KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
QUALITY COUNCIL

Thursday, June 20, 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; Tom Gray 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;*
   - **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 May 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 May 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. **Leapfrog Fall 2024 Safety Score Review Report**
    - 4.2. **Renal Services – Network 18 Quality Report**
    - 4.3. **Subacute Quality Report**
    - 4.4. **Trauma Services Quality Report**
    - 4.5. **Health Equity Quality Report**

5. **Hand Hygiene Report –** A review of current performance and actions focused on the clinical goal for Hand Hygiene. *Shawn Elkin, Infection Prevention Manager.*

6. **Value Based Purchasing –** A review of completed and planned initiatives to identify and address Value Based Purchasing. *Erika Pineda, Quality Improvement Manager*.

7. **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.*

8. **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

Leapfrog Spring 2024 Safety Grade

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

May 2024

KH Leapfrog Spring 2024 Safety Grade

Kaweah Health

Hospital Grade SPRING 2024: C

KH Leapfrog Spring Score Compared to Past

Kaweah Health Spring 2024 Leapfrog Safety Grade (May 2024)

Measure Domain	Measure	Data Date Range	Kaweah Health Spring 2024 Scores	Mean	Final Weight (N/A redistributes)	KH Fall 2023 Score	Fall 2023 NATIONAL Mean	KH Spring 2023 Score	Spring 2023 NATIONAL Mean
Process/Structural Measures (higher is better)	Computerized Physician Order Entry (CPOE)	June 2023	100	91.81	5.6%	100	90.56	100	91.70
	Bar Code Medication Administration (BCMA)	June 2023	100	93.42	5.4%	100	92.65	100	91.21
	ICU Physician Staffing (IPS)	June 2023	100	63.29	7.2%	100	62.23	100	67.49
	Safe Practice 1: Culture of Leadership Structures and Systems	June 2023	120.00	117.59	3.2%	110.77	117.46	120.00	116.82
	Safe Practice 2: Culture Measurement, Feedback, & Intervention	June 2023	110.00	117.08	3.3%	110.00	115.71	120.00	115.77
	Total Nursing Care Hours per Patient Day	June 2023	100	74.69	4.9%	100	70.88	100.00	98.06
	Hand Hygiene	June 2023	40	78.65	4.7%	40	77.29	40	71.62
	H-COMP-1: Nurse Communication	04/01/2022 - 03/31/2023	88	89.67	3.1%	88	89.55	89	89.81
	H-COMP-2: Doctor Communication	04/01/2022 - 03/31/2023	87	89.52	3.1%	87	89.45	88	89.70
	H-COMP-3: Staff Responsiveness	04/01/2022 - 03/31/2023	81	81.14	3.2%	82	80.97	84	81.30
	H-COMP-5: Communication about Medicines	04/01/2022 - 03/31/2023	71	74.09	3.2%	73	73.85	76	74.21
	H-COMP-6: Discharge Information	04/01/2022 - 03/31/2023	83	84.90	3.1%	84	84.80	85	85.07
Outcome Measures (lower is better)	Foreign Object Retained	07/01/2020 - 06/30/2022	0.000	0.014	4.3%	0.000	0.014	0.000	0.015
	Air Embolism	07/01/2020 - 06/30/2022	0.000	0.001	2.4%	0.000	0.001	0.000	0.001
	Falls and Trauma	07/01/2020 - 06/30/2022	0.273	0.428	4.9%	0.273	0.430	0.218	0.437
	CLABSI	07/01/2022 - 06/30/2023	1.165	0.730	4.5%	0.788	0.889	1.082	1.076
	CAUTI	07/01/2022 - 06/30/2023	0.654	0.627	4.6%	1.153	0.734	1.246	0.861
	SSI: Colon	07/01/2022 - 06/30/2023	1.277	0.845	3.4%	0.346	0.833	0.398	0.822
	MRSA	07/01/2022 - 06/30/2023	0.804	0.793	4.4%	0.861	0.926	1.585	1.095
	C. Diff.	07/01/2022 - 06/30/2023	0.641	0.455	4.5%	0.603	0.488	0.492	0.489
	PSI 4: Death rate among surgical inpatients with serious treatable conditions	07/01/2022 - 06/30/2023	181.40	168.38	2.0%	160.64	143.28	160.64	143.22
	CMS Medicare PSI 90: Patient safety and adverse events composite	07/01/2022 - 06/30/2023	1.39	1.01	15.0%	1.05	0.98	1.05	0.98
Process Measure Domain Score:			**-0.0039**			0.012		0.1033	
Outcome Measure Domain Score:			**-0.3691**			-0.059		-0.0754	
Process/Outcome Domains - Combined Score:			**-0.373**			-0.047		0.0279	
Normalized Numerical Score:			**2.627**			2.953		3.0279	
Hospital Safety Grade (Letter Grade):			C			C		B	

Letter Grade Key: A = >3.133 B= >2.964 C= >2.476 D= >2.047

KH Leapfrog Spring Score Compared to Future

Kaweah Health Spring 2024 Leapfrog Safety Grade (May 2024)

Measure Domain	Measure	Data Date Range	Kaweah Health Spring 2024 Scores	Mean	Final Weight (N/A redistributes)	PREDICTED KH Fall 2024 Score	Data Date Range
Process/Structural Measures (higher is better)	Computerized Physician Order Entry (CPOE)	June 2023	100	91.81	5.6%	100	June 2024
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	ICU Physician Staffing (IPS)	June 2023	100	63.29	7.2%	100	June 2024
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	Total Nursing Care Hours per Patient Day	June 2023	100	74.69	4.9%	100	June 2024
	Hand Hygiene	June 2023	40	78.65	4.7%	40	June 2024
	H-COMP-1: Nurse Communication	04/01/2022 - 03/31/2023	88	89.67	3.1%	88	10/01/2022 - 10/01/2023
	H-COMP-2: Doctor Communication	04/01/2022 - 03/31/2023	87	89.52	3.1%	88	10/01/2022 - 10/01/2023
	H-COMP-3: Staff Responsiveness	04/01/2022 - 03/31/2023	81	81.14	3.2%	82	10/01/2022 - 10/01/2023
	H-COMP-5: Communication about Medicines	04/01/2022 - 03/31/2023	71	74.09	3.2%	76	10/01/2022 - 10/01/2023
	H-COMP-6: Discharge Information	04/01/2022 - 03/31/2023	83	84.90	3.1%	85	10/01/2022 - 10/01/2023
Outcome Measures (lower is better)	Foreign Object Retained	07/01/2020 - 06/30/2022	0.000	0.014	4.3%	0.000	Same as previous
	Air Embolism	07/01/2020 - 06/30/2022	0.000	0.001	2.4%	0.000	Same as previous
	Falls and Trauma	07/01/2020 - 06/30/2022	0.273	0.428	4.9%	0.273	Same as previous
	CLABSI	07/01/2022 - 06/30/2023	1.165	0.730	4.5%	1.217	01/01/2023 - 12/31/2023
	CAUTI	07/01/2022 - 06/30/2023	0.654	0.627	4.6%	0.423	01/01/2023 - 12/31/2023
	SSI: Colon	07/01/2022 - 06/30/2023	1.277	0.845	3.4%	1.457	01/01/2023 - 12/31/2023
	MRSA	07/01/2022 - 06/30/2023	0.804	0.793	4.4%	1.178	01/01/2023 - 12/31/2023
	C. Diff.	07/01/2022 - 06/30/2023	0.641	0.455	4.5%	0.544	01/01/2023 - 12/31/2023
	PSI 4: Death rate among surgical inpatients with serious treatable conditions	07/01/2020 - 06/30/2023	181.40	168.38	2.0%	181.4 (Midas 180.85)	07/01/2020 - 06/30/2022
	CMS Medicare PSI 90: Patient safety and adverse events composite	07/01/2020 - 06/30/2022	1.39	1.01	15.0%	1.39 (Midas 1.94)	07/01/2020 - 06/30/2022
Process Measure Domain Score:			**-0.0039**			**0.125**	
Outcome Measure Domain Score:			**-0.3691**			**-0.638**	
Process/Outcome Domains - Combined Score:			**-0.373**			**-0.513**	
Normalized Numerical Score:			**2.627**			**2.487**	
Hospital Safety Grade (Letter Grade):			**C**			**C**	

***Data taken from Midas system which is not an apples to apples comparision to CMS**

CMS is not updating PSIs and HACs in July report used for Fall 2024 Safety Grade for undisclosed reason

Letter Grade Key: A = >3.133 B= >2.964 C= >2.476 D= >2.047

Kaweah Health Scores on the Spring 2024 Grade

Process items that we did not achieve full points in Spring and Fall 2024 (if not addressed):

- Hand Hygiene (current score 40/100)
  - Loss of 30 points for not having 200 HH observations per month (missed Nov 2023 in Mental Health; auditors confused because of BioVigil installation), We will not have an opportunity to gain these points until October 2024; survey would have to be resubmitted and this new score would reflect on Spring 2025 safety grade
  - Loss of 30 points because we do not validate HH compliance manually on all shifts, all days of week.
- Safe Practice 6 – Culture, Measurement, Feedback & Intervention (current score 110/120)
  - Loss of 10/120 points due to lack of follow up meeting with Chief and units with safety scores. Leapfrog indicates attendance rosters and meeting notes must be submitted if validation is requested

Outcome Measures not achieving at least national mean in Spring 2024, will continue for Fall 2024 safety grade:

- All Healthcare Acquired Infection Measures (CAUTI will be above National Mean for Fall 2024 safety grade)
- Both PSIs included in score: PSI4 and PSI90 (CMS has not released performance that will be used in Fall grade)

Questions?

The pursuit of healthiness

Unit/Department Specific Data Collection Summarization

Quality Committee

Unit/Department: Kaweah Health Dialysis Facility **QComm Report Date:** 4/26/2024

Measure Objective/Goal: Medical outcome goals for data reported via CrownWeb and outlined by CMS Quality Incentive Program

Date range of data evaluated: Mar 2023 – Feb 2024

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

Medical outcomes measured include

- Adequacy of dialysis
- Anemia management, including transfusions
- Infection prevention and control
- Ultrafiltration and fluid management
- Nutrition
- Vascular access
- Medication reconciliation
- Hospitalizations and readmissions
- Process audits
- Patient satisfaction (ICH CAHPS appendix A)
- CMS QIP Score and Payment Incentive program (Appendix B) = NO payment reduction for coverage year 2024.

