October 13, 2023

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in a Quality Council Committee meeting at 7:30AM on Thursday, October 19, 2023, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:31AM on Thursday, October 19, 2023, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277, pursuant to Health and Safety Code 32155 & 1461.

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Quality Council Committee meeting at 8:00AM on Thursday, October 19, 2023, in the Kaweah Health Lifestyle Fitness center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

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

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

KAWEAH DELTA HEALTH CARE DISTRICT
Michael Olmos, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
Board Clerk, Executive Assistant to CEO

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

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
QUALITY COUNCIL

Thursday, October 19, 2023
5105 W. Cypress Avenue
Kaweah Health Lifestyle Fitness Center Conference Room

ATTENDING: Board Members; David Francis – Committee Chair, Michael Olmos; Gary Herbst, CEO; Keri Noeske, RN, BSW, DNP, Chief Nursing Officer; Tom Gray CMO/CQO; Julianne Randolph, OD, Vice Chief of Staff and Professional Staff Quality Committee Chair; LaMar Mack, MD, Quality and Patient Safety Medical Director; Sandy Volchko DNP, RN CLSSBB, Director of Quality and Patient Safety; Ben Cripps, Chief Compliance and Risk Management Officer; Evelyn McEntire, Director of Risk Management; and Sylvia Salinas, Recording.

OPEN MEETING – 7:30AM

1. **Call to order** – *David Francis, Committee Chair*
2. **Public / Medical Staff participation –** Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdiction of the Board are requested to identify themselves at this time. For those who are unable to attend the beginning of the Board meeting during the public participation segment but would like to address the Board, please contact the Board Clerk (Cindy Moccio 559-624-2330) or cmoccio@kaweahhealth.org to make arrangements to address the Board.
3. **Approval of Quality Council Closed Meeting Agenda** – 7:31AM
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Julianne Randolph, OD, Vice Chief of Staff and Professional Staff Quality Committee Chair*
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Mara Miller, PharmD BCPS, Medication Safety Coordinator, Chair – Medication Safety Committee*
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management and Ben Cripps, Chief of Compliance and Risk Officer.*
4. **Adjourn Open Meeting** – *David Francis, Committee Chair*

CLOSED MEETING – 7:31AM

1. **Call to order** – *David Francis, Committee Chair & Board Member*

2. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Julianne Randolph, OD, Vice Chief of Staff and Professional Staff Quality Committee Chair*
3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Mara Miller, PharmD BCPS, Medication Safety Coordinator, Chair – Medication Safety Committee*
4. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management, and Ben Cripps, Chief Compliance and Risk Officer.*
5. **Adjourn Closed Meeting** – *David Francis, Committee Chair*

OPEN MEETING – 8:00AM

1. **Call to order** – *David Francis, Committee Chair*
2. **Public / Medical Staff participation –** Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves at this time. Members of the public or the medical staff may comment on agenda items after the item has been discussed by the Committee but before a Committee recommendation is decided. In either case, each speaker will be allowed five minutes.
3. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives:
    - 3.1. CAUTI Committee
    - 3.2. Rapid Response Team RRT
    - 3.3. CMS Core Measures
    - 3.4. Hospice, Home Health
    - 3.5. MRSA Quality Focus Team
4. **Diabetes Committee Report –** A review of key quality measures and action plans related to the care of in-patients with diabetes. *Emma Camarena DNP, RN, ACCNS-AG, CCRN, Director of Nursing Practice*
5. **Sepsis Quality Focus Team Report –** Update on process and outcome quality metrics associated with the care of the septic population and improvement action plans. *Erika Pineda, BSN, RN, PHN, CPHQ, Quality Improvement Manager, LaMar Mack, MD, Quality and Patient Safety Medical Director*
6. **Clinical Quality Goals Update-** A review of current performance and actions focused on the clinical quality goals for Sepsis, and Healthcare Acquired Infections. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*
7. **Adjourn Open Meeting** – *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.

Catheter Associated Urinary Tract Infection (CAUTI) Committee Report October 2023

Kari Knudsen, Director of Post-Surgical Care (Chair)

CAUTI- FY23 Goals

FY23 Clinical Quality Goals

	July 22 – May 23 (Higher is Better)	FY23 Goal	FY22	FY22 Goal
SEP-1 (% Bundle Compliance)	74%	≥ 77%	76%	≥ 75%

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

Our Mission

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

Our Vision

To be your world-class healthcare choice, for life

Lower is Better	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	June 2023	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual/ number expected)	FY23 Goal (VBP 2024: National Mean 2019)	FY22 FY21 FY20
CAUTI Catheter Associated Urinary Tract Infection Excluding COVID INCLUDING COVID-19 PATIENTS	1 0	1 0	2 0	0 1	2 0	3 0	0 0	0 0	0 0	1 0	2 0	0 0	14 (23 predicted over 12 months)	0.55 0.596 Including COVID	≤0.650	1.092 0.54 1.12

Kaweah Health

CAUTI Committee- Key Strategies

- Daily surveillance monitoring with Gemba on each IUC
- Proposed formation of an HAI QFT to encompass CAUTI, CLABSI and MRSA infection reduction
- Focused efforts to reduce CAUTI SIR to achieve FY 24 goals (strategic goal under review by ET)
  - Improvements to urine culture only orders to reduce cultures performed without positive urinalysis
- Focused efforts to reduce CAUTI SUR to achieve FY 24 goals (strategic goal under review by ET)
  - Partnership with Dr. Mack and other physician stakeholders to renovate the standardized procedure, nurse driven urinary catheter removal protocol. Rollout will include physician engagement and support of its use
  - Reduced Gemba questions to focus on line liberation in Med-Surg units
  - Multi-disciplinary Line liberation rounds for critical care units for all lines
  - Updated urinary retention management orders to reduce unnecessary urinary catheters

Live with passion.

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

Kaweah Health

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: CAUTI Committee **ProStaff/QIC Report Date:** 10/19/2023

Measure Objective/Goal:

- Goal for FY24 under review by ET
- FY 2023 SIR = 0.55; GOAL ≤ 0.650; Goal achieved
- Pre KAIZEN baseline SIR is 1.557

CAUTIs result in poor outcomes for patients, a negative public perception of care through publically reported safety scores and financially impact the organization through HAC and VBP programs as well as increased treatment costs and LOS.

Date range of data evaluated: FYTD SIR (7/2022 – 6/2023)

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):

CAUTI Committee Dashboard										
Measure Description	**Jul-22**	**Aug-22**	**Sep-22**	**Oct-22**	**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**
OUTCOME MEASURES										
Number of CAUTI	1	1	2	1	2	3	0	0	0	1
FYTD SIR	0.57	0.54	0.75	0.697	0.779	0.9	0.77	0.75	0.66	0.6
PROCESS MEASURES IUC Gemba										
% of pts with appropriate cleanliness	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
% of pts with order present with indication	95%	93%	93%	96%	94%	94%	93%	92%	90%	88%
% of IUCs where removal was attempted	2%	5%	7%	7%	3%	2%	2%	13%	20%	12%
% of pts where alternatives have been attempt	5%	10%	10%	8%	5%	4%	5%	28%	9%	12%
# of Pt Catheter days rounded on	871	975	848	733	760	683	737	564	621	503
% of IUCs removed because of Gemba Round	2%	5%	3%	3%	2%	1%	1%	1%	4%	3%
# of IUCs removed because of Gemba Round	19	45	29	19	13	9	8	8	23	16
*volume reduced due to reduced Gemba on weekends **FYTD includes cases removed in Mar 2021 *e=estimated										

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

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

1) Daily surveillance monitoring with Gemba on each IUC- *on-going*
2) Proposed formation of an HAI QFT to encompass CAUTI, CLABSI and MRSA infection reduction; *formation underway*
3) Focused efforts to reduce CAUTI SIR to achieve FY 24 goals (strategic goal under review by ET)
   - Improvements to urine culture only orders to reduce cultures performed without positive urinalysis
4) Focused efforts to reduce CAUTI SUR to achieve FY 24 goals (strategic goal under review by ET)
   - Partnership with Dr. Mack and other physician stakeholders to renovate the standardized procedure, nurse driven urinary catheter removal protocol. Rollout will include physician engagement and support of its use *Timeline: SP to committee for approval, go live expected December 2023*
   - Reduced Gemba questions to focus on line liberation in Med-Surg units *Timeline: go live will conicde with SP changes, December 2023*
   - Multi-disciplinary Line liberation rounds for critical care units for all lines *Timeline: Per intensivist group, planning underway*
   - Updated urinary retention management orders to reduce unnecessary urinary catheters *Timeline: go live will conicde with SP changes, December 2023*

Next Steps/Recommendations/Outcomes:

A. Continue to maintain: Daily IUC Gemba rounds, data collection, and dissemination and QI strategy development.

Submitted by Name: Kari Knudsen **Date Submitted:** 9/27/2023

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

RRT/Code Blue Pro Staff Report

Q2 2023

Shannon Cauthen MSN, CCRN-K

American Heart Association.

American Heart Association.
Get With The Guidelines.
Resuscitation

Our first award from the AHA!

The American Heart Association proudly recognizes

Kaweah Delta Health Care District
Visalia, CA

Get With The Guidelines® - Resuscitation SILVER

Achievement Award Hospital
Adult

The American Heart Association recognizes this hospital for its continued success in using the **Get With The Guidelines®** program.

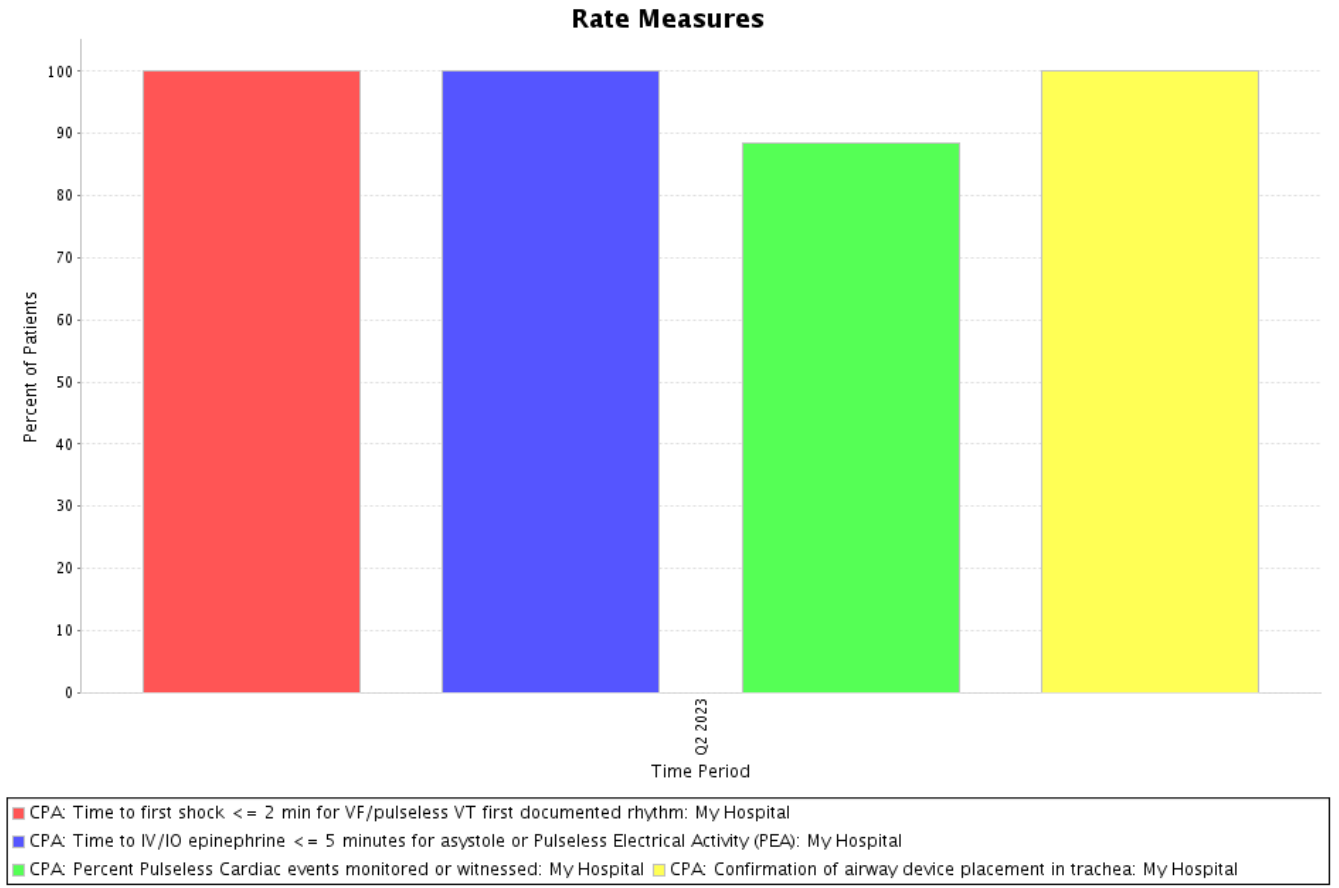
Thank you for applying the most up-to-date evidence-based treatment guidelines to improve patient care and outcomes in the community you serve.*

Nancy Brown
Chief Executive Officer
American Heart Association

Michelle A. Albert, MD, MPH, FACC, FAHA
President
American Heart Association

*For more information, please visit **Heart.org/GWTGQualityAwards**.

GTWG Performance



Breakdown of GWTG Metrics

CPA: Time to first shock <= 2 min for VF/pulseless VT first documented rhythm

Percent of events in adult patients with VF/pulseless VT first documented rhythm in whom time to first shock <=2 minutes of event recognition.
Time Period: Q2 2023 - Q2 2023; **Site:** KAWEAH DELTA HEALTH CARE DISTRICT (85227)

CPA: Time to first shock <= 2 min for VF/pulseless VT first documented rhythm				
Benchmark Group	**Time Period**	**Numerator**	**Denominator**	**% of Patients**
My Hospital	Q2 2023	3	3	100.0%

CPA: Time to IV/IO epinephrine <= 5 minutes for asystole or Pulseless Electrical Activity (PEA)

Percent of events in adult patients where time to epinephrine <= 5 minute of asystole or pulseless electrical activity.
Time Period: Q2 2023 - Q2 2023; **Site:** KAWEAH DELTA HEALTH CARE DISTRICT (85227)

CPA: Time to IV/IO epinephrine <= 5 minutes for asystole or Pulseless Electrical Activity (PEA)				
Benchmark Group	**Time Period**	**Numerator**	**Denominator**	**% of Patients**
My Hospital	Q2 2023	20	20	100.0%

CPA: Percent Pulseless Cardiac events monitored or witnessed

Percent of pulseless cardiac patient events were monitored or witnessed
Time Period: Q2 2023 - Q2 2023; **Site:** KAWEAH DELTA HEALTH CARE DISTRICT (85227)

CPA: Percent Pulseless Cardiac events monitored or witnessed				
Benchmark Group	**Time Period**	**Numerator**	**Denominator**	**% of Patients**
My Hospital	Q2 2023	23	26	88.5%

CPA: Confirmation of airway device placement in trachea

Percent of CPA events in adult patients who had confirmation of airway device placement in trachea
Time Period: Q2 2023 - Q2 2023; **Site:** KAWEAH DELTA HEALTH CARE DISTRICT (85227)

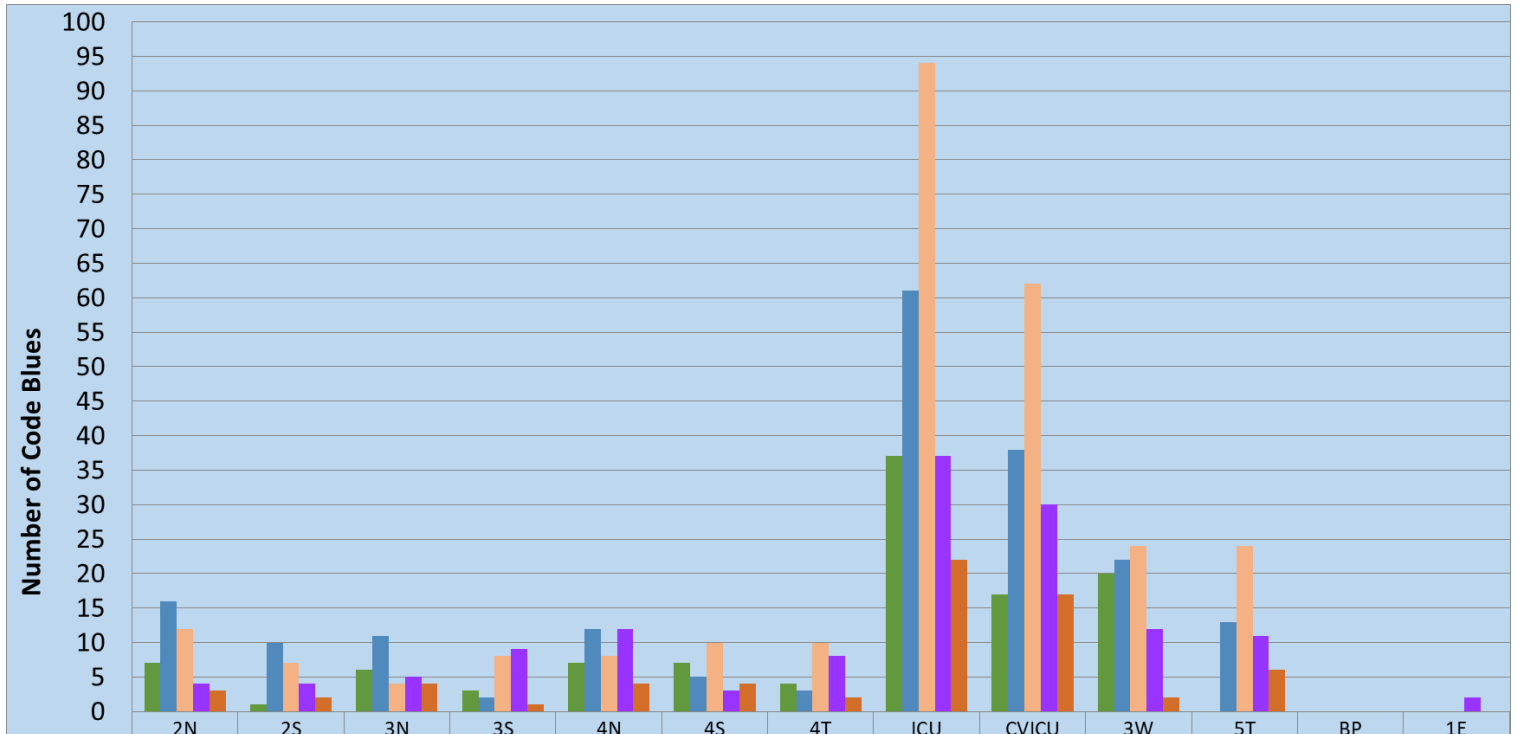
CPA: Confirmation of airway device placement in trachea				
Benchmark Group	**Time Period**	**Numerator**	**Denominator**	**% of Patients**
My Hospital	Q2 2023	24	24	100.0%

RRT and Resuscitation Scorecard

Measure Description	All GWTG Hospitals (External Benchmark)	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Mean (Rolling 12 months)
Code Blue Data														
Total Code Blues (Med/Surg/ICCU/CC)		7	12	7	9	9	17	14	14	13	9	2	14	11
Total COVID-19 Positive Code Blues		1	1	1	0	0	2	4	1	0	0	0	0	1
Code Blues per 1000 Discharges Med Surg/ICCU		2	2	3	5	6	8	3	4	7	3	0	6	4
Code Blues per 1000 Discharges Critical Care		4	8	3	3	2	5	8	9	3	5	2	6	5
Percent of Codes in Critical Care	66% (↑ is better)	71%	83%	57%	44%	22%	38%	71%	71%	29%	67%	100%	50%	59%
Event Survival Rates					56%	67%	47%	57%	71%	43%	33%	100%	79%	61%
Code Blue: Survival to Discharge	20% (↑ is better)	29%	17%	57%	22%	22%	6%	14%	0%	14%	0%	100%	21%	25%
Deaths from Cardiac Arrest (expired during event)		3	3	0	4	3	9	8	4	8	6	0	3	4
Overall Hospital Mortality Rate		2.05	2.06	2.89	2.4	2.15	3.05	3.54	3.2	2.29	2.84	2.47	2.85	2.65
RRT Data														
Total RRTS		94	111	98	110	98	125	121	96	133	104	102	90	107
RRTs per 1000 Patient Discharge Days		72	85	86	93	83	100	98	87	100	88	81	71	87
RRT Mortality	21% (↓ is better)	20% n-19	16% n-18	14% n-14	17% n-19	21% n-21	18% n-22	22% n-27	17% n-16	17% n-22	16% n-17	15% n-15	24% n-22	18%
RRTs Within 24 hours of Arriving to Inpatient Unit	15% (↓ is better)	17% n-16	22% n-24	21% n-21	23% n-25	22% n-22	23% n-29	26% n-31	24% n-23	26% n-35	24% n-25	28% n-29	36% n-32	24%
RRT- Med-Surg to Intermediate Critical Care Transfers	*9%	19% n-18	17% n-19	20% n-20	23% n-25	15% n-15	16% n-20	14% n-17	24% n-23	23% n-30	27% n-28	18% n-18	22% n-20	20%
RRT- Med-Surg to Critical Care Transfers	*29%	3% n-3	10% n-11	9% n-9	6% n-7	14% n-14	9% n-11	9% n-11	1% n-1	10% n-13	7% n-7	17% n-17	10% n-9	9%
RRT-Intermediate Critical Care Transfers to Critical Care	*32%	6% n-6	11% n-12	5% n-5	8% n-9	4% n-4	9% n-11	10% n-12	8% n-8	9% n-12	5% n-5	10% n-10	6% n-5	8%

Green	Better than Target
Yellow	Within 10% of Target
Red	Does not meet Target
*	Target Goal not Being Established

Code Blues by Location

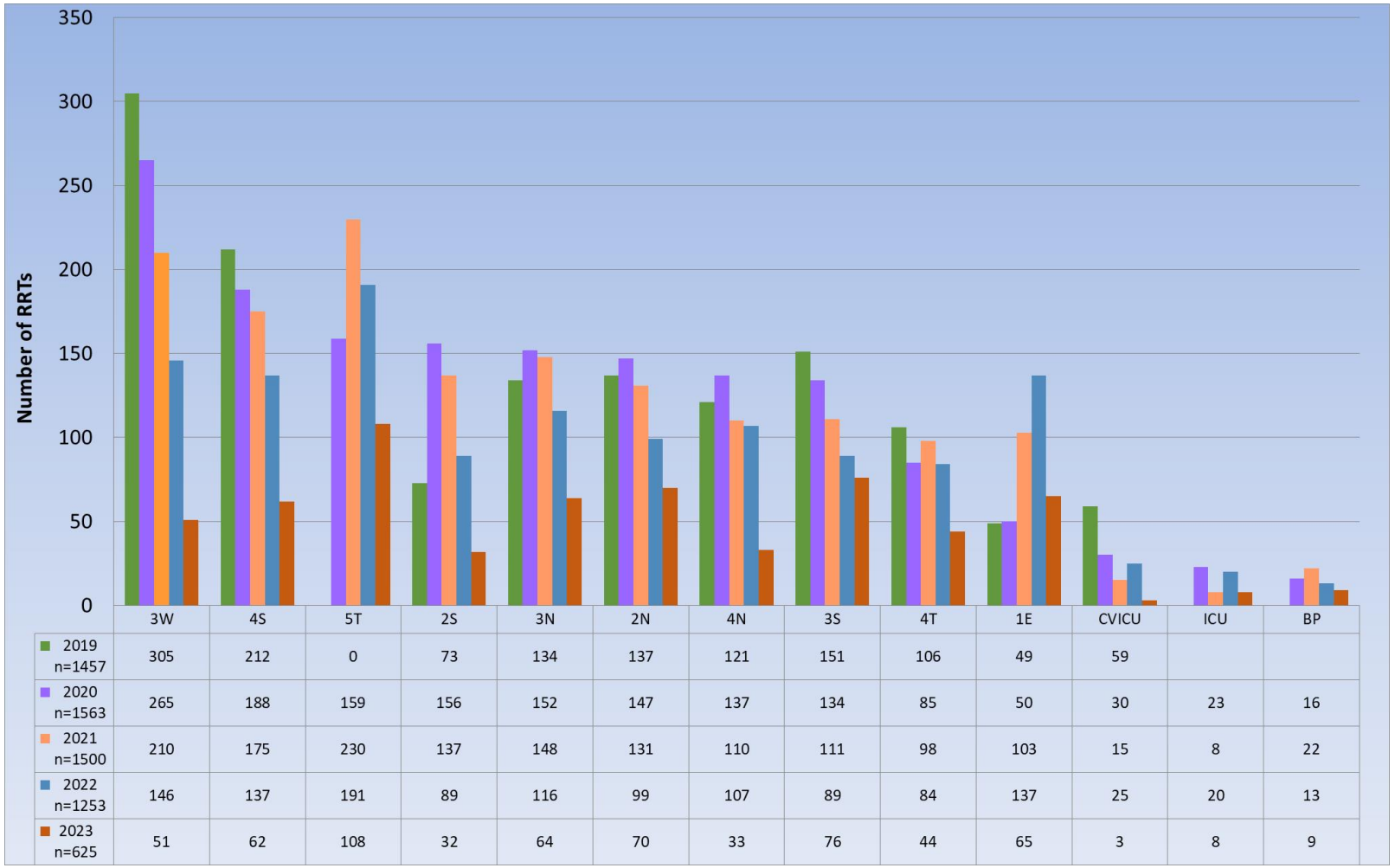


	2N	2S	3N	3S	4N	4S	4T	ICU	CVICU	3W	5T	BP	1E
2019 n=115	7	1	6	3	7	7	4	37	17	20	0	0	
2020 n=200	16	10	11	2	12	5	3	61	38	22	13	0	
2021 n=263	12	7	4	8	8	10	10	94	62	24	24	0	
2022 n=137	4	4	5	9	12	3	8	37	30	12	11	0	2
2023 n=67	3	2	4	1	4	4	2	22	17	2	6	0	0

Code Blues: For Q2, 72% of our code blues occurred in ICU/CVICU. An impressive 23% increase from Q1.

