October 14, 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, October 21, 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, October 21, 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, October 21, 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

Cindy Moccio
Board Clerk, Executive Assistant to CEO

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

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
QUALITY COUNCIL

Thursday, October 21, 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, Vice President & CNO; Monica Manga, MD, Chief of Staff; Daniel Hightower, MD, Professional Staff Quality Committee Chair; Tom Gray, MD, Quality and Patient Safety Medical Director; Sandy Volchko DNP, RN CLSSBB, Director of Quality and Patient Safety; Ben Cripps, Vice President, Chief Compliance and Risk Management Officer; Evelyn McEntire, 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 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 – *Daniel Hightower, MD, and Professional Staff Quality Committee Chair*
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 - *James McNulty, PharmD, Director of Pharmacy, Dale Costantino, PharmD, Medication Safety Coordinator.*
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management and Ben Cripps, Vice President & Chief Compliance and Risk 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 – *Daniel Hightower, MD, and Professional Staff Quality Committee Chair*
3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *James McNulty, PharmD, Director of Pharmacy, and Dale Costantino, PharmD, Medication Safety Coordinator*
4. **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.*
5. **Adjourn Closed Meeting** – *David Francis, Committee Chair*

OPEN MEETING – 8:00AM

1. **Call to order** – *David Francis, Committee Chair*
2. **Public / Medical Staff participation –** Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves at this time. Members of the public or the medical staff may comment on agenda items after the item has been discussed by the Committee but before a Committee recommendation is decided. In either case, each speaker will be allowed five minutes.
3. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives:
    - 3.1. **Rapid Response Team (RRT)**
    - 3.2. **Stroke Service Line**
    - 3.3. **CMS Core Measures**
    - 3.4. **Hospice, Home Health Service Line**
    - 3.5. **Sepsis Quality Focus Team (QFT)**
    - 3.6. **Catheter Associated Urinary Tract Infections (CAUTI) Quality Focus Team (QFT)**
4. **Disparities in Care Committee –** A review of data analysis to identify disparities in care related to defined population groups. *Lori Winston, MD, VP Medical Education, Inbal Epstein, MD, Emergency Medicine Resident.*
5. **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*.
6. **Adjourn Open Meeting** – *David Francis, Committee Chair*

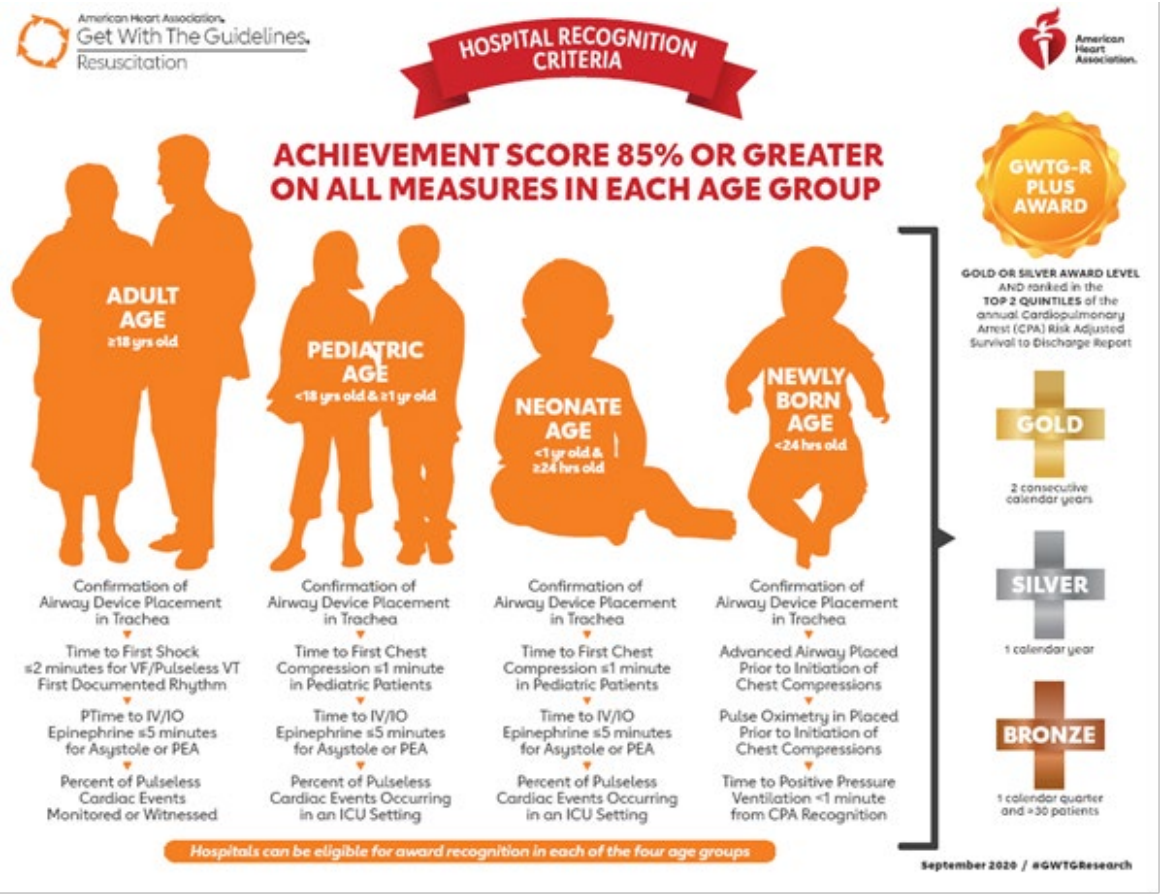
In compliance with the Americans with Disabilities Act, if you need special assistance to participate at this meeting, please contact the Board Clerk (559) 624-2330. Notification 48 hours prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to the Kaweah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

RRT/Code Blue ProStaff Report Q2 2021

Dr. Tang, Shannon Cauthen and Stacey Cajimat

GWTG Resuscitation Criteria

- The RRT/Code Blue Committee has joined Get with the Guidelines (GWTG) Resuscitation, AHA's National Registry, to have access to national and state benchmarks for code blue and RRT measures.
- This information has been used to create a new RRT and Resuscitation Scorecard.
- The RRT/Code Blue Committee will also begin measuring GWTG hospital recognition criteria benchmarks as well. These will improve the quality of our codes and qualify us for awards.
    1. Confirmation of airway device placement
    2. Time to first shock
    3. Time to IV epinephrine
    4. Percent of Pulseless Events monitored or witnessed



RRT and Resuscitation Quality Scorecard

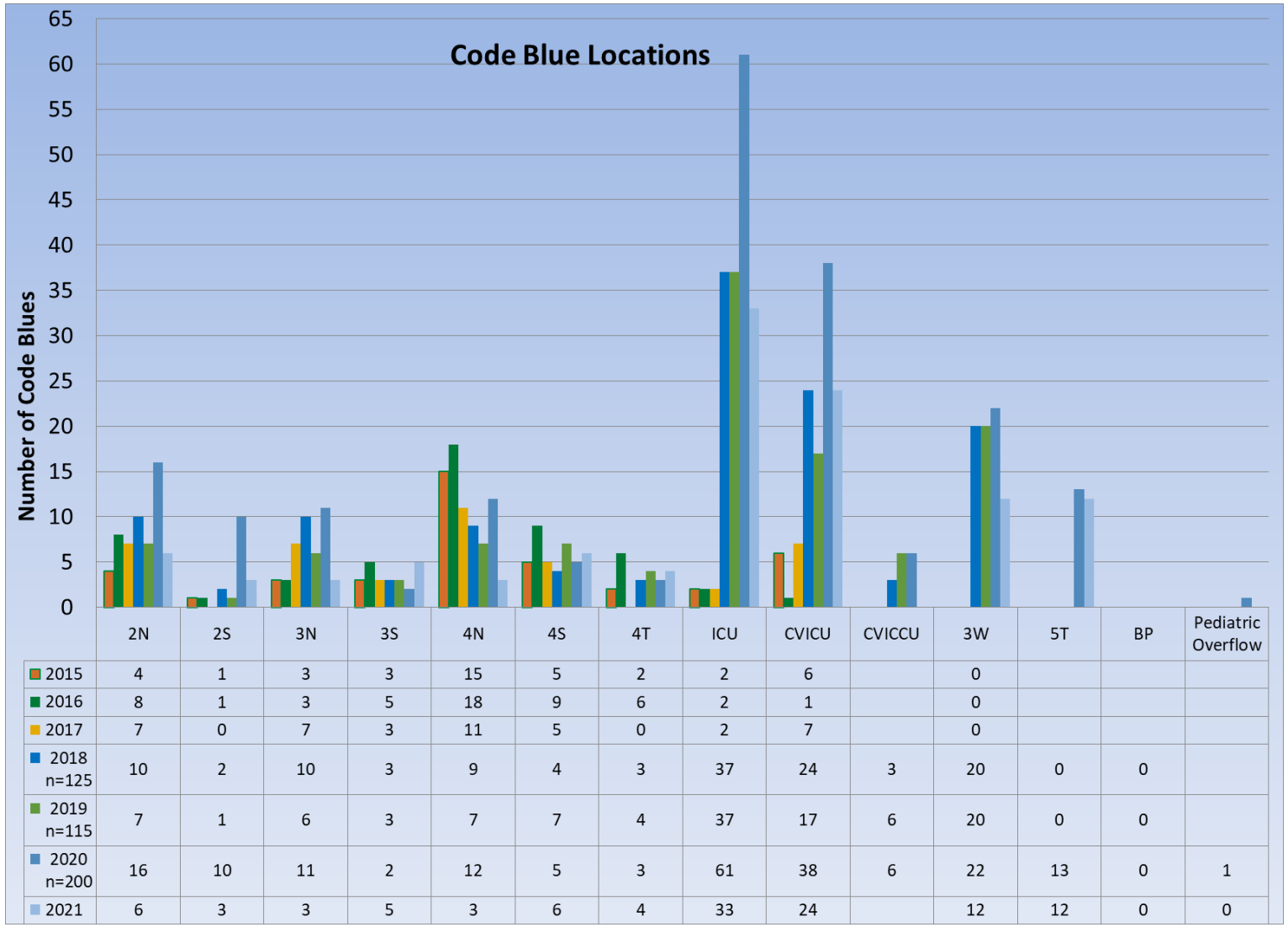
RRT and Resuscitation - Quality Scorecard

Measure Description	California Hospitals External Benchmark	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Mean YTD 2021
Code Blue Data								
Total Code Blues		27	30	17	15	12	10	19
Total COVID-19 Positive Code Blues		17	14	0	0	0	0	5
Code Blues per 1000 Discharges Med Surg		8	8	5	8	7	1	6
Code Blues per 1000 Discharges Critical Care		12	17	7	4	2	7	8
Percent of Codes in Critical Care	70% (↑ is better)	59%	50%	59%	33%	25%	90%	53%
Code Blue: Survival to Discharge	22% (↑ is better)	11%	7%	18%	27%	25%	40%	21%
Deaths from Cardiac Arrest		24	15	5	8	5	2	10
Overall Hospital Mortality per 1000 Patients		7.629	5.661	3.29	3.132	2.778	1.897	4.06
RRT Data								
RRTs per 1000 patient discharge days		131	129	109	101	117	75	110
RRT mortality percentage	20% (↓ is better)	40% n-70	31% n-47	20% n-22	23% n-23	15% n-18	16% n-16	24%
RRTs within 24 hours of Admit from ED (percentage)	12.5% (↓ is better)	20% n-30	16% n-26	29% n-29	28% n-28	27% n-32	29% n-30	25%
Green	Better than Target							
Yellow	Within 10% of Target							
Red	Does not meet Target							

Kaweah Health

Kaweah Health

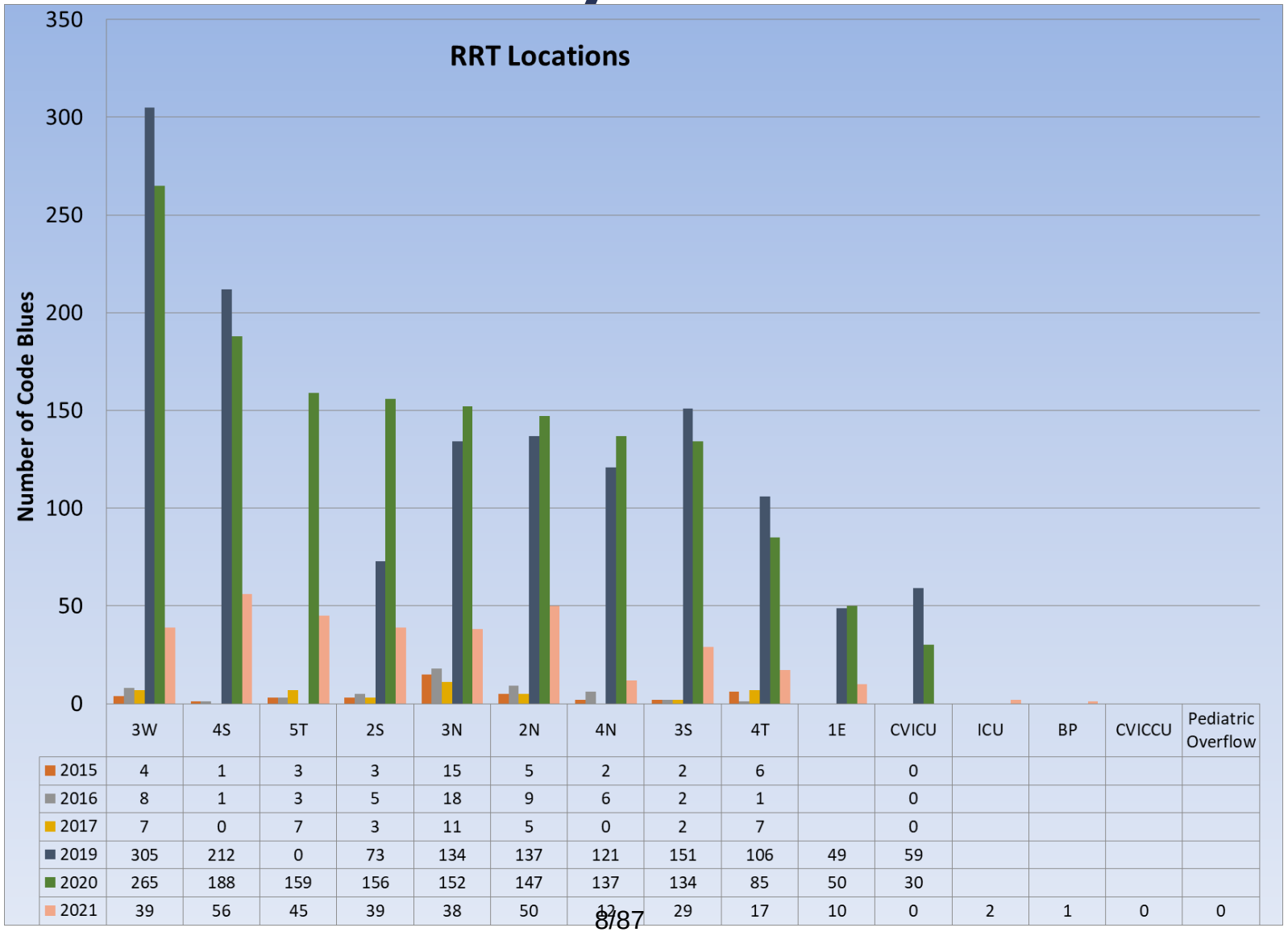
Code Blues by Location



	2N	2S	3N	3S	4N	4S	4T	ICU	CVICU	CVICCU	3W	5T	BP	Pediatric Overflow
2015	4	1	3	3	15	5	2	2	6		0			
2016	8	1	3	5	18	9	6	2	1		0			
2017	7	0	7	3	11	5	0	2	7		0			
2018 n=125	10	2	10	3	9	4	3	37	24	3	20	0	0	
2019 n=115	7	1	6	3	7	7	4	37	17	6	20	0	0	
2020 n=200	16	10	11	2	12	5	3	61	38	6	22	13	0	1
2021	6	3	3	5	3	6	4	33	24		12	12	0	0

Kaweah Health

RRTs by Location



	3W	4S	5T	2S	3N	2N	4N	3S	4T	1E	CVICU	ICU	BP	CVICCU	Pediatric Overflow
2015	4	1	3	3	15	5	2	2	6		0				
2016	8	1	3	5	18	9	6	2	1		0				
2017	7	0	7	3	11	5	0	2	7		0				
2019	305	212	0	73	134	137	121	151	106	49	59				
2020	265	188	159	156	152	147	137	134	85	50	30				
2021	39	56	45	39	38	50	12	29	17	10	0	2	1	0	0

Code Blues and RRTs Q2-2021

Code Blue Summary

- The committee's goal is for code blues to occur in critical care where there are resources, monitoring, and an intensivist on the unit. For the first time this year, code blues in critical care are higher than the California Benchmark (CA Benchmark is 70% and KH had 90%)! This a drastic improvement from previous months. The yearly mean is still below the CA benchmark but the increase in June's numbers is a positive indicator that we are moving in the right direction!
- Code blue survival to discharge benchmark outperformed the California Benchmark for the last three months- another considerable improvement for the RRT team. The YTD average is still below the California Benchmark average but only by 1%, something we anticipate will change in the next quarter with the current improvement in monthly data.
- Time to first shock below benchmark (higher is better).
    - Need to revise code blue sheet to capture time of first shock.
    - Preliminary discussion about educating staff to utilize AED mode on ZOLL until arrival of Code Team.
    - All other code blue process measures are above goal.

Rapid Response Team Summary

- Highest amount of RRTs per 1000 patient discharge days: 117 (May)
- Highest mortality percentage: 23% (April)
- Average year to date RRT mortality (24%) is above the California hospital average (20%). However, the gradual decline in RRT mortality over the last three months (23% April, 15% May, 16% June), we anticipate additional improvement going forward.
- Average 2021 RRTs within 24 hours of Admit from ED are 25% (up 3% from last quarter) compared to the California hospital average of 12.5%.

Code Blues and RRTs 2021

Analysis

- Observed a direct correlation in number of COVID patients and increase volume of code blues, RRTs, and mortality.
- Had hoped to be able to re-collate data to include code blues occurring in the ICUs and ICCUs as Codes Occurring in Critical Care but GWTG clarified their expectations and only allow for code blues inside the ICUs to count as codes in "critical care. Anticipate a decline in percentage of code blues in critical care since the re-classification of data and another COVID surge occurred at or about the same time.
- ED hold times are increased, patient's status can change while they are awaiting an admit bed or 1 East. Initiation of admit orders and re-evaluation of patient condition is not consistent and patients are sometimes admitted to inappropriate level of care. Subsequently, an RRT is then called shortly after admit to inpatient unit.

Kaweah Health

Next Steps

- Transition in roles. Jeanette, RRT Nurse and QFT Lead, and Linde, Quality RN liaison, both transitioned out of their roles with the RRT program. As such, added quality component to replacement RRT position; lead and coordinate RRT QFT, attend SIM meetings, attend Stroke and Sepsis QFT, etc. Additionally, new Quality RN liaison, Stacey, is learning the GWTFG criteria and how to collect and collate data. In-progress
- Revise code blue form to easily capture all code blue process elements to meet GWTG standards. In-progress
- Assess teaching hospital GWTG benchmarks vs. California benchmarks. In-progress
- Formalization of role definition of each team member of the Code team using the developed assignment sheet. In-progress
- Review of Redivus Code Blue App for Consistent Documentation and Data collection. In progress
- Quality RN and Resident Physician to review all 130 RRTs that were activated within 24-hours of admit from ED to observe for trends and then QFT team to determine action plan. Pending
- Add QR code to RRT form that will link to Survey about RRT staff approachability and leadership. Pending
- Formalization of non-licensed staff and family activated RRT process. Pending
- Re-instate Hi-Fidelity mock in-situ code blues. Pending
- Develop reporting structure for debrief information to be protected by CA 1157 to promote staff participation and anonymity. Complete
- Create a second RRT backpack w/ emergency supplies (IO Gun, Butterfly U/S). Complete

Next Steps: Education

- Resume using Sim Lab/Sim Man for In-Situ Mock Codes
- RRT staff are utilizing Code Blue Debrief Form to obtain timely and specific information regarding opportunities for improvement and to teach staff as needed.
- RRT nurse will be working to form partnerships with specific units to “champion” and be a go-to person to help with education and reinforce utilizing RRT.
- Looking to start a project to teach staff to utilize AED function on ZOLLS while awaiting code team- will decrease time to first shock per GWTG criteria.
- Incorporate advanced training for the resuscitation of our special populations of patients (trauma and post-Open Heart Surgery). Use TCAR and CALS for resuscitation guidelines. Standardize training.

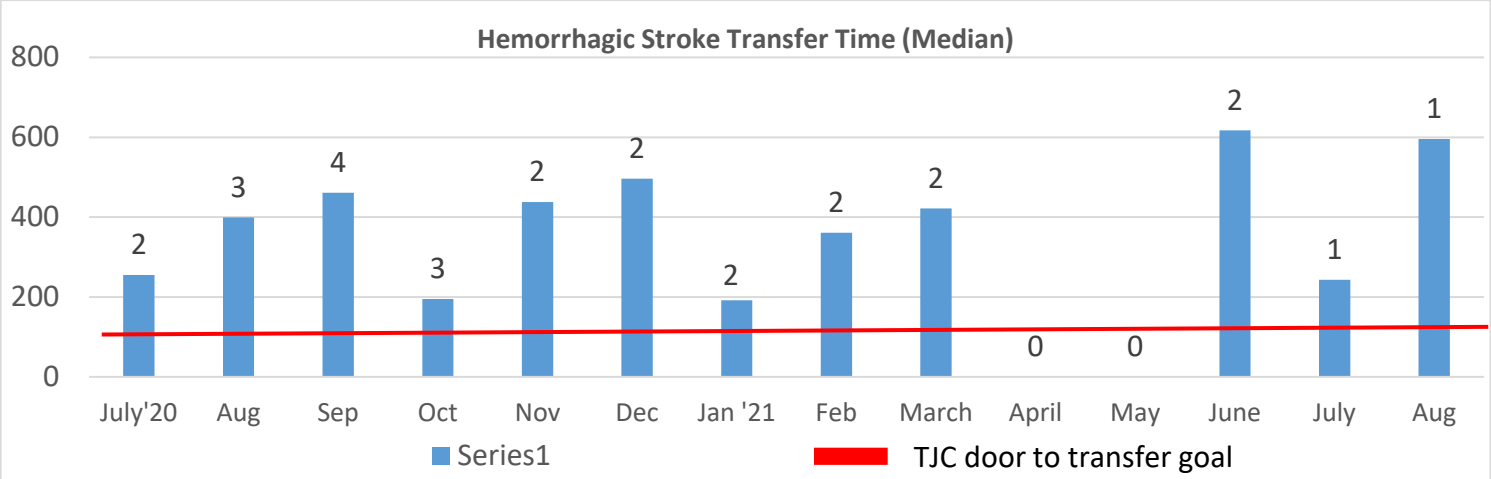
Questions?

Live with passion.

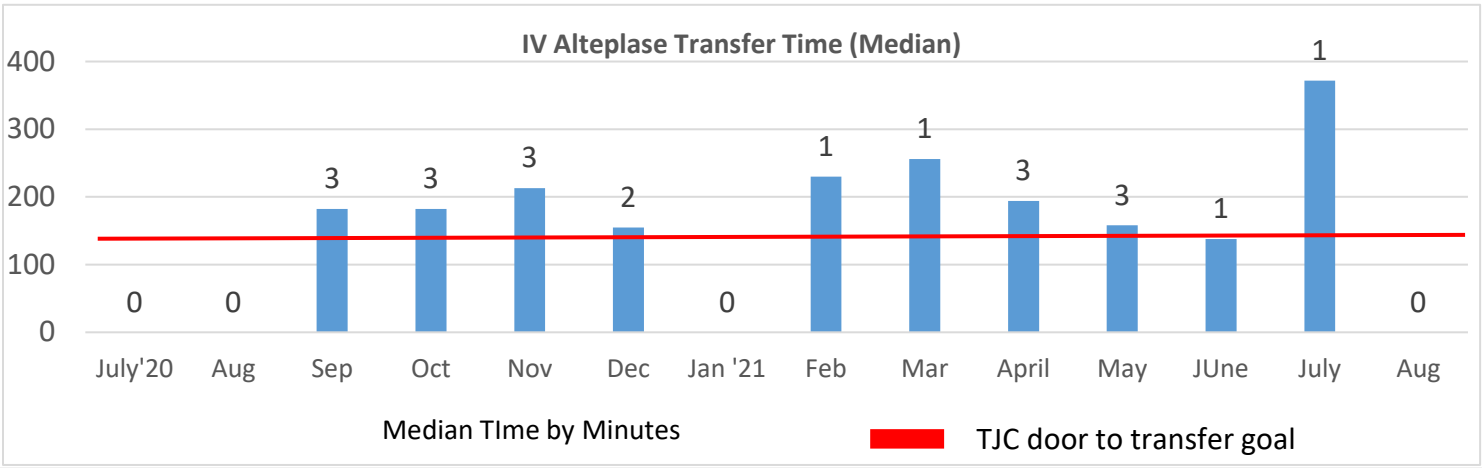
Health is our passion. Excellence is our focus. Compassion is our promise.

