September 6, 2019

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Quality Council Committee meeting at 7:00AM on Thursday September 12, 2019, in the Kaweah Delta Medical Center – Acequia Wing – Executive Office Conference Room {400 W. Mineral King, Visalia}.

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee meeting immediately following the 7:00AM Open Quality Council Committee meeting on Thursday September 12, 2019, in the Kaweah Delta Medical Center – Acequia Wing – Executive Office Conference Room {400 W. Mineral King, Visalia} pursuant to Health and Safety Code 32155 & 1461.

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 Delta 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 the Kaweah Delta 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 http://www.kaweahdelta.org.

KAWEAH DELTA HEALTH CARE DISTRICT
Nevin House, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
Board Clerk, Executive Assistant to CEO

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

KAWEAH DELTA HEALTH CARE DISTRICT
BOARD OF DIRECTORS
QUALITY COUNCIL

Thursday, September 12, 2019

Kaweah Delta Medical Center – Acequia Wing
400 W. Mineral King Avenue, Visalia, CA Executive Conference Room

ATTENDING: Nevin House, Board Member; David Francis, Board Member; Gary Herbst, CEO; Regina Sawyer, RN, VP & CNO; Byron Mendenhall, MD, Chief of Staff; Monica Manga, MD, Professional Staff Quality Committee Chair; Daniel Hightower, MD, Secretary/Treasurer; Harry Lively, MD, Past Chief of Staff; Lori Winston, MD, DIO; Tom Gray, MD, Quality and Patient Safety Medical Director; Sandy Volchko, Director of Quality and Patient Safety; Evelyn McEntire, Director of Risk Management; Ben Cripps, Compliance and Privacy Officer, and Heather Goyer, Recording.

OPEN MEETING – 7:00AM

Call to order – *Herb Hawkins, Committee Chair & Board Member*

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.

1. **Written Quality Reports –** A review of key quality metrics and actions associated with the following populations:

   1.1. **Value-Based Purchasing Report**
   1.2. **Patient Experience**
   1.3. **Maternal Child Health Careline Quality Report**
   1.4. **Fall Prevention**

2. **Emergency Department Quality Update** – A review of key measures and actions for the Emergency Department. *Kona Seng, OD, Medical Director of Emergency Services, and Tom Siminski, RN Director of Emergency Services.*

3. **Update: Fiscal Year 2019 Clinical Quality Goals** - A review of current performance and actions focused on the FY 2019 clinical quality goals. *Sandy Volchko, RN, Director of Quality and Patient Safety.*
4. **Cardiology Services Quality Report – ** A review of key quality indicators and actions through the American College of Cardiology quality program. *A. Verma, MD, Director of Cardiac Cath Lab*
5. **Infection Prevention Quarterly Report – ** A review of infection prevention measures, and actions for improvement and enhancement of the infection prevention program. *Shawn Elkin, MPA, BSN, RN, PHN, CIC, Infection Prevention Manager.*

6. **Approval of Quality Council Closed Meeting Agenda** – Kaweah Delta Medical Center Executive Conference Room – immediately following the open Quality Council meeting
    - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of Professional Staff Quality Committee (Pro-Staff) – *Monica Manga, MD, and Professional Staff Quality Committee Chair;*
    - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of Professional Staff Quality Committee (Pro-Staff) – *Evelyn McEntire, Director of Risk Management.*

Adjourn Open Meeting – *Herb Hawkins, Committee Chair & Board Member*

CLOSED MEETING – Immediately following the 7:00AM open meeting

Call to order – *Herb Hawkins, Committee Chair & Board Member*

1. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of Professional Staff Quality Committee (Pro-Staff) – *Monica Manga, MD, and Professional Staff Quality Committee Chair*
2. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of Professional Staff Quality Committee (Pro-Staff) – *Evelyn McEntire, Director of Risk Management.*

Adjourn Open Meeting – *Herb Hawkins, Committee Chair & Board Member*

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.

Value Base Purchasing
FY 2020

KAWEAH DELTA HEALTH CARE DISTRICT

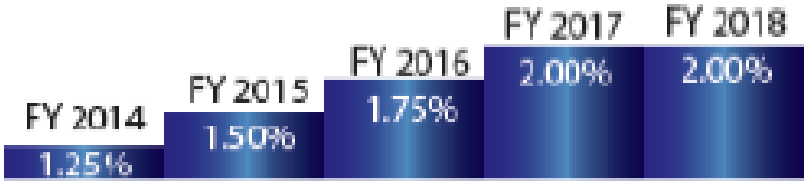
Abbreviations

- CMS: Centers for Medicare and Medicaid Services
- DRG: Diagnosis Related Groups
- FY: Fiscal Year
- CY: Calendar Year
- TPS: Total Performance Score
- VPB: Value Based Purchasing
- AHRQ: Agency For Health Care Research and Quality
- PSI-90: Patient Safety Indicators-90
- SNF: Skilled Nursing Facility
- RRT: Rapid Response Team

VBP Payment Method

- *"The Hospital VBP Program is funded by a 2% reduction from participating hospitals' base operating diagnosis-related group (DRG) payments for FY 2018. Resulting funds are redistributed to hospitals based on their Total Performance Scores (TPS). The actual amount earned by each hospital depends on the range and distribution of all eligible/participating hospitals' TPS scores for a FY. It is possible for a hospital to earn back a value-based incentive payment percentage that is less than, equal to, or more than the applicable reduction for that program year."*

CMS Quality Patient Assessment Instruments



Value Based Purchasing Measures

FY 2020 Payment (CY 2018 Reporting Period)

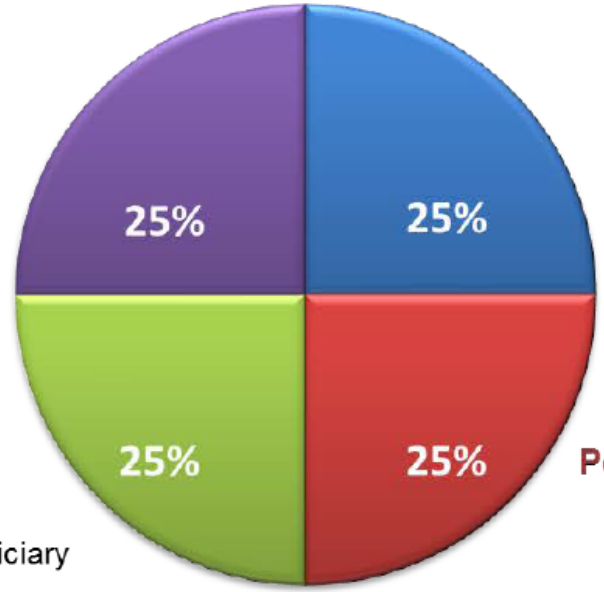
Safety

1. **CDI**: Clostridium difficile Infection
2. **CAUTI**: Catheter-Associated Urinary Tract Infection
3. **CLABSI**: Central Line-Associated Bloodstream Infection
4. **MRSA**: Methicillin-Resistant *Staphylococcus aureus* Bacteremia
5. **SSI**: Surgical Site Infection Colon Surgery & Abdominal Hysterectomy
6. **PC-01**: Elective Delivery Prior to 39 Completed Weeks Gestation

Efficiency and Cost Reduction

1. **MSPB**: Medicare Spending per Beneficiary

Domain Weights



Clinical Care

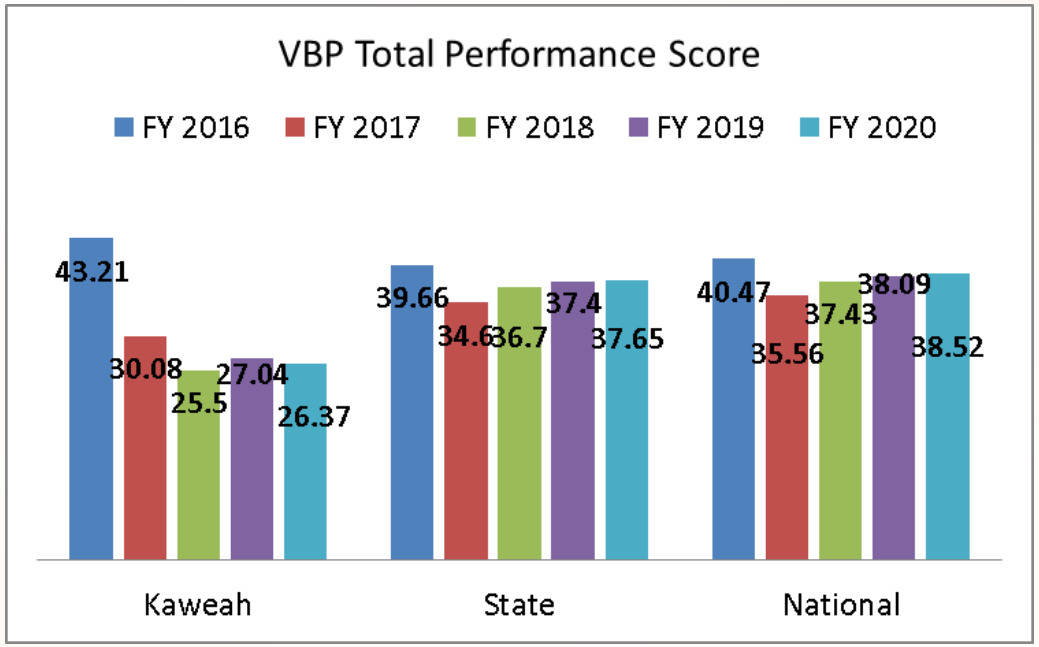
1. **MORT-30-AMI**: Acute Myocardial Infarction (AMI) 30-Day Mortality Rate
2. **MORT-30-HF**: Heart Failure (HF) 30-Day Mortality Rate
3. **MORT-30-PN**: Pneumonia (PN) 30-Day Mortality Rate
4. **THA/TKA**: Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Complication Rate

Person and Community Engagement

HCAHPS Survey Dimensions

1. Communication with Nurses
2. Communication with Doctors
3. Responsiveness of Hospital Staff
4. Communication about Medicines
5. Cleanliness and Quietness of Hospital Environment
6. Discharge Information
7. Care Transition
8. Overall Rating of Hospital

Kaweah Delta Performance
FY 2020 Payment Performance



	Base Operating DRG Amount Reduction	Value-Base Incentive Payment %
FY 2016	1.75%	2.09%
FY 2017	2%	1.84%
FY 2018	2%	1.47%
FY 2019	2%	1.53%
FY 2020	2%	1.48%

Actual Points & Costs

	FY 2020 (Points Received)
Clinical Outcomes - Domain Score	**52.50%**
Acute Myocardio Infarction	8
Heart Failure	1
Pneumonia	2
Complication elective THA/TKA	10
Safety - Healthcare Associated infections - Domain Score	**20.00%**
CLABSI - Per 1000 line days	0
CAUTI - Per 1000 catheter days	0
SSI Colon - Rate Per 100 procedures	0
SSI Abdominal Hysterectomy - Rate Per 100	0
C. difficile - Per 10,000 patient days	7
MRSA - Per 10,000 patient days	0
PC-01 Early Elective Deliveries	5
Person and Community Engagement - Domain Score	**13%***
Communication with Nurses	0
Communication with Doctors	0
Responsiveness of Hospital Staff	0
Communication about Medicines	0
Cleanliness of Hospital Environment	0
Quietness of Hospital Environment	0
Discharge Information	0
Care Transition	0
Overall Rating of Hospital	0
Efficiency and Cost Reduction-Domain Score	**20.00%**
Medicare Spending per Beneficiary	2

*Consistency Score

FY 2020 VBP Cost Analysis	
Contribution	Payment Percentage
2% = $1,669,200	1.48%=$1,236,376
($432,823)	

Action Plan & Teams

Mortality

- Mortality committee meets once month and has identified the largest improvement opportunity is earlier palliative care. Disease specific resource effectiveness teams are also working on best practices.

Hip & Knee Complications

- Orthopedic service line reviews all complications to assess if complications are true (re-code) and identify opportunities for improvement.

Infection Prevention

- Infection prevention has teams in each area meet every month. In 2019, Kaweah implemented and IV safety team to round on all lines and monitor expired IVs. Since this team, Kaweah MRSA and CLABSI rates are trending down.

Ear lily Elective Deliveries

- Implemented hard stop of scheduling early elective deliveries.

Patient Experience

- Implementation of "Operation Always" with department specific action plans, increased leader patient rounding, and use of new survey vendor in July 2019.

Medicare Spending

- Resource Effectiveness Committee teams are all working on efficiency and lowering costs.

Questions?

Patient Experience – Excellent Service - HCAHPS

The data is for patients discharged: **First Quarter 2018 through Fourth Quarter 2018**. 1469 surveys completed with a 21% response rate.

