

April 13, 2023

## NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in a Quality Council Committee meeting at 7:30AM on Thursday, April 20, 2023, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

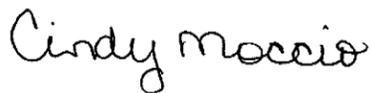
The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:31AM on Thursday, April 20, 2023, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277, pursuant to Health and Safety Code 32155 & 1461.

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Quality Council Committee meeting at 8:00AM on Thursday, April 20, 2023, in the Kaweah Health Lifestyle Fitness center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

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

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

KAWEAH DELTA HEALTH CARE DISTRICT  
Michael Olmos, Secretary/Treasurer



Cindy Moccio  
Board Clerk, Executive Assistant to CEO

### DISTRIBUTION:

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

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

Thursday, April 20, 2023

5105 W. Cypress Avenue

Kaweah Health Lifestyle Fitness Center Conference Room

**ATTENDING:** Board Members; David Francis – Committee Chair, Michael Olmos; Gary Herbst, CEO; Keri Noeske, RN, BSW, DNP, Chief Nursing Officer; William Brien, MD, CMO/CQO, Monica Manga, MD, Chief of Staff; Daniel Hightower, MD, Professional Staff Quality Committee Chair; Tom Gray, MD, Quality and Patient Safety Medical Director; Sandy Volchko DNP, RN CLSSBB, Director of Quality and Patient Safety; Ben Cripps, Chief Compliance and Risk Management Officer; Evelyn McEntire, Director of Risk Management; and Sylvia Salinas, Recording.

**OPEN MEETING – 7:30AM**

1. **Call to order** – *David Francis, Committee Chair*
2. **Public / Medical Staff participation** – Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdiction of the Board are requested to identify themselves at this time. For those who are unable to attend the beginning of the Board meeting during the public participation segment but would like to address the Board, please contact the Board Clerk (Cindy Moccio 559-624-2330) or [cmoccio@kaweahhealth.org](mailto:cmoccio@kaweahhealth.org) to make arrangements to address the Board.
3. **Approval of Quality Council Closed Meeting Agenda** – 7:31AM
  - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Daniel Hightower, MD, and Professional Staff Quality Committee Chair*
  - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management and Ben Cripps, Chief of Compliance and Risk Officer.*
4. **Adjourn Open Meeting** – *David Francis, Committee Chair*

**CLOSED MEETING – 7:31AM**

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

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

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

**OPEN MEETING – 8:00AM**

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

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

3. **Written Quality Reports** – A review of key quality metrics and actions associated with the following improvement initiatives:

3.1. [CAUTI Committee Report](#)

3.2. [Trauma Committee Quality Report](#)

3.3. [Centers for Medicare & Medicaid Services CMS Core Measures Report](#)

3.4. [Hospice and Home Health Quality Report](#)

4. [Methicillin-Resistant Staphylococcus Aureus \(MRSA\) Quality Focus Team Report](#)- A review of current performance and actions focused on to prevention of healthcare acquired MRSA. *Tendai R. Zinyemba, MBA, MSMIS, CHESP, Director - Environmental Services, Laundry, & Patient Transport*

5. [Environment of Care Infection Prevention Comprehensive Rounds](#) - Action plan related to process and follow up activities for Infection Prevention Comprehensive Rounds. *Keri Noeske, DNP, Chief Nursing Officer and Dr. William Brien, MD, Chief Medical and Quality Officer.*

6. [Hospital Acquired Conditions Program Review](#) - A review of performance related to the Centers for Medicare & Medicaid Services Quality Incentive Program: Hospital Acquired Conditions. *William Brien, MD, Chief Medical and Quality Officer and Lamar Mack, MD, Medical Director of Quality & Patient Safety.*

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

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.*

# Catheter Associated Urinary Tract Infection (CAUTI) Committee Report April 2023

Kari Knudsen, Director of Post-Surgical Care (Chair)



[kaweahhealth.org](https://kaweahhealth.org)



# CAUTI- FY23 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

	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	June 2023	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual/ number expected)	FY23 Goal <small>(VBP 2024; National Mean 2019)</small>	FY22 FY21 FY20
<b>CAUTI</b> <small>Catheter Associated Urinary Tract Infection Excluding COVID INCLUDING COVID-19 PATIENTS</small>	<b>1</b> <small>0</small>	<b>1</b> <small>0</small>	<b>2</b> <small>0</small>	<b>1</b> <small>1</small>	<b>2</b> <small>0</small>	<b>3</b> <small>0</small>	<b>0</b> <small>0</small>	<b>1</b> <small>0</small>					<b>14</b> <small>(23 predicted over 12 months)</small>	<b>0.680</b> <small>0.748 Including COVID</small>	≤0.650	1.092 0.54 1.12

Lower is Better

March 2023- 0 events at time of report

\*based on July-Dec 2021 NHSN predicted

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

# Kaizen Root Cause

## Analysis:

### Identified Root Causes

(in order from most significant to least):

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

Kaizen  
improvement  
strategies  
focused on  
addressing  
the top 4 root  
causes

Initial KAIZEN initiatives focused on the top 4 root causes

Since April 2020 we have incorporated strategies to address all 8 of the root causes

# Post KAIZEN-Gemba Data

**FY 23**

Total Catheter days rounded on = **5607**  
**99%** of patients with daily bath and peri-care each shift  
**Avg 94%** have order and valid rationale  
**142** catheters removed as a result of the Gemba

CAUTI Committee Dashboard																											
Measure Description	Benchmark/Target	Mar-20	Qtr 2 2020	Qtr 3 2020	Qtr 4 2020	Qtr 1 2021	Qtr 2 2021	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	
<b>OUTCOME MEASURES</b>																											
Number of CAUTI	0	0	4	2	3	1	3	1	3	5	2	2	1	3	3	2	1	1	1	1	1	2	1	2	3	0	
FYTD SIR	≤0.651							0.569			1.436	1.319	1.177	1.22	1.24	1.22	1.17	1.09	1.09	0.57	0.54	0.75	0.697	0.779	0.9	0.77	
<b>PROCESS MEASURES IUC Gemba</b>																											
% of pts with appropriate cleanliness	99%	98%	97%	97%	99%(e)	99%	99%(e)	98%			95%	100%	99%	99%	99%	N/A	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
% of pts with order present with indication	100%	90%	93%	92%	95%(e)	93%	93%(e)	94%			96%	97%	95%	98%	96%	N/A	89%	95%	94%	95%	93%	93%	96%	94%	94%	93%	
% of IUCs where removal was attempted	n/a	8%	6%	6%	4%(e)	4%	4%(e)	6%			3%	3%	7%	27%	26%	N/A	4%	3%	1%	2%	5%	7%	7%	3%	2%	2%	
% of pts where alternatives have been attempted	n/a	15%	11%	11%	9%(e)	10%	10%(e)	15%			8%	7%	11%	19%	10%	10%	10%	7%	8%	5%	10%	10%	8%	5%	4%	5%	
# of Pt Catheter days rounded on	n/a	616	2545	3280	2093	2757	1879	1045			1068	902	874	802	931	N/A	1169	852	749	871	975	848	733	760	683	737	
% of IUCs removed because of Gemba Round	n/a	7%	4%	4%	5%(e)	6%	6%(e)	6%			4%	5%	7%	6%	4%	N/A	6%	5%	4%	2%	5%	3%	3%	2%	1%	1%	
# of IUCs removed because of Gemba Round	n/a	46	110	142	104	152	94	43			43	49	64	48	37	N/A	63	39	29	19	45	29	19	13	9	8	
*volume reduced due to reduced Gemba on weekends																											
**FYTD includes cases removed in Mar 2021																											
*e=estimated																											
		Equal or Better than Target					Within 5% of Target					Does not meet Target															

# CAUTI Comm. – Key Strategies

## Continued

- Extensive case review by IP and individual units for near miss and CAUTI events
- Daily surveillance monitoring with Gemba on each IUC
- Culture of Culturing work by IP to promote awareness and consistency with culturing practices

## Next Steps

- HAI Playbook development with partnership with CMO and IP
- Completion of gap analysis of current root cause and planned initiatives
- Proposal of shift in daily Gemba to daily line necessity/line liberation rounds
- Renovation of nurse driven protocol and a culture that supports its use; CMO partnership

# Live with passion.

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



# Unit/Department Specific Data Collection Summarization

## Quality Improvement Committee

**Unit/Department:**

**Trauma**

**Report Date:**

**April 2023**

**Reporting Period**

**Aug 2022 – Jan 2023**



### Trauma Department

Trauma Tracking		Benchmark	Aug - 22	Sept - 22	Oct - 22	Nov - 22	Dec - 22	Jan - 23
Critical Trauma		N/A	46	33	45	41	35	29
Moderate Trauma		N/A	156	177	173	160	149	140
Non Activation		N/A	62	72	68	70	83	48
Surgeon Response Time to Critical Trauma Activation		80%	100.0%	94.9%	95.3%	80.0%	94.4%	100.0%
Screening, Brief Intervention, and Referral (SBIRT) Screening		80%	10% (N-20)	36% (N-77)	26% (N-68)	31% (N-63)	57% (N-187)	62% (N-168)
Screening, Brief Intervention, and Referral (SBIRT) Intervention		80%	15% (3/20)	5% (1/19)	0% (0/18)	0% (0/14)	4% (2/49)	10% (3/29)
Door to Femur Fixation < 24 hr.		80%	69% (9/13)	58% (7/12)	58% (7/12)	75% (15/20)	44% (8/18)	57% (4/7)
Door to Antibiotics for open fractures < 1 hr.		80%	89%	63%	86%	75%	80.0%	42% (3/7)
Door to Transfer < 4 hr. (Set for Region)		80%	15%	12%	25%	22.00%	14% (3/22)	23% (3/13)
Mortality (TQIP Report)			April 19- Mar 20	Oct 19 - Sept 20	Apr 20 - Mar 21	Oct 20 - Sept 21	Apr 21 - Mar 22	TBD
All Patients	Mortality % (Expected %)		5.1% (N-766) (4.8%)	5.2% (N-771) (4.4%)	6.3% (N-854) (5.2%)	7.4% (N-948) (5.9%)	7.9% (N-1021) (5.4%)	?
Elderly > 65 years old	Mortality % (Expected %)		5.4% (N-202) (5.7%)	8.4% (N-178) (6.3%)	10.4% (N-192) (7.3%)	10.5% (N-267) (6.9%)	11.6% (N-319) (6.4%)	?
Isolated Hip Fractures	Mortality % (Expected %)		0% (N-18) (2.8%)	0% (N-19) (5.6%)	2.3% (N-43) (3.3%)	4.9% (N-82) (2.6%)	5.5% (N-110) (2.8%)	?
<b>KEY</b>			Fall 2020	Spring 2021	Fall 2021	Spring 2022	Fall 2022	Spring 2023
			>10% above goal/benchmark	Within 10% of goal/benchmark	Outperforming/meeting goal/benchmark			

## Surgeon Response Time

### Problem/Opportunity

#### Surgeon Response Time to Critical Trauma Activations

The benchmark set by the American College of Surgeons sets the benchmark at < 30 min. The on-call physician has < 30 min to arrive in the patient's room from the time of the patient arrival.

