January 3, 2020

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 January 9, 2020, 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 January 9, 2020, 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

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KAWEAH DELTA HEALTH CARE DISTRICT
BOARD OF DIRECTORS
QUALITY COUNCIL

Thursday, January 9, 2020

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

ATTENDING: Herb Hawkins – Committee Chair, 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 Rosie Gonzales, 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. **Rapid Response Team Quality Report**
   1.2. **Stroke Quality Report**
   1.3. **Acute Rehabilitation Hospital Quality Report**

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 2020 Clinical Quality Goals** - A review of current performance and actions focused on the FY 2020 clinical quality goals. *Sandy Volchko, RN, Director of Quality and Patient Safety.*

4. **Annual Review of the Effectiveness of the Quality and Patient Safety Plans** – A review of the effectiveness of the Quality and Patient Safety Plans including key measures, actions and the committee reporting schedule for 2020. *Sandy Volchko, RN, Director of Quality and Patient Safety; Tom Gray, MD, Medical Director of Quality and Patient Safety.*

5. **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.

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: Rapid Response **ProStaff/QIC Report Date: November 12, 2019**

Measures Analyzed:

1. Code Blue Rates/1000 discharges (Slide 3 & 9)
2. RRT Rates/1000 discharges (Slide 3 &11)
3. Code Blue Classifications of Med Surg and ICCU (Slide 4 &5)
4. Code Blue and RRT by unit location (Slide 6 & 12)
5. Code Blue Classification of Vfib/Vtac to PEA/Asystole; survival to discharge (Slide 7&8)
6. Critical Care Code Blue Rates/1000 discharges (Slide 9)
7. Patients with multiple RRTs (Slide 14)
8. RRT Mortality (Slide 13,15)
9. RRT Disposition (Slide 16)
10. RRT within 24 hours of admission from the ED (Slide 17 & 18)
11. RRT within 4 hours, 8 hours, and 12 hours of admission from the ED (Slide 19)
12. RRTs on 3w (Slide 20 &21)
13. Narcan Administration during RRTs (Slide 22)

Date range of data evaluated:

July 2019 to Sept 2019

Analysis of all measures/data: (See Attachment)

- Quarter 3 2019 non-critical care code blues have resulted in a decrease incidence of 3/1000 discharges; this is a decrease from quarter 2 2019 of 6/1000 discharges. The overall code blue average for quarter 3 2019 is 3 code blues per month which is a significant decrease from the previous quarter.
- Code Blues in critical care areas (ICU, CVICU) decreased for quarter 3 2019 at 2/1000 discharges when compared to quarter 2 2019 with 3/1000 discharges.
- Quarter 3 2019 units with the highest incidence of code blues are 3W(4), 3N(4)
- Quarter 3 2019 units with the highest incidence of RRTs are 3W, 4S, 3S, and 2N.
- RRT cases for quarter 3 2019 resulted in 51/1000 discharges for a total N of 338. This is a decrease in RRT cases from the previous quarter.
- 14% of all quarter 3 2019 RRT cases were transferred to an ICU/CVICU level of care, 33% of all quarter 3 2019 RRT cases were transferred to the ICCU level of care. The remaining 48% of cases stayed in the room and 4% had a resuscitation status change.
- Mortality for all RRT cases is 17% of all RRTs in quarter 3 of 2019. This is a decrease in mortality from previous quarter.

- Quarter 3 2019 mortality for multiple RRTs cases is 28% and is down from 40% in previous quarter.
- 32% of RRTs are called within the first 24 hours of admission with the majority occurring in the first 4-8 hours. No change noted from previous quarter.

Next Steps/Recommendations/Outcomes:

1. Mock Code Blues and RRT simulations are being implemented in the hospital. Dr. Sokol presented the Mock Code Blue plan to the Acute Care Managers at PCM on 4/4/19.
2. RRT Data reviewed with Acute Care Managers at PCM on 6/6/19. Encouraged Managers to invite RRT RN's to Department Staff Meetings for Q & A sessions with staff.
3. Code blue case studies that met 10 SOV and did not have an RRT called prior are being sent to managers to review with their staff.
4. Continue the Resident RRT rotation.
5. Daily identification and role assignment for Code Blue team implemented.
6. RRT form revised and streamlined. RRT form has a section for nurses to chart if patients were admitted/transferred within 12 hours prior to the RRT, Narcan effectiveness, and time zero. There is also a section for debriefing points to guide RRT nurses in debriefing. RRT revised form was implemented throughout the hospital starting May 2019.
7. Updates made in Cerner RRT charting: Added more interventions (fluid bolus), fluid bolus start time and stop time, Narcan effectiveness, phlebotomist arrival time, and debriefing completed.

Submitted by Name:
Jon Knudsen
Eileen Paul
Tiffany Quintyn
Kassie Waters
Jeanette Callison
Roxanne Mendez

Date Submitted:
11/13/2019

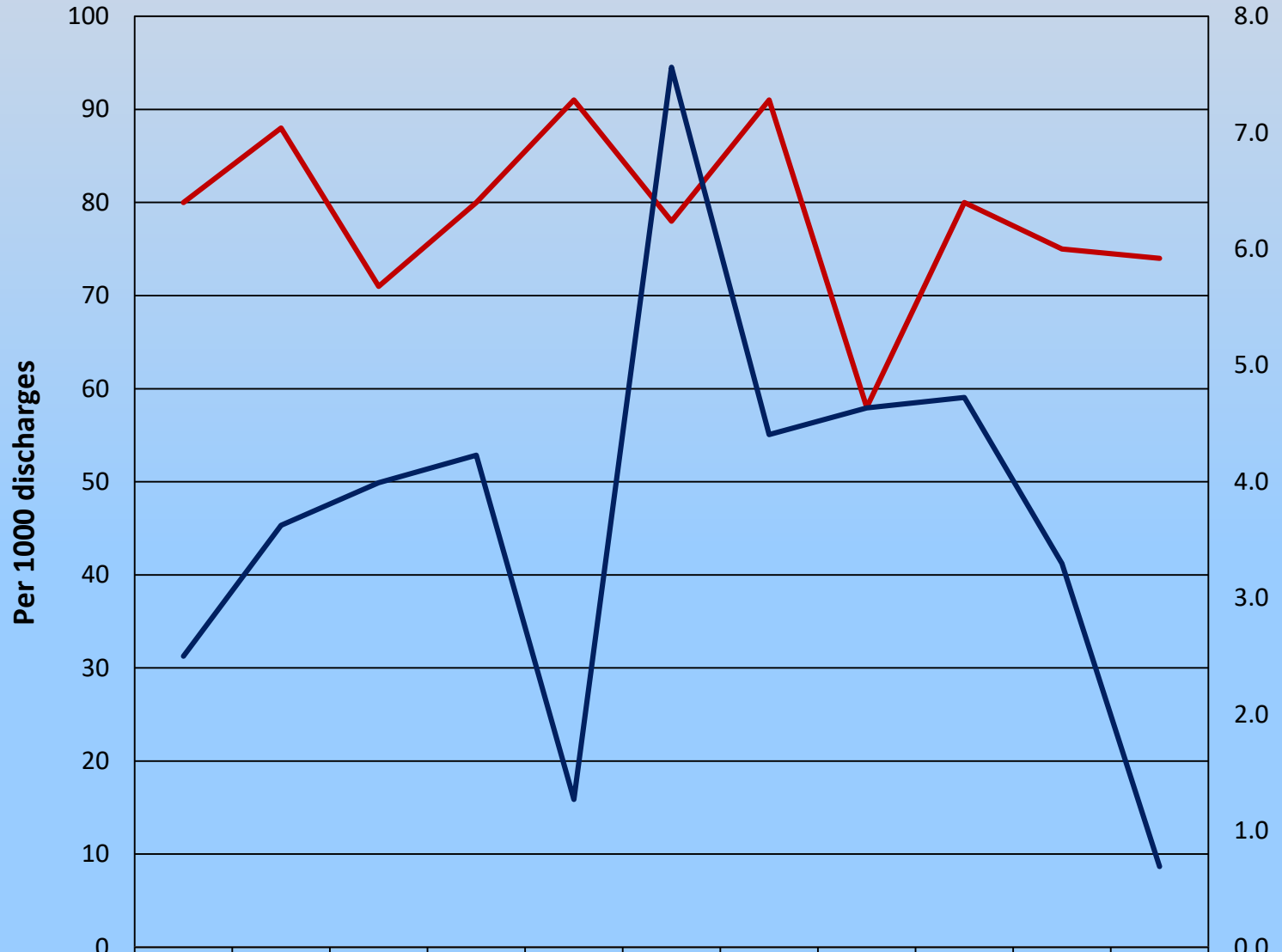
Code Blue and Rapid Response System

October 2019

KAWEAH DELTA HEALTH CARE DISTRICT

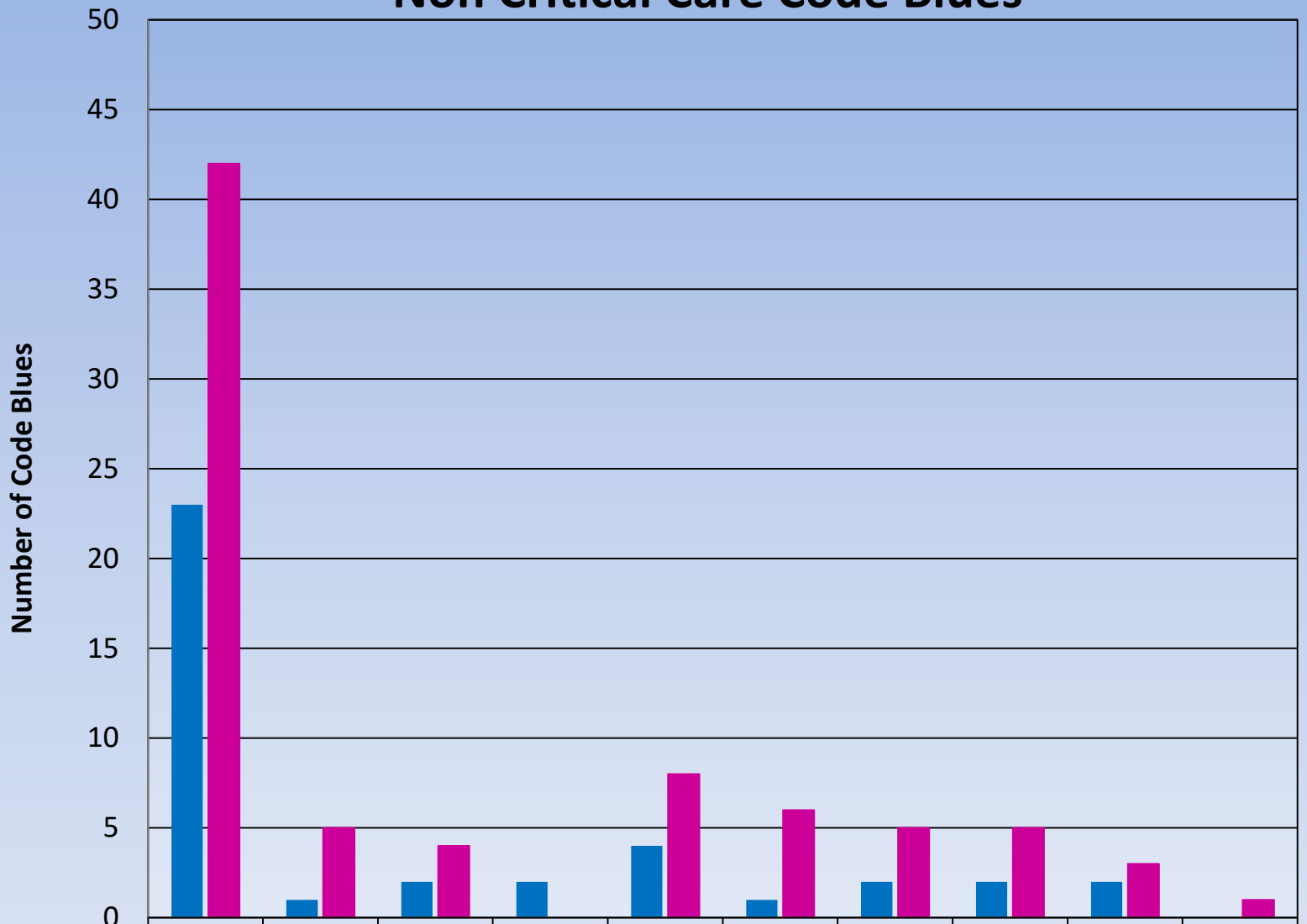
Code Blue Data

Resuscitations (Code Blues) & Rapid Response Team Alerts (RRT's)



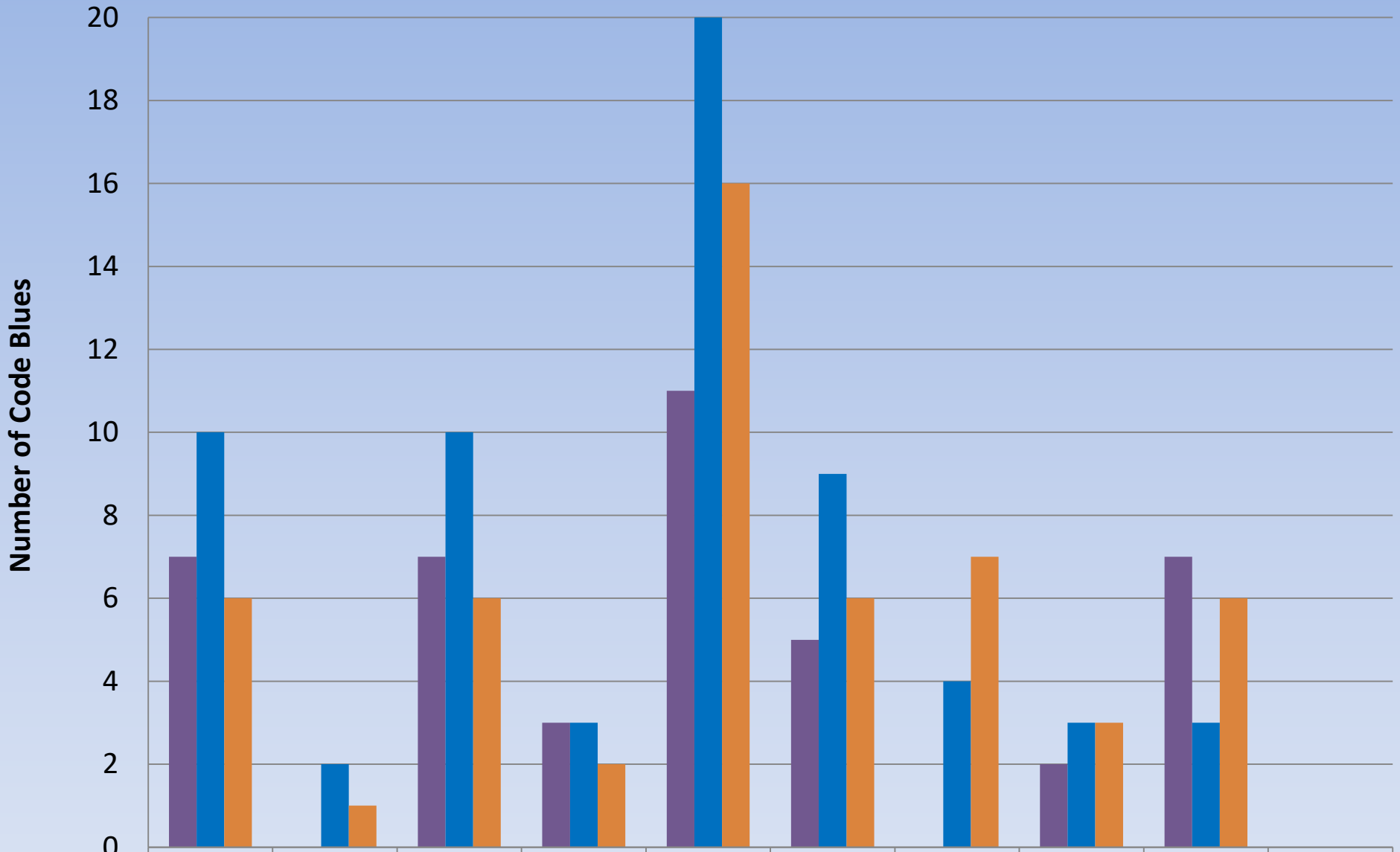
	2017	2018	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
RRT Rate per 1000 discharges	80	88	71	80	91	78	91	58	80	75	74
Code Blue Rate per 1000 discharges	2.5	3.6	4.0	4.2	1.3	7.6	4.4	4.6	4.7	3.3	1

Non Critical Care Code Blues



	2018	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Intermediate Care Code Blue	23	1	2	2	4	1	2	2	2	0
Med Surg Code Blue	42	5	4	0	8	6	5	5	3	1

Code Blue Locations

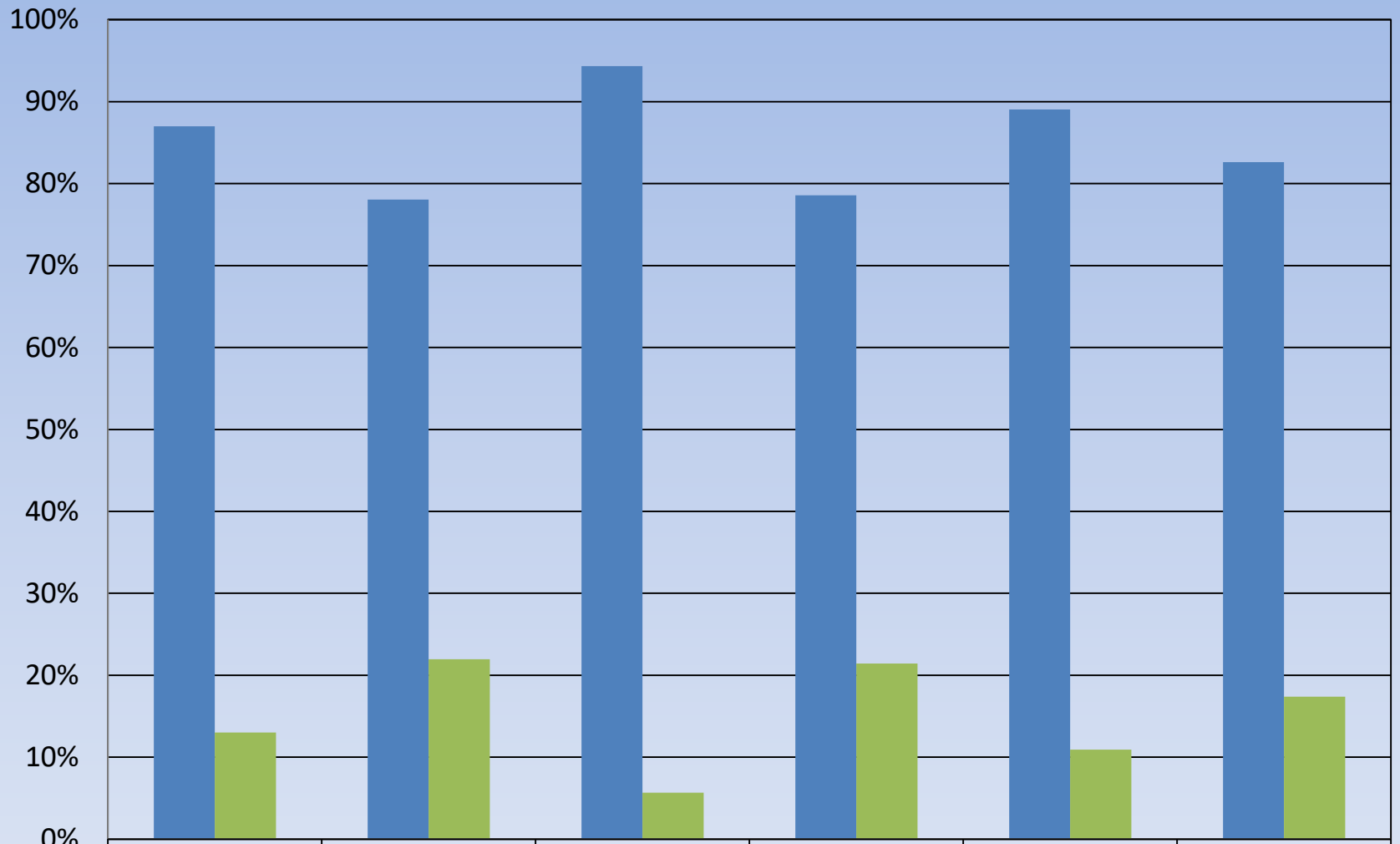


	2N	2S	3N	3S	3W	4N	4S	4T	CVICCU	BP
2017	7	0	7	3	11	5	0	2	7	0
2018	10	2	10	3	20	9	4	3	3	0
2019	6	1	6	2	16	6	7	3	6	0

Code Blues for CVICU and ICU

	CVICU & ICU	CVICU	ICU
2017	65	32	33
2018	62	24	37
Jan-19	5	3	2
Feb-19	6	1	5
Mar-19	3	0	3
Q1 2019	14	4	10
Apr-19	2	0	2
May-19	7	1	6
Jun-19	4	1	3
Q2 2019	13	2	11
Jul-19	5	3	2
Aug-19	4	1	3
Sept-19	2	0	2
Q3 2019	11	4	7

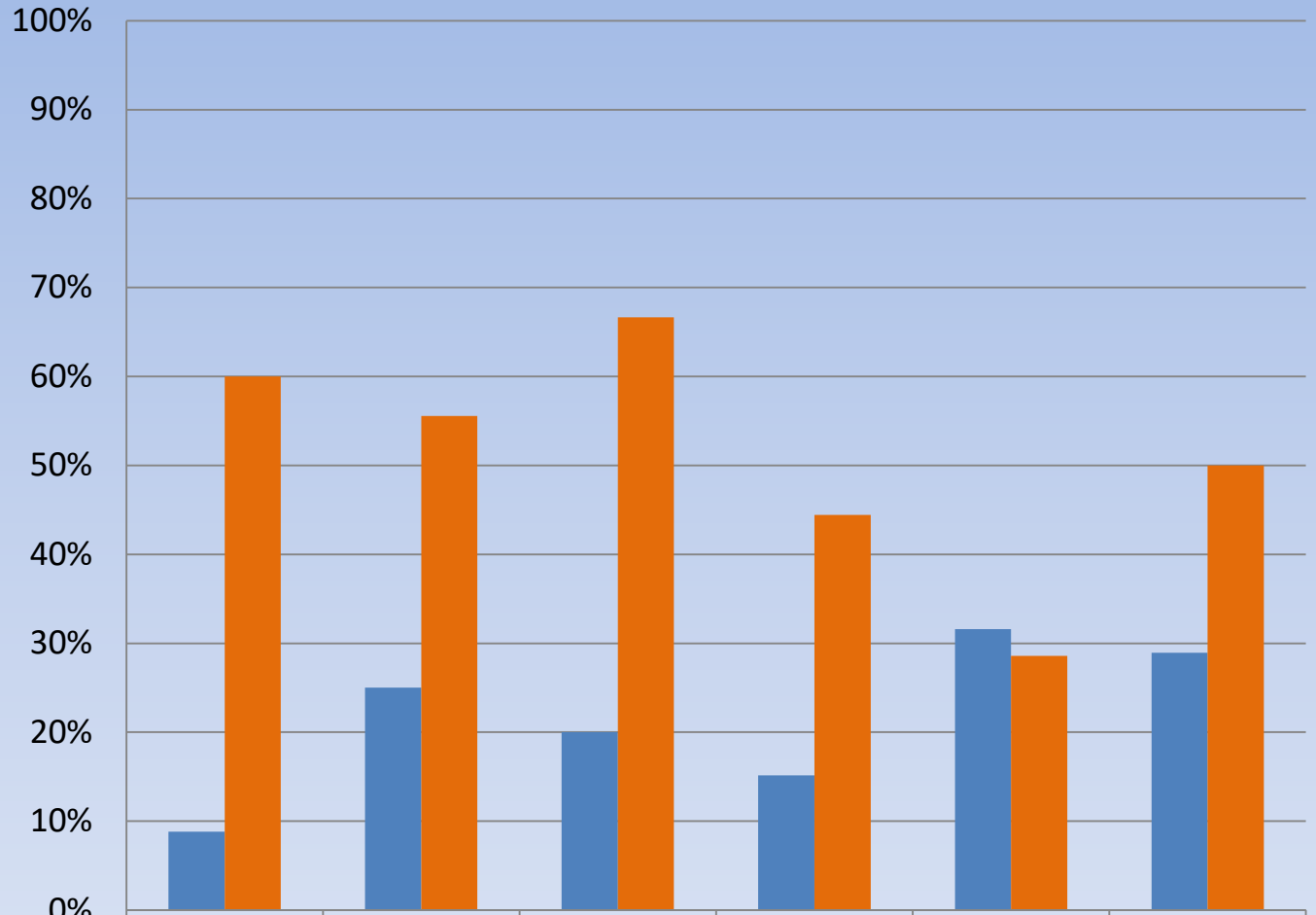
Med Surg- Code Type



	2014	2015	2016	2017	2018	2019
Asystole and PEA	87%	78%	94%	79%	89%	83%
V Fib and V Tac	13%	22%	6%	21%	11%	17%

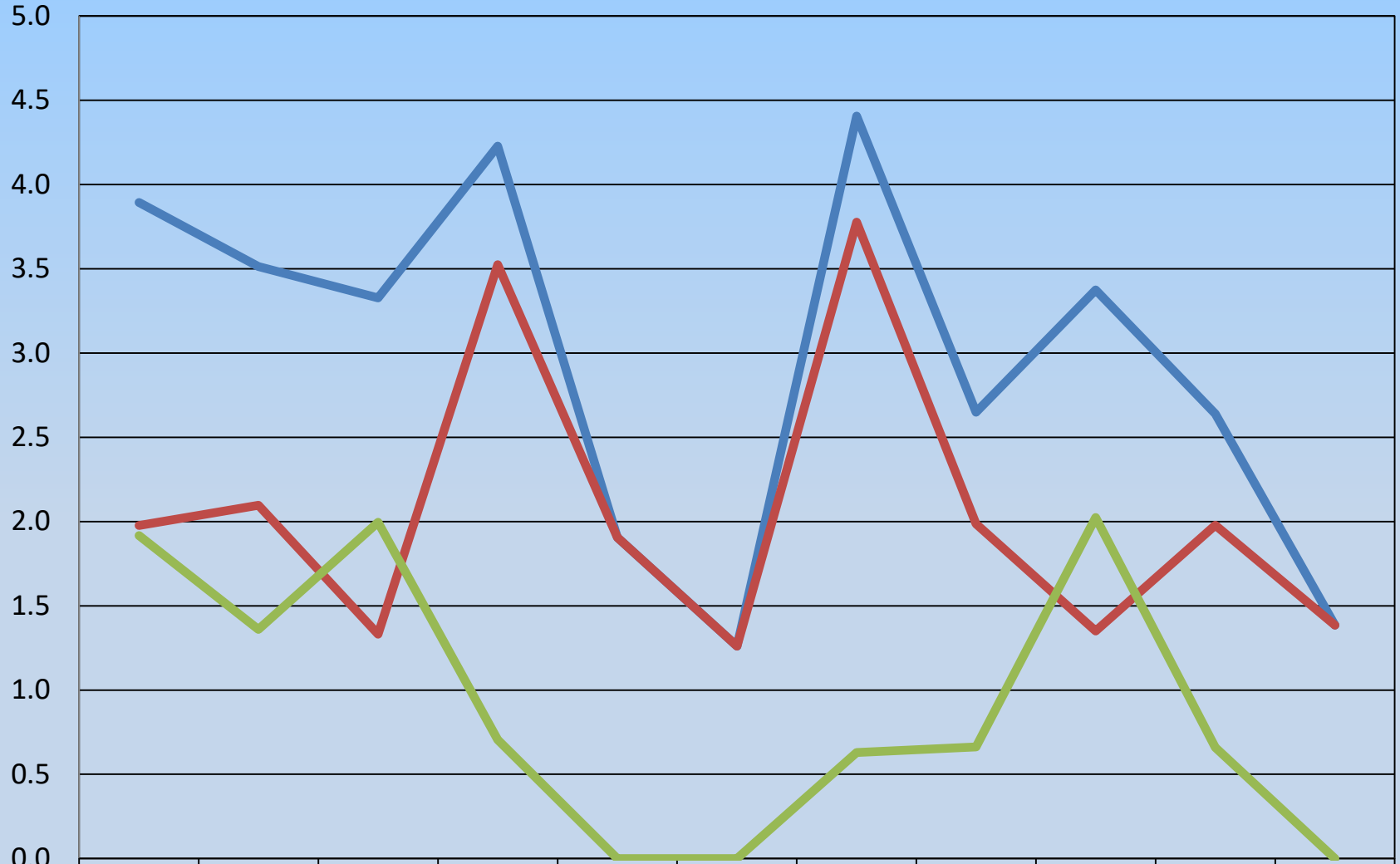
Med Surg- Shockable vs Non Shockable Codes
Survival to Hospital Discharge

AHA Survival Outcomes
Discharged Alive
PEA/A=11.4%
VF/VT= 36.5%



	2014	2015	2016	2017	2018	2019
Asystole and PEA: Survived to Hospital Discharge	9%	25%	20%	15%	32%	29%
Vfib and Vtac: Survived to Hospital Discharge	60%	56%	67%	44%	29%	50%

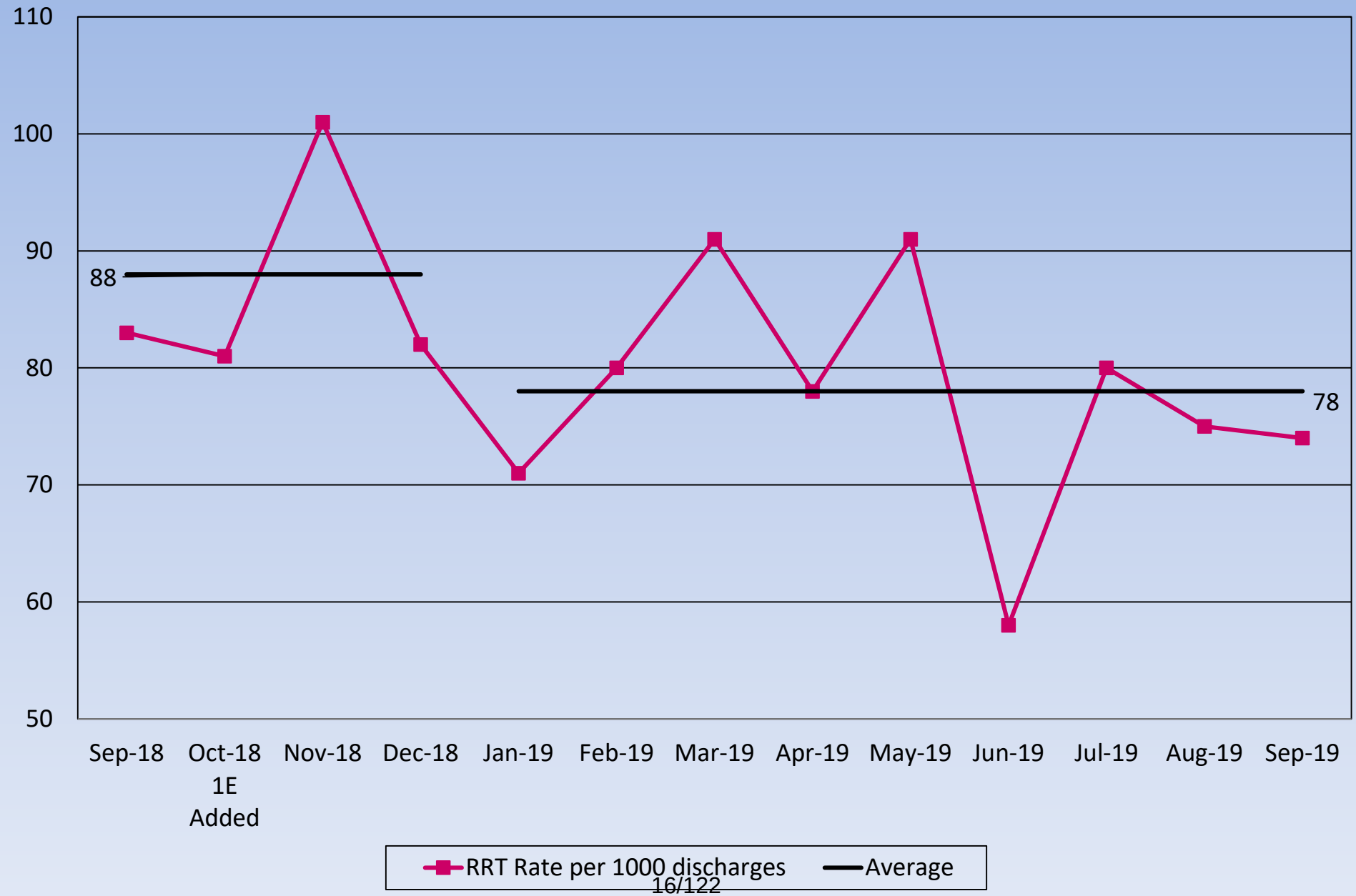
Code Blues per 1000 discharges for CVICU and ICU



	2017	2018	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
CVICU & ICU	3.9	3.5	3.3	4.2	1.9	1.3	4.4	2.6	3.4	2.6	1.4
ICU	2.0	2.1	1.3	3.5	1.9	1.3	3.8	2.0	1.3	2.0	1.4
CVICU	1.9	1.4	2.0	0.7	0.0	0.0	0.6	0.7	2.0	0.7	0

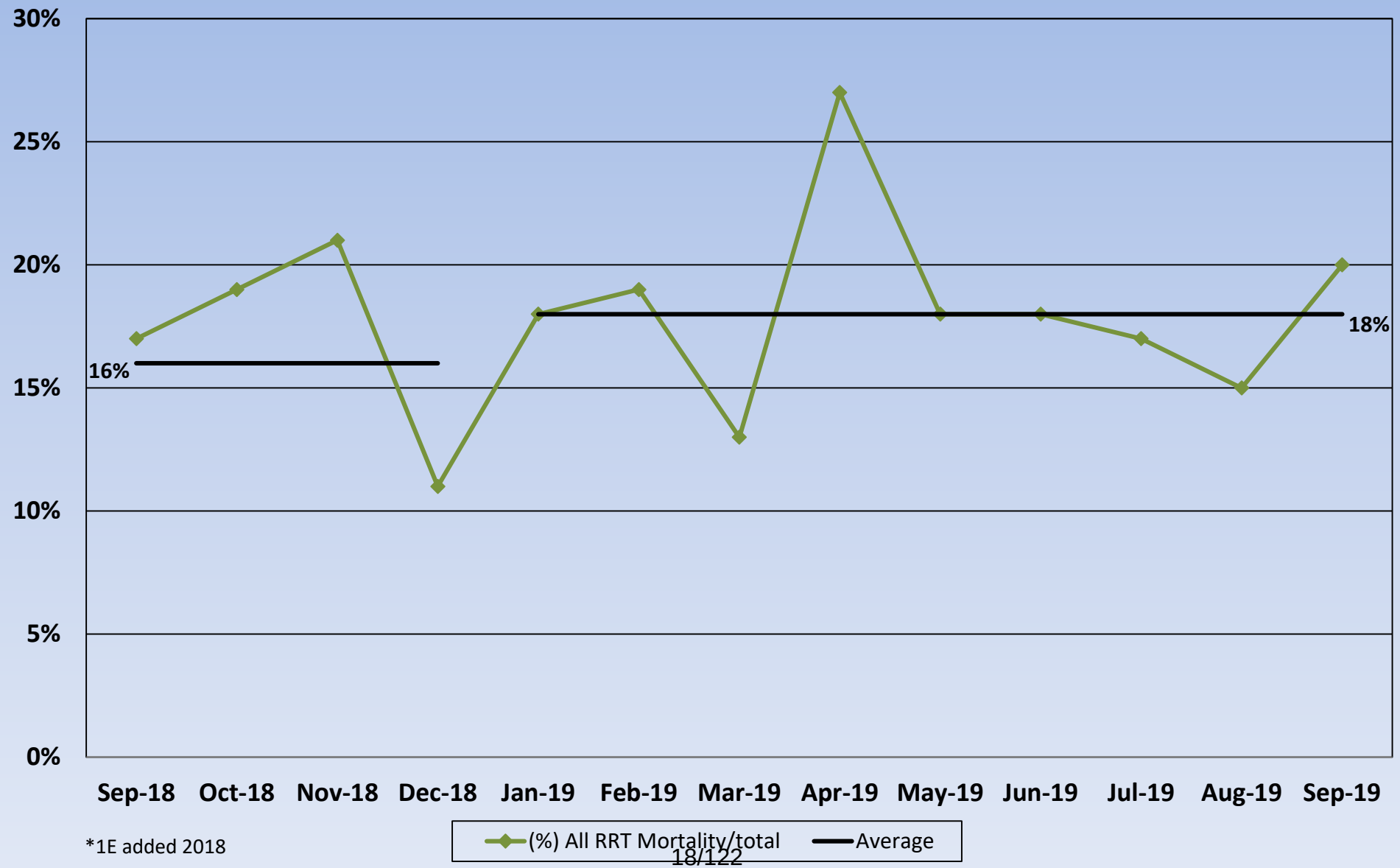
Rapid Response System Data

RRTs per 1000 Patient Discharge Days



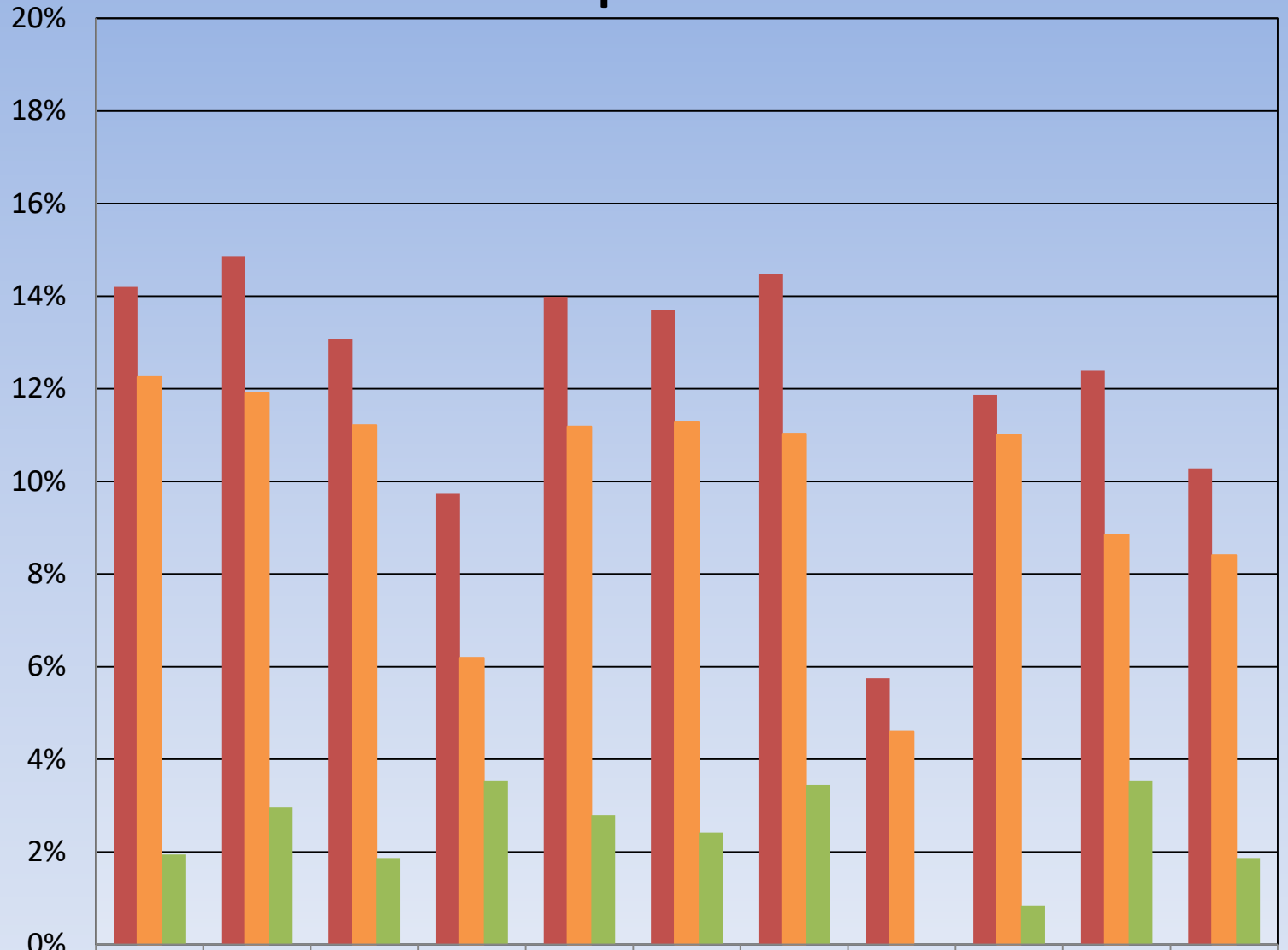
Alert Location	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Totals
KDMC 3W	24	28	31	32	33	14	23	21	20	226
KDMC 4S	14	17	21	20	21	10	24	17	16	160
KDMC 3N	15	14	17	14	15	10	9	10	14	118
KDMC 3S	12	12	11	11	19	10	14	8	14	111
KDMC 2N	8	9	15	15	11	8	17	9	7	99
KDMC 14	7	10	11	7	17	6	10	9	9	86
KDMC 4N	10	7	7	3	9	15	11	14	11	87
KDMC 2S	2	6	13	6	5	6	3	5	5	51
KDMC CV	3	2	9	5	4	4	2	6	4	39
KDMC 1E	3	4	7	5	4	3	2	6	4	38
KDMC IC	7	2	1	4	4	1	3	5	1	28
KDMC BP	2	2	0	2	2	0	0	3	2	13
RRT Tracked Total	**107**	**113**	**143**	**124**	**144**	**87**	**118**	**113**	**107**	**1056**
KDMC CVOR/Cath lab	3	2	2	3	3	0	0	0	0	13
Labor Triage/ Mother Baby	1	1	4	0	2	3	1	2	1	15
KDMC 2E	1	2	0	3	1	1	0	2	0	10
Surgery (Pre/Post op)	1	1	1	1	1	1	2	1	4	13
KDMC ED	0	0	1	1	1	0	0	0	0	3
KDMC CT/radiology	0	0	0	1	0	0	0	0	0	1
KDMC Pediatric	0	0	0	0	0	0	0	0	0	0
Endoscopy	0	0	0	0	3	0	1	0	0	4
RRT Not Tracked Total	**6**	**6**	**8**	**9**	**11**	**5**	**4**	**5**	**5**	**59**