Kaweah Health

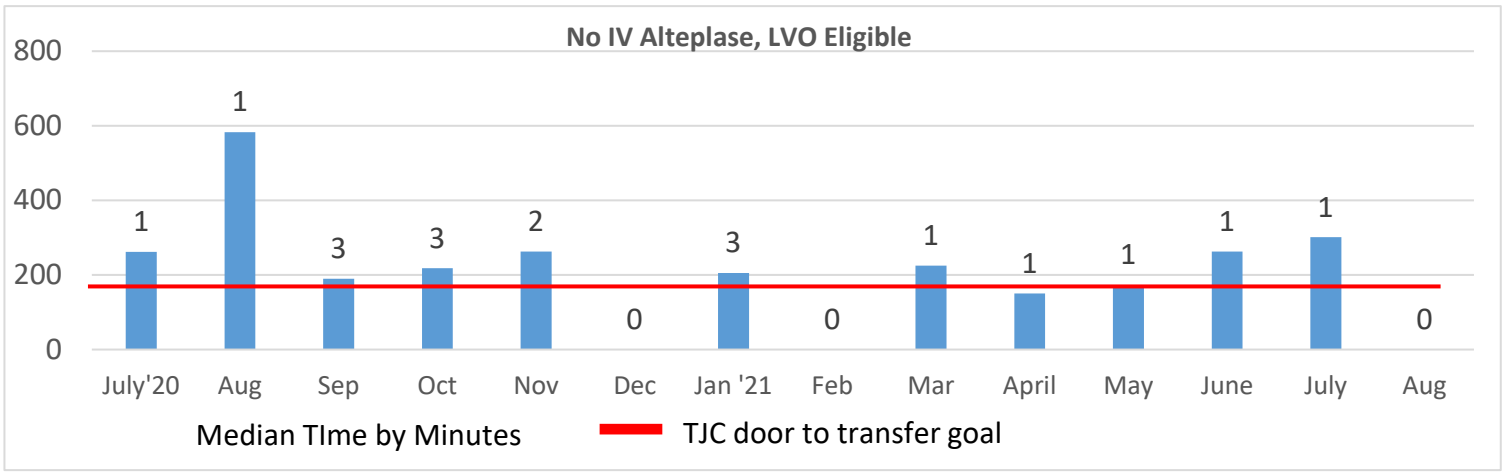
2020-2021 TRANSFERS FROM ED TO ANOTHER ACUTE CARE FACILITY
Median Time by Minutes - Goal 120 Minutes



Hemorrhagic patients are transferred out for other procedures not done at KDH, specifically coiling/clipping of aneurysms or bleeds. A task force has been set up to help streamline the process, all action items are captured in PDSA document. The Covid 19 pandemic has caused delays in transfer times due to the additional precautions, resources and screening needed.



Transfers for ischemic strokes occur primarily if a large vessel occlusion is noted and would be eligible for endovascular treatment. As a result of the efforts made by the ED Stroke Alert Committee and the Transfer Process Task Force door to transfer times have improved; however the Covid 19 pandemic has caused delays in transfer times due to the additional precautions, resources, and screening needed in the recent months.

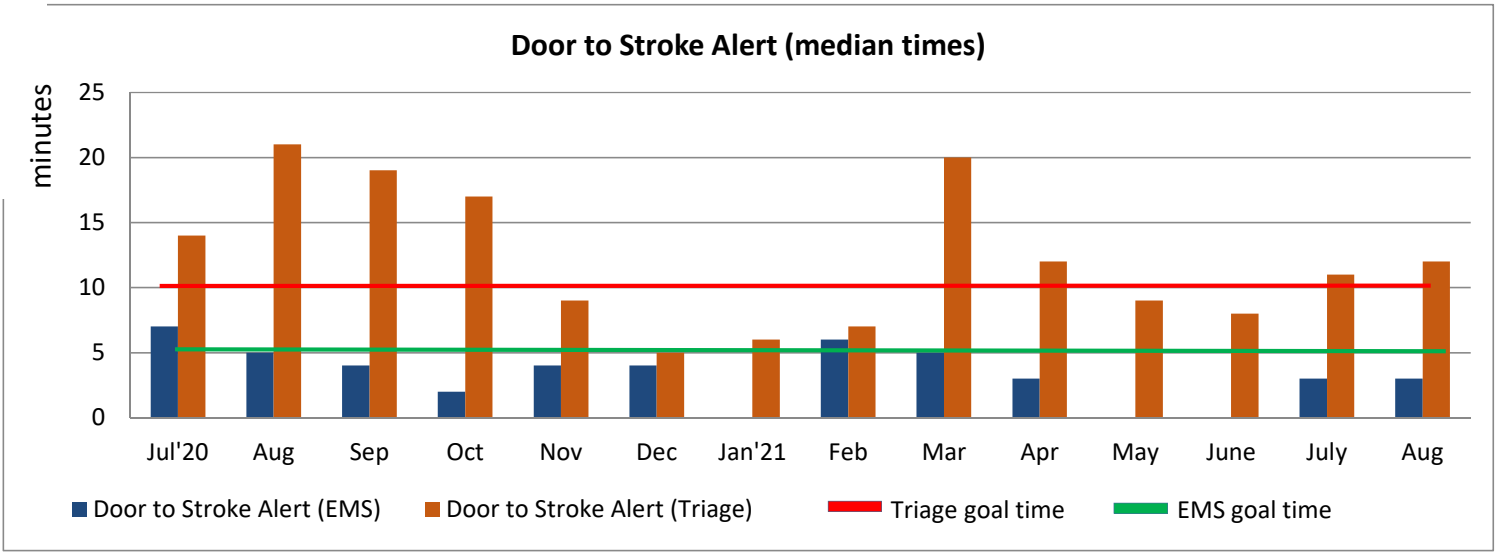


This cohort of patients have a large vessel occlusion that would be eligible for endovascular treatment and do not meet criteria for Alteplase administration. The Covid 19 pandemic has caused delays in transfer times due to the additional precautions, resources and screening needed in the recent months.

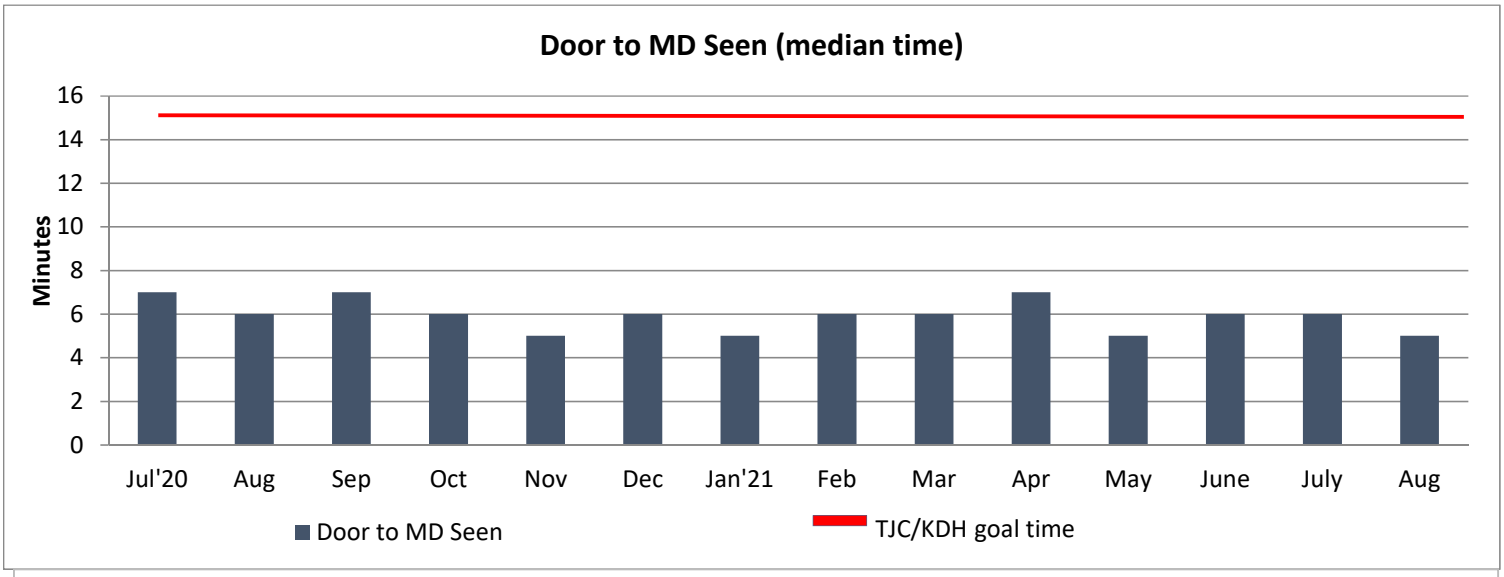
Stroke Program Dashboard 2019-2021

			2020																	
	Bench-marks	2019 Totals	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan'21	Feb	Mar	Apr	May	Jun
Grouping of Stroke Patients																				
Ischemic		*460*	39	42	38	23	28	32	31	29	34	27	24	34	34	33	32	36	39	37
Hemorrhagic		*98*	8	6	5	7	6	4	4	8	7	8	14	1	5	12	8	5	9	12
TIA (in-patient and observation)		*344*	33	44	29	24	21	13	27	20	16	24	19	11	18	18	26	19	20	16
Transfers to Higher Level of Care (Ischemic)		*27*	1	2	3	3	2	6	1	3	4	3	5	2	3	1	2	4	4	2
Transfers to Higher Level of Care (Hemorrhagic)		*17*	1	1	1	1	1	0	2	1	6	6	2	2	2	2	2	0	0	2
TOTAL NUMBER OF PATIENTS		*946*	82	95	72	58	58	55	65	61	67	68	64	50	62	66	70	64	72	69
Total # of Pts who rec'd Alteplase (Admitted/Transferred)		*65*	8	6	4	2	2	4	4	0	4	3	4	3	1	2	1	5	7	5
% of Alteplase - Inpatient & Transfers		*13%*	20%	14%	10%	8%	7%	11%	13%	0%	11%	10%	14%	8%	3%	6%	3%	13%	16%	13%
% Appropriate vital sign monitoring post Alteplase	90%	*68%*	75%	75%	100%	100%	100%	75%	75%	NA	75%	88%	100%	33%	100%	100%	100%	80%	100%	100%
Rate of hemorrhagic complications for Alteplase pts	0%	*0%*	0%	0%	0%	0%	0%	0%	0%	NA	0%	0%	0%	0%	0%	0%	0%	0%	14%	0%
Core Measure: OP-23 Head CT/MRI Results	72%	*54%*	100%	NA	0%	100%	NA	100%	0%	50%	100%	100%	100%	50%	NA	100%	100%	100%	67%	50%
% Appropriate stroke order set used (In-Patient)	90%	*93%*	95%	97%	99%	97%	96%	92%	90%	98%	91%	95%	91%	93%	93%	96%	95%	90%	88%	87%
% Appropriate stroke order set used (ED)	90%	*90%*	94%	92%	88%	89%	98%	90%	82%	89%	88%	80%	93%	92%	86%	88%	86%	91%	92%	88%
STK-1 VTE (GWTG, TJC)	85%	*99%*	100%	100%	95%	100%	91%	85%	85%	92%	96%	90%	88%	97%	89%	92%	91%	90%	95%	70%
STK-2 Discharged on Antithrombotic (GWTG, TJC)	85%	*99%*	100%	100%	100%	100%	100%	100%	97%	97%	97%	100%	100%	100%	100%	97%	100%	100%	100%	100%
STK-3 Anticoag for afib/aflutter ordered at Dc (GWTG, TJC)	85%	*96%*	100%	89%	100%	100%	100%	75%	80%	100%	100%	100%	100%	100%	100%	100%	NA	50%	100%	100%
STK-4 Alteplase Given within 60 min (GWTG, TJC)	75%	*80%*	100%	100%	100%	NA	NA	100%	100%	NA	NA	50%	NA	100%	NA	NA	NA	100%	100%	100%
STK-5 Early Antithrombotics by end of day 2 (GWTG, TJC)	85%	*99%*	92%	93%	97%	100%	96%	92%	96%	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
STK-6 Discharged on Statin (GWTG, TJC)	85%	*98%*	100%	98%	100%	100%	97%	100%	96%	100%	100%	93%	100%	100%	90%	94%	100%	100%	100%	100%
STK-8 Stroke Education (GWTG, TJC)	75%	*94%*	93%	97%	94%	100%	96%	88%	85%	100%	100%	100%	91%	90%	95%	97%	100%	100%	94%	100%
STK-10 Assessed for Rehab (GWTG, TJC)	75%	*100%*	100%	100%	100%	100%	97%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
% Dysphagia Screen prior to po intake (GWTG)	75%	*94%*	85%	85%	91%	90%	77%	81%	97%	97%	72%	85%	90%	90%	78%	90%	88%	71%	90%	88%
% Smoking Cessation (GWTG)	85%	*99%*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
% LDL Documented (GWTG)	75%	*94%*	91%	84%	96%	100%	90%	90%	91%	100%	97%	90%	92%	100%	100%	100%	100%	100%	100%	100%
Intensive Statin Therapy (GWTG)	75%	*90%*	94%	91%	88%	88%	97%	94%	91%	79%	93%	93%	100%	100%	90%	94%	100%	100%	88%	100%
% tPA Arrive by 3.5 Hrs; Treat by 4.5 Hrs (GWTG)	75%	*97%*	100%	86%	100%	100%	100%	100%	100%	NA	100%	100%	80%	100%	100%	NA	100%	100%	100%	100%
% NIHSS Reported (GWTG)	75%	*98%*	100%	93%	92%	100%	96%	94%	92%	96%	90%	100%	96%	97%	100%	100%	90%	100%	100%	97%
Ischemic ALOS/GMLOS excess	<1.0	*NA*	1.45	1.67	2.2	0.18	0.49	1.68	0.91	0.18	1.23	0.53	3.94	3.11	1.9	2.76	3.63	0.75	1.49	2.23
Hemorrhagic ALOS/GMLOS excess	<1.0	*NA*	1.63	0.43	3.74	0.49	3.53	17.98	1.42	6.11	5.01	-1.66	0.62	-3.4	3.46	3.05	11.17	1.12	6.2	1.84
Ischemic Mortality IP O/E Ratio (Midas)	<1.0	*NA*	0.8	0.9	0.8	0	0	1.4	0	1.1	0.8	1.7	4.3	3.96	0	1.66	0	1.37	1.26	1.41

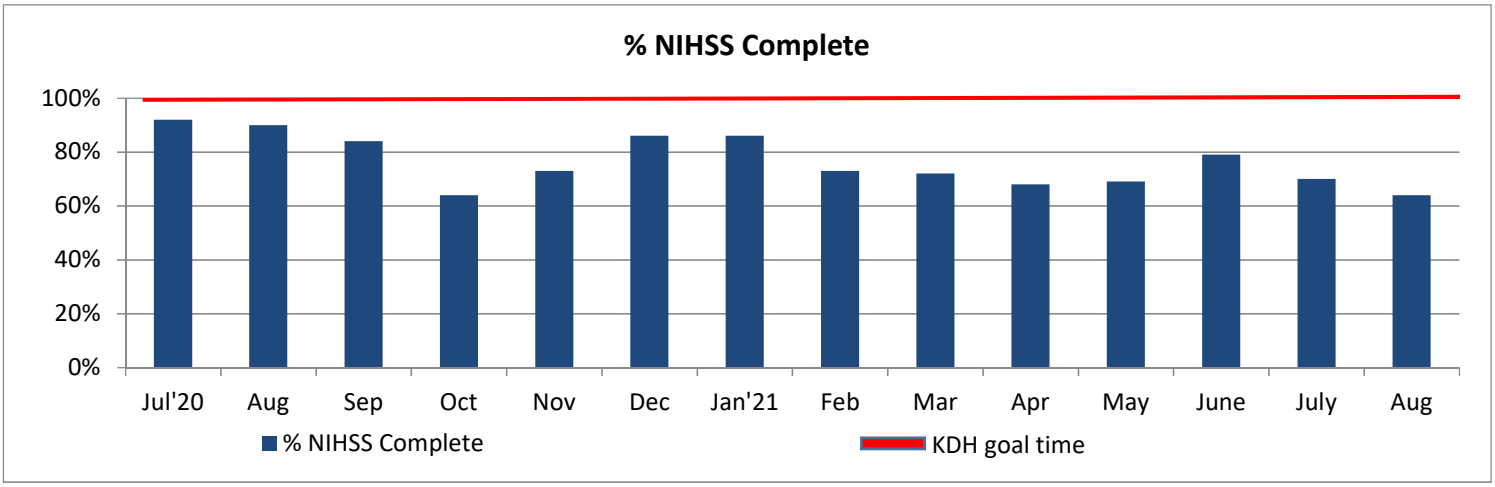
2020-2021 Stroke Alert Dashboard



Per KDH ED Stroke Alert process; stroke alerts to be called within 5 min for EMS and 10 min for Triage. ED Stroke Alert Triage task force convened to look for opportunities for improvement March 2020.

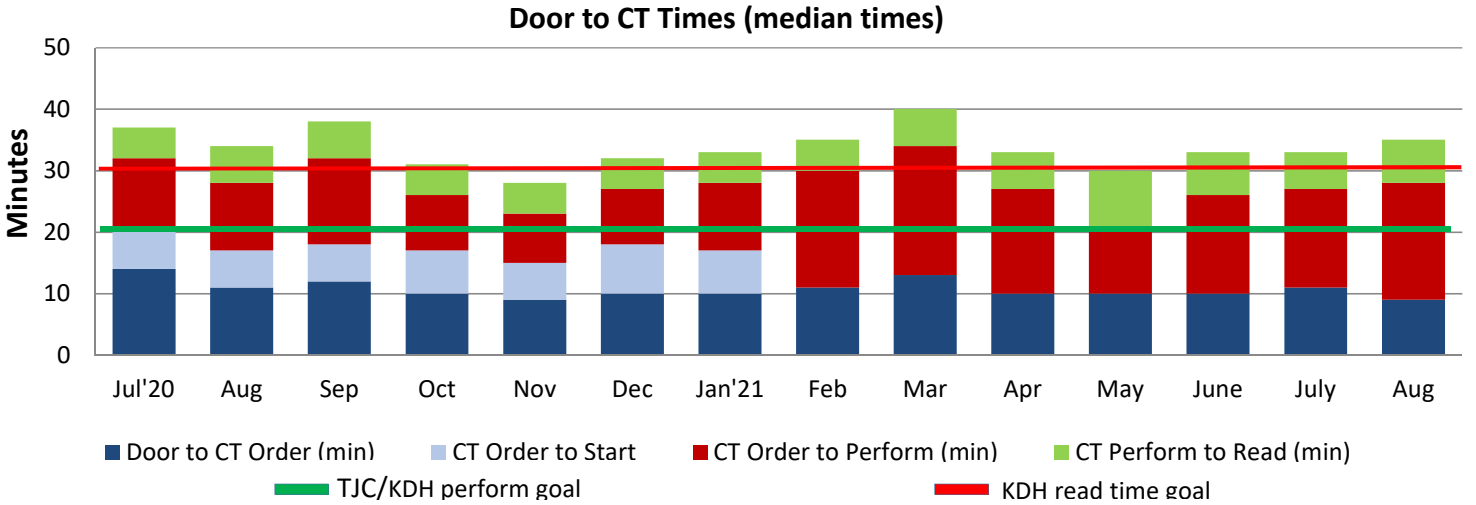


The expectation is that the physician will see the stroke alert patient within 15 minutes of arrival. Improvements made throughout the past year include: early notification from EMS, MD meets the pt at the door upon arrival, scribe documents first seen time in the record.

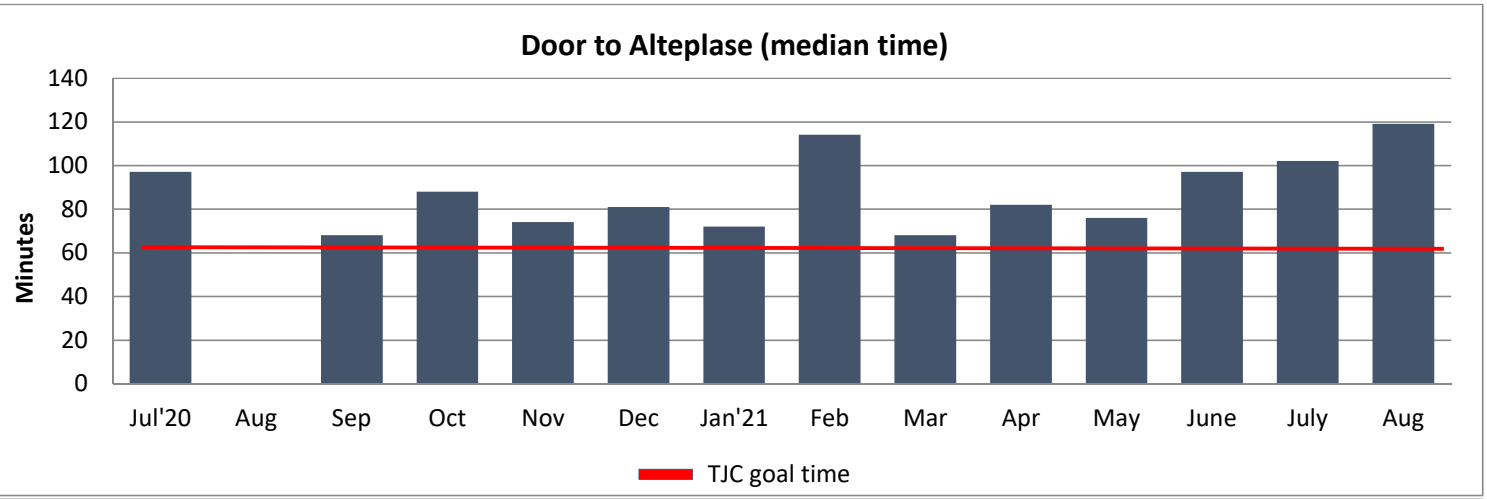


The expectation is that all stroke alert patients will have a NIHSS completed by a certified ED staff member and/or the attending physician; the primary responsible person is the attending/resident physician.

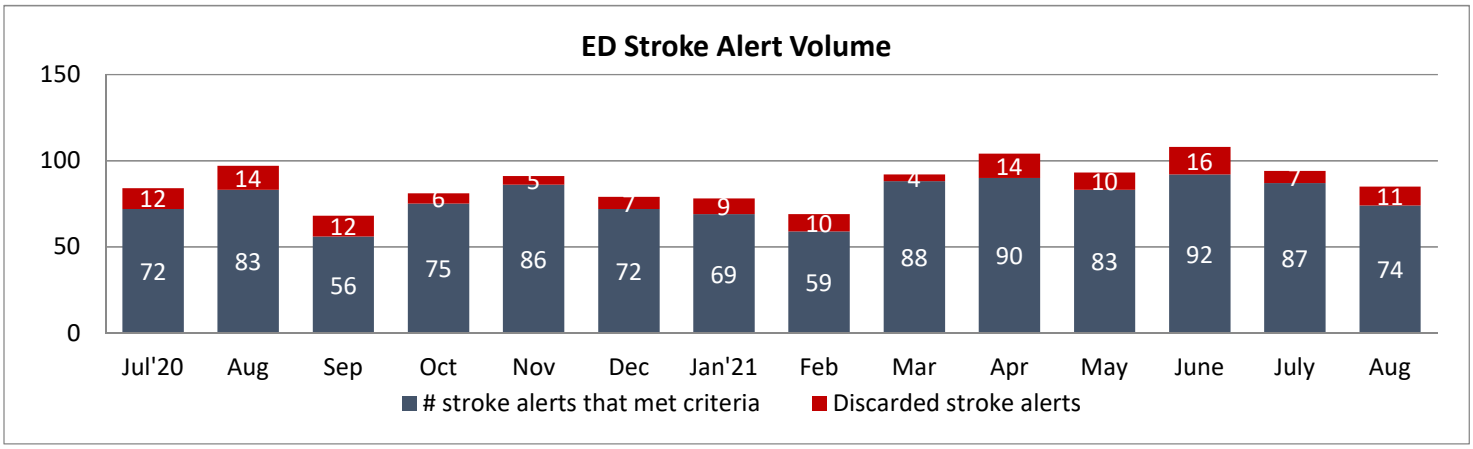
2020-2021 Stroke Alert Dashboard



CMS and TJC expectation is that the CT will be performed by 20 minutes and read by 45 minutes of arrival. KDH's CT read time goal is 30 minutes. Starting 2019; tracking of CT start times will be included in this measurement. start time is define by the first CT images in Synapse. **Feb 2021 removed CT start time metric.



