

June 10, 2021

## NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in a Quality Council Committee meeting at 7:00AM on Thursday, June 17, 2021, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

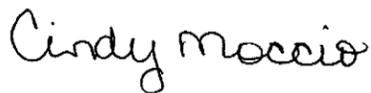
The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:01AM on Thursday, June 17, 2021, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277, pursuant to Health and Safety code 32155 & 1461.

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Quality Council Committee meeting at 8:00AM on Thursday, June 17, 2021, in the Kaweah Health Lifestyle Fitness center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

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

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

KAWEAH DELTA HEALTH CARE DISTRICT  
Garth Gipson, Secretary/Treasurer



Cindy Moccio  
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, June 17, 2021

5105 W. Cypress Avenue

Kaweah Health Lifestyle Fitness Center Conference Room

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

**OPEN MEETING – 7:00AM**

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

**CLOSED MEETING – 7:01AM**

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

2. [Quality Assurance pursuant to Health and Safety Code 32155 and 1461](#) – *Monica Manga, MD, and Professional Staff Quality Committee Chair*
3. [Quality Assurance pursuant to Health and Safety Code 32155 and 1461](#) — *Evelyn McEntire, RN, BSN, Interim Director of Risk Management, and Ben Cripps, Chief Compliance Officer.*
4. **Adjourn Closed Meeting** – *David Francis, Committee Chair*

**OPEN MEETING – 8:00AM**

1. **Call to order** – *David Francis, Committee Chair*
2. **Public / Medical Staff participation** – Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves at this time. Members of the public or the medical staff may comment on agenda items after the item has been discussed by the Committee but before a Committee recommendation is decided. In either case, each speaker will be allowed five minutes.
3. **Written Quality Reports** – A review of key quality metrics and actions associated with the following improvement initiatives:
  - 3.1. [Value Based Purchasing](#)
  - 3.2. [Patient Experience](#)
  - 3.3. [Renal Services – Network 18](#)
  - 3.4. [Infection Prevention](#)
  - 3.5. [Hospital Acquired Pressure Injury \(HAPI\) Quality Focus Team \(QFT\)](#)
  - 3.6. [Handoff Communication Quality Focus Team \(QFT\)](#)
4. **Update: Clinical Quality Goals** - A review of current performance and actions focused on the fiscal year 2021 clinical quality goals. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*
5. **Midas Event Triage and Ranking Committee (METER)** – Overview of new committee designed to rank and escalate event reports daily to senior leadership. *Ben Cripps, Chief Compliance Officer.*
6. **Diversion Prevention Committee** – A review of the committee oversight plan of diversion prevention activities. *Keri Noeske, RN, Chief Nursing Officer.*
7. **Subacute & Transitional Care Service** – A review of key clinical quality measures and associated action plans. *Elisa Venegas, RN, Director of Nursing, Rehab and Skilled Nursing.*
8. **Adjourn Open Meeting** – *David Francis, Committee Chair*

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



# Value Based Purchasing Fiscal Year 2021

ProStaff – April 2021

Dr. Tom Gray, Medical Director Q&PS / Evelyn McEntire, QI Manager

# Abbreviations

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

# VBP Payment Method

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

*CMS Quality Patient Assessment Instruments*



# Value Based Purchasing Measures Fiscal Year 2021

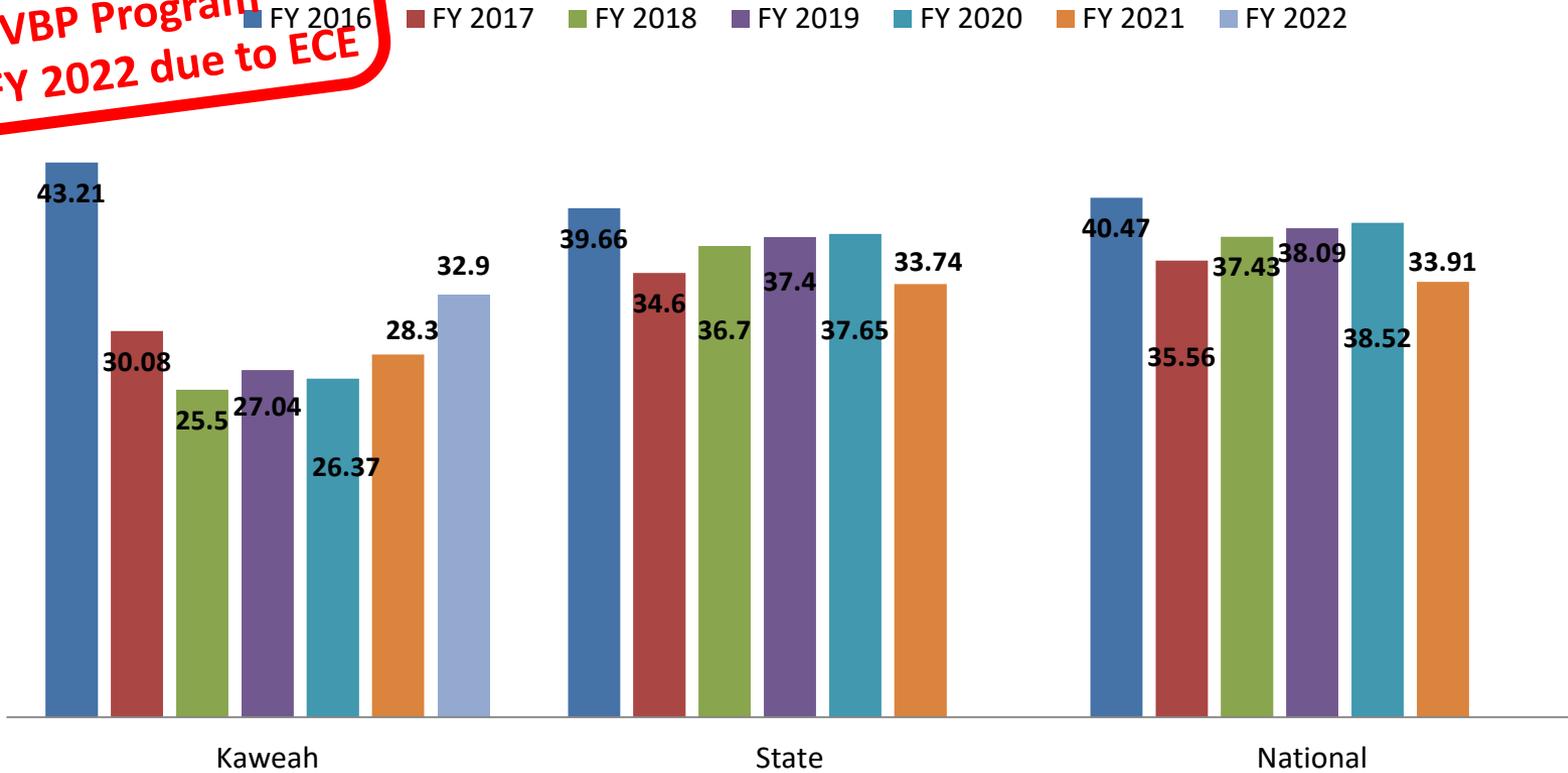
- Payment adjustment effective for discharges from Oct 1, 2020 and Sept 30, 2021
- Safety, Efficiency and Engagement Domains Outcomes = CY19
- Clinical Care Domain Outcomes = July 1, 2016 through June 30, 2019

FY 2021 Hospital Value-Based Purchasing Guide			
Payment adjustment effective for discharges from October 1, 2020 and September 30, 2021			
<b>Baseline Period</b> July 1, 2011–June 30, 2014		<b>Performance Period</b> July 1, 2016–June 30, 2019	
<b>Measures</b>		<b>Threshold</b>	<b>Benchmark</b>
30-Day Mortality, Acute Myocardial Infarction (MORT-30-AMI)		0.860355	0.879714
30-Day Mortality, Heart Failure (MORT-30-HF)		0.883803	0.906144
30-Day Mortality, COPD (MORT-30-COPD)		0.923253	0.938664
<b>Baseline Period</b> July 1, 2012–June 30, 2015		<b>Performance Period</b> September 1, 2017–June 30, 2019	
<b>Measure</b>		<b>Threshold</b>	<b>Benchmark</b>
30-Day Mortality, Pneumonia (MORT-30-PN Updated Cohort)		0.836122	0.870506
<b>Baseline Period</b> April 1, 2011–March 31, 2014		<b>Performance Period</b> April 1, 2016–March 31, 2019	
<b>Measure</b>		<b>Threshold</b>	<b>Benchmark</b>
IElective Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Complication Rate (COMP-HIP-KNEE)		0.031157	0.022418
<b>Clinical Outcomes</b>		25%	
<b>Safety</b>		25%	
<b>Baseline Period</b> January 1–December 31, 2017		<b>Performance Period</b> January 1–December 31, 2019	
<b>Measures (Healthcare-Associated Infections)</b>		<b>Threshold</b>	<b>Benchmark</b>
ICentral Line-Associated Bloodstream Infections (CLABSI)		0.687	0.000
ICatheter-Associated Urinary Tract Infections (CAUTI)		0.774	0.000
ISurgical Site Infection (SSI): Colon		0.754	0.000
ISSI: Abdominal Hysterectomy		0.726	0.000
IMethicillin-resistant <i>Staphylococcus aureus</i> (MRSA)		0.763	0.000
IClostridium difficile Infection (CDI)		0.748	0.067
<b>Person and Community Engagement</b>		25%	
<b>Efficiency and Cost Reduction</b>		25%	
<b>Baseline Period</b> January 1–December 31, 2017		<b>Performance Period</b> January 1–December 31, 2019	
<b>Measures</b>		<b>Threshold</b>	<b>Benchmark</b>
IMedicare Spending per Beneficiary (MSPB)		Median Medicare Spending per Beneficiary ratio across all hospitals during the performance period	Mean of lowest decile of Medicare Spending per Beneficiary ratios across all hospitals during the performance period

# Kaweah Delta Performance - FY 2022 Payment Performance

**Kaweah Delta is EXEMPT from VBP Program for FY 2022 due to ECE**

Actual VBP Total Performance Score



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

FY 2022 <u>Estimated</u> VBP Cost	
Contribution	Payment Received
\$1,930,400	\$2,019,000
\$88,600	

# FY 2022 *Estimated* VBP Points by Domain

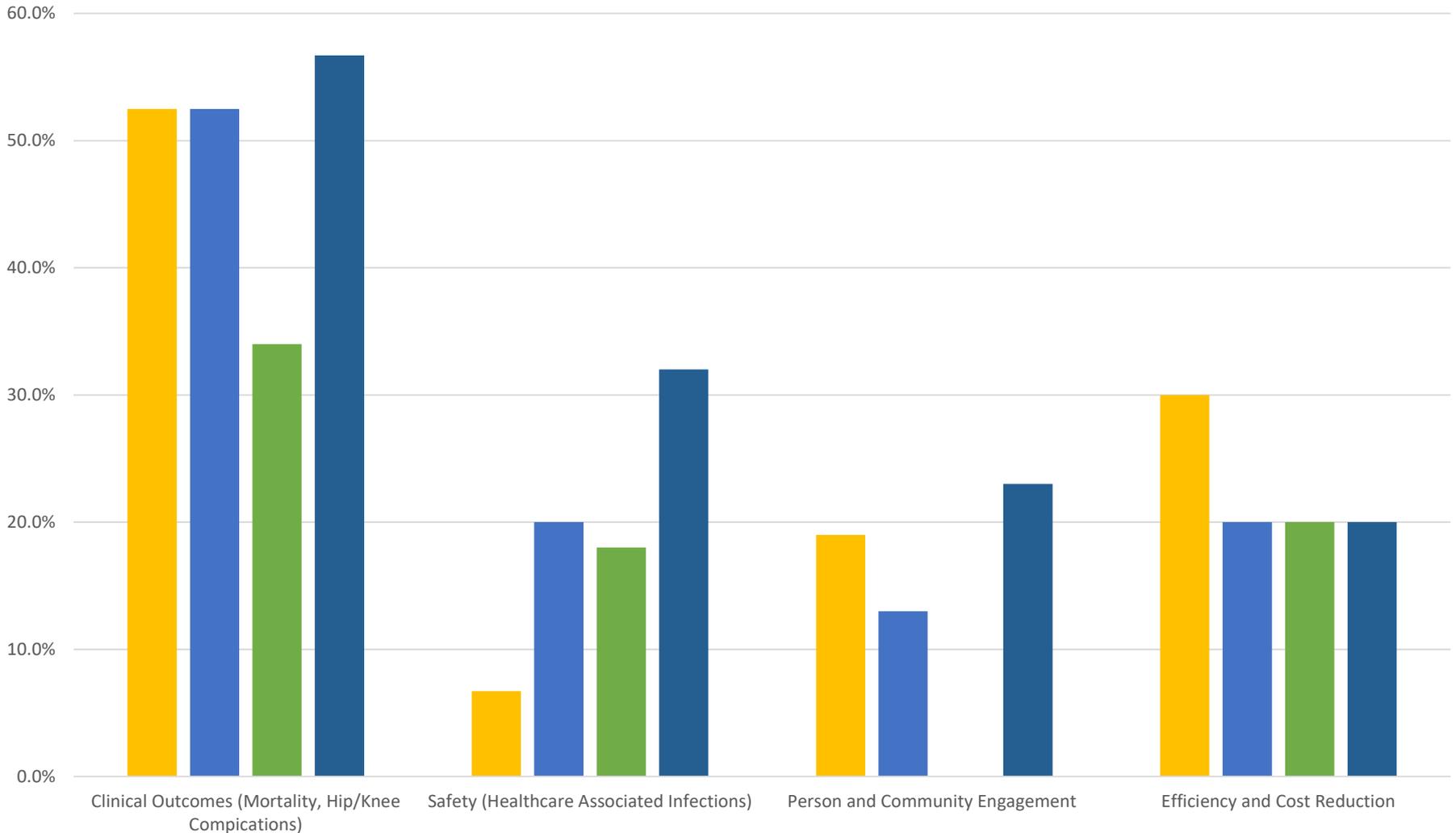
Domains	FY 2022 (Points out of 10 Possible)
<b>Clinical Outcomes - Domain Score (% of all points possible for this 25% of VBP)</b>	<b>57%</b>
Acute Myocardial Infarction	6 
Heart Failure	6 
Pneumonia	3
COPD*	2
CABG (New)	10 
Complication Elective Total Hip/Knee	7
<b>Safety - Healthcare Associated infections - Domain Score (% of all points possible for this 25% of VBP)</b>	<b>32%</b>
CLABSI - Per 1000 line days	3 
CAUTI - Per 1000 catheter days*	0
SSI Surgical Site Infection	4 
SSI Colon - Rate Per 100 procedures	4 
C. difficile - Per 10,000 patient days	6 
MRSA - Per 10,000 patient days	3 
<b>Person and Community Engagement - Domain Score (% of all points possible for this 25% of VBP)</b>	<b>23%</b>
Communication with Nurses*	0
Communication with Doctors	1 
Responsiveness of Hospital Staff	2 
Communication about Medicines*	0
Cleanliness of Hospital Environment*	0
Quietness of Hospital Environment*	0
Discharge Information	2 
Care Transition*	0
Overall Rating of Hospital	1 
HCAHPS Consistency Score	17 
<b>Efficiency and Cost Reduction-Domain Score (% of all points possible for this 25% of VBP)</b>	<b>20%</b>
<b>Medicare Spending per Beneficiary*</b>	2

\*Largest opportunity for Improvement

# FY Comparison for VBP Domain Scores

## % of all Points Possible for the 25% Domain

FY 2019 Actual    FY 2020 Actual    FY 2021 Actual    FY 2022 Estimated



# Action Plan & Teams

## **Mortality**

- Mortality committee meets once month and has identified the largest improvement opportunity is earlier palliative care. Disease-specific resource effectiveness teams are also working on best practices.

## **Hip & Knee Complications**

- Orthopedic service line reviews all complications to assess if complications are true (re-code) and identify opportunities for improvement. Initiating Enhanced Recovery After Surgery (ERAS) program in 2020 which aims to reduce complications and decrease length of stay through implementation of evidenced-based care pathways.

