October 8, 2020

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in a Quality Council Committee meeting at 7:00AM on Thursday, October 15, 2020, in the Kaweah Delta Lifestyle Center, Conference Room A, 5105 W. Cypress Avenue, or via GoTo Meeting form your computer, tablet or smartphone. https://global.gotomeeting.com/join/881426077 or call (224) 501-3412 - Access Code: 881-426-077.

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:01AM on Thursday, October 15, 2020, in the Kaweah Delta Lifestyle Center, Conference Room A, 5105 W. Cypress Avenue, pursuant to Health and Safety code 32155 & 1461. Board members and Quality Council closed session participants will access closed meeting via Confidential GoTo Meeting phone number provided to them.

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Quality Council Committee meeting at 8:00AM on Thursday October 15, 2020, in the Kaweah Delta Lifestyle Center, Conference Room A, 5105 Cypress Avenue, or via GoTo Meeting via computer, tablet or smartphone. https://global.gotomeeting.com/join/881426077 or call (224) 501-3412 - Access Code: 881-426-077.

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.

Due to COVID 19 visitor restrictions to the Medical Center - the disclosable public records related to agendas can be obtained by contacting the Board Clerk at Kaweah Delta Medical Center – Acequia Wing, Executive Offices (Administration Department) {1st floor}, 400 West Mineral King Avenue, Visalia, CA via email: cmoccio@kdhcd.org, via phone: 559-624-2330 or on the Kaweah Delta Health Care District web page http://www.kaweahdelta.org.

KAWEAH DELTA HEALTH CARE DISTRICT
David Francis, 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, October 15th, 2020

5105 W. Cypress Avenue

The Lifestyle Center; Conference Room A

Call in option: 1-224-501-3412 Access Code: 881-426-077

ATTENDING: Board Members; Herb Hawkins – Committee Chair, David Francis; Gary Herbst, CEO; Keri Noeske, RN, BSW, DNP, VP & CNO; Anu Banerjee, PhD, VP & Chief Quality Officer, 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 & VP of Medical Education; Tom Gray, MD, Quality and Patient Safety Medical Director; Sandy Volchko, Director of Quality and Patient Safety; Ben Cripps, Chief Compliance Officer, and Michelle Adams, Recording.

OPEN MEETING – 7:00AM

1. **Call to order** – *Herb Hawkins, Committee Chair*
2. **Public / Medical Staff participation –** Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves at this time. Members of the public or the medical staff may comment on agenda items after the item has been discussed by the Committee but before a Committee recommendation is decided. In either case, each speaker will be allowed five minutes.
3. **Approval of Quality Council Closed Meeting Agenda** – 7:01AM
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Monica Manga, MD, and Professional Staff Quality Committee Chair;*
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Anu Banerjee, PhD, VP & Chief Quality Officer*
4. **Adjourn Open Meeting** – *Herb Hawkins, Committee Chair*

CLOSED MEETING – 7:01AM

1. **Call to order** – *Herb Hawkins, Committee Chair & Board Member*
2. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Monica Manga, MD, and Professional Staff Quality Committee Chair*
3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 — *Anu Banerjee, PhD, VP & Chief Quality Officer*

4. **Adjourn Closed Meeting** – *Herb Hawkins, Committee Chair*

OPEN MEETING – 8:00AM

1. **Call to order** – *Herb Hawkins, Committee Chair*
2. **Public / Medical Staff participation –** Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves at this time. Members of the public or the medical staff may comment on agenda items after the item has been discussed by the Committee but before a Committee recommendation is decided. In either case, each speaker will be allowed five minutes.
3. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives:
    - 3.1. **Rapid Response Team Quality Report**
    - 3.2. **Stroke Program Quality Report**
    - 3.3. **Mental Health Quality Report**
    - 3.4. **Hospice Quality Report**
    - 3.5. **Home Health Services Quality Report**
    - 3.6. **Sepsis Quality Focus Team Update**
    - 3.7. **COVID-19 Clinical Quality Outcomes Monthly Update**
4. **Follow Up From Previous Meetings** – *Anu Banerjee, PhD, VP & Chief Quality Officer; Tom Gray, MD, Quality and Patient Safety Medical Director; Sandy Volchko, RN, DNP, Director of Quality and Patient Safety*
    - 4.1 **Handoff Quality Focus Team**
    - 4.2 **Bathing for central line and urinary catheter patients**
    - 4.3 **Health Information Management Documentation H&P**
5. **Catheter Associated Urinary Tract Infection (CAUTI) Quality Focus Team Report**– Report on CAUTI rates and quality improvement actions aimed at reducing these healthcare acquired infections. *Kari Knudsen, MPA, BSN, RN NE-BC, Director of Post-Surgical Care*
6. **Update: Proposed Clinical Quality Goals** **-** A review of current performance and actions focused on the FY 2020 clinical quality goals. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety*
7. **Adjourn Closed Meeting** – *Herb Hawkins, Committee Chair*