The dashboard shows an average surgeon response time is currently less than 30 min. During the reporting period, we had physician times that were outliers. Factors that played a part in their times being outside the time frame were: In surgery or lack of documentation.

### Solution

**Physician Outliers:** Every physician that does not meet this benchmark is coached individually by Dr. Vincent Kirkpatrick, MD.

**Documentation:** We are improving the documentation by educating staff on the importance of documenting accurate times of arrival for the physicians. The staff has been instructed to keep an eye out while documenting for trauma surgeon's arrival and to place that time on the trauma flowsheet.

*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

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We have educated the providers that once they arrive in the Emergency Department they need to make sure that either the Health Unit Coordinator (HUC) or Trauma Team Lead (TTL) knows they are there to document the time.

Next metrics that will be track will be the orthopedic surgeons (2022) and neurosurgeon (response time). Each specialty will have the same response time rate as the trauma surgeons.

We have started to track and trend the orthopedic surgeon response times. We are working with our liaisons to create a better process. We are looking at adding documentation that helps identify ACS criteria to accurately capture response time.

### **Measures**

The measurement used to track response time is the time the patient has arrived to the time the surgeon arrives in the patient's room.

### **Next Steps**

Continue to track and trend along with coaching.

## **Screening, Brief Intervention, and Referral to Treatment (SBIRT)**

### **Problem/Opportunity**

What is SBIRT: Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based approach to the screening and identification of individuals engaged in substance use, the delivery of early brief interventions in order to reduce use, and the referral to treatment for high-risk use.

In all trauma centers, at least 80 percent of patients who have screened positive for alcohol misuse must receive a brief intervention by appropriately trained staff prior to discharge. This intervention must be documented.

Level III trauma centers must have a mechanism for referral if brief intervention is not available as an inpatient.

This is a new measure by the American college of Surgeons. The identified opportunities are:

- Accurately capture all patients screened.
- Create work group to identify who will follow-up with patients once identified
- Work with billing to make sure we can capture charges for interventions/referrals.

***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

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### Solution

**Documentation:** We identified that once the patient was admitted they were being screening on the admission forms. As you see in our data our success rate was very low but now that we identified patients were screened on admission we believe our screening rate will be much higher going forward.

**Follow-up:** Meeting with PFS leadership to identify process for intervention along with what the intervention will be.

### Measures

SBIRT screening: all patients admitted need to receive an alcohol misuse screening.

Alcohol misuse intervention report. The number of patients that received an intervention to the patients that had screened positive via questionnaire or alcohol level.

### Next Steps

**Follow-up:** Meeting with PFS leadership to identify the process for intervention along with what the intervention will be.

Billing: Schedule a meeting with our billing/coding team and provide them with billing codes given by the American college of Surgeons. Create a process for billing.

## Door to Femur Fixation

### Problem/Opportunity

This benchmark is set by collaboration with the Trauma Department and Orthopedic surgeons. American College of Surgeons (ACS) provides information regarding best practices for orthopedic care for trauma patients and one area is the treatment for long bone fractures. We have agreed upon a door to fixation rate of < 24 hours for distal and proximal femur fractures. The ACS provides data that the longer the fixation rate for these types of injuries increases the risk of ARD's and Fat Embolism syndrome. Early fixation also decreases the ICU length of stay and overall hospital length of stay.

### Solution

**Collaboration:** Setting a reasonable time frame and success rate with the orthopedic surgeons was the first step to the solution. We had a meeting with the surgeons in November of 2021 to agree to this new standard for trauma patients with proximal and distal femur fractures. We have mutually agreed upon a 80% success rate of patients receiving care in < 24 hours.

### **Monitoring and reporting**

Reports are sent monthly to the orthopedic service line Director and Liaison detailing outliers.

### Measures

*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

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The process for measurement is through our DI registry system. Our registrars extract this information and input it into our system. The registrars utilize the time the patient arrived in the emergency room to the time that patient arrived in surgery.

### **Next Steps**

We will continue to track and trend these cases. We will continue to work with our liaisons to find solutions to any problems stopping them from stabilizing the femur. Some of these patients are very complex which contributes to the delays. I will also loop in the new director of the OR service line so she is aware of the goals.

### **Door to Antibiotics**

#### **Problem/Opportunity**

The goal for antibiotic administration with open fractures is set at < 1 hour. The standard is set by the American College of Surgeons Trauma Quality Improvement Program.

As a facility, we struggle to meet these goals due to several different reasons. The areas that we have identified are knowledge deficit for staff and lack of documentation.

#### **Solution**

**Knowledge Deficit:** We have done daily rounds with Trauma Team Leads in educating them along with education newsletters to the emergency department regarding timely antibiotic administration.

**Documentation:** The trauma flow sheet as been redesigned to include a reminder for antibiotics and has been approved. The next shipment will have the changes.

#### **Measures**

We will measure success through our DI system where we will track patient arrival to antibiotic administration time frames. Success will be when 90% of the open fracture cases receive antibiotics in < 1 hour.

#### **Next Steps**

Revision is complete and we should have the new run of flow sheets in October 2022. In the meantime, we continue to work with staff and send education regarding open fractures needing antibiotics in < 60 min. (completed)

We noted marginal performance improvement for the last change made so we created a work group to look for other opportunities. We are currently looking at changing the EMR order set as a reminder for the providers. We also identified another misunderstanding which was open hand injuries are included in this report. We have sent out education to the providers through our liaison that hand and GSW fractures are considered open fractures.

*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

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## Door to Transfer

### Problem/Opportunity

Transferring Trauma patients for higher level of care on average for our facility is approx. 8 hours is double the recommended time frame set by the Emergency Medical Services Authority of California (EMSA). EMSA recommends that the patient be transferred <4 hours from the patient's arrival.

### Solution

**Early Recognition:** We noticed that the case managers who are no longer housed in the department waited for a phone call from the physician when the patient needed to be transferred. We worked with ISS and case management to find a solution, we figured out a method for electronic notification. The request order for the transfer fires off a notification to case management to work on the transfer.

**Transfer Algorithm:** Transferring patients from our facility is difficult and there are several different pathways our patients can take. We created a transfer algorithm to aid the case managers on the fastest way to get our patients to their destination by looking at the weather, time, weight of the patient, and if the patient needs an RN or not.

**Monthly Dashboard:** We have created a monthly dashboard for tracking our average transfer times along with the percentage of transfers that leave in <4 hours.

**Created a call tree for trauma centers:** We created a call tree that lists trauma centers listed closest to furthest away to help the transfer center identify all facilities in California.

**Transfer guidelines:** Written guidelines for staff so they understand the expectation for transferring a trauma patient.

**Early recognition:** TBD

### Measures

We measure this outcome utilizing our DI system that captures the time frames between the patient's arrival and the patient's departure. Monitoring our transfers is a requirement by the ACS; we review every transfer out of our facility.

### Next Steps

Early recognition change put in place has proven to be marginally effective and we can back to the table to implement new process changes.

Trauma center call tree put in place March 2023.

Transfer center creating guidelines for expectations (TBD 2023)

*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

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## TQIP Mortality Data

### Problem/Opportunity

TQIP is the Trauma Quality Improvement Program which is part of the American College of Surgeons. Every quarter we upload our Data to them and they send us back our risk-adjusted data. They look at the mortality rate for our patients in three areas: all patients, > 65 years old, and isolated hip fractures. The two areas of focus are all patient mortality and those that are > 65 years old.

### Solution

We have been reviewing all our mortalities and looking for trends. This measure continues to be developed.

We are working with EMS to ensure they are bringing in appropriate patients. EMS agency has a policy for their staff that states which patients to bring to the facility and those that stay at the scene. When we find questionable cases, we send them to the EMS agency for review.

We also reviewed our thoracotomy rates with our ED liaison and trauma surgeons. They have all agreed to use the East guidelines for thoracotomies. The East Association for the Surgery of Trauma has approved guidelines to help providers determine if a patient would benefit (improve survival) from a thoracotomy. Dr. Pho is also working on placing a poster in the trauma rooms so if there is a question regarding the guidelines it can easily be referenced. (Completed)

### Measures

We will utilize the bi-annual TQIP report for our data and continually review all our mortalities every month.

### Next Steps

Unfortunately, at the time of this report we have not received our data from TQIP. We expect to receive it this month with positive improvements from our hard work. We have cleaned our data and are currently working to standardize our abstraction by having weekly education topics with the registrars.