HCAHPS Measure	**CMS** 50th percentile 1Q18-4Q18	**Kaweah Delta** 1Q18-4Q18	**Adjustments to Kaweah Delta** 1Q18-4Q18	**Kaweah Delta RAW** 3Q18-2Q19	**Comments/Improvement Efforts**
# of surveys	-	**1469**	-	**1661**	-
Communication with Nurses	81%	**77%** **Below**	84.9% (RAW) *MODE ADJ: -4.2%* *~PT MIX ADJ: -3.7%* *~ TOTAL ADJ: -7.9%*	83%	Opening and closing encounters Narrate the care Communication white boards
Communication with Doctors	81%	**74%** **Below**	84.0% (RAW) *MODE ADJ: -2.8%* *~PT MIX ADJ: -5.2%* *~ TOTAL ADJ: -8.0%*	83%	Greet patients & companions with a smile Sit at the bedside Conclude with "Is there anything else I can do for you?"
Responsiveness of Staff	70%	**63%** **Below**	70.2% (RAW) *MODE ADJ: -0.8%* *~PT MIX ADJ: -6.4%* *~ TOTAL ADJ: -7.2%*	70%	Hourly Rounding Proactive toileting
Communication about Meds	66%	**61%** **Below**	69.5% (RAW) *MODE ADJ: -1.7%* *~PT MIX ADJ: -6.8%* *~ TOTAL ADJ: -8.5%*	67%	Medicine Guide
Cleanliness of Environment	75%	**67%** **Below**	70.5% (RAW) *MODE ADJ: -2.8%* *~PT MIX ADJ: -0.7%* *~ TOTAL ADJ: -3.5%*	70%	Linen delivery revamp EVS competency re-validation
Quietness of Environment	62%	**48%** **Below**	64.8% (RAW) *MODE ADJ: -8.6%* *~PT MIX ADJ: -8.2%* *~ TOTAL ADJ: -16.8%*	63%	*No new interventions*
Discharge Information *(Yes)*	87%	**85%** **Within**	89.2% (RAW) *MODE ADJ: -1.7%* *~PT MIX ADJ: -2.5%* *~ TOTAL ADJ: -4.2%*	88%	Medicine Guide Use discharge advocates to onboard new admits of preferences and expectations Implement solution for Discharge Phone Calls Rebuild Discharge Instructions (Fall 2019)
Care Transition *(Strongly Agree)*	53%	**46%** **Below**	50.5% (RAW) *MODE ADJ: -0.6%* *~PT MIX ADJ: -3.9%* *~ TOTAL ADJ: -4.5%*	49%	*Same as above*
Overall Rating of Hospital (0 = worst; 10 = best)	73%	**69%** *(9 or 10)* **Below**	76.2% (RAW) *MODE ADJ: -2.0%* *~PT MIX ADJ: -5.2%* *~ TOTAL ADJ: -7.2%*	77%	**OPERATION ALWAYS** *Purpose: Consistently provide world-class service* →Department-specific action plans reviewed by Executive Team **→Increase leader rounding on patients** →Regular monthly data and comments →New Survey Vendor: JL Morgan →Launch Gold Star Discharge Program (early discharges home) →New patient menu
Willingness to Recommend ***(Definitely Recommend)***	72%	**68%** **Within**	76.2% (RAW) *MODE ADJ: -3.5%* *~PT MIX ADJ: -4.7%* *~ TOTAL ADJ: -8.2%*	77%	*Same as above*

Legend: *Above or at benchmark* *Within 3% of benchmark* *Below benchmark by more than 3%*

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Labor and Delivery **ProStaff Report Date: July, 2019**

Measures Objectives/Goals:

- Patients will ready for C-Section within 30 min of MD Decision for unscheduled C-section. Goal 95%

Date range of data evaluated:

January – June 2019: Measure is performing at 84% Goal is 95%.

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

There has been marked improvement in this measure. The biggest opportunity centers around documentation, making changes to the EMR and nursing education about where to document.

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

Action plan for ready for C-section within 30 min of decision: Will send this issue to the Cerner Documentation committee to identify needed changes to the documentation, make the change, and educate nursing. Resolution planned end of FY quarter 2.

Next Steps/Recommendations/Outcomes:

Make changes to documentation and educate nursing. Then audit for compliance

Submitted by Name: Tracie Plunkett **Date Submitted:** July, 2019

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Labor & Delivery **ProStaff Report Date: July, 2019**

Measure Objective/Goal:

Early Elective Deliveries: Goal is 2.42%

Date range of data evaluated:

Quarter January – June 2019

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

Quarter January – June 2019: Goal Met, Zero Early Elective Deliveries

Continue to monitor and work with OB Department Leadership on any potential issues

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

Continue current plan, monitor for any issues.

Next Steps/Recommendations/Outcomes:

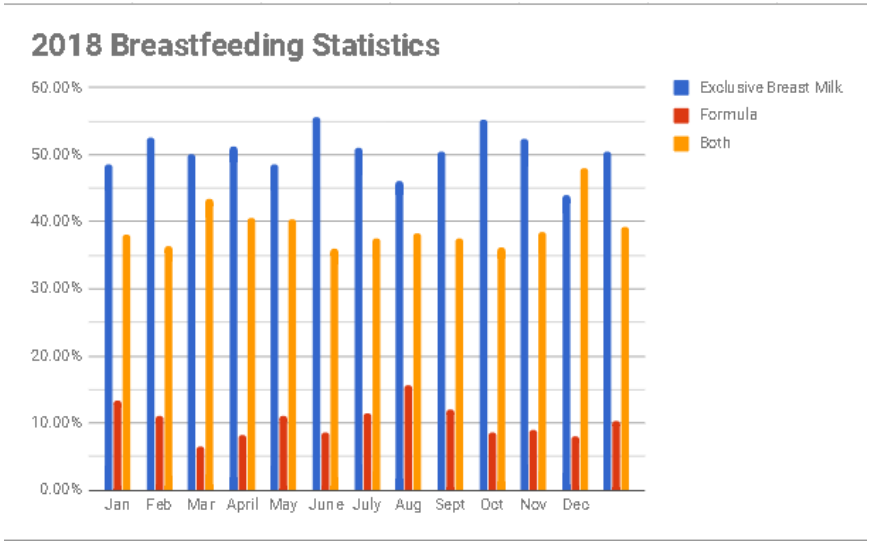
Continue current plan

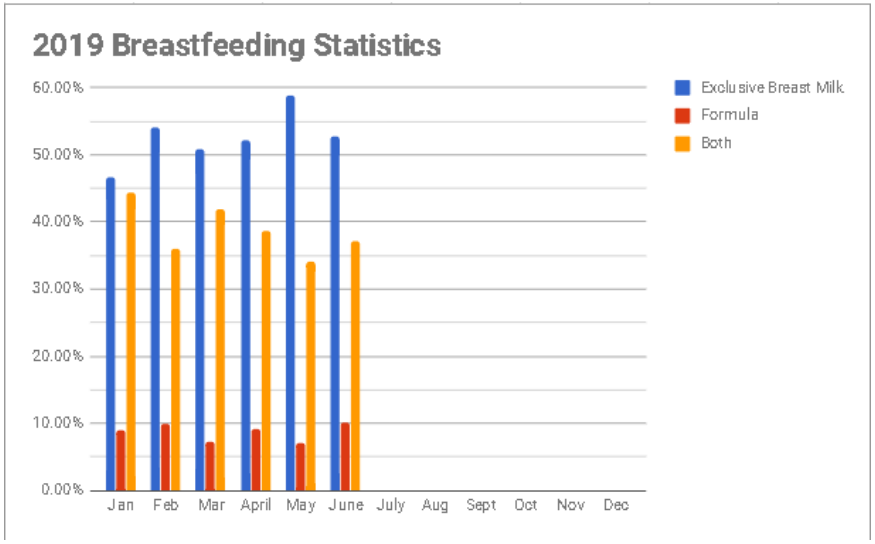
Submitted by Name: Tracie Plunkett MSN, RNC-OB, NE-BC

Date Submitted: July, 2019

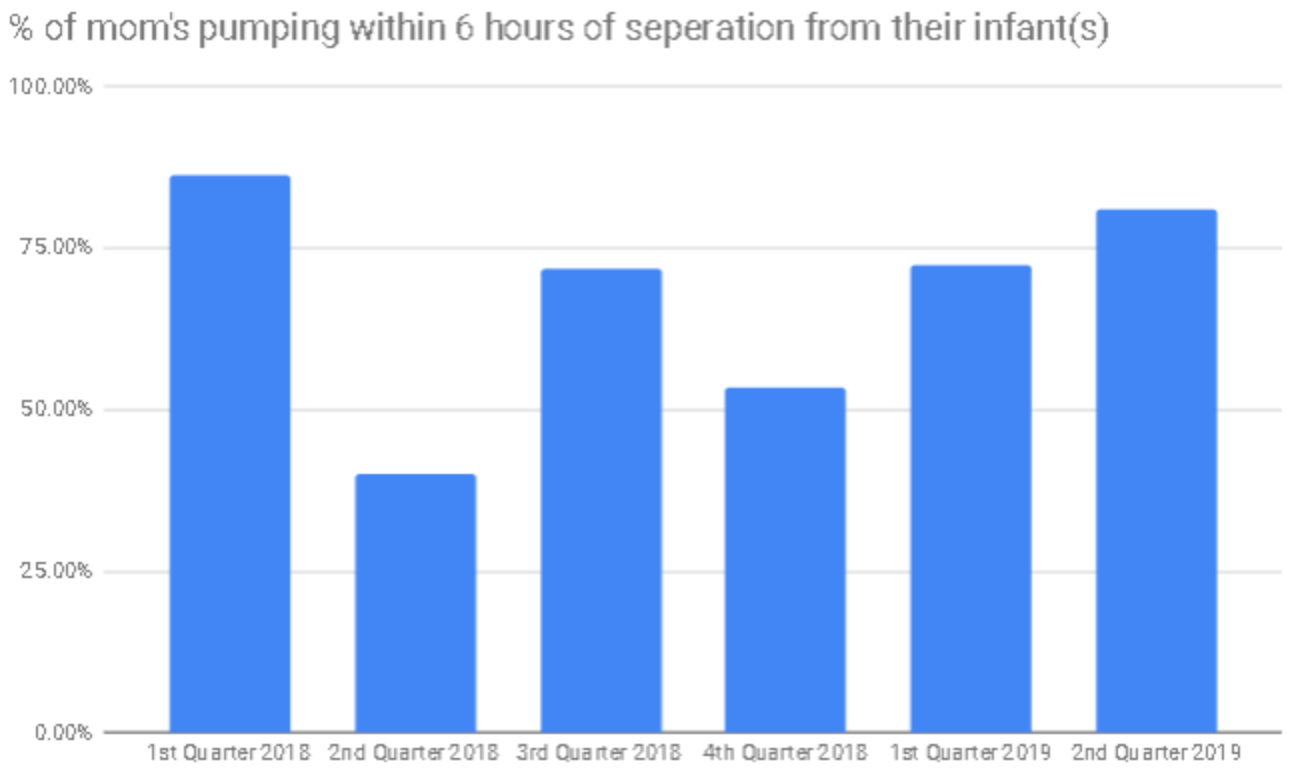
Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Breastfeeding Stats

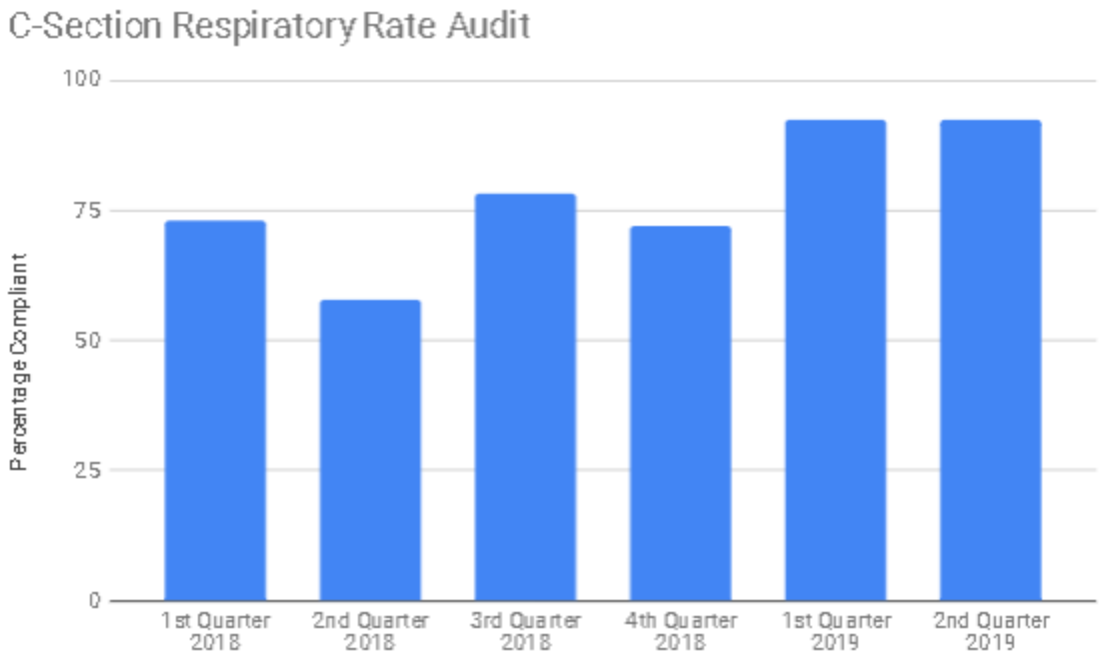




NICU Mom's Pumping



C-Section Respiratory Rate Audit



Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Unit/Department: Mother Baby **QIC Report Date: July 2019**

Measure Objective/Goal:

Babies receiving any breast milk while in the hospital 91.24% (CDPH 2017 benchmark of 93.9%)

Date range of data evaluated:

January – June 2019

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

We currently are performing below the benchmark of 93.9%.

