October 4, 2019

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Quality Council Committee meeting at 7:00AM on Thursday October 10, 2019, in the Kaweah Delta Medical Center – Acequia Wing – Executive Office Conference Room {400 W. Mineral King, Visalia}.

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

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

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

KAWEAH DELTA HEALTH CARE DISTRICT
Nevin House, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
Board Clerk, Executive Assistant to CEO

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

KAWEAH DELTA HEALTH CARE DISTRICT
BOARD OF DIRECTORS
QUALITY COUNCIL

Thursday, October 12, 2019

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

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

OPEN MEETING – 7:00AM

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

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

1. **Written Quality Reports –** A review of key quality metrics and actions associated with the following populations:
   - 1.1. **Stroke Quality Report**
   - 1.2. **Mental Health Quality Report**
   - 1.3. **Hospice Quality Report**
   - 1.4. **Home Health Quality Report**
   - 1.5. **Sepsis Quality Focus Team 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. **Leapfrog Hospital Safety Grade –** A review of performance on the quality indicators that constitute the Leapfrog Hospital Safety Score. *Sandy Volchko, RN, Director of Quality and Patient Safety; Kassie Waters, RN, Manager of Quality and Patient Safety.*

5. **Rapid Response Team Quality Report –** A review of key quality indicators related to the rapid response processes and outcomes. *Jon Knudsen, NP, Director of Renal, Oncology and Critical Care Services.*

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

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

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

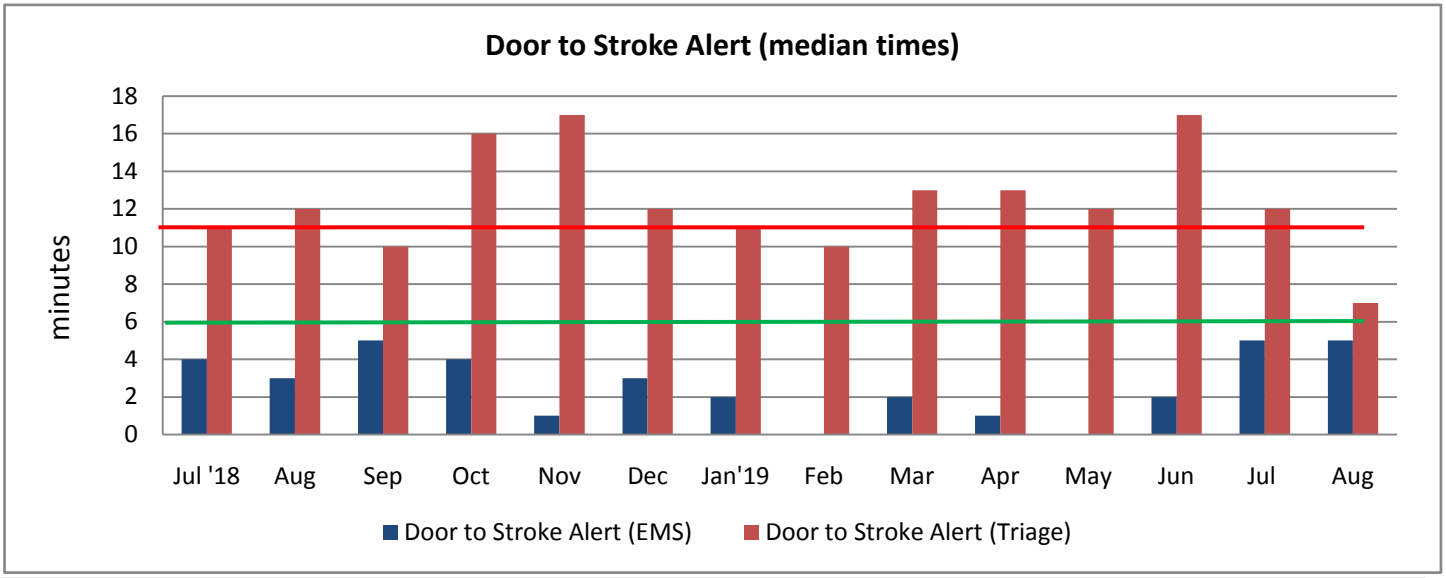
Call to order – *Herb Hawkins, Committee Chair & Board Member*

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

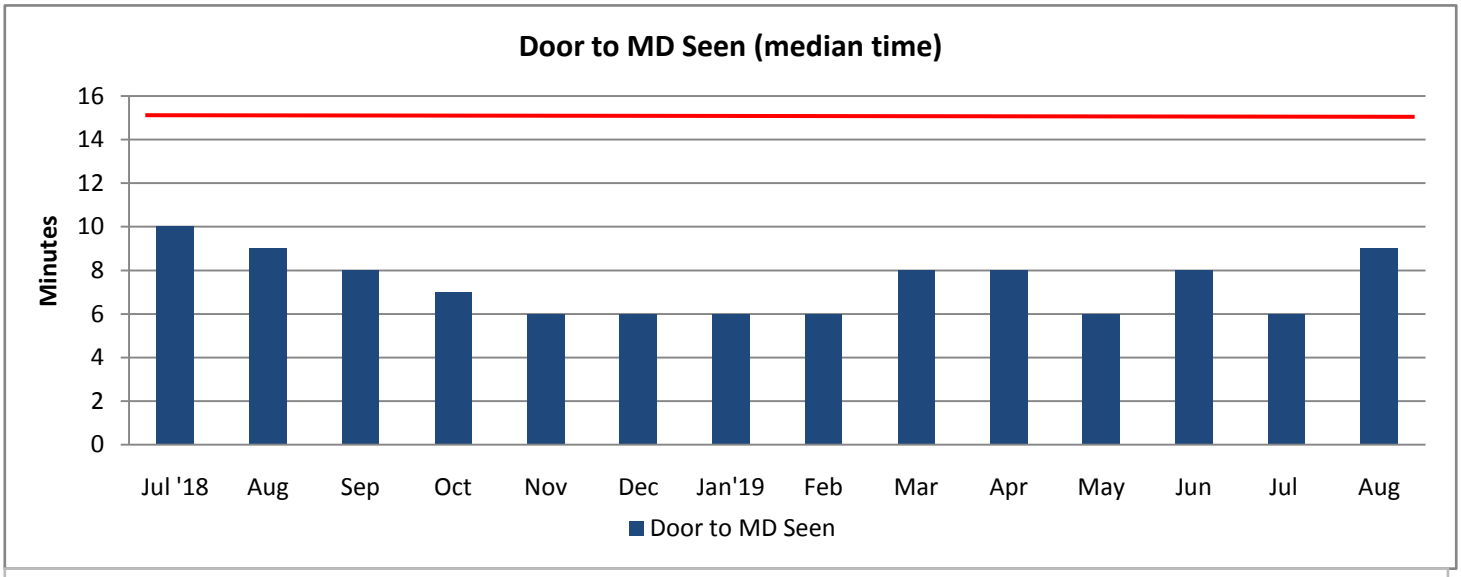
Adjourn Open Meeting – *Herb Hawkins, Committee Chair & Board Member*

In compliance with the Americans with Disabilities Act, if you need special assistance to participate at this meeting, please contact the Board Clerk (559) 624-2330. Notification 48 hours prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to the Kaweah Delta Health Care District Board of Directors committee meeting.

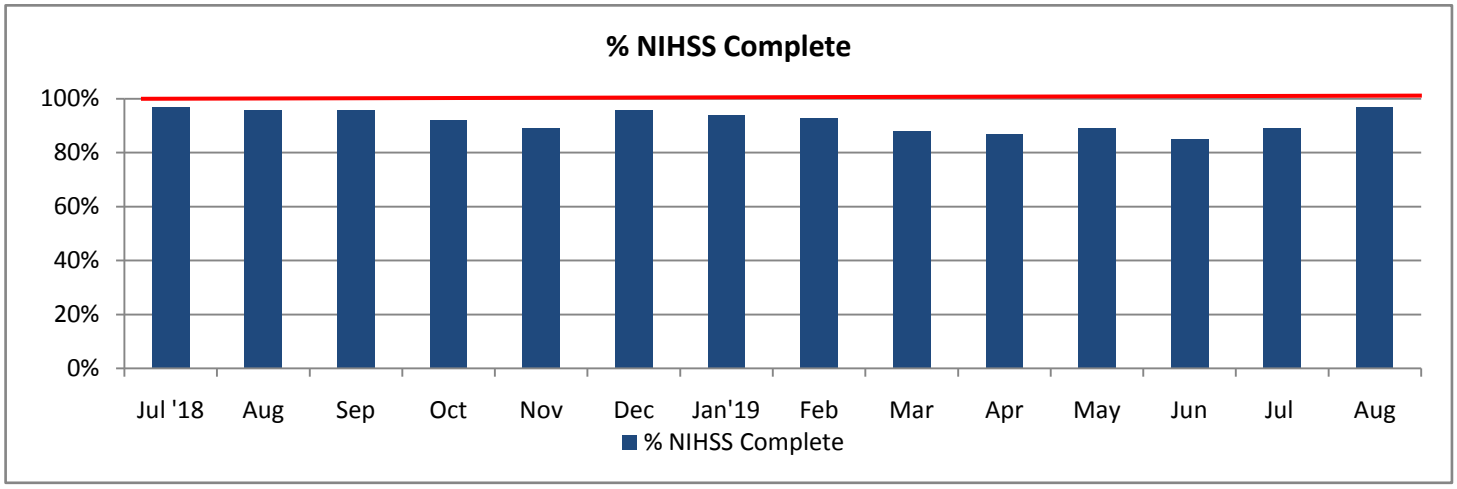
ED Stroke Alert Dashboard
2018-2019



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



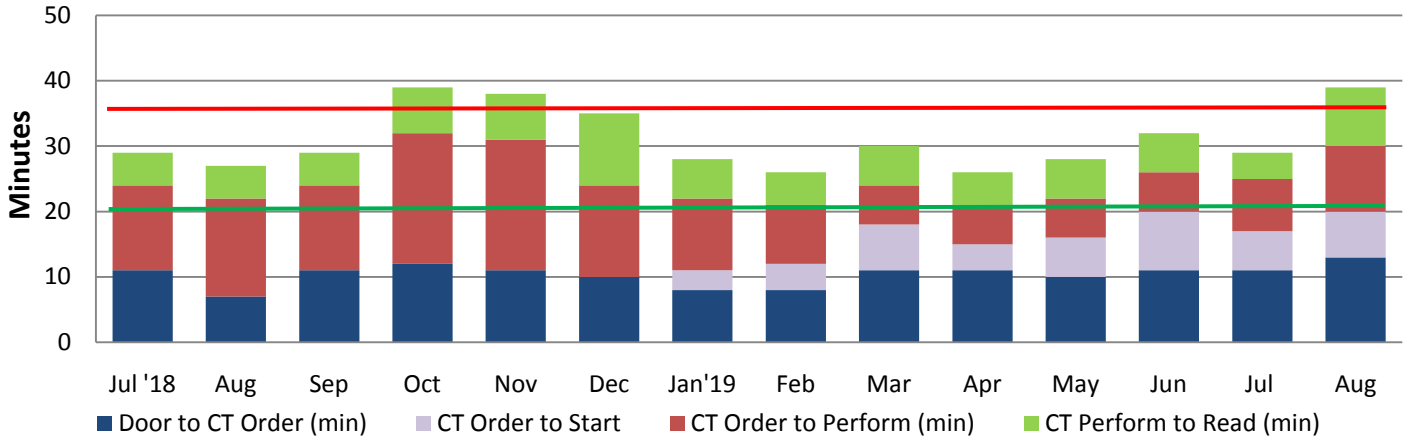
The expectation is that the physician will see the stroke alert patient within 15 minutes of arrival. Improvements made throughout the past year include: early notification from EMS, MD meets the pt at the door upon arrival, scribe documents first seen time in the record.



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.

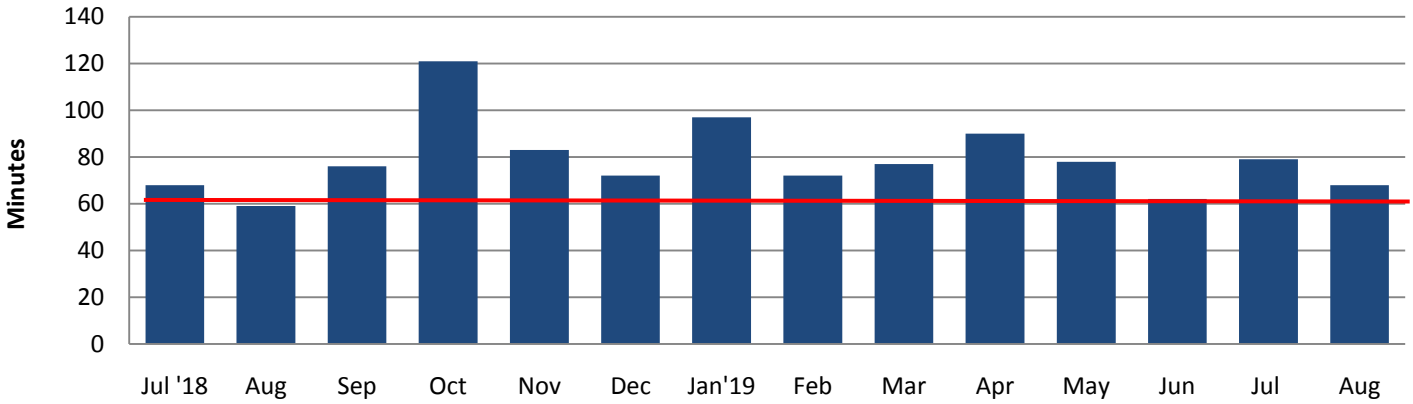
ED Stroke Alert Dashboard
2018-2019

Door to CT Times (median times)



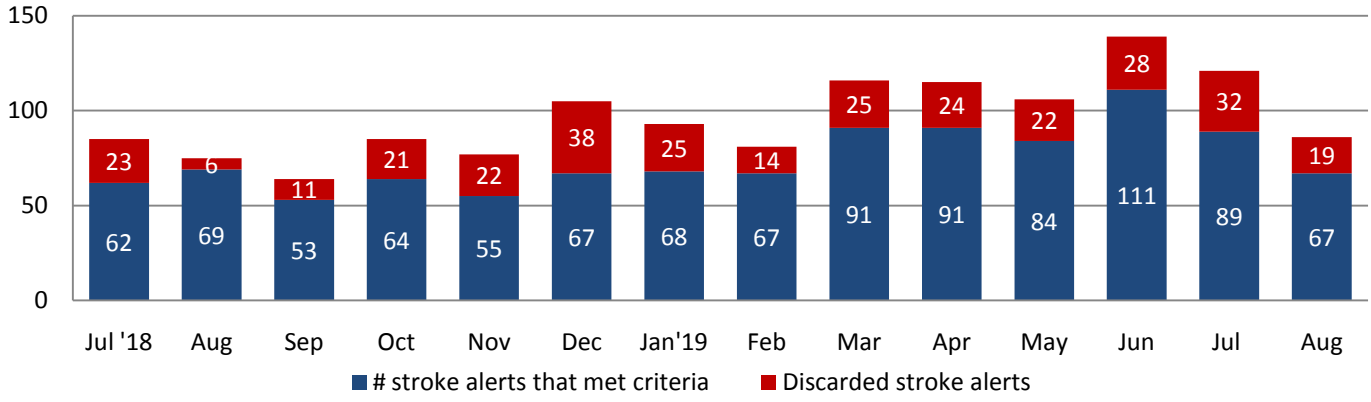
CMS and TJC expectation is that the CT will be performed by 20 minutes and read by 45 minutes of arrival. KDH's CT read time goal is 35 minutes. Starting 2019; tracking of CT start times will be included in this measurement. start time is define by the first CT images in Synapse.

Door to Alteplase (median time)



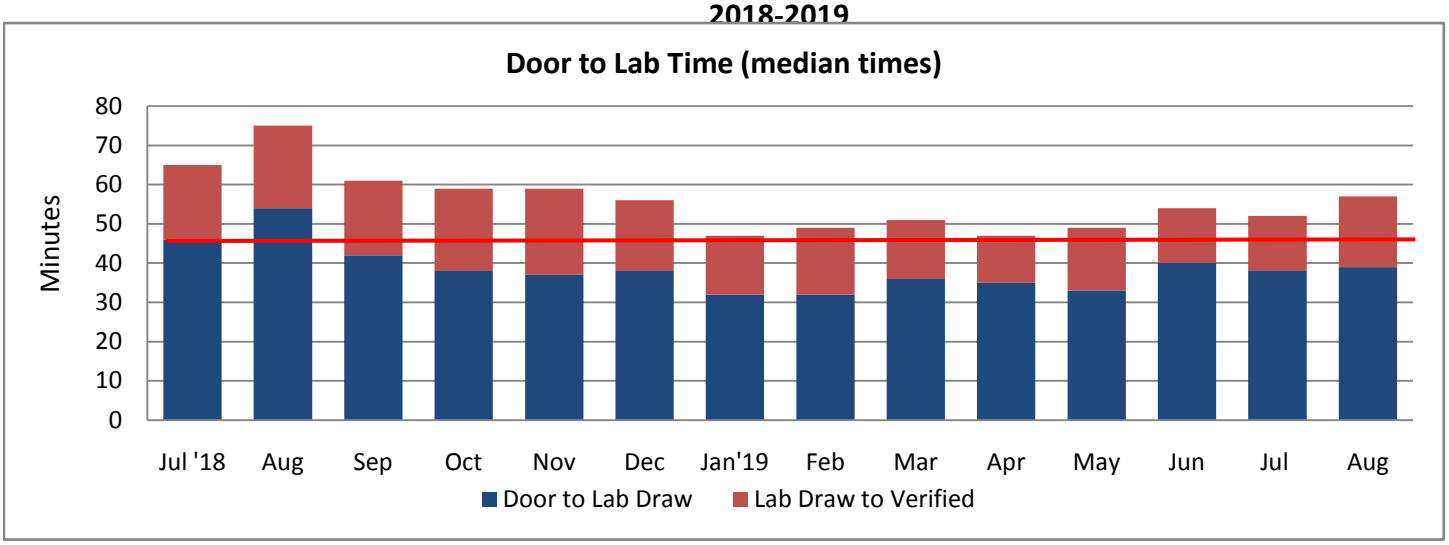
The data in this graph includes all Alteplase patients, no exclusion criteria. TJC expectation is that IV thrombolytics are given within 60 minutes to eligible patients who present for stroke care at least 50% of the time. 2019 AHA/ASA has set new IV thrombolytic goal time to 45 minutes at least 75%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

ED Stroke Alert Volume

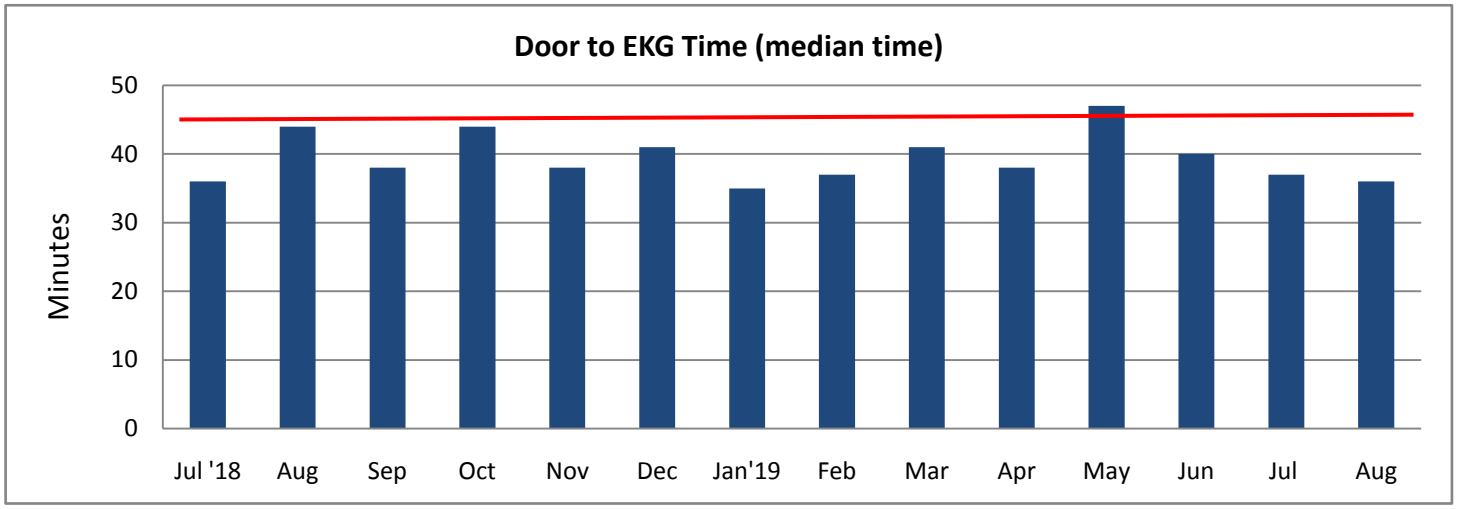


Stroke alert criteria includes: pt presenting with stroke like symptoms +FAST screen, stroke alerts called prior to arrival and up to 1 hour after arrival. Excluded cases: >1 after arrival or if stroke alert was cancelled.

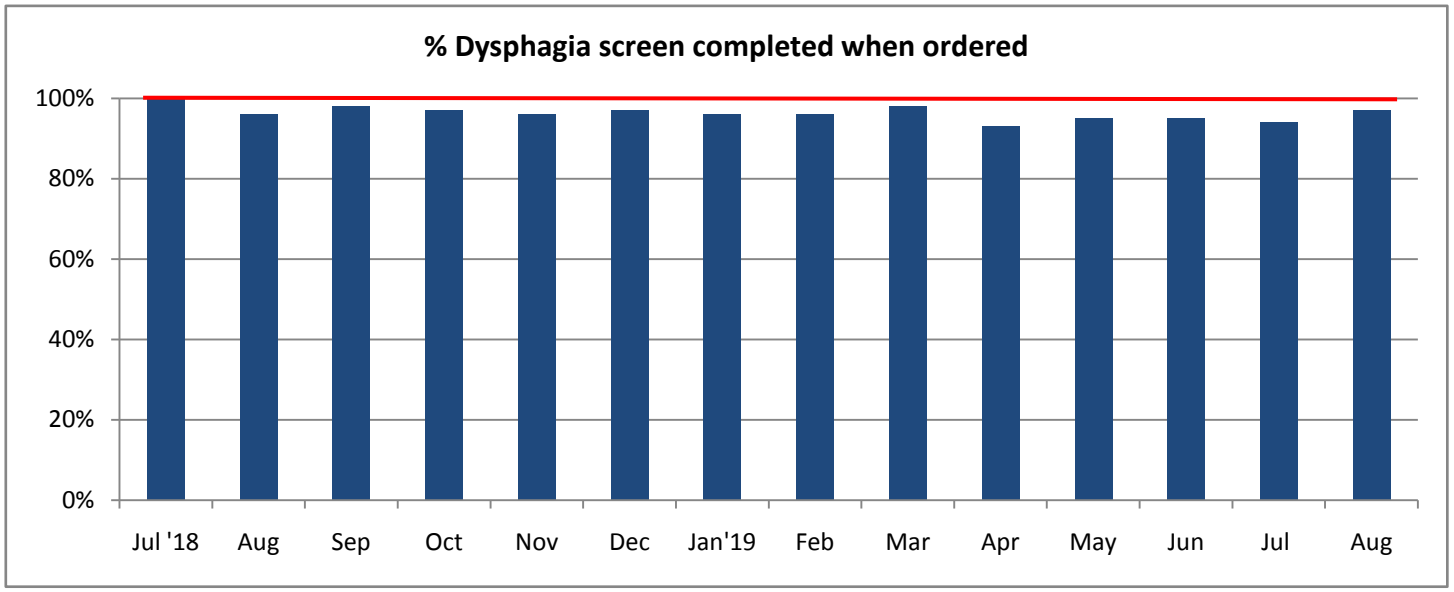
ED Stroke Alert Dashboard
2018-2019



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.



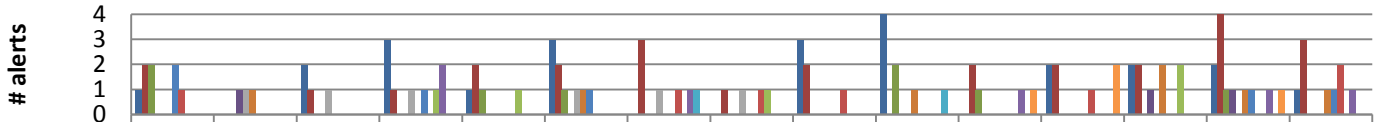
TJC expectation is that EKGs are completed within 45 minutes of arrival.



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.

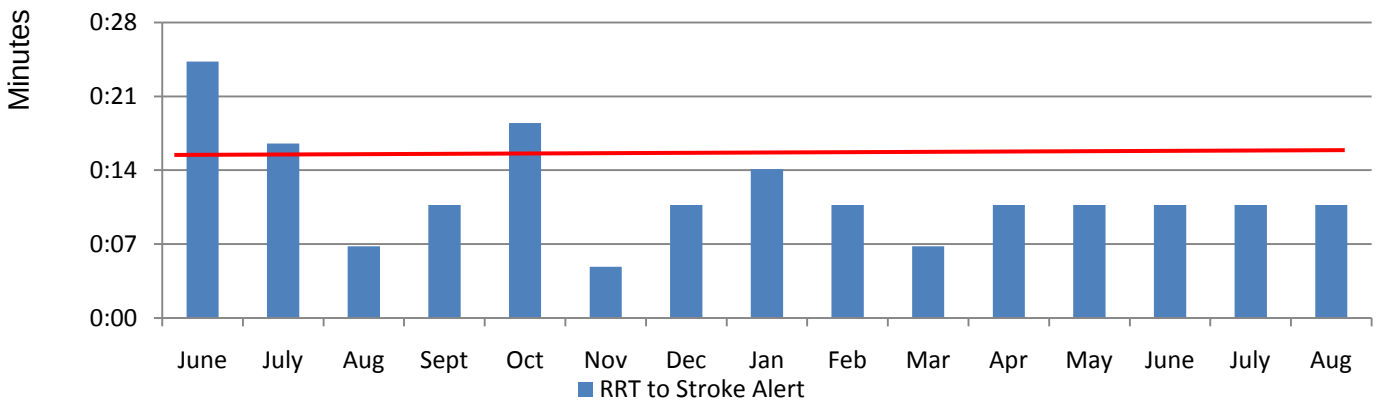
In-House Stroke Alert Dashboard 2018-2019

Stroke Alert Location



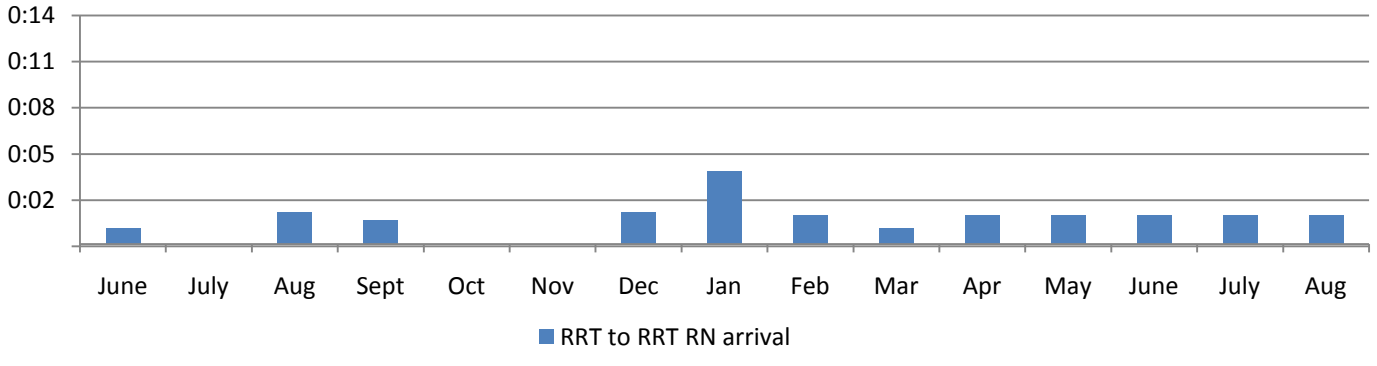
	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
3W	1		2	3	1	3			3	4		2	2	2	1
4S	2		1	1	2	2	3	1	2		2	2	2	4	3
2S	2				1	1				2	1			1	
3S		1											1	1	
Cath Lab		1	1	1		1	1	1							
CVICU		1				1				1			2	1	1
ICU	2			1		1								1	1
4N	1						1	1	1			1			2
3N				1	1			1					2		
4T				2			1				1			1	1
PACU							1			1					
2N											1	2		1	

RRT to Stroke Alert



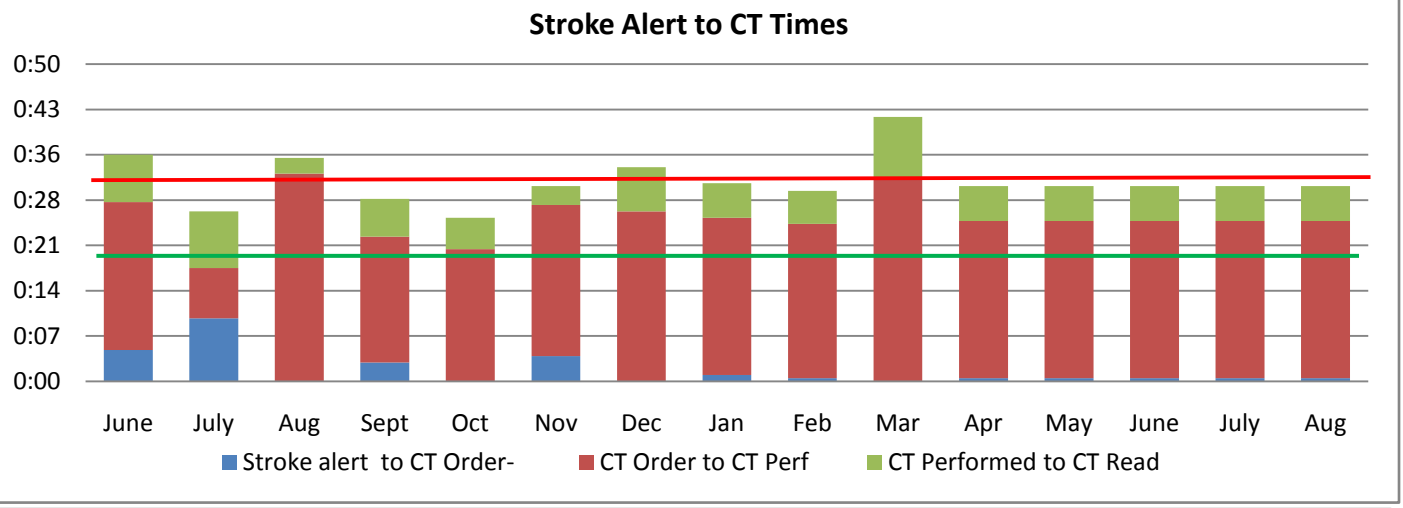
If patients exhibit any new or worsening neuro deficits while in the hospital; RNs are to call an RRT. The RRT RN will evaluate and determine if a stroke alert should be called. The goal from calling RRT to stroke alerts should be <15 minutes.

