October 10, 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, October 17, 2024, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

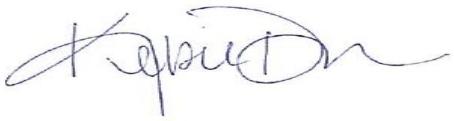
The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:31AM on October 17, 2024, 2024, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277, pursuant to Health and Safety Code 32155 & 1461.

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, October 17, 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, October 17, 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; Mara Miller, PharmD BCPS, 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, Chief of Compliance and Risk Officer.*
4. **Adjourn Open Meeting** – *Mike Olmos, Committee Chair*

CLOSED MEETING – 7:31AM

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

2. **Approval of September 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; Mara Miller, PharmD BCPS, Medication Safety Coordinator*

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

5. **Adjourn Closed Meeting** – *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 September 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. **Health Equity Quality Report**
    4.2. **Hospice Home Health Quality Report**

5. **Trauma Committee Quality Report –** a review of key process and outcome measures related to trauma processes. *Frank Martin, Director of Trauma Program.*

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, September 19, 2024
The Lifestyle Center Conference Room

Attending: Board Members: Mike Olmos (Chair) & David Francis, Board Member; Dr. Paul Stefanacci, CMO/CQO; Sandy Volchko, Director of Quality & Patient Safety; Mark Mertz; Dr. Mack; Ryan Gates, Chief Population Health Officer; Shawn Elkin, Infection Prevention Manager; Erika Pineda, Sepsis Manager; Wendy Jones, Director of Respiratory Services; Maribel Aguilar, Life Safety Manager; Shannon Cauthen, Director of Critical Care Services; Emma Camarena, Director of Nursing Practice; Kyndra Licon, Program Coordinator – Recording.

Mike Olmos called to order at 7:30 am.

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

Mike Olmos adjourned the meeting at 8:30 am.

Mike Olmos called to order at 8:15 am.

3. **Approval of August Quality Council Open Session Minutes –** Mike Olmos, Committee Chair; Dean Levitan, Board Member.
    - Approval of August Quality Council Open Session Minutes by David Francis and Mike Olmos.
4. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives: Reviewed with no discussion.

    4.1 Best Practice Quality Report
    4.2 Fall Prevention Quality Report
    4.3 Environment of Care Quality Report
    4.4 Maternal Child Health Quality Report

5. **Rapid Response Team Code Blue Quality Report –** A review of key process and outcome measures related to rapid response and code blue processes. Shannon Cauthen, MSN, RN, CCRN-K, NE-BC, Director of Critical Care Services.
    - We've added 10 full-time equivalents (FTEs), all but one being new hires. There has been significant improvement in documenting that respiratory therapists (RTs) are completing their required competencies, and this issue is not expected to persist. Other metrics are also exceeding expectations. The overall scorecard reflects the percentage of Code Blue events in critical care units and the internal arrest rate for patients in the Med-Surg unit. Early intervention is improving, and while ICU and Stepdown units are performing above 75%, the American Heart Association does not count codes from these areas in our statistics. We are hopeful that with the support of the ACTS (Advanced Critical Team Support) team, we can further reduce the number of Code Blues. Over time, we expect to see ICU and Stepdown units functioning more effectively like intensive care units. The team is focusing on survival to discharge rates and RRT mortality. A challenge noted was the failure to admit patients to the appropriate level of care within 24 hours, which leads to delayed interventions. We need to be more thoughtful in placing patients in the correct

care levels. One potential improvement is using the Modified Early Warning Score (MEWS), a 5-point scale to measure patient risk, as part of a 30-day trial in the ER. This will help adjust care levels more quickly. We are also addressing the issue of patients not being placed in appropriate acute care levels, particularly in Med-Surg units, where patients often arrive in worse conditions than anticipated. This is partly due to physician assessments that sometimes miss the evolving status of the patient. Further screening and consistent monitoring are needed. There has been a noted increase in rapid response activations, which is linked to having many new nurses. As part of their onboarding process, the clinical education team has revamped the orientation to a six-day program, which includes rapid response training. Overflow in the 5T unit and long-term patients who are not acutely ill have contributed to an increase in rapid response calls. We are seeing a steady number of Code Blues in ICU, CVICU, and 3 West. Upcoming projects will focus on community engagement and identifying additional opportunities for improvement. Action plan is trail of ER-STOP (Research project for DNP student) implements re-vevaluation of boarded patients every 2 hours using Risk Assessment Score (MEWS). Trail period: September 1st-30th.

3. **Hospital Acquired Pressure Injury Quality Report –** A review of performance and action plans associated with the prevention of pressure injuries. Emma Camarena, DNP, RN, ACCNS-AG, CCRN, Director of Nursing Practice.
    - This year, we are not meeting our goal. A recurring issue is the lack of regular bathing, which is crucial for HAPI prevention. The concern isn't just about scheduled baths, but about maintaining hygiene during hourly rounding and ensuring patients are kept dry and clean. The documentation process has also been inconsistent. Nurses are either not completing tasks or not documenting them properly. We've provided education on the importance of documenting care, including when a patient refuses care. We've identified gaps in knowledge, particularly around basic hygiene and wound care. Moving forward, we'll be offering more comprehensive training, including a secondary skin assessment during shift changes and implementing interventions every two hours. The clinical education team has already begun competency validation and retraining efforts. Accountability has been a challenge, and we will be reinforcing the monitoring of care practices, with leadership taking a more active role in ensuring staff adherence to policies. There's an ongoing need for consistent rounding and proactive leadership engagement in patient care to hold staff accountable. We are focusing on interdisciplinary interventions and ensuring that risk assessments are integrated into care plans. Starting next week, nurses will participate in a mandatory secondary skin assessment as part of ongoing efforts to reduce HAPI.
3. **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.*
    - A historical baseline for sepsis and HAIs has been established, and strategies are in place to improve performance. We are awaiting the finalized FY25 goals. The team identified key issues, including inconsistent use of the sepsis order set by physicians. The use of the full order set is crucial for timely and complete care. Emergency Department throughput challenges have also been identified, and we are targeting specific opportunities, particularly the one-hour sepsis bundle. Engaging residents and ensuring their consistent participation is a high priority. Work is also underway to enhance the EMR system to

ensure all steps in the sepsis order set are completed in the correct sequence. Simulation training for sepsis is ongoing, and a sepsis mortality review meeting has been introduced to help identify areas for improvement. For CAUTI, CLABSI, and MRSA, we are seeing some positive trends. CAUTI has met its goal, while MRSA is improving, though it has not yet reached its target. CLABSI remains stable without significant improvement. Our line utilization rates for July and August are on track to meet our goals. However, we are focusing on further reducing MRSA rates through improvements in hand hygiene compliance, environmental cleaning, and more appropriate line utilization. The Biovigil hand hygiene pilot program for physicians has been in place for a month and a half, and we are in the process of expanding its use in the ICU. Initial compliance rates were as expected.

4. **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

Health Equity at Kaweah Health

August 20, 2024

Kaweah's Health Equity Committee

Kaweah Health's - Health Equity Committee

- ✓ Identify an individual to lead activities to improve health care equity
- ✓ Assess the patient's health-related social needs
- ❑ Analyze quality and safety data to identify disparities
- ❑ Develop an action plan to improve health care equity
- ❑ Take action when the organization does not meet the goals in its action plan
- ❑ Inform key stakeholders about progress to improve health care equity

https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_npsg-16.pdf?db=web&hash=F4FA36C38D4D4146D38956F0392272DE

KH Current Health Equity Activities

- Health Equity Committee formed – March 2023
  - Identification of responsible individual and committee membership
- Health Equity Committee Charter approved - August 2023
- Review of regulatory health equity standards
  - Joint Commission, CMS and HCAI
- Review, selection and completion of Health Equity assessment tool
  - HSAG's Health Equity Roadmap
- Review, selection and implementation of Social of Determinants of Health (SDOH) patient screening tool
  - PRAPARE Tool implemented December 2023
  - SDOH HealtheAnalytics Dashboard validation under way, estimated completion 9/30/24.
  - Will assist in monitoring implementation, compliance and disparity identification

KH Current Health Equity Activities Cont.

- Application and award of HRSA Rural Care Coordination Grant for Maternal Health
  - Goal of the grant is identify disparities in maternal health outcomes and put interventions in place to address disparities with a focus on the farmworker population
- CalAIM Programs impacting health equity
  - Enhanced Care Management – expanding populations of focus
  - Community Supports – emphasis on housing
- Participation in completion of the Community Health Needs Assessment (CHNA)
- Attendance to NCQA's Health Equity Summit by Health Equity Committee leadership
  - Sonia Duran-Aguilar, Dr. Omar Guzman, Ryan Gates
- Presenter and Break-Out Session facilitator at the Annual Women Farmworker Women's Conference Nov. 2023 – Sonia Duran-Aguilar

KH Current Health Equity Activities Cont.

- Presenters/Panel Speakers- Norman Scharrer Symposium: Addressing Social Drivers of Health in the Healthcare Setting Dr. Guerrero, Dr. Guzman, Dr. Ryan Gates, Sonia Duran-Aguilar October 22, 2024

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department:
Home Health

ProStaff/QIC Report Date:
August 2024

Data for this report was obtained from two sources; the *Star Report* on the *Care Compare* website, the Centers for Medicare & Medicaid Services (CMS) platform for which quality measures are publicly reported for home health agencies. Currently, the *Care Compare* website reflects data from July 1, 2022 to June 30, 2023. Kaweah Health Home Health has an overall 3-Star rating, out of a 5-Star rating system.

In order to review *real time data* for analysis that reflects the outcomes of the current interventions in place, Strategic Healthcare Programs (SHP), a web-based program that analyzes the Outcome and Assessment Information Set (OASIS*) submitted to CMS monthly, was evaluated.