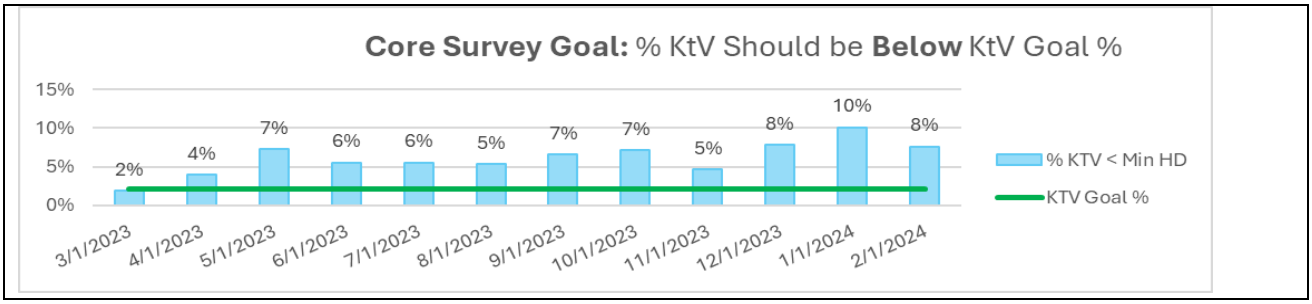
Table 8 - Preview Performance Score Details

Category	Facility Score	State Average Score*	National Average Score*
Total Performance Score Before Applicable Deductions+	70	65	64
Clinical Care Domain (40.00%)	67.750	65.019	64.472

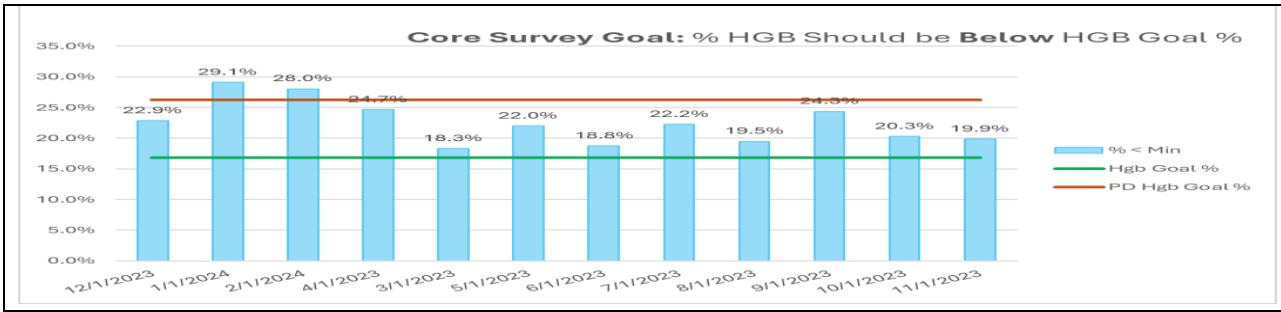
Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

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

- Recent loss of adequacy results seen. Retraining in adequacy protocol will take place.



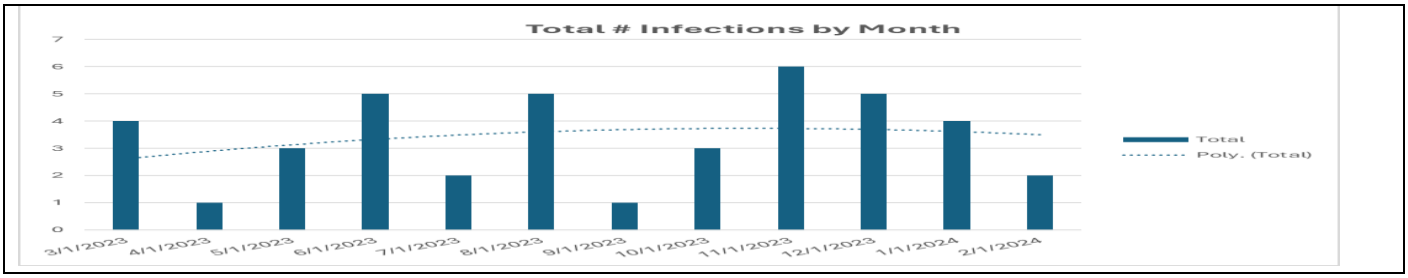
- Anemia management has seen some improvement yet room for improvement remains. Newer drugs are being looked at.



Transfusions:

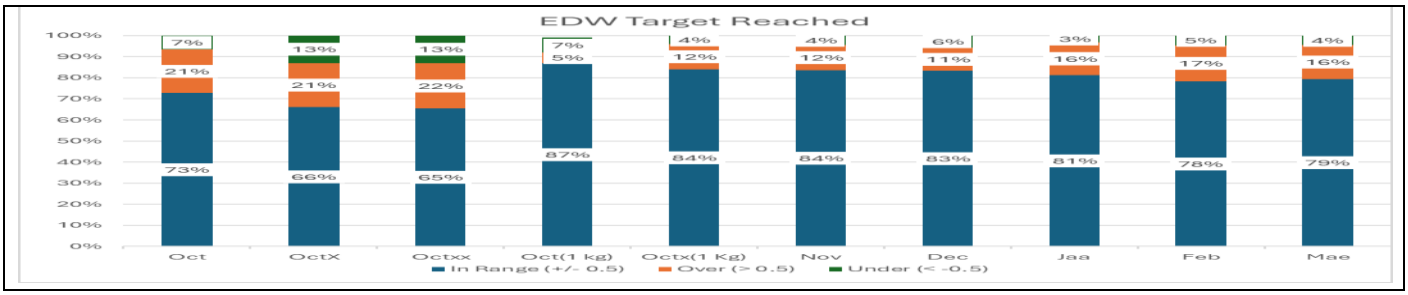
	J	F	M
# of Transfusions	2	1	1

- Immunizations are adequate. Access and blood stream infections are near expected levels.

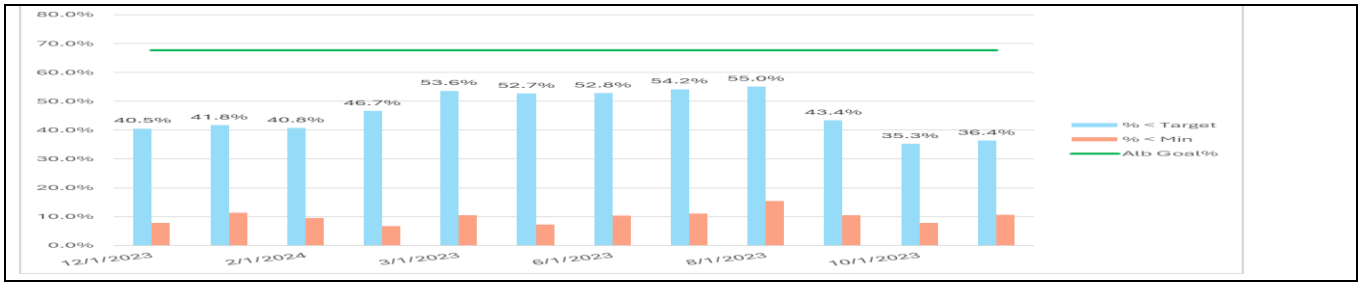


Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

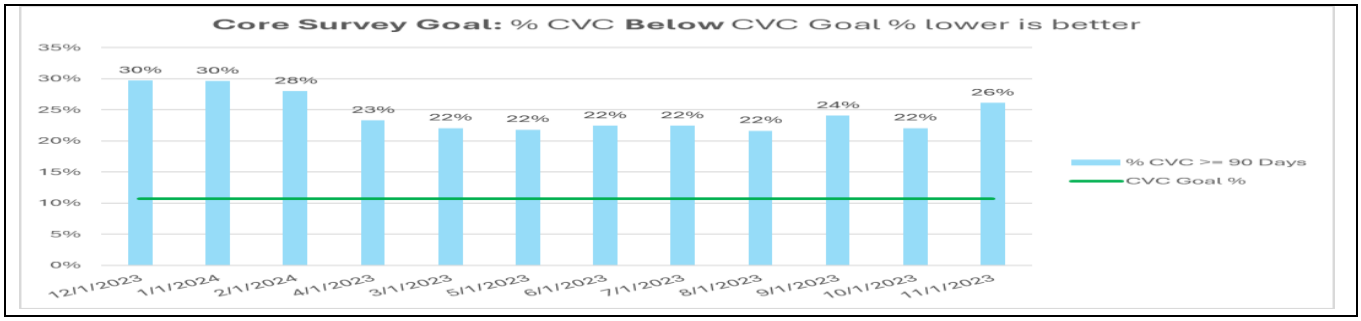
- We have implemented improved monitoring of fluid management.



- Nutrition parameters are improved, remain suboptimal in our patient population (a safety net facility). Registered dieticians are on constant monitoring.



- Vascular access type remains suboptimal, a chronic, often discussed, unsolved conundrum. An access coordinator works exhaustively with patients



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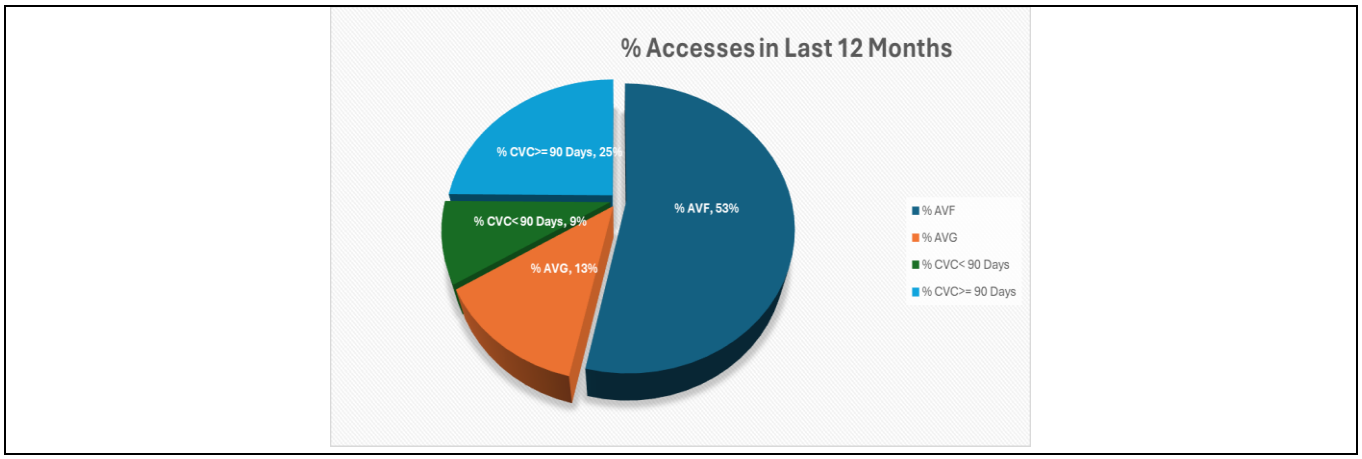
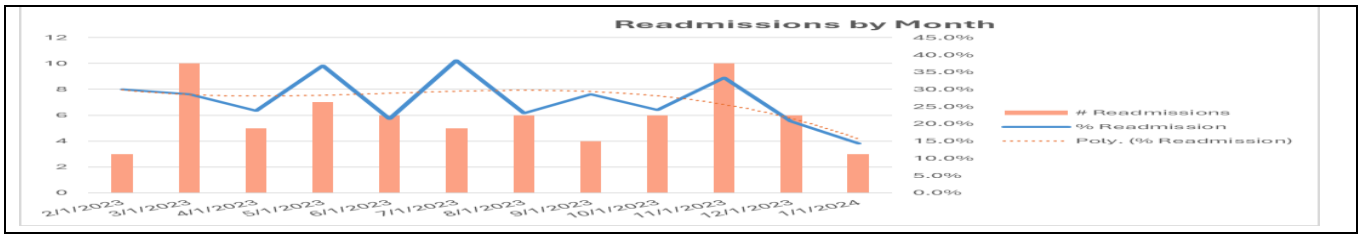
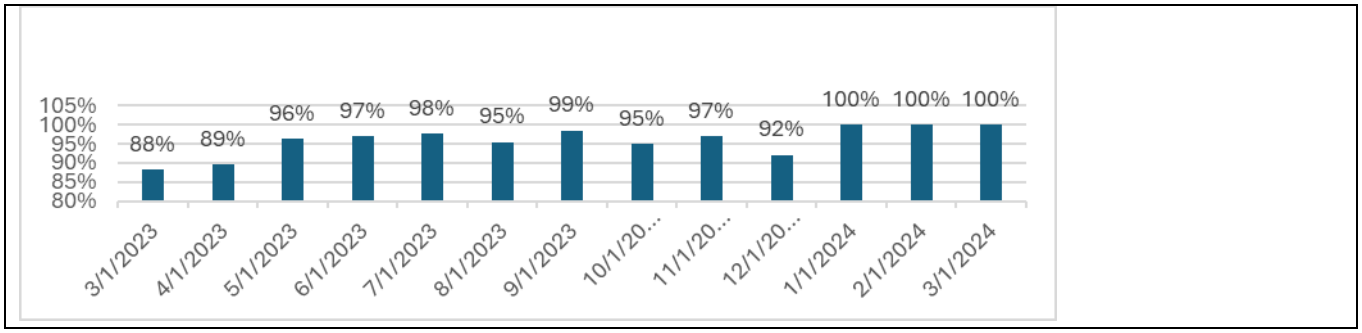


