June 9, 2022

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, June 16, 2022, 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 Thursday, June 16, 2022, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277, pursuant to Health and Safety Code 32155 & 1461.

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Quality Council Committee meeting at 8:00AM on Thursday, June 16, 2022, 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
Michael Olmos, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
Board Clerk, Executive Assistant to CEO

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

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
QUALITY COUNCIL

Thursday, June 16, 2022
5105 W. Cypress Avenue
Kaweah Health Lifestyle Fitness Center Conference Room

ATTENDING: Board Members; David Francis – Committee Chair, Michael Olmos; Gary Herbst, CEO; Keri Noeske, RN, BSW, DNP, Chief Nursing Officer; Monica Manga, MD, Chief of Staff; Daniel Hightower, MD, Professional Staff Quality Committee Chair; Tom Gray, MD, Quality and Patient Safety Medical Director; Sandy Volchko DNP, RN CLSSBB, Director of Quality and Patient Safety; Ben Cripps, Chief Compliance and Risk Management Officer; Evelyn McEntire, Director of Risk Management; and Rita Pena, Recording.

OPEN MEETING – 7:30AM

1. **Call to order** – *David Francis, Committee Chair*
2. **Public / Medical Staff participation –** Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdiction of the Board are requested to identify themselves at this time. For those who are unable to attend the beginning of the Board meeting during the public participation segment but would like to address the Board, please contact the Board Clerk (Cindy Moccio 559-624-2330) or cmoccio@kaweahhealth.org to make arrangements to address the Board.
3. **Approval of Quality Council Closed Meeting Agenda** – 7:31AM
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Daniel Hightower, MD, and Professional Staff Quality Committee Chair.*
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Keri Noeske, RN, BSW, DNP, Chief Nursing Officer*
   - **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** – *David Francis, Committee Chair*

CLOSED MEETING – 7:31AM

1. **Call to order** – *David Francis, Committee Chair & Board Member*
2. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Daniel Hightower, MD, and Professional Staff Quality Committee Chair*

3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Keri Noeske, RN, BSW, DNP, Chief Nursing Officer*
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** – *David Francis, Committee Chair*

OPEN MEETING – 8:00AM

1. **Call to order** – *David Francis, Committee Chair*
2. **Public / Medical Staff participation –** Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves at this time. Members of the public or the medical staff may comment on agenda items after the item has been discussed by the Committee but before a Committee recommendation is decided. In either case, each speaker will be allowed five minutes.
3. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives:
    - 3.1. Emergency Department Quality Report
    - 3.2. Renal Services Quality Report
    - 3.3. Subacute and Transitional Care Unit Quality Report
    - 3.4. Handoff Communication Quality Focus Team
    - 3.5. Diversion Prevention Committee
4. **Best Practice Teams Report –** A review of key performance indicators and improvement actions focused on four medical populations: Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Pneumonia, and Non-STEMI Acute Myocardial Infarction. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety, Wendy Jones, Director of Respiratory Services, BS, RRT, RPFT, Molly Niederreiter, Director of Rehabilitation Services, MSPT, Emma Mozier, Director of Medical-Surgical, MSN, RN, CNML, Christine Aleman, Director of Cardiovascular Operations, RN, MSN, & Michael Tedaldi, MD - Kaweah Health Medical Director of Best Practice Teams.*
5. **Nursing Workforce Study –** A review of the nursing work force, staffing, and improvement plans. *Keri Noeske, RN, BSW, DNP, Chief Nursing Officer.*
6. **Update: Clinical Quality Goals** - A review of current performance and actions focused on the fiscal year 2022 clinical quality goals. *Sandy Volchko, DNP, RN, Director of Quality and Patient Safety*.
7. **Adjourn Open Meeting** – *David Francis, Committee Chair*

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

Emergency Department Quality Report

Michelle Peterson MSN, RN – Director of Emergency Services

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Unit/Department: Emergency Dept.

QIC Report Date: May 2022

Reporting Period: Aug 2021 – Dec 2021

Kaweah Health

EMERGENCY DEPARTMENT PROCEDURAL SEDATION DASHBOARD

CONSENT METRICS	Jan 2021 KHMC	Feb 2021 KHMC	Mar 2021 KHMC	April 2021 KHMC	May 2021 KHMC	June 2021 KHMC	July 2021 KHMC	Aug 2021 KHMC	Sept 2021 KHMC	Oct 2021 KHMC	Nov 2021 KHMC	Dec 2021 KHMC
Volume of Procedures	33	30	46	32	31	41	38	26	27	27	42	32
Consent Initated	100%	79%	91%	94%	93%	94%	100%	100%	96%	100%	85%	87%
Consent Complete	13%	39%	53%	48%	47%	56%	41%	32%	52%	30%	44%	30%
MD Signed Consent	94%	75%	91%	84%	87%	94%	97%	86%	92%	100%	83%	78%
Patient Signed Consent	100%	71%	88%	93%	93%	92%	97%	95%	100%	96%	83%	87%
Witness Signed Consent								91%	92%	96%	69%	73%
FLOWSHEET METRICS												
Allergies	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Previous Anesthesia	88%	72%	72%	87%	77%	78%	81%	91%	96%	86%	57%	83%
MD Sign ASA	94%	72%	74%	90%	80%	92%	84%	95%	92%	86%	51%	87%
MD Sign Meds	91%	72%	77%	90%	80%	92%	84%	91%	100%	86%	57%	87%
RN Sign Meds	91%	76%	77%	87%	80%	83%	84%	100%	100%	86%	54%	80%
Pre/Intra/Post Pain Assessment	63%	55%	60%	74%	67%	72%	59%	77%	58%	63%	34%	67%
Pre/Intra/Post Vital Assessment	69%	62%	67%	84%	70%	61%	72%	82%	85%	83%	40%	70%
Pre Education	97%	83%	93%	97%	97%	95%	100%	100%	100%	100%	98%	100%
Post Education	83%	79%	75%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Timeout	55%	57%	63%	63%	52%	63%	53%	41%	41%	48%	52%	63%
Reversal Agent Usage	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

KEY	>10% above goal/benchmark	Within 10% of goal/benchmark	Outperforming/meeting goal/benchmark

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

Measure Objective/Goal:

The Emergency Department (ED) will strive to be within 10% of goal for the following procedural sedation metrics that are in the red.

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

For the last two quarters many of the metrics for procedural sedation components have been in the red.

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

March 7, 2022, an email was sent to all charge nurse/team lead (CN/TL) and ED RNs with a new process. This process will be shared and staff educated in person at the March 10, 2022 staff meeting, all procedural sedation packets will be reviewed by a CN/TL in real time. The CN/TL will check for accuracy and completeness allowing for time to address incomplete areas, the packets will then be placed in the HIM basket for pick up and scanning daily. We recently found for January 2022 that there were 15 packets that were left in the department and not sent to HIM for scanning resulting in the charts not being able to be abstracted. As well an ensuring the timeouts are completed per policy.

Next Steps/Recommendations/Outcomes:

Evaluate the process and the data.

Falls

Measure Objective/Goal:

We will be evaluating falls within the department for the last two quarters. This is a new metric for us to evaluate, we are working on getting data

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

Once we get the data we will evaluate the metrics and propose a plan

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

Quality Improvement Committee

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

Once we get the data we will evaluate the metrics and propose a plan

Next Steps/Recommendations/Outcomes:

Evaluate data and prepare plan to decrease falls, increase education

Submitted by Name:	**Date Submitted:**
Michelle Peterson	March 2022

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

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Kaweah Health

Renal Services Quality Report

Amy Baker MSN, RN – Director of Renal Services

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department:
Outpatient Renal: Kaweah Health Dialysis Clinic

ProStaff/QIC Report Date:
June 2022

Measure Objective/Goal:

Outperform the national mean and/or benchmark in reported quality measures

1. **Central Venous Access Management:**
   a. **Increase number of patients with arteriovenous fistula - Goal: 70% by end of year 2022**
   b. **Decrease number of patients with central venous catheter greater than 90 days- Goal: 10.7% by end of year 2022**
2. **Bloodstream Infection Reduction – Goal: Zero bloodstream infections**