RRTs Mortality



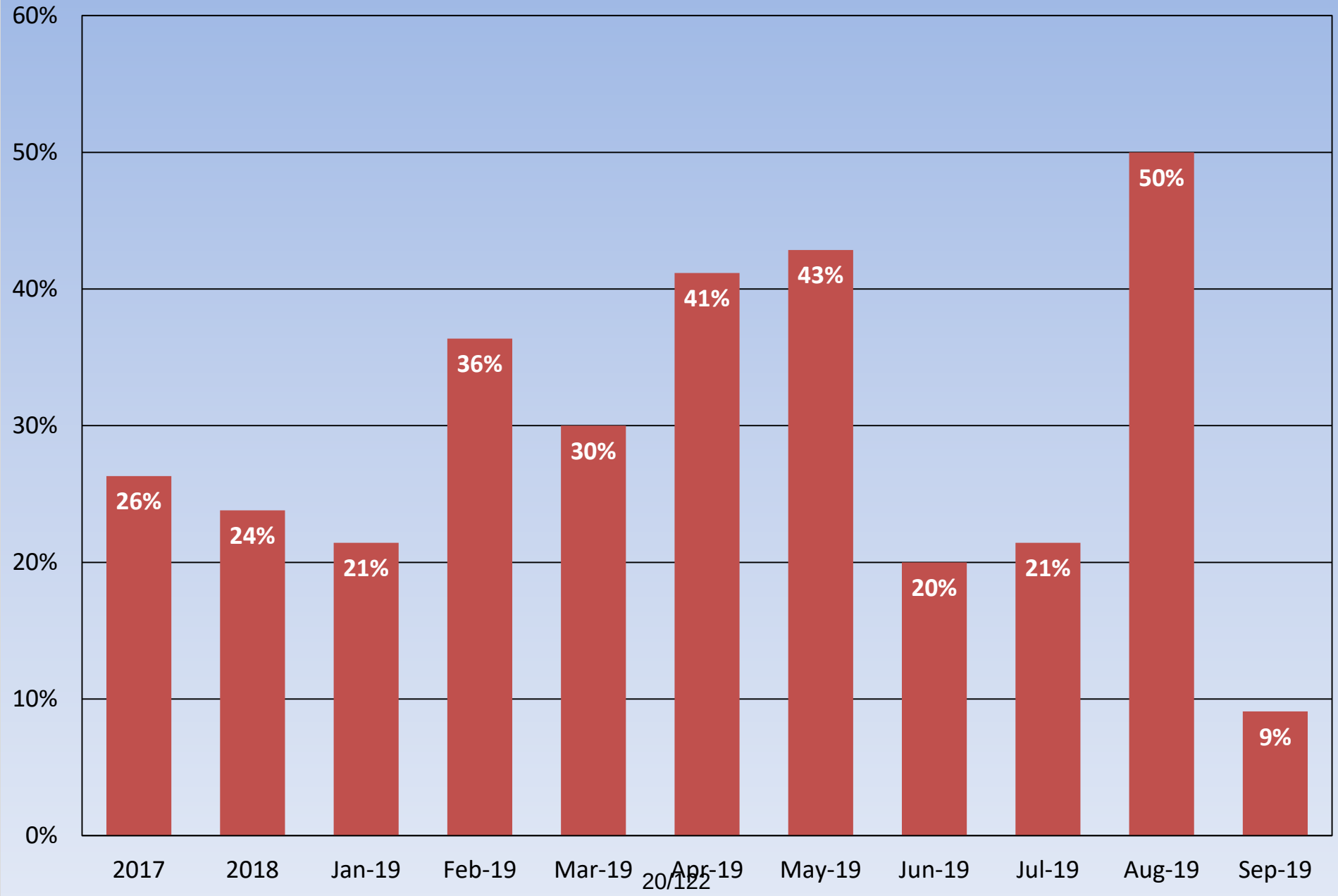
*1E added 2018

Patients with Multiple RRT's

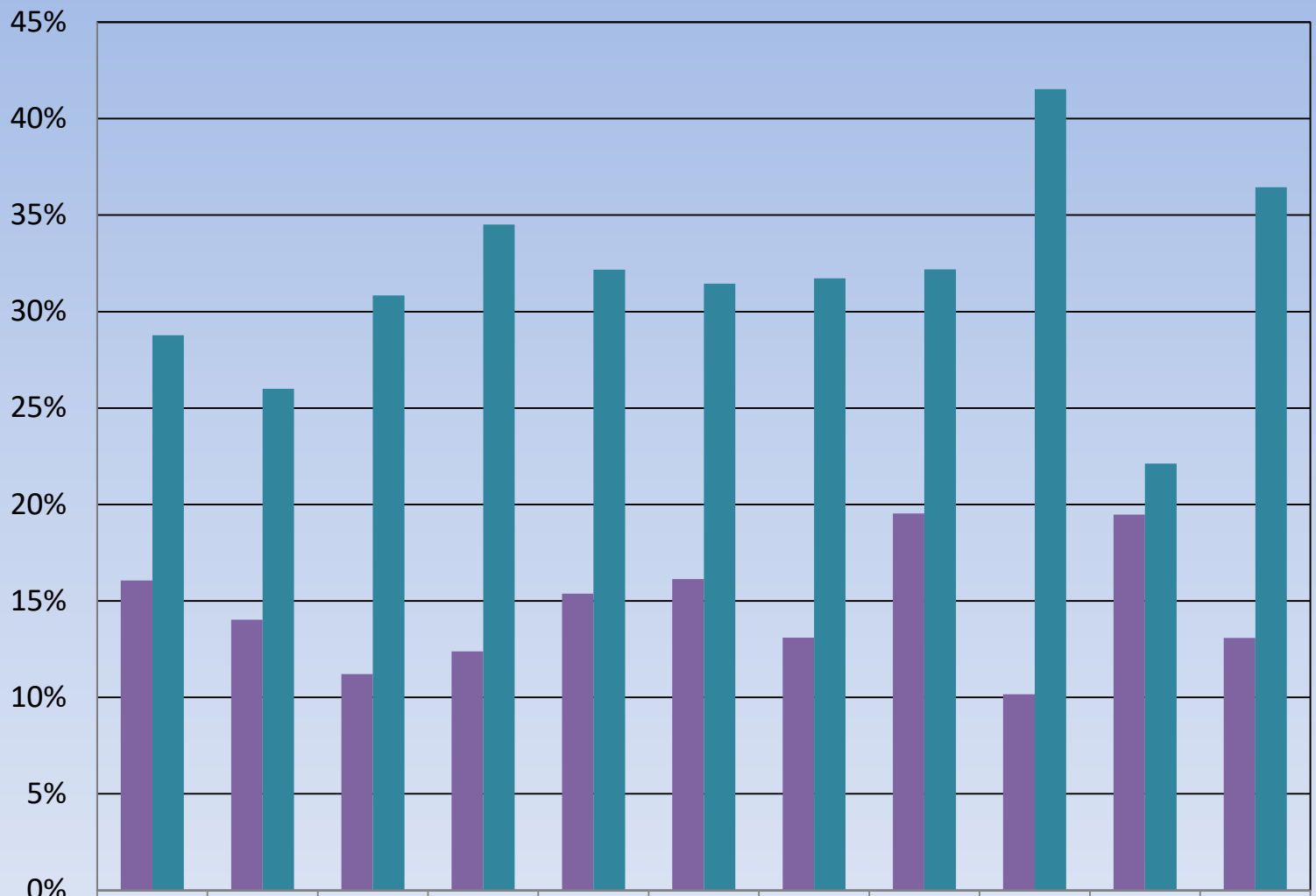


	2017	2018	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Total Number of Multiple RRT's	14%	15%	13%	10%	14%	14%	14%	6%	12%	12%	10%
2 RRT's	12%	12%	11%	6%	11%	11%	11%	5%	11%	9%	8%
3 or more RRT's	2%	3%	2%	4%	3%	2%	3%	0%	1%	4%	2%

Multiple RRT mortality



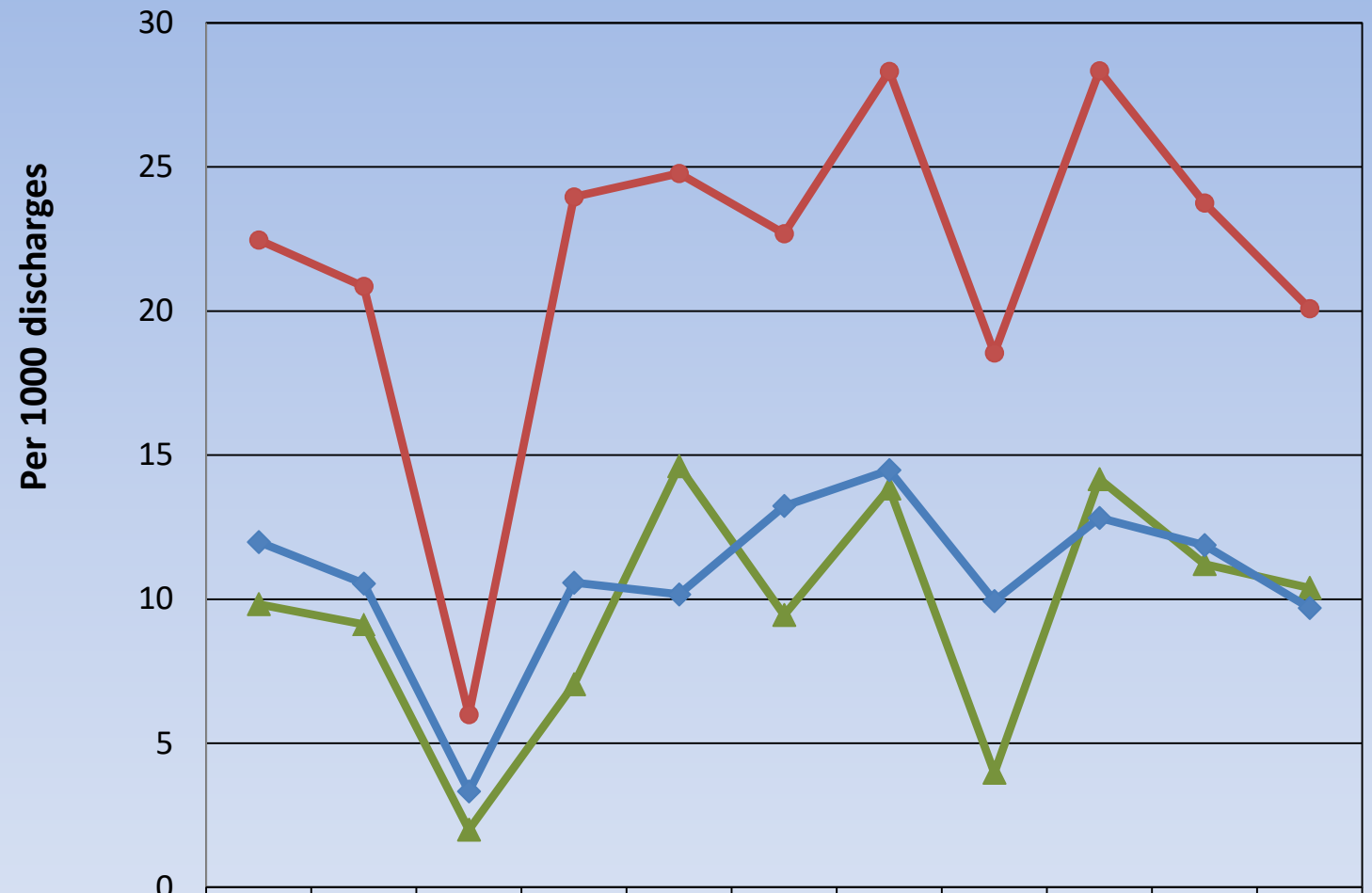
Disposition of RRT



	2017	2018	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
(%) Transferred to ICU/CVICU	16%	14%	11%	12%	15%	16%	13%	20%	10%	19%	13%
(%) Transferred to ICCU	29%	26%	31%	35%	32%	31%	32%	32%	42%	22%	36%

*1E added 2018

RRTs Admitted from ED within 24 hours

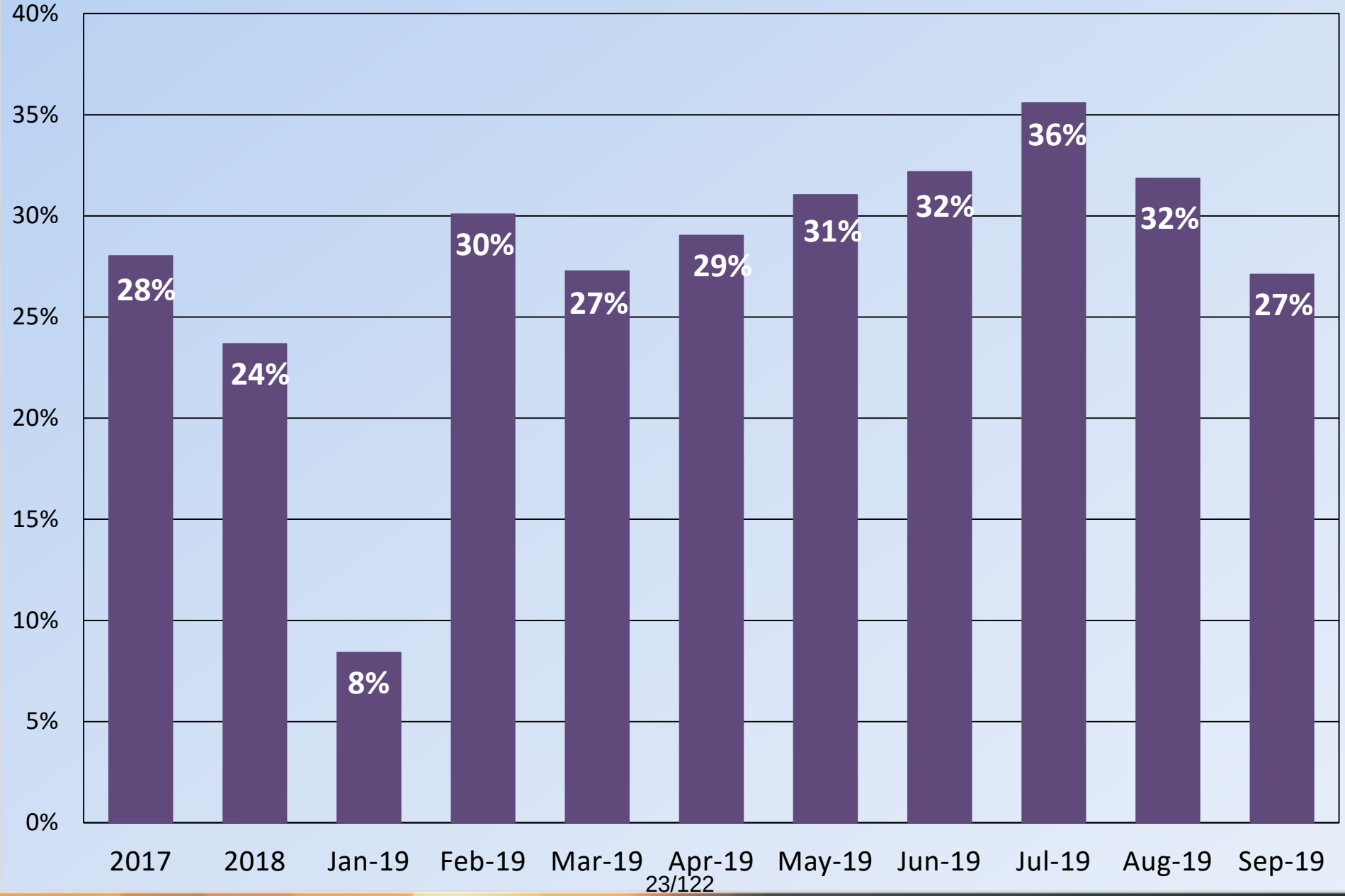


*1E added 2018

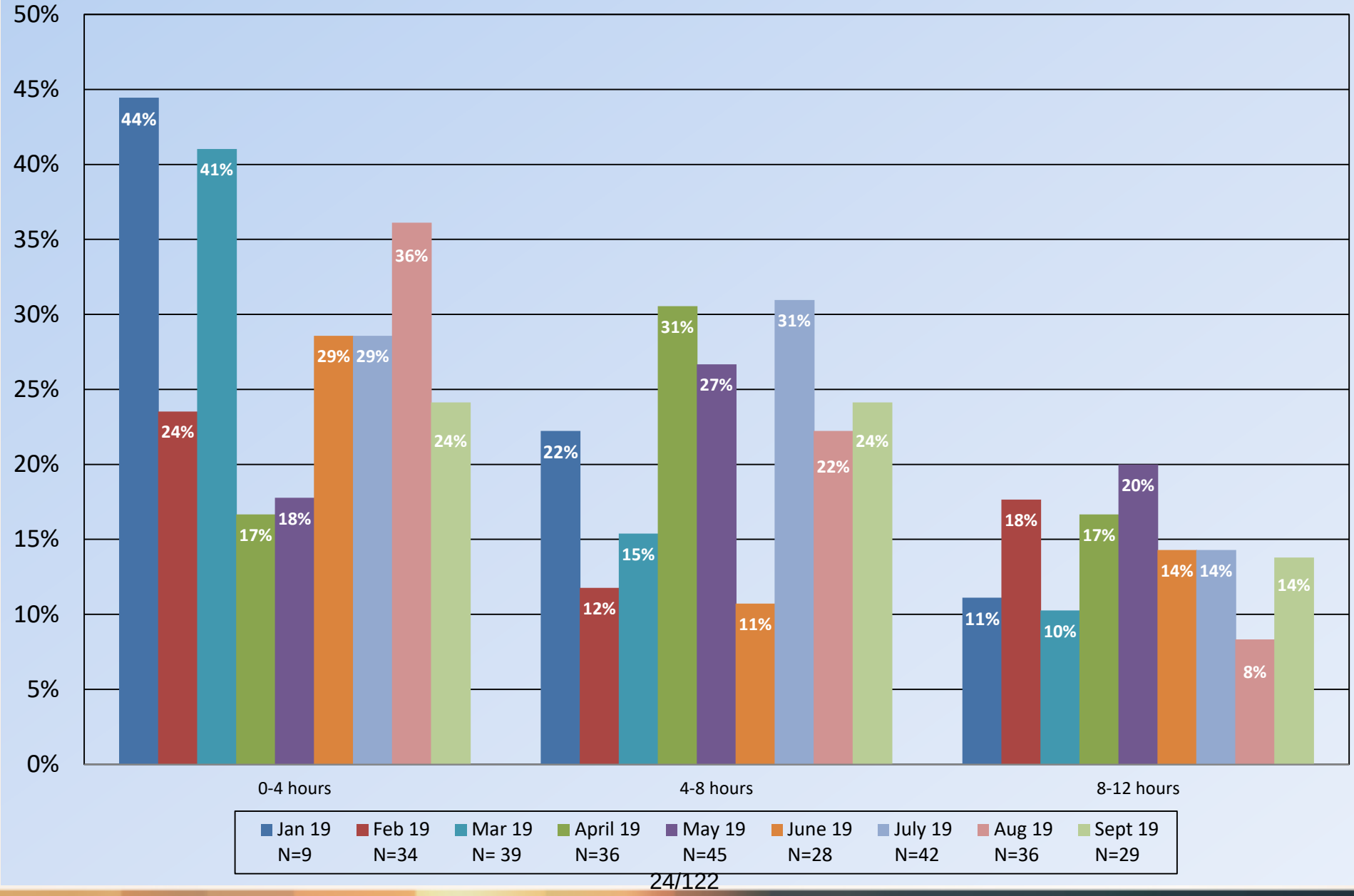
	2017	2018	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
RRT within 24 hr admit from ED	22	21	6	24	25	23	28	19	28	24	20
RRT within 24 hours of admit transferred to (ICU/ICCU)	10	9	2	7	15	9	14	4	14	11	10
RRT within 24 hours of admit from ED: Stayed in Room	12	11	3	11	10	13	14	10	13	12	10

RRTs within 24 hours of Admit from ED

*1E added 2018



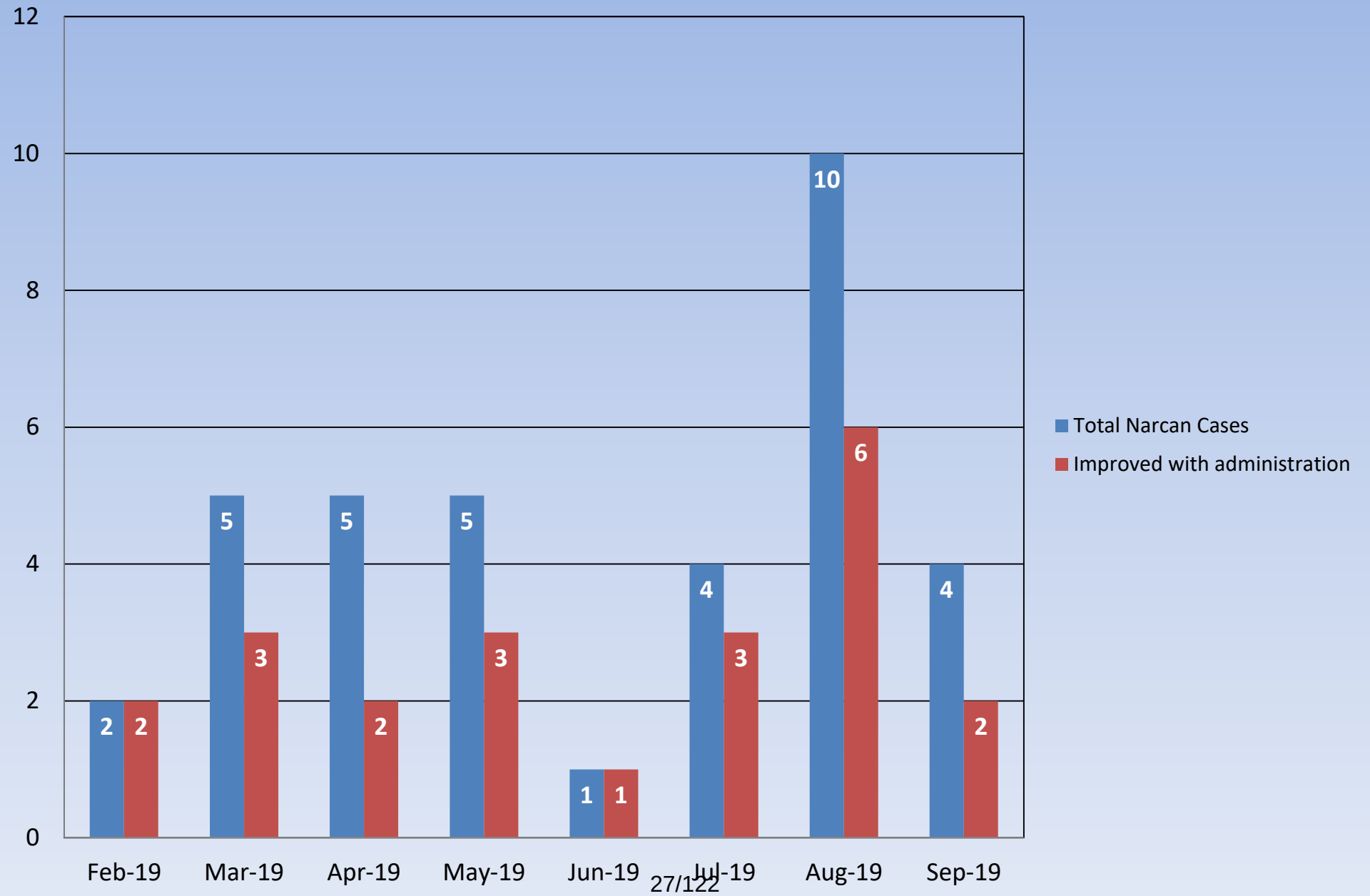
RRTs within 12 hours of Admit from ED



RRTs on 3w	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Total
Total Number of RRTs on 3w	24	28	31	32	33	14	23	21	19	225
Primary RRT on 3w	21	21	24	24	30	14	20	15	19	188
Multiple RRTs on 3w	1	4	3	5	1	0	0	3	0	17
RRT's within 12 hours of transfer to 3w from a lower level of care (with previous RRT)	2	1	1	0	1	0	6	4	5	20
RRTs on 3w transferred to critical care	5	8	6	9	5	6	5	5	5	54

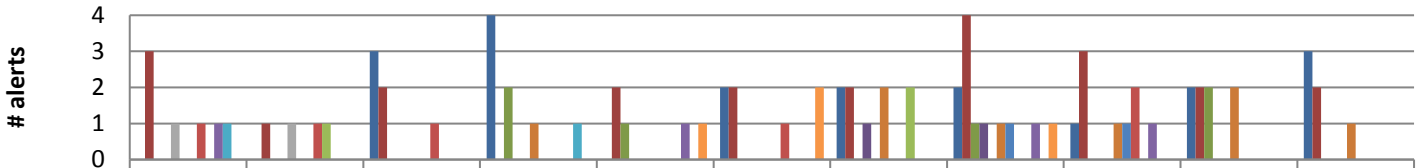
RRTs on 3w within 12 hours after admission from ED	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Total
RRTs on 3w within 12 hours after admission from ED	3	5	5	8	9	8	8	12	5	63
Transferred to critical care	0	2	1	1	3	4	4	3	0	18
Stayed in room	3	3	4	7	6	4	4	8	5	44
Multiple rrt	0	2	0	0	0	0	1	1	0	4

Narcan Administation during RRTs



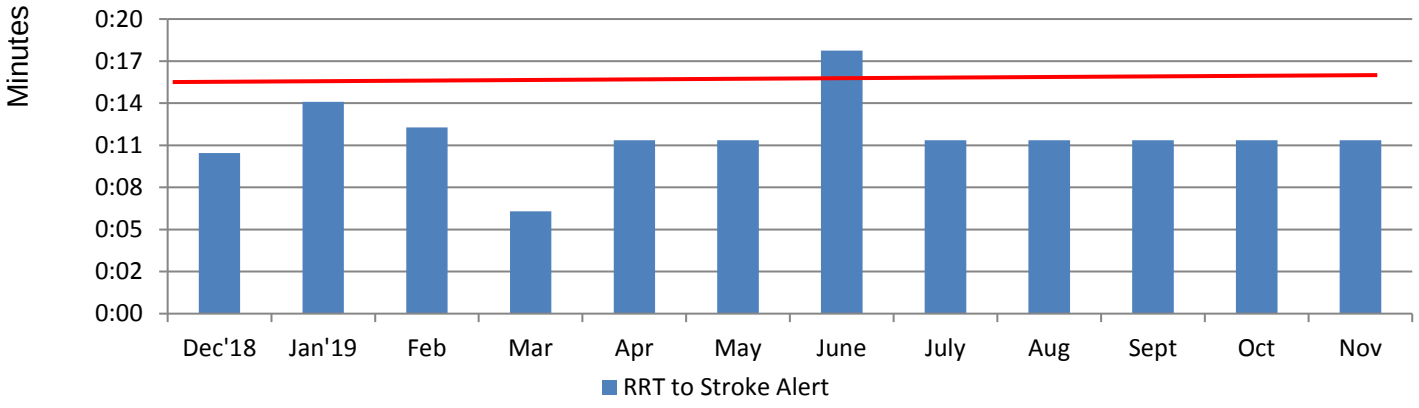
In-House Stroke Alert Dashboard 2018-2019

Stroke Alert Location



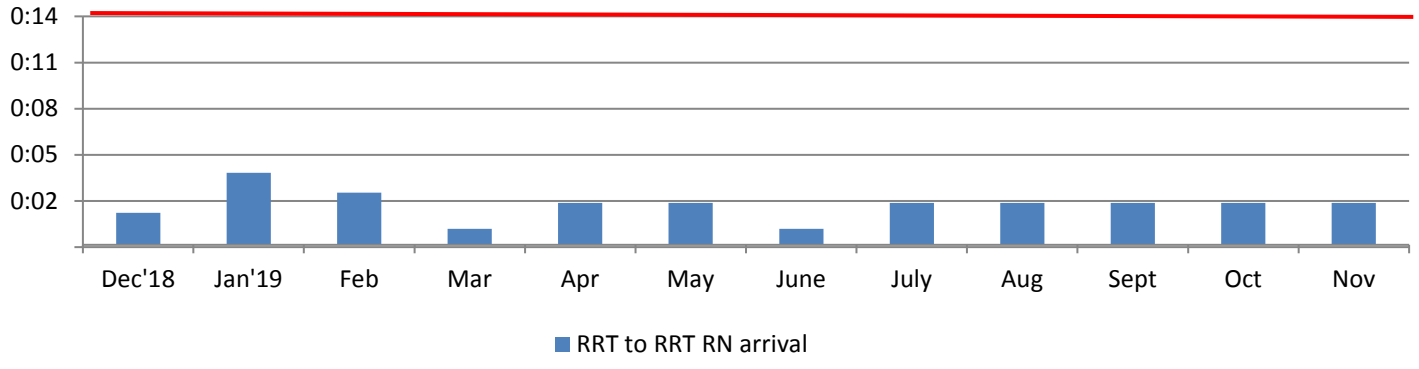
	Dec'18	Jan'19	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct
3W			3	4		2	2	2	1	2	3
4S	3	1	2		2	2	2	4	3	2	2
2S				2	1			1		2	
3S							1	1			
Cath Lab	1	1								0	
CVICU				1			2	1	1	2	1
ICU								1	1	0	
4N	1	1	1			1			2		
3N		1					2			0	
4T	1				1			1	1	0	
PACU	1			1							
2N					1	2		1			

RRT to Stroke Alert



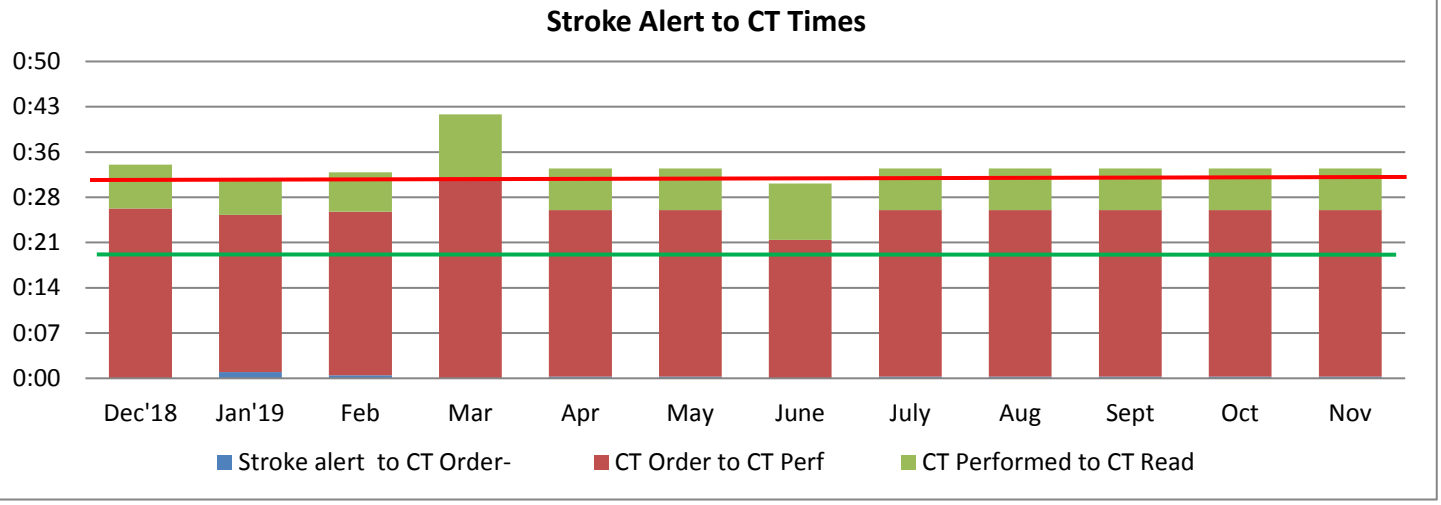
If patients exhibit any new or worsening neuro deficits while in the hospital; RNs are to call an RRT. The RRT RN will evaluate and determine if a stroke alert should be called. The goal from calling RRT to stroke alerts should be <15 minutes.

RRT to RRT RN arrival

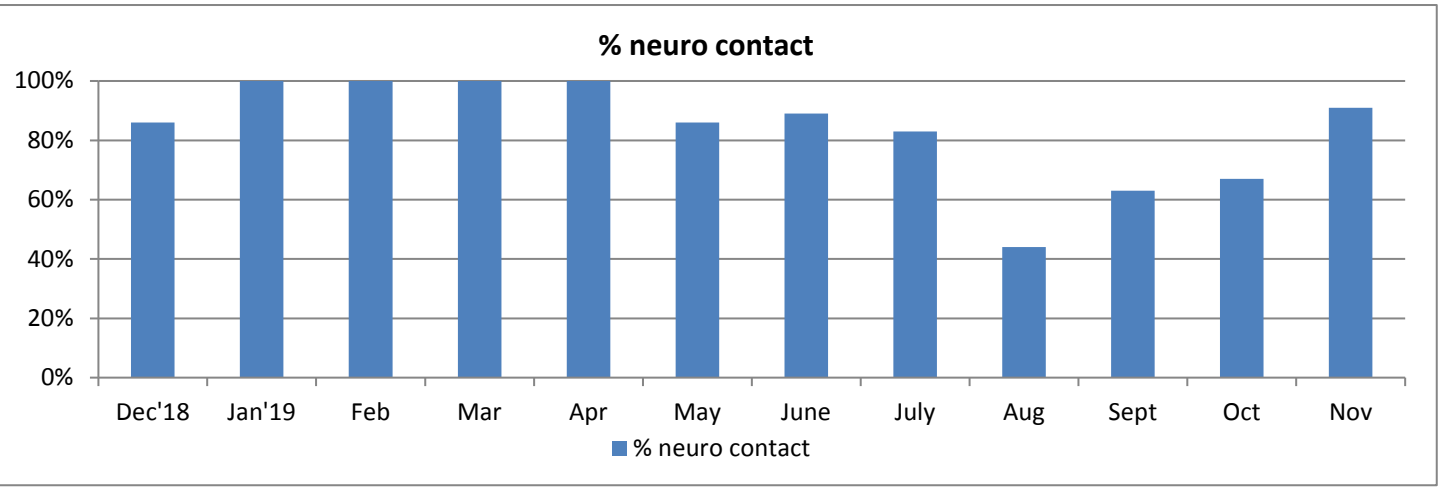


TJC expectation is that a designated provider is at the bedside within 15 minutes of stroke alert. KDH has designated the RRT RN as the provider for in-house stroke alerts.

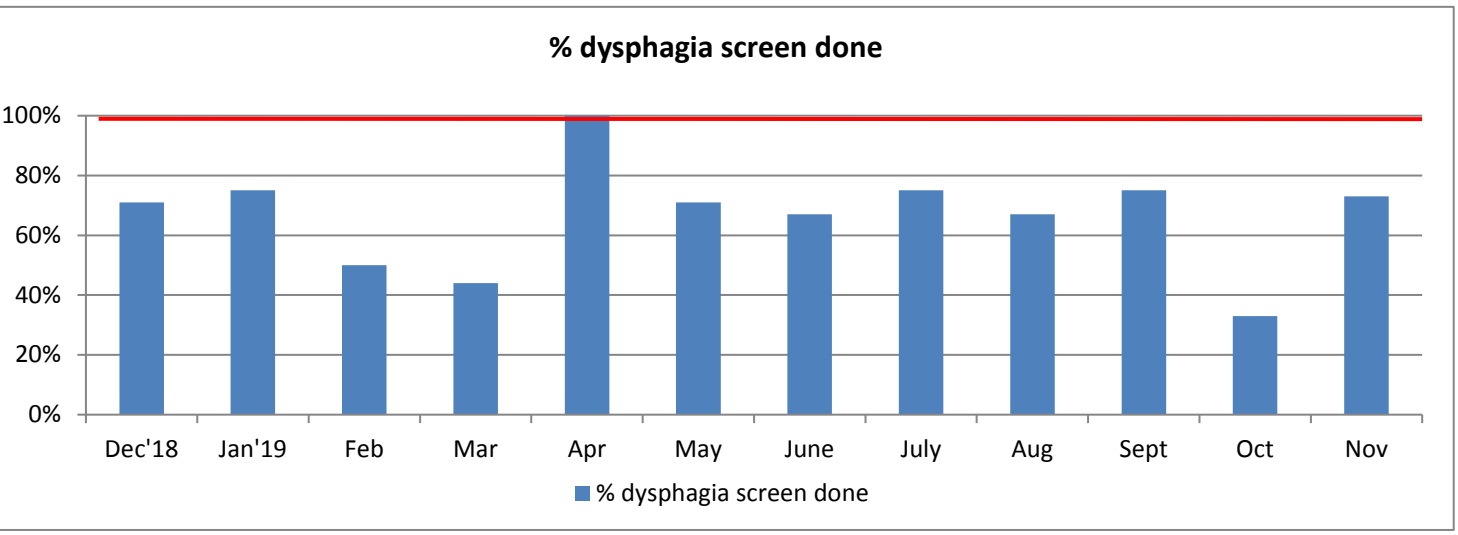
In-House Stroke Alert Dashboard 2018-2019



TJC expectation is that the CT will be read within 45 minutes of arrival. KDH's goal is 30 minutes **(red line).** TJC added a new metric in 2018; the expectation is that the CT will be performed within 20 minutes of alert **(green line).**

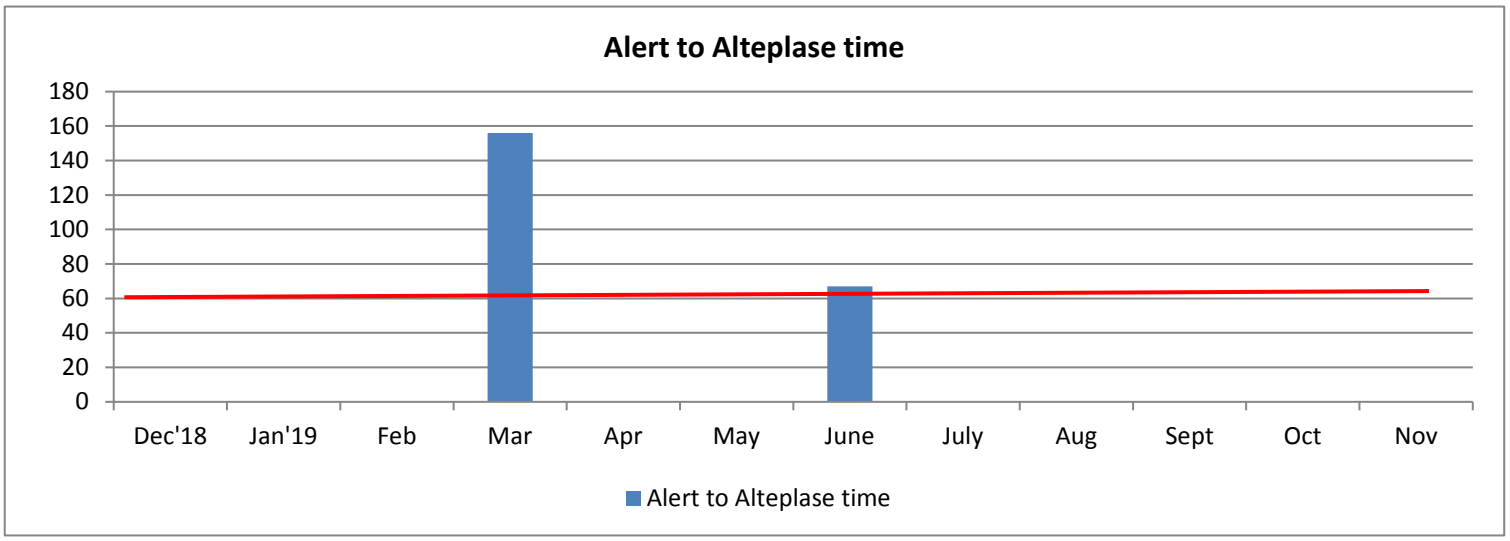


Neurology consultation should occur on all in-house stroke alerts.

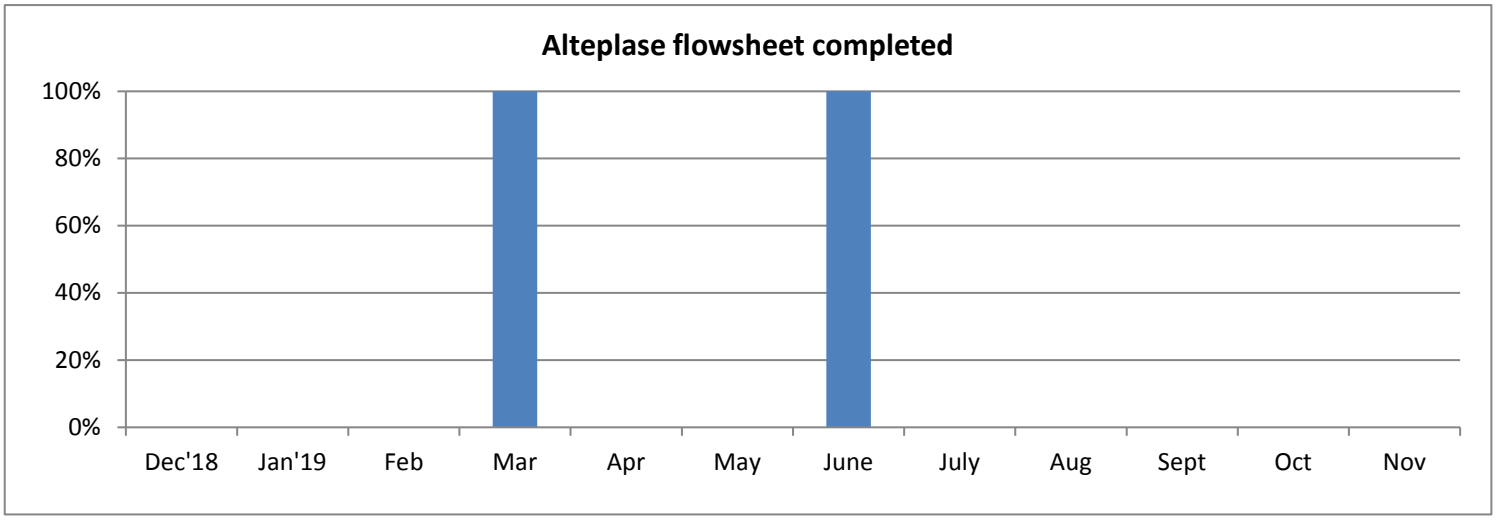


Whenever there are new or worsening neurological deficits ≥3 points, the RN should perform a dysphagia screen to evaluate the patient's ability to swallow.