## **Infection Prevention**

- Infection prevention committees implement best practices for each measure. CAUTI and CLBASI Kaizen Events (Rapid Improvement) in Jan and Feb 2020 with robust action plans implemented. IV safety team continues round on all lines and monitor expired IVs. Hand Hygiene (HH) monitoring system (Biovigil) currently rolling out on a number of units with HH rates greater than 98%.

## **Patient Experience**

- Continued implementation of “Operation Always” with department specific action plans, increased leader patient rounding, and use of new survey vendor in July 2019.

## **Medicare Spending**

- Resource Effectiveness Committee and teams in place and reorganizing structure to maximize heightened focus on biggest opportunities to reduce costs.

# FY 2023 VBP Measures

Payment adjustment effective for discharges from Oct 1, 2022 and Sept 30, 2023

## New Safety Measure: PSI 90

Performance Period 7/1/19 – 6/30/21

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

Note: PSI 90 was removed from VBP in FY 2019 and will be re-integrated in FY 2023.

FY 2023 Hospital Value-Based Purchasing Quick Reference Guide				
Payment adjustment effective for discharges from October 1, 2022 to September 30, 2023				
Clinical Outcomes	<b>Mortality Measures</b>			
	Baseline Period July 1, 2013–June 30, 2016		Performance Period July 1, 2018–June 30, 2021*	
	Measure ID	Measure Name	Achievement Threshold	Benchmark
	MORT-30-AMI	Acute Myocardial Infarction 30-Day Mortality	0.866548	0.885499
	MORT-30-CABG	Coronary Artery Bypass Graft Surgery 30-Day Mortality	0.968747	0.979620
	MORT-30-COPD	Chronic Obstructive Pulmonary Disease 30-Day Mortality	0.919769	0.936349
	MORT-30-HF	Heart Failure 30-Day Mortality	0.881939	0.906798
	MORT-30-PN	Pneumonia 30-Day Mortality	0.840138	0.871741
	<b>Complication Measure</b>			
	Baseline Period April 1, 2013–March 31, 2016		Performance Period April 1, 2018–March 31, 2021*	
Measure ID	Measure Name	Achievement Threshold	Benchmark	
COMP-HIP-KNEE	Total Hip Arthroplasty/Total Knee Arthroplasty Complication	0.027428	0.019779	
Person and Community Engagement	Baseline Period Jan. 1, 2019–Dec. 31, 2019		Performance Period Jan. 1, 2021–Dec. 31, 2021	
	HCAHPS Survey Dimensions		Floor (%)	Benchmark (%)
	Communication with Nurses	53.50	79.42	87.71
	Communication with Doctors	62.41	79.83	87.97
	Responsiveness of Hospital Staff	40.40	65.52	81.22
	Communication about Medicines	39.82	63.11	74.05
	Hospital Cleanliness and Quietness	45.94	65.63	79.64
	Discharge Information	66.92	87.23	92.21
	Care Transition	25.64	51.84	63.57
	Overall Rating of Hospital	36.31	71.66	85.39
Safety	<b>Patient Safety Composite</b>			
	Baseline Period Oct. 1, 2019–June 30, 2021		Performance Period July 1, 2021–June 30, 2023	
	Measure ID	Measure Name	Achievement Threshold	Benchmark
	★ PSI 90	Patient Safety and Adverse Events Composite	0.972658	0.760882
	<b>Healthcare-Associated Infections</b>			
	Baseline Period Jan. 1, 2019–Dec. 31, 2019		Performance Period Jan. 1, 2021–Dec. 31, 2021	
	Measure ID	Measure Name	Achievement Threshold	Benchmark
	↓ CAUTI	Catheter-Associated Urinary Tract Infection	0.676	0.000
	↓ CDI	Clostridium <i>difficile</i> Infection	0.544	0.010
	↓ CLABSI	Central Line-Associated Bloodstream Infection	0.596	0.000
↓ MRSA	Methicillin-Resistant Staphylococcus aureus	0.727	0.000	
↓ SSI	Colon Surgery Abdominal Hysterectomy	0.734 0.732	0.000 0.000	
Efficiency and Cost Reduction	Baseline Period Jan. 1, 2019–Dec. 31, 2019		Performance Period Jan. 1, 2021–Dec. 31, 2021	
	Measure ID	Measure Name	Achievement Threshold	Benchmark
↓ MSPB	Medicare Spending per Beneficiary	Median MSPB ratio across all hospitals during the performance period	Mean of lowest decile of MSPB ratios across all hospitals during the performance period	

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

↓ Indicates lower values are better for the measure.

★ Indicates a new measure in the Hospital VBP Program.

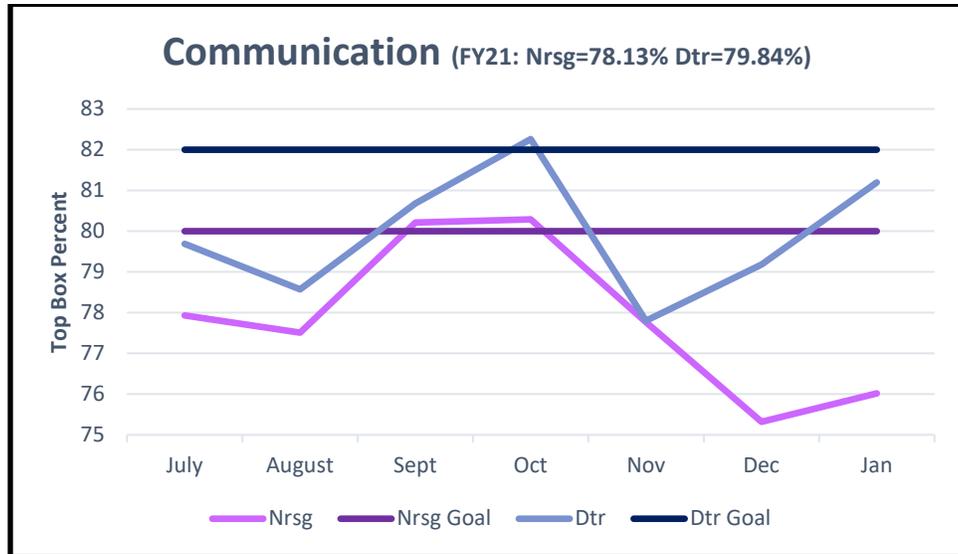
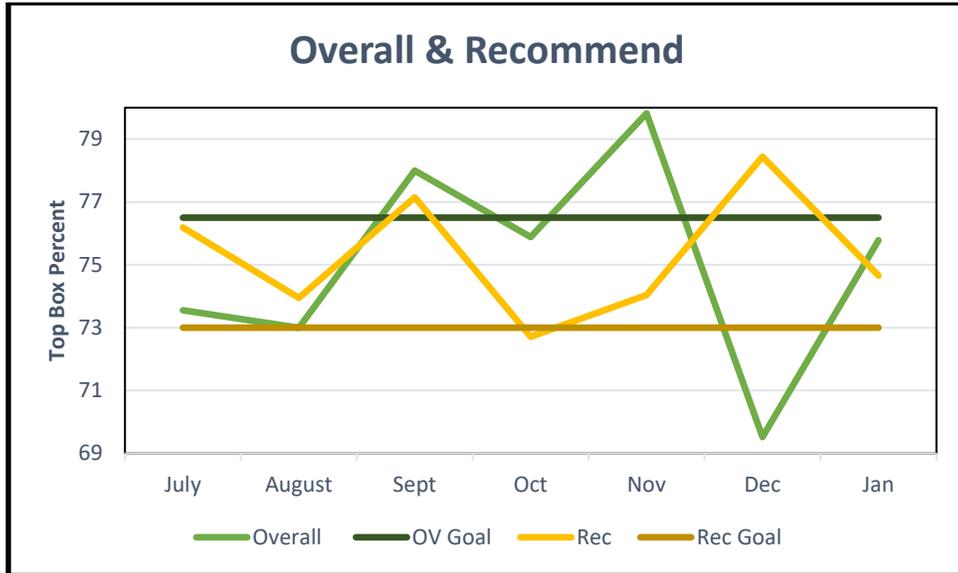
Questions?



**Quality Council Update**  
**Patient Experience (HCAHPS) Performance: June 2021**

Time Period	1Q19 -4Q19		July – March 2021	
HCAHPS Measure	Full Adj (Mode Adj + Pt Mix Adj)	CMS 50 <sup>th</sup> percentile <b>National</b>	Scores (Mode Adj Only)	Comments/Improvement Efforts
# of surveys 22% response rate	2026	-	1755	-
Communication with Nurses	77%	81%	79%	-Consistent use of <b>communication white boards</b> -Pilot <b>Patient Service Navigator</b> (3 North)
Communication with Doctors	76%	82%	80%	- <b>Patient Rounding</b> by coordinators to evaluate communication
Responsiveness of Staff	67%	70%	<b>70%</b>	- <b>Hourly rounding</b> (4 South) -Pilot <b>Patient Service Navigator</b> (3 North)
Communication about Meds	60%	66%	<b>69%</b>	- <b>Medicine guide</b> for chemotherapy and immunotherapy (3 South)
Cleanliness of Environment	68%	76%	70%	- <b>Tent cards</b> to inform patients and increase EVS accessibility - <b>Increased rounding</b> on units with low cleanliness scores
Quietness of Environment	49%	62%	57%	- <b>Increased staff awareness</b> , engagement, and commitment (4 North)
Discharge Information (Yes)	87%	87%	<b>89%</b>	- <b>Discharge rounds</b> to identify and address discharge needs -Use of <b>communication white boards</b> to communicate discharge needs
Care Transition (Strongly Agree)	47%	54%	49%	- <b>Discharge rounds</b> to identify & address discharge needs -Use of <b>communication white boards</b> to communicate discharge needs
Overall Rating of Hospital (0 = worst; 10 = best)	71% (9 or 10)	73%	<b>75%</b>	<b>OPERATION ALWAYS</b> <i>Purpose: Consistently provide world-class service</i> →Restart <b>Nurse Leader Rounding</b> →Develop <b>Kaweah Care Service Standards Class</b> →Pilot <b>Patient Service Navigator</b> (3 North) →Developing strategies to improve <b>Wayfinding</b> at downtown campus → Developing strategies to better manage patient belongings
Willingness to Recommend (Definitely Recommend)	70%	72%	<b>75%</b>	<i>Same as above</i>

**Patient Experience (HCAHPS) Trended Data: July-Dec 2020**



# Kaweah Health Dialysis Facility QAPI report

Summary of attachments:

<b>QAPI tools (excel workbooks) both dialysis facilities, as explained in Appendix A.</b>																						
monthly analysis numerous parameters indicating performance and outcomes discussing bold a disciplinary committee. There are challenges that remain in areas where improvement is needed.																						
<b>Impact On hemoglobin of hospitalization for COVID-19</b>																						
Results:																						
<table border="1"> <thead> <tr> <th colspan="3">Unpaired t-tests</th> </tr> <tr> <th></th> <th>No COVID Hospitalization</th> <th>Results within 90d of hospitalization for COVID-19</th> </tr> </thead> <tbody> <tr> <td>Mean Hgb</td> <td>10.8</td> <td>10.2</td> </tr> <tr> <td>+ SEM</td> <td>+ 0.02</td> <td>+ 0.12</td> </tr> <tr> <td colspan="3" style="text-align: center;">p&lt;0.001</td> </tr> </tbody> </table>	Unpaired t-tests				No COVID Hospitalization	Results within 90d of hospitalization for COVID-19	Mean Hgb	10.8	10.2	+ SEM	+ 0.02	+ 0.12	p<0.001			<table border="1"> <caption>Hgb impact of COV</caption> <thead> <tr> <th>Group</th> <th>Mean Hgb</th> </tr> </thead> <tbody> <tr> <td>No COVID Hospitalization</td> <td>10.6</td> </tr> <tr> <td>Results within 90d of hospitalization for COVID-19</td> <td>10.2</td> </tr> </tbody> </table>	Group	Mean Hgb	No COVID Hospitalization	10.6	Results within 90d of hospitalization for COVID-19	10.2
Unpaired t-tests																						
	No COVID Hospitalization	Results within 90d of hospitalization for COVID-19																				
Mean Hgb	10.8	10.2																				
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Group	Mean Hgb																					
No COVID Hospitalization	10.6																					
Results within 90d of hospitalization for COVID-19	10.2																					
Report focused on hemoglobin values following hospitalization with COVID-19 for patients within End stage renal disease.																						
<b>Inpatient Mortality due to COVID-19</b>																						
analysis of mortality rates in patients hospitalized with COVID-19 with a diagnosis end stage renal disease. this revealed no difference in mortality compared with patients without end stage renal failure.																						
<b>Failure of SOFA scores to adequately reflect risk of mortality for triage purposes in ESRD patients with SARS COV2 infection</b>																						
Abstract: SOFA scores were correlated with in-hospital mortality for patients suffering with COVID 19. Suspected bias introduced by the SOFA methodology in patients with end stage renal disease was investigated. Analysis revealed that the SOFA score overestimated in-hospital mortality for patients with ESRD. At the same score (or score group as defined by a triage/care rationing plan) patients without ESRD had a mortality risk 2.2 times that of patients with ESRD. It is recommended that the score for patients with ESRD be changed to reflect this disparity by using a score of 0 for the SOFA renal component.																						
<b>End-Stage Renal Disease Quality Incentive Program - Preview Performance Score Report</b>																						
scoring report for the quality incentive program for CMS																						

## Kaweah Health Dialysis Facility QAPI report Appendix A

How to read the reports:

See the spreadsheet for parameter list. Each parameter is evaluated monthly against a goal. The optimal goal represents 90th percentile functioning or higher in the US. The clinic goal represents the minimum of 50%-tile functioning, or recognized authorities such as USRDS, or establish internally by facility staff.

Optimal goals coded green, clinic goal with yellow.

Goals are grouped according to staff responsibilities for reporting and improvement.

See “Medical Director” tab for overall comments

Snapshot of QAPI Indicators											
KAWEAH DELTA VISALIA HEMODIALYSIS											
QAPI Indicators											
Month							J	F	M	A	M
INDICATORS	QIP Benchmark (90th percentile)	QIP Performance Standard (50th)	QIP Achievement Threshold (15th)	US Threshold (Core Survey)	Optimal Goal	Clinic Goal	HD	HD	HD	HD	HD
Total Patient Census							135	138	143	140	
> 90 days on ESRD, > 30 days in clinic (as indicated by QIP)							126	122	120	117	
RENAL CARE COORDINATOR											
% KT/V ≥ 1.2 (QIP)	99.42%	97.61%	94.33%	97.9%	99.42%	97.61%	97.3%	93.0%	97.3%	95.6%	
Standardized Transfusion Ratio (STrR) Reporting Measure (QIP)	Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	
# of Transfusions					0	0	4	1	4	0	
NHSN BSI Ratio (SIR = # observed BSI / # of predicted BSI) (QIP)	0	0.516	1.193		0	1.5	4.662	0.000	3.493	3.461	
# of BSI's	0	9	20		0	9	5	0	4	4	
Dialysis events/ required components reported in NHSN (QIP)	Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	
Standardized Readmission Ratio (SRR) (QIP & DFC) (2 months behind QAPI reporting)	0.629	0.998	1.268		0.629	0.998	2.198	2.198	1.709		
# of Readmissions	31	49	62		2.5	4	9	9	7		
Standardized Hospitalization Ratio (SHR) (QIP & DFC)	0.670	0.967	1.248		0.670	0.967	1.786	1.471	1.628	0.735	
# of Hospitalizations	153	228	289		12.75	19	34	28	31	14	
% of Patients with Hepatitis B											

## Correction plans for each section in respective tabs

FACILITY: Kaweah Delta Visalia Hemodialysis

### ADEQUACY MANAGEMENT - Response by Clinical Coordinator

QIP needed?	Yes	X	No	
Follow up needed?	Yes	X	No	

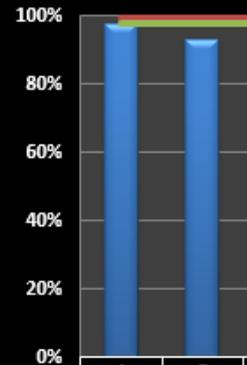
#### Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold	Optimal Goal	Clinic Goal
99.42%	97.61%	94.33%	97.90%	99.42%	97.61%

#### Notes

Data Source: QMAT, Clinical Coordinator internal tracking

Note clinic goal exceeds Threshold goals



	J	F
% Kt/V >= 1.2 (QIP)	97.3%	93.0%
Optimal Goal	99.42%	99.42%
Clinic Goal	97.61%	97.61%

### PDCA CYCLE

**FINDINGS:** 3 patients did not meet Clearance, Kt/V <1.2 (Clinic Goal >1.2)

1. Treatment time not maximized, pt previous orders to increase tx time. Pt requested decreased tx time, MD reduced tx time.
2. Recent CABG, patient previous meeting clinic adequacy goal prior to procedure.
3. Poor functioning TDC related to bleeding disorder. Elevated TMP's -requiring full change of circuit during treatment.

