November 7, 2024

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in a Quality Council Committee meeting at 7:30AM on Thursday, November 14, 2024, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

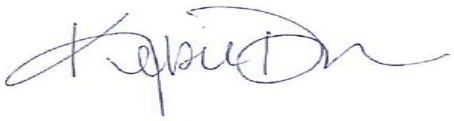
The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:31AM on November 14, 2024, 2024, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277, pursuant to Health and Safety Code 32155 & 1461.

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, November 14, 2024, 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
David Francis, Secretary/Treasurer



Kelsie Davis
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, November 14, 2024
5105 W. Cypress Avenue
Kaweah Health Lifestyle Fitness Center Conference Room

ATTENDING: Board Members: Michael Olmos (Chair), Dean Levitan, MD; Gary Herbst, CEO; Keri Noeske, Chief Nursing Officer; Paul Stefanacci CMO/CQO; Julianne Randolph, OD, Vice Chief of Staff and Quality Committee Chair; LaMar Mack, MD, Quality and Patient Safety Medical Director; Sandy Volchko, Director of Quality and Patient Safety; Ben Cripps, Chief Compliance and Risk Management Officer; Evelyn McEntire, Director of Risk Management; and Kyndra Licon, Recording.

OPEN MEETING – 7:30AM

1. **Call to order** – *Mike Olmos, Committee Chair*
2. **Public / Medical Staff participation –** Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the 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 (Kelsie Davis 559-624-2330) or kedavis@kaweahhealth.org to make arrangements to address the Board.
3. **Approval of Quality Council Closed Meeting Agenda** – 7:31AM
    - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Julianne Randolph, DO, Vice Chief of Staff and Quality Committee Chair; Erika Pineda, RN, BSN, CPHQ, Quality Improvement Manger*
    - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management; Ben Cripps, Chief of Compliance and Risk Officer; Cindy Vander Schuur, RN, BSN, Patient Safety Manager.*
4. **Adjourn Open Meeting** – *Mike Olmos, Committee Chair*

CLOSED MEETING – 7:31AM

1. **Call to order** – *Mike Olmos, Committee Chair*

2. **Approval of October Quality Council Closed Session Minutes –** Mike Olmos, Committee Chair; Dean Levitan, Board Member
3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Julianne Randolph, DO, Vice Chief of Staff and Quality Committee Chair; Erika Pineda, RN, BSN, CPHQ, Quality Improvement Manager*
4. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management; Ben Cripps, Chief of Compliance and Risk Officer; Cindy Vander Schuur, RN, BSN, Patient Safety Manager.*
5. **Adjourn Closed Meeting** – *Mike Olmos, Committee Chair*

OPEN MEETING – 8:00AM

1. **Call to order** – *Mike Olmos, Committee Chair*
2. **Public / Medical Staff participation –** Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves at this time. Members of the public or the medical staff may comment on agenda items after the item has been discussed by the Committee but before a Committee recommendation is decided. In either case, each speaker will be allowed five minutes.
3. **Approval of October Quality Council Open Session Minutes –** Mike Olmos, Committee Chair; Dean Levitan, Board Member
4. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives:

    4.1. **Cardiology Services- ACC Outstanding Health Outcomes Report**

5. **Emergency Department Quality Update –** A review of key quality metrics and associated actions plans. *Keri Noeske, Chief Nursing Officer.*
6. **Clinical Quality Goals Update-** A review of current performance and actions focused on the clinical quality goals for Sepsis, and Healthcare Acquired Infections. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*
7. **Adjourn Open Meeting** – *Mike Olmos, 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.

Agenda item intentionally omitted

OPEN Quality Council Committee
Thursday, October 17, 2024
The Lifestyle Center Conference Room

Attending: Board Members: Mike Olmos (Chair) & Dean Levitan, Board Member; Dr. Paul Stefanacci, CMO/CQO; Sandy Volchko, Director of Quality & Patient Safety; Mark Mertz; Dr. Mack; Jag Batth, Chief Operation Officer; Keri Noeske, Chief Nursing Officer; Ryan Gates, Chief Population Health Officer; Shawn Elkin, Infection Prevention Manager; Erika Pineda, Sepsis Manager; Tiffany Bullock, Director of Home Health, Hospice, Home Care Services & The Ruth Wood Open Arms House; Frank Martin, Director of Trauma Program; Cindy Vander Schuur, Patient Safety Manager; Kyndra Licon, Program Coordinator – Recording.

Mike Olmos called to order at 7:30 am.

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

Mike Olmos adjourned the meeting at 8:35 am.

Mike Olmos called to order at 8:35 am.

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

    4.1 Health Equity Quality Report – reviewed with no discussion.

    4.2 Hospice Home Health Quality Report

    Medication education - declined from 60%, but we are addressing this. On the discharge form, staff are reminded to review the list of medications with patients, including potential side effects and risks. Medication education remains a challenge, with fluctuations in staffing. New staff members are being trained to use appropriate language when communicating with families, particularly regarding side effects. We expect improvement with ongoing reminders and support for newer nurses, as this has historically been an area of variability. Additionally, both nursing and physical therapy (PT) teams are involved in patient education. However, there has been some disconnect where nursing concludes their part of the case, and PT continues. We've reinforced communication with PT to ensure they provide medication education, and PT feels confident doing so within their scope of practice. We are hopeful that these efforts will lead to an upward trend in performance.

5. **Trauma Committee Quality Report –** A review of key processes and outcome measures related to trauma processes. Frank Martin, Director of Trauma Program.
    - **Trauma Quality Improvement Program (TQIP) Report**: The spring 2024 benchmark report covers data from October 2022 to September 2023, with 205 Level III trauma centers in the U.S. contributing. A total of 97,728 patients are included in the report, with 1,425 being

Kaweah Health trauma patients. The fall 2024 benchmark report will be available next time. As of May 2024, we successfully completed our reverification survey. We are experiencing a 10% year-to-date growth in 2024, with 2,292 trauma cases between January and August.

- **TQIP Mortality Report**: Areas for improvement were identified; Frank will be reviewing all 78 charts. One opportunity noted was the lack of consistent documentation from physicians (radiology and surgeons) and the absence of autopsy results. We are not considered a high outlier, but we will continue monitoring and reviewing these cases. Questions were raised about what defines a Level III trauma center. We provide trauma services including neurosurgery, orthopedic surgery, trauma surgery, and emergency room (ER) physicians. Unlike Level II centers, we do not have ophthalmology or gastrointestinal (GI) services available on-site. With the addition of two traumatologists, we expect to retain more cases at our facility, benefiting both the facility and community.
- **Door-to-Transfer Time**: There has been improvement in door-to-transfer times. We were 22 minutes' shy of meeting our risk-adjusted time but have since reduced the time to 7 minutes. Efforts are ongoing to expedite transfers to a higher level of care.
- **SBIRT Screening**: The SBIRT (Screening, Brief Intervention, and Referral to Treatment) process for alcohol-related behaviors is in place, but follow-up processes were previously lacking. Social workers are now conducting screenings using the CAGE tool (Cut, Annoyed, Guilty, Eye-opener). Monthly audits will be performed, with quarterly reports identifying opportunities for improvement.
- **Body Mass Index (BMI) Compliance**: We achieved 81% compliance for BMI documentation, with mandatory fields for height and weight. ED beds provide weight for our trauma patients and we have a 24hr window to retrieve those. Height can be obtained anytime during hospital stay.
- **Community Outreach**: Our focus is on pedestrian safety, fall prevention activities and speaking to kids at the Visalia Rescues Mission about pedestrian and water safety.
- **Reverification Status**: We successfully obtained a one-year reverification, with three areas identified as non-compliant: Trauma Registry Staffing, Trauma Multidisciplinary PIPS committee Attendance, and Trauma Mortality Review. Staffing will be compliant by November. We have six months to address these standards, to obtain an additional two-year re-verification by March. Trauma billing and coding practices were also discussed, and we are working to ensure the appropriate capture of trauma activation fees and services. Recommendation for Frank to connect with Malinda Tupper.
- All mortality cases are thoroughly reviewed, and two providers missed the attendance threshold for our PIPS (Performance Improvement and Patient Safety) meeting. We have six months to address this. Dr. Dean has been an excellent addition to the trauma team, and we continue to work on improving our trauma department.

6. **Clinical Quality Goals Update-** A review of current performance and actions focused on the clinical quality goals for Sepsis, and Healthcare Acquired Infections. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*
   - Reviewed HAI Review (CLABSI, CAUTI, MRSA): we are meeting the CLABSI and MRSA goal for the first two months of FY 2024 but we are not meeting the CAUTI goal. Opportunities to

further reduce infection rates are being reviewed and we are on track with line utilization goals for FY 2025. We are 100% compliant with MRSA decolonization of 100% of patients who test positive for nasal MRSA when screened upon entry. Not all patients admitted from a Skilled Nursing Facility or readmitted from another hospital are screened. The team is addressing workflows to ensure these patients are screened upon entry.

- Use of the BioVigil Hand Hygiene (HH) Monitoring system is less than goal, the team is identifying the lowest-performing areas and system barriers. Tendai and the team are working on expanding efforts in environmental cleaning and raising compliance goals. Infection Prevention staff continue to conduct manual HH audits in collaboration to meet Leapfrog requirements.
- The compliance rate for the sepsis bundle remains flat, with a risk-adjusted mortality rate of 1. In July, compliance was 72%. Early treatment and recognition are critical, and the goal is to reach 30% compliance with the one-hour bundle, particularly in the ED, which accounts for 85% of sepsis cases. There are challenges in ensuring timely execution of the one-hour bundle, though ED residents, under the guidance of Dr. Tu, are engaged and aware of the need for continuous recognition and communication.

Adjourn Open Meeting – *Mike Olmos, Committee Chair*

Mike Olmos adjourned the meeting at 9:41 am.

