October 13, 2022

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in a Quality Council Committee meeting at 7:30AM on Thursday, October 20, 2022, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:31AM on Thursday, October 20, 2022, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277, pursuant to Health and Safety Code 32155 & 1461.

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Quality Council Committee meeting at 8:00AM on Thursday, October 20, 2022, in the Kaweah Health Lifestyle Fitness center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

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

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

KAWEAH DELTA HEALTH CARE DISTRICT
Michael Olmos, Secretary/Treasurer

Cindy Moccio

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, October 20, 2022
5105 W. Cypress Avenue
Kaweah Health Lifestyle Fitness Center Conference Room

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

OPEN MEETING – 7:30AM

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

CLOSED MEETING – 7:31AM

1. **Call to order** – *David Francis, Committee Chair & Board Member*
2. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Daniel Hightower, MD, and Professional Staff Quality Committee Chair*
3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 - *James McNulty, PharmD, Director of Pharmacy.*
4. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management, and Ben Cripps, Chief Compliance and Risk Officer.*
5. **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. Diabetes Quality Focus Team Report
    - 3.2. Rapid Response Team Quality Report
    - 3.3. Mental Health Core Measures Quality Report
    - 3.4. Hospice & Home Health Quality Report
    - 3.5. Catheter Associated Urinary Tract Infection (CAUTI) Quality Focus Team Report
4. **Methicillin-resistant Staphylococcus Aureus (MRSA) Quality Focus Team Report –** A review of key metrics and action plans to reduce and prevent hospital acquired Methicillin-resistant Staphylococcus Aureus. *Tendai Zinyemba, MBA, MSMIS, CHESP, Director - Environmental Services. Laundry, & Patient Transport.*
5. **Trauma Committee Report –** Review of metrics submitted to the American College of Surgeons Trauma Quality Improvement Program (TQIP) and improvement actions - *Franklin Martin, RN, Director of Trauma Program*
6. **Clinical Quality Goal Fiscal Year 2023 Review -** A review of current performance and actions focused on the fiscal year 2022 clinical quality goals. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*
7. **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.

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Diabetes Management Committee

Submitted by:
Emma Camarena, DNP, RN, ACCNS-AG, CCRN Director of Nursing Practice
Thomas Gray, MD Medical Director Quality & Patient Safety
Cody Ericson MSN, RN, FNP, CCRN Advanced Practice Nurse-Critical Care Services

Unit/Department Specific Data Collection Summarization

ProStaff and Quality Improvement Committee

Unit/Department: Diabetes Management Committee **Report Date:** October 2022

Measure Objective / Goal:

Glucommander™

The key component of the eGlycemic Management System® from Glytec, Glucommander™ supports intravenous and subcutaneous insulin dosing (and transitions between) for patients with diabetes. Glucommander™ utilizes evidence-based multivariate algorithms to provide care teams with computer-guided dosing recommendations that continuously recalculate and dynamically adjust to each individual patient's blood glucose trends, insulin sensitivities and response to therapy. Surveillance and summary data are accessed through an online platform.

Society of Hospital Medicine (SHM)

Through an annual subscription, Kaweah Health participates in the Electronic Quality Improvement Programs (eQUIPS), a web-based online collaborative program that provides bi-annual performance tracking and benchmarking focused on optimizing care of inpatients with hypoglycemia, hyperglycemia and diabetes. *There are currently no regulatory metrics by which to benchmark results*.

Goal 1 Safety: Achieve benchmark performance for hypoglycemia in Critical Care (CC) and Non-Critical Care (NCC) patient population, defined as percent *patient days* with blood glucose (BG) <70
**Excludes Pediatrics, Post-Partum, Mental Health and Skilled Adult Units*

Glycemic Control:

Goal 2 Achieve benchmark performance for hyperglycemia, defined as percent *patient stays* with weighted mean BG >180 for CC and NCC* patients

Goal 3 Achieve benchmark performance [rank] for mean time between first BG <70 and resolution for CC and NCC* patients

Goal 4 *New* Achieve benchmark performance for percent of patients with hypoglycemia with at least one recurrent hypoglycemic day.

Length of Stay (LOS) *Retiring FY 2023*

LOS metrics for diabetes mellitus (DM) are challenging to identify, as DM is often a significant co-morbidity and not a primary diagnosis upon admission. Centers for Medicare & Medicaid Services (CMS) utilize Medicare Severity Diagnosis Related Groups (MS-DRGs) to assign a specific geometric mean length of stay (GMLOS) to each DRG in their system; the Kaweah Health finance team groups MSDRGs associated with DM and provides summary comparisons of average LOS with GMLOS, identifying average opportunity days and associated cost savings opportunities.

Goal 4 Improve total average length of stay (ALOS) for reported relevant MS-DRGs (602,603,637,638,639,640,641,682,683,684) by 5% over FY20 ALOS

- FY20 ALOS = 3.79 → FYE21 Target 3.60

Date Range of Data Evaluated:

- SHM Reports
  November 2021 – April 2022
- Glytec GlucoMetrics® Reports (dataset includes patients on Glucommander™, *only*)
  April 2022-September 2022
- Length of Stay
  FY 2022

Analysis of Measures / Data: (include key findings, improvements, opportunities)

∅ **GOAL 1** Partially Met: Met the available benchmark statistic for hypoglycemia for CC units (Chart 3) and Underperformed available benchmark statistic for NCC units (Chart 4).

∅ **GOAL 2** Partially Met: Underperformed the available benchmark statistic for CC units (Chart 3) and met the available benchmark statistic NCC units (Chart 4).

Although we continue to partially underperform in Goals 1 and 2, our first 6 months/last 6 months SHM 5-year comparison data demonstrates an overall improvement in both areas (Charts 1 and 2).

- The first 6 months data is from the first 6 months of the last 5 years of data collection
- The last 6 months data is from the most current data

Chart 1: SHM Report for Critical Care and Non-Critical Care Units: first 6 months compared to the last 6 months of data. KH CC and NCC units showed an improvement in percent of days with blood glucose results less than 70% (decrease of 23% and 3.3% respectively)

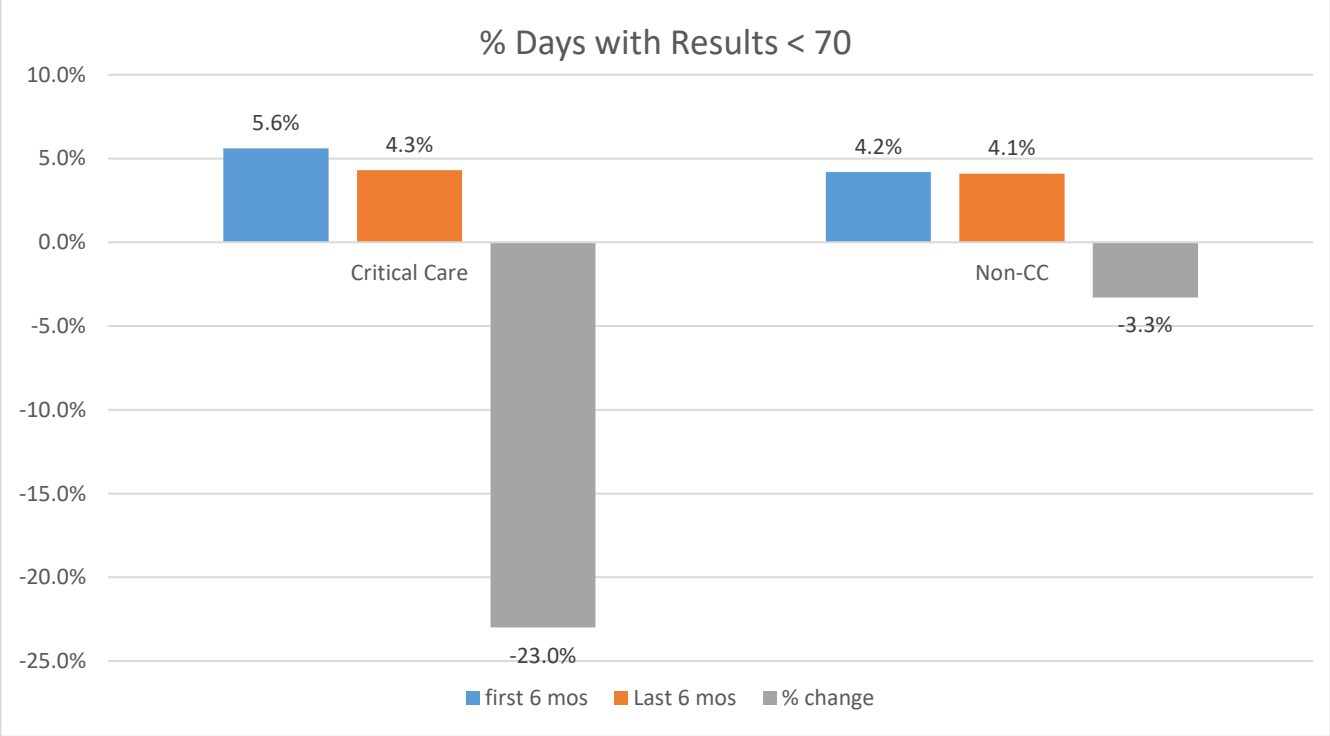


Chart 2: SHM Report for Critical Care and Non-Critical Care Units: first 6 months compared to the last 6 months of data. KH CC and NCC units showed an improvement in % stays with day weighted mean (DWM) greater than or equal to 180 (decrease of 1.4% and 13% respectively)

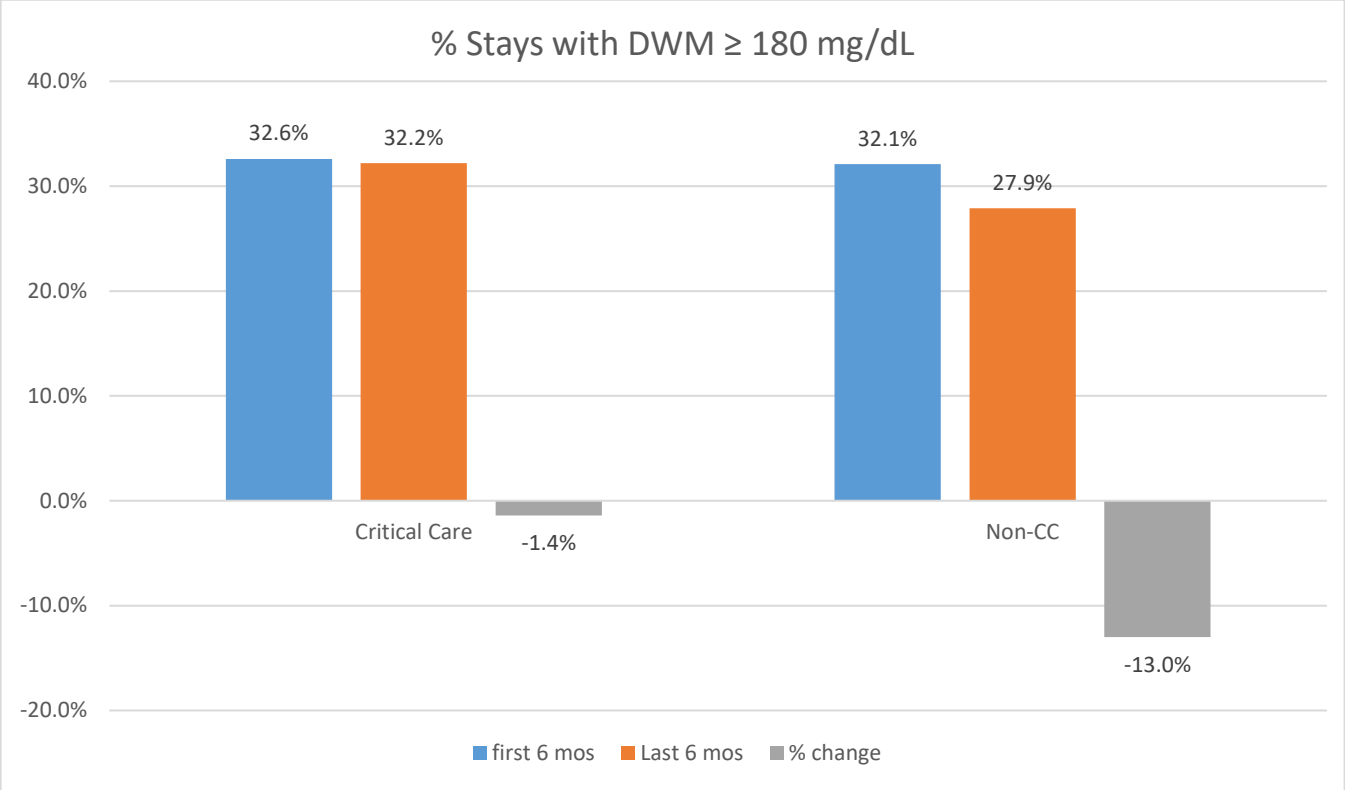
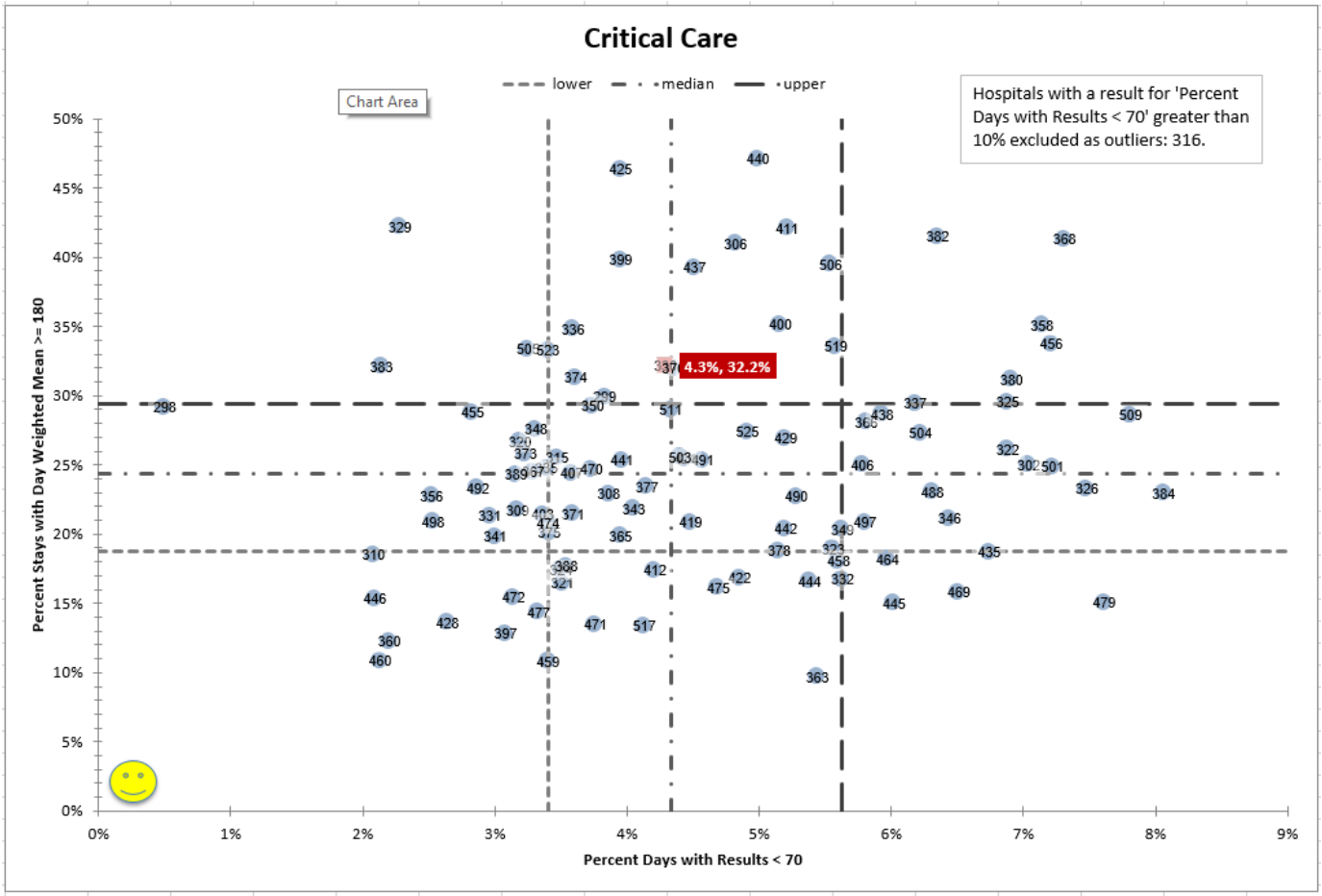


Chart 3– SHM Report for Critical Care Units

(ICU, 3West, CVICU, 1-5Tower)

SHM Scatterplot displays most recent SHM benchmarks for <u>percent of days < 70</u> for hypoglycemia and <u>percent patient stays with day weighted mean blood glucose (BGs) ≥ 180</u> among CC units.

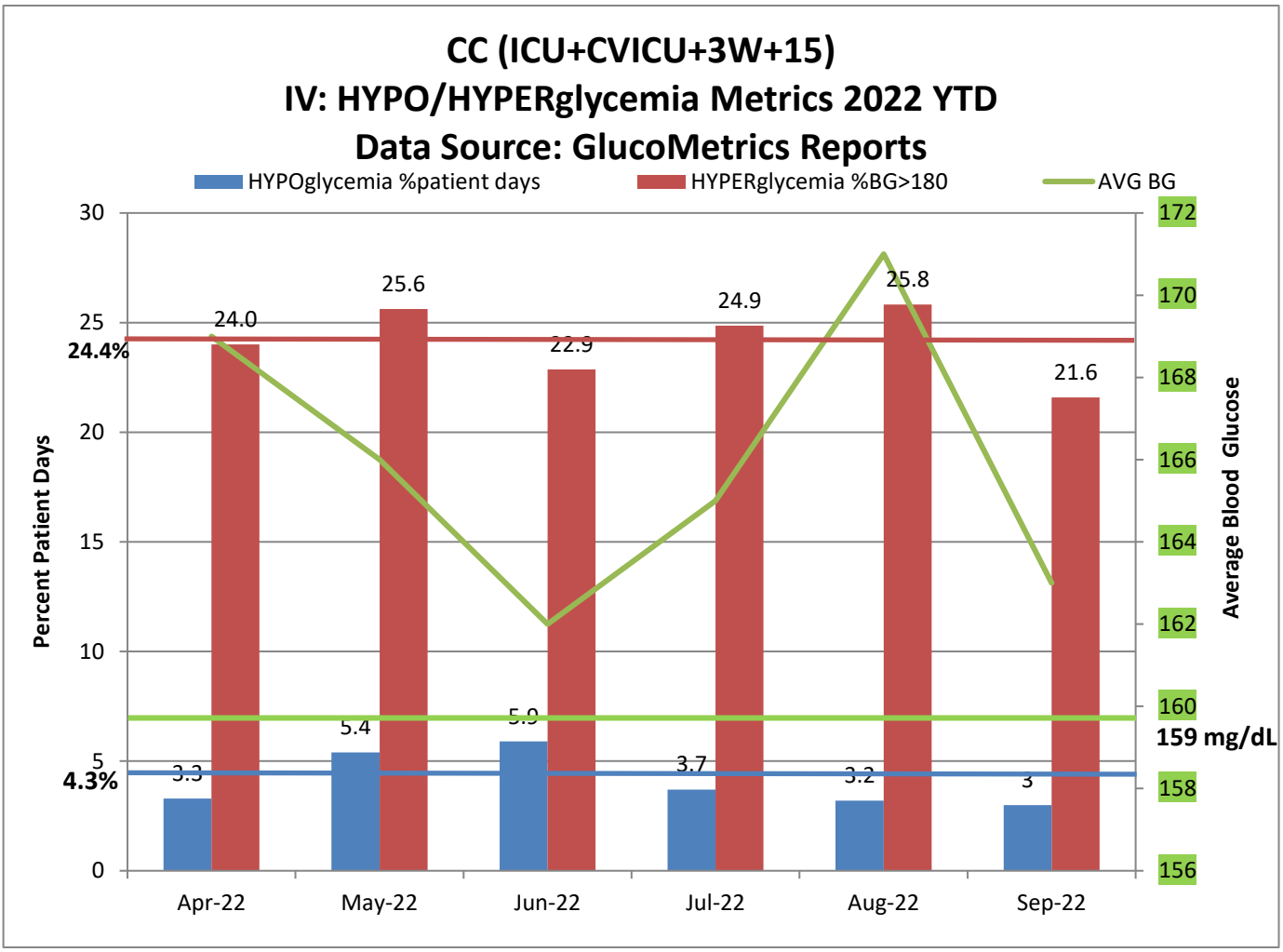
- Hypoglycemia, KHMC CC was at 4.3%, which is an increase from previous reporting interval (4.0%), but met the SHM benchmark of 4.3%
- Hyperglycemia, KHMC CC was at 32.2%, which is above the SHM benchmark of 24.4%
    - In this reporting period, SHM CC hyperglycemia benchmark increased from 23.5% to 24.4%. Although the benchmark was not met, CC experienced a decrease in hyperglycemia from 33.5% to 32.2%.



