI)	**IR/SIR**						**SSIs calculated internally though standard incidence rate and externally through Standardized Infection Ratio (SIR) from National Health and Safety Network (NHSN).**

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2021							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
A. #Total Procedure Count		1279	1112				**Cumulative Ct.:** 2391
B. Total Infection Count *[note: SSI events can be identified up to 90 days from the last day of the month in each quarter and only DIP and Organ Spc SSI are reported in NSHN]*		**9**	**8**				**1st QTR:** 9 **Predicted:** 17.262 **2nd QTR:** 8 **Predicted:** 14.446 **3rd QTR:** **Predicted:** (Available in February)
C. Incidence Rate (IR) [# of total SSI infections/# total procedures x 100]	Internal 0.70 Goal	**0.7**	**0.7**				**1st QTR:** Total of number of SSI events matched the Statewide threshold of 0.70. **2nd QTR:** Total number of SSI events are no different than Statewide threshold of 0.70. **3rd QTR:** (Available in February)
D. SIR Confidence Interval (CI-KDHCD predicted range, based on risks)		0.077, 0.822	0.257, 1.052				**1st QTR:** Same as State average. **2nd QTR:** Same as State average. **3rd QTR:** (Available in February)
E. Standardized Infection Ratio (SIR)	NHSN	**0.521**	**0.554**				**1st QTR:** 1 APPY, 1 CBGB, 1 CRAN, 1 SB, 1 KPRO, 1 FX, 1 XLAP, 1 FUSN. Contributing factors: Outside facilities where surgical patients are transferred are not following discharge orders and/or discharge instructions were not sent. Glucose control for Diabetic surgical patients. Post-op education and patient compliance. All of these factors are discussed at the SSI prevention committee and interventions are being considered for implementation. **2nd QTR:** 1 HYST, 1 CHOL, 1 COLO, 1 BRST, 1 FUSN, 1 FX, 2 SB. Generally SSI events during 2nd QTR occured between days 12 and 27 post operatively (primarily on day 12). **3rd QTR:** (Available in February)
II. Specific Surgical Review	**SIR**						
A. Colon Surgery (COLO) CMS/VBP							
1. #Total Procedure Count		36	39				**Cumulative Ct.:** 75
2. Total Infection Count		**0** **[0]**	**1** **[0]**				**1st QTR:** 0 **Predicted:** 3.053/**(CMS)** 0 **Predicted:** 1.043 **2nd QTR:** 1 **Predicted:** 2.659/**(CMS)** 0 **Predicted:** 1.219 **3rd QTR:** **Predicted:** /**(CMS)** **Predicted:**
3. SIR CI (KDHCD predicted range, based on risks)		, 0.981	0.019, 1.855				**1st QTR:** Better than national benchmarks. **2nd QTR:** Better than national benchmarks. **3rd QTR:** (Available in February)
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.749	**0** **[0]**	**0.38** **[0]**				**1st QTR:** No COLO events excellent work! **2nd QTR:** 1 COLO event. 27 days post-op. Multiple intra-operative variables (hair removal in OR, misfiring stapler, cut-time prior to arrival of surgeon, difficult indwelling urinary catheter insertion, very high intra-op blood glucose). **3rd QTR:** (Available in February)
B. Cesarean Section (CSEC)							
1. #Total Procedure Count		348	254				**Cumulative Ct.:** 602
2. Total Infection Count		**0**	**0**				**1st QTR:** 0 **Predicted:** 3.089 **2nd QTR:** 0 **Predicted:** 2.311 **3rd QTR:** **Predicted:** (Available in February)
3. SIR CI (KDHCD predicted range, based on risks)		, 0.970	, 1.297				**1st QTR:** Better than predicted **2nd QTR**: Better than predicted **3rd QTR:** (Available in February)
4. SIR (Standardized Infection Ration) total	Goal SIR <1.00	**0**	**0**				**1st QTR:** No C-section events excellent! **2nd QTR:** No C-section events excellent work! **3rd QTR:** (Available in February)
C. Spinal Fusion (FUSN)							
1. #Total Procedure Count		52	50				**Cumulative Ct.:** 102

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2021							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
2. Total Infection Count		1	1				**1st QTR:** 1 **Predicted:** 0.763 **2nd QTR:** 1 **Predicted:** 0.753 **3rd QTR:** **Predicted:** (Available in February)
3. SIR CI (KDHCD predicted range, based on risks)		NA	NA				**1st QTR:** No C.I. **2nd QTR:** No C.I. **3rd QTR:** (Available in February)
4. SIR (Standardized Infection Ration) total	Goal SIR <1.00	1.31	1.33				**1st QTR:** Greater than predicted number of FUSN SSI events. Patient discharged home 2 days post-op. Event occurred 23 days post-op and patient went AMA when providers in ED recommended an I&D of abscess - he returned on day 29 post-op for the I&D procedure. Patient's glucose remained elevated post-op (DM) and his wound dehisced several days post-op. **2nd QTR:** Event occured 22 days post-op. Wound dehiscence noted along spinal incision. Wound culture positive for MSSA (typical skin flora). **3rd QTR:** (Available in February)
D. Hysterectomy (HYST) CMS/VBP							
1. #Total Procedure Count		29	15				**Cumulative Ct.:** 44
2. Total Infection Count		1 [1]	1 [0]				**1st QTR:** 1 **Predicted:** 0.5 /**(CMS)** 1 **Predicted:** 0.248 **2nd QTR**: 1 **Predicted:** 0.283/**(CMS)** 0 **Predicted:** 0.126 **3rd QTR:** **Predicted:** /**(CMS)** **Predicted:** (Available in February)
3. SIR CI (KDHCD predicted range, based on risks)		NA	NA				**1st QTR:** No C.I. **2nd QTR:** No C.I. **3rd QTR:** (Available in February)
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.727	1 [4.03]	3.53 [0]				**1st QTR:** 1 HYST event. **2nd QTR:** No HYST SSI events! **3rd QTR:** (Available in February)
III. Ventilator Associated Events (VAE)							
A. Ventilator Device Use SUR (standardized utilization ratio)	Goal <1.0	2.20	1.8	2.13			**1st QTR:** 1247 device days **Predicted:** 567 device days **2nd QTR:** 915 devices days **Predicted:** 508 device days **3rd QTR:** 1296 devices days **Predicted**: 608.59 device days
B. Total VAEs ICU (NHSN Reportable)	Includes IVAC Plus						
1. SIR Total VAE CI (KDHCD predicted range, based on risks)		,0.304	1.687, 1.920	0.179, 1.082			**1st QTR:** Greater than predicted device days **2nd QTR**: Greater than predicted device days **3rd QTR:** Greater than predicted device days
2. Total VAEs		7	0	5			**1st QTR:** All events were related to alterations in PEEP resulting in a VAC in the ICU. **2nd QTR:** 0 event Predicted: 7.231 **3rd QTR:** 5 events, Prediceted 10.242
C. Total IVAC Plus -ICU		0	0	4			**1st QTR:** No IVAC or PVAP events. **2nd QTR:** 0 IVAC Predicted: 2.683 **3rd QTR:** 4 IVAC & 1 PVAP, Predicted 3.8
1. Total IVAC Plus CI (KDHCD predicted range, based on risks)		,0.819	, 1.117	0.482, 2.916			**1st QTR:** Less than predicted events **2nd QTR**: Less than predicted events **3rd QTR:** Worse than predicted

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2021							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
2. Total IVAC *Plus* ICU SIR	Goal SIR <1.00	0	0	1.316			**1st QTR:** No IVAC or PVAP events, only Ventilator Associated Conditions (VAC) which involves changes in PEEP and/or Fi02. Education provided to Respiratory Therapy re: limiting increases in PEEP to increments < or = 2 points. **2nd QTR:** 0 VAE events. There was 1 PVAP event that occured on a non-ICU (5T), and therefore is not reportable. **3rd QTR:** 5 VAC, 4 IVAC, 1 PVAP
D. Total VAEs CVICU (NHSN Reportable)	Includes IVAC Plus						
1. Total VAEs		0	0	0			**1st QTR:** No VAE events occurred. **2nd QTR:** No VAE events occurred. **3rd QTR:** Not VAE events occurred.
2. Total IVAC Plus CVICU SIR	Goal SIR <1.00	0	0	0			**1st QTR:** No VAE events occurred. **2nd QTR:** No VAE events occurred. **3rd QTR:** No VAE events occurred.
3. Total VAEs-Both Units		7	0	0			**1st QTR:** Only VAC identified for the quarter in the presence of increased ventilator days related to the COVID-19 pandemic. **2nd QTR:** No VAE events occurred. **3rd QTR:** No VAE events occurred.
1. VAE Prevention Process Measures	Goal 100%						
% Head of Patient >or=30 Degrees (per visual inspection)		98%	98.7%	100%			**1st QTR:** Process measure close to goal, still some opportunity for improvement. **2nd QTR**: Slight improvement in this process indicator yet goal not achieved. **3rd QTR:** Denominator of audited information very small and this could mean result is a bit misleading. Audit process will be improving next quarter with IP back-up to support measures data is being collected.
% Sedation Vacation		98%	91.7%	100%			**1st QTR:** Process measure close to goal, still some opportunity for improvement. **2nd QTR:** Significant drop providing sedation vacation. Will explore reason for this action. **3rd QTR:** Denominator of audited information very small and this could mean result is a bit misleading. Audit process will be improving next quarter with IP back-up to support measures data is being collected.
% Oral Care Provided (per visual inspection)		98%	98.0%	100%			**1st QTR:** Process measure close to goal, still some opportunity for improvement. **2nd QTR:** Process measure holding steady at 2% marks below goal. Will work on ways to encourage consistent oral care 100% of the time. **3rd QTR:** Denominator of audited information very small and this could mean result is a bit misleading. Audit process will be improving next quarter with IP back-up to support measures data is being collected.
% CHG Bath within last 24 hours			97.3%	100%			**2nd QTR:** CHG bathing has improved across the organization, however, there are challenges with access and implementation that are being addressed. **3rd QTR:** Denominator of audited information very small and this could mean result is a bit misleading. Audit process will be improving next quarter with IP back-up to support measures data is being collected.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2021							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
% Vent Tubing Position Appropriately (drain away from patient - visual inspection)			100.0%	100%			**2nd QTR:** Goal achieved. **3rd QTR:** Denominator of audited information very small and this could mean result is a bit misleading. Audit process will be improving next quarter with IP back-up to support measures data is being collected.
IV. Pneumonia Long Term Care/Rehabilitation	Goal = 0						
Short Stay (# of Infections/ Incidence Rate)		0	0	0			**1st QTR:** No events. **2nd QTR:** No events. **3rd QTR:** No events.
Transitional Care (# of Infections/ Incidence Rate)		0	0	0			**1st QTR:** No events. **2nd QTR:** No events. **3rd QTR:** No events.
Subacute (# of Infections/ Incidence Rate)		2/(0.76)	1/(0.397)	1			**1st QTR:** Two patients that met Pneumonia criteria. Education provided about elevating the head-of-bed and mobility. **2nd QTR:** 1 patient that met Pneumonia criteria. **3rd QTR:** 1 patient that met Pneumonia criteria.
VI. Central Line Associated Blood Stream Infections (CLABSI) CMS/VBP	**NHSN SIR**						
A. Total number of Central Line Days (CLD)		4360	2684	4461			**1st QTR:** 4360 CLD **Predicted:** 5613 CLD **2nd QTR**: 2684 CLD **Predicted:** 3716 CLD **3rd QTR:** 4461 CLD **Predicted:** 6223 CLD
B. Central Line Device Use SUR (standardized utilization ratio)		0.875	0.722	0.717			**1st QTR:** CLD during this quarter remained <90% predicted. **2nd QTR:** CLD during this quarter was 72% of predicted. **3rd QTR:** CLD continues to hover between 72-73% of predicted utilization.
C. Total Infection Count Valule Based Purchasing (VBP) # events = [ ]		3 [3]	1 [1]	7 [6]			**1st QTR:** 3 **Predicted:** 4.306 /**(CMS)** 3 **Predicted:** 2.624 **2nd QTR:** 1 **Predicted:** 2.662/**(CMS)** 1 **Predicted:** 1.682 **3rd QTR:** 7 **Predicted:** 4.449/**(CMS)** 6 **Predicted**: 2.092
D. SIR Confidence Interval		0.177, 1.896	0.019, 1.852	0.688, 3.112			**1st QTR:** Same as national benchmarks. **2nd QTR**: Same as national benchmarks. **3rd QTR:** Same as national benchmarks.
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.633	0.697 [1.143]	0.376 [0.595]	1.573 [2.092]			**1st QTR:** Several interventions underway to address CLABSI (Culture of culturing; Midlines as an alternative; Gemba Rounds; Just in case culture; Nurse/Resident education; BC Alert; Candida Score; Fever defined; TPN-Enteral Feeding and Antimicrobial Stewardship - IV to PO conversion). **2nd QTR:** Interventions are starting to make a dent in the rate of CLABSI events. Actively working on a the Candida Scoring tool, Blood Culture Decision Tree - CRBSI Protocol, changed Blood Culture Alert to allow ordering every 72 hours instead of every 24 hours. **3rd QTR:** Identified a significant increase in comparison to 2nd QTR data. Unfortunately the recent surge of COVID cases coupled with supply and staffing shortages are negatively affecting outcomes. We still strive to maintain interventions set in place to reduce these types of events. Monthly HAI case review meetings with CME offered continue to be scheduled. Attendance unfortunately to these meetings is low (especially amongst providers).
F. CLABSI Prevention Process Measures	Goal 100%						

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2021							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
% of patients with a bath within 24 hours		96%	95%	NA			**1st QTR:** Consistent bathing is improving. **2nd QTR:** 5% = 108 opportunities for a bath not performed. **3rd QTR**: Gemba data entry impeded by demands to address COVID. Results not available.
% of central lines inserted with a valid rationale		98%	98%	NA			**1st QTR:** Documentation of indication for central lines has gotten much better. **2nd QTR:** 2% = 43 observations in which patients with a central had not a valid rationale for a central line. **3rd QTR:** Gemba data entry impeded by demands to address COVID. Results not available.
% of central line dressings clean, dry and intact		95.3%	96%	NA			**1st QTR:** Dressing management needs to improve. **2nd QTR:** 4% = 87 observations in which patients with a central line covered with an unintact and/or dirty dressing. **3rd QTR:** Gemba data entry impeded by demands to address COVID. Results not available.
% of central line dressing changes no > than 7 days		99%	98.5%	NA			**1st QTR:** Dressing changes within 7 days has greatly improved. **2nd QTR:** 1.5% = 32 observations in which patients with a central line had a dressing over the line insertion site unchanged for > 7 days. **3rd QTR:** Gemba data entry impeded by demands to address COVID. Results not available.
% of patients with properly placed CHG patch		92.7%	94%	NA			**1st QTR:** Education for both new hire and current nurses hired within the past 1 1/2 years regarding CLABSI prevention and dressing management initiated toward the end of this quarter. **2nd QTR:** 6% = 127 observations in which patients with a central line had a GuardIVa CHG patch that didn't properly encircle the line insertion site. **3rd QTR:** Gemba data entry impeded by demands to address COVID. Results not available.
% of patients with appropriate & complete documentation		92.7%	92.50%	NA			**1st QTR:** Documentation appears to be posing some difficulty. Further analysis required regarding this issue. **2nd QTR:** 7.5% = 162 observations in which patients with a central line did not have documentation in the electronic health record describing interventions associated with the device. **3rd QTR:** Gemba data entry impeded by demands to address COVID. Results not available.
# of central line days rounded on		3,256	2,166	NA			**1st QTR:** Gemba Rounds were performed on 74.7% of all days in which a patient had a central line in place. **2nd QTR:** Note that the amount of GEMBA Rounds depicted for 2nd QTR include only April and May. June data was not yet compiled. **3rd QTR:** Gemba data entry impeded by demands to address COVID. Results not available.
Skilled Nursing/Acute Rehab % of central dressing clean/dry/intact			99%	94%			**1st QTR:** New measure no data available. **2nd QTR:** Goal nearly achieved. **3rd QTR:** Fell short of goal. IP working with staff reminding them to perform dressing care when the dressing is observed non-intact, wet or soiled.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2021							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
Skilled Nursing/Acute Rehab % of central line dressings changed no > 7 days			93.5%	98%			**1st QTR:** New measure no data available. **2nd QTR:** Central line dresssing changes are not occuring in a timely manner which increases risk for infection. IP is working with nursing staff to improve response to this measure. **3rd QTR:** Much improved this quarter. Nearly 100% of observed central dressing were changed no later than day 7.
VII. Catheter Associated Urinary Tract Infections (CAUTI) CMS/VBP	**NHSN SIR**						
A. Total number of Catheter Device Days (CDD)		4048	2429	4175			**1st QTR:** 4048 CDD **Predicted:** 4874 CDD **2nd QTR:** 2429 CDD **Predicted:** 3192 CDD **3rd QTR:** 4175 CDD **Predicted:** 5189 CDD
B. Catheter Device Days SUR (Standardized Utilization Ratio)	Goal <1.0	0.787	0.761	0.805			**1st QTR:** CDD during this quarter remained <79% of predicted. **2nd QTR:** CDD during this quarter dropped a few percentage point to 76% of predicted. **3rd QTR:** CDD during this quarter continues to hover at 80% of predicted.
C. Total Infection Count Value Based Purchasing (VBP) # of events = [ ]		1 [0]	4 [4]	9 [4]			**1st QTR:** 1 **Predicted:** 5.278 /**(CMS)** 0 **Predicted:** 2.879 **2nd QTR:** 4 **Predicted:** 3.160/**(CMS)** 4 Predicted: 1.625 **3rd QTR:** 9 **Predicted:** 5.457/**(CMS)** 4 **Predicted:** 2.971
D. SIR Confidence Interval		0.009, 0.934	0.402, 3.053	0.804, 3.027			**1st QTR:** Better than national benchmarks. **2nd QTR:** No different than national benchmarks. **3rd QTR:** No different than national benchmarks.
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.727	0.189 [0]	1.266 [2.461]	1.649 [1.346]			**1st QTR: Several interventions underway to address CAUTI** (Alternatives to an IUC; Management of Urinary Retention; Urine Culture algorithm; Peri-care & Bathing; Integreation of reminders in PowerPlans) **2nd QTR**: Indwelling Urinary Catheters are being removed more readily during GEMBA rounds. Management of Urinary Retention still needs to be addressed. **3rd QTR:** Slight decrease in SIR noted for 3rd QTR in comparison to 2nd QTR. Unfortunately the recent surge of COVID cases coupled with supply and staffing shortages are negatively affecting outcomes. We still strive to maintain interventions set in place to reduce these types of events. Monthly HAI case review meetings with CME offered continue to be scheduled. Attendance unfortunately to these meetings is low (especially amongst providers).
F. CAUTI Prevention Process Measures	Goal 100%						
% of patients with appropriate cleanliness		98.5%	98.5%	NA			**1st QTR:** While patient bathing is readily being complied with, it didn't quite achieve goal. **2nd QTR:** 2.5% = about 47 observations in which a patient hadn't received appropriate cleanliness. **3rd QTR:** Gemba data entry impeded by demands to address COVID. Results not available.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2021							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
% of IUCs with order and valid rationale		93.5%	93%	NA			**1st QTR:** The rationale for an indwelling urinary catheter should be sought every shift during hand-off and shared at Gemba. This element needs to improve. **2nd QTR:** 7% = about 131 observations in which a patient had an indwelling urinary catheter inserted within them without a documented valid rationale provided. **3rd QTR:** Gemba data entry impeded by demands to address COVID. Results not available.
% of IUCs where removal was attempted		4%	4%	NA			**1st QTR:** This low percentage is an indication that generally IUC placed in patients are required. **2nd QTR:** There were approximately 75 attempts toward removal of indwelling urinary catheters during Gemba rounds, that didn't result in removal. **3rd QTR:** Gemba data entry impeded by demands to address COVID. Results not available.
% of patients where alternatives have been attempted		10%	8%	NA			**1st QTR:** One in every 10 patients with an IUC was transitioned to an alternative method for urine collection. **2nd QTR:** Approximately 150 Gemba observations involved attempts of providing a patient a non-invasive alternative to an indwelling urinary catheter for urine elimination. **3rd QTR:** Gemba data entry impeded by demands to address COVID. Results not available.
% of IUCs removed because of unit "GEMBA" rounds		6%	6%	NA			**1st QTR:** A greater amount of IUC are removed as a part of Gemba Rounds, than through conventional means. **2nd QTR:** Approximately 103 indwelling urinary catheters were discontinued as a result of Gemba rounds. **3rd QTR:** Gemba data entry impeded by demands to address COVID. Results not available.
# of IUCs removed because of unit "GEMBA" rounds		152	103	NA			**1st QTR:** 152 indwelling urinary catheters were removed because of Gemba Rounds. **2nd QTR:** 103 indwelling urinary catheter were removed because of Gemba Rounds. Volume reduced due to reduced Gemba during weekends. **3rd QTR:** Gemba data entry impeded by demands to address COVID. Results not available.
# of Indwelling Urinary Catheter days rounded on		2757	1879*	NA*			**Total IUC days rounded on:** 4,636 **2nd QTR reflects only 2 months of data.* **3rd QTR data not reflected in total IUC days rounded.*
Skilled Nursing/Acute Rehab % of complete baths performed within 24 hours			93%	83%			**1st QTR:** New measure no data available. **2nd QTR:** Below goal. IP working with nursing to improve frequency in which patients receive complete baths. **3rd QTR:** Well below goal. Staffing has been problematic and impacting patient care. However, continued measures are needed to ensure patients are receiving bathing regularly.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2021							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
Skilled Nursing/Acute Rehab % of peri care performed within in a 12 hour shift			93%	90%			**1st QTR:** New measure no data available. **2nd QTR:** Below goal. IP working with nursing to ensure that peri care is performed at least once a shift if not more often based the needs of the patient. **3rd QTR:** Similar to complete bathing staffing shortages have impacted patient care. While the goal was not achieved, there is evidence that at a minimum peri-care is being performed more frequently that complete baths. However, continued measures are needed to ensure patients are receiving peri-care regularly.
VIII. Catheter Associated Urinary Tract Infections Long Term Care/Rehabilitation	Goal = 0						
Short Stay (# of Infections/ Incidence Rate)		0	0	1			**1st QTR:** No events. **2nd QTR:** No events. 3rd QTR:
Transitional Care (# of Infections/ Incidence Rate)		0	0	0			**1st QTR:** No events. **2nd QTR:** No events. 3rd QTR:
Subacute (# of Infections/ Incidence Rate)		0	0	0			**1st QTR:** No events. **2nd QTR:** No events. 3rd QTR:
Acute Rehabilitiation (# of Infections/ Incidence Rate)		0	0	0			**1st QTR:** No events. **2nd QTR:** No events. **3rd QTR:**
IX. LTC Symptomatic Urinary Tract Infections	Goal = 0						
Short Stay (# of Infections/ Incidence Rate)		1	0	1			**1st QTR:** 1 SUTI event. **2nd QTR:** No events **3rd QTR:**
Transitional Care (# of Infections/ Incidence Rate)		0	0	0			**1st QTR:** No events. **2nd QTR:** No events **3rd QTR:** No events
Subacute (# of Infections/ Incidence Rate)		0	0	1			**1st QTR:** No events. **2nd QTR:** No events **3rd QTR:** 1 SUTI event
X. Clostridium *difficile* Infection (CDI) CMS/VBP	**SIR**						
A. Total Infection Count	All units	8	9	9			**1st QTR:** 8 **Predicted**: 17 **2nd QTR**: 9 **Predicted:** 17.946 **3rd QTR:** 9 **Predicted:** 19.463
B. SIR CI (KDHCD predicted range, based on risks)		0.222, 0.907	0.245, 0.920	0.226, 0.849			**1st QTR:** Same as national benchmark **2nd QTR:** Same as national benchmark **3rd QTR:** Same as national benchmark
C. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.646	0.478	0.501	0.462			**1st QTR:** This metric is consistently performing well. Continued antimicrobial stewardship and education appears to be effective. **2nd QTR:** Continued use of the CDIFF algorithm. Seeing an upward trend that may require more messaging and refresher education be provided. **3rd QTR:** Well below predicted levels of CDIFF.
XII. Hand Hygiene							

