September 9, 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, September 16, 2021, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:01AM on Thursday, September 16, 2021, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277, pursuant to Health and Safety Code 32155 & 1461.

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Quality Council Committee meeting at 8:00AM on Thursday, September 16, 2021, in the Kaweah Health Lifestyle Fitness center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

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

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

KAWEAH DELTA HEALTH CARE DISTRICT
Garth Gipson, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
Board Clerk, Executive Assistant to CEO

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

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
QUALITY COUNCIL

Thursday, September 16, 2021
5105 W. Cypress Avenue
Kaweah Health Lifestyle Fitness Center Conference Room

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

OPEN MEETING – 7:00AM

1. **Call to order** – *David Francis, Committee Chair*
2. **Public / Medical Staff participation –** Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdiction of the Board are requested to identify themselves at this time. For those who are unable to attend the beginning of the Board meeting during the public participation segment but would like to address the Board, please contact the Board Clerk (Cindy Moccio 559-624-2330) or cmoccio@kaweahhealth.org to make arrangements to address the Board.
3. **Approval of Quality Council Closed Meeting Agenda** – 7:01AM
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Daniel Hightower, MD, and Professional Staff Quality Committee Chair;*
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – Evelyn McEntire*, RN, BSN, Director of Risk Management and Ben Cripps, Vice President & Chief Compliance and Risk Officer.*
4. **Adjourn Open Meeting** – *David Francis, Committee Chair*

CLOSED MEETING – 7:01AM

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

3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 — Evelyn McEntire, RN, BSN, Interim Director of Risk Management, and Ben Cripps, Chief Compliance 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. **Value Based Purchasing**
    - 3.2. **Maternal Child Health Service Line**
    - 3.3. **Falls Prevention Committee**
    - 3.4. **Infection Prevention Quarterly Dashboard**

4. **Emergency Department Throughput Dashboard –** Review of key measures related to throughput in the Emergency Department and associated action plans. *Kona Seng, DO, Medical Director of Emergency Services and Michelle Peterson, RN, MSN, Director of Emergency Services.*

5. **Diversion Prevention Committee –** Review of current initiatives and measures related to the prevention of medication diversion. *Keri Noeske, DNP, VP/Chief Nursing Officer.*

6. **Update: Clinical Quality Goals** - A review of current performance and actions focused on the fiscal year 2021 clinical quality goals. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*

7. **Medical Director QI Projects Update –** A review of quality initiatives being pursued with various Medical Directors. *Tom Gray, MD, Medical Director of Quality & Patient Safety and Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*

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

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

Value-Based Purchasing

August 2021

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

Tom Gray, MD
Medical Director of Quality & Patient Safety

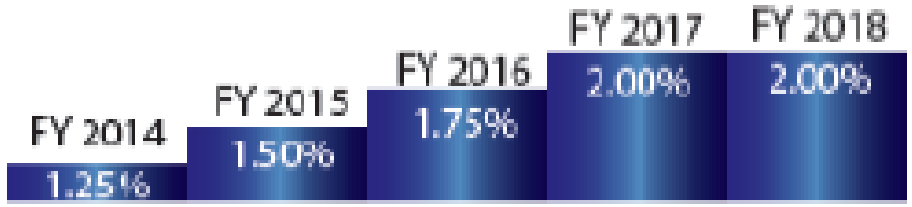
Abbreviations

CMS: Centers for Medicare and Medicaid Services
DRG: Diagnosis Related Groups
ECE: Extraordinary Circumstances Exception
FY: Fiscal Year
CY: Calendar Year
TPS: Total Performance Score
VBP: Value Based Purchasing
CHA: California Hospital Association
CAUTI – Catheter Associated Urinary Tract Infection
CLABSI – Central Line Associated Blood Stream Infection
COPD – Chronic Obstructive Pulmonary Disease
MRSA - Methicillin-resistant Staphylococcus Aureus

VBP Payment Method

- "The Hospital VBP Program is funded by a 2% reduction from participating hospitals' base operating diagnosis-related group (DRG) payments for FY 2018 and beyond.
- Resulting funds are redistributed to hospitals based on their Total Performance Scores (TPS).
- The actual amount earned by each hospital depends on the range and distribution of all eligible/participating hospitals' TPS scores for a FY.
- It is possible for a hospital to earn back a value-based incentive payment percentage that is less than, equal to, or more than the applicable reduction for that program year."

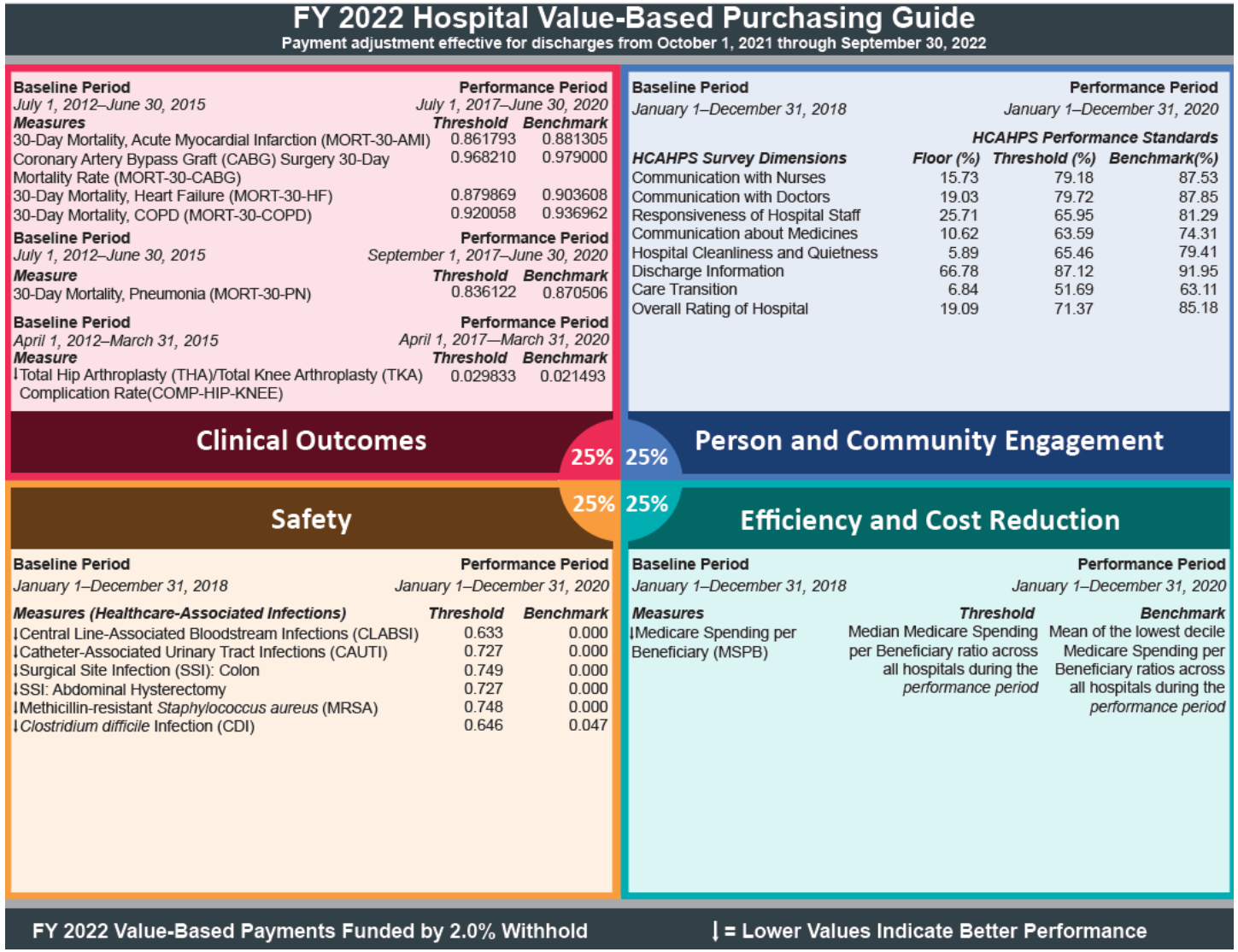
CMS Quality Patient Assessment Instruments



FY2022 VBP

Payment adjustment effective for discharges from Oct 1, 2021 through Sept 30, 2022 for performance achieved during the following performance periods:

- Safety, Efficiency and Engagement Domains Outcomes = CY20
- Clinical Care Domain Outcomes = July 1, 2017 through June 30, 2020



FY 2022 Hospital Value-Based Purchasing Guide

Payment adjustment effective for discharges from October 1, 2021 through September 30, 2022

Clinical Outcomes — 25%

Baseline Period *July 1, 2012–June 30, 2015* | **Performance Period** *July 1, 2017–June 30, 2020*

Measures	Threshold	Benchmark
30-Day Mortality, Acute Myocardial Infarction (MORT-30-AMI)	0.861793	0.881305
Coronary Artery Bypass Graft (CABG) Surgery 30-Day Mortality Rate (MORT-30-CABG)	0.968210	0.979000
30-Day Mortality, Heart Failure (MORT-30-HF)	0.879869	0.903608
30-Day Mortality, COPD (MORT-30-COPD)	0.920058	0.936962

Baseline Period *July 1, 2012–June 30, 2015* | **Performance Period** *September 1, 2017–June 30, 2020*

Measure	Threshold	Benchmark
30-Day Mortality, Pneumonia (MORT-30-PN)	0.836122	0.870506

Baseline Period *April 1, 2012–March 31, 2015* | **Performance Period** *April 1, 2017–March 31, 2020*

Measure	Threshold	Benchmark
↓Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA) Complication Rate(COMP-HIP-KNEE)	0.029833	0.021493

Person and Community Engagement — 25%

Baseline Period *January 1–December 31, 2018* | **Performance Period** *January 1–December 31, 2020*

HCAHPS Survey Dimensions	Floor (%)	Threshold (%)	Benchmark(%)
	HCAHPS Performance Standards		
Communication with Nurses	15.73	79.18	87.53
Communication with Doctors	19.03	79.72	87.85
Responsiveness of Hospital Staff	25.71	65.95	81.29
Communication about Medicines	10.62	63.59	74.31
Hospital Cleanliness and Quietness	5.89	65.46	79.41
Discharge Information	66.78	87.12	91.95
Care Transition	6.84	51.69	63.11
Overall Rating of Hospital	19.09	71.37	85.18

Safety — 25%

Baseline Period *January 1–December 31, 2018* | **Performance Period** *January 1–December 31, 2020*

Measures (Healthcare-Associated Infections)	Threshold	Benchmark
↓Central Line-Associated Bloodstream Infections (CLABSI)	0.633	0.000
↓Catheter-Associated Urinary Tract Infections (CAUTI)	0.727	0.000
↓Surgical Site Infection (SSI): Colon	0.749	0.000
↓SSI: Abdominal Hysterectomy	0.727	0.000
↓Methicillin-resistant *Staphylococcus aureus* (MRSA)	0.748	0.000
↓*Clostridium difficile* Infection (CDI)	0.646	0.047

Efficiency and Cost Reduction — 25%

Baseline Period *January 1–December 31, 2018* | **Performance Period** *January 1–December 31, 2020*

Measures	Threshold	Benchmark
↓Medicare Spending per Beneficiary (MSPB)	Median Medicare Spending per Beneficiary ratio across all hospitals during the *performance period*	Mean of the lowest decile Medicare Spending per Beneficiary ratios across all hospitals during the *performance period*

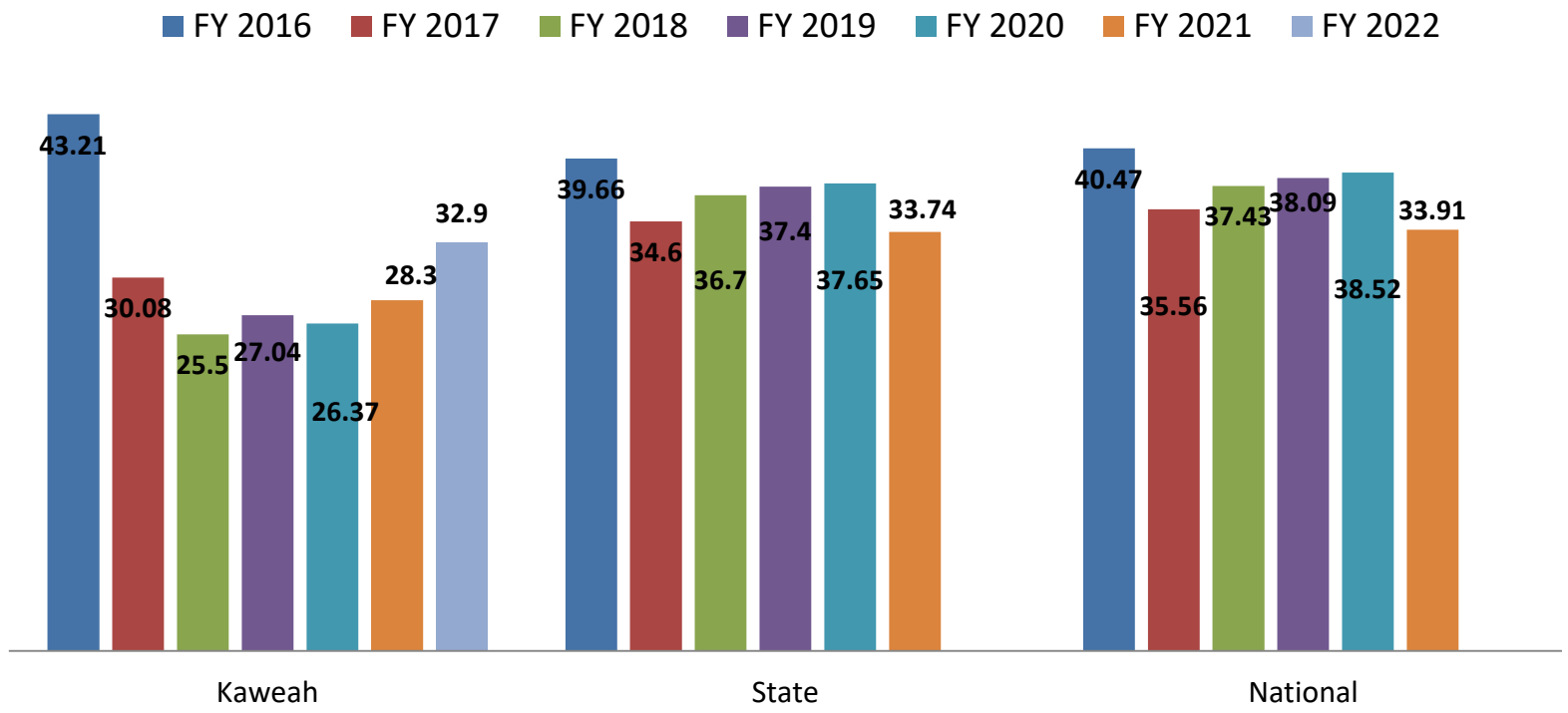
FY 2022 Value-Based Payments Funded by 2.0% Withhold

↓ = Lower Values Indicate Better Performance

FY2022 VBP

- VBP total performance score improved over 3 consecutive years. 2019 = 26.37; 2022=32.9
- FY2022 actuals not reported through CHA until March/April 2022
- Kaweah Health is exempt from VBP program for FY2022 due to ECE

Actual VBP Total Performance Score

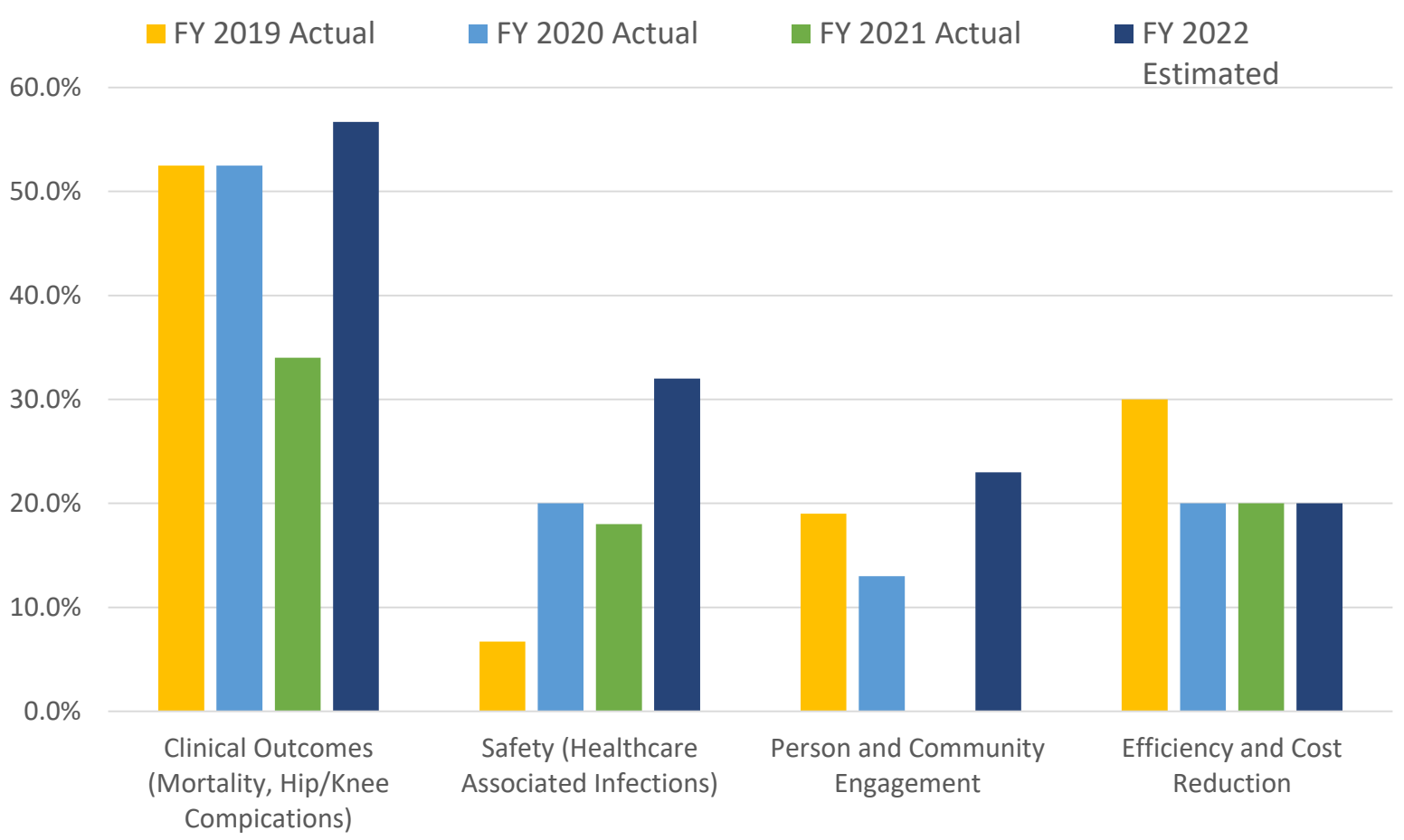


FY 2021 Actual VBP Cost	
Contribution	Payment Received
2% = $1,868,400	1.48% = $1,693,100
($175,300)	

FY 2022 *Estimated* VBP Cost	
Contribution	Payment Received
$1,930,400	$2,019,000
$88,600	

FY2022 VBP

- FY2022 estimated VBP points improved from last 3 years in 3 domains: Clinical Outcomes, Safety and Person & Community Engagement



FY2023 VBP

★New Safety Measure: PSI 90

PSI 90 PATIENT SAFETY FOR SELECTED INDICATORS[1]
PSI 3 Pressure Ulcer Rate
PSI 6 Iatrogenic Pneumothorax Rate
PSI 8 In-Hospital Fall with Hip Fracture Rate
PSI 9 Perioperative Hemorrhage or Hematoma Rate
PSI 10 Postoperative Acute Kidney Injury Requiring Dialysis Rate
PSI 11 Postoperative Respiratory Failure Rate
PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate
PSI 13 Postoperative Sepsis Rate
PSI 14 Postoperative Wound Dehiscence Rate
PSI 15 Abdominopelvic Accidental Puncture or Laceration Rate

Payment adjustment effective for discharges from Oct 1, 2022 through Sept 30, 2023 for performance achieved during the following performance periods:

- Safety, Efficiency and Engagement Domains Outcomes = CY21
- Clinical Care Domain Outcomes = July 1, 2018 through June 30, 2021
- PSI90 = July 1, 2019 through June 30, 2021

FY 2023 Hospital Value-Based Purchasing Quick Reference Guide

Payment adjustment effective for discharges from October 1, 2022 to September 30, 2023

Clinical Outcomes — 25%

Mortality Measures

Baseline Period: July 1, 2013–June 30, 2016 | Performance Period: July 1, 2018–June 30, 2021*

Measure ID	Measure Name	Achievement Threshold	Benchmark
MORT-30-AMI	Acute Myocardial Infarction 30-Day Mortality	0.866548	0.885499
MORT-30-CABG	Coronary Artery Bypass Graft Surgery 30-Day Mortality	0.968747	0.979620
MORT-30-COPD	Chronic Obstructive Pulmonary Disease 30-Day Mortality	0.919769	0.936349
MORT-30-HF	Heart Failure 30-Day Mortality	0.881939	0.906798
MORT-30-PN	Pneumonia 30-Day Mortality	0.840138	0.871741

Complication Measure

Baseline Period: April 1, 2013–March 31, 2016 | Performance Period: April 1, 2018–March 31, 2021*

Measure ID	Measure Name	Achievement Threshold	Benchmark
COMP-HIP-KNEE	Total Hip Arthroplasty/Total Knee Arthroplasty Complication	0.027428	0.019779

Person and Community Engagement — 25%

Baseline Period: Jan. 1, 2019–Dec. 31, 2019 | Performance Period: Jan. 1, 2021–Dec. 31, 2021

HCAHPS Survey Dimensions	Floor (%)	Achievement Threshold (%)	Benchmark (%)
Communication with Nurses	53.50	79.42	87.71
Communication with Doctors	62.41	79.83	87.97
Responsiveness of Hospital Staff	40.40	65.52	81.22
Communication about Medicines	39.82	63.11	74.05
Hospital Cleanliness and Quietness	45.94	65.63	79.64
Discharge Information	66.92	87.23	92.21
Care Transition	25.64	51.84	63.57
Overall Rating of Hospital	36.31	71.66	85.39

Safety — 25%

Patient Safety Composite

Baseline Period: Oct. 1, 2015–June 30, 2017 | Performance Period: July 1, 2019–June 30, 2021*

Measure ID	Measure Name	Achievement Threshold	Benchmark
★⇩ PSI 90	Patient Safety and Adverse Events Composite	0.972658	0.760882

Healthcare-Associated Infections

Baseline Period: Jan. 1, 2019–Dec. 31, 2019 | Performance Period: Jan. 1, 2021–Dec. 31, 2021

Measure ID	Measure Name	Achievement Threshold	Benchmark
⇩ CAUTI	Catheter-Associated Urinary Tract Infection	0.676	0.000
⇩ CDI	Clostridium *difficile* Infection	0.544	0.010
⇩ CLABSI	Central Line-Associated Bloodstream Infection	0.596	0.000
⇩ MRSA	Methicillin-Resistant Staphylococcus *aureus*	0.727	0.000
⇩ SSI	Colon Surgery	0.734	0.000
	Abdominal Hysterectomy	0.732	0.000

Efficiency and Cost Reduction — 25%

Baseline Period: Jan. 1, 2019–Dec. 31, 2019 | Performance Period: Jan. 1, 2021–Dec. 31, 2021

Measure ID	Measure Name	Achievement Threshold	Benchmark
⇩ MSPB	Medicare Spending per Beneficiary	Median MSPB ratio across all hospitals during the performance period	Mean of lowest decile of MSPB ratios across all hospitals during the performance period

(*) These performance periods are impacted by the ECE granted by CMS on March 22, 2020, further specified by CMS on March 27, 2020 and amended in the August 25, 2020 COVID-19 Interim Final Rule. Claims from Quarter (Q)1 2020 and Q2 2020 will not be used in the claims-based measure calculations.