- Hospitalizations and readmissions occur more frequently than expected, in part due to patient population, readmissions improved



- Medication reconciliation consistent:



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

- Process audits are ongoing and result in staff education when deficiencies noted

	JAN	FEB	MAR
Hand Hygiene Observed by Staff	**96%**	**94.9%**	**95.0%**
Hand Sanitizer Observed by Staff			
Catheter Connection	**100%**	**100%**	**100%**
Catheter Disconnection	**100%**	**100%**	**100%**
CVC Exit Site Care	**100%**	**100%**	**100%**
AVF/AVG Cannulation	**80%**	**100%**	**100%**
AVF/AVG Decannulation	**85%**	**100%**	**100%**
Dialysis Station Disinfection	**95%**	**95%**	**92%**
Injection Safety Preparation	**90%**	**100%**	**100%**
Infection Safety Administration	**95%**	**100%**	**90%**
Hand Hygiene Observed by Patients			**100%**
Station Disinfection Observed by Patients	**100%**	**90%**	**100%**

- Patient satisfaction remains high see Appendix

Next Steps/Recommendations/Outcomes:

Each of these outcomes is measured and reviewed monthly. Action plans reviewed and applied monthly.

The primary concern that I have is an apparent fall off in adequacy measures. This needs correction immediately. It is in part due to the vascular access issue. Ideally the access of choice is an arteriovenous fistula created 6 months prior to the need for dialysis. This burden lies squarely with the patient's nephrologist **if** chronic kidney disease has been recognized and referral to a nephrologist has been made. More than half of our patients do not have a nephrologist of record before admission to the Medical Center in need of urgent dialysis.

Submitted by Name: Roger J. Haley, M.D., F.A.C.P.

Date Submitted: 4/26/2024

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

ICH CAHPS Spring 2023

Kaweah Health Dialysis Center

PRELIMINARY REPORT

nrc HEALTH | Human understanding

1245 Q Street | Lincoln, NE 68508
P: 1 800 388 4264 | F: 1 402 475 9061

nrchealth.com

* Reporting has been produced by NRC Health for quality improvement purposes and does not represent official CMS Results.

Question Table Client Name: Kaweah Health Time Period: Spring 2023

Question Text	Benchmark	Kaweah Health Dialysis Center	
		Positive Score	n-size
Center was clean	78.7%	79.2%	24
Connected to machine within 15 min	46.4%	52.2%	23
Doctors cared	66.7%	83%	24
Doctors explained things understandably	63.9%	86%	23
Doctors listened carefully	65.8%	85%	24
Doctors showed respect	71.9%	97%	24
Doctors spent enough time	53.5%	79%	23
Doctors up to date about care from other doctors	88.5%	91.3%	23
Doctors/staff talked about peritoneal dialysis	65.8%	70.8%	24
Doctors/staff talked about what treatment was right	85.8%	91.7%	24
Felt comfortable asking about dialysis care	94.5%	95.8%	24
Involved as much as wanted in choosing treatment	88.3%	95.8%	24
Know how to take care of dialysis connection method	94.3%	95.8%	24
Rate center	78.4%	91.7%	24
Rate kidney doctors	65.5%	83%	24
Rate staff	77.6%	92%	24
Staff behaved professionally	75.7%	97%	24
Staff cared	70.5%	91%	23
Staff checked on patient as closely as wanted	67.4%	79.2%	24
Staff discussed diet	91.9%	91.7%	24

Staff explained blood test results understandably	66.7%	83.3%	24
Staff explained things understandably	68.2%	87.5%	24
Staff explained what to do if problems at home	86.8%	87.5%	24

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Staff gave written info re: patient rights 88.9%

Significance Color Code
- No Significance
- Score statistically significantly greater than benchmark
- Score statistically significantly less than benchmark

Question Table Client Name: Kaweah Health Time Period: Spring 2023

Question Text Staff explained what to do if problems at home	Benchmark86.8%	Kaweah Health Dialysis Center	
		Positive Score	n-size
Staff gave written info re: patient rights	88.9%	95.8%	24
Staff inserted needles painlessly as possible	Null	73.7%	19
Staff kept patient information private	92.3%	100.0%	24
Staff listened carefully	69.9%	95.8%	24
Staff made patient comfortable	74.4%	91.7%	24
Staff reviewed rights as patient	82.6%	91.7%	24
Staff showed respect	72.2%	91.7%	24
Staff spent enough time	65.7%	87.5%	24
Staff told you how to disconnect from machine	92.9%	75.0%	24

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Significance Color Code
- No Significance
- Score statistically significantly greater than benchmark
- Score statistically significantly less than benchmark

CMS Infection Event Data Submission Requirements

It is required to document peritoneal dialysis infections for all patients when these events occur. The information below details requirements for infection data submission.

Data Submission Requirements

Included Infections
While additional infections may be required at a later date, patient data for the following infection event is currently expected: ● *Peritonitis*

Submission Process and Timeframe
In event-based submissions, submitters are required to provide patient data regarding infections only when an infection event occurs. Anytime a qualifying event occurs, the facility should submit data within 90 days of the event. However, users can continue to edit and/or add additional data after submission to enhance data quality and completeness.

Users can save data entry progress within the module and return later to complete the remaining required fields until it is ready to be submitted. Data within the Infections module remains editable even after submission.

Level of Detail by Infection
It is expected that as much detail as practical is provided for all infections. It is expected that facilities should be able to report full details for infection events that occurred at the facility. For

infection events which occurred at another provider or via self-report, as much detail as available is expected.

Nested Fields and Table Formatting

Conditional fields (sub-fields that appear conditionally based on the response to the main field) are highlighted in grey in the table below. The cells are darker the more “nested” they are under the top-level field. The maximum level of nested fields is four.

1

End-Stage Renal Disease Quality Incentive Program - Preview Performance Score Report
Payment Year: 2024
Facility: 053506

Report Run Date: 07/11/2023

Clinical Care Domain

Improvement Period: 01/01/2019-12/31/2019

Performance Period: 01/01/2022-12/31/2022

Table 1 - Clinical Care Domain Measures and Measure Topics (Clinical Measures)

Clinical Care Measures/Measure Topics	Improvement Period Numerator	Improvement Period Denominator	Improvement Period Rate/Ratio	Performance Period Numerator	Performance Period Denominator	Performance Period Rate/Ratio	Achievement Threshold	Benchmark	Improvement Score	Achievement Score	Measure Score	Measure Weight (% of Domain)
Hypercalcemia	6	2116	0.28%	6	1614	0.37%	1.54%	0.00%	0	7	7	7.50%
Kt/V Comprehensive	1899	1957	97.04%	1455	1496	97.26%	94.33%	99.42%	0	6	6	22.50%
Vascular Access Type Topic	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	3°	30.00%
Standardized Fistula Rate	3258598.12	5343702	60.98%	3136339.14	5062268	61.96%	53.29%	76.77%	0	4	4	N/A
Long-term Catheter Rate	496	1823	27.21%	306	1432	21.37%	18.35%	4.69%	2	0	2	N/A

Table 2 - Clinical Care Domain Measures (Reporting Measures)

Clinical Care Measures	Number of Successfully Reported Months	Number of Eligible Months	Number of Patient-Years at Risk	Measure Score	Measure Weight (% of Domain)
Standardized Transfusion Ratio	N/A	N/A	53.545	10	25.00%
Ultrafiltration Rate	1380	1396	N/A	10	15.00%

Eligible Clinical Care Measures/Measure Topics: 5 of 5

Weighted Clinical Care Domain Score: 67.750

° The measure score was calculated by aggregating its component measure scores

Notes:

- "N/A" indicates the value is not applicable to the measure/measure topic scoring calculation.

Report Run Date: 07/11/2023

Care Coordination Domain

Improvement Period: 01/01/2019-12/31/2019

Performance Period: 01/01/2022-12/31/2022

Table 3 - Care Coordination Domain Measures (Clinical Measures)

Care Coordination Measures	Improvement Period Numerator	Improvement Period Denominator	Improvement Period Rate/Ratio	Performance Period Numerator	Performance Period Denominator	Performance Period Rate/Ratio	Achievement Threshold	Benchmark	Improvement Score	Achievement Score	Measure Score	Measure Weight (% of Domain)
Percentage of Prevalent Patients Waitlisted	1269563.17	4417636	28.74%	1433045.11	4391840	32.63%	8.12%	33.90%	7	9	9	13.33%
Standardized Hospitalization Ratio	202	216.50	145.09	121	162.88	106.83	187.80	105.54	9	9	9	40.00%
Standardized Readmission Ratio	45	49.68	24.54	30	29.43	27.08	34.27	17.02	0	4	4	40.00%

Table 4 - Care Coordination Domain Measures (Reporting Measure)

Care Coordination Measure	Number of Successfully Reported Patients	Number of Eligible Patients	Measure Score	Measure Weight (% of Domain)
Clinical Depression Screening and Follow Up	164	164	10	6.67%

Eligible Care Coordination Domain Measures: 4 of 4

Weighted Care Coordination Domain Score: 70.667

Notes:

- "N/A" indicates the value is not applicable to the measure/measure topic scoring calculation.