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

We are currently fully staffed with 7 day a week coverage spanning an average of 20 hours a day. We implemented coverage on Labor/Delivery to see our new mom's prior to delivery providing them with education so they can make an informed decision on how they want to feed their baby while in the hospital. We are beginning to roll out our breastfeeding bundle which included the following: change in lactation scheduling, mandatory breastfeeding education for RN's, breastfeeding education provided to our pediatricians, selection preference form to be collected on admission to Labor and Delivery and an investigative form for nursing to complete when formula is given.

Next Steps/Recommendations/Outcomes:

We continue to support our mother's choice of breastfeeding

Submitted by Name: **Date Submitted:**

Melissa Filiponi, RNC-MNN, BSN 07/11/19

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

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Unit/Department: Mother Baby **QIC Report Date: July 2019**

Measure Objective/Goal:

Monitoring c-section respiratory rates to ensure they are performed and documented as ordered within the first 24 hours. For this reporting period we are at 92.33% compliance.(Internal 80.0%)

Date range of data evaluated:

January – June 2019

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

We currently are performing above the benchmark of 80.0%.

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

Education has been provided to the staff and respiratory rate charting is being audited during bedside report.

Next Steps/Recommendations/Outcomes:

We will continue to monitor this measure until we achieve and sustain a 80% compliance rate.

Submitted by Name: **Date Submitted:**

Melissa Filiponi, RNC-MNN, BSN 07/11/19

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

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Unit/Department: Mother Baby **QIC Report Date: July 2019**

Measure Objective/Goal:

Babies receiving exclusive breast milk while in the hospital 52.57% (Benchmark 52.2%)

Date range of data evaluated:

January – June 2019

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

We currently are performing above the benchmark of 52.2%.

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

We are currently fully staffed with 7 day a week coverage spanning an average of 20 hours a day. We implemented coverage on Labor/Delivery to see our new mom's prior to delivery providing them with education so they can make an informed decision on how they want to feed their baby while in the hospital. We are beginning to roll out our breastfeeding bundle which included the following: change in lactation scheduling, mandatory breastfeeding education for RN's, breastfeeding education provided to our pediatricians, selection preference form to be collected on admission to Labor and Delivery and an investigative form for nursing to complete when formula is given.

Next Steps/Recommendations/Outcomes:

We continue to support our mother's choice of exclusive breastfeeding.

Submitted by Name: **Date Submitted:**

Melissa Filiponi, RNC-MNN, BSN 07/11/2019

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

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Unit/Department: Mother Baby **QIC Report Date: July 2019**

Measure Objective/Goal:

To initiate NICU mom's pumping within 6 hours of separation from their baby 76.67% (Internal benchmark of 75%).

Date range of data evaluated:

January – June 2019

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

We currently are performing above the benchmark of 75%.

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

Education provided to staff on the importance of pumping for both mother and babies well-being. We will begin auditing the charts of NICU moms and providing one on one education to staff so that they are charting in the correct location within the EHR.

Next Steps/Recommendations/Outcomes:

We continue to audit, monitor and support the mother's choice of pumping.

Submitted by Name: Melissa Filiponi, RNC-MNN, BSN

Date Submitted: 07/11/19

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: NICU **ProStaff Report Date: July-2019**

Measure Objective/Goal:

1. CLABSI per 1000 device days; Goal= Meet or exceed benchmark
2. VAP per 1000 ventilator device days; Goal= meet or exceed benchmark

Date range of data evaluated:

January 2019 through June 2019

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

1. KD NICU- 1/1000 central line days. 1 CLABSI identified in May of this year. The NICU has had 200 central line days in the first 6 months of the year putting us at 1/200, and or 0.5 patients per 200 central line days.
    a. Improvements & Opportunities: Continue to follow central line insertion bundle, maintain vigilance of hand hygiene, daily rounds for all patients with central lines.

2. KD NICU-0: Below the level of benchmark, 3 years with no VAP. (19 devise days in the last six months)

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

1. Continue to participate in NICU & CLABSI collaborative. Maintain central line bundle. Report findings to CPQCC. Scheduled to attend CLABSI prevention case review – unit level assessment in August of this year.

2. VAP policy and bundle in place. No cases of VAP.

Next Steps/Recommendations/Outcomes:

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

1. Continue with current standardized insertion practice and care of all central lines.

2. No VAP. Benchmark met; continue to support current P&P.

Submitted by Name:
Felicia Vaughn

Date Submitted:
July 2019

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Pediatrics **ProStaff Report Date: July 2019**

Measure Objective/Goal:

Catheter Associated Urinary Tract Infection
Goal: 0.00

Date range of data evaluated:

January-March 2019

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

We had 0 CAUTIs for this quarter. We are performing equal to the benchmark.

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

Next Steps/Recommendations/Outcomes:

We will continue to use aseptic technique to insert urinary catheters, and we will continue to provide perineal care every shift. We will also continue to evaluate need for urinary catheter on a daily basis.

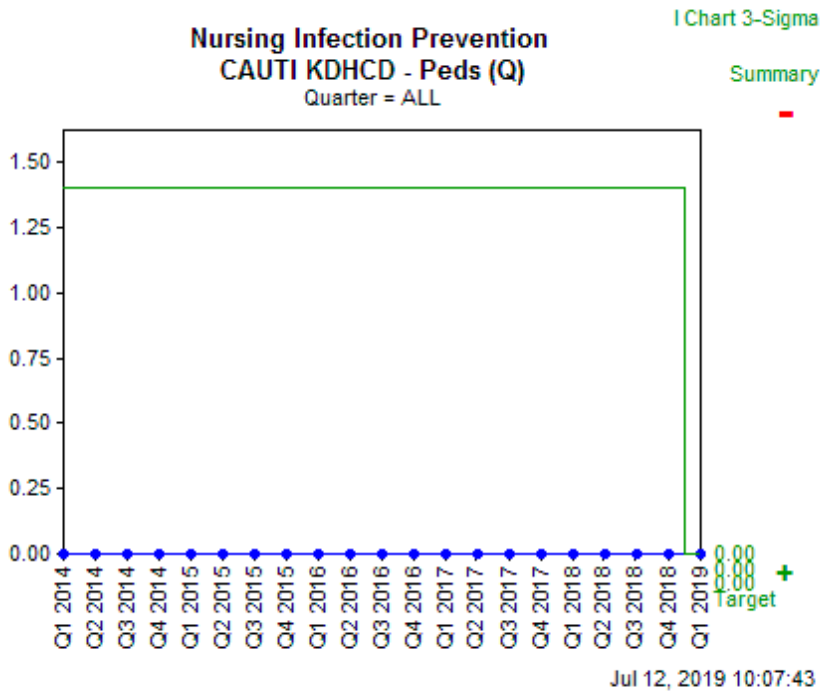
Submitted by Name: Danielle Grimaldi, RN, BSN, CPN

Date Submitted: 07/12/19

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



Date	KDHCD	Target
Q1 2019	0.00	0.00
Q4 2018	0.00	1.40
Q3 2018	0.00	1.40
Q2 2018	0.00	1.40
Q1 2018	0.00	1.40
Q4 2017	0.00	1.40
Q3 2017	0.00	1.40
Q2 2017	0.00	1.40
Q1 2017	0.00	1.40
Q4 2016	0.00	1.40
Q3 2016	0.00	1.40
Q2 2016	0.00	1.40
Q1 2016	0.00	1.40
Q4 2015	0.00	1.40
Q3 2015	0.00	1.40
Q2 2015	0.00	1.40
Q1 2015	0.00	1.40
Q4 2014	0.00	1.40
Q3 2014	0.00	1.40
Q2 2014	0.00	1.40
Q1 2014	0.00	1.40

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Pediatrics **ProStaff Report Date: July 2019**

Measure Objective/Goal:

Central Line Associated Blood Infections
Goal: 0.00

Date range of data evaluated:

January-March 2019

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

We had 0 CLABSIs for this quarter. We are performing equal with the benchmark.

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

Next Steps/Recommendations/Outcomes:

We will continue to use aseptic technique to perform scheduled dressing and cap changes. We will also continue to evaluate need for central line on a daily basis.

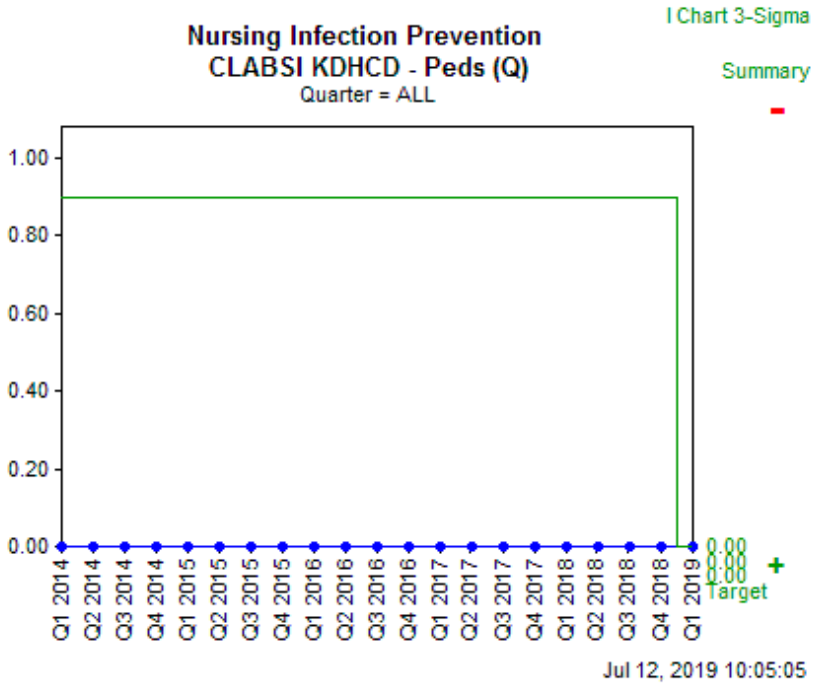
Submitted by Name: Danielle Grimaldi, RN, BSN, CPN

Date Submitted: 712/19

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



Date	KDHCD	Target
Q1 2019	0.00	0.00
Q4 2018	0.00	0.90
Q3 2018	0.00	0.90
Q2 2018	0.00	0.90
Q1 2018	0.00	0.90
Q4 2017	0.00	0.90
Q3 2017	0.00	0.90
Q2 2017	0.00	0.90
Q1 2017	0.00	0.90
Q4 2016	0.00	0.90
Q3 2016	0.00	0.90
Q2 2016	0.00	0.90
Q1 2016	0.00	0.90
Q4 2015	0.00	0.90
Q3 2015	0.00	0.90
Q2 2015	0.00	0.90
Q1 2015	0.00	0.90
Q4 2014	0.00	0.90
Q3 2014	0.00	0.90
Q2 2014	0.00	0.90
Q1 2014	0.00	0.90

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Pediatrics **ProStaff Report Date: July 2019**

Measure Objective/Goal:

Falls per 1000 patient days
Goal: 1.35

Date range of data evaluated:

January-March 2019

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

We had 0.00 per 1000 patient days for this quarter.

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

.

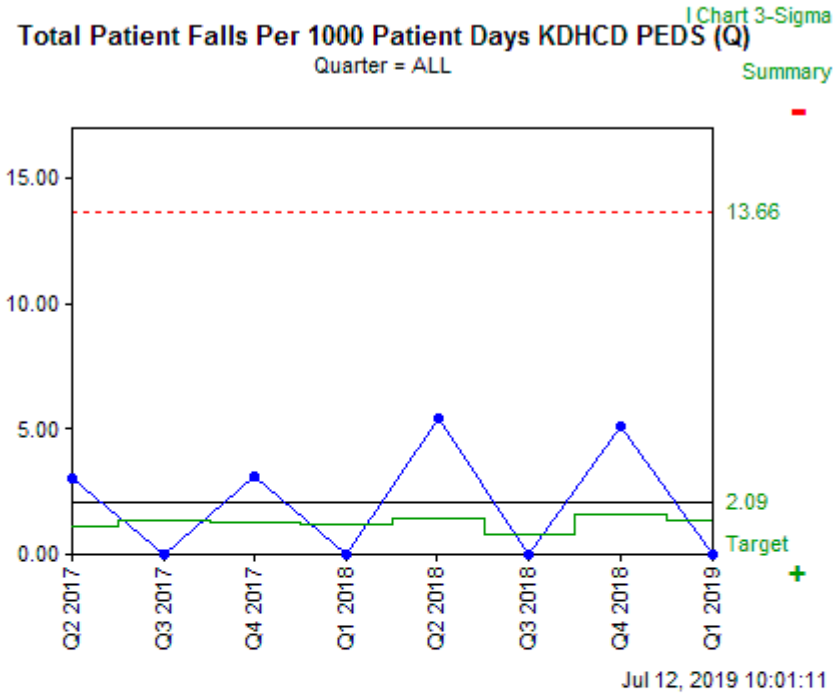
Next Steps/Recommendations/Outcomes:

We will continue to implement fall risk precautions and educate families on safe sleep.
We will continue to have parents sign waivers when they decline Safe Sleep.