If you include the ICCUs (which are rich in resources and advanced monitoring), 72% of our code blues occurred in CC-> a 3% increase from Q1.

RRTs by Location



	3W	4S	5T	2S	3N	2N	4N	3S	4T	1E	CVICU	ICU	BP
2019 n=1457	305	212	0	73	134	137	121	151	106	49	59		
2020 n=1563	265	188	159	156	152	147	137	134	85	50	30	23	16
2021 n=1500	210	175	230	137	148	131	110	111	98	103	15	8	22
2022 n=1253	146	137	191	89	116	99	107	89	84	137	25	20	13
2023 n=625	51	62	108	32	64	70	33	76	44	65	3	8	9

Completed Projects

- LUCAS Go-Live (June 1st)
- Sidewalk CPR (June 6th)->article coming soon in Vital Signs Magazine

Next Steps

- Mega Mock Open Chest Code (in partnership with Sim Lab): August 2023
- Implementation of unit-led Mock Code Blues: September 2023
- ER-STOP: Re-assessment program led by DNP student to < RRTs within 24 hours of admission.
- Review strategies to further increase compliance with witnessed/monitored arrests.

The pursuit of healthiness

Kaweah Health
MORE THAN MEDICINE. LIFE.

	Metrics	Hospital Compare	CMS Standards of Excellence Benchmark	CMS Benchmark / *TJC National Rate	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Den	Num	Fail	Comments/Action Plan
ED-2b	Admit Decision Time to ED Departure for Admitted ED Patients **(in minutes - down trend positive) Internal Monitoring Only**	Y	42	139 (Hosp Comp)	505	408	458	453	489	196	182	462	443	391	317	122				Data tracked & monitored by ED Operations. CMS clasifies KH with "Very High Volume Facility". Data reflecs sample of cases. ED Operations tracks all cases.
OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients **(in minutes - down trend positive)**	Y	93	183 (Hosp Comp)	276	252	330	326	269	232	249	284	258	267	283	274				Data tracked & monitored by ED Operations. Barriers: Lack of nursing staff, above benchmark CT turn around times causing delays to discharge. CMS clasifies KH as "Very High Volume Facility". Data reflecs sample of cases.
OP-18c	Median Time from ED Arrival to ED Departure for Discharged ED Patients Psychiatric/Mental Health Patients **(in minutes - down trend positive)**	Y		128 (Hosp Comp)	1941	411	389	394	430	710	254	412	330	671	786	347				Will be added to ED Operations tracking & trending. Barriers: No Psych consults overnight. Tulare county utilizes crisis team (not in house). If crisis team conflict with provider clinical assement - have to await for 2nd opinion; Psych provider the next day ultimately delaying discharge (s). CMS clasifies KH as "Very High Volume Facility". Data reflecs sampled of cases.
OP-23	Head CT or MRI scan results for Acute Ischemic Stroke or Hemorrhagic Stroke	Y	100.00%	72.00%	100.0%	50.0%	0.0%	100.0%	33.3%	100.0%	100.0%	100.0%	100.0%	100.0%	75%	33.3%	3	1	2	
IMM-2	Influenza Immunization **(Internal Monitoring Only)**	N	100.00%	86.00%	N/A	N/A	N/A	N/A	N/A	83.91%	89.74%	95.18%	97.62%	98.73%	98.75%	N/A	N/A	N/A	N/A	
VTE-6	Hospital acquired potentially-preventable Venous Thromboembolism **(down trend positive)**	Y	0.00%	2.00%	0.00%	N/C	N/C	0.00%	0.00%	N/C	N/C	N/C	N/C	0.00%	N/C	N/C	N/C	N/C	N/C	
HBIPS-2a	**Physical Restraint-Overall Rate - **(down trend positive)**	Y	N/A	0.44	0.551	0.412	0.471	0.774	0.168	0.523	0.296	0.06	0.185	0.422	0.09	1.066				
HBIPS-3a	**Seclusion-Overall Rate - **(down trend positive)**	Y	N/A	0.29	0.474	0.06	1.386	1.106	1.367	1.48	0.45	0.551	0.894	0.591	0.829	1.568				Mental Health Leadership ongoing Quality Improvement initiative to address performance consistently above desired benchmark. Updates are provided to Quality Improvement Committee.
HBIPS-5a	Multiple antipsychotic medications at discharge with appropriate justification - overall rate	Y	N/A	65.00%	100.0%	100.0%	100.0%	87.5%	100.0%	50.0%	66.7%	75.0%	100.0%	100.0%	100.0%	100.0%	3	3	0	
SUB-2 (MH)	Alcohol Use Intervention Provided/Offered	Y	N/A	69.92%	91.67%	83.33%	100.0%	88.89%	90.00%	85.71%	60.00%	100.0%	75.0%	90.0%	70.0%	100.0%	8	8	0	
SUB-2A (MH)	Alcohol Use Brief Intervention	Y	N/A	61.76%	66.67%	50.00%	40.00%	55.56%	70.00%	42.86%	30.00%	60.00%	57.14%	50.00%	40.00%	50.00%	8	4	4	The intent of this measure is to have a discussion focused on increasing insight and awareness regarding alcohol use and motivation toward behavioral change. The majority of patients screened and offered brief counceling refuse. Pt refusal to have alcohol intervention during Mental Health stay considered a fall out for this measure.
SUB-3 (MH)	Alcohol/Other Drug Use Tx provided/offerred at D/C	Y	N/A	36%	95.24%	100.00%	92.31%	100.00%	94.12%	100.00%	100.00%	95.46%	100.00%	100.00%	100.00%	100.00%	23	23	0	
SUB-3A (MH)	Alcohol/Other Drug Use Disorder Tx at D/C	Y	N/A	36%	95.24%	100.00%	92.31%	100.00%	94.12%	100.00%	100.00%	95.46%	100.00%	100.00%	100.00%	100.00%	23	23	0	
IMM-2	Influenza Immunization (Mental Health) Start Oct 2015	Y	N/A	80.98%	N/A	N/A	N/A	N/A	N/A	48.08%	82.69%	100.00%	100.00%	100.00%	100.00%	N/A	N/A	N/A	N/A	
TOB-2 (MH)	Tobacco Cessation FDA Approved Provided during stay	Y	N/A	76.62%	91.18%	93.33%	95.65%	95.83%	88.00%	91.30%	82.61%	77.27%	85.00%	91.30%	90.91%	85.71%	28	24	4	
TOB-2A (MH)	Tobacco Treatment Provided During Stay (Practical Counseling)	Y	N/A	41.52%	39.39%	36.67%	30.44%	30.44%	44.00%	30.44%	39.13%	22.73%	35.00%	17.39%	27.27%	21.43%	28	6	22	Mental Health team actively working with ISS to update screening form. High incidence of pt refusal for this metric. Patient refusal is not an exclusion criteria for this measure.
TOB-3 (MH)	Tobacco Treatment Provided/Offered at Discharge	Y	N/A	40.80%	53.13%	33.33%	15.00%	20.00%	17.39%	23.81%	45.46%	40.00%	63.16%	72.73%	77.27%	77.78%	27	21	6	Mental Health Leadership actively working with ISS for ease of use for caregivers when creating referals for smoking cesassion. Caregivers not providing referal at discharge.
TOB-3A (MH)	Tobacco Cessation Medication FDA Approved Provided at Discharge	Y	N/A	9.52%	12.50%	0.00%	0.00%	0.00%	4.35%	0.00%	0.00%	10.00%	5.26%	4.55%	13.64%	14.82%	27	4	23	Mental Health Leadership actively working with ISS to assist Providers in Prescribing FDA approve medication cesasion at discharge. Evaluating option to electronically alert provider (electronic prompt) and/or document reason for no FDA approved medication provided at discharge.
CT-2	Care Transitions w/specified elements received by discharged patients	Y	N/A	30%	86.44%	88.68%	86.79%	77.36%	82.69%	88.68%	90.39%	79.25%	83.02%	75.47%	92.45%	92.45%	53	49	4	
SMD-1	Screening for Metabolic Disorders	Y	N/A	90%	97.44%	100.00%	91.67%	92.31%	96.30%	97.44%	94.44%	97.44%	100.00%	100.00%	100.00%	100.00%	33	33	0	
PCB-05	Exclusive Breast Milk Feeding		N/A	*52.44%	64.71%	58.33%	61.29%	64.52%	64.87%	65.71%	53.13%	48.57%	53.33%	56.25%	60.61%	45.16%	31	14	17	

Metrics		Hospital Compare	CMS Standards of Excellence Benchmark	CMS Benchmark / *TJC National Rate	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Den	Num	Fail	Comments/Action Plan
PCM-01	Early Elective Deliveries **(down trend positive)**		0	2.42%	0.00%	0.00%	0.00%	16.67%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	N/C	N/C	N/C	
PCM-2a	C-Section Overall Rate **(down trend positive)**		N/A	*25.54%	31.82%	4.76%	27.59%	11.11%	13.33%	17.24%	11.11%	23.08%	46.15%	33.33%	27.78%	12.50%	24	3	3	
PC-06	Unexpected Complications in Term Newborns-Overall Rate **per 1,000 live births (down trend positive)**		N/A	N/A	17.4%	9.2%	12.0%	28.8%	12.0%	27.1%	26.5%	18.6%	28.7%	16.3%	29.9%	33.0%	N/C	N/C	N/C	
PC-06.1	Unexpected Complications in Term Newborns-Severe **per 1,000 live births (down trend positive)**		N/A	5%	6.97%	6.08%	3.01%	11.53%	6.01%	15.06%	17.70%	18.6%	28.7%	3.3%	13.3%	11.0%	273	3	3	Maternal Child Health Leadership working with Obstetrics Medical Staff leadership to address potential clinical and medical record documentation opportunities. The only benchmark available at time of this report was 5%. A more recent TJC update has set national benchmark at 13%.
OP Web-29	Endoscopy/Polyp Surveillance - appropriate follow-up interval for normal colonoscopy in average risk patients		100%	85%	100.0%	85.7%	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	7	7	0	
Sep-1	Sepsis Bundle Followed	Y	81%	61%	78.95%	63.64%	78.13%	83.33%	81.82%	75.00%	76.19%	61.77%	65.63%	60.00%	100.0%	62.5%	24	15	9	

N/C=No Cases
N/A=Not available

Meets/Exceeds standars of Excellence Benchmark
Compliance Does Not Meet National Benchmark

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

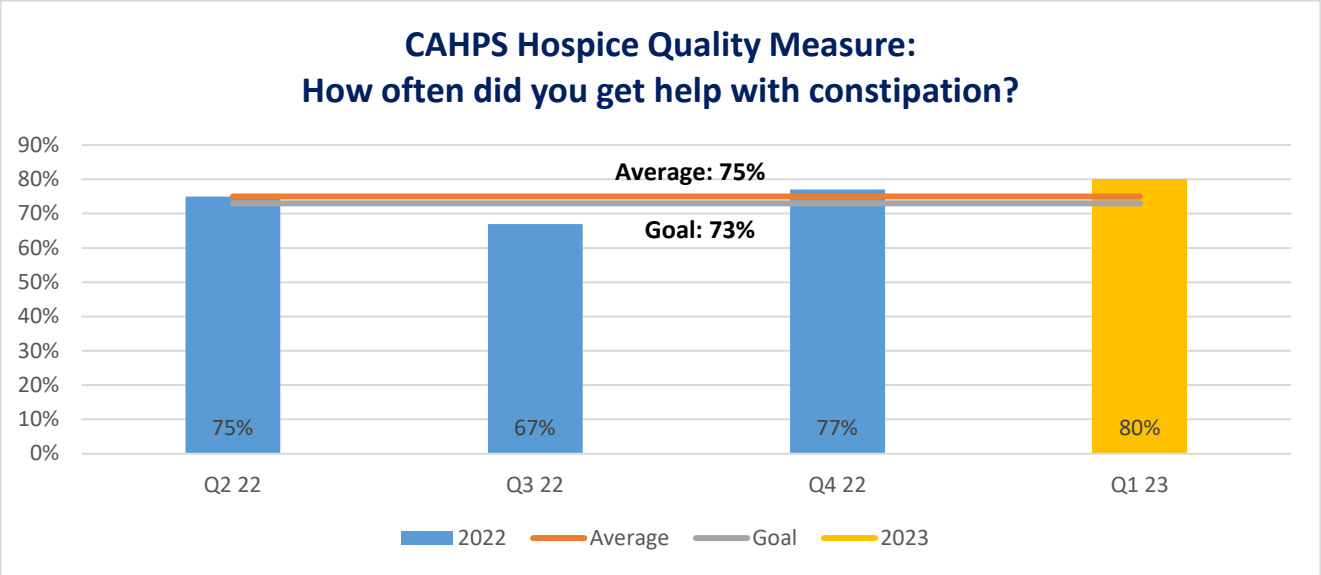
Unit/Department:
Hospice

ProStaff/QIC Report Date:
August, 2023

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

Measure Objective/Goal:
Got help with constipation

- **Average of Quarters April 1, 2022-March 31, 2023: 75%**



Date range of data evaluated:
April 1, 2022-March 31, 2023

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

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

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

Averge

--Current data from the date range shows an average score on this initiative of 75%. This denotes an increase from 65.7% as reported to the committee in March 2023. This initiative was chosen as constipation can greatly affect the comfort level a patient is able to achieve, comfort being intrinsic in the hospice philosophy, and we had been below the national average. The interventions as implemented have shown the positive increase we were hoping that it would. Since this was a new item added in March 2023, we will continue this initiative for another cycle to ensure this change is sustainable and that the interventions are the direct cause of the increase.

If improvement opportunities identified, provide action plan and expected resolution date:
There is always opportunity for improvement in this area and we want to ensure longevity in this success. Therefore the following plan of action continue to be implemented:

--Unless otherwise indicated, upon admission to Hospice, all patients will be provided with stool softeners and suppositories as ordered by the Hospice Medical Director.
--Bowel regimen will be initiated on all patients upon admission to Hospice and documented in the patient record.
--Documentation as to the patient's last bowel movement is mandatory in the patient record and must be addressed by staff.
--Reinforcement of these initiatives will take place at every Hospice skilled nursing meeting.

Next Steps/Recommendations/Outcomes:

With the interventions implemented as outlined above, we shall continue to monitor and analyze NRC data over next 4 quarters. Due to the lag time in these reports (approximately 6 months), it may take at least 4 quarters before we can be assured these interventions will result in longevity of sustaining the results as outlined above. Hospice will continue to utilize the interventions put into place in hopes of sustaining, or increasing, the score. The goal for this initiative will remain at 73%.

Submitted by Name:
Tiffany Bullock, Director
Kaweah Health Hospice

Date Submitted:
August 2023

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

Unit/Department Specific Data Collection Summarization

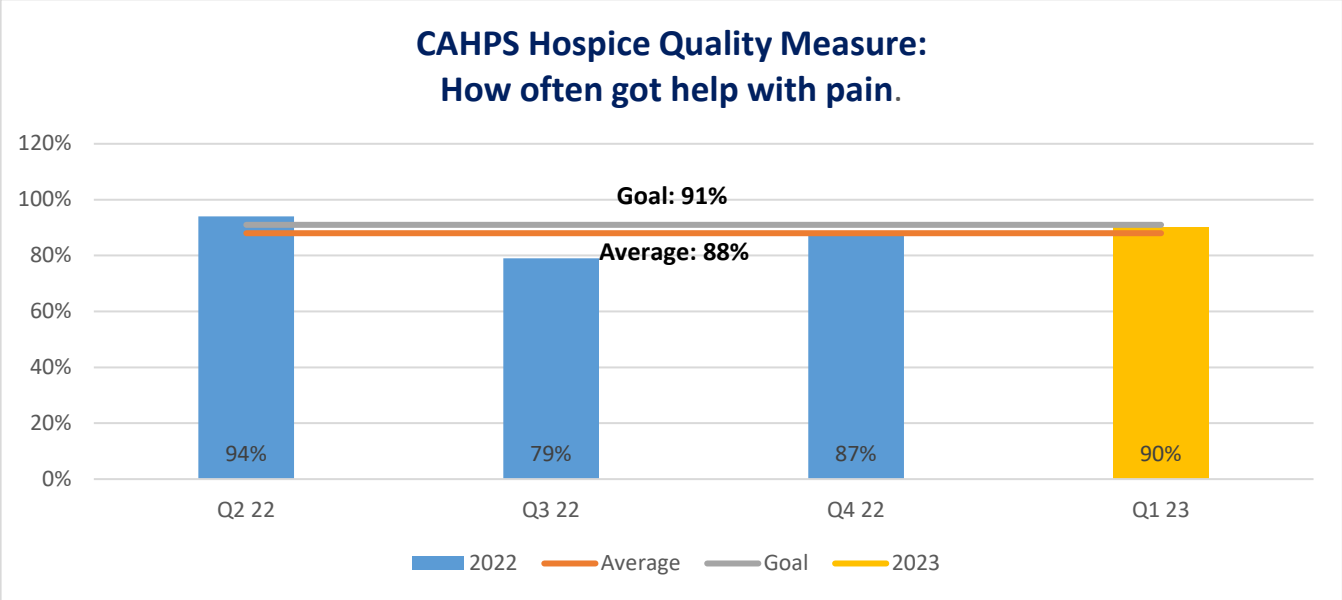
Professional Staff Quality Committee/Quality Improvement Committee

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

Measure Objective/Goal:

Got help with pain

- **Average of Quarters April 1, 2022-March 31, 2023: 88%**



Date range of data evaluate

April 1, 2022-March 31, 2023

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

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

--Current data from the date range shows an average score on this initiative of 88%. While the NRC benchmark average is 85.2% and we exceed this, this initiative was chosen in March 2023 due to a decrease from 94.1% to 78.6% from quarter 2 of 2022 and quarter 3 of 2022. Such a significant decrease in what is arguably the most pivotal metric for Hospice care demands attention. You will note that quarter 1 of 2023 showed an increase to 90%.

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

Hospice will continue to utilize the interventions put into place in hopes of sustaining, or increasing, the score. We will continue this initiative in hopes of continuing the upward trend.

<u>If improvement opportunities identified, provide action plan and expected resolution date:</u>
There is opportunity for improvement in this area. The following plan of action shall be implemented:

--Medications will be immediately available to patients upon admission to Hospice utilizing the Kaweah Health Home Infusion Pharmacy.
--Ensure staff are aware of the availability of the symptom management orders set forth by the Hospice Medical Director to assist in titrating medications when needed to achieve comfort for patient.
--A pain assessment will be required at every visit. Documentation of this into the patient record will be mandatory.
--Reinforcement of these initiatives will take place at every Hospice skilled nursing meeting.

<u>Next Steps/Recommendations/Outcomes:</u>

Interventions will continue to be reinforced. We shall continue to monitor and analyze NRC data over next 4 quarters. Due to the lag time in these reports (approximately 6 months), it may take at least 4 quarters before results of the above-outlined plan are shown. The goal for this initiative will be 91%.