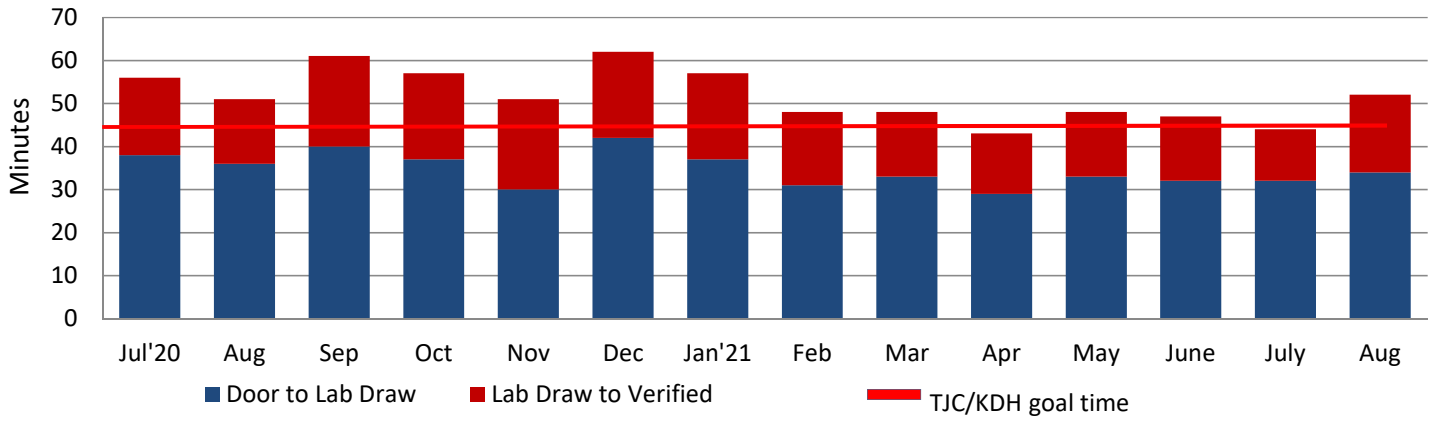
The data in this graph includes all Alteplase patients which differs from the TJC rate because exclusion criteria is not used. TJC expectation is that IV thrombolytics are given within 60 minutes to eligible patients who present for stroke care. AHA/ASA GWTG expectations were update in 2019 with new IV thrombolytic goal time to 45 minutes at least 75% of the time (when applicable). To meet this goal, continued changes to the stroke alert process have been made.



Stroke alert criteria includes: pt presenting with stroke like symptoms +FAST screen, stroke alerts called prior to arrival and up to 1 hour after arrival. Excluded cases: >1 after arrival or if stroke alert was cancelled.

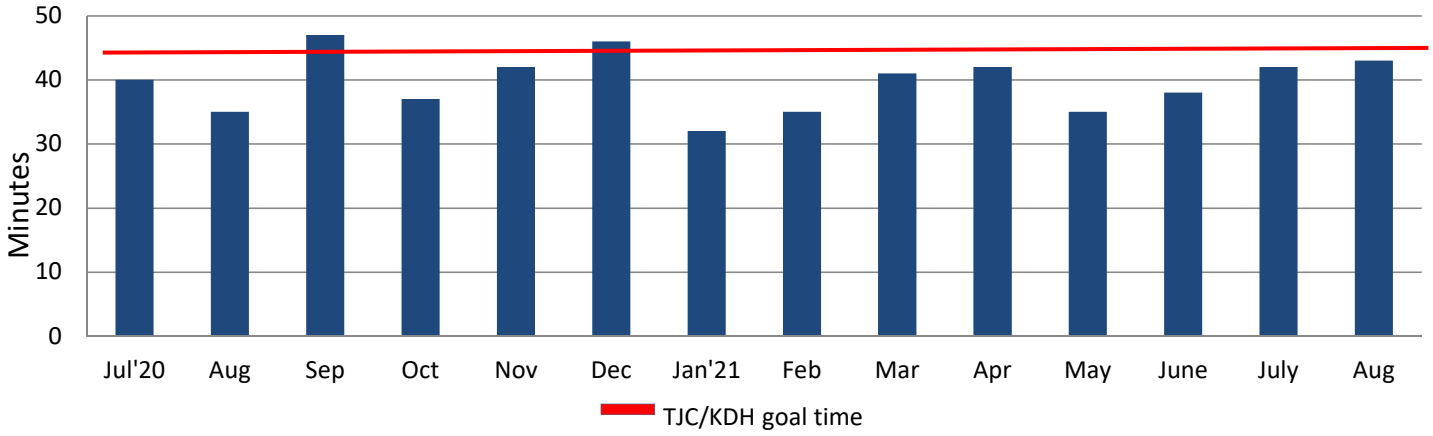
2020-2021 Stroke Alert Dashboard

Door to Lab Time (median times)



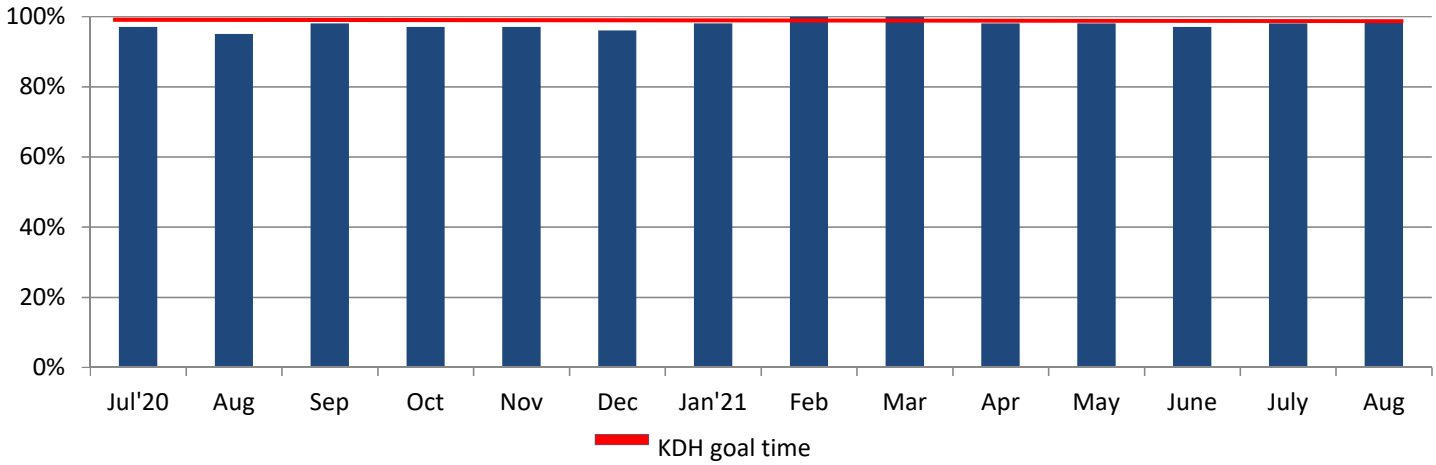
TJC expectation is that laboratory tests are completed within 45 minutes of arrival. Changes in stroke alert process has been made early 2019 to improve lab verified times. Action items taken: IV start kits in CT rooms with lab tubes, lab lable makers in both CT rooms and specimens taken immediately down to lab.

Door to EKG Time (median time)



TJC expectation is that EKGs are completed within 45 minutes of arrival.

% Dysphagia screen completed when ordered



Dysphagia screening should be completed by the RN on all stroke alert patients prior to any po intake, including meds. Dysphagia screening is part of the ED stroke alert order sets. Goal is 100% compliance.

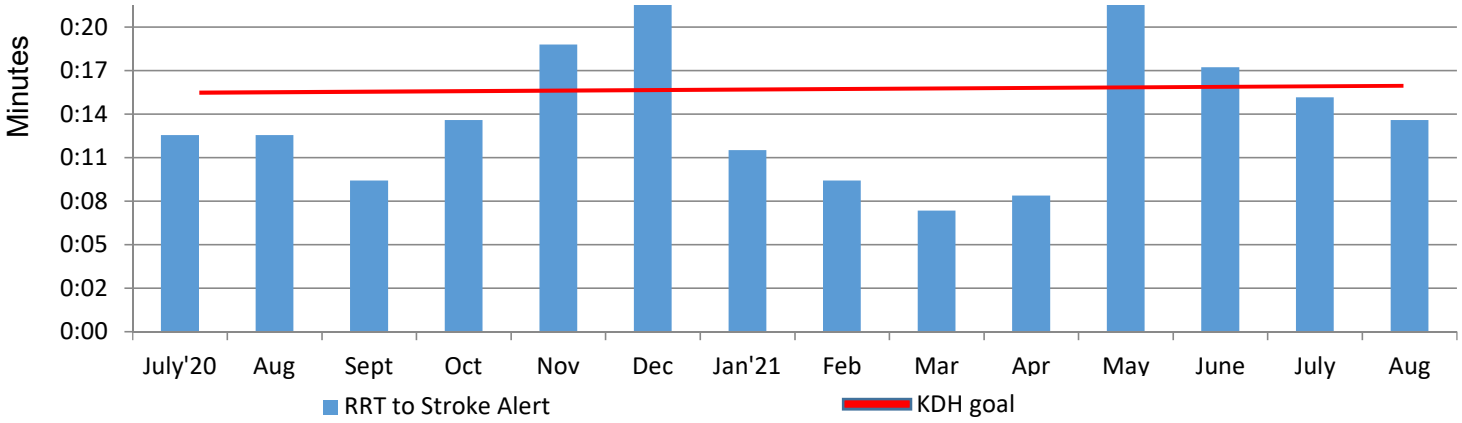
2020-2021

In-House Stroke Alert Dashboard

Stroke Alert Location

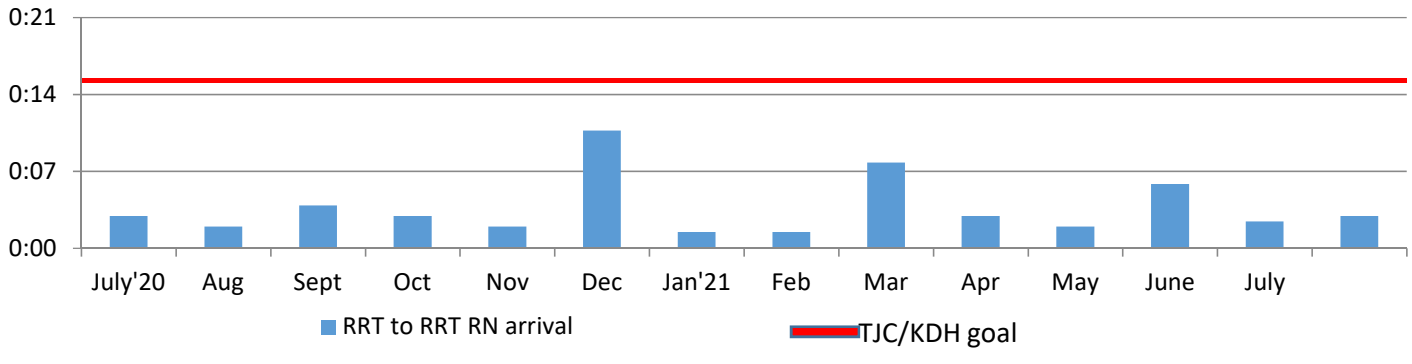
	July'20	Aug	Sept	Oct	Nov	Dec	Jan'21	Feb	Mar	Apr	May	June	July	Aug
3W	1	2		5		1	4	1	1	3	2	2		1
4S	2	3	2	6	2	3	6	2	4	4	1	3	3	2
2S			1	1		2	1			1	1	3		1
3S		1		2	2	1				1		1	1	1
Cath Lab			1						1		1			
CVICU	3				1						1	1	1	1
ICU														
4N	1	2	4	1		1	1	2		1			3	2
3N	1	2		1								1		1
4T		1			1			1			1	1	2	1
PACU											1			
2N		1	3			1		1		1				
5T		2	1	1	1	3	1		1	2	1	1	1	1
BP						1								
MB													1	

RRT to Stroke Alert



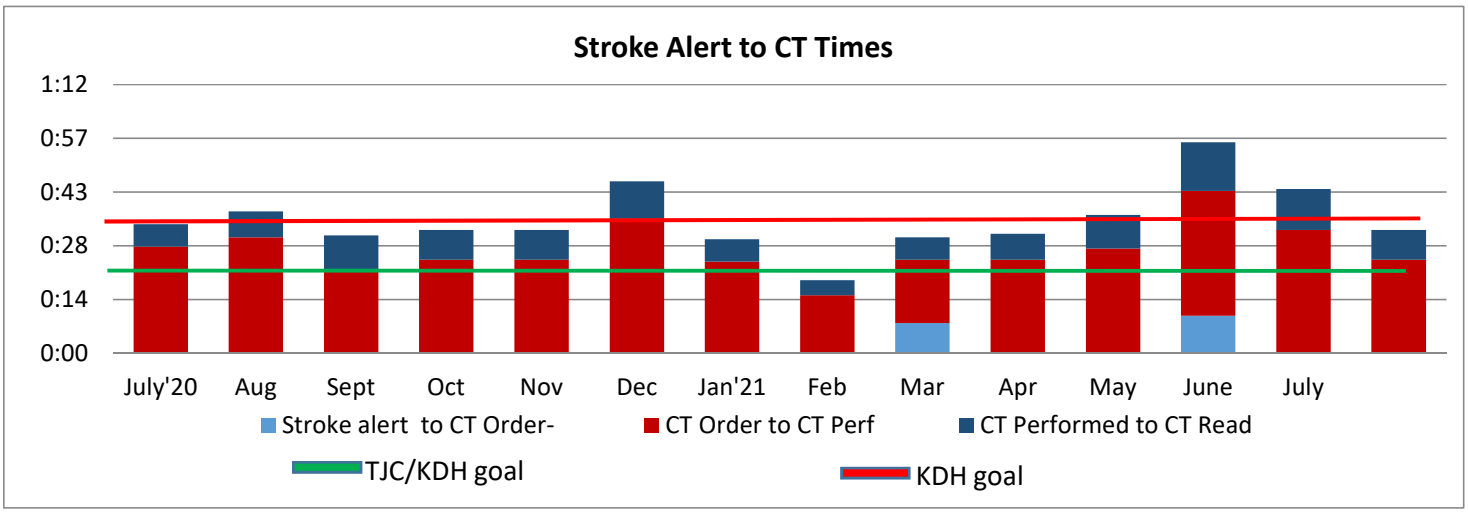
If patients exhibit any new or worsening neuro deficits while in the hospital; RNs are to call an RRT. The RRT RN will evaluate and determine if a stroke alert should be called. The goal from calling RRT to stroke alerts should be <15 minutes.

RRT to RRT RN arrival

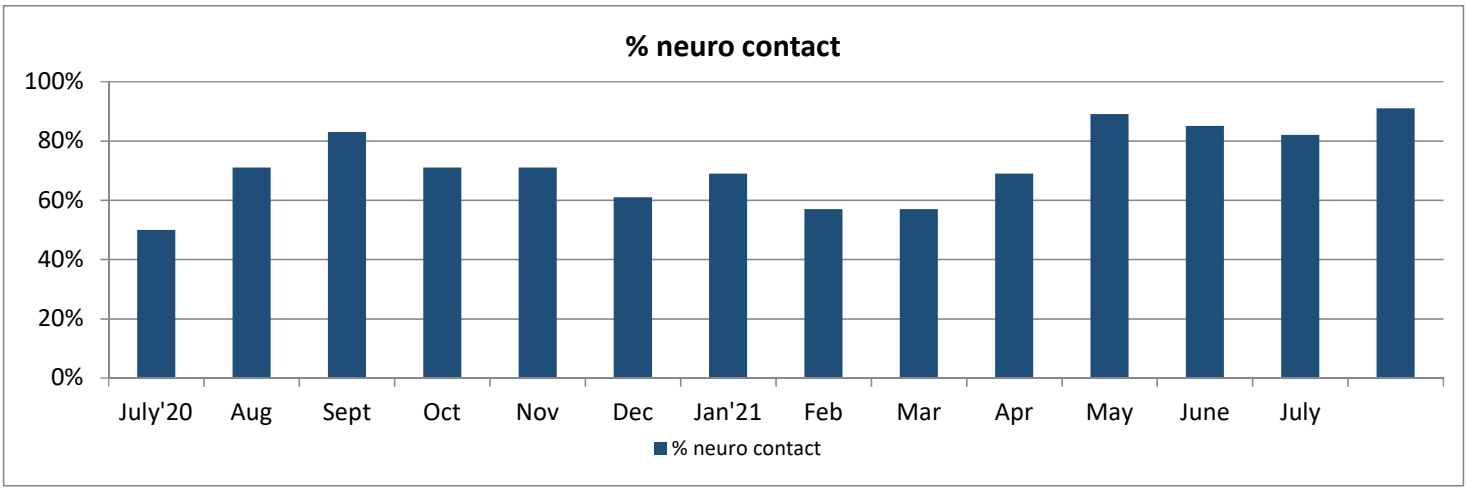


TJC expectation is that a designated provider is at the bedside within 15 minutes of stroke alert. KDH has designated the RRT RN as the provider for in-house stroke alerts.

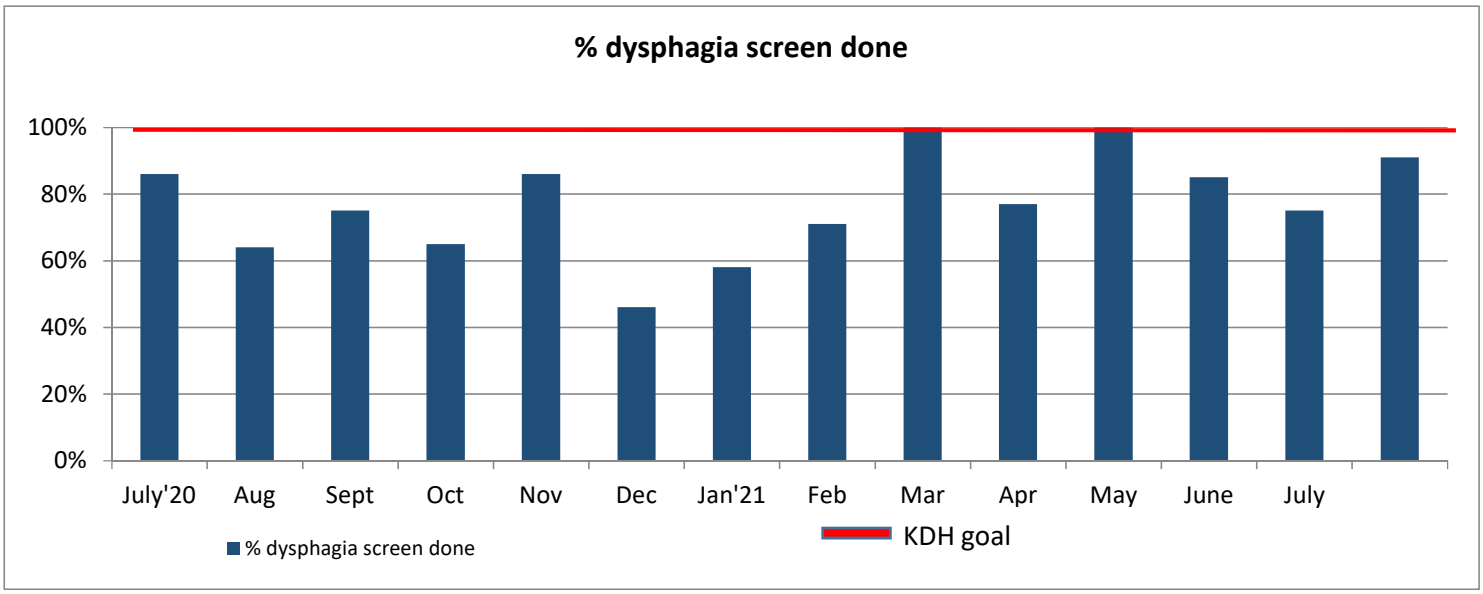
2020-2021
In-House Stroke Alert Dashboard



TJC expectation is that the CT will be read within 45 minutes of arrival. KDH's goal is 30 minutes **(red line).** TJC added a new metric in 2018; the expectation is that the CT will be performed within 20 minutes of alert **(green line).**



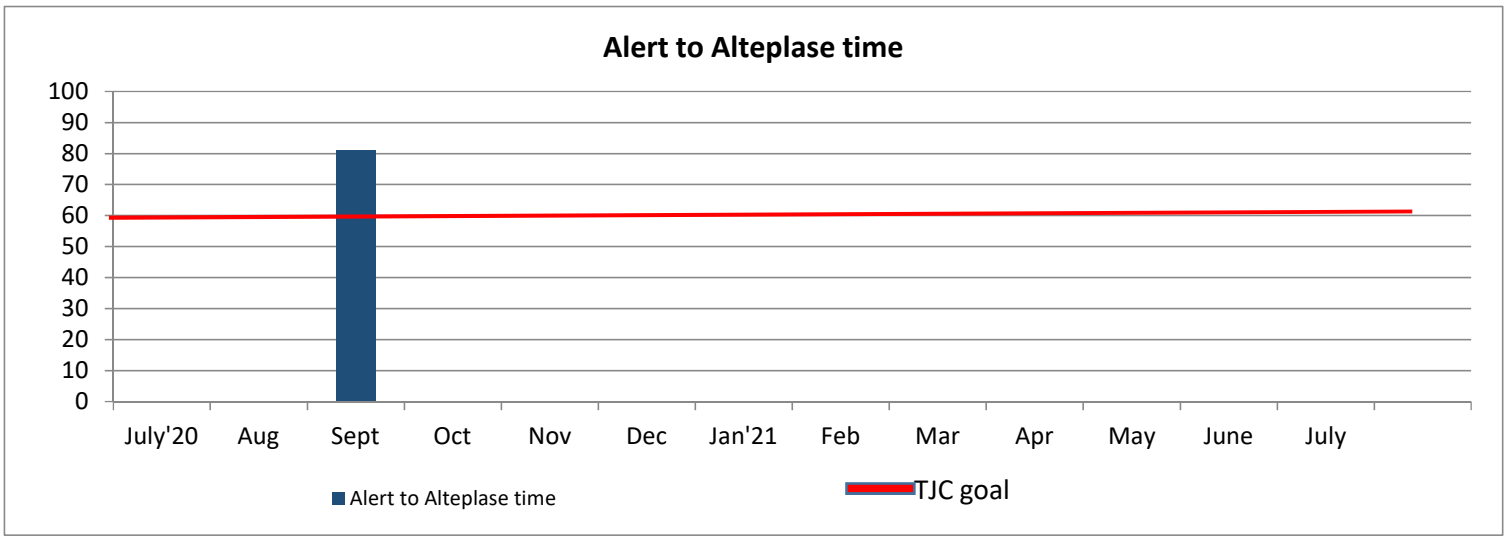
Neurology consultation should occur on all in-house stroke alerts.



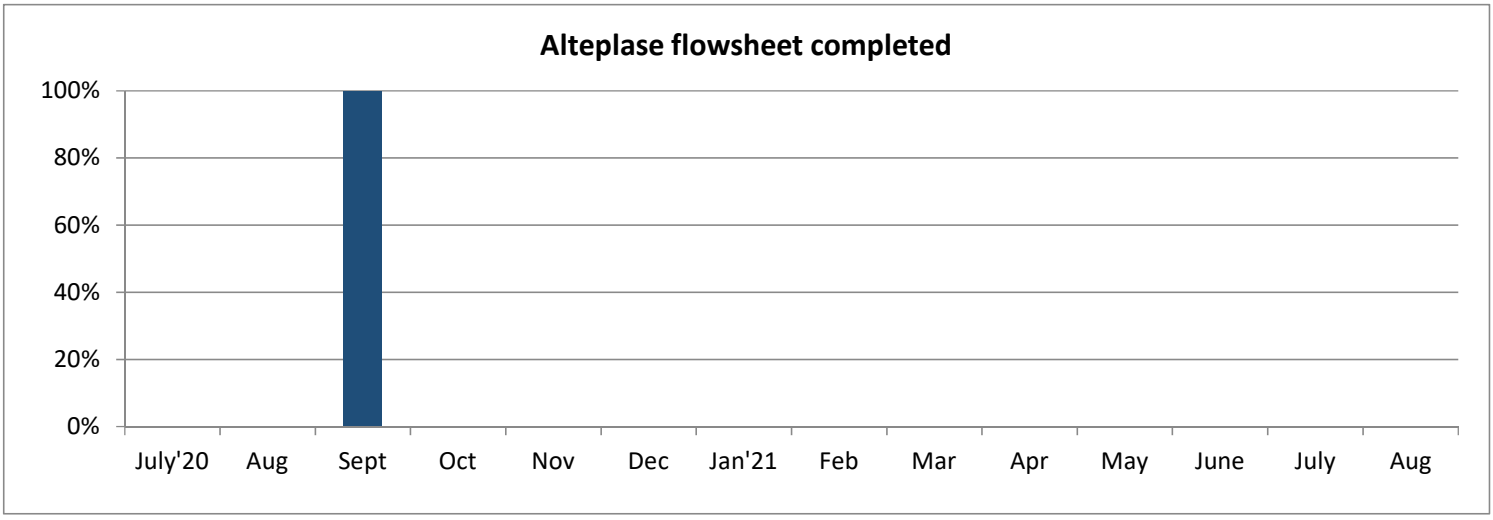
Whenever there are new or worsening neurological deficits ≥3 points, the RN should perform a dysphagia screen to evaluate the patient's ability to swallow.