Graph 1 – GlucoMetrics® Report for Critical Care Units

Displays % patient days < 70 for hypoglycemia, % BGs > 180, and average BGs for 2022 YTD among critical care units for patients **treated with Glucommander™ IV.** *The objective is to decrease both metrics simultaneously.*

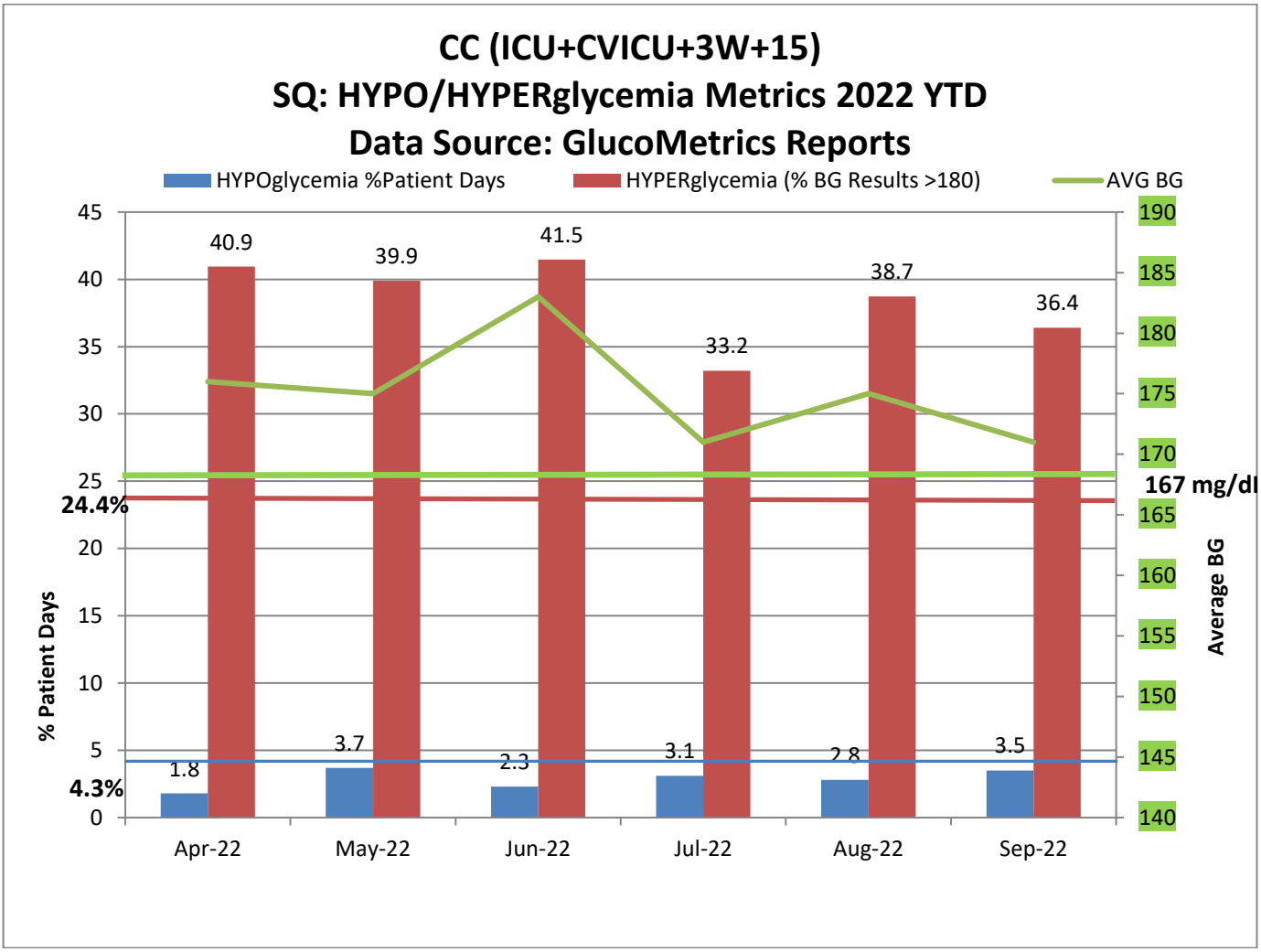
- In the last 6 months, four of the last 6 months hypoglycemia rates were below the SHM benchmark of 4.3%. Hyperglycemia rates (% BG > 180) were below the SHM benchmark of 24.4% for 3 of the last 6 months, with September well below the benchmark. Average BG values were between 161-171 mg/dL.



SHM Benchmarks: HYPOglycemia=4.3% and HYPERglycemia=24.4%

Graph 2 – GlucoMetrics® Report for Critical Care Units
Displays % patient days < 70 for hypoglycemia, % BGs > 180, and average BGs for 2022 YTD among critical care units for patients **treated with Glucommander™ SQ.**

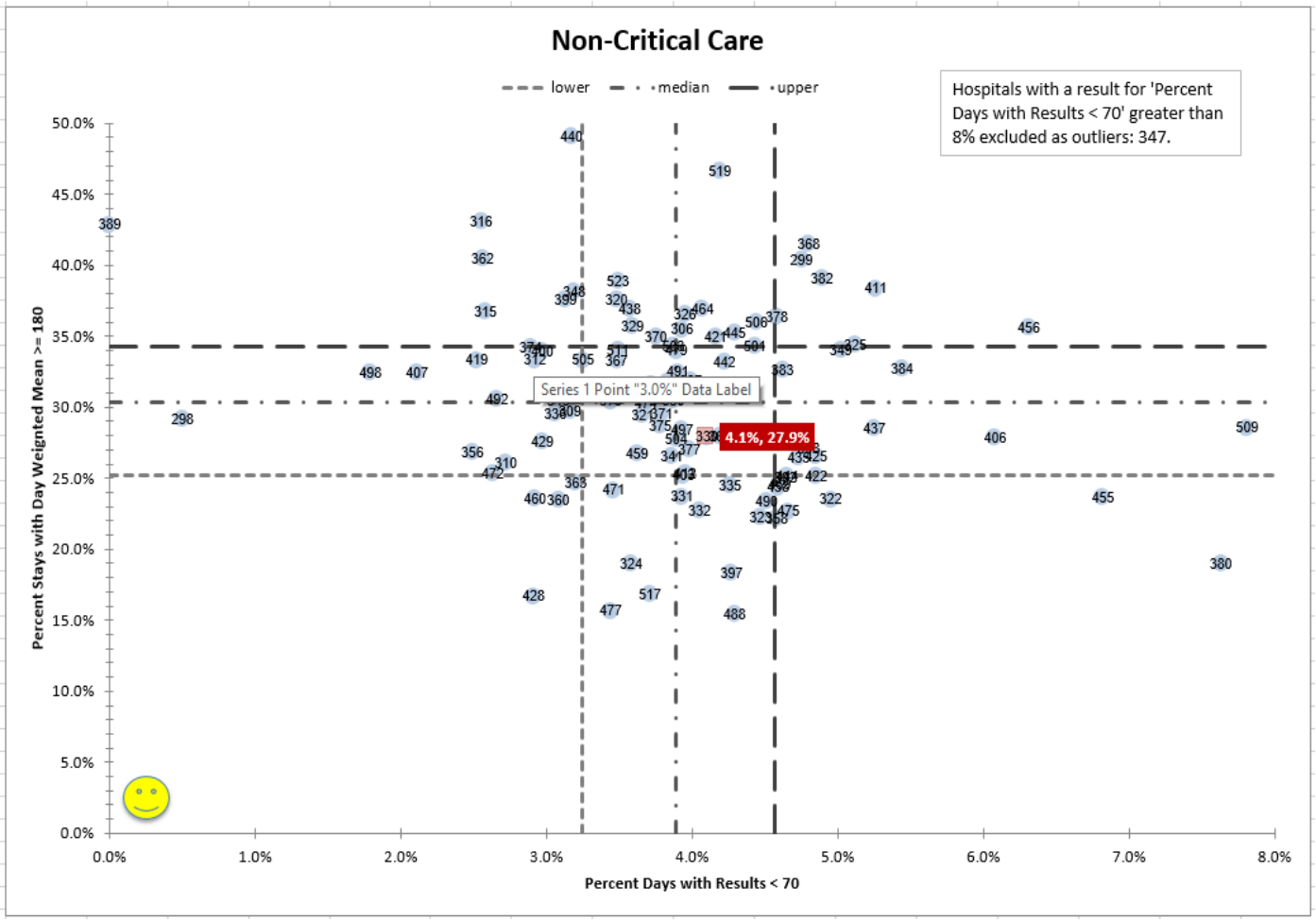
- Rate of hypoglycemia continues to fall below the SHM benchmark of 4.3% from April-September 2022 with a corresponding decrease in hyperglycemia rates.
- CC hyperglycemia % BG results > 180 continues to be above the benchmark, but appears to be on a downward trend for July-September 2022.



SHM Benchmarks: HYPOglycemia=4.3% and HYPERglycemia=24.4%

Chart 2 – SHM Report for Non-Critical Care Units
(1-4Tower, 2North, 2South, 3North, 3South, 4North, 4South, Broderick Pavilion)
SHM Scatterplot displays SHM benchmarks for <u>percent of days < 70</u> for hypoglycemia and <u>percent patient stays with day weighted mean blood glucose (BGs) ≥ 180</u> among NCC units.

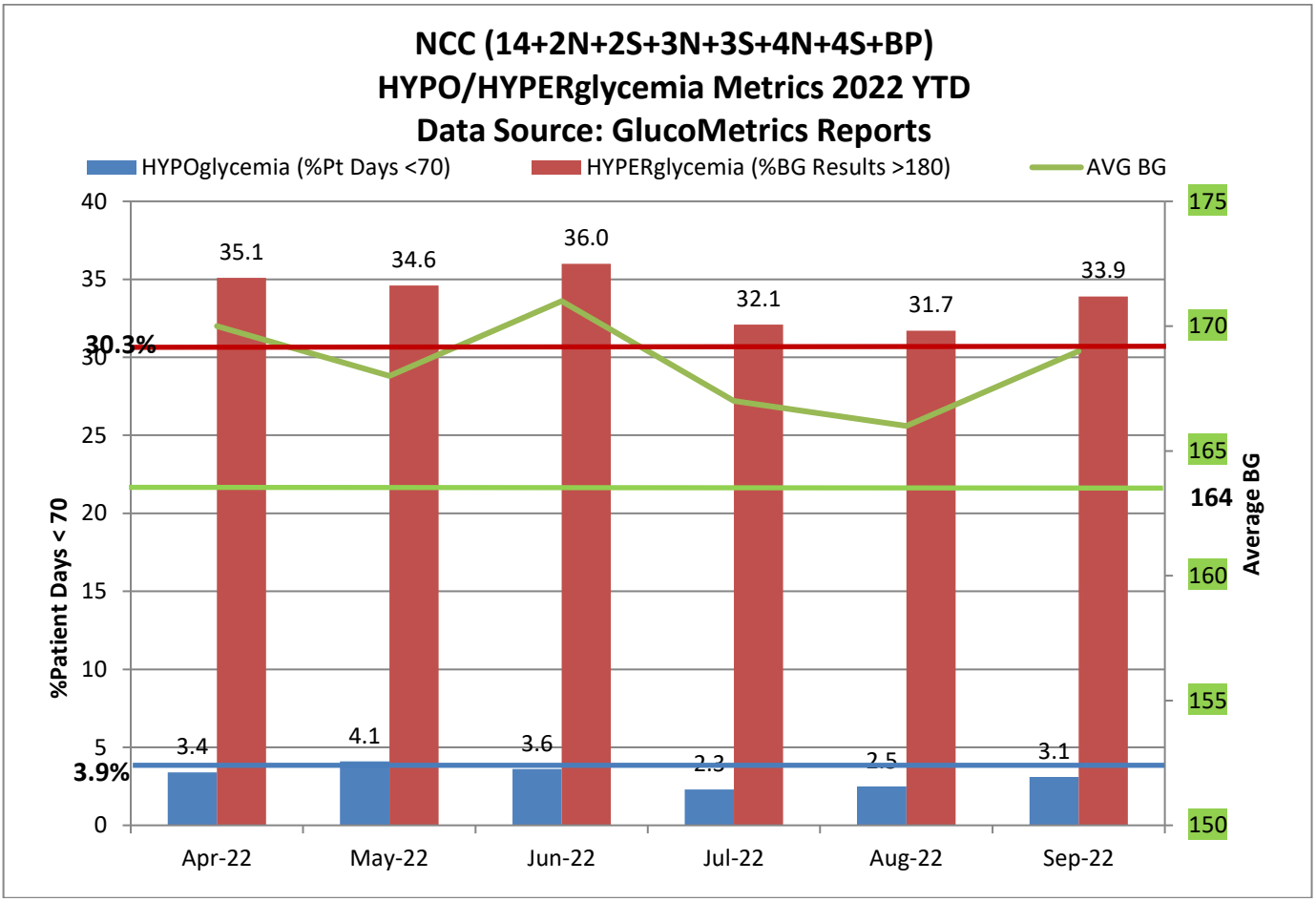
- Hypoglycemia: KHMC NCC was at 4.1%, which is slightly above the SHM benchmark of 3.9%
    - KHMC saw an increase from previous reporting interval (3.9%)
- Hyperglycemia, Of note: KHMC NCC was at 27.9%, which is below the SHM benchmark of 30.3%
    - KHMC improved in the DWM blood glucose ≥ 180 from 32.5% to 27.9% from the previous reporting interval (percentage change of 14.2%).



Graph 3 – GlucoMetrics® Report for Non-Critical Care Units

Displays % patient days < 70 for hypoglycemia, % BGs > 180 and average BGs for 2021 YTD among NCC units for patients **treated with Glucommander™ SQ.**

- Rates for hypoglycemia remain stable with 5 out of 6 months below the SHM benchmark of 3.9%.
- The average hyperglycemia rates stayed below 180 mg/dL but continue to be above the benchmark.



SHM Benchmarks: HYPOglycemia=3.9% and HYPERglycemia=30.3%

- ✓ **GOAL 3** Met: In the last 6 years, KH has met this goal and consistently achieved top quartile performance for resolution of hypoglycemia after initial identification of hypoglycemic event for CC units (Chart 5) and NCC units (Chart 6)

Chart 3 – SHM Report (Nov 2021-April 2022) for Critical Care Units

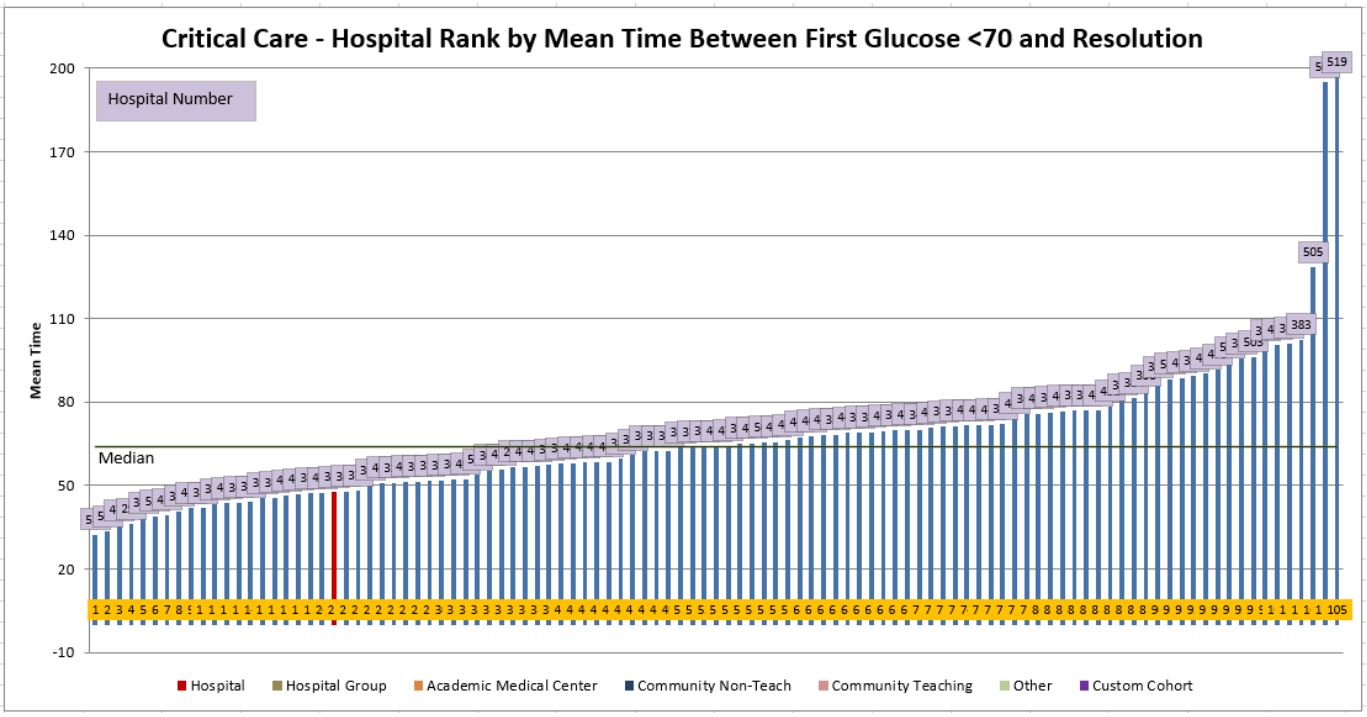
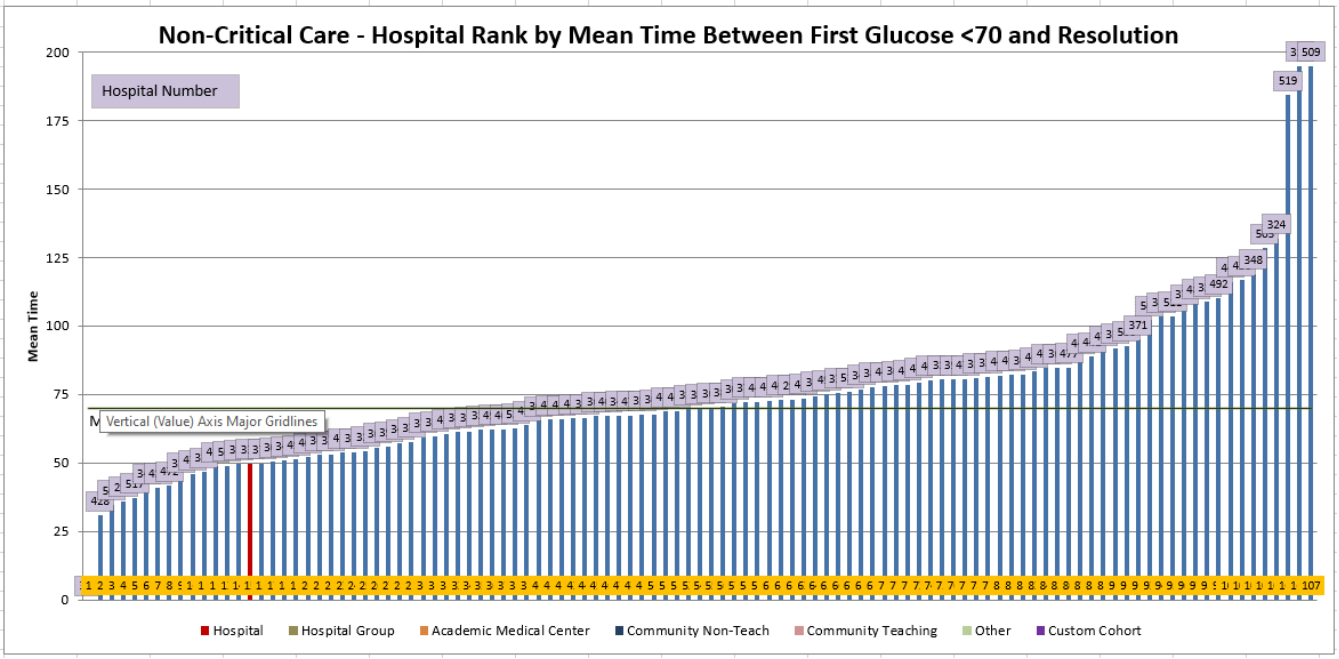


Chart 4 – SHM Report (Nov 2021-April 2022) for Non-Critical Care Units



∅ **GOAL 4** Not Met

- FY22 Average LOS (6.49 through June-2022) increased in comparison to FY21 ALOS of 5.96 (Table 1 REC NonCOVID)
  - Stretch goal: Target/Geometric Length of Stay (GMLOS)= 4.21
  - Cost savings opportunity:
    - FY22 Sum of Cost Savings Opportunity for Diabetes $25,242,184
    - On average, opportunity days each month is ≈ 2.28 days.
    - If LOS were reduced by 2.28 days, *we could save* ≈ $2.1 million/month or > $25 million/year.
  - Opportunity: Reducing ALOS (6.49) to GMLOS (4.21) would save KH $25,242,184 (*Sum of Cost Savings Opportunity July21-June22)*
  - Our goal was to reduce the LOS for patients with Diabetes by 25% but with Diabetes being a co-morbidity rather than a primary diagnosis in many admissions at Kaweah Health, it is difficult to affect the LOS based on diabetes alone. For this reason, we are retiring the LOS measure in FY 23.