Report Run Date: 07/11/2023

Safety Domain

Improvement Period: 01/01/2019-12/31/2019

Performance Period: 01/01/2022-12/31/2022

Table 5 - Safety Domain Measures (Clinical Measure)

Safety Measure	Improvement Period Numerator	Improvement Period Denominator	Improvement Period Rate/Ratio	Performance Period Numerator	Performance Period Denominator	Performance Period Rate/Ratio	Achievement Threshold	Benchmark	Improvement Score	Achievement Score	Measure Score	Measure Weight (% of Domain)
NHSN Bloodstream Infection	33	17.058	1.935	11	11.891	0.925	1.193	0.000	5	3	5	53.33%

Table 6 - Safety Domain Measures (Reporting Measures)

Safety Measures	Number of Successfully Reported Months/Patient-Months	Number of Eligible Months/Patient-Months	Measure Score	Measure Weight (% of Domain)
Medication Reconciliation Reporting	1572	1612	10	26.67%
NHSN Dialysis Event Reporting	12	12	10	20.00%

Eligible Safety Measures: 3 of 3

Weighted Safety Domain Score: 73.333

Notes:

- "N/A" indicates the value is not applicable to the measure/measure topic scoring calculation.

Report Run Date: 07/11/2023

Patient and Family Engagement Domain

Improvement Period: 01/01/2019-12/31/2019

Performance Period: 01/01/2022-12/31/2022

Table 7 - Patient and Family Engagement Domain Measures

Patient and Family Engagement Measures	Improvement Period Numerator	Improvement Period Denominator	Improvement Period Rate/Ratio	Performance Period Numerator	Performance Period Denominator	Performance Period Rate/Ratio	Achievement Threshold	Benchmark	Improvement Score	Achievement Score	Measure Score	Measure Weight (% of Domain)
ICH CAHPS	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**7°**	**100.00%**
Neph Comm and Caring	N/A	N/A	73.02%	N/A	N/A	72.28%	58.20%	79.15%	0	7	7	N/A
Quality of Dialysis Care and Ops	N/A	N/A	71.96%	N/A	N/A	71.32%	54.64%	72.66%	0	9	9	N/A
Providing Info to Patients	N/A	N/A	83.77%	N/A	N/A	75.88%	74.49%	87.80%	0	1	1	N/A
Overall Rating of Neph	N/A	N/A	71.28%	N/A	N/A	61.96%	49.33%	76.57%	0	5	5	N/A
Overall Rating of Dialysis Staff	N/A	N/A	89.20%	N/A	N/A	77.83%	50.02%	78.30%	0	9	9	N/A
Overall Rating of Dialysis Facility	N/A	N/A	95.04%	N/A	N/A	85.79%	54.51%	83.72%	No Score	10	10	N/A

Eligible Patient and Family Engagement Measures: 1 of 1
Weighted Patient and Family Engagement Domain Score: 70.000

° The measure score was calculated by aggregating its component measure scores

Notes:

- "N/A" indicates the value is not applicable to the measure/measure topic scoring calculation.

End-Stage Renal Disease Quality Incentive Program - Preview Performance Score Report
Payment Year: 2024
Facility: 053506

Report Run Date: 07/11/2023

Preview Performance Score

Table 8 - Preview Performance Score Details

Category	Facility Score	State Average Score*	National Average Score*	Facility Measure Weights	Facility Weighted Score
Total Performance Score Before Applicable Deductions+	**70**	**65**	**64**	**N/A**	**N/A**
Clinical Care Domain (40.00%)	**67.750**	**65.019**	**64.472**	**N/A**	**27.1000**
Hypercalcemia	7	5	6	7.50%	0.5250
Kt/V Comprehensive	6	5	5	22.50%	1.3500
Standardized Transfusion Ratio Reporting	10	10	10	25.00%	2.5000
Ultrafiltration Rate	10	10	10	15.00%	1.5000
Vascular Access Type Topic	3	5	4	30.00%	0.9000
Care Coordination Measures Domain (30.00%)	**70.667**	**59.771**	**55.134**	**N/A**	**21.2000**
Clinical Depression Screening and Follow Up Reporting	10	10	10	6.67%	0.6670
Percentage of Prevalent Patients Waitlisted	9	6	4	13.33%	1.1997
Standardized Hospitalization Ratio	9	6	6	40.00%	3.6000
Standardized Readmission Ratio	4	5	5	40.00%	1.6000
Safety Domain (15.00%)	**73.333**	**80.884**	**82.141**	**N/A**	**11.0000**
Medication Reconciliation Reporting	10	9	9	26.67%	2.6670
NHSN Bloodstream Infection	5	7	7	53.33%	2.6665
NHSN Dialysis Event Reporting	10	10	10	20.00%	2.0000
Patient And Family Engagement Domain (15.00%)	**70.000**	**48.871**	**43.265**	**N/A**	**10.5000**
ICH CAHPS	7	5	4	100.00%	7.0000

*** State and National Average Scores are unweighted**

Minimum Total Performance Score: 57 points

Extraordinary Circumstance Exception Approved:

+Total Performance Score Before Applicable Deductions: 70 points

Reduction for Noncompliance with CMS EQRS or NHSN Validation Studies: 0 points

Total Performance Score: 70 points

Total Payment Reduction: No Reduction

Please consult the CMS ESRD Measures Manual (https://www.cms.gov/files/document/esrd-measures-manual-v71.pdf) and the CMS ESRD QIP Guide to the PSR (https://qualitynet.org/esrd/esrdqip/reports) for additional details on scoring calculations.

Sub Acute and Short Stay SNF Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Sub Acute and Short Stay SNF **Report Date:** **April 2024**

Measure Objective/Goal:

1. Falls (internal data)
2. Pressure Injuries (internal data)
3. Psychoactive medication use (MDS/Casper)

Date range of data evaluated:

Data evaluated populated from internal data as well as CASPER report period: 7/01/2023 – 12/31/2023. Data compared with Casper Report and QTR 3 2023 through QTR 4 2023, internal data.

Nationally benchmarked quality data is collected through the MDS submissions process to CMS where data is populated into the CASPER report. CMS divides data between short-stay cases (<100 day length) and long-stay cases (>100 day length). The Skilled Nursing program client group is predominately in the short-stay category. Statistically this means that Long-Stay measures typically have a denominator of 33-34. Short-Stay measures typically have a denominator of 200+. Internal data is based on total units of service and does not differentiate based upon length of stay. There is no comparable national bench-marking of Short Stay cases for falls, and for HAPI prevalence overall. For these two indicators, we assess ourselves to internal performance goals.

FALLS

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

The rate of falls per 1000/pt. days in 3Q23 and 4Q23 totaling 0.32 falls per 1000 patient days. Facility observed percent for falls for long stay patients in the most current CASPER report is 3.3%, remaining well below national average of 43.7%, placing the program in the top 1 percentile nationally.

Falls per Unit per 1000 Pt Days per Quarter 2022-23										
Unit	1Q22	2Q22	3Q22	4Q22	2022 Total	1Q23	2Q23	3Q23	4Q23	2023 Total
SNF (Combined Total)	0.88	0.79	0.57	0.88	0.77	0.51	0.75	0.00	0.00	0.32
SAC	0.00	0.00	1.14	0.00	0.15	0.36	0.70	0.00	0.00	0.19
TC-W	3.06	1.83	0.91	5.00	0.62	1.70	0.87	0.00	0.00	0.19
TC-S	0.86	1.42	1.31	0.00	0.26					

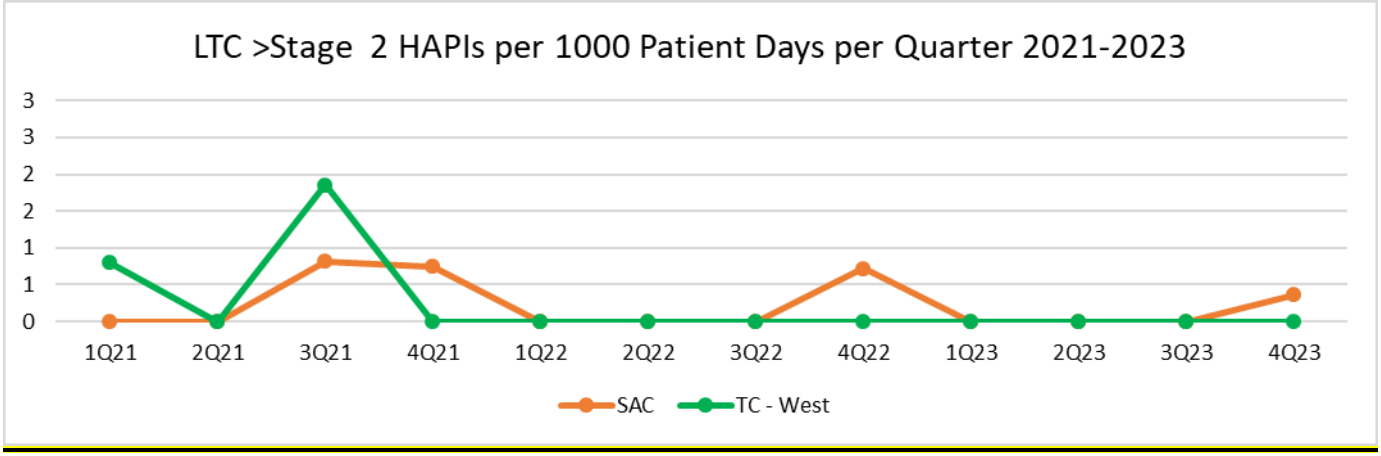
Falls per Unit per Quarter 2023					
Unit	1Q23	2Q23	3Q23	4Q23	T
SNF (Co	2	3	0	0	5
SAC	1	2	0	0	3
TC-S	0	0	0	0	0
TC-W	2	1	0	0	3

If improvement opportunities identified, provide action plan and expected resolution date:
Staff continues to participate in district-wide initiatives for fall prevention including Falls University to identify trends and communicate “take-aways”. Falls occur most commonly with our short-stay population, this skilled nursing units has many patients who participate in physical and occupational therapy sessions with varying functional levels. Therapy sessions are designed to promote mobility and independence ultimately preparing the residents to discharge home. The Short Stay unit utilizes several interventions, such as adding fall review during staff meetings for educational purposes and increasing the availability of fall prevention equipment such as tele sitters and chair alarms.

PRESSURE INJURIES
Analysis of all measures/data: (Include key findings, improvements, opportunities)
Incidence of new or worsening pressure ulcers for short stay patients, which would include Sub Acute patients with a length of stay under 100 days, as reported on the Casper report is 0.0 %, below the national average of 2.7 %.

Patients at high risk for pressure ulcers (long stay residents, defined as high risk, who have > stage II pressure ulcers) is 14.3%. This is a decrease from 16.1% in the last report. The definition for this long stay quality measure asks if a wound is present, not if acquired in the facility. This is particularly challenging in a program that preferentially admits cases with pressure ulcers for ongoing treatment. The measure triggers a flag until the wound completely heals (and through the 6-month period). Very large wounds that have healed down to very small, chronic wounds will continue to trigger this measure. Thus, it is common to see a delay in improvement on the CASPER report, while seeing improvement more immediately in our internal data.

Overall, the total wound rate for the two SNF units per 1000/pt. days for Q3 and Q4 2023 was 0. This is equal to the last report of 0. Both SNF units participate in Kaweah health Clinical Skin Institute when pressure injuries are discovered on the unit, staff capture skin injuries during routine assessments and preventative measures are implemented early leading to better patient outcomes.



If improvement opportunities identified, provide action plan and expected resolution date:
We will continue to work within the high standards of the District, with close management of our fragile, chronic wound cases, collaborating closely with the Kaweah Health wound nurses and utilizing the standardized treatment sets available to us.

