Kaweah Health
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Kaweah Delta Health Care District

Board Of Directors Committee Meeting

***Health** is our Passion. **Excellence** is our Focus. **Compassion** is our Promise.*

NOTICE

The Quality Council Committee of the Kaweah Delta Health Care District will meet at the Kaweah Health Lifestyle Fitness Center Conference Room {5105 W. Cypress Avenue, Visalia, CA} on Thursday, March 20, 2025:

- 7:30AM Closed meeting.
- 8:00AM Open meeting.

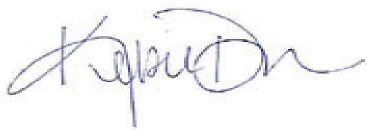
In compliance with the Americans with Disabilities Act, if you need special assistance to participate at this meeting, please contact the Board Clerk (559) 624-2330. Notification 48 hours prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to the Kaweah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

All Kaweah Delta Health Care District regular board meeting and committee meeting notices and agendas are posted 72 hours prior to meetings (special meetings are posted 24 hours prior to meetings) in the Kaweah Health Medical Center, Mineral King Wing near the Mineral King entrance.

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

KAWEAH DELTA HEALTH CARE DISTRICT

David Francis, Secretary/Treasurer



Kelsie Davis

Board Clerk / Executive Assistant to CEO

DISTRIBUTION:

Governing Board, Legal Counsel, Executive Team, Chief of Staff, www.kaweahhealth.org

Mike Olmos • Zone 1
President

Lynn Havard Mirviss • Zone 2
Vice President

Dean Levitan, MD • Zone 3
Board Member

David Francis • Zone 4
Secretary/Treasurer

Amando Murrieta • Zone 5
Board Member

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Kaweah Delta Health Care District

Board Of Directors Committee Meeting

***Health** is our Passion. **Excellence** is our Focus. **Compassion** is our Promise.*

Kaweah Delta Health Care District Board of Directors Quality Council
Meeting held: Thursday, March 20, 2025 • Kaweah Health Lifestyle Fitness Center Conference Room
Attending: Board Members: Michael Olmos (Chair), Dean Levitan, MD; Gary Herbst, CEO; Keri Noeske, Chief Nursing Officer; Paul Stefanacci CMO/CQO; Julianne Randolph, OD, Vice Chief of Staff and Quality Committee Chair; LaMar Mack, MD, Quality and Patient Safety Medical Director; Sandy Volchko, Director of Quality and Patient Safety; Ben Cripps, Chief Compliance and Risk Management Officer; Evelyn McEntire, Director of Risk Management; Cindy Vander Schuur, Patient Safety Manager; and Kyndra Licon, Recording.

OPEN MEETING – 7:30 AM

1. **CALL TO ORDER –** Mike Olmos, 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 jurisdictions 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 (Kelsie Davis 559-624-2330) or kedavis@kaweahhealth.org to make arrangements to address the Board.

3. **Approval of Quality Council Closed Meeting Agenda – 7:31 AM**
    - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – Julianne Randolph, DO, Vice Chief of Staff and Quality Committee Chair

    - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – Evelyn McEntire, RN, BSN, Director of Risk Management; Ben Cripps, Chief of Compliance and Risk Officer; Cindy Vander Schuur, RN, BSN, Patient Safety Manager

4. **ADJOURN OPEN MEETING –** Mike Olmos, Committee Chair

CLOSED MEETING – 7:31 AM

3. **CALL TO ORDER –** Mike Olmos, Committee Chair

Kaweah Delta Health Care District

Board Of Directors Committee Meeting

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4. **Approval of February Quality Council Closed Session Minutes –** Mike Olmos, Committee Chair; Dean Levitan, Board Member
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – Julianne Randolph, DO, Vice Chief of Staff and Quality Committee Chair
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management; Ben Cripps, Chief Compliance and Risk Officer*

5. **ADJOURN CLOSED MEETING –** Mike Olmos, Committee Chair

OPEN MEETING – 8:00 AM

1. **CALL TO ORDER -** Mike Olmos, Committee Chair

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

3. **Approval of February Quality Council Open Session Minutes -** Mike Olmos, Committee Chair; Dean Levitan, Board Member

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

   4.1 Quality Incentive Pool (QIP) Report
   4.2 Diabetes Quality Report
   4.3 Falls Prevention Quality Report

5. **Healthcare Acquired Pressure Injury Quality Report** – A review of current performance and initiatives aimed at improving healthcare-acquired pressure injury outcomes. *Emma Camarena, Director of Clinical Nursing.*

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

Mike Olmos • Zone 1 President | **Lynn Havard Mirviss • Zone 2** Vice President | **Dean Levitan, MD • Zone 3** Board Member | **David Francis • Zone 4** Secretary/Treasurer | **Amando Murrieta • Zone 5** Board Member

Kaweah Delta Health Care District
Board Of Directors Committee Meeting

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7. ADJOURN OPEN MEETING - Mike Olmos, Committee Chair

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Mike Olmos • Zone 1 President
Lynn Havard Mirviss • Zone 2 Vice President
Dean Levitan, MD • Zone 3 Board Member
David Francis • Zone 4 Secretary/Treasurer
Amando Murrieta • Zone 5 Board Member

Agenda item intentionally omitted

OPEN Quality Council Committee
Thursday, February 20, 2025
The Lifestyle Center Conference Room

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Attending: Board Members: Mike Olmos (Chair) & Dean Levitan, Board Member; Gary Herbst, Chief Executive Officer; Sandy Volchko, Director of Quality and Patient Safety; Ryan Gates, Chief Population Health Officer; Erika Pineda, Quality Improvement Manager; Shawn Elkin, Infection Prevention Manager; Cindy Vander Schuur, Patient Safety Manager; Sandy Volchko – Recording.

Mike Olmos called to order at 8:48 am.

Approval of Closed Session Agenda: Dean Levitan made a motion to approve the closed agenda, there were no objections.

Mike Olmos adjourned the meeting at 8:47 am.

Mike Olmos called to order at 8:48 am.

3. **Approval of December Quality Council Open Session Minutes –** Mike Olmos, Committee Chair; Dean Levitan, Board Member.
    - Approval of December Quality Council Open Session Minutes by Dean Levitan and Mike Olmos. With update to year from 2024 to 2025.
4. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives:

    4.1 Environment of Care EOC Quality Report – reviewed, no questions. Mike commented on how well the report was completed.

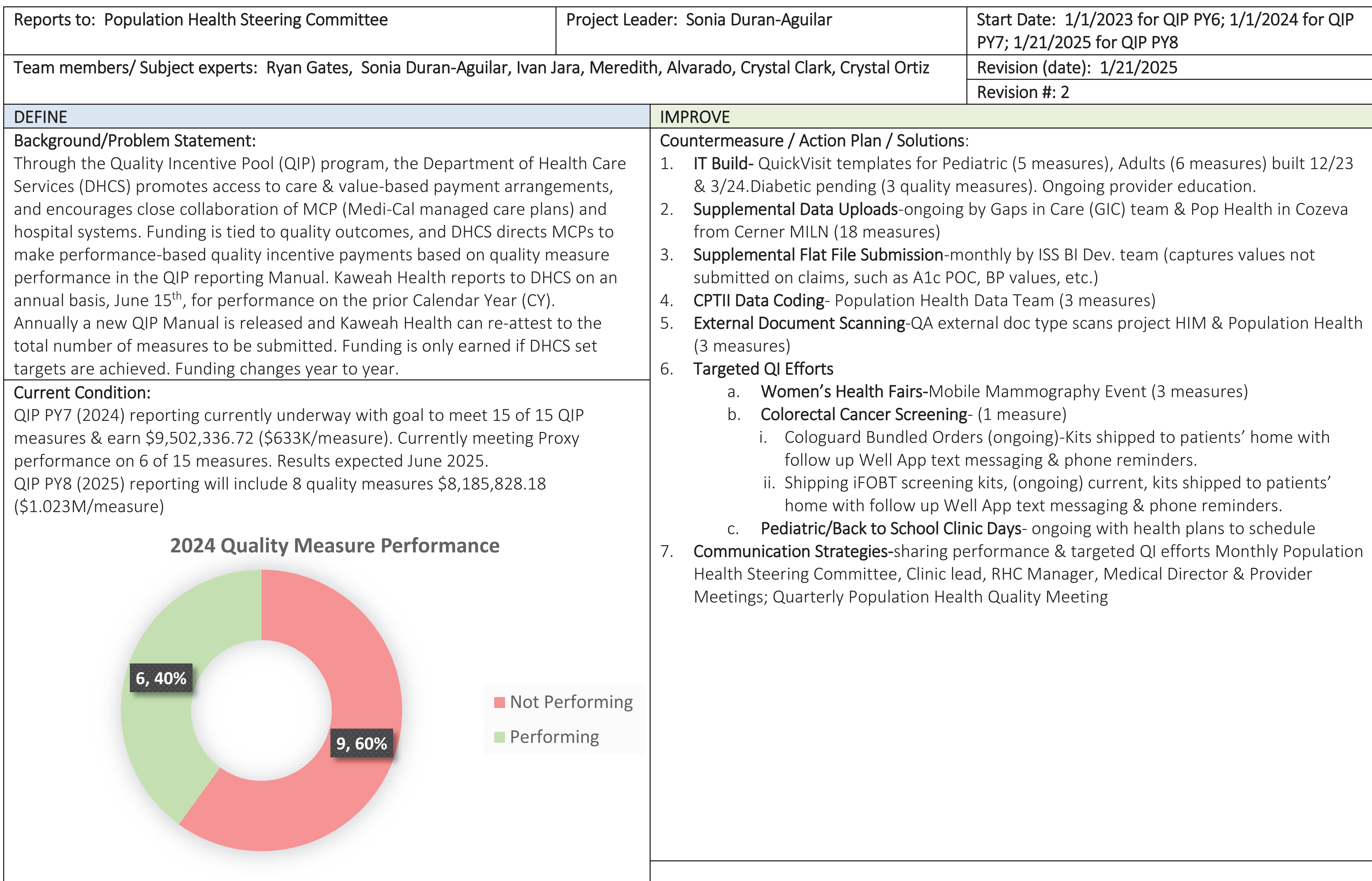
3. **Clinical Quality Goals Update-** A review of current performance and actions focused on the clinical quality goals for Sepsis, and Healthcare Acquired Infections. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*
    - HAI Goals and Performance; five key goals: three infection ratios and two utilization metrics. One of five is meeting goal, central line utilization; reminder that our goals are set to top 30% in the country. We have had seven CLABSIs FYTD, which equals an SIR of 0.88. We have five CAUTIs, we are about 0.05 away from goal. We have had four MRSA FYTD, expected to have about four, SIR equals 0.99. Targeted opportunities, reducing lines, especially our Foley catheters as the utilization ratio is higher than goal. We need to get to a place where we are doing meaningful daily line management, through rounds. The decolonization of SNF and readmitted patients to reduce MRSA has an electronic solution, which takes time to implement but is moving forward. We will ask for an ETA on this from ISS and report next month. Hand hygiene compliance continues to be less than goal, current FYTD rates are 94%. Next steps are looking at staff level data to determine non-compliance and working with unit leadership to address. Environmental cleaning: Bed rails most often not passing testing, EVS looking at kill time of cleaning product. They are also looking a rough vs smooth surfaces and the different cleaning product may be more effective.
    - Sepsis – we have had 3 months over goal for our sepsis bundle compliance, great progress. Our Sepsis Coordinator is abstracting cases ahead of time to catch