<u>Submitted by Name:</u>
Tiffany Bullock, Director
Kaweah Health Hospice

<u>Date Submitted:</u>
August 2023

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

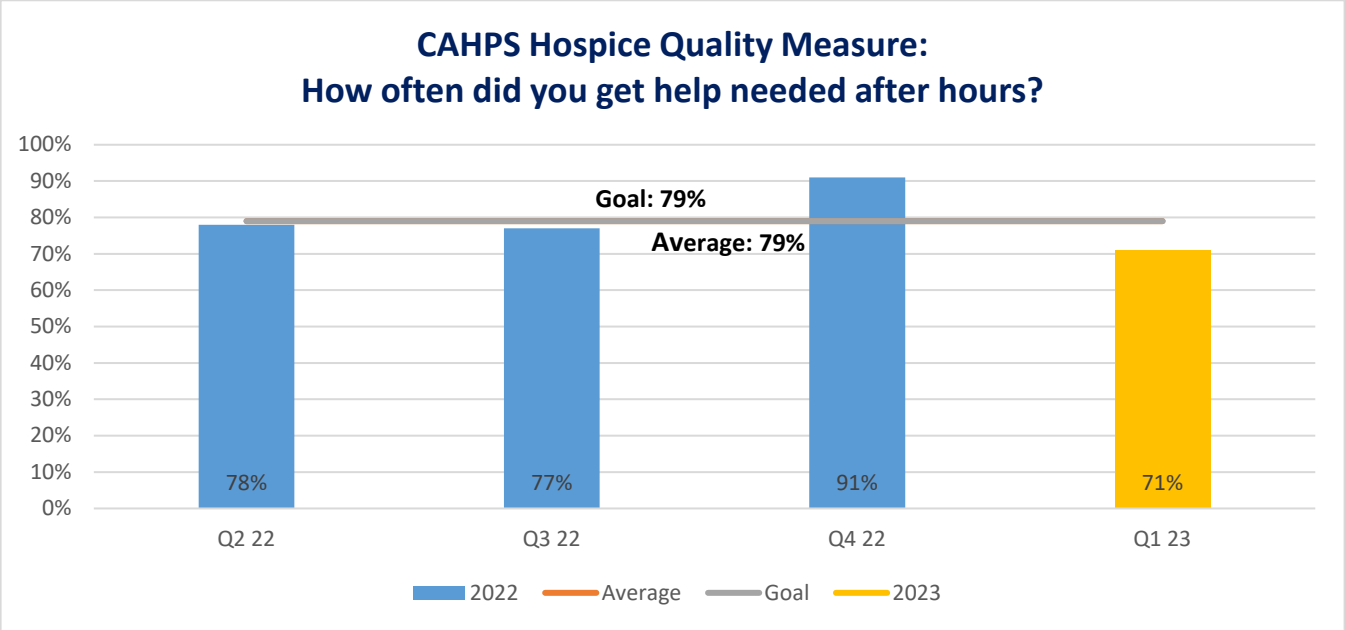
Unit/Department:
Hospice

ProStaff/QIC Report Date:
August 2023

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

Measure Objective/Goal:
How often did you get help needed after hours?

- **Average of Quarters April 1, 2022-March 31, 2023 : 79%**



Date range of data evaluated:
April 1, 2022-March 31, 2023

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

Analysis of all measures/data: (Include key findings, improvements, opportunities)
-- Current data from the date range shows an average score on this initiative of 79%. While the NRC benchmark is 76% and we exceed this, the decision was made to focus on

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

this initiative due to a drop between quarter 4 of 2022 and quarter 1 of 2023 of 20%. The ability for families/patients in hospice to reach an on call nurse is crucial. We want to ensure this drop is not the beginning of a trend and initiate action immediately.

<u>If improvement opportunities identified, provide action plan and expected resolution date:</u>
There is opportunity for improvement in this area. The following plan of action shall be implemented/continued:

--Leadership of Hospice to meet with PBX leadership to ensure PBX operators are not attempting to triage calls to Hospice, but rather placing all calls to the on call nurse regardless of if the patient is currently on service with Kaweah Health Hospice.
--Reinforce to hospice nurses the importance of timely returning calls. Ensure weekend nurse utilizes back up nurse for triaging calls if nurse is busy and return calls could be delayed.
-- Reinforcement of these initiatives will take place at every Hospice skilled nursing meeting.

<u>Next Steps/Recommendations/Outcomes:</u>

Once initiatives are implemented, we shall continue to monitor and analyze vendor data over next 4 quarters. Due to the lag time in these reports (approximately 6 months), it may take at least 4 quarters before results of the above-outlined plan are shown. The goal will be 79%.

<u>Submitted by Name:</u>
Tiffany Bullock, Director
Kaweah Health Hospice

<u>Date Submitted:</u>
August 2023

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

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

Unit/Department:
Home Health

ProStaff/QIC Report Date:
August 2023

Data for this report is obtained from the *Star Report* on the *Care Compare* website, the Centers for Medicare & Medicaid Services (CMS) platform for which quality measures are publicly reported for home health agencies. Currently, the July 2023 refresh on *Care Compare* reflects data from October 1, 2021 thru September 30, 2022. Kaweah Health Home Health is at an overall 3-Star rating, out of a 5-Star rating system.

In order to show real time data and ensure the most current data for analysis, Strategic Healthcare Programs (SHP), a web-based program that analyzes the Outcome and Assessment Information Set (OASIS) submitted to CMS monthly, was evaluated.

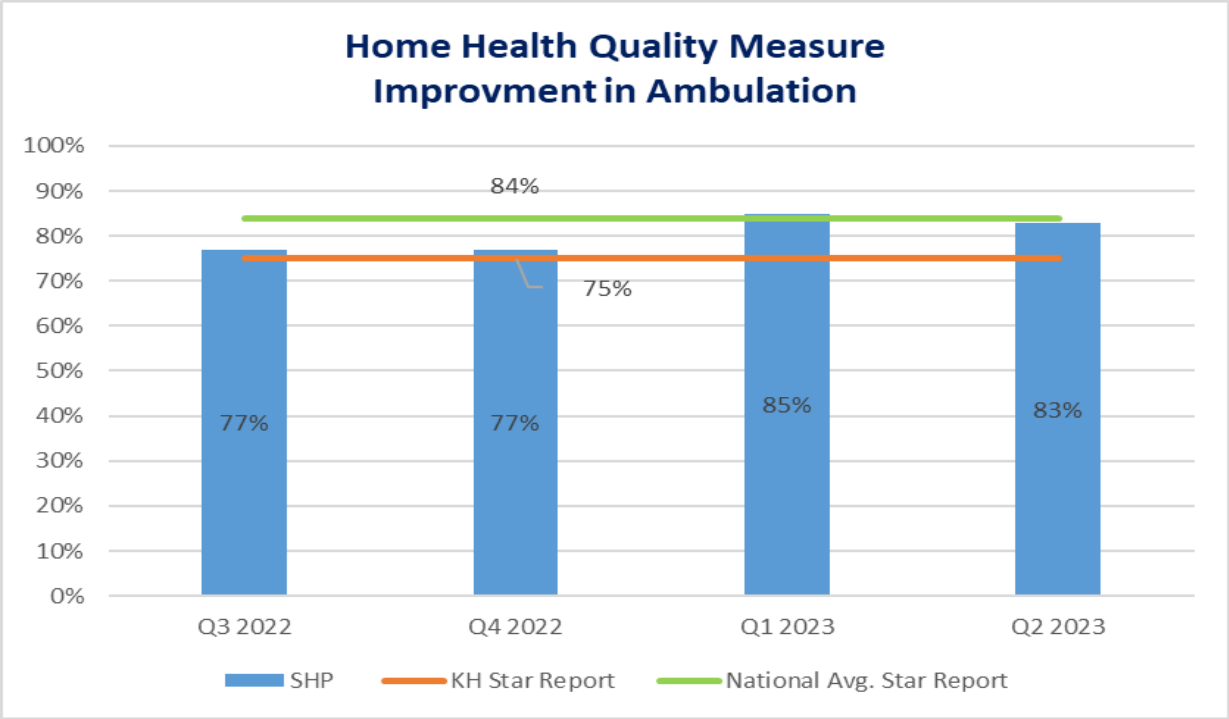
OASIS is a data collection tool that all Medicare-certified home health agencies are required to collect and transmit to CMS for all patients whose care is reimbursed by Medicare and Medicaid.

Measure Description:
"How often patients got better at walking or moving around"

--Home Health Clinicians (registered nurses, physical therapists) complete OASIS data upon a patient's admission to home health. Clinicians must assess the patient's ability to walk SAFELY on a variety of surfaces using a 6-point scale; ranging from 0-independent to 6-bedfast. At discharge, the patient's ability is reassessed. If a patient is assessed to be at the same level, they are considered *stabilized*. "Stabilized" is counted as a negative outcome for this measure. Patients who are assessed to have *less ability* to walk safely at discharge, are considered to have *deteriorated*, also a negative outcome. Patients assessed to be independent upon admission and remain independent upon discharge are not counted as a negative outcome in this measure.

Measure Objective/Goal:
Improvement in Ambulation/Locomotion

- **CMS Star Report July 2023: KH HH 75%, National avg. 84%**



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

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

- **Star Report July 2023; Oct 1, 2021 to September 30, 2022; avg. 75%, National avg. 84%**
- **SHP data; July 1, 2022 to June 30, 2023; avg. 80%**

Analysis of all measures/data: (Include key findings, improvements, opportunities)
Opportunity for improvement in this area existed and a multifocal plan was executed that included two additional outcome measures to help ensure overall *Outstanding Community Health* consistent with Kaweah Health District Pillar.
--Clinician barriers to completing an accurate assessment; home environment may include clutter, pets, patient may have draining wounds, tubing from oxygen, lack of equipment to help with mobility and function, and understanding of ability vs *safe ability* when performing their activities of daily living.
--Charting fatigue and over estimation of patient ability is reported by clinicians as reason for inconsistencies in scoring OASIS ambulation data accurately. OASIS questions focusing on ambulation are located near the end of a lengthy assessment. An attempt

was previously made to 'move up' the OASIS sections related to ambulation but per our EMR software, this is not possible.
--SHP, home health OASIS scrubber tool, is being underutilized by field clinicians prior to submission of OASIS documentation.

<u>If improvement opportunities identified, provide action plan and expected resolution date:</u>
There is an opportunity for improvement in this area. The following plan of action shall be implemented;
--Clinicians will be provided with early feedback on their OASIS scoring of functional assessment to ensure accurate capture of patient's ability and appropriateness for home health services.
--Encourage clinicians to utilize the 5 day rule and reach out to the next clinician who sees patient within the assessment time frame. CMS encourages a collaboration between all clinicians who assessed a patient within 5 days of the first OASIS assessment. This ensures an accurate capture of a patient's need and the opportunity to provide the resources needed to help achieve *Outstanding Community Health* consistent with the Kaweah Health District pillar.
--Educator and Intake Utilization RN will perform daily audits of clinician charting, and identify OASIS inconsistencies and provide immediate feedback to clinician.
--Educator will meet with Intake Utilization RN, bi-weekly to provide feedback on OASIS inconsistencies and identify trends.
--Next all staff meeting in July 2023, educator will provide in-service on use of SHP when completing OASIS, to ensure all staff are following best practice to reduce any inconsistencies prior to OASIS submission. Educator will review report of staff who are using SHP and meet one-on-one with staff who need additional education.
--Therapy clinicians will present in-service at future nursing meeting on determining *safe* ambulation vs at-risk behaviors and environment.

<u>Next Steps/Recommendations/Outcomes:</u>
Educator and RN Intake Auditor will perform chart audits to monitor the effectiveness of these interventions. Educator will report current SHP data along with these findings, including any identifiable trends to Home Health Manager at least every 30 days. Educator will analyze OASIS outcome data reports for this measure quarterly and report to Home Health Manager and Director. Educator and Home Health Manager will modify interventions until we meet, or exceed, the national average for three or more quarters.

<u>Submitted by Name:</u>	**<u>Date Submitted:</u>**
Shannon Esparza, RN	**July 19, 2023**

Care Compare Data

October 1, 2021 to September 30, 2022

- *Quality of Patient Care*
- *Scorecard*

Kaweah Health Home Health

Quality of patient care

While the quality of patient care star rating provides a summary of agency performance, you may prefer to compare agencies on the individual measures that are related to the types of services you'll need, based on your own condition.

Find out why these measures are important

Get more information about the data

Get current data collection period

Quality rating

The star ratings are based on 7 measures of quality that give a general overview of performance. Measures that are included in the star ratings are identified in the results table below.

- A 4- or 5-star rating means that the agency performed better than other agencies on the 7 measured care practices and outcomes.
- A 1- or 2-star rating means that the agency's average performance on the 7 measured care practices and outcomes was below the averages of other agencies.
- Across the country, most agencies fall "in the middle" with 3 or 3½ stars.

Managing daily activities

How often patients got better at walking or moving around

↑ *Higher percentages are better*

74.6%

National average: 84.1%

California average: 80.6%

This measure was included in the quality star rating calculation.

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

↑ *Higher percentages are better*

83.8%

National average: 85.4%

California average: 81.1%

This measure was included in the quality star rating calculation.

How often patients got better at bathing

↑ *Higher percentages are better*

82.9%

National average: 86.4%

California average: 84.5%

This measure was included in the quality star rating calculation.

Preventing harm

How often the home health team began their patients' care in a timely manner

Higher percentages are better

98.2%
National average: 96%
California average: 94.6%

This measure was included in the quality star rating calculation.

How often the home health team taught patients (or their family caregivers) about their drugs

Higher percentages are better

97.6%
National average: 98.5%
California average: 97.9%

How often patients got better at taking their drugs correctly by mouth

Higher percentages are better

75%
National average: 82%
California average: 78.7%

This measure was included in the quality star rating calculation.

Quality of Patient Care Star Rating Scorecard[1] Kaweah Health Home Health (057255) Visalia, California

		Measure Score Cut Points by Initial Decile Rating						
1	Initial Group Rating	Measure 1. Timely Initiation of Care	Measure 2. Improvement in Management of Oral Medications	Measure 3. Improvement in Ambulation	Measure 4. Improvement in Bed Transferring	Measure 5. Improvement in Bathing	Measure 6. Improvement in Dyspnea	Measure 7. Acute Care Hospitalization
2	0.5	0.0-82.9	0.0-51.6	0.0-57.7	0.0-57.5	0.0-61.9	0.0-54.3	18.8-100.0
3	1.0	83.0-90.4	51.7-63.1	57.8-68.6	57.6-69.9	62.0-72.9	54.4-68.8	16.8-18.7
4	1.5	90.5-94.2	63.2-70.0	68.7-74.9	70.0-77.1	73.0-78.8	68.9-76.7	15.6-16.7
5	2.0	94.3-96.4	70.1-75.0	75.0-79.0	77.2-81.1	78.9-82.2	76.8-81.3	14.7-15.5
6	2.5	96.5-97.8	75.1-78.9	79.1-82.0	81.2-83.9	82.3-85.2	81.4-84.7	13.9-14.6
7	3.0	97.9-98.7	79.0-82.4	82.1-84.6	84.0-86.1	85.3-87.7	84.8-87.3	13.1-13.8
8	3.5	98.8-99.3	82.5-85.7	84.7-87.1	86.2-88.2	87.8-90.0	87.4-89.6	12.2-13.0
9	4.0	99.4-99.8	85.8-88.8	87.2-89.6	88.3-90.4	90.1-92.3	89.7-91.9	11.0-12.1
10	4.5	99.9-99.9	88.9-93.7	89.7-93.1	90.5-94.0	92.4-95.4	92.0-95.4	9.3-10.9
11	5.0	100.0-100.0	93.8-100.0	93.2-100.0	94.1-100.0	95.5-100.0	95.5-100.0	0.0-9.2
12	Your HHA Score	98.2	75.0	74.6	83.8	82.9	85.5	16.0
13	Your Initial Group Rating	3.0	2.0	1.5	2.5	2.5	3.0	1.5
14	Your Number of Cases (N)	2,255	1,560	1,655	1,620	1,718	846	455
15	National (All HHA) Middle Score	97.9	78.9	82.1	84.0	85.2	84.8	13.9
16	Your Statistical Test Probability Value (p-value)	0.157	0.000	0.000	0.435	0.004	0.288	0.106
17	Your Statistical Test Results (Is the p-value < 0.050?)	No	Yes	Yes	No	Yes	No	No
18	Your HHA Adjusted Group Rating	3.0	2.0[2]	1.5[2]	2.5	2.5	3.0	2.0[2]

19	Your Average Adjusted Rating	2.4
20	Your Average Adjusted Rating Rounded	2.5
21	**Your Quality of Patient Care Star Rating (1.0 to 5.0)**	**★★★ (3.0 stars)**

[1] *OASIS data from October 1, 2021 to September 30, 2022; claims data from July 1, 2020 to June 30, 2021.*

[2] *Based on your HHA's results, we suggest that you focus your attention on measures with a rating of 2.0 or less before the next quarterly reporting period. Review your HHA's care protocols that are or could be associated with this outcome or process and consider convening a meeting of your clinical staff to brainstorm how these outcomes or processes that affect the quality of patient care can be improved. Finally, once you have identified the source of the problem regarding your low score consider providing focused training of your staff to modify your existing quality of patient care practices.*

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: **ProStaff/QIC Report Date:**

Home Health **August 2023**

Data for this report is obtained from the *Star Report* on the *Care Compare* website, the Centers for Medicare & Medicaid Services (CMS) platform for which quality measures are publicly reported for home health agencies. Currently, the July 2023 refresh on *Care Compare* reflects data from October 1, 2021 thru September 30, 2022. Kaweah Health Home Health is at an overall 3-Star rating, out of a 5-Star rating system.

In order to show real time data and ensure the most current data for analysis, Strategic Healthcare Programs (SHP), a web-based program that analyzes the Outcome and Assessment Information Set (OASIS) submitted to CMS monthly, was evaluated.

OASIS is a data collection tool that all Medicare-certified home health agencies are required to collect and transmit to CMS for all patients whose care is reimbursed by Medicare and Medicaid.

Measure Description:

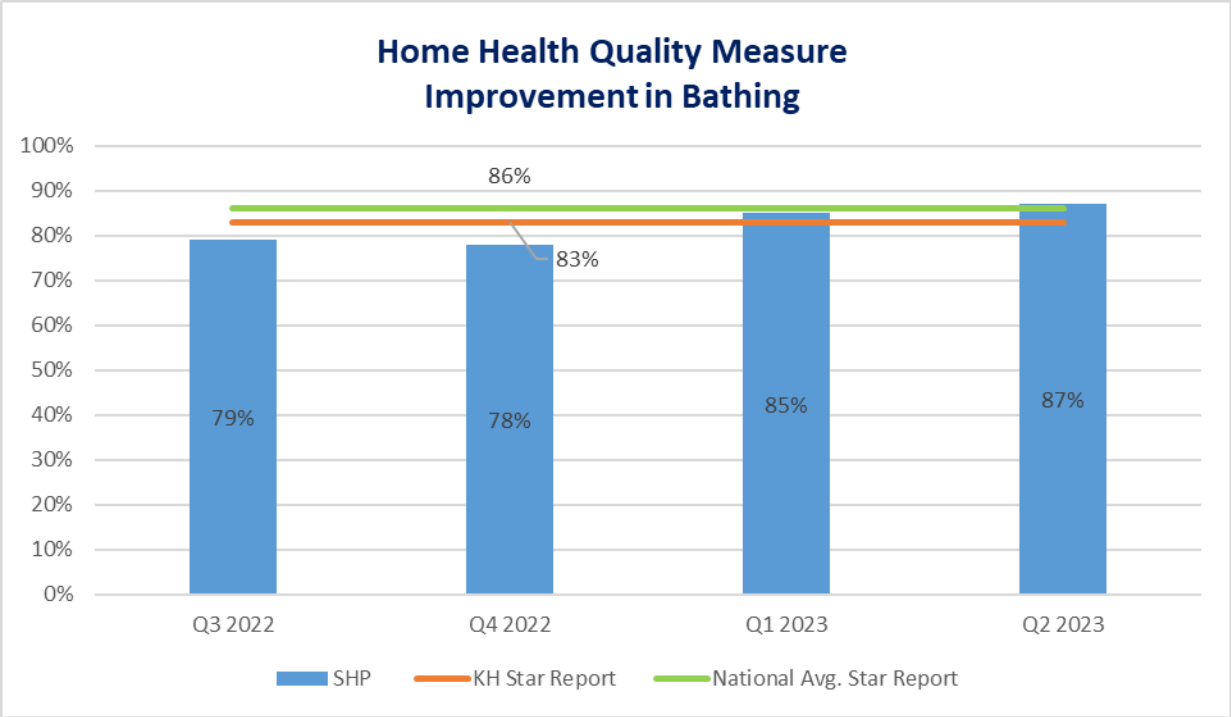
"How often patients got better at bathing"

--Clinicians (registered nurses, physical therapists) complete OASIS data upon a patient's admission to home health. A patient's current ability to bathe entire body and what level of assistance may be required to *safely* bath including *transferring in/out of the tub/shower*, is measured upon admission to home health using a 6-pt-scale. The 6-point bathing scale represents the most independent level first, then proceeds to the most dependent. At discharge, this ability is again measured using the same scale. If a patient is assessed to be at the same level, they are considered *stabilized*. "Stabilized" is counted as a negative outcome for this measure. Patients who are assessed to have *less ability* to bathe their entire body safely at discharge, are considered to have *deteriorated*, also a negative outcome. Patients assessed to be independent in bathing upon admission and again at discharge are not counted in this measure.

Measure Objective/Goal:

Improvement in Bathing

- **CMS Star Report July 2023: KH HH 83%, National Average 86%**



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

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

- **Star Report July 2023; Oct 1, 2021 to September 30, 2022; avg. 83%**
- **SHP data; July 1, 2022 to June 30, 2023; avg. 82%**

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

--Clinicians must assess the patient's ability to bathe the entire body and the assistance that may be required to *safely* bathe, including transferring in/out of the tub/shower.
--Adaptive methods, assistive devices, and MD ordered restrictions need to be communicated to the first clinician assessing the patient to ensure an accurate scoring of patient ability. Intake clinicians work with case managers in the hospital to be sure that information is obtained in the referral order prior to clinician assessment.
--Clinicians must utilize their professional, clinical judgement when determining what level the patient can perform the task *safely,* not just simply complete the activity.

-- CMS guidance stresses the importance of considering mental/emotional/cognitive status when assessing this measure.

If improvement opportunities identified, provide action plan and expected resolution date:
There is an opportunity for improvement in this area. The following plan of action shall be implemented;
--Educator and Intake RN will review data from clinician charting and OASIS for inconsistencies and meet with clinician to provide immediate feedback.
--Clinicians will utilize the "5 Day Rule" allowed by CMS. CMS encourages a collaboration between all clinicians who assessed a patient within 5 days of the first OASIS assessment. This will ensure accurate capture of a patient's need and the opportunity to provide the resources needed to help achieve *Outstanding Community Health* consistent with the Kaweah Health District pillar.
-- OASIS-E staff education in July staff meeting discussing all areas of functional mobility, including bathing.

Next Steps/Recommendations/Outcomes:
Educator and RN Intake Auditor will monitor the effectiveness of these interventions weekly during chart audits. Educator will report these findings along with trends to Home Health Manager at least every 30 days. Educator will analyze OASIS outcome data reports for this measure quarterly and report to Home Health Manager and Director. Educator and Home Health Manager will modify interventions until we meet, or exceed, the national average for three or more quarters.

Submitted by Name:
Shannon Esparza, RN

Date Submitted:
July 2023

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department:
Home Health

ProStaff/QIC Report Date:
August 2023

Data for this report is obtained from the *Star Report* on the *Care Compare* website, the Centers for Medicare & Medicaid Services (CMS) platform for which quality measures are publicly reported for home health agencies. Currently, the July 2023 refresh on *Care Compare* reflects data from October 1, 2021 thru September 30, 2022. Kaweah Health Home Health is at an overall 3-Star rating, out of a 5-Star rating system.