RRT to RRT RN arrival

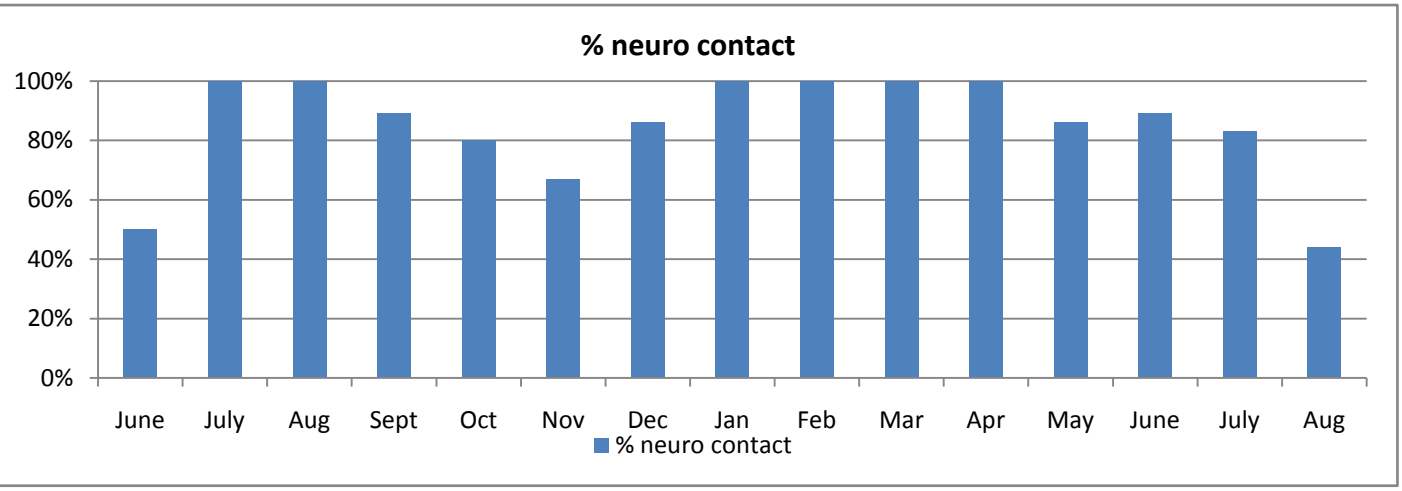


TJC expectation is that a designated provider is at the bedside within 15 minutes of stroke alert. KDH has designated the RRT RN as the provider for in-house stroke alerts.

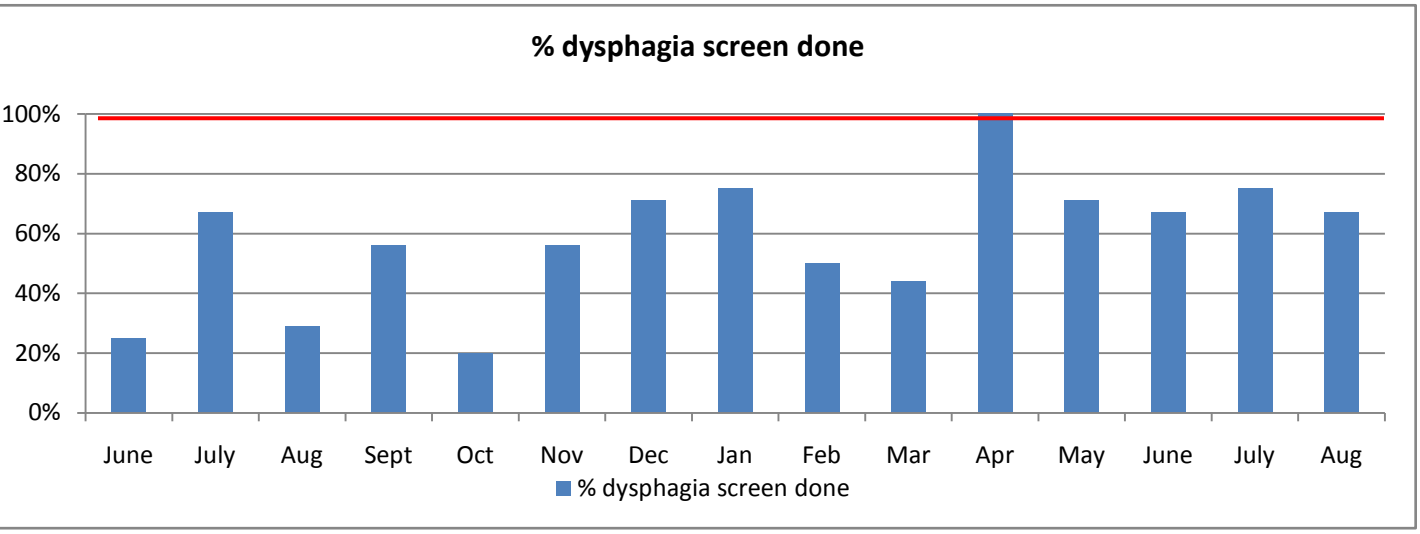
In-House Stroke Alert Dashboard 2018-2019



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).**

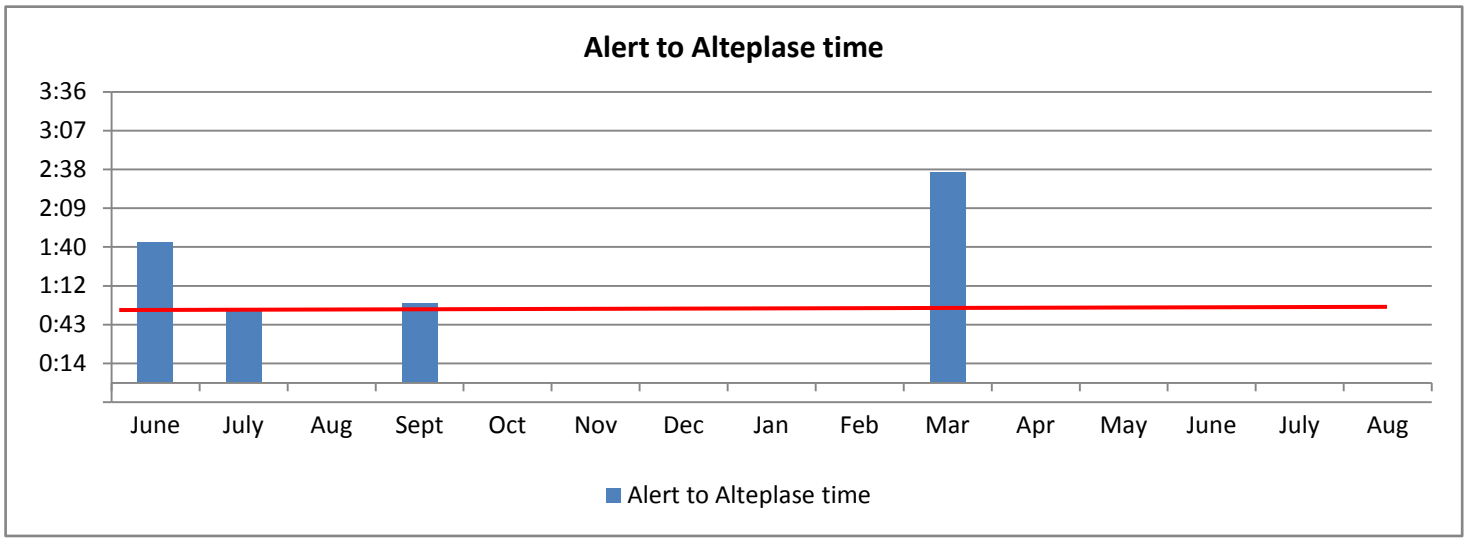


Neurology consultation should occur on all in-house stroke alerts.

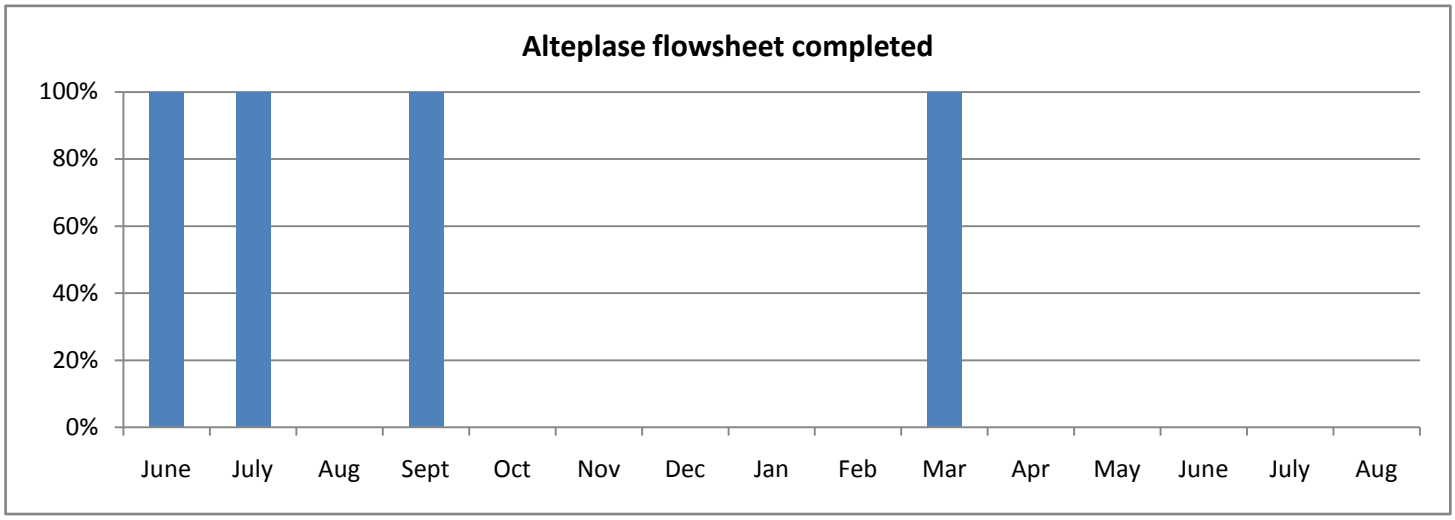


Whenever there are new or worsening neurological deficits ≥3 points, the RN should perform a dysphagia screen to evaluate the patient's ability to swallow.

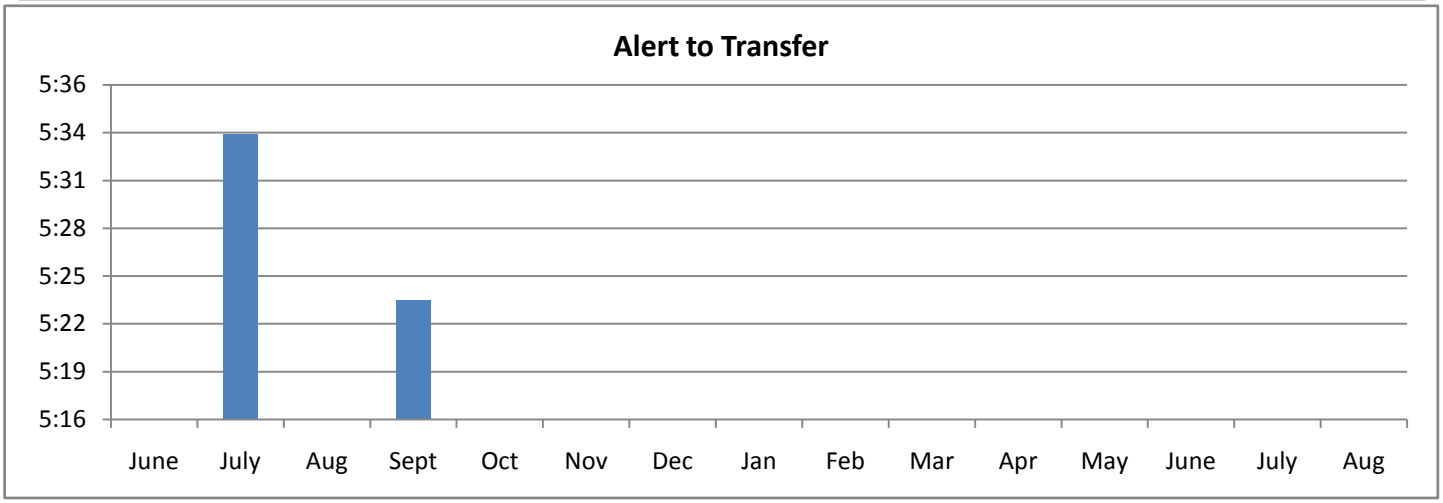
In-House Stroke Alert Dashboard 2018-2019



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

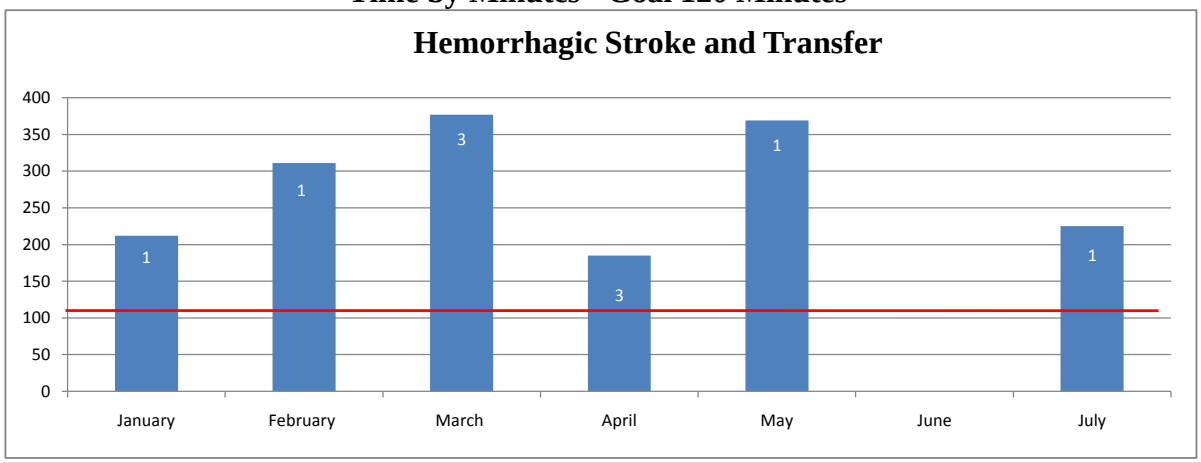


KDH expectation is that post Alteplase monitoring is in compliance with our standardized protocol. All key elements must be completed to be determined as compliant.

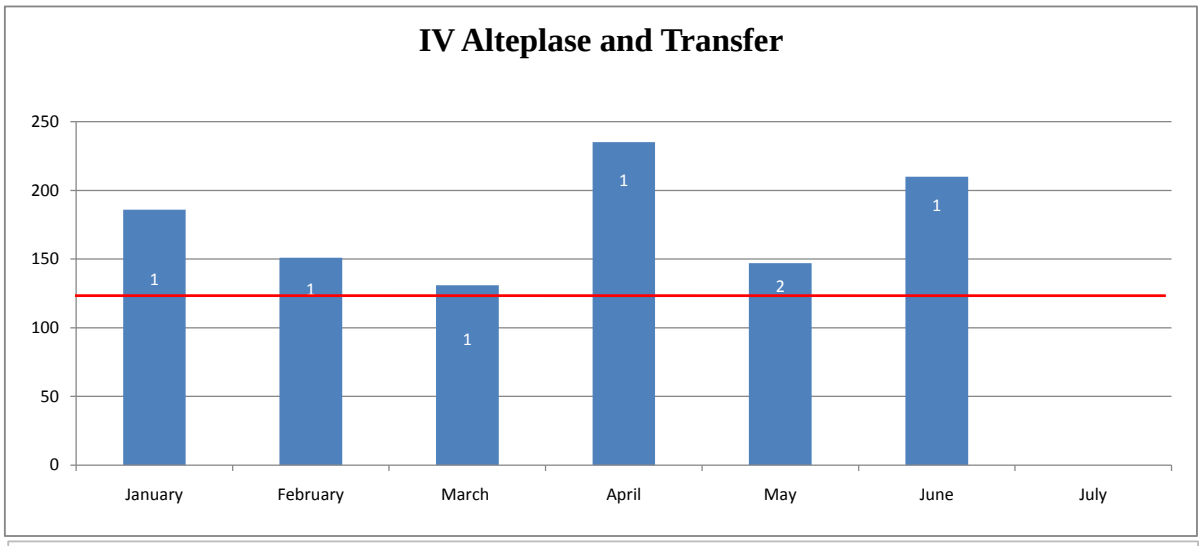


Effective January 2019, TJC will require data collection for patients transferred to another facility from the ED. KDH Stroke program now monitors the "door in - door out" times in the ED but we wanted to also monitor how we do when transferring our in-house stroke alert patients. No goal has been set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

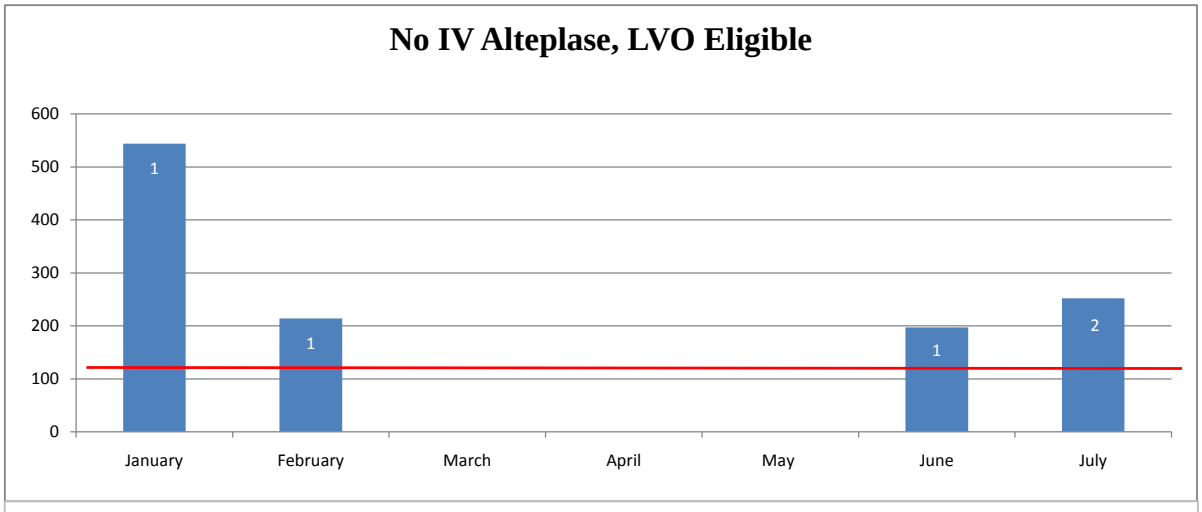
2019 TRANSFERS FROM ED TO ANOTHER ACUTE CARE FACILITY Median Time by Minutes - Goal 120 Minutes



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.

Stroke Dashboard 2018-2019

* NEW TRACKING PROCESS AS OF JULY 1, 2019 ONLY include Hemorrhage and Ischemic (No TIA)	Bench mark	2018 July	Aug	Sept	Oct	Nov	Dec	2019 Jan	Feb	Mar	Apr	May	June
Grouping of Stroke Patients													
Ischemic		40	47	31	30	39	41	30	42	39	43	36	41
Hemorrhagic		7	13	9	9	8	5	4	10	10	9	7	8
TIA (in-patient and observation)		23	20	28	21	30	27	20	28	35	25	24	22
Transfers to Higher Level of Care (Ischemic)		2	1	3	4	3	6	2	2	3	3	2	1
Transfers to Higher Level of Care (Hemorrhagic)		0	1	1	1	1	0	1	1	2	1	1	1
% of Alteplase - Inpatient & Transfers		7%	10%	26%	6%	5%	11%	16%	14%	14%	13%	18%	21%
Total # of Pts who rec'd Alteplase (Admitted Patients)		2	4	6	1	1	2	4	4	4	4	5	8
Total # of Pts who rec'd Alteplase (& Transferred Out)		1	1	3	1	2	3	1	2	2	2	2	1
TOTAL NUMBER OF PATIENTS		72	82	72	65	81	79	57	83	89	81	70	73
Rate of hemorrhagic complications for Alteplase pts	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%
Core Measure: OP-23 Head CT/MRI Results	99.2%	100%	50%	33%	100%	50%	20%	NA	50%	100%	100%	33%	66%
% tPA Arrive by 2 Hrs; Treat by 3 Hrs. (GWTG)	85%	50%	83%	100%	100%	100%	80%	100%	100%	83%	100%	100%	100%
STK-5 Early Antithrombotics by end of day 2 (Ishcemic)	85%	98%	97%	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%
STK-1 VTE (Hem and Ischemic)	85%	90%	84%	90%	94%	88%	95%	100%	100%	100%	100%	100%	100%
STK-2 Discharged on Antithrombotic (Ischemic)	85%	98%	98%	98%	97%	98%	100%	100%	97%	100%	98%	98%	94%
STK-3 Anticoag for afib/aflutter ordered at Dc (Ischemic)	85%	100%	100%	100%	100%	100%	100%	80%	89%	100%	100%	100%	100%
% Smoking Cessation (GWTG)	85%	91%	95%	92%	100%	94%	100%	100%	100%	100%	100%	100%	100%
STK-6 Discharged on Statin (Ischemic)	85%	100%	90%	98%	100%	96%	100%	100%	100%	100%	100%	98%	96%
% Dysphagia Screen prior to po intake (GWTG)	75%	91%	90%	90%	89%	94%	94%	100%	93%	94%	88%	88%	98%
STK-8 Stroke Education (Hem and Ischemic)	75%	82%	93%	100%	100%	96%	85%	88%	91%	84%	89%	93%	92%
STK-10 Assessed for Rehab (Hem and Ischemic)	75%	100%	98%	97%	96%	97%	100%	97%	100%	100%	100%	97%	100%
STK-4 Alteplase Given within 60 min (Ischemic Admits)	75%	100%	75%	NA	NA	100%	100%	100%	25%	25%	100%	100%	100%
% LDL Documented (GWTG)	75%	90%	88%	85%	95%	91%	100%	92%	88%	100%	96%	94%	96%
Intensive Statin Therapy (GWTG)	75%	88%	79%	57%	58%	81%	75%	91%	82%	90%	89%	91%	80%
% 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%
% NIHSS Reported (GWTG)	75%	97%	95%	100%	96%	97%	98%	97%	98%	97%	100%	97%	100%
% Appropriate stroke order set used (In-Patient)	90%	92%	92%	86%	90%	90%	94%	90%	97%	97%	94%	93%	90%
% Appropriate stroke order set used (ED)	90%	78%	89%	88%	85%	85%	84%	85%	92%	90%	92%	94%	93%
LOS Hemorrhagic (Mean)		7.29	6.29	7.14	16	14.5	12	13.5	10.8	6.86	13.88	4	4.38
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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee / Quality Improvement Committee

Unit/Department: Mental Health **ProStaff / QIC Report Date:** 8/12/19

Measure Objective/Goal:

The Joint Commission and the National Association of Psychiatric Health Systems (NAPSH), the National Association of State Mental Health Program Directors (NASMHPD) and the NASMHPD Research Institute, Inc. (NRI) collaborated on the development of a set of core performance measures for Hospital-Based Inpatient Psychiatric Services (HBIPS). Following successful pilot testing, hospital data collection for the HBIPS measures began with October 1, 2008 discharges. HBIPS measures were endorsed by the National Quality Forum (NQF) in May 2010. The measure maintenance process is guided by expertise and advice provided by the Technical Advisory Panel; measures are updated periodically.

The **Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program** was established by the Affordable Care Act with the intent to encourage inpatient psychiatric facilities and clinicians to improve the quality of inpatient care. The program was implemented on October 1, 2012 as a CMS pay-for-reporting program

FY2019 Chart-Abstracted Measures

MEASURE ID	MEASURE NAME	ENDORSED BY	
		CMS (IPFQR)	THE JOINT COMMISSION
HBIPS-1a	Admission Screening		✓
SMD-1	Screening for Metabolic Disorders	✓	
HBIPS-2a	Hours of Physical Restraint Use	✓	✓
HBIPS-3a	Hours of Seclusion Use	✓	✓
HBIPS-5a	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	✓	✓
SUB-2	Alcohol Use Brief Intervention Provided or Offered	✓	✓
SUB-2a	Alcohol Use Brief Intervention	✓	✓
SUB-3	Alcohol/Other Drug Use Treatment Provided or Offered at Discharge	✓	✓
SUB-3a	Alcohol/Other Drug Use Disorder Treatment at Discharge	✓	✓
TOB-2	Tobacco Use Treatment Provided or Offered	✓	✓
TOB-2a	Tobacco Use Treatment	✓	✓
TOB-3	Tobacco Use Treatment Provided or Offered at Discharge	✓	✓
TOB-3a	Tobacco Use Treatment at Discharge	✓	✓
CT-2	Care Transitions with Specified Elements Received by Discharged Patients	✓	
CT-3	Timely Transmission of Transition Record	✓	

We anticipate that CMS will establish performance benchmarks in the future, with financial penalties for underperformance. KD mental health leadership team partners with quality/patient safety department liaisons to establish internal benchmarks aligned with national standards available in the public domain.

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

Measure Objective/Goal:

The **National Database of Nursing Quality Indicators (NDNQI)** was founded by the American Nurses Association (ANA) in 1998. Having been managed by The University of Kansas School of Nursing since 2001, NDNQI was purchased by Press Ganey, a long-standing leader in performance measurement, in 2014. NDNQI promotes nursing excellence through the most robust source of comparative norms in the industry. Nursing sensitive quality measures and indicators reflect the impact of nursing actions on patient outcomes.

NDNQI is the largest provider of unit-level performance data to hospitals and its metrics satisfy Joint Commission and CMS requirements. KD mental health outcomes are compared with other adult inpatient psychiatric units (grouped by hospital size/number of staffed beds and teaching status) for the following indicators:

- Total Falls per 1,000 Patient Days
- Injury Falls per 1,000 Patient Days
- Total Assault Rate per 1,000 Patient Days
- Injury Assault Rate per 1,000 Patient Days

Date Ranges of Data Evaluated:

May2018 – May2019	: SUB-3, 3a, CT-2	**Q1 2016 – Q1 2019**	: HBIPS-5a
Q1 2017 – Q2 2019	: SMD-1, CT-3	**Q3 2016 – Q2 2019**	: Remaining Measures
Q2 2017 – Q1 2019	: Fall, Assault Indicators		

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

- Twelve (12) of 19 total indicators outperform the target/benchmark statistic majority of the reporting intervals (>50%)
- Of the 16 indicators that outperform the target/benchmark for the most recent reporting interval:
  - 10 outperform at least four of the most recent consecutive reporting intervals
  - 3 outperform at least the most recent two consecutive reporting intervals
- Of the 12 indicators that outperform the median statistic for the most recent reporting interval:
  - 5 outperform at least four of the most recent consecutive reporting intervals
  - 3 outperform at least the most recent two consecutive reporting intervals

Improvements

- Improved performance: **HBIPS-1a; HBIPS-5a; TOB-3, 3a; CT-3**
- Decline in hours of physical restraint (**HBIPS-2a**) and seclusion use (**HBIPS-3a**)
- Decline in **Total Fall** rate
  - Below median and benchmark statistic in most recent four consecutive reporting intervals
- Decline in **Injury Fall** rate
  - Below median and benchmark statistic in most recent two consecutive reporting intervals
- Decline in **Injury Assault** rate
  - Below median and benchmark statistic in most recent two consecutive reporting intervals

Opportunities

- **HBIPS-1a:** *while significantly improved most recent 3 quarters, remains below the median and benchmark statistic*
  This indicator requires specific timeframes on violence risk to self/others (over the past 6 months) and substance use (over the past 12 months). Documentation is improving as the medical director and program director partner with clinical informatics.