⇩ Indicates lower values are better for the measure. ★ Indicates a new measure in the Hospital VBP Program.

FY2023 VBP Clinical Outcome (25% of VBP Points)

Mortality monitored through the Midas system which is not a direct comparison to CMS mortality measures but provides a reliable indication of risk adjusted mortality outcomes. Midas is in hospital observed/expected ratio; CMS reports a risk adjusted 30 day mortality percent.

	VBP FY 2022 Performance	VBP FY2023 Performance
Clinical Outcome Population Measure (Medicare population)	July 1, 2017 through June 30, 2020 (PN Sept 1, 2017 through June 30, 2020) (THA/TKA April 1, 2017-–March 31, 2020) VBP 2022 Performance Period	July 1, 2018 through June 30, 2021 VBP 2023 Performance Period
Acute Myocardial Infarction (AMI) Mortality observed/expected	0.877	0.82
Coronary Artery Bypass Graft (CABG) Surgery; Mortality observed/expected	1.22	1.17
Heart Failure Mortality observed/expected	1.00	0.95
COPD Mortality observed/expected	1.13	1.26
Pneumonia –Viral Mortality observed/expected	0.62	0.84
Pneumonia –Bacterial Mortality observed/expected	1.02	0.96
Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA) complication Rate	1.44	1.39

*Midas initiated June 2015; unable to obtain VBP 2023 baseline since the period for VBP 2023 is July 1, 2013 through June 30, 2016

FY2023 VBP Safety (25% of VBP Points)

PSI-90 monitored through the Midas system which is not a direct comparison to CMS PSI measures but provides an indication of the direction of performance.

	VBP FY 2022 Performance	VBP 2023 Baseline Performance	VBP FY2023 Performance
Safety Measure	CY2020 VBP 2022 Performance Period	CY 2019 Infections PSI-90 3Q 2015–2Q 2017	CY 2021 (YTD ending July 2021) VBP 2023 Performance Period
CAUTI Standardized Infection Ratio	0.340	1.168	0.592
CLABSI Standardized Infection Ratio	0.598	0.790	0.605
MRSA Standardized Infection Ratio	2.481	1.218	2.269
C Diff Standardized Infection Ratio	0.123	0.226	0.490
SSI – Colon Standardized Infection Ratio	0.154	0.167	0.350
SSI – Hysterectomy Standardized Infection Ratio	0.0	1.451	0.0
Patient Safety Indicator (PSI) 90 (composite score)	n/a	0.93	1.22

*CMS through the VBP program awards achievement points and improvement points based on the organizations baseline performance

FY2023 VBP Patient Engagement* (25% of VBP Points)

	VBP FY 2022 Performance	VBP 2023 Baseline Performance	VBP FY2023 Performance
HCAHPS Measure (Medicare population)	CY2020 VBP 2022 Performance Period	CY 2019	CY 2021 (YTD ending June 2021) VBP 2023 Performance Period
Communication with Nurses	78.51%	81.48%	78.82%
Communication with Doctors	79.53%	81.80%	79.67%
Responsiveness of Hospital Staff	67.92%	71.81%	70.47%
Communication about Medicines	67.70%	66.11%	67.37%
Hospital Quietness	55.38%	59.75%	57.27%
Hospital Cleanliness	70.79%	71.45%	71.36%
Discharge Information	88.77%	88.52%	88.31%
Care Transition	51.63%	50.08%	49.69%
Overall Rating of Hospital	74.48%	76.45%	74.50%

*Data from JL Morgan
CMS through the VBP program awards achievement points and improvement points based on the organizations baseline performance

Questions?

Live with passion.

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

Kaweah Health

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

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

Measure Objective/Goal:

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

Date range of data evaluated:

January 2021 – June 2021

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

We currently are performing above the benchmark of 80.0%.

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

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

Next Steps/Recommendations/Outcomes:

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

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

Date Submitted: 07/09/2021

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

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

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

Measure Objective/Goal:

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

Date range of data evaluated:

January 2021 – June 2021

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

We currently are performing above the benchmark of 52.2%.

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

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

Next Steps/Recommendations/Outcomes:

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

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

Date Submitted: 07/09/2021

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

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

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

Measure Objective/Goal:

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

Date range of data evaluated:

January 2021 – June 2021

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

We currently are performing below the benchmark of 93.9%.

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

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

Next Steps/Recommendations/Outcomes:

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

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

Date Submitted: 07/09/2021

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

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

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

Measure Objective/Goal:

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

Date range of data evaluated:

January 2021 – June 2021

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

We currently are performing above the benchmark of 75%.

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

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

Next Steps/Recommendations/Outcomes:

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

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

Date Submitted: 07/09/2021

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

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

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

Measure Objective/Goal:

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

Date range of data evaluated:

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

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

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

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

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

5. **Goal Met at 94%**

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

1. Goal met no interventions, continue to monitor.

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

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

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

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

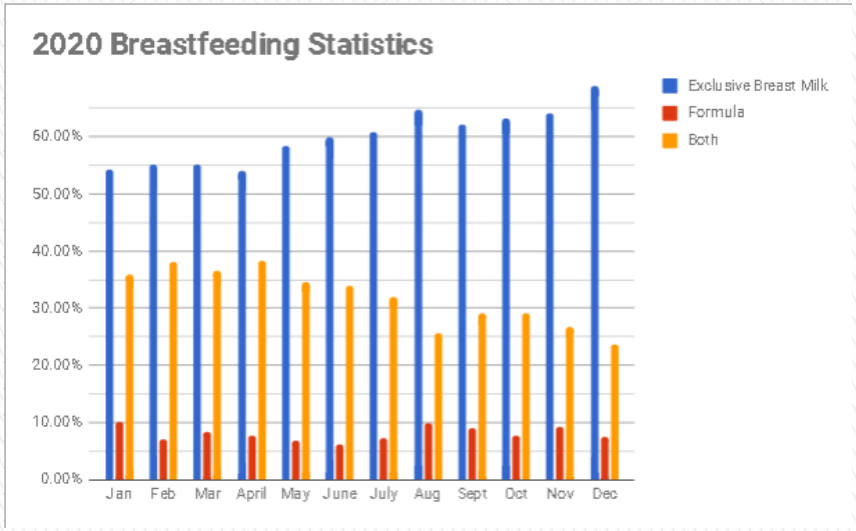
Submitted by Name: **Roberta DeCosta** **Date Submitted:** **7-2-2021**

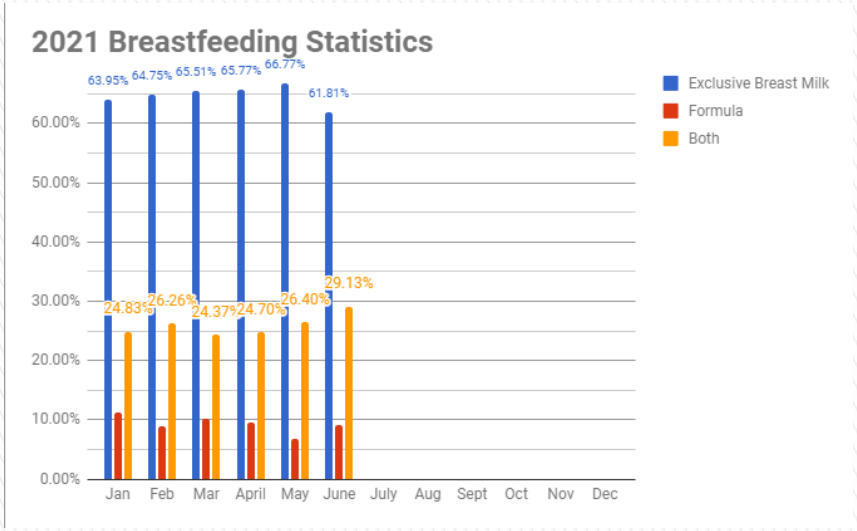
Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Mother/Baby Quality Data

January – June 2021

Breastfeeding Stats

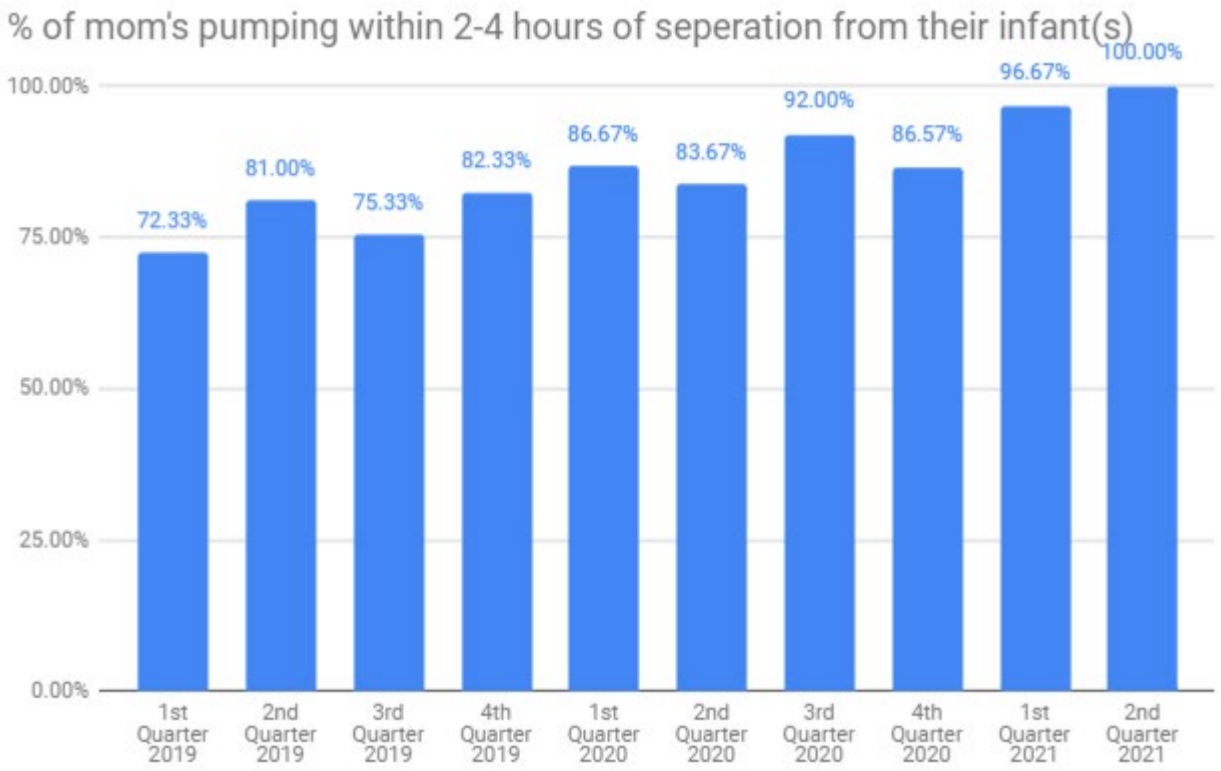




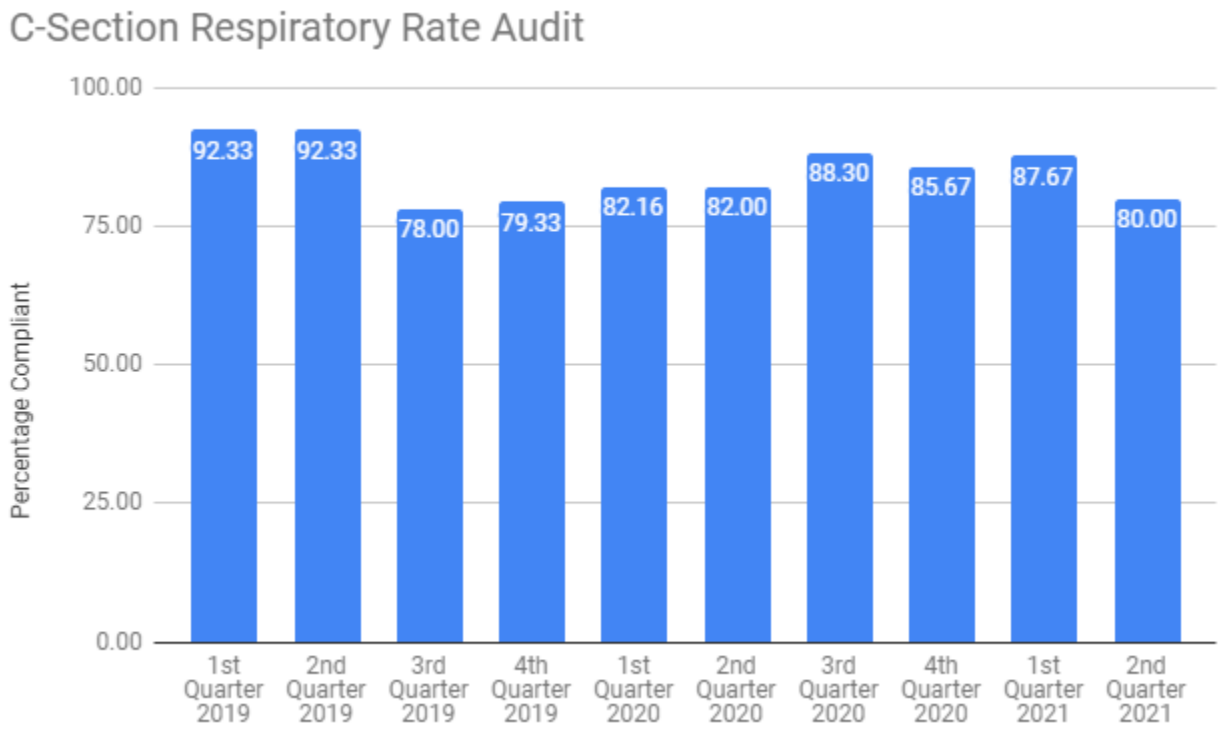
2020

2021

NICU MOM'S PUMPING



C-SECTION RESPIRATORY RATE AUDIT



Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

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

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

Date range of data evaluated:
January-June 2021

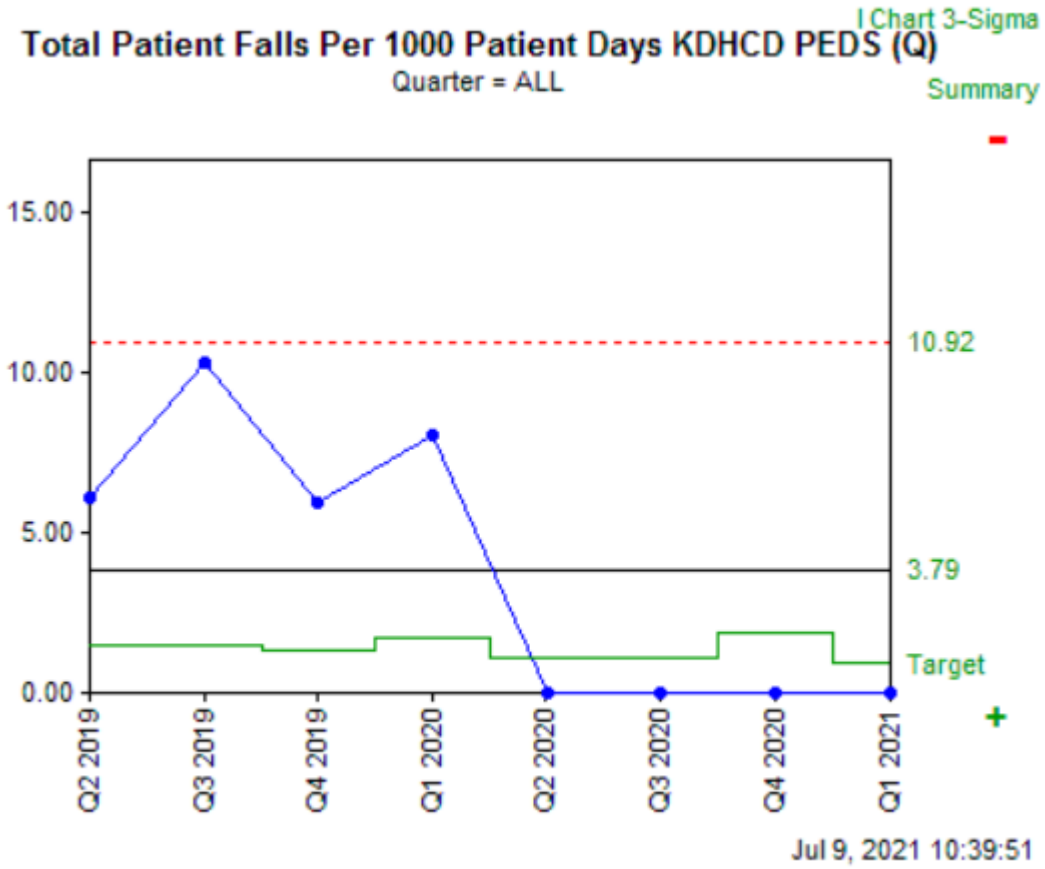
Analysis of all measures/data: (Include key findings, improvements, opportunities)
We have 0 Patient falls during this quarter. This is better than the benchmark.