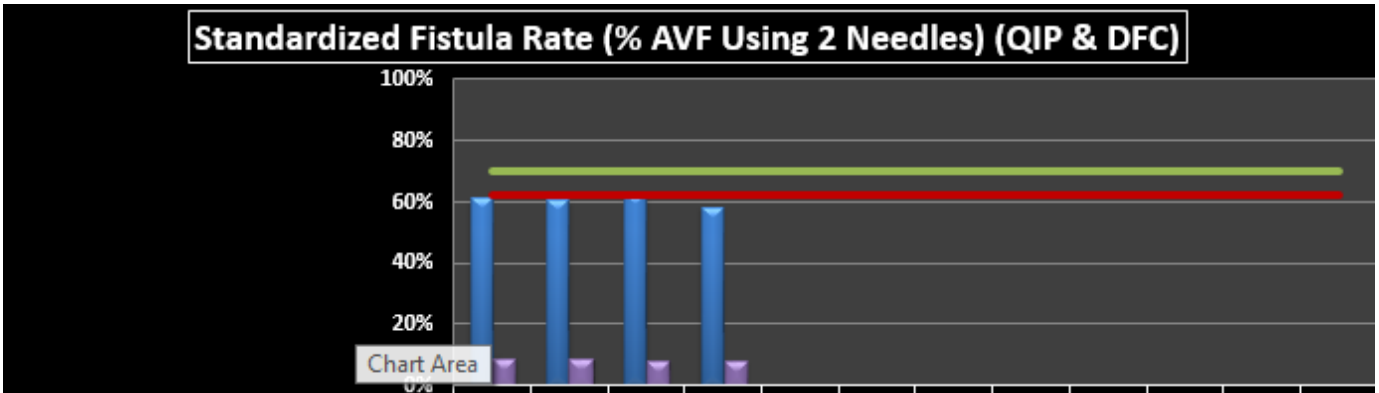
Date range of data evaluated:

January 2022 – April 2022

Analysis of all measures/data: (Include key findings, improvements, opportunities)
(If this is not a new measure please include data from your previous reports through your current report):

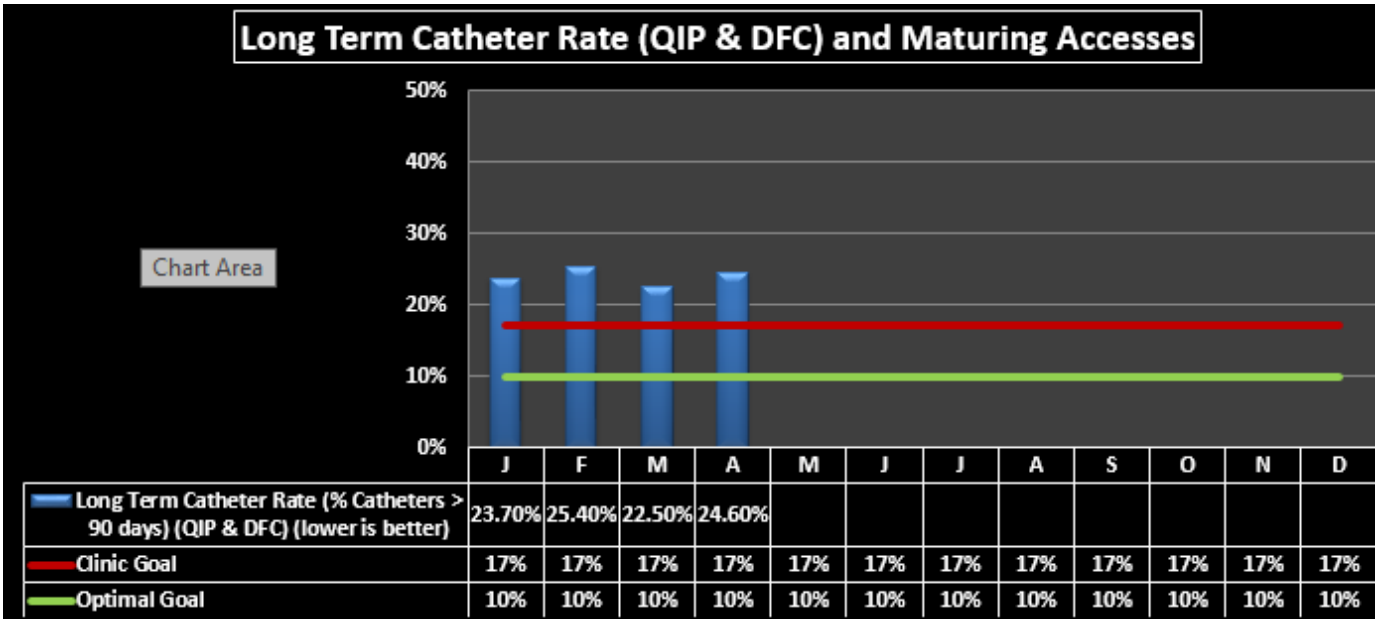
Month	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct
Pt Census	131	129	134	134						
Vascular Access										
AVF	61%	60.3%	62.4%	58.2%						
AVG	8.4%	8.7%	8.3%	8.2%						
Central Venous Catheter										
Total CVC	30.5%	31%	29.3%	33.6%						
CVC w/AVF Maturing	5.3%	4.0%	1.5%	4.5%						
CVC w/AVG Maturing	0%	0%	0%	0.7%						
CVC <90 day	6.9%	5.6%	6.8%	8.9%						
CVC >90 day	23.7%	25.4%	22.5%	24.6%						

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



	J	F	M	A	M	J	J	A	S	O	N	D
Standardized Fistula Rate (SFR) (% AVF using 2 needles) (QIP & DFC) (higher is better)	61.00%	60.30%	62.40%	58.20%								
% AVG	8.4%	8.7%	8.3%	8.2%								
AVF Clinic Goal	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%
AVF Optimal Goal	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%

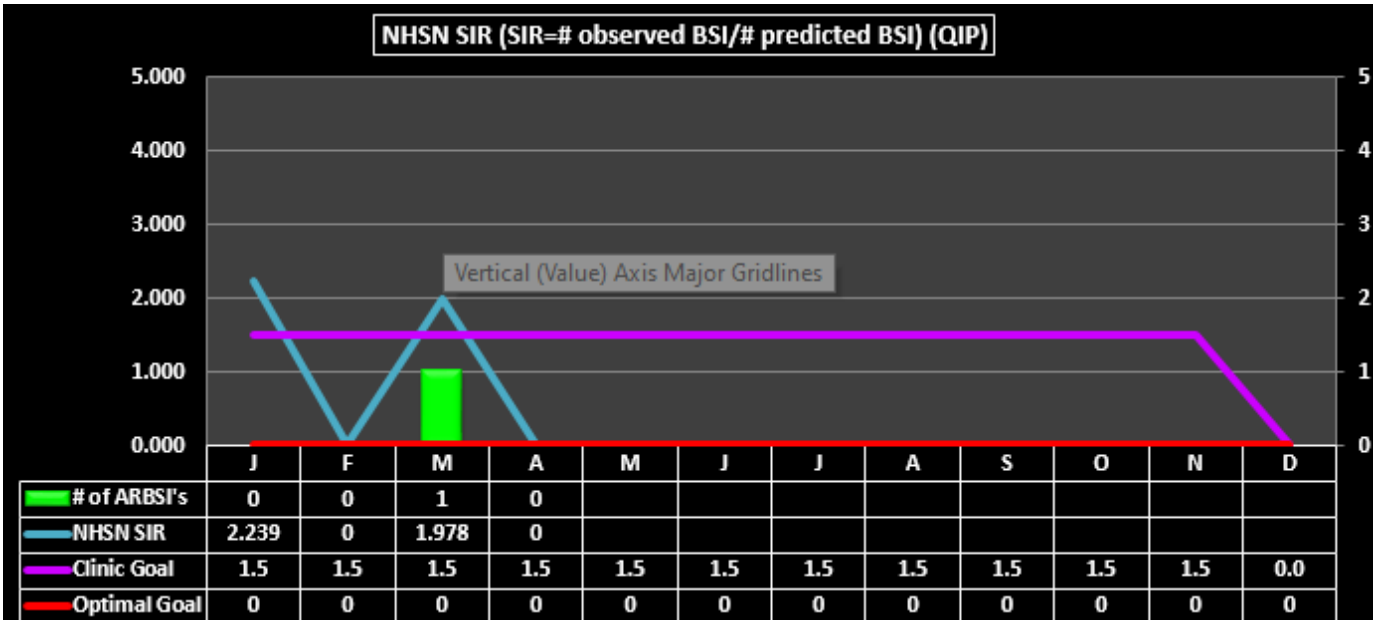
1. Vascular access management is below our clinic goal and optimal goal. The CMS QIP PY2022 benchmark (90th percentile of performance rates nationally for AVF (arteriovenous fistula) is 70%. Working with the clinical coordinator to establish a workflow to speed up referral process. We are utilizing clinic secretaries to schedule appointments for fistula placement. In addition, the secretaries are providing reminders to patients. These reminders include appointment reminders and procedure reminders to ensure compliance to increase the number of patients with fistulas at our dialysis clinic.



	J	F	M	A	M	J	J	A	S	O	N	D
Long Term Catheter Rate (% Catheters > 90 days) (QIP & DFC) (lower is better)	23.70%	25.40%	22.50%	24.60%								
Clinic Goal	17%	17%	17%	17%	17%	17%	17%	17%	17%	17%	17%	17%
Optimal Goal	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%

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

2. The CMS QIP PY 2022 benchmark (90th percentile of performance rates nationally) for CVC >90 days is 5.07%. The optimal goal is to be at the Network 18 goal of 10% CVC >90 days by year end 2022. Our clinic goal is to reach 17% by the end of year 2022. Currently, our central venous catheters in for longer than 90 days is 25.40%. We continue to have new patients accepted into the dialysis clinic with catheters. Immediately upon admission to our clinic with a catheter, we began to schedule appointments to get a fistula created for patient. This process takes longer than 90 days due to high volume of patients seeing vascular surgeons. Will continue to work on throughput for this measure.



