April 14, 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, April 21, 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, April 21, 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, April 21, 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, April 21, 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, 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, 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*
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety*
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 - *James McNulty, PharmD, Director of Pharmacy, Dale Costantino, PharmD, Medication Safety Coordinator*
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management and Ben Cripps, Chief Compliance and Risk Officer.*
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*
4. **Adjourn Open Meeting** – *David Francis, Committee Chair*

CLOSED MEETING – 7:31AM

1. **Call to order** – *David Francis, Committee Chair*
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. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*
4. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 - *James McNulty, PharmD, Director of Pharmacy, Dale Costantino, PharmD, Medication Safety Coordinator.*
5. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management, and Ben Cripps, Chief Compliance and Risk Officer.*
6. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 –*Sandy Volchko, RN, DNP, Director of Quality and Patient Safety*.
7. **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. Rapid Response Team Quality Report
    - 3.2. CMS Core Measures Quality Report
    - 3.3. Hospice, Home Health Quality Report
    - 3.4. Catheter Associated Urinary Tract Infection (CAUTI) Quality Focus Team Quality Report
4. **Cardiac Surgery Quality Report** – A review of key measures and actions related to cardiac surgery quality as reported through the Society of Thoracic Surgery data registry. *F. Mayer, MD., Medical Director of Cardiothoracic Surgery*
5. **Diabetes Quality Focus Team Report –** A review of key outcome measures associated with the diabetic population and diabetes management. *Emma Camarena, DNP, Director of Nursing Practice & T. Gray, MD, Medical Director of Quality & Patient Safety.*

6. **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*.

7. **Adjourn Open Meeting** – *David Francis, Committee Chair*

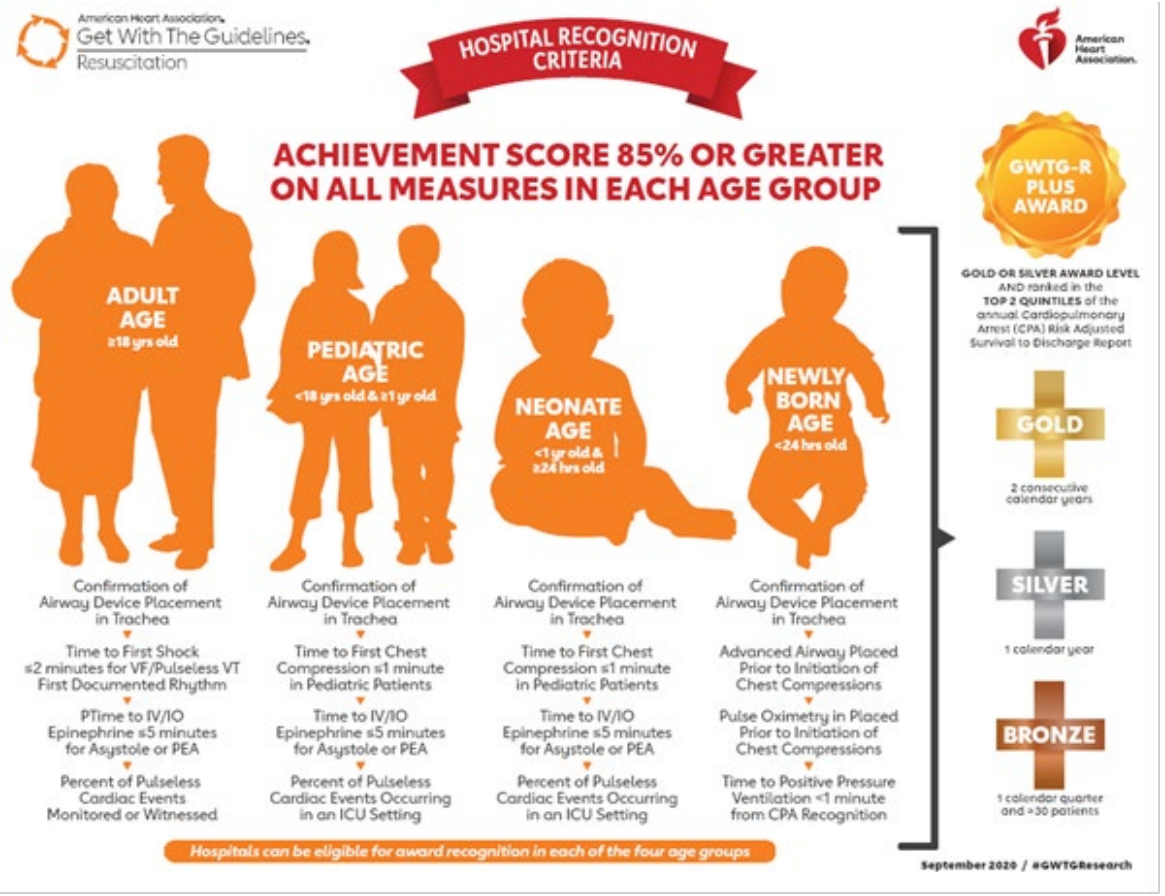
In compliance with the Americans with Disabilities Act, if you need special assistance to participate at this meeting, please contact the Board Clerk (559) 624-2330. Notification 48 hours prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to the Kaweah Delta Health Care District Board of Directors committee meeting.

RRT/Code Blue ProStaff Report Q4 2021

Shannon Cauthen and Stacey Cajimat

GWTG Resuscitation Criteria

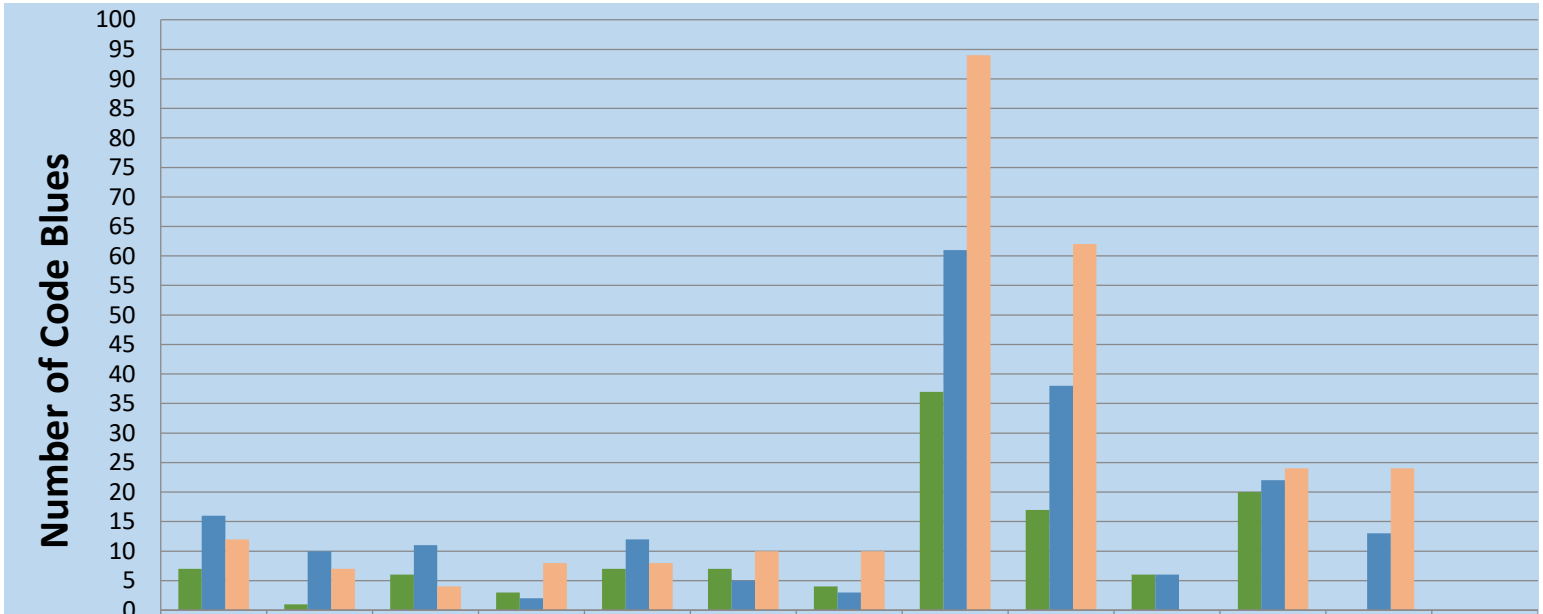
- The RRT/Code Blue Committee has joined Get with the Guidelines (GWTG) Resuscitation, AHA's National Registry, to have access to national and state benchmarks for code blue and RRT measures.
- This information has been used to create a new RRT and Resuscitation Scorecard.
- The RRT/Code Blue Committee has begun measuring GWTG hospital recognition criteria benchmarks. These benchmarks will improve the quality of our codes and qualify us for awards.
    1. Confirmation of airway device placement
    2. Time to first shock (defibrillation)
    3. Time to intravenous (IV) epinephrine
    4. Percent of pulseless events monitored or witnessed



RRT and Resuscitation Quality Scorecard

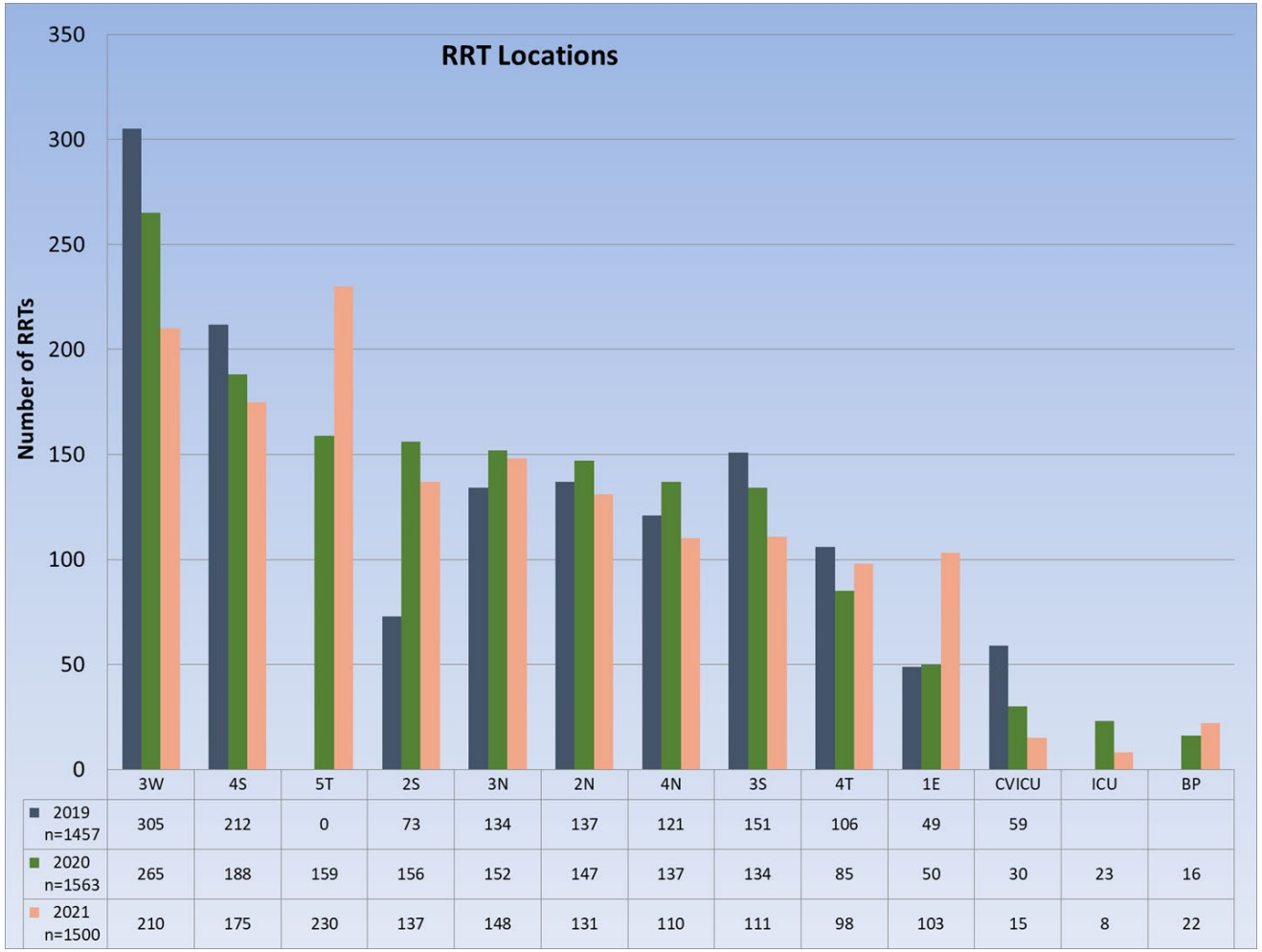
Measure Description	California Hospitals External Benchmark	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Mean YTD 2021
Code Blue Data														
Total Code Blues		27	30	17	15	12	10	16	15	30	34	37	20	22
Total COVID-19 Positive Code Blues		17	14	0	0	0	0	1	9	13	15	16	8	8
Code Blues per 1000 Discharges Med Surg		8	8	5	8	7	1	5	5	6	14	8	3	6
Code Blues per 1000 Discharges Critical Care		12	17	7	4	2	7	7	7	17	12	23	12	11
Percent of Codes in Critical Care	72% (↑ is better)	59%	50%	59%	33%	25%	90%	56%	60%	73%	47%	73%	80%	59%
Code Blue: Survival to Discharge	23% (↑ is better)	11%	7%	18%	27%	25%	40%	25%	0%	7%	6%	3%	10%	15%
Deaths from Cardiac Arrest		24	15	5	8	5	2	6	6	10	14	14	10	10
Overall Hospital Mortality per 1000 Patients		7.629	5.661	3.29	3.132	2.778	1.897	2.539	3.323	5.279	4.866	6.023	4.105	4.21
RRT Data														
Total RRTS		175	154	109	101	116	103	110	134	185	182	124	110	134
RRTs per 1000 patient discharge days		131	129	109	101	117	75	82	106	145	139	104	85	110
RRT mortality percentage	22% (↓ is better)	40% n-70	31% n-47	20% n-22	23% n-23	16% n-18	16% n-16	20% n-22	27% n-36	33% n-61	39% n-71	50% n-62	30% n-33	29%
RRTs within 24 hours of Admit from ED (percentage)	15% (↓ is better)	20% n-35	16% n-25	29% n-32	28% n-28	28% n-32	29% n-30	28% n-31	16% n-22	18% n-33	17% n-31	17% n-21	26% n-29	23%
Green	Better than Target													
Yellow	Within 10% of Target													
Red	Does not meet Target													

Code Blues by Location



	2N	2S	3N	3S	4N	4S	4T	ICU	CVICU	CVICCU	3W	5T	BP
2019 n=115	7	1	6	3	7	7	4	37	17	6	20	0	0
2020 n=200	16	10	11	2	12	5	3	61	38	6	22	13	0
2021 n=263	12	7	4	8	8	10	10	94	62	0	24	24	0

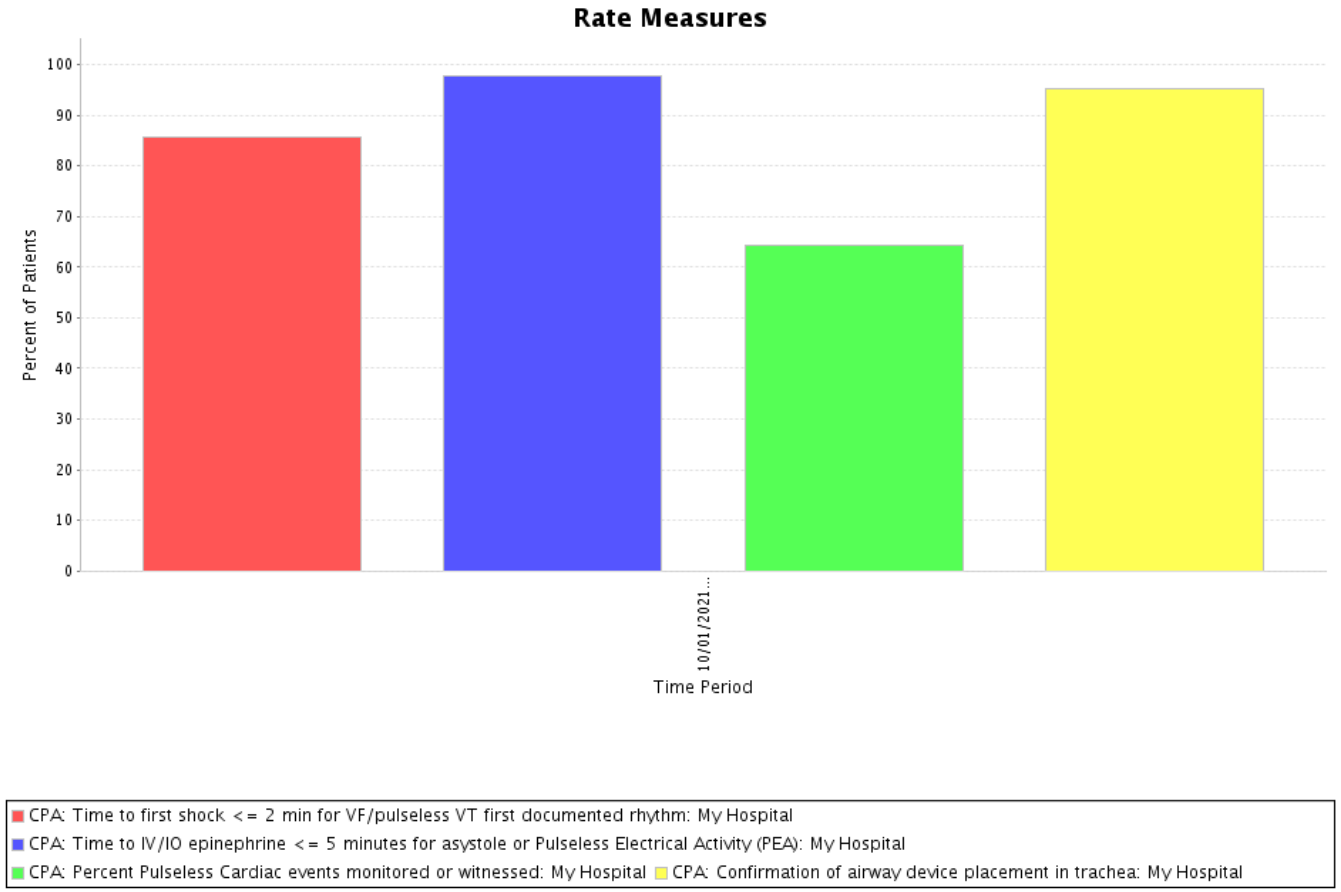
RRTs by Location



	3W	4S	5T	2S	3N	2N	4N	3S	4T	1E	CVICU	ICU	BP
2019 n=1457	305	212	0	73	134	137	121	151	106	49	59		
2020 n=1563	265	188	159	156	152	147	137	134	85	50	30	23	16
2021 n=1500	210	175	230	137	148	131	110	111	98	103	15	8	22

GWTG Recognition Measures- Q4 2021

Goal= 85% Compliance



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GWTG Recognition Measures Q4 2021

Numerator and Denominators

CPA: Time to first shock <= 2 min for VF/pulseless VT first documented rhythm

Percent of events in adult patients with VF/pulseless VT first documented rhythm in whom time to first shock <=2 minutes of event recognition.
Time Period: 10/01/2021 - 12/31/2021; **Site:** KAWEAH DELTA HEALTH CARE DISTRICT (85227)

CPA: Time to first shock <= 2 min for VF/pulseless VT first documented rhythm				
Benchmark Group	**Time Period**	**Numerator**	**Denominator**	**% of Patients**
My Hospital	10/01/2021 - 12/31/2021	6	7	85.7%

CPA: Time to IV/IO epinephrine <= 5 minutes for asystole or Pulseless Electrical Activity (PEA)

Percent of events in adult patients where time to epinephrine <= 5 minute of asystole or pulseless electrical activity.
Time Period: 10/01/2021 - 12/31/2021; **Site:** KAWEAH DELTA HEALTH CARE DISTRICT (85227)

CPA: Time to IV/IO epinephrine <= 5 minutes for asystole or Pulseless Electrical Activity (PEA)				
Benchmark Group	**Time Period**	**Numerator**	**Denominator**	**% of Patients**
My Hospital	10/01/2021 - 12/31/2021	46	47	97.9%

CPA: Percent Pulseless Cardiac events monitored or witnessed

Percent of pulseless cardiac patient events were monitored or witnessed
Time Period: 10/01/2021 - 12/31/2021; **Site:** KAWEAH DELTA HEALTH CARE DISTRICT (85227)

CPA: Percent Pulseless Cardiac events monitored or witnessed				
Benchmark Group	**Time Period**	**Numerator**	**Denominator**	**% of Patients**
My Hospital	10/01/2021 - 12/31/2021	58	90	64.4%

CPA: Confirmation of airway device placement in trachea

Percent of CPA events in adult patients who had confirmation of airway device placement in trachea
Time Period: 10/01/2021 - 12/31/2021; **Site:** KAWEAH DELTA HEALTH CARE DISTRICT (85227)

CPA: Confirmation of airway device placement in trachea				
Benchmark Group	**Time Period**	**Numerator**	**Denominator**	**% of Patients**
My Hospital	10/01/2021 - 12/31/2021	80	84	95.2%

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GWTG Recognition Measures

Get With the Guideline Recognition Measures (GWTG) include:

Time to first shock; goal <2 mins for Ventricular Fibrillation (Vfib) or Ventricular Tachycardia (VT) first documented rhythm (higher is better)

Quarter 4 2021= 85.7%
Cumulative CY 2021= 79.2%

Time to Intravenous/Intraosseus (IV/IO) epinephrine; goal <5 minutes for asystole or Pulseless Electrical Activity (PEA) (higher is better)

Quarter 4 2021= 97.9%
Cumulative CY 2021= 99.4%

Percent Pulseless Cardiac events are monitored or witnessed (higher is better)

Quarter 4 2021= 64.4%
Cumulative CY= 71.9%

Confirmation of airway device placement in trachea (higher is better)

Quarter 4 2021=95.2%
Cumulative CY= 96.6%

GWTG Next Steps…

Of the four GWTG benchmarks, we are performing well above goal in two of them and underperforming in the other two. We will continue to be diligent to maintain the high level of care we have demonstrated in *"Time to first IV/IO epinephrine"* and *"Confirmation of airway device placement in the trachea."*

The other two benchmarks (*Time to first shock* and *Percent pulseless Cardiac events monitored or witnessed*) have not experienced the improvements that we would have hoped for with our current practice. The below are our plans for improve compliance in the coming months:

1. Time to first shock

-Initiated a themed training-up fair called "Taco 'bout Training Up" on December 8th, 2021. This event was an open-house style training session for all in-house staff to increase their comfortability with the RRT and the equipment used in an emergency resuscitation event. We had 15 participants in attendance at this event and staff have been excitedly talking about similar upcoming events. This event will be held quarterly; twice a year the event will be an open-house style in a conference room with learning stations and twice a year this will be conducted in a "show on the road style" by the RRT nurses. We will aim to capture both day and night shift and will incorporate topics like a crash cart scavenger hunt and hands on time with the Zoll.

-Educate staff to AED Function on Defibrillators. Teach staff to use the "analyze" button to analyze patient's rhythm and deliver a shock if indicated while awaiting the Rapid Response Team's arrival.

-Work with Lacey Jensen and Clinical Education team to ensure this is being taught in BLS

-Incorporate hands-on time and simulated scenarios during training up sessions.

Continued on next page…

GWTG Next Steps continued…

2. Percent Pulseless Cardiac Events are monitored or witnessed

Previously, we thought compliance was achieved if patient was on telemetry at time of event. After discussing with our AHA representative, it was realized that the rhythm strip from the time of the event must be attached to patient's chart for validation. With the correction in how we classify the data, we had a significant and unfortunate downward trend in our compliance data. I believe we are monitoring a higher percent of patients than what is identified in the data so the following measures are our efforts to validate that monitoring is happening.

-Verified that telemetry monitor technicians print strips of all cardiac arrest patients and fax them to the floor of patient's location in real time.

-RRT nurses often view these rhythm strips to try and understanding the event(s) that may have precipitated the arrest. Once RRT nurses review the rhythm strips, unsure what happens to the strips but suspect they often get thrown away or misplaced instead of being placed in patient's chart.

-Going forward, RRT nurses will review the strip and then attach them to the code packet that goes to Performance Improvement for review and data collation.

-Also, working with HIM and the forms committee to update the code blue form to add verbiage that identifies if an arrest was "witnessed" to prevent ambiguity in completing the code blue documentation.

Code Blues and RRTs Q4-2021

Code Blue Summary

- The goal of the Rapid Response Team is to respond to the early recognition of patient deterioration through the use of the 10 Signs of Vitality (SOV) for activation of a Rapid Response. Additionally, early identification helps aide in the reduction of events that convert from a rapid response to a cardiac arrest and it helps hospital staff appropriately place patients to try and reduce the number of cardiac arrests/code blues that occur outside of the ICU. In the past 12 months, we have had COVID surges that have significantly impacted the acuity of our patients throughout the organization, especially those in our ICCUs. Even though our ICCUs have many of the same resources as our ICUs, a code that occurs in an ICCU is not considered to be a code within a critical care unit per GWTG standards. As a result, our percent of codes in critical care is much lower than the California average.
- Code blue survival to discharge benchmark had started to show signs of improvement at the end of Q2 but with the resurgence of COVID in Q3, our Q4 mean percentage dropped 3% from last quarter and remains below the California mean.

Rapid Response Team Summary

- Highest amount of RRTs per 1000 patient discharge days: 139 in October.
- Highest mortality percentage: 50% in November (previous single highest month was January 2021 at 40%).
- Average 2021 RRTs within 24 hours of Admit from ED stayed the same from last quarter (23%).

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Next Steps

- Recruit and fill Medical Director Position- Vacant since December 2021. In-progress
- Revise code blue form to easily capture all code blue process elements to meet GWTG standards. Point person-Abel. In-progress
- Review of Redivus Code Blue App for Consistent Documentation and Data collection. Point person- Evan. In-progress
- Teach nursing staff to use AED “Analyze” function in code blues. Point persons- Rosalinda. In-progress
- Advanced Training for TCAR, CALS, IABP, Impella. In-progress.
- Formalization of non-licensed staff and family activated RRT process. Pending
- Re-instate Hi-Fidelity mock in-situ code blues. Point Person- Shannon. Pending
- Taco ‘bout Training Up- training event for all in-house staff to familiarize themselves with the resuscitation team and equipment. Complete.
- Fill three vacant RRT positions. Complete.

Next Steps: Education

- RRT nurse will be working to form partnerships with specific units to “champion” and be a go-to person to help with education and reinforce utilizing RRT.
- Continue Training up sessions: some open-house style, others “show on the road” to familiarize staff with equipment. Once we have a few sessions of this style of training, plan to kick off in-situ mock code blues.
- First TCAR (Trauma Care After Resuscitation) Course being hosted at KH May 13th-14th. This is our first course!
- CALS (Cardiovascular Advanced Life Support) is being taught and we are aiming to have all RRT nurses trained and certified. Next course April 20th.

Questions?

