January 14, 2021

# NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in a Quality Council Committee meeting at 7:00AM on Thursday, January 21, 2021, in the Kaweah Delta Lifestyle Center, Conference Room A, 5105 W. Cypress Avenue, or via GoTo Meeting from your computer, tablet or smartphone. https://global.gotomeeting.com/join/881426077 or call (224) 501-3412 - Access Code: 881-426-077.

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:01AM on Thursday, January 21, 2021, in the Kaweah Delta Lifestyle Center, Conference Room A, 5105 W. Cypress Avenue, pursuant to Health and Safety code 32155 & 1461. Board members and Quality Council closed session participants will access closed meeting via Confidential GoTo Meeting phone number provided to them.

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, January 21, 2021, in the Kaweah Delta Lifestyle Center, Conference Room A, 5105 Cypress Avenue, or via GoTo Meeting via computer, tablet or smartphone. https://global.gotomeeting.com/join/881426077 or call (224) 501-3412 - Access Code: 881-426-077.

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 Delta Medical Center, Mineral King Wing entry corridor between the Mineral King lobby and the Emergency Department waiting room.

Due to COVID 19 visitor restrictions to the Medical Center - the disclosable public records related to agendas can be obtained by contacting the Board Clerk at Kaweah Delta Medical Center – Acequia Wing, Executive Offices (Administration Department) {1st floor}, 400 West Mineral King Avenue, Visalia, CA via email: cmoccio@kdhcd.org, via phone: 559-624-2330 or on the Kaweah Delta Health Care District web page http://www.kaweahdelta.org.

KAWEAH DELTA HEALTH CARE DISTRICT
David Francis, President

Cindy Moccio

Cindy Moccio
Board Clerk, Executive Assistant to CEO

DISTRIBUTION:
Governing Board, Legal Counsel, Executive Team, Chief of Staff
http://www.kaweahdelta.org

# KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
# QUALITY COUNCIL

Thursday, January 21, 2021
5105 W. Cypress Avenue
The Lifestyle Center; Conference Room A
**Call in option: 1-224-501-3412 Access Code: 881-426-077**

ATTENDING: Board Members; David Francis – Committee Chair, Mike Olmos; Gary Herbst, CEO; Keri Noeske, RN, BSW, DNP, VP & CNO; Anu Banerjee, PhD, VP & Chief Quality Officer, Byron Mendenhall, MD, Chief of Staff; Monica Manga, MD, Professional Staff Quality Committee Chair; Daniel Hightower, MD, Secretary/Treasurer; Harry Lively, MD, Past Chief of Staff; Lori Winston, MD, DIO & VP of Medical Education; Tom Gray, MD, Quality and Patient Safety Medical Director; Sandy Volchko DNP, RN CLSSBB, Director of Quality and Patient Safety; Ben Cripps, Chief Compliance Officer, and Michelle Adams, Recording.

## OPEN MEETING – 7:00AM

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. **Approval of Quality Council Closed Meeting Agenda** – 7:01AM
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Monica Manga, MD, and Professional Staff Quality Committee Chair;*
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Anu Banerjee, PhD, VP & Chief Quality Officer*
4. **Adjourn Open Meeting** – *David Francis, Committee Chair*

## CLOSED MEETING – 7:01AM

1. **Call to order** – *David Francis, Committee Chair & Board Member*
2. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Monica Manga, MD, and Professional Staff Quality Committee Chair*
3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 –– *Anu Banerjee, PhD, VP & Chief Quality Officer*
4. **Adjourn Closed Meeting** – *David Francis, Committee Chair*

## OPEN MEETING – 8:00AM

1. **Call to order** – *David Francis, Committee Chair*
2. **Public / Medical Staff participation –** Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves at this time. Members of the public or the medical staff may comment on agenda items after the item has been discussed by the Committee but before a Committee recommendation is decided. In either case, each speaker will be allowed five minutes.
3. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives:
   - 3.1. **Patient Experience**
   - 3.2. **Emergency Department Dashboard and Report**
   - 3.3. **Rapid Response Team (RRT)**
   - 3.4. **Stroke Committee Quality Report**
   - 3.5. **Rehabilitation Service Line Quality Report**
   - 3.6. **Sepsis Quality Focus Team (QFT)**
   - 3.7. **Catheter Associated Urinary Tract Infection (CAUTI) Quality Focus Team (QFT)**
4. **Follow Up From Previous Meetings**
5. **Update: Clinical Quality Goals** - A review of current performance and actions focused on the FY 2021 clinical quality goals. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*
6. **Annual Review of Quality and Patient Safety Plans** – A review of the effectiveness of the Quality and Patient Safety Plans including key measures and actions. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*
7. **Review 2021 Quality Council Reporting Calendar** – A review of the annual schedule for quality and patient safety reports. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*
8. **Adjourn Closed 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.*

## *Quality Council Update*
## *Patient Experience (HCAHPS) Performance: Dec 2020*

| Time Period | 1Q19 -4Q19 | | July – November 2020 | |
|---|---|---|---|---|
| **HCAHPS Measure** | **Full Adj** *(Mode Adj + Pt Mix Adj)* | **CMS** 50th percentile ***National*** | **Mode Adj Only** | **Comments/Improvement Efforts** |
| **# of surveys** 22% response rate | 2026 | - | 1074 | - |
| **Communication with Nurses** | **77%** ↑ Below CMS | 81% | 79% | -Install **new communication white boards** |
| **Communication with Doctors** | **76%** ↑ Below CMS | 82% | 80% | -**Standardize communication** between consulting and attending physicians.<br>-Quality **introductions**<br>-**Explaining** findings and treatment plans |
| **Responsiveness of Staff** | **67%** ↑ Below CMS | 70% | **69%** | -**Hourly rounding** (4 South) |
| **Communication about Meds** | **60%** ↑ Below CMS | 66% | **70%** | **-Medicine guide** for chemotherapy and immunotherapy (3 South) |
| **Cleanliness of Environment** | **68%** ↑ Below CMS | 76% | 71% | -**Tent cards** to inform patients and increase EVS accessibility<br>-**Increased rounding** on units with low cleanliness scores |
| **Quietness of Environment** | **49%** Below CMS | 62% | 57% | -**Increased staff awareness**, engagement, and commitment (4 North) |
| **Discharge Information** *(Yes)* | **87%** ↑ Below CMS | 87% | **90%** | -**Discharge rounds** to identify and address discharge needs |
| **Care Transition** *(Strongly Agree)* | **47%** ↑ Below CMS | 54% | 48% | -**Discharge rounds** to identify and address discharge needs |
| **Overall Rating of Hospital (0 = worst; 10 = best)** | **71%** ***(9 or 10)*** Below CMS | 73% | **76%** | **OPERATION ALWAYS**<br>*Purpose: Consistently provide world-class service*<br>→**Leader Rounding** (Clinical and non-clinical)<br>→**Development of class for Kaweah Care Service Standards**<br>1) Warm Introductions & Caring Closures<br>2) With our colleagues<br>3) Over the phone |
| **Willingness to Recommend** ***(Definitely Recommend)*** | **70%** Below CMS | 72% | **75%** | *Same as above* |

Kaweah Delta HEALTH CARE DISTRICT

# EMERGENCY DEPARTMENT DASHBOARD

| GENERAL METRICS | Bench-mark | June 2020 KDHCD | July 2020 KDHCD | Aug 2020 KDHCD | Sept 2020 KDHCD | Oct 2020 KDHCD | Nov 2020 KDHCD |
|---|---|---|---|---|---|---|---|
| ED Volume | | 5964 | 6672 | 6097 | 5854 | 5950 | 6022 |
| % pts Left without being seen | 1.5% | 0.5% | 0.5% | 0.7% | 0.8% | 0.7% | 1.0% |
| % of Pts Admitted | | 27% | 25% | 27% | 27% | 27% | 27% |
| % of Pts Discharged | | 64% | 67% | 65% | 62% | 64% | 63% |
| **ED THROUGHPUT METRICS** | | | | | | | |
| Median Length of Stay (LOS) for Admitted Pts (hrs) | 407 (6.8) | 487 (8.1) | 513 (8.6) | 394 (6.6) | 347 (5.8) | 387 (6.5) | 525 (8.7) |
| Median LOS in Min for discharged Pts (hrs) | 186 (3.1) | 234 (3.9) | 214 (3.6) | 229 (3.8) | 244 (4.0) | 233 (3.9) | 236 (3.9) |
| Median LOS in Min for Admit decision to ED Depart | 197 (3.3) | 258 (4.3) | 280 (4.7) | 156 (2.6) | 119 (2.0) | 155 (2.6) | 289 (4.8) |
| Average LOS in minutes for Admitted Mental Health Pts | | 918 (15.3) | 993 (16.6) | 805 (13.4) | 994 (16.6) | 941 (15.7) | 823 (13.7) |
| **PATIENT EXPERIENCE** | | | | | | | |
| **ED Overall Care Percent 9s & 10s** | 62%* | 69.23% | 71.00% | 68.88% | 66.85% | 65.78% | Pending |
| Would Recommend Percent Definitely YES | 76%* | 76.39% | 77.66% | 73.37% | 75.98% | 72.13% | Pending |
| **CENSUS TOTALS BY DISPOSITION** | | | | | | | |
| Number of Patients Arriving by Ambulance | | 1782 | 1874 | 1921 | 1687 | 1885 | 1880 |
| Number of Trauma Patients | | 155 | 178 | 173 | 227 | 217 | 231 |
| Number of Patients Admitted | | 1589 | 1675 | 1627 | 1594 | 1609 | 1640 |
| Number of Patients Discharged | | 3829 | 4442 | 3939 | 3641 | 3790 | 3809 |
| Number of Mental Health Patients Admitted | | 120 | 92 | 110 | 126 | 104 | 107 |

**KEY**

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

* benchmark Press Ganey 50th Percentile

**Discern report used: 1_KDHD_ED_VISIT_LOG_EXPANDED_June-V2**

| GENERAL METRICS | DATA DEFINITION |
|---|---|
| ED Volume | Total volume of all patients who enter ED |
| % pts Left without being seen | Numerator: # of pts with d/c disposition as LWBS<br>Denominator: # of total patients who enter ED |
| % of Pts Admitted | Numerator: # of pts with d/c disposition as Admitted to this hospital as inpatient**<br>Denominator: # of total patients who enter ED |
| % of Pts Discharged | Numerator: # of pts with d/c disposition as Discharged home (routine), discharged home with HH, discharge Hospice (home), and discharged to assisted living/Board and care, Discharged to SNF<br>Denominator: # of total patients who enter ED |
| **ED THROUGHPUT METRICS** | **DATA DEFINITION** |
| Median Length of Stay (LOS) for Admitted Pts (hrs) | Median time of ED arrival to ED depart for pts with d/c disposition as Admitted to this hospital as inpatient** |
| Median LOS in Min for discharged Pts (hrs) | Median time of ED arrival to ED depart for pts with d/c disposition as Discharge home (routine)discharged home with HH, discharge Hospice (home), and discharged to assisted living/Board and care, discharged to SNF |
| Median LOS in Min for Admit decision to ED Depart | Median time of ED admit decision to ED depart for pts with d/c disposition as Admitted to this hospital as inpatient |
| Average LOS in minutes for Admitted Mental Health Pts | Mean time of ED arrival to ED depart for pts with d/c disposition as D/T to Psych Hosp or Unit who only admit to KDMHH* See note below |
| **PATIENT EXPERIENCE** | **DATA DEFINITION** |
| ***90TH PERCENTILE - ED Overall Care Percent 9s & 10s** | As defined by press ganey - data obtained through Roxanne Mendez in Q&P/S |
| Would Recommend Percent Definitely YES | As defined by press ganey - data obtained through Roxanne Mendez in Q&P/S |
| **CENSUS TOTALS BY DISPOSITION** | **DATA DEFINITION** |
| Number of Patients Arriving by Ambulance | # of patients who have "ambulance" or "ACLS Transport" documented in their arrival mode |
| Number of Trauma Patients | Total number of Trauma pts as noted at bottom of report received from Amber Woods/Kathy M |
| Number of Patients Admitted | # of pts with d/c disposition as Admitted to this hospital as inpatient** |
| Number of Patients Discharged | # of pts with d/c disposition as Discharge home (routine)discharged home with HH, discharge Hospice (home), and discharged to assisted living/Board and care |
| Number of Mental Health Patients Admitted | # pts with d/c disposition as D/T to Psych Hosp or Unit who only admit to KDMHH* See note below |

*NOTE - Soarian financials must discharge patients from ED to admit them to our KDMHH. Patients with a discharge disposition in our EMR as D/T to Psych Hosp or Unit have both KDMHH patients and patients who transfer to another non-KD psych facility. All medical records of these patients with this discharge disposition have to be reviewed to separate the KHMHH pt's from the non so that only KDMHH patients are included in the ALOS measure for admitted MH patients

** NOTE - At times staff document the wrong d/c disposition for 2-emergent 5150 acuity patients (see data cleaning instructions); the medical record of these pts has to be reviewed to ensure accurate d/c dispo to medical center (admitted pt) vs psych facility.

1. Column L has to be reformatted first to remove LOS text and reformat cells so that they calculate
2. filter for Admitted, discharged and discharge to psych (per data defintions) and place on their own tab

3. Admitted patients:
a) Filter column I (Acutity) for “2 – Emergent 5150 Risk”. Review EMR to verify that those patient were admitted to medical center vs psych facility. To find this review the ED Disposition note (hoping the nurse marked disposition location and report called information), and also look at PFS notes to see who they have been contact with and where there is confirmed disposition location. If patients are found that were admitted to KDMHH remove those patients and place in the "discharge to psych" tab. If pt's were tx to outside psych facility, remove from admitted population and place on their own tab (no data is calculated for non-KDMHH pt's). If they were admitted to medical center, leave in the admitted population tab
b) Filter column M "ADMIT_DEC_TO_DEPART" for blanks. Chart review to verify the pt was admitted. If they were admitted, find and enter the time admit decision to depart in minutes. If they were not admitted (discharged, etc) move to the appropriate population tab (ie. discharged pt's to dishcarge tab)

4. d/c to psych:
Review each chart to determine which patients were admitted to KDMHH vs another outside psych facility. Remove the non-KDMHH pt's and put on a separate tab (no data is calculated for non-KDMHH pt's)
5. Discharged Pts - review column M for ED discharge to ED dept times. If there is a value in here that likely means the patient was admitted. Review chart to verify pt was admiitted vs discharged

# Code Blue and Rapid Response System

January 2021

KAWEAH DELTA HEALTH CARE DISTRICT

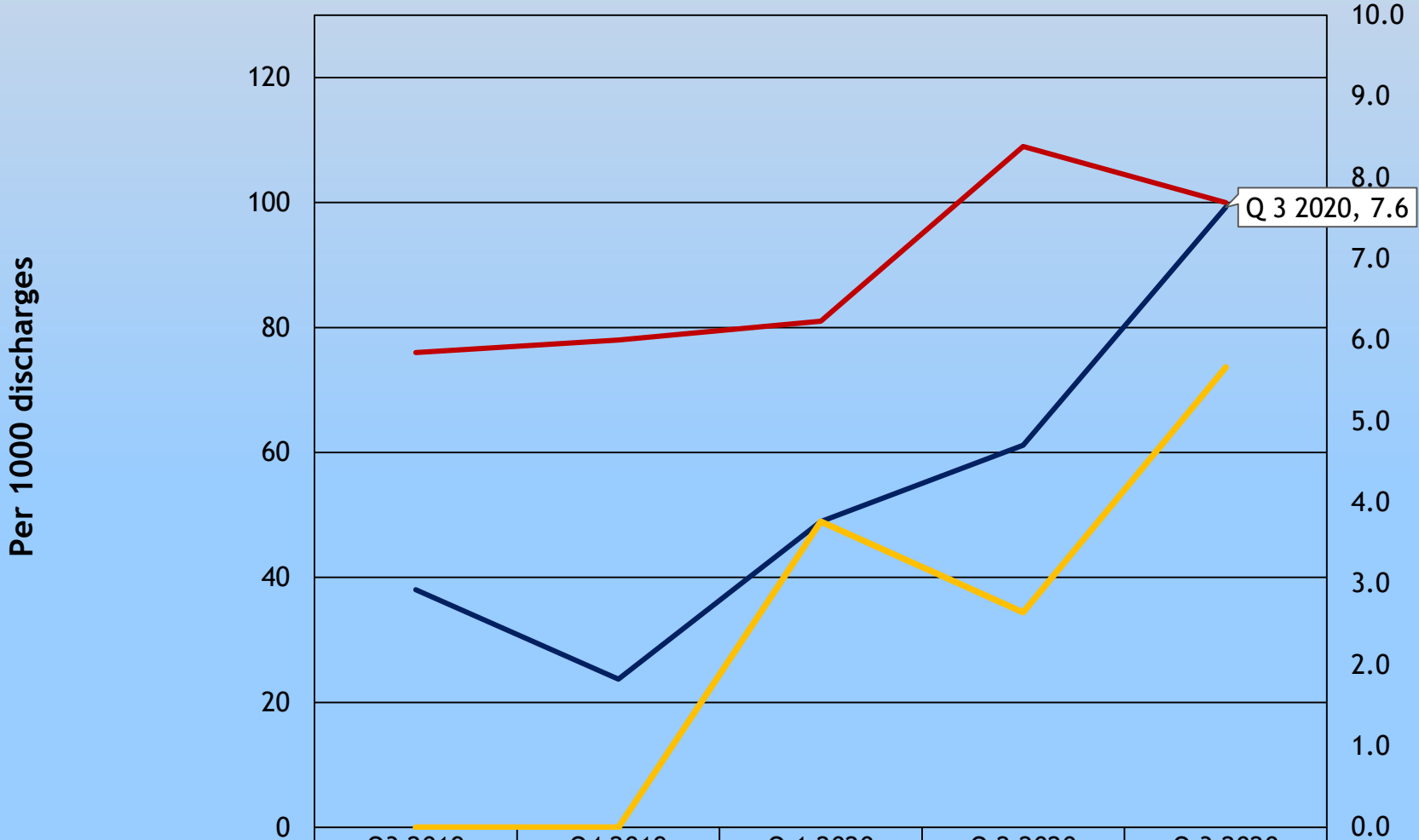
# Code Blue Data

# Inpatient Code Blues Data

| | Q1 2020 | Q2 2020 | Q3 2020 | YTD Total 2020 | Total 2019 |
|---|---|---|---|---|---|
| **No. of Cardiac Arrests** | 41 | 36 | 70 | 147 | 136 |
| **COVID-19 Positive Code Blues** | - | 8/36<br>22% | 26/70<br>37% | 32/147<br>22% | |
| **Deaths from Cardiac Arrests (Unsuccessful Codes)** | 7/41<br>17% | 7/36<br>19% | 30/70<br>43% | 43/147<br>29% | 47/136<br>35% |
| **COVID-19 Unsuccessful Codes** | - | 3/7<br>43% | 17/30<br>57% | 20/43<br>47% | |
| **In-hospital Deaths During Hospital Stay for Code Blue Patients** | 21/41<br>51% | 24/36<br>67% | 53/70<br>76% | 97/147<br>66% | 92/136<br>68% |
| **COVID-19 In-Hospital Deaths for Code Blues** | - | 8/24<br>33% | 24/53<br>45% | 32/97<br>33% | |
| **No. of days in ICU post arrest** | 302<br>n=25 | 85<br>n=20 | 231<br>n=29 | 618<br>n=74 | 315<br>n=54 |
| **No. of days in Hospital post arrest** | 531<br>n=25 | 196<br>n=20 | 429<br>n=29 | 1156<br>n=74 | 672<br>n=80 |
| **Overall Hospital Mortality Rate per 1000 patients** | 2.839 | 3.165 | 3.446 | 3.146 | 2.197 |

Data excludes ED, maternal, and pediatric patients.

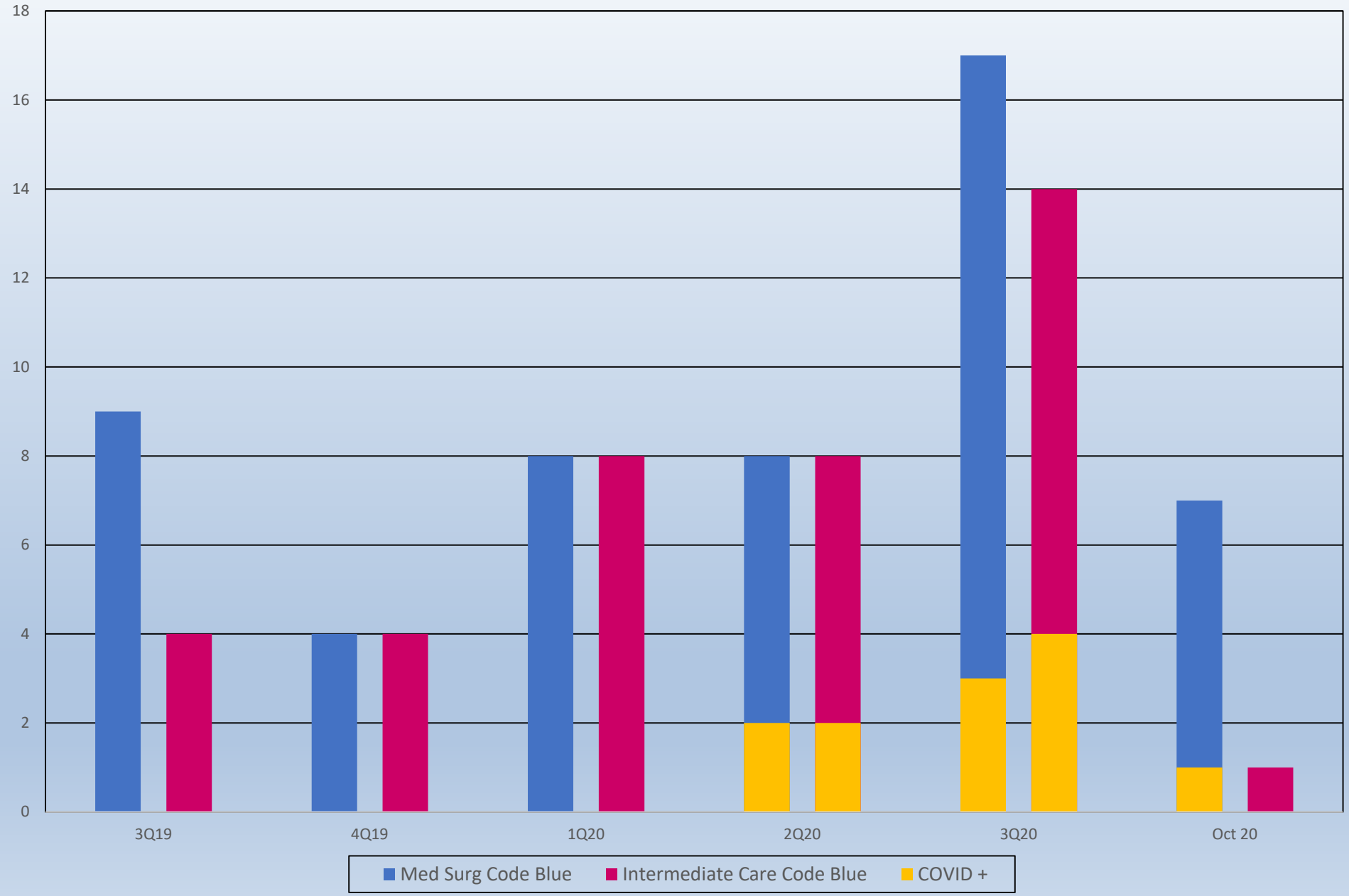
# Resuscitations (Code Blues) & Rapid Response Team Alerts (RRT's)



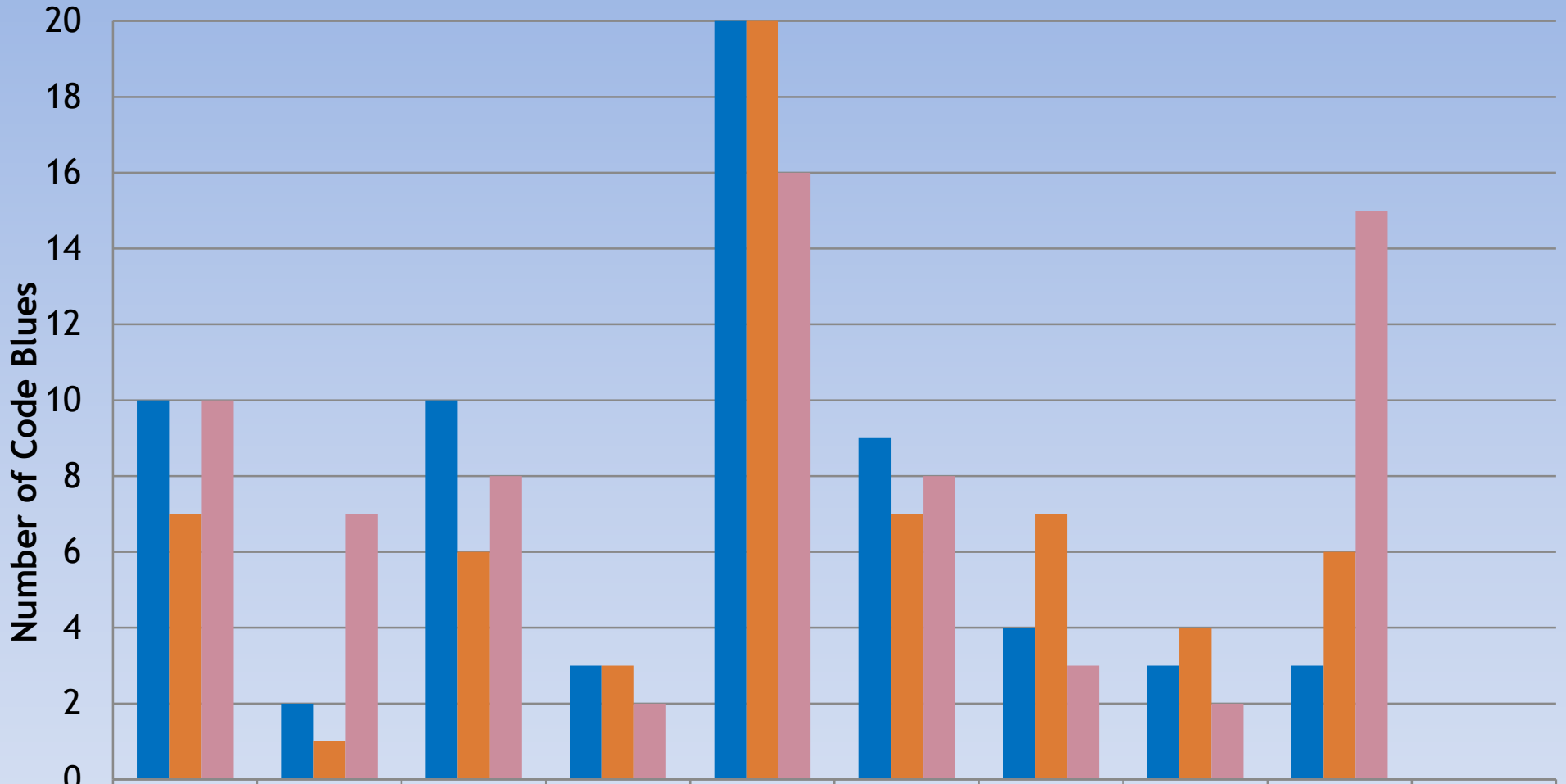

| | Q3 2019 | Q4 2019 | Q 1 2020 | Q 2 2020 | Q 3 2020 |
|---|---|---|---|---|---|
| RRT Rate per 1000 discharges | 76 | 78 | 81 | 109 | 100 |
| Code Blue Rate per 1000 discharges | 2.9 | 1.8 | 3.8 | 4.7 | 7.6 |
| Non-COVID Code Blue Patients | 0 | 0 | 3.8 | 2.6 | 5.7 |

*Increase in MS codes Q 3 2020 in July and August.

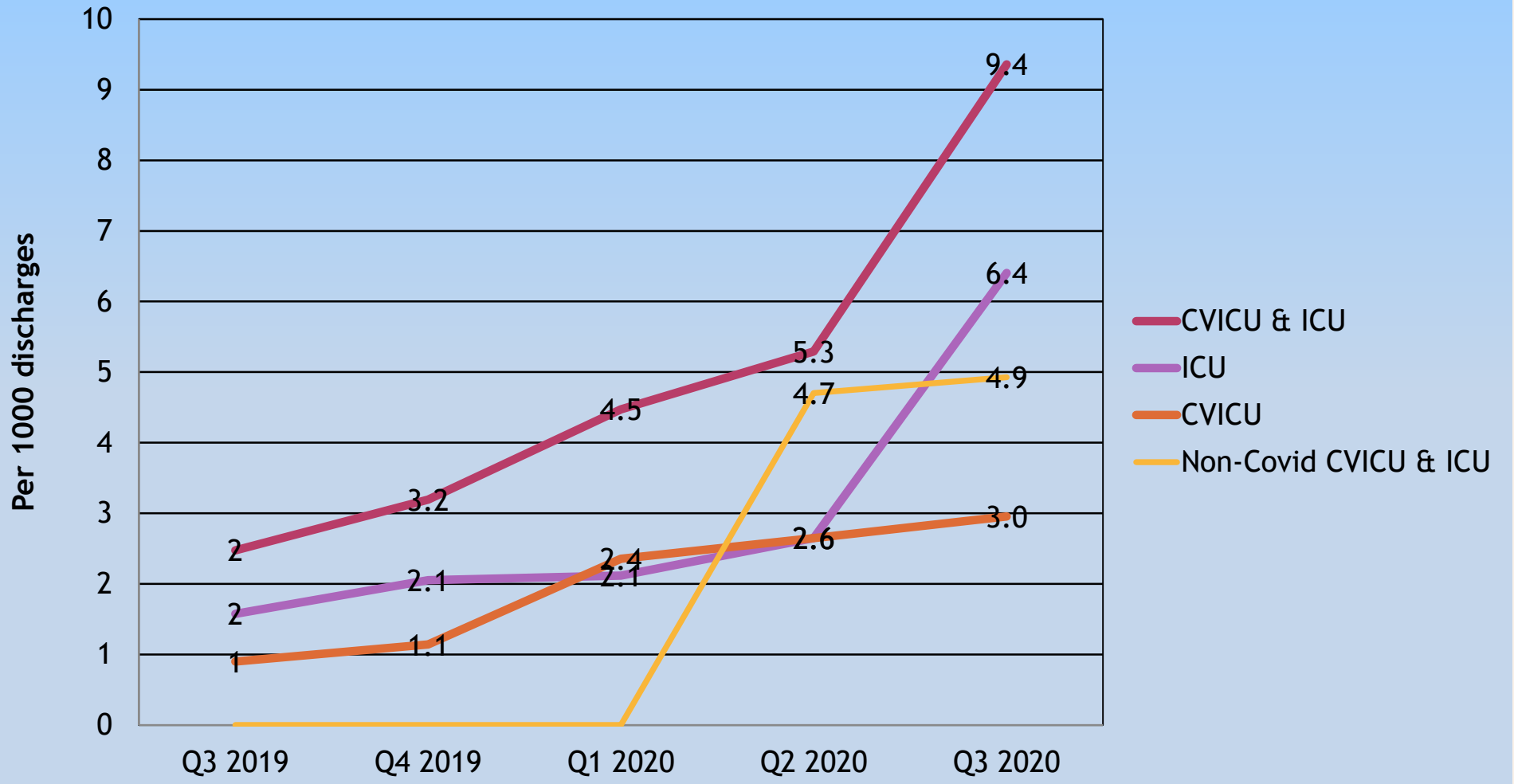
# Non Critical Care Code Blues



# Code Blue Locations Jan-Oct 2020



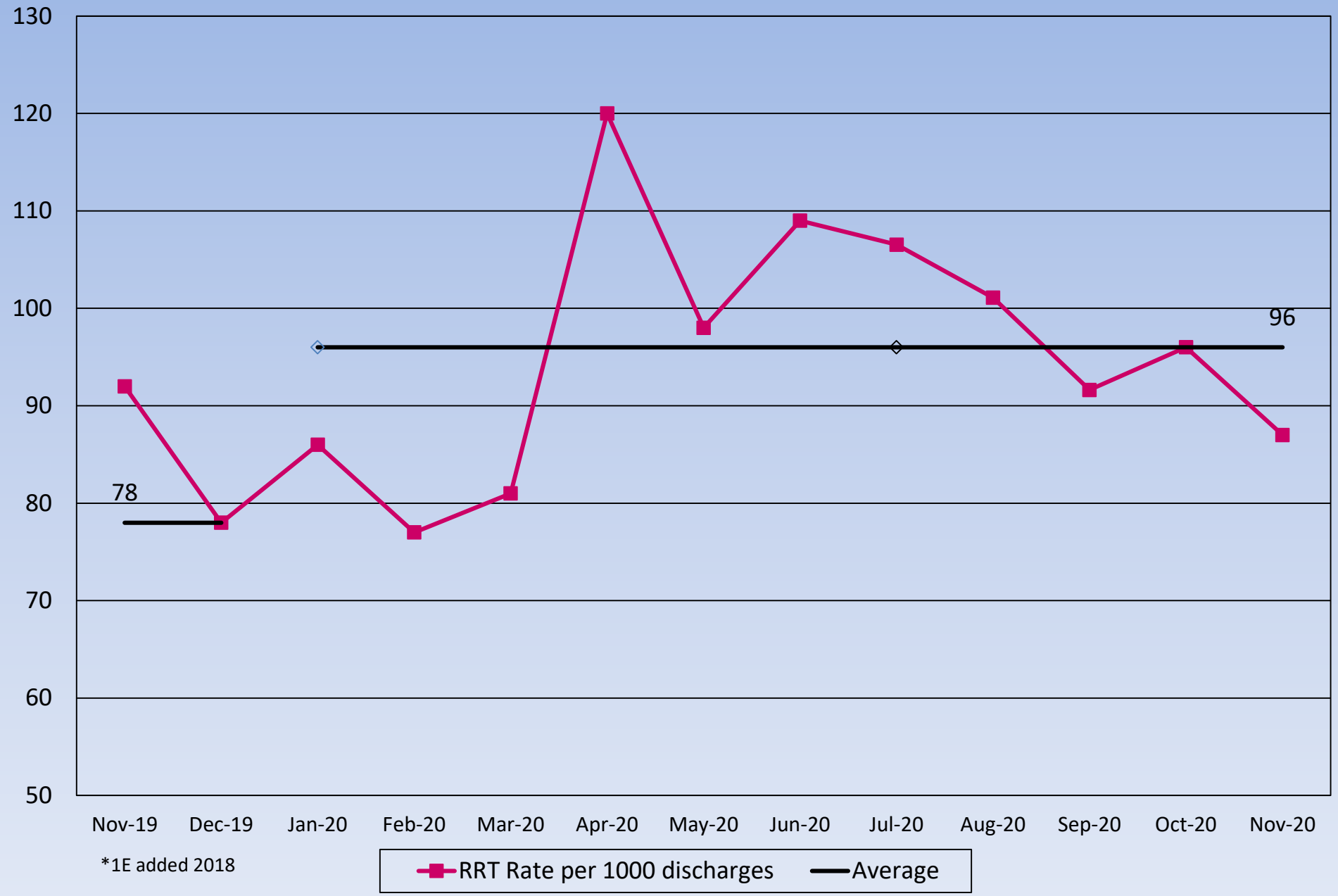

| | 2N | 2S | 3N | 3S | 3W | 4N | 4S | 4T | CVICCU/ 5T | BP |
|---|---|---|---|---|---|---|---|---|---|---|
| 2018 n=64 | 10 | 2 | 10 | 3 | 20 | 9 | 4 | 3 | 3 | 0 |
| 2019 n=61 | 7 | 1 | 6 | 3 | 20 | 7 | 7 | 4 | 6 | 0 |
| 2020 n=71 | 10 | 7 | 8 | 2 | 16 | 8 | 3 | 2 | 15 | 0 |




| Count of Critical Care Code Blues | | | | | |
|---|---|---|---|---|---|
| | Q 3 2019 | Q 4 2019 | Q 1 2020 | Q 2 2020 | Q 3 2020 |
| CVICU and ICU | 11 | 14 | 19 | 18 | 38 |
| Non-COVID CVICU and ICU | 0 | 0 | 0 | 16 | 20 |
| ICU | 4 | 9 | 9 | 9 | 26 |
| CVICU | 7 | 5 | 10 | 9 | 12 |