Submitted by Name: Danielle Grimaldi, RN, BSN, CPN

Date Submitted: 07/12/19

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



Date	KDHCD	Target
Q1 2019	0.00	1.35
Q4 2018	5.13	1.60
Q3 2018	0.00	0.83
Q2 2018	5.46	1.41
Q1 2018	0.00	1.18
Q4 2017	3.10	1.30
Q3 2017	0.00	1.36
Q2 2017	3.07	1.13

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Pediatrics **ProStaff Report Date: July 2019**

Measure Objective/Goal:
Percent of PIV infiltrations
Goal: 0.68

Date range of data evaluated:
January- March 2019

Analysis of all measures/data: (Include key findings, improvements, opportunities)
We had 0 PIV infiltrations for this quarter. This is better than the benchmark.

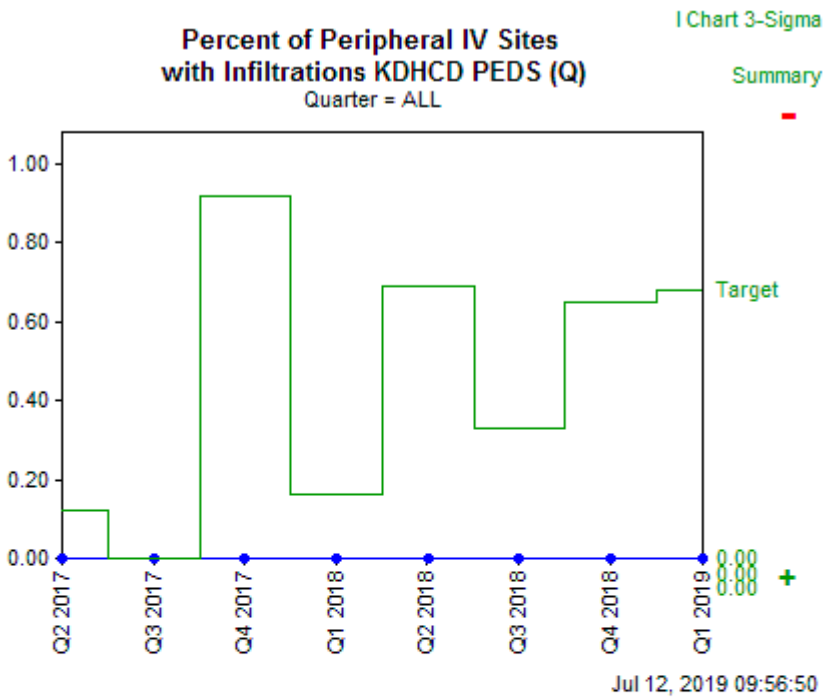
If improvement opportunities identified, provide action plan and expected resolution date:

Next Steps/Recommendations/Outcomes:
We will continue to perform hourly assessments for patients that have continuous infusions running.

Submitted by Name: Danielle Grimaldi, RN, BSN, CPN

Date Submitted: 7/12/19

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



Date	KDHCD	Target
Q1 2019	0.00	0.68
Q4 2018	0.00	0.65
Q3 2018	0.00	0.33
Q2 2018	0.00	0.69
Q1 2018	0.00	0.16
Q4 2017	0.00	0.92
Q3 2017	0.00	0.00
Q2 2017	0.00	0.12

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Pediatrics **ProStaff Report Date: July 2019**

Measure Objective/Goal:

Percent of PEWS fallouts-PEWS score charted every 4 hours on every patient.
Goal: 90% or greater no fallouts.

Date range of data evaluated:

January-June 2019

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

Using data received within the last 180 days, we have had a 94% success rate in PEWS score being charted every 4 hours. Results are better than benchmark for PEWS score.

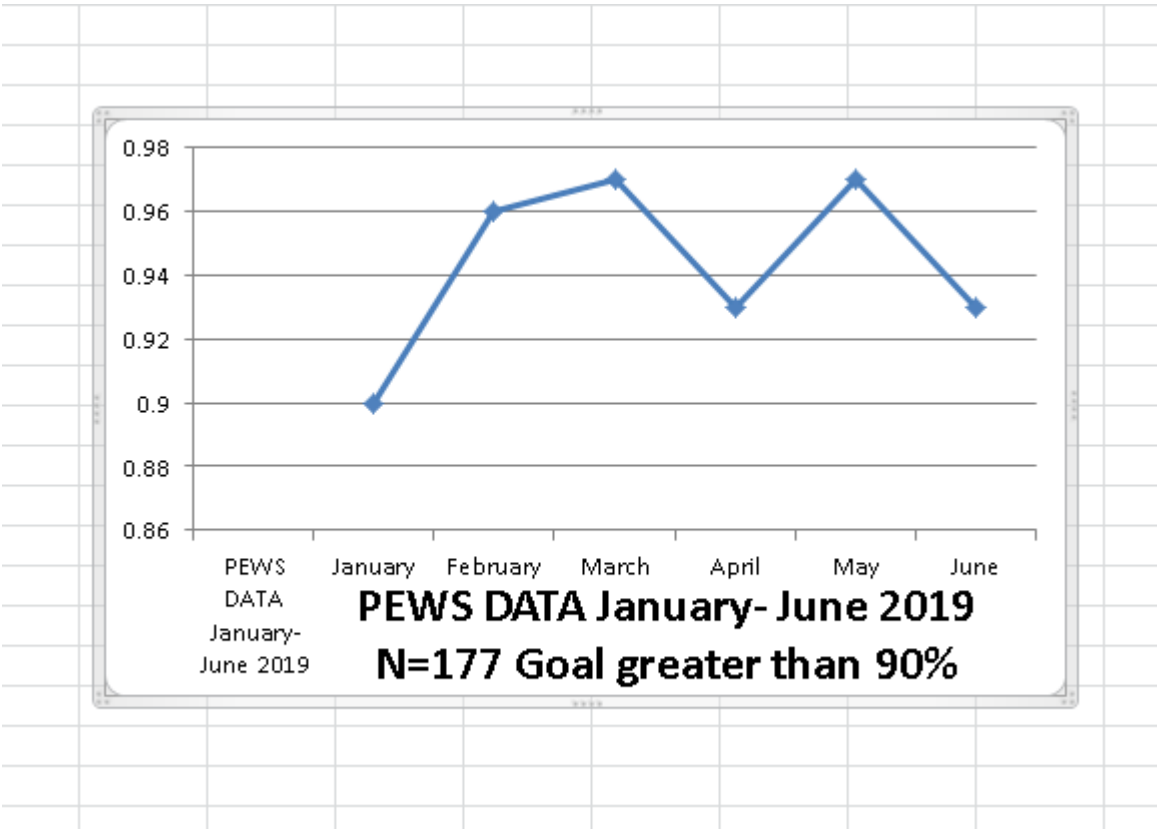
If improvement opportunities identified, provide action plan and expected resolution date

Next Steps/Recommendations/Outcomes:

Continue to maintain PEWS scoring greater than 90% expected with next report date.

Submitted by Name:	**Date Submitted:**
Danielle Grimaldi, RN, BSN, CPN	07/12/19

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 Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Pediatrics **ProStaff Report Date: July 2019**

Measure Objective/Goal:

Percent of patients with stage 2 or greater HAPI: 0.00
Goal: 0.16

Date range of data evaluated:

January-March 2019

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

We had 0 HAPIs stage 2 or greater for this quarter. This is better than the benchmark.

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

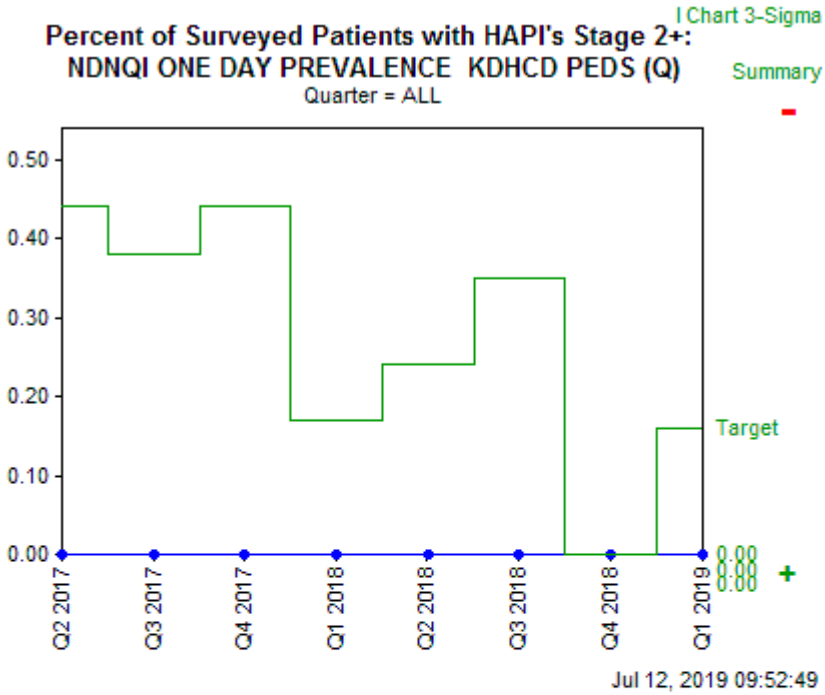
Next Steps/Recommendations/Outcomes:

We will continue identifying patients at risk for skin breakdown and implement appropriate preventative measures.

Submitted by Name: Danielle Grimaldi, RN, BSN, CPN

Date Submitted: 07/12/19

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



Date	KDHCD	Target
Q1 2019	0.00	0.16
Q4 2018	0.00	0.00
Q3 2018	0.00	0.35
Q2 2018	0.00	0.24
Q1 2018	0.00	0.17
Q4 2017	0.00	0.44
Q3 2017	0.00	0.38
Q2 2017	0.00	0.44

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

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

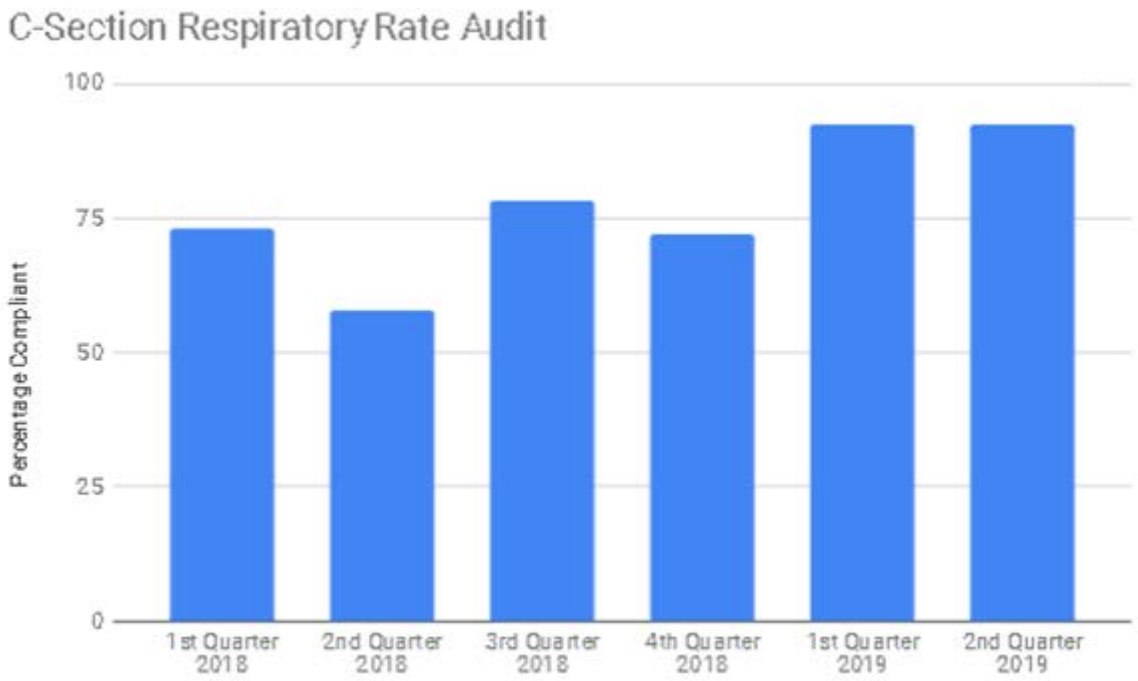
Unit/Department: Mother Baby **QIC Report Date: July 2019**

Measure Objective/Goal:

Monitoring c-section respiratory rates to ensure they are performed and documented as ordered within the first 24 hours. For this reporting period we are at 92.33% compliance.(Internal 80.0%)

Date range of data evaluated:

January – June 2019



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

We currently are performing above the benchmark of 80.0%.

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

Education has been provided to the staff and respiratory rate charting is being audited during bedside report.