**FINDINGS:** 4 patients did not meet Clearance, Kt/V <1.2 (Clinic Goal >1.2)

1. Treatment time not maximized, pt previous orders to increase tx time. Pt requested decreased tx time, MD reduced tx time.

**INTERVENTIONS:** 1. F/U with MD, notified of values and of not meeting clinic goal of 1.2. No new orders recieved.

2. Orders recieved to increase tx time by 15minutes. Unable to redraw due to hospitalization.

3. Alteplased TDC, rescheduled KT/V. On Plavix.Maturing AVF. No new orders. (Pt passed for February 2021).

**INTERVENTIONS:** 1. F/U with MD, notified of values and of not meeting clinic goal of 1.2. No new orders recieved.

2. MD aware of values, pending maturing AVF.

**Plan:** 1. Redraw Kt/V with monthly lab draws. 2. Consult with MD regarding all patients not meeting clinic goal of 1.2 and

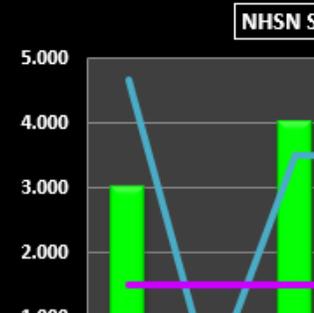
### INFECTIONS: NHSN BSI Rate - Response by Clinical Coordinator

QIP needed?	Yes	X	No	
Follow up needed?	Yes	X	No	

#### Data Comparison

QIP Benchmark	QIP Perf Standard	QIP Achieve Threshold	US Threshold	Optimal Goal	Clinic Goal
0.000	0.516	1.193	N/A	0.000	1.500

#### Notes



Data 
  **Renal Care Coordinator**
 Dietitians 
  Clinic Pharmacist 
  CRAC 
  Clinic Manager

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2021							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
<b>I. Environmental Surveillance</b>							
<b>A. Sterilization and High Level Disinfection Quality Control</b>							
Goal <2% Immediate Use Sterilization		1.20%					1st QTR: SPD saw a 0.5% decrease in IUSS events compared to the 1st QTR 2020 and has done well in sustaining limited IUSS.
<b>B. Dialysis Water/Dialysate Quality Control</b> (AAMI RD52:2004) (% of machines that did not exceed limits)							
RO Water [Target: <200cfu] [Action: > or = 50cfu]	Goal 100%	100%					1st QTR: 6 Reverse Osmosis & 5 Dialysis Machine samples tested all passed with no action required.
Endospore [Target: <2EU] [Action: > or = 1EU]		100%					1st QTR: 6 Reverse Osmosis & 5 Dialysis Machine samples tested all passed with no action required.
<b>C. Environmental Cleaning (ATP testing surfaces)</b>							
Pass/Fail based on a threshold of ATP score of <200. Multiple high-touch surfaces tested each month.	Goal 100%	67%					1st QTR: A total of 103 surfaces were tested and 69 passed the first time.
<b>II. Antimicrobial Stewardship Measures</b>							
Number of antibiotic IV to PO conversion interventions		185					1st QTR: CVICU has seen the greatest number of IV to PO conversion as there are greater opportunities for conversions due to the selections of medications often used on the unit.
<b>III. Employee Health</b>							
<b>A. Needlestick Injuries</b>							
Number of sharps/needle stick reports		23					1st QTR: There were 23 needle stick exposures (5 in January, 8 in February, 10 in March). A total of 9 of the needle stick exposures involved a SQ needle (Lovenox, Insulin, Heparin, Epoetin). There were 8 needle sticks that occurred during disposal of a needle before activating the safety mechanism and a remaining 4 needle stick injuries that occurred before activating the safety mechanism involving a different action such as obtaining a specimen, giving medications, and performing patient care. Employee Health developed an educational flyer about appropriate handling of sharps that has been shared twice at the new Safety Liaison Committee.
<b>B. Blood/Body Fluid Exposures</b>							
Number of blood/body fluid exposures		1					1st QTR: There was one blood/body fluid exposures during this quarter. Splashes are no longer required reporting per OSHA and are only internally monitored.
<b>IV. Healthcare Associated Infection Measures</b>							
<b>I. Overall Surgical Site Infections (SSI)</b>							
	IR/SIR						SSIs calculated internally though standard incidence rate and externally through Standardized Infection Ratio (SIR) from National Health and Safety Network (NHSN).
A. #Total Procedure Count		1279					Cumulative Ct.: 1279
B. Total Infection Count <i>[note: SSI events can be identified up to 90 days from the last day of the month in each quarter and only DIP and Organ Spc SSI are reported in NHSN]</i>		9					1st QTR: 9 Predicted: 17.262
C. Incidence Rate (IR) [# of total SSI infections/# total procedures x 100]	Internal 0.70 Goal	0.7					1st QTR: Total of number of SSI events matched the Statewide threshold of 0.70.
D. SIR Confidence Interval (CI-KDHCD predicted range, based on risks)		0.077, 0.822					1st QTR: Same as State average.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2021							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
E. Standardized Infection Ratio (SIR)	NHSN	0.521					1st QTR: 1 APPY, 1 CBGB, 1 CRAN, 1 SB, 1 KPRO, 1 FX, 1 XLAP, 1 FUSN. Contributing factors: Outside facilities where surgical patients are transferred are not following discharge orders and/or discharge instructions were not sent. Glucose control for Diabetic surgical patients. Post-op education and patient compliance. All of these factors are discussed at the SSI prevention committee and interventions are being considered for implementation.
<b>II. Specific Surgical Review</b>							
<b>A. Colon Surgery (COLO) CMS/VBP</b>							
1. #Total Procedure Count		36					Cumulative Ct.: 36
2. Total Infection Count		0 [0]					1st QTR: 0 Predicted: 3.053/(CMS) 0 Predicted: 1.043
3. SIR CI (KDHCD predicted range, based on risks)		, 0.981					1st QTR: Better than national benchmarks.
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.749	0 [0]					1st QTR: No COLO events excellent work!
<b>B. Cesarean Section (CSEC)</b>							
1. #Total Procedure Count		348					Cumulative Ct.: 348
2. Total Infection Count		0					1st QTR: 0 Predicted: 3.089
3. SIR CI (KDHCD predicted range, based on risks)		, 0.970					1st QTR: Better than predicted
4. SIR (Standardized Infection Ration) total	Goal SIR <1.00	0					1st QTR: No C-section events excellent!
<b>C. Spinal Fusion (FUSN)</b>							
1. #Total Procedure Count		52					Cumulative Ct.: 52
2. Total Infection Count		1					1st QTR: 1 Predicted: 0.763
3. SIR CI (KDHCD predicted range, based on risks)		NA					1st QTR:
4. SIR (Standardized Infection Ration) total	Goal SIR <1.00	1.31					1st QTR: Greater than predicted number of FUSN SSI events. Patient discharged home 2 days post-op. Event occurred 23 days post-op and patient went AMA when providers in ED recommended an I&D of abscess - he returned on day 29 post-op for the I&D procedure. Patient's glucose remained elevated post-op (DM) and his wound dehisced several days post-op.
<b>D. Hysterectomy (HYST) CMS/VBP</b>							
1. #Total Procedure Count		29					Cumulative Ct.: 29
2. Total Infection Count		1 [1]					1st QTR: 1 Predicted: 0.5 /(CMS) 1 Predicted: 0.248
3. SIR CI (KDHCD predicted range, based on risks)		NA					1st QTR:
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.727	2 [4.03]					1st QTR: 1 Predicted: 0.5 /(CMS) 1 Predicted: 0.248
<b>III. Ventilator Associated Events (VAE)</b>							
A. Ventilator Device Use SUR (standardized utilization ratio)	Goal <1.0	2.20					1st QTR: 1247 device days Predicted: 567 device days
<b>B. Total VAEs ICU (NHSN Reportable)</b>							
1. SIR Total VAE CI (KDHCD predicted range, based on risks)	Includes IVAC Plus	,0.304					1st QTR: Greater than predicted device days
2. Total VAEs		7					1st QTR: All events were related to alterations in PEEP resulting in a VAC in the ICU.
<b>C. Total IVAC Plus -ICU</b>							
1. Total IVAC Plus CI (KDHCD predicted range, based on risks)		,0.819					1st QTR: No IVAC or PVAP events. 1st QTR: Less than predicted device days

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2021							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
2. Total IVAC Plus ICU SIR	Goal SIR <1.00	0					1st QTR: No IVAC or PVAP events, only Ventilator Associated Conditions (VAC) which involves changes in PEEP and/or FiO2. Education provided to Respiratory Therapy re: limiting increases in PEEP to increments < or = 2 points.
D. Total VAEs CVICU (NHSN Reportable)	Includes IVAC Plus						
1. Total VAEs		0					1st QTR: No VAE events occurred.
2. Total IVAC Plus CVICU SIR	Goal SIR <1.00	0					1st QTR: No VAE events occurred.
3. Total VAEs-Both Units		7					1st QTR: Only VAC identified for the quarter in the presence of increased ventilator days related to the COVID-19 pandemic.
1. VAE Prevention Process Measures	Goal 100%						
% Head of Patient >or=30 Degrees (per visual inspection)		98%					1st QTR: Process measure close to goal, still some opportunity for improvement.
% Sedation Vacation		98%					1st QTR: Process measure close to goal, still some opportunity for improvement.
% of patients with oral care appropriately documented		98%					1st QTR: Process measure close to goal, still some opportunity for improvement.
<b>IV. Pneumonia Long Term Care/Rehabilitation</b>	Goal = 0						
Short Stay (# of Infections/ Incidence Rate)		0					1st QTR: No events.
Transitional Care (# of Infections/ Incidence Rate)		0					1st QTR: No events.
Subacute (# of Infections/ Incidence Rate)		2/(0.76)					1st QTR: Two patients that met Pneumonia criteria. Education provided about elevating the head-of-bed and mobility.
<b>VI. Central Line Associated Blood Stream Infections (CLABSI) CMS/VBP</b>	NHSN SIR						
A. Total number of Central Line Days (CLD)		4360					1st QTR: 4360 CLD Predicted: 5613 CLD
B. Central Line Device Use SUR (standardized utilization ratio)		0.875					1st QTR: CLD during this quarter remained <90% predicted.
C. Total Infection Count Value Based Purchasing (VBP) # events = [ ]		3 [3]					1st QTR: 3 Predicted: 4.306 /(CMS) 3 Predicted: 2.624
D. SIR Confidence Interval		0.177, 1.896					1st QTR: Same as national benchmarks.
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.633	0.697 [1.143]					1st QTR: Several interventions underway to address CLABSI (Culture of culturing; Midlines as an alternative; Gemba Rounds; Just in case culture; Nurse/Resident education; BC Alert; Candida Score; Fever defined; TPN-Enteral Feeding and Antimicrobial Stewardship - IV to PO conversion).
F. CLABSI Prevention Process Measures	Goal 100%						
% of patients with a bath within 24 hours		96%					1st QTR: Consistent bathing is improving.
% of central lines inserted with a valid rationale		98%					1st QTR: Documentation of indication for central lines has gotten much better.
% of central line dressings clean, dry and intact		95.3%					1st QTR: Dressing management needs to improve.
% of central line dressing changes no > than 7 days		99%					1st QTR: Dressing changes within 7 days has greatly improved.
% of patients with properly placed CHG patch		92.7%					1st QTR: Education for both new hire and current nurses hired within the past 1 1/2 years regarding CLABSI prevention and dressing management initiated toward the end of this quarter.
% of patients with appropriate & complete documentation		92.7%					1st QTR: Documentation appears to be posing some difficulty. Further analysis required regarding this issue.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2021							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
# of central line days rounded on		3,256					1st QTR: Gemba Rounds were performed on 74.7% of all days in which a patient had a central line in place.
<b>VII. Catheter Associated Urinary Tract Infections (CAUTI) CMS/VBP</b>		<b>NHSN SIR</b>					
A. Total number of Catheter Device Days (CDD)		4048					1st QTR: 4048 CDD Predicted: 4874 CDD
B. Catheter Device Days SUR (Standardized Utilization Ratio)	Goal <1.0	0.787					1st QTR: CDD during this quarter remained <79% of predicted.
C. Total Infection Count Value Based Purchasing (VBP) # of events = [ ]		1 [0]					1st QTR: 1 Predicted: 5.278 (CMS) 0 Predicted: 2.879
D. SIR Confidence Interval		0.009, 0.934					1st QTR: Better than national benchmarks.
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.727	0.189 [0]					1st QTR: Several interventions underway to address CAUTI (Alternatives to an IUC; Management of Urinary Retention; Urine Culture algorithm; Peri-care & Bathing; Integration of reminders in PowerPlans)
F. CAUTI Prevention Process Measures	Goal 100%						
% of patients with appropriate cleanliness		98.5%					1st QTR: While patient bathing is readily being complied with, it didn't quite achieve goal.
% of IUCs with order and valid rationale		93.5%					1st QTR: The rationale for an indwelling urinary catheter should be sought every shift during hand-off and shared at Gemba. This element needs to improve.
% of IUCs where removal was attempted		4%					1st QTR: This low percentage is an indication that generally IUC placed in patients are required.
% of patients where alternatives have been attempted		10%					1st QTR: One in every 10 patients with an IUC was transitioned to an alternative method for urine collection.
% of IUCs removed because of unit "GEMBA" rounds		6%					1st QTR: A greater amount of IUC are removed as a part of Gemba Rounds, than through conventional means.
# of IUCs removed because of unit "GEMBA" rounds		152					1st QTR: 152 indwelling urinary catheters were removed because of Gemba Rounds.
<b>VIII. Catheter Associated Urinary Tract Infections Long Term Care/Rehabilitation</b>		Goal = 0					
Short Stay (# of Infections/ Incidence Rate)		0					1st QTR: No events.
Transitional Care (# of Infections/ Incidence Rate)		0					1st QTR: No events.
Subacute (# of Infections/ Incidence Rate)		0					1st QTR: No events.
Acute Rehabilitation (# of Infections/ Incidence Rate)		0					1st QTR: No events.
<b>IX. LTC Symptomatic Urinary Tract Infections</b>		Goal = 0					
Short Stay (# of Infections/ Incidence Rate)		1					1st QTR: 1 SUTI event.
Transitional Care (# of Infections/ Incidence Rate)		0					1st QTR: No events.
Subacute (# of Infections/ Incidence Rate)		0					1st QTR: No events.
<b>X. Clostridium difficile Infection (CDI) CMS/VBP</b>		<b>SIR</b>					
A. Total Infection Count	All units	8					1st QTR: 8 Predicted: 17
B. SIR CI (KDHCD predicted range, based on risks)		0.222, 0.907					1st QTR: Same as national benchmark.
C. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.646	0.478					1st QTR: This metric is consistently performing well. Continued antimicrobial stewardship and education appears to be effective.
<b>XII. Hand Hygiene</b>							
A. Total Hand Hygiene Observations (combination of manual and electronic hand hygiene surveillance)		2,837,294					1st QTR: Nearly 3 million hand hygiene observations performed via a combination of electronic hand hygiene and manual hand hygiene compliance surveillance.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2021							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
B. All unit/departments Percentage of Hand Hygiene compliance based on observations (>200 observations/ month/unit minimum)	Goal >95%	97.2%					1st QTR: Achieved 97.2% hand hygiene compliance exceeding goal.
<b>XIII. VRE (HAI) Blood-Hospital Onset (HO)</b>							
	Goal = 0						
A. Total Infection Count		1					1st QTR: 1 Predicted: 0
B. Prevalence Rate (x100)		0.016					1st QTR: Very low prevalence rate. We rarely have VRE bloodstream infections.
C. Number Admissions		6115					Cumulative Ct.: 6115
<b>XIV. MRSA BSI LABID (HAI) Blood CMS/VBP</b>							
	SIR						
A. Total Infection Count (IP Facility-wide)		5					1st QTR: 5 Predicted: 1.494
B. SIR CI (KDHCD predicted range, based on risks)		1.226, 7.416					1st QTR: Greater than national benchmarks.
C. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.748	3.346					1st QTR: Poorest performing HAI type. Contacted State HAI Program for clarification related to State MRSA study
<b>XV. MRSA BSIs LABID - Long Term Care</b>							
Short Stay (# of Infections/ Incidence Rate)	Goal = 0	0					1st QTR: No events.
Transitional Care (# of Infections/ Incidence Rate)		0					1st QTR: No events.
Subacute (# of Infections/ Incidence Rate)		1/(0.74)					1st QTR: 1 Clostridium difficile event. Reviewed antibiotics that patient was receiving.
<b>XVI. Influenza Rates (Year 2020-2021)</b>							
	Healthy People 2020 Goal 90%						
A. All Healthcare Workers		87.5%					Of a total of 4,671 healthcare personnel including providers, volunteers and contractors worked at least 1 day during the seasonal influenza timeframe. A total of 4,085 received influenza vaccination at Kaweah Delta or provided documentation of receiving influenza vaccination elsewhere. A total of 10.4% (487) of healthcare personnel at Kaweah Delta indicated a contraindication to receiving influenza vaccine. A total of 0.5%(22) of healthcare personnel declined influenza vaccination. A total of 1.6%(77) of healthcare personnel had an unknown vaccination status through the end of the seasonal influenza timeframe.
<b>XVII. COVID-19 Vaccination Rates (Year 2020-2021)</b>							
A. All Healthcare Workers with a completed series of COVID-19 vaccinations.		57.2%					1st QTR: As of March 31st 3,321 (55.8%) or 5,949 healthcare workers received their completed series of COVID-19 vaccination doses. Another 82 (1.3%) employees received their initial dose of COVID-19 vaccine. The remaining 2,546 (42.8%) healthcare workers did not receive COVID-19 vaccine.
Approved IPC: 5/27/2021 Approved IPC: Approved IPC: Approved IPC:							
Prepared by: Shawn Elkin							

# Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

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**Unit/Department:** HAPI QFT & Inpatient Wound Prevention

**Report Date:** June 2021

## **Measure Objective / Goal:**

### The National Database of Nursing Quality Indicators® (NDNQI) Prevalence Study

Founded by the American Nurses Association (ANA) in 1998 and having been managed by The University of Kansas School of Nursing since 2001, NDNQI was purchased by PressGaney, a long-standing leader in performance measurement, in 2014. NDNQI promotes nursing excellence through the most robust source of comparative norms in the industry. Nurse sensitive quality measures and indicators reflect the impact of nursing actions on patient outcomes.

The NDNQI computes hospital acquired pressure injury (HAPI) rates based on surveys carried out by each participating hospital unit on *one (1) day each quarter*. A trained survey team carries out a skin inspection of each patient on the unit, classifies each pressure injury as hospital- or community-acquired (i.e., present on admission), and categorizes each pressure injury according to standardized guidelines as Stage 1-4, unstageable, suspected deep tissue pressure injury, or indeterminable. Hospitals report to the NDNQI the number of patients on the units who were assessed for pressure injuries and the count and category of pressure injuries observed. The NDNQI uses these data to compute pressure injury rates and, based on these rates, the percentile ranking among units/hospitals of same type.

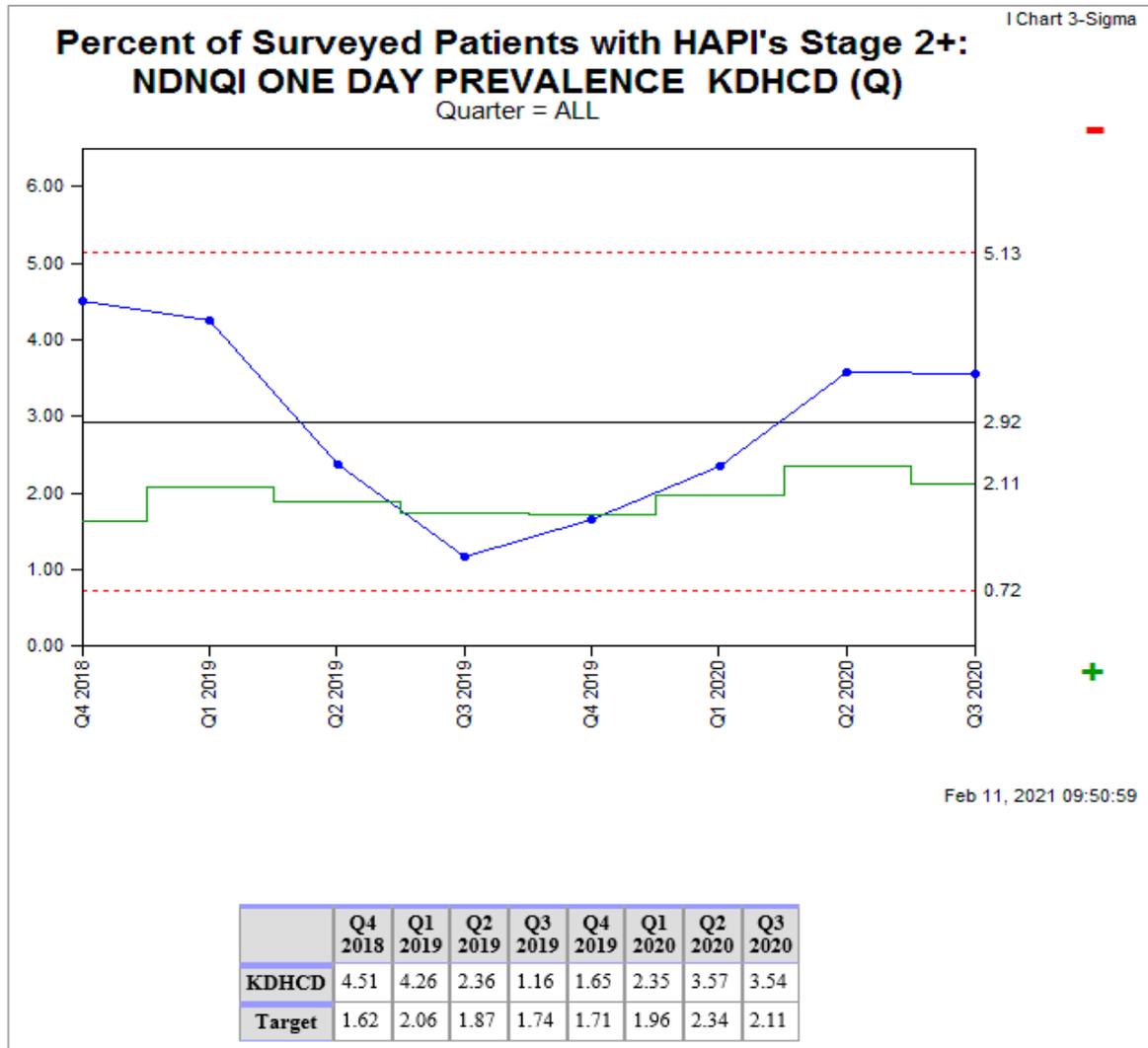
**Indicator #1** NDNQI Prevalence Study – Percent Stage 2+ HAPI in Surveyed Patients

**Goal** Outperform national target metric

**Date Range** Q3 2020

# Unit/Department Specific Data Collection Summarization

Quality Improvement Committee



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

- ⊘ **Goal #1** Not Met: Q3 2020 (3.54) underperforms compared to national target benchmark (2.11)
  - Most recent reported quarter shows slight reduction (0.84%) in HAPI Stage 2+ compared to Q2 2020

## Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

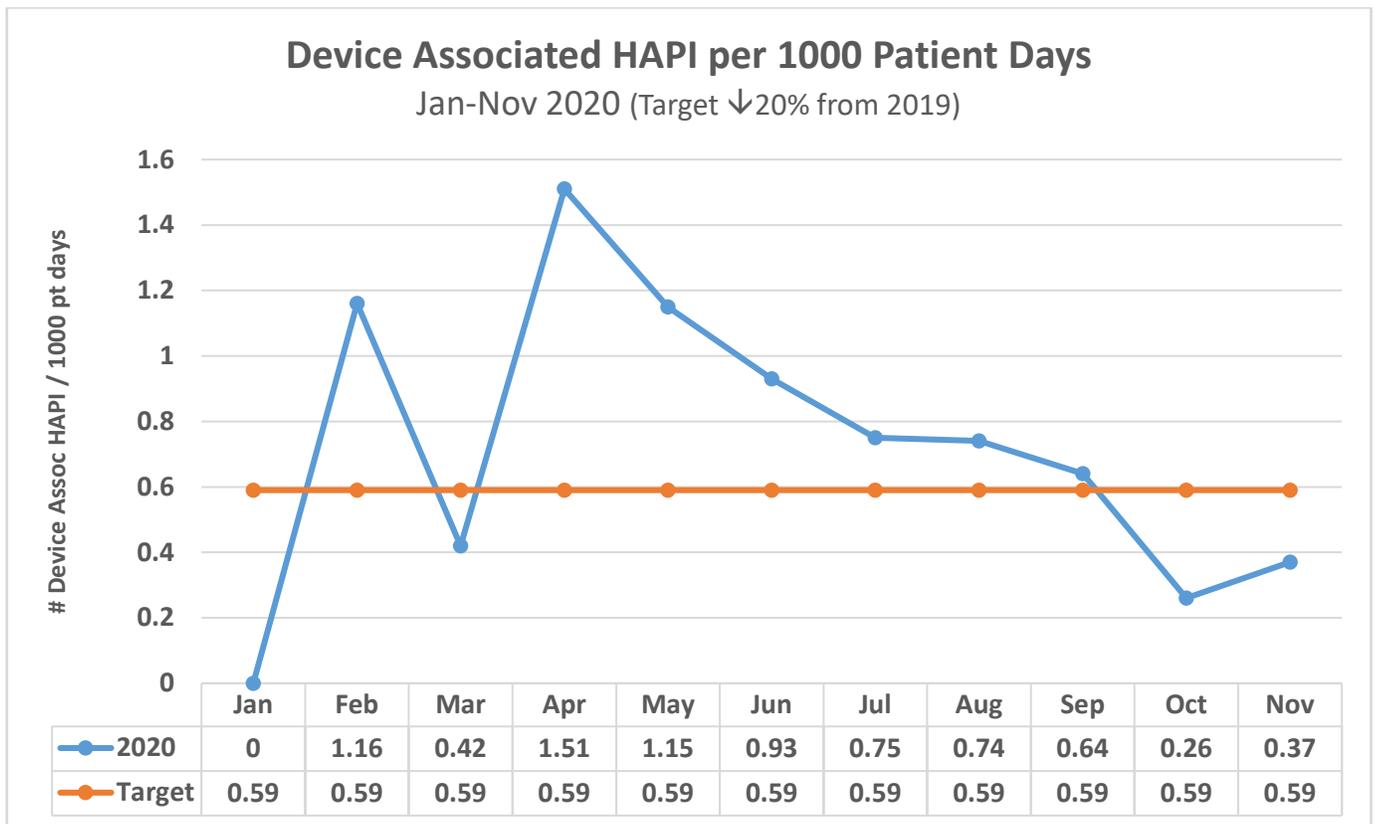
### Hospital Acquired Pressure Injuries (HAPI), Total and Device-Related

Incidence data are compiled from staff/unit-level self-report, with and without prompting from wound nurse consultant. Includes Stage 1-4, unstageable, suspected deep tissue pressure injury (DTPI).

**Indicator #2** Device Associated HAPI per 1000 Patient Days

**Goal** 0.59 (-20% from 2019)

**Date Range** October 2020 – November 2020



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

✓ **Goal #2 Met:** Oct (0.26) and Nov (0.37) below target (0.59)

## Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

HAPI QFT Dashboard														
Measure Description	Benchmark/ Target	2019												
		Baseline	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	YTD 2020
Outcome Measures														
HAPI Stage 2+ per 1,000 pt days (all HAPIs)	1.31 (-20% from 2019)	1.64	0.60	3.08	1.26	2.35	1.73	2.13	1.37	1.23	2.42	1.06	1.23	1.65
Device Associated HAPI per 1,000 pt days	0.59 (-20% from 2019)	0.74	0.00	1.16	0.42	1.51	1.15	0.93	0.75	0.74	0.64	0.26	0.37	0.70
NDNQI % Surveyed Patients Stage 2+ (1 day prevalence per quarter)	1.96 (1Q, 2020) 2.34 (2Q, 2020) 2.11 (3Q, 2020)	2.62			2.35			3.57			3.54			3.14
PSI 3 - Claims-based HAPI Stage 3, 4, and Unstageable per 1,000 discharges	0.6 - Hospital Compare (Q3 2017-Q2 2019) 0.35 - Midas 50th Percentile (2019)	0.79	1.98	1.03	2.25	0	0	1.35	2.16	1.11	0	1.20	0	1.15
Process Measures														
NEW MEASURE: Respiratory Device associated HAPI per 1,000 pt days			0	0.13	0.14	1.01	1.01	0.66	0.50	0.61	0.51	0.26	0.12	0.43
% of Respiratory Devices/All Devices			0%	11%	33%	67%	88%	71%	67%	83%	80%	100%	33%	61%
Unit Level (-15% from 2019)														
4N - HAPI 2+ per 1,000 pt days	1.14	1.34	1.15	11.03	1.24	1.69	0.00	1.29	0.00	0.00	3.79	0.00	1.24	1.98
3W - HAPI 2+ per 1,000 pt days	1.92	2.26	0.00	2.58	1.30	1.70	3.96	13.13	1.77	1.70	3.71	3.90	1.81	2.97
ICU - HAPI 2+ per 1,000 pt days	6.04	7.1	1.97	12.58	4.26	9.43	12.74	10.18	1.92	9.94	14.61	7.08	6.38	8.21
CVICU - HAPI 2+ per 1,000 pt days	4.42	5.2	4.38	8.79	9.05	8.15	1.77	4.63	14.34	6.87	9.84	0.00	5.08	6.62
2N - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	0.1	0.00	0.00	1.41	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.12
2S - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	0.7	0.00	0.00	0.00	8.81	5.85	0.00	4.21	0.00	0.00	0.00	0.00	1.72
3N - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	0.86	0.00	2.07	0.00	1.28	0.00	1.17	0.00	1.06	1.03	1.06	1.06	0.79
3S - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	0.46	0.00	0.00	0.00	0.00	0.00	1.18	0.00	0.00	0.00	0.00	3.41	0.44
4S - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	1.37	1.01	0.00	0.00	0.00	0.00	0.00	0.00	1.08	2.16	1.18	0.00	0.52
4T - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	1.23	0.00	1.72	0.00	0.00	0.00	0.00	3.62	0.00	0.00	0.00	0.00	0.50
BP - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Rehab - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	0.75	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
5T - HAPI 2+ per 1,000 pt days	n/a							0.00	0.00	0.00	1.55	1.44	0.00	0.49
Other Units														
ED	n/a	4	0	2	0	0	0	0	0	0	0	0	0	2
Sub-acute	n/a	5	0	1	0	0	0	1	0	0	1	1	2	6
Surgery	n/a	6	0	0	0	0	0	0	0	0	0	0	0	0
Cath Lab	n/a	1	0	0	0	0	0	0	0	0	0	0	0	0
MA	n/a	1	0	0	0	0	0	0	0	0	0	0	0	0
TCS	n/a	1	0	0	0	0	0	0	0	1	0	0	0	1
Green	Better than Target													
Yellow	Within 10% of Target													
Red	Does not meet Target													