- **SUB-2a:** *above the median for most recent 5 quarters; below benchmark statistic for most recent 2 consecutive quarters*
  Scoring thresholds for brief intervention requirement are different for men and women upon admission; reference text is available as a guide for nursing staff. Most recent data reviewed (May 2019) outperforms the benchmark statistic, with 4 deficiencies out of 11 cases (2 fall-outs for refusal of intervention; and, 2 for female patients whose score met intervention threshold, but no documentation of brief intervention offered/provided).

- **ASSAULTS:** *while demonstrating positive trend for most recent quarter, total assault rates are above previously reported result for most recent 2 consecutive quarters*

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

- **HBIPS-1a:** Indicator results are available to psychiatry medical staff leaders (medical director and program director) for review prior to monthly HBIPS multidisciplinary team meeting; report detail includes individual attending/resident names for each deficiency. Medical director and program director will follow-up in person with individual identified for each fall-out prior to and provide feedback at monthly HBIPS meeting, by the end of Q3 2019. Also, documentation template modifications, suggested by resident, are under consideration by program director and medical informatics support team.

- **SUB-2a:** Leadership team is partnering with quality data abstractor and clinical informatics specialist to modify Audit-C reference text, relocating women's lower threshold instructions above guiding text related to men's score, by the end of Q4 2019 (prioritize after regulatory/survey-related Cerner modification requests). Also exploring feasibility and options for creating mandatory fields. Finally, mental health department-specific competency fair included focus on HBIPS documentation (completed 8/7-8/2019).

- **ASSAULTS:** Results of multidisciplinary feedback facilitated by risk management and mental health clinical leaders (July 2019):
  - Include "known history of violence" in nursing handoff, Treatment Team meetings and FLASH meetings (by 8/31/19)
  - Relocate video surveillance camera from gymnasium to E2 unit (by 8/5/19; completed)
  - Include security officers in daily FLASH meetings (safety huddles); security officer will incorporate new information in security daily pass-down report (by 7/31/19; completed)

- Implement documentation of known history of violence into the electronic record as an adjunct to the Broset screening tool (defer to organization-wide implementation of work-place violence prevention strategy to "flag" known violence-risk persons in Cerner)
- Evaluate the availability of additional crisis prevention training to include techniques to physically contain a physically aggressive person, when verbal de-escalation is no longer effective (currently under review by safety specialist)

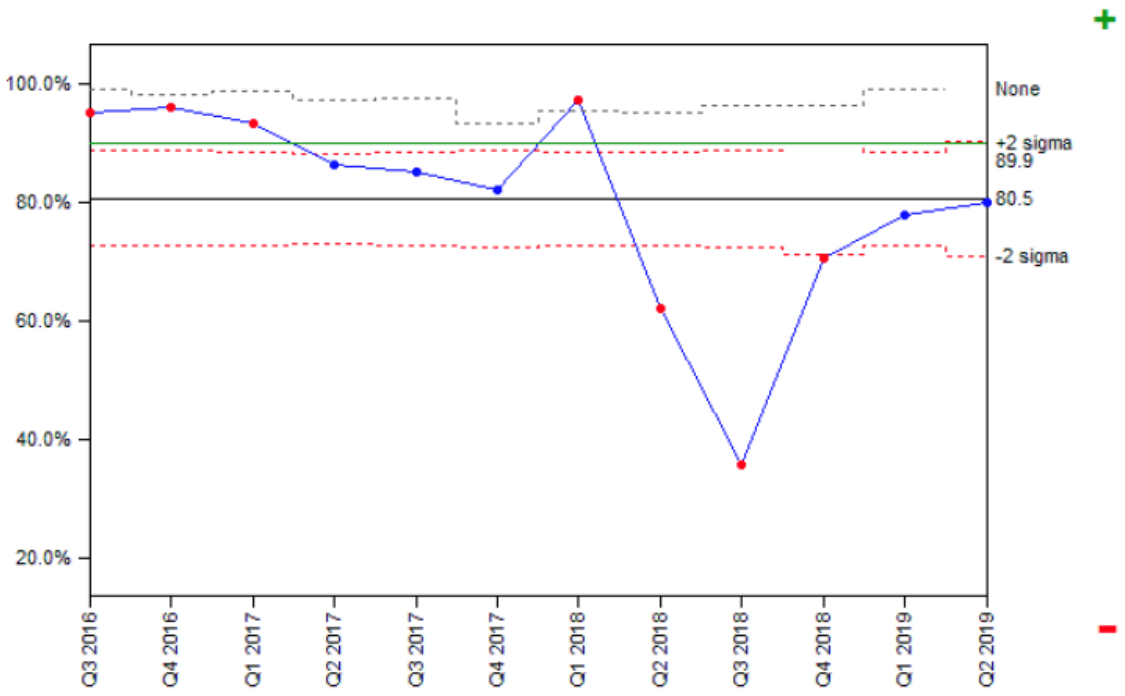
At the invitation of nurse managers, Kaweah Delta safety specialist attended June 2019 staff meeting to answer questions and actively participated in mental health competency fair 8/7-8/2019.

Next Steps/Recommendations/Outcomes:

In addition to plans and outcomes detailed above, in August 2019 the clinical and medical staff leadership submitted request for changes within PowerChart and the BH Admission Powerform, specifically modifications to include the use of an agitation scale by nursing and a tiered approach to PRN medication management of the agitated patient.

Submitted by Name: *Mary Laufer, DNP, RN, NE-BC* **Date Submitted:** 8/12/19

MH HBIPS-1a Admission Screening
(Q3 2016 – Q2 2019)



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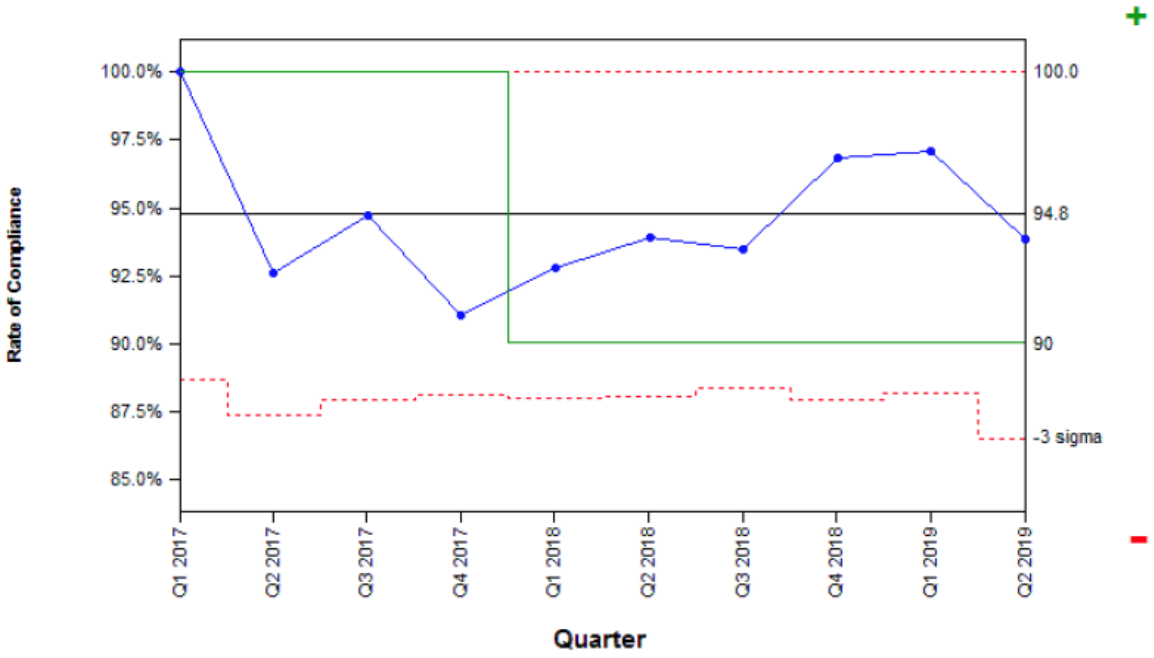
	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019
Numerator	93	94	95	94	85	78	100	64	34	50	80	55
Denominator	98	98	102	109	100	95	103	103	95	71	103	69
Percent	94.9%	95.9%	93.1%	86.2%	85.0%	82.1%	97.1%	62.1%	35.8%	70.4%	77.7%	79.7%
Target	89.9%	89.9%	89.9%	89.9%	89.9%	89.9%	89.9%	89.9%	89.9%	89.9%	89.9%	89.9%
Benchmark	98.8%	98.1%	98.5%	97.2%	97.4%	93.0%	95.2%	95.0%	96.3%	96.2%	98.9%	

MH SMD-1 Screening for Metabolic Disorders
(Q1 2017 – Q2 2019)



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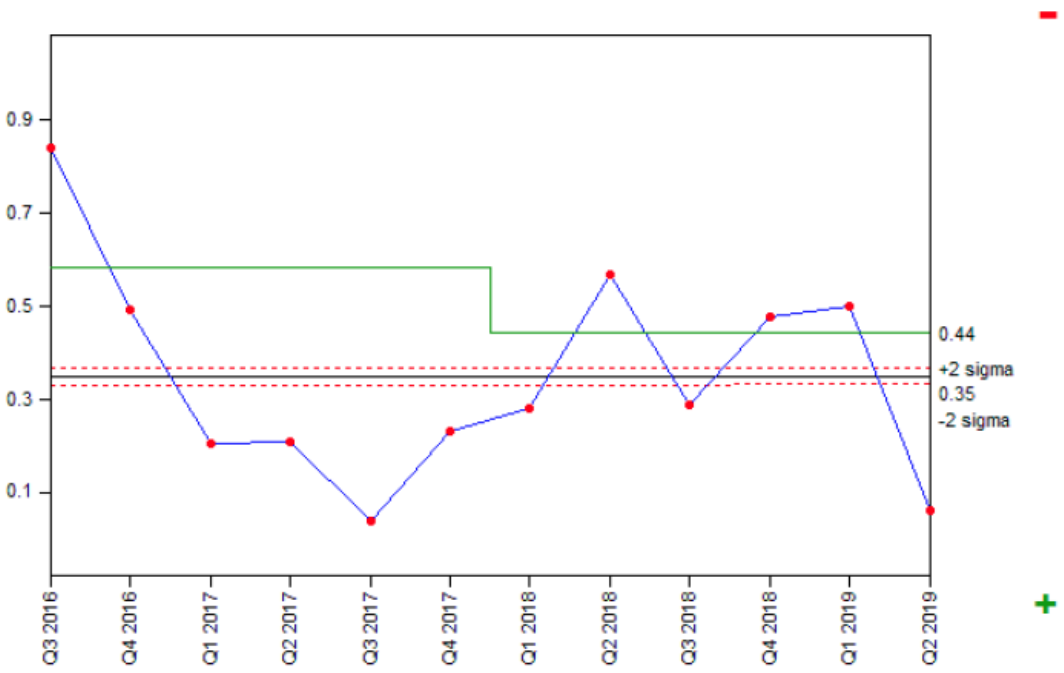
	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019
Numerator	118	75	89	91	90	92	100	91	99	61
Denominator	118	81	94	100	97	98	107	94	102	65
Rate of Compliance	100.0%	92.6%	94.7%	91.0%	92.8%	93.9%	93.5%	96.8%	97.1%	93.8%
Target	100.0%	100.0%	100.0%	100.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%

MH HBIPS-2a Hours of Physical Restraint Use / 1000 Patient Hours (Q3 2016 – Q2 2019)



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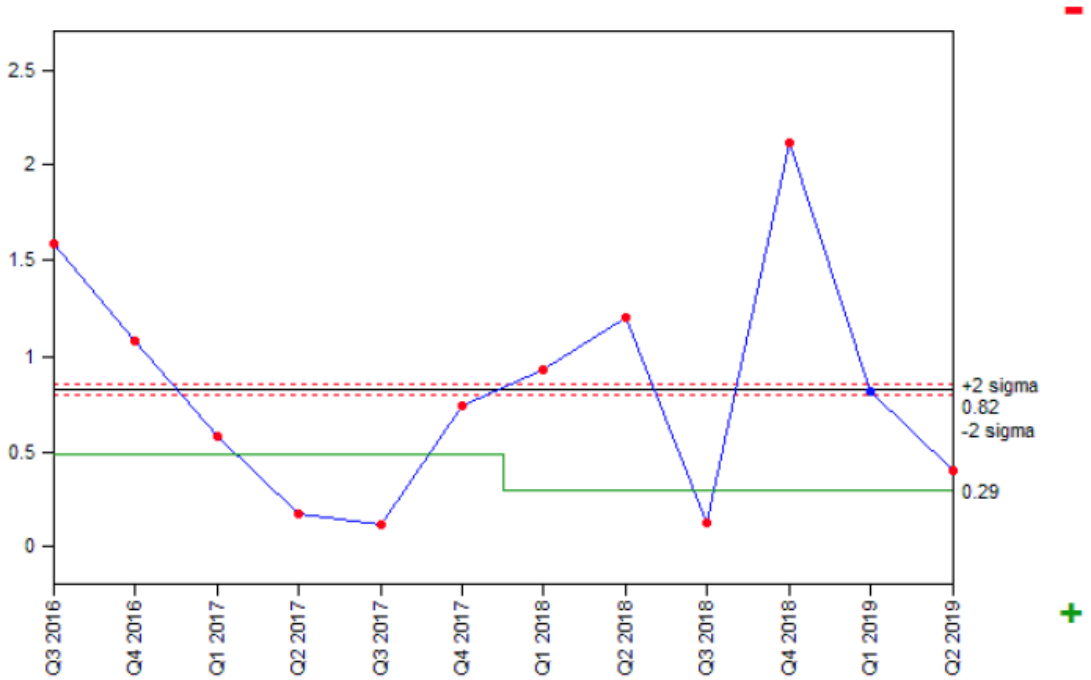
	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019
Numerator	3707	2160	853	878	154	996	1165	2424	1295	2190	2353	285
Denominator	4423	4397	4188	4256	4305	4332	4183	4280	4543	4615	4717	4850
Rate	0.84	0.49	0.20	0.21	0.04	0.23	0.28	0.57	0.29	0.47	0.50	0.06
Target	0.58	0.58	0.58	0.58	0.58	0.58	0.44	0.44	0.44	0.44	0.44	0.44

MH HBIPS-3a Hours of Seclusion Use / 1000 Patient Hours (Overall)
(Q3 2016 – Q2 2019)



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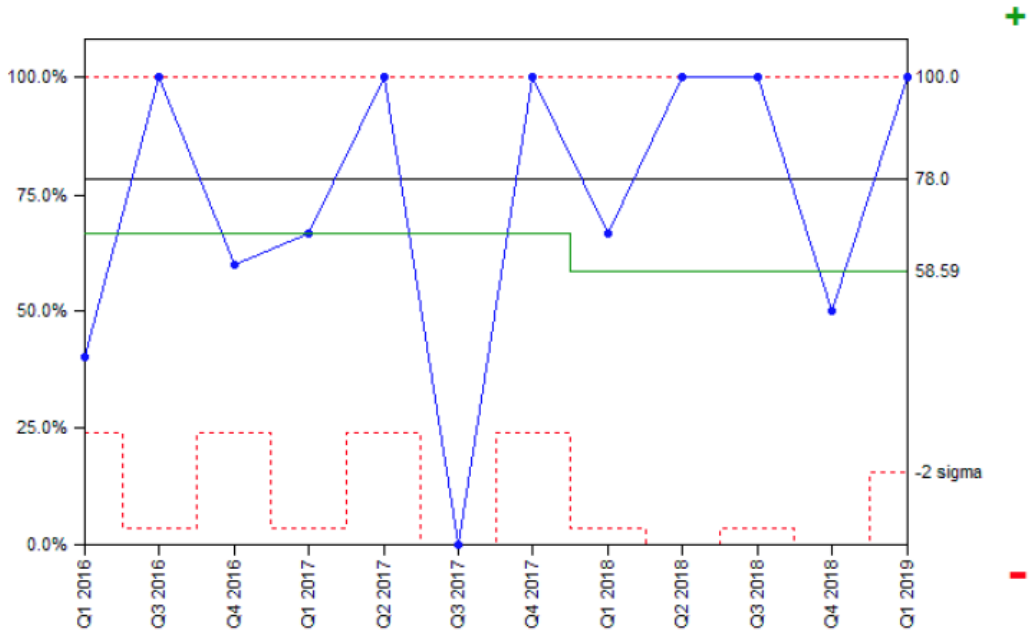
	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019
Numerator	7018	4739	2426	717	497	3204	3862	5117	565	9760	3844	1933
Denominator	4423	4397	4188	4256	4305	4332	4183	4280	4543	4615	4717	4850
Rate	1.59	1.08	0.58	0.17	0.12	0.74	0.92	1.20	0.12	2.11	0.81	0.40
Target	0.48	0.48	0.48	0.48	0.48	0.48	0.29	0.29	0.29	0.29	0.29	0.29

MH HBIPS-5a Patients D/C on Multiple Antipsychotic Meds with Appropriate Justification (Q1 2016 – Q1 2019)



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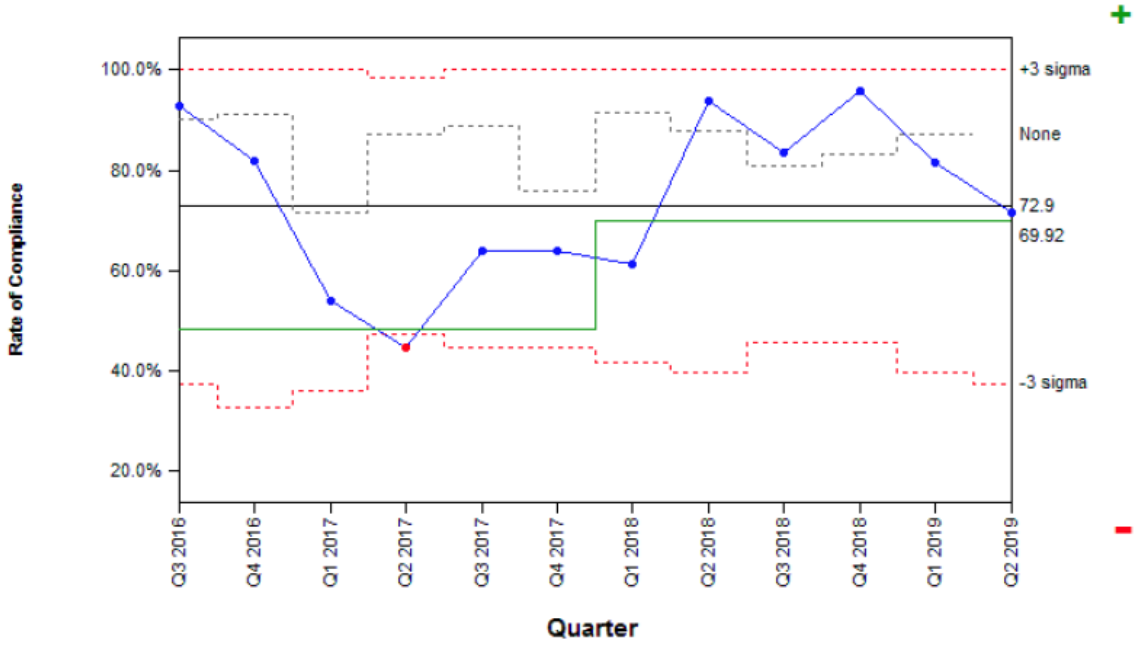
	Q1 2016	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019
Numerator	2	3	3	2	5	0	5	2	2	3	1	4
Denominator	5	3	5	3	5	1	5	3	2	3	2	4
Percent	40.0%	100.0%	60.0%	66.7%	100.0%	0.0%	100.0%	66.7%	100.0%	100.0%	50.0%	100.0%
Target	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	58.6%	58.6%	58.6%	58.6%	58.6%

MH SUB-2 Alcohol Use Brief Intervention Provided or Offered (Q3 2016 – Q2 2019)



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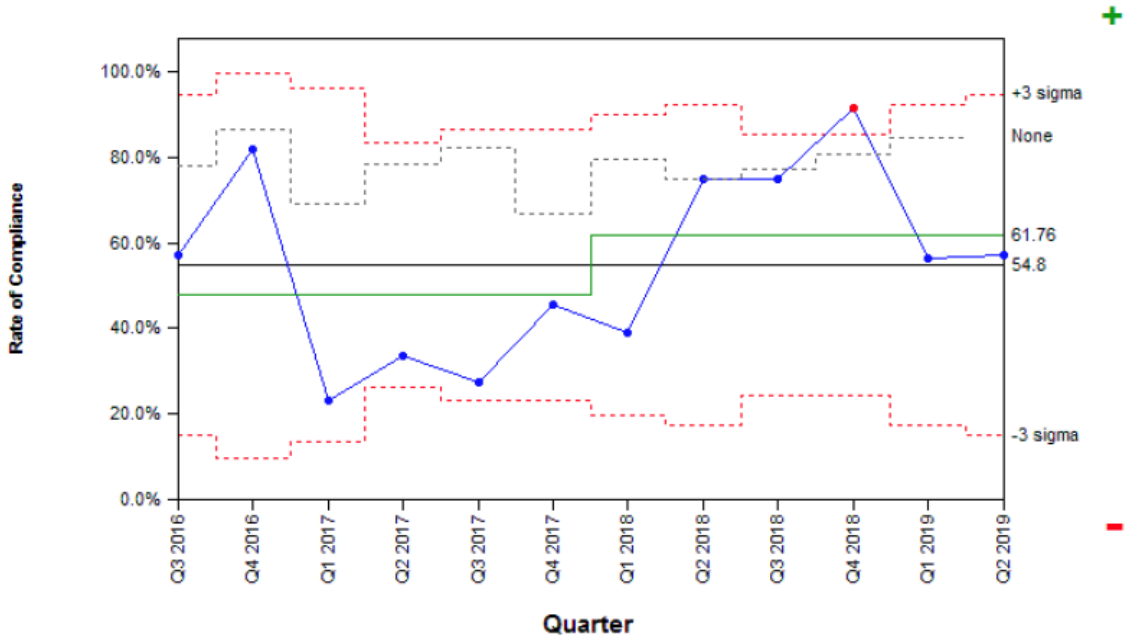
	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019
Numerator	13	9	7	12	14	14	11	15	20	23	13	10
Denominator	14	11	13	27	22	22	18	16	24	24	16	14
Rate of Compliance	92.9%	81.8%	53.8%	44.4%	63.6%	63.6%	61.1%	93.8%	83.3%	95.8%	81.2%	71.4%
Target	48.0%	48.0%	48.0%	48.0%	48.0%	48.0%	69.9%	69.9%	69.9%	69.9%	69.9%	69.9%
Benchmark	90.0%	90.9%	71.4%	87.0%	88.9%	75.7%	91.4%	87.9%	80.8%	83.1%	87.0%	

MH SUB-2a Alcohol Use Brief Intervention
(Q3 2016 – Q2 2019)



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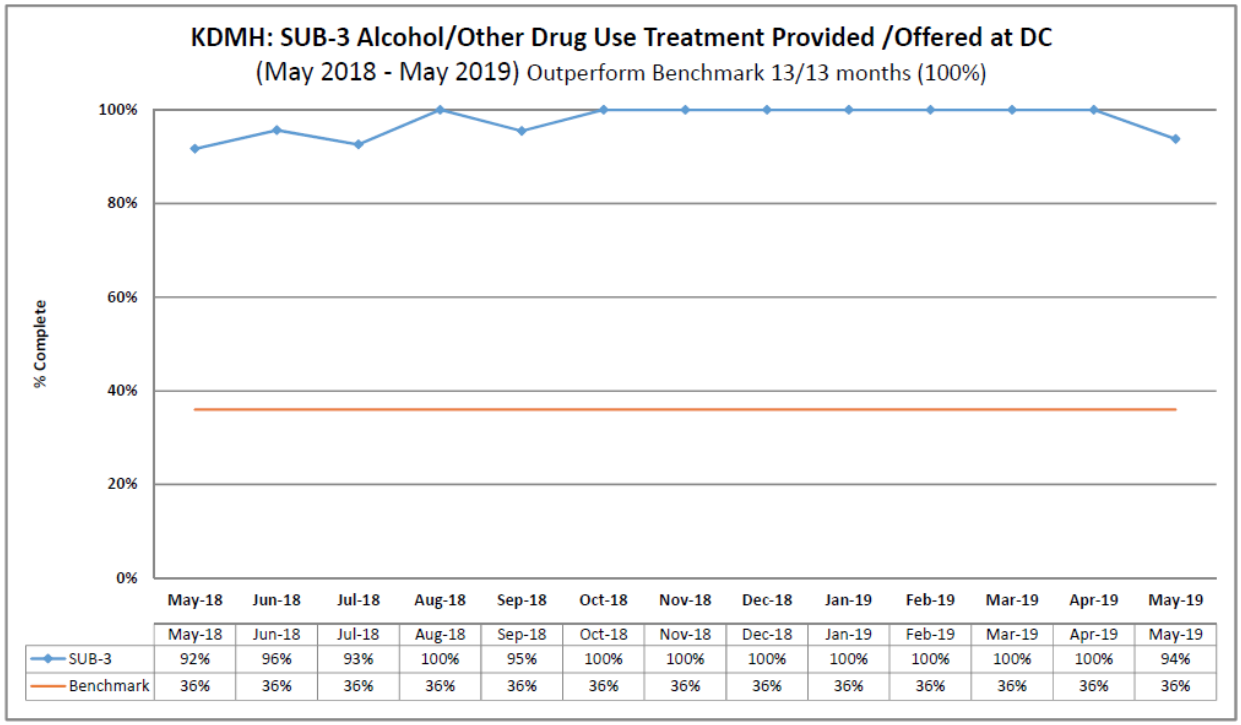
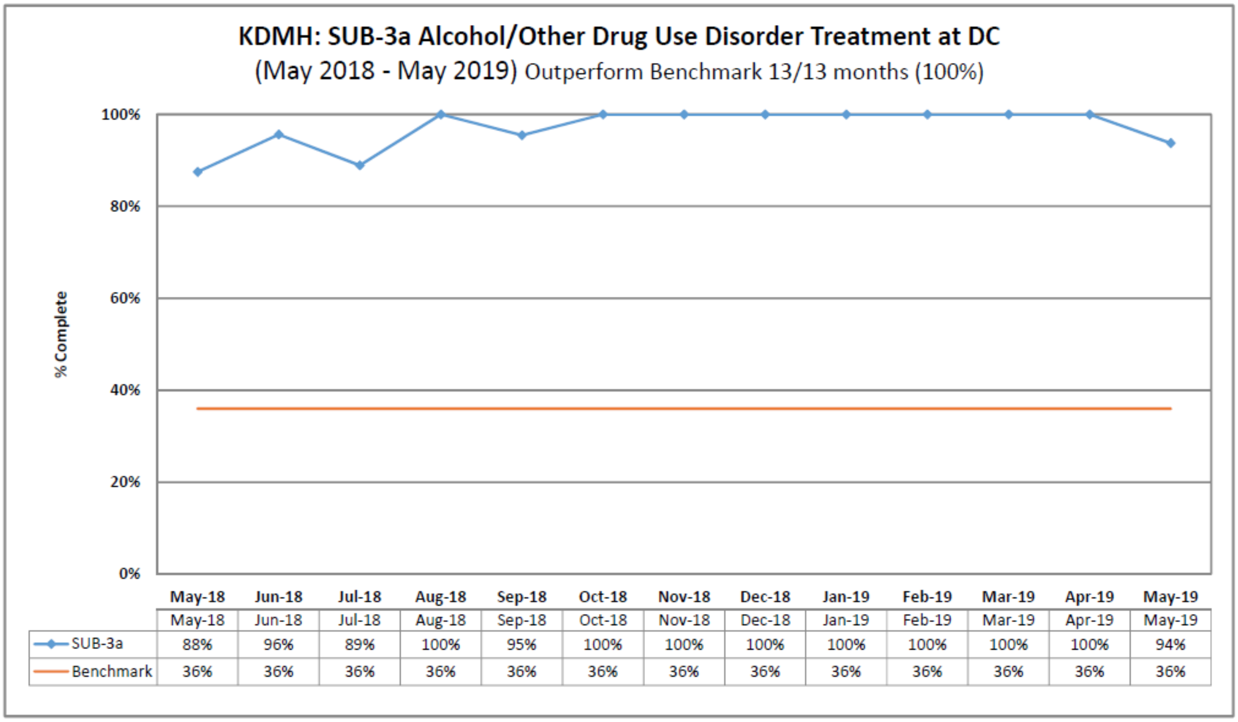
	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019
Numerator	8	9	3	9	6	10	7	12	18	22	9	8
Denominator	14	11	13	27	22	22	18	16	24	24	16	14
Rate of Compliance	57.1%	81.8%	23.1%	33.3%	27.3%	45.5%	38.9%	75.0%	75.0%	91.7%	56.2%	57.1%
Target	48.0%	48.0%	48.0%	48.0%	48.0%	48.0%	61.8%	61.8%	61.8%	61.8%	61.8%	61.8%
Benchmark	77.8%	86.4%	69.0%	78.3%	82.3%	66.7%	79.4%	75.0%	77.1%	80.8%	84.6%	

