November 10, 2023

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, November 16, 2023, 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, November 16, 2023, 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, November 16, 2023, 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, November 16, 2023
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, Chief Nursing Officer; Tom Gray CMO/CQO; Julianne Randolph, OD, Vice Chief of Staff and Professional Staff Quality Committee Chair; LaMar Mack, 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 Michelle Adams, 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 – *Julianne Randolph, OD, Vice Chief of Staff and Professional Staff Quality Committee Chair*
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management and Ben Cripps, Chief of Compliance and Risk Officer.*
4. **Adjourn Open Meeting** – *David Francis, Committee Chair*

CLOSED MEETING – 7:31AM

1. **Call to order** – *David Francis, Committee Chair & Board Member*
2. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Julianne Randolph, OD, Vice Chief of Staff and Professional Staff Quality Committee Chair*

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

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

OPEN MEETING – 8:00AM

1. **Call to order** – *David Francis, Committee Chair*

2. **Public / Medical Staff participation –** Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves at this time. Members of the public or the medical staff may comment on agenda items after the item has been discussed by the Committee but before a Committee recommendation is decided. In either case, each speaker will be allowed five minutes.

3. **Surgical Services Quality Report –** A review of quality and safety outcome metrics related to the care of the surgical population. *Christine Aleman, MSN, RN, Director of Surgical Services, LaMar Mack, MD, Medical Director of Quality & Patient Safety & Kyle Ota, MD, Medical Director of Surgical Quality*

4. **Environment of Care Rounds Follow Up** – Review of current status of action plans submitted by Kaweah Health leaders in response to surveillance round findings. *Maribel Aguilar, Hospital Safety Officer and Shawn Elkin, MPA, BSN, RN, PHN, CIC, Manager of Infection Prevention*

5. **Review of AP.41 Quality Improvement Plan** – A review of revisions to Kaweah Health's Quality Improvement Plan. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*

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

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.

Surgical Quality Improvement Program (SQIP) Report

KAWEAH DELTA HEALTH CARE DISTRICT

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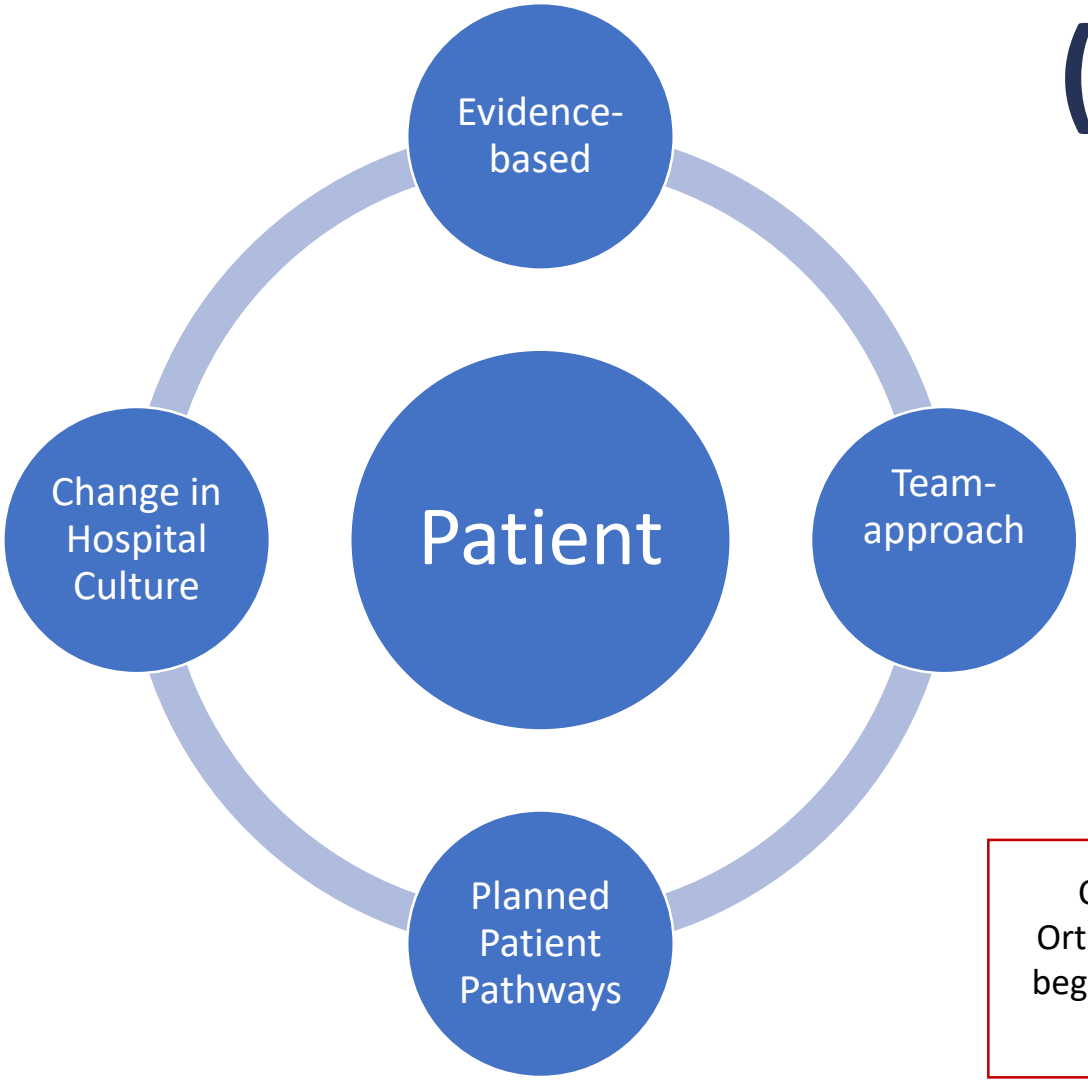
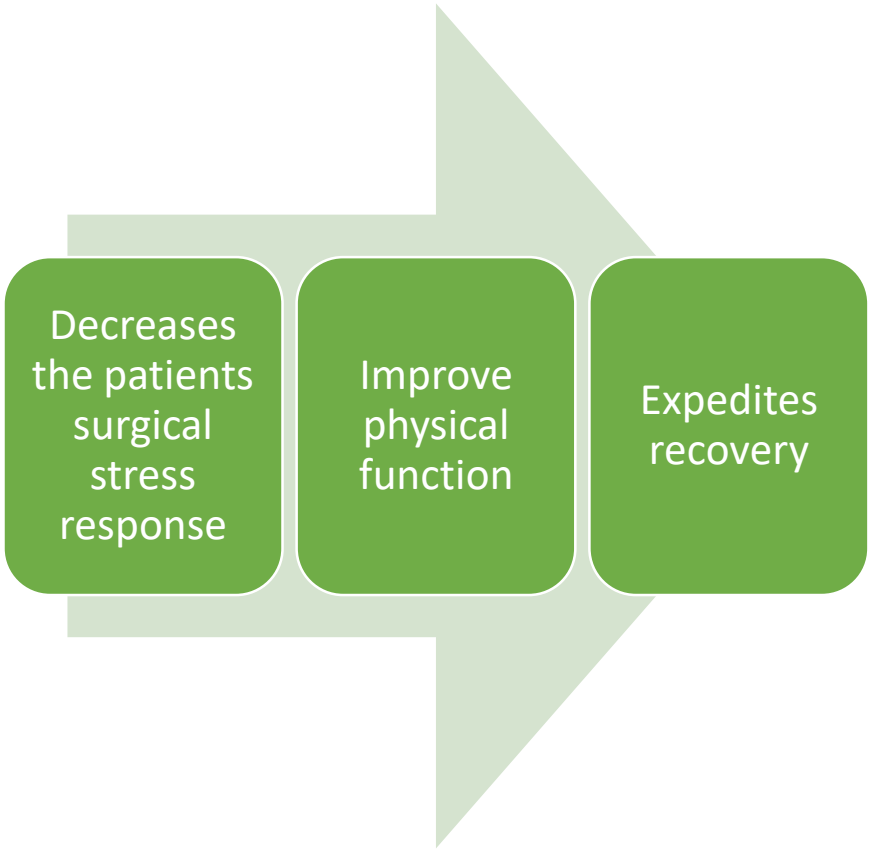
Surgical Quality Improvement Program

- Is a program designed to help improve quality across the surgical patients care.
- It assesses structures to enable quality data to drive our improvement processes.
- Utilize MIDAS automated electronic surgical quality and the National Healthcare Safety Network (NHSN) surgical site infection data to populate an overall dashboard to track and trend.