## Unit/Department Specific Data Collection Summarization

### Quality Improvement Committee

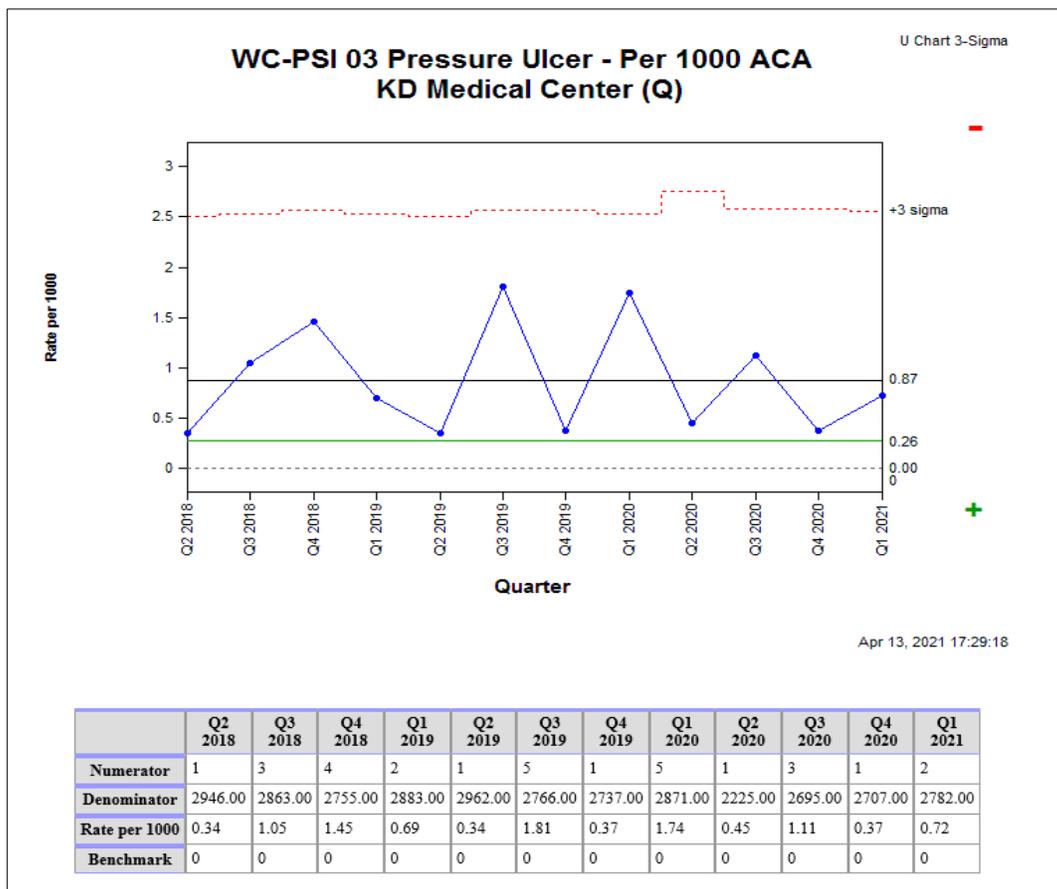
#### PSI 03: Pressure Ulcer Rate

Pressure ulcers have been associated with an extended length of hospitalization, sepsis, and mortality. The Agency for Healthcare Research and Quality (AHRQ) developed measures that health providers use to identify potential in-hospital patient safety problems for targeted institution-level quality improvement efforts. Patient Safety Indicator (PSI) 03 includes stage 3 or 4 pressure ulcers or unstageable (secondary diagnosis) per 1000 discharges among surgical or medical patients ages 18 years and older. *Exclusions: stays less than 3 days; cases with principal stage 3 or 4 (or unstageable) pressure ulcer diagnosis; cases with a secondary diagnosis of stage 3 or 4 pressure ulcer (or unstageable) that is present on admission; obstetric cases; severe burns; exfoliative skin disorders.*

**Indicator #3** PSI-03 Claim-based HAPI Stage 3, 4, Unstageable per 1000 discharges

**Goal** 0.6 (Hospital Compare)

**Date Range** Q4 2020 – Q1 2021



	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021
<b>Numerator</b>	1	3	4	2	1	5	1	5	1	3	1	2
<b>Denominator</b>	2946.00	2863.00	2755.00	2883.00	2962.00	2766.00	2737.00	2871.00	2225.00	2695.00	2707.00	2782.00
<b>Rate per 1000</b>	0.34	1.05	1.45	0.69	0.34	1.81	0.37	1.74	0.45	1.11	0.37	0.72
<b>Benchmark</b>	0	0	0	0	0	0	0	0	0	0	0	0

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

- ✓ **Goal #3** Met for Q4 2020 (0.37)
- ∅ **Goal #3** Not Met for Q1 2021 (0.72)

## Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

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### Improvement Opportunities Identified, Action Plan and Expected Resolution Date / Next Steps, Recommendations, Outcomes:

#### Ongoing

- ✓ Presented at data to patient care managers and requested written action plans for respiratory device associated HAPIs for all clinical units, as well as respiratory therapy services. Plans will be reviewed by Wound RN Team and progress monitored by HAPI Quality Focus Team (April 2021).
- ✓ Developed user-friendly HAPI Dashboard to include NDNQI and PSI benchmarks, trend unit-level HAPI incidence rates (per 1,000 patient days). In deference to nurse manager workload and direct care priorities during pandemic surge, response time for HAPI investigation was temporarily extended; therefore, the current dashboard display is current through September 2020. A recent survey of nurse managers supports reset of response timeline from 6 weeks to 3 weeks; HAPI QFT collaborated with clinical leaders to bundle HAPI responses in 2-month increments through March 2021 to facilitate return to timely reporting. See *Dashboard on p. 4*
- ✓ Expanded weekday GEMBA participation by Wound RNs to intensive care unit (ICU) to mitigate development/progression of skin issues (Oct 2020). Wound RNs participate in GEMBA in ICU Tuesday, Thursday, and Friday -- and participate in CVICU GEMBA on Wednesdays.
- ✓ Comprehensive Wound Class for new hire nursing staff held twice monthly; retro-fit staff hired post-pandemic.

#### Work in Progress

- In partnership with Quality & Patient Safety Team, utilize Lean Six Sigma tools to explore HAPI data and develop *process metrics* to include in new dashboard.

#### Ready-Set-GO!

- ★ Launching “*Clinical Skin Institute*” (CSI) Wednesday, April 14 at 2pm, creating a non-punitive learning environment to promote involvement of direct care staff in efforts to reduce HAPIs through event review, discussion and education; program tools are in development stage. The structure and function of CSI fulfills multiple action items and accountability/feedback requirements identified by work groups (as documented on corresponding Four Corner Charts) during the HAPI 6-Sigma event in November 2020. Another advantage to CSI is timely review and feedback, which is essential to monitoring impact of improvement strategies. Ideally, CSI will be the springboard to process improvement, accountability / monitoring, and HAPI event review with key stakeholders (front line staff and leaders) using Just Culture principles. See agenda and root cause analysis documents (p.7).



# Unit/Department Specific Data Collection Summarization

## Quality Improvement Committee



**Clinical Skin Institute**  
**Date: April 14, 2021**  
**GoToMeeting, 2:00-3:00pm**

**Facilitators:** *Mary Laufer, Rebekah Foster and Wendy Jones*

KDHCD is committed to eliminating hospital acquired pressure injuries (HAPI) and ensuring zero harm. The purpose of Clinical Skin Institute (CSI) is to provide a non-punitive learning environment for review all HAPIs Stage 2+ at the Medical Center. Through Review of each HAPI event includes recommendations for improvement ("takeaways") to share with other clinical staff and leaders.

**Participants / Units:** *2North, ICU, 4Tower*

*"The information discussed during Clinical Skin Institute meetings is confidential and is protected under the Attorney/Client Privilege and protected from disclosure under California Evidence Code Section 1157. If protected by the attorney/client privilege or by California Evidence Code Section 1157, the discussion shall continue to be protected and will not be negated by virtue of sending meeting minutes to other individuals or committees within the District."*

Table-1

	12 hours	24 hours	36 hours	48 hours	60 hours	72 hours
<b>Stage 1:</b> Nonblanchable erythema occurs within 12-24h						
<b>Stage 2:</b> Superficial injury with ulceration of skin presents within 24h						
<b>Deep tissue pressure injury (DTPI):</b> Dark red, maroon or purple intact skin presents within 48h						
<b>Stage 3:</b> Full-thickness loss of skin and soft tissue presents within 72h						
<b>Stage 4:</b> Full-thickness loss of skin and soft tissue occurs extending to the ligament or bone presents within 72h of assessment						
<b>Unstageable:</b> Extent of the wound bed occluded by slough or eschar presents within 72h or earlier						

Black, J.M. (2019). Root cause analysis for hospital-acquired pressure injury. *Journal Wound Ostomy Continence Nursing*, 46(4), 298-304.

\*Medical device related pressure injury (MDRPI): The PI under a medical device that appears in the shape of the medical device. The PI often involves the mucous membrane, which cannot be staged using the staging system. The time frame present here likely still applies.

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ROOT CAUSE ANALYSIS				
Unit:	FIN:	Age:	Gender:	
1. <b>Skin / soft tissue wound is a pressure injury (PI)</b>		Stage:	<input type="checkbox"/> <b>Device related:</b> <i>(describe)</i>	
		Check if Respiratory: <input type="checkbox"/>		
2. <b>When did the PI start? Pressure injuries develop over time...</b> <i>The time frame may guide decisions about where the patient was located at the time pressure was applied to soft tissue (see Table-1). It is important to understand the timing of PI development so that changes to care processes may improve the entire span of care.</i>		Admit Date: _____/_____/_____	PI Discovery Date: _____/_____/_____	
3. <b>Where is the PI (anatomical site)?</b> <i>Identifying the location of a PI provides clues to events leading to its occurrence. Combining duration of pressure and location of the injury may narrow investigation to a more circumscribed series of events preceding the PI.</i>		Anatomical Site: _____		
4. <b>Based on #2 &amp; #3, what was facility location / treatment of patient at the time pressure was applied to soft tissue?</b> <i>(see Table-1)</i>		Unit & Treatment: Duration of Treatment / Procedure: _____		
5. <b>Examine the Processes of Care</b>		Documented PI risk injury assessment:		
a. <b>Assess accuracy of initial PI risk injury assessment</b>		<input type="checkbox"/> Braden Score: _____ <input type="checkbox"/> Mobility/activity level: <input type="checkbox"/> Nutritional status: <input type="checkbox"/> RASS Score: _____		
i. Braden Scale				
ii. Physical Therapist's notes (mobility & activity level)				
iii. Dietician's notes (nutritional status)				
iv. Richmond-Agitation-Sedation Scale (RASS) (level of consciousness)				
b. <b>Determine if a logical plan of care was formulated based on initial PI risk assessment.</b>		<input type="checkbox"/> iPOC initiated based on risk level Documented Interventions / Assessments:		
v. Preventative interventions initiated (PIP)		<input type="checkbox"/> PIP		
vi. Skin assessment		<input type="checkbox"/> skin assessments (per policy)		
vii. Risk assessment		<input type="checkbox"/> hemodynamic stability		
viii. Routine turning & repositioning		<input type="checkbox"/> risk assessments		
ix. Support surfaces		<input type="checkbox"/> turning & repositioning q 2		
x. Use of repositioning devices		<input type="checkbox"/> support surfaces		
xi. Preventative dressings		<input type="checkbox"/> repositioning devices		
		<input type="checkbox"/> preventative dressings		
6. <b>Brief summary of gaps in patient care processes:</b>				
7. <b>System-level aspects identified:</b>				
COMMON CAUSE ANALYSIS ...			YES	NO
<i>Seeks out common threads of timing, personnel, equipment, and processes resulting in a recurrent event</i>				
A. <b>Was the event related to human factors?</b> <i>(ie. fatigue, lack of complex critical thinking, failure to follow P&amp;P, inability to focus on task, inattentional blindness, rushing to complete task)</i>				
B. <b>Was the event related to equipment / device?</b>				
C. <b>Was the event related to staffing?</b> <i>(Was staffing adequate?)</i>				
D. <b>Would training/education have prevented the event?</b> <i>(staff competency)</i>				
E. <b>Was the event related to failure in communication?</b> <i>(between staff, or between pt/family and staff)</i>				
*STAFF* KEY TAKEAWAY				
<b>Because of this experience, what is one thing that you would share with another staff member?</b>				

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## Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

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*Of note, I have assumed new leadership responsibilities as Director of Clinical Education and Nursing Practice and am working with Rebekah Foster, Director of Throughput and Specialty Practice, to handoff HAPI QFT and oversight of our exceptional Wound RN Team. I will continue to provide mentoring and support to Rebekah and the team during our ongoing transition.*

**Submitted By:**

Mary Laufer, DNP, RN, NE-BC  
Director of Clinical Education & Nursing Practice

**Date Submitted:** April 13, 2021

# Handoff Quality Focus Team

## 06/02/2021

**Kassie Waters, Director of Cardiac Critical Care Services**

# Team Mission

**Implement standardize structure for nurse to nurse handoff when admitting a patient from the Emergency Department to in-patient departments.**

**Standardize structure will:**

- Include critical content to eliminate communication errors.**
- Provide accurate and complete information to the receiver.**
- Meet the needs of the sender and receiver to handoff and receive care.**
- Accomplish a timely handoff (transfer) of the patient to the admitting department by removing barriers.**



# Team Deliverables & Goals

## Deliverables

1. Establish standard process
2. Standardize critical content elements
3. Build standard handoff tool utilizing EMR
4. Standardize training & education