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Core Meausure Snapshot-Jan 2022
Nov. 2020-Oct. 2021

Metrics		Hospital Compare	CMS Standards of Excellence Benchmark	CMS Benchmark / *TJC National Rate	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Den	Num	Fail
ED-2b	Admit Decision Time to ED Departure for Admitted ED Patients **(in minutes - down trend positive)**	Y	42	139 (Hosp Comp)	185	553	325	224	224	218	260	332	314	587	863	731	N/A	N/A	N/A
OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients **(in minutes - down trend postive)**		93	170 (Hosp Comp)	310	227	303	277	286	278	316	380	302	289	276	261	NA	N/A	N/A
OP-23	Head CT or MRI scan results for Acute Ischemic Stroke or Hemorrhagic Stroke		100.00%	72.00%	100.0%	50.0%	N/C	100.0%	100.0%	100.0%	66.7%	50.0%	66.7%	N/C	100.0%	100.0%	1	1	0
IMM-2	Influenza Immunization	Y	100.00%	93.00%	98.8%	95.9%	97.5%	97.3%	97.6%	N/A	N/A	N/A	N/A	N/A	N/A	98.6%	69	68	1
VTE-6	Hospital acquired potentially-preventable Venous Thromboembolism **(down trend positive)**	Y	0.00%	2.00%	N/C	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7	0	0
HBIPS-1a	Admissions Screening		N/A	89.90%	88.89%	93.55%	86.96%	93.75%	96.43%	100.00%	86.36%	86.36%	81.48%	75.00%	78.79%	76.19%	21	16	5
HBIPS-2a	**Physical Restraint-Overall Rate - **(down trend positive)**	Y	N/A	0.44	1.149	1.188	0.323	0.292	1.408	0.639	0.720	0.071	0.987	0.276	0.767	0.754	N/A	N/A	N/A
HBIPS-3a	**Seclusion-Overall Rate - **(down trend positive)**	Y	N/A	0.29	1.095	1.629	1.710	0.723	0.449	0.077	0.145	0.460	0.629	0.17	0.185	0.314	N/A	N/A	N/A
HBIPS-5a	Multiple antipsychotic medications at discharge with appropriate justification - overall rate	Y	N/A	58.59%	N/C	N/C	25.0%	100.0%	0.0%	100.0%	0.0%	0.0%	100.0%	N/C	0.0%	0.0%	1	0	1
SUB-2 (MH)	Alcohol Use Intervention Provided/Offered	Y	N/A	69.92%	100.00%	90.00%	50.00%	100.00%	100.00%	100.00%	90.00%	100.00%	88.89%	91.67%	75.00%	80.00%	10	8	2
SUB-2A (MH)	Intervention provided	Y	N/A	61.76%	80.00%	50.00%	25.00%	100.00%	70.00%	75.00%	40.00%	40.00%	55.56%	66.67%	75.00%	50.00%	10	5	5
SUB-3 (MH)	Alcohol/Other Drug Use Tx provided/offerred at D/C	Y	N/A	36%	100.00%	100.00%	100.00%	100.00%	95.46%	100.00%	100.00%	100.00%	100.00%	96.55%	100.00%	94.74%	19	18	1
SUB-3A (MH)	Alcohol/Other Drug Use Disorder Tx at D/C	Y	N/A	36%	100.00%	100.00%	100.00%	100.00%	95.46%	100.00%	100.00%	100.00%	95.00%	96.55%	100.00%	94.74%	19	18	1
IMM-2 (MH)	Influenza Immunization (Mental Health) Start Oct 2015	Y	N/A	80.98%	94.12%	98.00%	100.00%	100.00%	94.00%	N/A	N/A	N/A	N/A	N/A	N/A	94.12%	51	48	3
TOB-2 (MH)	Tobacco Cessation FDA Approved Provided during stay.	Y	N/A	76.62%	95.00%	100.00%	95.24%	96.43%	90.91%	100.00%	90.32%	84.62%	92.00%	81.08%	82.61%	95.83%	24	23	1

Core Meausure Snapshot-Jan 2022
Nov. 2020-Oct. 2021

Metrics		Hospital Compare	CMS Standards of Excellence Benchmark	CMS Benchmark / *TJC National Rate	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Den	Num	Fail
TOB-2A (MH)	Tobacco Treatment Provided During Stay (Practical Counseling)	Y	N/A	41.52%	45.00%	50.00%	38.10%	46.43%	29.03%	25.00%	41.94%	30.77%	43.48%	53.13%	23.81%	45.83%	24	11	13
TOB-3 (MH)	Tobacco Treatment Provided/Offered at Discharge	Y	N/A	40.80%	44.44%	82.35%	68.42%	76.00%	56.67%	56.00%	81.48%	63.63%	73.91%	58.62%	50.00%	65.22%	23	15	8
TOB-3A (MH)	Tobacco Cessation Medication FDA Approved Provided at Discharge	Y	N/A	9.52%	5.56%	0.00%	10.53%	8.00%	16.67%	36.00%	32.14%	18.18%	17.39%	20.69%	5.00%	8.70%	23	2	21
CT-2	Care Transitions w specified elements received by disharged patients	Y	N/A	30%	86.79%	90.57%	86.79%	86.79%	84.91%	86.79%	80.77%	81.13%	88.68%	90.57%	96.23%	84.91%	53	45	8
CT-3	Timely Transmission of Transition Record	Y	N/A	30%	84.91%	83.02%	79.25%	83.02%	83.02%	84.91%	78.85%	71.70%	81.13%	81.13%	86.79%	81.13%	53	43	10
SMD-1	Screening for Metabolic Disorders	Y	N/A	90%	96.97%	100.00%	97.06%	94.60%	100.00%	94.60%	100.00%	100.00%	96.67%	100.00%	96.88%	100.00%	40	40	0
PCB-05	Exclusive Breast Milk Feedings		N/A	*52.44%	69.44%	61.77%	66.67%	62.50%	45.46%	41.67%	63.16%	66.67%	48.57%	50.00%	51.43%	63.89%	36	23	13
PCM-01	Early Elective Deliveries **(down trend positive)**		0	2.42%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	10	0	0
PCM-2a	C-Section Overall Rate **(down trend positive)**		N/A	*25.54%	29.41%	18.18%	23.81%	22.22%	25.00%	11.11%	34.62%	34.62%	27.27%	4.76%	22.22%	20.00%	25	5	5
PCM-06	Unexpected Complications in Term Newborns-Overall Rate **(down trend possitive)**		N/A	N/A	2.02%	2.05%	0.37%	2.80%	0.69%	2.80%	2.12%	1.07%	2.28%	1.73%	3.39%	1.56%	321	5	5
OP Web-29	Endoscopy/Polyp Surveillance - appropriate follow-up interval for normal colonoscopy in average risk patients		100%	85%	85.7%	100.0%	N/C	100.0%	77.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	83.3%	6	5	1
Sep-1	Sepsis Bundle Followed		81	61%	71.43%	78.95%	60.00%	74.07%	76.00%	77.27%	76.70%	76.67%	65.60%	75.00%	56.67%	76.92%	39	30	9

N/C=No Cases
N/A=Not available

Meets/Exceeds standars of Excellence Benchmark
Compliance Does Not Meet National Benchmark

Hospice/Home Health Quality Report

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department:
Hospice

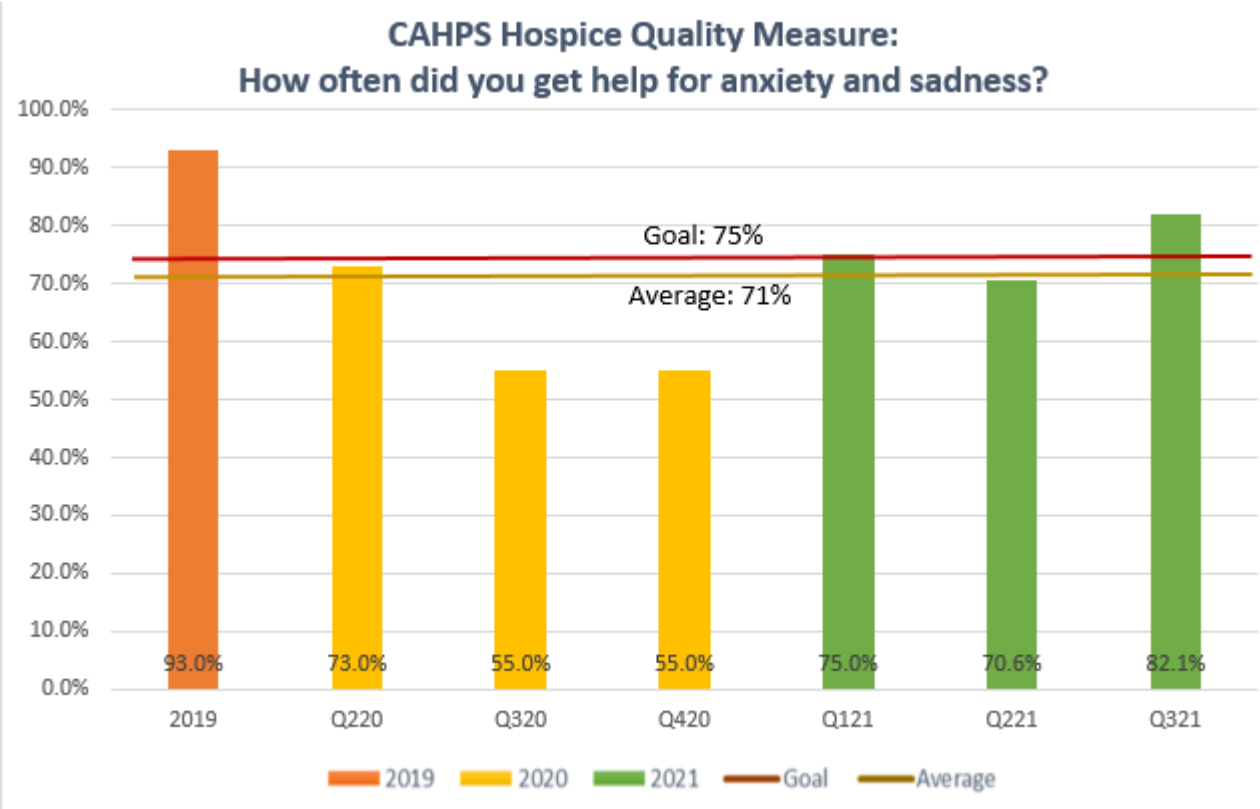
ProStaff/QIC Report Date:
March 2022

Due to the public health emergency that began in March, 2020, CMS placed a waiver in instituting a freeze on quality reporting for hospice agencies. Therefore, data reported by CMS on Hospice Compare, the platform for which quality measures are publicly reported for hospice agencies, has not been updated and displays only data up through December 31, 2019. In order to ensure the most currently and relevant data, more current data from patient satisfaction surveys was utilized for analysis. This information will eventually be submitted by Percy & Company, a third party vendor which administers the CAHPS surveys, to CMS and will be publicly reported.

Measure Objective/Goal:

How often did you get help for anxiety or sadness?

- **Percy & Company data 2019: 93%**
- **Average of Quarters 2-4, 2020; Quarter 1, 2021 Percy & Company: 65%**
- **Average of Quarter 4, 2020 and Quarters 1-3, 2021 Percy 7 Company: 71%**



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

Date range of data evaluated:
Percy & Company: October 1, 2020 to September 30, 2021

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

Analysis of all measures/data: (Include key findings, improvements, opportunities)
--Data from CY 2019 showed a strong score on this initiative of 93%. When data was last submitted to Quality Improvement Council, the average of the most recent four quarters available at that time noted a significant drop of 28 points to 65%. This initiative was chosen as it goes without saying that anxiety and sadness experienced by families/patients during the highly emotional time of losing a loved one or patients coming to terms with their own mortality could be very high. This measure of ensuring help is provided to patients/families for that anxiety and sadness is paramount in the Hospice philosophy. It is because of this philosophy and the substantial decrease in scores for the measure as reported in 2019, that we have chosen to focus our attention on this finding. As a result of improvement opportunities being identified and actions being taken, the most recent four quarters shows an improvement of 6% to an average of 71%. This has made a positive change, but we will continue on this initiative in an attempt to reach our goal of 75%.

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

--Kaweah Health Hospice UBC will continue to work to develop educational materials for staff to ensure they are recognizing subtle signs of anxiety/depression in patients/families.
--Sharing of progress and statistics at staff meetings to allow discuss on obstacles. Education to staff via projects developed by UBC.
--Immediate intervention by Medical Social Workers and/or Spiritual Counselors when signs of anxiety/depression are noted with families. For those families that decline MSW or SC services, the case manager nurse will revisit allowing MSW and/or SC again at appropriate intervals based on the patient's condition and family acceptance/readiness.

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

--Rounding by management staff shall be completed on a weekly basis via telephone with patients/families to ensure they feel confident these issues, if any, are being addressed to their satisfaction.

Next Steps/Recommendations/Outcomes:

Once interventions have been implemented as outlined above, we shall continue to monitor and analyze Percy & Company over next 4 quarters. Due to the lag time in these reports (approximately 6 months), it may take at least 4 quarters before results of the above-outlined plan are shown.

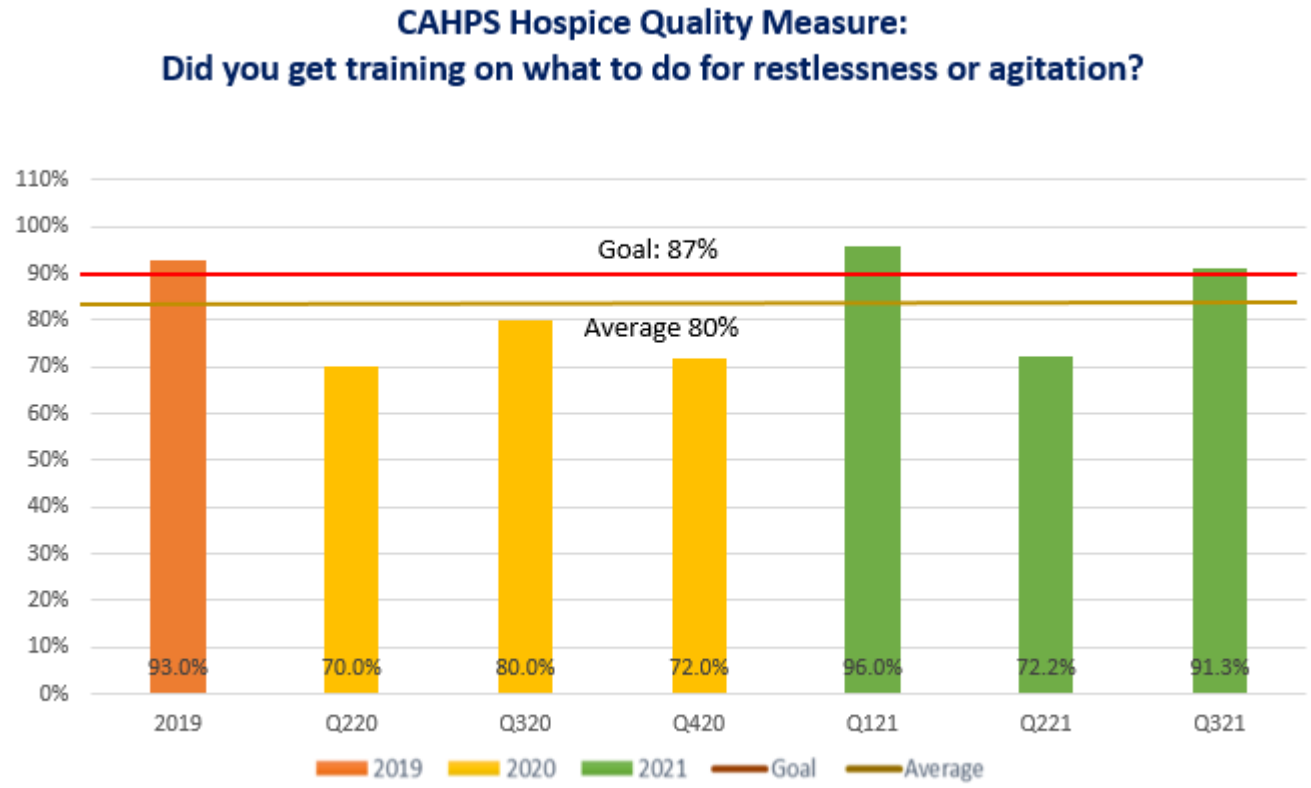
Submitted by Name:	**Date Submitted:**
Tiffany Bullock, Director **Kaweah Health Hospice**	**2/4/22**

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

Measure Objective/Goal:

Did you get training on what to do for restlessness or agitation?

- **Percy & Company data 2019: 93%**
- **Average of Quarters 2-4, 2020; Quarter 1, 2021 Percy & Company: 77%**
- **Average of Quarter 4, 2020 and Quarters 1-3, 2021 Percy 7 Company: 80%**



Date range of data evaluated:

Percy & Company: October 1, 2020 to September 30, 2021

--Data is gathered from the surveys administered by a third party vendor, Percy & Company as part of the Hospice CAHPS survey. Hospices are required to participate in these surveys which measures caregiver satisfaction. Information is then submitted to CMS by Percy & Company and will be publicly reported on Hospice Compare.

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

Data from CY 2019 showed a strong score on this initiative of 93%. When data was last submitted to Quality Improvement Council, the average of the most recent four quarters available at that time noted a significant drop of 16 points to 77%. Restlessness or

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

agitation in the final stages of life cannot only inhibit comfort in patients, but can be very emotionally challenging to families who witness this in their loved one. The Hospice philosophy is intended to alleviate suffering and provide comfort measures to allow patients and their families to live out the final stage of life with as much quality as possible. To be unable to manage agitation or restlessness is a barrier to that goal. It is because of this philosophy and the decrease in scores for the measure as reported in 2019, that we chose to focus our attention on this finding. As a result of improvement opportunities being identified and actions being taken, the most recent four quarters shows an improvement of 3% to an average of 80%. This has made a positive change, but will continue on this initiative in an attempt to reach our goal of 87%.

<u>If improvement opportunities identified, provide action plan and expected resolution date:</u>
There is opportunity for improvement in this area. The following plan of action shall be implemented:

--Written handouts in language easily understood shall be created for patients/families to better understand terminal agitation and restlessness that can be experience in the final days to weeks of life. This information shall be given to patients/families during the beginning days of admission to Hospice. This shall not only provide written information to the patients, but also ensure a robust conversation about this issue between the hospice nurse and the relevant caregivers. By doing this, families will better know what to expect and that there is in fact interventions that can be implemented to control these symptoms. Hospice leadership began this process in September 2021 with goal of full implementation by November 1, 2021. During this time, different educational tools were determined to be of a better benefit and Hospice leadership is revamping the information for families. The goal is to have this approved by the Medical Director in March 2022.
--Education was provided to nursing staff at monthly RN meeting to ensure understanding not only of the new process but to ensure they feel confident with this education and appropriate interventions. Based on feedback, further educational tools have been used and the project is ongoing.
--Rounding by management staff shall be completed on a weekly basis via telephone with patients/families to ensure interventions can be implemented in real time should any issues be identified through rounding.

<u>Next Steps/Recommendations/Outcomes:</u>

Continue to monitor and analyze Percy & Company over next 4 quarters. Due to the lag time in these reports (approximately 6 months), it may take at least 4 quarters before results of the above-outlined plan are shown.

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

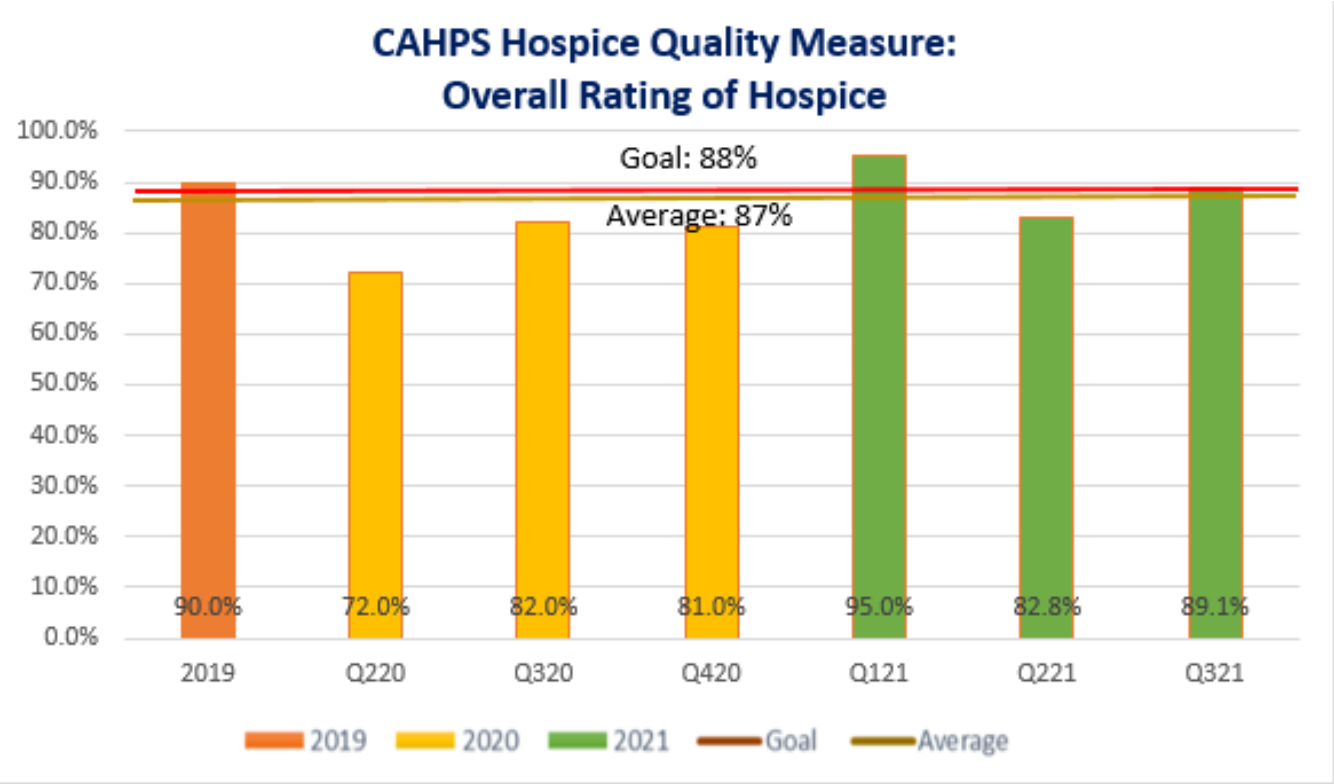
Professional Staff Quality Committee/Quality Improvement Committee

Submitted by Name:
Tiffany Bullock, Director
Kaweah Health Hospice

Date Submitted:
2/4/22

Measure Objective/Goal:
Overall Rating of Hospice

- **Percy & Company data 2019: 90%**
- **Average of Quarters 2-4, 2020; Quarter 1, 2021 Percy & Company: 83%**
- **Average of Quarter 4, 2020 and Quarters 1-3, 2021 Percy 7 Company: 87%**



Date range of data evaluated:
Percy & Company: October 1, 2020 to September 30, 2021

--Data is gathered from the surveys administered by a third party vendor, Percy & Company as part of the Hospice CAHPS survey. Hospices are required to participate in these surveys which measures caregiver satisfaction. Information is then submitted to CMS by Percy & Company and will be publicly reported on Hospice Compare.

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

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

--Data from CY 2019 shows a strong score on this initiative of 90%. The goal as set by Kaweah Health Executive Team in conjunction with Hospice leadership on this initiative is 88%. In 2019 we slightly exceeded this benchmark. The average of the most recent four quarters is 87%. In analysis of data, noted two items were significantly below that goal, more so than all others were. Those two measures are identified above as needing improvement. It is the expectation that by increasing these lower performing measures, the result will be greater overall satisfaction with the services Hospice provides. It is expected this should lead to improvement in this initiative, which is supported by the fact that we have increased in other two initiatives over the last two quarters, as well as an increase in the overall score for the agency from 83% to 87%.

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

--Current CAHPS scores will be a standing agenda item during all staff meetings. This will allow staff to see progress or decline in more real time and allow feedback for suggestions to identify opportunities and interventions for improvement. This began on September 14, 2021.
--Rounding by management staff shall be completed on a weekly basis via telephone with patients/families to ensure interventions can be implemented in real time should any issues be identified through rounding. This is currently being done.

Next Steps/Recommendations/Outcomes:

Continue to monitor and analyze Percy & Company over next 4 quarters. Due to the lag time in these reports (approximately 6 months), it may take at least 4 quarters before results of the above-outlined plan are shown.

Submitted by Name:	**Date Submitted:**
Tiffany Bullock, Director	**2/4/22**

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: **ProStaff/QIC Report Date:**
Home Health **February 14, 2022**

Due to the public health emergency declared in March 2020, the Centers for Medicare & Medicaid Services (CMS) froze the data reported on the Care Compare website, the platform for which quality measures are publicly reported for home health agencies. In January 2022, the website performed a 'data refresh' and resumed public reporting for quality measures, based on three quarters of OASIS assessment data, Q3 & Q4, 2020 and Q1, 2021. We are currently at a 3-Star rating, out of a 5-Star rating system. The next refresh on Care Compare will be in April 2022, reporting on four quarters of data Q3, 2020 thru Q2, 2021.

In order to ensure the most current and relevant data for analysis in this report, information was obtained from Internet Quality Improvement and Evaluation System (iQIES), a CMS platform that allows Medicare-certified home health agencies to view quality reports based on the Outcome and Assessment Information Set (OASIS) data submitted by that agency.

****OASIS is a data collection tool that all Medicare-certified home health agencies are required to collect and transmit to CMS for all patients whose care is reimbursed by Medicare and Medicaid with the following exceptions; patients receiving maternity services, patients under 18, or patients receiving housekeeping services only.***

Measure Description:

How often patients got better at walking or moving around?

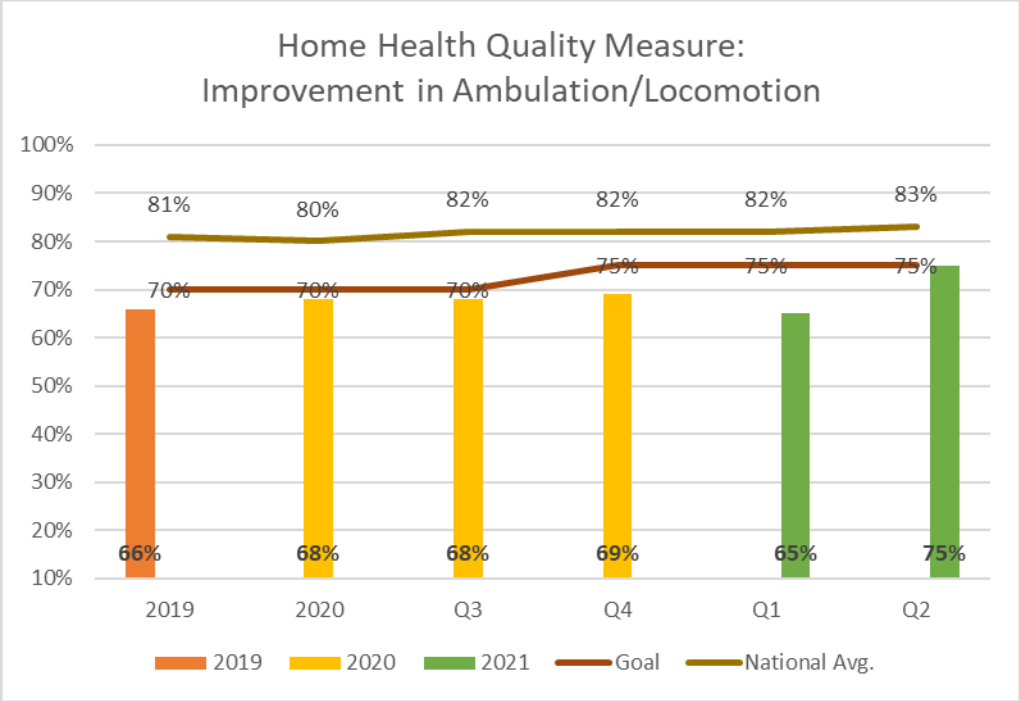
--Home Health Clinicians (registered nurses, physical therapists) complete OASIS data upon a patient's admission to home health. Clinicians must assess the patient's ability to walk SAFELY on a variety of surfaces using a 6-point scale; ranging from 0-independent to 6-bedfast. At discharge, the patient's ability is reassessed. If a patient is assessed to be at the same level, they are considered *stabilized*. Stabilized is counted as a negative outcome for this measure. Patients who are assessed to have less ability to walk safely, are considered to have *deteriorated*, also a negative outcome. Patients assessed to be independent upon admission and remain independent upon discharge are not counted as a negative outcome in this measure.

Measure Objective/Goal:

***Improvement in Ambulation/Locomotion*;**

- **iQIES data 2019: 66%**
- **iQIES data 2020: 68%**
- **iQIES data Quarters 3 & 4, 2020 and Quarters 1 & 2 2021: 69%**

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



**Higher percentages are better for this measure. Graph depicts the last 4 quarters as individual quarters to accurately assess response to previous interventions and guide upcoming action plan*

Date range of data evaluated:
iQIES data Quarters 3 & 4, 2020 and Quarters 1 & 2 2021

Analysis of all measures/data: (Include key findings, improvements, opportunities)
--CY 2020 data of 68%, remains below the National Average of reporting home health agencies at 75%.
--Clinician barriers to accurate assessment; assessing in home environment (clutter, need for equipment to help with mobility), and understanding of ability vs *safe* ability.
--Charting fatigue for clinicians reported as reason for inconsistencies in scoring OASIS accurately. OASIS questions focusing on ambulation are located near the end of a lengthy assessment. An attempt was previously made to 'move up' the OASIS sections related to ambulation but per our EMR software, this is not possible.

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

If improvement opportunities identified, provide action plan and expected resolution date:
There is an opportunity for improvement in this area. The following plan of action shall be implemented;
--Home Health Educator will work with UBC to create a "checklist/tool" to be used when assessing function in addition to current methods clinician already use. Educator will provide demonstration to all clinicians on use of the checklist once finalized, no later than March staff meeting.
--Educator and Intake RN will review data from clinician charting and OASIS for inconsistencies and meet with clinician to provide immediate feedback.
--Clinicians will utilize the "5 Day Rule" allowed by CMS. CME encourages a collaboration between all clinicians who assessed a patient within 5 days of the first OASIS assessment. This will ensure accurate capture of a patient's need and the opportunity to provide the resources needed to help achieve *Outstanding Community Health* consistent with the Kaweah Health District pillar.

Next Steps/Recommendations/Outcomes:
Educator and RN Intake Auditor will monitor the effectiveness of these interventions weekly during chart audits. Educator will report these findings along with trends to Home Health Manager at least every 30 days. Educator will analyze OASIS outcome data reports for this measure quarterly and report to Home Health Manager and Director. Educator and Home Health Manager will modify interventions until we meet, or exceed, the national average for three or more quarters.

Submitted by Name:
Shannon Esparza, RN

Date Submitted:
February 10, 2022

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: **ProStaff/QIC Report Date:**

Home Health **February 14, 2022**

Due to the public health emergency declared in March 2020, the Centers for Medicare & Medicaid Services (CMS) froze the data reported on the Care Compare website, the platform for which quality measures are publicly reported for home health agencies. In January 2022, the website performed a 'data refresh' and resumed public reporting for quality measures, displaying data for Q3 & Q4, 2020 and Q1, 2021. We are currently at a 3-Star rating, out of a 5-Star rating system. The next refresh on Care Compare will be in April 2022, with the expectation to resume reporting on 4 quarters of data; Q3, 2020 thru Q2, 2021.

In order to ensure the most current and relevant data for analysis in this report, information was obtained from Internet Quality Improvement and Evaluation System (iQIES), a CMS platform that allows Medicare-certified home health agencies to view quality reports based on the Outcome and Assessment Information Set (OASIS) data submitted by that agency.

****OASIS is a data collection tool that all Medicare-certified home health agencies are required to collect and transmit to CMS for all patients whose care is reimbursed by Medicare and Medicaid with the following exceptions; patients receiving maternity services, patients under 18, or patients receiving housekeeping services only.***

Measure Description:

How often patients got better at bathing

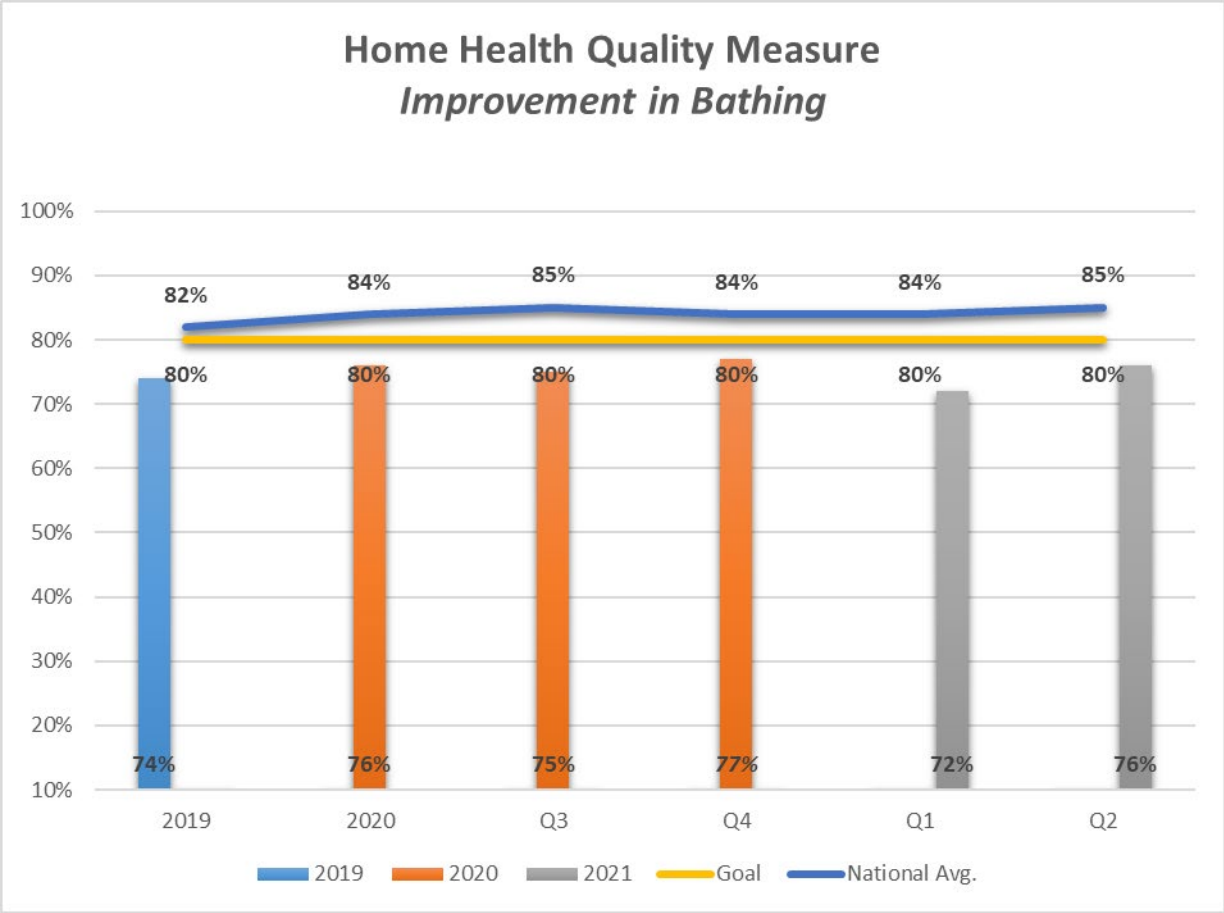
--Clinicians (registered nurses, physical therapists) complete OASIS data upon a patient's admission to home health. A patients current ability to wash their entire body safely is measured upon admission to home health using a 6-pt-scale. The 6-point bathing scale represents the most independent level first, then proceeds to the most dependent. At discharge, this ability is again measured using the same scale. If a patient is assessed to be at the same level, they are considered *stabilized*. Stabilized is counted as a negative outcome for this measure. Patients who are assessed to have less ability to bathe their entire body safely, are considered to have *deteriorated*, also a negative outcome. Patients assessed to be independent in bathing upon admission and again at discharge are not counted in this measure.