Enhanced Recovery After Surgery (ERAS)





Colorectal Surgery, Orthopedic Surgery, and beginning phases of GYN Surgery

Kaweah Health
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Surgical Quality Dashboard

ERAS Elective Colorectal (n=)	↓ ISCR Benchmark	2022	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Total
		57	2	5	5	10	5	8	7	7	49
Preop Oral Antibiotics	68.68%	85%	50.0%	50.0%	50.0%	57.1%	33.3%	0.0%	66.7%	33.3%	42.6%
Multi-modal Pain Management	84.12%	100%	100.0%	100.0%	100.0%	90.0%	100.0%	100.0%	85.7%	85.7%	95.2%
Postop VTE Chemoprophylaxis	75.16%	79%	N/C	100.0%	100.0%	N/C	100.0%	75.0%	100.0%	100.0%	95.8%
Postop Mobilization	63.82%	92%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Postop Intake of Liquids	86.15%	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Foley Removal	95.77%	89%	N/C	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

*note: ERAS Ortho go-live March 2022 -all qualifying cpt codes for ortho cases reviewed to obtain baseline Nov 21-Feb 22 (only includes pts admitted to inpatient unit post op)

ERAS Ortho (n=)	ISCR Benchmark	Dec-21	Jan-22	Feb-22	Mar-22	Total
		16	12	13	22	63
Perioperative Antibiotics		100%	100%	100%	100%	100%
Multi-modal Pain Management		100%	100%	100%	100%	100%
Postop VTE Chemoprophylaxis		100%	100%	86%	86%	93%
Postop Mobilization		100%	92%	100%	100%	98%
Postop Intake of Liquids		93%	83%	86%	82%	86%
Foley Removal		93%	100%	88%	89%	92%

Kaweah Health

Surgical Quality Dashboard

	CMS Benchmark	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23*	Jul-23	Aug-23	Total
PSI 4 - Death with serious treatable complication	161.73 / 143.04*	250 3/12	375 9/24	153.85 2/13	90.91 1/11	307.69 4/13	142.86 2/14	238.10 5/21	250 3/12	454.55 5/11	111.11 2/18	304.35 4/23	71.43 1/14	214.27 3/14	235 47/200
PSI 5- Retained surgical item	0.03	0.00 0/1358	0.00 0/1193	0.00 0/1222	0.00 0/1211	0.00 0/1312	0.00 0/1239	0.00 1162	0.00 0/1387	0.00 0/1222	0.00 0/1308	0.00 0/1307	0.00 0/1287	0.00 0/1317	0.00 0/16511
PSI 9 - Perioperative Hemorrhage or Hematoma	2.60 / 2.39*	6.14 2/326	0.00 0/267	6.87 2/291	3.64 1/275	0.00 0/295	3.79 1/264	0.00 0/282	0.00 0/329	0.00 0/301	16.29 5/307	3.29 1/304	3.30 1/303	0.00 0/296	3.86 13/3839
PSI 10 - Postoperative Kidney Injury	1.32 / 0.92*	0.00 0/115	11.77 1/85	10.99 1/91	0.00 0/87	0.00 0/86	26.32 2/76	0.00 0/73	0.00 0/101	0.00 0/98	0.00 0/91	0.00 0/96	0.00 0/81	0.00 0/81	3.45 4/1160
PSI 11-Postoperative Respiratory Failure	7.88 / 6.47*	0.00 0/122	0.00 0/86	11.36 1/88	0.00 0/87	0.00 0/93	14.09 1/71	0.00 0/74	0.00 0/99	0.00 0/95	0.00 0/91	0.00 0/96	11.77 1/85	0.00 0/85	2.56 3/1171
PSI 12- Perioperative PE/VTE	3.86 / 3.41*	0.00 0/340	14.55 4/275	3.25 1/308	0.00 0/291	0.00 0/307	3.65 1/274	6.85 2/292	0.00 0/339	3.17 1/315	0.00 0/321	3.07 1/326	6.33 2/316	0.00 0/323	2.98 12/4028
PSI 13 Postoperative Sepsis	5.23 / 4.09*	0.00 0/119	0.00 0/83	0.00 0/89	0.00 0/88	0.00 0/89	13.33 1/75	0.00 0/68	0.00 0/120	0.00 0/93	0.00 0/90	0.00 0/94	0.00 0/82	0.00 0/81	0.87 1/1153
PSI 14 Postoperative Wound Dehiscence	0.86 / 0.82*	13.70 1/73	0.00 0/61	0.00 0/61	16.13 1/62	0.00 0/58	19.23 1/52	0.00 0/50	0.00 0/67	0.00 0/70	0.00 0/51	0.00 0/53	0.00 0/79	0.00 0/81	3.67 3/818
PSI 15 - Accidental Puncture or Laceration	1.29 / 1.04*	0.00 0/225	0.00 0/227	4.39 1/228	4.76 1/210	4.57 1/219	0.00 0/213	0.00 0/201	7.72 2/259	4.22 1/237	0.00 0/203	9.05 2/221	3.75 1/267	0.00 0/253	3.04 9/2962

Patient Safety Indicators (PSI's)

- Claims-based quality measures (ICD-10 Billing Codes)

- Provides information on potentially avoidable safety events that represent opportunities for improvement in the delivery of care. More specifically, they focus on potential in-hospital complications and adverse events following surgeries and procedures.

- SQIP is in partnership with the Quality Department and the PSI Committee to monitor Patient Safety Indicator events and trends. **Currently monitoring nine (9) indicators** along with Surgical Site Infections.
  - PSI cases reviewed for coding and documentation accuracy and clinical quality opportunities.

- Current priority work in **Pulmonary Embolism/Deep Vein Thrombosis (PE/DVT)** prevention processes.

Surgical Site Infections (SSIs)

	CMS Benchmark	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23*	Jul-23	Aug-23	Total
SSI Colon	Actual	1	1	1	2	0	0	2	0	0	2	0	0	N/C	9
	Predicted (benchmark)	0.837	0.69	1.247	0.475	0.755	1.497	1.448	0.53	1.06	0.702	0.512	0.758	N/C	10.511
SSI Abdominal Hysterectomy	Actual	1	0	0	0	0	0	0	1	0	1	0	1	N/C	3
	Predicted (benchmark)	0.201	0.123	0.145	0.08	0.05	0.096	0.116	0.203	0.187	0.702	0.512	0.702	N/C	2.415
Ht/Wt Documented	99%		99% 459/464	99% 478/481	95% 434/455	99% 422/428	98% 432/443	99% 405/410	97% 423/438	99% 390/392	99% 450/454	98% 430/439	98% 457/468	98% 417/424	98% 4323/4405

- **Surgical Site Infection data:**
  - SSI Colon:
    - We are better than predicted with 7 cases within the last calendar year, March 2022-March 2023.
      - Use of clean closure protocols identified as an opportunity for improvement
  - SSI Abdominal Hysterectomy:
    - Post operative wound care identified as an opportunity for improvement

Kaweah Health

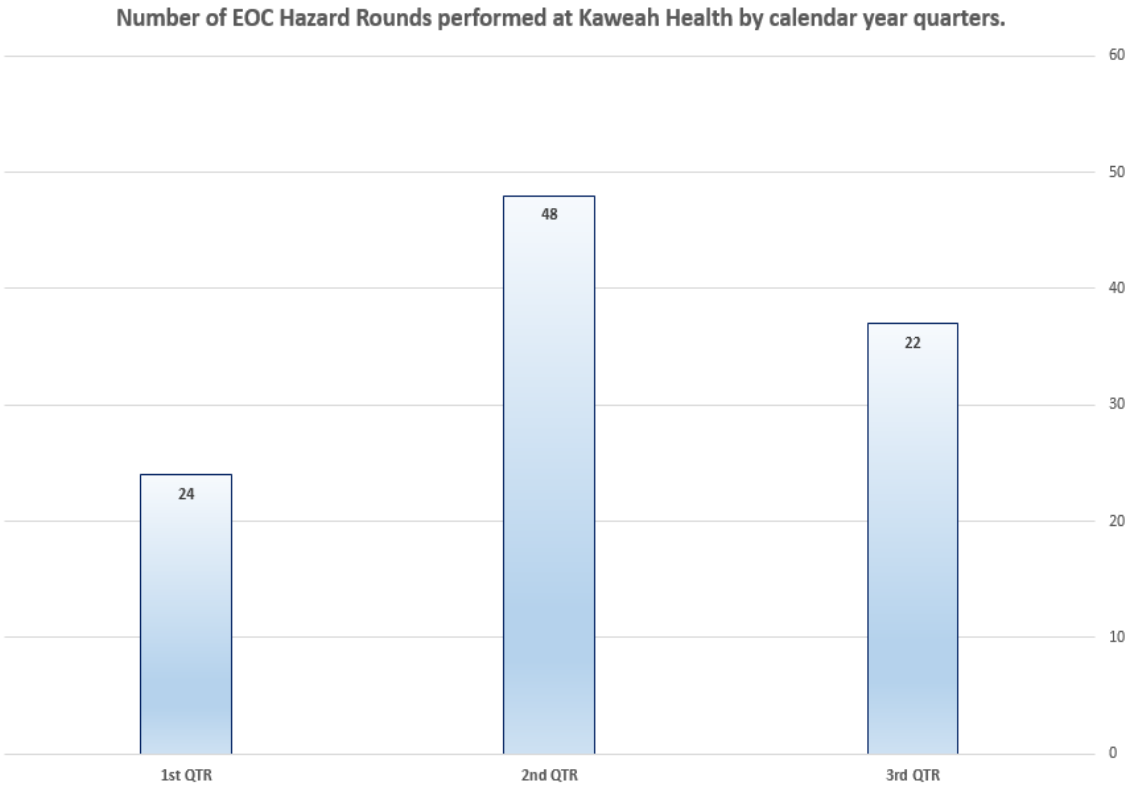
Live with passion.