# Rapid Response System Data

# RRTs per 1000 Patient Discharge Days



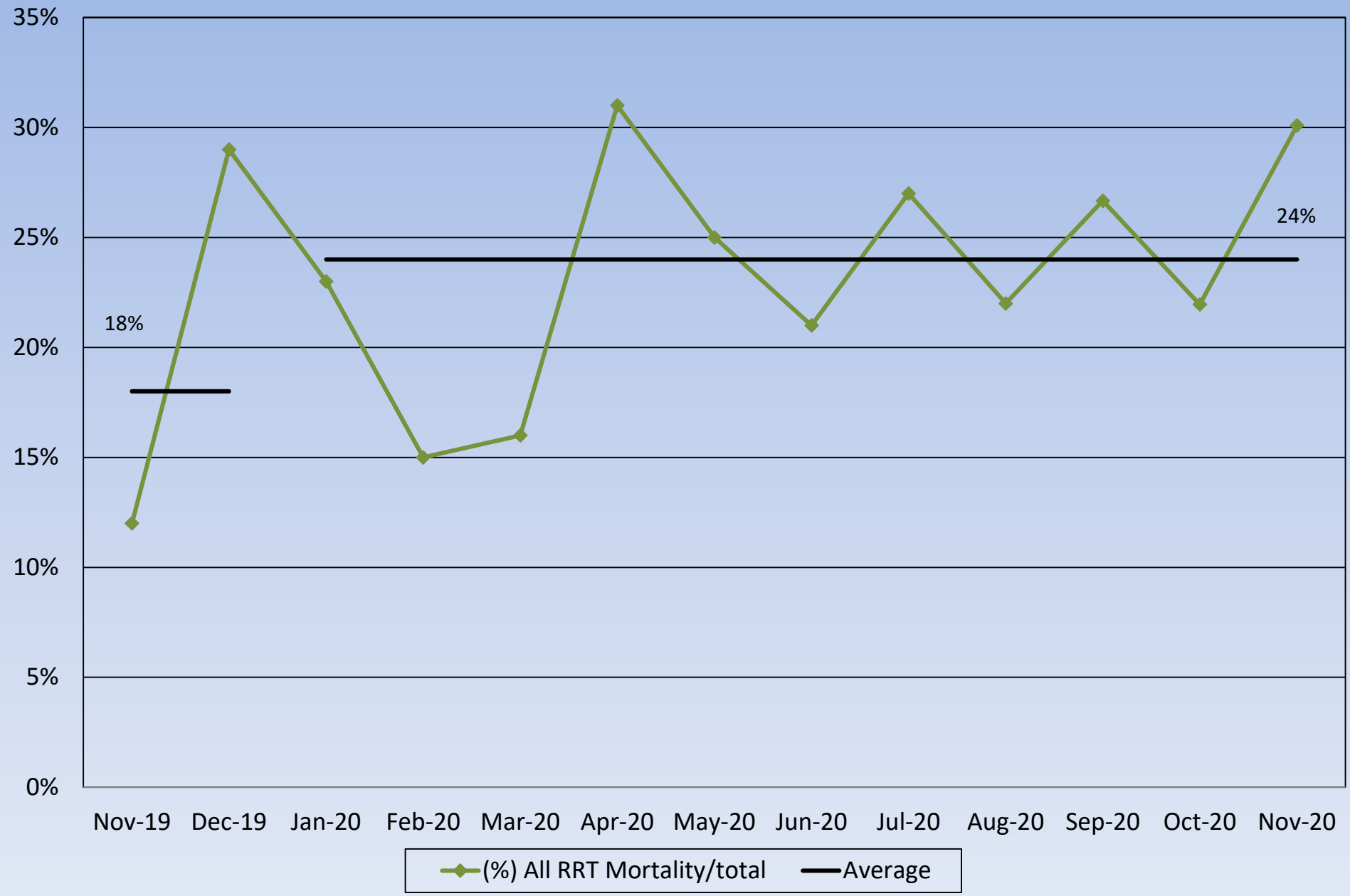

*1E added 2018

# RRT Locations 2020

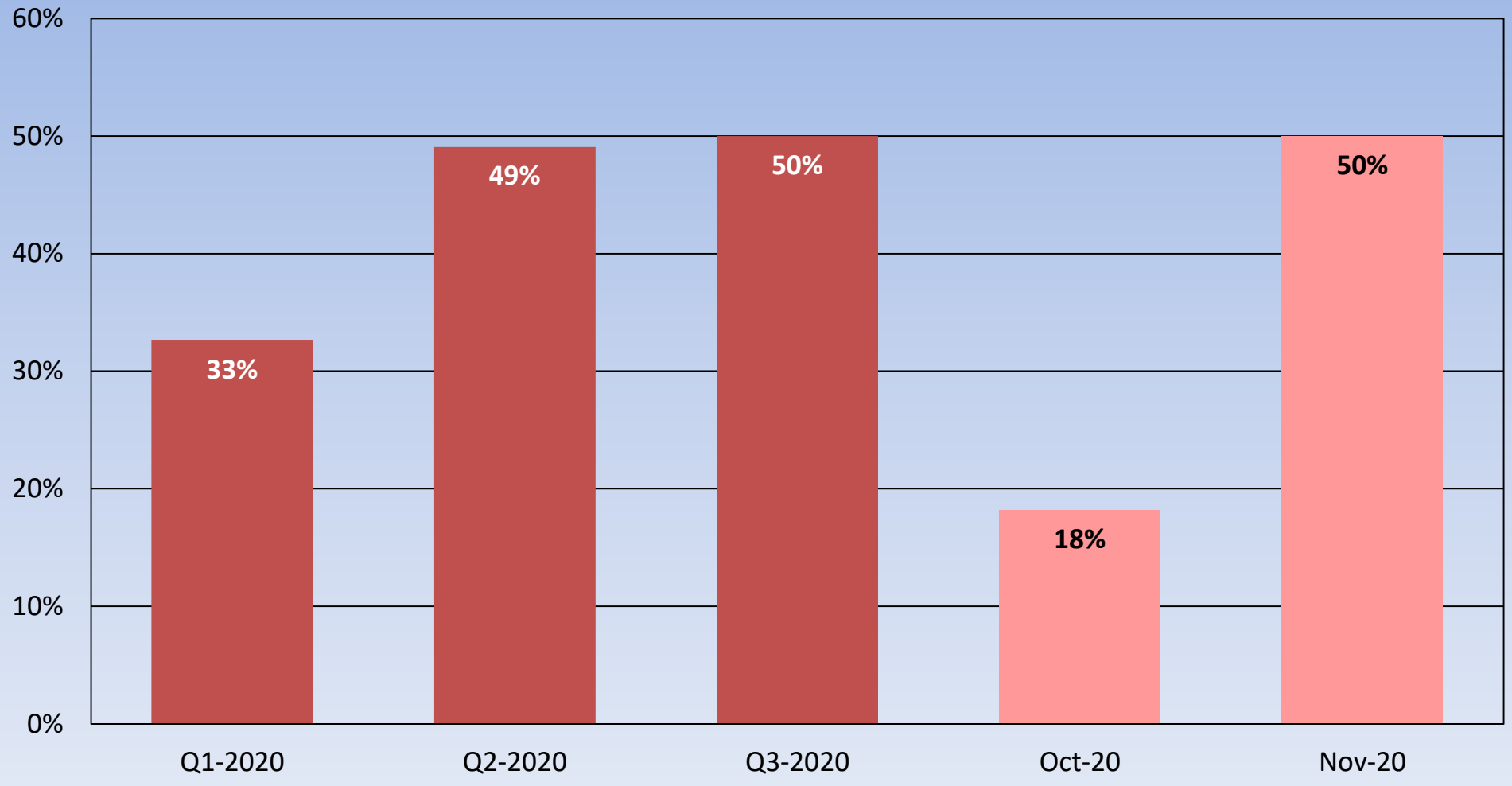
| Alert Location | Q 1 2020 | Q 2 2020 | Q 3 2020 | Oct 2020 | Nov 2020 | Totals |
|---|---|---|---|---|---|---|
| KDMC 3W | 72 | 60 | 68 | 15 | 12 | **227** |
| KDMC 4S | 46 | 51 | 46 | 14 | 15 | **172** |
| KDMC 5T | - | 24 | 60 | 25 | 23 | **132** |
| KDMC 3N | 34 | 38 | 36 | 17 | 7 | **132** |
| KDMC 3S | 36 | 35 | 34 | 15 | 9 | **129** |
| KDMC 4N | 30 | 44 | 38 | 11 | 6 | **129** |
| KDMC 2N | 39 | 28 | 36 | 9 | 14 | **126** |
| KDMC 2S | 30 | 41 | 36 | 6 | 13 | **126** |
| KDMC 14 | 21 | 18 | 27 | 7 | 6 | **79** |
| KDMC 1E | 16 | 10 | 9 | 2 | 4 | **41** |
| KDMC CV | 12 | 6 | 7 | 0 | 1 | **26** |
| KDMC IC | 7 | 10 | 2 | 0 | 3 | **22** |
| KDMC BP | 2 | 4 | 6 | 2 | 0 | **14** |
| KDMC Pediatric Adult | - | - | 3 | 0 | 0 | **3** |
| **RRT Tracked Total** | **273** | **369** | **408** | **123** | **113** | **1259** |
| Labor Triage/ Mother Baby | 5 | 5 | 6 | 0 | 4 | **20** |
| Surgery (Pre/Post op) | 3 | 4 | 1 | 2 | 1 | **11** |
| KDMC CVOR/Cath lab | 7 | 0 | 3 | 0 | 0 | **10** |
| KDMC Pediatric | 1 | 1 | 2 | 0 | 0 | **4** |
| KDMC 2E | 0 | 0 | 5 | 0 | 1 | **5** |
| KDMC ED | 2 | 0 | 1 | 0 | 0 | **3** |
| Endoscopy | 0 | 0 | 0 | 0 | 0 | **0** |
| KDMC CT/radiology | 0 | 0 | 0 | 0 | 0 | **0** |
| **RRT Not Tracked Total*** | **18** | **10** | **18** | **2** | **6** | **54** |

*Untracked RRTs have historically been excluded from the RRT total and RRT Graphs. They are shown here to identify trends in these locations.

# RRTs Mortality



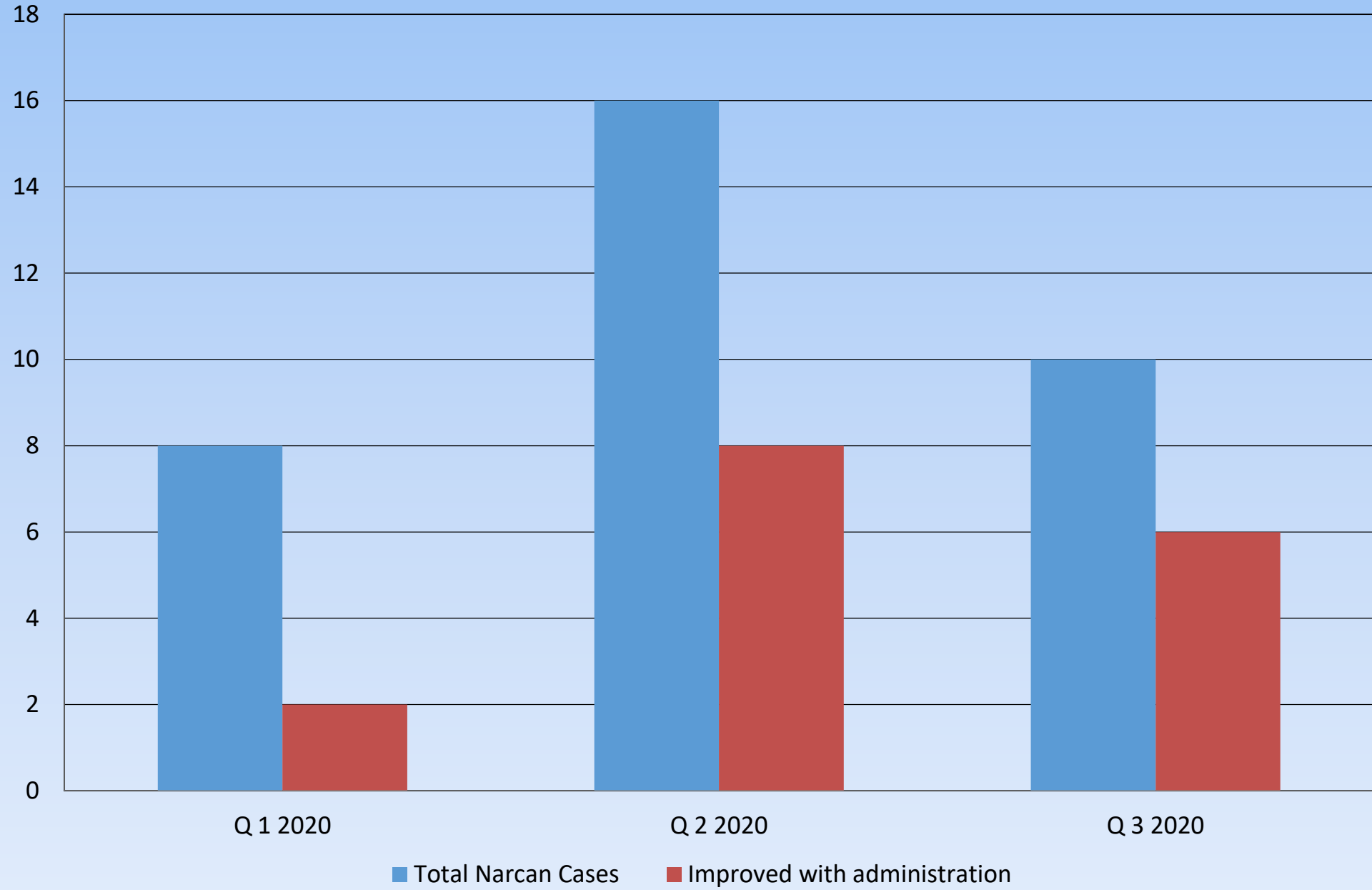
# Multiple RRT mortality




| | | | | | |
|---|---|---|---|---|---|
| Total Number Multiple RRTs | 46 | 53 | 64 | 22 | 18 |
| Multiple RRT Mortality | 15 | 26 | 32 | 4 | 9 |

| RRTs on 3w | Q 1 2020 | Q 2 2020 | Q 3 2020 | Oct 2020 | Nov 2020 |
|---|---|---|---|---|---|
| Total Number of RRTs on 3w | 72 | 58 | 68 | 15 | 12 |
| RRTs on 3w transferred to critical care | 16 | 15 | 28 | 3 | 7 |
| Multiple RRTs on 3w (last RRT in 3w) | 9 | 15 | 22 | 4 | 3 |
| Multiple RRTs Transferred to critical care | 1 | 6 | 8 | 0 | 2 |
| Multiple RRTs Stayed in room | 8 | 8 | 12 | 4 | 1 |
| Multiple RRTs Change in resuscitation status | 0 | 1 | 2 | 0 | 0 |

# Narcan Administation during RRTs



# Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

**Unit/Department: Rapid Response** **ProStaff/QIC Report Date: January 12th, 2021**

**Measures Analyzed:**

1. Inpatient Code Blues Data (Slide 3 & 5)
2. Code Blue Rates/1000 discharges (Slide 4)
3. RRT Rates/1000 discharges (Slide 9)
4. Code Blue Classifications of Med Surg and ICCU (Slide 5)
5. Code Blue and RRT by unit location (Slide 6 & 10)
6. Critical Care Code Blue Rates (Slide 7)
7. RRT Mortality (Slide 11&12)
8. RRTs on 3w (Slide 13)
9. Narcan Administration during RRTs (Slide 14)

**Date range of data evaluated:**

Code blue: Q319 to October 2020

**Analysis of all measures/data: (See Attachment)**

- In-patient Code Blues:
  - 2020 total code blues YTD not including ED, maternal units, and pediatrics have exceeded 2019 code blue totals.
  - 22% of patient with a Code blues in from Q1-Q3 2020 had a diagnosis of COVID-19.
  - Q 3 2020 had a 94% increase in code blues compared to Q2 2020.
  - 43% of codes were unsuccessful at achieving Return of Spontaneous Circulation (ROSC) for Q3 2020.
- Med Surg Code Blues: 2020 Q 3 code blues have resulted in an increased incidence of 7.6/1000 discharges; this is an increase from Q1 (2.6) and Q 2 (4.7) 2020.
  - 18% of patients in Q 3 2020 that had a Med Surg/ICCU codes are positive for COVID-19.
  - 2020 Q 3 Non-COVID patients code blues have resulted in an increased incidence of 5.7/100 discharges: this is an increase from Q2 (2.6) 2020.
- Med Surg: There has been a 94% increase in code blues in Med Surg Q 3 2020 compared to Q 1 and Q2 2020.
  - 23% of Med Surg Code Blues in Q 3 2020 occurred on 5T
  - 5T opened in 2020, increasing CVICCU capacity by 24 beds.
- ICU/CVICU Code Blues: 2020 Q 3 code blues have resulted in an increased incidence of 9.4/1000 discharges; this is an increase from Q1 (4.5) and Q 2 (5.3) 2020.
  - July was an outlier for Q 3 2020 with 18 codes in one month compared to Q 2 2020 that had 18 codes in one quarter.
  - 50% of patients with Q 3 2020 that had a Critical Care code are positive for COVID-19.
- RRTs per 1000 Patient Discharge Days: Total RRT cases for 2020 average 96/1000 discharges. There has been a decrease in RRTs in Q 3 2020 and Q 4 2020.

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

  - There has been a 150% increase in RRTs on 5T.
- RRT Mortality: Average RRT Mortality has increased 33% from the previous year.
  - Analysis of RRT initiation after time zero is in progress.
- Multiple RRT Mortality: November mortality for multiple RRTs cases is 50%.
  - The reason for this is under investigation.
- The committee was interested in monitoring RRT cases on 3W for 2020.
  - Although the number of RRTs has remained relatively constant, the % transferred to CC has doubled in Q3.
- The committee was interested in monitoring RRT cases with Narcan adminstration for 2020.
  - Trends not identified at this time.

**Next Steps/Recommendations/Outcomes:**

1. Dr. Tang has filled the medical director role in January 2020. Under his leadership the following quality improvement projects have been started.
   a. RRT nurses are attending quality improvement committees to increase RRT presence and participation in quality initiatives.
   b. Formalization of processes and role definition of each member of the RRT team. We are developing checklists to ensure consistency with practice.
   c. Formalization of RRT handoff after a rapid response and utilizing a physician communication handoff tool.
   d. ICU step-down and downgrade rounding protocols. This process includes checking for SIRS criteria, lab work, rounding on previous RRT patients, and following up with the nursing staff caring for the patient to ensure patients are continuing to improve clinically.
   e. Improve early identification. Educational opportunities for our bedside nurses and ensuring the information taught during the orientation process for newly hired nurses and care providers are accurate and that it relays the urgency of our cause.
   f. Formalization of family activated of RRT process.
2. The committee plans to compare our 2020 data to the following benchmark studies after implementation of our quality improvement projects.
   a. Reduction in number of cardiac arrest (in-hospital)
   b. Reduction in deaths from cardiac arrest
   c. Reduction in number of days in ICU post arrest
   d. Reduction in number of days in hospital after arrest
   e. Inpatient deaths
3. A time zero report for RRTs and Code blues is being created to identify missed RRT opportunities.
4. Education:
   a. The RRT nurses are working to educate staff during the event and to circle back with staff after the event to discuss quality of care.
   b. 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.
5. The committee continues to evaluate the cause for an increase in the number of code blues and RRTs for 2020.

**Submitted by Name:** **Date Submitted:**

***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

Dr. Tang 1/12/2021
Dr. Gray
Linde Swanson
Jeanette Callison
Jon Knudsen
Eileen Paul

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

# Stroke Quality Update January 2021

# Stroke Program Leadership

**Sean Oldroyd, DO**
Stroke Program Medical Director

**Cheryl Smit, RN**
Stroke Program Manager

# Abbreviations Used During this Presentation

TJC = The Joint Commission
AHA/ASA = American Heart Association; American Stroke Association
GWTG = Get with the Guidelines
EMS = Emergency Medical Services
ED = Emergency Department
ICU = Intensive Care Unit
TIA = Transient Ischemic Attack
Dc = Discharge
rt-PA or Alteplase = thrombolytic therapy “clot busting medication”
CT/CTA = Computed tomography scan/computed tomography angiography
LVO = Large vessel occlusion
CMS = Centers for Medicare and Medicaid Services
VTE = Venous thromboembolism
LDL = low-density lipoproteins
NIHSS = National Institutes of Health Stroke Scale

# Primary Stroke Certification through The Joint Commission (TJC)

- **TJC Recertification survey has been postponed due to COVID 19**
- 2 year certification cycle
- Initial accreditation March 9, 2018
  100% compliant with all Standards; No plans for improvement requested

# Stroke Program Initiatives 2019-2020

## ED Stroke Alert Process

- Process changes in 2020 as a result of AHA/ASA new guidelines for ischemic stroke patients (December 2019)
- ED triage stroke alert process modification to improve door to stroke alert timing
- RAPID software now available which will enhance imaging to evaluate patients who may be candidates for endovascular treatment. This requires a transfer to a tertiary care center
- Door to transfer goal is 120 minutes

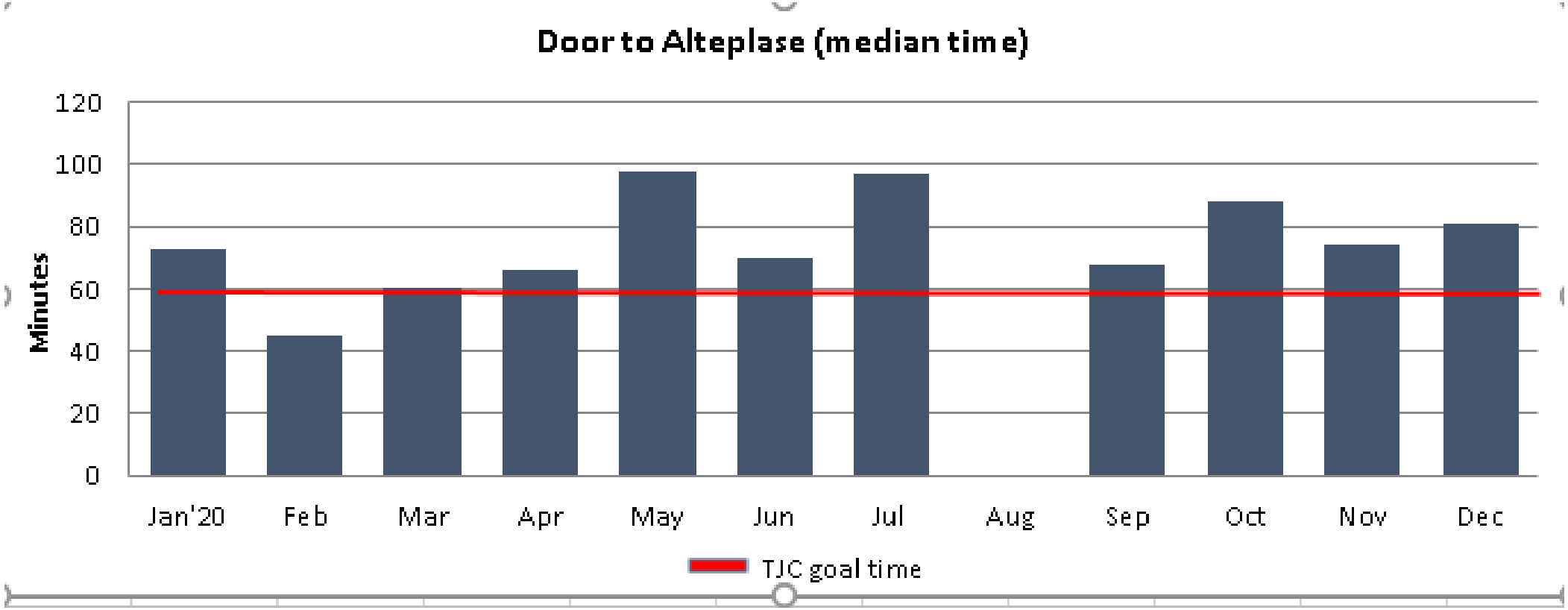
# Key Initiatives to Improve Time to Thrombolytic Therapy

TJC expectation is to administer thrombolytics (Alteplase) within 60 minutes 50% of the time for all patients who meet criteria. AHA/ASA GWTG expectations were update in 2019 with new goal of 45 minutes at least 75% of the time for all patients who meet criteria. KDH/ED goal is Door to Alteplase  within 45 minutes of arrival.

Initiatives:

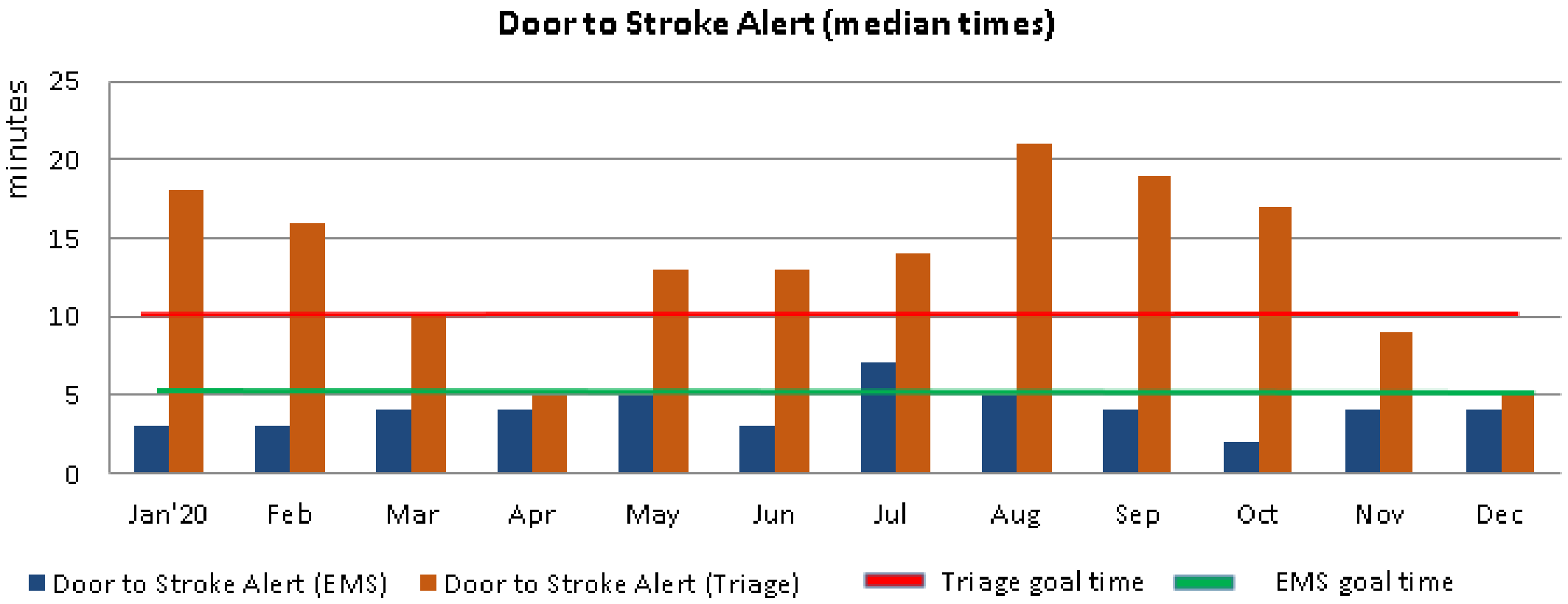
- Designated Stroke Team Lead in the ED
- Stroke Packet with documents needed for timely administration of thrombolytic therapy
- Patients go directly to CT from Triage or EMS after a brief physician evaluation
- Decreased images on CT/CTA scans
- Radiologist calls Stroke Team Lead when CT read and if a large vessel occlusion is found on CTA images
- Patient immediately evaluated by Resident/Physician upon return from CT
- 24/7 interpreter services available in the ED
- Staff, Physician, Resident and EMS education on stroke alert process
- Follow up communication with key stakeholders after thrombolytic therapy
- **RECENT ACTION ITEM**: Dotphrase was developed for the ED physicians with prompts to document reasons for delay in alteplase or why alteplase was not given if last known well (LKW) time was <4.5 hours
- **RECENT ACTION ITEM**: Stroke Team Lead (STL) Orientation packet developed and implemented

# 2020 ED Stroke Alert Dashboard



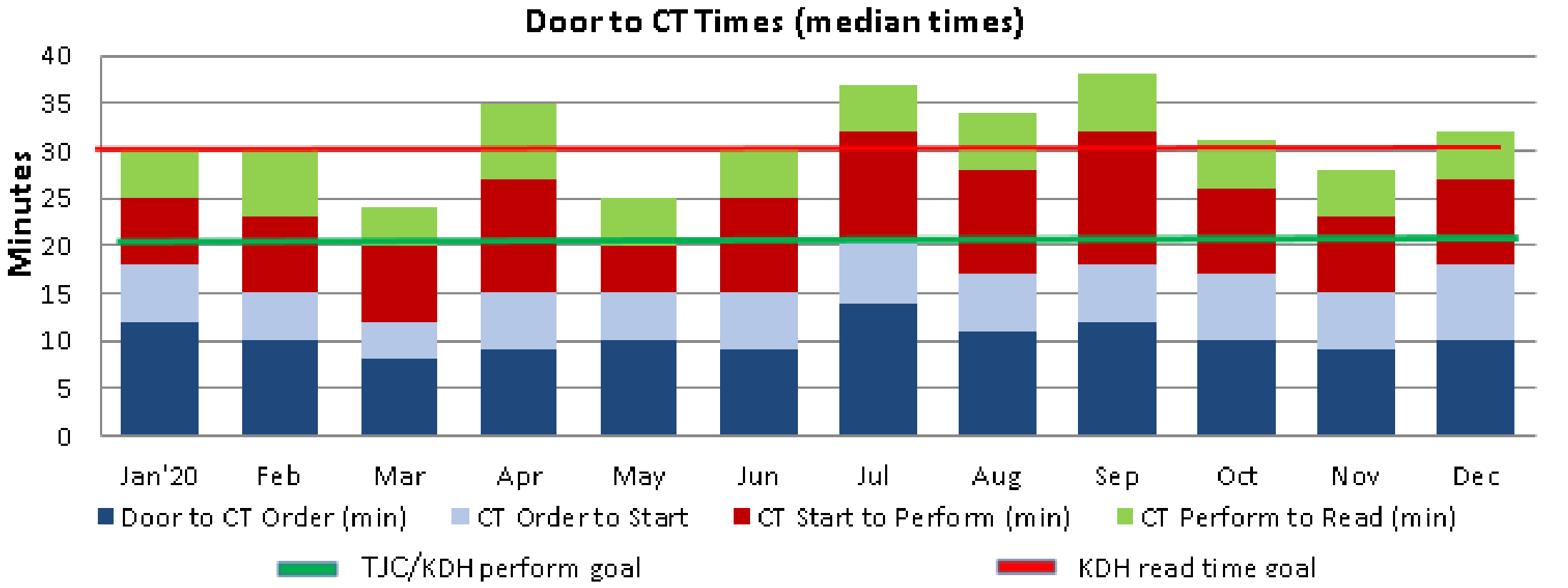

The data in this graph includes all Alteplase patients, no exclusion criteria. TJC expectation is that IV thrombolytics are given within 60 minutes to eligible patients who present for stroke care. AHA/ASA GWTG expectations were update in 2019 with new IV thrombolytic goal time to 45 minutes at least 75% of the time (when applicable). To meet this goal, changes to the stroke alert process <4 hours have been made.

# 2020 ED Stroke Alert Dashboard




Per KDH ED Stroke Alert process; stroke alerts to be called within 5 min for EMS and 10 min for Triage. ED Stroke Alert Triage task force convened to look for opportunities for improvement March 2020.

# 2020 ED Stroke Alert Dashboard




CMS and TJC expectation is that the CT will be performed by 20 minutes and read by 45 minutes of arrival. KDH's CT read time goal is 30 minutes. Starting 2019; tracking of CT start times will be included in this measurement. start time is define by the first CT images in Synapse.

# Stroke Program Initiatives 2019-2020

## ED Transfer Process on Ischemic/Hemorrhagic Stroke Patients

January 2019: TJC added new metrics on door to transfer times. Door to transfer goal <120 minutes.

- Hemorrhage
- IV Alteplase and Transfer “drip and ship”
- Large Vessel Occlusion and Endovascular Eligible
- Large Vessel Occlusion and Not Endovascular Eligible
- No Large Vessel Occlusion and Not Endovascular Eligible

Transfer Task Force has been established and includes all key stakeholders; Skylife, EMS, ED and Case Management

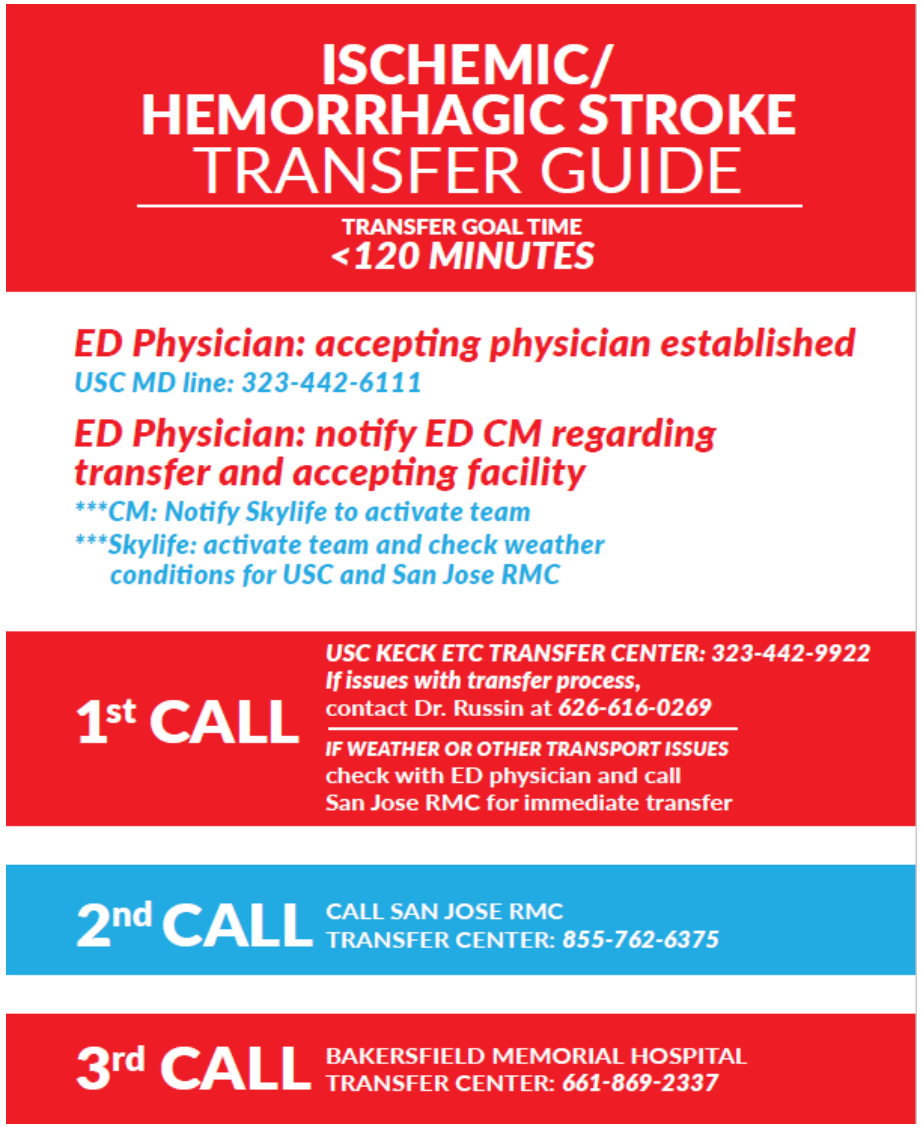
**RECENT ACTION ITEM:** Ischemic/hemorrhagic stroke transfer guidelines established

**RECENT ACTION ITEM:** Transfer agreements signed with San Jose RMC and USC/Keck

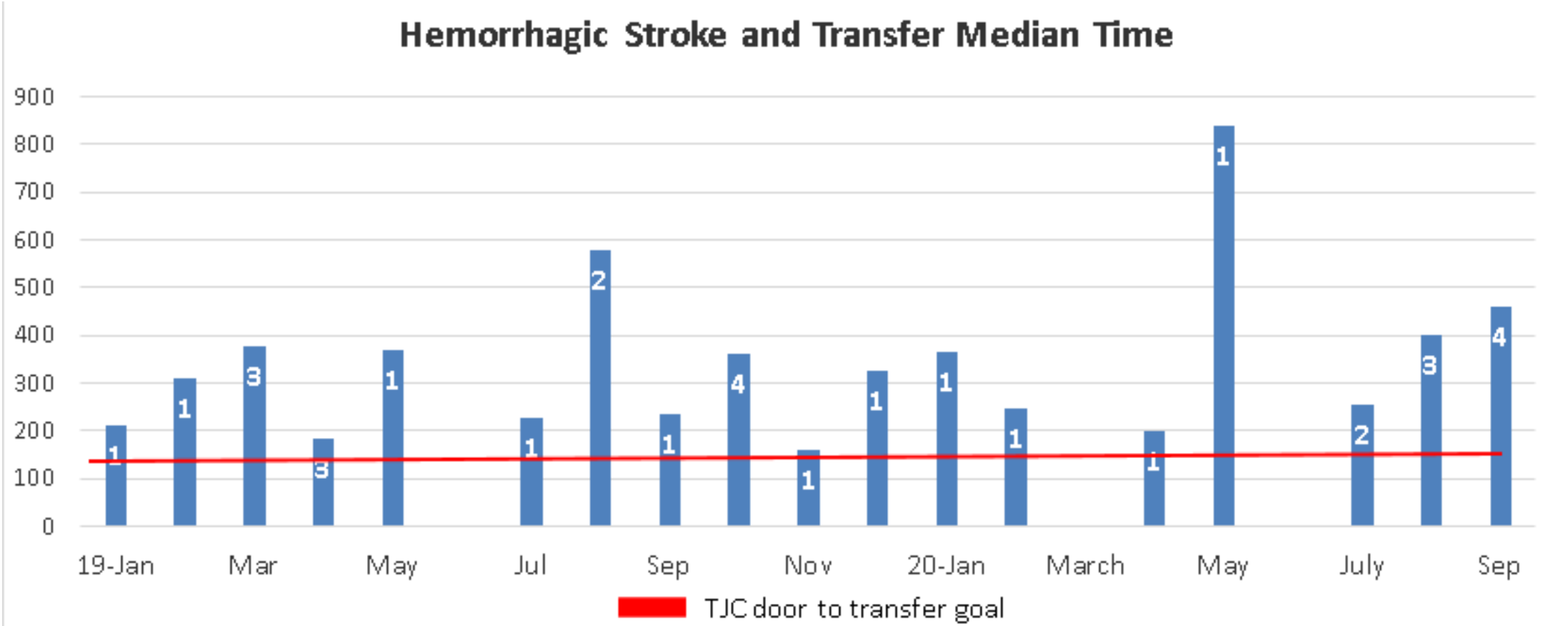
**RECENT ACTION ITEM:** Education to physicians and staff regarding transfer goal time of <120 minutes

**RECENT ACTION ITEM:** RAPID software now available which will enhance imaging to evaluate if patients are candidates for endovascular treatment.