Measure Objective/Goal:

Improvement in bathing

- **iQIES data 2019: 74%**
- **iQIES data 2020: 76%**
- **iQIES data Quarters 3 & 4, 2020 and Quarters 1 & 2 2021: 75%**

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



Date range of data evaluated:
iQIES data; July 1, 2020 to June 30, 2021

Analysis of all measures/data: (Include key findings, improvements, opportunities)
--Clinicians must take into account multiple factors when determining the patient's ability to ambulate to the bathroom, and what level of assistance they require to do so s*afely*.
--Adaptive methods, assistive devices, and MD ordered restrictions need to be communicated to the first clinician assessing the patient to ensure an accurate scoring of patient ability. Intake clinicians work with case managers in the hospital to be sure that information is obtained in the referral order prior to clinician assessment.
--Clinicians must utilize their professional, clinical judgement when determining what level the patient can perform the task *safely,* not just simply complete the activity.

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

If improvement opportunities identified, provide action plan and expected resolution date:
There is an opportunity for improvement in this area. The following plan of action shall be implemented;
--Home Health Educator will work with UBC to create a "checklist/tool" to be used when assessing function in addition to current methods clinicians already use. Educator will provide demonstration to all clinicians on use of the checklist once finalized, no later than March staff meeting.
--Educator and Intake RN will review data from clinician charting and OASIS for inconsistencies and meet with clinician to provide immediate feedback.
--Clinicians will utilize the "5 Day Rule" allowed by CMS. CME encourages a collaboration between all clinicians who assessed a patient within 5 days of the first OASIS assessment. This will ensure accurate capture of a patient's need and the opportunity to provide the resources needed to help achieve *Outstanding Community Health* consistent with the Kaweah Health District pillar.

Next Steps/Recommendations/Outcomes:
Educator and RN Intake Auditor will monitor the effectiveness of these interventions weekly during chart audits. Educator will report these findings along with trends to Home Health Manager at least every 30 days. Educator will analyze OASIS outcome data reports for this measure quarterly and report to Home Health Manager and Director. Educator and Home Health Manager will modify interventions until we meet, or exceed, the national average for three or more quarters.

Submitted by Name:
Shannon Esparza, RN

Date Submitted:
February 10, 2022

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department:
Home Health

ProStaff/QIC Report Date:
February 2022

Due to the public health emergency declared in March 2020, the Centers for Medicare & Medicaid Services (CMS) froze the data reported on the Care Compare website, the platform for which quality measures are publicly reported for home health agencies. In January 2022, the website performed a 'data refresh' and resumed public reporting for quality measures, displaying data for Q3 & Q4, 2020 and Q1, 2021. We are currently at a 3-Star rating, out of a 5-Star rating system. The next refresh on Care Compare will be in April 2022, with the expectation to resume reporting on 4 quarters of data; Q3, 2020 thru Q2, 2021.

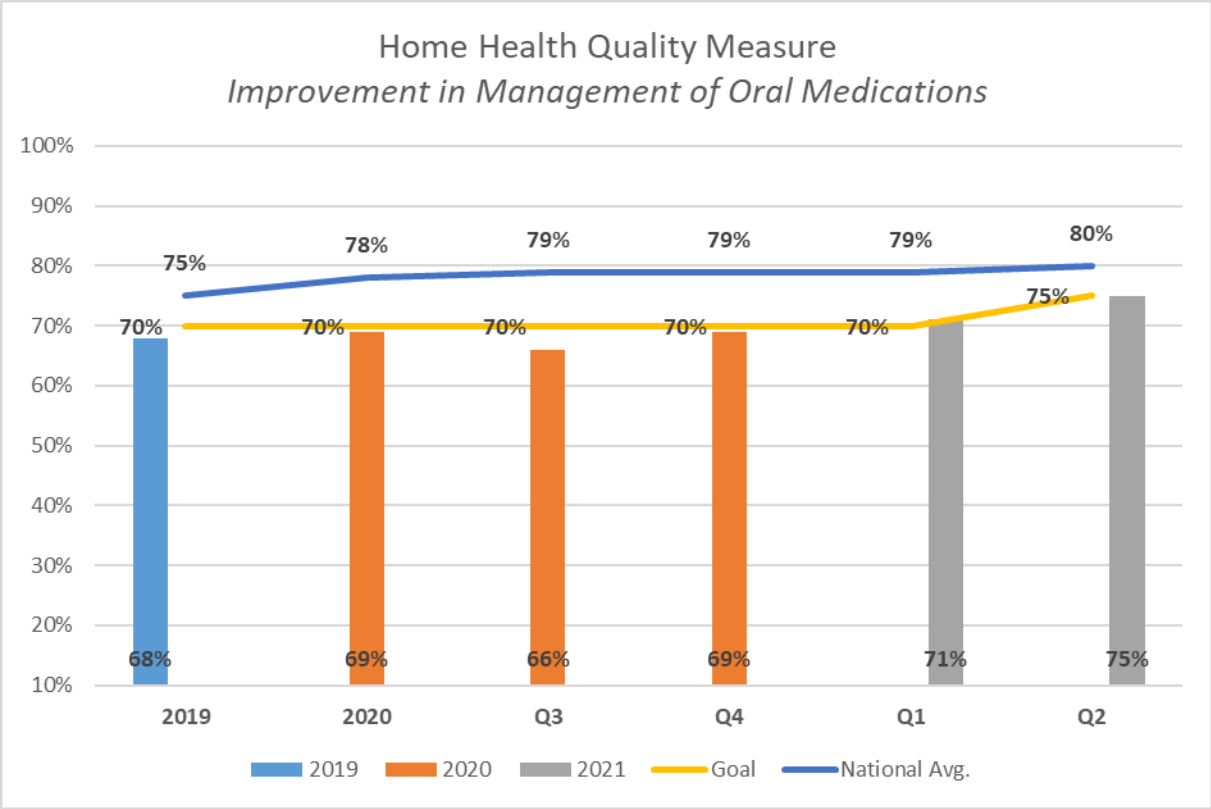
In order to ensure the most current and relevant data for analysis in this report, information was obtained from Internet Quality Improvement and Evaluation System (iQIES), a CMS platform that allows Medicare-certified home health agencies to view quality reports based on the Outcome and Assessment Information Set (OASIS) data submitted by that agency.
****OASIS is a data collection tool that all Medicare-certified home health agencies are required to collect and transmit to CMS for all patients whose care is reimbursed by Medicare and Medicaid with the following exceptions; patients receiving maternity services, patients under 18, or patients receiving housekeeping services only.***

Measure Description:
How often patients got better at taking their drugs correctly by mouth
--Home Health Clinicians (registered nurses, physical therapists) complete OASIS data upon a patient's admission to home health. Clinicians must assess the patient's ability to take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times. At discharge, the same assessment is performed. If a patient is assessed to be at the same level, they are considered *stabilized*. Stabilized is counted as a negative outcome for this measure. Patients who require more assistance are considered to have *deteriorated*, also a negative outcome. Patients assessed to be independent upon admission and remain independent upon discharge, or who do not take any oral medications are not counted in this measure.

Measure Objective/Goal:
Improvement in Management of Oral Medications

- **iQIES data 2019: 68%**
- **iQIES data 2020: 69%**
- **iQIES data Quarters 3 & 4, 2020 to Quarters 1 & 2, 2021: 70%**

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



**Higher percentages are better for this measure. Graph depicts the last 4 quarters in individual quarters to accurately assess response to previous interventions and guide upcoming action plan.*

Date range of data evaluated:
iQIES; July 1, 2020 to June 30, 2021

Analysis of all measures/data: (Include key findings, improvements, opportunities)
--CY 2020 data of 69%, is below the National Average of all home health reporting agencies.
--Opportunity for teaching with staff due to the multi-level assessment in this measure. Clinicians must differentiate patient's ability to perform the steps in this measure independently versus the level of family/caregiver assistance with medication regimen. Patient's ability to obtain the medication from where it is routinely stored, the ability to read the label or accurately identify medication by placing a character on label, open the container, remove the correct quantity and orally ingest at the correct frequency.
--Functional ability as well as cognitive ability may impact patient's ability to safely manage medications.

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

--Medical record review noted inconsistencies with clinicians scoring of oral medication administration and ability to ambulate. OASIS guidance requires the clinician consider the patient's ability to obtain the medication from where it is routinely stored.
--Educator met with clinicians who were inconsistent in scoring medication regime ability and function. Education based on CMS guidance for scoring patients ability reviewed with clinicians, focused and follow up education provided.

<u>If improvement opportunities identified, provide action plan and expected resolution date:</u>
There is an opportunity for improvement in this area. The following plan of action shall be implemented;
--Home Health Educator will work with UBC to create a "checklist/tool" to be used when assessing function in addition to current methods clinician already use. Educator will provide demonstration to all clinicians on use of the checklist once finalized, no later than March staff meeting.
--Educator and Intake RN will review data from clinician charting and OASIS for inconsistencies and meet with clinician to provide immediate feedback.
--Clinicians will utilize the "5 Day Rule" allowed by CMS. CME encourages a collaboration between all clinicians who assessed a patient within 5 days of the first OASIS assessment. This will ensure accurate capture of a patient's need and the opportunity to provide the resources needed to help achieve *Outstanding Community Health* consistent with the Kaweah Health District pillar.

<u>Next Steps/Recommendations/Outcomes:</u>
Educator and RN Intake Auditor will monitor the effectiveness of these interventions weekly during chart audits. Educator will report these findings along with trends to Home Health Manager at least every 30 days. Educator will analyze OASIS outcome data reports for this measure quarterly and report to Home Health Manager and Director. Educator and Home Health Manager will modify interventions until we meet, or exceed, the national average for three or more quarters.

<u>Submitted by Name:</u>
Shannon Esparza, RN

<u>Date Submitted:</u>
February 10, 2022

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

Live with passion.

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

Kaweah Health

Catheter Associated Urinary Tract Infection (CAUTI) Quality Focus Team Report April 2022

Kari Knudsen, Director of Post-Surgical Care (Chair)
Alisha Sandidge, Advanced Practice Nurse (Co-Chair)

CAUTI- FY22 Goals

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							16 (12 predicted over 6 months)	1.177	≤0.676	0.54 1.12

*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.

Kaizen Root Cause

Analysis:

Identified Root Causes
(in order from most significant to least):

1. Communication
2. Leadership Standard Work
3. Peri-care/Bathing
4. Prompt Catheter Removal
5. Culture Ordering
6. Retention Management
7. Staff Consistency with prevention bundle
8. Alternatives to Catheter Insertion

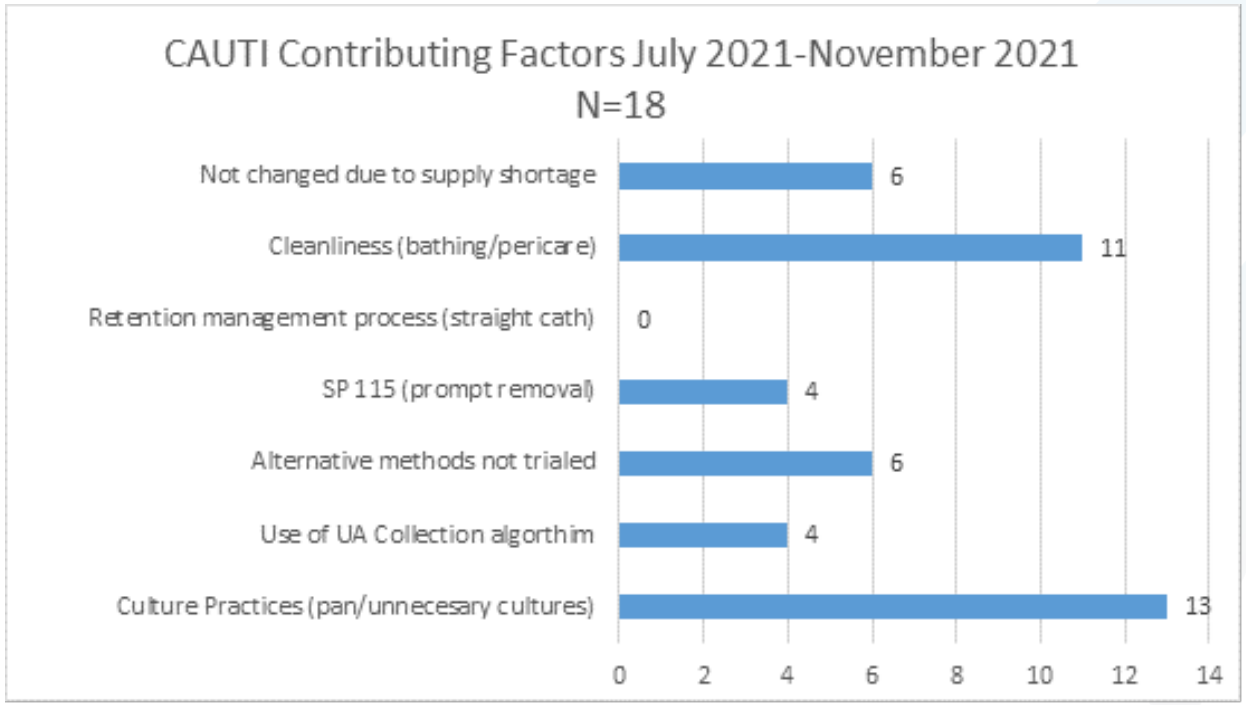
Kaizen improvement strategies focused on addressing the top 4 root causes

Initial KAIZEN initiatives focused on the top **4** root causes

Since April 2020 we have incorporated strategies to address **7** of the root causes, including:
Culture ordering
Retention Management
Alternatives to Catheter Insertion

Kaweah Health

Background



- Multidisciplinary team reviews CAUTI events and counts contributing factors to events based on CDC evidenced-based guidelines
- Daily Gemba Rounds occur to review lines for necessity and appropriateness for alternatives
- FY 22: 54% CAUTI events a second culture was ordered within 24 hours of urine culture = pan culturing
- Single episode of fever or leukocytosis precipitated the urine culture in 38.2% of events (2021 thru Oct)
- Surge documentation in effect during this time frame skews the data; unknown if bathing performed and not documented or not done

Kaweah Health

Post KAIZEN-Gemba Data

CAUTI Committee Dashboard

Measure Description	Benchmark/ Target	Mar-20	Qtr 2 2020	Qtr 3 2020	Qtr 4 2020	Qtr 1 2021	Qtr 2 2021	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
OUTCOME MEASURES															
Number of CAUTI	0	0	4	2	3	1	3	1	3	5	2	2	1	3	3
FYTD SIR	≤0.676							0.569			1.436	1.319	1.177	1.22	1.24
PROCESS MEASURES IUC Gemba Rounds															
% of pts with appropriate cleanliness	99%	98%	97%	97%	99% (e)	99%	99% (e)	98%			95%	100%	99%	99%	99%
% of pts with order present with indication	100%	90%	93%	92%	95% (e)	93%	93% (e)	94%			96%	97%	95%	98%	96%
% of IUCs where removal was attempted	n/a	8%	6%	6%	4%(e)	4%	4%(e)	6%			3%	3%	7%	27%	26%
% of pts where alternatives have been attempted	n/a	15%	11%	11%	9%(e)	10%	10% (e)	15%			8%	7%	11%	19%	9%
# of Pt Catheter days rounded on	n/a	616	2545	3280	2093	2757	1879	1045			1068	902	874	802	931
% of IUCs removed because of Gemba Round	n/a	7%	4%	4%	5%(e)	6%	6%(e)	6%			4%	5%	7%	6%	4%
# of IUCs removed because of Gemba Round	n/a	46	110	142	104	152	94	43			43	49	64	48	37
*volume reduced due to reduced Gemba on weekends **FYTD includes cases removed in Mar 2021 *e=estimated	Equal or Better than Target						Within 5% of Target				Does not meet Target				

FY22

Total Catheter days rounded on = **5622**

99% of patients with daily bath and peri-care each shift

96% have order and valid rationale

284 catheters removed as a result of the Gemba

Kaweah Health

CAUTI QFT – Key Strategies

- "Culture of Culturing"
  - "Pan Culture" rates
  - Quantify volume of cultures ordered when a previous culture was ordered within 48-72 hrs
  - Reviewed data set and results with hospitalists Jan 2022
  - Data review with intensivists planned
  - Case review of all CAUTI since July were pan culturing suspected by resident MD and NP in progress
- Closing the loop on best practice development from the ICU Forum- hardwiring best practice continues
- Medline Urology product line conversion complete
- Final SonoSite Bladder scanners purchased- each unit has a state of the art ultrasound machine to scan the bladder ~ thank you Foundation!

Live with passion.

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

Kaweah Health

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: CAUTI QFT **ProStaff/QIC Report Date:** 4/12/2022

Measure Objective/Goal:

- Goal for FY22 ≤ 0.676 (CMS 50th percentile); **Current SIR = 1.24**
- Pre KAIZEN baseline SIR is 1.557
- SIR is as of February 2022; Actual CAUTI FY22 is 22

CAUTIs result in poor outcomes for patients, a negative public perception of care through publically reported safety scores and financially impact the organization through HAC and VBP programs as well as increased treatment costs and LOS.

Date range of data evaluated: FYTD SIR (7/2021 – 2/2022)

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):

CAUTI Committee Dashboard

Measure Description	Benchmark/ Target	Mar-20	Qtr 2 2020	Qtr 3 2020	Qtr 4 2020	Qtr 1 2021	Qtr 2 2021	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
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FY 22 Total Catheter Days rounded on = 5622

99% of patients with daily bath and peri-care per shift

96% with order and valid rationale

284 catheters removed as a result of the Gemba

Opportunities:

- Accurate, timely and clinically indicated cultures; reduce pan-culturing practices
- Appropriate indications for IUC, reduction in IUC use; using alternatives to IUC
- Learning from Fallouts

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

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

CAUTI QUALITY IMPROVEMENT STRATEGIES	STATUS
1. Adding sticker to IUC GOAL: Visual reminder to replace IUC prior to specimen collection after 72 hours to reduce false positives from biofilm	Go live in May 2022
2. Fever Indication for Culture Task Force: CAUTI/CLABSI medical case review complete for all events this FY where pan culturing present, data synthesis pending; Data presentation for intensivist group	In progress
3. ICU Forum- follow up to action plan implementation	In progress
4. Create Gemba rounds, daily M-F on every patient with a urinary catheter	3/2020
5. Create change IUC task at 30 days following documented insertion GOAL- trigger nursing staff to change chronically retained IUC	12/23/20
6. Hide single Insert IUC orderable for downtown campus and Rehab GOAL: Improve bundle compliance by driving use of the insert IUC Powerplan which contains needed maintenance elements	10/27/20
7. Kaizen strategy: evaluate option for time clock for line info GOAL- Improve prompt removal, visual reminder of how long the line has been in place	11/24/2020
8. CAUTI Case Reviews Lessons Learned GOAL – Reduce CAUTI by ensuring identified opportunities are addressed globally	On-going
9. Bathing Prioritization (in collaboration with CLABSI Committee) GOAL – Improve bathing/peri-care of IUC patients	10/27/20
10. Add 'restricted use' to the urine culture only orderable GOAL- reduce use of culture only order in defined populations without accompanying UA	7/28/20
11. Develop insert IUC Powerplan to include important maintenance elements: straight cath option prior to IUC insertion, change IUC prior to specimen collection, change IUC at 30 days GOAL- Create and bundle essential orders for IUC maintenance	8/25/20
12. Develop provider update/education related to current CAUTI status and how to order IUC/Culturing awareness GOAL- create awareness	9/29/20
13. Changes to discontinue IUC orderable- alerts RN to dc the insert IUC Powerplan and related maintain order GOAL- assist with order clean up	8/25/20
14. Develop orders for Adult Urinary Retention management GOAL- orders for retention management currently exist as one off options, bundling them together for ease of ordering increases use	9/29/20
15. Place all IUC order resources on eCoach GOAL- Increase IUC appropriateness/ prompt removal, bundle compliance (improving ease of access for providers and nursing staff)	2/16/21
16. Develop Urine Culture only powerplan to replace single orderable. GOAL- Reduce CAUTI events related to culture ordering by guiding intentional use of this risky order	2/23/21
17. Add 3-way catheter as trigger to device list GOAL- accurate collection of device count	4/22/21
18. Safety Summit (CAUTI education for new hires) relaunch post-COVID GOAL – Improve/sustain RN bundle compliance	6/22/21
19. Changes to the discontinue order- alert will prompt the provider to order retention management order GOAL- provides orders for nursing to manage post IUC DC retention	5/25/21
20. Kari will discuss CN "review" of culture orders before obtaining specimen at PPC for input, bring back to QFT	3/22/21
21. Medline urology assessment	5/25/21
22. Powerchart changes- IUC dynamic group for POA include present on transfer from OR/procedure GOAL- capture device list for lines already in place	7/21/22
23. Embed IUC insert power plan in existing Powerplans where the insert IUC order exists	10/25/21

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

GOAL – Improve IUC order appropriateness and bundle compliance with increased use of Powerplan which contains needed IUC maintenance elements	
24. IUC inserted in OR/procedural areas- no insert order = no maintain order = no reason for insertion. Create maintain subphase and insert in existing appropriate powerplans. GOAL: Functional efficiencies to require rationale of IUC.	10/25/21
25. Resident Notifications of near misses and events GOAL: Resident request for awareness and learning opportunities.	11/23/21
26. Mandatory CBL Resident education On-going monitoring	5/25/21
27. Letter for providers on events (like CLABSI) GOAL: Provider awareness of HAI.	3/19/22
28. Rapid Cycle Post Gemba Rounds 29. GOAL – reduce IUC utilization, verify completion of follow up	11/23/21
30. Primofit & Medline External Male Catheter Product Trial GOAL: Reliable method for male external alternative to IUC	3/19/22
31. SonoSite Bladder Scanner conversion	3/19/22
32. On-going attempts to do in person Resident education	8/23/21
33. ICU Forum	1/24/22
34. Add number of attempts for IUC insertion, Policy no more than 2 attempts.	1/24/22
35. Medline Urology product line conversion	3/22/22

*QI strategies colored green indicate completed; yellow indicates in process strategies

Next Steps/Recommendations/Outcomes:

A. Continue to maintain Kaizen initiatives: Daily IUC Gemba rounds, data collection, and dissemination and QI strategy development.
B. Continue to monitor CAUTI events, reviewed with unit leadership at the HAI review meeting, unit leadership creates quality improvement plan and implements at the unit level. The QFT monitors QI opportunities for global implementation
C. Continue to address culturing practices in newly revised Fever as an Indication for Culture Taskforce with medical staff partnership

Submitted by Name: Kari Knudsen **Date Submitted:** 4/6/2022

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

Cardiac Surgery Data Quality Analysis

Q3 2020 → Q2 2021

Risk Adjusted Data

Green = Better or Equal to the STS National Average

Red = Worse than the STS National Average

Gray = Non-Risk Adjusted Value (for Reference only)

DATA ANALYSES BY THE SOCIETY OF THORACIC SURGEONS NATIONAL ADULT CARDIAC SURGERY DATABASE

Duke Clinical Research Institute
DUKE UNIVERSITY MEDICAL CENTER

Kaweah Health
MORE THAN MEDICINE. LIFE.

Star Ratings 2020
Isolated Coronary Artery Bypass Grafting

Star Ratings are only calculated ending Q2 & Q4 each year

The Society of Thoracic Surgeons

STS CABG Composite Quality Rating
Participant: 30045
STS Period Ending Jun 2021

Domain	Rating	Participant		STS				
		Score	98% CI	Score	Min - Max	10th	50th	90th
Overall	★★	**96.96%**	(96.10-97.70)	**96.79%**	(91.04-98.98)	95.30%	96.95%	98.06%
Absence of Mortality	★★	**97.72%**	(96.61-98.58)	**97.54%**	(92.00-99.32)	96.28%	97.70%	98.60%
Absence of Morbidity	★★	**88.98%**	(86.55-91.20)	**89.42%**	(74.39-96.26)	85.06%	89.83%	93.24%
Use of IMA	★★	**99.00%**	(98.06-99.62)	**99.36%**	(80.47-99.99)	98.63%	99.63%	99.90%
Medications	★★★	**98.44%**	(97.28-99.27)	**94.30%**	(45.31-99.96)	86.59%	96.90%	99.46%

★ Worse than Expected. Participant's performance is significantly worse than expected for their specific case-mix.

★★ As Expected. Participant's performance is not statistically different than expected for their specific case-mix.

★★★ Better than Expected. Participant's performance is significantly better than expected for their specific case-mix.

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Star Ratings 2020
Aortic Valve Replacement

Star Ratings are only calculated ending Q2 & Q4 each year

The Society of Thoracic Surgeons

STS AVR Composite Quality Rating
Participant: 30045
STS Period Ending Jun 2021

Domain	Rating	Participant		STS				
		Score	95% CI	Score	Min - Max	10th	50th	90th
Overall	★★	**95.45%**	(92.97-97.26)	**95.39%**	(85.27-98.60)	93.11%	95.70%	97.28%
Absence of Mortality	★★	**98.02%**	(96.31-99.09)	**97.80%**	(93.02-99.40)	96.65%	97.96%	98.76%
Absence of Morbidity	★★	**89.26%**	(84.54-92.99)	**89.93%**	(77.51-95.90)	86.34%	90.25%	93.10%

★ Worse than Expected. Participant's performance is significantly worse than expected for their specific case-mix.

★★ As Expected. Participant's performance is not statistically different than expected for their specific case-mix.

★★★ Better than Expected. Participant's performance is significantly better than expected for their specific case-mix.

Kaweah Health

STAR RATINGS 2020
CABG w/ AORTIC VALVE REPLACEMENT

STAR RATINGS ARE ONLY CALCULATED ENDING Q2 & Q4 EACH YEAR

The Society of Thoracic Surgeons

STS AVR + CABG Composite Quality Rating
Participant: 30045
STS Period Ending Jun 2021

Domain	Rating	Participant		STS				
		Score	95% CI	Score	Min - Max	10th	50th	90th
Overall	★★	**92.90%**	(89.64-95.40)	**92.20%**	(79.35-97.47)	88.61%	92.63%	95.23%
Absence of Mortality	★★	**96.29%**	(93.35-98.22)	**96.02%**	(86.94-99.01)	93.79%	96.34%	97.85%
Absence of Morbidity	★★	**84.09%**	(77.53-89.45)	**83.23%**	(65.03-93.39)	77.26%	83.71%	88.60%

★ Worse than Expected. Participant's performance is significantly worse than expected for their specific case-mix.

★★ As Expected. Participant's performance is not statistically different than expected for their specific case-mix.