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

Kaweah Health

Kaweah Health Environment-of-Care Hazard Rounds 3rd Quarter 2023

To better depict the extent to which Kaweah Health performs audits to ensure a safe patient ready environment, findings from all entities that generate observations during EOC Hazard Rounds have been collated and analyzed.



Action Plans are submitted within 14 days of receipt of fallouts identified during EOC Hazard Rounds.

Quarter	% Returned in 14 days	% Returned >14 days	% Not Returned	# Returned in 14 days	# Returned >14 days	# Not Returned
1st QTR	71%	29%	0%	17	7	0
2nd QTR	58%	38%	4%	28	18	2
3rd QTR	55%	36%	5%	13	8	1

Kaweah Health Environment-of-Care Hazard Tour Findings 3rd Quarter 2023

Goal: Ensure a safe patient ready environment.

Start Date: July 1, 2023

End Date: September 30, 2023

Champion: Keri Noeske

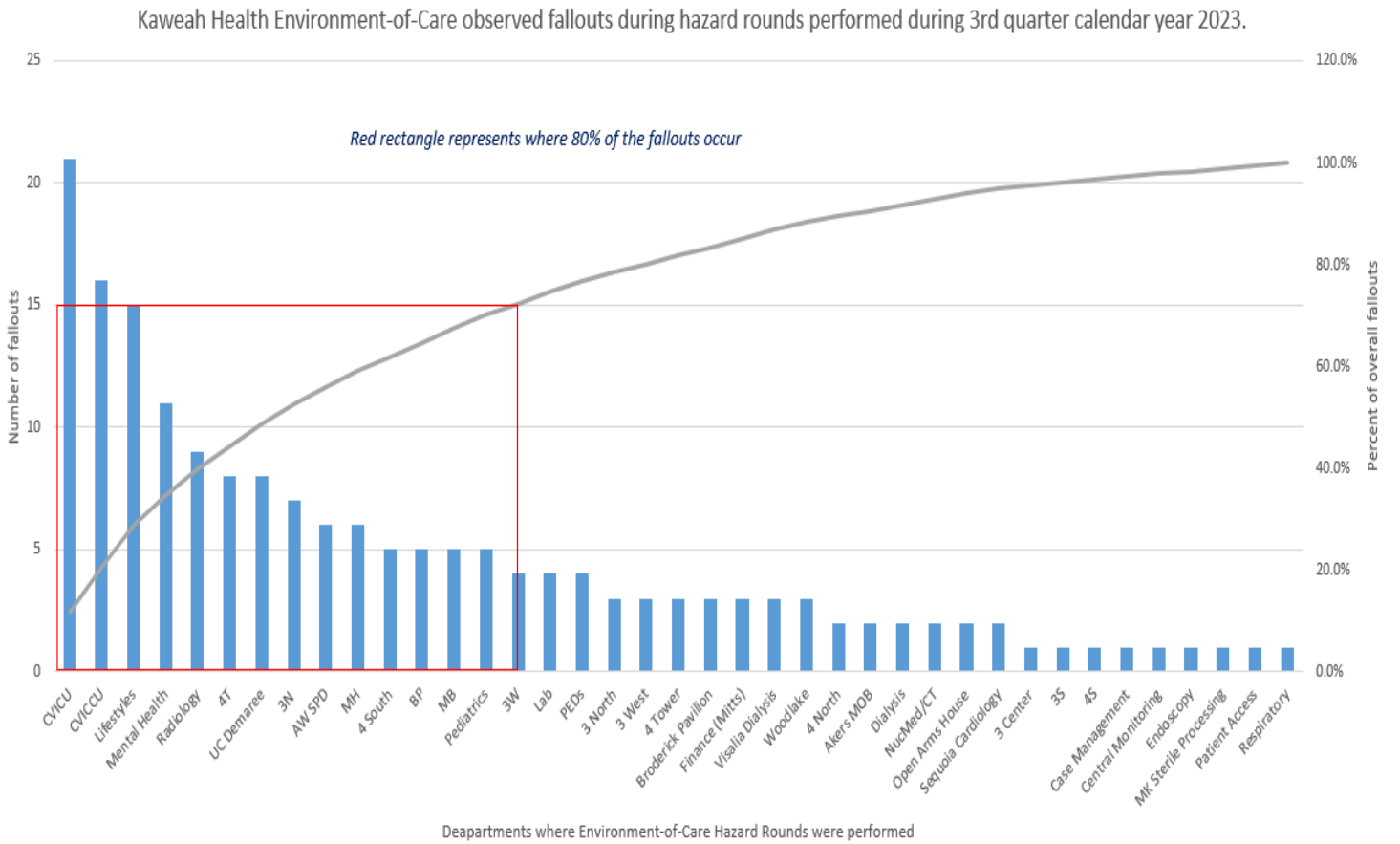
Team: Maribel Aguilar, Christine Madera, Miguel Morales, Edward Cordeiro Jr., Paul Gatley, Matt Howard, Shawn Elkin, Jaynell Tipton, Joetta Denney, Kerry Sommers, Josue Rodriguez, Damon Rolfo, Tendai Zinyemba, Cecelia Cantu, Cherise Mosqueda, Steve Gloeckler, Eric Davidson, Tyler Plumlee, David Valdez, Rebecca Leal

Measure:
Audits are performed to review the environment of care from the following perspectives, using observations:

Safety	Fire Life Safety, Medical Gases, Chemicals, Waste Stream
Security	Potential risk of harm to others and self
Clinical Engineering	Medical equipment
Infection Prevention	Hand hygiene, Isolation/PPE, Airflow, Storage
Environmental Services	Cleanliness of surfaces
Facilities	Intact surfaces, HVAC, Electrical, Water
Laundry	Linens
Accreditation	Oversight of regulatory/accreditation standards
Risk Management	Potential risk associated with the patient care environment

Background: A total of 22 locations were audited. There were 181 fallouts with approximately 1,200 items surveyed over a 3-month timeframe.

Summary:
The CVICU and CVICCU presented the greatest number of fallouts observed during this time period. The bulk (80%) of findings include: storage of items (15), cleanliness (25), doors propped open inappropriately (12), stained ceiling tiles (21), obstacles blocking egresses (9), and waste materials improperly discarded (9). A total of 41 work orders to correct findings were created. Some observations were addressed during the audit phase.



Kaweah Delta Health Care District

Administrative Manual

Policy Number: AP41	**Date Created: Not Set**
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	**Date Approved: 01/26/2022**
Approvers: Board of Directors (Administration)	
Quality Improvement Plan	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

I. Purpose

The purpose of Kaweah Health's Quality Improvement Plan is to have an effective, data-driven Quality AssessmentPerformance Improvement program that delivers high-quality, excellent clinical services and enhances patient safety.

II. Scope

All Kaweah Health facilities, departments, patient care delivery units and/or serviceareas fall within the scope of the quality improvement plan requirements.

III. Structure and Accountability

Board of Directors

The Board of Directors retain overall responsibility for the quality of patient care. The Board approves the annual Quality Improvement Plan and assures that appropriate allocation of resources is available to carry out that plan.

The Board receives reports from the Medical Staff and Quality Council. The Board shall act as appropriate on the recommendations of these bodies and assure that efforts undertaken are effective and appropriately prioritized.

Quality Council

The Quality Council is responsible for establishing and maintaining the organization's Quality Improvement Plan and is chaired by a Board member. The Quality Council shall consist of the Chief Executive Officer, representatives of the Medical Staff and other key hospital leaders. It shall hold primary responsibility for the functioning of the Quality Assessment and Performance Improvement program. Because District quality improvement activities may involve both the Medical Staff and other representatives of the District, membership is multidisciplinary. The Quality Council requires the Medical Staff and the organization's staff to implement and report on the activities for identifying and evaluating opportunities to improve patient care and services throughout the organization. The effectiveness of the quality

improvement and patient safety activities will be evaluated and reported to the Quality Council.

Quality Committee ("QComm")

In accordance with currently approved medical staff bylaws, shall be accountable for the quality of patient care. The Board delegates' authority and responsibility for the monitoring, evaluation and improvement of medical care to the Quality Committee "QComm", chaired by the Vice Chief of Staff and co-chaired by the CMO/CQO (or designee). The Chief of Staff delegates accountability for monitoring individual performance to the Clinical Department Chiefs. QComm shall receive reports from and assure the appropriate functioning of the Medical Staff committees. QComm providesoversight for medical staff quality functions including peer review.

