May 12, 2021

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in a Quality Council Committee meeting at 7:00AM on Thursday, May 20, 2021, in the Kaweah Health Support Services Building, Granite Room, 520 W. Mineral King Avenue, or via GoTo Meeting from your computer, tablet or smartphone. https://global.gotomeeting.com/join/881426077 or call (224) 501-3412 - Access Code: 881-426-077.

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:01AM on Thursday, May 20, 2021, in the Kaweah Health Support Services Building, Granite Room, 520 W. Mineral King Avenue, pursuant to Health and Safety code 32155 & 1461. Board members and Quality Council closed session participants will access closed meeting via Confidential GoTo Meeting phone number provided to them.

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Quality Council Committee meeting at 8:00AM on Thursday May 20, 2021, in the Kaweah Health Support Services Building, Granite Room, 520 W, Mineral King Avenue, or via GoTo Meeting via computer, tablet or smartphone. https://global.gotomeeting.com/join/881426077 or call (224) 501-3412 - Access Code: 881-426-077.

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

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

KAWEAH DELTA HEALTH CARE DISTRICT
Garth Gipson, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
Board Clerk, Executive Assistant to CEO

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

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
QUALITY COUNCIL

Thursday, May 20, 2021
520 W. Mineral King Avenue
Granite Room, 4th Floor – Support Services Building

GoToMeeting: https://global.gotomeeting.com/join/881426077
Call in option: 1-224-501-3412 Access Code: 881-426-077

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

OPEN MEETING – 7:00AM

1. **Call to order** – *David Francis, Committee Chair*
2. **Public / Medical Staff participation –** Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves at this time. Members of the public or the medical staff may comment on agenda items after the item has been discussed by the Committee but before a Committee recommendation is decided. In either case, each speaker will be allowed five minutes.
3. **Approval of Quality Council Closed Meeting Agenda** – 7:01AM
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Monica Manga, MD, and Professional Staff Quality Committee Chair;*
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – Evelyn McEntire*, RN, BSN, Interim Director of Risk Management, and Ben Cripps, Chief Compliance Officer.*
4. **Adjourn Open Meeting** – *David Francis, Committee Chair*

CLOSED MEETING – 7:01AM

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

David Francis *President* | *Lynn Havard Mirviss* *Vice President* | *Garth Gipson* *Secretary/Treasurer* | *Mike Olmos* *Board Member* | *Ambar Rodriguez* *Board Member*

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

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

OPEN MEETING – 8:00AM

1. **Call to order** – *David Francis, Committee Chair*
2. **Public / Medical Staff participation –** Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves at this time. Members of the public or the medical staff may comment on agenda items after the item has been discussed by the Committee but before a Committee recommendation is decided. In either case, each speaker will be allowed five minutes.
3. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives:
   - 3.1. **Length of Stay/Resource Effectiveness**
   - 3.2. **Surgical Services Quality Improvement Program**
   - 3.3. **CLABSI/MRSA Quality Focus Team**
4. **Written Quality Reports: Quality and Patient Safety Plan Review** – A review of revisions to each plan which incorporate processes to monitor medication diversion quality assurance activities. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*
5. **Update: Clinical Quality Goals** **-** A review of current performance and actions focused on the FY 2021 clinical quality goals. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*
6. **Leapfrog Hospital Safety Grade** **–** A review of the quality measures included in the Leapfrog Hospital Safety Grade, scoring methodology, and associated improvement actions. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*
7. **Centers for Medicare and Medicaid Services Star Rating Report** – An analysis of the quality indicators included in the CMS Star Rating Report and associated improvement actions. *Evelyn McEntire, RN BSN, Manager Quality Improvement/Interim Director of Risk Management, Tom Gray, MD, Medical 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.

David Francis	***Lynn Havard Mirviss***	***Garth Gipson***	***Mike Olmos***	***Ambar Rodriguez***
President	***Vice President***	***Secretary/Treasurer***	***Board Member***	***Board Member***

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

<u>Unit/Department</u>: Resource Effectiveness Committee **<u>ProStaff/QIC Report Date</u>: 2/1/21**

Deferred from June 2020 d/t COVID related projects.

<u>Measure Objective/Goal:</u> Decrease organizational length of stay

	FY2018	FY2019	FY2020	FY2021 YTD
Actual LOS	4.97	5.07	4.81	5.93
Expected LOS	3.96	3.84	3.90	4.32
Opportunity Days	1.01	1.22	0.91	1.61

<u>Date range of data evaluated:</u>
July 1, 2019 through January 31, 2021, monthly length of stay averages for all adult patients. Excludes Pediatrics, Obstetrics, Mental Health and Post-acute patients.

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

The Resource Effectiveness Committee (REC) has not met in an organized manner since June 2020 due to leaders involved with the REC initiatives being heavily involved with COVID related operations and changes. FY2020 to FY 2021 plans involved restructuring of the team. The most significant change was moving from a DRG based LOS focus to a more barriers focused approach. Top barriers were identified using rounding data and trends from FY2019 and FY2020. These barriers were timeliness of consults and follow-up on recommendations, discharge placement delays, financial limitations with payers and resources, and certain clinical processes that took longer than expected for completion. We also eliminated the cost savings branch of the committee. The teams in this group already focus solely on cost savings through their normal operations and did not do anything different in their operations within the REC structure.

Focused LOS barriers
Group team leads were identified for ownership of the initiatives. They met and developed a charter. They were not able to move forward in focused improvement work during the first six months of fiscal year 21. The leaders were involved in rapid changes to ensure operational responses in place related to COVID related care. The teams will move forward for the remainder of FY 21 to develop new processes and eliminate barriers found within their areas.

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

Patient Flow Committee

The Patient Flow and Efficiency groups continued to maintain the work they were doing. The discharge management/LOS committee performed a new analysis of barriers and began implementation of changes within their team in the second quarter of FY21. The handoff team was also reassigned and a quality focus team began piloting handoff changes in November 2021. These communication changes are taking place in handoff from the ED to the inpatient units. As the tool and process is improved, it will be implemented in subsequent areas for use.

LOS values

In FY19, many of the initiatives within the REC were initiated. Improvement in the LOS value was seen as early as February of 2019 and continued to improve for the next 11 months. Significant improvement was made through FY20 in closing the gap from the expected LOS to the actual LOS. FY2020 ended with an average of 0.91 opportunity days realized. In March 2020, the organization opened the Hospital Incident Command in response to the threat of a pandemic from the 2019 novel coronavirus (COVID-19/SARS-CoV-2). Resources were shifted to patient care, safety, education and quality of care. The new environment in which we were doing health care created a need to create new processes, protocols, education and extensive communication to our health care team members throughout the organization. Leaders were heavily involved in planning and operationalization of changes to ensure patients and health care team members were safe while experiencing shortages of supplies, including PPE.

Challenges during the pandemic response led to lengthening of the LOS for patients rather than shortening. Patients with COVID had an average LOS of 12 days. Patients with and without COVID had delayed discharges due to limited post-acute facilities able to take patients. Post-acute services had delays in opening new cases safely due to staffing and increased demands. The hospital also experienced staffing shortage crises that led to delays in decision making around discharge for patients. Patients with COVID take more resources to complete procedures. We adjusted decision-making and processes around accessing tests and procedures to ensure safety but get the tests or procedures completed, this created delays to discharge. Through January 2021, the average LOS gap increased to 1.61 days.

We collaborated with post-acute facilities and other services in the region to facilitate discharges sooner. We worked closely with primary care physician (PCP) offices to ensure post-discharge follow-up visits are scheduled and even had their support to decrease hospitalizations during especially high census times. The PCP team members continue to be available to their patients and to the ED providers to help with planning to avoid hospitalization of patients.

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

The team had several goals planned for FY21. We will be working to address the following goals before the end of the fiscal year.

FY 21 Goals	Action Plans	Resolution Date
Evaluate an increase in availability of services (6-7 days/week)	Review services without weekend availability. Assess volume with leadership of the services. Determine if benefits of services are greater than cost of services.	July 2021
Remove discharge placement barriers	Discharge management/LOS team meeting. Subgroups formed to work on standardization of work. Implementation of easier to use throughput data tracking tool.	February 2021
Engage consultants earlier	Work with physician groups to develop easier methods of communication around consultants' role.	July 2021
Create organizational plan for ED surge response	Continue to stream line response to volume surges in the ED with rapid movement of patients within 2 hours to available beds. Improve communication of activities underway to minimize duplication or disruption of efforts	July 2021
Provide individual feedback to physicians on discharge times and LOS, increase physician involvement in problem solving throughput concerns.	Create dashboards for physicians to increase awareness of LOS and discharge times associated with their patients	May 2021
Create physician support for length of stay and medical necessity documentation issues	Bring on full time physician advisor to collaborate with physicians on medical necessity, discharge barriers, documentation and length of stay concerns.	February 2021

Next Steps/Recommendations/Outcomes:
Bring REC committee team leads together. Assess progress in all patient flow areas. Initiate work with primary LOS barrier groups. Begin to align operational efficiency work with FY 22 strategic plan groups. Increase resources and support for leaders working to implement

changes that will decrease length of stay. Support periodization and standardization of the work to simplify action steps. Help frontline health care team members understand the importance of each of the steps for the overall outcomes for the patients and the organization with routine updates in shared decision-making and staff meetings.