documentation issues so they can be addressed, that may be a contributing factor. Our sepsis physician champions are looking at post ED care opportunities, more in the ICU, for mortality improvement. Also documentation is another contributing factor in mortality, working to bridging the gap with CDI and HIM to ensure the severity of disease is accurate. Our strategies are heavily focused on GME as they are the key group who execute the sepsis bundle. Mike asked if we have a way to know which provider did or did not execute the bundle. Erika indicated yes, that is tracked and follow up is provided. There are no trends by providers.

Adjourn Open Meeting – *Mike Olmos, Committee Chair*

Mike Olmos adjourned the meeting at 9:24am.

DMAIC Project Summary: **Quality Incentive Pool (QIP) Program**



Reports to: Population Health Steering Committee	Project Leader: Sonia Duran-Aguilar	Start Date: 1/1/2023 for QIP PY6; 1/1/2024 for QIP PY7; 1/21/2025 for QIP PY8
Team members/ Subject experts: Ryan Gates, Sonia Duran-Aguilar, Ivan Jara, Meredith, Alvarado, Crystal Clark, Crystal Ortiz		Revision (date): 1/21/2025
		Revision #: 2

DEFINE

Background/Problem Statement:

Through the Quality Incentive Pool (QIP) program, the Department of Health Care Services (DHCS) promotes access to care & value-based payment arrangements, and encourages close collaboration of MCP (Medi-Cal managed care plans) and hospital systems. Funding is tied to quality outcomes, and DHCS directs MCPs to make performance-based quality incentive payments based on quality measure performance in the QIP reporting Manual. Kaweah Health reports to DHCS on an annual basis, June 15th, for performance on the prior Calendar Year (CY). Annually a new QIP Manual is released and Kaweah Health can re-attest to the total number of measures to be submitted. Funding is only earned if DHCS set targets are achieved. Funding changes year to year.

Current Condition:

QIP PY7 (2024) reporting currently underway with goal to meet 15 of 15 QIP measures & earn $9,502,336.72 ($633K/measure). Currently meeting Proxy performance on 6 of 15 measures. Results expected June 2025.
QIP PY8 (2025) reporting will include 8 quality measures $8,185,828.18 ($1.023M/measure)

IMPROVE

Countermeasure / Action Plan / Solutions:

1. **IT Build-** QuickVisit templates for Pediatric (5 measures), Adults (6 measures) built 12/23 & 3/24.Diabetic pending (3 quality measures). Ongoing provider education.
2. **Supplemental Data Uploads**-ongoing by Gaps in Care (GIC) team & Pop Health in Cozeva from Cerner MILN (18 measures)
3. **Supplemental Flat File Submission**-monthly by ISS BI Dev. team (captures values not submitted on claims, such as A1c POC, BP values, etc.)
4. **CPTII Data Coding**- Population Health Data Team (3 measures)
5. **External Document Scanning**-QA external doc type scans project HIM & Population Health (3 measures)
6. **Targeted QI Efforts**
   a. **Women's Health Fairs**-Mobile Mammography Event (3 measures)
   b. **Colorectal Cancer Screening**- (1 measure)
      i. Cologuard Bundled Orders (ongoing)-Kits shipped to patients' home with follow up Well App text messaging & phone reminders.
      ii. Shipping iFOBT screening kits, (ongoing) current, kits shipped to patients' home with follow up Well App text messaging & phone reminders.
   c. **Pediatric/Back to School Clinic Days**- ongoing with health plans to schedule
7. **Communication Strategies**-sharing performance & targeted QI efforts Monthly Population Health Steering Committee, Clinic lead, RHC Manager, Medical Director & Provider Meetings; Quarterly Population Health Quality Meeting

Kaweah Health

DMAIC Project Summary: **Quality Incentive Pool (QIP) Program**

MEASURE

SMART Target / Goal:

Demonstrate Kaweah Health provides high quality care for the Medi-Cal managed care population as evidenced by meeting QIP performance targets for 15 QIP measures and earn $9,502,336.72 ($633K/measure).

ANALYZE

Problem Analysis / Root Cause, Gap:

The Population Health Team tracks performance on a monthly basis on quality measures in Cozeva, a Population Health Tool that contains performance across both Medi-Cal Managed Care Plans and assigned population. Broad QI efforts include monthly performance monitoring, gaps in care closure by dedicated team, collaboration with Well App team for text messaging outreach, targeted on Hold messaging and use of a Wellness Campaign Calendar to deploy targeted social media campaigns. Monthly meetings take place with Population Health Team (RHC leadership included) and Health Plan (Anthem BC and HealthNet) Quality HEDIS teams to discuss trends, opportunities for collaboration and barriers to performance. Gaps for underperforming measures include:

1. IT infrastructure - (automated codes/claims; lack of validated documentation tools in Cerner)
2. Performance Dashboards (for all Populations served at Kaweah Health)
3. Provider Documentation
4. Staff Documentation (Drift)
5. Patient Behavioral factors (vaccine hesitancy, no-shows, etc.)

Results / Metrics: Currently meeting 6 of 15 measures for 2024

Quality Measure	29-Oct-24 Aggregate Performance Oct	13-Nov-24 Aggregate Performance Nov	12/31/2024 Aggregate Performance Dec	Target	Delta	Trends
Q-CBP Controlling High BP	64.01%	64.68%	72.74%	65.60%	-7.14%	
Q- CDC-H9 Comprehensive DM Poor Care HbA1c Poor Control (>9%) ↓-→ Q-GSD Glycemic Status Assessment for patients with Diabetes	45.73%	45.76%	48.69%	31.08%	17.61%	
Q-QPP47 Advance Care Plan						
Q-CMS130 Colorectal Cancer Screening (1) (Trending Break PY5, new Population 45-75)	33.56%	36.08%	37.84%	29.88%	-7.96%	
Q-CMS138 Preventative Care and Screening: Tobacco Use-Screening and Cessation Intervention Rate 1, Rate 2, & Rate 3						
Q-CMS349 HIV Screening						
Q-W30: Well-Child Visits in the First 15 Months	43.09%	43.09%	46.29%	68.09%	21.80%	
Q-W30: Well-Child Visits in the First 30 Months of Life 15-30 Months	71.32%	71.32%	72.82%	75.61%	2.79%	
Q-WCC Prevention and Screening|Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile	89.71%	89.78%	92.51%	83.20%	-9.31%	
Q-WCC Prevention and Screening|Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	18.68%	20.22%	37.05%	69.05%	32.00%	
Q-WCC Prevention and Screening|Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	18.68%	20.18%	36.97%	69.26%	32.29%	
Q-IMA: Immunizations for Adolescents	25.26%	25.79%	26.22%	29.44%	3.22%	
Q-LSC- Lead Screening in Children	82.64%	82.64%	82.59%	58.52%	-24.07%	
Q-PPC-PRE Prenatal Care	86.82%	86.82%	**41.38%**	88.40%	47.02%	
Q-PPC-PST Post Natal Care	73.31%	73.31%	**38.24%**	79.48%	41.24%	
Q-BCS Breast Cancer Screening	59.11%	59.18%	61.40%	49.84%	-11.56%	
Q-CCS Cervical Cancer Screening	56.40%	56.54%	60.45%	56.24%	-4.21%	
Q-CHL Chlamydia Screening	54.15%	55.19%	61.50%	49.65%	-11.85%	

CONTROL

Follow-Up / Sustainability:

Control Plan:

1. **IT infrastructure** - ongoing work with ISS to advance EHR builds, tracked via Jira Tickets.
2. **Performance dashboards**- work to build out HealthERegistries remains underway. Funding obtained from MCP health plan. Awaiting build out by ISS.
3. **Provider documentation**-work remains underway to optimize QuickVisits built out & ensure they are properly leveraged by providers
4. **Staff documentation**-ongoing monthly lead meetings taking place to review performance and provide education.
5. **Patient Behavioral factors**- ongoing in partnership with health plans to address vaccine hesitancy.