QComm has responsibility for oversight of organizational performance improvement. Membership includes key medical staff and organizational leaders including the Chief of Staff, Medical Director of Quality and Patient Safety, Secretary-Treasurer, Immediate Past Chief of Staff, Chief Executive Officer, Chief Operating Officer, Chief Nursing Officer, Chief Informatics Officer, Chief Human Resources Officer, Chief Financial Officer, Chief Compliance and Risk Management Officer, Chief Strategy Officer, Directors of Quality and Patient Safety, Nursing Practice, Pharmacy, Accreditation, and Risk Management; Manager of Quality and Patient Safety, Manager of Infection Prevention and Environmental Safety Officer. This committee reports to Medical Executive Committee and the Quality Council.

The QComm shall have primary responsibility for the following functions:

1. **Health Outcomes:** The QComm shall assure that there is measureable improvement in indicators with a demonstrated link to improved healthoutcomes. Such indicators include but are not limited to measures reported to the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC), and other quality indicators, as appropriate.

2. **Quality Indicators:**
   a. The QComm shall oversee measurement, and shall analyze and track quality indicators and other aspects of performance. These indicators shall measure the effectiveness and safety of services and quality of care.
   b. The QComm shall approve the specific indicators used for these purposes along with the frequency and detail of data collection.
   c. The Board shall ratify the indicators and the frequency and detail of data collection used by the program.

3. **Prioritization:** The QComm shall prioritize quality improvement activities toassure that they are focused on high- risk, high-volume, or problem- prone areas. It shall focus on issues of known frequency, prevalence or severity and shall give precedence to issues that affect health

outcomes, quality of care and patient safety. The QComm is responsible toestablish organizational Quality Focus Teams who:

a. Are focused on enterprise-wide high priority, high risk, problem prone QI issues
b. May require elevation, escalation and focus from senior leadership
c. Have an executive team sponsor
d. Are chaired by a Director or Vice President
e. May have higher frequency of meetings as necessary to focus work and create sense of urgency.
f. Report quarterly into the QAPI program

4. **Improvement:** The QComm shall use the analysis of the data to identifyopportunities for improvement and changes that will lead to improvement. The QComm will also oversee implementation of actions aimed at improving performance.

5. **Follow- Up:** The QComm shall assure that steps are taken to improve performance and enhance safety are appropriately implemented, measured and tracked to determine that the steps have achieved and sustained the intended effect.

6. **Performance Improvement Projects:** The QComm shall oversee quality improvement projects, the number and scope of which shall be proportional to the scope and complexity of the hospital's services and operations. The QComm must also ensure there is documentation of what quality improvement projects are being conducted, the reasons for conducting those projects, and the measureable progress achieved onthe projects.

Medical Executive Committee

The Medical Executive Committee (MEC) receives, analyzes and acts on performance improvement and patient safety findings from committees and is accountable to the Board of Directors for the overall quality of care

IV. Graduate Medical Education

Graduate Medical Education (Designated Institutional Official (DIO), faculty and residents, are involved in achieving quality and patient safety goals and improving patient care through several venues including but not limited to:

a) Collaboration between Quality and Patient Safety Department, Risk Management, and GME Quality Subcommittee
b) GME participation in Quality Improvement Committee and Patient Safety Committee
c) GME participation in KDHCD quality committees and root cause analysis (including organizational dissemination of lessons learned)

V. Methodologies:

Quality improvement (QI) models present a systematic, formal framework for

establishing QI processes within an organization. QI models used include the following:

- Model for Improvement (FOCUS Plan-Do-Study-Act [PDSA] cycles)
- Six Sigma: Six Sigma is a method of improvement that strives to decrease variation and defects with the use of the DMAIC roadmap.
- Lean: is an approach that drives out waste and improves efficiency in work processes so that all work adds value with the use of the DMAIC roadmap.

1. The **FOCUS**-**Plan, Do, Check, Act (PDCA)** methodology is utilized to plan, design, measure, assess and improve functions and processes related to patient care and safety throughout the organization.

   - **F**—**Find** a process to improve
   - **O**—**Organize** effort to work on improvement
   - **C**—**Clarify** knowledge of current process
   - **U**---**Understand** process variation
   - **S**—**Select** improvement

   - **Plan:**

     - Objective and statistically valid performance measures are identified for monitoring and assessing processes and outcomes of care including those affecting a large percentage of patients, and/or place patients at serious risk if not performed well, or performed when not indicated, or not performed when indicated; and/or have been or likely to be problem prone.

     - Performance measures are based on current knowledge and clinical experience and are structured to represent cross-departmental, interdisciplinary processes, as appropriate.

   - **Do:**

     - Data is collected to determine:
       - ♦ Whether design specifications for new processes were met
       - ♦ The level of performance and stability of existing processes
       - ♦ Priorities for possible improvement of existing processes

   - **Check:**

     - Assess care when benchmarks or thresholds are reached in order to identify opportunities to improve performance or resolve problem areas

   - **Act:**

- Take actions to correct identified problem areas or improve performance
- Evaluate the effectiveness of the actions taken and document the improvement in care
- Communicate the results of the monitoring, assessment and evaluation process to relevant individuals, departments or services

3. **DMAIC (Lean Six Sigma):** DMAIC is an acronym that stands for Define, Measure, Analyze, Improve, and Control. It represents the five phases that make up the road map for Lean Six Sigma QI initiatives.

- **Define** the problem, improvement activity, opportunity for improvement, the project goals, and customer (internal and external) requirements. QI tools that may be used in this step include:
  - Project charter to define the focus, scope, direction, and motivation for the improvement team
  - Process mapping to provide an overview of an entire process, starting and finishing at the customer, and analyzing what is required to meet customer needs
- **Measure** process performance.
  - Run/trend charts, histograms, control charts
  - Pareto chart to analyze the frequency of problems or causes
- **Analyze** the process to determine root causes of variation and poor performance (defects).
  - Root cause analysis (RCA) to uncover causes
  - Failure mode and effects analysis (FMEA) for identifying possible product, service, and process failures

Improve process performance by addressing and eliminating the root causes.

  - Pilot improvements and small tests of change to solve problems from complex processes or systems where there are many factors influencing the outcome
  - Kaizen event to introduce rapid change by focusing on a narrow project and using the ideas and motivation of the people who do the work
- **Control** the improved process and future process performance.
  - Quality control plan to document what is needed to keep an improved process at its current level. Statistical process control (SPC) for monitoring process behavior
  - Mistake proofing (poka-yoke) to make errors impossible or immediately detectable

VI. Confidentiality

All quality assurance and performance improvement activities and data are protected under the Health Care Quality Improvement Act of 1986, as stated in the Bylaws, Rules and Regulations of the Medical Staff, and protected from discovery pursuant to California Evidence Code §1157.

VII. Annual Evaluation

Organization and Medical Staff leaders shall review the effectiveness of the Quality Improvement Plan at least annually to insure that the collective effort is comprehensive and improving patient care and patient safety. An annual evaluation is completed to identify components of the plan that require development, revision or deletion. Organization and Medical Staff leaders also evaluate annually their contributions to the Quality Improvement Program and to the efforts in improving patient safety.

VIII. Attachments

Components of the Quality Improvement and Patient Safety Plan:

Attachment 1: Quality Improvement Committee Structure
Attachment 2: Kaweah Health Reporting Departments
Attachment 3: Quality and Patient Safety Priorities, Outstanding Health Outcomes Strategic Plan

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

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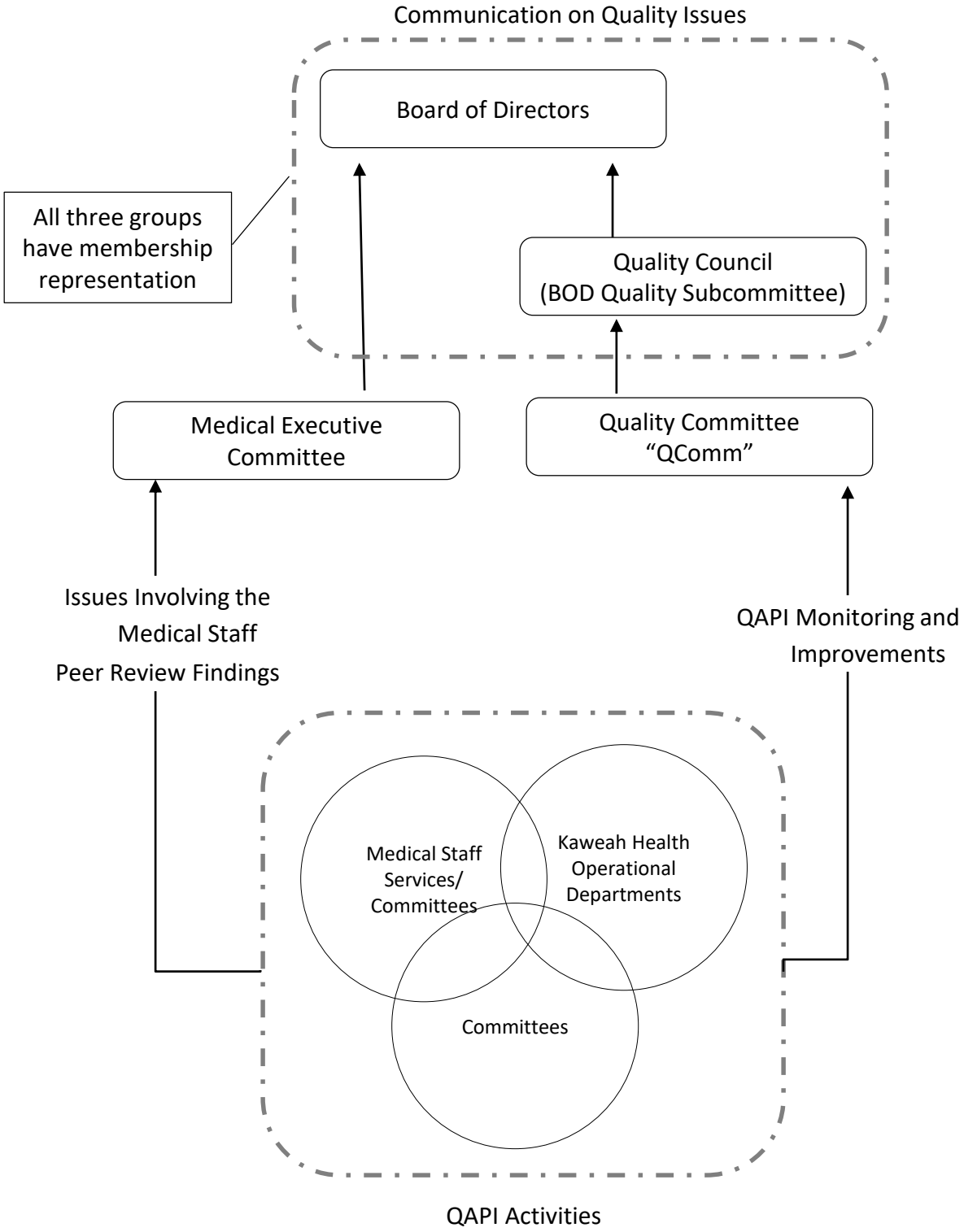
Kaweah Health

