December 09, 2021

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in a Quality Council Committee meeting at 7:00AM on Thursday, December 16, 2021, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:01AM on Thursday, December 16, 2021, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277, pursuant to Health and Safety Code 32155 & 1461.

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Quality Council Committee meeting at 8:00AM on Thursday, December 16, 2021, in the Kaweah Health Lifestyle Fitness center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

All Kaweah Delta Health Care District regular board meeting and committee meeting notices and agendas are posted 72 hours prior to meetings in the Kaweah Health Medical Center, Mineral King Wing entry corridor between the Mineral King lobby and the Emergency Department waiting room.

The disclosable public records related to agendas are available for public inspection at Kaweah Health Medical Center – Acequia Wing, Executive Offices (Administration Department) {1st floor}, 400 West Mineral King Avenue, Visalia, CA and on the Kaweah Delta Health Care District web page https://www.kaweahhealth.org.

KAWEAH DELTA HEALTH CARE DISTRICT
Garth Gipson, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
Board Clerk, Executive Assistant to CEO

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

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
QUALITY COUNCIL

Thursday, December 16, 2021
5105 W. Cypress Avenue
Kaweah Health Lifestyle Fitness Center Conference Room

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

OPEN MEETING – 7:00AM

1. **Call to order** – *David Francis, Committee Chair*
2. **Public / Medical Staff participation –** Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdiction of the Board are requested to identify themselves at this time. For those who are unable to attend the beginning of the Board meeting during the public participation segment but would like to address the Board, please contact the Board Clerk (Cindy Moccio 559-624-2330) or cmoccio@kaweahhealth.org to make arrangements to address the Board.
3. **Approval of Quality Council Closed Meeting Agenda** – 7:01AM
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Daniel Hightower, MD, and Professional Staff Quality Committee Chair*
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management and Ben Cripps, Vice President & Chief Compliance and Risk Officer.*
4. **Adjourn Open Meeting** – *David Francis, Committee Chair*

CLOSED MEETING – 7:01AM

1. **Call to order** – *David Francis, Committee Chair & Board Member*
2. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Daniel Hightower, MD, and Professional Staff Quality Committee Chair*
3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management, and Ben Cripps, Vice President & Chief Compliance and Risk Officer.*
4. **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 Report and Dashboard**
   - 3.2. **Subacute & Transitional Care Unit**
   - 3.3. **Hospital Acquired Pressure Injury Quality Focus Team Report**
   - 3.4. **Handoff Communication Quality Focus Team Report**
   - 3.5. **Diversion Prevention Committee Report**
   - 3.6. **Safety Culture Improvement Action Plan Update**

4. **Update: Clinical Quality Goals** - A review of current performance and actions focused on the fiscal year 2022 clinical quality goals. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety*.

5. **Review of AP.41 Quality Improvement Plan –** A review of plan revisions including reporting departments and the annual reporting schedule. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety*.

6. **Best Practice Teams Quality Initiative Update -** Inaugural report for the new Best Practice Teams initiative with the overall goal of improving patient outcomes for four key patient populations. Report will review the plan for Clinical Practice Guideline implementation through Care Pathways and standardized provider practices and includes key performance indicators for the four targeted populations. *Michael Tedaldi, MD, Medical Director of Best Practice Teams, Sandy Volchko, RN, DNP, 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.

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Unit/Department:

Emergency Dept.

QIC Report Date:

October 1, 2021

Measure Objective/Goal:

The Emergency Department (ED) will strive to be at or below identified benchmarks for all metrics.

Date range of data evaluated:

June 2021 – September 2021

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

- Since January we have continued to see a steady and quick increase in our ED volume. With that volume increase our overall hospital census has also been continuing to stay high/full.
- The % of patients being admitted/discharged remains steady.
- The % of patients left without being seen increased and was over the benchmark. September the left without being seen rate reached the benchmark at 1.5%. I attribute this to heavy volumes of patients in our lobby area and an inability to move patients through the needed zones for care at times.
- In order to address all of these metrics, achieved or not, the ED leadership team has been focusing on a few key strategies:
    - Leadership role support: A permanent Nursing Director has been hired and started end of June. Two permanent candidates for the ANM role have been hired both will began role in September. The ED manager stepped down as of September 3, 2021, we are reviewing and interviewing viable candidates in October.
    - Provider Leadership collaboration: The ED leadership team continues to collaborate very closely with the ED Medical Director on initiatives to improve the department and overall care that is provided. As changes are needed or ideas

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

brought forward, this relationship proves to be strong and effective. With our permanent ED nursing leadership coming together, our ED Medical Director will prove to be a support and resource for unit development and growth.

- Staffing: Role responsibility, staffing patterns, and staffing volume continue to be analyzed. Positions are filled and/or posted as it is determined to be needed. We have hired LVNs to support our department and assist in various areas to free a RN up to do their scope of care in other areas. New RNs continue be hired but while we have a shortage, travel RNs have been brought in to ensure we have adequate staffing to care for our increasing volumes. We are increasing the amount of clinical staff assigned in the lobby to ensure care is provided to all patients timely. We are increasing our ED tech hiring to ensure we have enough on shift to support the department needs as well as the patient care sitters that are required. We are in the process of accepting applications for the charge nurse position in the ED, we will be hiring four for days and four on nights.
- Quality monitoring: as opportunities are identified to improve care or processes they are addressed. Continue to work with the ED Unit Based Council (UBC) and Comprehensive Unit-based Safety Program (CUSP) in order to ensure our frontline staff escalate needs, identify solutions, and are the informal leaders of the department. Staff are included in outcome reviews and just culture applied to any follow up. We are diligently working on plans of correction monitoring and continue to coach the team.

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

As our ED leadership team continues to grow and stabilize, I am confident that growth from the department and improved care will be seen. More details of changes will be elaborated in future reports.

Next Steps/Recommendations/Outcomes:

Addressed above

Submitted by Name:	**Date Submitted:**
Michelle Peterson	October 1, 2021

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

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Emergency Department Scorecard

Check In Da.. 4/1/2020 12:00:00 AM to 10/1/2021 12:00:00 AM

General Metrics

	2020									2021								
	Q2			Q3			Q4			Q1			Q2			Q3		
	April	May	June	July	August	Septem..	October	Novem..	Decemb..	January	February	March	April	May	June	July	August	Septem..
ED Volume	4,186	5,044	5,969	6,675	6,102	5,857	5,949	6,024	6,282	5,598	5,235	6,161	6,311	7,023	7,067	7,309	7,225	6,688
% Visits Left without being seen	0.3%	0.6%	0.5%	0.6%	0.7%	0.8%	0.7%	1.0%	1.0%	0.5%	0.9%	0.6%	1.2%	1.7%	1.9%	1.4%	2.4%	1.5%
% of Pts Admitted	29%	29%	27%	25%	27%	27%	27%	27%	27%	28%	29%	29%	28%	26%	25%	24%	23%	25%
% of Pts Discharged	62%	62%	64%	67%	65%	62%	64%	63%	64%	64%	61%	62%	62%	63%	63%	65%	64%	65%

ED Throughput Metrics

	2020									2021								
	Q2			Q3			Q4			Q1			Q2			Q3		
	April	May	June	July	August	Septem..	October	Novem..	Decemb..	January	February	March	April	May	June	July	August	Septem..
Median LOS in Minutes for Admitted Patients	382	431	515	532	387	340	394	533	740	610	583	577	550	648	734	714	1,099	1,120
Median LOS in Minutes for Discharged ED Patients	193	211	237	217	230	244	232	236	237	229	246	243	257	259	268	267	266	252
Median Request for Admit to Check out	214	239	282	304	154	114	160	306	508	379	369	345	322	396	527	458	831	851
Average LOS in Minutes for Admitted Mental Health Patients	853	782	996	1,021	946	1,029	962	816	910	1,481	1,391	1,253	1,561	1,619	1,653	1,273	1,321	1,248

Census Totals by Disposition

	2020									2021								
	Q2			Q3			Q4			Q1			Q2			Q3		
	April	May	June	July	August	Septem..	October	Novem..	Decemb..	January	February	March	April	May	June	July	August	Septem..
Number of Patients Arriving by Ambulance	1,479	1,585	1,783	1,874	1,922	1,836	1,885	1,880	2,038	1,741	1,642	1,933	1,844	1,972	2,005	2,007	2,062	1,786
Number of Trauma Patients	115	126	109	151	142	199	191	198	147	144	128	212	200	203	202	190	173	208
Number of Patients Admitted	1,226	1,475	1,601	1,700	1,642	1,591	1,618	1,650	1,709	1,545	1,539	1,770	1,736	1,842	1,791	1,773	1,657	1,651
Number of Patients Discharged	2,611	3,133	3,837	4,441	3,941	3,645	3,781	3,811	4,041	3,557	3,180	3,833	3,885	4,395	4,441	4,750	4,660	4,340
Number of Mental Health Patients Admitted to KDMH	86	105	106	85	101	122	96	103	92	75	66	94	77	85	83	99	90	98

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

Unit/Department: Sub Acute, TCS, and SS Rehab **Report Date: October, 2021**

Measure Objective/Goal:

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

Date range of data evaluated:

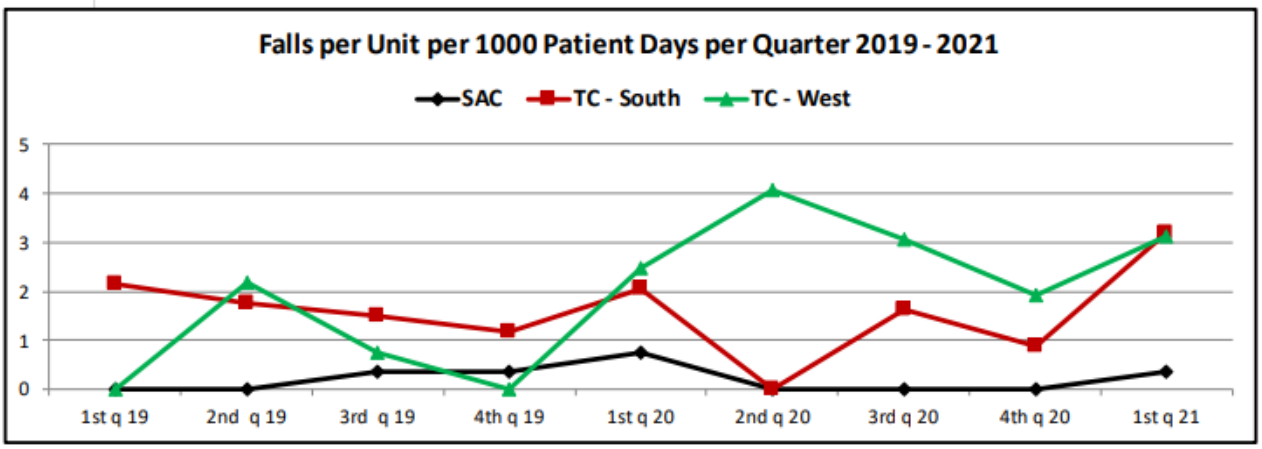
All categories are from the Report Period: 2020-2021. Comparison group: Casper Report from 10/04/2021 for time period 04/01/2021-09/30/2021, and 1st quarter 2020 through 1st quarter 2021, internal data.

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 for 2019 through 1ST quarter 2021 shows an overall increase over time at 1st quarter 2021. Facility observed percent for falls for long stay patients in the most current CASPER report is 0%, remaining well below national average of 44.5%, placing the program in the top 1 percentile nationally.



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

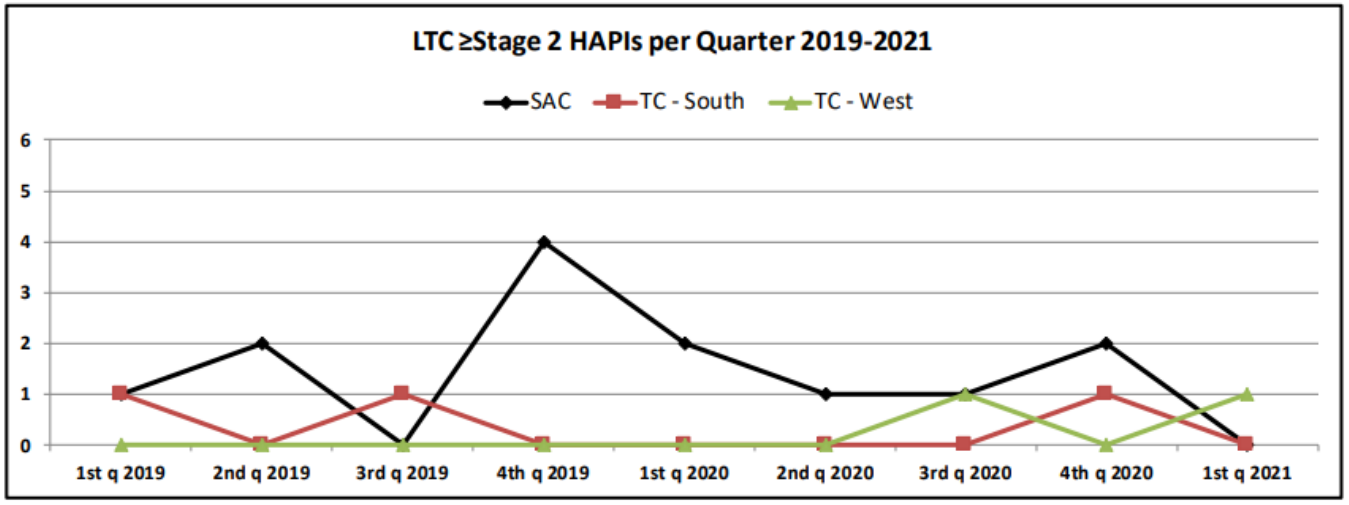
Staff continues to participate in, and has a high rate of compliance with, district-wide initiatives for fall prevention. The skilled nursing units have many mobile patients and a "no restraint" environment. Falls occur most commonly with our short-stay population, all of whom are involved with therapy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

Measure Objective/Goal: Pressure Injuries

a. There was one pressure injury stage 2, new or worsened (HAPI) reported for 1st quarter internal data for the two departments typically housing our shorter stay clients (Transitional Care and Short Stay Rehab). 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 0.7%, well below the national average of 3.8%.

b. Patients at High risk for Pressure Ulcers (Long Stay residents, defined as high risk, who have Stage II-IV pressure ulcers) showed a decrease to 10.9% from 12.5%, with a national average of 8.3% and a state average of 7.7%. This puts us at the 68th percentile. The definition for this long-stay quality measure asks if a wound is present, not if it is acquired by the facility. This is particularly challenging in a program that preferentially admits cases with pressure ulcers for ongoing treatment. The measure is triggered until the wound is completely healed (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. So, it is common to see a delay in improvement on the CASPER report, while seeing improvement more immediately in our internal data.

c. Internal data from 2019 through 1st quarter 2021 shows a decline in total HAPI across all settings from 9 in 2019 to 7 in the last 4 quarters. Overall, the total SNF rate per 1000/pt. days for 2020 was 0.33; year-to-date for 2021 we are at an average of 0.19. All three SNF units participate in KD prevalence studies quarterly. No unexpected wounds were identified during prevalence studies during the past 4 quarters. All skin injuries are captured by staff during routine assessments and preventative measures are implemented early leading to better patient outcomes.



2. **If improvement opportunities identified, provide action plan and expected resolution date:**
   - **a.** We will continue to participate actively in district-wide HAPI prevention plan. We will continue to work within the high standards of the District, with close management of our fragile, chronic wound cases, partnering closely with the wound nurses and utilizing the standardized treatment sets available to us.

   - **b.** UBC teams for South Campus nursing are reorganizing, after a pause due to COVID-19, to monitor progress on this and review clinical cases using a Peer review methodology to assess for and remediate practice concerns.