	J	F	M	A	M	J	J	A	S	O	N	D
# of ARBSI's	0	0	1	0								
NHSN SIR	2.239	0	1.978	0								
Clinic Goal	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	0.0
Optimal Goal	0	0	0	0	0	0	0	0	0	0	0	0

1. Bloodstream reduction management has had some areas of notable improvement but continues to be an area for improvement. The CMS QIP PY2022 benchmark (90th percentile of performance rates nationally) for Standardized (SIR) (# of observed infections/# of predicted infections) is 0.000 and an Achievement Threshold (15th percentile of performance rates nationally) of 1.365. The clinic monthly goal is zero infections. Our NHSN SIR is 0 for February, 1.978 for March and 0 for April 2022.

<u>If improvement opportunities identified, provide action plan and expected resolution date:</u>

1. The state dialysis network advocates a central venous catheter rate of less than 10% for patients in treatment greater than 90 days. The vascular access management process has been overseen by clinical coordinator, who has taken over the access manager role. The education process has become a team approach, involving all disciplines. Each new patient that is admitted to the dialysis clinic is scheduled for vein mapping to start the process of receiving a fistula. The clinical coordinator meets with the patient shortly after admission to review the steps to receive a fistula and to provide education. Some barriers

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

include access to vascular surgeons. We do have some patients refuse to receive a fistula. A challenge we have faced is the refusal by patients to be referred for a fistula.

2. Though our required participation in Network 18 (Medicare's geographical name for California) projects has concluded, we have opted to continue monthly infection prevention audits. These audits include weekly observations of hand hygiene compliance, medication preparation and administration, and central venous access exit site care. With our spikes in blood stream infections, this year we have provided education to patients about importance of washing their hands and fistula sites prior to initiating dialysis. We have provided patient and employee education on importance of chlorhexidine. Additionally, we implemented BioVigil hand hygiene monitoring system to ensure appropriate hand hygiene is being completed. This should also assist with reducing blood stream infections.

Next Steps/Recommendations/Outcomes:

1. With our clinical coordinator overseeing access, we have seen an increase in referrals and catheter being taken out. Renal Director and Clinical Access Coordinator continue to meet every week to discuss developments and work on improvement plans as needed.
2. New clinical educator working on education to prevent bloodstream infections.

Submitted by Name: Amy Baker, MSN, RN- Director of Renal Services

Date Submitted: June 2022

Acronym Key:
AVF- arteriovenous fistula
AVG- arteriovenous graft
CVC- central venous catheter
QIP-quality incentive program
DFC- dialysis facility compare
ESRD- End Stage Renal Disease
CMS- Centers for Medicare and Medicaid Services
PY2022- plan year 2022
NHSN- National Healthcare Safety Network
SIR- standard infection ratio
BSI- bloodstream infection
ARBSI- access related bloodstream infection

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

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Kaweah Health

Subacute and Transitional Care Unit Quality Report

Elisa Venegas MSN, RN, CRRN – Director of Nursing - Rehab and Skilled Nursing

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Sub Acute, TCS, and SS Rehab **Report Date: April 2022**

Measure Objective/Goal:

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

Date range of data evaluated:

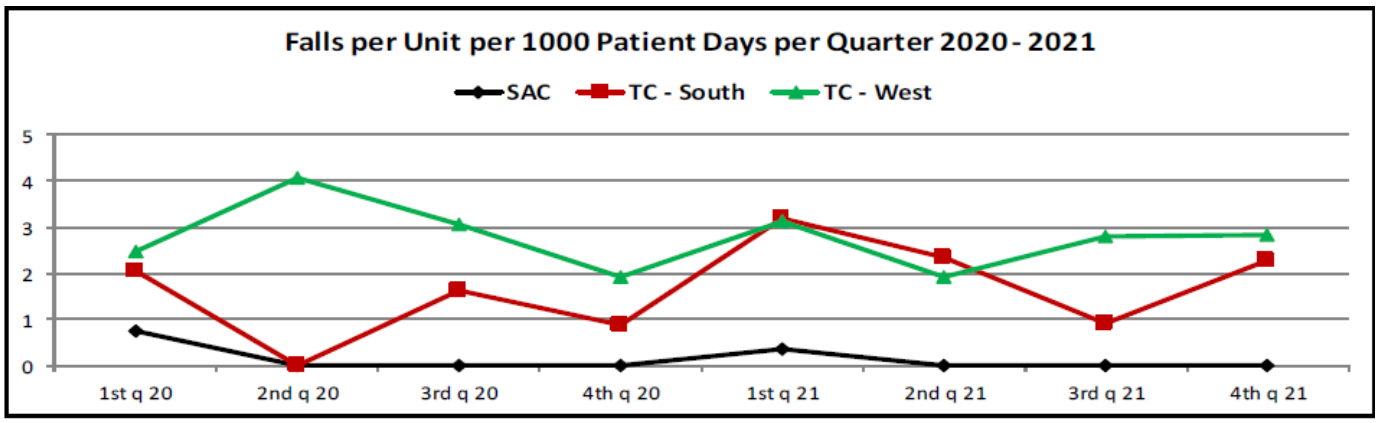
All categories are from the Report Period: 2020-2021. Comparison group: Casper Report from 2/2/2022 for period 08/01/2021-11/30/2021, and 1st quarter 2021 through 4th quarter 2021, internal data.

Nationally benchmarked quality data is collected through the MDS submissions process. 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 275+. 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 as related to internal performance.

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

Measure Objective/Goal: Falls

The rate of falls per 1000/pt. days in 2021 at 1.22 show an overall increase from 2020 at 0.99. Facility observed percent for falls for long stay patients in the most current CASPER report is 0%, remaining well below national average of 44%, placing the program in the top 1 percentile nationally.



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

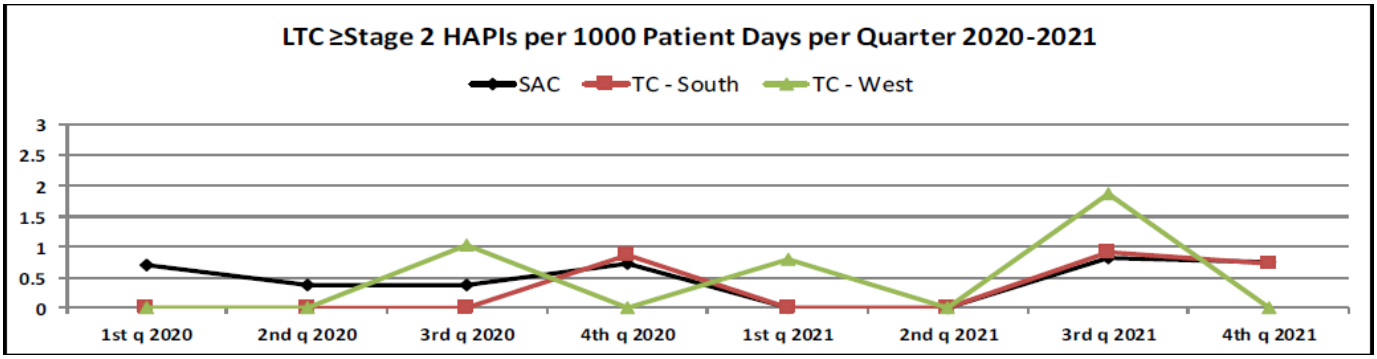
Staff continues to participate in, and has a high rate of compliance with, district-wide initiatives for fall prevention. The skilled nursing units have many mobile patients and a "no restraint" environment. Falls occur most commonly with our short-stay population, all of whom are involved with therapy programs to enhance functional mobility. We will continue fully participation in the Kaweah Health prevention protocols. The recent increase in falls on the units prompted several interventions, these include increased orientation transfer competency for new staff.

Measure Objective/Goal: Pressure Injuries

a. Incidence of new or worsening pressure ulcers for short stay patients (which would also include Sub Acute patients with a length of stay under 100 days) as reported on the Casper report is 1%, well below the national average of 2.7%.

b. Patients at High risk for Pressure Ulcers (Long Stay residents, defined as high risk, who have Stage II-IV pressure ulcers) is 7.4%. This is a decrease from 10.9% in the last report, with a national average of 9% and a state average of 8.5%. This puts us at the 46th percentile, an improvement from a previous 86th percentile. 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 report 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.

c. Overall, the total wound rate for the three SNF units rate per 1000/pt. days for 2021 was 0.46. This is an increase from last year 2020 at 0.33. All three 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.



2. **<u>If improvement opportunities identified, provide action plan and expected resolution date:</u>**
   - **a.** 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.