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

Core Measures

Metrics		Hospital Compare	CMS Standards of Excellence Benchmark	CMS Benchmark / *TJC National Rate	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Den	Num	Fail
ED-2b	Admit Decision Time to ED Departure for Admitted ED Patients (in minutes - down trend positive)	Y	42	139 (Hosp Comp)	1008	1139	686	534	505	408	458	453	489	196	182	462	N/A	N/A	N/A
OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients (in minutes - down trend positive)	Y	93	183 (Hosp Comp)	258	335	280	302	276	252	330	340	269	223	249	284	N/A	N/A	N/A
OP-18c	Median Time from ED Arrival to ED Departure for Discharged ED Patients - Psychiatric/Mental Health Patients (in minutes - down trend positive)	Y		128 (Hosp Comp)	920	996	771	274	1941	411	389	394	430	710	254	412			
OP-23	Head CT or MRI scan results for Acute Ischemic Stroke or Hemorrhagic Stroke	Y	100.00%	72.00%	100.0%	N/C	66.7%	100.0%	100.0%	50.0%	0.0%	100.0%	33.3%	100.0%	60.0%	100.0%	1	1	0
IMM-2	Influenza Immunization	N	100.00%	86.00%	92.3%	91.5%	95.2%	N/A	N/A	N/A	N/A	N/A	N/A	83.91%	89.74%	95.18%	83	79	4
VTE-6	Hospital acquired potentially-preventable Venous Thromboembolism (down trend positive)	Y	0.00%	2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	N/C	N/C	0.00%	0.00%	0.00%	0.00%	0.00%	N/C	N/C	N/C
HBIPS-1a	Admissions Screening		N/A	89.90%	95.83%	86.21%	88.24%	61.54%	87.50%	91.67%	95.65%	89.47%	92.86%	96.43%	96.77%	100%	24	24	0
HBIPS-2a	**Physical Restraint-Overall Rate - (down trend positive)	Y	N/A	0.44	0.499	0.582	0.723	0.454	0.551	0.412	0.471	0.774	0.168	0.523	0.296	0.060			
HBIPS-3a	**Seclusion-Overall Rate - (down trend positive)	Y	N/A	0.29	3.154	0.722	0.202	0.424	0.474	0.060	1.386	1.106	1.367	1.480	0.450	0.551			
HBIPS-5a	Multiple antipsychotic medications at discharge with appropriate justification - overall rate	Y	N/A	65.00%	0.0%	0.0%	0.0%	0.0%	100.0%	N/C	N/C	100.0%	100.0%	0.0%	100.0%	100.0%	1	1	0
SUB-2 (MH)	Alcohol Use Intervention Provided/Offered	Y	N/A	69.92%	87.50%	84.62%	71.43%	72.73%	91.67%	83.33%	83.33%	88.89%	90.00%	85.71%	60.00%	100.0%	10	10	0
SUB-2A (MH)	Intervention provided	Y	N/A	61.76%	75.00%	66.67%	61.54%	40.00%	66.67%	50.00%	33.33%	55.56%	70.00%	42.86%	30.00%	60.00%	10	6	4
SUB-3 (MH)	Alcohol/Other Drug Use Tx provided/offered at D/C	Y	N/A	36%	100.00%	100.00%	100.00%	100.00%	95.24%	100.00%	92.31%	100.00%	94.12%	100.00%	100.00%	95.46%	22	21	1
SUB-3A (MH)	Alcohol/Other Drug Use Disorder Tx at D/C	Y	N/A	36%	100.00%	100.00%	100.00%	100.00%	95.24%	100.00%	92.31%	100.00%	94.12%	100.00%	100.00%	95.46%	22	21	1

Core Measures

Metrics		Hospital Compare	CMS Standards of Excellence Benchmark	CMS Benchmark / *TJC National Rate	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Den	Num	Fail
IMM-2	Influenza Immunization (Mental Health) Start Oct 2015	Y	N/A	80.98%	97.96%	98.21%	98.36%	N/A	N/A	N/A	N/A	N/A	N/A	48.08%	82.69%	100.00%	51	51	0
TOB-2 (MH)	Tobacco Cessation FDA Approved Provided during stay.	Y	N/A	76.62%	95.65%	90.48%	91.18%	95.65%	91.18%	93.33%	100.00%	92.00%	88.00%	91.30%	82.61%	77.27%	22	17	5
TOB-2A (MH)	Tobacco Treatment Provided During Stay (Practical Counseling)	Y	N/A	41.52%	43.48%	65.00%	69.70%	34.78%	39.39%	36.67%	47.62%	30.44%	44.00%	30.44%	39.13%	22.73%	22	5	17
TOB-3 (MH)	Tobacco Treatment Provided/Offered at Discharge	Y	N/A	40.80%	38.10%	40.00%	66.67%	43.48%	53.13%	33.33%	10.53%	20.00%	17.39%	23.81%	45.46%	40.00%	20	8	12
TOB-3A (MH)	Tobacco Cessation Medication FDA Approved Provided at Discharge	Y	N/A	9.52%	4.76%	10.00%	3.33%	4.35%	12.50%	0.00%	0.00%	0.00%	4.35%	0.00%	0.00%	10.00%	20	2	18
CT-2	Care Transitions w specified elements received by discharged patients	Y	N/A	30%	88.68%	87.72%	89.23%	96.23%	86.44%	88.68%	84.91%	77.36%	82.69%	88.68%	90.39%	79.25%	53	42	11
SMD-1	Screening for Metabolic Disorders	Y	N/A	90%	91.89%	97.50%	93.88%	96.97%	97.44%	100.00%	91.67%	92.31%	96.30%	97.44%	94.44%	97.44%	39	38	1
PCB-05	Exclusive Breast Milk Feedings		N/A	*52.44%	58.07%	58.33%	64.52%	62.86%	64.71%	58.33%	61.29%	64.52%	64.87%	65.71%	53.13%	48.57%	35	17	18
PCM-01	Early Elective Deliveries (down trend positive)		0	2.42%	0.00%	0.00%	0.00%	11.11%	0.00%	0.00%	0.00%	16.67%	0.00%	0.00%	0.00%	0.00%	N/C	N/C	N/C
PCM-2a	C-Section Overall Rate (down trend positive)		N/A	*25.54%	12.50%	22.22%	17.39%	31.25%	31.82%	4.76%	27.59%	11.11%	13.33%	17.24%	11.11%	23.08%	26	6	6
PC-06	Unexpected Complications in Term Newborns-Overall Rate, per 1,000 live births (down trend positive)		N/A	N/A	6.5%	7.8%	25.8%	11.6%	17.4%	9.2%	12.0%	28.8%	12.0%	27.1%	26.5%	18.6%	N/C	N/C	N/c
PC-06.1	Unexpected Complications in Term Newborns-Severe, per 1,000 live births (down trend positive)		N/A	5%	3.23%	3.91%	3.69%	0.00%	6.97%	6.08%	3.01%	11.53%	6.01%	15.06%	17.70%	18.6%	323	6	6
OP Web-29	Endoscopy/Polyp Surveillance - appropriate follow-up interval for normal colonoscopy in average risk patients		100%	85%	100.0%	100.0%	100.0%	66.7%	100.0%	85.7%	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%	7	7	0
Sep-1	Sepsis Bundle Followed	Y	81%	61%	57.58%	81.08%	82.76%	91.18%	78.95%	63.64%	78.13%	83.87%	81.82%	75.00%	76.19%	61.77%	34	21	13

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

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

**Unit/Department Specific Data Collection Summarization**  
Professional Staff Quality Committee/Quality Improvement Committee

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**Unit/Department:**  
Home Health

**ProStaff/QIC Report Date:**  
March 2023

Data for this report is obtained from the *Star Report* on the *Care Compare* website, the Centers for Medicare & Medicaid Services (CMS) platform for which quality measures are publicly reported for home health agencies. Currently, the January 2023 refresh on *Care Compare* reflects April 1, 2021 thru March 31, 2022 and Kaweah Health Home Health is at an overall 3-Star rating, out of a 5-Star rating system. In April 2023, the site will refresh with the next four rolling quarters of data from July 1, 2021 thru June 30, 2022.

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

**Measure Description:**

***“How often patients got better at walking or moving around”***

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

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

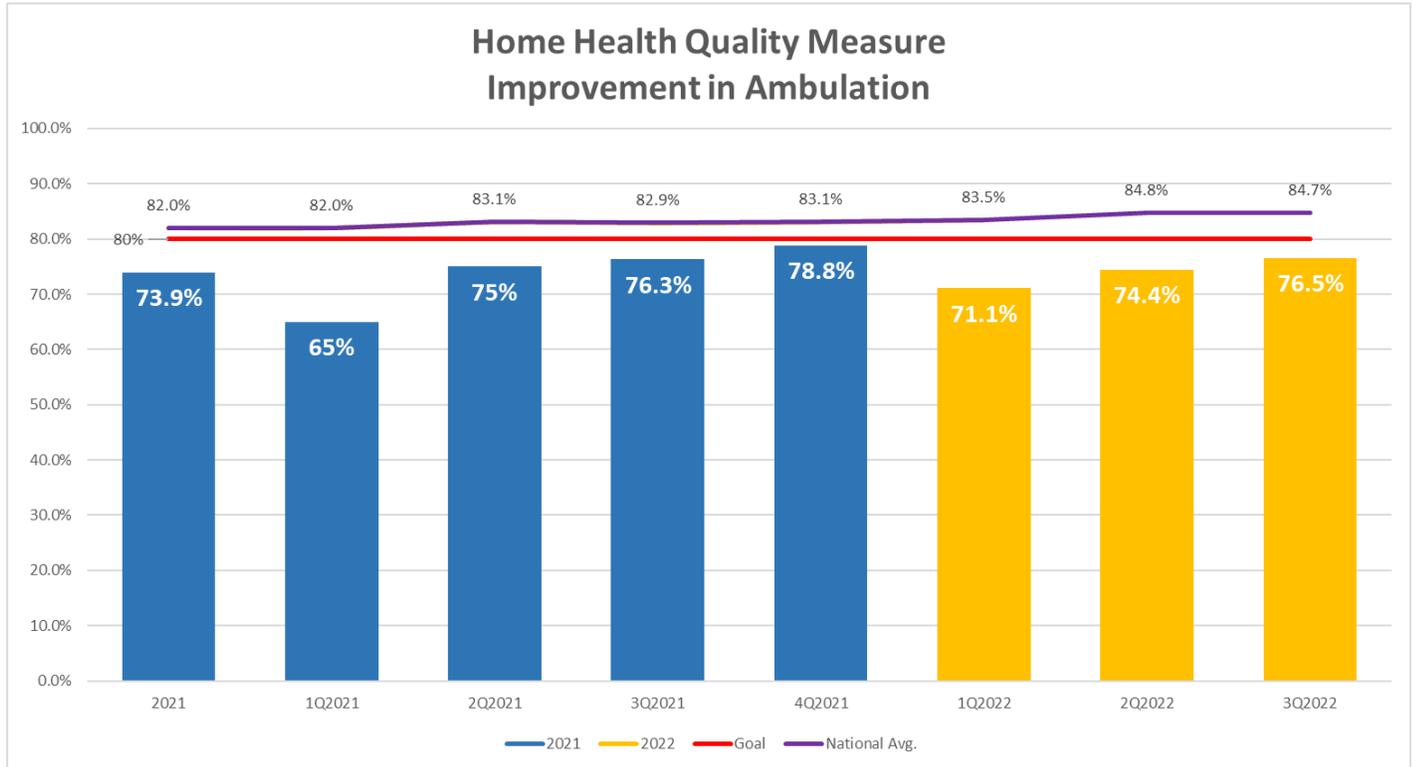
**Unit/Department Specific Data Collection Summarization**  
Professional Staff Quality Committee/Quality Improvement Committee

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**Measure Objective/Goal:**

**Improvement in Ambulation/Locomotion;**

- **CMS Star Report January 2023: KH HH 74.7%, National Average: 81.1%**
- **CMS Star Report April 2023 (Preview): KH HH 75.1%, National Average 81.6%**



plan.