Kaweah Health

Outstanding Health Outcomes (OHO) QUALITY & PATIENT SAFETY PRIORITY

Inpatient Diabetes Care – Hypoglycemia Reduction

January 2025

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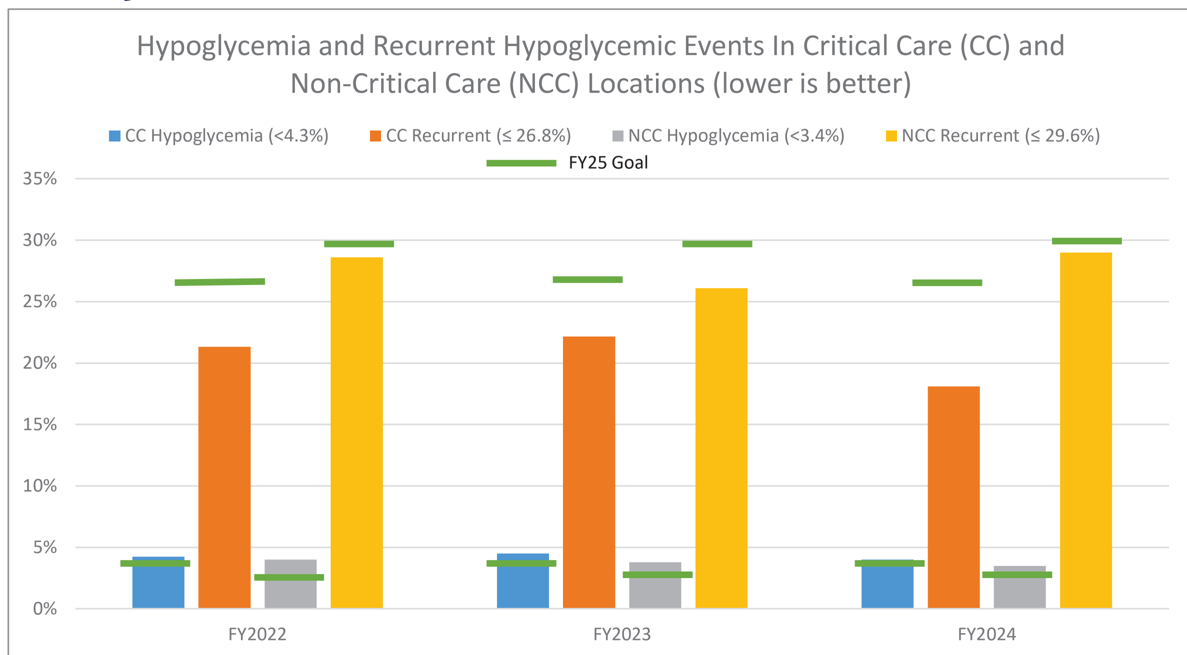
OHO Annual Plan: Inpatient Diabetes Care

Hypoglycemia Reduction in Critical Care (CC) and Non-Critical Care (NCC) Locations



FY25 GOAL

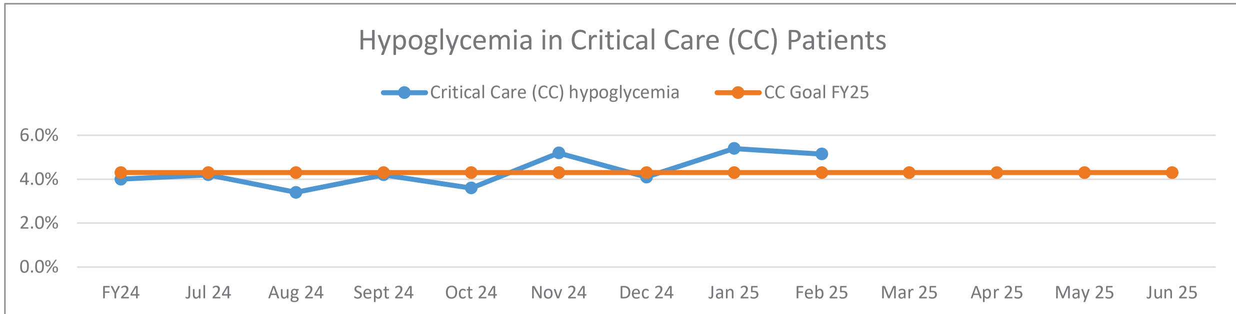
Achieve < 4.3% benchmark performance for hypoglycemia in Critical Care (CC) patient population, defined as percent patient days with blood glucose (BG) <70

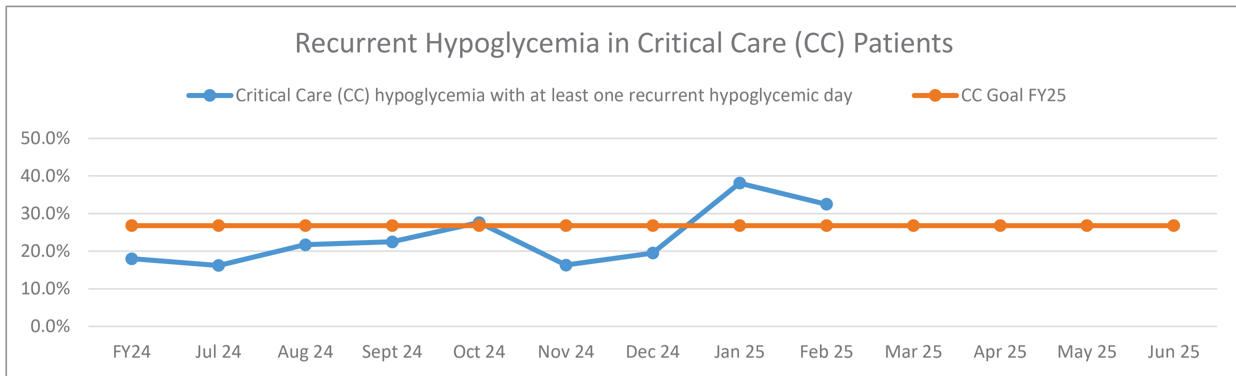
FY25 PLAN – Hypoglycemia Reduction

High Level Action Plan

- Increase IV insulin usage upon arrival to MICU from 170 to 187 (10% increase) by June 30, 2025.
- APN will round 2-3 times per week to encourage use of IV Insulin usage providing rational and education to GME residents as needed.
- APN will monitor patients in the MICU using Glucometrics utilizing set parameters to avoid hypoglycemia or recurrent hypoglycemia (BG < 90 mg/dL)

OHO Annual Plan: Inpatient Diabetes Care
Hypoglycemia Reduction in Critical Care Locations





Achieve < 4.3% benchmark performance for hypoglycemia in Critical Care (CC) patient population, defined as percent patient days with blood glucose (BG) <70

FY25 PLAN – Hypoglycemia Reduction

High Level Action Plan

- The metrics on this slide include both IV and SQ insulin in all critical care areas (MICU, CVICU, ICCU and CVICCU)
- For the Jan & Feb 2025, the hypoglycemia and recurrent hypoglycemia rates underperformed the benchmark. The team will continue to monitor.
- Increase APN rounding in the MICU to encourage the use of IV Insulin for critically ill patients who are intubated and hemodynamically unstable. DM NP to met with Dr. Javed to establish a process. Dr. Javed will bring information forward with Sound group. DM NP to monitor for usage.

OHO Annual Plan: Inpatient Diabetes Care
Hypoglycemia Reduction in Critical Care Locations

The last data point did not meet goal because:

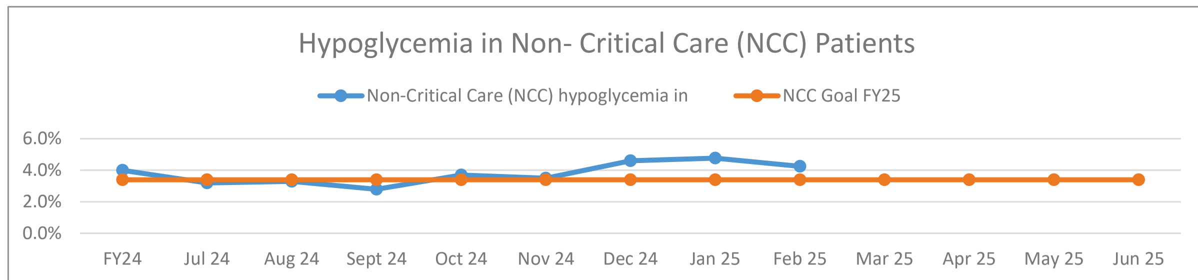
- Over usage of subcutaneous insulin, need to move to IV (American Diabetes Association recommended practice) IV is first line therapy
- Why? Education Gap Intensivists & hospitalists (3W & 5T)
- Residents order 70% of insulin in MICU
- **Targeted Opportunities (What specifically is causing the fallouts?)**

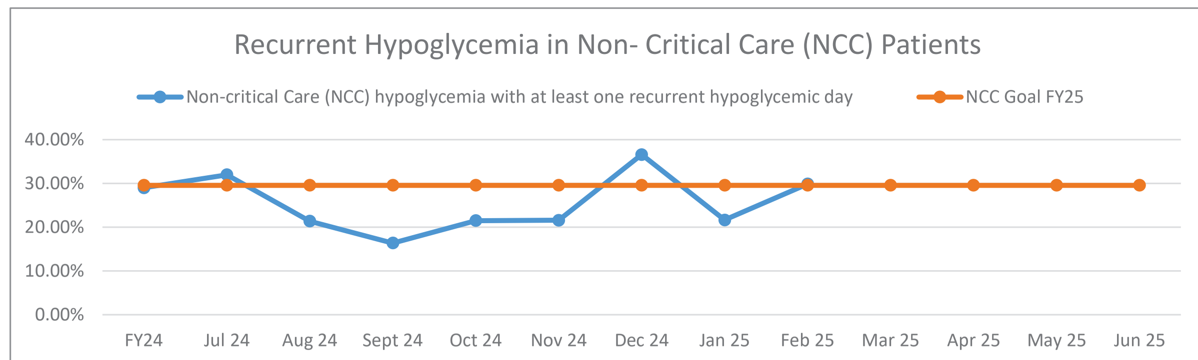
1. Intensivist/GME managing patients in MICU has most opportunity as there is a higher volume of patients who require IV insulin
2. MICU Workflow ordering, nursing influence (labor intensive to manage a patient on IV insulin)

CURRENT IMPROVEMENT ACTIVITIES	COMPLETION DATE	BARRIERS
Glytec to help review hypoglycemic patient chart review to determine which patients are not treated according to best practice guidelines (started on SQ rather than IV insulin	Ongoing	
Upgrade in May assisted in EMR issues in transcribing diabetes management orders	May 2024	
Communicating inability to adjust basal insulin at anytime, currently have to wait for morning BG to be input in GM by the nurse	TBD	1. Glytec waiting for FDA approval 2. Nurses not inputting BG into GM in a timely manner
Improve knowledge and skillset of nursing, pharmacist and medical staff through education, training, consultative services.	ongoing	

OHO Annual Plan: Inpatient Diabetes Care

Hypoglycemia Reduction in MED/SURG Locations





FY25 GOAL

Achieve < 3.4% benchmark performance for hypoglycemia in Non-Critical Care (NCC) patient population, defined as percent patient days with blood glucose (BG) <70

FY25 PLAN – Hypoglycemia Reduction

High Level Action Plan

- Optimize the difficult to manage patients (i.e. Renal, recurrent hypoglycemia, insulin resistant, steroid-induced hyperglycemia) using a non-GM power plan
- Continue to work with Glytec to improve glycemic control through product improvement recommendations: adjust basal dose prior to morning BG input into GM
- For January & February 2025, the hypoglycemia rate underperformed the identified SHM benchmark for NCC. The recurrent hypoglycemia rates for the same time period outperformed or equaled the benchmark. We will continue to monitor and develop improvement strategies in the upcoming Diabetes Management meetings.