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

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD QUALITY COUNCIL COMMITTEE

THURSDAY OCTOBER 15, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 4-22

KDHCD - BOARD QUALITY COUNCIL COMMITTEE

THURSDAY OCTOBER 15, 2020

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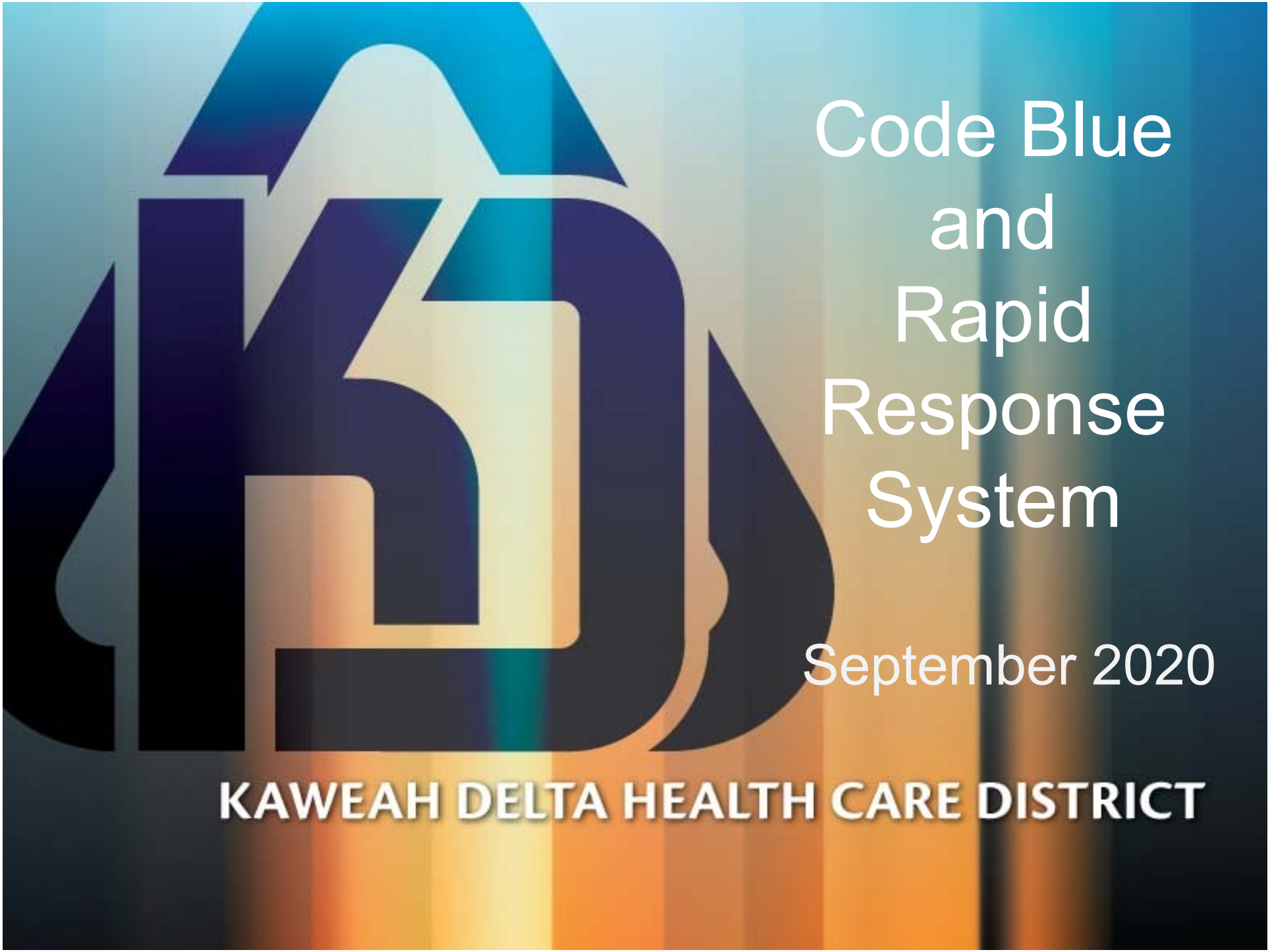