Committee minutes were approved for distribution to the Board by the Committee Chair on

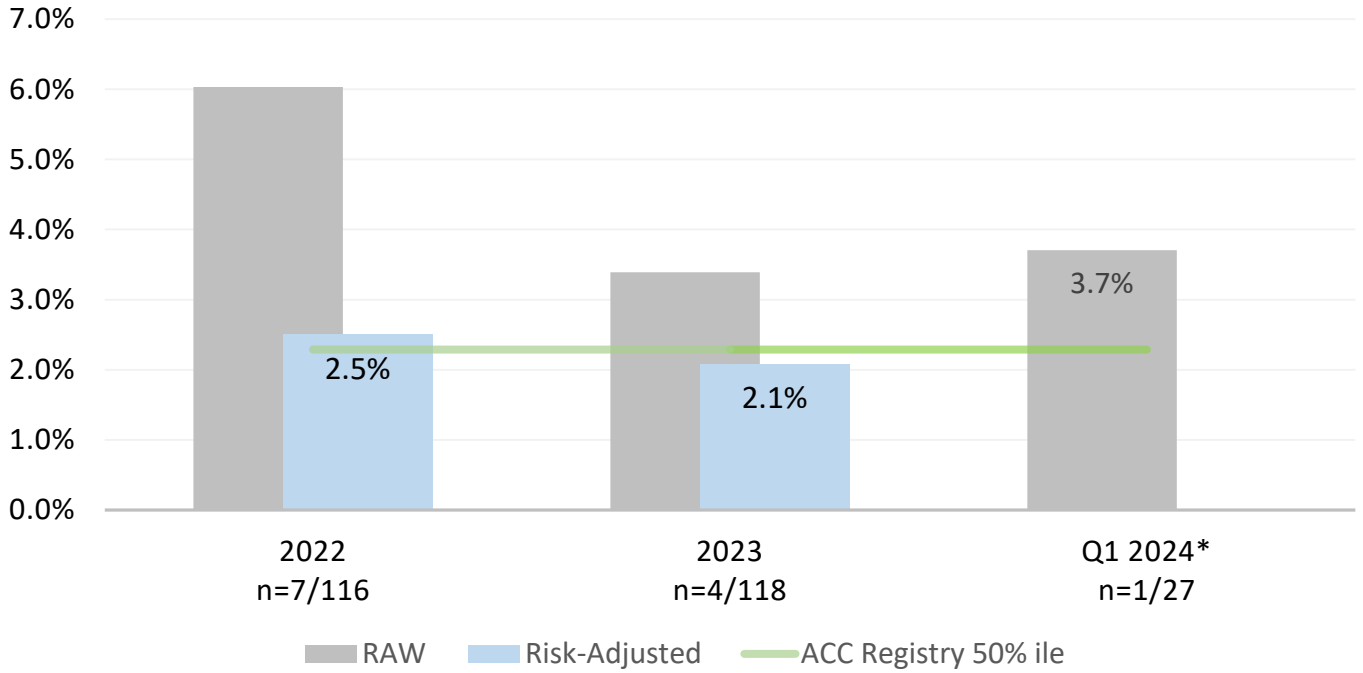
Outstanding Health Outcomes (OHO)
QUALITY & PATIENT SAFETY PRIORITY

Acute Myocardial Infarction (AMI) STEMI
Mortality & Processes of Care

August 2024

OHO Monthly Update: AMI STEMI Mort & Processes

STEMI Mortality Reduction



***Q1 2024 and R4Q not risk-adjusted yet per NCDR**. Establishing a new model this quarter

FY25 GOAL

Decrease PCI In-Hospital Risk-Adjusted Mortality Rate – STEMI Patients to </= 1.9% (ACC goal is national mean from Q2 2023-Q1 2024)

FY25 PLAN – Mortality Reduction

High Level Action Plan

- Thoughtful Pause initiative
  - Thoughtful Pause documented 100% by 2/1/2026
- Improve door to balloon time from outside facilities by Q2 2025
  - 2024 Jan – Aug = 149 minutes
  - Reduce by 40 minutes by 3/31/25

OHO Monthly Update: AMI STEMI Mort & Processes

STEMI Mortality Reduction

The last data point did not meet goal because:

- Case selection
- Appropriateness of PCI

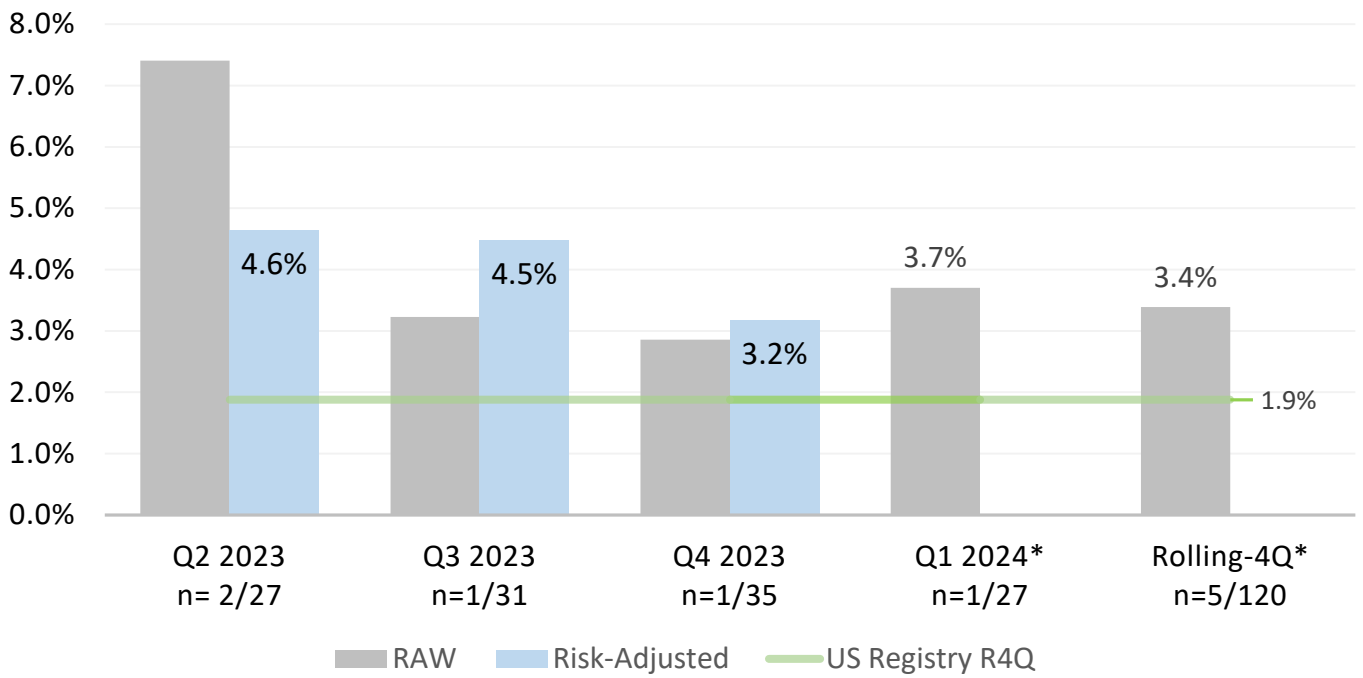
Targeted Opportunities (What specifically is causing the fallouts?)

1. Inconsistent use of “Thoughtful Pause”
2. Monthly M&M poorly attended. Limited discussion about cases due to low peer involvement. Results in limited learning opportunity, not likely to change behaviors)
3. Physician engagement low
4. Improve D2B time for transfers (currently 150 mins – goal is 109 mins)

CURRENT IMPROVEMENT ACTIVITIES	COMPLETION DATE	BARRIERS
Review fall outs with Cath Lab medical director	11/30/2024	Data for provider level detail is not available through NCDR; manual chart review has to be done
Review ACC metric appropriate use criteria (AUC) with cardiologists with fall outs	12/31/2024	Requires individual meetings – time constraints
Cath Lab medical director to assist with the above – meet with peers regarding AUC	12/31/2024	As above
If lack of documentation fall out trend is identified, work with ISS for EMR revisions to capture required patient history	2/1/2025	Requires EMR form build to capture “thoughtful pause” metrics
Engage with transferring facilities about D2B	1/31/25	Scheduling for outside facilities ED directors, nursing leaders, Medical Director of KH Cath Lab, etc.

OHO Monthly Update: AMI STEMI Mort & Processes

STEMI Mortality Reduction



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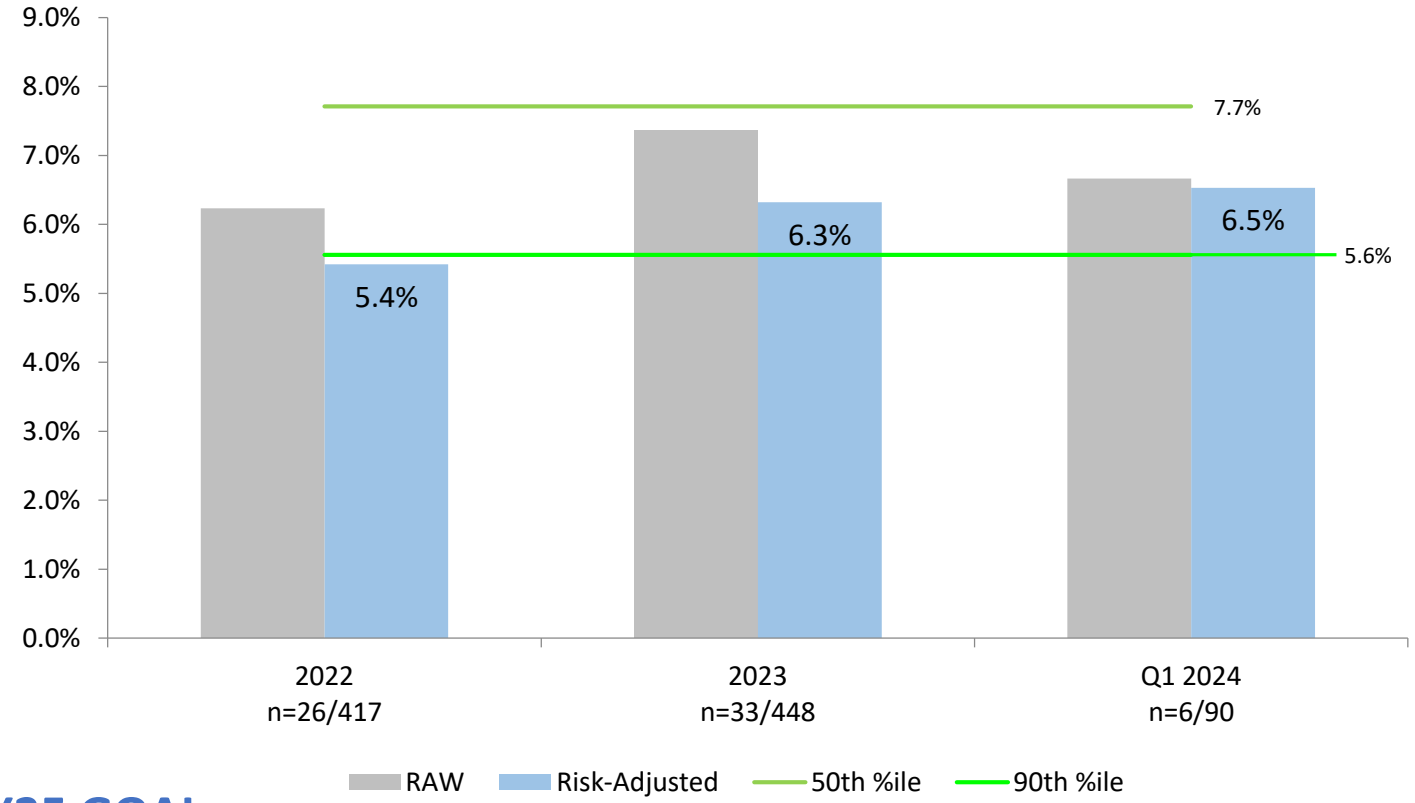
OHO Monthly Update: AMI STEMI Mort & Processes