Submitted by Name: Keri Noeske, DNP VP Chief Nursing Officer **Date Submitted:** 2/16/21

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: Surgery **ProStaff Report:** April 12, 2021

Measure Objective/Goal:

1. **Immediate Use Sterilization (IUSS):** Goal 2.0%
2. **First case delays:** Decrease by 20%
3. **Block Utilization:** 60%
4. **Turnover:** 28 minutes
5. **Non-Operative Time "Surgeon Wait Time":** 70 minutes
6. **Enhanced Recovery after Surgery (ERAS):** ASC/PACU will be measuring this objective.

Date range of data evaluated:

1. **Immediate Use Sterilization (IUSS):** March 2020- April 2021
2. **First Case Delays:** March 2020- April 2021
3. **Block Utilization:** March 2020- April 2021
4. **Turnover:** March 2020- April 2021
5. **Non-Operative Time "Surgeon Wait Time:** March 2020- April 2021

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

1. **Immediate Use Sterilization (IUSS):** *(IUSS is compared to the total # of cases)*
2. **First Case Delays:**
3. **Block Utilization:**
4. **Turnover:**
5. **Non-Operative Time "Surgeon Wait Time":**

2020-2021 Surgical Department Quality Dashboard (ProStaff/QIC)

Throughput	KD Goal	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21
First Case Delay Minutes in O.R.	650	750	1385	1507	925	594	757	429	715	926	719
Block Utilization	60%	51%	53%	46%	53%	53%	40%	22%	41%	51%	51%
Patient Safety	**Percentage**										
Immediate Use Steam Sterilization (IUSS)	2%	2%	2%	1%	2%	2%	1%	2%	1%	1%	2%
O.R. Efficiency	**Minutes**										
Turnover Data	28	24	27	36	28	28	30	30	25	32	30
Surgeon (Non-Op) Wait Time	70	76	83	85	82	78	86	83	80	86	73

Better than target
Within 10% of target
Does not meet target

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

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

1. **Immediate Use Sterilization (IUSS):**
    a. Continue to purchase instrumentation to decrease IUSS.
    b. Increase Vender Trays to decrease IUSS for the following cases.
    c. Decrease scheduling conflicts to allow sterile processing adequate time to turn over trays/instrumentation.
    d. Continue a 1430 huddle. The huddle consists of Surgery Manager, Sterile Processing Manager, Surgery Charge Nurse, Sterile processing a.m. and p.m. Team Leads, Radiology Tech lead, and 2 Surgery Schedulers.
        1. Each person comes to the meeting prepared to discuss the following day's schedule. This has eliminated miscommunication between departments, scheduling conflict, etc…
2. **First Case Delays:**
    b. Educate staff in pre-op and intra-op on proper delay codes.
    c. Delay codes will be reported at the OR Governance Committee, Department of Surgery, and Department of Anesthesia.
    d. Data will be displayed on the electronic communication board in the surgeons lounge for transparency.
    e. Trends with specific surgeons will be addressed by the OR Governance Committee representatives. Trends with specific surgeons could affect their allotted block time.
    f. First case delays due to anesthesia are reported to the Medical directors and reported at the Department of Anesthesia.
3. **Block Utilization:**
    a. There is a need for block time in the Operating Room and there are underutilized block times surgeons currently have.
    b. Utilization is defined as total allotted minutes for a specific surgeon compared to the total minutes used.
    c. The goal is to decrease wasted OR utilization time and give time to current surgeons who need more time and to new surgeons who are entering the district.
    d. Dr. Wiseman, Dr. Tang and Surgical Services Leadership have created a formalized way to track utilization time.
        i. Formula: Surgery minutes + Turnover minutes / Block minutes – Released block minutes = Block Utilization.
    e. Letters have been sent to surgeons regarding their utilization data. If they are below 50% utilization, they have 1 quarter to increase their volume to maintain or it will be released back to the department.
        i. March was the first round of restructuring and removing block.
        ii. We assigned block to eight surgeons who did not have time and to surgeons who needed more time.
        iii. *Due to the COVID-19, block utilization data for March through January will not be counted against surgeon's utilization.*
    f. O.R. Governance and Department of Surgery have approved block to release 1 week in advance instead of 72 hours in advance.
        i. Provides more time for other surgeons looking for block to schedule.
    g. O.R. Governance and Department of Surgery approved for schedules to be finalized 48° in advance. This created more efficiency on the operations side.

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

h. November 2, 2020 started staggering surgeon first case start times. This will provide surgeons with more block time to add more cases.
    ii. Goal is to have 2-3 surgeons a day be in the room at 0700 instead of 0730.
    iii. Helps with anesthesia residency program.
    iv. As of December 2020, we have 7 surgeons who start block at 0700.

Next Steps/Recommendations/Outcomes:

1. Immediate Use Sterilization (IUSS):

a. Continue to meet with new surgeons to understand their need vs want. Budget accordingly to their expected volume.
b. Surgery/Sterile Processing Liaison committee makes recommendations for more instrumentation purchases.
c. Surgery and Sterile Processing have a small list in the departments on instrumentation they need or have replaced. These lists are looked at on a monthly basis by the Sterile Processing
    i. Supervisor
        a) **Outcome: New goal IUSS at 2.0%.**

2. First Case Delays:

a. Clean current delay codes up from the EMR. *Completed*
b. Educate staff on proper coding. *Ongoing education*
c. Present at the above committees for transparency. *Ongoing*
d. Display First case start (pt. in the room) broken down into minutes. *Ongoing*
e. Hold surgeons accountable for delaying first cases. *In progress through the O.R. Governance*
f. Anesthesia accountability. *In process*
    * 1/13/21, had a meeting with anesthesia medical directors to discuss anesthesia delays.
    * 2/3/21, had a meeting to discuss delay codes, communication between anesthesia and the surgical team.

3. Block Utilization:

a. Complete data extraction, present the data to the OR Governance Committee, and have a letter sent to individual surgeons who have underutilization. *Ongoing*
b. Give the surgeons who have underutilized time 1 quarter to increase their volume.
c. After the quarter, remove time currently allotted to surgeons who have not met criteria and give the new time to surgeons who need more block and to new surgeons.

4. Turnover:

a. Completed a Surgical Team Assistant Boot camp with the help of Alexandra Bennett.
b. Budgeting for an additional 3 STAs. 1 will be for the day to day operations and 2 will be for supply management. The focus of the supply is to ensure it is always there and stock supply in between cases.
c. This will help with staff having appropriate supply in all areas.

5. Non-Operative "Surgeon Wait Time".

a. Working with ISS to help with surgical services data. We need to be able to break the data into specialty. Larger cases will automatically have longer non-operative times due to room set-up.
b. Once the data is broken down, we can focus on the specialties that have longer non-op times.
c. Budgeting to have 1.4 RN FTE per room. This will provide support when needed to the rooms that are larger with longer non-op times.

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

d. Non-operative times will then have a goal per specialty. Having an overall non-operative goal with every specialty included will be hard to meet.

Example: Orthopedics will have a longer goal due to the set-up and positioning compared to a general laparoscopic gallbladder surgery with minimal instrumentation and standard positioning.

Submitted by Name:
Brian Piearcy, Director Surgical Services

Date Submitted:
April 12, 2021
Updated: May 13, 2021

Central Line Blood Stream Infection (CLABSI) Quality Focus Team Report
March 2021

Amy Baker, Director of Renal Services (Chair)
Emma Camarena, Advanced Practice Nurse (Co-Chair)
Shawn Elkin, infection Prevention Manager (IP Liaison)

Background: Patients are acquiring CLABSIs at rates that exceed national benchmarks. The CLABSI SIR from July 2019 to December 2019 was 1.47 with a goal (CMS 50th percentile) of ≤ 0.784; the number of CLABSIs was higher than expected (9 observed, 6 expected). CLABSIs result in poor outcomes for patients, a negative public perception of care through publically reported safety scores and financially impact the organization through HAC and VBP programs as well as increased treatment costs and length of stay.