**Date range of data evaluated:**

- **CMS Star Report April 2023; July 1, 2021 to June 30, 2022**
- **iQIES data; 4Q2021 thru 3Q2022**

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

**Opportunity for improvement in this area existed and a multifocal plan was executed that included two additional outcome measures to help ensure overall *Outstanding Community Health* consistent with Kaweah Health District Pillar.**

**--Clinician barriers to accurate assessment; assessing in home environment (clutter, need for equipment to help with mobility), and understanding of ability vs *safe* ability.**

**--Charting fatigue for clinicians reported as reason for inconsistencies in scoring OASIS accurately. OASIS questions focusing on ambulation are located near the end of a**

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## **Unit/Department Specific Data Collection Summarization**

Professional Staff Quality Committee/Quality Improvement Committee

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lengthy assessment. An attempt was previously made to ‘move up’ the OASIS sections related to ambulation but per our EMR software, this is not possible.

--Timely auditing of initial assessment OASIS scoring and return to clinician if inconsistencies were present.

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

There is an opportunity for improvement in this area. The following plan of action shall be implemented;

--Educator and Intake Utilization RN will review data from clinician charting and OASIS for inconsistencies and meet with clinician to provide immediate feedback.

--Clinicians will utilize the “5 Day Rule” allowed by CMS. CMS encourages a collaboration between all clinicians who assessed a patient within 5 days of the first OASIS assessment. This will ensure accurate capture of a patient’s need and the opportunity to provide the resources needed to help achieve *Outstanding Community Health* consistent with the Kaweah Health District pillar.

--Educator will meet with Intake Utilization RN who assists with audits, bi-weekly to provide feedback on OASIS inconsistencies.

--Education to all staff on use of SHP, OASIS tool to assist with inconsistencies prior to submission.

--OASIS-E education at discipline meetings in March on functional assessment.

--Reach out to therapy clinician for future in-service at nursing meeting on assessing safe ambulation.

### **Next Steps/Recommendations/Outcomes:**

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

**Submitted by Name:**

Shannon Esparza, RN

**Date Submitted:**

March 2023

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

**Unit/Department Specific Data Collection Summarization**  
Professional Staff Quality Committee/Quality Improvement Committee

---

**Unit/Department:**

Home Health

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March 2023

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**Measure Description:**

***How often patients got better at bathing***

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

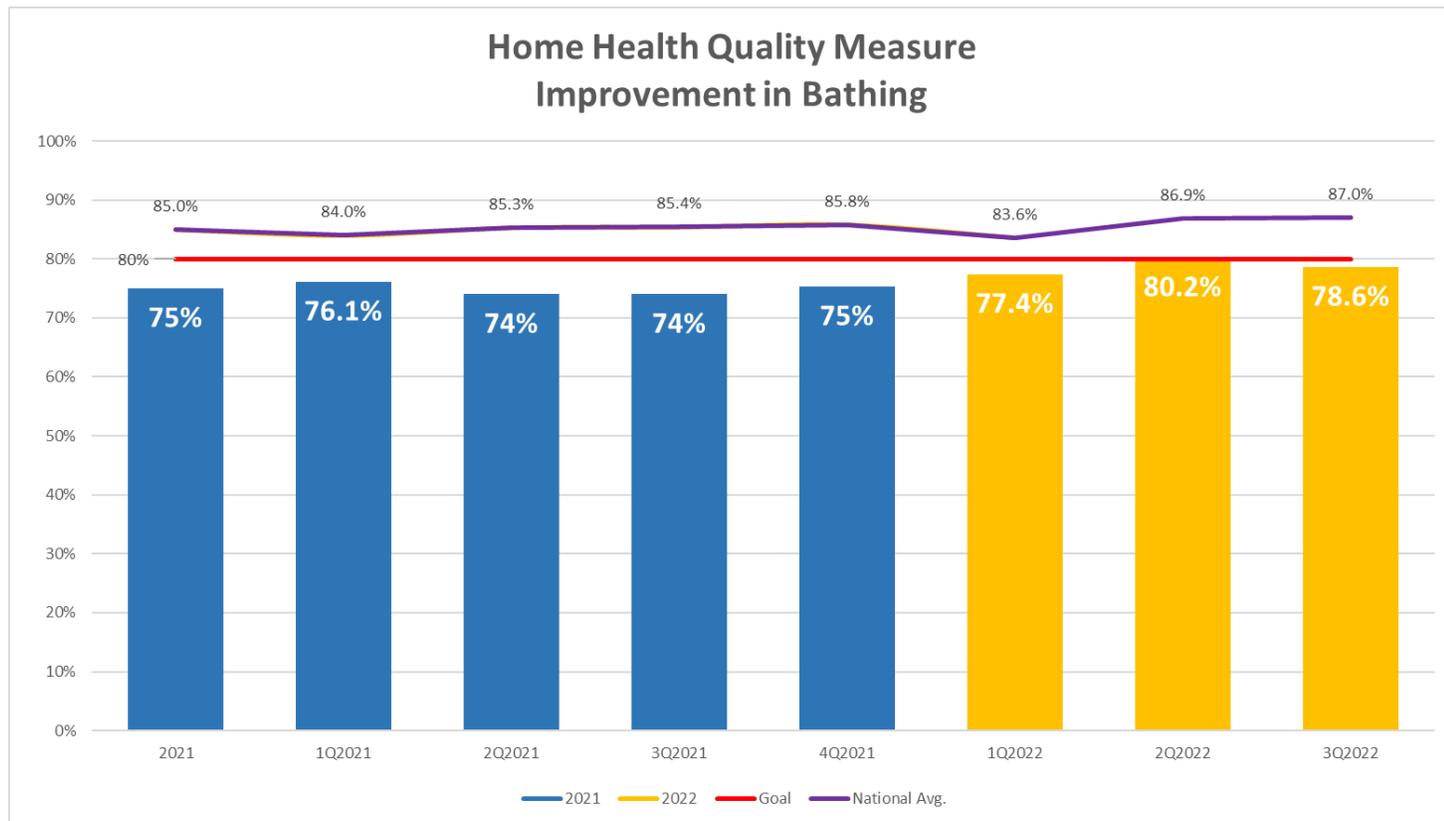
*Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.*

**Unit/Department Specific Data Collection Summarization**  
Professional Staff Quality Committee/Quality Improvement Committee

**Measure Objective/Goal:**

**Improvement in bathing**

- **CMS Star Report January 2023: KH HH 81.8%, National Average: 84.3%**
- **CMS Star Report April 2023 (Preview): KH HH 82.4%, National Average: 84.8%**



**Date range of data evaluated:**

**CMS Star Report April 2023; July 1, 2021 to June 30, 2022**

**iQIES data; 4Q2021 thru 3Q 2022**

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

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

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

## **Unit/Department Specific Data Collection Summarization**

Professional Staff Quality Committee/Quality Improvement Committee

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--Input from UBC assisted Home Health Educator in creating an “OASIS ADL/IADL” decision tree. Feedback from staff was positive but lack of use of tool was evident.

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

There is an opportunity for improvement in this area. The following plan of action shall be implemented;

--Educator and Intake RN will review data from clinician charting and OASIS for inconsistencies and meet with clinician to provide immediate feedback.

--Clinicians will utilize the “5 Day Rule” allowed by CMS. CMS encourages a collaboration between all clinicians who assessed a patient within 5 days of the first OASIS assessment. This will ensure accurate capture of a patient’s need and the opportunity to provide the resources needed to help achieve *Outstanding Community Health* consistent with the Kaweah Health District pillar.

--OASIS-E staff education planned for March discipline meetings to discuss functional mobility, including bathing.

### **Next Steps/Recommendations/Outcomes:**

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

### **Submitted by Name:**

Shannon Esparza, RN

### **Date Submitted:**

March 2023

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**Unit/Department Specific Data Collection Summarization**  
Professional Staff Quality Committee/Quality Improvement Committee

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**Unit/Department:**  
Home Health

**ProStaff/QIC Report Date:**  
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**Measure Description:**

*“How often patients got better at taking their drugs correctly by mouth”*

--Home Health Clinicians, i.e. registered nurses and physical therapists, assess the patient’s ability to take all oral medications *reliably* and *safely*, including administration of the correct medication, the correct dosage, and at the prescribed frequency, upon admission to home health. At discharge, the same assessment is performed. If a patient is assessed to be at the same level at discharge as they were at admission, they are considered to have *stabilized* in their medication regime. Stabilized is counted as a negative outcome for this measure. Patients who require more assistance are considered to have *deteriorated*, also a negative outcome for this measure. Patients assessed to be independent upon admission and remain independent upon discharge, or who do not take any oral medications are not counted in this measure.