OHO Annual Plan: Inpatient Diabetes Care

Hypoglycemia Reduction in MED/SURG Locations

The last data point did not meet goal because:

- 4N Patients, renal patients are complex as they lack renal system to metabolize insulin
- ADA guidelines indicate best practice to manage this population you need to ensuring Lantus (longer acting) is not 50% of insulin, and need close monitoring/management to successfully avoid hypoglycemia

- **Targeted Opportunities (What specifically is causing the fallouts?)**

1. Are there best practice guidelines for managing diabetes for renal insufficiency patients?
2. Need very focused resources to closely manage patients who have renal insufficiency, very complex population, very dynamic with their glucose levels (factors include: timing of dialysis, times for eating, amount eaten, renal function)

CURRENT IMPROVEMENT ACTIVITIES	COMPLETION DATE	BARRIERS
Review patients with BG less than 90 mg/dL and adjust insulin as needed to avoid hypoglycemia or prevent recurrent hypoglycemia	Ongoing	Lack of time for CC APN to review all patients
Monitor patients on the non-GM power plan to ensure they are receiving correct dose of insulin. Discern report is used to identify patients on the non-GM power plan.	Ongoing	
Demonstrate return on investment (ROI) through improved throughput, decreased length of stay to increase time APN spends monitoring and caring for patients with diabetes.	12/27/2024	
Improve knowledge and skillset of nursing, pharmacist and medical staff through education, training, consultative services.	Ongoing	
Meeting with Dr. Javed from Sound Intensivist group to discuss underuse of insulin infusions.	3/11/2025	Practitioner practice may not change. Nursing staff may still push for SQ insulin when patients are not medically ready for transition to SQ insulin

Thank you

Live with passion.

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PATIENT SAFETY PRIORITY

Falls Committee: Falls Reduction Initiative

March 2025

Emma Camarena, DNP, RN, ACCNS-AG, CCRN

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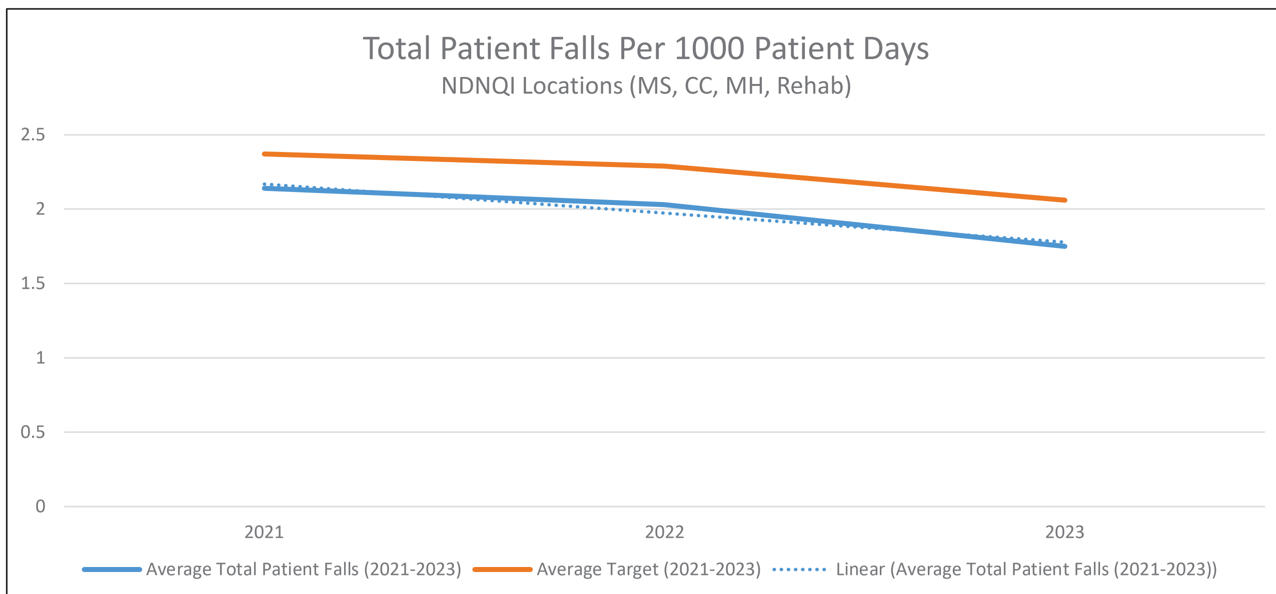
Falls Reduction Annual Plan



2025 GOAL

Benchmark is 2.08 Total Falls per 1000 patient days.

Average total falls for CY2024 is 1.7 total falls per 1000 patient days.

Goal: will continue to be less than the quarterly target established by NDNQI.

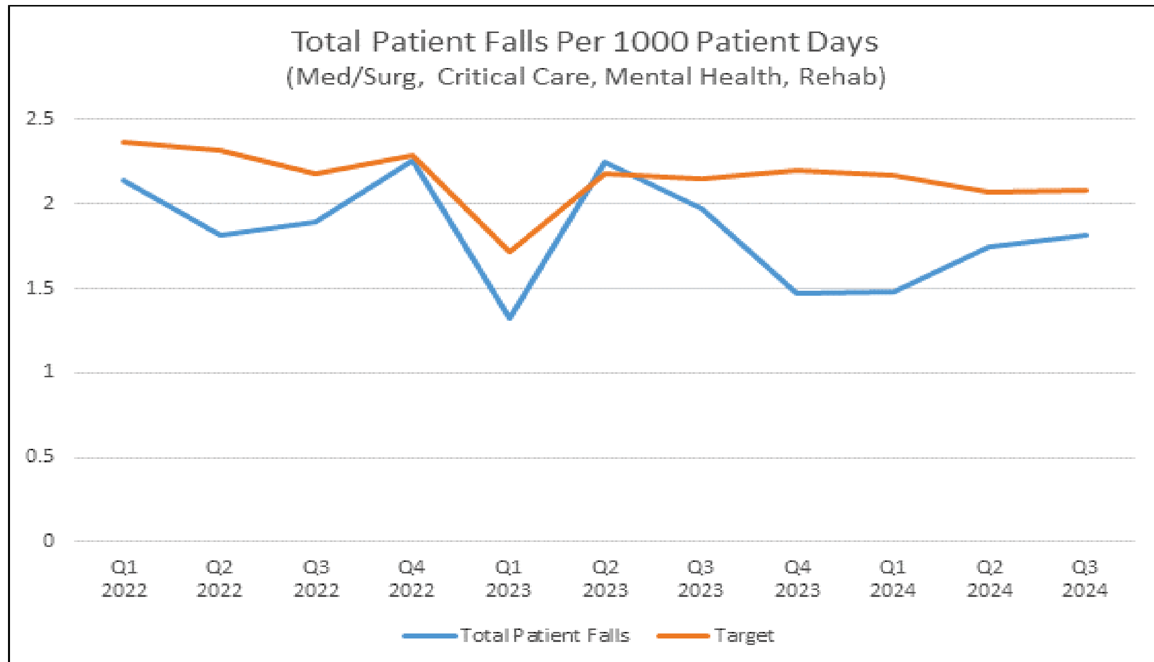
2025 PLAN

High Level Action Plan

Fall preventative strategies include:

- Develop a Smart Sheet to establish "close loop" communication related to fallouts and take-aways for the leadership team.
- Educate staff on proper sizing of fall socks. (Nursing, PT, CNAs or techs)
- Discussion started with Director of Clinical Engineering and CNO re: the Umano bed and lower rail heights increasing chance for patient to roll over the raised side rail.
- Assessment of Tele Sitter use
- Revamp Falls education to include proper sizing of fall socks, Tele Sitter use, shift to shift report and documentation, bed or chair pad alarm on

Fall Reduction Update



2025 GOAL

Benchmark is 2.08 Total Falls per 1000 patient days.

Average total falls for CY2024 is 1.7 total falls per 1000 patient days.

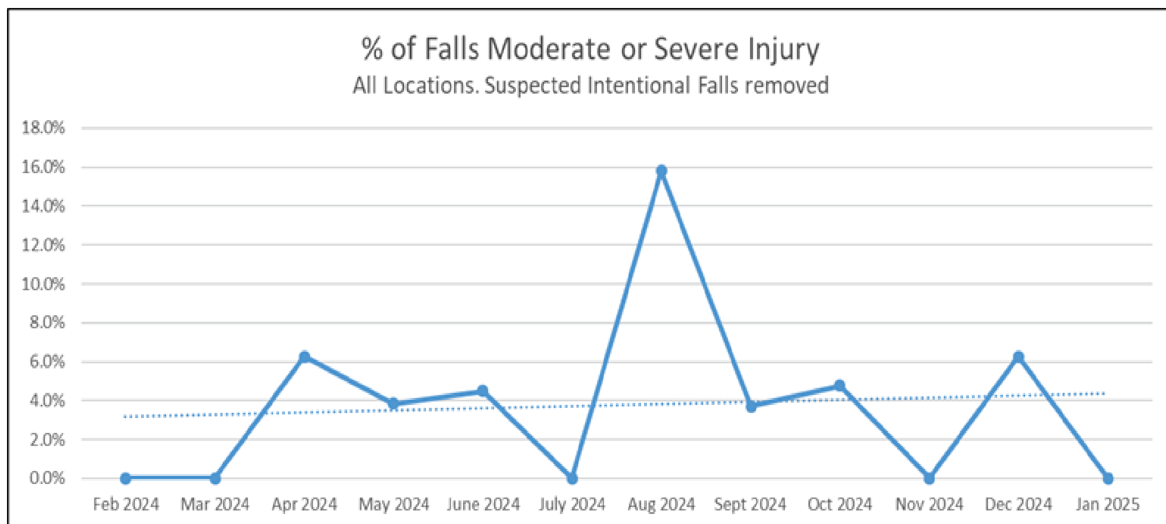
Goal: will continue to be less than the quarterly target established by NDNQI.