MH SUB-3 Alcohol/Other Drug Use Treatment Provided or Offered at D/C (May 2018 – May 2019)



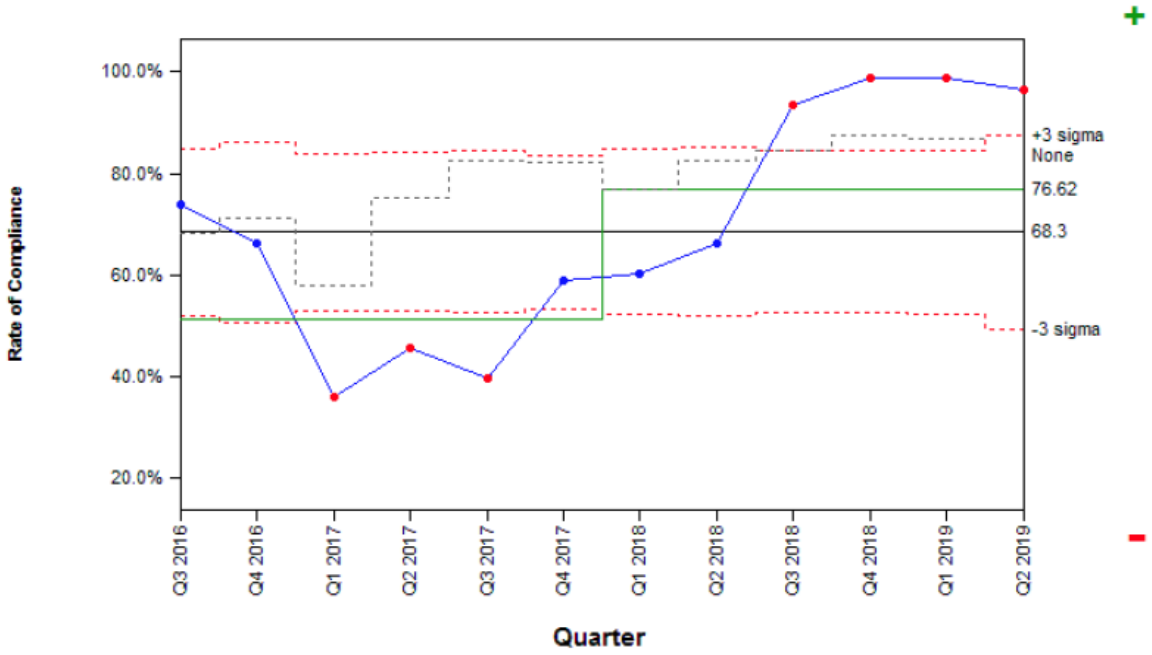
	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
SUB-3	92%	96%	93%	100%	95%	100%	100%	100%	100%	100%	100%	100%	94%
Benchmark	36%	36%	36%	36%	36%	36%	36%	36%	36%	36%	36%	36%	36%

MH SUB-3a Alcohol/Other Drug Use Disorder Treatment at D/C
(May 2018 – May 2019)



	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
SUB-3a	88%	96%	89%	100%	95%	100%	100%	100%	100%	100%	100%	100%	94%
Benchmark	36%	36%	36%	36%	36%	36%	36%	36%	36%	36%	36%	36%	36%

MH TOB-2 Tobacco Use Treatment Provided or Offered (Q3 2016 – Q2 2019)



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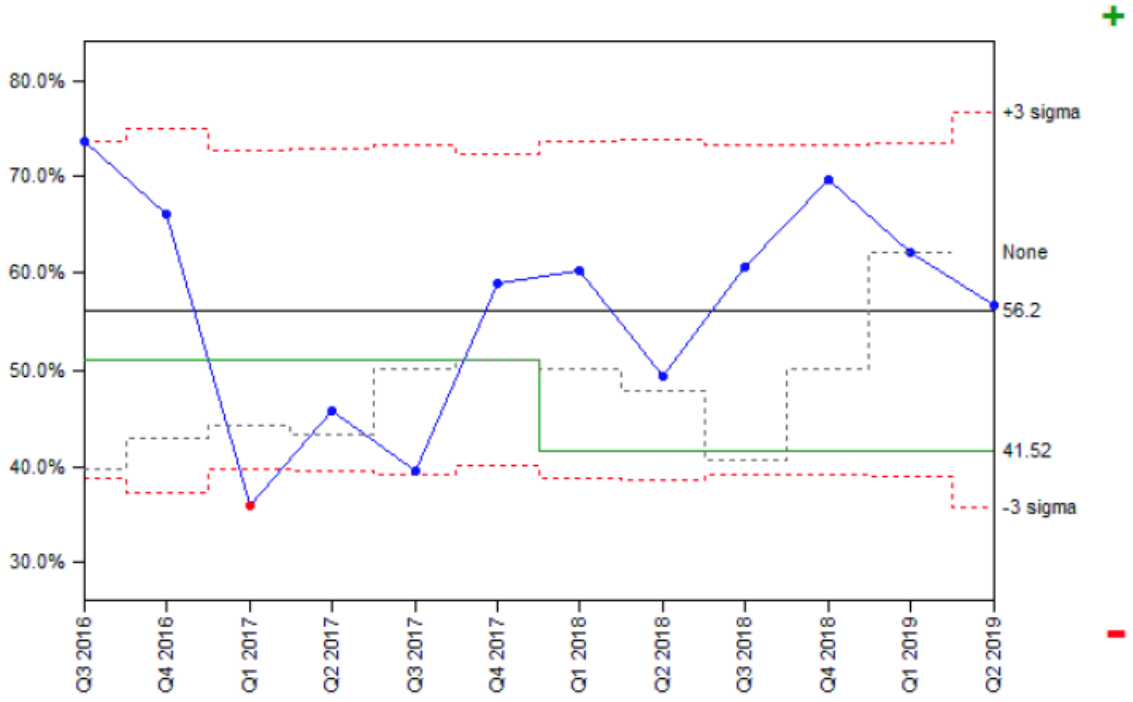
	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019
Numerator	53	41	29	36	30	50	44	47	71	75	73	51
Denominator	72	62	81	79	76	85	73	71	76	76	74	53
Rate of Compliance	73.6%	66.1%	35.8%	45.6%	39.5%	58.8%	60.3%	66.2%	93.4%	98.7%	98.6%	96.2%
Target	51.0%	51.0%	51.0%	51.0%	51.0%	51.0%	76.6%	76.6%	76.6%	76.6%	76.6%	76.6%
Benchmark	68.2%	71.2%	57.7%	75.0%	82.5%	82.1%	76.7%	82.3%	84.4%	87.3%	86.7%	

MH TOB-2a Tobacco Use Treatment
(Q3 2016 – Q2 2019)



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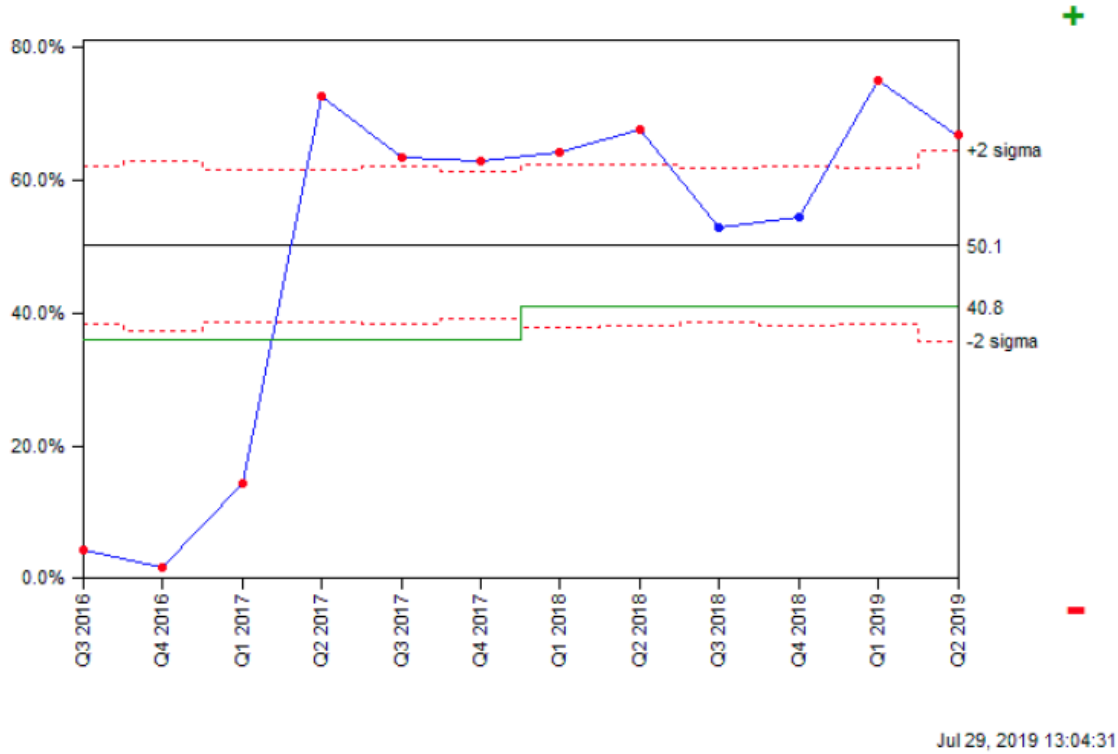
	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019
Numerator	53	41	29	36	30	50	44	35	46	53	46	30
Denominator	72	62	81	79	76	85	73	71	76	76	74	53
Percent	73.6%	66.1%	35.8%	45.6%	39.5%	58.8%	60.3%	49.3%	60.5%	69.7%	62.2%	56.6%
Target	51.0%	51.0%	51.0%	51.0%	51.0%	51.0%	41.5%	41.5%	41.5%	41.5%	41.5%	41.5%
Benchmark	39.6%	42.9%	44.2%	43.2%	50.0%	51.0%	50.0%	47.8%	40.6%	50.0%	62.2%	

MH TOB-3 Tobacco Use Treatment Provided or Offered at D/C (Q3 2016 – Q2 2019)



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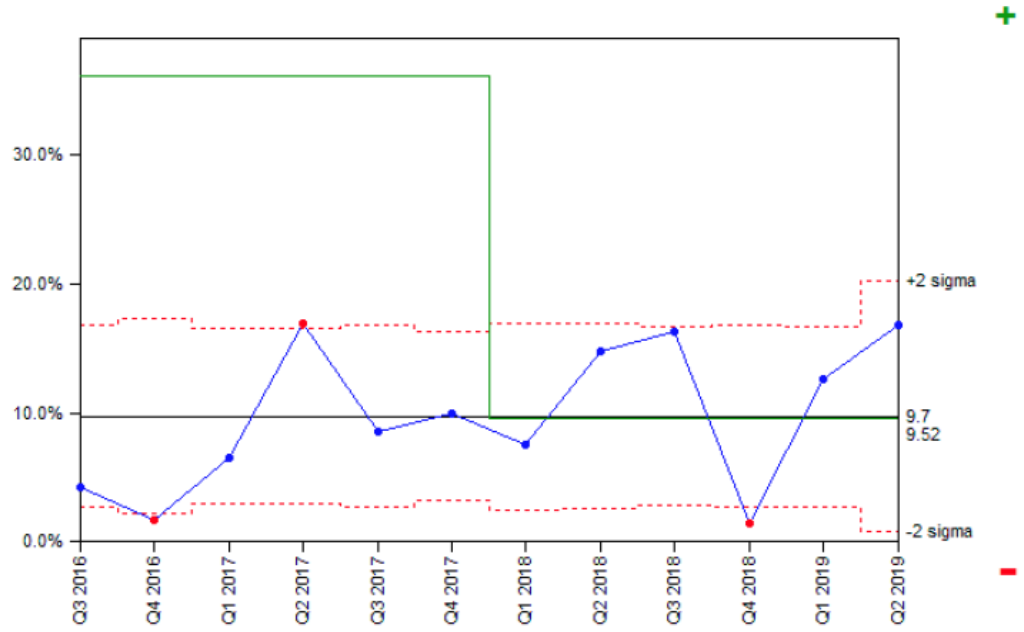
	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019
Numerator	3	1	11	56	45	51	43	46	39	38	54	32
Denominator	71	61	77	77	71	81	67	68	74	70	72	48
Percent	4.2%	1.6%	14.3%	72.7%	63.4%	63.0%	64.2%	67.6%	52.7%	54.3%	75.0%	66.7%
Target	36.0%	36.0%	36.0%	36.0%	36.0%	36.0%	40.8%	40.8%	40.8%	40.8%	40.8%	40.8%

MH TOB-3a Tobacco Use Treatment at Discharge
(Q3 2016 – Q2 2019)



Small Subgroup Size Adjusted

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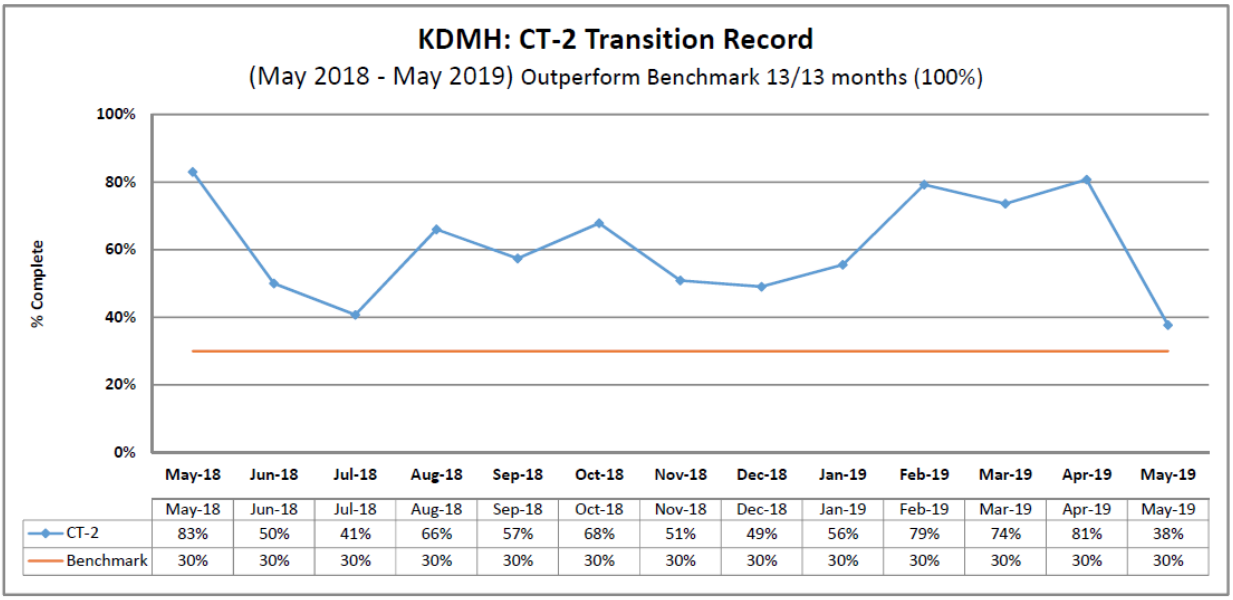
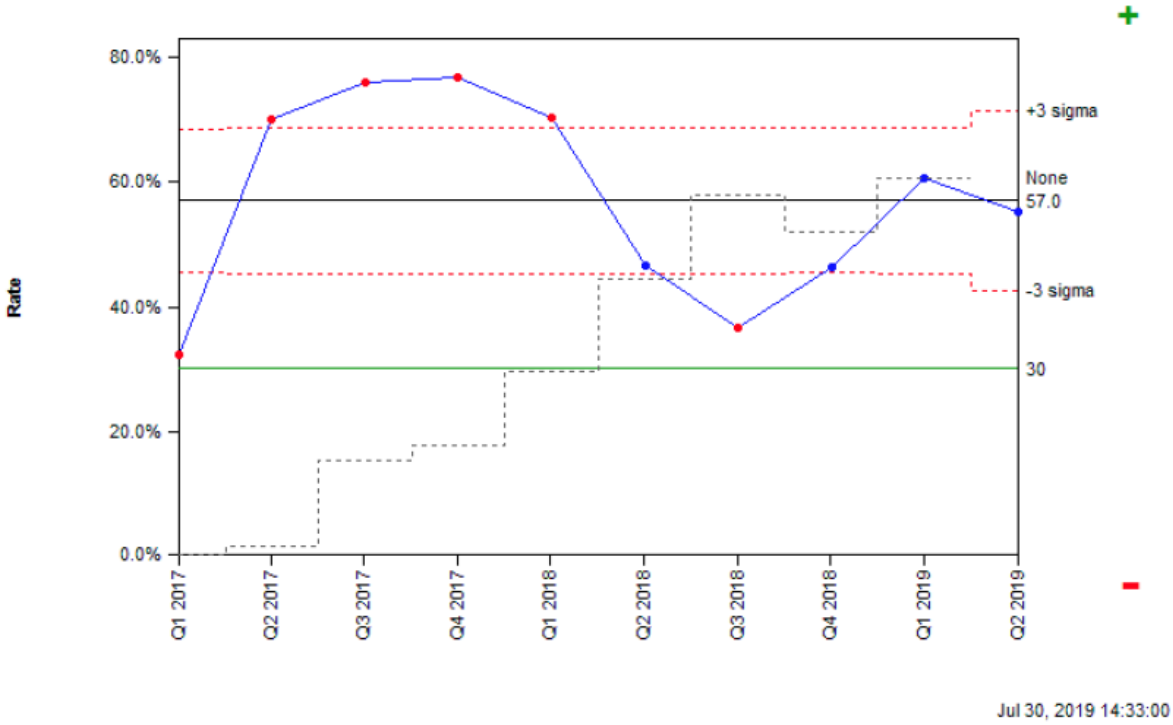
	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019
Numerator	3	1	5	13	6	8	5	10	12	1	9	8
Denominator	71	61	77	77	71	81	67	68	74	70	72	48
Percent	4.2%	1.6%	6.5%	16.9%	8.5%	9.9%	7.5%	14.7%	16.2%	1.4%	12.5%	16.7%
Target	36.0%	36.0%	36.0%	36.0%	36.0%	36.0%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%

MH CT-2 Care Transitions with Specified Elements Received by D/C Patients (May 2018 – May 2019)



	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
CT-2	83%	50%	41%	66%	57%	68%	51%	49%	56%	79%	74%	81%	38%
Benchmark	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%

MH CT-3 Timely Transmission of Transition Record
(Q1 2017 – Q2 2019)



	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019
Numerator	53	112	121	123	112	75	59	76	97	58
Denominator	165	160	159	160	159	161	161	164	160	105
Rate	32.1%	70.0%	76.1%	76.9%	70.4%	46.6%	36.6%	46.3%	60.6%	55.2%
Target	30.0%	30.0%	30.0%	30.0%	30.0%	30.0%	30.0%	30.0%	30.0%	30.0%
Benchmark	0.0%	1.4%	15.2%	17.7%	29.5%	44.5%	57.8%	51.9%	60.6%	

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Hospice **ProStaff Report Date: 07/15/2019**

Measure Objective/Goal:

Results of the Hospice Quality Measure of **"Getting Timely Help"** will meet or exceed the US national percent.

Date range of data evaluated:

The data displayed in Table 1 compares data currently posted on Hospice Compare; Hospice's most recent Press Ganey quarterly (Qtr. 1, 2019). Hospice CAHPS survey results for reporting period of 1/1/2019-3/31/2019 is listed in column 3 and shows a significant improvement in this score.

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

Hospices are required to participate in the Hospice CAHPS survey, which is a caregiver satisfaction survey mandated by CMS. Failure to participate in the survey will result in a 2% reduction in reimbursement. The primary caregiver information is submitted monthly to Press Ganey who sends the survey to the primary caregiver two months after the death of the patient. The survey recipient can respond any time up to 12 months after the survey has been received. Results are submitted by Press Ganey who submits it to CMS. CMS began posting survey results on the Hospice Compare website in Q4 2017. There is a lag time in the quarterly Press Ganey results and the data posted on Hospice Compare. Hospice has implemented interventions to improve the measure. Most recent quarterly Press Ganey results show a large improvement in overall results posted on Hospice Compare.

CAHPS Hospice Quality Measure: Getting Timely Help

Table 1.

Source	Current Hospice Compare	Hospice Compare Previewer Report	Press Ganey Quarterly Results
Reporting Period	07/01/2016 – 06/30/2018	07/01/2016 – 06/30/2018	01/01/2019 – 03/31/2019
Top Box Score : Response "always"	72%	72%	95 %
National Average	78%	78%	78%

This table displays "top box" scores, defined as the proportion of respondents who gave the most favorable response(s) for each measure.

Key findings:

As of quarter 1 of 2019 Kaweah Delta Hospice has exceeded the US National Percent in all 9 items measured. "Getting Timely Help" has improved significantly (see scores Table 2). Hospice Compare has not yet refreshed for the current time frame. The data will continue to lag behind current data found on Press Ganey site. The domain "Getting Timely Help" was selected as a new project because we met the US National Benchmark only one quarter in 2017. The domain includes two measures: 1) How often did you get the help you needed from the hospice team during evenings, weekends, or holidays; and, 2) When you or your family member asked for help from the hospice team, how often did you get help as soon as you needed it? Survey respondents can select "always", "usually", "sometimes", or "never". The top box score includes the percent who answered "always".

Opportunities:

There is still opportunity to improve this score. The goal is to get to the 99% or greater. A major component of hospice care is support of the patient and family. They are informed on admission that a registered nurse (RN) is available 24 hours a day, 7 days a week. Key opportunities to ensure the patient/family feel they receive timely care include:

- Consistent messaging and education on response times during business hours and after hours – all disciplines
    - Triage
    - Phone calls
    - Keep family informed if there is a delay
- Determine if referral sources have accurate information on response times
- Consistent messaging at end of visit
- Determine if staffing after hours and on weekends and holidays is adequate
    - Call volumes
    - Number of visits – days/nights
    - Census
- Determine if primary caregiver information is accurate to ensure survey is sent to the appropriate person
- Determine if patient and family are provided with an alternate phone number to use in the event PBX goes down
- Determine if PBX operators understand method and expected time frame to contact on call RN, as well as method to ensure message is received

The following Action Plan was instituted in response to previous low scores:

Mandatory education sessions were held in 2018 & 2019 including the following:

- Survey results
- A review of the Family and friends form is to be completed on admissions to ensure primary caregiver is identified and address and phone numbers are accurate – was implemented 2/2018
- Use of key phrases “scripting” for consistent messaging in major areas: response times and staff roles, providing consistent information, educating patients and families, and respect
- Best practices were implemented including: checking in with patient/family; always scheduling visit times (no drop-ins) and keeping patient/family informed if any delays; instructing family on what they can do until the nurse arrives; helping patient/family understand why they may see a different team member

Multiple measures were implemented to improve this indicator.

- Magnetic business cards with the hospice main telephone number and telephone number were created in English and Spanish. Each patient is given a magnet and instructed to display it where they will have quick access.

- Kaweah Delta Hospital PBX operators were educated on the afterhours/weekend process.
- The hospice director and PBX manager met and collaborated on improved "Administrator On Call (AOC)" system. This has since been revised and improved.
- Timeframe for patient callback was set at 15 minutes or less. If no callback in that time period the AOC is notified and follows up with the patient, and then the on-call nurse.
- The PBX operators have been educated on the new system and that when in doubt always call the AOC.
- Monitor quarterly survey vendor results (Press Ganey), which are reported to CMS quarterly – this is ONGOING
- The quantity of after-hours and weekend telephone calls and visits was evaluated. The volume of calls and visits supported a fulltime night nurse. This has been in place for 2 years.
    - Currently there is an RN on duty from 6pm-6am every night. If there is not an RN available for the 12 scheduled night shift, then a per diem nurse or full time RNs covers nights as an on-call status.
    - Evaluation also found that when census is high or if multiple admits occur on Thursday and Fridays, the 12 weekend RN could not cover all patient calls efficiently. A back-up (standby) nurse is available most weekends to provide help for the weekend RN staff so that visits are not delayed

Expected Resolution Date:

Quarter 1 of 2019 Results: 95%: Press Ganey survey results are more current and provide more "real time" measurements of improvement. Qtr. 2 results have not been posted yet.

Plan of action for 2019

- Continue the current staffing model. Evaluate and analyze data.
    - Addition of a part-time LVN has been added.
    - A back up nurse has been added when census is high or when high number of admissions have occurred later in the week.
    - All RNs are required to share in on call responsibilities providing less on call burden for case managers.
    - The admit nurse position has been transitioned to a float RN and all staff cross-trained to admissions and on call.
- Families are reminded that there is a nurse on call 24 hours a day 7 days a week. They have been instructed to call the back up emergency line if the nurse has not called back in 15 minutes.
- Change in scripting: Offer a visit every time a family calls to report issues.

Next Steps/Recommendations/Outcomes:

- Continue to monitor and analyze over the next 3 quarters to confirm improvement is sustained.

Table 2

Hospice CAHPS Quarterly Scores by Category 2019

Domain Question	Q1		
	% Score	n	%ile Ranking
1.Rate Hospice *Response: 9-10*	▲100.0%	20	99
2. Recommend the Hospice Care *Response: Definitely Yes*	▲100.0%	20	99
3. Getting Timely Care *Response: always* • Hospice team help after hours • Help as soon as needed	▲95.0%	20	99
4. Hospice Team Comm *Response: always* • Kept informed about care arrival • Explain in way you understand • Kept informed about care • Given confusing info re: care • Listen carefully re: care problems • Listen carefully to you	▲ 94.2%	20	99
5. Treating Family with Respect *Response: always* • Treat patient with dignity/respect • Really cared about patient	▲ 97.5%	20	98
6. Getting Help for Symptoms *Response: Yes, definitely/Always* • Get as much help w/ pain as needed • Get help for trouble breathing • Help for trouble with constipation • Helped with anxiety or sadness	▲ 90.5%	16	99
7. Getting Hsp Care Training *Response: Yes, definitely* • Discuss pain med side effects • Identify pain med side effects • Info re: if/when to give pain med • Train to help trouble breathing • Train to help restless or agitated	▲ 90.3%	19	99
8. Additional Rating Questions *Response: Top Box* • Train to safely move • Info re: what to expect while dying • Nursing home/hospice work together • Nursing home/hospice info different	▲ 86.2%	20	99
9. Getting Support Rel/Emot *Response: right amount* • Religious/spiritual beliefs support • Emotional support received • Emotional support after death	▼ 91.1%	20	99

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Measure Objective/Goal:

Results of the Hospice Quality Measure of **"Getting Support Relative/Emotion "** will meet or exceed the US national percent (90%). The current score is 91.1% which exceeds the national average but is a drop in score from 94.9%

Date range of data evaluated:

Hospice's most recent Press Ganey quarterly (Qtr. 1, 2019) survey results are reflective of the period from 1/1/2019-3/31/2019.

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

There has been a decrease in the score for providing emotional and spiritual support. Although there was no clear cut reason for the drop in survey results, based on Hospice has implemented interventions to improve the measure. Discussion at staff meetings and with Quality coordinator did not show a definitive cause of this drop. Among the possible causes discussed high number of patients who decline the social worker and spiritual care counselor. Late referrals to hospice. The adult population has a very short length of stay sometimes only hours or days after admit to hospice. The family lives in other cities and are not always available to receive support as needed.

Key findings:

There has been a 3.8% decrease in survey scores for "Getting Support Rela. to Emotional". This measure includes getting emotional and spiritual support. As of quarter 1 of 2019 Kaweah Delta Hospice has exceeded the US National Percentage in all 9 items measured. While 91.1% exceeds the national percentage, any drop in scores is analyzed for opportunities for improvement.

Opportunities:

There is opportunity to improve this score. The goal is to get to the 99% or greater. A major component of hospice care is to provide emotional and spiritual care for patients and their families. Although no clear cut cause could be found for this decrease in satisfaction, a thorough discussion was held with social workers and spiritual care counselors. Last year the process for introducing the different team members was implemented in an attempt to overcome the local trend of refusing social worker (SW), spiritual care counselor (SCC) and hospice aide (HHA).

The following Action Plan was instituted 2018:

Changes were implemented in how the team was introduced to the patient. Detailed information was deleted from the admission process and a brief description of the hospice team. Scripts were prepared and discussed with the SW and SCC.

- In the past the admission nurse talked to patients and families about each discipline that made up the hospice team. This was a detailed discussion/explanation of the role each team member. An increasing trend was noted that a significant number of patients were declining the SW and SCC members.

- As a result of discussion at the quality meetings, it was decided that the admission nurse would only mention that the patient would get a call from other team members to explain the services each could provide.
- The script included that patients would get a call from each member of the team to share their services but that the patient could opt out at the time of admission.
- Therefore, the MSW, and SCC would call the patient and introduce themselves.
- At this point the scripting has been changed. The admit nurse, SW, and SCC will state that they will be making one visit to introduce themselves.
- It will be up to the patient whether they have regular visits or decline their services.