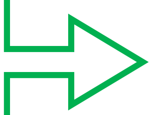
Current State Review - Feb 2020:

- Days between CLABSI from 4/2018 to 4/2020 is 18.74.
- CLABSIs are associated with both insertion practices and maintenance practices
- CLABSIs have not increased because we have more central lines or insert them under emergent circumstances
- We do not have consistency with best practices in CLABSI prevention
- No standard MD training on CLABSI prevention training
- The "Vital Few" are:
  - Central Line site: IJ or Femoral
  - Bath not received
  - Line necessity was not addressed
  - Hemodialysis
  - Expired peripheral IV
- CLABSIs are not isolated to one unit or unit type
- The weekly HAI audit (for best practices) has not helped consistency in bundle practices or reduced CLABSI

Analysis:

Identified Root Causes (in order from most significant to least):

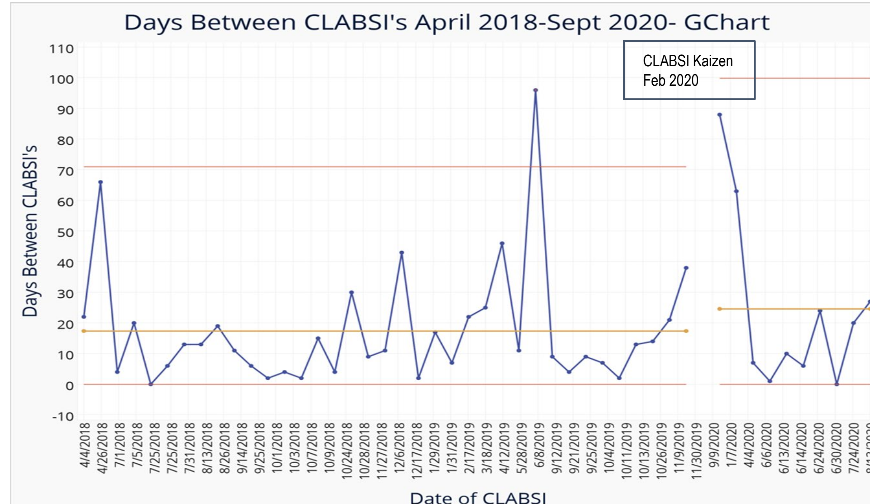
1. Line Necessity
2. Bundle Practice
3. Education
4. Cultures
5. Central Line Insertion
6. Bathing
7. Leadership Standard Work
8. Documentation
9. Human Factors



Kaizen improvement strategies focused on addressing the top 4 root causes

Action Plan: Goal CLABSI SIR ≤0.633 (new) and Mean Days Between CLABSI > 40.5

Improvement Strategy	Who?	When?
Line Necessity –Implementation of interventions delayed due to COVID-19 pandemic	Emma C. Joetta D.	March 31, 2020 (TPN orders 7/2020)
Bundle Practice-Implementation of interventions delayed due to COVID-19 pandemic	Amy Baker	March 31, 2020
Education-Implementation of interventions delayed due to COVID-19 pandemic priorities	Eileen P. Enri S.	March 31, 2020 (Comp Fair 6/20)
Blood Cultures: The Culture of Culturing	Dr. Gray & Shawn Elkin	
Leadership Standard Work	Mary Laufer	
Improve location and par of central line supplies • Include in manager communication plan; • Include in RN & CNA education that they need to follow up with CN or manager that PAR level needs to be adjusted; also talk to manager & central distribution	Kaizen Team Education Team	
Email Take-Always after CLABSI committee review of events	Amy Baker	
Insertion: New site = New kit to be included with MD/resident education with Dr. LeDonne—Conference cancelled due to COVID-19 pandemic.	Dr. Gray Shawn Elkin	



Results Report

BASELINE DATA

July-Dec 2019
SIR = 1.47
Goal = ≤0.784

Mean days between CLABSIs 4/2018 to 1/2020 = 17
Goal > 40.5

Update: Sept 2020

April – June 2020
SIR = 1.63
Goal = ≤0.633

Mean days between CLABSI 1/2020 to 9/2020 = 24.6

Post Kaizen- Gemba Data

CLABSI Committee Dashboard

Measure Description	Benchmark/ Target	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
OUTCOME MEASURES													
Number of CLABSI	0	0	1	0	5	2	1	2	0	1	2	1	2
FYTD SIR	≤ 0.633				1.63			1.28			1.2		
PROCESS MEASURES CL Gemba Rounds													
% of pts with bath within 24 hrs	99%	n/a	81%	78%	80%	84%	88%	88%		95%	96%	96%	96%
% of CL with valid rationale order	100%	n/a	93%	93%	97%	96%	95%	96%		98%	98%	97%	99%
% of CL dressings clean, dry and intact	100%	n/a	92%	92%	95%	91%	92%	95%		97%	95%	94%	97%
% of CL that had drsg change no > than 7 days	100%	n/a	97%	90%	90%	89%	96%	98%		98%	98%	99%	99%
% of patients with proper placed gardiva patch	100%	n/a	83%	81%	93%	90%	89%	92%		93%	94%	94%	93%
% of CL pts with app & complete documentation	100%	n/a	81%	81%	86%	86%	87%	87%		92%	91%	93%	95%
# of Pt Central Line days rounded on	n/a	n/a	426	1050	1315	1194	1087	1372		1084	1194	1067	1010

Better than Target	Jan-Jul: Within 10% of Target As of Aug: Within 5% of Target	Does not meet Target

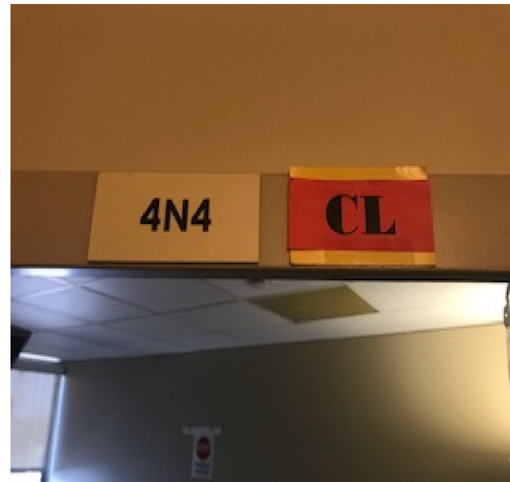
Total Number of Patient Central Line Days Rounded on = 10,799

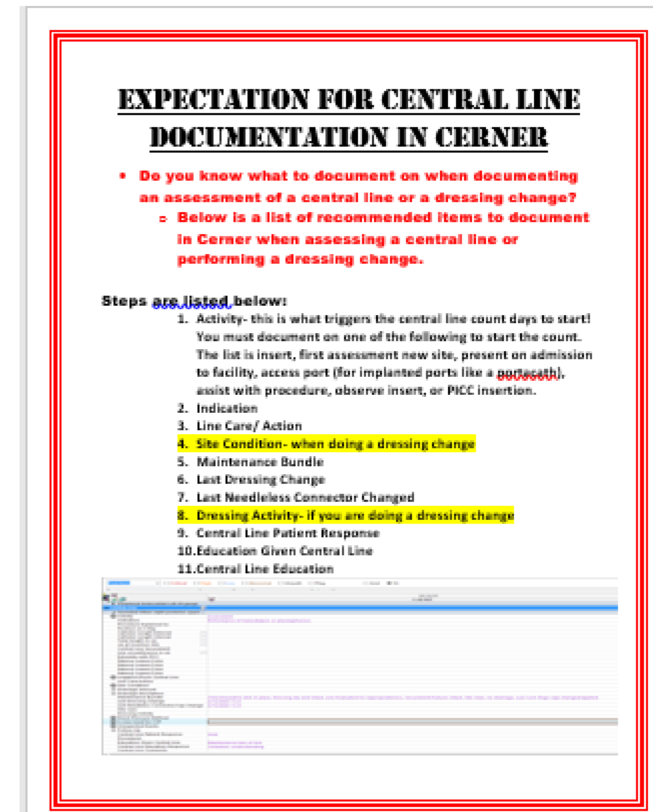
99% had there central line dressing changed within seven days for the month of February

99% of patients with central line had a valid rationale order for the month of February

Clabsi Kaizen Next Steps

- All Clabsi Kaizen material was resent in March to each unit to reinforce best practice. These include computer borders with bundle measures listed, magnets to identify central line patients, do not enter signs, flyers to support reducing unnecessary blood culture orders, documentation expectations, and general information about central line options.





EXPECTATION FOR CENTRAL LINE DOCUMENTATION IN CERNER

- Do you know what to document on when documenting an assessment of a central line or a dressing change?
  - Below is a list of recommended items to document in Cerner when assessing a central line or performing a dressing change.