Acute Kidney Injury (AKI) Reduction



FY25 GOAL

Decrease Risk-Standardized Acute Kidney Injury Post PCI to ≤ 5.6% (ACC goal is 90th percentile from Q2 2023-Q1 2024)

FY25 PLAN – Acute Kidney Injury (AKI) Reduction

High Level Action Plan

- Medical Director engagement with high contrast users
  - Reduce contrast use by 25%
  - 2024 Jan – Aug average contrast use = 173ml
  - Goal by 3/1/2025 = 154ml
- Oral hydration education to elective patients
  - Oral hydration handout given to all elective patients, when appropriate, by 3/1/2025

OHO Monthly Update: AMI STEMI Mort & Processes

Acute Kidney Injury (AKI) Reduction

The last data point did not meet goal because:

- Patients are not fully hydrated prior to cath procedure
- Patients not receiving full amount of ordered pre-hydration
- Contrast use is a possible contributor

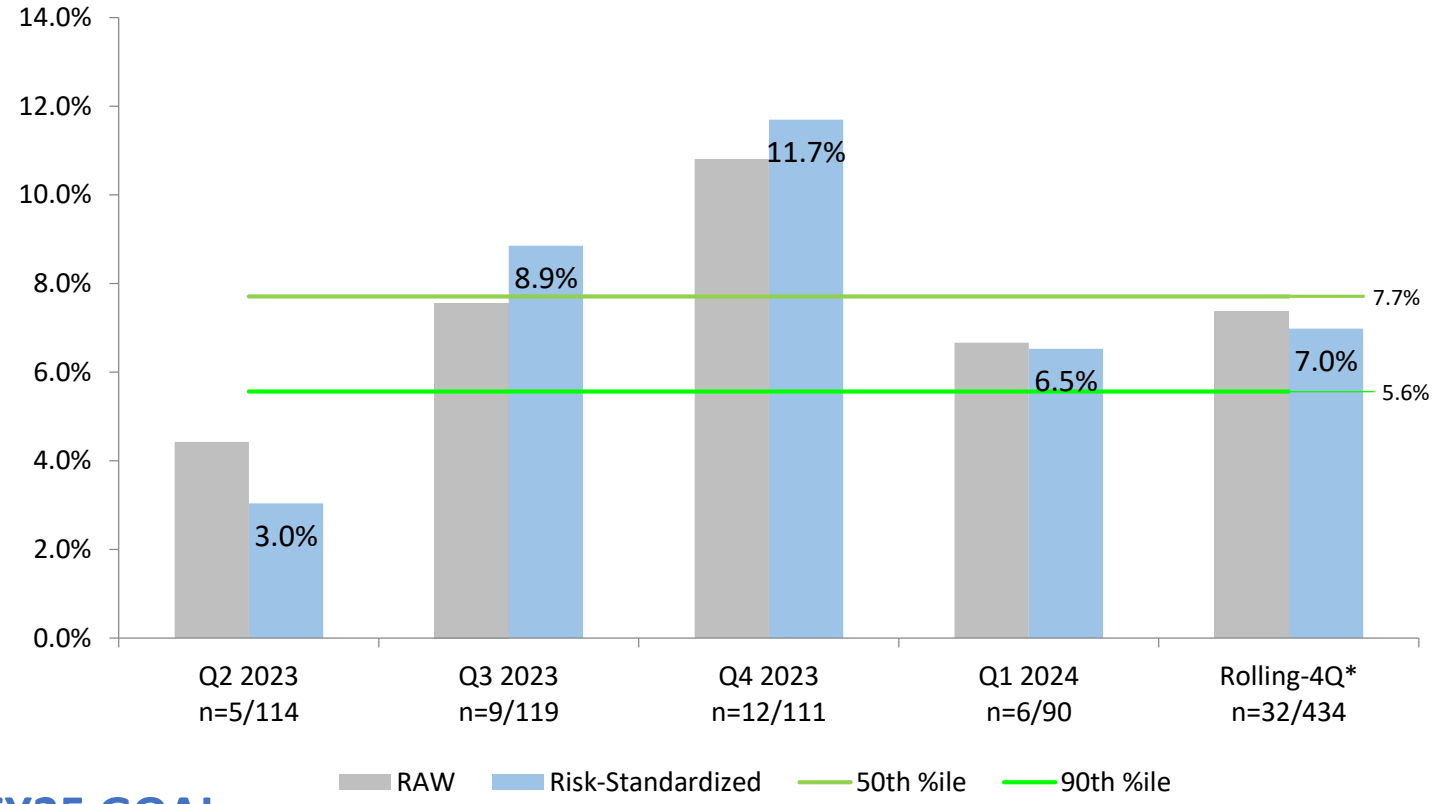
Targeted Opportunities (What specifically is causing the fallouts?)

1. Patients receiving pre-hydration but not full ordered amount per protocol (500 ml) due to cardiologist ready for the patient to be on table, or CV unit late to start IV/pre-hydration (IV access issue, patient late for check-in)
2. Reluctance of cardiologist to order full hydration amount due to patient history (i.e. heart failure)

CURRENT IMPROVEMENT ACTIVITIES	COMPLETION DATE	BARRIERS
Data review at physician level; address outliers	On-going	NA
Audit for physician compliance in using standardized order set (that includes pre-hydration order)	On-going	Manual process; need to enlist ISS help for automated report, if possible
Audit contract usage by cardiologist; Cath Lab medical director addresses with high contrast using cardiologists	On-going	Change in practice difficult for physicians
Top 5 cardiologists with lowest AKI rate & lowest contrast use posted in MD lounge (blinded)	On-going	NA
Patient instructed to increase oral fluids prior to procedure; develop oral hydration educational handout for all cardiology offices performing elective PCIs	On-going	No way to monitor this has been done

OHO Monthly Update: AMI STEMI Mort & Processes

Acute Kidney Injury (AKI) Reduction



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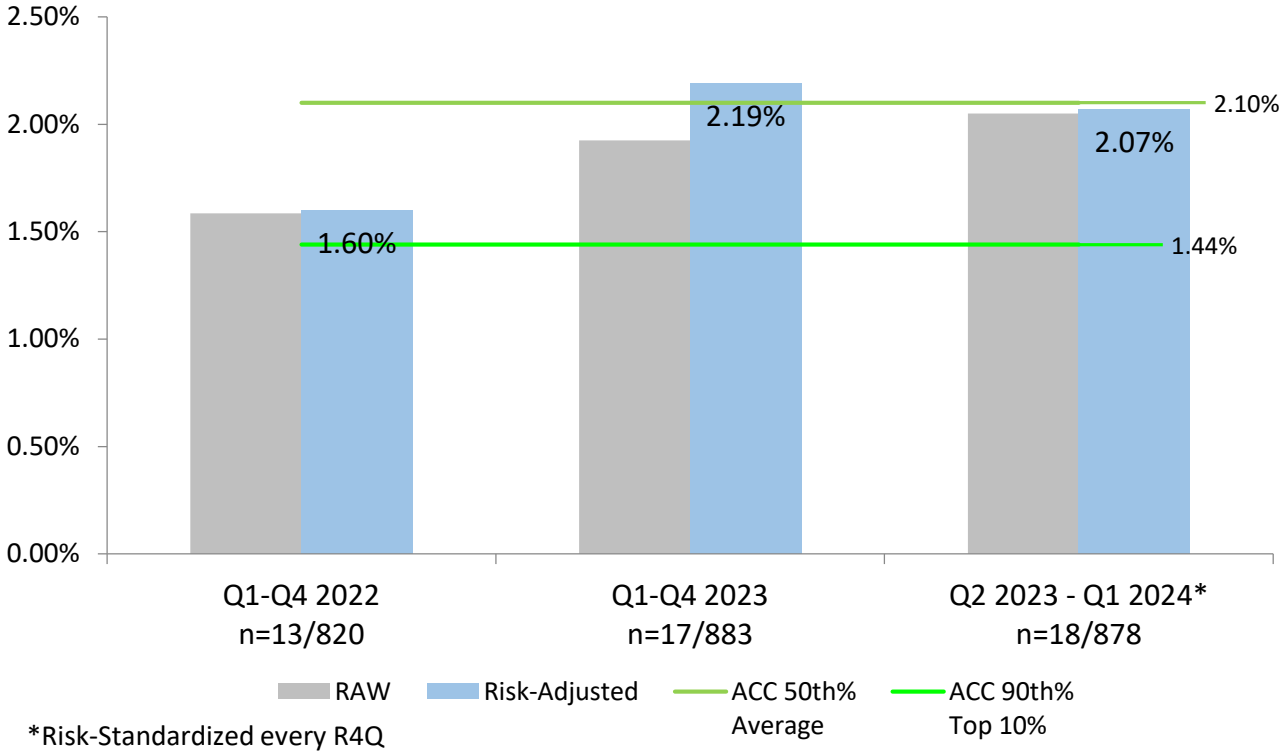
OHO Monthly Update: AMI STEMI Mort & Processes

Bleeding Rate Reduction



FY25 GOAL

Decrease Risk Standardized Bleeding Rate to </= 1.24% (ACC goal is 90th percentile from Q2 2023-Q1 2024)

FY25 PLAN – Bleeding Rate Reduction

High Level Action Plan

- Medical Director 1:1s with cardiologists to increase radial usage
  - 2024 Jan – Aug radial access usage = 50.9%
  - Goal = 64.8%
- Identify trends with bleeds unrelated to radial usage
  - Case study for each fall out completed by 12/31/2024

OHO Monthly Update: AMI STEMI Mort & Processes

Bleeding Rate Reduction

The last data point did not meet goal because:

- Some cardiologists not using radial access which has less incidence of bleeding