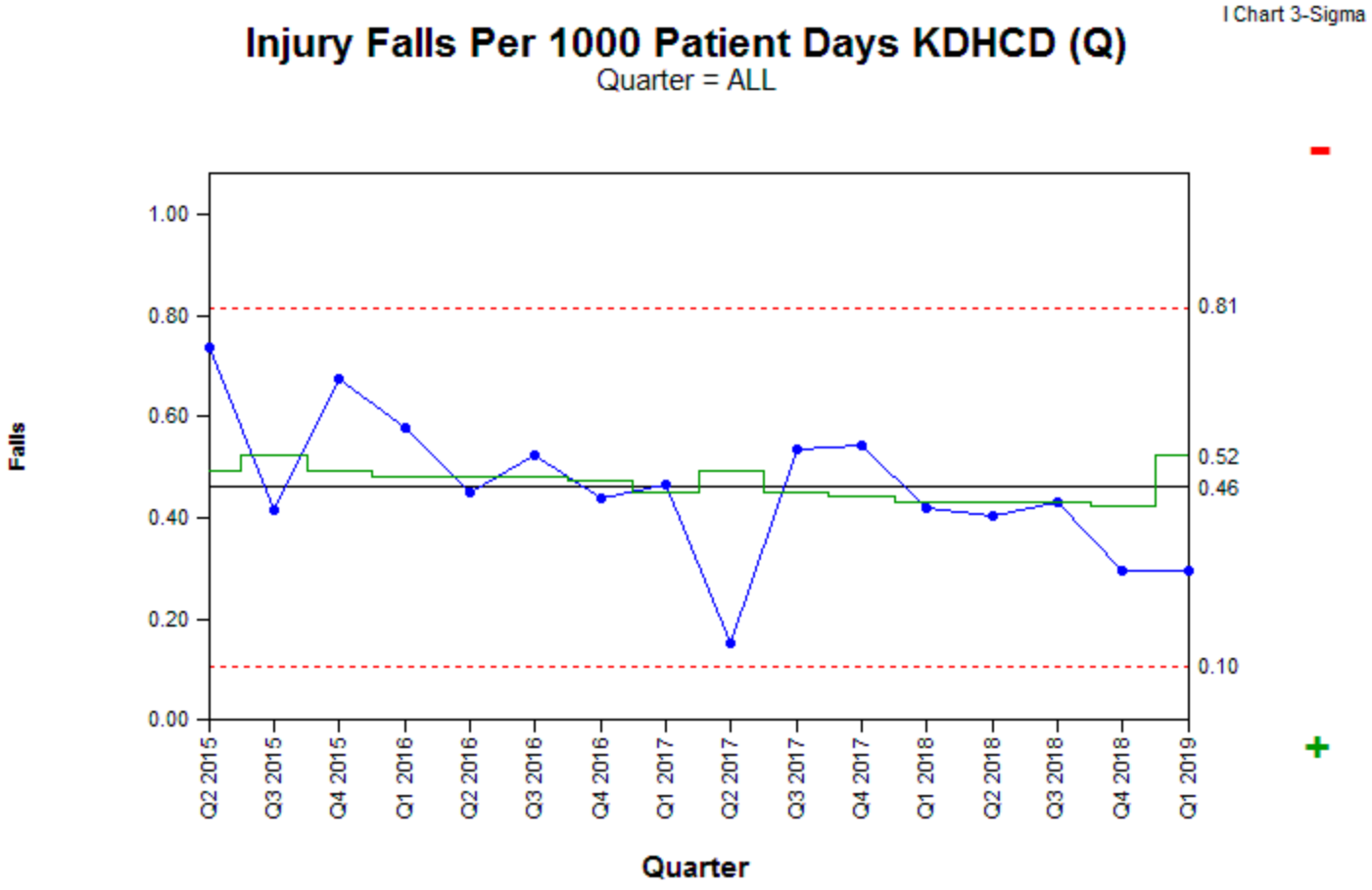
Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Next Steps/Recommendations/Outcomes:

We will continue to monitor this measure until we achieve and sustain a 80% compliance rate.

Submitted by Name:	**Date Submitted:**
Melissa Filiponi, RNC-MNN, BSN	07/11/19

I Chart 3-Sigma



Aug 16, 2019 16:05:41

Validated by Cindy Vander Schuur at 06/25/19 14:22

	Q2 2015	Q3 2015	Q4 2015	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019
Falls	0.73	0.41	0.67	0.58	0.45	0.52	0.44	0.46	0.15	0.53	0.54	0.42	0.40	0.43	0.29	0.29
Target	0.49	0.52	0.49	0.48	0.48	0.48	0.47	0.45	0.49	0.45	0.44	0.43	0.43	0.43	0.42	0.52

Description	
Owners	
Expert	Erick Nad
Notes 1	
Notes 2	
Cautions	
Disclaimer	

Unit/Department Specific Data Collection Summarization

QIC/Professional Staff Committee Report

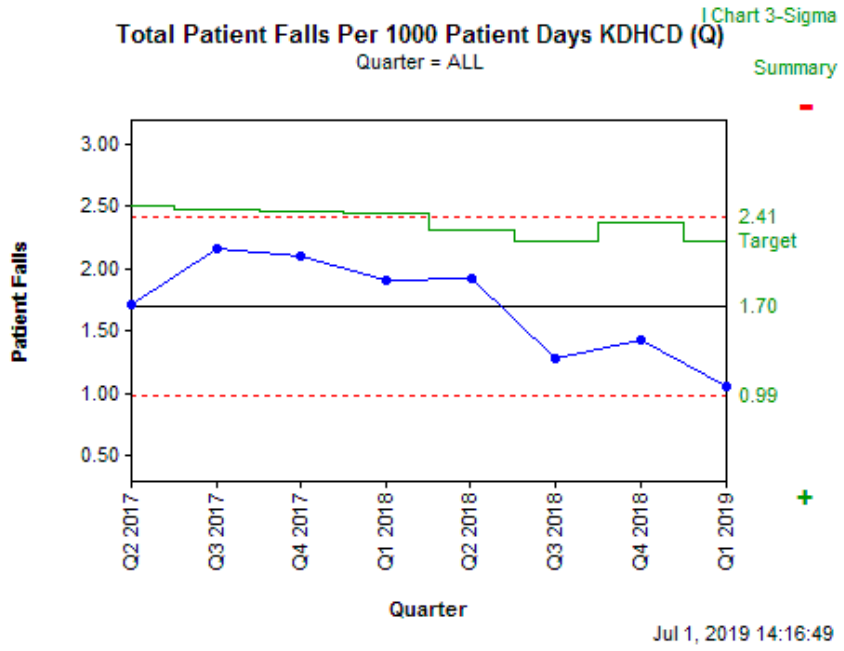
Unit/Department: Falls Committee **QIC/ProStaff Report Date: September 4, 2019**

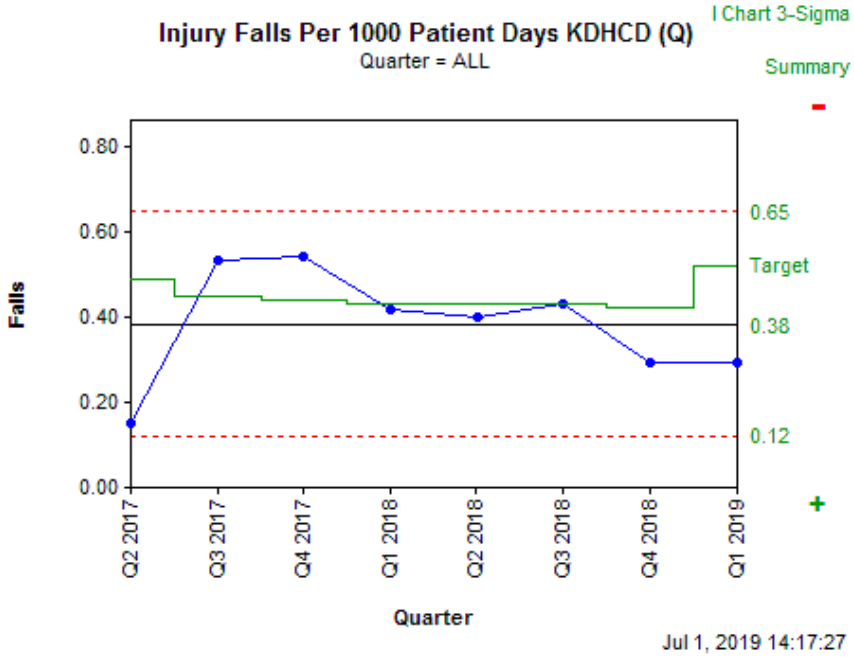
Measure Objective/Goal:

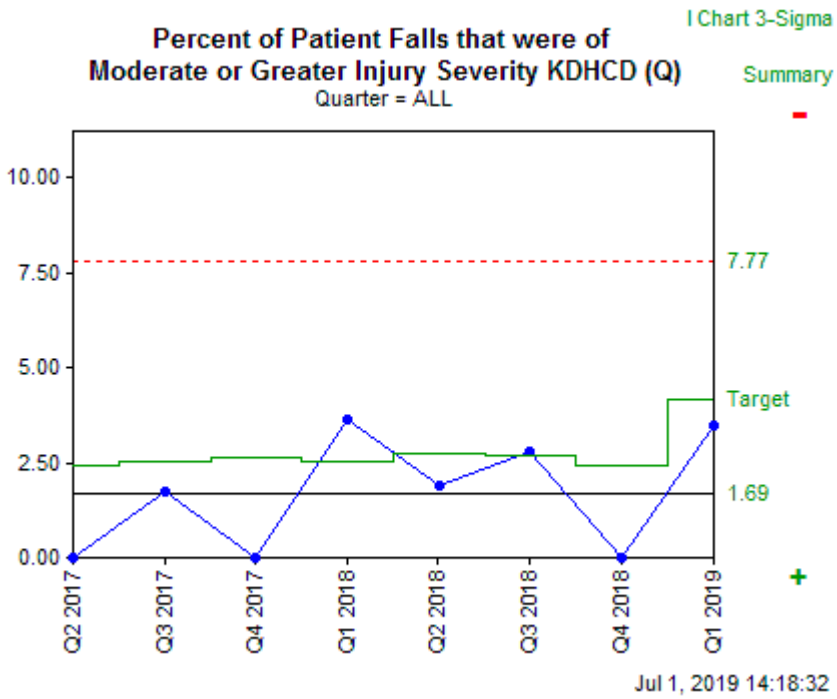
1. KDHCD Nursing Unit Falls Data:
   - Total Falls per 1000 patient days
   - Total Injury Falls per 1000 patient days
   - Percent of Falls with Moderate to Severe Injury

Date range of data evaluated:

1. KDHCD Q 1, 2019







Injury Falls Summary 1Q 2019: n/33

Injury Level	#	Unit
None	23	Multiple
Minor	9	Multiple
Moderate	1	Mental Health
Severe	0	n/a

Analysis of all measures/data for Q4, 2018- Q1, 2019: (Include key findings, improvements, opportunities)

1. KDHCD hospital data:

- Overall, fall metrics remain at or below target for all indicators.
- Total falls per 1000 patient days 1.07, below target (2.23).
- Total injury falls per 1000 patient days 0.29, below target (0.52).
- Percent of falls with moderate or greater injury 3.45 (1 fall), below target (4.17). This injury was a laceration on the back of the head which required 4 staples to close the wound. It is important to note 70% of falls were without injury and 27% were minor.
- Seasonal variations in census and patient acuity are typically seen late Q3 through Q1.
- As previously reported, more obvious risk factors are mitigated and plans of care initiated but some patient populations are emerging as more challenging. Patients and families with behavioral issues, history of substance abuse and unusual psychosocial issues are proving most difficult to develop effective plans of care to mitigate the risk for falls.

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

Next Steps/Recommendations/Outcomes:

- Improve onboarding of clinical staff. Various unit-level projects are under way to improve hourly rounding and communication. Explore creation of an enduring class which educates new staff on the pathophysiology of falls and the KDHCD falls prevention program.
- Continue weekly review of falls at Falls University with publication of Falls U Take Aways each week. This continues to be an excellent opportunity to provide real time education and discussion of prevention strategies.
- Reinforcement of unit level accountability: 1) Falls University, 2) inclusion of NDNQI Falls metrics in unit-level QIC reports, 3) review of outliers as appropriate at NPIC and Falls Committee.
- K. Gilmore, NM Urgent Care provided a report to the Falls Committee on fall prevention strategies and identification of at-risk patients within this outpatient setting. At-risk patients are assisted by staff and placed in an observation room. If family is not available, staff remains with the patient. Currently all patients are screened for risk at first contact. Providers are responsible for all discharge instructions. One identified opportunity is to conduct an environmental assessment at the Urgent Care Centers to determine if any other opportunities exist. This will be facilitated by K. Glimore.
- L. McClain, Hospice Director provided a report to the Falls Committee on efforts to decrease falls in this patient population. It is important to note, this population is not included in the NDNQI data submissions. This patient population is a higher risk for falls. A review of their data indicates opportunities for patients at skilled facilities and in the home. A detailed plan of action was provided to the Committee to address these opportunities.
- S. Lee NM 3S, provided a report to the Falls Committee on the work 3S has undertaken after the team identified an uptick of falls for patients on comfort care. The team has developed and implemented a diagnosis-specific action plan for this population. A random audit is currently under way to determine effectiveness of this plan. The results of this audit and effectiveness of this plan will be reported to the Falls Committee in November, 2019.
- A. Baker, NM 4N, provided a report to the Falls Committee re an uptick in falls Jan-June 2019. An analysis of this trend notes several common opportunities: 1) traveler onboarding, 2) bed alarm refusals by patients and 3) patients sitting on the edge of the bed. Action planning under way with update to the Committee in July 2019.
- Evaluate yellow sock options, completed May 2019. After a trial of various sock options, none were found to be superior to the current sock. A recommendation was made to the nursing units by the Falls Committee to replace socks, daily if needed, if the socks were found to be ill-fitting.
- Environmental assessment of adult patient rooms at the Medical Center was completed in May, 2019 in collaboration with Stryker, report pending

