May 12, 2022

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in a Quality Council Committee meeting at 7:30AM on Thursday, May 19, 2022, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:31AM on Thursday, May 19, 2022, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277, pursuant to Health and Safety Code 32155 & 1461.

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Quality Council Committee meeting at 8:00AM on Thursday, May 19, 2022, in the Kaweah Health Lifestyle Fitness center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

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

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

KAWEAH DELTA HEALTH CARE DISTRICT
Michael Olmos, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
Board Clerk, Executive Assistant to CEO

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

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
QUALITY COUNCIL

Thursday, May 19, 2022
5105 W. Cypress Avenue
Kaweah Health Lifestyle Fitness Center Conference Room

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

OPEN MEETING – 7:30AM

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

CLOSED MEETING – 7:31AM

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

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

4. **Adjourn Closed Meeting** – *David Francis, Committee Chair*

OPEN MEETING – 8:00AM

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

2. **Public / Medical Staff participation –** Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves at this time. Members of the public or the medical staff may comment on agenda items after the item has been discussed by the Committee but before a Committee recommendation is decided. In either case, each speaker will be allowed five minutes.

3. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives:
    3.1. Sepsis Quality Focus Team
    3.2. CLABSI Quality Focus Team

4. **Length of Stay Quality Report –** A review of key length of stay metrics and action plans to improve performance. *Jag Batth, Chief Operating Officer, PT, DPT. Kassie Waters, RN, BSN, MPA, Director of Cardiac Critical Care Services, Rebekah Foster, RN, CCDS, PHN, BSN, Director of Care Management and Specialty Care.*

5. **Surgical Services Quality Report** – A review of key process measures associated with surgical services efficiency. *Brian Piearcy, Director of Surgical Services, LaMar Mack MD., Medical Director of Surgical Quality.*

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

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.

Sepsis Quality Focus Team

April 2022
Prostaff/QIC Report

Kaweah Health
MORE THAN MEDICINE. LIFE.

SEP-1 Early Management Bundle Compliance

CA State Compliance 64% ~ National Compliance 60% ~ Top Performing Hospitals 82%

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

Goal for FY22 = ≥75%

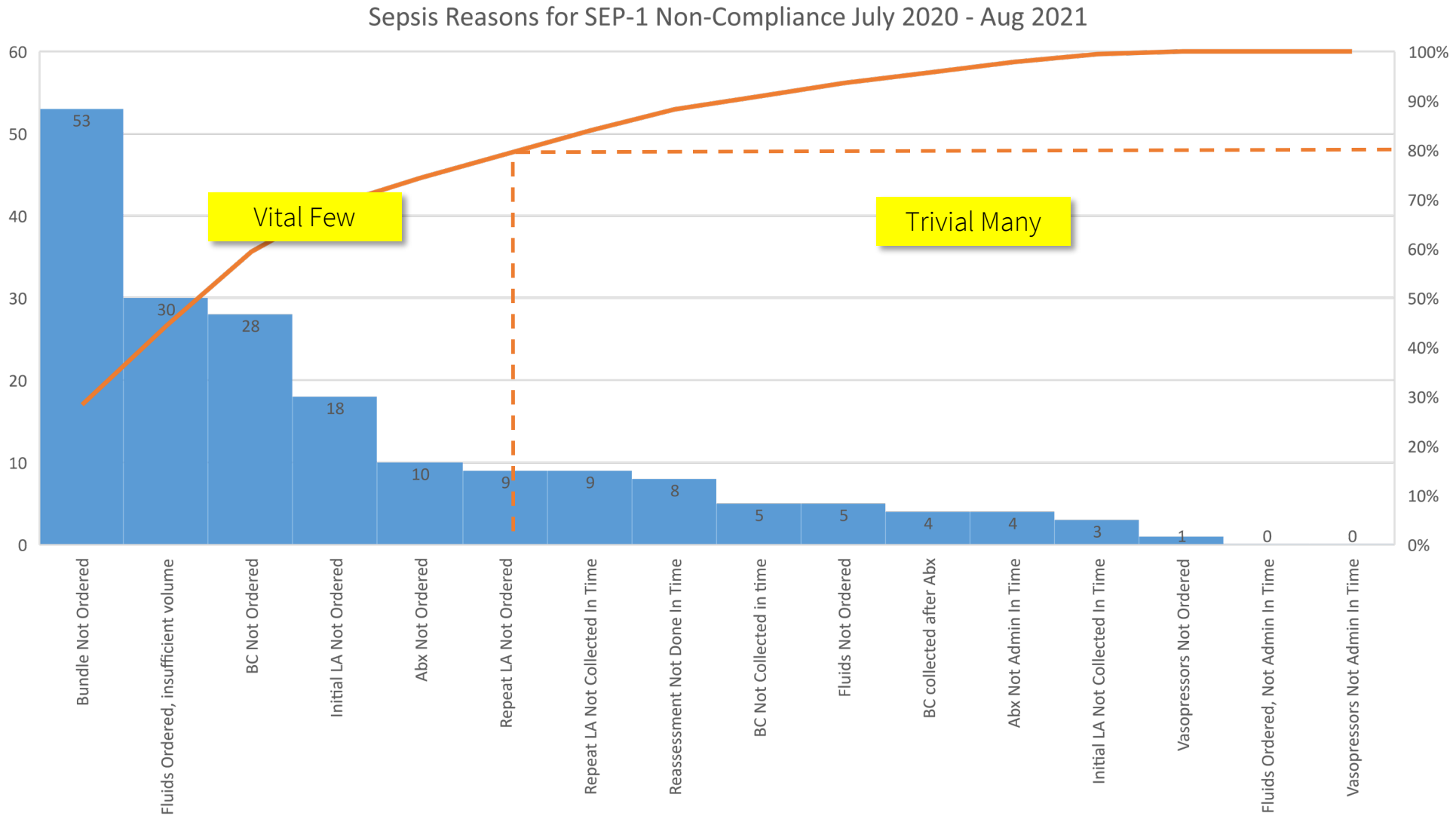
Kaweah Health

Sepsis Quality Focus Team DASHBOARD

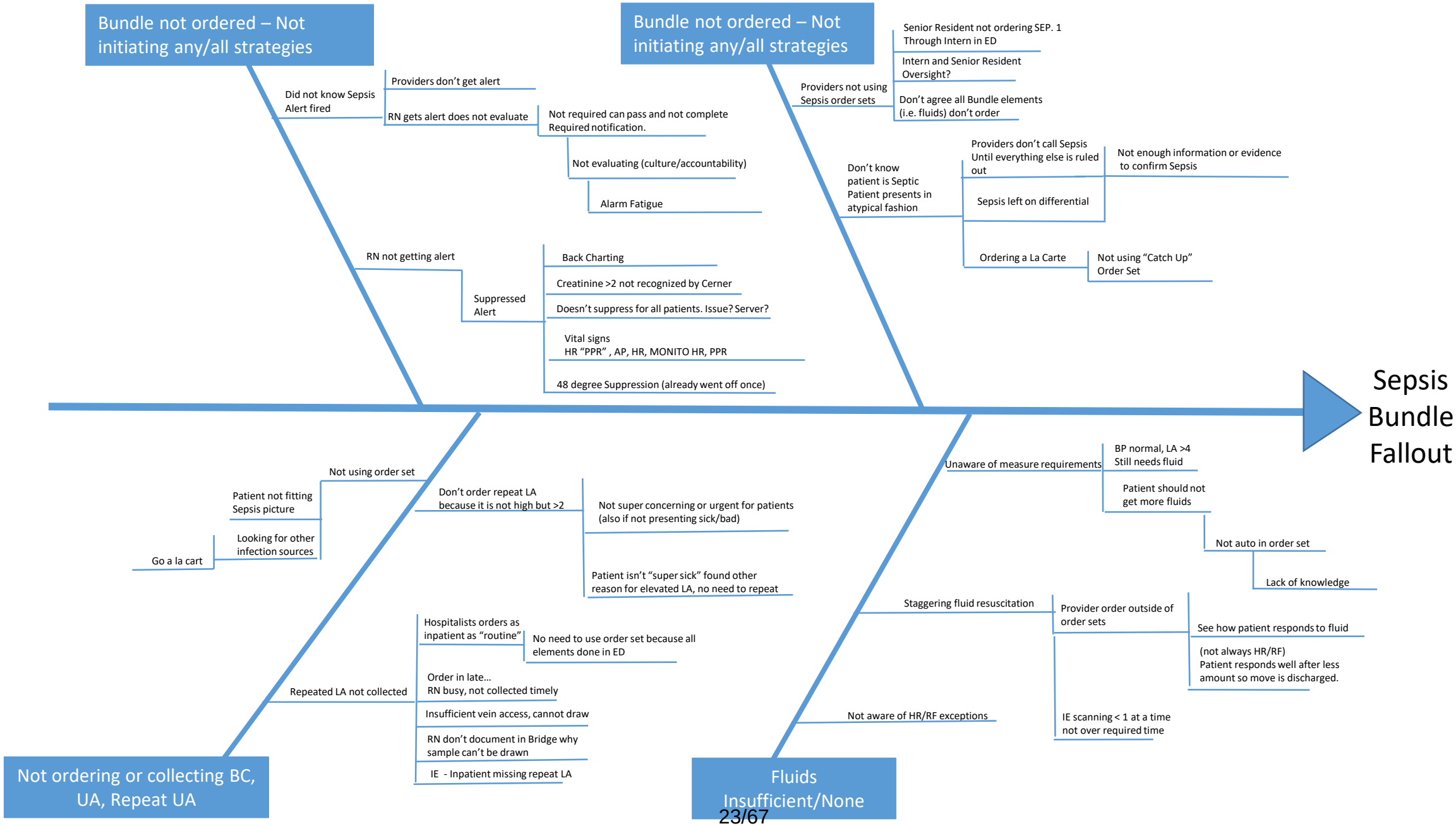
CMS SEP-1 Bundle Compliance	Goal	FY2019	FY2020	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	YTD
SEP-1 CMS % bundle compliance	75%	66.9%	74.6%	68%	75%	57%	77%	90%	82%	56%	81%					73%
Number of CMS compliant cases (n)	n/a	198	206	21	24	17	30	27	27	18	30					194
Total number CMS cases abstracted (d)	n/a	296	276	32	32	30	39	30	33	32	37					265

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

Pareto Diagram



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



Root Causes & Improvement Strategies

Root Cause of SEP-1 Bundle Not Fully Implemented	Data	Potential/Actual QI Strategy Action

Do not know patient is septic because the alert did not fire
• Alert suppressed for 48 hrs after initial alert
• Creatinine >2 not recognized by Cerner/in the alert algorithm
• Alert does not fire when a string of VS are documented all at one, it suppresses an abnormal VS(s) that require patient evaluation
• Alert does not fire when multiple VS (ie.HR, PPR, AP, etc) and one value is abnormal and the others are not
• Alert does not fire for providers (fires inappropriately such as when ED providers reestablishes a relationship with an in-patient to back document, or fires for triage provider after patient is in "back")
	SEPSIS ALERT EVALUATION
	Inpatient & ED Patients
	•Patients with a Sepsis alert are 0.26 times (26%) more likely to have sepsis than not (424/1619 = 0.26)
	• The odds a patient with no sepsis alert is septic is 0.01 (1%) (319/31,021)
	Sensitivity – 0.57; Specificity – 0.95
	Inpatient ONLY
	• Patients with a Sepsis alert are 0.28 times (28%) more likely to have sepsis than not (417/1470 = 0.28)
	• The odds a patient with no sepsis alert is septic is 0.03 (3%) (295/9,127)
	Sensitivity – 0.59; Specificity – 0.83
		• Improve sensitivity and specificity of alert
		  • Work with Cerner to evaluate criteria in "the cloud" can alert fire when Cr <2.0
		  • 30 hour alert "look back" on VS and labs
		• Suppress alert in ICU based on ICD10 sepsis dx – IN PROCESS
		• Alert suppression (for RNs) changed from 48 hrs to 13 hrs (per shift) COMPLETE
		• Optimize alert and turn on for providers – UNDER EVALUATION
		  • Alert cannot fire when provider is no longer caring for patient (ie. alert fires for ED provider when documenting and patient has been admitted, or triage provider when pt is in "back" under care of another ED provider)

Do not know the patient is septic because the RN did not evaluate the alert and execute provider notification process • Alert fatigue, accountability	See provider notification data analysis slides • "6 Attributes Test" completed indicating that 4/4 RNs surveyed in different units were able to articulate the who, what, where, when, why and how of the provider notification process	• Root cause analysis indicates that options on the provider notification form need to be expanded. RNs not completing form because options for not notifiying the provider do not include all applicable options. Form under revision - IN PROCESS
Provider not using order sets for known septic patients where bundle elements are easily accessed • Resident & provider knowledge • Personal preference to go a la cart	12/21 (57%) ED SEP-1 fallouts did not use order set (July – Sept 2021)	• ED simulation training to cover SEP-1 elements for all EM residents; held 3/21/22. COMPLETE • FM simulation training to occur approx. 5/2022 IN PROCESS • Including breakdown of order set usage by inpatient and ED and sharing with provider stakeholders IN PROCESS

