November 8, 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 November 14, 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 November 14, 2019, in the Kaweah Delta Medical Center – Acequia Wing – Executive Office Conference Room {400 W. Mineral King, Visalia} pursuant to Health and Safety Code 32155 & 1461.

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

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

KAWEAH DELTA HEALTH CARE DISTRICT
Nevin House, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
Board Clerk, Executive Assistant to CEO

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

KAWEAH DELTA HEALTH CARE DISTRICT
BOARD OF DIRECTORS
QUALITY COUNCIL

Thursday, November 14, 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. **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.*
2. **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.*
3. **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.*
4. **National Surgical Quality Improvement Program (NSQIP) –** A review of performance on the key quality measures in the NSQIP program as administered by the American College of Surgeons. *Lamar Mack, MD, Physician Champion NSQIP; Kassie Waters, RN, Manager of Quality and Patient Safety.*
5. **Approval of Quality Council Closed Meeting Agenda** – Kaweah Delta Medical Center Executive Conference Room – immediately following the open Quality Council meeting
    - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of Professional Staff Quality Committee (Pro-Staff) – *Monica Manga, MD, and Professional Staff Quality Committee Chair;*

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

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

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

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

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

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

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

Kaweah Delta HEALTH CARE DISTRICT

Emergency Department Metrics

	AUGUST 2019		SEPTEMBER 2019		OCTOBER 2019	
GENERAL METRICS	**KDHCD**	**GOAL**	**KDHCD**	**GOAL**	**KDHCD**	**GOAL**
ED Volume	7698		7100		7117	
Percent of Patients Left Without Being Seen	2.0%	1.5%	1.3%	1.5%	1.0%	1.5%
Percent of Patients Left During Treatment	2.4%	1.5%	2.4%	1.5%	1.9%	1.5%
Percent of Patients Left Against Medical Advice	1.0%	NA	0.9%	NA	1.0%	NA
Percent of Patients Admitted	23%	NA	24%	NA	25%	NA
Percent of Patients Discharged	69%	NA	69%	NA	69%	NA
		CMS		CMS		CMS
ED THROUGHPUT METRICS		Benchmark		Benchmark		Benchmark
Median Length of Stay in Minutes for Admitted Patient (Hours)	462 (7.7)	423 (7.05)	457 (7.6)	423 (7.05)	438 (7.3)	423 (7.05)
Median Length of Stay in Minutes for Discharged Patient (Hours)	225 (3.8)	204 (3.4)	217 (3.6)	204 (3.4)	212 (3.5)	204 (3.4)
Median Length of Stay in Minutes for Admit Decision to ED Depart (Hours)	225 (3.8)	180 (3)	225 (3.8)	180 (3)	215 (3.6)	180 (3)
Average Length of Stay in Minutes for Admitted Mental Health Patients (Hours)	846 (14.1)		861 (14.4)		513 (8.6)	
CENSUS TOTALS BY DISPOSITION						
Number of Patients Arriving by Ambulance	2002		1799		1959	
Number of Trauma Patients	188		185		177	
Number of Patients Admitted	1764		1685		1744	
Number of Patients Discharged	5289		4897		4893	
Number of Mental Health Patients Admitted	109		93		79	
PATIENT EXPERIENCE						GOAL
Emergency Room Overall Care Percentile Ranking					52%	50%
Likelihood to Recommend the ED at KD Percentile Ranking						

KEY			
Outperforming or Meeting Benchmark/Goal		> 10% Above Benchmark/Goal	Within 10% of Benchmark/Goal