Expected Resolution Date:

Expected resolution is Quarter 3 of 2019. The goal is for improvement each quarter with a 95% or higher.

Plan of action for 2019

- Test new scripting
- The admission nurse will recommend one visit from each team member in person within the first 5 days or per pt. request.
- Opting out at admission to hospice will not be mentioned
- A phone call will be made by each team member to chat and to set up the appt. Patients will be encouraged to meet the team members at least once.

Next Steps/Recommendations/Outcomes:

- Continue to monitor and analyze over the next 3 quarters to establish prolonged improvement. If no improvement, then form a team to discuss and implement a new action plan.

Submitted by Name: **Date Submitted: 7/15/19**

Lizabeth McClain, MSN, RN
Director of Hospice Services

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department:
Home Health

ProStaff/QIC Report Date:
July, 2019

Measure Objective/Goal:

Improvement in Ambulation – How Often Patients Got Better at Walking or Moving Around

- **Latest CMS Star Rating Home Health Score: 68.6%**
- **Latest CMS Star Rating National Middle Score: 74.8%**
- **KDHH Home Health Gold Score: 68%**

***Home Health Gold (HHG) is a private vendor with up-to-date data that should forecast Star Report data. [The Improvement in Ambulation measure is risk-adjusted on the 5-Star Report. HHG results are not yet risk-adjusted. These results are then typically lower than Star Report results, but are true reflections of the projection of the measure.]**

Date range of data evaluated:

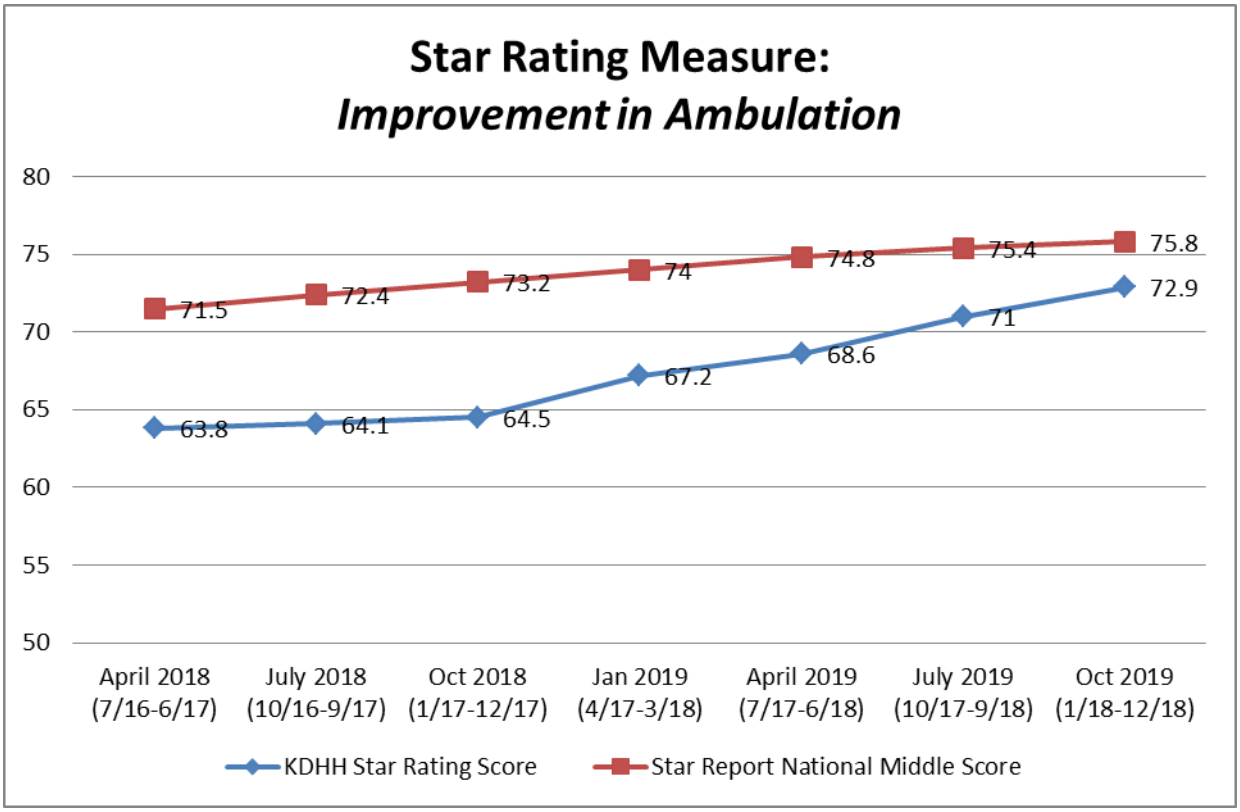
CMS Star Ratings Report: January 1, 2018 through December 31, 2018
Home Health Gold: August 2018 through July 2019 to date

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

--The clinician must take into account multiple factors when determining the patient's ability to ambulate, and what level of assistance they require to do so safely. The clinician needs to take adaptive methods, assistive devices, and MD ordered restrictions into account. They should consider all aspects of safety, whether or not required assistance is available, either from caregiver or from a device. They must utilize their professional, clinical judgement when determining what level the patient can perform at and truly be safe.

--A patient that "stabilizes" (has the same score from Start to Discharge) counts negatively in this measure. Many times clinicians were not counting *supervision* or *stand by assist* as "needing assistance to ambulate safely" and they were scoring the patient as having a higher level of function at Start of Care. Many new home health patients require this level of assistance at Start, but hopefully require less assistance as they improve and get stronger through the home health episode.

--There has been a notable difference in the way nursing staff perceives a patient's ability versus a therapy assessment. Many times nursing staff has commented that they feel hesitant to score a patient lower due to perception that lack of safety is the clinician's responsibility.



<u>If improvement opportunities identified, provide action plan and expected resolution date:</u>

--Continue Start of Care (SOC) and Discharge audit efforts to check for discrepancies between how OASIS was answered versus what clinicians documented.

--Comparison of OASIS ADL/mobility answers to documentation of therapy notes after nursing SOC and upon discharge of all disciplines. Utilize the "5 Day Rule" that if additional assessments by qualified clinicians are performed within 5 days of the OASIS assessment, these can be used to support changes in how the OASIS question is answered, if appropriate. This is done by both returning chart to clinician if the chart is from a Start of Care, and consulting clinician directly by email or verbally if regarding a discharge. Both are done prior to the deadline for OASIS data submission of the chart.

--Continue to emphasize evaluating safety and differentiating between patient willingness or non-compliance versus actual ability.

--OASIS was revised in January 2019 to include a "Section GG" that contained additional questions that intensified the focus on the patients' ability to perform more specific tasks than those previously identified. We began to notice a downward trend in our ambulation scores after these new questions were added. This could possibly be due to auditing focus on this new section, and less attention to the general ADL section that drives our Star Rating. It was determined that we should be utilizing the new GG section to guide general ADL answers. Although the GG OASIS currently does not directly relate to the

Star Rating, we should be using it to help validate functional status scoring indicating that the patient needs more assistance.
--We must verify that all ADL answers correlate, and that there is adequate documentation to support how they are answered.
-- Staff are encouraged to utilize initiating therapy referrals, if not initially ordered, to ensure that the patient is able to achieve maximum functional ability by time of discharge.
--Direct auditor consultation with assessing clinician if there is a lack of information or discrepancies.
--We encourage the continued use of PPS Plus analysis software. This allows assessing clinicians to have real-time chart reviews to identify areas of concern/discrepancy and increased scrutiny in the way OASIS questions were answered prior to completion of the chart.
--We are planning to have some HH Therapy staff conduct an in-service to HH Skilled Nursing Staff on how to efficiently and thoroughly conduct a functional assessment in the home and how it relates to scoring OASIS ADL and "GG" questions. This will occur in August 2019.

Next Steps/Recommendations/Outcomes:

This measure has been an ongoing action item for over a year. Ratings data does show that, based on our efforts, we are continuing to improve and it should be reflected on future Star reports. We will continue to monitor and provide proactive, in-the-moment teaching opportunities until benchmark goals have been achieved or exceeded for three or more reporting cycles.

Submitted by Name:	**Date Submitted:**
Allison Carey, RN	**July 11, 2019**

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

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

Home Health **July, 2019**

Measure Objective/Goal:

Unplanned Hospitalization During the First 60 Days of Home Health

- **Latest CMS Star Rating Data Home Health: 13.6%**
- **Latest CMS Star Rating National Average Data: 15.1%**
- **Kaweah Delta Home Health Gold Score: 14% (current data 8/18 - 7/19)**

***Home Health Gold (HHG) is a private vendor with up-to-date data that should forecast 5-Star data. [This measure is risk-adjusted on the 5-Star Report.]**

Date range of data evaluated:

CMS 5Star Report: January 1, 2018 through December 31, 2018
Home Health Gold: August 2018 through July 2019 to date

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

--Our Star Rating scores for hospital admissions within the first 60 days of home health services show consistently lower than the national average. Adjusted Group Rating values for those measures for which we are better than the National Average are generally 3.5 or higher. Our Adjusted Group Rating value for Acute Care Hospitalizations has maintained at 3.0. Home Health would like to reduce the rate of hospitalizations even further to try to increase the Adjusted Group Rating to 3.5 or 4.0, and thus help improve our overall 5-Star Rating.

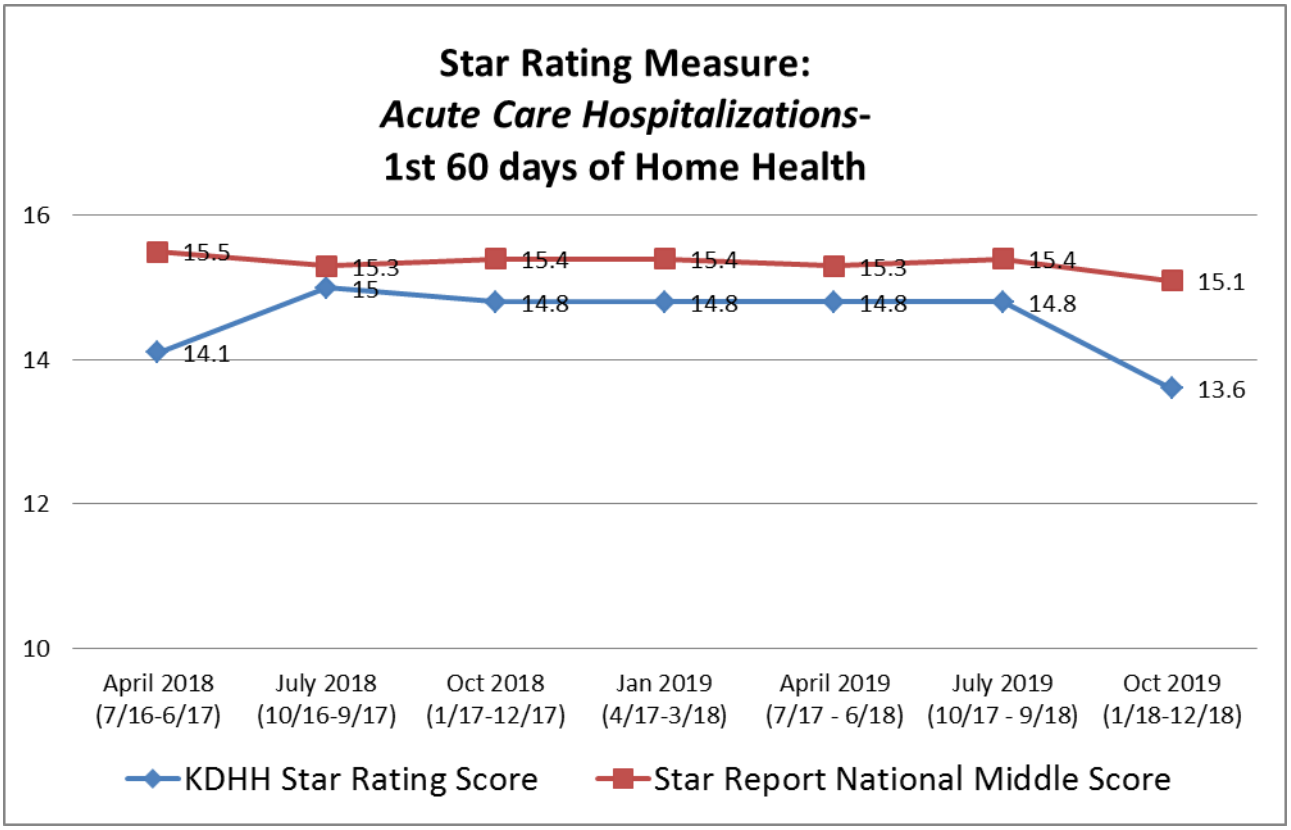
--We can track all patients that are hospitalized while on service with the agency using the Home Health Gold program and conducting chart reviews on each case. It is our goal to conduct individual case reviews daily.

--Individual chart reviews provide pertinent information to identify possible trends and areas of potential intervention. The focus is to determine whether the reason for hospitalization is related to why the patient is on service with the HH agency, and was it preventable.

--Reviews over the past 4 months have identified that the more prevalent reasons for acute care admission include those related to falls in the home, wound infection and failed outpatient antibiotic therapy, complications related to active cancer diagnoses, issues related to electrolyte imbalances/dehydration, and cardiac complications. Other areas of concern are uncontrolled pain, pneumonia, and exacerbations of both CHF and COPD.

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee



<u>If improvement opportunities identified, provide action plan and expected resolution date:</u>

-- Manual data collection and Home Health Gold data has shown that a majority of acute care admissions occur within the first 30 days of the Home Health episode.

--We also look for documentation on recent home visits to determine if the patient presented with any signs or symptoms of the potential for ER use/hospital admission and what actions were taken by HH staff if indicated. Documentation of patient compliance and HH clinician interventions are reviewed.

--Clinicians involved in the case are personally contacted by the reviewer if discrepancies or areas of concern arise to provide feedback and education.

--Clinicians of all disciplines have been encouraged to "front-load" the frequency of revisits during the first 2 weeks of service to allow for more frequent assessments, medication reconciliation and teaching, evaluating patient compliance and understanding of primary diagnoses, and providing caregiver support.

--Clinicians are required to complete assessment tools to screen for those patients that are at higher risk for ED use and/or hospitalization with every Start of Care, Resumption of Care, and 60 Day Recertification assessment on every patient. Additional risk screenings are Fall risks, Depression, Home Oxygen and Fire Safety. Any area that is identified as high risk must be included in the patient's Plan of Care.

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

--The Plan of Care must include interventions related to patient/caregiver education and disease management, especially focusing on primary diagnoses.
--Clinicians are to ensure that each patient has an appointment with their Primary Care Provider after Start of Care, and is compliant with follow up appointments.
--If consistent trends are identified, these will be presented to the HH UBC and/or staff meetings for collaboration, potential trouble shooting, or recommendations of action plans.

Next Steps/Recommendations/Outcomes:

It would be ideal to significantly reduce the frequency of hospital admissions not only for improving scores, but for the overall benefit to the health and wellbeing of the patient. We will continue to track our CMS Star Ratings for 60 Day re-admissions when they are released quarterly. Home Health Gold will be used to track those patients who are placed on a "transferred status" when care is transferred from the agency to an acute care facility. It is the expectation that the Home Health educator, or designee, will conduct chart reviews daily to determine the reason for hospital admission and the length of time from HH admission to transfer, as well as other key elements regarding the patients' health status prior to admit. It is our goal that the average percentage of patients admitted to a hospital during their first 60 days of Home Health services will be less than 10%. We will continue intensified monitoring of this until our goal is sustained for 3 or more reporting cycles.

Submitted by Name: **Allison Carey, RN**

Date Submitted: **July 11, 2019**

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department:
Home Health

ProStaff/QIC Report Date:
July, 2019

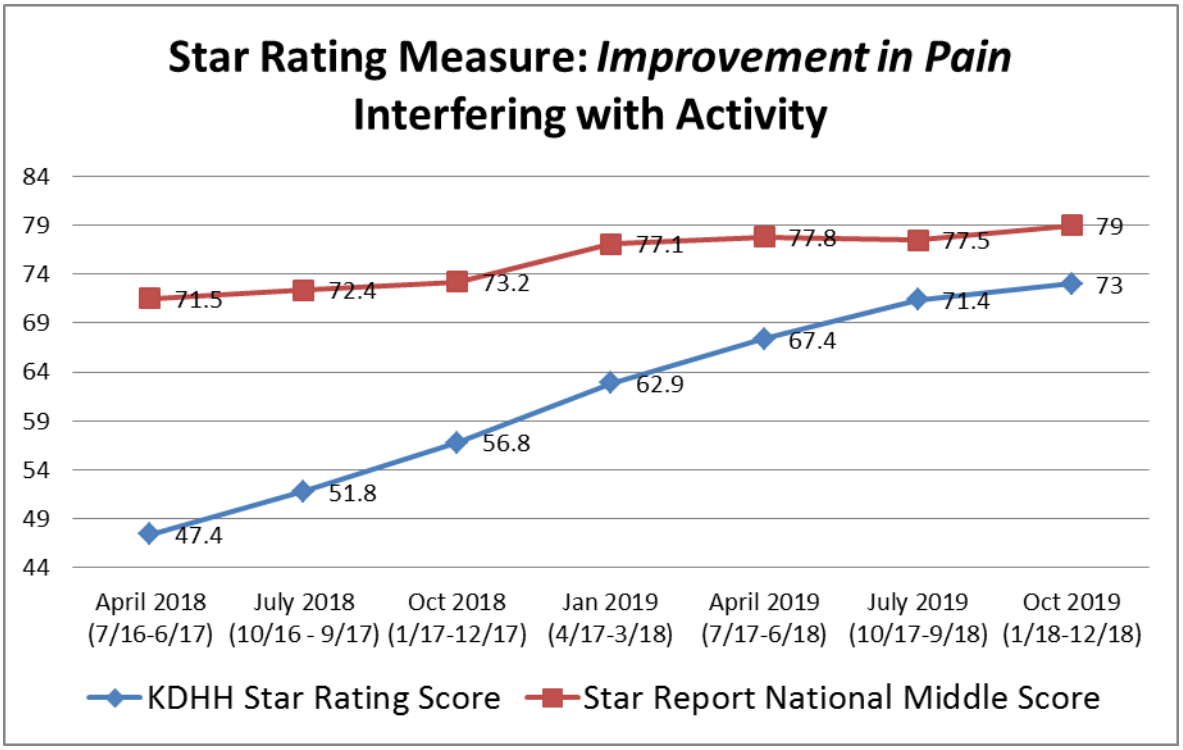
Measure Objective/Goal:
Improvement in Pain Interfering with Activity

- **Latest CMS Star Rating Home Health Score: 73%**
- **Latest CMS Star Rating National Middle Score: 79%**
- **KDHH Home Health Gold Score: 73%**

***Home Health Gold (HHG) is a private vendor with up-to-date data that should forecast Star Report data. [The Improvement in Ambulation measure is risk-adjusted on the Star Report. HHG results are not yet risk-adjusted. These results are then typically lower than Star Report results, but are true reflections of the projection of the measure.]**

Date range of data evaluated:
CMS Star Ratings Report: January 1, 2018 through December 31, 2018
Home Health Gold: August 2018 through July 2019 to date

Analysis of all measures/data: (Include key findings, improvements, opportunities)
--After open discussions with home health clinicians, it was determined that the majority of staff were interpreting the question as whether or not the patient had pain in general. Their focus was not on the sole idea that they were only to address how frequently any pain interfered with the patients' ability to perform activities. The OASIS question is not asking how frequently the patient has pain, but how frequently it *interferes*.
--The Crescendo documentation system that Home Health uses will sometimes "auto-fill" some OASIS answers based on assessment data and previous assessments. Many times the system kept the same selection as it was answered on Start of Care when filling in the answer on Discharges. Direct discussion with the clinicians if the chart did not show improvement at discharge often times would reveal that the patient did, in fact, have a decrease in the frequency that pain interfered with activity.
--If pain was documented, auditors will ensure that interventions regarding pain management are in the Plan of Care. This should prompt all clinicians involved in the patients care to thoroughly assess for pain and be proactive in managing the patients' pain to a tolerable level.



<u>If improvement opportunities identified, provide action plan and expected resolution date:</u>
-- Continue Start of Care and Discharge audits to check for discrepancies between how OASIS question was answered versus what clinicians documented.
--Staff is encouraged to include pain management in the patient's Plan of Care for any patient that reports their pain interferes with activities, even if minor. Previously, some clinicians would assess pain, but not include interventions in the plan of care if the patient's pain was not rated as "severe".
--Auditors will consult with clinicians after auditing process has identified areas of concern: discrepancy between charting and the way OASIS was answered, clarification of clinicians' understanding of the question and intent of answer, lack of supportive charting, and/or need for interventions regarding pain management in the MD ordered Plan of Care. This is done by both returning chart to clinician if regarding a Start of Care, and consulting clinician directly by email or verbally if a discharge record. Both are done prior to the deadline for OASIS data submission of the chart.
--The clinicians can use PPS Plus system analysis software. This allows assessing clinicians to have real-time chart reviews to identify areas of concern/discrepancy and increased scrutiny of the way OASIS questions were answered prior to completion of the chart.

--Review of current HHG data with all clinicians at monthly staff meetings. Reinforcement of emphasis regarding intent of the question and common potential factors that impact pain management.
--Ensuring appropriate PT/OT referrals to address impact on functional activity and adaptive methods to help manage pain.
--Whole staff education in July, reminding that time frame of the pain assessment is only the day of assessment and recent pertinent past. Pain that was reported outside of that time frame is not relevant when answering how frequently it would interfere with activities.
--Staff are encouraged to verify coding of chronic pain conditions that may impact patient's ability to improve.

Next Steps/Recommendations/Outcomes:
This measure has been an ongoing action item for more than a year. In the past year we have seen our agency score increase from 47% to 73%, while the National Average has increased from 71% to 79%. HHG shows that we continue to improve in this area, and thus, this increase will eventually be reflected on future 5 Star reports. We will continue to monitor, analyze data, provide in-the-moment teaching opportunities, and track progress until benchmark goals have been achieved or exceeded for three or more reporting cycles.

Submitted by Name:
Allison Carey, RN

Date Submitted:
July 11, 2019

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

		Measure Score Cut Points by Initial Decile Rating							
1	Initial Group Rating	Measure 1. Timely Initiation of Care	Measure 2. Improvement in Management of Oral Medications	Measure 3. Improvement in Ambulation	Measure 4. Improvement in Bed Transferring	Measure 5. Improvement in Bathing	Measure 6. Improvement in Pain Interfering with Activity	Measure 7. Improvement in Dyspnea	Measure 8. Acute Care Hospitalization
2	0.5	0.0-82.6	0.0-43.5	0.0-57.0	0.0-53.6	0.0-55.8	0.0-53.9	0.0-49.6	19.6-100.0
3	1.0	82.7-89.0	43.6-52.6	57.1-65.0	53.7-62.8	55.9-65.5	54.0-64.4	49.7-62.2	17.9-19.5
4	1.5	89.1-92.4	52.7-58.5	65.1-70.0	62.9-68.7	65.6-70.9	64.5-70.6	62.3-69.7	16.8-17.8
5	2.0	92.5-94.8	58.6-62.8	70.1-73.2	68.8-72.6	71.0-74.8	70.7-75.4	69.8-74.2	15.9-16.7
6	2.5	94.9-96.3	62.9-66.0	73.3-75.7	72.7-75.5	74.9-77.9	75.5-79.0	74.3-77.9	15.1-15.8
7	3.0	96.4-97.4	66.1-68.9	75.8-78.0	75.6-77.8	78.0-80.5	79.1-82.4	78.0-80.9	14.4-15.0
8	3.5	97.5-98.3	69.0-72.1	78.1-80.5	77.9-80.3	80.6-83.2	82.5-85.9	81.0-83.7	13.5-14.3
9	4.0	98.4-99.0	72.2-76.1	80.6-83.7	80.4-83.1	83.3-86.4	86.0-89.7	83.8-86.7	12.3-13.4
10	4.5	99.1-99.6	76.2-82.2	83.8-88.1	83.2-87.6	86.5-91.0	89.8-94.5	86.8-90.8	10.4-12.2
11	5.0	99.7-100.0	82.3-100.0	88.2-100.0	87.7-100.0	91.1-100.0	94.6-100.0	90.9-100.0	0.0-10.3
12	Your HHA Score	97.9	69.4	72.9	83.3	80.8	73.0	82.5	13.6
13	Your Initial Group Rating	3.5	3.5	2.0	4.5	3.5	2.0	3.5	3.5
14	Your Number of Cases (N)	1,861	1,085	1,292	1,176	1,383	1,096	697	731
15	National (All HHA) Middle Score	96.4	66.0	75.8	75.6	78.0	79.0	78.0	15.1
16	Your Statistical Test Probability Value (p-value)	0.000	0.009	0.008	0.000	0.005	0.000	0.002	0.154
17	Your Statistical Test Results (Is the p-value < 0.050?)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
18	Your HHA Adjusted Group Rating	3.5	3.5	2.0[2]	4.5	3.5	2.0[2]	3.5	3.0

19	Your Average Adjusted Rating	3.2
20	Your Average Adjusted Rating Rounded	3.0
21	**Your Quality of Patient Care Star Rating (1.0 to 5.0)**	**★★★½ (3.5 stars)**

[1] *OASIS and claims data from January 1, 2018 to December 31, 2018*

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

Kaweah Delta Home Health
08/01/2018 to 07/11/2019
Current Payor=MCR/MCR-HMO/MCD/MCD-HMO

	Agency
*** MANAGING DAILY ACTIVITIES ***	
How often patients got better at walking or moving around. (5-star, VBP)	68% (Met - 969 / Not Met - 442)
How often patients got better at getting in and out of bed. (5-star, VBP)	68% (Met - 885 / Not Met - 392)
How often patients got better at bathing. (5-star, VBP)	77% (Met - 1181 / Not Met - 335)
*** MANAGING PAIN AND TREATING SYMPTOMS ***	
How often the home health team checked patients for pain.	41% (Met - 868 / Not Met- 1273)
How often the home health team treated their patients' pain.	96% (Met - 1493 / Not Met- 60)
How often patients had less pain when moving around. (5-star, VBP)	73% (Met - 833 / Not Met - 295)
How often the home health team treated heart failure patient's symptoms.	98% (Met - 121 / Not Met - 2)
How often patients' breathing improved. (5-star, VBP)	85% (Met - 587 / Not Met - 101)
*** TREATING WOUNDS AND PREVENTING PRESSURE SORES ***	
How often patients' wounds improved or healed after an operation.	76% (Met - 349 / Not Met - 110)
How often does team check for the risk of developing pressure ulcers.	41% (Met - 871 / Not Met - 1270)
How often does the team include treatments to prevent pressure ulcers in POC.	14% (Met - 199 / Not Met - 1269)
How often the team took doctor ordered action to prevent pressure ulcers	3% (Met - 43 / Not Met - 1270)
*** PREVENTING HARM ***	
How often the home health team began their patients' care in a timely manner.	98% (Met - 2105 / Not Met - 34)
How often the home health team taught patients about their drugs. (5-star, VBP)	99% (Met - 2080 / Not Met - 27)
How often patients got better at taking their drugs correctly by mouth. (VBP)	68% (Met - 842 / Not Met - 377)
How often the home health team checked patients' risk of falling.	100% (Met - 1886 / Not Met - 7)
How often the home health team checked patients for depression.	98% (Met - 2094 / Not Met - 37)
How often the team determined patients had received flu shot for the current season. (VBP)	81% (Met - 1188 / Not Met - 276)
How often the team determined patients had received PPV. (VBP)	82% (Met - 1544 / Not Met - 334)
How often did diabetic patients receive doctor orders for foot care and teaching.	91% (Met - 773 / Not Met - 78)
*** PREVENTING UNPLANNED HOSPITAL CARE ***	
How often did patients need unplanned medical care in ER without being admitted. (VBP)	3% (Met - 58 / Not Met - 1694)
How often patients had unplanned hospitalizations within 60 days. (5-star, VBP)	14% (Admit - 271 / Non-Adm - 1736)
Patient remained in the community after discharge. (VBP)	97% (Met - 1564 / Not Met - 43)

Sepsis Core Measure
(Sep-1 Early Management Bundle)