# ED Transfer Process on Ischemic/Hemorrhagic Stroke Patients



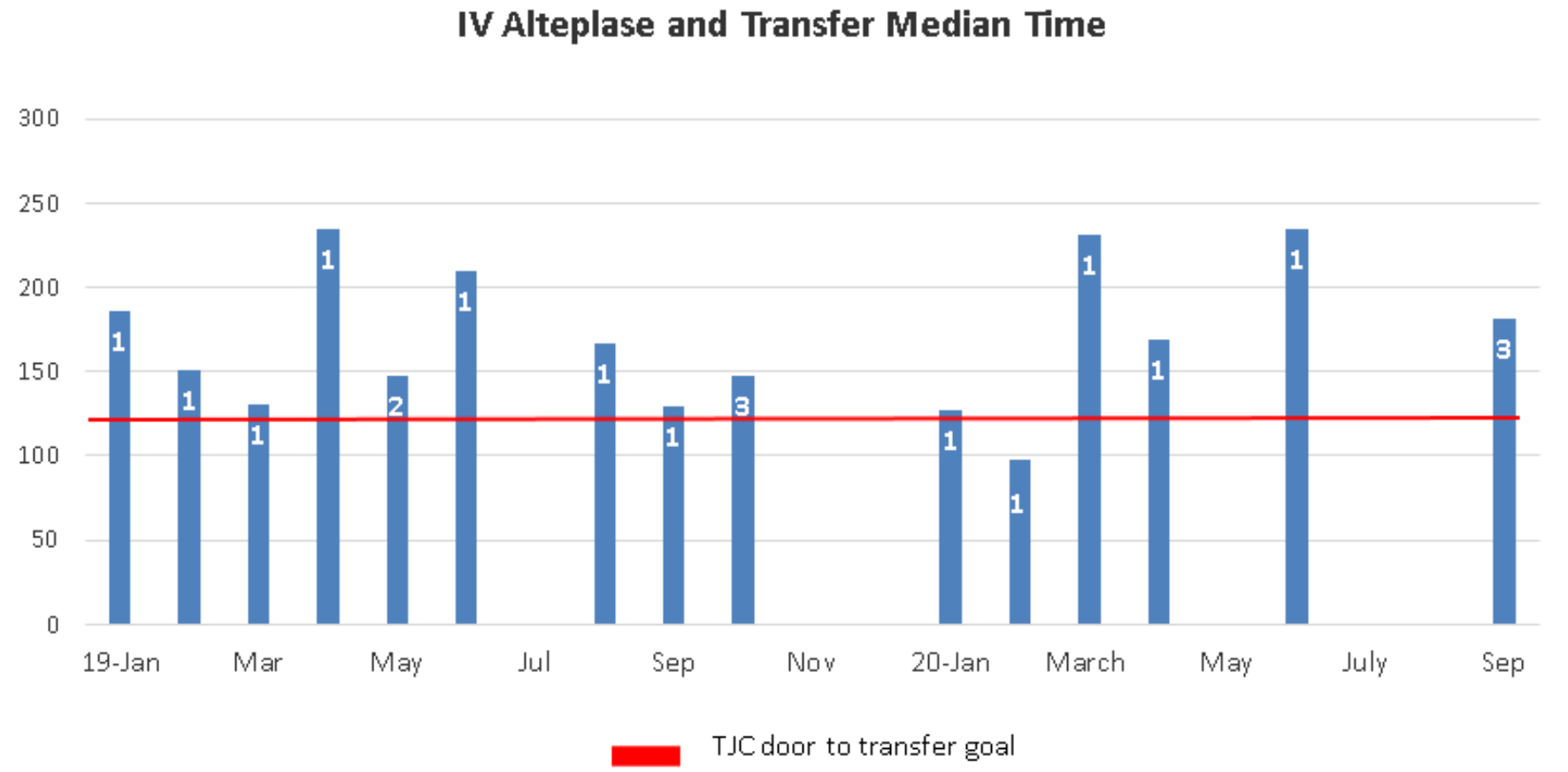
# ED Transfer Process on Ischemic/Hemorrhagic Stroke Patients
# 2019/2020 Transfer from ED to Another Acute Care Facility Dashboard




New TJC metric as of January 2019. TJC expectation is that if patients require transfer to a tertiary center that the door to transfer should be <120 minutes. Only a few hemorrhagic patients are transferred out for other procedures not done at KDH, specifically coiling/clipping of aneurysms or bleeds. A Transfer Task Force has been set up to help streamline the process, all action items are captured in PDSA document.

# ED Transfer Process on Ischemic/Hemorrhagic Stroke Patients

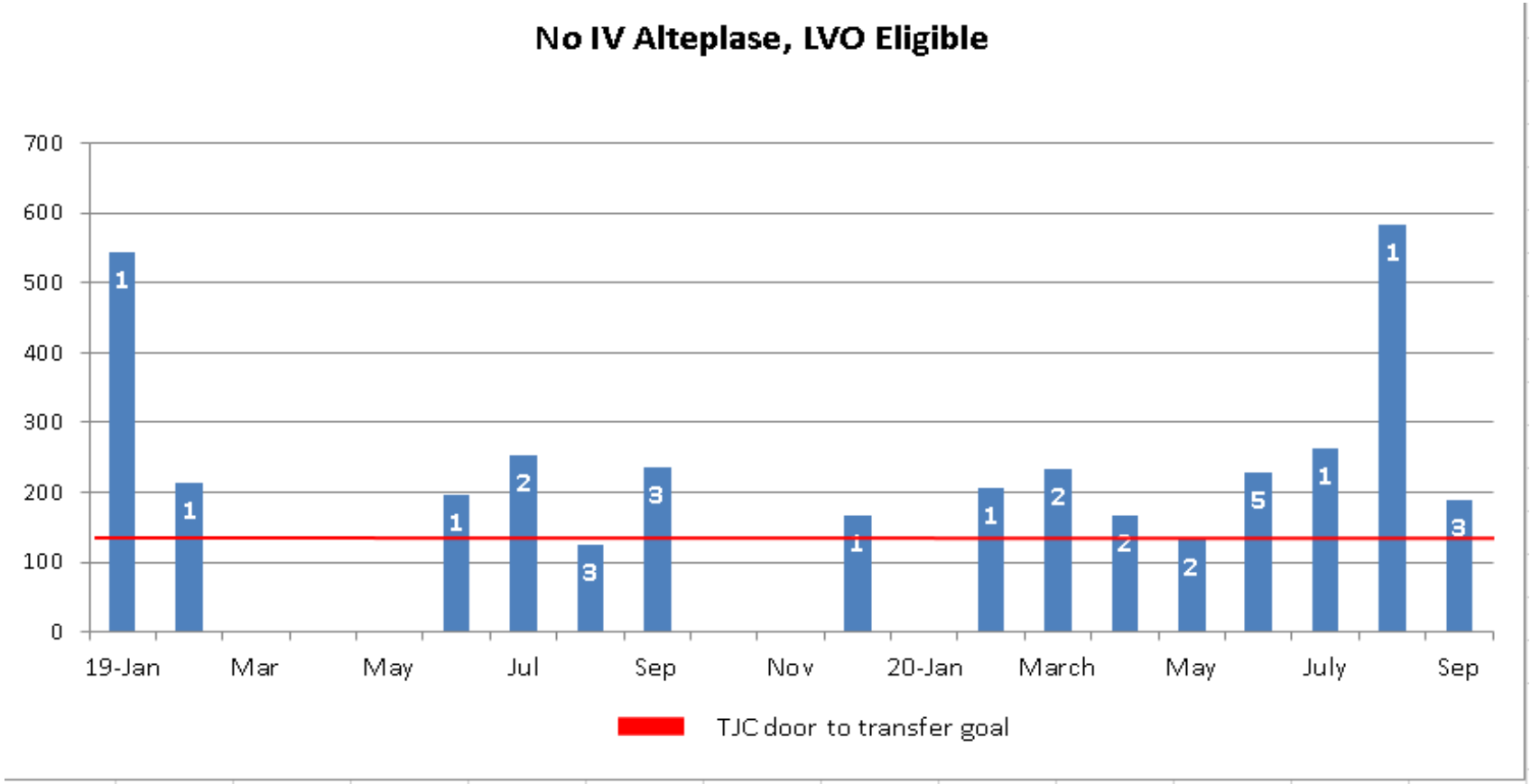
## 2019/2020 Transfer from ED to Another Acute Care Facility Dashboard




New TJC metric as of January 2019. TJC expectation is that if patients require transfer to a tertiary center that the door to transfer should be <120 minutes. These are considered our "drip and ship" cases. Transfers for ischemic strokes occur primarily if a large vessel occlusion is noted on CTA that would be eligible for endovascular treatment. As a result of the effects made by the ED Stroke Alert Committee and the Transfer Process Task Force door to transfer times have improved over the last several months.

# ED Transfer Process on Ischemic/Hemorrhagic Stroke Patients

## 2019/2020 Transfer from ED to Another Acute Care Facility Dashboard




New TJC metric as of January 2019. TJC expectation is that patients requiring transfer to a tertiary care center that the door to transfer should be less than 120 minutes. This cohort of patients have a large vessel occlusion that would be eligible for endovascular treatment and do not meet criteria for Alteplase administration. A Transfer Task Force has been set up to help streamline the process.

# 2019-2020 Stroke Program Dashboard

| | Bench-marks | 2019 Jan | Feb | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov | Dec | 2020 Jan | Feb | March | April | May | June | July | Aug | Sept |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Grouping of Stroke Patients | | | | | | | | | | | | | | | | | | | | | | |
| Ischemic | | 30 | 42 | 39 | 43 | 36 | 41 | 31 | 33 | 32 | 50 | 40 | 43 | 39 | 42 | 38 | 23 | 28 | 32 | 31 | 29 | 34 |
| Hemorrhagic | | 4 | 10 | 10 | 9 | 7 | 8 | 2 | 13 | 8 | 10 | 11 | 6 | 8 | 6 | 5 | 7 | 6 | 4 | 4 | 8 | 7 |
| TIA (in-patient and observation) | | 20 | 28 | 35 | 25 | 24 | 22 | 36 | 36 | 19 | 29 | 42 | 28 | 33 | 44 | 29 | 24 | 21 | 13 | 27 | 20 | 16 |
| Transfers to Higher Level of Care (Ischemic) | | 2 | 2 | 3 | 3 | 2 | 1 | 2 | 4 | 4 | 3 | 0 | 1 | 1 | 2 | 3 | 3 | 2 | 6 | 1 | 3 | 4 |
| Transfers to Higher Level of Care (Hemorrhagic) | | 1 | 1 | 2 | 1 | 1 | 1 | 1 | 2 | 1 | 4 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 2 | 1 | 6 |
| TOTAL NUMBER OF PATIENTS | | 57 | 83 | 89 | 81 | 70 | 73 | 72 | 88 | 64 | 96 | 94 | 79 | 82 | 95 | 72 | 58 | 58 | 55 | 65 | 61 | 67 |
| Total # of Pts who rec'd Alteplase (Admitted/Transferred) | | 5 | 6 | 6 | 6 | 7 | 9 | 2 | 5 | 2 | 6 | 6 | 5 | 8 | 6 | 4 | 2 | 2 | 4 | 4 | 0 | 4 |
| % of Alteplase - Inpatient & Transfers | | 16% | 14% | 14% | 13% | 18% | 21% | 6% | 14% | 6% | 11% | 15% | 11% | 20% | 14% | 10% | 8% | 7% | 11% | 13% | 0% | 11% |
| % Appropriate vital sign monitoring post Alteplase | 90% | 50% | 50% | 57% | 66% | 71% | 67% | 75% | 100% | 50% | 80% | 83% | 67% | 75% | 75% | 100% | 100% | 100% | 75% | 75% | NA | 75% |
| Rate of hemorrhagic complications for Alteplase pts | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | NA | 0% |
| Core Measure: OP-23 Head CT/MRI Results | 72% | NA | 50% | 100% | 100% | 33% | 66% | 0% | 0% | 75% | 75% | 100% | 50% | 100% | NA | 0% | 100% | NA | 100% | 0% | 50% | 100% |
| % Appropriate stroke order set used (In-Patient) | 90% | 90% | 97% | 97% | 94% | 93% | 90% | 95% | 96% | 99% | 95% | 87% | 84% | 95% | 97% | 99% | 97% | 96% | 92% | 90% | NA | NA |
| % Appropriate stroke order set used (ED) | 90% | 85% | 92% | 90% | 92% | 94% | 93% | 93% | 94% | 88% | 88% | 84% | 87% | 94% | 92% | 88% | 89% | 98% | 90% | 82% | NA | NA |
| STK-1 VTE (GWTG, TJC) | 85% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 97% | 93% | 95% | 98% | 100% | 100% | 95% | 100% | 91% | 85% | 89% | 92% | 95% |
| STK-2 Discharged on Antithrombotic (GWTG, TJC) | 85% | 100% | 97% | 100% | 98% | 98% | 94% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 97% | 94% |
| STK-3 Anticoag for afib/aflutter ordered at Dc (GWTG, TJC) | 85% | 80% | 89% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 90% | 89% | 100% | 89% | 100% | 100% | 100% | 75% | 80% | 100% | 100% |
| STK-4 Alteplase Given within 60 min (GWTG, TJC) | 75% | 100% | 25% | 25% | 100% | 100% | 100% | NA | 50% | 100% | 100% | 100% | NA | 100% | 100% | 100% | NA | NA | 100% | 100% | NA | NA |
| STK-5 Early Antithrombotics by end of day 2 (GWTG, TJC) | 85% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 97% | 100% | 100% | 96% | 92% | 93% | 97% | 100% | 96% | 92% | 100% | 96% | 100% |
| STK-6 Discharged on Statin (GWTG, TJC) | 85% | 100% | 100% | 100% | 100% | 98% | 96% | 92% | 94% | 94% | 98% | 100% | 100% | 100% | 98% | 100% | 100% | 97% | 100% | 96% | 100% | 100% |
| STK-8 Stroke Education (GWTG, TJC) | 75% | 88% | 91% | 84% | 89% | 93% | 92% | 100% | 92% | 96% | 100% | 100% | 100% | 93% | 97% | 94% | 100% | 96% | 88% | 96% | 100% | 100% |
| STK-10 Assessed for Rehab (GWTG, TJC) | 75% | 97% | 100% | 100% | 100% | 97% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 97% | 100% | 100% | 100% | 100% |
| % Dysphagia Screen prior to po intake (GWTG) | 75% | 100% | 93% | 94% | 88% | 88% | 98% | 94% | 92% | 92% | 96% | 96% | 96% | 85% | 85% | 91% | 90% | 77% | 81% | 93% | 94% | 90% |
| % Smoking Cessation (GWTG) | 85% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 88% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| % LDL Documented (GWTG) | 75% | 92% | 88% | 100% | 96% | 94% | 96% | 98% | 88% | 97% | 93% | 98% | 92% | 91% | 84% | 96% | 100% | 90% | 90% | 94% | 100% | 97% |
| Intensive Statin Therapy (GWTG) | 75% | 91% | 82% | 90% | 89% | 91% | 80% | 90% | 88% | 91% | 96% | 93% | 94% | 94% | 91% | 88% | 88% | 97% | 94% | 94% | 79% | 93% |
| % tPA Arrive by 2 Hrs; Treat by 3 Hrs. (GWTG) | 85% | 100% | 100% | 83% | 100% | 100% | 100% | 100% | 100% | 100% | 67% | 100% | 100% | 100% | 80% | NA | 100% | 100% | 100% | 67% | NA | 100% |
| % tPA Arrive by 3.5 Hrs; Treat by 4.5 Hrs (GWTG) | 75% | 100% | 80% | 86% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 86% | 100% | 100% | 100% | 100% | 100% | NA | 100% |
| % NIHSS Reported (GWTG) | 75% | 97% | 98% | 97% | 100% | 97% | 100% | 100% | 95% | 97% | 96% | 97% | 98% | 100% | 93% | 92% | 100% | 96% | 94% | 96% | 96% | 90% |
| Ischemic ALOS/GMLOS excess | <1.0 | 1.54 | 3.15 | 1.55 | 1.38 | 3.03 | 1.43 | 1.91 | 1.28 | 0.14 | 2.04 | 1.05 | 2.01 | 1.45 | 1.67 | 2.2 | 0.18 | 0.49 | 1.68 | 0.91 | 0.18 | 1.23 |
| Hemorrhagic ALOS/GMLOS excess | <1.0 | 1.33 | 5.73 | 1.08 | 8.23 | 0.34 | -0.32 | -1.3 | 3.97 | 0.69 | 8.11 | 3.77 | -0.81 | 1.63 | 0.43 | 3.74 | 0.49 | 3.53 | 17.98 | 1.42 | 6.11 | 5.01 |
| Ischemic Mortality O/E Ratio (Midas) | <1.0 | 0 | 1.08 | 0.64 | 0 | 3.73 | 1.96 | 3 | 0.83 | 0.84 | 1.01 | 1.74 | 0.74 | 0.88 | 0.61 | 0 | 0 | 0.74 | 0 | 0.8 | 0.74 | |

# Vital Sign and Neuro check monitoring after Alteplase

| | | 2019 | | | | | | | | | | | | 2020 | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Bench-marks | Jan | Feb | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | March | April | May | June | July | Aug | Sept |
| Grouping of Stroke Patients | | | | | | | | | | | | | | | | | | | | | | |
| Ischemic | | 30 | 42 | 39 | 43 | 36 | 41 | 31 | 33 | 32 | 50 | 40 | 43 | 39 | 42 | 38 | 23 | 28 | 32 | 31 | 29 | 34 |
| Hemorrhagic | | 4 | 10 | 10 | 9 | 7 | 8 | 2 | 13 | 8 | 10 | 11 | 6 | 8 | 6 | 5 | 7 | 6 | 4 | 4 | 8 | 7 |
| TIA (in-patient and observation) | | 20 | 28 | 35 | 25 | 24 | 22 | 36 | 36 | 19 | 29 | 42 | 28 | 33 | 44 | 29 | 24 | 21 | 13 | 27 | 20 | 16 |
| Transfers to Higher Level of Care (Ischemic) | | 2 | 2 | 3 | 3 | 2 | 1 | 2 | 4 | 4 | 3 | 0 | 1 | 1 | 2 | 3 | 3 | 2 | 6 | 1 | 3 | 4 |
| Transfers to Higher Level of Care (Hemorrhagic) | | 1 | 1 | 2 | 1 | 1 | 1 | 1 | 2 | 1 | 4 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 2 | 1 | 6 |
| **TOTAL NUMBER OF PATIENTS** | | 57 | 83 | 89 | 81 | 70 | 73 | 72 | 88 | 64 | 96 | 94 | 79 | 82 | 95 | 72 | 58 | 58 | 55 | 65 | 61 | 67 |
| Total # of Pts who rec'd Alteplase (Admitted/Transferred) | | 5 | 6 | 6 | 6 | 7 | 9 | 2 | 5 | 2 | 6 | 6 | 5 | 8 | 6 | 4 | 2 | 2 | 4 | 4 | 0 | 4 |
| % of Alteplase - Inpatient & Transfers | | 16% | 14% | 14% | 13% | 18% | 21% | 6% | 14% | 6% | 11% | 15% | 11% | 20% | 14% | 10% | 8% | 7% | 11% | 13% | 0% | 11% |
| % Appropriate vital sign monitoring post Alteplase | 90% | 50% | 50% | 57% | 66% | 71% | 67% | 75% | 100% | 50% | 80% | 83% | 67% | 75% | 75% | 100% | 100% | 100% | 75% | 75% | NA | 75% |

Vital signs and neuro checks are to be completed after the initiation of Alteplase: q 15 minutes x2 hours, q30 minutes x6 hours, then q 1 hour x16 hours. The expectation is that we are 90% compliant with this metric. Working closely with ED and ICU leadership the last several months on various actions needed for improvement in this area. A task force had met in March 2020 to address the issues, as noted in the chart above we have been 100% compliant since the action items were implemented.

Action plans:

- Bedside handoff communication between the ED and ICU RN
- Key staff member education with staff member involved in missing elements
- **RECENT ACTION ITEM:** Current annual computer based learning (CBL) competencies for ICU, CVICU and ED will be updated to include post alteplase monitoring, flowsheet review and the importance of compliance
- **RECENT ACTION ITEM:** Provide education to ICU, CVICU and ED staff on face-to-face hand-off and review of the post alteplase form

# Stroke Program
# Performance Improvement Initiatives
# Fiscal Year 2021

Door to Alteplase <60 minutes.

Continue this metric since it is a TJC and GWTG measure.  KDH goal is now <45 minutes.

Nutritional Support s/p Failed Swallow Evaluation

Continue this measure; we want to ensure that timely nutritional support continues and monitoring for compliance is needed.

Follow-Up Calls/Perception of Care

Continue TJC requirement that we monitor perception of care.

Dysphagia screening process

Continue to monitor/track.

TIA work-up/admission

**New measure.** The goal of this project is to reduce TIA length of stay by using a visible LOS time tracker for physicians which may improve the length of stay, this would be similar to how the ED tracks their patients.

# Stroke Program
# Performance Improvement Initiatives
# Fiscal Year 2021

Patient Education

**New measure.** This project was initiated by our GME TY resident during the previous year and will be continued for the upcoming year. Goal is to improve patient education metric in GWTG and improve 30 day readmission and mortality rates by physician engagement in stroke education, primarily in lifestyle modification.

Transfer Process

**New measure.** Goal is to reduce door to transfer time to <120 minutes. Task Force has been established to address issue.

Admission guideline criteria

**New measure.** KDH has historically had admission guidelines but a task force has recently reconvened to review admission guidelines.

New guidelines developed and implemented in May 2020.

# Kaweah Delta
# Primary Stroke Certification through The Joint Commission (TJC)



The Joint Commission®

American Heart Association®

American Stroke Association®

CERTIFICATION

Meets standards for

**Primary Stroke Center**



**Unit/Department:** Rehabilitation Services **Pro Staff Report Date:** November 2020

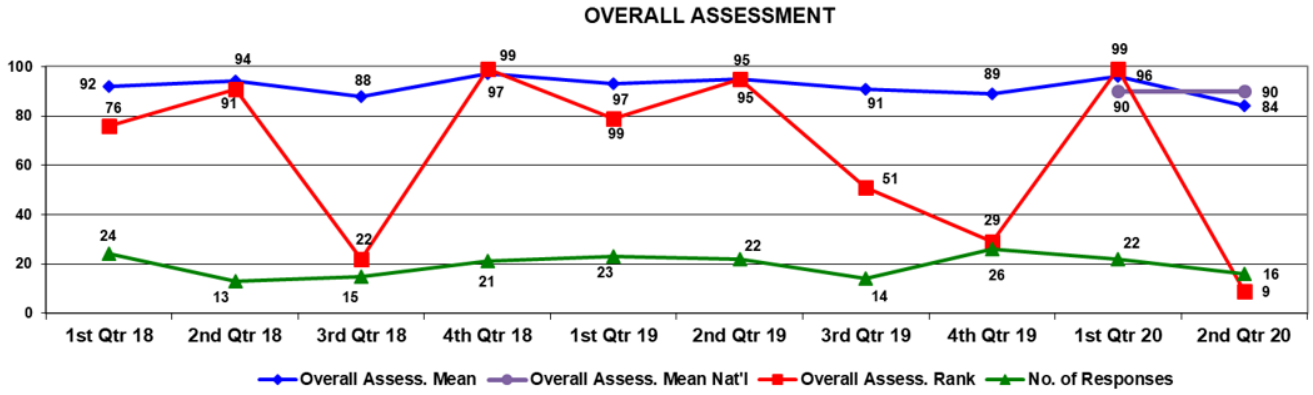
**Measure Objective/Goal:**

Acute rehabilitation program evaluation, including patient satisfaction, clinical quality including functional outcomes and referral review

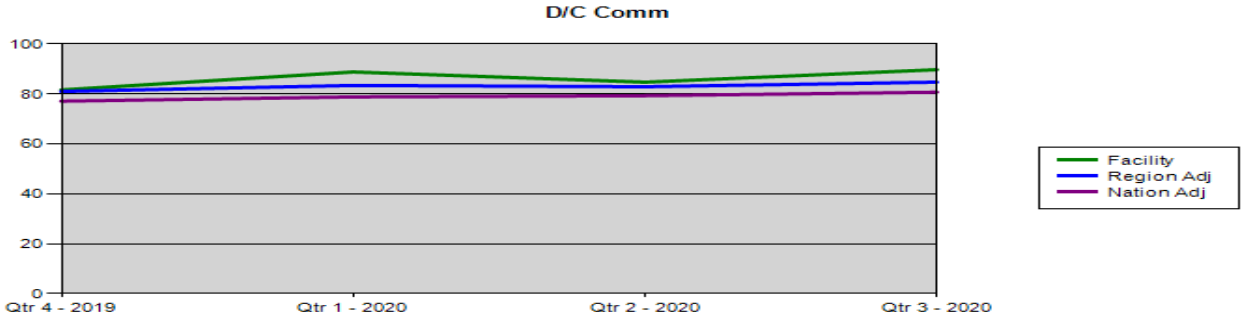
**Date range of data evaluated:** Rehab quarterly report, 1st and 2nd quarters of 2020

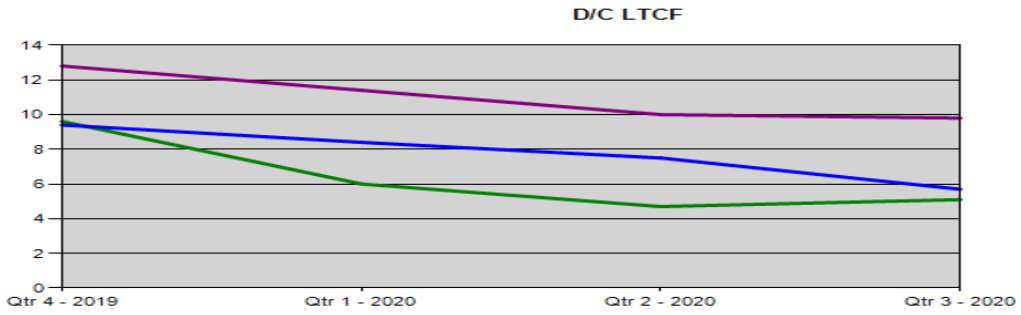
**Analysis of all measures/data: (Include key findings, improvements, opportunities)**

Patient satisfaction: Mean score for the overall assessment of care was 96 in the first quarter of 2020, placing the program in the 99th percentile. That score dropped in the second quarter to 84, with the onset of the COVID pandemic having a significant impact on overall satisfaction, with decreased family contact with the patient and the program.

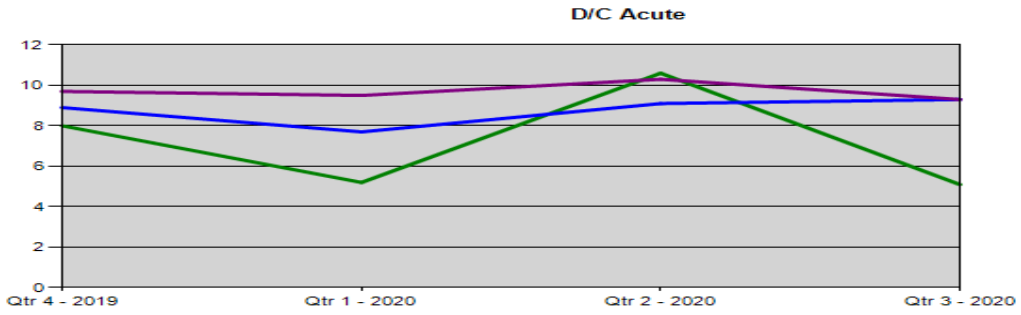



Outcomes: 85% of patients returned to community in the most recent quarter (2nd quarter 2020), above national average of 80. Skilled Nursing Facility discharges were 5% compared to national average of 10%. Acute care discharges were 10%, same as the national average.



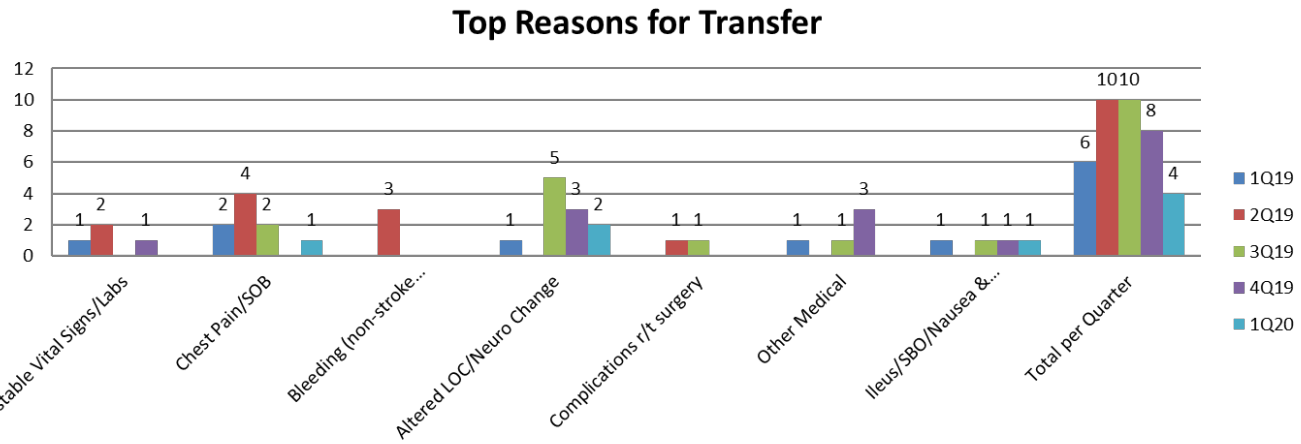



| Variable Name | Qtr 4 - 19 | Qtr 1 - 20 | Qtr 2 - 20 | Qtr 3 - 20 |
|---|---|---|---|---|
| D/C LTCF | | | | Graph |
| Facility | 9.6 | 6.0 | 4.7 | 5.1 |
| Region Adj | 9.4 | 8.4 | 7.5 | 5.7 |
| Nation Adj | 12.8 | 11.4 | 10.0 | 9.8 |




| Variable Name | Qtr 4 - 19 | Qtr 1 - 20 | Qtr 2 - 20 | Qtr 3 - 20 |
|---|---|---|---|---|
| D/C Acute | | | | Graph |
| Facility | 8.0 | 5.2 | 10.6 | 5.1 |
| Region Adj | 8.9 | 7.7 | 9.1 | 9.3 |
| Nation Adj | 9.7 | 9.5 | 10.3 | 9.3 |

## Transfer of Care Analysis




- Total transfers to acute were 4 for the 1st quarter. No trends noted or common diagnoses.

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

Patient satisfaction appears to be improving recently as communication to families has improved with more experience managing the pandemic. Plans are underway to implement a survey during the patient's stay to help surface issues that can be addressed while the patient is still on site. Therapists have implemented a goal board to assist in patient engagement in setting and reviewing their goals, which has led to improvements in that score. EVS and maintenance have completed an assessment of patient bathrooms to improve appearance and functioning of equipment. Clinical outcomes continue to be strong.

**Measure Objective/Goal:**

Nursing indicators relative to NDNQI

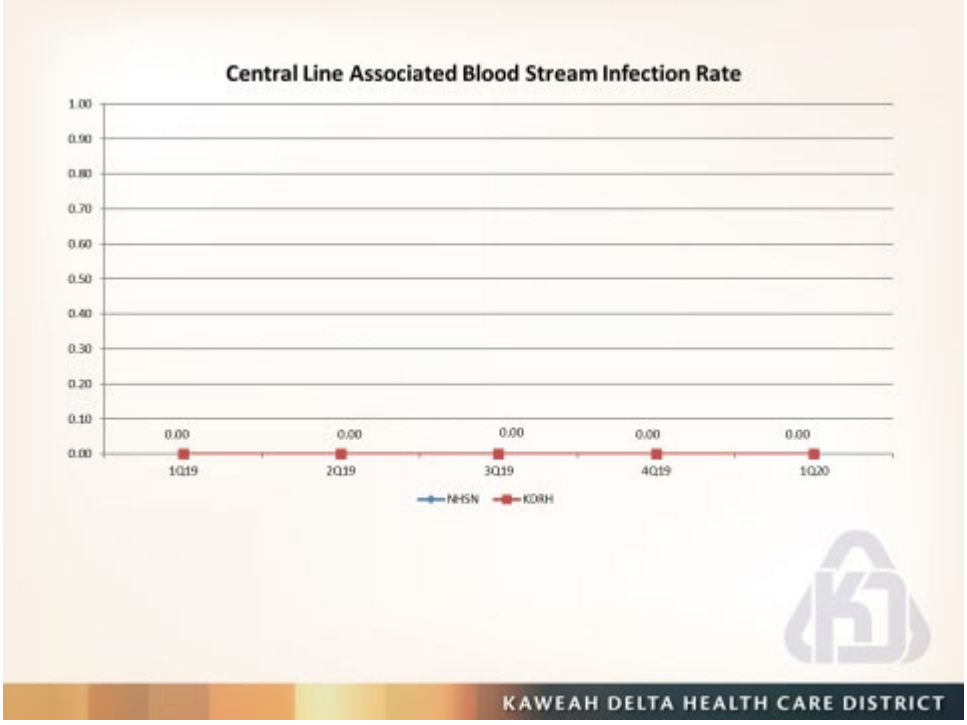
**Date range of data evaluated:** 1st quarter 2020

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

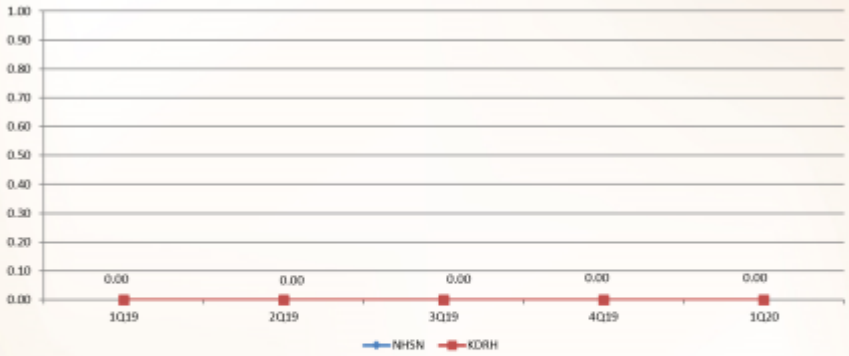
Kaweah Delta Rehab had zero incidence of catheter associated urinary tract infection, central line blood stream infections or hospital acquired pressure ulcer stage II or above. Fall rate per 1000 patient days was below NDNQI benchmarks. There were no injuries

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

Continue existing initiatives for CAUTI, pressure ulcer. Developing a CNA superuser program so that these CNA's can assist less experienced aides in how to safely complete patient transfers.



## Catheter Associated Urinary Tract Infection Rate (per 1000 patient days)

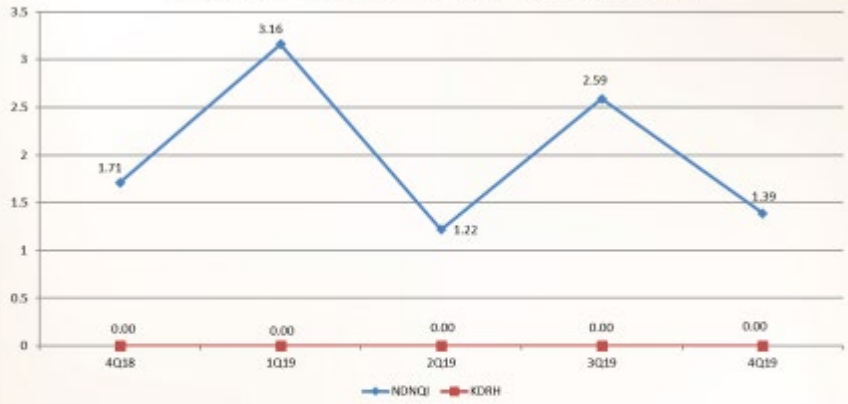



Follow Gemba guidelines

- Daily bath for all patient with Foley catheters
- Peri care q shift
- Discontinuation of Foley catheter ASAP if not indicated to continue
- Practice Hand washing

KAWEAH DELTA HEALTH CARE DISTRICT

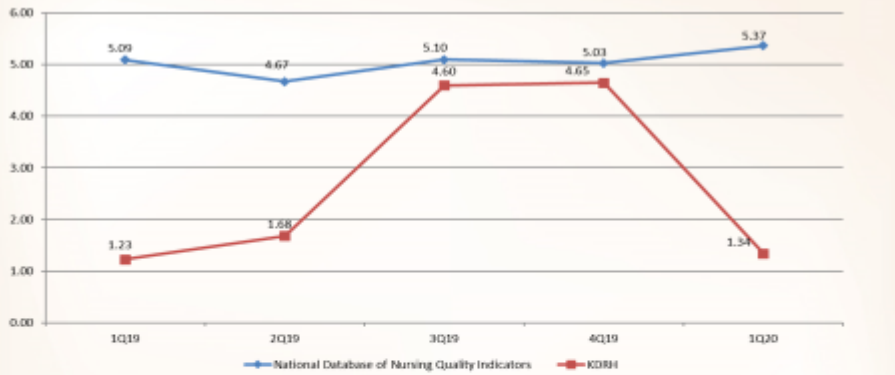
## Hospital Acquired Pressure Ulcer (Stage 2 and above)




No findings with unit Prevalence study for last quarter

KAWEAH DELTA HEALTH CARE DISTRICT

## Fall Rate/1000 Patient Days




Total of 7 Rehab falls. Two falls from the same patient intentionally sitting on the floor both incidents the patient stated she was hot and wanted to sit on the floor.. Two falls with therapy , one with a PTA during a car transfer when the patient lost balance and safely lowered to the floor. The other one with OT while toileting and the patient began to slide out of the WC. and was safely assisted to the floor.

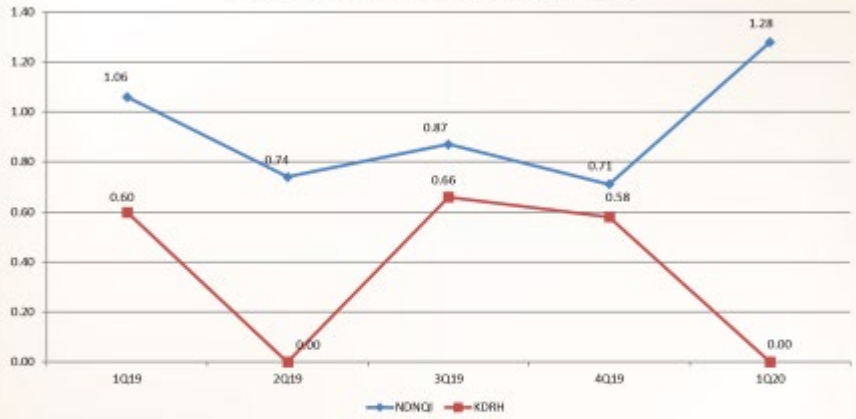
The other three falls were assisted falls ,

1. The patient was sliding out of the WC and assisted to the floor,
2. The patient was showering and had a muscle spasm and slid off the chair, the Cna was present, however turned away to get his clothes. The pt slid to the floor and the CNA was able to keep him in a sitting position .
3. The pt was assisted to BR and her leg twisted and lost her balance. She was safely lowered to the floor .

There were no injuries and all were appropriately assisted. The education department will partner with nursing and thersapy to develop a CNA super user fall prevention program to roll out in August.