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

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

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

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



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

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

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

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

Date range of data evaluated:
January-June 2021

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

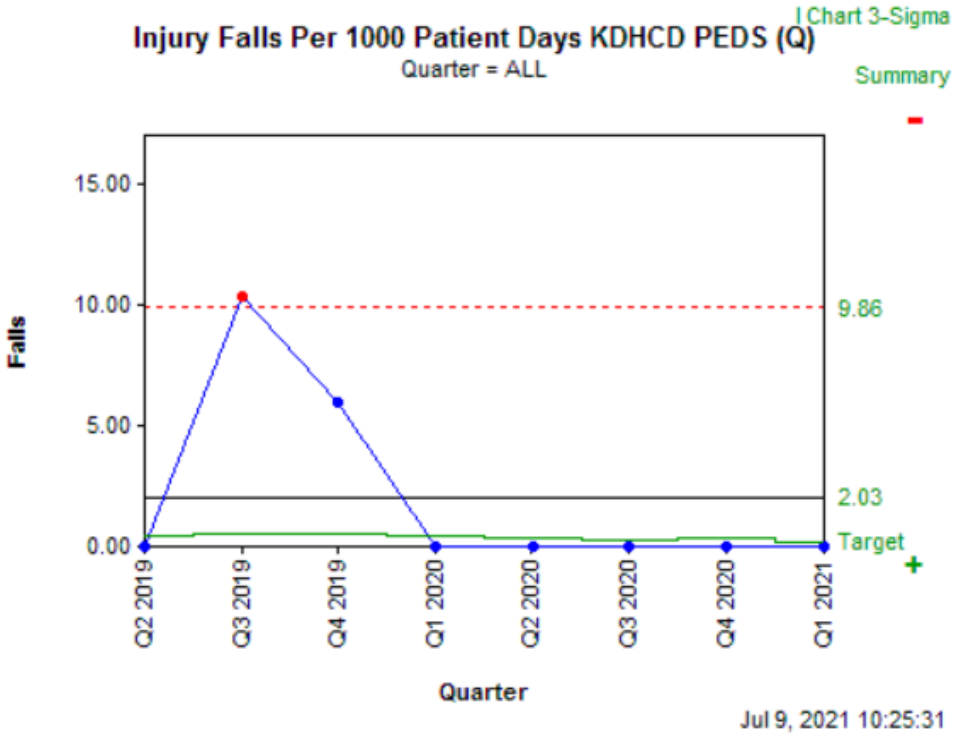
If improvement opportunities identified, provide action plan and expected resolution date:

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

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

Date Submitted: 07/09/21

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



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

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

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

Measure Objective/Goal:

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

Date range of data evaluated:

January-June 2021

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

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

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

Next Steps/Recommendations/Outcomes:

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

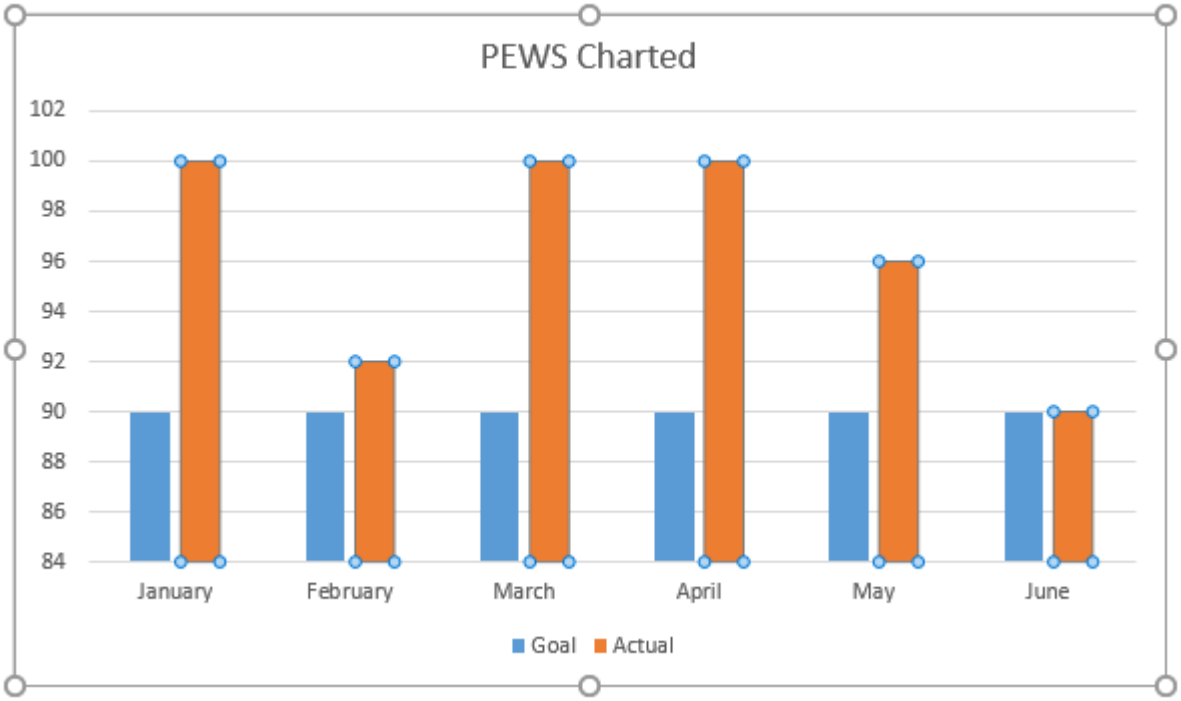
Submitted by Name: Danielle Grimaldi, RN, BSN, CPN

Date Submitted: 07/09/21

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee



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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

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

Measure Objective/Goal:

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

Date range of data evaluated:

January-June 2021

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

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

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

Next Steps/Recommendations/Outcomes:

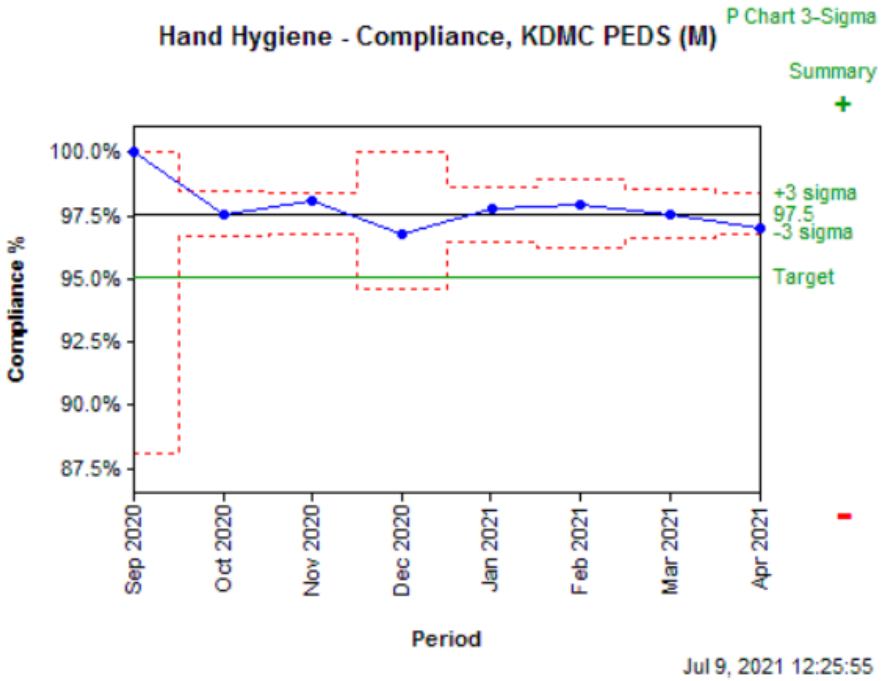
Continue to maintain hand hygiene compliance scoring greater than 95% expected with next report date.

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

Date Submitted: 07/09/21

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

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



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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

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

Measure Objective/Goal:

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

Date range of data evaluated:

January-June 2021

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

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

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

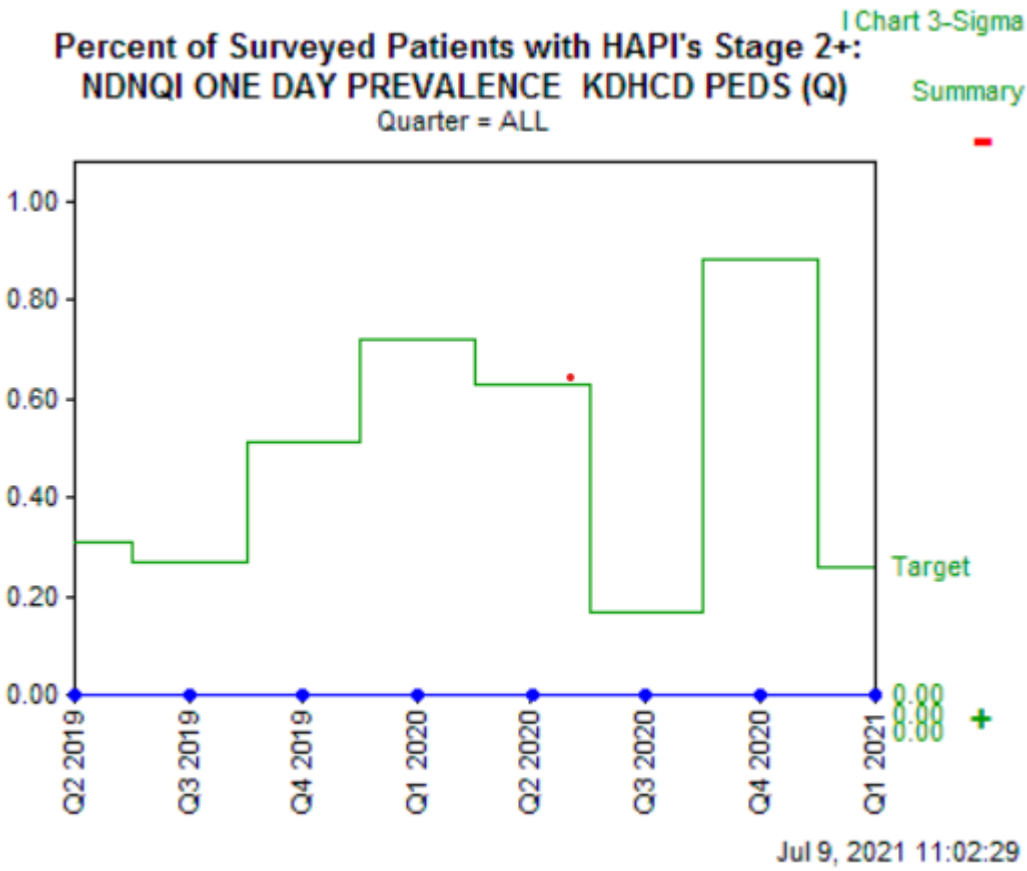
Next Steps/Recommendations/Outcomes:

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

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

Date Submitted: 07/09/21

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



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

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

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

Measure Objective/Goal:

Catheter Associated Urinary Tract Infection
Goal: 0.00
Goal met.

Date range of data evaluated:

January-June 2021

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

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

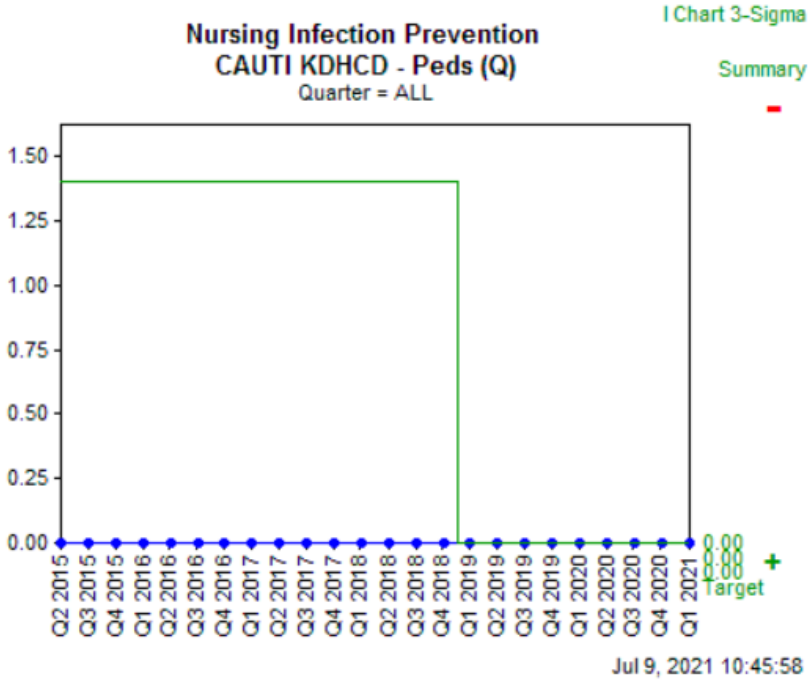
If improvement opportunities identified, provide action plan and expected resolution date:

Next Steps/Recommendations/Outcomes:

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

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

Date Submitted: 07/09/21



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

Unit/Department Specific Data Collection Summarization

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

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

Date range of data evaluated:
January-June 2021

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

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

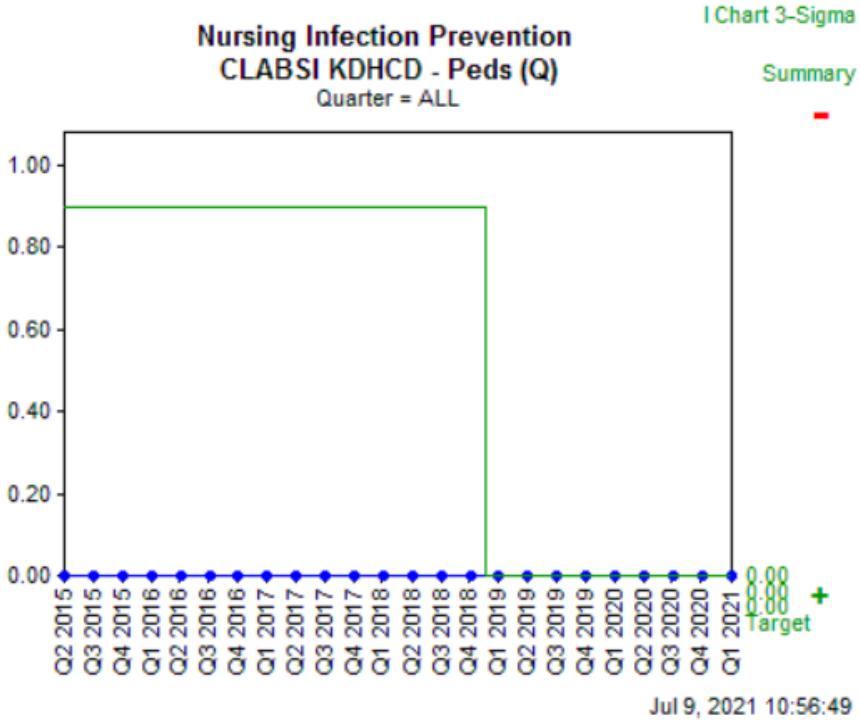
Next Steps/Recommendations/Outcomes:
We will continue to use aseptic technique to perform scheduled dressing and cap changes. We will also continue to evaluate need for central line on a daily basis.

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

Date Submitted: 07/09/21

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

Unit/Department Specific Data Collection Summarization



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

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

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

Measure Objective/Goal:

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

Date range of data evaluated:

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

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

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

CLASBI Rate for KDMC NICU 2021

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

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

VAP Rate NICU 2021

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

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

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

BIOVIGIL®
Kaweah Delta

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

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

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

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

Next Steps/Recommendations/Outcomes:

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

Submitted by Name:
Felicia T. Vaughn

Date Submitted:
July 8th, 2021

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

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

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

Measure Objective/Goal:

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

Date range of data evaluated:

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

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

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

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

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

5. **Goal Met at 94%**

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

1. Goal met no interventions, continue to monitor.

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

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

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

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

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

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

Unit/Department Specific Data Collection Summarization

QIC/ProStaff Committee Report

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

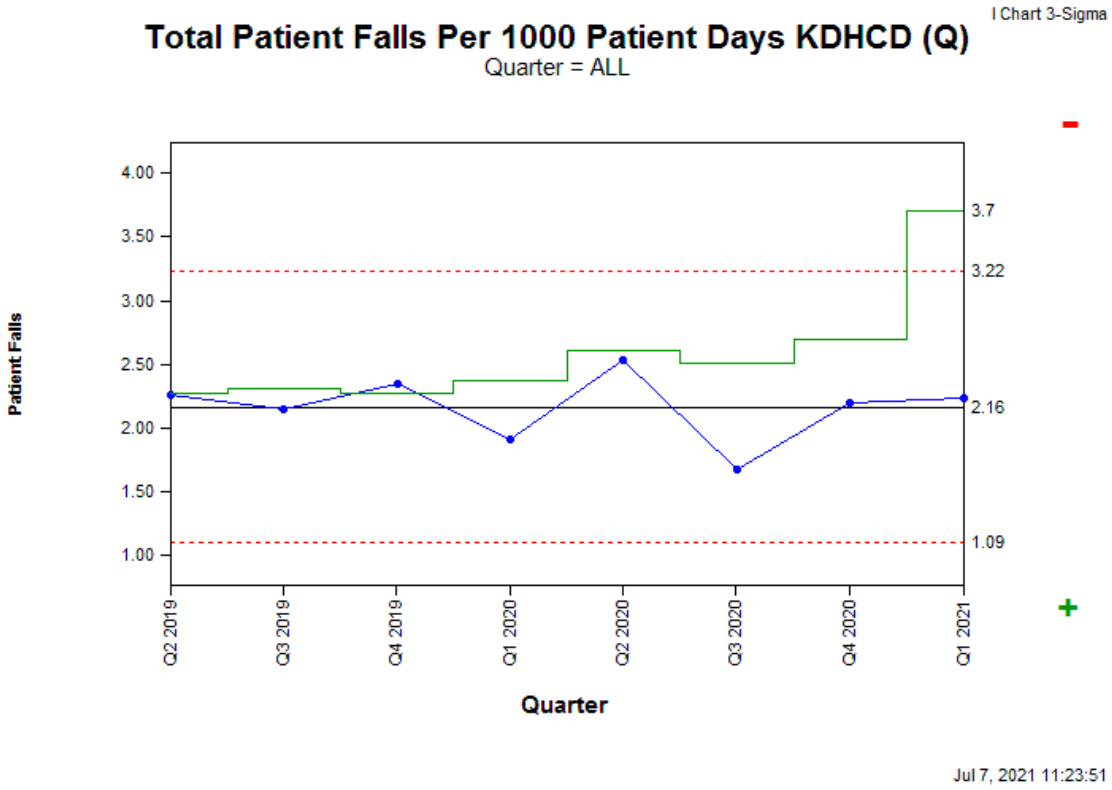
Kaweah Delta Nursing Unit Falls Data, Benchmarked Nationally:

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

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

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

DATE RANGE **Q4 2020 – Q1 2021**



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

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

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

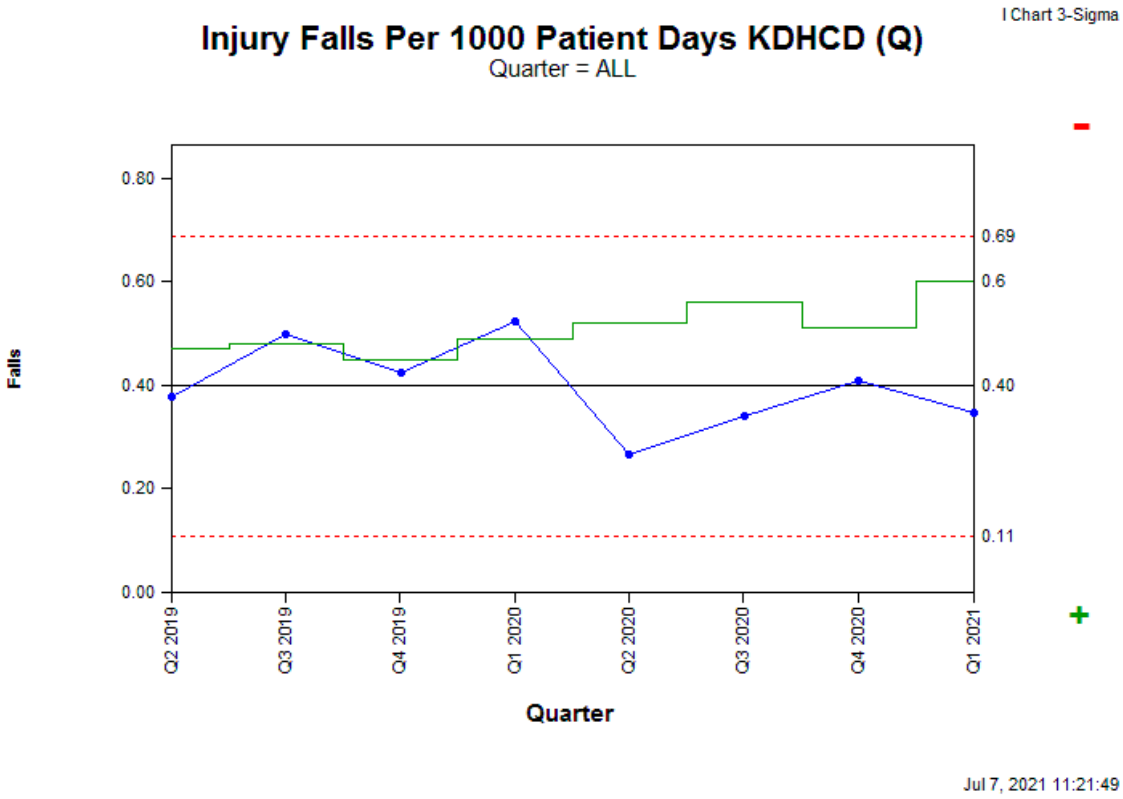
Unit/Department Specific Data Collection Summarization