Quality Reporting Structure



Quality Committee "QComm" Reporting Depts/Services/Committees

Departments within Kaweah Health participate in the Quality Improvement plan by prioritizing performance improvement activities based on high-risk, high-volume, or problem-prone areas. Department level indicators shall focus on issues of known frequency, prevalence or severity and shall give precedence to issues that affect health outcomes, quality of care and patient safety. Departments include, but are not limited to:

Professional & Patient Care Services
Laboratory
Blood Utilization
Dept of Radiology/imaging Services (including Radiation Safety Report)
Dept of Emergency Medicine
Dept of Pathology (Annual)
EOC **(Security, Facilities,Clinical Engineering, EVS, Employee Health, WPV; WPV annual report)**
Peer Review (Semi-Annual)
CME Report
Patient Access
Population Health
Nutrition Services
Staffing Analysis and Adverse Events
Quality Incentives Program (previously PRIME), includes all Rural Health Clinics (Exeter, Lindsay, Woodlake, Dinuba, Tulare)
ISS Services
ISS - Clinical Informatics
ISS - Application Services
ISS - Technical Services
CPOE MUE (eCQMs)
Pharmacy
Inpatient Pharmacy
Med Safety & ADE (Quarterly)
MERP Annual Review
Chemo Annual Review
Infection Prevention Services
Infection Prevention Quarterly Report
Hand Hygiene
Risk Management
Risk Management (RCA and Focus Review Summary)
Grievances
Mental Health Services
Dept of Psychiatry, MHH
Behavioral Health Committee
Maternal Child Health/ Dept of OB/GYN & Peds
Labor & Delivery
Mother Baby
Neonatal Intensive Care Unit
Pediatrics
Respiratory Services
Sleep Lab and EEG
Respiratory Therapy and Pulmonary Function Test
Care Management
Patient & Family Services

Case Management
Interpreter Services
Palliative Care Committee Minutes
Episodic Care
Emergency Dept. Quality Report (Including Conscious Sedation, Dashboard..)
Trauma Service
Urgent Cares
Cardiovascular Services
Dept of Cardiovascular Services (ACC, STS) Cath lab, IR, CVCU and Cardiac Surgery
CVICU
2 North
4 Tower
Telemonitoring Report
Non Invasive Inpatient Services
Critical Care Services
Intensive Care Unit, CVICU (non-cardiac)
3 West
5 Tower
Organ Donation (Annual)
Rehabilitation Services
Rehabilitation
Inpatient Therapies (KDMC, Rehab, South Campus)
Outpatient Therapies: Medical Office Building Akers (MOB), Exeter, Sunnyside, Dinuba, Lovers Lane, Therapy Specialists at Rehab/Neuro
Outpatient Wound Clinic at Rehab (included in Rehab report)
Post Acute Services
KH Home Infusion Pharmacy (KHHIP)
Hospice
Home Care Services (Home Health)
Short-Stay Rehab
Skilled Nursing Services (subacute and short-stay)
Surgical Services
SQIP - Surgical Quality Improvement Committee
Ambulatory Surgery Center/PACU/KATS
Operating Room
Sterile Processing Department
Broderick Pavilion
3 North
4 South
Anesthesia Services
Orthpedics
Endoscopy
Renal Services/ Dept of Renal Services
4 North
KH Visalia Dialysis
Med/Surg
2 South
3 South
Publically Reported Measures
Quality Monthly Dashboard: I.P., PSIs, HACs, Mortality, HCAHPS, Core Measures

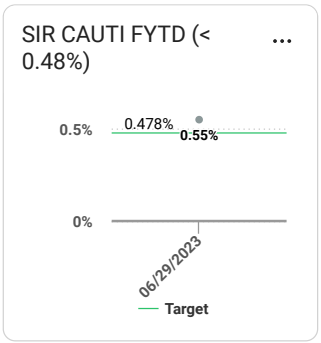
Care Compare Quarterly Report
Value Based Purchasing Report
Healthgrades
Leapfrog Hospital Safety Score
Committees
Disparities in care
Falls Committee
RRT/Code Blue
Pain Management
HAPI Committee (includes inpatient wound care)
Sepsis Quality Focus Team
CAUTI Committee
CLABSI Quality Focus Team
Stroke Committee Report
Diabetes Committee Report
Handoff Communication Quality Focus Team
Accreditation Regulatory Committee Minutes & Audit Summary
Workplace Violence Committee (annual report required by Cal-OSHA)
Diversion Prevention Committee
Bioethics Committee
MRSA Quality Focus Team
Throughput Project Report
Mortality Committee
Patient Safety Committee Minutes
HIM - HIM Committee Minutes and Suspensions
Professional Practice Committee (PPC) Minutes

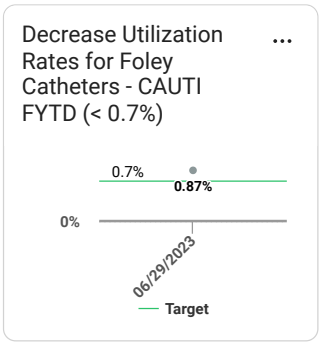
Standardized Infection Ratio (SIR) Champions: Sandy Volchko

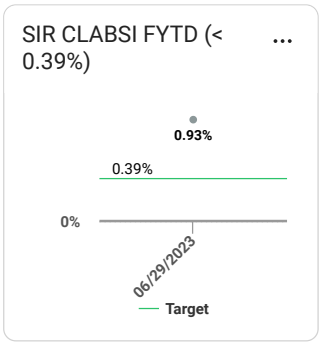
***Objective**: Reduce the Hospital Acquired Infections (HAIs) to the national 70th percentile in FYTD24 as reported by the Centers for Medicare and Medicaid Services*