2020-2021

In-House Stroke Alert Dashboard



ED Patients: TJC expectation is that IV thrombolytics are given within 60 minutes to eligible patients who present for stroke care at least 50% of the time. In-House Stroke alerts: KDH expectation is that IV thrombolytics are given within 60 minutes to eligible patients who have been identified with new or worsening stroke symptoms



Core Measures Snapshot - September 2021

July 2020 - June 2021

Metrics		Hospital Compare	CMS Standards of Excellence Benchmark	CMS Benchmark / *TJC National Rate	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Den	Num	Fail
ED-2b	Admit Decision Time to ED Departure for Admitted ED Patients **(in minutes - down trend positive)**	Y	42	139 (Hosp Comp)	199	171	171	185	553	325	224	224	218	260	332	314	N/A	N/A	N/A
OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients **(in minutes - down trend postive)**		93	170 (Hosp Comp)	207	281	247	310	227	303	277	286	278	316	393	302	N/A	N/A	N/A
OP-23	Head CT or MRI scan results for Acute Ischemic Stroke or Hemorrhagic Stroke		100.00%	72.00%	50.0%	100.0%	100.0%	100.0%	50.0%	N/C	100.0%	100.0%	100.0%	66.7%	50.0%	66.7%	3	2	1
IMM-2	Influenza Immunization	Y	100.00%	93.00%	N/A	N/A	92.7%	98.8%	95.9%	97.5%	97.3%	97.6%	N/A	N/A	N/A	N/a	N/A	N/A	N/A
VTE-6	Hospital acquired potentially-preventable Venous Thromboembolism **(down trend positive)**	Y	0.00%	2.00%	0.00%	0.00%	0.00%	N/C	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6	6	0
HBIPS-1a	Admissions Screening		N/A	89.90%	93.94%	75.76%	89.66%	88.89%	93.55%	86.96%	93.75%	96.43%	100.00%	86.36%	86.36%	81.48%	27	22	5
HBIPS-2a	**Physical Restraint-Overall Rate - **(down trend positive)**	Y	N/A	0.44	1.123	1.745	2.178	1.149	1.188	0.323	0.292	1.408	0.639	0.720	0.071	0.987	N/A	N/A	N/A
HBIPS-3a	**Seclusion-Overall Rate - **(down trend positive)**	Y	N/A	0.29	1.304	0.727	1.205	1.095	1.629	1.710	0.723	0.449	0.077	0.145	0.460	0.629	N/A	N/A	N/A
HBIPS-5a	Multiple antipsychotic medications at discharge with appropriate justification - overall rate	Y	N/A	58.59%	N/C	N/C	100.0%	N/C	N/C	25.0%	100.0%	0.0%	100.0%	0.0%	0.0%	100.0%	1	1	0

N/C = No Cases

Metrics		Hospital Compare	CMS Standards of Excellence Benchmark	CMS Benchmark / *TJC National Rate	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Den	Num	Fail
SUB-2 (MH)	Alcohol Use Intervention Provided/Offered	Y	N/A	69.92%	77.79%	88.89%	83.33%	100.00%	90.00%	50.00%	100.00%	100.00%	100.00%	90.00%	100.00%	88.89%	9	8	1
SUB-2A (MH)	Intervention provided	Y	N/A	61.76%	62.50%	55.56%	66.67%	80.00%	50.00%	25.00%	100.00%	70.00%	75.00%	40.00%	40.00%	55.56%	9	5	4
SUB-3 (MH)	Alcohol/Other Drug Use Tx provided/offerred at D/C	Y	N/A	36%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	95.46%	100.00%	100.00%	100.00%	100.00%	20	20	0
SUB-3A (MH)	Alcohol/Other Drug Use Disorder Tx at D/C	Y	N/A	36%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	95.46%	100.00%	100.00%	100.00%	95.00%	20	19	1
IMM-2 (MH)	Influenza Immunization (Mental Health) Start Oct 2015	Y	N/A	80.98%	N/A	N/A	98.08%	94.12%	98.00%	100.00%	100.00%	94.00%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TOB-2 (MH)	Tobacco Cessation FDA Approved Provided during stay.	Y	N/A	76.62%	93.10%	100.00%	96.00%	95.00%	100.00%	95.24%	96.43%	90.91%	100.00%	90.32%	84.62%	92.00%	25	23	2
TOB-2A (MH)	Tobacco Treatment Provided During Stay (Practical Counseling)	Y	N/A	41.52%	44.83%	44.00%	44.00%	45.00%	50.00%	38.10%	46.43%	29.03%	25.00%	41.94%	30.77%	43.48%	23	10	13
TOB-3 (MH)	Tobacco Treatment Provided/Offered at Discharge	Y	N/A	40.80%	89.29%	95.46%	83.33%	44.44%	82.35%	68.42%	76.00%	56.67%	56.00%	81.48%	63.63%	73.91%	23	17	6
TOB-3A (MH)	Tobacco Cessation Medication FDA Approved Provided at Discharge	Y	N/A	9.52%	0.00%	4.55%	0.00%	5.56%	0.00%	10.53%	8.00%	16.67%	36.00%	32.14%	18.18%	17.39%	23	4	19
CT-2	Care Transitions w specified elements received by disharged patients	Y	N/A	30%	86.79%	84.91%	83.02%	86.79%	90.57%	86.79%	86.79%	84.91%	86.79%	80.77%	81.13%	88.68%	53	47	6
CT-3	Timely Transmission of Transition Record	Y	N/A	30%	77.36%	84.91%	83.02%	84.91%	83.02%	79.25%	83.02%	83.02%	84.91%	78.85%	71.70%	81.13%	53	43	10
SMD-1	Screening for Metabolic Disorders	Y	N/A	90%	94.56%	94.12%	100.00%	96.97%	100.00%	97.06%	94.60%	100.00%	94.60%	100.00%	100.00%	96.67%	30	29	1

N/C = No Cases

Metrics		Hospital Compare	CMS Standards of Excellence Benchmark	CMS Benchmark / *TJC National Rate	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Den	Num	Fail
PCB-05	Exclusive Breast Milk Feedings		N/A	*52.44%	51.52%	58.82%	66.75%	69.44%	61.77%	66.67%	62.50%	45.46%	41.67%	63.16%	66.67%	48.57%	35	17	18
PCM-01	Early Elective Deliveries **(down trend positive)**		0	2.42%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	11	11	0
PCM-2a	C-Section Overall Rate **(down trend positive)**		N/A	*25.54%	34.38%	14.29%	22.73%	29.41%	18.18%	23.81%	22.22%	25.00%	11.11%	34.62%	34.62%	27.27%	22	16	6
PCM-06	Unexpected Complications in Term Newborns-Overall Rate **(down trend possitive)**		N/A	N/A	1.65%	1.94%	4.04%	2.02%	2.05%	0.37%	2.80%	0.69%	2.80%	2.12%	1.07%	2.28%	307	300	7
OP Web-29	Endoscopy/Polyp Surveillance - appropriate follow-up interval for normal colonoscopy in average risk patients		100%	85%	66.7%	66.7%	100.0%	85.7%	100.0%	N/C	100.0%	77.8%	100.0%	100.0%	100.0%	100.0%	6	6	0
Sep-1	Sepsis Bundle Followed		81	61%	84.21%	82.61%	68.42%	71.43%	78.95%	60.00%	74.07%	76.00%	77.27%	76.70%	76.67%	60.00%	25	15	10

N/C = No Cases

Color Code
Meets/Exceeds Standards of Excellence Benchmark
Compliance Does Not Meet National Benchmark

Unit/Department: **ProStaff/QIC Report Date:**
Home Health **July, 2021**

Due to the public health emergency declared in March 2020, the Centers for Medicare & Medicaid Services (CMS) froze the data that they report on the Care Compare website, the platform for which quality measures are publicly reported for home health agencies. Data has not been updated and currently displays data through December 31, 2019.

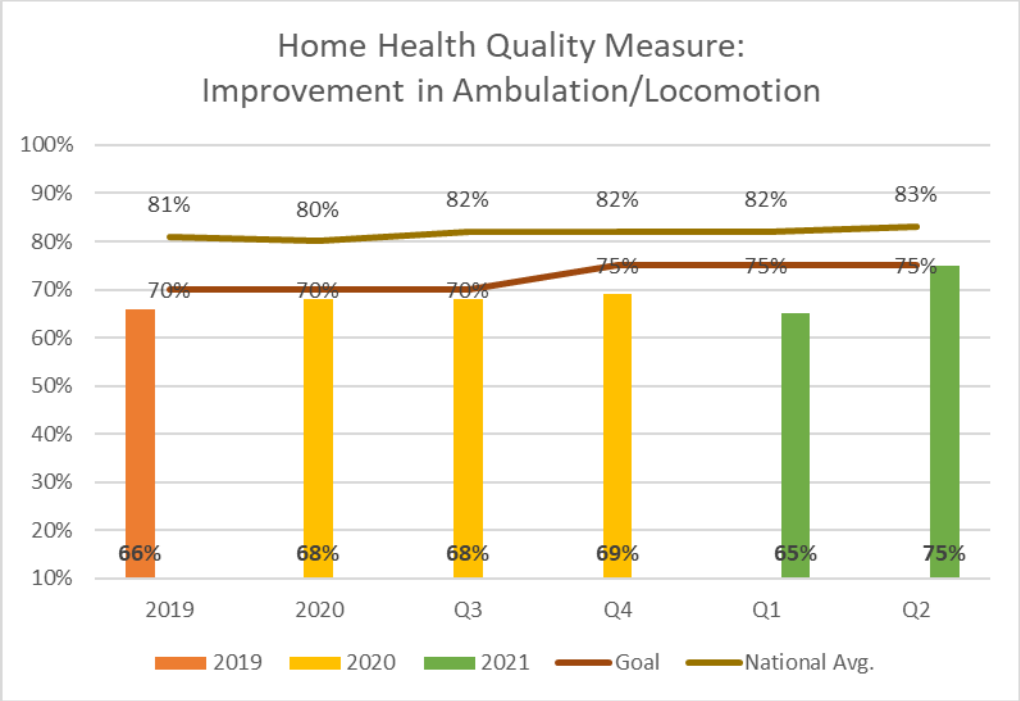
In order to ensure the most current and relevant data for analysis, information was obtained from Internet Quality Improvement and Evaluation System (iQIES), a CMS platform that allows Medicare-certified home health agencies to view quality reports based on the Outcome and Assessment Information Set (OASIS) data submitted by that agency. OASIS is a data collection tool that all Medicare-certified home health agencies are required to collect and transmit to CMS for all patients whose care is reimbursed by Medicare and Medicaid with the following exceptions; patients receiving maternity services, patients under 18, or patients receiving housekeeping services only.

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

Measure Objective/Goal:
***Improvement in Ambulation/Locomotion*;**

- **iQIES data 2019: 66%**
- **iQIES data 2020: 68%**
- **iQIES data Quarters 3 & 4, 2020 and Quarters 1 & 2 2021: 69%**

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



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

Date range of data evaluated:
iQIES data Quarters 3 & 4, 2020 and Quarters 1 & 2 2021: 69%

Analysis of all measures/data: (Include key findings, improvements, opportunities)
--CY 2020 data of 68%, remains below the National Average of reporting home health agencies at 75%.
--1264 eligible cases (patients with outcome) were seen during this period; Findings; *Improved:* 869, *Stabilized*: 332 and *Deteriorated:* 63.
--Clinician barriers to accurate assessment; assessing in home environment (clutter, need for equipment to help with mobility), and understanding of ability vs *safe* ability.
--Charting fatigue for clinicians considered as possible reason for inconsistencies in scoring OASIS accurately. OASIS questions focusing on ambulation are located near the end of a lengthy assessment. An attempt was previously made to 'move up' the OASIS sections related to ambulation but per our EMR software, this is not possible.

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

If improvement opportunities identified, provide action plan and expected resolution date:
There is an opportunity for improvement in this area. The following plan of action shall be implemented;
--Home Health Manager and educator will develop a 'checklist' to help all clinicians better assess *safe* ability when ambulating. Checklist will be presented to UBC in October for review and final adjustments. Educator will provide discussion and demonstration to all clinicians on use of the checklist once finalized, no later than December UBC. Educator and Intake RN will review data from clinician charting and OASIS for inconsistencies.
--Clinicians will utilize the "5 Day Rule" allowed by CMS. CME encourages a collaboration between all clinicians who assessed a patient within 5 days of the first OASIS assessment. This will ensure accurate capture of a patient's need and the opportunity to provide the resources needed to help achieve outstanding community health consistent with Kaweah Health District pillar.

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

Submitted by Name:	**Date Submitted:**
Shannon Esparza, RN	**July, 2021**

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

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

Home Health **July, 2021**

Due to the public health emergency declared in March 2020, the Centers for Medicare & Medicaid Services (CMS) froze the data that they report on the Care Compare website, the platform for which quality measures are publicly reported for home health agencies. Data has not been updated and currently displays data through December 31, 2019.

In order to ensure the most current and relevant data for analysis, information was obtained from Internet Quality Improvement and Evaluation System (iQIES), a CMS platform that allows Medicare-certified home health agencies to view quality reports based on the Outcome and Assessment Information Set (OASIS) data submitted by that agency. OASIS is a data collection tool that all Medicare-certified home health agencies are required to collect and transmit to CMS for all patients whose care is reimbursed by Medicare and Medicaid with the following exceptions; patients receiving maternity services, patients under 18, or patients receiving housekeeping services only.

Measure Description:

How often patients got better at bathing

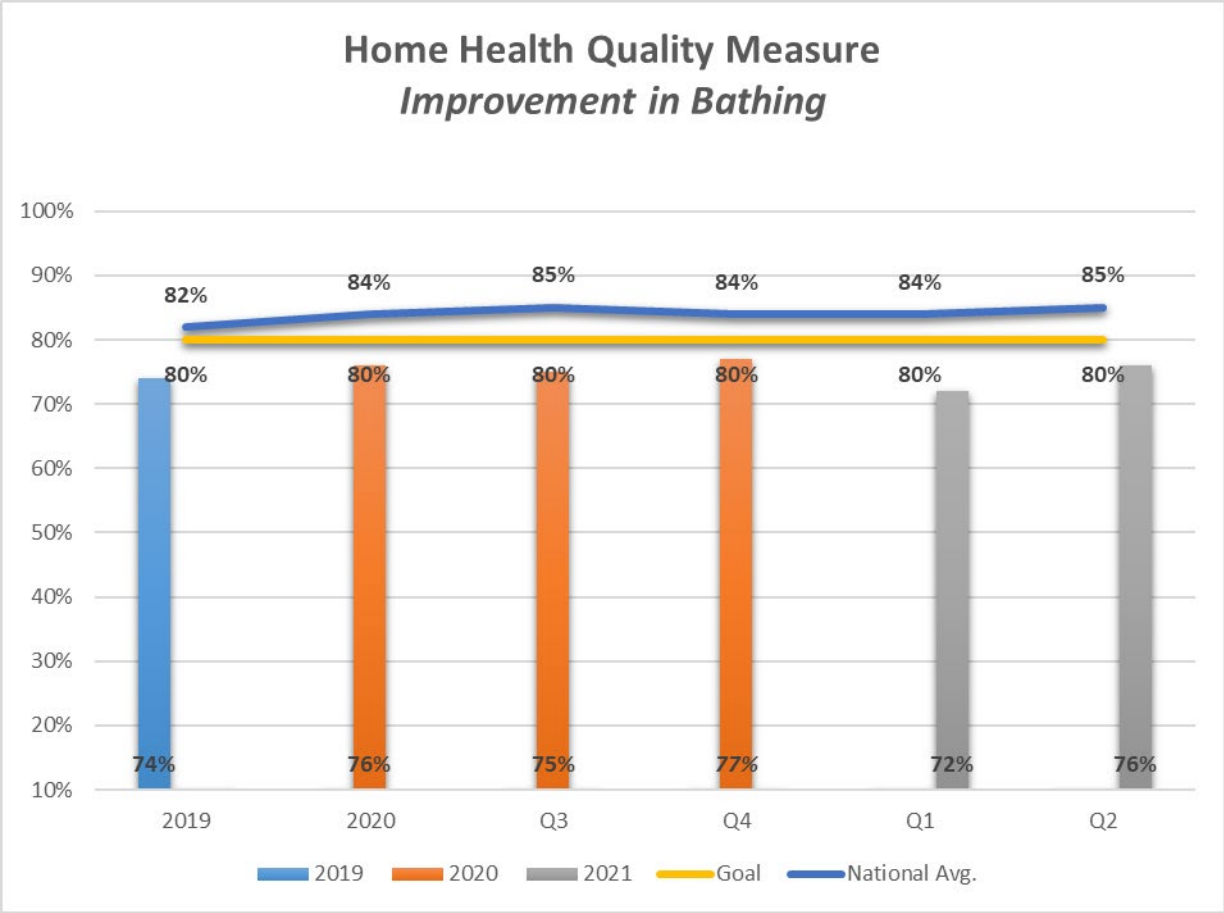
--Clinicians (registered nurses, physical therapists) complete OASIS data upon a patient's admission to home health. A patients current ability to wash their entire body safely is measured upon admission to home health using a 6-pt-scale. The 6-point bathing scale represents the most independent level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

Measure Objective/Goal:

Improvement in bathing

- **iQIES data 2019: 74%**
- **iQIES data 2020: 76%**
- **iQIES data Quarters 3 & 4, 2020 and Quarters 1 & 2 2021: 75%**

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



Date range of data evaluated:
iQIES data; July 1, 2020 to June 30, 2021

Analysis of all measures/data: (Include key findings, improvements, opportunities)
--Clinicians must take into account multiple factors when determining the patient's ability to ambulate to the bathroom, and what level of assistance they require to do so s*afely*.
--Adaptive methods, assistive devices, and MD ordered restrictions need to be communicated to the first clinician assessing the patient to ensure an accurate scoring of their ability. Intake clinicians work with case managers in the hospital to be sure that information is obtained in the referral order.
--Clinicians must utilize their professional, clinical judgement when determining what level the patient can perform at and truly be *Safe,* not just simply complete the activity.

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

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

There is an opportunity for improvement in this area. The following plan of action will be implemented;
--Home Health Manager and educator will develop a 'checklist' to help all clinicians better assess *safe* ability when ambulating. This checklist will be utilized for assessing the ability to get to the bathroom safely to bathe. Checklist will be presented to UBC in October for review and final adjustments. Educator will provide discussion and demonstration to all clinicians on use of the checklist once finalized, no later than December UBC. Educator and Intake RN will review data from clinician charting and OASIS for inconsistencies.
--Clinicians will utilize the "5 Day Rule" allowed by CMS. CME encourages a collaboration between all clinicians who assessed a patient within 5 days of the first OASIS assessment. This will ensure accurate capture of a patient's need and the opportunity to provide the resources needed to help achieve outstanding community health consistent with Kaweah Health District pillar.

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

Submitted by Name:	**Date Submitted:**
Shannon Esparza, RN	**July, 2021**

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department:
Home Health

ProStaff/QIC Report Date:
July 2021

Due to the public health emergency declared in March 2020, the Centers for Medicare & Medicaid Services (CMS) froze the data that they report on the Care Compare website, the platform for which quality measures are publicly reported for home health agencies. Data has not been updated and currently displays data through December 31, 2019.

In order to ensure the most current and relevant data for analysis, information was obtained from Internet Quality Improvement and Evaluation System (iQIES), a CMS platform that allows Medicare-certified home health agencies to view quality reports based on the Outcome and Assessment Information Set (OASIS) data submitted by that agency. OASIS is a data collection tool that all Medicare-certified home health agencies are required to collect and transmit to CMS for all patients whose care is reimbursed by Medicare and Medicaid with the following exceptions; patients receiving maternity services, patients under 18, or patients receiving housekeeping services only.

Measure Description:

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

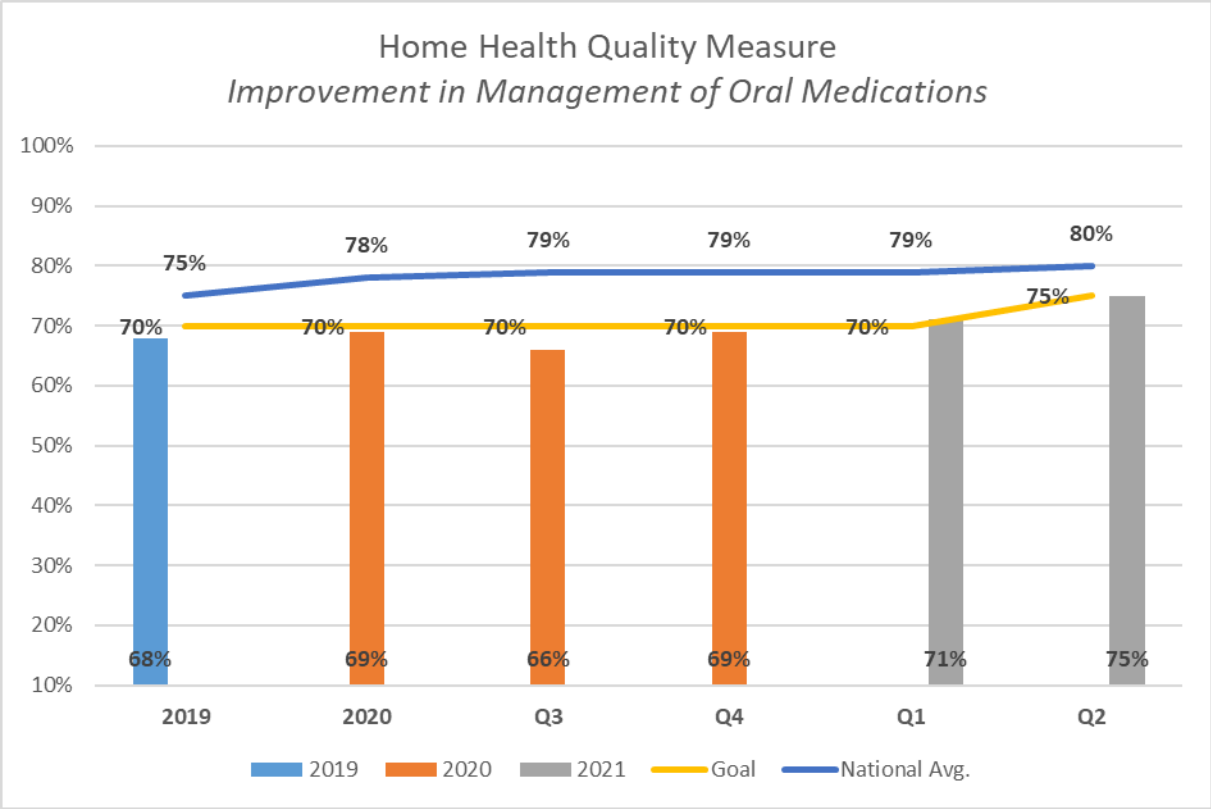
--Clinicians (registered nurses, physical therapists) complete OASIS data upon a patient's admission to home health. Clinicians must assess the patient's ability to take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times. At discharge, the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

Measure Objective/Goal:

Improvement in Management of Oral Medications

- **iQIES data 2019: 68%**
- **iQIES data 2020: 69%**
- **iQIES data Quarters 3 & 4, 2020 to Quarters 1 & 2, 2021: 70%**

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



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

Date range of data evaluated:
iQIES data; July 1, 2020 to June 30, 2021

Analysis of all measures/data: (Include key findings, improvements, opportunities)
--CY 2020 data of 69%, is below the National Average of all home health reporting agencies.
--Opportunity for teaching with staff due to the multilevel assessment in this measure. Clinicians must differentiate patient's ability to perform the steps in this measure independently versus the level of family/caregiver assistance with medication regimen. Patient's ability to obtain the medication from where it is routinely stored, the ability to read the label or accurately identify medication by placing a character on label, open the container, remove the correct quantity and orally ingest at the correct frequency.
--Functional ability as well as cognitive ability may impact patient's ability to safely manage medications.

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

--Medical record review noted inconsistencies with clinicians scoring of oral medication administration and ability to ambulate. OASIS guidance requires the clinician consider the patient's ability to obtain the medication from where it is routinely stored.