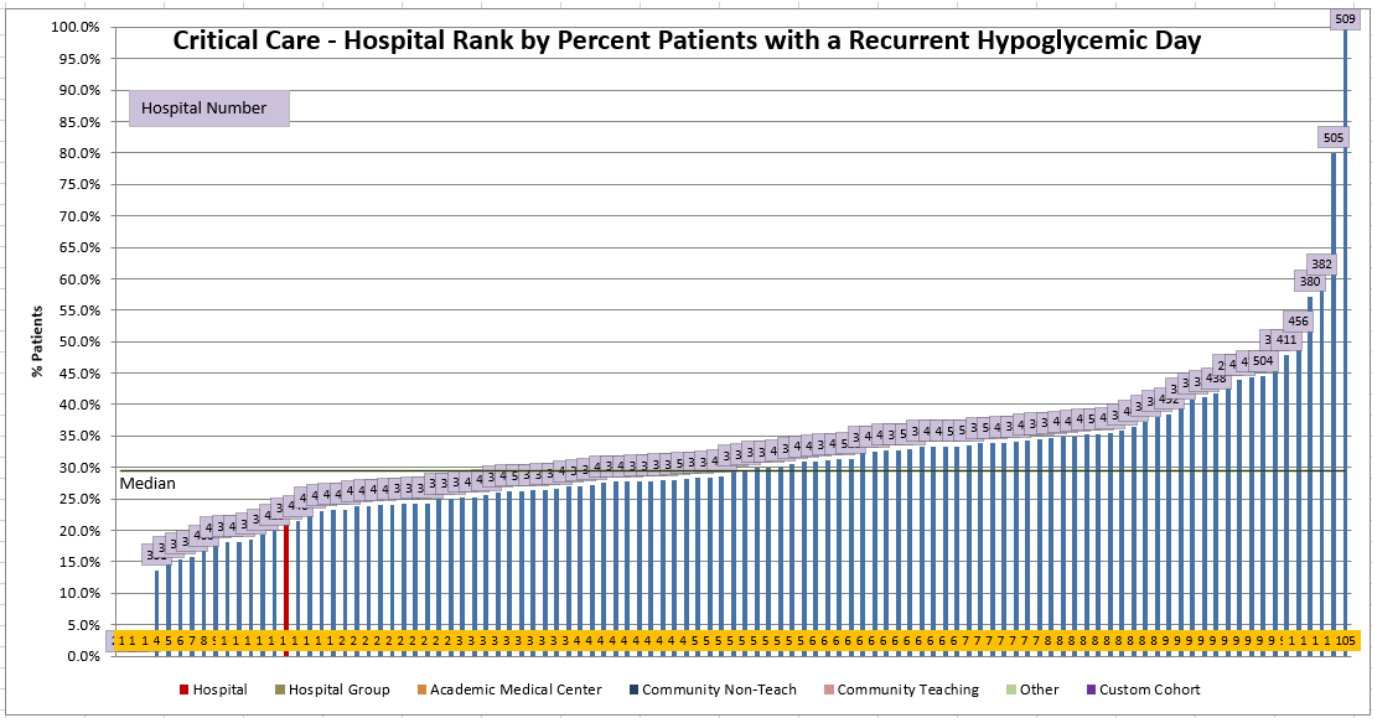
Table 1

Diabetes TC Flag

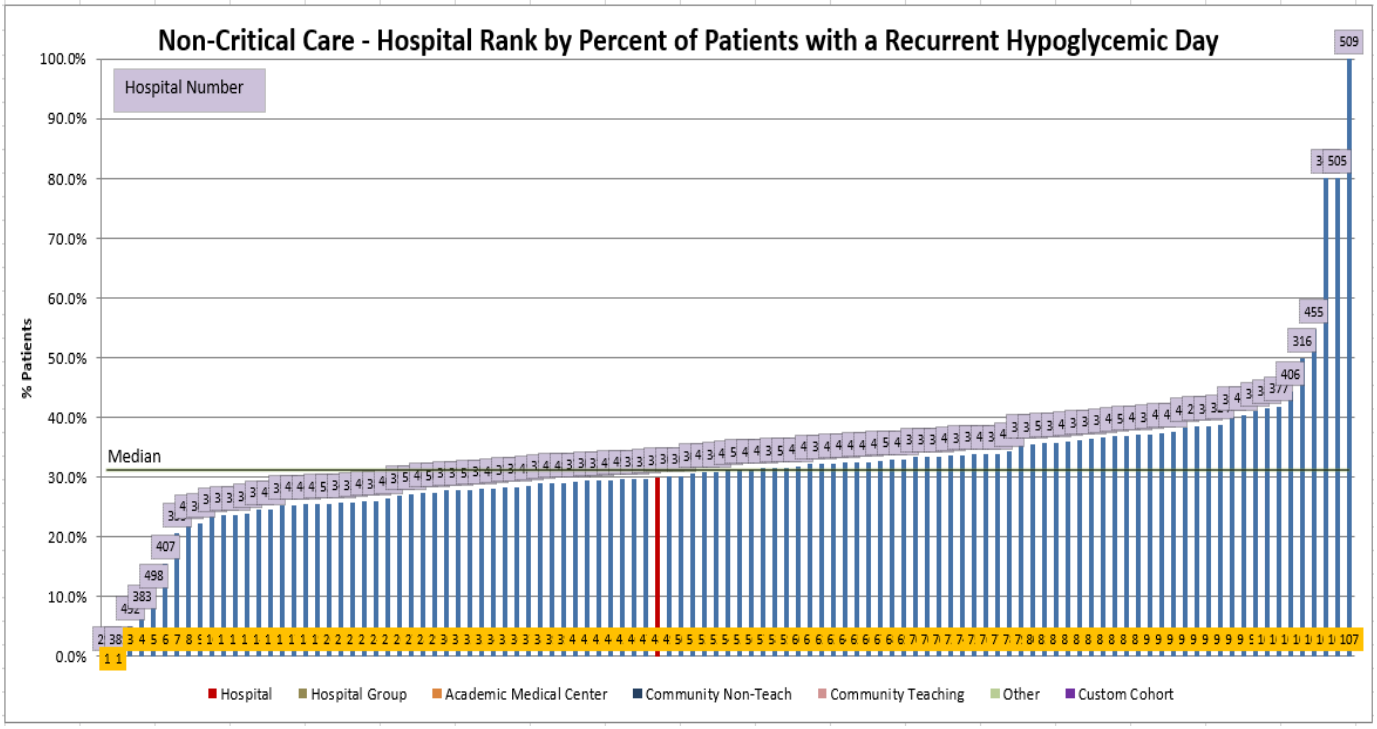
Values

Discharge FY	Discharge Fiscal Period	Sum of Patient Cases	Average of LOS	Average of GMLOS	Average of Oppty Days	Sum of Cost Savings Oppty
2021	July	408	5.42	4.29	1.12	785,795
	August	398	5.26	4.13	1.13	771,239
	September	398	6.26	4.29	1.97	1,502,657
	October	394	5.78	4.34	1.44	1,238,155
	November	370	6.42	4.45	1.97	1,632,047
	December	317	5.89	4.18	1.70	1,275,085
	January	276	6.40	4.52	1.88	1,106,958
	February	339	6.58	4.25	2.33	2,129,641
	March	427	5.41	4.27	1.14	1,754,748
	April	413	6.08	4.26	1.82	1,970,745
	May	398	6.14	4.24	1.90	1,591,942
	June	466	6.14	4.12	2.02	2,277,235
2021 Total		**4,604**	**5.96**	**4.27**	**1.69**	**18,036,246**
2022	July	439	6.43	4.23	2.20	2,580,643
	August	363	6.69	4.28	2.41	2,137,444
	September	376	7.23	4.63	2.59	2,199,927
	October	362	6.01	4.23	1.77	1,853,701
	November	348	6.61	4.18	2.43	1,820,470
	December	405	6.97	4.20	2.77	2,612,046
	January	380	6.22	4.23	1.99	1,833,398
	February	346	6.20	3.89	2.31	1,767,938
	March	402	6.44	4.09	2.35	2,335,126
	April	437	6.01	4.18	1.83	1,855,022
	May	458	6.74	4.27	2.47	2,425,418
	June	411	6.34	4.05	2.29	1,821,050
2022 Total		**4,727**	**6.49**	**4.21**	**2.28**	**25,242,184**
Grand Total		**9,331**	**6.23**	**4.24**	**1.99**	**43,278,431**

NEW: Goal #4: Achieve benchmark performance for percent of patient with hypoglycemia with at least one recurrent hypoglycemic day for CC and NCC patients. CC achieved top quartile for this goal. The percent of patients with a recurrent hypoglycemic day is at 21%, which is better than the top quartile for this SHM measure (≤ 24.3%).



Non-critical care rate is 30%, which is better than the benchmark of 31.2%. Top quartile is ≤ 27.3%.



Improvement Opportunities Identified:

1. The Advance Nursing Practice Team partners with medical staff to foster collaboration and improvement:
    - APN invited by individual Hospitalist to provide diabetes and Glucommander™ education every 2-3 weeks.
    - Established an AMION number for easier access to assist in the optimization of patients on Glucommander™.
    - Collaborating with Glytec for a speaker presentation by Cody Ericson Inpatient Diabetes Management, Advanced Practice Nurse. **Speaking at Time to Target: The Future of Glycemic Management annual conference, Continuous Spotlight Sessions. Conference Dates: October 25-26, 2022.**
2. Exploration of structure, function, impact of consult team developed to respond to needs of nursing and medical staff with goals to
    - Improve glycemic management and patient outcomes
    - Improve knowledge and skillset of nursing, pharmacist and medical staff through education, training, consultative services. Super User training beginning in March 2022 (72 staff)-complete
    - Partner with Food & Nutrition Services to improve carbohydrate intake (carb-consistent diet)
    - Demonstrate return on investment (ROI) through improved throughput, decreased length of stay
        - Inpatient Diabetes Management NP now available through AMION M-F 08-1700. Devotes 2-3 hours daily to reviewing management of targeted cases, 8-10 new cases daily, maintaining a daily caseload of 25-30 patients.
        - Meeting with Sr. Consultant from Project Management & Consulting and Director of Population Health to develop a strategic business plan for the Inpatient Diabetes Management team
3. The Advance Nursing Practice Team reviews and responds to Adverse Drug Events (ADEs) related to hypoglycemia and Glucommander™ (GM), such as:
    - Transcription errors of GM orders to GM
        - Order integration project is in progress to eliminate need for nursing order re-entry; actively working towards MAR and Order integration with Glytec team; Go-Live anticipated Spring 2023
    - Inappropriate selection of modifier / target range
    - Recommendation for Inpatient Diabetes Management Team referral for recurrent hypoglycemia or persistent hyperglycemia or previous history of same
4. Inpatient Glycemic Management team (APN and Endocrinologist)
    - Help to optimize the difficult to manage patients (i.e. Renal, recurrent hypoglycemia, insulin resistant, hyperglycemia >300)
    - Reduce rates of inpatient hypoglycemia/hyperglycemia to or below SHM benchmark
    - Reduce preventable readmissions of high-risk patients with diabetes
    - Partner with key stakeholders to improve perioperative glycemic management
    - Conduct clinical case review for outlier cases

Unit/Department Specific Data Collection Summarization

ProStaff and Quality Improvement Committee

Submitted by:

Emma Camarena, DNP, RN, ACCNS-AG, CCRN
Director of Nursing Practice

Thomas Gray, MD
Medical Director Quality & Patient Safety

Cody Ericson MSN, RN, FNP, CCRN
Advanced Practice Nurse-Critical Care Services

Date Submitted: Oct. 11, 2022

Live with passion.

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

Kaweah Health

RRT/Code Blue ProStaff Report Q2 2022

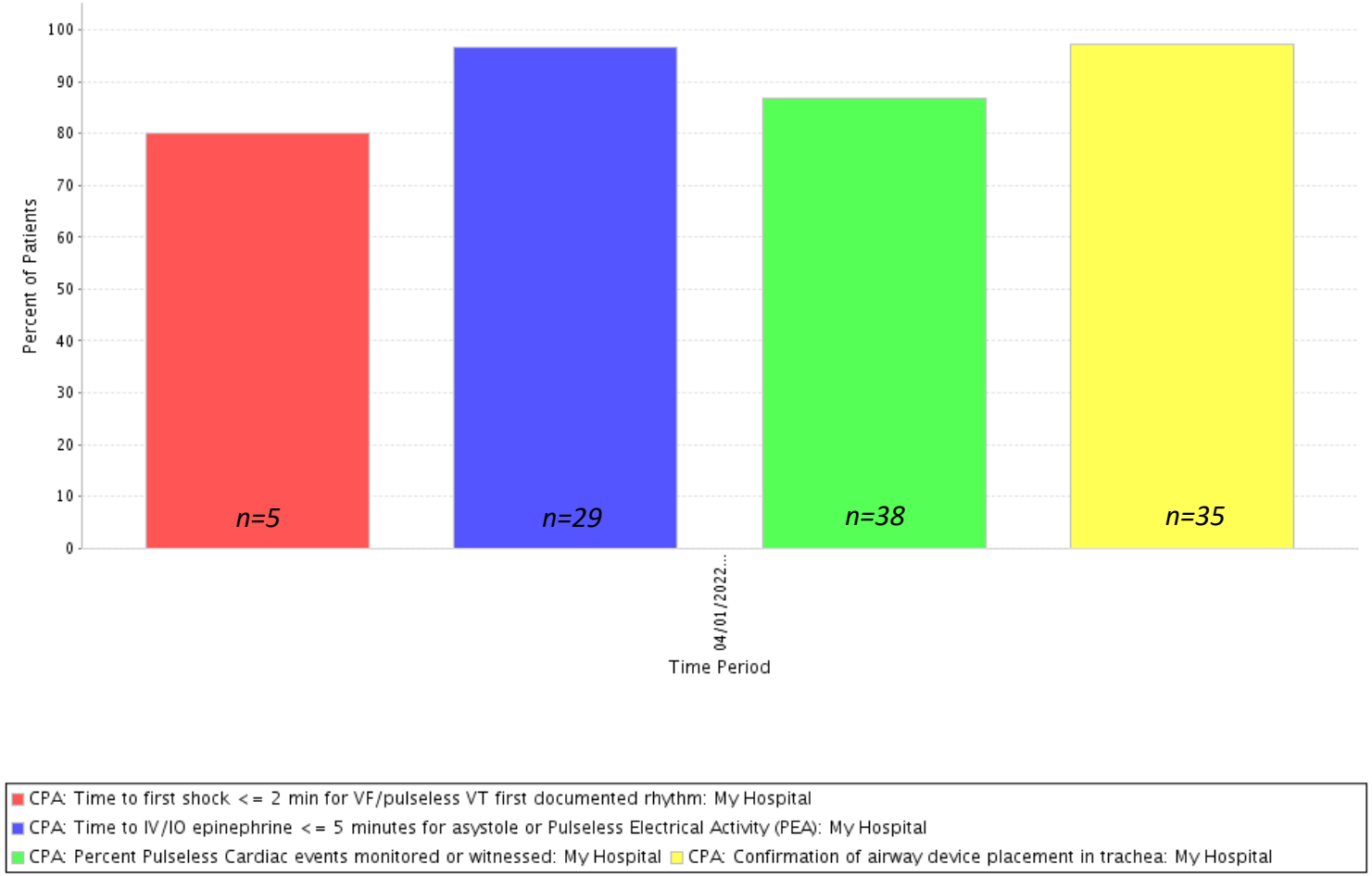
Shannon Cauthen and Stacey Cajimat

The Rapid Response Team Mission Statement

“To facilitate learning opportunities and build relationships with patient care staff to foster a trust that encourages earlier activation of the RRT system.”

GWTG Metrics

April-June 2022= 40 Code Blue Events
(Goal=85%)

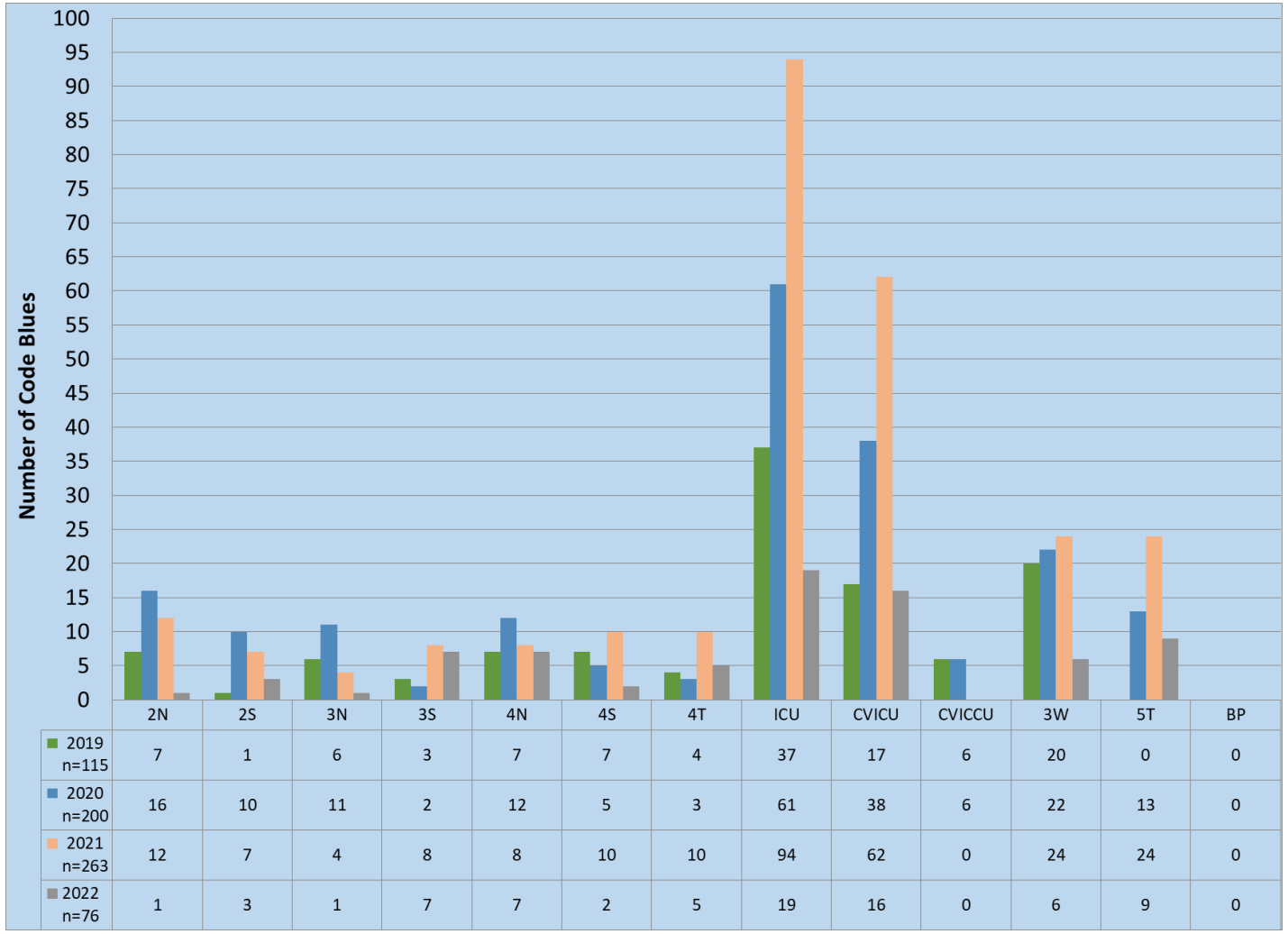


RRT and Resuscitation Scorecard

Measure Description	All GWTG Hospitals (External Benchmark)	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Mean 2021-2022
Code Blue Data														
Total Code Blues		16	15	30	34	37	20	17	16	10	9	9	15	19
Total COVID-19 Positive Code Blues		1	9	13	15	16	8	8	4	2	0	0	3	7
Code Blues per 1000 Discharges Med Surg/ICCU		5	5	6	14	8	3	8	9	3	5	4	3	6
Code Blues per 1000 Discharges Critical Care		7	7	17	12	23	12	4	4	4	3	3	9	9
Percent of Codes in Critical Care	66% (↑ is better)	56%	60%	73%	47%	73%	80%	35%	31%	50%	44%	33%	73%	55%
Code Blue: Survival to Discharge	20% (↑ is better)	19%	0%	7%	6%	3%	10%	0%	13%	20%	44%	11%	7%	12%
Deaths from Cardiac Arrest		6	6	10	14	14	10	9	5	0	3	5	6	7
Overall Hospital Mortality Rate		2.539	3.323	5.279	4.866	6.023	4.105	4.47	4.399	2.632	2.853	2.399	3.094	3.83
RRT Data														
Total RRTS		110	134	185	182	124	110	137	112	103	100	93	115	125
RRTs per 1000 Patient Discharge Days		82	106	145	139	104	85	102	93	77	78	71	90	98
RRT Mortality	21% (↓ is better)	20% n-22	27% n-36	33% n-62	39% n-54	50% n-51	30% n-29	26% n-36	21% n-24	13% n-13	14% n-14	19% n-18	19% n-22	26%
RRTs Within 24 hours of Arriving to Inpatient Unit	15% (↓ is better)	28% n-31	16% n-22	18% n-33	17% n-31	17% n-21	26% n-29	20% n-27	17% n-19	26% n-27	21% n-21	24% n-22	17% n-19	21%
RRT- Med-Surg to Intermediate Critical Care Transfers	9%							12% n-16	16% n-18	9% n-9	18% n-18	14% n-13	21% n-24	15%
RRT- Med-Surg to Critical Care Transfers	29%							8% n-14	9% n-10	11% n-11	10% n-10	6% n-6	23% n-27	12%
RRT-Intermediate Critical Care Transfers to Critical Care	32%							10% n-14	5% n-6	8% n-8	4% n-4	6% n-6	6% n-7	7%

Green	Better than Target
Yellow	Within 10% of Target
Red	Does not meet Target

Code Blues by Location



	2N	2S	3N	3S	4N	4S	4T	ICU	CVICU	CVICCU	3W	5T	BP
2019 n=115	7	1	6	3	7	7	4	37	17	6	20	0	0
2020 n=200	16	10	11	2	12	5	3	61	38	6	22	13	0
2021 n=263	12	7	4	8	8	10	10	94	62	0	24	24	0
2022 n=76	1	3	1	7	7	2	5	19	16	0	6	9	0

Code **Blues** in Critical Care

The goal is to have the majority of our patients arresting in our critical care units which are rich with resources: ACLS staff and providers, Pharmacists specially trained in Critical Care Medicine, and advanced monitoring techniques/equipment.