UBC teams for South Campus nursing are reviewing clinical cases using a Peer review methodology to assess for and remediate practice concerns.

During the first two weeks of admission meeting in south campus, patients at high risk for developing pressure ulcers are discussed with the IDT and treatment teams and preventative options are implemented.

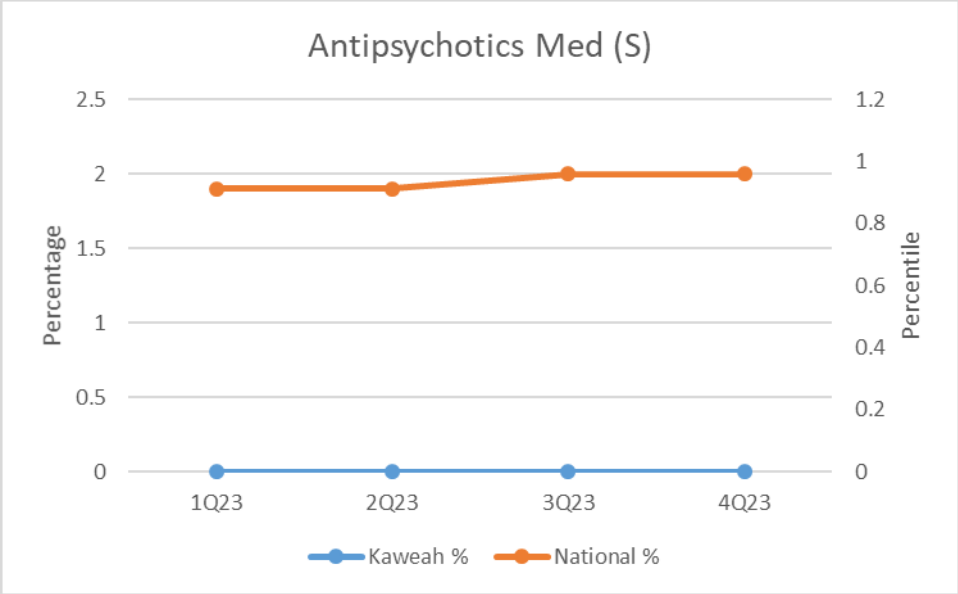
Any wounds that are present and worsening wounds or pressure ulcer are discussed shift to shift during safety huddles for all SNF units. Weekly summaries are done for patients to identify high risk patients for developing pressure sores.

PSYCHOACTIVE MEDICATION USE
Definitions/Assumptions:
This measure is collected through the Minimum Data Sets that are completed and submitted to CMS at the defined intervals by the program. The data includes only the information regarding prescribed medications by drug category (not by intended use or indication). Therefore, for instance, a practice change in the use of anxiolytics like lorazepam to antipsychotics like quetiapine for ventilator management would affect this data directly

Increased use of medications in the antipsychotic drug-class for management of depression is also impacting our results in these measures. Antianxiety and hypnotic medication use is not reported as a quality measure for the short-stay population. The data is collected through the

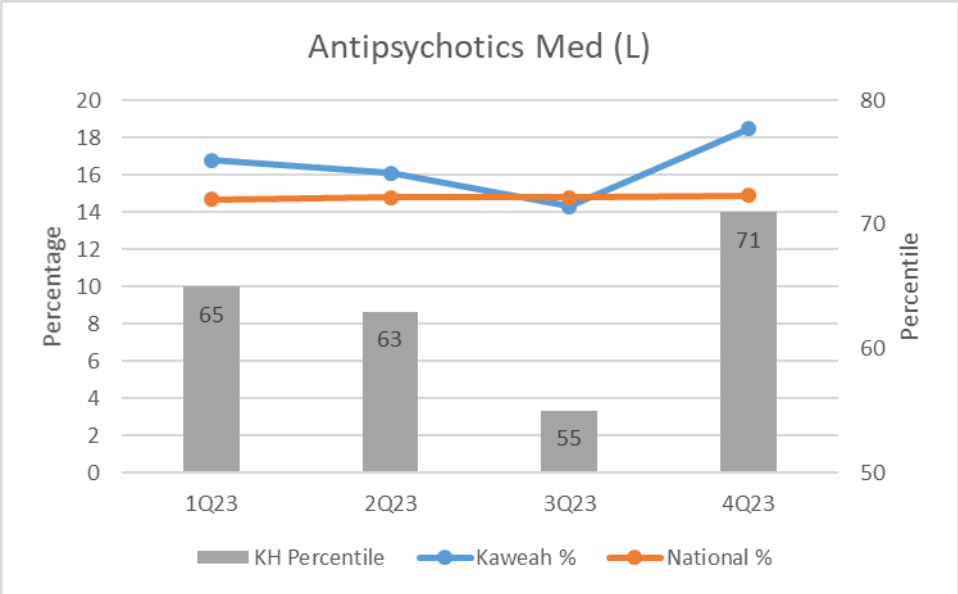
MDS, but is not included in the measures that make up our quality ranking. All values are expressed in percentile rankings.

Analysis of all measures/data: (Include key findings, improvements, opportunities)
Short Stay residents (<100 days) Antipsychotic medication use for short stay patients is below the national average, which measures only cases with newly prescribed antipsychotics. The short stay patients who begin a new anti-psychotic during their stay is 0% for both 3Q23 and 4Q23, compared to the national average of 2.0%



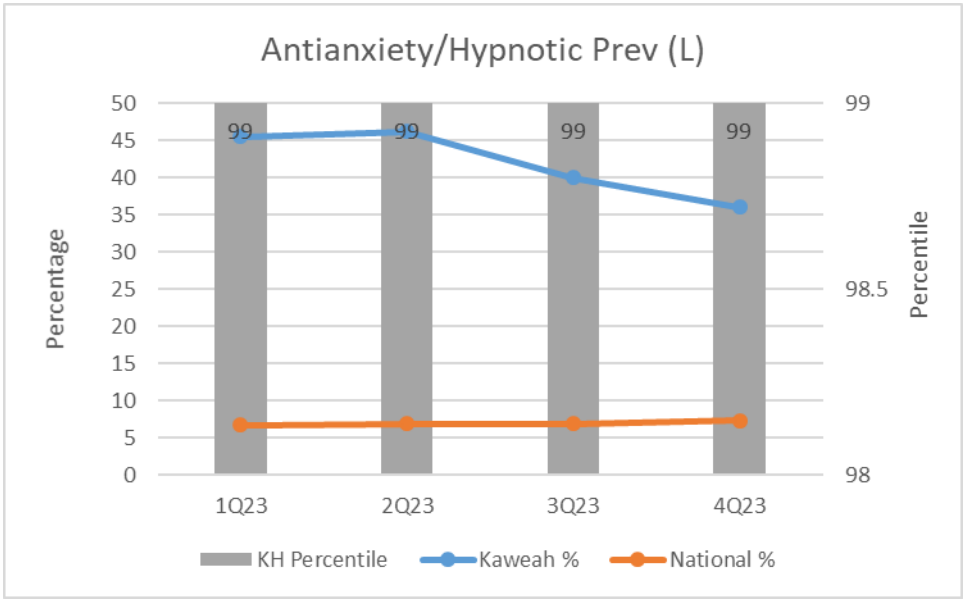
Long Stay residents.
The facility percent for antipsychotic use in long stay residents for 3Q23 14.3% and 4Q23 is 18.5% compared to the national average of 14.8% (55th percentile) and 14.9% (77th percentile) respectively. Unlike the short stay measure, which only includes newly prescribed antipsychotics, the long stay measure includes all patients on the medication for any portion of the time(even if it was a home medication). Included in this measure are medications like quetiapine, used for depression or for ventilator management cases. There is another instance where our target client group for long-term care (Sub Acute program) is the primary driver of our performance.

SNF leadership has been working closely with the medical team and our MDS nurses to ensure that appropriate psychiatric diagnoses are captured in the medical record whenever possible. A small number of these diagnoses are excluded from this quality measure.



Long Stay residents.

Antianxiety/Hypnotic Medication use for long stay residents has remained high at the 99th percentile for 3Q23 and 4Q23, consistent throughout the year. This is reflective of the use of these meds for our ventilated patients in the subacute unit. There are no exclusions for medical diagnosis for this measure.



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

Psychotropic medications are under constant scrutiny by CMS. Concerns around these medications are primarily founded in two concepts:

1. Inappropriate or excessive use of medications

2. Using psychotropic medications to control behaviors (as a chemical restraint) or for more convenient management of difficult patients.
3. Informed consent for psychotherapeutic drugs.

While the majority of our client group has clear and compelling indications for these agents, we continue to monitor the medications very closely. Our LTC pharmacist plays an important role in helping us ensure we track these medications closely during the transition process. Our primary focus is unnecessary medications, like prn hypnotics, hence we also monitor for the potential to reduction when possible.

All residents receive a monthly medication regimen review and physician consultation by our LTC pharmacist and Medical Director. This close partnership has helped reduce psychoactive medication used generally, including dose reduction practices.

There have been no findings around inappropriate use of psychotropic mediations in any of our programs, including the most recent CMS recertification survey in March 2024.

Submitted by Name:
Molly Niederreiter

Date Submitted:
April 2024

Trauma Department

June 2024

Summary Information

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

Hospital Registry

Year	Case Volume	% Change
2021	2,969	24.1%
2022	2,988	0.64%
2023	3,245	8.60%
2024	1,054 (Jan-Apr)	4.90% (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, we have increased our Mortality rates.

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, we send them to the EMS agency for review.
- Monthly staff education with the trauma registrars.
- Autopsy reports from our coroner's office.

Measures

- We will use the bi-annual TQIP report for our data and review our mortalities monthly.

Next Steps

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

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 is a significant step. This 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.