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2021							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
A. Total Hand Hygiene Observations (combination of manual and electronic hand hygiene surveillance)		2,837,294	2,379,412	2,236,272			**1st QTR:** Nearly 3 million hand hygiene observations performed via a combination of electronic hand hygiene and manual hand hygiene compliance surveillance. **2nd QTR**: Identified just about 500,000 less hand hygiene observations compared with 1st QTR data. Reasons for this decrease are documented below. **3rd QTR:** A little over 2 million hand hygiene observations performed via combination of electronic hand hygiene and manual hand hygiene compliance surveillance.
B. All unit/departments Percentage of Hand Hygiene compliance based on observations (>200 observations/ month/unit minimum)	Goal >95%	**97.2%**	**97.4%**	**97.2%**			**1st QTR:** Achieved 97.2% hand hygiene compliance exceeding goal. **2nd QTR:** Achieved 97.4% hand hygiene compliance. However, there was a significant drop in users of the electronic hand hygiene surveillance system, in part due to transition from a BioVigil access card to the new branded hospital ID card being used for BioVigil badge access. Additionally, late May into June BioVigil becons or sensors batteries failed and large amounts of patient rooms did not registered user activity. On July 5th all batteries were exchanged. The system is working well. Just about 50% of employees have transitioned to using their hospital ID card for BioVigil badge access. Vice Presidents have been given access to receive BioVigil unit/department reports weekly. **3rd QTR:** Achieved 97.2% hand hygiene compliance. A great deal of work implemented to improve hand hygiene opportunity and compliance data capture. Assigned light-duty staff to perform hand hygiene observations (200/mo/ per location) in areas that BioVigil not in use. In BioVigil locations installed more sensitive sensors on base stations, fixed accessibility issues. Still need to work on increase user compliance and user rates. Those staff wearing a BioVigil badge are performing hand hygiene appropriately.
XIII. VRE (HAI) Blood-Hospital Onset (HO)	Goal = 0						
A. Total Infection Count		**1**	**0**	**0**			**1st QTR:** 1 **Predicted:** 0 **2nd QTR:** 0 **Predicted:** 0 **3rd QTR:** 0 **Predicted:** 0
B. Prevalence Rate (x100)		**0.016**	**0**	**0**			**1st QTR:** Very low prevalence rate. We rarely have VRE bloodstream infections. **2nd QTR:** No events. **3rd QTR:** No events.
C. Number Admissions		6115	6516	7198			**Cumulative Ct.:** 12,631
XIV. MRSA BSI LABID (HAI) Blood CMS/VBP	**SIR**						
A. Total Infection Count (IP Facility-wide)		**5**	**2**	**3**			**1st QTR:** 5 **Predicted:** 1.494 **2nd QTR:** 2 **Predicted:** 1.591 **3rd QTR:** 2 **Predicted:** 1.095
B. SIR CI (KDHCD predicted range, based on risks)		1.226, 7.416	0.211, 4.154	0.449, 4.808			**1st QTR:** Greater than national benchmarks. **2nd QTR:** No different than national benchmarks. **3rd QTR:** not different than national benchmarks.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2021							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
C. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.748	3.346	1.257	1.767			**1st QTR:** Poorest performing HAI type. Contacted State HAI Program for clarification related to State MRSA study findings. Implementing CHG bathing, Hand Hygiene Surveillance (BioVigil), **2nd QTR:** Over 50% complete with transition to new hospital ID card and BioVigil access. Will be providing VPs with access to departmental hand hygiene compliance rates via BioVigil. Several BioVigil updates performed. Anaylzed the frequency in which patients are screened and treated for MRSA nasal colonization. Devising plan to improve this process. Also, working on making CHG bathing more accessible and hardwired . **3rd QTR:** MRSA BSI events continue to be problematic. Transitioning intervention planning into a Quality Focus Team with Executive member support. Will be focusing on nasal decolonization, hand hygiene, environmental disinfection, and patient bathing.
XV. MDRO LABID - Long Term Care	Goal = 0						
Short Stay (# of Infections/ Incidence Rate)		0	0	0			**1st QTR:** No events. **2nd QTR:** No events. **3rd QTR**: No events.
Transitional Care (# of Infections/ Incidence Rate)		0	1/(0.76)	0			**1st QTR:** No events. **2nd QTR:** 1 Clostridium difficile event. **3rd QTR:** No events.
Subacute (# of Infections/ Incidence Rate)		1 /(0.74)	0	0			**1st QTR:** 1 Clostridium difficile event. Reviewed antibiotics that patient was receiving. **2nd QTR**: No events. **3rd QTR:** No events.
XVI. Influenza Rates (Year 2020-2021)	Healthy People 2020 Goal 90%						
A. All Healthcare Workers		87.5%					Of a total of 4,671 healthcare personnel including providers, volunteers and contractors worked at least 1 day during the seasonal influenza timeframe. A total of 4,085 received influenza vaccination at Kaweah Delta or provided documentation of receiving influenza vaccination elsewhere. A total of 10.4% (487) of healthcare personnel at Kaweah Delta indicated a contraindication to receiving influenza vaccine. A total of 0.5%(22) of healthcare personnel declined influenza vaccination. A total of 1.6%(77) of healthcare personnel had an unknown vaccination status through the end of the seasonal influenza timeframe.
XVII. COVID-19 Vaccination Rates (Year 2020-2021)							

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2021							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
A. All Healthcare Workers with a completed series of COVID-19 vaccinations.		55.8%	55%	74%			**1st QTR:** As of March 31th 3,321 (55.8%) or 5,949 healthcare workers received their completed series of COVID-19 vaccination doses. Another 82 (1.3%) employees received their initial dose of COVID-19 vaccine. The remaining 2,546 (42.8%) healthcare workers did not receive COVID-19 vaccine. *[note: revision to 1st QTR data to reflect vaccination rate for completed vaccinations.* **2nd QTR:** As of July 21st, 2021, (55.6) 3,238 of 5930 healthcare workers received their completed series of COVID-19 vaccination doses. An additional 82 healthcare personnel received 1 dose of a two part vaccination series. 2,528 healthcare personnel have not received COVID-19 vaccine. **3rd QTR**: July 26, 2021 State Governor order that healthcare personnel are required to receive COVID vaccination or undergo COVID testing twice a week through active surveillance measures. Healthcare personel vaccination rates did increase under this order and the FDA approval of mRNA vaccines (removing it from Emergency Use Authorization). Greatest vaccination rate increase seen amongst providers.
Approved IPC: 5/27/2021 Approved IPC: 7/29/2021 Approved IPC: 10/27/2021 Approved IPC: Prepared by: Shawn Elkin							

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Kaweah Health

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Unit/Department: Mother Baby **QIC Report Date: July 2021**

Measure Objective/Goal:

Monitoring c-section respiratory rates to ensure they are performed and documented as ordered within the first 24 hours post c-section. For this reporting period, we are at 83.83% compliance. (Internal benchmark 80.0%)

Date range of data evaluated:

January 2021 – June 2021

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

We currently are performing above the benchmark of 80.0%.

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

We recently experienced changes in these orders as ordered by our anesthesia team. Education has been provided to the staff and respiratory rate charting is being audited during bedside report.

Next Steps/Recommendations/Outcomes:

We will continue to monitor this measure until we achieve and sustain 80% compliance rate.

Submitted by Name: Melissa Filiponi, RNC-MNN, BSN

Date Submitted: 07/09/2021

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

Maternal Child Health

Enhanced Recovery After C-Section Dashboard

	Benchmark	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Early Mobilization															
% of elective C-Section cases who ambulate within 24 hrs post op	90%	100%	97.00%	97.30%	94.30%	98.50%	100.00%	95.80%	98.80%	95.00%	94.50%	97.61%	100.00%	98.20%	97.90%
numerator/denominator		54/54	65/67	73/75	50/53	67/68	77/77	70/73	83/84	76/80	86/91	41/42	73/73	56/57	46/47
Early Urinary Catheter Removal															
% of elective C-section cases who have foley catheter removed within 12 hrs after delivery (start time when they leave PACU)	90%	51%	47.70%	45.30%	47.10%	64.10%	62.30%	64.30%	69.00%	61.20%	65.93%	73.80%	83.10%	85.40%	82.90%
numerator/denominator		28/54	32/67	34/75	25/53	43/67	48/77	47/73	58/84	49/80	60/91	31/42	59/71	47/55	39/47
Breastfeeding Support															
% Lactation Consult postpartum	TBD	93%	100%	100%	88.60%	94.10%	98.60%	100.00%	100.00%	98.70%	97.80%	97.61%	100.00%	100.00%	97.90%
numerator/denominator		50/54	67/67	75/75	47/53	64/68	75/76	73/73	84/84	79/80	89/91	41/42	74/74	57/57	46/47
Breastfeeding Support and Maternal Infant Bonding															
% skin to skin contact /breastfeeding attempted in OR/PACU	90%	92%	76.10%	80.20%	77.00%	82.20%	68.00%	74.20%	74.00%	81.30%	83.52%	87.17%	87.50%	94.40%	97.80%
numerator/denominator		49/53	48/63	57/71	37/48	51/62	51/75	49/66	57/77	61/75	71/85	34/39	63/72	51/54	45/46
Multimodal Analgesia															
% of elective C-Section cases who have multimodal analgesia administered within 12 hours of surgery end time (usually use toradol/tylenol)	TBD	100%	100%	100%	100%	98.50%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
numerator/denominator		54/54	67/67	75/75	54/54	67/68	77/77	73/73	84/84	80/80	91/91	42/42	74/74	57/57	47/47
Antibiotic Prophylaxis															
% of elective C-Section cases who have antibiotic prophylaxis before cut time (anesthesia record)	TBD	100%	100%	100%	100%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.20%	100.00%
numerator/denominator		54/54	67/67	75/75	54/54	68/68	77/77	73/73	84/84	80/80	91/91	42/42	74/74	56/57	47/47
Promotion of Return of Bowel Function															
% of elective C-sections without ANY administered IV opioids postpartum	TBD	89%	95.50%	97.30%	92.40%	88.20%	100.00%	95.80%	92.80%	96.20%	98.90%	97.61%	92.40%	92.90%	97.90%
numerator/denominator		48/54	64/67	73/75	49/53	60/68	77/77	70/73	78/84	77/80	90/91	41/42	73/79	53/57	46/47

KEY

>10% above goal/benchmark	Within 10% of goal/benchmark	Outperforming/meeting goal/benchmark

Data includes elective C-sections only

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Unit/Department: Mother Baby **QIC Report Date: July 2021**

Measure Objective/Goal:

Babies receiving exclusive breast milk while in the hospital 64.76% (TJC PC-05 Benchmark 52.2%)

Date range of data evaluated:

January 2021 – June 2021

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

We currently are performing above the benchmark of 52.2%.

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

We are currently fully staffed with 7 day a week coverage spanning an average of 21 hours a day. We implemented coverage on Labor/Delivery to see our new mom's prior to delivery providing them with education so they can make an informed decision on how they want to feed their baby while in the hospital. We have implemented our our breastfeeding bundle which included the following: change in lactation scheduling, mandatory breastfeeding education for RN's, breastfeeding education provided to our pediatricians, selection preference form to be collected on admission to Labor and Delivery and an investigative form for nursing to complete when formula is given. In addition to the above bundle, our lactation team has now changed their focus to include assisting with the first feed post-delivery and following the mothers who choose to do both breast and formula encouraging only breastfeeding while in the hospital. We most recently implemented BIB University (Breast is Best), very similar to Falls U, where staff are invited to share their stories so we can identify gaps in care.

Next Steps/Recommendations/Outcomes:

We continue to support our mother's choice of exclusive breastfeeding.

Submitted by Name: Melissa Filiponi, RNC-MNN, BSN

Date Submitted: 07/09/2021

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

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Unit/Department: Mother Baby **QIC Report Date: July 2021**

Measure Objective/Goal:

Babies receiving any breast milk while in the hospital 90.57% (CDPH 2018 benchmark of 93.8%)

Date range of data evaluated:

January 2021 – June 2021

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

We currently are performing below the benchmark of 93.9%.

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

We are currently fully staffed with 7 day a week coverage spanning an average of 21 hours a day. We implemented coverage on Labor/Delivery to see our new mom's prior to delivery providing them with education so they can make an informed decision on how they want to feed their baby while in the hospital. We have implemented our our breastfeeding bundle which included the following: change in lactation scheduling, mandatory breastfeeding education for RN's, breastfeeding education provided to our pediatricians, selection preference form to be collected on admission to Labor and Delivery and an investigative form for nursing to complete when formula is given. In addition to the above bundle, our lactation team has now changed their focus to include assisting with the first feed post-delivery and following the mothers who choose to do both breast and formula encouraging only breastfeeding while in the hospital. We most recently implemented BIB University (Breast is Best), very similar to Falls U, where staff are invited to share their stories so we can identify gaps in care.

Next Steps/Recommendations/Outcomes:

We continue to support our mother's choice for feeding her baby(ies).

Submitted by Name: Melissa Filiponi, RNC-MNN, BSN

Date Submitted: 07/09/2021

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

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Unit/Department: Mother Baby **QIC Report Date: July 2021**

Measure Objective/Goal:

To initiate NICU mom's pumping within 2-4 hours of separation from their baby 98.33% (Internal benchmark of 75%).

Date range of data evaluated:

January 2021 – June 2021

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

We currently are performing above the benchmark of 75%.

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

Education provided to staff on the importance of pumping for both mother and babies well-being. We have been auditing the charts of NICU moms and providing one on one education to staff so that they are charting in the correct location within the EHR. Our lactation team began following all of our NICU moms to ensure that timely pumping was occurring.

Next Steps/Recommendations/Outcomes:

We continue to audit, monitor and support the mother's choice of pumping.