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%

AUGUST 2019
66%

JULY-AUG 2019
HIGHER IS BETTER
67%

MRSA

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

GOAL ≤.815

AS OF JULY 2019
INFECTIONS: 4
PREDICTED: ≤2 EVENTS

SEPT. 2019
NUMBER OF PATIENTS WHO ACQUIRED MRSA
1

JULY-SEPT 2019
LOWER IS BETTER
2.04

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: 9
PREDICTED: ≤4 EVENTS

SEPT 2019
NUMBER OF PATIENTS WHO ACQUIRED CAUTI
4

JULY - SEPT 2019
LOWER IS BETTER
2.53

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: 3
PREDICTED: ≤3 EVENTS

SEPT 2019
NUMBER OF PATIENTS WHO ACQUIRED CLABSI
3

JULY - SEPT 2019
LOWER IS BETTER
1.27

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

SEPTEMBER 2019:
0.99

JUL - SEPT 2019:
0.87

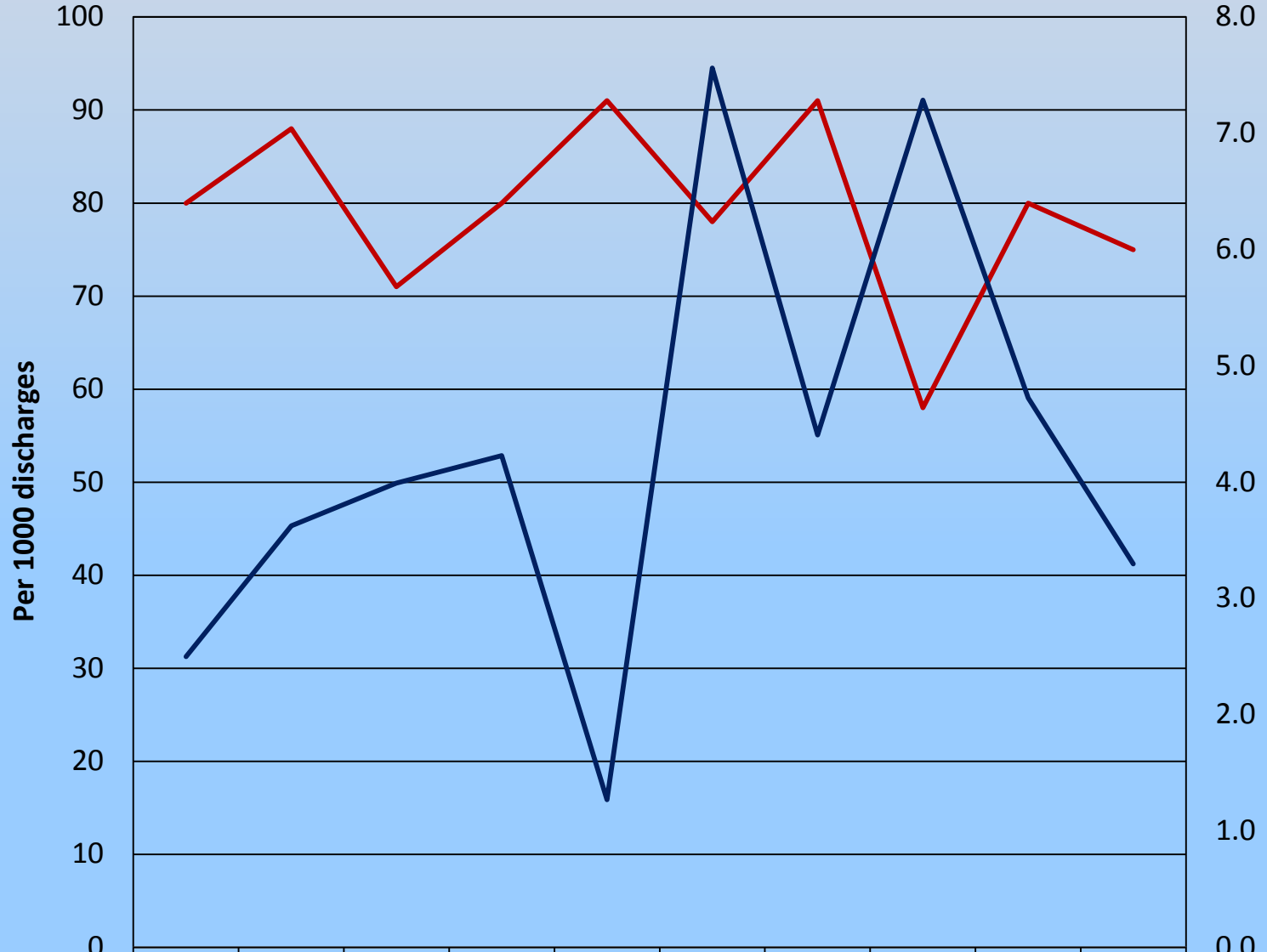
Code Blue and Rapid Response System

September 2019

KAWEAH DELTA HEALTH CARE DISTRICT

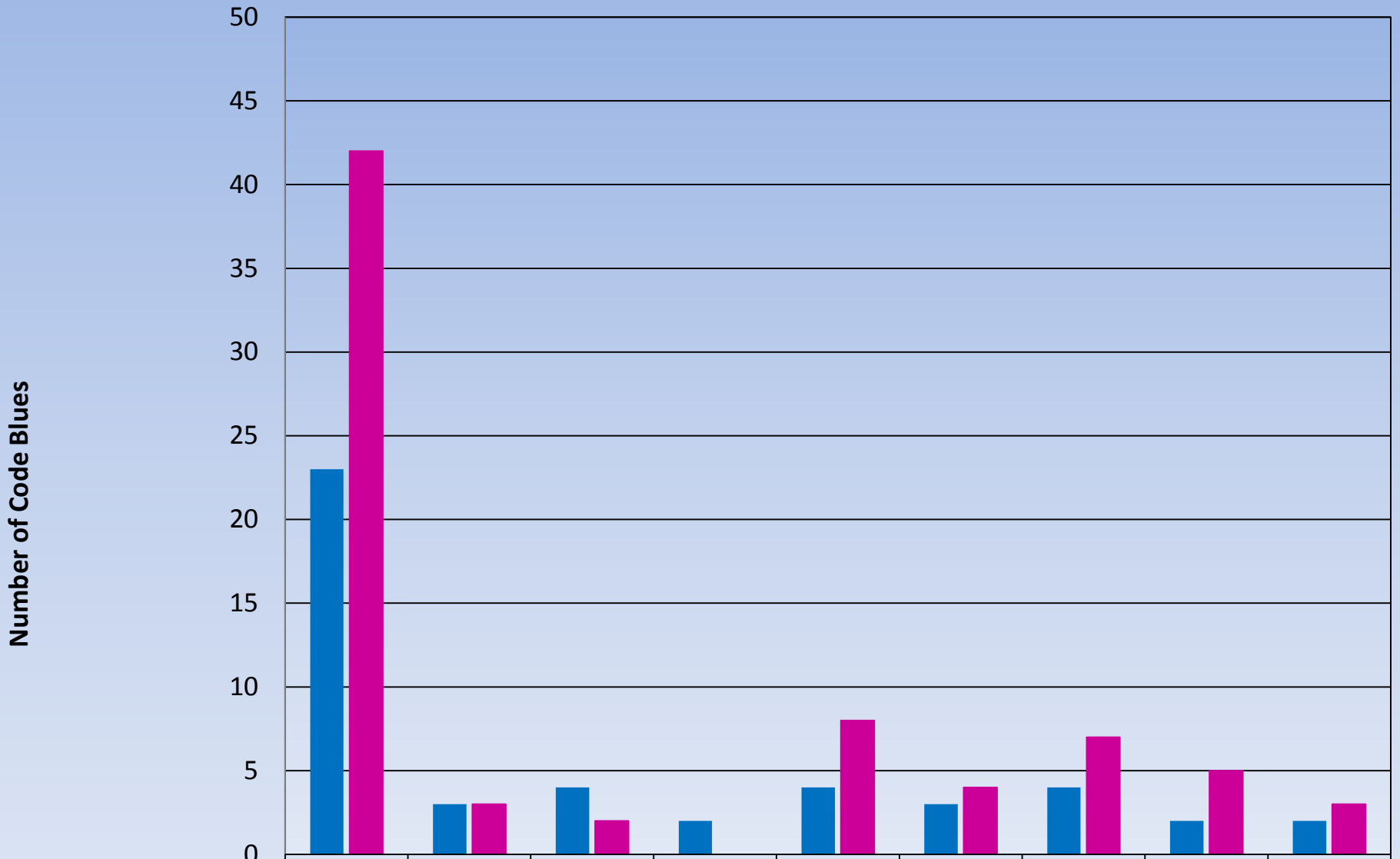
Code Blue Data

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



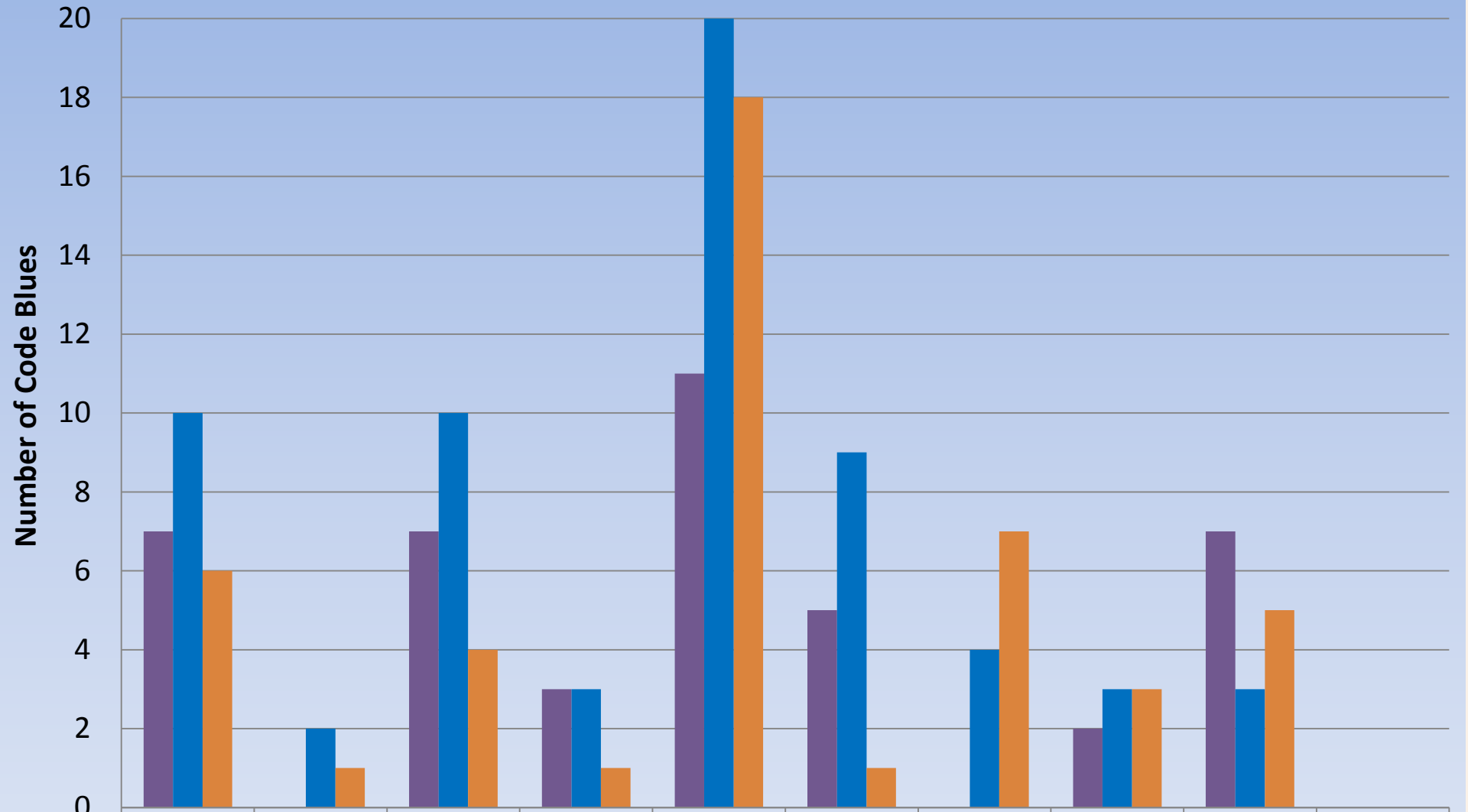
	2017	2018	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
RRT Rate per 1000 discharges	80	88	71	80	91	78	91	58	80	75
Code Blue Rate per 1000 discharges	2.5	3.6	4.0	4.2	1.3	7.6	4.4	7.3	4.7	3.3

Non Critical Care Code Blues



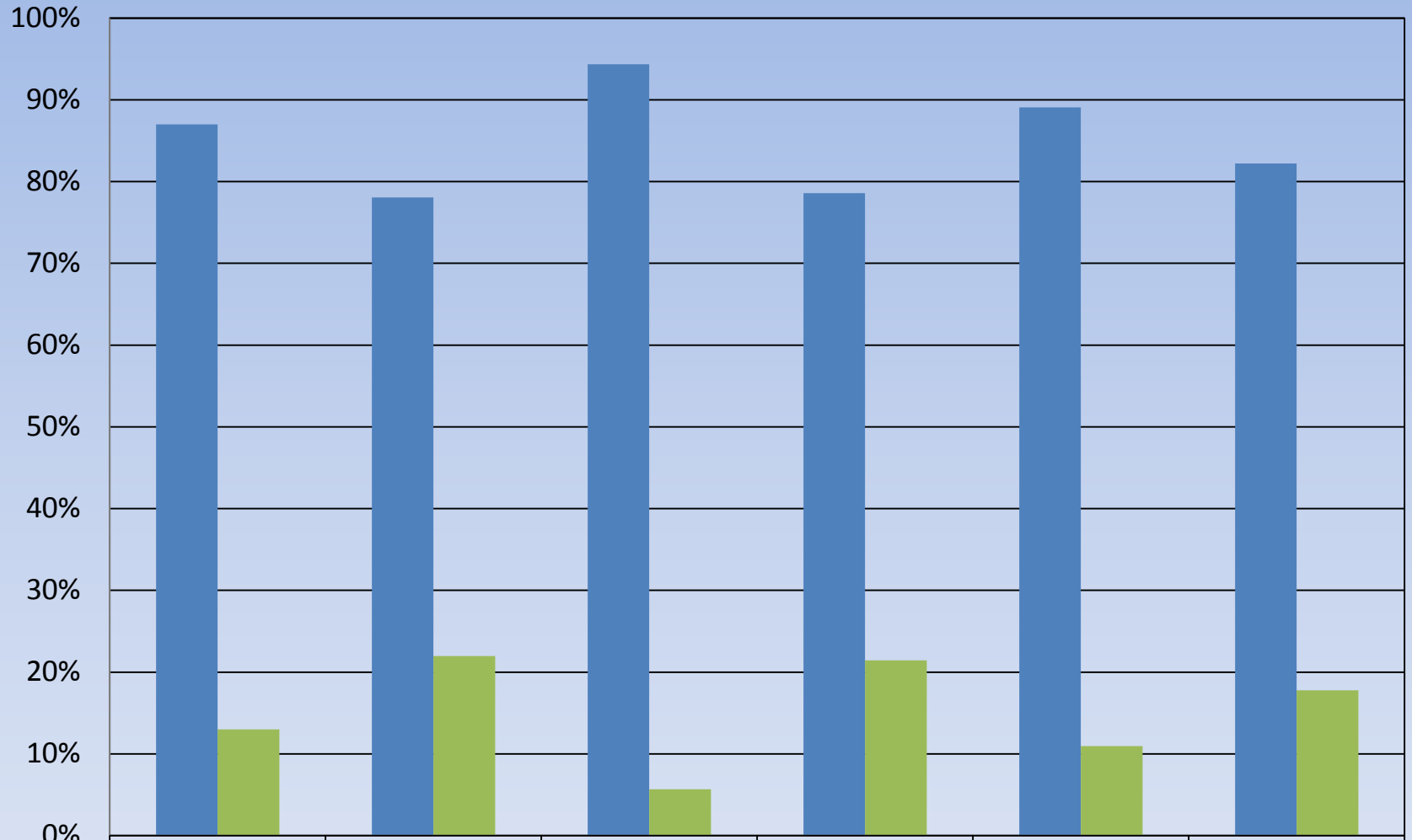
	2018	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Intermediate Care Code Blue	23	3	4	2	4	3	4	2	2
Med Surg Code Blue	42	3	2	0	8	4	7	5	3