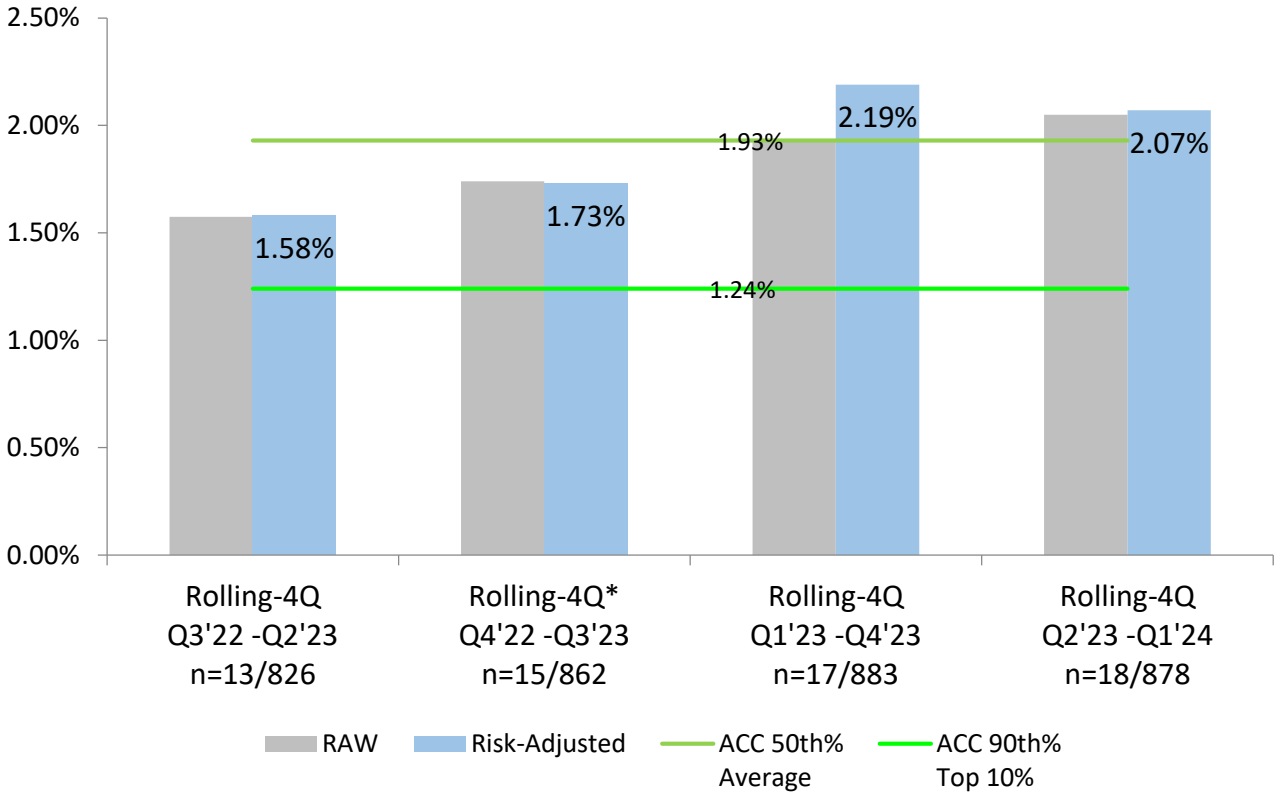
Targeted Opportunities (What specifically is causing the fallouts?)

1. Nursing education identified as an opportunity for improvement; re-education conducted; also added to mandatory RN annual competency
2. Manual audit of fall outs continues; Cath Lab medical director meeting with individual cardiologists with fall outs

CURRENT IMPROVEMENT ACTIVITIES	COMPLETION DATE	BARRIERS
Sharing provider level radial access rates to encourage increased utilization; top 5 cardiologists using radial access posted in MD lounge; Cath Lab medical director encouraging radial use/offering assistance to individual cardiologists to increase radial usage	On-going	Low radial usage mostly attributed to seasoned cardiologists so low change of a change in practice
Audit of each bleed to determine trend, if any	12/31/24	Manual audit; resources to complete this
If trend identified with the above, develop plan to address (i.e. staff education for appropriate sheath pull & hold, diligent vascular access site & pain assessment, etc.)		
Manual sheath removal & vascular sealant device education is now RN annual mandatory competency	On-going	Ensuring compliance for multiple nursing units (4T, 2N, 3W, CVICU, ICU & CVICCU)

OHO Monthly Update: AMI STEMI Mort & Processes

Bleeding Rate Reduction



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Thank you

Live with passion.

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

Kaweah Health

PATIENT SAFETY PRIORITY

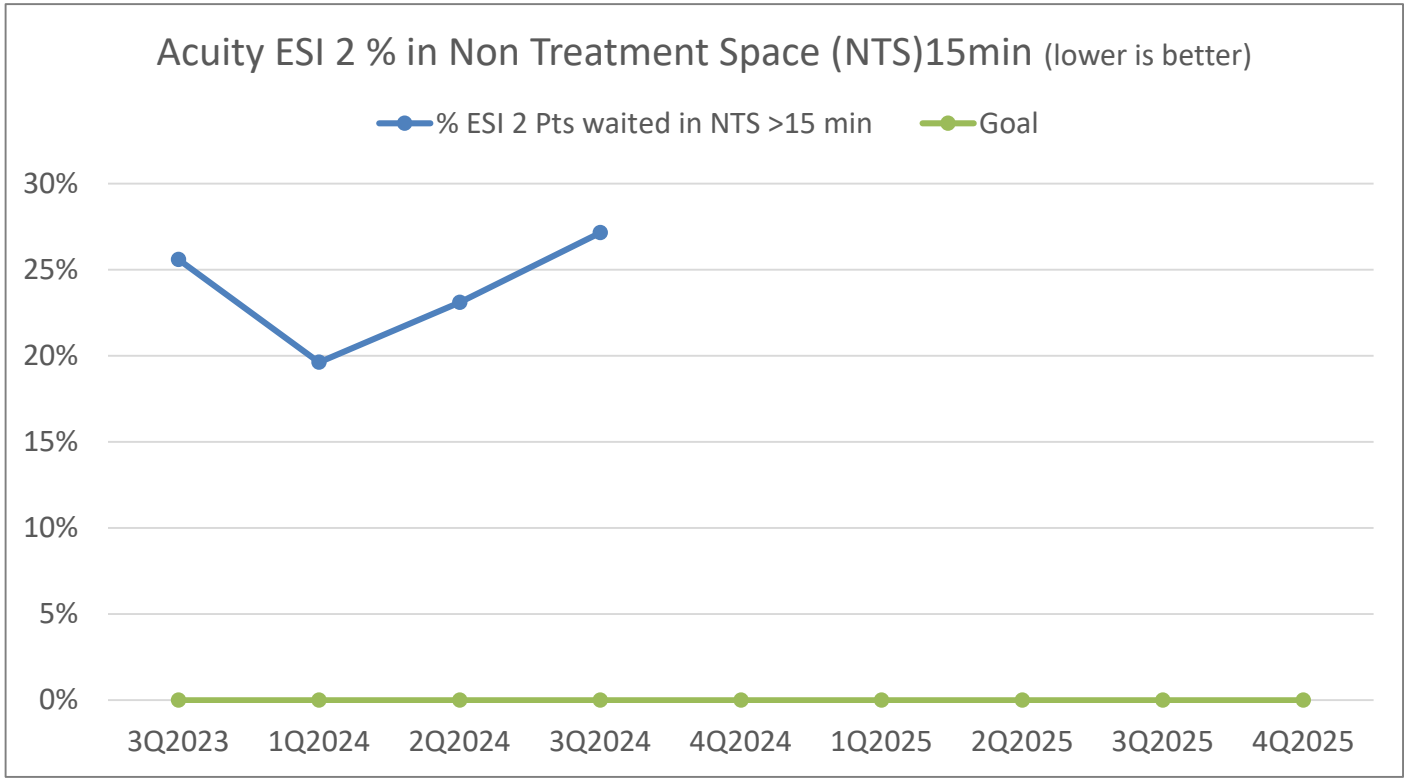
Emergency Department Quality Report

Quality Committee Report

November 2024

Refer to ED SBAR Reports, ED Kaizen Reports in QComm, and Patient Safety Committee Reports for detailed historical project information Pre Oct 2024.

ED Quality Report: Care of ESI 2 Patients in a Treatment Space



Emergency Department ESI 2 Management

High Level Action Plan

- Triage RN Training – 11/22/2024
- Goal: 0% waiting greater than 15 min
- Current Performance: September 2024 20%, October 2024 17%

ESI level-2 patients are high priority, and placement and treatment should be initiated rapidly. ESI level-2 patients have the potential to be very ill and at high risk for decompensation. ESI is a triage acuity algorithm that is valid for evaluating patient acuity and resource needs as determined by a trained triage nurse upon the patient's presentation to the emergency department. It is a process to differentiate between those who are at risk of decompensation and those who are more stable.

- Emergency Severity Index Handbook Fifth Edition (2023), Emergency Nurses Association: https://californiaena.org/wp-content/uploads/2023/05/ESI-Handbook-5th-Edition-3-2023.pdf

ED Quality Report: Care of ESI 2 Patients in a Treatment Space

Kaweah Health
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ED Safe Care Patient Flow Dashboard

ESI-2 Patients Flow NTS: Non-Treatment Space	Target	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	July 2024	Aug 2024	Sept 2024	Rolling 12M Av
# ESI 2 pts waited in NTS >15 min	0	264	200	216	265	196	210	228	156	157	141	125	160	193
% ESI 2 Pts waited in NTS >15 min	0%	26%	20%	23%	27%	23%	24%	24%	17%	19%	17%	16%	20%	21%
Avg. LOS ESI 2 pts waited in NTS >15 min	0	102	74	74	117	100	79	93	77	85	79	62	67	84
Max LOS ESI 2 Pt's waiting in NTS >15 min	0	786	480	501	1,002	729	456	474	830	907	741	288	650	654

NTS: Non Treatment Space where a complete care team (nurse and provider) is not assigned to the patient