QIC/ProStaff Committee Report

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

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

DATE RANGE **Q4 2020 – Q1 2021**



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

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

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

Unit/Department Specific Data Collection Summarization

QIC/ProStaff Committee Report

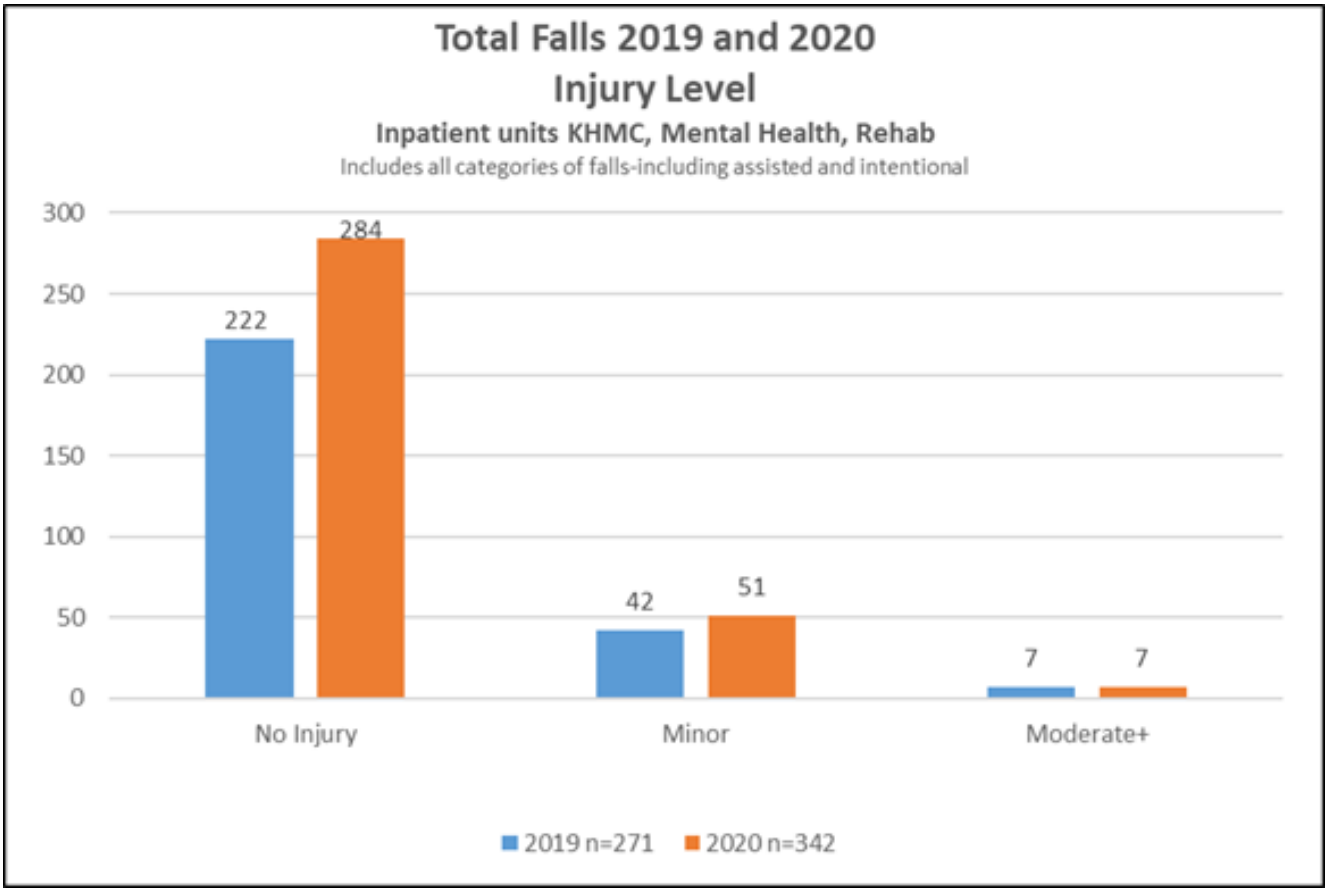
INDICATOR #3 **Total Falls – Injury Level**

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

DATE RANGE **CY 2019 – 2020**

NDNQI Defined Injury Levels

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



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

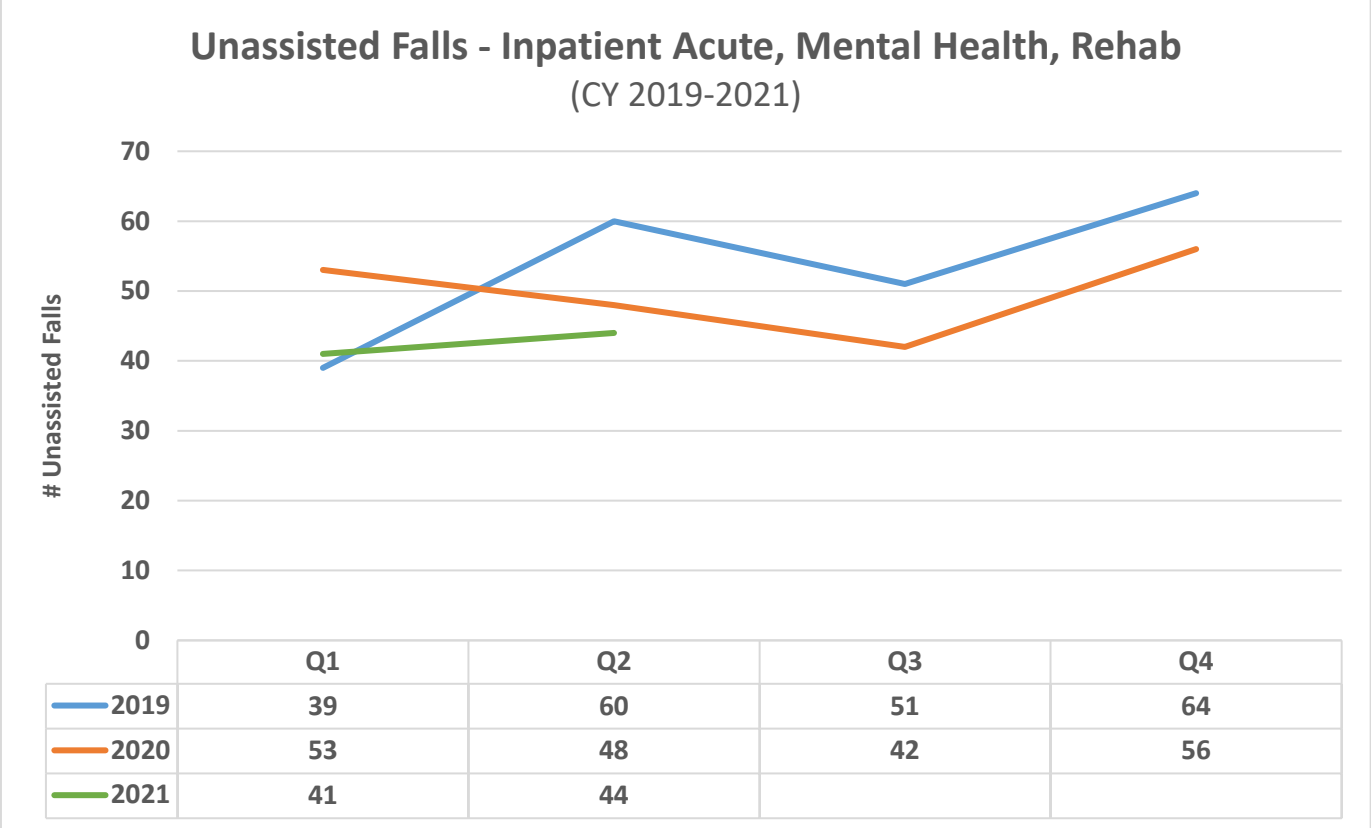
⦸ **Goal not met:**

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

INDICATOR #4 **Unassisted Falls**

GOAL **Reduce unassisted falls by 10%**

DATE RANGE **Q1 – Q2 2021**



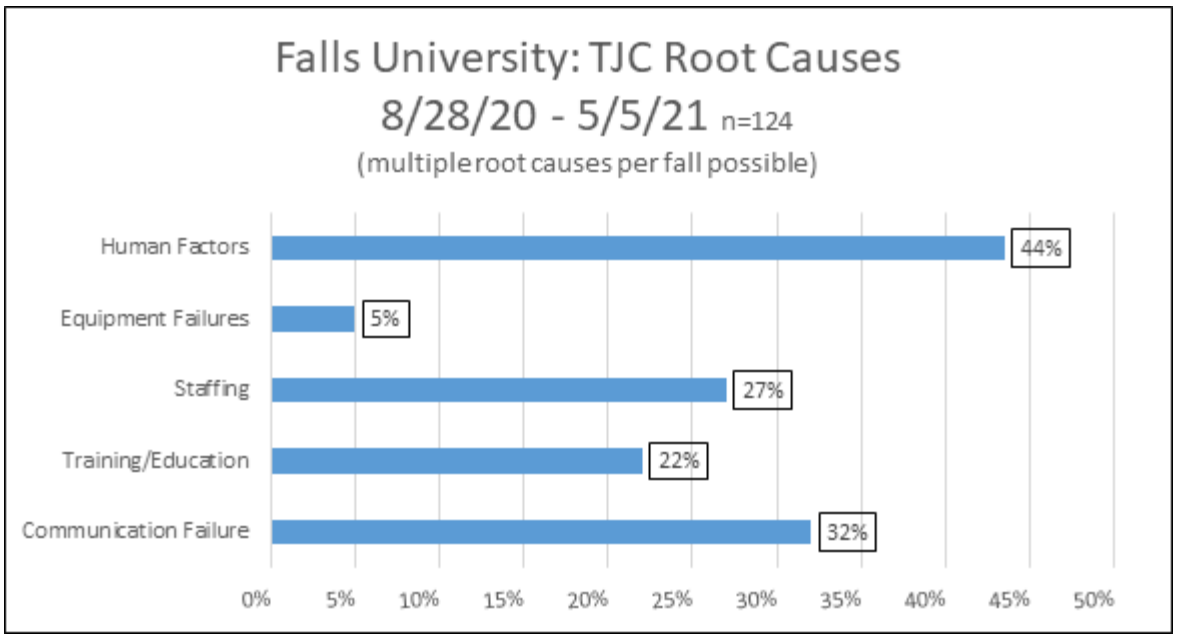
	Q1	Q2	Q3	Q4
2019	39	60	51	64
2020	53	48	42	56
2021	41	44		

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

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

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

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



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

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

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

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

DATE SUBMITTED: **July 8, 2021**

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2021							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
I. Environmental Surveillance							
A. Sterilization and High Level Disinfection Quality Control	Goal <2%						
Goal <2% Immediate Use Steam Sterilization		1.20%	2.1%				**1st QTR:** SPD saw a 0.5% decrease in IUSS events compared to the 1st QTR 2020 and has done well in sustaining limited IUSS. **2nd QTR:** Goal not met. Both April and especially June exceeded 2% IUSS threshold. SPD has requested purchase of additional surgical instruments to offset future needs and reduce IUSS.
B. Dialysis Water/Dialysate Quality Control (AAMI RD52:2004) (% of machines that did not exceed limits)	Goal 100%						
RO Water [Target: <200cfu] [Action: > or = 50cfu]		100%	100%				**1st QTR:** 6 Reverse Osmosis & 5 Dialysis Machine samples tested all passed with no action required. **2nd QTR: (Outpatient Dialysis)** 6 Reverse Osmosis & 8 Dialysis Machine samples tested all passed with no action required. **(Acute Dialysis)** 51 Reverse Osmosis & 12 Dialysis Machine samples tested all passed with no action required.
Endospore [Target: <2EU] [Action: > or = 1EU]		100%	100%				**1st QTR:** 6 Reverse Osmosis & 5 Dialysis Machine samples tested all passed with no action required. **2nd QTR: (Outpatient Dialysis)** 8 Dialysis machines tested for bacteria and endotoxins all passed with no action required. **(Acute Dialysis)** 51 Reverse Osmosis samples were tested for bacteria and endotoxins all passed with no action required.
C. Environmental Cleaning (ATP testing surfaces)							
Pass/Fail based on a threshold of ATP score of <200. Multiple high-touch surfaces tested each month.	Goal 100%	67%	43.1%				**1st QTR:** A total of 103 surfaces were tested and 69 passed the first time. **2nd QTR:** A total of 65 surfaces were tested and 28 passed the first time. There has been a lower rate of surfaces tested
II. Antimicrobial Stewardship Measures							
Number of antibiotic IV to PO conversion interventions		185	273				**1st QTR:** CVICU has seen the greatest number of IV to PO conversion as there are greater opportunities for conversions due to the selections of medications often used on the unit. **2nd QTR:** CVICU remains the unit with the highest IV to PO conversion rate. However, 3N, 3S, and ICU demonstrated substantial increases in IV-to-PO conversion. This is very helpful in reducing the need for IV access that increases risk for bloodstream infection.
Average Days of Therapy per 1,000 patient days - Fluoroquinolones	Goal <7.87	5.84	7.63				**1st QTR:** Data received late. Goal achieved. **2nd QTR:** An uptick in use by almost 2 points. Barely achieved goal. Will continue to monitor for increase use and rationales.
Average Days of Therapy per 1,000 patient days - Carbapenems	Goal <19.72	15.45	16.41				**1st QTR:** Data received late. Goal achieved. **2nd QTR:** An uptick in use by almost 1 point, but well within goal.
III. Employee Health							
A. Needlestick Injuries							
Number of sharps/needle stick reports		23	17				**1st QTR:** There were 23 needle stick exposures (5 in January, 8 in February, 10 in March). A total of 9 of the needle stick exposures involved a SQ needle (Lovenox, Insulin, Heparin, Epoetin). There were 8 needle sticks that occurred during disposal of a needle before activating the safety mechanism and a remaining 4 needle stick injuries that occurred before activating the safety mechanism involving a different action such as obtaining a specimen, giving medications, and performing patient care. Employee Health developed an educational flyer about appropriate handling of sharps that has been shared twice at the new Safety Liaison Committee. **2nd QTR:** There was a 74% reduction in Sharps exposures comparing 1st to 2nd QTR rates. A combination of same day on-site investigation with employee and follow-up with manager, along with Sharps education provided to new employees as part of orientation appears to be helping decrease Sharps exposure events.
B. Blood/Body Fluid Exposures							
Number of blood/body fluid exposures		1	0				**1st QTR:** There was one blood/body fluid exposures during this quarter. Splashes are no longer required reporting per OSHA and are only internally monitored. **2nd QTR:** No blood/body fluid exposures during 2nd QTR.
IV. Healthcare Associated Infection Measures							

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
I. Overall Surgical Site Infections (SSI)	**IR/SIR**						**SSIs calculated internally though standard incidence rate and externally through Standardized Infection Ratio (SIR) from National Health and Safety Network (NHSN).**
A. #Total Procedure Count		1279	1112				**Cumulative Ct.:** 2391
B. Total Infection Count *[note: SSI events can be identified up to 90 days from the last day of the month in each quarter and only DIP and Organ Spc SSI are reported in NSHN]*		9	8				**1st QTR:** 9 **Predicted:** 17.262 **2nd QTR:** 8 **Predicted:** 14.446
C. Incidence Rate (IR) [# of total SSI infections/# total procedures x 100]	Internal 0.70 Goal	0.7	0.7				**1st QTR:** Total of number of SSI events matched the Statewide threshold of 0.70. **2nd QTR:** Total number of SSI events are no different than Statewide threshold of 0.70.
D. SIR Confidence Interval (CI-KDHCD predicted range, based on risks)		0.077, 0.822	0.257, 1.052				**1st QTR:** Same as State average. **2nd QTR:** Same as State average.
E. Standardized Infection Ratio (SIR)	NHSN	0.521	0.554				**1st QTR:** 1 APPY, 1 CBGB, 1 CRAN, 1 SB, 1 KPRO, 1 FX, 1 XLAP, 1 FUSN. Contributing factors: Outside facilities where surgical patients are transferred are not following discharge orders and/or discharge instructions were not sent. Glucose control for Diabetic surgical patients. Post-op education and patient compliance. All of these factors are discussed at the SSI prevention committee and interventions are being considered for implementation. **2nd QTR:** 1 HYST, 1 CHOL, 1 COLO, 1 BRST, 1 FUSN, 1 FX, 2 SB. Generally SSI events during 2nd QTR occured between days 12 and 27 post operatively (primarily on day 12).
II. Specific Surgical Review	**SIR**						
A. Colon Surgery (COLO) CMS/VBP							
1. #Total Procedure Count		36	39				**Cumulative Ct.:** 75
2. Total Infection Count		0 [0]	1 [0]				**1st QTR:** 0 **Predicted:** 3.053/**(CMS)** 0 **Predicted:** 1.043 **2nd QTR:** 1 Predicted: 2.659/**(CMS)** 0 **Predicted:** 1.219
3. SIR CI (KDHCD predicted range, based on risks)		, 0.981	0.019, 1.855				**1st QTR:** Better than national benchmarks. **2nd QTR:** Better than national benchmarks.
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.749	0 [0]	0.38 [0]				**1st QTR:** No COLO events excellent work! **2nd QTR:** 1 COLO event. 27 days post-op. Multiple intra-operative variables (hair removal in OR, misfiring stapler, cut-time prior to arrival of surgeon, difficult indwelling urinary catheter insertion, very high intra-op blood glucose).
B. Cesarean Section (CSEC)							
1. #Total Procedure Count		348	254				**Cumulative Ct.:** 602
2. Total Infection Count		0	0				**1st QTR:** 0 **Predicted:** 3.089 **2nd QTR:** 0 **Predicted:** 2.311
3. SIR CI (KDHCD predicted range, based on risks)		, 0.970	, 1.297				**1st QTR:** Better than predicted **2nd QTR**: Better than predicted
4. SIR (Standardized Infection Ration) total	Goal SIR <1.00	0	0				**1st QTR:** No C-section events excellent! **2nd QTR:** No C-section events excellent work!
C. Spinal Fusion (FUSN)							
1. #Total Procedure Count		52	50				**Cumulative Ct.:** 102
2. Total Infection Count		1	1				**1st QTR:** 1 **Predicted:** 0.763 **2nd QTR:** 1 **Predicted:** 0.753
3. SIR CI (KDHCD predicted range, based on risks)		NA	NA				**1st QTR:** No C.I. **2nd QTR:** No C.I.
4. SIR (Standardized Infection Ration) total	Goal SIR <1.00	1.31	1.33				**1st QTR:** Greater than predicted number of FUSN SSI events. Patient discharged home 2 days post-op. Event occurred 23 days post-op and patient went AMA when providers in ED recommended an I&D of abscess - he returned on day 29 post-op for the I&D procedure. Patient's glucose remained elevated post-op (DM) and his wound dehisced several days post-op. **2nd QTR:** Event occured 22 days post-op. Wound dehiscence noted along spinal incision. Wound culture positive for MSSA (typical skin flora).
D. Hysterectomy (HYST) CMS/VBP							
1. #Total Procedure Count		29	15				**Cumulative Ct.:** 44
2. Total Infection Count		1 [1]	1 [0]				**1st QTR:** 1 **Predicted:** 0.5 /**(CMS)** 1 **Predicted:** 0.248 **2nd QTR**: 1 **Predicted:** 0.283/**(CMS)** 0 **Predicted:** 0.126
3. SIR CI (KDHCD predicted range, based on risks)		NA	NA				**1st QTR:** No C.I. **2nd QTR:** No C.I.
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.727	1 [4.03]	3.53 [0]				**1st QTR:** 1 HYST event. **2nd QTR:** No HYST SSI events!
III. Ventilator Associated Events (VAE)							
A. Ventilator Device Use SUR (standardized utilization ratio)	Goal <1.0	2.20	1.8				**1st QTR:** 1247 device days **Predicted:** 567 device days **2nd QTR:** 915 devices days **Predicted:** 508 device days

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
B. Total VAEs ICU (NHSN Reportable)	Includes IVAC Plus						
1. SIR Total VAE CI (KDHCD predicted range, based on risks)		,0.304	1.687, 1.920				**1st QTR:** Greater than predicted device days **2nd QTR**: Greater than predicted device days
2. Total VAEs		7	0				**1st QTR:** All events were related to alterations in PEEP resulting in a VAC in the ICU. **2nd QTR:** 0 event Predicted: 7.231
C. Total IVAC Plus -ICU		0	0				**1st QTR:** No IVAC or PVAP events. **2nd QTR:** 0 IVAC Predicted: 2.683
1. Total IVAC Plus CI (KDHCD predicted range, based on risks)		,0.819	, 1.117				**1st QTR:** Less than predicted events **2nd QTR**: Less than predicted events
2. Total IVAC *Plus* ICU SIR	Goal SIR <1.00	0	0				**1st QTR:** No IVAC or PVAP events, only Ventilator Associated Conditions (VAC) which involves changes in PEEP and/or Fi02. Education provided to Respiratory Therapy re: limiting increases in PEEP to increments < or = 2 points. **2nd QTR:** 0 VAE events. There was 1 PVAP event that occured on a non-ICU (5T), and therefore is not reportable.
D. Total VAEs CVICU (NHSN Reportable)	Includes IVAC Plus						
1. Total VAEs		0	0				**1st QTR:** No VAE events occurred. **2nd QTR:** No VAE events occurred.
2. Total IVAC Plus CVICU SIR	Goal SIR <1.00	0	0				**1st QTR:** No VAE events occurred. **2nd QTR:** No VAE events occurred.
3. Total VAEs-Both Units		7	0				**1st QTR:** Only VAC identified for the quarter in the presence of increased ventilator days related to the COVID-19 pandemic. **2nd QTR:** No VAE events occurred.
1. VAE Prevention Process Measures	Goal 100%						
% Head of Patient >or=30 Degrees (per visual inspection)		98%	98.7%				**1st QTR:** Process measure close to goal, still some opportunity for improvement. **2nd QTR**: Slight improvement in this process indicator yet goal not achieved.
% Sedation Vacation		98%	91.7%				**1st QTR:** Process measure close to goal, still some opportunity for improvement. **2nd QTR:** Significant drop providing sedation vacation. Will explore reason for this action.
% Oral Care Provided (per visual inspection)		98%	98.0%				**1st QTR:** Process measure close to goal, still some opportunity for improvement. **2nd QTR:** Process measure holding steady at 2% marks below goal. Will work on ways to encourage consistent oral care 100% of the time.
% CHG Bath within last 24 hours			97.3%				**2nd QTR:** CHG bathing has improved across the organization, however, there are challenges with access and implementation that are being addressed.
% Vent Tubing Position Appropriately (drain away from patient - visual inspection)			100.0%				**2nd QTR:** Goal achieved.
IV. Pneumonia Long Term Care/Rehabilitation	Goal = 0						
Short Stay (# of Infections/ Incidence Rate)		0	0				**1st QTR:** No events. **2nd QTR:** No events.
Transitional Care (# of Infections/ Incidence Rate)		0	0				**1st QTR:** No events. **2nd QTR:** No events.
Subacute (# of Infections/ Incidence Rate)		2/(0.76)	1/(0.397)				**1st QTR:** Two patients that met Pneumonia criteria. Education provided about elevating the head-of-bed and mobility. **2nd QTR:** 1 patient that met Pneumonia criteria.
VI. Central Line Associated Blood Stream Infections (CLABSI) CMS/VBP	**NHSN SIR**						
A. Total number of Central Line Days (CLD)		4360	2684				**1st QTR:** 4360 CLD **Predicted:** 5613 CLD **2nd QTR**: 2684 CLD **Predicted:** 3,716 CLD
B. Central Line Device Use SUR (standardized utilization ratio)		0.875	0.722				**1st QTR:** CLD during this quarter remained <90% predicted. **2nd QTR:** CLD during this quarter was 72% of predicted.
C. Total Infection Count Valule Based Purchasing (VBP) # events = [ ]		3 [3]	1 [1]				**1st QTR:** 3 **Predicted:** 4.306 /**(CMS)** 3 **Predicted:** 2.624 **2nd QTR:** 1 Predicted: 2.662/**(CMS)** 1 **Predicted:** 1.682
D. SIR Confidence Interval		0.177, 1.896	0.019, 1.852				**1st QTR:** Same as national benchmarks. **2nd QTR**: Same as national benchmarks.
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.633	0.697 [1.143]	0.376 [0.595]				**1st QTR:** Several interventions underway to address CLABSI (Culture of culturing; Midlines as an alternative; Gemba Rounds; Just in case culture; Nurse/Resident education; BC Alert; Candida Score; Fever defined; TPN-Enteral Feeding and Antimicrobial Stewardship - IV to PO conversion). **2nd QTR:** Interventions are starting to make a dent in the rate of CLABSI events. Actively working on a the Candida Scoring tool, Blood Culture Decision Tree - CRBSI Protocol, changed Blood Culture Alert to allow ordering every 72 hours instead of every 24 hours.
F. CLABSI Prevention Process Measures	Goal 100%						