AHA doesn't consider the Intermediate Critical Care Units to be a CC unit for the purposes of data collection, but as an organization, we believe our ICCUs are among some of the safest places for our patients to be in the event of an arrest so the below percentage is a reflection of that sentiment.

-65% of our code blues occurred in our ICUs and ICCUS. This is a 3% increase from last quarter.

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RRTs by Location

	3W	4S	5T	2S	3N	2N	4N	3S	4T	1E	CVICU	ICU	BP
2019 n=1457	305	212	0	73	134	137	121	151	106	49	59		
2020 n=1563	265	188	159	156	152	147	137	134	85	50	30	23	16
2021 n=1500	210	175	230	137	148	131	110	111	98	103	15	8	22
2022 n=637	71	66	97	52	60	45	49	33	48	76	18	12	10

-21% of all RRTs occur within 24 hours of admission.

-Working with DNP Student and ER nurse, Francis Tesoriere, on a project that would try to reduce the number of RRTs within 24 hours of admission. The proposed project is called ER-STOP (Emergency Room Safer Transfer of Patients).

-4N and 3S have the highest number of code blues for MS units but have the fewest number of RRTs- indicating the need for more education and earlier activation of the RRT system.

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Next Steps: General

- Create educational video, in conjunction with Sim Lab team, that outlines the first steps nursing staff should take during a code blue called “The First 2 Minutes.” Plan to share this video with all nursing staff In-progress
- Conduct a site visit at a medical center with a high-performing RRT program. In-progress
- Recruit and fill Medical Director Position- Vacant since December 2021. In-progress
- Re-instate in-situ mock code blues (high-fidelity when feasible). Point Person- Shannon. In-progress
- Formalization of non-licensed staff and family activated RRT process. On hold.
- Review of Redivus Code Blue App for Consistent Documentation and Data collection. Point person- Evan. On hold.
- Advanced Training for TCAR, CALS, IABP, Impella. Complete
- RRT Partners (all RRT nurses have designated partner unit; attend one staff meeting/quarter to provide education and build rapport. Complete.
- Revised code blue form to easily capture all code blue process elements to meet GWTG standards. Approved by Forms Committee and draft approved. Waiting for them to be printed and dispersed. Point person-Shannon. Complete.
- Go-live with use of AED “Analyze” function in code blues. Point person- Shannon. Complete.

Education Details

- AED Zoll teaching was completed by first week of June. The RRT nurses completed education on all floors/departments in the hospital and the information was well-received. *Have already had one code blue where the patient was shocked before RRT arrival based on this resuscitation initiative!*

- TBTU (Taco 'Bout Training Up) continues quarterly as a show on the road. This quarter (Q3) the topic of discussion will be a refresh on the 10 Signs of Vitality and encouraging nurses to activate earlier!

- TCAR (Trauma Care After Resuscitation)- next course offering November 12th-13th.

Mental Health Core Measures Quality Report

Submitted by:
Melissa Quinonez
Director of Mental Health Services

Mental Health Department Specific Data Collection Summarization

Professional Staff Quality Committee / Quality Improvement Committee

Unit/Department: Mental Health **ProStaff Report Date: 8/29/22**

Measure Objective/Goal:

Monthly Overview

Measure		CMS Standards of Excellence Benchmark	CMS Benchmark / *TJC National Rate	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
HBIPS-1	Admissions Screening	N/A	89.90%	86.36%	86.36%	81.48%	75.00%	78.79%	76.19%	81.48%	85.19%	95.83%	86.21%	88.24%	61.54%
HBIPS-2a	Physical Restraints Overall Rate (down trend positive)	N/A	0.44	0.72	0.708	0.987	0.276	0.767	0.754	0.647	0.858	0.499	0.582	0.723	0.453
HBIPS-3a	Seclusions Overall Rate (down trend positive)	N/A	0.29	0.145	0.46	0.629	0.17	0.185	0.314	0.872	1.077	3.154	0.644	0.202	0.424
HBIPS-5a	Multiple Antipsychotic Medications at Discharge with Appropriate Justification Overall Rate	N/A	58.59%	0.00%	0.00%	100.00%	N/C	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
SUB-2	Alcohol Use Intervention Provided/Offered	N/A	69.92%	90.00%	100.00%	88.89%	91.67%	75.00%	80.00%	87.50%	87.50%	87.50%	84.62%	71.43%	72.73%
SUB-2A	Intervention Provided	N/A	61.76%	40.00%	40.00%	55.56%	66.67%	75.00%	50.00%	62.50%	87.50%	75.00%	66.67%	61.54%	40.00%
SUB-3	Tobacco Treatment Provided/Offered at Discharge	N/A	36.00%	100.00%	100.00%	100.00%	96.55%	100.00%	94.74%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
SUB-3A	Alcohol/Other Drug Use Disorder Tx at D/C	N/A	36.00%	100.00%	100.00%	95.00%	96.55%	100.00%	94.74%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
IMM-2	Influenza Immunization (Oct-Mar)	N/A	80.98%	N/C	N/C	N/C	N/C	N/C	92.16%	98.08%	98.08%	97.96%	98.21%	98.26%	N/A
TOB-2	Tobacco Cessation FDA Approved Provided During Stay	N/A	76.62%	90.32%	84.62%	92.00%	81.08%	82.61%	95.83%	95.83%	100.00%	95.65%	90.48%	91.18%	95.65%
TOB-2A	Tobacco Treatment Provided During Stay (Practical Counseling)	N/A	41.52%	41.94%	23.08%	43.48%	53.13%	23.81%	45.83%	29.17%	51.72%	43.48%	65.00%	69.70%	34.78%
TOB-3	Tobacco Treatment Provided/Offered at D/C	N/A	40.80%	81.48%	63.63%	73.91%	58.62%	50.00%	65.22%	70.00%	53.57%	38.10%	40.00%	66.67%	43.48%
TOB-3A	Tobacco Outpatient Referral & Tobacco Cessation Medication at D/C	N/A	9.52%	32.14%	18.18%	17.39%	20.69%	5.00%	8.70%	0.00%	3.57%	4.76%	10.00%	3.33%	4.35%
CT-2	Care Transitions w/ Specified Elements Received by Discharged Patients	N/A	30.00%	80.77%	81.13%	88.68%	90.57%	96.23%	84.91%	88.68%	92.45%	88.68%	91.23%	89.23%	96.23%
SMD-1	Screening for Metabolic Disorders	N/A	90.00%	100.00%	100.00%	96.67%	100.00%	96.88%	100.00%	90.63%	97.14%	97.06%	92.50%	89.80%	96.97%

Mental Health Department Specific Data Collection Summarization

Professional Staff Quality Committee / Quality Improvement Committee

Kaweah Health
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MENTAL HEALTH QI DASHBOARD

WORKPLACE VIOLENCE EVENTS BY LOCATION (MIDAS)	CY 2019	CY 2020	CY2021	TARGET	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	YTD total events
TOTAL NUMBER OF MH WPV EVENTS	86	86	60	54	4	5	4	7	7	2	29
MH WPV EVENTS PER 1000 PT DAYS	5.02	5.16	4.66	4.19	3.58	3.93	3.21	5.70	4.90	1.55	23
WORKPLACE VIOLENCE FOCUS STUDY	22-Jan	22-Feb	22-Mar	22-Apr	22-May	22-Jun	22-Jul	22-Aug	22-Sep	22-Oct	YTD Total
VERBAL ABUSE	38	17	18	7	20	7	27				96
NON-VERBAL ABUSE/POSTURING	19	22	12	2	6	2	22				66
SELF-ABUSE	14	14	11	5	7	5	10				52
ASSAULT: PATIENT-PATIENT	4	1	1	1	0	1	3				7
ASSAULT: PATIENT-STAFF	18	7	8	5	11	3	13				47
BATTERY: PATIENT-PATIENT	2	3	2	2	0	0	1				8
BATTERY: PATIENT-STAFF	5	0	6	3	3	0	9				21
SECLUSION/RESTRAINT FOCUS STUDY	22-Jan	22-Feb	22-Mar	22-Apr	22-May	22-Jun	22-Jul	22-Aug	22-Sep	22-Oct	YTD Total
PHYSICAL/MANUAL HOLD EVENTS	6	8	9	12	11	10	16				72
MANUAL HOLD TOTAL MINUTES	15	29	27	45	23	25	57				221
RESTRAINT EVENTS	8	11	9	9	9	6	10				62
RESTRAINTS TOTAL MINUTES	85982	1402	1462	1111	1654	784	1217				93612
SECLUSION EVENTS	35	16	10	8	15	6	25				115
SECLUSION TOTAL MINUTES	6349	1282	639	660	1439	517	2381				13267
Hand Hygiene	**Target**	2Q20	3Q20	4Q20	1Q21	2Q21	3Q21	4Q21	1Q22	2Q22	3Q22
Hand Hygiene % compliant	95.00%	40.0%	93.8%	76.1%	96.0%	99.0%	100.0%	100.0%	98.0%	100.0%	

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

Mental Health

	Question	Yes	No	Total	8/12/22-8/18/22	8/05/22-8/11/22
1	Columbia Initial Screening done	20	0	20	100%	100% 20/20
2	C-SSRS shift screen been done every shift	20	0	20	100%	100% 20/20
3	Is the room competed every shift	20	0	20	100%	100% 20/20
4	No excess clothing/linens present in room	18	2	20	90%	90% 18/20
5	RN/Sitter able to identify any remaining ligature risks in room	20	0	20	100%	100% 20/20
6	Moderate: patient is being monitored per policy (Q15 min. checks)	20	0	20	100%	100% 18/18
7	Moderate: Order is present for No sharps are found in patient's room during Gemba.	20	0	20	100%	100% 18/18
8	Moderate: Order is present for Safety Blanket and Safety Blanket is found in room (no regular linen in room, including roommate's bed)	20	0	20	100%	94% 17/18
9	Moderate: Patient risk level noted on assignment sheet.	20	0	20	100%	100% 18/18
10	High: The 1:1 sitter has panic alarm with them, is in the room with the patient and attentive & able to respond or in the doorway if sitter safety is at risk.	N/C	N/C	N/C	N/C	100% 2/2

Mental Health Department Specific Data Collection Summarization

Professional Staff Quality Committee / Quality Improvement Committee

11	High: Sitter can verbalize they are aware of the patient's head and hands at all times and why this is important (strangulation risk under blanket)	N/C	N/C	N/C	N/C	100% 2/2
12	High: The 1:1 sitter has an environmental checklist with them to use as a resource for the shift to keep the room safe for the patient.	N/C	N/C	N/C	N/C	100% 2/2
13	High: Order is present for NO sharps and no sharps are found in patient's room during Gemba.	N/C	N/C	N/C	N/C	100% 2/2
14	High: Order is present for a safety blanket and safety blanket is found in room (no regular linen in room, including roommate's bed)	N/C	N/C	N/C	N/C	100% 2/2
15	High: Order for 1:1	N/C	N/C	N/C	N/C	100% 2/2
16	High: Patient risk level noted on assignment sheet.	N/C	N/C	N/C	N/C	100% 2/2

Comments:
curtains not removed, RN notified to remove
removed curtains

Date: Aug 29, 2022 09:04 BCMA Compliance Report 1 / 1

Facility	Nurse Unit	Total Medications Given	Medications Scanned	Medications Scanned %	Wristbands Scanned	Wristbands Scanned %
KH Mental Health		**87560**	**83405**	**95.25%**	**72691**	**83.02%**
	KHMH AP	52551	50058	95.26%	43079	81.98%
	KHMH PW	35009	33347	95.25%	29612	84.58%
Grand Total		**87560**	**83405**	**95.25%**	**72691**	**83.02%**

Date range of data evaluated:

HBIPS: May 2021-April 2022
Seclusion and Restraints Focus Study: January 2022-July 2022
Hand Hygiene: 2Q20-2Q22
Workplace Violence: January 2019 – July 2022 *new measure
Suicide Prevention (Gemba): August 2022 *new measure
BCMA: January 2022-August 2022

Mental Health Department Specific Data Collection Summarization

Professional Staff Quality Committee / Quality Improvement Committee

Analysis of all measures/data:

Meeting target in 8/12 HBIPS measures. Meeting hand hygiene target. Opportunities for improvement in the following areas:

- Workplace Violence
- Admissions Screening (HBIPS-1)
- Physical Restraints (HBIPS-2a)
- Seclusion Rate (HBIPS 3a)
- Multiple Antipsychotics at discharge (HBIPS-5a)
- Alcohol use Intervention provided (Sub-2a)
- Tobacco Treatment-practical counseling (TOB-2a)
- Tobacco Cessation-Outpatient Referral (TOB-3a)
- Suicide Prevention
- BCMA-Barcode Medication Administration Scanning

Action plan and expected resolution date:

Admission Screening: This measure requires documentation of 2 patient strengths by the admitting RN and documentation of Violence Risk by the Psychiatrist. With action plan items noted below we expect to see improvements in the July 2022 data.

Action Plan:

- Provided education to the RN's and Psychiatrists regarding these requirements.
- Modified the field in Cerner with the language "Select at least 2 strengths".
- The BEH IP Admission power form has been changed to require the psychiatrist to mark Yes or No in the Violence Risk to self/others fields.

Multiple Antipsychotics at discharge: This measure requires documentation of justification for a patient being discharged on more than 1 antipsychotic medication at discharge. With action plan items noted below we expect to see improvements in the August 2022 data.

Action Plan:

- Education provided to the Psychiatrist
- Modification made to Cerner with a pop-up that prompts the psychiatrist to document the justification. This alert went live at the end of July Alcohol use intervention: This measure requires the admitting RN to provide a brief intervention during admission regarding alcohol use if the patient scores at risk during the assessment.

Tobacco Cessation- counseling and outpatient referral: Tobacco measures require the patient to be offered practical counseling and an outpatient referral by discharge. *Please note, if patients refuse, this counts as an outlier. With action plan items noted below we expect to see improvements in the August 2022 data.

Action Plan:

- We have requested changes to Cerner to eliminate some of the options such as "referral not offered" and referral information given, appointment not made" as these are not valid reasons. Staff will now only have the option to select "referral made" or "refused referral".

Workplace Violence: The Mental Health hospital has seen a dramatic increase in Workplace Violence Events in the past several years. Upon reviewing the Workplace Violence Committee data it was found that the actual work place violence events reported to committee was much lower than the actual events occurring at Mental Health. It was determined that the Midas events were being entered under patient behavior and not work place violence. To prevent staff members from entering 2 events on every patient behavior event, Mental Health leadership worked with the Quality Department to develop a focus study to allow us to analyze data and provide a better understanding of the types of events we are facing in our facility. We are now gathering data on verbal abuse, assault and battery with a goal of decreasing these events by 5% in the next 6 months.

Action Plan:

- Continue to educate new employees and coach all employees in the Recovery Model of treatment. This education is now required for oncoming residents.
- Implement Workplace Violence Committee at the Mental Health hospital (began May 2022) and participate in the hospital wide Workplace Violence Committee.
- Increase the frequency of completing the Agitation Behavioral Scale from "when indicated" to every shift; potentially more frequently for patients scoring as a violence risk on the Broset. This became effective in July 2022.
- Continue Focus Study data collection for future analysis.
- All Mental Health staff completed Advanced CPI training this summer.
- Re-test and possibly upgrade Aeroscout Badge Alert system so that staff can wear an audible and trackable badge at all times. Badges were tested at the beginning of August and many required repair. Location testing was completed and several errors were noted. Working with ISS to re-test.
- Advocate for two full time indoor security at Mental Health with officers selected specifically to work with mental health population. Additionally, a second/support officer on the West campus at all times.
- Reconstruct the nurse's station to require badge scanning to enter. Make entry doors higher and counter more difficult to jump over. Several events in the past several months have involved patients coming behind the nurse's station. One event resulting in a staff member being choked and subsequently resigning due to safety concerns.
- Improve Group Program to ensure patients stay busy and focused on recovery
- Work with Tulare County Public Guardian in regards to placement of conserved patients as there has been a correlation between conserved patients and the workplace violence events.
- Debrief of all events in the moment
- Report events in safety huddle and treatment team

Mental Health Department Specific Data Collection Summarization

Professional Staff Quality Committee / Quality Improvement Committee

Seclusion and Restraint Rates: We have remained consistently above the CMS Benchmark/Joint Commission National Rate for seclusion and restraints for the past year. Seclusion and Restraints are considered a treatment failure and used as a last resort when patients are in imminent danger of harming themselves and/or others and less restrictive interventions have failed. The increase in seclusion and restraints seems to correlate strongly with the workplace violence events and many of the action plan items are applicable in both areas. When analyzing the focus study data, it was found that the same 6 patients make up 41.6% of the events. These patients are long term patients, 6/7 of them are conserved patients that are difficult placements. 1 is a frequent admission that will likely be conserved in the future. 4/7 of these patients have self-harming behaviors and/or are developmentally delayed. All of these patients have behavioral issues and assaultive behaviors. Our goal is to decrease time in seclusion and restraints and meet the CMS/TJC benchmark each month.

Action Plan:

- See Workplace Violence action plan above
- Restraint and Seclusion Policy review / Annual Competency Modules assigned to all staff and completed in July 2022

Suicide Prevention: The Mental Health Hospital has been working on a hospital-wide project to improve the process for identification, assessment and proper care of patients found to be at risk for suicide. Our goal is that 100% of patients are assessed for suicide risk and the proper interventions are implemented based on the assessment findings.

Action Plan:

- Service Line Director and Mental Health Clinical Educator participated in Suicide Kaizen
- Ordered and reviewed the 2022 Preventing Patient Suicide publication from the Joint Commission to ensure process was aligned with JC recommendations
- C-SSRS risk assessment training completed for all RN's at Mental Health in July 2022
- Working with ISS to add CSSRS assessment to Cerner and eliminate paper form
- Frequent screener removed from BEH admission assessment due to full assessment being completed on admission for all patients regarding of risk level
- Ligature risk analysis and mitigation completed (and ongoing)
- Suicide Gemba being completed daily and tracked on Huron Rounding. Outliers have included missing order for Safety Blanket and curtains in room with safety blanket order. These issues are being addressed and staff educated in the moment.
- Suicide Prevention education topics have been added to the monthly Mental Health Newsletter

Mental Health Department Specific Data Collection Summarization

Professional Staff Quality Committee / Quality Improvement Committee

Barcode Medication Administration Scanning: Bar Code Medication Administration has improved significantly from 2021. AP unit increased from 78.4% to 95.2%. PW unit increased from 80.4% to 95.2%. Wristband scanning is currently below benchmark for 2022 at 81.9% for AP unit and 84.5 for PW unit. Our goal is to reach 95% compliance with both measures.