Steps are listed below:

1. Activity- this is what triggers the central line count days to start! You must document on one of the following to start the count. The list is insert, first assessment new site, present on admission to facility, access port (for implanted ports like a portacath), assist with procedure, observe insert, or PICC insertion.
2. Indication
3. Line Care/ Action
4. Site Condition- when doing a dressing change
5. Maintenance Bundle
6. Last Dressing Change
7. Last Needleless Connector Changed
8. Dressing Activity- if you are doing a dressing change
9. Central Line Patient Response
10. Education Given Central Line
11. Central Line Education

Clabsi QFT- Plans for Improvement

- Several Subcommittees have formed to help reduce different aspects of CLABSI
  - Culture of Culturing Committee- work on reduce number of pan culturing and discuss TPN utilization related to CLABSI's
  - HAI Review Committee- Review each CLABSI case to identify learning opportunities, barriers and identify root causes
  - MRSA Subcommittee- develop plan to address MRSA infections. Discussing nasal decolonization

In addition to subcommittees the CLABSI QFT has been

- Reviewing unit specific action plans to address CLABSI's- for example 4 North auditing compliance of CHG bathing for high risk infection patients with central lines
- Working on Power Plan to create ease of use and understanding
- Update policy with Lippincott links so staff can see video's of central line dressing changes
- Working with shared governance teams to get feedback on barriers facing each unit

Future State Predications

FY 21 Clinical Quality Goals

	Jul-Dec 2020 (Higher is Better)	FYTD %	FY21 Goal	FY20	Last 6 Months FY20
SEP-1 (% Bundle Compliance)	National Av = 66%, Top 10% = 82%; 75%	75%	≥ 70%	67%	69%

Percent of patients with this serious infection complication that received "perfect care". Perfect care is the right treatment at the right time for our se

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

Lower is Better	July 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual divided by number expected)	FY21 Goal	FY20
CAUTI Catheter Associated Urinary Tract Infection	3	0	1	1	1	2	0	1	13	0.84	≤0.727	1.12
CLABSI Central Line Associated Blood Stream Infection	2	1	2	0	1	2	1	2	9	1.33	≤0.633	1.2
MRSA Methicillin-Resistant Staphylococcus Aureus	2	4	2	2	1	1	2	0	5-6	2.53	≤0.748	1.02

*based on FY20 NHSN predicted

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

QUESTIONS?

Subcategories of Department Manuals not selected.

Policy Number: AP41	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	
Quality Improvement Plan	

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

I. Purpose

The purpose of Kaweah Delta Health Care District's (KDHCD) Quality Improvement Plan is to have an effective, data-driven Quality Assessment Performance Improvement program that delivers high-quality, excellent clinical services and enhances patient safety.

II. Scope

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

III. Structure and Accountability

Board of Directors

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

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

Quality Council

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

Medical Staff

The Medical Staff, in accordance with currently approved medical staff bylaws, shall be accountable for the quality of patient care. The Board delegates authority and responsibility for the monitoring, evaluation and improvement of medical care to the Professional Staff Quality Committee "Prostaff", chaired by the Vice Chief of Staff. The Chief of Staff delegates accountability for monitoring individual performance to the Clinical Department Chiefs. Prostaff shall receive reports from and assure the

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

~~**Professional Staff**~~ **Quality Improvement Committee (QIC)**- ~~**"Prostaff":** The Prostaff Committee~~ QIC has responsibility for oversight of organizational performance improvement. Membership includes key organizational leaders including the Medical Director of Quality and Patient Safety or Chief Quality Officer, Chief Operating Officer, Chief Nursing Officer, Assistant Chief Nursing Officer, Directors of Quality and Patient Safety, Nursing Practice, and Risk Management; Manager of Quality and Patient Safety and Manager of Infection Prevention. ~~ing: Medical Executive Committee members, Medical Director of Quality and Patient Safety, Chief Executive Officer, Chief Operating Office, Chief Medical Officer/Chief Quality Officer, Chief Nursing Officer, member of the Board of Directors, and Directors of Nursing, Quality and Patient Safety, Risk Management and Pharmacy.~~
This committee reports to Prostaff and the Quality Council.

The QIC ~~Prostaff Committee~~ shall have primary responsibility for the following functions:

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

2. **Quality Indicators:**

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

3. **Prioritization:** The QIC ~~Prostaff Committee~~ shall prioritize ~~performance~~ quality improvement activities to assure that they are focused on high- risk, high- volume, or problem- prone areas. It shall focus on issues of known frequency, prevalence or severity and shall give precedence to issues that affect health outcomes, quality of care and patient safety. The QIC is responsible to establish organizational Quality Focus Teams who:

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

   ~~3.~~

4. **Improvement:** The QIC ~~Prostaff Committee~~ shall use the analysis of the data to identify opportunities for improvement and changes that will lead to improvement. The QIC ~~Prostaff Committee~~ will also oversee implementation of actions aimed at improving performance.

5. **Follow- Up:** The QIC ~~Prostaff Committee~~ shall assure that steps are taken to improve performance and enhance safety are appropriately

implemented, measured and tracked to determine that the steps have achieved and sustained the intended effect.

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

Medical Executive Committee

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

Nursing Practice Improvement Council

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

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

Graduate Medical Education

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

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

Methodologies:

Quality improvement (QI) models present a systematic, formal framework for establishing QI processes within an organization. QI models used include the following:

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

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

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

- **U---Understand** process variation
- **S—Select** improvement

- **Plan:**
  - Objective and statistically valid performance measures are identified for monitoring and assessing processes and outcomes of care including those affecting a large percentage of patients, and/or place patients at serious risk if not performed well, or performed when not indicated, or not performed when indicated; and/or have been or likely to be problem prone.
  - Performance measures are based on current knowledge and clinical experience and are structured to represent cross-departmental, interdisciplinary processes, as appropriate.
- **Do:**
  - Data is collected to determine:
    - Whether design specifications for new processes were met
    - The level of performance and stability of existing processes
    - Priorities for possible improvement of existing processes
- **Check:**
  - Assess care when benchmarks or thresholds are reached in order to identify opportunities to improve performance or resolve problem areas
- **Act:**
  - Take actions to correct identified problem areas or improve performance
  - Evaluate the effectiveness of the actions taken and document the improvement in care
  - Communicate the results of the monitoring, assessment and evaluation process to relevant individuals, departments or services

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

- **Define** the problem, improvement activity, opportunity for improvement, the project goals, and customer (internal and external) requirements. QI tools that may be used in this step include:
  - Project charter to define the focus, scope, direction, and motivation for the improvement team

- Process mapping to provide an overview of an entire process, starting and finishing at the customer, and analyzing what is required to meet customer needs
- **Measure** process performance.
  - Run/trend charts, histograms, control charts
  - Pareto chart to analyze the frequency of problems or causes
- **Analyze** the process to determine root causes of variation and poor performance (defects).
  - Root cause analysis (RCA) to uncover causes
  - Failure mode and effects analysis (FMEA) for identifying possible product, service, and process failures
- **Improve** process performance by addressing and eliminating the root causes.
  - Pilot improvements and small tests of change to solve problems from complex processes or systems where there are many factors influencing the outcome
  - Kaizen event to introduce rapid change by focusing on a narrow project and using the ideas and motivation of the people who do the work
- **Control** the improved process and future process performance.
  - Quality control plan to document what is needed to keep an improved process at its current level
  - Statistical process control (SPC) for monitoring process behavior
  - Mistake proofing (poka-yoke) to make errors impossible or immediately detectable

IVIV. Confidentiality

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

V. Annual Evaluation

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

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

Attachment 1: Quality Improvement Committee Structure
Attachment 2: KDHCD- Prostaff Reporting Documents
Attachment 3: 20198-2020196 Value Based Purchasing (VBP) Objectives

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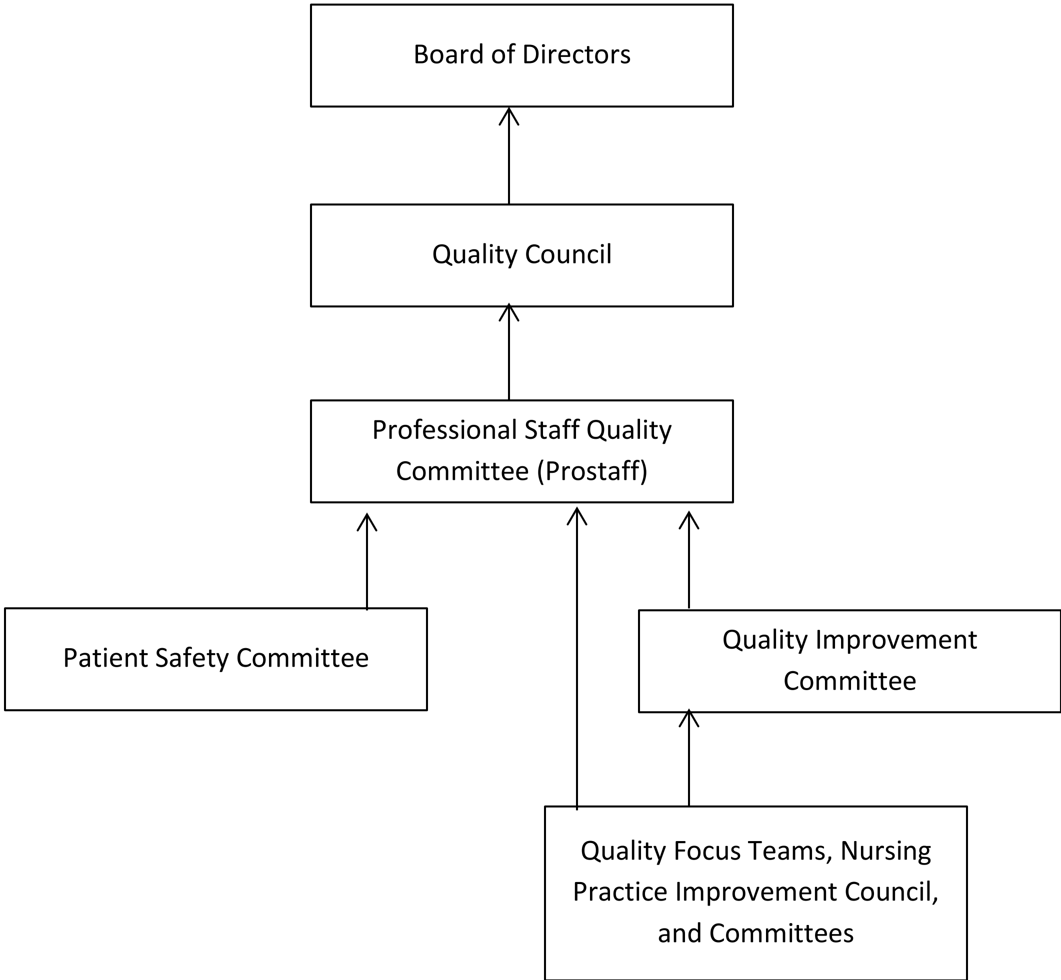
Attachment 1