Code Blue Locations



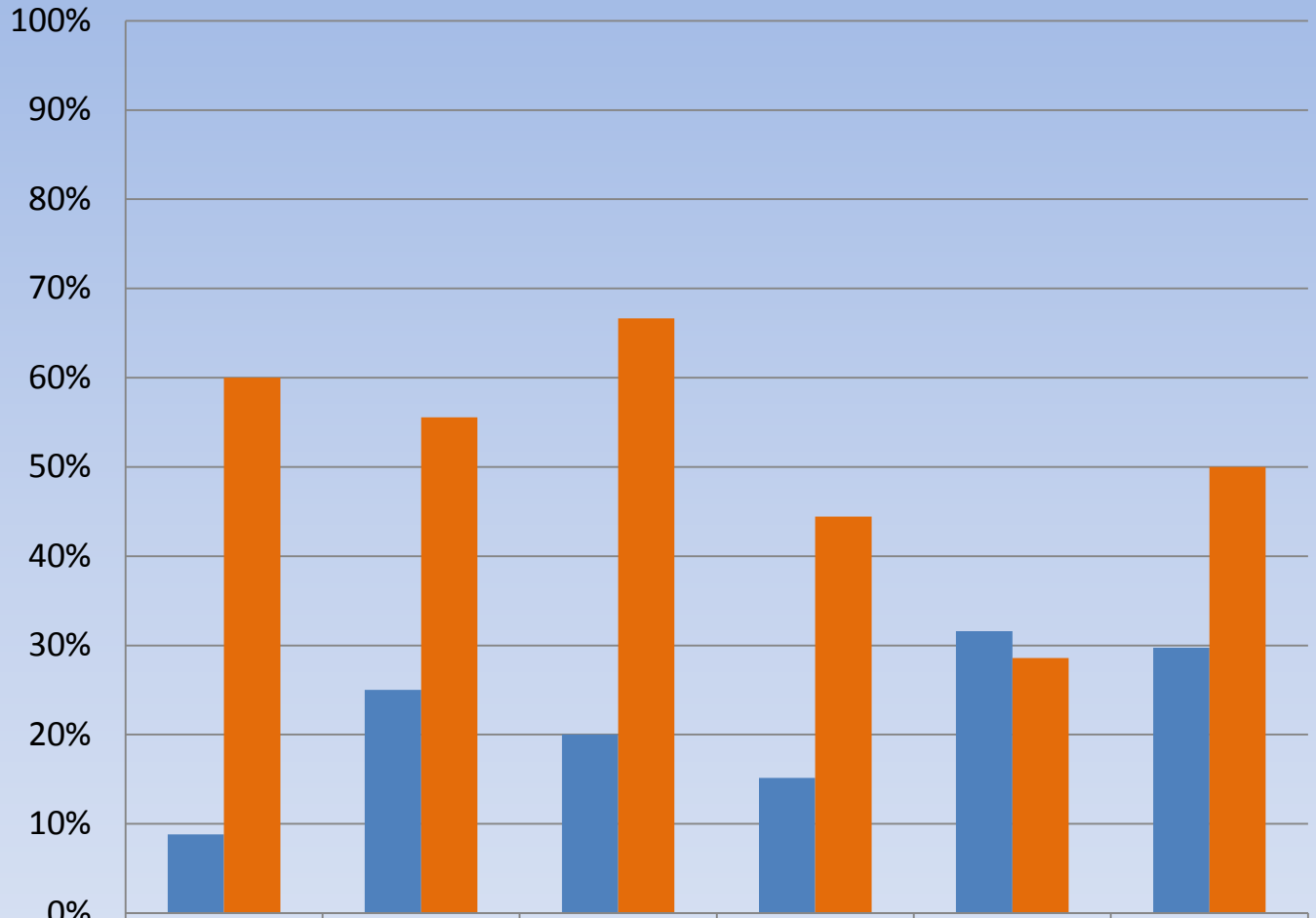
	2N	2S	3N	3S	3W	4N	4S	4T	CVICCU	BP
2017	7	0	7	3	11	5	0	2	7	0
2018	10	2	10	3	20	9	4	3	3	0
2019	6	1	4	1	18	1	7	3	5	0