KAWEAH DELTA HEALTH CARE DISTRICT

Sep-1 Early Management Bundle

One - Three Hours

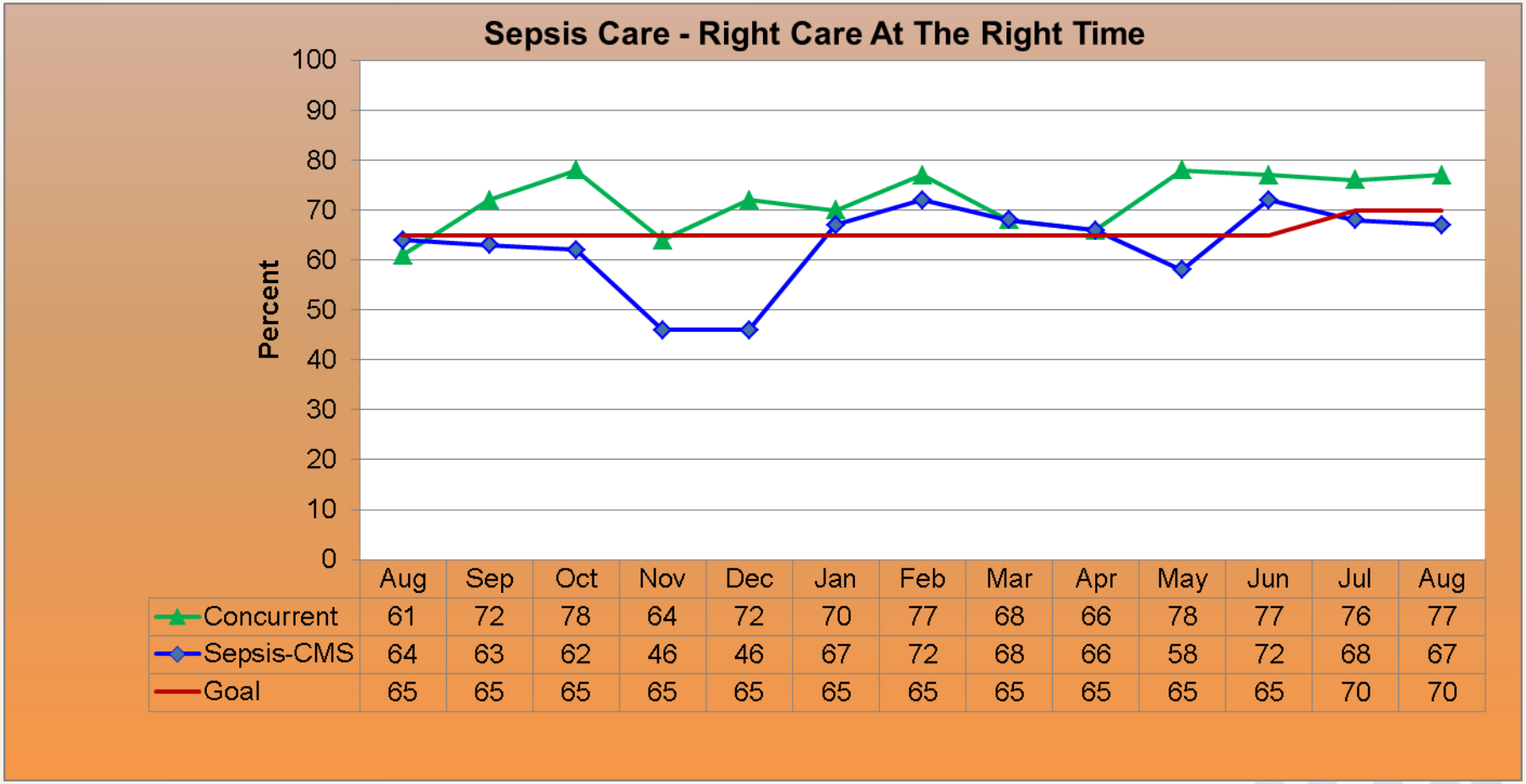
- **Blood Cultures prior to ABX**
- Lactic Acid & **REPEAT in 6 hours if elevated (>2)**
- Broad Spectrum Antibiotics
- Initial Hypotension/Lactic Acidosis (SBP<90 or LA≥4) – 30ml/kg crystalloid fluids **(MUST DOCUMENT WEIGHT THAT YOU USED TO CALULATE FLUIDS – IT CAN BE AN ESTIMATED WEIGHT)**

Six Hours Septic Shock

If hypotension persists after fluid administration

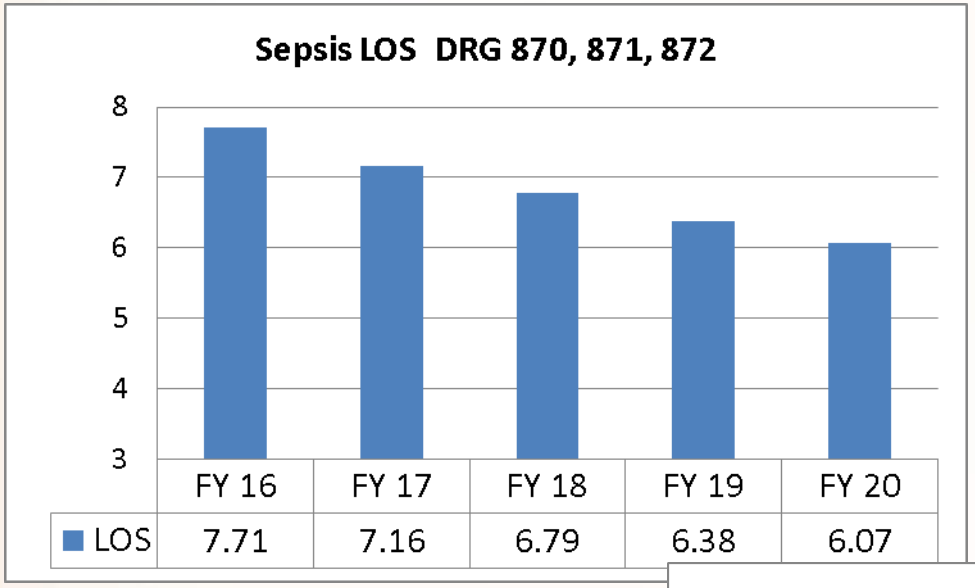
- Vasopressors
- Reassessment (if hypotension persists or initial LA ≥ 4)
- Any of the following:
  - CVP
  - SvO2
  - Bedside Cardiovascular US
  - Passive Leg Raise
- OR
  - Focus Exam – by physician (dot phrase)
    - VS, SpO2, Cardiopulmonary, Cap refill, skin, & peripheral pulses, UO

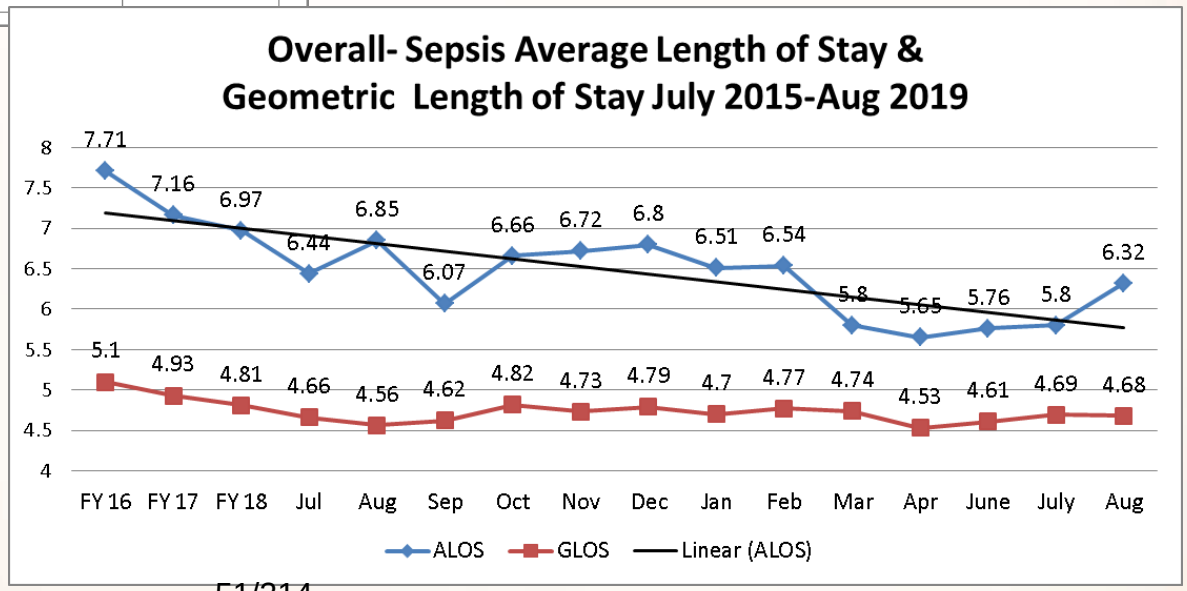
Sep-1 Early Management Bundle Compliance
CA State Compliance 61%
National Compliance 57%



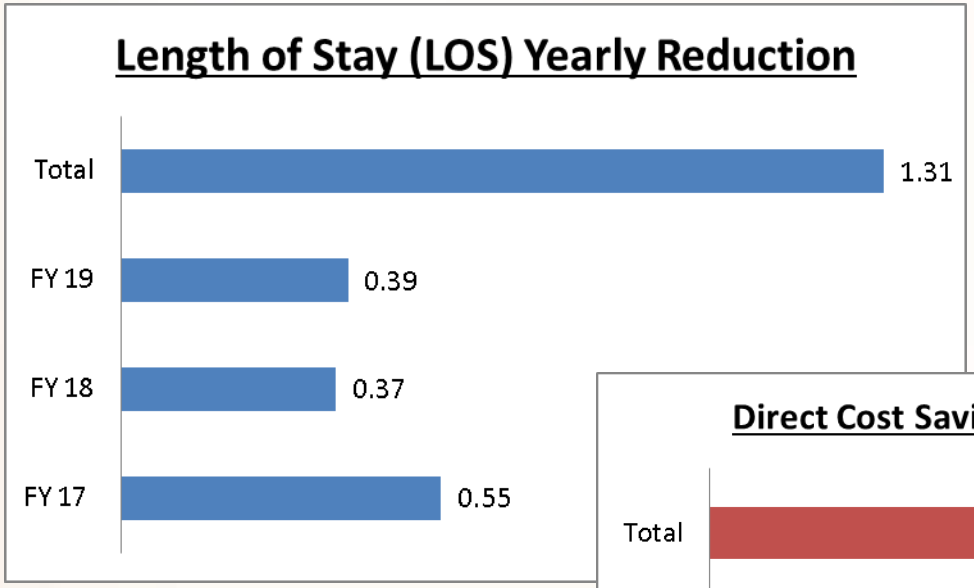
	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Concurrent	61	72	78	64	72	70	77	68	66	78	77	76	77
Sepsis-CMS	64	63	62	46	46	67	72	68	66	58	72	68	67
Goal	65	65	65	65	65	65	65	65	65	65	65	70	70

Sepsis Length of Stay

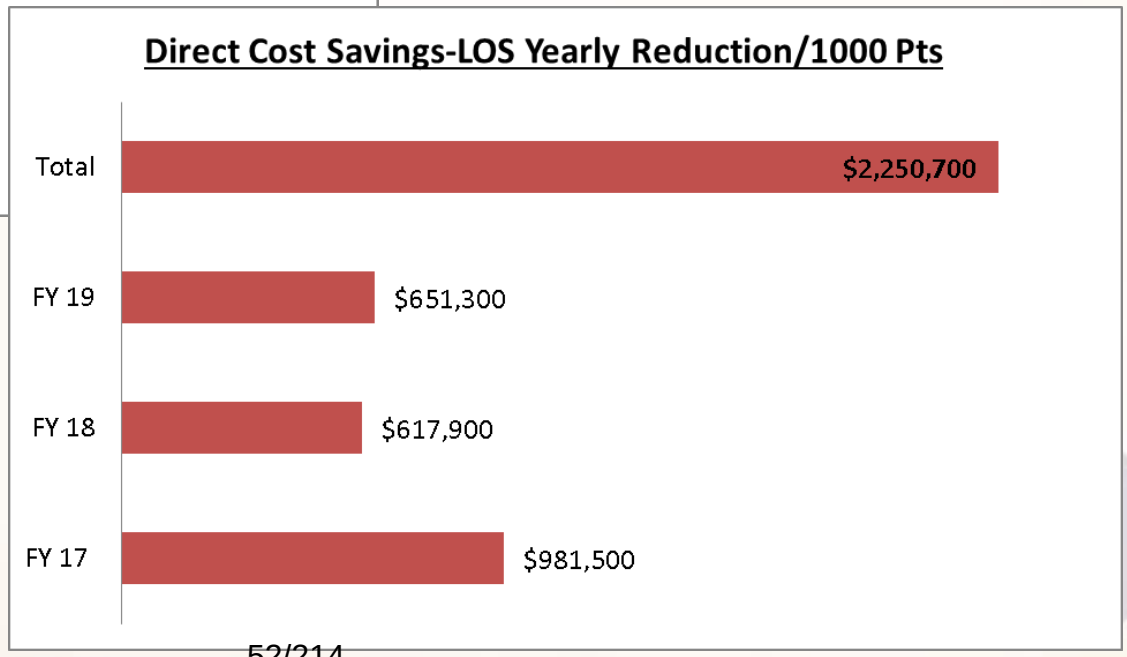




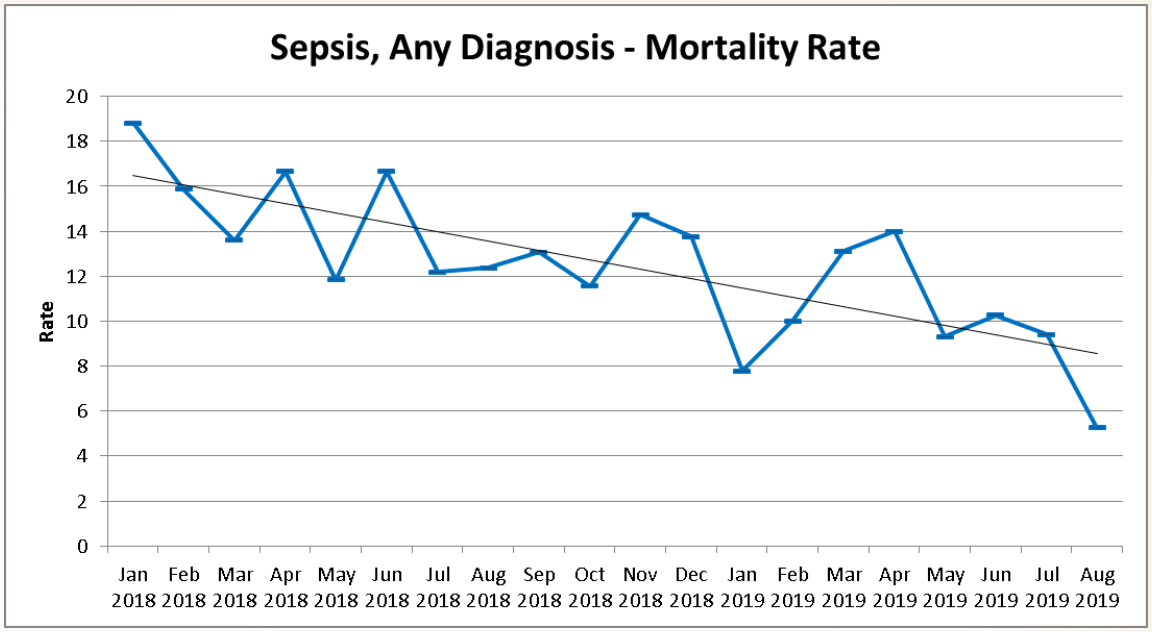
Length of Stay Reduction & Savings

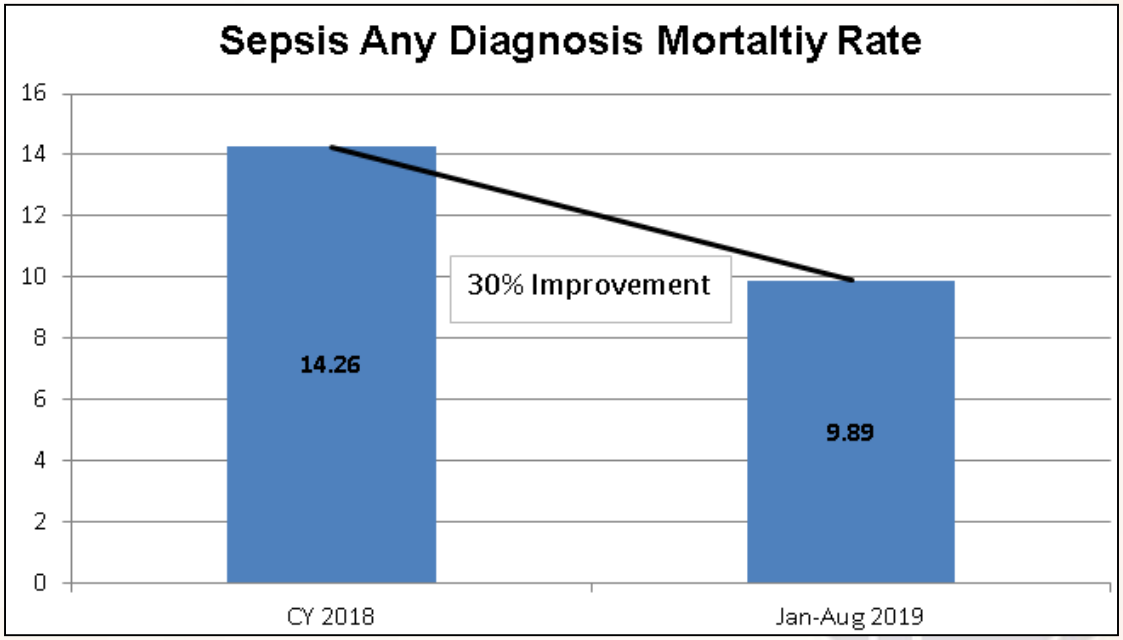


Still Have 1.70 ALOS Excess that Equals to $3.5 Million in Remaining Cost Savings



Reducing Mortality & Saving Lives





What You Need To Know – Provider Education

- **WRITE SEPSIS = TREAT SEPSIS & TREAT SEPSIS=WRITE SEPSIS**
  - Use order sets: ***Med Adult Sepsis & Septic Shock***
  - **PLEASE DON'T FORGET TO ORDER BLOOD CULTURES!**
- Start crystalloids (30ml/kg) in three hours (if patient is hypotensive or has initial LA ≥ 4)
- Use Dot Phrases

  ..sepsisra →Septic Shock Reassessment

  ..ibw → Ideal Body Weight (limit # liters of LR)
- Convert IV to PO ABX when appropriate

Summary & Actions

Summary

- Sepsis Bundle Compliance Jan-June2019 =67%.
  - Meeting org goal of 65%.
  - Fluid resuscitation, proper documentation, and obtaining blood cultures continue to be a concern.
- LOS is steadily decreasing
- Mortality has shown a decrease as sepsis bundle compliance goes up.

Actions

- Dr. Tu is a new member of the Sepsis Committee as the emergency department physician quality lead. Great supporter of the team.
- Education to providers regarding fluid resuscitation based on ideal body weight and not actual body weight.
- Sepsis Coordinator following patients on day two to assess readiness for discharge.
- Recognize staff for being a sepsis hero for their perfect care via e-mail.
- Providers received notification when sepsis bundle not met via e-mail
- Continue to assess need for second Sepsis Coordinator.
- Evaluating & Improving discharge patient education

Questions?

Kaweah Delta HEALTH CARE DISTRICT

ED Metric July 2019 to Sept 2019

General Metrics	Jul-19 KDHCD	Jul-19 Benchmark	Aug-19 KDHCD	Aug-19 Benchmark	Sep-19 KDHCD	Sep-19 Benchmark
ED Volume	7695		7698		7100	
Percent of Patients Left Without Being Seen	2.0%	1.5%	2.0%	1.5%	1.3%	1.5%
Percent of Patients Left During Treatment	2.4%	1.5%	2.4%	1.5%	2.4%	1.5%
Percent of Patients Left Against Medical Advice	0.8%	NA	1.0%	NA	0.9%	NA
Percent of Patients Admitted	24%	NA	23%	NA	24%	NA
Percent of Patients Discharged	69%	NA	69%	NA	69%	NA
ED Throughput Metrics						
Total Minutes from Door to Provider						
Length of Stay in Minutes for Admitted Patient (Hours)	490/486 (8.1)	423 (7.05)	501/462 (8.3)	423 (7.05)	498/457 (8.3)	423 (7.05)
Length of Stay in Minutes for Discharged Patient (Hours)	258/256 (4.3)	204 (3.4)	254/225 (4.2)	204 (3.4)	245/217 (4.1)	204 (3.4)
Length of Stay in Minutes from Admit Decision to ED Depart (Hours)	281/269 (4.7)	180 (3)	271/225 (4.5)	180 (3)	271/225 (4.5)	180 (3)
Length of Stay in Minutes for Admitted Mental Health Patients	905 (15.8)		846 (14.1)		861 (14.4)	
Census Totals by Disposition						
Number of Patients Arriving by Ambulance	1993		2002		1799	
Number of Trauma Patients	170		188		179	
Number of Patients Admitted	1758		1764		1685	
Number of Patients Discharged	5319		5289		4897	
Number of Mental Health Patients Admitted	108		109		93	
Patient Experience						
Emergency Room Overall Care Percentile Ranking						
Likelihood to Recommend the ED at KD Percentile Ranking						
KEY	Outperforming benchmark		Underperforming Benchmark		Equal to Benchmark	

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%

PREVIOUS MONTH
72%

JULY 2019
HIGHER IS BETTER
68%

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: 3
PREDICTED: <1 EVENTS

AUG. 2019
NUMBER OF PATIENTS WHO ACQUIRED MRSA
2

JULY-AUG. 2019
LOWER IS BETTER
2.26

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: 6
PREDICTED: <2 EVENTS

AUG. 2019
NUMBER OF PATIENTS WHO ACQUIRED CAUTI
5

JULY - AUG. 2019
LOWER IS BETTER
2.29

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: 0
PREDICTED: <1 EVENTS

AUG. 2019
NUMBER OF PATIENTS WHO ACQUIRED CLABSI
0

JULY - AUG. 2019
LOWER IS BETTER
0.00

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 ≤0.50

AUGUST 2019:
0.88

JUL - AUG 2019:
0.81

Leapfrog Hospital Safety Score

Fall 2019

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

KAWEAH DELTA HEALTH CARE DISTRICT

Leapfrog Safety Grade

KDHCD Hospital Safety Score Spring 2019 = 2.9465

Letter Grade Key: A = >3.133 B= >2.964 C= >2.476 D= >2.047

Time Frame	Grade
May 2019	C
October 2018	C
May 2018	A
October 2017	B

Components of the Hospital Safety Score

- **Safe Practices** (National Quality Forum) submitted through the Leapfrog Survey, annually

From Hospital Compare*:

- **5 Patient Experience Measures**
- 3 Healthcare acquired conditions (HACs)
- **5 Healthcare acquired infections** (HAIs)
- 6 Patient Safety Indicators (PSIs)

*Data date ranges vary

LEAPFROG HOSPITAL SAFETY SCORE FALL 2019

*Fall 2019 data from Hospital Compare and Leapfrog Survey

Measure Domain	Measure	Kaweah Delta Spring 2019	Spring 2019 Mean	Kaweah Delta Fall 2019	Data Date Range
Process/Structural Measures 2019 Fall Time Frame SP 2018, H-COMP CY 2018 **(higher is better)**	Computerized Physician Order Entry (CPOE)	100	69.71	100	June 2019
	Bar Code Medication Administration (BCMA)	100	71.26	100	
	ICU Physician Staffing (IPS)	100	52.31	100	
	SP 1: Culture of Safety Leadership Structures & Systems	120	117.41	120	
	SP 2: Culture Measurement, Feedback, & Intervention	120	115.63	120	
	SP 4: Identification & Mitigation of Risks & Hazards	100	97.18	100	
	SP 9: Nursing Workforce	100	97.61	100	
	SP 19: Hand Hygiene	60	57.98	60	
	H-COMP-1: Nurse Communication	89	90.82	89	CY 2018
	H-COMP-2: Doctor Communication	88	90.88	88	
	H-COMP-3: Staff Responsiveness	83	84.31	84	
	H-COMP-5: Communication about Medicines	75	78.00	76	
	H-COMP-6: Discharge Information	85	86.72	85	
Outcome Measures 2018 Fall Time Frame PSI 7/2016-6/20 IC CY 2018 **(lower is better)**	Foreign Object Retained - **Reported Once A Year**	0.079	0.02	0.135	Q3 (2016) - Q2 (2018)
	Air Embolism- **Reported Once A Year**	0.000	0.00	0.000	
	Falls and Trauma- **Reported Once A Year (3,700 codes)**	0.237	0.44	0.472	
	CLABSI	1.122	0.82	1.277	CY 2018
	CAUTI	0.632	0.90	1.052	
	SSI: Colon	0.722	0.86	0.797	
	MRSA	2.438	0.92	2.160	
	C. Diff.	0.999	0.85	0.580	
	PSI 3: Pressure Ulcer Rate	0.41	0.38	0.65	Q3 (2016) - Q2 (2018)
	PSI 4: Death Rate, Surg. Inpatients w/ Serious Treatable Complications	188.48	161.65	212.08	
	PSI 6: Iatrogenic Pneumothorax Rate	0.22	0.29	0.26	
	PSI 11: Postoperative Respiratory Failure Rate	3.62	8.22	6.62	
	PSI 12: Perioperative PE/DVT Rate	4.03	3.84	3.80	
	PSI 14: Postoperative Wound Dehiscence Rate	1.07	0.85	0.82	
	PSI 15: Abdominopelvic Accidental Puncture/Laceration Rate	1.70	1.29	1.31	

Summary – Fall 2019

- Perfect score in all Safe Practices, including CPOE evaluation
- 3/5 Patient experience scores stayed the same from last reporting period, 2 improved by 1 point
- 2 out of 5 HAIs improved from last reporting period
- 5 of 10 HACs and PSIs above the spring 2019

Summary – Fall 2019

Performance on each component is based on a z-score. This means KDs score is dependent on how other hospitals perform which is unknown to any hospital until the day the scores are released to the public.

How are other hospitals doing? Spring 2019

- Safe Practices: National mean improved in 6 out of 8; a full 5 points in CPOE
- Patient experience: 2/5 national means improved
- Healthcare Acquired Infections: national mean improved in 3/5 measures, stayed the same in 2
- OVERALL: 11 improved, 11 stayed the same and 6 got worse (28 measures total)

Action Summary

- Maintain the CPOE and Safe Practice scores
  - heavy focus in 2018 in ISS clinical decision support tools have lead to success in the CPOE measure, this needs to sustain
  - Continued support in full implementation of safe practices
- INFECTION PREVENTION
  - improvement in all areas and sustain
  - IV Safety Team in place January 2019, enhanced work in hand hygiene (ie. D.U.D.E. Campaign)
- Patient Satisfaction improvements
  - New vendor in place, current scores will affect future hospital safety scores
- HACs and PSI
  - Timely review and action (ie. coding vs clinical issues identified and addressed)
  - Redesign of Hospital Acquired Pressure Ulcer program

Questions?