Submitted by Name: Melissa Filiponi, RNC-MNN, BSN

Date Submitted: 07/09/2021

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: **2E Labor and Delivery**

ProStaff/QIC Report Date: **January 2021 to June 2021**

Measure Objective/Goal:

1. Early Elective Induction of patient with no medical indication
    a. **Goal is 0%**
2. Decision to ready time for unscheduled Cesareans Sections less than or equal to 30 minutes
    a. **Goal is 90%**
3. Pitocin use for labor induction/augmentation to be started in less than or equal to 1 hour of order received
    a. Goal is 90%
4. Pitocin increased by 2 mu/min every 30 minutes until regular uterine contractions achieved defined as contractions every 2-3 minutes, lasting 80-90 seconds
    a. Goal is 90%
5. Consistent documentation of Montevideo units montevideo units when an intrauterine pressure catheter is used.
    a. **Goal is 90%**

Date range of data evaluated:

January 2021 to June 2021 Measures 3-5 are new measures.

Analysis of all measures/data: (Include key findings, improvements, opportunities)
(If this is not a new measure please include data from your previous reports through your current report):

1. **Goal met at 0%** – Will continue to monitor
    a. Prior reporting July 2020 to December 2020 met goal at 0%
2. **Goal not met at 63%** - Improvements have been made since last report with completion of ISS documentation changes. Education of staff was completed in February on the documentation changes and definition of decision time and ready time.
    a. Prior reporting July 2020 to December 2020 partially met goal at 60%.

3. **Goal not met at 72%**
4. **Goal not met 72%**

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

5. **Goal Met at 94%**

If improvement opportunities identified, provide action plan and expected resolution data Next Steps/Recommendations/Outcomes:

1. Goal met no interventions, continue to monitor.

2. Continue to monitor and follow up with staff in the moment to educate and coach. Also in the process of making documentation appear “face up” to make it easier to remember to document this piece.

3. Pitocin started less thanor equal to 1 hour of order: Will continue to monitor and follow up with staff in the moment if possible or after the fact if necessary. Identify barriers to staff starting on time. Report monthly to maintain at or better than benchmark.

4. Pitocin increased by 2 mu/min every 30 min until regular contractions: Will continue to monitor and follow up with staff in the moment if possible or after if necessary. Identify barriers to staff starting on time. Report monthly to UBC to get feedback and via prostaff.

5. Goal met, no intervention needed. Continue to monitor.

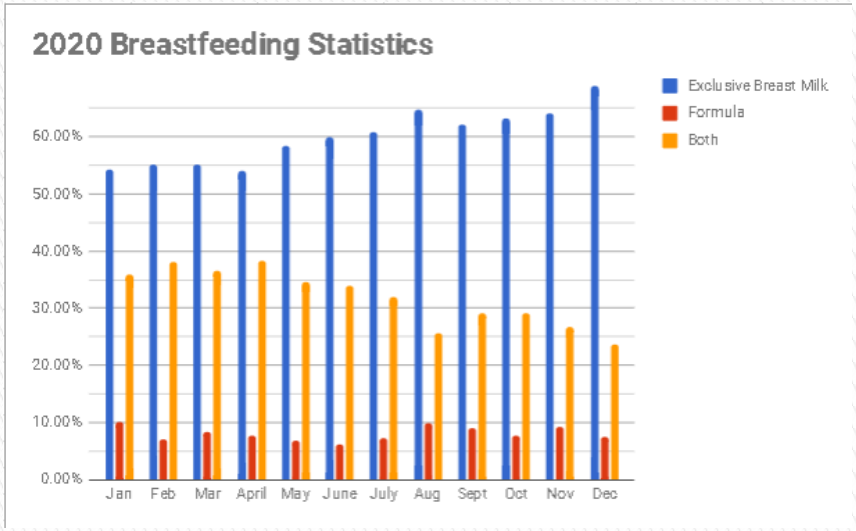
Submitted by Name: **Roberta DeCosta** **Date Submitted:** **7-2-2021**

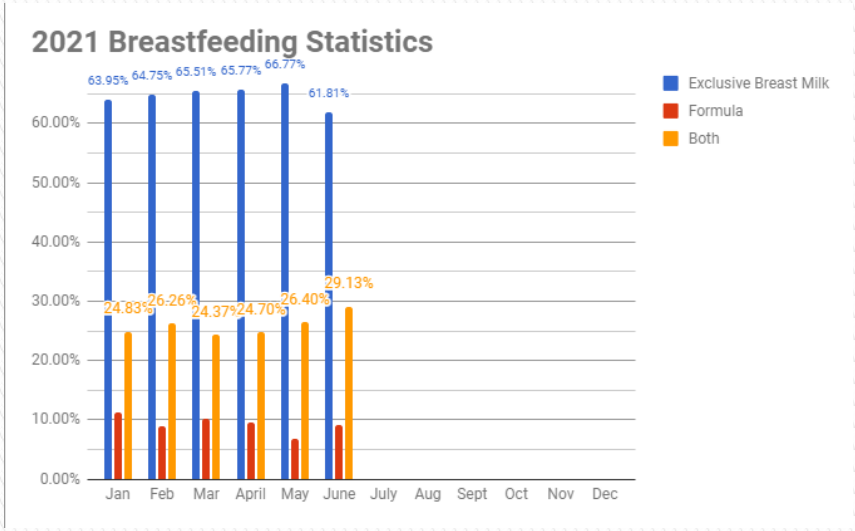
Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Mother/Baby Quality Data

January – June 2021

Breastfeeding Stats

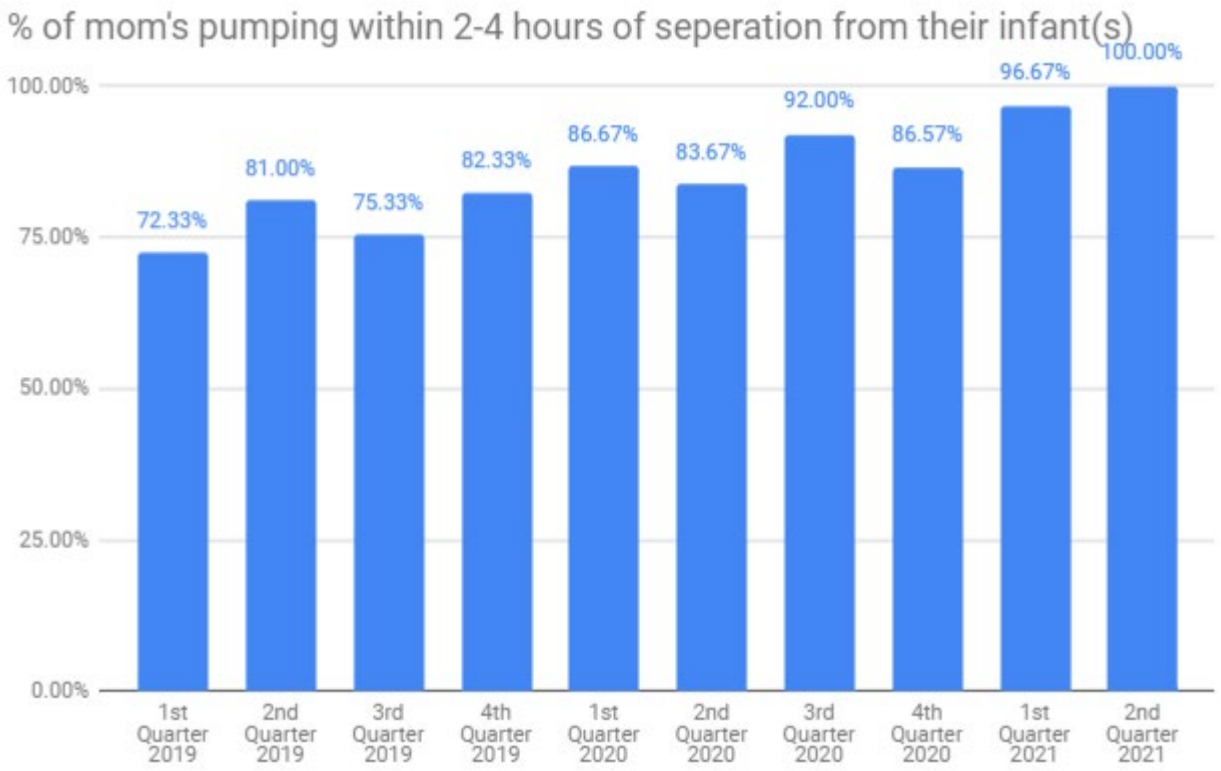




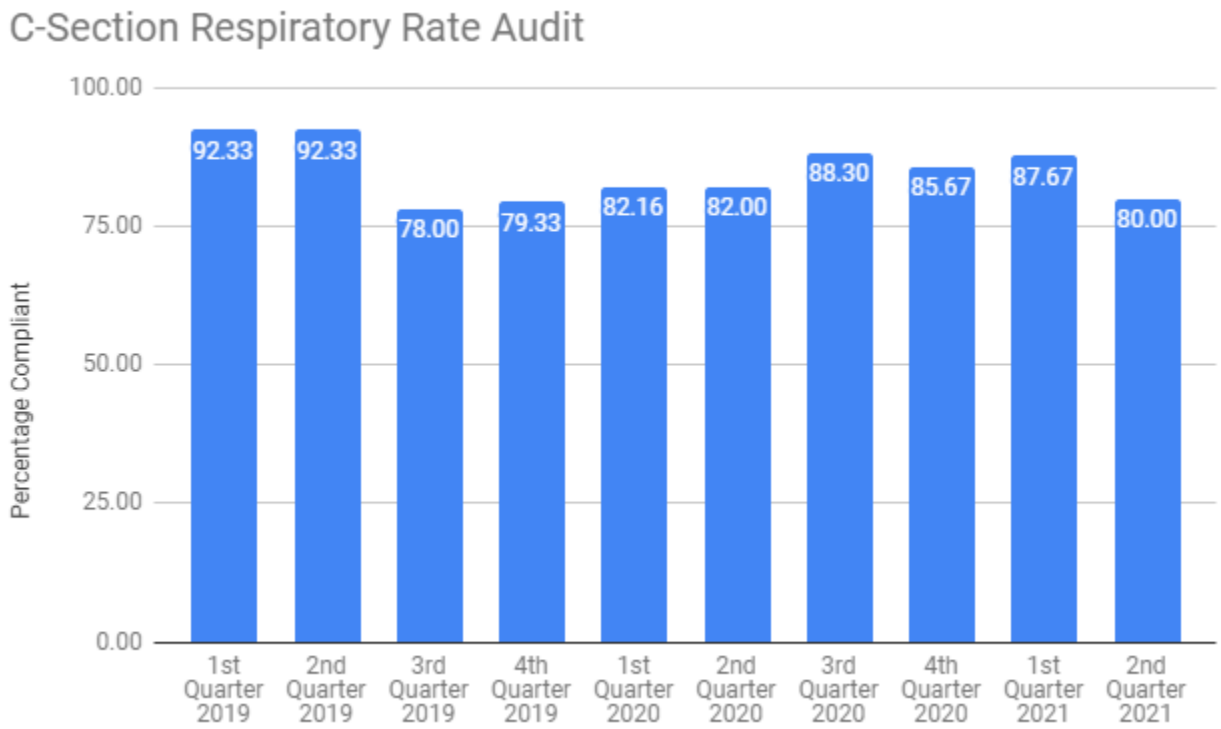
2020

2021

NICU MOM'S PUMPING



C-SECTION RESPIRATORY RATE AUDIT



Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Pediatrics **ProStaff Report Date: July 2021**

Measure Objective/Goal:
Total Patient Falls per 1000 patient days
Goal: 0.90
Goal met

Date range of data evaluated:
January-June 2021

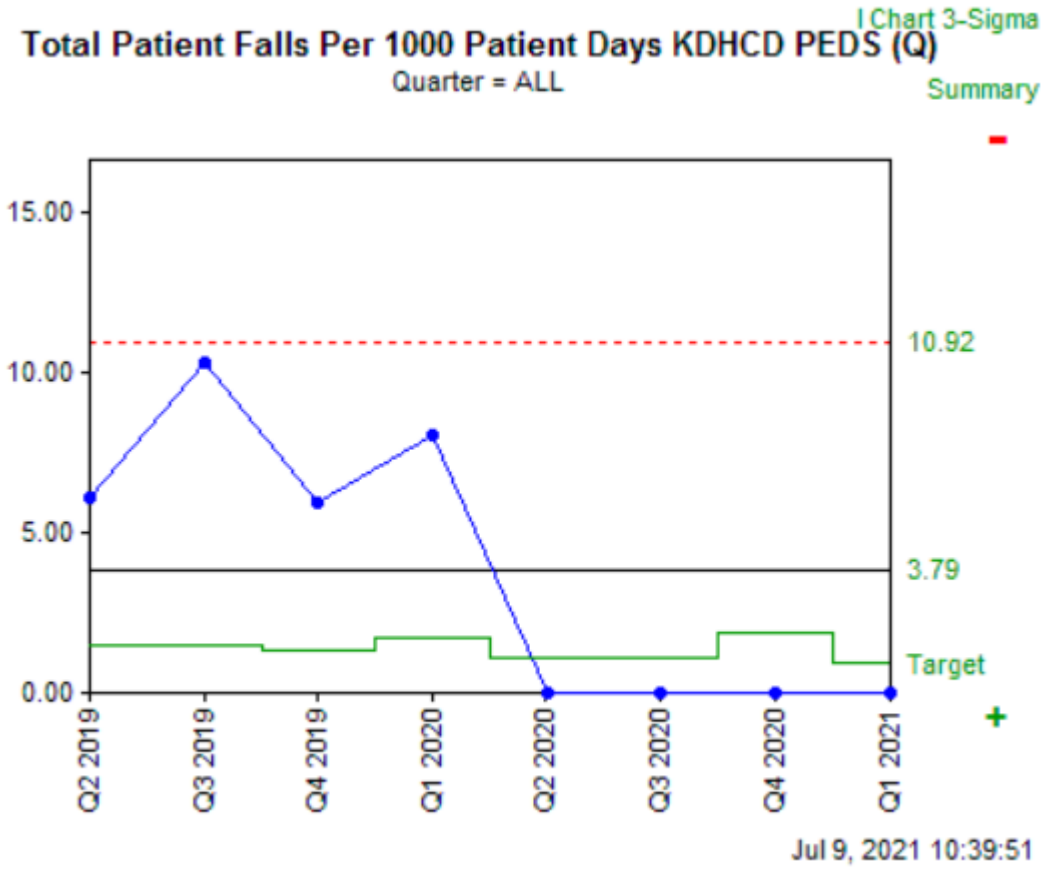
Analysis of all measures/data: (Include key findings, improvements, opportunities)
We have 0 Patient falls during this quarter. This is better than the benchmark.

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

Next Steps/Recommendations/Outcomes:
We will continue to implement fall risk precautions and educate families on safe sleep as well as monitored activities within room by caregiver. We will continue to have parents sign waivers when they decline Safe Sleep.

Submitted by Name:	**Date Submitted**
Danielle Grimaldi, RN, BSN, CPN	07/09/21

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



Date	KDHCD	Target
Q1 2021	0.00	0.90
Q4 2020	0.00	1.84
Q3 2020	0.00	1.10
Q2 2020	0.00	1.09
Q1 2020	8.02	1.68
Q4 2019	5.92	1.34
Q3 2019	10.31	1.47
Q2 2019	6.06	1.46

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Pediatrics **ProStaff Report Date: July 2021**

Measure Objective/Goal:
Injury Falls per 1000 patient days
Goal: 0.13
Goal Met

Date range of data evaluated:
January-June 2021

Analysis of all measures/data: (Include key findings, improvements, opportunities)
We had 0 injury falls during this quarter. This is better than benchmark for Injury Falls per 1000 patient days during this data range.

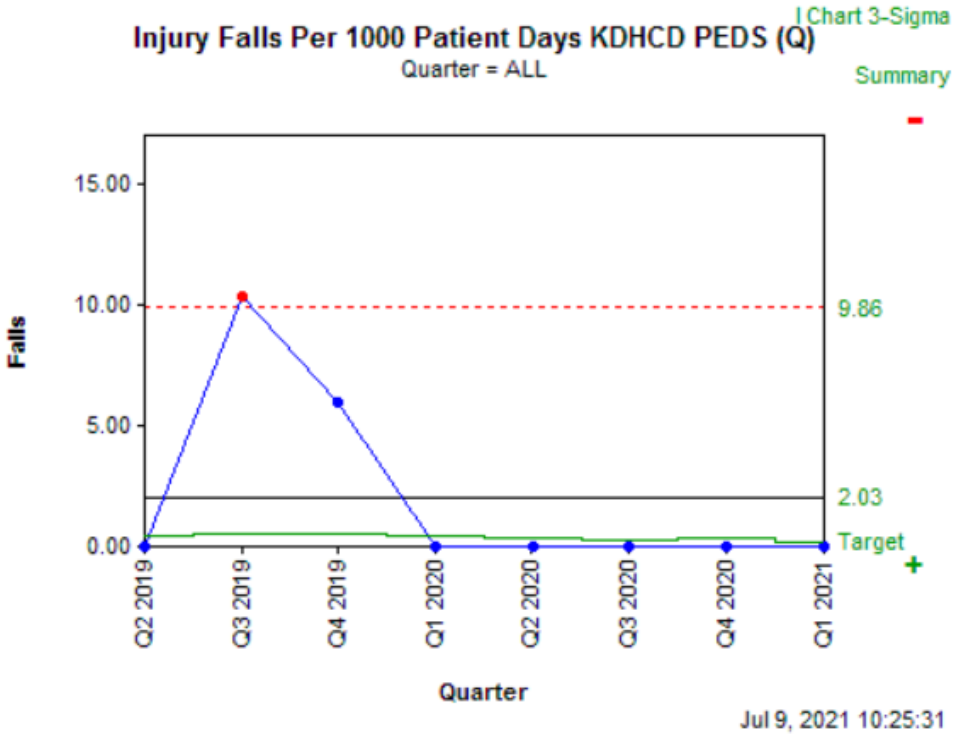
If improvement opportunities identified, provide action plan and expected resolution date:

Next Steps/Recommendations/Outcomes:
We will continue to implement fall risk precautions and educate families on safe sleep as well as monitored activities within room by caregiver. We will continue to have parents sign waivers when they decline Safe Sleep. We will trial using soft play mats on the floor next to the bedside of active toddlers.

Submitted by Name: Danielle Grimaldi, RN, BSN, CPN

Date Submitted: 07/09/21

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



Quarter	Falls	Target
Q1 2021	0.00	0.13
Q4 2020	0.00	0.30
Q3 2020	0.00	0.27
Q2 2020	0.00	0.33
Q1 2020	0.00	0.44
Q4 2019	5.92	0.51
Q3 2019	10.31	0.53
Q2 2019	0.00	0.42

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Pediatrics **ProStaff Report Date: July 2021**

Measure Objective/Goal:

Percent of PEWS fallouts-PEWS score charted every 4 hours on every patient.
Goal: 90% or greater no fallouts.
Goal Met

Date range of data evaluated:

January-June 2021

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

Using data received within the last 180 days, we have had a 96% success rate in PEWS score being charted every 4 hours. Results are better than benchmark for PEWS score.