## Goals

### Quality of Handoff Measurement

1. ED nurse "sender" provided accurate and complete information with 80% of handoffs (Current state is 15%)

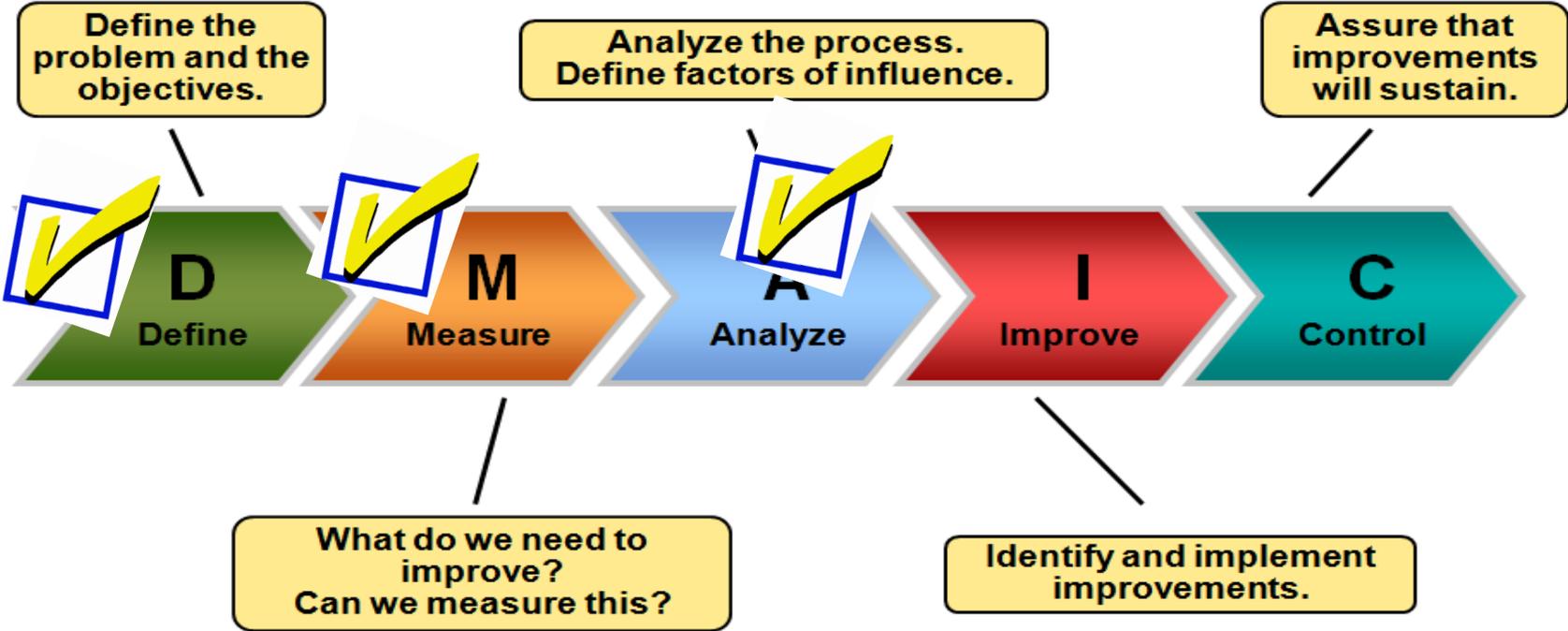
### Timeliness Measurement

2. Handoff completed and bed occupied with in 30 minutes of the bed being ready. (Current state is 1hour 18 minutes)



# DMAIC

## DMAIC Roadmap



# Identified EMR Handoff Dashboard For All Acute MS and Critical Care

**Visit Summary**

Attending Physician:	Beggs, Leland K	05/22/21 12:53
Service:	Intermediate Critical Care	05/11/21 11:16
Resuscitation Status:	06/01/21 14:37:00 PDT, Do Not Resuscitate (Allow Natural Death)	06/01/21 14:37
Advance Directive:	No results found	
Isolation:	No results found	
Head of Bed:	05/11/21 15:40:00 PDT, Head of Bed Level: 30 degrees or GREATER, Stop: 05/11/21 15:40:00 PDT	05/11/21 15:40
Chopped Diet:	05/14/21 10:07:00 PDT	05/14/21 10:07
Pain Score:	0 = No pain	06/02/21 17:00

**Vital Signs**

	Latest within	Previous within	
Temp	37.1 32 mins	↑ 37.9 32 mins	37.8 92 mins
HR	91 32 mins	91 32 mins	89 92 mins
Respiratory Rate	↑ 31 32 mins	↑ 23 92 mins	↑ 22 3 hrs
BP	117/55 32 mins		

**Psychosocial Factors (3)**

Preferred Communication Mode	Verbal	05/11/21 15:12
Faith/Denomination	Roman Catholic, Other: Catholic	05/11/21 15:12
Domestic Concerns	None	05/11/21 11:39

**Problems**

Priority	Problem
	Acute blood loss anemia
	AKI (acute kidney injury)
	Cholecystitis with cholelithiasis
	Group B streptococcal infection
	Hepatitis C
	NSTEMI (non-ST elevated myocardial infarction)
	Paroxysmal atrial fibrillation with RVR

**Flagged Events (7)**

Event/Comment	Date
Oxygen Therapy BiPAP	06/01/21 19:55
ET Tube Centimeter Marking Depth 24 cm	05/24/21 19:42

**Overdue Tasks (0)**

No results found

**Media Gallery (0)**

All Visits: Last 30 days

Filter applied

View Selection Clear Selection Search

No results found

**Lines, Tubes, and Drains (4)**

Lines (3)	Last Documented
er) eresis catheter	06/02/21 17:51
m Right 18 gauge	06/02/21 13:12
men Right,	06/02/21 07:29
	06/02/21 17:50

Met with ICU, ED, and MS front line staff and reviewed EMR tools used for handoff. All staff interviewed already used or liked the dashboard nurse view.

- Every nurse seeing the same information in the same order.

# EMR Handoff Tool Next Steps

1. Meet with ISS to review dashboard functions and options.
2. Present dashboard tool to Nursing Shared Decision group to obtain feedback.
3. Finalize handoff tool.
4. Organize education and roll out.
5. Measure accuracy and completeness of report.

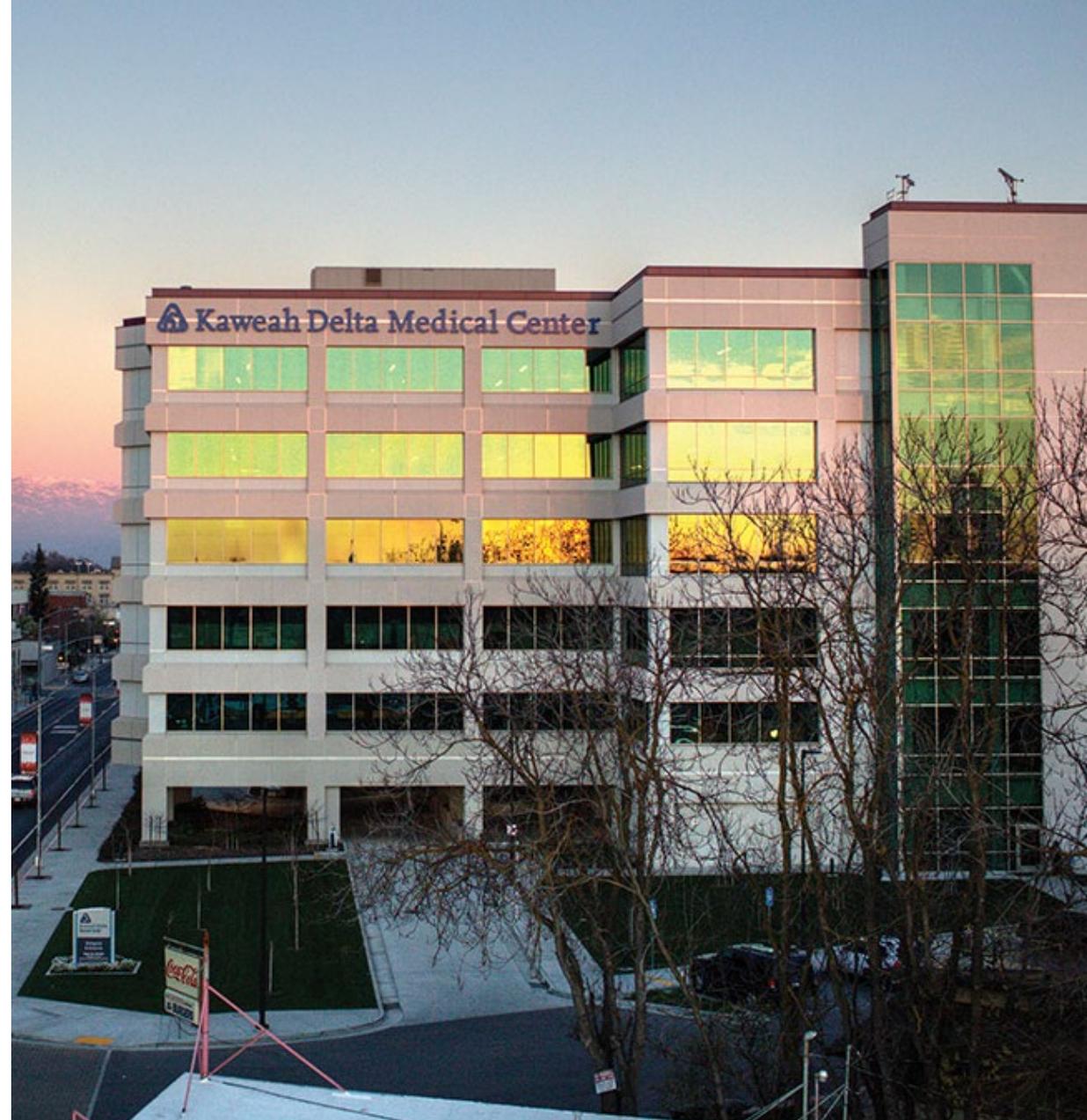
## Other Steps

1. Implementing standard process to utilize the LVN break nurse to receive handoff between departments for admissions and transfers when the primary RN not available. In-Process → Working on department education.

# Questions

# Clinical Quality Goal Update

June 2021



# FY 21 Clinical Quality Goals

**Jul 20 - Apr 21**  
Higher Is Better

FY21 Goal

FY20

Last 6 Months  
FY20

<b>SEP-1</b> (% Bundle Compliance)	<b>75%</b>	≥ 70%	67%	69%
---------------------------------------	------------	-------	-----	-----

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

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

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

	July 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual divided by number expected)	FY21/ FY22 Goal	FY20
<b>CAUTI</b> Catheter Associated Urinary Tract Infection	1	0	1	1	1	1	0	1	0	3	1	18	0.537	≤0.727 ≤0.676	1.12
<b>CLABSI</b> Central Line Associated Blood Stream Infection	2	1	1	0	1	2	1	2	0	0	1	15	0.743	≤0.633 ≤0.596	1.2
<b>MRSA</b> Methicillin-Resistant Staphylococcus Aureus	1	3	2	2	1	1	2	2	1	2	0	5-6	3.033	≤0.748 ≤0.727	1.02

\*based on FYTD21 NHSN predicted

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

# CAUTI & CLABSI Near Misses May 2021

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

CLABSI Near Miss Event	Amt.	Unit	LOS	CAUTI Near Miss Event	Amt.	Unit	LOS
5/2/2021	1	4N	9	5/5/2021	1	4S	8
5/5/2021	1	4N	13	5/8/2021	1	4S	9
5/24/2021	1	ICU	5	5/12/2021	1	2N	18
				5/16/2021	1	4T	20
<b>TOTAL</b>	<b>3</b>			<b>TOTAL</b>	<b>4</b>		

# Key Strategies

## Sepsis, CAUTI & CLABSI

- Sepsis required physician notification of sepsis alert - results in timely best practice intervention, “the bundle”
  - Finalizing notification form with ISS
  - Education in development with Clinical Education
  - Rounding in all units by Sepsis Coordinators on all shifts to reinforce education
- CAUTI & CLABSI
  - Gemba’s! And trialing handoff process using Gemba elements
  - Task force for retention management
  - Letter to providers who were involved with a CAUTI event, going to physician leaders for approval
  - EMR changes to improve catheter appropriateness, adherence to bundle elements and to manage retention
  - New alternatives to catheter products trials
  - Including peripheral IVs to critical care gemba (evaluating “just in case lines” and care practices)
  - Evaluating new midline dressing kits (current kits missing necessary items)
  - Education on CAUTI & CLABSI prevention for all residents completed and on annual schedule!

# Key Strategies

## MRSA

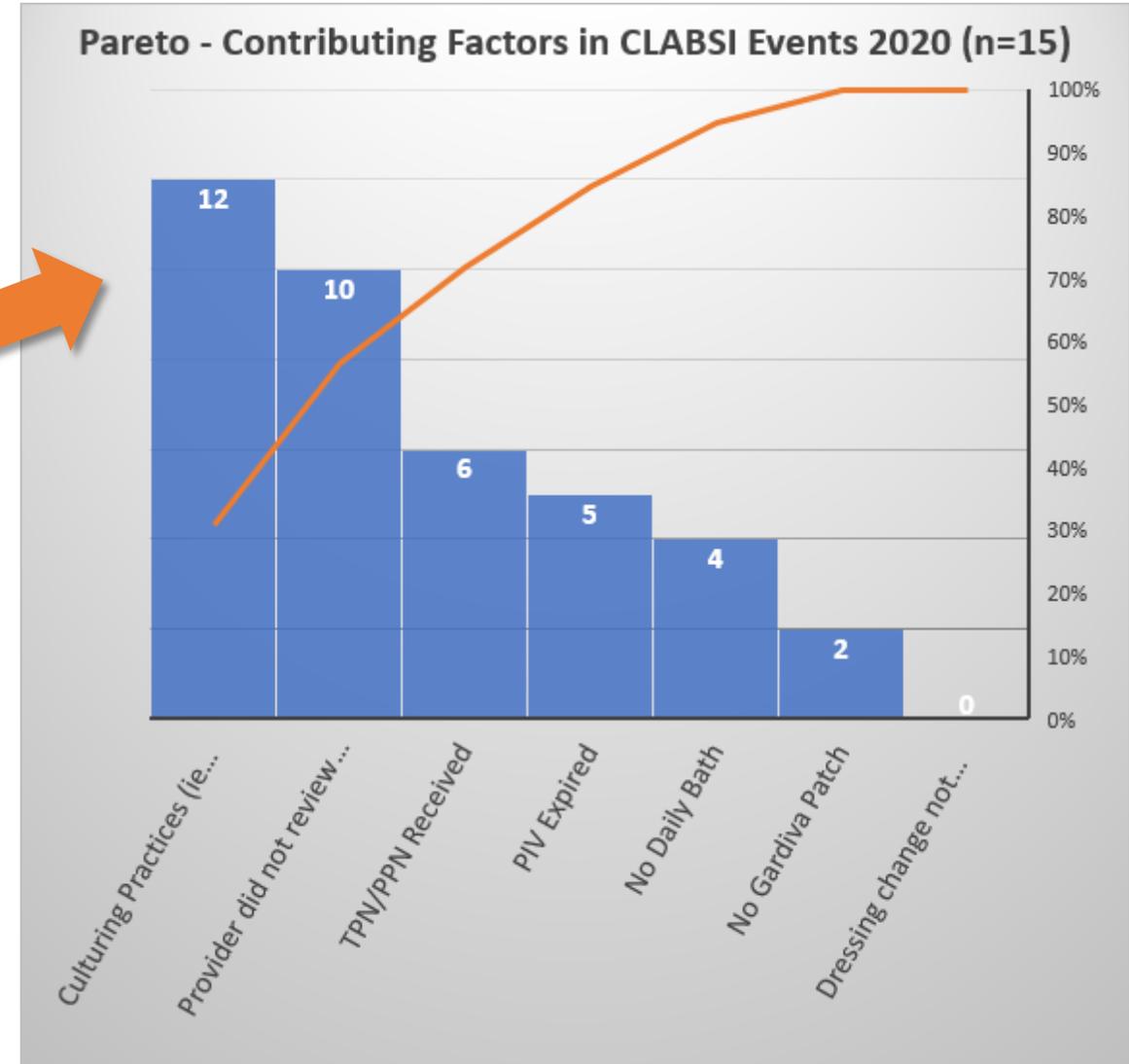
- Nasal Decolonization – evaluating current process
  - Review process and best practices with Infection Prevention Officer (Dr. Boken)
  - Screening on admission of identified high risk patients
  - Nasal swab MRSA testing of those with positive screen
  - Evaluating hardwiring treatment of positive nasal screens
  - MRSA process compliance results disseminated unit-level
- CHG Bathing – review of process in Med/Surg locations
- BioVigil
  - Transitioning to KD badge use – allows efficient management of system and accurate identification of staff using the system and hand hygiene compliance results
  - Manager one-on-ones for report reviews

# Key Strategies

## Culture of Culturing

### Why are we working so hard on culturing practices?

- Culture practices are the top contributing factor in CLABSI and CAUTI
- Specimens are collected (often blood or urine) to see if the patient has microorganisms present that may require treatment, like antibiotics
- Culture of culturing refers to knowing when to obtain cultures
- Cultures that are obtained when they are not indicated can lead to:
  - Patients receiving treatments (ie. antibiotics) that are not needed, which can lead to other problems such as C Diff.
  - The misidentification of infectious process in a patient with a line – CLABSI, CAUTI & MRSA



# Action Plan Status June 2021

## Culture of Culturing

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

### SUMMARY

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

# Questions?

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# METER

## Midas Event Triage & Ranking Committee

June 2021



[kawahhealth.org](https://www.kawahhealth.org)



# Need

## Timely Notifications

Regulatory activity nationally and recent events indicates a need to enhance processes to escalate events quickly to Medical Staff Leadership and Org Leadership so that appropriate action can occur to prevent patient harm



# Enhancing Processes

## Triaging and Ranking Events

### Process:

A multidisciplinary committee meets each weekday to review event reports from the previous 24 hrs. (10-15/day, additional time allocated for Mondays).