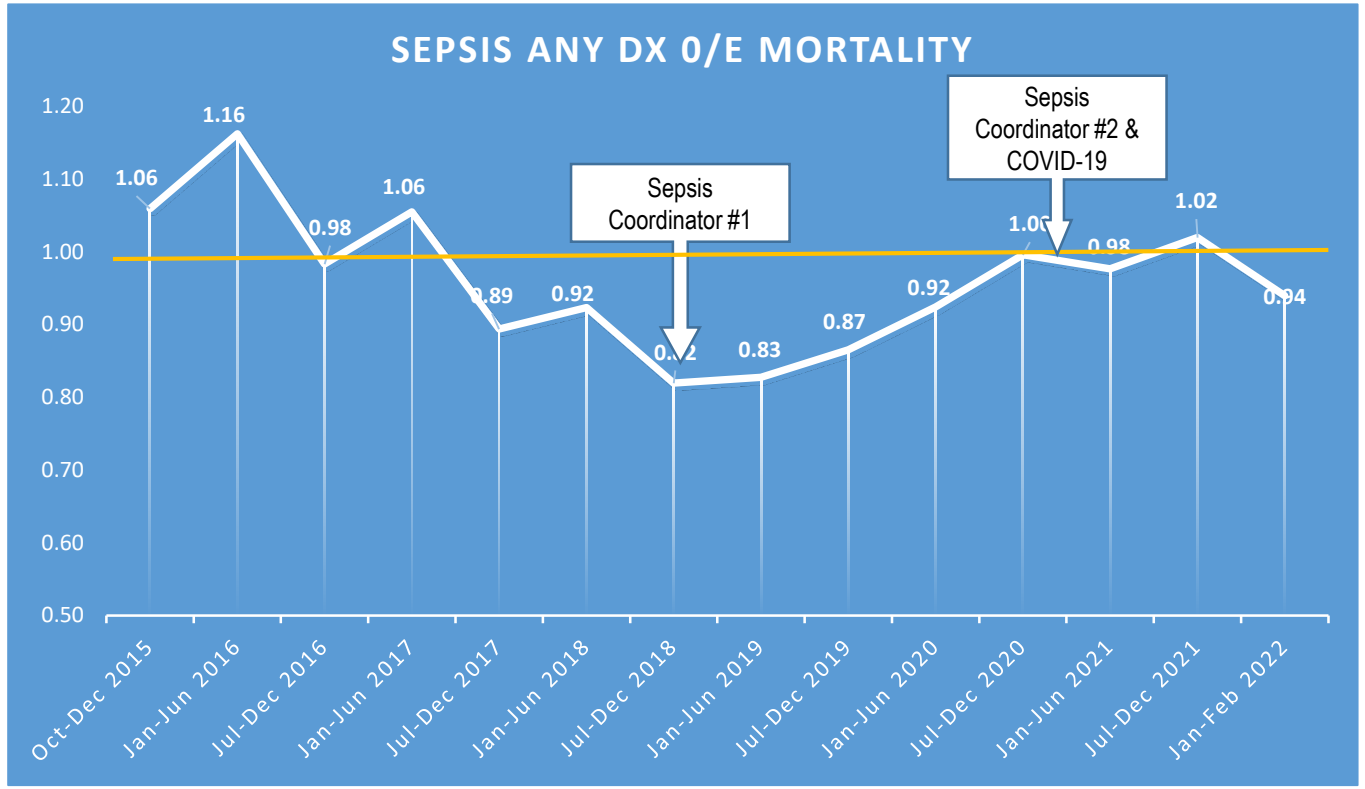
Root Causes & Improvement Strategies

Root Cause of SEP-1 Bundle Not Fully Implemented	Data	Potential QI Strategy
Fluids (none ordered or not enough) • Pt should not get more fluids • BP is normal, LA>2, still needs fluids • Not using order set - Staggering fluid resuscitation, see how pt responds and d/c fluids before needed amount is infused (pt doesn't need more and literature support is low grade)	96% SEP-1 abstracted patients meet fluid requirements (July – Oct 2021)	Brainstorm with team

Repeat lactic acid (LA) or blood culture (BC) not ordered
• Providers don't order repeat LA because the first result was not that high and perhaps expected due to pt's comorbid conditions
• Provider orders "routine" so lab is not completed timely; there is no need to use the SEP-1 power plans since all the elements were completed in ED
• Do not know the patient is septic
  • Patient not presenting in typical fashion, looking for other sources of infection
  • No sepsis alert for providers
  • RNs not executing provider notification process consistently
  • RRT not called for abnormal VS/labs (RRT initiates bundle as indicated)
  • No one is closely identifying sepsis (no sepsis coordinator patient oversight)
	94% SEP-1 abstracted patients meet BC bundle requirements (July – Oct 2021)
	
	89% SEP-1 abstracted patients meet repeat LA bundle requirements (July – Oct 2021)
		• Reflux order for any LA
		• Provider orders repeat LA "timed" or "STAT" (provider awareness)
		
		• Optimize alert and turn on for providers (see previous section)
		• Improve the RN provider notification process
		• 3rd Sepsis Coordinator

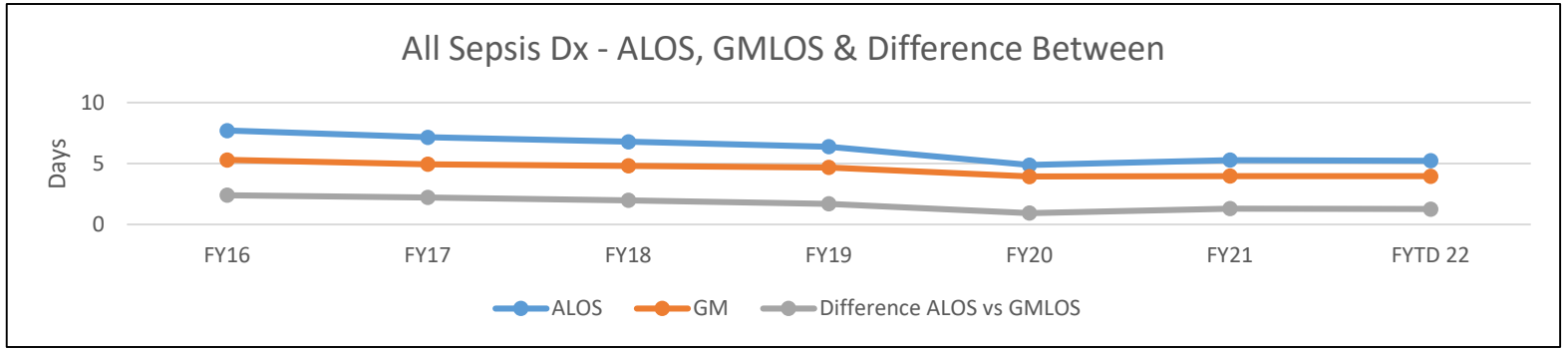
Patients sepsis not recognized because they present in atypical fashion • Order bundle elements a la cart as work up is completed • Sepsis left on the differential (not using dot phrase)	n/a	Education on dot phrase – included in simulation training. COMPLETE

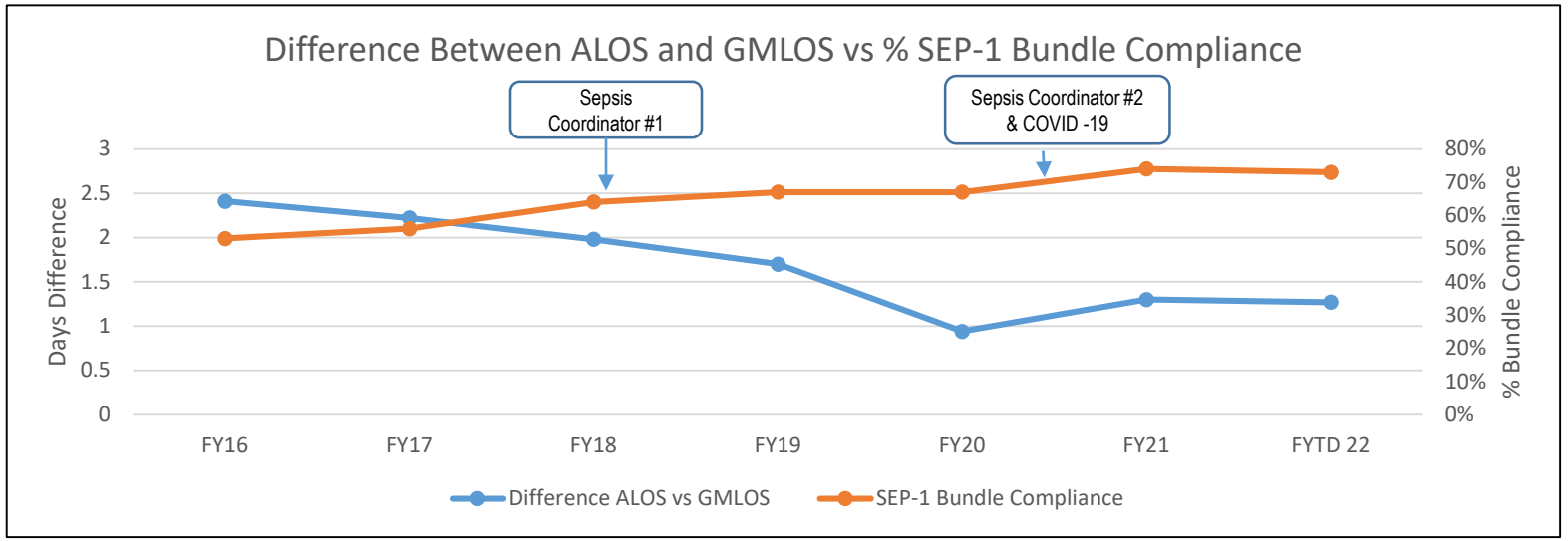
Sepsis Any Diagnosis – Outcomes Observed/Expected (o/e) Mortality



- Goal ≤ 1.0 which indicates that at least expected deaths do not exceed actual
- Significant change in how sepsis mortality is measured since o/e mortality includes septic patients with COVID-19 dx starting in 2020, but does risk adjust for COVID
- Sepsis o/e mortality is not a direct comparison pre and post pandemic
- Despite COVID-19 patient inclusion, o/e mortality remains at ≤ 1.0

Sepsis Any Diagnosis - Outcomes Length of Stay





- Consistent decrease in ALOS from FY16 through FYTD 22, with exception of first pandemic year FY20.
- 32% decrease in ALOS from FY16 (ALOS=7.71) to FYTD22 (ALOS=5.23)
- 47% Decrease in the difference between ALOS and GMLOS from FY16 (difference 2.41 days) to FYTD22 (difference 1.27 days).
- Bundle compliance increases, difference in ALOS vs GMLOS decreases
- COVID-19 cases removed in FY20-22. SEP-1 bundle does not apply to COVID-19 patients.

Sepsis QFT Actions & Next Steps

- 3 Improvement strategies in process:
    1. Executing enduring Emergency Medicine and Family Medicine enduring (annual) GME Sepsis simulation training, with goal of multidisciplinary involvement
    2. Optimizing sepsis alert to reduce alert fatigue (ie. suppressing alerts for circumstances where patient is already known to be septic)
    3. Evaluate and improve the RN provider notification process for sepsis alerts

Next Steps:

- Review root causes identified with complete stakeholder group for input and additions
- Review suggested improvement strategies with complete stakeholder group, and solicit input to expand list
- Prioritize and execute improvement strategies

Questions?