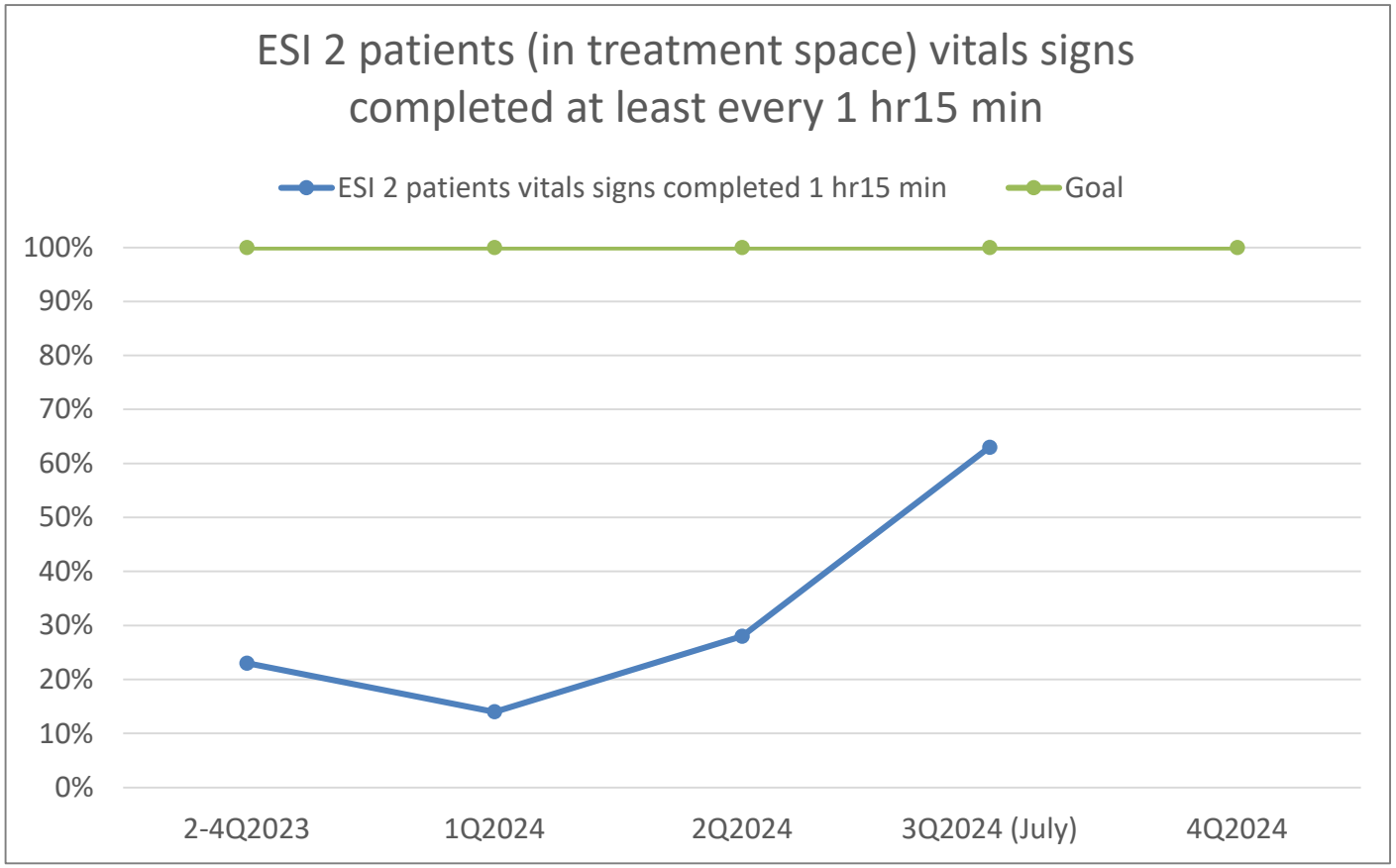
Targeted Opportunities (why goal not achieved in most recent month)

1. A Triage assessment training need was identified as patients being assigned an ESI of 2 is not consistent. Nurses receive Triage training during orientation. Plans include moving training to after orientation and only nurses with Triage training to be assigned to that role. Scheduled for 11/22/24.
2. Oversight by leadership monitoring patients in NTS, escalation of the need for placement in treatment spaces for ESI 2 patients.
3. Patients with an ESI 2 are kept in the triage area for monitoring until a patient room is available.

ED Quality Report: Care of ESI 2 Patients in a Treatment Space

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS/UPDATES
Triage RN training	11/22/2024	Training scheduled with simulations on 11/22/2024. Two sessions to provide training to all RNs who are assigned to triage, start, Intake coordinator roles, stroke team lead/EMS hallway roles.
The care delivery transition from having shift Charge Nurses to shift Clinical Leaders began in June with an intent to have all roles hired by the end of the summer.	Fall 2024	Charge nurses remain in place. All positions now filled (3 on days, 3 on nights). Clinical Supervisor role initiated, two positions filled and two positions vacant. One day supervisor, one night supervisor – orientation complete. Role expectations include review of patients in the department to ensure all ESI 2 patients are placed into patient rooms. Clinical escalation of concern policy implemented, any ESI 2 patient who cannot be placed in a bed from triage/EMS is escalated to the charge nurse and/or supervisor (supervisor not always on shift).
Staffing Goals – Increase RN staffing	TBD	Continued work to onboard 45 travel nurses, currently at 22. Two leaders focused on onboarding permanent and temporary.

ED Quality Report: ESI 2 Patient Vital Sign Monitoring



Emergency Department ESI 2 Management

High Level Action Plan

- Temperature probe staff education completed 08/2024
- Goal: 100% compliance by 12/31/2024
- Current Performance: September 2024 45% Compliance
- Challenges with temperature probe sensing temp and securing, looking for new securement device.
- Resumed disciplinary action for incomplete vital signs (not monitored in August 2024).
- Increased leadership rounding on day and night shift
- Reviewed EMR notification challenges, sent communication on expectations to check VS for patients – not to rely on EMR notification.

ESI level-2 patients are high priority, and placement and treatment should be initiated rapidly. ESI level-2 patients have the potential to be very ill and at high risk for decompensation.

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ED Quality Report: ESI 2 Patient Vital Sign Monitoring

Kaweah Health
MORE THAN MEDICINE. LIFE.

ED Safe Care Patient Flow Dashboard

ESI-2 Vital Signs (patients in treatment space)(

	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 2024	May 24	Jun 24	July 24	Aug 2024	Sept 2024	Rolling 12M Av
% Vital Signs completed every 1 hour	100%	31.0%	8.8%	13.0%	5.0%	8.8%	28.0%	24.0%	28.0%	33.0%	63.0%	N/A	45%	26%
% VS completed excluding temp for all pts							70.0%		100.0%	100.0%				

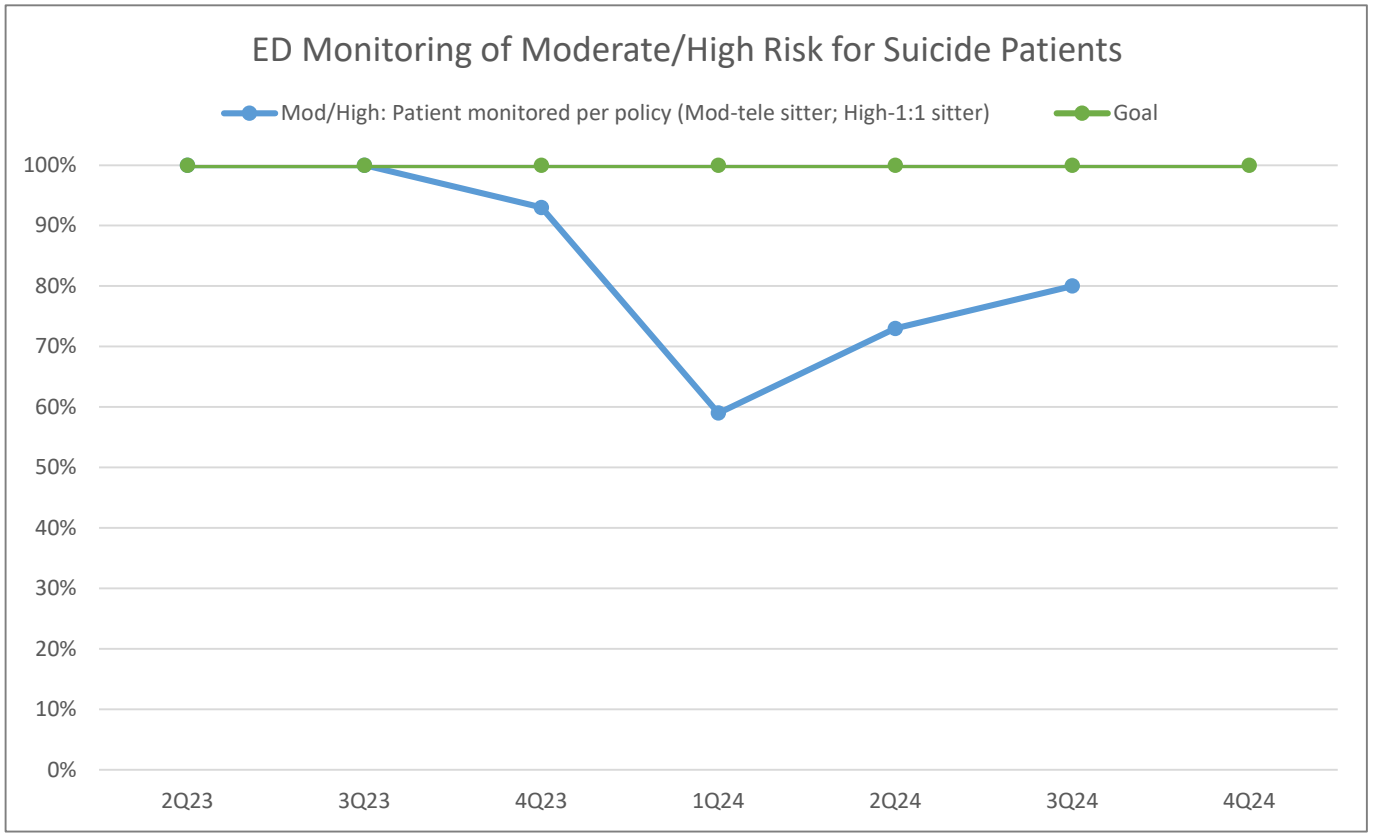
Targeted Opportunities (why goal not achieved in most recent month)

1. Not completing temperature checks with each vital sign check
2. Not completing VS in the expected time – ED Tech responsibility delegated by RN.
3. Patients are in rooms with assigned care team, VS checks not being completed by the team as expected.
4. Disciplinary action being delivered to RN and ED Tech responsible for checks.
5. When patient acuity changes, frequency of VS checks not being updated with a new order.
6. Identify team members assigned to hallway beds to perform vital signs and rechecks – LVNs will be pulled in patient surge.
7. Staffing still not at desired number for RNs to maximize patient rooms. 22 of 45 Traveler positions filled.

ED Quality Report: ESI 2 Patient Vital Sign Monitoring

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
Temperature probes for automatic monitoring are on now on site. ED leadership and Clinical Education are developing an education plan and training to ensure compliance.	8/26/2024	Temperature probes in place. Challenges with securement and accuracy. Working with clinical engineering.
Evaluating temperature monitoring frequency best practices	11/30/2024	Best practices being reviewed to change ESI 2 VS frequency or remove temperature requirement with every set.

ED Quality Report: Monitoring of Moderate/High Risk for Suicide



ED – Monitoring of Mod/High Risk for Suicide

High Level Action Plan

- Goal: 100% monitored per policy (1:1)
- Current Performance: September 2024 100%, increased the monitoring to evaluate more patients per month in October.