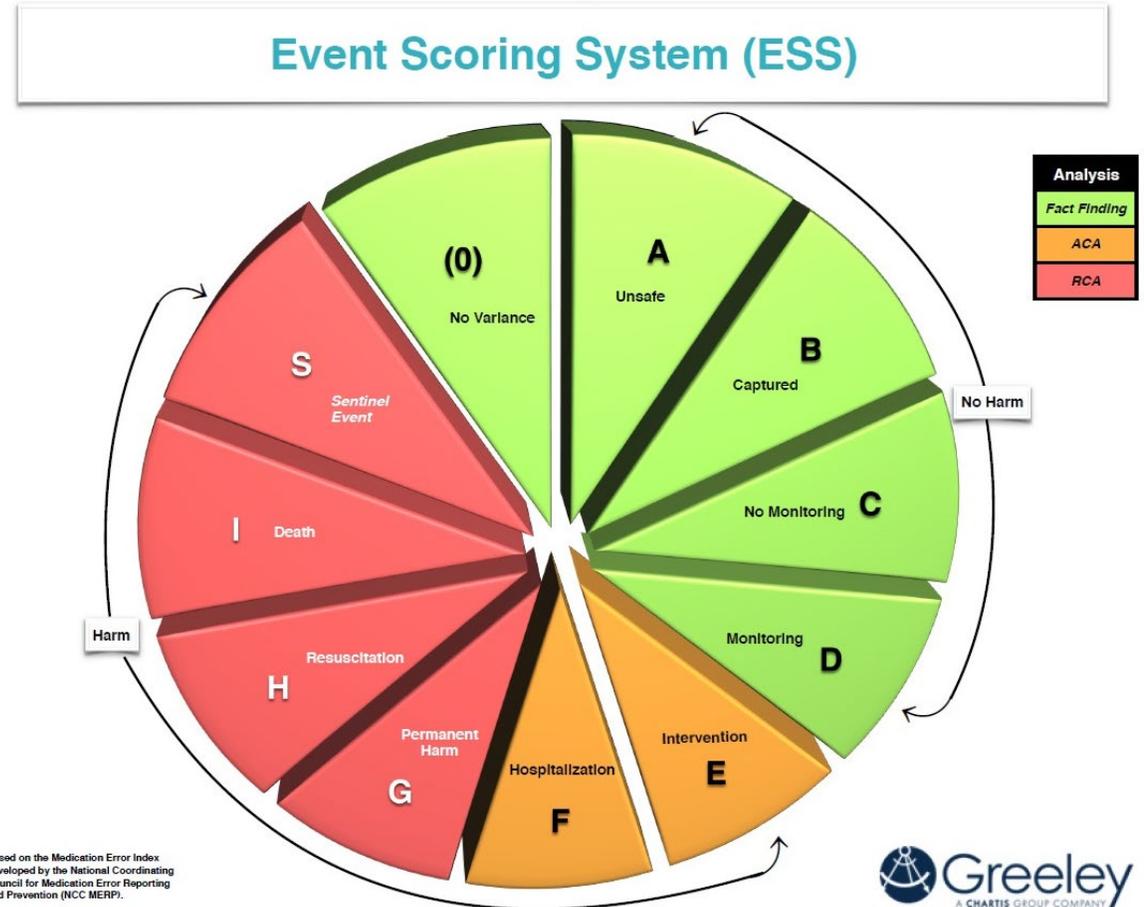
### Membership Includes:

- Chief Compliance Officer (Sponsor)
- Medical Director of Quality
- Director of Risk Management
- Director of Quality & Patient Safety
- Peer Review Coordinator
- Medication Safety Coordinator
- Director of Pharmacy
- Nursing Director on Call (each week)
- Admin on call (each week)

# METER

## Midas Event Triage & Ranking Committee

- Objective: Rank and Triage Events through a multidisciplinary team daily so that immediate notification of high risk events can be made to Medical Staff Leadership and Hospital Leadership
- Events are reviewed daily Monday through Friday (weekend events reviewed Monday with RM notification processes in place on weekends)
- Events are triaged using a criticality matrix in which members of the committee would come to consensus on event scoring

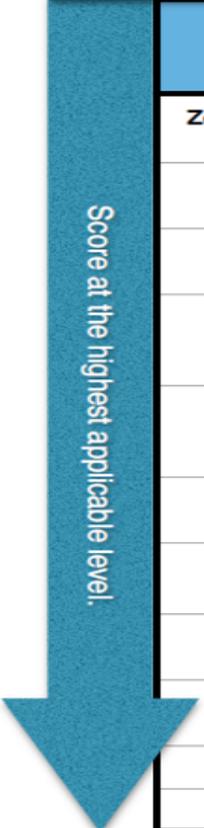


# METER

## Midas Event Triage & Ranking Committee

Sifting Through Adverse Events			
ESS	Description	Infrastructure	Harm?
Zero (0)	<b>No Variance:</b> No known or suspected error or adverse state. Includes recommendation for improvement.	✓	No Harm
A	<b>Unsafe:</b> There was in increased capacity for error, even though no error was identified.	✓	No Harm
B	<b>Captured:</b> An error occurred but it did not reach a person or infrastructure.	✓	No Harm
C	<b>No Monitoring:</b> An error occurred that reached a person or the infrastructure, but there was <i>no need</i> for monitoring or intervention.	✓	No Harm
D	<b>Monitoring</b> was necessary to look for potential signs of harm or damage. Monitoring includes non-invasive diagnostic testing.	✓	No Harm
E	An <b>Intervention</b> was necessary to avoid further harm to the patient or infrastructure.	✓	Harm
F	The error lead to an initial or prolonged <b>hospitalization</b> .		Harm
G	The error contributed to <b>permanent harm</b> to a person or the infrastructure.	✓	Harm
H	<b>Resuscitation:</b> Intervention necessary to sustain life that involved advanced life support protocols.		Harm
I	<b>Death</b>		Harm
S	<b>Defined Sentinel Event</b>		Harm

Score at the highest applicable level.



# METER

## Midas Event Triage & Ranking Committee

### NOTIFICATION:

The hospital Executive Team and Chief of Staff (when appropriate) shall be promptly notified when he/she/they become aware of an event that meets one or more of the ESCALATION CRITERIA described below. The Chief Executive Officer should use discretion to determine whether, when, and how the Board of Directors is notified of the event.

### ESCALATION CRITERIA:

- Adverse Events scored by METER as an actual or Near Miss category:
  - G - The event contributed to permanent harm to a person or the hospital's infrastructure
  - H - The event resulted in the need to initiate life support protocols (e.g. CPR, ALS)
  - I - The event resulted in the death of an individual
  - S - The event was a "sentinel event" as defined in the hospital's AP.87 "Sentinel Event and Adverse Event Response and Reporting"

# METER

## Midas Event Triage & Ranking Committee

### ESCALATION CRITERIA CONTINUED:

- Events that are required by law to be reported to a state, federal, or accrediting agency
- A report alleging potentially illegal activity by a hospital employee, contractor, student (undergraduate or postgraduate), or Practitioner. Such potentially illegal activities include but are not necessarily limited to
  - Diversion of controlled substances, or
  - Abuse, or
  - Neglect
- A report alleging harassment based on gender or ethnicity
- A citation or finding by a regulatory or accrediting agency; and
- Any other verified or unverified event that places the hospital at significant risk, including the risk of adverse publicity.

# METER

## Midas Event Triage & Ranking Committee

### MONITORING

- A summary report of significant occurrences will be provided monthly to the Patient Safety Committee
- A summary report of significant occurrences will be provided to the Quality Improvement Committee

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# Diversion Prevention Committee Charter

California Evidence Code section §1157

<b>PROJECT NAME:</b> <b>DIVERSION PREVENTION COMMITTEE</b>	<b>PHYSICIAN CHAMPION:</b> <b>Dr. Tom Gray</b> <b>Dr. Eric Morell</b>	<b>Facilitator:</b> <b>Keri Noeske</b>	<b>SPONSOR:</b> <b>Keri Noeske</b> <b>Dianne Cox</b>
<b>TEAM MEMBERS:</b> Dr. E. Morell, Dr. T. Gray, James McNulty, Evelyn McEntire, Raleen Larez, Ben Cripps, Miguel Morales, Laura Florez-McCusker, Sandy Volchko, Mary Laufer, Gaby Robles, Dr. S. Park, Dr. K. Nguyen, Lacey Jensen, Dr. L. Winston, Shannon Cauthen			
<b>PROBLEM STATEMENT:</b> Organization has strong processes for gathering data and dissemination reports to monitor control of drugs. We are missing a standardized expectation of follow-up on those reports by the managers and medical staff. We also have an opportunity to broaden awareness of concerning behaviors and build a culture of escalating observations of strange behaviors.	<b>PROJECT GOAL:</b> Develop organizational program to build awareness of and response to behaviors suspicious for drug diversion. Build a culture within the organization of attention to drug diversion prevention. Implement education into orientation and annual training related to drug diversion and awareness for all health care professionals. Ensure accountability for action items related to routine audits and medication related reports by department leaders. Use technology and automation to ensure reporting is routine and applicable. Determine expected actions to be taken and communicate those actions to department leaders when abnormal reports are shared.		
<b>SCOPE:</b> Education – Organization Wide (Orientation and Annual) Accountability - Standardization of use of reports and follow-up with team members Sustainability – Identify best course for ongoing reporting and follow-up with organization action items. Committee as part of the organizational Quality Assessment Performance Improvement (QAPI) program reports to Patient Safety Committee and Med Safety Committee	<b>MEASURES:</b> <ul style="list-style-type: none"> <li>• Implementation of annual education, orientation education for employees and medical staff related to drug diversion.</li> <li>• Interviews of KDHC team members and medical staff to determine understanding of the education and organizational expectations.</li> <li>• Development of a supervisor/leadership training program to provide enhanced skills for detecting and preventing diversion activities.</li> <li>• Compliance with audits outlined in CMS plan of correction.</li> </ul>		

CONFIDENTIALITY - Pursuant to the Kaweah Health Staff Bylaws, and consistent with California Evidence Code section §1157, all records and proceedings of Medical Staff committees are confidential.

# Diversion Prevention Committee Charter

California Evidence Code section §1157

	<ul style="list-style-type: none"> <li>• Monthly review of audit dashboard reveals improvements in audit outcomes.</li> <li>• Timely follow-up by organizational leaders for action plans and identified improvements.</li> </ul>
<p><b>FINANCIAL IMPLICATIONS:</b>          Workshop Time          Diversion Committee Membership Time and Hours          0.25 FTE for Data Analysis, Trends and Organization Education Oversight – Chair of Diversion Prevention Committee, reporting responsibility into QAPI program</p>	
<p><b>TIMELINE &amp; PLAN:</b></p> <ol style="list-style-type: none"> <li>1. 6/1/21 – Charter Development including roles of individuals on committee</li> <li>2. 6/1/21 Monthly meetings scheduled with agendas to include review of audits and reports from pharmacy.</li> <li>3. 6/1/21 Information on role of committee shared with organization leadership – including expectations for reporting back into DPC when action items assigned.</li> <li>4. 6/30/21 reviewed the existing reports and audits to see which ones will be reviewed at the committee</li> <li>5. 7/31/21 Onboarding education for leadership – checklist updated</li> <li>6. 7/31/21 Assess first quarter meetings, actions and follow-ups completed. Determine committee changes and opportunities for improved impact on organization diversion prevention.</li> <li>7. 8/31/21 Review compliance by patient care departments with ongoing improvements related to diversion action plans. Escalate follow-up concerns to Quality Improvement Council for assessment and action steps.</li> <li>8. 7/31/21 Implement monthly reporting to Patient Safety Committee and Medication Safety Committee on work and measures of success for DPP.</li> <li>9. 9/30/21 Implement quarterly reporting to Quality Committee on work and measures of success for DPC.</li> </ol>	

CONFIDENTIALITY - Pursuant to the Kaweah Health Staff Bylaws, and consistent with California Evidence Code section §1157, all records and proceedings of Medical Staff committees are confidential.

**Diversion Prevention Committee**  
**May 24, 2021**  
**Minutes**

California Evidence Code section §1157

<b>Members Present: Keri Noeske, James McNulty, Evelyn McEntire, Raleen Larez, Ben Cripps, Miguel Morales, Laura Florez-McCusker, Mary Laufer, Shannon Cauthen, Lacey Jensen</b>			
Dianne Cox (HR, Administration)	James McNulty (Pharmacy)	Laura Florez-McCusker (Media/Communications)	Dr. Tom Gray (Quality, Medicine)
Raleen Larez (Employee Health, Employee Relations)	Evelyn McEntire (Risk)	Miguel Morales (Security)	Dr. Lori Winston (GME, EM)
Dr. Eric Morell (Anesthesiology)	Shannon Cauthen (Nursing – Critical Care)	Gaby Robles (Employee Health)	Ben Cripps (Compliance/Risk)
Dr. Kinh-Vy Nguyen (Resident – Anesthesiology)	Dr. Sang Park (Resident – Anesthesiology)	Keri Noeske (Nursing, Administration)	Sandy Volchko (Quality)

SUBJECT	DISCUSSION/CONCLUSION	RECOMMENDATIONS, ACTIONS FOLLOW-UP
<b>CALL TO ORDER</b>	Keri Noeske, committee chair called the meeting to order on May 24, 2021 at 11:00 a.m.	<b>Called to Order.</b>
<b>REVIEW THE COMMITTEE CHARTER</b>	<p><b>PROBLEM STATEMENT:</b>            Organization has strong processes for gathering data and dissemination reports to monitor control of drugs. We are missing a standardized expectation of follow-up on those reports by the managers and medical staff. We also have an opportunity to broaden awareness of concerning behaviors and build a culture of escalating observations of strange behaviors.</p> <p><b>PROJECT GOAL:</b></p> <ul style="list-style-type: none"> <li>○ Develop organizational program to build awareness of and response to behaviors suspicious for drug diversion.</li> <li>○ Build a culture within the organization of attention to drug diversion prevention.</li> <li>○ Implement education into orientation and annual training related to drug diversion and awareness for all health care professionals.</li> <li>○ Ensure accountability for action items related to routine audits and medication related reports by department leaders.</li> <li>○ Use technology and automation to ensure reporting is routine and applicable.</li> <li>○ Determine expected actions to be taken and communicate those actions to department leaders when abnormal reports are shared.</li> </ul> <p><b>MEASURES:</b></p> <ul style="list-style-type: none"> <li>○ Implementation of annual education and orientation education for all employees and medical staff related to drug diversion as it pertains to their roles.</li> <li>○ Follow-up actions identified and expectations shared with department leaders for accountability to abnormal trends as they are identified.</li> </ul>	