Kaweah Delta Healthcare District
Quality Reporting Structure



Attachment 2

KDHCD – QUALITY IMPROVEMENT COMMITTEE REPORTING DEPARTMENTS

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

PROFESSIONAL and PATIENT CARE SERVICES
Laboratory
Nursing Quality Dashboard
Advanced Nursing Practice
Wound Care, Inpatient (Skin and Wound Committee)
Patient Access
Community Outreach
Patient & Family Services
Case Management/Utiliz Mgt & Bed Alloc
Interpreter Services
EOC (Security, facilities, Clinical Engineering, EVS)
Chaplain Services
Exeter Health Clinic (includes Lindsay, Woodlake, Dinuba)
Inpatient Pharmacy
Conscious Sedation (ED) Annual
Organ Donation (Annual)
Maternal Child Health
Labor & Delivery
Mother Baby
Neonatal Intensive Care Unit
Pediatrics
Mental Health Services
Mental Health
Episodic Care
Emergency
Trauma Service
Urgent Care
Cardiovascular Services
Dept of Cardiovascular Services (ACC/STS/) - Cath lab, IR, CVCU and Cardiac Surgery
CVICU
2N
4T
Critical Care Services
Intensive Care Unit
3W
Rehabilitation Services
Rehabilitation
Inpatient Therapies (KDMC, Rehab, South Campus)

Outpatient Therapies: Medical Office Building (MOB), Exeter, Sunnyside, Dinuba, Lovers Lane, Therapy Specialists at Rehab
Outpatient Wound Care at Rehab
Post Acute Services
KD Home Infusion Pharmacy
Home Care Services (Home Health & Hospice)
Transitional Care Svc/Short-Stay Rehab
Skilled Nursing Services
Surgical Services
Ambulatory Surgery Center/PACU/KATS
Operating Room
SPD
Broderick Pavilion
3N
4 South
Renal Services
4 North -
CAPD/ CCPD (Dialysis Maintenance)
Visalia Dialysis
Med/Surg
2S
3S
PUBLICALLY REPORTED MEASURES
Infection Prevention
Patient Safety Indicators/HACs
Value Based Purchasing Report
Patient Experience
Core Measures
Hospital Compare Quarterly Report
Healthgrades
Leapfrog Hospital Safety Score
COMMITTEES
Med Safety & ADE
Disparities in care
Falls committee
RRT/Code Blue
Pain Management
Resource Effectiveness Committee
Sepsis Quality Focus Team
Stroke
Diabetes QFT
Blood Utilization
Handoff Communication QFT
Accreditation Regulatory Committee
Diversion Prevention Committee

Policy Number: AP175	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Cindy Moccio (Board Clerk/Exec Assist-CEO)	

Patient Safety Plan

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

I. Purpose

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

II. Scope

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

III. Structure and Accountability

A. Board of Directors

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

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

B. Quality Council

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

C. Patient Safety Committee

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

The scope of the Patient Safety Team includes medical/healthcare risk events involving the patient population of all ages, visitors, hospital/medical staff, students and volunteers. Aggregate data* from internal (IS data collection, incident reports, questionnaires,) and external resources (Sentinel Event Alerts, evidence based medicine, etc.) will be used for review and analysis in prioritization of improvement efforts, implementation of action steps and follow-up monitoring for effectiveness. The Patient Safety Committee has oversight of KDHCD activities related to the National Quality Forum's (NQF) Safe Practices (SP) Medication Safety, Section #4 Maternity Care, #5 ICU physician staffing, #6 A-D Culture of Safety Leadership Structures & System Documentation, Culture Measurement, Feedback & Intervention Documentation, Nursing workforce and Hand Hygiene, #7 Managing Serious Errors, and #8 Bard Code Medication Administration.

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

D. Medication Safety Quality Focus Team

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

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

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

IV. Organization and Function

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

1. Reporting of potential or actual occurrences through the Occurrence Reporting Process Policy (AP10) by any employee or member of the medical staff. Examples of potential or actual occurrences include pressure ulcers, falls, adverse drug events, and misconnecting of: intravenous lines, enteral feeding tubes and epidural lines.
2. Reporting of potential or actual concerns in a daily leadership safety huddle which involves issues which occurred within the last 24 hours, a review the steps taken to resolve those matters when applicable, and anticipate challenges or safety issues in the next 24 hours. The daily safety huddle occurs Monday to Friday with the exception of holidays and includes directors and vice presidents that represent areas throughout the organization. The purpose of the daily safety huddle is immediate organizational awareness and action when warrented. Examples of issues brought forth in the Daily Safety Huddle include, patients at risk for elopement, violence, or suicide, and also can include potential diversion events, patient fall events, and medication related events.

3. Communication between the Patient Safety Officer and the Chief Operating Officer to assure a comprehensive knowledge of not only clinical, but also environmental factors involved in providing an overall safe environment.
4. Reporting of patient safety and operational safety measurements/activity to the performance improvement oversight committees, Professional Services Quality Committee "Prostaff" and Quality Improvement Committee (QIC). Prostaff is a multidisciplinary medical staff committee composed of various key organizational leaders including: Medical Executive Committee members, Chief Executive Officer, Chief Medical Officer/Chief Quality Officer, Chief Nursing Officer, and Directors of Nursing, Performance Improvement, Risk Management, and Pharmacy. QIC is a multidisciplinary committee comprised of various key organizational leaders including the CEO, CNO, CIO, CFO, VP of Human Resources, VP Surgical Services, VP of Post Acute Care and Ancillary Services, Directors of Quality & Patient Safety, Risk Management, and Nursing Practice and the manager of Infection Prevention.
5. Graduate Medical Education
    i. Graduate Medical Education (Designated Institutional Official (DIO), faculty and residents, are involved in achieving quality and patient safety goals and improving patient care through several venues including but not limited to:
        1. Collaboration between Quality and Patient Safety Department, Risk Management, and GME Quality Subcommittee
        2. GME participation in Quality Improvement Committee and Patient Safety Committee
        3. GME participation in KDHCD quality committees and root cause analysis (including organizational dissemination of lessons learned)

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

C. As this organization supports the concept that events most often occur due to a breakdown in systems and processes, staff involved in an event with an adverse outcome will be supported by:
    1. A non-punitive approach without fear of reprisal (just culture concepts).
    2. Voluntary participation into the root cause analysis for educational purposes and prevention of further occurrences.
    3. Resources such as Pastoral Care, Social Services, or EAP should the need exist to counsel the staff
    4. Safety culture staff survey (i.e. the Safety Attitudes Questionnaire) administered at least every 2 years to targeted staff and providers.

D. As a member of an integrated healthcare system and in cooperation with system initiatives, the focus of Patient Safety activities include processes that are high risk, high volume or problem prone, and may include:
    1. Adverse Drug Events
    2. Nosocomial Infections
    3. Decubitus Ulcers
    4. Blood Reactions
    5. Slips and Falls
    6. Restraint Use
    7. Serious Event Reports
    8. DVT/PE

E. A proactive component of the program includes the selection at least every 18 months of a high risk or error prone process for proactive risk assessment such as a Failure Modes

Effects Analysis (FMEA), ongoing measurement and periodic analysis. The selected process and approach to be taken will be approved by the Patient Safety Committee and Quality Council.