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Kaweah Health

Healthgrades

Specialty Clinical Quality Awards & Ratings

Specialty Clinical Quality Awards

America's 50 Best Hospitals for Cardiac Surgery Award™ (2022, 2021, 2020)
Superior clinical outcomes in heart bypass surgery and heart valve surgery

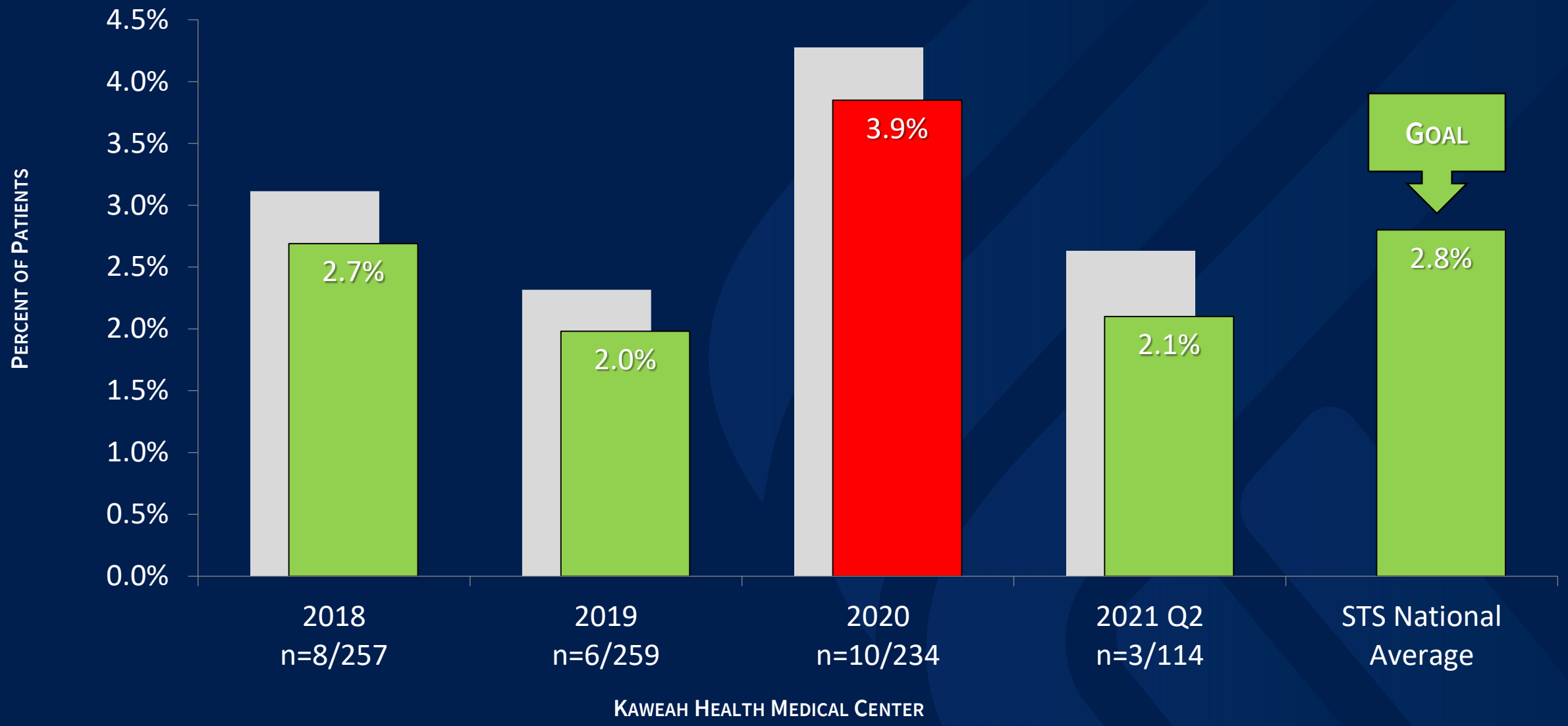
America's 100 Best Hospitals for Cardiac Care Award™ (2019)
Superior clinical outcomes in heart bypass surgery, coronary interventional procedures, heart attack treatment, heart failure treatment, and heart valve surgery

Hospital Quality Awards

America's 250 Best Hospitals Award™ (2021, 2020, 2019)
Top 5% in the nation for consistently delivering clinical quality

Resource 12/10/2021: www.healthgrades.com/hospital-directory/california-ca-southern/kaweah-health

All Operative Mortality[1]
Risk Adjusted in Color

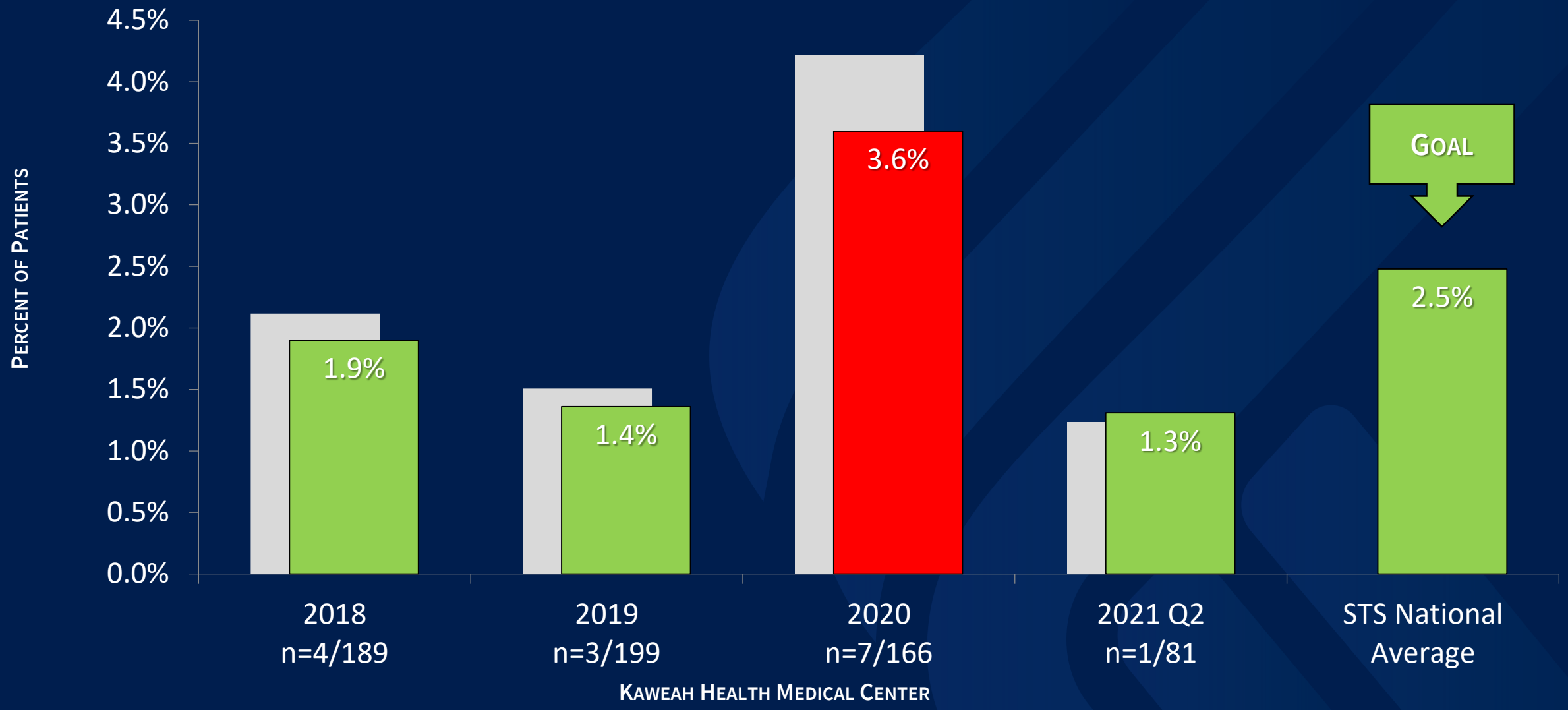


2021 Risk-adjusted O/E = 0.8

*STS National Average Comparison reporting period 01/01/2021 through 06/30/2021

[1] Includes all 7 Major Procedure Categories (CABG, AVR, AVR+CABG, MVR, MVR+CABG, MVP, MVP+CABG) Excludes Other category procedures, Q3-2020 forward COVID+ pt.'s Excluded.

CABG Operative Mortality
Risk Adjusted in Color

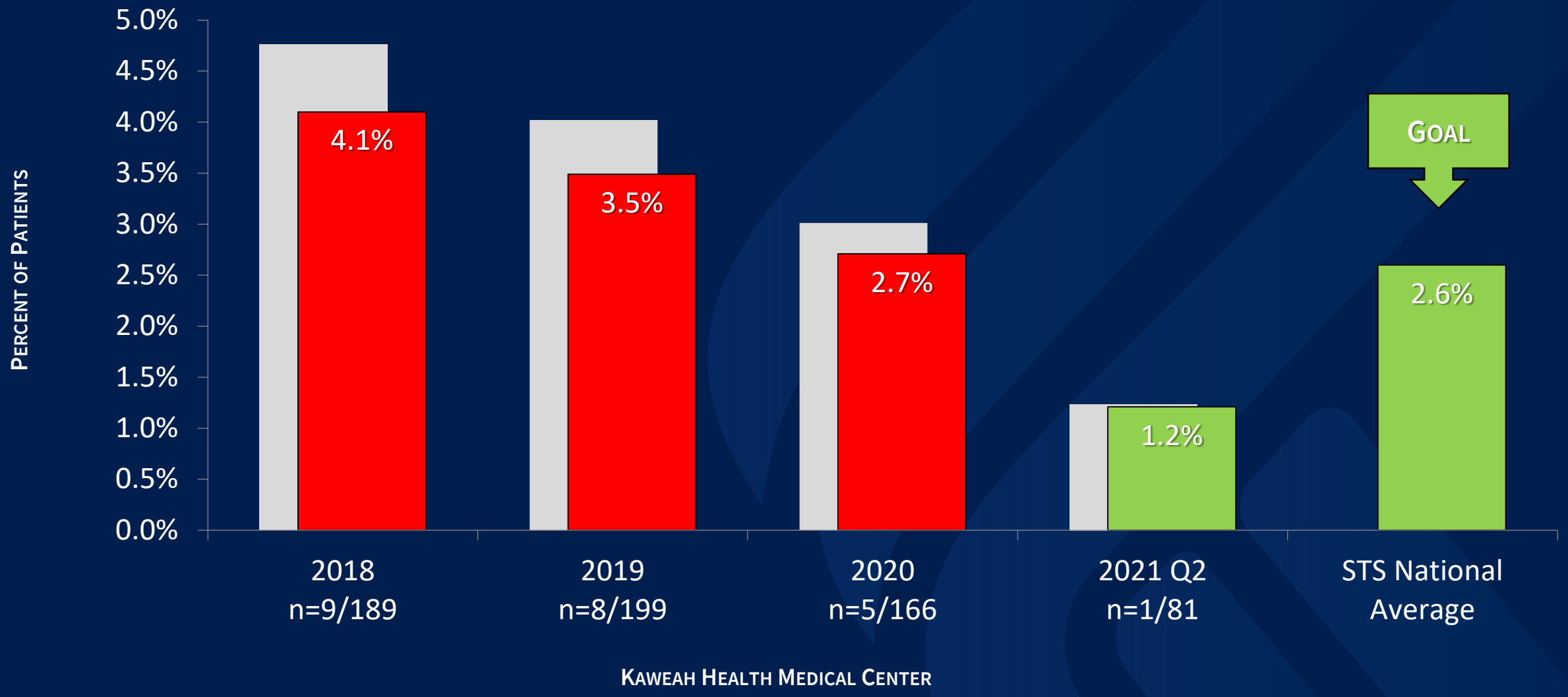


2021 Risk-adjusted O/E = 0.5
*STS National Average Comparison reporting period 01/01/2021 through 06/30/2021
Q3-2020 forward COVID+ pt.'s Excluded.

Kaweah Health Pt. Populations

*STS National Average Comparison reporting period 01/01/2021 through 06/30/2021– Isolated CABG cases ONLY

CABG Re-Operation[1]
Risk Adjusted in Color



2021 Risk-adjusted O/E = 0.46

*STS National Average Comparison reporting period 01/01/2021 through 06/30/2021

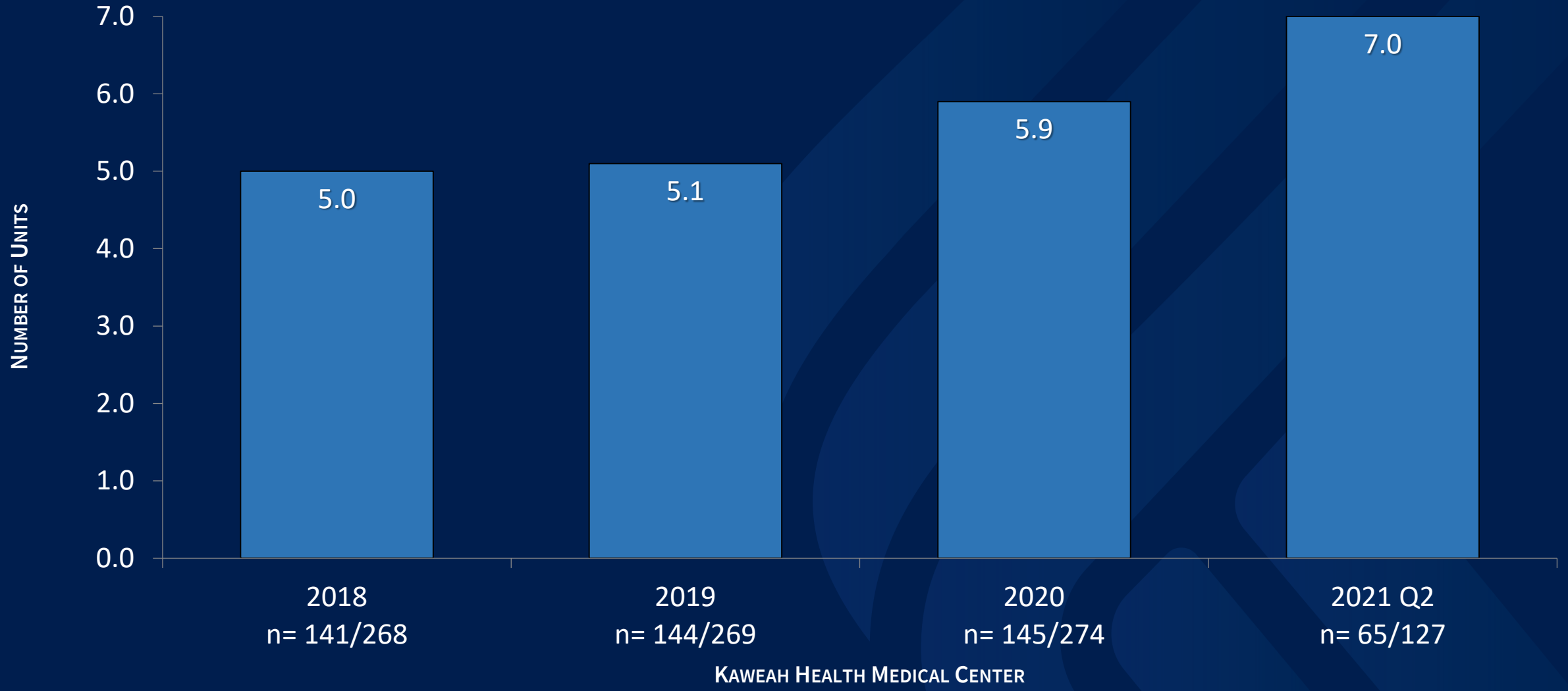
[1]Surgeries include Reoperation for bleeding/tamponade, valvular dysfunction, unplanned coronary artery intervention, aortic reintervention or other cardiac reason, Q3-2020 forward COVID+ pt.'s Excluded.

Quality Initiative:

Intra-operative Patient Safety

- Time out performed with entire surgical team (Surgeon, Anesthesia, RN, Techs and Perfusion)
- Surgeon led briefing on procedure expectations with entire surgical team after each Time out
- Perfusion check list completed prior to each case
- Minimize trips to the Sterile Core by Nursing staff
- Minimize OR traffic (i.e.: coordinated switching of staff for breaks)
- Noise reduction implemented during cases:
  - Discussions about current surgical case only
  - Avoid conversations about other issues
  - Music to be calming and at a lower volume
  - All phones & beepers at the Nurses desk

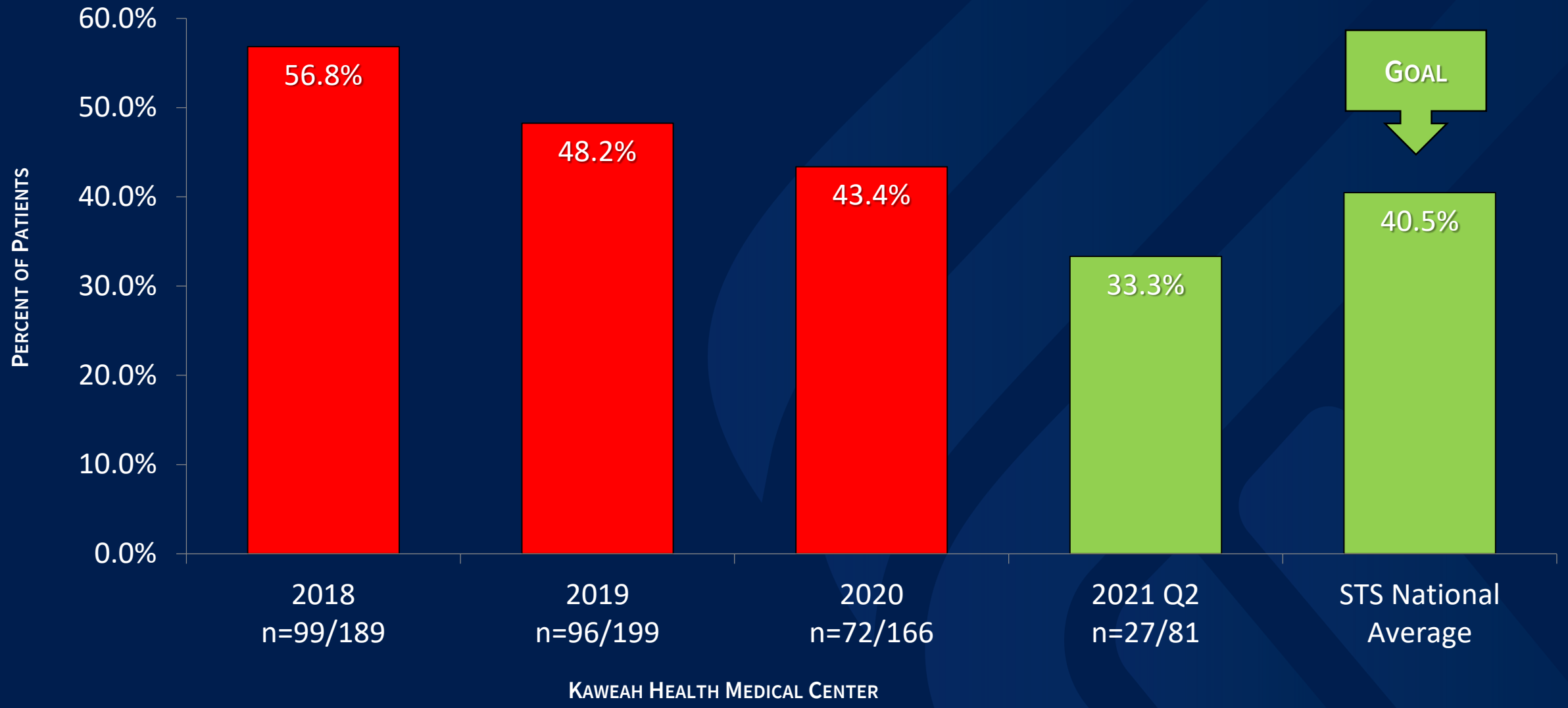
Blood Usage – Average Units / Pt. receiving products[1] (No National Comparison Data)



[1] All STS surgeries – Includes any blood products given Intra-op and Post-op (Excludes patients that did not receive any blood products; excludes pre-op Hgb<8, Emergent/Salvage, COVID+)

*Data is not reported on the STS National Outcomes Report

CABG Intra & Post-Op Blood Product Usage[1]



2021 O/E = 0.8

*STS National Average Comparison reporting period 01/01/2021 through 06/30/2021

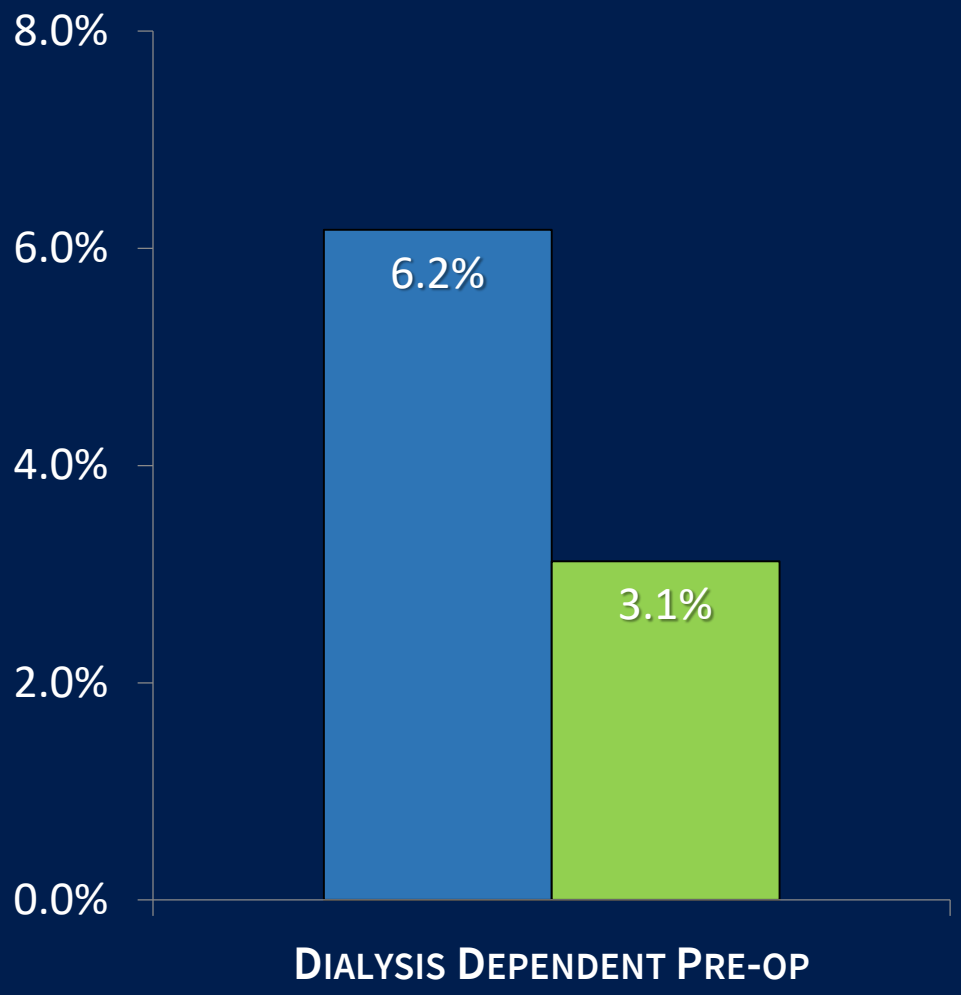
[1]Surgeries where at least one unit of Red Blood Cells, Fresh Frozen Plasma, Platelets or Cryoprecipitate was given Intra-and/or Post-operatively. Q3-2020 forward COVID+ pt.'s Excluded.

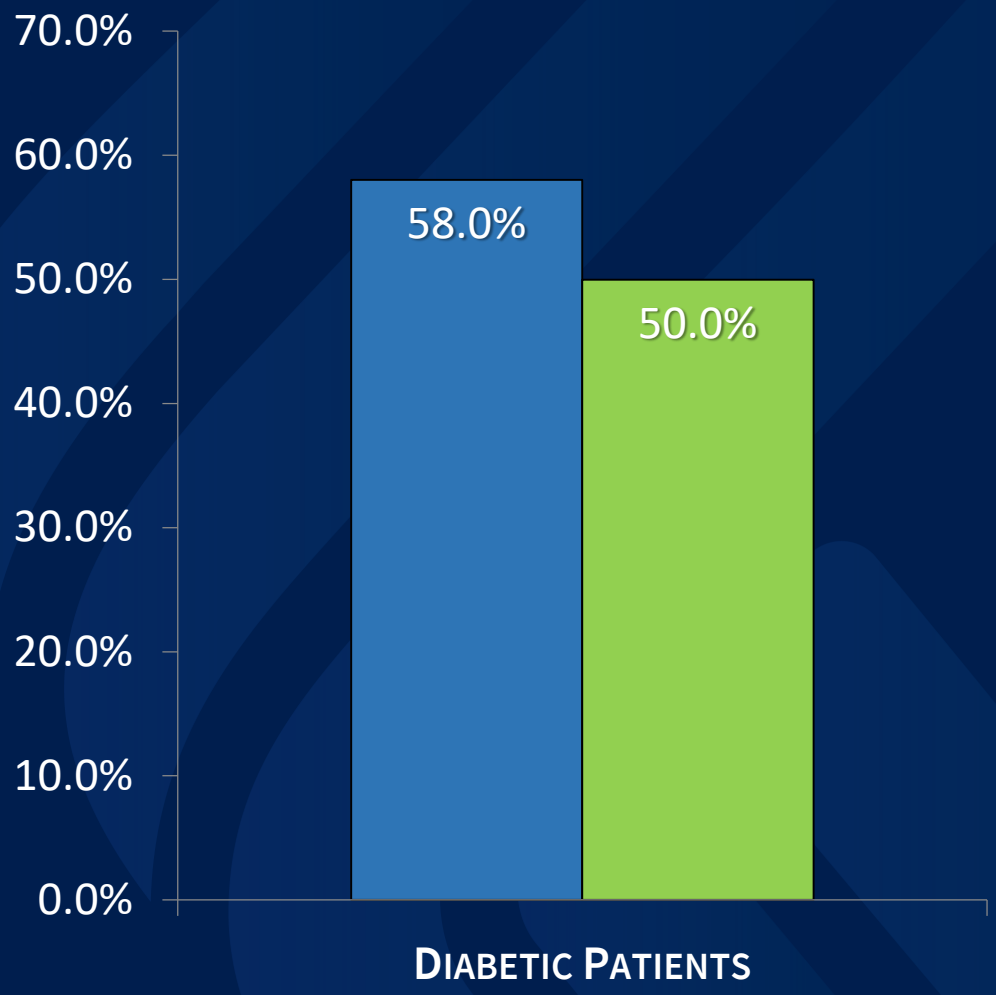
Quality Initiative:

Bleeding Event & Blood Product Usage

- Quarterly review of blood usage throughout Pt. stay
- TEG coagulation monitoring
- Antifibrinolytic agents
- Heparin monitoring
- Heparin coated circuits
- Hemostasis achieved during procedure
- Cell saver utilized during surgery
- Restrictive transfusion criteria
- Surgeon approval of each transfusion
- Treatment of pre-operative anemia or transfusion as needed

Kaweah Health Pt. Populations



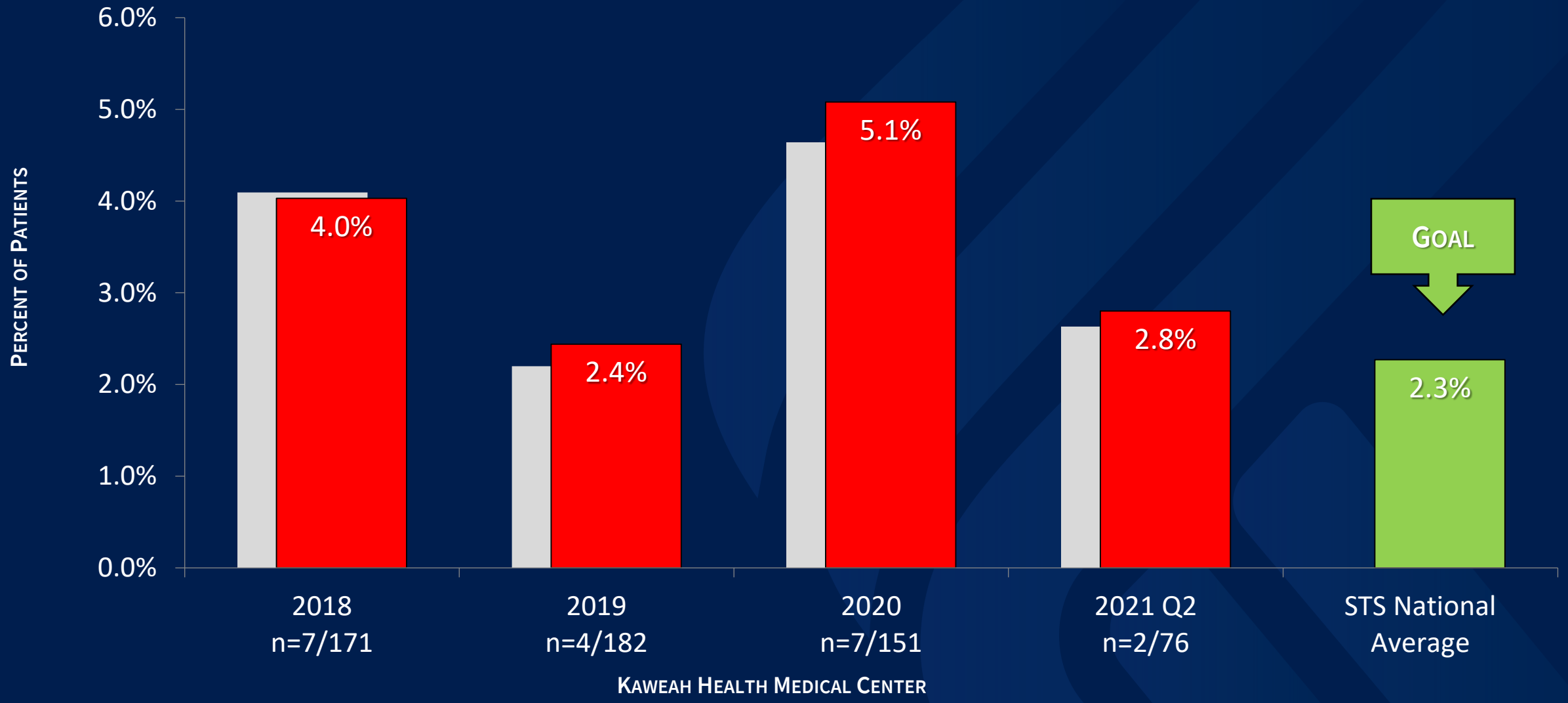


Kaweah Health Rate

STS National Rate

*STS National Average Comparison reporting period 01/01/2021 through 06/30/2021- Isolated CABG cases ONLY

CABG Post-Op Renal Failure[1]
Risk Adjusted in Color



2021 Risk-adjusted O/E = 1.2

*STS National Average Comparison reporting period 01/01/2021 through 06/30/2021

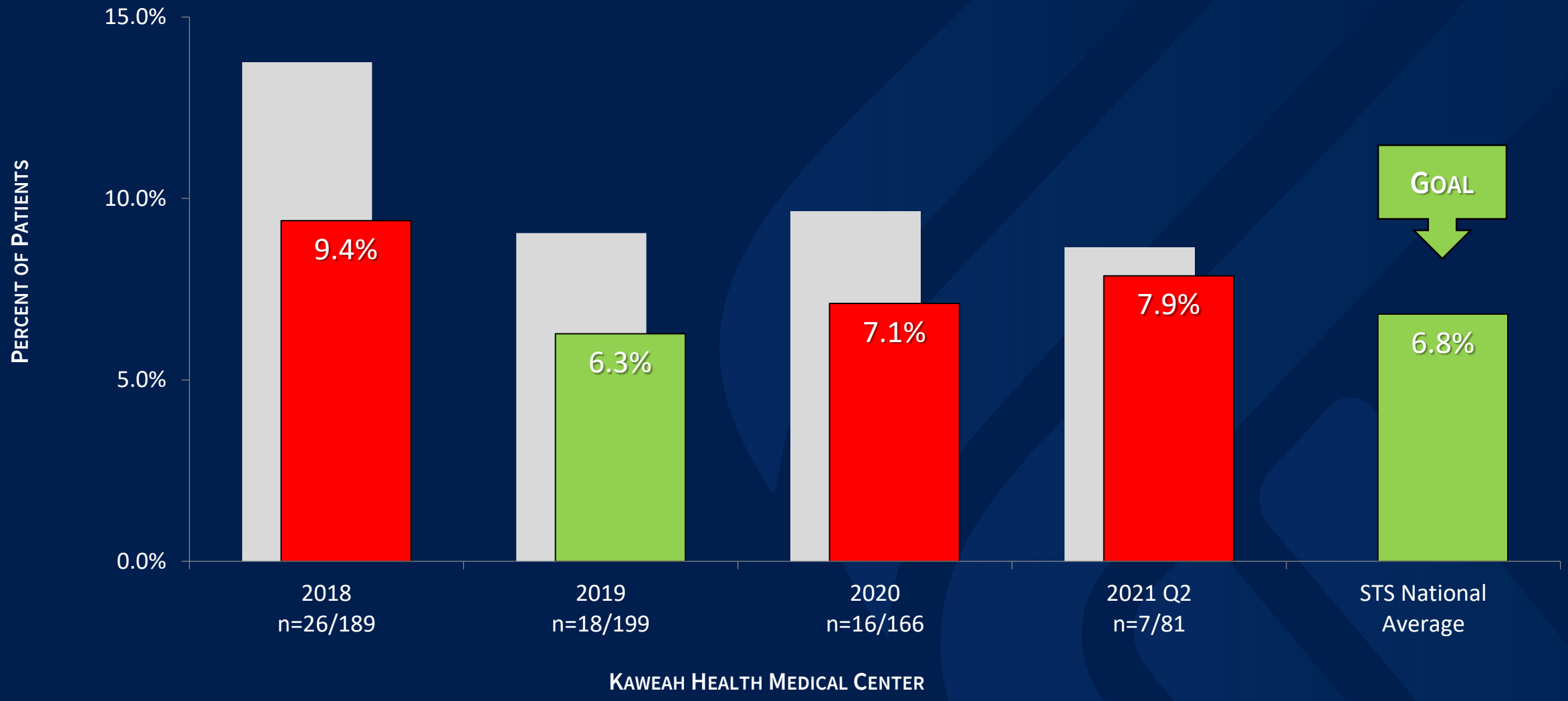
[1] Excludes patients with preoperative dialysis or preoperative Creatinine ≥ 4, Q3-2020 forward COVID+ pt.'s Excluded.