Code Blue
and
Rapid
Response
System
September 2020
KAWEAH DELTA HEALTH CARE DISTRICT

Code Blue Data

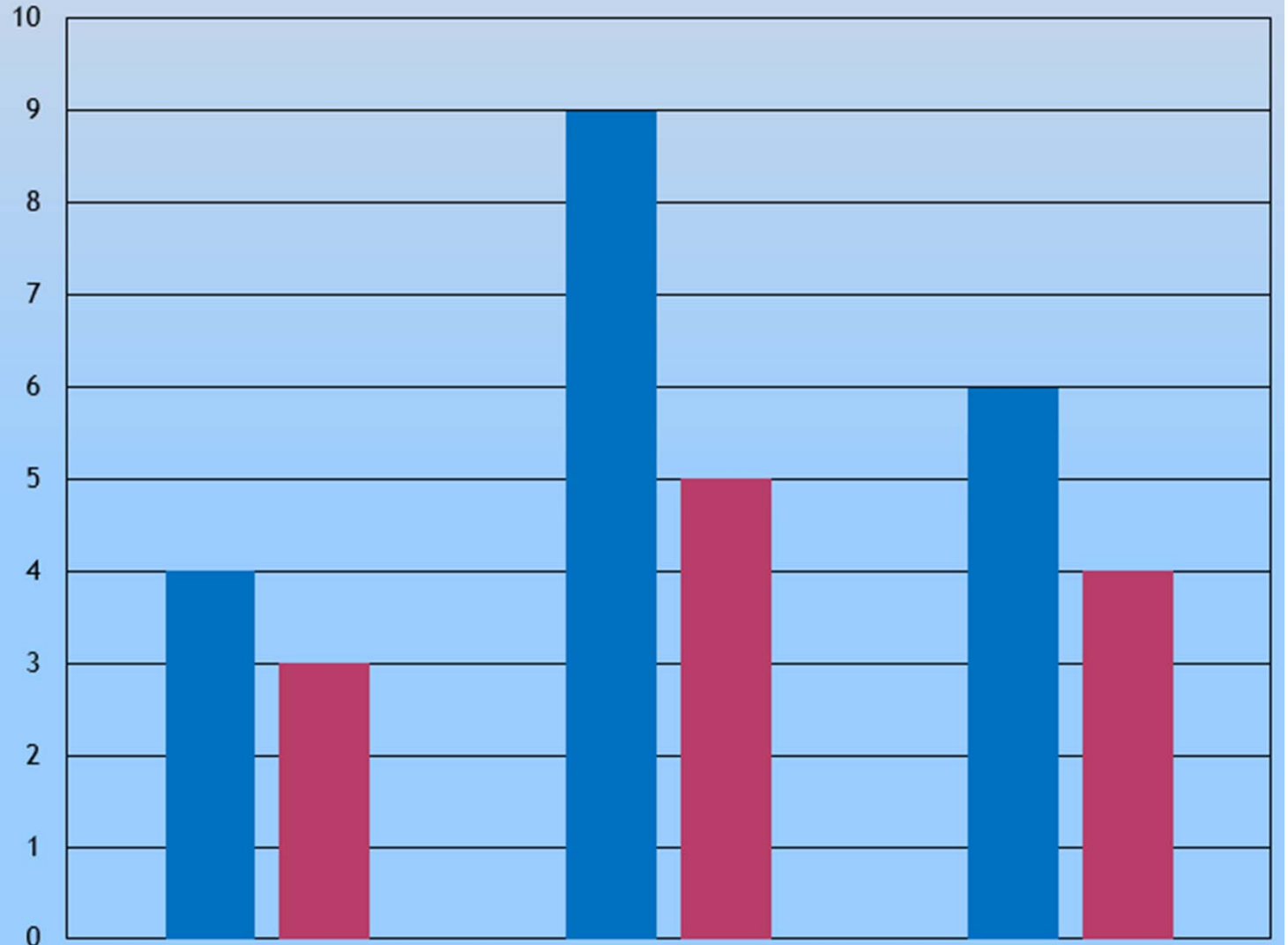
KAWEAH DELTA HEALTH CARE DISTRICT

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