Submitted by Name:

Rose Newsom, MSN NE-BC
Director of Nursing Practice
Falls Committee Chair

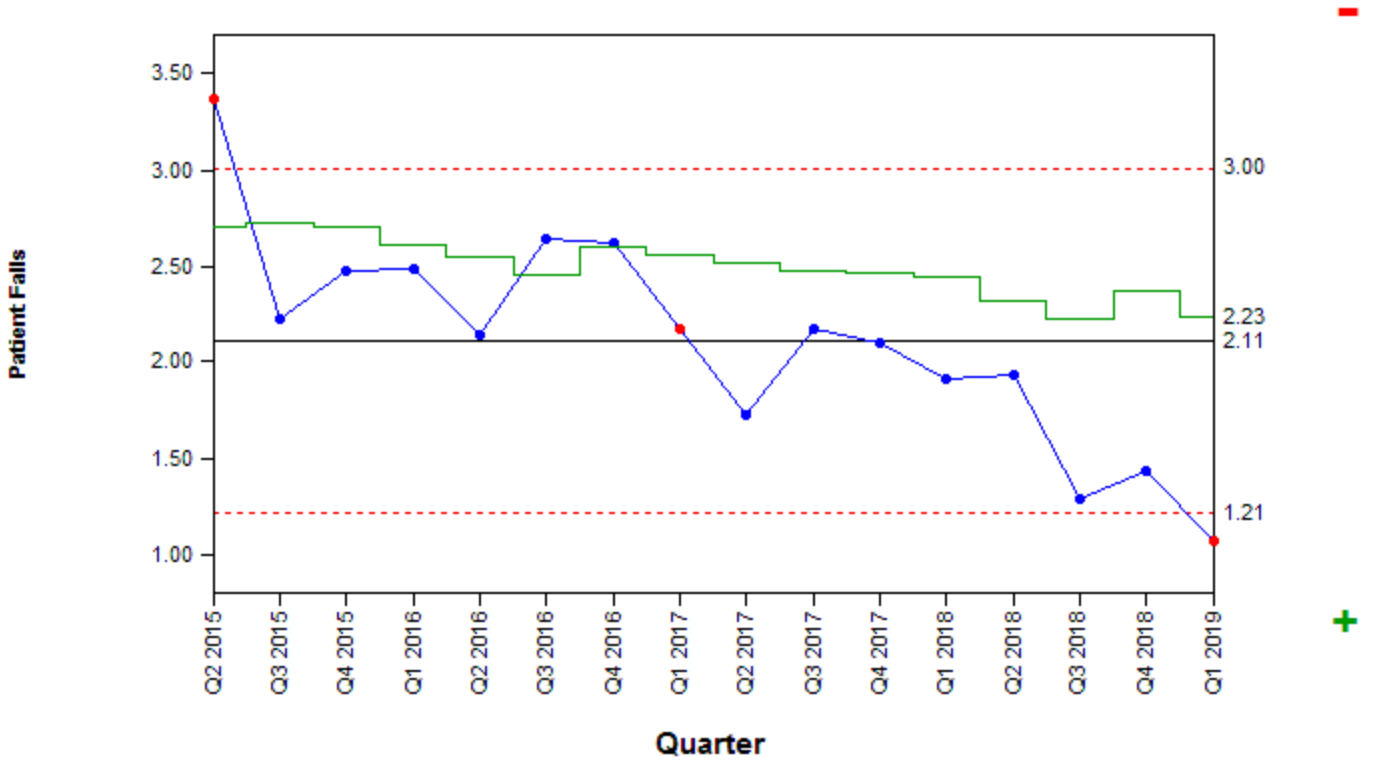
Date Submitted:

July 17, 2019

I Chart 3-Sigma

Total Patient Falls Per 1000 Patient Days KDHCD (Q)

Quarter = ALL



Aug 16, 2019 15:49:17

Validated by Cindy Vander Schuur at 06/25/19 14:21

	Q2 2015	Q3 2015	Q4 2015	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019
Patient Falls	3.36	2.22	2.47	2.48	2.13	2.64	2.61	2.18	1.72	2.17	2.10	1.91	1.93	1.29	1.43	1.07
Target	2.70	2.72	2.70	2.61	2.54	2.45	2.60	2.56	2.51	2.47	2.46	2.44	2.32	2.22	2.37	2.23

Description	
Owners	
Expert	Erick Nad
Notes 1	
Notes 2	
Cautions	
Disclaimer	

Kaweah Delta HEALTH CARE DISTRICT

ED Metric May 2019 to July 2019

General Metrics	Jun-19 KDHCD	Jun-19 Benchmark	Jul-19 KDHCD	Jul-19 Benchmark	Aug-19 KDHCD	Aug-19 Benchmark
ED Volume	7119		7695		7698	
Percent of Patients Left Without Being Seen	1.5%	1.5%	2.0%	1.5%	2.0%	1.5%
Percent of Patients Left During Treatment	2.1%	1.5%	2.4%	1.5%	2.4%	1.5%
Percent of Patients Left Against Medical Advice	0.90%	NA	0.8%	NA	1.0%	NA
Percent of Patients Admitted	26%	NA	24%	NA	24%	NA
Percent of Patients Discharged	68%	NA	69%	NA	69%	NA
ED Throughput Metrics						
Total Minutes from Door to Provider						
Length of Stay in Minutes for Admitted Patient (Hours)	497 (8.2)	423 (7.05)	490 (8.1)	423 (7.05)	501 (8.3)	423 (7.05)
Length of Stay in Minutes for Discharged Patient (Hours)	257 (4.3)	204 (3.4)	258 (4.3)	204 (3.4)	254 (4.2)	204 (3.4)
Length of Stay for Discharged Patients (Median)	257.5		256		250	
Length of Stay in Minutes from Admit Decision to ED Depart (Hours)	284 (4.7)	180 (3)	281 (4.7)	180 (3)	271 (4.5)	180 (3)
Length of Stay in Minutes for Admitted Mental Health Patients	1110 (18.5)		905 (15.8)		846 (14.1)	
Number of Patients Arriving by Ambulance	1850		1993		2002	
Number of Trauma Patients	178		170			
NEDOCS- % of time considered Overcrowded	47%		47%		48%	
Patient Experience						
Emergency Room Overall Care Percentile Ranking	38th percentile					
Likelihood to Recommend the ED at KD Percentile Ranking	60th percentile					
KEY	Outperforming benchmark		Underperforming Benchmark		Equal to Benchmark	

CLINICAL QUALITY GOALS

SEPSIS

Sepsis is a potentially life-threatening complication of an infection. It's most dangerous in older adults or those with weakened immune systems. Early treatment of sepsis, usually with antibiotics and large amounts of intravenous fluids, improves chances for survival.

GOAL >65%

PREVIOUS MONTH 59%

JUNE 2019
HIGHER IS BETTER

72%

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

MRSA

Methicillin-resistant Staphylococcus aureus (MRSA) is a type of staph bacteria that is resistant to certain antibiotics. More severe or potentially life-threatening MRSA infections occur most frequently among patients in healthcare settings.

GOAL <.85%

PREVIOUS QUARTER 3.00

JULY 2019
NUMBER OF PATIENTS WHO ACQUIRED MRSA **0**

APR-JUNE 2019
LOWER IS BETTER

1.43

Standardized Infection Ratio (SIR)
The number of patients who acquired MRSA while in the hospital divided by the number of patients who were expected.

CAUTI

A catheter-associated urinary tract infection (CAUTI) is one of the most common infections a person can contract in the hospital. Indwelling urinary catheters are the cause of this infection.

GOAL <.62

PREVIOUS QUARTER 1.93

JULY 2019
NUMBER OF PATIENTS WHO ACQUIRED CAUTI **1**

APR-JUNE 2019
LOWER IS BETTER

1.33

Standardized Infection Ratio: The number of patients who acquired a CAUTI while in the hospital divided by the number of patients who were expected.

CLABSI

A central line-associated bloodstream infection (CLABSI) is a serious infection that occurs when germs (usually bacteria or viruses) enter the bloodstream through the central line.

GOAL <.86

PREVIOUS QUARTER 1.58

JULY 2019
NUMBER OF PATIENTS WHO ACQUIRED CLABSI **0**

APR-JUNE 2019
LOWER IS BETTER

0.97

Standardized Infection Ratio (SIR) The number of patients who acquired a CLABSI while in the hospital divided by the number of patients who were expected.

eReports Dashboard

Ending Timeframe : 2018Q4 **Category :** ALL

Participant : 906004 - Kaweah Delta Hospital District

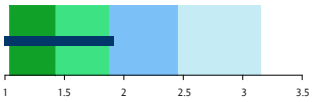
Data Submission Status	Base	2019Q3	2019Q2	2019Q1	2018Q4	2018Q3	2018Q2
	Latest Submission Jul 11, 2019 6:09:34 PM	G	G	G	G	G	G

Metrics Aggregated on : Apr 16, 2019 11:59:00 PM

PCI Performance Measures PCI = Percutaneous Coronary Intervention (Stent or Balloon)

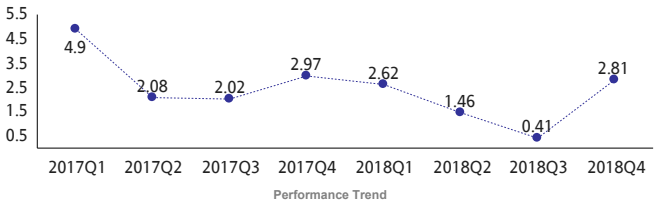
1 - PCI in-hospital risk adjusted mortality (all patients)

1.91
My Hospital
R4Q Performance



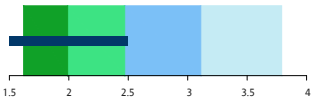
10th	25th	50th	75th	90th
3.15	2.45	1.87	1.42	1.04

US Hospital R4Q Performance Distribution for 2018Q4



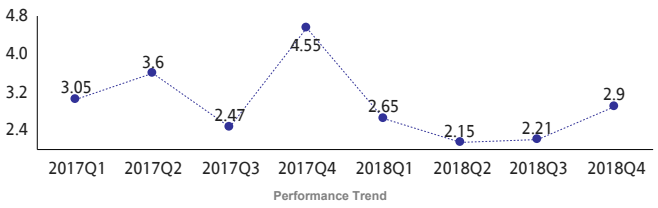
40 - PCI in-hospital risk standardized rate of bleeding (all patients)

2.49
My Hospital
R4Q Performance



10th	25th	50th	75th	90th
3.79	3.11	2.47	1.99	1.62

US Hospital R4Q Performance Distribution for 2018Q4



eReports Dashboard

Ending Timeframe : 2018Q4 **Category :** ALL

Participant : 906004 - Kaweah Delta Hospital District

Data Submission Status	Base	2019Q3	2019Q2	2019Q1	2018Q4	2018Q3	2018Q2
	Latest Submission Jul 11, 2019 6:09:34 PM	G	G	G	G	G	G

Metrics Aggregated on : Apr 16, 2019 11:59:00 PM

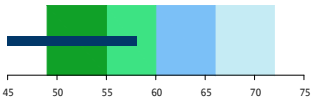
Quality Metrics

STEMI = ST Elevated Myocardial Infarction (Cardiac Alert-Emergency)

3 - Median time to immediate PCI (patients with STEMI)

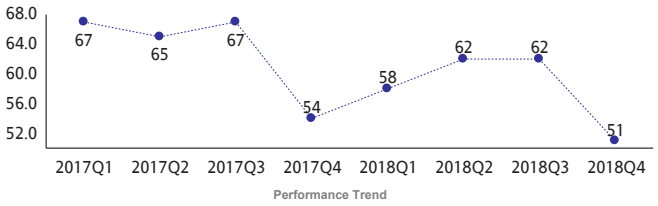
58 min

My Hospital R4Q Performance



10th	25th	50th	75th	90th
72	66	60	55	49

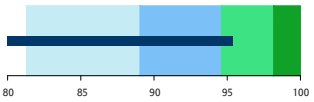
US Hospital R4Q Performance Distribution for 2018Q4



4 - PCI within 90 minutes (patients with STEMI)

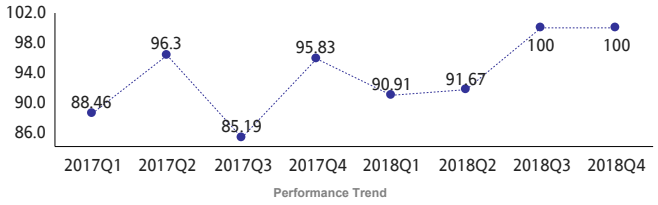
95.37%

My Hospital R4Q Performance



10th	25th	50th	75th	90th
81.29	89.04	94.62	98.17	100

US Hospital R4Q Performance Distribution for 2018Q4

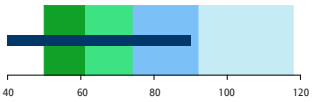


5 - Median transfer time from door to door (patients with STEMI)