Quality Initiative:

Renal Failure

- Risk factor evaluation pre-operatively
- Timing of surgery considered
- Diabetes control
- Liberal hydration
- Intra-operative blood flow & pressure controlled by perfusion and anesthesia
- Blood pressure management peri-operatively

CABG Prolonged Ventilation
Risk Adjusted in Color



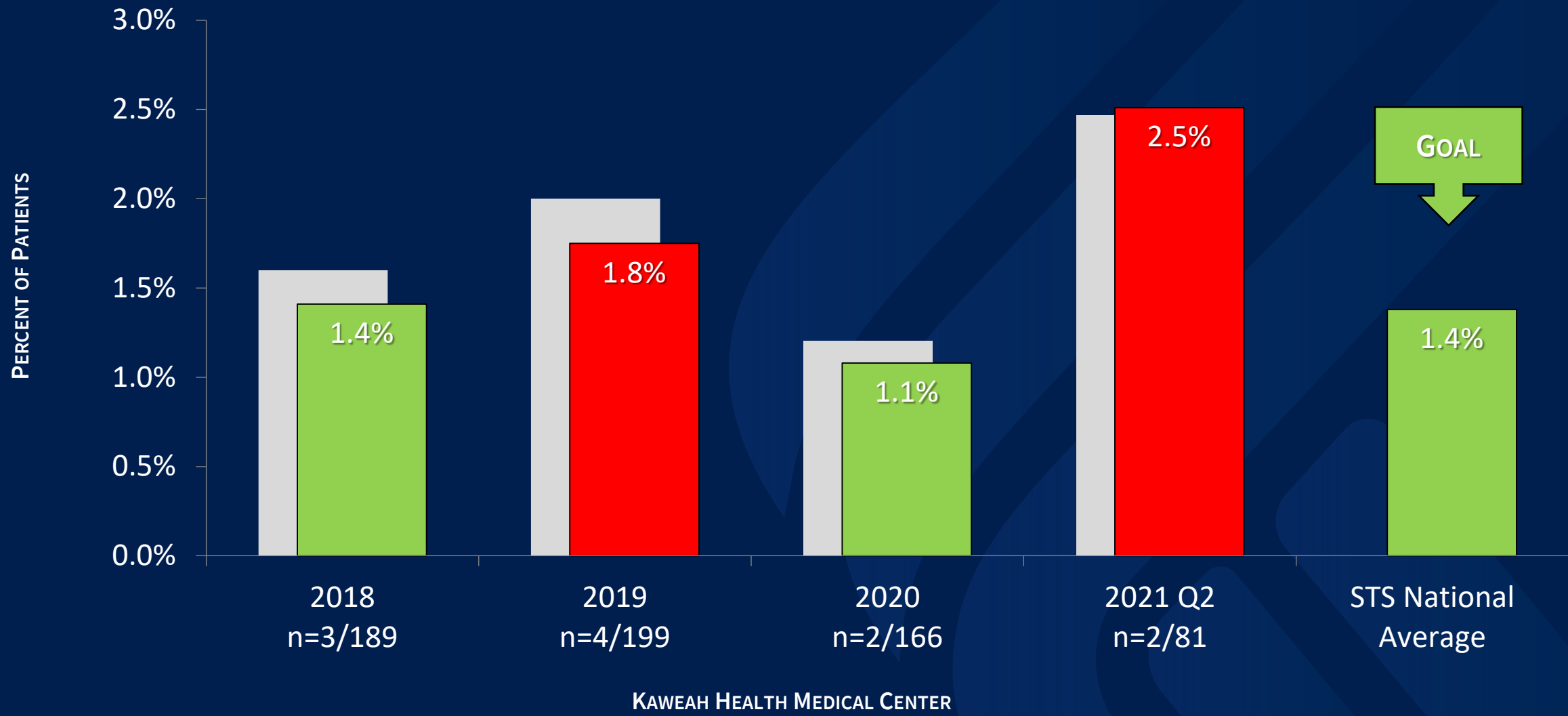
2021 Risk-adjusted O/E = 1.15
*STS National Average Comparison reporting period 01/01/2021 through 06/30/2021
Q3-2020 forward COVID+ pt.'s Excluded.

Quality Initiative:

Prolonged Ventilation

- Monthly audit & analysis of prolonged ventilation times and delayed Extubation due to medical necessity
- Action Plan for 100% completion of Cardiac Extubation Tool ~ monitored by CVICU nurse manager
- Sedation and Analgesia to be used in an appropriate and conservative manner
- Avoid Benzodiazepines and narcotic drips
- To illicit calm awakening utilize Propofol & precedex drips when medically necessary
- Train nursing, medical and ancillary staff on the Fast Track Extubation Protocol available in PolicyTech
- Address ventilation time of each Pt. in rounds and shift reports by RN, RT & MD
- Promote Respiratory Therapy Education Tool for patients
- Review of Anesthesia Protocols
- Positive Base excess or > -2.0 on CVICU arrival
- Core Temperature > 36.0°C on CVICU arrival

CABG Post Op Permanent Stroke
Risk Adjusted in Color



Kaweah Health Medical Center

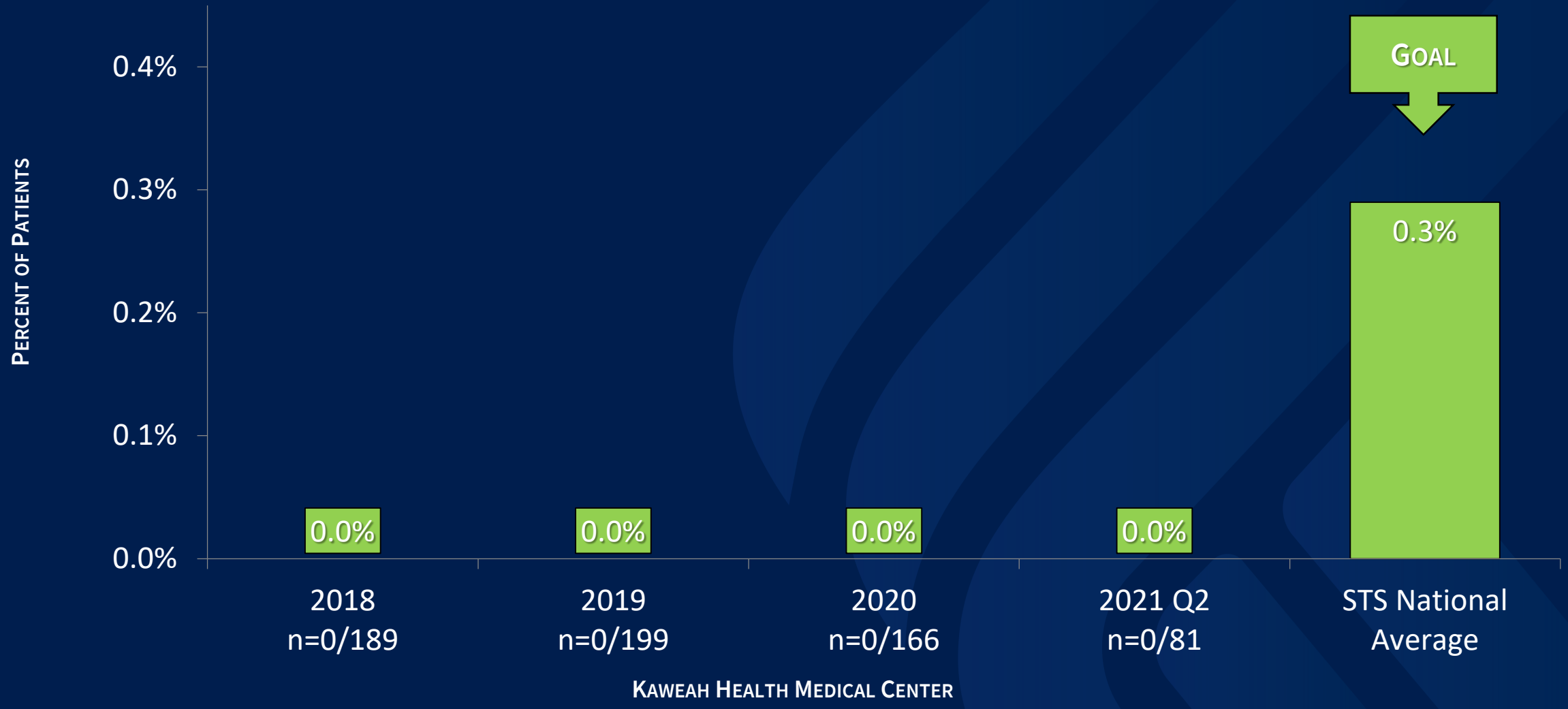
2021 Risk-adjusted O/E = 1.8
*STS National Average Comparison reporting period 01/01/2021 through 06/30/2021
Q3-2020 forward COVID+ pt.'s Excluded.

Quality Initiative:

Stroke Prevention

- Risk factor, neurological evaluation
- TEE, CT of the aorta with evaluation as needed
- Carotid Doppler ~ Ultrasound
- Invox cortical brain monitoring
- Intraoperative blood flow & pressure control by perfusion and anesthesia
- Intraoperative temperature control

CABG Post Op Deep Sternal Wound Infection
Risk Adjusted in Color



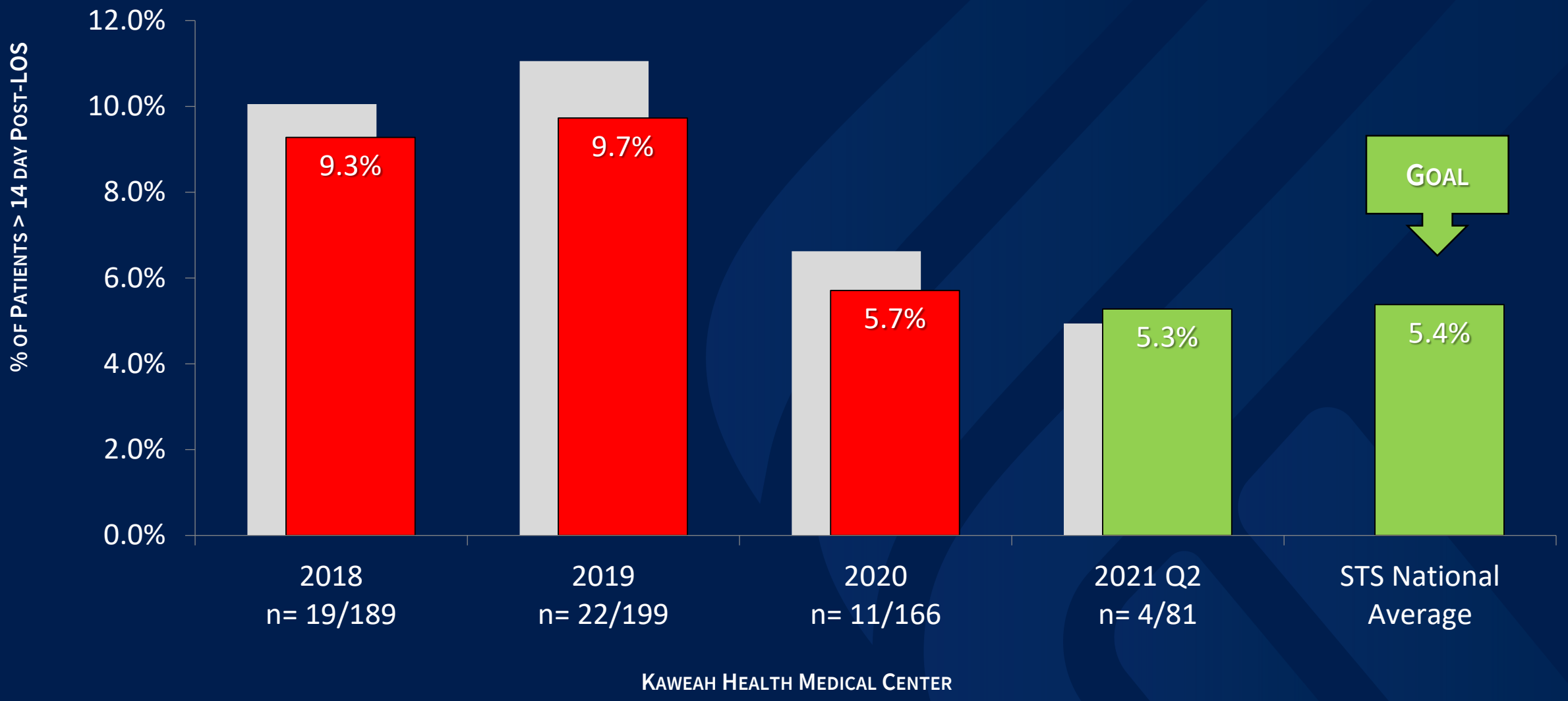
2021 Risk-adjusted O/E = 0
*STS National Average Comparison reporting period 01/01/2021 through 06/30/2021
Q3-2020 forward COVID+ pt.'s Excluded.

Quality Initiative:

Infection Prevention

- Glucose control w/ Glucommander – insulin drip or subcutaneous
- Two Chlorhexidine baths prior to surgery
- Chlorhexidine mouth wash used morning of surgery
- MRSA screening of each patient
- Terminal cleaning of operating rooms monitored daily
- Disposable ECG monitoring cables on each patient
- Use of Early closure technique for vein harvest incisions
- Vancomycin paste for sternal application
- Silver Nitrate or Prevena suction dressing applied to sternum
- Prophylactic antibiotic treatment for 48 hours
- Early removal of central lines and Foley catheter

CABG Post Op Length of Stay >14 Days
Risk Adjusted in Color



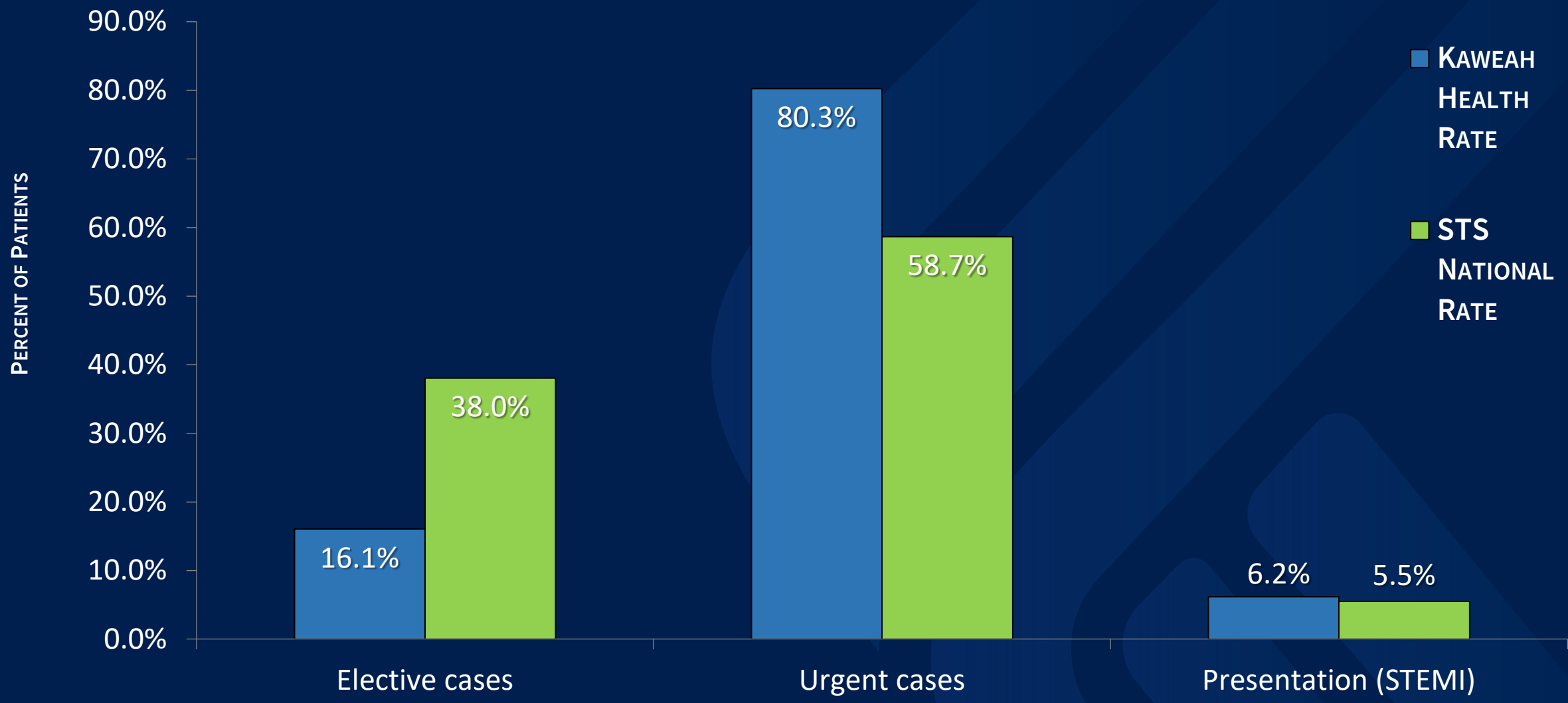
Kaweah Health Medical Center

2021 Risk-adjusted O/E = 1.0

*STS National Average Comparison reporting period 01/01/2021 through 06/30/2021

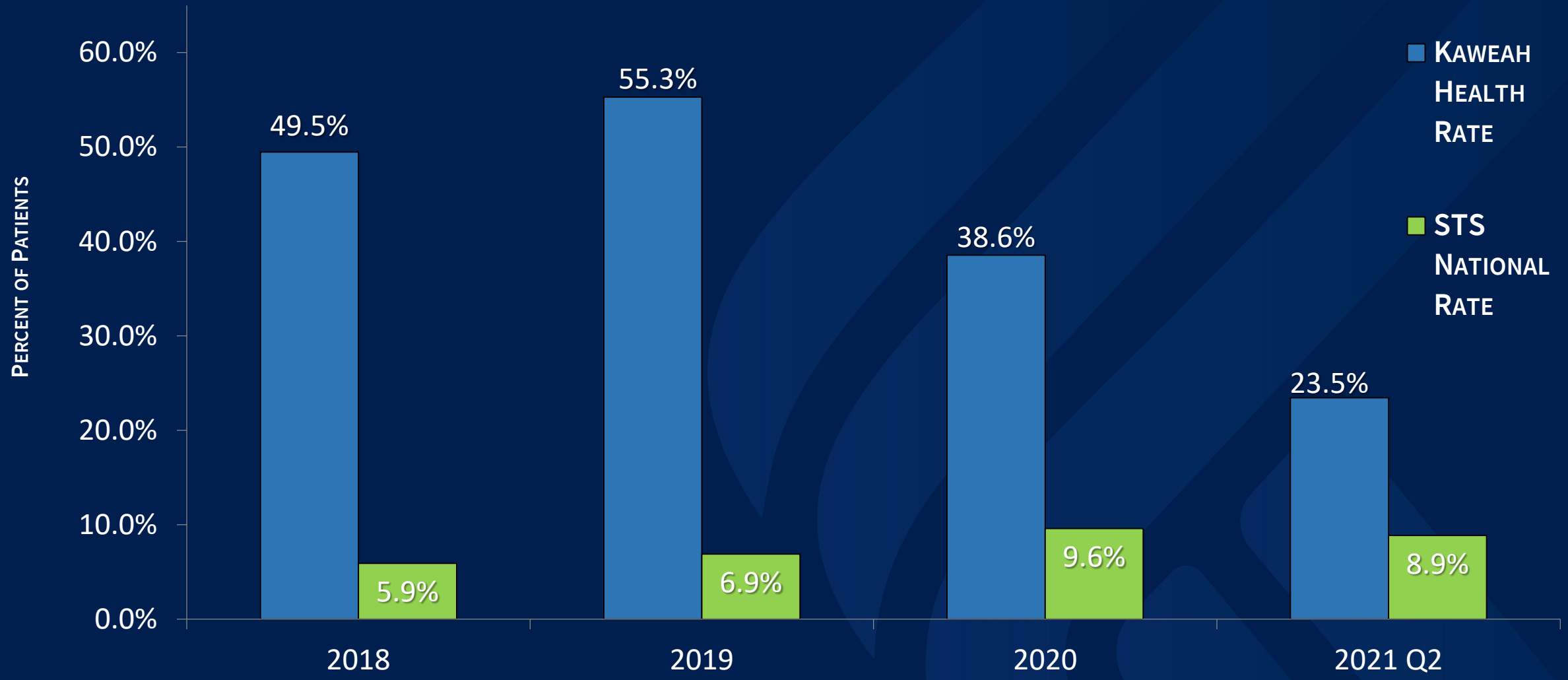
Post-operative Length of Stay: Long Stay is greater than 14 days (PLOS > 14 Days), Q3-2020 forward COVID+ pt.'s Excluded.

Kaweah Health Pt. Populations



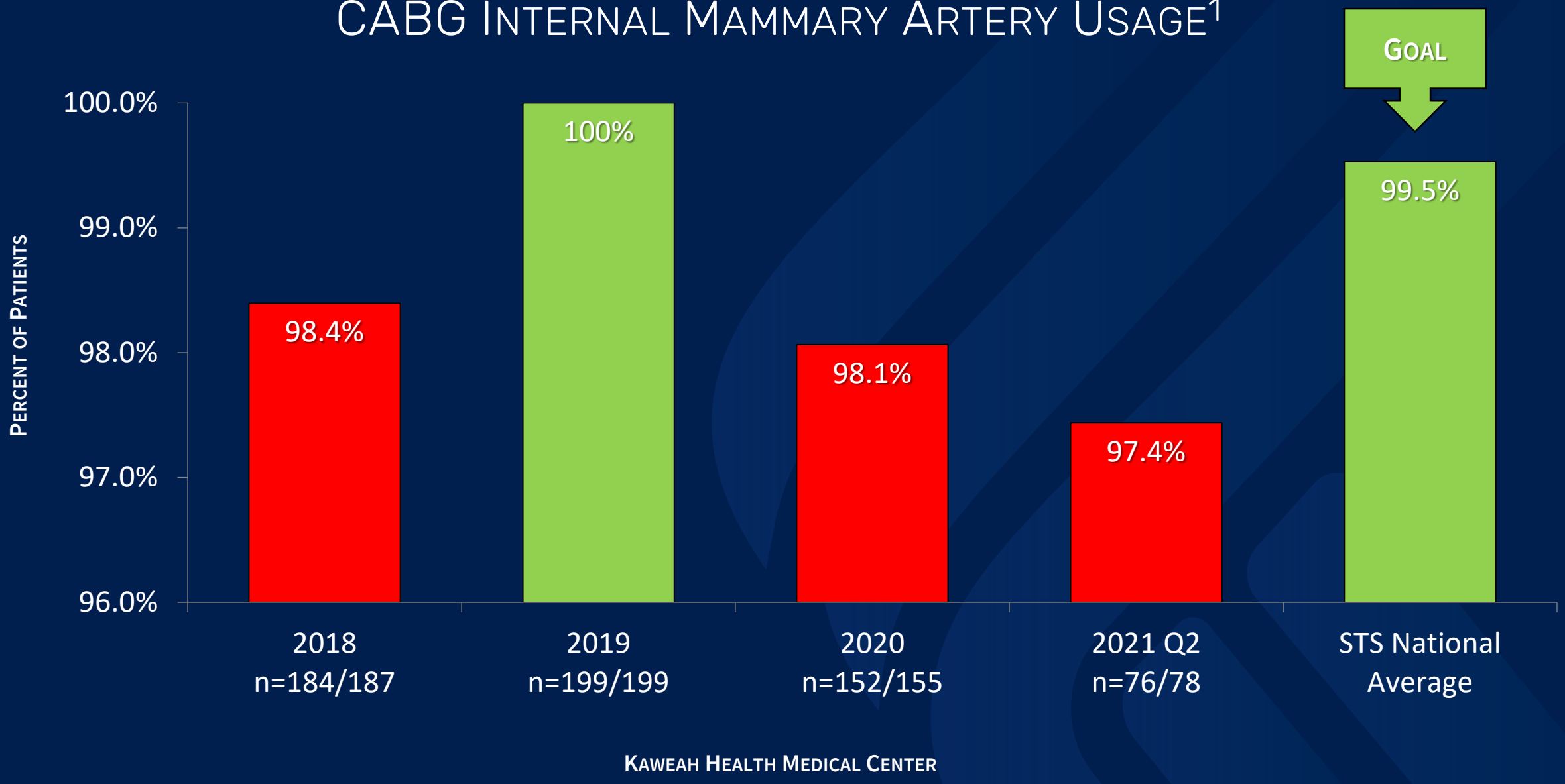
*STS National Average Comparison reporting period 01/01/2021 through 06/30/2021– Isolated CABG cases ONLY

Kaweah Health Radial Artery Usage



*STS National Average Comparison reporting period - 1/1 through 12/31 of each year – Isolated CABG cases ONLY

CABG Internal Mammary Artery Usage[1]



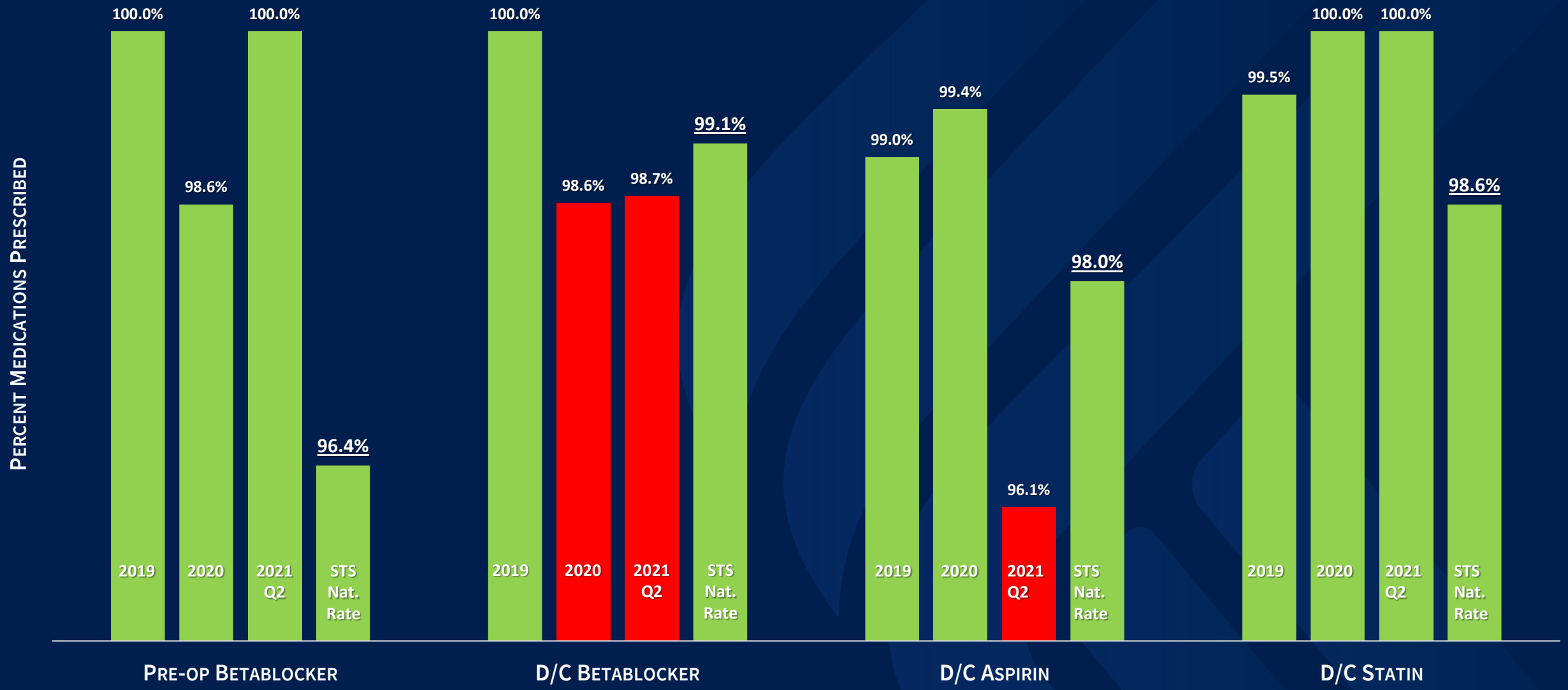
Kaweah Health Medical Center

2021 O/E = 1.0

*STS National Average Comparison reporting period 01/01/2021 through 06/30/2021

[1]Surgeries where at least one internal mammary artery, left or right, was used as a bypass graft. Excludes emergent or salvage cases, No LAD disease, previous thoracic or cardiac surgery, subclavian stenosis or Hx of mediastinal radiation. Q3-2020 forward COVID+ pt.'s Excluded.

CABG Prescribed Medications Pre-op & Discharge



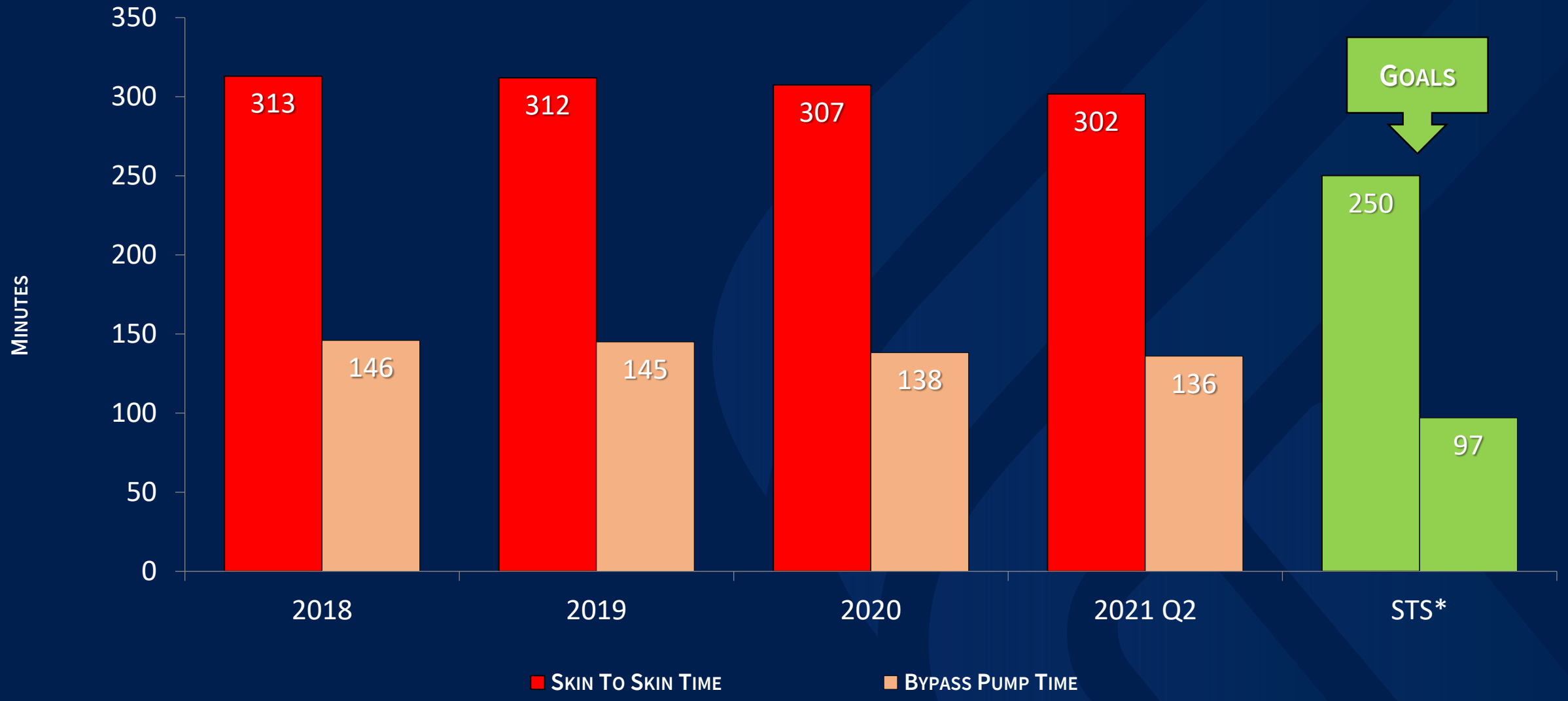
2021 O/E = 1.0

*STS National Average Comparison reporting period 01/01/2021 through 06/30/2021

Performance is measured by the proportion of patients who receive all of the perioperative medications for which the patient is eligible . The required perioperative medications are: 1) preoperative beta blockade therapy; 2) discharge anti-platelet medication; 3) discharge beta blockade therapy; and 4) discharge anti-lipid medication.