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

Next Steps/Recommendations/Outcomes:

Continue to maintain PEWS scoring greater than 90% expected with next report date.

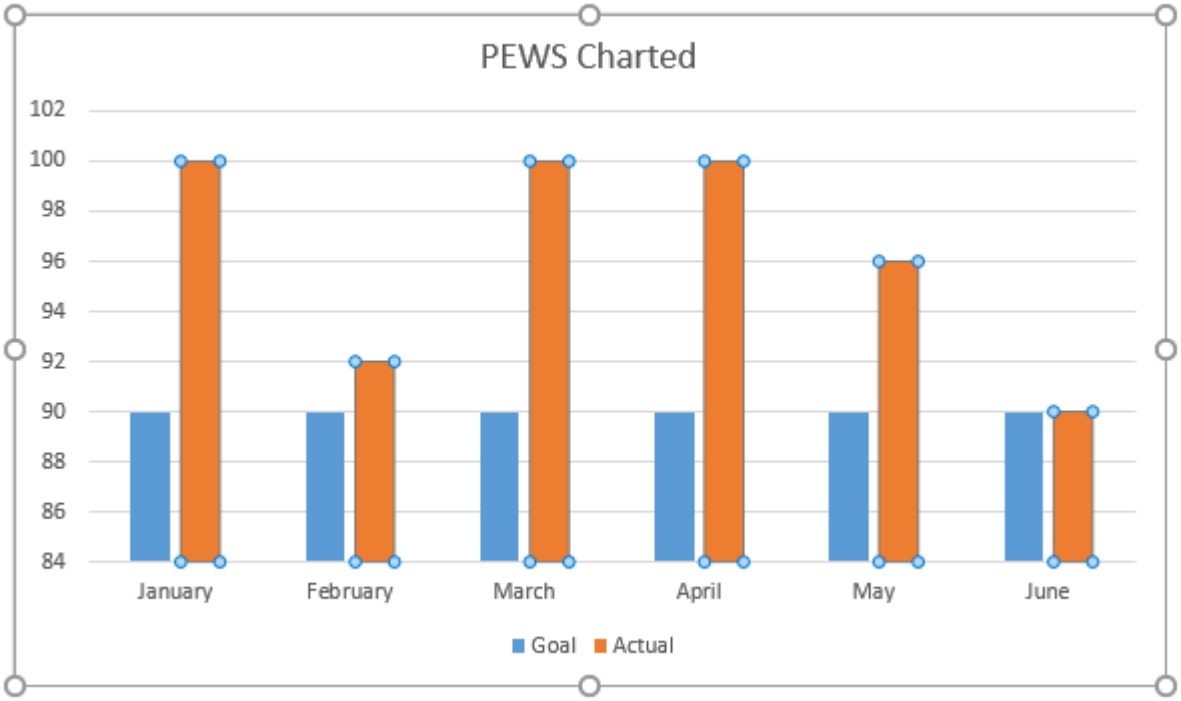
Submitted by Name: Danielle Grimaldi, RN, BSN, CPN

Date Submitted: 07/09/21

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee



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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Pediatrics **ProStaff Report Date: July 2021**

Measure Objective/Goal:

Hand Hygiene- Compliance KDMC PEDS
Goal: 95%
Goal Met.

Date range of data evaluated:

January-June 2021

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

Using data received within the last 180 days, we have had a 97.5% success rate in hand hygiene compliance. Results are better than benchmark for hand hygiene compliance goal.

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

Next Steps/Recommendations/Outcomes:

Continue to maintain hand hygiene compliance scoring greater than 95% expected with next report date.

Submitted by Name: Danielle Grimaldi, RN, BSN, CPN

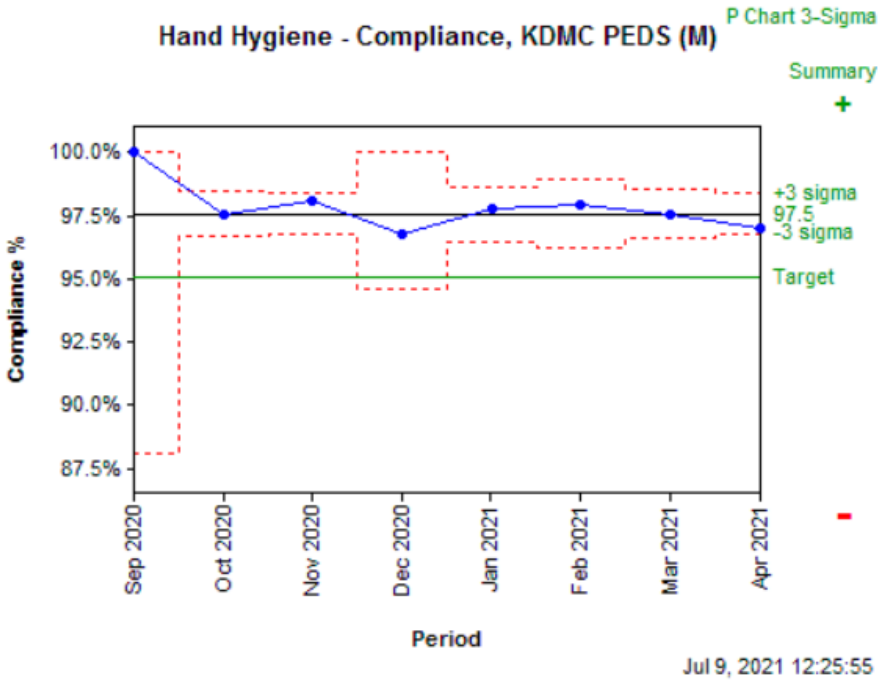
Date Submitted: 07/09/21

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Period	# Compliant	# Screens	Compliance %
Apr 2021	3414	3521	97.0%
Mar 2021	2177	2232	97.5%
Feb 2021	1171	1196	97.9%
Jan 2021	1797	1838	97.8%
Dec 2020	240	248	96.8%
Nov 2020	2961	3020	98.0%
Oct 2020	2721	2791	97.5%
Sep 2020	24	24	100.0%



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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Pediatrics **ProStaff Report Date: July 2021**

Measure Objective/Goal:

Percent of patients with stage 2 or greater HAPI: 0.00
Goal: 0.26
Goal Met

Date range of data evaluated:

January-June 2021

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

We had 0 HAPIs stage 2 or greater for this quarter. This is better than the benchmark.

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

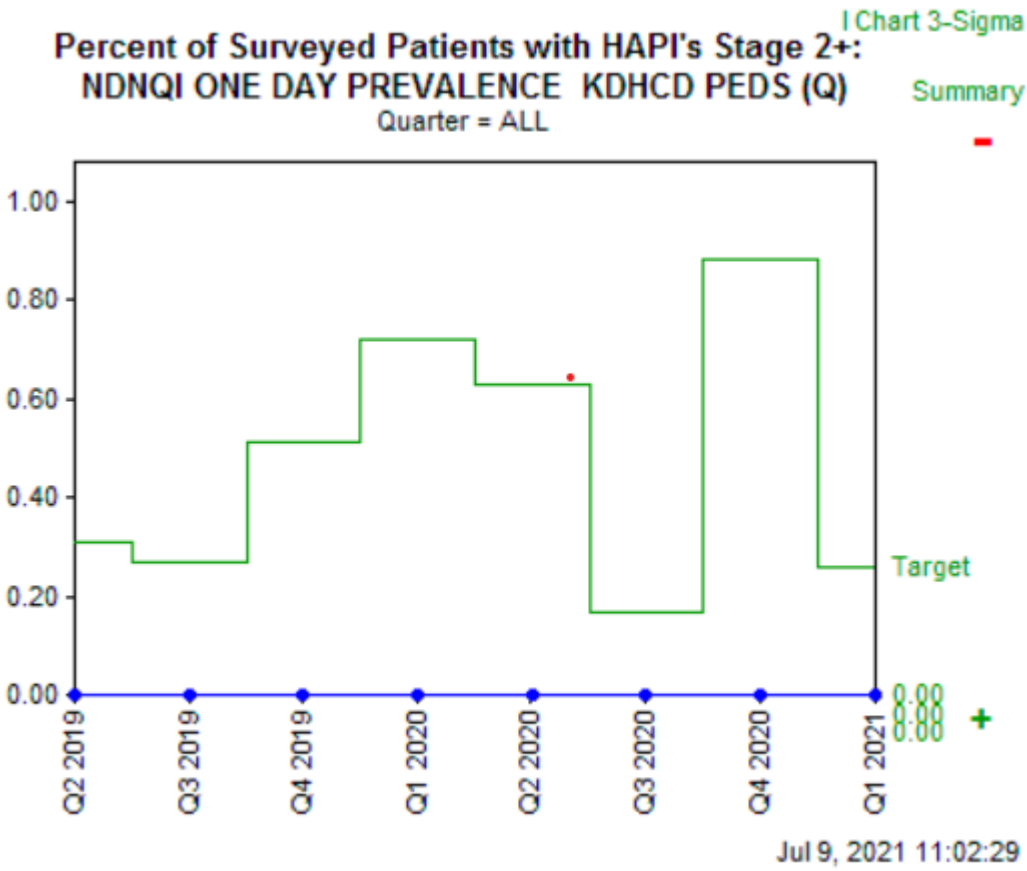
Next Steps/Recommendations/Outcomes:

We will continue identifying patients at risk for skin breakdown and implement appropriate preventative measures.

Submitted by Name: Danielle Grimaldi, RN, BSN, CPN

Date Submitted: 07/09/21

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



Date	KDHCD	Target
Q1 2021	0.00	0.26
Q4 2020	0.00	0.88
Q3 2020	0.00	0.17
Q2 2020	0.00	0.63
Q1 2020	0.00	0.72
Q4 2019	0.00	0.51
Q3 2019	0.00	0.27
Q2 2019	0.00	0.31

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Pediatrics **ProStaff Report Date: July 2021**

Measure Objective/Goal:

Catheter Associated Urinary Tract Infection
Goal: 0.00
Goal met.

Date range of data evaluated:

January-June 2021

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

We had 0 CAUTIs for this quarter. We are performing equal to the benchmark.

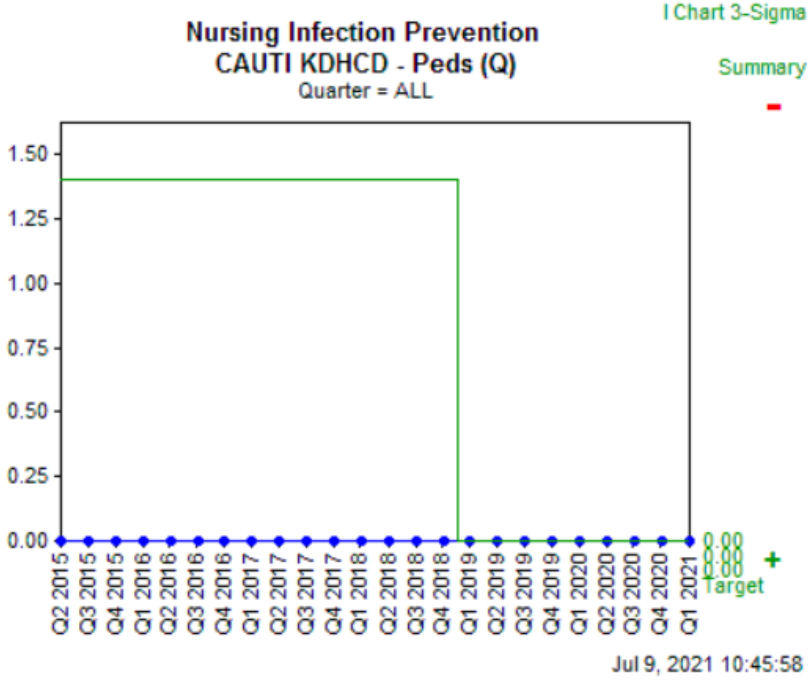
If improvement opportunities identified, provide action plan and expected resolution date:

Next Steps/Recommendations/Outcomes:

We will continue to use aseptic technique to insert urinary catheters, and we will continue to provide perineal care every shift. We will also continue to evaluate need for urinary catheter on a daily basis.

Submitted by Name: Danielle Grimaldi, RN, BSN, CPN

Date Submitted: 07/09/21



Date	KDHCD	Target
Q1 2021	0.00	0.00
Q4 2020	0.00	0.00
Q3 2020	0.00	0.00
Q2 2020	0.00	0.00
Q1 2020	0.00	0.00
Q4 2019	0.00	0.00
Q3 2019	0.00	0.00
Q2 2019	0.00	0.00
Q1 2019	0.00	0.00
Q4 2018	0.00	1.40
Q3 2018	0.00	1.40
Q2 2018	0.00	1.40
Q1 2018	0.00	1.40
Q4 2017	0.00	1.40
Q3 2017	0.00	1.40
Q2 2017	0.00	1.40
Q1 2017	0.00	1.40
Q4 2016	0.00	1.40
Q3 2016	0.00	1.40
Q2 2016	0.00	1.40
Q1 2016	0.00	1.40
Q4 2015	0.00	1.40
Q3 2015	0.00	1.40
Q2 2015	0.00	1.40

Unit/Department Specific Data Collection Summarization

Unit/Department: Pediatrics **ProStaff Report Date: July 2021**

Measure Objective/Goal:
Central Line Associated Blood Infections
Goal: 0.00
Goal Met.

Date range of data evaluated:
January-June 2021

Analysis of all measures/data: (Include key findings, improvements, opportunities)
We had 0 CLABSIs for this quarter. We are performing equal with the benchmark.

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

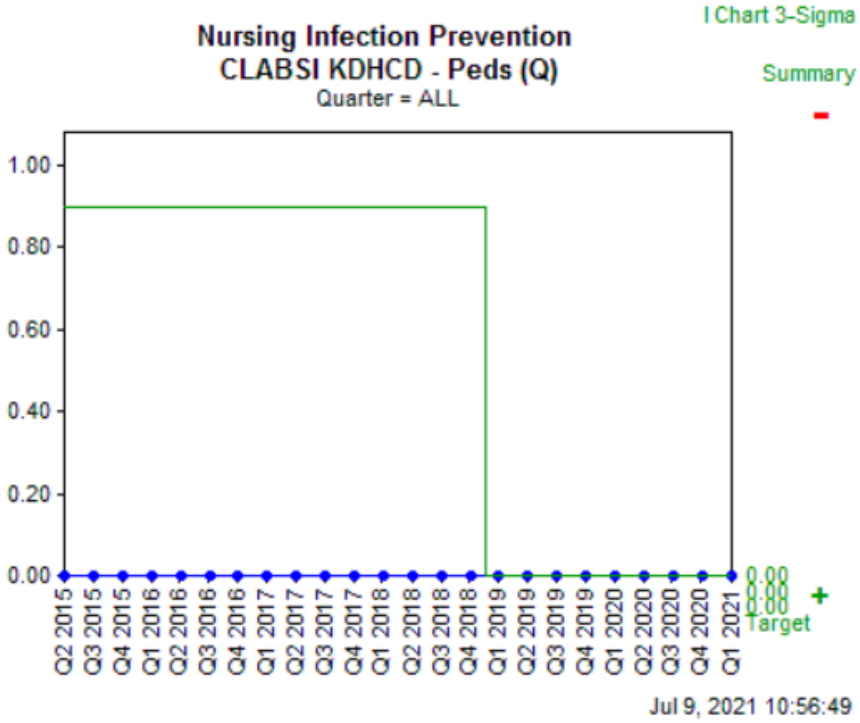
Next Steps/Recommendations/Outcomes:
We will continue to use aseptic technique to perform scheduled dressing and cap changes. We will also continue to evaluate need for central line on a daily basis.

Submitted by Name: Danielle Grimaldi, RN, BSN, CPN

Date Submitted: 07/09/21

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

Unit/Department Specific Data Collection Summarization



Date	KDHCD	Target
Q1 2021	0.00	0.00
Q4 2020	0.00	0.00
Q3 2020	0.00	0.00
Q2 2020	0.00	0.00
Q1 2020	0.00	0.00
Q4 2019	0.00	0.00
Q3 2019	0.00	0.00
Q2 2019	0.00	0.00
Q1 2019	0.00	0.00
Q4 2018	0.00	0.90
Q3 2018	0.00	0.90
Q2 2018	0.00	0.90
Q1 2018	0.00	0.90
Q4 2017	0.00	0.90
Q3 2017	0.00	0.90
Q2 2017	0.00	0.90
Q1 2017	0.00	0.90
Q4 2016	0.00	0.90
Q3 2016	0.00	0.90
Q2 2016	0.00	0.90
Q1 2016	0.00	0.90
Q4 2015	0.00	0.90
Q3 2015	0.00	0.90
Q2 2015	0.00	0.90

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: ***NICU*** **ProStaff/QIC Report Date:** *July, 2021*

Measure Objective/Goal:

1. *CLABSI per 1000 device days: Goal-Meet or exceed benchmark*
2. *VAP per 1000 ventilator device days: Goal-Meet or exceeds benchmark*
3. *Monthly hand hygiene compliance: Goal-Meet or exceeds benchmark*

Date range of data evaluated:

January 2021 through June 2021 (Central line days and vent days for entire year)

Analysis of all measures/data: (Include key findings, improvements, opportunities)
(If this is not a new measure please include data from your previous reports through your current report):

1. *KD NICU 0/1000 central line days. No CLABSI in 25 months. 318 Central line days in this reporting timeframe.* ***Goal met.***

CLASBI Rate for KDMC NICU 2021

Month	Indicator Value	Benchmark Value	Central line days in this month	# of CLABSI	Year to date # of Central Line Days
1st quarter					
January	0/1000	1.32/1000	26	0	26
February	0/1000	1.32/1000	29	0	55
March	0/1000	1.32/1000	54	0	109
2nd Quarter					
April	0/1000	1.32/1000	50	0	159
May	0/1000	1.32/1000	77	0	236
June	1/1000	1.32/1000	82	0	318

2. *KD NICU VAP- No VAP in the NICU. 52 vent days in this reporting timeframe.* ***Goal met***

VAP Rate NICU 2021

1st Quarter	Indicator Value	Benchmark Value	Vent Days
January	0	1.15/1000	0
February	0	1.15/1000	0
March	0	1.15/1000	8
			Total Vent days-8
2nd Quarter			
April	0	1.15/1000	7
May	0	1.15/1000	19
June	0	1.15/1000	18
			Total Vent days-44

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

3. *Monthly Hand Hygiene Opportunities > 96%- Over all Hand Hygiene date for the given reporting timeframe-99.65%.* ***Goal met***

BIOVIGIL®
Kaweah Delta

Department Compliance by Month
1/1/2021 1:00:00 AM (-07:00) - 6/30/2021 5:01:00 PM (-07:00)

Department	Month	Compliant HHOs	Non Compliant HHOs	Total HH Os	Entry Com pliance	Exit Compli ance	Total Compli ance
Neonatal ICU-NICU	February 2021	4,276	16	4,292	99.5%	99.8%	99.6%
Neonatal ICU-NICU	March 2021	47,802	178	47,980	99.5%	99.8%	99.6%
Neonatal ICU-NICU	April 2021	41,562	136	41,698	99.6%	99.8%	99.7%
Neonatal ICU-NICU	May 2021	33,892	105	33,997	99.6%	99.8%	99.7%
Neonatal ICU-NICU	June 2021	14,970	63	15,033	99.3%	99.8%	99.6%
Total		***142,502***	***498***	***143,000***	***99.51%***	***99.79%***	***99.65%***

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

1. *Continue to participate in CLABSI collaborative. Maintain central line bundle. Report findings to CPQCC. Daily GEMBA rounding on all central lines.*
2. *NICU VAP policy and bundle in place.*
3. *Soap and water as well as hand sanitizer available in every patient room. Continue to monitor compliance beyond reporting requirements. Include NICU parents in hand hygiene monitoring. Continue to monitor success and opportunities with Biovigil data.*

Next Steps/Recommendations/Outcomes:

1. *Continue with current standardized insertion practice and care of all central lines.*
2. *No VAP. Benchmark met; continue to support current P&P.*
3. *Continue to monitor HH compliance through Biovigil.*

Submitted by Name:
Felicia T. Vaughn

Date Submitted:
July 8th, 2021

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: **2E Labor and Delivery**

ProStaff/QIC Report Date: **January 2021 to June 2021**

Measure Objective/Goal:

1. Early Elective Induction of patient with no medical indication
    a. **Goal is 0%**
2. Decision to ready time for unscheduled Cesareans Sections less than or equal to 30 minutes
    a. **Goal is 90%**
3. Pitocin use for labor induction/augmentation to be started in less than or equal to 1 hour of order received
    a. Goal is 90%
4. Pitocin increased by 2 mu/min every 30 minutes until regular uterine contractions achieved defined as contractions every 2-3 minutes, lasting 80-90 seconds
    a. Goal is 90%
5. Consistent documentation of Montevideo units montevideo units when an intrauterine pressure catheter is used.
    a. **Goal is 90%**

Date range of data evaluated:

January 2021 to June 2021 Measures 3-5 are new measures.