Measure Objective/Goal: Psychoactive medication use:

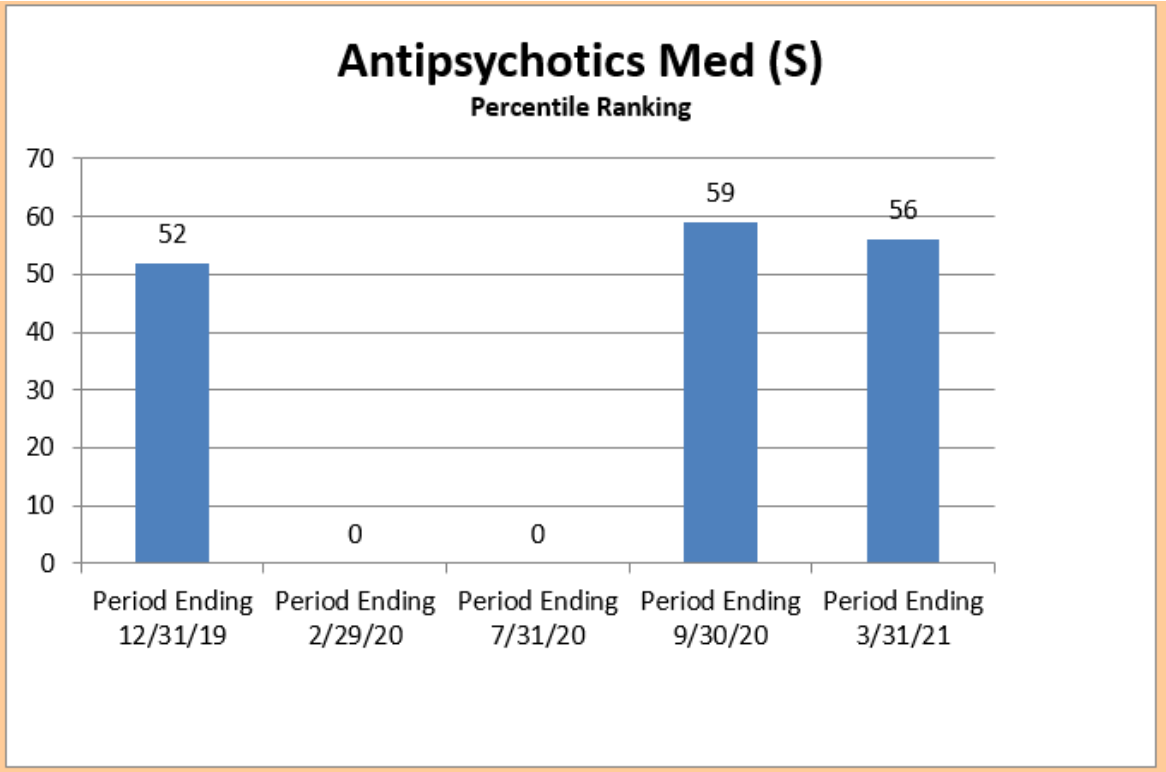
Definitions/Assumptions:

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). So, 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.

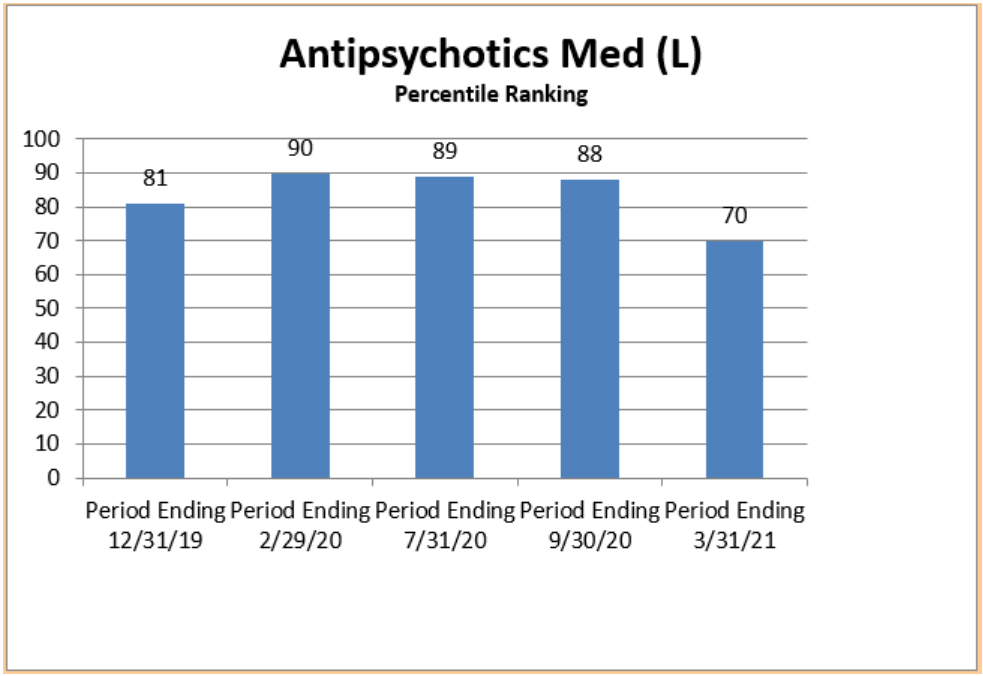
Short Stay residents (<100 days). Antipsychotic medication use for short stay patients is below national average, which measures only cases with newly prescribed antipsychotics. The facility

four quarter percent for short stay patients who begin a new anti-psychotic during their stay is 0.5%, putting us at the 56th percentile (lower is better). The comparison national average is 1.9%.

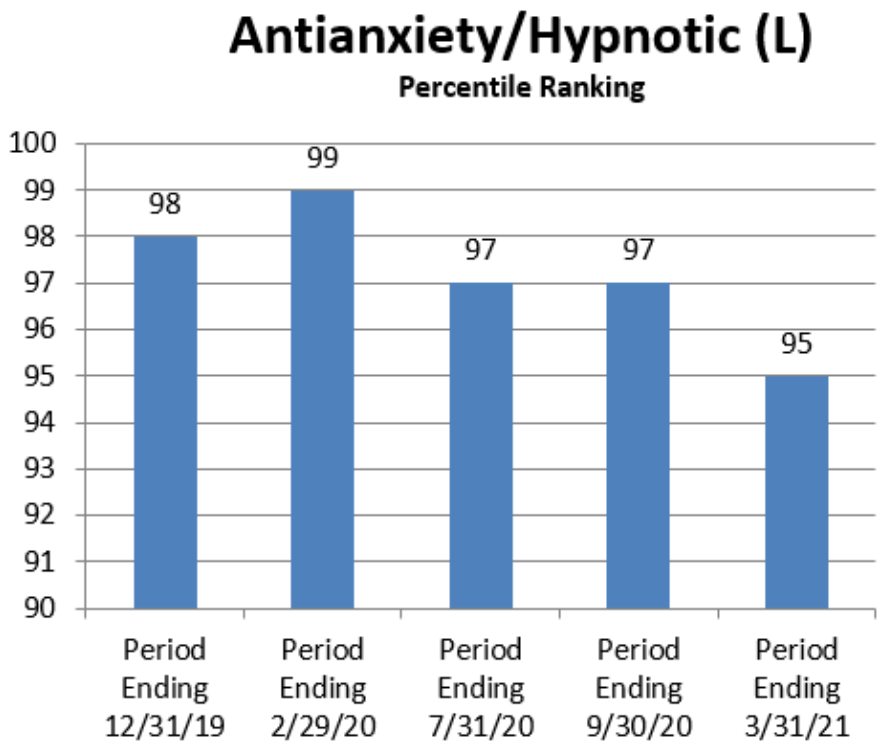


Long Stay residents. The facility percent for antipsychotic use in long stay residents is 25.9%, an increase from 20% prior quarter. This puts us at the 70th percentile (lower is better). The national average is 14.4%. Unlike the short stay measure, which only includes newly prescribed antipsychotics, 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 which may be 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 95th percentile from the 97th percentile the previous year. Our utilization rate is unchanged 39.3%, but national rates have declined 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: October 2021

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Unit/Department: HAPI QFT & Inpatient Wound Prevention **Report Date:** November 2021

Measure Objective / Goal:

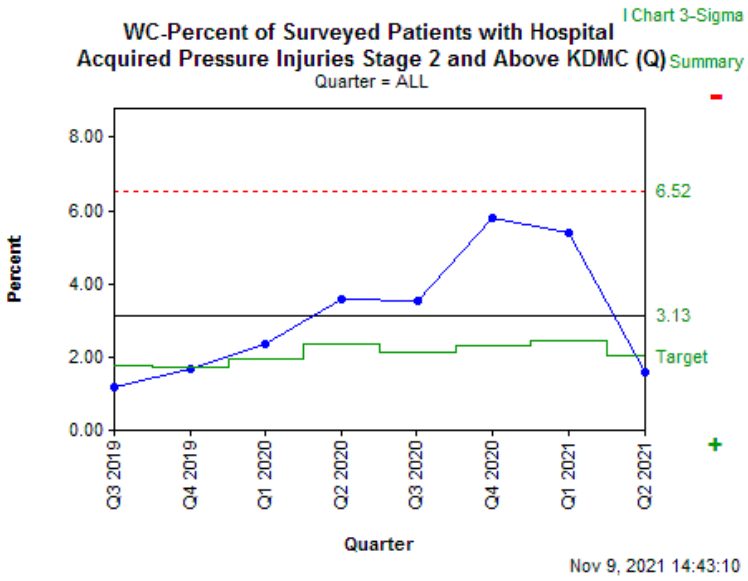
The National Database of Nursing Quality Indicators® (NDNQI) Prevalence Study

After much deliberation among the quality and wound care teams, we have determined that we will no longer continue to hold our quarterly prevalence studies. We have developed an in house dashboard that provides much more relevant data that gives us a more accurate picture of how are teams are doing with HAPIs. This will be the last time we report the prevalence study data to this committee.

Indicator #1 NDNQI Prevalence Study – Percent Stage 2+ HAPI in Surveyed Patients

Goal Outperform national target metric

Date Range Q2 2021



Quarter	Percent	Target
Q2 2021	1.57	2.02
Q1 2021	5.38	2.43
Q4 2020	5.80	2.30
Q3 2020	3.54	2.11
Q2 2020	3.57	2.34
Q1 2020	2.35	1.96
Q4 2019	1.65	1.71
Q3 2019	1.16	1.74

Analysis of Measures / Data: (include key findings, improvements, opportunities)

∅ **Goal #1** Not Met: Q1 2021 (5.38) underperforms compared to national target benchmark (2.43)

∅ **Goal #1** Met: Q2 2021 (1.57) over performs compared to national target benchmark (2.02)

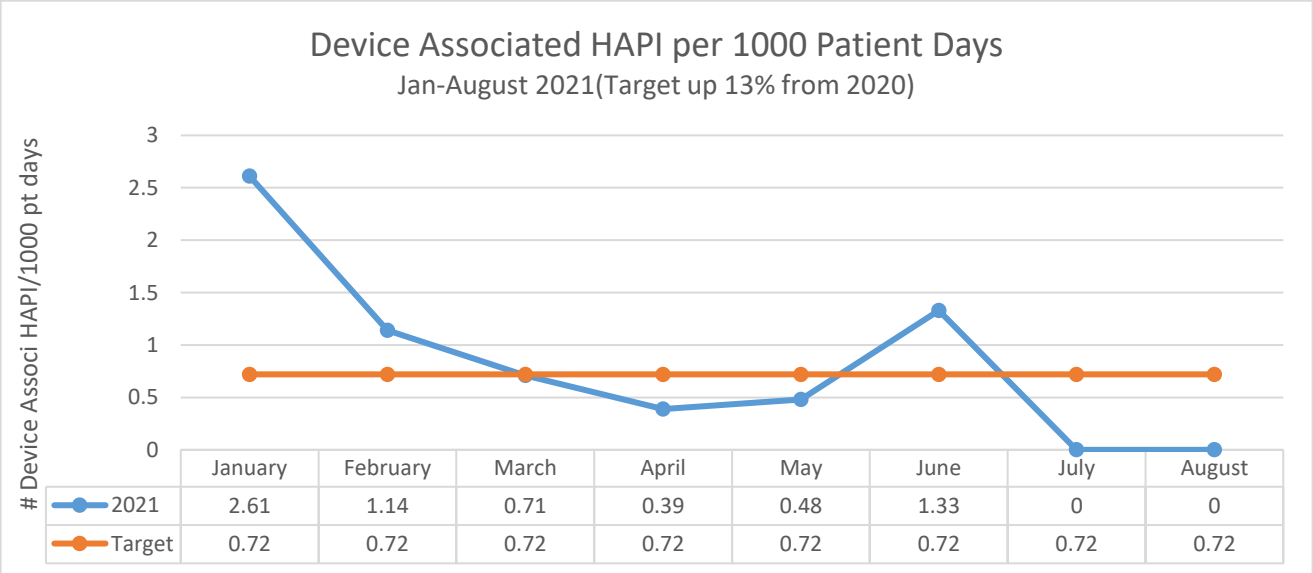
- Quarter 1 2021 quarter shows a slight reduction (.42%) in HAPI Stage 2+ compared to Q4 2020 as January continued to remain high due to COVID surge.
- Quarter 2 2021 shows a drastic improvement in HAPI Stage 2+ compared to Q1 2021. Number of COVID had diminished by this time.

Hospital Acquired Pressure Injuries (HAPI), Total and Device-Related
Incidence data compiled from staff/unit-level self-report, with and without prompting from wound nurse consultant. Includes Stage 1-4, unstageable, suspected deep tissue pressure injury (DTPI).

Indicator #2 Device Associated HAPI per 1000 Patient Days

Goal 0.59 (-20% from 2019)

Date Range January 2021 – August 2021



	January	February	March	April	May	June	July	August
2021	2.61	1.14	0.71	0.39	0.48	1.33	0	0
Target	0.72	0.72	0.72	0.72	0.72	0.72	0.72	0.72

Analysis of Measures / Data: (include key findings, improvements, opportunities)

Ø **Goal #2** Met: July (0), and August (0).But due to January 2021 results, YTD above target (0.84)

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

HAPI Stage 2+ QFT Dashboard

Measure Description Outcome Measures	Benchmark/ Target	2019 Baseline	2020	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	YTD 2021
HAPI Stage 2+ per 1,000 pt days (all HAPIs)	1.31 (-20% from 2019)	1.64	1.61	3.52	1.39	2.14	0.91	1.32	3.15	0.36	0.44	1.66
Device Associated HAPI per 1,000 pt	0.59 (-20% from 2019)	0.74	0.72	2.61	1.14	0.71	0.39	0.48	1.33	0	0	0.84
NDNQI % Surveyed Patients Stage 2+ (1 day prevalence per quarter)	**2.43** (1Q 2021) **2.02** (2Q 2021)	2.62	3.76			5.38			1.57			3.50
PSI 3 - Claims-based HAPI Stage 3, 4, and Unstageable per 1,000 discharges	**0.6** - Hospital Compare (Q3 2017-Q2 2019) **0.35** - Midar 50th Percentile (2019)	0.79	0.95	0	1.11	1.10	0	1.15	2.12	0	0	0.68
Process Measures												
Respiratory Device associated HAPI 2+ per 1,000 pt days			0.44	2.50	0.63	0.71	0.26	0.24	0.12	0	0	0.57
% of Respiratory Device associated HAPI's 2+ (out of all of the device associated HAPI's 2+)			61%	96%	55%	100%	67%	50%	9%	0%	0%	68%
Unit Level	(-15% from 2019)											
4N - HAPI 2+ per 1,000 pt days	1.14	1.34	2.02	3.60	0.00	2.39	0.00	2.48	2.46	1.18	0.00	1.55
3W - HAPI 2+ per 1,000 pt days	1.92	2.26	3.2	15.13	1.55	5.44	4.21	1.88	1.96	0.00	0.00	3.97
ICU - HAPI 2+ per 1,000 pt days	6.04	7.1	7.44	8.87	7.23	15.77	2.35	4.63	11.16	2.23	1.87	6.73
CVICU - HAPI 2+ per 1,000 pt days	4.42	5.2	6.23	5.70	0.00	18.52	0.00	7.84	21.62	0.00	2.89	6.31
2N - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	0.1	0.22	2.37	0.00	0.00	1.31	1.15	1.19	0.00	1.15	0.92
2S - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	0.7	1.51	5.04	1.46	0.00	0.00	0.00	4.74	0.00	0.00	1.47
3N - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	0.86	0.72	0.00	2.23	0.00	2.14	0.00	3.96	1.00	0.00	1.16
3S - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	0.46	0.50	0.00	0.00	0.00	0.00	1.05	0.00	0.00	0.00	0.14
4S - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	1.37	0.66	3.22	0.00	1.07	0.00	2.07	5.46	0.00	0.00	1.48
4T - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	1.23	0.45	0.00	0.00	0.00	1.76	0.00	0.00	0.00	0.00	0.21
BP - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	0	0.62	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Rehab - HAPI 2+ per 1,000 pt days	YTD ≤ 2019	0.75	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
5T - HAPI 2+ per 1,000 pt days	n/a		0.4	2.61	6.25	0.00	0.00	0.00	2.49	0.00	1.30	1.51
Other Units												
ED	n/a	4	3	0	0	0	0	0	0	0	0	0
Sub-Acute	n/a	5	6	0	0	0	0	0	0	0	1	1
Surgery	n/a	6	0	0	0	0	0	0	0	0	0	0
Cath Lab	n/a	1	0	0	0	0	0	0	0	0	0	0
Pediatrics	n/a	0	0	1	1	0	0	0	0	0	0	2
Mother Baby	n/a	1	0	0	0	0	0	0	0	0	0	0
Transitional Care (South Campus)	n/a	1	1	0	0	0	0	0	0	1	0	1