PROGRESS ON 2024-2025 PLAN

High Level Data Plan:

- Initial assessment of fall risk using the Johns Hopkins Fall Risk Assessment Tool (JHFRAT). Goal 100%
- Documentation of the fall prevention plan (IPOC) for patients deemed at risk for fall. Goal: 100%
- All moderate or high-risk patients have a fall agreement signed (or documented refusal). Goal 100%
- All moderate or high-risk patients have bed or chair alarms on(or documented refusal after use of chain of command to explain safety importance). Goal 100%

Fall Reduction Update



2025 GOAL

No benchmark available due to information from Midas and all KH locations . Will monitor for moderate or severe injury falls, review at Falls committee and escalate information as needed.

PROGRESS ON 2024-2025 PLAN

High Level Action Plan

- Initial assessment of fall risk using the Johns Hopkins Fall Risk Assessment Tool (JHFRAT). Goal 100% Actual: 92%
- Documentation of the fall prevention plan (IPOC) for patients deemed at risk for fall. Goal: 100% Actual: 44.2% (this goal is steadily increasing since Feb. 2023.
- All moderate or high-risk patients have a fall agreement signed. Goal 100% (or documented refusal). New.
- All moderate or high-risk patients have bed or chair alarms on. Goal 100% (or documented refusal after use of chain of command to explain safety importance). New

Fall Reduction Opportunities

Targeted Opportunities (What specifically is causing the fallouts?)

1. Bed alarms not on, patients getting out of bed without notification to staff
2. Staff not within arms reach of patient when patient is deemed moderate or high-risk
3. Telesitter monitoring: appropriateness for patient, telesitter monitor tech not calling when patient getting up, not aware of policy or not providing correct indication for telesitter
4. Patients rolling over side rails of Umano beds, escalated to Director of Clinical Engineering and CNO
5. Lack of communication: not reporting moderate or high-risk patients in shift report
6. Fall socks not fitting patients correctly, socks too large slip and do not grip when patient is ambulating

Fall Reduction Action Plan

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED/ACTUAL COMPLETION DATE	BARRIERS
Developed a Smart Sheet form to help with “closed loop communication” with leaders	3/3/2025	Need to ensure all leaders have access to Smart Sheet
Develop Smart Sheet reports to provide leaders with fallout information. Need to set up meeting with Kim Vliem	3/7/2025	None anticipated
APN rounding to educate staff on correct fit of yellow fall socks	1/13/2025 ongoing	Sock sizes not available on units
Email sent to CNO and director of Clinical Engineering regarding Umano beds and patients rolling over upright side rails. Director of CE to contact manufacturer to set up meeting to discuss issues	3/5/2025	None at this time
Discuss incorporating into shift report: moderate or high-risk for fall patient and interventions	3/6/2025	Not in staff shift report “brain”, too many other items to report
Revamp Falls Education to include proper use of Telesitter, Fall socks, and importance of relaying fall risk in shift-to-shift report	3/31/2025	None anticipated

Thank you

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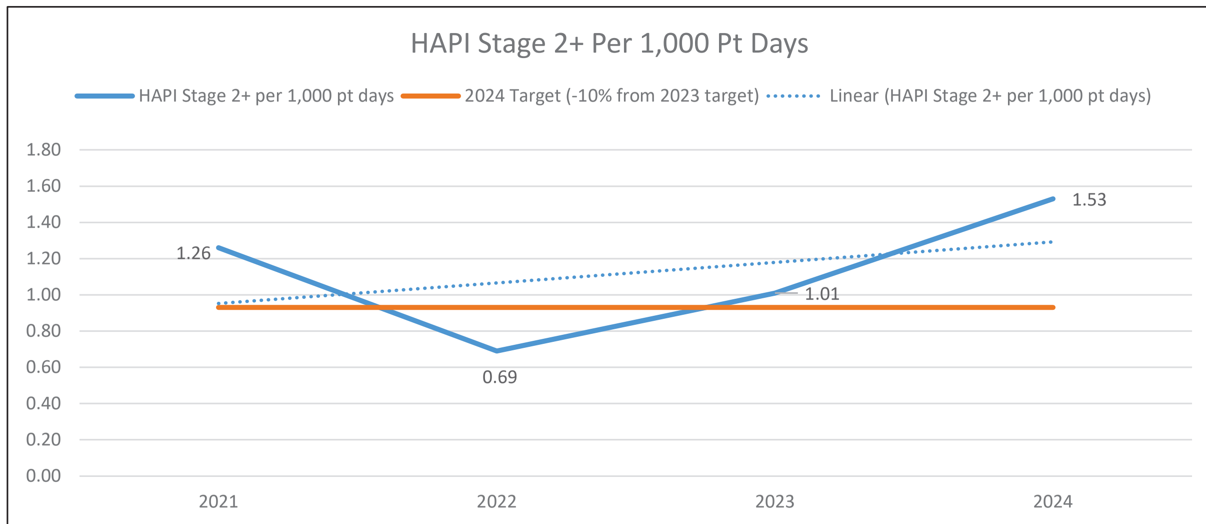
PATIENT SAFETY PRIORITY

Hospital Acquired Pressure Injury (HAPI) Reduction Initiative

March 2025

Emma Camarena, DNP, RN, ACCNS-AG, CCRN
Kari Knudsen, MPA, BSN, RN NE-BC

HAPI Reduction Annual Plan



2025 GOAL

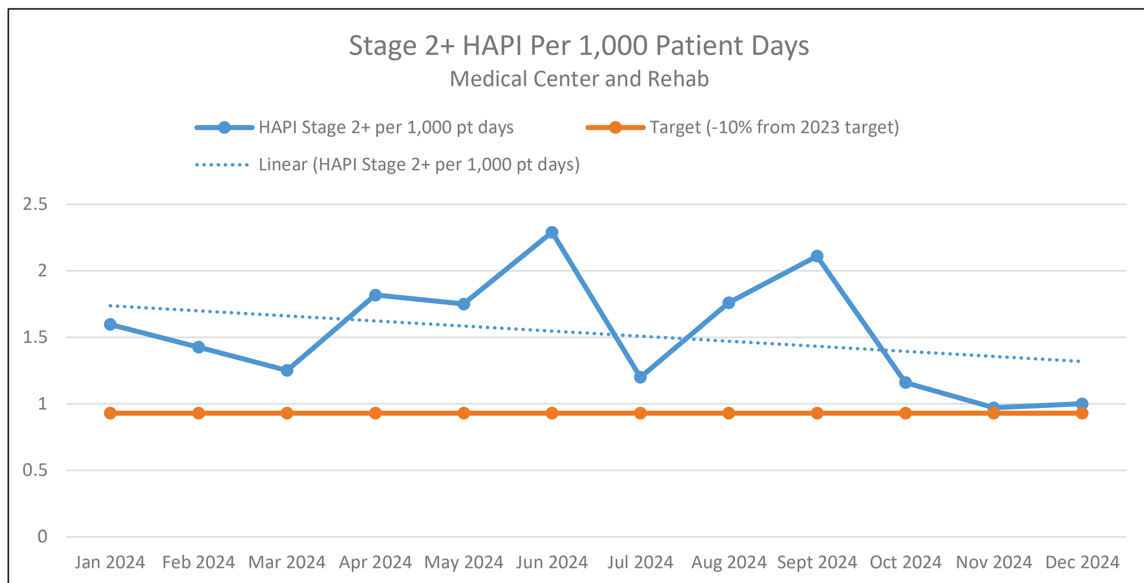
HAPI Stage 2+ per 1,000 pt days will be reduced to 0.54. The previous benchmark was an internal target set by the committee. The current benchmark of 0.54 per 1000 patient days is a result of a review of the current literature.

Calendar Year 2025 PLAN

High Level Action Plan

- Standardize and enculturate evidence-based prevention practices with 100% compliance:
  - Skin assessments
  - Q2 hour turning
  - Shift handoff on prevention strategies
- Patients with Braden Scores less than 18 are placed on evidenced-based recommended pressure relieving surfaces 100% of the time
- Wound Treatment
  - 100% of wounds are treated when identified
- Staff Training, including wound identification
  - 100% of licensed staff who are identified as priority (approximately 380 staff) are trained by April 30, 2025.

HAPI Reduction Update



2025 GOAL

HAPI Stage 2+ per 1,000 pt days will be reduced to 0.54. The previous benchmark was an internal target set by the committee. The current benchmark of 0.54 per 1000 patient days is a result of a review of the current literature.

PROGRESS ON 2024-2025 PLAN

High Level Action Plan

- Standardize and enculturate evidence-based prevention practices with 100% compliance:
  - Skin assessments – 3 units met goal & moved to quarterly audit.
  - Q2 hour turning- 100% for 3 consecutive months-but would like to continue to ensure this process is hardwired and part of nursing workflow.
  - Shift handoff on prevention strategies – January 94% (fallouts r/t IPOC, meal %, last photo taken, Braden score). Fallouts appear to be from staff floating to other units-process not standardized
- 4T Hapi RCA: Patients with Braden score < 18, are placed on evidenced-based recommended pressure relieving surfaces 100% of the time –education went out on the revised Support Surfaces. Audit to begin in Jan 2025. Update: February 100%
- Aggregate RCA: Wound Identification and Wound Treatment
  - 100% of licensed staff who are identified as priority (approximately 380 staff) are trained by April 30, 2025. Courses increase in January 2025 to 4/month; Monitoring to begin in January. Approximately 136 staff identified, 66 enrolled, 60 left to sign up and attend.
  - 100% of wounds are treated when identified – Feb 2025- 86% No orders in place-leadership coach and council staff
- 3W RCA: Education on trach care and trach care power plans completed on 12/19/2024. Audit started on 12/20/24. Audit 100% for 3 consecutive months-closed.