## Fall Rate with Injury/ 1000 Patient Days

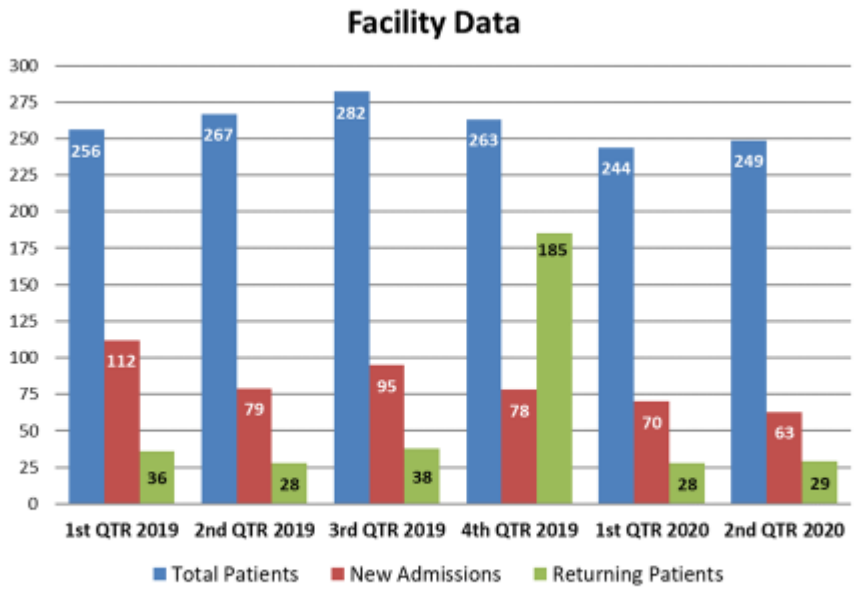


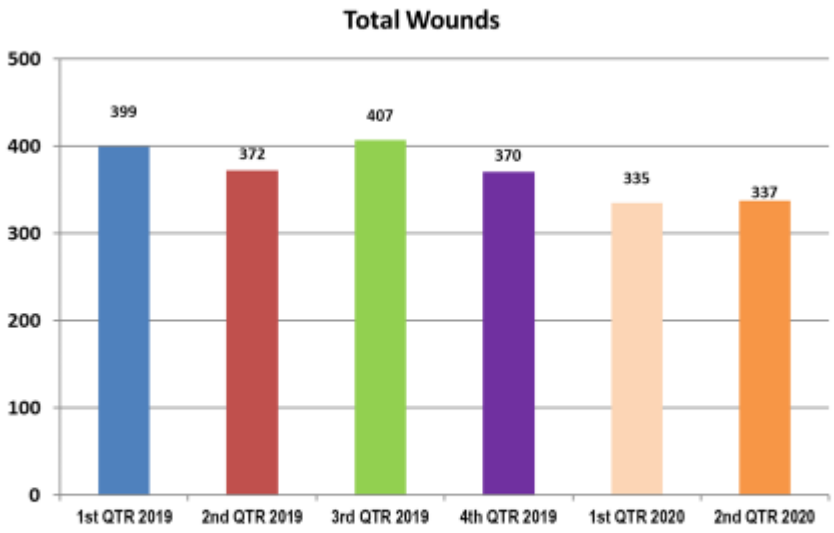
**Measure Objective/Goal:** Wound Center outcomes

**Date range of data evaluated:** 2nd quarter 2020

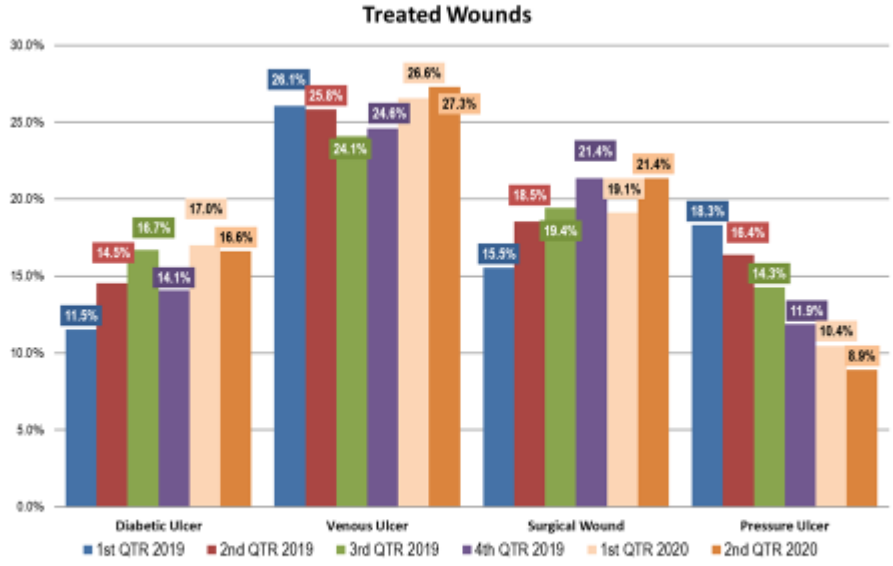
**Analysis of all measures/data: (Include key findings, improvements, opportunities)**

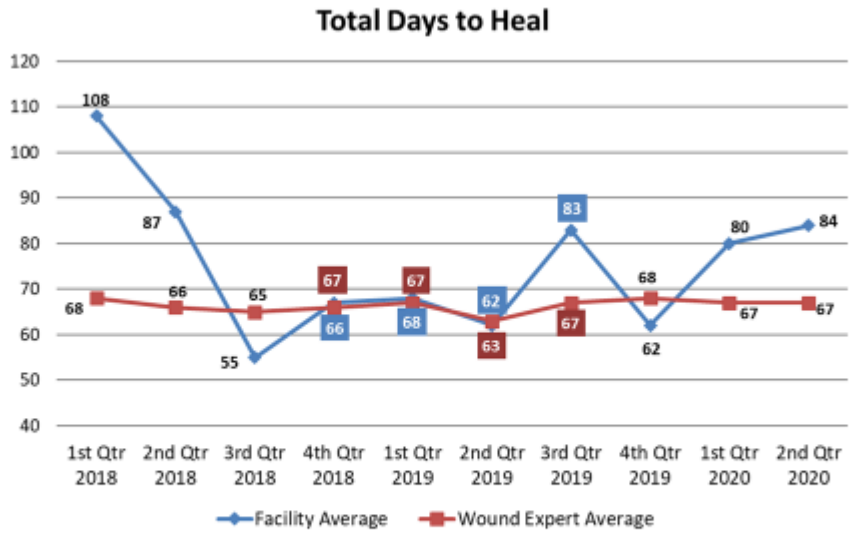
Total number of patients stable with a decrease in overall visits and total number of wounds treated. Overall types of wounds being treated remain stable for diabetic ulcers, venous ulcers and surgical wounds, with a trend of decreasing pressure ulcers in treatment. The percentage of patients who successfully complete treatment continues to improve, with 67% completing treatment this quarter and fewer patients discharged for not attending treatment. Total days to heal was 84 compared to 67 benchmark in the Wound Expert database. There were 13 diabetic ulcer patients, 4 took more than 100 days, one took 280 days to heal. 5 Pressure ulcers , one took 371 days, one took 126 days so days to heal above the benchmark. Surgical wounds continue to be below the benchmark. Venous ulcers above benchmark – one took 365, another 223, another with two wounds both close to 200 days. The department continues to evaluate new products and is looking at multiwrap product alternatives to address venous stasis ulcers.



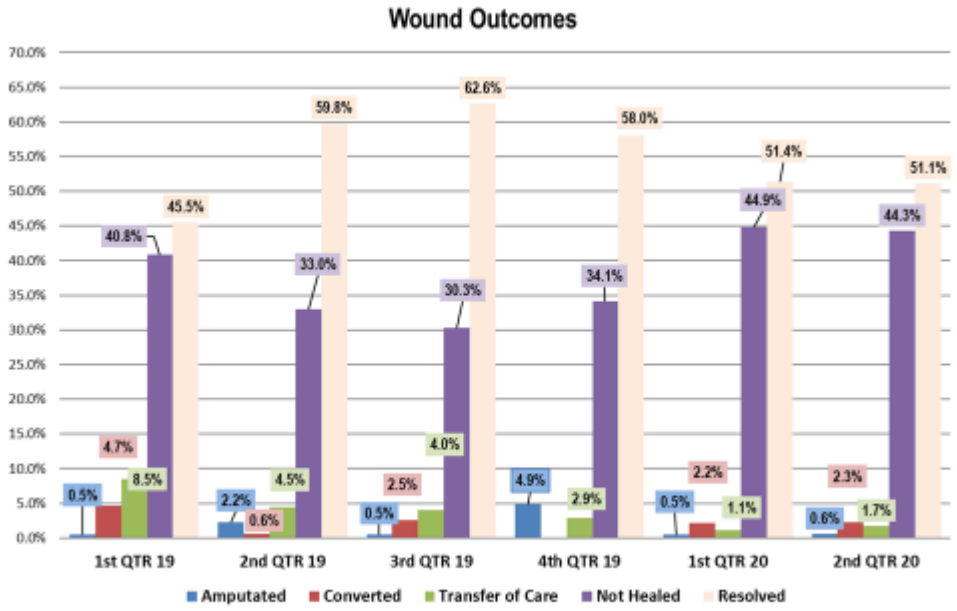

Total Wounds
500
400
300
200
100
0
399
372
407
370
335
337
1st QTR 2019
2nd QTR 2019
3rd QTR 2019
4th QTR 2019
1st QTR 2020
2nd QTR 2020



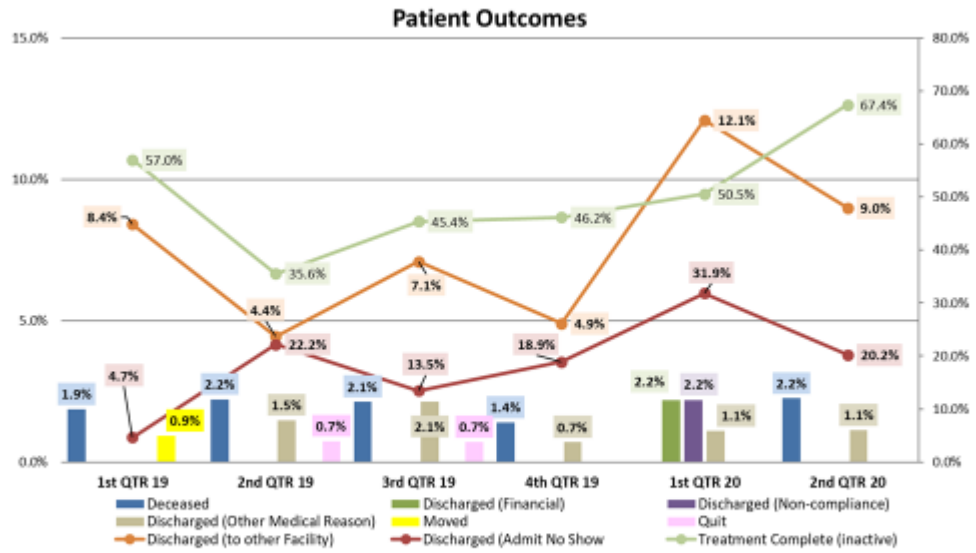

Treated Wounds
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
11.5%
14.5%
16.7%
14.1%
17.0%
16.6%
26.1%
25.6%
24.1%
24.8%
26.6%
27.3%
15.5%
18.5%
19.4%
21.4%
19.1%
21.4%
18.3%
16.4%
14.3%
11.9%
10.4%
8.9%
Diabetic Ulcer
Venous Ulcer
Surgical Wound
Pressure Ulcer
1st QTR 2019
2nd QTR 2019
3rd QTR 2019
4th QTR 2019
1st QTR 2020
2nd QTR 2020






More than medicine. Life.
Kaweah Delta






**Submitted by Name:** Lisa Harrold **Date Submitted:** November 12, 2020

## Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

**Unit/Department:** Outpatient Therapies (7799, 7800, 7803, 7804, 7806, 7807)

**ProStaff Report Date:** 10/30/20

**Measure Objective/Goal:** The outpatient therapy departments objectively measure function by using specific functional outcome measures consistently throughout the episode of a patients' care. Measuring outcomes of care, including body functions and activity completion, among patients with similar diagnosis is the foundation for determining which intervention approaches comprise best clinical practice. The goal of this data collection is to look at how each clinic is performing with regards to improving function in patients in each of the outpatient settings. With this data, we are able to identify trends and areas for improvement when providing care to specific body regions. There are 5 different outcome measures utilized pending the body region that is being evaluated. Those measures consist of one for arm impairments, one for leg impairments, one for neck impairments, one for back impairments, and one for neurological impairments (such as after stroke or brain injury).

Functional Outcome Measure Questionnaires, which list a number of daily activities and require patients to scale how easy or difficult it is to complete those activities based on their condition, are completed by patients prior to initiating therapy, at regular intervals during therapy, and upon discharge.

**Date range of data evaluated:** Quarterly data beginning April 2017 to Sept 2020

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

1) Dinuba Therapy Specialists:
   - Is meeting goal for patient improvements on all functional outcome measures, but with downward trends on all measures

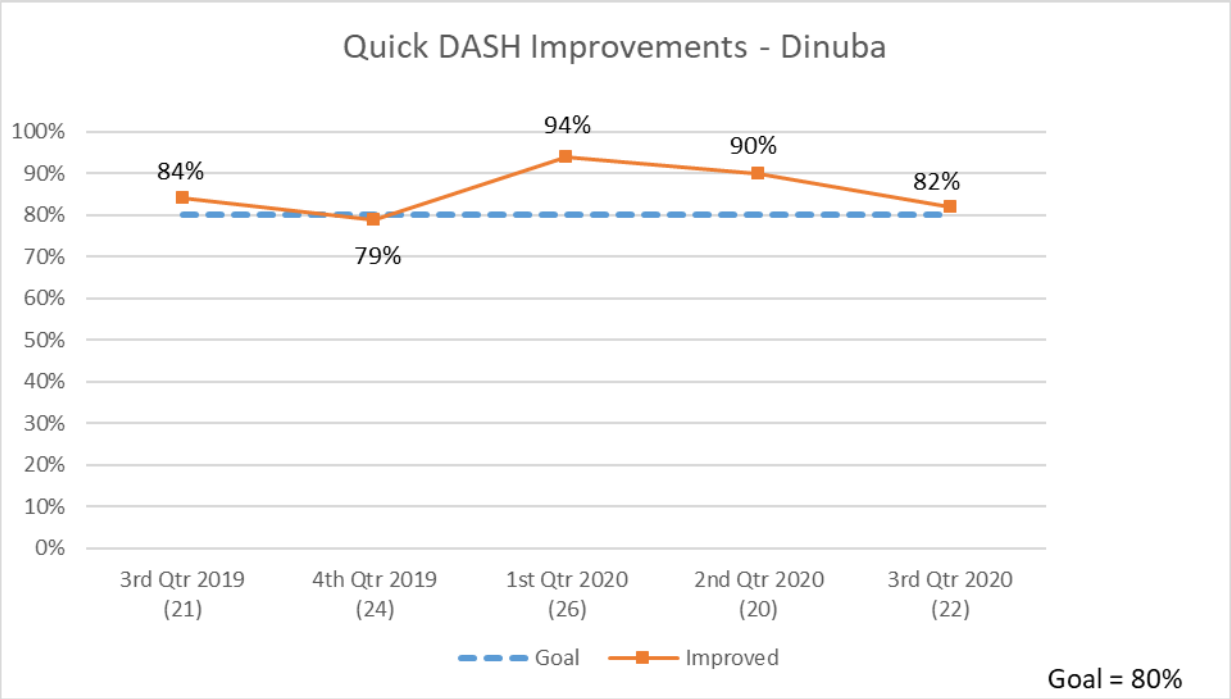
2) Exeter Therapy Specialists:
   - Is meeting goal for all outcome measures, with the exception of measures for diagnosis' related to the back. Scores are comparable to same quarter last year.
   - Much improved scoring for Lower Extremity compared to last quarter.
   - Improving volume of scores being captured

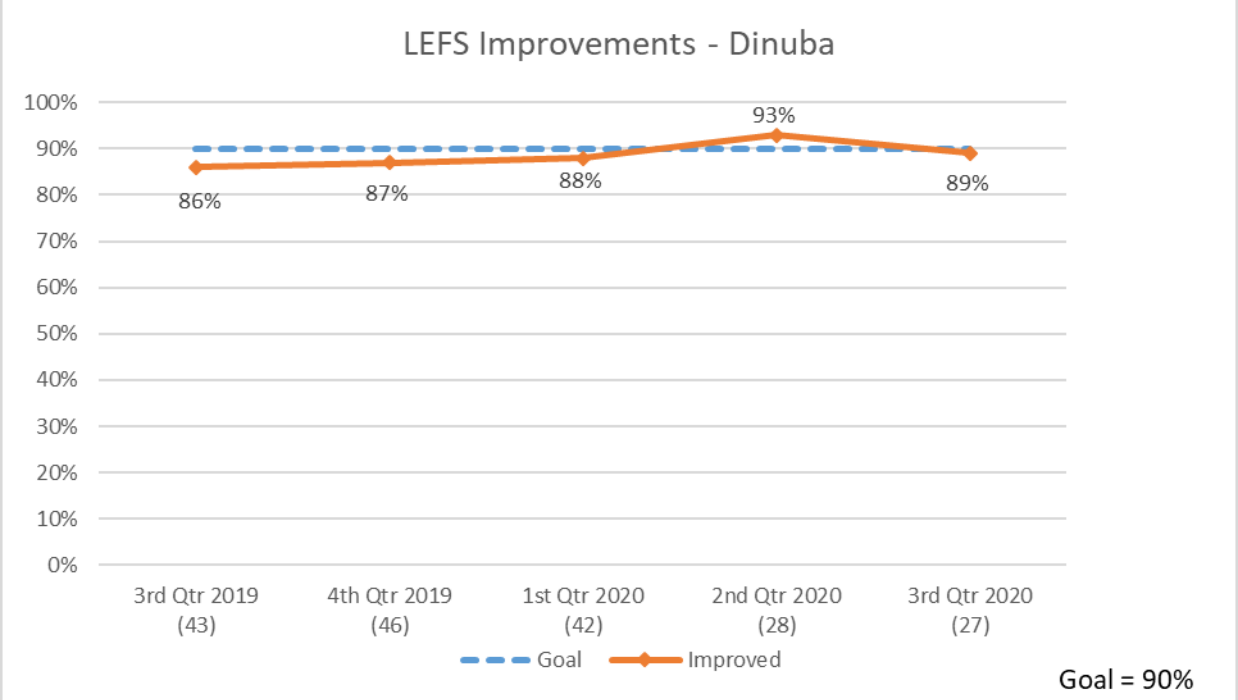
3) Loves Lane Therapy Specialists:
   - Is meeting goal for patient improvements on all functional outcome measures.

4) Therapy Specialists at MOB:
   - Is at, or close to, meeting goals for all functional outcome measures.

5) Therapy Specialists at Neuro clinic:
   - Is meeting goal for patient improvements on outcome measure involving neurological disorders.
   - No data for Lower Extremity or Upper Extremity measures.

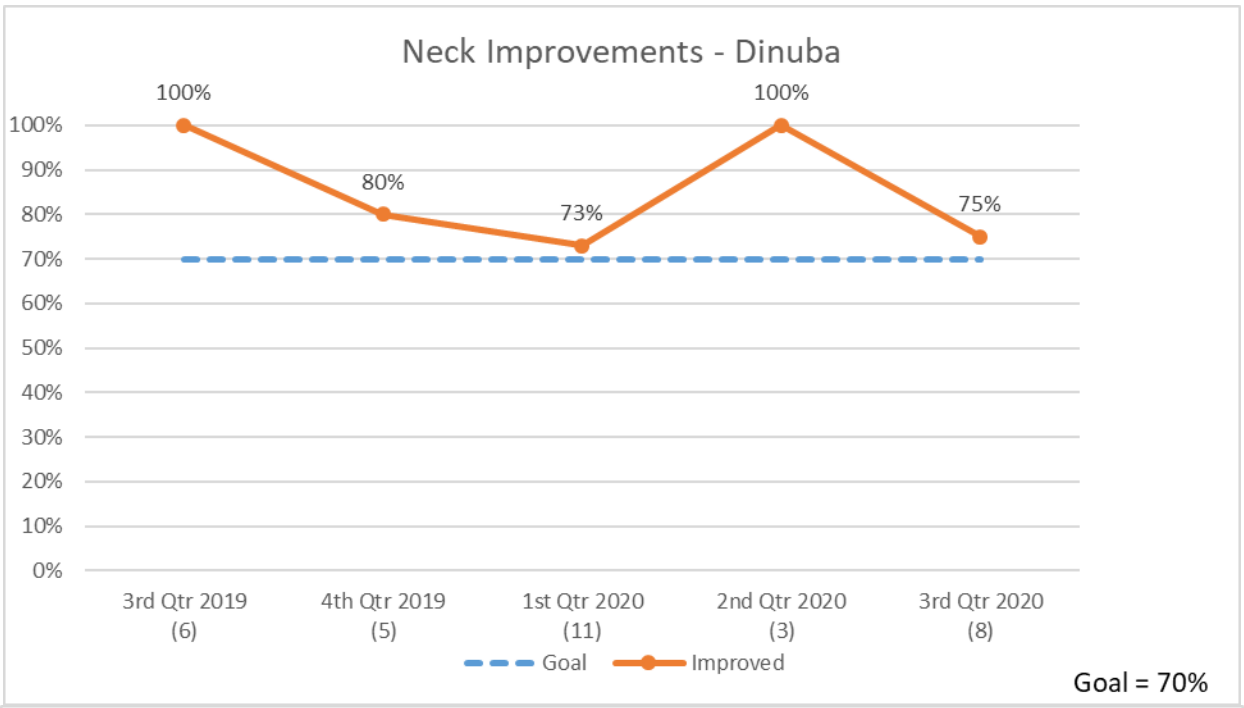
6) Hand Therapy Specialists:
   - Is close to goal for Disabilities of the Shoulder/Hand.

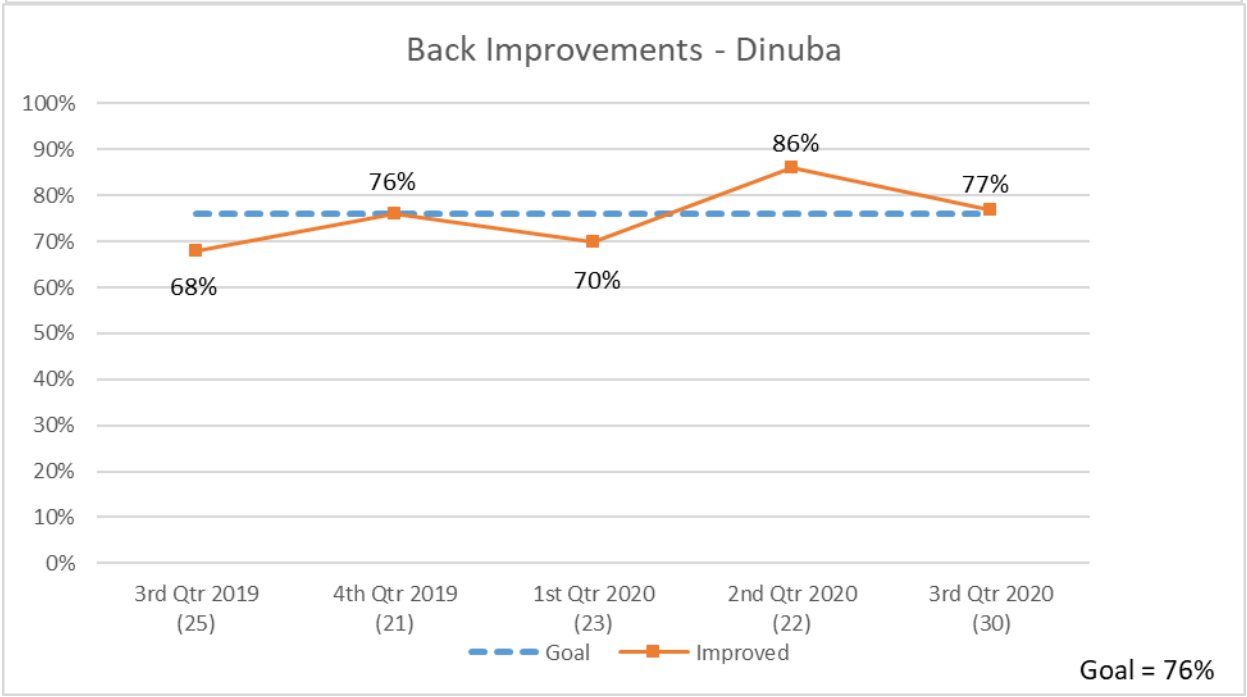

Quick DASH Improvements - Dinuba
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
84%
79%
94%
90%
82%
3rd Qtr 2019 (21)
4th Qtr 2019 (24)
1st Qtr 2020 (26)
2nd Qtr 2020 (20)
3rd Qtr 2020 (22)
Goal
Improved
Goal = 80%

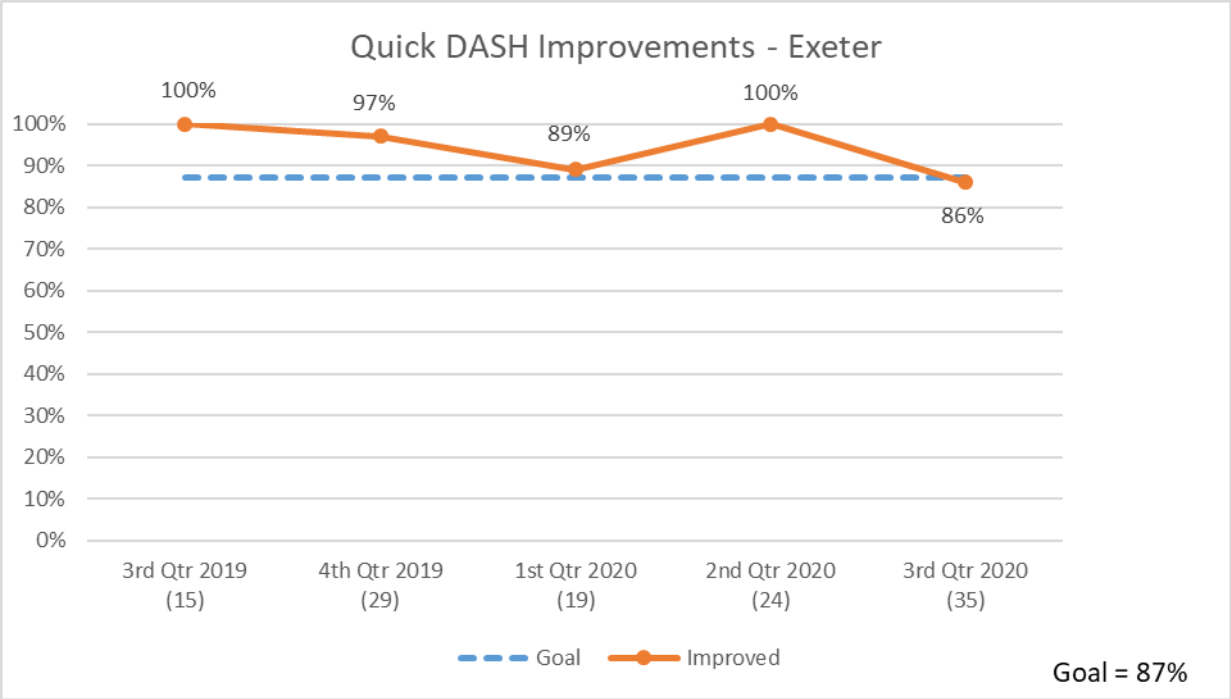

LEFS Improvements - Dinuba
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
86%
87%
88%
93%
89%
3rd Qtr 2019 (43)
4th Qtr 2019 (46)
1st Qtr 2020 (42)
2nd Qtr 2020 (28)
3rd Qtr 2020 (27)
Goal
Improved
Goal = 90%

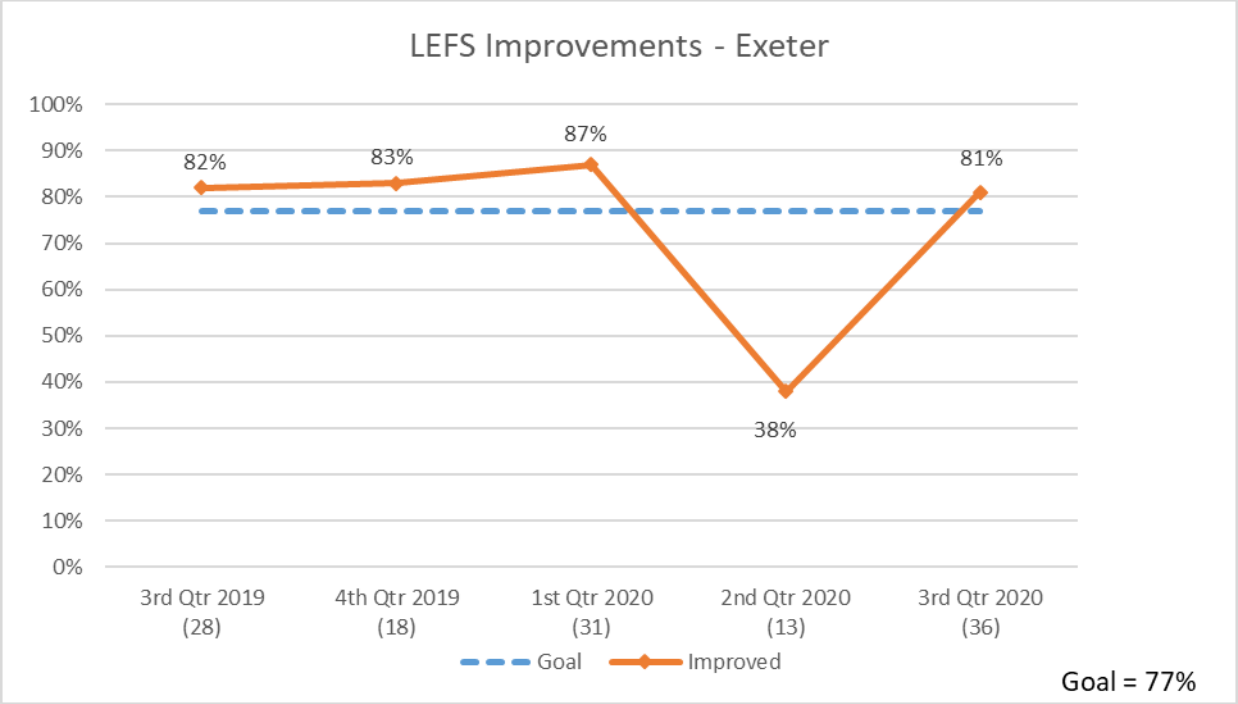
## Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee



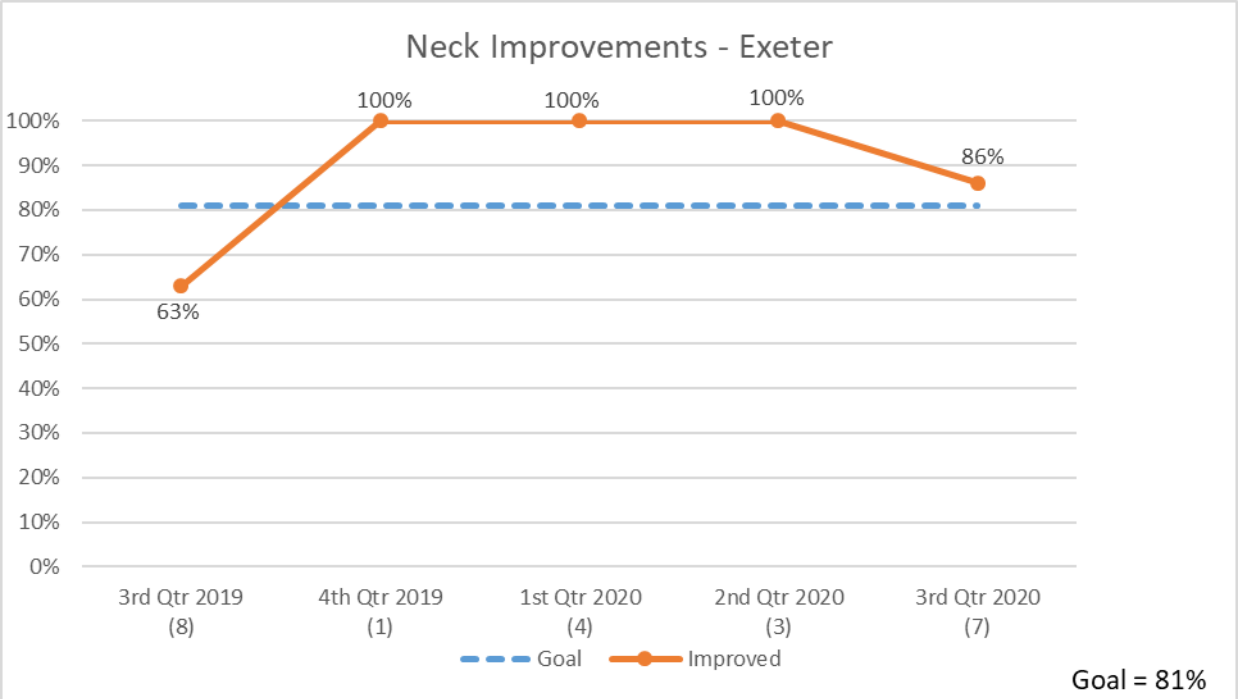




Quick DASH Improvements - Exeter
100%
97%
89%
100%
86%
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
3rd Qtr 2019 (15)
4th Qtr 2019 (29)
1st Qtr 2020 (19)
2nd Qtr 2020 (24)
3rd Qtr 2020 (35)
Goal
Improved
Goal = 87%

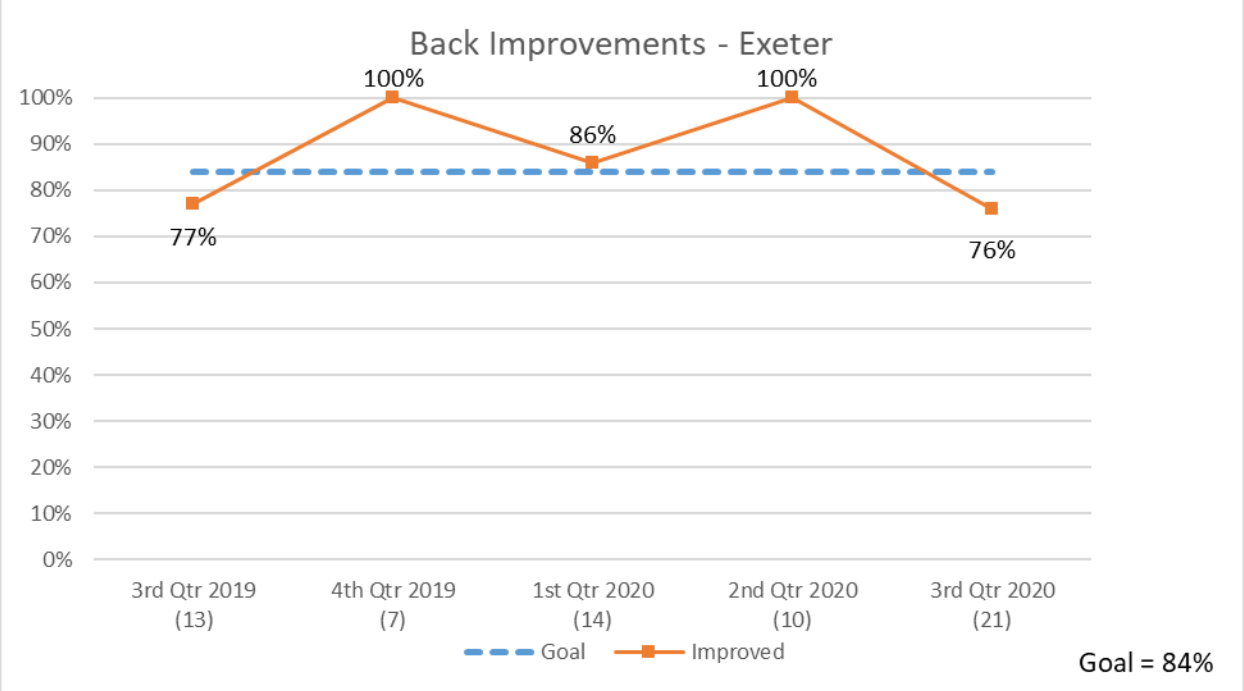

LEFS Improvements - Exeter
82%
83%
87%
38%
81%
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
3rd Qtr 2019 (28)
4th Qtr 2019 (18)
1st Qtr 2020 (31)
2nd Qtr 2020 (13)
3rd Qtr 2020 (36)
Goal
Improved
Goal = 77%