Action Plan:

- Intermittently functional bar code scanners have been replaced.
- LPTs and LVNs who did not formally give medications were given scanning access. Our goal is to reach 95% compliance with both measures
- Education for all licensed staff has been added to the Mental Health Newsletter including how to instructions for printing armbands
- Clinical Educator running report monthly and rounding with staff to provide face to face feedback

Submitted by Name:
Melissa Quinonez
Director of Mental Health Services

Date Submitted:
8/29/22

Live with passion.

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

Kaweah Health

Hospice and Home Health Quality Report

Submitted by:
Tiffany Bullock, Director of Kaweah Health Hospice
Shannon Esparza, RN-OASIS Coordinator/Education

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department:
Hospice

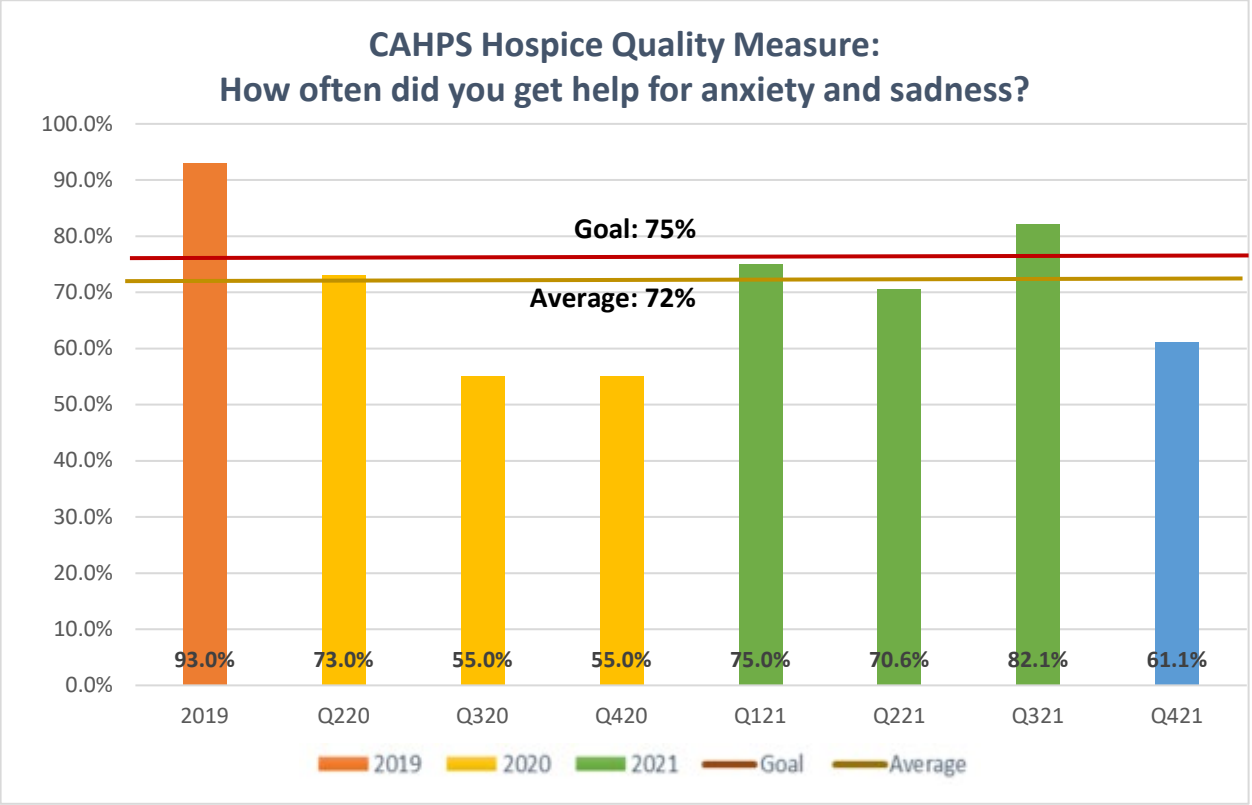
ProStaff/QIC Report Date:
July 2022

Kaweah Health Hospice currently utilizes Percy & Company, a CMS approved third party vendor for distribution of satisfaction surveys and reporting of results. These results have more current, relevant and detailed data than that reported by CMS on Hospice Compare. Therefore, these results were used for analysis. This information will eventually be submitted by Percy & Company to CMS and will be publicly reported.

Measure Objective/Goal:

How often did you get help for anxiety or sadness?

- **Percy & Company data 2020: 64%**
- **Average of Quarter 4, 2020 and Quarters 1-3, 2021 Percy 7 Company: 71%**
- **Average of Quarters 1-4, 2021, Percy & Company: 72%**



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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Date range of data evaluated:

Percy & Company: January 1, 2021 to December 31, 2021

--Data is gathered from the surveys administered by a third party vendor, Percy & Company, as part of the Hospice CAHPS survey. Hospices are required to participate in these surveys, which measures caregiver satisfaction. Information is then submitted to CMS by Percy & Company.

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

--Current data from CY 2020 showed a score on this initiative of 64%. This initiative was chosen as it goes without saying that anxiety and sadness experienced by families/patients during the highly emotional time of losing a loved one or patients coming to terms with their own mortality could be very high. This measure of ensuring help is provided to patients/families for that anxiety and sadness is paramount in the Hospice philosophy. It is because of this philosophy and the lower than desired score, in addition to a significant drop from CY 2019, that we have chosen to focus our attention on this finding. As a result of improvement opportunities being identified and actions being taken, the most recent four quarters shows an improvement of 1% to an average of 72%. This has made a positive change, but we will continue on this initiative in an attempt to reach our goal of 75%.

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

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

--Palliative care specific education, both in the form of modules as well as in person by the Hospice Medical Director to Hospice clinical staff, related to specific topics that would impact this initiative have been instituted. This is to help staff continue to recognize the subtle signs of anxiety/depression in patients/families as well as feel empowered to seek resources that create interventions to make a positive impact on this for patients and families.

--Sharing of progress and statistics at staff meetings to allow discuss on obstacles. Education to staff via projects developed by UBC if needed.

--Immediate intervention by Medical Social Workers and/or Spiritual Counselors when signs of anxiety/depression are noted with families. For those families that decline MSW or SC services, the case manager nurse will revisit allowing MSW and/or SC again at appropriate intervals based on the patient's condition and family acceptance/readiness.

--Rounding by management staff shall be completed on a weekly basis via telephone with patients/families to ensure they feel confident these issues, if any, are being addressed to their satisfaction.

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

Next Steps/Recommendations/Outcomes:

Once interventions have been implemented as outlined above, we shall continue to monitor and analyze Percy & Company over next 4 quarters. Due to the lag time in these reports (approximately 6 months), it may take at least 4 quarters before results of the above-outlined plan are shown.

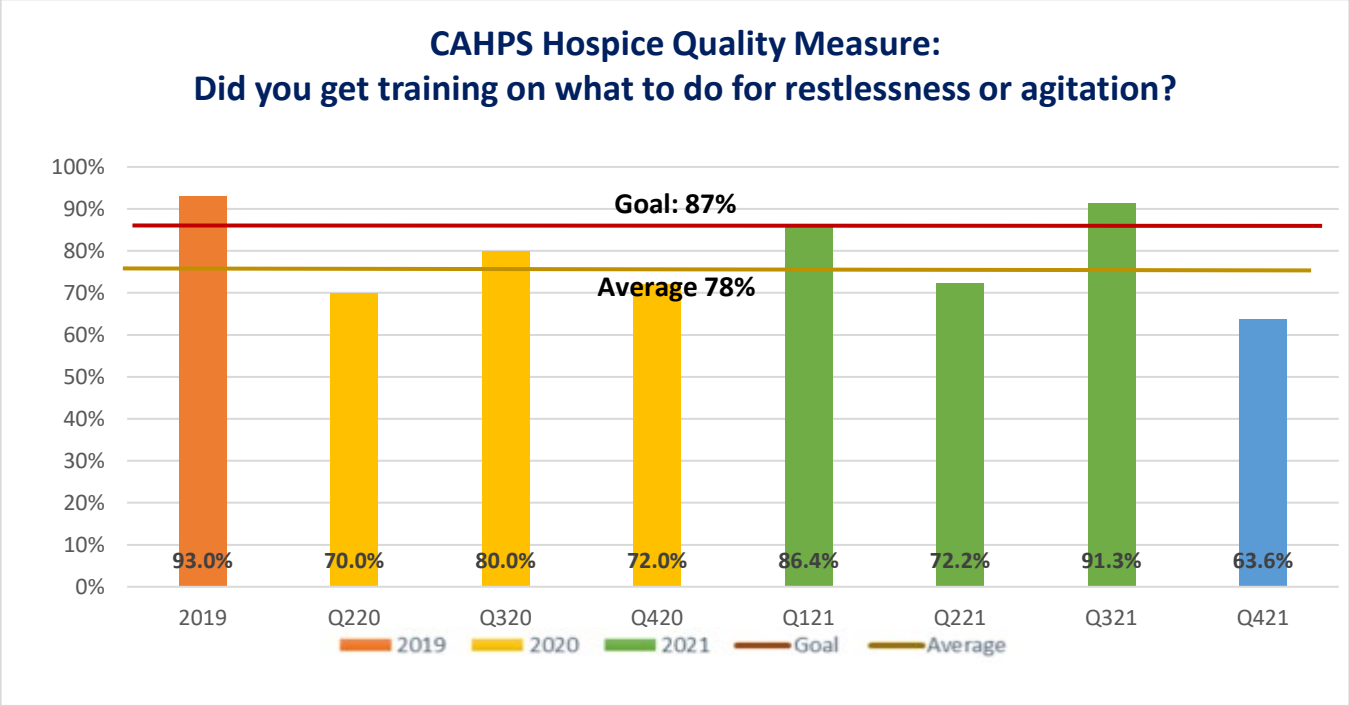
Submitted by Name:	**Date Submitted:**
Tiffany Bullock, Director **Kaweah Health Hospice**	**July 2022**

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

Measure Objective/Goal:

Did you get training on what to do for restlessness or agitation?

- **Percy & Company data 2020: 75%**
- **Average of Quarters 2-4, 2020; Quarter 1, 2021 Percy & Company: 77%**
- **Average of Quarters 1-4, 2021 Percy & Company: 78%**



Date range of data evaluated:

Percy & Company: January 1, 2021 to December 31, 2021

--Data is gathered from the surveys administered by a third party vendor, Percy & Company as part of the Hospice CAHPS survey. Hospices are required to participate in these surveys which measures caregiver satisfaction. Information is then submitted to CMS by Percy & Company and will be publicly reported on Hospice Compare.

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

Current data from CY 2020 showed a score on this initiative of 75%. This initiative was chosen as restlessness or agitation in the final stages of life cannot only inhibit comfort in patients, but can be very emotionally challenging to families who witness this in their loved one. The Hospice philosophy is intended to alleviate suffering and provide comfort measures to allow patients and their families to live out the final stage of life with as much quality as possible. To be unable to manage agitation or restlessness is a barrier to that goal. It is because of this philosophy and the lower than desired score that we

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

have chosen to focus our attention on this finding. As a result of improvement opportunities being identified and actions being taken, the most recent four quarters shows an improvement of 1% to an average of 78%. This has made a positive change, but we will continue on this initiative in an attempt to reach our goal of 80%.

If improvement opportunities identified, provide action plan and expected resolution date:
There is opportunity for improvement in this area. The following plan of action shall be implemented:

-- Palliative care specific education, both in the form of modules as well as in person by the Hospice Medical Director to Hospice clinical staff, related to specific topics that would impact this initiative have been instituted to ensure they feel confident with this education and appropriate interventions.
--Rounding by management staff shall be completed on a weekly basis via telephone with patients/families to ensure interventions can be implemented in real time should any issues be identified through rounding.

Next Steps/Recommendations/Outcomes:

Continue to monitor and analyze Percy & Company over next 4 quarters. Due to the lag time in these reports (approximately 6 months), it may take at least 4 quarters before results of the above-outlined plan are shown.

Submitted by Name:
Tiffany Bullock, Director
Kaweah Health Hospice

Date Submitted:
July 2022

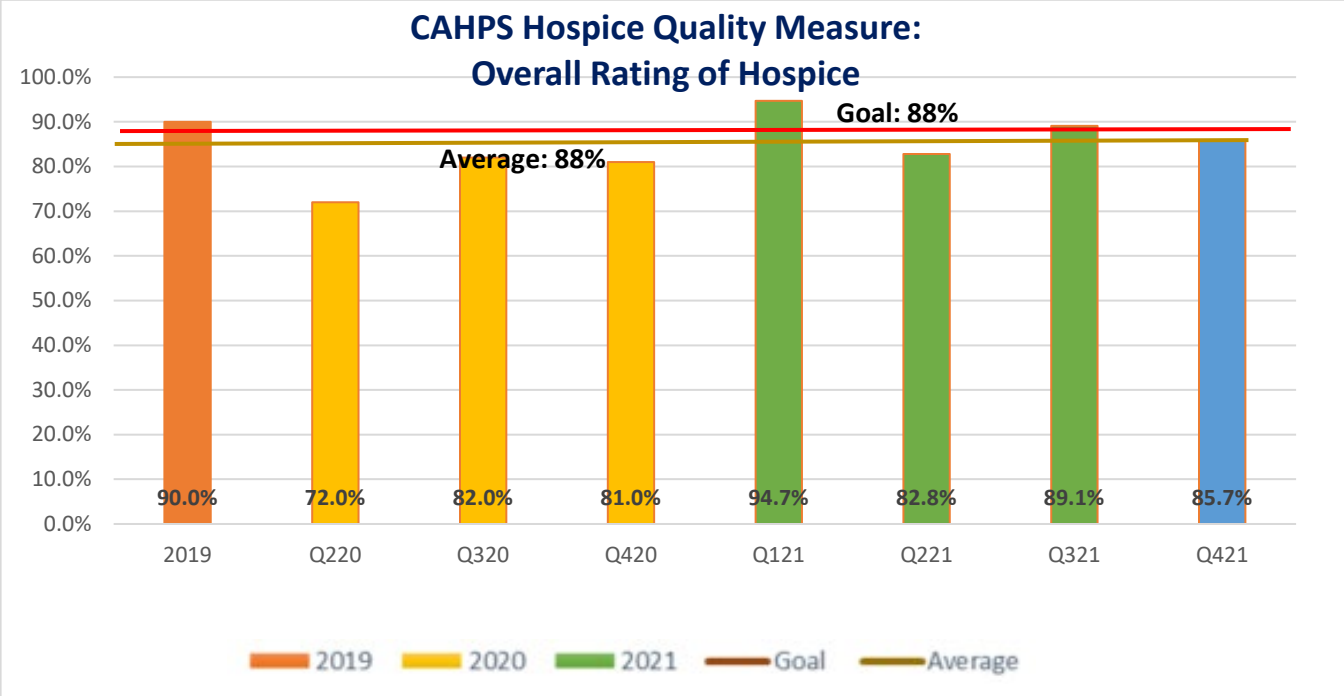
Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Measure Objective/Goal:

Overall Rating of Hospice

- **Percy & Company data 2020: 86%**
- **Average of Quarters 2-4, 2020; Quarter 1, 2021 Percy & Company: 83%**
- **Average of Quarters 1-4, 2021, Percy & Company: 88%**
- **National Average per Hospice Compare, data being reported July 1, 2020 to June 30, 2021 – 81%**



Date range of data evaluated:

Percy & Company: January 1, 2021 to December 31, 2021

--Data is gathered from the surveys administered by a third party vendor, Percy & Company as part of the Hospice CAHPS survey. Hospices are required to participate in these surveys, which measures caregiver satisfaction. Information is then submitted to CMS by Percy & Company and will be publicly reported on Hospice Compare.

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

--Data from CY 2021 shows a score on this initiative of 88%. The goal as set by Kaweah Health Executive Team in conjunction with Hospice leadership on this initiative is 88. In analysis of data, it noted two items were significantly below that goal, more so than all others were. Those two measures are identified above as needing improvement. It is the expectation that by increasing these lower performing measures, the result will be greater

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

overall satisfaction with the services Hospice provides. It is expected this should lead to improvement in this initiative, which is supported by the fact that we have increased slightly in other two initiatives over the last two quarters, as well as an increase in the overall score for the agency from 87% to 88%.

If improvement opportunities identified, provide action plan and expected resolution date:
There is opportunity for improvement in this area. The following plan of action shall be implemented:

--Current CAHPS scores will be a standing agenda item during all staff meetings. This will allow staff to see progress or decline in more real time and allow feedback for suggestions to identify opportunities and interventions for improvement.
--Rounding by management staff shall be completed on a weekly basis via telephone with patients/families to ensure interventions can be implemented in real time should any issues be identified through rounding. This is currently being done.

Next Steps/Recommendations/Outcomes:

Continue to monitor and analyze Percy & Company over next 4 quarters. Due to the lag time in these reports (approximately 6 months), it may take at least 4 quarters before results of the above-outlined plan are shown.

Submitted by Name:	**Date Submitted:**
Tiffany Bullock, Director	**July 2022**

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: **ProStaff/QIC Report Date:**
Home Health **July, 2022**

Due to the public health emergency declared in March 2020, the Centers for Medicare & Medicaid Services (CMS) froze the data reported on the Care Compare website, the platform for which quality measures are publicly reported for home health agencies quarterly. In April 2022, the website resumed publically reporting on four rolling quarters of data; Q3, 2020 thru Q2, 2021. The next refresh to Care Compare will be July 2022, covering Q4, 2020 thru Q3, 2021. KH Home Health is currently at a 3-Star rating, out of a 5-Star rating system.

In order to ensure the most current and relevant data for analysis in this report, information was obtained from Internet Quality Improvement and Evaluation System (iQIES), a CMS platform that allows Medicare-certified home health agencies to view quality reports based on the Outcome and Assessment Information Set (OASIS) data submitted by that agency.