In order to show real time data and ensure the most current data for analysis, Strategic Healthcare Programs (SHP), a web-based program that analyzes the Outcome and Assessment Information Set (OASIS) submitted to CMS monthly, was evaluated.

> ***OASIS is a data collection tool that all Medicare-certified home health agencies are required to collect and transmit to CMS for all patients whose care is reimbursed by Medicare and Medicaid.***

Measure Description:

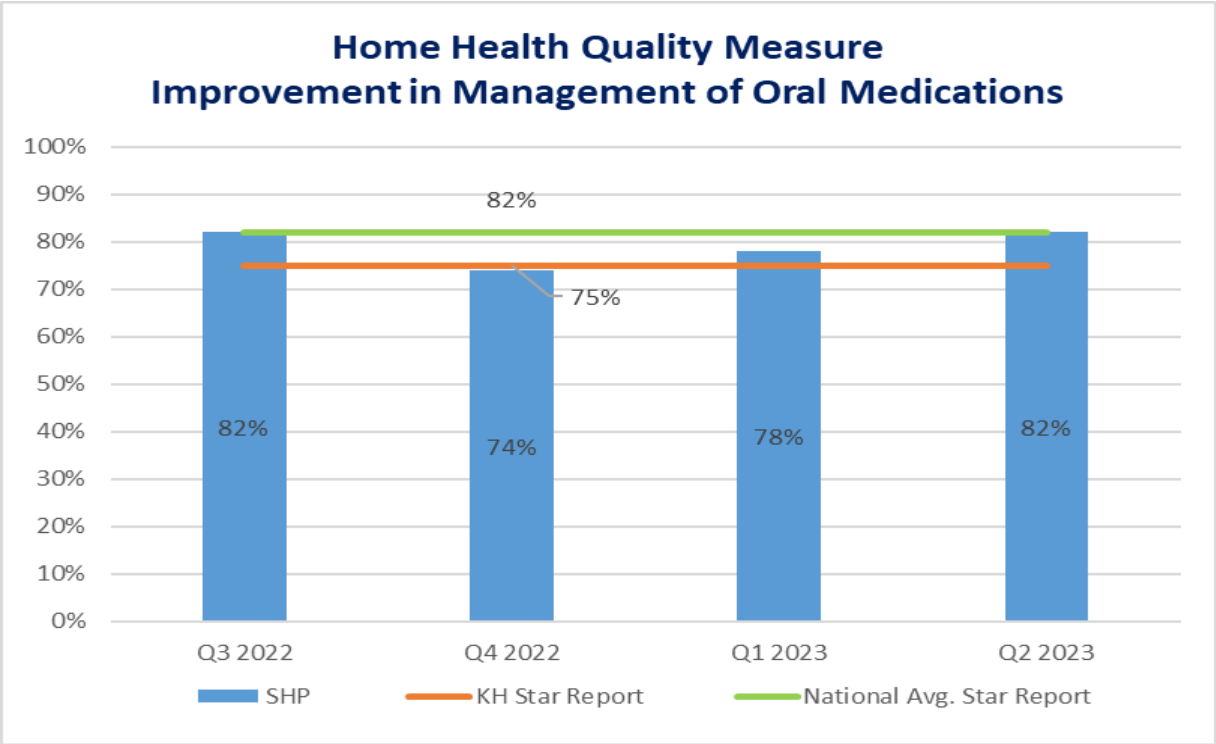
"How often patients got better at taking their drugs correctly by mouth"

--Home Health Clinicians, i.e. registered nurses and physical therapists, assess the patient's ability to take all oral medications *reliably* and *safely* upon admission to home health. The ability to self-administer the correct medication, the correct dosage, and at the prescribed frequency via the prescribed route, upon admission to home health. At discharge, the same assessment is performed. If a patient is assessed to be at the same level at discharge as they were at admission, they are considered to have *stabilized* in their medication regime. "Stabilized" is counted as a negative outcome for this measure. Patients who require more assistance at discharge are considered to have *deteriorated* in their ability, which is a negative outcome for this measure. Patients assessed to be independent upon admission and remain independent upon discharge, or who do not take any oral medications are not counted in this measure.

Measure Objective/Goal:

Improvement in Management of Oral Medications

- **CMS Star Report July 2023: KH HH 75%, National Average 82%**



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

Date range of data evaluated:

- **Star Report July 2023; Oct 1, 2021 to September 30, 2022; avg. 75%, National avg. 82%**
- **SHP data; July 1, 2022 to June 30, 2023; avg. 79%**

Analysis of all measures/data: (Include key findings, improvements, opportunities)
--Clinicians must differentiate the patient's ability to perform the steps in this measure *independently* versus the *level of family/caregiver assistance* with medication regimen.
--Patient's ability to obtain the medication from where it is routinely stored, the ability to read the label or accurately identify medication by placing a character on label, open the container, remove the correct dosage at the appropriate times/intervals, and consistently, is evaluated.

--Medical record review noted inconsistencies with clinicians scoring *of oral medication administration* and *ability to ambulate*. OASIS guidance requires the clinician consider the patient's ability to obtain the medication from where it is routinely stored.
--Educator met with clinicians who were inconsistent in scoring patient medication regime ability and functional ability. Additional individualized education provided opportunity for directed teaching based on the individualized scenarios clinicians were observing in patient homes.
--Cognitive ability can impact patient's ability to safely manage medications.
--Clinicians report hesitancy to consider a patient to have a higher level of need for assistance with oral medications

If improvement opportunities identified, provide action plan and expected resolution date:
There is an opportunity for improvement in this area to ensure we reach our goal of meeting, and exceeding the National Average. The following plan of action shall be implemented;
--Frequent education to all clinical staff who complete OASIS, due to the multi-level assessment needed in this measure.
--Educator and Intake RN auditor will review data from clinician charting and OASIS for inconsistencies and meet with clinician to provide immediate feedback.
--Clinicians will utilize the "5 Day Rule" allowed by CMS. CMS encourages collaboration between all clinicians who assessed a patient, within 5 days of the first OASIS assessment.
This will ensure accurate capture of a patient's need and the opportunity to provide the resources needed to help achieve *Outstanding Community Health* consistent with the Kaweah Health District pillar.

Next Steps/Recommendations/Outcomes:
Educator and RN Intake Auditor will monitor the effectiveness of these interventions weekly during chart audits. Educator will report these findings along with trends to Home Health Manager at least every 30 days. Educator will analyze OASIS outcome data reports for this measure quarterly and report to Home Health Manager and Director. Educator and Home Health Manager will modify interventions until we meet, or exceed, the national average for three or more quarters.

Submitted by Name: **Shannon Esparza, RN**

Date Submitted: **July 19, 2023**

SHP Data

July 1, 2022 to June 30, 2023

- *Quality Outcome Analyzer Report*

Outcome	Group By	Eligible Episodes	Count	Observed Score
Improvement in Ambulation	SHP National	4,418,992	3,911,530	88.5%
Improvement in Ambulation	SHP State (CA)	388,555	321,190	82.7%
Improvement in Ambulation	Kaweah Health Home Health	1,614	1,298	80.4%
Improvement in Ambulation	July 2022	137	94	68.6%
Improvement in Ambulation	August 2022	119	98	82.4%
Improvement in Ambulation	September 2022	161	127	78.9%
Improvement in Ambulation	October 2022	139	112	80.6%
Improvement in Ambulation	November 2022	151	112	74.2%
Improvement in Ambulation	December 2022	138	106	76.8%
Improvement in Ambulation	January 2023	119	105	88.2%
Improvement in Ambulation	February 2023	119	93	78.2%
Improvement in Ambulation	March 2023	159	143	89.9%
Improvement in Ambulation	April 2023	112	88	78.6%
Improvement in Ambulation	May 2023	134	111	82.8%
Improvement in Ambulation	June 2023	126	109	86.5%
Improvement in Bathing	SHP National	4,439,815	3,992,356	89.9%
Improvement in Bathing	SHP State (CA)	391,374	333,835	85.3%
Improvement in Bathing	Kaweah Health Home Health	1,652	1,354	82.0%
Improvement in Bathing	July 2022	139	112	80.6%
Improvement in Bathing	August 2022	124	100	80.6%
Improvement in Bathing	September 2022	162	123	75.9%
Improvement in Bathing	October 2022	143	112	78.3%
Improvement in Bathing	November 2022	155	119	76.8%
Improvement in Bathing	December 2022	145	116	80.0%
Improvement in Bathing	January 2023	120	107	89.2%
Improvement in Bathing	February 2023	123	97	78.9%
Improvement in Bathing	March 2023	162	139	85.8%
Improvement in Bathing	April 2023	113	99	87.6%
Improvement in Bathing	May 2023	138	118	85.5%
Improvement in Bathing	June 2023	128	112	87.5%
Improvement in Bed Transferring	SHP National	4,403,039	3,964,206	90.0%
Improvement in Bed Transferring	SHP State (CA)	385,572	326,812	84.8%
Improvement in Bed Transferring	Kaweah Health Home Health	1,597	1,408	88.2%
Improvement in Bed Transferring	July 2022	135	110	81.5%
Improvement in Bed Transferring	August 2022	119	112	94.1%
Improvement in Bed Transferring	September 2022	158	143	90.5%
Improvement in Bed Transferring	October 2022	132	98	74.2%
Improvement in Bed Transferring	November 2022	148	120	81.1%

SHP **Outcome Analyzer**

Kaweah Health Home Health

07/01/2022 - 06/30/2023

Report Date: 7/20/2023

Outcome	Group By	Eligible Episodes	Count	Observed Score
Improvement in Management of Oral Meds	Kaweah Health Home Health	1,532	1,212	79.1%
Improvement in Management of Oral Meds	July 2022	125	105	84.0%
Improvement in Management of Oral Meds	August 2022	115	98	85.2%
Improvement in Management of Oral Meds	September 2022	149	116	77.9%
Improvement in Management of Oral Meds	October 2022	127	99	78.0%
Improvement in Management of Oral Meds	November 2022	142	101	71.1%
Improvement in Management of Oral Meds	December 2022	130	95	73.1%
Improvement in Management of Oral Meds	January 2023	114	94	82.5%
Improvement in Management of Oral Meds	February 2023	116	84	72.4%
Improvement in Management of Oral Meds	March 2023	151	121	80.1%
Improvement in Management of Oral Meds	April 2023	111	91	82.0%
Improvement in Management of Oral Meds	May 2023	132	106	80.3%
Improvement in Management of Oral Meds	June 2023	120	102	85.0%

Methicillin-Resistant Staphylococcus Aureus (MRSA)
Quality Focus Team Report
October 2023

Quality Focus Team Members

- *Jag Batth - Chief Operating Officer (ET)*
- *Kylie Jarrell – Admin Assistant Environmental Services, Laundry/Linen, & Patient Transport Service (Recorder)*
- *Tendai Zinyemba - Director of Environmental Services. Laundry/Linen, & Patient Transport Service (Chair)*
- *Shane Reynolds - Assistant Nurse Manager 4N (Co-Chair)*
- *Justin Ma – Infectious Disease Pharmacist*
- *Amy Baker – Director of Renal Services*
- *Sandy Volchko - Director of Quality & Patient Safety*
- *Shawn Elkin – Infection Prevention & Control Manager*
- *Joetta Denny – Infection Prevention*
- *Gloria Dickerson – Clinical Educator*
- *Johnny Mata – Respiratory Care Manager*

MRSA- FY23 Goals

Healthcare onset MRSA bloodstream infection rate that does not exceed a standardized infection ratio of 0.726 or (<0.5 cases a month/1.5 cases a quarter/6 cases a year)

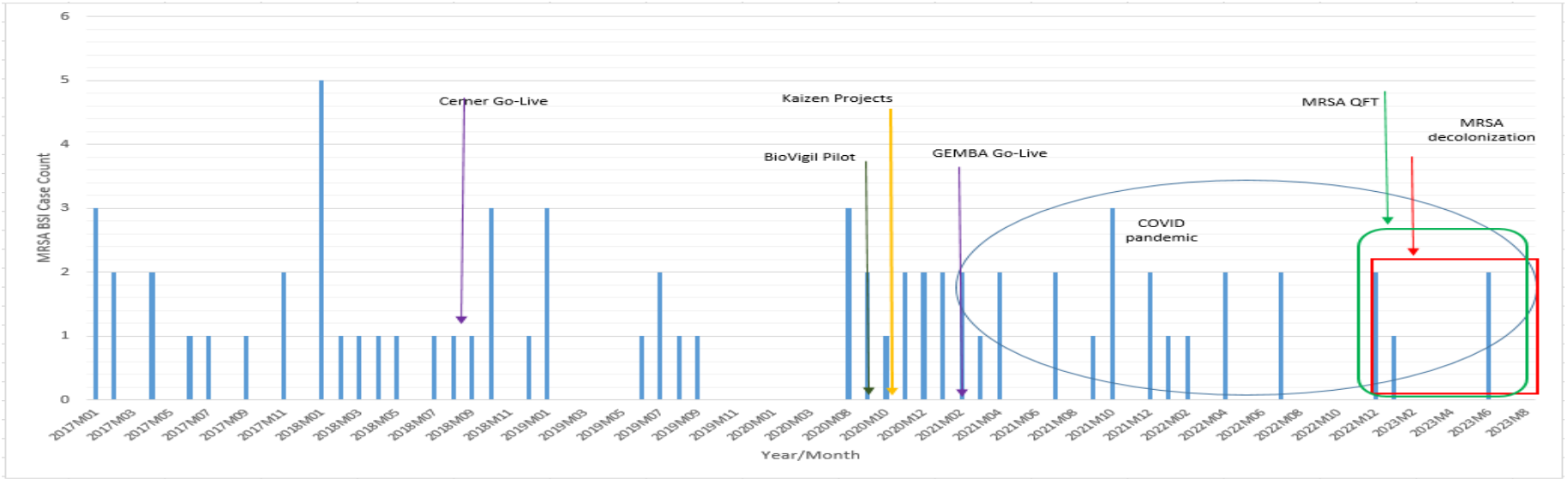
We reported 0 MRSA BSI events July 2023 – August 2023.

*based on July-August 2022 NHSN predicted

**Standardized Infection Ratio (SIR) is the number of patients with a healthcare acquired infection (HAI) divided by the number of patients who were predicted to have an HAI. MRSA Bloodstream Infection is impacted by the number of inpatient days for a given time period.

Background Data – MRSA Bloodstream Infection Events

Number of MRSA Bloodstream Infection events at Kaweah Health from over calendar years 2017 through August 2023 with emphasis on implementation of MRSA Quality Focus Team and MRSA Nasal Decolonization Pilot Study.

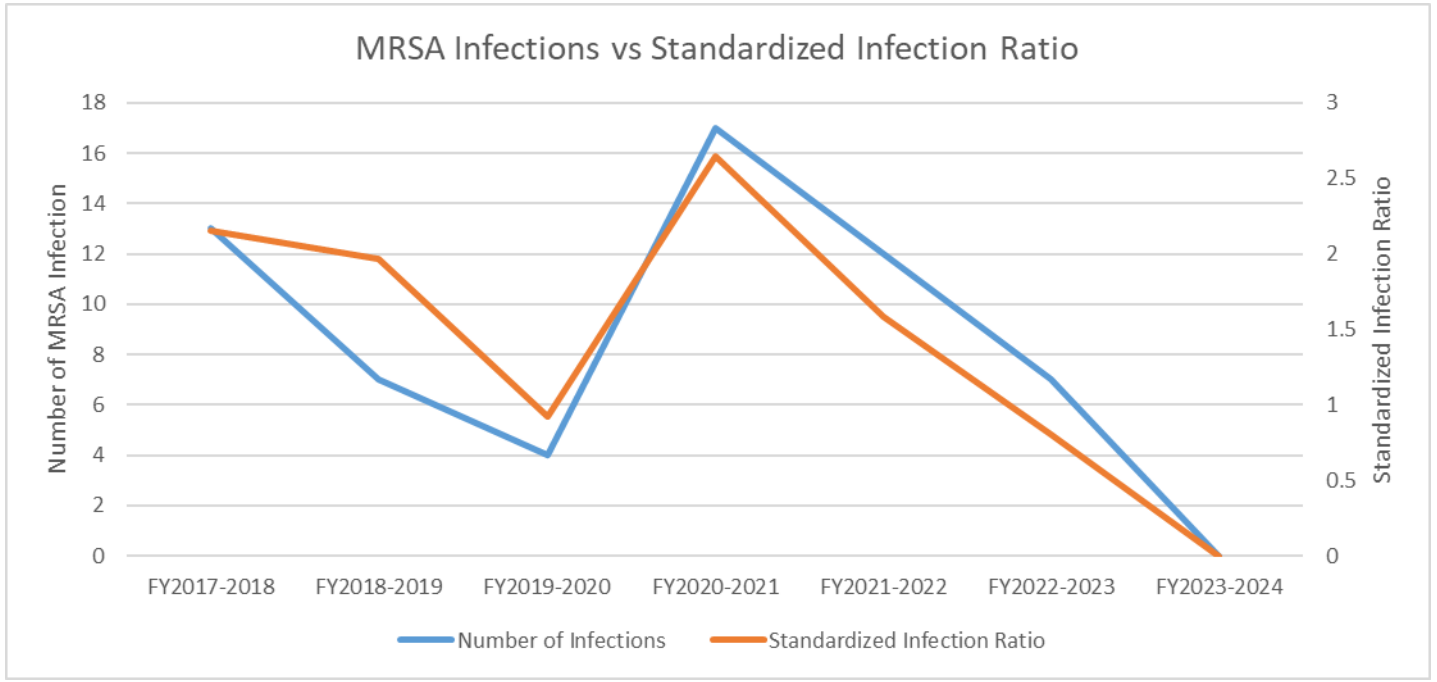


Number of MRSA BSI events dipped during November 2019 through March of 2020 in part due to the electronic hand hygiene system pilot on 4N, and ICU and the added attention given to healthcare associated infections (e.g. CLABSI/CAUTI) with Kaizen Projects and initiation of GEMBA Rounds. The increase in MRSA BSI events after March 2019 was associated with the COVID-19 pandemic, extended lengths of stays, blood culturing practices, and source control of the primary infection site. FY2023 has demonstrated a significant decrease in MRSA BSI events proximal to the time automated orders for Mupirocin decolonization treatment went live for 4N and ICU.

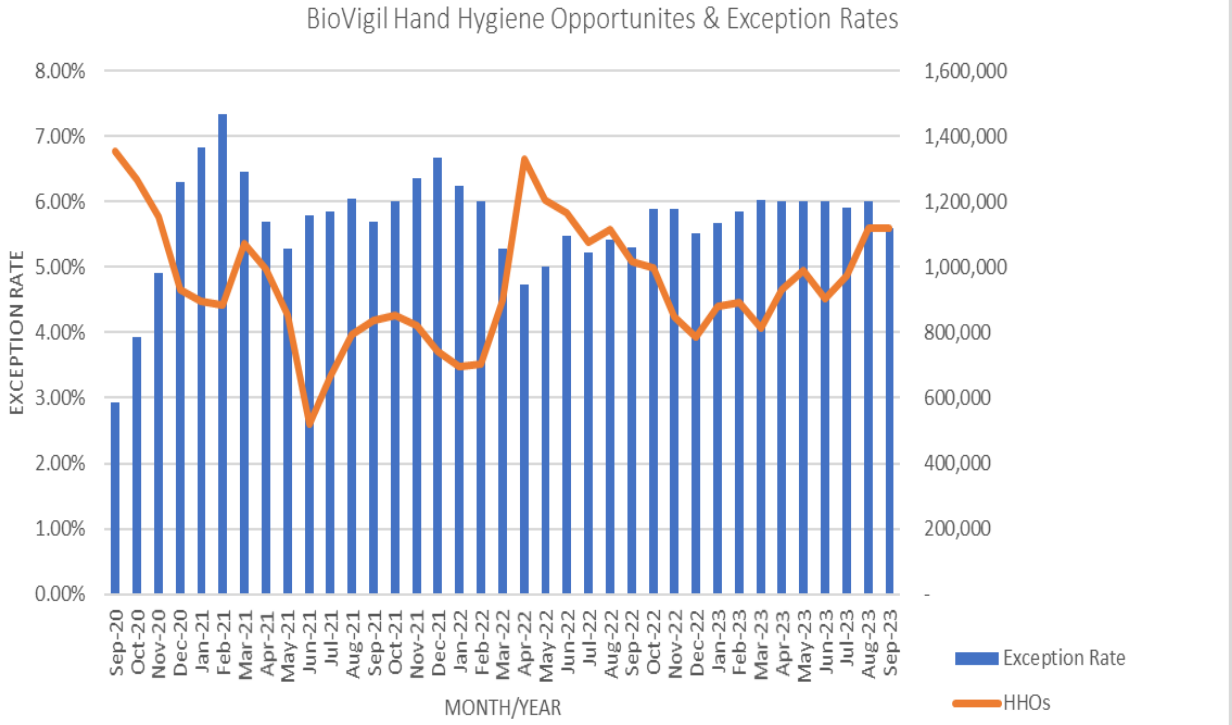
Fiscal Year	Number of Infections	Standardized Infection Ratio
FY2017-2018	13	2.152
FY2018-2019	7	1.97
FY2019-2020	4	0.923
FY2020-2021	17	2.648
FY2021-2022	12	1.585
FY2022-2023	7	0.804
FY2023-2024	0	0

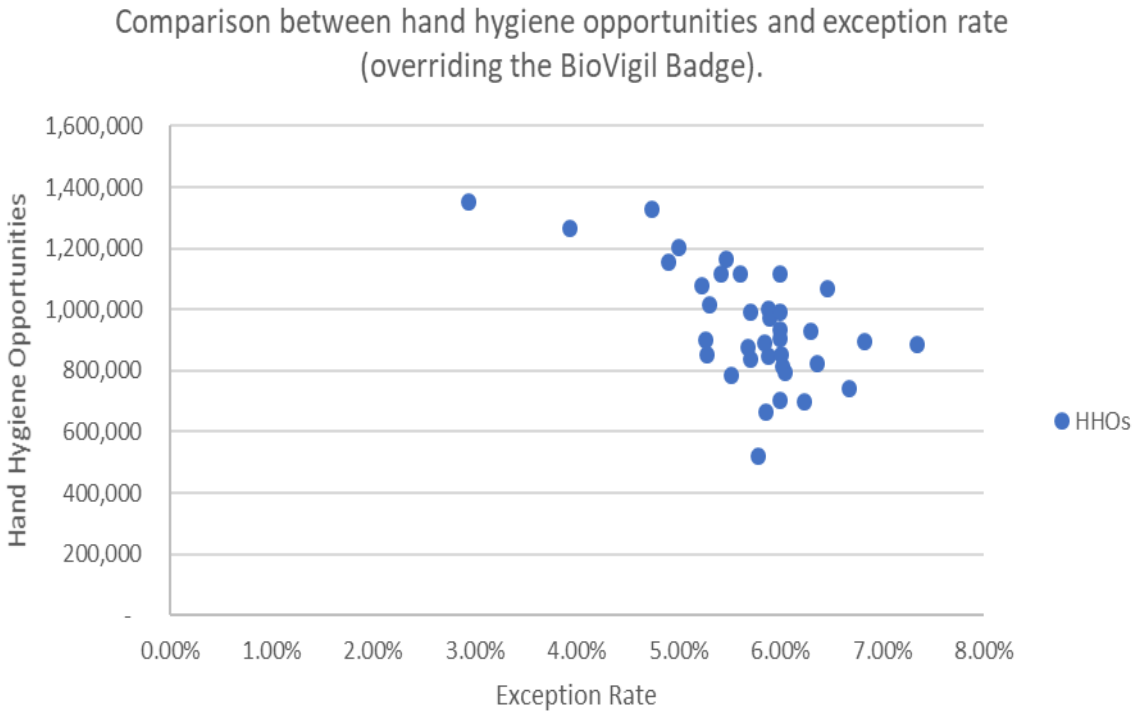
Background Data – MRSA Bloodstream Infections & Standardized Infection Ratio Trend