<u>If improvement opportunities identified, provide action plan and expected resolution date:</u>
--There is an opportunity for improvement in this area. The following plan of action shall be implemented;
--Timely audit of clinical OASIS documentation to ensure an accurate capture of patient's ability to safely take all of their oral medication as indicated. RN Educator and RN intake auditor to consult with clinician if auditing has identified areas of discrepancy between clinician documentation and OASIS answer.
--Utilize planned 'checklist' tool to ensure level of need to safely ambulate is determined prior to scoring OASIS medication questions.
--Clinicians will utilize the "5 Day Rule" allowed by CMS. CME encourages a collaboration between all clinicians who assessed a patient within 5 days of the first OASIS assessment. This will ensure accurate capture of a patient's need and the opportunity to provide the resources needed to help achieve *Outstanding Community Health* consistent with Kaweah Health District pillar.

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

<u>Submitted by Name:</u>	**<u>Date Submitted:</u>**
Shannon Esparza, RN	**July, 2021**

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

Sepsis
Quality Focus Team (QFT)
October 2021

Kaweah Health
MORE THAN MEDICINE. LIFE.

What is Sepsis?

Sepsis is the body's overwhelming and life-threatening response to infection that can lead to tissue damage, organ failure, and death.

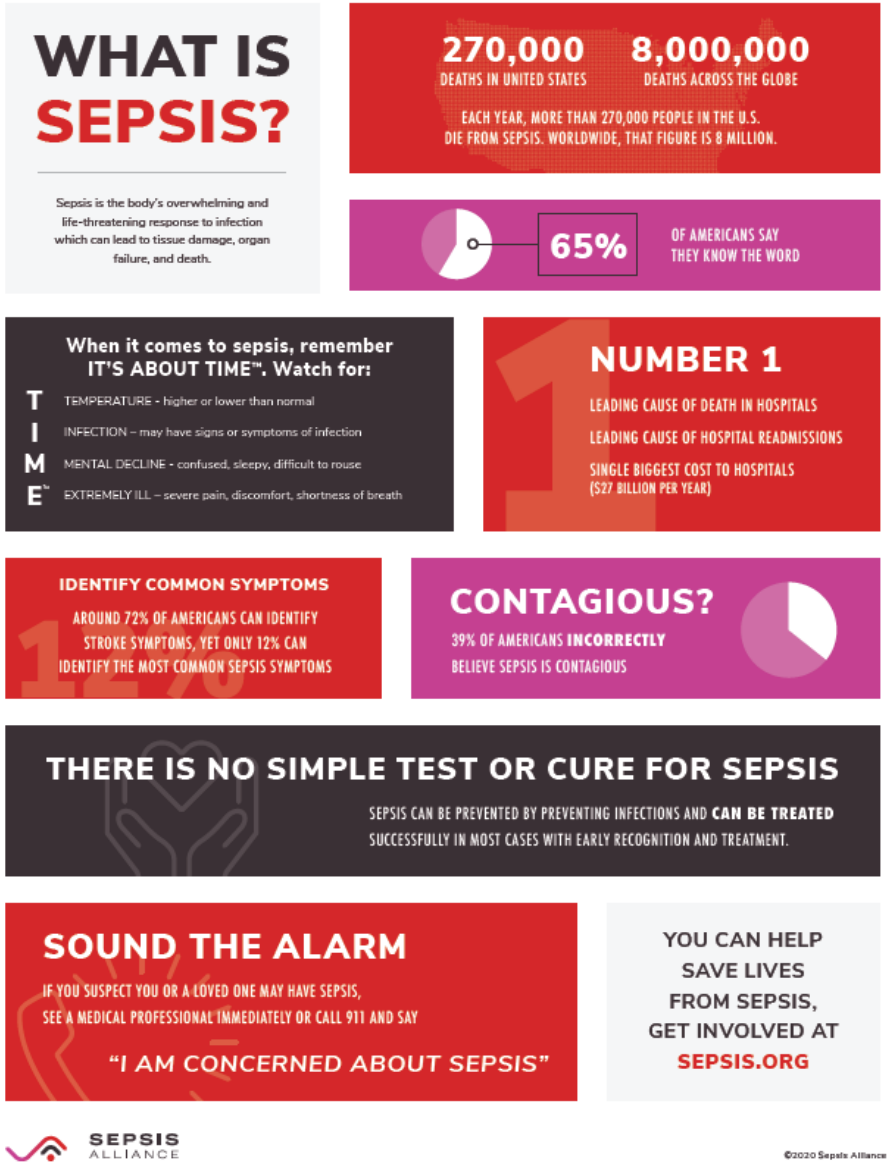
- the body's overactive and toxic response to an infection.
- a medical emergency that requires rapid diagnosis and treatment
- Sepsis can lead to severe sepsis and septic shock.

Key Sepsis Facts:

- Sepsis is the number 1 cost of hospitalization in the U.S. - estimated to be $62 billion annually.
- Estimated that 30% of patients diagnosed with severe sepsis do not survive.
- Up to 50% of survivors suffer from post-sepsis syndrome. **Until a cure for sepsis is found, early detection and treatment is essential for survival and limiting disability for survivors.**
- Every 2 minutes in the United States Sepsis takes a life

At Kaweah Health:

- One of the highest volume medical diagnosis
- One of the most expensive DRGs
- A leading cause of mortality



SEP-1 Early Management Bundle

The risk of dying from sepsis increases by as much as 8% for every hour treatment is delayed*

- In 2015, the Centers for Medicare and Medicaid Services (CMS) instituted an all-or-none sepsis performance measure bundle (SEP-1) to promote high-quality, cost-effective care.

- In general, the current SEP-1 version requires patients with suspected sepsis have:
  - lactate level
  - blood cultures
  - broad-spectrum antibiotics
  - if hypotensive, a fixed 30 mL/kg fluid infusion within 3 hours
  - repeat lactate if initially elevated within 6 hours.
- In addition, for patients in septic shock:
  - Vasopressors
  - repeat assessment completed within 3 & 6 hrs.

<table>
<tr><th rowspan="2">Required Action</th><th colspan="2">Severe Sepsis</th><th colspan="2">Septic Shock</th></tr>
<tr><th>3-Hr Bundle</th><th>6-Hr Bundle</th><th>3-Hr Bundle</th><th>6-Hr Bundle</th></tr>
<tr><td>Initial Lactate Collection</td><td>Yes</td><td colspan="3" rowspan="3">Must be completed within 3-hrs of Severe Sepsis Presentation</td></tr>
<tr><td>Blood Culture Collection</td><td>Yes</td></tr>
<tr><td>Initial Antibiotic Started</td><td>Yes</td></tr>
<tr><td>Repeat Lactate Collection (if Initial Lactate is > 2)</td><td>N/A</td><td>Yes</td><td colspan="2">Completed within 6-hrs of Severe Sepsis presentation</td></tr>
<tr><td>30 mL/kg Crystalloid Fluids Started</td><td>N/A</td><td>N/A</td><td>Yes</td><td>Completed within 3-hrs of initial hypotension and/or septic shock</td></tr>
<tr><td>Vasopressor Given (if hypotension persists)</td><td>N/A</td><td>N/A</td><td rowspan="2">Completed within 6-hrs of septic shock</td><td>Yes</td></tr>
<tr><td>Repeat Volume Status Assessment</td><td>N/A</td><td>N/A</td><td>Yes</td></tr>
</table>

*Kumar A, Roberts D, Wood KE, et al. Duration of hypotension before initiation of effective antimicrobial therapy is the critical determinant of survival in human septic shock. Crit Care Med. 2006;34(6):1589-1596. http://www.ncbi.nlm.nih.gov/pubmed/16625125

Sepsis Alerts

Early recognition leads to early treatment

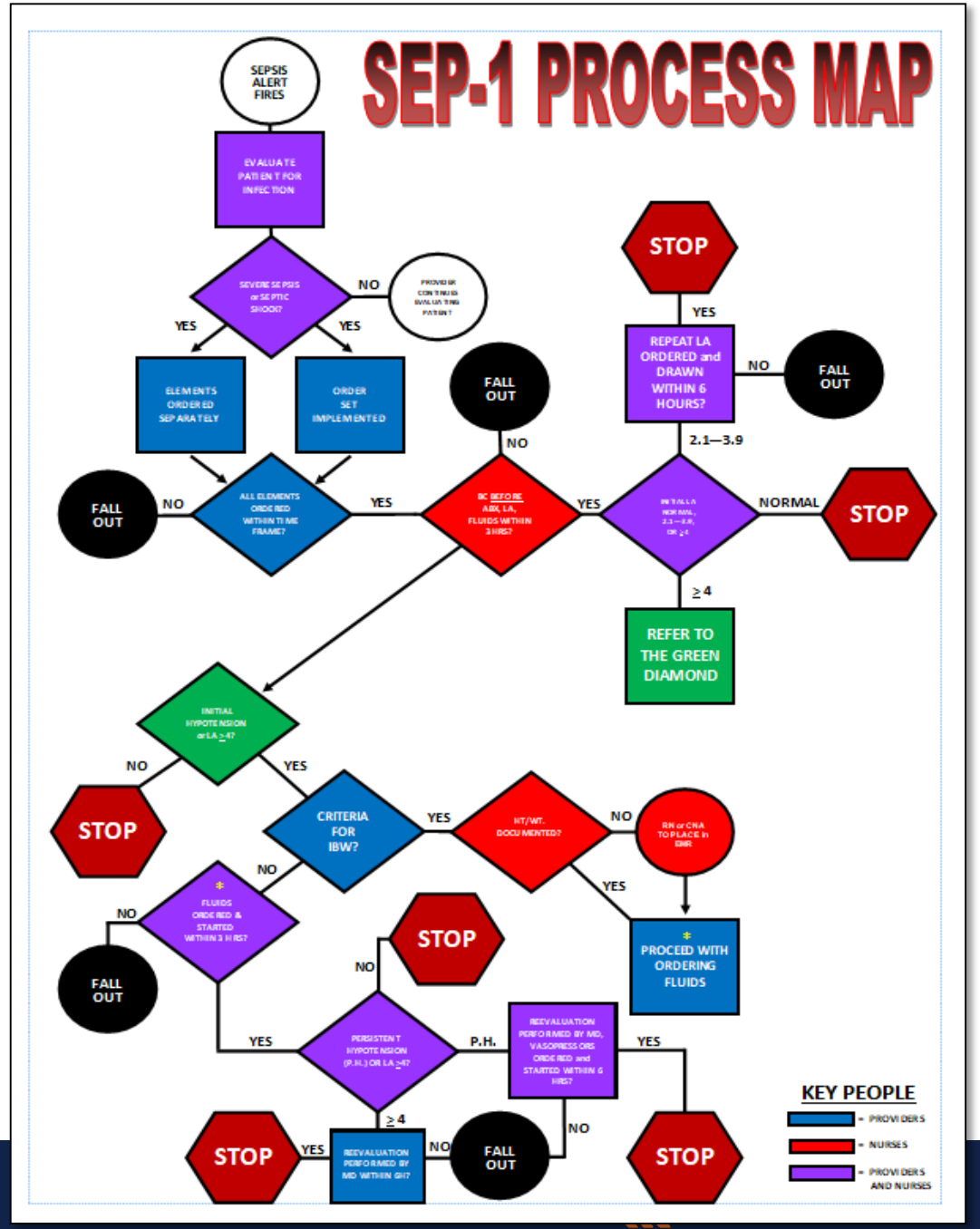
Kaweah Health utilizes The St. John Sepsis Surveillance Agent to identify high risk patients to initiate the SEP-1 bundle

- developed by Cerner Corporation in 2010, draws from the best published evidence and uses cloud computing with big data analytics to screen and activate on high-risk patients early in their infectious process, while increasing precision in estimating mortality risk to enable medical decision.
- Between July 2020 and September 2021 Kaweah Health averages 522 electronic sepsis alerts per month, estimated annual total of 6,265
- Approximately 13% of alerts meet sepsis criteria requiring intervention, equating to 68 patients per month or 816 patients per year
- Approximately 67% of sepsis alerts and severe septic patients are followed by a Sepsis Coordinator at Kaweah Health

SEP-1 Early Management Bundle

Bundled care to achieve optimal patient outcomes

- The CMS Sepsis bundle requires a multidisciplinary team approach; the care requirements are timed, with several decision points throughout the process , and the required documentation is precise
- To make it easier, the early management bundle has been put into order sets



SEP-1 Early Management Bundle

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

FY22 Clinical Quality Goals

	July-Aug 2021 Higher is Better	FY22 Goal	FY21	FY21 Goal
SEP-1 (% Bundle Compliance)	65%	≥ 75%	74%	≥ 70%

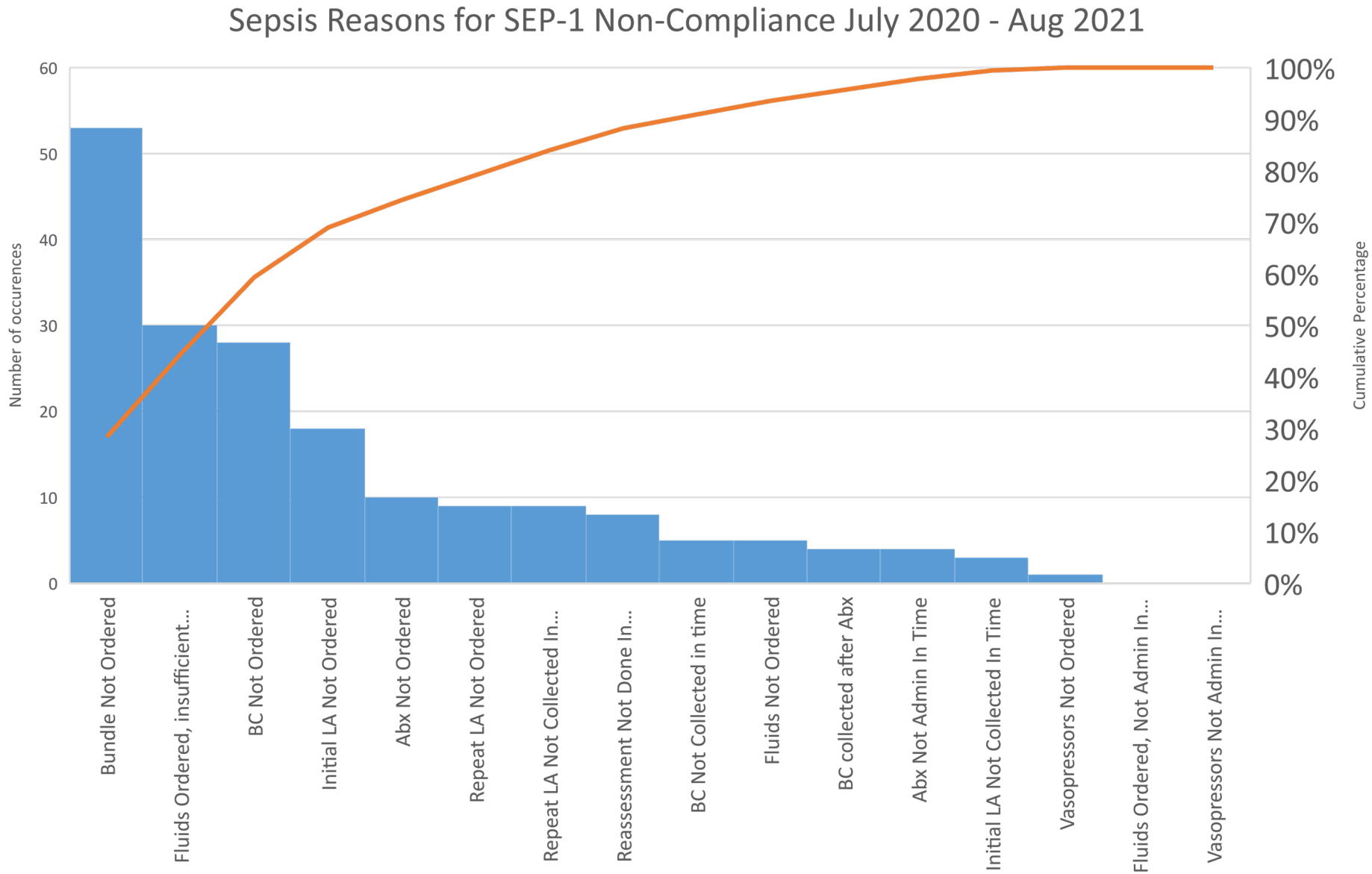
Percent of patients with this serious infection complication that received “perfect care”. Perfect care is the right treatment at the right time for our sepsis patients.

SEP-1 Early Management Bundle

Key root causes

- Bundle not ordered/timely
- Patient does not present in a clear sepsis picture, or during hospitalization
- Fluids ordered, insufficient volume due to patient with heart failure or kidney disease.

New SEP-1 criteria as of July 1, 2021 now include reduced fluid requirements for HF and KD patients (must be documented by provider)



BC= Blood Cultures, LA = Lactic Acid, Abx = Antibiotics

SEP-1 Early Management Bundle

Key Quality Improvement (QI) Initiatives

Sepsis QI Strategy Prioritization Grid

Group Strategy Affects	Improvement Strategy		DIFFICULTY or Cost/ Time to Implement Rate 5 to 1 High = 1 Low = 5		FEASIBILITY (likelihood of Success/ability to achieve the outcome Rate 5 to 1 High = 5 Low = 1		SCOPE Strategy affects multiple or a high volume root cause Rate 5 to 1 High = 5 Low = 1		LEVERAGE (Positive Impact on Other Processes) Rate 5 to 1 High = 5 Low = 1		Total Project Priority
CC/INPT RN	6. Make form revisions to "provider notification"; provide prompts for critical thinking and order set initiation, and title it differently to eliminate confusion	x	2.0	x	4.0	x	4.0	x	5.0		**160.0**
ED Pro	1. Improve ED provider notification by Sepsis Coordinator when attempting to avoid fallouts concurrently	x	4.0	x	2.0	x	4.0	x	3.5		**112.0**
ED/CC RN	20. Hand off sheet/pathway checklist (concerns about paper lost); can checklist be triggered electronically for RN when order set is used? This way checklist is available electronically, and can be available to print anywhere in patients Sepsis hospitalization course regardless of location. Similar to existing workflow with MRI safety form, belonging forms "ad hoc" forms. Ideally it populate, and reminder to complete.	x	3	x	2	x	4	x	4		**96.0**
CC/INPT RN	7. Mandatory for RN to fill out "provider notification form" after sepsis alert fires – alerts suppressed for 48hrs, so RNs do not receive multiple alerts. THIS IS DEPENDENT ON #6 Investigate what happens If you bypass the alert one time it appears very difficult to get it back – further education/awareness of where to find alert.	x	4.5	x	3.0	x	2.0	x	3.0		**81.0**
ED Pro	16. Reflex alert, when Abx ordered (specific list of Abx) provider gets alert "do you want BC"	x	4	x	4	x	4	x	1		**64.0**

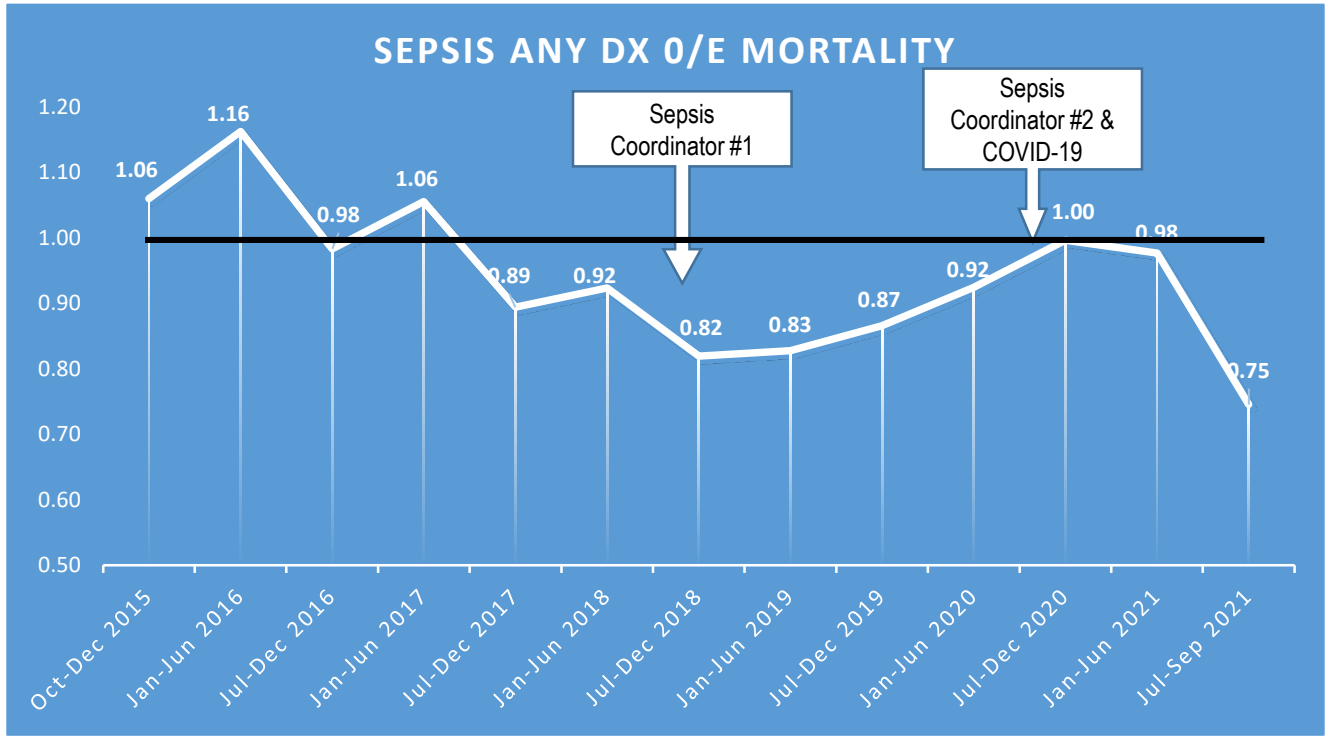
- Six sigma approach taken to analyze data and identify root causes of SEP-1 bundle fallouts, and prioritize QI strategies
- <u>19 improvement strategies implemented over 18 months</u>
- COMPLETE – Provider Notification Form went live at KHMC on 6/29/21
- COMPLETE – Sepsis education has officially gone live and will be mandatory for RNs throughout the organization on an annual basis. Thank you, Mary Laufer and the clinical education team for ensuring this was retrofitted for RNs hired in 2020 (as COVID placed the Safety Summit on hold).
- IN PROGRESS – Electronic handoff checklist in development
- ONGOING – Continuous review of cases where bundle was not fully implemented to identify further opportunities for QI as overseen by the multidisciplinary QFT

Outcomes of Sepsis Bundle Compliance

Sepsis Mortality Observed/Expected (O/E)

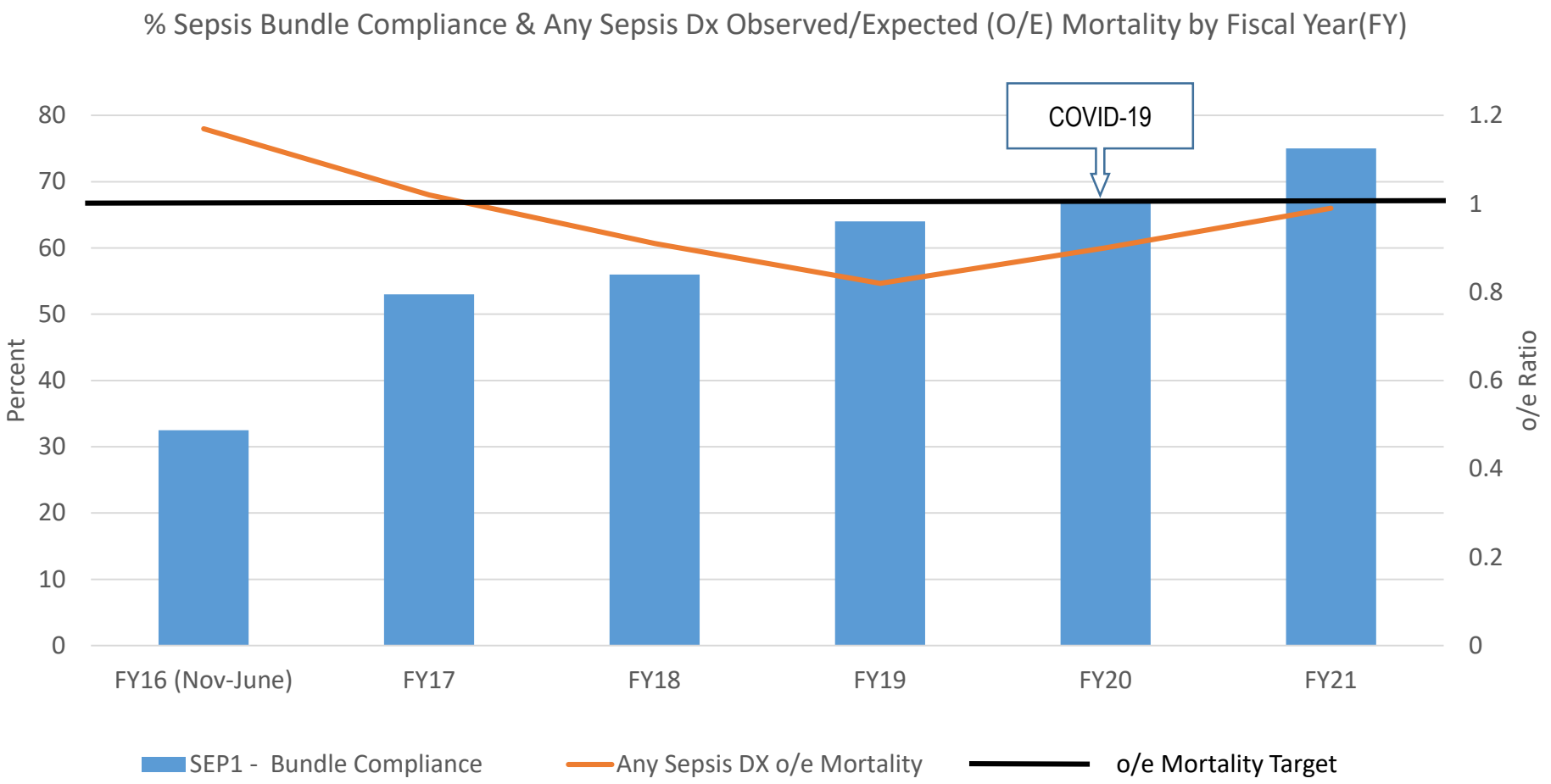
Goal: <1.0

*includes COVID-19 patients, but included in risk adjustment



Year	Sepsis Dx Volume
2015	787
2016	1144
2017	1431
2018	1614
2019	1523
2020	1445
2021 (*annualized)	1323

Outcomes of Sepsis Bundle Compliance



Provides a gauge on outcomes related to Sepsis care

- CMS Bundle compliance excludes COVID-19 patients
- O/E mortality includes COVID-19 patients, but included in risk adjustment
- Despite COVID-19 surge, o/e ratios remain <1 (less mortality than expected)

Questions?