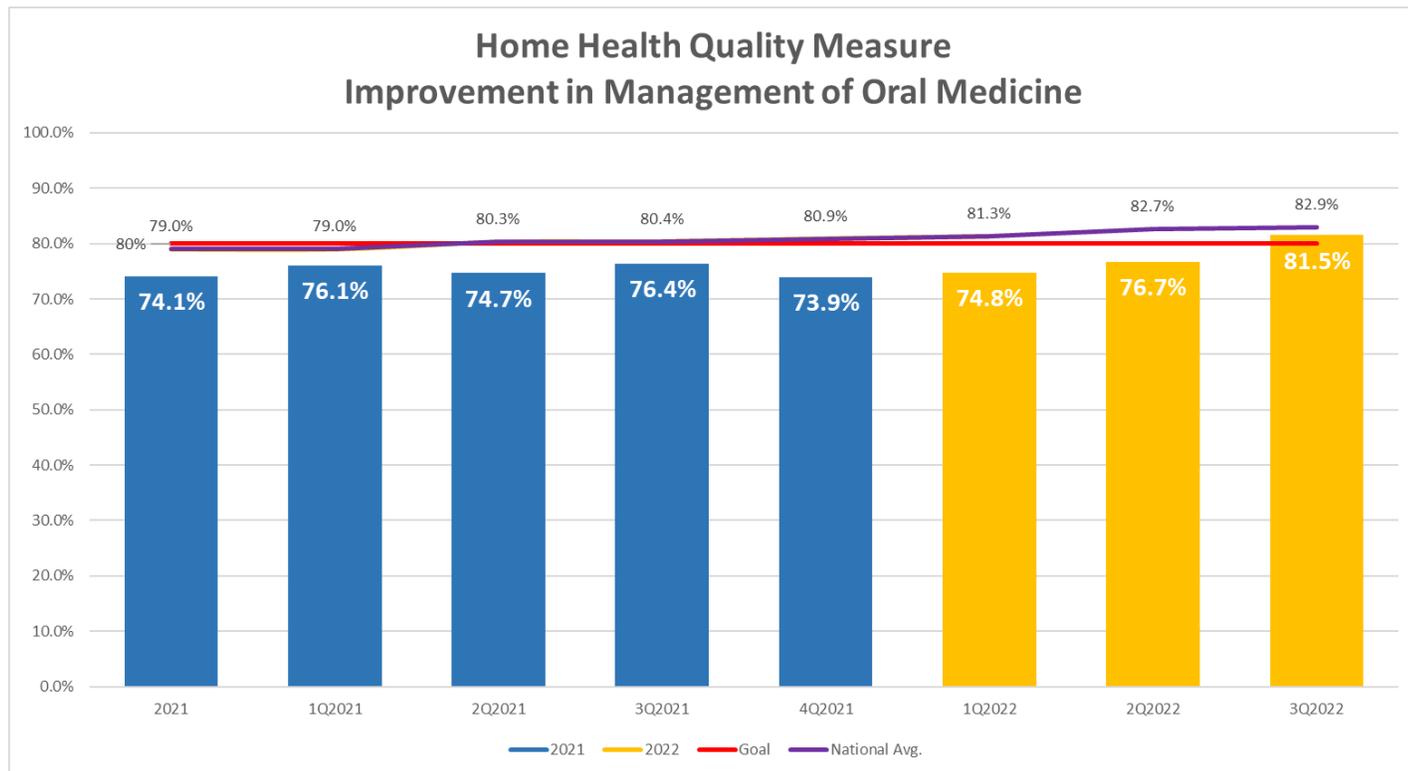
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**Unit/Department Specific Data Collection Summarization**  
Professional Staff Quality Committee/Quality Improvement Committee

**Measure Objective/Goal:**

**Improvement in Management of Oral Medications**

- CMS Star Report January 2023: KH HH 73.3%, National Average: 77.9%
- CMS Star Report April 2023 (Preview): KH HH 74%, National Average 78.4%



plan.

**Date range of data evaluated:**

- CMS Star Report April 2023; July 1, 2021 to June 30, 2022
- iQIES data; 4Q2021 thru 3Q2022

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

- Clinicians must differentiate patient's ability to perform the steps in this measure *independently* versus the *level of family/caregiver assistance* with medication regimen.
- Patient's ability to obtain the medication from where it is routinely stored, the ability to read the label or accurately identify medication by placing a character on label, open the container, remove the correct dosage at the appropriate times/intervals, and consistently, is evaluated.
- Medical record review noted inconsistencies with clinicians scoring of *oral medication administration and ability to ambulate*. OASIS guidance requires the clinician consider the patient's ability to obtain the medication from where it is routinely stored.

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

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- Educator met with clinicians who were inconsistent in scoring patient medication regime ability and functional ability. Additional individualized education provided opportunity for directed teaching based on the individualized scenarios clinicians were observing in patient homes.
- Cognitive ability can impact patient's ability to safely manage medications.
- iQIES data reflects positive gradual trend.
- Input from UBC assisted Home Health Educator in creating an "OASIS ADL/IADL" decision tree. Feedback from staff was positive but lack of use of tool was evident.

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

There is an opportunity for improvement in this area to ensure we reach our goal of meeting/exceeding the National Average. The following plan of action shall be implemented;

- Education to all clinical staff who complete OASIS, due to the multi-level assessment needed in this measure.
  - Educator and Intake RN auditor will review data from clinician charting and OASIS for inconsistencies and meet with clinician to provide immediate feedback.
  - Clinicians will utilize the "5 Day Rule" allowed by CMS. CMS encourages collaboration between all clinicians who assessed a patient, within 5 days of the first OASIS assessment.
- This will ensure accurate capture of a patient's need and the opportunity to provide the resources needed to help achieve *Outstanding Community Health* consistent with the Kaweah Health District pillar.

### **Next Steps/Recommendations/Outcomes:**

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

**Submitted by Name:**  
Shannon Esparza, RN

**Date Submitted:**  
March 2023

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

# Methicillin-Resistant Staphylococcus Aureus (MRSA)

## Quality Focus Team Report

### April 2023

#### Quality Focus Team Members

- *Jag Batth - Chief Operating Officer (ET)*
- *Kylie Jarrell – Admin Assistant Environmental Services, Laundry/Linen, & Patient Transport Service (Recorder)*
- *Tendai Zinyemba - Director of Environmental Services. Laundry/Linen, & Patient Transport Service (Chair)*
- *Shane Reynolds - Assistant Nurse Manager 4N (Co-Chair)*
- *Justin Ma – Infectious Disease Pharmacist*
- *Amy Baker – Director of Renal Services*
- *Sandy Volchko - Director of Quality & Patient Safety*
- *Shawn Elkin – Infection Prevention & Control Manager*
- *Joetta Denny – Infection Prevention*
- *Gloria Dickerson – Clinical Educator*
- *Johnny Mata – Respiratory Care Manager*



# MRSA- FY22 Goals

Healthcare onset MRSA bloodstream infection rate that does not exceed a standardized infection ratio of 0.748 or (<0.63 cases a month/2.52 cases a quarter/7.57 cases a year)

We reported 12 MRSA BSI events (only 3 of which were related to COVID-19, during prior FY)

**\*based on July-Dec 2021 NHSN predicted**

\*\*Standardized Infection Ratio (SIR) is the number of patients with a healthcare acquired infection (HAI) divided by the number of patients who were predicted to have an HAI. MRSA Bloodstream Infection is impacted by the number of inpatient days for a given time period.

# MRSA- FY23 Goals

Healthcare onset MRSA bloodstream infection rate that does not exceed a standardized infection ratio of 0.726 or (<0.5 cases a month/1.5 cases a quarter/6 cases a year)

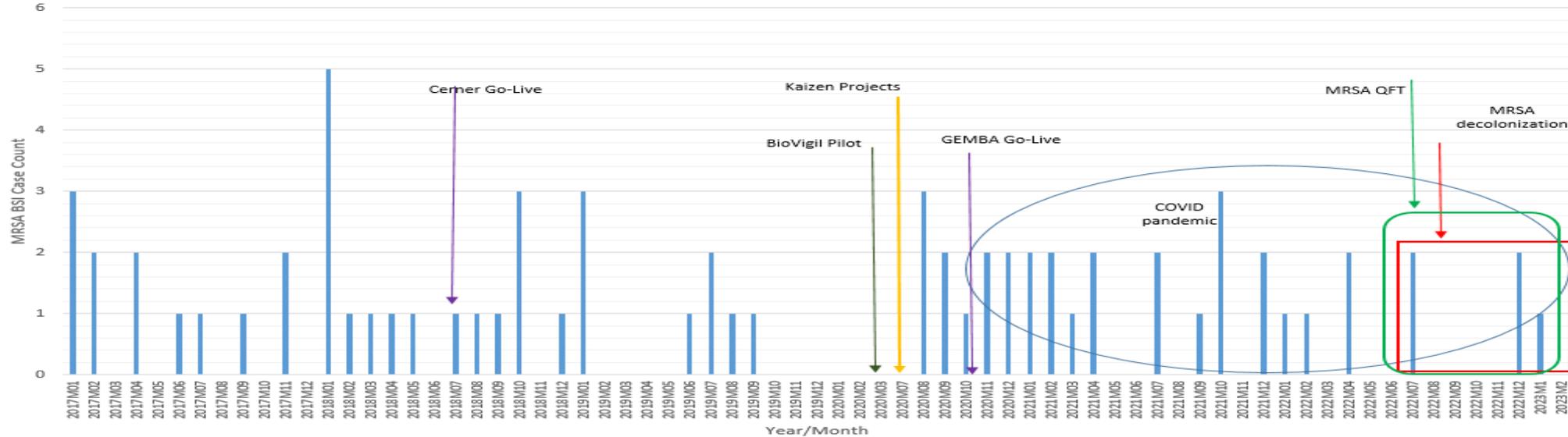
We reported 5 MRSA BSI events July 2022 – March 2023. (Only 1 of which was related to COVID-19 during FY)

**\*based on July-August 2022 NHSN predicted**

**\*\*Standardized Infection Ratio (SIR) is the number of patients with a healthcare acquired infection (HAI) divided by the number of patients who were predicted to have an HAI. MRSA Bloodstream Infection is impacted by the number of inpatient days for a given time period.**

# Background Data – MRSA Bloodstream Infection Events

Number of MRSA Bloodstream Infection events at Kaweah Health from over calendar years 2017 through July 2022 with emphasis on implementation of MRSA Quality Focus Team and MRSA Nasal Decolonization Pilot Study.