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
% of patients with a bath within 24 hours		96%	95%				**1st QTR:** Consistent bathing is improving. **2nd QTR:** 5% = 108 opportunities for a bath not performed.
% of central lines inserted with a valid rationale		98%	98%				**1st QTR:** Documentation of indication for central lines has gotten much better. **2nd QTR:** 2% = 43 observations in which patients with a central had not a valid rationale for a central line.
% of central line dressings clean, dry and intact		95.3%	96%				**1st QTR:** Dressing management needs to improve. **2nd QTR:** 4% = 87 observations in which patients with a central line covered with an unintact and/or dirty dressing.
% of central line dressing changes no > than 7 days		99%	98.5%				**1st QTR:** Dressing changes within 7 days has greatly improved. **2nd QTR:** 1.5% = 32 observations in which patients with a central line had a dressing over the line insertion site unchanged for > 7 days.
% of patients with properly placed CHG patch		92.7%	94%				**1st QTR:** Education for both new hire and current nurses hired within the past 1 1/2 years regarding CLABSI prevention and dressing management initiated toward the end of this quarter. **2nd QTR:** 6% = 127 observations in which patients with a central line had a GuardIVa CHG patch that didn't properly encircle the line insertion site.
% of patients with appropriate & complete documentation		92.7%	92.50%				**1st QTR:** Documentation appears to be posing some difficulty. Further analysis required regarding this issue. **2nd QTR:** 7.5% = 162 observations in which patients with a central line did not have documentation in the electronic health record describing interventions associated with the device.
# of central line days rounded on		3,256	2,166				**1st QTR:** Gemba Rounds were performed on 74.7% of all days in which a patient had a central line in place. **2nd QTR:** Note that the amount of GEMBA Rounds depicted for 2nd QTR include only April and May. June data was not yet compiled.
Skilled Nursing/Acute Rehab % of central dressing clean/dry/intact			99%				**1st QTR:** New measure no data available. **2nd QTR:** Goal nearly achieved.
Skilled Nursing/Acute Rehab % of central line dressings changed no > 7 days			93.5%				**1st QTR:** New measure no data available. **2nd QTR:** Central line dresssing changes are not occuring in a timely manner which increases risk for infection. IP is working with nursing staff to improve response to this measure.
VII. Catheter Associated Urinary Tract Infections (CAUTI) **CMS/VBP**	**NHSN SIR**						
A. Total number of Catheter Device Days (CDD)		4048	2429				**1st QTR:** 4048 CDD **Predicted:** 4874 CDD **2nd QTR:** 2429 CDD **Predicted:** 3192 CDD
B. Catheter Device Days SUR (Standardized Utilization Ratio)	Goal <1.0	0.787	0.761				**1st QTR:** CDD during this quarter remained <79% of predicted. **2nd QTR:** CDD during this quarter dropped a few percentage point to 76% of predicted.
C. Total Infection Count Value Based Purchasing (VBP) # of events = [ ]		1 [0]	4 [4]				**1st QTR:** 1 **Predicted:** 5.278 /**(CMS)** 0 **Predicted:** 2.879 **2nd QTR:** 4 **Predicted:** 3.160/**(CMS)** 4 Predicted: 1.625
D. SIR Confidence Interval		0.009, 0.934	0.402, 3.053				**1st QTR:** Better than national benchmarks. **2nd QTR:** No different that national benchmarks.
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.727	0.189 [0]	1.266 [2.461]				**1st QTR: Several interventions underway to address CAUTI** (Alternatives to an IUC; Management of Urinary Retention; Urine Culture algorithm; Peri-care & Bathing; Integreation of reminders in PowerPlans) **2nd QTR**: Indwelling Urinary Catheters are being removed more readily during GEMBA rounds. Management of Urinary Retention still needs to be addressed.
F. CAUTI Prevention Process Measures	Goal 100%						
% of patients with appropriate cleanliness		98.5%	98.5%				**1st QTR:** While patient bathing is readily being complied with, it didn't quite achieve goal. **2nd QTR:** 2.5% = about 47 observations in which a patient hadn't received appropriate cleanliness.
% of IUCs with order and valid rationale		93.5%	93%				**1st QTR:** The rationale for an indwelling urinary catheter should be sought every shift during hand-off and shared at Gemba. This element needs to improve. **2nd QTR:** 7% = about 131 observations in which a patient had an indwelling urinary catheter inserted within them without a documented valid rationale provided.
% of IUCs where removal was attempted		4%	4%				**1st QTR:** This low percentage is an indication that generally IUC placed in patients are required. **2nd QTR:** There were approximately 75 attempts toward removal of indwelling urinary catheters during Gemba rounds, that didn't result in removal.

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
% of patients where alternatives have been attempted		10%	8%				**1st QTR:** One in every 10 patients with an IUC was transitioned to an alternative method for urine collection. **2nd QTR:** Approximately 150 Gemba observations involved attempts of providing a patient a non-invasive alternative to an indwelling urinary catheter for urine elimination.
% of IUCs removed because of unit "GEMBA" rounds		6%	6%				**1st QTR:** A greater amount of IUC are removed as a part of Gemba Rounds, than through conventional means. **2nd QTR:** Approximately 103 indwelling urinary catheters were discontinued as a result of Gemba rounds.
# of IUCs removed because of unit "GEMBA" rounds		152	103				**1st QTR:** 152 indwelling urinary catheters were removed because of Gemba Rounds. **2nd QTR:** 103 indwelling urinary catheter were removed because of Gemba Rounds. Volume reduced due to reduced Gemba during weekends.
# of Indwelling Urinary Catheter days rounded on		2757	1879*				**Total IUC days rounded on:** 4,636 **2nd QTR reflects only 2 months of data.*
Skilled Nursing/Acute Rehab % of complete baths performed within 24 hours			93%				**1st QTR:** New measure no data available. **2nd QTR:** Below goal. IP working with nursing to improve frequency in which patients receive complete baths.
Skilled Nursing/Acute Rehab % of peri care performed within in a 12 hour shift			93%				**1st QTR:** New measure no data available. **2nd QTR:** Below goal. IP working with nursing to ensure that peri care is performed at least once a shift if not more often based the needs of the patient.
VIII. Catheter Associated Urinary Tract Infections Long Term Care/Rehabilitation	Goal = 0						
Short Stay (# of Infections/ Incidence Rate)		0	0				**1st QTR:** No events. **2nd QTR:** No events.
Transitional Care (# of Infections/ Incidence Rate)		0	0				**1st QTR:** No events. **2nd QTR:** No events.
Subacute (# of Infections/ Incidence Rate)		0	0				**1st QTR:** No events. **2nd QTR:** No events.
Acute Rehabilitiation (# of Infections/ Incidence Rate)		0	0				**1st QTR:** No events. **2nd QTR:** No events.
IX. LTC Symptomatic Urinary Tract Infections	Goal = 0						
Short Stay (# of Infections/ Incidence Rate)		1	0				**1st QTR:** 1 SUTI event. **2nd QTR:** No events
Transitional Care (# of Infections/ Incidence Rate)		0	0				**1st QTR:** No events. **2nd QTR:** No events
Subacute (# of Infections/ Incidence Rate)		0	0				**1st QTR:** No events. **2nd QTR:** No events
X. Clostridium *difficile* Infection (CDI) CMS/VBP	**SIR**						
A. Total Infection Count	All units	8	9				**1st QTR:** 8 **Predicted**: 17 **2nd QTR**: 9 **Predicted:** 17.946
B. SIR CI (KDHCD predicted range, based on risks)		0.222, 0.907	0.245, 0.920				**1st QTR:** Same as national benchmark **2nd QTR:** Same as national benchmark
C. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.646	0.478	0.501				**1st QTR:** This metric is consistently performing well. Continued antimicrobial stewardship and education appears to be effective. **2nd QTR:** Continued use of the CDIFF algorithm. Seeing an upward trend that may require more messaging and refresher education be provided.
XII. Hand Hygiene							
A. Total Hand Hygiene Observations (combination of manual and electronic hand hygiene surveillance)		2,837,294	2,379,412				**1st QTR:** Nearly 3 million hand hygiene observations performed via a combination of electronic hand hygiene and manual hand hygiene compliance surveillance. **2nd QTR**: Identified just about 500,000 less hand hygiene observations compared with 1st QTR data. Reasons for this decrease are documented below.
B. All unit/departments Percentage of Hand Hygiene compliance based on observations (>200 observations/ month/unit minimum)	Goal >95%	97.2%	97.4%				**1st QTR:** Achieved 97.2% hand hygiene compliance exceeding goal. **2nd QTR:** Achieve 97.4% hand hygiene compliance. However, there was a significant drop in users of the electronic hand hygiene surveillance system, in part due to transition from a BioVigil access card to the new branded hospital ID card being used for BioVigil badge access. Additionally, late May into June BioVigil becons or sensors batteries failed and large amounts of patient rooms did not registered user activity. On July 5th all batteries were exchanged. The system is working well. Just about 50% of employees have transitioned to using their hospital ID card for BioVigil badge access. Vice Presidents have been given access to receive BioVigil unit/department reports weekly.
XIII. VRE (HAI) Blood-Hospital Onset (HO)	Goal = 0						
A. Total Infection Count		1	0				**1st QTR:** 1 **Predicted:** 0 **2nd QTR:** 0 **Predicted:** 0

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B. Prevalence Rate (x100)		0.016	0				**1st QTR:** Very low prevalence rate. We rarely have VRE bloodstream infections. **2nd QTR:** No events.
C. Number Admissions		6115	6516				**Cumulative Ct.:** 12,631
XIV. MRSA BSI LABID (HAI) Blood CMS/VBP	**SIR**						
A. Total Infection Count (IP Facility-wide)		5	2				**1st QTR:** 5 **Predicted:** 1.494 **2nd QTR:** 2 **Predicted:** 1.591
B. SIR CI (KDHCD predicted range, based on risks)		1.226, 7.416	0.211, 4.154				**1st QTR:** Greater than national benchmarks. **2nd QTR:** No different than national benchmarks.
C. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.748	3.346	1.257				**1st QTR:** Poorest performing HAI type. Contacted State HAI Program for clarification related to State MRSA study findings. Implementing CHG bathing, Hand Hygiene Surveillance (BioVigil), **2nd QTR:** Over 50% complete with transition to new hospital ID card and BioVigil access. Will be providing VPs with access to departmental hand hygiene compliance rates via BioVigil. Several BioVigil updates performed. Anaylzed the frequency in which patients are screened and treated for MRSA nasal colonization. Devising plan to improve this process. Also, working on making CHG bathing more accessible and hardwired .
XV. MRSA BSI LABID - Long Term Care	Goal = 0						
Short Stay (# of Infections/ Incidence Rate)		0	0				**1st QTR:** No events. **2nd QTR:** No events.
Transitional Care (# of Infections/ Incidence Rate)		0	1/(0.76)				**1st QTR:** No events. **2nd QTR:** 1 Clostridium difficile event.
Subacute (# of Infections/ Incidence Rate)		1 /(0.74)	0				**1st QTR:** 1 Clostridium difficile event. Reviewed antibiotics that patient was receiving. **2nd QTR**: No events.
XVI. Influenza Rates (Year 2020-2021)	Healthy People 2020 Goal 90%						
A. All Healthcare Workers		87.5%					Of a total of 4,671 healthcare personnel including providers, volunteers and contractors worked at least 1 day during the seasonal influenza timeframe. A total of 4,085 received influenza vaccination at Kaweah Delta or provided documentation of receiving influenza vaccination elsewhere. A total of 10.4% (487) of healthcare personnel at Kaweah Delta indicated a contraindication to receiving influenza vaccine. A total of 0.5%(22) of healthcare personnel declined influenza vaccination. A total of 1.6%(77) of healthcare personnel had an unknown vaccination status through the end of the seasonal influenza timeframe.
XVII. COVID-19 Vaccination Rates (Year 2020-2021)							
A. All Healthcare Workers with a completed series of COVID-19 vaccinations.		55.8%	55%				**1st QTR:** As of March 31th 3,321 (55.8%) or 5,949 healthcare workers received their completed series of COVID-19 vaccination doses. Another 82 (1.3%) employees received their initial dose of COVID-19 vaccine. The remaining 2,546 (42.8%) healthcare workers did not receive COVID-19 vaccine. *[note: revision to 1st QTR data to reflect vaccination rate for completed vaccinations.* **2nd QTR:** As of July 21st, 2021, (55.6) 3,238 of 5930 healthcare workers received their completed series of COVID-19 vaccination doses. An additional 82 healthcare personnel received 1 dose of a two part vaccination series. 2,528 healthcare personnel have not received COVID-19 vaccine.
Approved IPC: 5/27/2021 Approved IPC: Approved IPC: Approved IPC: Prepared by: Shawn Elkin							

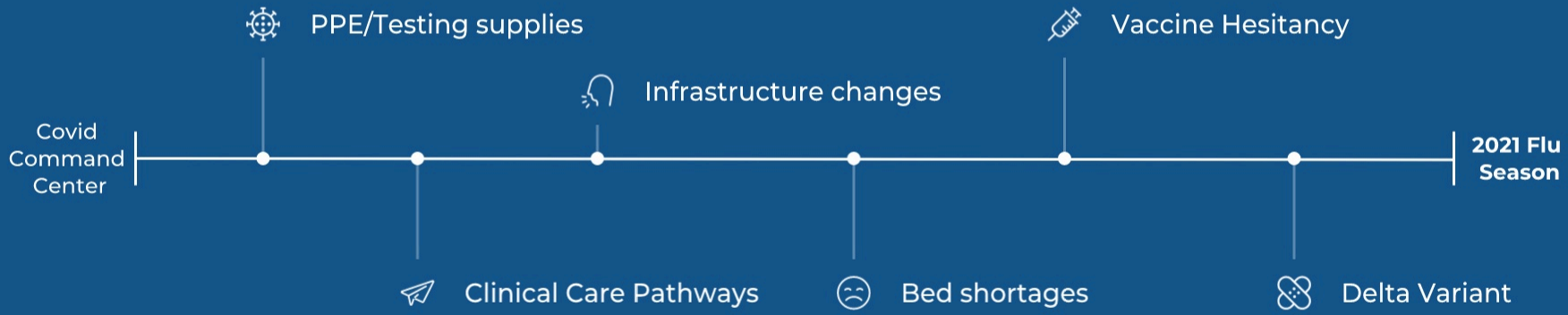
DEPT OF EMERGENCY MEDICINE

Dr. Kona Seng, Michelle Peterson, Cortni Byl, Monica Romero, Patrick Ramirez

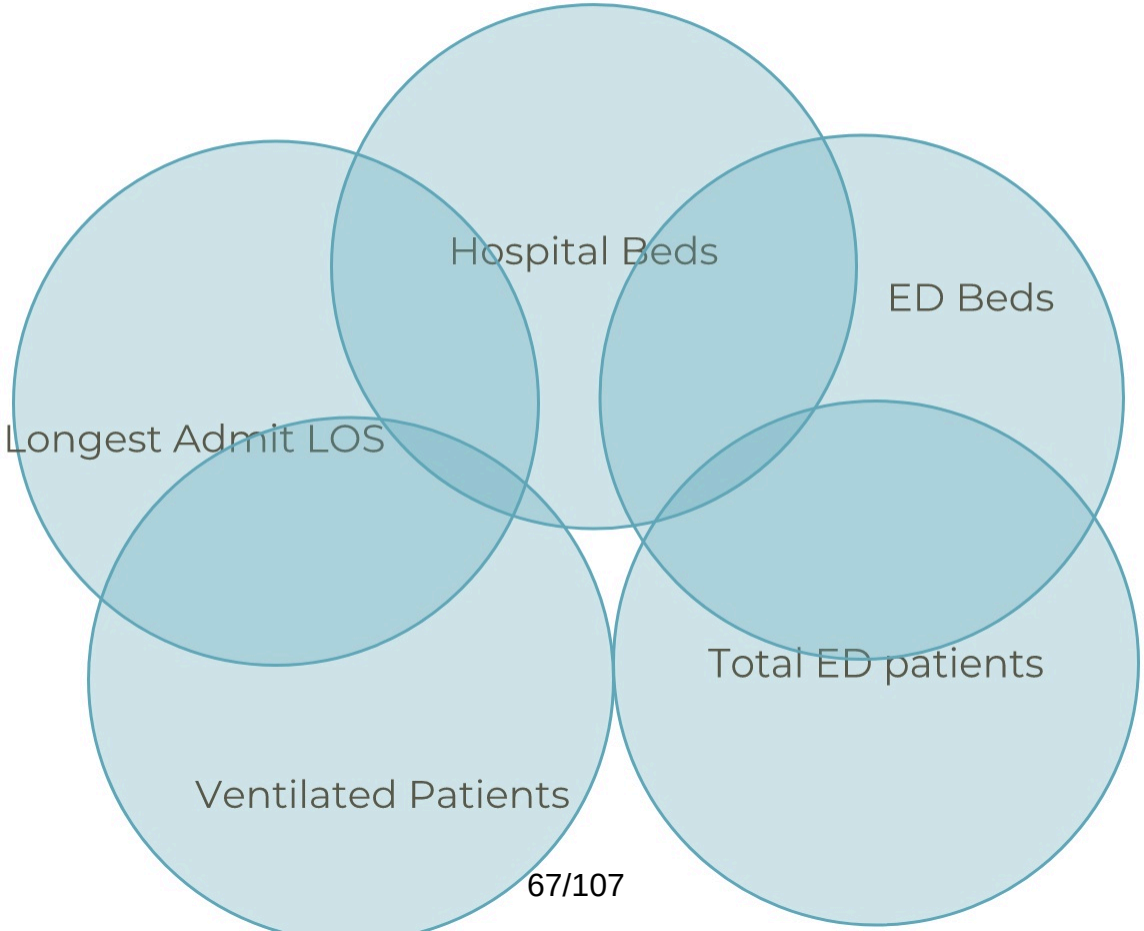
Board of Directors Report

Sept 27th 2021

Covid Timeline



National ED Overcrowding Score




0-50
Normal
51-100
Busy
101-140
Overcrowded
141-180
Severe
Above 180
Disaster

1-Aug	130	171	129	96	85	91	97	101	99	96	99	112	119	120	116	119	127	109	129	139	126	117	112	122
2-Aug	132	135	145	115	121	113	114	116	116	123	132	149	164	182	153	154	165	165	165	176	189	200	200	200
3-Aug	198	194	172	160	143	142	142	150	147	156	175	184	196	200	200	200	200	200	200	200	200	200	200	200
4-Aug	200	200	200	200	200	194	200	188	196	200	200	199	198	200	200	154	152	158	147	160	168	149	166	170
5-Aug	189	197	198	200	200	172	164	119	116	124	125	132	157	167	161	184	186	193	192	184	170	186	170	160
6-Aug	156	157	151	152	155	150	152	145	200	154	167	190	200	200	200	200	200	200	185	187	160	180	144	131
7-Aug	141	136	128	126	118	115	114	116	125	128	141	155	168	180	200	200	197	170	181	189	167	139	154	146
8-Aug	160	175	137	134	108	91	88	87	104	103	107	124	133	142	140	149	143	143	152	136	138	150	151	159
9-Aug	160	183	135	143	135	137	148	130	125	139	131	145	165	185	175	192	194	200	200	200	190	185	184	200
10-Aug	200	200	200	200	185	155	128	200	134	130	147	146	154	175	197	194	200	200	200	200	200	179	192	144
11-Aug	144	158	115	115	112	125	116	140	132	133	133	152	158	182	173	180	173	188	200	185	200	200	200	200
12-Aug	200	197	190	137	163	165	118	114	115	126	136	144	155	174	198	200	200	200	200	191	186	188	184	183
13-Aug	182	168	140	139	146	103	91	111	92	90	104	109	117	136	172	186	175	200	200	199	182	200	182	191
14-Aug	192	179	185	154	200	104	104	111	108	110	123	144	166	175	197	200	200	200	200	200	200	200	200	200
15-Aug	200	200	197	200	200	200	195	181	178	172	175	183	200	200	200	200	200	200	200	200	189	200	200	200
16-Aug	200	200	200	196	190	198	193	192	197	200	200	200	200	200	200	200	200	200	200	200	200	200	200	200
17-Aug	200	200	200	200	200	200	200	193	189	172	190	179	200	200	200	198	178	153	148	154	143	128	126	123
18-Aug	69	62	61	50	54	58	60	63	63	74	91	97	95	97	113	109	115	115	133	133	147	125	140	146
19-Aug	114	105	106	102	97	98	91	96	101	107	122	149	114	129	139	145	145	152	158	156	150	154	120	108
20-Aug	107	109	111	114	114	107	105	105	106	116	123	137	147	166	182	174	175	197	177	185	188	185	188	182
21-Aug	192	180	166	152	148	123	128	127	124	119	126	141	151	170	164	172	178	189	172	185	200	200	173	194
22-Aug	193	200	200	164	157	166	170	168	147	147	148	157	157	157	156	148	148	136	140	151	141	147	154	155
23-Aug	129	145	146	144	145	126	132	138	125	148	147	160	168	160	178	189	173	195	198	188	187	200	194	173
24-Aug	200	181	200	200	152	148	154	139	141	149	150	164	163	176	171	167	173	166	168	166	179	200	200	200
25-Aug	200	200	200	181	140	136	130	130	129	134	147	152	167	181	133	150	151	146	150	162	161	178	184	182
26-Aug	161	182	169	151	150	128	123	120	129	122	123	132	147	154	165	186	166	173	159	174	163	200	186	171
27-Aug	181	181	162	152	151	151	151	144	140	152	160	174	181	200	200	200	200	200	200	200	200	200	200	200
28-Aug	200	200	200	200	200	200	200	198	194	194	191	194	198	200	200	200	200	200	173	181	191	196	191	200
29-Aug	200	187	184	174	173	173	175	177	178	186	200	200	200	198	200	200	200	200	200	200	200	200	200	200
30-Aug	200	200	200	200	200	200	200	200	195	200	200	200	200	200	200	200	200	200	200	200	200	164	159	162