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

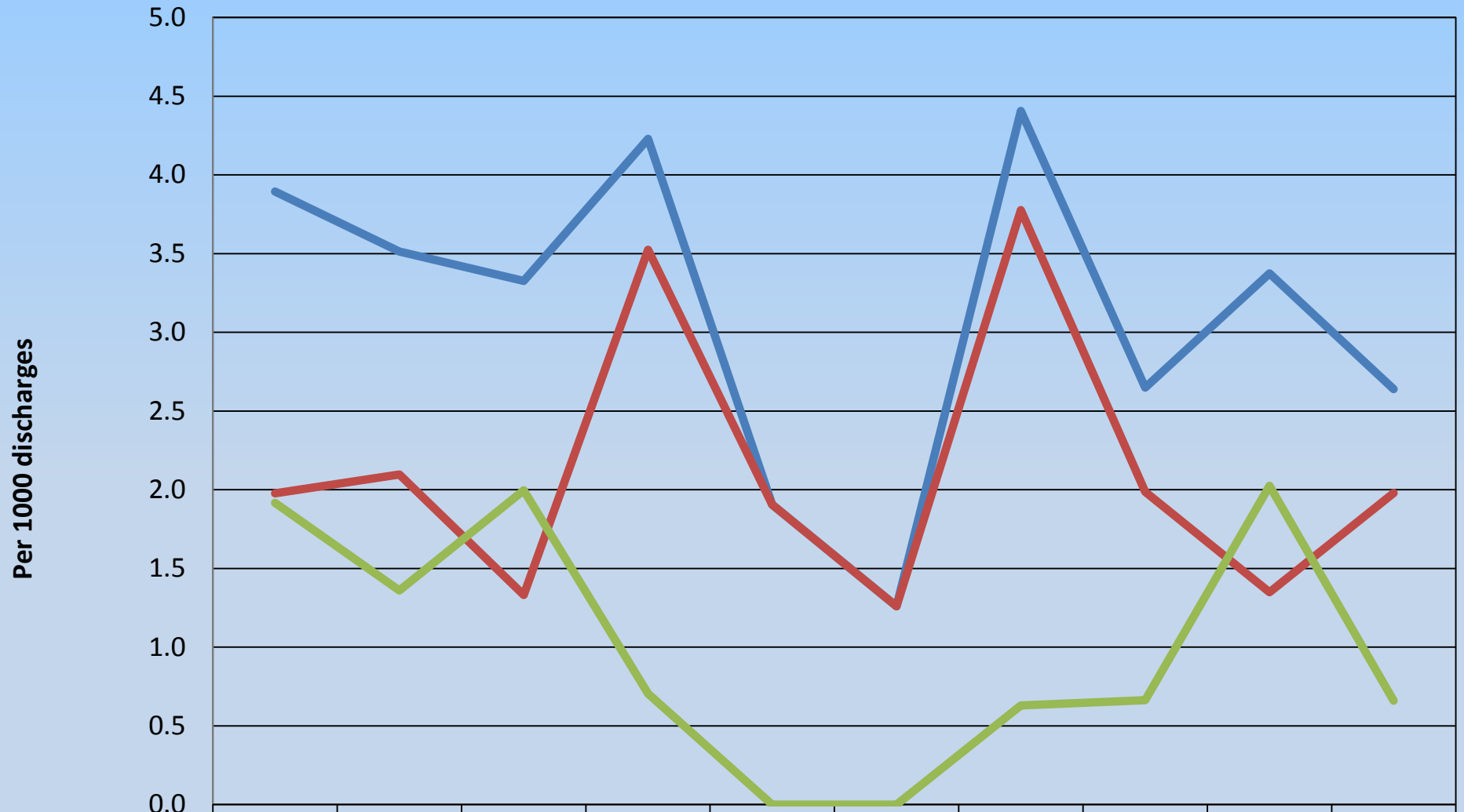


AHA Survival Outcomes
Discharged Alive
PEA/A=11.4%
VF/VT= 36.5%

	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%

12/155

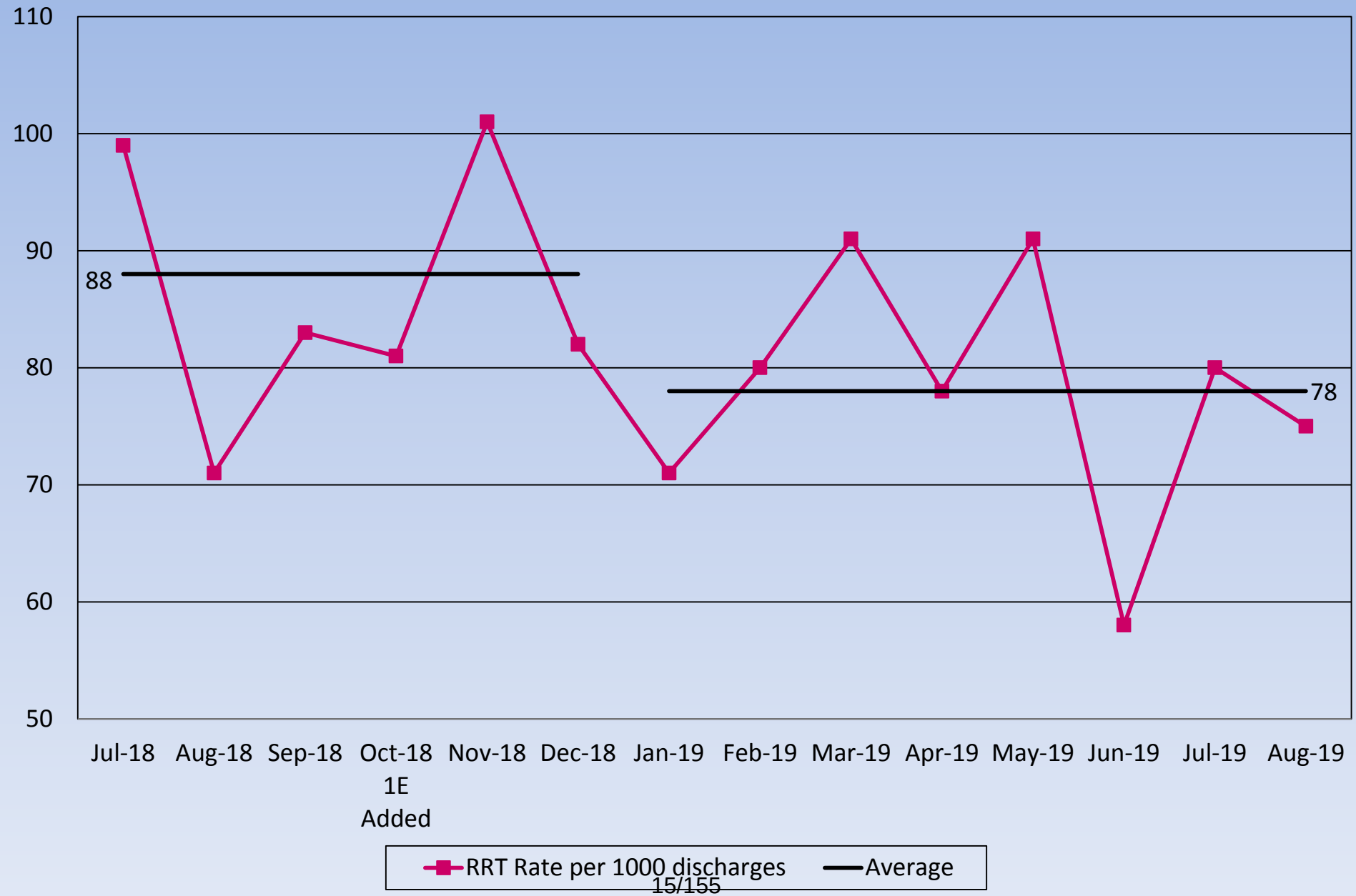
Code Blues per 1000 discharges for CVICU and ICU