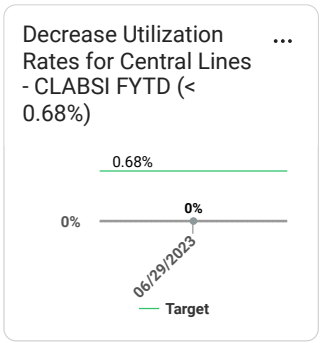
Plan

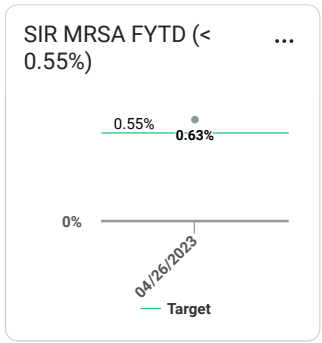
#	Level	Name	Start Date	Due Date	Assigned To	Status	Last Comment
5.1.1	Objective	CAUTI, CLABSI, MRSA Quality Focus Teams	07/01/2023	06/30/2024	Sandy Volchko	Not Started	
5.1.2	Objective	Daily catheter and central line Gemba rounds	07/01/2023	06/30/2024	Sandy Volchko	Not Started	
5.1.3	Objective	Bio-Vigil	07/01/2023	06/30/2024	Sandy Volchko	Not Started	
5.1.4	Objective	MRSA Decolonization	07/01/2023	06/30/2024	Sandy Volchko	Not Started	
5.1.5	Outcome	Standardized Infection Ratio (SIR) CAUTI (CMS data FYTD)	07/01/2023	06/30/2024	Sandy Volchko	Not Started	FY24 Goal .48 (70th Percentile) Baseline FYTD .55 (June 2023) FY23 Goal .65 (national mean)
5.1.5.1	Outcome	Decrease Utilization Rates for Foley Catheters (CAUTI)	07/01/2023	06/30/2024	Sandy Volchko	Not Started	FY24 Goal .70 (70th Percentile) Baseline FYTD .87 (June 2023) FY23 Goal - N/A (new metric)
5.1.6	Outcome	Standardized Infection Ratio (SIR) CLABSI (CMS data FYTD)	07/01/2023	06/30/2024	Sandy Volchko	Not Started	FY24 Goal .39 (70th Percentile) Baseline FYTD .93 (June 2023) FY23 Goal .589 (national mean)
5.1.6.1	Outcome	Decrease Utilization Rates for Central Lines (CLABSI)	07/01/2023	06/30/2024	Sandy Volchko	Not Started	FY24 Goal .68 (70th Percentile) Pending baseline data FY23 Goal - N/A (new metric)
5.1.7	Outcome	Standardized Infection Ratio (SIR) MRSA (CMS data FYTD)	07/01/2023	06/30/2024	Sandy Volchko	Not Started	FY24 Goal .55 (70th Percentile) Baseline FYTD .63 (June 2023) FY23 Goal .726 (national mean)









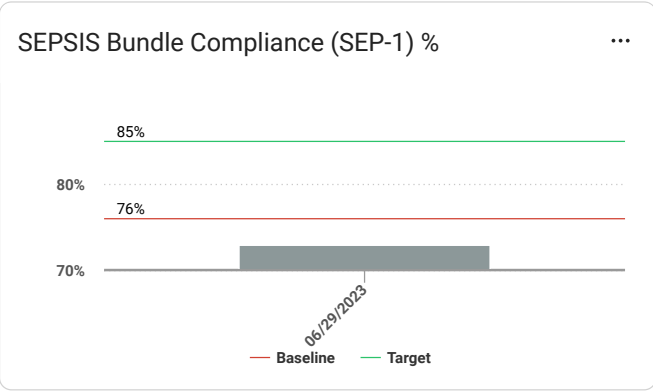


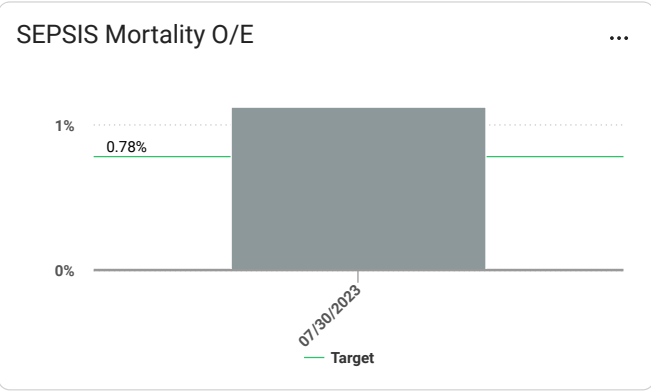
SEPSIS Bundle Compliance (SEP-1) Champions: Sandy Volchko

Objective: *Increase SEP-1 bundle compliance to overall 85% compliance rate for FY24 through innovative improvement strategies based on root causes.*

Plan

#	Level	Name	Start Date	Due Date	Assigned To	Status	Last Comment
5.2.1	Objective	Utilize SEPSIS Coordinators to identify and monitor patients	07/01/2023	06/30/2024	Sandy Volchko	Not Started	
5.2.2	Objective	SEPSIS Alerts-Required MD notifications	07/01/2023	06/30/2024	Sandy Volchko	Not Started	
5.2.3	Objective	Quality Focus Team-RCAs/Fall out review	07/01/2023	06/30/2024	Sandy Volchko	Not Started	
5.2.4	Outcome	SEPSIS Bundle Compliance (SEP-1) % FYTD	07/01/2023	06/30/2024	Sandy Volchko	Not Started	FY24 Goal .85 (no percentile) Baseline FY end .73 (June 2023) FY23 Goal .77
5.2.4.1	Outcome	SEPSIS Mortality O/E	07/01/2023	06/30/2024	Sandy Volchko	Not Started	FY24 Goal .78 (no percentile) Baseline FY end 1.12 (June 2023) FY23 Goal - N/A (new metric)





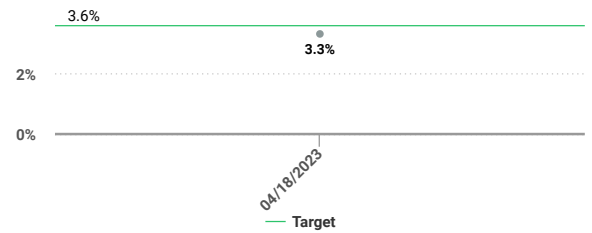
Mortality and Readmissions Champions: Sandy Volchko

Objective: *Reduce observed/expected mortality through the application of standardized best practices.*

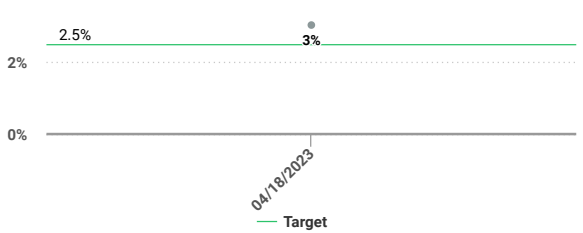
Plan

#	Level	Name	Start Date	Due Date	Assigned To	Status	Last Comment
5.3.1	Objective	Enhanced diagnosis specific workgroups/committees	07/01/2023	06/30/2024	Sandy Volchko	Not Started	
5.3.2	Objective	Standardized care based on evidence	07/01/2023	06/30/2024	Sandy Volchko	Not Started	
5.3.3	Outcome	Hospital Readmissions % AMI (CMS data FYTD)	07/01/2023	06/30/2024	Sandy Volchko	Not Started	Goal = 80th Percentile / Baseline FYTD (March 2023)
5.3.4	Outcome	Hospital Readmissions % COPD (CMS data FYTD)	07/01/2023	06/30/2024	Sandy Volchko	Not Started	Goal = 80th Percentile / Baseline FYTD (March 2023)
5.3.5	Outcome	Hospital Readmissions % HF (CMS data FYTD)	07/01/2023	06/30/2024	Sandy Volchko	Not Started	Goal = 75th Percentile / Baseline FYTD (March 2023)
5.3.6	Outcome	Hospital Readmissions % PN Viral/Bacterial (CMS data FYTD)	07/01/2023	06/30/2024	Sandy Volchko	Not Started	Goal = 70th Percentile / Baseline FYTD (March 2023)
5.3.7	Outcome	Decrease Mortality Rates AMI FYTD	07/01/2023	06/30/2024	Sandy Volchko	Not Started	Goal = 90th Percentile / Baseline FYTD (March 2023)
5.3.8	Outcome	Decrease Mortality Rates COPD FYTD	07/01/2023	06/30/2024	Sandy Volchko	Not Started	Goal = 60th Percentile / Baseline FYTD (March 2023)
5.3.9	Outcome	Decrease Mortality Rates HF FYTD	07/01/2023	06/30/2024	Sandy Volchko	Not Started	Goal = 90th Percentile / Baseline FYTD (March 2023)
5.3.10	Outcome	Decrease Mortality Rates PN Bacterial FYTD	07/01/2023	06/30/2024	Sandy Volchko	Not Started	Goal = 90th Percentile / Baseline FYTD (March 2023)
5.3.11	Outcome	Decrease Mortality Rates PN Viral FYTD	07/01/2023	06/30/2024	Sandy Volchko	Not Started	Percentile TBD (specifics unavailable) / Baseline FYTD (March 2023)
5.3.12	Outcome	Percutaneous Coronary Intervention (PCI) In Hospital Mortality Rate - STEMI	07/01/2023	06/30/2024	Sandy Volchko	Not Started	Goal = 50th Percentile / Baseline Rolling 4 quarters (10/1/21 - 9/30/22)
5.3.12.1	Outcome	Door to Balloon Time PCI for STEMI (< 50 mins)	07/01/2023	06/30/2024	Sandy Volchko	Not Started	Goal = 90th Percentile / Baseline of 63 - Rolling 4 quarters (10/1/21 - 9/30/22)
5.3.13	Outcome	Acute Kidney Injury Post PCI	07/01/2023	06/30/2024	Sandy Volchko	Not Started	Goal = 90th Percentile / Baseline Rolling 4 quarters (10/1/21 - 9/30/22)
5.3.14	Outcome	Risk Standardized Bleeding Rate	07/01/2023	06/30/2024	Sandy Volchko	Not Started	Goal = 75th Percentile / Baseline Rolling 4 quarters (10/1/21 - 9/30/22)