HAPI Reduction Status Update

Targeted Opportunities (What specifically is causing the fallouts?)

1. Wound care orders implemented timely: leadership aware, coaching and counseling provided to staff members
   a. 7 patients without wound orders or wound orders not implemented correctly
      - No preventative orders but treating patient with Calazime (1 patient)
      - Wound consult ordered for patient, but no preventative orders in place (3 patients)
      - Protective wound orders not in place for all wounds documented (2 patients)
      - Wound orders in place but only first day with documentation of wound treatment done (1 patient)
2. Bedside nurse incorrectly identifying wounds potentially not obtaining correct preventative orders
   a. 2 patients identified incorrectly
      - Inconsistent documentation of wounds, not all wounds documented
      - Emphasis on wound documentation added to wound class
3. Shift to shift handoff (3 units with fallouts)
   a. Meal % not communicated
   b. Last photo not communicated
   c. IPOC not communicated
4. Wound identification and treatment
   a. Approximately 136 staff members still need to attend the wound class to aid in the identification and care of wounds. These staff members are considered priority attendees such as charge nurses, mentors/preceptors and those who have been at KH for greater than 3 years. Worked with NM to identify current staff who need to attend the class. All NMs were able to review staff records and establish a list of who needs the wound class. Approximately 136 staff identified, 66 are enrolled, 60 left to sign up and attend. Currently working on signing up the last 60 staff members

HAPI Reduction Update

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED/ACTUAL COMPLETION DATE	BARRIERS
Wound Course training availability of current courses: triage current courses by 1. charge nurses, 2) preceptors/mentors, 3) nurses who have > 3 years of tenure, 4) nurses who have tenure of < 3 years or less.	Ongoing	The actual triage process of nurses attending the class. How to do the triage and who will do the triage process
Wound Care training: develop plan to increase number of course offerings to address volume of backlog and future new hire attendees Assign courses to required attendees only for courses from Jan-April 2025. Other participants will not attend wound course until May 2025.	In progress	Need to prepare a list of staff who need to attend the class for the NMs. Develop a process for how to get the backlog assigned for the available classes.
Discussion related to wound class and if a large class is needed to accommodate the rest of staff who need to attend (catch-up class). This was discussed in the HAPI QFT. Will continue discussions with CNO (Wound Camp)	2/10/2025 ongoing	Staff who can help with training
In the moment education for staff who do not provide predetermined information related to wound report.	Ongoing	Staff not using the tools developed and available to ensure all elements of wound report are given

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Outstanding Health Outcomes (OHO) QUALITY & PATIENT SAFETY PRIORITY

Healthcare Acquired Infection (HAI) Reduction

March 2025

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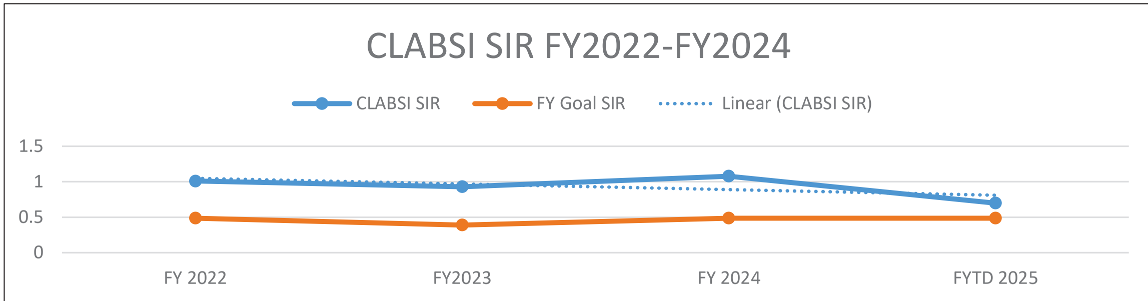
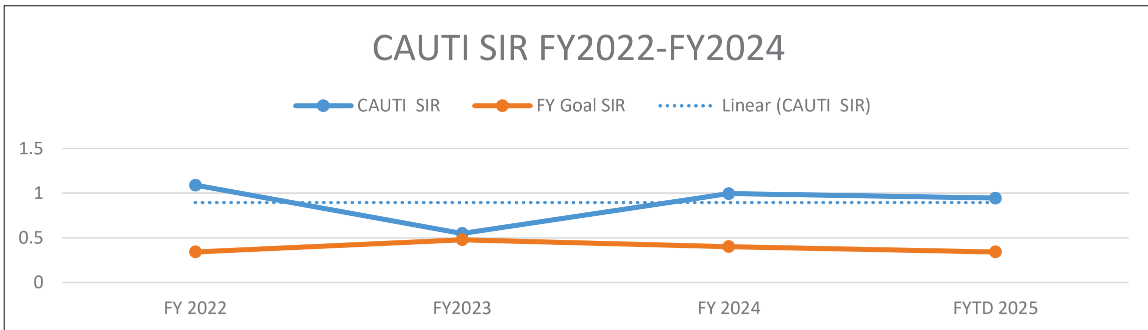
OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

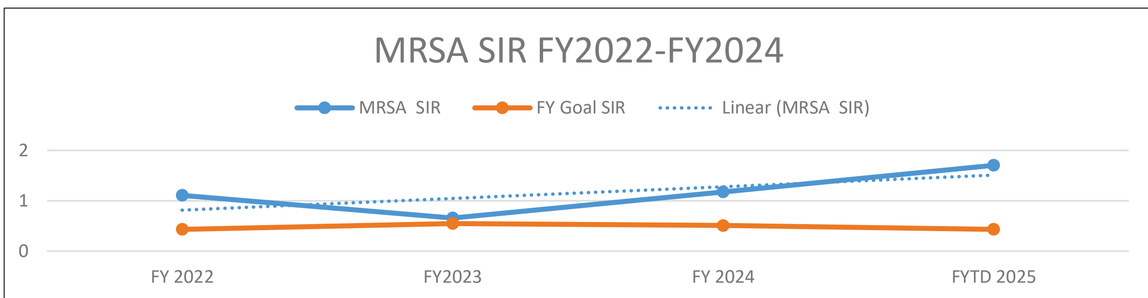
(number of actual infections/number of predicted infections by CMS)

CLABSI - Central Line-Associated Bloodstream Infection; CAUTI - Catheter-Associated Urinary Tract Infection; MRSA - Methicillin-Resistant Staphylococcus Aureus

Historical Baseline







FY25 PLAN – HAI Reduction CLABSI, CAUTI & MRSA SIR

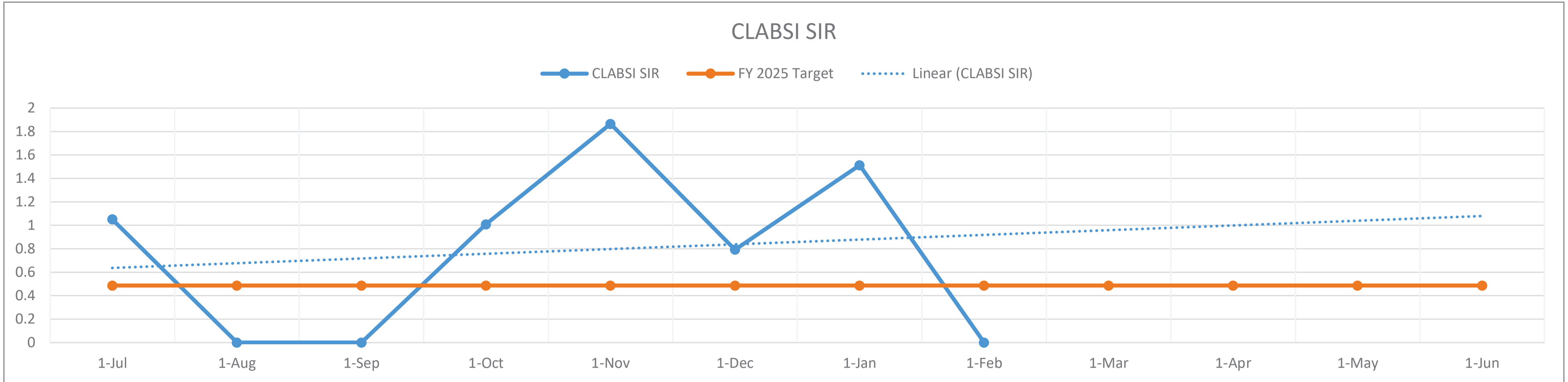
High Level Action Plan

- Reduce line utilization; less lines, less opportunity for infections to occur
  - Goal: reduce central line utilization ratio to <0.66
  - Goal: reduce urinary catheter utilization ratio to <0.64
- MRSA nasal and skin decolonization for patients with lines.
  - Goal: 100% of at risk patients nasally decolonized
  - Goal: 100% of patients with lines have a CHG bath
- Improve hand hygiene (HH) through increased use of BioVigil electronic HH monitoring system
  - Goal: 60% of staff are active users of BioVigil
  - Goal: 95% compliance with hand hygiene
- Improve environmental cleaning effectiveness for high risk areas
  - Goal: 90% of areas in high risk areas are cleaned effectively the first time (all area not passing are re-cleaned immediately)