Live with passion.

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

Kaweah Health

Catheter Associated Urinary Tract Infection (CAUTI) Quality Focus Team Report October 2021

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

CAUTI- FY21 Goals

Lower is Better	July 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual/ number expected)	FY21/ FY22 Goal	FY20
CAUTI Catheter Associated Urinary Tract Infection	1	0	1	1	1	1	0	1	0	3	1	1	20	52%↓ 0.542	≤0.727 ≤0.676	1.12

*based on FY20 NHSN predicted values
**Standardized Infection Ratio – Number of actual infections Kaweah had divided by the number of infections CMS predicts Kaweah should have

Kaizen Root Cause

Analysis:

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

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

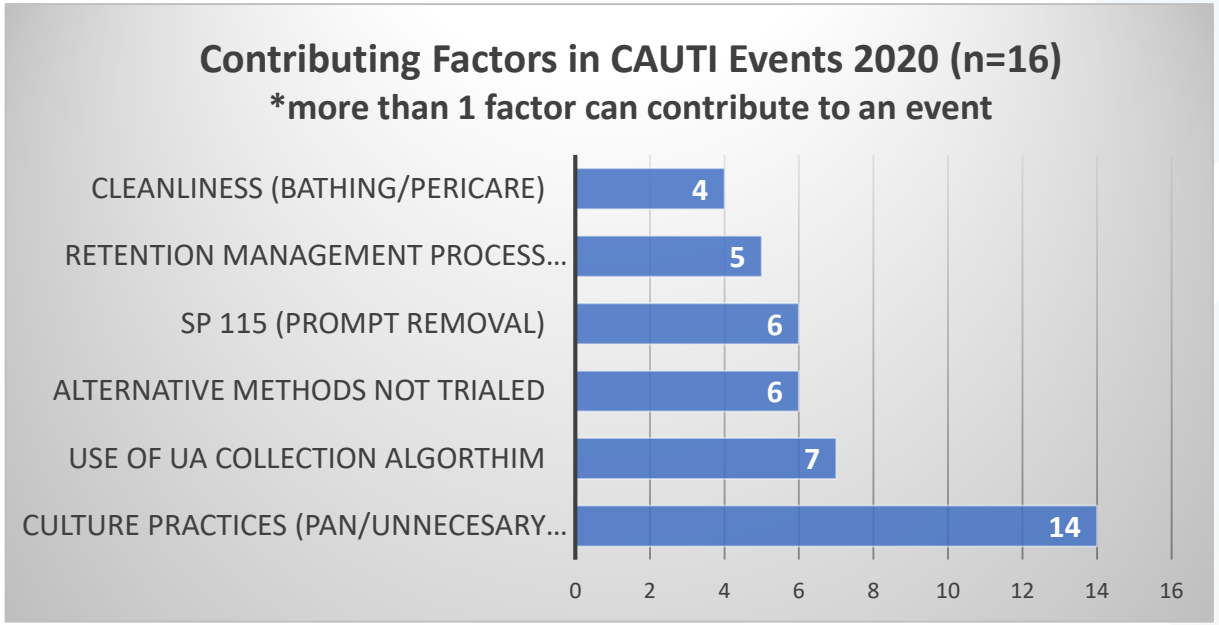
Kaizen improvement strategies focused on addressing the top 4 root causes

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

Since April 2020 we have incorporated strategies to address **7** of the root causes, including:
Culture ordering
Retention Management
Alternatives to Catheter Insertion

Kaweah Health

BACKGROUND



- Multidisciplinary team reviews CAUTI events and counts contributing factors to events based on CDC evidenced-based guidelines
- Top 3 contributing factors to CAUTI events culturing practices, use of UA algorithm and alternative methods not tried

2020 Key Strategies

- Daily line rounds to ensure best practices are consistent (bathing, peri-care), and line necessity.
- Specimen collection practices and necessity
- Culturing – addressing pan culturing practices
- Culturing – optimization of orders for line placement, maintenance of line and retention management

Kaweah Health

Post KAIZEN-Gemba Data

CAUTI Committee Dashboard

Measure Description	Benchmark/ Target	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
OUTCOME MEASURES																
Number of CAUTI	0	3	1	1	0	1	1	1	1	0	1	0	3	0	0	1
FYTD SIR	≤0.676					0.78**			1.04**			0.432	0.583	0.537		0.569
PROCESS MEASURES IUC Gemba																
% of pts with appropriate cleanliness	99%	98%	95%	97%	96%	98%		98%	99%	99%	98%	99%	99%	98%		98%
% of IUCs with order & valid rationale	100%	92%	93%	92%	92%	93%		94%	95%	93%	94%	93%	94%	92%		94%
% of IUCs where removal was attempted	n/a	6%	7%	0%	9%	9%		6%	2%	3%	7%	3%	3%	4%		6%
% of pts where alternatives have been attempted	n/a	12%	10%	8%	14%	12%		12%	6%	9%	10%	12%	11%	8%		15%
# of Pt Catheter days rounded on	n/a	948	877	1037	1098	1145		1047	1046	900*	931*	926*	951*	928*		1045
% of IUCs removed because of Gemba Round	n/a	3%	4%	2%	4%	6%		6%	4%	6%	6%	5%	5%	6%		6%
# of IUCs removed because of Gemba Round	n/a	33	35	22	46	74		64	40	50	52	50	43	51		43

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

Better than Target

Jan-Jul: Within 10% of Target
As of Aug: Within 5% of Target

Does not meet Target

FY21

Total Catheter days rounded on = 10,009

98% of patients with daily bath and peri-care each shift

93% have order and valid rationale

560 catheters removed as a result of the Gemba

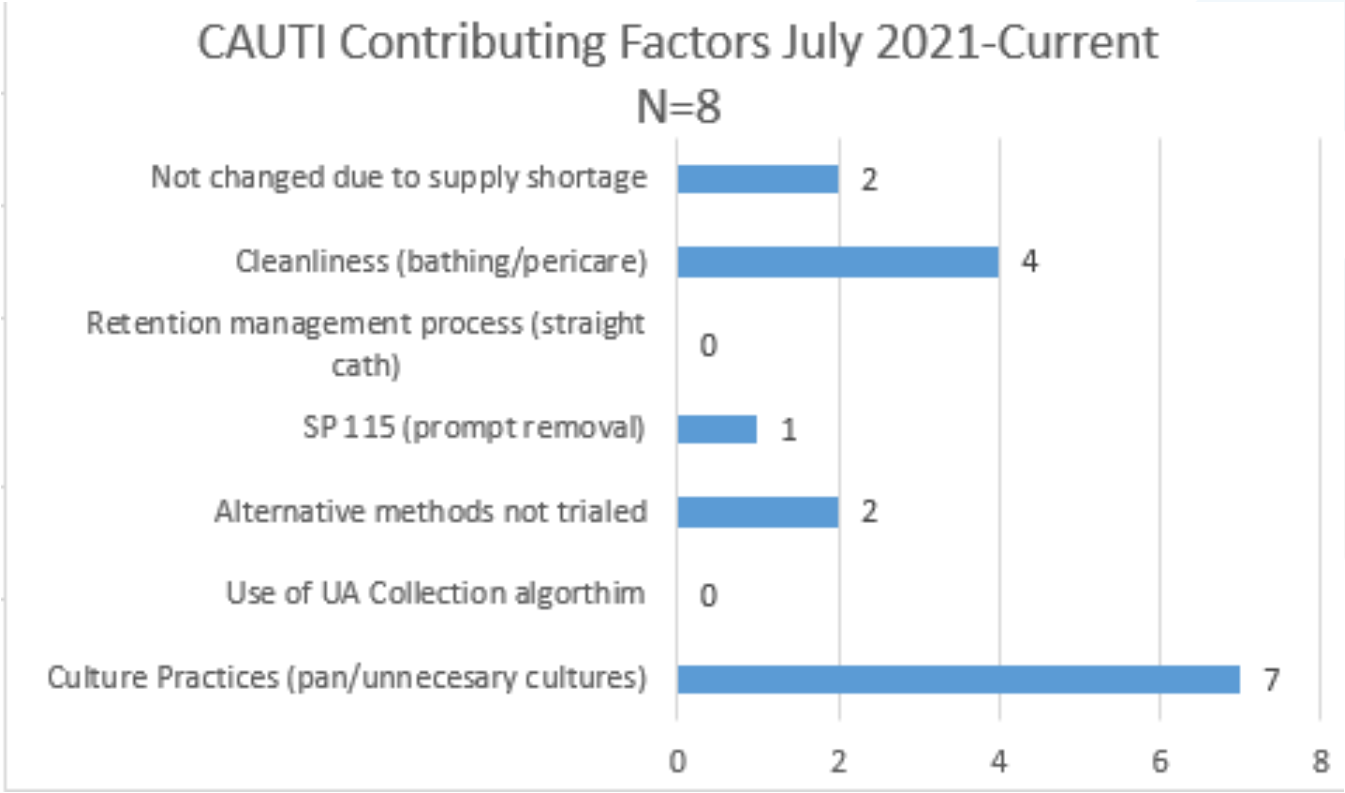
Kaweah Health

CAUTI QFT – Plans for Improvement

CAUTI QI Strategy	Status
1. Embed IUC insert power plan in existing Powerplans where the insert IUC order exists GOAL – Improve IUC order appropriateness and bundle compliance with increased use of Powerplan which contains needed IUC maintenance elements	Plan to complete by October 2021
2. Powerchart changes- IUC dynamic group for POA include on arrival to unit from OR/ED, other GOAL- capture device list for lines already in place	July 1, 2021
3. Evaluate reasons for IUC insertion orders GOAL – Reduce IUC utilization/appropriate indications for IUC. Monitor reasons for insertion.	Modified Kaizen 9/24/21
4. Rapid Cycle Post Gemba Rounds GOAL – reduce IUC utilization, verify completion of follow up	Long-term, ongoing strategy
5. Handoff Gemba evaluation GOAL: Continuity of care with IUC reduction on both shifts.	Initial pilot completed, evaluating second pilot unit
6. Bladder training order and education GOAL: IUC utilization reduction with evidence based management of urinary retention.	Modified Kaizen 9/24/21
7. Culture of Culturing committee for urine specimens GOAL: Variation in culturing practices are the most prevalent cause of CAUTI	Committee ongoing, progress made
8. Resident Notifications of near misses and events GOAL: Residents requested notification for awareness and learning.	August 2021
9. Letter for providers on events (like CLABSI) GOAL: Provider awareness of HAI.	August 2021
10. Primofit & Medline & Hollister External Male Catheter Product Trial GOAL: Reliable method for male external alternative to IUC.	November 2021
11. IUC inserted in OR/procedural areas- no insert order = no maintain order = no reason for insertion. Create Maintain subphase and insert in existing appropriate powerplans. GOAL: Functional efficiencies to require rationale of IUC.	October 2021
12. SonoSite Bladder Scanner conversion- purchase of 18 new devices	December 2021
13. Develop orders for Adult Urinary Retention management GOAL- orders for retention management currently exist as one off options, bundling them together for ease of ordering increases use	9/2020
14. Develop Urine Culture only powerplan to replace single orderable. GOAL- Reduce CAUTI events related to culture ordering by guiding intentional use of this risky order	2/23/21
15. Culture of Culturing committee for urine specimens GOAL: Variation ins culturing practices is the largest contributing factor to CAUTI	2/2021
16. Bathing Prioritization (in collaboration with CLABSI Committee) GOAL – Improve bathing/peri-care of IUC patients	10/2020
17. Add 'restricted use' to the urine culture only orderable GOAL- reduce use of culture only order in defined populations without accompanying UA	7/2020
18. Develop insert IUC Powerplan to include important maintenance elements: straight cath option prior to IUC insertion, change IUC prior to specimen collection, change IUC at 30 days GOAL- Create and bundle essential orders for IUC maintenance	8/2020
19. Develop provider update/education related to current CAUTI status and how to order IUC/Culturing awareness GOAL- create awareness	9/2020
20. Changes to discontinue IUC orderable- alerts RN to dc the insert IUC Powerplan and related maintain order GOAL- assist with order clean up	8/2020
21. Safety Summit (CAUTI education for new hires) relaunch post-COVID GOAL – Improve/sustain RN bundle compliance	3/22/21
22. Rapid Cycle Post Gemba Rounds GOAL – reduce IUC utilization, verify completion of follow up	On-going
23. CAUTI Case Reviews Lessons Learned GOAL – Reduce CAUTI by ensuring identified opportunities are addressed globally	Occurs monthly at QFT
24. Place all IUC order resources on eCoach GOAL- Increase IUC appropriateness/ prompt removal, bundle compliance (improving ease of access for providers and nursing staff)	Begin Jan 2021
25. Develop Urine Culture only powerplan to replace single orderable. GOAL- Reduce CAUTI events related to culture ordering by guiding intentional use of this risky order	12/29/20
26. Create change IUC task at 30 days following documented insertion GOAL- trigger nursing staff to change chronically retained IUC	12/23/20
27. Hide single Insert IUC orderable for downtown campus and Rehab GOAL: Improve bundle compliance by driving use of the insert IUC Powerplan which contains needed maintenance elements	10/2020
28. Kaizen strategy: evaluate option for time clock for line info GOAL- Improve prompt removal, visual reminder of how long the line has been in place	11/2020
29. Add 3-way catheter as trigger to device list GOAL- accurate collection of device count	4/22/21
30. Changes to the discontinue order- alert will prompt the provider to order retention management order. Single orderable done, powerplan additions in progress. GOAL- provides orders for nursing to manage post IUC DC retention	October 2021
31. Thoughtful pause= primary RN confers with charge nurse prior to specimen collection for algorithm use GOAL: Reduce unnecessary urine cultures	3/22/21
32. Mandatory CBL Resident education at beginning and end of first year. GOAL: Standardized on-boarding of CAUTI reduction practices	5/25/21
33. Medline urology assessment of current practices and care of IUCs GOAL: Evaluate CAUTI reduction program for improvement opportunities.	5/25/21

Green items are completed; yellow are in progress

Current State



- Multidisciplinary team reviews CAUTI events and counts contributing factors to events based on CDC evidenced-based guidelines
- All current initiatives continue, on 9/24/21 a modified Kaizen narrowed work on root causes for this FY

2021 Critical Contributors

- Sterile urinary catheter insertion tray national backorder certainly affected sterility of insertion despite intervention and education
- 7 of 8 events are COVID +

Kaweah Health

Live with passion.

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

Kaweah Health

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: CAUTI QFT **ProStaff/QIC Report Date:** 10/12/2021

Measure Objective/Goal:

- Goal for FY22 ≤ 0.676 (CMS 50th percentile); **Current SIR = 0.537**
- Pre KAIZEN baseline SIR is 1.557
- SIR is as of May 2021; Actual CAUTI FY22 is 8

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

Date range of data evaluated: FYTD SIR (7/2020 – 6/2021)

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

(If this is not a new measure please include data from your previous reports through your current report):

CAUTI Committee Dashboard

Measure Description	Benchmark/ Target	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
OUTCOME MEASURES																
Number of CAUTI	0	3	1	1	0	1	1	1	1	0	1	0	3	0	0	1
FYTD SIR	≤0.676					0.78**			1.04**			0.432	0.583	0.537		0.569
PROCESS MEASURES IUC Gemba																
% of pts with appropriate cleanliness	99%	98%	95%	97%	96%	98%		98%	99%	99%	98%	99%	99%	98%		98%
% of IUCs with order & valid rationale	100%	92%	93%	92%	92%	93%		94%	95%	93%	94%	93%	94%	92%		94%
% of IUCs where removal was attempted	n/a	6%	7%	0%	9%	9%		6%	2%	3%	7%	3%	3%	4%		6%
% of pts where alternatives have been attempted	n/a	12%	10%	8%	14%	12%		12%	6%	9%	10%	12%	11%	8%		15%
# of Pt Catheter days rounded on	n/a	948	877	1037	1098	1145		1047	1046	900*	931*	926*	951*	928*		1045
% of IUCs removed because of Gemba Round	n/a	3%	4%	2%	4%	6%		6%	4%	6%	6%	5%	5%	6%		6%
# of IUCs removed because of Gemba Round	n/a	33	35	22	46	74		64	40	50	52	50	43	51		43

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

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

FY 21 Total Catheter Days rounded on = 10,009	**98%** of patients with daily bath and peri-care per shift
93% with order and valid rationale	**560** catheters removed as a result of the Gemba

Opportunities:

- Appropriate indications for IUC, reduction in IUC use; using alternatives to IUC
- Reduced culturing
- Learning from Fallouts
- Sterile insertion trays- national shortage, back order

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

CAUTI QI Strategy	Status
1. Embed IUC insert power plan in existing Powerplans where the insert IUC order exists GOAL – Improve IUC order appropriateness and bundle compliance with increased use of Powerplan which contains needed IUC maintenance	Plan to complete by October 2021

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

CAUTI QI Strategy	Status
elements	
2. Powerchart changes- IUC dynamic group for POA include on arrival to unit from OR/ED, other GOAL- capture device list for lines already in place	July 1, 2021
3. Evaluate reasons for IUC insertion orders GOAL – Reduce IUC utilization/appropriate indications for IUC. Monitor reasons for insertion.	Modified Kaizen 9/24/21
4. Rapid Cycle Post Gemba Rounds GOAL – reduce IUC utilization, verify completion of follow up	Long-term, ongoing strategy
5. Handoff Gemba evaluation GOAL: Continuity of care with IUC reduction on both shifts.	Initial pilot completed, evaluating second pilot unit
6. Bladder training order and education GOAL: IUC utilization reduction with evidence based management of urinary retention.	Modified Kaizen 9/24/21
7. Culture of Culturing committee for urine specimens GOAL: Variation in culturing practices are the most prevalent cause of CAUTI	Committee ongoing, progress made
8. Resident Notifications of near misses and events GOAL: Residents requested notification for awareness and learning.	August 2021
9. Letter for providers on events (like CLABSI) GOAL: Provider awareness of HAI.	August 2021
10. Primofit & Medline & Hollister External Male Catheter Product Trial GOAL: Reliable method for male external alternative to IUC.	November 2021
11. IUC inserted in OR/procedural areas- no insert order = no maintain order = no reason for insertion. Create Maintain subphase and insert in existing appropriate powerplans. GOAL: Functional efficiencies to require rationale of IUC.	October 2021
12. SonoSite Bladder Scanner conversion- purchase of 18 new devices	December 2021
13. Develop orders for Adult Urinary Retention management GOAL- orders for retention management currently exist as one off options, bundling them together for ease of ordering increases use	9/2020
14. Develop Urine Culture only powerplan to replace single orderable. GOAL- Reduce CAUTI events related to culture ordering by guiding intentional use of this risky order	2/23/21
15. Culture of Culturing committee for urine specimens GOAL: Variation ins culturing practices is the largest contributing factor to CAUTI	2/2021
16. Bathing Prioritization (in collaboration with CLABSI Committee) GOAL – Improve bathing/peri-care of IUC patients	10/2020
17. Add 'restricted use' to the urine culture only orderable GOAL- reduce use of culture only order in defined populations without accompanying UA	7/2020
18. Develop insert IUC Powerplan to include important maintenance elements: straight cath option prior to IUC insertion, change IUC prior to specimen collection, change IUC at 30 days GOAL- Create and bundle essential orders for IUC maintenance	8/2020
19. Develop provider update/education related to current CAUTI status and how to order IUC/Culturing awareness GOAL- create awareness	9/2020
20. Changes to discontinue IUC orderable- alerts RN to dc the insert IUC Powerplan and related maintain order GOAL- assist with order clean up	8/2020

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

21. Safety Summit (CAUTI education for new hires) relaunch post-COVID GOAL – Improve/sustain RN bundle compliance	3/22/21
22. Rapid Cycle Post Gemba Rounds GOAL – reduce IUC utilization, verify completion of follow up	On-going
23. CAUTI Case Reviews Lessons Learned GOAL – Reduce CAUTI by ensuring identified opportunities are addressed globally	Occurs monthly at QFT
24. Place all IUC order resources on eCoach GOAL- Increase IUC appropriateness/ prompt removal, bundle compliance (improving ease of access for providers and nursing staff)	Begin Jan 2021
25. Develop Urine Culture only powerplan to replace single orderable. GOAL- Reduce CAUTI events related to culture ordering by guiding intentional use of this risky order	12/29/20
26. Create change IUC task at 30 days following documented insertion GOAL- trigger nursing staff to change chronically retained IUC	12/23/20
27. Hide single Insert IUC orderable for downtown campus and Rehab GOAL: Improve bundle compliance by driving use of the insert IUC Powerplan which contains needed maintenance elements	10/2020
28. Kaizen strategy: evaluate option for time clock for line info GOAL- Improve prompt removal, visual reminder of how long the line has been in place	11/2020
29. Add 3-way catheter as trigger to device list GOAL- accurate collection of device count	4/22/21
30. Changes to the discontinue order- alert will prompt the provider to order retention management order. Single orderable done, powerplan additions in progress. GOAL- provides orders for nursing to manage post IUC DC retention	October 2021
31. Thoughtful pause= primary RN confers with charge nurse prior to specimen collection for algorithm use GOAL: Reduce unnecessary urine cultures	3/22/21
32. Mandatory CBL Resident education at beginning and end of first year. GOAL: Standardized on-boarding of CAUTI reduction practices	5/25/21
33. Medline urology assessment of current practices and care of IUCs GOAL: Evaluate CAUTI reduction program for improvement opportunities.	5/25/21

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

Next Steps/Recommendations/Outcomes:

A. Continue to maintain Kaizen initiatives: Daily IUC Gemba rounds, data collection, and dissemination and QI strategy development.
B. Continue to monitor CAUTI events, reviewed with unit leadership at the HAI review meeting, unit leadership created quality improvement plan and implement at the unit level. The QFT monitors QI opportunities for global implementation
C. Address culturing practices in Culture of Culturing committee with medical staff partnership
D. Added deep dive case review on near miss events with unit level planning and QFT review for global implementation of learning opportunities.
E. Modified Kaizen completed on 9/24/21 for data review and root cause analysis; initiatives pending.