Green	Better than Target
Yellow	Within 10% of Target
Red	Does not meet Target

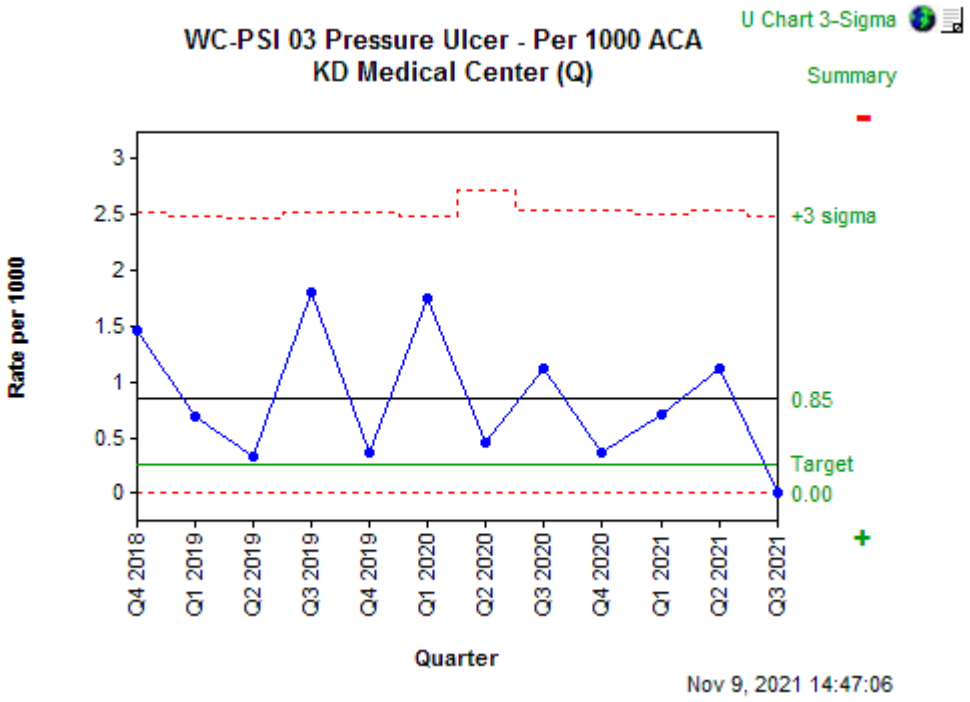
PSI 03: Pressure Ulcer Rate

Pressure ulcers have been associated with an extended length of hospitalization, sepsis, and mortality. The Agency for Healthcare Research and Quality (AHRQ) developed measures that health providers use to identify potential in-hospital patient safety problems for targeted institution-level quality improvement efforts. Patient Safety Indicator (PSI) 03 includes stage 3 or 4 pressure ulcers or unstageable (secondary diagnosis) per 1000 discharges among surgical or medical patients ages 18 years and older. *Exclusions: stays less than 3 days; cases with principal stage 3 or 4 (or unstageable) pressure ulcer diagnosis; cases with a secondary diagnosis of stage 3 or 4 pressure ulcer (or unstageable) that is present on admission; obstetric cases; severe burns; exfoliative skin disorders.*

Indicator #3 PSI-03 Claim-based HAPI Stage 3, 4, Unstageable per 1000 discharges

Goal 0.6 (Hospital Compare)

Date Range Q1 2021 – Q3 2021



Quarter	Numerator	Denominator	Rate per 1000
Q3 2021	0	2868.00	0.00
Q2 2021	3	2671.00	1.12
Q1 2021	2	2800.00	0.71

Analysis of Measures / Data: (include key findings, improvements, opportunities)

- ∅ **Goal #3** Not Met for Quarter 1 2021 (0.71)
- ∅ **Goal #3** Not Met for Quarter 2 2021 (1.12)
- ∅ **Goal #3** Met for Quarter 3 2021 (0.00)

Improvement Opportunities Identified, Action Plan and Expected Resolution Date / Next Steps, Recommendations, Outcomes:

Ongoing

- ✓ Continue GEMBA rounds on critical care floors.

- ✓ Work with HAPI QFT team to focus on turning and repositioning as our quality focus for November and December. Work on initiatives to educate and ensure proper turning and repositioning is occurring and documented in medical record. Will create a subcommittee to work on initiatives.

- ✓ CSI has been put on hold due to COVID surge. Have continued to require RCA worksheets from each floor to be sent to wound team and discussed. Will reconvene CSI as soon as we see our COVID numbers trending down.

- ✓ NDNQI One day prevalence study will be suspended permanently at this time. Will continue to report numbers through our dashboard and work with quality on creating an internal benchmark from previous data we have from NDNQI.

Work in Progress

- ☐ In partnership with Quality & Patient Safety Team, will look at completing a 5-day Kaizen before the end of the calendar year 2021.

Submitted By: **Date Submitted:** November 9, 2021
Rebekah Foster, Director of Care Management and Specialty Care

Handoff Quality Focus Team 12/8/2021

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

Quality of Handoff Measurement

1. ED nurse "sender" provided accurate and complete information with 80% of handoffs (Current state is 15%)

Timeliness of Admission/Handoff – Chartis ED to Inpatient Admission Team

Timeliness of Admission/Handoff

Chartis Consulting Team

At Chartis, we're committed to helping healthcare organizations thrive.

Our teams bring leading-edge subject matter expertise and proven approaches to the issues and opportunities facing healthcare today. We help our clients harness their experience, technology, data, and analytics to navigate through uncertainty—powerfully collaborating with them to define and execute their path forward. We call this Next Intelligence.

Consulting team is assessing ED throughput efficiencies and has been meeting with many staff members and touring departments to gather data (October).

Next Steps – Work with Chartis and form ED to Inpatient Admission Process team to work on efficiencies regarding timely throughput of admitted patients. More to come.

EMR Handoff Tool Update & Next Steps

1. Meet with ISS to review dashboard functions and options.- DONE
2. Present dashboard tool to Nursing Shared Decision group to obtain feedback. - DONE
3. Finalize handoff tool.- On Hold. Waiting October Cerner upgrade. Not sure if “summary handoff landing page” will be supported with new upgrade.

SUMMARY LANDING PAGE WILL NO LONGER BE SUPPORTED BY CERNER

Changes in Cerner will now require the team to select a new handoff tool. Clinical Informatics team attended November’s Handoff committee meeting and presented Cerner’s updated handoff best practice. Committee agreed use best practice tool and informatics will start the build.

Next Step – Committee to meet in January and assess build and establish rollout timeline.

Questions

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: Kaweah Health – Diversion Prevention Committee

ProStaff/QIC Report Date: 9/1/2021

Measure Objective/Goal:

The Diversion Prevention Committee Goals include:

Develop 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 into orientation and annual training related to drug diversion and awareness for all health care professionals.

Ensure accountability for action items related to routine audits and medication related reports by department leaders.

Use technology and automation to ensure reporting is routine and applicable.

Determine expected actions to be taken and communicate those actions to department leaders when abnormal reports are shared.

The Diversion Prevention Committees Measures of Success include:

Implementation of annual education, orientation education for employees and medical staff related to drug diversion.

Interviews of KDHCD team members and medical staff to determine understanding of the education and organizational expectations.

Development of a supervisor/leadership training program to provide enhanced skills for detecting and preventing diversion activities.

Compliance with audits outlined in CMS plan of correction.

Monthly review of audit dashboard reveals improvements in audit outcomes.

Timely follow-up by organizational leaders for action plans and identified improvements.

Date range of data evaluated:

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

From April 2021 to September 2021 the following goals have been achieved:

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

- Creation and implementation of comprehensive education on diversion awareness, prevention, sign and symptoms of abuse and diversion and expectations as health care team members. The audience for this education was organization wide to increase awareness and surveillance for suspicious activity and to support the health and well being of our team members. Education has been integrated into Mandatory Education modules with the next module planned for spring 2022. Completion of first module was done in June 2021.
- Leadership training is being created and implemented by Diversion Prevention Committee members,
    - Organization wide leadership training completed and scheduled to be delivered to leadership in September and October 2021. Informal training and awareness delivered to leadership in July 2021 via the Leadership Meeting presentation.
- Centers for Medicare/Medicaid Services post survey audits reporting into Diversion Prevention Committee demonstrating good compliance with action items. More details below.

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):
Audits document attached to this report to provide details of each items as it related to the CMS action plan.

13 action plan audits are being reported into the Diversion Prevention Committee. July audits all 100% compliant. June audits 100% compliant except for one fallout with a patient's own home medications stored in the pharmacy. The stored medications included a controlled substance that required more monitoring that was not completed. This was not repeated in July 2021. Will continue to monitor for success with these measures.

If improvement opportunities identified, provide action plan and expected resolution date:
The Diversion Prevention Committee purpose is to identify opportunities and create action items on an ongoing basis.

At this time, the improvement opportunity is the education and awareness of the risks of diversion. After education is complete, interviews of staff and leaders will be done by committee members to validate the effectiveness of the education. Education will be changed or reinforced based on those findings.

Review of pharmacy internal audits, risk management events and employee behavior reports will lead to continued efforts of the committee to educate, inform and monitor the activities to prevent the diversion of medications in the health care setting.

Next Steps/Recommendations/Outcomes:
Monitor the effectiveness of the education through staff, provider and leader interviews by committee members.
Create additional education as needed based on audits and incident reports.

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

Monitor for abnormal events and increase surveillance by the organization staff and providers for unusual events reported.
Adopt new goals with the Diversion Prevention Committee to expand the scope of the program in the organization.
Incorporate Substance Abuse awareness and actions into the scope of the committee to support our teams.

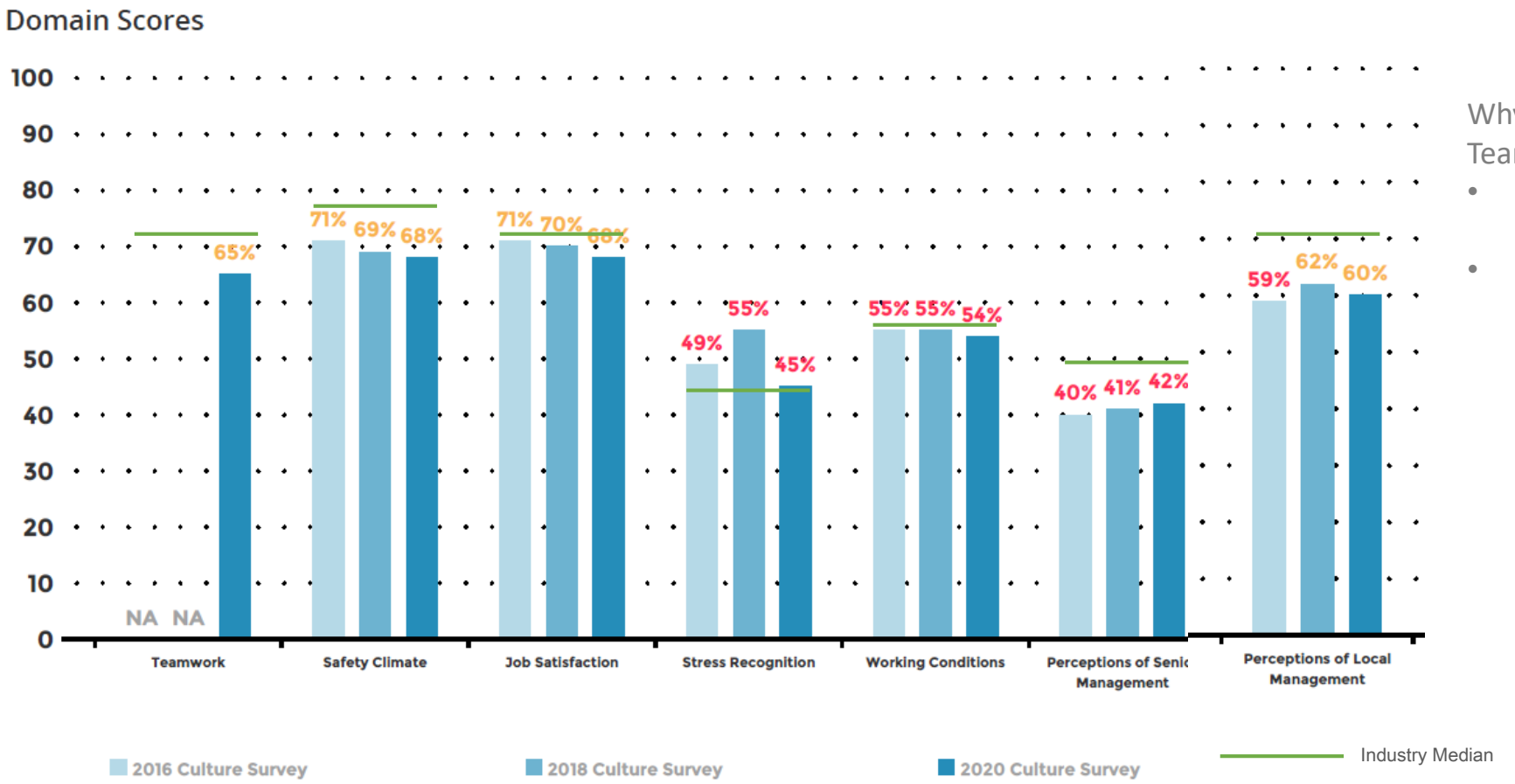
Submitted by Name: Keri Noeske, VP Chief Nursing Officer **Date Submitted:** 9/9/21

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

Safety Culture Action Plan Update

December 2021

SAQ - Trending by Domain



Why is there no historical data in Teamwork Category?