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

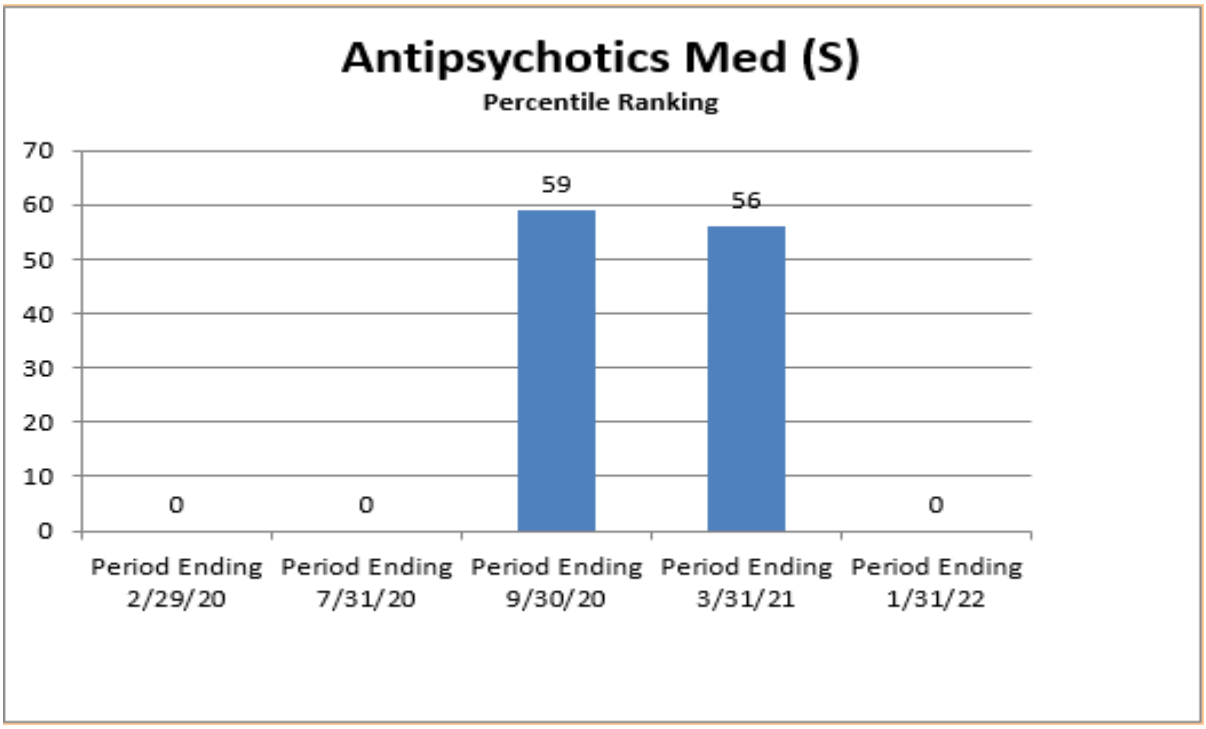
<u>Measure Objective/Goal: Psychoactive medication use:</u>

<u>Definitions/Assumptions:</u>

This measure is collected through the MDSs that are completed and submitted to CMS at defined intervals by the program. The data includes only 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 impact this data directly.

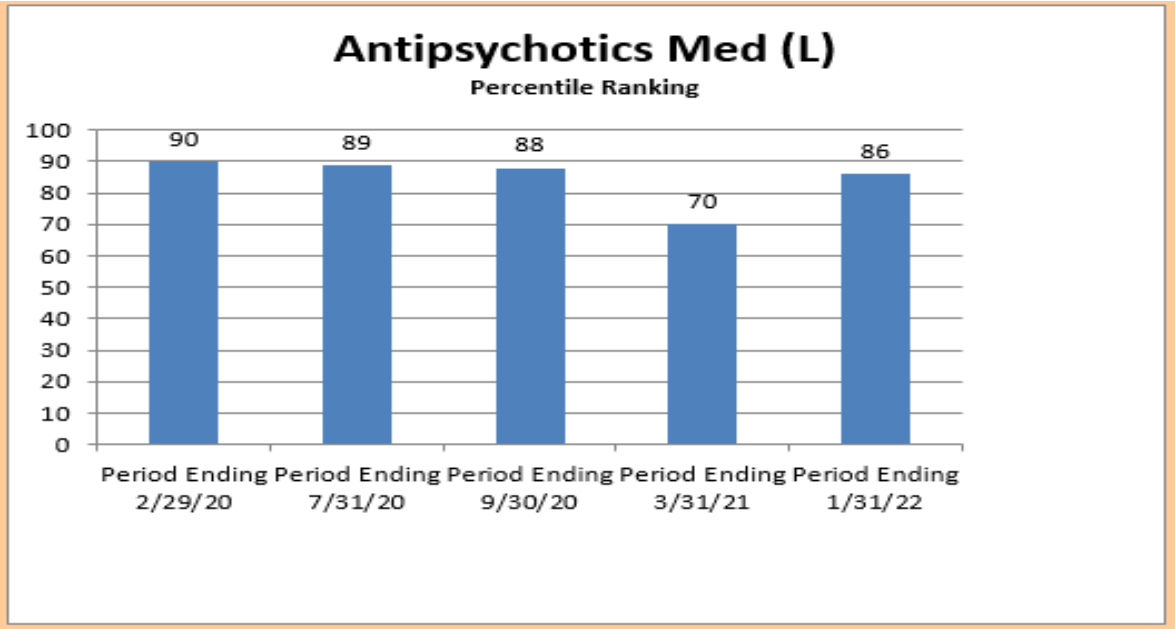
Increased use of medications in the antipsychotic drug-class for management of depression is also moving our results in these measures. Antianxiety and hypnotic medication use is not reported as a quality measure for the short-stay population. The data is collected through the MDS, but is not included in the measures that make up our quality ranking. All values are expressed in percentile rankings.

<u>Short Stay residents (<100 days).</u> Antipsychotic medication use for short stay patients is below national average, which measures only cases with newly prescribed antipsychotics. The facility four quarter percent for short stay patients who begin a new anti-psychotic during their stay is 0%, putting us at the zero percentile (lower is better). The comparison national average is 1.9%.

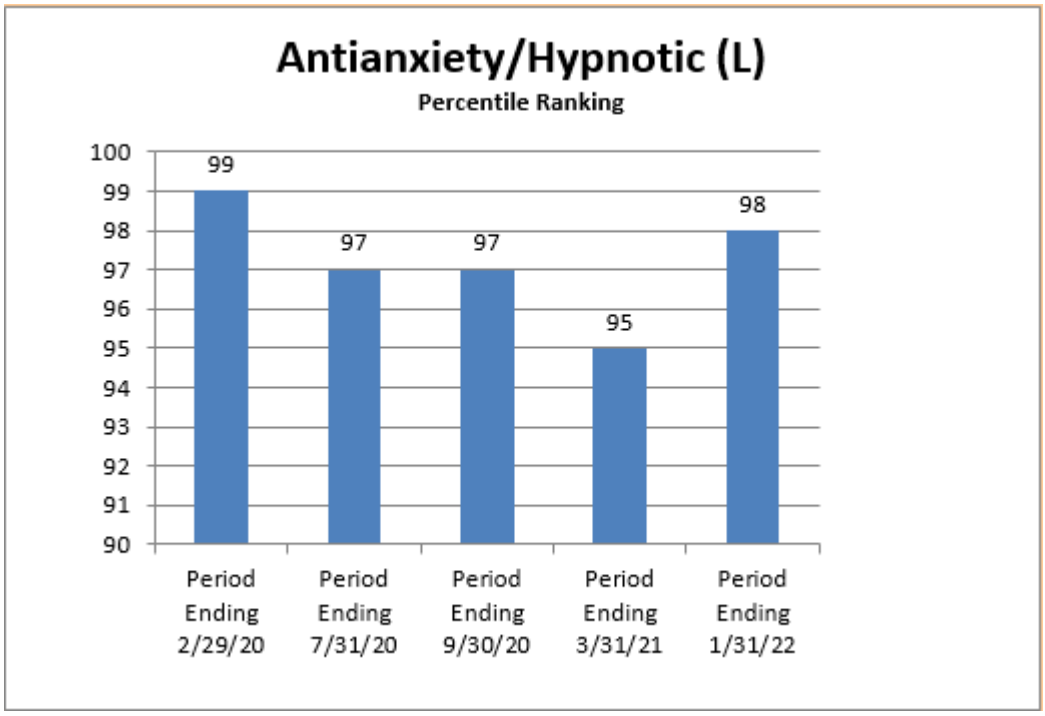


Long Stay residents. The facility percent for antipsychotic use in long stay residents is 24.1%. This puts us at the 86th percentile (lower is better). The national average is 14.6%. Unlike the short stay measure, which only includes newly prescribed antipsychotics, the long-stay measure includes all 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. This is another instance where our target client group for long-term care (our 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 98th percentile from the 95th percentile the previous year. Our utilization rate is 50%, but national rates remain at 19.6%. 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 medications and 2: using psychotropic medications to control behaviors (as a chemical restraint) or for more "convenient" management of "difficult" patients. 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 that we follow all of these medications closely during the transition process. Our primary focus is on unnecessary medications, (like prn hypnotics). Hence, we also monitor for the potential for dose reductions when possible.