ED Quality Report: Monitoring of Moderate/High Risk for Suicide

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Suicide Risk Daily Compliance Surveillance Data
ED

Question	Goal	Qtr 2 2023	Qtr 3 2023	Qtr 4 2023	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
4a. Mod/High: Patient monitored per policy (Mod-tele sitter; High-1:1 sitter)	100%	100% 93/93	100% 20/20	93% 159/171	68% 68/100	46% 76/166	69% 91/131	57% 116/202	87% 136/156	80.0% 128/160	79.57% 74/93	75.00% 84/112	100% 25/25
4b. Mod/High: Patients without a Sitter- volume								16				3	

Targeted Opportunities (why goal not achieved in most recent month)

1. Suicide risk patient volume typically runs 8-10 patients/shift. ED Techs and Inpatient CNAs are used as possible but patient demands during surge lead to decisions to move resources from the 1:1 sitter.
2. Work with medical staff to discontinue sitters on patients when appropriate.
3. Evaluate MHW staffing opportunities.
4. Increase capacity at acute mental health hospital for appropriate transfers (January 2025).

ED Quality Report: Monitoring of Moderate/High Risk for Suicide

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS/UPDATES
The ED leadership team will continue to assess the feasibility of a policy change to 2:1 sitters in Zone 4. This will be taken to Patient Safety Committee and Patient Care Leadership for process change evaluation too	12/31/2024	Concern with plans for appropriate monitoring when in a 2:1 assignment. Implement increased leadership presence to ensure expected behaviors are happening.
Increase staffing in the ED to allow for fluctuations in the safety sitter staffing.	TBD	Continue to hire into vacancies. Director and ANM focused on the hiring process for permanent and temporary staff.

ED Quality Report: Decrease Patients who Left During Treatment

Kaweah Health MORE THAN MEDICINE. LIFE.	EMERGENCY DEPARTMENT DASHBOARD														
		CY23Q3			Y23Q4			CY24Q1			CY24Q2			CY24Q3	
	Benchmark/Goal	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024
ED Volume	N/A	7889	8264	7838	7818	7910	8589	8208	7564	8039	7898	8416	8161	8303	8120	7875
% of Pts Left during treatment	<3%	4.1%	4.2%	4.4%	3.6%	4.1%	5.7%	5.3%	4.6%	3.4%	5.0%	5.0%	6.2%	6.4%	5.5%	6.3%

The goal for the ED team is for patients to be assessed, treated, and a final disposition discussed with the patient and family by the provider. Patients who leave during treatment have been assessed by the provider but have not stayed for the duration of the treatment and to receive the results of their tests and treatments. These patients typically leave without informing the clinical team they are leaving. We are seeing higher rates of patient leaving during treatment due to our longer length of stay. Patient leaving during treatment can be a risk to the patients when they do not have the results to help develop a plan of care for their primary complaint.

ED Quality Report: Decrease Patients who Left During Treatment

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS /UPDATES
Utilize intake space near triage for low acuity ED patients pending discharge due to nursing treatments. Help improve flow and access for these patients.	12/31/24	Intake Space currently shared with D/C lounge. Will move D/C lounge to resume use of Intake for ED pts.
Continue to decrease turnaround time and validate appropriate use of imaging tests and procedures in the ED setting.	12/31/24	Analysis and process changes underway with throughput committee.
Implement a split flow front end model to move low acuity patients to Zone 6/Fast Track. Ensure stable nurse and provider staffing for this area to be used consistently.	TBD	Staffing challenges delaying the opening of Zone 6.
Increase communication by the clinical team with the patients on what to expect while they are being treated.	10/31/24	Underway at this time, monitoring occurring.
Communicate with the patients about progress and updates while waiting for treatments, procedures, or results.	10/31/24	Underway at this time, monitoring occurring.

Thank you

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Outstanding Health Outcomes (OHO)
QUALITY & PATIENT SAFETY PRIORITY

Healthcare Acquired Infection (HAI) Reduction

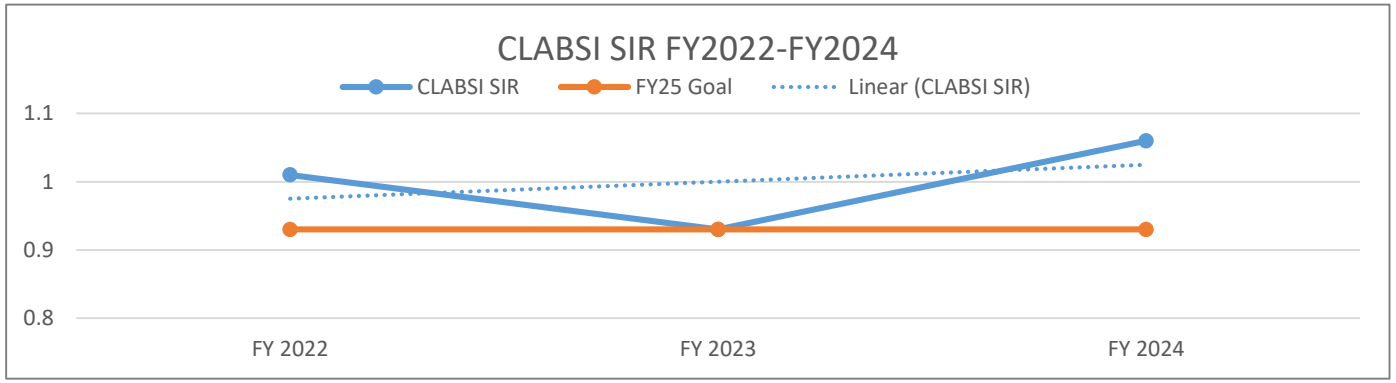
November 2024

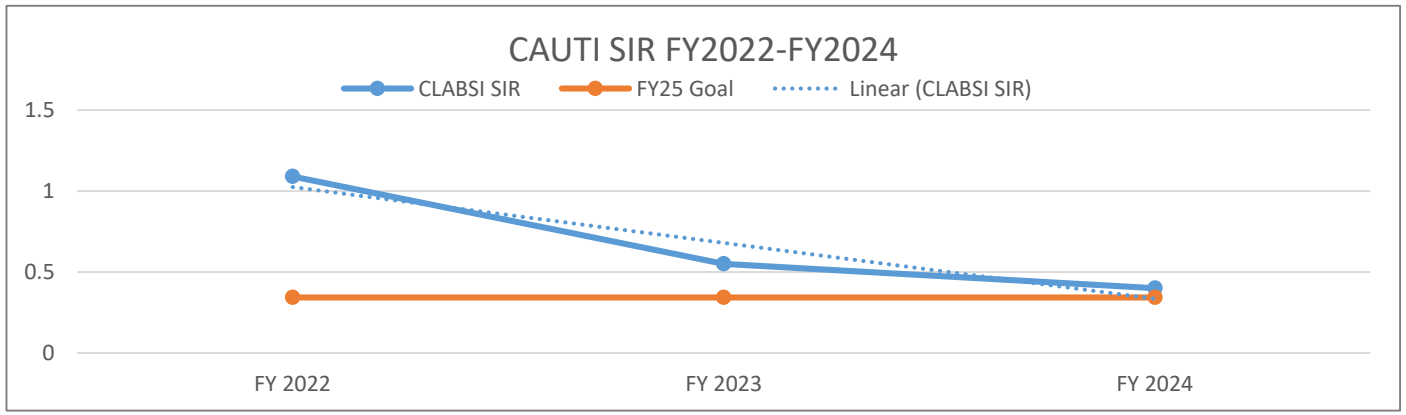
OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

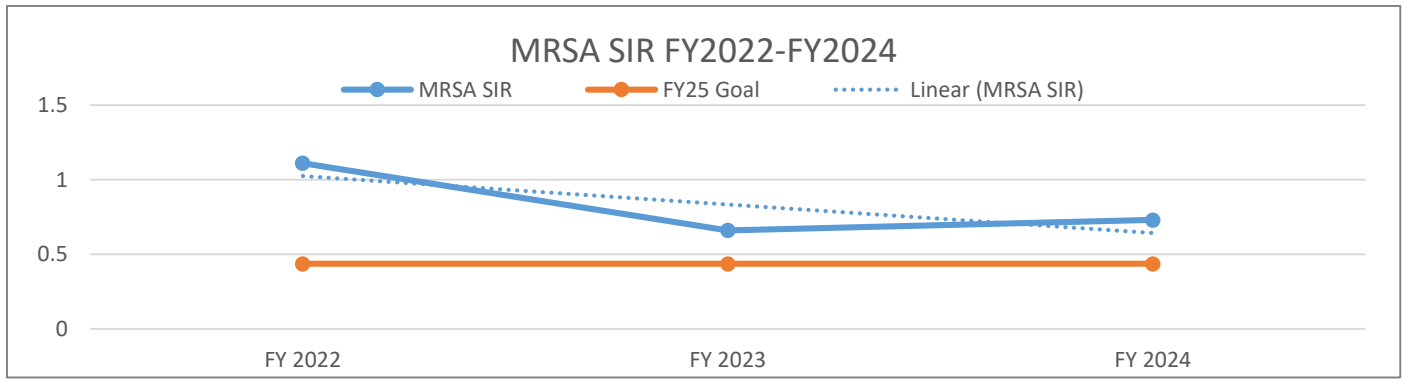
(number of actual infections/number of predicted infections by CMS)

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

Historical Baseline







FY25 PLAN – HAI Reduction CLABSI, CAUTI & MRSA SIR

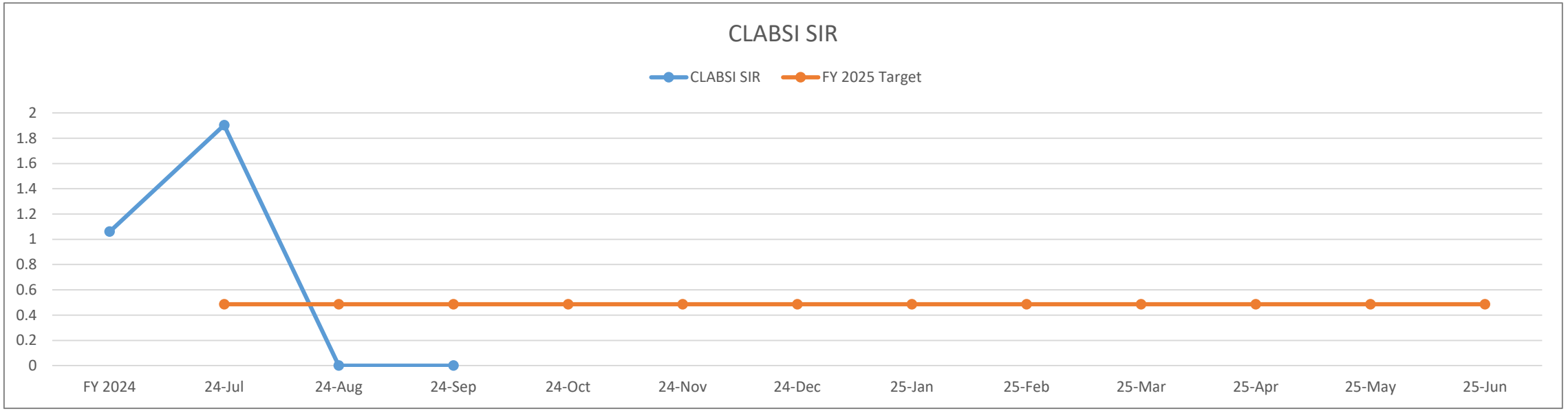
High Level Action Plan

- Reduce line utilization; less lines, less opportunity for infections to occur
  - Goal: reduce central line utilization ratio to <0.93
  - Goal: reduce urinary catheter utilization ratio to <0.64
- MRSA nasal and skin decolonization for patients with lines.
  - Goal: 100% of at risk patients nasally decolonized
  - Goal: 100% of patients with lines have a CHG bath
- Improve hand hygiene (HH) through increased use of BioVigil electronic HH monitoring system
  - Goal: 60% of staff are active users of BioVigil
- Improve environmental cleaning effectiveness for high risk areas
  - Goal: 80% of areas in high risk areas are cleaned effectively the first time (all area not passing are re-cleaned immediately)