Fiscal Year	Number of Infections	Standardized Infection Ratio
FY2017-2018	13	2.152
FY2018-2019	7	1.97
FY2019-2020	4	0.923
FY2020-2021	17	2.648
FY2021-2022	12	1.585
FY2022-2023	7	0.804
FY2023-2024	0	0



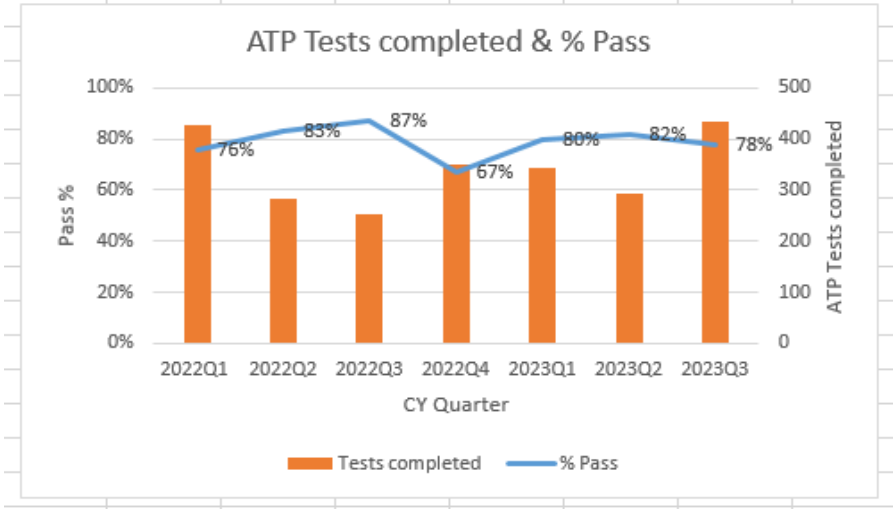
BioVigil Data - Hand Hygiene Opportunities





ATP Data

Filter: Date Collected Between 2023-07-01 and 2023-09-30, Area = '5T - ICCU,AW OBOR,Cath Lab,CVICU,CVOR,ICU,Main OR,OB OR'

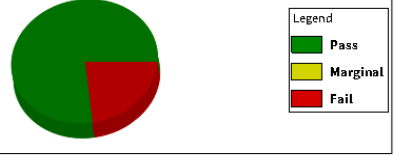


Qtr	% Pass	Tests completed
2022Q1	76%	429
2022Q2	83%	283
2022Q3	87%	252
2022Q4	67%	351
2023Q1	80%	343
2023Q2	82%	293
2023Q3	78%	433
Avg	79%	

kaweahhealth.org

Filter: Date Collected Between 2023-07-01 and 2023-09-30, Area = '5T - ICCU,AW OBOR,Cath Lab,CVICU,CVOR,ICU,Main OR,OB OR'

Total	Pass	Marginal	Fail
433	336	0	97
100.0%	77.6%	0%	22.4%



Rank Report By Site

Filter: Date Collected Between 2023-07-01 and 2023-09-30, Area = '5T - ICCU,AW OBOR,Cath Lab,CVICU,CVOR,ICU,Main OR,OB OR'

	Pass		Marginal		Fail		
Site	#	%	#	%	#	%	Total
RM Doorknob	1	33.33%	0	0.0%	2	66.67%	3
RM Sink	3	33.33%	0	0.0%	6	66.67%	9
Bedside TBL	6	46.15%	0	0.0%	7	53.85%	13
Call Button	10	47.62%	0	0.0%	11	52.38%	21
Overbed TBL	16	51.61%	0	0.0%	15	48.39%	31
Bedrail	24	53.33%	0	0.0%	21	46.67%	45
IV Pole	23	65.71%	0	0.0%	12	34.29%	35
Chair	8	72.73%	0	0.0%	3	27.27%	11
ORBedControl	12	85.71%	0	0.0%	2	14.29%	14
Counter	41	87.23%	0	0.0%	6	12.77%	47
Miscellanous	31	88.57%	0	0.0%	4	11.43%	35
RM Light SW	10	90.91%	0	0.0%	1	9.09%	11
OR Light	46	93.88%	0	0.0%	3	6.12%	49
Anes Cart	33	94.29%	0	0.0%	2	5.71%	35
OR Table	50	96.15%	0	0.0%	2	3.85%	52
Back Table	9	100.0%	0	0.0%	0	0.0%	9
Flush Handle	4	100.0%	0	0.0%	0	0.0%	4
RR Doorknob	2	100.0%	0	0.0%	0	0.0%	2
RR Sink	2	100.0%	0	0.0%	0	0.0%	2
Telephone	5	100.0%	0	0.0%	0	0.0%	5

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ATP Data - Plan for sustainable improvement

- Determined our World-class goal to be 90% moving forward – no industry benchmark.
- Hired EVS Coordinator for standardized training – complete (Julian Medrano currently in training).
- Retraining of all EVS leaders to include certification from ATP reader manufacturer (Neogen) - 100% complete.
  - Streamlined timing and communication on conducting ATP tests.
- Annual competency validation of staff – work in progress.
- Track & trend data, to include high touch areas of focus and align needs to analyzed trend.

Root Causes Identified

Culturing Practices

- Late blood cultures eliminating present-on admission designation.
- Serial blood cultures that exceed 14-day repeat infection timeframe (RIT).
- Positive MRSA serial blood cultures that exceed 14 days are considered a new event and healthcare acquired.
- Serial positive cultures across patient room assignments.

Source Control

- Endocarditis
  (Life-threatening inflammation of the inner lining of heart chambers and valves)
- Osteomyelitis
  (*Inflammation or swelling that occurs in the bone)*
  maybe a contributing factors to seeding of the bloodstream.
- Delayed consultations, incomplete diagnostic studies, or avoidance of obtaining a specimen from the likely source of infection.
- Without addressing the primary source of infection there will be continued seeding of the bloodstream.

MRSA QFT: Key Strategies

- Automated Mupiriocin MRSA nasal decolonization treatment (house-wide go-live scheduled for 7/17/2023
- Improved utilization of the BioVigil electronic hand hygiene surveillance system
- Clinic based ‘Patient as observer’ hand hygiene program using NRC Picker Survey tool
- Do You Disinfect Every time (D.U.D.E.) Campaign
- Environmental cleaning – quality metrics Adenosine Triphosphate (ATP) monitoring
- Targeted use of Electrostatic Disinfectant Sprayer that produces an electrical charge so that disinfectant attaches to surfaces directly and indirectly facing the sprayer, ensuring thorough coverage over surfaces

MRSA QFT: Recommendations

1. Provider involvement needed to help:
    - Process to effectively order/perform blood cultures
        - Prostaff will be reviewing/approving an evidence-based decision flow map for blood culturing practices
        - Decision flow map addresses source control monitoring (i.e. endocarditis, osteomyelitis, and device related sources)
2. Double down on MRSA Key strategies shared on prior slide (Decolonization; Hand hygiene; Patient care environment cleaning & disinfection etc…)

The pursuit of healthiness

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Unit/Department Specific Data Collection Summarization

ProStaff and Quality Improvement Committee

Unit/Department: Diabetes Management Committee **Report Date:** October 2023

Measure Objective / Goal:

Glucommander™

The key component of the eGlycemic Management System® from Glytec, Glucommander™ supports intravenous and subcutaneous insulin dosing (and transitions between) for patients with diabetes. Glucommander™ utilizes evidence-based multivariate algorithms to provide care teams with computer-guided dosing recommendations that continuously recalculate and dynamically adjust to each individual patient's blood glucose trends, insulin sensitivities and response to therapy. Surveillance and summary data are accessed through an online platform.

Society of Hospital Medicine (SHM)

Through an annual subscription, Kaweah Health participates in the Electronic Quality Improvement Programs (eQUIPS), a web-based online collaborative program that provides bi-annual performance tracking and benchmarking focused on optimizing care of inpatients with hypoglycemia, hyperglycemia and diabetes. *There are currently no regulatory metrics by which to benchmark results*.

Goal 1 Safety: Achieve benchmark performance for hypoglycemia in Critical Care (CC) and Non-Critical Care (NCC) patient population, defined as percent *patient days* with blood glucose (BG) <70
**Excludes Pediatrics, Post-Partum, Mental Health and Skilled Adult Units*

Glycemic Control:

Goal 2 Achieve benchmark performance for hyperglycemia, defined as percent *patient stays* with weighted mean BG >180 for CC and NCC* patients

Goal 3 Achieve benchmark performance [rank] for mean time between first BG <70 and resolution for CC and NCC* patients

Goal 4 Achieve benchmark performance for percent of patients with hypoglycemia with at least one recurrent hypoglycemic day.

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

Glytec updated their reporting system (Glucometrics) which now provides graphs readily available to their users. Our previous graphs included hypoglycemia, hyperglycemia and average blood glucoses on the same graph. Hypoglycemia and in-range patient day's data will now be separated into graphs 1a, 1b, 2a and 2b for CC and graphs 3a and 3b NCC.

∅ **GOAL 1** Not Met: Underperformed the available benchmark statistic for CC units (chart 3) and met the available benchmark statistic for hyperglycemia for NCC units (Chart 4).

∅ **GOAL 2** Not Met: Underperformed the available benchmark statistic for CC units (Chart 3) and NCC units (Chart 4).

Although we continue to partially underperform in Goals 1 and 2, our first 6 months/last 6 months SHM 5-year comparison data demonstrates an overall improvement in NCC areas in both hypoglycemia and hyperglycemia and a decrease in hyperglycemia in CC (Charts 1 and 2).

Definition of SHM comparison data:

- The first 6 months data is from the first 6 months of the last 5 years of data collection
- The last 6 months data is from the most current data

Chart 1: SHM Report for Critical Care and Non-Critical Care Units: first 6 months compared to the last 6 months of data. KH CC showed an increase in hypoglycemia for the first time since comparing the first 6 months of GM use and the most recent 6 months (Nov 2022-April 2023). NCC units showed an improvement in percent of days with blood glucose results less than 70 mg/dL (decrease from 4.5% to 4.2%)

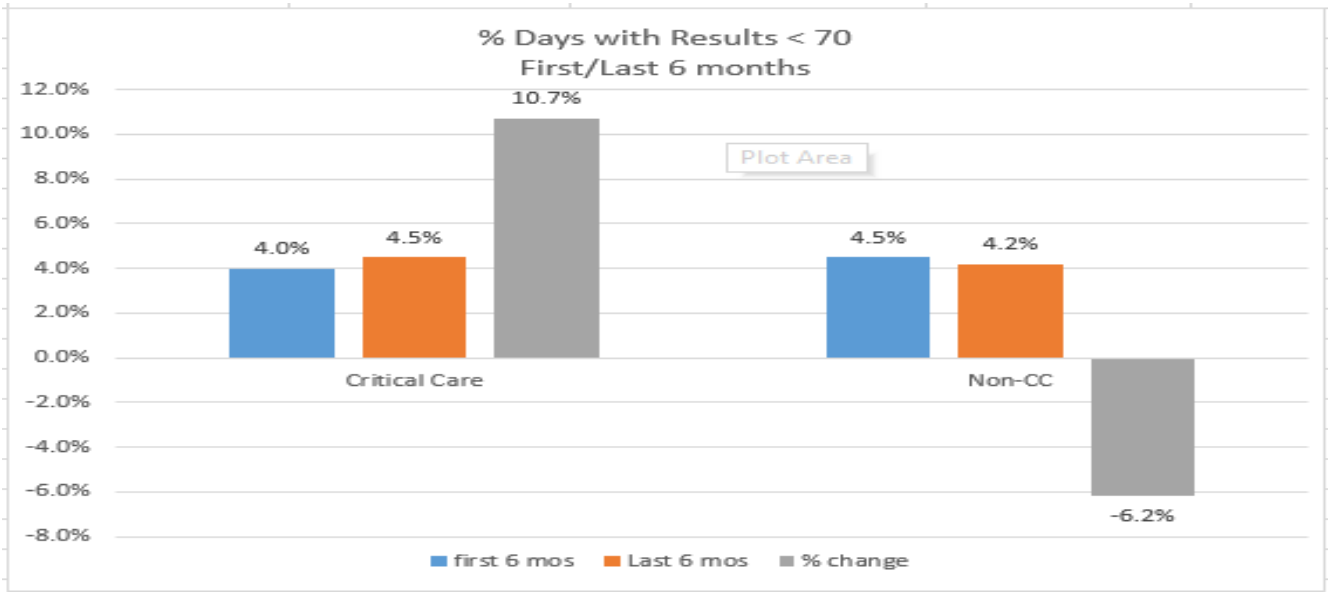


Chart 2: SHM Report for Critical Care and Non-Critical Care Units: first 6 months compared to the last 6 months of data. KH CC had a decrease of 8.9% in % stays with a day weighted mean (DWM) greater than or equal to 180 while the NCC units showed an improvement of 8.8% stays with DWM greater than or equal to 180.

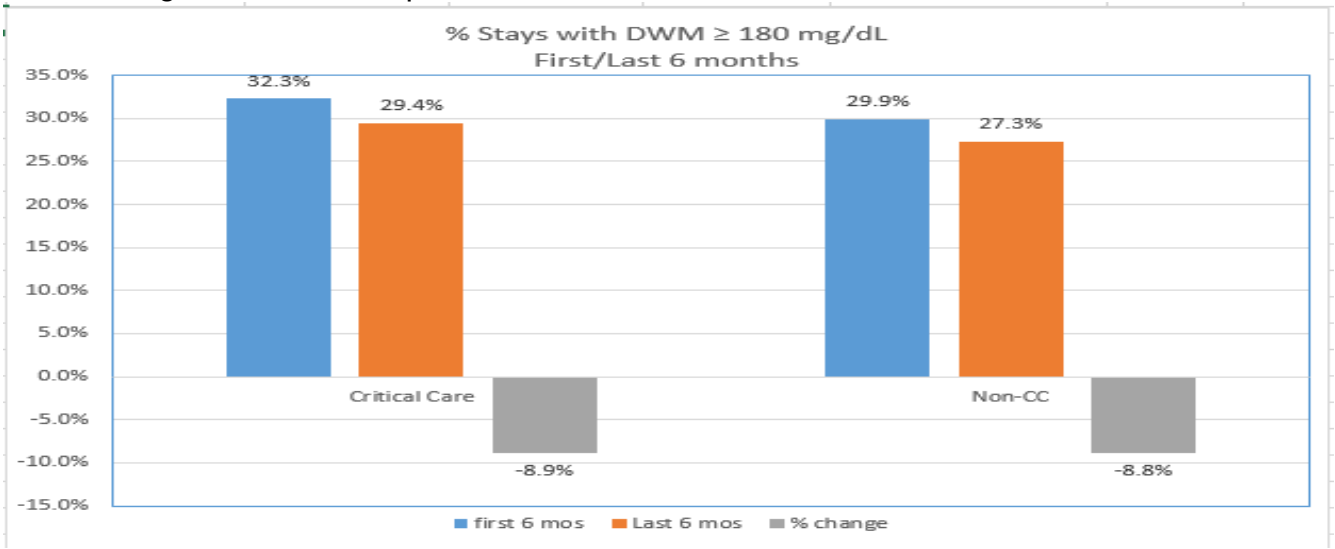
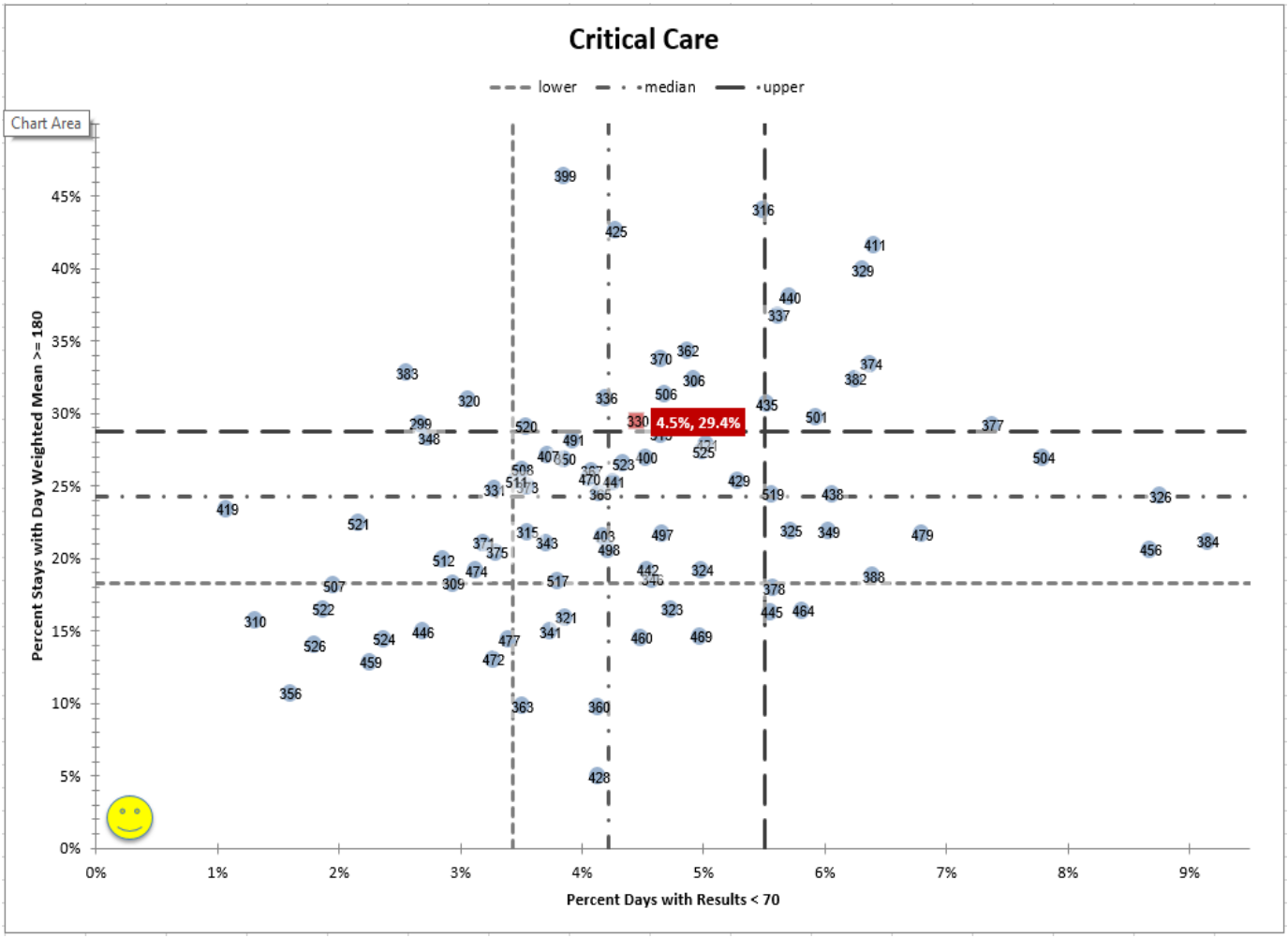


Chart 3– SHM Report for Critical Care Units

(ICU, 3West, CVICU, 1-5Tower)

SHM Scatterplot displays most recent SHM benchmarks for <u>percent of days < 70</u> for hypoglycemia and <u>percent patient stays with day weighted mean blood glucose (BGs) ≥ 180</u> among CC units.

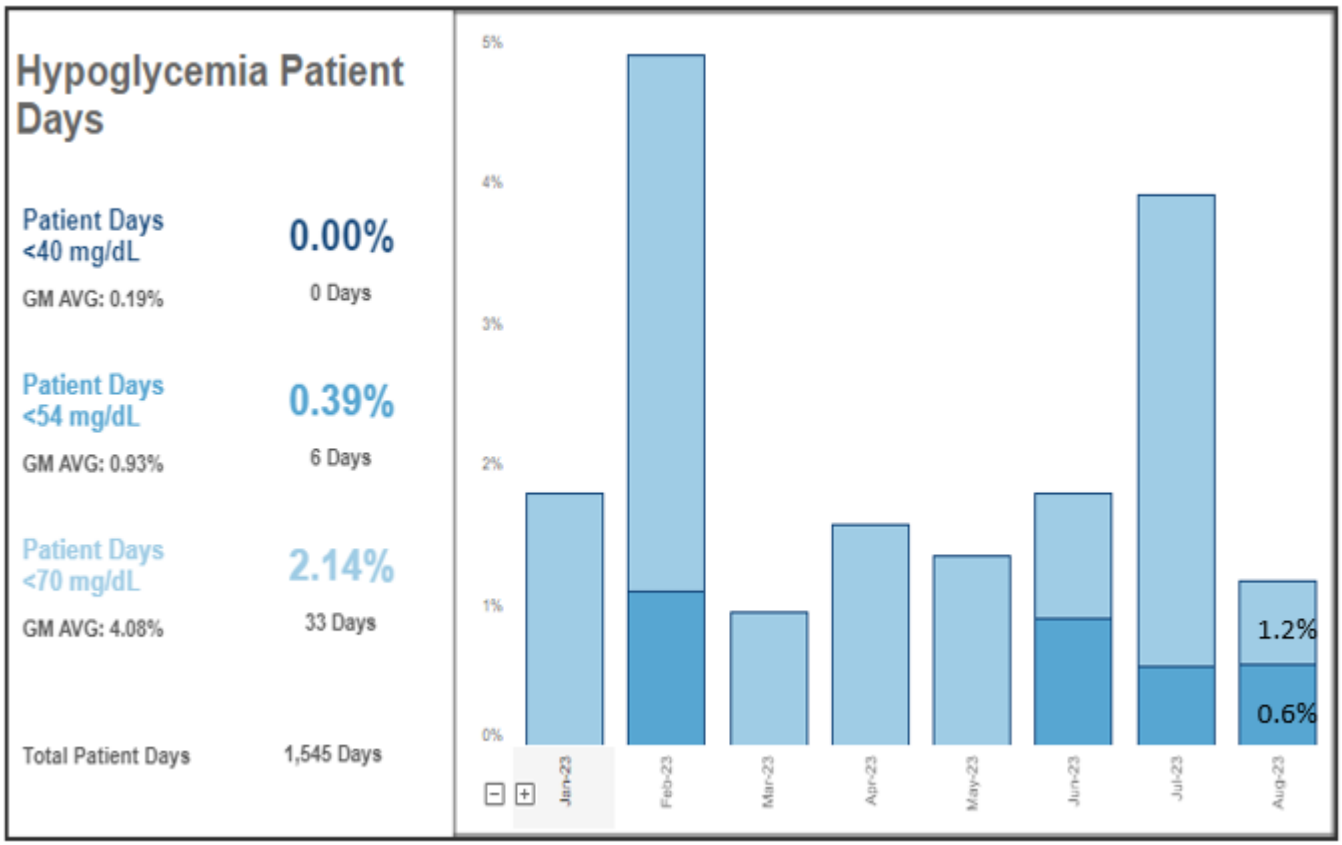
- Hypoglycemia, KHMC CC was at 4.5%, which is a decrease from previous reporting interval 4.8%, but continues to be above the SHM benchmark of 4.2%
- Hyperglycemia, KHMC CC was at 29.4% which is above the SHM benchmark of 24.3%
    - In this reporting period, SHM CC hyperglycemia benchmark decreased from 28.5% to 24.3%. We continue to monitor hyperglycemia rates monthly using Glucometric data.