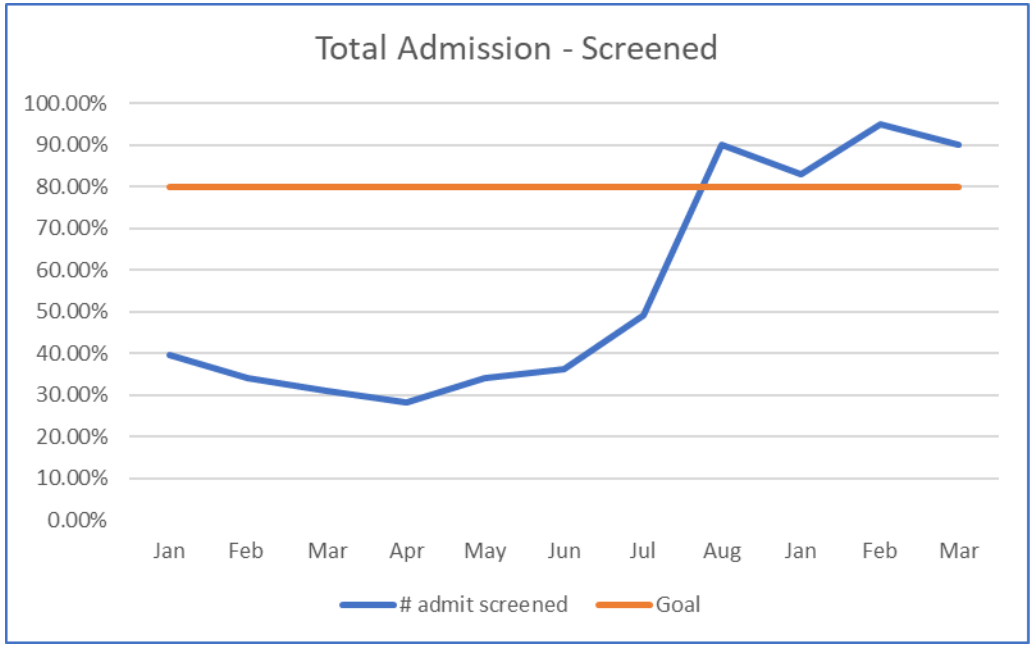
Measures

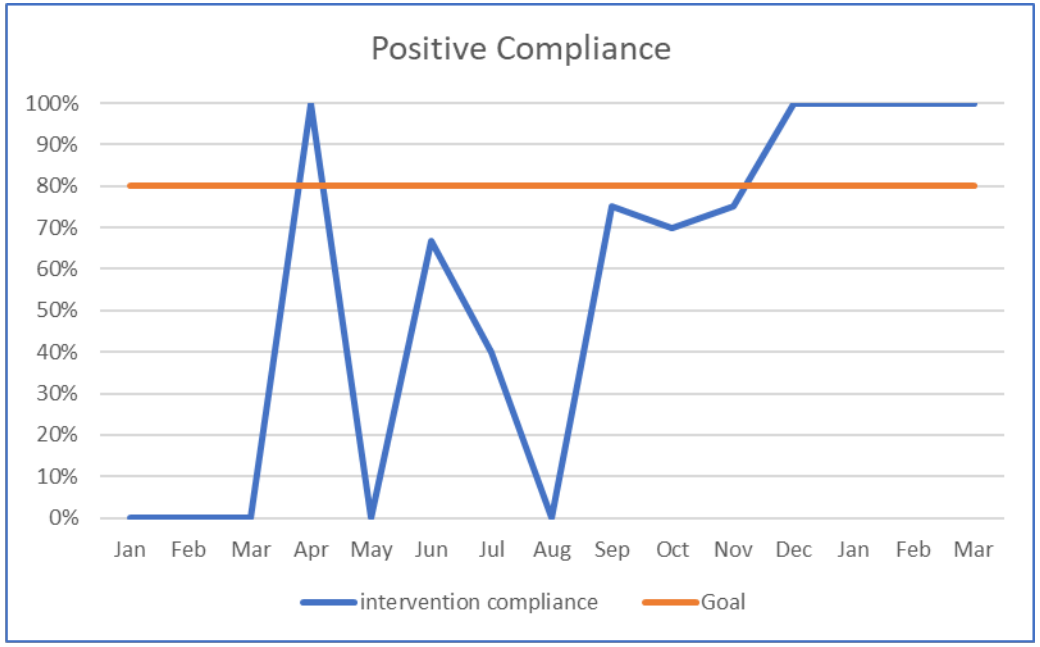
We utilize our trauma registry program to measure the time from the patient's arrival to departure. We are required by the ACS to monitor all transfers out of our facility.

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





SBIRT is the process of screening patients for alcohol abuse utilizing our CAGE 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)

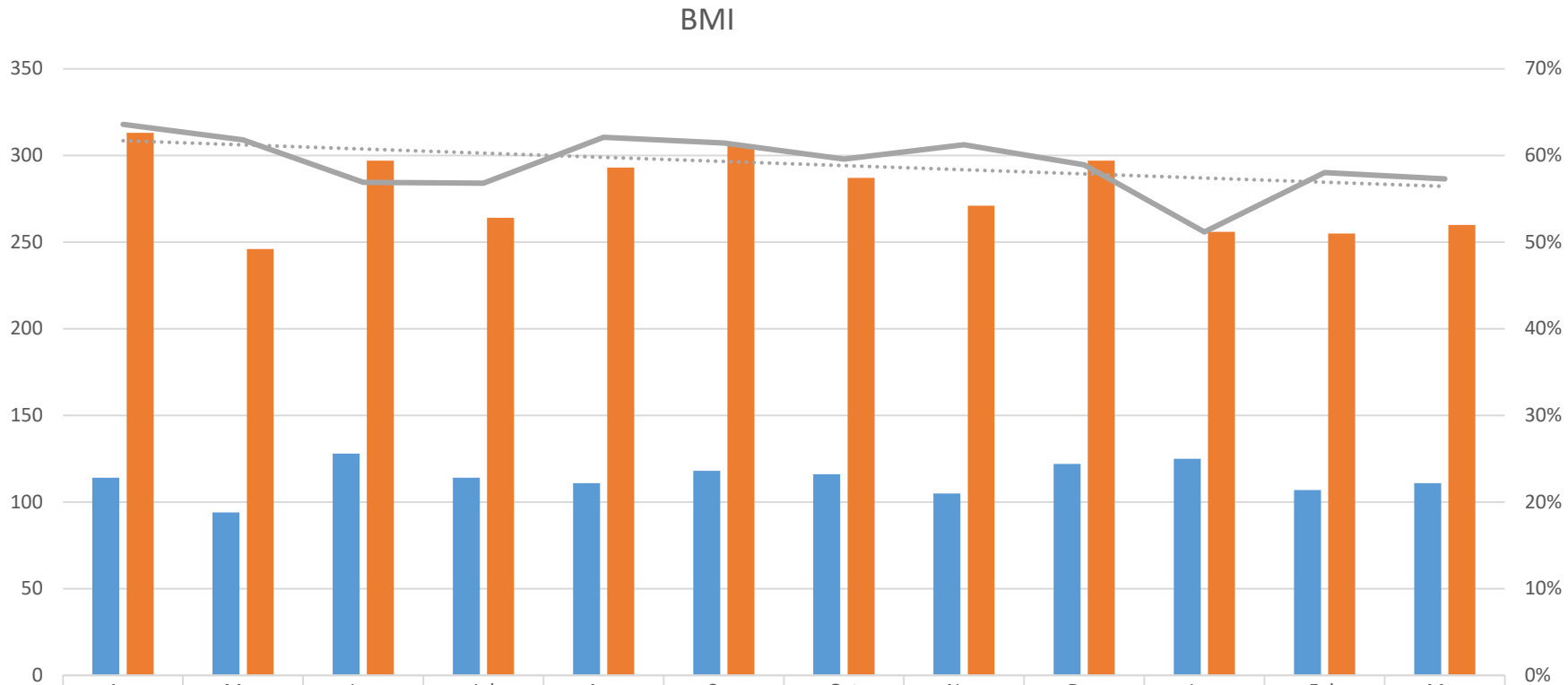
Measures

The process for measurement occurs through our DI registry system. Our registrars extract this information and input it into our system, which I review on a monthly basis.

Next Steps

Since November 2023, we have been monitoring the progress of this change and have achieved over 80% compliance for 5 months. We will continue to monitor this change for further improvement opportunities.

BMI



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Missing	114	94	128	114	111	118	116	105	122	125	107	111
Total cases	313	246	297	264	293	306	287	271	297	256	255	260
% compliance	64%	62%	57%	57%	62%	61%	60%	61%	59%	51%	58%	57%

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, etc.

Solution

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

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

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

Measures

The measurement process is through our DI registry system. Our registrars extract this information and input it into our system, which I review monthly.

Next Steps

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

Trauma Flowsheet: We will add a spot on the written trauma flowsheet for height and weight.

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. We attended in 2023, provided reflective slap bands to kids, and discussed pedestrian safety measures.

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Health Equity at Kaweah Health

March 27, 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

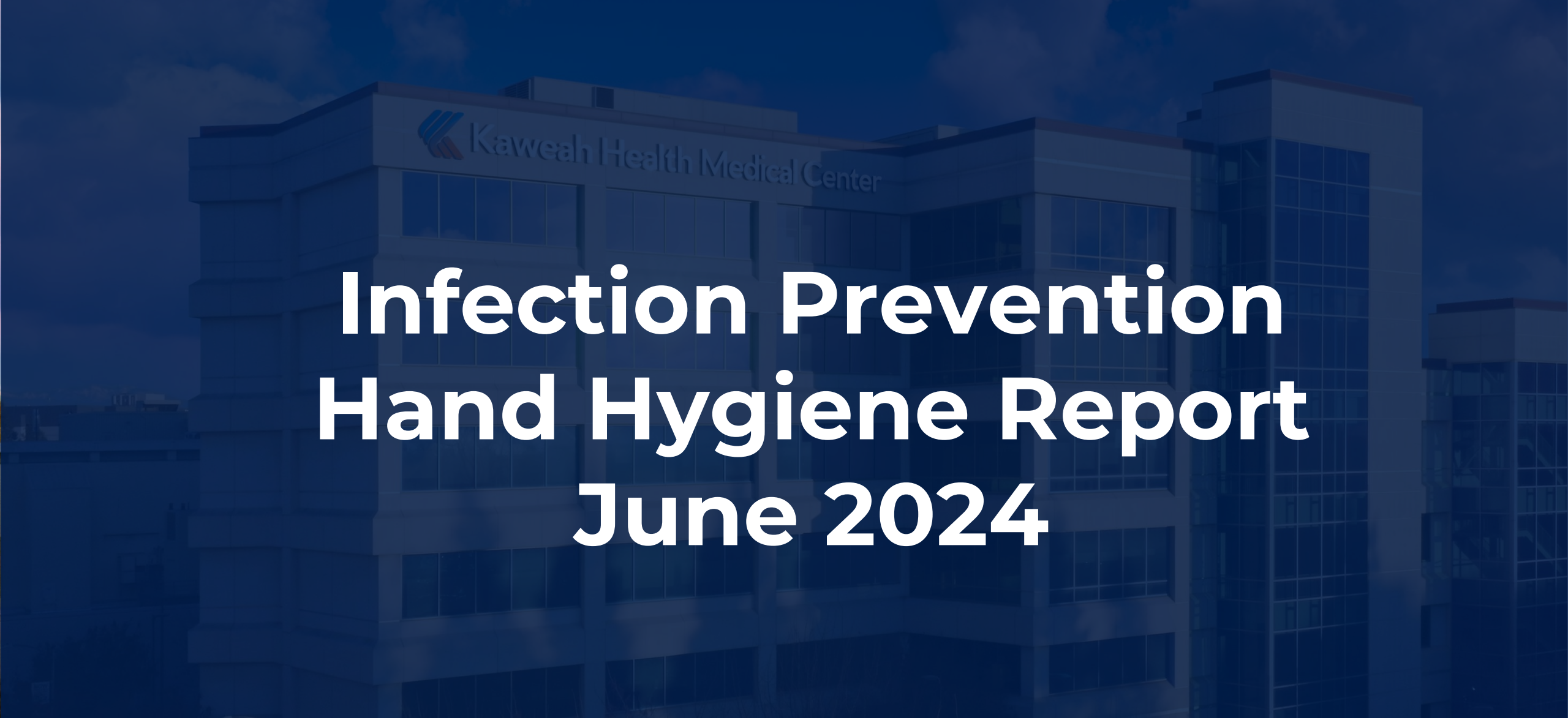
https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_npsg-16.pdf?db=web&hash=F4FA36C38D4D4146D38956F0392272DE