- 2 Questions in the Teamwork Climate category changed
- An analysis was conducted by Pascal Metrics and it was determined that you cannot trend at the domain level or those specific questions when changing from one domain to the other. Therefore we cannot compare Teamwork Climate domain scores to our past survey results

Questions ≥ 80% Positive Response

Domain	Question
Teamwork Climate	It's easy for personnel here to ask questions when there is something that they do not understand
Safety Climate	I know the proper channels to direct questions regarding patient safety in this work setting
	I am encouraged by others in this work setting to report any patient safety concerns I may have
	Medical errors are handled appropriately in this work setting
Job Satisfaction	I like my job
	I am proud to work in this work setting
Custom - Just Culture	When I see others doing something unsafe for patients, I speak up
	Nurses/staff support a culture of patient safety in this work setting
	When staff make clinical errors, we focus on learning rather than blaming
	The unit manager supports and leads a culture of patient safety in my work setting

Questions Less than 60% Positive Response

Domain	Question	Analysis (solicited during staff debrief sessions)	Action Plan
Job Satisfaction	Morale in this work setting is high	• Analyze results with employee engagement survey results (July 2021); SAQ administered in Dec 2020 to Feb 2021, SAQ results could be associated with timing of survey during COVID-19 surge	• Leadership Team and BOD meeting 7/26/21 to review results; action plan pending. • Update Dec 2021 – results compared which showed several employee engagement questions scored higher than similar SAQ questions which indicates timing of SAQ survey could have been a factor. Will include a measure in the April 2022 pulse survey. Add "overall I feel morale in my work setting is high."
Stress Recognition	I am more likely to make errors in tense or hostile situations	• Significant increase in SAQ Stress Recognition domain score from 2016 to 2018 due to mandatory training for all staff in SAQ departments/units approximately 4 months before 2018 SAQ administered; Training was embedded in new hire orientation only ongoing • Overall 10 point drop in the 2021 Stress Recognition domain score from the 2018 survey, but above the industry median. • Pascal Metrics (industry expert) indicates improvement strategies are focused on education	• Include the stress recognition module into mandatory annual testing rotation scheduled in advance of the SAQ • Update Dec 2021 – included Stress Recognition in MAT I in 2022. Administered 2/7/22-3/28/22 • Evaluate pulse survey or use module post test to evaluate progress. • Update Dec 2021 – pulse survey scheduled for April 2022
Stress Recognition	Fatigue impairs my performance during emergency situations (e.g., emergency resuscitation, seizure)		

Questions Less than 60% Positive Response

Domain	Question	Analysis (solicited during staff debrief sessions)	Action Plan
Working Conditions	Problem personnel are dealt with constructively by our senior management	• Results analyzed from highest to lowest by work setting and disseminated to VP	• Employee Relations class targeted to leaders within chain of command Ongoing • Update Dec 2021 - tracking employees with an evaluation score of less than 2.5% and will be working with the Directors and Managers to ensure improvement or appropriate next steps. We will continue to do this each quarter (first of January, April, and July).

Questions Less than 60% Positive Response

Domain	Question	Analysis (solicited during staff debrief sessions)	Action Plan
Custom - Just Culture	The event reporting system is easy to use	Feedback solicited during SAQ staff debrief sessions which revealed the following insight: • Staff commented on the difficulty of selecting category type and several mandatory fields. The requirement to select a category was removed approximately 1.5 years ago, as well as several categories were removed. Many staff not aware of changes. Staff who were commented on other event forms that continue to be long (ie. falls and adverse drug events). • Staff commented they do not submit events because they don't know if anyone reads them or does anything with them • Some commented that the event reporting process feels punitive and unaware that events can be submitted anonymously	• Targeted education through staff meetings (lowest score, high risk processes/care) by Dec 31, 2021. Education objectives to include: Importance of reporting and why, what and how to report, and just culture review • Update Dec 2021 – 28/33 Targeted areas for event reporting training completed. Remaining 5 in process. 3 additional areas added at leaders request • Stakeholder review and revision of falls and adverse drug event reporting forms completion target date • Updated Dec 2021 - Pending • Implementing staff email thank you and acknowledgement of receipt of event report and communication of review by METER. Completion target August 1, 2021 • Updated Dec 2021 – Pending, seeking stakeholder input on draft letter • Pulse survey to be administered 1Q 2022 • Update Dec 2021 – pulse survey scheduled for April 2022

Questions Less than 60% Positive Response

Domain	Question	Analysis	Action Plan
Perceptions of Senior Management	The staffing levels in this work setting are sufficient to handle the number of patients	• Analyze results with employee engagement survey results (July 2021); SAQ results could be associated with timing of survey during COVID-19 surge. • Results analyzed from highest to lowest by work setting and disseminated to VP	• Conduct pulse surveys in FY22 – May 2022 • Budget planning included leader sign off • Recruiting events • Hiring in anticipation turnover, shift bonuses • Student RN interns, travelers • Improving efficiency for staff, for example, reducing documentation time • Eliminating work that is not necessary or impactful
Perceptions of Local Management	Problem personnel are dealt with constructively by our local management	• Analyze results with employee engagement survey results; SAQ results could be associated with timing of survey during COVID-19 surge. • Results analyzed from highest to lowest by work setting and disseminated to VP	• Employee Relations class targeted to leaders within chain of command Ongoing. • Update Dec 2021 - tracking employees with an evaluation score of less than 2.5% and will be working with the Directors and Managers to ensure improvement or appropriate next steps. We will continue to do this each quarter (first of January, April, and July).

Safety Culture – Organizational Initiatives – 2021/22

Addresses SAQ Domain	Safety Culture QI Strategy
Teamwork Climate	TeamSETPPS Leadership (Medical Team Training) • 38 Kaweah leaders participated in training May & June 2021. • Evaluation indicated the training accomplished goals: participants felt it was useful to their role/work, and learning occurred • >60 medical team tools implemented in 38 Kaweah locations/departments TeamSTEPPS Staff • All new hires in patient care roles complete CUS (I am concerned, uncomfortable, this is a safety situation) training; achieved training goals (>90% correct response rate) from 2017-2020 (2020 n=698). Post test indicates 100% correct response rate for each question. 100% of staff indicate ability to use CUS during a patient safety situation • Broad dissemination of "Say it again, Sam" (aka 2 challenge rule) TeamSTEPPS tool, approved by Patient Safety Committee for 3Q 2021 • 1Q 2022 Staff version of TeamSTEPPs simulation training go live
Perceptions of Local and Senior Management Safety Climate	Just Culture Steering Committee • Plan for Just Culture expanded staff awareness campaign 2021-2022 to include: • GME Just Review lessons learned published • Video rolled out at staff meetings and incorporated into new employee and physician orientations • Leadership refresher training and scenario reviews • Monthly topic deep dives (LTM, staff meetings, Communication Board, Compass) • Evaluate training of new medical staff leaders and charge nurses • Incorporating JC into mandatory annual training • Pulse survey for staff to gage effectiveness
Safety Climate	• 12 Good Catch awards (staff and providers) in 2021 • Hero of the Year awarded in 2021 • Sepsis Heroes awarded monthly (providers and RNs who provide best practice care to septic patients • Safety Star – awarded monthly for exceptional hand hygiene compliance as noted in the BioVigil system

Safety Culture – Organizational Initiatives – 2021/22

Addresses SAQ Domain	Safety Culture **BY ROLE** QI Strategy
Teamwork Climate	Action Plan: • Local leadership evaluate role & unit/department specific concerns; corrective action plan • Continue to reinforce TeamSTEPPS® tool "CUS" through the organization, and broadly introduce, spread and reinforce the TeamSTEPPS® 2 Challenge Rule (Kaweah Health terms this tool: "Say it again, Sam".). Say is again Sam campaign started Nov 2021. • Developing plan to incorporate job shadowing in RN orientation to gain a better understanding of ancillary roles (ie. telemonitors, lab, and transporters). In progress

SAFETY ATTITUDES QUESTIONNAIRE TIMELINE

MARCH 2021
Result reports disseminated to leadership

JUNE 2021
Action plans developed and received by 6/18/21

JULY - OCT 2021
SAQ role debriefs completed by 9/20/21, action plan developed QIC by 10/15/21

AUG 2021
Leaders submit worksheets to VP for employees ≤ 2.88 on annual evaluation or believed to be under-performing

1Q 2022
Pulse Survey Administered
Stress Recognition Annual training completed; Safety culture action plan by role completed

APR – MAY 2021
Unit/Department results debriefed with staff
Leader TeamSTEPPS training
Just culture staff awareness campaign

JULY 2021
Results and action plan reported to Board of Directors

JULY- DEC 2021
Event reporting and just culture education to targeted units/depts. Revisions to select event reporting forms and acknowledgements

4Q 2021
Staff TeamSTEPPS simulation training offered ongoing

2Q 2022
Action plan update and survey results reported to Board of Directors

Leapfrog Survey Requirement

The below Leapfrog/National Quality Forum Safe Practice was not met:

6B: Practice #2 - Culture Measurement, Feedback, and Intervention.

2.4 Within the last 24 months, in regard to culture measurement, feedback, and interventions, our organization has done the following (or has had the following in place): disseminated the results of the survey widely across the institution, and *senior administrative leadership held follow-up meetings with the sampled units to discuss the unit's results and concerns.*

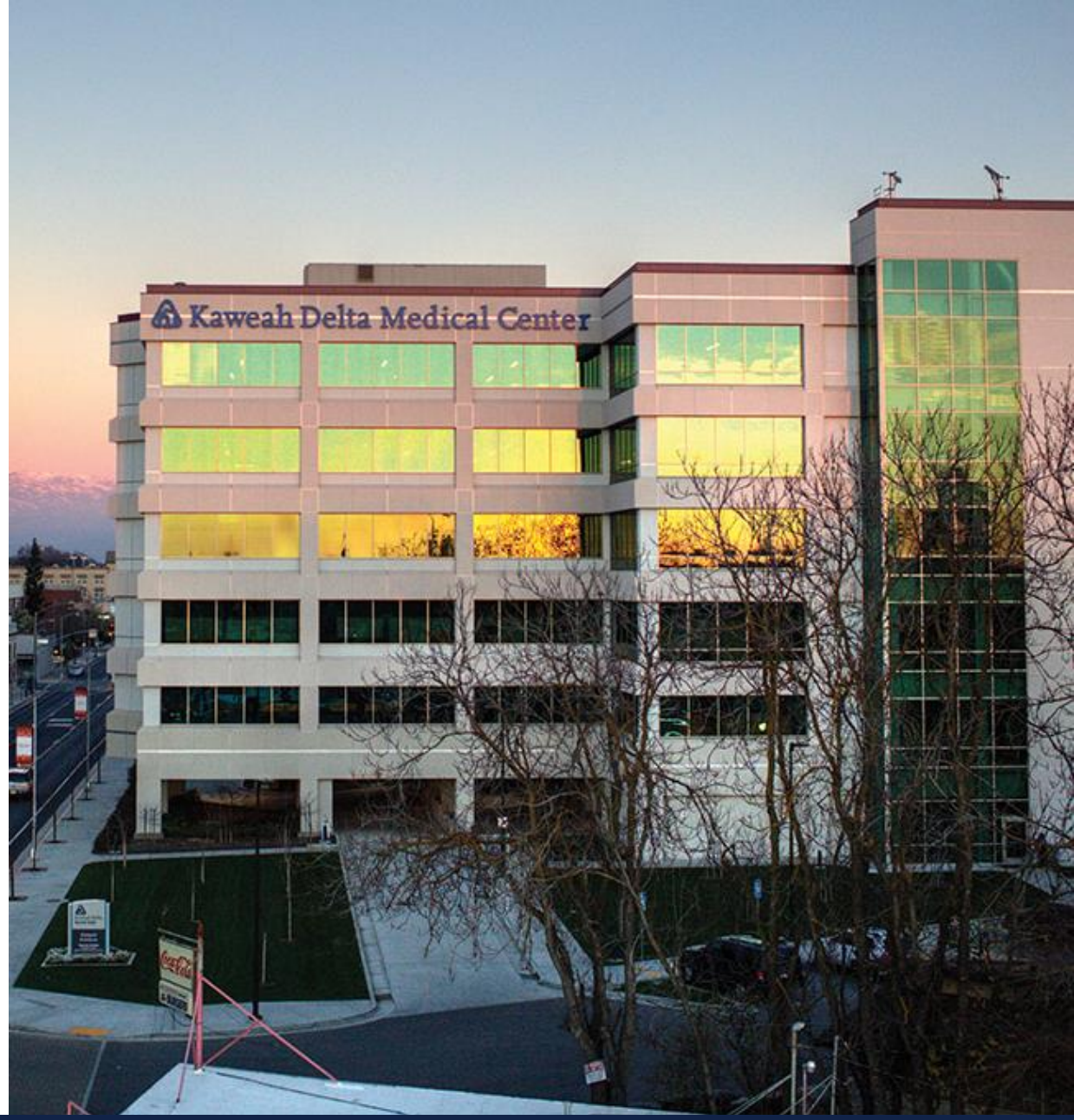
FAQ from Leapfrog:

- 2.4b requires senior administrative leadership to engage each sampled unit in a discussion about the survey results and their concerns.
- Senior administrative leadership refers to administrators who are responsible for hospital-wide departments or services (e.g., Chief Executive Officer, Chief Administrative Officer, Chief Nursing Officer, Chief Medical Officer, etc.).

Questions?

Clinical Quality Goal Update

December 2021



FY22 Clinical Quality Goals

	July-Sept 2021 Higher is Better	FY22 Goal	FY21	FY21 Goal
SEP-1 (% Bundle Compliance)	66%	≥ 75%	74%	≥ 70%

Our Mission

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

Our Vision

To be your world-class healthcare choice, for life

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

Lower is Better	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual/ number expected)	FY22 Goal	FY21 FY20
CAUTI Catheter Associated Urinary Tract Infection	1	3	4	2									20	1.436	≤0.676	0.54 1.12
CLABSI Central Line Associated Blood Stream Infection	0	4	3	3									16	1.600	≤0.596	0.75 1.20
MRSA Methicillin-Resistant Staphylococcus Aureus	2	0	1	3									6	2.571	≤0.727	2.78 1.02

*based on FY21 NHSN predicted

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

Key Strategies

Sepsis – SEP-1 is an "all or nothing" measure

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

July 2021

Overall Sep-1 Compliance: 66%

21/32 (10/11 fallouts occurred during Sepsis Coordinator off hours)

- Initial LA: 92%
- Abx: 88%
- BC: 93%
- Fluids: 96%
- Repeat LA: 93%
- Vasopressors: 100%
- Reassessment: 89%

August 2021

Overall Sep-1 Compliance: 75%

24/32 (7/8 fallouts occurred during Sepsis Coordinator off hours)

- Initial LA: 97%
- Abx: 94%
- BC: 97%
- Fluids: 96%
- Repeat LA: 87%
- Vasopressors: 100%
- Reassessment: 100%