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	<ul style="list-style-type: none"> <li>○ Reports and trends – reviewing existing reports             <ul style="list-style-type: none"> <li>- <b>Med safety</b> <ul style="list-style-type: none"> <li>▪ Annual occurrence report - reviewing shifts and trends in different categories – <b>committee agreed to review for any control substance related issues or challenges</b></li> </ul> </li> <li>- <b>Anesthesia sub-committee</b> –review minutes for any action steps</li> <li>- <b>RX Auditor</b> - report review for any outliers (Mistie to present)</li> <li>- <b>PNT</b></li> <li>- <b>Nursing med safety</b></li> </ul> </li> </ul> <p><b>SCOPE:</b></p> <ul style="list-style-type: none"> <li>○ Education – Organization Wide (Orientation and Annual)             <ul style="list-style-type: none"> <li>- Quarterly checklist for managers – Manager orientation build</li> </ul> </li> <li>○ Accountability - Standardization of use of reports and follow-up with team members</li> <li>○ Sustainability – Identify best course for ongoing reporting and follow-up with organization action items.</li> <li>○ <b>Committee reports to Patient Safety Committee and Med Safety Committee</b></li> </ul> <p><b>TIMELINE &amp; PLAN:</b></p> <ol style="list-style-type: none"> <li>1. 6/1/21 – Charter Development including roles of individuals on committee</li> <li>2. 6/1/21 Monthly meetings scheduled with agendas to include review of audits and reports from pharmacy.</li> <li>3. 6/1/21 Information on role of committee shared with organization leadership – including expectations for reporting back into DPP when action items assigned.</li> <li>4. 6/30/21 reviewed the existing reports and audits to see which ones will be reviewed at the committee</li> <li>5. 7/31/21 Onboarding education for leadership – checklist updated</li> <li>6. 7/31/21 Assess first quarter meetings, actions and follow-ups completed. Determine committee changes and opportunities for improved impact on organization diversion prevention.</li> <li>7. 8/31/21 Review compliance by patient care departments with ongoing improvements related to diversion action plans. Escalate follow-up concerns to Quality Improvement Council for assessment and action steps.</li> <li>8. 9/30/21 Implement quarterly reporting to XXX committee on work and measures of success for DPP.</li> </ol> <ul style="list-style-type: none"> <li>• Greeley representative (Bud Pate) recommended not making the Diversion Prevention Committee a long-standing committee. Suggestion to making it a temporary committee for about a year.</li> </ul>	<p><b>Mary Laufer agreed to schedule a workgroup with Mistie, Nicole and a volunteer RN to develop what the curriculum would look like – goal would be to roll out in August.</b></p> <p><b>Committee agreed to reassess the committee in 6 months to a year.</b></p>
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	<p>Keri Noeske presented the committee charter. Committee as a group accepted the charter with revisions. All in favor.</p>	<p><b>Charter approved with revisions.</b></p>
<p><b>ONGOING PROJECTS</b></p>	<ul style="list-style-type: none"> <li>• <b>Plan of Correction Development – Keri Noeske</b> <ul style="list-style-type: none"> <li>○ Plan of corrections is being developed from a CMS CDPH survey related to diversion activities (Sandy Volchko)</li> </ul> </li>   <li>• <b>Organization Education – Mary Laufer</b> <ul style="list-style-type: none"> <li>○ 60 education slides related to the plan of corrections for the staff. Will be sent via Netlearning to intended audiences by clinical education. Plan to send no later than 5/31/21.</li> </ul> </li>   <li>• <b>Current audits and reports reviewed – James McNulty</b> <ul style="list-style-type: none"> <li>○ Processes that manage to control substances start at ordering through distribution – waste management accountability</li> <li>○ Current process: James McNulty gives the pharmacy power of attorney to receive an ordered product – currently doing an internal audit. James suggested an organization audit as well.</li> <li>○ Monthly receiving audit</li> <li>○ Medication room access – new process</li> <li>○ Pyxis discrepancy resolution &amp; inventory</li> <li>○ Weekly pharmacy inventory</li> <li>○ Nursing inventory – f/u by Mistie if there are any discrepancies</li> <li>○ Drips – challenge made at the pharmacy – pink sheets documenting           <ul style="list-style-type: none"> <li>▪ Problem is that the pink slip doesn't get back to the pharmacy for a med reconciliation</li> <li>▪ Anesthesia – pink slip – challenge signature is required</li> </ul> </li> <li>○ Refilling Pyxis – report</li> <li>○ Patient personal medication – log sheet – 2 nurses document</li> <li>○ RX auditor – monthly report</li> <li>○ Emergency department – 10-80 charts a month audit</li> <li>○ Audit one anesthesiologist case a month</li> <li>○ Spot check providers</li> <li>○ Oral morphine equivalence – developed a baseline – audit</li> <li>○ OR space – audit 100% of charges that are placed in OR – look for mismatches</li> </ul> </li> </ul>	
<p><b>NEW BUSINESS</b></p>	<ul style="list-style-type: none"> <li>• <b>Identify reports to be reviewed by committee</b> <ul style="list-style-type: none"> <li>○ Pyxis discrepancy resolved within 24 hours</li> <li>○ 100 charts a week audit - nursing control substances – education</li> <li>○ Pink sheets – completed and resolved</li> </ul> </li> </ul>	

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	<ul style="list-style-type: none"> <li>○ Anesthesia discrepancies</li> <li>○ Gasper reports and trends (month)</li> <li>● <b>Develop avenue to communicate action needed</b> <ul style="list-style-type: none"> <li>○ Decisions made during the committee – f/u and action items</li> </ul> </li> <li>● <b>Define expectations for reporting back to group on action</b> <ul style="list-style-type: none"> <li>○ Trends on units – reaching out to direct supervision for f/u - report back to the committee</li> </ul> </li> </ul>	
<b>ACTION ITEMS</b>	<ul style="list-style-type: none"> <li>● <b>Diversion awareness education roll-out</b> <ul style="list-style-type: none"> <li>○ Education Module will go out – part of our plan of corrections – built in our annual training</li> </ul> </li> <li>● <b>Leadership education on diversion program and expectations</b> <ul style="list-style-type: none"> <li>○ Committee suggested that Dr. Morell send out an education</li> <li>○ Leadership meeting – education presentation</li> </ul> </li> <li>● <b>Future items:</b> <ul style="list-style-type: none"> <li>○ Reporting loss and define sizable loss</li> <li>○ Investigation tactics and resources –developing education</li> <li>○ Review of polices that are applicable and if they are being followed</li> </ul> </li> </ul>	<p style="text-align: center;"><b>Shannon Cauthen and Keri Noeske agreed to present at the leadership meeting.</b></p>
<b>OPEN DISCUSSION</b>	<ul style="list-style-type: none"> <li>● <b>Committee is protected with California Evidence Code section 1157</b></li> <li>● ASHP Guidelines on preventing diversion of controlled substances article provided via-email to the group</li> <li>● Drug diversion in healthcare article provided via-email to the group</li> </ul>	<p style="text-align: center;"><b>Miguel Morales agreed to follow up on badge auditing.</b></p>
<b>AJOURNMENT</b>		<p style="text-align: center;"><b>Keri Noeske declared the meeting adjourned.</b></p>

Minutes prepared by: Belen Contreras, Administrative Assistant to Care Management & Renal Services

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\_\_\_\_\_, Keri Noeske, VP Chief Nursing Officer

# Sub Acute, TCS, And SS Rehab

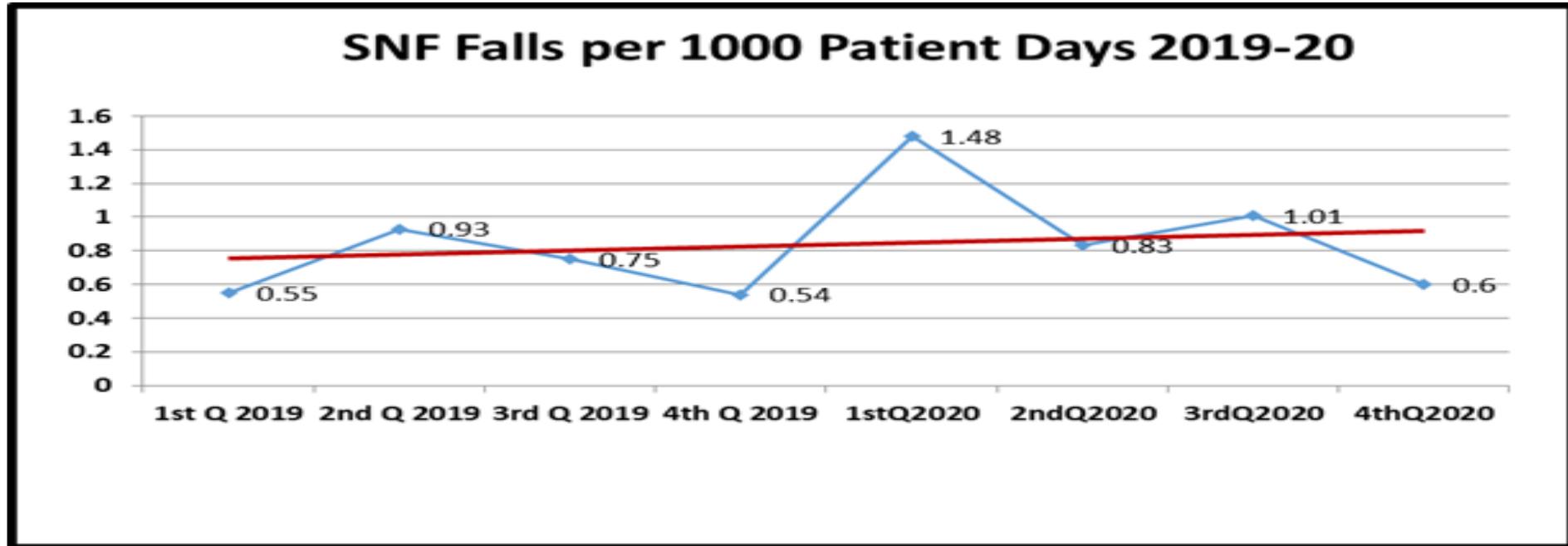
## QC Report



[kawahhealth.org](https://www.kawahhealth.org)

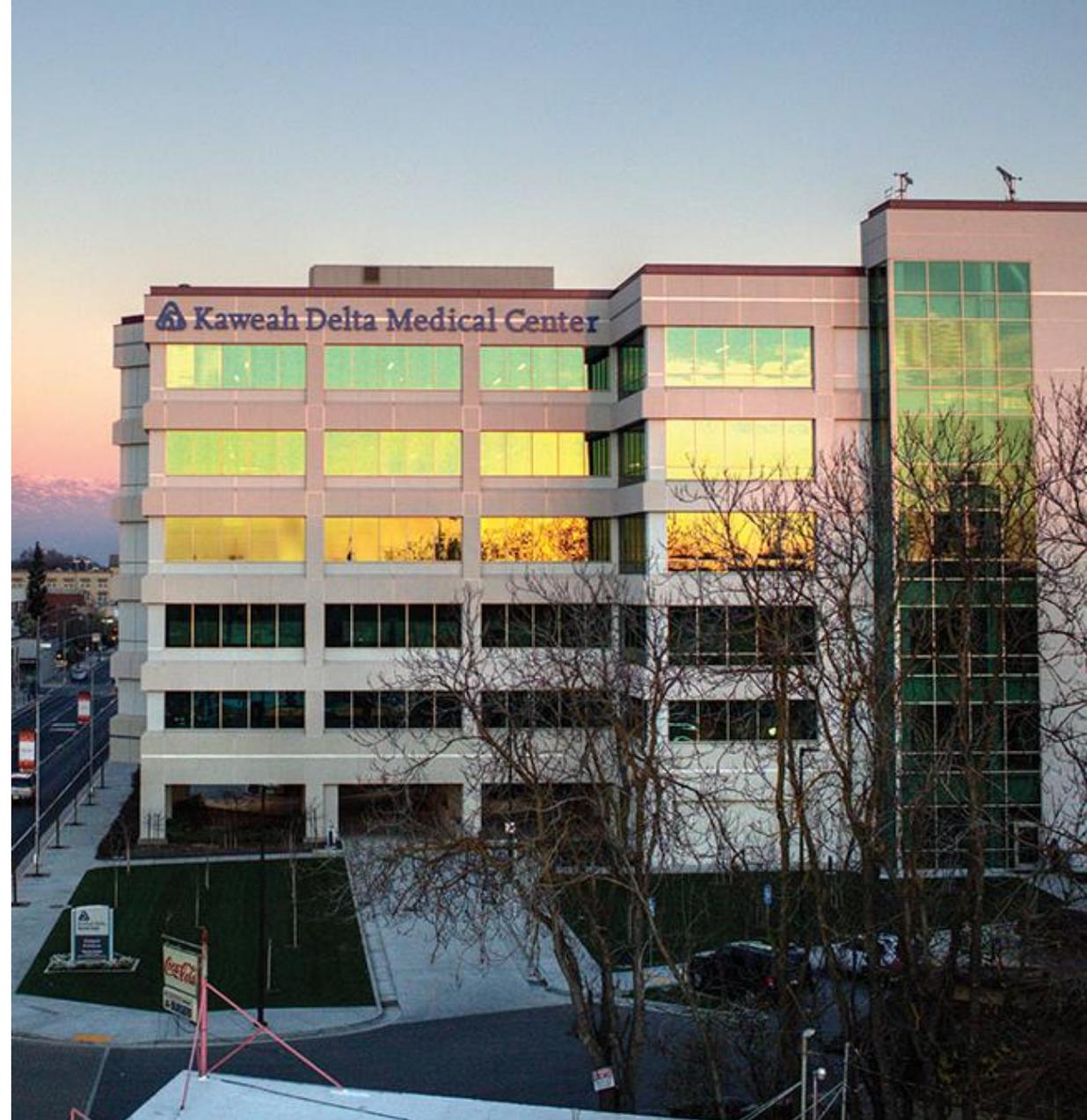
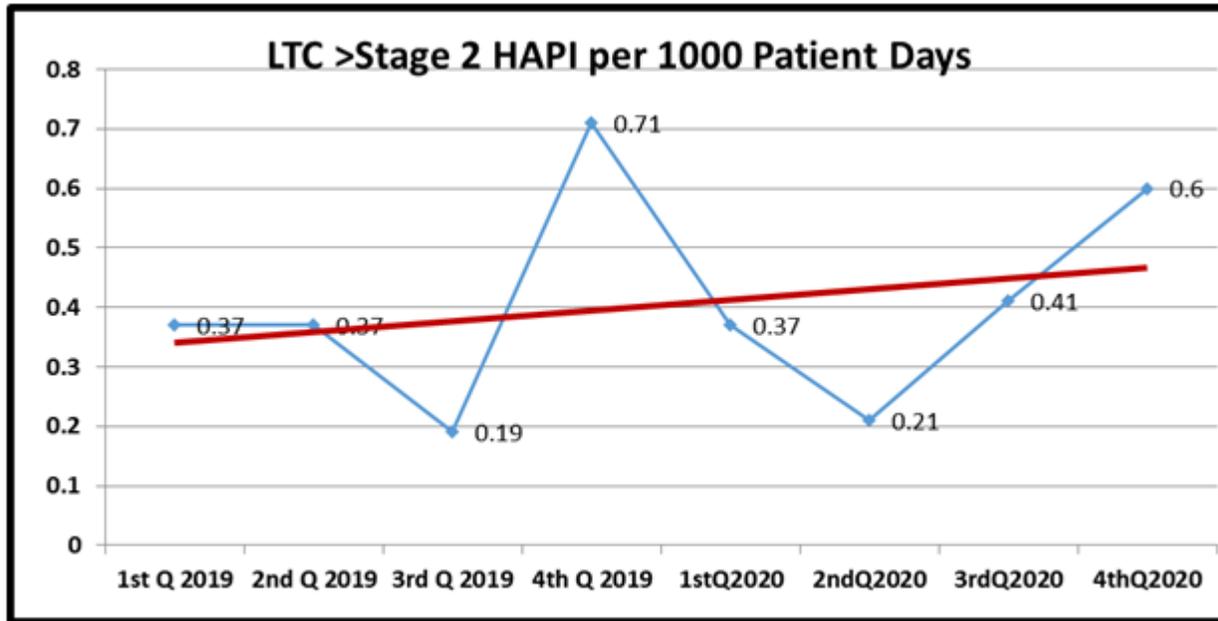
# Measure

## Falls



# Measure

## Pressure Injuries



# Measure

## Psychoactive Medication Use

- Short Stay Patients- Below national average at 0.6%. National Average is 2.0%
- Long Term Patients is above the national average at 20%. National Average is 14.6%.
- Long Term patients on the Subacute Unit drive this performance.
- Leadership works with the medical team, pharmacy, and MDS nurses to ensure appropriate diagnosis and reduction in psychoactive medications use.

# CMS 5 STAR Ratings



Care Compare Five-Star Ratings of Nursing Homes  
Provider Rating Report for April 2021

Ratings for Kaweah Delta Skilled Nursing Center (555396)  
Visalia, California

Overall Quality	Health Inspection	Quality Measures	Staffing	RN Staffing
★★★★★	★★★★	★★★★★	★★★★	★★★★

# Two Consecutive Years



Thank you.

# Live with passion.

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