Analysis of all measures/data: (Include key findings, improvements, opportunities)
(If this is not a new measure please include data from your previous reports through your current report):

1. **Goal met at 0%** – Will continue to monitor
    a. Prior reporting July 2020 to December 2020 met goal at 0%
2. **Goal not met at 63%** - Improvements have been made since last report with completion of ISS documentation changes. Education of staff was completed in February on the documentation changes and definition of decision time and ready time.
    a. Prior reporting July 2020 to December 2020 partially met goal at 60%.

3. **Goal not met at 72%**
4. **Goal not met 72%**

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

5. **Goal Met at 94%**

If improvement opportunities identified, provide action plan and expected resolution data Next Steps/Recommendations/Outcomes:

1. Goal met no interventions, continue to monitor.

2. Continue to monitor and follow up with staff in the moment to educate and coach. Also in the process of making documentation appear “face up” to make it easier to remember to document this piece.

3. Pitocin started less thanor equal to 1 hour of order: Will continue to monitor and follow up with staff in the moment if possible or after the fact if necessary. Identify barriers to staff starting on time. Report monthly to maintain at or better than benchmark.

4. Pitocin increased by 2 mu/min every 30 min until regular contractions: Will continue to monitor and follow up with staff in the moment if possible or after if necessary. Identify barriers to staff starting on time. Report monthly to UBC to get feedback and via prostaff.

5. Goal met, no intervention needed. Continue to monitor.

Submitted by Name: **Roberta DeCosta** **Date Submitted:** **7-2-2021**

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

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Unit/Department: HAPI QFT & Inpatient Wound Prevention **Report Date:** November 2021

Measure Objective / Goal:

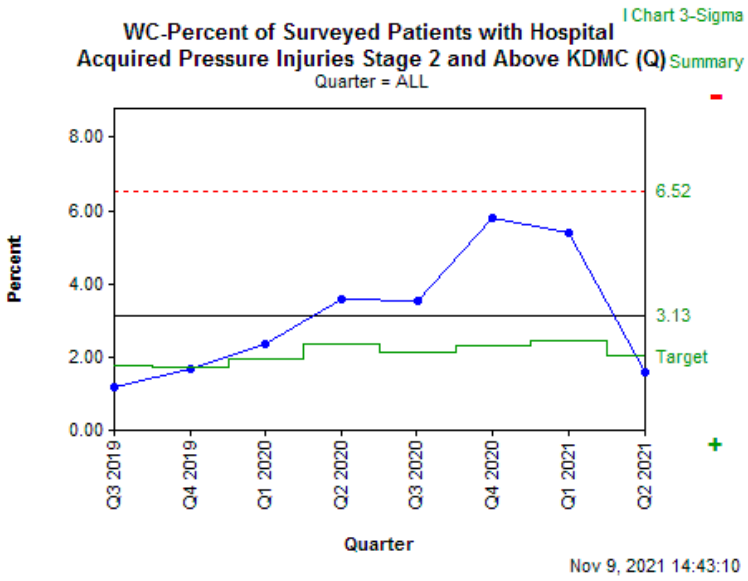
The National Database of Nursing Quality Indicators® (NDNQI) Prevalence Study

After much deliberation among the quality and wound care teams, we have determined that we will no longer continue to hold our quarterly prevalence studies. We have developed an in house dashboard that provides much more relevant data that gives us a more accurate picture of how are teams are doing with HAPIs. This will be the last time we report the prevalence study data to this committee.

Indicator #1 NDNQI Prevalence Study – Percent Stage 2+ HAPI in Surveyed Patients

Goal Outperform national target metric

Date Range Q2 2021



Quarter	Percent	Target
Q2 2021	1.57	2.02
Q1 2021	5.38	2.43
Q4 2020	5.80	2.30
Q3 2020	3.54	2.11
Q2 2020	3.57	2.34
Q1 2020	2.35	1.96
Q4 2019	1.65	1.71
Q3 2019	1.16	1.74

Analysis of Measures / Data: (include key findings, improvements, opportunities)

∅ **Goal #1** Not Met: Q1 2021 (5.38) underperforms compared to national target benchmark (2.43)

∅ **Goal #1** Met: Q2 2021 (1.57) over performs compared to national target benchmark (2.02)

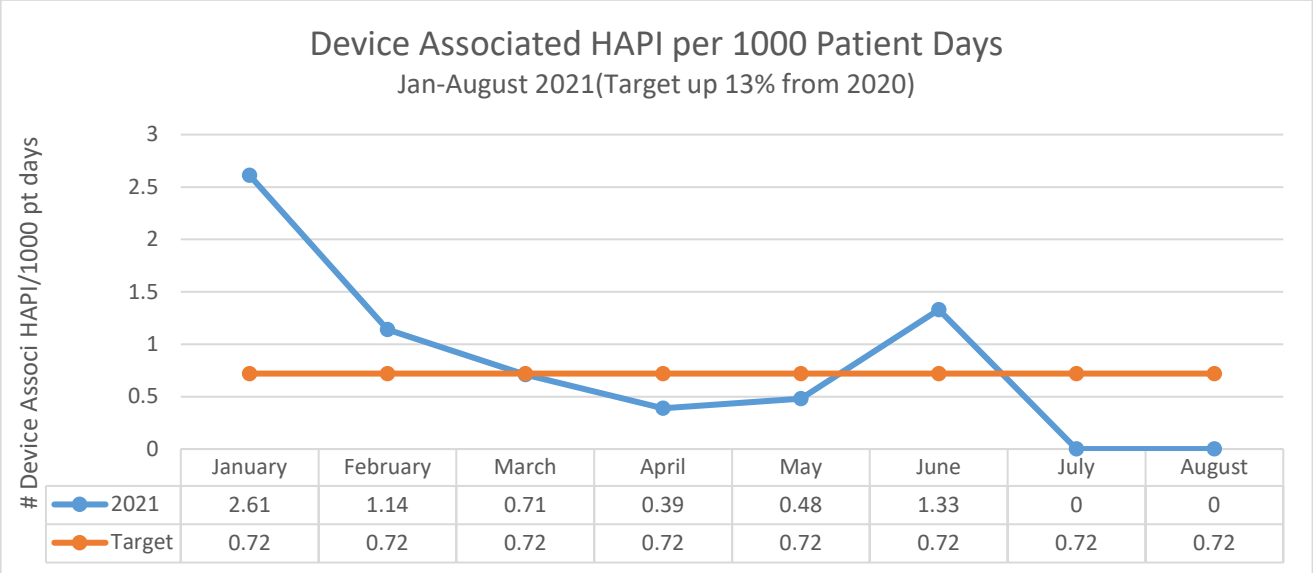
- Quarter 1 2021 quarter shows a slight reduction (.42%) in HAPI Stage 2+ compared to Q4 2020 as January continued to remain high due to COVID surge.
- Quarter 2 2021 shows a drastic improvement in HAPI Stage 2+ compared to Q1 2021. Number of COVID had diminished by this time.

Hospital Acquired Pressure Injuries (HAPI), Total and Device-Related
Incidence data compiled from staff/unit-level self-report, with and without prompting from wound nurse consultant. Includes Stage 1-4, unstageable, suspected deep tissue pressure injury (DTPI).

Indicator #2 Device Associated HAPI per 1000 Patient Days

Goal 0.59 (-20% from 2019)

Date Range January 2021 – August 2021



	January	February	March	April	May	June	July	August
2021	2.61	1.14	0.71	0.39	0.48	1.33	0	0
Target	0.72	0.72	0.72	0.72	0.72	0.72	0.72	0.72

Analysis of Measures / Data: (include key findings, improvements, opportunities)

Ø **Goal #2** Met: July (0), and August (0).But due to January 2021 results, YTD above target (0.84)

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

HAPI Stage 2+ QFT Dashboard

Measure Description Outcome Measures	Benchmark/ Target	2019 Baseline	2020	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	YTD 2021
HAPI Stage 2+ per 1,000 pt days (all HAPIs)	1.31 (-20% from 2019)	1.64	1.61	3.52	1.39	2.14	0.91	1.32	3.15	0.36	0.44	1.66
Device Associated HAPI per 1,000 pt	0.59 (-20% from 2019)	0.74	0.72	2.61	1.14	0.71	0.39	0.48	1.33	0	0	0.84
NDNQI % Surveyed Patients Stage 2+ (1 day prevalence per quarter)	**2.43** (1Q 2021) **2.02** (2Q 2021)	2.62	3.76			5.38			1.57			3.50
PSI 3 - Claims-based HAPI Stage 3, 4, and Unstageable per 1,000 discharges	**0.6** - Hospital Compare (Q3 2017-Q2 2019) **0.35** - Midar 50th Percentile (2019)	0.79	0.95	0	1.11	1.10	0	1.15	2.12	0	0	0.68
Process Measures												
Respiratory Device associated HAPI 2+ per 1,000 pt days			0.44	2.50	0.63	0.71	0.26	0.24	0.12	0	0	0.57
% of Respiratory Device associated HAPI's 2+ (out of all of the device associated HAPI's 2+)			61%	96%	55%	100%	67%	50%	9%	0%	0%	68%
Unit Level	(-15% from 2019)											
4N - HAPI 2+ per 1,000 pt days	1.14	1.34	2.02	3.60	0.00	2.39	0.00	2.48	2.46	1.18	0.00	1.55
3W - HAPI 2+ per 1,000 pt days	1.92	2.26	3.2	15.13	1.55	5.44	4.21	1.88	1.96	0.00	0.00	3.97
ICU - HAPI 2+ per 1,000 pt days	6.04	7.1	7.44	8.87	7.23	15.77	2.35	4.63	11.16	2.23	1.87	6.73
CVICU - HAPI 2+ per 1,000 pt days	4.42	5.2	6.23	5.70	0.00	18.52	0.00	7.84	21.62	0.00	2.89	6.31
2N - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	0.1	0.22	2.37	0.00	0.00	1.31	1.15	1.19	0.00	1.15	0.92
2S - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	0.7	1.51	5.04	1.46	0.00	0.00	0.00	4.74	0.00	0.00	1.47
3N - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	0.86	0.72	0.00	2.23	0.00	2.14	0.00	3.96	1.00	0.00	1.16
3S - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	0.46	0.50	0.00	0.00	0.00	0.00	1.05	0.00	0.00	0.00	0.14
4S - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	1.37	0.66	3.22	0.00	1.07	0.00	2.07	5.46	0.00	0.00	1.48
4T - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	1.23	0.45	0.00	0.00	0.00	1.76	0.00	0.00	0.00	0.00	0.21
BP - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	0	0.62	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Rehab - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	0.75	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
5T - HAPI 2+ per 1,000 pt days	n/a		0.4	2.61	6.25	0.00	0.00	0.00	2.49	0.00	1.30	1.51
Other Units												
ED	n/a	4	3	0	0	0	0	0	0	0	0	0
Sub-Acute	n/a	5	6	0	0	0	0	0	0	0	1	1
Surgery	n/a	6	0	0	0	0	0	0	0	0	0	0
Cath Lab	n/a	1	0	0	0	0	0	0	0	0	0	0
Pediatrics	n/a	0	0	1	1	0	0	0	0	0	0	2
Mother Baby	n/a	1	0	0	0	0	0	0	0	0	0	0
Transitional Care (South Campus)	n/a	1	1	0	0	0	0	0	0	1	0	1

Green	Better than Target
Yellow	Within 10% of Target
Red	Does not meet Target

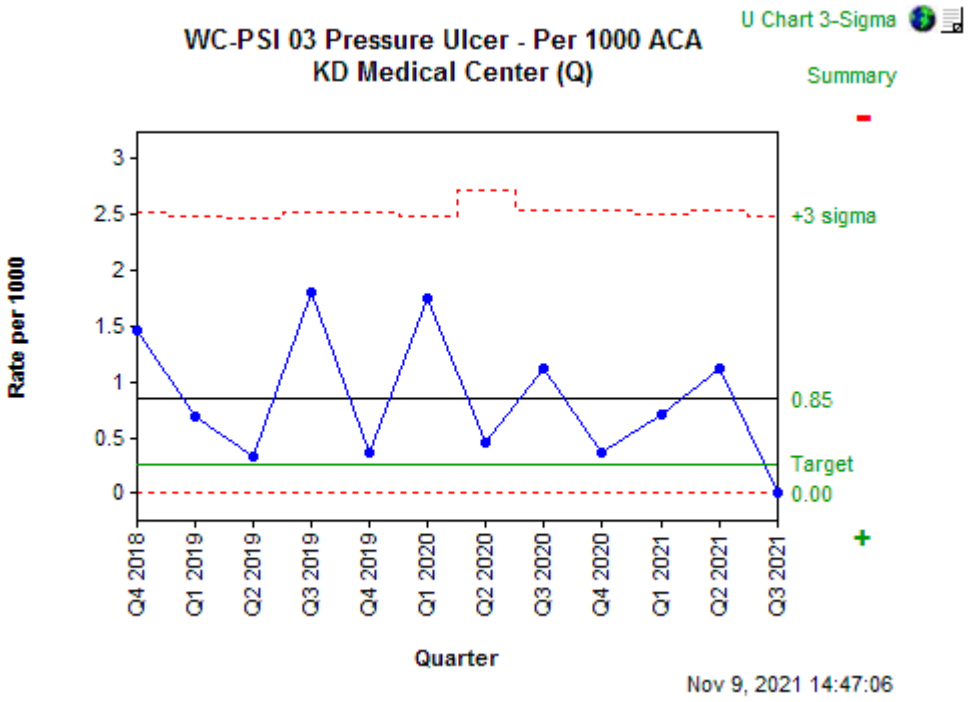
PSI 03: Pressure Ulcer Rate

Pressure ulcers have been associated with an extended length of hospitalization, sepsis, and mortality. The Agency for Healthcare Research and Quality (AHRQ) developed measures that health providers use to identify potential in-hospital patient safety problems for targeted institution-level quality improvement efforts. Patient Safety Indicator (PSI) 03 includes stage 3 or 4 pressure ulcers or unstageable (secondary diagnosis) per 1000 discharges among surgical or medical patients ages 18 years and older. *Exclusions: stays less than 3 days; cases with principal stage 3 or 4 (or unstageable) pressure ulcer diagnosis; cases with a secondary diagnosis of stage 3 or 4 pressure ulcer (or unstageable) that is present on admission; obstetric cases; severe burns; exfoliative skin disorders.*

Indicator #3 PSI-03 Claim-based HAPI Stage 3, 4, Unstageable per 1000 discharges

Goal 0.6 (Hospital Compare)

Date Range Q1 2021 – Q3 2021



Quarter	Numerator	Denominator	Rate per 1000
Q3 2021	0	2868.00	0.00
Q2 2021	3	2671.00	1.12
Q1 2021	2	2800.00	0.71

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Analysis of Measures / Data: (include key findings, improvements, opportunities)

- ∅ **Goal #3** Not Met for Quarter 1 2021 (0.71)
- ∅ **Goal #3** Not Met for Quarter 2 2021 (1.12)
- ∅ **Goal #3** Met for Quarter 3 2021 (0.00)

Improvement Opportunities Identified, Action Plan and Expected Resolution Date / Next Steps, Recommendations, Outcomes:

Ongoing

- ✓ Continue GEMBA rounds on critical care floors.

- ✓ Work with HAPI QFT team to focus on turning and repositioning as our quality focus for November and December. Work on initiatives to educate and ensure proper turning and repositioning is occurring and documented in medical record. Will create a subcommittee to work on initiatives.

- ✓ CSI has been put on hold due to COVID surge. Have continued to require RCA worksheets from each floor to be sent to wound team and discussed. Will reconvene CSI as soon as we see our COVID numbers trending down.

- ✓ NDNQI One day prevalence study will be suspended permanently at this time. Will continue to report numbers through our dashboard and work with quality on creating an internal benchmark from previous data we have from NDNQI.

Work in Progress

- ☐ In partnership with Quality & Patient Safety Team, will look at completing a 5-day Kaizen before the end of the calendar year 2021.

Submitted By: **Date Submitted:** November 9, 2021

Rebekah Foster, Director of Care Management and Specialty Care

Handoff Quality Focus Team 03/08/2021

Kassie Waters, Director of Cardiac Critical Care Services

Kaweah Health
MORE THAN MEDICINE. LIFE.

Team Mission

Implement standardize structure for nurse to nurse handoff when admitting a patient from the Emergency Department to in-patient departments.

Standardize structure will:
- Include critical content to eliminate communication errors.
- Provide accurate and complete information to the receiver.
- Meet the needs of the sender and receiver to handoff and receive care.
-Accomplish a timely handoff (transfer) of the patient to the admitting department by removing barriers.

Team Deliverables & Goals

Deliverables

1. Establish standard process
2. Standardize critical content elements
3. Build standard handoff tool utilizing EMR
4. Standardize training & education

Goals

<u>Quality of Handoff Measurement</u>

1. ED nurse "sender" provided accurate and complete information with 80% of handoffs (Current state is 15%)

<u>Timeliness of Admission/Handoff – Chartis ED to Inpatient Admission Team</u>

Timeliness of Admission/Handoff

Chartis Consulting Team

At Chartis, we're committed to helping healthcare organizations thrive.