## Unit/Department Specific Data Collection Summarization

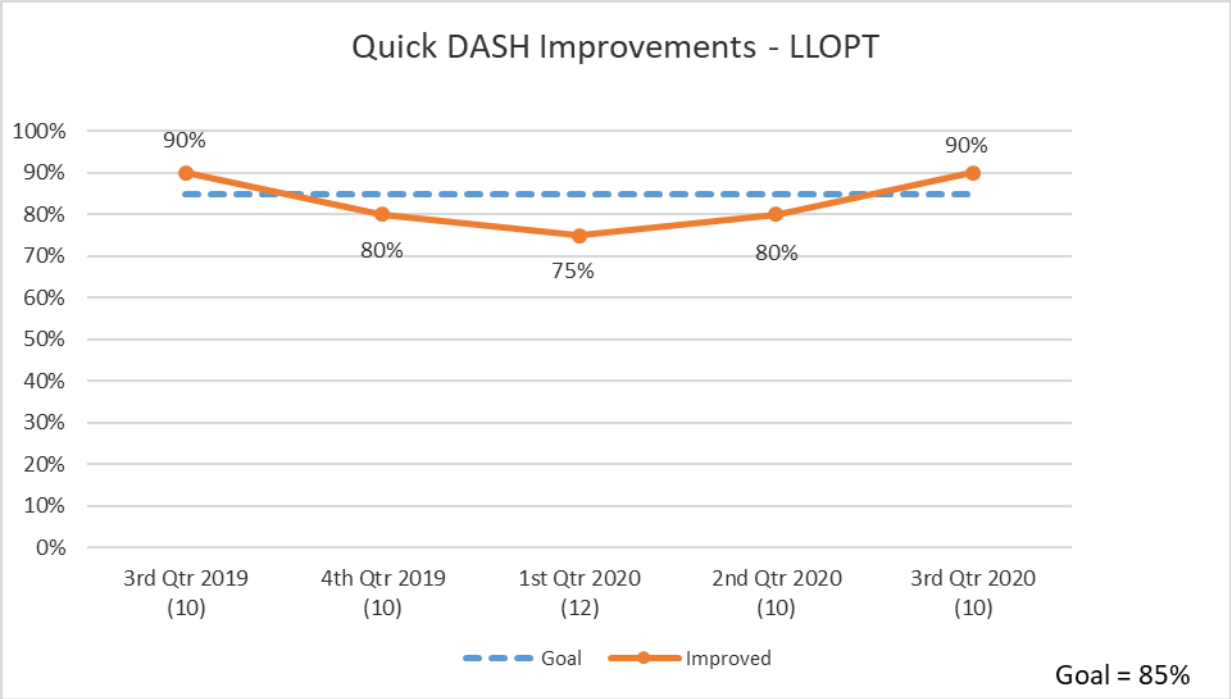
Professional Staff Quality Committee



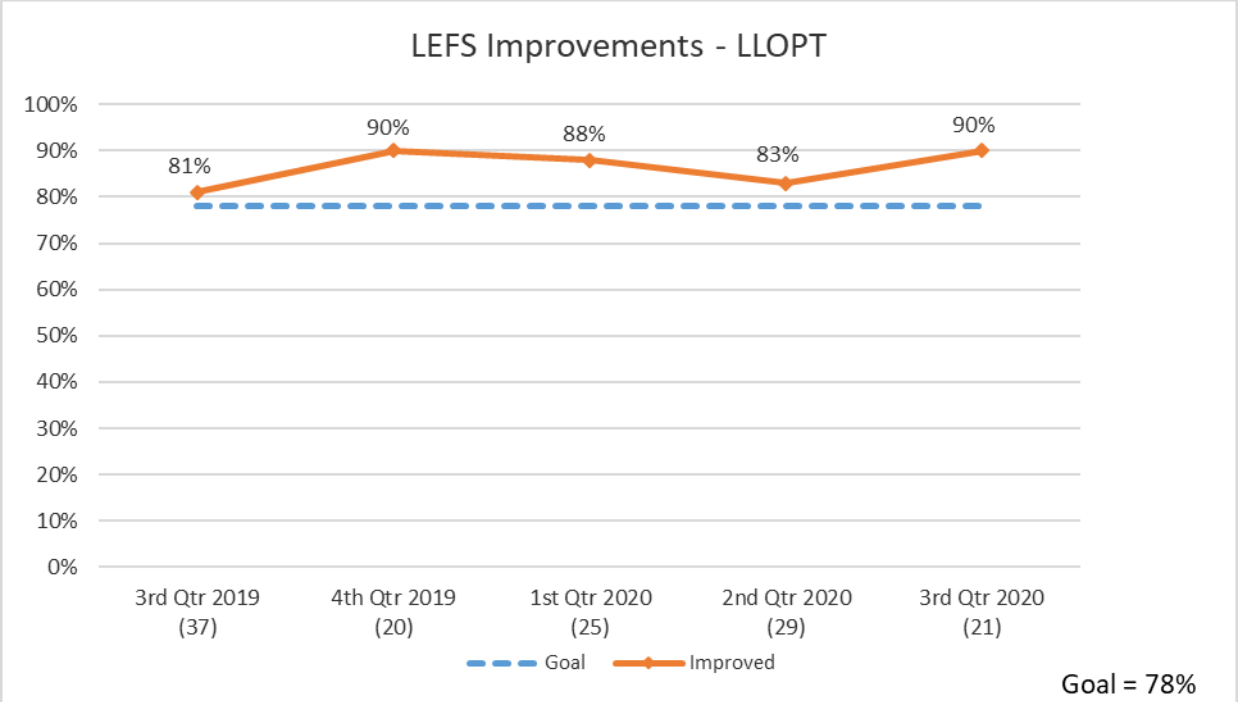

Goal = 81%



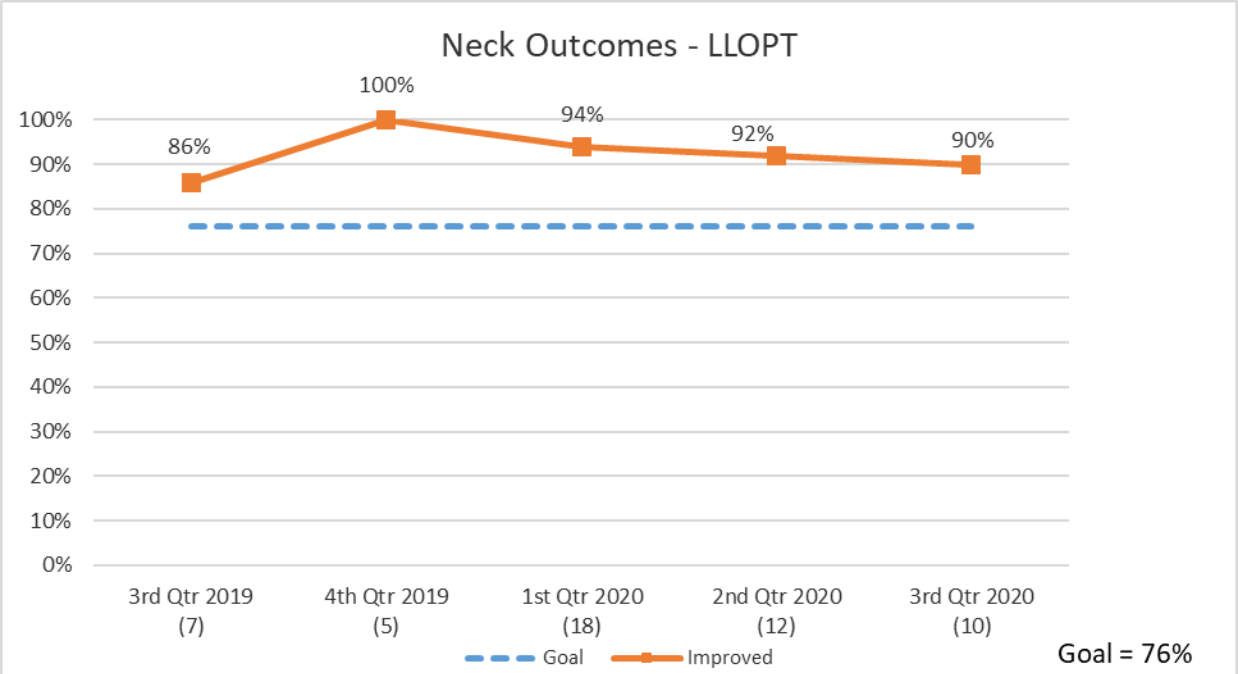

Goal = 84%

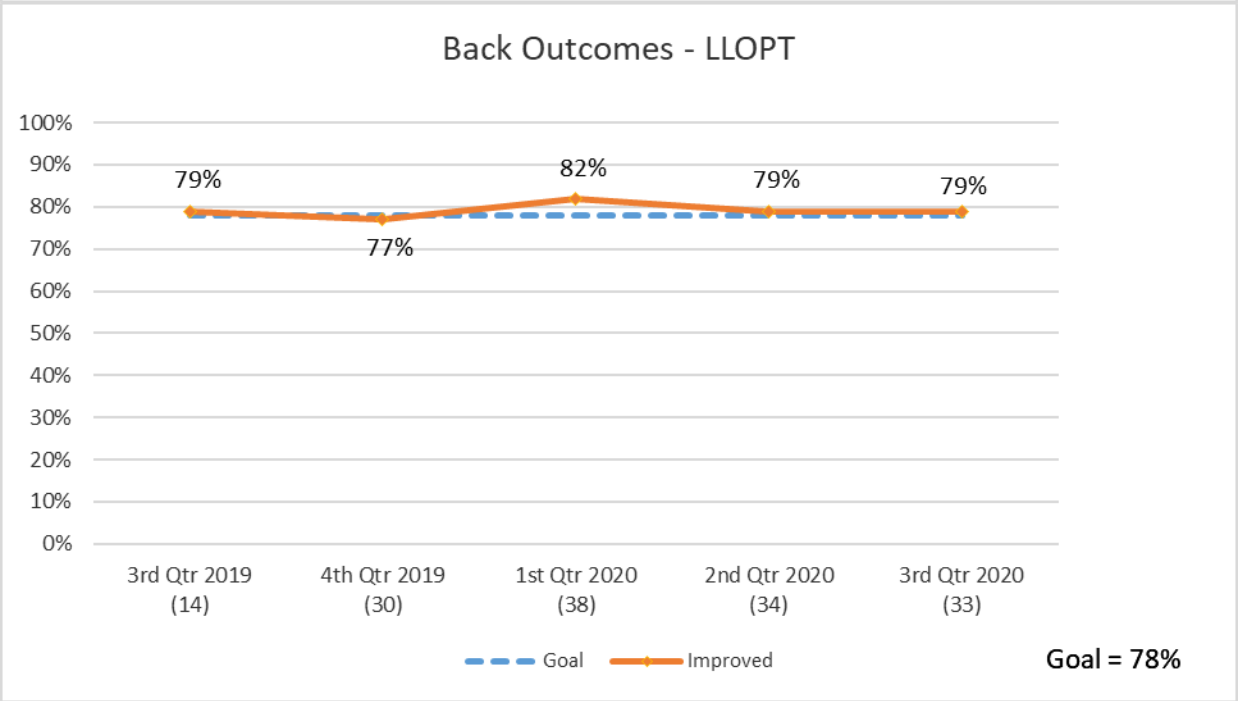


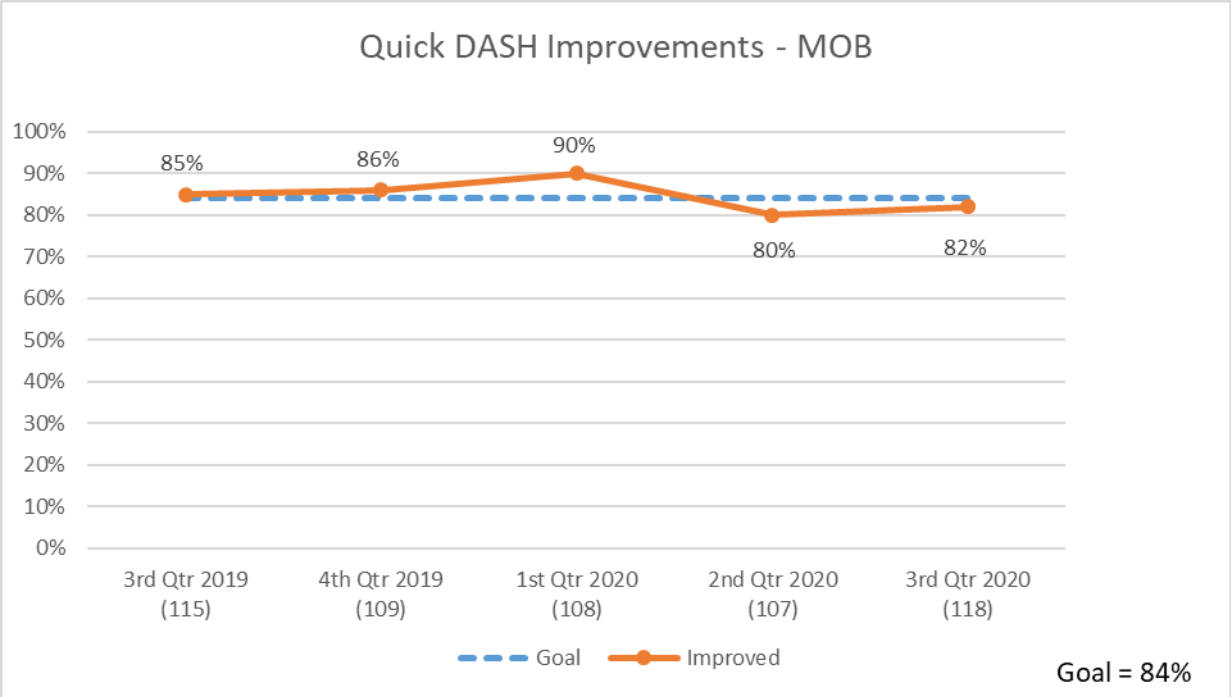

Goal = 85%



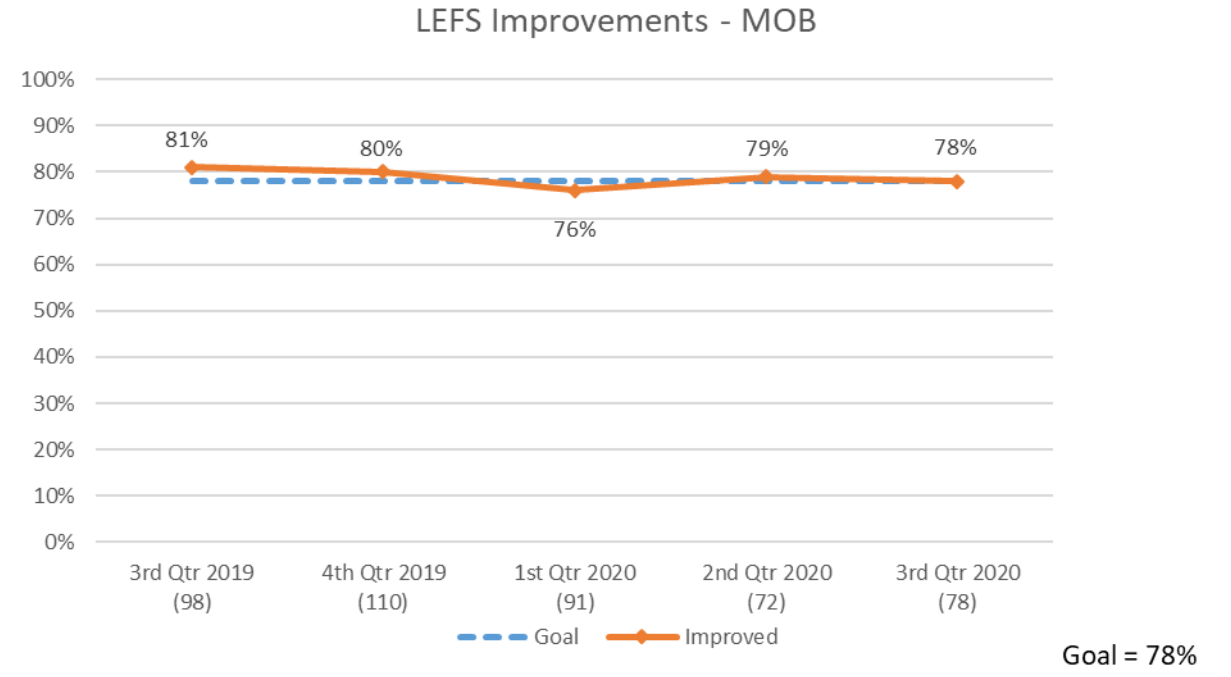

Goal = 78%


Neck Outcomes - LLOPT
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
86%
100%
94%
92%
90%
3rd Qtr 2019 (7)
4th Qtr 2019 (5)
1st Qtr 2020 (18)
2nd Qtr 2020 (12)
3rd Qtr 2020 (10)
Goal
Improved
Goal = 76%

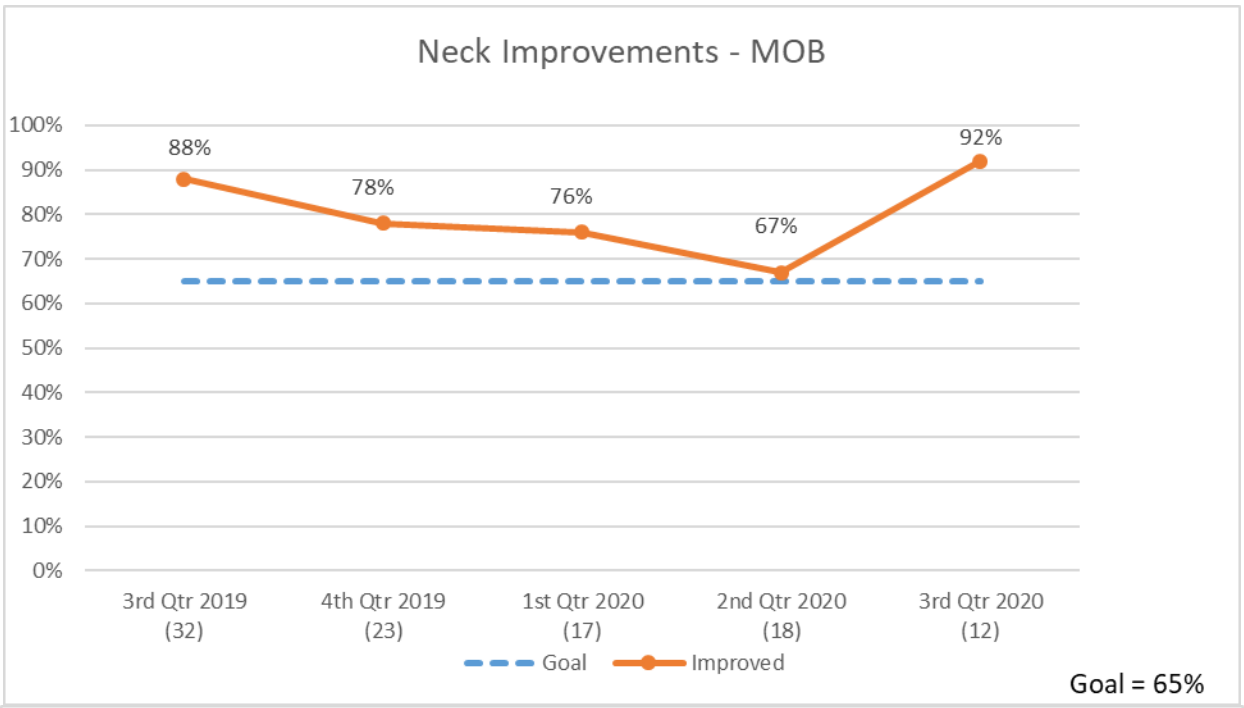

Back Outcomes - LLOPT
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
79%
77%
82%
79%
79%
3rd Qtr 2019 (14)
4th Qtr 2019 (30)
1st Qtr 2020 (38)
2nd Qtr 2020 (34)
3rd Qtr 2020 (33)
Goal
Improved
Goal = 78%

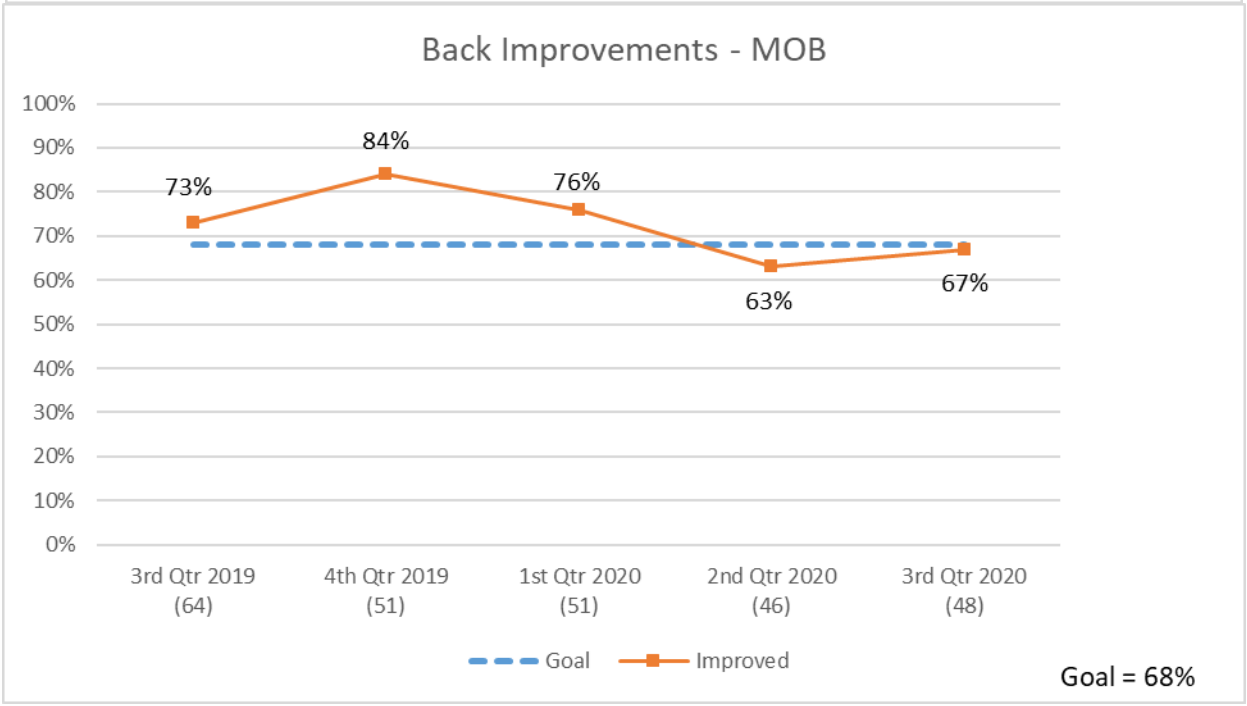



Goal = 84%



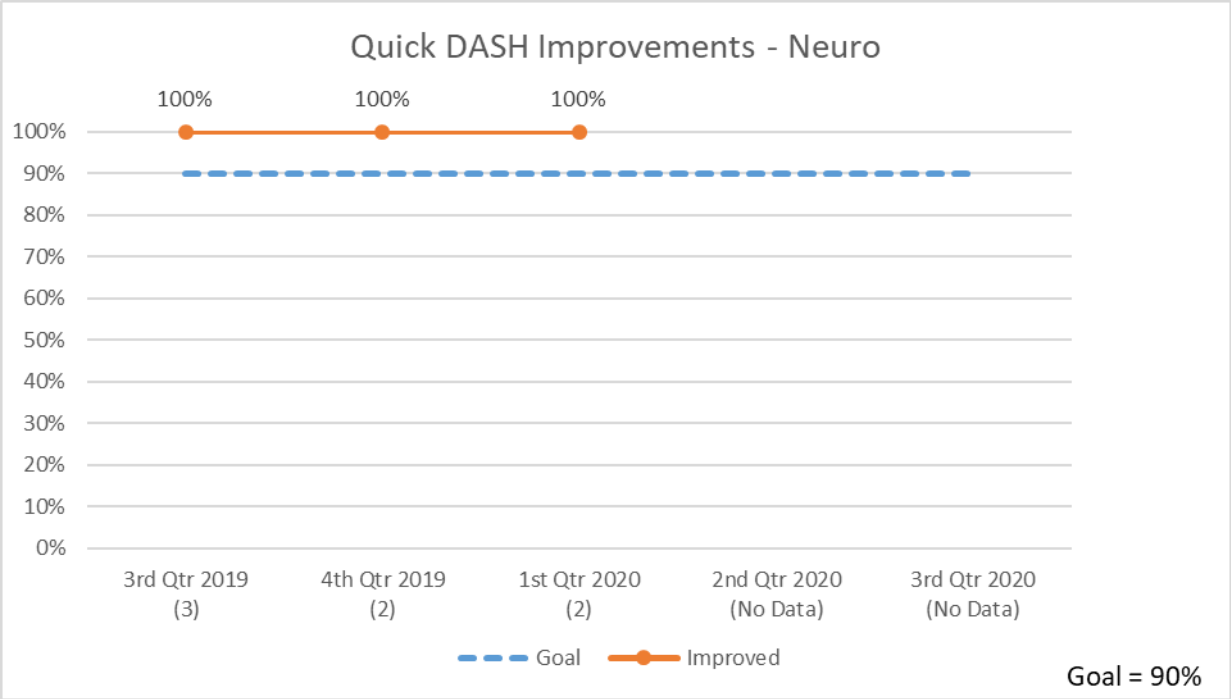

Goal = 78%


Neck Improvements - MOB
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
88%
78%
76%
67%
92%
3rd Qtr 2019 (32)
4th Qtr 2019 (23)
1st Qtr 2020 (17)
2nd Qtr 2020 (18)
3rd Qtr 2020 (12)
Goal
Improved
Goal = 65%

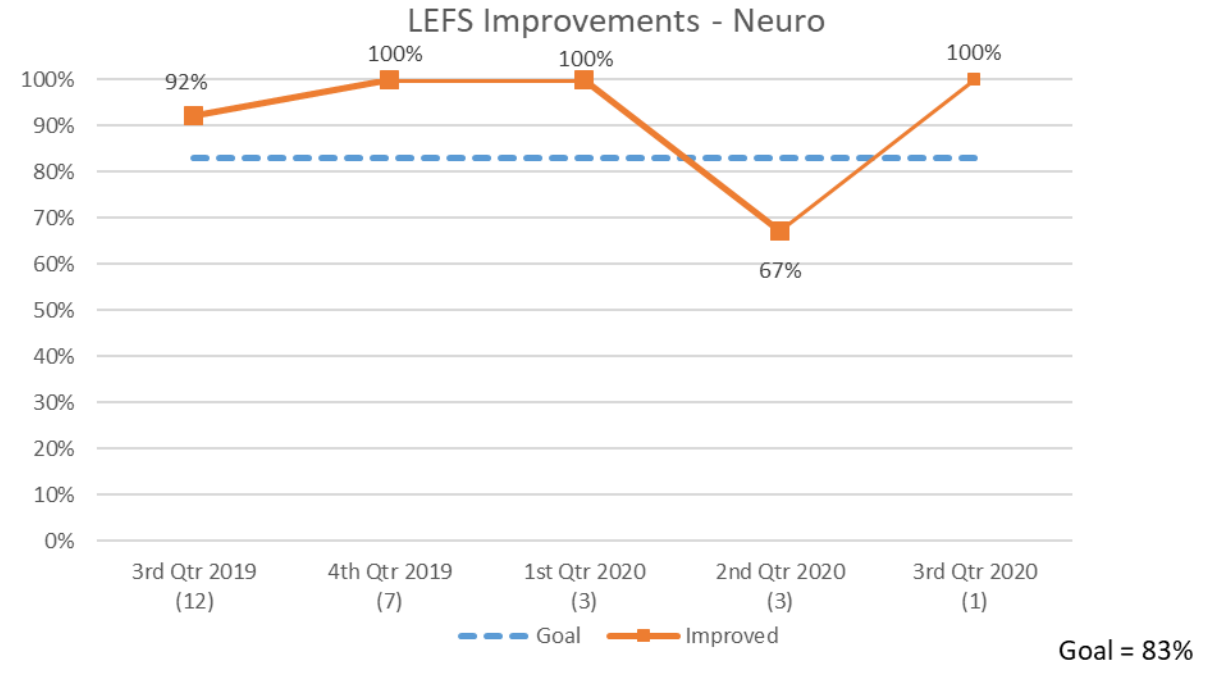

Back Improvements - MOB
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
73%
84%
76%
63%
67%
3rd Qtr 2019 (64)
4th Qtr 2019 (51)
1st Qtr 2020 (51)
2nd Qtr 2020 (46)
3rd Qtr 2020 (48)
Goal
Improved
Goal = 68%

**Unit/Department Specific Data Collection Summarization**

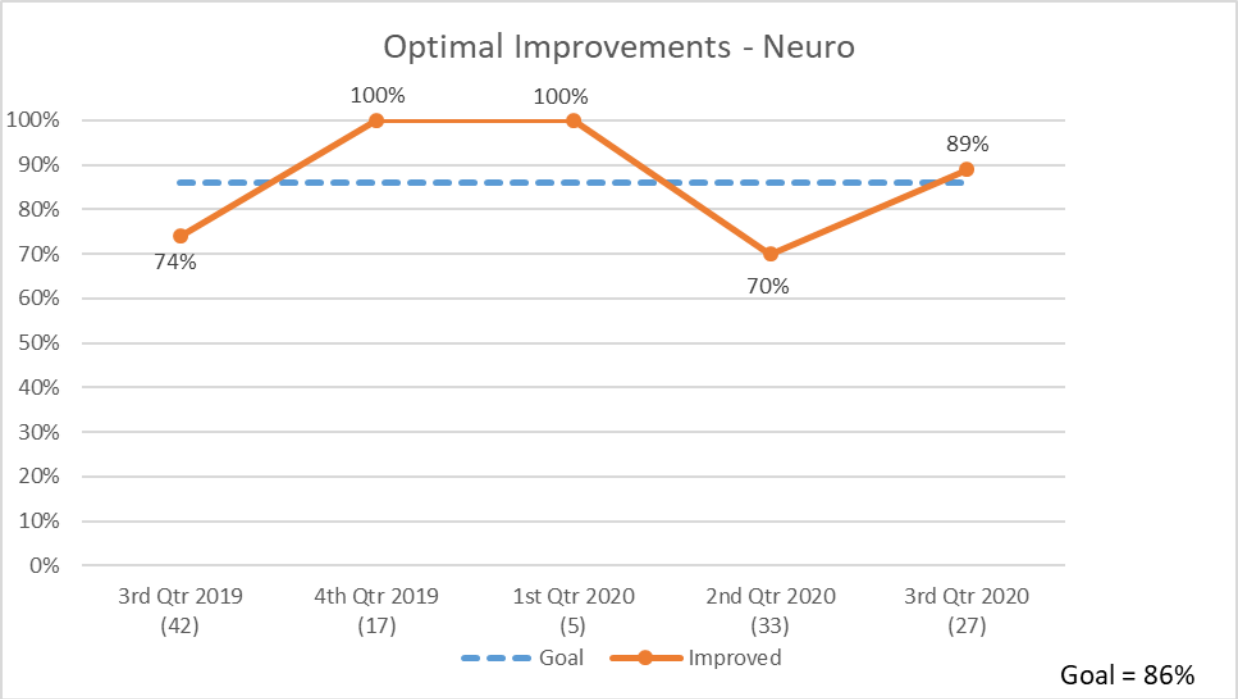
Professional Staff Quality Committee

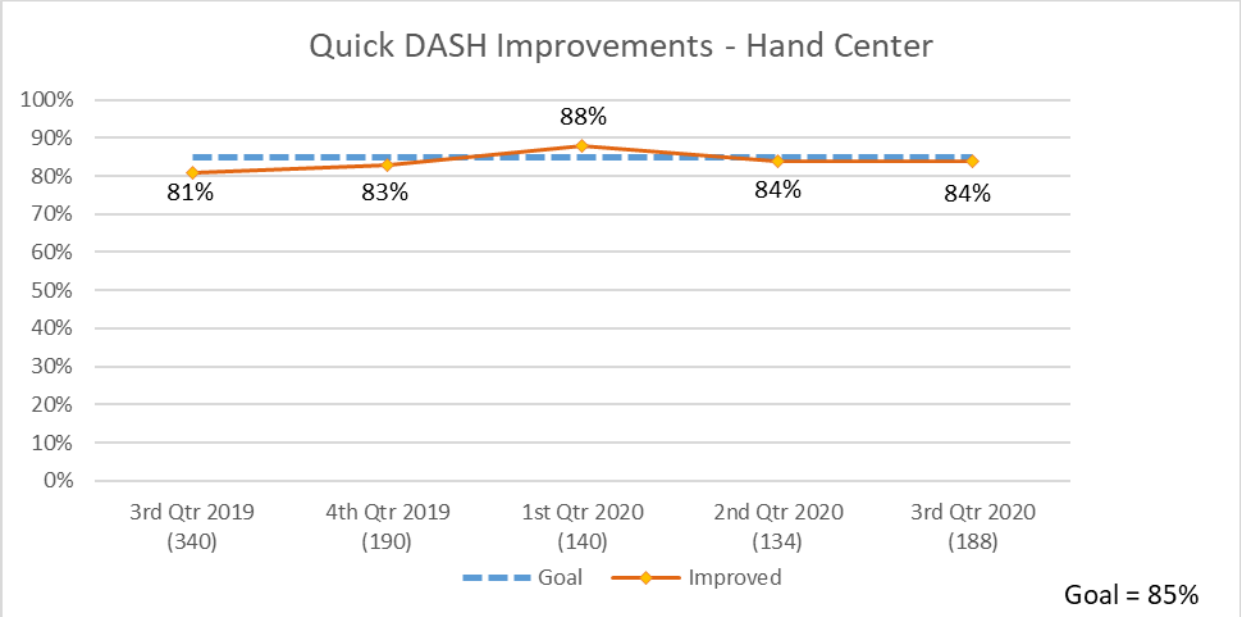



Goal = 90%




Goal = 83%




**<u>If improvement opportunities identified, provide action plan and expected resolution date:</u>**

In-Services have been completed at the outpatient clinics to drive scores in lower scoring areas. Staff training and education provided to improve volume of scores being captured. This has resulted in different score capturing process for the Exeter and Neuro clinics. There has been a low volume of scores being captured at neuro for Lower Extremity Functional Scoring and Disabilities of the Arm and Shoulder due to a shift in utilizing different outcome measures to capture appropriate outcomes for the patient population

.

**Next Steps/Recommendations/Outcomes:** Will no longer be measuring the LEFS and Quick DASH for the neuro clinic. Will begin collecting data on new outcome measures being used in that department which more accurately represent their patient population and diagnosis'.

Managers will be notified of individual staff member scores for outcome measures so that they can be compared to clinic averages. This will enable a more individual analysis of scores to find those that do exceptionally well with their patient outcomes, as well as those that have room for improvement. This will allow for individual staff awareness and opportunities for them to build their knowledge base and skills to improve scoring.

**Submitted by Name:** Jonah Miller, MPT **Date Submitted:** 10/30/20

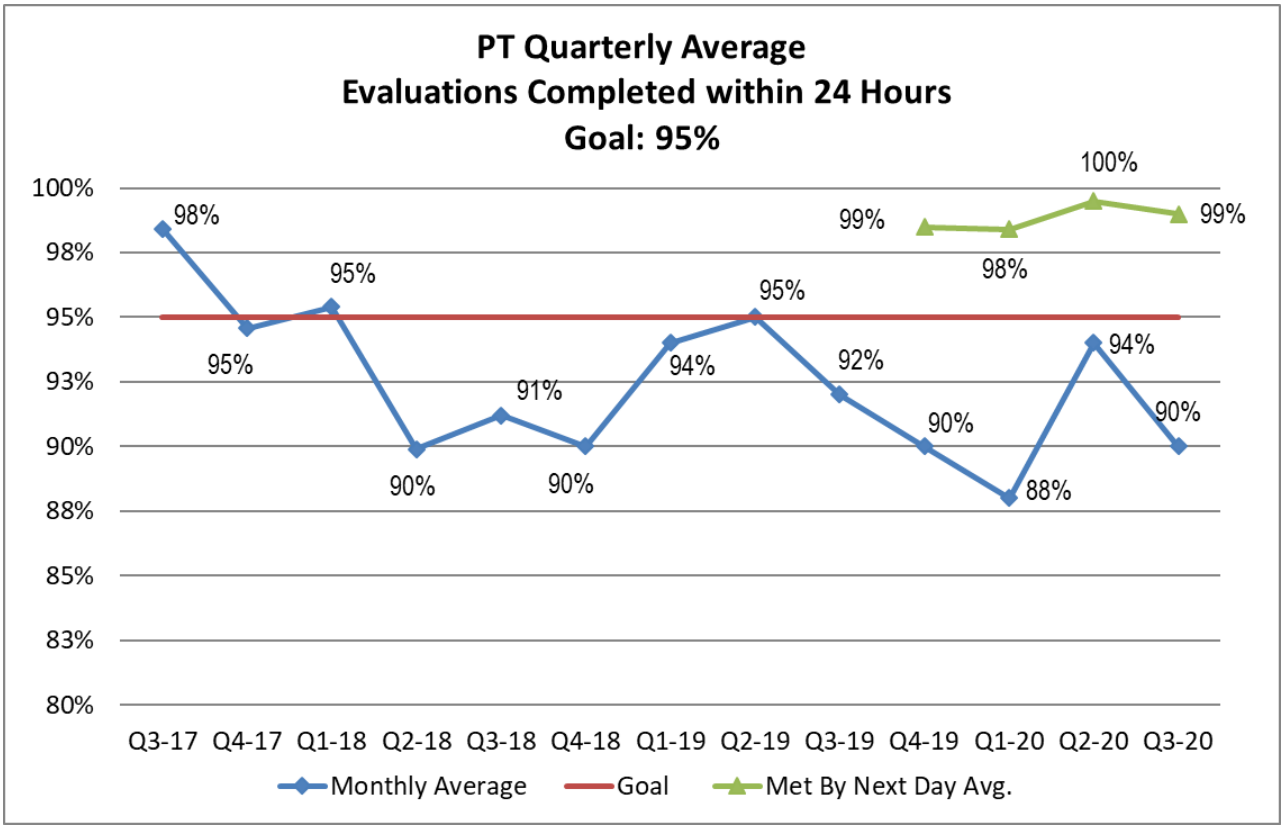
## Acute Therapy Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

**Unit/Department:** Acute Therapy PT and ST **ProStaff/QIC Report Date:** Nov 2, 2020

**Measure Objective/Goal:** Monitoring the time between when PT/ST is ordered and the 1st documentation therapy evaluation or reason patient not seen is completed. This is an indicator of our services ability to respond to patient & physician needs and provide valuable information to assist in both medical & discharge planning. Goal is 95% of PT and ST Evaluations are completed within 24 hours.

**Date range of data evaluated:** 3rd quarter 2020




**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):** Response to PT evaluation orders within 24 hours decreased from 2nd quarter 2020 94.0% to 90.0% 3rd quarter 2020. Total number of PT evaluations per month/% completed in 24 hours – July 863/90.3% Aug 909/87.6% Sept 842/91.6%. New data point (in green) measures evaluations attempted/completed by the next day (exceeding 24 hours) which for the 3rd quarter is 99.0% July 99.1% Aug 99.0% Sept 99.0%.

- Patients are admitted to 1E with Therapy orders without nursing functional assessment to determine if Therapy is indicated. When patients arrive to nursing units nursing needs to complete admission assessments, etc. limiting their availability.
- 6 PT students from Fresno State assigned to 6 PTs (only 1 new grad/new hire PT without student). It takes a significant amount of time to properly orient, train, and supervise students reducing productivity and efficiency. 37 out of 113 (33%) of evaluations missing 24 hours were completed by students.
- Efforts continue to be focused on triaging and prioritizing patients to address decreasing LOS including facilitating last minute discharges and equipment needs, case management requests for difficult to discharge patients, Ortho/Neuro surgeries, CVA and

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

elective surgery patients. This impacts the “24 hour” turnaround however the flexibility is necessary to address these issues.