FY25 GOAL

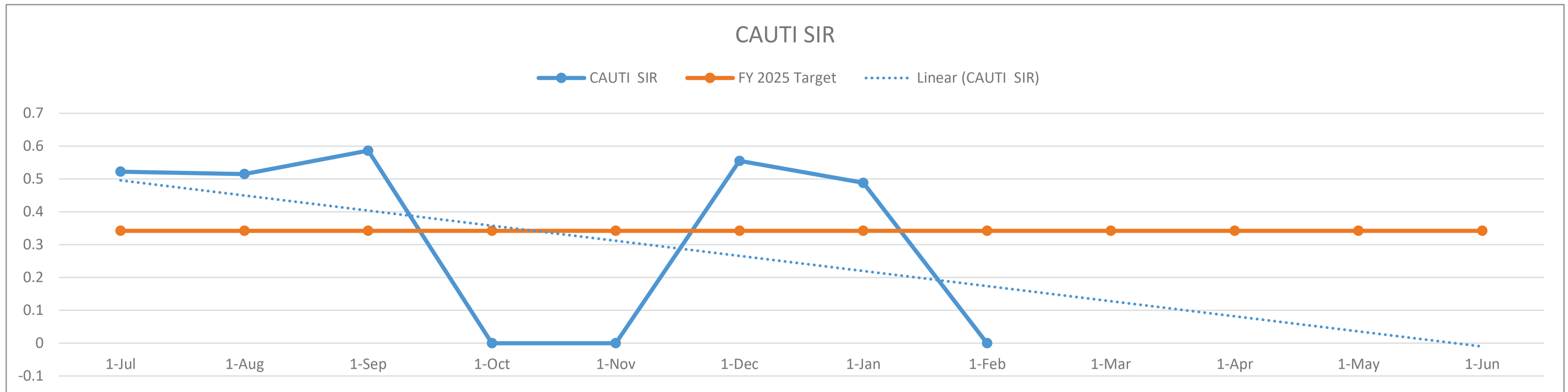
Decrease: CLABSI SIR to <0.486; CAUTI SIR to < 0.342; MRSA <0.435

OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)
(number of actual infections/number of predicted infections by CMS)



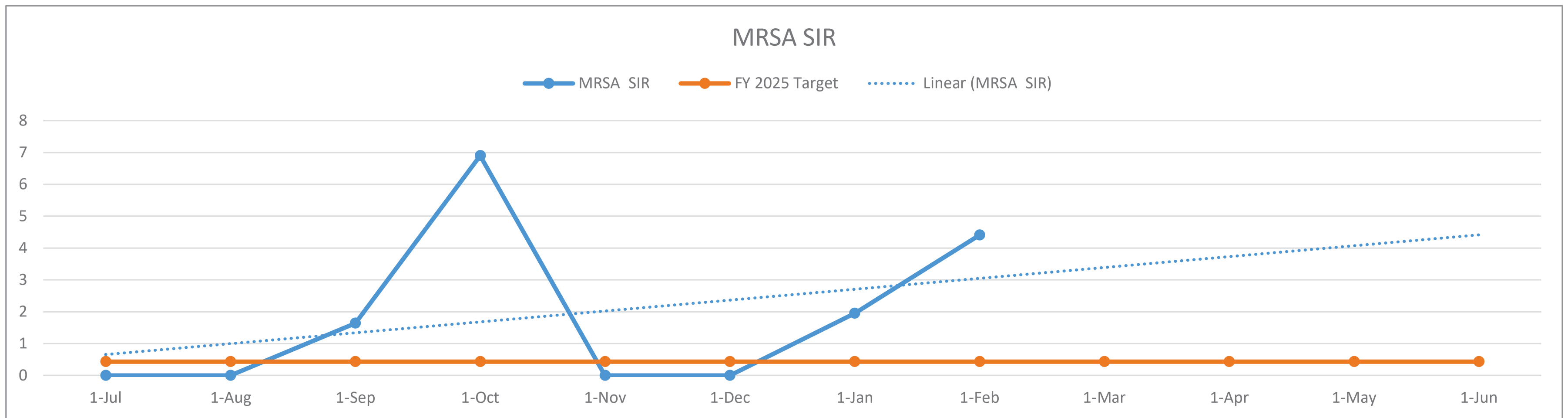
	FY 2025 Target	FY 2024	24-Jul	24-Aug	24-Sep	24-Oct	24-Nov	24-Dec	25-Jan	25-Feb	25-Mar	25-Apr	25-May	25-Jun	FYTD 25
CLABSI Events		17	2	0	0	1	1	1	2	0					7
CLABSI Predicted Events		16.06	1.051	1.117	0.121	1.008	1.072	1.262	1.323	0.848					8.802
CLABSI SIR	<0.486	1.06	1.903	0	0	0.992	1.865	0.792	1.512	0					0.80

OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)
(number of actual infections/number of predicted infections by CMS)



	FY 2025 Target	FY 2024	24-Jul	24-Aug	24-Sep	24-Oct	24-Nov	24-Dec	25-Jan	25-Feb	25-Mar	25-Apr	25-May	25-Jun	FYTD 25
CAUTI Events		9	1	1	1	0	0	1	1	0					5
CAUTI Predicted Events		22.58	1.917	1.94	1.707	1.577	1.54	1.801	2.05	1.404					13.936
CAUTI SIR	<0.342	0.4	0.522	0.515	0.586	0.00	0	0.555	0.488	0					0.36

OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)
(number of actual infections/number of predicted infections by CMS)



	FY 2025 Target	FY 2024	24-Jul	24-Aug	24-Sep	24-Oct	24-Nov	24-Dec	25-Jan	25-Feb	25-Mar	25-Apr	25-May	25-Jun	FYTD 25
MRSA Events		7	0	0	1	2	0	0	1	2					6
MRSA Predicted Events		9.62	0.501	0.482	0.485	0.290	0.451	4.74	0.512	0.454					4.491
MRSA SIR	<0.435	0.73	0	0	1.64	6.9	0	0	1.95	4.41					1.34

OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

The last data point did not meet goal because:

- Evidenced-based prevention strategies to reduce HAIs are not occurring

Targeted Opportunities

- Reduce line utilization; less lines, less opportunity for infections to occur
  - Goal: reduce central line utilization ratio to <0.663
  - July 2024 - Feb 2025 0.65
  - Goal: reduce urinary catheter ratio to <0.64
  - July 2024 - Feb 2025 0.90
- MRSA nasal and skin decolonization for patients with lines.
  - Goal: 100% of at risk patients nasally decolonized
  - Jul 2024 - Feb 2025 100% of screen patients nasally decolonized
  - Jul 2024 - Feb 2025 13% of patients admitted from a skilled nursing facility (at risk population) not screened or decolonized (if screen has a positive result)
  - Jul 2024 - Feb 2025 23% of patients re-admitted from another acute care facility within 30 days not screened or decolonized (if screen has a positive result)
  - Goal: 100% of line patients have CHG bathing
  - Will provide update following process implementation, delayed from 10/8 to 11/19 due to Cerner upgrade processes
- Improve hand hygiene (HH) through increased use of BioVigil electronic HH monitoring system
  - Goal: 60% of staff are active users of BioVigil
  - Jul 2024- Feb 2025 54% of staff are active users (Jan-Feb 2025 2025 increased to **60%**)
  - HH Compliance rate overall 94% (goal 95%) – decreasing trend noted over 3 quarters
- Improve environmental cleaning effectiveness for high risk areas
  - Goal: >90% of areas in high risk areas are cleaned effectively the first time (all area not passing are re-cleaned immediately)
  - July 2024 – Feb 2025 2024 Pass cleanliness effectiveness testing **92%** of the time in high risk areas

OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
Expand Multidisciplinary rounds to include other stakeholders to reduce line use	3/31/25	Buy in from physician stakeholders
Skin decolonization for all line patients through CHG bathing training for CNAs and implementation to all units	10/8/24 Delayed until 11/19/24	Completed, some staff not yet signed off. Completion reports sent to mangers regularly with options to get CNAs signed off if they work in an area where there are less patients with central lines.
MRSA screening form workflow changes to ensure patients who reside at a SNF and/or have been readmitted in past 30 days are automatically MRSA decolonized for a positive nasal swab result	3/31/25	Time to establish Cerner workflows for patient access to assist nursing in collecting relevant information from patients
Hand Hygiene compliance dashboard disseminated monthly to leadership (increase awareness and accountability). QI resources disseminated to leadership to use for unit/dept level improvement work	12/2/24 and ongoing	Requests for additional badges/docking stations; periodic inaccurate reports due to the workflow behind electronic removal of termed employees (inhibits leaders ability to hold staff accountability)
Communication with managers of units that are not achieving goal to review their staff level HH compliance reports and follow up with staff. "D.U.D.E, your red" campaign (peer to peer accountability when BioVigil shows need for HH)	3/17/25	None
Effective cleaning – Post staff competency, identify targeted equipment/surfaces for focused QI work	12/31/24	None, completed
Bedrails most frequently failing testing. EVS leadership coaching consistently in staff huddles. Also evaluating different cleaning products with faster kill times that pass testing more often	3/31/25	None, Feb 2025 bed rail 100% cleanliness effectiveness testing
Transport staff to help with patient care equipment cleaning	Ongoing	None

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Outstanding Health Outcomes (OHO) QUALITY & PATIENT SAFETY PRIORITY