FY25 GOAL

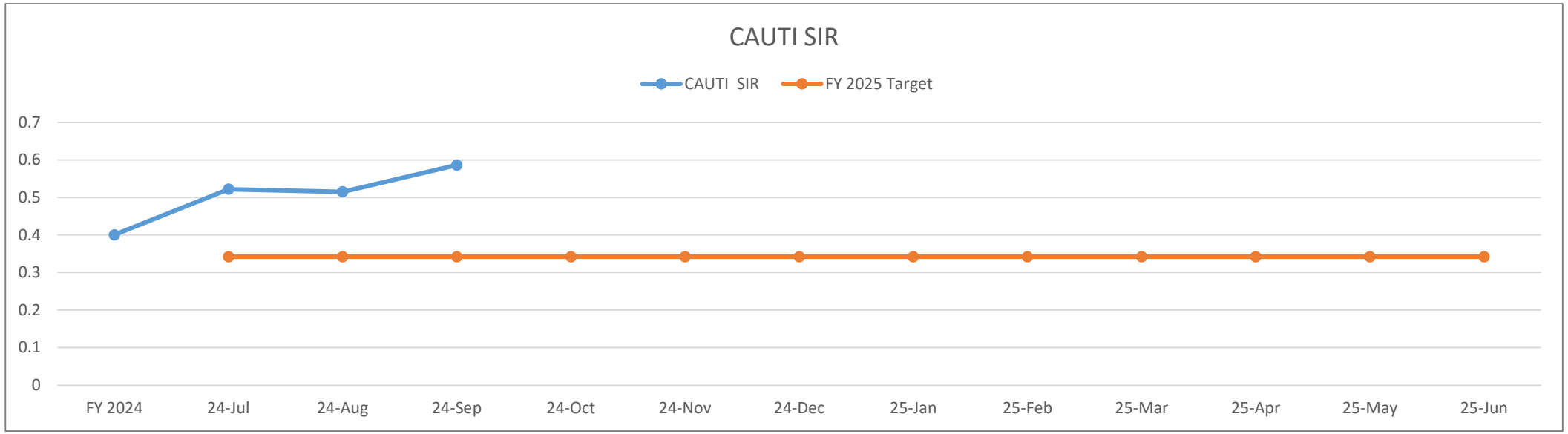
Decrease: CLABSI SIR to <0.92; CAUTI SIR to < 0.341; MRSA <0.434

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



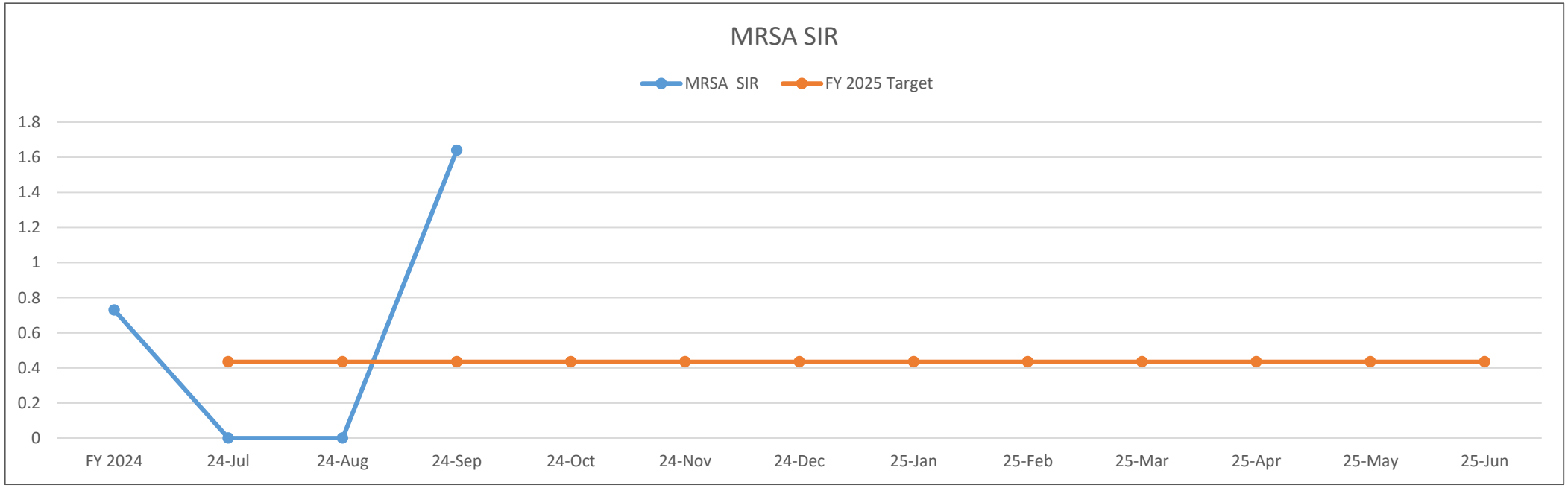
	FY 2025 Target	FY 2024	24-Jul	24-Aug	24-Sep	24-Oct	24-Nov	24-Dec	25-Jan	25-Feb	25-Mar	25-Apr	25-May	25-Jun	FYTD 25
CLABSI Events		17	2	0	0										**2**
CLABSI Predicted Events		16.06	1.051	1.117	0.121										2.168
CLABSI SIR	<0.486	1.06	1.903	0	0										0.61

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



	FY 2025 Target	FY 2024	24-Jul	24-Aug	24-Sep	24-Oct	24-Nov	24-Dec	25-Jan	25-Feb	25-Mar	25-Apr	25-May	25-Jun	FYTD 25
CAUTI Events		9	1	1	1										3
CAUTI Predicted Events		22.58	1.917	1.94	1.707										5.564
CAUTI SIR	<0.342	0.4	0.522	0.515	0.586										0.54

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



	FY 2025 Target	FY 2022	FY 2023	FY 2024	24-Jul	24-Aug	24-Sep	24-Oct	24-Nov	24-Dec	25-Jan	25-Feb	25-Mar	25-Apr	25-May	25-Jun	FYTD 25
MRSA Events		12 10 Ex COVID	7 6 Ex COVID	7	0	0	1										1
MRSA Predicted Events		9	9	9.62	0.75	0.69	0.61										2.05
MRSA SIR	<0.435	1.11 Ex COVID	0.66 Ex COVID	0.73	0	0	1.64										0.49

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

The last data point did not meet goal because:

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

Targeted Opportunities

- Reduce line utilization; less lines, less opportunity for infections to occur
  - Goal: reduce central line utilization ratio to <0.663
  - July-Sept 2024 0.62
  - Goal: reduce urinary catheter ratio to <0.64
  - July-Sept 2024 0.98
- MRSA nasal and skin decolonization for patients with lines.
  - Goal: 100% of at risk patients nasally decolonized
  - Jul-Sept 2024 100% of screen patients nasally decolonized
  - Jul-Sept 2024 11% of patients admitted from a skilled nursing facility (at risk population) not screened or decolonized (if screen has a positive result)
  - Jul-Sept 2024 22% of patients re-admitted from another acute care facility within 30 days not screened or decolonized (if screen has a positive result)
  - Goal: 100% of line patients have CHG bathing
  - Will provide update following process implementation, delayed from 10/8 to 11/19 due to Cerner upgrade processes
- Improve hand hygiene (HH) through increased use of BioVigil electronic HH monitoring system
  - Goal: 60% of staff are active users of BioVigil
  - Jul-Sept 2024 49% of staff are active users
  - HH Compliance rate overall 94.35% (goal 95%) – decreasing trended noted over 3 quarters
- Improve environmental cleaning effectiveness for high risk areas
  - Goal: >90% of areas in high risk areas are cleaned effectively the first time (all area not passing are re-cleaned immediately)
  - July- Aug 2024 Pass cleanliness effectiveness testing **94%** of the time in high risk areas

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

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
Expand Multidisciplinary rounds to include other stakeholders to reduce line use	12/2/24	None
Skin decolonization for all line patients through CHG bathing training for CNAs and implementation to all units	10/8/24 Delayed until 11/19	Cerner update – ISS instituted a "Freeze" from 10/16-11/4. Order sets need to be updated for CHG order. Still classified as a medication in Cerner until after the freeze
MRSA screening form workflow changes to ensure patients who reside at a SNF and/or have been readmitted in past 30 days are automatically MRSA decolonized for a positive nasal swab result	12/1/24	None
Hand Hygiene compliance proposal under development by Infection Prevention to be reviewed by CMO/QCO	11/31/24	
Effective cleaning - Share data with staff real-time post testing and also trends bi-monthly in staff meetings, to ensure that staff continue to be aware of their impact on HAIs reduction.	Ongoing	None
Transport staff to help with patient care equipment cleaning	Tbd	None