> ***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.***

Measure Description:

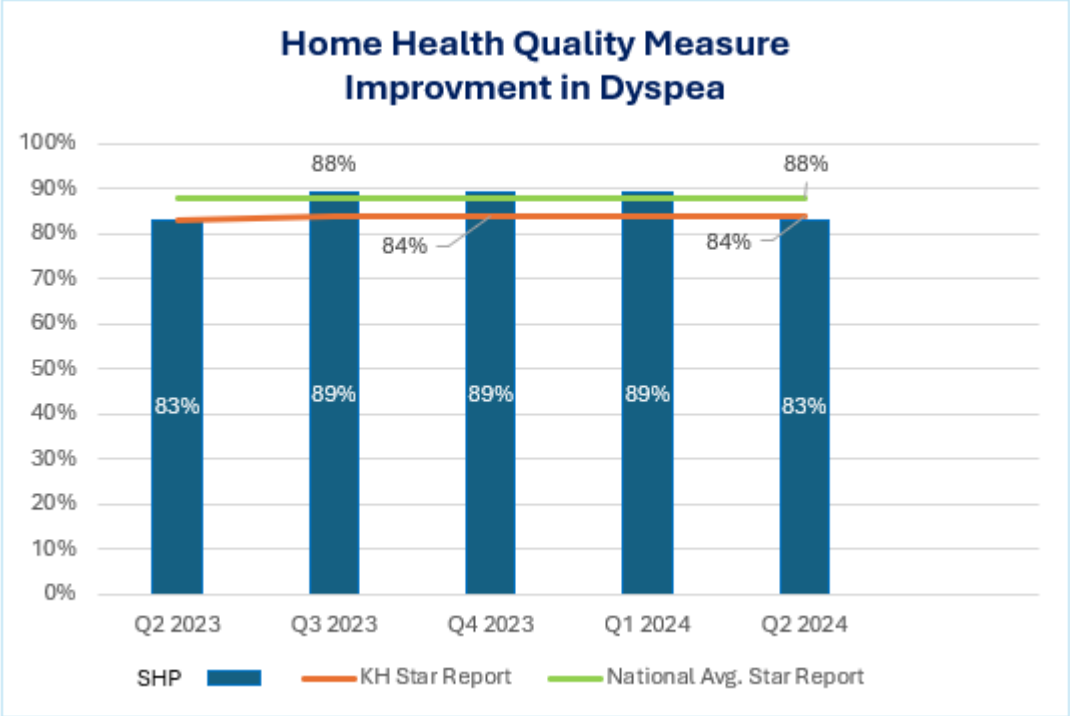
"How often patients' breathing improved"

Percentage of home health quality episodes during which the patient became less short of breath or dyspneic.

Measure Objective/Goal:

Improvement in Dyspnea

-- Patients are assessed upon admission to home health services and again at discharge to determine what level of exertion/activity results in dyspnea or shortness of breath; i.e. when walking more than 20 feet and/or climbing stairs, with *moderate* exertion (dressing, using a commode/bedpan, walking distances less than 20 feet), with *minimal* exertion (while eating, talking, performing other ADLs) or when agitated, when *at rest* or they do not experience shortness of breath with activity.



**Higher percentages are better for this measure. Graph depicts the most recent data in individual quarters to accurately assess response to most recent performance improvement interventions and guide upcoming action plans.*

Date range of data evaluated: *(indicated in graph above)*

- **Star Report: July 1, 2022 to June 30, 2023; KH HH Average 84%, National Average 88%**
- **SHP data; April 1, 2023 to March 31, 2024; KH Average 87%**
  - **Q2 2024 avg. dropped to 83%**

Analysis of all measures/data: (Include key findings, improvements, opportunities)
Current data from the last four quarters reflects an average of 87%, which shows an increase in the home health reported average of 84% on the Star Report but less than the National average for this measure of 88%.

- **When reviewing data for this measure it was noted that there was a significant drop in Q2 2024. Therefore, this measure requires immediate action to ensure this downward trend does not continue.**

--Accurate assessment by Home Health Clinicians, i.e. registered nurses, physical therapists, occupational therapists and speech language pathologists of the patients' respiratory status upon admission assists with early identification of respiratory needs to help reduce re-hospitalization due to respiratory compromises.
--RN Intake auditor and Educator review data from clinician charting and OASIS for inconsistencies and meet with clinician to provide immediate feedback.

<u>If improvement opportunities identified, provide action plan and expected resolution date:</u>
Our interventions are reflecting a positive upward trend towards our goals. However, the National Average also increased during this time. Opportunity for improvement continues to exist in this area to ensure we reach our goal of meeting and *exceeding* the National Average. The following plan of action shall be implemented:
--Encourage collaboration when multiple disciplines/services lines are caring for a patient to ensure clinicians utilize the "5 Day Rule" allowed by CMS. CMS encourages collaboration between all clinicians who assess a patient, within 5 days of the first OASIS assessment, to ensure positive outcomes for all patients.
--Education with scenarios will be provided at the August staff meeting to ensure understanding of the levels of dyspnea, and CMS guidance when assessing patients.
--HH RN auditor and Educator will continue to provide immediate feedback to clinicians with inconsistencies between documentation and OASIS scoring.
--Identify any trends in OASIS dyspnea scoring to ensure if additional education is needed for a specific clinician.
--Share monthly SHP scoring of this measure at discipline meetings to ensure continued engagement from staff.

<u>Next Steps/Recommendations/Outcomes:</u>
RN Intake auditor and educator will continue to monitor the effectiveness of these interventions during weekly chart audits. 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. This will ensure accurate capture of a patient's need and the opportunity to provide the resources needed to help achieve *Outstanding Community Health* consistent with the Kaweah Health District pillar.

<u>Submitted by Name:</u>	**<u>Date Submitted:</u>**
Shannon Esparza, RN	**August 2024**

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

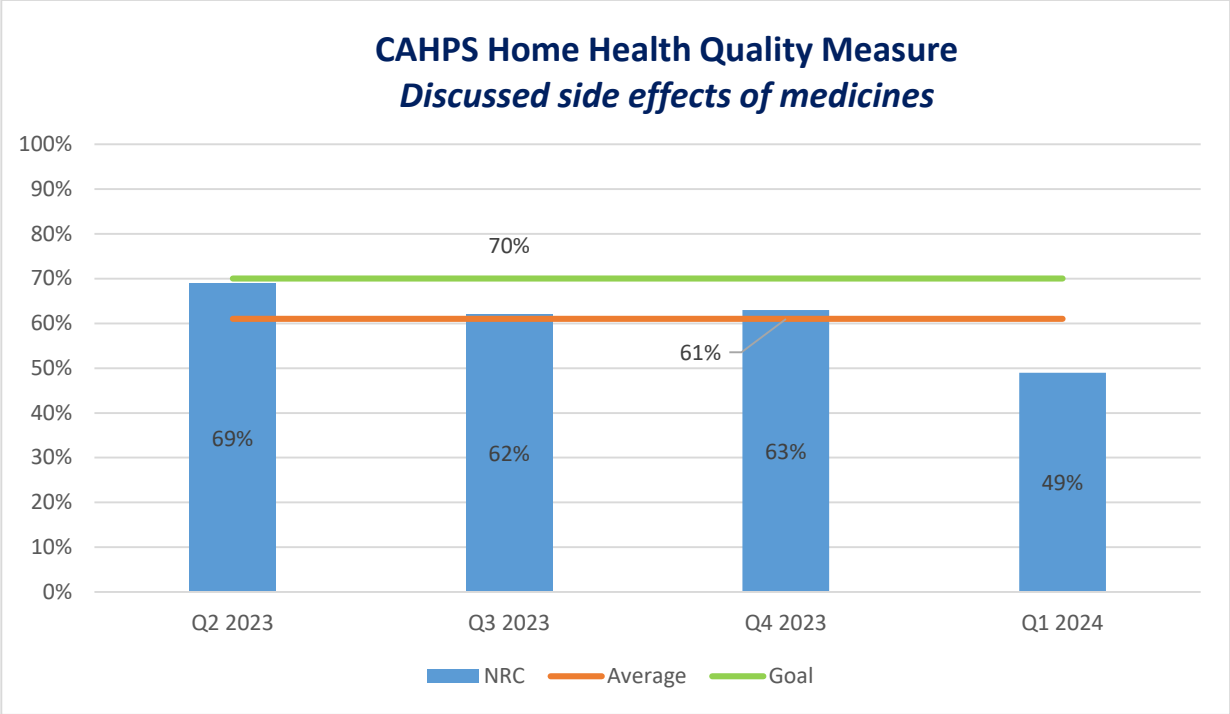
Unit/Department:
Home Health

ProStaff/QIC Report Date:
August 2024

Kaweah Health Home Health utilizes NRC, a CMS approved third-party vendor for distribution of satisfaction surveys and reporting of results. When calculating, an average of the last 4 quarters was used. By utilizing this data, the results have more current, relevant and detailed data than that reported by CMS on Home Health Care Compare. This information from NRC will eventually be submitted to CMS and will be publicly reported on the CMS Care Compare website.

Measure Objective/Goal:
Discussed side effects of medicines

- **April 1, 2023-March 31, 2024: avg. 61%**



Date range of data evaluated:
April 1, 2023-March 31, 2024

--Data is gathered from the surveys administered by a third-party vendor, as part of the Home Health CAHPS survey. Home Health Agencies are required to participate in these

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

surveys, which measures caregiver satisfaction. Information is then submitted to CMS by the third-party vendor.

Analysis of all measures/data: (Include key findings, improvements, opportunities)
--Current data from the date range shows an average score on this initiative of 61%. Q1 2024 showed a significant decrease compared to previous quarters which is why this measure was chosen. We want to ensure this drop is not the beginning of a trend and initiate action immediately.

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

--Clinician education will be provided at the August staff meeting on why we chose this measure, new interventions and goal.
--Discharge paperwork education will be provided with clinicians to ensure side effects are being reviewed one final time with patients at discharge to ensure understanding and to ensure patients are aware of their resources after discharge from home health services, i.e. their pharmacist and primary care doctor.
--Medication side effects will continue to be documented on the patient medication profile and audited during the admission process.
--Educator will call all patients discharged from home health services within two weeks of discharge to follow up on the final medication list the clinicians provide at discharge to ensure patients are aware of the side effects of their medications.
--Reinforcement of these initiatives will take place at every clinical meeting.

Next Steps/Recommendations/Outcomes:

With the interventions implemented as outlined above, we shall continue to monitor and analyze NRC data over the next 4 quarters. Due to the significant drop in Q1 2024 and the delay in reports to the NRC website (approximately 6 months), it may take at least 4 quarters before we can be assured these interventions will result in longevity of sustaining the results as outlined above.