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 patient screening tool
  - PRAPARE Tool implemented December 2023
  - SDOH HealtheAnalytics Dashboard under construction to monitor implementation and assist with disparities 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



Infection Prevention Hand Hygiene Report June 2024

BioVigil Hand Hygiene Performance

Measure Description	Benchmark /Target	2020Q3	2020Q4	2021Q1	2021Q2	2021Q3	2021Q4	2022Q1	2022Q2	2022Q3	2022Q4	2023Q1	2023Q2	2023Q3	2023Q4	2024Q1
OUTCOME MEASURES																
HH Overall Compliance	95%	98	98	97	97	97	97	97	97	96	96	97	96	96	95	95
Number of HH Audits Performed	n/a	1,800,659	3,323,059	2,816,935	2,359,124	2,318,073	2,446,660	2,279,162	3,700,926	3,226,589	2,648,996	2,872,214	2,776,657	2,677,800	2,908,151	3,140,804
HH Overall Compliance - Patient Care Areas	95%	98	98	97	97	97	97	97	97	97	97	97	96	96	95	95
Number of HH Audits Performed - Patient Care Areas	n/a	1,800,659	3,323,059	2,816,935	2,359,124	2,318,073	2,446,660	2,222,112	3,105,912	2,816,731	2,422,678	2,623,609	2,488,916	2,441,458	2,664,822	2,886,456
% of Active Biovigil Users Achieving Target Badge Hours (>80hrs/month)		FY2022	FY2023	23-Jul	23-Aug	23-Sep	23-Oct	23-Nov	23-Dec	24-Jan	24-Feb	24-Mar	24-Apr	24-May	24-Jun	FYTD-24
Target of 80 badge hous (paired badge time) per month dervied from using a 50% and 75% usage goal basd on most full time staf work approximately 160 huors a month[Nursing staff work 144 hours a month.] An employee would have exceptional use if the badge hours increase to greater than 30 hours/wk. An employee working a 36hr./wk. could potentially meet target badge hours by pairing with it for 18 hours/wk. He or she would have exceptional use if the badge hours increase to greater than 27 hours/wk.	50% (10% increase annually FY25+)	38%	31%	43%	47%	45%	49%	47%	50%	51%	68%	56%	55%	not available yet	not available yet	51%

We are achieving our organizational goal of at least 50% of active Biovigil users pairing to a badge ≥80 hours a month. As predicted, with a greater number of active Biovigil users and paired badge time, hand hygiene compliance rates have decreased. With continued use of Biovigil as a reminder for hand hygiene opportunities, we expect hand hygiene compliance rates to return to ≥95%.

BioVigil Hand Hygiene Performance

Trends in Hand Hygiene

- Increased users of Biovigil has lead to a drop in compliance, this is related to a learning curve for staff in system functionality.
- Night shift has a slight better hand hygiene compliance rate compared to day shift while using the Biovigil hand hygiene monitoring system.
- Day shift has an overall larger volume of hand hygiene opportunities compared with night shift.
- Weekend hand hygiene opportunities account for only 32% of the volume that occurs during weekdays.
- Locations with ≥5 quarter of performance below 95% hand hygiene compliance are: 2N, CVICU, 5T, CVICCU, ED.
- Job categories with consistent performance below 95% hand hygiene compliance are: Certified Nurses Assistants.
- Job categories with low number of hand hygiene opportunities (reflection of low Biovigil usage) are: Respiratory Therapy, and Physicians/Residents/Advance Practice Practitioners (Nurse Practitioners/Physician Assistants).

BioVigil Hand Hygiene Performance

Hand Hygiene Improvement Strategies

- New hire orientation
  - Instructions on how to perform HH
  - Hand hygiene competency for new employees as part of the 48 hour orientation checklist
  - Discussion about the importance of hand hygiene, the Biovigil hand hygiene monitoring system, hand hygiene patient surveys performed in the clinics
  - Viewing the Norwegian Institute of Public Health – Gloves do not replace hand hygiene. The invisible challenge II. Video
- Quarterly audits and trending HH supply processes (refill soap, paper towels, sanitizer) by EVS
- Biovigil electronic HH reminder system in place; manual observations completed in patient care areas where Biovigil is not present
- Hand Hygiene compliance data disseminated to leadership for action; ready to use power points and written materials easily accessible to all staff and leaders for QI work
- Healthcare Associated Infection Quality Focus Team expected a drop in compliance related to increase use of the Biovigl system; as such strategies are heavily focused on supporting leaders and staff in using the system and compliance will be monitored.
- Visual reminders to perform hand hygiene posted in the location throughout the hospital
- Ad Hoc HH Campaigns

  Examples:
  - DUDE VP/CEO videos available on Kaweah Compass
  - Monthly Hi Five Hand Hygiene awards provided to units with greatest Biovigil badge paired time and hand hygiene opportunities

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Kaweah Health

VALUE BASED PURCHASING

Erika Pineda, BSN, RN

Abbreviations

CMS: Centers for Medicare and Medicaid Services
DRG: Diagnosis Related Groups
ECE: Extraordinary Circumstances Exception
FY: Fiscal Year
CY: Calendar Year
TPS: Total Performance Score
VBP: Value Based Purchasing
CHA: California Hospital Association
HAI: Healthcare-Associated Infection
CAUTI – Catheter Associated Urinary Tract Infection
CLABSI – Central Line Associated Blood Stream Infection
MRSA - Methicillin-resistant Staphylococcus Aureus
CDIFF – Clostridium Difficile Infection
SSI: Surgical Site Infection

MSPB: Medicare Spending per Beneficiary
IQR: Inpatient Quality Reporting
THA/TKA: Total Hip Arthroplasty/or Total Knee Arthroplasty
HCAPHS: Hospital consumer Assessment of Healthcare Providers and Systems
AMI: Acute Myocardial Infarction
COPD: Chronic Obstructive Pulmonary Disease
HF: Heart Failure
PN: Pneumonia
HF: Heart Failure
CABG: Coronary Artery Bypass Grafting
EMR: Electronic Medical Record
HCAHPS: Hospital Consumer Assessment of Healthcare Providers and Systems

VBP Program Overview

- Set forth under section 1886(0) of the social security act
- Ties hospital reimbursement to the quality of care, not just the quantity of inpatient acute care services
- Funded by a 2% reduction from participating hospitals' base operating Medicare Severity Diagnosis Related Group (MS-DRG) payments
- When selecting new measures for the Hospital VBP program the measure must have been originally specified under the Hospital Inpatient Quality Reporting (IQR) Program
- CMS will refrain from beginning the performance period for any new measure until the data on that measure have been posted on Hospital Compare for at least a year
- It is an estimated budget-neutral program (Federal FY 2024 estimated available funds 1.7 Billion)

FY 2024 Domains and Measures CY 2022 Discharges

Clinical Outcomes (25%)

MORT-30-AMI: Acute Myocardial Infarction (AMI) 30-Day Mortality Rate
MORT-30-CABG: Coronary Artery Bypass Graft (CABG) Surgery 30-Day Mortality Rate
MORT-30-COPD: Chronic Obstructive Pulmonary Disease (COPD) 30-Day Mortality Rate
MORT-30-HF: Heart Failure (HF) 30-Day Mortality Rate
MORT-30-PN: Pneumonia (PN) 30-Day Mortality Rate
COMP-HIP-KNEE: Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Complication Rate

Efficiency and Cost Reduction (25%)

MSPB: Medicare Spending per Beneficiary

Person and Community Engagement (25%)

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Dimensions

Communication with Nurses
Responsiveness of Hospital Staff
Cleanliness and Quietness of Hospital Environment
Care Transition
Communication with Doctors
Communication about Medicines
Discharge Information
Overall Rating of Hospital

Safety (25%)

CAUTI: Catheter-associated Urinary Tract Infection
CDI: *Clostridium difficile* Infection
CLABSI: Central Line-associated Bloodstream Infection
MRSA: Methicillin-resistant Staphylococcus aureus Bacteremia
SSI: Surgical Site Infection- Colon Surgery and Abdominal Hysterectomy

Kaweah Health VBP FY 2024 Performance Report CMS Snapshot (CY 2022 Discharges)

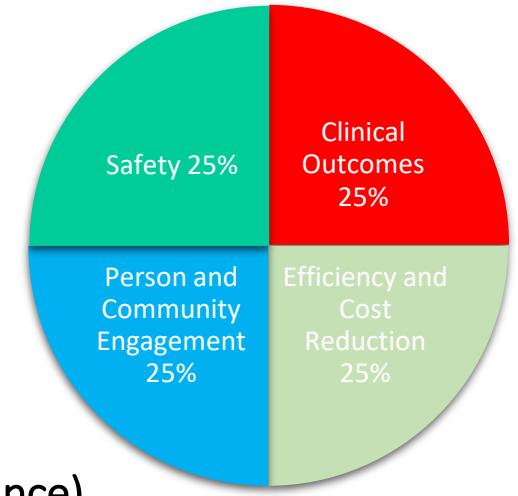
CHA FY 2024 VBP Estimated Cost	
Contribution	CHA Estimated Payment Received
2% = $1,759,600	$1,111,800
Estimated Loss: ($-647,700)	

Outperforming (Earned points):

- Elective THA/TKA Complication Rate (Safety Domain)
- HAIs: CAUTI, CLABSI, MRSA, SSI Colon (Safety Domain)
- Medicare Spending per Beneficiary (MSPB) [Efficiency & Cost Reduction Domain]

Opportunities (Did not earn points [Zero]):

- Mortality: AMI, COPD, CABG, HF, & PN (Clinical Outcomes Domain)
- HAIs: C Diff (Safety Domain)
- Pt Experience Survey/HCAPHS (we performed lower in all dimensions compared to our baseline performance for VBP HCAPHS) [Person & Community Engagement Domain]