90 min

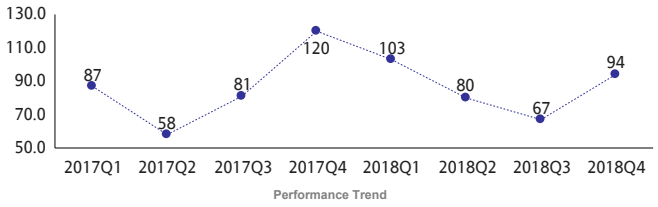
My Hospital R4Q Performance

Time from transferring ED arrival to arrival at KDHCD



10th	25th	50th	75th	90th
118	92	74	61	50

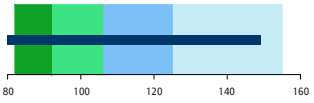
US Hospital R4Q Performance Distribution for 2018Q4



6 - Median time to immediate PCI (transfer patients with STEMI)

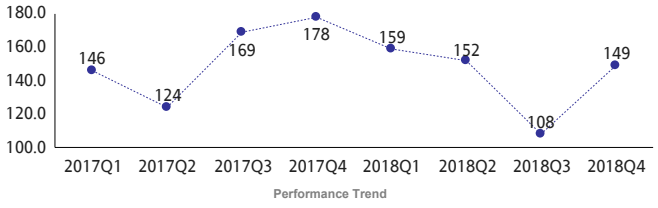
149 min

My Hospital R4Q Performance



10th	25th	50th	75th	90th
155	125	106	92	82

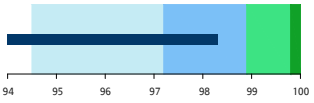
US Hospital R4Q Performance Distribution for 2018Q4



8 - Aspirin prescribed at discharge

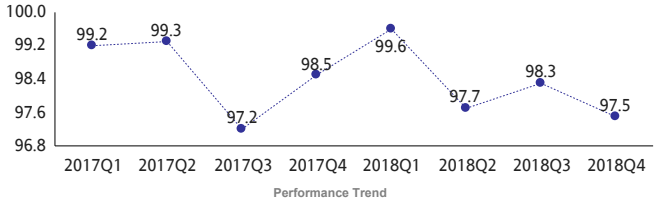
98.3%

My Hospital R4Q Performance



10th	25th	50th	75th	90th
94.5	97.2	98.9	99.8	100

US Hospital R4Q Performance Distribution for 2018Q4



eReports Dashboard

Ending Timeframe : 2018Q4 **Category :** ALL

Participant : 906004 - Kaweah Delta Hospital District

Data Submission Status

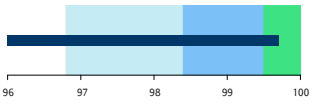
Base
Latest Submission
Jul 11, 2019 6:09:34 PM

2019Q3	2019Q2	2019Q1	2018Q4	2018Q3	2018Q2
G	G	G	G	G	G

Metrics Aggregated on : Apr 16, 2019 11:59:00 PM

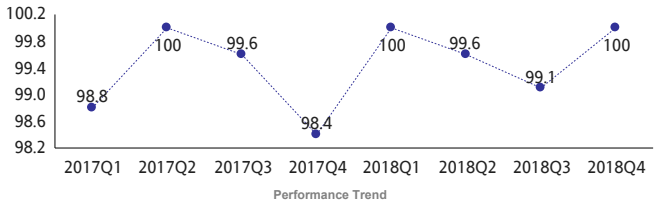
9 - P2Y12 inhibitor prescribed at discharge

99.7%
My Hospital R4Q Performance



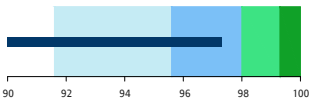
10th	25th	50th	75th	90th
96.8	98.4	99.5	100	100

US Hospital R4Q Performance Distribution for 2018Q4



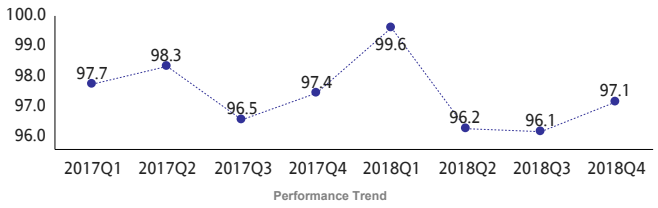
10 - Statin prescribed at discharge

97.3%
My Hospital R4Q Performance



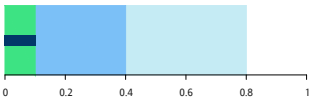
10th	25th	50th	75th	90th
91.6	95.6	98	99.3	100

US Hospital R4Q Performance Distribution for 2018Q4



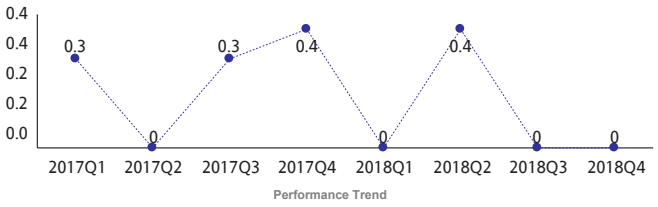
16 - Intra/post-procedure stroke

0.1%
My Hospital R4Q Performance



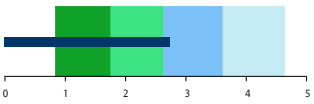
10th	25th	50th	75th	90th
0.8	0.4	0.1	0	0

US Hospital R4Q Performance Distribution for 2018Q4



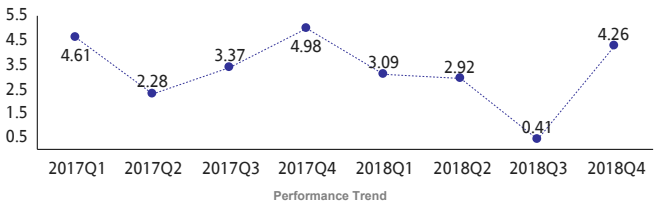
17 - Composite: Major adverse events (all patients)

2.72%
My Hospital R4Q Performance



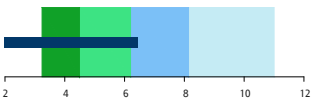
10th	25th	50th	75th	90th
4.63	3.6	2.61	1.74	0.84

US Hospital R4Q Performance Distribution for 2018Q4



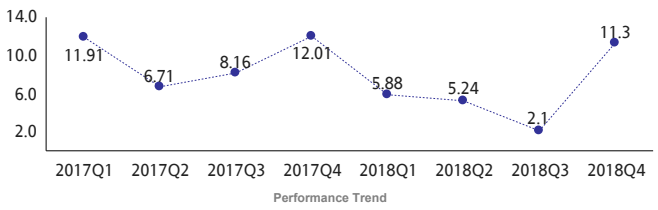
18 - PCI in-hospital risk adjusted mortality (patients with STEMI)

6.43
My Hospital R4Q Performance



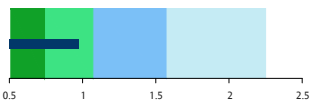
10th	25th	50th	75th	90th
11	8.14	6.2	4.49	3.24

US Hospital R4Q Performance Distribution for 2018Q4



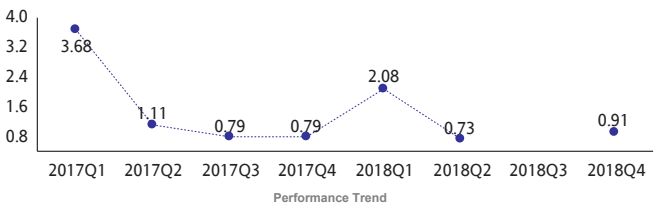
19 - PCI in-hospital risk adjusted mortality (STEMI patients excluded)

0.97
My Hospital R4Q Performance



10th	25th	50th	75th	90th
2.25	1.57	1.07	0.74	0.51

US Hospital R4Q Performance Distribution for 2018Q4



eReports Dashboard

Ending Timeframe : 2018Q4 **Category :** ALL

Participant : 906004 - Kaweah Delta Hospital District

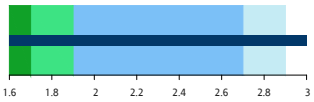
Data Submission Status	Base	2019Q3	2019Q2	2019Q1	2018Q4	2018Q3	2018Q2
	Latest Submission Jul 11, 2019 6:09:34 PM	G	G	G	G	G	G

Metrics Aggregated on : Apr 16, 2019 11:59:00 PM

22 - Median post-procedure length of stay (patients with STEMI)

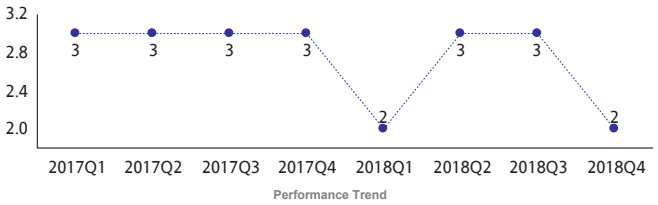
3 Day

My Hospital R4Q Performance



10th	25th	50th	75th	90th
2.9	2.7	1.9	1.7	1.6

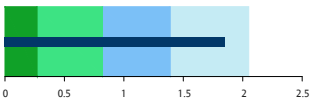
US Hospital R4Q Performance Distribution for 2018Q4



25 - Transfusion post PCI

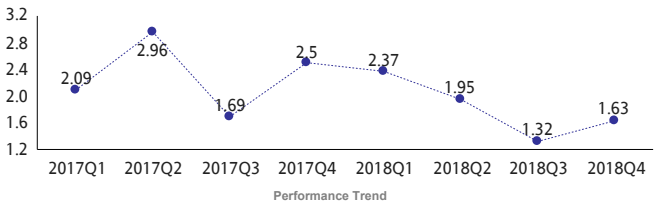
1.85%

My Hospital R4Q Performance



10th	25th	50th	75th	90th
2.05	1.39	0.82	0.27	0

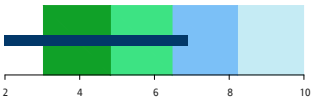
US Hospital R4Q Performance Distribution for 2018Q4



39 - PCI in-hospital risk adjusted acute kidney injury (all patients)

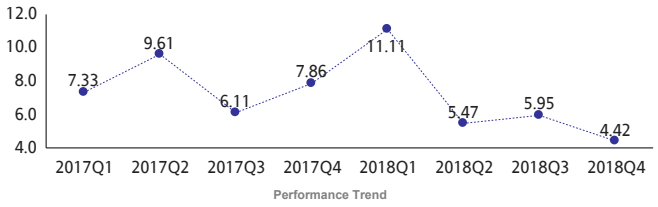
6.88

My Hospital R4Q Performance



10th	25th	50th	75th	90th
9.99	8.22	6.47	4.82	3.03

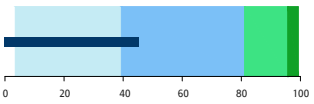
US Hospital R4Q Performance Distribution for 2018Q4



45 - Cardiac rehabilitation referral

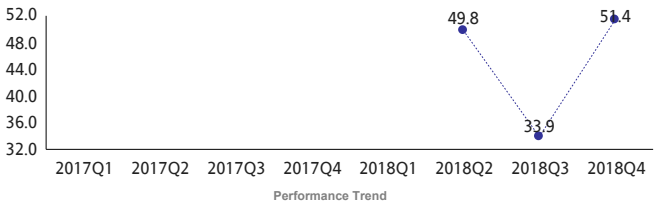
45.3%

My Hospital R4Q Performance



10th	25th	50th	75th	90th
3.5	39.4	81.1	95.7	99.3

US Hospital R4Q Performance Distribution for 2018Q4



Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2019

		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
I. Overall Surgical Site Infections (SSI)	**IR/SIR**						**SSIs calculated internally though standard incidence rate and externally through Standardized Infection Ratio (SIR) from National Health and Safety Network (NHSN).**
A. #Total Procedure Count		1458	*1034*				**Annual running total:** *2492*
B. Total Infection Count *[note: SSI events can be identified up to 90 days from the last day of the month in each quarter]*		**5**	***9***				**1st QTR:** 5 **Predicted:** 17.45 **2nd QTR: Predicted:**
C. Incidence Rate (IR) [# of total SSI infections/# total procedures x 100]	Internal 0.70 Goal	**0.34**	***0***				**1st QTR:** Well exceeded the District's goal of 0.70 SSI incidence rate - 36% better. **2nd QTR:**
D. SIR Confidence Interval (CI-KDHCD predicted range, based on risks)		0.105 - 0.635					**1st QTR:** Better than California 2017 SSI Benchmark of 0.89. *[Benchmark provided by CDPH 2017 Annual Report for overall top performance]* **2nd QTR:**
E. Standardized Infection Ratio (SIR)	NHSN	**0.29**	***0***				**1st QTR:** SB, FUSN x 2, KPRO, FX, CHOL, PACE, COLO, VHYS, CSEC, CBGB (6 of these events were superficial and are not counted by CMS or by CDPH for public reporting) **2nd QTR:** COLO x 2, HPRO, CHOL, FUSN, HER, BRST, CSEC, HYST
F. Action Plan for Improvement							**1st QTR:** Scripting for 3 different Time-Out sessions almost complete (1st pre-op antibiotic administration check; 2nd universal timeout; 3rd debrief timeout verfiy whether a change in wound status occurred). Pursuuing questions about clean closure for colorectal surgeries - some surgeons have resevations about the process, whether or not it is an effective process for reducing SSI (it is supported by data meta-analysis and described prevention guidelines). **2nd QTR:** Clean closure for gastrointestinal procedures now supported by all surgeons. Timely pre-op antibiotic administration improved slightly. Hematomas were involved in SSI development for 2 events. Anastomosis leaks identified as potential source of 2 SSI events. Endogenous skin flora and care of the incision at home post-operatively is also suspected as source of infections for remaining SSI events.
II. Specific Surgical Review	**SIR**						
A. Colon Surgery (COLO) CMS/VBP							
1. #Total Procedure Count		53	***34***				**Annual running total:** *140*