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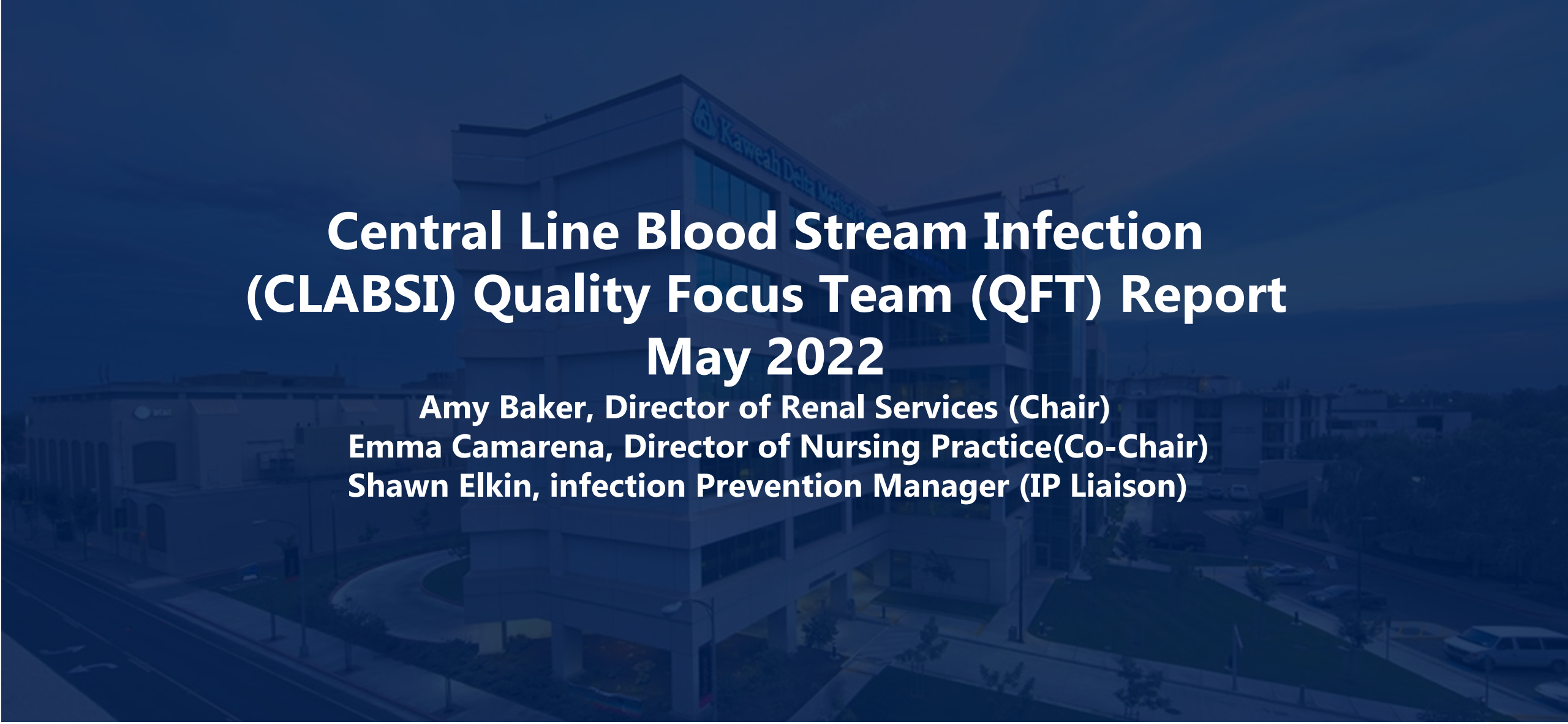


Central Line Blood Stream Infection (CLABSI) Quality Focus Team (QFT) Report May 2022

Amy Baker, Director of Renal Services (Chair)
Emma Camarena, Director of Nursing Practice(Co-Chair)
Shawn Elkin, infection Prevention Manager (IP Liaison)

Post Kaizen- Gemba Data

- **Continue to struggle with process measure of % of CL patient with appropriate and complete documentation**
- **Focusing on complete documentation education**

Measure Description	Benchmark/ Target	Mar-20	Qtr 2 2020	Qtr 3 2020	Qtr 4* 2020	Qtr 1* 2021	Qtr 2* 2021	Jul-21*	Aug-21*	Sep-21*	Oct-21*	Nov-21*	Dec-21*	Jan-22	Feb-22
OUTCOME MEASURES															
Number of CLABSI	0	0	6	5	3	3	2	0	4	3	3	1	1	1	0
FYTD SIR	≤0.596	0	1.84	1.28	0.78	0.7	0.38	0.000	1.374	1.57	1.6	1.37	1.26	1.18	1.05
PROCESS MEASURES CL Gemba Rounds															
% of pts with bath within 24 hrs	99%	n/a	80%	87%	96%(e)	96%	95%(e)	97%			96%	97%	97%	97%	95%
% of CL with valid rationale order	100%	n/a	94%	96%	98%(e)	98%	98%(e)	99%			99%	96%	96%	99%	95%
% of CL dressings clean, dry and intact	100%	n/a	93%	93%	96%(e)	95%	96%(e)	97%			97%	96%	98%	97%	99%
% of CL that had drsg change no > than 7 days	100%	n/a	92%	94%	98%(e)	99%	96%(e)	98%			99%	99%	99%	97%	99%
% of patients with proper placed gardiva patch	100%	n/a	86%	90%	94%(e)	94%	94%(e)	96%			97%	88%	97%	98%	96%
% of CL pts with app & complete documentation	100%	n/a	83%	87%	92%(e)	93%	93%(e)	94%			96%	96%	97%	96%	92%
# of Pt Central Line days rounded on	n/a	n/a	2791	3653	2278(e)	3256	2166(e)	1092			1240	1265	1047	990	834
*volume reduced due to reduced Gemba on weekends e=estimated	Equal or Better than Target					Within 5% of Target					Does not meet Target				

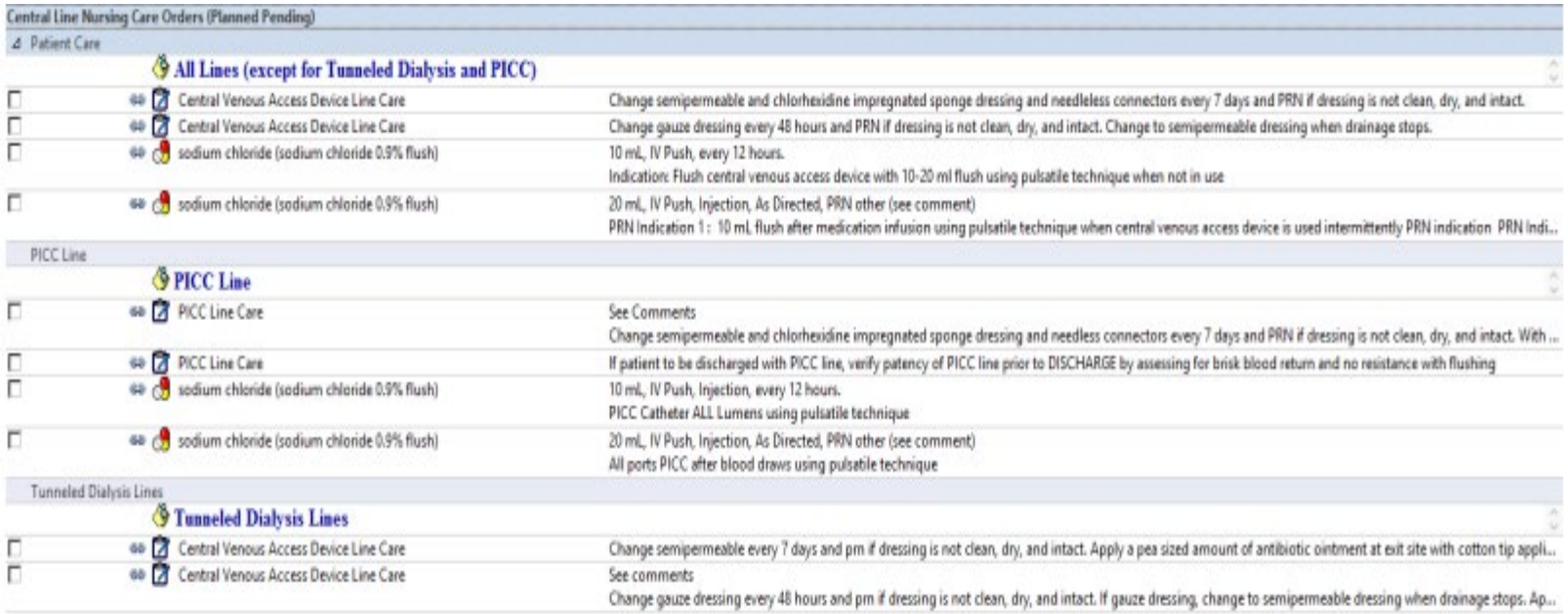
CLABSI QFT- Ongoing Meeting Objectives

- CLABSI Quality Focus Team continues to meet once a month
  - Each CLABSI case is reviewed with unit nurse manager and bedside nurses who provided care to patient
  - CLABSI's are reviewed monthly during Hospital Acquired Infection Case Reviews.
    - Nurse Manager attends to hear case review and see identified fallouts
  - Unit specific action plans are and reviewed based on any deficiencies
  - Unit RN's provide feedback from the bedside
  - Action plan is reviewed with units UBC's
- Additional projects are reviewed and implemented by CLABSI QFT

CLABSI QFT- Plans for Improvement

- Reviewed all Power Plans for Central Lines
  - Consolidated all orders to one Power Plan with three different line types listed. This will help the RN look for one order that includes all care for different types of central lines.

KD Hub Education flyer with new information sent out to all RN's



Central Line Nursing Care Orders (Planned Pending)

Patient Care

All Lines (except for Tunneled Dialysis and PICC)

Central Venous Access Device Line Care	Change semipermeable and chlorhexidine impregnated sponge dressing and needleless connectors every 7 days and PRN if dressing is not clean, dry, and intact.
Central Venous Access Device Line Care	Change gauze dressing every 48 hours and PRN if dressing is not clean, dry, and intact. Change to semipermeable dressing when drainage stops.
sodium chloride (sodium chloride 0.9% flush)	10 mL, IV Push, every 12 hours. Indication: Flush central venous access device with 10-20 ml flush using pulsatile technique when not in use
sodium chloride (sodium chloride 0.9% flush)	20 mL, IV Push, Injection, As Directed, PRN other (see comment) PRN Indication 1 : 10 mL flush after medication infusion using pulsatile technique when central venous access device is used intermittently PRN indication PRN Indi...

PICC Line

PICC Line

PICC Line Care	See Comments Change semipermeable and chlorhexidine impregnated sponge dressing and needless connectors every 7 days and PRN if dressing is not clean, dry, and intact. With ...
PICC Line Care	If patient to be discharged with PICC line, verify patency of PICC line prior to DISCHARGE by assessing for brisk blood return and no resistance with flushing
sodium chloride (sodium chloride 0.9% flush)	10 mL, IV Push, Injection, every 12 hours. PICC Catheter ALL Lumens using pulsatile technique
sodium chloride (sodium chloride 0.9% flush)	20 mL, IV Push, Injection, As Directed, PRN other (see comment) All ports PICC after blood draws using pulsatile technique

Tunneled Dialysis Lines

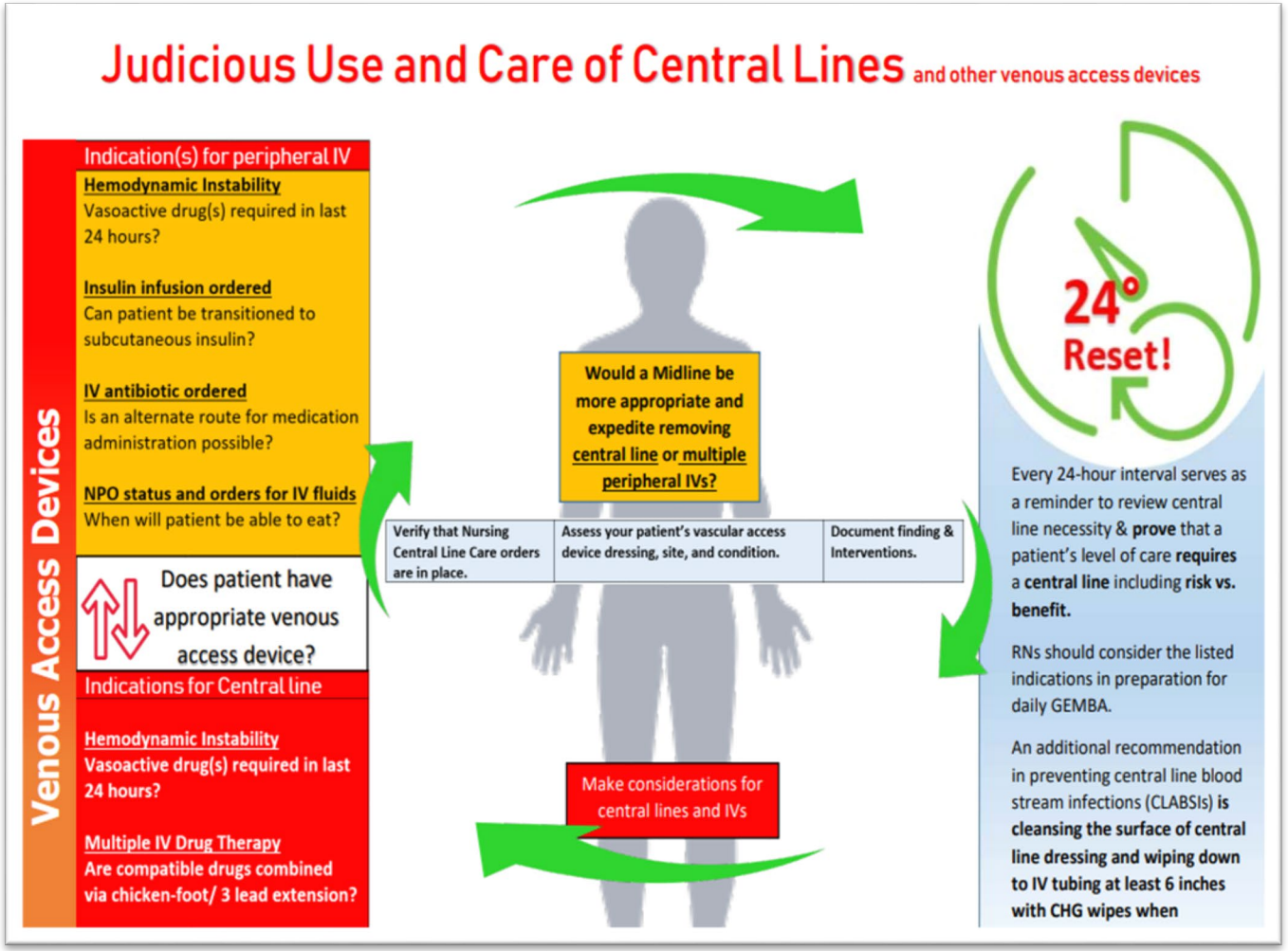
Tunneled Dialysis Lines

Central Venous Access Device Line Care	Change semipermeable every 7 days and pm if dressing is not clean, dry, and intact. Apply a pea sized amount of antibiotic ointment at exit site with cotton tip appli...
Central Venous Access Device Line Care	See comments Change gauze dressing every 48 hours and pm if dressing is not clean, dry, and intact. If gauze dressing, change to semipermeable dressing when drainage stops. Ap...