All residents receive a monthly medication regimen review and physician consultation by our LTC pharmacist. This close partnership has helped reduce psychoactive medication use generally, including reducing doses through gradual dose reduction practices. We have seen a reduction in the use of hypnotic medications in our short-term (under100 days) patients, in particular.

Although we struggle in this measure, in the past three years of CMS surveys (including the last annual survey in April 2019) there have been no findings around inappropriate use of psychotropic medications in any of our programs.

Submitted by Name: Elisa Venegas

Date Submitted: April 2022

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Kaweah Health

Handoff Quality Focus Team 6/7/2022

Kassie Waters, Director of Cardiac Critical Care Services

Team Mission

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

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

Team Deliverables & Goals

Deliverables

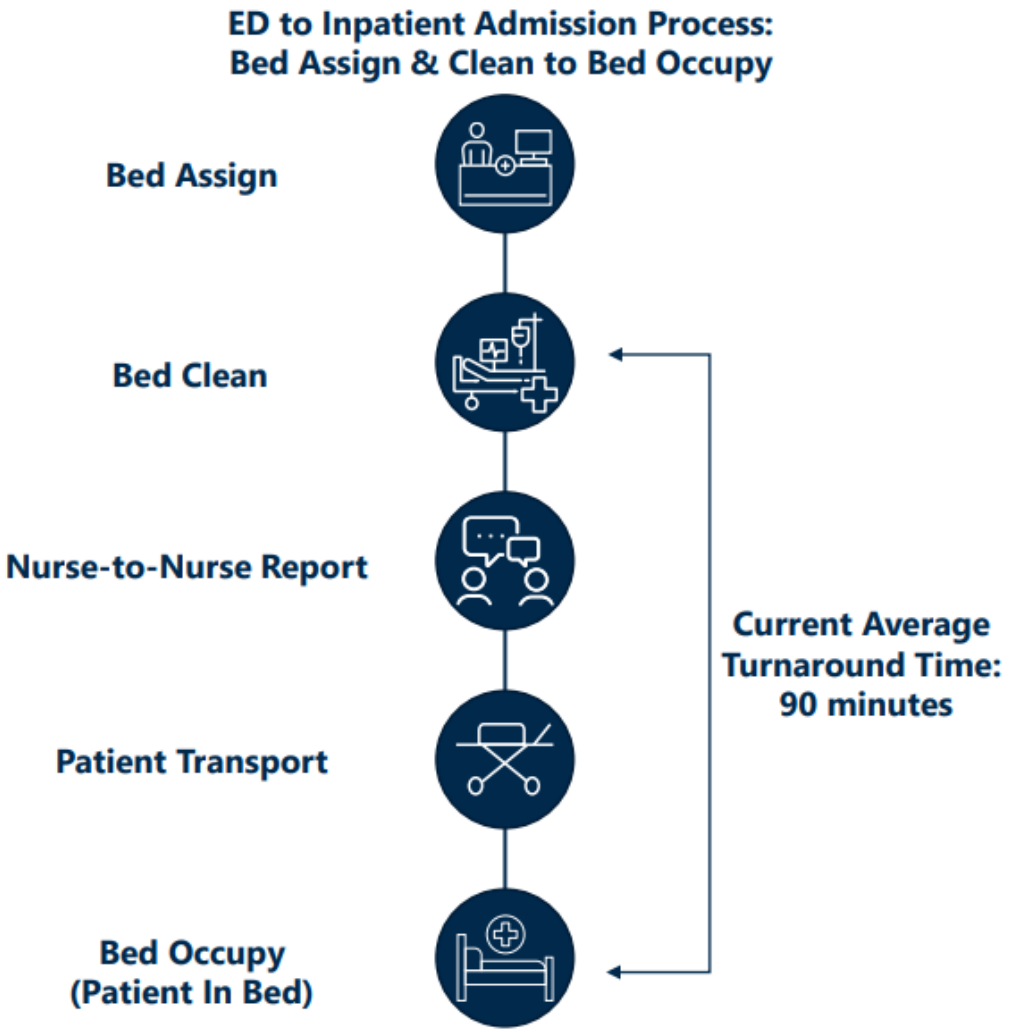
1. Establish standard process
2. Standardize critical content elements
3. Build standard handoff tool utilizing EMR
4. Standardize training & education

Goals

<u>Quality of Handoff Measurement</u>

1. ED nurse "sender" provided accurate and complete information with 80% of handoffs (Current state is 15%)
2. Timeliness of Admission/Handoff – Clean bed to occupied 60 minutes. (Current time is 90 minutes)

Timeliness of Admission/Handoff



PROJECT OBJECTIVE

• Problem – Once a patient is assigned to a bed and the bed is cleaned, it can take upwards of 90 minutes for the patient to arrive to the receiving unit

• Solution – Develop a goal for bed assign & clean to bed occupy turnaround time and set clear expectations with Emergency Department nursing, inpatient nursing and patient transport staff.

PROGRESS TO-DATE

• Proposed goal of 60 minutes and stretch goal of 45 minutes for average turnaround time (in minutes) from bed assign & clean to bed occupy.

Drafted guiding principles and reviewed supporting tools to facilitate RN-to-RN handoff between the Emergency Department (ED) and receiving inpatient units (present to leadership in June).

NEXT STEPS

• Finalize and rollout guiding principles and supporting tools to ED and inpatient unit nursing and hospital unit clerks.

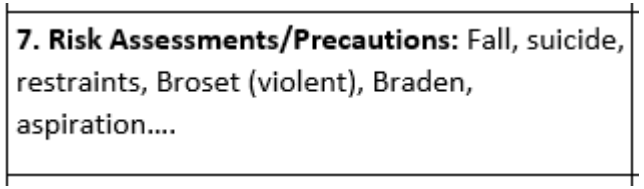
• Develop patient placement dashboard including various turnaround times to drive continuous improvements.

• Collaborate with Patient Transport to establish goals and discuss potential future state parallel processes for RN-to-RN handoff & patient transport.

Handoff Tool Update & Next Steps

Standardize Handoff

- Met with emergency department (ED) leadership and reviewed Greely findings regarding standardize handoff.
  - ED will utilize 11 Absolutes SBAR (Situation, Background, Assessment, and Recommendation) handoff tool until Cerner tool is completed. ED educator will provide education for all staff and include tool on-boarding new employees.
  - Added risk assessments to tool.



  - ED also making condense flyers to post in key areas where handoff occurs.
  - Will rollout process to all other acute care departments.
- July – perform department rounds to assess that everyone can speak and are utilizing standard tool.

EMR Handoff Tool Update & Next Steps

Electronic Medical Record Handoff Tool

Progress to Date

1. ISS presented New Cerner Handoff best practices.- DONE
2. Present tool to Nursing Shared Decision group to obtain feedback. - DONE

Next Steps

1. Finalize and build handoff tool. July-Aug
2. Rollout and educate staff. Aug-Sept (will review best time for education with Directors)
3. Re-evaluate tool. October

Side Note

- Need to assess if Cerner handoff patient information can be reviewed retrospectively.
- Evaluating if hardcopy of handoff can be printed to assist with efficiency of nursing workflow.

Questions

Diversion Prevention Committee Report

Evelyn McEntire BSN, RN – Director of Risk Management
Shannon Cauthen MSN, RN, CCRN-K – Director of Critical Care Services and 3W

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: Kaweah Health – Diversion Prevention Committee

ProStaff/QIC Report Date: 3/14/2022

Measure Objective/Goal:

The Diversion Prevention Committee Goals include:

- Develop an organizational program to build awareness of and response to behaviors suspicious for drug diversion.
- Build a culture within the organization of attention to drug diversion prevention.
- Implement education with orientation and annual training related to awareness of and response to drug diversion for all staff and providers.
- Ensure continued awareness and knowledge of diversion prevention strategies at all levels of the healthcare team including non-patient care areas.
- Develop a Leadership training program to provide enhanced skills for detecting and preventing diversion activities.
- Ensure accountability for action items related to routine audits and medication related reports by department leaders.
- Use of technology and automation to ensure audits and reporting are routine and applicable.
- Communicate noted trends identified through Pharmacy audits such as Bluesight, Pyxis overrides, etc. or the occurrence reporting system to department leaders.
- Monitor all active audits outlined in the CMS diversion plan of correction until compliance is met and audits are closed.