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

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

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

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

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

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

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

V. Evaluation and Approval

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

VI. Confidentiality

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

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

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appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

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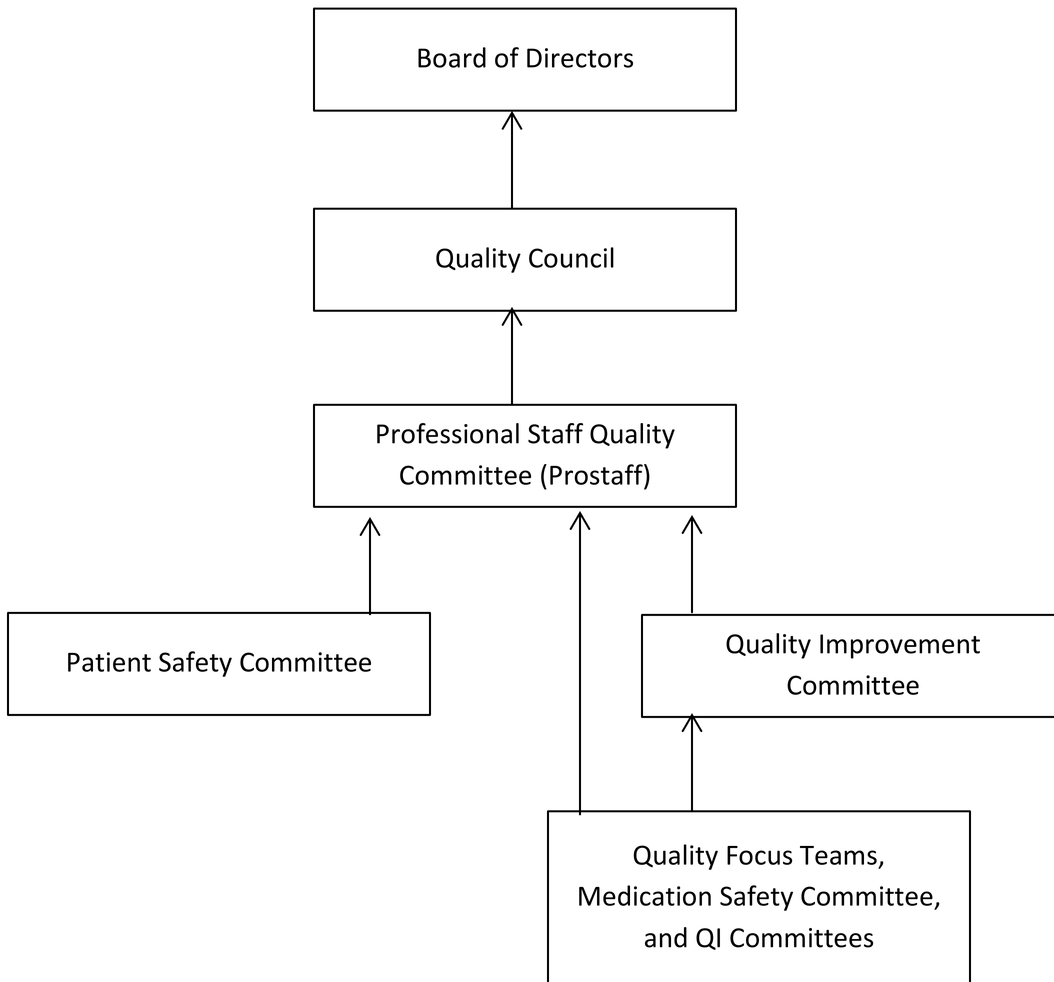
Quality Reporting Structure



Clinical Quality Goal Update

May 2021

FY 21 Clinical Quality Goals

	Jul 20 -Mar 21 Higher is Better	FY21 Goal	FY20	Last 6 Months FY20
SEP-1 (% Bundle Compliance)	74%	≥ 70%	67%	69%

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.

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

Lower is Better	July 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual divided by number expected)	FY21/ FY22 Goal	FY20
CAUTI Catheter Associated Urinary Tract Infection	1	0	1	1	1	1	0	1	0	3	15	0.583	≤0.727 ≤0.676	1.12
CLABSI Central Line Associated Blood Stream Infection	2	1	1	0	1	2	1	2	0	0	10	0.823	≤0.633 ≤0.596	1.2
MRSA Methicillin-Resistant Staphylococcus Aureus	1	3	2	2	1	1	2	2	1	tbd	4-5	3.319	≤0.748 ≤0.727	1.02

*based on FYTD21 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.

CAUTI & CLABSI Near Misses April 2021

Cultures resulted on line patients that did NOT indicate CAUTI or CLABSI infection or criteria was not met after case evaluation

CLABSI Near Miss Event	Amt.	Unit	LOS	CAUTI Near Miss Event	Amt.	Unit	LOS
4/5/2021	1	3W	4	4/3/2021	1	2N	6
4/6/2021	1	3W	19	4/11/2021	1	2S	10
4/8/2021	1	4N	28	4/14/2021	1	4T	34
4/10/2021	2	4S/CVICU	9 & 76				
4/18/2021	1	4N	10				
4/21/2021	1	CVICU	13				
4/23/2021	1	3W	39				
4/27/2021	1	3N	29				
3/24/2021	1	CVICU	13				
TOTAL	10			TOTAL	3		

Key Strategies

Sepsis, CAUTI & CLABSI

- Provider notification of sepsis alert
- Peripheral IV Processes – adding elements to Gemba and evaluating standardization of additional and "just in case" lines
- Retention management processes
- Culture of Culturing
  - Culturing the most likely source of infection:
  - Remove BC on admit to ICU order (sputum cultures rather than blood cultures when respiratory infection suspected)
  - Review all power plans for blood culture orders
  - Culture ordering before previous culture results known
  - Display previous culture results when ordering new culture
  - Culture orders based on fever
    - Develop algorithm to guide ordering practices for providers, draft nursing algorithm drafted
    - Fever workup training for providers, residents and nursing
    - Evaluating color coding of temperature results

Kaweah Health

Key Strategies

MRSA

- Nasal Decolonization – redesigning current process
  - Screening on admission of identified high risk patients
  - Nasal swab MRSA testing of those with positive screen
  - Evaluating hardwiring treatment of positive nasal screens
  - MRSA process compliance results disseminated unit-level
- CHG Bathing – review of process in Med/Surg locations
- BioVigil
  - Transitioning to KD badge use – allows efficient management of system and accurate identification of staff using the system and hand hygiene compliance results
  - Developing a "lunch and learn" for leaders to dive into reports

Questions?

Live with passion.

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

Leapfrog Spring 2021 Hospital Safety Score

Quality Council May 2021

kaweahhealth.org

Kaweah Health

Acronyms

- CAUTI - catheter-associated urinary tract infection
- C Diff - Clostridioides difficile
- CLABSI - central line-associated bloodstream infection
- CPOE – Computerized Provider Order Entry
- Gemba – Observing the work where the work is done
- HAC – Healthcare Acquired Condition
- H-COMP – refers to questions from the Hospital Consumer Assessment of Healthcare Providers Survey
- ISS – Information systems
- PSIs – Patient Safety Indicator
- SP – Safe Practice
- SSI – Surgical Site Infection

Hospital Safety Score Comparison

- Safety score has improved and sustained since May 2020
- Previous to October 2017 Kaweah Health had 6 consecutive A grades

Time Frame	Grade
May 2021	B
Dec 2020	B
May 2020	C
October 2019	C
May 2019	C
October 2018	C
May 2018	A
October 2017	B

Kaweah Health

Key Points

Leapfrog Hospital Safety Grade

Components of the Safety Score

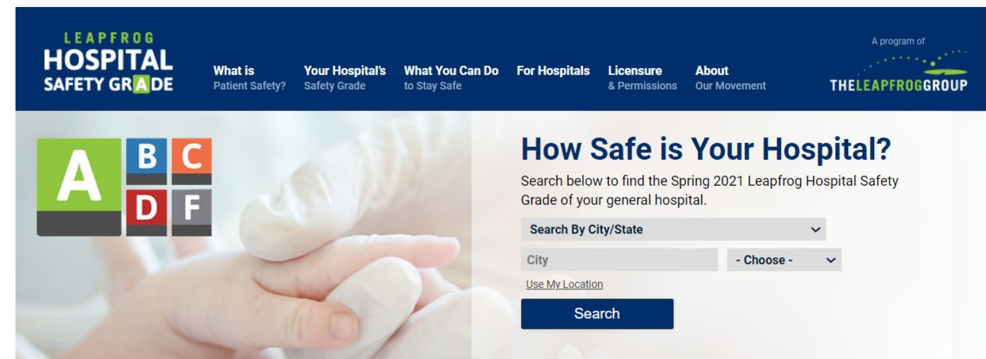
Submitted annually thorough Leapfrog Survey:

- Safe Practices (National Quality Forum)

From Hospital Compare*:

- 5 Patient Experience Measures
- 3 Healthcare acquired conditions (HACs)
- 5 Healthcare acquired infections (HAIs)
- 6 Patient Safety Indicators (PSIs)

*Data date ranges vary



Note:

- Performance on each component is based on a z-score. This means Kaweah's score is dependent on how other hospitals perform which is unknown to any hospital until the day the scores are released to the public.