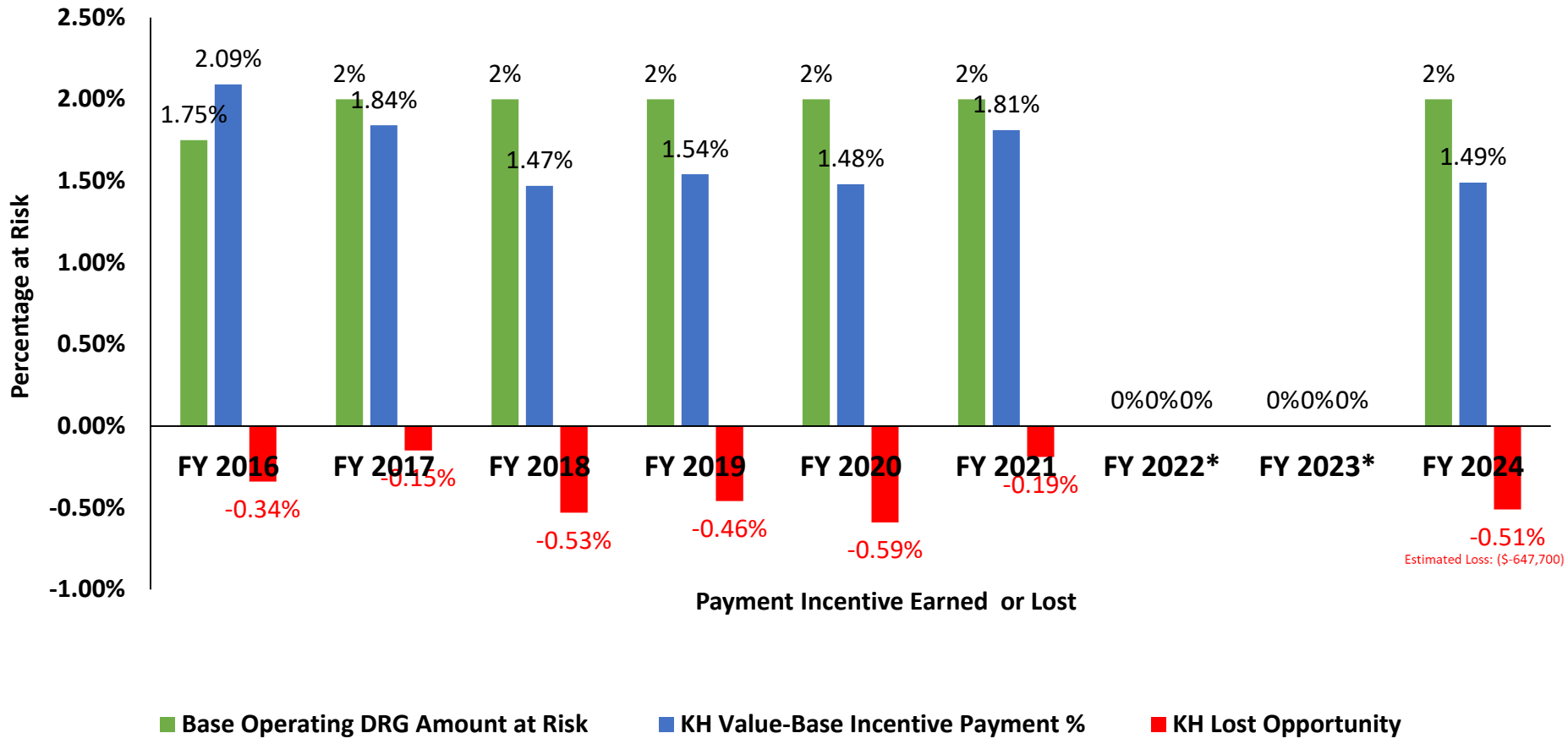
Not enough volume of cases to compare or generate a score (does not negatively impact performance)

- SSI-Abdominal Hysterectomy

Kaweah Health VBP Performance

*VBP Exclusion Reason for FY 2022 & FY 2023:

- Due to a public health emergency, CMS suppressed several measures
- There was not enough data to award a Total Performance Score



FY 2025 Domains and Measures CY 2023 Discharges

No metric changes

Clinical Outcomes (25%)

MORT-30-AMI: Acute Myocardial Infarction (AMI) 30-Day Mortality Rate
MORT-30-CABG: Coronary Artery Bypass Graft (CABG) Surgery 30-Day Mortality Rate
MORT-30-COPD: Chronic Obstructive Pulmonary Disease (COPD) 30-Day Mortality Rate
MORT-30-HF: Heart Failure (HF) 30-Day Mortality Rate
MORT-30-PN: Pneumonia (PN) 30-Day Mortality Rate
COMP-HIP-KNEE: Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Complication Rate

Efficiency and Cost Reduction (25%)

MSPB: Medicare Spending per Beneficiary

Person and Community Engagement (25%)

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Dimensions

- Communication with Nurses
- Responsiveness of Hospital Staff
- Cleanliness and Quietness of Hospital Environment
- Care Transition
- Communication with Doctors
- Communication about Medicines
- Discharge Information
- Overall Rating of Hospital

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SSI: Surgical Site Infection- Colon Surgery and Abdominal Hysterectomy

FY 2026 Domains Measures & Timelines

NEW: SEP-1 Severe Sepsis and Septic Shock Management Bundle (Composite Measure) added to CY 2024 discharges

Domain	Measure	Baseline Period	Performance Period
Clinical Outcomes	Mortality Measures (AMI, CABG, COPD, HF)	July 1, 2016– June 30, 2019	July 1, 2021– June 30, 2024
	Complication Measure	April 1, 2016– March 31, 2019	April 1, 2021– March 31, 2024
Person and Community Engagement	HCAHPS Survey	January 1, 2022– December 31, 2022	January 1, 2024– December 31, 2024
Safety	Healthcare-associated infection (HAI) Measures & SEP-1 Measure	January 1, 2022– December 31, 2022	January 1, 2024– December 31, 2024
Efficiency and Cost Reduction	MSPB Hospital	January 1, 2022– December 31, 2022	January 1, 2024– December 31, 2024

VBP Performance Period Happening Now!

FY 2026 Action Plans & Next Steps

EFFICIENCY & COST REDUTION

Medicare Spending

- Operation back in black teams are all working on efficiency and lowering costs

CLINICAL OUTCOMES

Mortality

- Best Practice team initiative working on standardizing best practices and key performance indicators for COPD, PN, & HF population

Hip & Knee Complications

- Nurse Practitioner performs daily patient rounding, collaborates with care team, & patient/family to ensure a safe discharge plan. Current efforts to enhance preoperative education, family/friend support throughout the surgical process and staying up to date to follow evidence-based clinical treatment pathways

PERSON AND COMMUNITY ENGAGEMENT

HCAHPS Survey

- Multidisciplinary rounds, hourly rounding, smile and greet as well as expanded focus on the human connection campaign

FY 2026 Action Plans & Next Steps

SAFETY

CLABSI

- Reduce line utilization, multidisciplinary rounds, & adherence to safe patient care environment including Hand hygiene practices.

CAUTI

- Reduce indwelling urinary catheter utilization, multidisciplinary rounds, adherence to nurse driven indwelling urinary catheter removal. Compliance with supporting a safe patient care environment including hand hygiene practices.

MRSA

- MRSA nares decolonization, Chlorhexidine gluconate bathing for selected patients or when inserting central lines. Compliance with supporting a safe patient care environment including hand hygiene practices.

C. DIFF

- Advocate for compliance with C Diff testing policy, ongoing communication with care team regarding testing practices, & EMR prompts to aid in decision making for C Diff testing. Compliance with supporting a safe patient care environment including hand hygiene practices.

SEPSIS

- Enhancements to EMR, & Expansion of Sepsis One Hour bundle to inpatient setting. Ongoing education to Medical Staff, Residents & Care Team

The pursuit of healthiness

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More than medicine. Life.

Outstanding Health Outcomes Update

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

June 2024

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Outstanding Health Outcomes (OHO) Dashboard

Sepsis (SEP)	FY 2024 Target	FY 2022	FY 2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	FYTD 24
SEP-1 CMS % bundle compliance	85%	75%	73%	68%	77%	76%	76%	82%	69%	71%	85%	71%				75%
Sepsis and Related Conditions o/e mortality	≤0.78		1.12	0.75	0.82	0.78	0.84	1.38	1.02	0.92	0.93	0.93				0.96

Central Line Associated Blood Stream Infection (CLABSI)	FY 2024 Target	FY 2022	FY 2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	FYTD 24
CLABSI Events		18 Ex COVID	14 Ex COVID	1	2	3	0	3	0	2	3	1	2	0		17
CLABSI SIR	0.39	1.01 Ex COVID	0.93 Ex COVID	0.83	1.16	2.22	0.00	1.15	0.00	1.29	2.31	0.86	1.50	0.00		1.14
Central Line Utilization Rate	0.68	1.02	0.88	0.749	0.791	0.828	0.774	0.685	0.876	0.822	0.799	0.66	0.79	0.749		0.77

Catheter Associated Urinary Tract Infection (CAUTI)	Target	FY	FY	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	FYTD 24
CAUTI Events		23 Ex COVID	12 Ex COVID	0	0	2	0	2	1	1	0	0	2	0		8
CAUTI SIR	0.40	1.09 Ex COVID	0.55 Ex COVID	0.00	0.00	1.06	0.00	0.97	0.46	0.46	0.00	0.00	0.07	0.00		0.38
Indwelling Uninary Catheter (IUC) Utilization Rate (ICU)	0.70	1.18	1.22	0.869	0.925	1.040	1.080	1.10	1.077	1.025	1.07	0.98	1.00	0.82		1.00

Methicillin-Resistant Staphylococcus Aureus (MRSA)	Target	2022	2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	FYTD 24
MRSA Events		10 Ex COVID	6 Ex COVID	0	0	1	0	1	3	2	0	0	0	0		7
MRSA SIR	0.55	1.11 Ex COVID	0.66 Ex COVID	0.00	0.00	1.47	0.00	1.32	3.00	2.26	0.00	0.00	0.00	0.00		0.80

KEY	Does not meet goal/benchmark	Within 10% of goal/benchmark	Outperforming/ meeting goal/benchmark

Action Plan Summary

Our Mission

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

Our Vision

To be your world-class healthcare choice, for life

Sepsis

- Focus on 1 hr bundle and expanding to inpatient areas, new order sets/power plans in process with physician stakeholders
- Six Sigma improvement work in process to re-identifying root causes of SEP-1 non-compliance to focus improvement work on the highest contributing factors

Healthcare Acquired Infections

- Super "HAI Brain Trust" Quality Focus Team established, approved by Quality Improvement Committee
- Combine and focus efforts on process metrics that affect the SIRs for CAUTI, CLABSI & MRSA and includes:
    - Line utilization (both central lines and indwelling urinary catheters
        - Multidisciplinary Rounds (MDR) started January 2024 in ICU, addresses line necessity (less lines=less infections), monitoring line utilization rates to evaluate effectiveness; ICU central line and ICU utilization rates for last 2 months (March & April 2024) have been lower that FY23 SUR. Plan to spread MDRs to DCVICU and Step Down units following Intensivist-Hospitalist transitions.
        - Reinvigorate the Standardized Procedure – medical staff approved criteria for nurses to remove urinary catheters
    - Decolonization rates
        - Nasal Decolonization– Significantly improved from 32% (Jan-June 2023) to 84% (July – Jan 2024). Includes patients who are screened and test positive for MRSA upon admission and not discharged within 24 hours of Mupirocin order (decolonization agent). Next Steps – determining and addressing root causes of patients missed screening, and review of workflow of Mupirocin order to administration processes
        - Skin Decolonization – developing process for skin decolonization through CHG bathing
    - Cleaning effectiveness in high risk areas
        - Quantifying the effectiveness of cleaning during EVS onboarding and annual review with ATP testing; continue to measure cleaning effectiveness through ATP testing in high risk areas (ie. OR's, ICUs)
    - Hand Hygiene (use of BioVigil system for monitoring)
        - Increase use of BioVigil system, improvement from 31% of active users achieving target badge hours in FY 2023, to 51% (July 23' to Mar 24'). Next steps, additional tools provided to leaders and staff to support increase use, and evaluation of active users with the denominator
        - Started March 2024 – RECOGNITION PROGRAMS for units/departments that have achieve highest % of staff meeting 80hrs active time (paired) per month!

Questions?

The pursuit of healthiness