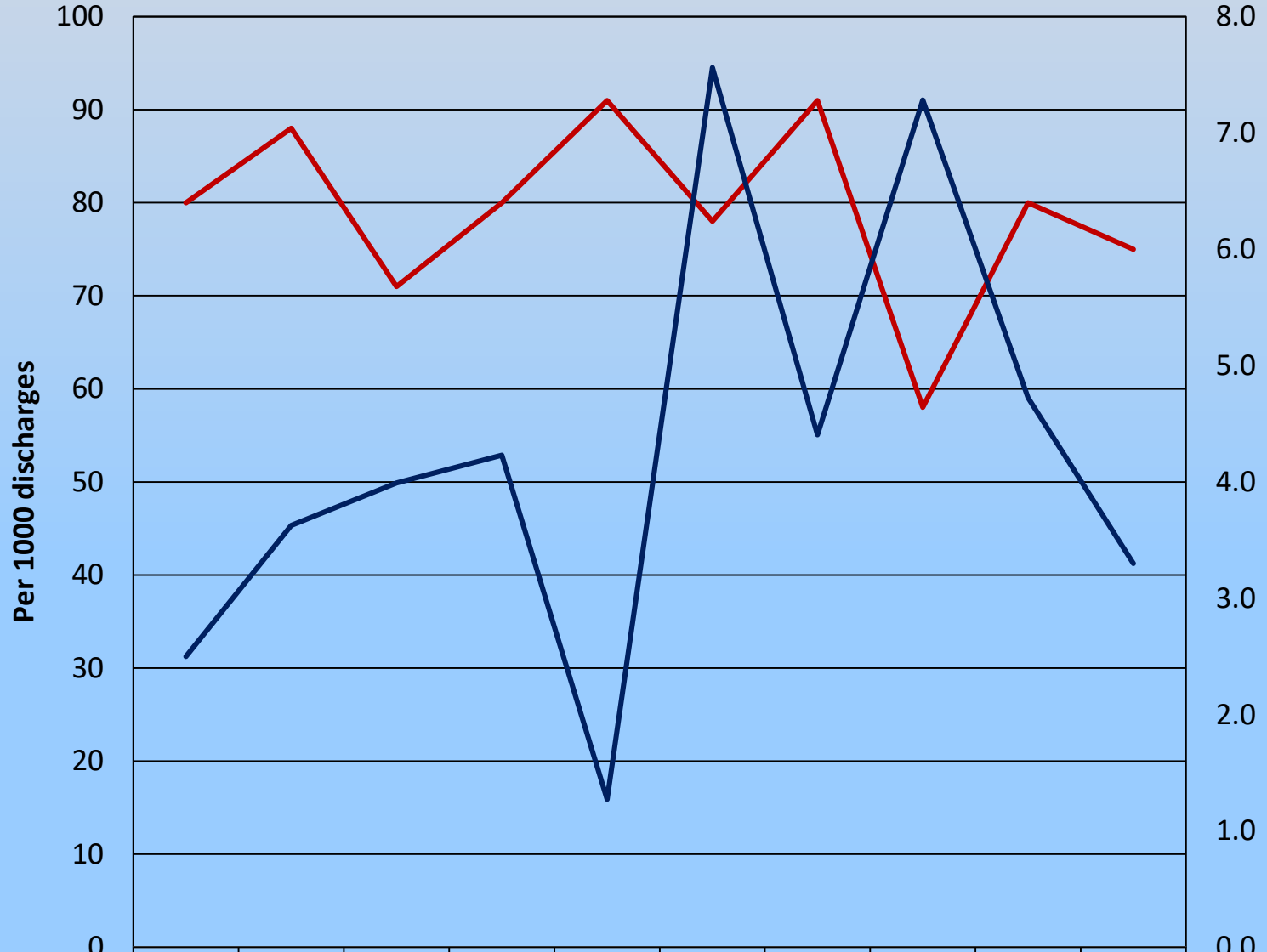
Code Blue and Rapid Response System

September 2019

KAWEAH DELTA HEALTH CARE DISTRICT

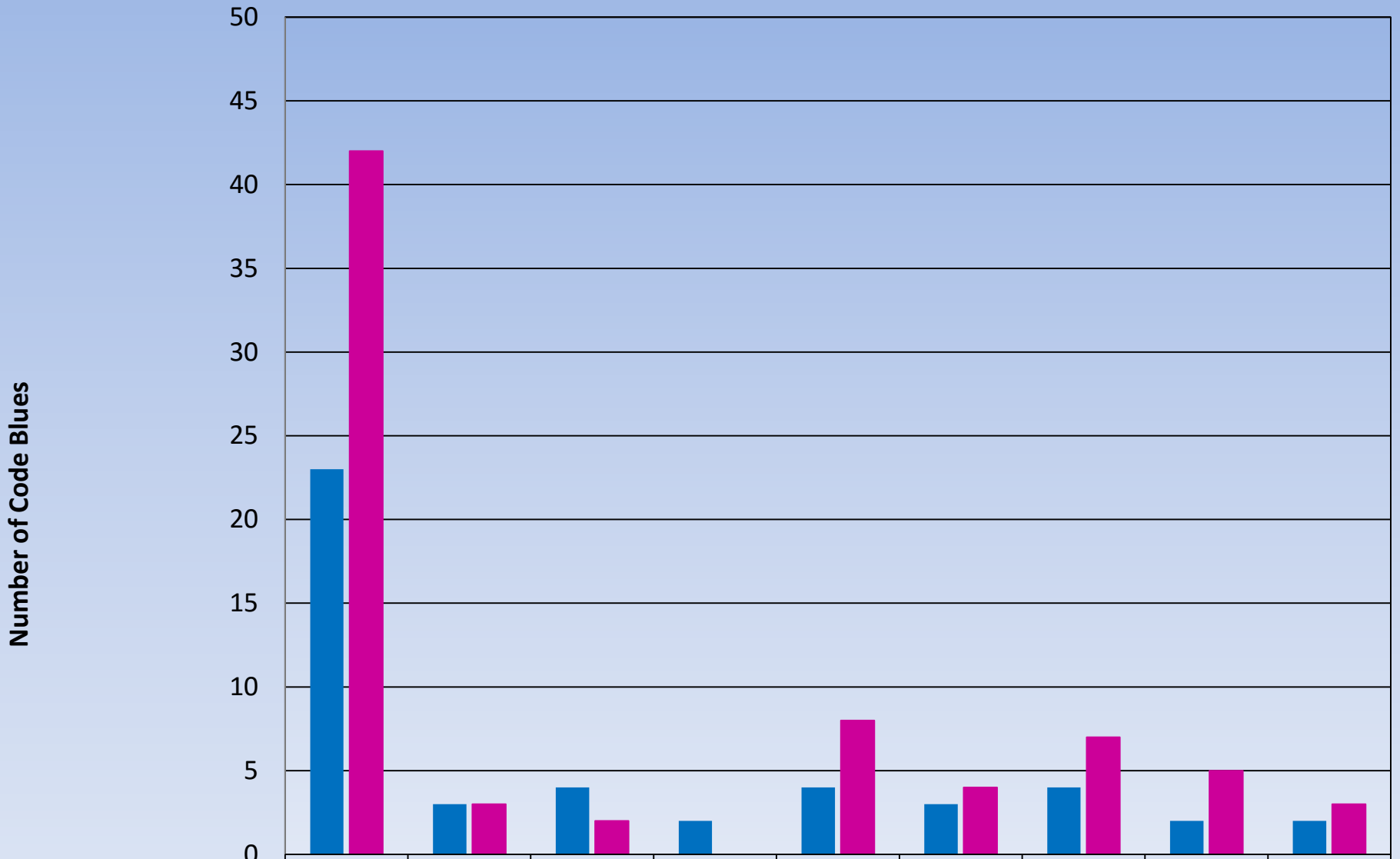
Code Blue Data

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



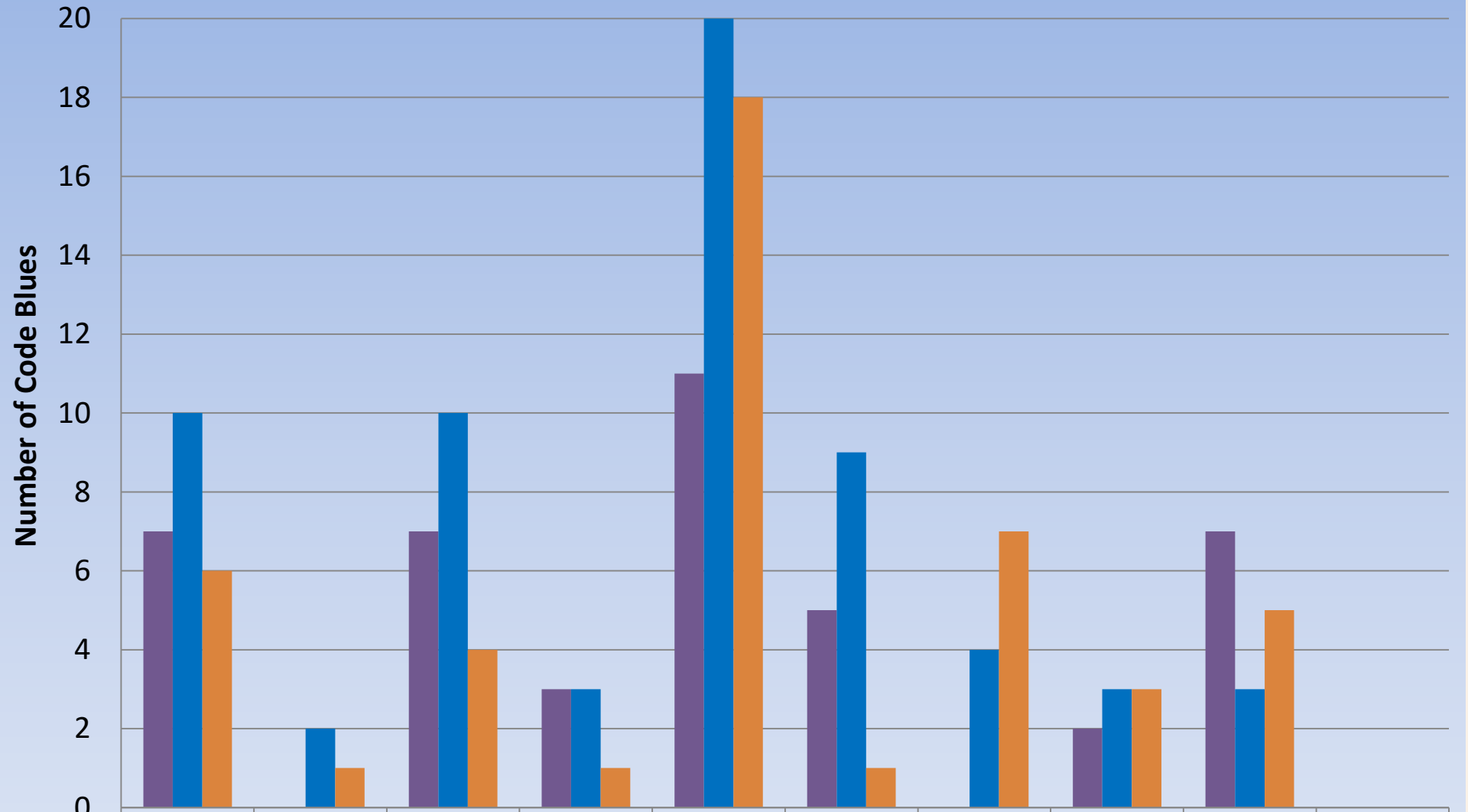
	2017	2018	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
RRT Rate per 1000 discharges	80	88	71	80	91	78	91	58	80	75
Code Blue Rate per 1000 discharges	2.5	3.6	4.0	4.2	1.3	7.6	4.4	7.3	4.7	3.3

Non Critical Care Code Blues



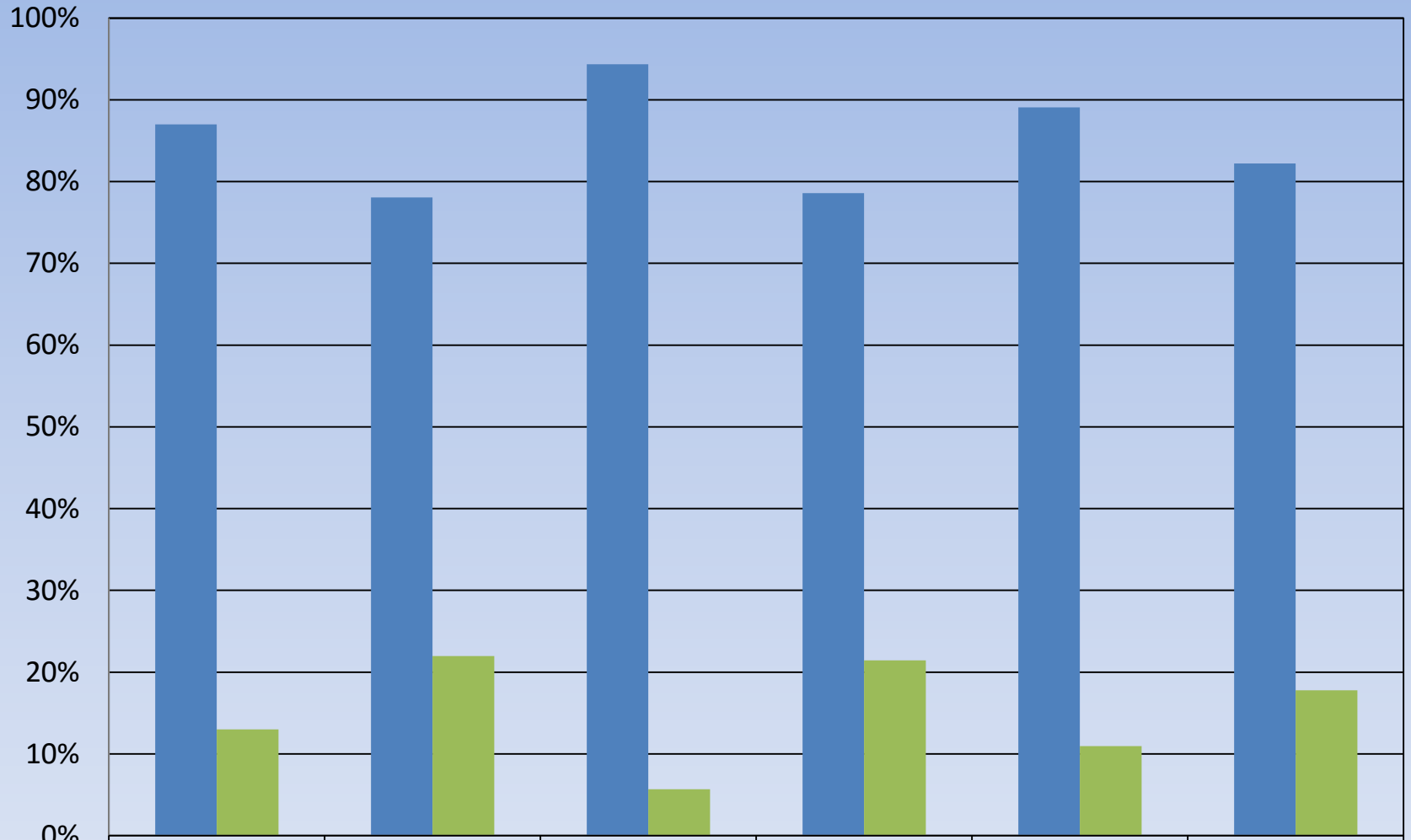
	2018	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Intermediate Care Code Blue	23	3	4	2	4	3	4	2	2
Med Surg Code Blue	42	3	2	0	8	4	7	5	3

Code Blue Locations



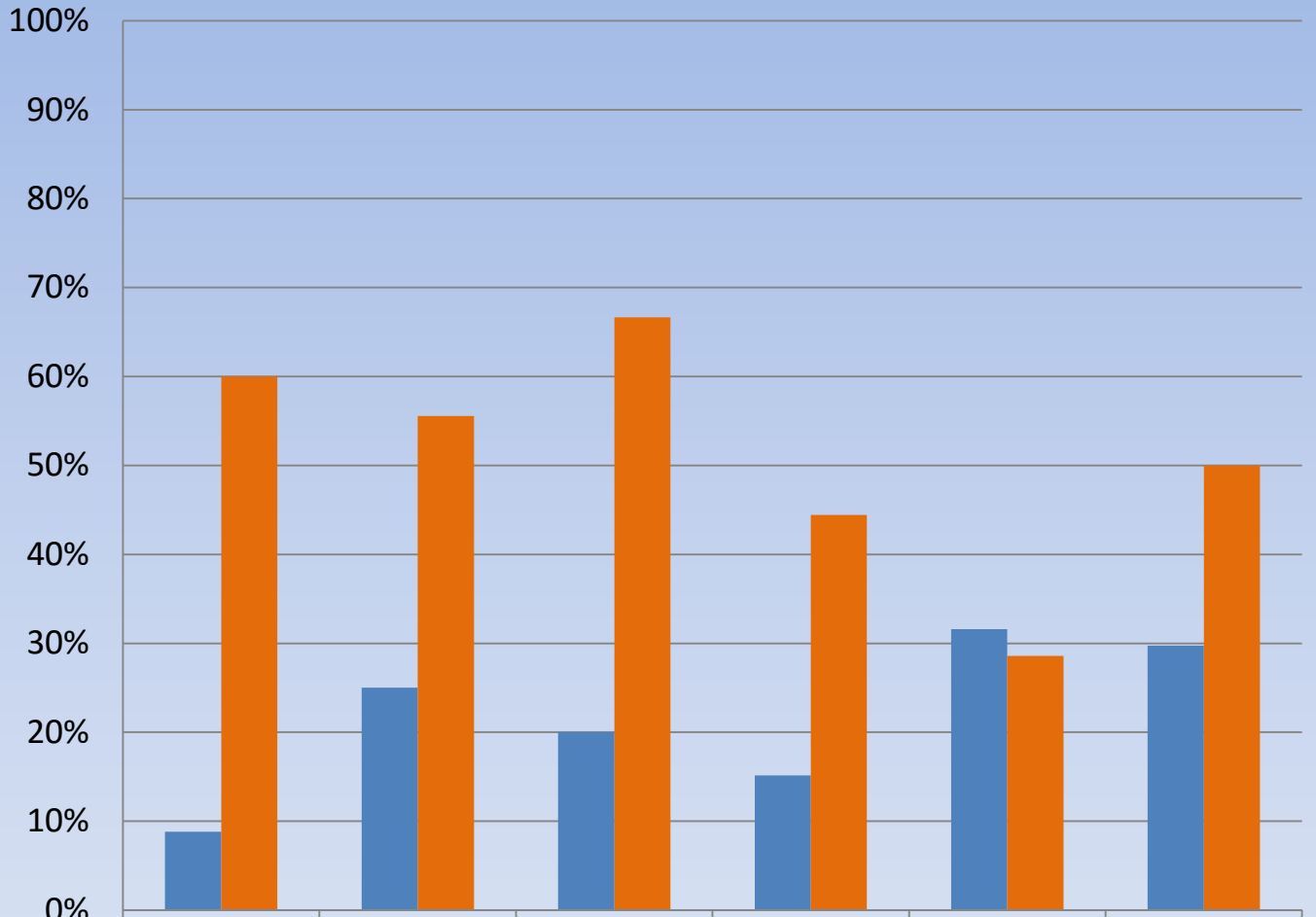
	2N	2S	3N	3S	3W	4N	4S	4T	CVICCU	BP
2017	7	0	7	3	11	5	0	2	7	0
2018	10	2	10	3	20	9	4	3	3	0
2019	6	1	4	1	18	1	7	3	5	0

Med Surg- Code Type



	2014	2015	2016	2017	2018	2019
Asystole and PEA	87%	78%	94%	79%	89%	82%
V Fib and V Tac	13%	22%	6%	21%	11%	18%

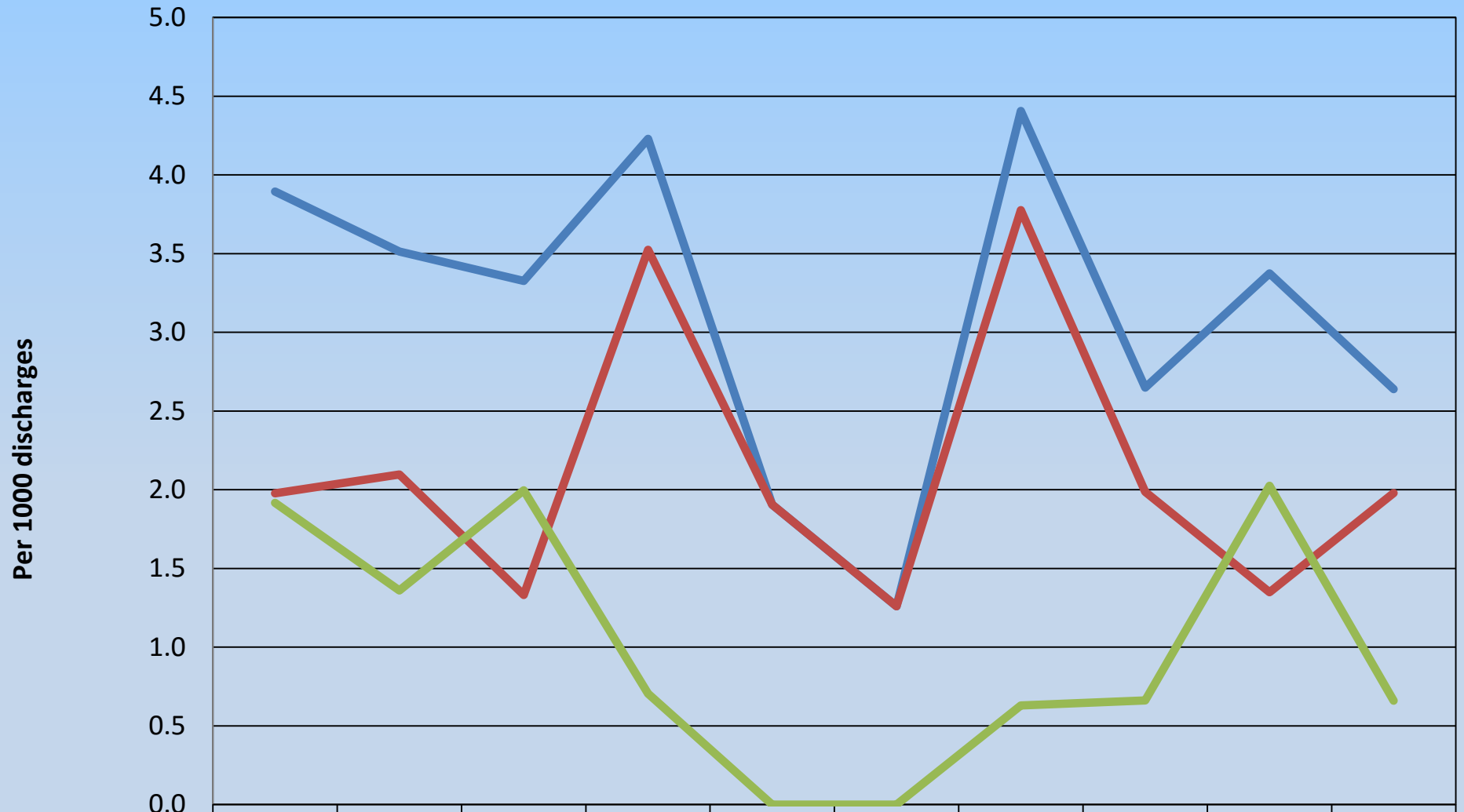
Med Surg- Shockable vs Non Shockable Codes
Survival to Hospital Discharge



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%	30%
Vfib and Vtac: Survived to Hospital Discharge	60%	56%	67%	44%	29%	50%

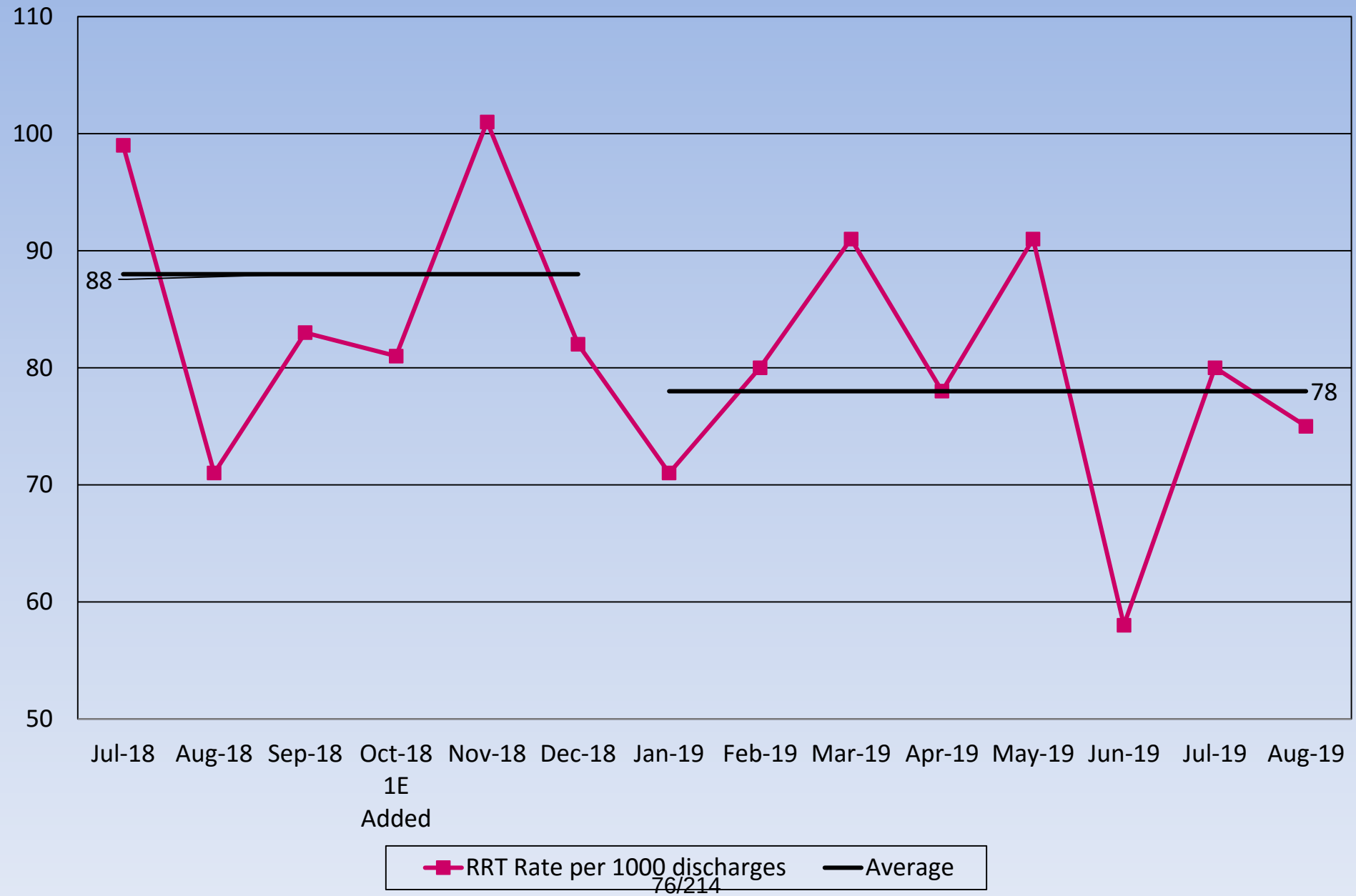
Code Blues per 1000 discharges for CVICU and ICU