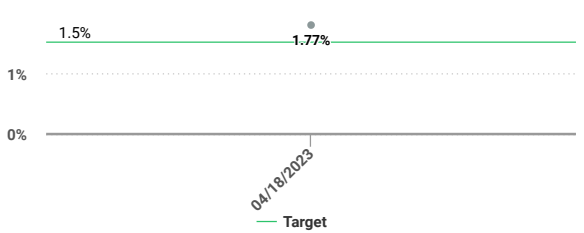
Acute Kidney Injury Post PCI (< 3.6%)



PCI In-Hospital Mortality Rate - STEMI (< 2.5%)

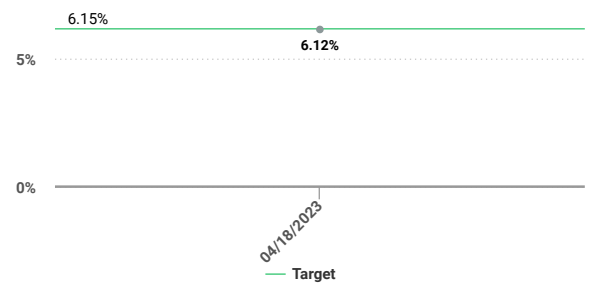


Risk Standardized Bleeding Rate (< 1.5%)

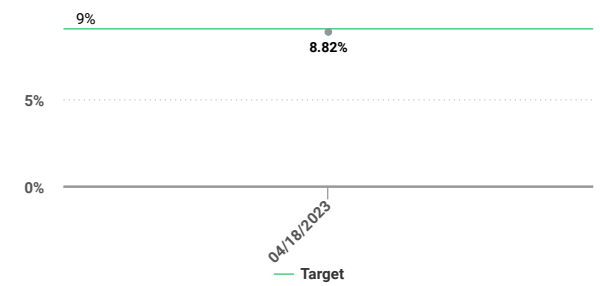


Mortality and Readmissions Champions: Sandy Volchko

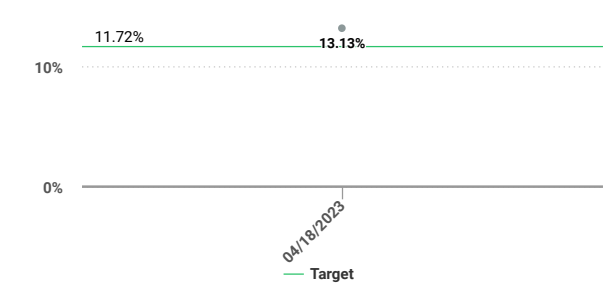
Hospital Readmissions % AMI FYTD (< 6.15%)



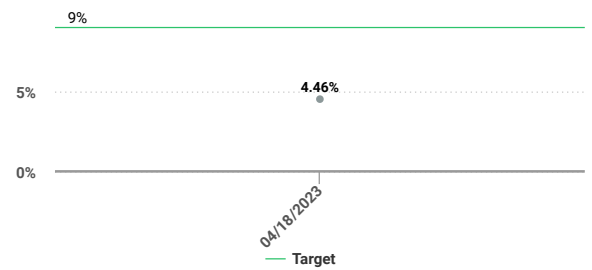
Hospital Readmissions % COPD FYTD (< 9%)



Hospital Readmissions % HF FYTD (< 11.72%)

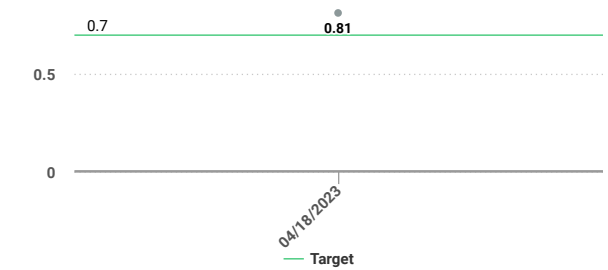


Hospital Readmissions % PN Viral/Bacterial FYTD (< 9%)

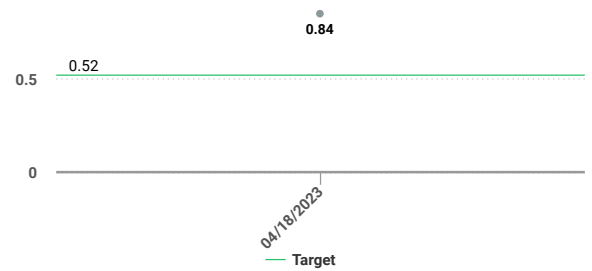


Decrease Mortality Rates AMI FYTD (< 0.7)

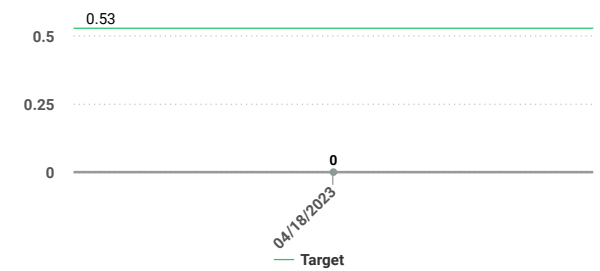
Decrease Mortality Rates COPD FYTD (< 0.7)



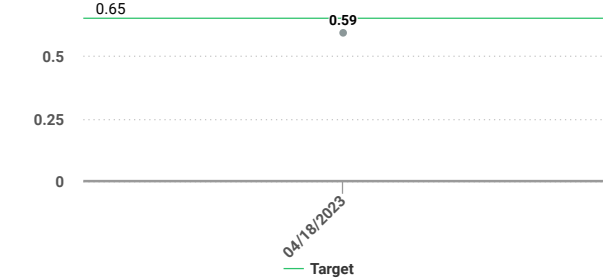
Decrease Mortality Rates HF FYTD (< 0.52)



Decrease Mortality Rates PN Bacterial FYTD (< 0.53)



Decrease Mortality Rates PN Viral FYTD (<0.65)



Health Equity Champions: Ryan Gates and Sonia Duran-Aguilar

Objective: *Identify health disparities that improve affordable access to care by enhancing care coordination and more effective treatment through healthy living.*

Plan

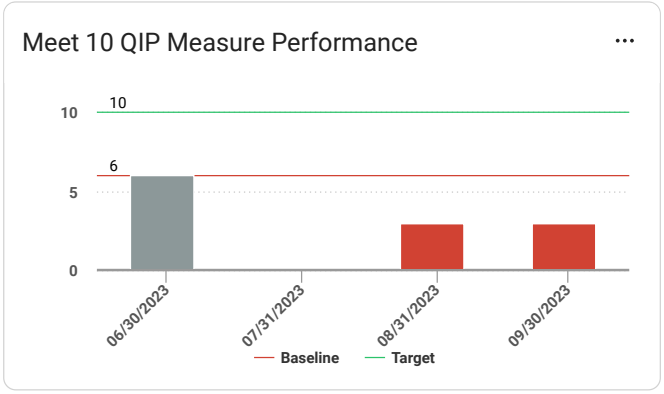
#	Level	Name	Start Date	Due Date	Assigned To	Status	Last Comment
5.5.1	Objective	Identify an individual to lead activities to improve Health Care Equity	07/01/2023	06/30/2024	Sonia Duran-Aguilar	Achieved	Chief Of Population Health Ryan Gates leading Health Equity Committee along with Sonia Duran-Aguilar Director of Population Health and Dr. Omar Guzman.
5.5.2	Objective	Develop Organizational Multi-Year Health Equity Plan/Road Map	07/01/2023	06/30/2024	Sonia Duran-Aguilar	Not Started	
5.5.3	Objective	Review and Select Toolkit to be used, and identify gaps and develop plans to resolve	07/01/2023	06/30/2024	Sonia Duran-Aguilar	Not Started	
5.5.4	Objective	Select Social Screening Data Collection Tool by 7/1/23	07/01/2023	06/30/2024	Sonia Duran-Aguilar	Achieved	PRAPARE Tool Selected and to be built out end of December 2023.
5.5.4.1	Objective	Build out tool in Cerner	07/01/2023	06/30/2024	Sonia Duran-Aguilar	Not Started	
5.5.4.2	Objective	Develop training materials for front line staff and complete training	07/01/2023	06/30/2024	Sonia Duran-Aguilar	Not Started	
5.5.4.3	Objective	Evaluate reporting capabilities/dashboards	07/01/2023	06/30/2024	Sonia Duran-Aguilar	Not Started	
5.5.4.4	Objective	Implement new screening tool and monitor and reinforce progress using available reports	07/01/2023	06/30/2024	Sonia Duran-Aguilar	Not Started	
5.5.5	Objective	Identify Disparities in data collected by 3/30/2024	07/01/2023	06/30/2024	Sonia Duran-Aguilar	Not Started	

Quality Improvement Program (QIP) Reporting Champions: Sonia Duran-Aguilar

***Objective**: Achieve performance on the Quality Incentive Pool measures to demonstrate high quality care delivery in the primary care space.*