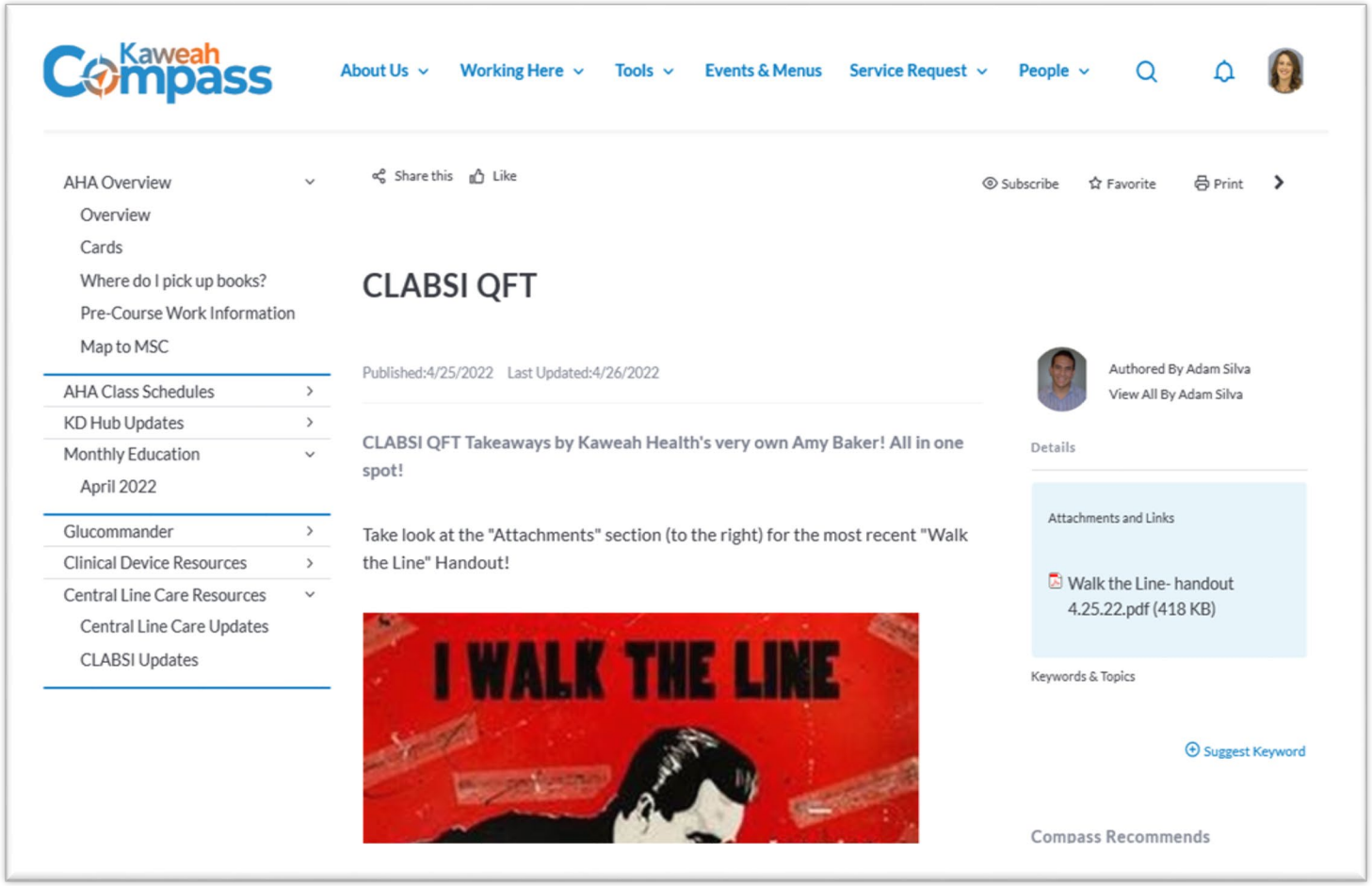
CLABSI QFT- Plans for Improvement

New educational material developed with our clinical educator assigned to the CLABSI QFT

- Clinical Educators will round with bedside RN's and discuss flyer
- Focusing on
  - making sure the patients have the appropriate venous access device
  - 24 hour reset- each day evaluate if central line is needed
  - Wiping central line dressing with chlorhexidine wipes while bathing patients



CLABSI QFT- Plans for Improvement



- Created a Central Line Care Resource tab under Clinical Education in KD Hub
  - All CLABSI educational flyers will be available here
  - Clabsi take away emails will be listed to review

End of Fiscal Year Performance

FY22 Clinical Quality Goals

	July-Feb 21 (Higher is Better)	FY22 Goal	FY21	FY21 Goal
SEP-1 (% Bundle Compliance)	73%	≥ 75%	74%	≥ 70%

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

Our Mission

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

Our Vision

To be your world-class healthcare choice, for life

Lower is Better	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual/ number expected)	FY22 Goal	FY21 FY20
CAUTI Catheter Associated Urinary Tract Infection COVID-19 PATIENTS	1 / 0	3 / 1	5 / 5	2 / 0	2 / 1	1 / 0	3 / 1	3 / 2	2 / 0				16 (12 predicted over 6 months)	1.22 0.67 Excluding COVID (Feb 2022)	≤0.676	0.54 1.12
CLABSI Central Line Associated Blood Stream Infection COVID-19 PATIENTS	0 / 0	4 / 3	3 / 3	3 / 0	1 / 1	1 / 0	1 / 0	0 / 0	2 / 0				11 (9.5 predicted over 6 months)	1.093 0.58 Excluding COVID	≤0.596	0.75 1.20
MRSA Methicillin-Resistant Staphylococcus Aureus COVID-19 PATIENTS	2 / 0	0 / 0	1 / 0	3 / 1	0 / 0	2 / 0	1 / 1	1 / 1	0 / 0				5 (3.6 predicted over 6 months	1.704 1.19 Excluding COVID	≤0.727	2.78 1.02

*based on July-Dec 2021 NHSN predicted

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

- Kaweah Health has had 15 events in FY22 exceeding the estimated goal
- If excluded COVID-19 patients, we would have 8 CLABSI's, which is less then our goal of 11.

Questions?