Zone 5, New WR

Opened Aug 18th

Expanded areas for evaluation and treatment

Positive feedback from teams

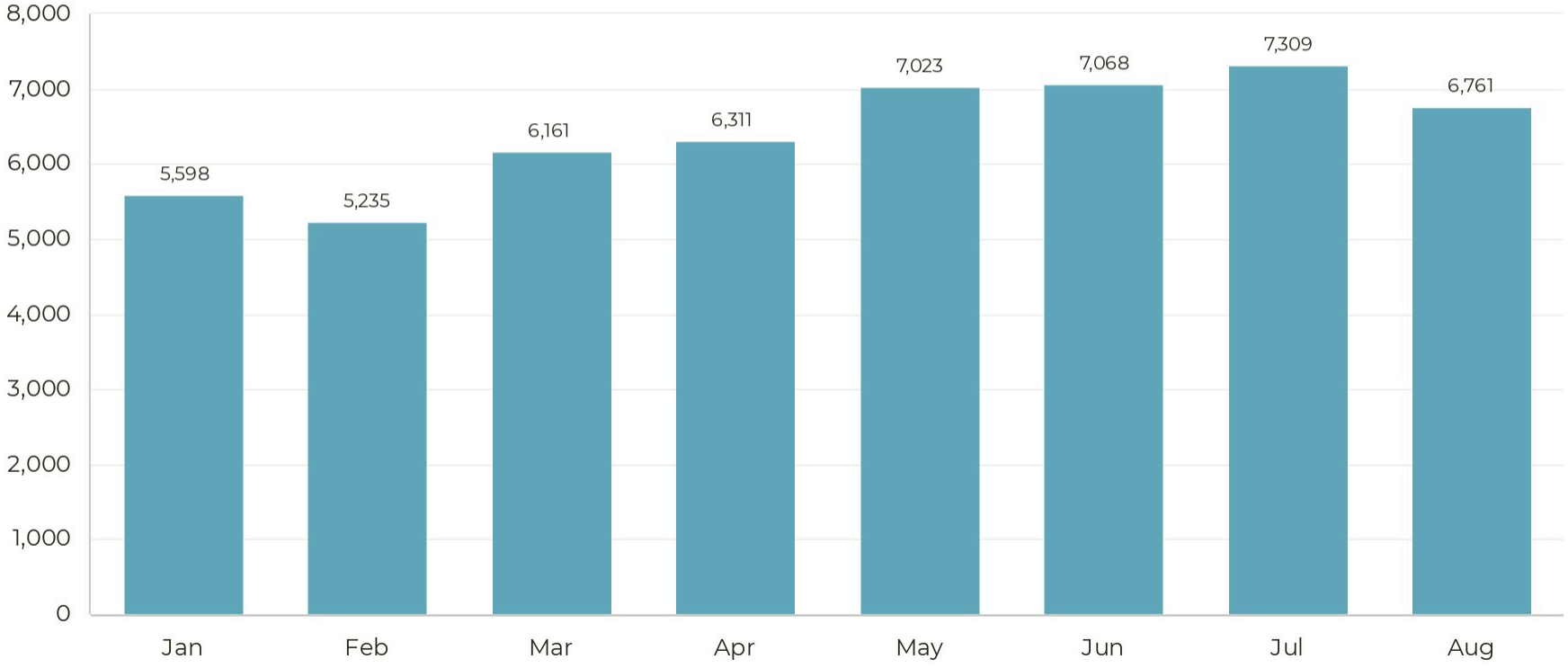
Security is improved

Workflow changes are in process

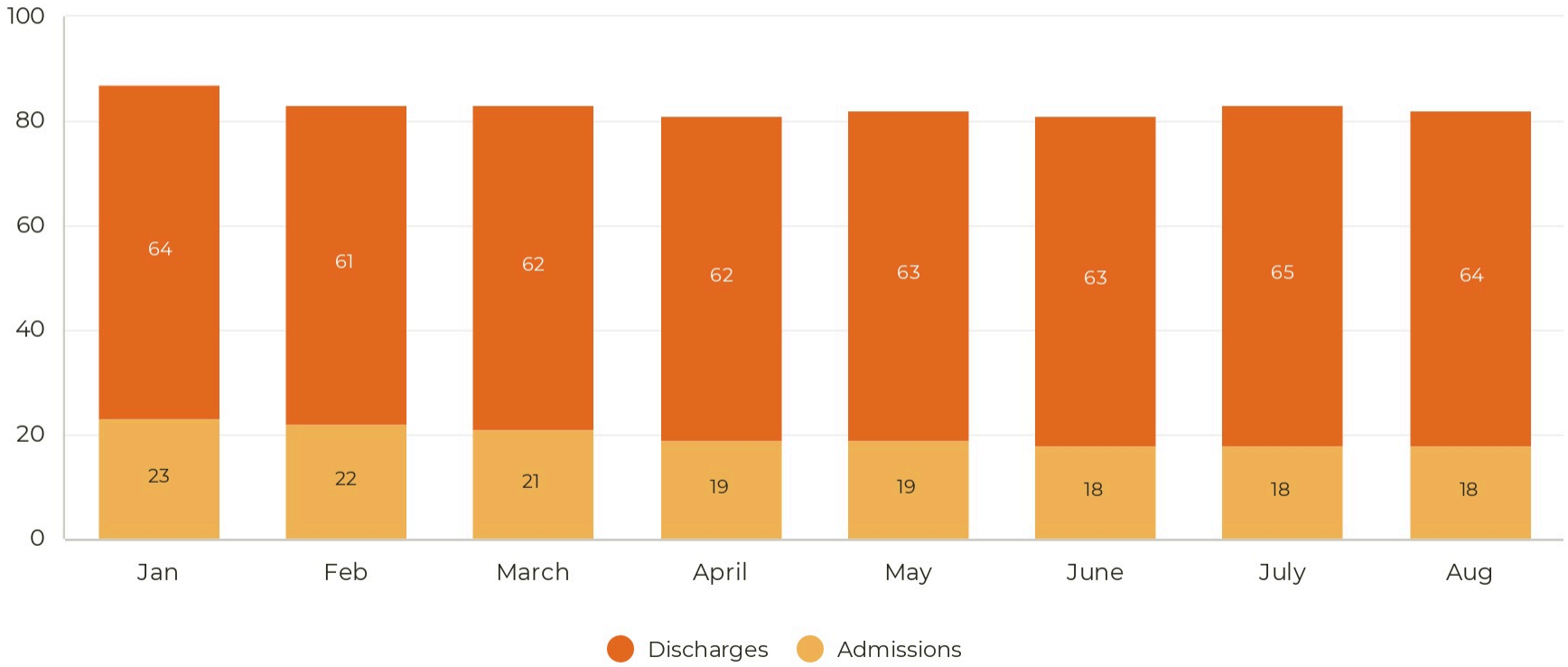
Tracking Board development

Communication tools

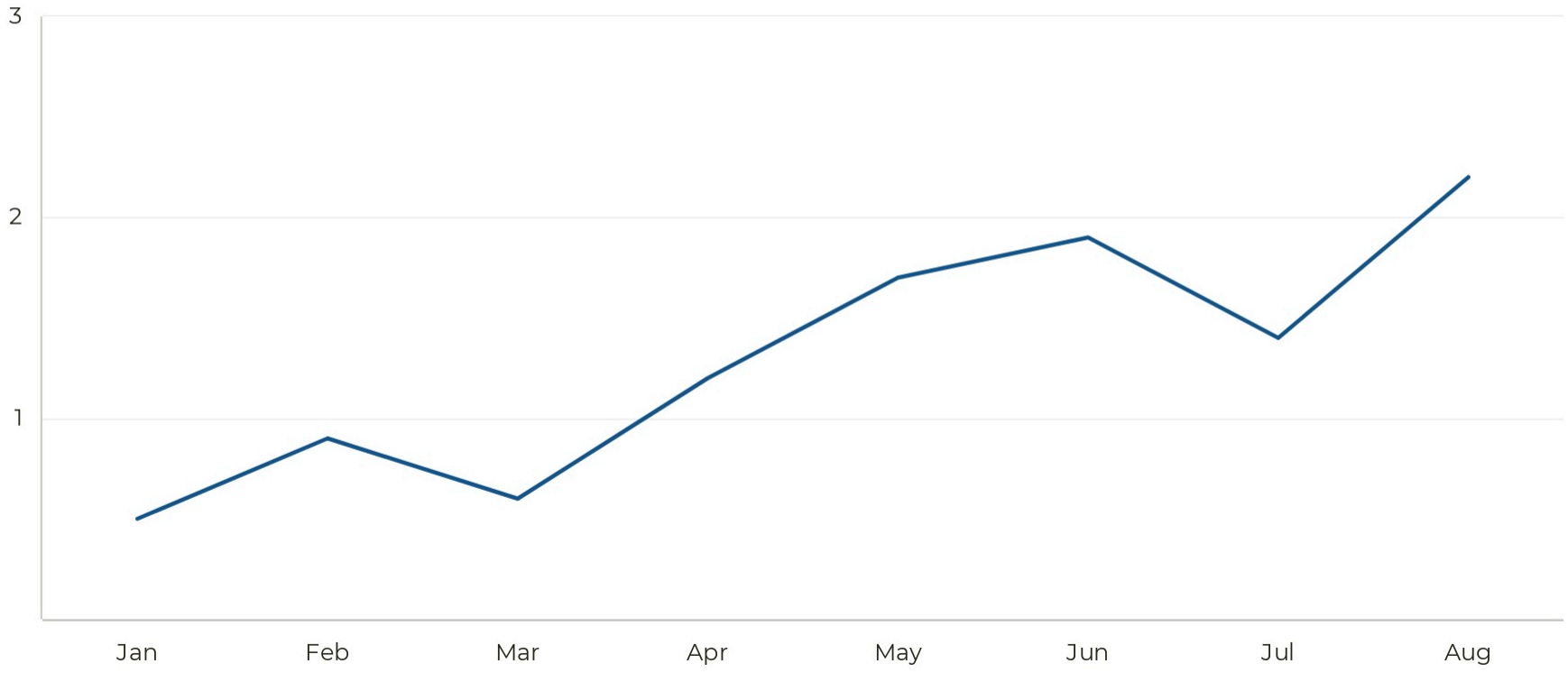
ED VOLUME


8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
5,598
5,235
6,161
6,311
7,023
7,068
7,309
6,761
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug

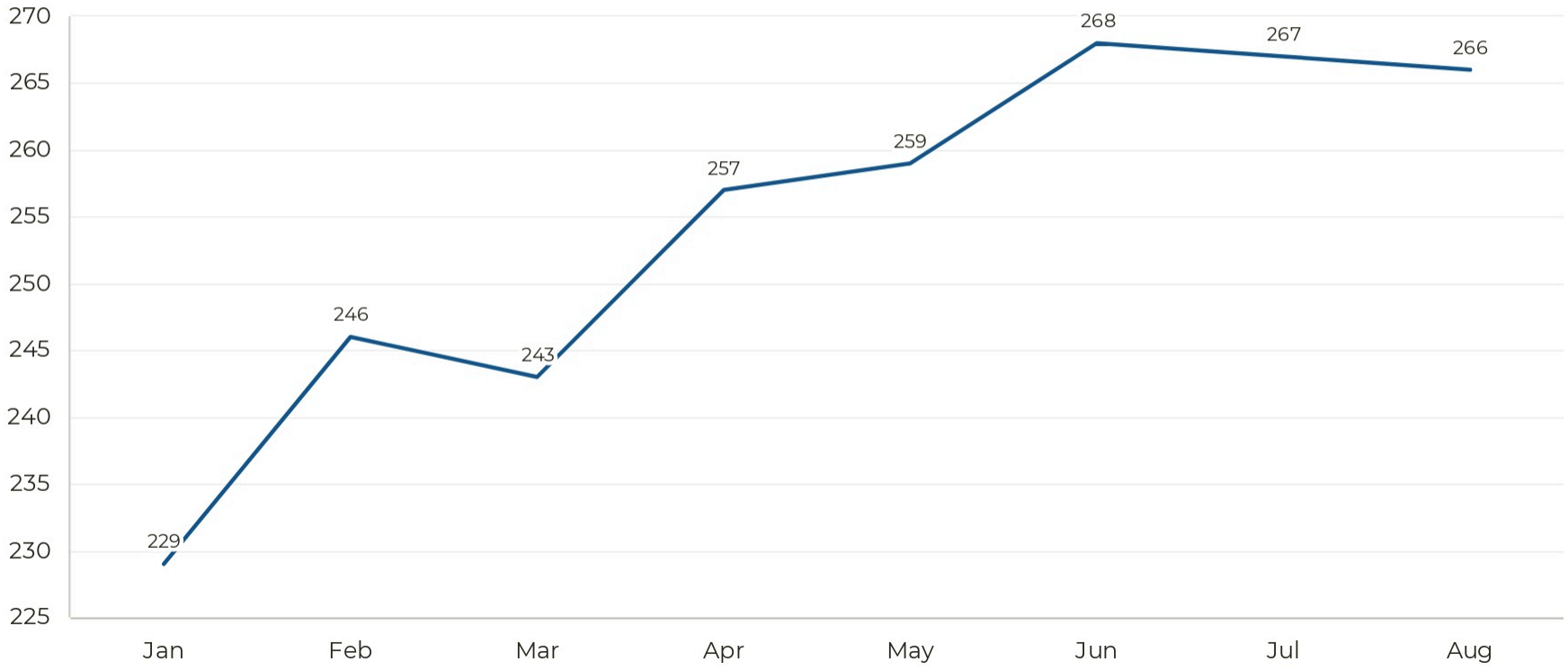
Admissions/Discharge Percentages



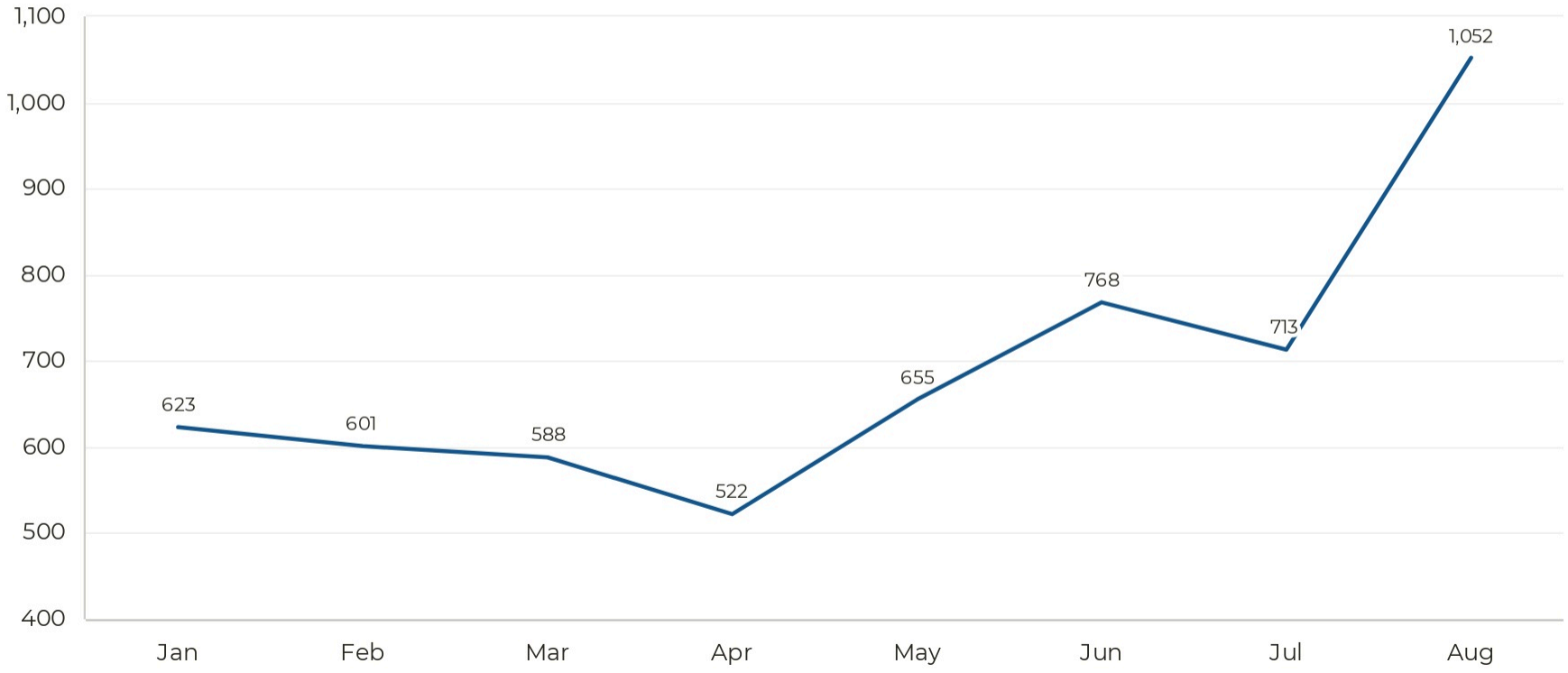
LEFT WITHOUT BEING SEEN(%)