Thank you

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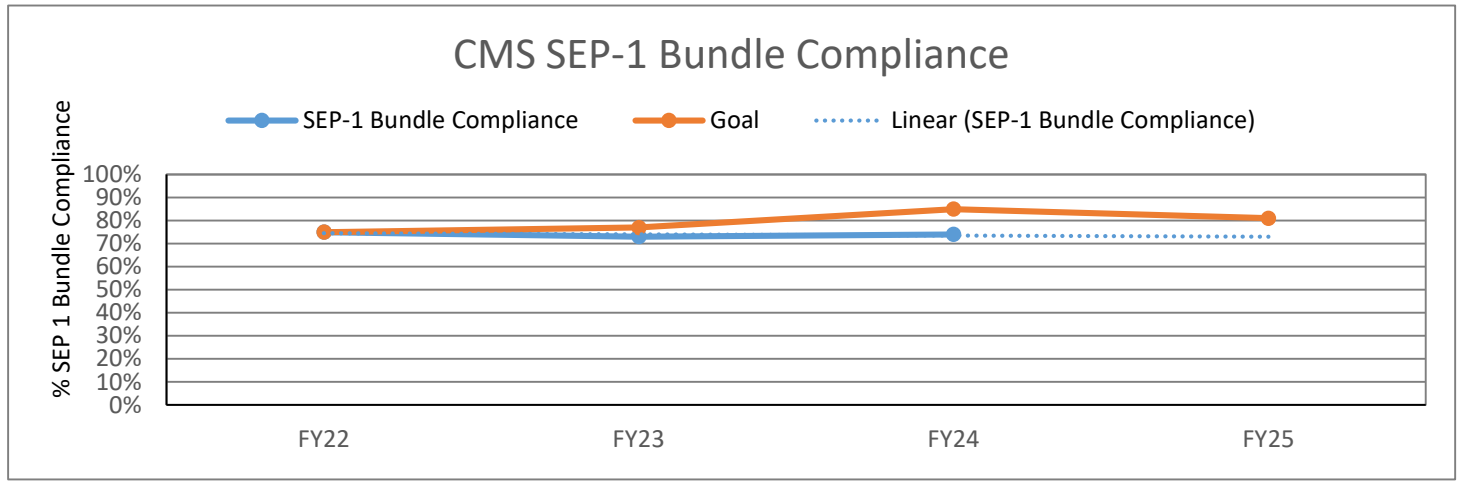
Outstanding Health Outcomes (OHO)
QUALITY & PATIENT SAFETY PRIORITY

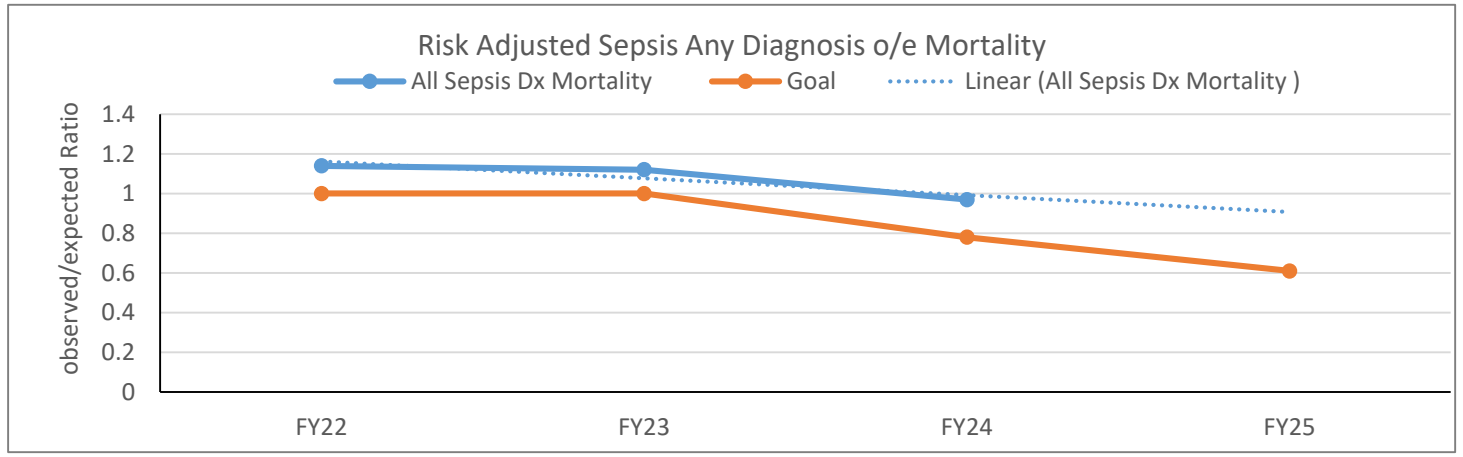
Sepsis CMS SEP-1 & Sepsis Mortality

November 2024

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

Historical Baseline





FY25 GOAL

Increase SEP-1 Bundle Compliance ≥ 81%

Decrease Sepsis any diagnosis Mortality ≤ 0.61

FY25 PLAN – CMS SEP-1

High Level Action Plan

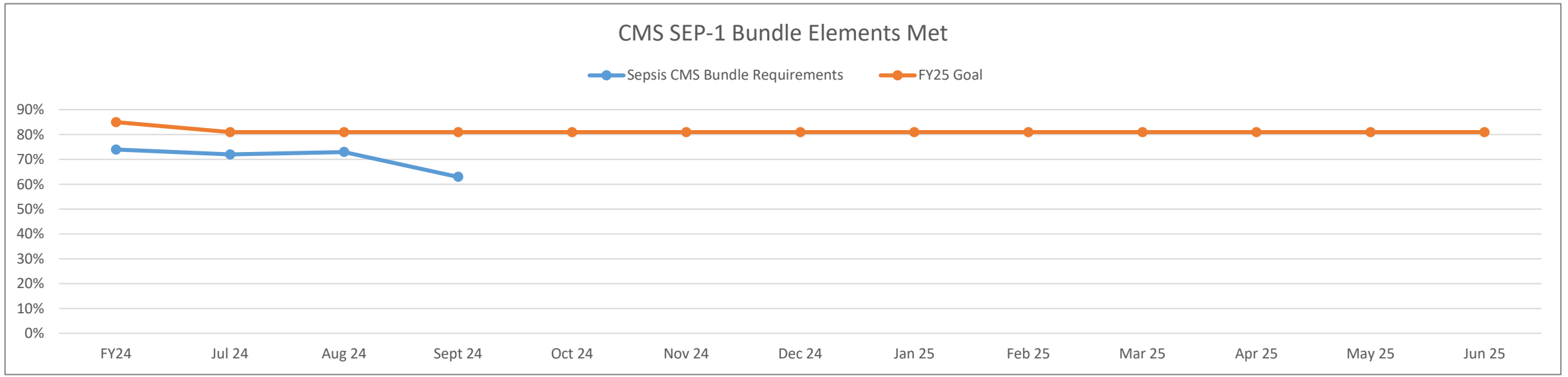
- Provide Early Goal Directed Therapy (Sepsis work up and Treatment)

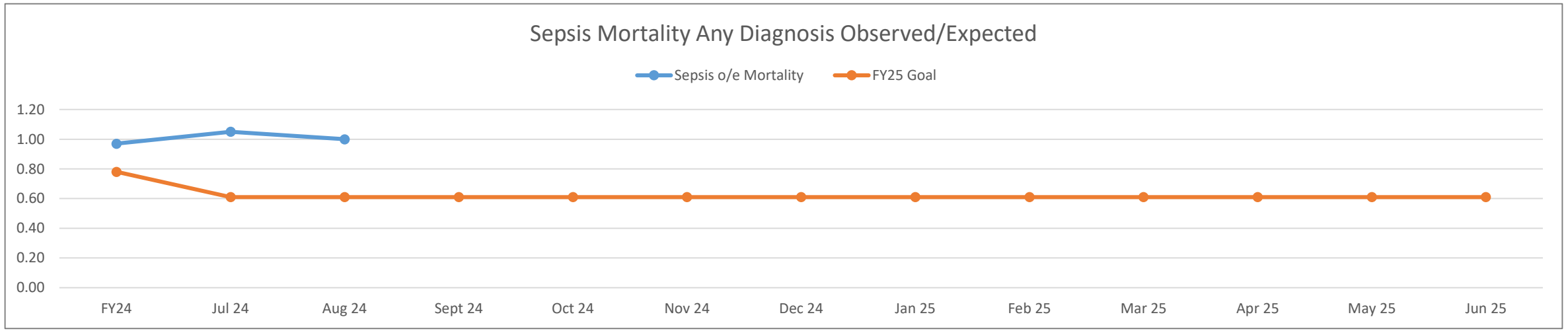
  % of Patients provided top 3 most frequently missed Sepsis bundle elements

  Baseline data (FY24) – Goal 95%

  - IV Fluid Resuscitation – July 2024 93%
  - Antibiotic Administered – July 2024 88%
  - Blood Cultures Drawn – July 2024 91%
- Provide Early Goal Directed Therapy (Sepsis Treatment)
  - Pts with Sepsis that Received Abx within 60 Minutes of Pt 1st Seen
  - Pts Met 1- Hr Bundle
  - Goal FY 25 = 30%

OHO FY25 Monthly Update: CMS SEP-1 & Mortality





OHO FY25 Monthly Update: CMS SEP-1 & Mortality

The last data point did not meet goal because:

- Differential diagnosis of infections are not being treated with Sepsis interventions or are not being refuted when Sepsis is no longer entertained
- Providers ordering Sepsis bundle elements outside the Sepsis power plan omitting important information required by CMS (i.e., lesser fluids)
- Delayed Sepsis order entry or not utilizing Sepsis order set (Sepsis power plan)
- Providers prefer to order or not order fluid at their discretion due to concerns for fluid overloading patients (afraid to harm pts)
- Blood Culture X 2 not ordered and Broad Spectrum Abx not ordered or administered timely (within 3 hour of CMS Sepsis criteria met)
- ED Throughput challenges (Combination or Provider and Nurse related fall outs July - September)

Targeted Opportunities

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

  FY25

  - % of Patients provided top 3 most frequently missed Sepsis bundle elements at KH
  - IV Fluid Resuscitation 95%
  - Antibiotic Administered 90%
  - Blood Cultures collection 92%
  - Goal = 95%
- Provide Early Goal Directed Therapy (Sepsis Treatment)

  FY25

  - Pts with Sepsis that Received Abx within 60 Minutes of Pt 1st Seen by ED Provider 27%
  - Pts Met 1- Hr Bundle 24%
  - Goal = 30%

OHO FY25 Monthly Update: CMS SEP-1 & Mortality

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
1. GME Resident engagement and ongoing education throughout the year, not just during yearly orientation ○ Ongoing collaboration with Chief ED Residents ○ Resident project focus on Sepsis power plan utilization awareness ○ Collaboration with Dr. Stanley for engaging educational material	Ongoing	GME program strict curriculum limited time to devote to ongoing Sepsis education throughout the year
2. Code Sepsis in ED (workgroup in progress)	Preliminary Discussion to continue in December 2024	ED Throughput challenges, treatment space limitations & staffing challenges No designated blood culture resource Potential for 13-16 code Sepsis in a 24 hour window Awaiting on ED leadership support onboarding
3. Enhancements to EMR to help care team identify patients that need Sepsis work up and treatment timely ○ Sepsis reference checklist to be added to Sepsis order set	10/2024	None
4. Sepsis multidisciplinary collaboration with SIM (Simulation in Medical Science) Lab ○ Planned for Spring 2025 (possible in situ SIM)	Spring 2025	Potential Inpatient (hospitalist, intensivist) engagement limitations
5. Mortality summary reviews presented to Sepsis committee workgroup for Sepsis 1-hour bundle success review, analysis & improvement strategies	November 25, 2024	None

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