Submitted by Name:	**Date Submitted:**
Shannon Esparza, Educator	**August 2024**

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

Home Health CAHPS

Home Health CAHPS | Dimensions Table | Questions Dashboard | Questions Table

Home Health CAHPS - Questions

Selected Period: 4/1/2023 - 6/30/2023 | Previous Period: 1/1/2023 - 3/31/2023 | Benchmark Quarter: Q2 2023

Start Date	End Date	CCN	Benchmark	Benchmark Quarter
4/1/2023	6/30/2023	All	CMS HHCAHPS 50th Percentile	Q2 2023

Dimension	Question	Previous Score	Current Score & Benchmark	Difference
Care of Patient	Problems with care through agency		96.9%	
	Providers informed re: all care/treatment		79.5%	
	Treated gently by providers		93.9%	
	Treated with courtesy/respect by providers		98.0%	
Overall Rating of Care	Rate care from home health providers		91.8% 85.0%	
Provider Communication	Days to get help/advice after calling office		76.0%	
	Got help needed when contacting agency		100.0%	
	Kept informed of provider arrival times		95.9%	
	Providers explained things understandably		89.8%	
	Providers listened carefully		92.9%	
	Told what care/services would receive		99.0%	
Specific Care Issues	Asked to see medicines you were taking		94.7%	
	Discussed purpose of new/changed meds		88.6%	
	Discussed side effects of medicines		68.6%	
	Discussed when to take medicines		78.4%	
	Talked about medicines you were taking		96.8%	
	Talked about safe home set up		90.2%	
	Talked with provider about pain		92.9%	
Would Recommend Agency	Would recommend agency		88.7% 80.0%	

nrc HEALTH Human understanding

Home Health CAHPS

Home Health CAHPS | Dimensions Table | Questions Dashboard | Questions Table

Home Health CAHPS - Questions

Selected Period: 7/1/2023 - 9/30/2023 | Previous Period: 4/1/2023 - 6/30/2023 | Benchmark Quarter: Q3 2023

Start Date	End Date	CCN	Benchmark	Benchmark Quarter
7/1/2023	9/30/2023	All	CMS HHCAHPS 50th Percentile	Q32023

Dimension	Question	Previous Score	Current Score & Benchmark	Difference
Care of Patient	Problems with care through agency		96.8%	
	Providers informed re: all care/treatment		80.2%	
	Treated gently by providers		94.7%	
	Treated with courtesy/respect by providers		98.9%	
Overall Rating of Care	Rate care from home health providers		91.5% 85.0%	
Provider Communication	Days to get help/advice after calling office		95.0%	
	Got help needed when contacting agency		95.2%	
	Kept informed of provider arrival times		88.3%	
	Providers explained things understandably		88.3%	
	Providers listened carefully		92.5%	
	Told what care/services would receive		100.0%	
Specific Care Issues	Asked to see medicines you were taking		90.4%	
	Discussed purpose of new/changed meds		88.2%	
	Discussed side effects of medicines		61.8%	
	Discussed when to take medicines		84.8%	
	Talked about medicines you were taking		95.4%	
	Talked about safe home set up		90.7%	
	Talked with provider about pain		90.5%	
Would Recommend Agency	Would recommend agency		81.3% 80.0%	

Home Health CAHPS

Home Health CAHPS | Dimensions Table | Questions Dashboard | Questions Table

Home Health CAHPS - Questions

Selected Period: 10/1/2023 - 12/31/2023 | Previous Period: 7/1/2023 - 9/30/2023 | Benchmark Quarter: Q4 2023

Start Date	End Date	CCN	Benchmark	Benchmark Quarter
10/1/2023	12/31/2023	All	CMS HHCAHPS 50th Percentile	Q4 2023

Dimension	Question	Previous Score	Current Score & Benchmark	Difference
Care of Patient	Problems with care through agency		100.0%	
	Providers informed re: all care/treatment		76.6%	
	Treated gently by providers		94.0%	
	Treated with courtesy/respect by providers		96.3%	
Overall Rating of Care	Rate care from home health providers		90.1% 85.0%	
Provider Communication	Days to get help/advice after calling office		72.4%	
	Got help needed when contacting agency		100.0%	
	Kept informed of provider arrival times		79.5%	
	Providers explained things understandably		80.2%	
	Providers listened carefully		91.4%	
	Told what care/services would receive		97.5%	
Specific Care Issues	Asked to see medicines you were taking		88.5%	
	Discussed purpose of new/changed meds		77.8%	
	Discussed side effects of medicines		62.9%	
	Discussed when to take medicines		77.1%	
	Talked about medicines you were taking		93.8%	
	Talked about safe home set up		86.1%	
	Talked with provider about pain		96.4%	
Would Recommend Agency	Would recommend agency		85.5% 80.0%	

Home Health CAHPS

Home Health CAHPS | Dimensions Table | Questions Dashboard | Questions Table

Home Health CAHPS - Questions

Selected Period: 1/1/2024 - 3/31/2024 | Previous Period: 10/1/2023 - 12/31/2023 | Benchmark Quarter: Q1 2024

Start Date	End Date	CCN	Benchmark	Benchmark Quarter
1/1/2024	3/31/2024	All	CMS HHCAHPS 50th Percentile	Q1 2024

Dimension	Question	Previous Score	Current Score & Benchmark	Difference
Care of Patient	Problems with care through agency		86.4%	
	Providers informed re: all care/treatment		74.3%	
	Treated gently by providers		91.2%	
	Treated with courtesy/respect by providers		94.6%	
Overall Rating of Care	Rate care from home health providers		88.2% 86.0%	
Provider Communication	Days to get help/advice after calling office		94.7%	
	Got help needed when contacting agency		91.7%	
	Kept informed of provider arrival times		75.9%	
	Providers explained things understandably		84.4%	
	Providers listened carefully		85.5%	
	Told what care/services would receive		95.2%	
Specific Care Issues	Asked to see medicines you were taking		87.9%	
	Discussed purpose of new/changed meds		76.1%	
	Discussed side effects of medicines		48.9%	
	Discussed when to take medicines		60.9%	
	Talked about medicines you were taking		92.0%	
	Talked about safe home set up		84.6%	
	Talked with provider about pain		92.8%	
Would Recommend Agency	Would recommend agency		87.5% 80.0%	

Home Health CAHPS

Home Health CAHPS | Dimensions Table | Questions Dashboard | Questions Table

Home Health CAHPS - Questions

Selected Period: 4/1/2023 - 6/30/2023 | Previous Period: 1/1/2023 - 3/31/2023 | Benchmark Quarter: Q2 2023

Start Date	End Date	CCN	Benchmark	Benchmark Quarter
4/1/2023	6/30/2023	All	CMS HHCAHPS 50th Percentile	Q2 2023

Dimension	Question	Previous Score	Current Score & Benchmark	Difference
Care of Patient	Problems with care through agency		86.9%	
	Providers informed re: all care/treatment		79.5%	
	Treated gently by providers		93.9%	
	Treated with courtesy/respect by providers		98.0%	
Overall Rating of Care	Rate care from home health providers		91.8% 85.0%	
Provider Communication	Days to get help/advice after calling office		76.0%	
	Got help needed when contacting agency		100.0%	
	Kept informed of provider arrival times		95.9%	
	Providers explained things understandably		89.8%	
	Providers listened carefully		92.9%	
	Told what care/services would receive		99.0%	
Specific Care Issues	Asked to see medicines you were taking		94.7%	
	Discussed purpose of new/changed meds		88.6%	
	Discussed side effects of medicines		68.6%	
	Discussed when to take medicines		78.4%	
	Talked about medicines you were taking		96.8%	
	Talked about safe home set up		90.2%	
	Talked with provider about pain		92.9%	
Would Recommend Agency	Would recommend agency		88.7% 80.0%	

OASIS-BASED Measures [1]

Process Measures

(REPORTING PERIOD: 07/01/2022 - 06/30/2023)

Measure Name	Agency Average % [2]	State Average % [3]	National Average %
Timely Initiation of Care	98.53	94.54	96.11
Influenza Immunization Rec'd For Current Flu Season	72.43	76.82	72.75
Drug Regimen Review Conducted with Follow-up for Identified Issues	86.72	93.14	95.21
Percent of Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function	98.93	98.61	98.55

End Result Outcome Measures

(REPORTING PERIOD: 07/01/2022 - 06/30/2023)

Measure Name	Agency Average % [2]	State Average % [3]	National Average %
Improvement in Bathing	84.98	86.29	87.96
Improvement in Bed Transfer	85.29	82.79	87.08
Improvement in Ambulation/Locomotion	78.37	83.01	86.06
Improvement in Management of Oral Medications	78.31	80.63	84.16
Improvement in Dyspnea	84.00	88.16	88.30
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	0.88	0.31	0.30
Percent of Patients Experiencing One or More Falls with Major Injury	0.49	0.60	0.93

How often patients got better at getting in and out of bed

Higher percentages are better

85.3%
National average: 87.1%
California average: 82.8%

This measure was included in the quality star rating calculation.

How often patients got better at bathing

Higher percentages are better

85%
National average: 88%
California average: 86.3%

This measure was included in the quality star rating calculation.

How often a patient's functional abilities were assessed at admission and discharge and functional goals were included in their care plan

Higher percentages are better

98.9%
National average: 98.6%
California average: 98.6%

Treating symptoms

How often patients' breathing improved

Higher percentages are better

84%
National average: 88.3%
California average: 88.2%

This measure was included in the quality star rating calculation.

Outcome	Group By	Eligible Episodes	Count	Observed Score
Improvement in Dyspnea	SHP National	4,918,335	4,504,673	91.6%
Improvement in Dyspnea	SHP State (CA)	381,638	343,451	90.0%
Improvement in Dyspnea	Kaweah Health Home Health	1,038	903	87.0%
Improvement in Dyspnea	April 2023	57	47	82.5%
Improvement in Dyspnea	May 2023	63	53	84.1%
Improvement in Dyspnea	June 2023	53	44	83.0%
Improvement in Dyspnea	July 2023	43	38	88.4%
Improvement in Dyspnea	August 2023	67	57	85.1%
Improvement in Dyspnea	September 2023	67	63	94.0%
Improvement in Dyspnea	October 2023	71	66	93.0%
Improvement in Dyspnea	November 2023	103	94	91.3%
Improvement in Dyspnea	December 2023	71	59	83.1%
Improvement in Dyspnea	January 2024	80	66	82.5%
Improvement in Dyspnea	February 2024	74	69	93.2%
Improvement in Dyspnea	March 2024	93	85	91.4%
Improvement in Dyspnea	April 2024	68	57	83.8%
Improvement in Dyspnea	May 2024	73	60	82.2%
Improvement in Dyspnea	June 2024	55	45	81.8%