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

Measure Description:
How often patients got better at walking or moving around

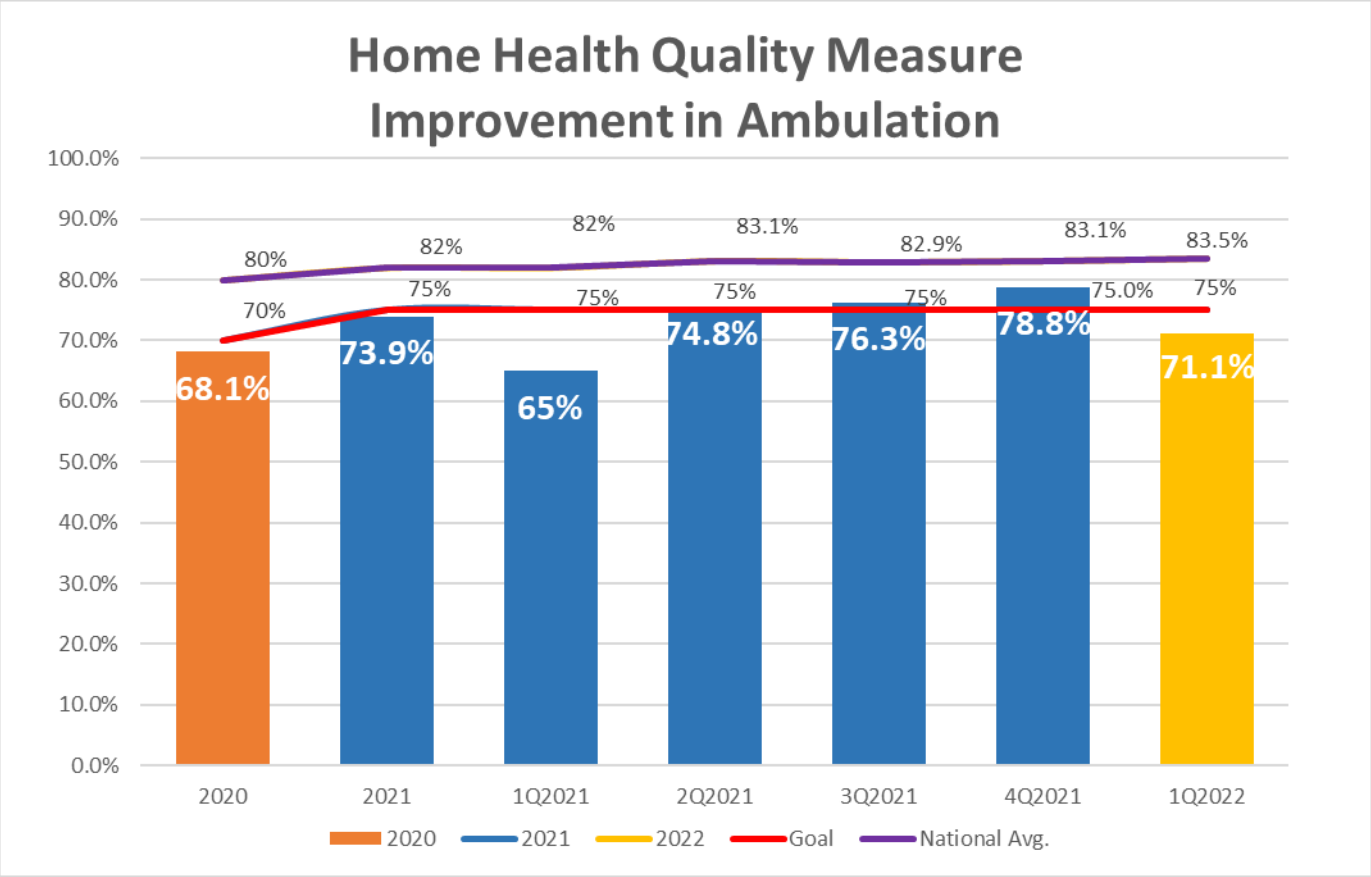
--Home Health Clinicians (registered nurses, physical therapists) complete OASIS data upon a patient's admission to home health. Clinicians must assess the patient's ability to walk SAFELY on a variety of surfaces using a 6-point scale; ranging from 0-independent to 6-bedfast. At discharge, the patient's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

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

Measure Objective/Goal:

***Improvement in Ambulation/Locomotion*;**

- **iQIES data Quarter 3, 2021: 76.3%**
- **iQIES data Quarter 4, 2021: 78.8%**
- **iQIES data Quarters 1, 2022: 71.1%**



**Higher percentages are better for this measure. Graph depicts the last 4 quarters as individual quarters to accurately assess response to previous interventions and guide upcoming action plan*

Date range of data evaluated:

- **CMS Star Report July 2022; Oct 1, 2020 to September 30, 2021**
- **iQIES data; Q3 & Q4, 2021 and Q1, 2022**

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

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

--CY 2020 data at 68% was below the National Average of 75% for all reporting home health agencies. Opportunity for improvement in this area existed and a multifocal plan was executed that included two additional outcome measures to help ensure overall *Outstanding Community Health* consistent with Kaweah Health District Pillar.
--Clinician barriers to accurate assessment; assessing in home environment (clutter, need for equipment to help with mobility), and understanding of ability vs *safe* ability.
--Charting fatigue for clinicians reported as reason for inconsistencies in scoring OASIS accurately. OASIS questions focusing on ambulation are located near the end of a lengthy assessment. An attempt was previously made to 'move up' the OASIS sections related to ambulation but per our EMR software, this is not possible.
--Clinical documentation review indicated OASIS inconsistencies by the discipline of the clinician assessing.
--Staffing challenges related to unexpected leave of absences presented workflow challenges with timely auditing.

<u>If improvement opportunities identified, provide action plan and expected resolution date:</u>
There is an opportunity for improvement in this area. The following plan of action shall be implemented;
-- Input from UBC assisted Home Health Educator in creating an "OASIS ADL/IADL" decision tree. Tool will be used when assessing patient's ability to safely obtain medications and adhere to their medication regimen.
--Educator and Intake Utilization RN will review data from clinician charting and OASIS for inconsistencies and meet with clinician to provide immediate feedback.
--Clinicians will utilize the "5 Day Rule" allowed by CMS. CMS encourages a collaboration between all clinicians who assessed a patient within 5 days of the first OASIS assessment. This will ensure accurate capture of a patient's need and the opportunity to provide the resources needed to help achieve *Outstanding Community Health* consistent with the Kaweah Health District pillar.
--Educator will meet with Intake Utilization RN and field RN who assists with audits, bi-weekly to provide feedback on OASIS inconsistencies.
--Education to all staff on use of OASIS "scrubber" at July staff meeting.

<u>Next Steps/Recommendations/Outcomes:</u>
Educator and RN Intake Auditor will monitor the effectiveness of these interventions weekly during chart audits. Educator will report these findings along with trends to Home

Health Manager at least every 30 days. Educator will analyze OASIS outcome data reports for this measure quarterly and report to Home Health Manager and Director. Educator and Home Health Manager will modify interventions until we meet, or exceed, the national average for three or more quarters.

Submitted by Name:	**Date Submitted:**
Shannon Esparza, RN	**July 2022**

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: **ProStaff/QIC Report Date:**

Home Health **July 2022**

Due to the public health emergency declared in March 2020, the Centers for Medicare & Medicaid Services (CMS) froze the data reported on the Care Compare website, the platform for which quality measures are publicly reported for home health agencies. In April 2022, the website resumed publically reporting on four rolling quarters of data; Q3, 2020 thru Q2, 2021. The next refresh to Care Compare will be July 2022, covering Q4, 2020 thru Q3, 2021. KH Home Health is currently at a 3-Star rating, out of a 5-Star rating system.

In order to ensure the most current and relevant data for analysis in this report, information was obtained from Internet Quality Improvement and Evaluation System (iQIES), a CMS platform that allows Medicare-certified home health agencies to view quality reports based on the Outcome and Assessment Information Set (OASIS) data submitted by that agency.

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

Measure Description:

How often patients got better at bathing

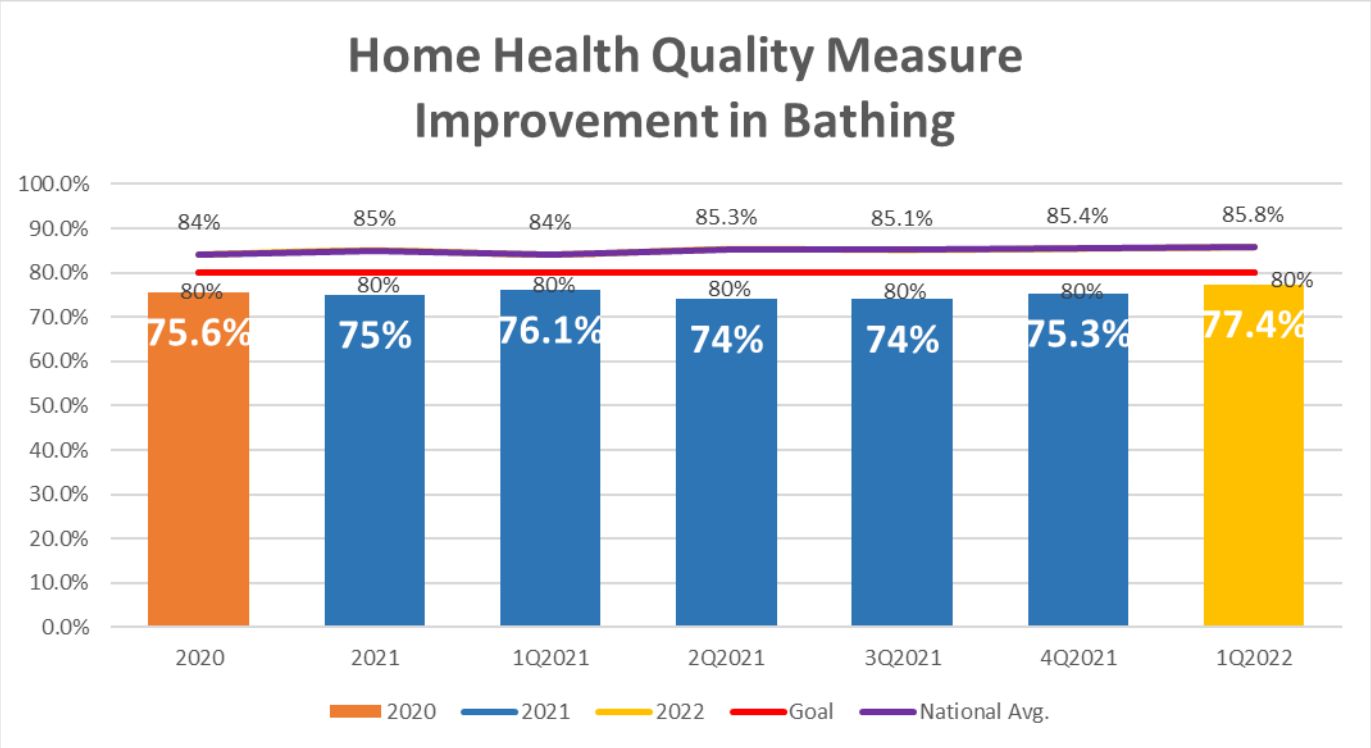
--Clinicians (registered nurses, physical therapists) complete OASIS data upon a patient's admission to home health. A patient's current ability to bathe entire body and the assistance that may be required to safely bath including transferring in/out of the tub/shower, is measured upon admission to home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

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

Measure Objective/Goal:

Improvement in bathing

- **iQIES data Q3, 2021: 74%**
- **iQIES data Q4, 2021: 75.3%**
- **iQIES data Q1, 2022: 77.4%**



**Higher percentages are better for this measure. Graph depicts the last 4 quarters in individual quarters to accurately assess response to previous interventions and guide upcoming action plan.*

Date range of data evaluated:

CMS Star Report July 2022; Oct 1, 2020 to September 30, 2021
iQIES data; Q3 & Q4, 2021 and Q1, 2022

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

--Clinicians must take into account multiple factors when determining the patient's ability to ambulate to the bathroom, and what level of assistance they require to do so s*afely*.
--Adaptive methods, assistive devices, and MD ordered restrictions need to be communicated to the first clinician assessing the patient to ensure an accurate scoring of

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

patient ability. Intake clinicians work with case managers in the hospital to be sure that information is obtained in the referral order prior to clinician assessment.
--Clinicians must utilize their professional, clinical judgement when determining what level the patient can perform the task *safely,* not just simply complete the activity.

<u>If improvement opportunities identified, provide action plan and expected resolution date:</u>
There is an opportunity for improvement in this area. The following plan of action shall be implemented;
-- Input from UBC assisted Home Health Educator in creating an "OASIS ADL/IADL" decision tree. Tool will be used when assessing patient's ability to safely transfer in/out of the tub/shower.
--Educator and Intake RN will review data from clinician charting and OASIS for inconsistencies and meet with clinician to provide immediate feedback.
--Clinicians will utilize the "5 Day Rule" allowed by CMS. CMS encourages a collaboration between all clinicians who assessed a patient within 5 days of the first OASIS assessment. This will ensure accurate capture of a patient's need and the opportunity to provide the resources needed to help achieve *Outstanding Community Health* consistent with the Kaweah Health District pillar.

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

<u>Submitted by Name:</u>	**<u>Date Submitted:</u>**
Shannon Esparza, RN	**July 2022**

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department:
Home Health

ProStaff/QIC Report Date:
July 2022

Due to the public health emergency declared in March 2020, the Centers for Medicare & Medicaid Services (CMS) froze the data reported on the Care Compare website, the platform for which quality measures are publicly reported for home health agencies. In April 2022, the website resumed publically reporting on four rolling quarters of data; Q3, 2020 thru Q2, 2021. The next refresh to Care Compare will be July 2022, covering Q4, 2020 thru Q3, 2021. KH Home Health is currently at a 3-Star rating, out of a 5-Star rating system.

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

Measure Description:

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

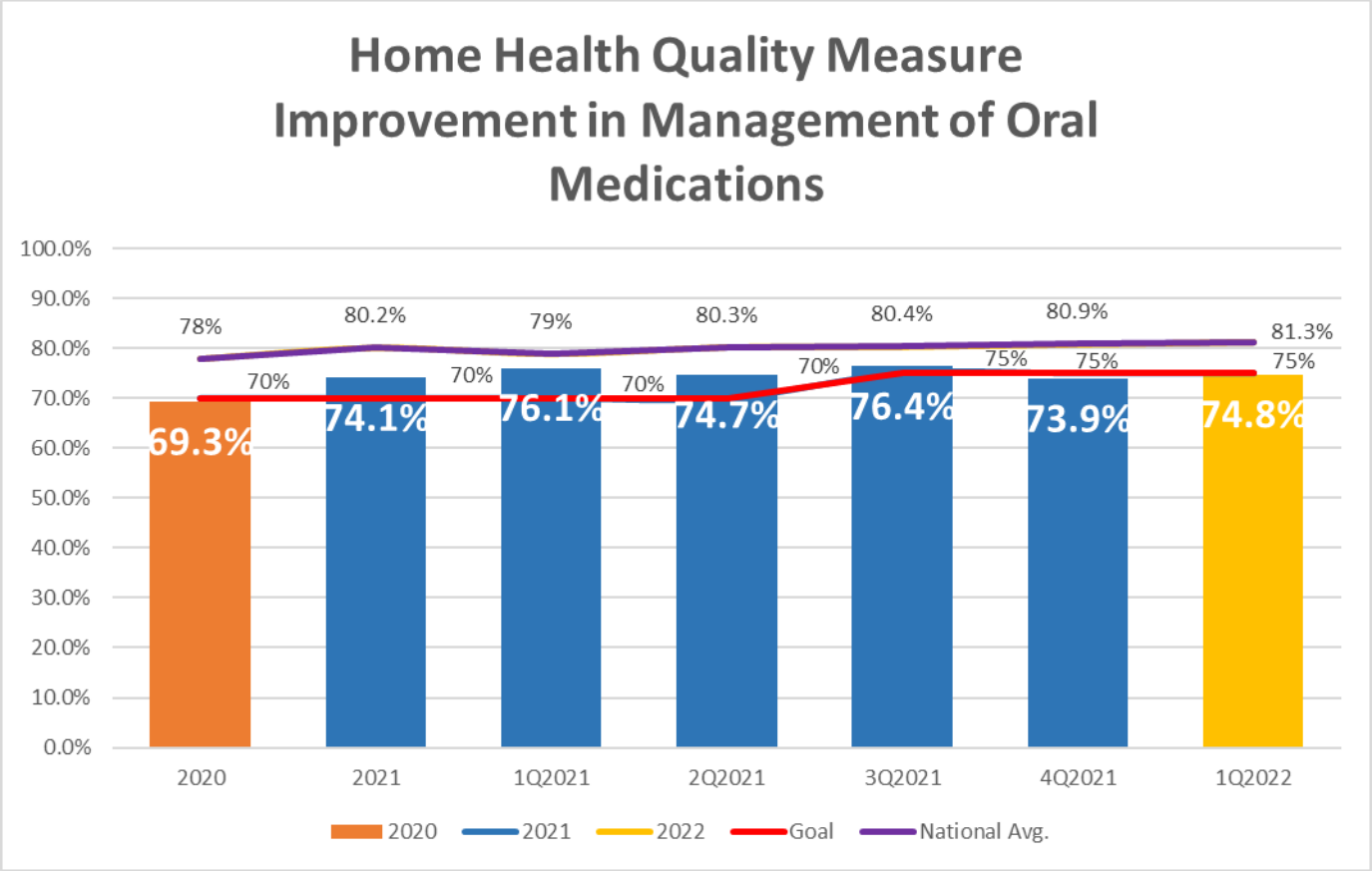
--Home Health Clinicians (registered nurses, physical therapists) complete OASIS data upon a patient's admission to home health. Clinicians must assess the patient's ability to take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times. At discharge,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

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

Measure Objective/Goal:

Improvement in Management of Oral Medications

- **iQIES data report Q3, 2021: 76.4%**
- **iQIES data report Q4, 2021: 73.9%**
- **iQIES data Q 1, 2022: 74.8%**



**Higher percentages are better for this measure. Graph depicts the last 4 quarters in individual quarters to accurately assess response to previous interventions and guide upcoming action plan.*

Date range of data evaluated:

- **CMS Star Report July 2022; Oct 1, 2020 to September 30, 2021**
- **iQIES data; Q3 & Q4, 2021 and Q1, 2022**

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

--CY 2020 at 69% for this measure was below the National Average of all home health reporting agencies. Current July 2022 Star Report evaluation revealed additional

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

opportunity for improvement. Opportunity for improvement in this area existed and a multifocal plan was executed. Current July 2022 Star Report evaluation revealed additional opportunity for improvement.
--Education to all clinical staff who complete OASIS, due to the multi-level assessment needed in this measure.
--Clinicians must differentiate patient's ability to perform the steps in this measure independently versus the level of family/caregiver assistance with medication regimen. Patient's ability to obtain the medication from where it is routinely stored, the ability to read the label or accurately identify medication by placing a character on label, open the container, remove the correct dosage at the appropriate times/intervals, consistently.
--Functional ability as well as cognitive ability may impact patient's ability to safely manage medications.
--Medical record review noted inconsistencies with clinicians scoring of oral medication administration and ability to ambulate. OASIS guidance requires the clinician consider the patient's ability to obtain the medication from where it is routinely stored.
--Educator met with clinicians who were inconsistent in scoring patient medication regime ability and functional ability within their home. Additional individualized education provided opportunity for directed teaching based on the individualized scenarios clinicians were observing in patient homes.
--iQIES data reflects positive gradual trend.

<u>If improvement opportunities identified, provide action plan and expected resolution date:</u>
There is an opportunity for improvement in this area to ensure we reach our goal of meeting/exceeding the National Average. The following plan of action shall be implemented;
--Input from UBC, assisted Home Health Educator in creating an "OASIS ADL/IADL" decision tree. Tool will be used when assessing patient's ability to safely obtain medications and adhere to their medication regimen.
--Educator and Intake RN auditor will review data from clinician charting and OASIS for inconsistencies and meet with clinician to provide immediate feedback.
--Clinicians will utilize the "5 Day Rule" allowed by CMS. CMS encourages collaboration between all clinicians who assessed a patient, within 5 days of the first OASIS assessment. This will ensure accurate capture of a patient's need and the opportunity to provide the resources needed to help achieve *Outstanding Community Health* consistent with the Kaweah Health District pillar.

<u>Next Steps/Recommendations/Outcomes:</u>
Educator and RN Intake Auditor will monitor the effectiveness of these interventions weekly during chart audits. Educator will report these findings along with trends to Home Health Manager at least every 30 days. Educator will analyze OASIS outcome data reports

for this measure quarterly and report to Home Health Manager and Director. Educator and Home Health Manager will modify interventions until we meet, or exceed, the national average for three or more quarters.

Submitted by Name:
Shannon Esparza, RN

Date Submitted:
July 2022

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

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Kaweah Health

Catheter Associated Urinary Tract Infection (CAUTI) Quality Focus Team Report October 2022

Kari Knudsen, Director of Post-Surgical Care (Chair)
Alisha Sandidge, Advanced Practice Nurse (Co-Chair)

CAUTI- FY22 Goals

Our Mission

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

Our Vision

To be your world-class healthcare choice, for life

Lower is Better	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual/ number expected)	FY22 Goal	FY21 FY20
CAUTI Catheter Associated Urinary Tract Infection COVID-19 PATIENTS	1 0	3 1	5 5	2 0	2 1	1 0	3 1	3 2	2 0	1 0	1 0	1 0	16 (12 predicted over 6 months)	1.092 0.66 Excluding COVID (Feb 2022)	≤0.676	0.54 1.12

Goal achieved with removal of COVID cases = 0.66

*based on July-Dec 2021 NHSN predicted

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

Kaizen Root Cause

Analysis:

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

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

Kaizen improvement strategies focused on addressing the top 4 root causes

Initial KAIZEN initiatives focused on the top **4** root causes

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

Kaweah Health

Post KAIZEN-Gemba Data

CAUTI Committee Dashboard

Measure Description	Benchmark/ Target	Mar-20	Qtr 2 2020	Qtr 3 2020	Qtr 4 2020	Qtr 1 2021	Qtr 2 2021	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
OUTCOME MEASURES																			
Number of CAUTI	0	0	4	2	3	1	3	1	3	5	2	2	1	3	3	2	1	1	1
FYTD SIR	≤0.676							0.569			1.436	1.319	1.177	1.22	1.24	1.22	1.17	1.09	1.09
PROCESS MEASURES IUC Gemba																			
% of pts with appropriate cleanliness	99%	98%	97%	97%	99%(e)	99%	99%(e)	98%			95%	100%	99%	99%	99%	N/A	99%	99%	99%
% of pts with order present with indication	100%	90%	93%	92%	95%(e)	93%	93%(e)	94%			96%	97%	95%	98%	96%	N/A	89%	95%	94%
% of IUCs where removal was attempted	n/a	8%	6%	6%	4%(e)	4%	4%(e)	6%			3%	3%	7%	27%	26%	N/A	4%	3%	1%
% of pts where alternatives have been attempt	n/a	15%	11%	11%	9%(e)	10%	10%(e)	15%			8%	7%	11%	19%	9%	N/A	10%	7%	8%
# of Pt Catheter days rounded on	n/a	616	2545	3280	2093	2757	1879	1045			1068	902	874	802	931	N/A	1169	852	749
% of IUCs removed because of Gemba Round	n/a	7%	4%	4%	5%(e)	6%	6%(e)	6%			4%	5%	7%	6%	4%	N/A	6%	5%	4%
# of IUCs removed because of Gemba Round	n/a	46	110	142	104	152	94	43			43	49	64	48	37	N/A	63	39	29

*volume reduced due to reduced Gemba on weekends
**FYTD includes cases removed in Mar 2021
*e=estimated

Equal or Better than Target | Within 5% of Target | Does not meet Target

FY END '22

Total Catheter days rounded on = **7554**

99% of patients with daily bath and peri-care each shift

Avg 95% have order and valid rationale

415 catheters removed as a result of the Gemba

Kaweah Health

CAUTI QFT – Key Strategies

- Extensive case review by IP and individual units for near miss and CAUTI events
- Daily surveillance monitoring with Gemba on each IUC
- Continued focused educational blasts, most recent; IUC maintenance prior to specimen collection, pericare and IUC insertion methods
- UA order management

Kaweah Health

CAUTI QFT – Proposal

- Situation: Our QFT committee membership has shrunk to a small group of key stakeholders, the amount of time consumed by QFT meeting maintenance is significant and could be used to produce action, sustainable processes are in place for data collection, IUC monitoring, near miss and event case review.
- Background: CAUTI QFT has been meeting since 3/2020, has met the goal the last 2 FY (with removing covid cases FY22), all improvement initiatives identified at Kaizen have been achieved.
- Assessment: Daily Gemba produces ample, unit specific data, IP monitors clinical data to mine near misses and CAUTI cases, a reliable process exists for unit case review for near miss/CAUTI events, HAI committee reviews cases in detail with unit leadership, dedicated small group of stakeholders remain committed to PI initiatives for prevention of CAUTI by responding to evolving data.