	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

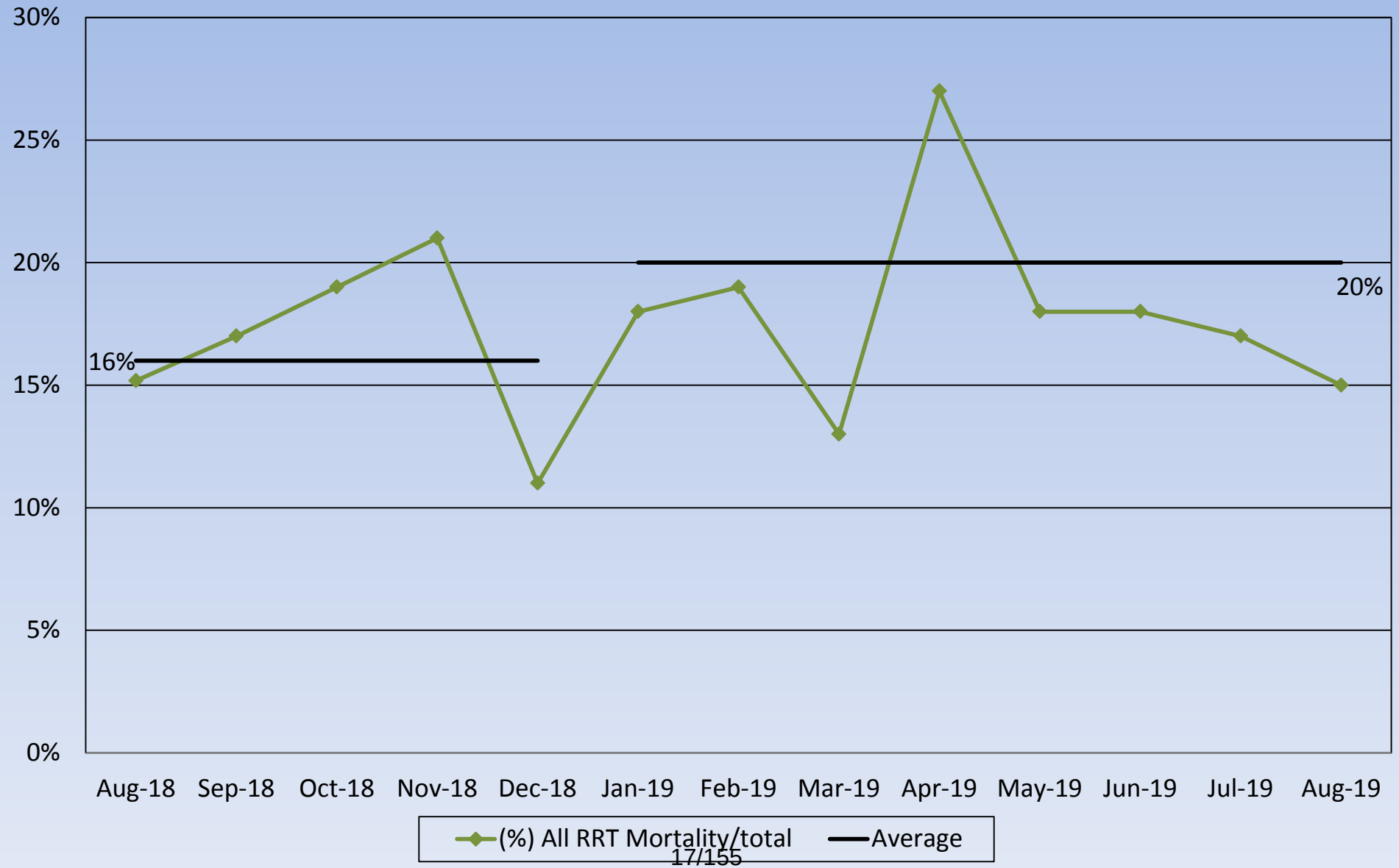
Rapid Response System Data

RRTs per 1000 Patient Discharge Days

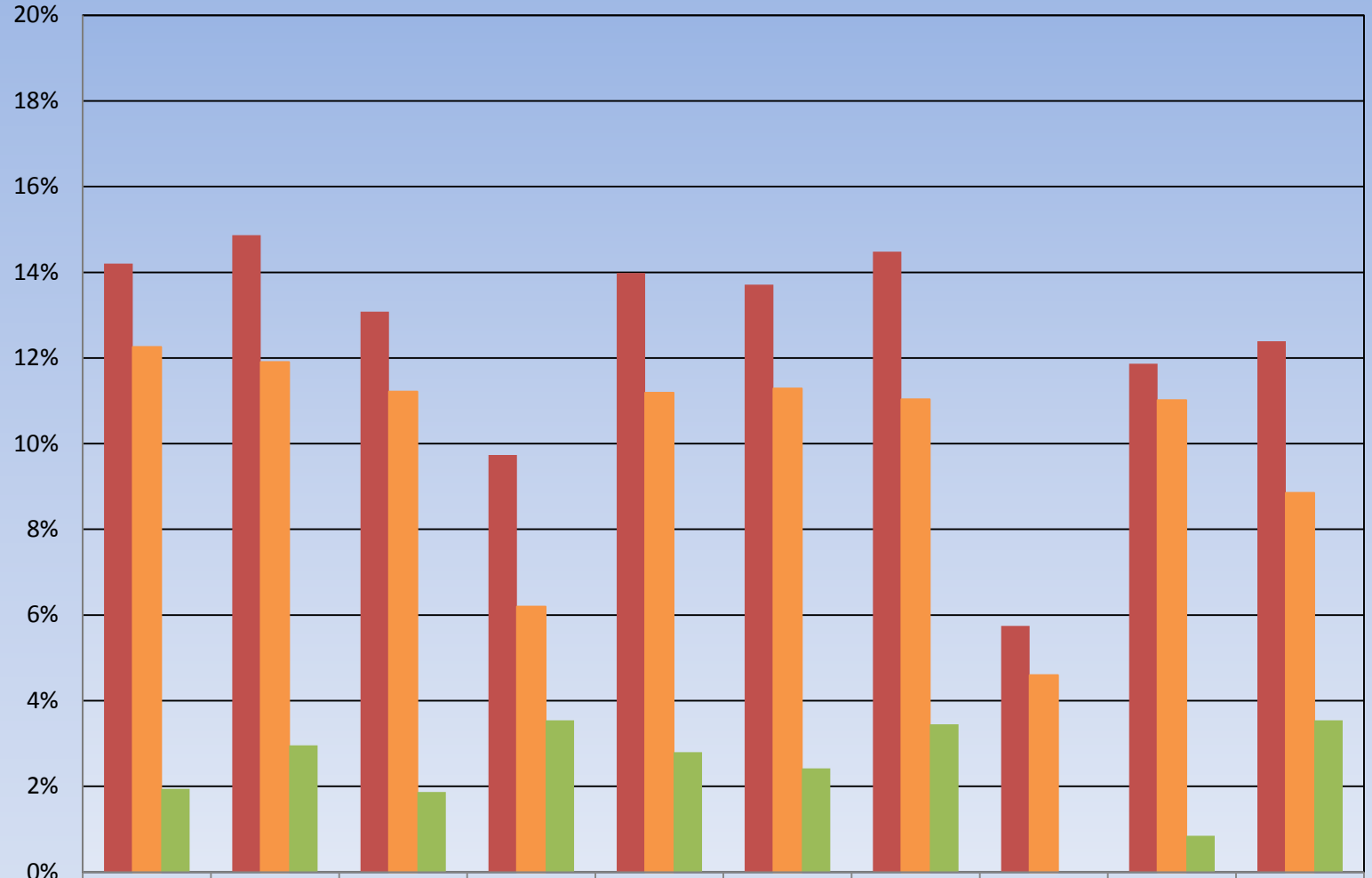


Alert Location	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Totals
KDMC 3W	24	28	31	32	33	14	23	21	206
KDMC 4S	14	17	21	20	21	10	24	17	144
KDMC 3N	15	14	17	14	15	10	9	10	104
KDMC 3S	12	12	11	11	19	10	14	8	97
KDMC 2N	8	9	15	15	11	8	17	9	92
KDMC 14	7	10	11	7	17	6	10	9	77
KDMC 4N	10	7	7	3	9	15	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

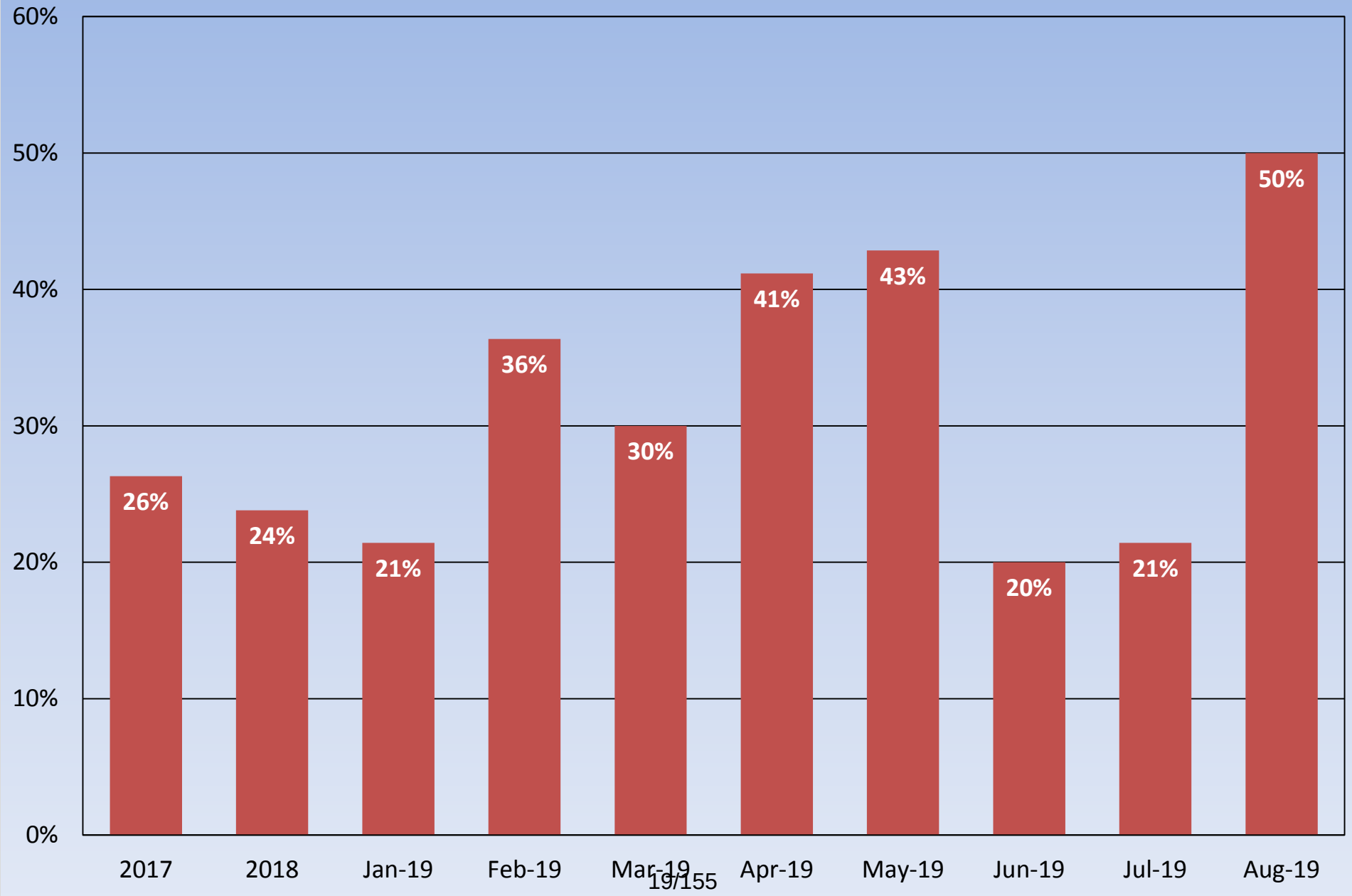


Patients with Multiple RRT's



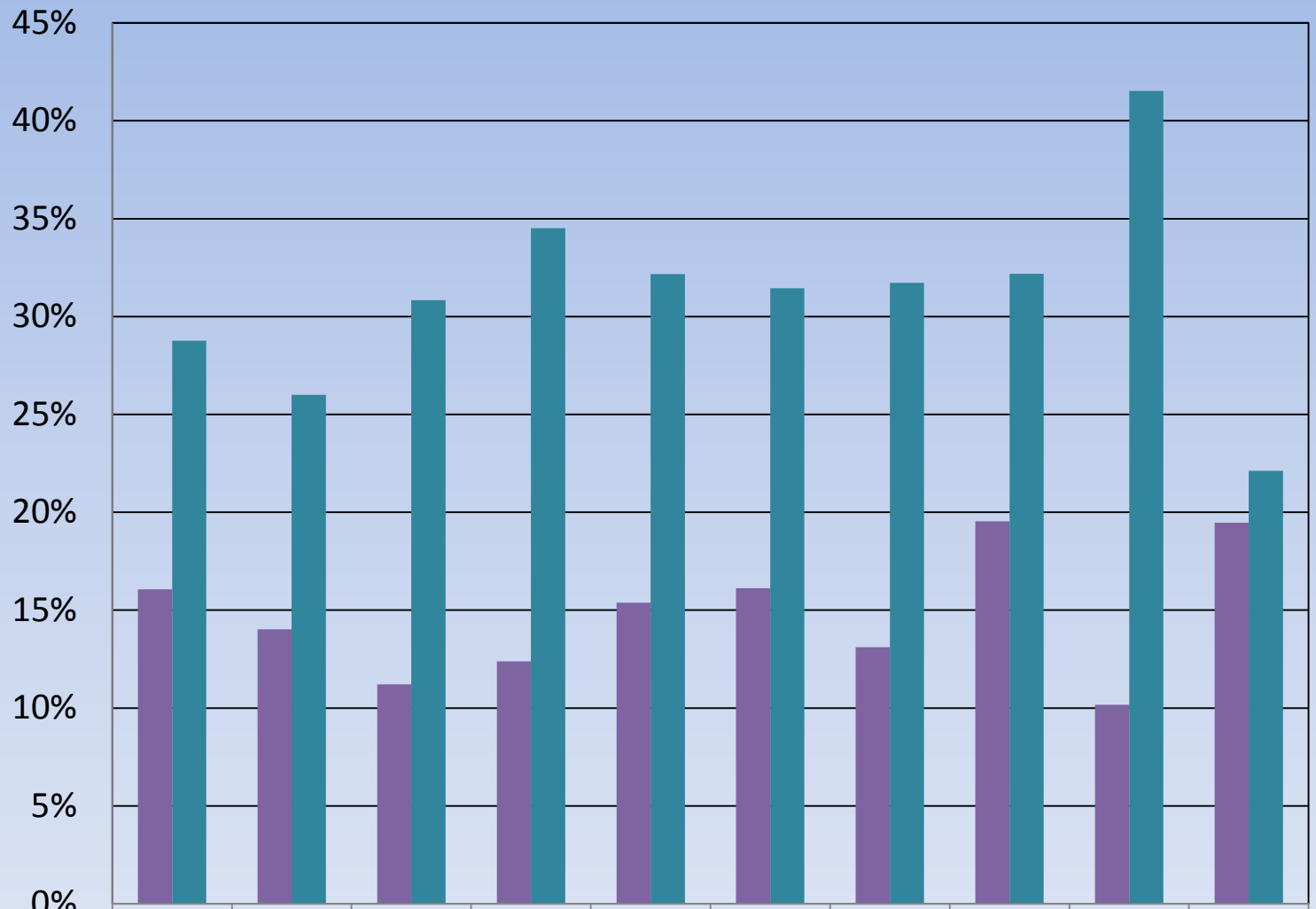
	2017	2018	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Total Number of Multiple RRT's	14%	15%	13%	10%	14%	14%	14%	6%	12%	12%
2 RRT's	12%	12%	11%	6%	11%	11%	11%	5%	11%	9%
3 or more RRT's	2%	3%	2%	4%	3%	2%	3%	0%	1%	4%