Kaweah Health Leapfrog Hospital Safety Score 2021 Comparison

Measure Domain	Measure	Final Weight	Fall 2020 Score	Fall 2020 Mean	Spring 2021 Score	Spring 2021 Mean	Data Timeframes
Process/Structural Measures (higher is better)	Computerized Physician Order Entry (CPOE)	6.0%	100	83.53	100	82.19	June 2020
	Bar Code Medication Administration (BCMA)	6.0%	100	83.41	100	81.76	June 2020
	ICU Physician Staffing (IPS)	7.3%	100	60.18	100	60.72	June 2020
	SP 1: Culture of Safety Leadership Structures & Systems	3.2%	120.00	117.26	120	117.30	June 2020
	SP 2: Culture Measurement, Feedback, & Intervention	3.3%	120.00	116.86	120	117.11	June 2020
	SP 9: Nursing Workforce	4.3%	100.00	98.39	100	98.38	June 2020
	Hand Hygiene	4.2%	60	59.10	60	59.22	June 2020
	H-COMP-1: Nurse Communication	3.1%	90	91.05	90	91.03	Q1 (2019) - Q4 (2019)
	H-COMP-2: Doctor Communication	3.1%	89	90.94	89	90.91	Q1 (2019) - Q4 (2019)
	H-COMP-3: Staff Responsiveness	3.2%	85	84.28	86	84.20	Q1 (2019) - Q4 (2019)
	H-COMP-5: Communication about Medicines	3.2%	76	77.74	77	77.52	Q1 (2019) - Q4 (2019)
	H-COMP-6: Discharge Information	3.1%	85	86.50	87	86.49	Q1 (2019) - Q4 (2019)
Outcome Measures (lower is better)	Foreign Object Retained	4.3%	0.065	0.02	0.065	0.02	Q3 (2017) - Q2 (2019)
	Air Embolism	2.5%	0.000	0.000	0	0.0004	Q3 (2017) - Q2 (2019)
	Falls and Trauma	4.6%	0.327	0.43	0.327	0.43	Q3 (2017) - Q2 (2019)
	CLABSI	4.6%	1.071	0.67	1.071	0.67	Q1 (2019) - Q4 (2019)
	CAUTI	4.4%	1.627	0.72	1.627	0.72	Q1 (2019) - Q4 (2019)
	SSI: Colon	3.5%	0.498	0.81	0.498	0.81	Q1 (2019) - Q4 (2019)
	MRSA	4.5%	1.454	0.79	1.454	0.80	Q1 (2019) - Q4 (2019)
	C. Diff.	4.2%	0.291	0.58	0.291	0.58	Q1 (2019) - Q4 (2019)
	PSI 3: Pressure Ulcer Rate	4.0%	0.41	0.58	0.41	0.57	Q3 (2017) - Q2 (2019)
	PSI 4: Death Rate, Surg. Inpatients w/ Serious Treatable Complications	2.0%	168.71	164.47	168.71	164.57	Q3 (2017) - Q2 (2019)
	PSI 6: Iatrogenic Pneumothorax Rate	2.1%	0.30	0.25	0.3	0.25	Q3 (2017) - Q2 (2019)
	PSI 11: Postoperative Respiratory Failure Rate	2.2%	6.66	6.36	6.66	6.36	Q3 (2017) - Q2 (2019)
	PSI 12: Perioperative PE/DVT Rate	2.2%	2.94	3.74	2.94	3.74	Q3 (2017) - Q2 (2019)
	PSI 14: Postoperative Wound Dehiscence Rate	2.0%	0.98	0.91	0.98	0.91	Q3 (2017) - Q2 (2019)
	PSI 15: Abdominopelvic Accidental Puncture/Laceration Rate	2.9%	1.27	1.26	1.27	1.26	Q3 (2017) - Q2 (2019)
	Hospital Safety Score		2.9833		3.0315		

Letter Grade Key: A = >3.133 B= >2.964 C= >2.476 D= >2.047

Kaweah Health Leapfrog Hospital Safety Score 2021 Scenario

Measure Domain	Measure	Final Weight	Spring 2021 Score	Spring 2021 Mean	Scenario	Data Timeframes
Process/Structural Measures (higher is better)	Computerized Physician Order Entry (CPOE)	6.0%	100	82.19	100	June 2020
	Bar Code Medication Administration (BCMA)	6.0%	100	81.76	100	June 2020
	ICU Physician Staffing (IPS)	7.3%	100	60.72	100	June 2020
	SP 1: Culture of Safety Leadership Structures & Systems	3.2%	120	117.30	120	June 2020
	SP 2: Culture Measurement, Feedback, & Intervention	3.3%	120	117.11	120	June 2020
	SP 9: Nursing Workforce	4.3%	100	98.38	100	June 2020
	Hand Hygiene	4.2%	60	59.22	60	June 2020
	H-COMP-1: Nurse Communication	3.1%	90	91.03	90	Q1 (2019) - Q4 (2019)
	H-COMP-2: Doctor Communication	3.1%	89	90.91	89	Q1 (2019) - Q4 (2019)
	H-COMP-3: Staff Responsiveness	3.2%	86	84.20	86	Q1 (2019) - Q4 (2019)
	H-COMP-5: Communication about Medicines	3.2%	77	77.52	77	Q1 (2019) - Q4 (2019)
	H-COMP-6: Discharge Information	3.1%	87	86.49	87	Q1 (2019) - Q4 (2019)
Outcome Measures (lower is better)	Foreign Object Retained	4.3%	0.065	0.02	0.065	Q3 (2017) - Q2 (2019)
	Air Embolism	2.5%	0	0.0004	0	Q3 (2017) - Q2 (2019)
	Falls and Trauma	4.6%	0.327	0.43	0.327	Q3 (2017) - Q2 (2019)
	CLABSI	4.6%	1.071	0.67	**0.832**	**July 1, 2020-Apr 2021**
	CAUTI	4.4%	1.627	0.72	**0.583**	**July 1, 2020-Apr 2021**
	SSI: Colon	3.5%	0.498	0.81	0.498	Q1 (2019) - Q4 (2019)
	MRSA	4.5%	1.454	0.80	1.454	Q1 (2019) - Q4 (2019)
	C. Diff.	4.2%	0.291	0.58	0.291	Q1 (2019) - Q4 (2019)
	PSI 3: Pressure Ulcer Rate	4.0%	0.41	0.57	0.41	Q3 (2017) - Q2 (2019)
	PSI 4: Death Rate, Surg. Inpatients w/ Serious Treatable Complications	2.0%	168.71	164.57	168.71	Q3 (2017) - Q2 (2019)
	PSI 6: Iatrogenic Pneumothorax Rate	2.1%	0.3	0.25	0.3	Q3 (2017) - Q2 (2019)
	PSI 11: Postoperative Respiratory Failure Rate	2.2%	6.66	6.36	6.66	Q3 (2017) - Q2 (2019)
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	PSI 15: Abdominopelvic Accidental Puncture/Laceration Rate	2.9%	1.27	1.26	1.27	Q3 (2017) - Q2 (2019)
	Hospital Safety Score		3.0315	3.1379		

Scenario:
If Kaweah's current CAUTI and CLABSI rates were used to calculate the score Kaweah would receive an "A" grade

Letter Grade Key: A = >3.133 B= >2.964 C= >2.476 D= >2.047

Leapfrog Hospital Safety Score Regional Comparison

Hospitals within 100 Miles	Spring 2021 Grade
Adventist Medical Center - Selma	A
Adventist Medical Center - Hanford	A
Adventist Medical Center - Selma	C
Sierra View Medical Center	C
Community Regional Medical Center	C
Clovis Community Medical Center	C
Saint Agnes Medical Center	C
Kaiser Permanente Medical Center – Fresno	A
Delano Regional Medical Center	A
Madera Community Hospital	A
Bakersfield Heart Hospital	B
Bakersfield Memorial Hospital	B
Adventist Health – Bakersfield	A
Mercy Hospital – Downtown	C
Kern Medical Center	C
Mercy Hospital – Southwest	C
Mercy Medical Center	B
Twin Cities Community Hospital	A
Other Facilities	
Cleveland Clinic -Euclid Hospital	B
Johns Hopkins Hospital	A
University of California Ronald Reagan UCLA Medical Center	B
Harbor UCLA Medical Center	C
Mayo Clinic	A

Kaweah Health

Kaweah Health

Action Summary

Improve and Sustain

- Maintain the CPOE and Safe Practice scores
  - heavy focus in past in ISS clinical decision support tools have lead to success in the CPOE measure, this needs to sustain and group work is established
  - Continued support in full implementation of safe practices which includes: safety culture measurement, dissemination and improvement actions; robust hand hygiene program, regular review and analysis of staffing involved adverse events
- INFECTION PREVENTION
  - Gemba rounds daily to ensure best practices applied daily
  - culture of culturing work
  - MRSA decolonization
  - BioVigil
- Patient Satisfaction improvements with new rounding campaign
- HAC and PSIs:
  - Timely review and action (ie. coding vs clinical issues identified and addressed)
  - Redesign of Hospital Acquired Pressure Ulcer program

Questions?

Live with passion.