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

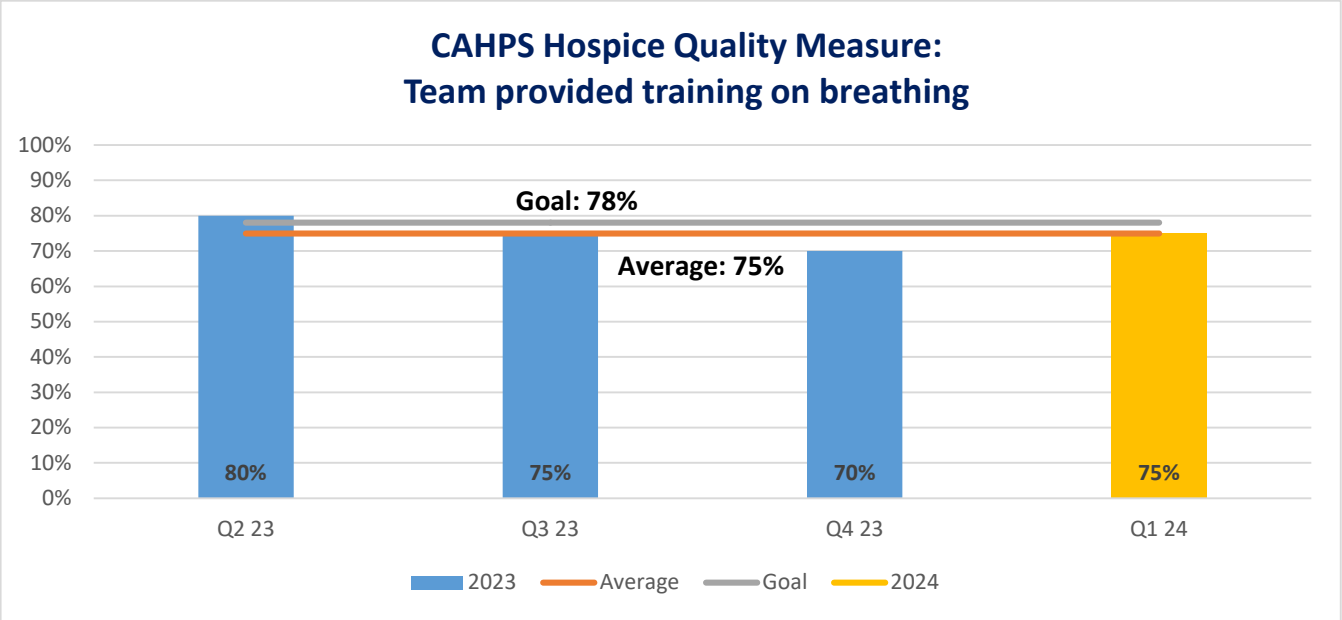
Unit/Department:
Hospice

Date submitted:
August 2024

Kaweah Health Hospice utilizes NRC, a CMS approved third party vendor for distribution of satisfaction surveys and reporting of results. When calculating, an average of the last 4 quarters was used. By utilizing this data, the results have more current, relevant and detailed data than that reported by CMS on Hospice Compare. This information from NRC will eventually be submitted to CMS and will be publicly reported.

Measure Objective/Goal:
Team provided training on breathing

- **Average of Quarters April 1, 2023-March 31, 2024: 75%**



Date range of data evaluated:
April 1, 2023-March 31, 2024

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

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

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

-- Current data from the date range shows an average score on this initiative of 75%. The NRC benchmark is 77.2%. In addition to being below the NRC benchmark, we also had a significant drop from our previous score of 88.6% on this item. While we do understand breathing at end of life may be labored, agonal or shallow, ensuring we educate families on the variances, what they may present as and explaining the "normalcy" of this is paramount in emotionally supporting these families through this challenging time. Additionally, we want to ensure they understand the importance of appropriately medicating the patient during this time to ensure comfort.

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

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

--Explore resources available in Lippincott that could be used to develop a handout to be given to families upon admission to Hospice. Verbal education can be provided, but many times families are overwhelmed at this time and may not retain verbal instructions. Written material could be used to reinforce later or for families to reference.
--Enlist the help of Hospice UBC to develop handout and education plan for families related to this initiative.
--Reinforce/remind staff about ensuring time is taken to explain and train families on the importance of variations in breathing at end of life and medications utilized to provide comfort to patient.
--Reinforcement of these initiatives will take place at every Hospice skilled nursing meeting and feedback received from staff for any adjustments that should be made to the improvement plan.

Next Steps/Recommendations/Outcomes:

Once initiatives are implemented, we shall continue to monitor and analyze vendor data over next 4 quarters. Due to the lag time in these reports (approximately 6 months), it may take at least 4 quarters before results of the above-outlined plan are shown. The goal will be 78%.

Submitted by Name:
Tiffany Bullock, Director
Kaweah Health Hospice

Date Submitted:
August 2024

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

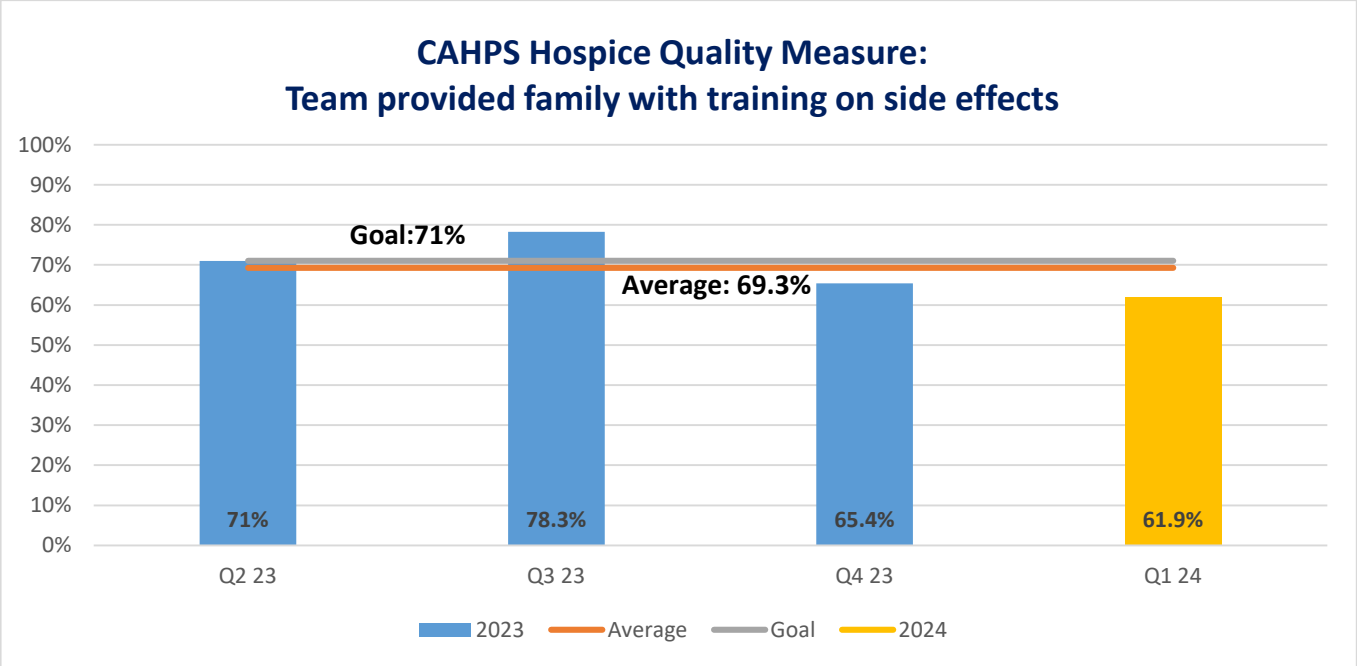
Unit/Department:
Hospice

Date submitted:
August 2024

Kaweah Health Hospice utilizes NRC, a CMS approved third party vendor for distribution of satisfaction surveys and reporting of results. When calculating, an average of the last 4 quarters was used. By utilizing this data, the results have more current, relevant and detailed data than that reported by CMS on Hospice Compare. This information from NRC will eventually be submitted to CMS and will be publicly reported.

Measure Objective/Goal:
Team provided family with training on side effects

- **Average of Quarters April 1, 2023-March 31, 2024: 69.3%**



Date range of data evaluated:
April 1, 2023-March 31, 2024

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

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

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

-- Current data from the date range shows an average score on this initiative of 69.3%. The NRC benchmark is 69.3%. While this is barely meeting the average, more importantly this initiative was chosen due to a decrease of over 6 points from the previous score of 76%. Ensuring retention with family members on medication side effects if important in any realm, but especially important in hospice. The goal of hospice is to provide comfort at end of life. Managing untoward side effects is key to that goal. Additionally, educating families on some side effects that might actually be expected but unavoidable will help families.

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

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

--Reinforce/remind staff about ensuring time is taken to explain and train families on side effects of medications and when to report to hospice nurse.
--Common side effects to be written on medication list left in patient's home by hospice nurse.
--Reinforcement of these initiatives will take place at every Hospice skilled nursing meeting and feedback received from staff for any adjustments that should be made to the improvement plan.

Next Steps/Recommendations/Outcomes:

Once initiatives are implemented, we shall continue to monitor and analyze vendor data over next 4 quarters. Due to the lag time in these reports (approximately 6 months), it may take at least 4 quarters before results of the above-outlined plan are shown. The goal will be 71%.

Submitted by Name:
Tiffany Bullock, Director
Kaweah Health Hospice

Date Submitted:
August 2024

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

Trauma Department

August 2024

Summary Information

Trauma Quality Improvement Program (TQIP) Report

- Spring 2024 Benchmark Report
  - Data dates: October 2022 – Sept 2023
- All level III Trauma centers in the United States
  - 205 TQIP centers
- 97,728 patients included in this report (All patients)
  - 1,425 Kaweah Trauma patients
- May 2024 - Successful Reverification Survey

Hospital Registry

Year	Case Volume	% Change
2021	2,969	24.1%
2022	2,988	0.64%
2023	3,245	8.60%
2024	2,292 (Jan-Aug)	10.0% (YTD)

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TQIP Mortality

II. Risk-Adjusted Mortality

Expected rates are estimated based on statistical models and take into account the risk profile of patients cared for in your center. The TQIP Average column displays summaries based on data from all TQIP hospitals and can be used as a point of reference for your center-specific results.

Observed rates and expected rates shown below can only be used to approximate the odds ratio due to model factors which account for risk-factor effects, sample size, data transformations, and outcome variability.