Multiple RRT Mortality



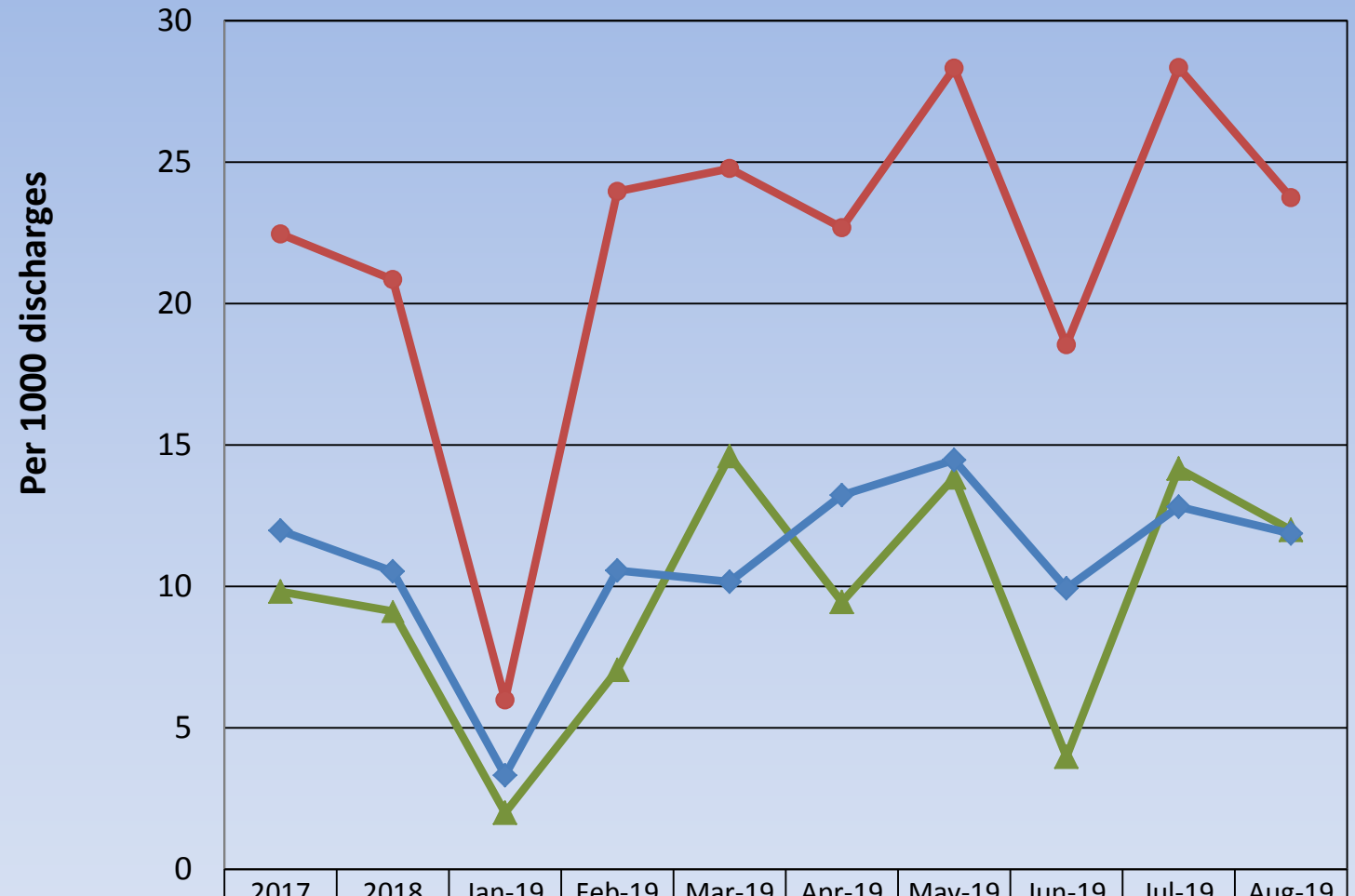
Disposition of RRT

*Oct includes 1E



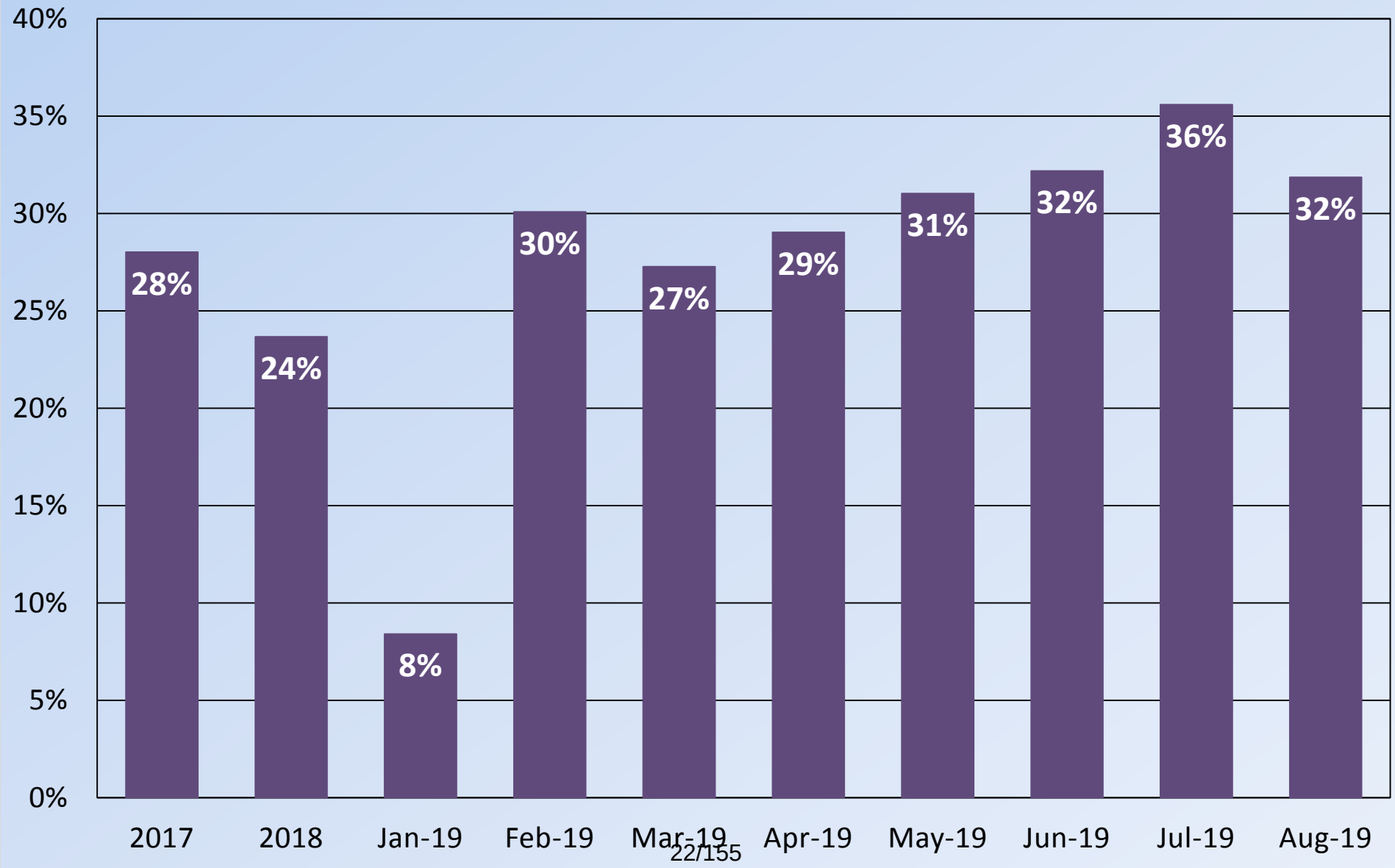
	2017	2018	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
(%) Transferred to ICU/CVICU	16%	14%	11%	12%	15%	16%	13%	20%	10%	19%
(%) Transferred to ICCU	29%	26%	31%	35%	32%	31%	32%	32%	42%	22%