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Kaweah Health

Patient Throughput Initiative Update

Steering Committee

April 27th, 2022

THE CHARTIS GROUP

Kaweah Health
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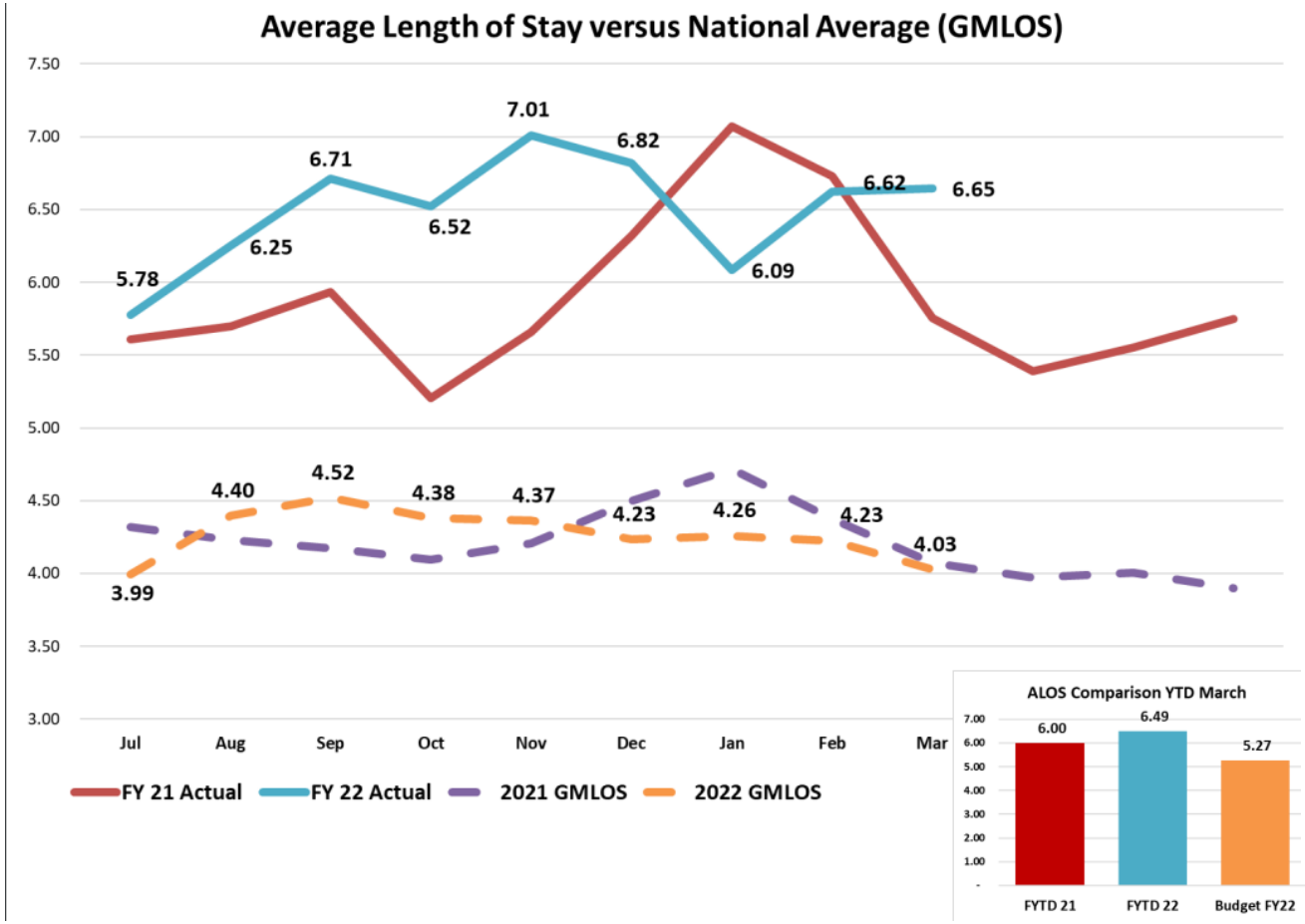
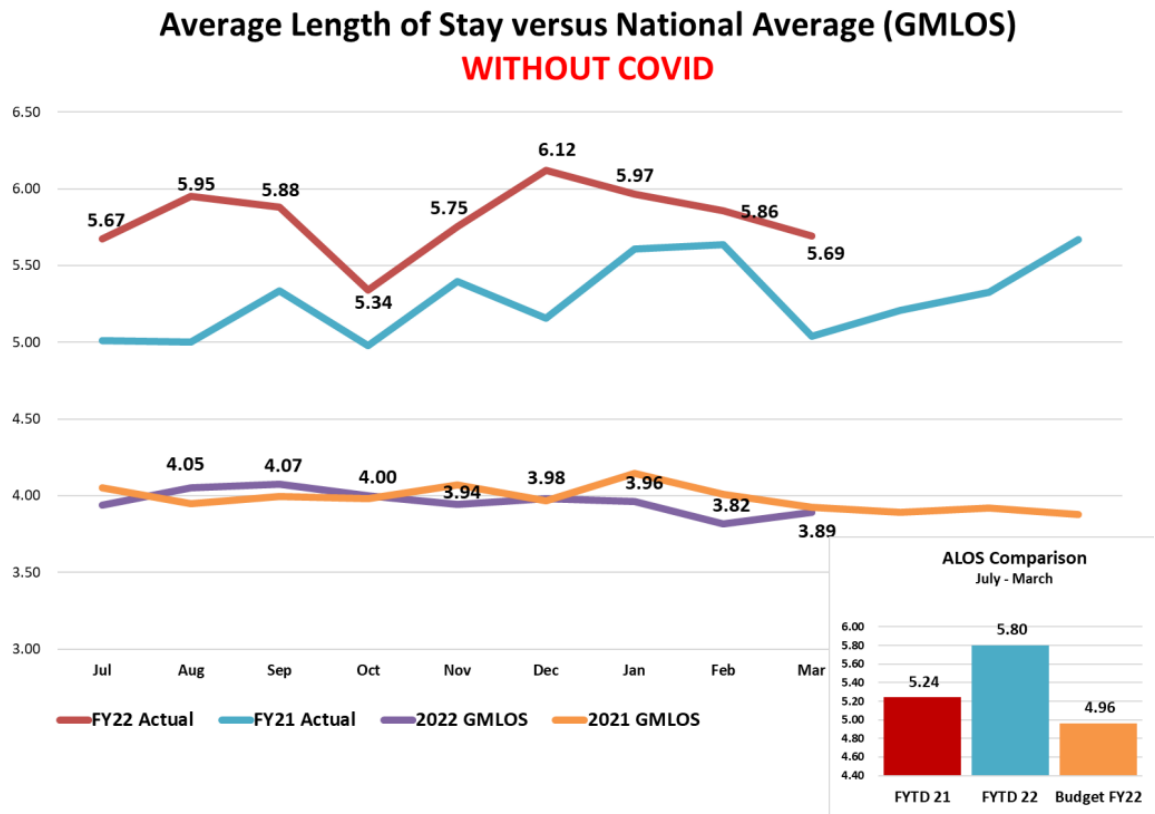
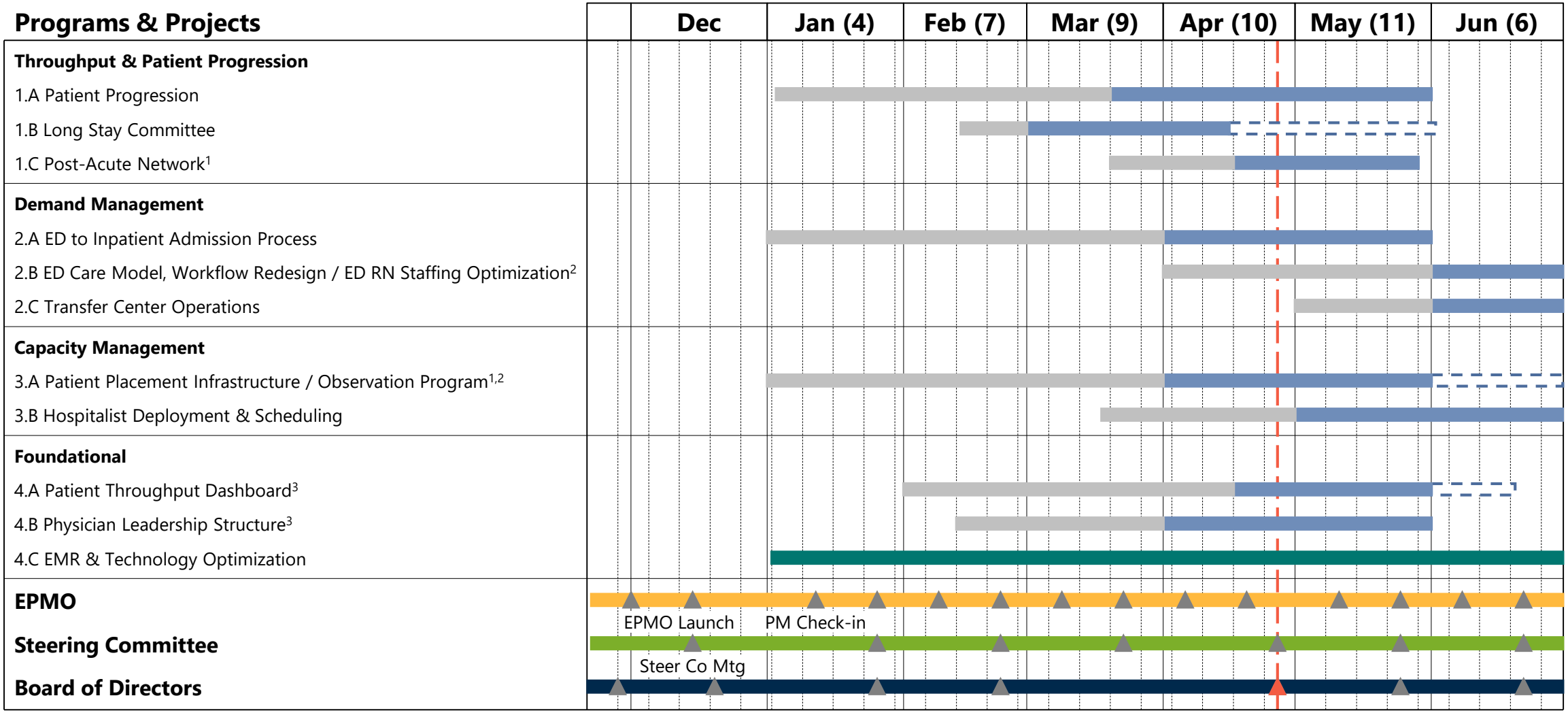
February 2022-Third Covid Patient Surge Contributes to Increase in ALOS
April & May 2022 have decrease in Covid patient population





Patient Throughput Initiatives Kicked Off With Rapid Improvement Teams January 2022

Implementation Timeline



Notes: [1]Accelerated project timeline, [2]Consolidated projects, [3]Accelerated project kickoff

Project Updates

Patient Progression

Project Kicked-off 1/11/22

Team Rounds Implementation Timeline

Key: ★ Meeting

Key Activities	Week 0	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10
Pre-Work & Education	★										
Launch											
Implementation & Training		★		★		★					
Feedback & Optimization								★		★	

Pre-Work & Education

- Learn team rounds goals, processes, and scripting through implementation packet
- Shadow 2N rounds to see team rounds in action
- Review PDD Methodology

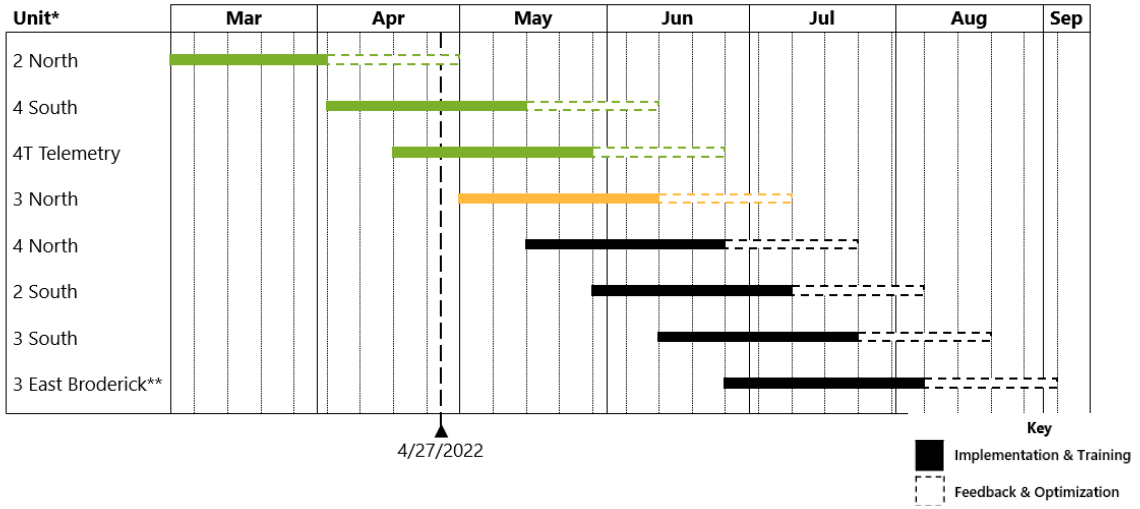
Launch, Implementation, & Training

- Launch Team Rounds
- Refine processes as team learns processes
- Solicit feedback from role-based champions
- Track progress to Discharge Before Noon goals

Feedback & Optimization

- Finalize processes based on learnings from initial launch
- Track progress to Discharge Before Noon goals

Updated Team Rounds Implementation Timeline



PROJECT OBJECTIVE

- **Problem** – Care team **roles and responsibilities are not aligned**; current huddles and rounds **do not meet the needs** of the care team members to achieve multidisciplinary approach to care facilitation and timely discharges
- **Solution** – **Leverage 2 North Team Rounds Pilot** to launch rounds across the hospital and **clearly delineate care team roles and responsibilities**

PROGRESS TO-DATE

- Finalized **updated implementation plan and timeline** for Team Rounds Pilot with 2 North team, nursing and physician leadership
- **Implemented 2N improvement initiatives** and **launched rounds** on **4 South and 4 Tower**
- Finalized **clearly delineated roles and responsibilities for Case Management / Social Work / Nursing**

NEXT STEPS

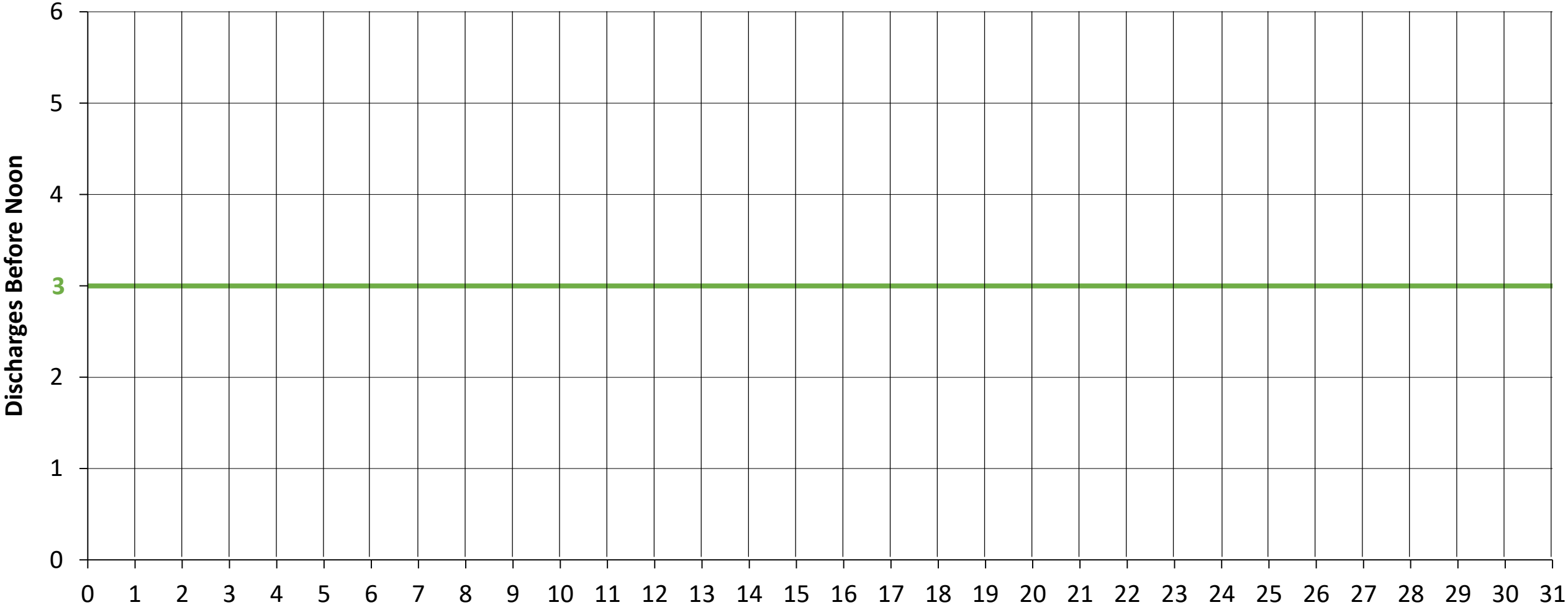
- **Launch team rounds** on remaining med / surg units
- **Implement hospital huddle** to proactively identify and resolve patient throughput issues
- Develop and implement **anticipated date of discharge (ADD) training**

ITEMS TO DISCUSS / SHARE

- **Addition of expected LOS / GMLOS to Cerner** patient banner bar
- Rollout of **Patient-Centered Discharges** unit-based dashboards