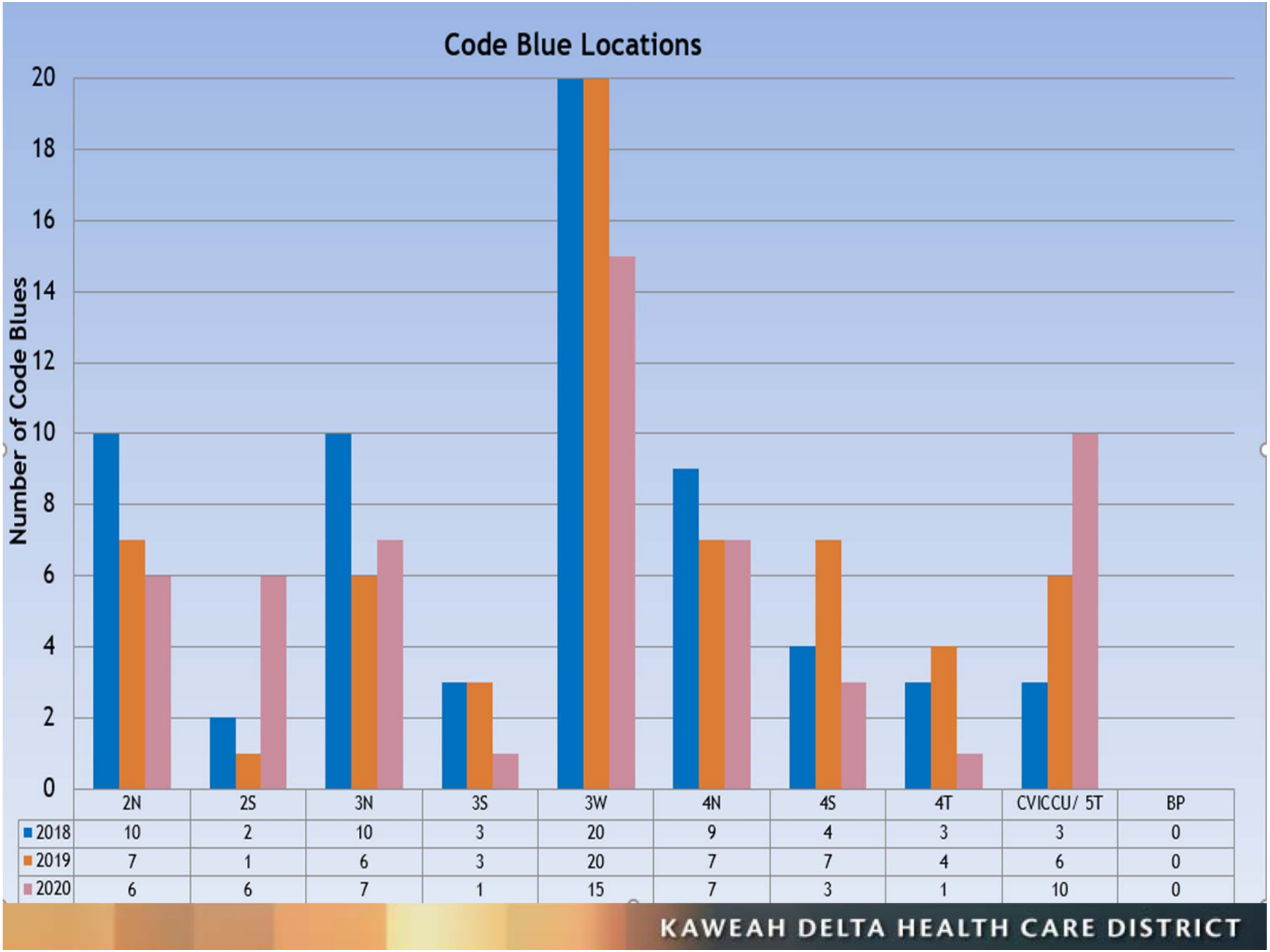
	Jan-20	Feb-20	Mar-20	April-20	May-20	June-20	Jul-20	Aug-20
RRT Rate per 1000 discharges	86	77	81	120	98	109	106	93
Code Blue Rate per 1000 discharges	3.4	3.5	4.5	3.0	5.3	5.5	9.8	6.7