Submitted by Name: Kari Knudsen **Date Submitted:** 10/11/2021

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

CULTURAL DIVERSITY COMMITTEE

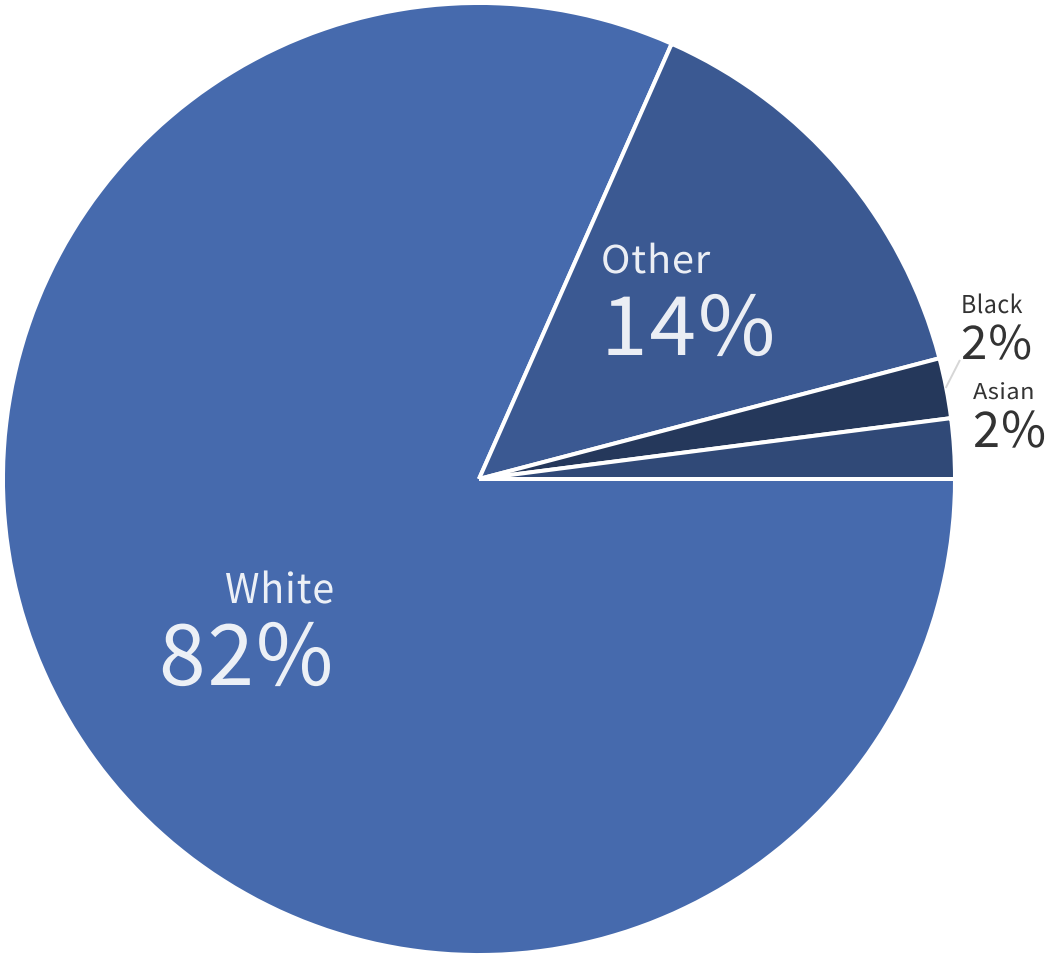
October 21, 2021

Inbal Epstein, MD, PGY2
Kaweah Health Emergency Medicine Residency

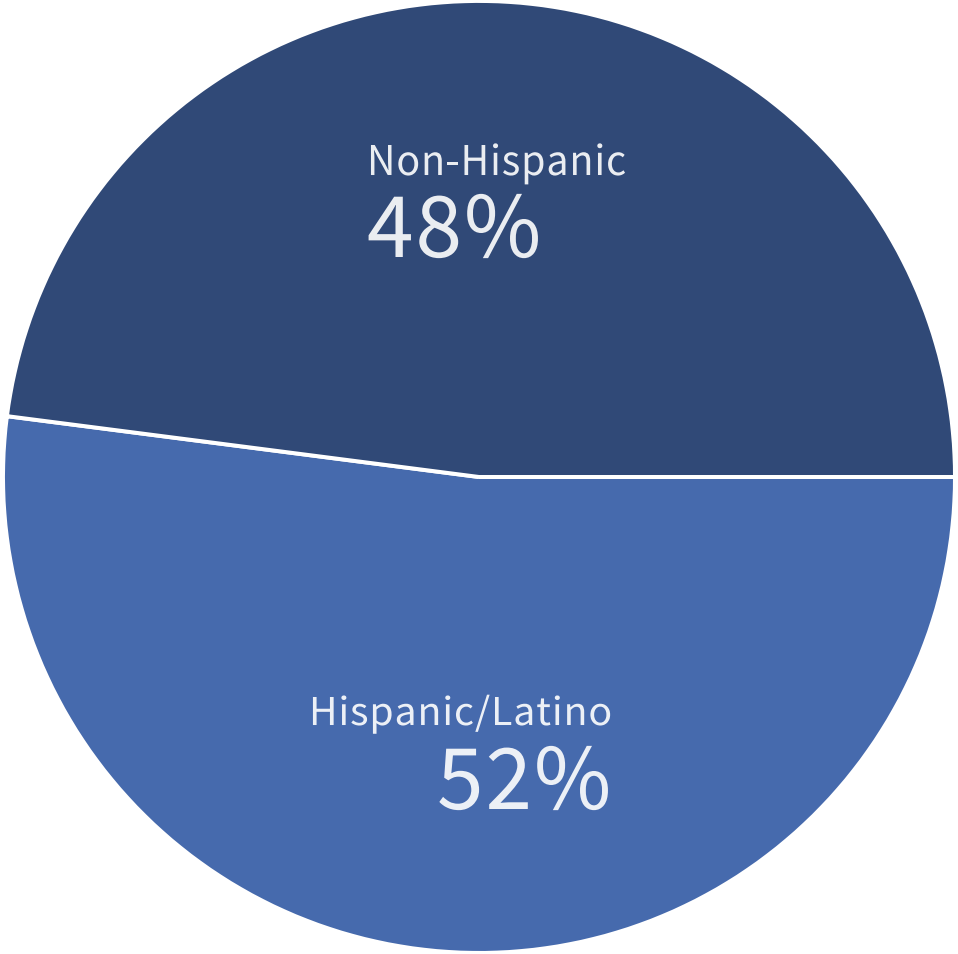
COMMON REASONS FOR ADMISSION

PREGNANCY AND CHILDBIRTH	TRAUMA	RESPIRATORY	INFECTION
KIDNEY DISEASE	DIABETES	CARDIAC	NEUROLOGIC
GASTROINTESTINAL		SUBSTANCE USE	
MENTAL HEALTH	ELECTIVE SURGERY	CANCER	

RACE

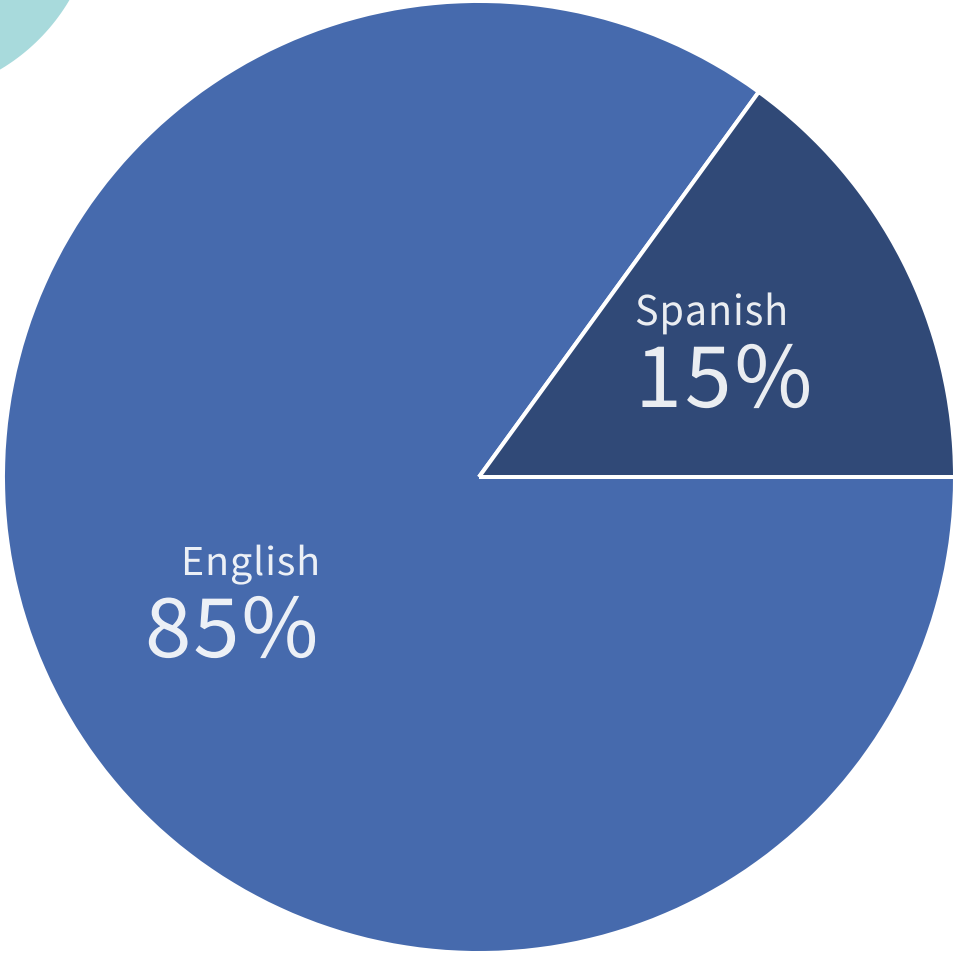


ETHNICITY



LANGUAGE

<1%
Lao
Portuguese
Arabic



INPATIENT MORTALITY, %

	Kaweah 2018-2021	US (2010)*
All-Cause	2.72%	2.00%
Sepsis	11.79%	16.30%
Kidney Disease	5.27%	3.50%
Stroke	3.50%	4.70%
Pneumonia (Non-COVID)	3.29%	3.30%
Heart Disease	3.28%	3.10%
COVID	17.97%	10-20%**

“OTHER” RACE - MORTALITY

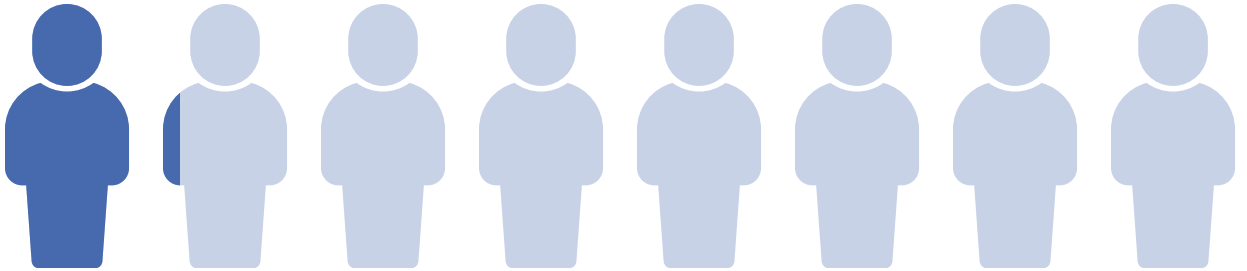
	n	Overall	Sepsis	Cardiac	COPD	COVID	Kidney Disease	Stroke
White	66,129	2.58%	10.82%	2.68%	8.50%	18.33%	5.07%	3.42%
Other	11,655	3.64%	18.27%	7.43%	27.20%	17.50%	11.03%	5.44%

MORTALITY- LANGUAGE

ENGLISH	PANJABI	LAO
2.68%	6.25%	7.89%

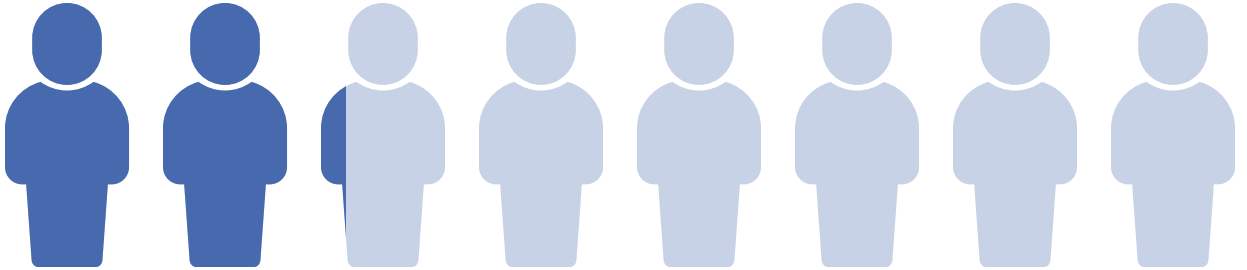
COVID ADMISSIONS AMONG SPANISH-SPEAKING PATIENTS

13.8%



All Admissions

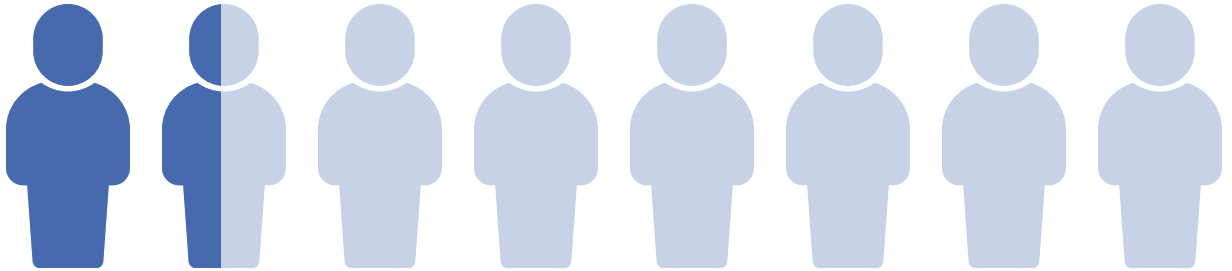
26.9%



COVID Admissions

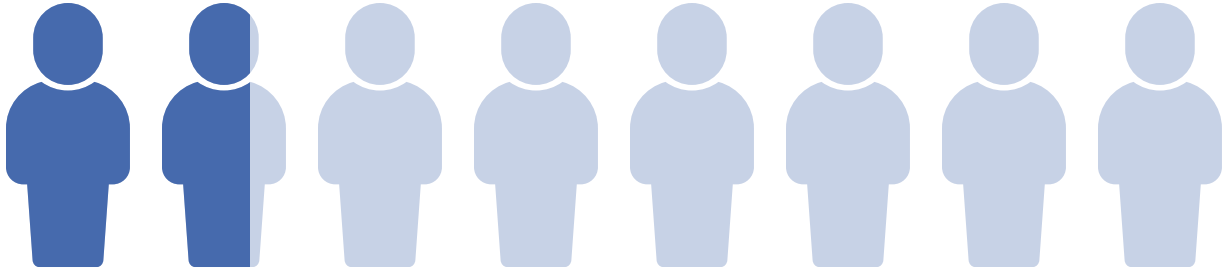
COVID MORTALITY

17.2%



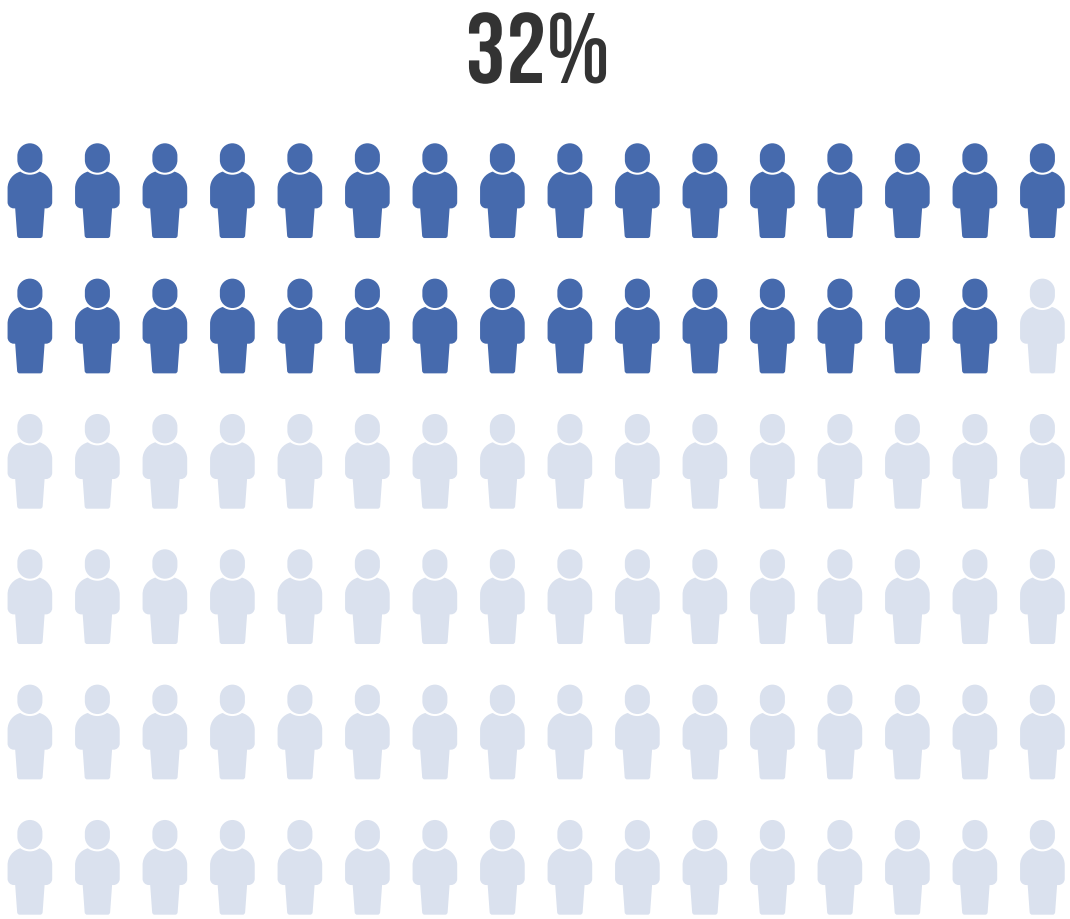
English

19.5%

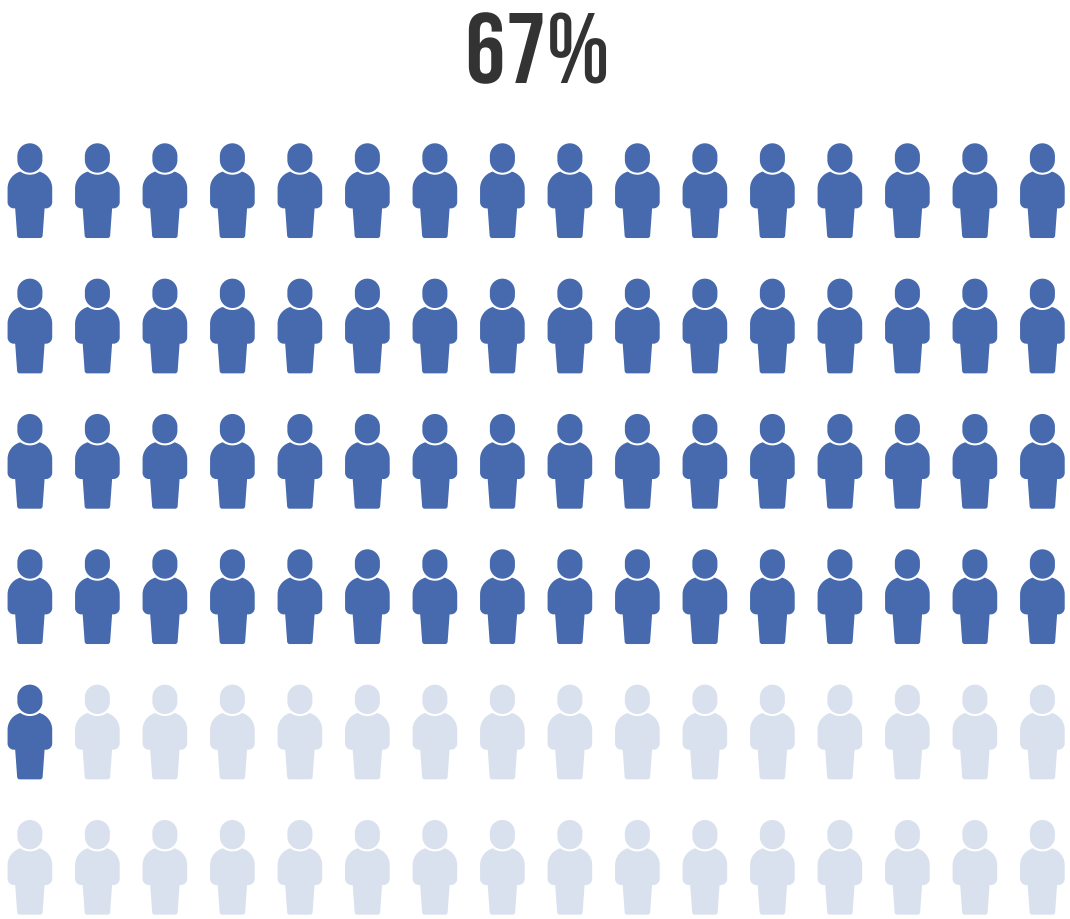


Spanish

CHRONIC OBSTRUCTIVE PULMONARY DISEASE - ADMISSION



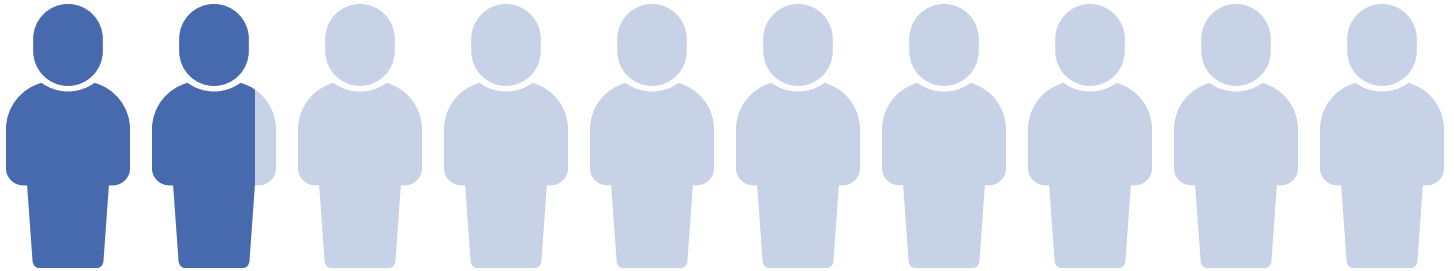
Hispanic



Non-Hispanic

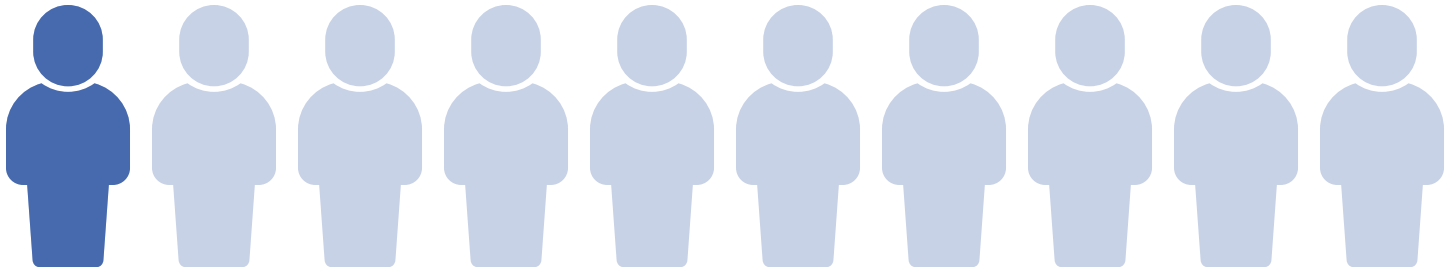
CHRONIC OBSTRUCTIVE PULMONARY DISEASE MORTALITY RATE

17%



Hispanic/Latino

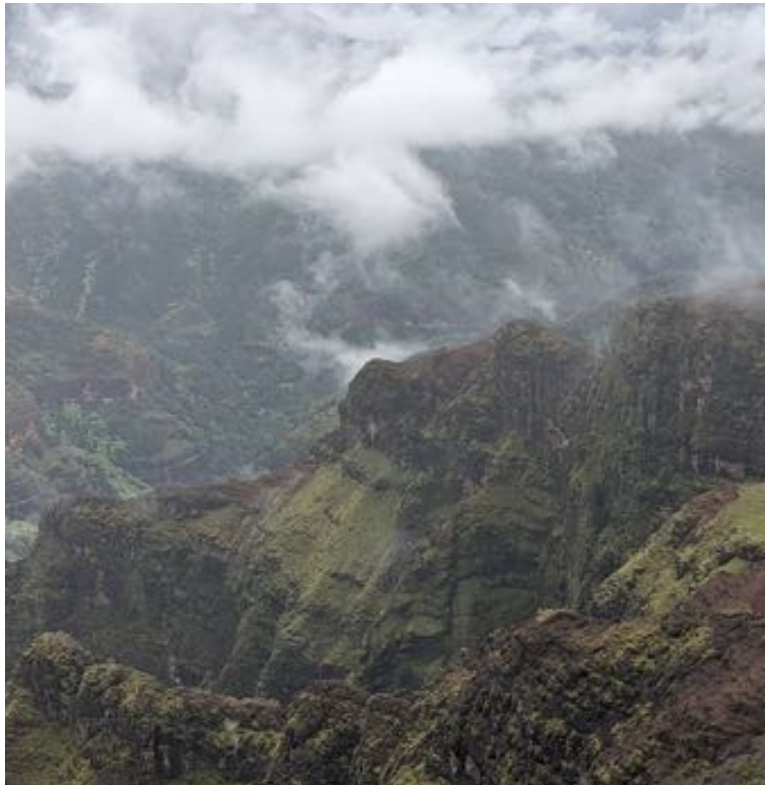
10%



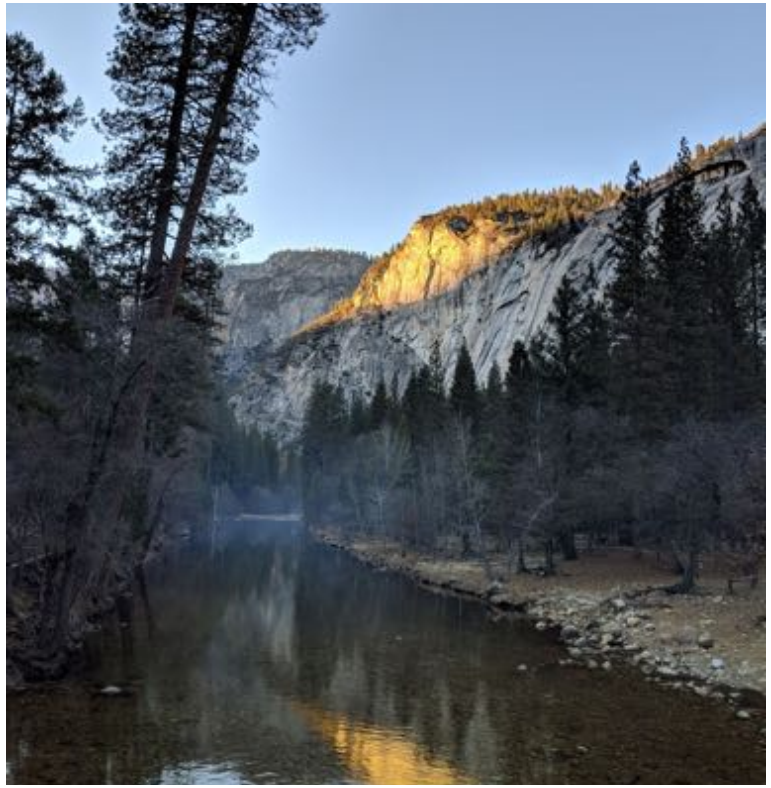
Non-Hispanic

SUMMARY

Kaweah serves a diverse range of patients



Demographic information highlights disparities among patient groups



This information can be used to improve patient outcomes

REFERENCES

https://www.cdc.gov/nchs/products/databriefs/db118.htm

https://www.census.gov/quickfacts/tularecountycalifornia

https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2778237

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7920817/

Clinical Quality Goal Update

October 2021

FY22 Clinical Quality Goals

	July-Aug 2021 Higher is Better	FY22 Goal	FY21	FY21 Goal
SEP-1 (% Bundle Compliance)	65%	≥ 75%	74%	≥ 70%

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.