Graph 1a and 1b – GlucoMetrics® Report for Critical Care Units
Displays % patient days < 70 for hypoglycemia and Patient Days In-Range patient days (70-180 mg/dL) for 2023 YTD among critical care units for patients **treated with Glucommander™ IV.**

Graph 1a: Critical Care IV Hypoglycemia Data

- Since Jan 2023, KH has outperformed other hospitals who also use Gucommander. Color coding indicates categories for patient days < 70 mg/dL, <54 mg/dL and <40 mg/dL.
- Although our goal is to achieve benchmark performance for BG < 70 mg/dL, graph 1 provides information for three categories of hypoglycemia. Compared to GM Avg, we are better than GM average in all three categories
- The 2023 YTD average of 2.14% is also better than the SHM benchmark of 4.2%

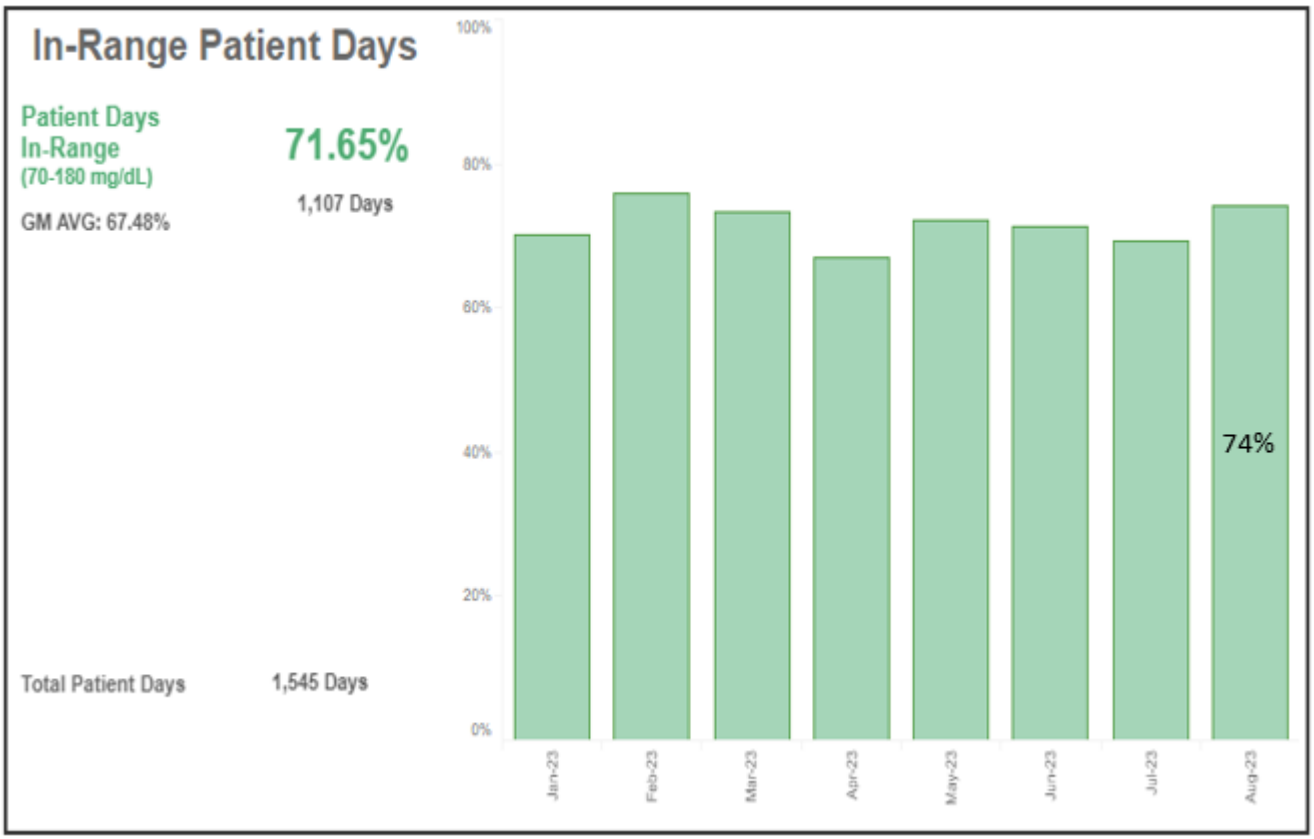


SHM Benchmarks: HYPOglycemia=4.2% and

Graph 1b. Critical Care IV In-Range Data

Glucometrics does not provide the hyperglycemia data we used in the past.

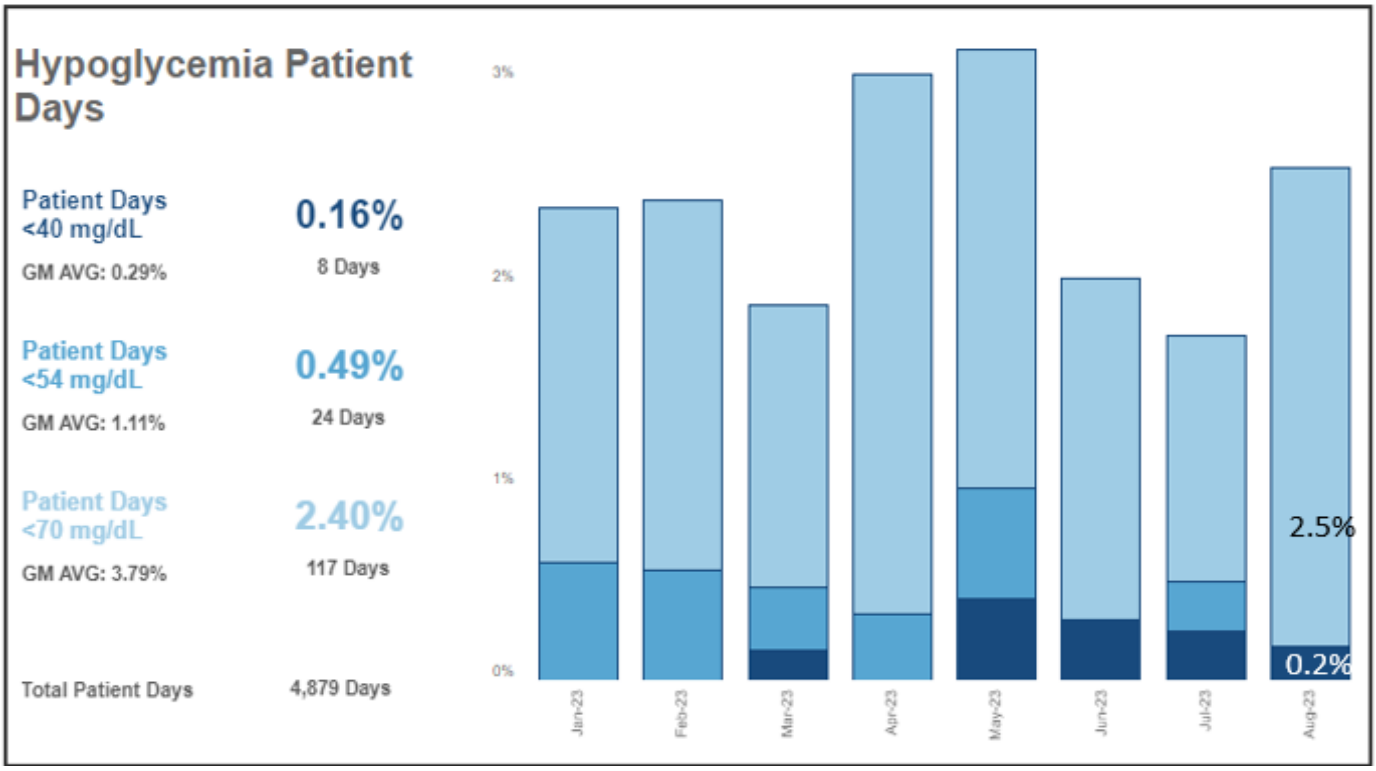
- For patient days in range (70-18 mg/dL), patients **treated with Glucommander™ IV,** KH is at 74% for the month of August which is above the GM average of 67.48%. For this metric: higher is better.
- For YTD 2023, KH is at 71.65%



Graph 2a and 2b – GlucoMetrics® Report for Critical Care Units
Displays % patient days < 70 for hypoglycemia and Patient Days In-Range (70-180 mg/dL) for 2023 YTD among critical care units for patients **treated with Glucommander™ SQ.**

Graph 2a: Critical Care SQ Data

- Since Jan 2023, KH has outperformed other hospitals who also use Gucommander.
- Aug 2023: patient days with BG < 70 mg/dL was 2.5%, better than GM average of 3.79% and better than the SHM benchmark of 4.2%



SHM Benchmarks: HYPOglycemia=4.2%

Graph 2b – Critical Care SQ In-Range Data
Glucometrics does not provide the hyperglycemia data we used in the past.

- For patient days in range (70-18 mg/dL) for patients **treated with Glucommander™ SQ.** , KH is at 59.6% for the month of August which is above the GM average of 55.7%. For this metric: higher is better.
- For YTD 2023, KH is at 59.56%

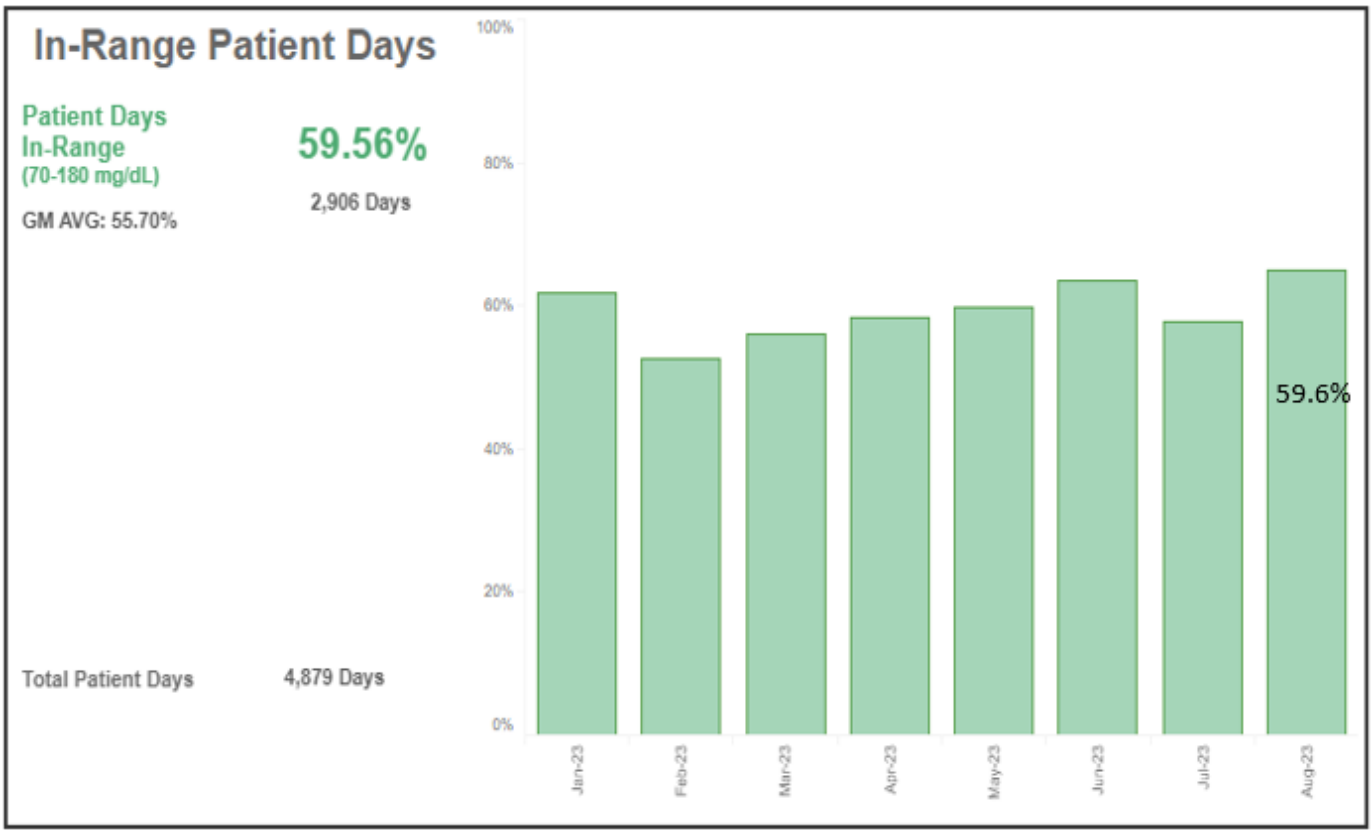
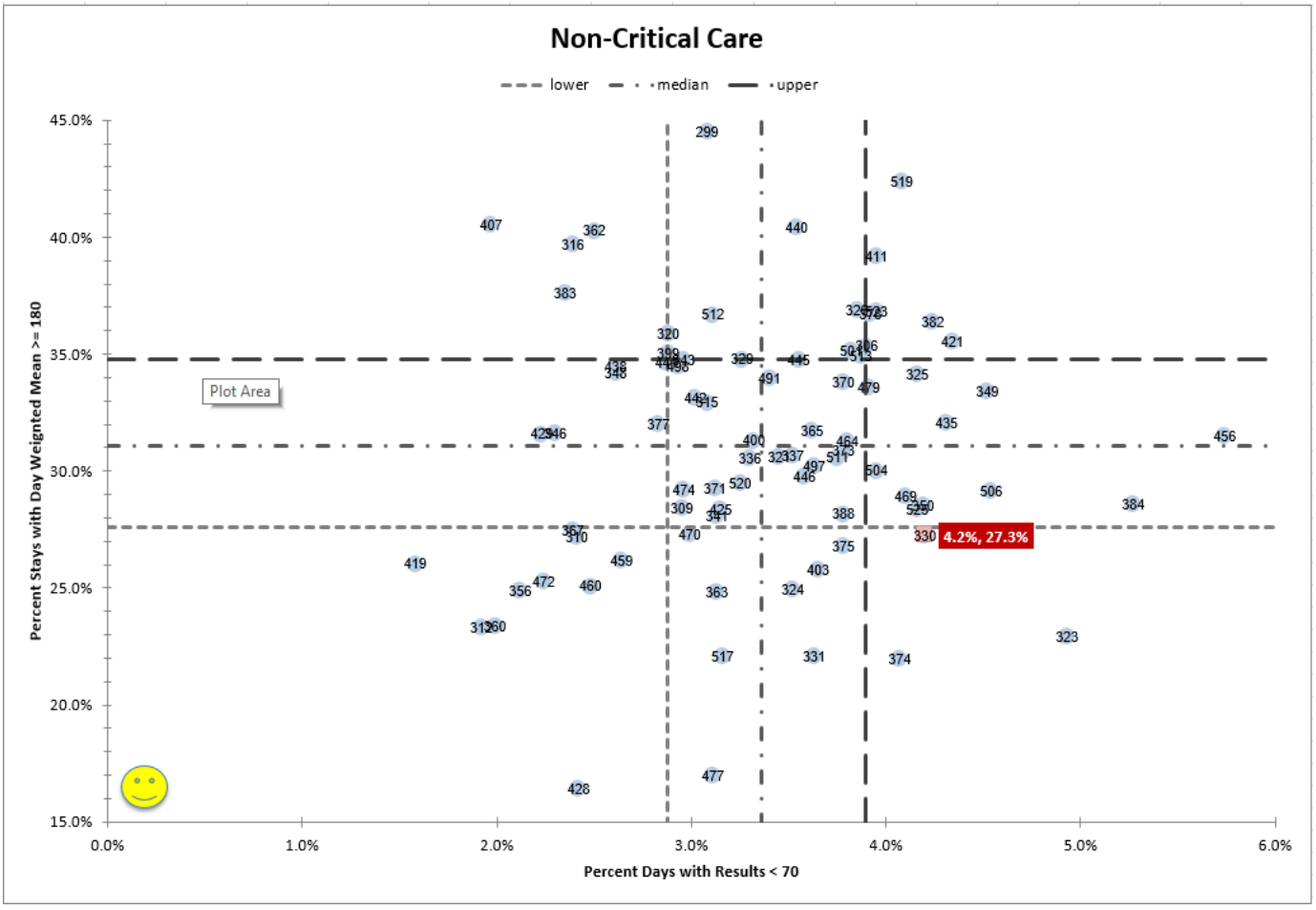


Chart 4– SHM Report for Non-Critical Care Units
(1-4Tower, 2North, 2South, 3North, 3South, 4North, 4South, Broderick Pavilion)

SHM Scatterplot displays SHM benchmarks for <u>percent of days < 70</u> for hypoglycemia and <u>percent patient stays with day weighted mean blood glucose (BGs) ≥ 180</u> among NCC units.

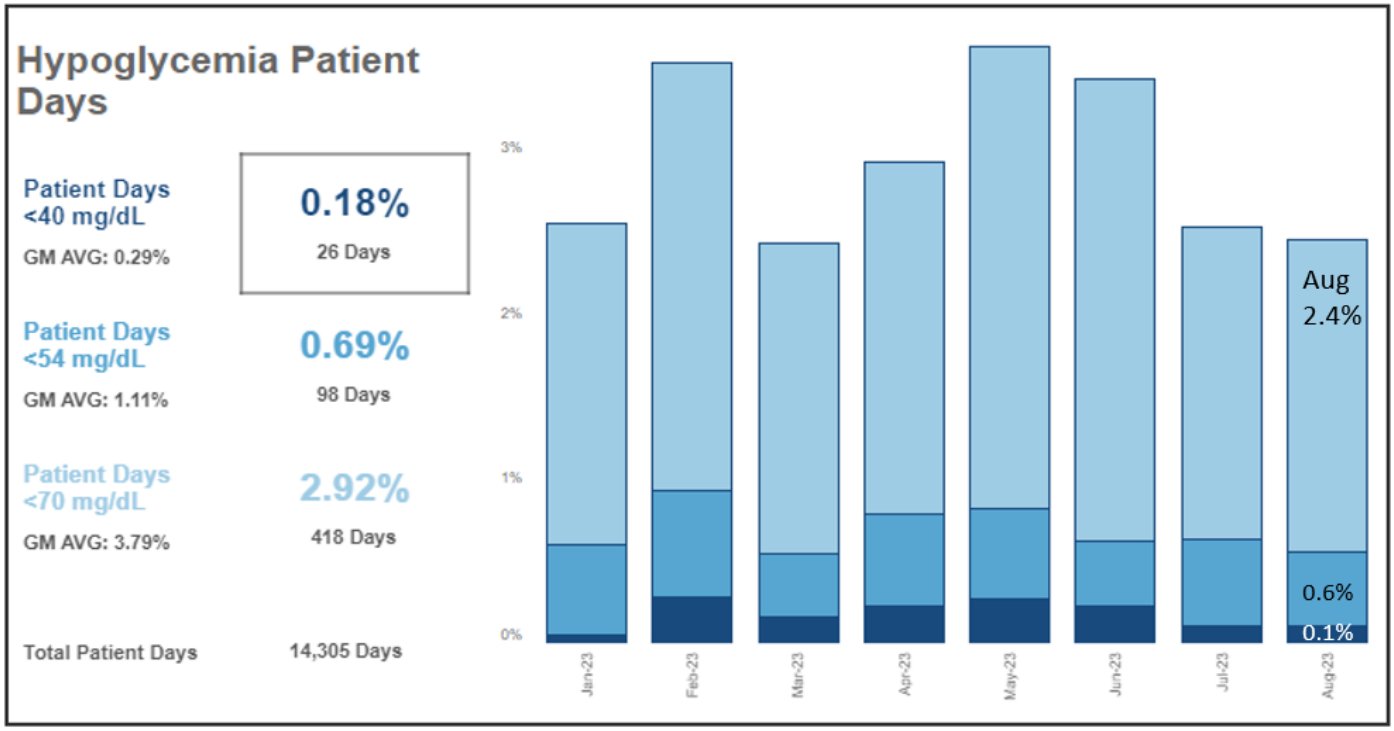
- Hypoglycemia: KHMC NCC increased from 3.3% from 4.2%, which is above the SHM benchmark of 3.4%
- Hyperglycemia: NCC had an increase in hyperglycemia rates from 26% from 27.3%, but continues to be below the SHM benchmark of 31.1%.