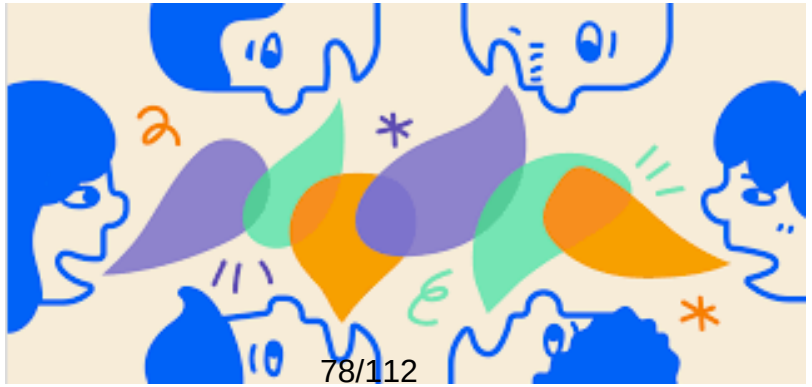
Our teams bring leading-edge subject matter expertise and proven approaches to the issues and opportunities facing healthcare today. We help our clients harness their experience, technology, data, and analytics to navigate through uncertainty—powerfully collaborating with them to define and execute their path forward. We call this Next Intelligence.

Consulting team is assessing ED throughput efficiencies and has been meeting with many staff members and touring departments to gather data (October).

Next Steps – Work with Chartis and form ED to Inpatient Admission Process team to work on efficiencies regarding timely throughput of admitted patients. More to come.

EMR Handoff Tool Update & Next Steps

1. ISS shared Cerner's new handoff update and best practices to committee. Committee approved to move forward with the build. DONE
2. Presented new handoff tool to Nursing Shared Decision group to obtain feedback. – DONE (March)
3. ISS to continue final build of handoff tool. (March-April)
4. Committee to establish education and rollout plan. Will assess competing factors and best date for rollout.
5. 30 days post implementation committee will gather data and assess effectiveness of handoff communication.



Questions?

Unit/Department: Kaweah Health – Diversion Prevention Committee

ProStaff/QIC Report Date: 11/12/2021

Measure Objective/Goal:

The Diversion Prevention Committee Goals include:

Develop organizational program to build awareness of and response to behaviors suspicious for drug diversion.

Build a culture within the organization of attention to drug diversion prevention.

Implement education into orientation and annual training related to drug diversion and awareness for all health care professionals.

Ensure accountability for action items related to routine audits and medication related reports by department leaders.

Use technology and automation to ensure reporting is routine and applicable.

Determine expected actions to be taken and communicate those actions to department leaders when abnormal reports are shared.

The Diversion Prevention Committees Measures of Success include:

Implementation of annual education, orientation education for employees and medical staff related to drug diversion.

Interviews of KDHCD team members and medical staff to determine understanding of the education and organizational expectations.

Development of a supervisor/leadership training program to provide enhanced skills for detecting and preventing diversion activities.

Compliance with audits outlined in CMS plan of correction.

Monthly review of audit dashboard reveals improvements in audit outcomes.

Timely follow-up by organizational leaders for action plans and identified improvements.

Date range of data evaluated:

Diversion Prevention Committee was formed in April of 2021. The initial goals were to increase awareness of the risk of diversion in the health care setting and to increase knowledge of the signs and symptoms of diversion. The committee was formed in response to a recognized need for education and monitoring after two unrelated diversion events were identified in the organization.

From September 2021 to November 2021 the following goals have been achieved:

- Leadership training created and implemented by Diversion Prevention Committee member.
    - Organization wide leadership training developed and scheduled to be delivered to leadership in November (delayed from September 2021 due to conflicting education

demands). Informal training and awareness delivered to leadership in July 2021 via the Leadership Meeting presentation, more formal education to be delivered via Netlearning CBL in November.

- Centers for Medicare/Medicaid Services post survey audits reporting into Diversion Prevention Committee have all demonstrated compliance. Monitoring has changed from monthly to spot checks for areas of concern as compliance requirements met in accordance with the plan of correction.

Analysis of all measures/data: (Include key findings, improvements, opportunities)
(If this is not a new measure please include data from your previous reports through your current report):

Plan of correction audits by pharmacy that reported into the Diversion Prevention Committee are successfully completed. They sustained compliance over three consecutive months and now will revert to spot-checking for sustainability. These audits are included at the end of this report for review.

New data and measures include effectiveness of education and implementation of BlueSight technology. These two data collection measures were initiative in November 2021. Based on findings, actions are developed and implemented. We anticipate needing to deliver additional education on recognizing diversion or other suspicious activities and reporting it immediately. We will closely watch trends in the BlueSight data for concerning practices. BlueSight software implementation is a collaborative project in the patient care areas and offers reports on all individuals with access to medication administration technologies such as PYXIS, Cerner documentation and medication handling. The leaders in patient care areas are provided daily reports of occurrences requiring routine follow-up to address practice issues and investigate concerns.

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

The Diversion Prevention Committee purpose is to identify opportunities and create action items on an ongoing basis. Action plans and dates will be identified in the next report based on data being collected now.

Next Steps/Recommendations/Outcomes:

Continue to monitor the effectiveness of the education through staff, provider and leader interviews by committee members.
Create additional education as needed based on audits and incident reports.
Monitor for abnormal events and increase surveillance by the organization staff and providers for unusual events reported.
Adopt new goals with the Diversion Prevention Committee to expand the scope of the program in the organization.
Incorporate Substance Abuse awareness and actions into the scope of the committee to support our teams.

Submitted by Name: Keri Noeske, VP Chief Nursing Officer **Date Submitted:** 11/15/2021

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

Best Practice Team Update

Michael Tedaldi, MD
Kaweah Health Medical Director of Best Practice Teams

Quality Council
March 2022

Kaweah Health Best Practice Teams Acronyms

- ACE - Angiotensin Converting Enzyme inhibitors(medication to treat heart failure)
- ARBs - Angiotensin-Receptor Blocker (medication to treat heart failure)
- ARNI - Angiotensin Receptor-Neprilysin Inhibitor (medication to treat heart failure)
- AMI NSTEMI – Non-ST Elevation Acute Myocardial Infarction
- BB – Beta Blocker (heart medication)
- CAP – Community Acquired Pneumonia
- CHFrEF (“reduced EF” or “systolic HF”)
- CKD – Chronic Kidney Disease
- CMS - Centers for Medicare & Medicaid Services
- COPD - Chronic Obstructive Pulmonary Disease
- CPG – Clinical Practice Guideline
- CPW – Care Pathway
- D - denominator
- ED – Emergency Department
- EF – Ejection Fraction
- EKG - electrocardiogram
- FYTD – Fiscal Year to Date
- GFR - glomerular filtration rate
- GOLD Standards - Global Initiative for Chronic Obstructive Lung Disease
- HF – Heart Failure
- KPI – Key Performance Indicator
- LOS – Length of stay
- N - Numerator
- O/E – Observed divided by Expected
- PN – Pneumonia
- QI - Quality Improvement
- SARA - Selective Aldosterone Receptor Antagonist

Kaweah Health Best Practice Teams

Goal: Improve patient outcomes by standardizing care on 4 key patient populations (AMI- NSTEMI, COPD, HF & PN)

- Standardized care based on Clinical Practice Guideline (CPGs) and operationalize the standardized care through Care Pathways, provider power plans and new Cerner functionality (Care Pathways)
- 4 “Core Teams” established for each population, includes Medical Director, Quality Facilitator, Operational Director & Advanced Nurse Practitioner (APN)
- Outcomes include: Mortality, Readmission and Length of Stay

Best Practice Teams

AMI (non-STEMI), COPD, Heart Failure & Pneumonia

Clinical Practice Guidelines (CPGs)

Institute of Medicine - "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances." They may offer concise instructions on which diagnostic or screening tests to order, how to provide medical or surgical services, how long patients should stay in hospital, or other details of clinical practice.

Clinical Pathways (CPWs)

Clinical pathways (CPWs) are tools used to guide evidence-based healthcare. Their aim is to translate clinical practice guideline recommendations into clinical processes of care within the unique culture and environment of a healthcare institution.
A CPW is a structured multidisciplinary care plan with the following characteristics:

1. it is used to translate guidelines or evidence into local structures;
2. it details the steps in a course of treatment or care in a plan, pathway, algorithm, guideline, protocol or other "inventory of actions"; and
3. it aims to standardize care for a specific clinical problem, procedure or episode of healthcare in a specific population.

Rotter T, de Jong RB, Lacko SE, et al. Clinical pathways as a quality strategy. In: Busse R, Klazinga N, Panteli D, et al., editors. Improving healthcare quality in Europe: Characteristics, effectiveness and implementation of different strategies [Internet]. Copenhagen (Denmark): European Observatory on Health Systems and Policies; 2019. (Health Policy Series, No. 53.) 12. Available from: https://www.ncbi.nlm.nih.gov/books/NBK549262/

Best Practice Teams

AMI (non-STEMI), COPD, Heart Failure & Pneumonia

Initiation

- Prioritized & staggered
- Team identification: Q&P/S Facilitator, MD Champion, RN Director, process stakeholders
- Best Practice Guideline selection

Goal: Identify clinical processes that will yield optimal patient outcomes

Phase I

- Clinical KPIs Selection
- Measures defined
- Dashboard developed
- Initial QI work (ie. power plan optimization/ work flow) to achieve targets

Goal: Identify KPIs that will reduce mortality o/e & complications (2° LOS & Readmission)

Phase II

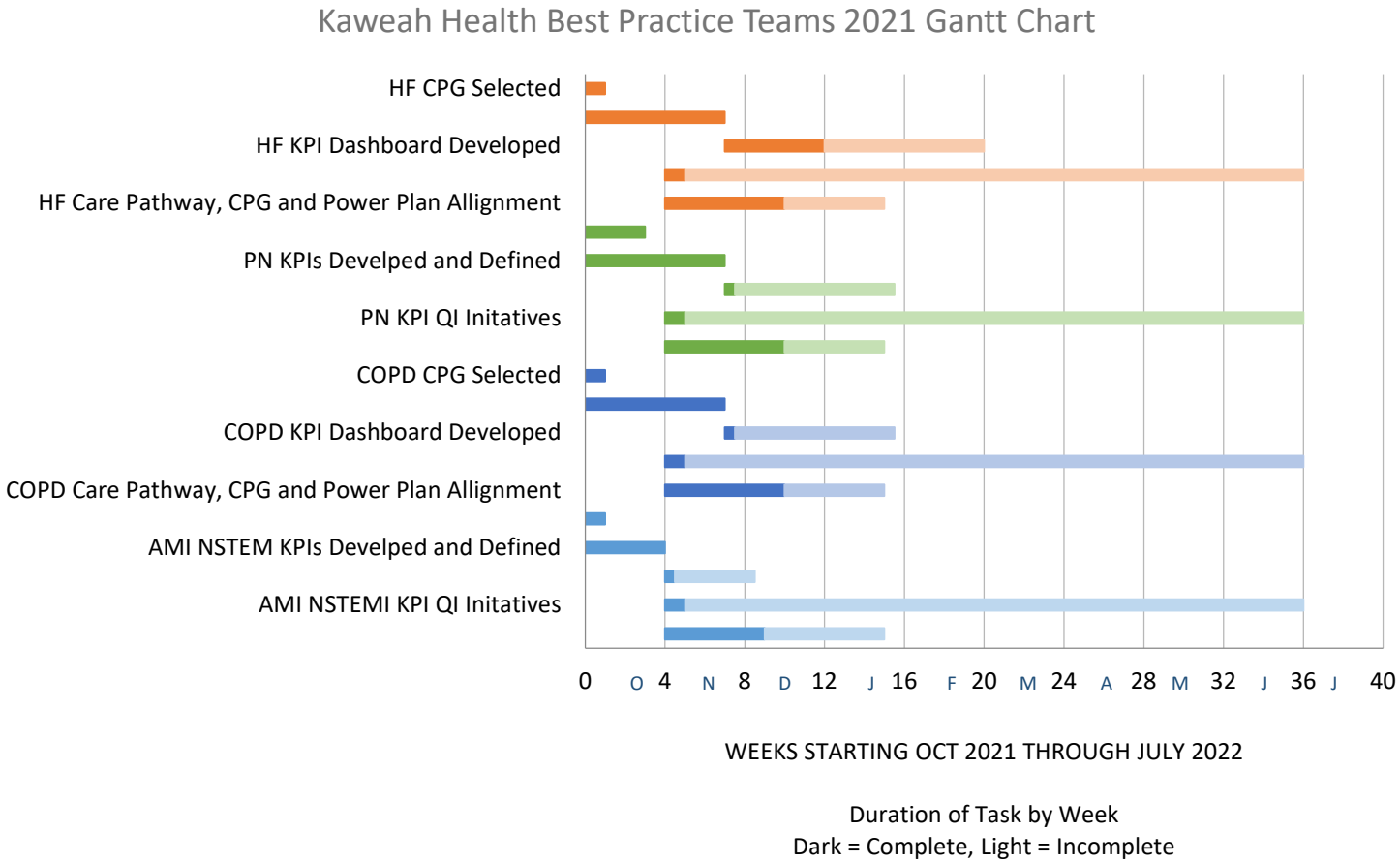
- Care Pathway developed
- Integrated into Cerner power plans & workflow
- QI Measures added to dashboard
- QI work to achieve targets

Goal: Improve efficiency and further reductions in LOS, mortality o/e & readmission

Kaweah Health Best Practice Teams

Goal: Improve patient outcomes by standardizing care on 4 key patient populations (AMI- NSTEMI, COPD, HF & PN)

- Standardized care based on Clinical Practice Guideline (CPGs) and operationalize the standardized care through Care Pathways, provider power plans and new Cerner functionality (Care Pathways)
- 4 “Core Teams” established for each population, includes Medical Director, Quality Facilitator, Operational Director & Advanced Nurse Practitioner (APN)
- Outcomes include: Mortality, Readmission and Length of Stay
- Key Performance Indicators (KPIs) defined, dashboards in development and QI work underway!!



Outcome Data

Kaweah Health Best Practice Teams Outcome Dashboard FY 2021

	Goal	Baseline (FY 2019)	1Q - 2Q 2021*	3Q 2021*	4Q 2021*	FYTD July-Dec.*
Readmission Medicare Population	AMI (non-STEMI) – 11.01	12.34	12.5	7.14% (1/14)	12.5% (3/24)	10.5% (4/38)
	COPD – 12.87	16.09	10	27.27% (3/11)	28.57 (2/7)	27.78% (5/18)
	HF – 14.58	18.22	21.28	15.79% (6/38)	12.20 (5/41)	13.92% (11/79)
	PN Viral/Bacterial – 11.30 *includes COVID-19 patients	14.13	13.51	15.79% (6/38)	15.39 (6/39)	15.58% (12/77)
O/E Mortality Medicare Population	AMI (non-STEMI) - 0.71	0.75	0.84	0.85 (n=16)	0.96 (n=13)	0.90 (n=29)
	COPD – 1.92	2.4	0.93	2.73 (n=13)	0 (n=9)	2.52 (n=22)
	HF – 1.42	1.78	0.911	0.38(n=44)	0.62 (n=51)	0.54 (95)
	PN Bacterial – 1.48	1.85	1.04	0 (n=6)	1.15 (n=13)	1.05 (n=19)
	PN Viral - 1.07 *includes COVID-19 patients	1.34	0.64	1.25 (n=23)	1.65 (n=26)	1.49 (n=49)

*Midas updated to version 4.0 with revised risk adjustment algorithm

Team Charter

Heart Failure (HF)

Key Initiatives March 2022

- Dashboard developed with sample size data
- CPGs and order set(s) reviewed for alignment
- HF Order set revisions in process to operationalize best practices including: addition of medication options with specific evidenced-based parameters (ie. Aldactone, Hydralazine, Entresto

PROJECT NAME: Heart Failure	CHAMPION: Dr. M. Tedaldi	QI Facilitator: Melissa Quinonez
DIRECTOR: Emma Mozier	APN: Craig Dixon	ET SPONSOR: Keri Noeske

PROBLEM STATEMENT:
Mortality, readmission and LOS data indicates opportunity in standardizing care and reducing variation through clinical practice guideline and care pathway implementation.

PROJECT GOAL:
Short term:
1. Select clinical practice guidelines (CPGs) COMPLETE
2. Develop and improve Key Performance Indicators (KPIs) IN PROCESS

Long Term:
1. Reduce mortality
2. Reduce readmission

SCOPE: (WHAT DOES THIS INCLUDE AND NOT INCLUDE?) Medical Center processes

FINANCIAL IMPLICATIONS:
Penalties associated with the CMS Value-Based Purchasing Program (mortality), penalties associated with CMS Readmission Reduction Program & reputational costs with CMS star ratings.

MEASURES:
KPIs (in order of priority)
1. What percentage of patients with Systolic Heart Failure (EF <40%) are discharged on correct BB, ACE/ARB/ARNI/SARA
   1b. contraindications to (goal directed) med therapy documented appropriately? I.E Bradycardia/ hypotension for BB as well as CKD Stage 3b and greater(GFR≤30) and or serum potassium above 5 meq
2. What percentage of our patients with CHFrEF ("reduced EF" or "systolic HF") that are eligible have been switched over to Entresto (ARNI) in house?
3. Percent of patients who started on ACE and d/c'd on an ARNI (Entresto)

TIMELINE & PLAN:

Initiation	Team identification and guideline selection
Phase I	Key Performance Indicator selection, plan and initiate QI activities to achieve KPI goals
Phase II	Development/revision of care pathway, measure expansion, dashboard development

Team Charter

Chronic Obstructive Pulmonary Disease (COPD)

Key Initiatives March 2022

- Dashboard under development
- CPGs and order set(s) reviewed for alignment
- COPD Order set revisions in process to operationalize best practices including: Antibiotic options, steroid dosing/frequency, defining medication based on GOLD category, delineating medications for acute and maintenance therapy, diagnostic studies

PROJECT NAME: COPD BPT	CHAMPION: Dr. M. Tedaldi	QI Facilitator: Stacey Cajimat
DIRECTOR: Wendy Jones	APN: Emma Camarena	SPONSOR: Keri Noeske

PROBLEM STATEMENT:

Mortality, readmission and LOS data indicates opportunity in standardizing care and reducing variation through clinical practice guideline and care pathway implementation.

PROJECT GOAL:

Short term:

1. CPG- GOLD Standards COMPLETE
2. Develop and improve Key Performance Indicators (KPIs) IN PROCESS

Long Term:

1. Reduce mortality from 2.40 to 1.92, by end of FY 22
2. Reduce readmissions from 16.09 percent to to 12.87%, by end of FY 22.

SCOPE: (WHAT DOES THIS INCLUDE AND NOT INCLUDE?) Inpatient admissions and discharges.