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

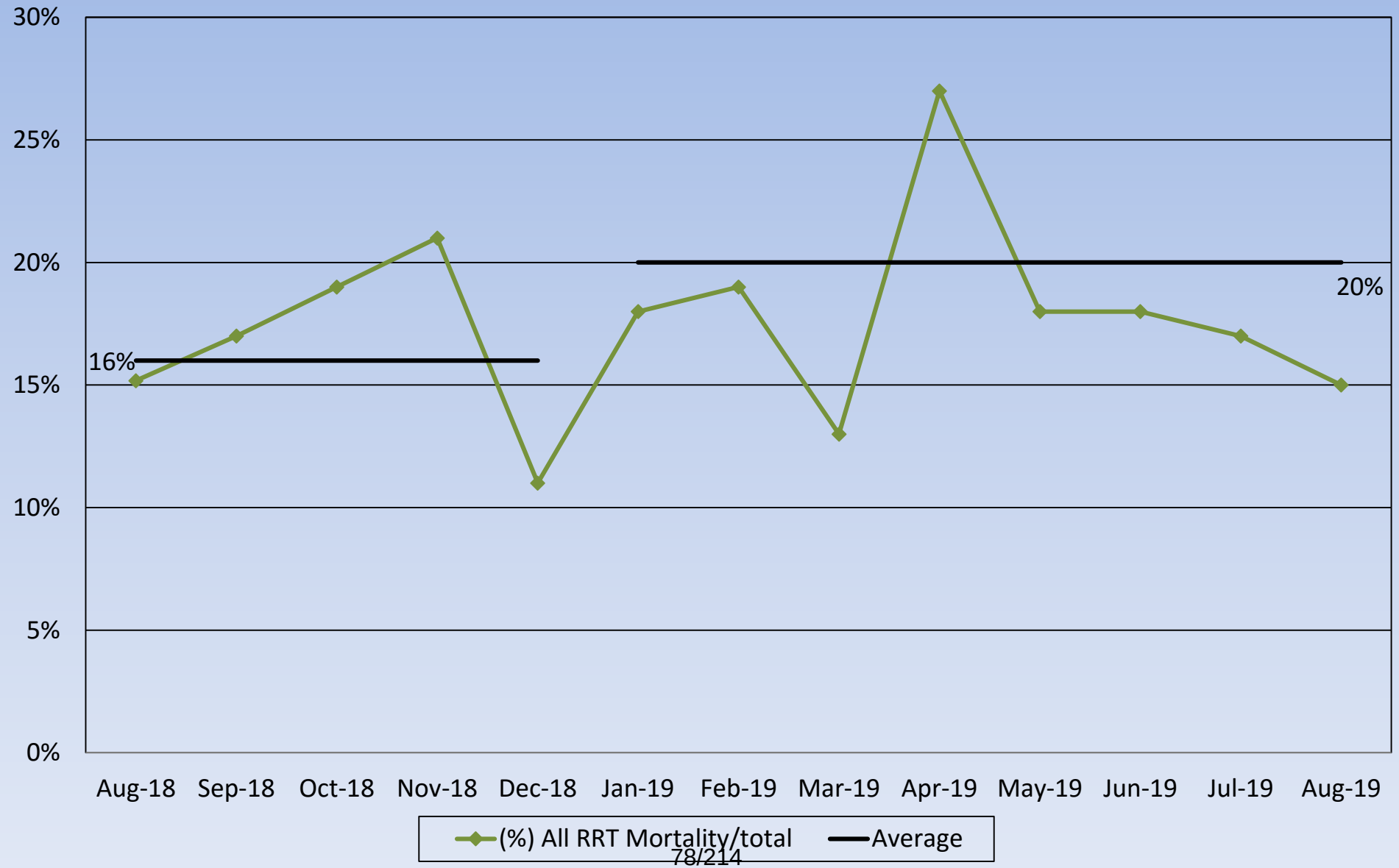
Rapid Response System Data

RRTs per 1000 Patient Discharge Days

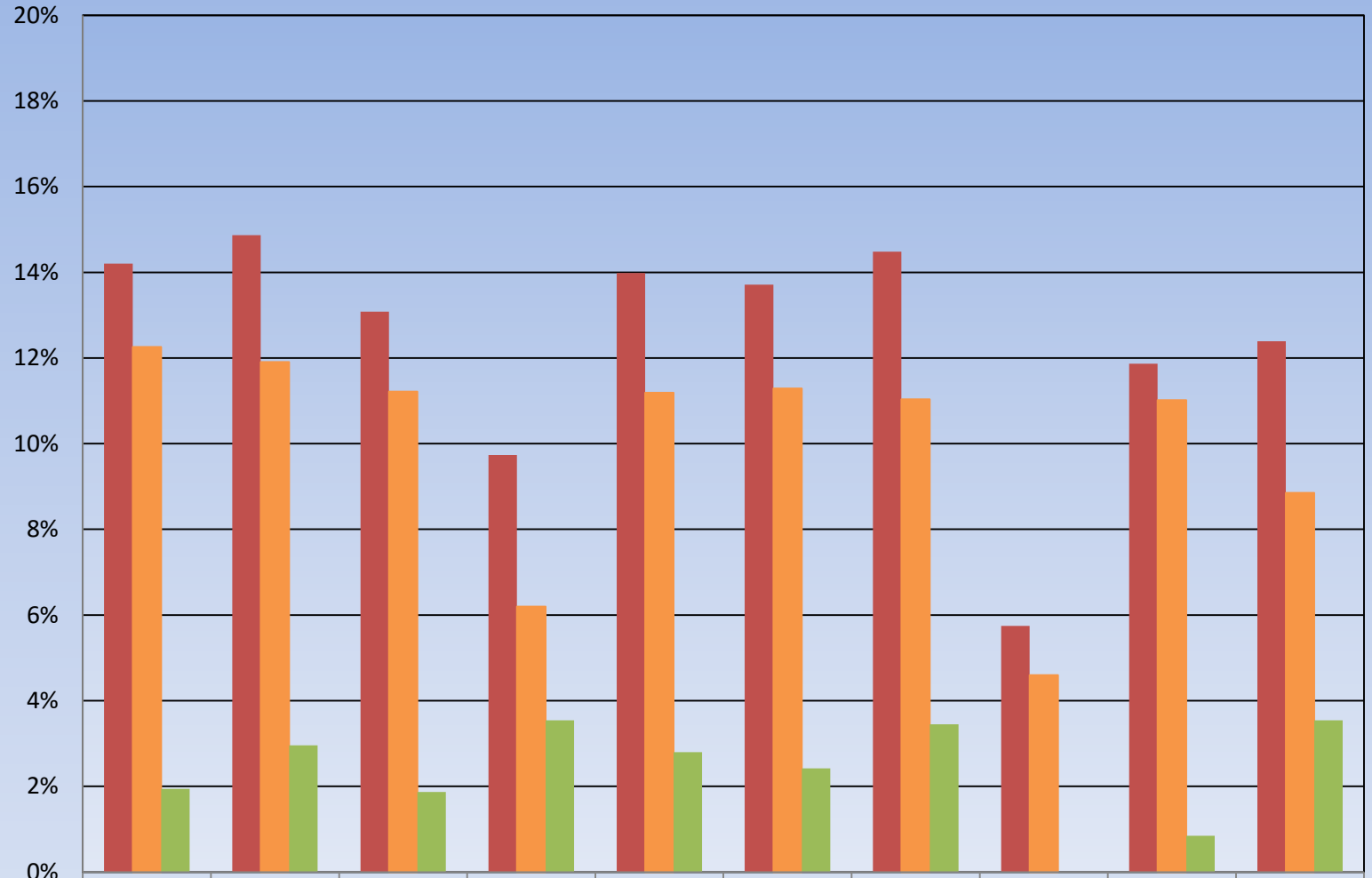


Alert Location	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Totals
KDMC 3W	24	28	31	32	33	14	23	21	206
KDMC 4S	14	17	21	20	21	10	24	17	144
KDMC 3N	15	14	17	14	15	10	9	10	104
KDMC 3S	12	12	11	11	19	10	14	8	97
KDMC 2N	8	9	15	15	11	8	17	9	92
KDMC 14	7	10	11	7	17	6	10	9	77
KDMC 4N	10	7	7	3	9	15	11	14	76
KDMC 2S	2	6	13	6	5	6	3	5	46
KDMC CV	3	2	9	5	4	4	2	6	35
KDMC 1E	3	4	7	5	4	3	2	6	34
KDMC IC	7	2	1	4	4	1	3	5	27
KDMC BP	2	2	0	2	2	0	0	3	11
RRT Tracked Total	**107**	**113**	**143**	**124**	**144**	**87**	**118**	**113**	**949**
KDMC CVOR/Cath lab	3	2	2	3	3	0	0	0	13
Labor Triage/ Mother Baby	1	1	4	0	2	3	1	2	14
KDMC 2E	1	2	0	3	1	1	0	2	10
Surgery (Pre/Post op)	1	1	1	1	1	1	2	1	9
KDMC ED	0	0	1	1	1	0	0	0	3
KDMC CT/radiology	0	0	0	1	0	0	0	0	1
KDMC Pediatric	0	0	0	0	0	0	0	0	0
Endoscopy	0	0	0	0	3	0	1	0	4
RRT Not Tracked Total	**6**	**6**	**8**	**9**	**11**	**5**	**4**	**5**	**54**

RRTs Mortality
1E added on Oct 2018

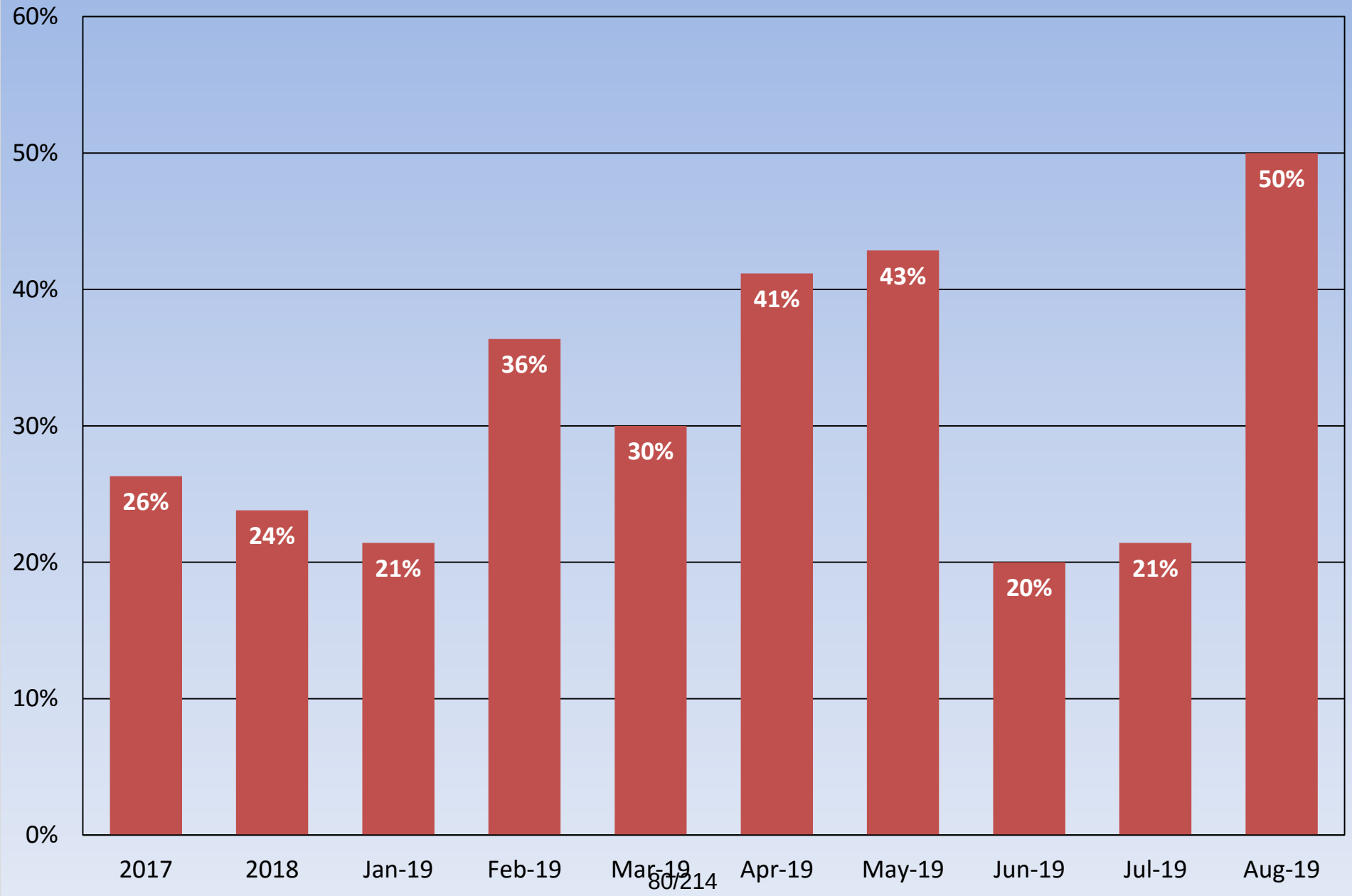


Patients with Multiple RRT's



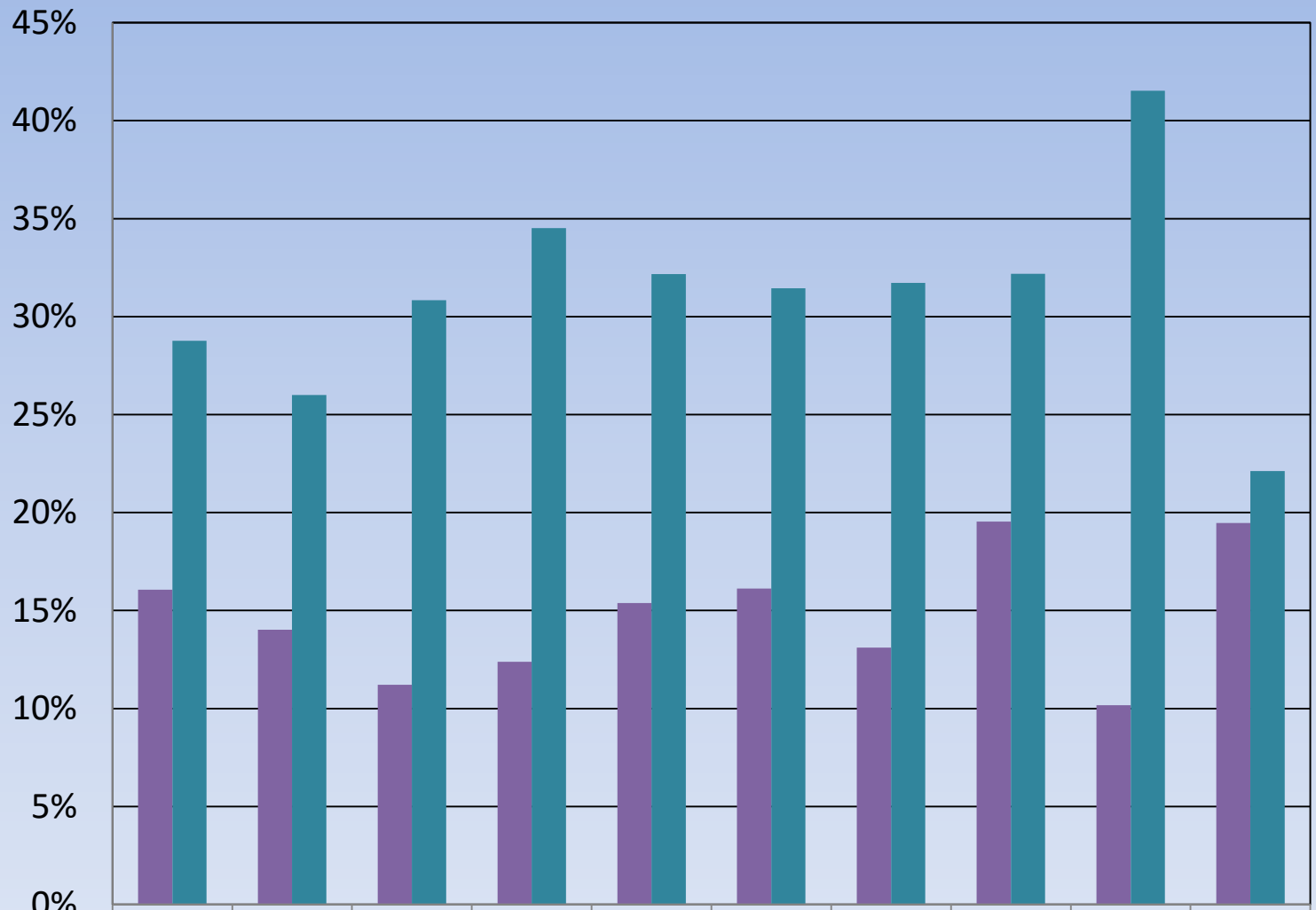
	2017	2018	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Total Number of Multiple RRT's	14%	15%	13%	10%	14%	14%	14%	6%	12%	12%
2 RRT's	12%	12%	11%	6%	11%	11%	11%	5%	11%	9%
3 or more RRT's	2%	3%	2%	4%	3%	2%	3%	0%	1%	4%

Multiple RRT Mortality



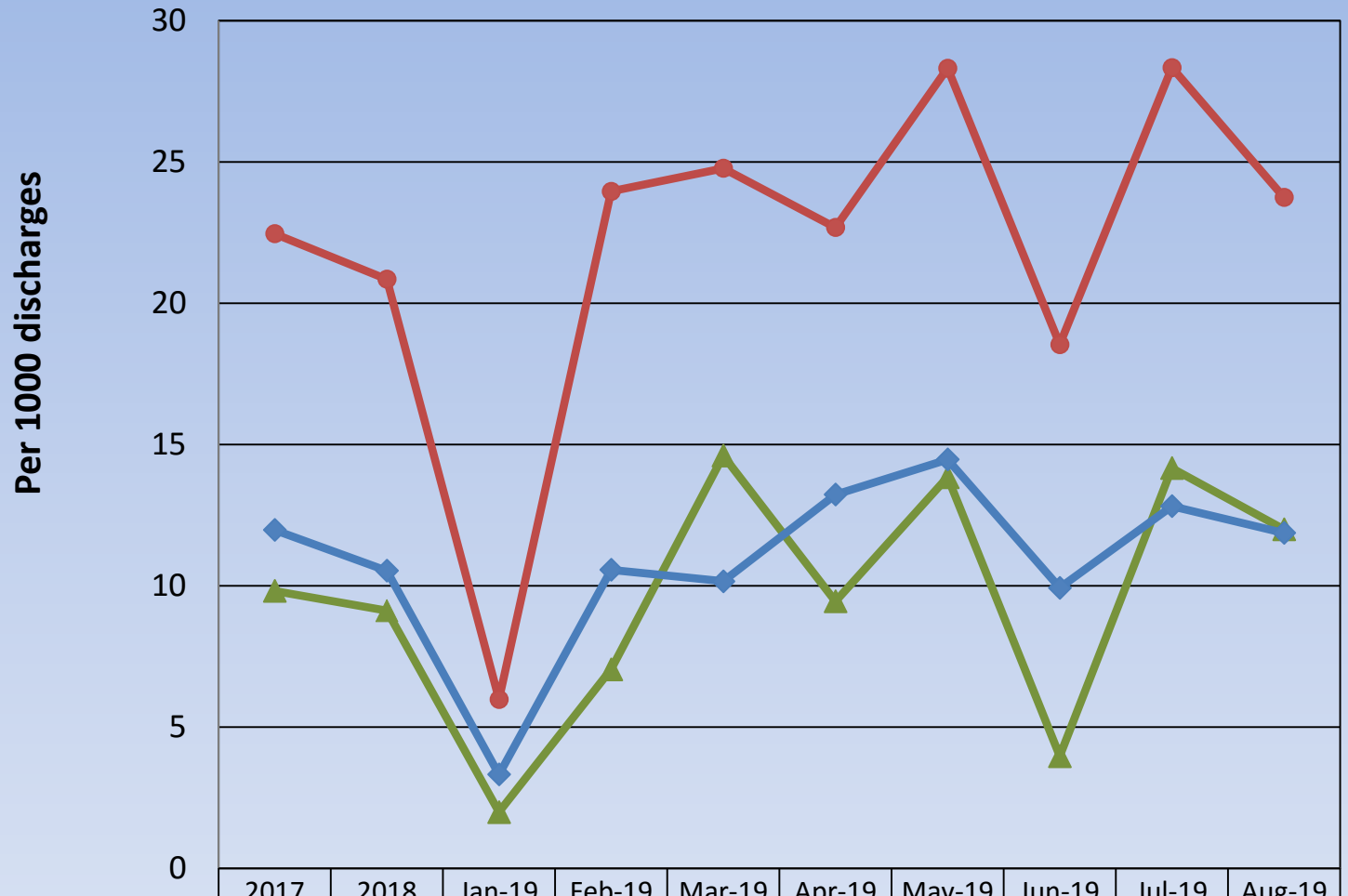
Disposition of RRT

*Oct includes 1E



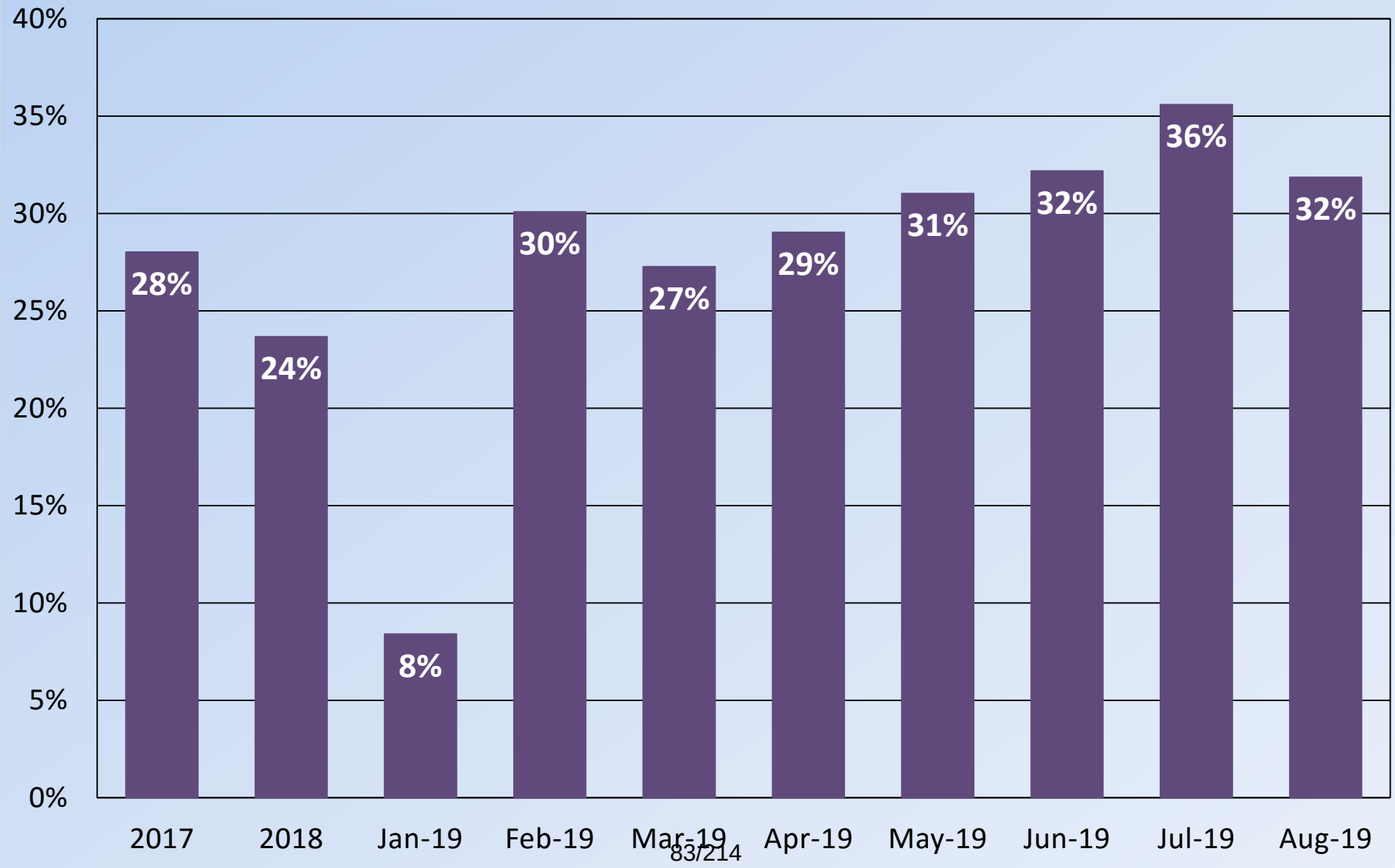
	2017	2018	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
(%) Transferred to ICU/CVICU	16%	14%	11%	12%	15%	16%	13%	20%	10%	19%
(%) Transferred to ICCU	29%	26%	31%	35%	32%	31%	32%	32%	42%	22%

RRTs Admitted from ED within 24 hours
1E Added Oct 2018

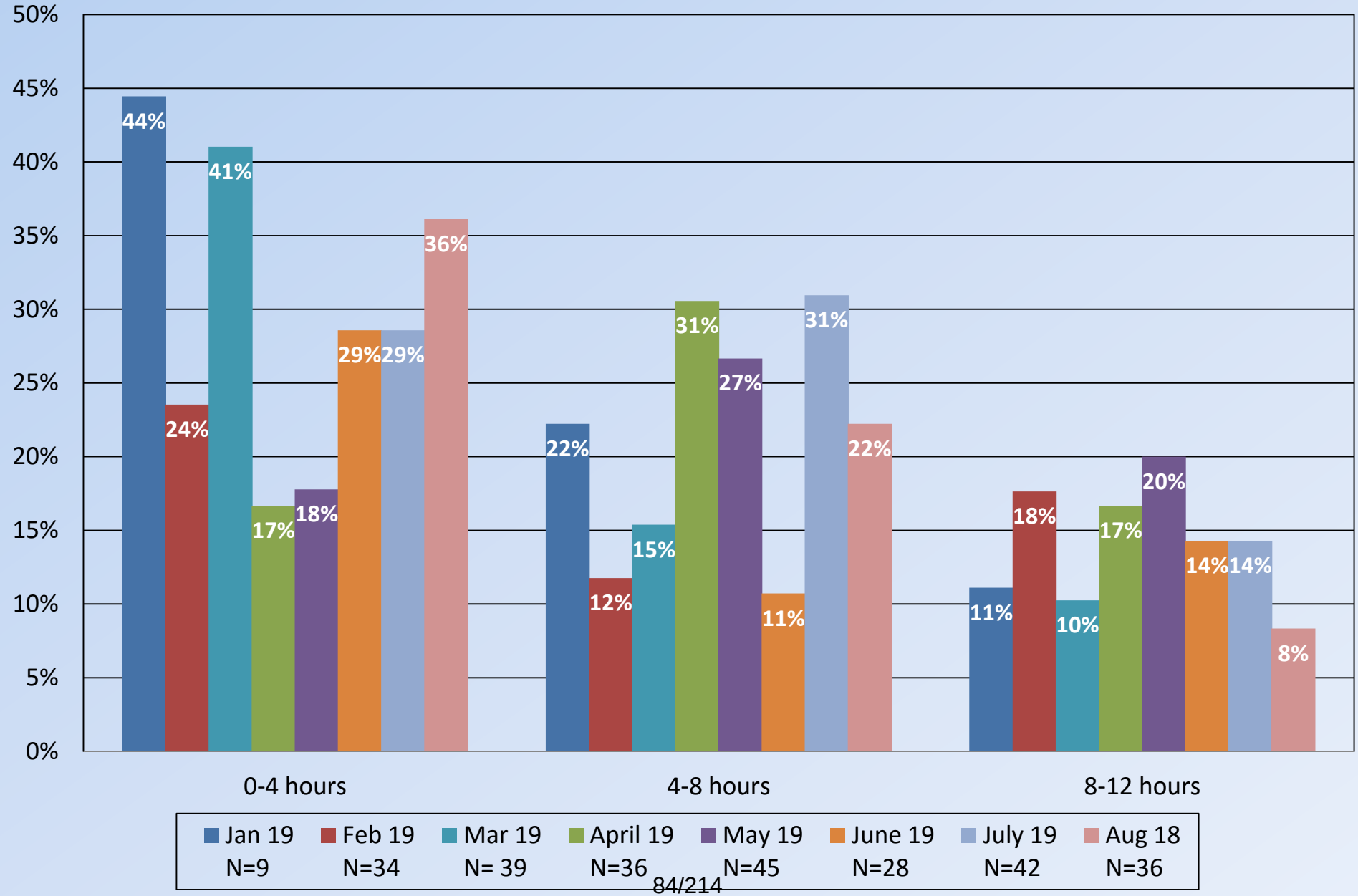


	2017	2018	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
RRT within 24 hr admit from ED	22	21	6	24	25	23	28	19	28	24
RRT within 24 hours of admit transferred to (ICU/ICCU)	10	9	2	7	15	9	14	4	14	12
RRT within 24 hours of admit from ED: Stayed in Room	12	11	3	11	10	13	14	10	13	12

RRTs within 24 hours of Admit from ED
1E Added Oct 2018



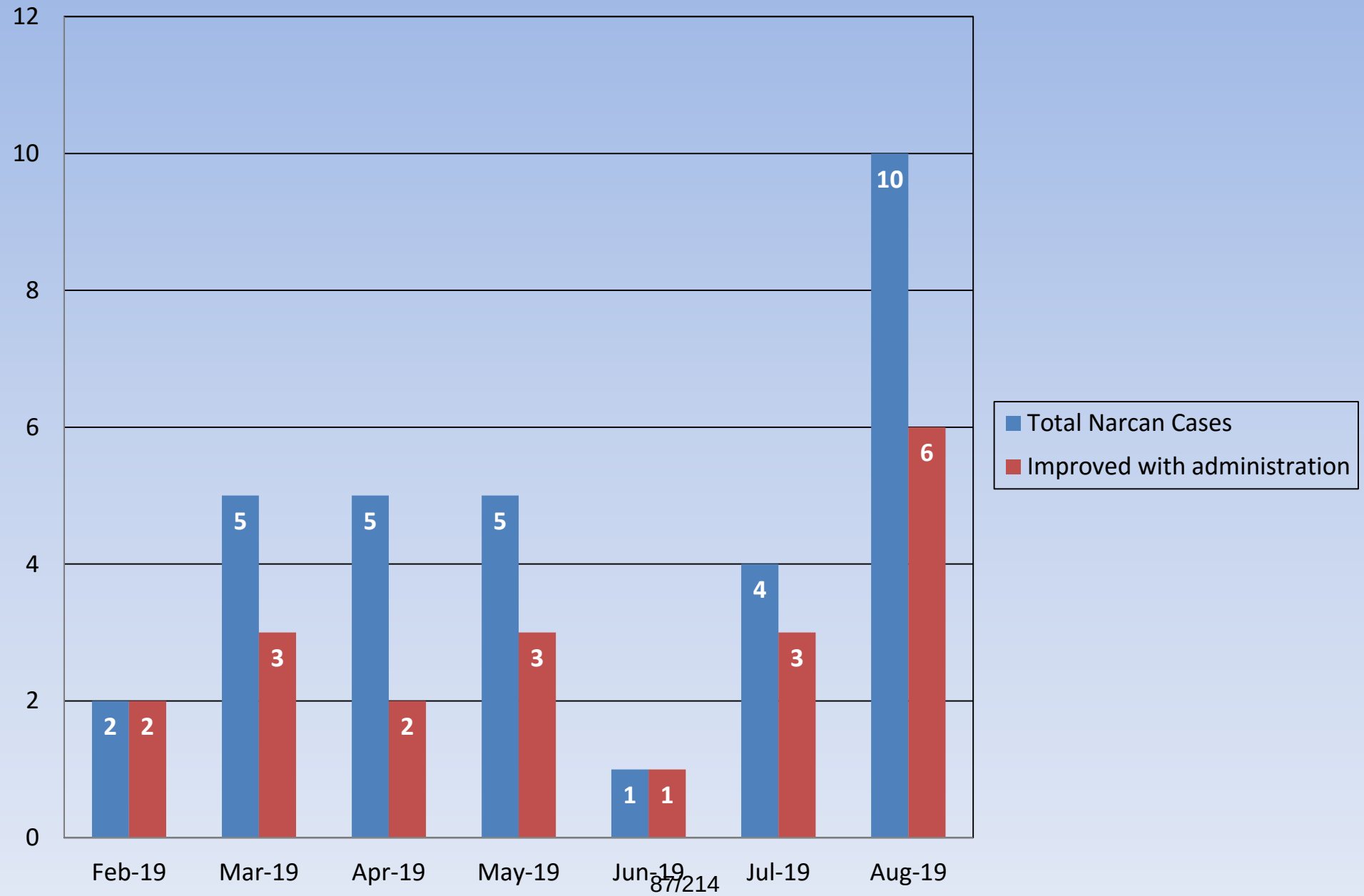
RRTs within 12 hours of Admit from ED



RRTs on 3w	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Total
Total Number of RRTs on 3w	24	28	31	32	33	14	23	21	206
Primary RRT on 3w	21	21	24	24	30	14	20	15	169
Multiple RRTs on 3w	1	4	3	5	1	0	0	3	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	15
RRTs on 3w transferred to critical care	5	8	6	9	5	6	5	5	49

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	Total
RRTs on 3w within 12 hours after admission from ED	3	5	5	8	9	8	8	12	58
Transferred to critical care	0	2	1	1	3	4	4	3	18
Stayed in room	3	3	4	7	6	4	4	8	39
Multiple rrt	0	2	0	0	0	0	1	1	4

Narcan Administration during RRTs



KAWEAH DELTA HEALTH CARE DISTRICT

QUALITY COUNCIL MEETING

THURSDAY OCTOBER 10, 2019

CLOSED MEETING SUPPORTING DOCUMENTS

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