- Recommendation: Transition CAUTI QFT to CAUTI committee with ad hoc meeting frequency based on needed interventions. Kari Knudsen, Quality, IP continue to meet quarterly to review updated Pareto charts on event root causes as identified by the HAI committee and review trends identified in input reviews of near miss and CAUTI events to drive on-going performance improvement initiatives. This group engages the CAUTI committee as needed to produce work and oversee necessary decisions related to practice changes.

Kaweah Health

CAUTI QFT – Proposal

CAUTI Committee Dashboard

Measure Description	Benchmark/ Target	Mar-20	Qtr 2 2020	Qtr 3 2020	Qtr 4 2020	Qtr 1 2021	Qtr 2 2021	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
OUTCOME MEASURES																					
Number of CAUTI	0	0	4	2	3	1	3	1	3	5	2	2	1	3	3	2	1	1	1	1	1
FYTD SIR	≤0.676							0.569			1.436	1.319	1.177	1.22	1.24	1.22	1.17	1.09	1.09	0.57	0.54
PROCESS MEASURES IUC Gemba																					
% of pts with appropriate cleanliness	99%	98%	97%	97%	99%(e)	99%	99%(e)	98%			95%	100%	99%	99%	99%	N/A	99%	99%	99%	99%	99%
% of pts with order present with indication	100%	90%	93%	92%	95%(e)	93%	93%(e)	94%			96%	97%	95%	98%	96%	N/A	89%	95%	94%	95%	93%
% of IUCs where removal was attempted	n/a	8%	6%	6%	4%(e)	4%	4%(e)	6%			3%	3%	7%	27%	26%	N/A	4%	3%	1%	2%	5%
% of pts where alternatives have been attempted	n/a	15%	11%	11%	9%(e)	10%	10%(e)	15%			8%	7%	11%	19%	9%	N/A	10%	7%	8%	5%	10%
# of Pt Catheter days rounded on	n/a	616	2545	3280	2093	2757	1879	1045			1068	902	874	802	931	N/A	1169	852	749	871	975
% of IUCs removed because of Gemba Round	n/a	7%	4%	4%	5%(e)	6%	6%(e)	6%			4%	5%	7%	6%	4%	N/A	6%	5%	4%	2%	5%
# of IUCs removed because of Gemba Round	n/a	46	110	142	104	152	94	43			43	49	64	48	37	N/A	63	39	29	19	45
*volume reduced due to reduced Gemba on weekends **FYTD includes cases removed in Mar 2021 *e=estimated	Equal or Better than Target							Within 5% of Target				Does not meet Target									

	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	June 2023	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual/ number expected)	FY23 Goal PROPOSED	FY22 FY21 FY20
Lower is Better																
CAUTI Catheter Associated Urinary Tract Infection COVID-19 PATIENTS	1 0	1 0											18 (23 predicted over 12 months)	0.620 0.620 Excluding COVID	≤0.650	1.092 0.54 1.12

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Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: CAUTI QFT **ProStaff/QIC Report Date:** 10/18/2022

Measure Objective/Goal:

- Goal for FY22 ≤ 0.676 (CMS 50th percentile); **Current SIR = 0.54**
- FYE 2022 SIR = 1.09; Actual CAUTI FY22 is 25, with 11 COVID cases removed SIR is 0.66 and goal is achieved
- Pre KAIZEN baseline SIR is 1.557

CAUTIs result in poor outcomes for patients, a negative public perception of care through publically reported safety scores and financially impact the organization through HAC and VBP programs as well as increased treatment costs and LOS.

Date range of data evaluated: FYTD SIR (7/2022 – 9/2022)

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):

Benchmark/ Target	Mar-20	Qtr 2 2020	Qtr 3 2020	Qtr 4 2020	Qtr 1 2021	Qtr 2 2021	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
0	0	4	2	3	1	3	1	3	5	2	2	1	3	3	2	1	1	1	1	1
≤0.676							0.569			1.436	1.319	1.177	1.22	1.24	1.22	1.17	1.09	1.09	0.57	0.54
99%	98%	97%	97%	99%(e)	99%	99%(e)	98%			95%	100%	99%	99%	99%	N/A	99%	99%	99%	99%	99%
100%	90%	93%	92%	95%(e)	93%	93%(e)	94%			96%	97%	95%	98%	96%	N/A	89%	95%	94%	95%	93%
n/a	8%	6%	6%	4%(e)	4%	4%(e)	6%			3%	3%	7%	27%	26%	N/A	4%	3%	1%	2%	5%
n/a	15%	11%	11%	9%(e)	10%	10%(e)	15%			8%	7%	11%	19%	9%	N/A	10%	7%	8%	5%	10%
n/a	616	2545	3280	2093	2757	1879	1045			1068	902	874	802	931	N/A	1169	852	749	871	975
n/a	7%	4%	4%	5%(e)	6%	6%(e)	6%			4%	5%	7%	6%	4%	N/A	6%	5%	4%	2%	5%
n/a	46	110	142	104	152	94	43			43	49	64	48	37	N/A	63	39	29	19	45
Equal or Better than Target							Within 5% of Target				Does not meet Target									

FY 22 Total Catheter Days rounded on = **7554**	**99%** of patients with daily bath and peri-care per shift
95% Avg. with order and valid rationale	**415** catheters removed as a result of the Gemba

Opportunities:

- Accurate, timely and clinically indicated cultures; reduce pan-culturing practices
- Appropriate indications for IUC, reduction in IUC use; using alternatives to IUC
- Learning from Fallouts

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

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

CAUTI QUALITY IMPROVEMENT STRATEGIES	STATUS
1. Male and female external urine collection device conversion, Purewick to Versette, condom cath to Men's Liberty Acute	Nov 2022
2. Rejuvenate use of nurse driven IUC removal standardized procedure	In progress
3. Adding sticker to IUC GOAL: Visual reminder to replace IUC prior to specimen collection after 72 hours to reduce false positives from biofilm	10/3/22
4. Fever Indication for Culture Task Force: CAUTI/CLABSI medical case review complete for all events this FY where pan culturing present, data synthesis reviewed	8/2022
5. Create Gemba rounds, daily M-F on every patient with a urinary catheter	3/2020
6. Create change IUC task at 30 days following documented insertion GOAL- trigger nursing staff to change chronically retained IUC	12/23/20
7. Hide single Insert IUC orderable for downtown campus and Rehab GOAL: Improve bundle compliance by driving use of the insert IUC Powerplan which contains needed maintenance elements	10/27/20
8. Kaizen strategy: evaluate option for time clock for line info GOAL- Improve prompt removal, visual reminder of how long the line has been in place	11/24/2020
9. CAUTI Case Reviews Lessons Learned GOAL – Reduce CAUTI by ensuring identified opportunities are addressed globally	On-going
10. Bathing Prioritization (in collaboration with CLABSI Committee) GOAL – Improve bathing/peri-care of IUC patients	10/27/20
11. Add 'restricted use' to the urine culture only orderable GOAL- reduce use of culture only order in defined populations without accompanying UA	7/28/20
12. Develop insert IUC Powerplan to include important maintenance elements: straight cath option prior to IUC insertion, change IUC prior to specimen collection, change IUC at 30 days GOAL- Create and bundle essential orders for IUC maintenance	8/25/20
13. Develop provider update/education related to current CAUTI status and how to order IUC/Culturing awareness GOAL- create awareness	9/29/20
14. Changes to discontinue IUC orderable- alerts RN to dc the insert IUC Powerplan and related maintain order GOAL- assist with order clean up	8/25/20
15. Develop orders for Adult Urinary Retention management GOAL- orders for retention management currently exist as one off options, bundling them together for ease of ordering increases use	9/29/20
16. Place all IUC order resources on eCoach GOAL- Increase IUC appropriateness/ prompt removal, bundle compliance (improving ease of access for providers and nursing staff)	2/16/21
17. Develop Urine Culture only powerplan to replace single orderable. GOAL- Reduce CAUTI events related to culture ordering by guiding intentional use of this risky order	2/23/21
18. Add 3-way catheter as trigger to device list GOAL- accurate collection of device count	4/22/21
19. Safety Summit (CAUTI education for new hires) relaunch post-COVID GOAL – Improve/sustain RN bundle compliance	6/22/21
20. Changes to the discontinue order- alert will prompt the provider to order retention management order GOAL- provides orders for nursing to manage post IUC DC retention	5/25/21
21. Kari will discuss CN "review" of culture orders before obtaining specimen at PPC for input, bring back to QFT	3/22/21
22. Medline urology assessment	5/25/21
23. Powerchart changes- IUC dynamic group for POA include present on transfer from OR/procedure GOAL- capture device list for lines already in place	7/21/22

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

24. Embed IUC insert power plan in existing Powerplans where the insert IUC order exists GOAL – Improve IUC order appropriateness and bundle compliance with increased use of Powerplan which contains needed IUC maintenance elements	10/25/21
25. IUC inserted in OR/procedural areas- no insert order = no maintain order = no reason for insertion. Create maintain subphase and insert in existing appropriate powerplans. GOAL: Functional efficiencies to require rationale of IUC.	10/25/21
26. Resident Notifications of near misses and events GOAL: Resident request for awareness and learning opportunities.	11/23/21
27. Mandatory CBL Resident education On-going monitoring	5/25/21
28. Letter for providers on events (like CLABSI) GOAL: Provider awareness of HAI.	3/19/22
29. Rapid Cycle Post Gemba Rounds 30. GOAL – reduce IUC utilization, verify completion of follow up	11/23/21
31. Primofit & Medline External Male Catheter Product Trial GOAL: Reliable method for male external alternative to IUC	3/19/22
32. SonoSite Bladder Scanner conversion	3/19/22
33. On-going attempts to do in person Resident education	8/23/21
34. ICU Forum	1/24/22
35. Add number of attempts for IUC insertion, Policy no more than 2 attempts.	1/24/22
36. Medline Urology product line conversion	3/22/22

*QI strategies colored green indicate completed; yellow indicates in progress strategies

Next Steps/Recommendations/Outcomes:

A. Continue to maintain Kaizen initiatives: Daily IUC Gemba rounds, data collection, and dissemination and QI strategy development.
B. Continue to monitor CAUTI events, reviewed with unit leadership at the HAI review meeting, unit leadership creates quality improvement plan and implements at the unit level. The QFT monitors QI opportunities for global implementation
C. Continue to address culturing practices in newly revised Fever as an Indication for Culture Taskforce with medical staff partnership

Submitted by Name: Kari Knudsen **Date Submitted:** 9/29/2022

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

Methicillin-Resistant Staphylococcus Aureus (MRSA) Quality Focus Team Report October 2022

<u>Quality Focus Team Members</u>

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

MRSA- FY22 Goals

Our Mission

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

Our Vision

To be your world-class healthcare choice, for life

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

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

*based on July-Dec 2021 NHSN predicted

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

MRSA- FY23 Goals

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

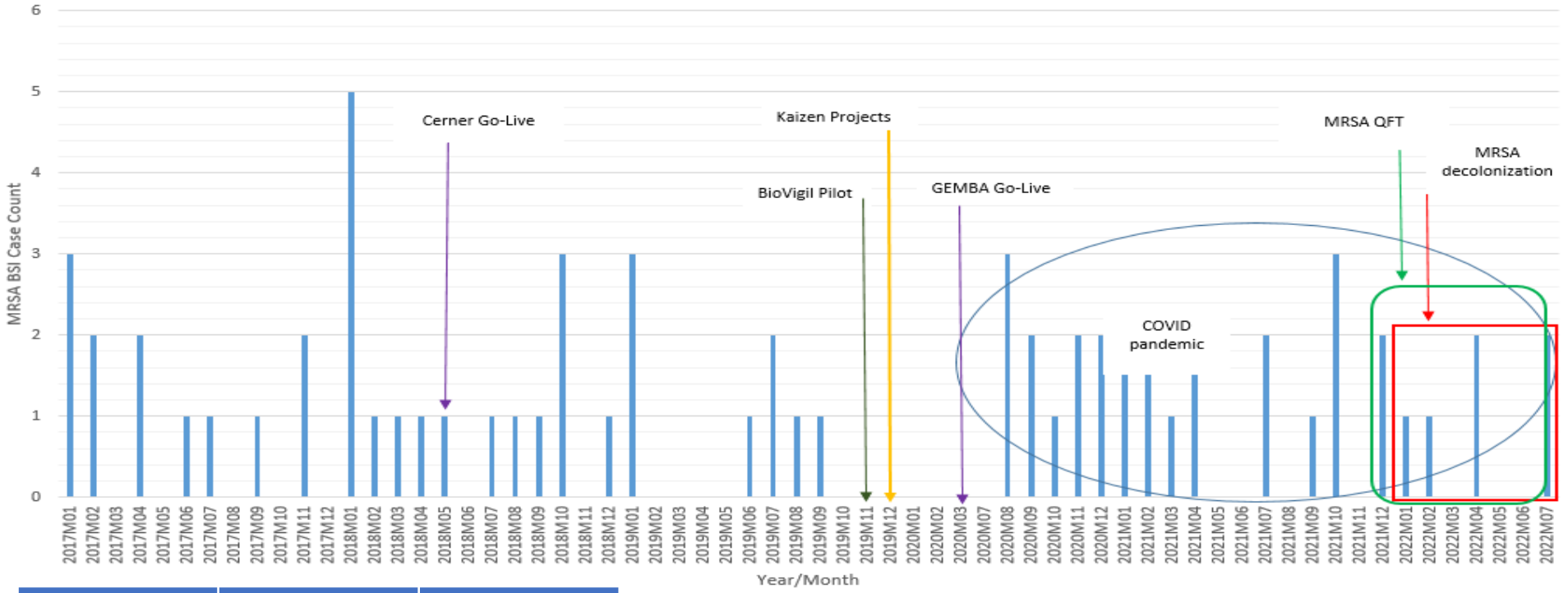
We reported 2 MRSA BSI events during the first 2 months of current FY (these events did not effect our standardized infection ratio).

*based on July-August 2022 NHSN predicted

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

Background Data – MRSA Blood Stream Infection events

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

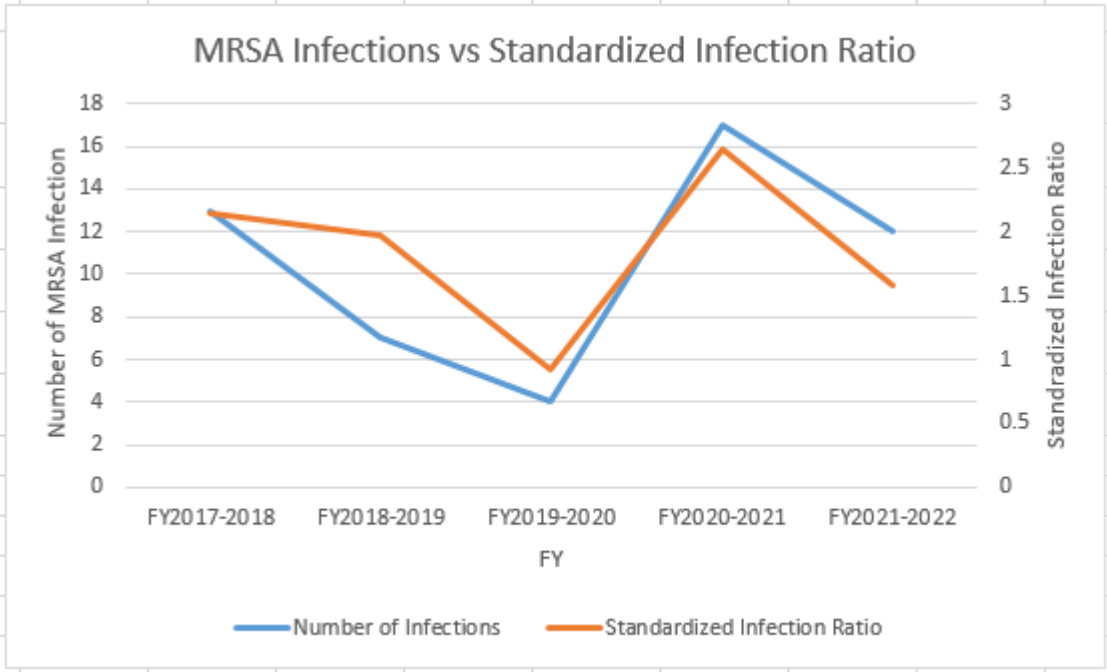


Fiscal Year	Number of Infections	Standardized Infection Ratio
FY2017-2018	13	2.152
FY2018-2019	7	1.970
FY2019-2020	4	0.923
FY2020-2021	17	2.648
FY2021-2022	12	1.585
FY2022-2023	2	0

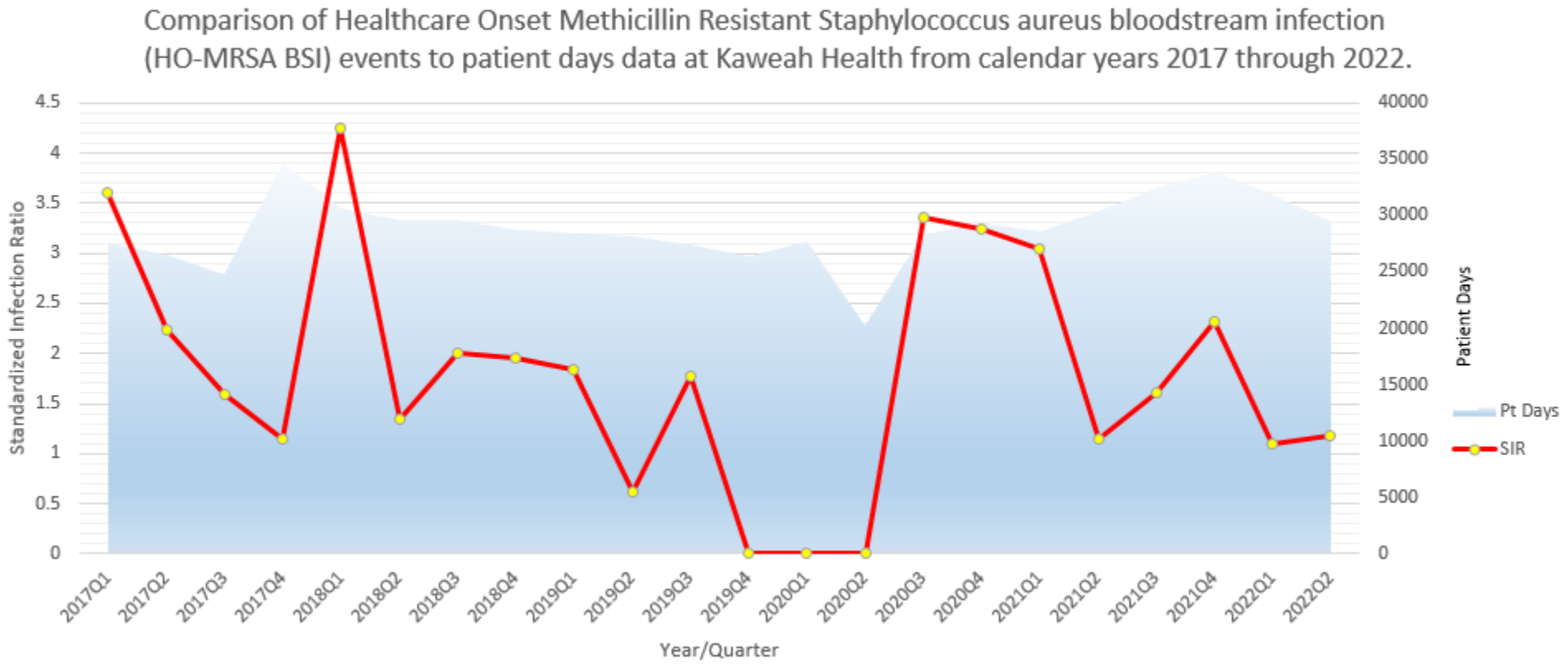
Number of MRSA BSI events dipped during November 2019 through March of 2020 in part due to the electronic hand hygiene system pilot on 4N, and ICU and the added attention given to healthcare associated infections (e.g. CLABSI/CAUTI) with Kaizen Projects and initiation of GEMBA Rounds. The increase in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