Table 2: Risk-Adjusted Mortality by Cohort

	Patients	Mortality				Odds Ratio and 90% Confidence Interval				
Cohort	N	Observed Events	Observed (%)	Expected (%)	TQIP Average (%)	Odds Ratio	Lower	Upper	Outlier	Decile
All Patients	1,040	78	7.5	5.9	3.8	1.63	1.23	2.15	High	10
Elderly	411	35	8.5	5.8	4.6	1.67	1.19	2.34	High	10
Isolated Hip Fracture	174	5	2.9	2.7	3.3	1.02	0.64	1.61	Average	6

TQIP Mortality

Opportunity

- TQIP is the Trauma Quality Improvement Program part of the American College of Surgeons. They look at the mortality rate for our patients in three areas: all patients, > 65 years old, and isolated hip fractures.

- Since our last TQIP report, Our mortality rates have increased according to our TQIP report.

Solution

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

- We are working with EMS to ensure they bring in appropriate patients. The EMS agency has a policy for their staff that states which patients should be brought to the facility and those that stay at the scene. When we find questionable cases such patients that are deceased or have nonsurvivable injuries, we send them to the EMS agency for review. The ask is for them to provide re-education to the EMS providers involved.

- Bi-Monthly staff education with the trauma registrars. Covering audits, NTDB definitions, and general questions. This has helped in the past in increasing the coding of injuries in our registry. The higher the injury severity number the increased likelihood of mortality.

- Autopsy reports from our coroner's office. (We have reconnected with Tulare County as they transitioned to a new group). This connection allows us to code injuries that were not captured previously for the patient.

Measures

- We will use the bi-annual TQIP Mortality report for our data. (See previous slide for TQIP Mortalities).

Next Steps

We will continue our monthly mortality reviews and follow up with identified educational opportunities.

All mortalities are reviewed at our Trauma Performance Improvement Patient Safety (PIPS) meeting every month.

Door to Transfer

Early transfer is defined as ED or hospital transfers out of your institution occurring within 12 hours from ED/hospital arrival.

The TQIP Average column displays summaries based on data from all TQIP hospitals and can be used as a point of reference for your center-specific results.

Table 5: Risk-Adjusted Average Time to Transfer

	Patients	Average Time to Transfer (minutes)			Difference from TQIP Average (minutes) and 95% Confidence Interval				
Cohort	N	Observed	Expected	TQIP Average	Difference	Lower	Upper	Outlier	Decile
Early Transfer	211	152	130	144	22	10	36	High	8

Opportunity

Transferring Trauma patients for a higher level of care on average for our facility is observed to be 22 min on average longer than TQIP expects to transfer a patient. (Previous TQIP report we were observed 27 min on average longer, 5 min improvement)

Solution

Completed items: Early Recognition, Transfer Algorithm, and Monthly Dashboard

Transfer destination list: Creating a comprehensive transfer destination list and ranking trauma centers in California from closest to farthest made a significant impact. The tool empowers our transfer center nurses with a clear roadmap for efficient patient transfers.

Transfer guidelines: Transfer center leadership is finalizing transfer call center guidelines so that staff understand patient transfer expectations.

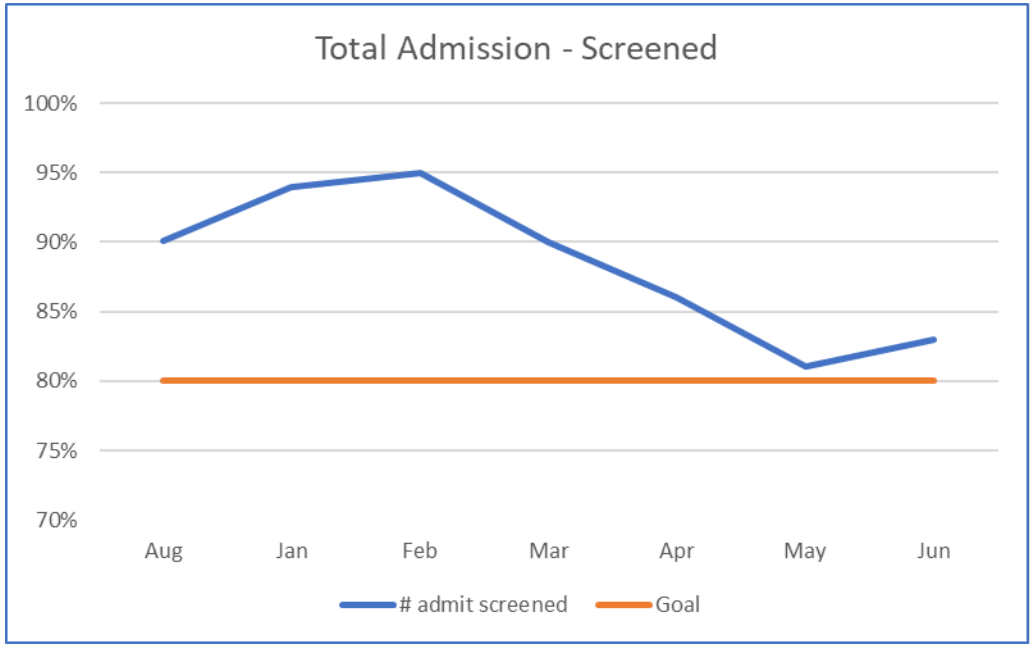
Measures

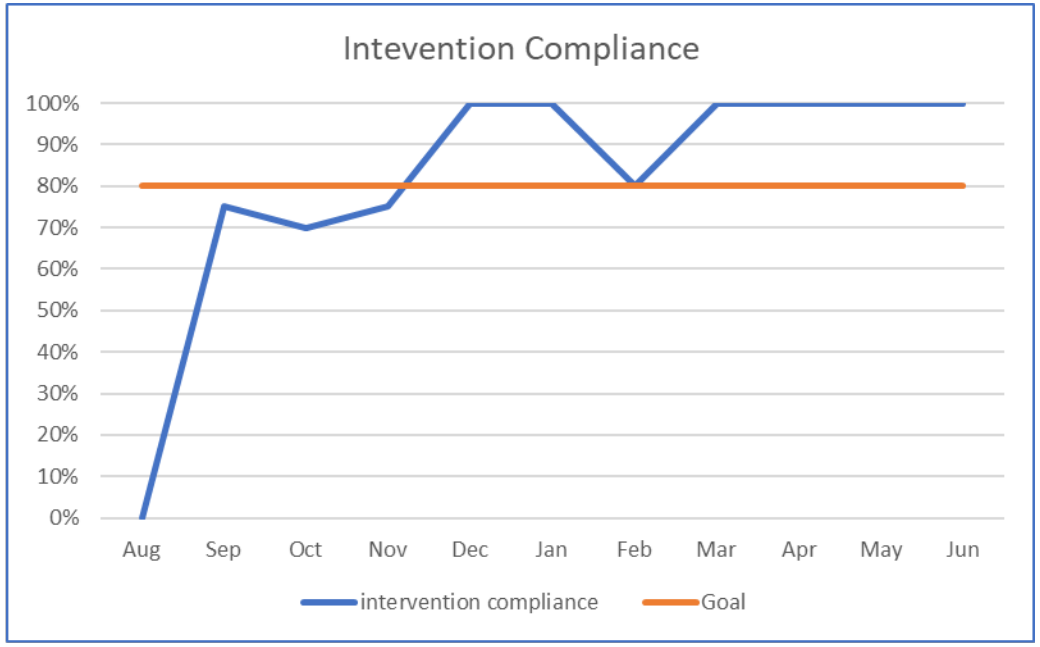
We utilize our trauma registry program to measure the time from the patient's arrival to departure. We are required by the ACS to monitor all transfers out of our facility.

Next Steps

A thorough review of the 211 charts that TQIP has identified as transfer cases. This review will focus on data abstraction and delays in initiating transfers.

SBIRT – Screening, Brief Intervention and Referral to Treatment





SBIRT is the process of screening patients for alcohol abuse utilizing our CAGE (Cut, Annoyed, Guilty, and Eye) questionnaire and providing them with referrals for treatment in the event they have positive screen results.

SBIRT

Opportunity

During our last review, it was identified that we did not have a process for identifying patients who suffer from alcohol abuse and referral for treatment when they are identified.

Solution

EMR: The CAGE questionnaire triggers a task for PFS to provide a referral for treatment. (Completed)

Education: Registrar education on where to find alcohol screening in the inpatient units. (Ongoing)