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

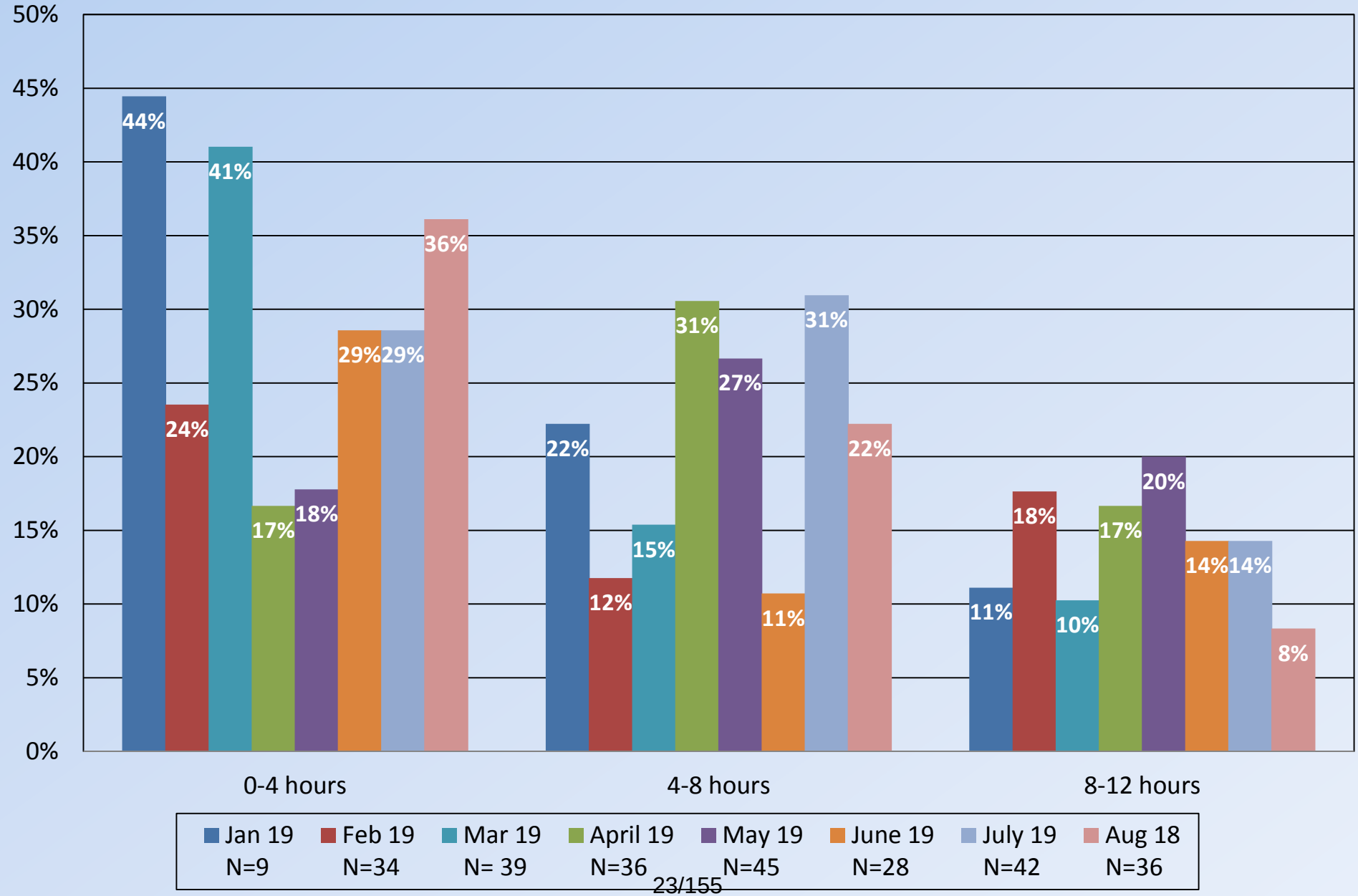


	2017	2018	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
RRT within 24 hr admit from ED	22	21	6	24	25	23	28	19	28	24
RRT within 24 hours of admit transferred to (ICU/ICCU)	10	9	2	7	15	9	14	4	14	12
RRT within 24 hours of admit from ED: Stayed in Room	12	11	3	11	10	13	14	10	13	12

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



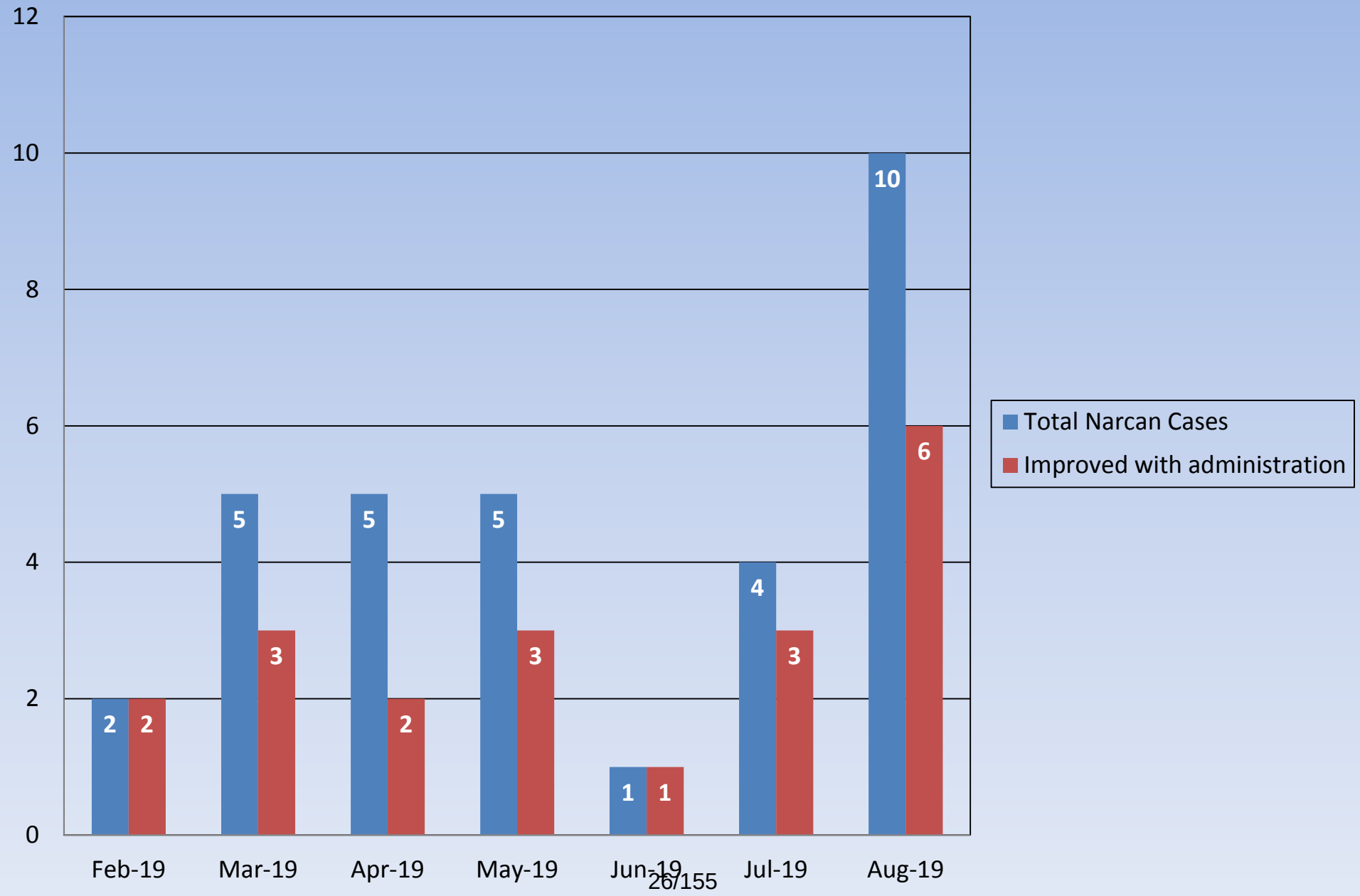
RRTs within 12 hours of Admit from ED



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



American College of Surgeons
National Surgical Quality Improvement Program

Dr. Mack – Surgeon Champion
Kassie Waters BSN MPA CPHQ– Quality Improvement Manager
Shaye Garrett – Data Analyst

AMERICAN COLLEGE OF SURGEONS
Inspiring Quality:
Highest Standards, Better Outcomes

Program Overview

- ACS NSQIP is a data-driven, risk-adjusted, outcomes-based program to measure and improve the quality of surgical care.

- Benefits of participation include:
  - Identifying quality improvement targets
  - Improving patient care and outcomes
  - Decreasing institutional healthcare costs

NSQIP Semiannual Report Post Surgical Complications

04/01/2018 - 03/31/2019

ACS NSQIP Interim Semiannual Report: Site Summary

Kaweah Delta District Hospital

Site Number: 2258

All Cases

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

NSQIP Semiannual Report Summary

Analysis:

- Pneumonia and Urinary Tract Infection complications are low and performance was noted as “Exemplary”
- Renal Failure complications were higher than expected and performance was noted as “Needs Improvement”
- All other quality metrics were “As Expected”

Actions/Next Steps:

- Urology reviewed all renal failure cases at last NSQIP committee and noted no correlations. Recommendation is to involve urology earlier in cases.

Kaweah Medical Center
Enhanced Recovery After Surgery
Improving Surgical Care & Recovery Program Registry

JOHNS HOPKINS MEDICINE

AMERICAN COLLEGE OF SURGEONS
Inspiring Quality: Highest Standards, Better Outcomes
100+years