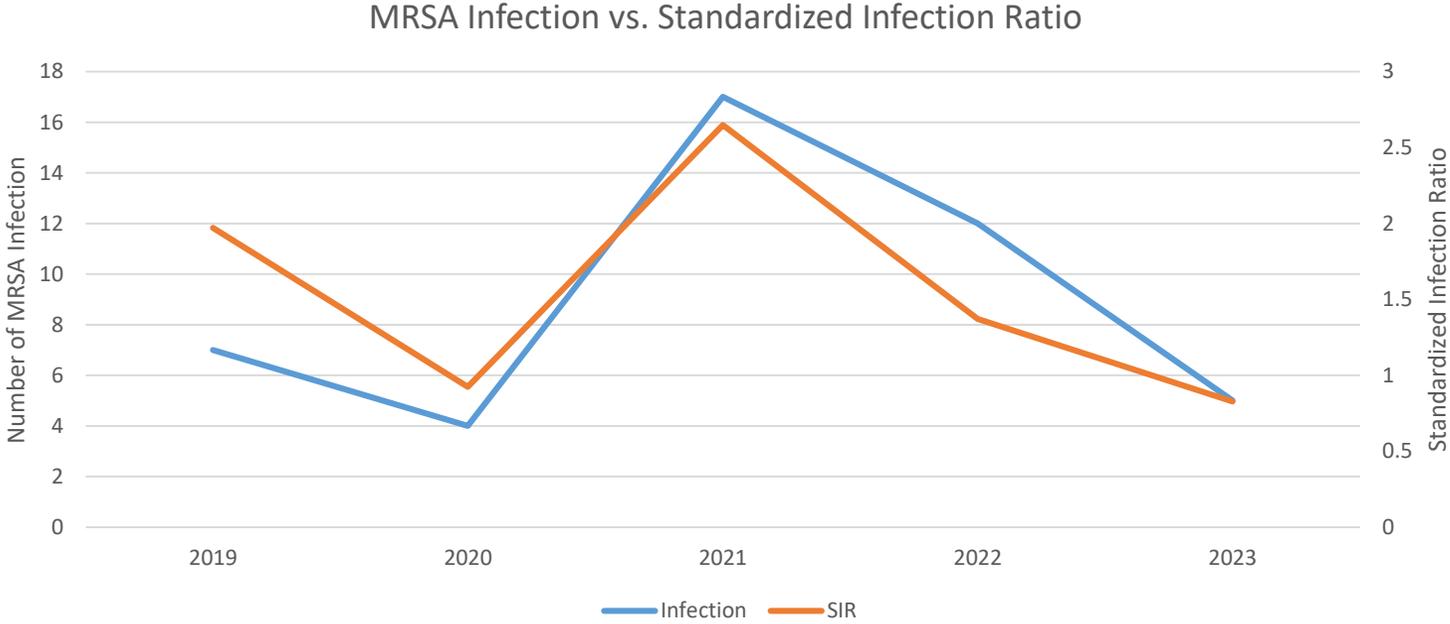


Number of MRSA BSI events dipped during November 2019 through March of 2020 in part due to the electronic hand hygiene system pilot on 4N, and ICU and the added attention given to healthcare associated infections (e.g. CLABSI/CAUTI) with Kaizen Projects and initiation of GEMBA Rounds. The increase in MRSA BSI events after March 2019 was associated with the COVID-19 pandemic, extended lengths of stays, blood culturing practices, and source control of the primary infection site.

Fiscal Year	Infection	SIR
2018	9	2.958
2019	7	1.97
2020	4	0.923
2021	17	2.648
2022	12	1.371
2023	5	0.827

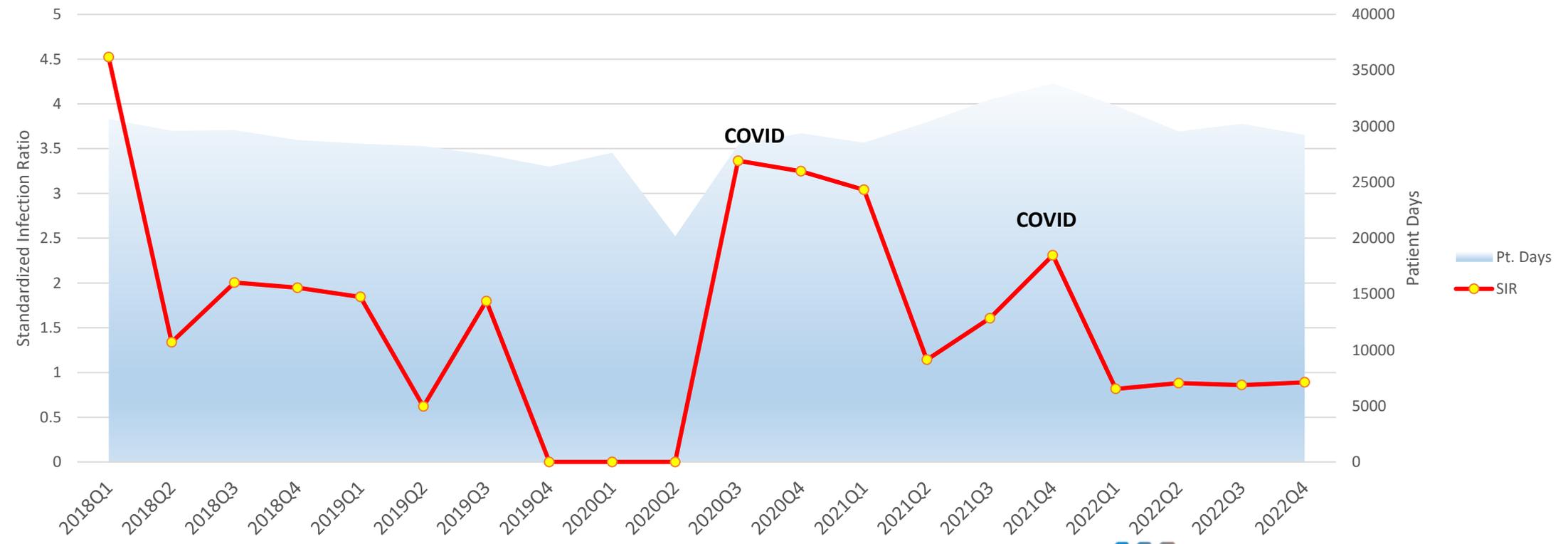
# Background Data – MRSA Bloodstream Infections & Standardized Infection Ratio Trend

Fiscal Year	Infection	SIR
2018	9	2.958
2019	7	1.97
2020	4	0.923
2021	17	2.648
2022	12	1.371
2023	5	0.827



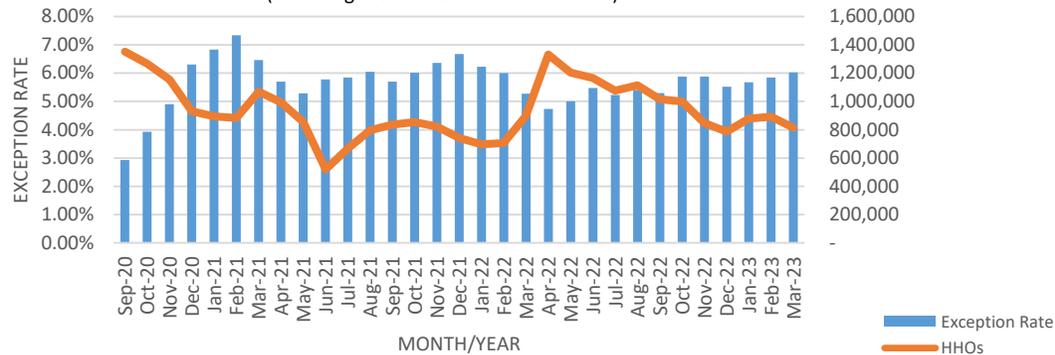
# Background Data - MRSA Bloodstream Infections vs Patient Days

Comparison of Healthcare Onset Methicillin Resistant Staphylococcus Aureus bloodstream infection (HO-MRSA BSI) events to patient days data at Kaweah Health from calendar years 2018 through 2023.

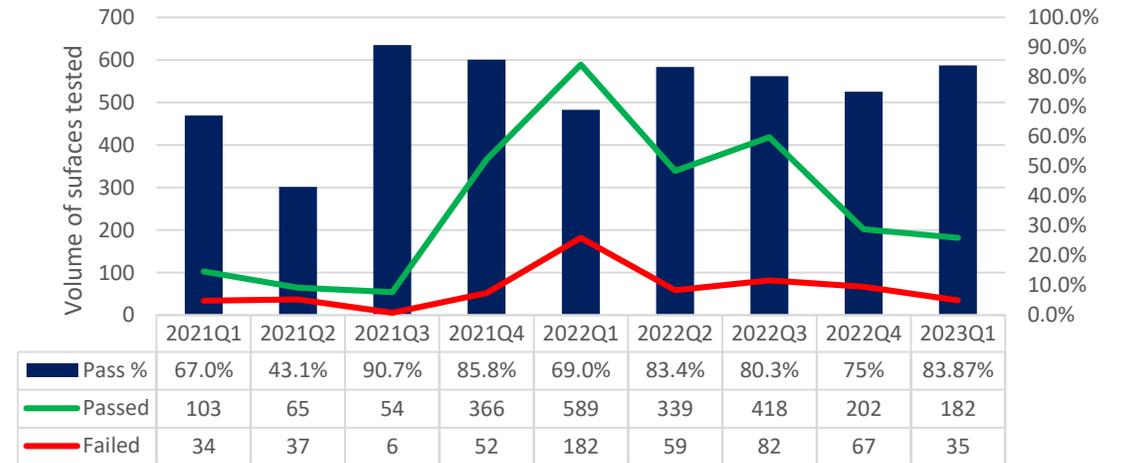


# Background Data - BioVigil Hand Hygiene Opportunities & ATP Testing

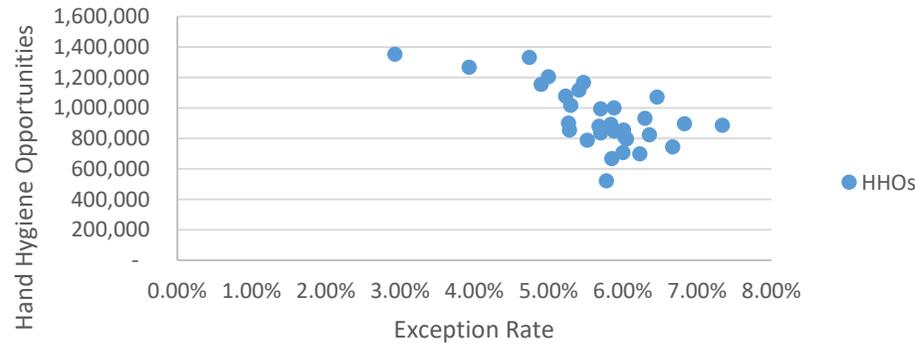
BioVigil Hand Hygiene Opportunities & Exception Rates  
(Excluding Mental Health & Rural Clinics)



ORs ATP data 2021Q1 - 2023Q1



Comparison between hand hygiene opportunities and exception rate (overriding the BioVigil Badge).



**A few EVS Updates to help with process improvement and sustainable service deliverables:**

- Streamlining ATP testing process to just ORs & Critical Care units effective 4/10/23.
- EVS Lead role (Internal promotion) filled to help real-time assessment of workflow opportunities for improvement in ORs during terminal cleaning.
- EVS Coordinator role posted (internal recruitment) to help with standardized training on an ongoing basis, among other responsibilities.
- ATP testing recertification for all 6 EVS Leader 100% complete as of 3/24/23.

# Root Causes Identified

## Culturing Practices

- Late blood cultures eliminating present-on admission designation.
- Serial blood cultures that exceed 14-day repeat infection timeframe (RIT).
- Positive MRSA serial blood cultures that exceed 14 days are considered a new event and healthcare acquired.
- Serial positive cultures across patient room assignments.

## Source Control

- Endocarditis  
*(Life-threatening inflammation of the inner lining of heart chambers and valves)*
- Osteomyelitis  
*(Inflammation or swelling that occurs in the bone)*  
maybe a contributing factors to seeding of the bloodstream.
- Delayed consultations, incomplete diagnostic studies, or avoidance of obtaining a specimen from the likely source of infection.
- Without addressing the primary source of infection there will be continued seeding of the bloodstream.