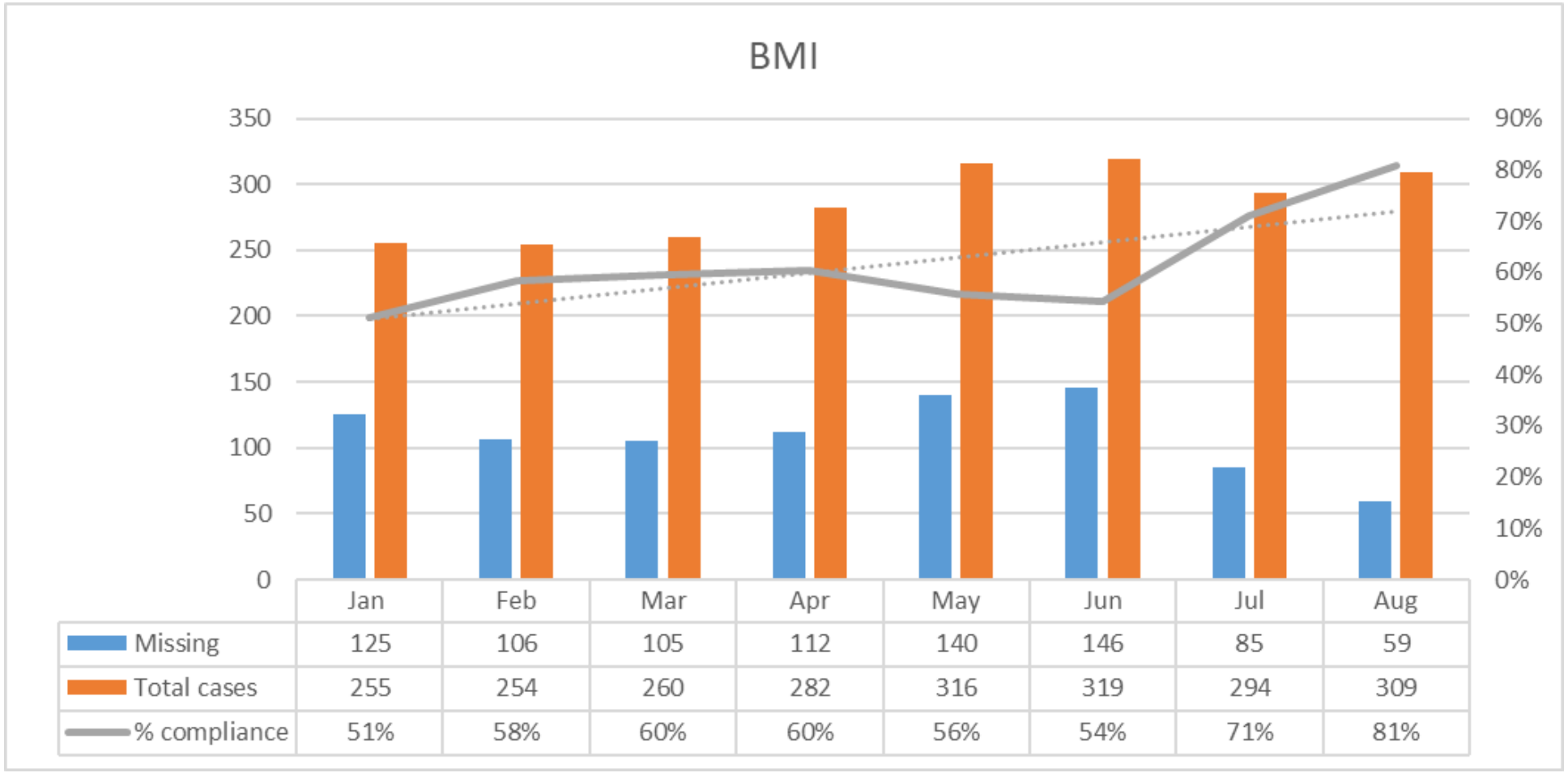
Measures

The process for measurement occurs through the Digital Innovation trauma registry program . Registrars extract this information and input it into our system. Reviewed monthly by Trauma Program Director.

Next Steps

Since November 2023, we have been monitoring the progress of this change and have achieved over 80% compliance. We will continue to monitor this change for further improvement opportunities and move on to other Performance improvement projects.

Body Mass Index



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Missing	125	106	105	112	140	146	85	59
Total cases	255	254	260	282	316	319	294	309
% compliance	51%	58%	60%	60%	56%	54%	71%	81%

BMI

Opportunity

The lack of documentation of patients' height and weight affects care in many ways. Some examples include anesthesia for surgery, antibiotics, vent settings, nutrition, etc.

Solution

Education: Emergency Department education was sent out on 3/2/23 via daily huddle.

EMR: Task added to every patient that comes to the ED on 5/3/23.

Equipment: Tape measures and scales were added to the ED on 6/2023.

Measures

The measurement process is through our DI registry system. Registrars extract this information and input it into the system, reviewed by Trauma Program Director monthly.

Next Steps

EMR: ISS is working on pulling height from previous visits to help increase compliance. Completed July 2024.

Trauma Flowsheet: Add a spot on the written trauma flowsheet for height and weight. Weight: Approval from forms committee.

August 2024 compliance is 80%

Community Outreach

		Patients	Mechanism							
Cohort	Group	N	Fall (%)	MVT Occupant and Other (%)	MVT Motorcyclist (%)	Pedestrian/ Pedal (%)	Struck by/ Against (%)	Firearm (%)	Cut/ Pierce (%)	Other (%)
All Patients	All Hospitals	60,261	70.5	12.6	2.0	3.6	3.8	1.7	1.4	4.5
	Your Hospital	1,040	47.8	27.1	3.0	7.2	3.7	4.4	4.2	2.6

As an ACS-verified trauma center, we must perform community prevention activities based on the mechanism of injuries we see in our program registry.

Our new TQIP report Identified a few areas we will focus on in 2024.

Kaweah Health Community Outreach team members perform fall prevention activities.

We will review the pedestrian accidents and look for patterns or opportunities throughout our community. We plan to attend the back-to-school event at the Visalia Rescue Mission and speak to kids about pedestrian safety along with water safety.

2024 – Reverification

Non-Compliant Standards

Standard	Non-Compliant Standards	Comments	Corrective action	Involved with Compliance	Date completed	Measurement of Compliance
4.31	Trauma Registry Staffing Req.	Optimal Mx of registry entries 1.0 FTE per 600	Hired new registrar	Director of Trauma/ Trauma Medical Director	March 2025	Registrars and registry volumes
7.6	Trauma Multidisciplinary PIPS committee Attendance	Minimal attendance req is 50% per liaison. Neuro and trauma fallout	6 months of tracking	Director of Trauma/ Trauma Medical Director	March 2025	PIPS attendace Aug - Jan25
7.7	Trauma Mortality Review	PIPS mortality review do not indicate significant discussion concerning care rendered and alternative methods for the care of patients that may have improved outcomes.	Document and increase mortality dicussion next 6 months	Director of Trauma/ Trauma Medical Director	March 2025	Document Mortality discussions - PIPS

2024 – Reverification

Weaknesses in Standards

Standard	Opportunities for Improvement	Comments	Corrective action	Involved with Compliance	Date completed	Measurement of Compliance
3.1	Operating Room Availability	The policy for OR staffing should include the expectation that staffing, and a room must be available within 30 min of notification in trauma cases where this is required. Currently, there is no such expectation.	Policy change	Director of Surgical Services		Policy Change SS 2018 Staffing for the OR
3.3	Operating Room for Orthopaedic Trauma Care	There is no dedicated block time for ortho trauma cases. This leads to half of trauma ortho cases completed beyond the 24-hour goal. Rec: Create dedicated block time for ortho trauma	Dedicated ortho trauma block	Director of Surgical Services	Sept 2024	Creation of block time/ OR schudule
3.4	Blood Products	The critical nature of blood availability requires attention. Possibly another vender.	Monitor blood utilization and supply	Blood Bank		Steps taken to increase blood. 2025-2026
4.11	Orthopaedic Trauma Care	The ortho trauma service has a concerning low percentage of hip and femur fx operative fixation within 24 hrs.	Creation of block time and hiring of trauma fellowship trained ortho surgeons woud help remedy these issues.	Director of Surgical Services	Sept 2024	List of surgeons. Block schedule. Monitor rates of fixation.
4.35	Performance Improvement staffing req.	OFI: Standard 4.35 requires "at least" 1 FTE for trauma volumes greater than 1,000 annually. KHMC's volume of over 3,000 patients annually presents a significant challenge to their single PI nurse.	It is highly recommended that the center consider hiring an additional PI nurse(s).	Director of Trauma/ Trauma Medical Director		PI staffing
5.1	Clinical Practice Guidelines	The practice guidelines are limited in number, with some notable absences (solid organ injury) and one outdated guideline (high frequency oscillating ventilation)	The guidelines should be updated to reflect the issues listed in the OFI.	Director of Trauma/ Trauma Medical Director		Solid Organ Injury, etc.
5.3	Levels of Trauma Activation	With only two levels for trauma activations, an unnecessary burden of minor trauma evaluation and management is allocated to trauma services.	An additional third tier of trauma activations for patients with less significant injury would allow Trauma Services to concentrate their efforts on the significantly injured patients.	Director of Trauma/ Trauma Medical Director		3 tier system
5.13	Decision to Transfer	A large number of orthopedic patients are transferred out, many of who were never seen by an orthopedic surgeon.	Increase the number of trauma fellowship trained ortho surgeons	Orthopedic Service line	Sept 2024	Ortho recruitment. Decrease # of transfers
7.3	Documented Effectiveness of the PIPS program	While some of the issues identified at PI lead to changes within the trauma program and the hospital in general, potentially important issues were frequently missed.	PI should be more in-depth and critical, and with more of these cases reviewed at the tertiary level to identify both patient care and system issues.	Director of Trauma/ Trauma Medical Director		PI documentation
7.5	Physician Participation in Prehospital Performance Improvement	Provided documents include the EMS "Spinal Immobilization" protocol which was last revised nine years ago and uses terminology (spinal immobilization) which is not consistent with current nomenclature (spine motion restriction). This was evident in other protocols as well.	The trauma center's involvement with EMS should encourage appropriate timely reviews of standing protocols.	Director of Trauma/ Trauma Medical Director		Spinal Immobilization

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Outstanding Health Outcomes (OHO)
QUALITY & PATIENT SAFETY PRIORITY

Healthcare Acquired Infection (HAI) Reduction

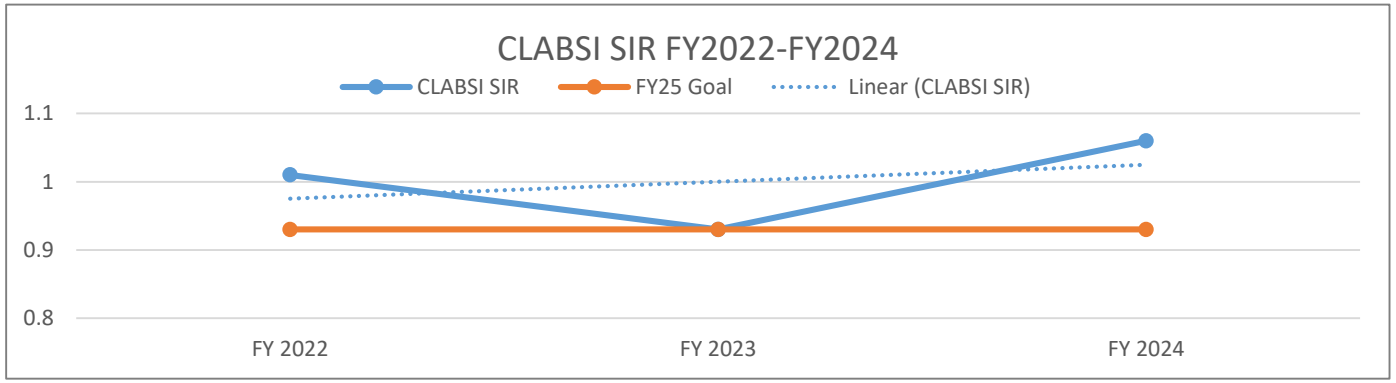
September 2024

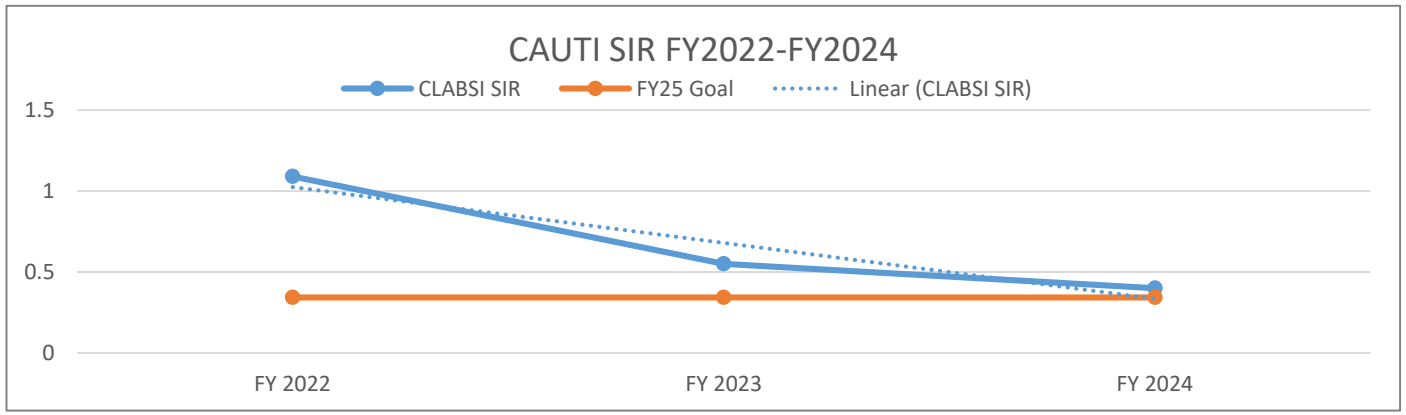
OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