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

2021 Star Rating Report

Executive Team

Dr. Tom Gray, Medical Director of Quality and Patient Safety,
Sandy Volchko, Director of Quality and Patient Safety &
Evelyn McEntire, QI Manager

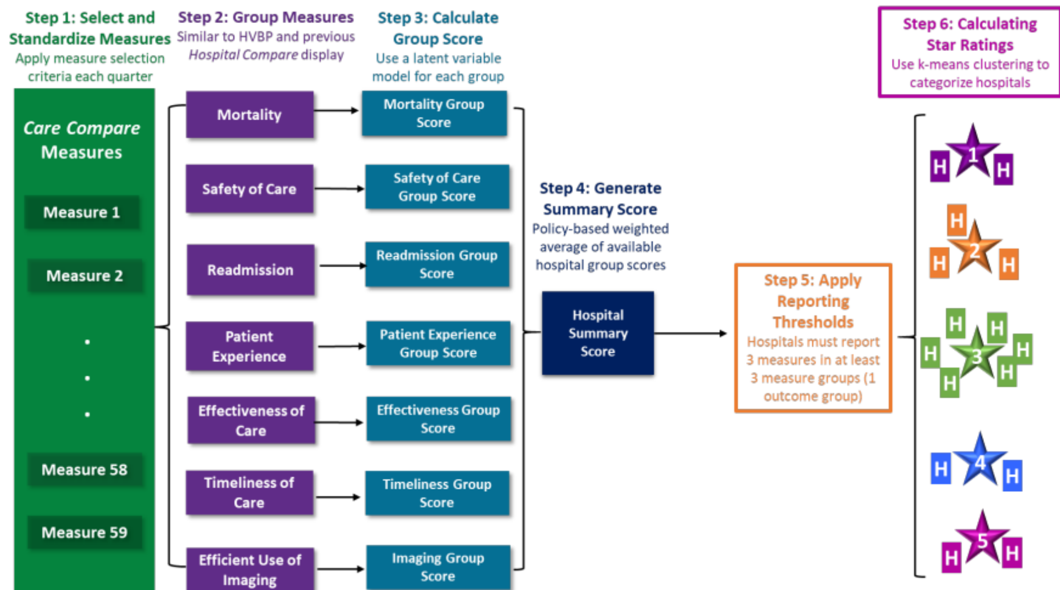
March 2021

OBJECTIVES

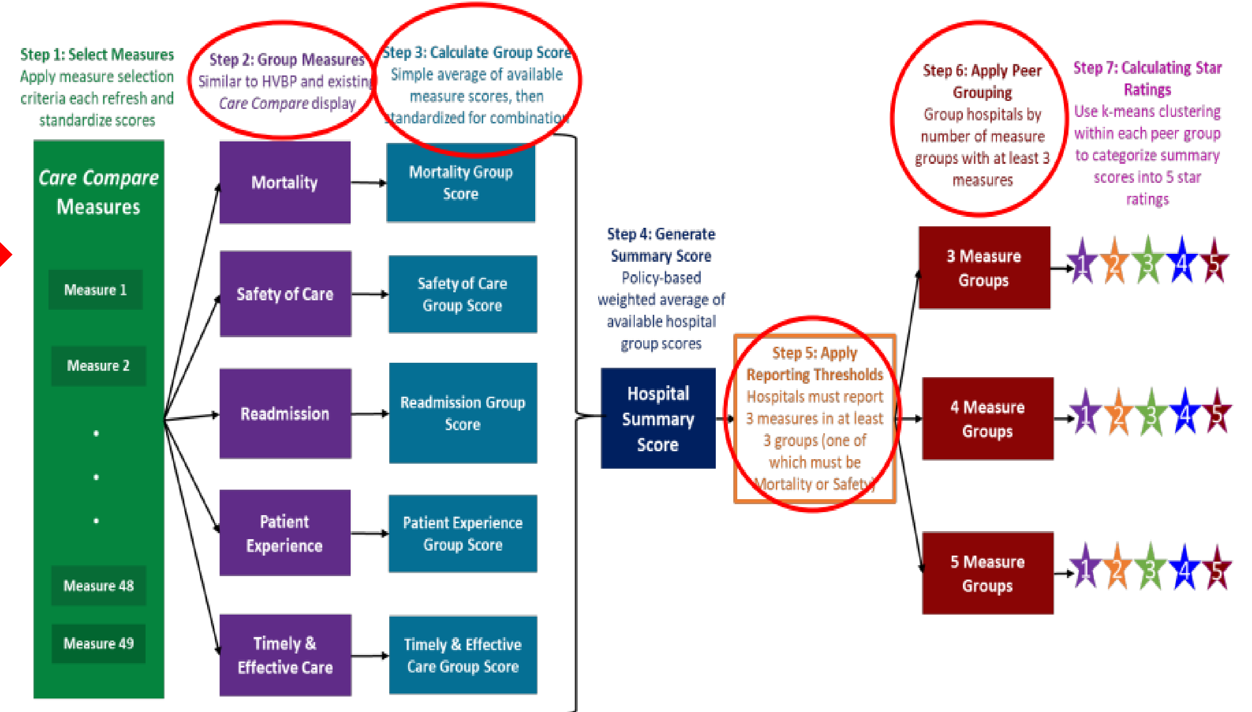
- Methodology changes
  - v3.0 to v4.0 (CMS' first re-design)
- Kaweah Health's Star Rating Results
- Peer Group Comparisons
- Action Plans

METHODOLOGY CHANGES

Prior Overall Star Rating Methodology (v3.0)



New Star Rating Methodology (v4.0)



METHODOLOGY CHANGES CONT.

- CMS continues to use Z-scores to standardize measure scores
- CMS did not use 1Q20 -2Q20 data to calculate the Star Rating due to the COVID-19 pandemic

Star Rating v3.0	Star Rating v4.0
7 measure groups; 49 metrics	5 measure groups; 57 metrics
Latent variable model	Simple average of measure scores
Each measure weighted 22% except Timeliness and Effectiveness of Care weighted 4% each	Each measure weighted 22% except Timeliness & Effectiveness of Care weighted 12% combined
Hospitals must report ≥3 measure groups	Continue with requirement, but one group must be '*Mortality*' or '*Safety of Care*' (125 fewer hospitals qualify)
N/A	Peer Grouping (size, volume, case & service mixes, teaching hospitals) CAH and VA Hospitals now included
N/A	Star Ratings calculated within each peer group (5 measure groups scored against other 5 measure groups)

More than medicine. Life.

Kaweah Delta

KAWEAH DELTA'S JANUARY 2021 STAR RATING (APRIL RELEASE)

Overall Star Rating: -0.56

Overall Hospital Star Rating			
Kaweah's Overall Star Rating		2 out of 5	
Kaweah's Overall Summary Score		-0.56 (worsened from -0.44) / National Average: -0.05	
Measure Group	Kaweah Delta Group Score	National Group Score	Kaweah Delta
Outcome: Mortality	0.02	-0.009	Same as the national average
Outcome: Safety	-0.66	-0.02	Below the national average
Outcome: Readmission	-0.69	-0.002	Below the national average
Patient Experience	-0.68	0.00	Below the national average
Process: Timely & Effectiveness Care	-0.98	0.01	Below the national average

Opportunities

- Safety *(CY19)*: CAUTI
- Readmission *(3Q16 – 2Q19)*: Excess Days in Acute Care after Hospitalization for AMI/HF/PNA
- PX *(CY19)*: Communication with providers / Care Transition / Cleanliness & Quietness
- Timely & Effective Care *(CY19)*: ED Throughput / Colonoscopy follow-up appointments

OVERALL DISTRIBUTION BY PEER GROUPS

- Hospitals by peer group
  - 3-measure: 348 (10%)
  - 4-measure: 583 (17%)
  - 5-measure: 2,509 (73%)

Distribution of Overall Star Ratings by Peer Group – April 2021

Overall Star Rating	3-Measure groups # Hospitals (%)	4-Measure groups # Hospitals (%)	5-Measure groups # Hospitals (%)
★★★★★	35 (10.4%)	39 (7.1%)	381 (15.4%)
★★★★	93 (27.6%)	143 (25.86%)	752 (30.5%)
★★★	111 (32.9%)	194 (35.1%)	714 (29.0%)
★★	72 (21.4%)	144 (26.0%)	474 (19.2%)
★	26 (7.7%)	33 (6.0%)	145 (5.9%)

Kaweah Health

Star Ranking Comparison within 100 miles

1-star	2-star	3-star (national average)	4-star and 5-star
Sierra View Medical Center Kern Medical Center CRMC	KDMC St. Agnes	Adventist Health – Hanford Kaiser Hospital – Fresno Clovis Community	None

ACTIONS TO IMPROVE STAR RATING

Measure Group	Strategy

Safety of Care	• Continue with heightened focus through Quality Focus Teams (Gemba rounds, bath prioritization, EMR enhancements)
	• Provider-focused task force to address:
	  • Culture of culturing
	  • Candidemia and TPN utilization
	• Continued use of Biovigil
	• Reinstituted Surgical Quality Improvement Committee

Readmissions	• Best-Practice Teams: COPD and HF readmissions are prioritized in 2021
Patient Experience	• Launched discharge outcomes calls by JL Morgan • Installation of communication white boards in patient rooms • Scripting for providers when communicating with patients • Leader rounding program
Timeliness & Effectiveness of Care	• LOS Committee – 3 task forces: Discharge rounds, Discharge by 10 a.m., and leadership standard work (report-based action at the unit level) • Resource effectiveness committee under restructure

QUESTIONS?