September 2021

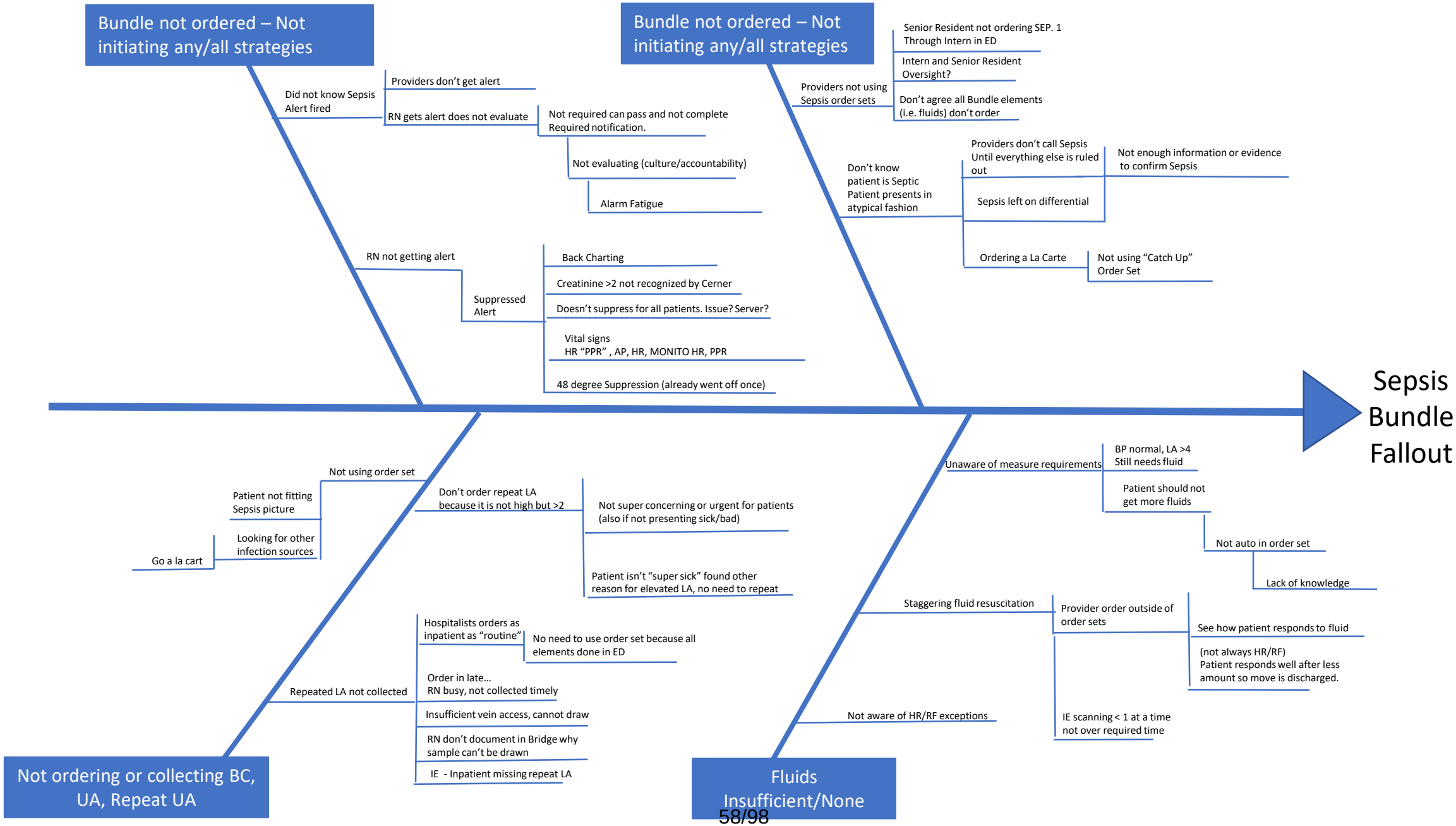
Overall Sep-1 Compliance: 57%

17/30 (12/13 fallouts occurred during Sepsis Coordinator off hours)

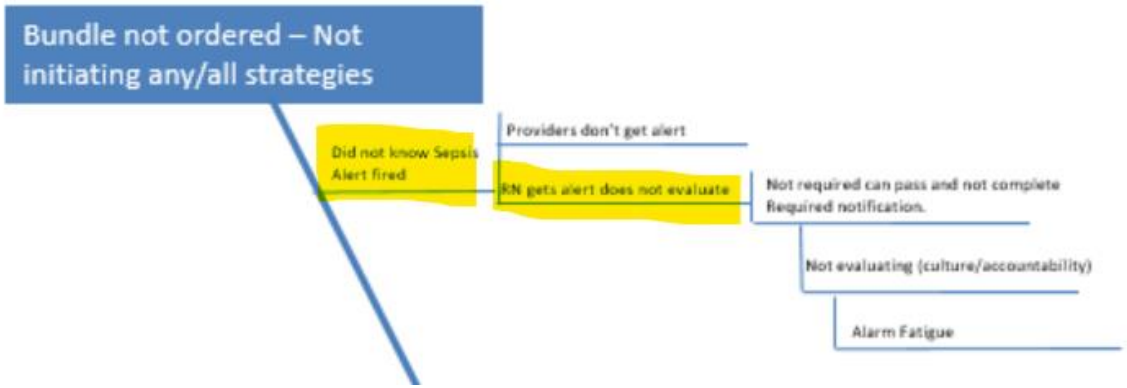
- Initial LA: 95%
- Abx: 80%
- BC: 88%
- Fluids: 94%
- Repeat LA: 86%
- Vasopressors: 100%
- Reassessment: 100%

- Sepsis required physician notification of sepsis alert - results in timely best practice intervention, "the bundle" COMPLETE, GO LIVE 6/29/21!
- Increasing CMS sampling during COIVD to generate a more statistically significant denominator
- Re-identifying root causes of SEP-1 bundle non-compliance to revise prioritized QI strategy list with stakeholders. Completion goal 11/30/21
- Exploring alert triggers with ISS
- Exploring RRT RNs helping with sepsis alerts during coordinator off hours

Root Cause Analysis Cause & Effect Diagram DRAFT: Sepsis Bundle Non-Compliance "Vital Few" November 2021



Root Cause Data Analysis



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- Vasopressors: 100%
- Reassessment: 100%

- July 2021 – Sept 2021 32/94 patients failed the SEP-1 measure
- 29/32 (90%) of the failures occur during Sepsis Coordinator off hours
- Action Plan - Required provider notification went live June 29, 2021, evaluate effectiveness of strategy and revise if indicated

Data Analysis

Required Sepsis Alert Provider Notification Process

Summary July 2021- October 2021

- 38% of alerts are evaluated, of those 27% have a score ≥3 (n=374)
- For the 374 pts with score ≥3, 77% of the time providers are notified (n=288)
- Of the 288 pt's who's providers are notified, 14% order a SEP power plan
- If 27% of alerts have scores ≥3, the providers would have been notified on 595 of 2205 alerts that were not evaluated (potentially alerts were not legitimate)
- ACTION – Evaluate alert notification process with ISS and nursing to optimize

Sepsis alert fires → RN Evaluates patient using provider notification form → RN notifies provider if score ≥3 → Provider orders SEP-1 power plan if warranted

Sepsis Alert Location	# of Alerts	# of Forms w Score	% Sepsis Alerts w Form Completed
KDMC 14	79	33	42%
KDMC 15	491	229	47%
KDMC 1E	401	35	9%
KDMC 2E	6	0	0%
KDMC 2N	138	72	52%
KDMC 2S	95	60	63%
KDMC 3N	135	75	56%
KDMC 3S	163	90	55%
KDMC 3W	316	142	45%
KDMC 4N	137	78	57%
KDMC 4S	79	44	56%
KDMC BP	22	9	41%
KDMC CV	534	150	28%
KDMC ED	242	6	2%
KDMC IC	702	346	49%
KDMC MA	35	0	0%
Grand Total	**3575**	**1370**	**38%**

Form Location	# Sepsis Alerts w Score of 3	# Forms Score 3 and Provider Notified	%Sepsis Alerts w Forms Score 3 and Provider Notified
KDMC 14	6	4	67%
KDMC 15	55	46	84%
KDMC 1E	4	4	100%
KDMC 2N	14	14	100%
KDMC 2S	16	17	106%
KDMC 3N	23	23	100%
KDMC 3S	26	19	73%
KDMC 3W	31	20	65%
KDMC 4N	20	16	80%
KDMC 4S	7	6	86%
KDMC CV	43	36	84%
KDMC ED	3	1	33%
KDMC IC	126	82	65%
Grand Total	**374**	**288**	**77%**

Form Location	Count of FIIN Number	# Forms w Score 3 and Provider Notified and Plan	% Forms w Score 3 and Provider Notified that Have a Plan
KDMC 14	5	2	40%
KDMC 15	79	17	22%
KDMC 1E	15	2	13%
KDMC 2N	18	2	11%
KDMC 2S	27	6	22%
KDMC 3N	35	7	20%
KDMC 3S	37	7	19%
KDMC 3W	68	4	6%
KDMC 4N	35	4	11%
KDMC 4S	14	1	7%
KDMC CV	60	8	13%
KDMC ED	6	1	17%
KDMC IC	168	19	11%
Grand Total	**567**	**80**	**14%**

Key Strategies

CAUTI & CLABSI

- "ICU Forum" January 2022, educate & inspire!
  - Goal: gather insight on challenges and solutions to applying the CLABSI and CAUTI prevention bundles to ICU/COVID patients
- Kaizen Reboot for CAUTI prevention;
  - additional root causes identified and QI strategies developed focused on RN implementation of protocols and cleanliness
- CLABSI QFT
  - Peripheral IV QI - Including peripheral IVs to critical care gemba, and evaluating "just in case lines" and care practices
- Culture of Culturing
  - "Pan Culture" rates
  - Quantify volume of cultures ordered when a previous culture was ordered within 48-72 hrs

"Operation Catheter Insertion Kits" October 2021

Key Strategies MRSA QFT

Planned Interventions to reduce MRSA Bloodstream Infection

1. Hand Hygiene

- BioVigil and Non-BioVigil areas, 95% compliance & use of BioVigil system

2. Decolonization Processes

- ICU and 4N Trial with standardize procedure, live Dec 7, 2021
- Dashboards (over all and unit level) for steps of decolonization process outside trial units

3. Environment & Equipment Cleaning

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

4. Evaluating MRSA Patient Movement

Decolonization

Decolonization entails treatment of persons colonized with a specific MDRO, usually MRSA, to eradicate carriage of that organism However, decolonization of persons carrying MRSA in their nares has proved possible with several regimens that include topical mupirocin alone or in combination with orally administered antibiotics (e.g., rifampin in combination with trimethoprim- sulfamethoxazole or ciprofloxacin) plus the use of an antimicrobial soap for bathing(303).

Key Strategies MRSA QFT

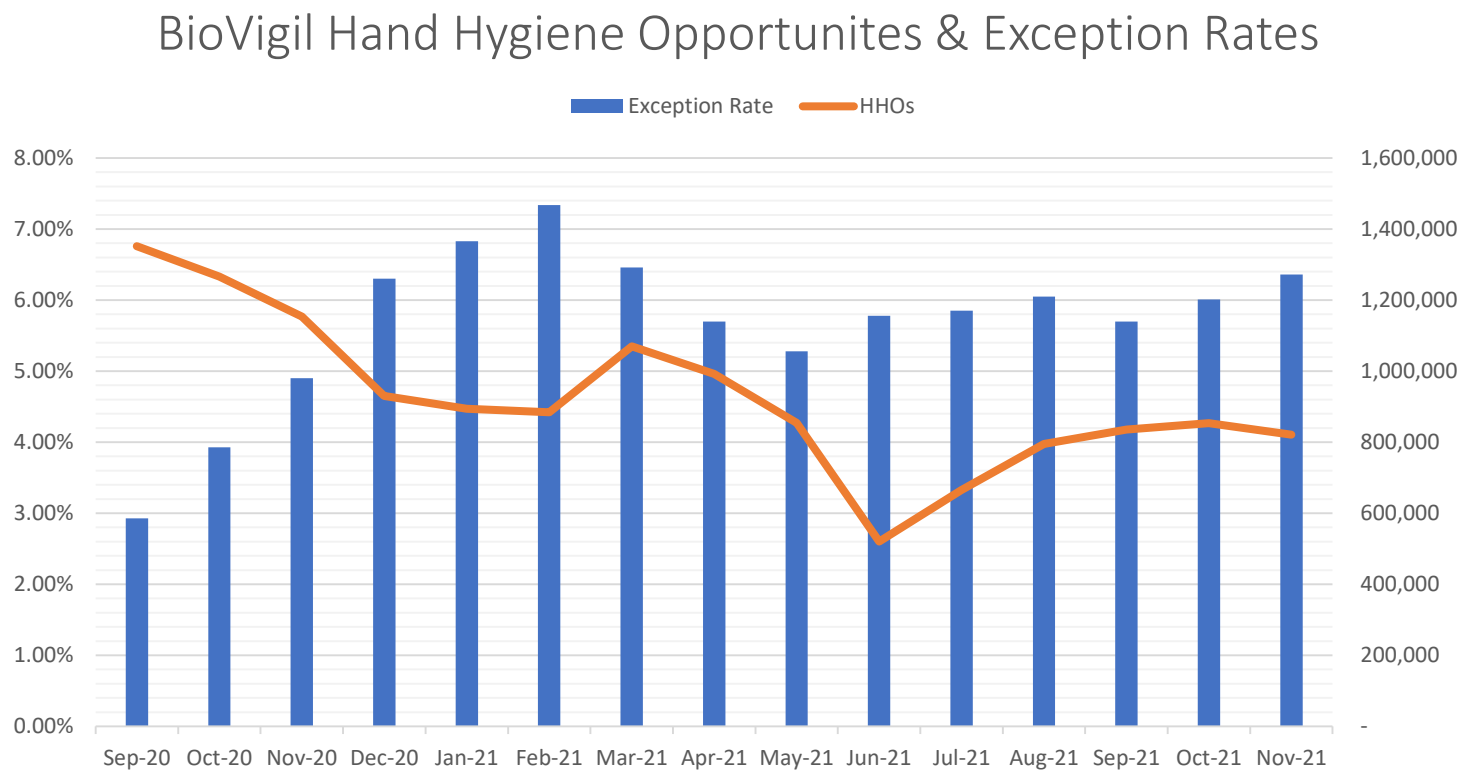
Planned Interventions to reduce MRSA Bloodstream Infection

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

Goal: return to September 2020

High volume of HHO

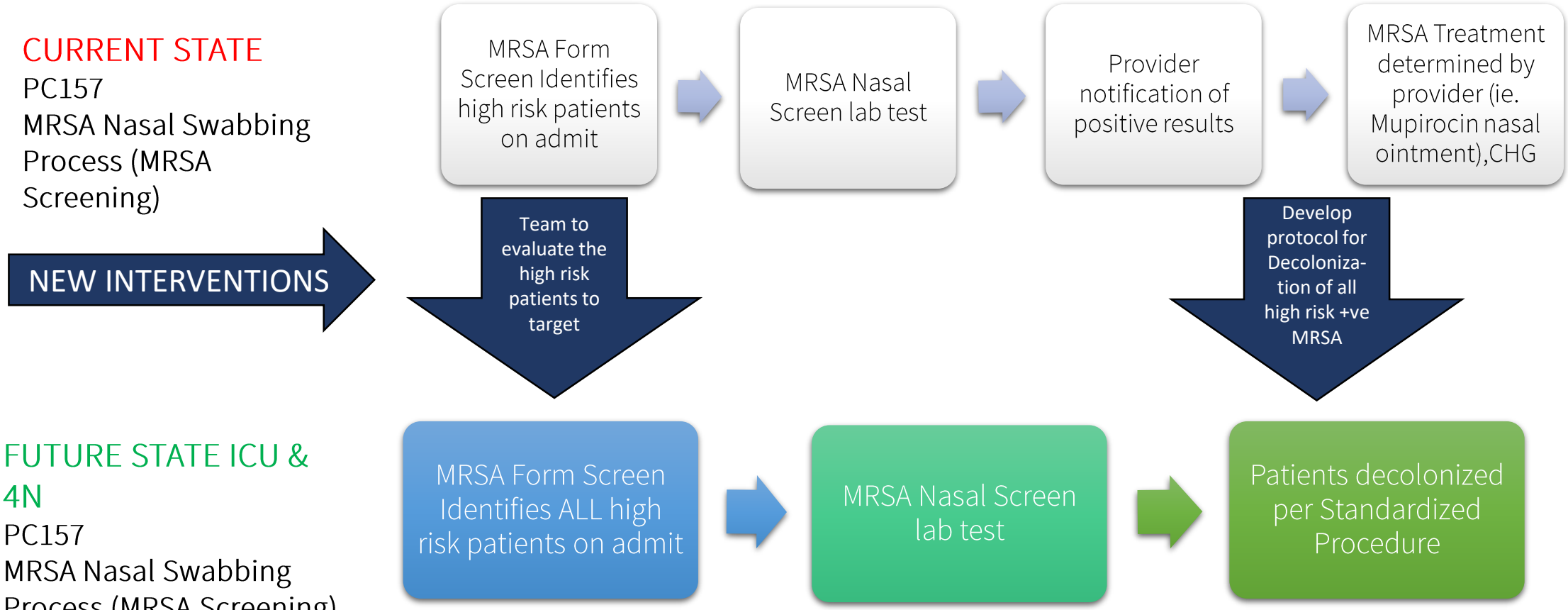
Low exception rates



Key Strategies

2. Decolonization Processes

- ICU and 4N Trial with standardize procedure, goal November go live DEC 7, 2021, other units follow PC157



Key Strategies MRSA QFT

2. Decolonization Processes

Next Steps:

- ICU and 4N Trial with standardize procedure, goal November go live Dec 7, 2021, other units follow PC157
  - Once 3 month pilot is evaluated team will determine if further spread of standardize procedure is an option
- Taskforce team (ISS, Nursing, Quality &P/S and Infection Prevention) evaluating methods to automate PC157 processes for all other units; actions include:
  - Autotasking for nasal screening/testing of high risk populations identified in PC157 (i.e. patients admitted from a Skilled Nursing Facility, and patients readmitted from another acute care facility 30 days previous)
  - Auto provider notification when nasal screen lab result is MRSA positive

Essential Information to know:

MRSA positive result: New PC-SP.125T1

Where: 4N and ICU (trial units)

Background: Upon admission history adult form completion - if the patient meets high risk criteria, a MRSA nasal swab test order is automatically generated.