Lower is Better	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual/ number expected)	FY22 Goal	FY21 FY20
CAUTI Catheter Associated Urinary Tract Infection	1	3	5										20	1.649	≤0.676	0.54 1.12
CLABSI Central Line Associated Blood Stream Infection	0	4	3										16	1.573	≤0.596	0.75 1.20
MRSA Methicillin-Resistant Staphylococcus Aureus	2	0	1										6	1.767	≤0.727	2.78 1.02

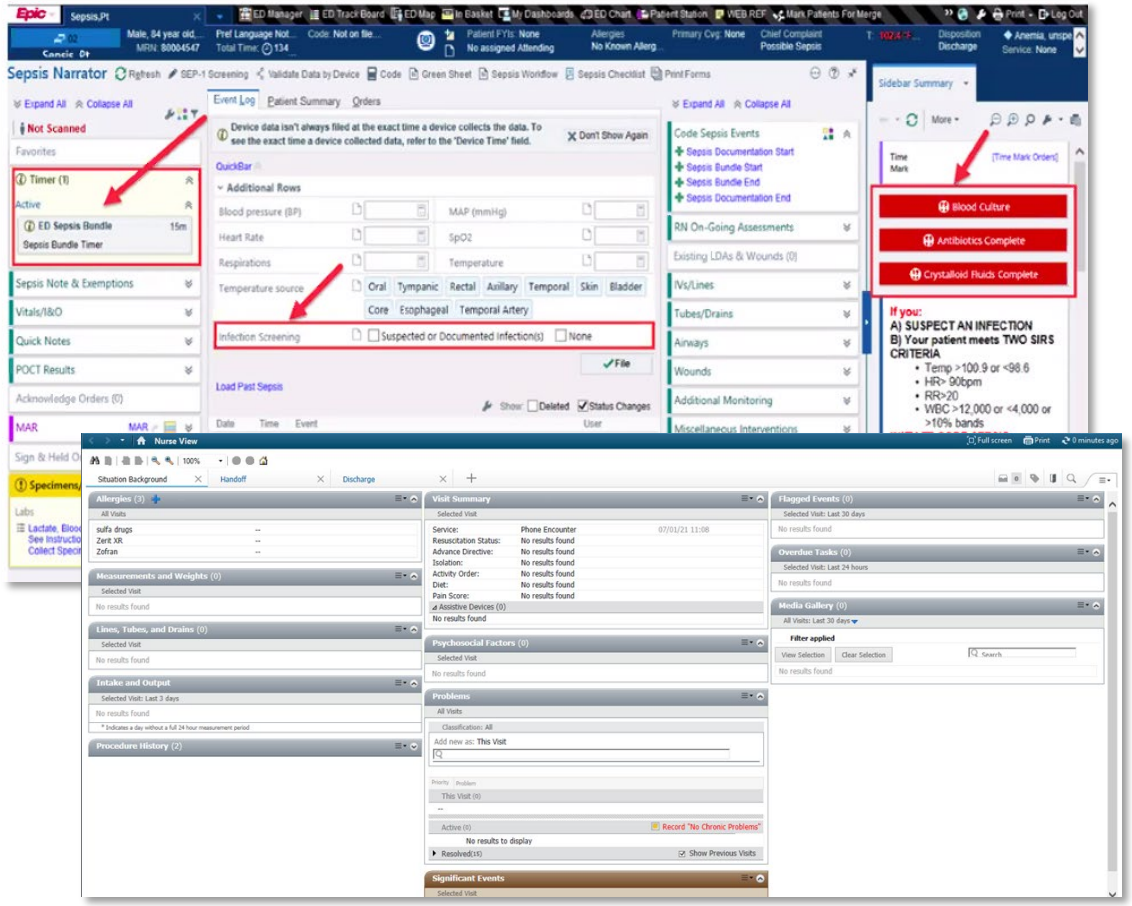
*based on FY21 NHSN predicted

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

Key Strategies

Sepsis

- Sepsis required physician notification of sepsis alert - results in timely best practice intervention, “the bundle” COMPLETE, GO LIVE 6/29/21!
- Exploring “Resident Sepsis Resource” for Coordinator off hours with Dr. Winston
- NEXT - sepsis handoff checklist, which is used to identify any remaining CMS SEP-1 elements needed for the treatment of patients suffering from severe sepsis.
  - Checklist used as a handoff from nurse to nurse, and identifies the remaining elements needed to fulfill SEP-1 requirements.
  - Ideal for instances when a patient transitions from the ED to their respective inpatient bed, or upon transitioning from a previous inpatient location to a new inpatient location (e.g., patients transitioning to a higher level of care).



This Just In…

Changes in the 2020 national healthcare-associated infection (HAI) standardized infection ratios (SIRs) for acute-care hospitals, compared to respective 2019 quarters

	2020 Q1	2020 Q2	2020 Q3	2020 Q4
CLABSI	↓ −11.8%	↑ 27.9%	↑ 46.4%	↑ 47.0%
CAUTI	↓ −21.3%	No Change[1]	↑ 12.7%	↑ 18.8%
VAE	↑ 11.3%	↑ 33.7%	↑ 29.0%	↑ 44.8%
SSI: Colon surgery	↓ −9.1%	No Change[1]	↓ −6.9%	↓ −8.3%
SSI: Abdominal hysterectomy	↓ −16.0%	No Change[1]	No Change[1]	↓ −13.1%
Laboratory-identified MRSA bacteremia	↓ −7.2%	↑ 12.2%	↑ 22.5%	↑ 33.8%
Laboratory-identified CDI	↓ −17.5%	↓ −10.3%	↓ −8.8%	↓ −5.5%

Fig. 1. Changes in the 2020 national healthcare-associated infection (HAI) standardized infection ratios (SIRs) for acute-care hospitals, compared to respective 2019 quarters. Note. CLABSI, central-line–associated bloodstream infection; CAUTI, catheter-associated urinary tract infection; VAE, ventilator-associated event; SSI, surgical site infection; MRSA, methicillin-resistant *Staphylococcus aureus*; CDI, *Clostridioides difficile* infection. Interpretation: Unless otherwise noted, the results of the significance tests comparing consecutive annual pairs of quarterly SIRs are based on a 2-tailed test $P \leq .05$; however, the directional percentage change is based on the relative change in magnitude. An arrow pointing down, and a negative percentage change value, indicate that the 2020 SIR is lower than the 2019 SIR for the same quarter. An arrow pointing up, and a positive percentage change value, indicate that the 2020 SIR is higher than the 2019 SIR for the same quarter. Note. 1. "No change" signifies that the change in SIR was not statistically significant.

Infection Control & Hospital Epidemiology (2021), 1–14
doi:10.1017/ice.2021.362

SHEA The Society for Healthcare Epidemiology of America

Original Article

The impact of coronavirus disease 2019 (COVID-19) on healthcare-associated infections in 2020: A summary of data reported to the National Healthcare Safety Network

Lindsey M. Weiner-Lastinger MPH[1], Vaishnavi Pattabiraman MSc, MS, MPH[1,2], Rebecca Y. Konnor MPH[1,3], Prachi R. Patel MPH[1,3], Emily Wong MPH[1,2], Sunny Y. Xu MPH[1,3], Brittany Smith MPH[1,4], Jonathan R. Edwards MStat[1] and Margaret A. Dudeck MPH[1]

[1]Division of Healthcare Quality Promotion, Centers for Disease Control and Prevention, Atlanta, Georgia, [2]Leidos, Atlanta, Georgia, [3]CACI, Atlanta, Georgia and [4]Oak Ridge Institute of Science and Education, Oak Ridge, Tennessee

Abstract

Objectives: To determine the impact of the coronavirus disease 2019 (COVID-19) pandemic on healthcare-associated infection (HAI) incidence in US hospitals, national- and state-level standardized infection ratios (SIRs) were calculated for each quarter in 2020 and compared to those from 2019.

Methods: Central–line–associated bloodstream infections (CLABSIs), catheter-associated urinary tract infections (CAUTIs), ventilator-associated events (VAEs), select surgical site infections, and *Clostridioides difficile* and methicillin-resistant *Staphylococcus aureus* (MRSA) bacteremia laboratory-identified events reported to the National Healthcare Safety Network for 2019 and 2020 by acute-care hospitals were analyzed. SIRs were calculated for each HAI and quarter by dividing the number of reported infections by the number of predicted infections, calculated using 2015 national baseline data. Percentage changes between 2019 and 2020 SIRs were calculated. Supporting analyses, such as an assessment of device utilization in 2020 compared to 2019, were also performed.

Results: Significant increases in the national SIRs for CLABSI, CAUTI, VAE, and MRSA bacteremia were observed in 2020. Changes in the SIR varied by quarter and state. The largest increase was observed for CLABSI, and significant increases in VAE incidence and ventilator utilization were seen across all 4 quarters of 2020.

Conclusions: This report provides a national view of the increases in HAI incidence in 2020. These data highlight the need to return to conventional infection prevention and control practices and build resiliency in these programs to withstand future pandemics.

(Received 12 July 2021; accepted 15 July 2021)

Key Strategies

CAUTI & CLABSI

- Kaizen Reboot for CAUTI prevention;
  - additional root causes identified and QI strategies developed focused on RN implementation of protocols and cleanliness
- 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
- Peripheral IV QI - Including peripheral IVs to critical care gemba, and evaluating “just in case lines” and care practices
- Increasing midline insertion in ED through EM Resident and PICC team partnership

Key Strategies

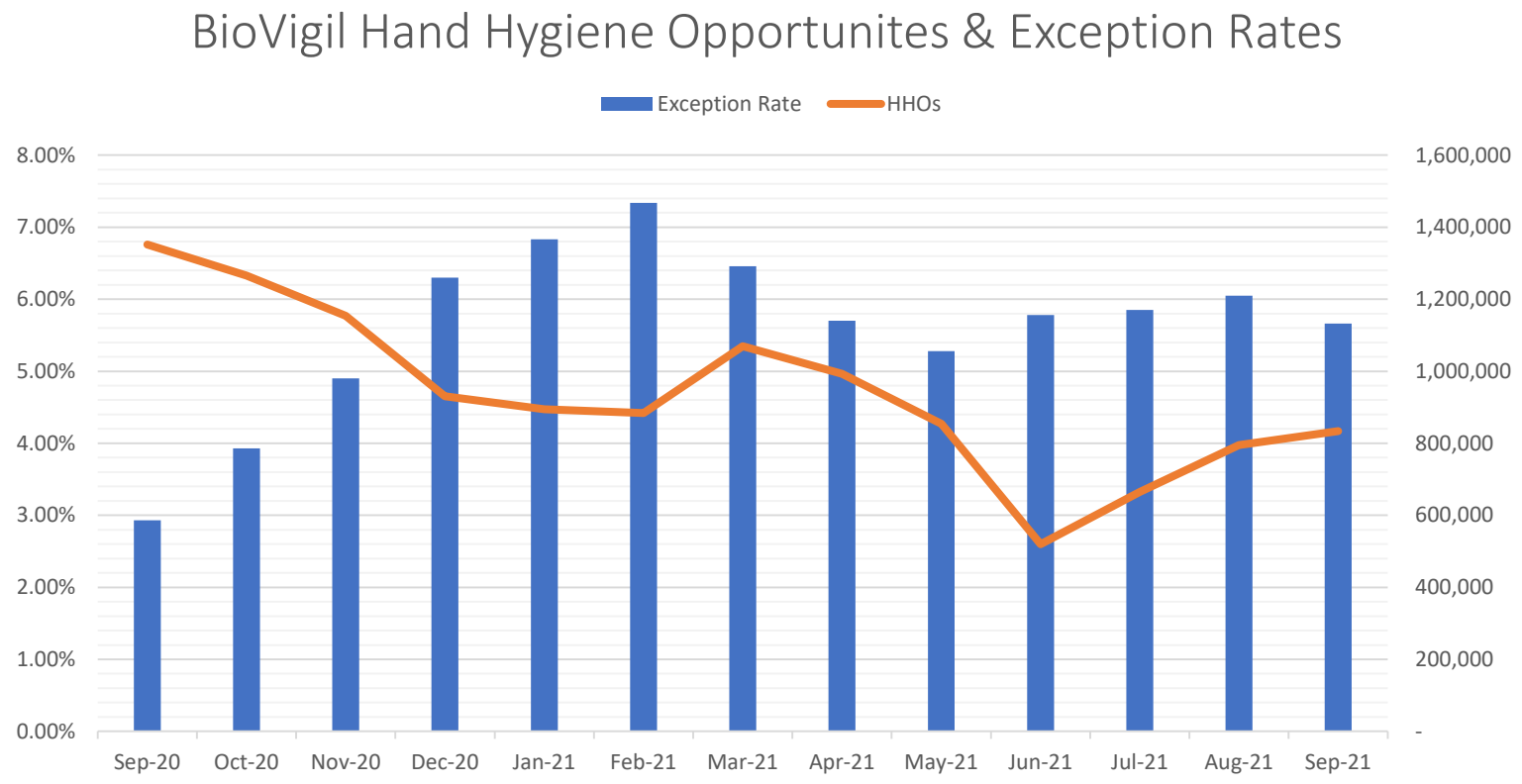
Planned Interventions to reduce MRSA Bloodstream infection

1. Hand Hygiene – BioVigil and Non-BioVigil areas, 95% compliance & use of BioVigil system

Goal: return to September 2020

High volume of HHO

Low exception rates



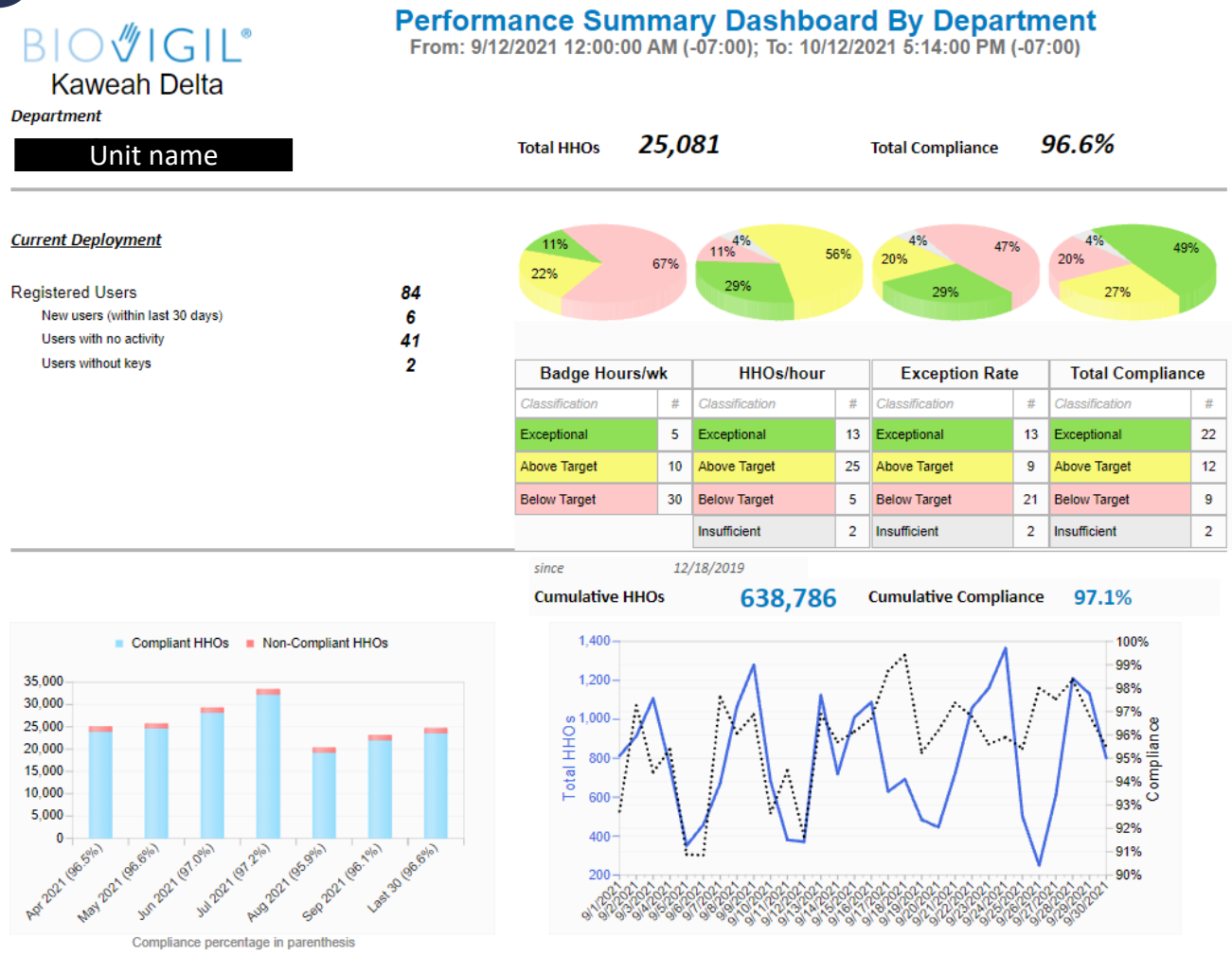
Key Strategies

Planned Interventions to reduce MRSA Bloodstream infection

1. Hand Hygiene – BioVigil Report to Leadership

   Dashboard View Provides:

   a) Over all compliance for date range (goal >95%)
   b) Total Hand Hygiene Opportunities (HHOs)
   c) Number of registered users (includes LOAs)
   d) Number of users with no activity (includes LOAs)



Key Strategies

Planned Interventions to reduce MRSA Bloodstream infection

2. Decolonization Processes

- ICU and 4N Trial with standardize procedure, goal Nov 1st go live
- Dashboards (over all and unit level) for steps of decolonization process outside trial units

3. Environment & Equipment Cleaning

- By end of September use ATP monitoring to evaluate cleanliness/compliance with policy on patient care equipment cleaning (primarily nursing processes)
- Ongoing efforts to address cleanliness (primarily EVS processes), prioritize units

Key Strategies

Planned Interventions to reduce MRSA Bloodstream infection
4N and ICU Decolonization Trial – Tentative Start: Nov 1, 2021

CURRENT STATE
PC157
MRSA Nasal Swabbing
Process (MRSA Screening)

MRSA Form Screen Identifies high risk patients on admit → MRSA Nasal Screen lab test → Provider notification of positive results → MRSA Treatment determined by provider (ie. Mupirocin nasal ointment),CHG

NEW INTERVENTIONS

Team to evaluate the high risk patients to target

Develop protocol for Decoloniza-tion of all high risk +ve MRSA

FUTURE STATE
PC157
MRSA Nasal Swabbing
Process (MRSA Screening)

MRSA Form Screen Identifies ALL high risk patients on admit → MRSA Nasal Screen lab test → Patients decolonized per Standardized Procedure

Action Plan Status Sept 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) **IN PROCESS**

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

FY22 Clinical Quality Goals

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

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

Performance Measure	Baseline	FY22 Goal	Jan 2021- June 2021	Status
Hospital Readmissions (%) Medicare Population	(FY2019) AMI – 12.34 COPD – 16.09 HF – 18.22 PN Viral/Bacterial – 14.13	AMI – 11.10 COPD – 12.87 HF – 14.58 PN Viral/Bacterial – 11.03	AMI – 12.5 COPD – 10.0 HF – 21.28 PN Viral/Bacterial – 13.51	• Medical Director position filled • COPD Team monitoring new process and follow up on identified opportunities
Decrease Mortality Observed/Expected Rates Medicare Population	(2019) AMI - 0.75 COPD – 2.40 HF – 1.78 PN Bacterial – 1.85 PN Viral – 1.34	AMI - 0.71 COPD – 1.92 HF – 1.42 PN Bacterial – 1.48 PN Viral 1.07	AMI – 0.84 COPD – 0.93 HF – 0.911 PN Bacterial – 1.04 PN Viral -0.64	• Medical Director position filled • Guideline review and measures/dashboard development with key performance indicators
Home Medication List Review of High Risk Patients (inpatient admission)	57% (Avg Oct 2020 and Feb 2021)	100%	71% Jan-June 2021 91% July 1-July 31, 2021	• Jan-June 2021 • *2-3 Pharmacy Techs (M-F, 8 hour shifts)* • July 2021 • *4.5 Pharmacy Techs (weekend coverage added, 10 hour shifts*)
Complete Initial Home Medication w/in 12 hours of Inpatient Admission	N/A	100%	n/a	• Exploring reporting capabilities with ISS
Outpatient Medication Reconciliation w/in 30 days Post Discharge (MRP)	N/A	44%	21% Jan-June 2021 41% July 1-August 31, 2021	• Improvement noted due to optimization in CERNER Millennium for all ambulatory care providers
Team Round Implementation	MICU currently does this	Design & Pilot on 1-2 units	n/a	• In Progress-identifying nursing leaders to develop design

Best Practice Teams

AMI (non-STEMI), COPD, Heart Failure & Pneumonia

- Kick off meeting held 9/24/21
- Clinical Practice Guidelines selected for each population
- Key performance indicators (KPIs) developed, goal to complete finalized data definitions by Oct 31, 2021

Initiation

- Prioritized & staggered
- Team identification: Q&P/S Facilitator, MD Champion, RN Director, process stakeholders
- Best Practice Guideline selection

Goal: Identify clinical processes that will yield optimal patient outcomes

Phase I

- Clinical KPIs Selection
- Measures defined
- Dashboard developed
- Initial QI work (ie. power plan optimization/ work flow) to achieve targets

Goal: Identify KPIs that will reduce mortality o/e & complications (2° LOS & Readmission)

Phase II

- Care Pathway developed
- Integrated into Cerner power plans & workflow
- QI Measures added to dashboard
- QI work to achieve targets

Goal: Improve efficiency and further reductions in LOS, mortality o/e & readmission

Questions?

Live with passion.

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

Kaweah Health