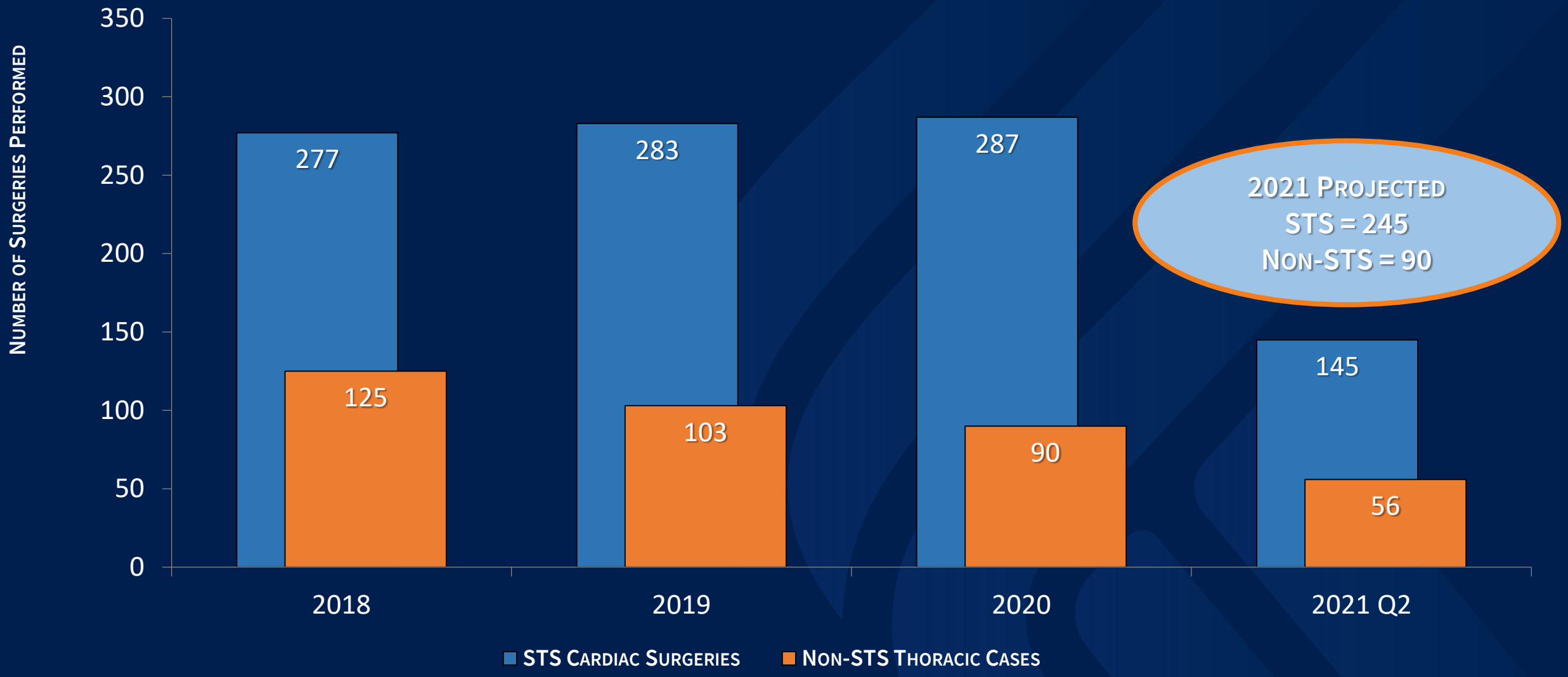
Note: patients who die prior to discharge are not eligible for discharge medications; contraindicated medications are considered non-eligible.

CABG Skin-to-Skin and Bypass Pump Durations



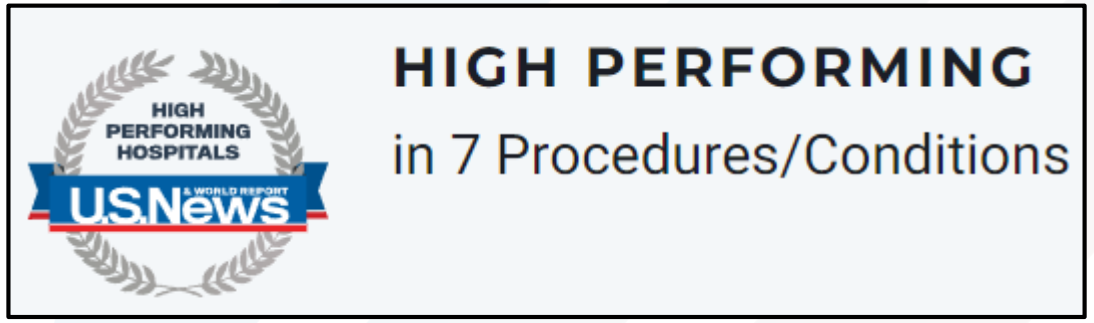
2021 O/E Skin Times = 1.2
2021 O/E Pump Times = 1.4
*STS National Average Comparison reporting period 01/01/2021 through 06/30/2021

Kaweah Health Cardiothoracic Surgery Volumes[1]



[1] Cardiac surgery as defined per STS database. Includes all 7 Major Procedure Categories (CABG, AVR, AVR+CABG, MVR, MVR+CABG, MVP, MVP+CABG) + Other Heart only procedures.

U.S. News & World Report



- Kaweah Health Medical Center recognized for being "Regionally Ranked" in California among the Best Hospitals in the Central Valley. Only two institutions among the 46 Central Valley Hospitals and Clinics reviewed by U.S. News & World Report accomplished this standing
- Kaweah Health achieved the **Highest Score** for Hospitals within 100 miles for *Cardiology & Heart Surgery*
- Kaweah Health earned **High Performing** as a *Heart Failure* and *Heart Attack treatment center*
- Kaweah Health *Cardiology & Heart Surgery* scored **Above Average** in 30-Day survival after being admitted relative to other hospitals treating similarly complex conditions

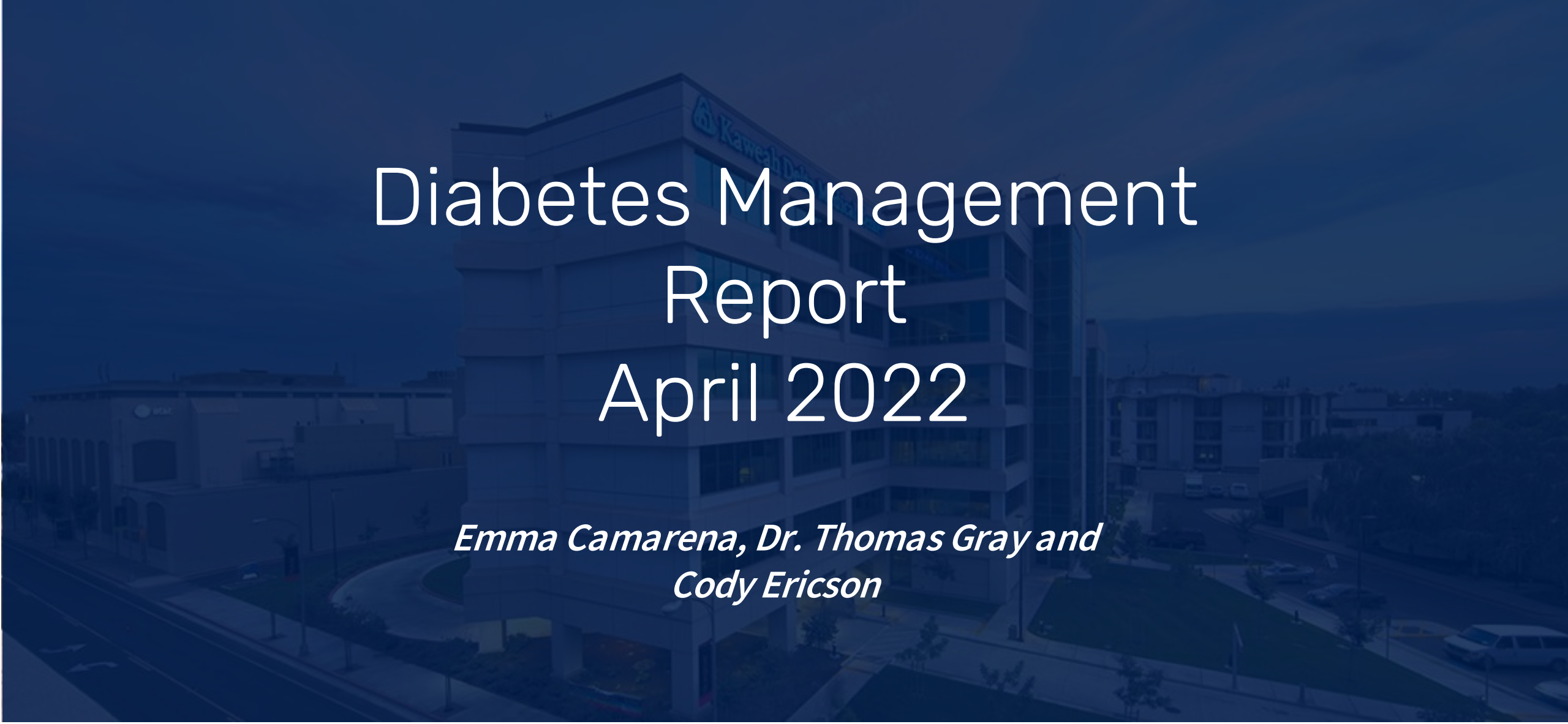
Resource 12/10/2021: https://health.usnews.com/best-hospitals/area/ca/kaweah-delta-health-care-district-6933850

Kaweah Health

Live with passion.

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

Kaweah Health



Diabetes Management Report April 2022

Emma Camarena, Dr. Thomas Gray and Cody Ericson

Diabetes Management Committee

- Improving care takes a team
- Multidisciplinary team
  - Nursing leadership (Directors, Nurse Managers, Assistant Nurse Managers)
  - Physicians
  - Pharmacists
  - Community Outreach/Population Health
  - Food Nutrition Services
  - Clinical Educators/APNs
  - Informatics
  - Glytec partners

Diabetes Management Committee

- Purpose: Continuously improve the health of the patient with diabetes at Kaweah Health and in the community
- Importance of diabetes control:
  - Uncontrolled diabetes is the leading cause of cardiovascular disease, kidney disease, amputation and blindness
  - Preventable:
    - Smoking 19.8% tobacco users
    - Overweight/Obesity: 89.9%
    - Physical Inactivity: 34.3% (less than 10 minutes/week of activity)
    - A1C: 49.4% (greater than 7.0% or higher, normal below 5.7%)
    - High blood pressure: 69% systolic blood pressure greater than 140 mmHg
    - High cholesterol: 44.3% had a non-HDL level of greater than 130 mg/dL

https://www.cdc.gov/diabetes/data/statistics-report/risks-complications.html

Burden of Diabetes in the United States 2019

Prevalence:

- Diabetes (diagnosed)
  - 28.7 million people with diabetes (8.7% of pop)
  - 1.6 million adults (5.7%) with type I/use insulin
  - 3.1 million adults over 20 yrs old (5.7%) using insulin within a year of diagnosis
- Characteristics
  - American Indian/Alaska Native: 14.5%
  - Asian, non-Hispanic, overall: 9.5%
  - Black, non-Hispanic: 12.1%
  - Hispanic, overall: 11.8%
  - White, non-Hispanic: 7.4%
  - Men > women (except American/Indian/Alaska native)
  - Adults with income below FPL: highest prevalence for men (13.7%), women (14.4%)
- Morbidity/Mortality
  - 7th leading cause of death
  - Adults >50 years with diabetes die 4.6 year earlier
  - Develop disabilities 6-7 years earlier
  - Spend 1-2 years disabled than without diabetes

https://www.cdc.gov/diabetes/data/statistics-report/diagnosed-diabetes.html

Diabetes in the Central Valley

Bringing Perspective Home

Prevalence of Diabetes	Tulare County[1]	California[1]	United States[2]	World[3]
	13.7%	8.6%	8.7%	9.3%

Death Due to:	Tulare	Kings	Fresno	Kern	Goal*	California
Diabetes	**36th**	**31st**	**48th**	**57th**	n/a	n/a
Age Adjusted Death Rate	*21.7*	*19.9*	*27.6*	*37.8*	n/a	21.3
Coronary Heart Disease	**49th**	**52th**	**50th**	**54th**	n/a	n/a
Age Adjusted Death Rate	*103.5*	*112.2*	*104.8*	*115.3*	*103.4*	*95.6*
Cerebrovascular Disease	**47th**	**45th**	**48th**	**31st**	n/a	n/a
Age Adjusted Death Rate	*42.8*	*42.1*	*42.9*	*34.4*	*34.8*	*34.4*

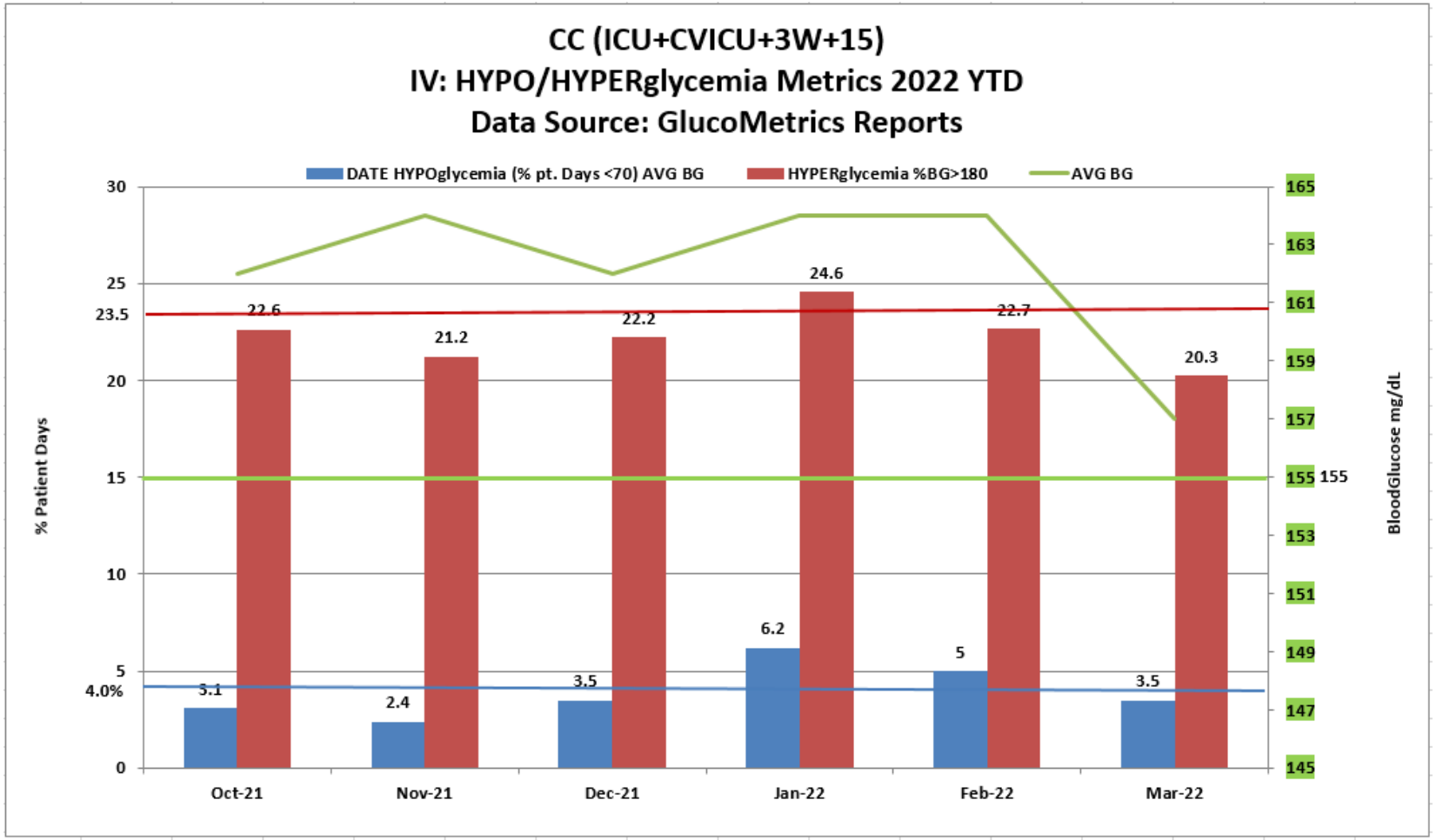
*Healthy People 2020 National Objective

Death Rate = Deaths/100,000 population from 2017-2019

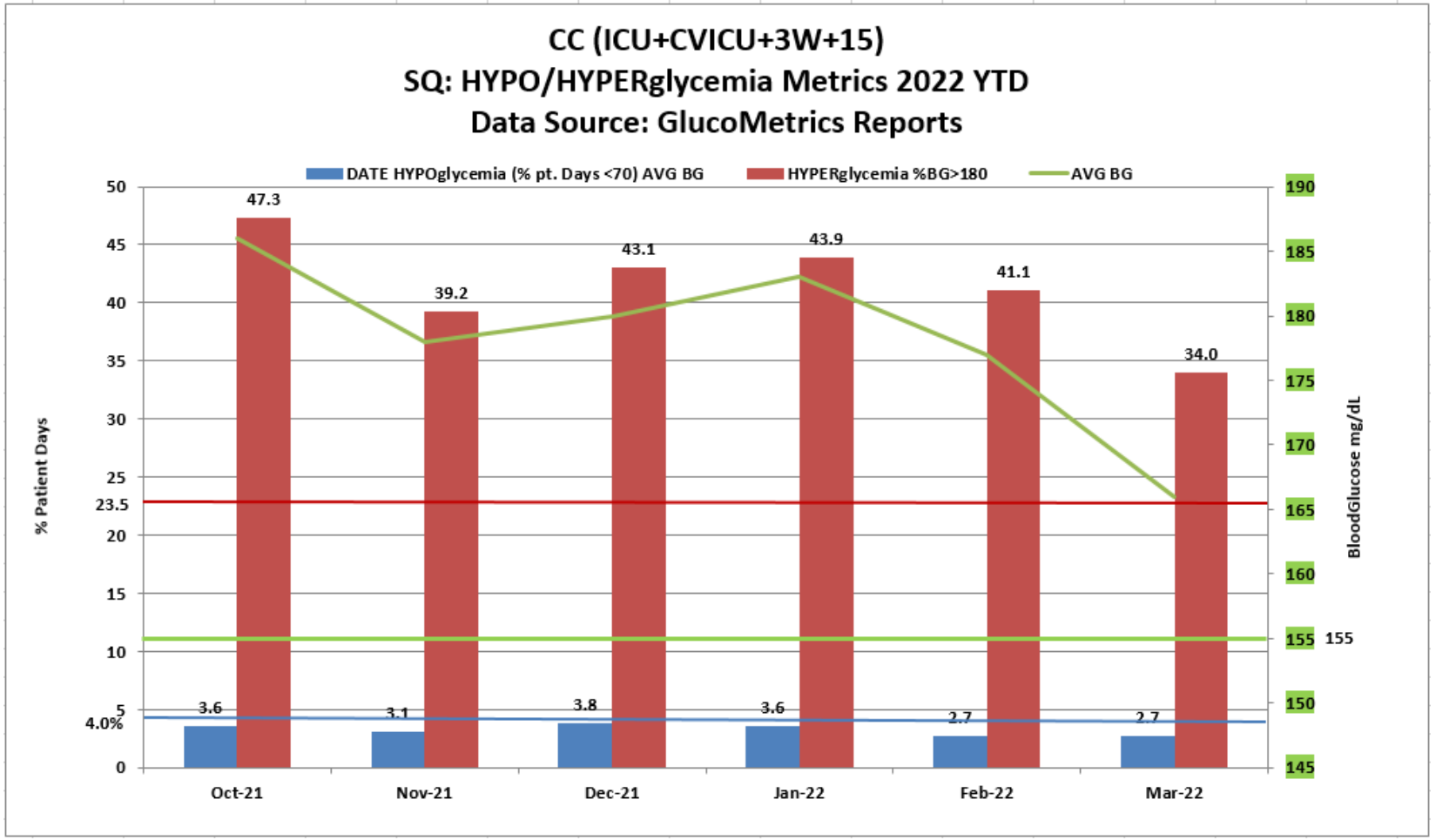
The Diabetes Committee at Work

- Review and monitor metrics using KH length of Stay data, Glucometrics and Society of Hospital Medicine (SHM) benchmarks:
  - Glucometrics allows us to review data more frequently, providing a monthly snapshot of Glucommander data
  - SHM data is reviewed biannually (Spring and Fall): all point of care blood glucose data at KH
  - Review LOS data quarterly
- Partner with Food and Nutrition Services (FNS): consistent carbohydrate diet
- Partner with Community Outreach: Diabetes Self-Management Program, educational opportunities for providers/staff, Walk with a Doc
- Education: Super User training for 72 RNs
- Develop a strategic business plan for the Inpatient Diabetes Management team: Director of Population Health and Sr. consultant from Project Management and Consulting team

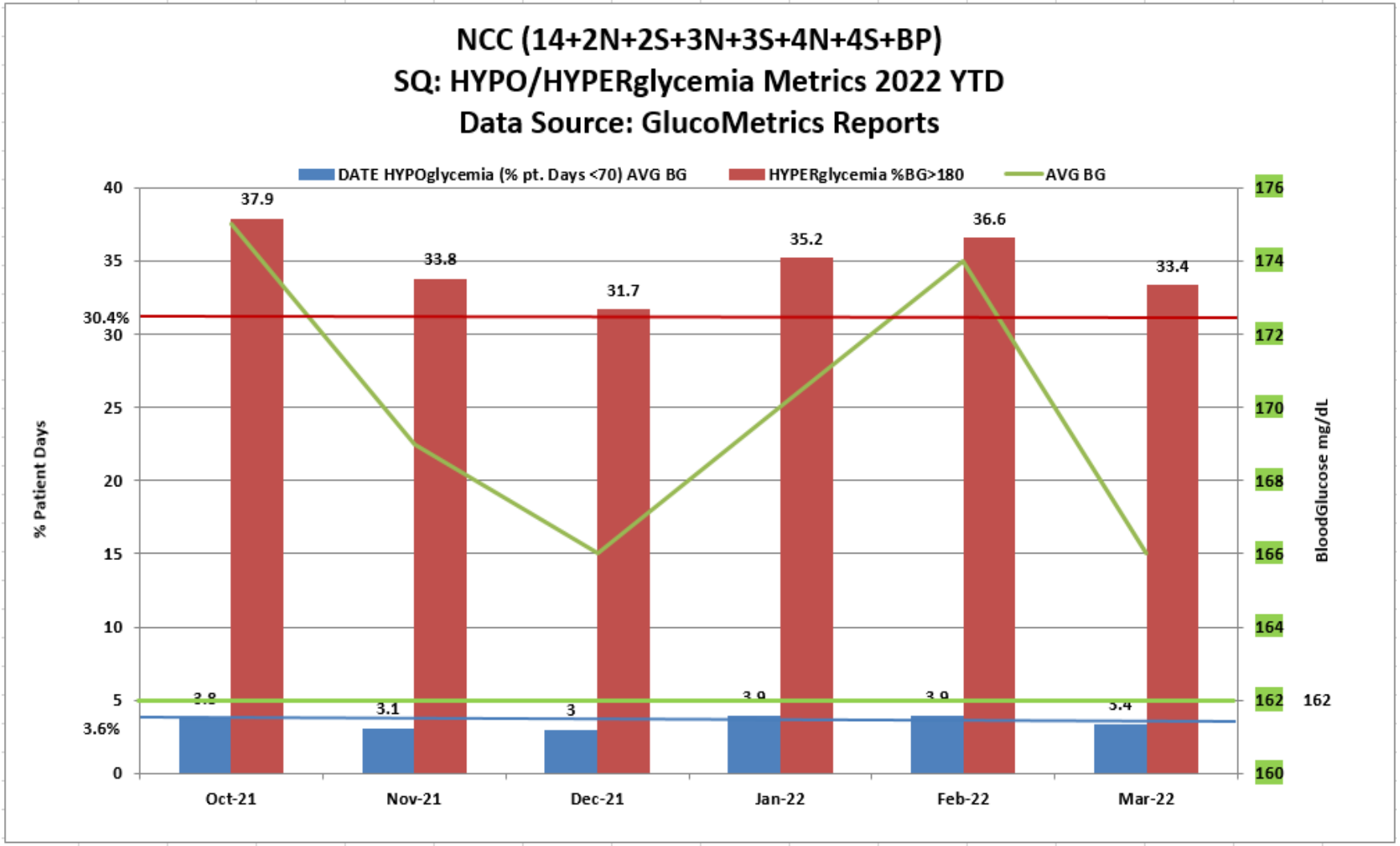
GlucoMetrics Reports (Critical Care)



GlucoMetrics Reports (Critical Care)

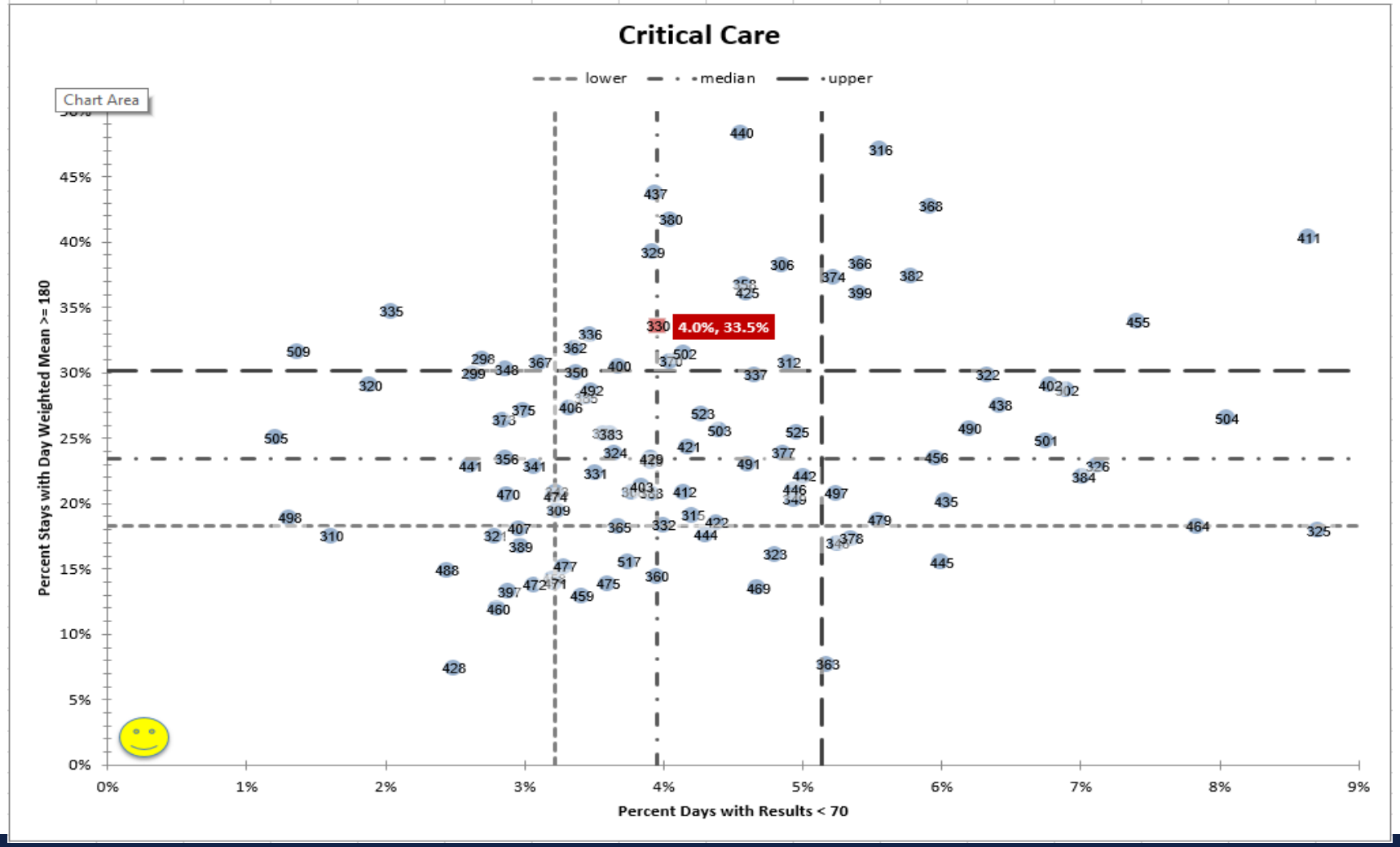


GlucoMetrics Reports (Non-Critical Care)