What is it: Positive MRSA nasal swab lab result will now auto generate an order for Mupirocin Nasal Ointment per PC-SP.125T1

Exclusions: Patients with an allergy to Mupirocin

If the nurse observes any of the following during the MRSA nasal swab test or subsequent administration of the Mupirocin administration.

- Epistaxis
- Resistance to advancing a nasal swab/cotton tip applicator
- Intolerance or refusal to allow passage of nasal swab/cotton tip applicator

The RN will stop the procedure immediately and inform the licensed independent provider.

Go-live date – Tuesday December 7th

For questions, please contact your unit manager

Kaweah Health

December 7, 2021

Key Strategies MRSA QFT

3. Environment & Equipment Cleaning

	Bladder Scanner / Ultrasound machine	Blood Glucose Monitor	Vitals Machines	Cardiac Monitor Leads	Cardiac Monitor Leads	EKG monitor leads	IV Pumps	IV poles	Lift Equipment	CAPD Warmer handles	Blanket Warmer handles	02 monitors on crash carts
Unit 1	4 (new machine)	8	557			6			69		148	33
Unit 2		12	7						97		76	42
Unit 3		5	19						12		63	117
Unit 4	23 (new machine)	42	46						58	127	156	2
Unit 5	9 (new machine)	7	151			35			7		22	7304*
Unit 6		13	663	33 (tele)		46	16	18	45		63	15
Unit 7	11	233	5	17	0		21	66	105			37
Unit 8	9 (new machine)	24	5								20	7
Unit 9	845	61	n/a	127	54		9	18	3			
Unit 10	31	47	142	224	121		97	56		47	79	82

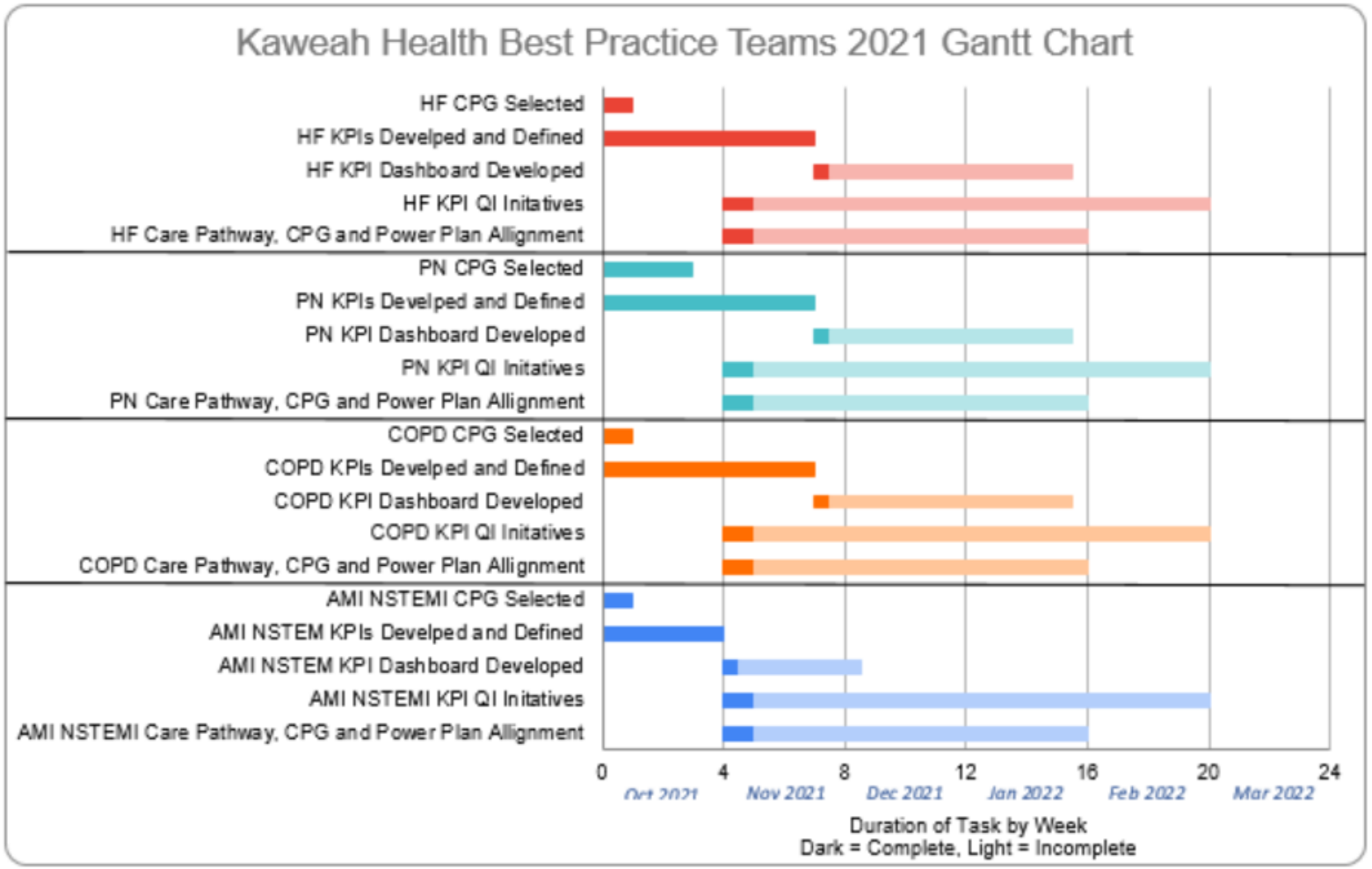
Environment & Equipment Cleaning

- ATP testing evaluates the effectiveness of cleaning practices
- ATP Testing in 10 units (med/surg & critical care)
- 71 pieces of patient care equipment tested with a 94% “Pass” which is <500 RLU

Kaweah Health Best Practice Teams Update

Summary:

- Clinical Practice Guidelines (CPGs) selected
- Key Performance Indicators (KPIs) chosen and defined
- Dashboards under development
- QI strategies in progress
- Alignment of CPG, pathways and power plans in progress



Kaweah Health Best Practice Teams Outcome Data

Kaweah Health Best Practice Teams Outcome Dashboard FY 2021

	Goal	Baseline (FY 2019)	1Q - 2Q 2021*	3Q 2021*	FYTD July-Oct*
Readmission Medicare Population	AMI (non-STEMI) – 11.01	12.34	12.5	7.14% (1/14)	10% (2/20)
	COPD – 12.87	16.09	10	27.27% (3/11)	30.77% (4/13)
	HF – 14.58	18.22	21.28	15.79% (6/38)	15.39% (8/52)
	PN Viral/Bacterial – 11.30	14.13	13.51	15.79% (6/38)	18.37% (9/49)
O/E Mortality Medicare Population	AMI (non-STEMI) - 0.71	0.75	0.84	0.86 (n=16)	0.85 (n=18)
	COPD – 1.92	2.4	0.93	2.73 (n=13)	2.66 (n=17)
	HF – 1.42	1.78	0.911	0.38(n=44)	0.49 9n=60)
	PN Bacterial – 1.48	1.85	1.04	0 (n=6)	1.52 (n=10)
	PN Viral - 1.07	1.34	0.64	0.42 (n=23)	1.32 (n=32)

*Midas updated to version 4.0 with revised risk adjustment algorithm

FY22 Clinical Quality Goals

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

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

Performance Measure	Baseline	FY22 Goal	Jan 2021- June 2021	FYTD July 2021-Oct 2021	Status
Hospital Readmissions (%) Medicare Population	(FY2019) AMI – 12.34 COPD – 16.09 HF – 18.22 PN Viral/Bacterial – 14.13	AMI – 11.10 COPD – 12.87 HF – 14.58 PN Viral/Bacterial – 11.03	AMI – 12.5* COPD – 10.0* HF – 21.28* PN Viral/Bacterial – 13.51*	AMI – 10*(2/20) COPD – 30.77*(4/13) HF – 15.39*(8/52) PN Viral/Bacterial – 18.37* (9/49)	• Medical Director position filled • COPD Team monitoring new process and follow up on identified opportunities
Decrease Mortality Observed/Expected Rates Medicare Population	(2019) AMI - 0.75 COPD – 2.40 HF – 1.78 PN Bacterial – 1.85 PN Viral – 1.34	AMI - 0.71 COPD – 1.92 HF – 1.42 PN Bacterial 1.48 PN Viral 1.07	AMI – 0.84* COPD – 0.93* HF – 0.911* PN Bacterial – 1.04 PN Viral -0.64*	AMI – 0.85* (n=18) COPD – 2.66*(n=17) HF – 0.49*(n=60) PN Bacterial – 1.52* (n=10) PN Viral -1.32* (n=32)	• Medical Director position filled • Guideline review and measures/dashboard development with key performance indicators
Home Medication List Review of High Risk Patients (inpatient admission)	57% (Avg Oct 2020 and Feb 2021)	100%	71% Jan-June 2021 91% July 1-July 31, 2021	July 2021 – 91% Aug 2021 – 87% Sept 2021 – 94% Oct 2021 – 100% Nov 2021 – 100%	• Jan-June 2021 • *2-3 Pharmacy Techs (M-F, 8 hour shifts)* • July 2021 • *4.5 Pharmacy Techs (weekend coverage added, 10 hour shifts*)
Complete Initial Home Medication w/in 12 hours of Inpatient Admission	N/A	100%	n/a	n/a	• Exploring reporting capabilities with ISS
Outpatient Medication Reconciliation w/in 30 days Post Discharge (MRP)	N/A	44%	21% Jan-June 2021 41% July 1-August 31, 2021	July 2021 – 41% Aug 2021 – 44% Sept 2021 – 68% Oct – 66%	• Improvement noted due to optimization in CERNER Millennium for all ambulatory care providers
Team Round Implementation	MICU currently does this	Design & Pilot on 1-2 units	n/a	n/a	• In Progress-identifying nursing leaders to develop design

*Midas updated to version 4.0 with revised risk adjustment algorithm

Questions?

Live with passion.

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

Kaweah Health

Policy Number: AP41	Date Created: No Date Set
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration)	

Quality Improvement Plan

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

I. Purpose

The purpose of Kaweah Delta Health Care District's (KDHCD) Quality Improvement Plan is to have an effective, data-driven Quality Assessment Performance Improvement program that delivers high-quality, excellent clinical services and enhances patient safety.

II. Scope

All KDHCD facilities, departments, patient care delivery units and/or service areas fall within the scope of the quality improvement plan requirements.

III. Structure and Accountability

Board of Directors

The Board of Directors retain overall responsibility for the quality of patient care. The Board approves the annual Quality Improvement Plan and assures that appropriate allocation of resources is available to carry out that plan.

The Board receives reports from the Medical Staff and Quality Council. The Board shall act as appropriate on the recommendations of these bodies and assure that efforts undertaken are effective and appropriately prioritized.

Quality Council

The Quality Council is responsible for establishing and maintaining the organization's Quality Improvement Plan and is chaired by a Board member. The Quality Council shall consist of the Chief Executive Officer, representatives of the Medical Staff and other key hospital leaders. It shall hold primary responsibility for the functioning of the Quality Assessment and Performance Improvement program. Because District quality improvement activities may involve both the Medical Staff and other representatives of the District, membership is multidisciplinary. The Quality Council requires the Medical Staff and the organization's staff to implement and report on the activities for identifying and evaluating opportunities to improve patient care and services throughout the organization. The effectiveness of the quality

improvement and patient safety activities will be evaluated and reported to the Quality Council.

Medical Staff

The Medical Staff, in accordance with currently approved medical staff bylaws, shall be accountable for the quality of patient care. The Board delegates authority and responsibility for the monitoring, evaluation and improvement of medical care to the Professional Staff Quality Committee "Prostaff", chaired by the Vice Chief of Staff. The Chief of Staff delegates accountability for monitoring individual performance to the Clinical Department Chiefs. Prostaff shall receive reports from and assure the appropriate functioning of the Medical Staff committees. "Prostaff" provides oversight for medical staff quality functions including peer review.

Quality Improvement Committee (QIC)

QIC has responsibility for oversight of organizational performance improvement. Membership includes key organizational leaders including the Medical Director of Quality and Patient Safety or Chief Quality Officer, Chief Operating Officer, Chief Nursing Officer, Assistant Chief Nursing Officer, Directors of Quality and Patient Safety, Nursing Practice, and Risk Management; Manager of Quality and Patient Safety and Manager of Infection Prevention. This committee reports to Prostaff and the Quality Council.

The QIC shall have primary responsibility for the following functions:

1. **Health Outcomes:** The QIC shall assure that there is measureable improvement in indicators with a demonstrated link to improved health outcomes. Such indicators include but are not limited to measures reported to the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC), and other quality indicators, as appropriate.

2. **Quality Indicators:**
   a. The QIC shall oversee measurement, and shall analyze and track quality indicators and other aspects of performance. These indicators shall measure the effectiveness and safety of services and quality of care.
   b. The QIC shall approve the specific indicators used for these purposes along with the frequency and detail of data collection.
   c. The Board shall ratify the indicators and the frequency and detail of data collection used by the program.

3. **Prioritization:** The QIC shall prioritize quality improvement activities to assure that they are focused on high- risk, high- volume, or problem-prone areas. It shall focus on issues of known frequency, prevalence or severity and shall give precedence to issues that affect health

outcomes, quality of care and patient safety. The QIC is responsible to establish organizational Quality Focus Teams who:

a. Are focused on enterprise-wide high priority, high risk, problem prone QI issues
b. May require elevation, escalation and focus from senior leadership
c. Have an executive team sponsor
d. Are chaired by a Director or Vice President
e. May have higher frequency of meetings as necessary to focus work and create sense of urgency.
f. Report quarterly into the QAPI program

4. **Improvement:** The QIC shall use the analysis of the data to identify opportunities for improvement and changes that will lead to improvement. The QIC will also oversee implementation of actions aimed at improving performance.

5. **Follow- Up:** The QIC shall assure that steps are taken to improve performance and enhance safety are appropriately implemented, measured and tracked to determine that the steps have achieved and sustained the intended effect.

6. **Performance Improvement Projects:** The QIC shall oversee quality improvement projects, the number and scope of which shall be proportional to the scope and complexity of the hospital's services and operations. The QIC must also ensure there is documentation of what quality improvement projects are being conducted, the reasons for conducting those projects, and the measureable progress achieved on the projects.

Medical Executive Committee

The Medical Executive Committee (MEC) receives, analyzes and acts on performance improvement and patient safety findings from committees and is accountable to the Board of Directors for the overall quality of care.

Nursing Practice Improvement Council

The Nursing Practice Improvement Council is designed to ensure quality assessment and continuous quality improvement and to oversee the quality of patient care (with focus on systems improvements related to nursing practices and care outcomes).