The Diversion Prevention Committees Measures of Success include:

- All existing District staff will complete the appropriate MAT training module regarding diversion prevention topics with at least 90% compliance each quarter.
- All new hire District staff will complete orientation education regarding diversion prevention topics with at least 90% compliance each quarter.
- Committee members to verify efficacy of ongoing diversion prevention education by conducting 15 or more interviews each of varied District staff, residents, and medical staff each quarter with at least 90% answering 4/4 questions correctly.
- Provide education to the Leadership group at least once per quarter to provide enhanced knowledge and skills for detecting and preventing diversion activities.
- Monthly review of audit dashboard reveals improvements in audit outcomes.

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

Date range of data evaluated: Jan – Feb 2022

The Diversion Prevention Committee was formed in April 2021 in response to a recognized need for education and monitoring after two unrelated diversion events were identified within the organization. The initial goals are to increase awareness of the risk of diversion in the health care setting and increase knowledge of the signs and symptoms of diversion.

From January – February 2022 the following goals were achieved:

Diversion Prevention Awareness Mandatory Education (Ongoing):

- Diversion Prevention Strategies Education (ongoing) – All Employees – In progress through April 2022 via MAT I module
- Leadership Awareness Education (ongoing): In progress through April 2022 via MAT I module
- Pharmacy-Related Monitoring:
    - 7 of 7 audits successfully completed with expected compliance rates:
        - Diversion 5 - Revenue Integrity Technician (Closed)
        - Diversion 6 - Monitoring of Diluted Controlled Substance and Fentanyl Waste (Closed, but continued monitoring by Pharmacy with reduced sample size with monthly monitoring);
        - Monitoring Plan 2 – Fentanyl Waste and Diluted Controlled Substance Waste (Closed);
        - Diversion 9 - Securing Scheduled Medications Diversion (Closed);
        - Diversion 9 – Lorazepam IV Bulk Storage (Closed);
        - Diversion 10 - Follow-up on Drug Losses from Manufacturer (Closed); and
        - Diversion 11 – Short Case Reviews (Closed, but continued monitoring by Pharmacy with reduced sample size with monthly monitoring).

Analysis of all measures/data: (Include key findings, improvements, opportunities)
(If this is not a new measure please include data from your previous reports through your current report):

- In Progress – end of April 2022: Existing District staff completed the appropriate MAT I training module regarding with at least 90% compliance this quarter.
- In Progress – end of April 2022: New hire District staff completed the appropriate MAT I training module on diversion awareness, prevention, signs and symptoms of abuse and diversion and expectations of all team members diversion prevention topics with at least 90% compliance this quarter.
- In Progress – end of April 2022: Diversion Prevention Committee members conducted 119 interviews of varied District staff, residents, and medical staff each quarter with *X*% of staff, residents, and medical staff answering 4/4 questions correctly.

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

- In Progress – end of March 2022: Ongoing Leadership education was provided on diversion recognition and prevention strategies in November 2021. Education regarding the District's current investigative process for reported diversion concerns was provided in December 2021.
- In Progress – end of March 2022: Monthly review of CMS Plan of Correction Pharmacy-related audits which report to the Diversion Prevention Committee continue to be monitored by the Committee. They are closed, continued, or intermittently spot-checked as determined by the Committee.

Please see the document attached to this report which provides details of each item as it relates to the CMS action plan. Seven (7) action plan audits are being reported into the Diversion Prevention Committee.

All seven audits remained 100% compliant. The Committee has agreed to close the seven (7) remaining audits as indicated on page 2 of this report. There will be no remaining audits reported to the Committee as of 1Q2022.

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

The purpose of the Diversion Prevention Committee is to identify opportunities and create action items on an ongoing basis.

At this time, the improvement opportunity continues to be to raise awareness and increase knowledge of the identification and risks of diversion for all staff and providers at KDHCD using creative and varied methods in addition to computer-based learning. Interviews of staff and leaders by Committee members will continue on a quarterly basis to monitor learning retention and effectiveness of ongoing education. This will allow the Committee to identify existing gaps and associated actions. Education will be changed or reinforced based on those findings.

Review of Pharmacy-related internal audits such as Bluesight analytics and Pyxis report review as well as monitoring of occurrence reports and employee behavior concerns will also steer the Committee's continued efforts to educate, inform and monitor diversion-related activities to prevent the diversion of medications in the health care setting.

Next Steps/Recommendations/Outcomes:

Continue to monitor the effectiveness of the education through staff, provider and leader interviews by Committee members.

Create additional education as needed based on interviews, audits and occurrence reports.

Continue to monitor potential diversion-related events and increase surveillance by organizational staff and providers.

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

Modify existing goals within the Diversion Prevention Committee to meet the identified needs and opportunities for growth within the organization.

Incorporate Substance Abuse awareness and actions into the scope of the committee to support our teams.

Submitted by:
Shannon Cauthen, Co-Chair – Director of Critical Care Services
Evelyn McEntire, Co-Chair – Director of Risk Management

Date Submitted:
March 14, 2022

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

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Kaweah Health

Best Practice Team Update

Michael Tedaldi, MD - Kaweah Health Medical Director of Best Practice Teams
Wendy Jones, Director of Respiratory Services
Molly Niederreiter, Director of Rehabilitation Services
Emma Mozier, Director of Medical-Surgical
Christine Aleman, Director of Cardiovascular Operations

Quality Council
June 2022

Kaweah Health Best Practice Teams Acronyms

- ACE - Angiotensin Converting Enzyme inhibitors(medication to treat heart failure)
- ARBs - Angiotensin-Receptor Blocker (medication to treat heart failure)
- ARNI - Angiotensin Receptor-Neprilysin Inhibitor (medication to treat heart failure)
- AMI NSTEMI – Non-ST Elevation Acute Myocardial Infarction
- BB – Beta Blocker (heart medication)
- CAP – Community Acquired Pneumonia
- CHFrEF (“reduced EF” or “systolic HF”)
- CKD – Chronic Kidney Disease
- CMS - Centers for Medicare & Medicaid Services
- COPD - Chronic Obstructive Pulmonary Disease
- CPG – Clinical Practice Guideline
- CPW – Care Pathway
- D - denominator
- ED – Emergency Department
- EF – Ejection Fraction
- EKG - electrocardiogram
- FYTD – Fiscal Year to Date
- GFR - glomerular filtration rate
- GOLD Standards - Global Initiative for Chronic Obstructive Lung Disease
- HF – Heart Failure
- KPI – Key Performance Indicator
- LOS – Length of stay
- N - Numerator
- O/E – Observed divided by Expected
- PN – Pneumonia
- QI - Quality Improvement
- SARA - Selective Aldosterone Receptor Antagonist

Kaweah Health Best Practice Teams

Goal: Improve patient outcomes by standardizing care on 4 key patient populations (AMI- NSTEMI, COPD, HF & PN)

- Standardized care based on Clinical Practice Guideline (CPGs) and operationalize the standardized care through Care Pathways, provider power plans and new Cerner functionality (Care Pathways)
- 4 “Core Teams” established for each population, includes Medical Director, Quality Facilitator, Operational Director & Advanced Nurse Practitioner (APN)
- Outcomes include: Mortality, Readmission and Length of Stay