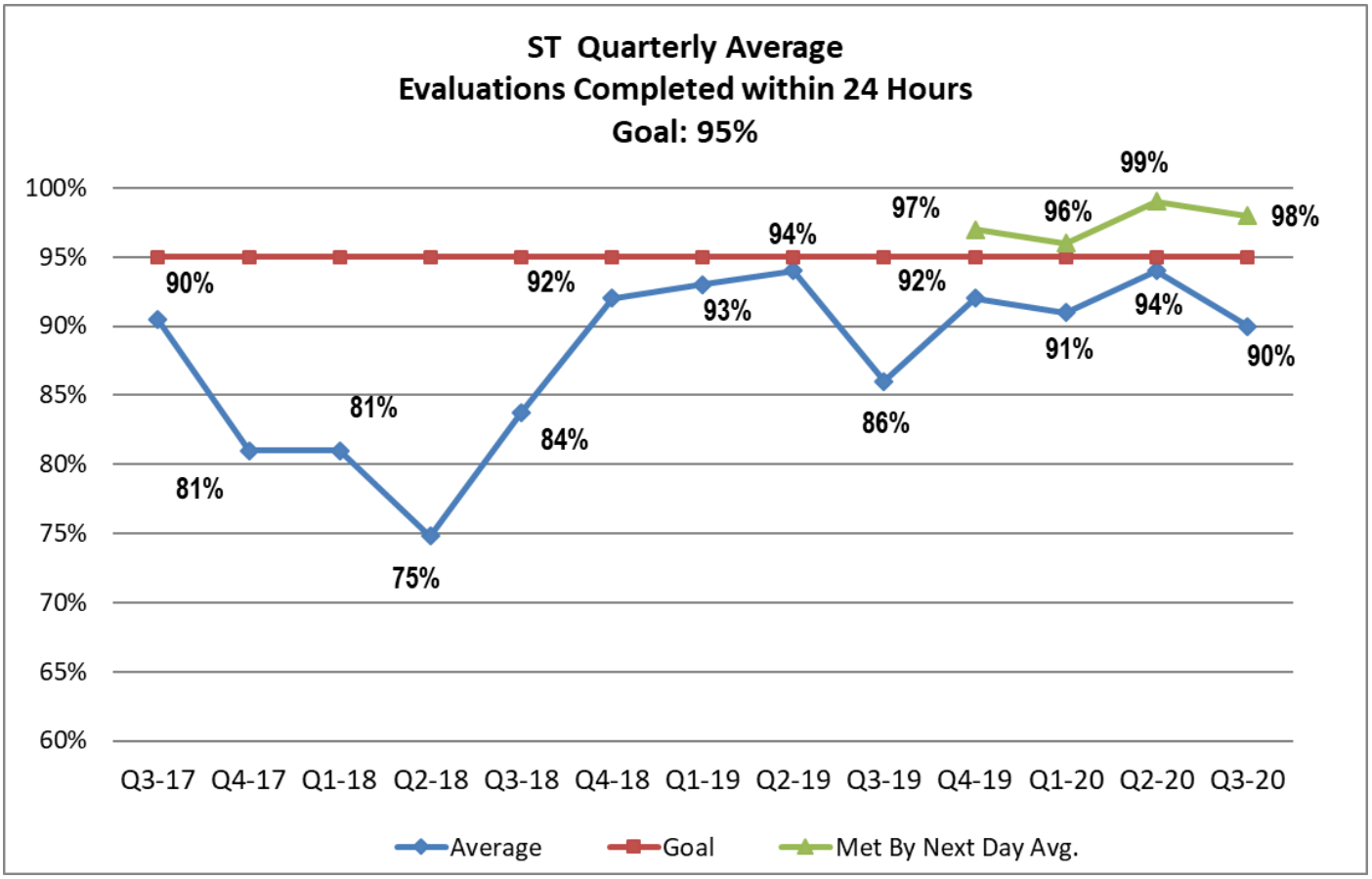
- Fluctuation in number of evaluations (18 to 49) ordered without a discernable pattern making staffing a challenge as additional staff are not available “on call”
- Physical Therapy caseload has been 140-160 patients/day in addition to elective surgeries, with 7 PTs and 2 PTA the expectation would be approximately 100 patients will be seen each week day.
- With the increased caseload, there is additional time spent in order to prioritize, triage, and organize and make sure frequencies are being met.

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

- Staff education as to workflow and processes to improve our response time - COMPLETED
- Piloting Nursing Mobility Program on 4S including utilize Rehab Aides to mobilize patients as time allows and use of KD Therapy Audit which is report of DTAs representing assist level and distanced ambulated during Therapy to better communicate this information with nursing.. – on HOLD 2’ to staffing for Nursing due to COVID
- Ongoing education - present to nursing units, Hospitalists and the GME Residents providing education as to the scope of practice for Therapy services in an effort to ensure appropriate Therapy orders are being placed. – COMPLETED for Family Practice Residents.
- Education needed for Nursing and Case Management staff re: location of Therapy documentation, Therapy department workflow and communication. DECEMBER 2020

**Next Steps/Recommendations/Outcomes:**

- Adapt Mobility report to take a look a nursing documentation of mobilizing patients with activity orders.
- Look into orders for PT evaluation that are placed at time of admission, criteria for order.
- Continue to focus on staffing appropriately when there are not a consistent number of evaluations throughout the month.
- Evaluate weekend staffing as >1/3 of the orders missing 24 hours were on the weekend.




**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):** Response to ST orders for swallow evaluation within 24 hours decreased from 2nd quarter 2020 94.0% to 90.0% in the 3rd quarter 2020. The total numbers of ST evaluations per month/% completed in 24 hours - July 189/94.2% Aug 218/86.7% Sept 190/90.0%. New data point (in green) measures evaluations attempted/completed by the next day (exceeding 24 hours) which for the 3rd quarter is 98.0%, July 98.9% Aug 96.3% Sept 98.9%.

- Acute ST providing training of new ST staff to take over services at South Campus and Home Health.
- Acute ST's are the only FEES certified staff and requested to go to perform FEES evaluations for patients on other campuses without back up coverage.
- Efforts continue to be focused on triaging and prioritizing patients to address multiple factors associated with decreasing LOS including NPO status and PEG tube placement, facilitating last minute discharges, case management requests for difficult to discharge patients. This impacts the "24 hour" turnaround however the flexibility is necessary to address these issues.
- Patients are admitted to 1E with Therapy orders without first performing nursing swallow assessment to determine if Therapy is indicated.
- Fluctuation in number of evaluations ordered without a discernable pattern making staffing a challenge as additional staff are not available "on call"
- Fluctuation in number of swallow evaluations ordered from 1 – 15/day making staffing a challenge.

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

## Acute Therapy Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

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

- Tracking data as to daily caseload for swallow and cognition evaluations as well as follow up/treatments. JANUARY 2020.
- Working c ISS to add “pass/fail” to Acute Therapy worksheet in Results Review-COMPLETED

**Next Steps/Recommendations/Outcomes:**

- Speech Therapy staff continuing to present to nursing units, Hospitalists and the GME Residents providing education as to the scope of practice for Therapy services in an effort to ensure appropriate Therapy orders are being placed.

**Submitted by Name:** Molly Niederreiter **Date Submitted:** Nov 2, 2020

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


# Sepsis Quality Focus Team
## Quality Council Report – January 2021

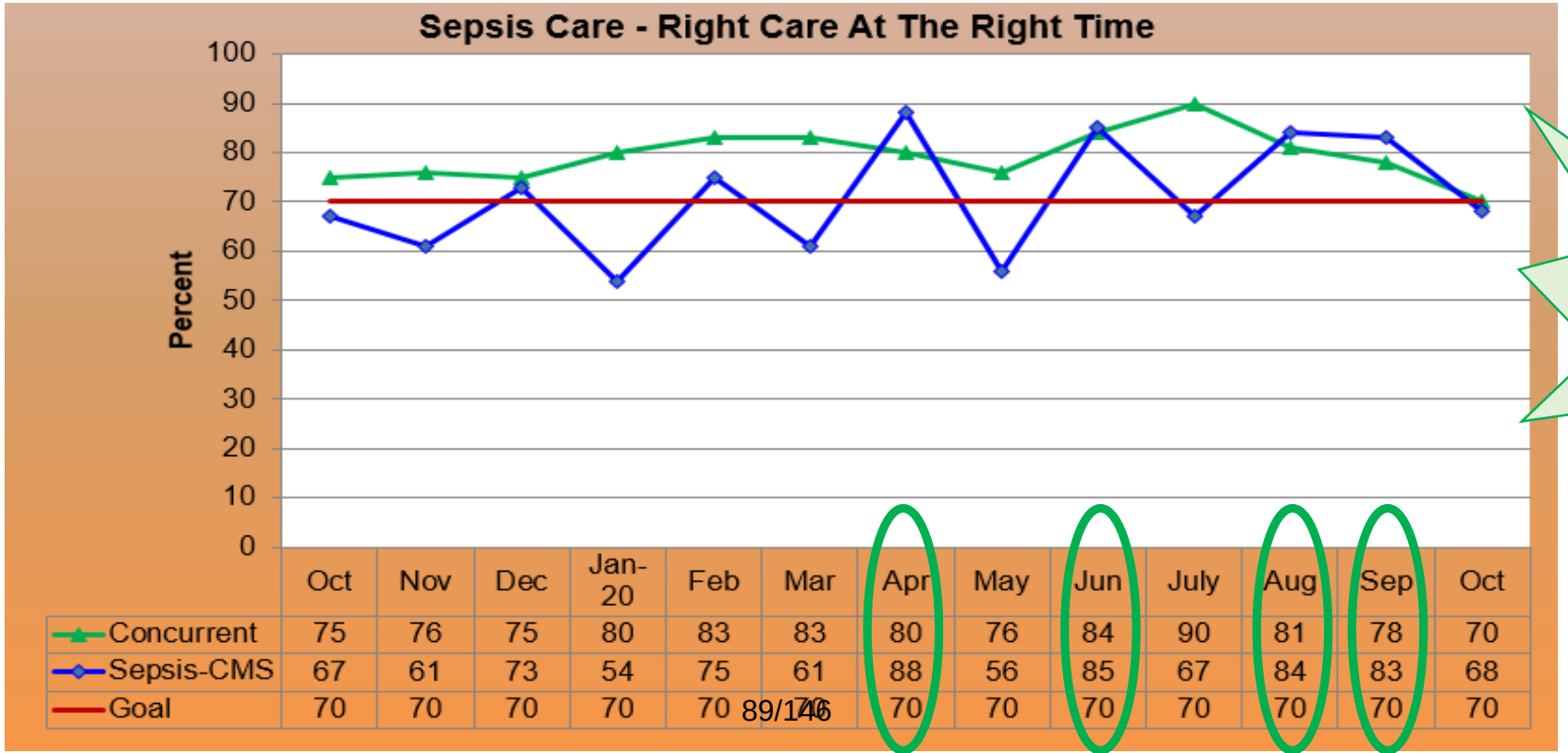
**Dr. Tom Gray, Q&PS Medical Director &**
**Evelyn McEntire, QI Manager**

# SEP-1 Early Management Bundle Compliance

*CA State Compliance 64% ~ National Compliance 60% ~ Top Performing Hospitals 82%*

Percent of patients with sepsis that received "perfect care." Perfect care is the right treatment at the right time.

| | Jul-Oct 2020<br>Higher is Better | FYTD % | FY21 Goal | FY20 | Last 6 Months FY20 |
|---|---|---|---|---|---|
| SEP-1<br>(% Bundle Compliance) | 76% | 76% | ≥ 70% | 67% | 69% |

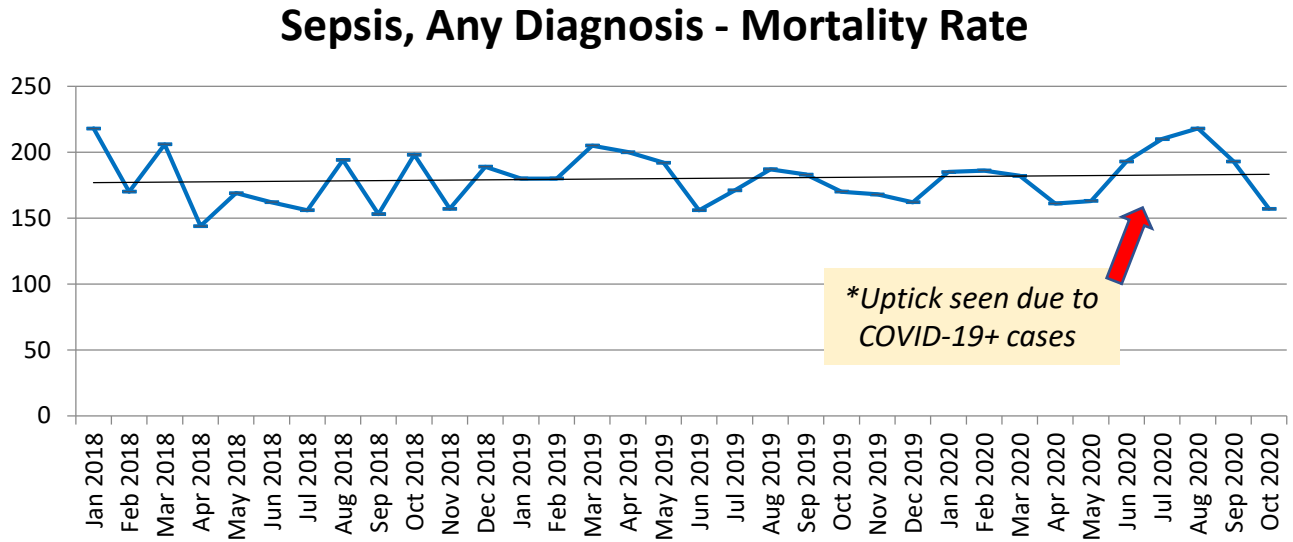


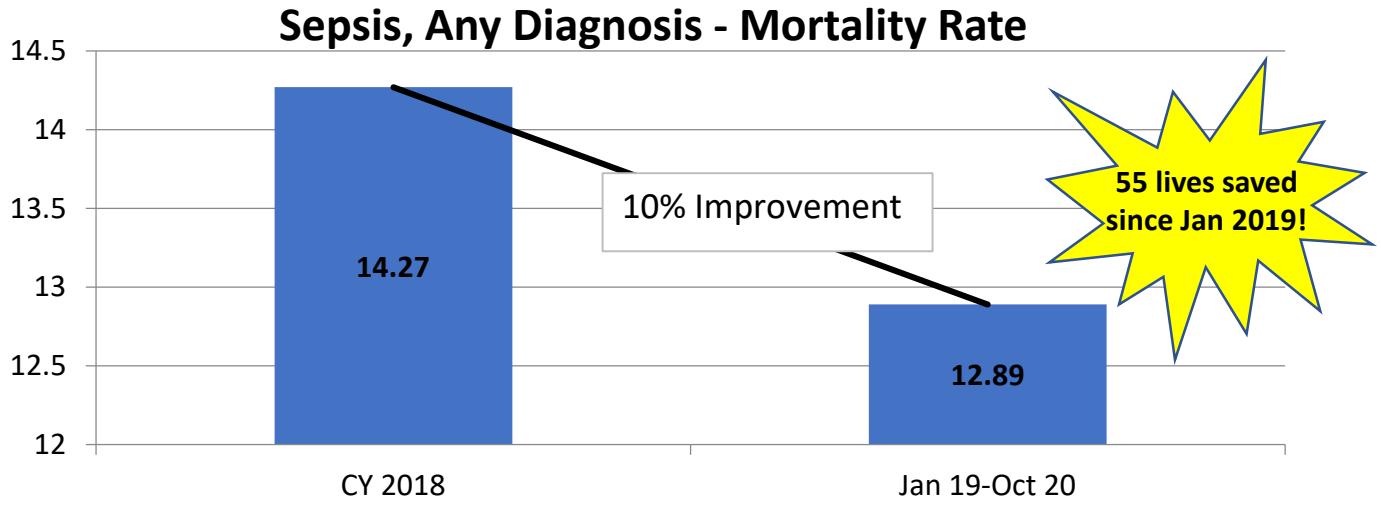

| | Oct | Nov | Dec | Jan-20 | Feb | Mar | Apr | May | Jun | July | Aug | Sep | Oct |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Concurrent | 75 | 76 | 75 | 80 | 83 | 83 | 80 | 76 | 84 | 90 | 81 | 78 | 70 |
| Sepsis-CMS | 67 | 61 | 73 | 54 | 75 | 61 | 88 | 56 | 85 | 67 | 84 | 83 | 68 |
| Goal | 70 | 70 | 70 | 70 | 70 | 70 | 70 | 70 | 70 | 70 | 70 | 70 | 70 |

KDMC is in the **TOP DECILE** in the nation for CMS sepsis bundle compliance for multiple months!

# Reducing Mortality & Saving Lives

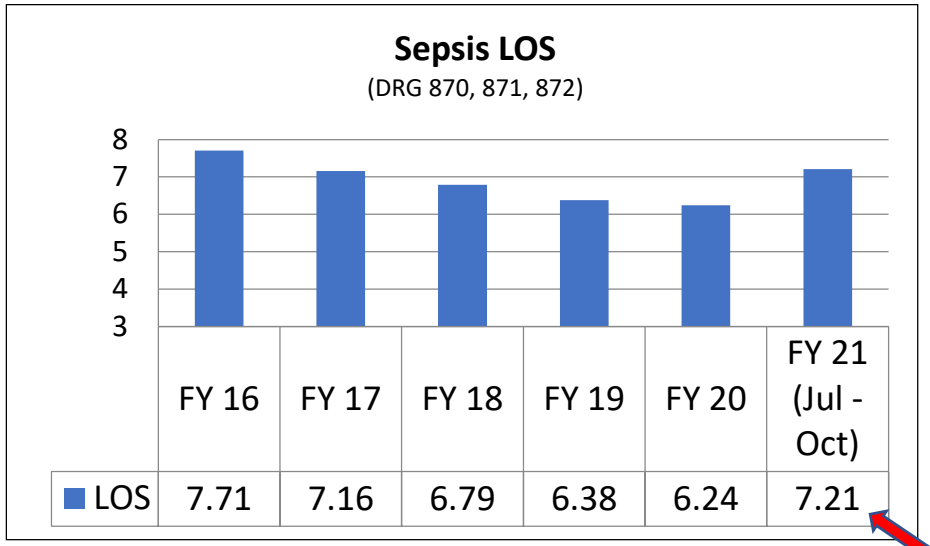
*This data includes COVID-19+ cases; however, CMS bundle data does not.



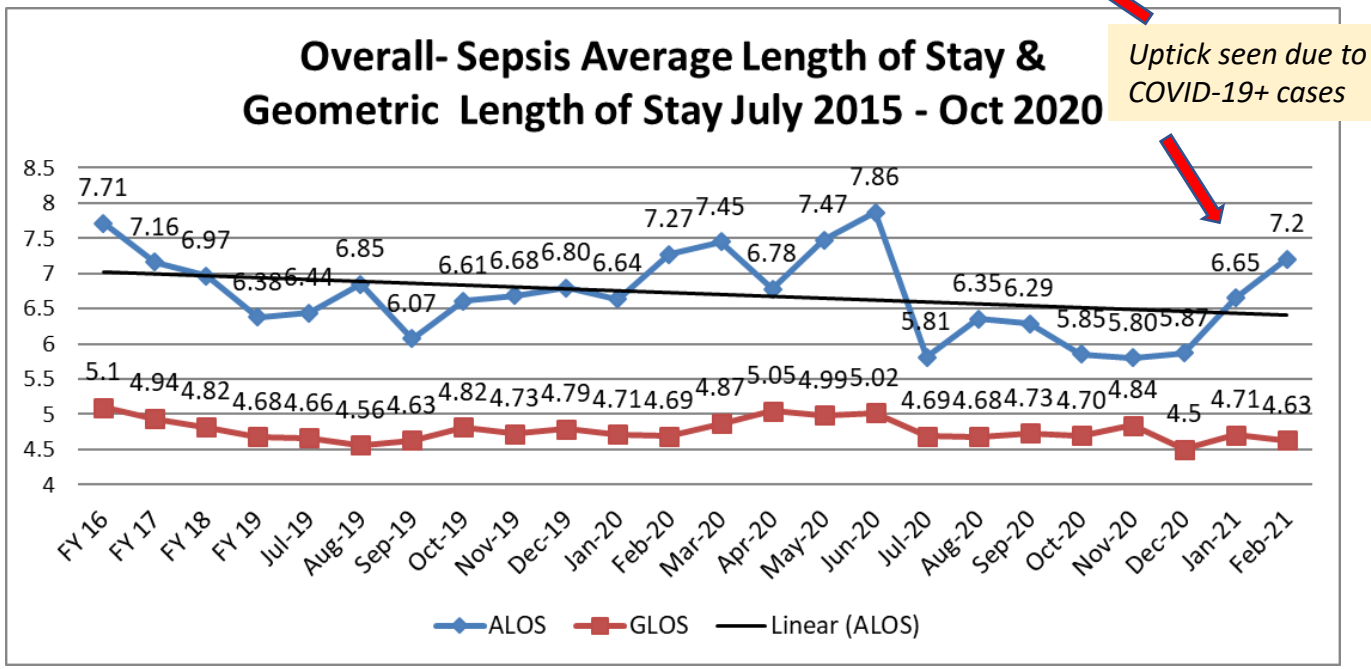



# Sepsis Length of Stay (LOS)

*This data includes COVID-19+ cases; however, CMS bundle data does not.

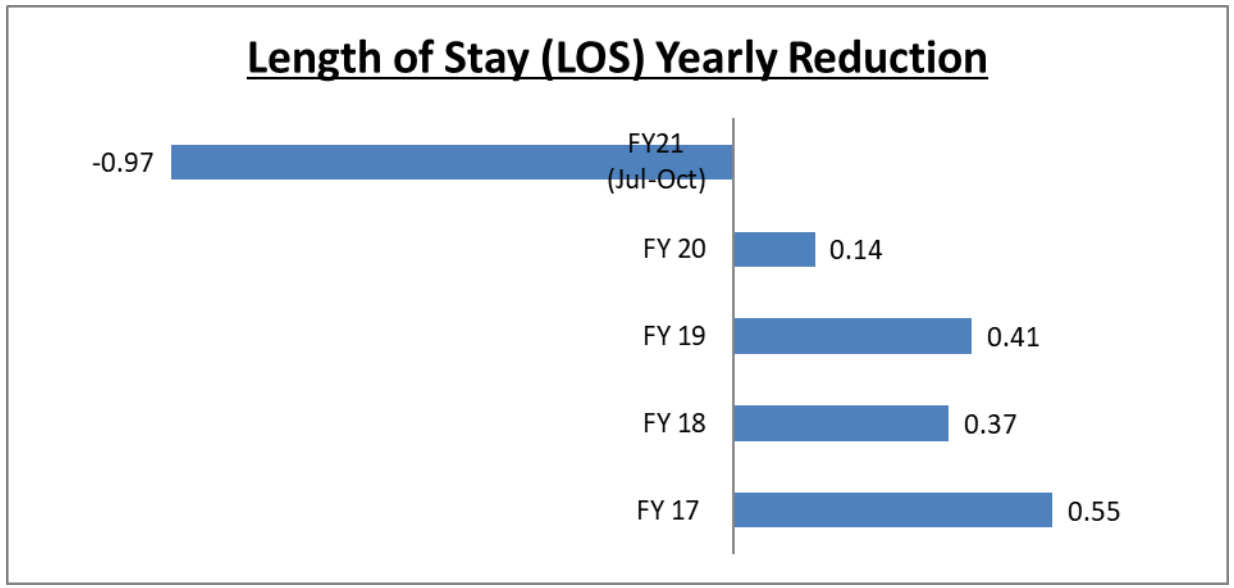


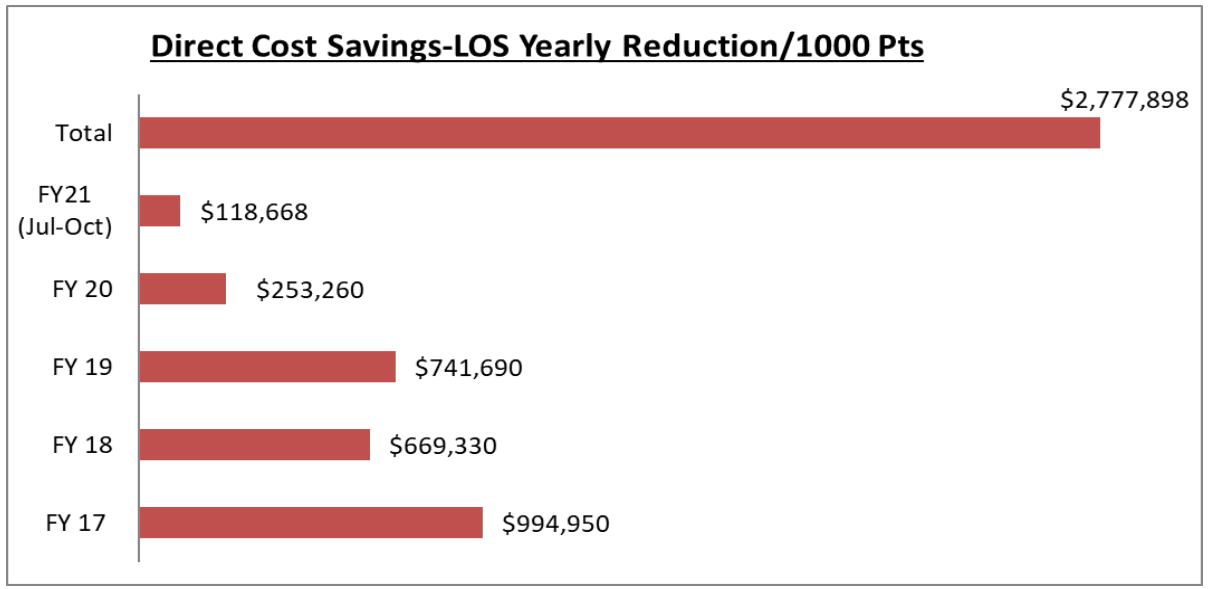

*Uptick seen due to COVID-19+ cases*



# Sepsis LOS Reduction & Savings

*This data includes COVID-19+ cases; however, CMS data does not.

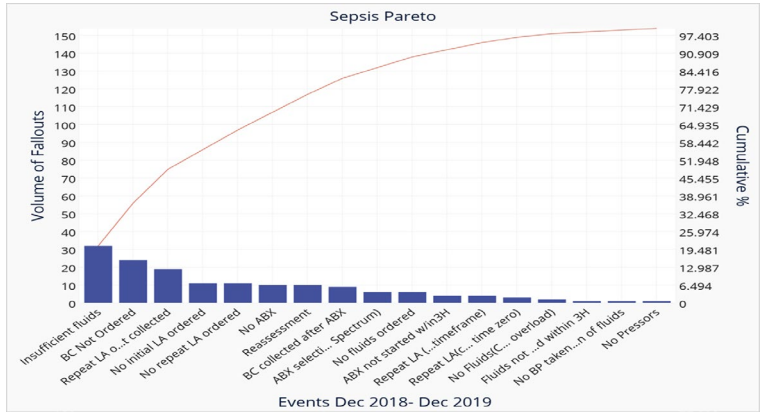



FY20 LOS continued to show a reduction through March; however, we have seen an increase in LOS for septic patients as related to COVID-19 infections from April – July 2020.

# 2020 Sepsis Kaizen Update

## 80/20 Rule




## Top Fallouts

| Fall Out | Total | Cumulative Total | % | Cumulative % |
|---|---|---|---|---|
| Insufficient Fluids | 32 | 32 | 20.78 | 20.78 |
| BC Not Ordered | 24 | 56 | 15.58 | 36.36 |
| Repeat LA Not Collected | 19 | 75 | 12.34 | 48.70 |
| No Initial LA Ordered | 11 | 86 | 7.14 | 55.84 |
| No Repeat LA Ordered | 11 | 97 | 7.14 | 62.99 |
| No Abx | 10 | 107 | 6.49 | 75.47 |
| Reassessment | 10 | 117 | 6.49 | 75.47 |
| BC Collected after Abx | 9 | 126 | 5.84 | 81.82 |

## Prioritized QI Strategies

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ED Pra | 2. ED - Build and utilize SEP-1A "Catch Up" order set so all bundle components can be ordered (not "grayed out") | x | 4.0 | x | 5.0 | x | 5.0 | x | 5.0 | | 500.0 |
| CC/INPT RN | 6. Make form revisions to "provider notification"; provide prompts for critical thinking and order set initiation, and title it differently to eliminate confusion | x | 2.0 | x | 4.0 | x | 4.0 | x | 5.0 | | 160.0 |
| ED Pra & CC/HOS | 11. Build dot phrase - If it's not Sepsis, document it | x | 4 | x | 2 | x | 4 | x | 5 | | 160.0 |
| ED Pra/ ED GME | 9. Schedule ED and GME regular education/awareness of bundle, and order set usage | x | 2 | x | 4 | x | 4 | x | 4 | | 128.0 |
| ED Pra | 1. Improve ED provider notification by Sepsis Coordinator when attempting to avoid fallouts concurrently | x | 4.0 | x | 2.0 | x | 4.0 | x | 3.5 | | 112.0 |
| ED/CC RN | [illegible] about paper last); can checklist be triggered electronically for RN when order set is used? This way checklist is available electronically, and can be available to print anywhere in patients Sepsis hospitalization course regardless of location. Similar to existing workflow with MRI safety form, balancing forms "ad hoc" forms. Ideally it populates, and reminder to complete. | x | 3 | x | 2 | x | 4 | x | 4 | | 96.0 |
| CC/INPT RN | [illegible] form" after sepsis alert fires – alerts suppressed for 48hrs, so RNs do not receive multiple alerts. THIS IS DEPENDENT ON #6 Investigate what happens if you bypass the alert one time it appears very difficult to get it back – Further education/awareness of where to find alert. | x | 4.5 | x | 3.0 | x | 2.0 | x | 3.0 | | 81.0 |
| CC/INPT RN | 10. (Q&P/S) obtain safety summit compliance rates to validate if new staff are getting instructions upon hire of requirements | x | 4 | x | 3 | x | 2 | x | 3 | | 72.0 |
| ED Pra | 16. Reflex alert, when Abx ordered (specific list of Abx) provider gets alert "do you want BC" | x | 4 | x | 4 | x | 4 | x | 1 | | 64.0 |
| ED/CC/ HOS pra | 15. > 126ml/hr option added to ED AND INPATIENT ADULT SEPSIS orders sets | x | 4 | x | 3 | x | 2 | x | 2 | | 48.0 |
| ED RN | 18. Evaluate BC labeling process; set up meeting with ED and Lab and ISS/Bridge to determine if there is a process where the actual time the labs were drawn (via generic label) can be used when "real" label is printed after provider order is obtained | x | 1 | x | 2 | x | 5 | x | 4 | | 40.0 |
| CC/INPT RN | 5. Evaluate Workflow in Cerner/Epsis alerts & notification (long term) (Sepsis Q&P/S team). Potentially alerts can fire to cell phones. | x | 1.0 | x | 2.0 | x | 4.0 | x | 4.0 | | 32.0 |
| ED/CC/ HOS Pra | 19. Add to ED AND INPATIENT order set Reflex LA order when previous LA >2 | x | 2 | x | 4 | x | 4 | x | 1 | | 32.0 |
| CC/HOS Pra | 3. Admit to CC/SW Orders: Short list of orders... if this not done... for each piece of bundle, this is like a continuation of initial sepsis orders or active "hold" orders to keep the ball rolling. | x | 1.5 | x | 4.0 | x | 1.0 | x | 3.5 | | 21.0 |
| ED/CC/ HOS Pra | 17. Dot phrase for when Abx are urgent and BC cannot be drawn beforehand, so provider documentation is in EMR (...sepsisbc) | x | 4 | x | 3 | x | 1 | x | 1 | | 12.0 |
| CC/INPT RN | 8. Evaluate what clin Ed provider to new RNs about sepsis alerts and how to respond? Ideally hands on training upon hire, look at alerted patient and walk through documentation. | x | 1 | x | 4 | x | 2 | x | 1 | | 8.0 |
| CC/HOS Pra | 22. Standardized documentation of attending reassessment (Dr. Malli's phrase) | x | 3 | x | 2 | x | 1 | x | 1 | | 6.0 |
| ED RN | 13. ED Tech input height and weight in EMR; RN input for BIBA patients HOLD dependent on #14 | x | 2 | x | 1 | x | 1 | x | 1 | | 2.0 |
| ED RN | 14. IBW automated in fluid order when height and weight are documented | x | 2 | x | 1 | x | 1 | x | 1 | | 2.0 |
| CC/INPT RN | 4. Evaluate criteria of firing an alert (Q&P/S team) | x | 1.0 | x | 1.0 | x | 1.0 | x | 1.0 | | 1.0 |

- ✓ Over 20 QI strategies identified
  - Eight (8) strategies have been completed and implemented
  - Eight (8) strategies are in development and nearing completion – **On hold due to COVID-19 surge**
    - Mandatory RN Education - New Hire and Annual
    - Provider Notification Form
    - Antibiotic reflex alert – 'Do you want blood cultures?'
  - Five (5) strategies in parking lot
- ✓ **CMS compliance is in the top decile for 4 of the last 6 months!**
- ✓ Second Sepsis Coordinator joined team in May 2020 (7 days/week coverage)

# 2020 Sepsis Summary & Actions

## Summary

Successes as a result of Kaizen work:

- Improved CMS bundle compliance leading to top decile performance in the nation
- Improved provider documentation and use of sepsis order sets
- Improved sepsis 3-hour bundle compliance (lactate management, blood culture orders, antibiotic administration)
- Improved sepsis 6-hour bundle compliance (repeat lactic acid lab, fluid resuscitation, and reassessment by provider)

## 2021 Actions

Continued work by Kaizen group *(Progress will continue with these strategies as team is able due to the impacts of the COVID-19 surge):*

- Increased use of sepsis order sets
- Administer IV fluid resuscitation within expected timeframe
- Ongoing sepsis education to nursing, providers, and GME residents
- Nursing documentation – Mandatory Provider Notification form *to be completed following COVID-19 surge*
- Antibiotic reflex order currently on hold until COVID vaccine distribution and tracking build is complete

## SEP-1 Measure Change (effective January 1, 2021)

NEW EXCLUSION: Hypotensive readings (SBP < 90 and MAP < 65) obtained during dialysis procedures will no longer be used to define initial hypotension, persistent hypotension, or septic shock

## Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

**Unit/Department:** CAUTI QFT **ProStaff/QIC Report Date:** 10/13/2020

**Measure Objective/Goal:**

- Goal for FY21 ≤ 0.727 (CMS 50th percentile); Current SIR = 0.98, however for the last 6 months SIR trends at 0.85. Pre KAIZEN baseline SIR is 1.557
- Estimated annual number not to exceed to achieve goal= 13. Current actual number of CAUTI = 3

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 (7/2019 – 7/2020)

**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 | Apr-20 | May-20 | Jun-20 | Jul-20 |
|---|---|---|---|---|---|---|
| **OUTCOME MEASURES** | | | | | | |
| Number of CAUTI | 0 | 0 | 1 | 3 | 1 | 3 |
| Quarterly SIR (all payor) | ≤ 0.838 | 0.52 | | | 1.02 | |
| FYTD SIR (all payor) BASELINE (FY19) =1.557 | ≤ 0.838 | 0.96 | 0.93 | 1.09 | 1.03 | |
| **PROCESS MEASURES** | | | | | | |
| **IUC Shift Huddles** | | | | | | |
| % Huddles Accurately Completed | 100% | 74% | 89% | 93% | 88% | 92% |
| % insertion missed (removed in July) | 0% | 19% | 40% | 46% | 50% | |
| % cleanliness missed | 0% | 81% | 60% | 54% | 50% | |
| **IUC Gemba Rounds** | | | | | | |
| % of pts with appropriate cleanliness | 100% | 98% | 99% | 98% | 95% | 97% |
| % of IUCs with order & valid rationale | 100% | 90% | 93% | 92% | 93% | 92% |
| % of IUCs where removal was attempted | n/a | 8% | 5% | 6% | 7% | 0% |
| % of pts where alternatives have been attempted | n/a | 15% | 12% | 12% | 10% | 8% |
| # of Pt Catheter days rounded on | n/a | 616 | 720 | 948 | 877 | 1037 |
| % of IUCs removed because of Gemba Round | n/a | 7% | 6% | 3% | 4% | 2% |
| # of IUCs removed because of Gemba Round | n/a | 46 | 42 | 33 | 35 | 22 |

Total catheter days rounded on = 4198

97% of patients with daily bath and peri-care per shift

92% have order and valid rationale

178 catheters removed as a result of the Gemba

Opportunities:

- Appropriate indications for IUC, using alternatives to IUC
- Continued order optimization for ease of use
- Learning from Fallouts

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

***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

| CAUTI QI Strategy | When? |
|---|---|
| 1. Embed IUC insert power plan in existing Powerplans where the insert IUC order exists | 02/2021 |
| 2. Place all IUC order resources on eCoach | 11/2020 |
| 3. Develop Urine Culture only powerplan to replace single orderable. | 11/2020 |
| 4. Create change IUC task at 30 days following documented insertion of IUC | 11/2020 |
| 5. Hide single Insert IUC orderable for downtown campus and Rehab | 12/2020 |
| 6. Evaluate workflow for POA IUC, consider Powerplan | 12/2020 |
| 7. CAUTI Case Reviews Lessons Learned | On-going |
| 8. Evaluate reasons for IUC insertion orders | On-going |
| 9. Safety Summit (CAUTI education for new hires) relaunch post-COVID | pending |
| 10. Rapid Cycle Post Gemba Rounds | 10/2020 |
| 11. Bathing Prioritization (in collaboration with CLABSI Committee) | 11/2020 |
| 12. Add 'restricted use' to the urine culture only orderable | 7/28/20 |
| 13. 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 | 8/25/20 |
| 14. Develop provider update/education related to current CAUTI status and how to order IUC/Culturing awareness | 9/29/20 |
| 15. Changes to discontinue IUC orderable- alerts RN to dc the insert IUC Powerplan and related maintain order | 8/25/20 |
| 16. Develop orders for Adult Urinary Retention management | 9/29/20 |

**Next Steps/Recommendations/Outcomes:**

A. Continue to maintain Kaizen initiatives: Daily IUC Gemba rounds, IUC NOC shift huddles
B. Continue to monitor CAUTI events, effective 10/2020 events are reviewed with unit leadership at the HAI review meeting, unit leadership to create quality improvement plan and implement at the unit level. The QFT monitors those QI opportunities for global implementation
C. Continued order optimization

**Submitted by Name:** Kari Knudsen **Date Submitted:** 10/12/2020

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

# Clinical Quality Goal Update
# January 2021

# FY 21 Clinical Quality Goals

| | Jul-Oct 2020 Higher is Better | FYTD % | FY21 Goal | FY20 | Last 6 FY20 |
|---|---|---|---|---|---|
| SEP-1 (% Bundle Compliance) | 76% | 76% | ≥ 70% | 67% | 69% |

**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**

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.

| Lower is Better | July 2020 | Aug 2020 | Sept 2020 | Oct 2020 | Nov 2020 | Dec 2020 | Estimated Annual Number Not to Exceed to Achieve Goal* | FYTD SIR** (number of actual divided by number expected) | FY21 Goal | FY20 |
|---|---|---|---|---|---|---|---|---|---|---|
| CAUTI Catheter Associated Urinary Tract Infection | 3 | 0 | 1 | 0 | 1 | 2 | 13 | 0.78 | ≤0.727 | 1.12 |
| CLABSI Central Line Associated Blood Stream Infection | 2 | 1 | 2 | 0 | 1 | 2 | 9 | 1.18 | ≤0.633 | 1.2 |
| MRSA Methicillin-Resistant Staphylococcus Aureus | 2 | 2 | 1 | 0 | 0 | 1 | 5-6 | 0.82 | ≤0.748 | 1.02 |

*based on FY20 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 2021

| Indicator | Action Plan |
|---|---|
| Sepsis | • Continued patient evaluation and care coordination by Sepsis Coordinators 7 days/week; in the moment education and identification of QI strategies and trend identification through Quality Focus Team data abstraction & analysis<br>Completion of remaining QI strategies from six sigma work:<br>• Enhanced sepsis alert worksheet for RN alert evaluation<br>• Mandatory provider notification of sepsis alerts<br>• Relaunch of required new hire and annual education |
| CAUTI | • Continued focus on best practice bundle application through am & pm Gembas<br>• Continued monitoring and dissemination of events, lessons learned, near misses and dashboard monthly; QI work through QFT on bundle components that have not reached goal; progressive improvement achieved in bundle elements in 2020<br>• EMR automation; alerts, workflow enhancements, & orders<br>• Relaunch of new hire education (2Q21) |

# Key Strategies 2021

| Indicator | Action Plan |
|---|---|
| CLABSI | • Continued focus on best practice bundle application through am & pm Gembas<br>• Monitoring and dissemination of events, lessons learned, near misses and dashboard monthly; QI work through QFT on bundle components that have not reached goal<br>• Relaunch of new hire education (2Q21)<br>OPERATION STOMP OUT CLABSI FEBRUARY 2021:<br>• Develop a process in which central line intravenous access is gradually downgraded to different forms of peripheral access.<br>• Encourage peripheral access over central intravenous access when feasible.<br>• Implementing strategies using technology to guide evidence-based decisions and actions.<br>• Determine the scope of activities to the “culture-of-culturing”.<br>• Develop interventions that hone ordering practices for cultures to when they are indicated.<br>• Establish a process for a “thoughtful pause” to determine the purpose for specimen culture prior to order.<br>• Development of an expert team for vascular access and line maintenance |
| MRSA | • Biovigil; Consistent use and hand hygiene compliance >95% goal<br>  • System integrated into HR system (starts Feb 2021), so user tracking can be established<br>• Evaluating the decolonization of patients upon admission<br>• CHG Bathing in med/surg locations (part of universal decolonization)<br>• Continue disseminating lessons learned & oral care program |

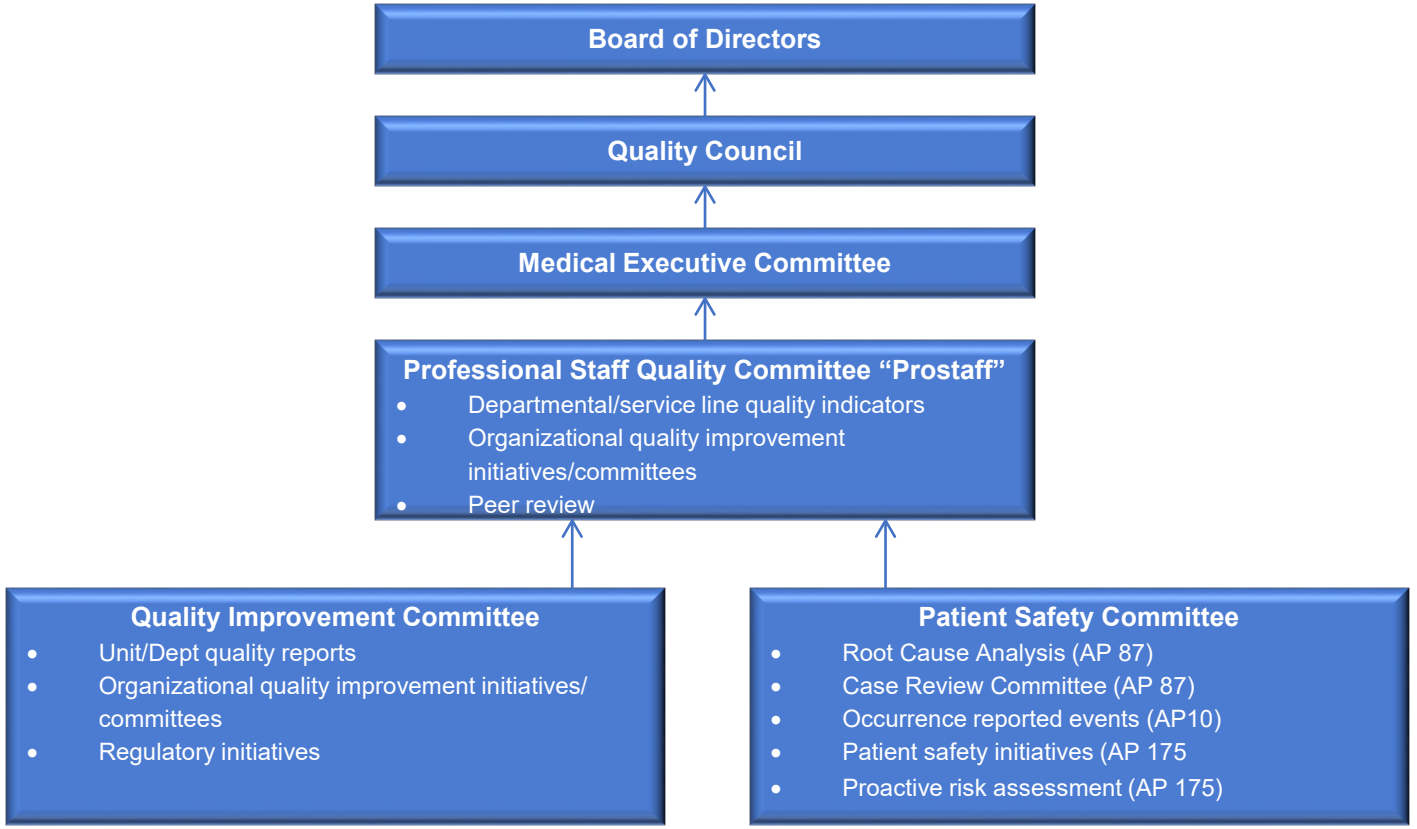
# Questions?