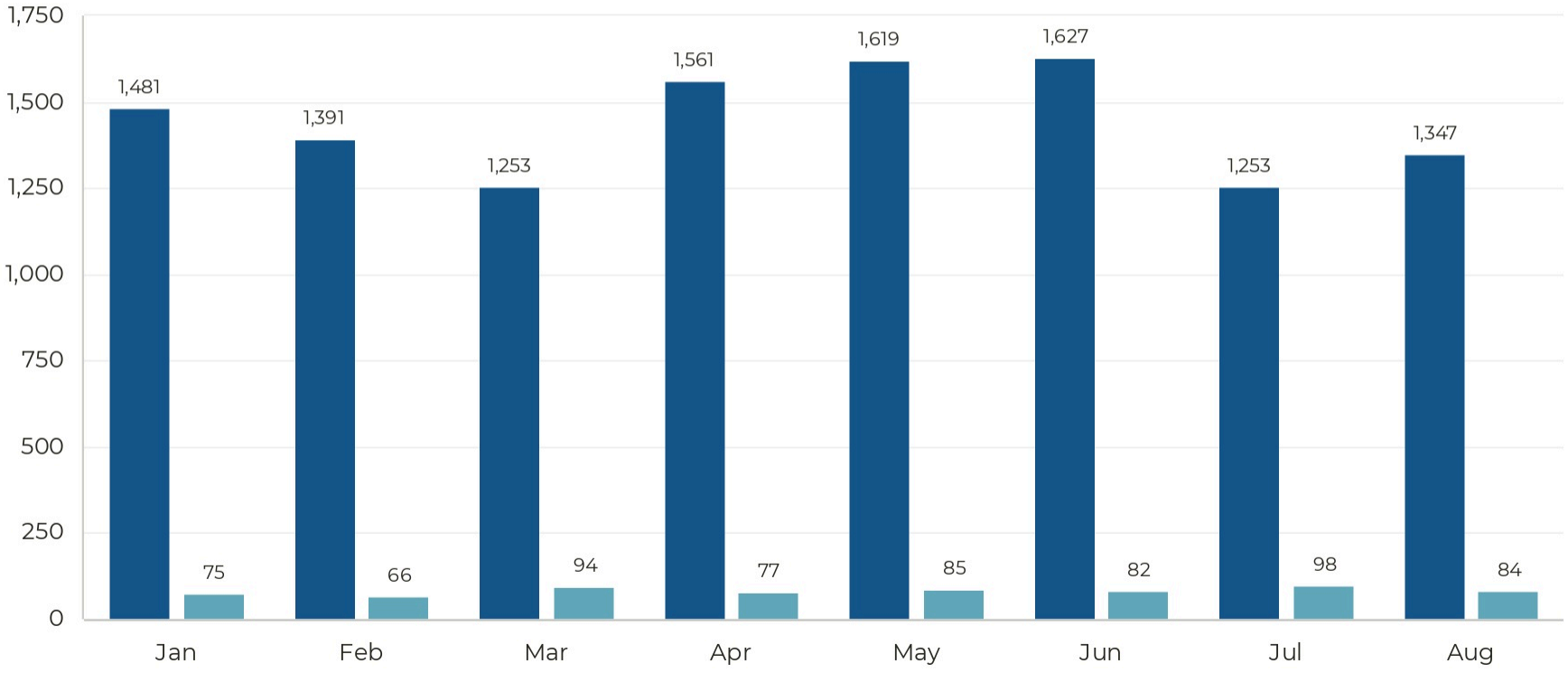
MEDIAN LOS DISCHARGED PATIENTS



MEDIAN LOS ADMISSIONS



MH MEDIAN LOS VS MH ADMITS




OPEN


COMPASSION

THROUGHPUT AND ORGANIZATIONAL EFFICIENCY

RESOURCE EFFECTIVENESS COMMITTEE

HS-TROPONINS TO REDUCE CHEST PAIN ADMISSIONS

MIRRORED ROOMS TO IMPROVE STOCKING EFFICIENCY

RN-PRINTED DC INSTRUCTIONS

DAILY CHECKLISTS FOR CHARGE RN AND TEAM LEADS

FURTHER REFINE TRIAGE WORKFLOWS

Quality and Patient Safety

SEPSIS BUNDLES

CULTURE OF CULTURING

HOSPITAL ACQUIRED INFECTIONS

PROCEDURAL SEDATION/BLOOD CONSENTS

VENTILATION ORDERS

PEDIATRIC SAFE ED

Kaweah Culture

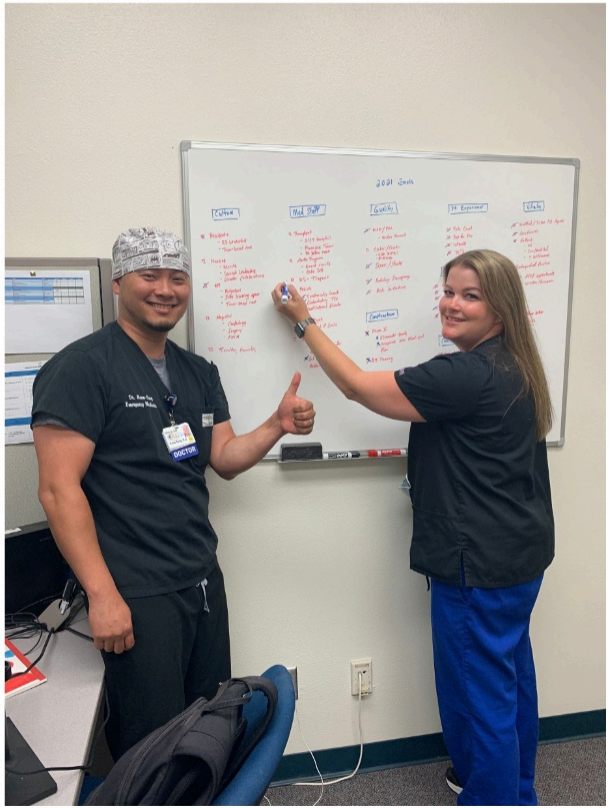
ONBOARDING OF NEW RN LEADERSHIP

EXPECTATIONS FOR DEPT SCRIPTING

DESIGN FORMAL PROCESS FOR LOBBY CARE

CONTINUE VITUITY PATIENT CALLBACK PROGRAM

CONTINUE VITIUTY PATIENT CARE ADVOCATE PROGRAM



Education and Innovation

ATLS AT KAWEAH HEALTH

VITUITY POST ED FOLLOWUPS

SOCIAL EM JOURNAL CLUBS

NITROUS OXIDE

WELLNESS CURRICULUM

PEARLS AND PITFALLS

Outpatient Delivery Network

Continue ED Care Advocate Program for PMD appointments for ED Patients

Continue collaboration with Bridge Program on High Utilization patients

Continue expansion of ED Street Medicine Program

Develop Vituity Fellowship Social Determinants of Health to start July 2022

Summary

-ED continues to work in a high volume, high acuity environment

-ED Expansion provides potential space for improved flow and timely care

-Participate with Hospital Throughput initiatives

-Lobby care is still a reality with Delta variant emergence (Medications, Re-evaluations, Food/Water, Blankets, Pt and Family communication, EVS)

-Prioritize towards Clinician wellness

-Staffing efforts continue

IN REMEMBRANCE OF

Leo Dorado

Clinical Quality Goals Update

August 2021

FY 21-22 Clinical Quality Goals

	Fiscal Year 2021 (Higher is Better)	FY21 Goal	FY20	Last 6 Months FY20
SEP-1 (% Bundle Compliance)	74%	≥ 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 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual/ number expected)	FY22 Goal	FY21 FY20
CAUTI Catheter Associated Urinary Tract Infection	1												20	0.569	≤0.676	0.54 1.12
CLABSI Central Line Associated Blood Stream Infection	0												16	0.00	≤0.596	0.75 1.20
MRSA Methicillin-Resistant Staphylococcus Aureus	2												6	tbd	≤0.727	2.78 1.02

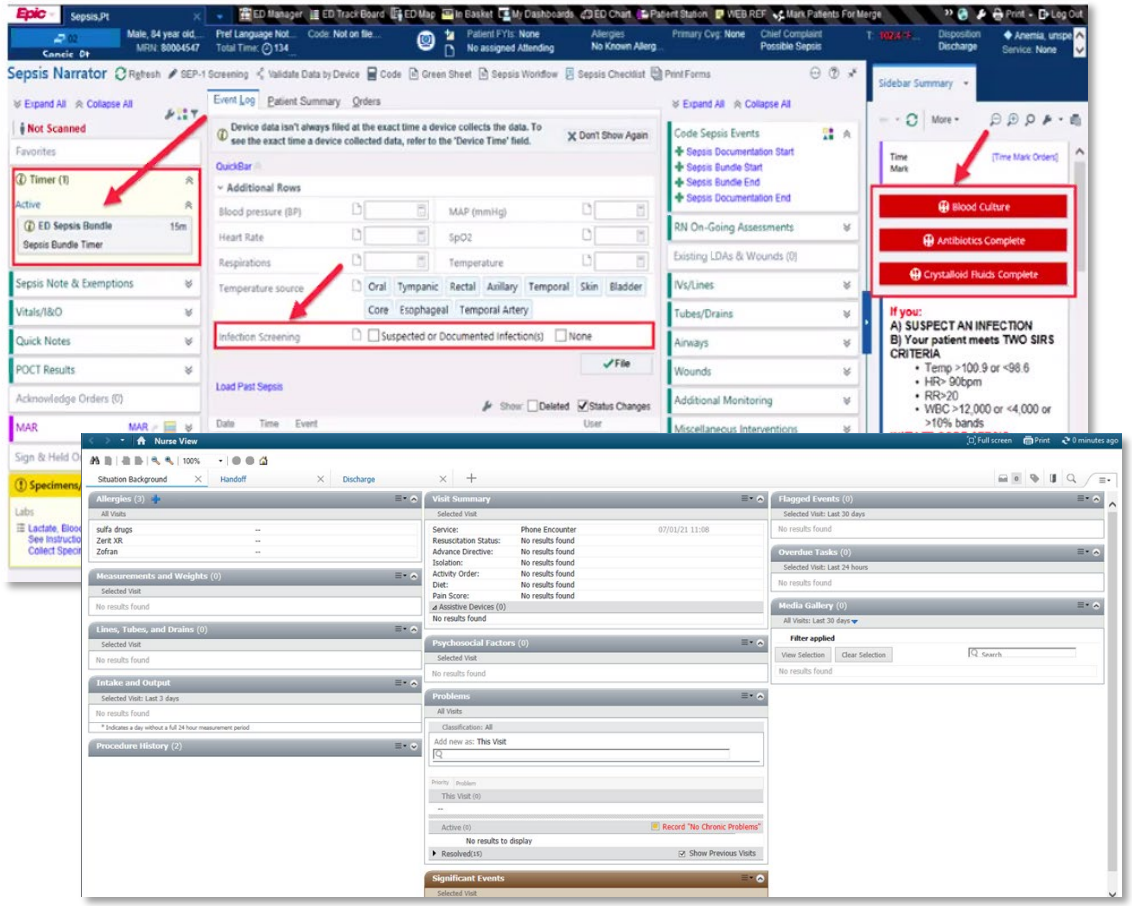
*based on FY21 NHSN predicted

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

Key Strategies

Sepsis

- Sepsis required physician notification of sepsis alert - results in timely best practice intervention, “the bundle” COMPLETE, GO LIVE 6/29/21!
- Exploring “Resident Sepsis Resource” for Coordinator off hours with Dr. Winston
- NEXT - sepsis handoff checklist, which is used to identify any remaining CMS SEP-1 elements needed for the treatment of patients suffering from severe sepsis.
  - Checklist used as a handoff from nurse to nurse, and identifies the remaining elements needed to fulfill SEP-1 requirements.
  - Ideal for instances when a patient transitions from the ED to their respective inpatient bed, or upon transitioning from a previous inpatient location to a new inpatient location (e.g., patients transitioning to a higher level of care).



Key Strategies

CAUTI & CLABSI

- Gemba's! And trialing handoff process using Gemba elements
- Mini Kaizen Planning for CAUTI prevention!
- Letter to providers who were involved with a CAUTI event, going to physician leaders for approval
- EMR changes to improve catheter appropriateness, adherence to bundle elements and to manage retention
- New alternatives to catheter products trials
- Including peripheral IVs to critical care gemba (evaluating "just in case lines" and care practices)
- Evaluating new midline dressing kits (current kits missing necessary items)
- Increasing midline insertion in ED through EM Resident and PICC team partnership

Key Strategies

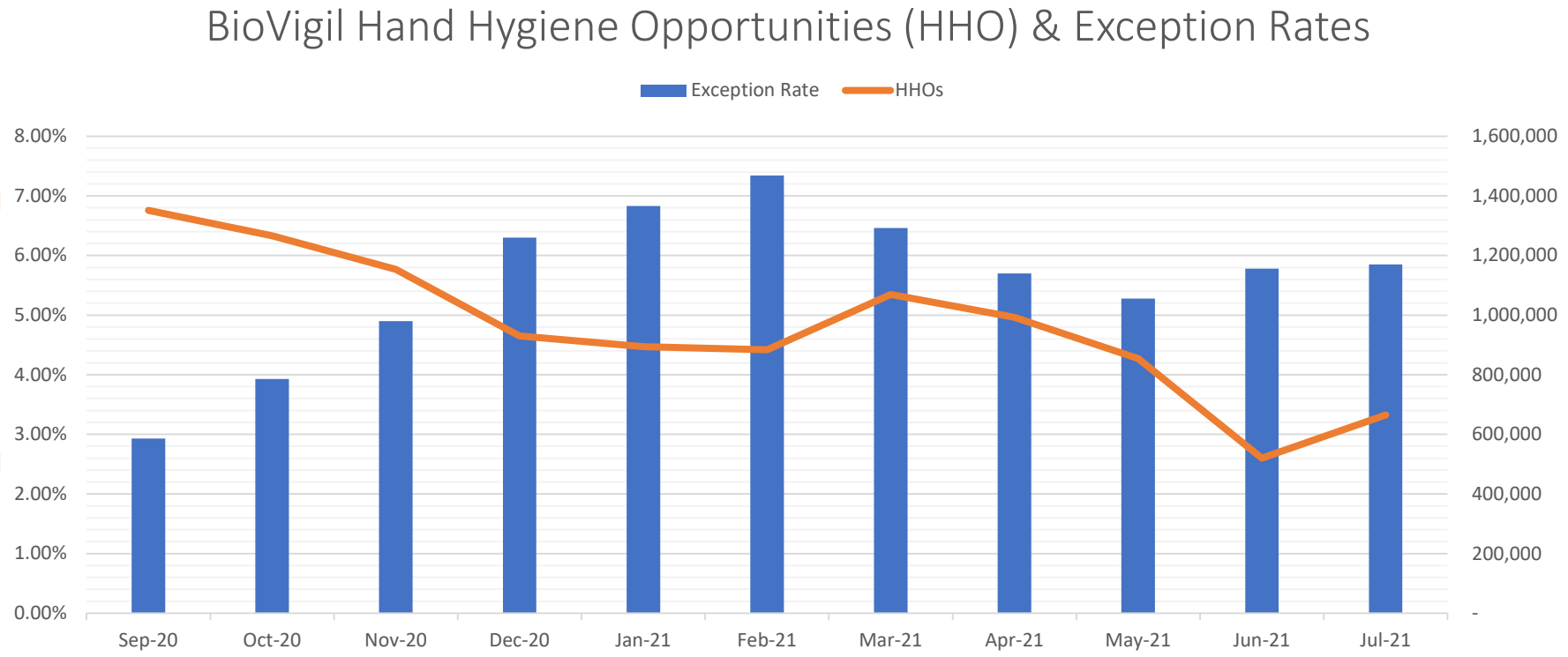
Planned Interventions to reduce MRSA Bloodstream infection

1. Hand Hygiene – BioVigil and Non-BioVigil areas, 95% compliance & use of BioVigil system

Goal: return to September 2020

High volume of HHO

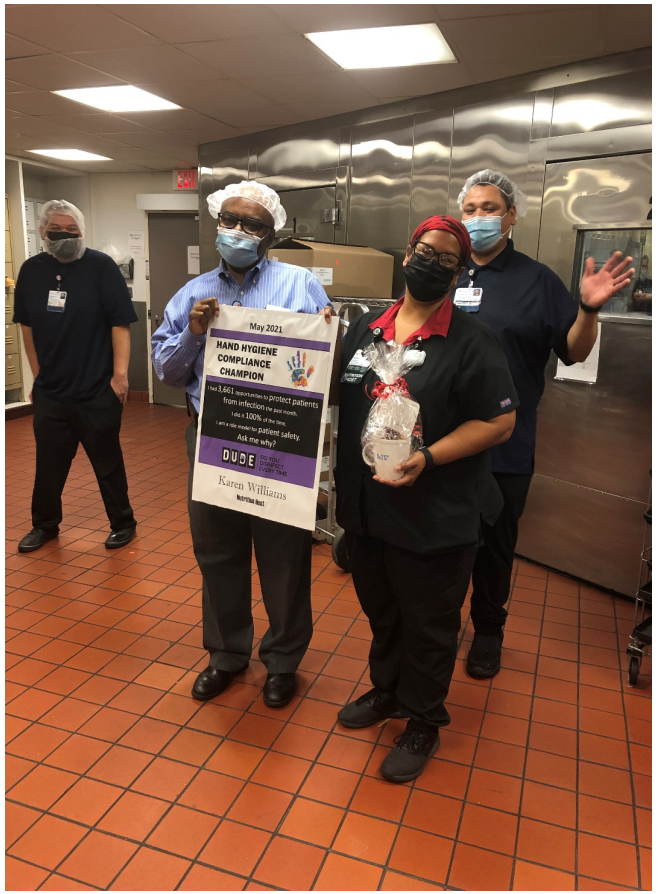
Low exception rates



Key Strategies

BioVigil Update:

- Troubleshooting Resource document shared with managers.
- Expansion of the BioVigil surveillance approved in new FY Budget. Awaiting a list of dates for installation of BioVigil at the West and South Campuses and procedural locations (e.g. Endoscopy, ASC).
- Shared during the safety huddle call on 3 occasions how important it is for staff to wear their BioVigil badges – it supports safe hand hygiene habits and has been very helpful with contact-tracing activities related to COVID-19 exposures.
- Continuing to celebrate the monthly hand hygiene champion based on the largest volume hand hygiene opportunities performed appropriately 100% of the time. Food and Nutrition Services has been a BIG WINNER – 3 times in a row.



Karen Williams, Food Nutrition Host

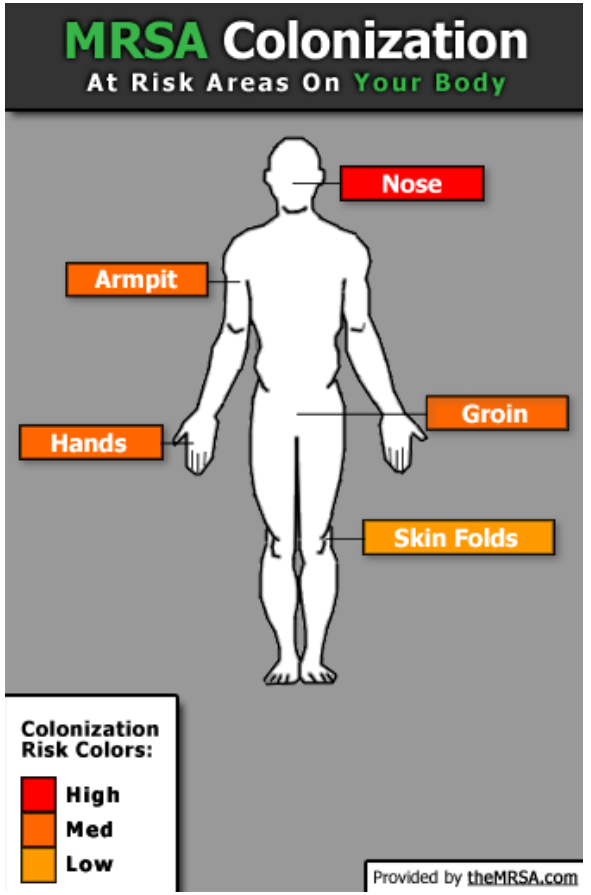
3,661 HHO with 100% HH Compliance!

Key Strategies

Planned Interventions to reduce MRSA Bloodstream infection

2. High Risk Patient Decolonization

- Patients who are colonized with MRSA means they carry it in their nose or on their skin but are not sick with a MRSA infection. Hospitalization is a high risk time for patients, this MRSA that patients carry with them can travel to wounds or lungs, and other areas of patient's bodies that can lead to poor outcomes during hospitalization
- Decolonization therapy is the administration of. antimicrobial or antiseptic agents to eradicate or. suppress MRSA carriage. – includes an Intranasal antibiotic or antiseptic (e.g., mupirocin, povidone-iodine) – Topical antiseptic (e.g., chlorhexidine)
- For Kaweah this means:
  - Decolonization with CHG Bathing (topical antiseptic) for all at risk MRSA positive patients
  - Decolonization with Mupirocin (Antibiotic)



Key Strategies

Planned Interventions to reduce MRSA Bloodstream infection

CURRENT STATE
PC157
MRSA Nasal Swabbing
Process (MRSA Screening)

MRSA Form Screen Identifies high risk patients on admit → MRSA Nasal Screen lab test → Provider notification of positive results → MRSA Treatment determined by provider (ie. Mupirocin nasal ointment),CHG

NEW INTERVENTIONS

Team to evaluate the high risk patients to target

Develop protocol for Decoloniza-tion of all high risk +ve MRSA

FUTURE STATE
PC157
MRSA Nasal Swabbing
Process (MRSA Screening)

MRSA Form Screen Identifies ALL high risk patients on admit → MRSA Nasal Screen lab test → Patients decolonized per protocol

Key Strategies

Planned Interventions to reduce MRSA Bloodstream infection

3. Environment & Equipment Cleaning

- By end of August use ATP monitoring to evaluate cleanliness/compliance with policy on patient care equipment cleaning (primarily nursing processes)
- Ongoing efforts to address cleanliness (primarily EVS processes)

4. NEW MRSA Quality Focus Team (MRSA)

- BioVigil/HH
- Decolonization
- Environment/Equipment Cleaning

Action Plan Status Aug 2021

Culture of Culturing

1. Get sputum cultures in ICU when respiratory infection suspected rather than BC **COMPLETE**
2. Display previous culture results when ordering new culture **COMPLETE**
3. Remove the pre checked order on the ICU admission order set which order BC for temp >38.5. Review all order sets for embedded pre-checked orders **COMPLETE, reviewing RRT orders**
4. Providers to attend HAI meeting to help identify barriers and challenges to HAIs/cultures **ONGOING, NOW A CME!**
5. Extending serial blood culture Alert (for when BC are ordered after BC orders have been placed within 24 hrs) **COMPLETE**
6. Fever workup training for providers, residents and nursing **IN PROCESS**
7. Color coding of temperatures in EMR **COMPLETE**
8. Evaluating EMR functionality for fever work ups (ie. alerts for ordering cultures based off 1 abnormal temp, axillary temp) **IN PROCESS**
9. Evaluating CRBSI process with medical staff stakeholders (sequencing of blood cultures by lab for patients who have a central line that is necessary and an infectious process that needs evaluation) **IN PROCESS**

SUMMARY

- Educating providers and RNs on culturing the right thing at the right time for the right reasons and soliciting feedback on the barriers
- Using the EMR as a tool to aid in culturing practices:
  - Removing pre-checked orders to elicit a thoughtful pause
  - Using an alert to avoid unnecessary cultures (over 200 avoided over a 2 week period!)
  - Evaluating functionality in culture ordering practices based on fever
- Evaluating a process where lab takes care of culturing timing for patients who have a central line

FY22 Clinical Quality Goals

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

Our Vision
To be your world-class healthcare choice, for life

Performance Measure	Baseline	FY22 Goal	Jan 2021- June 2021	Status
Hospital Readmissions (%) Medicare Population	(FY2019) AMI – 12.34 COPD – 16.09 HF – 18.22 PN Viral/Bacterial – 14.13	AMI – 11.10 COPD – 12.87 HF – 14.58 PN Viral/Bacterial – 11.03	AMI – 12.5 COPD – 10.0 HF – 21.28 PN Viral/Bacterial – 13.51	• Medical Director position filled • COPD Team monitoring new process and follow up on identified opportunities
Decrease Mortality Observed/Expected Rates Medicare Population	(2019) AMI - 0.75 COPD – 2.40 HF – 1.78 PN Bacterial – 1.85 PN Viral – 1.34	AMI - 0.71 COPD – 1.92 HF – 1.42 PN Bacterial – 1.48 PN Viral 1.07	AMI – 0.84 COPD – 0.93 HF – 0.911 PN Bacterial – 1.04 PN Viral -0.64	• Medical Director position filled • Guideline review and measures/dashboard development with key performance indicators

Home Medication List Review of High Risk Patients (inpatient admission)	57%
	(Avg Oct 2020 and Feb 2021)
		100%	71% Jan-June 2021
			91% July 1-July 31, 2021
				• Jan-June 2021
				  • *2-3 Pharmacy Techs (M-F, 8 hour shifts)*
				• July 2021
				  • *4.5 Pharmacy Techs (weekend coverage added, 10 hour shifts*)

Complete Initial Home Medication w/in 12 hours of Inpatient Admission	N/A	100%	n/a	• Exploring reporting capabilities with ISS
Outpatient Medication Reconciliation w/in 30 days Post Discharge (MRP)	N/A	44%	21% Jan-June 2021 41% July 1-August 31, 2021	• Improvement noted due to optimization in CERNER Millennium for all ambulatory care providers
Team Round Implementation	MICU currently does this	Design & Pilot on 1-2 units	n/a	• In Progress-identifying nursing leaders to develop design

Questions?