Graph 3a and 3b – GlucoMetrics® Report for Non-Critical Care Units
Displays % patient days < 70 for hypoglycemia and Patient Days In-Range (70-180 mg/dL) for 2023 YTD among NCC units for patients **treated with Glucommander™ SQ.**

Graph3a: NCC SQ Hypoglycemia rates

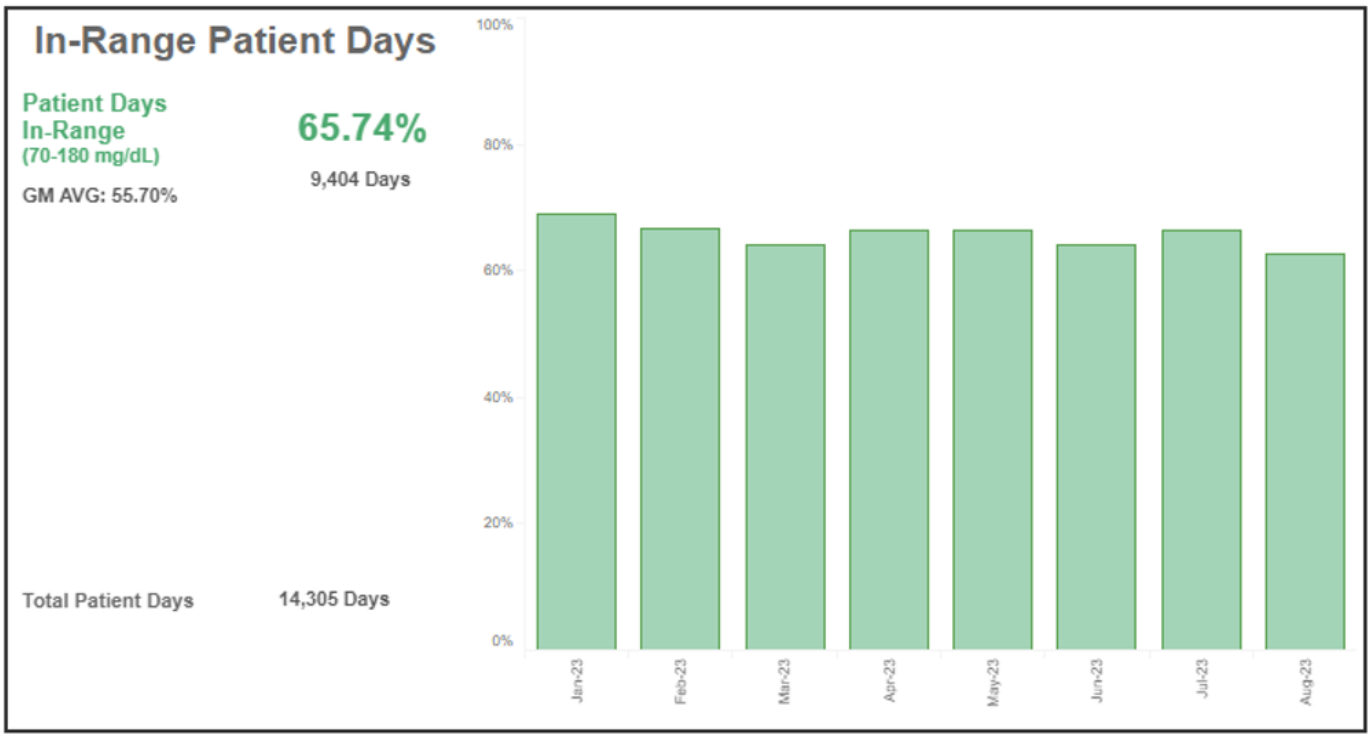
- Since Jan 2023, KH has outperformed other hospitals who also use Gucommander.
- Aug 2023: patient days with BG < 70 mg/dL was 2.5%, better than GM average of 3.79% and better than the SHM benchmark of 4.2%



SHM Benchmarks: HYPOglycemia=3.4%

Graph 2b – NCC SQ In-Range Data
Glucometrics does not provide the hyperglycemia data we used in the past.

- For patient days in range (70-18 mg/dL) for patients **treated with Glucommander™ SQ.** , KH is at 59.6% for the month of August which is above the GM average of 55.7%. For this metric: higher is better.
- For YTD 2023, KH is at 59.56%



- ✓ **GOAL 3** Met: In the last 6 years, KH has met this goal and consistently achieved top quartile performance for resolution of hypoglycemia after initial identification of hypoglycemic event for CC units (Chart 5) and NCC units (Chart 6)

Chart 5 – SHM Report (November 2022-April 2023) for Critical Care Units

Kaweah Health time between glucose < 70mg/dL and documented resolution of hypoglycemia for critical care is 50.06 minutes. This time is below the top quartile of ≤50.6 minutes.

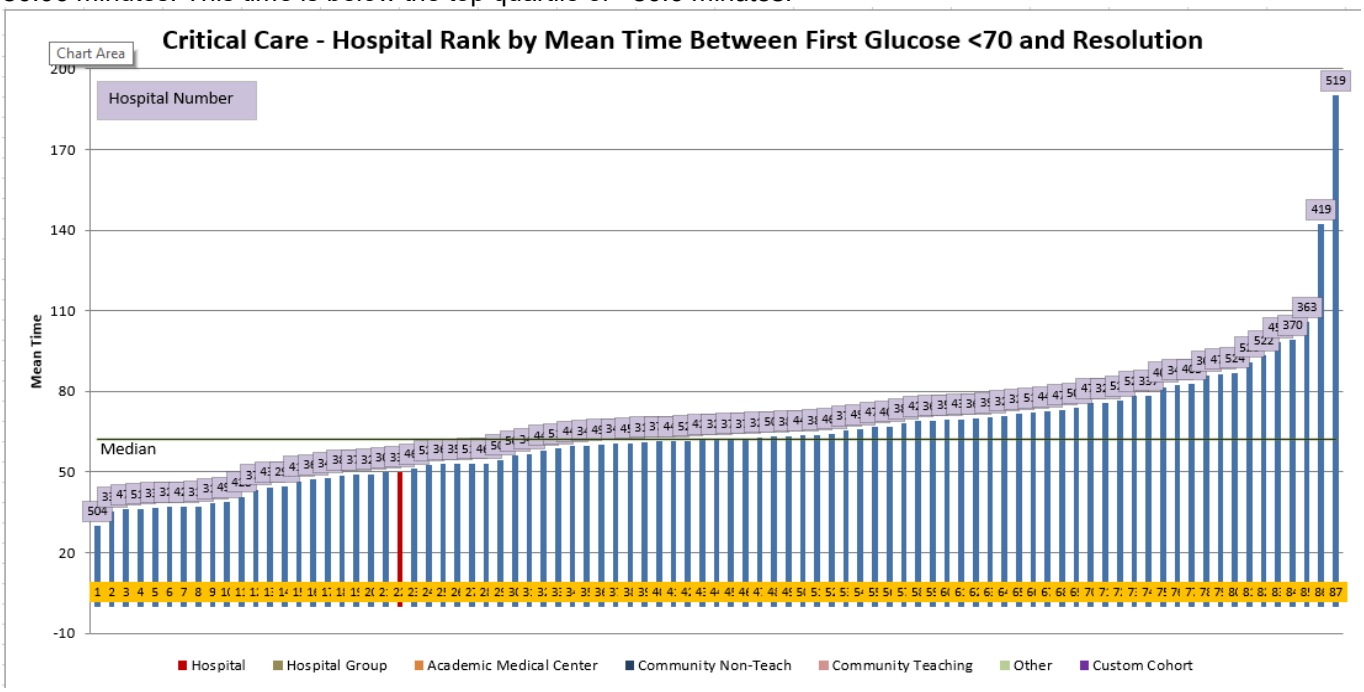
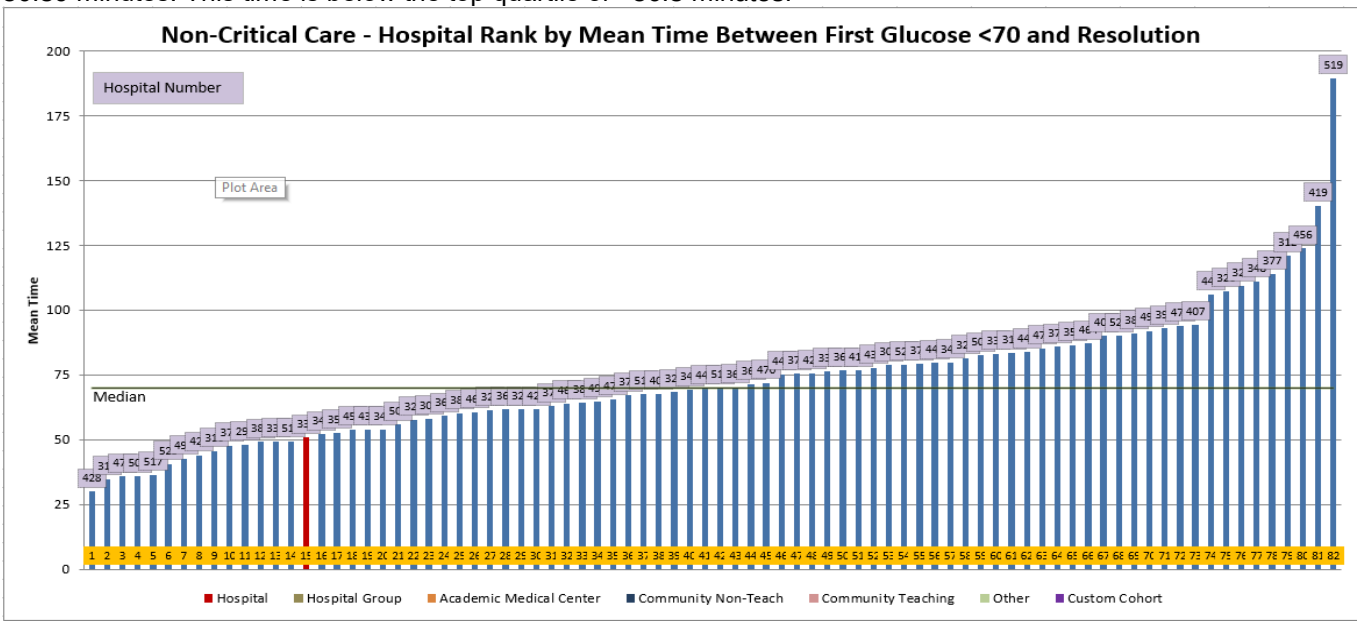
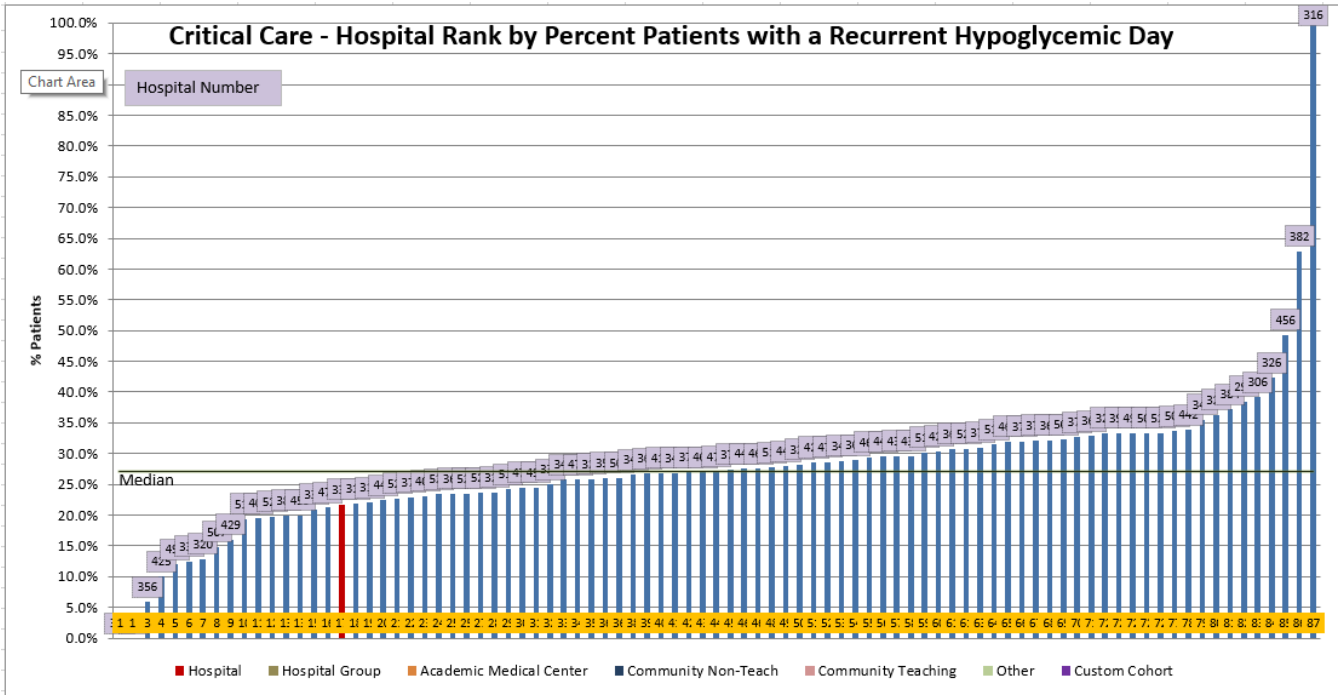


Chart 6 – SHM Report (November 2022-April 2023) for Non-Critical Care Units

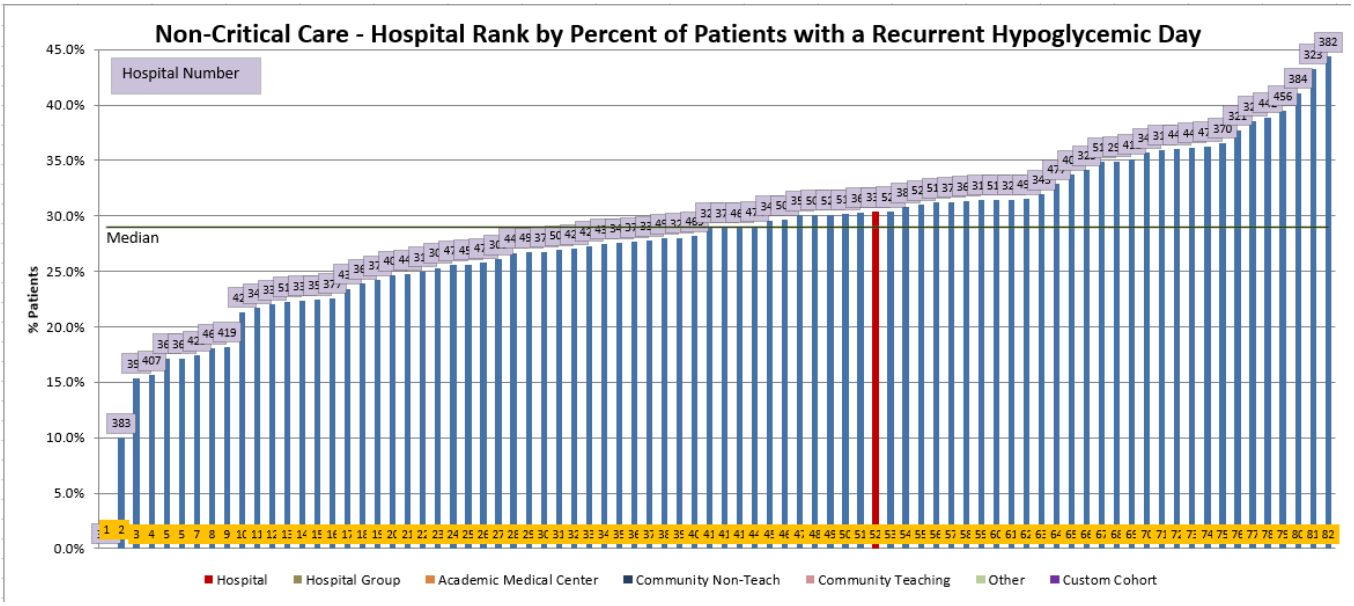
Kaweah Health time between glucose < 70mg/dL and documented resolution of hypoglycemia for non-critical care is 50.89 minutes. This time is below the top quartile of ≤56.3 minutes.



Goal #4: Achieve benchmark performance for percent of patient with hypoglycemia with at least one recurrent hypoglycemic day for CC (chart 7) and NCC patients (chart 8).
√ Goal Met (chart 7): CC is better than the top quartile for this goal. The percent of patients with a recurrent hypoglycemic day is at 21.7%, which is better than the top quartile for this SHM measure 23%.



∅ Goal Not Met (chart 8): NCC did not achieve this goal. The percent of patients with a recurrent hypoglycemic day is at 30.4%, which is above the benchmark for this SHM measure (29%).



Improvement Opportunities Identified:

1. The Advance Nursing Practice Team partners with medical staff to foster collaboration and improvement:
    - APN invited by individual Hospitalist to provide diabetes and Glucommander™ education every 2-3 weeks.
    - Established an AMION number for easier access to assist in the optimization of patients on Glucommander™.
    - Dr. Zhao is now our physician champion for the committee. He has made connections with providers both in critical care and med-surg to identify needs and how the committee can meet those needs.
    - Work with GME residents on future projects.
2. Exploration of structure, function, impact of consult team developed to respond to needs of nursing and medical staff with goals to
    - Improve glycemic management and patient outcomes.
    - Improve knowledge and skillset of nursing, pharmacist and medical staff through education, training, consultative services.
    - Demonstrate return on investment (ROI) through improved throughput, decreased length of stay
        - Inpatient Diabetes Management (IPDM) NP now available through AMION M-F 08-1700. Continues to devotes 3 hours daily to reviewing management of targeted cases, 8-10 new cases daily, maintaining a daily caseload of 25-30 patients.
        - Compiling data for IPDM NP to review potential cost avoidance in the prevention of hypoglycemic events.
        - Continue to meet with Sr. Consultant from Project Management & Consulting and Director of Population Health to develop a strategic business plan for the Inpatient Diabetes Management team
3. The Advance Nursing Practice Team reviews and responds to Adverse Drug Events (ADEs) related to hypoglycemia and Glucommander™ (GM), such as:
    - Transcription errors of GM orders to GM
        - Order integration project is in progress to eliminate need for nursing order re-entry; actively working towards MAR and Order integration with Glytec team; Go-Live anticipated February 2023
    - Inappropriate selection of modifier / target range
    - Recommendation for Inpatient Diabetes Management Team referral for recurrent hypoglycemia or persistent hyperglycemia or previous history of same
4. Inpatient Glycemic Management team (APN and Endocrinologist)
    - Help to optimize the difficult to manage patients (i.e. Renal, recurrent hypoglycemia, insulin resistant, hyperglycemia >300)
    - Reduce rates of inpatient hypoglycemia/hyperglycemia to or below SHM benchmark. Improve efficiency of progression to goal. Goal: change of 10% if not meeting benchmark numbers.
    - Review root cause of severe hypoglycemia (< 40mg/dL)
    - Partner with Glytec, Dr. Zhao and KH team to review transition from IV to SQ insulin to optimize patient glycemic control

- Regular meetings with KH ISS, clinical education, Glytec to implement/transition to the GM upgrade scheduled for Feb 2024 (3.5.3.0)

Submitted by: **Date Submitted:** Sept 10, 2023

Emma Camarena, DNP, RN, ACCNS-AG, CCRN
Director of Nursing Practice

Cody Ericson MSN, RN, FNP, CCRN
Advanced Practice Nurse-Critical Care Services

Dr. Lu Zhao, DO
Critical Care Pulmonary & Adult Hospital Medicine
Diabetes Physician Champion

Sepsis Quality Focus Team Report

October 2023

Erika Pineda BSN, RN, PHN, CPHQ
Quality Improvement Manager
Dr. Lamar Mack, MD, MHA
Medical Director of Quality & Patient Safety

Acronyms

- ALOS - Average Length of Stay
- BC – Blood Culture lab test
- Dx - Diagnosis
- ED – Emergency Department
- EM – Emergency Medicine GME Program
- FM – Family Medicine GME Program
- GMLOS – Geometric Length of Stay
- ICD10 – Billing Codes
- LA – Lactic Acid Lab Test
- RRT – Rapid Response Team
- SEP-1 – CMS Sepsis Bundle Measure
- VBG – Venous Blood Gas lab test
- VS – Vital Signs
- HR – Heart Rate
- PPR – Peripheral Pulse Rate
- APR – Apical Pulse Rate
- IBW – Ideal Body Weight
- PNF – Provider Notification Form
- OFI – Opportunity for Improvement

SEP-1 Early Management Bundle Compliance

CA State Compliance 65% ~ National Compliance 58% ~ Top Performing Hospitals 79%

Percent of patients with sepsis that received "perfect care." Perfect care is the right treatment at the right time.

Goal for FY24 = ≥85%

Kaweah Health

Sepsis Quality Focus Team DASHBOARD

CMS SEP-1 Bundle Compliance

	Goal	FY2020	FY2021	FY2022	FY2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	YTD
SEP-1 CMS % bundle compliance	85%	66.9%	74.6%	75.0%	73.0%	68%												68%
Number of CMS compliant cases (n)	n/a	198	206	300	243	13												13
Total number CMS cases abstracted (d)	n/a	296	276	400	333	19												19
% Concurrent bundle compliant cases	75%	78%	77%	79%	86%	88%												88%
Number of concurrent compliant cases (n)	n/a	646	785	656	479	46												46
Number of concurrent cases abstracted (d)	n/a	829	1013	835	560	52												52
Number of Non-Compliant CMS cases *with*coordinator	n/a					1												1
Number of Non-Compliant CMS cases *without coordinator*	n/a					5												5
% of Non-Compliant CMS cases *with* coordinator	n/a					20%												20%
% of Non-Compliant CMS cases *without* coordinator	n/a					80%												80%

KEY

>10% away from goal	Within 10% of goal	Within 5% of goal	Outperforming/meeting goal

SEP-1 Early Management Bundle Compliance

CA State Compliance 65% ~ National Compliance 58% ~ Top Performing Hospitals 79%

Percent of patients with sepsis that received "perfect care." Perfect care is the right treatment at the right time.