Background Data – MRSA Blood Stream Infections & Standardized Infection Ratio trend

Fiscal Year	Number of Infections	Standardized Infection Ratio
FY2017-2018	13	2.152
FY2018-2019	7	1.97
FY2019-2020	4	0.923
FY2020-2021	17	2.648
FY2021-2022	12	1.585

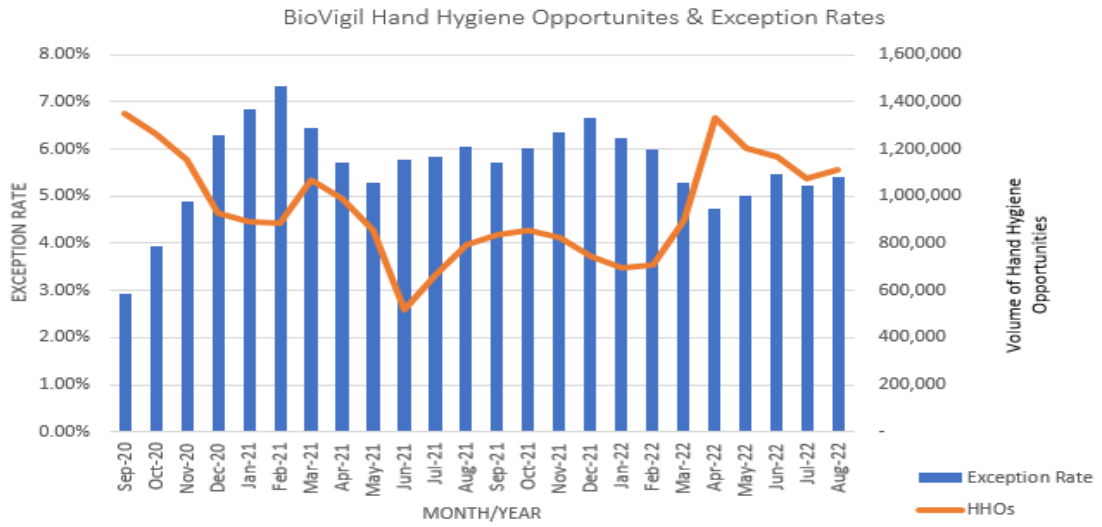


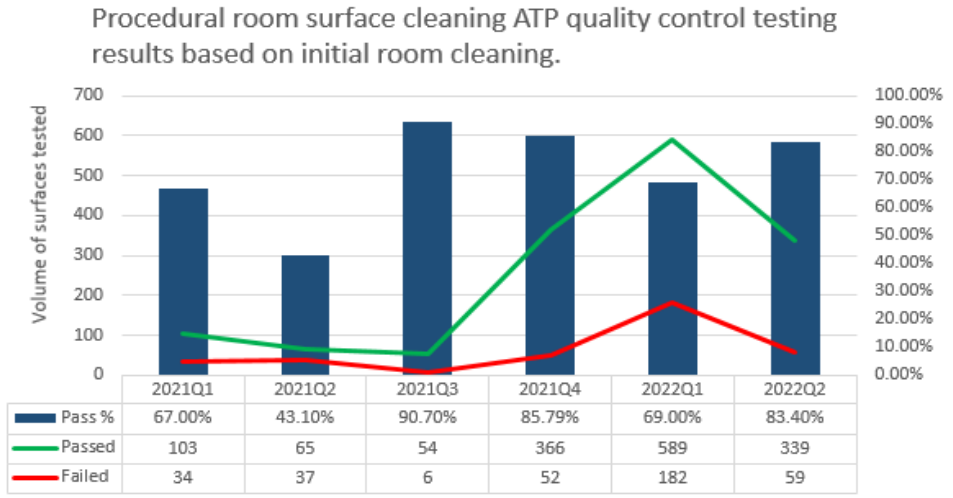
Background Data - MRSA Blood stream Infections vs Patient days

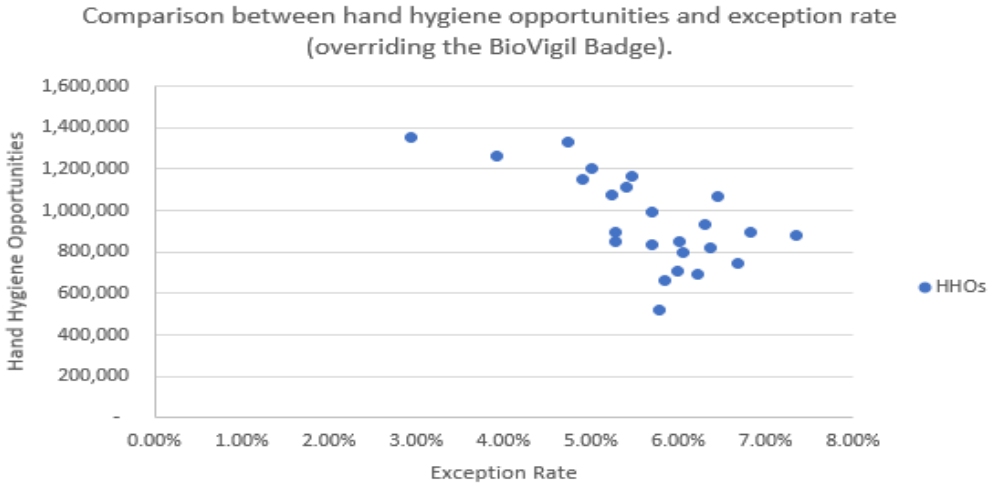


Key Takeaways: Based on data depicted above, there is a positive correlation between Standardized Infection Ratio vs. Patient days

Background Data - BioVigil Hand Hygiene Opportunities and ATP Testing







Root Causes identified

Culturing Practices

- Late blood cultures when a patient presents with early evidence of infection. Example patient: receives urine culture in E.D. for urosepsis, then on day 4 into admission patient receives blood cultures that are positive for MRSA.
- Serial blood cultures that exceed 14 days. Evidence supports serial blood cultures for patients identified with MRSA septicemia until the first negative blood culture is identified. The first negative result sets the duration of continued antimicrobial therapy.
- Positive MRSA serial blood cultures that exceed 14 days are considered a new event and healthcare acquired.

Source Control

- Too many Kaweah Health MRSA bloodstream infection events are related to positive serial blood cultures that well exceed 14 days.
- In these cases endocarditis (Life-threatening inflammation of the inner lining of heart chambers and valves) or osteomyelitis (Inflammation or swelling that occurs in the bone) maybe a contributing factor to seeding of the bloodstream.
- For these events either required diagnostic testing to rule-in/out endocarditis wasn't performed, and/or osteomyelitis was not addressed with surgical intervention.
- In these situations, patients test positive for MRSA bloodstream infection for up to a month while on appropriate treatment for MRSA. The primary source continues to spread in the bloodstream, making treatment ineffective.

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MRSA QFT- Key Strategies

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

Quality Focus Team Recommendations

Strides have been made to better understand root-cause, and continuously assess impact of key strategies. The following are recommendations:

- Provider involvement is needed to help determine a process to effectively order/perform blood cultures (i.e. when treatment will be implemented or changed as a result of what is identified by culture).
- Provider involvement is needed to help devise a protocol to diagnostically determine the presence of endocarditis that is consistent with NHSN criteria.
- Provider involvement is needed to help determine a process by which source control can be better managed.

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Trauma Committee Report

Submitted by:
Franklin Martin, Director of Trauma Program

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Unit/Department: **Trauma**
Report Date: **September 2022**
Reporting Period **Jan 2022 – June 2022**

Trauma Tracking	Benchmark	Jan - 22	Feb - 22	Mar - 22	Apr - 22	May - 22	Jun - 22
Critical Trauma	N/A	35	43	43	40	40	30
Moderate Trauma	N/A	146	148	152	177	178	181
Non Activation	N/A	39	51	55	63	45	55
Surgeon Response Time to Critical Trauma Activation	< 30 min	83.8%	94.9%	87.5%	82.1%	93.9%	92.9%
% of Over Triaged Patients	< 30%	70.59%	65.71%	75.68%	68.42%	81.25%	67.86%
% of Under Triaged Patients	< 5%	4.58%	6.13%	4.86%	6.33%	3.65%	3.59%
Door to Femur Fixation < 24 hr.	80%	50% (5)	0% (2)	100% (5)	60% (5)	66.6% (4)	100% (1)
Door to Antibiotics for open fractures < 1 hr.	90%	100% (6)	100% (6)	0% (1)	20% (5)	40% (5)	70% (10)
Door to Transfer < 4 hr. (Set for Region)	80%	12% (17)	13% (15)	13% (23)	38% (30)	43% (24)	31% (13)

Mortality (TQIP Report)		Oct 18 - Sept 19	April 19-Mar 20	Oct 19 - Sept 20	Apr 20 - Mar 21	Oct 20 - Sept 21	Apr 21 - Mar 22
All Patients	Mortality %	5.0% (N- 886)	5.1% (N-766)	5.2% (N-771)	6.3% (N-854)	7.4% (N-948)	7.9% (N-1021)
	(Expected %)	(4.6%)	(4.8%)	(4.4%)	(5.2%)	(5.9%)	(5.4%)
Elderly > 65 years old	Mortality %	6.9% (N-232)	5.4% (N-202)	8.4% (N-178)	10.4% (N-192)	10.5% (N-267)	11.6% (N-319)
	(Expected %)	(5.8%)	(5.7%)	(6.3%)	(7.3%)	(6.9%)	(6.4%)
Isolated Hip Fractures	Mortality %	0% (N-21)	0% (N-18)	0% (N-19)	2.3% (N-43)	4.9% (N-82)	5.5% (N-110)
	(Expected %)	(2.9%)	(2.8%)	(5.6%)	(3.3%)	(2.6%)	(2.8%)

KEY	Spring 2020	Fall 2020	Spring 2021	Fall 2021	Spring 2022	Fall 2022
	>10% above goal/benchmark		Within 10% of goal/benchmark		Outperforming/meeting goal/benchmark	

Surgeon Response Time

Problem/Opportunity

Surgeon Response Time to Critical Trauma Activations

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

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

Solution

Physician Outliers: Every physician that does not meet this benchmark is coached individually by Dr. Nichole Atherton, MD.

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

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

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

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

Measures

The measurement used to track response time is the time the Trauma Surgeon is paged to the time the surgeon arrives in the patient's room.

Next Steps

Continue to track and trend along with coaching.

Over Triage

Problem/Opportunity

Definition: A patient that is considered over triage is a patient that was called as a critical trauma that did not end up with significant coded injuries.

The benchmark set by the American College of Surgeons sets the benchmark at < 30% for Critical Traumas only. Critical Traumas are called on select patients that meet specific criteria based on mechanisms of injury along with physiological factors

The dashboard shows a rate of 60-80% over the current reporting period. Factors that play a part in our over triage rate being high are activating a trauma patients that don't meet criteria, documentation issues in our Digital innovation (DI) reporting system, missing injury documentation, and knowledge deficit (Staff stated they believed they could not downgrade or cancel traumas).

Solution

Knowledge Deficit: We have re-educated staff in a newsletter along with rounding with staff during the months of November and December to raise awareness. We have also spoken to the physicians during ED operations and Trauma operations/Performance improvement program (PIPS) regarding this issue.

Documentation: We are performing chart audits of all of our patients that are considered over triage to review factors that are contributing to the over triage rate. Missed injuries by the providers are coached by Dr. Nichole Atherton, MD, and the missed coding injuries by the registrars are done by Franklin Martin Director of Trauma.

Measures

The DI registry database determines the over triage rate based on its built-in programming. It utilizes the Cribari matrix to formulate the percentage of patients that are over triaged. The formula is patients that have an injury severity score (ISS) of < 15 divided by the total Critical trauma patients multiplied by 100. Every injury is assigned an injury severity score from either 1 to 75 (untreatable conditions).

Next Steps

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

Continue to track and trend over triage rates. As we continually added new staff to the organization, we take the time and speak with them regarding over-triage. Our rates from the last reporting period have improved but we still have an opportunity for improvement.

Under Triage

Problem/Opportunity

Definition: A under triage patient are those that did either did not receive an activation or did receive a moderate activation but should have been upgraded due to severity of their condition.

The benchmark set by the American College of Surgeons sets the benchmark at < 5 % for Moderate Traumas only. Critical Traumas are called on select patients that meet specific criteria based on mechanisms of injury along with physiological factors

The dashboard shows a rate of <5% to 5.95% over the current reporting period. Factors that played a part in our under triage rate being high are under-calling patients that should have been upgraded, documentation issues from the emergency room, and knowledge deficit (Staff stated they did not know they could upgrade traumas when the patient arrives).

Solution

Documentation: Documentation concerns fall into two different areas, we have documentation from the trauma team lead and the documentation done by the unit secretaries. The unit secretaries are responsible for paging out the trauma notifications to the surgeons along with documenting the times in the patient's chart. The Trauma Team Lead is responsible for documenting what level of activation was called for the patient on the trauma flow sheet. On occasion we have activations upgraded but not documented in both locations. We are working with Emergency department leadership and coaching staff one on one to help accurately document the trauma activation times.

Knowledge Deficit: We have re-educated staff in an Emergency department newsletter along with rounding with staff during the months of November and December to raise awareness. We have also spoken to the physicians during ED operations and Trauma operations/PIPS regarding this issue.

Measures

The DI registry database determines the undertriage rate based on its built-in programming. It utilizes the Cribari matrix to formulate the percentage of patients that are under triaged. This formula takes a look at patients that were called a moderate trauma activation level and nonactivation patients that had an injury severity score (ISS) >15.

Next Steps

Track and Trend. Since the talking with staff and reeducating them in the moment we have noticed and document reduction in our under triage rates over the last 3 months.

Door to Femur Fixation

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

Problem/Opportunity

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

Solution

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

Monitoring and reporting

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

Measures

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

Next Steps

We will continue to track and trend these cases. As shown in the table above, we were successful for several months, but others were not so good. We will continue to work with our liaisons to find solutions to any problems stopping them from stabilizing the femur.

Door to Antibiotics

Problem/Opportunity

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

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

Solution

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

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

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

Measures

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

Next Steps

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

Door to Transfer

Problem/Opportunity

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

Solution

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

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

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

Measures

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

Next Steps

We are still in the monitoring window of our last process change with the transfer center. As you can see in the data we have tripled most months in our success rate. We will continue to track and trend along with looking for other opportunities for improvement.

TQIP Mortality Data

Problem/Opportunity

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

Solution

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

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

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

Measures

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

Next Steps

We just received our latest TQIP report and will be reviewing the data. Our mortalities have gone up but at this time we do not have a definitive answer in what opportunities are present in this group.

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

Live with passion.

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Kaweah Health

Clinical Quality Goal Update

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

October 2022

FY23 Clinical Quality Goals

	July-Aug 22 Higher is Better	FY23 Goal PROPOSED	FY22	FY22 Goal
SEP-1 (% Bundle Compliance)	81%	≥ 77%	76%	≥ 75%

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 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	June 2023	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual/ number expected)	FY23 Goal PROPOSED (CMS Mean CY21)	FY22 FY21 FY20
CAUTI Catheter Associated Urinary Tract Infection COVID-19 PATIENTS	1 0	1 0											18 (23 predicted over 12 months)	0.620 0.620 Excluding COVID	≤0.793	1.092 0.54 1.12
CLABSI Central Line Associated Blood Stream Infection COVID-19 PATIENTS	3 0	0 0											16 (17 predicted over 6 months)	1.301 1.301 Excluding COVID	≤0.983	1.132 0.75 1.20
MRSA Methicillin-Resistant Staphylococcus Aureus COVID-19 PATIENTS	2 0	0 0											8 (8 predicted over 6 months	1.684 1.684 Excluding COVID	≤1.085	1.585 2.78 1.02

*based on July 2021-June 2022 NHSN predicted

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

Key Strategies

Sepsis

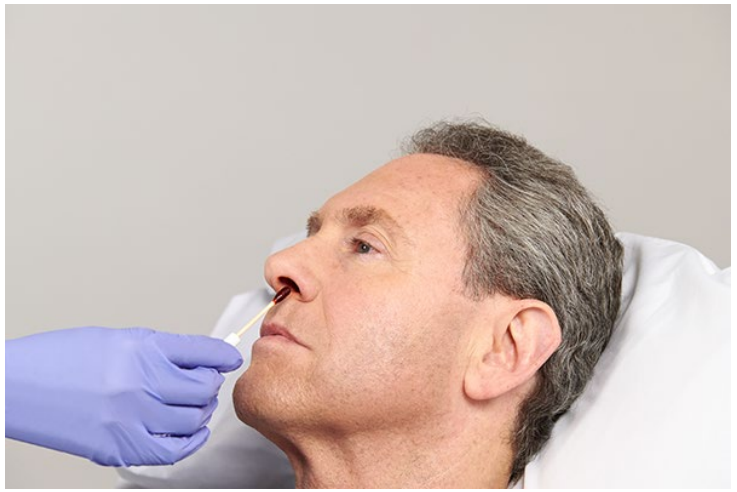
1. Planning and executing EM GME monthly conference sessions
2. Provider notification of Sepsis Alert
   - Revised process so it's easier for RNs to document
3. Sepsis Simulation training (GME)
   - Emergency Management GME program sim program in March 2022; Family Medicine sim program simulation completed for Oct 7, 2022

Key Strategies

CAUTI, CLABSI & MRSA

CONGRATULATIONS ICU!

3. Culturing Practices
   - Engage provider groups in QI in culturing practices
   - Alert for repeat cultures in place
4. Root Cause Analysis
   - Review of current data & cases and quantifying contributing factors to target improvement strategies
5. MRSA Decolonization
   - 4N & ICU Pilot – 100% patients decolonized, ended June 2022; evaluation and recommendation to spread to other inpatient units
   - Prostaff approved wide-spread targeted decolonization program, NOW LIVE 9/29/22
   - Reviewing dashboard process measures
   - Key element in process is identification of the at risk patient through medical record triggers and workflow



Outcome Data

Best Practice Teams
evidence based practices for world-class patient care

Kaweah Health Best Practice Teams Outcome Dashboard FY 2022-23

	Goal	Baseline (FY 2019)	FYTD July 21-June 22*	FY2023 Goals	3Q 2022
Readmission Medicare Population	AMI (non-STEMI) – 11.01	12.34	7.35% (5/68)	7.16%	4.0% (1/25)
	COPD – 12.87	16.09	23.53% (8/34)	12.87%	8.3% (1/12)
	HF – 14.58	18.22	13.02% (25/192)	11.72%	21.43% (6/28)
	PN Viral/Bacterial – 11.30	14.13	16.67% (27/162)	11.30%	2.63% (1/38)
O/E Mortality Medicare Population	AMI (non-STEMI) - 0.71	0.75	0.99 (n=49)	0.71	0 (n=13)
	COPD – 1.92	2.4	1.41 (n=40)	0.93	0 (n=10)
	HF – 1.42	1.78	0.52 (223)	0.52	1.53 (n=43)
	PN Bacterial – 1.48	1.85	0.53 (n=43)	0.53	0 (n=7)
	PN Viral - 1.07	1.34	1.09 (n=109)	0.81	0 (n=18)

More Updates to Come…

- Team Round Implementation
  - To design and pilot team rounds to improve work environment, patient care and outcomes by enhancing coordination of care, communication, and culture among the health care team.
- Quality Improvement Program (QIP)
- Humana
  - Improve annual assessment of Hierarchical Chronic Conditions (HCCs) and closing quality gaps to maintain a 4 STAR Medicare Advantage Rating and > 80% HCC reassessment/PAF visit completion rate for HUMANA MA. Lives assigned to Kaweah Health Rural Health Clinics, SHWC and KHMG.
- Diabetes
  - Optimize inpatient glycemic management to reduce hypoglycemic events

Questions?

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