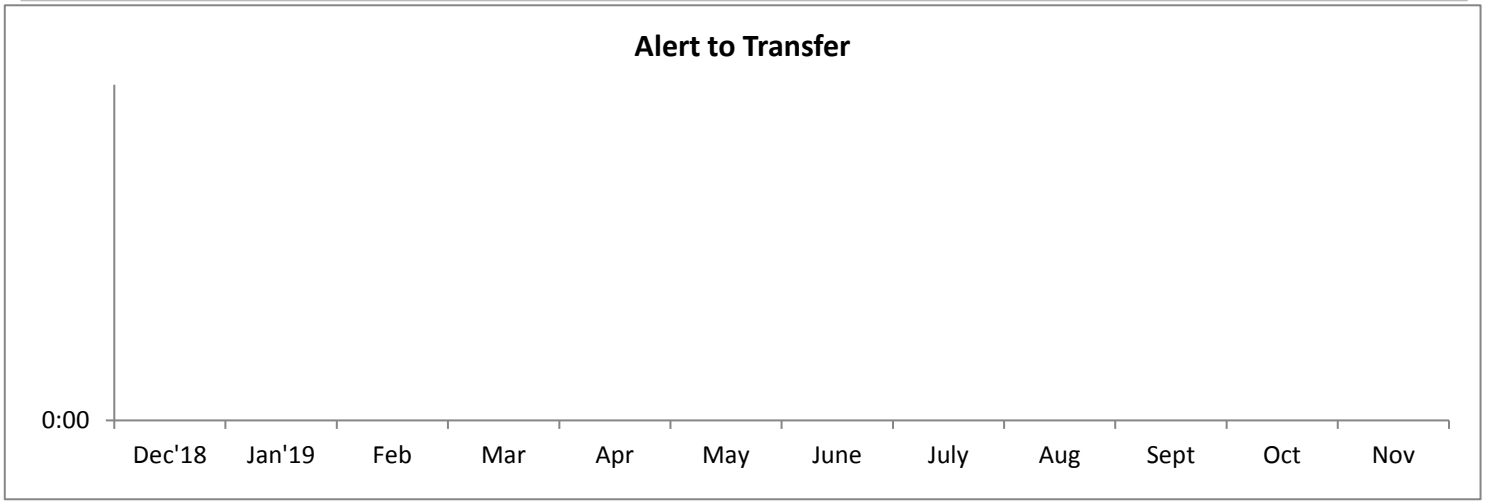
In-House Stroke Alert Dashboard 2018-2019



ED Patients: TJC expectation is that IV thrombolytics are given within 60 minutes to eligible patients who present for stroke care at least 50% of the time. In-House Stroke alerts: KDH expectation is that IV thrombolytics are given within 60 minutes to eligible patients who have been identified with new or worsening stroke symptoms

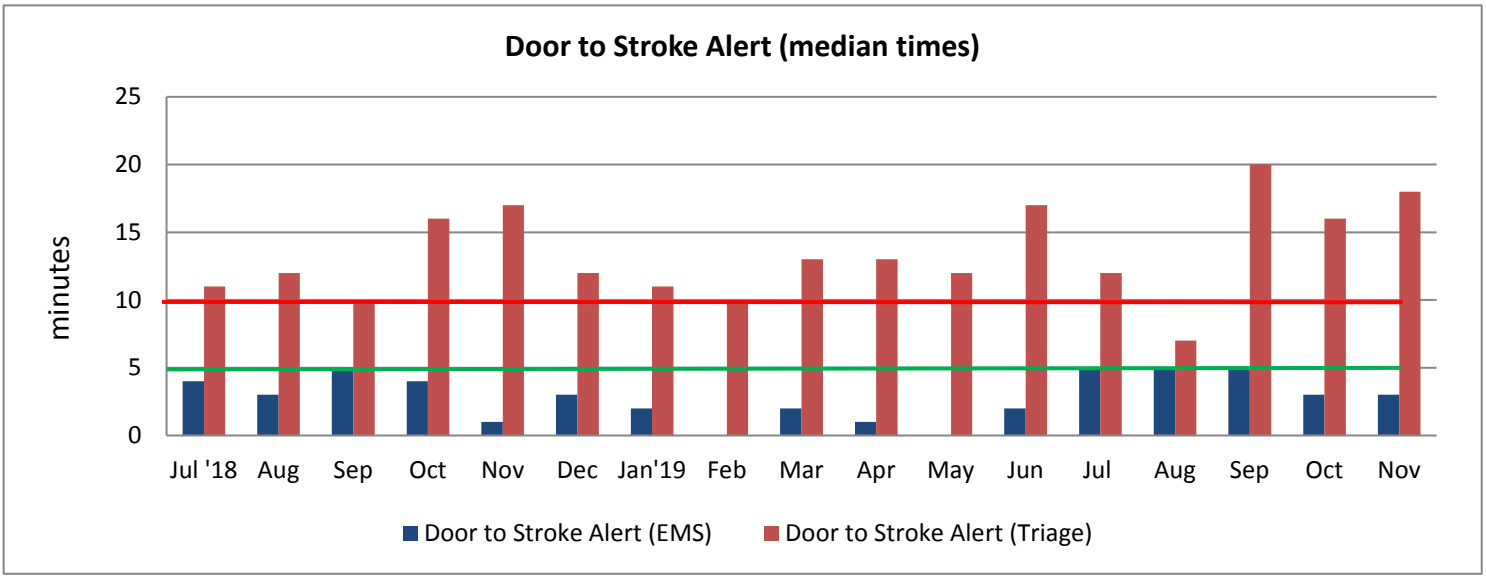


KDH expectation is that post Alteplase monitoring is in compliance with our standardized protocol. All key elements must be completed to be determined as compliant.

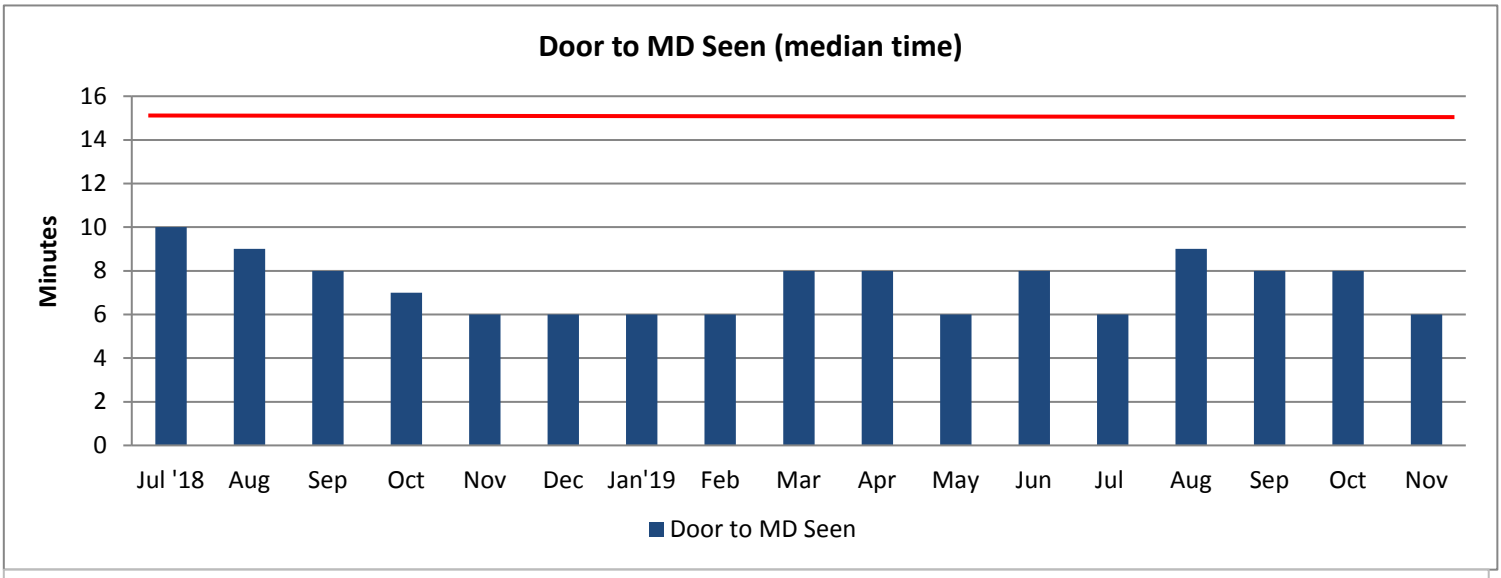


Effective January 2019, TJC will require data collection for patients transferred to another facility from the ED. KDH Stroke program now monitors the "door in - door out" times in the ED but we wanted to also monitor how we do when transferring our in-house stroke alert patients. No goal has been set for this measure at this time; the stroke quality committee will determine what is a realistic goal at the October 2018 meeting. no transfers in this timeframe.

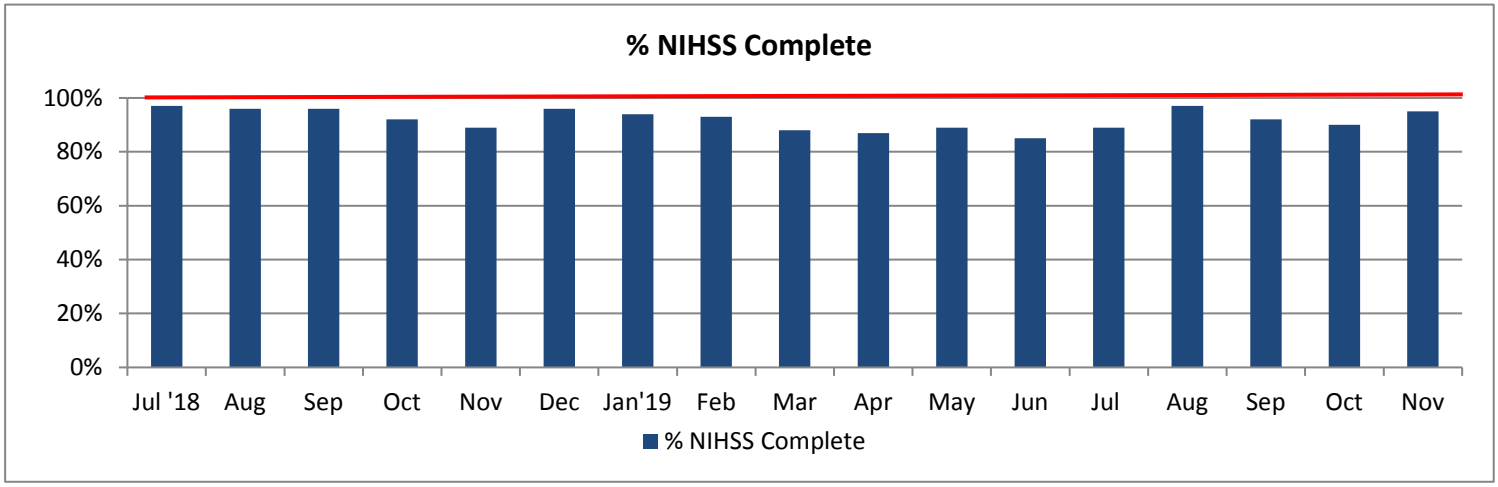
ED Stroke Alert Dashboard
2018-2019



Per KDH ED Stroke Alert process; stroke alerts to be called within 5 min for EMS and 10 min for Triage.



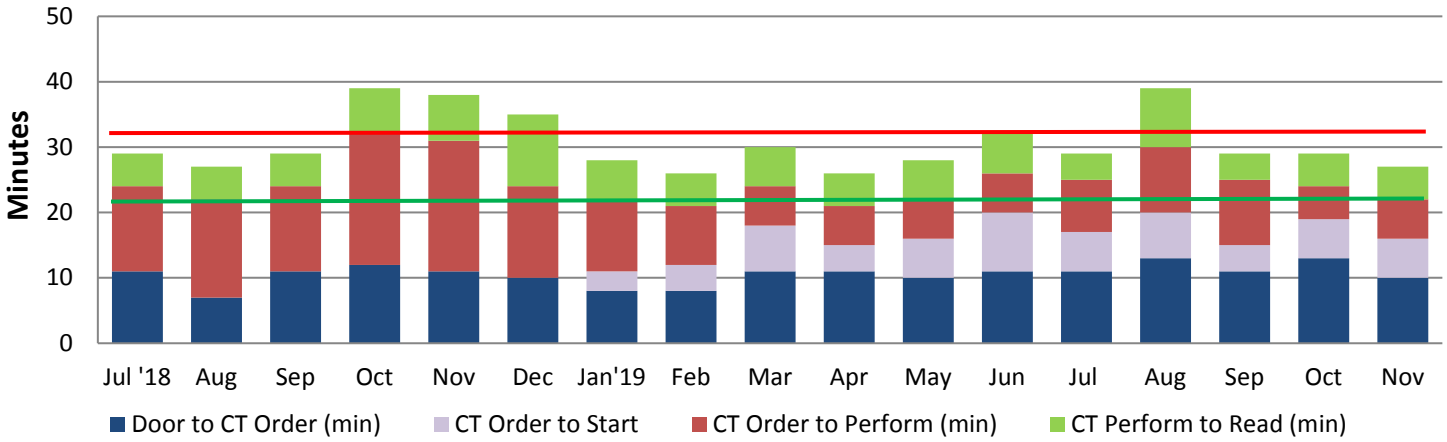
The expectation is that the physician will see the stroke alert patient within 15 minutes of arrival. Improvements made throughout the past year include: early notification from EMS, MD meets the pt at the door upon arrival, scribe documents first seen time in the record.



The expectation is that all stroke alert patients will have a NIHSS completed by a certified ED staff member and/or the attending physician; the primary responsible person is the attending/resident physician.

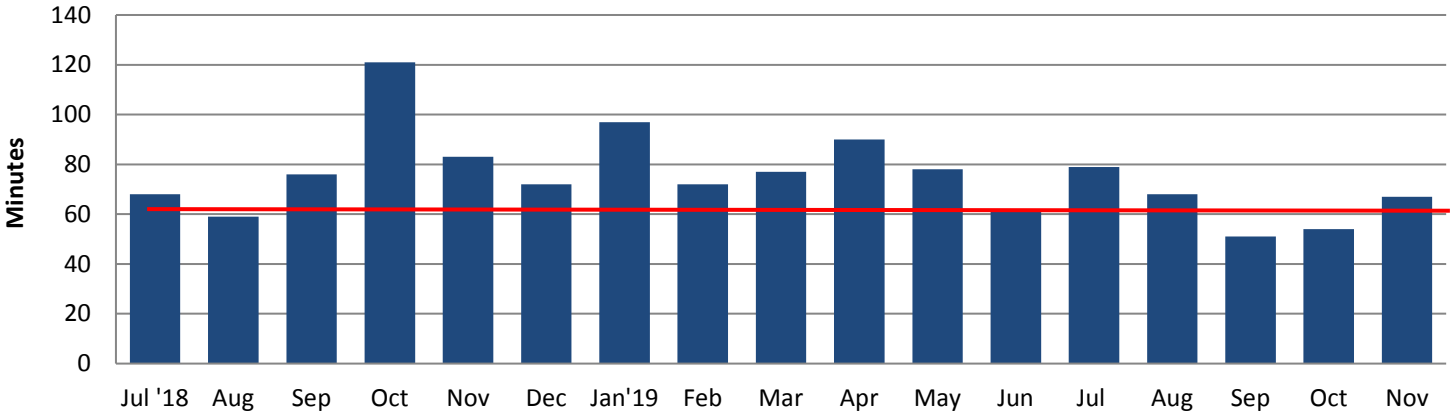
ED Stroke Alert Dashboard
2018-2019

Door to CT Times (median times)



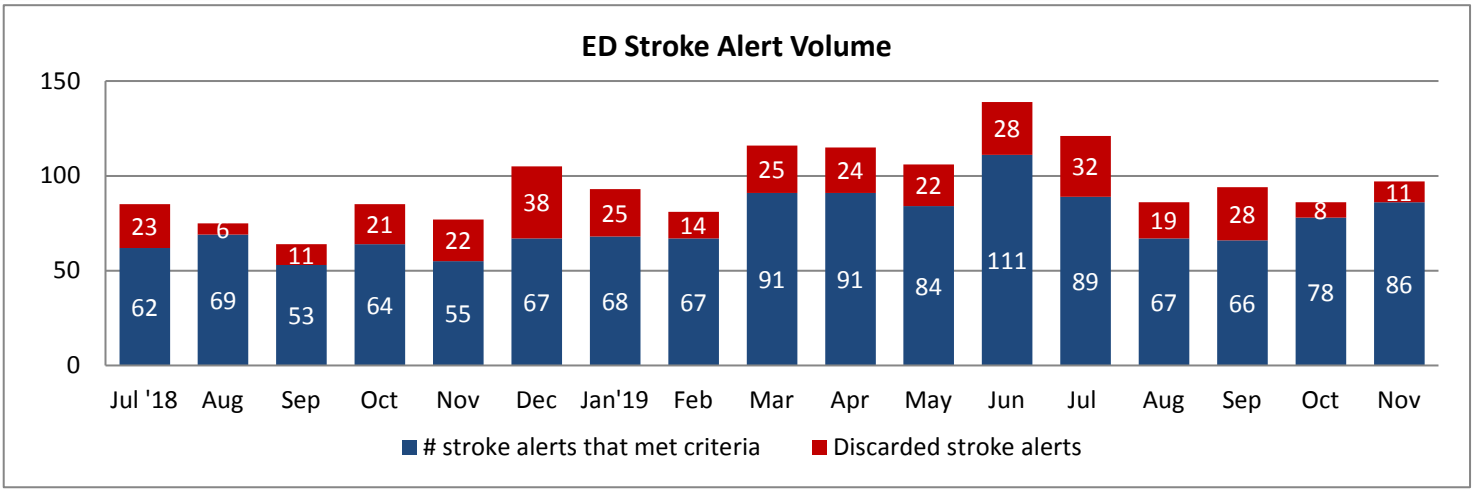
CMS and TJC expectation is that the CT will be performed by 20 minutes and read by 45 minutes of arrival. KDH's CT read time goal is 30 minutes. Starting 2019; tracking of CT start times will be included in this measurement. start time is define by the first CT images in Synapse.

Door to Alteplase (median time)



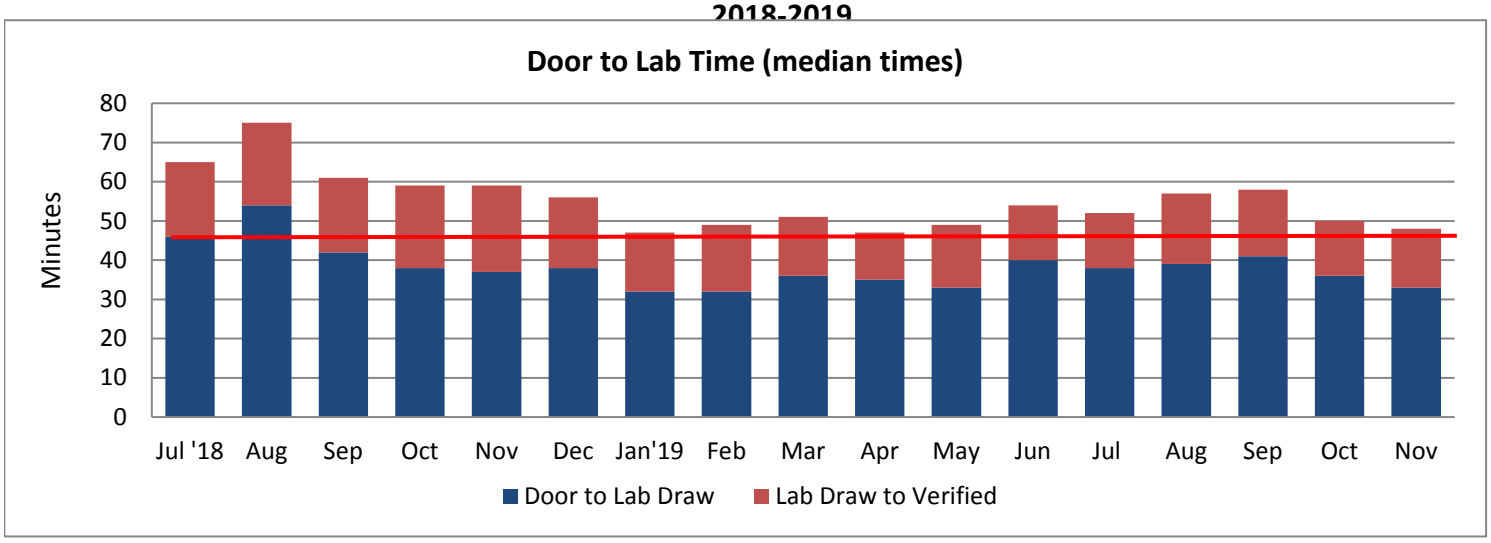
The data in this graph includes all Alteplase patients, no exclusion criteria. TJC expectation is that IV thrombolytics are given within 60 minutes to eligible patients who present for stroke care at least 50% of the time. 2019 AHA/ASA has set new IV thrombolytic goal time to 45 minutes at least 75% of the time. To meet this goal, changes to the stroke alert process <4 hours have been made.

ED Stroke Alert Volume

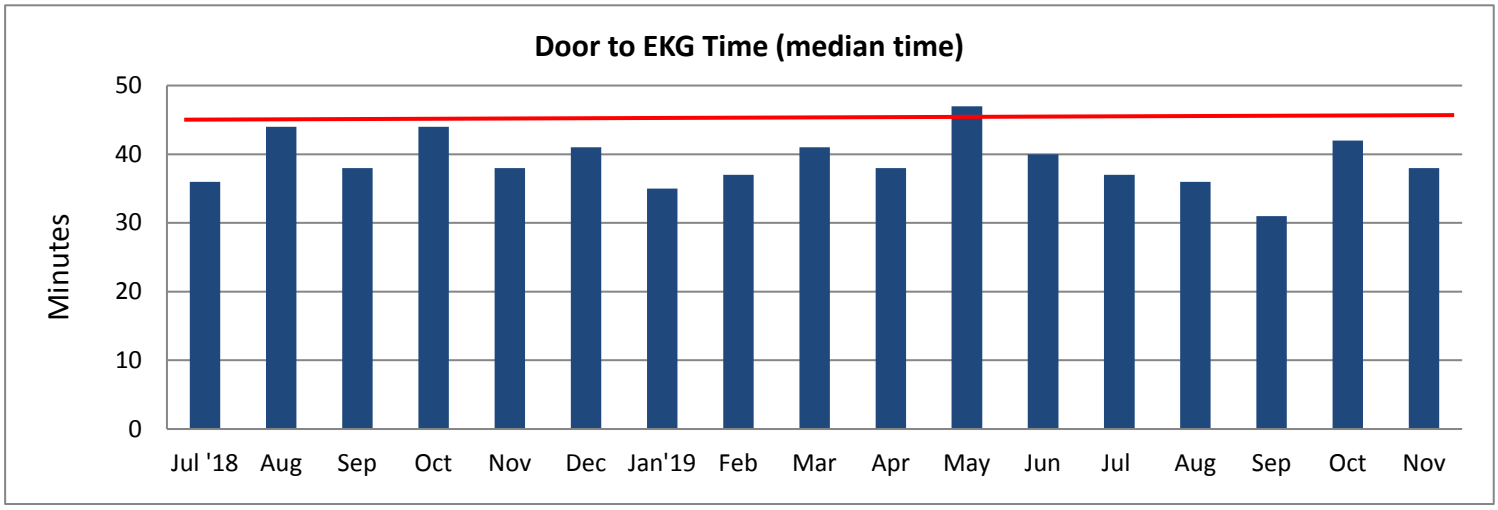


Stroke alert criteria includes: pt presenting with stroke like symptoms +FAST screen, stroke alerts called prior to arrival and up to 1 hour after arrival. Excluded cases: >1 after arrival or if stroke alert was cancelled.

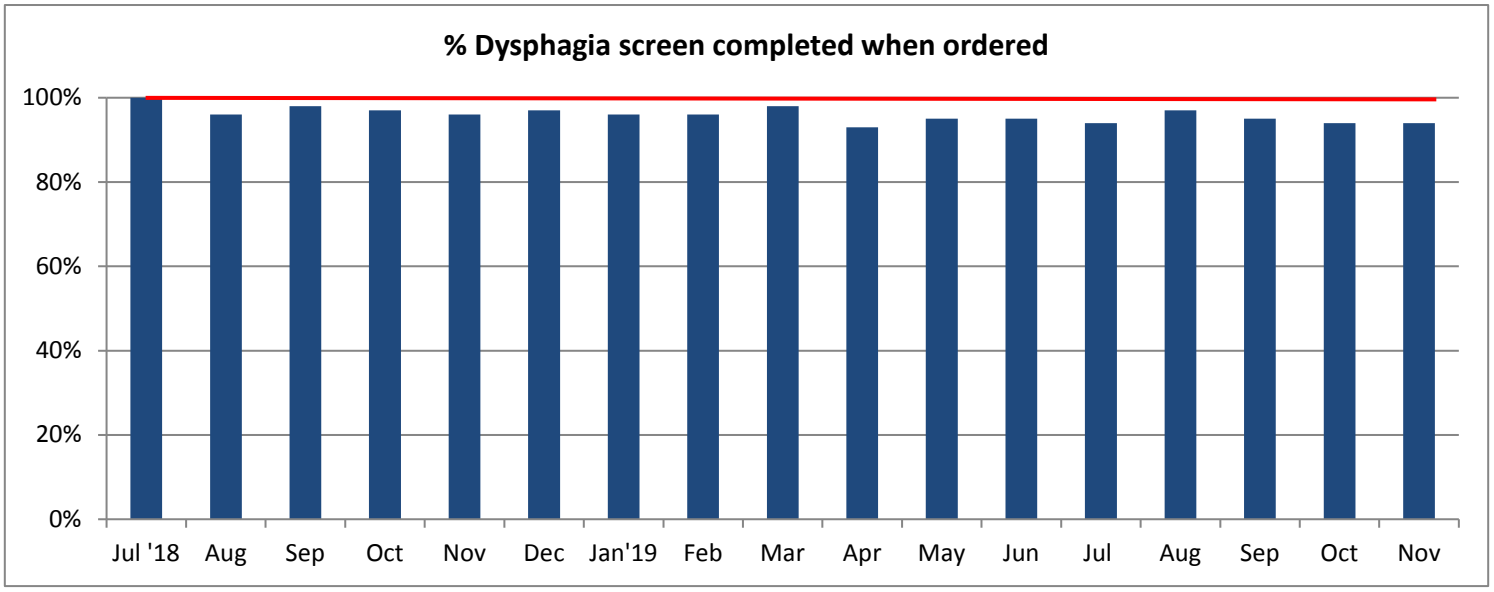
ED Stroke Alert Dashboard
2018-2019



TJC expectation is that laboratory tests are completed within 45 minutes of arrival. Changes in stroke alert process has been made early 2019 to improve lab verified times. Action items taken: IV start kits in CT rooms with lab tubes, lab lable makers in both CT rooms and specimens taken immediately down to lab.

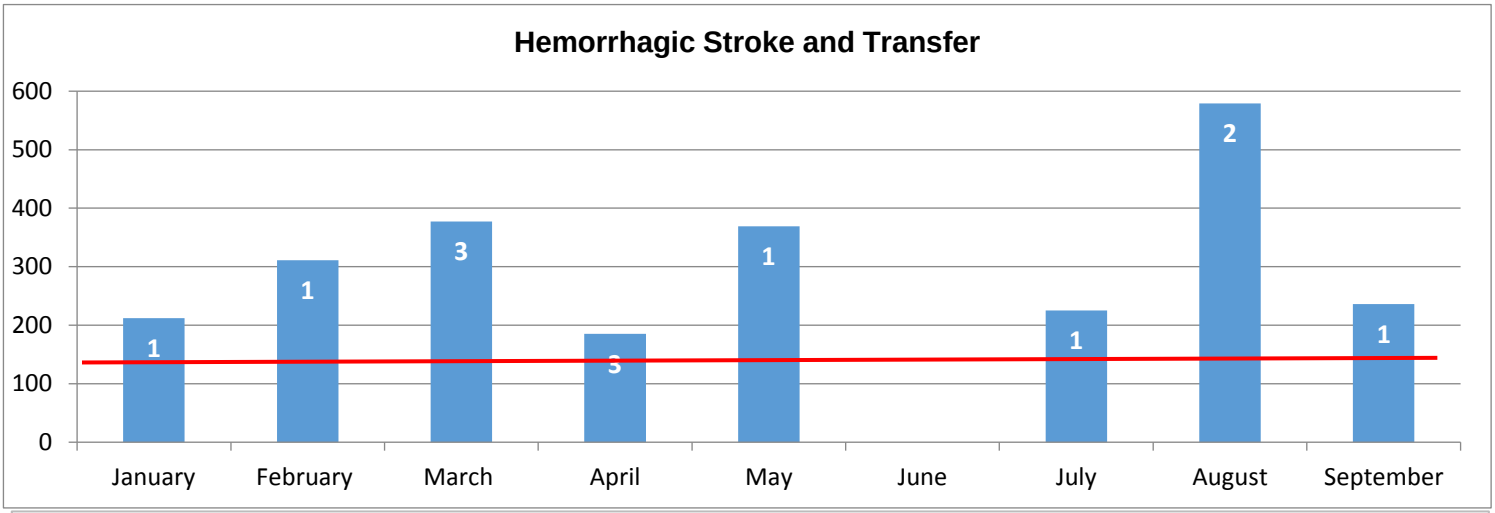


TJC expectation is that EKGs are completed within 45 minutes of arrival.

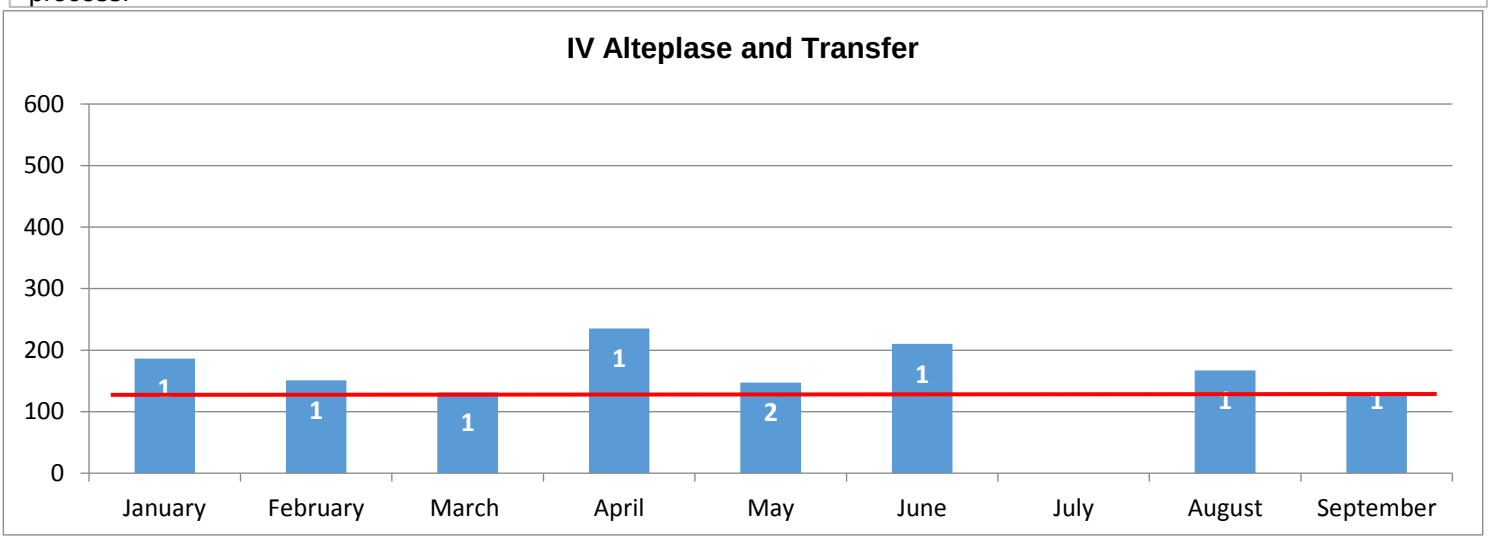


Dysphagia screening should be completed by the RN on all stroke alert patients prior to any po intake, including meds. Dysphagia screening is part of the ED stroke alert order sets. Goal is 100% compliance.

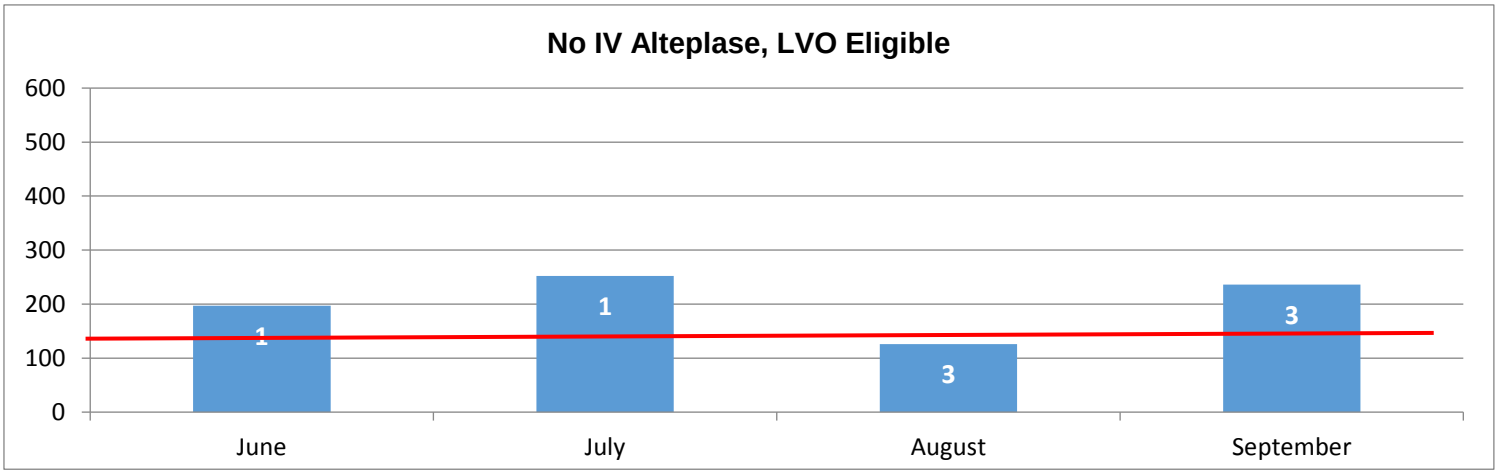
2019 TRANSFERS FROM ED TO ANOTHER ACUTE CARE FACILITY
Median Time by Minutes - Goal 120 Minutes



New TJC metric as of January 2019. TJC expectation is that if patients require transfer to a tertiary center that the door to transfer should be <120 minutes. Only a few hemorrhagic patients are transferred out for other procedures not done at KDH, specifically coiling/clipping of aneurysms or bleeds. A Transfer Task Force has been set up to help streamline the process.



New TJC metric as of January 2019. TJC expectation is that if patients require transfer to a tertiary center that the door to transfer should be <120 minutes. These are considered our "drip and ship" cases. Transfers for ischemic strokes occur primarily if a large vessel occlusion is noted on CTA that would be eligible for endovascular treatment. A Transfer Process Task Force has been set up to help streamline the process.



New TJC metric as of January 2019. TJC expectation is that patients requiring transfer to a tertiary care center that the door to transfer should be less than 120 minutes. This cohort of patients have a large vessel occlusion that would be eligible for endovascular treatment and do not meet criteria for Alteplase administration. A Transfer Task Force has been set up to help streamline the process.

Unit/Department: Rehabilitation Services **Pro Staff Report Date:** November 2019

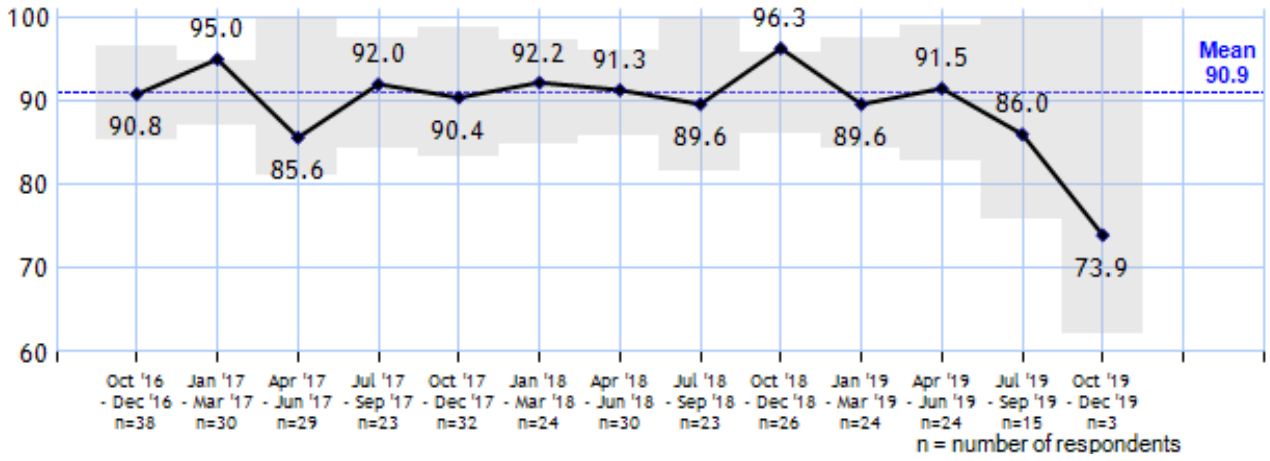
Measure Objective/Goal:

Acute rehabilitation program evaluation, including patient satisfaction, clinical quality including functional outcomes and referral review

Date range of data evaluated: Rehab annual report, Fiscal year 2019 internal data, April 2018-March 2019 external data

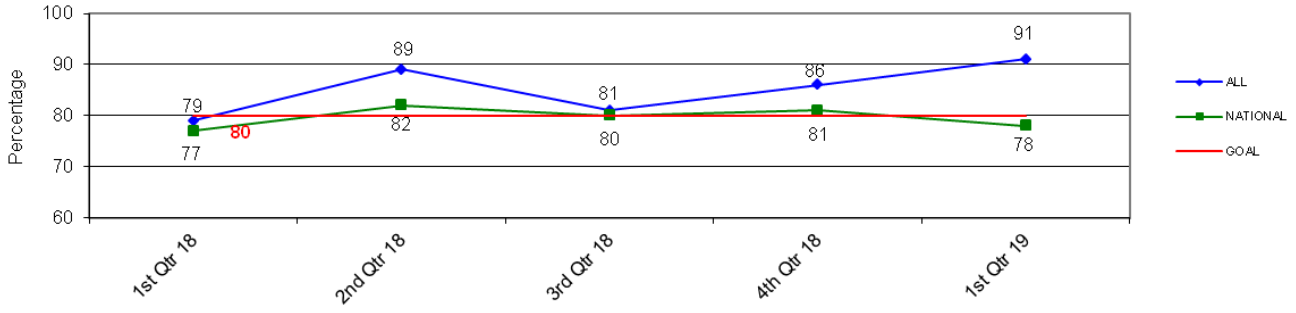
Analysis of all measures/data: (Include key findings, improvements, opportunities)

Patient satisfaction: Mean score was 91.9 placing the program in the 77th percentile for the year.

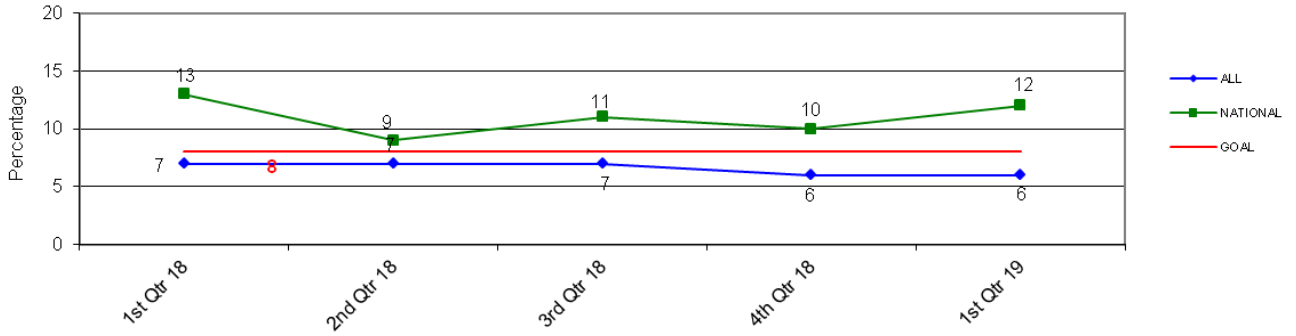


Outcomes: 87% of patients returned to community, above national average of 80. Skilled Nursing Facility discharges were 6% compared to national average of 11%. Acute care discharges were 6%, well below the national average of 9%.

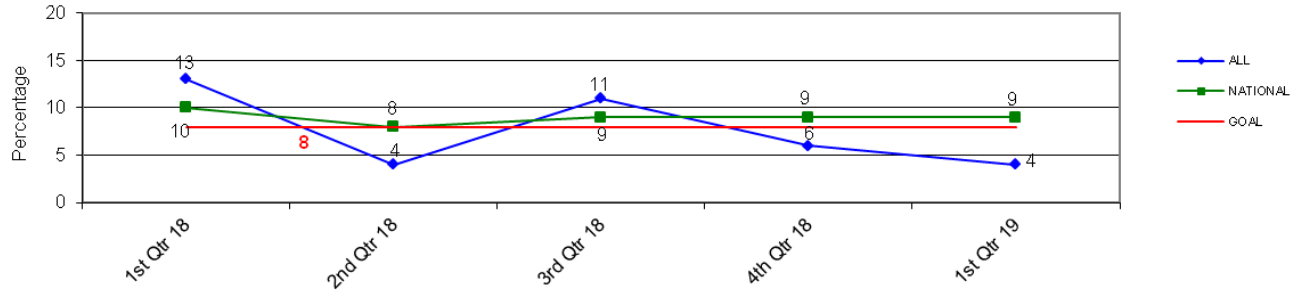
KDRH Patients Discharged to Community - ALL



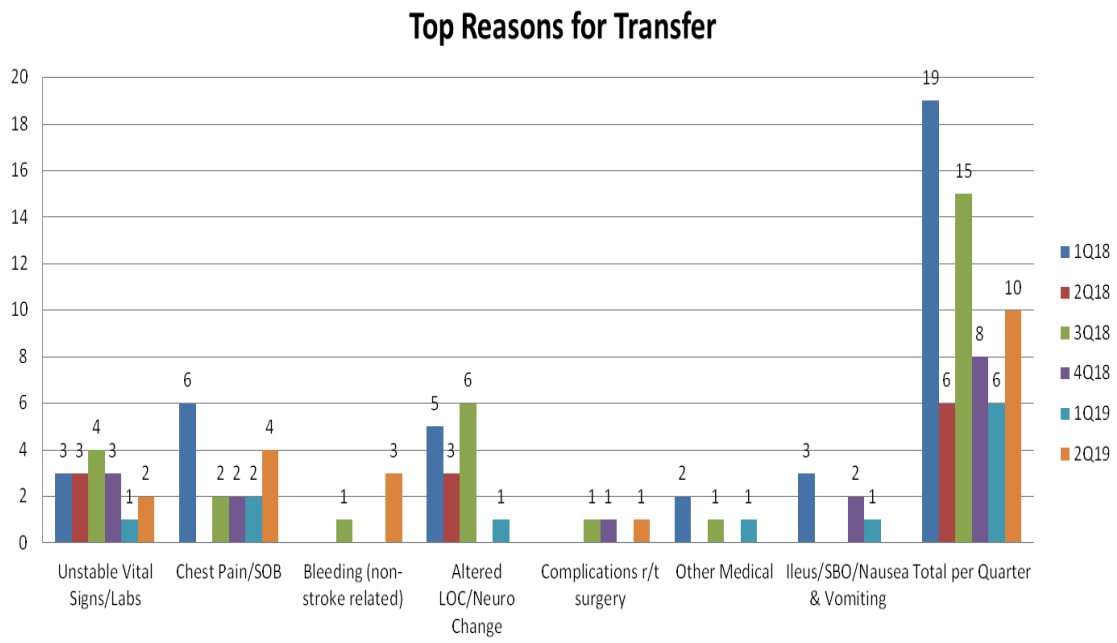
KDRH Patients Discharged to LTCF - ALL



KDRH Patients Discharged to Acute - ALL



Transfer of Care Analysis



- Total transfers to acute were 39 for the year. Spike in events 3rd quarter 2018, but no significant patterns were identified.

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

Patient satisfaction remains high overall, but therapy and nursing teams are working to improve satisfaction with readiness for discharge and explanation of rehab stay. Recent scores show improvement in both of these areas. Clinical outcomes continue to be strong.