Patient-Centered Discharges

Month: _____



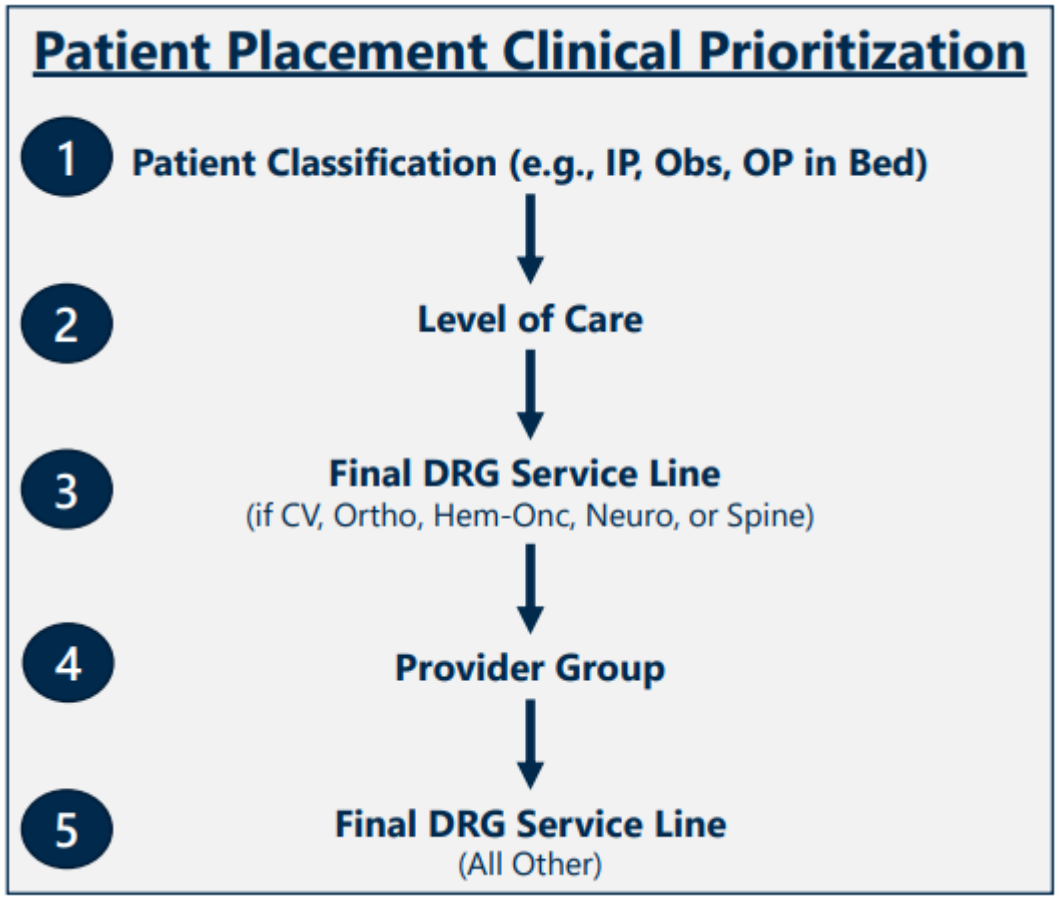
Goal	Definition
3 Patients Discharged Before Noon per Day	Patient left the unit and discharged from Cerner before noon

Last Date Updated:

_____

Patient Placement Infrastructure

Project Kicked-off 2/10/22



*Current State does not account for patients who are Med/Surg in an ICU Bed/CCU Bed (ADC 3.9)
Source: Kaweah Census Data 01/01/21-12/31/21, includes BH, Newborn, Mother, and Baby

PROJECT OBJECTIVE

- **Problem** – Patients of similar clinical cohorts and providers are **spread across the hospital** contributing to inefficient care facilitation
- **Solution** – Design an **optimized configuration** based on clinical and provider priorities to enable enhanced patient progression

PROGRESS TO-DATE

- **Finalized patient scenario** to gather feedback on proposed cohort and placement guidelines
- **Drafted patient placement guideline, including primary and secondary units** for placement in cases of limited capacity
- Reviewed **draft patient placement guideline** with project team

NEXT STEPS

- **Finalize patient placement guideline** with input from a variety of key stakeholders (Nursing Directors, Physician Stakeholders, Steering Committee)
- **Develop implementation plan**, including staff education and communication

ITEMS TO DISCUSS / SHARE

- **Key stakeholder review** draft patient placement guidelines
- Communication, education and **implementation planning**

Long Stay Committee

3/8/22 Weekly Meeting Go-Live

Identified LSC Sub-Groups

Sub-Group	Action Items
Reporting Tool – TRT Changes	• Formalize reporting tool to capture and report on barriers • Have CMs trial entering data on all patients in TRT vs email handoffs • Impact could be felt beyond LSC • Complex team to start utilizing the TRT tool to communicate action plans for their patients

Education	• Research and develop options/protocols for Case Management
	• Develop standardized training
	• Develop early intervention strategies to key elements that prevent discharge
	  • i.e. psych medication use and SNF reluctance
	  • Medi-Cal Pending
	  • Restraints/Sitters
	• Identify and share other best practices

Identified LSC Key Barriers to Address

Barrier	Identified Issue
SNF Placement	• Behavior issues that cause SNFs to not accept • Medi-Cal pending for post-acute needs
Complex Patients	• Being followed by complex team • Challenges are social issues (behavior, placement and funding)

POST-GO-LIVE OPTIMIZATION

- Continue to streamline meeting logistics, Case Manager report out on all pts 10+ days, and scripting is focused on **barriers to discharge.**
- Developed education regarding LSC member roles and **feedback loop for improvements** to CMs

STRATEGIC TAKEAWAYS *(preliminary)*

- Develop task lists and assign to various committee members for follow up
- Optimize **financial counseling** / application facilitation processes for pending Medi-Cal cases
- Develop ongoing **pro-active relationships with skilled nursing facility** (SNF) leadership in community
- Engage **behavioral health and psychiatry**
- Explore **alternative** resources

NEXT STEPS

- Continue to **refine Committee processes** and identify immediate follow-up items and strategic takeaways

ITEMS TO DISCUSS / SHARE

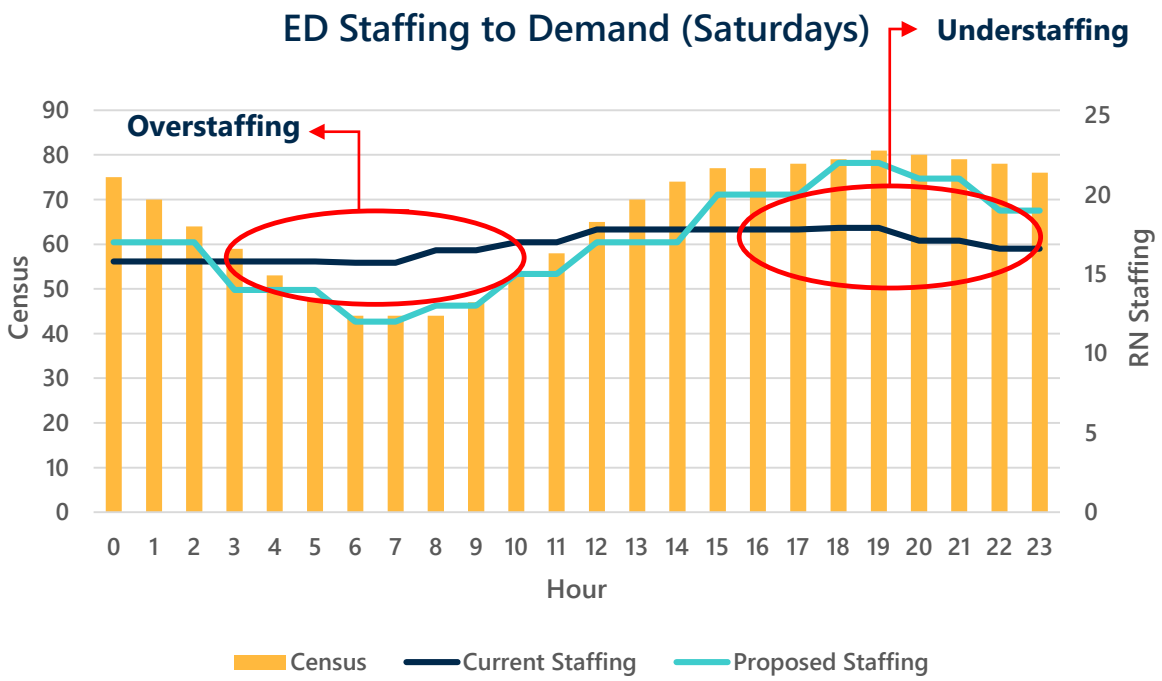
- **Management of behavioral patients** with complex placement issues

ED RN Staffing Optimization

Project Kicked-off 3/14/22

ED Census by Day of Week and Hour of Day

	12AM	1AM	2AM	3AM	4AM	5AM	6AM	7AM	8AM	9AM	10AM	11AM	12PM	1PM	2PM	3PM	4PM	5PM	6PM	7PM	8PM	9PM	10PM	11PM
Sun	72	68	64	59	54	51	47	46	47	50	55	60	66	71	75	78	78	79	78	79	78	77	77	76
Mon	73	71	67	63	58	55	52	52	53	58	65	72	79	86	92	94	95	98	99	100	101	99	97	93
Tue	88	83	75	70	66	59	56	55	56	59	65	72	79	84	88	90	91	92	93	95	95	92	88	85
Wed	79	74	70	62	58	54	50	49	50	54	60	67	73	79	82	85	86	87	88	89	88	87	84	80
Thu	76	71	66	61	55	51	47	47	48	54	62	69	76	82	86	87	88	90	91	93	91	88	85	81
Fri	75	68	63	57	52	48	44	44	46	51	56	64	72	78	83	86	88	90	91	93	91	87	83	80
Sat	75	70	64	59	53	48	44	44	44	47	53	58	65	70	74	77	77	78	79	81	80	79	78	76



PROJECT OBJECTIVE

- **Problem** – ED RN staffing is constrained due to numerous open positions and a **lack of staffing to demand**
- **Solution** – **Reconfigure the staffing schedule** to optimally staff to demand by day of week and hour of day

PROGRESS TO-DATE

- Developed **updated schedule that aligns closely to demand**
- **Identified targeted hiring of vacant positions** to shifts with greatest variance
- **Forecasted future demand patterns** based on ED length of stay goals

NEXT STEPS

- **Utilize staffing software Clairvia** to optimize adherence to optimal schedule
- **Balance staffing schedules variably based on day of the week demand,** rather than consistent scheduling across the week
- **Emphasize and implement mid shifts** to cover 12P-12A more effectively with arrival patterns

ITEMS TO DISCUSS / SHARE

- Implementation of **30-60-90-day plan**

Project-Level Metrics

Unit-Level Performance

Discharges Before Noon (DBN)

Key
<10%
10%-14%
>14%

There is still significant opportunity to meet 35% DBN goal. However, for CY22 Q1, 2 North improved by 1.6% (or 18% over CY21). The Patient Progression team is rolling out Patient-Centered Discharges unit-based dashboards to the med / surg units to support ongoing improvement.

Type	Unit	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	CY21	CY22 Q1	Avg. DC/ Month
Med / Surg	1 East	15.9%	23.8%	16.7%	33.3%	55.6%	33.3%	18.2%	47.4%	13.9%	23.1%	38.5%	33.3%	21.2%	26.0%	10.7%	28.1%	21.5%	35
	2 North	12.2%	9.7%	6.5%	14.8%	6.0%	5.3%	5.6%	9.3%	5.5%	6.8%	12.4%	10.3%	7.7%	11.5%	12.4%	8.7%	10.3%	173
	2 South	9.8%	8.6%	9.1%	7.1%	8.9%	5.2%	9.4%	5.8%	5.8%	8.5%	7.1%	11.9%	11.7%	9.5%	6.7%	8.1%	9.4%	112
	3 North	10.7%	14.3%	10.5%	14.2%	13.0%	12.2%	13.2%	10.0%	4.4%	6.8%	10.4%	18.4%	9.2%	9.9%	13.5%	11.8%	11.0%	171
	3 South	16.3%	15.5%	15.6%	14.9%	13.1%	12.8%	12.2%	10.7%	12.6%	9.7%	10.4%	15.4%	11.5%	15.8%	6.6%	13.3%	11.1%	172
	4 North	8.0%	6.5%	4.0%	5.6%	9.4%	9.8%	4.9%	6.2%	4.7%	9.6%	7.6%	4.6%	7.8%	6.3%	3.6%	6.7%	5.6%	130
	4 South	6.1%	12.7%	8.4%	6.6%	8.5%	7.6%	8.3%	9.1%	11.9%	9.1%	2.4%	17.2%	4.2%	8.3%	6.9%	9.0%	6.3%	154
	4T Tele	5.3%	9.8%	7.1%	7.4%	9.6%	7.4%	7.3%	6.5%	6.3%	4.6%	7.0%	6.6%	6.6%	5.2%	6.3%	7.1%	6.1%	130
	BP	22.1%	10.3%	18.9%	10.7%	16.9%	17.2%	13.3%	18.8%	8.5%	15.1%	23.4%	23.5%	18.1%	22.6%	20.4%	16.6%	20.3%	73
	Peds	19.1%	3.0%	0.0%	N/A	27.8%	13.0%	33.3%	16.7%	16.7%	25.0%	0.0%	N/A	0.0%	12.5%	60.0%	15.6%	16.2%	16
ICU	3W ICCU	35.7%	16.1%	18.2%	33.3%	9.7%	14.3%	10.7%	14.3%	21.1%	8.7%	17.1%	12.9%	18.9%	35.3%	10.8%	17.9%	21.3%	30
	ICCU	27.3%	17.3%	7.8%	13.6%	9.9%	9.0%	12.0%	19.0%	25.5%	20.4%	13.2%	15.6%	17.5%	9.1%	21.3%	15.4%	16.2%	58
	CVICU	23.3%	15.4%	41.7%	33.3%	15.8%	9.1%	15.8%	19.2%	20.0%	10.7%	23.7%	24.3%	35.9%	13.5%	10.0%	20.6%	20.8%	27
	ICU	25.6%	34.2%	18.5%	33.3%	12.9%	34.6%	22.9%	16.7%	31.7%	40.5%	37.8%	29.7%	24.3%	22.9%	27.3%	28.6%	24.8%	34
Overall		13.3%	12.5%	10.3%	12.1%	11.0%	10.3%	9.9%	11.4%	9.9%	10.8%	11.8%	14.9%	11.6%	12.7%	10.7%	11.5%	11.6%	1,328

Unit-Level Performance

Observed-to-Expected Length of Stay (O/E LOS)

Key
>1.7
1.32 -1.7
<1.32

Compared CY21 to CY22 Q1, O/E LOS has improved on 2 South and 3 North, which are both close to goal of 1.32. Chartis team will analyze further, and Patient Progression project team will debrief and identify any lessons learned that can be applied across other med / surg units.