# Quality and Patient Safety Plan Annual Review 2020

## Quality Council January 2021

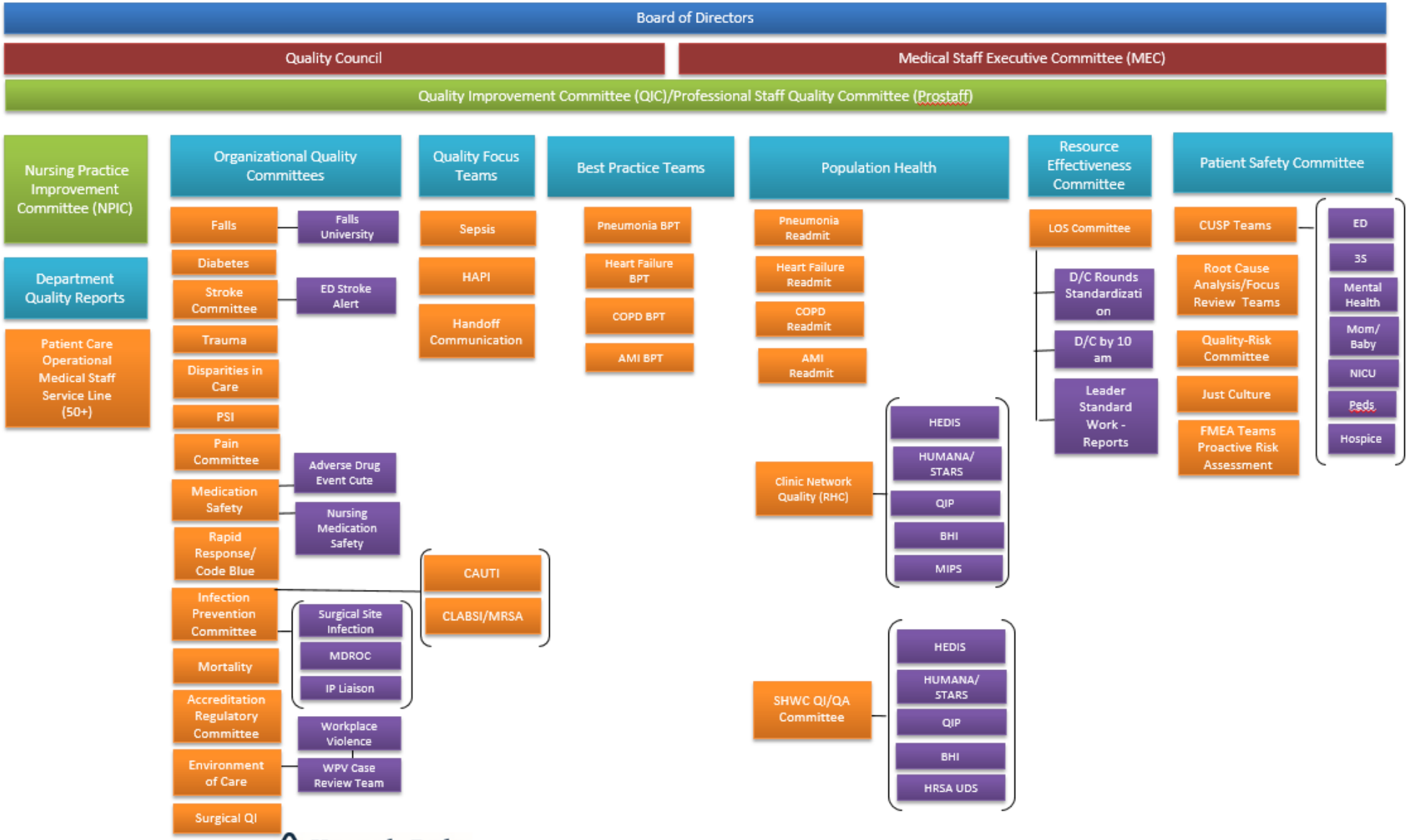
# OUTSTANDING HEALTH OUTCOMES

## Quality Improvement Committee Structure 2020/21
## Quality Improvement & Patient Safety Plan



# OUTSTANDING HEALTH OUTCOMES

## Quality Improvement Committees/Teams 2020-21




Kaweah Delta Clinical Quality Improvement Committees & Teams 2020/21 (Reporting structure noted in QIC/Prostaff schedules)

# OUTSTANDING HEALTH OUTCOMES

*Core Measures - CY 2020 data*

## 2020 Achievements

### *CMS Core Measures – Immunization / VTE / Sepsis*

- Outperforming in all 3 metrics
- Zero → Hospital-acquired VTEs
- Second Sepsis Coordinator position added
- Sepsis outperforming CMS national and KD internal benchmarks for 4 of the last 6 months
- Performing in the top decile in the nation for sepsis bundle at least 4 months in 2020

### *HBIPS*

- Newly implemented template for admission screening successful – Outperformed 6 months in the last year
- Outperforming in 9 of 16 measures

### *Perinatal Care*

- Outperforming in 2 of 3 measures

## 2021 Areas of Focus

### *CMS Core Measures – Sepsis*

- Complete the few remaining QI strategies identified during 2020 Sepsis Six Sigma project (ie. mandatory notification of sepsis alert)
- Continue to outperform national and internal benchmarks

### *HBIPS*

- HBIPS 5a - Resident QI project initiated to identify potential gaps and develop process improvements to standardize prescription of multiple anti-psychotic medications at discharge

### *Perinatal Care*

- PCM 2a – Physician QI project initiated to identify potential gaps and develop process improvements to reduce Overall C-Section Rate

# OUTSTANDING HEALTH OUTCOMES

## *Value-Based Purchasing*

*CY 2019 data*

| | Total Performance Score | Base Operating DRG Amount Reduction | Value-Base Incentive Payment % |
|---|---|---|---|
| FY 2021 Payment (CY 2019 Data) | 28.3 Improved from 26.4 last year | 2% Same as last year | 1.5% Improved from 1.48% last year |

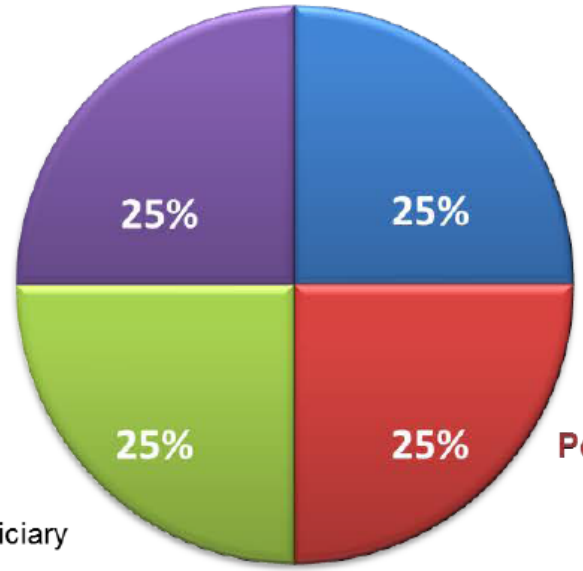
### Safety

1. **CDI**: Clostridium difficile Infection
2. **CAUTI**: Catheter-Associated Urinary Tract Infection
3. **CLABSI**: Central Line-Associated Bloodstream Infection
4. **MRSA**: Methicillin-Resistant *Staphylococcus aureus* Bacteremia
5. **SSI**: Surgical Site Infection Colon Surgery & Abdominal Hysterectomy
6. **PC-01**: Elective Delivery Prior to 39 Completed Weeks Gestation

### Efficiency and Cost Reduction

1. **MSPB**: Medicare Spending per Beneficiary

### Domain Weights




### Clinical Care

1. **MORT-30-AMI**: Acute Myocardial Infarction (AMI) 30-Day Mortality Rate
2. **MORT-30-HF**: Heart Failure (HF) 30-Day Mortality Rate
3. **MORT-30-PN**: Pneumonia (PN) 30-Day Mortality Rate
4. **THA/TKA**: Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Complication Rate

### Person and Community Engagement

**HCAHPS Survey Dimensions**

1. Communication with Nurses
2. Communication with Doctors
3. Responsiveness of Hospital Staff
4. Communication about Medicines
5. Cleanliness and Quietness of Hospital Environment
6. Discharge Information
7. Care Transition
8. Overall Rating of Hospital

# OUTSTANDING HEALTH OUTCOMES

*Value-Based Purchasing (VBP)* *CY 2019 data*

## Actual Points & Costs

| Domains | FY 2021 (Points out of 10 Possible) |
|---|---|
| **Clinical Outcomes - Domain Score (% of all points possible for this 25% of VBP)** | **48%** |
| Acute Myocardial Infarction | 7 |
| Heart Failure | 4 |
| Pneumonia* | 3 |
| COPD | 3 |
| Complication elective Total Hip/Knee | 7 |
| **Safety - Healthcare Associated infections - Domain Score (% of all points possible for this 25% of VBP)** | **38%** |
| CLABSI - Per 1000 line days* | 0 |
| CAUTI - Per 1000 catheter days* | 0 |
| SSI Surgical Site Infection | 5 |
| SSI Colon - Rate Per 100 procedures | 5 |
| C. difficile - Per 10,000 patient days | 7 |
| MRSA - Per 10,000 patient days | 2 |
| **Person and Community Engagement - Domain Score (% of all points possible for this 25% of VBP)** | **15%**** |
| Communication with Nurses | 0 |
| Communication with Doctors | 0 |
| Responsiveness of Hospital Staff | 1 |
| Communication about Medicines* | 0 |
| Cleanliness of Hospital Environment | 0 |
| Quietness of Hospital Environment* | 0 |
| Discharge Information | 0 |
| Care Transition | 0 |
| Overall Rating of Hospital* | 0 |
| **Efficiency and Cost Reduction-Domain Score (% of all points possible for this 25% of VBP)** | **20%** |
| **Medicare Spending per Beneficiary** | 2 |

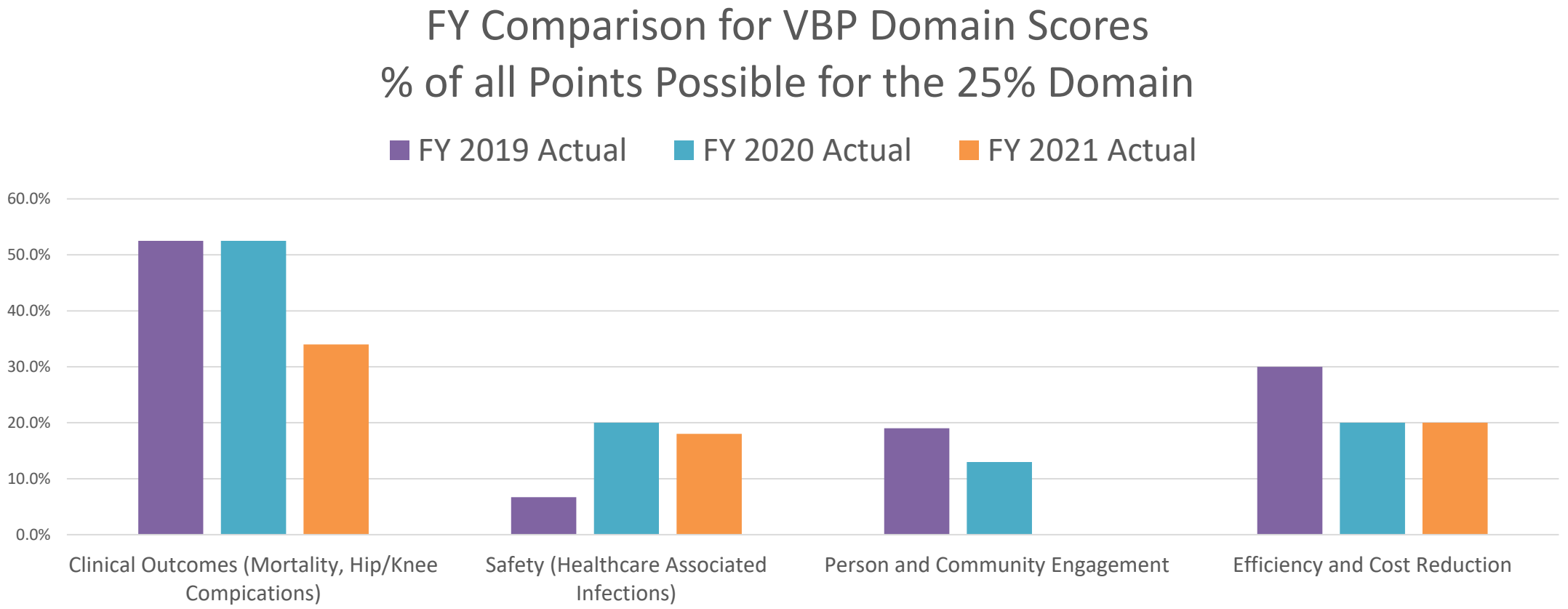
*Largest opportunity for Improvement
**Consistency Score

| FY 2021 VBP Cost Analysis | |
|---|---|
| KDHCD Contribution | Performance-Based Payment |
| 2% = $1,889,800 | 1.5% = $1,420,300 |
| ($469,500) | |

Note: Points are received for sustained top performance OR for improvement, up to 10 points each; CMS applies the higher point category to the VBP cost calculation (i.e.: If a hospital earns 0 achievement points and 5 improvement points CMS uses the 5 improvement points in the cost calculation.)

# OUTSTANDING HEALTH OUTCOMES

*Value-Based Purchasing (VBP)* *CY 2019 data*

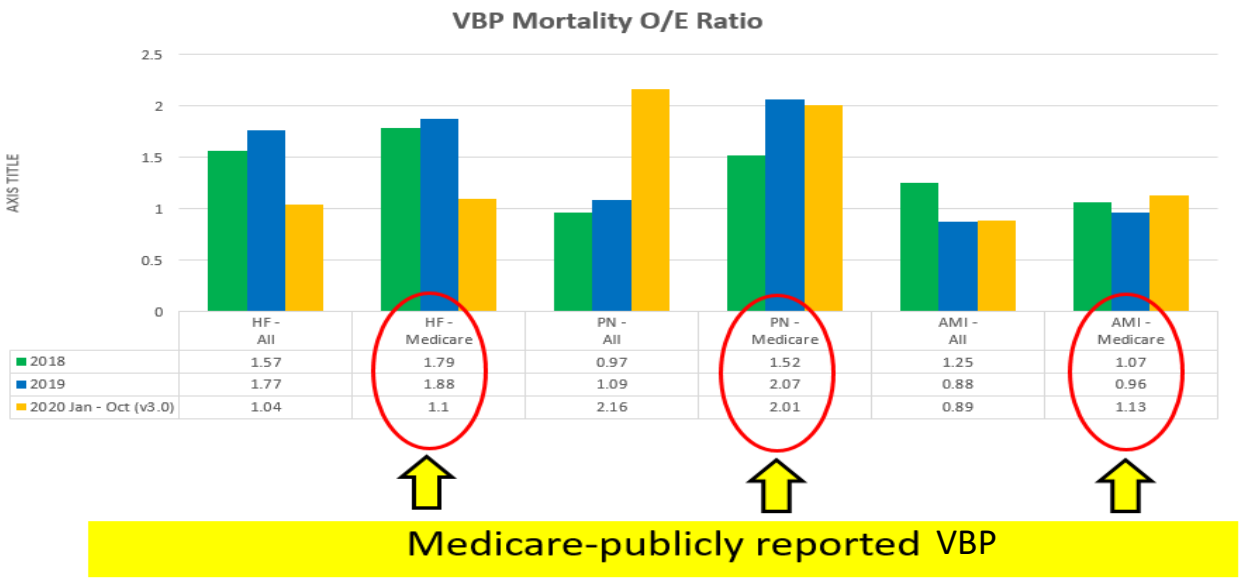



Note: Points are received for sustained top performance OR for improvement, up to 10 points each; CMS applies the higher point category to the VBP cost calculation (i.e.: If a hospital earns 0 achievement points and 5 improvement points CMS uses the 5 improvement points in the cost calculation.)

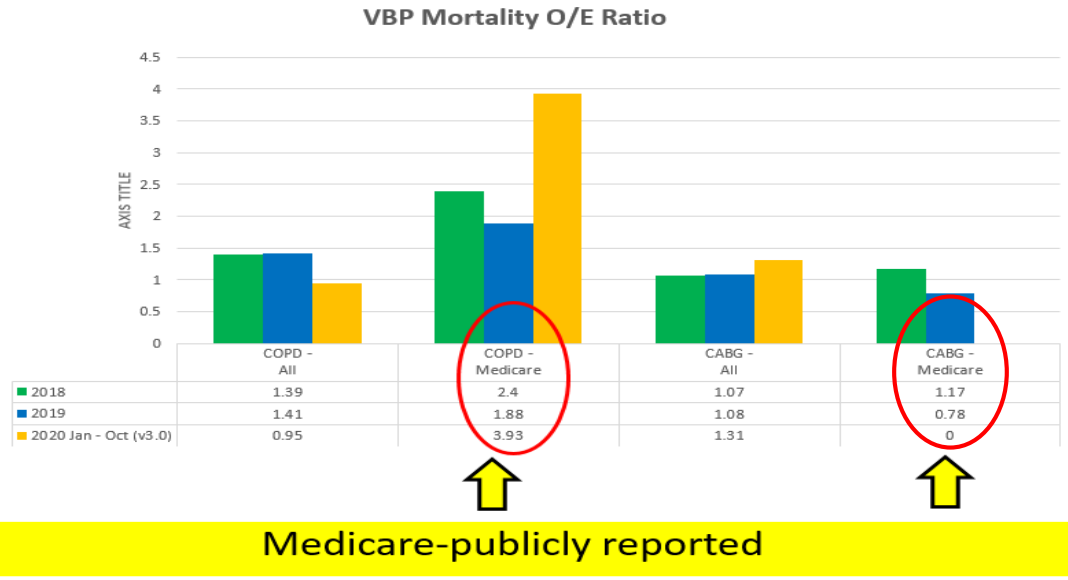
# OUTSTANDING HEALTH OUTCOMES

## *KDHCD Mortality – Value-Based Purchasing*

*CY 2019 data*




Medicare-publicly reported VBP




Medicare-publicly reported

### 2021 VBP Achievements

- Improved performance in SSI, MRSA, HF/PN mortalities, and Hip/Knee complications
- *Total Performance Score* improved from 2020: 26.4 to 2021: 28.3
- Biovigil implementation for all inpatient units

### 2021 Mortality Achievements

- Performing 'same as' nationally in HF, PN, AMI, COPD, and CABG
- Restructured Mortality Review Committee to focus on greatest opportunity which is earlier Palliative Care
- Tulare Co. Public Guardian and Mortality Committee successfully developed and implemented a screening tool for conserved patients to identify goals of care and end-of-life decision-making

### 2021 VBP Areas of Focus

- AM Gemba rounds and PM Post Gemba rounds continue for CAUTI/CLABSI
- Bathing prioritization and central line dressing changes standardization and implementation on all units
- 'Operation Always' & Increased Leadership Rounding in Inpatient and Outpatient areas

### 2021 Mortality Areas of Focus

- Expand Palliative Care services at KDHCD and within community
- Increase in community referrals to KD Hospice Program
- Diagnosis-specific teams (HF, PN, AMI, COPD) for best practices

# OUTSTANDING HEALTH OUTCOMES

## *KDHCD Patient Safety Indicators (PSI)*

*CY 2020 data*

### 2020 Achievements

- PSI 3 - Hospital-Acquired Pressure Injuries
  - Nov 2020 - Kaizen conducted where root causes of HAPIs were identified and prioritized by key stakeholders
- PSI 4 – Death Rate among surgical Inpatients with Serious Treatable Conditions
  - Detailed analysis of 2020 cases conducted which revealed no concerning trends/system issues at this time
  - Downward trend noted from early 2018 through mid 2020 until COVID-19
  - Improvements in performance seen in the last 4 months; Nearing national benchmark
- PSI 5 – Retained Surgical Item
  - Zero cases in 2020
- Re-implementation of Surgical Quality Improvement Program (SQIP) post COVID-19 to provide additional oversight and input of surgical PSI performance

### 2021 Areas of Focus

- PSI 3 – Hospital-Acquired Pressure Injuries
  - QFT to identify and implement improvement strategies for top 4 priority opportunities resulting from Kaizen
- PSI 9 – Perioperative hemorrhage
  - Detailed analysis of 2020 cases conducted which revealed no concerning trends/system issues at this time; Continue to monitor in collaboration with SQIP
- PSI 10 – Postoperative kidney injury
  - QI project to be conducted by Surgery Medical Director to identify pre-operative opportunities for surgical patients with known decreased kidney function
- Continue interdisciplinary proactive case review to reflect accurate coding and documentation of clinical care; monitoring of 13 PSIs

# OUTSTANDING HEALTH OUTCOMES

## *2020 CMS Star Report*

*Various data – CY 2016 - 2019*

- Star rating measures include:
  - *Mortality* – Same as National Average
  - *Patient Safety* (ie: infection prevention, PSIs, HACs.) – Same as National Average (decreased)
  - *Readmission* – Same as National Average (increased)
  - *Patient Experience* – Below National Average
  - *Effectiveness of care* (ie: proper discharge medications, early elective delivery) – Same as National Average
  - *Timeliness of care* (ie: throughput) – Below National Average
  - *Effective use of medical imaging* – Same as National Average

- Various performance periods included from 2016 to 2019; ratings are 1-5 stars

- Beginning in CY 2021, CMS is simplifying methodology; standardizing the calculation of scores; begin to use averages of measure scores with equal weightings; and updating the reporting thresholds and peer grouping. Critical-access and VA hospitals will now be included in Overall Ratings.

# OUTSTANDING HEALTH OUTCOMES

*Actions to Improve VBP and Star Rating 2021*

| Measures | Strategy |
|---|---|
| Mortality | • Establish best practice teams 4/1/21 for AMI (non-STEMI, COPD, HF & Pneumonia and select best practice guideline.<br>• Identification of key performance indicators (KPIs), dashboard development & initial QI work on KPIs<br>• Development of care pathways |
| Readmissions | • Readmission teams for AMI (non-STEMI), COPD, HF & Pneumonia<br>• COPD and HF established in 2020, Prioritized and staggered in 2021 |
| Patient Experience | • Leader rounding<br>• Operation always |
| Healthcare Acquired Infections (HAIs) | • Continue with heightened focus through Quality Focus Teams<br>• Provider focused task force to address:<br>  • Culture of culturing<br>  • Vascular access team |
| Timeliness of Care (throughput) | • LOS Committee – 3 task forces: Discharge rounds; discharge by 10 am, and leadership standard work (report-based action at the unit-level) |

# OUTSTANDING HEALTH OUTCOMES

## *Healthgrades*

Healthgrades Methodology

- Ratings based on 3 years of Medicare claims data (2017 – 2020)
- Measures risk-adjusted mortality (inpatient and 30 day) or surgical complications in 30 different diagnoses or procedures
- Star ratings are presented as:
  - “better” – 5 stars (top 15%)
  - “as expected” – 3 stars (middle 70%)
  - “worse” – 1 star (bottom 15%)

# 2021 Specialty Excellence Awards

## Kaweah Delta Medical Center


Top 5% in the Nation
**4** years in a row
(2017 – 2021)


Top 5% in the Nation
**2** years in a row
(2020 – 2021)


Top 5% in the Nation
**3** years in a row
(2019 – 2021)


Top 5% in the Nation
**8** years in a row
(2014 – 2021)


Top 5% in the Nation
**2** years in a row
(2020 – 2021)

# OUTSTANDING HEALTH OUTCOMES

*Healthgrades Achievements*

## 2021 Quality Awards & Achievements – KDMC

| |
|---|
| **Hospital Wide** |
| Recipient of Healthgrades® 'America's 250 Best Hospitals' Award™ for 3 Years in a Row (2019-2021) |
| **Best Specialty** |
| One of Healthgrades America's 50 Best Hospitals for Cardiac Surgery™ for 4 Years in a Row (2018-2021) |
| One of Healthgrades America's 100 Best Hospitals for Stroke Care™ in 2021 |
| One of Healthgrades America's 100 Best Hospitals for Pulmonary Care™ in 2021 |
| One of Healthgrades America's 100 Best Hospitals for Critical Care™ in 2021 |
| **Cardiac** |
| Recipient of the Healthgrades Cardiac Surgery Excellence Award™ for 5 Years in a Row (2017-2021) |
| Named Among the Top 5% in the Nation for Cardiac Surgery for 4 Years in a Row (2018-2021) |
| Named Among the Top 10% in the Nation for Cardiac Surgery for 5 Years in a Row (2017-2021) |
| Five-Star Recipient for Coronary Bypass Surgery for 5 Years in a Row (2017-2021) |
| Five-Star Recipient for Valve Surgery in 2021 |
| Five-Star Recipient for Treatment of Heart Failure in 2021 |

# OUTSTANDING HEALTH OUTCOMES

## *Healthgrades Achievements*

**Neurosciences**

Recipient of the Healthgrades Neurosciences Excellence Award™ for 2 Years in a Row (2020-2021)

Recipient of the Healthgrades Stroke Care Excellence Award™ for 3 Years in a Row (2019-2021)

Named Among the Top 5% in the Nation for Treatment of Stroke for 3 Years in a Row (2019-2021)

Named Among the Top 10% in the Nation for Neurosciences for 2 Years in a Row (2020-2021)

Named Among the Top 10% in the Nation for Treatment of Stroke for 3 Years in a Row (2019-2021)

Five-Star Recipient for Treatment of Stroke for 7 Years in a Row (2015-2021)

**Pulmonary**

Recipient of the Healthgrades Pulmonary Care Excellence Award™ for 8 Years in a Row (2014-2021)

Named Among the Top 5% in the Nation for Overall Pulmonary Services in 2021

Named Among the Top 10% in the Nation for Overall Pulmonary Services for 8 Years in a Row (2014-2021)

Five-Star Recipient for Treatment of Chronic Obstructive Pulmonary Disease in 2021

Five-Star Recipient for Treatment of Pneumonia for 8 Years in a Row (2014-2021)

**Gastrointestinal**

Five-Star Recipient for Gallbladder Removal Surgery in 2021

**Critical Care**

Recipient of the Healthgrades Critical Care Excellence Award™ for 2 Years in a Row (2020-2021)

Named Among the Top 5% in the Nation for Critical Care in 2021

Named Among the Top 10% in the Nation for Critical Care for 2 Years in a Row (2020-2021)

Five-Star Recipient for Treatment of Sepsis for 9 Years in a Row (2013-2021)

Five-Star Recipient for Treatment of Respiratory Failure for 3 Years in a Row (2019-2021)

# OUTSTANDING HEALTH OUTCOMES

## Leapfrog Hospital Safety Score Dec 2020

KDHCD Hospital Safety Score Dec 2020 = 2.9833

| Date | Grade |
|---|---|
| Dec 2020 | B |
| May 2020 | C |
| Oct 2019 | C |
| May 2019 | C |
| Oct 2018 | C |
| May 2018 | A |

Letter Grade Key:

A = >3.133

B = >2.964

C = >2.476

D = >2.047

# OUTSTANDING HEALTH OUTCOMES

*Components of the Leapfrog Hospital Safety Score*

- **PSIs/Healthcare Acquired Infections (HAIs) and Healthcare Acquired Conditions (HACs)**
- **Patient Experience**
- **3 Sections of the Leapfrog Survey:**
    - ICU physician Staffing
    - Computerized Provider Order Entry (CPOE)
    - Safe Practice Score

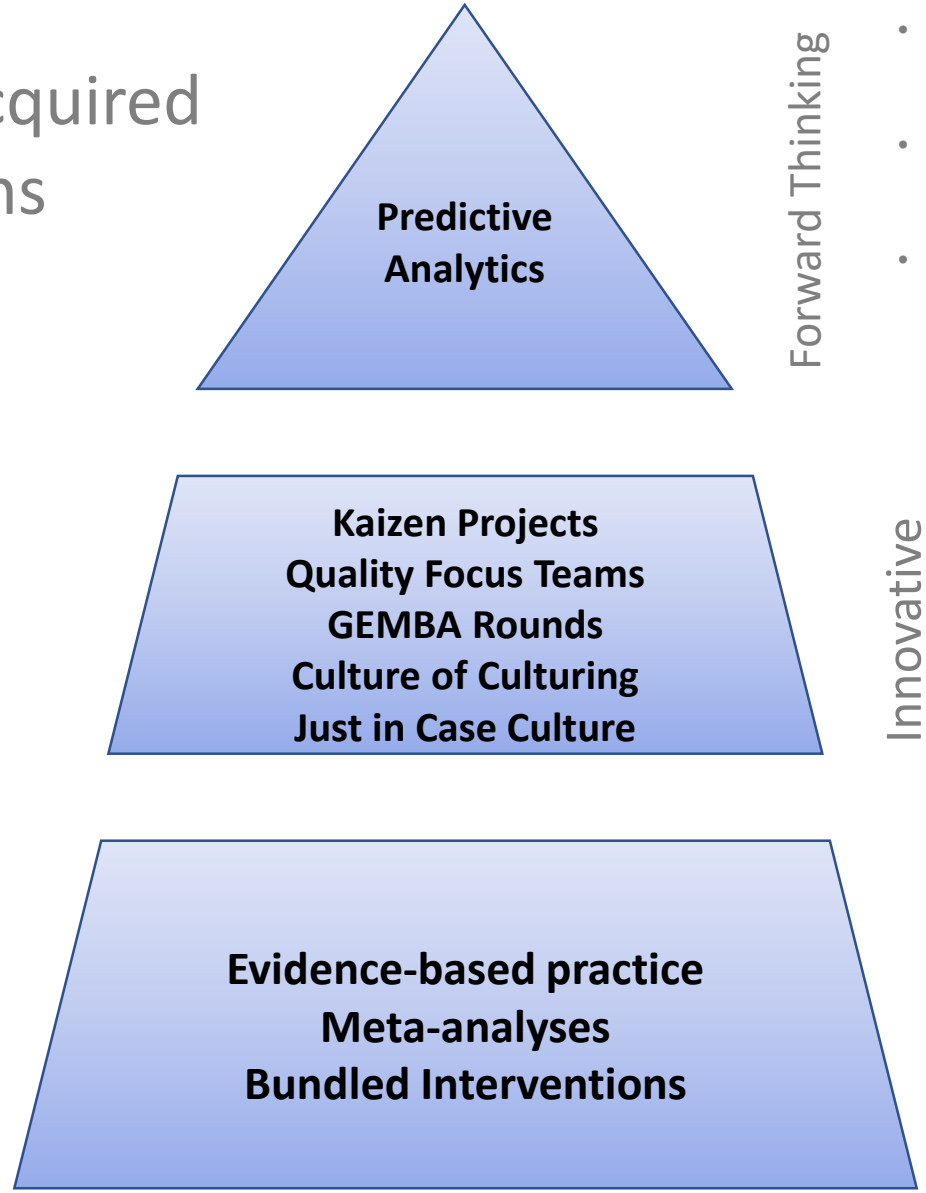
# OUTSTANDING HEALTH OUTCOMES

*Leapfrog Hospital Safety Score – Actionable Steps to Achieve "A"*

- Continue with 100% Safe Practices
  - Commitment from Board and leadership to quality and safety culture improvement
  - Compliance with approx. 75 evidenced based safe practices focused on: Culture of leadership structures/systems, safety culture measurement & feedback, nursing workforce (events & nurse staffing), hand hygiene and medication safety
- Continue improvement in Patient Experience
  - New vendor JL Morgan
  - Operation always
  - Leader rounding
- Continue optimizing CPOE
- Continue focused improvement efforts on:
  - Healthcare acquired Infections—Achieve ZERO events
  - PSIs—Achieve ZERO events

# Reducing Healthcare Acquired Infections - Interventions

What are we doing to prevent health care associated infections?




Forward Thinking

- Review of variables leading up to previously identified HAI.
- Statistical analyses of these variables to determine risks/odds of occurrence.
- Technology based alerts for events before they happen.

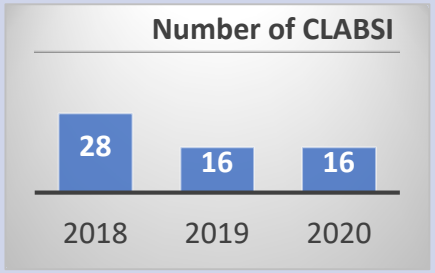
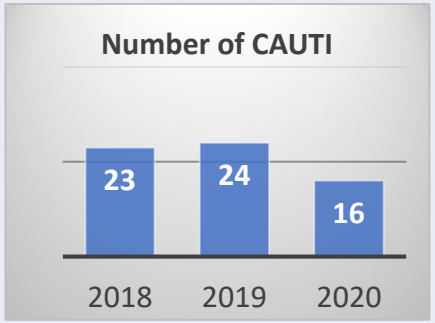
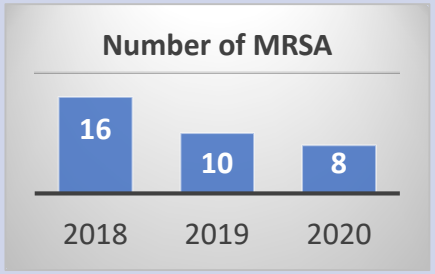
Innovative

- Retrospective review and analysis of healthcare districts HAI's.
- Deep dive into the "Why and How" for reported events.
- Collaborative action plans/stakeholder involvement.