Measure Objective/Goal:

Nursing indicators relative to NDNQI

Date range of data evaluated: 2nd quarter 2019

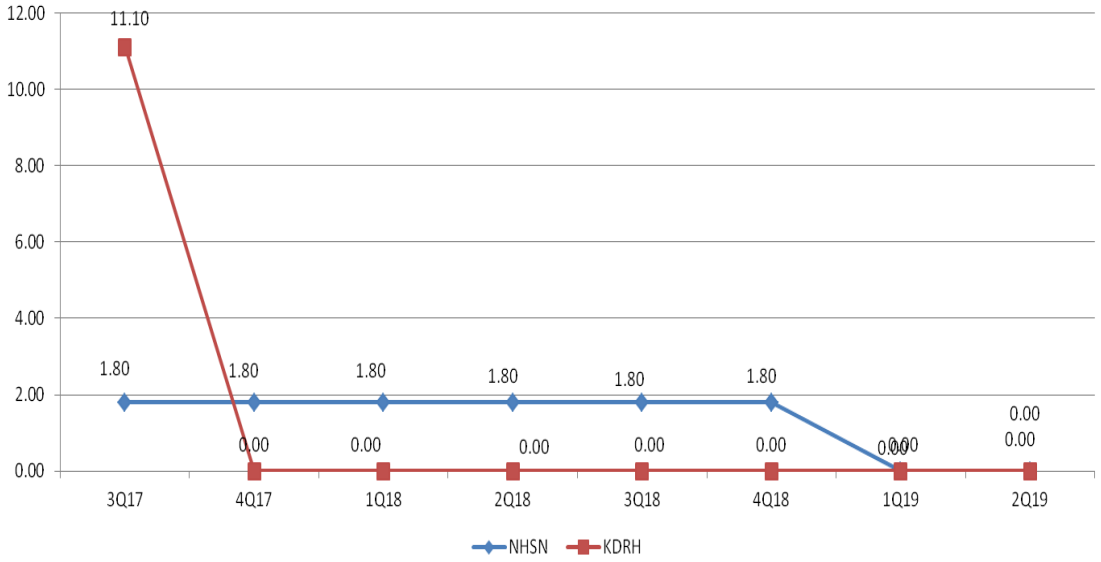
Analysis of all measures/data: (Include key findings, improvements, opportunities)

Kaweah Delta Rehab had zero incidence of catheter associated urinary tract infection, central line blood stream infections or hospital acquired pressure ulcer stage II or above. Fall rate per 1000 patient days was below NDNQI benchmarks and there were no falls with injury.

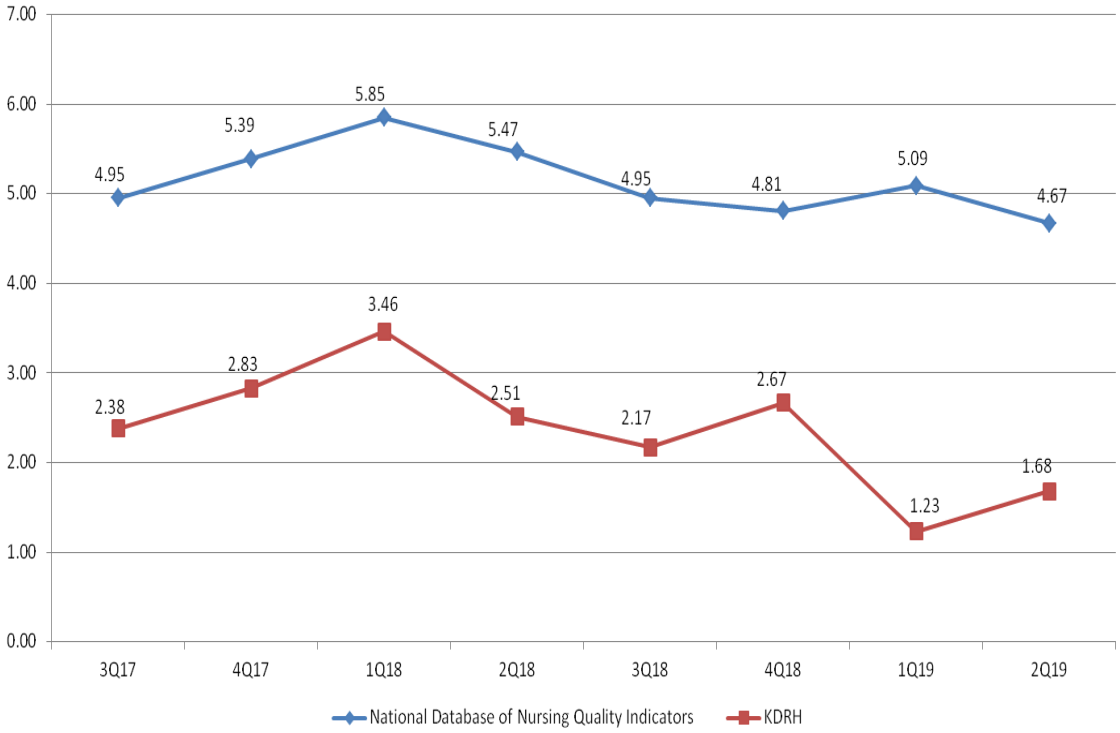
If improvement opportunities identified, provide action plan and expected resolution date:

Continue existing initiatives for CAUTI, pressure ulcer and fall prevention to maintain performance.

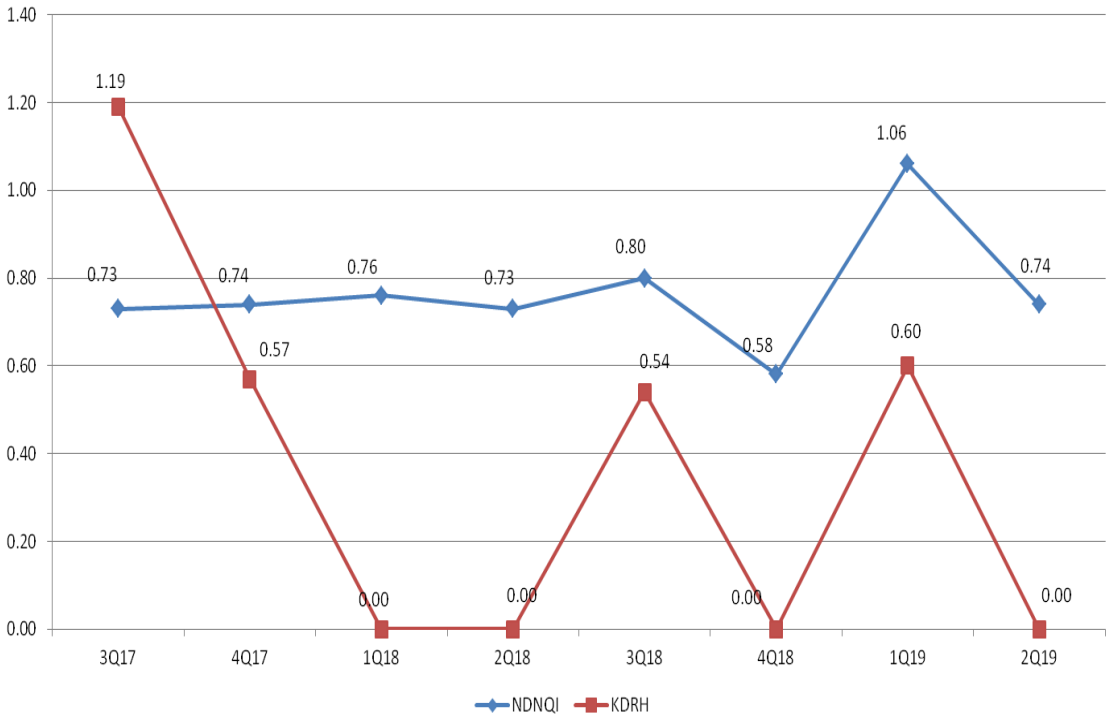
Catheter Associated Urinary Tract Infection Rate (per 1000 patient days)



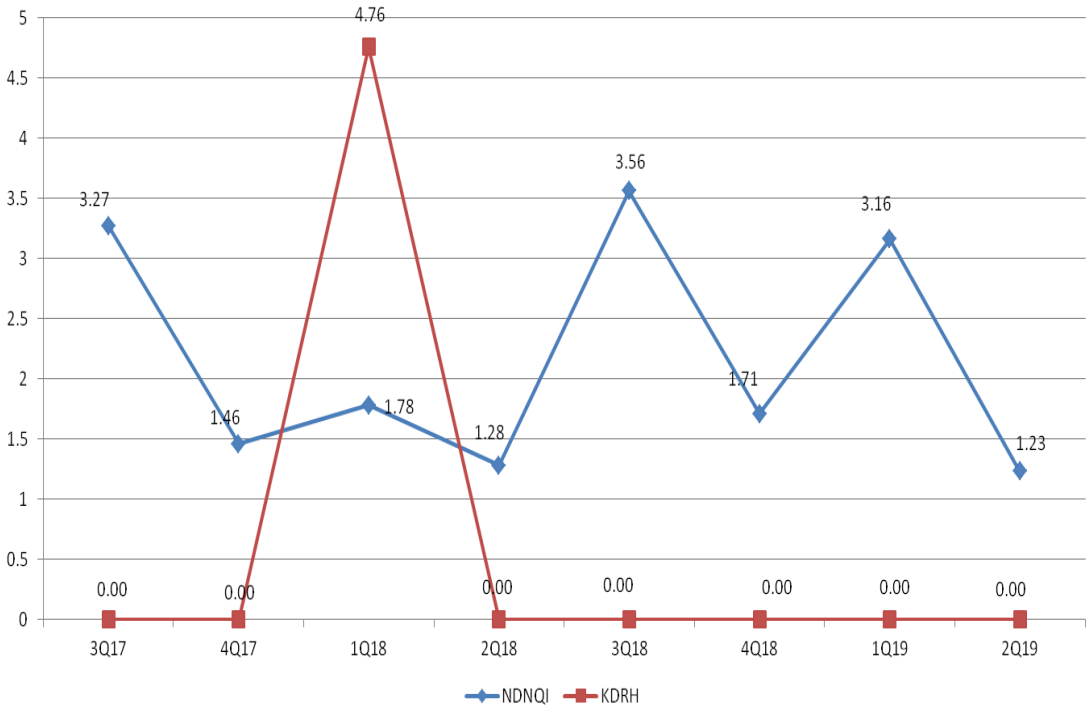
Fall Rate/1000 Patient Days

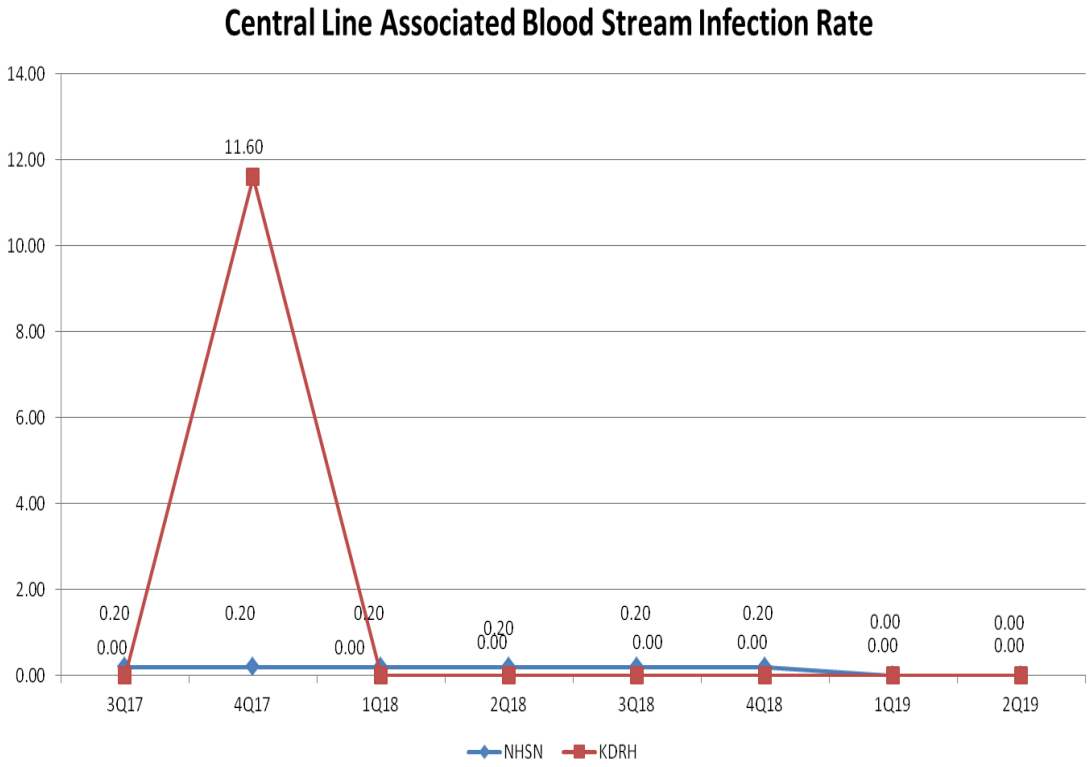


Fall Rate with Injury/ 1000 Patient Days



Hospital Acquired Pressure Ulcer (Stage 2 and above)



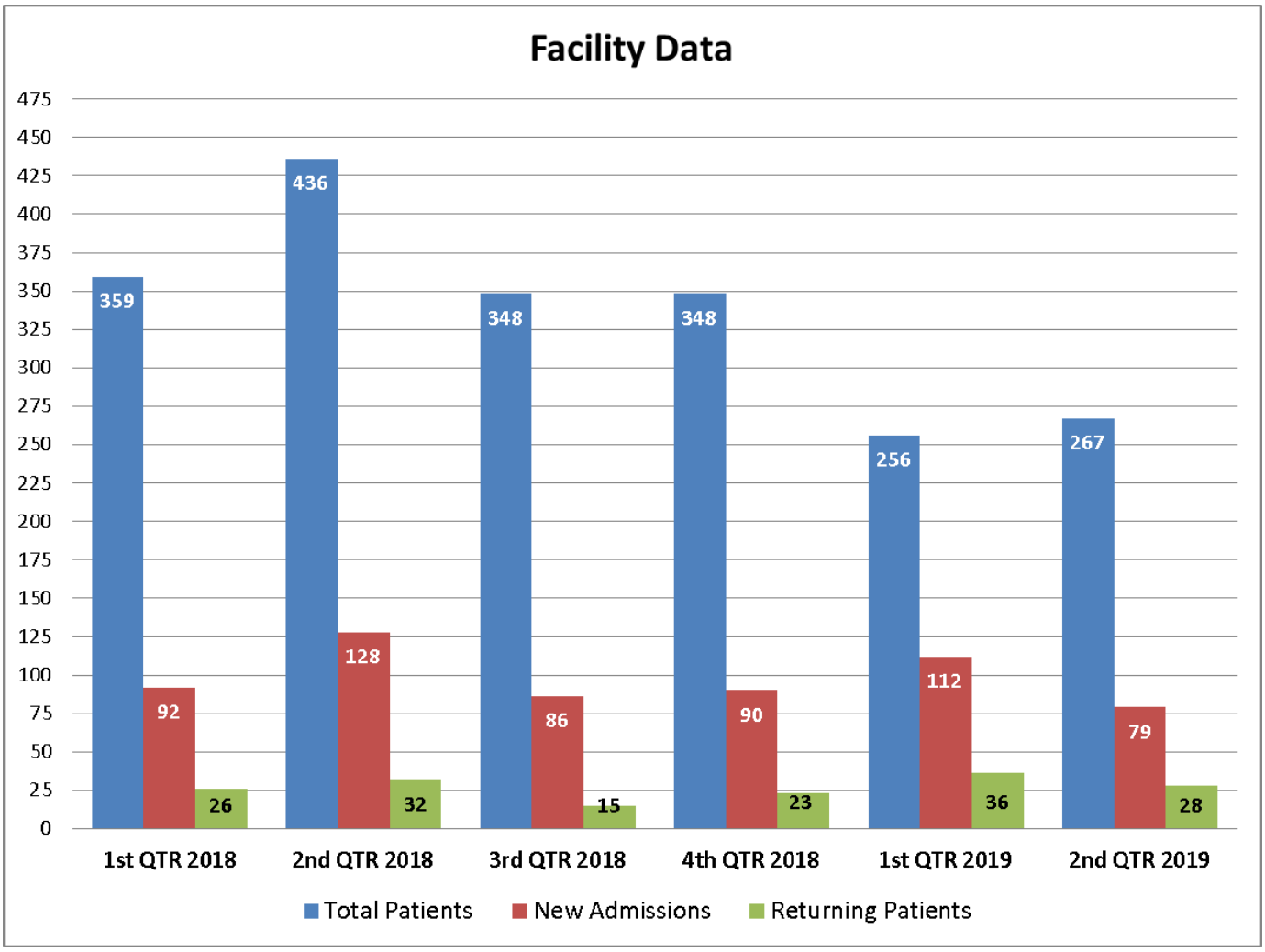


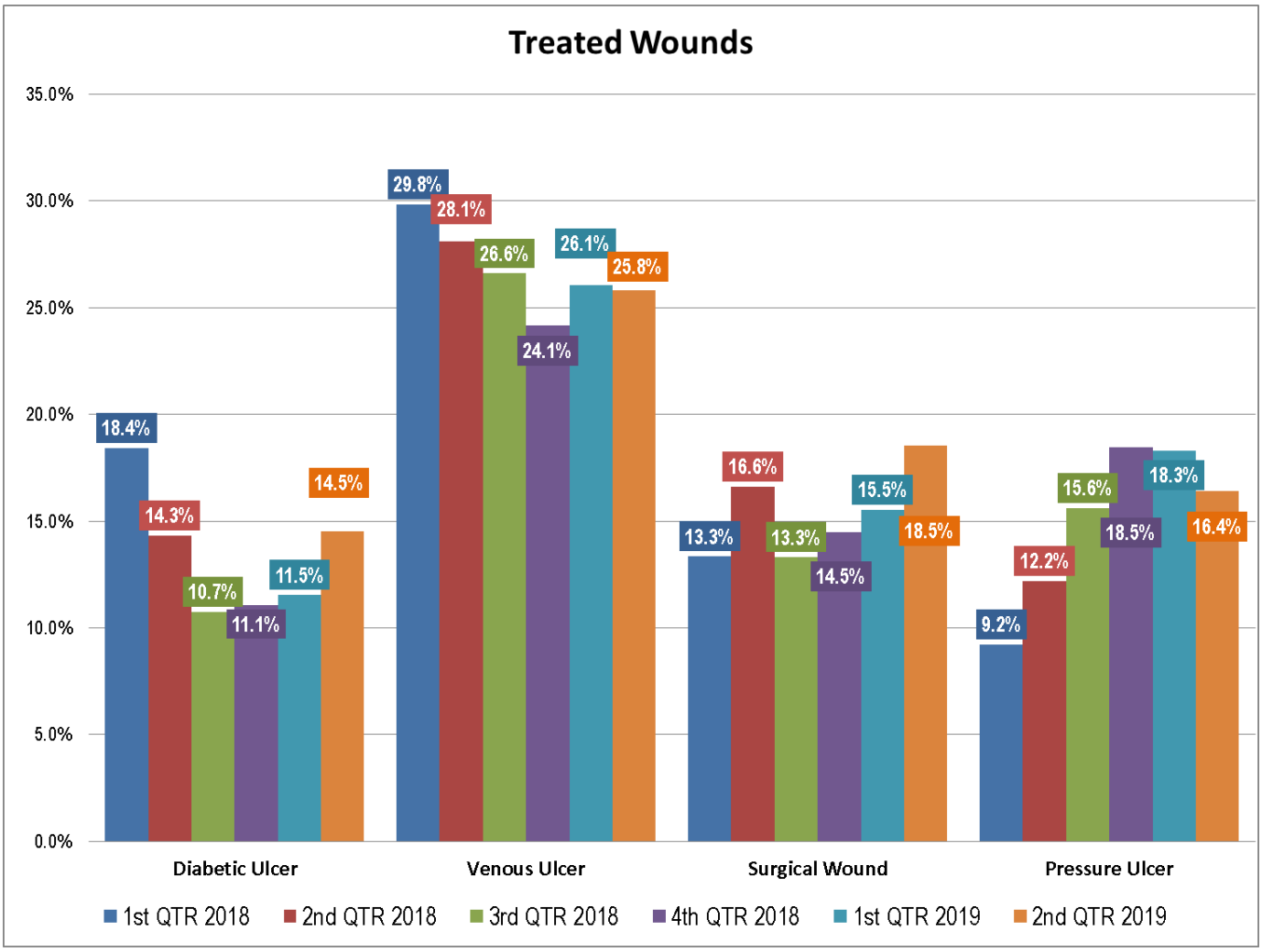
Measure Objective/Goal: Wound Center outcomes

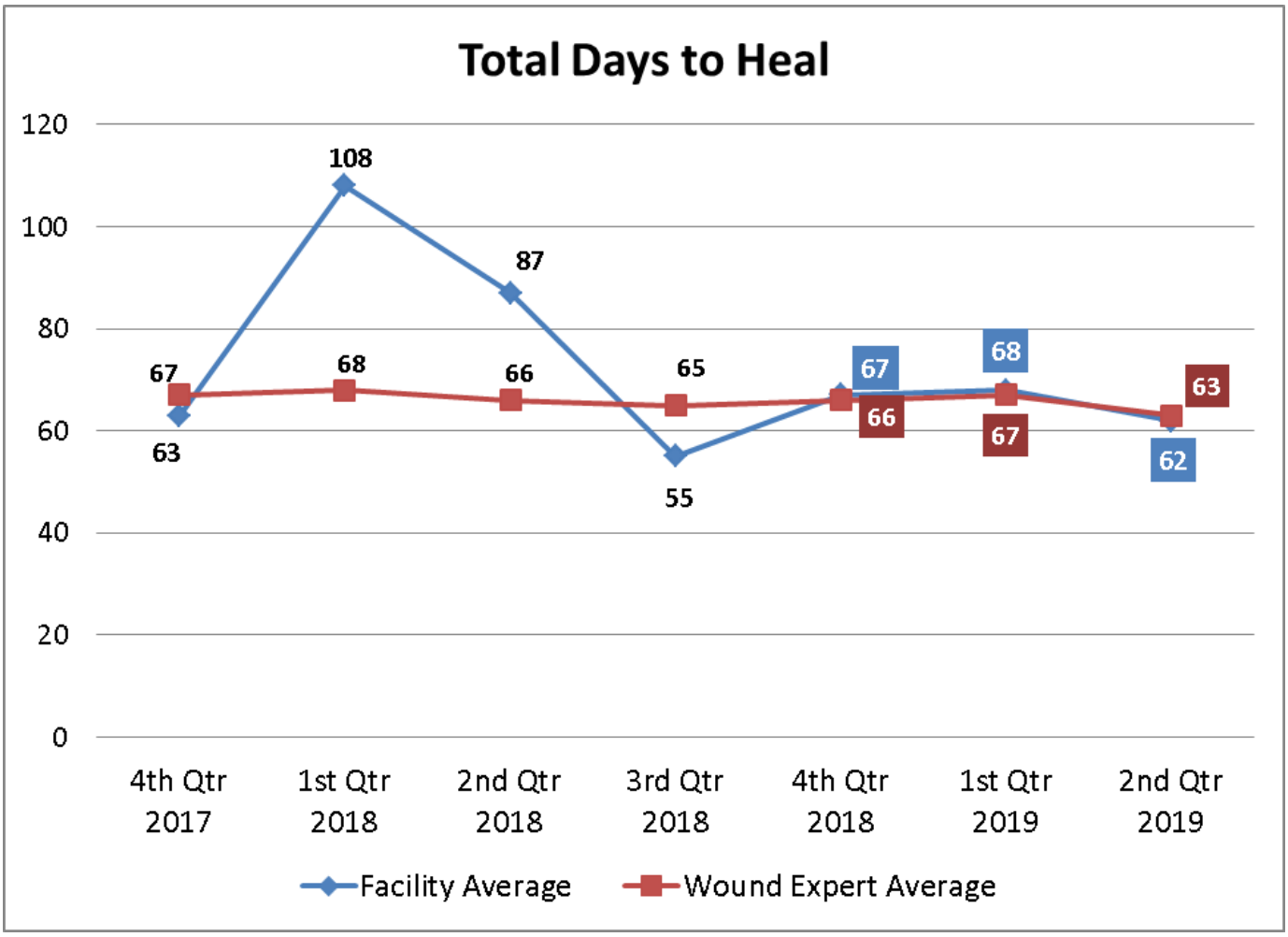
Date range of data evaluated: 2nd quarter 2019

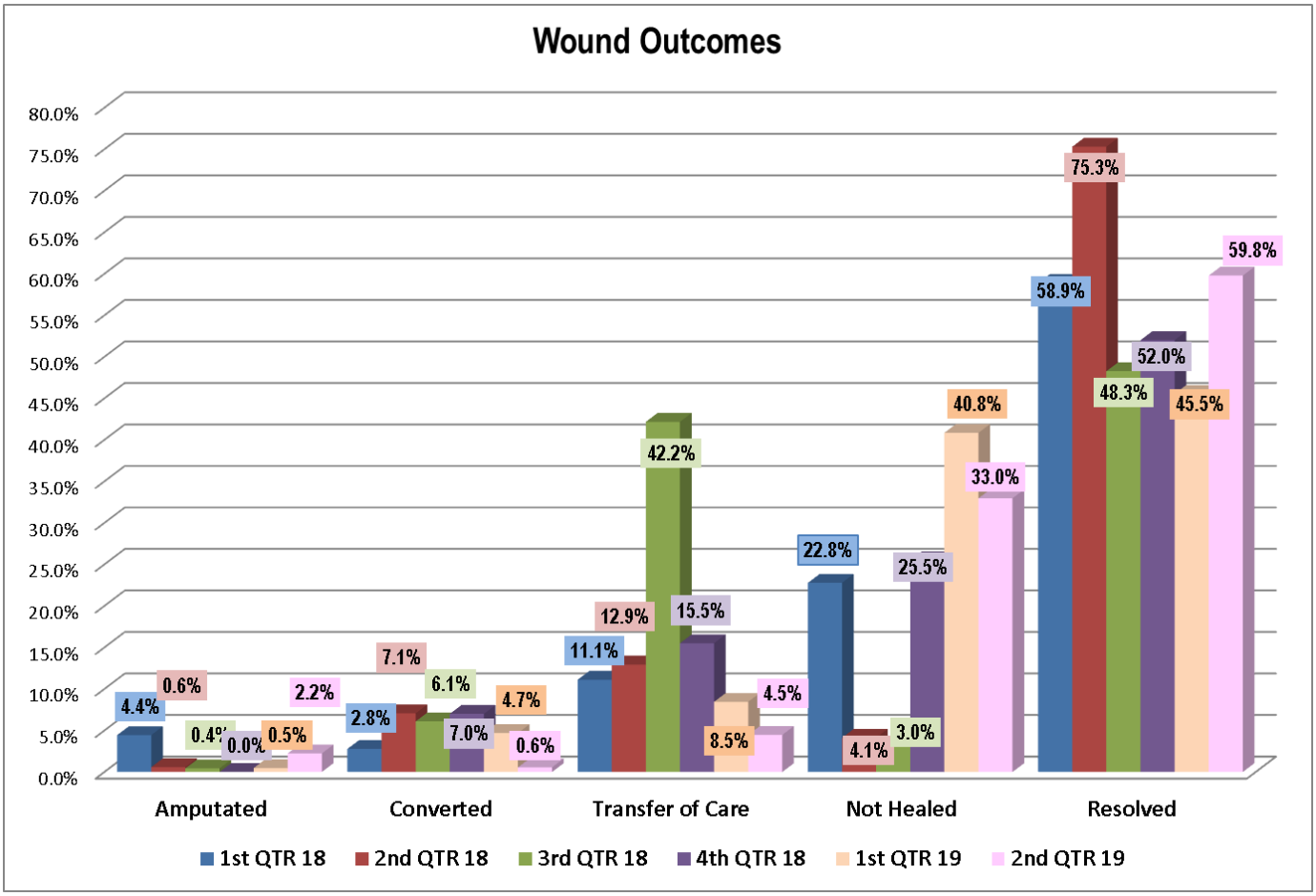
Analysis of all measures/data: (Include key findings, improvements, opportunities)

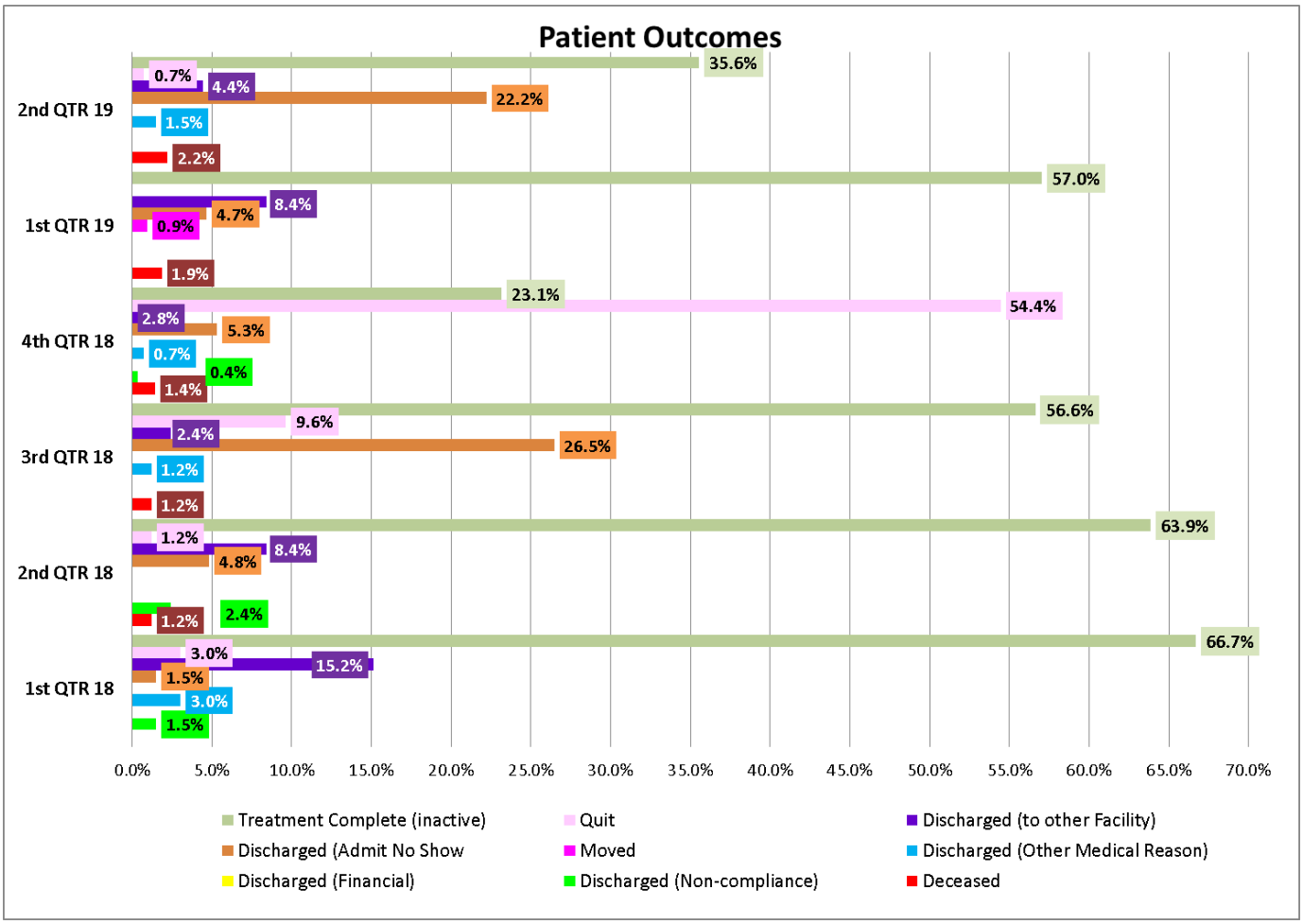
Average days to heal were one day below the national benchmark this quarter. Continue to see improving results in regards to patients completing treatment and overall percent of resolved wounds. Multidisciplinary case review with the medical director continues for stalled wounds, which is facilitating improved interdisciplinary coordination and faster resolution of wounds. Ostomy services are now being offered by the clinic as well, for patients who are having difficulty managing an existing or new ostomy. Previously patients had to travel to Fresno for this service.


Facility Data
475
450
425
400
375
350
325
300
275
250
225
200
175
150
125
100
75
50
25
0
359
92
26
436
128
32
348
86
15
348
90
23
256
112
36
267
79
28
1st QTR 2018
2nd QTR 2018
3rd QTR 2018
4th QTR 2018
1st QTR 2019
2nd QTR 2019
Total Patients
New Admissions
Returning Patients


Treated Wounds
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
18.4%
14.3%
10.7%
11.1%
11.5%
14.5%
29.8%
28.1%
26.6%
24.1%
26.1%
25.8%
13.3%
16.6%
13.3%
14.5%
15.5%
18.5%
9.2%
12.2%
15.6%
18.5%
18.3%
16.4%
Diabetic Ulcer
Venous Ulcer
Surgical Wound
Pressure Ulcer
1st QTR 2018
2nd QTR 2018
3rd QTR 2018
4th QTR 2018
1st QTR 2019
2nd QTR 2019


Total Days to Heal
120
100
80
60
40
20
0
108
87
67
68
66
65
63
55
67
68
63
66
67
62
4th Qtr 2017
1st Qtr 2018
2nd Qtr 2018
3rd Qtr 2018
4th Qtr 2018
1st Qtr 2019
2nd Qtr 2019
Facility Average
Wound Expert Average


Wound Outcomes
80.0%
75.0%
70.0%
65.0%
60.0%
55.0%
50.0%
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
4.4%
0.6%
0.4%
0.0%
0.5%
2.2%
2.8%
7.1%
6.1%
7.0%
4.7%
0.6%
11.1%
12.9%
42.2%
15.5%
8.5%
4.5%
22.8%
4.1%
3.0%
25.5%
40.8%
33.0%
58.9%
75.3%
48.3%
52.0%
45.5%
59.8%
Amputated
Converted
Transfer of Care
Not Healed
Resolved
1st QTR 18
2nd QTR 18
3rd QTR 18
4th QTR 18
1st QTR 19
2nd QTR 19



Submitted by Name: Lisa Harrold **Date Submitted:** November 6, 2019

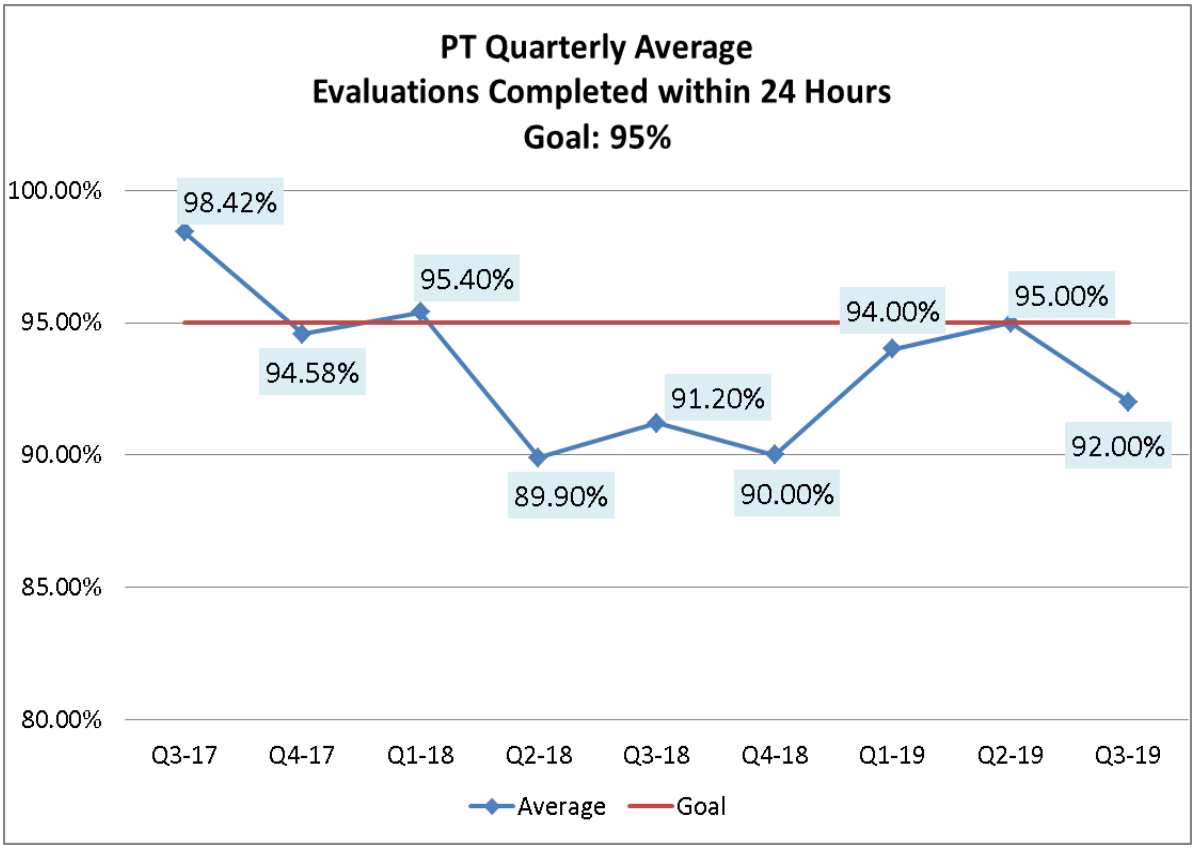
Acute Therapy Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: Acute Therapy PT and ST **ProStaff/QIC Report Date:** October 28 2019

Measure Objective/Goal: Monitoring the time between when PT/ST is ordered and the 1st documentation therapy evaluation or reason patient not seen is completed. This is an indicator of our services ability to respond to patient & physician needs and provide valuable information to assist in both medical & discharge planning. Goal is 95% of PT and ST Evaluations are completed within 24 hours.

Date range of data evaluated: 3rd quarter 2019



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):

Response to PT evaluation orders within 24 hours decreased from 2nd quarter 95.0% to 3rd quarter 92.0%. Total number of PT evaluations per month/% completed in 24 hours - June 871/95.1%, July 900/93.9% and August 931/91.4% demonstrates increase in # of orders relationship with decrease in timeliness of evaluation.

- Stat Requests for Evaluations on patients pending DC, transfer to SNF vs Rehab, etc to facilitate Throughput result in triaging evaluations which effects ability to meet the 24 hour metric.
- # of evaluation orders/day can vary from 21 to 49 making staffing a challenge in addition to fluctuating number of scheduled surgeries.

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

- Continue to focus on staffing appropriately when there are not a consistent number of evaluations throughout the month. - Ongoing
- PTO coverage with PTAs who are unable to complete evaluations for PTO taken at end of summer. Need to hire per diem PTs who are available Mon – Friday. – One hired in September.

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

Acute Therapy Specific Data Collection Summarization

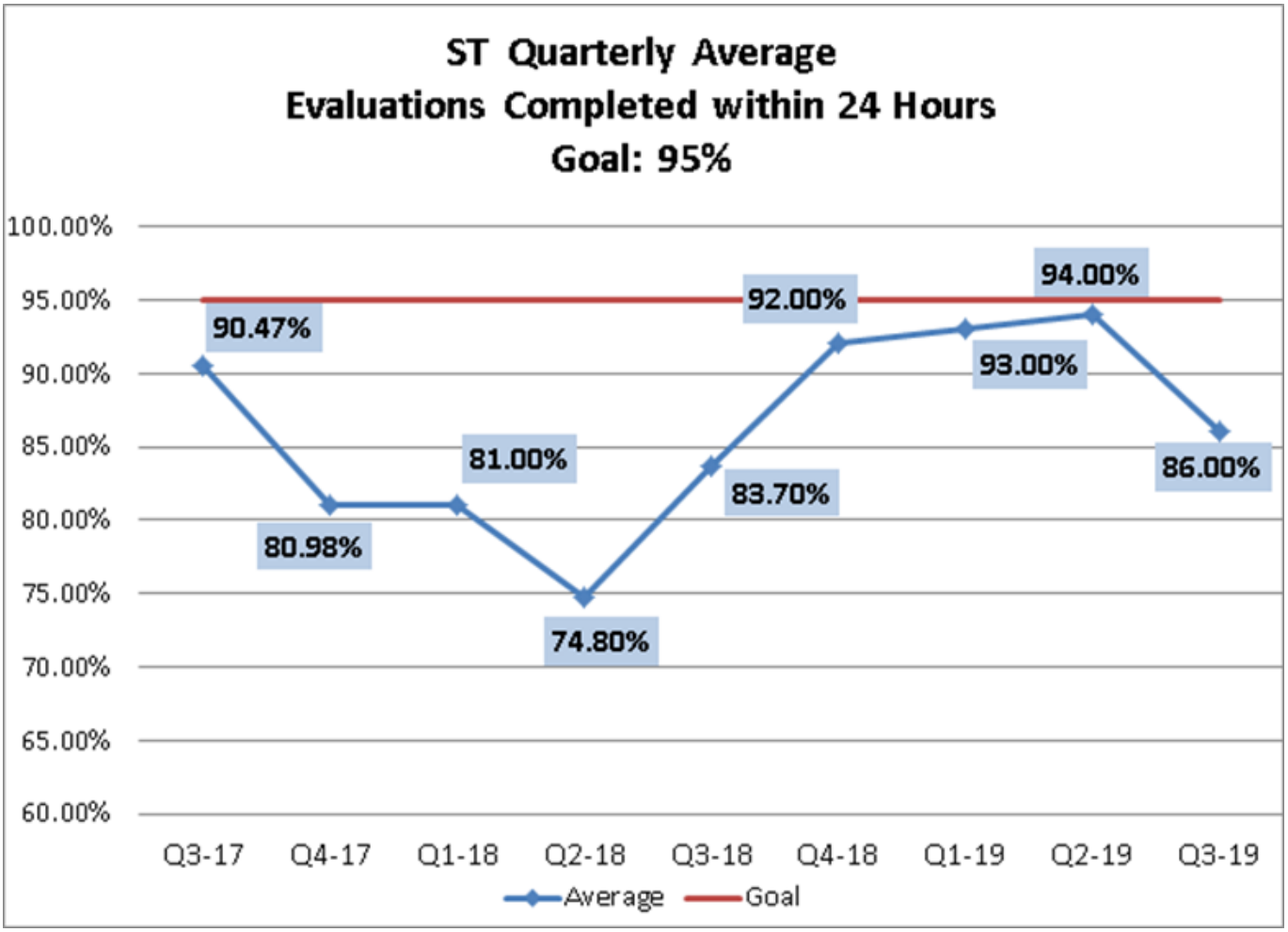
Professional Staff Quality Committee/Quality Improvement Committee

Next Steps/Recommendations/Outcomes:

- Physical Therapy staff continuing to present to nursing units, Neuro surgery, Ortho group, Hospitalists and the GME Residents providing education as to the scope of practice for Therapy services in an effort to ensure appropriate Therapy orders are being placed.
- Educate Nursing staff as to increase the mobilization of patients outside of Therapy.
- Created report to take a look a nursing documentation of mobilizing patients with activity orders.
- Piloting Nursing Mobility Program on 4S.

Acute Therapy Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee



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): Response to ST orders for swallow evaluation within 24 hours declined from 2nd quarter 94.0% to 86.0% in the 3rd quarter 2019. The total numbers of ST evaluations per month//% completed in 24 hours - June 214/91.6%, July 244/88.1%, August 235/80.9%.