Type	Unit	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	CY21	CY22 Q1	Avg. DC/ Month
Med / Surg	1 East	0.72	0.55	0.30	0.37	0.35	0.34	0.36	0.36	0.39	0.37	0.35	0.34	0.36	0.37	0.34	**0.43**	**0.36**	**35**
	2 North	1.43	1.37	1.31	1.17	1.56	1.34	1.51	1.68	1.60	1.50	1.66	1.71	1.69	1.72	1.82	**1.49**	**1.74**	**173**
	2 South	1.72	1.61	1.80	1.24	1.17	1.30	1.26	1.22	1.31	1.22	1.62	1.58	1.23	1.36	1.59	**1.43**	**1.38**	**112**
	3 North	1.36	1.41	1.16	1.41	1.41	1.56	1.55	1.30	1.41	2.05	1.64	1.69	1.14	1.38	1.68	**1.47**	**1.39**	**171**
	3 South	1.62	1.83	1.68	1.60	1.75	1.82	1.42	1.83	1.71	1.75	1.95	1.91	1.91	2.02	1.88	**1.73**	**1.93**	**172**
	4 North	1.37	1.51	1.50	1.54	1.38	1.27	1.55	1.36	1.76	1.59	1.93	1.66	1.67	2.01	1.85	**1.53**	**1.84**	**130**
	4 South	1.60	1.70	1.81	1.59	1.65	1.62	1.67	1.68	1.64	2.10	1.99	2.09	2.16	1.98	2.03	**1.75**	**2.06**	**154**
	4T Tele	1.37	1.41	1.24	1.33	1.35	1.47	1.71	1.50	1.73	1.18	1.37	1.55	1.51	1.71	1.66	**1.42**	**1.62**	**130**
	BP	0.98	0.98	0.93	0.80	0.80	1.07	0.88	1.01	1.18	1.03	0.88	1.01	1.26	1.06	0.95	**0.97**	**1.08**	**73**
	Peds	1.17	0.79	0.79	N/A	1.20	0.95	0.44	1.44	1.11	0.87	0.63	N/A	1.00	1.18	1.09	**1.05**	**1.13**	**16**
ICU	3W ICCU	1.81	2.50	2.00	1.17	1.68	1.64	1.57	1.85	1.20	1.56	1.64	2.00	1.13	1.75	1.14	**1.72**	**1.35**	**30**
	ICCU	1.90	2.11	1.00	1.23	0.94	1.18	1.09	1.07	1.64	1.35	1.51	1.57	1.37	1.47	1.62	**1.39**	**1.50**	**58**
	CVICU	0.89	0.93	0.76	1.23	1.32	0.99	0.96	1.09	0.97	1.33	1.75	1.77	1.60	1.18	1.25	**1.23**	**1.37**	**27**
	ICU	1.72	1.60	1.34	1.19	0.71	2.29	1.33	1.05	1.58	1.64	1.92	1.28	1.46	1.35	1.69	**1.52**	**1.48**	**34**
Overall		**1.47**	**1.54**	**1.42**	**1.37**	**1.41**	**1.48**	**1.47**	**1.43**	**1.52**	**1.52**	**1.67**	**1.66**	**1.49**	**1.56**	**1.67**	**1.50**	**1.57**	**1,328**

Performance Scorecard

Draft Performance Scorecard

Leading Performance Metrics – Inpatient & Observation

Metric	Patient Type	Definition	Goal	Current Performance Compared to Baseline: Jan - Nov '21 Baseline (Monthly Average or Median)	Dec '21	Jan '22	Feb '22	Mar '22	Apr '22
Observation Average Length of Stay (Obs ALOS) *(Lower is better)*	**Overall**	Average length of stay (hours) for observation patients	**38.0**	**TBD**	TBD	TBD	TBD	TBD	
Inpatient Average Length of Stay (IP ALOS) *(Lower is better)*	**Overall**	Average length of stay (days) for inpatient discharges	**5.64**	**6.31**	7.03	6.11	6.54	6.59	
	Non-COVID		**N/A**	**5.62**	6.31	5.71	5.78	5.72	
	COVID		**N/A**	**10.63**	13.77	6.27	9.19	20.32	
Inpatient Observed-to-Expected Length of Stay *(Lower is better)*	**Overall**	ALOS / geometric mean length of stay for inpatient discharges	**1.32**	**1.48**	1.65	1.48	1.56	1.67*	
% of Discharges Before 12 PM *(Higher is better)*	**Overall**	% of inpatients discharged before 12 PM	**35%**	**11.5%**	15.1%	11.9%	12.7%	10.9%	
Surgical Backfill Volume *(Higher is better)*	**Overall**	Incremental inpatient elective surgical cases over baseline; pending established baseline	**TBD**	**TBD**	TBD	TBD	TBD	TBD	
Discharges	**Overall**	Count of IP & observation discharges	**N/A**	**1,938**	1,760	1,694	1,594	1,829	
	Inpatient-Non-COVID	Count of non-COVID IP discharges	**N/A**	**1,264**	1,218	1,092	984	1,280	
	Inpatient-COVID	Count of COVID IP discharges	**N/A**	**197**	130	299	282	81	
	Observation	Count of observation discharges	**N/A**	**TBD**	TBD	TBD	TBD	TBD	

***O/E LOS to be updated to include cases with missing DRG when available.**

Source: Encounter Data Excludes: Mother/Baby, Behavioral Health, and Pediatrics

Draft Performance Scorecard

Leading Performance Metrics – Emergency Department

				Current Performance Compared to Baseline					
Metric	**Patient Type**	**Definition**	**Goal**	**Jan - Nov '21 Baseline (Monthly Average or Median)**	**Dec '21**	**Jan '22**	**Feb '22**	**Mar '22**	**Apr '22**
ED Boarding Time *(Lower is better)*	**Overall**	Median time (minutes) for admission order written to check out for inpatients and observation patients	**286**	**336**	727	998	1,085	378	
	Inpatients	Median time (minutes) for admission order written to check out for admitted patients	**287**	**338**	721	983	1,070	376	
	Observation Patients	Median time (minutes) for admission order written to check out for observation patients	**259**	**304**	1,110	1,284	1,295	444	
ED Admit Hold Volume *(Lower is better)*	**Overall**	Count of patients (volume) with ED boarding time	**N/A**	**1,028**	1,185	1,245	1,139	1,153	
	Overall >4 Hours	Count of patients (volume) with ED boarding time ≥ 4 hours	**N/A**	**640**	902	1,061	951	756	
ED Average Length of Stay (ED ALOS) *(Lower is better)*	**Overall**	Median ED length of stay (minutes) for admitted and discharged patients	**N/A**	**347**	352	362	422	359	
	Discharged Patients	Median ED length of stay (minutes) for discharged patients	**214**	**268**	264	276	310	277	
	Inpatients	Median ED length of stay (minutes) for admitted inpatients	**612**	**720**	1,127	1,449	1,538	739	
	Observation Patients	Median ED length of stay (minutes) for observation patients	**577**	**679**	1,272	1,524	1,569	839	
ED Visits	**Overall**	Count of ED visits	**N/A**	**5,596**	5,339	5,975	4,956	5,520	
	Discharged	Count of ED visits for discharged patients	**N/A**	**3,998**	3,801	4,431	3,546	3,971	
	Inpatients	Count of ED Visits for admitted patients	**N/A**	**1,216**	1,229	1,312	1,129	1,172	
	Observation Patients	Count of ED Visits for observation patients	**N/A**	**380**	313	231	278	377	

Source: ED Encounter Data Excludes: Mother/Baby, Behavioral Health, and Pediatrics

What's Planned for May

1. Finalize Patient Placement Infrastructure project recommendations
2. Continue ED RN Staffing Optimization / Care Model Redesign
3. Launch Transfer Center Operations project
4. Collaborate with project teams to develop transition plans

May 2022

Surgical Quality Improvement Program

Brian Piearcy
Director of Surgical Services

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: Surgery **ProStaff Report:** May 10, 2022

Measure Objective/Goal:

1. **First case delays:** Goal is 650 min in delays a month.
2. **Assigned Block Utilization:** 60%
3. **Overall Block Utilization:** 63%
4. **Turnover: Surgical Services Goal:** 28 minutes *National Average: 30 min*
5. **Non-Operative Time "Surgeon Wait Time":** 70 minutes

Date range of data evaluated:

1. **April 2021- April 2022**

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

1. **First Case Delays:**
2. **Assigned Block Utilization:**
3. **Overall OR Utilization:**
4. **Turnover:**
5. **Non-Operative Time "Surgeon Wait Time":**

Surgical Services Dashboard

Overall Surgical Services Throughput Initiatives	Goal	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22
First Case Delay Minutes in O.R.	650	719	695	830	764	1095	749	771	652	787	729	660	796	703
Block Utilization	60%	52%	54%	53%	44%	48%	39%	42%	46%	45%	38%	43%	49%	56%
OR Utilization	63%	48%	59%	55%	55%	49%	52%	57%	61%	55%	49%	54%	58%	56%
O.R. Efficiency	**Goal**	**Minutes**												
Patient In to Surgery Start	30	32	32	34	33	33	31	33	33	32	33	33	32	33
Surgery End to Patient Out	10	11	12	12	11	12	11	11	12	10	12	11	12	10
Turnover Data	28	30	27	29	30	32	29	29	28	27	31	31	29	29
Surgeon (Non-Op) Wait Time	70	73	73	79	77	77	71	75	75	73	79	80	75	74

Better than target
Within 10% of target
Does not meet target

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. **First Case Delays:**
    a. Educate staff in pre-op and intra-op on proper delay codes.
    b. Delay codes will be reported to the OR Governance Committee, Department of Surgery, and Department of Anesthesia.
    c. Data will be displayed on the electronic communication board in the surgeons lounge for transparency.
    d. Trends with specific surgeons will be addressed by the OR Governance Committee representatives. Trends with specific surgeons could affect their allotted block time.
        i. The top (3) three surgeons who have trends in the last 6 months have met with the O.R. Governance. They did not show up on the December data. We have 3 new surgeons who are now the top 3 who the OR Governance will be meeting.
    e. Dr. Wiseman and Brian met with ISS to discuss the Power chart Touch app. This will provide the surgeons an easy application to update their 24 hr. updates.
    f. First case delays due to anesthesia are reported to the Medical directors and reported at the Department of Anesthesia. They have given education to the all providers.