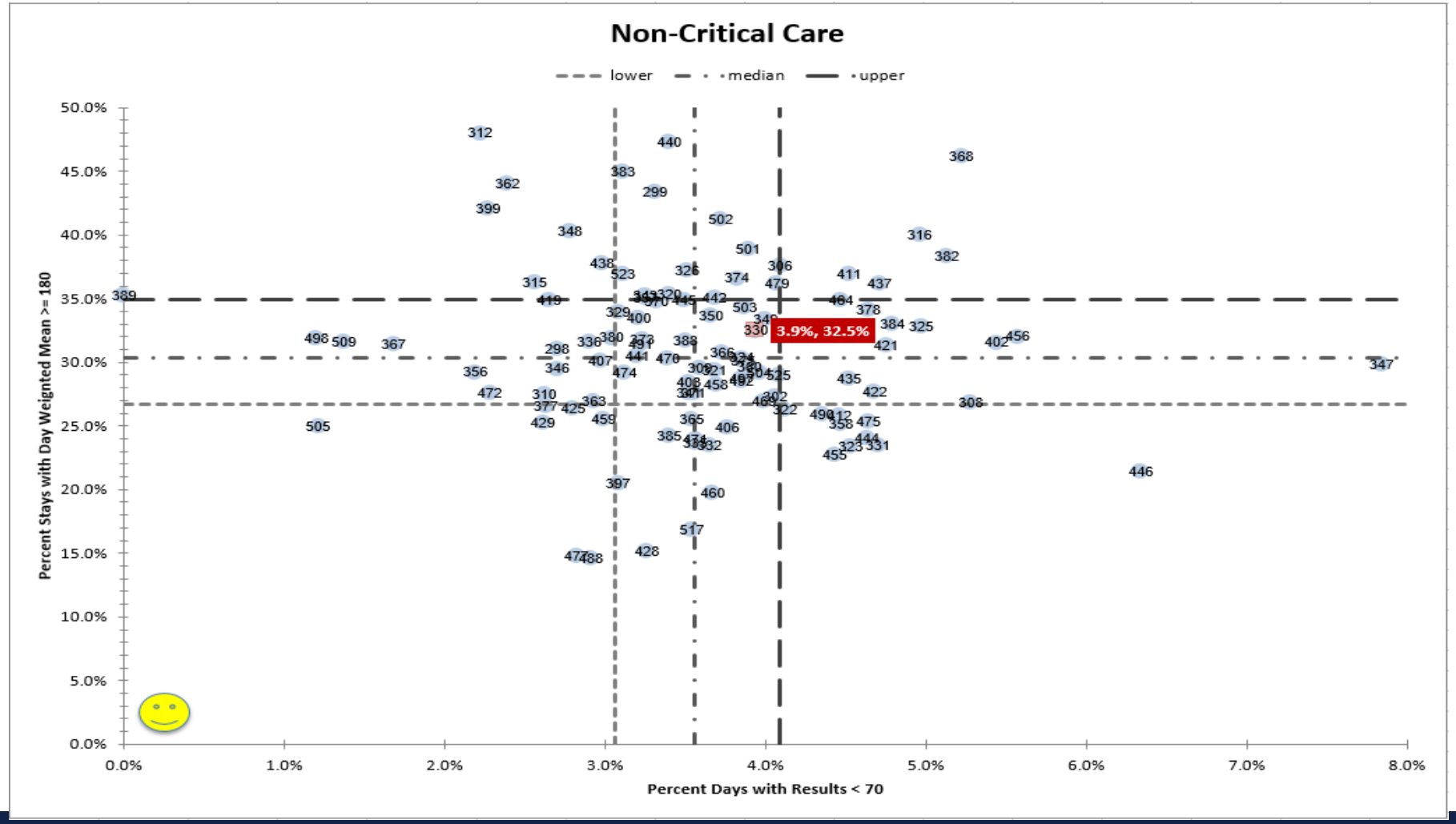
SHM Reports (Fall 2021)

Critical Care



SHM Reports (Fall 2021)

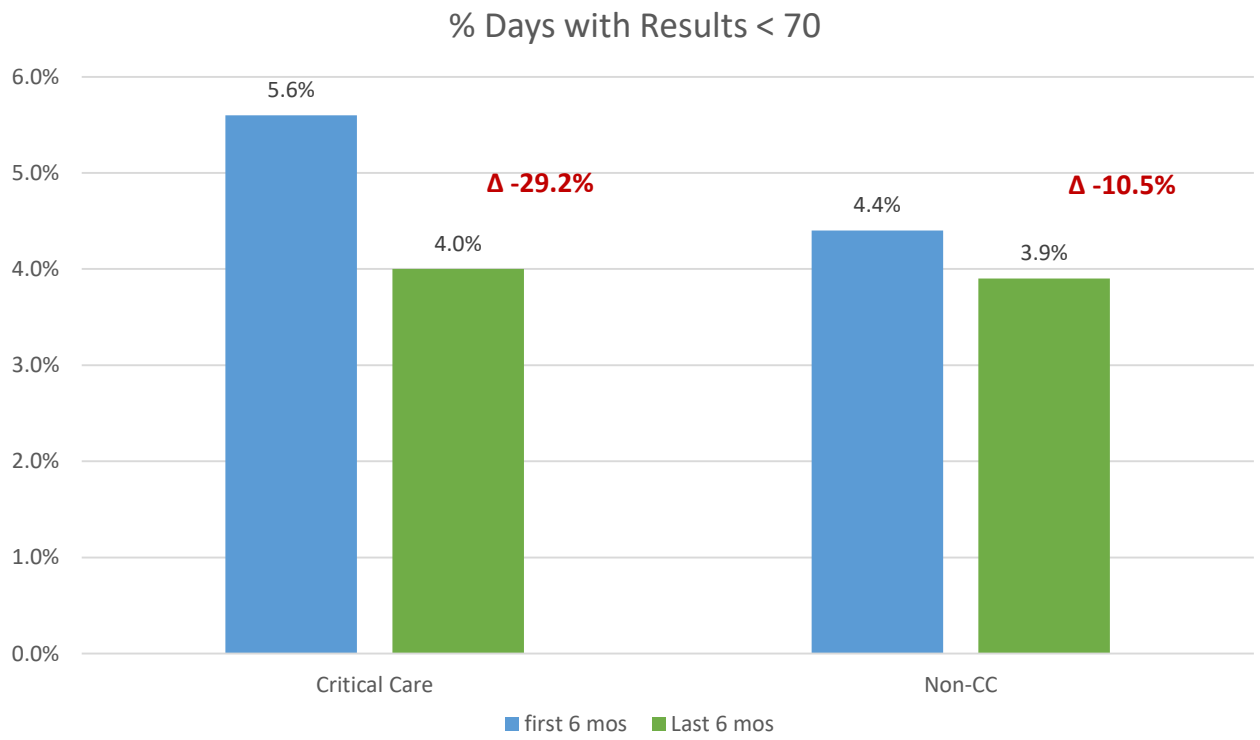
Non-Critical Care



SHM Reports (Fall 2021)

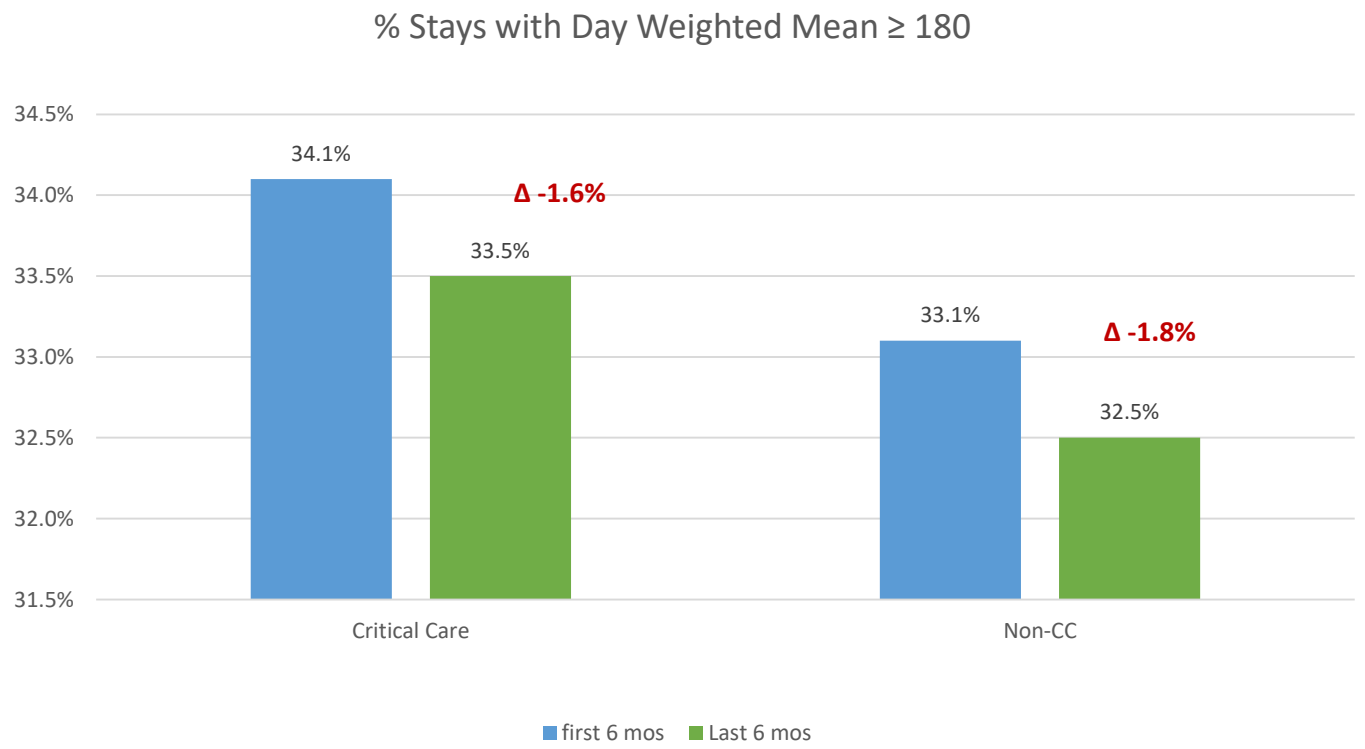
First 6 months/Last 6 months

Chart 1: SHM Report for Critical Care and Non-Critical Care Units: first 6 months compared to the last 6 months of data. KH CC and NCC units showed an improvement in % of days with blood glucose results less than 70% (decrease of 29.2% and 10.5% respectively)



SHM Reports (Fall 2021)
First 6 months/Last 6 months

SHM Report for Critical Care and Non-Critical Care Units: first 6 months compared to the last 6 months of data. KH CC and NCC units showed an improvement in % stays with day weighted mean (DWM) greater than or equal to 180 (decrease of 1.6% and 1.8% respectively)



Kaweah Health Length of Stay Data

- FY21 Average LOS (5.95 through June-2021) increased in comparison to FY20 ALOS of 5.52 (Table 1 REC NonCOVID)
- Stretch goal: Target/Geometric Length of Stay (GMLOS)= 4.27
- Cost savings opportunity:
  - FY21 Sum of Cost Savings Opportunity for Diabetes $18,022,215
  - On average, opportunity days each month is ≈ 1.68 days.
  - If LOS were reduced by 1.68 days, *we could save* ≈ $1.5 million/month or > $18 million/year.
- Opportunity: Reducing ALOS (5.95) to GMLOS (4.27) would save KH $18,022,215 (*Sum of Cost Savings Opportunity July21-June22)*
- *DM committee goal: 25% reduction or 0.42 LOS reduction. Just reducing LOS for our patients with diabetes by less than half a day would save KH $400,000/month or $4.8 million/year*

Diabetes TC Flag

Discharge FY	Discharge Fiscal Period	Sum of Patient Cases	Average of LOS	Average of GMLOS	Average of Oppty Days	Sum of Cost Savings Oppty
2020	July	516	5.36	3.99	1.37	1,453,940
	August	515	5.24	4.10	1.15	1,150,460
	September	450	5.70	4.04	1.66	1,533,254
	October	485	5.01	4.01	1.00	1,058,058
	November	433	5.34	4.16	1.18	977,224
	December	513	5.21	4.08	1.13	1,224,665
	January	458	6.29	4.35	1.95	2,881,932
	February	483	5.59	4.23	1.36	1,334,034
	March	432	6.11	4.32	1.79	1,718,875
	April	311	5.91	4.30	1.61	1,165,974
	May	354	5.03	4.42	0.61	539,291
	June	381	5.65	4.34	1.31	1,391,967
2020 Total		**5,331**	**5.52**	**4.18**	**1.34**	**16,429,674**
2021	July	410	5.40	4.29	1.11	783,625
	August	398	5.26	4.13	1.13	771,239
	September	398	6.26	4.29	1.97	1,502,657
	October	394	5.78	4.34	1.44	1,238,155
	November	370	6.42	4.45	1.97	1,632,047
	December	317	5.89	4.18	1.70	1,275,085
	January	277	6.39	4.52	1.87	1,105,323
	February	338	6.58	4.26	2.33	2,126,494
	March	429	5.40	4.27	1.13	1,747,361
	April	415	6.06	4.27	1.80	1,952,742
	May	400	6.12	4.24	1.88	1,585,551
	June	471	6.13	4.11	2.03	2,301,936
2021 Total		**4,617**	**5.95**	**4.27**	**1.68**	**18,022,215**
Grand Total		**9,948**	**5.72**	**4.22**	**1.50**	**34,451,889**

Diabetes Management Committee Opportunities for Improvement

1. The Advance Nursing Practice Team partners with GME leadership and medical staff to foster collaboration and improvement
2. Exploration of structure, function, impact of consult team developed to respond to needs of nursing and medical staff with goals to
   - Improve knowledge and skillset of nursing, pharmacist and medical staff through education, training, consultative services. Super User training beginning in March 2022 (72 staff)

Diabetes Management Committee Opportunities for Improvement

3. The Advance Nursing Practice Team reviews and responds to Adverse Drug Events (ADEs) related to hypoglycemia and Glucommander™ (GM), such as:

- Transcription errors of GM orders to GM
    - Order integration project is in progress to eliminate need for nursing order re-entry; actively working towards MAR and Order integration with Glytec team; Go-Live anticipated Fall 2022
- Inappropriate selection of modifier / target range
- Recommendation for endocrinology referral for recurrent hypoglycemia or persistent hyperglycemia or previous history of same

Diabetes Management Committee Opportunities for Improvement

4. Inpatient Glycemic Management team (APN and Endocrinologist)
   - Help to optimize difficult to manage patients (i.e. Renal, recurrent hypoglycemia, insulin resistant, hyperglycemia >300, poor nutritional status)
   - Reduce rates of inpatient hypoglycemia/hyperglycemia to or below SHM benchmark
   - Reduce preventable readmissions of high-risk patients with diabetes
   - Partner with key stakeholders to improve perioperative glycemic management
   - Conduct clinical case review for outlier cases
   - Maximize use of Continuous Glucose Monitoring

Diabetes Management Committee Opportunities for Improvement

4. Inpatient Glycemic Management team (APN and Endocrinologist)

- Demonstrate return on investment (ROI) through improved throughput, decreased length of stay
  - Inpatient Diabetes Management NP now available through AMION M-F 08-1700 (2-3 hours per day)
  - Feb. 8-March 31, 2022: NP saw 74 patients with blood glucose <70 or > 300
  - Average patient load was 8 in 2-3 hour increments per day
  - Currently widen range BG < 90 to > 250
  - Potentially increase work load per day = 8 patients, would also increase hours needed to assess and make changes

  NOTE: NP is the critical care APN and adds extra hours/day to assess/round on patients with diabetes


Questions are the path to learning

Live with passion.

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

Kaweah Health

Unit/Department Specific Data Collection Summarization

ProStaff and Quality Improvement Committee

Unit/Department: Diabetes Management Committee **Report Date:** April 2022

Measure Objective / Goal:

Glucommander™

The key component of the eGlycemic Management System® from Glytec, Glucommander™ supports intravenous and subcutaneous insulin dosing (and transitions between) for patients with diabetes. Glucommander™ utilizes evidence-based multivariate algorithms to provide care teams with computer-guided dosing recommendations that continuously recalculate and dynamically adjust to each individual patient's blood glucose trends, insulin sensitivities and response to therapy. Surveillance and summary data are accessed through online platform.

Society of Hospital Medicine (SHM)

Through an annual subscription, Kaweah Delta participates in the Electronic Quality Improvement Programs (eQUIPS), a web-based online collaborative program that provides bi-annual performance tracking and benchmarking focused on optimizing care of inpatients with hypoglycemia, hyperglycemia and diabetes. *There are currently no regulatory metrics by which to benchmark results*.

Goal 1 Safety: Achieve top quartile performance for hypoglycemia in Critical Care (CC) and Non-Critical Care (NCC) patient population, defined as percent *patient days* with blood glucose (BG) <70
**Excludes Pediatrics, Post-Partum, Mental Health and Skilled Adult Units*

Glycemic Control:

Goal 2 Achieve top quartile performance for hyperglycemia, defined as percent *patient stays* with weighted mean BG >180 for CC and NCC* patients

Goal 3 Achieve top quartile performance [rank] for mean time between first BG <70 and resolution for CC and NCC* patients

Length of Stay (LOS)

LOS metrics for diabetes mellitus (DM) are challenging to identify, as DM is often a significant co-morbidity and not a primary diagnosis upon admission. Centers for Medicare & Medicaid Services (CMS) utilize Medicare Severity Diagnosis Related Groups (MS-DRGs) to assign a specific geometric mean length of stay (GMLOS) to each DRG in their system; the Kaweah Health finance team groups MSDRGs associated with DM and provides summary comparisons of average LOS with GMLOS, identifying average opportunity days and associated cost savings opportunities.

Goal 4 Improve total average length of stay (ALOS) for reported relevant MS-DRGs (602,603,637,638,639,640,641,682,683,684) by 5% over FY20 ALOS
- FY20 ALOS = 3.79 → FYE21 Target 3.60

Date Range of Data Evaluated:

- SHM Reports
  November 2020 – May 2021
- Glytec GlucoMetrics® Reports (dataset includes patients on Glucommander™, *only*)
  October 2021-March 2022
- Length of Stay
  July 2020 – June 2021

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

∅ **GOAL 1** Not Met: Underperformed available benchmark statistic for CC units (Chart 3) and NCC units (Chart 4), although CC met the benchmark for hypoglycemia.

∅ **GOAL 2** Not Met: Underperformed available benchmark statistic for CC units (Chart 3) and NCC units (Chart 4)

Although we continue to underperform in Goals 1 and 2, our first 6 months/last 6 months SHM 5-year comparison data demonstrates an improvement in both areas (Charts 1 and 2).

- The first 6 months data is from the first 6 months of the last 5 years of data collection
- The last 6 months data is from the most current data

Chart 1: SHM Report for Critical Care and Non-Critical Care Units: first 6 months compared to the last 6 months of data. KH CC and NCC units showed an improvement in % of days with blood glucose results less than 70% (decrease of 29.2% and 10.5% respectively)

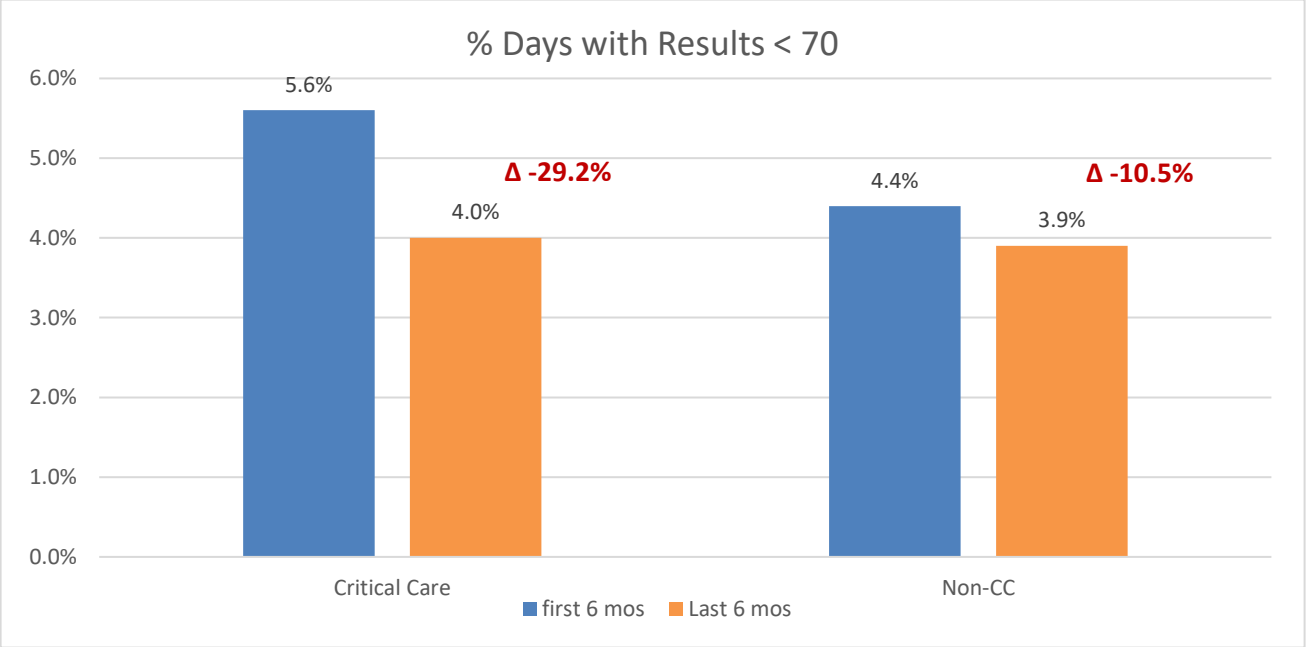


Chart 2: SHM Report for Critical Care and Non-Critical Care Units: first 6 months compared to the last 6 months of data. KH CC and NCC units showed an improvement in % stays with day weighted mean (DWM) greater than or equal to 180 (decrease of 1.6% and 1.8% respectively)

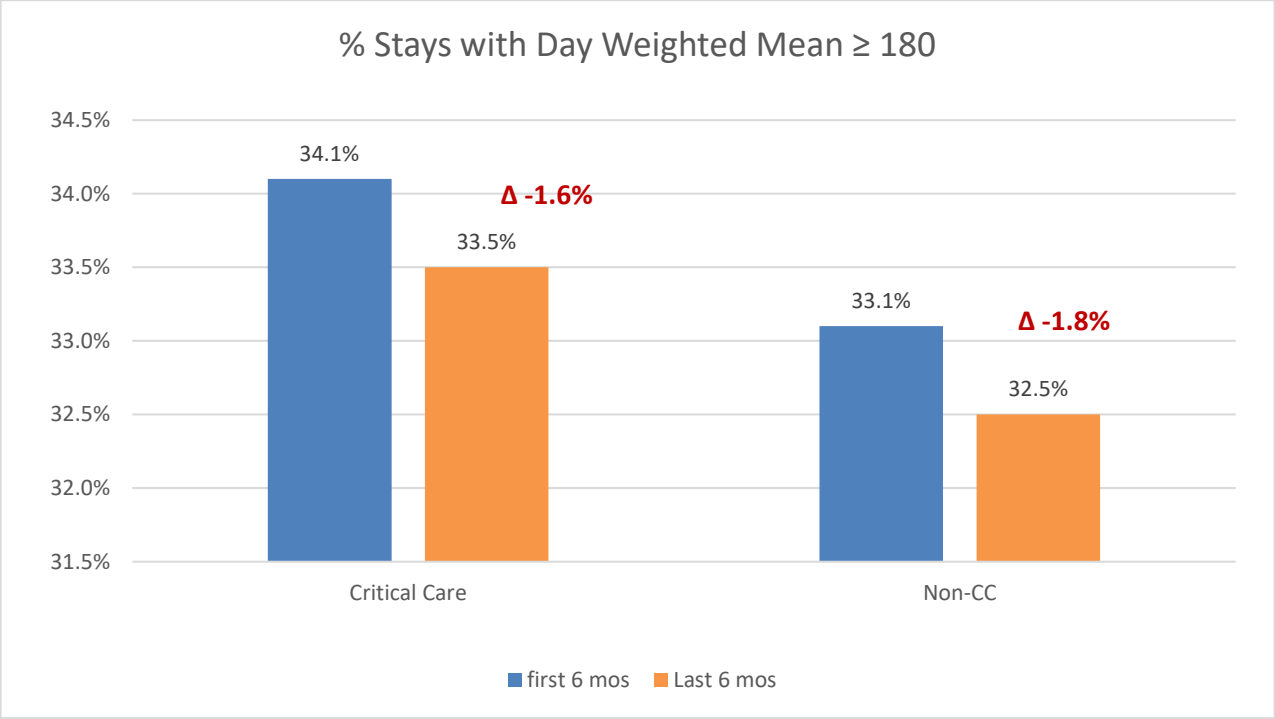
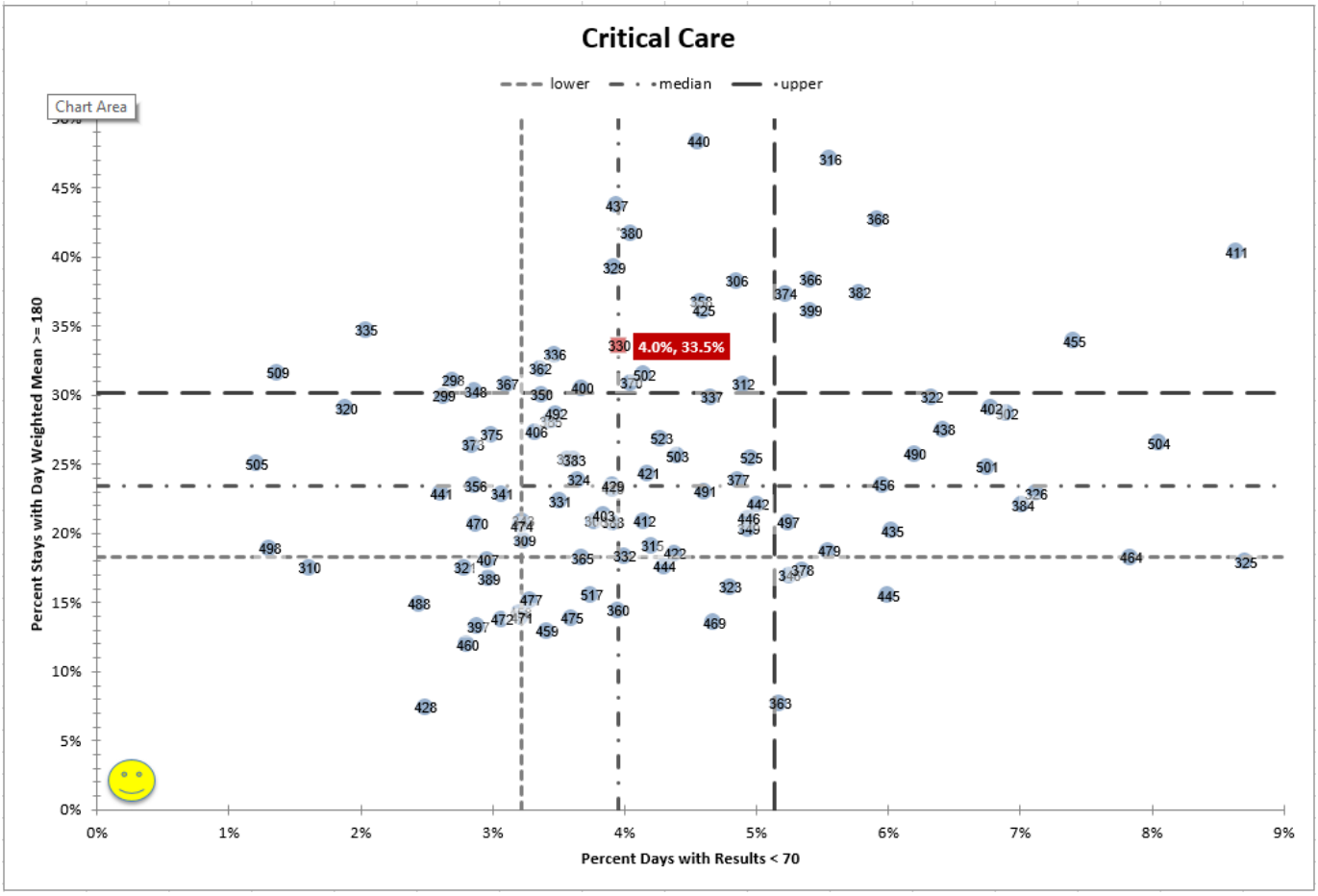


Chart 3– SHM Report for Critical Care Units

(ICU, 3West, CVICU, 1-5Tower)

SHM Scatterplot displays most recent SHM benchmarks for <u>percent of days < 70</u> for hypoglycemia and <u>percent patient stays with day weighted mean blood glucose (BGs) ≥ 180</u> among CC units.

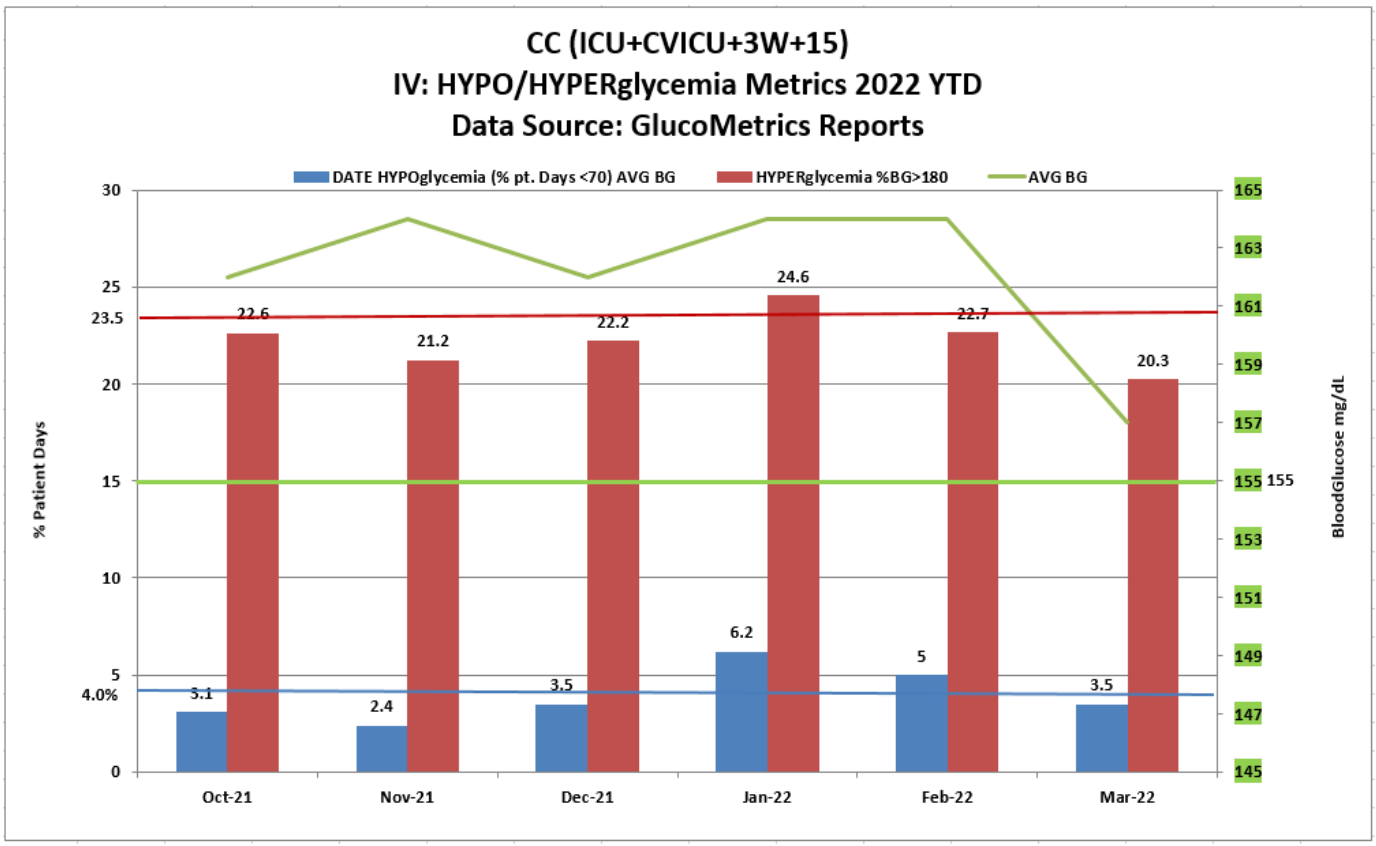
- Hypoglycemia, KHMC CC was at 4.0%, which is a decrease from previous reporting interval (4.8%)
    - Although the SHM benchmark decreased from the previous reporting interval (May 2021-Nov 2021) from 4.4% to 4.0% KHMC CC equaled the SHM benchmark.
- Hyperglycemia, KHMC CC was at 33.5%, which is above the SHM benchmark of 23.5%
    - In this reporting period, SHM CC hyperglycemia benchmark decreased from 25.4% to 23.5%. KHMC CC experienced a decrease in hyperglycemia from 34.4% to 33.5%.