- Fluctuation in number of swallow evaluations ordered from 1 – 15/day making staffing a challenge.

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

- sick call 4 days leaving 1 SLP, hiring hire of per diem SLP to help with Monday and Friday coverage. – completed September.
- FEES training over 4 days in August – completed
- Speech Therapy staff to contact ED re: need to complete evaluation in the ED on a patient by patient basis for 1E patients. Contacted Nurse manager for Secretary extension and pt location. – completed.

Next Steps/Recommendations/Outcomes:

- Determine feasibility of weekend Therapy staff performing evaluations in the ED on a regular basis for 1E patients
- Speech Therapy staff continuing to present to nursing units, Neuro surgery, Ortho group, Hospitalists and the GME Residents providing education as to the scope of practice for Therapy services in an effort to ensure appropriate Therapy orders are being placed.

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

Acute Therapy Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Submitted by Name: Molly Niederreiter **Date Submitted:** October 28 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: Outpatient Therapies (7799, 7800, 7803, 7804, 7806, 7807)

ProStaff Report Date: 10/30/19

Measure Objective/Goal: The outpatient therapy departments objectively measure function by using specific functional outcome measures consistently throughout the episode of a patients' care. Measuring outcomes of care, including body functions and activity completion, among patients with similar diagnosis is the foundation for determining which intervention approaches comprise best clinical practice. The goal of this data collection is to look at how each clinic is performing with regards to improving function in patients in each of the outpatient settings. With this data, we are able to identify trends and areas for improvement when providing care to specific body regions. There are 5 different outcome measures utilized pending the body region that is being evaluated. Those measures consist of one for arm impairments, one for leg impairments, one for neck impairments, one for back impairments, and one for neurological impairments (such as after stroke or brain injury).

Functional Outcome Measure Questionnaires, which list a number of daily activities and require patients to scale how easy or difficult it is to complete those activities based on their condition, are completed by patients prior to initiating therapy, at regular intervals during therapy, and upon discharge.

Date range of data evaluated: Quarterly data beginning April 2017 to present

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) Dinuba Therapy Specialists:
   - Is meeting goal for patient improvements with Disabilities of the Shoulder/Hand and diagnosis' involving the neck.
   - Showing steady scores for diagnosis' involving the lower extremity and back, but have seen a downward trend. Analysis of lower extremity diagnosis' show a shift towards treating more patients with chronic pain vs surgical which affects rate of recovery.

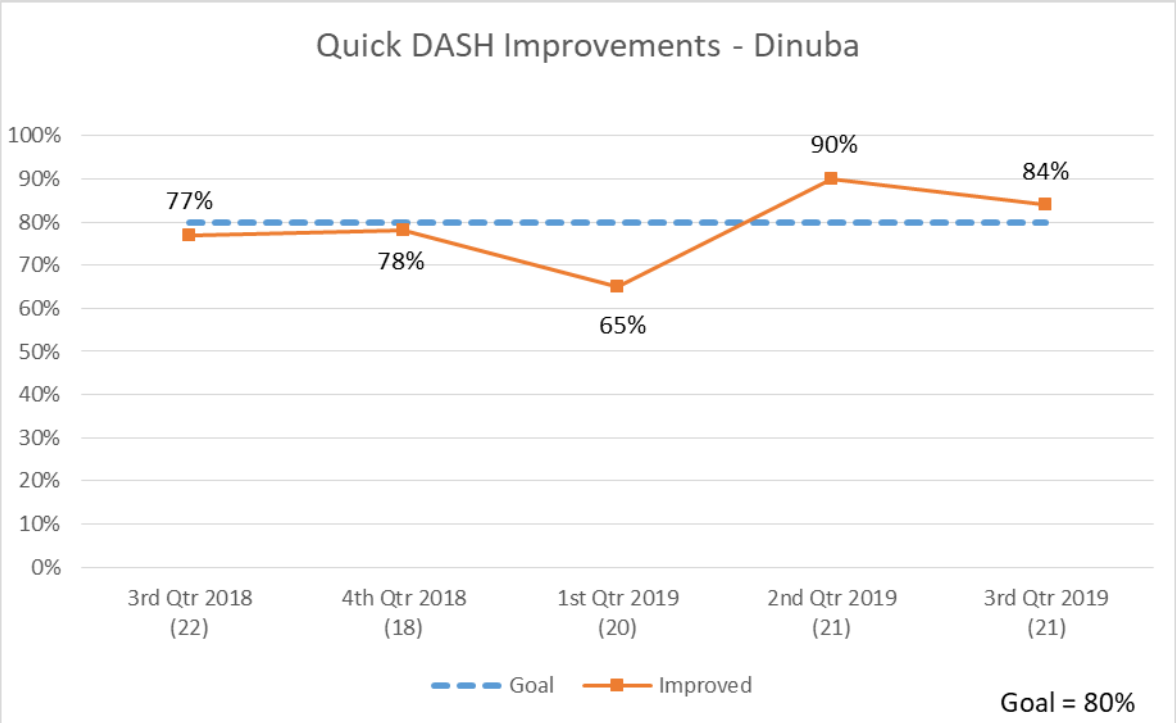
2) Exeter Therapy Specialists:
   - Seeing an upward trend for patient improvements with Disabilities of the Shoulder/Hand, and is meeting goal.
   - Is meeting goal for Lower Extremity Functional Scoring
   - Is trending downwards for diagnosis' involving the neck and is not meeting goal.
   - Showing steady scores for diagnosis involving the back

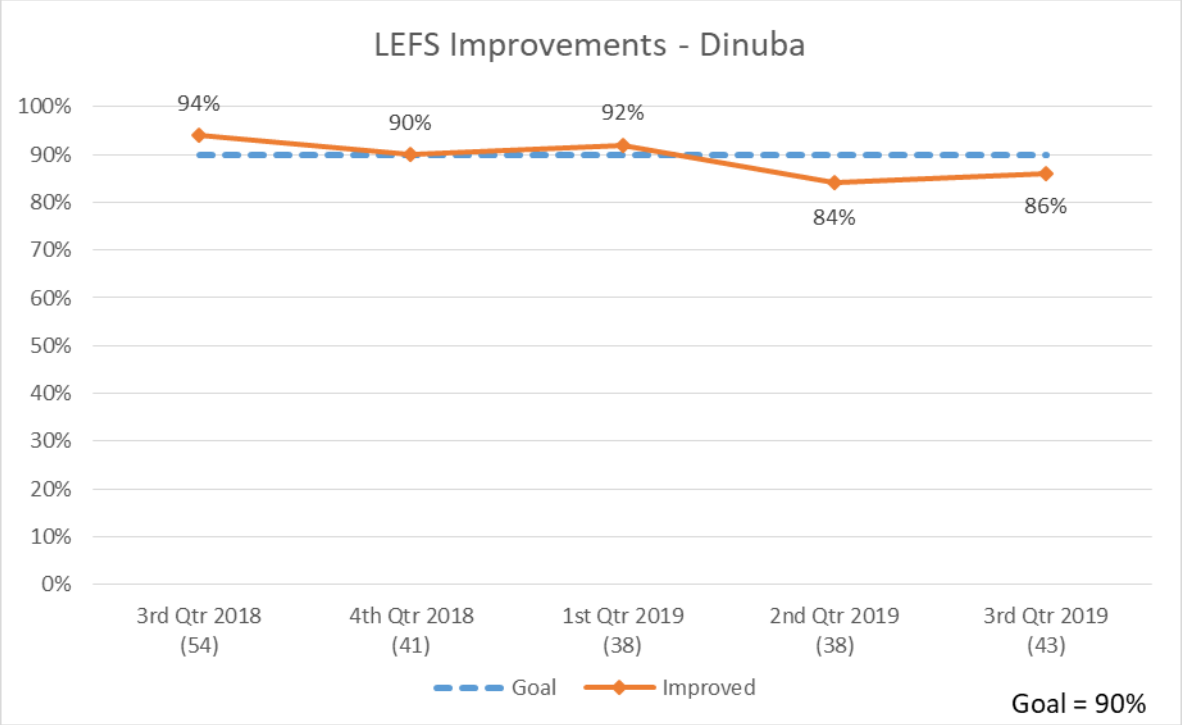
3) Loves Lane Therapy Specialists:
   - There is increased data to see trends for Disabilities of the Shoulder/Hand and neck over the past 2 quarters.
   - Is meeting goals for all areas measured.

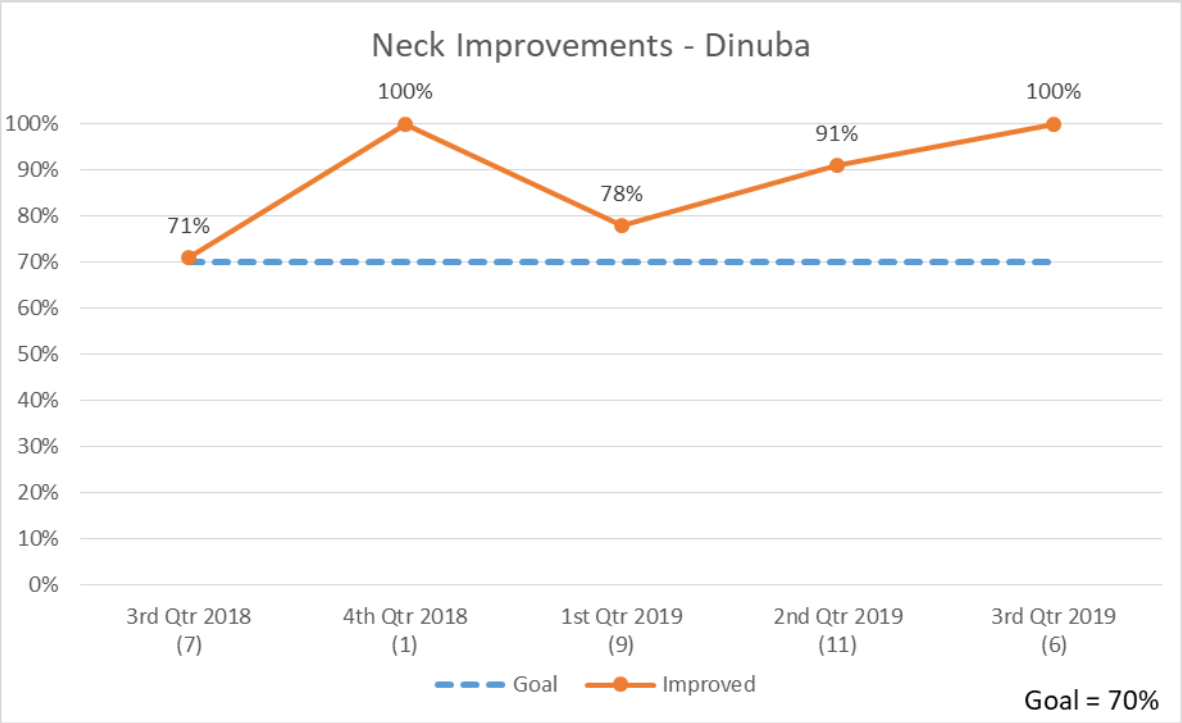
4) Therapy Specialists at MOB:
   - Is meeting goals for all areas measured. Did show a downward dip in scores involving the back in the 2nd Quarter, but is now meeting goal.

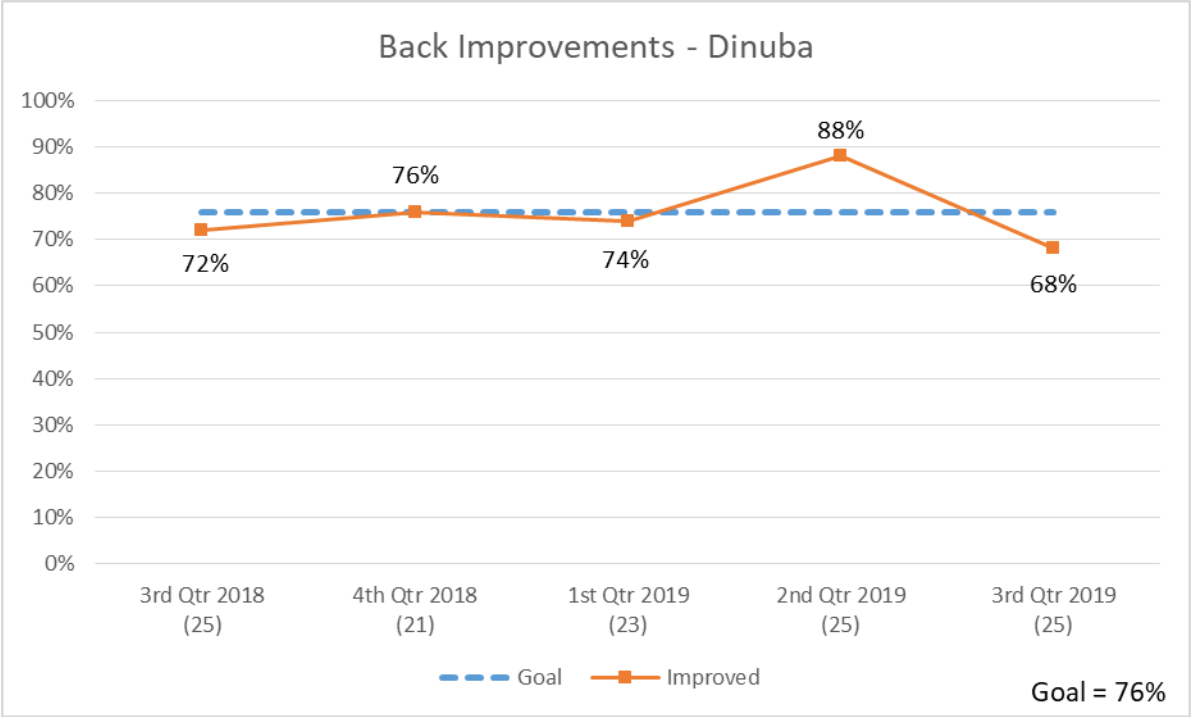
5) Therapy Specialists at Neuro clinic:
   - Is meeting goal for patient improvements with Disabilities of the Shoulder/Hand as well as for Lower Extremity Functional Scoring – low volume reporting
   - Is not meeting the goal for OPTIMAL (Outpatient Physical Therapy Improvement in Movement Assessment Log) and is trending downward. Manager has been notified for further investigation and staff training.

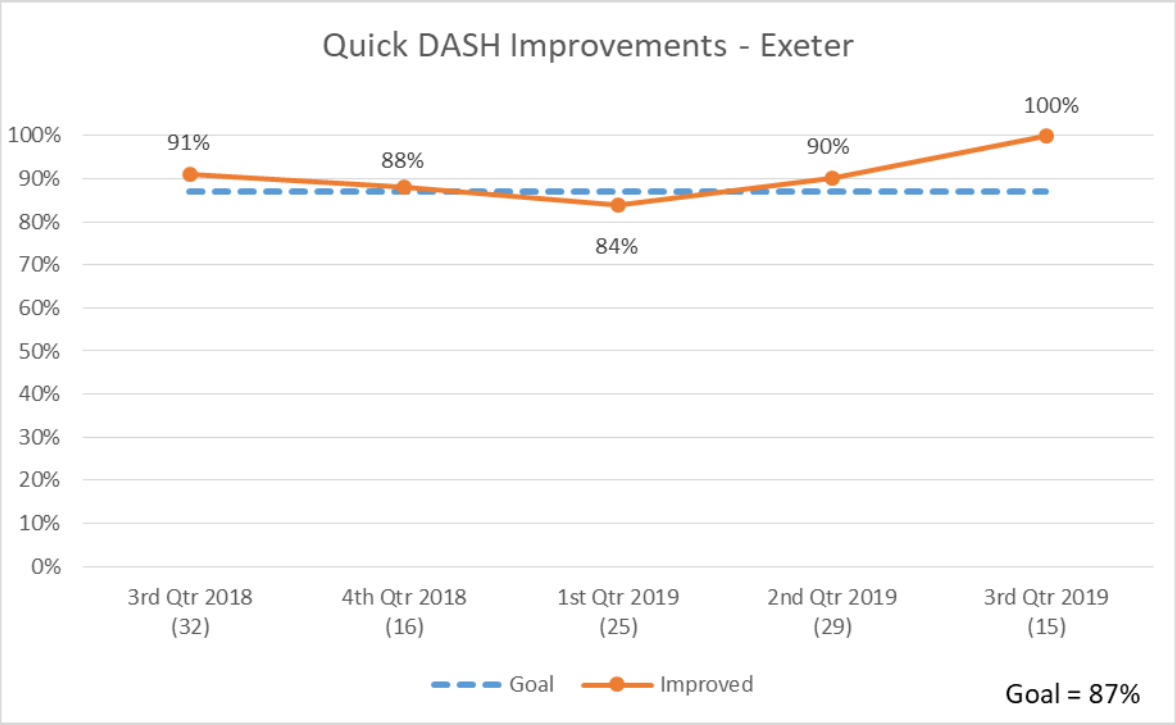
6) Hand Therapy Specialists:
   - Is just under meeting goal, but outcomes are steady.

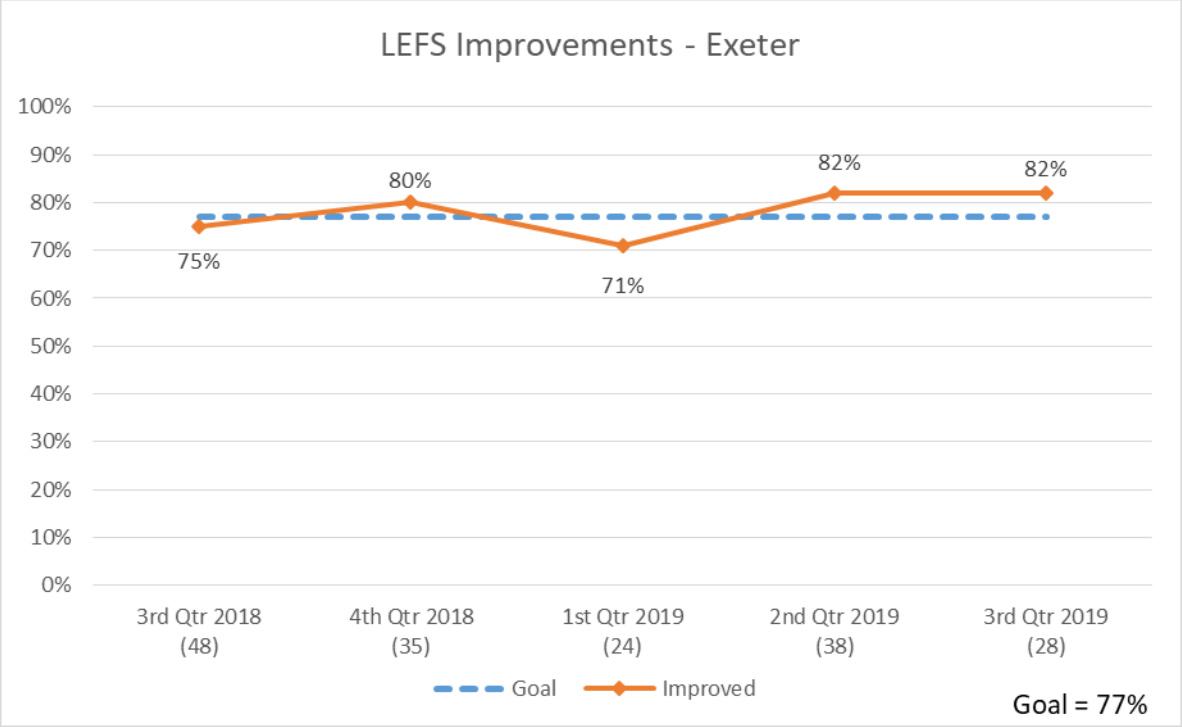

Quick DASH Improvements - Dinuba
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
77%
78%
65%
90%
84%
3rd Qtr 2018 (22)
4th Qtr 2018 (18)
1st Qtr 2019 (20)
2nd Qtr 2019 (21)
3rd Qtr 2019 (21)
Goal
Improved
Goal = 80%

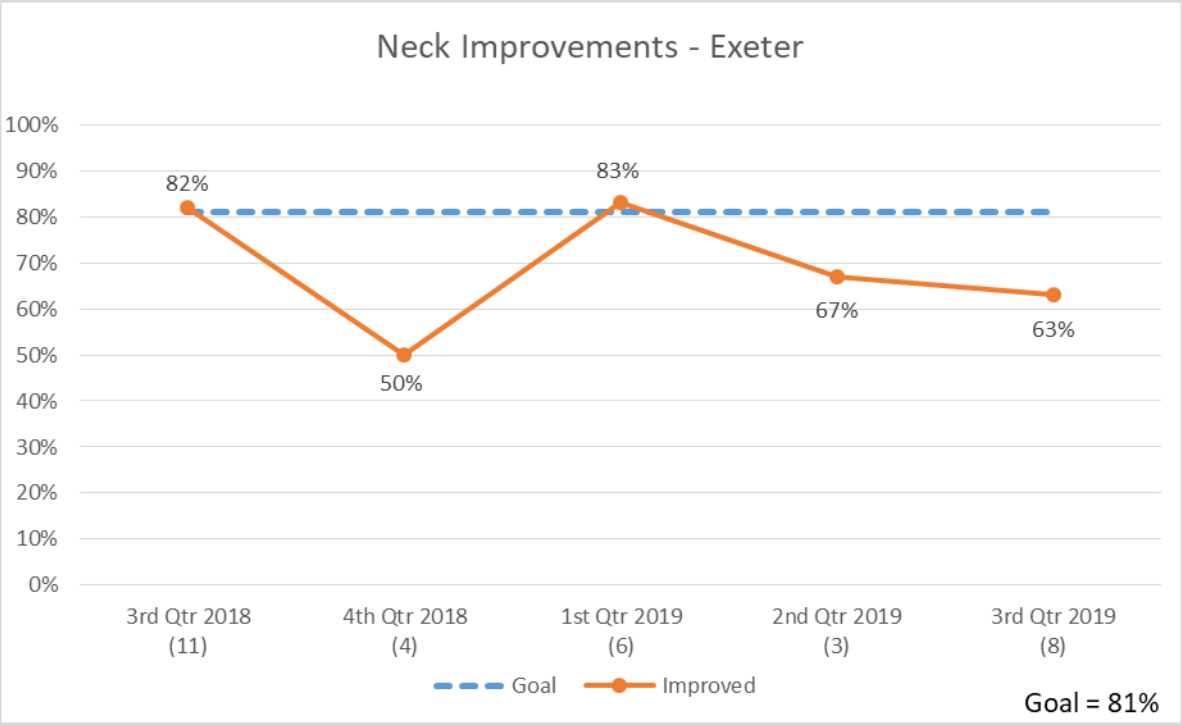

LEFS Improvements - Dinuba
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
94%
90%
92%
84%
86%
3rd Qtr 2018 (54)
4th Qtr 2018 (41)
1st Qtr 2019 (38)
2nd Qtr 2019 (38)
3rd Qtr 2019 (43)
Goal
Improved
Goal = 90%

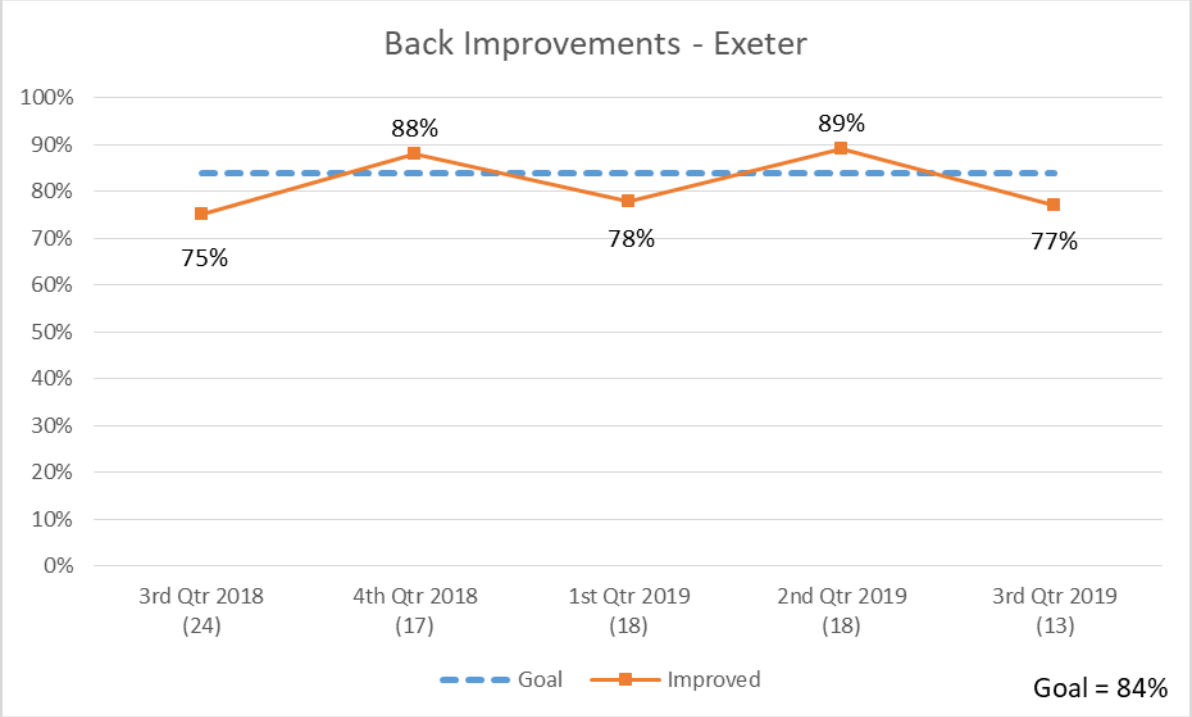

Neck Improvements - Dinuba
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
71%
100%
78%
91%
100%
3rd Qtr 2018 (7)
4th Qtr 2018 (1)
1st Qtr 2019 (9)
2nd Qtr 2019 (11)
3rd Qtr 2019 (6)
Goal
Improved
Goal = 70%

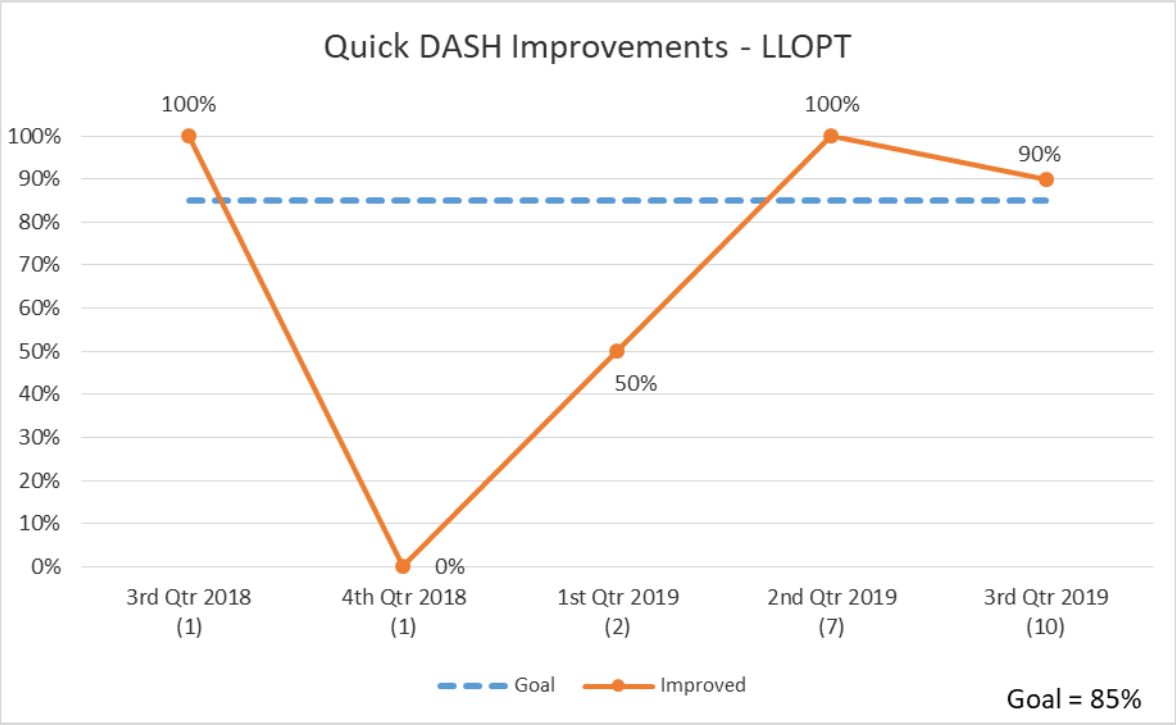

Back Improvements - Dinuba
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
72%
76%
74%
88%
68%
3rd Qtr 2018 (25)
4th Qtr 2018 (21)
1st Qtr 2019 (23)
2nd Qtr 2019 (25)
3rd Qtr 2019 (25)
Goal
Improved
Goal = 76%

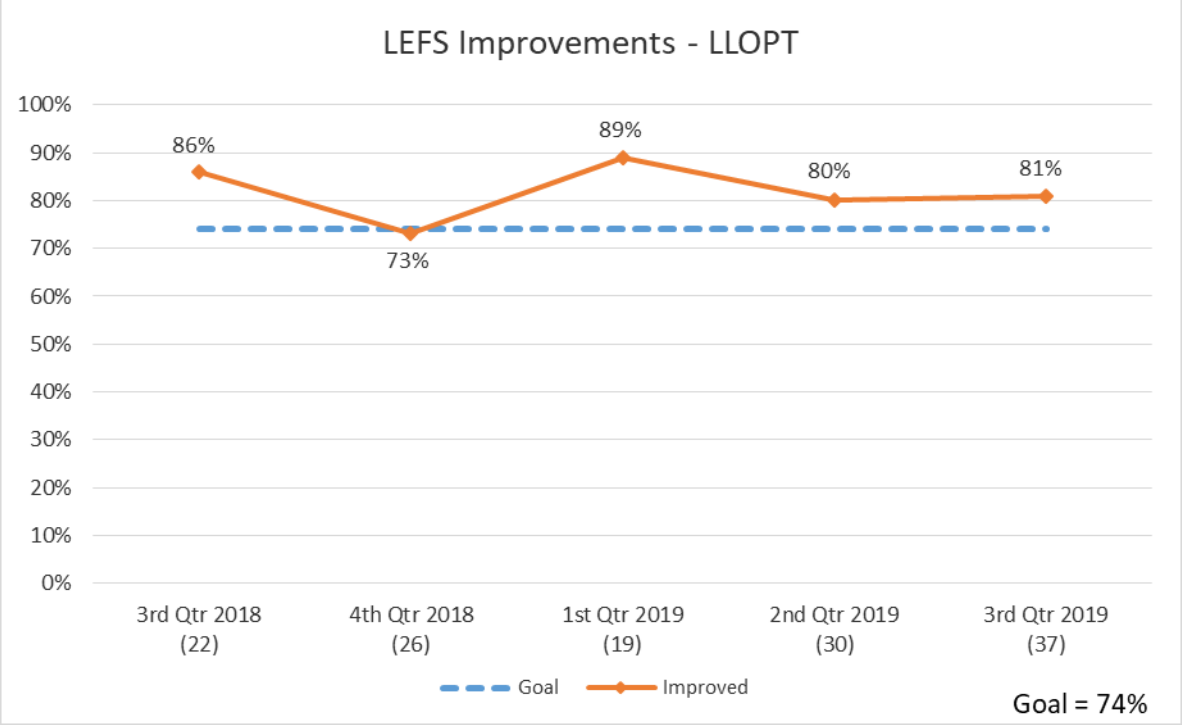

Quick DASH Improvements - Exeter
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
91%
88%
84%
90%
100%
3rd Qtr 2018 (32)
4th Qtr 2018 (16)
1st Qtr 2019 (25)
2nd Qtr 2019 (29)
3rd Qtr 2019 (15)
Goal
Improved
Goal = 87%

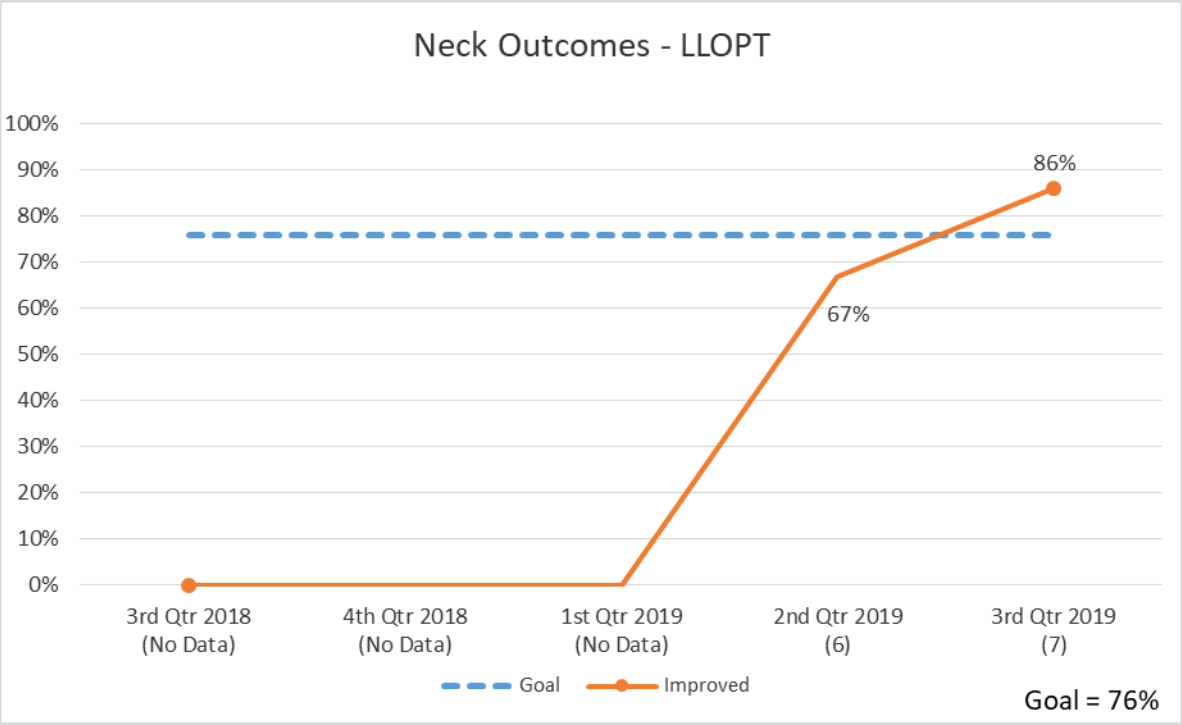

LEFS Improvements - Exeter
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
75%
80%
71%
82%
82%
3rd Qtr 2018 (48)
4th Qtr 2018 (35)
1st Qtr 2019 (24)
2nd Qtr 2019 (38)
3rd Qtr 2019 (28)
Goal
Improved
Goal = 77%

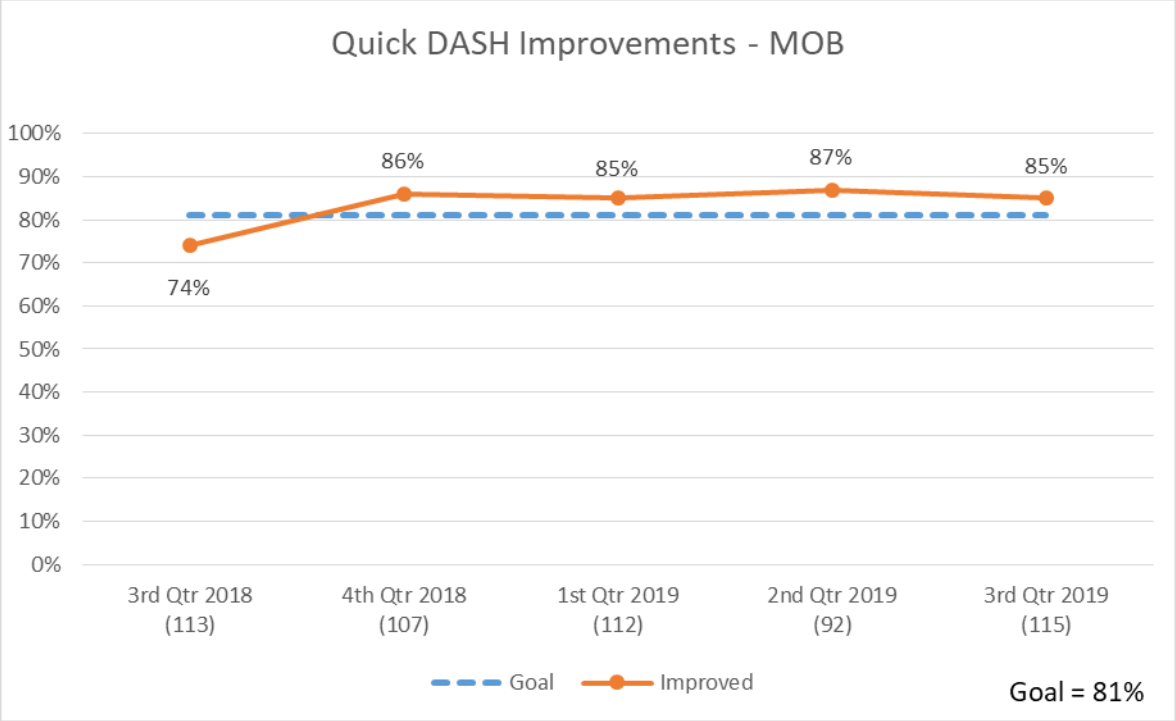

Neck Improvements - Exeter
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
82%
50%
83%
67%
63%
3rd Qtr 2018 (11)
4th Qtr 2018 (4)
1st Qtr 2019 (6)
2nd Qtr 2019 (3)
3rd Qtr 2019 (8)
Goal
Improved
Goal = 81%

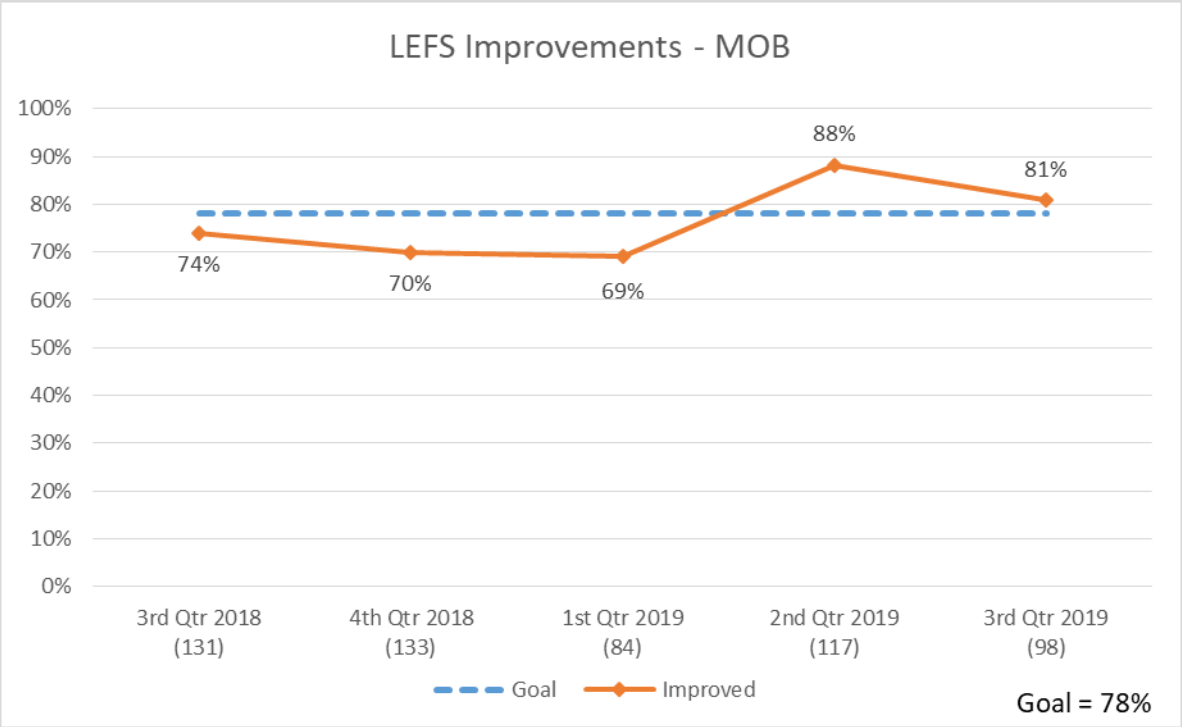

Back Improvements - Exeter
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
75%
88%
78%
89%
77%
3rd Qtr 2018 (24)
4th Qtr 2018 (17)
1st Qtr 2019 (18)
2nd Qtr 2019 (18)
3rd Qtr 2019 (13)
Goal
Improved
Goal = 84%

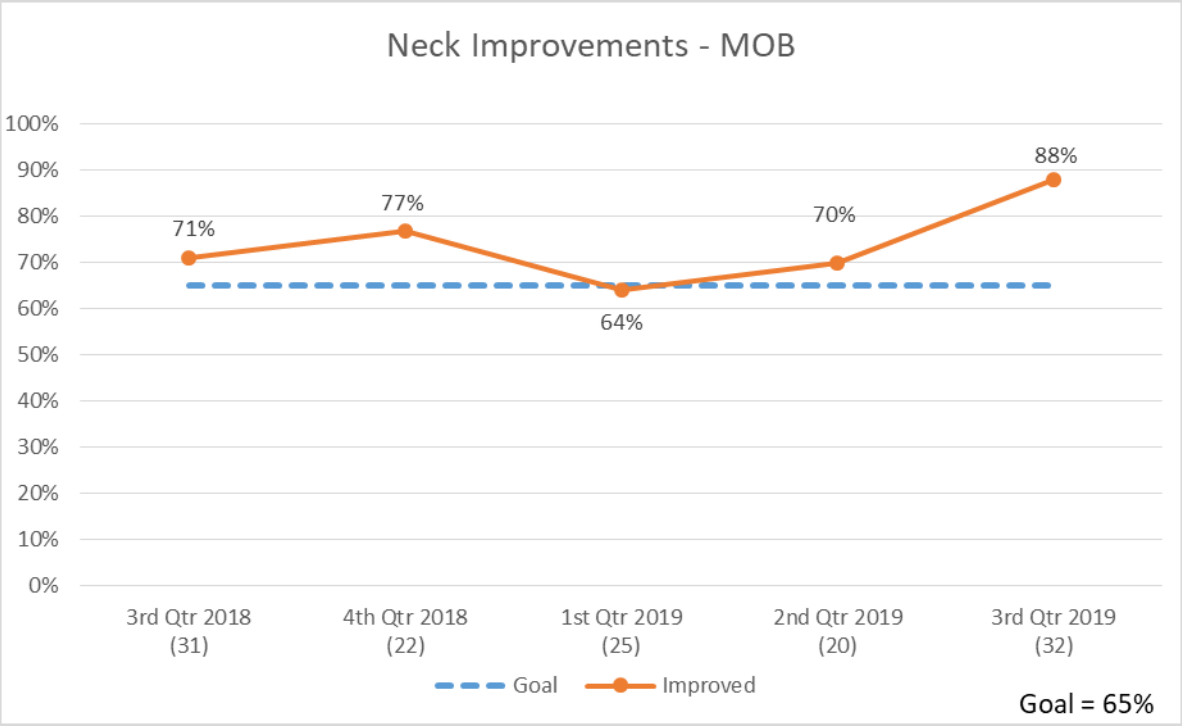

Quick DASH Improvements - LLOPT
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
100%
0%
50%
100%
90%
3rd Qtr 2018
(1)
4th Qtr 2018
(1)
1st Qtr 2019
(2)
2nd Qtr 2019
(7)
3rd Qtr 2019
(10)
Goal
Improved
Goal = 85%