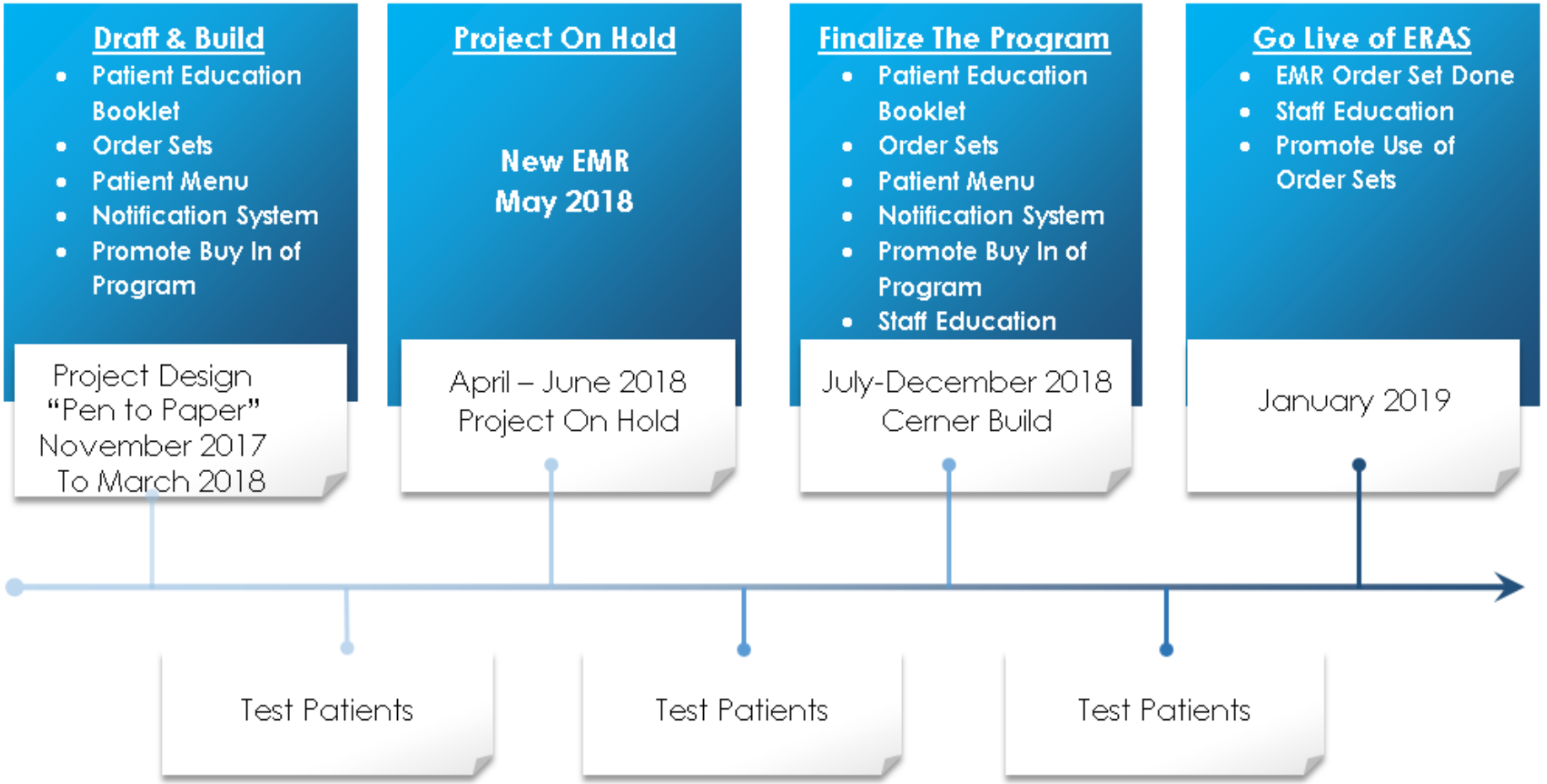
Comprehensive Program

Goal: Improving perioperative care that includes the principles of enhance recovery but also incorporates best practices to reduce:

- SSI
- VTE
- UTI
- Opioid use
- LOS

Team Members – ERAS Colorectal Program	
(1) ISCR project lead	Kassie Waters, Quality Manager
(2) Surgeon champion	Dr. Mack & Dr. Potts
(3) Anesthesia champion	Dr. Tang
(5) Senior executive	Regina Sawyer, CNO
(6) Unit champions	Brian Piearcy, Director of Surgical Services Kari Knudsen, Director of Post-Surgical Services, Andrea Hodgkins, Nurse Manager, Leticia Quinn, Nurse Manager, Amanda Tercero, Nurse Manager, Kris Daugherty, Nutrition Manager, Ryann Jung, Registered Dietitian
3 North – Med/Surgical	
ACS/PACU	
Surgery	
Dietary	
(7) Pharmacist	Blake Bartlett, Pharmacist-IT, & Kelly Mendoza, Pharmacist
(8) Health information technology (IT) specialist	Kurtis Stutsman, Clinical Content, IT

Colorectal ERAS Project Timeline



Johns Hopkins Site Visit October 8, 2019
Enhanced Recovery After Surgery

JOHNS HOPKINS MEDICINE

AMERICAN COLLEGE OF SURGEONS
Inspiring Quality: Highest Standards, Better Outcomes
100+years

Four Johns Hopkins representatives met with individual team members all day and reviewed:

- Current state of program
- Implementation successes and barriers
- Best practices seen at other hospitals

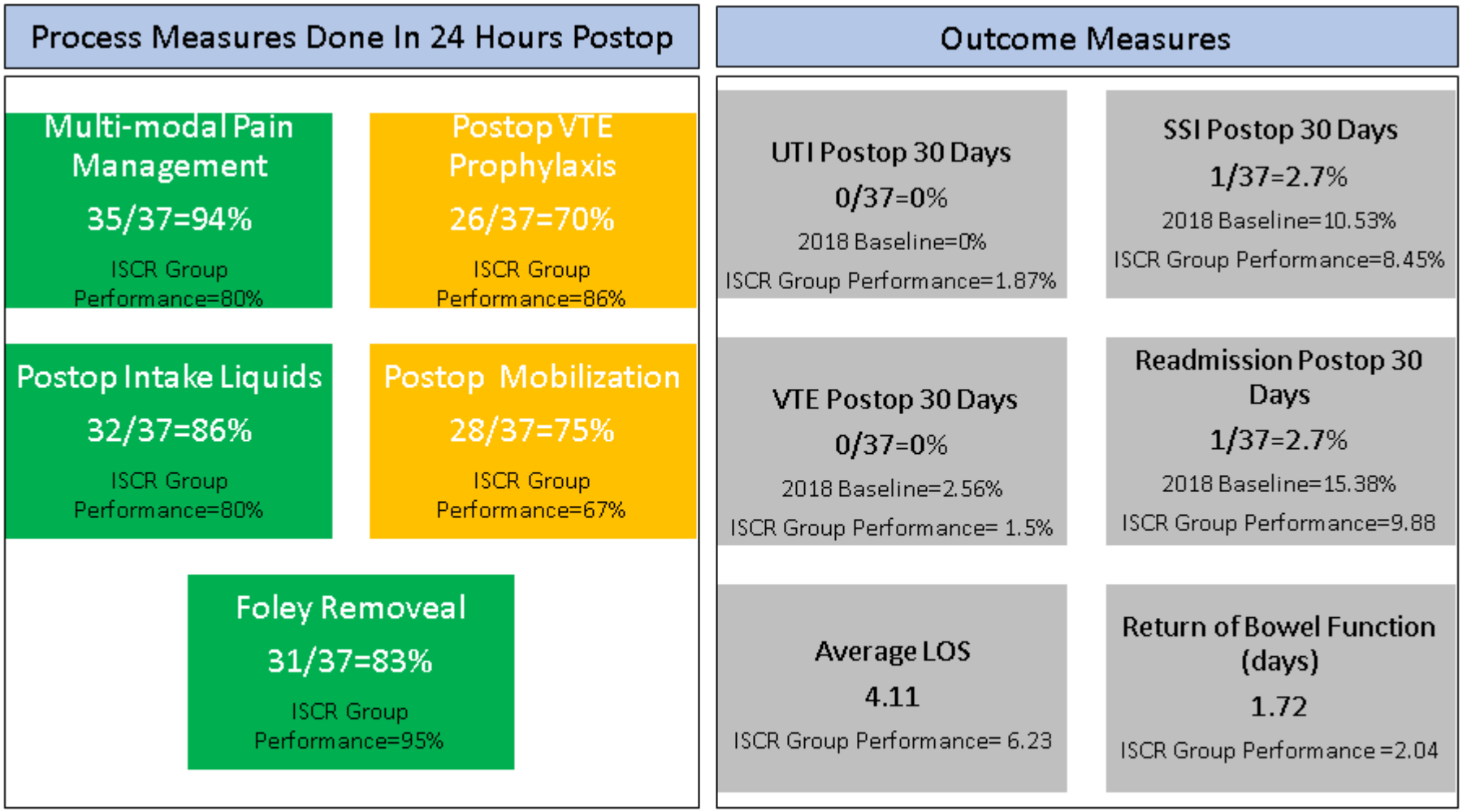
Findings:

- Excellent teamwork and alignment
- High level of support of the program
- Timeline of implementation on track with other hospitals
- Great program outcomes

Suggested Next Steps:

- Implement ERAS or program components into all surgical areas

Enhanced Recovery after Surgery Dashboard
January – August 2019 (Total 37 Elective Cases)



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

Enhanced Recovery After Surgery Dashboard

Analysis:

- Postop VTE prophylaxis has the lowest compliance rate. Reasons for non-compliance include: patient refusal, held for procedure, ordered late, not ordered, and ordered but given on POD 2.
- Postop Mobilization was the second to the lowest compliance rate. Noted these patients were mobilized late in the afternoon on POD 1, but not within 24 hours of Surgery Stop Time.
- All outcome measures are performing well compared to baseline and ISCR Group Performance.

Actions/Next Steps:

- Postop VTE prophylaxis - Establish concurrent case reviews with providers when opportunities for improvement are identified. Also, meet with pharmacy and review cases when lovenox is canceled and if contraindications were noted.
- Postop Mobilization – Most fallouts were due to ambulating late in the evening on POD 1. Provide staff education and feedback.

ERAS Projects

NSQIP Committee Oversite of ERAS Teams (meet quarterly)

- Enhanced Recovery After Surgery Workgroup Teams (meet monthly)
  - Colorectal – Project completed - Continue to monitor
  - In-Patient Colorectal – New team

    Team Lead: Surgical Resident project
  - Orthopedic – New Team

    Team Lead: Megan Goddard, Nurse Practitioner
  - GYN – New Team

    Team Lead: Dr. Sabogal