The Nursing Practice Improvement Council is chaired by the Director of Nursing Practice and facilitated by a member of the Quality and Patient Safety department. This Council has staff nurse representation from a broad scope of inpatient and out-patient nursing units, and procedural nursing units. The Council will report to Patient Care Leadership, Professional Practice Council (PPC) and the Professional Staff Quality Committee.

Graduate Medical Education
Graduate Medical Education (Designated Institutional Official (DIO), faculty and residents, are involved in achieving quality and patient safety goals and improving patient care through several venues including but not limited to:

a) Collaboration between Quality and Patient Safety Department, Risk Management, and GME Quality Subcommittee
b) GME participation in Quality Improvement Committee and Patient Safety Committee
c) GME participation in KDHCD quality committees and root cause analysis (including organizational dissemination of lessons learned)

Methodologies:

Quality improvement (QI) models present a systematic, formal framework for establishing QI processes within an organization. QI models used include the following:

- Model for Improvement (FOCUS Plan-Do-Study-Act [PDSA] cycles)
- Six Sigma: Six Sigma is a method of improvement that strives to decrease variation and defects with the use of the DMAIC roadmap.
- Lean: is an approach that drives out waste and improves efficiency in work processes so that all work adds value with the use of the DMAIC roadmap.

1. The **FOCUS-Plan, Do, Check, Act (PDCA)** methodology is utilized to plan, design, measure, assess and improve functions and processes related to patient care and safety throughout the organization.

   - **F—Find** a process to improve
   - **O—Organize** effort to work on improvement
   - **C—Clarify** knowledge of current process
   - **U---Understand** process variation
   - **S—Select** improvement

   - **Plan:**

     - Objective and statistically valid performance measures are identified for monitoring and assessing processes and outcomes of care including those affecting a large percentage of patients, and/or place patients at serious risk if not performed well, or performed when not indicated, or not performed when indicated; and/or have been or likely to be problem prone.

     - Performance measures are based on current knowledge and clinical experience and are structured to represent cross-departmental, interdisciplinary processes, as appropriate.

- **Do:**
  - Data is collected to determine:
    - Whether design specifications for new processes were met
    - The level of performance and stability of existing processes
    - Priorities for possible improvement of existing processes
- **Check:**
  - Assess care when benchmarks or thresholds are reached in order to identify opportunities to improve performance or resolve problem areas
- **Act:**
  - Take actions to correct identified problem areas or improve performance
  - Evaluate the effectiveness of the actions taken and document the improvement in care
  - Communicate the results of the monitoring, assessment and evaluation process to relevant individuals, departments or services

3. DMAIC (Lean Six Sigma): DMAIC is an acronym that stands for Define, Measure, Analyze, Improve, and Control. It represents the five phases that make up the road map for Lean Six Sigma QI initiatives.

- **Define** the problem, improvement activity, opportunity for improvement, the project goals, and customer (internal and external) requirements. QI tools that may be used in this step include:
  - Project charter to define the focus, scope, direction, and motivation for the improvement team
  - Process mapping to provide an overview of an entire process, starting and finishing at the customer, and analyzing what is required to meet customer needs
- **Measure** process performance.
  - Run/trend charts, histograms, control charts
  - Pareto chart to analyze the frequency of problems or causes
- **Analyze** the process to determine root causes of variation and poor performance (defects).
  - Root cause analysis (RCA) to uncover causes
  - Failure mode and effects analysis (FMEA) for identifying possible product, service, and process failures

- **Improve** process performance by addressing and eliminating the root causes.
  - Pilot improvements and small tests of change to solve problems from complex processes or systems where there are many factors influencing the outcome
  - Kaizen event to introduce rapid change by focusing on a narrow project and using the ideas and motivation of the people who do the work
- **Control** the improved process and future process performance.
  - Quality control plan to document what is needed to keep an improved process at its current level. Statistical process control (SPC) for monitoring process behavior
  - Mistake proofing (poka-yoke) to make errors impossible or immediately detectable

IV. Confidentiality

All quality assurance and performance improvement activities and data are protected under the Health Care Quality Improvement Act of 1986, as stated in the Bylaws, Rules and Regulations of the Medical Staff, and protected from discovery pursuant to California Evidence Code §1157.

V. Annual Evaluation

Organization and Medical Staff leaders shall review the effectiveness of the Quality Improvement Plan at least annually to insure that the collective effort is comprehensive and improving patient care and patient safety. An annual evaluation is completed to identify components of the plan that require development, revision or deletion. Organization and Medical Staff leaders also evaluate annually their contributions to the Quality Improvement Program and to the efforts in improving patient safety.

VI. Attachments

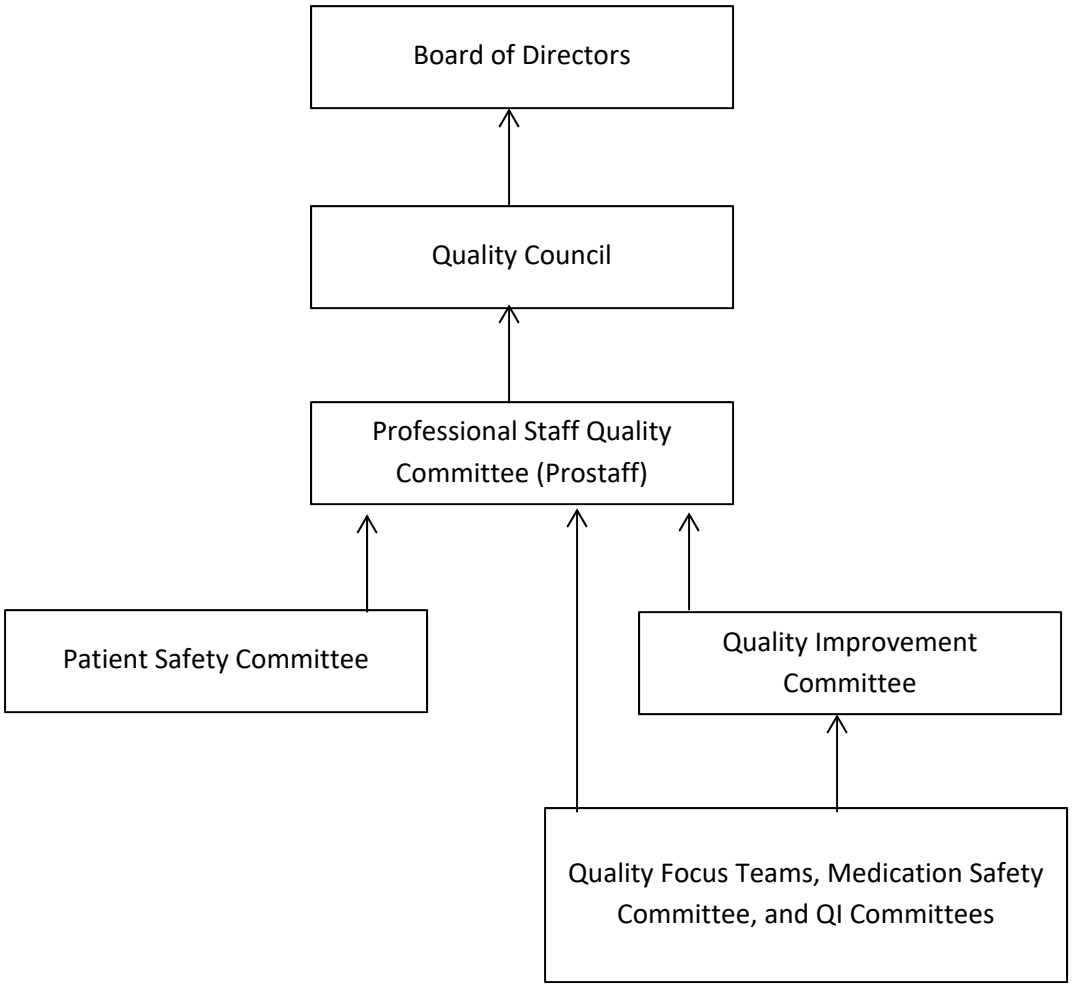
Components of the Quality Improvement and Patient Safety Plan:

Attachment 1: Quality Improvement Committee Structure
Attachment 2: KDHCD- Prostaff and QIC Reporting Departments
Attachment 3: Quality & Patient Safety Priorities – Outstanding Health Outcomes Strategic Plan~~ocuments~~
~~Attachment 3: 2019-2020 Value Based Purchasing (VBP) Objectives~~

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

Attachment 1

Kaweah Health
Quality Reporting Structure



Attachment 2

Kaweah Health - QUALITY IMPROVEMENT COMMITTEE REPORTING DEPARTMENTS

Departments within Kaweah Health participate in the Quality Improvement plan by prioritizing performance improvement activities based on high-risk, high-volume, or problem-prone areas. Department level indicators shall focus on issues of known frequency, prevalence or severity and shall give precedence to issues that affect health outcomes, quality of care and patient safety. Departments include, but are not limited to:

PROFESSIONAL and PATIENT CARE SERVICES
Laboratory
Nursing Quality Dashboard
Advanced Nursing Practice
Wound Care, Inpatient (Skin and Wound Committee)
Patient Access
Community Outreach
Patient & Family Services
Case Management/Utiliz Mgt & Bed Alloc
Interpreter Services
EOC (Security, facilities, Clinical Engineering, EVS)
Chaplain Services
Exeter Health Clinic (includes Lindsay, Woodlake, Dinuba)
Inpatient Pharmacy
Conscious Sedation (ED) Annual
Organ Donation (Annual)
Maternal Child Health
Labor & Delivery
Mother Baby
Neonatal Intensive Care Unit
Pediatrics
Mental Health Services
Mental Health
Episodic Care
Emergency
Trauma Service
Urgent Care
Cardiovascular Services
Dept of Cardiovascular Services (ACC/STS/) - Cath lab, IR, CVCU and Cardiac Surgery
CVICU
2N
4T
Critical Care Services
Intensive Care Unit
3W
Rehabilitation Services
Rehabilitation
Inpatient Therapies (KDMC, Rehab, South Campus)

PROFESSIONAL and PATIENT CARE SERVICES
Outpatient Therapies: Medical Office Building (MOB), Exeter, Sunnyside, Dinuba, Lovers Lane, Therapy Specialists at Rehab
Outpatient Wound Care at Rehab
Post Acute Services
KD Home Infusion Pharmacy
Home Care Services (Home Health & Hospice)
Transitional Care Svc/Short-Stay Rehab
Skilled Nursing Services
Surgical Services
Ambulatory Surgery Center/PACU/KATS
Operating Room
SPD
Broderick Pavilion
3N
4 South
Renal Services
4 North -
CAPD/ CCPD (Dialysis Maintenance)
Visalia Dialysis
Med/Surg
2S
3S
PUBLICALLY REPORTED MEASURES
Infection Prevention
Patient Safety Indicators/HACs
Value Based Purchasing Report
Patient Experience
Core Measures
Hospital Compare Quarterly Report
Healthgrades
Leapfrog Hospital Safety Score
COMMITTEES
Med Safety & ADE
Disparities in care
Falls committee
RRT/Code Blue
Pain Management
Resource Effectiveness Committee
Sepsis Quality Focus Team
Stroke
Diabetes QFT
Blood Utilization
Handoff Communication QFT
Accreditation Regulatory Committee
Diversion Prevention Committee

Strategic Initiative Charter: Outstanding Health Outcomes

Objective	Chair	ET Sponsor	Board Member
To consistently deliver high quality care across the health care continuum	Sonia Duran-Aguilar	Doug Leeper	Dave Francis

Performance Measure	Baseline	FY22 Goal	FY23 Goal	FY24 Goal
Standardized Infection Ratio (SIR) CAUTI, CLABSI, MRSA (CMS Data)	CAUTI 0.84 CLABSI 1.33 MRSA 2.53	CAUTI ≤ 0.676 CLABSI ≤ 0.596 MRSA ≤ 0.727	TBD	TBD
Percent Sepsis Bundle Compliance (SEP-1) (CMS Data)	75% (July-Dec2020)	≥75%	≥80%	≥82%
Hospital Readmissions (%)	(FY2019) AMI – 12.34 COPD – 16.09 HF – 18.22 PN Viral/Bacterial – 14.13	AMI – 9.99 COPD – 10.30 HF – 11.66 PN Viral/Bacterial – 9.04	TBD	TBD
Decrease Mortality Observed/Expected Rates	AMI - 0.75 COPD – 2.40 HF – 1.78 PN Bacterial – 1.85 PN Viral – 1.34	AMI - 0.67 COPD – 1.00 HF – 1.14 PN Bacterial – 1.18 PN Viral - 0.96	TBD	TBD
Home Medication List Review of High Risk Patients (inpatient admission)	57% (Avg Oct 2020 and Feb 2021)	100%	100%	100%
Complete Initial Home Medication w/in 12 hours of Inpatient Admission	N/A	100%	100%	100%
Outpatient Medication Reconciliation w/in 30 days Post Discharge (MRP)	N/A	44%	55%	78%
Team Round Implementation	MICU currently does this	Design & Pilot on 1-2 units	Roll out expectations for 2 additional units and measure at 6 months % adherence	80% Adherence for 3-4 units and roll out for units with hospital-based groups and measure at 6 months % adherence

Best Practice Team Update

Michael Tedaldi, MD
Kaweah Health Medical Director of Best Practice Teams

Quality Council
December 2021

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
- BB, ACE/ARB/ARNI/SARA

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

Clinical Practice Guidelines (CPGs)

Institute of Medicine - "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances." They may offer concise instructions on which diagnostic or screening tests to order, how to provide medical or surgical services, how long patients should stay in hospital, or other details of clinical practice.

Clinical Pathways (CPWs)

Clinical pathways (CPWs) are tools used to guide evidence-based healthcare. Their aim is to translate clinical practice guideline recommendations into clinical processes of care within the unique culture and environment of a healthcare institution.
A CPW is a structured multidisciplinary care plan with the following characteristics:

1. it is used to translate guidelines or evidence into local structures;
2. it details the steps in a course of treatment or care in a plan, pathway, algorithm, guideline, protocol or other "inventory of actions"; and
3. it aims to standardize care for a specific clinical problem, procedure or episode of healthcare in a specific population.