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2019							
		Q1	**Q2**	**Q3**	**Q4**	**AVG. or TOTAL YTD**	**SUMMARY / ACTION**
2. Total Infection Count		**0**	***2*** ***[0]***				**1st QTR:** 0 **Predicted:** NA **2nd QTR: Prediceted:**
3. SIR CI (KDHCD predicted range, based on risks)		0 - 0.959					**1st QTR:** No different than 2019 National Benchmark of 0.781. **2nd QTR:**
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]		**0** **[0]**					**1st QTR:** 1 COLO event (superficial SSI - not reported to CMS or CDPH). Intra-operatively there were 7 observers (non-staff) observing this procedure and a lot of activity going in and out of the surgery. **2nd QTR**:
B. Cesarean Section (CSEC)							
1. #Total Procedure Count		351	***235***				**Annual running total:** *586*
2. Total Infection Count		**0**	***1***				**1st QTR:** 0 **Predicted:** NA **2nd QTR: Predicted:**
3. SIR CI (KDHCD predicted range, based on risks)		0 - 0.908					**1st QTR:** No different than California 2016 CSEC Benchmark of 0.89. **2nd QTR:**
4. SIR (Standardized Infection Ration) total		**0**					**1st QTR:** 1 CSEC event (deep SSI); this case was likely unpreventable. Patient had a spontaneous appendiceal rupture post-operatively that complicated the post-operative course. **2nd QTR:**
C. Spinal Fusion (FUSN)							
1. #Total Procedure Count		37	***40***				**Annual running total:** *77*
2. Total Infection Count		**1**	***1***				**1st QTR:** 1 **Predicted:** 0.47 **2nd QTR: Predicted:**
3. SIR CI (KDHCD predicted range, based on risks)		NA					**1st QTR:** Worse than California 2016 FUSN Benchmark of 0.82. **2nd QTR:**

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2019

		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
4. SIR (Standardized Infection Ration) total		**2.12 [2.12]**					**1st QTR:** 2 FUSN events (2 deep SSI); A trend was identified with this particular type of SSI event. Spinal Fusion patients are transferred from the acute care setting to the District's long-term rehab facility. Identified a gap in continuity-of-care through communication of discharge orders, specialists do not follow their patients to long-term care rehab and will not be consulted regarding surgical wound healing and evaluation. Long-term care rehab nurses are unfamiliar with some interventions related to the SSI prevention bundle. Neurosurgery and Orthopedic service line representatives will now be attending SSI Prevention Committee. A midlevel practioner from the orthopedic service line will now follow patients to lont-term rehab to assess incision sites and consult. Long-term rehab nurses will be reintroduced to SSI Prevention Bundle interventions as a part of annual compentency training. **2nd QTR:**
D. Hysterectomy (HYST) CMS/VBP							
1. #Total Procedure Count		23	*17*				**Annual running total:** *40*
2. Total Infection Count		**0**	***1*** ***[0]***				**1st QTR:** 0 **Predicted:** NA **2nd QTR: Predicted:**
3. SIR CI (KDHCD predicted range, based on risks)		NA					**1st QTR:** Better than 2018 Benchmark of 0.722. **2nd QTR**:
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]		**0 [0]**					**1st QTR:** No events. **2nd QTR:**
II. Ventilator Associated Events (VAE)	**SIR**						
A. Ventilator Device Use SUR (standardized utilization ratio)		**1.23**	**1.519**				**1st QTR:** 758vd **Predicted:** 615.75vd **2nd QTR:**781vd **Predicted:** 514.09vd
B. Total VAEs ICU (NHSN Reportable)	Includes IVAC Plus	**4**	**5**				**1st QTR:** 4 **Predicted:** 3.97 **2nd QTR:** 5 **Predicted:** 4.08
1. SIR Total VAE CI (KDHCD predicted range, based on risks)		0.320 - 2.432	0.448- 2.711				This is an internal quality driven metric. A State or National benchmark has not been made available.
2. Total VAEs SIR		**1.35**	**2.62**				**1st QTR:** ICU had 2 VAC, 1 IVAC, 1 PVAP events. **2nd QTR:** ICU had 3 VAC, 3 IVAC, 1 PVAP events
C. Total IVAC Plus -ICU		**2**	**4**				**1st QTR:** 2 **Predicted:** 1.48 **2nd QTR:** 4 **Predicted:** 2.62

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2019							
		Q1	**Q2**	**Q3**	**Q4**	**AVG. or TOTAL YTD**	**SUMMARY / ACTION**
1. Total IVAC Plus CI (KDHCD predicted range, based on risks)		0.226 - 4.455	0.832- 6.314				This is an internal quality driven metric. A State or National benchmark has not been made available.
2. Total IVAC *Plus* ICU SIR		**1.01**	**2.617**				**1st QTR:** 2 PVAP events **2nd QTR:** 1 PVAP event
D. CVICU/**KDHCD** Total VAEs (not NHSN/Internal)		**2**	**5**				**1st QTR:** 1 PVAP event **2nd QTR:** 2 VAC & 1 IVAC event
E. Total VAEs-Both Units		**6**	**10**				**1st QTR:** 3 VAC,1 IVAC, 2 PVAP; pursuing implementation of subglottic suctioning, and scheduled oral care. **2nd QTR:** 5 VAC, 4 IVAC, 1 PVAP; pursuing methods to reduce VAC events thereby reducing IVAC plus events.
III. Central Line Associated Blood Stream Infections (CLABSI) CMS/VBP	**NHSN SIR**						
A. Total number of Central Line Days (CLD)		3648	3496				**Annual running total:** 7144
B. Central Line Device Use SUR (standardized utilization ratio)		**0.76**	**0.72**				**1st QTR:** 3648 **Predicted:** 4,787.70 **2nd QTR:** 3496 **Predicted:** 4,814.87
C. Total Infection Count Valule Based Purchasing (VBP) # events = [ ]		**5** **[4]**	**3** **[2]**				**1st QTR:** 5 **Predicted:** 3.17 **2nd QTR:** 3 **Predicted:** 3.21
D. SIR Confidence Interval		0.577 - 3.492	0.238 - 2.543				**1st QTR:** No different than 2019 National Benchmark of 0.784. **2nd QTR:** No different than 2019 National Benchmark of 0.784.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2019

		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]		**1.58** **[1.82]**	**0.97** **[0.93]**				**1st QTR:** 5 events - must attempt to achieve 1 or less CLABSI events per Quarter. Implementing "Operation Stomp-Out CLABSI" interventions (29 in all). IV Safety Team has been hard at work gathering daily data from observations and intervening in the moment to ensure safe and effective line CVC and PIV line management. Transitioning interventions toward providers and GME residents. Discussing different options such as rotating the line in the IJ position for more effective dressing securement, investigating axillary vein access for subclavian line placement. Contacting hospital affiliate- Cleveland Clinic Infection Prevention to determine CLABSI prevention practices employed by that organization. Developing a CLABSI prevention CBL for residents. Continuing to offer Safety Symposium regarding CLABSI prevention for nurses. **2nd QTR:** 3 events (61% decrease from 1st QTR SIR). To achieve an SIR of 0.784 <1 CLABSI is predicted per quarter. Implemented use of Prevantix CHG swabs for scrub-the-hub activities (5 sec scrub/5 second dry). Moving forward with Operation Stomp-Out CLABSI initiatives. Working on central line documentation in Cerner. IV Safety Team continues to perform interventions such as dressing changes/advocating for line discontinuation. IV Safety Team is undergoing their 6 month evaluation process as this intervention was temporarily piloted this year.
IV. Catheter Associated Urinary Tract Infections (CAUTI) CMS/VBP	**NHSN SIR**						
A. Total number of Catheter Device Days (CDD)		3908	3738				**Annual running total:** 3908
B. Catheter Device Days SUR (Standardized Utilization Ratio)		**0.743**	**0.749**				**1st QTR:** 3908 **Predicted:** 5257.86 **2nd QTR:** 3738 **Predicted:** 4,992.08
C. Total Infection Count Value Based Purchasing (VBP) # of events = [ ]		**7** **[6]**	**5** **[2]**				**1st QTR:** 7 **Predicted:** 3.95 **2nd QTR:** 5 **Predicted:** 3.76
D. SIR Confidence Interval		0.720 - 0.767	0.487- 2.945				**1st QTR:** Worse than 2019 National Benchmark of 0.828 **2nd QTR:** No different that National Benchmark of 0.828.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2019							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]		1.77 [2.89]	1.33 [0.87]				**1st QTR:** Many of these events are due to keeping the indwelling urinary catheter longer than indicated; collecting urine cultures when not indicated. Approvals are occuring for implementation of a new order set for Urine Cultures (to help ensure when cultures are ordered they are really indicated), also implementation of a CAUTI algorithim will be starting soon. Considering dual nurse insertion of indwelling urinary catheters to reduce risk of contamination during insertion. **2nd QTR:** Urinalysis orderset implemented, however, provider have not used it frequently as it hasn't been added to their favorites in Cerner, ISS is working to address this. CAUTI prevention algorithm has been added to the Nursing Standard of Practice which is still under revision. CAUTI prevention algorithm will be added to physician ordersets so that nursing has greaterly flexibility to inact appropriate measures without waiting for physician approval to do so.
V. Clostridium *difficile* Infection (CDI) CMS/VBP	**SIR**						
A. Total Infection Count	All units	5 [5]	3 [3]				**1st QTR:** 5 **Predicted:** 16.93 **2nd QTR:** 3 **Predicted:** 15.62
B. SIR CI (KDHCD predicted range, based on risks)		0.108 - 0.655	0.049- 0.523				**1st QTR:** Better than 2019 National Benchmark of 0.852 **2nd QTR:** Better than 2019 National Benchmark of 0.852.
C. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]		0.3 [0.30]	0.19 [0.19]				**1st QTR:** Continued implementation of the C. diff. algorithm, interventions provided by Antimicrobial Stewardship Pharmacist and Infection Prevention. **2nd QTR:** Incredible work done to consistently maintain a low C. difficile rate to interventions described during 1st QTR.
VI. Hand Hygiene	**95%**						
A. All units Percentage of correct Hand Hygiene observations/opportunities (30 observations/month/unit)		88%	90%				**1st QTR:** 3,397 of 3,877 hand hygiene observations were compliant. **2nd QTR:** 3,547 of 3,938 hand hygiene observations were compliant.
VII. VRE (HAI) Blood-Hospital Onset (HO)	**BM**						
A. Total Infection Count		0	0				**1st QTR:** 0 **Predicted:** 0 **2nd QTR:** 0 **Predicted: 0**
B. Prevalence Rate (x100)		0	0				**1st QTR:** 0 **2nd QTR:** 0
C. Number Admissions		7236	4984				

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2019

		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
VIII. MRSA (HAI) Blood CMS/VBP	**SIR**						
A. Total Infection Count (IP Facility-wide)		**3** **[3]**	**1** **[1]**				**1st QTR:** 3 **Predicted** 1.41 **2nd QTR:** 1 **Predicted:** 1.43
B. SIR CI (KDHCD predicted range, based on risks)		0.541 - 5.785	0.035- 3.462				**1st QTR:** No better than 2019 National Benchmark of 0.815. **2nd QTR:** No different than National Benchmark of 0.815.
C. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]		**2.13** **[2.13]**	**1.43** **[1.43]**				**1st QTR:** Many of the identified MRSA BSI are also CLABSI events. Reviewing culture practices with providers through our Operation Stomp-Out CLABSI campaign. Also, working on initiating a "Do U Disinfect Everytime (D.U.D.E.) campaign to highlight the importance of hand hygiene compliance, "scrub-the-hub" and cleaning the patient environment. Trialed and will be universally using Prevantics CHG wipes to perform "scrub-the-hub" a 5 second process. Stakeholders are supporting all these interventions. **2nd QTR:** Interventions described above under 1st QTR continue. There has been evaluation underway regarding nasal decolonization products that may be useful in addressing seasonal spike in MRSA BSI during the Flu Season.
IX. Influenza Rates (Year 2018-2019)	**NHSN**						
A. All Healthcare Workers 5,384 working/5,279 total vaccination (90 declined)		**98.0%**					**Season 2018-2019**: **Action:** Once again Kaweah Delta has consistently exceeded the Healthy People 2020 goal of 90% vaccination rate.

Approved IPC: 6/27/2019
Approved IPC:
Approved IPC:
Approved IPC:

Prepared by Shawn Elkin, MPA, BSN, RN, PHN, CIC
Infection Prevention Manager