Sepsis Quality Focus Team DASHBOARD

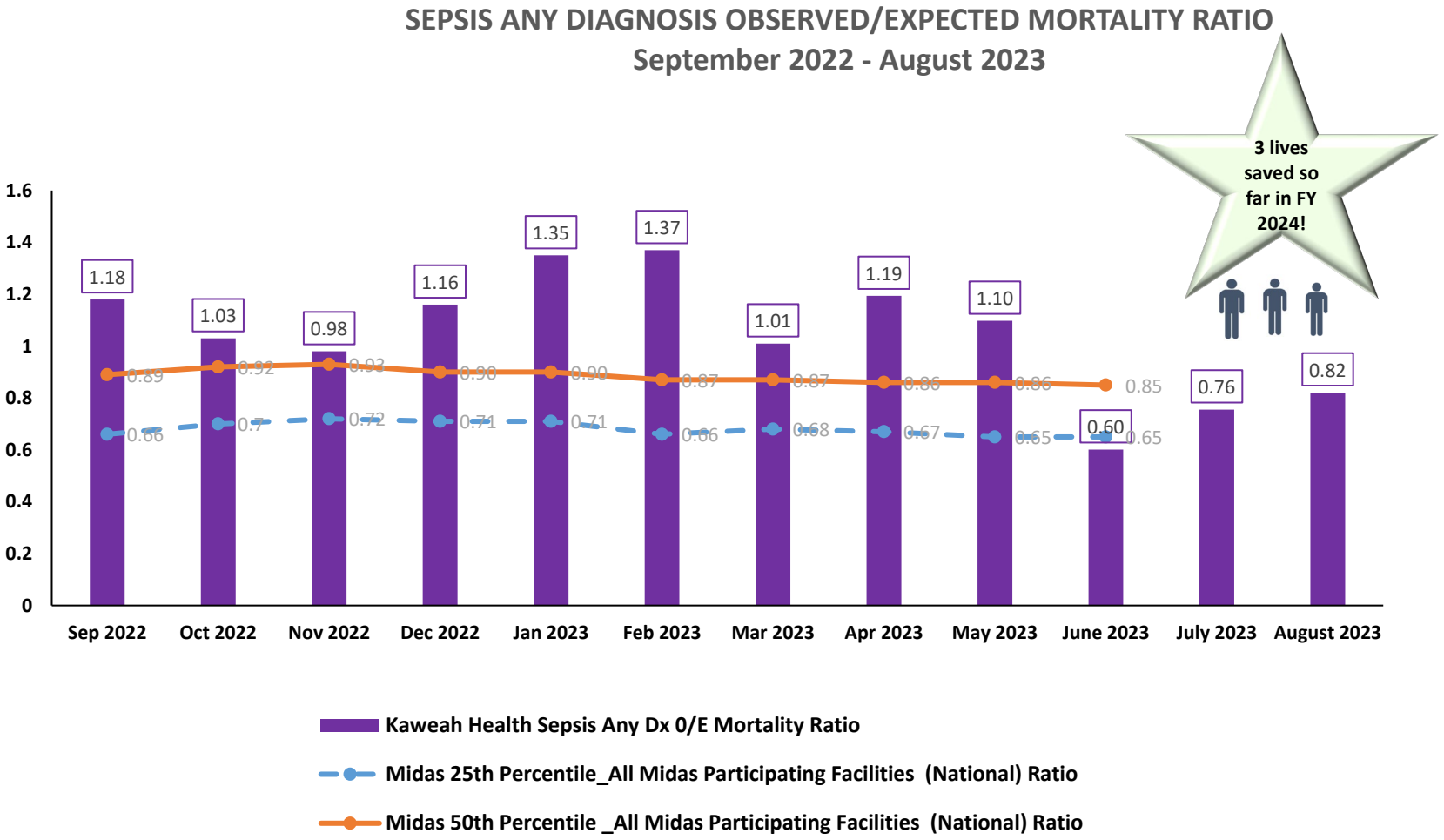
Kaweah Health

SEP-1 Bundle Elements

	Goal	FY2020	FY2021	FY2022	FY2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	YTD
3 hr SEP-1 Bundle % Compliance	95%	76.0%	78.6%	88.0%	79.0%	79%												79%
3hr SEP-1 BundleTotal Patients abstracted (d)	n/a	296	276	401	334	19												19
% Antibiotics adminstered	95%	97.3%	95.7%	93.0%	94.0%	95%												95%
% Blood Cultures drawn	95%	93.8%	92.0%	93.0%	94.0%	89%												89%
% Lactic Acid drawn	95%	95.6%	97.9%	98.0%	98.0%	100%												100%
% Fluid Resuscitation completed	95%	88.3%	90.7%	92.0%	84.0%	92%												92%
6 hr bundle % Compliance	95%	85.4%	93.5%	90.0%	91.0%	83%												83%
6hr SEP-1 BundleTotal Patients abstracted (d)	n/a	186	170	250	204	12												12
% Repeat LA drawn	95%	89.6%	94.0%	92.0%	92.0%	92%												92%
% Reassessment completed	95%	92.9%	98.5%	91.0%	99.0%	100%												100%
% Vasopressors initated when indicated	95%	93.30%	100%	100%	100%	89%												89%

KEY	>10% away from goal	Within 10% of goal	Within 5% of goal	Outperforming/meeting goal

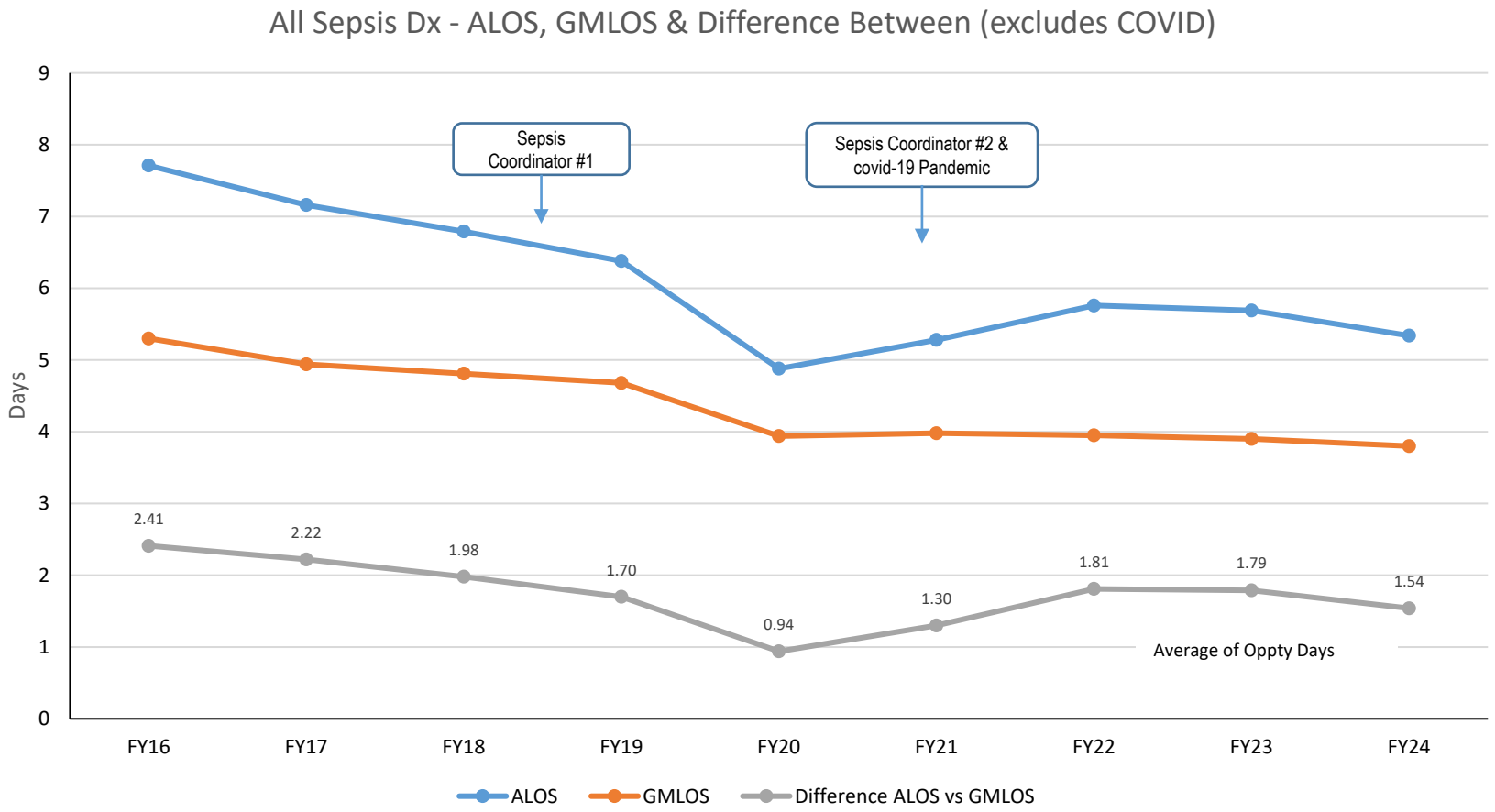
Sepsis Any Diagnosis – Outcomes Observed/Expected (o/e) Mortality



- Ratio < 1.0 indicates that at least expected deaths do not exceed actual (Lower ratio is better)
- FY 2023 KH Ratio: 1.12 (140/125)
- Best performing facilities have o/e ratios significantly lower than 1.0 (i.e. 0.6)
- KH Goal is 0.6 o/e sepsis Mortality
- FY 2024 (July – August) KH Ratio: 0.79 (13/16)

Midas Risk Adjusted Model v6 comparison analysis (582-624 sites)

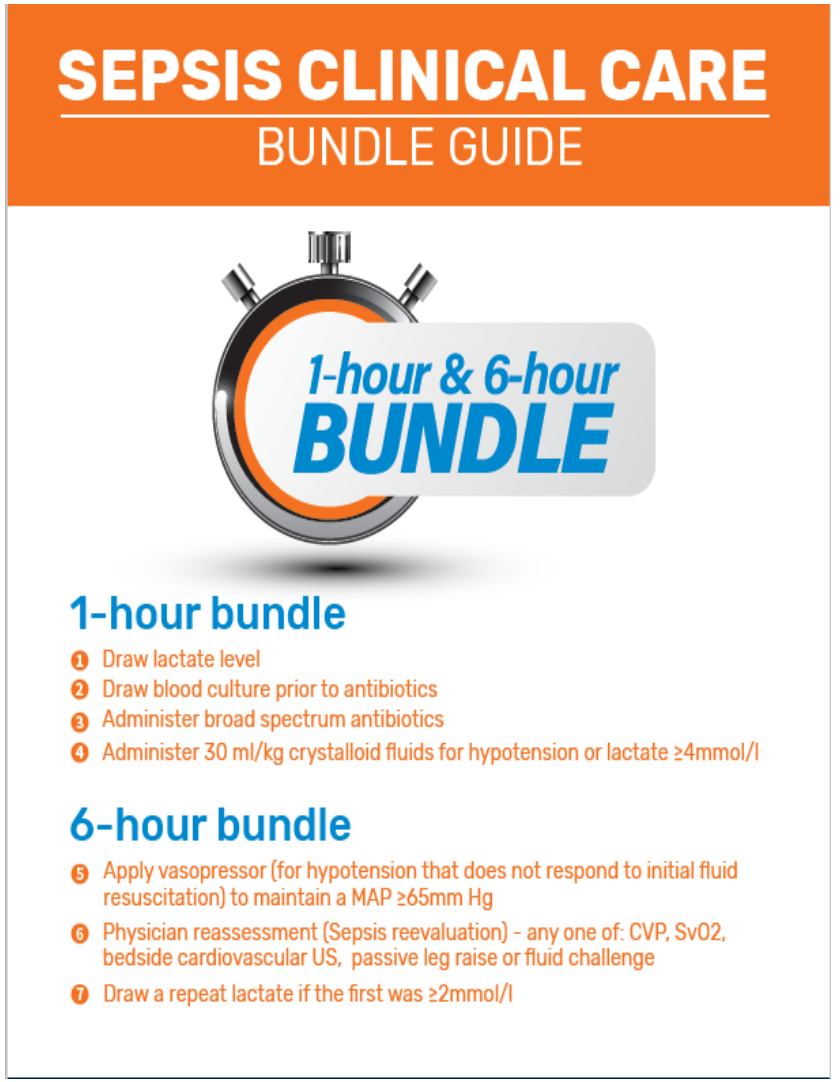
Sepsis Any Diagnosis – Outcomes Length of Stay



- 26.2% decrease in ALOS from FY16 (ALOS=7.71) to FY23 (ALOS=5.69)
- FY23 Kaweah Health ALOS 5.69 days vs. CMS GMLOS 3.94 Difference of 1.75 days.
- COVID-19 cases removed in FY20-23. SEP-1 bundle does not apply to COVID-19 patients.

Sepsis 1-Hour to Treatment Implementation Update

- The ED 1-hour Sepsis Bundle power plan went live on Tuesday, June 20th (Well received by care team)
- Aims of the 1-hour bundle: *reduce sepsis-related inpatient mortality*
- The ED 1-hour bundle includes pre-selected orders for blood cultures and serial lactate collection, Ceftriaxone 2 gram as the primary antibiotic option, and Normal Saline as the primary crystalloid option
- ..sepsisfluidoverload is the new dot phrase to address provider concerns for fluid overload or acknowledge a reduced targeted goal was used to effectively correct hypoperfusion/hypotension
- Sepsis education pertaining to the 1-Hour strategy is ongoing for ED caregivers and providers throughout the ED
- Currently Evaluating Impact of Sepsis 1 hr. bundle Sepsis Mortality



Sepsis QFT Actions & Next Steps

- Key Improvement strategies in process:
  1. Secure GME Resident engagement & Support: Secured one ED Chief Resident (s) to Attend Sepsis Committee meeting consistently (In progress)
  2. Resident education event (Orientation) Completed 6/21/23
  3. Standing educational activities for GME residency: Sepsis SIM and Sepsis didactic every 18 months (In progress)
  4. ED Provider (s) education ongoing by ED Medical Staff leadership (In progress)
  5. HealtheAnalytics Sepsis data retrieval dashboard developed to track 1-hr. bundle compliance (Currently undergoing validation) (In progress)
  6. ED Sepsis Decision Making tool rolled out to aid in ED Provider documentation enhancement (Ongoing evaluation to improve tool) In progress
  7. Sepsis Committee to meet on a monthly basis to address concerns timely (In progress)

Sepsis Decision Making

SIRS	Sepsis	Severe Sepsis	Septic Shock
T>38.3 or <36	Infection	Lactate >2	Lactate ≥ 4
HR > 90	+	Single SBP < 90	SBP <90 despite IVFs
RR >20	2 SIRS	BiPAP/Vent	
WBC > 12 or <4; Bands > 10%		Cr or Bili >2, INR > 1.5, Plts < 100k	

Sepsis Recognition Time: _
_▼

A sepsis re-evaluation was performed at:

Delays:
_ Waiting for blood cultures to be drawn would have resulted in a delay of >45 minutes in starting antibiotics.
_ After a risk/benefit discussion the patient/POA refused IV placement and blood draw (blood cultures, lactic acid).
_ After a risk/benefit discussion the patient/POA refused antibiotics.
_ After a risk/benefit discussion the patient/POA refused vasopressors
_ IV access was unattainable. Therefore, antibiotics were ordered and administered via the IM/IO route to avoid further delay.

Measured and Ideal Weights:
LWM Weight
No qualifying data available. Ideal Body Weight:

Resuscitation Volume:

Check One	Weight Range Actual Wt or IBW	30 mL/kg Resuscitation Volumes	OR	Check One	Lesser Resuscitation Volumes
	Exact Weight	30 mL/kg			500 mL
	<50 kg	1500 mL			1000 mL
	50-67 kg	2000 mL			1500 mL
	67-83 kg	2500 mL			2000 mL
	83-100 kg	3000 mL			
	>100 kg	Recommend IBW			

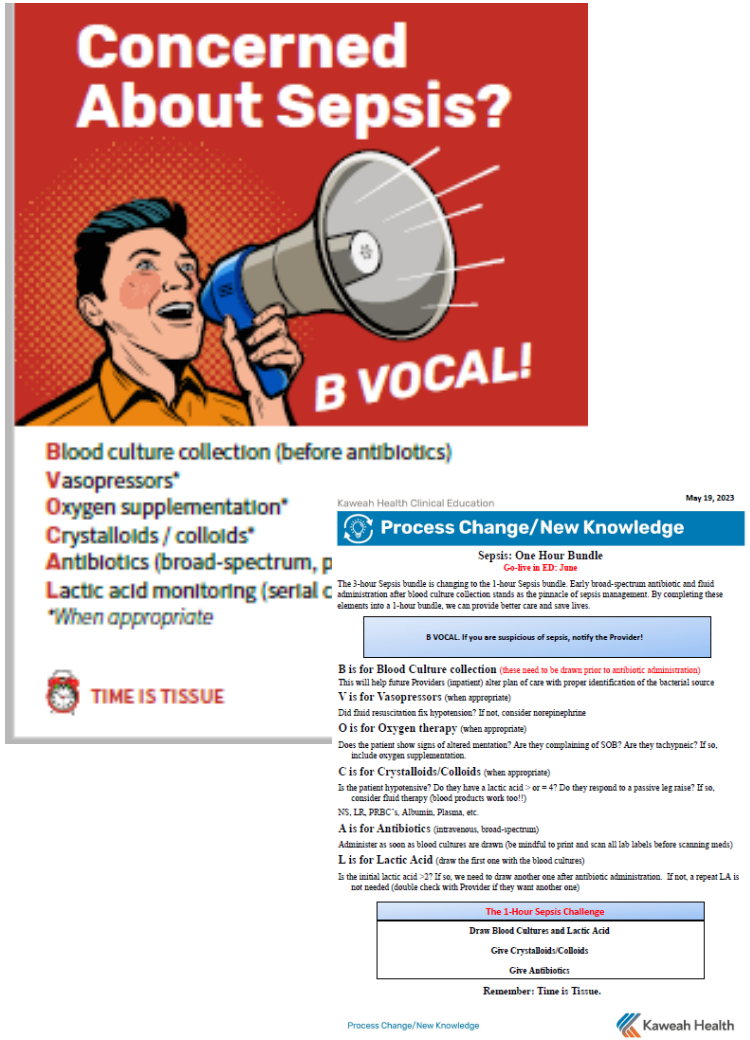
Sepsis Fluid Decision Making:
_ N/A Septic shock not present.
_ _mL of crystalloid fluids were given in lieu of a 30 mL/kg bolus because the blood pressure responded to a lesser volume.
_ The total volume of crystalloids and/or colloids given will now be _▼ in place of 30 mL/kg as there is a concern for fluid volume overload.

Code Status:
N/A▼

Sepsis QFT Actions & Next Steps

- Key Improvement strategies in process:

8. SEP 1 fall outs deep dive & discussion for strategies in Sepsis Committee (In progress)
9. Continue education/follow-up with providers, & caregivers during concurrent review of cases (In progress)
10. Engagement with Transitional year Resident (s) for a Sepsis Quality Improvement Project (In progress)
11. Ongoing partnership with Education Department as needed for refresher on CMS Sepsis requirement (Completed 9/26/23)
12. Improve communication regarding blood culture collection between nurse, phlebotomist & providers (In progress)
13. Acronym developed to assist as cognitive aid to remember SEP-1 Bundle elements: B VOCAL! Completed
14. Advocate for Unit Based Nurse Sepsis Champions hospital wide (presented to Patient Care Leadership 7/19/23 (Not feasible at the moment)
15. Exploring the use of Sepsis intervention tracker/Sepsis electronic checklist (Not feasible at the moment)



Sepsis QFT Actions & Next Steps

Next Steps:

- Exploring development of SIRS Sepsis Alert for Emergency Department
- Improve Severe Sepsis Alert accuracy
- Ongoing evaluation for the “One-Hour” Sepsis bundle to reduce Sepsis mortality
- Strengthen partnership with HIM/Coding related to Sepsis
- Explore rolling out 1 hour Sepsis bundle to the inpatient population
- Planned modified Kaizen event to evaluate current barriers to meeting SEP 1 requirements
- Ensure to secure the most points for SEP 1 composite measure for the CMS Value Based Purchasing program

CMS NEWS: Value Based Purchasing Domains & Measurement for Calendar Year 2024 Discharges

Safety

CAUTI: Catheter-associated Urinary Tract Infection
CDI: *Clostridium difficile* Infection
CLABSI: Central Line-associated Bloodstream Infection
MRSA: Methicillin-resistant *Staphylococcus aureus Bacteremia*
SSI: Surgical Site Infection – Colon Surgery and Abdominal Hysterectomy
SEP-1: Severe Sepsis and Septic Shock Management Bundle (Composite Measure)

Clinical Outcomes

MORT-30-AMI: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization
MORT-30-CABG: Hospital 30-Day RSMR Following Coronary Artery Bypass Graft (CABG) Surgery
MORT-30-COPD: Hospital 30-Day, All-Cause, RSMR Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization
MORT-30-HF: Hospital 30-Day, All-Cause, RSMR Following Heart Failure (HF) Hospitalization
MORT-30-PN: Hospital 30-Day, All-Cause, RSMR Following Pneumonia (PN) Hospitalization (updated cohort)
COMP-HIP-KNEE: Hospital-Level, Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

Person and Community Engagement

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

Efficiency and Cost Reduction

MSPB: Medicare Spending per Beneficiary

CMS has adopted SEP 1: Severe Sepsis and Septic Shock Management Bundle (Composite Measure) to the Safety Domain for Pay for performance Value based Purchasing Program starting Jan 1, 2024

VBP SEP 1 planned Measurement Period:
Baseline Period: January 1–December 31, 2022 (CY 2022)
Kaweah Health Performance Period in CY 2022: 76%

Performance Period: January 1–December 31, 2024 (We h*ave to perform better than our own and/or the National CMS Benchmark*
CMS Benchmark (s): Achievement Threshold 60% Benchmark/Top Decile: 84%

Sepsis Awareness Month Activities in September!

- Sepsis education community event at Rawhide Stadium on 8/18
- Sepsis Awareness video updated
- Sepsis Scholar Contest (chance to win gift cards)
- 6 Theme Sepsis Contest (chance to win a gift basket)
- Social Media Sepsis Campaign
- Radio/TV announcements (English/Spanish speaking Audience)

SEPSIS: Every Second Counts

Dr. LaMar Mack, Medical Director, Quality and Patient Safety Ext. 2117
Sandy Volchko, RN-Director, Quality and Patient Safety. Ext. 2169
Erika Pineda, RN-Manager, Quality and Patient Safety. Ext. 2876
Ryan Smith, RN-Sepsis Coordinator. Ext. 5905
Jared Cauthen, RN-Sepsis Coordinator. Ext. 6903

Outstanding Health Outcomes Update

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

October 2023

Kaweah Health
MORE THAN MEDICINE. LIFE.

Outstanding Healthoutcomes (OHO) Dashboard

Sepsis (SEP)	FY 2024 Target	FY 2022	FY 2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	FYTD 24
SEP-1 CMS % bundle compliance	85%	75%	73%	68%	68%											68%
Sepsis and Related Conditions o/e mortality	≤0.60		1.12	0.75	0.82											0.79

Central Line Associated Blood Stream Infection (CLABS	FY 2024 Target	FY 2022	FY 2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	FYTD 24
CLABSI Events		20	14	1	2											3
CLABSI SIR	tbd	1.13 Ex COVID	0.93 Ex COVID		1.16											1.16
Central Line Utilization Rate (ICU)	tbd				0.77											0.77

Catheter Associated Blood Stream Infection (CAUTI)	Target	FY	FY	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	FYTD 24
CAUTI Events		20	12	0	0											0
CAUTI SIR	tbd	1.09 Ex COVID	0.55 Ex COVID	0.00	0.00											0.00
Indwelling Uninary Catheter (IUC) Utilization Rate (ICU)	tbd				0.90											0.90

Methicillin-Resistant Staphylococcus Aureus (MRSA)	Target	FY	FY	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	FYTD 24
MRSA Events		13	6	0	0											0
MRSA SIR	tbd	1.59	0.63	0.00	0.00											0.00

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

Additional Acronyms/Definitions

SEP-1 - 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.

SIR - Standardized Infection Ratio is the number of patients who acquired one of these infections (excluding COVID patients) while in the hospital divided by the number of patients who were expected.

Action Plan Summary

Our Mission

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

Our Vision

To be your world-class healthcare choice, for life

Sepsis

- Focus on 1 hr bundle, expand to inpatient
- Re-identifying root causes of SEP-1 non-compliance to focus SEP-1 QI on the highest contributing factors

Healthcare Acquired Infections

- New super “HAI Brain Trust” Quality Focus Team established, approved by Quality Improvement Committee
- Combine and focus efforts on process metrics that affect the SIRs for CAUTI, CLABSI & MRSA and includes:
    - Line utilization (both central lines and indwelling urinary catheters)
    - Decolonization rates
    - Cleanling effectiveness in high risk areas
    - Hand Hygiene (use of BioVigil system for monitoring)

Questions?

The pursuit of healthiness