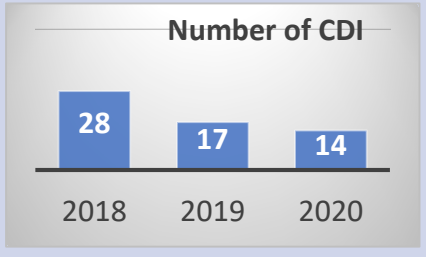
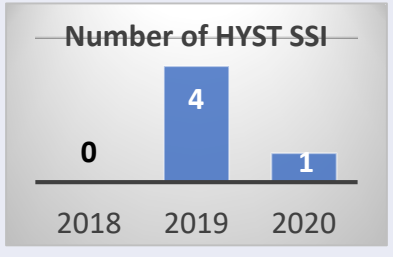
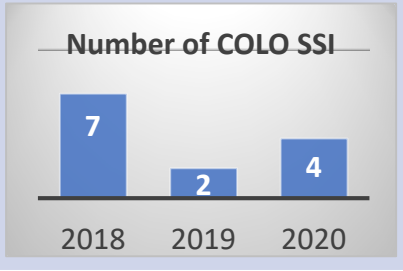
Evidence-Based

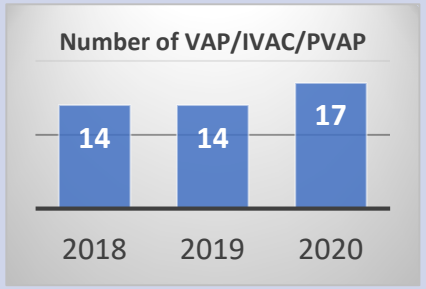
- CDC – HICPAC Guidelines for Reduction of Healthcare Associated Infections
- AHRQ – Toolkits for Reducing HAI
- CDC – STRIVE Infection Control Interventions

# OUTSTANDING HEALTH OUTCOMES

| HAI | # Infections | Above or Below | Team | Key Strategies |
|---|---|---|---|---|
| Central Line Associated Bloodstream Infection |  | 12.5% reduction in events compared to 2019<br><br>50% reduction in events compared to 2018 | • CLABSI Prevention Quality Focus Team<br>• Operation Stomp-Out CLABSI Committee<br>• HAI Case Review Committee | • "GEMBA" Unit-based rounds to de-escalate/remove central lines.<br>• Blood Culture Order Alert<br>• Midlines as an alternative<br>• TPN/Abdominal Surgery & Candidemia Scoring |
| Catheter Associated Urinary Tract Infection |  | 34.7% reduction in events compared to 2019<br><br>37.5% reduction in events compared to 2018 | • CAUTI Prevention Quality Focus Team<br>• HAI Case Review Committee | • "GEMBA" Unit-based rounds to remove indwelling urinary catheters or advocate for an alternative non-invasive device.<br>• Urinary Retention Management<br>• Urine Culture Algorithm (PowerPlan) |
| Healthcare Onset Methicillin Resistant Staphylococcus aureus Bloodstream Infection |  | 20% reduction in events compared to 2019<br><br>50% reduction in events compared to 2018 | • MDRO Prevention Committee<br>• HAI Case Review Committee | • Biovigil Hand Hygiene Electronic Surveillance System<br>• D.U.D.E. Hand Hygiene Campaign<br>• Blood Culture Order Alert |

# OUTSTANDING HEALTH OUTCOMES

| HAI | # Infections | Above or Below | Team | Key Strategies |
|---|---|---|---|---|
| Healthcare Onset Clostridium difficile Infection (CDI) |  | 23.5% reduction in events compared to 2019<br><br>53% reduction in events compared to 2018 | MDRO Prevention Committee | • Antimicrobial Stewardship<br>• Reminders to avoid testing when on bowel regimen, tube feedings, receiving Lactulose<br>• Policy PC.255 C. difficile Testing Criteria |
| Total Abdominal Hysterectomy Surgical Site Infection |  | 25% reduction in events compared to 2019<br><br>100% increase in events compared to 2018 | Surgical Site Infection Prevention Committee | • Reinforcing the use of clean-closure technique<br>• Pre/Post operative blood glucose management |
| Colorectal Surgical Site Infection |  | 100% increase in events compared to 2019<br><br>42.9% reduction in events compared to 2018 | Surgical Site Infection Prevention Committee | • Reinforcing the use of clean-closure technique<br>• Pre/Post operative blood glucose management |

| HAI | # Infections | Above or Below | Team | Strategy |
|---|---|---|---|---|
| Ventilator Associated Events (includes: Ventilator Associated Condition; Ventilator Infection Associated Condition; Probable Ventilator Associated Pneumonia) |  | 7% Increase in events compared to 2019<br><br>No increase/decrease in events compared to 2018 | VAP Prevention Committee | • Peridex Oral Solution Rinse<br>• Elevate head-of-bed<br>• Avoidance of PPIs<br>• Sedation Vacation<br>• Mobility |

# Primary Stroke Certification through The Joint Commission (TJC)

- **2020 TJC Recertification survey has been postponed due to COVID 19**
- 2 year certification cycle
- Initial accreditation March 9, 2018
  100% compliant with all Standards; No plans for improvement requested
- 20 Process and outcome measures are monitored on a monthly basis to maintain certification and award status for AHA Get with the Guidelines
  - 17 measures have performed above the goals set in 2020
  - 3 measures have performed at or below the goals set in 2020

# Stroke Program
# Performance Improvement Initiatives
# Fiscal Year 2021

Door to Alteplase <60 minutes.

Continue this metric since it is a TJC and GWTG measure. KDH goal is now <45 minutes.

Follow-Up Calls/Perception of Care

Continue TJC requirement that we monitor perception of care.

Dysphagia screening process

Continue to monitor/track.

TIA work-up/admission

**New measure.** The goal of this project is to reduce TIA length of stay by using a visible LOS time tracker for physicians which may improve the length of stay, this would be similar to how the ED tracks their patients.

Transfer Process

**New measure.** Goal is to reduce door to transfer time to <120 minutes. Task Force has been established to address issue.

# Stroke Program
# Performance Improvement Initiatives
# Fiscal Year 2021

Patient Education

**New measure.** This project was initiated by our GME TY resident during the previous year and will be continued for the upcoming year. Goal is to improve patient education metric in GWTG and improve 30 day readmission and mortality rates by physician engagement in stroke education, primarily in lifestyle modification.

Admission guideline criteria

**New measure.** KDH has historically had admission guidelines but a task force has recently reconvened to review admission guidelines.

New guidelines developed and implemented in May 2020.

Post Alteplase Monitoring

Continue to monitor/track.

# Kaweah Delta
# Primary Stroke Certification through The Joint Commission (TJC)



The Joint Commission®

American Heart Association®

American Stroke Association®

CERTIFICATION

Meets standards for

**Primary Stroke Center**



# OUTSTANDING HEALTH OUTCOMES

*Proactive Risk Assessment of High Risk Processes:*
*Failure Modes Effects Analysis (FMEA) 2020/21*

- Heparin Infusion FMEA & Action Team
  - FMEA Completed 2019
  - 2020 Action team to address identified potential high risk failure modes:
    - Evaluated required pharmacist documentation for all therapeutic anticoagulants
    - Worked toward a weight rule in Cerner to fire an alert when an outlier weight is entered
    - Heparin bolus vials are no longer available as an 'override' in Pyxis on 4 North
    - PTT/PTTh  Education sent out as an Essential Information/Bundle
    - Hold time of "0" included in the character function of Heparin Infusions
    - Double Check (IDC) challenges; Pharmacy Resident created IDC sticker to be attached to every Heparin bag.
  - 2021 - Finalize, pilot on unit, and education

- Radiation Dosing FMEA 2020/21
  - 2020 process defined, failure modes identified
  - 2021 risk mitigation strategies developed & implemented to address potential failure modes

# OUTSTANDING HEALTH OUTCOMES

## *Safety Culture*

Components of Safety Culture Program:

- Safety Attitudes Questionnaire (SAQ)
- Event Reporting
- Just Culture
- Team/Safety Culture Training
- CUSP – Comprehensive Unit-Based Safety Program
- Event Review (Root Cause Analysis/Focused Review)
- Recognition Programs

# 2018 KDHCD SAQ Domain Scores & Organizational Initiatives

**2020/21 SAQ currently in progress, survey closes 2/1/21**

- 5 categories below the 50th percentile, 1 above and 1 equal
- 3 domains have improved from 2016, 2 have decreased and 2 are unchanged

Score change is % change from KDHCD's 2016 SAQ survey

### JOB SATISFACTION

70% | -1% Score Change | 71% Industry Med.

View Dashboard

**Below Median**

ORG INITIATIVE 2018 - 2021

- Employee engagement initiatives
- Unit-Level SAQ action plans

### TEAMWORK CLIMATE

63% | 0% Score Change | 66% Industry Med.

**Below Median**

- TeamSTEPPS
- CUSP Program

### STRESS RECOGNITION

55% | 6% Score Change | 47% Industry Med.

**Above Median**

- Stress Recognition modules for all new hires and ad hoc

### PERCEPTIONS OF SENIOR MANAGEMENT

41% | 1% Score Change | 46% Industry Med.

**Below Median**

- CUSP ET Sponsors
- Leader rounding
- Just Culture

### SAFETY CLIMATE

69% | -2% Score Change | 73% Industry Med.

**Below Median**

ORG INITIATIVE 2018 - 2021

- Just Culture
- Midas system revisions
- Good catch/Hero
- CUSP/IP Liaison
- CUS mandatory new hire module
- Daily safety huddle

### PERCEPTIONS OF LOCAL MANAGEMENT

62% | 3% Score Change | 67% Industry Med.

**Below Median**

- CUSP
- Leader rounding
- Just Culture

### WORKING CONDITIONS

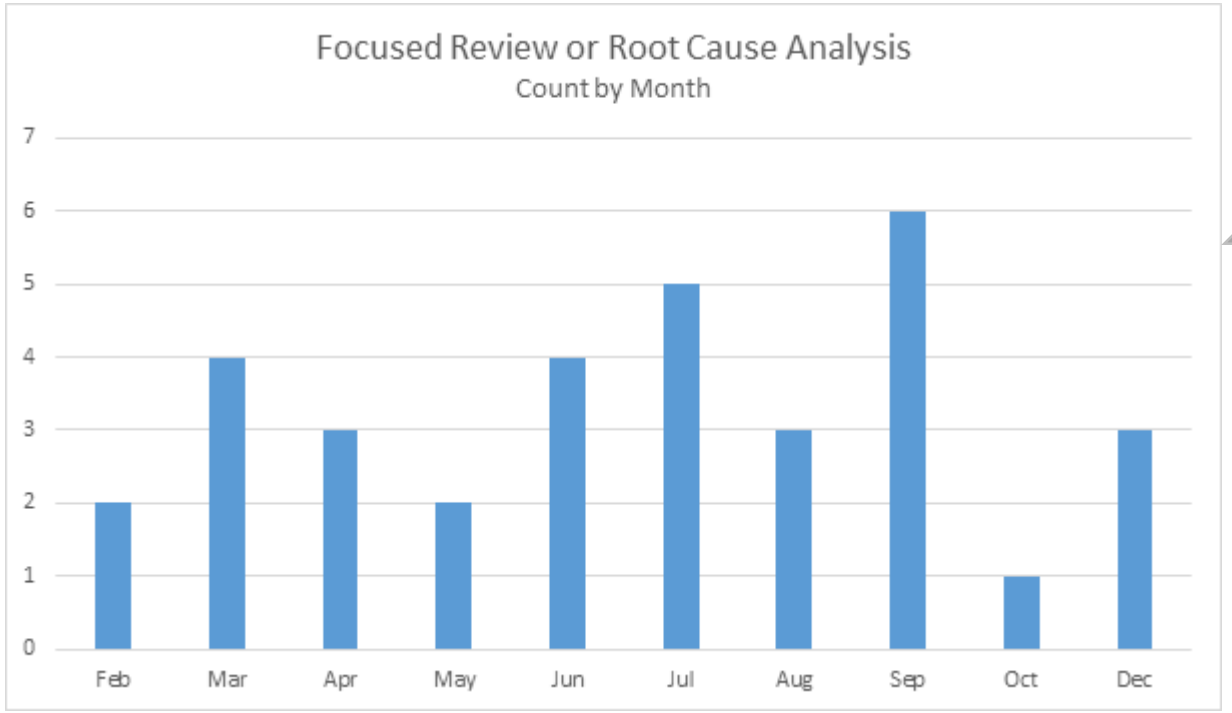
55% | 0% Score Change | 55% Industry Med.

**Equal to Median**

- Employee engagement initiatives
- Unit-Level SAQ action plans

# OUTSTANDING HEALTH OUTCOMES

*Safety Culture/Patient Safety Root Cause Analysis (RCA) & Focused Reviews (FR)*




Effectiveness

Actions Taken by Category - Implemented for RCA/FRs

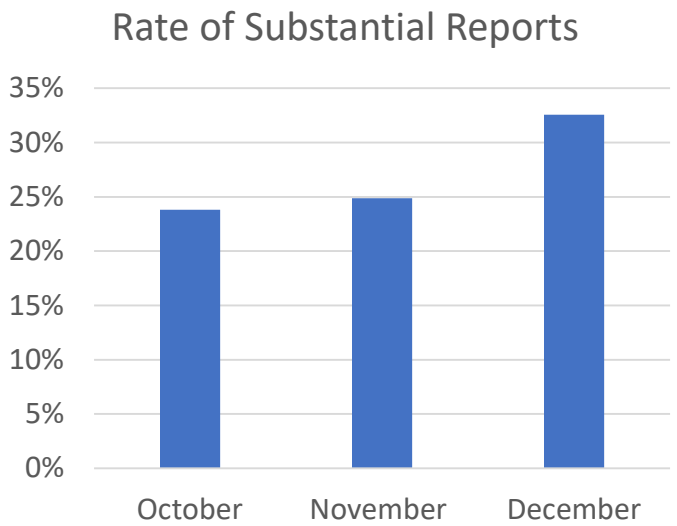
| Error Proofing Strategy | Number Implemented 2019 | Number Implemented 2020 |
|---|---|---|
| Forcing Functions | 0 | 1 |
| Automation & Computerization | 3 | 4 |
| Standardization & Protocols | 13 | 4 |
| Rules & Policies | 8 | 2 |
| Education/Information | 37 | 10 |
| "Be more vigilant" | 0 | 4 |
| Number of RCAs/FRs | 17 | 33 |

Goal is to increase systematic event review to:

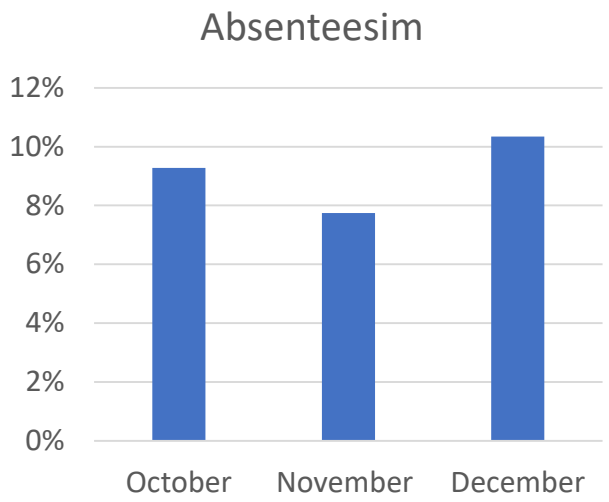
- Engage with leaders to proactively address issues or patterns of events
- Collaborate with teams to address opportunities

# Daily Enterprise Safety Huddles

- The Daily District Safety Huddle is a short, 15-minute meeting at 8:45 every morning to share any concerns that occurred in the last 24 hours, review the steps taken to resolve those matters, and anticipate challenges or safety issues in the next 24 hours.
- Includes all departments of Kaweah Delta; Manager or Director present and listen to safety topics
- Summary of reports is sent out by email to hospital and medical staff leaders within 30 minutes daily to support proactive risk mitigation and communication across the enterprise
- Rollout began October 1, 2020; more departments and campuses were added each month. On January 4, 2021 Enterprise Safety Huddle went live with every department in the organization!




"Substantial Reports" are those departments that are present and contribute information or safety concerns beyond a report of "safe", and is reflective of engagement and active participation




Absenteeism is the number of absent reporting departments out of the total reporting opportunities. Follow-up on expectations occurs with frequently absent individuals



Kaweah Delta

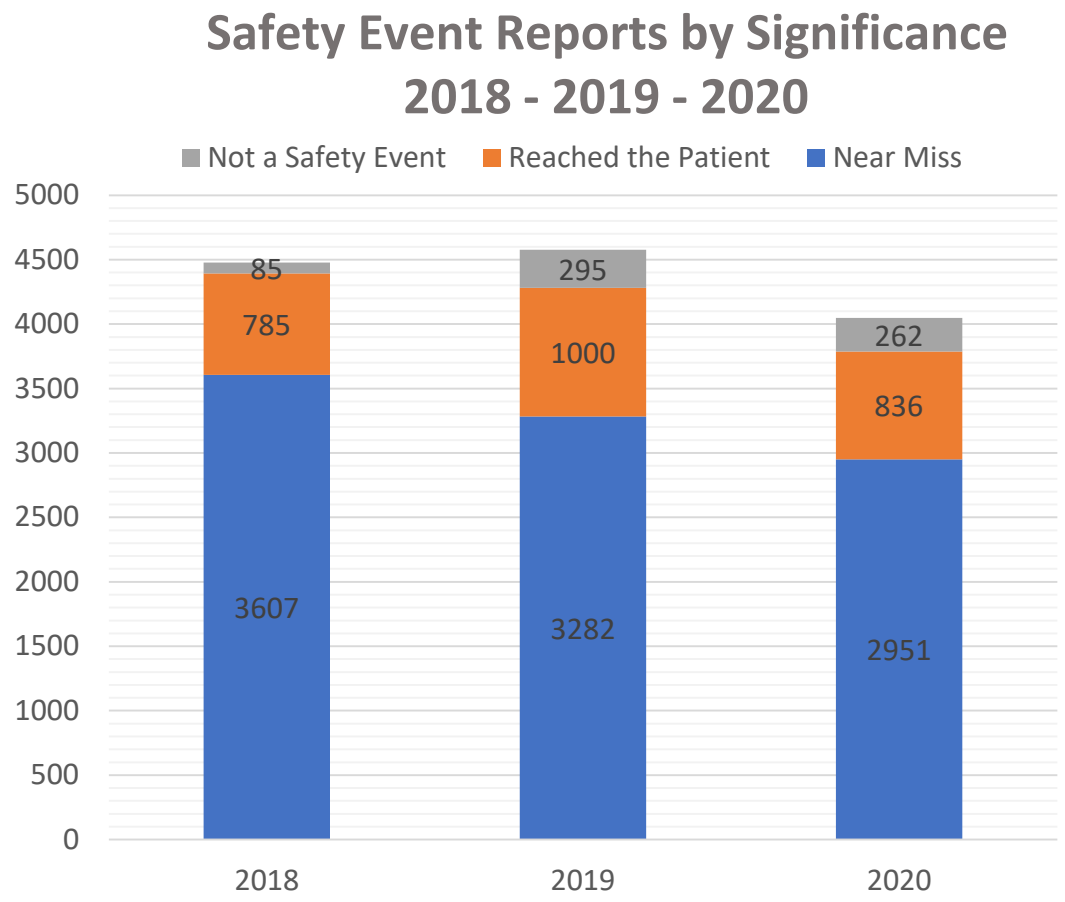
# OUTSTANDING HEALTH OUTCOMES

*Safety Culture/Patient Safety Root Cause Analysis (RCA) & Focused Reviews (FR)*

Summary

- 12% decrease in overall events submitted from 2019 to 2020
- Proportion of events reported that reached the patient has increased since 2018 (18%) to 2020 (21%)
  - Pro: Staff comfortable to report (just culture will be utilized)
  - Con: more events reported reached patient (does not indicate harm occurred)
- Possible reductions related to decrease in census in 2020

| | 2019 | 2020 | % Change |
|---|---|---|---|
| Acute Care Patient Days | 130,740 | 128,668 | 1.6% ↓ |
| Emergency Dept Visits | 86,918 | 73,132 | 15.8%↓ |



# OUTSTANDING HEALTH OUTCOMES

## *Safety Culture – Organizational Initiatives – 2020/21*

### Just Culture Steering Committee

- Plan for Just Culture staff awareness campaign early/mid 2021
- In 2020 Additions of Just Culture questions to event follow up in Midas
- Including the Just Culture focused questions in the 2020/21 SAQ (compare to 2018 baseline) to measure improvement
- 2021 Ongoing manager training to Just Culture and the Marx Algorithm

### Team Training

TeamSETPPS Leadership (Medical Team Training)

- 30 Kaweah leaders participated in training March 2020.
- Evaluation indicated the training accomplished goals: participants felt it was useful to their role/work, and learning occurred: 49% improvement in the understanding of TeamSTEPPS from before and after training
- 15 medical team tools implemented in 11 Kaweah locations
- 2Q 2021 3rd leadership cohort

TeamSTEPPS Staff

- All new hires in patient care roles complete CUS (I am concerned, uncomfortable, this is a safety situation) training; achieved training goals (>90% correct response rate) from 2017-2020 (2020 n=698). Post test indicates 100% correct response rate for each question. 100% of staff indicate ability to use CUS during a patient safety situation
- 2nd TeamSTEPPS tool approved by patient safety Committee for board implementation in 2021; "Say it again, Sam" (2 challenge rule); 2Q 2021 Staff version of TeamSTEPPs simulation

### Safety Culture Training

Stress Recognition Training

- 2017-2020 All new hires in patient care/support roles (2020 n=692)
- Post test indicates goal achieved (>90%) with >93% correct/ desirable responses

### SAQ

- Unit level Action plans June 2021
- Broad dissemination

### Recognitions

- 12 Good Catch awards (staff and providers) in 2020
- Hero of the Year awarded in 2020

### Event Reporting/ Event Review

- New mandatory training module process implemented for staff involved in 2 identifier events
- Daily safety huddle implemented 2020
- Just Culture Algorithm added to Manager Investigation Tab (Medical Director documentation in development)
- Education on Just Culture Event Response to Managers and Directors
- Education through Medical Staff departments on Just Culture response to event
- Link to Event Reporting in KD Compass

### CUSP (Unit Safety Teams)

- 6 teams in 2020; greatly affected by COVID-19
- Program under evaluation, enhancements planned for March 2021

# Questions?

Kaweah Delta Health Care District

Subcategories of Department Manuals not selected.

| Policy Number: AP41 | Date Created: Not Set |
|---|---|
| Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO) | Date Approved: 09/29/2020 |
| 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 Delta Health Care District's (KDHCD) Quality Improvement Plan is to have an effective, data-driven Quality Assessment Performance Improvement program that delivers high-quality, excellent clinical services and enhances patient safety.

## II. Scope

All KDHCD facilities, departments, patient care delivery units and/or service areas 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.

### Medical Staff

The Medical Staff, 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 Professional Staff Quality Committee "Prostaff", chaired by the Vice Chief of Staff. The Chief of Staff delegates accountability for monitoring individual performance to the Clinical Department Chiefs. Prostaff shall receive reports from and assure the

appropriate functioning of the Medical Staff committees. "Prostaff" provides oversight for medical staff quality functions including peer review.

**Quality Improvement Committee (QIC)** QIC has responsibility for oversight of organizational performance improvement. Membership includes key organizational leaders including the Medical Director of Quality and Patient Safety or Chief Quality Officer, Chief Operating Officer, Chief Nursing Officer, Assistant Chief Nursing Officer, Directors of Quality and Patient Safety, Nursing Practice, and Risk Management; Manager of Quality and Patient Safety and Manager of Infection Prevention. This committee reports to Prostaff and the Quality Council.

The QIC shall have primary responsibility for the following functions:

1. **Health Outcomes:** The QIC shall assure that there is measureable improvement in indicators with a demonstrated link to improved health outcomes. 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 QIC 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 QIC 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 QIC shall prioritize quality improvement activities to assure 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 QIC is responsible to establish 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 QIC shall use the analysis of the data to identify opportunities for improvement and changes that will lead to improvement. The QIC will also oversee implementation of actions aimed at improving performance.
5. **Follow- Up:** The QIC 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 QIC 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 QIC 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 on the 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.

**Nursing Practice Improvement Council**

The Nursing Practice Improvement Council is designed to ensure quality assessment and continuous quality improvement and to oversee the quality of patient care (with focus on systems improvements related to nursing practices and care outcomes).

The Nursing Practice Improvement Council is chaired by the Director of Nursing Practice and facilitated by a member of the Quality and Patient Safety department. This Council has staff nurse representation from a broad scope of inpatient and out-patient nursing units, and procedural nursing units. The Council will report to Patient Care Leadership, Professional Practice Council (PPC) and the Professional Staff Quality Committee.

**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)

**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

2. 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

**IV. 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.

**V. 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.

**VI. Attachments--** Components of the Quality Improvement and Patient Safety Plan:

| | |
|---|---|
| Attachment 1: | Quality Improvement Committee Structure |
| Attachment 2: | KDHCD- Prostaff Reporting Documents |
| Attachment 3: | 2019-2020 Value Based Purchasing (VBP) Objectives |

*"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."*

| | |
|---|---|
| **Policy Number: AP175** | **Date Created: Not Set** |
| **Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)** | **Date Approved: 04/08/2019** |
| **Approvers: Board of Directors (Administration), Cindy Moccio (Board Clerk/Exec Assist-CEO)** | |

# Patient Safety Plan

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

I. Purpose

- Encourage organizational learning about medical/health care risk events and near misses
- Encourage recognition and reporting of medical/health events and risks to patient safety using just culture concepts
- Collect and analyze data, evaluate care processes for opportunities to reduce risk and initiate actions
- Report internally what has been found and the actions taken with a focus on processes and systems to reduce risk
- Support sharing of knowledge to effect behavioral changes in itself and within Kaweah Delta Healthcare District (KDHCD)

II. Scope

All KDHCD facilities, departments, patient care delivery units and/or service areas fall within the scope of the quality improvement and patient safety plan requirements.

III. Structure and Accountability

A. Board of Directors

The Board of Directors retains overall responsibility for the quality of patient care and patient safety. The Board approves annually the Patient Safety Plan and assures that appropriate allocation of resources is available to carry out that plan.

The Board receives reports from the Patient Safety Committee through the Professional Staff Quality Committee. The Board shall act as appropriate on the recommendations of these bodies and assure that efforts undertaken are effective and appropriately prioritized.

B. Quality Council

The Quality Council is responsible for establishing and maintaining the organization's Patient Safety 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 performance 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.

C. Patient Safety Committee

The Patient Safety Team is a standing interdisciplinary group that manages the organization's Patient Safety Program through a systematic, coordinated, continuous approach. The Team will meet monthly to assure the maintenance and improvement of Patient Safety in establishment of plans, processes and mechanisms involved in the provision of the patient care.

The scope of the Patient Safety Team includes medical/healthcare risk events involving the patient population of all ages, visitors, hospital/medical staff, students and volunteers. Aggregate data* from internal (IS data collection, incident reports, questionnaires,) and external resources (Sentinel Event Alerts, evidence based medicine, etc.) will be used for review and analysis in prioritization of improvement efforts, implementation of action steps and follow-up monitoring for effectiveness. The Patient Safety Committee has oversight of KDHCD activities related to the National Quality Forum's (NQF) Safe Practices (SP) #1 Culture of Safety Leadership Structures & System Documentation; #2 Culture Measurement, Feedback & Intervention Documentation;#4 Risks & Hazards; #9 Nursing Workforce; #19 Hand Hygiene; and #23 Prevention of Ventilator Associated Complications.

1. The Patient Safety Officer is the Medical Director of Performance Improvement
2. The Patient Safety Committee is chaired by the Patient Safety Officer or designee.
3. The responsibilities of the Patient Safety Officer include institutional compliance with patient safety standards and initiatives, reinforcement of the expectations of the Patient Safety Plan, and acceptance of accountability for measurably improving safety and reducing errors. These duties may include listening to employee and patient concerns, interviews with staff to determine what is being done to safeguard against occurrences, and immediate response to reports concerning workplace conditions.
4. Team membership includes services involved in providing patient care, such as: Pharmacy, Laboratory, Surgical Services, Risk Management, Infection Prevention, Medical Imaging, and Nursing. The medical staff representative on the team will be the Vice Chief of Staff.

D. Medication Safety Quality Focus Team

The Medication Safety Quality Focus Team (MSQFT) is an interdisciplinary group that manages the organizations Medication Safety Program including the District Medication Error Reduction Plan (MERP).

The purpose of the MSQFT is to direct system actions regarding reductions in errors attributable to medications promoting effective and safe use of medication throughout the organization. Decisions are made utilizing data review, approval of activities, resource allocation, and monitoring activities. Activities include processes that are high risk, high volume, or problem prone, some of which may be formally approved by the MSQFT as a District MERP goal (see Policy AP154 Medication Error Reduction Plan).

The MSQFT provides a monthly report to the Pharmacy and Therapeutics Committee and quarterly reports to the Professional Staff Quality Committee and directly to Quality Council. The MSQFT Chair is a member of the Patient Safety Committee. A quarterly report is presented at Patient Safety Committee in addition to active participation in patient safety activities related to medication use.

IV. Organization and Function

A. The mechanism to insure all components of the organization are integrated into the program is through a collaborative effort of multiple disciplines. This is accomplished by:

1. Reporting of potential or actual occurrences through the Occurrence Reporting Process Policy (AP10) by any employee or member of the medical staff. Examples of potential or actual occurrences include pressure ulcers, falls, adverse drug events, and misconnecting of: intravenous lines, enteral feeding tubes and epidural lines.
2. Communication between the Patient Safety Officer and the Chief Operating Officer to assure a comprehensive knowledge of not only clinical, but also environmental factors involved in providing an overall safe environment.
3. Reporting of patient safety and operational safety measurements/activity to the performance improvement oversight group, Professional Services Quality Committee "Prostaff". Prostaff is a multidisciplinary medical staff committee composed of various key organizational leaders including: Medical Executive Committee members, Chief Executive Officer, Chief Operating Officer, Chief Medical Officer/Chief Quality Officer, Chief Nursing Officer, Member of the Board of Directors,

and Directors of Nursing, Performance Improvement, Risk Management, and Pharmacy.

4. Graduate Medical Education

    i. 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:

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

B. The mechanism for identification and reporting a Sentinel Event/other medical error will be as indicated in Organizational Policies AP87. Any root cause analysis of hospital processes conducted on either Sentinel Events or near misses will be submitted for review/recommendations to the Patient Safety Committee, Professional Staff Quality Committee and Quality Council.

C. As this organization supports the concept that events most often occur due to a breakdown in systems and processes, staff involved in an event with an adverse outcome will be supported by:

1. A non-punitive approach without fear of reprisal (just culture concepts).
2. Voluntary participation into the root cause analysis for educational purposes and prevention of further occurrences.
3. Resources such as Pastoral Care, Social Services, or EAP should the need exist to counsel the staff
4. Safety culture staff survey (i.e. the Safety Attitudes Questionnaire) administered at least every 2 years to targeted staff and providers.

D. As a member of an integrated healthcare system and in cooperation with system initiatives, the focus of Patient Safety activities include processes that are high risk, high volume or problem prone, and may include:

1. Adverse Drug Events
2. Nosocomial Infections
3. Decubitus Ulcers
4. Blood Reactions
5. Slips and Falls
6. Restraint Use
7. Serious Event Reports
8. DVT/PE

E. A proactive component of the program includes the selection at least every 18 months of a high risk or error prone process for proactive risk assessment such as a Failure Modes Effects Analysis (FMEA), ongoing measurement and periodic analysis. The selected process and approach to be taken will be approved by the Patient Safety Committee and Quality Council.

The selection may be based on information published by The Joint Commission (TJC) Sentinel Event Alerts, and/or other sources of information including risk management, performance improvement, quality assurance, infection prevention, research, patient/family suggestions/expectations or process outcomes.

F. Methods to assure ongoing inservices, education and training programs for maintenance and improvement of staff competence and support to an interdisciplinary approach to patient care is accomplished by:

1. Providing information and reporting mechanisms to new staff in the orientation training.

2. Providing ongoing education in organizational communications such as newsletters and educational bundles.
3. Obtaining a confidential assessment of staff's willingness to report medical errors at least once every two years.

G. Internal reporting – To provide a comprehensive view of both the clinical and operational safety activity of the organization:

1. The minutes/reports of the Patient SafetyCommittee, as well as minutes/reports from the Environment of Care Committee will be submitted through the Director of Performance Improvement and Patient Safety to the Professional Staff Quality Committee.
2. These monthly reports will include ongoing activities including data collection, analysis, and actions taken and monitoring for the effectiveness of actions.
3. Following review by Professional Staff Quality Committee, the reports will be forwarded to Quality Council.

H. The Patient Safety Officer or designee will submit an Annual Report to the KDHCD Board of Directors and will include:

1. Definition of the scope of occurrences including sentinel events, near misses and serious occurrences
2. Detail of activities that demonstrate the patient safety program has a proactive component by identifying the high-risk process selected
3. Results of the high-risk or error-prone processes selected for proactive risk assessment.
4. The results of the program that assesses and improves staff willingness to report medical/health care risk events
5. A description of the examples of ongoing in-service, and other education and training programs that are maintaining and improving staff competence and supporting an interdisciplinary approach to patient care.

V. Evaluation and Approval

The Patient Safety Plan will be evaluated at least every three years or as significant changes occur, and revised as necessary at the direction of the Patient Safety Committee, Professional Staff Quality Committee, and/or Quality Council. Annual evaluation of the plan's effectiveness will be documented in a report to the Quality Council and the KDHCD Board of Directors.

VI. Confidentiality

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Attachments - Attachment 1: Quality Improvement/Patient Safety Committee Structure

*"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."*

# 2021 Quality Council/Board Quality Review Schedule

| TOPIC | JAN | | FEB | | MAR | | APR | | MAY | | JUN | | JUL | | AUG | | SEP | | OCT | | NOV | | DEC | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Annual Review of Quality and Patient Safety Plans** | X | B | | | | | | | | | | | | | | | | | | | | | | |
| **Leadership Clinical Quality Goals** | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | |
| **Leapfrog Hospital Safety Score** | | | | | | | | | X | | | | | | | | | | X | | | | | |
| **Healthgrades** | | | | | | | | | | | | | | | | | | | | | X | | | |
| **Value Based Purchasing** | | | | | X | B | | | | | X | | | | | | X | | | | | | X | |
| **PATIENT EXPERIENCE** | | | | | X | | | | | | X | | | | | | X | | | | | | X | B |
| **Length of Stay** | | | | | | | | | X | B | | | | | | | | | | | X | B | | |
| **CARDIAC SERVICE** Society of Thoracic Surgery(STS) and American College of Cardiology (ACC) Data | | | X | | | | | | | | | | | | X | | | B | | | | | | |
| **CRITICAL CARE** | | | | | | | | | | | | | | | | | | | | | | | | |
| Emergency Dept Dashboard | | | | | X | | | | | | X | | | | | | X | | | | | | X | |
| Emergency Dept Report | | | | | | | | | | | X | | | B | | | | | | | | | X | |
| Rapid Response Team (RRT) | X | | | B | | | X | | | | | | X | | | | | | X | | | | | |
| Trauma Committee | | | | | | | X | | | | | | | | | | | | X | | | | | |
| **SURGICAL SERVICES** Surgical Quality Improvement Program | | | | | | | | | X | B | | | | | | | | | | | X | | | |
| **ORTHO/NEURO/REHAB** | | | | | | | | | | | | | | | | | | | | | | | | |
| Stroke | X | | | | | | X | | | | | | X | | | B | | | X | | | | | |
| Rehabilitation | X | | | | | | | | | | | | X | | | | | | | | | | | |
| Orthopedics | | | | | | | | | | | | | X | | | | | | | | | | | |
| **MATERNAL CHILD HEALTH** | | | | | | | | | | | | | | | | | | | | | | | | |
| Perinatal Core Measures, Peds, NICU, Labor & Delivery, Obstetrics | | | | | X | | | B | | | | | | | | | X | | | | | | | |
| **RENAL SERVICES** Network 18 | | | | | | | | | | | X | | | | | | | | | | | | X | |
| **MENTAL HEALTH** | | | | | | | X | | | | | | | | | | | | X | | | | | |

Revised: Jan 2021

# 2021 Quality Council/Board Quality Review Schedule

| TOPIC | JAN | | FEB | | MAR | | APR | | MAY | | JUN | | JUL | | AUG | | SEP | | OCT | | NOV | | DEC | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CMS Core Measures | | | | | | | | | | | | | | | | | | | | | | | | |
| **POST ACUTE CARELINE** | | | | | | | | | | | | | | | | | | | | | | | | |
| Subacute & Transitional Care Unit | | | | | | | | | | | X | | | | | | | | | | | | X | |
| Hospice, Home Health | | | | | | | X | | | | | | | | | | | | X | | | | | |
| **NURSING** | | | | | | | | | | | | | | | | | | | | | | | | |
| Falls | | | | | X | | | | | | | | | | | | X | | | | | | | |
| Infection Prevention Hand Hygiene, SSI, C Diff, CAUTI & CLABSI, quarterly dashboard | | | | | X | | | | | | X | B | | | | | X | | | | | | X | |
| Hand Hygiene Report (Leapfrog requirement) | X | | | | | | | | | | | | X | | | | | | | | | | | |
| **2021 QUALITY FOCUS TEAMS** | | | | | | | | | | | | | | | | | | | | | | | | |
| **SEPSIS Quality Focus Team (QFT)** | X | | | | | | X | | | | | | X | | | | | | X | B | | | | |
| **HAPI QFT** | | | | | X | | | | | | X | | | | | | X | | | | | | X | |
| **Handoff Communication QFT** | | | | | X | | | | | | X | | | | | | X | | | | | | X | |
| **CAUTI QFT** | X | | | | | | X | | | | | | X | | | | | | X | | | | | |
| **CLABSI/MRSA QFT** | | | X | | | | | | X | | | | | | X | | | | | | X | | | |
| **2021 BEST PRACTICE TEAMS** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Heart Failure BPT** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Pneumonia (PN) BPT** | | | | | | | | | | | | | | | | | | | | | | | | |
| **COPD BPT** | | | | | | | | | | | | | | | | | | | | | | | | |
| **AMI (non-STEMI) BPT** | | | | | | | | | | | | | | | | | | | | | | | | |
| **HF Readmission BPT** | | | | | | | | | | | | | | | | | | | | | | | | |
| **PN Readmission BPT** | | | | | | | | | | | | | | | | | | | | | | | | |
| **COPD Readmission BPT** | | | | | | | | | | | | | | | | | | | | | | | | |
| **AMI (non-STEMI) BPT** | | | | | | | | | | | | | | | | | | | | | | | | |
| ****CLOSED AGENDA ITEMS**** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Pro- Staff** | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | |
| **Medication Safety** | X | | | | | | X | | | | | | X | | | | | | X | | | | | |
| **RCA** | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | |

Revised: Jan 2021