Graph 1 – GlucoMetrics® Report for Critical Care Units

Displays % patient days < 70 for hypoglycemia, % BGs > 180, and average BGs for 2021-2022 YTD among critical care units for patients **treated with Glucommander™ IV.** *The objective is to decrease both metrics simultaneously.*

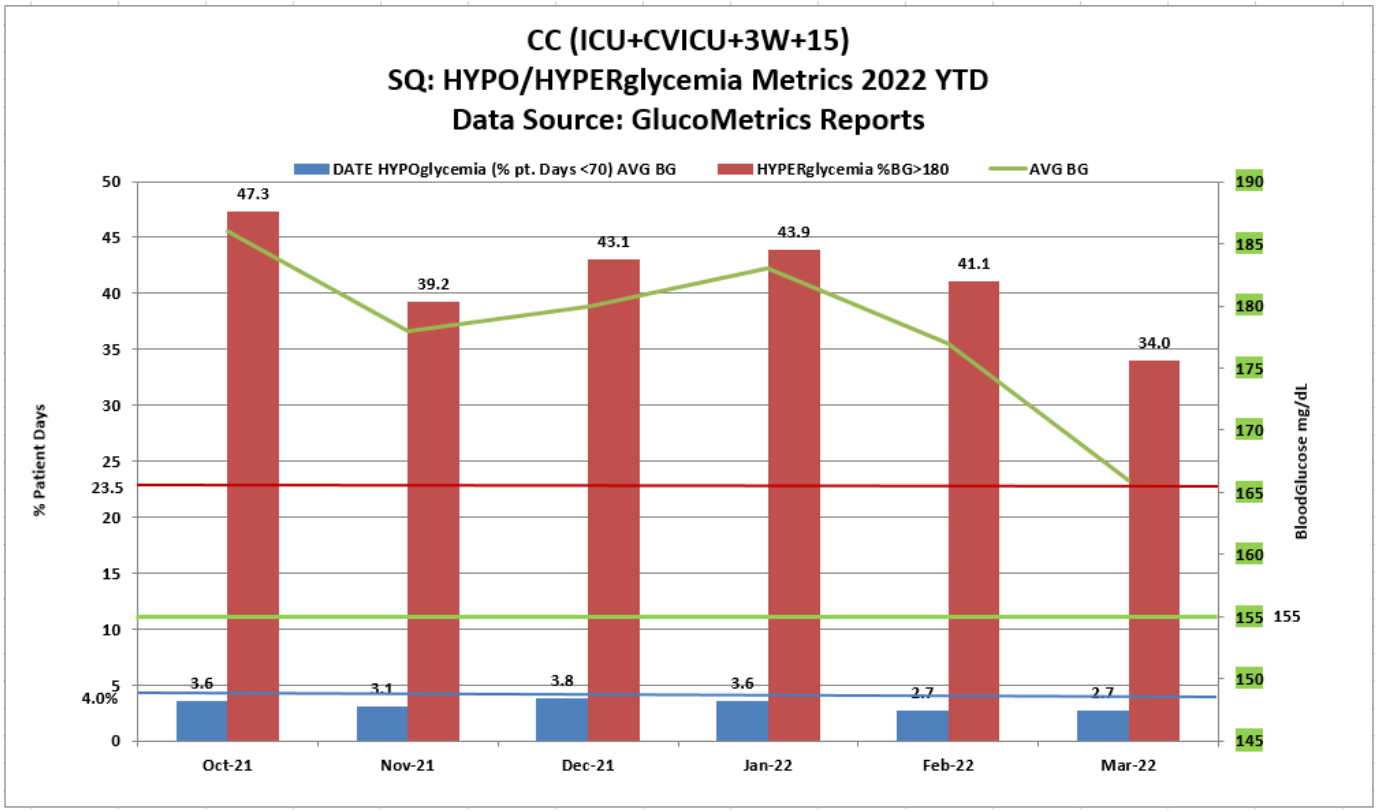
- In the last 6 months, we maintained hypoglycemia rates below the SHM benchmark of 4.0% in all months except for Jan/Feb 2022. Hyperglycemia rates (% BG > 180) were below the SHM benchmark of 23.5% with a slight uptick in Jan 2022 possibly due to the latest COVID surge and steroid-related treatment. Average BG values were between 157-164 mg/dL.



SHM Benchmarks: HYPOglycemia=4.0% and HYPERglycemia=23.5%

Graph 2 – GlucoMetrics® Report for Critical Care Units
Displays % patient days < 70 for hypoglycemia, % BGs > 180, and average BGs for 2021 YTD among critical care units for patients **treated with Glucommander™ SQ.**

- Rate of hypoglycemia maintained below the SHM benchmark from Oct 2021 to March 2022. There is a downward trend in BG maintenance <180 beginning in Jan 2022 possibly due to the decrease in COVID cases corresponding with a decrease in average BG values.



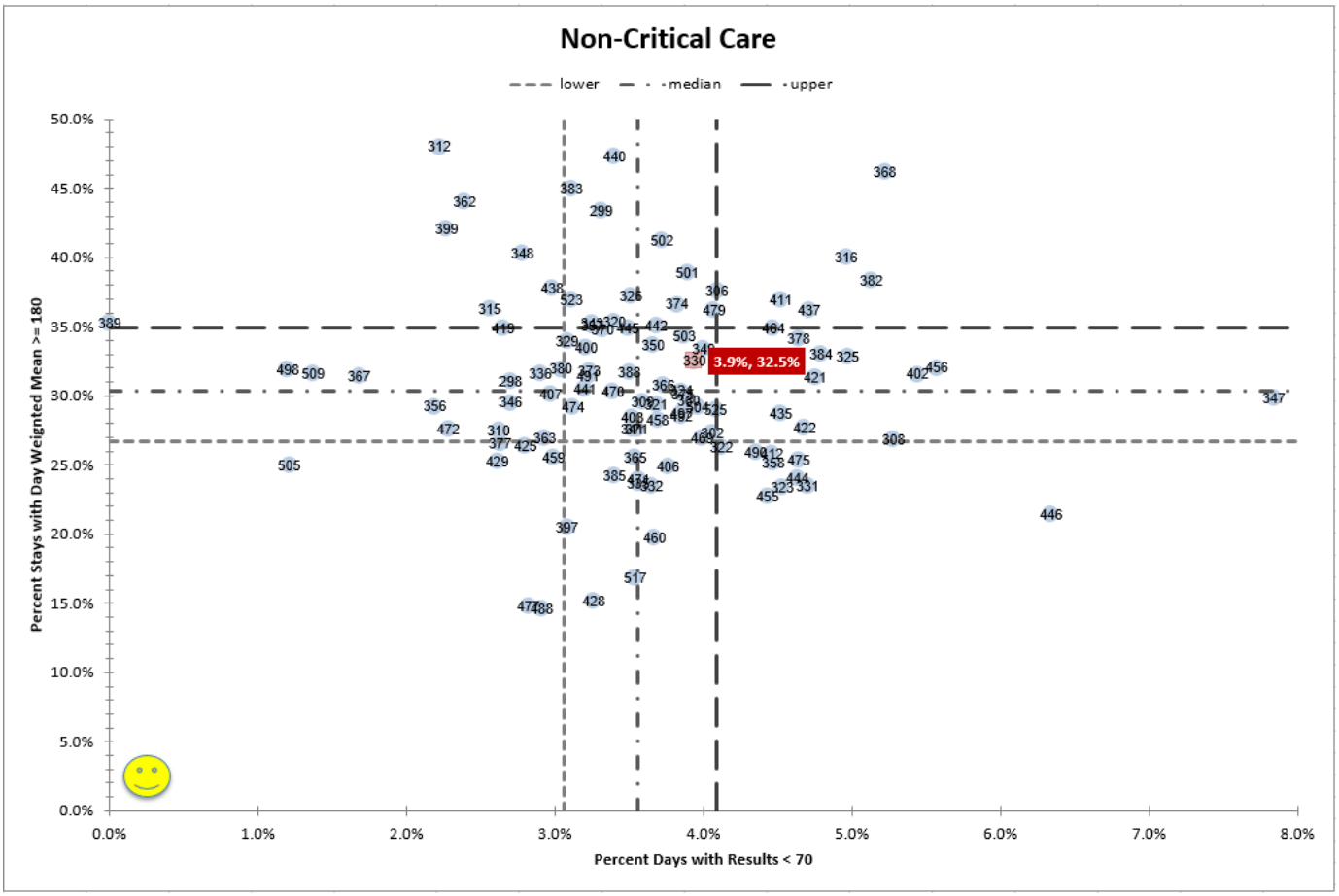
SHM Benchmarks: HYPOglycemia=4.0% and HYPERglycemia=23.5%

Chart 2 – SHM Report for Non-Critical Care Units

(1-4Tower, 2North, 2South, 3North, 3South, 4North, 4South, Broderick Pavilion)

SHM Scatterplot displays SHM benchmarks for <u>percent of days < 70</u> for hypoglycemia and <u>percent patient stays with day weighted mean blood glucose (BGs) ≥ 180</u> among NCC units.

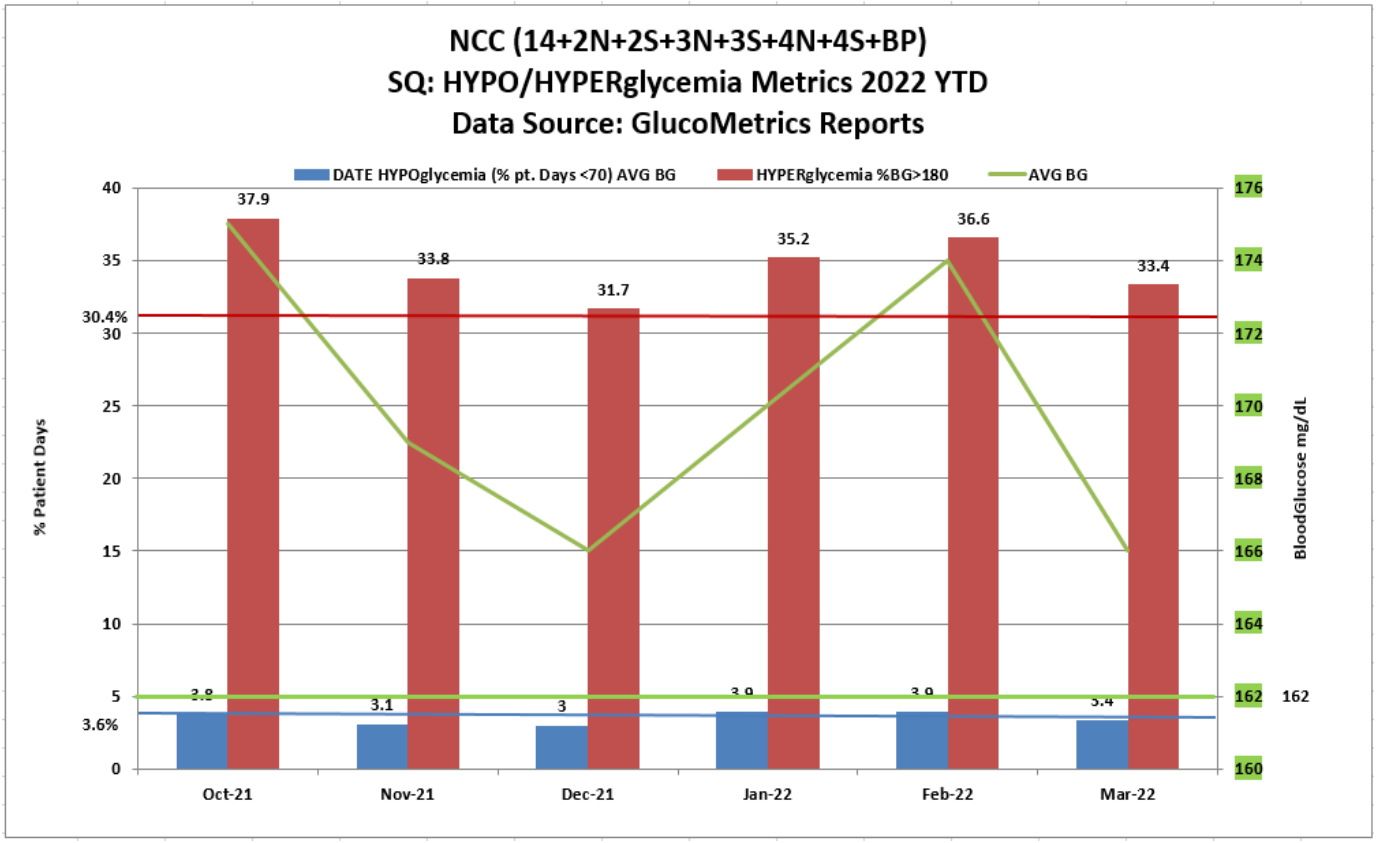
- Hypoglycemia: KHMC NCC was at 3.9%, which is slightly above the SHM benchmark of 3.6%
    - KHMC saw a decrease from previous reporting interval (4.8%)
- Hyperglycemia, KHMC NCC was at 32.5%, which is above the SHM benchmark of 30.4%
    - KHMC had a slight increase from the previous reporting interval (32%)



Graph 3 – GlucoMetrics® Report for Non-Critical Care Units

Displays % patient days < 70 for hypoglycemia, % BGs > 180 and average BGs for 2021 YTD among NCC units for patients **treated with Glucommander™ SQ.**

- Rates for hypoglycemia are stable.
- There was a downward trend of hyperglycemia in Nov-Dec 2021 and again in Mar 22. With many unpredictable months of COVID, it is difficult to determine if hyperglycemia events are due to effects of steroids.



SHM Benchmarks: HYPOglycemia=3.6% and HYPERglycemia=30.4%

- ✓ **GOAL 3** Met: In the last 5 years, KH has met this goal and consistently achieved top quartile performance for resolution of hypoglycemia after initial identification of hypoglycemic event for CC units (Chart 5) and NC units (Chart 6)

Chart 3 – SHM Report (May 2021-Oct 2021) for Critical Care Units

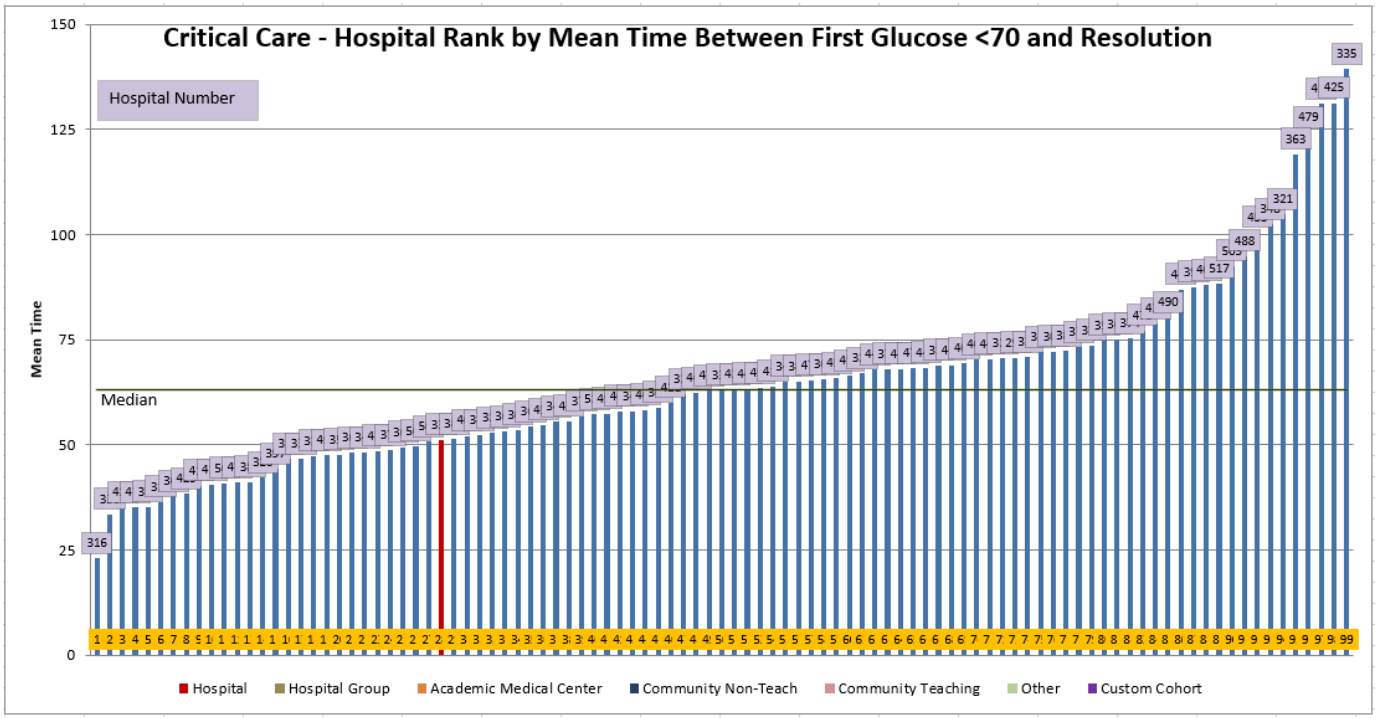
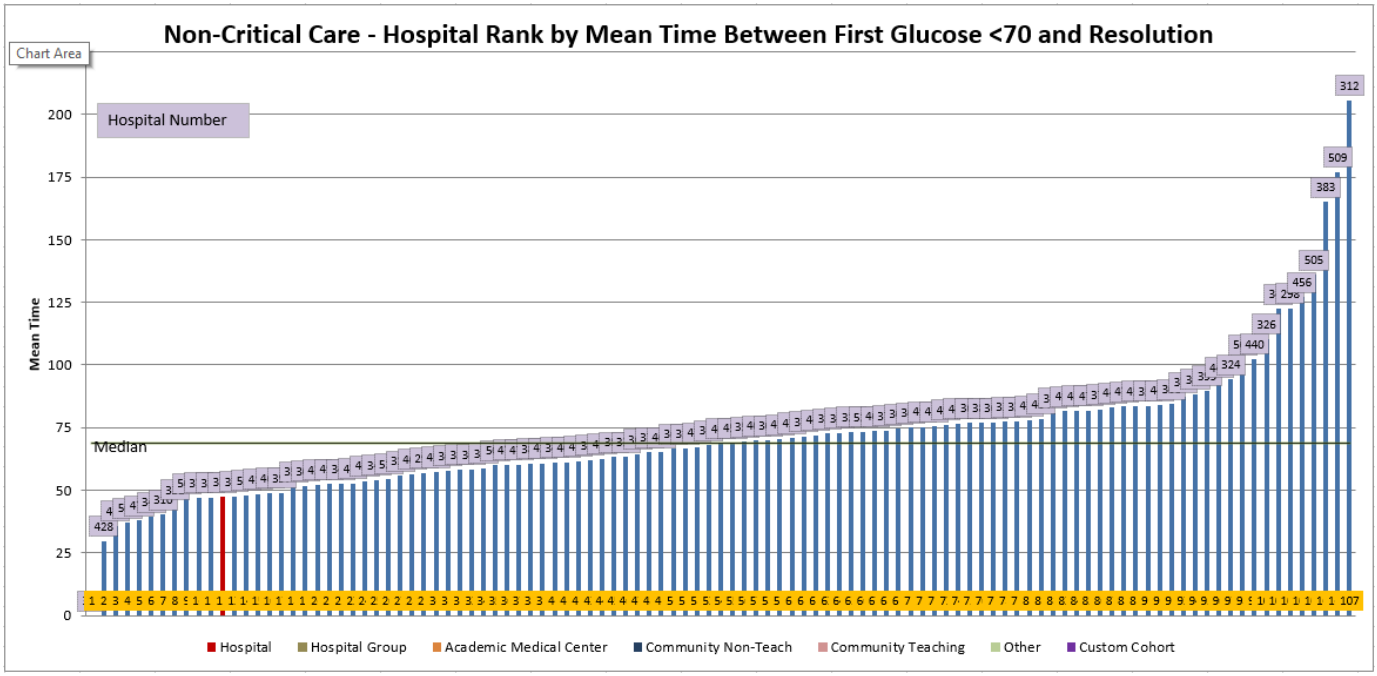


Chart 4 – SHM Report (May 2021-Oct 2021) for Non-Critical Care Units



∅ **GOAL 4** Not Met

- FY21 Average LOS (5.95 through June-2021) increased in comparison to FY20 ALOS of 5.52 (Table 1 REC NonCOVID)
  - Stretch goal: Target/Geometric Length of Stay (GMLOS)= 4.27
  - Cost savings opportunity:
    - FY21 Sum of Cost Savings Opportunity for Diabetes $18,022,215
    - On average, opportunity days each month is ≈ 1.68 days.
    - If LOS were reduced by 1.68 days, *we could save* ≈ $1.5 million/month or > $18 million/year.
  - Opportunity: Reducing ALOS (5.95) to GMLOS (4.27) would save KH $18,022,215 (*Sum of Cost Savings Opportunity July21-June22)*
    - DM committee goal: 25% reduction or 0.42 LOS reduction. Just reducing LOS for our patients with diabetes by less than half a day would save KH $400,000/month or $4.8 million/year.

Table 1

Diabetes TC Flag

		Values				
Discharge FY	Discharge Fiscal Period	Sum of Patient Cases	Average of LOS	Average of GMLOS	Average of Oppty Days	Sum of Cost Savings Oppty
2020	July	516	5.36	3.99	1.37	1,453,940
	August	515	5.24	4.10	1.15	1,150,460
	September	450	5.70	4.04	1.66	1,533,254
	October	485	5.01	4.01	1.00	1,058,058
	November	433	5.34	4.16	1.18	977,224
	December	513	5.21	4.08	1.13	1,224,665
	January	458	6.29	4.35	1.95	2,881,932
	February	483	5.59	4.23	1.36	1,334,034
	March	432	6.11	4.32	1.79	1,718,875
	April	311	5.91	4.30	1.61	1,165,974
	May	354	5.03	4.42	0.61	539,291
	June	381	5.65	4.34	1.31	1,391,967
2020 Total		**5,331**	**5.52**	**4.18**	**1.34**	**16,429,674**
2021	July	410	5.40	4.29	1.11	783,625
	August	398	5.26	4.13	1.13	771,239
	September	398	6.26	4.29	1.97	1,502,657
	October	394	5.78	4.34	1.44	1,238,155
	November	370	6.42	4.45	1.97	1,632,047
	December	317	5.89	4.18	1.70	1,275,085
	January	277	6.39	4.52	1.87	1,105,323
	February	338	6.58	4.26	2.33	2,126,494
	March	429	5.40	4.27	1.13	1,747,361
	April	415	6.06	4.27	1.80	1,952,742
	May	400	6.12	4.24	1.88	1,585,551
	June	471	6.13	4.11	2.03	2,301,936
2021 Total		**4,617**	**5.95**	**4.27**	**1.68**	**18,022,215**
Grand Total		**9,948**	**5.72**	**4.22**	**1.50**	**34,451,889**

Improvement Opportunities Identified:

1. The Advance Nursing Practice Team partners with GME leadership and medical staff to foster collaboration and improvement:
    - Changed date/time to accommodate GME schedule and allow opportunity for GME residents to participate in meetings and glycemic rounding; thus far, attendance/participation continues to be inconsistent/nonexistent
    - APN invited by individual Hospitalist to provide diabetes and Glucommander education every 2-3 weeks.
2. Exploration of structure, function, impact of consult team developed to respond to needs of nursing and medical staff with goals to
    - Improve glycemic management and patient outcomes
    - Improve knowledge and skillset of nursing, pharmacist and medical staff through education, training, consultative services. Super User training beginning in March 2022 (72 staff)
    - Partner with Food & Nutrition Services to improve carb intake (carb-consistent diet)
    - Demonstrate return on investment (ROI) through improved throughput, decreased length of stay
        - Inpatient Diabetes Management NP now available through AMION M-F 08-1700 (2-3 hours per day)
        - Meeting with Sr. Consultant from Project Management & Consulting and Director of Population Health to develop a strategic business plan for the Inpatient Diabetes Management team
3. The Advance Nursing Practice Team reviews and responds to Adverse Drug Events (ADEs) related to hypoglycemia and Glucommander™ (GM), such as:
    - Transcription errors of GM orders to GM
        - Order integration project is in progress to eliminate need for nursing order re-entry; actively working towards MAR and Order integration with Glytec team; Go-Live anticipated Fall 2022
    - Inappropriate selection of modifier / target range
    - Recommendation for endocrinology referral for recurrent hypoglycemia or persistent hyperglycemia or previous history of same
4. The Advance Nursing Practice Team partnered with Glytec and medical staff to mitigate pandemic impact on patient care:
    - Dexcom Continuous Glucose Monitoring (CGM) trial completed. Successfully implemented CGM in March 2021 despite intermittent supply chain disruptions.
    - CGM is currently on hold due to no COVID cases, but investigating research opportunities
5. Inpatient Glycemic Management team (APN and Endocrinologist)
    - Help to optimize the difficult to manage patients (i.e. Renal, recurrent hypoglycemia, insulin resistant, hyperglycemia >300)
    - Reduce rates of inpatient hypoglycemia/hyperglycemia to or below SHM benchmark
    - Reduce preventable readmissions of high-risk patients with diabetes
    - Partner with key stakeholders to improve perioperative glycemic management
    - Conduct clinical case review for outlier cases

Unit/Department Specific Data Collection Summarization

ProStaff and Quality Improvement Committee

Submitted by:
Emma Camarena, DNP, RN, ACCNS-AG, CCRN
Director of Nursing Practice

Thomas Gray, MD
Medical Director Quality & Patient Safety

Cody Ericson MSN, RN, FNP, CCRN
Advanced Practice Nurse-Critical Care Services

Date Submitted: April 11, 2022

Clinical Quality Goal Update

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

Quality Improvement Committee
April 2022

FY22 Clinical Quality Goals

	July-Feb 21 Higher is Better	FY22 Goal	FY21	FY21 Goal
SEP-1 (% Bundle Compliance)	73%	≥ 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	3 2					16 (12 predicted over 6 months)	1.18 0.56 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	0 0					11 (9.5 predicted over 6 months)	1.054 0.49 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	1 1					5 (3.6 predicted over 6 months	1.894 1.32 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.

Key Strategies

Sepsis, CAUTI, CLABSI & MRSA

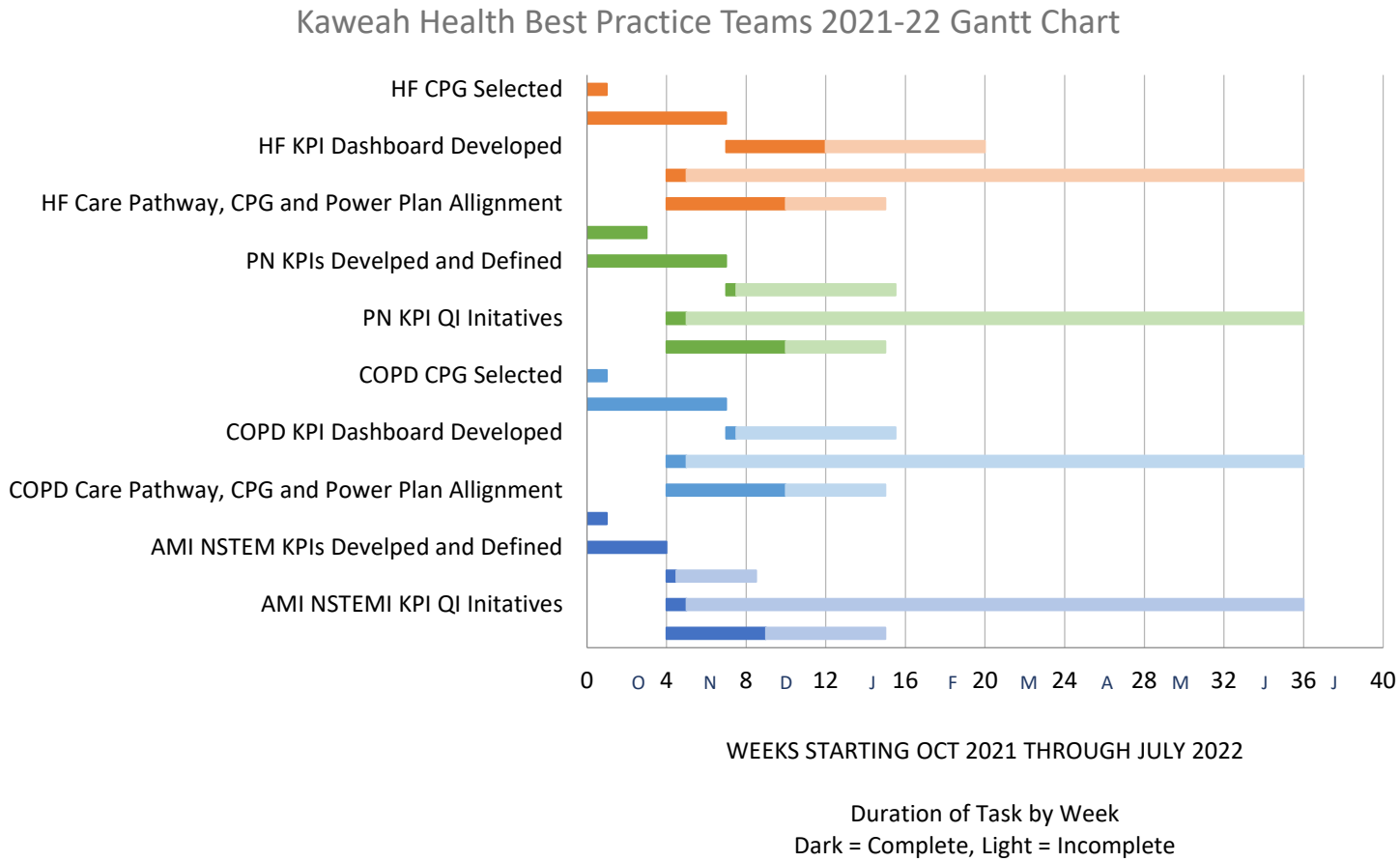
1. Refining root cause analysis of Sepsis order set utilization
2. Provider notification of Sepsis Alert
   - Evaluating root causes optimizing process
3. Sepsis Simulation training (GME)
   - Emergency Management GME program sim program in March 2022; developing Family Medicine sim program for May 2022
4. Sepsis Alert optimization
   - Improving specificity & specificity so true sepsis patients are not missed and truly not septic patients do not trigger the electronic alert

3. Culturing Practices
   - Data analysis and sharing with providers, determining next steps
4. MRSA Decolonization
   - 4N & ICU Pilot – 100% patients decolonized, expanded additional 3 months
   - All other units – targeting those who should be decolonized, working on optimizing processes to achieve decolonization
5. Root Cause Analysis
   - Review of current data & cases and quantifying contributing factors to target improvement strategies

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!!



AMI- NSTEMI - non-ST-elevation myocardial infarction , COPD - Chronic Obstructive Pulmonary Disease , HF – Heart Failure, PN - Pneumonia)

Questions?

Live with passion.

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

Kaweah Health