FINANCIAL IMPLICATIONS: Penalties associated with the CMS Value-Based Purchasing Program (mortality), penalties associated with CMS Readmission Reduction Program & reputational costs with CMS star ratings.

MEASURES:

KPIs (in order of priority)

1. What percentage of patients had Pulmonary Function Test (PFT) performed?
2. What percentage of COPD patients received the Pneumonia immunization on discharge?
3. What percentage of our patients the received Influenza immunization on discharge?
4. What percentage of patients accepted smoking cessation information on discharge?
5. What percentage of patients were referred to pulmonary rehab and attended?
6. What percentage of patients had principal discharge diagnosis of COPD and any diagnosis of CHF, any diagnosis of PN and any diagnosis of both CHF and PN?

TIMELINE & PLAN:

Initiation	Team identification and guideline selection
Phase I	Key Performance Indicator selection, plan and initiate QI activities to achieve KPI goals
Phase II	Development of care pathway, measure expansion, dashboard development

Team Charter

Pneumonia (PN)

Key Initiatives March 2022

- Dashboard under development
- CPGs and order set(s) reviewed for alignment
- Evaluating implementation of a Pneumonia Severity Index (PSI) tool
- Order set revisions in process to operationalize best practices including: Antibiotic (Abx) selection on ED Sepsis order set (used for severe PN, inclusion of PSI which would direct Abx type and level of care, and transition of IV to PO (by mouth) Abx

PROJECT NAME: Pneumonia BPT	CHAMPION: Dr. M. Tedaldi	QI Facilitator: Lorena Domenech
DIRECTOR: Molly Niederreiter	APN: Alisha Sandidge	ET SPONSOR: Keri Noeske

PROBLEM STATEMENT:
Mortality, readmission and LOS data indicates opportunity in standardizing care and reducing variation through clinical practice guideline and care pathway implementation.

PROJECT GOAL:
Short term:
1. Select clinical practice guidelines (CPGs)
2. Develop and improve Key Performance Indicators (KPIs)

Long Term:
1. Reduce mortality
2. Reduce readmissions

SCOPE: (WHAT DOES THIS INCLUDE AND NOT INCLUDE?) Includes CAP patients in Emergency Department and admitted into the Medical Center

FINANCIAL IMPLICATIONS:
Penalties associated with the CMS Value-Based Purchasing Program (mortality), penalties associated with CMS Readmission Reduction Program & reputational costs with CMS star ratings.

MEASURES:
KPIs (in order of priority)

1. Pneumonia ED power plan Utilization N:
   N:Patients with dx CAP/suspected Pneumonia & power plan used in the ED
   D: Patients with ED diagnosis of Community Acquired Pneumonia/suspected pneumonia
1. First dose of antibiotic administered within 3 hours of suspected or confirmed diagnosis
   N: Patients who received antibiotic within 3 hours of suspected or confirmed diagnosis
   D: All patients admitted with CAP
1. Pneumonia admission power plan Utilization In patients
   N: Patients with power plan ordered
   D: All patients admitted with CAP

4 Switch from IV to PO antibiotics within 48 hours of first antibiotic treatment
N: number of patients transitioned from IV to PO within 48 hours
D: All admitted patients with CAP

Future KPIS

- Rate of documented Pneumonia Severity Index (PSI)

N: Patients with a documented PSI score in the Emergency Department
D: Patients with diagnosis of Community Acquired Pneumonia/ suspected pneumonia in ED

- Documentation of Clinical Stability Tool

N:Number of patients who had a completed Clinical Stability Tool
D: The number of patients on med surge with CAP diagnosis

Initiation	Team identification and guideline selection
Phase I	Key Performance Indicator selection, plan and initiate QI activities to achieve KPI goals
Phase II	Development/revision of care pathway, measure expansion, dashboard development

Team Charter Acute Myocardial Infarction – Non ST Elevated Myocardial Infarction (AMI – NSTEMI)

Key Initiatives March 2022

- Dashboard under development
- CPGs and order set(s) reviewed for alignment
- Order set revisions in process for 4 different order sets that intersect with care of NSTEMI population
- Operationalizing best practices through order set revisions including: adding and revising medication orders and lab test to align with CPGs and pre-checking options

PROJECT NAME: AMI Non-STEMI BPT	CHAMPION: Dr. Michael Tedaldi	Quality RN Facilitator: Cindy Vander Schuur
DIRECTOR: Christine Aleman	APN: Cody Ericson	ET SPONSOR: Keri Noeske

PROBLEM STATEMENT:

Mortality, readmission, and length of stay (LOS) data indicates opportunity in standardizing care and reducing variation through clinical practice guideline and care pathway implementation.

PROJECT GOAL:

Short Term:

1. Select clinical practice guidelines (CPGs) COMPLETE
2. Develop and improve Key Performance Indicators (KPIs) IN PROCESS

Long Term:

1. Reduce mortality
2. Reduce readmissions
3. Reduce length of stay

SCOPE: (WHAT DOES THIS INCLUDE AND NOT INCLUDE?)

*Inpatient Medical Center processes.

GUIDELINES:

*Denominator: Patients with a diagnosis of NSTEMI who went to the Cath Lab.

NSTEMI Definition:

1. Negative EKG (no ST elevation)
2. Positive Troponin resulted ≥ 0.5

***Baseline Data:** Monthly starting July 2021

FINANCIAL IMPLICATIONS:

Penalties associated with the CMS Value-Based Purchasing Program (mortality), penalties associated with CMS Readmission Reduction Program & reputational costs with CMS star ratings.

MEASURES: KPIs (in order of priority)

Process Measures:

1. Percent of NSTEMI patients who have a 12 lead EKG done within 10 minutes of arrival.
2. Percent of NSTEMI patients administered oral beta blockers within 24 hours of positive Troponin.
3. Percent of NSTEMI patients who received IV UFH (unfractionated Heparin) or therapeutic subcutaneous (SQ) Lovenox (1mg/kg) within one hour of positive Troponin result.
4. Diagnostic Consideration/Measure: Percent of NSTEMI patients with a second Troponin done within 4 hours. (for risk stratification and early diagnosis) Using resulted time of initial Troponin.
5. Diagnostic Consideration/Measure: Percent of NSTEMI patients with a second EKG done within 4 hours. (for risk stratification and early diagnosis)
6. For NSTEMI patients who undergo revascularization: Percent of patients discharged on DAPT (dual antiplatelet therapy: Plavix, Effient, or Brilinta with aspirin) that do not have a contraindication such as aspirin sensitivity or history of gastrointestinal bleeding.

TIMELINE & PLAN:

Initiation	Team identification and guideline selection
Phase I	Key Performance Indicator selection, plan and initiate QI activities to achieve KPI goals
Phase II	Development/revision of care pathway, measure expansion, dashboard development. Address order sets including medication orders

Kaweah Health Best Practice Teams

Summary – Next Steps

- KPI data & dashboards under development
- Finalizing changes to order sets to ensure alignment with best practices(operationalizing best practices at the bed side)
- Evaluating removal care pathway papers and operationalize pathways through order sets
- Improvement work for each specific population based on the KPI data
- Meetings with Bridge and Community Outreach programs to better understand potential opportunities for collaboration

Thank you

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Kaweah Health

Centers for Medicare & Medicaid Services (CMS) Star Ratings

Sandy Volchko DNP, RN, CPHQ, CLSSBB
Director Quality & Patient Safety

Quality Council
March 2022

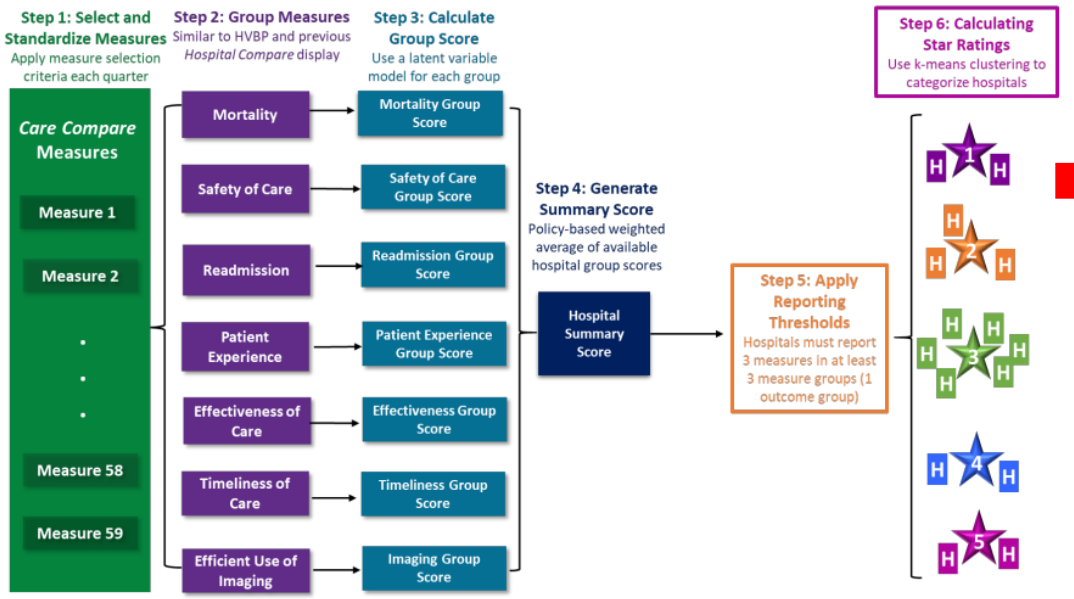
Acronyms

- CABG – Coronary Artery Bypass Graft (ie. open heart surgery)
- CMS - Centers for Medicare & Medicaid Services
- COPD - Chronic Obstructive Pulmonary Disease
- EDAC – Excess Days in Acute Care
- ED – Emergency Department
- EKG – electrocardiogram
- HAI – Healthcare Acquired Infection
- HCOMP - Hospital Consumer Assessment of Healthcare Providers and Systems (CMS survey of patient experience
- HF – Heart Failure
- MRSA - Methicillin-resistant Staphylococcus Aureus
- PC – Perinatal Care Core Measure
- PN – Pneumonia
- OP - Out Patient
- PSI – Patient Safety Indicator
- READM - Readmission
- SD – Standard Deviation
- V - Version

Methodology Changes

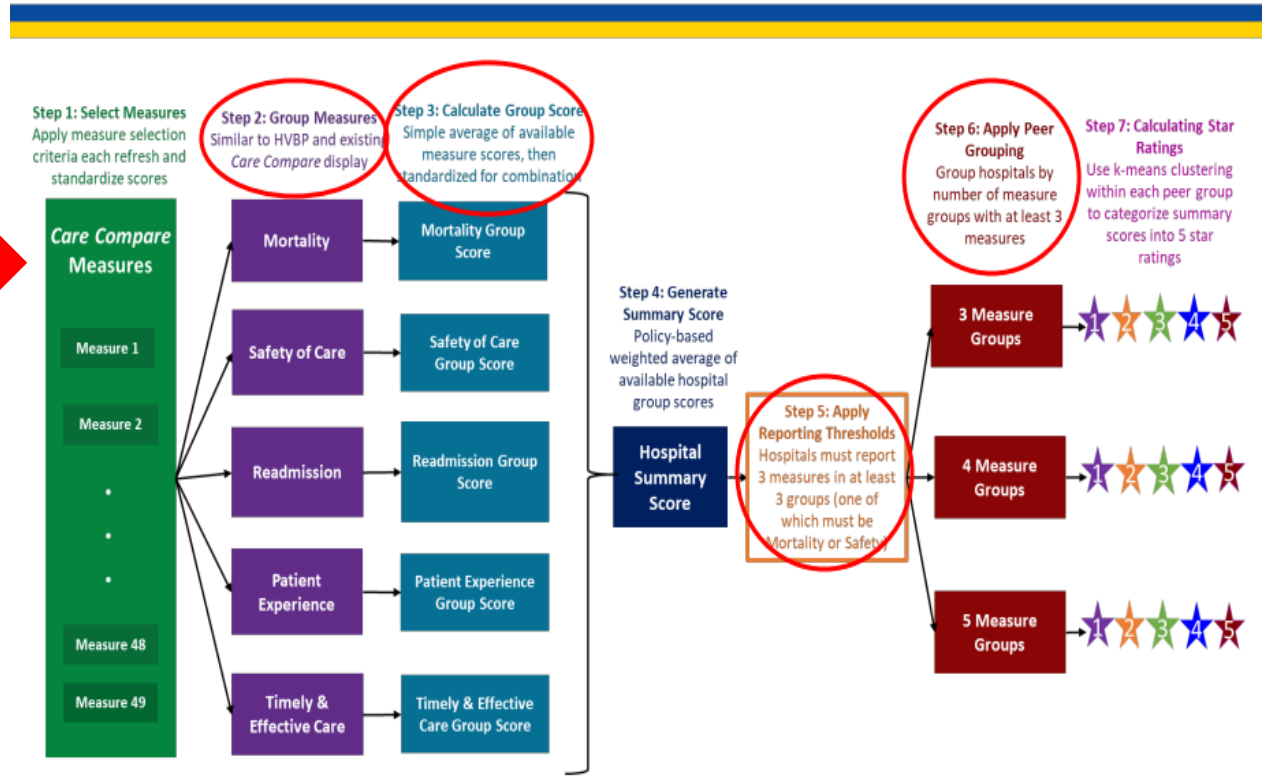
2020 and Previous Releases

Prior Overall Star Rating Methodology (v3.0)



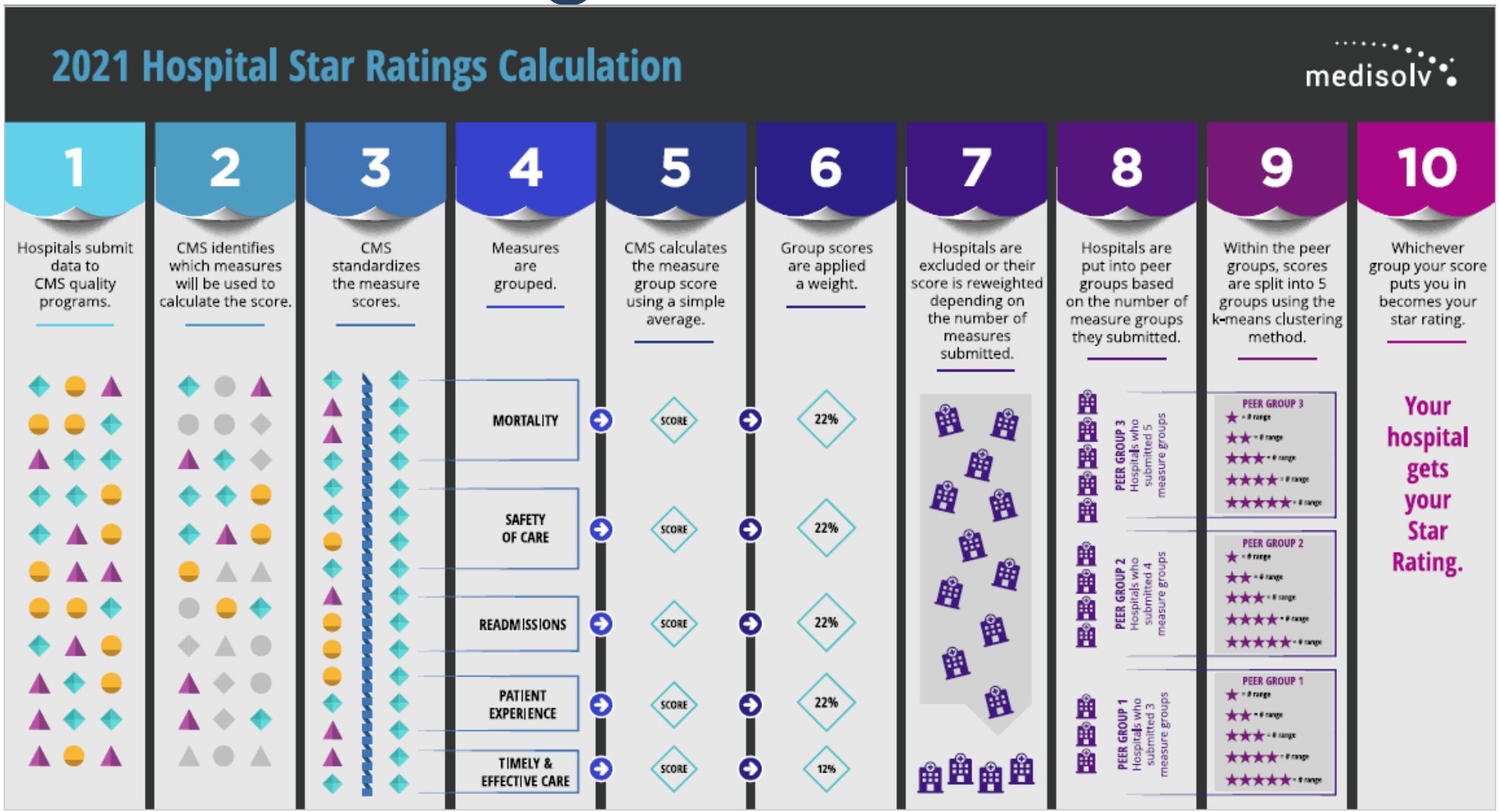
2021 Release

New Star Rating Methodology (v4.0)



2021 Star Ratings

Kaweah Health is scored based on performance of 42 different measures



2021 Star Ratings – Last Released April 2021

Hospital Compare Preview Report

Exported 01/27/2021
April 2021 | Page 1

KAWEAH DELTA MEDICAL CENTER
400 W MINERAL KING AVE
VISALIA, CA, 93291

CCN-050057
(559) 624-2000

Facility Type:	Short-term
Ownership Type:	Government - Hospital District or Authority
Emergency Service:	Yes

Star Rating Preview — 2 Stars

Summary Score: -0.56

	Standardized Group Score	Weight	Scored Measures	# Measures Better	# Measures Same	# Measures Worse
Safety of Care	-0.66	22%	7	1	5	1
Mortality	0.02	22%	7	0	7	0
Readmission	-0.69	22%	9	0	6	3
Patient Experience	-0.68	22%	8	N/A	N/A	N/A
Timely and Effective Care	-0.98	12%	11	N/A	N/A	N/A

Number of Measures per Group

7 measures
7 measures
9 measures
8 measures
11 measures

42 measures

Rating	5-measure group peer group (n=2,465)
1 Star	-2.21, -0.87
2 Star	-0.87, -0.41
3 Star	-0.41, -0.04
4 Star	-0.04, 0.34
5 Star	0.35, 1.39

Summary Score National Average: -0.05 Across all groups

The hospital's standardized measure group score is calculated using the following formula: (Your Hospital's Measure Group Result - Measure Group's National Mean of Scores)/ Measure Group's Standard Deviation Across Hospitals

2021 Star Ratings – Timely & Effective Care Measure Group

Measure Group [a]	Measure ID [b]	Measure Name [c]	Your Hospital's Measure Result [d]	Measure Performance Category [e]	Measure's National Mean of Scores [f]	Measure's Standard Deviation Across Hospitals [g]	Your Hospital's Standardized Measure Score [h]	Measure Weight [i]
Timely & Effective Care	OP-8	MRI Lumbar Spine for Low Back Pain	29.2%	--	39.9%	0.07	1.55	9.1%
Timely & Effective Care	OP-10	Abdomen CT Use of Contrast Material	5.2%	--	6.5%	0.06	0.21	9.1%
Timely & Effective Care	OP-13	Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery	1.8%	--	4.1%	0.02	1.23	9.1%
Timely & Effective Care	ED-2b	Admit Decision Time to ED Departure Time for Admitted Patients	183	--	99	74.41	-1.13	9.1%
Timely & Effective Care	OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients	232	--	142	47.21	-1.91	9.1%
Timely & Effective Care	OP-22	ED-Patient Left Without Being Seen	4%	--	1%	0.02	-1.61	9.1%
Timely & Effective Care	OP-23	ED-Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 Minutes of Arrival	55%	--	74%	0.18	-1.02	9.1%
Timely & Effective Care	OP-29	Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients	80%	--	89%	0.17	-0.52	9.1%
Timely & Effective Care	OP-30	Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use Last reported in 2018, retired measure by CMS	49%	--	92%	0.12	-3.47	9.1%
Timely & Effective Care	PC-01	Elective Delivery Prior to 39 Completed Weeks Gestation: Percentage of Babies Electively Delivered Prior to 39 Completed Weeks Gestation	1%	--	2%	0.04	0.20	9.1%
Timely & Effective Care	SEP-1	Severe Sepsis and Septic Shock	66%	--	59%	0.17	0.39	9.1%
		Measure Groups national Mean of Scores:	0.04			**Group Result:**	**-0.55**	0.12
		Measure Groups SD Across Hospitals	0.60			**Standardized Group Score:**	**-0.99**	
						Weighted Group Score	**-0.12**	

- Removal of retired measure (last reported timeframe 2018, affecting FY2021 payment – reduces standardized group score from -0.99 to -0.50 (reduction of approx. 100%)
- Further reducing ED Patient left without being seen to most current CMS reported 1%, and OP-29 Follow up interval for normal colonoscopy to 90%, and reducing 30 min off ED door to discharge times would result in a positive group score for this measure group.