Plan

#	Level	Name	Start Date	Due Date	Assigned To	Status	Last Comment
5.4.1	Objective	Improve Frontline staff (Clinic Primary Care/Internal Medicine/clinical staff) awareness of QIP performance and thereby ensure engagement and buy in QI efforts	07/01/2023	06/30/2024	Sonia Duran-Aguilar	Not Started	
5.4.2	Objective	Optimize workflows to drive and hardwire best practices for clinical care (registration, MA intake, provider documentation)	07/01/2023	06/30/2024	Sonia Duran-Aguilar	Not Started	
5.4.3	Objective	Continue with Monthly workgroups (MCPs, Revenue Integrity, Population Health/Clinic Teams) to track progress	07/01/2023	06/30/2024	Sonia Duran-Aguilar	Not Started	
5.4.4	Objective	Continue to monitor Quality Data Code documentation and impact on QIP measure performance	07/01/2023	06/30/2024	Sonia Duran-Aguilar	Not Started	
5.4.5	Objective	Optimize Patient Advisories/Health Maintenance that align with QIP measures	07/01/2023	06/30/2024	Sonia Duran-Aguilar	Not Started	
5.4.6	Objective	Develop HealtheAnalytics Performance Dashboards-25 measures	07/01/2023	06/30/2024	Sonia Duran-Aguilar	Not Started	
5.4.7	Objective	Completion of HealtheAnalytics Fall Out Worklists for QIP Measures-completed 18 FY23/ongoing for new and remaining measures (7 additional)	07/01/2023	06/30/2024	Sonia Duran-Aguilar	Not Started	
5.4.8	Objective	Explore within Cerner, tools that improve automated coding (ICD/Quality Data Codes) per clinical documentation (long term strategy)	07/01/2023	06/30/2024	Sonia Duran-Aguilar	Not Started	
5.4.9	Outcome	Meet 10 QIP measure performance	07/01/2023	06/30/2024	Sonia Duran-Aguilar	At Risk	Proxy performance out of Cozeva Population Health Platform shows performance at 30%



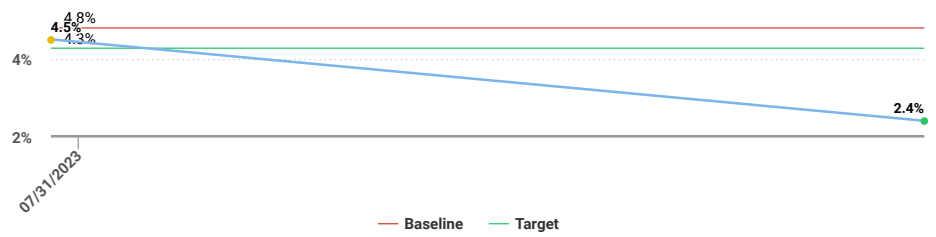
Inpatient Diabetes Management Champions: Emma Camarena and Cody Ericson

***Objective**: Optimize inpatient glycemic management using evidence-based practices to improve patient's glycemic control and reduce hypoglycemic events.*

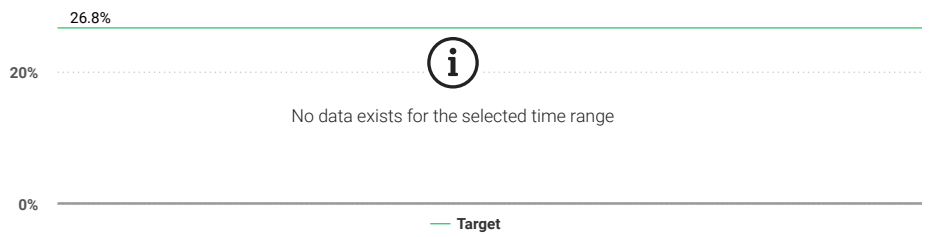
Plan

#	Level	Name	Start Date	Due Date	Assigned To	Status	Last Comment
5.6.1	Outcome	Achieve benchmark performance for hypoglycemia in Critical Care (CC) patient population, defined as percent patient days with blood glucose (BG) <70	07/01/2023	06/30/2024	Sandy Volchko	On Track	For May 2023. Will get next reporting in Fall of 2023. Monthly monitoring is done using gluco metrics.
5.6.2	Outcome	Achieve benchmark performance for hypoglycemia in Non-Critical Care (NCC) patient population, defined as percent patient days with blood glucose (BG) <70	07/01/2023	06/30/2024	Sandy Volchko	Not Started	
5.6.3	Outcome	Achieve benchmark performance for percent of patients with hypoglycemia with at least one recurrent hypoglycemic day for Critical Care (CC)	07/01/2023	06/30/2024	Sandy Volchko	Not Started	
5.6.4	Outcome	Achieve benchmark performance for percent of patients with hypoglycemia with at least one recurrent hypoglycemic day for Non Critical Care (NCC)	07/01/2023	06/30/2024	Sandy Volchko	Not Started	

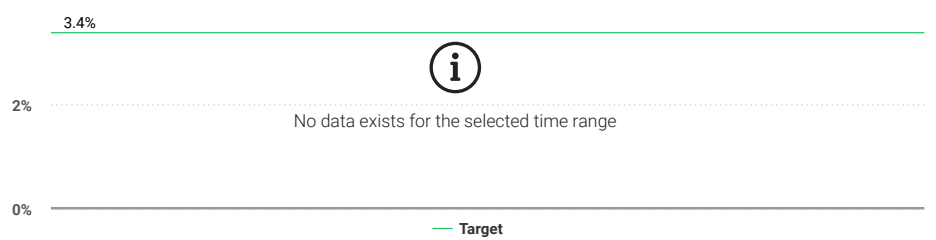
Hypoglycemia in Critical Care Patients (< 4.3%)



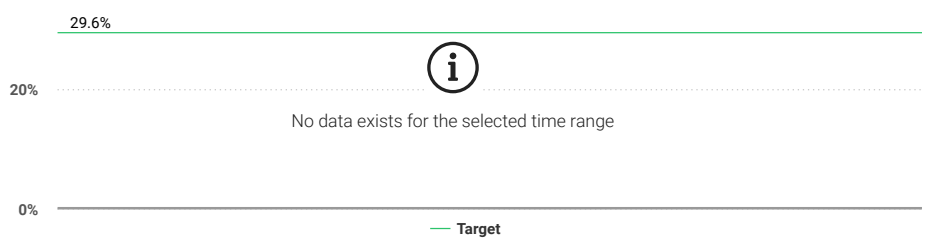
Recurrent Hypoglycemia in Critical Care Patients (< 26.8%)



Hypoglycemia in Non-Critical Care Patients (< 3.4%)



Recurrent Hypoglycemia in Non-Critical Care Patients (< 29.6%)



Outstanding Health Outcomes Update

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

November 2023

Kaweah Health
MORE THAN MEDICINE. LIFE.

Outstanding Health Outcomes (OHO) Dashboard

Sepsis (SEP)	FY 2024 Target	FY 2022	FY 2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	FYTD 24
SEP-1 CMS % bundle compliance	85%	75%	73%	68%	77%											73%
Sepsis and Related Conditions o/e mortality	≤0.60		1.12	0.75	0.82											0.79

Central Line Associated Blood Stream Infection (CLABSI)	FY 2024 Target	FY 2022	FY 2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	FYTD 24
CLABSI Events		18 Ex COVID	14 Ex COVID	1	2	3	0									6
CLABSI SIR	tbd	1.01 Ex COVID	0.93 Ex COVID	0.83	1.16	2.22	0.00									1.15
Central Line Utilization Rate (ICU)	tbd	0.76	0.67	0.75	0.77	0.83	0.77									0.78

Catheter Associated Blood Stream Infection (CAUTI)	FY 2024 Target	FY 2022	FY 2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	FYTD 24
CAUTI Events		23 Ex COVID	12 Ex COVID	0	0	2	0									2
CAUTI SIR	tbd	1.09 Ex COVID	0.55 Ex COVID	0.00	0.00	1.06	0									0.28
Indwelling Uninary Catheter (IUC) Utilization Rate (ICU)	tbd	0.85	0.87	0.87	0.90	1.04	1.08									0.97

Methicillin-Resistant Staphylococcus Aureus (MRSA)	FY 2024 Target	FY 2022	FY 2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	FYTD 24
MRSA Events		10 Ex COVID	6 Ex COVID	0	0	1	0									1
MRSA SIR	tbd	1.11 Ex COVID	0.66 Ex COVID	0.00	0.00	1.47	0.00									0.37

Addit
SEP-1
SIR - S

hat receiv at the right time for our sepsis patients

KEY	Does not meet goal/benchmark	Within 10% of goal/benchmark	Outperforming/ meeting goal/benchmark

Action Plan Summary

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

Sepsis

- Focus on 1 hr bundle, expand to inpatient
- Re-identifying root causes of SEP-1 non-compliance to focus SEP-1 QI on the highest contributing factors

Healthcare Acquired Infections

- New super “HAI Brain Trust” Quality Focus Team established, approved by Quality Improvement Committee
- Combine and focus efforts on process metrics that affect the SIRs for CAUTI, CLABSI & MRSA and includes:
  - Line utilization (both central lines and indwelling urinary catheters
  - Decolonization rates
  - Cleaning effectiveness in high risk areas
  - Hand Hygiene (use of BioVigil system for monitoring)

Questions?

The pursuit of healthiness