Best Practice Teams

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

Initiation

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

Goal: Identify clinical processes that will yield optimal patient outcomes

Phase I

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

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

Phase II

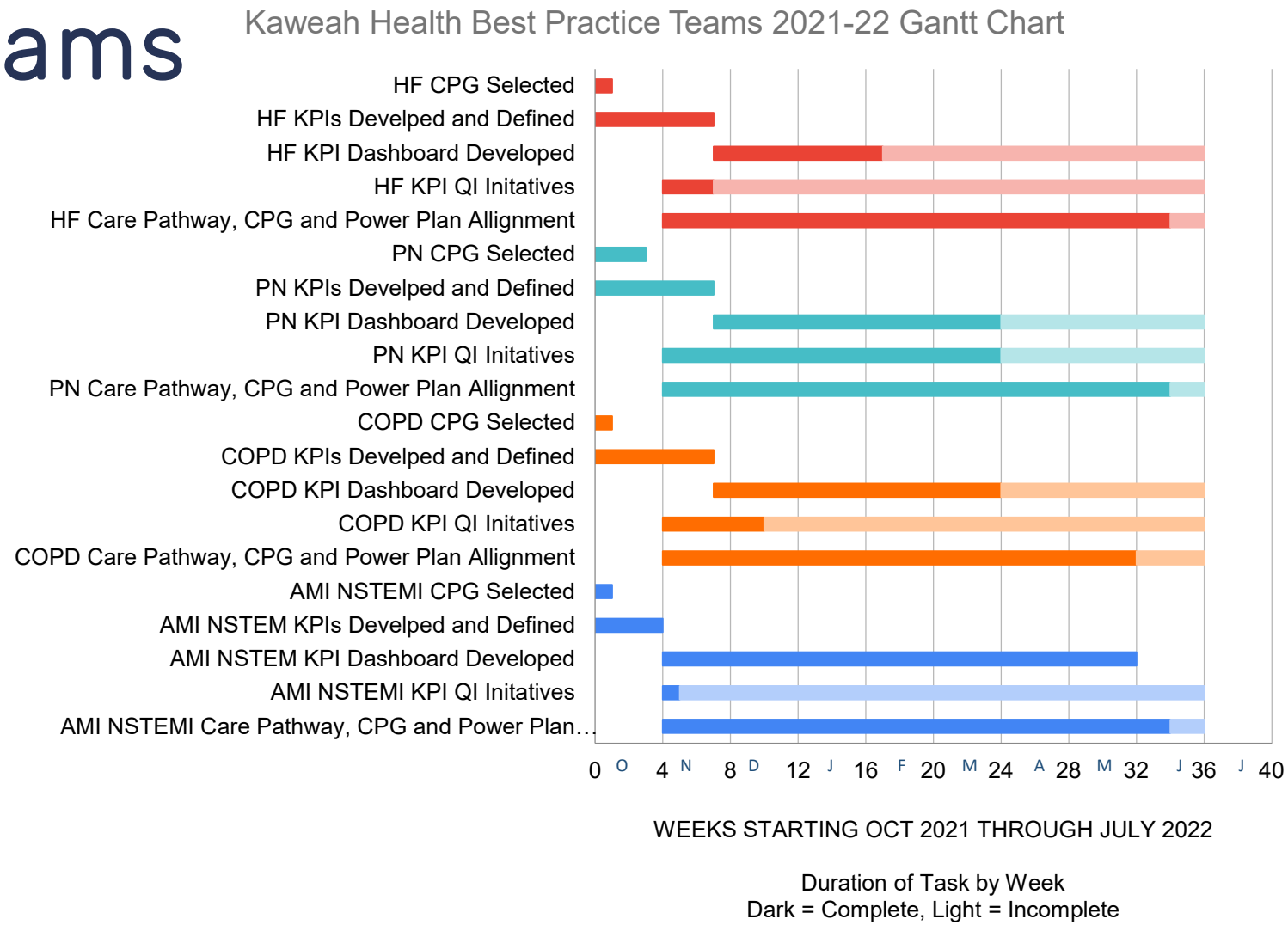
- Care Pathway developed
- Integrated into Cerner power plans & workflow
- QI Measures added to dashboard
- QI work to achieve targets

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

Kaweah Health Best Practice Teams

Goal: Improve patient outcomes by standardizing care on 4 key patient populations (AMI- NSTEMI, COPD, HF & PN)

- Standardized care based on Clinical Practice Guideline (CPGs) and operationalize the standardized care through Care Pathways, provider power plans and new Cerner functionality (Care Pathways)
- 4 “Core Teams” established for each population, includes Medical Director, Quality Facilitator, Operational Director & Advanced Nurse Practitioner (APN)
- Outcomes include: Mortality, Readmission and Length of Stay
- Key Performance Indicators (KPIs) defined, dashboards in development and QI work underway!!



Outcome Data

Kaweah Health Best Practice Teams Outcome Dashboard FY 2021

	Goal	Baseline (FY 2019)	1Q - 2Q 2021*	3Q 2021*	4Q 2021*	1Q 2022*	FYTD July 21-March 22*
Readmission Medicare Population	AMI (non-STEMI) – 11.01	12.34	12.5	7.14% (1/14)	12.5% (3/24)	6.67% (1/15)	9.43% (5/53)
	COPD – 12.87	16.09	10	27.27% (3/11)	28.57% (2/7)	22.22% (2/9)	25.93% (7/27)
	HF – 14.58	18.22	21.28	15.79% (6/38)	12.20% (5/41)	10.17% (6/59)	12.32% (17/138)
	PN Viral/Bacterial – 11.30	14.13	13.51	15.79% (6/38)	15.39% (6/39)	15.91% (7/44)	15.70% (19/121)
O/E Mortality Medicare Population	AMI (non-STEMI) - 0.71	0.75	0.84	0.85 (n=16)	0.96 (n=13)	1.50 (n=9)	0.98 (n=38)
	COPD – 1.92	2.4	0.93	2.73 (n=13)	0 (n=9)	1.49 (n=13)	1.87 (n=35)
	HF – 1.42	1.78	0.911	0.38(n=44)	0.62 (n=51)	0.78 (n=65)	0.87 (160)
	PN Bacterial – 1.48	1.85	1.04	0 (n=6)	1.15 (n=13)	0 (n=9)	0.98 (n=28)
	PN Viral - 1.07	1.34	0.64	1.25 (n=23)	1.65 (n=26)	1.21 (n=37)	1.38 (n=86)

*Midas updated to version 4.0 with revised risk adjustment algorithm

Team Charter

Pneumonia (PN)

Key Initiatives June 2022

- Dashboard under development
- CPGs and order set(s) reviewed for alignment
- Evaluating implementation of a Pneumonia Severity Index (PSI) tool
- Order set revisions in process to operationalize best practices including: Antibiotic (Abx) selection on ED Sepsis order set (used for severe PN, inclusion of PSI which would direct Abx type and level of care, and transition of IV to PO (by mouth) Abx

PROJECT NAME: Pneumonia BPT	CHAMPION: Dr. M. Tedaldi	QI Facilitator: Lorena Domenech
DIRECTOR: Molly Niederreiter	APN: Alisha Sandidge	ET SPONSOR: Keri Noeske

PROBLEM STATEMENT:
Mortality, readmission and LOS data indicates opportunity in standardizing care and reducing variation through clinical practice guideline and care pathway implementation.

PROJECT GOAL:
Short term:
1. Select clinical practice guidelines (CPGs)
2. Develop and improve Key Performance Indicators (KPIs)

Long Term:
1. Reduce mortality
2. Reduce readmissions

SCOPE: (WHAT DOES THIS INCLUDE AND NOT INCLUDE?) Includes CAP patients in Emergency Department and admitted into the Medical Center

FINANCIAL IMPLICATIONS:
Penalties associated with the CMS Value-Based Purchasing Program (mortality), penalties associated with CMS Readmission Reduction Program & reputational costs with CMS star ratings.

MEASURES:
KPIs (in order of priority)

1. Pneumonia ED power plan Utilization N:
   N:Patients with dx CAP/suspected Pneumonia & power plan used in the ED
   D: Patients with ED diagnosis of Community Acquired Pneumonia/suspected pneumonia
1. First dose of antibiotic administered within 3 hours of suspected or confirmed diagnosis
   N: Patients who received antibiotic within 3 hours of suspected or confirmed diagnosis
   D: All patients admitted with CAP
1. Pneumonia admission power plan Utilization In patients
   N: Patients with power plan ordered
   D: All patients admitted with CAP

4 Switch from IV to PO antibiotics within 48 hours of first antibiotic treatment
N: number of patients transitioned from IV to PO within 48 hours
D: All admitted patients with CAP

Future KPIS

- Rate of documented Pneumonia Severity Index (PSI)

N: Patients with a documented PSI score in the Emergency Department
D: Patients with diagnosis of Community Acquired Pneumonia/ suspected pneumonia in ED

- Documentation of Clinical Stability Tool

N:Number of patients who had a completed Clinical Stability Tool
D: The number of patients on med surge with CAP diagnosis

Initiation	Team identification and guideline selection
Phase I	Key Performance Indicator selection, plan and initiate QI activities to achieve KPI goals
Phase II	Development/revision of care pathway, measure expansion, dashboard development

Team Charter

Heart Failure (HF)

Key Initiatives June 2022

- Dashboard under development
- CPGs and order set(s) reviewed for alignment
- HF Order set revisions in process to operationalize best practices including: addition of medication options with specific evidenced-based parameters (ie. Aldactone, Hydralazine, Entresto

Next steps:

- Order set approval, working on increasing use
- Working with Population Health on frequently admitted patients
- Evaluating insurance coverage for key medication treatment (ie. Entresto) and communicating with provdiers

PROJECT NAME: Heart Failure	CHAMPION: Dr. M. Tedaldi	QI Facilitator: Lorena Domenech
DIRECTOR: Emma Mozier	APN: Craig Dixon	ET SPONSOR: Keri Noeske

PROBLEM STATEMENT:
Mortality, readmission and LOS data indicates opportunity in standardizing care and reducing variation through clinical practice guideline and care pathway implementation.

PROJECT GOAL:
Short term:

1. Select clinical practice guidelines (CPGs) COMPLETE
2. Develop and improve Key Performance Indicators (KPIs) IN PROCESS

Long Term:

1. Reduce mortality
2. Reduce readmission

SCOPE: (WHAT DOES THIS INCLUDE AND NOT INCLUDE?) Medical Center processes

FINANCIAL IMPLICATIONS:
Penalties associated with the CMS Value-Based Purchasing Program (mortality), penalties associated with CMS Readmission Reduction Program & reputational costs with CMS star ratings.