Sepsis CMS SEP-1 & Sepsis Mortality

March 2025

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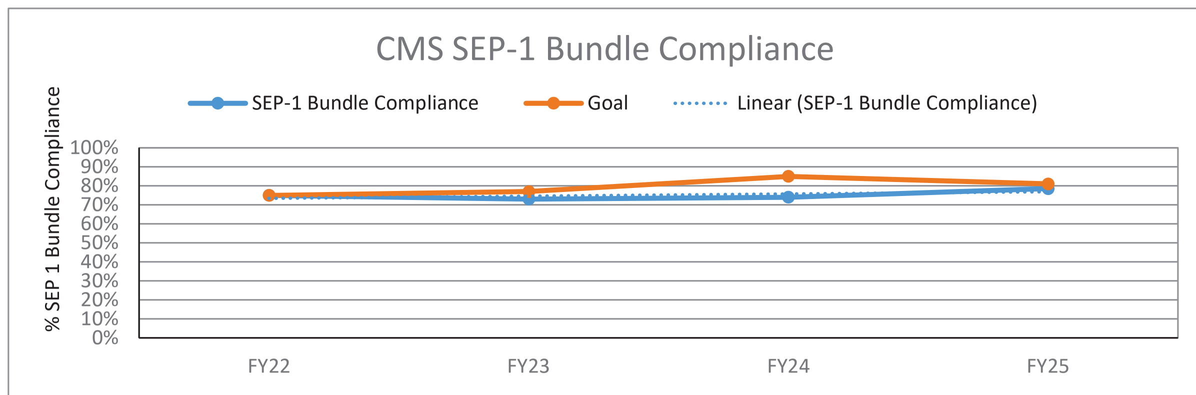
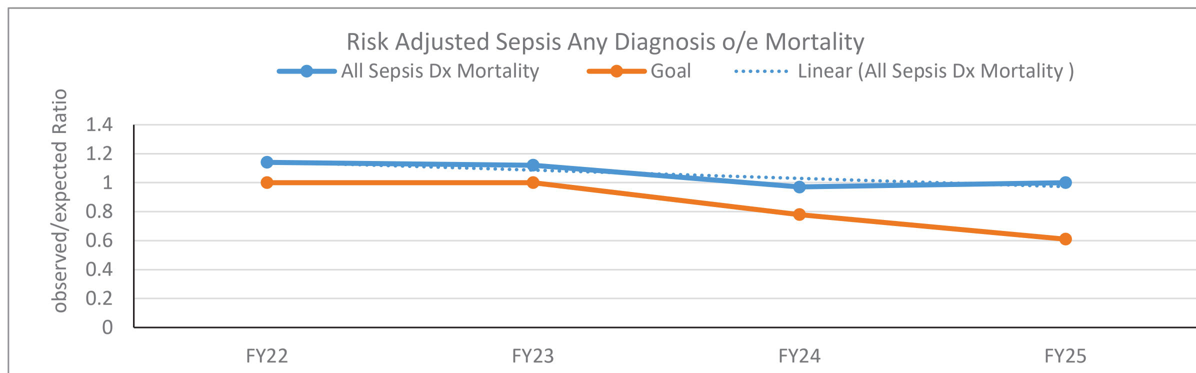
OHO FY25 Plan: CMS SEP 1 and Mortality (observed/expected)
Historical Baseline





FY25 GOAL

Increase SEP-1 Bundle Compliance ≥ 81%

Decrease Sepsis any diagnosis Mortality ≤ 0.61

FY25 PLAN – CMS SEP-1

High Level Action Plan

- Provide Early Goal Directed Therapy (Sepsis work up and Treatment)

  % of Patients provided top 3 most frequently missed Sepsis bundle elements

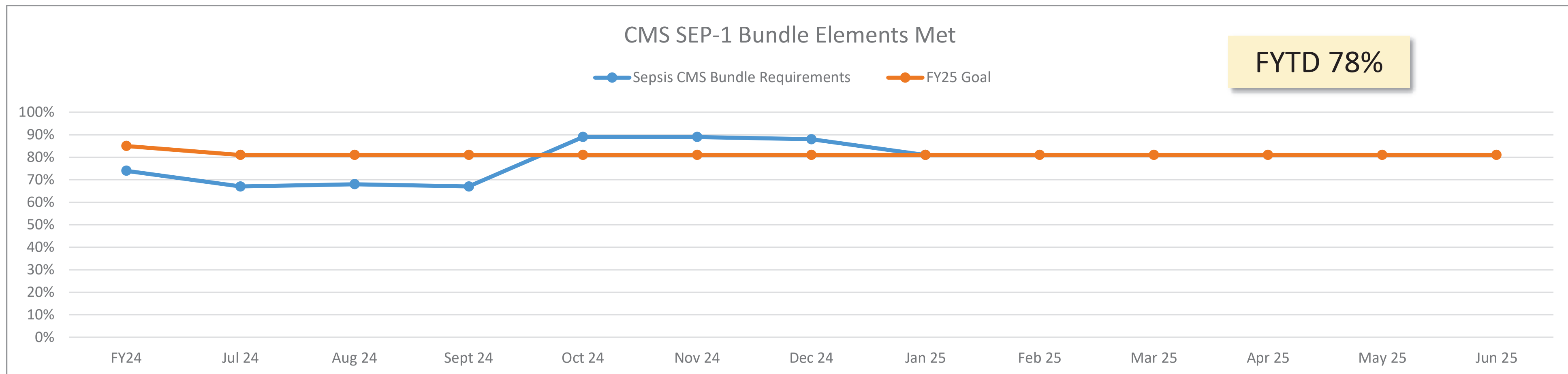
  Goal FY 25 95%

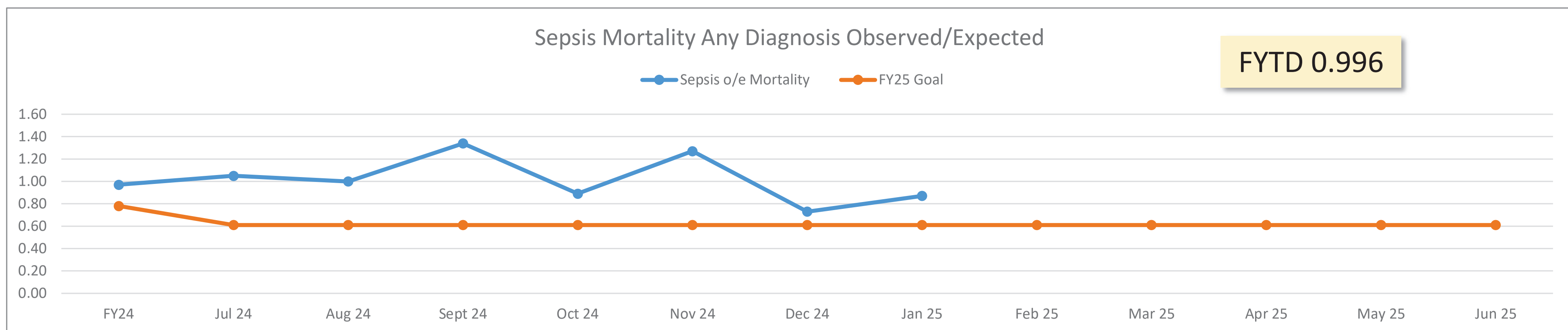
  - IV Fluid Resuscitation
  - Antibiotic Administered
  - Blood Cultures Drawn
- Provide Early Goal Directed Therapy (Sepsis Treatment)

  Goal FY 25 = 30%

  - Pts with Sepsis that Received Abx within 60 Minutes of Pt 1st Seen
  - Pts Met 1- Hr Bundle

OHO FY25 Monthly Update: CMS SEP-1 & Mortality





OHO FY25 Monthly Update: CMS SEP-1 & Mortality

The last data point did not meet goal because (Goal has been met for the last 4 months for SEP 1):

- Differential diagnosis of infections are not being treated with Sepsis interventions or are not being refuted when Sepsis is no longer entertained (i.e. Thrombocytopenia documented in ED Provider note)
- 2 (Two) cases abx administered outside the 3 hour window. 1 (one) case BC not ordered by hospitalist, 2 (Two) case All Sepsis elements not ordered timely by Intensivist, 1 (one) case abx not ordered timely by Intensivist & 1 case all sepsis elements not ordered timely by ED Provider
- Providers ordering Sepsis bundle elements outside the Sepsis power plan omitting important information required by CMS (i.e., lesser fluids)
  - Providers prefer to order or not order fluid at their discretion due to concerns for fluid overloading patients (afraid to harm pts)

Targeted Opportunities

- Provide Early Goal Directed Therapy (Sepsis work up and Treatment)

  FY25

  - % of Patients provided top 3 most frequently missed Sepsis bundle elements at KH (Higher performance = Better care)
  - IV Fluid Resuscitation 95%
  - Antibiotic Administered 91%
  - Blood Cultures collection 93%

  Goal = 95%
- Provide Early Goal Directed Therapy (Sepsis Treatment)

  FY25

  - Pts with Sepsis that Received Abx within 60 Minutes of Pt 1st Seen by ED Provider 29.7%
  - Pts Met 1- Hr Bundle 26.9%

  Goal = 30%

OHO FY25 Monthly Update: CMS SEP-1 & Mortality

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
1. GME Resident engagement and ongoing education throughout the year, not just during yearly orientation ○ Ongoing Strong collaboration with Chief ED Residents ✓ Ongoing education during weekly didactic ○ 2 Resident project focus on Sepsis power plan utilization awareness & ED Provider pop-up to declare or refute sepsis prior to inpatient transfer ○ Collaboration with Dr. Stanley for engaging educational material ○ Engage with ACTS team for ongoing Sepsis education to surgical residents ○ Incrementally engage Transitional Year & Psych residents	Ongoing	GME program strict curriculum limited time to devote to ongoing Sepsis education throughout the year
2. Code Sepsis in ED (workgroup in progress)	Discussion to continue once ED Throughput project advanced	ED Throughput challenges, treatment space limitations & staffing challenges No designated blood culture resource Potential for 13-16 code Sepsis in a 24 hour window New ED leadership 1/2025
3. Sepsis multidisciplinary collaboration with SIM (Simulation in Medical Science) Lab Planned for Spring 2025 (possible in situ SIM)	Spring 2025	Potential Inpatient (hospitalist, intensivist) engagement limitations

OHO FY25 Monthly Update: CMS SEP-1 & Mortality

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
4. Mortality summary reviews presented to Sepsis committee workgroup for Sepsis 1-hour bundle success review, analysis & improvement strategies	Ongoing	None
5. Improve Severe Sepsis Alert Specificity (EMR optimization) ○ Collaborate with ISS team and Cerner EMR resources to optimize Sepsis alert ○ Decrease lookback window (for labs and vital signs) from Cerner 36 hours to **8 hrs.** for more meaningful alerts	TBD	Limitations within Cerner cloud Concerns with disrupting existing algorithm
6. Sepsis documentation improvement project ○ Trialing reviewing All Sepsis cases for appropriateness of Physician documentation & coding to ensure clinical picture is reflected on the medical record (including Physician linking organism to Sepsis for a more descriptive ICD 10 diagnosis code) ○ Targeting Intensivist documentation opportunity (most Sepsis patients admitted to ICU)	Ongoing	None
7. Inpatient Providers Engagement ○ Sepsis team attending upcoming Valley Hospitalist meeting in March 2025	March 2025	Limited engagement with Family Healthcare Network providers

Thank you