Rotter T, de Jong RB, Lacko SE, et al. Clinical pathways as a quality strategy. In: Busse R, Klazinga N, Panteli D, et al., editors. Improving healthcare quality in Europe: Characteristics, effectiveness and implementation of different strategies [Internet]. Copenhagen (Denmark): European Observatory on Health Systems and Policies; 2019. (Health Policy Series, No. 53.) 12. Available from: https://www.ncbi.nlm.nih.gov/books/NBK549262/

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

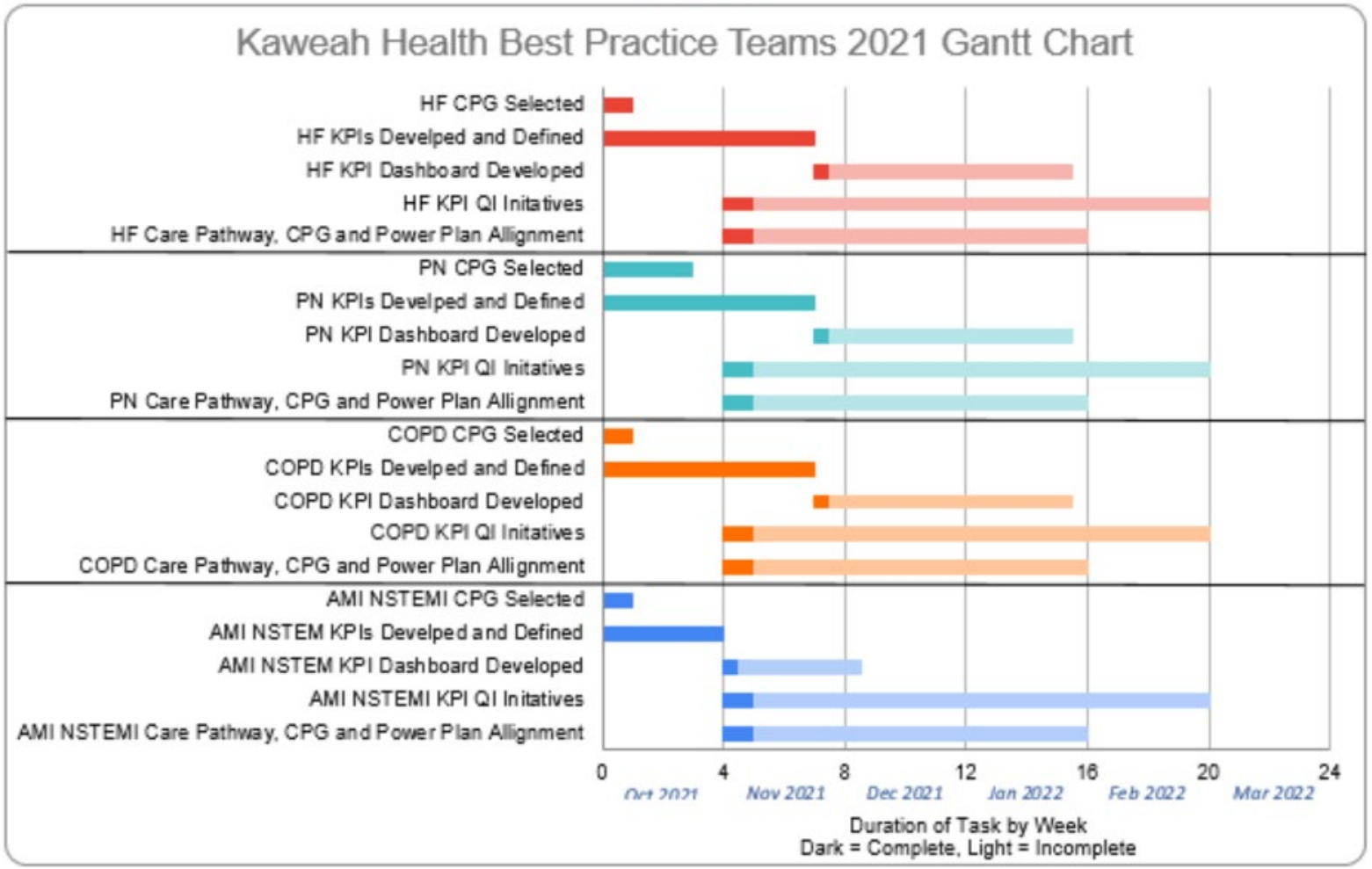
- Care Pathway developed
- Integrated into Cerner power plans & workflow
- QI Measures added to dashboard
- QI work to achieve targets

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

Kaweah Health Best Practice Teams Project Update

Summary:

- Clinical Practice Guidelines (CPGs) selected
- Key Performance Indicators (KPIs) chosen and defined
- Dashboards under development
- QI work on KPIs in process
- Alignment of CPG, pathways and power plans in progress



Outcome Data

Kaweah Health Best Practice Teams Outcome Dashboard FY 2021

	Goal	Baseline (FY 2019)	1Q - 2Q 2021*	3Q 2021*	FYTD July-Oct 2021*
Readmission Medicare Population	AMI (non-STEMI) – 11.01	12.34	12.5	7.14% (1/14)	10% (2/20)
	COPD – 12.87	16.09	10	27.27% (3/11)	30.77% (4/13)
	HF – 14.58	18.22	21.28	15.79% (6/38)	15.39% (8/52)
	PN Viral/Bacterial – 11.30	14.13	13.51	15.79% (6/38)	18.37% (9/49)
O/E Mortality Medicare Population	AMI (non-STEMI) - 0.71	0.75	0.84	0.86 (n=16)	0.85 (n=18)
	COPD – 1.92	2.4	0.93	2.73 (n=13)	2.66 (n=17)
	HF – 1.42	1.78	0.911	0.38(n=44)	0.49 9n=60)
	PN Bacterial – 1.48	1.85	1.04	0 (n=6)	1.52 (n=10)
	PN Viral - 1.07	1.34	0.64	0.42 (n=23)	1.32 (n=32)

*Midas updated to version 4.0 with revised risk adjustment algorithm

Team Charter

Heart Failure (HF)

PROJECT NAME: Heart Failure	CHAMPION: Dr. M. Tedaldi	QI Facilitator: Melissa Quinonez
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)
2. Develop and improve Key Performance Indicators (KPIs)

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)

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
2. Develop and improve Key Performance Indicators (KPIs)

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

Pneumonia (PN)

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

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

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)
2. Develop and improve Key Performance Indicators (KPIs)

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

Summary – Next Steps

- KPI data & dashboards under development
- Team is reviewing CPGs, care pathways, and physician power plans to ensure alignment (operationalizing best practices at the bed side)
- Improvement work for each specific population based on the KPI data

Thank you

Live with passion.

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

Kaweah Health

Prioritized Measure Name	Measure Definition	Data Source/Method & Notes
Heart Failure		
1. (HF): % of patients with systolic heart failure that are discharged on Beta Blocker and ACE/ARB/ARNI. ***Addresses MORTALITY AND READMISSION***	Numerator: Number of patients with systolic heart failure that are discharged on Beta Blocker and ACE/ARB/ARNI. For those not discharged on recommended medications, contraindications are documented appropriately (Diagnosis of bradycardia, hypotension, diastolic heart failure, GFR ≤30 or serum potassium above 5 meq) Denominator: # of inpatient HF patients with primary dx of HF (primary dx as defined by CMS, codes listed in Midas in CMS readmission population)	Manual Audit, requested from CV services
2. (HF): % of HF patients with CHFrEF (reduced EF or systolic heart failure that were on Entresto on admit ***Addresses MORTALITY AND READMISSION***	Numerator: Number of patients with CHFrEF (reduced EF or systolic heart failure) that were taking Entresto on admission Denominator: # of inpatient HF patients with primary dx of HF (primary dx as defined by CMS, codes listed in Midas in CMS readmission population)	Manual Audit, requested from CV services
3. (HF): % of HF patients with CHFrEF (reduced EF or systolic heart failure) who are on Entresto during inpatient stay ***Addresses MORTALITY AND READMISSION***	Numerator: Number of patients with CHFrEF (reduced EF or systolic heart failure) that were taking Entresto on during inpatient stay Denominator: # of inpatient HF patients with primary dx of HF (primary dx as defined by CMS, codes listed in Midas in CMS readmission population)	Manual Audit, requested from CV services
4. (HF): % of HF patients who were taking Entresto while inpatient who are discharged on Entresto. ***Addresses MORTALITY AND READMISSION***	Numerator: Number of HF patients who were taking Entresto while inpatient who are discharged on Entresto Denominator: # of inpatient HF patients with primary dx of HF (Exclude patients with diagnosis of diastolic heart failure or who are already on Entresto upon admission). (primary dx as defined by CMS, codes listed in Midas in CMS readmission population)	Manual Audit, requested from CV services
Pneumonia		
1.(PN) % Pneumonia ED power plan Utilization ***Addresses MORTALITY, LOS***	Numerator: Number of patients with CAP/suspected Pneumonia power plan used in the ED Denominator: Patients with primary dx of Community Acquired Pneumonia (pneumonia POA) (primary dx as defined by CMS, codes listed in Midas in CMS readmission population). ANY COVID DX REMOVED	Q&P/S Senior Data Analyst • Include ability to analyze data by ED attending provider
2.(PN) % First dose of antibiotic administered within 3 hours of suspected or confirmed diagnosis in ED or 1 East	Numerator: Patients who were administered an antibiotic within 3 hours of date/time CAP or Sepsis power plan initiated (whichever comes first) (time power plan initiated indicates CAP dx highly suspected)	Q&P/S Senior Data Analyst • Include ability to analyze data by ED and 1 East locations

Prioritized Measure Name	Measure Definition	Data Source/Method & Notes
Addresses MORTALITY, LOS	Denominator: Patients with primary dx of Community Acquired Pneumonia (pneumonia POA) (primary dx as defined by CMS, codes listed in Midas in CMS readmission population) ANY COVID DX REMOVED	• Include ability to analyze data by ED or 1 East location Abx administered • Locations include ED, and all inpatient care units in med/surg, ICCUs (3W and 5T) and CC (ICU and CVICU)
3.(PN) Pneumonia admission power plan Utilization In patients ***Addresses MORTALITY AND LOS***	Numerator: Adult patients Admitted to medical center patients with CAP power plan ordered Denominator: Patients with primary dx of Community Acquired Pneumonia (pneumonia POA) (primary dx as defined by CMS, codes listed in Midas in CMS readmission population) ANY COVID DX REMOVED	Q&P/S Senior Data Analyst • Include ability to analyze data by ADMITTING provider
4. (PN) % transitioned from IV to PO antibiotics within 48 hours of first antibiotic treatment ***Addresses MORTALITY, LOS***	Numerator: number of adult inpatients transitioned from IV to PO antibiotics within 48 hours. 48 hrs starts when first Abx documented as administered IV route, and ends when first Abx is documented PO route. Denominator: Patients with primary dx of Community Acquired Pneumonia (pneumonia POA) (primary dx as defined by CMS, codes listed in Midas in CMS readmission population) ANY COVID DX REMOVED	Q&P/S Senior Data Analyst • Include ability to analyze data by IV Abx ordering provider
COPD		
1. (COPD) percentage of patients had Pulmonary Function Studies (PFTs) performed? ***Addresses MORTALITY AND READMISSION***	Numerator: # of adult inpatient medical center COPD patients who had PFT performed. PFTs scanned into Cerner under Documentation Bar, Subject: Pulmonary Function Studies (Change Display All, apply Advanced Filters, click on Operative/Procedures, select option Pulmonary Function Studies) If multiple studies performed include results from the latest study. Denominator: # of adult inpatient medical center COPD patients with primary dx of COPD or, principal discharge dx of respiratory failure and/or secondary dx of COPD (primary dx as defined by CMS, codes listed in Midas in CMS readmission population)	Manual audit, requested from CV services
2. (COPD) percentage of our patients who received Pneumonia immunization on discharge? ***Addresses MORTALITY AND READMISSION***	Numerator: # of adult inpatient medical center COPD patients with primary dx of COPD or secondary dx of COPD who received Pneumococcal Vaccine prior to d/c with any of options selected on the Nursing Discharge Summary Form with the exception of "patient declined" (patient declined is not compliant)	Q&P/S Senior Data Analyst • Include ability to analyze data by location vaccine ORDERED in

Prioritized Measure Name	Measure Definition	Data Source/Method & Notes
	Denominator: # of inpatient COPD patients with primary OR secondary dx of COPD and or, primary dx of respiratory failure and secondary dx of COPD. (primary dx as defined by CMS, codes listed in Midas in CMS readmission population)	• Locations include all inpatient care units in med/surg, ICCUs (3W and 5T) and CC (ICU and CVICU)
3. (COPD) percentage of our patients received Influenza immunization during this flu season ***Addresses MORTALITY AND READMISSION***	Numerator: # of inpatient COPD patients with influenza vaccine status on discharge as: Vaccine given during this admission Pt states already had vaccine this flu season And Yes checked on influenza vaccine accepted including documentation of administration of the influenza vaccine in the MAR with any of the order names Denominator: # of inpatient COPD patients with principal discharge dx of COPD and or, principal discharge dx of respiratory failure and/or secondary dx of COPD	Q&P/S Senior Data Analyst • Include ability to analyze data by location vaccine ORDERED in • Locations include all inpatient care units in med/surg, ICCUs (3W and 5T) and CC (ICU and CVICU)
4. (COPD) percentage of patients accepted smoking cessation information on discharge? ***Addresses MORTALITY AND READMISSION***	Numerator: # of inpatient COPD patients with current smoking status as yes, active smoker and/or quit within the last year and answered accepted to question- Smoking cessation information given (as documented on Nursing Discharge Summary Form (see screenshot). Yes, active smoker Quit within the last year Denominator: # of inpatient COPD patients with principal discharge dx of COPD and or, principal discharge dx of respiratory failure and/or secondary dx of COPD (see attached list of ICDs)	Q&P/S Senior Data Analyst • Include ability to analyze data by discharge • Locations include all inpatient care units in med/surg, ICCUs (3W and 5T) and CC (ICU and CVICU)
5. (COPD) percentage of patients were referred to Pulmonary Rehab and attended? ***Addresses MORTALITY AND READMISSION***	Numerator: # of COPD patients who received a referral for Pulmonary Rehab (ordered as Cardiopulmonary Rehab, pulmonary rehab) in requested service column as located in Referral Management button on Cerner Tracking Shell (see screenshot) Denominator: # of inpatient COPD patients with principal discharge dx of COPD and or, principal discharge dx of respiratory failure and/or secondary dx of COPD (see attached list of ICDs)	Q&P/S Senior Data Analyst • Include ability to analyze data by ATTENDING/ DISHCARGING provider
6. (COPD) 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? (Dr. Tedaldi to do chart reviews)	Numerator: # of inpatient COPD who have principal or secondary dx of COPD including any dx of CHF, any dx of PN and or any dx of both CHF and PN (ICDs attached) Denominator: # of inpatient COPD patients with principal discharge dx of COPD and or, principal discharge dx of respiratory failure and/or secondary dx of COPD (see attached list of ICDs)	Midas Team • Provide a spreadsheet for Dr. Tedaldi to review FIINs

Prioritized Measure Name	Measure Definition	Data Source/Method & Notes
Addresses MORTALITY AND READMISSION		
Acute Myocardial Infarction (AMI) Non- STEMI		
1. (AMI) Percent of NSTEMI patients who have a 12 lead EKG done within 10 minutes of arrival. ***Addresses MORTALITY, READMISSION, LOS***	Numerator: number of NSTEMI patients who have a 12 lead EKG done within 10 minutes of arrival to ED. Denominator: Total number of patients with a diagnosis of NSTEMI who went to the Cath Lab.	CV Service- ACC database
2. (AMI) Percent of NSTEMI patients administered oral beta blockers within 24 hours of positive Troponin. ***Addresses MORTALITY, READMISSION, LOS***	Numerator: Number of NSTEMI patients administered oral beta blockers within 24 hours of positive Troponin. Denominator: Total number of patients with a diagnosis of NSTEMI who went to the Cath Lab.	CV Service- ACC database
3. (AMI) Percent of NSTEMI patients who received IV UFH (unfractionated Heparin) or therapeutic SQ Lovenox (1mg/kg) within one hour of positive Troponin result. ***Addresses MORTALITY, READMISSION, LOS***	Numerator: Number of NSTEMI patients who received IV UFH (unfractionated Heparin) or therapeutic SQ Lovenox (1mg/kg) within one hour of positive Troponin result. Denominator: Total number of patients with a diagnosis of NSTEMI who went to the Cath Lab.	CV Service- ACC database
4. (AMI) 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. ***Addresses MORTALITY, READMISSION, LOS***	Numerator: Number of NSTEMI patients with a second Troponin done within 4 hours. (for risk stratification and early diagnosis) Using resulted time of initial Troponin. Denominator: Total number of patients with a diagnosis of NSTEMI who went to the Cath Lab.	CV Service- ACC database
5. (AMI) Diagnostic Consideration/Measure: Percent of NSTEMI patients with a second EKG done within 4 hours. (for risk stratification and early diagnosis)	Numerator: Number of NSTEMI patients with a second EKG done within 4 hours. Denominator: Total number of patients with a diagnosis of NSTEMI who went to the Cath Lab.	CV Service- ACC database

Prioritized Measure Name	Measure Definition	Data Source/Method & Notes
Addresses MORALITY, READMISSION, LOS		
6. (AMI) 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. *Addresses MORTALITY, READMISSION*	Numerator: Number 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. Denominator: Total number of patients with a diagnosis of NSTEMI who went to the Cath Lab.	CV Service- ACC database