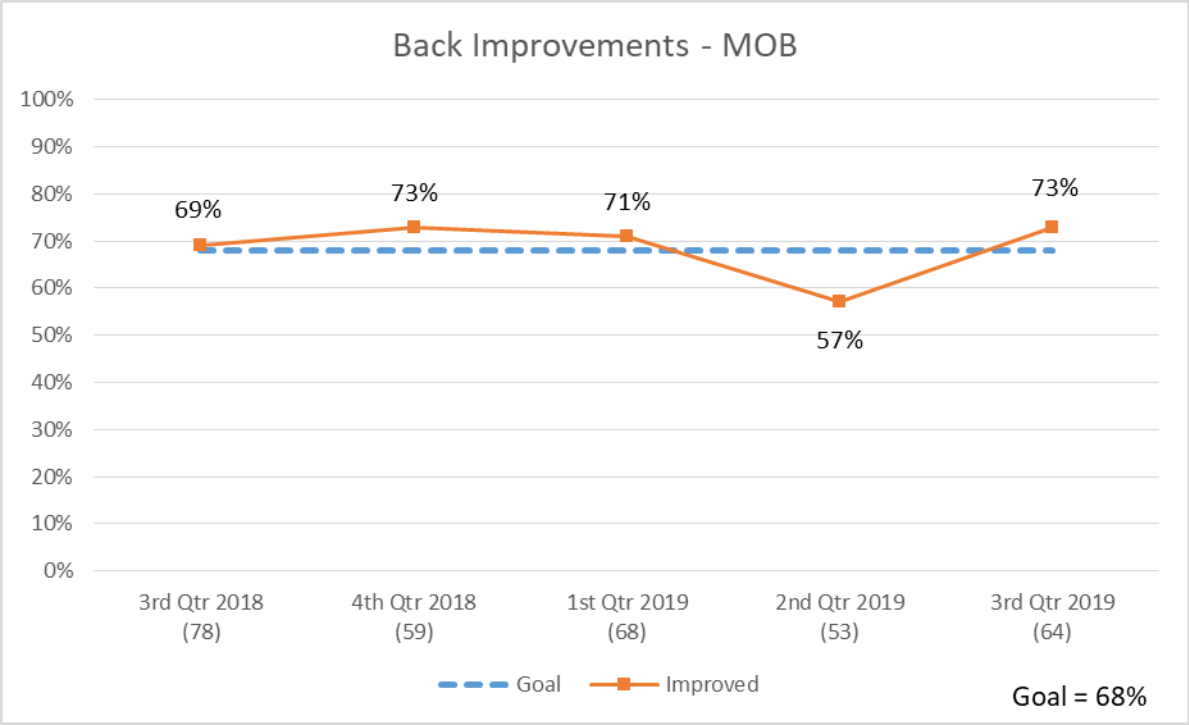

LEFS Improvements - LLOPT
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
86%
73%
89%
80%
81%
3rd Qtr 2018
(22)
4th Qtr 2018
(26)
1st Qtr 2019
(19)
2nd Qtr 2019
(30)
3rd Qtr 2019
(37)
Goal
Improved
Goal = 74%

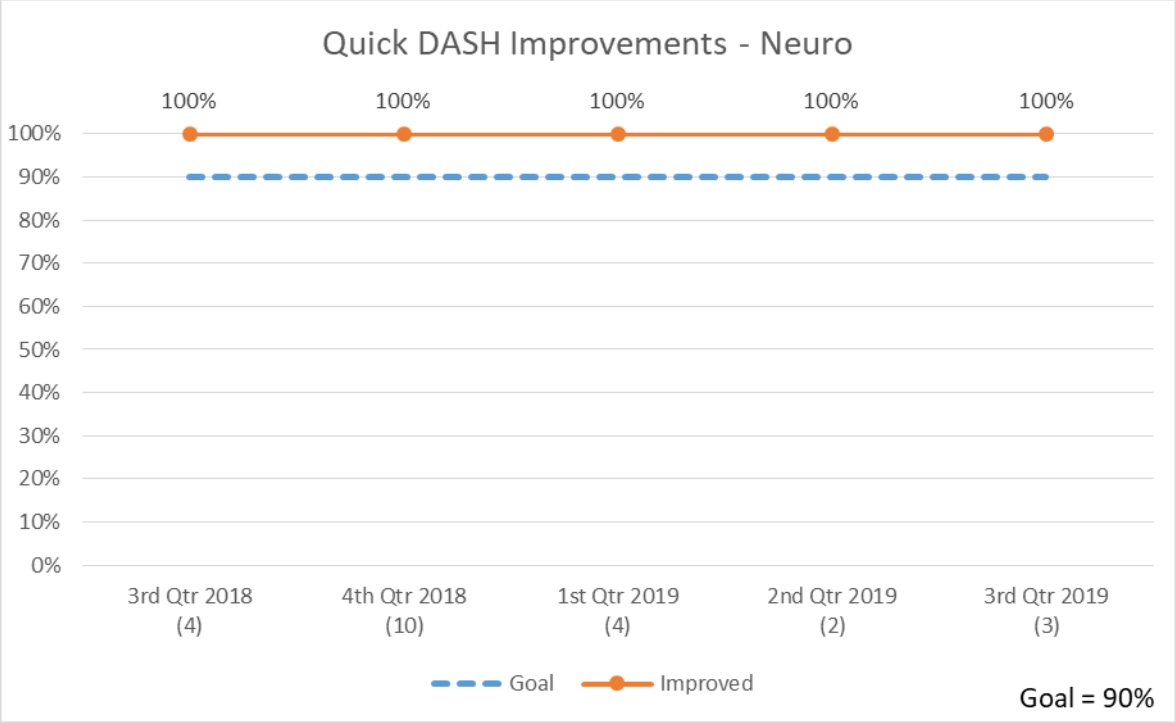

Neck Outcomes - LLOPT
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
86%
67%
3rd Qtr 2018 (No Data)
4th Qtr 2018 (No Data)
1st Qtr 2019 (No Data)
2nd Qtr 2019 (6)
3rd Qtr 2019 (7)
Goal
Improved
Goal = 76%

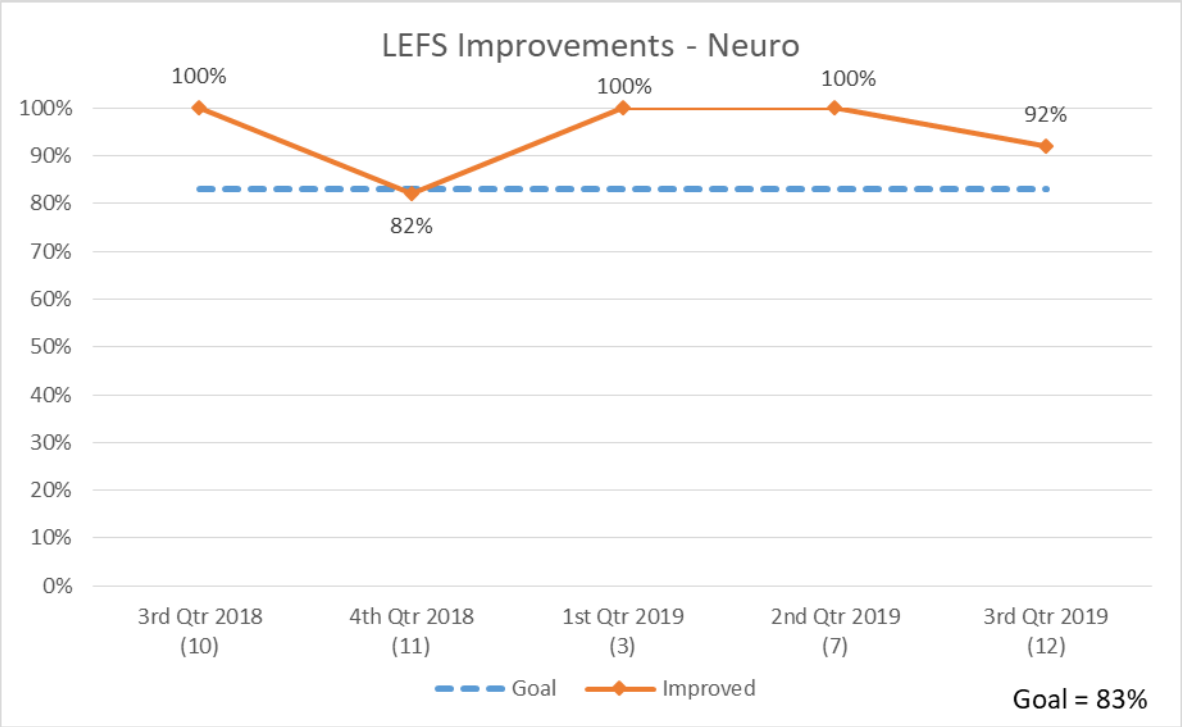

Quick DASH Improvements - MOB
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
74%
86%
85%
87%
85%
3rd Qtr 2018 (113)
4th Qtr 2018 (107)
1st Qtr 2019 (112)
2nd Qtr 2019 (92)
3rd Qtr 2019 (115)
Goal
Improved
Goal = 81%

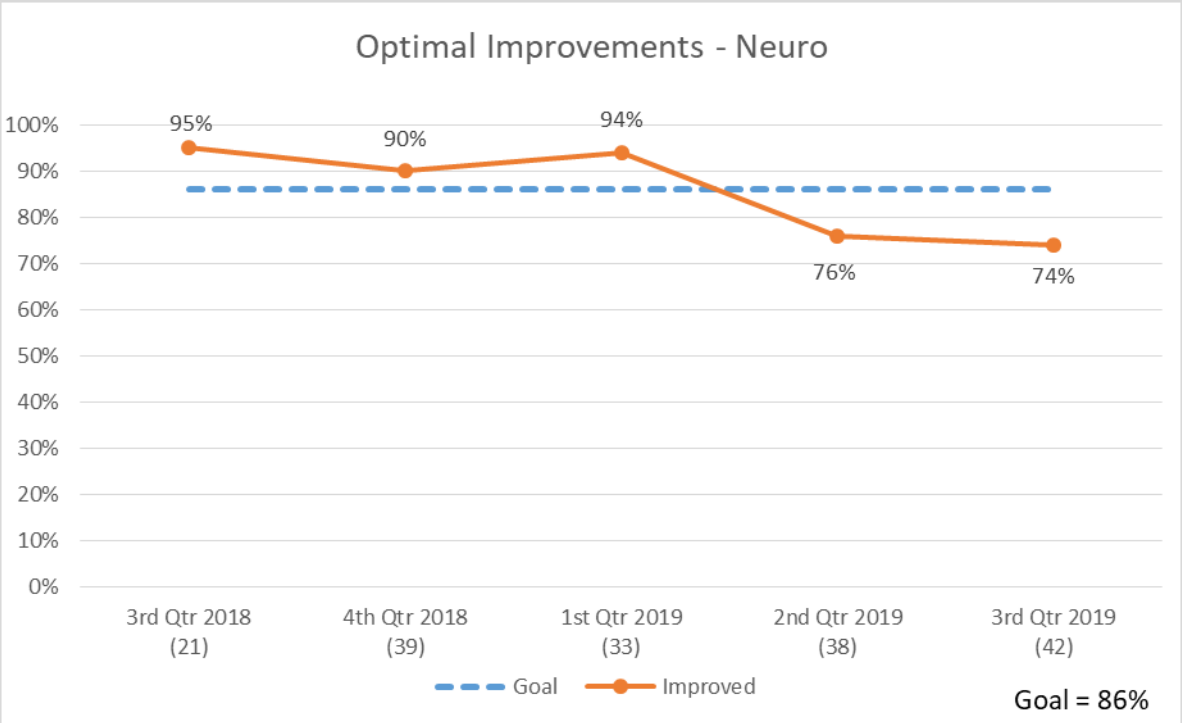

LEFS Improvements - MOB
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
74%
70%
69%
88%
81%
3rd Qtr 2018 (131)
4th Qtr 2018 (133)
1st Qtr 2019 (84)
2nd Qtr 2019 (117)
3rd Qtr 2019 (98)
Goal
Improved
Goal = 78%


Neck Improvements - MOB
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
71%
77%
64%
70%
88%
3rd Qtr 2018 (31)
4th Qtr 2018 (22)
1st Qtr 2019 (25)
2nd Qtr 2019 (20)
3rd Qtr 2019 (32)
Goal
Improved
Goal = 65%


Back Improvements - MOB
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
69%
73%
71%
57%
73%
3rd Qtr 2018 (78)
4th Qtr 2018 (59)
1st Qtr 2019 (68)
2nd Qtr 2019 (53)
3rd Qtr 2019 (64)
Goal
Improved
Goal = 68%

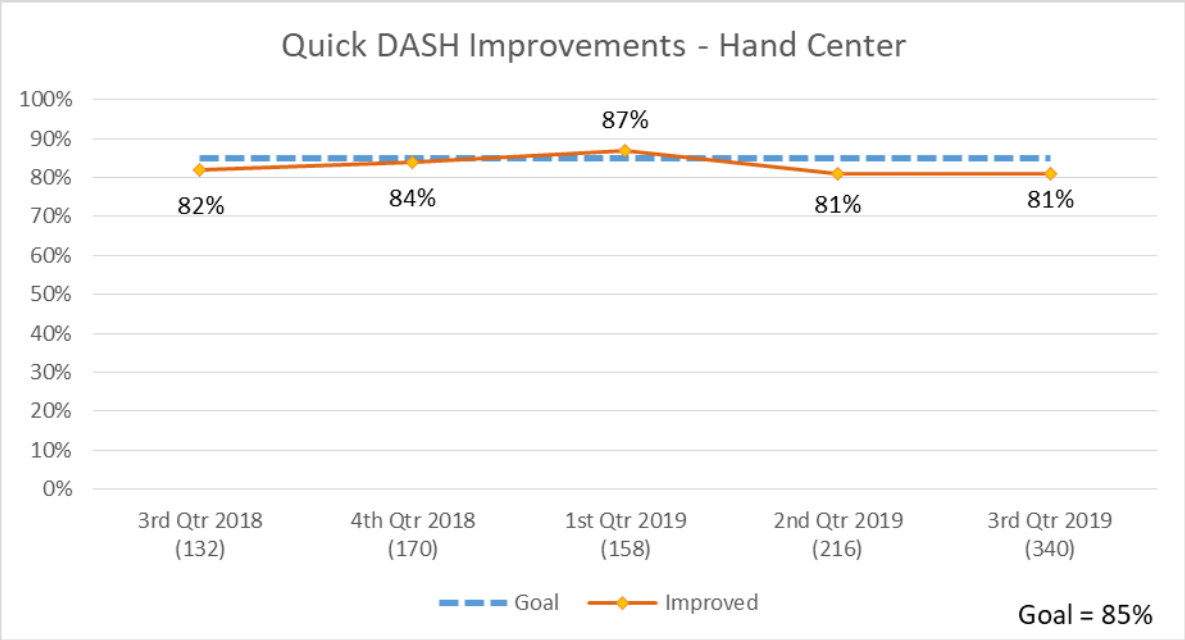

Quick DASH Improvements - Neuro
100%
100%
100%
100%
100%
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
3rd Qtr 2018 (4)
4th Qtr 2018 (10)
1st Qtr 2019 (4)
2nd Qtr 2019 (2)
3rd Qtr 2019 (3)
Goal
Improved
Goal = 90%


LEFS Improvements - Neuro
100%
100%
100%
92%
82%
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
3rd Qtr 2018 (10)
4th Qtr 2018 (11)
1st Qtr 2019 (3)
2nd Qtr 2019 (7)
3rd Qtr 2019 (12)
Goal
Improved
Goal = 83%


Optimal Improvements - Neuro
95%
90%
94%
76%
74%
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
3rd Qtr 2018 (21)
4th Qtr 2018 (39)
1st Qtr 2019 (33)
2nd Qtr 2019 (38)
3rd Qtr 2019 (42)
Goal
Improved
Goal = 86%

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee



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

In-Services scheduled for Dinuba Therapy Specialists staff to discuss treatment and assessment techniques for diagnosis with back injuries in November and December. Expect increase in scores for 1st Quarter of 2020..

For Exeter neck outcomes and Neuro OPTIMAL outcomes, manager has been notified for further assessment. Inservices planned as well as chart reviews to assess affects of comorbidities on pt outcomes. Have had a staff shortage in Neuro department with decreased availability of coverage to provide pt care as well as lack of consistency in providing care. Continued monitoring will be done to improve scores. Anticipate increased scores as staffing normalizes.

Next Steps/Recommendations/Outcomes: Department managers are notified of the results quarterly to develop plans with department staff to improve scoring. Department action plans vary pending department needs. Past examples include in-service on diagnosis and treatment options for involved area, staff discussion/case studies for involved areas, guidelines for consistent scoring protocols to ensure accurate report scoring.

Further staff may be needed in Neuro clinic to provide timely care and drive improved functional outcome scores.

Submitted by Name: Jonah Miller, MPT **Date Submitted:** 10/30/19

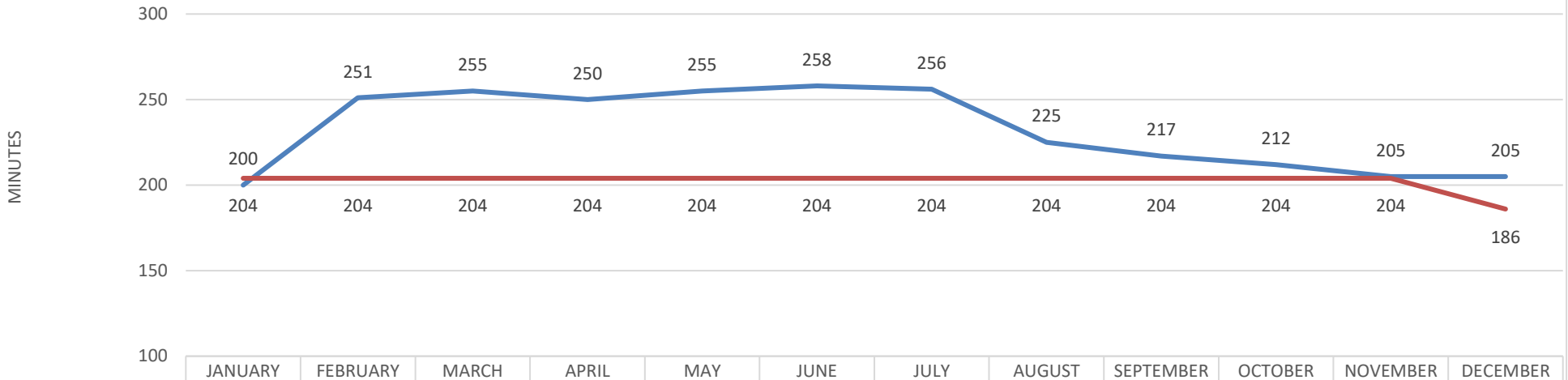
Kaweah Delta HEALTH CARE DISTRICT

	SEPTE	OCTOBER 2019		NOVEMBER 2019		***DECEMBER 2019	
GENERAL METRICS		KDHCD	GOAL	KDHCD	GOAL	KDHCD	GOAL
ED Volume		7117		7021		6931	
Percent of Patients Left Without Being Seen		1.0%	1.5%	1.1%	1.5%	1.1%	1.5%
Percent of Patients Left During Treatment		1.9%	1.5%	1.8%	1.5%	1.6%	1.5%
Percent of Patients Left Against Medical Advice		1.0%	NA	0.7%	NA	1.0%	NA
Percent of Patients Admitted		25%	NA	24%	NA	24%	NA
Percent of Patients Discharged		69%	NA	70%	NA	70%	NA
			CMS		*CMS State		*CMS State
ED THROUGHPUT METRICS			Benchmark		Benchmark		Benchmark
Median Length of Stay in Minutes for Admitted Patient (Hours)		438 (7.3)	423 (7.05)	416 (6.9)	407 (6.8)	445 (7.4)	407 (6.8)
Median Length of Stay in Minutes for Discharged Patient (Hours)		212 (3.5)	204 (3.4)	205 (3.4)	186 (3.1)	205 (3.4)	186 (3.1)
Median Length of Stay in Minutes for Admit Decision to ED Depart (Hours)		215 (3.6)	180 (3)	197 (3.3)	197 (3.3)	218 (3.6)	197 (3.3)
Average Length of Stay in Minutes for Admitted Mental Health Patients (Hours)		513 (8.6)		425 (7.1)		781 (13)	
CENSUS TOTALS BY DISPOSITION							
Number of Patients Arriving by Ambulance		1959		1882		1850	
Number of Trauma Patients		177		147		148	
Number of Patients Admitted		1744		1703		1654	
Number of Patients Discharged		4893		4880		4844	
Number of Mental Health Patients Admitted		79		84		79	
***NEW CMS BENCHMARK (STATE RATE)**							
PATIENT EXPERIENCE			GOAL				
Emergency Room Overall Care Percentile Ranking		52%	50%	52%	50%	52%	50%
Likelihood to Recommend the ED at KD Percentile Ranking							
		Within 10% of Benchmark/Goal		Outperforming or Meeting Benchmark/Goal		Outperforming or Meeting Benchmark/Goal	

***December 1-29th Data

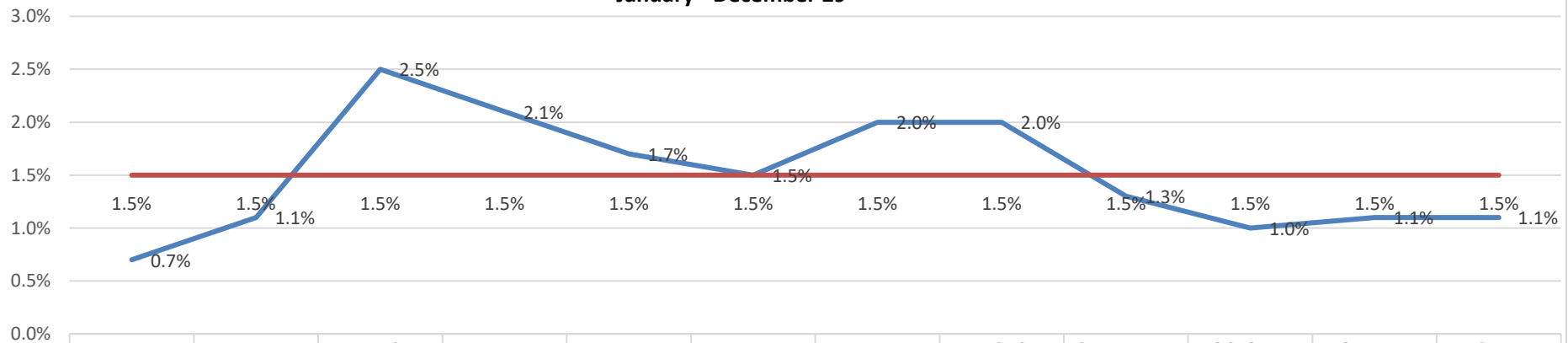
KEY

2019 LENGTH OF STAY - DISCHARGED PATEINTS
January - December 29 (MEDIAN)



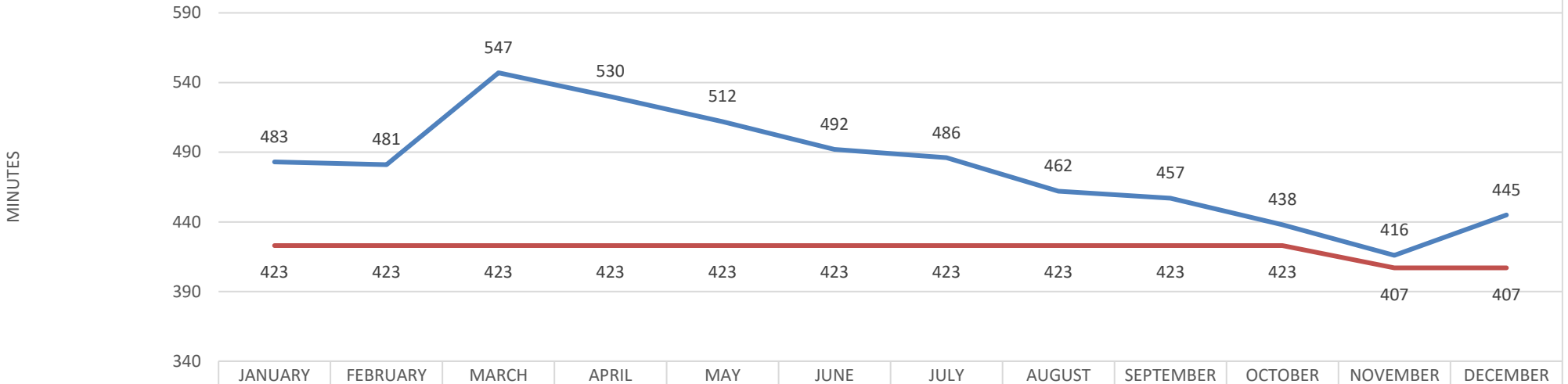
	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
DISCHARGE LOS	200	251	255	250	255	258	256	225	217	212	205	205
CMS BENCHMARK	204	204	204	204	204	204	204	204	204	204	204	186

2019 ED % PATIENTS THAT LWOT
January - December 29



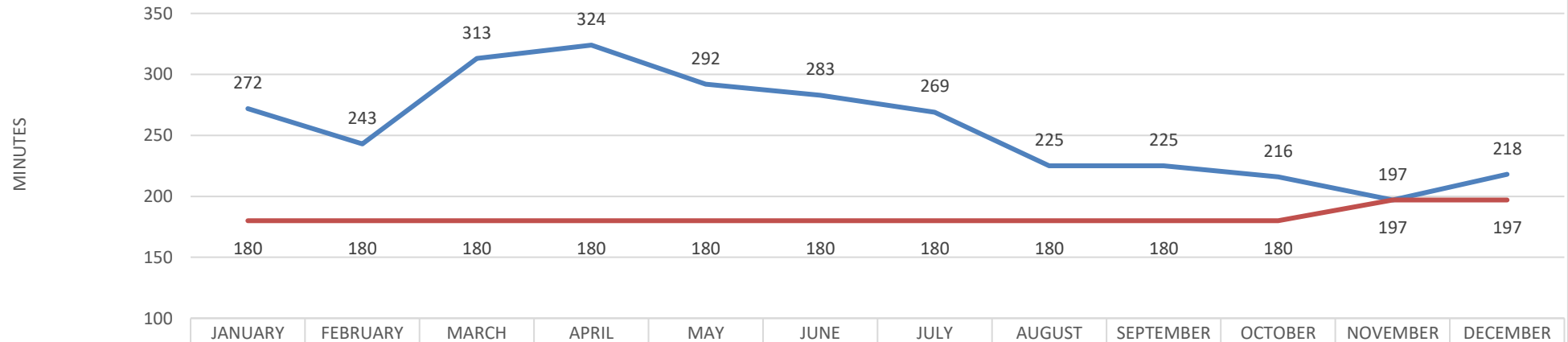
	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
%LWOT	0.7%	1.1%	2.5%	2.1%	1.7%	1.5%	2.0%	2.0%	1.3%	1.0%	1.1%	1.1%
GOAL	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%

2019 LENGTH OF STAY - ADMITTED PATIENTS
January - December 29 (MEDIAN)



	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
ADMITS LOS	483	481	547	530	512	492	486	462	457	438	416	445
CMS BENCHMARK	423	423	423	423	423	423	423	423	423	423	407	407

2019 ADMIT DECISION TO ED DEPART- ADMIT PATEINTS
January - December 29 (MEDIAN)



	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
ADM DEC TO DEP	272	243	313	324	292	283	269	225	225	216	197	218
CMS BENCHMARK	180	180	180	180	180	180	180	180	180	180	197	197

CLINICAL QUALITY GOALS

SEPSIS

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.

GOAL >70%

OCT. 2019
69%

JULY-OCT 2019
HIGHER IS BETTER

65%

MRSA

Methicillin-resistant Staphylococcus aureus (MRSA). Standardized Infection Ratio (SIR) is the the number of patients who acquired MRSA while in the hospital divided by the number of patients who were expected.

GOAL ≤.815

AS OF JULY 2019
INFECTIONS: 4
PREDICTED: ≤3 EVENTS

NOV 2019
NUMBER OF PATIENTS WHO ACQUIRED MRSA
0

JUL-NOV 2019
LOWER IS BETTER

1.36

CAUTI

A catheter-associated urinary tract infection (CAUTI) . Standardized Infection Ratio is the number of patients who acquired a CAUTI while in the hospital divided by the number of patients who were expected.

GOAL ≤.828

AS OF JULY 2019
INFECTIONS: 11
PREDICTED: ≤6 EVENTS

NOV 2019
NUMBER OF PATIENTS WHO ACQUIRED CAUTI
0

JUL - NOV 2019
LOWER IS BETTER

1.76

CLABSI

A central line-associated bloodstream infection (CLABSI). Standardized Infection Ratio (SIR) is the number of patients who acquired a CLABSI while in the hospital divided by the number of patients who were expected.

GOAL ≤.784

AS OF JULY 2019
INFECTIONS: 9
PREDICTED: ≤5 EVENTS

NOV 2019
NUMBER OF PATIENTS WHO ACQUIRED CLABSI
2

JULY - NOV 2019
LOWER IS BETTER

1.77

OPPORTUNITY LOS

Length of Stay (LOS). The difference between the expected LOS and the actual LOS of acute med/surg inpatients, excluding OB/Delivery, Normal Newborns, Neonatology and Uncoded plus Mental Health, Rehab, and SNF.

GOAL ≤0.75

NOVEMBER 2019:
0.89

JUL-NOV 2019:
0.89

Annual Quality & Patient Safety Plan Review 2019

Sandy Volchko DNP, RN, CPHQ, CLSSBB - Director of Quality & Patient Safety
Tom Gray, MD, Medical Director of Quality and Patient Safety

Kaweah Delta Quality and Patient Safety

Demonstrate top performance in clinical care, by achieving 100% compliance to evidenced-based practices

***Stoke Certification**
- Focus 2020: Reaccredation, Transfers

***Core Measures (CMS)**

Continued Monitoring (all)	Focus 2020
-Out patient	- ED Throughput
- VTE	- HBIPS (Mental Health)
- Maternal Child	- Sepsis
- Stroke	

Provide harm free care through reliable performance and elimination of defects that harm or have the potential to harm our patients.

***Infection Prevention (focus 2020)**
***Ortho complication rates**
***Patient Safety Indicators (PSIs)**
- Focus 2020: PSI 3 & PSI 4

***FMEA 2018-2019** - Heparin infusion process; and Design FMEA Workplace Violence
*** Falls, Pressure Ulcer Prevention**
*** Surgical Quality Program** –Focus 2020 Enhanced Recovery (ERAS)

Increase the survival of patients cared for in the hospital environment to levels that meet or exceed the best care in the U.S.

Focus 2020
***Mortality Committee**
***Disease specific improvement teams**

- Pneumonia/COPD	- Heart Failure
- Stroke	- CABG (Cardiac Surgery)
- Acute Myocardial Infarction (AMI)	- Sepsis

Advance hospital capability to achieve high reliability to take excellence to scale with zero defects

Focus 2020:
***Safety Culture Survey Administration**
***CUSP**
***TeamSTEPPS**
***Event Reporting**
***Just Culture**
***Good Catch Award & Hero of the Year**
***Safe Practices (Leapfrog)**

Create value through efficient, integrated systems of care that reduce the utilization of resources and costs associated with poor quality.

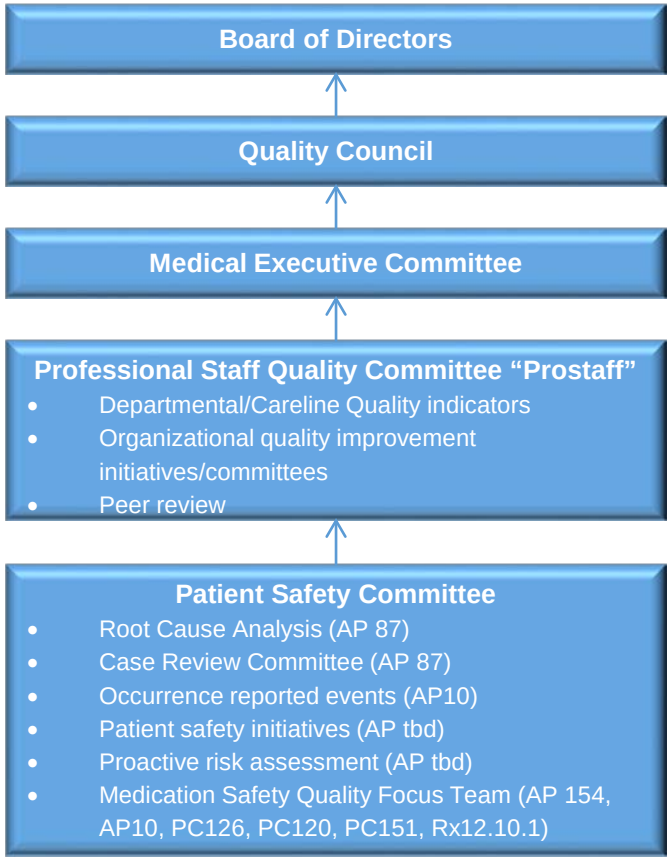
Focus 2020:
***Resource Effectiveness**
- Patient Flow (11 teams)
- Focused DRG/Population Management (10 teams)
- Cost-Savings Initiatives (6 teams)

Provide safe, high quality care though 100% compliance with regulatory standards

Focus 2020:
***Primary Stroke Center Reaccrediation**
***Joint Commission**
- Continuous monitoring

OUTSTANDING HEALTH OUTCOMES

Quality Improvement Committee Structure 2019
Quality Improvement & Patient Safety Plan



OUTSTANDING HEALTH OUTCOMES

Immunization/Venous Thromboembolism/Endoscopy/Sepsis

Metrics		CMS Excellence	CMS Benchmark	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Total
Core Measures - ED: Dr Seng & Tom Siminski, Director of Emergency Services. Dr. Sabogal & Tracie Plunkett, Director of Maternal Child Helath. Endoscopy: Dr. Wiseman, & Brian Piearcy, Director of Surgery. All Other Core Measures: Dr. Gray & Sandy Volchko, Director of Quality & Patient Safety Manager																
IMM-2	Influenza Immunization	100.00%	93.00%	95.1%	96.5%	93.0%	93.8%	98.7%	N/A	N/A	N/A	N/A	N/A	N/A	75.9%	
VTE-6	Hospital acquired potentially-preventable VTE	0.00%	2.00%	0.00%	0.00%	0.00%	N/C	0.00%	0.00%	N/C	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
OP Web-29	Endoscopy/Polyp Surveillance - appropriate follow-up interval for normal colonoscopy in average risk patients	100%	85%	66.7%	83.3%	100%	100%	85.7%	100%	83.3%	85.7%	100%	83.3%	100%	100%	90.91%
Sep-1	Sepsis	N/A	61%	46.67%	46.67%	67.86%	72.73%	67.86%	65.51%	58.62%	72.00%	68.42%	66.67%	56.52%	66.67%	64.11%

OUTSTANDING HEALTH OUTCOMES

Hospital-Based inpatient Psychiatric Services (HBIPS) Core Measures

	Metrics	CMS Standards of Excellence Benchmark	CMS Benchmark / *TJC National Rate	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
HBIPS-1	Admissions Screening	N/A	89.90%	82%	62%	64%	88%	70%	73%	75%	84%	62%	59%	45%	78%
HBIPS-2a	**Physical Restraint-Overall Rate - **(down trend positive)**	N/A	0.44	17%	46%	15%	76%	2%	29%	7%	2%	12%	7%	7%	15%
HBIPS-3a	**Seclusion-Overall Rate - **(down trend positive)**	N/A	0.29	346%	49%	92%	28%	34%	109%	8%	70%	30%	13%	0%	28%
HBIPS-5a	Multiple antipsychotic medications at discharge with appropriate justification - overall rate	N/A	58.59%	N/C	50%	N/C	N/C	100%	100%	N/C	N/C	100%	N/C	100%	100%
SUB-2 (MH)	Alcohol Use Intervention Provided/Offered	N/A	69.92%	92%	100%	100%	40%	100%	100%	33%	82%	100%	100%	75%	88%
SUB-2A (MH)	Intervention provided	N/A	61.76%	92%	100%	83%	40%	33%	100%	33%	64%	90%	40%	63%	88%
SUB-3 (MH)	Alcohol/Other Drug Use Tx provided/offerred at D/C	N/A	36%	100%	100%	100%	100%	100%	100%	100%	94%	100%	100%	95%	100%
SUB-3A (MH)	Alcohol/Other Drug Use Disorder Tx at D/C	N/A	36%	100%	100%	100%	100%	100%	100%	100%	94%	100%	100%	95%	100%
IMM-2 (MH)	Influenza Immunization (Mental Health) Start Oct 2015	N/A	80.98%	96%	94%	92%	94%	98%	98%	N/C	N/C	N/C	N/C	N/C	N/C

OUTSTANDING HEALTH OUTCOMES

Hospital-Based inpatient Psychiatric Services (HBIPS) Core Measures

Metrics		CMS Standards of Excellence Benchmark	CMS Benchmark / *TJC National Rate	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
TOB-2 (MH)	Tobacco Treatment Provided - Offered during stay	N/A	76.62%	100%	96%	100%	100%	96%	100%	92%	100%	96%	91%	95%	100%
TOB-2A (MH)	Tobacco Cessation FDA Approved Provided during stay.	N/A	41.52%	74%	70%	64%	61%	54%	73%	54%	59%	69%	50%	53%	67%
TOB-3 (MH)	Tobacco Treatment Provided/Offered at Discharge	N/A	40.80%	59%	43%	60%	74%	92%	57%	60%	74%	83%	81%	83%	83%
TOB-3A (MH)	Tobacco Cessation Medication FDA Approved Provided at Discharge	N/A	9.52%	4%	0%	0%	11%	8%	19%	8%	26%	0%	14%	17%	0%
CT-2	Care Transitions w specified elements received by disharged patients	N/A	30%	68%	51%	49%	56%	79%	74%	81%	38%	75%	72%	87%	93%
CT-3	Timely Transmission of Transition Record	N/A	30%	52%	47%	40%	41%	75%	67%	73%	38%	75%	70%	87%	87%
SMD-1	Screening for Metabolic Disorders	N/A	90%	91%	100%	100%	100%	97%	95%	91%	97%	100%	95%	100%	100%

OUTSTANDING HEALTH OUTCOMES

Perinatal Care Mother & Baby

	Metrics	CMS Standards of Excellence Benchmark	CMS Benchmark / *TJC National Rate	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
PCB-04	Health Care Associated BSI in Newborns **(down trend positive)**	N/A	*3.25%	0.00%	0.00%	N/C	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
PCB-05	Exclusive Breast Milk Feedings	N/A	*52.44%	54.50%	40.54%	35.90%	37.14%	40.00%	55.26%	57.14%	41.76%	45.71%	56.80%	41.18%	55.20%
PCM-01	Early Elective Deliveries **(down trend positive)**	0	*2.42%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
PCM-2a	C-Section Overall Rate **(down trend positive)**	N/A	*25.54%	9.40%	26.09%	38.89%	27.78%	25.00%	37.50%	43.80%	33.33%	19.05%	21.74%	17.86%	12.50%
PCM-03	Antenatal Steroids	N/A	*97.29%	100.0%	100.0%	100.0%	N/C	N/C	N/C	N/C	100.0%	100.0%	100.0%	100.0%	100.0%
PCM-06	Unexpected Complications in Term Newborns-Overall Rate **(down trend possitive)**	N/A	New Measure				0.97%	0.97%	0.29%	1.02%	1.12%	1.62%	1.35%	2.58%	1.00%

OUTSTANDING HEALTH OUTCOMES

Core Measures - Summary

2019 Achievements

- Emergency department: newly opened Zone 6 added eight additional bays for treatment with improvement in throughput and patient satisfaction.
- 14 out of 16 Hospital Based Inpatient Psychiatric Services improved with implementation of KDHUB in May and exceeding national benchmarks.
- Sepsis bundle compliance exceeds national benchmarks and overall has decrease mortality by 27% from 2018 to 2019.
- Zero→ Hospital Acquired VTE
- 4 out of 5 perinatal care measures are above national benchmarks.

OUTSTANDING HEALTH OUTCOMES

Core Measures - Summary

Areas of Continued Focus in 2020

- Emergency Department – Continue building expansion. Anticipating 33 additional treatment bays in 2020. Recruiting, hiring, training of staff and providers continues in earnest.
- Sepsis – evaluate resources to support sepsis alerts after business hours and weekends. Continue to improve design of order sets. evaluating expansion of Sepsis Coordinator role, real time support for Sepsis Alerts.
- Stroke – monitor that all outpatient possible strokes are coded correctly and are true stroke patients.
- HBIPS – Residents and providers to utilize admission screening template to meet compliance with measures.