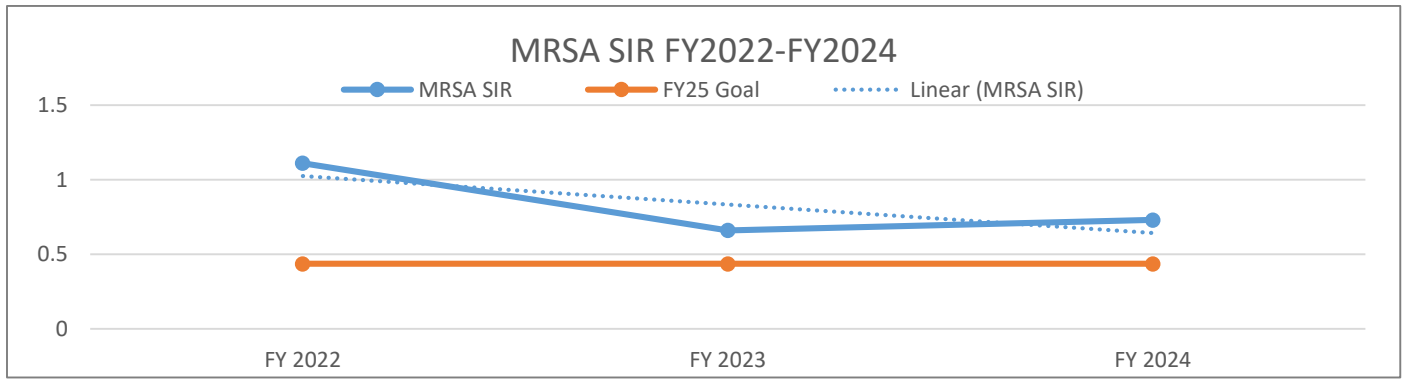
(number of actual infections/number of predicted infections by CMS)

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

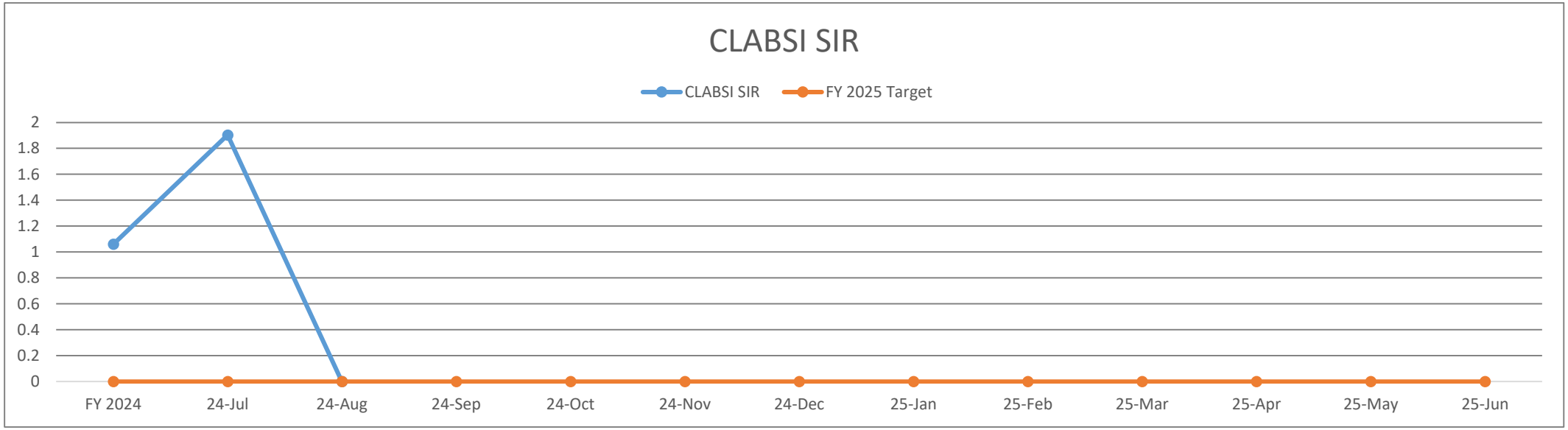
High Level Action Plan

- 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

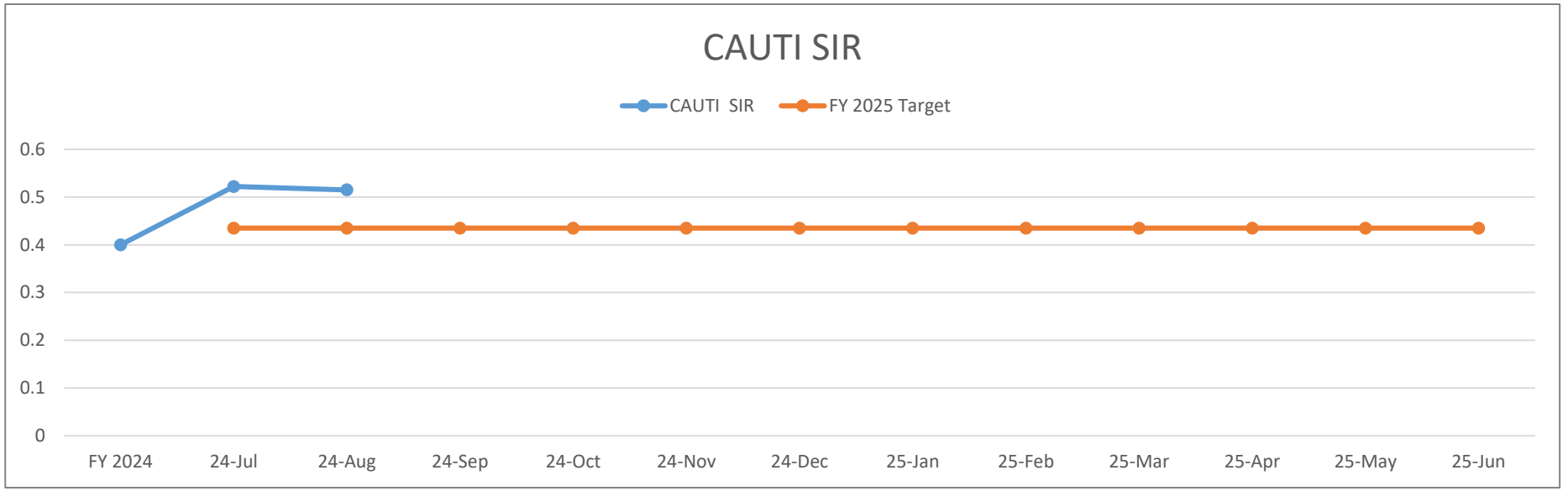
Decrease: CLABSI SIR to <0.92; CAUTI SIR to < 0.341; MRSA <0.434

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



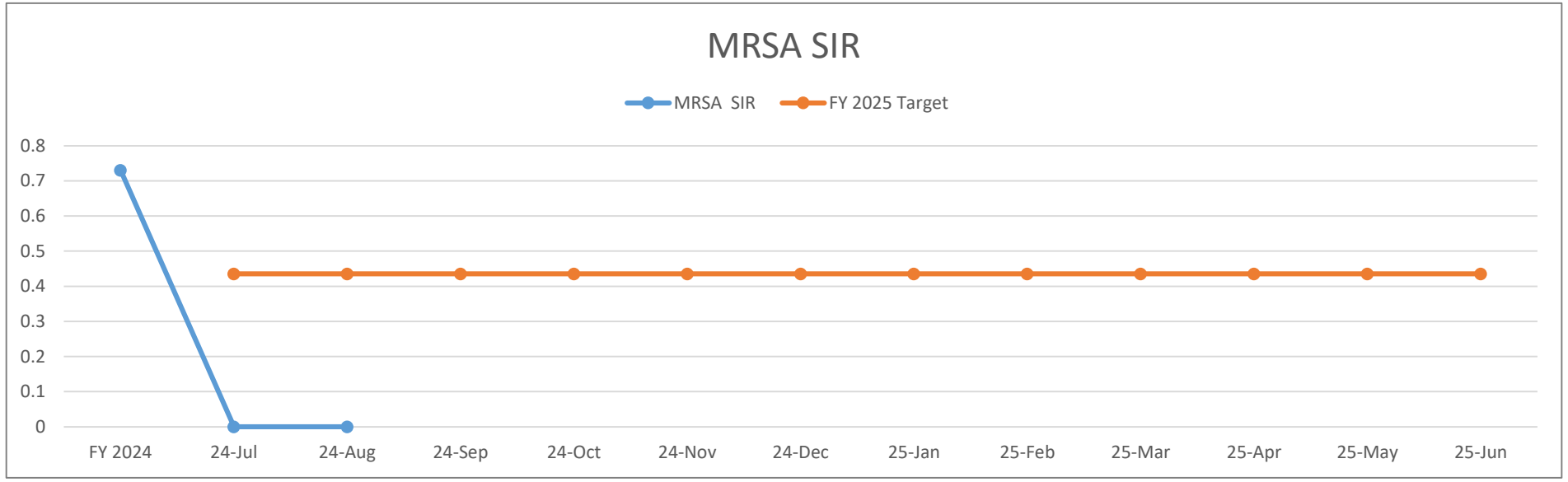
	FY 2025 Target	FY 2024	24-Jul	24-Aug	24-Sep	24-Oct	24-Nov	24-Dec	25-Jan	25-Feb	25-Mar	25-Apr	25-May	25-Jun	FYTD 25
CLABSI Events		17	2	0											**2**
CLABSI Predicted Events		16.06	1.051	1.117											2.168
CLABSI SIR	<0.93	1.06	1.903	0											0.92