MEASURES:
KPIs (in order of priority)

1. What percentage of patients with Systolic Heart Failure (EF <40%) are discharged on correct BB, ACE/ARB/ARNI/SARA
   1b. contraindications to (goal directed) med therapy documented appropriately? I.E Bradycardia/ hypotension for BB as well as CKD Stage 3b and greater(GFR≤30) and or serum potassium above 5 meq
2. What percentage of our patients with CHFrEF (“reduced EF” or “systolic HF”) that are eligible have been switched over to Entresto (ARNI) in house?
3. Percent of patients who started on ACE and d/c’d on an ARNI (Entresto)

TIMELINE & PLAN:

Initiation	Team identification and guideline selection
Phase I	Key Performance Indicator selection, plan and initiate QI activities to achieve KPI goals
Phase II	Development/revision of care pathway, measure expansion, dashboard development

Team Charter

Chronic Obstructive Pulmonary Disease (COPD)

Key Initiatives June 2022

- Dashboard under development
- CPGs and order set(s) reviewed for alignment
- COPD Order set revisions in process to operationalize best practices including: Antibiotic options, steroid dosing/frequency, defining medication based on GOLD category, delineating medications for acute and maintenance therapy, diagnostic studies

PROJECT NAME: COPD BPT	**CHAMPION: Dr. M. Tedaldi**	**QI Facilitator: Stacey Cajimat**
DIRECTOR: Wendy Jones	**APN: Emma Camarena**	**SPONSOR: Keri Noeske**

PROBLEM STATEMENT:

Mortality, readmission and LOS data indicates opportunity in standardizing care and reducing variation through clinical practice guideline and care pathway implementation.

PROJECT GOAL:

Short term:

1. CPG- GOLD Standards COMPLETE
2. Develop and improve Key Performance Indicators (KPIs) IN PROCESS

Long Term:

1. Reduce mortality from 2.40 to 1.92, by end of FY 22
2. Reduce readmissions from 16.09 percent to to 12.87%, by end of FY 22.

SCOPE: (WHAT DOES THIS INCLUDE AND NOT INCLUDE?) Inpatient admissions and discharges.

FINANCIAL IMPLICATIONS: Penalties associated with the CMS Value-Based Purchasing Program (mortality), penalties associated with CMS Readmission Reduction Program & reputational costs with CMS star ratings.

MEASURES:

KPIs (in order of priority)

1. What percentage of patients had Pulmonary Function Test (PFT) performed?
2. What percentage of COPD patients received the Pneumonia immunization on discharge?
3. What percentage of our patients the received Influenza immunization on discharge?
4. What percentage of patients accepted smoking cessation information on discharge?
5. What percentage of patients were referred to pulmonary rehab and attended?
6. What percentage of patients had principal discharge diagnosis of COPD and any diagnosis of CHF, any diagnosis of PN and any diagnosis of both CHF and PN?

TIMELINE & PLAN:

Initiation	Team identification and guideline selection
Phase I	Key Performance Indicator selection, plan and initiate QI activities to achieve KPI goals
Phase II	Development of care pathway, measure expansion, dashboard development

Team Charter

Acute Myocardial Infarction – Non ST Elevated Myocardial Infarction (AMI – NSTEMI)

Key Initiatives June 2022

- Dashboard under development
- CPGs and order set(s) reviewed for alignment
- Order set revisions in process for 4 different order sets that intersect with care of NSTEMI population
- Operationalizing best practices through order set revisions including: adding and revising medication orders and lab test to align with CPGs and pre-checking options

PROJECT NAME: AMI Non-STEMI BPT	CHAMPION: Dr. Michael Tedaldi	Quality RN Facilitator: Cindy Vander Schuur
DIRECTOR: Christine Aleman	APN: Cody Ericson	ET SPONSOR: Keri Noeske

PROBLEM STATEMENT:

Mortality, readmission, and length of stay (LOS) data indicates opportunity in standardizing care and reducing variation through clinical practice guideline and care pathway implementation.

PROJECT GOAL:

Short Term:

1. Select clinical practice guidelines (CPGs) COMPLETE
2. Develop and improve Key Performance Indicators (KPIs) IN PROCESS

Long Term:

1. Reduce mortality
2. Reduce readmissions
3. Reduce length of stay

SCOPE: (WHAT DOES THIS INCLUDE AND NOT INCLUDE?)

*Inpatient Medical Center processes.

GUIDELINES:

*Denominator: Patients with a diagnosis of NSTEMI who went to the Cath Lab.

NSTEMI Definition:

1. Negative EKG (no ST elevation)
2. Positive Troponin resulted ≥ 0.5

***Baseline Data:** Monthly starting July 2021

FINANCIAL IMPLICATIONS:

Penalties associated with the CMS Value-Based Purchasing Program (mortality), penalties associated with CMS Readmission Reduction Program & reputational costs with CMS star ratings.

MEASURES: KPIs (in order of priority)

Process Measures:

1. Percent of NSTEMI patients who have a 12 lead EKG done within 10 minutes of arrival.
2. Percent of NSTEMI patients administered oral beta blockers within 24 hours of positive Troponin.
3. Percent of NSTEMI patients who received IV UFH (unfractionated Heparin) or therapeutic subcutaneous (SQ) Lovenox (1mg/kg) within one hour of positive Troponin result.
4. Diagnostic Consideration/Measure: Percent of NSTEMI patients with a second Troponin done within 4 hours. (for risk stratification and early diagnosis) Using resulted time of initial Troponin.
5. Diagnostic Consideration/Measure: Percent of NSTEMI patients with a second EKG done within 4 hours. (for risk stratification and early diagnosis)
6. For NSTEMI patients who undergo revascularization: Percent of patients discharged on DAPT (dual antiplatelet therapy: Plavix, Effient, or Brilinta with aspirin) that do not have a contraindication such as aspirin sensitivity or history of gastrointestinal bleeding.

TIMELINE & PLAN:

Initiation	Team identification and guideline selection
Phase I	Key Performance Indicator selection, plan and initiate QI activities to achieve KPI goals
Phase II	Development/revision of care pathway, measure expansion, dashboard development. Address order sets including medication orders

Kaweah Health Best Practice Teams

Big Picture Next Steps

- To support our medical staff in the numerous changes to order sets the BPT Core Team is planning a Best Practice Team “Open House” for a medical staff “Drop-In” event
  - Target group is Valley Hospitalists group, private practice and Family Health Care Network providers
  - Goal is to communicate new order set changes, answer questions & concerns, and encourage use with “the why”
  - Planning in the very initial stages (ie. short 15 min summary with additional resources provided, contest giveaways, breakfast/appetizers, etc)

Thank you

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Kaweah Health

Clinical Quality Goal Update

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

June 2022

FY22 Clinical Quality Goals

	July 21-Apr 22 Higher is Better	FY22 Goal	FY21	FY21 Goal
SEP-1 (% Bundle Compliance)	76%	≥ 75%	74%	≥ 70%

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

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

Lower is Better	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual/ number expected)	FY22 Goal	FY21 FY20
CAUTI Catheter Associated Urinary Tract Infection COVID-19 PATIENTS	1 0	3 1	5 5	2 0	2 1	1 0	3 1	3 2	2 0	1 0			16 (12 predicted over 6 months)	1.66 0.66 Excluding COVID (Feb 2022)	≤0.676	0.54 1.12
CLABSI Central Line Associated Blood Stream Infection COVID-19 PATIENTS	0 0	4 3	3 3	3 0	1 1	1 0	1 0	0 0	2 0	2 0			11 (9.5 predicted over 6 months)	1.119 0.66 Excluding COVID	≤0.596	0.75 1.20
MRSA Methicillin-Resistant Staphylococcus Aureus COVID-19 PATIENTS	2 0	0 0	1 0	3 1	0 0	2 0	1 1	1 1	0 0	2 0			5 (3.6 predicted over 6 months	1.872 1.40 Excluding COVID	≤0.727	2.78 1.02

*based on July-Dec 2021 NHSN predicted

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

Key Strategies

Sepsis, CAUTI, CLABSI & MRSA

1. Refining root cause analysis of Sepsis order set utilization
2. Provider notification of Sepsis Alert
   - Evaluating root causes optimizing process
3. Sepsis Simulation training (GME)
   - Emergency Management GME program sim program in March 2022; Family Medicine sim program scheduled for summer 2022
4. Sepsis Alert optimization
   - Improving specificity & specificity so true sepsis patients are not missed and truly not septic patients do not trigger the electronic alert
3. Culturing Practices
   - Data analysis and follow up with provider groups
   - Alert for repeat cultures in place
4. Root Cause Analysis
   - Process & practice assessment from IV supply vendor
   - Equipment enhancements – conversion to medline products and new bladder scanners for each unit!
   - Review of current data & cases and quantifying contributing factors to target improvement strategies
5. MRSA Decolonization
   - 4N & ICU Pilot – 100% patients decolonized, expanded additional 3 months
   - All other units – targeting those who should be decolonized, working on optimizing processes to achieve decolonization. Key element in process is identification of the at risk patient through medical record triggers and workflow

Questions?

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Kaweah Health