OUTSTANDING HEALTH OUTCOMES

Value Based Purchasing (VBP) Clinical & Safety Domain

	Total Performance Score	Base Operating DRG Amount Reduction	Value-Base Incentive Payment %
FY 2020 Payment (CY 2018 Data)	26.37	2%	1.48%

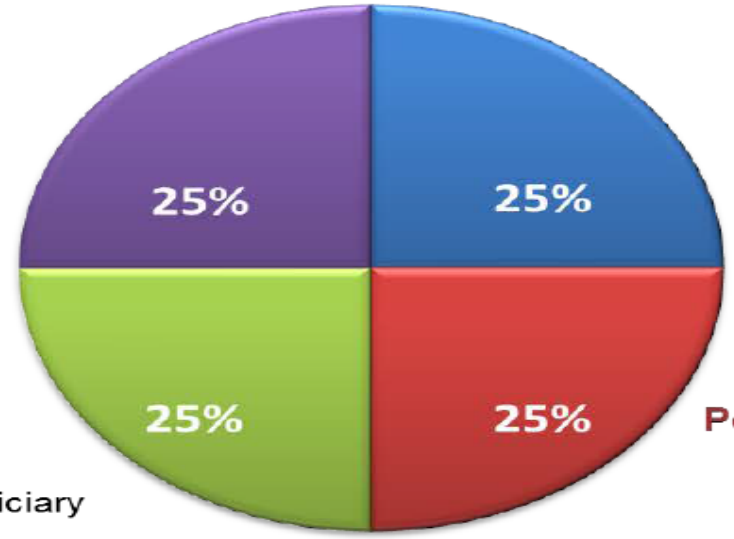
Safety

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

OUTSTANDING HEALTH OUTCOMES

Value Based Purchasing (VBP) Clinical & Safety Domain

Actual Points & Costs

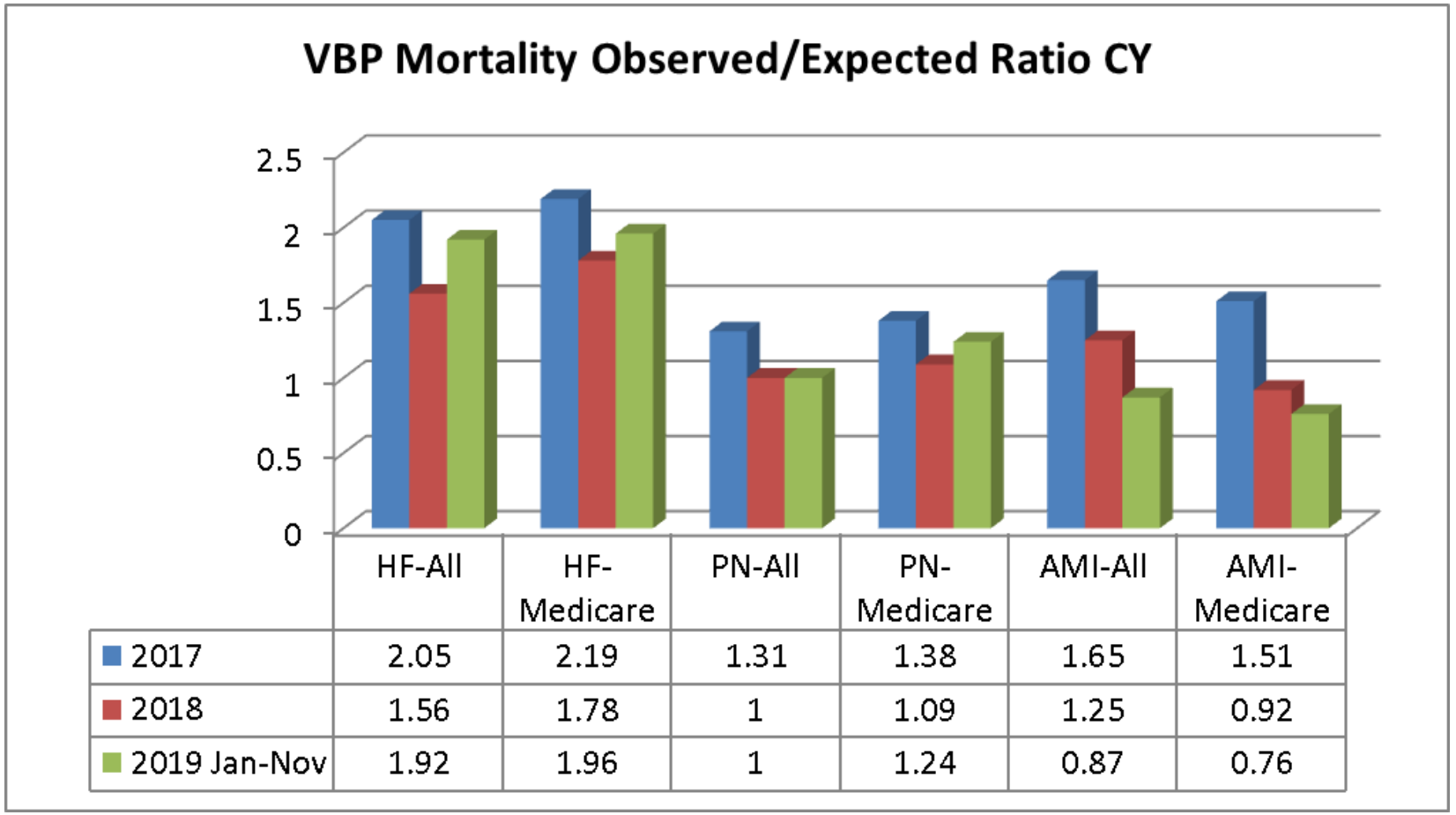
Domains	FY 2020 (Points Received)
Clinical Outcomes - Domain Score (% of all points possible for this 25% of VBP)	**52.50%**
Acute Myocardio Infarction	8
Heart Failure	1
Pneumonia	2
Complication elective THA/TKA	10
Safety - Healthcare Associated infections - Domain Score (% of all points possible for this 25% of VBP)	**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 procedures	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 (% of all points possible for this 25% of VBP)	**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 (% of all points possible for this 25% of VBP)	**20.00%**
Medicare Spending per Beneficiary	2

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

Note: points are received for sustained top performance OR for improvement, up to 10 points each; CMS applies the higher point category to the VBP cost calculation (ie. If a hospital earns 0 achievement points and 5 improvement points CMS uses the 5 improvement points in the cost calculation)

OUTSTANDING HEALTH OUTCOMES

KDHCD Mortality – Value Based Purchasing

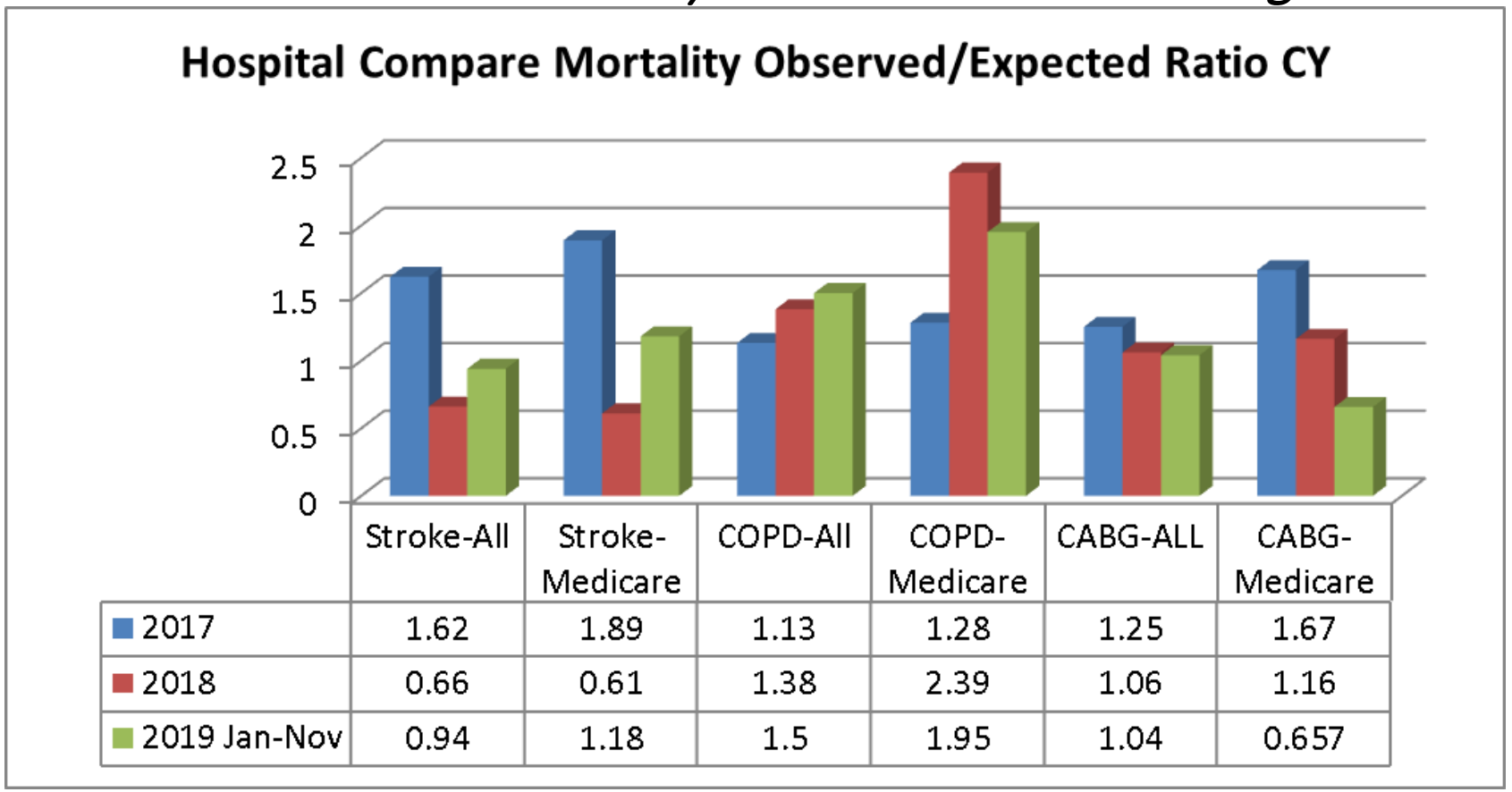


	HF-All	HF-Medicare	PN-All	PN-Medicare	AMI-All	AMI-Medicare
2017	2.05	2.19	1.31	1.38	1.65	1.51
2018	1.56	1.78	1	1.09	1.25	0.92
2019 Jan-Nov	1.92	1.96	1	1.24	0.87	0.76

- Medicare-publicly reported

OUTSTANDING HEALTH OUTCOMES

KDHCD Mortality – Value Based Purchasing



	Stroke-All	Stroke-Medicare	COPD-All	COPD-Medicare	CABG-ALL	CABG-Medicare
2017	1.62	1.89	1.13	1.28	1.25	1.67
2018	0.66	0.61	1.38	2.39	1.06	1.16
2019 Jan-Nov	0.94	1.18	1.5	1.95	1.04	0.657

- Medicare-publicly reported

OUTSTANDING HEALTH OUTCOMES

KDHCD Mortality – Value Based Purchasing

Focus for 2020:

- Diagnosis specific teams in place for each CMS diagnosis (COPD, Pneumonia, CHF, AMI, CABG, Stroke)
- Continue feedback letters to providers
  - More providers are consulting with Palliative Care team
- Evaluated “thoughtful pause” and proper patient selection
- Expand palliative care services
- General In-patient (GIP) hospice beds

OUTSTANDING HEALTH OUTCOMES

Value Base Purchasing - Summary

2019 Achievements:

- Complication of elective total knee and hip, mortalities, early elective deliveries, and Medicare spending are better than national benchmark .

Areas of focus in 2020:

Mortality

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

Infection Prevention

- Infection prevention has teams in each area meet every month. Kaizen Events will be completed for CAUTI and CLABSI in January & February 2020 (Lean Six Sigma QI methodology).

Patient Experience

- Implementation of "Operation Always" with department specific action plans, increased leader patient rounding, and use of new survey vendor will impact scores.

Medicare Spending

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

OUTSTANDING HEALTH OUTCOMES

KDHCD Patient Safety Indicators (PSI)

Metrics		CMS Benchmark	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Total
Patient Safety Indicators-PSI 03: Mary Laufer, Director of Nursing Practice. All OtherPSI: Dr. Mack/Dr. Gray & Sandy Volchko, Director of Quality & Patient Safety															
PSI 03	Pressure Ulcer	0.41	4.46	0.00	0.00	1.12	1.01	0.95	0.00	0.00	1.09	1.044	3.363	0	1.05
PSI 04	Surgical deaths w treatable complications	161.73	375.00	277.77	176.40	62.50	173.90	125.00	125.00	235.00	83.33	0.00	300.00	100.00	167.46
PSI 05	Retained surgical item	0.03	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PSI 06	Iatrogenic pneumothorax	0.29	0.79	0.00	0.00	0.00	0.00	0.00	1.34	0.00	0.00	0.00	1.53	0.73	0.36
PSI 08	Fall w hip fracture	0.11	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PSI 09	Perioperative hemorrhage	2.60	0.00	3.23	0.00	3.46	2.97	6.29	2.99	3.32	6.34	3.10	0.00	2.98	2.90
PSI 10	Postoperative kidney injury	1.32	0.00	7.19	0.00	0.00	7.51	0.00	0.00	7.40	0.00	0.00	0.00	6.29	2.47
PSI 11	Postoperative respiratory failure	7.88	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PSI 12	Perioperative PE/DVT	3.86	0.00	9.28	3.05	0.00	2.86	0.00	0.00	9.80	3.07	2.99	6.39	0.00	3.07
PSI 13	Postoperative sepsis	5.23	0.00	6.94	8.06	0.00	0.00	7.75	0.00	7.40	0.00	0.00	15.50	0.00	3.65
PSI 14	Postoperative wound dehiscence	0.86	0.00	0.00	12.05	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.88
PSI 15	Accidental puncture/laceration	1.29	0.00	0.00	0.00	4.32	3.95	0.00	0.00	0.00	0.00	3.86	0.00	3.52	0.97
PSI 90	Adverse Events Composite	1.00	0.28	0.82	0.90	0.36	0.79	0.69	0.21	1.67	0.68	0.76	2.35	0.25	0.81

OUTSTANDING HEALTH OUTCOMES

Patient Safety Indicators - Summary

Achievements 2019:

- PSI 3 Pressure Ulcer rate of 0.863 for 2019 is the lowest rate in the last 3 years
- PSI 4 Death in Surgical In-Patients with Treatable Complications is a rate of 157.89 in 2019 and is the lowest it has been in 4 years.
- **Focus in 2020:**
- Monthly multi-disciplinary patient safety indicator team meetings to assess for proper documentation and coding of cases and clinical care.
- All surgical PSI will now be included on the Surgical Quality Dashboard and reviewed at committee.

OUTSTANDING HEALTH OUTCOMES

2019 CMS Star Report

Star rating measures include:

- Mortality – Same as National Average
- Patient Safety (ie. infection prevention, PSIs, HACs.) – Above National Average
- Patient experience – Below National Average
- Effectiveness of care (ie.proper discharge medications, early elective delivery) – Same as National Average
- Timeliness of care (i.e. throughput) – Below National Average
- Effective use of medical imaging – Same as National Average
- Readmission – Same as National Average (decreased)

OUTSTANDING HEALTH OUTCOMES

*HAI Summary (1/19-9/19)

*HAI	# Infections**	Above or Below	Team	Strategy
SSI	**18 events** 10 superficial 8 deep/organ space	**Decrease** overall from 2018 to 2019 *Down by 12 events from 30* **Increase** in Hysterectomy SSI events	SSI Sub-Committee	**Significant reduction overall.** **4 HYST** – implemented a taskforce to address pre-op antibiotic administration, review of blood glucose monitoring, post-op education and addressing anxiety. *Action plan in process.*
VAE (Ventilator -Associated Events)	**10 events** ICU (**2 VAP**) **7 events** CVICU (**1 VAP**) (VAP = Ventilator-associated Pneumonia) **No NICU**	**Above** Predicted number. *More ventilator associated condition events due to manipulation of ventilator settings.*	VAE Sub-Committee	**ICU/CVICU.** Targeted oral care and mobility. Education regarding manipulation of ventilator settings. Spreading awareness to nursing, respiratory therapists, and Intensivist. *Action plan in process.*
CLABSI* **	**12** (no NICU)	**Above** predicted number. Decrease from 2018 to 2019, *Down by 7 from 19*	CLABSI Sub-Committee	Staff accountability for best practices. IV Safety Team. Provider education related to insertion practices.

* Healthcare-Associated Infection

** Information from CDC NHSN Report 9/30/2019

*** Value-based Purchasing

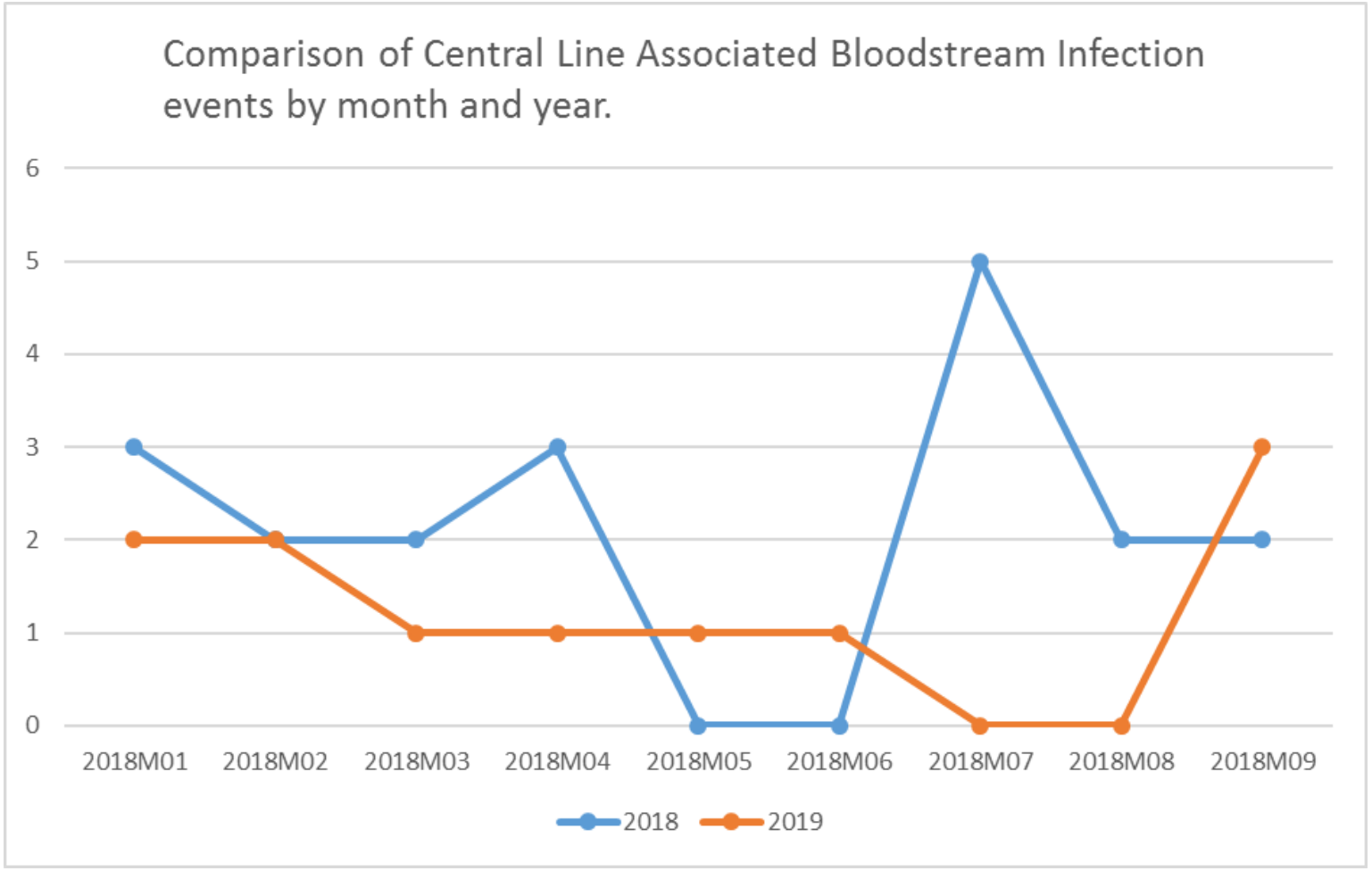
OUTSTANDING HEALTH OUTCOMES
*HAI Summary cont'd (1/19-9/19)

*HAI	# Infections**	Above or Below	Team	Strategy
CAUTI* **	**22**	**Increase** from 2018 to 2019 *Up by 4 from 18*	CAUTI Sub-Committee	CAUTI algorithm. Staff accountability for documenting actions and using alternatives to an indwelling catheter.
C.diff* **	**14**	**Better** than 2018 *Down by 6 from 20*	MDRO-C Sub-committee	New C.diff algorithm. No testing for cure. Reminders provided in the moment.
Hand Hygiene	**89%** Overall average	**Below** 95% Benchmark *No change from last year*	IPC	Installation of new hand sanitizers & dispensers. Do You Disinfect Everytime campaign. Hand hygiene surveillance system pilot x 2 units.
MRSA Blood* **	**8**	**Worse** than NHSN National Benchmark, *Down 3 from 11*	MRSA Task Force	Focus removing expired peripheral IVs and hand hygiene.

* Healthcare-Associated Infection
** Information from CDC NHSN Report 9/30/2019
*** Value-based Purchasing

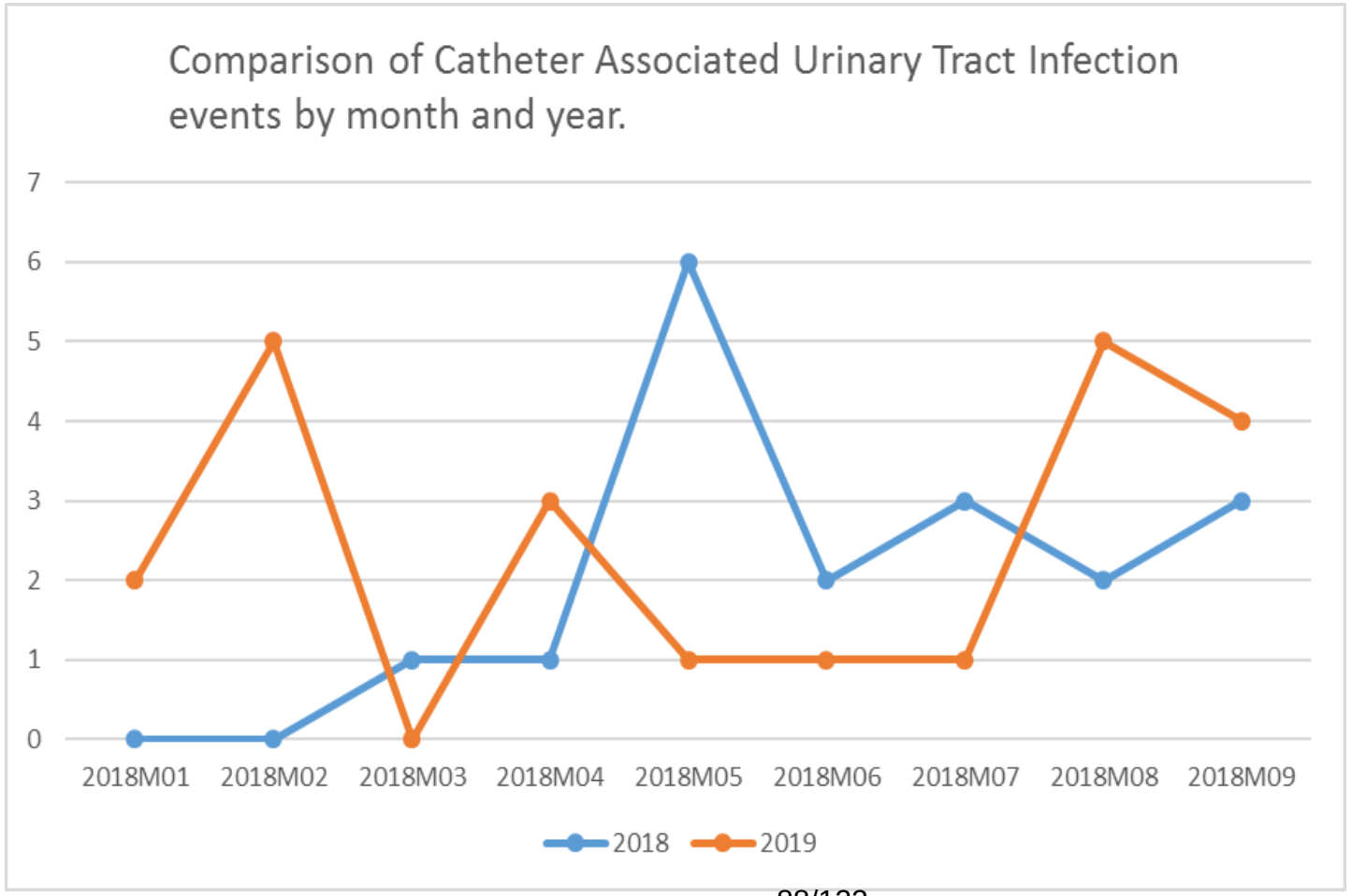
OUTSTANDING HEALTH OUTCOMES

HAI Summary - 2019



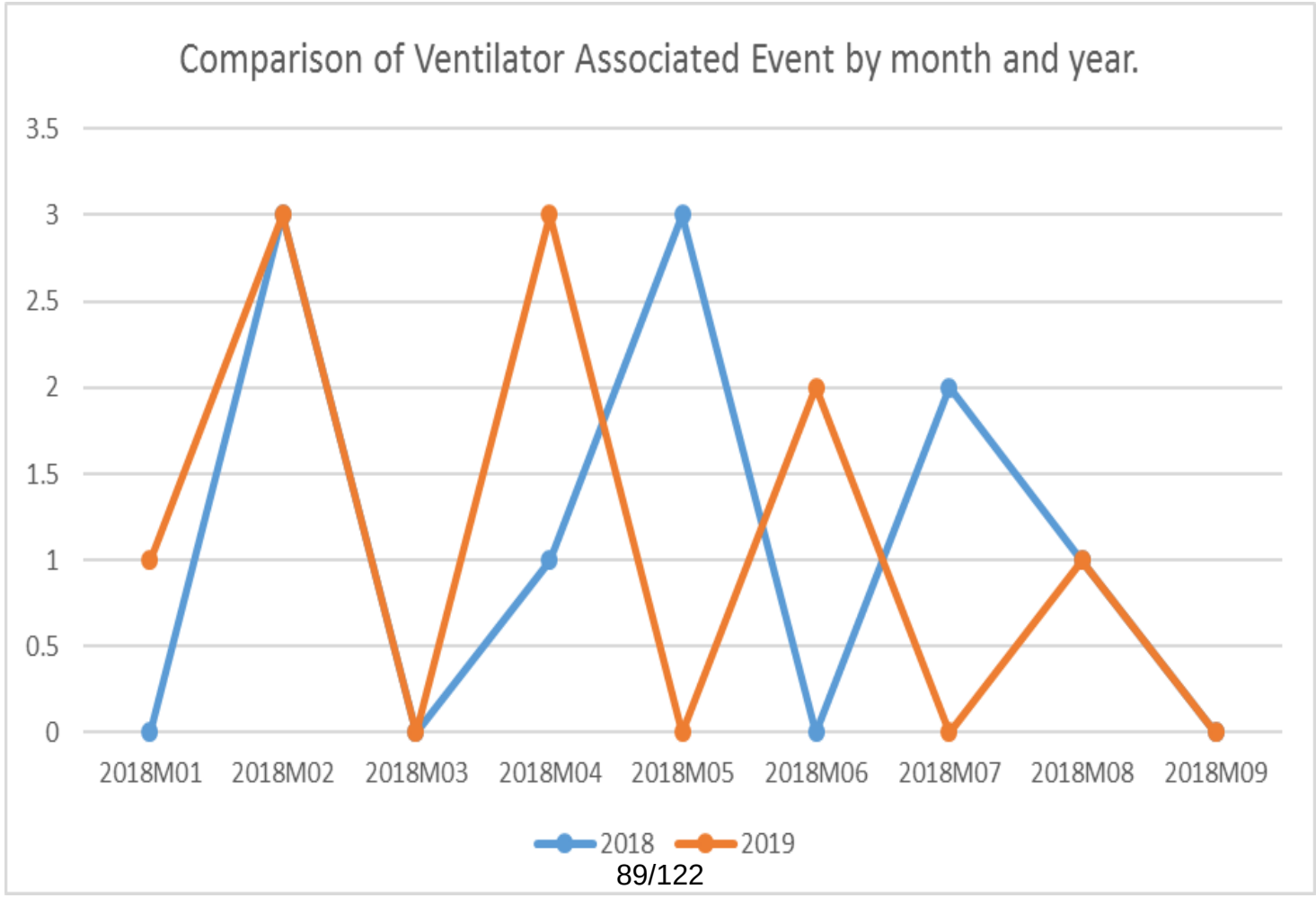
OUTSTANDING HEALTH OUTCOMES

HAI Summary - 2019



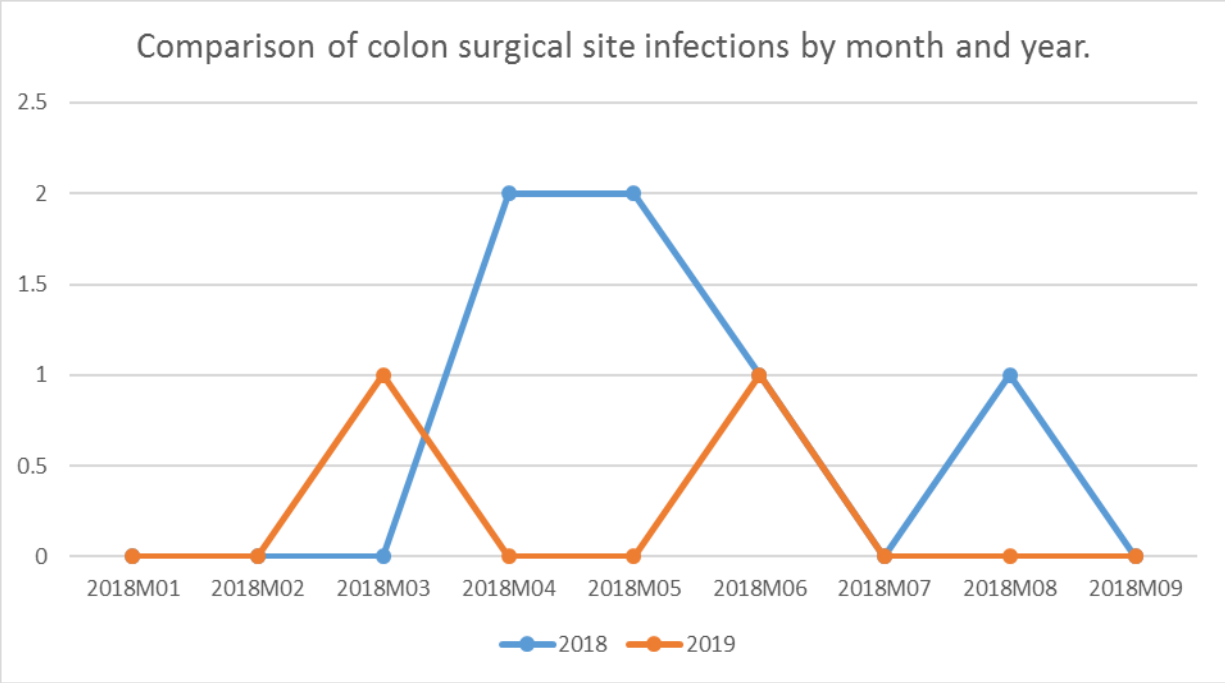
OUTSTANDING HEALTH OUTCOMES

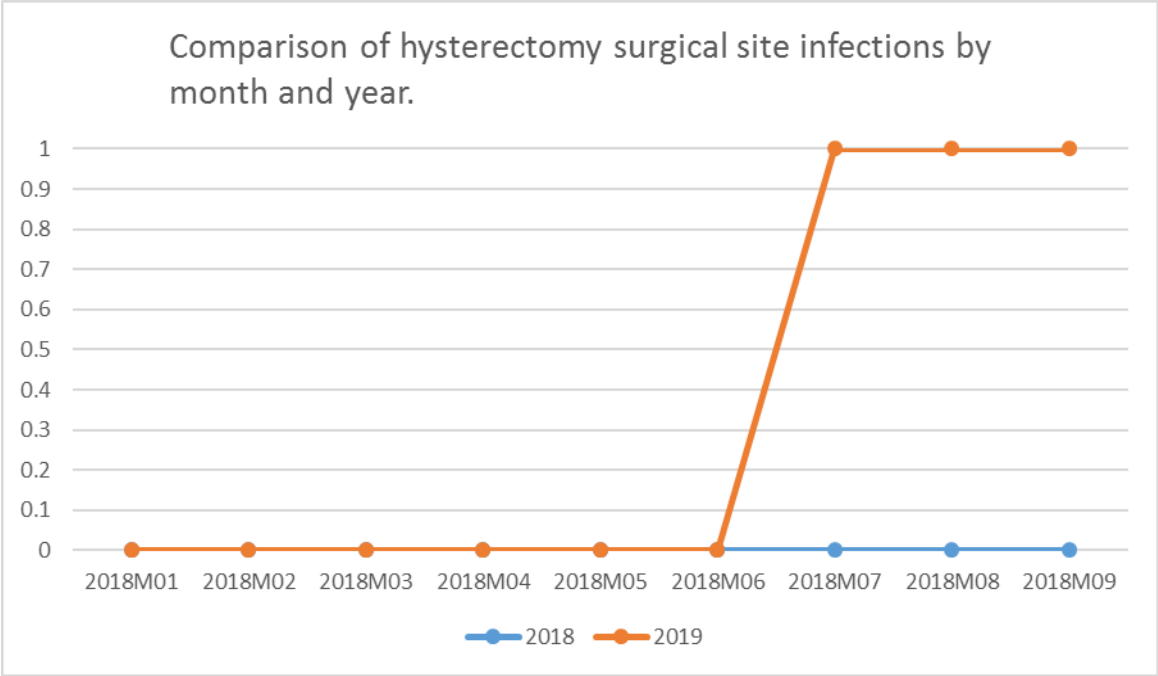
HAI Summary - 2019



OUTSTANDING HEALTH OUTCOMES

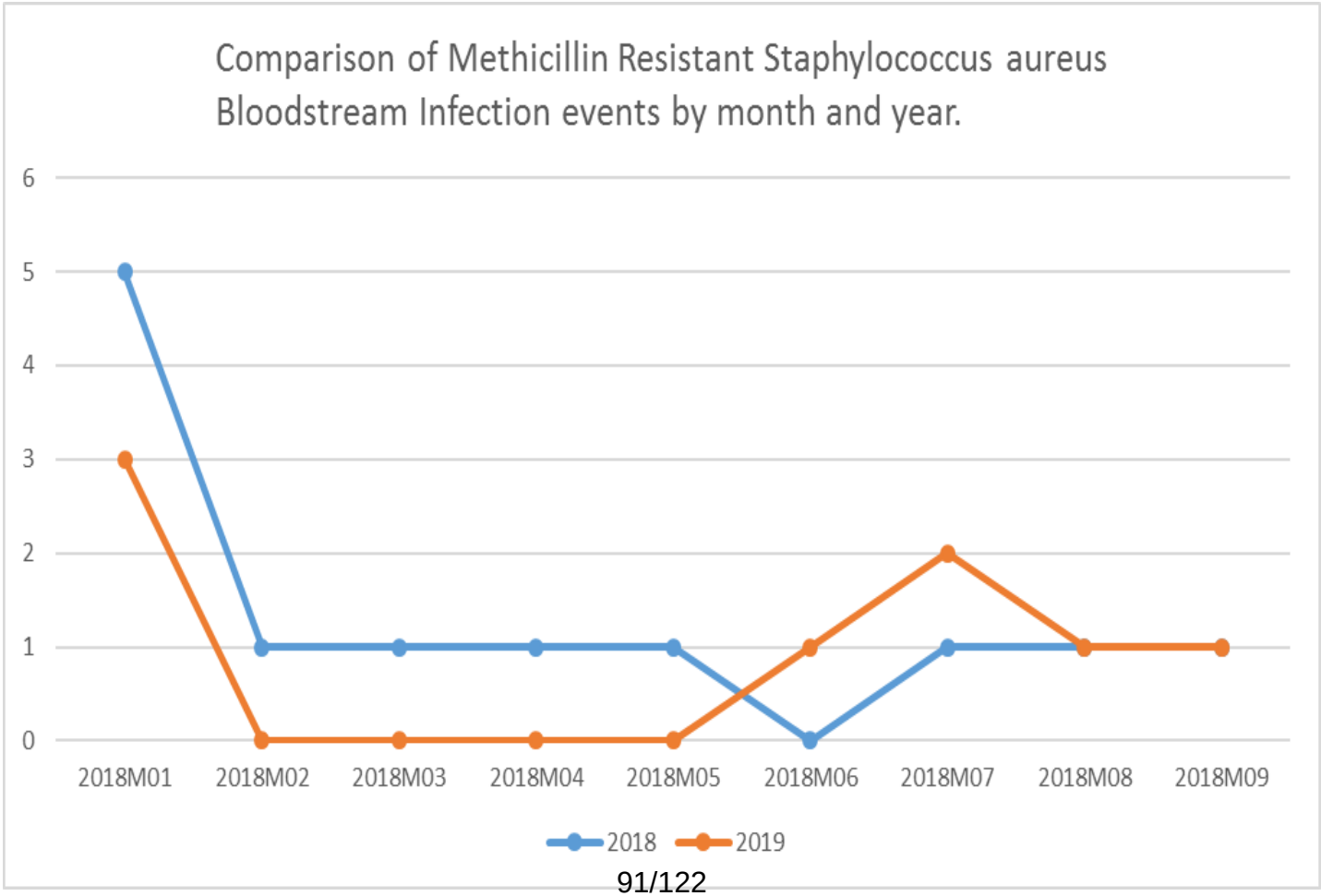
HAI Summary - 2019





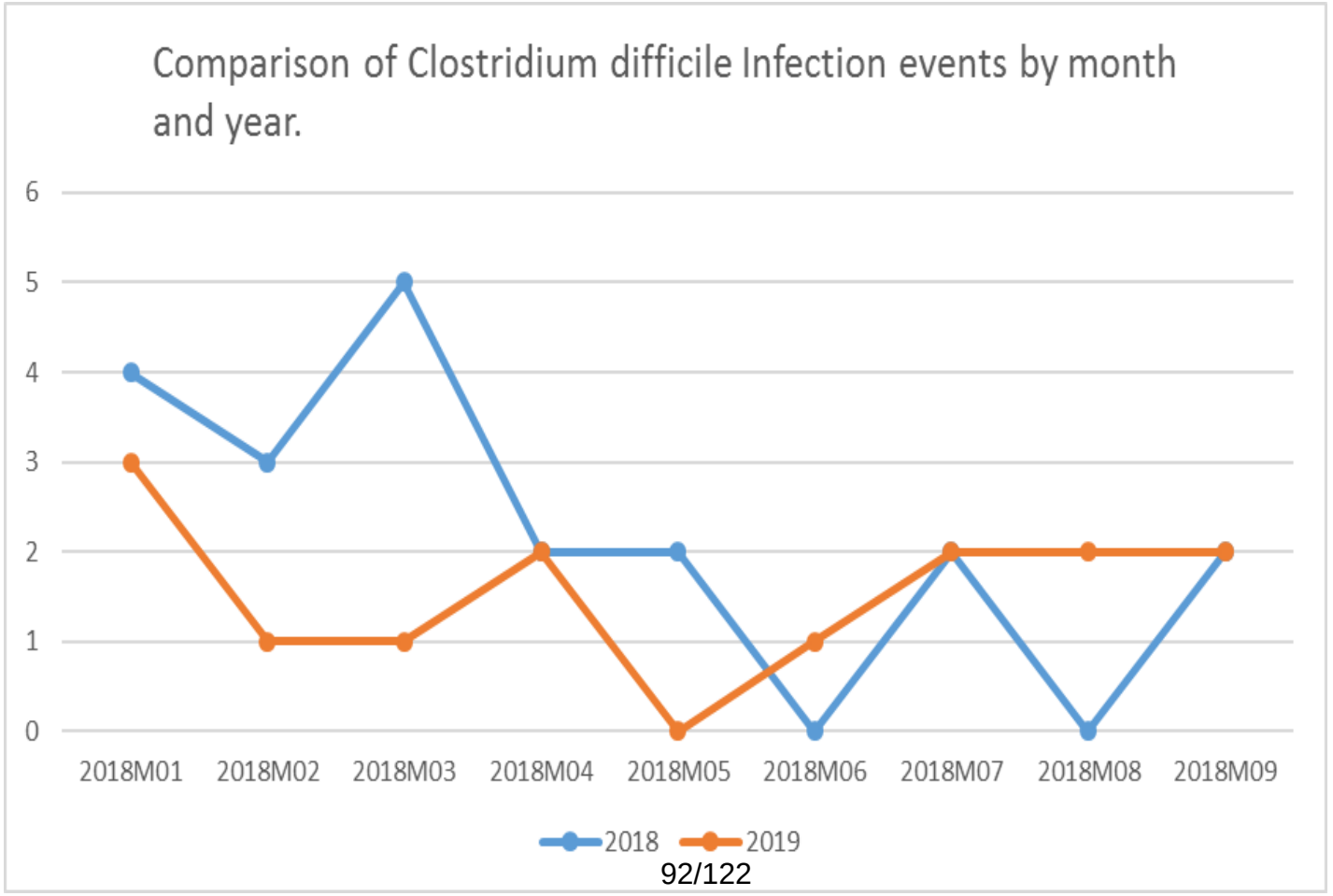
OUTSTANDING HEALTH OUTCOMES

HAI Summary- 2019



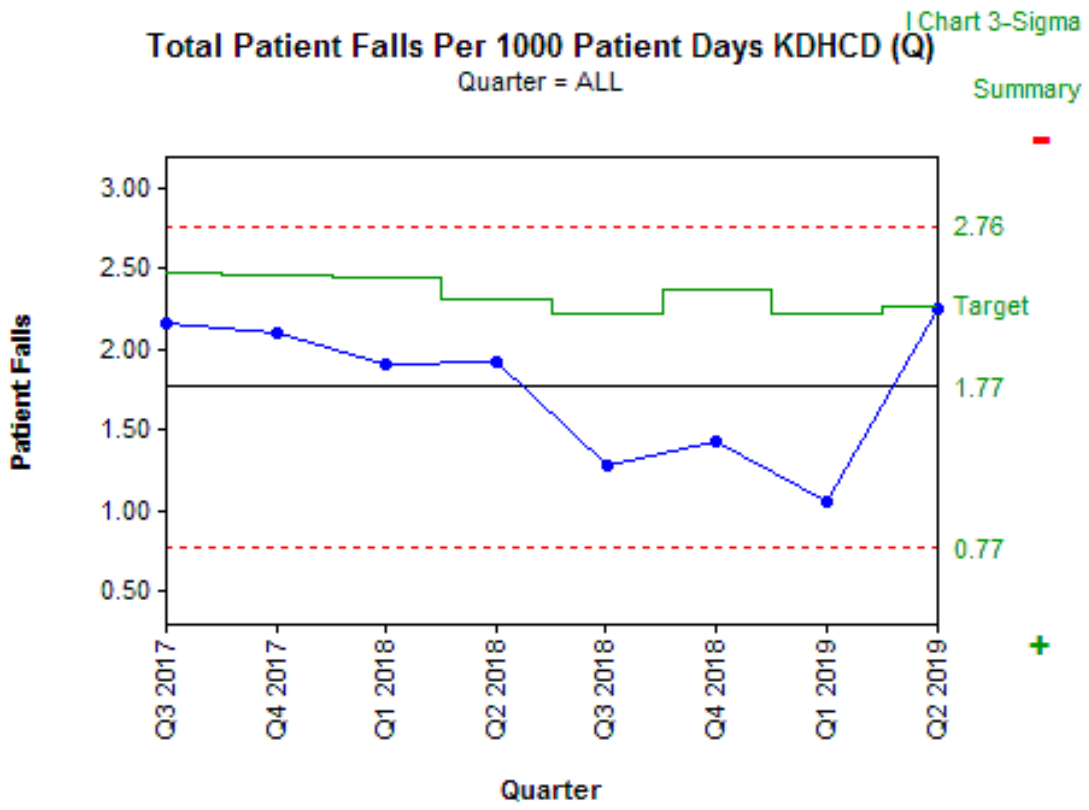
OUTSTANDING HEALTH OUTCOMES

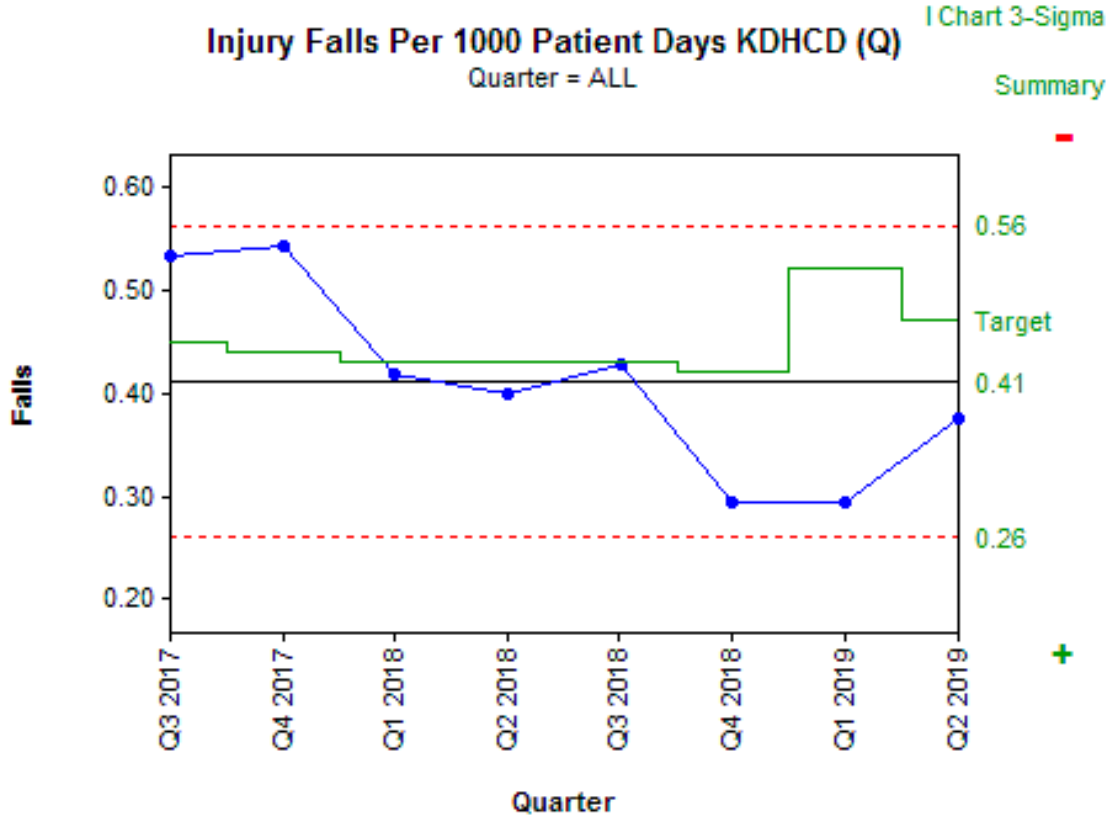
HAI Summary - 2019



OUTSTANDING HEALTH OUTCOMES

KDHCD Falls





OUTSTANDING HEALTH OUTCOMES

Leapfrog Hospital Safety Score Oct 2019

KDHCD Hospital Safety Score Oct 2018 = 2.834

Letter Grade Key: A = >3.133 B= >2.964 C= >2.476

Date	Grade
May 2018	A
Oct 2018	C
May 2019	C
Oct 2019	C

OUTSTANDING HEALTH OUTCOMES

Components of the Leapfrog Hospital Safety Score

- **PSIs/Healthcare Acquired Infections (HAIs) and Healthcare Acquired Conditions (HACs)**
- **Patient Experience**
- **3 Sections of the Leapfrog Survey:**
    - ICU physician Staffing
    - Computerized Provider Order Entry (CPOE)
    - Safe Practice Score