Running Scenario HOSPITAL SUMMARY SCORE -0.44

2021 Star Ratings – Readmission Measure Group

Measure Group [a]	Measure ID [b]	Measure Name [c]	Your Hospital's Measure Result [d]	Measure Performance Category [e]	Measure's National Mean of Scores [f]	Measure's Standard Deviation Across Hospitals [g]	Your Hospital's Standardized Measure Score [h]	Measure Weight [i]
Readmission	EDAC-30-AMI	Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction	20.6	Worse	6.3	24.70	-0.58	11.1%
Readmission	READM-30-CABG	Coronary Artery Bypass Graft (CABG) 30-Day Readmission Rate	12.3%	Same	12.7%	0.01	0.31	11.1%
Readmission	READM-30-COPD	Chronic Obstructive Pulmonary Disease (COPD) 30-Day Readmission Rate	21.6%	Same	19.6%	0.01	-1.91	11.1%
Readmission	EDAC-30-HF	Excess Days in Acute Care after Hospitalization for Heart Failure	30.3	Worse	4.2	24.71	-1.06	11.1%
Readmission	READM-30-Hip-Knee	Hospital-Level 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Elective Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA)	4.2%	Same	4.0%	0.005	-0.38	11.1%
Readmission	EDAC-30-PN	Excess Days in Acute Care after Hospitalization for Pneumonia (PN)	12.9	Worse	4.8	24.38	-0.33	11.1%
Readmission	READM-30-HOSP-WIDE	HWR Hospital-Wide All-Cause Unplanned Readmission	16.0%	Same	15.5%	0.009	-0.54	11.1%
Readmission	OP-32	Facility Seven-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy	14.7	Same	16.5	1.40	1.26	11.1%
Readmission	OP-36	Hospital Visits after Hospital Outpatient Surgery	1.0	Same	1.0	0.17	0.06	11.1%
READMISSION		Measure Groups national Mean of Scores:	0.0300			**Group Result:**	**-0.35**	0.22
		Measure Groups SD Across Hospitals	0.5500			**Standardized Group Score:**	**-0.69**	
						Weighted Group Score	**-0.1528**	

- Reduction of COPD readmission to 19.0%, AMI & HF EDAC BY 10 days and PN EDAC by 5 days = Positive group score, reduced Hospital score from -0.55 to -.44

- EDAC measures capture excess days that a hospital's patients spent in acute care within 30 days after discharge. The measures incorporate the full range of post-discharge use of care (emergency department visits, observation stays, and unplanned readmissions).

Running Scenario - HOSPITAL SUMMARY SCORE -0.28

2021 Star Ratings – Patient Experience Measure Group

Measure Group [a]	Measure ID [b]	Measure Name [c]	Your Hospital's Measure Result [d]	Measure Performance Category [e]	Measure's National Mean of Scores [f]	Measure's Standard Deviation Across Hospitals [g]	Your Hospital's Standardized Measure Score [h]	Measure Weight [i]
Patient Experience	H-COMP-1	Communication with Nurses	3.00	--	3.50	0.93	-0.54	12.5%
Patient Experience	H-COMP-2	Communication with Doctors	2.00	--	3.09	1.04	-1.05	12.5%
Patient Experience	H-COMP-3	Responsiveness of Hospital Staff	3.00	--	3.28	1.04	-0.27	12.5%
Patient Experience	H-COMP-5	Communication About Medicines	3.00	--	3.07	1.01	-0.07	12.5%
Patient Experience	H-COMP-6	Discharge Information	3.00	--	3.23	0.96	-0.25	12.5%
Patient Experience	H-COMP-7	Care Transition	2.00	--	3.12	1.06	-1.06	12.5%
Patient Experience	H-CLEAN-HSP / H-QUIET-HSP	Cleanliness and Quietness of Hospital Environment	2.00	--	3.05	0.94	-1.11	12.5%
Patient Experience	H-HSP-RATING / H-RECMND	Overall Rating of Hospital	3.00	--	3.24	0.93	-0.25	12.5%
		Measure Groups national Mean of Scores:	0.0000			**Group Result:**	-0.57	0.22
		Measure Groups SD Across Hospitals	0.8500			**Standardized Group Score:**	-0.68	
						Weighted Group Score	**-0.1486**	

- Increase of 1.0 for all items that scored 2.0 and increase of 0.50 for all items that scored a 3.0 (except overall hospital rating) would result in a positive group score

Running Scenario - HOSPITAL SUMMARY SCORE -0.12

2021 Star Ratings – Safety of Care Measure Group

Measure Group [a]	Measure ID [b]	Measure Name [c]	Your Hospital's Measure Result [d]	Measure Performance Category [e]	Measure's National Mean of Scores [f]	Measure's Standard Deviation Across Hospitals [g]	Your Hospital's Standardized Measure Score [h]	Measure Weight [i]
Safety of Care	HAI-1	Central-Line Associated Bloodstream Infection (CLABSI)	1.146	Same	0.692	0.63	-0.72	14.3%
Safety of Care	HAI-2	Catheter-Associated Urinary Tract Infection (CAUTI)	1.893	Worse	0.719	0.58	-2.02	14.3%
Safety of Care	HAI-3	Surgical Site Infection from Colon Surgery (SSI-colon)	0.498	Same	0.812	0.66	0.47	14.3%
Safety of Care	HAI-5	MRSA Bacteremia	1.577	Same	0.813	0.66	-1.16	14.3%
Safety of Care	HAI-6	Clostridium Difficile (C.difficile)	0.291	Better	0.584	0.47	0.62	14.3%
Safety of Care	COMP-HIP-KNEE	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA)	2.4%	Same	2.5%	0.005	0.11	14.3%
Safety of Care	PSI-90-Safety	Patient Safety and Adverse Events Composite	1.04	Same	0.99	0.19	-0.25	14.3%
		Measure Groups national Mean of Scores:	0.0100			**Group Result:**	**-0.42**	0.22
		Measure Groups SD Across Hospitals	0.6600			**Standardized Group Score:**	**-0.65**	
						Weighted Group Score	**-0.1440**	

- Reducing CAUTI, CLABSI and MRSA to SIR of 1.0 and reducing PSI90 to 0.95 would result in a positive group score (CLABSI is part of PSI90)

Running Scenario - HOSPITAL SUMMARY SCORE 0.03 (3 Star)

2021 Star Ratings – Mortality Measure Group

Measure Group [a]	Measure ID [b]	Measure Name [c]	Your Hospital's Measure Result [d]	Measure Performance Category [e]	Measure's National Mean of Scores [f]	Measure's Standard Deviation Across Hospitals [g]	Your Hospital's Standardized Measure Score [h]	Measure Weight [i]
Mortality	MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	12.7%	Same	12.7%	0.01	-0.04	14.3%
Mortality	MORT-30-CABG	Coronary Artery Bypass Graft (CABG) 30-Day Mortality Rate	1.9%	Same	3.1%	0.008	1.47	14.3%
Mortality	MORT-30-COPD	Chronic Obstructive Pulmonary Disease (COPD) 30-Day Mortality Rate	9.2%	Same	8.5%	0.01	-0.65	14.3%
Mortality	MORT-30-HF	Heart Failure (HF) 30-Day Mortality Rate	10.5%	Same	11.5%	0.02	0.57	14.3%
Mortality	MORT-30-PN	Pneumonia (PN) 30-Day Mortality Rate	16.0%	Same	15.7%	0.02	-0.17	14.3%
Mortality	MORT-30-STK	Acute Ischemic Stroke (STK) 30-Day Mortality Rate	15.0%	Same	13.6%	0.02	-0.92	14.3%
Mortality	PSI-4-SURG-COMP	Death Rate Among Surgical Inpatients with Serious Treatable Complications	168.71	Same	164.38	19.83	-0.22	14.3%
MORTALITY GROUP		Measure Groups national Mean of Scores:	-0.0050			**Group Result:**	**0.01**	
		Measure Groups SD Across Hospitals	0.6500			**Standardized Group Score:**	**0.02**	**0.22**
						Weighted Group Score	**0.00429**	

- Reducing COPD and Acute Ischemic Stroke to the national mean of scores (8.5% and 13.6%) would result in a standardized group measure score of 0.35

Running Scenario - HOSPITAL SUMMARY SCORE 0.10 (4 Star)

Adjusting all remaining negative numbers to 0.0 (national mean) = 0.35 or 5 star rating

Actions to Improve

Measure Group	Strategy
Safety of Care	• Continue with heightened focus through Quality Focus Teams (Gemba rounds, EMR enhancements, culture of culturing) • Continued use of Biovigil • MRSA targeted decolonization
Readmissions & Mortality	• Best-Practice Teams: COPD, HF, NSTEMI and Pneumonia – focused on operationalizing best practices to reduce mortality and readmissions
Patient Experience	• Installation of communication white boards in patient rooms • Scripting for providers when communicating with patients • Leader rounding program
Timeliness & Effectiveness of Care	• Chartis/Throughput Committee work

Distribution by Peer Group

- Hospitals by peer group
  - 3-measure: 348 (10%)
  - 4-measure: 583 (17%)
  - 5-measure: 2,509 (73%)

Distribution of Overall Star Ratings by Peer Group – April 2021

Overall Star Rating	3-Measure groups # Hospitals (%)	4-Measure groups # Hospitals (%)	5-Measure groups # Hospitals (%)
★★★★★	35 (10.4%)	39 (7.1%)	381 (15.4%)
★★★★	93 (27.6%)	143 (25.86%)	752 (30.5%)
★★★	111 (32.9%)	194 (35.1%)	714 (29.0%)
★★	72 (21.4%)	144 (26.0%)	474 (19.2%)
★	26 (7.7%)	33 (6.0%)	145 (5.9%)

Kaweah Health

Questions?

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

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Reference Materials

Measure Date Ranges Used in the April 2021 Star Ratings

The April 2021 Overall Star Ratings were calculated using the measure data from the October 2020 update on Care Compare on Medicare.gov to allow hospitals more time to preview results prior to publicly releasing Overall Star Ratings.

Mortality

Measure	Dates
MORT-30-AMI	July 1, 2016 - June 30, 2019
MORT-30-CABG	July 1, 2016 - June 30, 2019
MORT-30-COPD	July 1, 2016 - June 30, 2019
MORT-30-HF	July 1, 2016 - June 30, 2019
MORT-30-PN	July 1, 2016 - June 30, 2019
MORT-30-STK	July 1, 2016 - June 30, 2019
PSI-4-SURG-COMP	July 1, 2017 - June 30, 2019

Safety of Care

Measure	Dates
HAI-1	January 1, 2019 - December 31, 2019
HAI-2	January 1, 2019 - December 31, 2019
HAI-3	January 1, 2019 - December 31, 2019
HAI-4	January 1, 2019 - December 31, 2019
HAI-5	January 1, 2019 - December 31, 2019
HAI-6	January 1, 2019 - December 31, 2019
COMP-HIP-KNEE	April 1, 2016 - March 31, 2019
PSI-90-Safety	July 1, 2017 - June 30, 2019

Readmission

Measure	Dates
READM-30-CABG	July 1, 2016 - June 30, 2019
READM-30-COPD	July 1, 2016 - June 30, 2019
READM-30-Hip-Knee	July 1, 2016 - June 30, 2019
READM-30-HOSP-WIDE	July 1, 2018 - June 30, 2019
EDAC-30-AMI	July 1, 2016 - June 30, 2019
EDAC-30-HF	July 1, 2016 - June 30, 2019
EDAC-30-PN	July 1, 2016 - June 30, 2019
OP-32	January 1, 2016 - December 31, 2018
OP-35 ADM	January 1, 2018 - December 31, 2018
OP-35 ED	January 1, 2018 - December 31, 2018
OP-36	January 1, 2018 - December 31, 2018

Patient Experience

Measure	Dates
H-COMP-1	January 1, 2019 - December 31, 2019
H-COMP-2	January 1, 2019 - December 31, 2019
H-COMP-3	January 1, 2019 - December 31, 2019
H-COMP-5	January 1, 2019 - December 31, 2019
H-COMP-6	January 1, 2019 - December 31, 2019
H-COMP-7	January 1, 2019 - December 31, 2019
H-CLEAN-HSP / H-QUIET-HSP	January 1, 2019 - December 31, 2019
H-HSP-RATING / H-RECMND	January 1, 2019 - December 31, 2019

Timely and Effective Care

Measure	Dates
ED-2b	January 1, 2019 - December 31, 2019
IMM-3	October 1, 2019 - March 31, 2020
OP-10	July 1, 2018 - June 30, 2019
OP-13	July 1, 2018 - June 30, 2019
OP-18b	January 1, 2019 - December 31, 2019
OP-2	January 1, 2019 - December 31, 2019
OP-22	January 1, 2018 - December 31, 2018
OP-23	January 1, 2019 - December 31, 2019
OP-29	January 1, 2018 - December 31, 2018
OP-30	January 1, 2018 - December 31, 2018
OP-33	January 1, 2018 - December 31, 2018
OP-3b	January 1, 2019 - December 31, 2019
OP-8	July 1, 2018 - June 30, 2019
PC-01	January 1, 2019 - December 31, 2019
SEP-1	January 1, 2019 - December 31, 2019

Chart Elements Used in the April 2021 Star Ratings

Column Name	Description
Measure Group [a]	Contains the measure group to which the measure was assigned.
Measure ID [b]	Contains the measure ID displayed on Care Compare on Medicare.gov.
Measure Name [c]	Contains the full measure name.
Your Hospital's Measure Result [d]	Contains your hospital's score for the measure that was publicly reported on Care Compare on Medicare.gov.
Measure Performance Category [e]	Your hospital's measure performance category that was publicly reported Care Compare on Medicare.gov.
Measure's National Mean of Scores [f]	Contains the national mean score for each measure.
Measure's Standard Deviation Across Hospitals [g]	Contains the standard deviation for each measure.
Your Hospital's Standardized Measure Score [h]	Contains your hospital's standardized score for the measure.
Measure Weight [i]	Measures weights within the Measure Group.

[a] The measure group to which this measure is assigned. [b] ID associated with each measure and corresponds with the measure ID on Care Compare on Medicare.gov. [c] Measure name to describe each measure.

[d] Your hospital's measure result that was publicly reported in October 2020.

[e] Your hospital's measure performance category that was publicly reported in October 2020. The measure performance category is based on your hospital's measure results compared to the publicly reported national-level measure results.

[f] The national mean score for each measure based on the distribution of measure scores across all Overall Star Rating eligible hospitals.

[g] The standard deviation for each measure based on the distribution of hospital results. The standard deviation is the same for all hospitals across the nation.

[h] Your hospital's standardized measure score. The standardized measure score may have been flipped so that a higher score means a better score. Your hospital's standardized measure score is calculated using the following formula: (Column D [Your Hospital's Measure Result] - Column F [Measure's National Mean of Scores]) / Column G [Measure's Standard Deviation Across Hospitals]. Please note that the standardized measure score is multiplied by -1 for measures where a lower rate is better. See the Comprehensive Methodology Report v.4.0 posted on QualityNet for more information on how your hospital's standardized measure score is calculated.

[i] Measure weights are equally weighted across all measures reported by a hospital within a given measure group. 0% is used when hospital does not report measure. For measure groups where hospitals may not report all measures within a measure group, measure weights will be proportionally redistributed for measures reported within the group. The average of the standardized measure scores a hospital reports within a given measure group will be used to calculate the measure group scores. See the Comprehensive Methodology Report (v4.0) for further information.

Clinical Quality Goal Update

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Quality Council
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FY22 Clinical Quality Goals

	July-Dec 21 Higher is Better	FY22 Goal	FY21	FY21 Goal
SEP-1 (% Bundle Compliance)	75%	≥ 75%	74%	≥ 70%

Percent of patients with this serious infection complication that received "perfect care". Perfect care is the right treatment at the right time for our sepsis patients.

Our Mission

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

Our Vision

To be your world-class healthcare choice, for life

Lower is Better	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual/ number expected)	FY22 Goal	FY21 FY20
CAUTI Catheter Associated Urinary Tract Infection COVID-19 PATIENTS	1 0	3 1	5 5	2 0	2 1	1 0	2 1						16 (12 predicted over 6 months)	1.60 0.76 Excluding COVID	≤0.676	0.54 1.12
CLABSI Central Line Associated Blood Stream Infection COVID-19 PATIENTS	0 0	4 3	3 3	3 0	1 1	1 0	1 0						11 (9.5 predicted over 6 months)	1.261 0.63 Excluding COVID	≤0.596	0.75 1.20
MRSA Methicillin-Resistant Staphylococcus Aureus COVID-19 PATIENTS	2 0	0 0	1 0	3 1	0 0	2 0	2 1						5 (3.6 predicted over 6 months	2.293 1.49 Excluding COVID	≤0.727	2.78 1.02

*based on July-Dec 2021 NHSN predicted

**Standardized Infection Ratio is the number of patients who acquired one of these infections while in the hospital divided by the number of patients who were expected.