Live with passion.

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

Kaweah Health

Quality & Patient Safety Department Medical Director QI Projects Update

Sandy Volchko, Director of Quality & Patient Safety
Dr. Tom Gray, Medical Director of Quality & Patient Safety

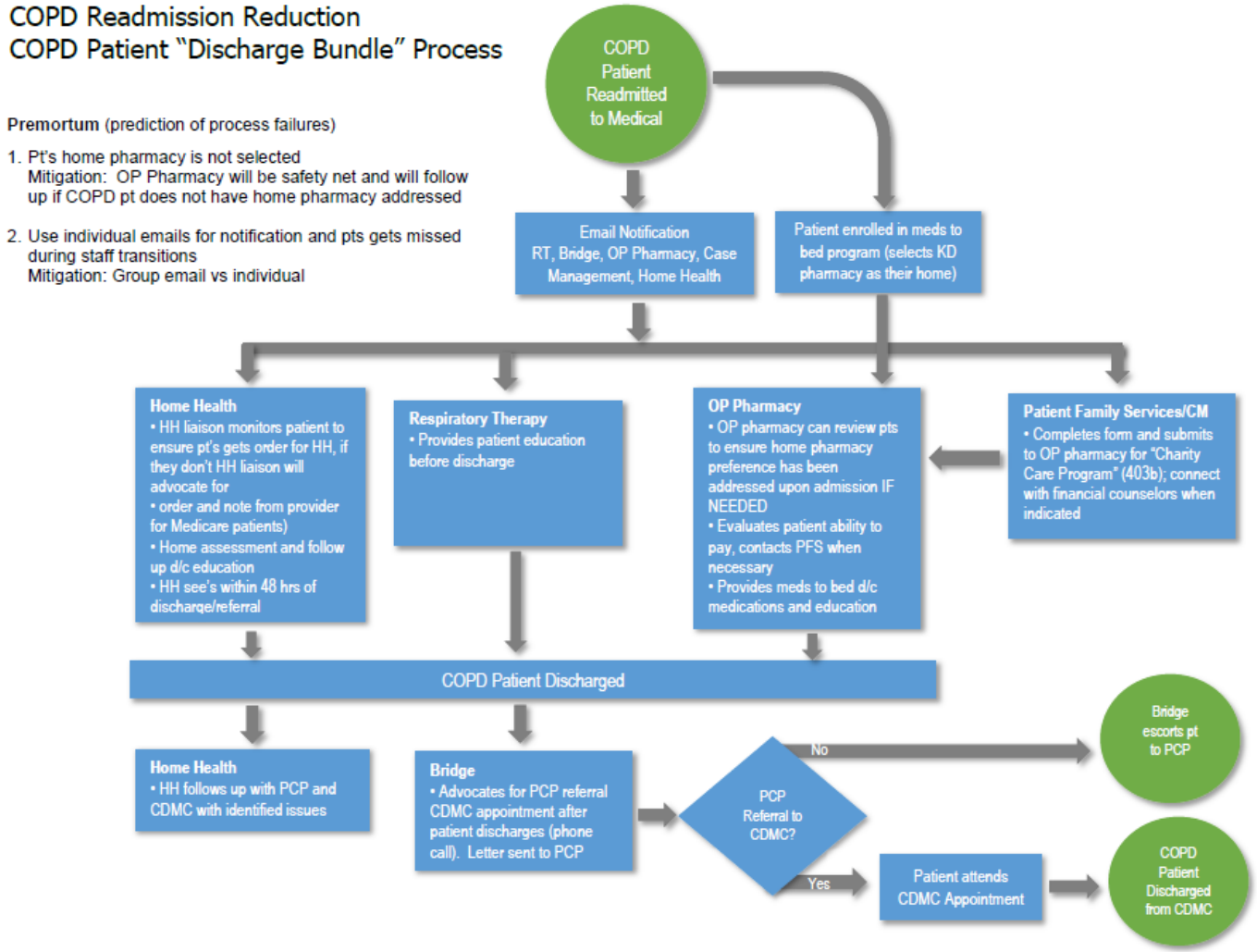
Chief of Staff – Dr. Manga

Project Description

COPD Readmissions

Project Status

- New Process Designed with CDMC, Home Health, Outpatient Pharmacy and Respiratory Therapy; went live Oct 2020
- Dashboard developed to measure process and enable team to identify opportunities to enhance process through regular team meetings
- COPD Readmission Rates:
  - July-Dec 2020 = 31.58% (6/19)
  - Jan – June 2021 = 10% (2/20)



Trauma– Dr. Atherton

Project Description	Project Status
Trauma Peer Review	• Midas focus study revisions to enhance peer review process
May 2021 - Antibiotic Administration for Patients arriving to ED with tibia open fracture	• Goal 100% of patient population receives Abx within 60 min of arrival • Measure definitions and cases under review by Quality RN

Internal Medicine – Dr. Pap

Project Description	Project Status
Process Development – notification of all VMC primary care physicians of patient discharge from hospital	• Goal follow up appointment within 5 days of discharge • Meetings began June 2021 with stakeholders; Ongoing work with ISS to develop workflow; system upgrade expected October 2021 which will address identified barriers to notification

Hospitalists – Dr. Said

Project Description	Project Status
Patient Satisfaction	• Survey developed, completed by Valley Hospitalists Group staff. Greatly affected by COVID, resumed survey in February 2021.
Office Admissions through ED	• Developing process to directly admit from Sequoia Wellness Center to Medical Center with out going through ED. Goal: reduce volume in ED to enhance throughput.
Culture of Culturing	• Algorithm development for residents for reflux culture ordering, case reviews by hospitalists & residents • Biweekly review of Blood Culture Alert report → 60% decrease repeat orders
Sepsis Bundle Compliance (rule out sepsis)	• Document ..sepsisnot when sepsis excluded • SOFA score and documentation education for hospitalists – facilitate CDI

OB/GYN – Dr. Sabogal

Project Description	Project Status
Vaginal Assessment Compliance – decrease primary C-section rate	• Review of cases based on ACOG best practice guidelines, completed April 2021 • Evaluating changes to Cervidil protocol • C-Section rates monitored monthly through CMS core measures

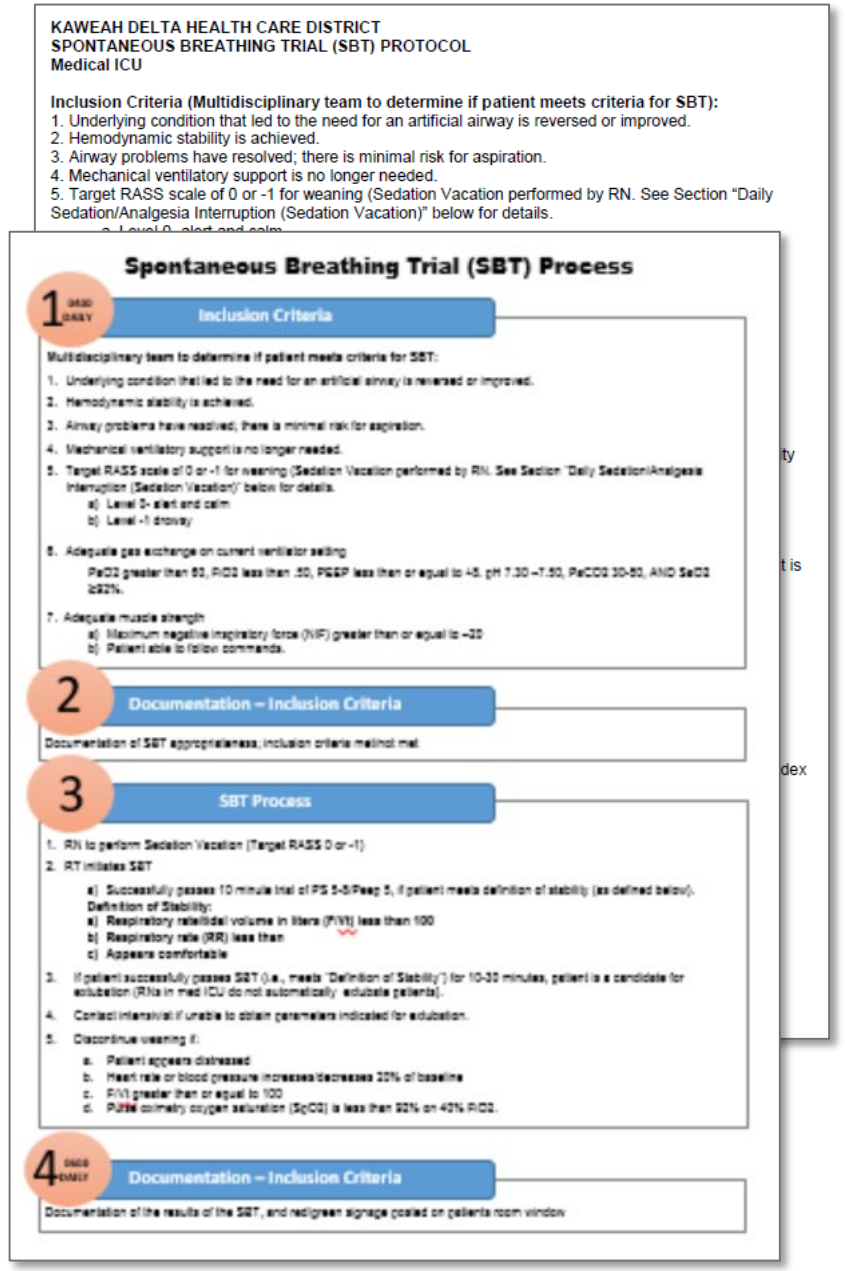
Pediatrics– Dr. Randolph

Project Description*	Project Status
Decreasing steroids and antibiotics for bronchiolitis	• Report developed to monitor usage, sent monthly for review (Feb 2021)
Appropriate Use of Clinical Pathways	• Power plan utilization reports finalized July 2021
Pediatric consult for peds transfers from ED	• July 2021 report completed to measure ordering compliance with “pediatric consult”
Post- Op Pain Management- Appendicitis w/Surgical Intervention (QI Project with Dr. Chu)	• Report of patients with appendicitis sent June 2021, case reviews in process with physician stakeholders
LOS for Pneumonia Patients	• Pediatric LOS data sent from Midas system April 2021
ED-Admit-Floor-Time	• Requested to add to ED throughput dashboard Aug 2021
PEWS Score (QI Project with Dr. Loomba)	• Dr. Loobma sent list of ED pediatric patients from Midas system monthly (initiated July 2021); resident case review to determine PEWS score; ISS report underdevelopment (to include PEWS score)
Pediatric Blood Culture Usage for Soft Tissue/Skin Infection- in progress-	• ISS report under development

*dashboard under development

Critical Care – Dr. Malli

Project Description	Project Status
Nursing Education focused on care of the bariatric patient,	• to include oxygenation needs during positioning activities that lower the head of the bed
Spontaneous Breathing Trial Process Improvement (SBT)	• Multidisciplinary team approach to process redesign including ISS, RT and nursing. Developed a process with protocol ordered for all intubated patients admitted to ICU, documentation components to enhance communication between disciplines and visual cues on result of SBT. • Process went live July 2021, significantly impacted by COVID-19 patients • Dashboard under development to measure mean days of ventilation and reintubation rates



KAWEAH DELTA HEALTH CARE DISTRICT
SPONTANEOUS BREATHING TRIAL (SBT) PROTOCOL
Medical ICU

Inclusion Criteria (Multidisciplinary team to determine if patient meets criteria for SBT):
1. Underlying condition that led to the need for an artificial airway is reversed or improved.
2. Hemodynamic stability is achieved.
3. Airway problems have resolved; there is minimal risk for aspiration.
4. Mechanical ventilatory support is no longer needed.
5. Target RASS scale of 0 or -1 for weaning (Sedation Vacation performed by RN. See Section "Daily Sedation/Analgesia Interruption (Sedation Vacation)" below for details.

Spontaneous Breathing Trial (SBT) Process

1 Inclusion Criteria

Multidisciplinary team to determine if patient meets criteria for SBT:

1. Underlying condition that led to the need for an artificial airway is reversed or improved.
2. Hemodynamic stability is achieved.
3. Airway problems have resolved; there is minimal risk for aspiration.
4. Mechanical ventilatory support is no longer needed.
5. Target RASS scale of 0 or -1 for weaning (Sedation Vacation performed by RN. See Section "Daily Sedation/Analgesia Interruption (Sedation Vacation)" below for details.
   a) Level 0- alert and calm
   b) Level -1 drowsy
6. Adequate gas exchange on current ventilator setting:
   PaO2 greater than 60, FiO2 less than .50, PEEP less than or equal to 45, pH 7.30 –7.50, PaCO2 30-50, AND SaO2 ≥92%.
7. Adequate muscle strength
   a) Maximum negative inspiratory force (NIF) greater than or equal to –20
   b) Patient able to follow commands.

2 Documentation – Inclusion Criteria

Documentation of SBT appropriateness, inclusion criteria met/not met

3 SBT Process

1. RN to perform Sedation Vacation (Target RASS 0 or -1)
2. RT initiates SBT
   a) Successfully passes 10 minute trial of PS 5-8/Peep 5, if patient meets definition of stability (as defined below).
   Definition of Stability:
   a) Respiratory rate/tidal volume in liters (f/Vt) less than 100
   b) Respiratory rate (RR) less than
   c) Appears comfortable
3. If patient successfully passes SBT (i.e., meets "Definition of Stability") for 10-30 minutes, patient is a candidate for extubation (RNs in med ICU do not automatically extubate patients).
4. Contact intensivist if unable to obtain parameters indicated for extubation.
5. Discontinue weaning if:
   a. Patient appears distressed
   b. Heart rate or blood pressure increases/decreases 20% of baseline
   c. f/Vt greater than or equal to 100
   d. Pulse oximetry oxygen saturation (SpO2) is less than 92% on 40% FiO2.

4 Documentation – Inclusion Criteria

Documentation of the results of the SBT, and red/green signage posted on patients room window

Radiology – Dr. Roper

Project Description	Project Status
MRI Delays: Use of Monitored Anesthesia Care in the Prevention of MRI delays for patients who are not able to hold still for procedure	• Monitored Anesthesia Care for patients with a history of unsuccessful MRI attempts; protocol developed • Results 2021: 7/7 patients were completed with anesthesia services; 3 patients with no delays, 3 had time delays but completed on same day, 1 bumped from Fri. to Mon. 1 patient was cancelled (Pt. able to tolerate procedure without MAC). April Results 2021: 4 patients - 3 with no delays; 1 had time delay: IV pump issues but still done same day.
CT Guided Biopsies - Impact CT Guided Biopsies on Length of STAY (LOS)	• Case review completed to determine impact • Power plan under development for CT-guided Biopsy which will prompt the provider on medical necessity for CT biopsy to be done as an inpatient

Hospice – Dr. Howard

Quality Liaison:

Measure Description	CURRENT NOTES	FOLLOW UP NOTES	Collaborating Leader
Quality			
Family Evaluation of Hospice Care (FEHC)	how should process go? Status? Requirement and contracted vendor, Kersey and Co. Mail survey month after pt expires, 1 mo to complete. Most recent scores from 3/2021. Publicly reported on CMS website Care Compare. Old info due to COVID. Info goes to Ed Largoza provides 12 mo rollup. No trends IDed in Hospice (unlike HH), trends difficult to ID. Concern about low response rate.	Quality: can we give direction issues to address based on survey? Tiffany to send last 1yr survey to Sandy to review.	
Patient Outcomes and Measures			
- Comfortable Dying Measure	part of that survey. Other quality measures reported.		
- Self-Determined Life Closure Measures (SDLC)			
Throughput			
Decreased time from hospice consult to enrollment	11/20 - It was identified that the time from hospice consult to enrollment is 1 day. Performance is better than expected and does not require improvement at this time.	Two Initiatives	
Increased # of days on service	8/2: LOS 33-59 days	Overall near doubling of days with same or less staff. Needs: increase staffing, PT RN position created considering additional FT. 147 referrals and 116 admission 2021Q2. 5% increase in admission rate	
Increased # of patients on service	8/2: Increase ADC 48-55		
Patient Safety			
Decrease falls	not currently looking at Pt Safety measure		
Population Health/ Transition of Care			
Increase community awareness of hospice care as best way to improve quality of life and prevent suffering at end of life.	11/20 - Dr. Howard/Tiffany will work with Linde to develop a CME event in early 2020. Marketing may assist with flyers, etc. 4/20/21 - CME event scheduled (for Visalia, Hanford, Porterville, Dinuba areas; Adventist - Tulare/Hanford/Selma); Linde changing positions/Evelyn is CME contact		
Improve public relations with potential referring physicians. (Town hall forum) *Baseline: 23 referrals from community physicians from 11/1/19 - 10/31/20*	4/22/21 - Lunch & learn w/ Holvik Spring 2021 - Lunch & learn w/ VMC -- done	3/17/21 - Will complete multiple community activities before re-assessing data/improvements made in referrals (originally postponed d/t COVID) -- 8/2 done. Marketing campaign coming in next 2 mo. Social media effort coming in Vital Signs.	
Increase number of SNFs with whom we are the preferred hospice agency. *Baseline: 2 referrals from SNFs from 9/1/19 - 8/31/20*	11/20 - Meeting with SNFs/Follow-up with Tiffany/Referrals Spring 2021 - KD Marketing (Stephanie) - Many handouts/trinkets to be given to SNFs	2021Q2 MD refers 4-13. Clarify data.	
Clinical Pathway			
Dr. Howard pursuing Board Certification - HMDCB	Planned for May/June 2021	completed and passed	

Other Notes: Certified as Medical Director of Hospice. 10/22 for Hospice and PM Board Exam. * New Initiative: meeting w Open Arms Hospice Home. County Center home 6 bedroom home newly renovated as residence for hospice patients from any hospice company. Private Ins only. Currently closed, employees furloughed. Investigating making it Kaweah specifically. Minor medical needs, assisted living for elderly. GIP: continues to be investigated. One fellow currently. Scheduling on Wednesday.

How often has Hospice and PC lecture reviewed? Check w FM, PS, EM, TY. Med student gave lecture

Anesthesiology – Dr. Tang

Project Description	Project Status
Opioid Abuse Education - CME	• Completed January 2021
Epidural Blocks	• Goal: improve pain management • ANES Epidural Post-op order set developed May 2021. Developed nursing documentation for monitoring of epidural June 2021. Education developed and rolled out to nursing July 2021.
Increasing peripheral nerve blocks – reducing barriers to use	• Goal: improve pain management and need for opioids • Power plan developed, live January 2021 • Peripheral nerve block volumes tracked and reported to pain committee, opportunities to increase use identified and addressed
Hip Fractures: Standardization of Care	• Order sets and metrics developed, pending ISS edit and Order Set Committee approval

NeuroPsych – Dr. Chen, Dr. Bagga, Dr. Saadabadi, Dr.

Project Description	Project Status
Development of a neuro-psych multidisciplinary QI committee	• Structure discussed August 2021 • Neurosurgery QI measures determined, dashboard under development

Surgery – Dr. Mack

Project Description	Project Status
Diabetes Control A1C < 6.5 (Surgical Patients)	• Data reviewed - Pre-op Surgical patients with A1C > 6.5at KDMC & ASC, inpt & outpt, including PCP for 6 month period • Further data/analysis pending
GFR <20 (Surgical Patients)	• Data reviewed - Pre-op Surgical patients with GFR < 40 at KDMC & ASC, inpt & outpt, including PCP for • Further data/analysis pending

Emergency – Dr. Seng

Project Description	Project Status
Electronic Throughput Dashboard	• Comprehensive ED throughput dashboard developed. Phase I live June 2021. Phase II pending.

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Kaweah Health