OUTSTANDING HEALTH OUTCOMES

Leapfrog Hospital Safety Score – Actionable Steps to Achieve "A"

- Continue with 100% Safe Practices
  - Commitment from Board and leadership to quality and safety culture improvement
- Continue improve Patient Experience
  - New vendor JL Morgan
  - Educate patients to vendor before discharge to increase survey volume
- Continue optimizing CPOE
  - New infrastructure to manage alerts (received full points on December 2018 CPOE evaluation)
- Continue <u>focused</u> improvement efforts on:
  - HACs—Achieve ZERO events
  - PSIs—Achieve ZERO events

Healthgrades Achievements Awarded in 2019

Best Specialty
One of Healthgrades America's 50 Best Hospitals for Cardiac Surgery™ for 3 Years in a Row (2018-2020)
Cardiac
Recipient of the Healthgrades Cardiac Surgery Excellence Award™ for 4 Years in a Row (2017-2020)
Named Among the Top 5% in the Nation for Cardiac Surgery for 3 Years in a Row (2018-2020)
Named Among the Top 10% in the Nation for Cardiac Surgery for 4 Years in a Row (2017-2020)
Five-Star Recipient for Coronary Bypass Surgery for 3 Years in a Row (2017-2020)
Neurosciences
Recipient of the 2020 Healthgrades Neurosciences Excellence Award™
Named Among the Top 10% in the Nation for Overall Neurosciences in 2020
Recipient of the Healthgrades Stroke Care Excellence Award™ for 2 Years in a Row (2019-2020)
Named Among the Top 5% in the Nation for Treatment of Stroke for 2 Years in a Row (2019-2020)
Named Among the Top 10% in the Nation for Treatment of Stroke for 2 Years in a Row (2019-2020)
Five-Star Recipient for Treatment of Stroke for 6 Years in a Row (2015-2020)
Pulmonary
Recipient of the Healthgrades Pulmonary Care Excellence Award™ for 7 Years in a Row (2014-2020)
Named Among the Top 10% in the Nation for Overall Pulmonary Services for 7 Years in a Row (2014-2020)
Five-Star Recipient for Treatment of Pneumonia for 7 Years in a Row (2014-2020)
Critical Care
Recipient of the 2020 Healthgrades Critical Care Excellence Award™
Named Among the Top 10% in the Nation for Critical Care Services in 2020
Five-Star Recipient for Treatment of Sepsis for 8 Years in a Row (2013-2020)
Five-Star Recipient for Treatment of Respiratory Failure for 2 Years in a Row (2019-2020)

OUTSTANDING HEALTH OUTCOMES

Surgical Quality Improvement Program

Semiannual Report Post Surgical Complications

04/01/2018 - 03/31/2019 ACS NSQIP Interim Semiannual Report: Site Summary

Kaweah Delta District Hospital **Site Number: 2258**

All Cases

	Total Cases	Observed Events	Observed Rate	Pred Obs Rate**	Expected Rate	Odds Ratio	95% C.I. Lower	95% C.I. Upper	Outlier	Decile	Adjusted Percentile	Adjusted Quartile	Assessment*
ALLCASES Mortality	1400	11	0.79%	0.75%	0.72%	1.04	0.69	1.55		7	55	3	As Expected
ALLCASES Morbidity	1400	52	3.71%	3.79%	4.20%	0.89	0.69	1.16		4	36	2	As Expected
ALLCASES Cardiac	1400	8	0.57%	0.51%	0.42%	1.22	0.68	2.18		8	63	3	As Expected
ALLCASES Pneumonia	1398	2	0.14%	0.31%	0.53%	0.58	0.30	1.13		1	17	1	Exemplary
ALLCASES Unplanned Intubation	1399	6	0.43%	0.39%	0.36%	1.08	0.63	1.85		7	56	3	As Expected
ALLCASES Ventilator > 48 Hours	1399	7	0.50%	0.49%	0.46%	1.05	0.57	1.97		6	52	3	As Expected
ALLCASES VTE	1400	5	0.36%	0.47%	0.53%	0.89	0.57	1.38		3	37	2	As Expected
ALLCASES Renal Failure	1400	9	0.64%	0.44%	0.29%	1.55	0.88	2.72		10	81	4	Needs Improvement
ALLCASES UTI	1399	7	0.50%	0.62%	0.93%	0.67	0.39	1.16		2	23	1	Exemplary
ALLCASES SSI	1395	20	1.43%	1.45%	1.49%	0.97	0.66	1.43		5	46	2	As Expected
ALLCASES Sepsis	1370	7	0.51%	0.51%	0.50%	1.01	0.57	1.81		6	50	2	As Expected
ALLCASES C.diff Colitis	1400	3	0.21%	0.21%	0.21%	1.01	0.52	1.98		6	50	2	As Expected
ALLCASES ROR	1400	27	1.93%	1.76%	1.54%	1.15	0.84	1.57		8	68	3	As Expected
ALLCASES Readmission	1400	50	3.57%	3.65%	3.80%	0.96	0.76	1.20		4	42	2	As Expected

OUTSTANDING HEALTH OUTCOMES

Surgical Quality Improvement Program Enhance Recovery after Surgery

January – August 2019 (Total 37 Elective Colorectal Cases)

Process Measures Done In 24 Hours Postop

Multi-modal Pain Management
35/37=94%
ISCR Group Performance=80%

Postop VTE Prophylaxis
26/37=70%
ISCR Group Performance=86%

Postop Intake Liquids
32/37=86%
ISCR Group Performance=80%

Postop Mobilization
28/37=75%
ISCR Group Performance=67%

Foley Removal
31/37=83%
ISCR Group Performance=95%

Outcome Measures

UTI Postop 30 Days
0/37=0%
2018 Baseline=0%
ISCR Group Performance=1.87%

SSI Postop 30 Days
1/37=2.7%
2018 Baseline=10.53%
ISCR Group Performance=8.45%

VTE Postop 30 Days
0/37=0%
2018 Baseline=2.56%
ISCR Group Performance= 1.5%

Readmission Postop 30 Days
1/37=2.7%
2018 Baseline=15.38%
ISCR Group Performance=9.88

Average LOS
4.11
ISCR Group Performance= 6.23

Return of Bowel Function (days)
1.72
ISCR Group Performance =2.04

Key: Green=>80% Yellow=70-80% Red=<70%. Improving Surgical Care & Recovery (ISCR)Group Performance=NSQIP participating hospitals (elective cases)

OUTSTANDING HEALTH OUTCOMES

Surgical Quality Improvement Program

Focus for 2020:

Implement of Enhanced Recovery after Surgery into other surgical service lines.

- Enhanced Recovery After Surgery Workgroup Teams (meet monthly)
  - Elective Colorectal – Project completed - Continue to monitor
  - In-Patient Colorectal – New team
    Team Lead: Surgical Resident project
  - Orthopedic – New Team
    Team Lead: Megan Goddard, Nurse Practitioner
  - GYN – New Team
    Team Lead: Dr. Sabogal

Kaweah Delta
Primary Stroke Certification through The Joint Commission (TJC)

- Initial Primary Stroke Certification in March 2018
  - 100% compliant with all Standards; No plans for improvement requested
- 2 year certification cycle
- Recertification Survey window is from January 25, 2020 – April 24, 2020
  - 1 day survey, 1 surveyor
  - 7 day notification prior to survey

Stroke Program
Performance Improvement Initiatives
Fiscal Year 2020

Focused Stroke Performance Improvement Projects for FY 2020

- Door to Alteplase <60 minutes.

  Continue this metric since it is a TJC and GWTG measure. KDH goal is now <45 minutes.

- Nutritional Support s/p Failed Swallow Evaluation

  Continue this measure; we want to ensure that timely nutritional support continues and monitoring for compliance is needed.

- Follow-Up Calls/Perception of Care

  Continue TJC requirement that we monitor perception of care.

- Dysphagia screening process

  Continue to monitor/track.

Stroke Program
Performance Improvement Initiatives
Fiscal Year 2020 (Continued)

Focused Stroke Performance Improvement Projects for FY 2020

- TIA work-up/admission

  New measure. The goal is to have a group review current evidence based guidelines on TIA work up and admission criteria. Look at outside resources for adequate follow up on TIA patients discharged from ED (currently we admit/observe all TIA patients).

- PEG placement

  New measure. PI project focused on a standardized process for PEG placement. Has been presented to GME program for possible resident PI project.

- Patient Education

  New measure. TY GME resident has already taken this project on. Goal is to improve patient education metric in GWTG and improve 30 day readmission and mortality rates by physician engagement in stroke education, primarily in lifestyle modification.

- Transfer Process

  New measure. Goal is to reduce door to transfer time to <120 minutes. Task Force has been established to address issue.

- Admission guideline criteria

  New measure. KDH has historically had admission guidelines but a task force has recently reconvened to review admission guidelines.

Stroke Program Dashboard

	GWTG Bench-marks	2018 July	Aug	Sept	Oct	Nov	Dec	2019 Jan	Feb	Mar	Apr	May	June	July	Aug	Sept
Grouping of Stroke Patients																
Ischemic		40	47	31	30	39	41	30	42	39	43	36	41	31	33	32
Hemorrhagic		7	13	9	9	8	5	4	10	10	9	7	8	2	13	8
TIA (in-patient and observation)		23	20	28	21	30	27	20	28	35	25	24	22	36	36	19
Transfers to Higher Level of Care (Ischemic)		2	1	3	4	3	6	2	2	3	3	2	1	2	4	4
Transfers to Higher Level of Care (Hemorrhagic)		0	1	1	1	1	0	1	1	2	1	1	1	1	2	1
% of Alteplase - Inpatient & Transfers		7%	10%	26%	6%	5%	11%	16%	14%	14%	13%	18%	21%	6%	14%	6%
Total # of Pts who rec'd Alteplase (Admitted Patients)		2	4	6	1	1	2	4	4	4	4	5	8	2	2	1
Total # of Pts who rec'd Alteplase (& Transferred Out)		1	1	3	1	2	3	1	2	2	2	2	1	0	3	1
TOTAL NUMBER OF PATIENTS		72	82	72	65	81	79	57	83	89	81	70	73	72	88	64
Rate of hemorrhagic complications for Alteplase pts	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
% Appropriate vital sign monitoring post Alteplase	90%	100%	80%	86%	100%	100%	100%	50%	50%	57%	66%	71%	67%	75%	100%	50%
Core Measure: OP-23 Head CT/MRI Results	99.2%	100%	50%	33%	100%	50%	20%	NA	50%	100%	100%	33%	66%	0%	0%	100%
% tPA Arrive by 2 Hrs; Treat by 3 Hrs. (GWTG)	85%	50%	83%	100%	100%	100%	80%	100%	100%	83%	100%	100%	100%	100%	100%	100%
STK-5 Early Antithrombotics by end of day 2	85%	98%	97%	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	97%
STK-1 VTE	85%	90%	84%	90%	94%	88%	95%	100%	100%	100%	100%	100%	100%	100%	100%	97%
STK-2 Discharged on Antithrombotic	85%	98%	98%	98%	97%	98%	100%	100%	97%	100%	98%	98%	94%	100%	100%	100%
STK-3 Anticoag for afib/aflutter ordered at Dc	85%	100%	100%	100%	100%	100%	100%	80%	89%	100%	100%	100%	100%	100%	100%	100%
% Smoking Cessation (GWTG)	85%	91%	95%	92%	100%	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%	88%
STK-6 Discharged on Statin	85%	100%	90%	98%	100%	96%	100%	100%	100%	100%	100%	98%	96%	92%	94%	94%
% Dysphagia Screen prior to po intake (GWTG)	75%	91%	90%	90%	89%	94%	94%	100%	93%	94%	88%	88%	98%	94%	92%	92%
STK-8 Stroke Education	75%	82%	93%	100%	100%	96%	85%	88%	91%	84%	89%	93%	92%	100%	92%	96%
STK-10 Assessed for Rehab	75%	100%	98%	97%	96%	97%	100%	97%	100%	100%	100%	97%	100%	100%	100%	100%
STK-4 Alteplase Given within 60 min	75%	100%	75%	NA	NA	100%	100%	100%	25%	25%	100%	100%	100%	NA	50%	100%
% LDL Documented (GWTG)	75%	90%	88%	85%	95%	91%	100%	92%	88%	100%	96%	94%	96%	98%	88%	97%
Intensive Statin Therapy (GWTG)	75%	88%	79%	57%	58%	81%	75%	91%	82%	90%	89%	91%	80%	90%	88%	91%
% tPA Arrive by 3.5 Hrs; Treat by 4.5 Hrs (GWTG)	75%	67%	83%	100%	100%	100%	80%	100%	80%	86%	100%	100%	100%	100%	100%	100%
% NIHSS Reported (GWTG)	75%	97%	95%	100%	96%	97%	98%	97%	98%	97%	100%	97%	100%	100%	95%	97%
% Appropriate stroke order set used (In-Patient)	90%	92%	92%	86%	90%	90%	94%	90%	97%	97%	94%	93%	90%	95%	96%	99%
% Appropriate stroke order set used (ED)	90%	78%	89%	88%	85%	85%	84%	85%	92%	90%	92%	94%	93%	93%	94%	88%
LOS Hemorrhagic (Mean)		7.29	6.29	7.14	16	14.5	12	13.5	10.8	6.86	13.88	4	4.38	3	7.5	5
LOS Ischemic (Mean)		5.81	5.76	5.54	4.62	5.46	4.31	5.61	6.42	4.94	5.21	6.72	4.95	4.5	5.25	4.32

Kaweah Delta
Primary Stroke Certification through The Joint Commission (TJC)

OUTSTANDING HEALTH OUTCOMES

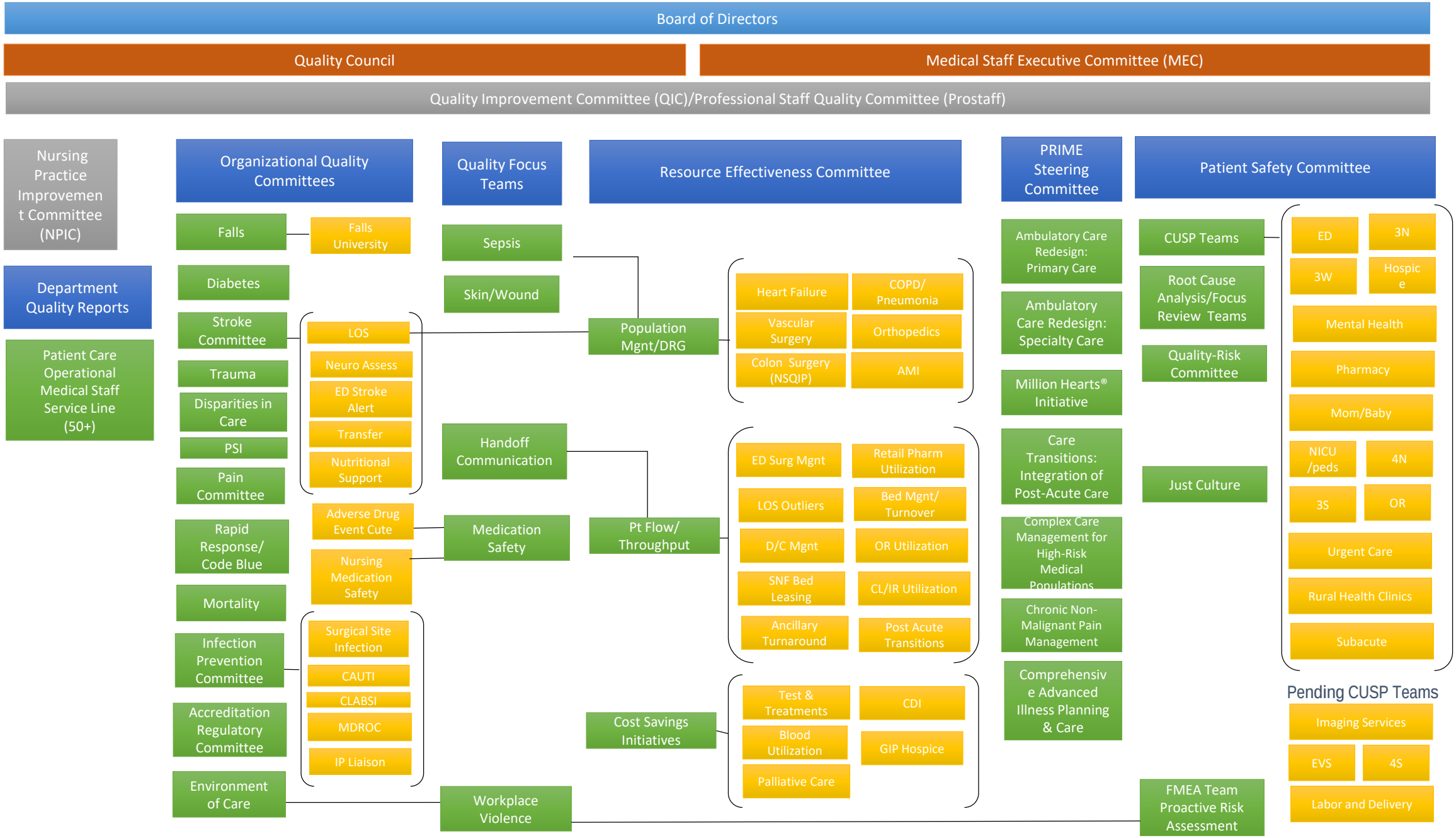
Quality Improvement Committees 2019

- 30+ Organizational Quality Improvement Teams/Committees

  Examples:

  - Several infection prevention groups
  - Disease specific: Stroke, sepsis, diabetes, heart failure, heart attack & wound care
  - Process specific: rapid response, fall prevention, throughput, medication safety, provider documentation
  - Does not include department/unit level improvement teams

- 14 CUSP Teams (Comprehensive Unit-Based Safety Program), 4 more pending for 2020



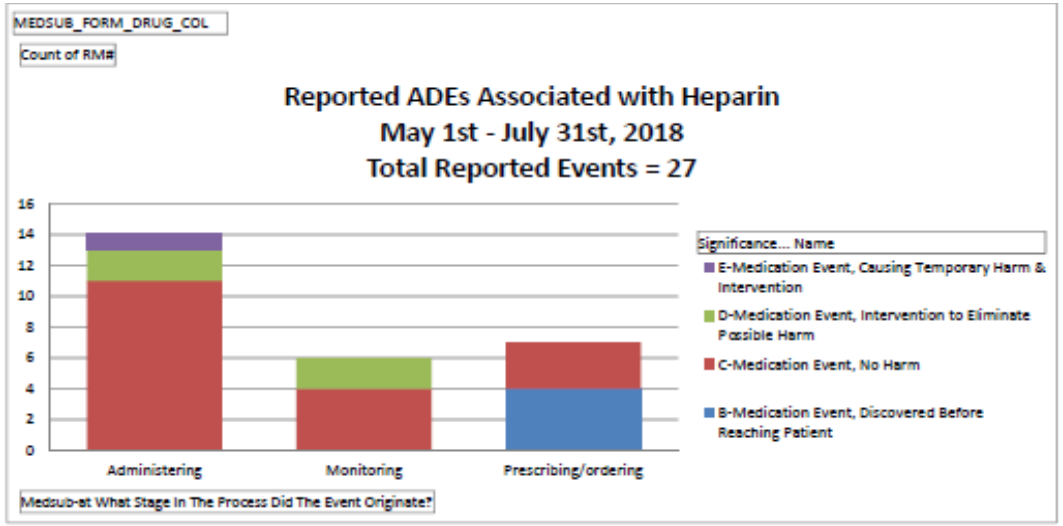
Kaweah Delta Clinical Quality Improvement Committees & Teams 2019- 2020 (Reporting structure noted in QIC/Prostaff schedules)

OUTSTANDING HEALTH OUTCOMES

Proactive Risk Assessment:
Failure Modes Effects Analysis (FMEA) 2019

- Initiation of Heparin Infusion FMEA
  - Completed Spring 2019
  - Action team currently in place to address identified potential high risk failure modes

- Design (D)FMEA Workplace Violence
  - DFMEAs look at program design rather than a process FMEA
  - Completed November 2019
  - WPV Team current working on action items associated with potential failure modes



OUTSTANDING HEALTH OUTCOMES

Accreditation

- Successful Joint Commission Survey 2019
- CMS Validation Survey completed (no condition level findings)

Focus 2020:

- Enhanced compliance monitoring (compliance and new standards)
- TJC Stroke Survey, preparation and tracers began fall 2019

KAWEAH CARE CULTURE

Safety Attitudes Questionnaire (SAQ) and Safety Culture

Actions taken to improve safety culture 2019:

- Continuation with SAQ Unit-level action plans
- CUSP teams with enhanced support, CUSP coaches and quarterly sessions for staff champions
- Just Culture (JC) Training from industry expert (David Marx), with follow up JC algorithm practice for all leaders
- System improvements to event reporting system (Midas) to make it easier to report events
- Good Catch and Hero of the Year Awards

Planned Enterprise-Wide Actions for 2020:

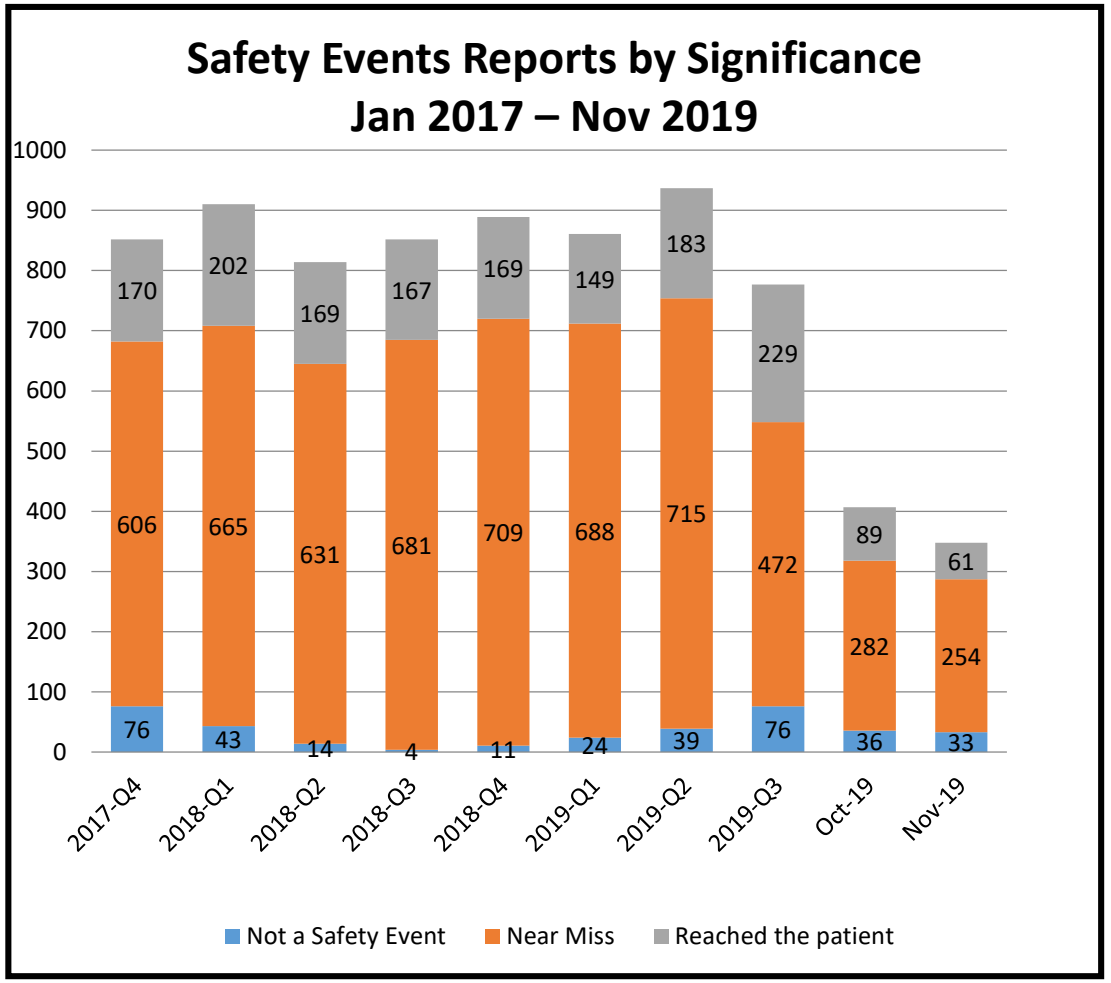
- SAQ to be administered Spring/Summer 2020
- Continue to broaden CUSP; program evaluation with “Taking Stock” tool
- Just Culture awareness campaign for all staff and providers; continued JC training for all new leaders
- 2nd TeamSTEPPS© Leadership Cohort (national evidenced-based medical team training program) late winter/early spring 2020

KAWEAH CARE CULTURE

Event Reporting

- 2019 Goal, increase volume of event reporting through:
  - Continued education & awareness
  - Implemented changes to the electronic system in June 2019 to make entering reports easier for staff and providers
  - As a result, estimated **20% increase** in volume of event reports submitted in 4Q 2019 compared to monthly mean before changes (numbers finalized upon December close)

- Actions 2020
  - Continued education and awareness
  - Remeasure staff perceptions through SAQ in 2020



Quarterly average volume of events before changes = 944
Estimated average 4Q 2019 = 1,133

KAWEAH CARE CULTURE

Event Reporting

- Changes to event reporting system in June 2019 decreased event entry time for staff and providers
- Estimate annual time saving of over 72 hrs
- Plan to monitor for 6 months and then ad hoc

Before Jul 2018-May 2019 After July 2019-Sept 2019	Mean Time to Enter Event	Change	# of events July 2018 to Sept 2019	Mean monthly # of events	Time Saved per month	Annualized
Mean (FA) Before	0:13:02	0:01:47	431	29	0:51:14	10:14:54
Mean (FA) After	0:14:49					
Mean (GE) Before	0:10:42	0:01:34	2562	171	4:27:35	51:30:00
Mean (GE) After	0:09:08					
Mean (WPV) Before	0:11:35	0:02:58	171	11	0:33:49	6:45:50
Mean (WPV) After	0:08:37					
Mean (BH) Before	0:10:47	0:03:20	452	30	1:40:27	20:05:20
Mean (BH) After	0:07:27					
Mean (Med) Before	0:09:44	0:00:15	1171	78	0:19:31	3:54:12
Mean (Med) After	0:09:29					
				TOTAL	**6:10:08**	**72:00:29**

Key: FA = Fall Event Report; GE = General Event Report; WPV = Workplace Violence Event Report; BH = Behavioral Event Report; and Med = Medication Event Report

OUTSTANDING HEALTH OUTCOMES/ KAWEAH CARE CULTURE

Root Cause Analysis & Focused Reviews

- 13 Focused Reviews and 5 RCAs conducted in 2019

Resulting Error Proofing Strategies Implemented:

Error Proofing Strategy	Number Implemented 2018
Forcing Functions	0
Automation & Computerization	3
Standardization & Protocols	13
Rules & Policies	8
Education/Information	37
“Be more vigilant”	0

EMPOWER THROUGH EDUCATION & EXCELLENT SERVICE

Annual Patient Safety Training

- 1,200+ licensed staff received patient safety training in 2019

  2019 Data-Driven Topics:

  - Ligature Risk
  - Advanced Directives
  - Pain Management
  - Safety Culture
  - Risk Assessments
  - Care Planning
  - Infection Prevention

EMPOWER THROUGH EDUCATION & EXCELLENT SERVICE

Patient Safety Symposium 2019

2019 Symposium: Free Text Evaluation Comments Worddle:

- Approximately 310 attendees, 15 scientific posters presented
- Just Culture leadership training from David Marx (industry expert); Kaweah Leader Ignite presentations
- Symposium participant Evaluation – 93%-97% of participants felt learning objectives were fully met (236 participants completed an evaluation)

1. Please indicate if you are able to achieve the learning objectives set for this activity: At the completion of the activity, the learner will be able to:	Fully Met	Partly Met	Not Met
a. Use Just Culture principles to encourage reporting and learning from errors	229	7	
a. Use Investigative Rules and concepts to analyze errors and events	229	6	
a. Identify systems and behavioral risks in their departments	221	14	
a. Manage system design features as one of the primary inputs to better outcomes	220	14	
a. Manage behavior using consistent and fair guidelines to enhance the employee's quality of choice	227	8	

March 2020 Symposium Speaker topic: "**Lead Courageous QI with Improv & Collaboration**"

KAWEAH CARE CULTURE & EMPOWER THROUGH EDUCATION

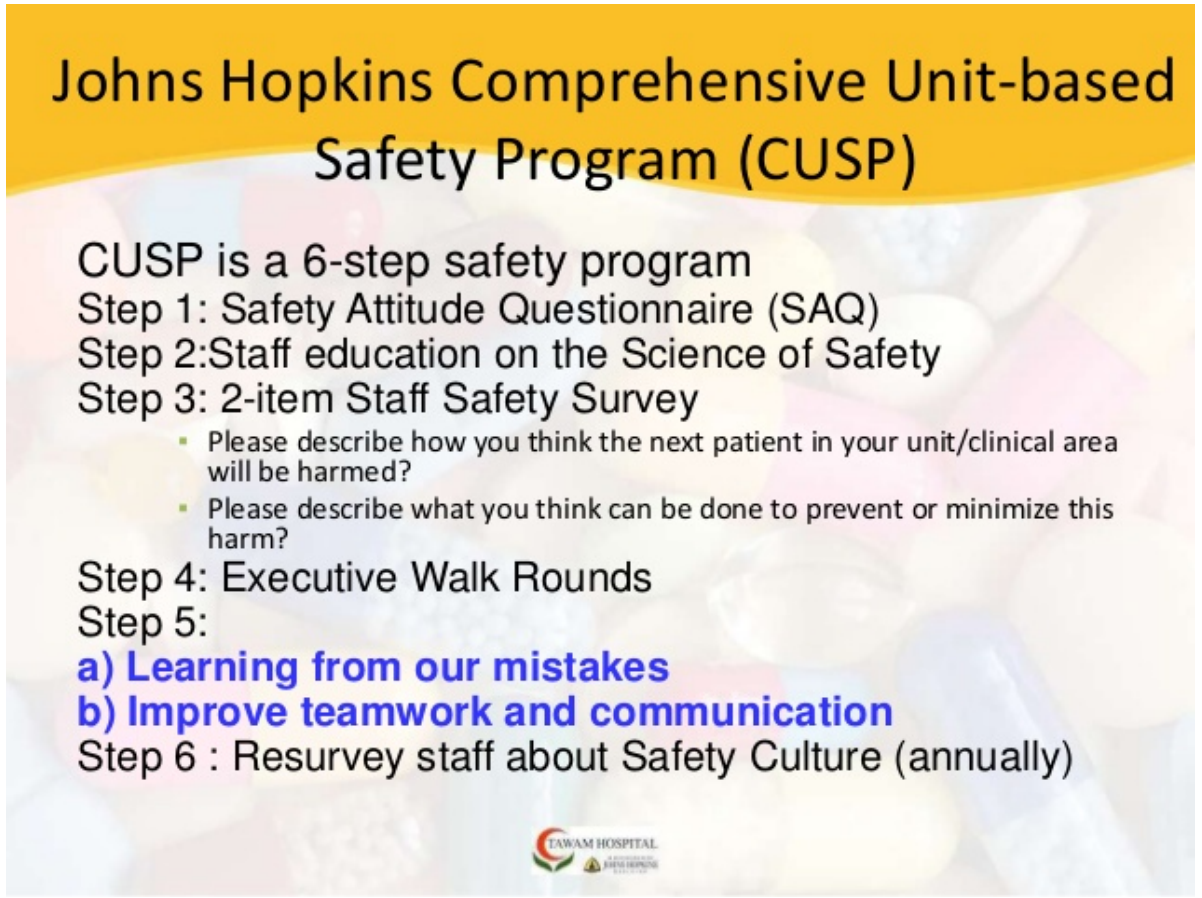
Comprehensive Unit-Based Safety Program (CUSP)

CUSP Teams working on patient safety in 2019:

Pending CUSP Teams

- Imaging Services
- EVS
- 4S
- Labor and Delivery

- ED
- 3N
- 3W
- Hospice
- Mental Health
- Pharmacy
- Mom/Baby
- NICU /peds
- 4N
- 3S
- OR
- Urgent Care
- Rural Health Clinics
- Subacute



KAWEAH CARE CULTURE & EMPOWER THROUGH EDUCATION

Comprehensive Unit-Based Safety Program (CUSP)

Focus for 2020:

- More CUSP Teams, with better support, measurable outcomes!
- CUSP Incentive Program: Passport Program
  - The Goal of this program is to help teams grow and engage staff in patient safety work
  - Teams compete to earn points by completing tasks that enhance their CUSP team (ie. work with another CUSP team, tour unit with executive sponsor)
  - Share learnings from national quality and patient safety conference

CUSP Champion Workshop Evaluation 2019

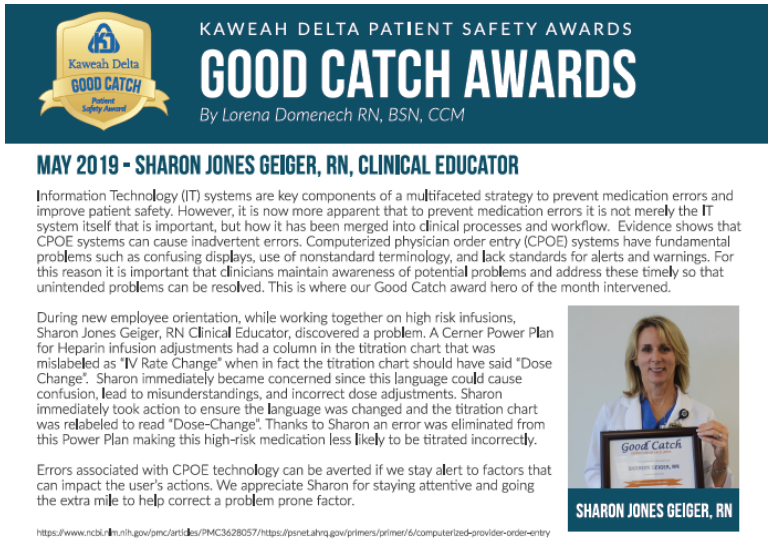
Content	Avg
Content is relevant to CUSP work	4.5
My understanding of the topic prior to the course	3.4
My understanding of the topic after the course	4.3
The quality of the materials or handouts provided	4.3
Speakers	
The presenters demonstrated knowledge of the subject	4.5
The presentation was well organized	4.5
The presenters ability to respond to participant's questions	4.6
Facility	
The classroom had adequate space	4.3
The lighting and acoustics in the classroom	4.5
The overall condition and temperature of the classroom	4.3

* One CUSP Champion Workshop conducted in 2019

KAWEAH CARE CULTURE

Good Catch Award Program and Hero of the Year

Quality & Patient Safety Department has awarded 12 "Good Catch Awards" in 2019!



KAWEAH DELTA PATIENT SAFETY AWARDS

GOOD CATCH AWARDS

By Lorena Domenech RN, BSN, CCM

MAY 2019 - SHARON JONES GEIGER, RN, CLINICAL EDUCATOR

Information Technology (IT) systems are key components of a multifaceted strategy to prevent medication errors and improve patient safety. However, it is now more apparent that to prevent medication errors it is not merely the IT system itself that is important, but how it has been merged into clinical processes and workflow. Evidence shows that CPOE systems can cause inadvertent errors. Computerized physician order entry (CPOE) systems have fundamental problems such as confusing displays, use of nonstandard terminology, and lack standards for alerts and warnings. For this reason it is important that clinicians maintain awareness of potential problems and address these timely so that unintended problems can be resolved. This is where our Good Catch award hero of the month intervened.

During new employee orientation, while working together on high risk infusions, Sharon Jones Geiger, RN Clinical Educator, discovered a problem. A Cerner Power Plan for Heparin infusion adjustments had a column in the titration chart that was mislabeled as "IV Rate Change" when in fact the titration chart should have said "Dose Change". Sharon immediately became concerned since this language could cause confusion, lead to misunderstandings, and incorrect dose adjustments. Sharon immediately took action to ensure the language was changed and the titration chart was relabeled to read "Dose-Change". Thanks to Sharon an error was eliminated from this Power Plan making this high-risk medication less likely to be titrated incorrectly.

Errors associated with CPOE technology can be averted if we stay alert to factors that can impact the user's actions. We appreciate Sharon for staying attentive and going the extra mile to help correct a problem prone factor.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3628057/ https://psnet.ahrq.gov/primers/primer/6/computerized-provider-order-entry

SHARON JONES GEIGER, RN

2019 Patient Safety Heroes of the Year!

KAWEAH DELTA HEALTH CARE DISTRICT

THE STANDARD

DELIVERING QUALITY AND SAFETY MAY/JUNE 2019

Patient Safety Heroes of the Year Awarded!

By Sandy Volchko, DNP, RN, CPHQ, Director of Quality and Patient Safety

It was a tie!

Congratulations to Amanda Silva, AWS, and Lorena Perez, RN who were recently awarded the Patient Safety Hero of the Year award for 2019. Our panel of Patient Safety experts reviewed each monthly Good Catch Award recipient from 2018 and scored them based on 4 criteria which include: the scope and severity of the problem intervened on, the impact to other patients, and the degree of action taken. Both of these phenomenal employees made a significant impact in Patient Safety at Kaweah Delta. Amanda's actions will keep our babies safe ongoing from at-risk discharge situations and Lorena identified high-risk miscommunications in critical lab results with our dialysis population. Our patients will be safer for a long time to come because of the actions taken by Amanda and Lorena. Congratulations, a well-deserved award!

Picture: Tom Gray, MD, Medical Director of Quality and Patient Safety with our Heroes of the Year, Amanda Silva, AWS and Lorena Perez, RN, at the 2019 Patient Safety Symposium.

THE STANDARD | 1

SUMMARY

Focus for 2020:

- HAI reduction and monitoring, Kaizen Events (Lean/Six Sigma)
- Resource Effectiveness
- Disease Specific Teams to address mortality
- Continued monitoring and actions to eliminate Healthcare Acquired Conditions
- Safety Attitudes Questionnaire administration
- TeamSTEPPs Leadership Cohort 2
- Just Culture Training (enterprise-wide)
- Joint Commission Primary Stroke Center Reaccrediation Survey
- Improving capability
    - Enhanced training on quality tools and methods for other district groups

QUESTIONS?

2020 Quality Council/Board Quality Review Schedule

TOPIC	JAN		FEB		MAR		APR		MAY		JUN		JUL		AUG		SEP		OCT		NOV		DEC	
Annual Review of Quality and Patient Safety Plans	X																							
Leadership Clinical Quality Goals	X		X		X		X		X		X		X		X		X		X		X		X	
Leapfrog Hospital Safety Score									X										X					
Healthgrades																					X			
Value Based Purchasing					X	B					X						X						X	
PATIENT EXPERIENCE					X						X						X						X	B
Resource Effectiveness									X	B											X	B		
CARDIAC CARELINE Society of Thoracic Surgery(STS) and American College of Cardiology (ACC) Data			X												X			B						
CRITICAL CARE CARELINE																								
Emergency Dept Dashboard	X		X		X		X		X		X		X		X		X		X		X		X	
Emergency Dept Report											X												X	
Rapid Response Team (RRT)	X			B			X						X						X					
SURGICAL SERVICES Surgical Quality Improvement Program									X	B											X			
ONR CARELINE																								
Stroke	X						X						X			B			X					
Rehabilitation	X												X											
Orthopedics													X											
MCH CARELINE																								
Perinatal Core Measures, Peds, NICU, Labor & Delivery, Obstectrics					X			B									X							
RENAL SERVICES CARELINE Network 18											X												X	
MENTAL HEALTH CARELINE							X												X					

Revised: 12/18

2020 Quality Council/Board Quality Review Schedule

CMS Core Measures																								
POST ACUTE CARELINE																								
Subacute & Transitional Care Unit											X												X	
Hospice, Home Health							X												X					
NURSING																								
Falls					X												X							
Infection Prevention Hand Hygiene, SSI, C Diff, CAUTI & CLABSI					X						X	B					X						X	
TOPIC	**JAN**		**FEB**		**MAR**		**APR**		**MAY**		**JUN**		**JUL**		**AUG**		**SEP**		**OCT**		**NOV**		**DEC**	
2020 QUALITY FOCUS TEAMS																								
Workplace Violence		B					X												X					
SEPSIS Quality Focus Team (QFT)							X												X	B				
HAPI QFT											X												X	
Handoff Communication QFT																								
****CLOSED AGENDA ITEMS****																								
Pro- Staff	X		X		X		X		X		X		X		X		X		X		X		X	
Medication Safety QFT – *James McNulty*	X						X						X						X					
RCA	X		X		X		X		X		X		X		X		X		X		X		X	
Parking Lot Items																								

Revised: 12/18