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											2
CAUTI Predicted Events		22.58	1.917	1.94											3.857
CAUTI SIR	<0.342	0.4	0.522	0.515											0.52

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											0
MRSA Predicted Events		9	9	9.62	0.75	0.69											1.44
MRSA SIR	<0.435	1.11 Ex COVID	0.66 Ex COVID	0.73	0	0											0

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 <0.93
  - July-Aug 2024 0.60
  - Goal: reduce urinary catheter ratio to <0.64
  - July-Aug 2024 0.52
- 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-Aug 2024 47% of staff are active users
- 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)
  - Data pending

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	10/31/24	None
Unit/dept recognition program for positive reinforcement for use of BioVigil system	Ongoing	None
Focused discussions with leaders of low performing units in BioVigil to understand challenges that will be addressed	11/30/24	None
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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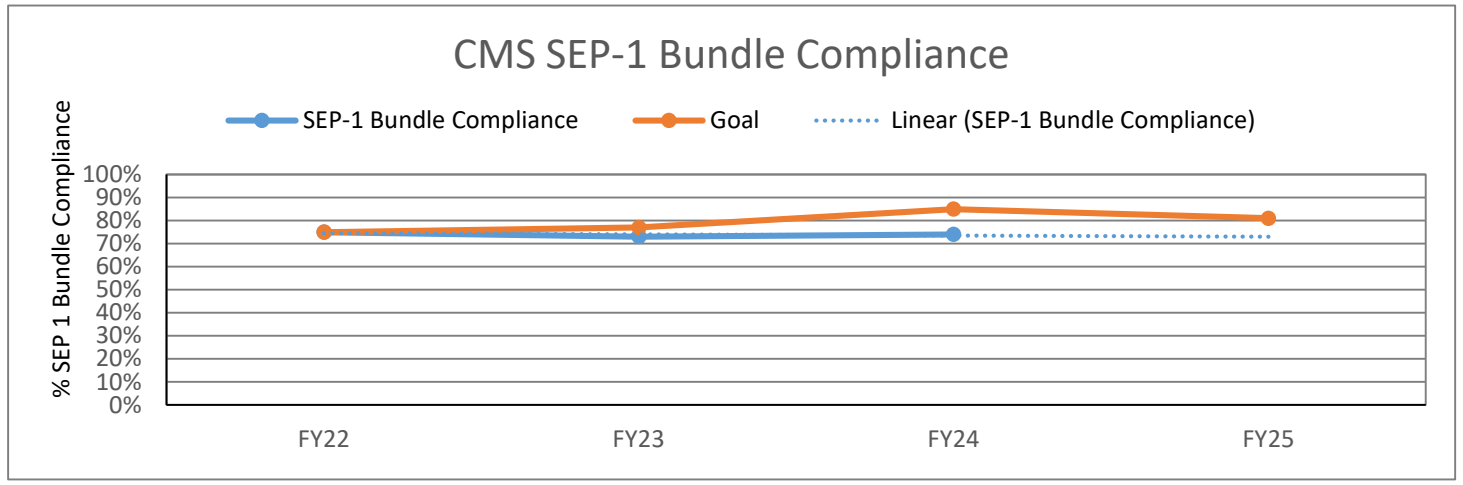
Outstanding Health Outcomes (OHO)
QUALITY & PATIENT SAFETY PRIORITY

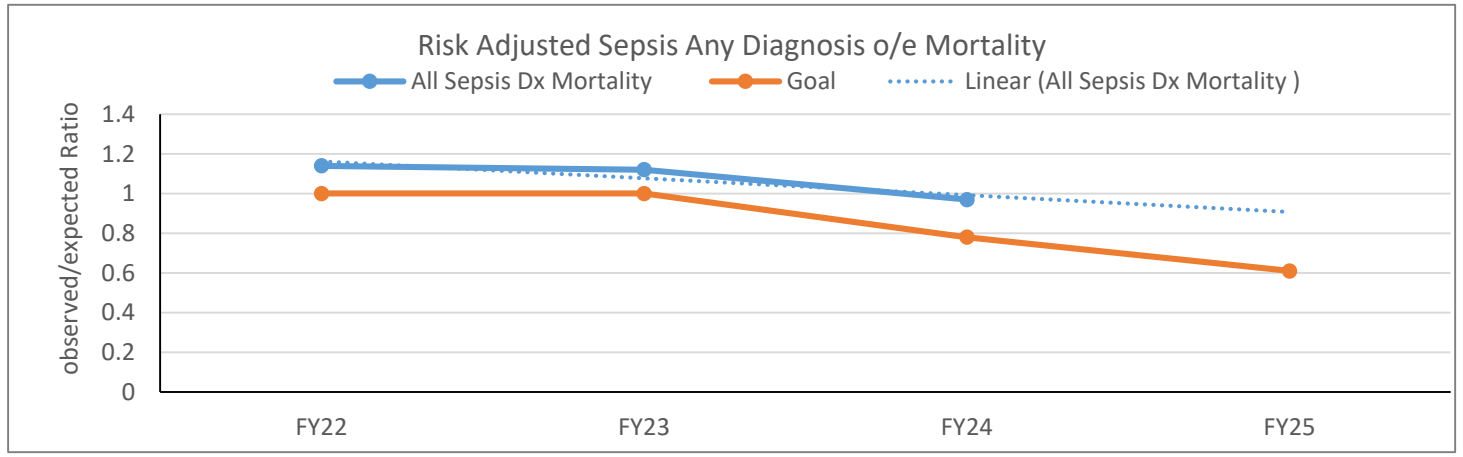
Sepsis CMS SEP-1 & Sepsis Mortality

October 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

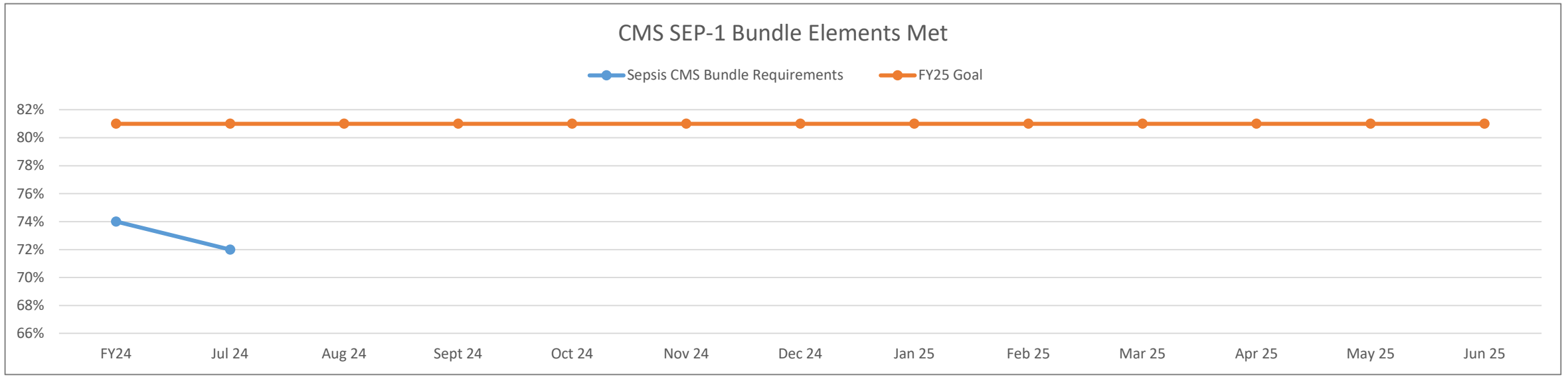
- Provide Early Goal Directed Therapy (Sepsis work up and Treatment)

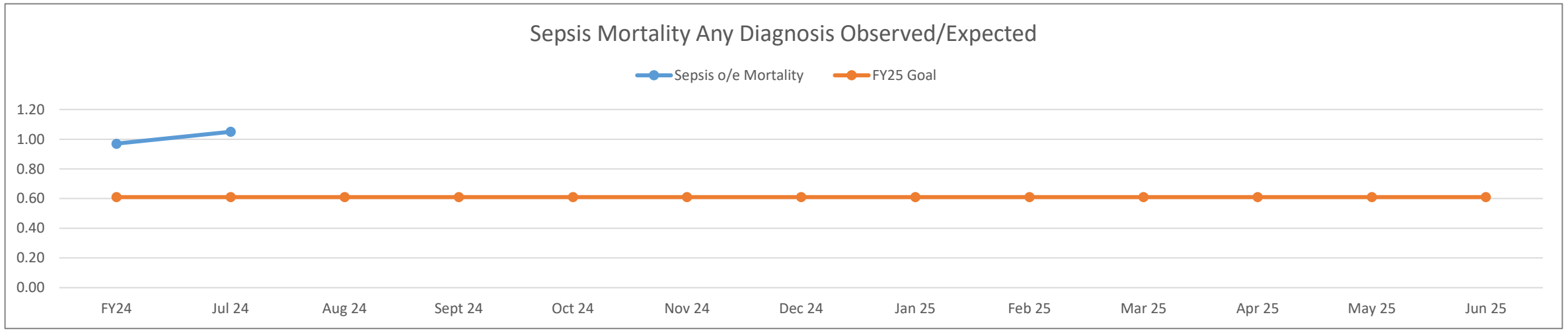
  % of Patients provided top 3 most frequently missed Sepsis bundle elements

  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 = under review

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

Targeted Opportunities

- Provide Early Goal Directed Therapy (Sepsis work up and Treatment)
    - **FY25 performance has not resulted yet, updated provided in October update**
    - % of Patients provided top 3 most frequently missed Sepsis bundle elements at KH
    - IV Fluid Resuscitation
    - Antibiotic Administered
    - Blood Cultures collection
    - Goal = new FY goals to be determined at 9/23/24 Sepsis Committee Meeting
- Provide Early Goal Directed Therapy (Sepsis Treatment)
    - **FY25 performance has not resulted yet, updated provided in October update**
    - Pts with Sepsis that Received Abx within 60 Minutes of Pt 1st Seen
    - Pts Met 1- Hr Bundle
    - Goal = new FY goals to be determined at 9/23/24 Sepsis Committee Meeting

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	One session June 2024	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 October 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
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	11/2024	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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