# MRSA QFT: Key Strategies

- Improvement in MRSA screening/testing
- MRSA Decolonization Pilot (Mupirocin treatment/CHG bathing)
- BioVigil electronic hand hygiene surveillance system
- Clinic based 'Patient as observer' hand hygiene program
- Do You Disinfect Every time (D.U.D.E.) Campaign
- Environmental cleaning – quality metrics Adenosine Triphosphate (ATP) monitoring
- Targeted use of Electrostatic Disinfectant Sprayer that produces an electrical charge so that disinfectant attaches to surfaces directly and indirectly facing the sprayer, ensuring thorough coverage over surfaces

# MRSA QFT: Recommendations

1. Provider involvement needed to help:
  - Process to effectively order/perform blood cultures
  - Protocol to diagnostically determine the presence of endocarditis that is consistent with NHSN criteria
  - Process by which source control can be better managed
2. Double down on MRSA Key strategies shared on prior slide (Decolonization; Hand hygiene; Patient care environment cleaning & disinfection etc...)



# The pursuit of healthiness



# Environment of Care

March 2023

Keri Noeske CNO &  
William Brien CMO



[kaweahhealth.org](http://kaweahhealth.org)



**EOC Component: SAFETY**

**Performance Standard: Infection Prevention: Comprehensive Rounds** - Each infection prevention based element of performance and/or environment-of-care criteria meets at least 90% compliance during unit/department rounds performed twice annually.

**Goal:** > 90% compliance

**Minimum Performance Level:** 90% compliance rate

**2022 Annual Evaluation:**

Overall compliance rate for elements during general area rounds in in 2022: 75%

Overall compliance rate for elements during specialty area rounds in in 2022: 86.7%

Overall goal of >90% compliance **not met** for 2022.

<b>General Areas (Inpatient Areas and Clinics): Infection Prevention Element Compliance %</b>	<b>2022</b>
Staff members can verbalize Infection Prevention principles.	94.1
Adherence to Kaweah Health's Hand Hygiene policies and procedures.	77.9
PPE is available, worn and stored appropriately.	86.9
Environment is clean, organized, and without factors that increase risk of infection.	52.4
Equipment is visibly clean and in working condition.	83.8
Hospital approved cleaner/disinfectant available and properly maintained.	81.3
Clean Supply Room maintained in accordance with Infection Prevention principles.	66.4
Dirty Supply Room maintained in accordance with Infection Prevention principles.	64.3
Linen maintained in accordance with Infection Prevention principles.	72.4
Patient care environment maintained in accordance with Infection Prevention principles.	80.7
Patients on transmission based precautions per Infection Prevention policy.	98.6
Patient Nutrition Area kept in accordance with Infection Prevention principles.	63.6
Medication Room maintained in accordance with Infection Prevention principles.	49.7
Staff Workspace maintained in accordance with Infection Prevention principles.	84.1
Staff Kitchen/Lounge maintained in accordance with Infection Prevention principles.	87.0

<b>Specialty Areas: Overall Area Compliance %</b>	<b>2022</b>
Laboratory Areas	67.9
Food Services Areas	79.8
Sterile Processing Areas	94.8
Surgical Services	72.8
Kaweah Kids Center	100.0
Pharmacy Areas	96.6
Laundry	95.0

**Plan for Improvement:**

Reports with rounding findings provided to department leadership. Action plans requested from leadership to address items out of compliance. Leaders of the area were to submit in writing to Infection Prevention their actions to correct the items out of compliance.

We will update this performance measure for 2023. The updated measure will reflect that corrective action plans are returned to the Infection Prevention department within 7 days of report of findings to unit leader. The goal of this update is to ensure findings are addressed in a reasonable timeframe to mitigate the risk of infection to patients and staff, to enhance patient safety and to optimize the environment of patient care.

# Environment of Care (EOC) Current State

- EOC Rounding Team Members
  - Environmental Services; Life Safety; Infection Prevention; Pharmacy
- Current work flow plan
- Historically audit & reporting of data
- Limited action plan
- Not rounding with the manager

# Environment of Care

## Proposed Improvement Plan

- EOC Team will round with the Unit Manager
- Action plan created & submitted to EOC Team within 14 days of the finding
- Action plan implemented within 7 days of creation
- Manager will “audit” the Unit to document correction sustained
  - Manager will submit audit to the EOC team for review quarterly
  - Deficiencies will be corrected within 7 days
- An EOC member performs follow-up audits (“audit the audit”) of deficiencies
  - If corrected will track & trend with quarterly Unit Manager audits
  - If not corrected EOC team member & Unit Manager will present to EOC
- Process improvement initiative will be presented at the July QC meeting
  - Covering the period of April, May & June

# The pursuit of healthiness



Centers for Medicare & Medicaid Services

# Hospital Acquired Condition (HAC) Program

Lamar Mack, MD, MHA

Medical Director, Quality & Patient Safety



# Acronyms

CDC - Centers for Disease Control and Prevention

CMS - Centers for Medicare & Medicaid Services

FFY – Federal fiscal year

HAC - Hospital-Acquired Condition NHSN

PSI – Patient Safety Indicator

SIR – Standardized Infection Ratio

Z-score - a statistical measurement that describes a value's relationship to the mean of a group of values. Z-score is measured in terms of standard deviations from the mean. If a Z-score is 0, it indicates that the data point's score is identical to the mean score.

Winsorized Z score - The winsor Z function identifies outliers based on Z-score cutoff and replaces with the next most extreme non-outlier value. This involves z-scoring the variable and identifying/replacing any cases beyond the z-score threshold.

# CMS HAC Program Overview

- The HAC Reduction Program is a value-based-purchasing program for Medicare that supports the Centers for Medicare and Medicaid Services' (CMS') long-standing effort to link Medicare payments to healthcare quality in the inpatient hospital setting.
- CMS reduces overall Medicare payments for hospitals that rank in the worst-performing quartile of all hospitals on measures of hospital-acquired conditions
- On an annual basis, CMS evaluates overall hospital performance by calculating Total HAC Scores as the equally weighted average of scores on measures included in the program.
- Hospitals with a Total HAC Score greater than the 75th percentile of all Total HAC Scores will receive a 1-percent payment reduction. This payment adjustment applies to all Medicare discharges for the applicable fiscal program year when CMS pays hospital claims.

# HAC Scoring

## 2 domains

Domain 1 - The CMS PSI 90 composite measure includes the ten CMS PSIs: (10/2015-6/2017)

Domain 2 – CDC NHSN HAI measures (1/2016-12/2017)

CMS uses the Total HAC Score to determine the worst-performing quartile of all subsection (d) hospitals based on data for six quality measures:

- One claims-based composite measure of patient safety:
  - Patient Safety and Adverse Events Composite (CMS PSI 90)
- Five chart-abstracted measures of healthcare–associated infections (HAI), submitted to the Centers for Disease Control and Prevention's National Healthcare Safety Network:
  - Central Line-Associated Bloodstream Infection (CLABSI)
  - Catheter-Associated Urinary Tract Infection (CAUTI)
  - Surgical Site Infection (SSI) for abdominal hysterectomy and colon procedures
  - Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia
  - Clostridium difficile Infection (CDI)

# CMS PSI 90 Composite Measure

## 10 PSIs

- PSI 03 – Pressure Ulcer Rate
- PSI 06 – Iatrogenic Pneumothorax Rate
- PSI 08 – In-Hospital Fall with Hip Fracture Rate
- PSI 09 – 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 – Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate

# NHSN HAI measure

- CDC standardized infection ratios (SIRs) = CLABSI + CAUTI + SSI + MRSA bacteremia + CDI measures.
- SIRs compare observed-to-predicted numbers of HAIs.
- The CLABSI, CAUTI, SSI, MRSA bacteremia, and CDI measures are risk-adjusted at the hospital and patient care unit level.
- For FY 2019, NHSN data used for infections that occurred between January 1, 2016 - December 31, 2017

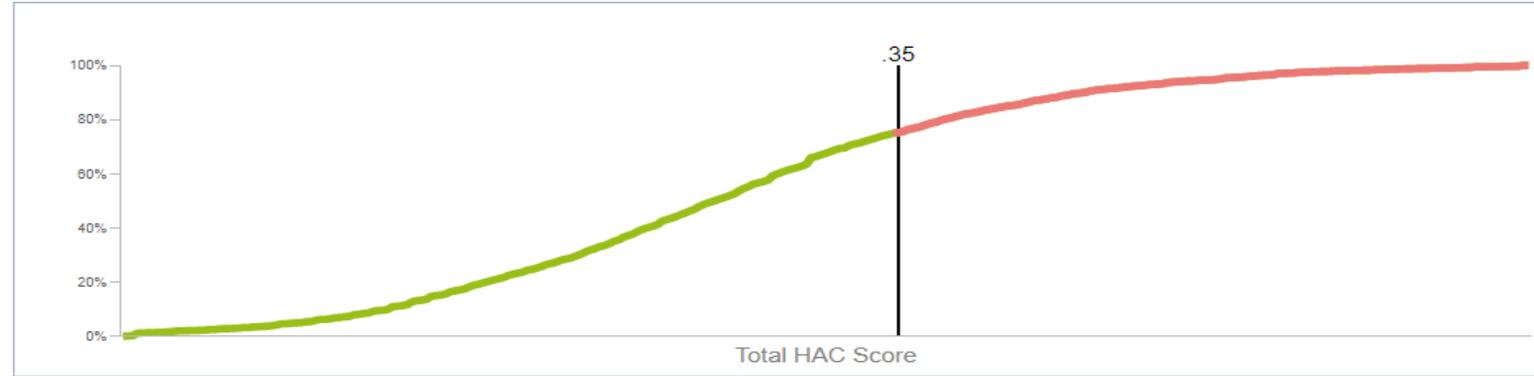
CMS PSI 90 Contribution to Total HAC Score [a]	CLABSI Contribution to Total HAC Score [b]	CAUTI Contribution to Total HAC Score [c]	SSI Contribution to Total HAC Score [d]	MRSA bacteremia Contribution to Total HAC Score [e]	CDI Contribution to Total HAC Score [f]	Total HAC Score for Your Hospital [g]	Payment Reduction Threshold (75th Percentile) [h]	Subject to Payment Reduction (Yes/No) [i]
-0.1664	0.1608	0.3651	0.1192	0.2377	-0.1279	0.5885	0.2998	Yes

# HAC Reduction Program Analysis

## Kaweah Health Medical Center

Program FFY:

- 2022
- 2024



### Actual FFY 2022 Performance

Total HAC Score	75th Cutoff	Payment Penalty?	Est. Annual Impact
0.5885	0.2998	Yes	(\$994,100)

### Actual FFY 2023 Performance

Total HAC Score	75th Cutoff	Payment Penalty?	Est. Annual Impact
-	-	No	\$0

### Estimated FFY 2024 Performance

Total HAC Score	75th Cutoff	Payment Penalty?	Est. Annual Impact
0.3466	↓ 0.3362	Yes	(\$1,062,300)

### Actual FFY 2022 Performance

Lower is Better

Measure	Measure Z-Score
<b>AHRQ Claims Based</b>	
PSI-90-Safety	-0.9983
<b>CDC Chart Abstracted</b>	
HAI-1	0.9649
HAI-2	2.1907
SSI	0.7154
HAI-5	1.4261
HAI-6	-0.7676

### Actual FFY 2023 Performance

Lower is Better

Measure	Base Score	Measure Z-Score
<b>AHRQ Claims Based</b>		
PSI-90-Safety	-	-
<b>CDC Chart Abstracted</b>		
HAI-1	1.2530	-
HAI-2	0.9330	-
SSI	0.9960	-
HAI-5	2.1070	-
HAI-6	0.4980	-

### Estimated FFY 2024 Performance

Lower is Better

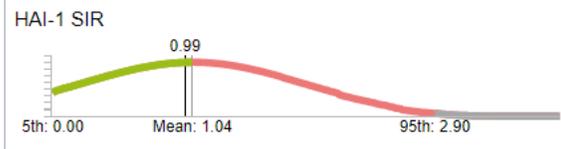
Measure	Base Score	Measure Z-Score
<b>AHRQ Claims Based</b>		
PSI-90-Safety	1.0500	0.6378 ↑
<b>CDC Chart Abstracted</b>		
HAI-1	0.9900	-0.0716 ↓
HAI-2	1.3170	0.7368 ↓
SSI	0.7640	-0.0474 ↓
HAI-5	1.6090	0.7067 ↓
HAI-6	0.5010	0.1171 ↑

# Kaweah Health Medical Center



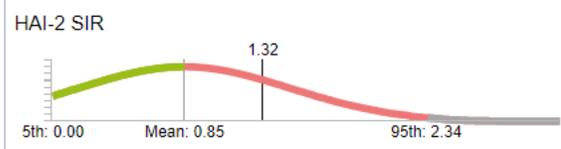
PSI-90: Safety and Adverse Events Composite (v10.0)

Composite Ratio	Winsorized Composite Ratio	Winsorized National Mean	Winsorized National Std. Deviation	PSI-90 Z-Score
1.0500	1.0500	0.9694	0.1264	0.6378



HAI-1: Central Line Associated Blood Stream Infection (CLABSI)

Numerator	Denominator	Standardized Infection Ratio (SIR)	Winsorized SIR	Winsorized National Mean	Winsorized National Std. Deviation	CLABSI Z-Score
11.00	11.11	0.9900	0.9900	1.0446	0.7628	-0.0716



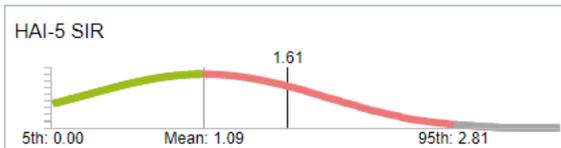
HAI-2: Catheter Associated Urinary Tract Infection (CAUTI)

Numerator	Denominator	Standardized Infection Ratio (SIR)	Winsorized SIR	Winsorized National Mean	Winsorized National Std. Deviation	CLABSI Z-Score
16.00	12.15	1.3170	1.3170	0.8474	0.6374	0.7368



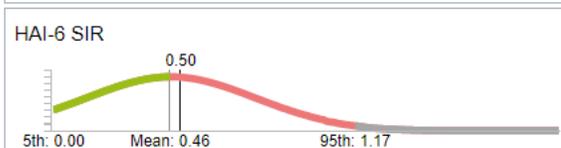
Surgical Site Infection (SSI) Pooled SIR

Numerator	Denominator	Standardized Infection Ratio (SIR)	Winsorized SIR	Winsorized National Mean	Winsorized National Std. Deviation	SSI Z-Score
4.00	5.24	0.7640	0.7640	0.7914	0.5793	-0.0474



HAI-5: Methicillin-resistant Staphylococcus Aureus (MRSA)

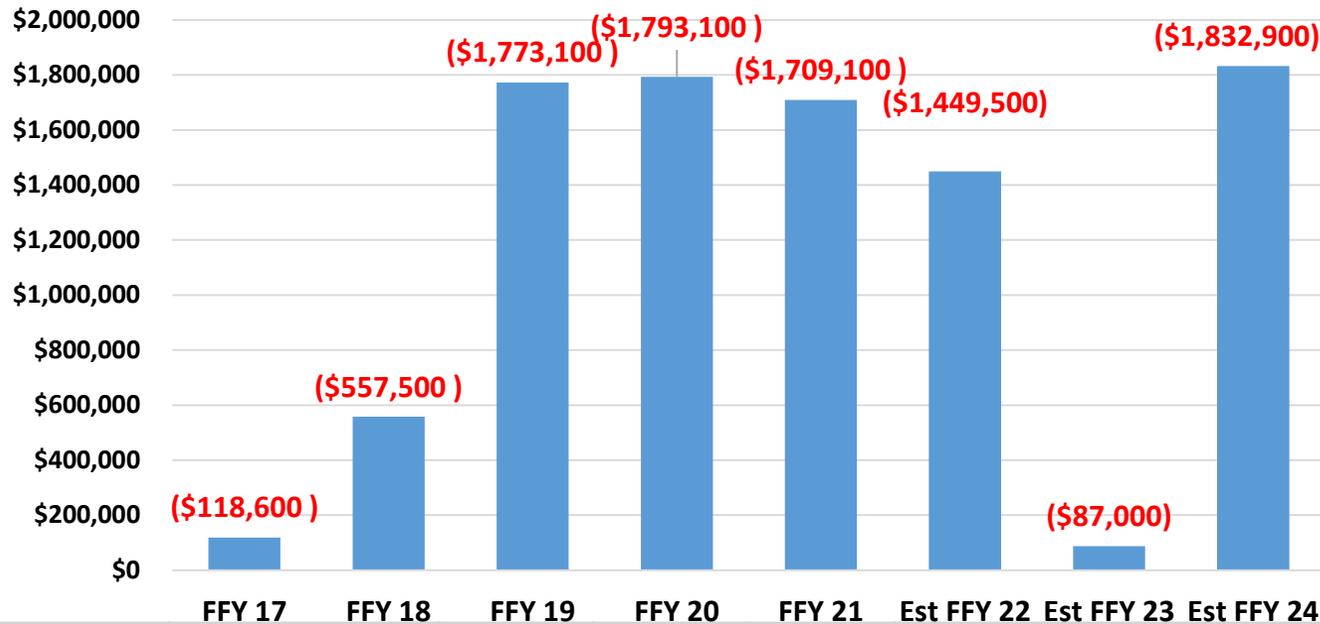
Numerator	Denominator	Standardized Infection Ratio (SIR)	Winsorized SIR	Winsorized National Mean	Winsorized National Std. Deviation	MRSA Z-Score
12.00	7.46	1.6090	1.6090	1.0854	0.7409	0.7067



HAI-6: Clostridium difficile (C.diff.)

Numerator	Denominator	Standardized Infection Ratio (SIR)	Winsorized SIR	Winsorized National Mean	Winsorized National Std. Deviation	C.diff Z-Score
38.00	75.87	0.5010	0.5010	0.4631	0.3239	0.1171

# Impacts



	FFY 17	FFY 18	FFY 19	FFY 20	FFY 21	FFY 22	FFY 23	FFY 24		
							CHA Estimated	CHA Estimated		
Value Based Purchasing Adjustment	(\$118,600)	(\$461,400)	(\$407,100)	(\$471,000)	(\$174,200)	\$0	\$0	(\$770,600)	Updated 1/6/23	3Q2022
Readmission Adjustment	\$0	(\$96,100)	(\$222,400)	(\$172,600)	(\$352,700)	(\$455,400)	(\$87,000)	\$0	Updated 11.9.22	CHA DataSuite Release:
HAC Reduction Program 1 % Penalty	\$0	\$0	(\$1,143,600)	(\$1,149,500)	(\$1,182,200)	(\$994,100)	\$0	(\$1,062,300)	Updated 3/22/23	
<b>Total</b>	<b>(\$118,600)</b>	<b>(\$557,500)</b>	<b>(\$1,773,100)</b>	<b>(\$1,793,100)</b>	<b>(\$1,709,100)</b>	<b>(\$1,449,500)</b>	<b>(\$87,000)</b>	<b>(\$1,832,900)</b>		



Questions?



# Outstanding Health Outcomes Update

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

April 2023



[kaweahhealth.org](https://kaweahhealth.org)



# FY23 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

**July-Feb 23**

Higher is Better

FY23 Goal

FY22

FY22 Goal

<b>SEP-1</b> (% Bundle Compliance)	<b>72%</b>	≥ 77%	76%	≥ 75%
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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.

	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	June 2023	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual/number expected)	FY23 Goal (VBP 2024; National Mean 2019)	FY22 FY21 FY20
<b>CAUTI</b> Catheter Associated Urinary Tract Infection Excluding COVID <small>INCLUDING COVID-19 PATIENTS</small>	1 0	1 0	2 0	0 1	2 0	3 0	0 0	1 0	0 0				14 (23 predicted over 12 months)	<b>0.600</b> 0.660 Including COVID	≤0.650	1.092 0.54 1.12
<b>CLABSI</b> Central Line Associated Blood Stream Infection Excluding COVID <small>INCLUDING COVID-19 PATIENTS</small>	2 1	0 0	0 0	1 0	1 0	2 1	1 0	1 0	1 0				10 (17 predicted over 12 months)	<b>0.79</b> 0.970 Including COVID	≤0.589	1.132 0.75 1.20
<b>MRSA</b> Methicillin-Resistant Staphylococcus Aureus Excluding COVID <small>INCLUDING COVID-19 PATIENTS</small>	2 0	0 0	0 0	0 0	0 0	2 0	0 1	0 0	0 0				5 (8 predicted over 12 months)	<b>0.59</b> 0.738 Including COVID	≤0.726	1.585 2.78 1.02

\*based on July 2021-June 2022 NHSN predicted

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