2. **Block Utilization:**
    a. There is a need for block time in the Operating Room and there are underutilized block times surgeons currently have.
    b. Utilization is defined as total allotted minutes for a specific surgeon compared to the total minutes used.
    c. The goal is to decrease wasted OR utilization time and give time to current surgeons who need more time and to new surgeons who are entering the district.
    d. The O.R. Governance has created a formalized way to track utilization time.
        i. Formula: Surgery minutes + Turnover minutes / Block minutes – Released block minutes = Block Utilization.
    e. Letters are sent to the surgeons regarding their utilization data. If they are below 50% utilization, they have 1 quarter to increase their volume to maintain or it will be released back to the department.
        i. March 20' was the first round of restructuring and removing block.
        ii. We assigned block to eight surgeons who did not have time and to surgeons who needed more time.
        iii. We have given 10 (ten surgeons) time. *Dr. Daniels, Dr. Ford, Dr. Kim, Dr. Patel, Dr. Machado, Dr. Roos, Dr. Ota, Dr. Hendy, Dr. Tan, and Dr. Livermore.*
        iv. January 2022, made nine (9) block adjustments to keep up with the surgeons who needed more block time.
    f. O.R. Governance and Department of Surgery have approved block to release 1 week in advance instead of 72 hours in advance.
        i. Provides more time for other surgeons looking for block to schedule.
    g. O.R. Governance and Department of Surgery approved for schedules to be finalized 48° in advance. This created more efficiency on the operations side.
    h. November 2, 2020 started staggering surgeon first case start times. This will provide surgeons with more block time to add more cases.
        ii. Goal is to have 2-3 surgeons a day be in the room at 0700 instead of 0730.
        iii. Helps with anesthesia residency program.
        iv. As of December 2020, we have (7) seven surgeons who start block at 0700.
    i. This physical year we have had to close down rooms periodically for construction, new lighting project, new floor project, and a new bed for Urology OPSHPD project.

3. **Turnover:** Turnover is when a patient leaves the room and the next patient rolls into the room.
    a. Standardize all of the supply and storage rooms within the department.

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

i. This has been an obstacle due to a lot of construction within the area.
ii. Once construction is complete, the team has a plan to re-organize the storage rooms.

b. Posted (3) three STAS to only focus on supply in the surgery area. This will ensure things are stocked and in the right place.
c. Completed an STA boot camp. The boot camp reinforced the importance of being efficient, education on equipment, and room set-ups.
d. Created a staging area in the department so that surgical technicians would not have to take their dirty cart to the Acequia sterile processing. An aide from sterile processing acts as a runner to take things to SPD and to surgery. This allows the surgical tech to be present and assist with turnover.
e. Barriers:
    i. OR Room closures throughout the department due to construction. Ongoing construction limits the number of rooms available and affects the normal pathway for patients, staff, and equipment.
    ii. A/C issues, OR floor replacement, PACU floor replacement, water leaks, Operating Room light replacements, and Urology Bed replacement.
    iii. The remaining projects:
        1. OR Room light replacements: OR 1 and OR 6 are large projects. We will be taking 1 room down at a time and each project will take 2-3 months to complete. Start date, TBD due to OSHPD.
        2. Urology Bed Replacement: Completion date is end of February. This room has been closed since June 21'.
    iv. Acequia Wing SPD construction: Started October 25, 2021.
        1. Plan is to install new washing sinks, a new cart washer, a new instrument washer, and new flooring in decontam.
        2. SPD decontam had to move to the Mineral King old SPD until the project is completed.
        3. The project splits the department in half, all of the washing in the Mineral King old SPD and all the sterilizing in Acequia Wing SPD.
        4. Slows down some of the sterilizing processes due to logistics.
        5. The old Mineral King SPD is a storage room for surgery. Surgery has lost this room until the project is complete. The storage room used to be used as a staging area for case carts and for supply for specialty cases.

4. **Non-Operative "Surgeon Wait" Time: Time when a patient leaves the room to when the surgeon makes an incision on the next case.** *Non-Operative time does not have a national average and we surgical services has set it as a goal to increase volume.*
    a. Anesthesia and OR Staffing is currently challenging and we are in the middle of hiring.
    b. Supply and equipment storage room locations have been an obstacle. This will be fixed once all projects are completed. Date is TBA.
    c. Operating room closures due to construction create limitations to having the ability to flip a surgeon out of one room and put into a flip room.
    d. STA Boot Camp was completed and the team has started staging the next cases equipment outside the room.
    e. Barriers:
        i. O.R. Room closures throughout the department due to construction. Ongoing construction limits the number of rooms available and impacts the normal pathway for patients, staff, and equipment.
        ii. A/C issues, OR floor replacement, PACU floor replacement, water leaks, Operating Room light replacements, and Urology Bed replacement.
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5. Next Steps/Recommendations/Outcomes:

a. **First Case Delays:**

i. Current delay codes up in the EMR. *Completed*
ii. Educate staff on proper coding. *Ongoing education*
iii. Present at the above committees for transparency. *Ongoing*
iv. Display First case start (pt. in the room) broken down into minutes. *Ongoing*
v. Hold surgeons accountable for delaying first cases. *Ongoing*
vi. Anesthesia accountability. *In process*
vii. Budget an automated system for "in" time tracking, automated communication, and provides up to date data. The system is called **Tagnos**

b. **Block Utilization:**

I. Complete data extraction, present the data to the OR Governance Committee, and have a letter sent to individual surgeons who have underutilization. *Ongoing*
II. Give the surgeons who have underutilized time 1 quarter to increase their volume. *Every quarter*
III. After the quarter, remove time currently allotted to surgeons who have not met criteria and give the new time to surgeons who need more block and to new surgeons.
i. This is being watched but surgeons are not being held accountable due to restricting admissions related to census and COVID.

iV. Budget an automated system for "in" time tracking, automated communication, and provides up to date data. The system is called **Tagnos.**

6. Turnover:

a. Completed a Surgical Team Assistant Boot camp with the help of quality department
b. Budgeted for an additional 3 STAs. 1 will be for the day to day operations and 2 will be for supply management. The focus of the supply is to ensure it is always there and stock supply in between cases. This will help with staff having appropriate supply in all areas. Ongoing
d. Budget an automated system for "in" time tracking, automated communication, and provides up to date data. The system is called **Tagnos**

7. Non-Operative "Surgeon Wait" Time.

a. Working with ISS to help with surgical services data. We need to be able to break the data into specialty. Larger cases will automatically have longer non-operative times due to room set-up.
b. Once the data is broken down, we can focus on the specialties that have longer non-op times.

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

c. Budgeting to have 1.4 RN FTE per room. This will provide support when needed to the rooms that are larger with longer non-op times.
d. Budget an automated system for "in" time tracking, automated communication, and provides up to date data. The system is called **Tagnos**.

e. Decreasing turnover, decreasing surgery end time to patient out, and decreasing the amount of time from when the patient enters the room to the surgery start time, will allow us to reach the Non-operative time goal.

Submitted by Name:
Brian Piearcy, Director Surgical Services

Date Submitted:
May 10, 2022

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

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Kaweah Health

Clinical Quality Goal Update

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

May 2022

FY22 Clinical Quality Goals

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

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

Our Mission

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

Our Vision

To be your world-class healthcare choice, for life

Lower is Better	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual/ number expected)	FY22 Goal	FY21 FY20
CAUTI Catheter Associated Urinary Tract Infection COVID-19 PATIENTS	1 0	3 1	5 5	2 0	2 1	1 0	3 1	3 2	2 0				16 (12 predicted over 6 months)	1.22 0.67 Excluding COVID (Feb 2022)	≤0.676	0.54 1.12
CLABSI Central Line Associated Blood Stream Infection COVID-19 PATIENTS	0 0	4 3	3 3	3 0	1 1	1 0	1 0	0 0	2 0				11 (9.5 predicted over 6 months)	1.093 0.58 Excluding COVID	≤0.596	0.75 1.20
MRSA Methicillin-Resistant Staphylococcus Aureus COVID-19 PATIENTS	2 0	0 0	1 0	3 1	0 0	2 0	1 1	1 1	0 0				5 (3.6 predicted over 6 months	1.704 1.19 Excluding COVID	≤0.727	2.78 1.02

*based on July-Dec 2021 NHSN predicted

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

Key Strategies

Sepsis, CAUTI, CLABSI & MRSA

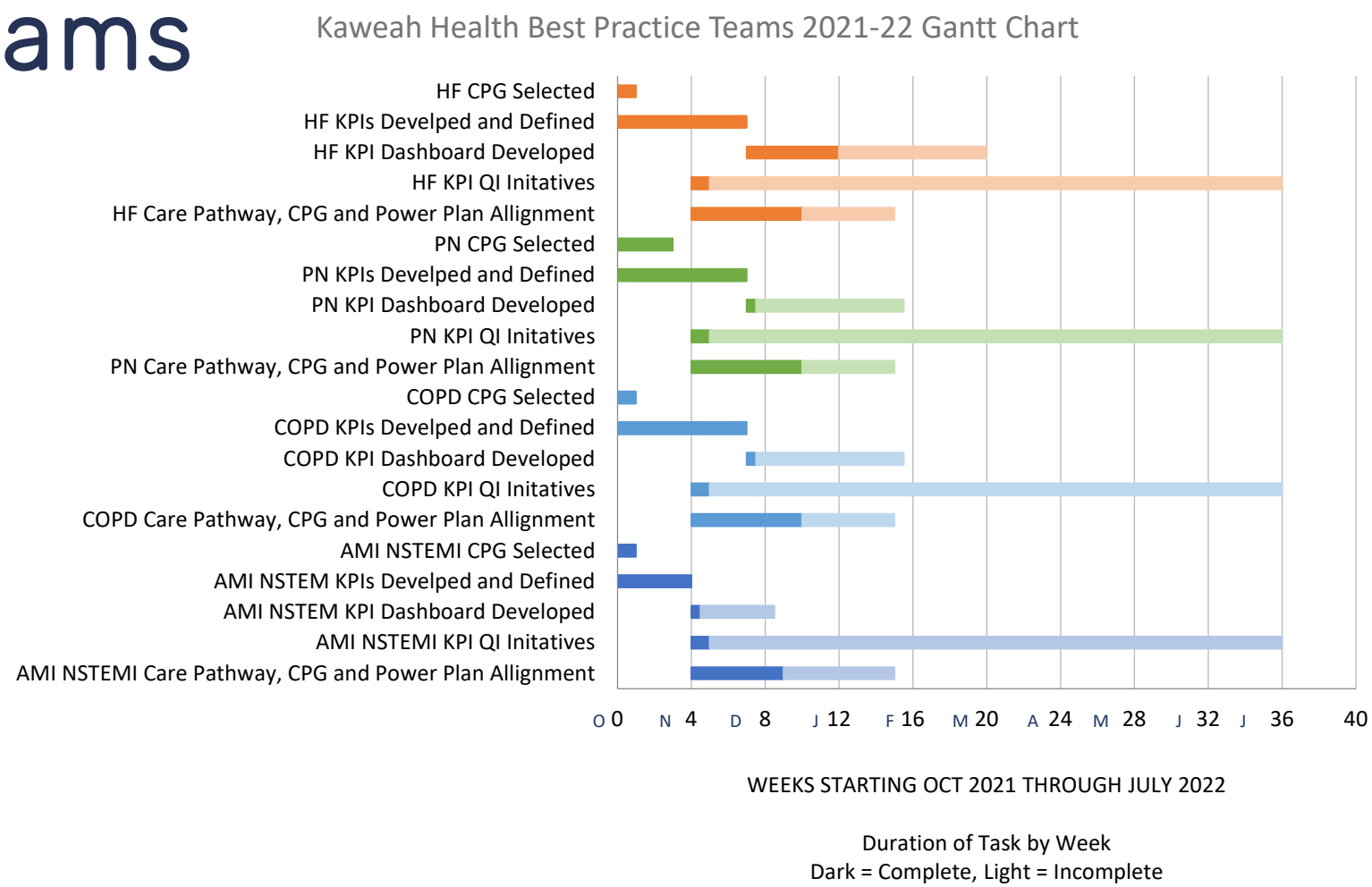
1. Refining root cause analysis of Sepsis order set utilization
2. Provider notification of Sepsis Alert
   - Evaluating root causes optimizing process
3. Sepsis Simulation training (GME)
   - Emergency Management GME program sim program in March 2022; Family Medicine sim program scheduled for summer 2022
4. Sepsis Alert optimization
   - Improving specificity & specificity so true sepsis patients are not missed and truly not septic patients do not trigger the electronic alert

3. Culturing Practices
   - Data analysis and follow up with provider groups
   - Alert for repeat cultures in place
4. Root Cause Analysis
   - 113 days in ICU with no CLABSI!
   - Process & practice assessment from BD
   - Equipment enhancements – conversion to medline products and new bladder scanners for each unit!
   - Review of current data & cases and quantifying contributing factors to target improvement strategies
5. MRSA Decolonization
   - 4N & ICU Pilot – 100% patients decolonized, expanded additional 3 months
   - All other units – targeting those who should be decolonized, working on optimizing processes to achieve decolonization

Kaweah Health Best Practice Teams

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

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



AMI- NSTEMI - non-ST-elevation myocardial infarction , COPD - Chronic Obstructive Pulmonary Disease , HF – Heart Failure, PN - Pneumonia)

Kaweah Health Best Practice Teams

Key Activities:

1. All Teams - Order Set Revisions; Aligning with Evidenced based care
2. Pneumonia – Developing an evidenced-base severity index score to drive best practices by severity
3. Heart Failure & COPD - Interface/communication of diagnostic testing results to cerner from non-cerner systems
4. Continuing to work on dashboard development

Questions?

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