KAWEAH DELTA HEALTH CARE DISTRICT

Non Critical Care Code Blues

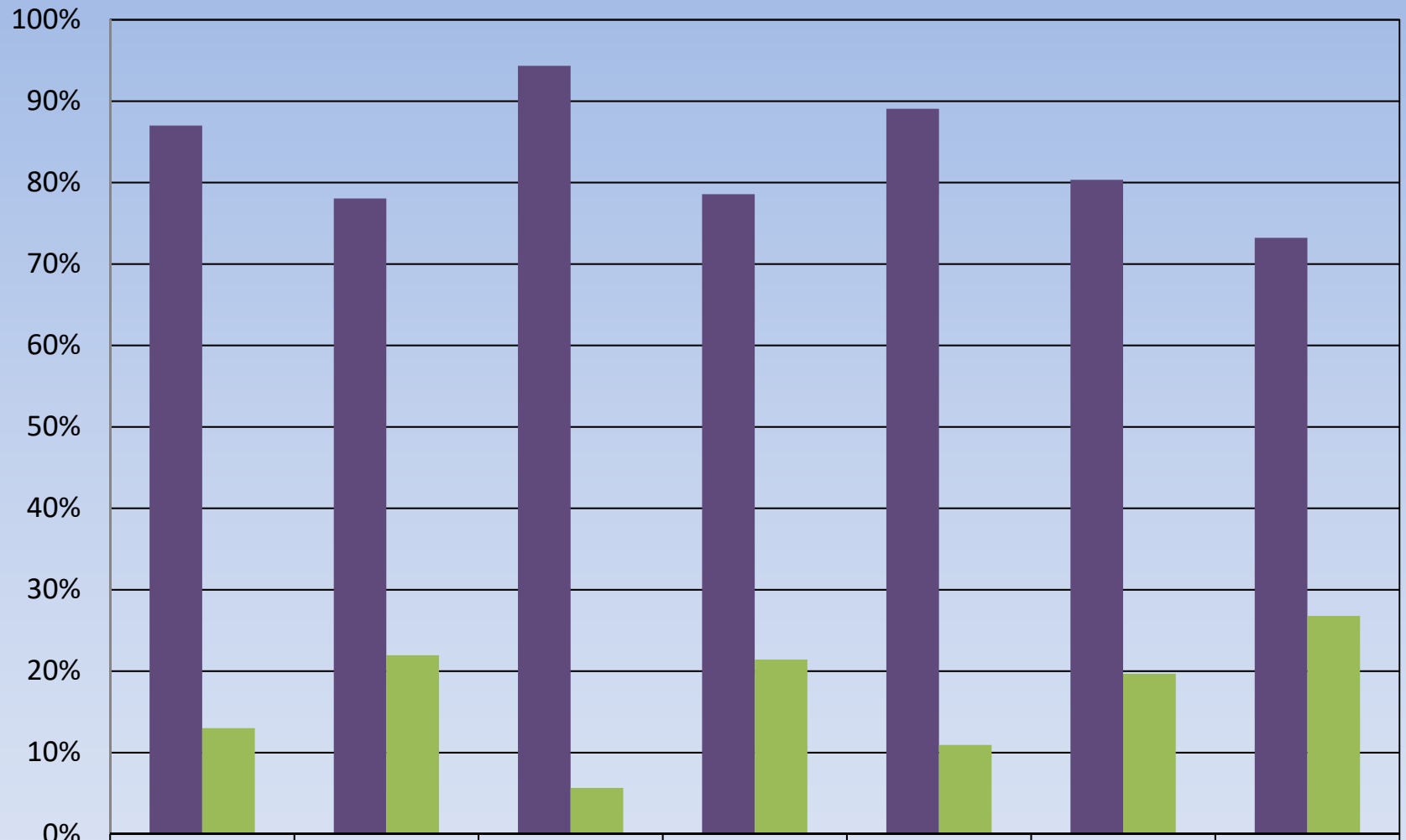


	Jun-20	Jul-20	Aug-20
Med Surg Code Blue	4	9	6
Intermediate Care Code Blue	3	5	4



	2N	2S	3N	3S	3W	4N	4S	4T	CVICCU/ 5T	BP
2018	10	2	10	3	20	9	4	3	3	0
2019	7	1	6	3	20	7	7	4	6	0
2020	6	6	7	1	15	7	3	1	10	0

Med Surg- Code Type



	2014	2015	2016	2017	2018	2019	2020
Asystole and PEA	87%	78%	94%	79%	89%	80%	73%
V Fib and V Tac	13%	22%	6%	21%	11%	20%	27%

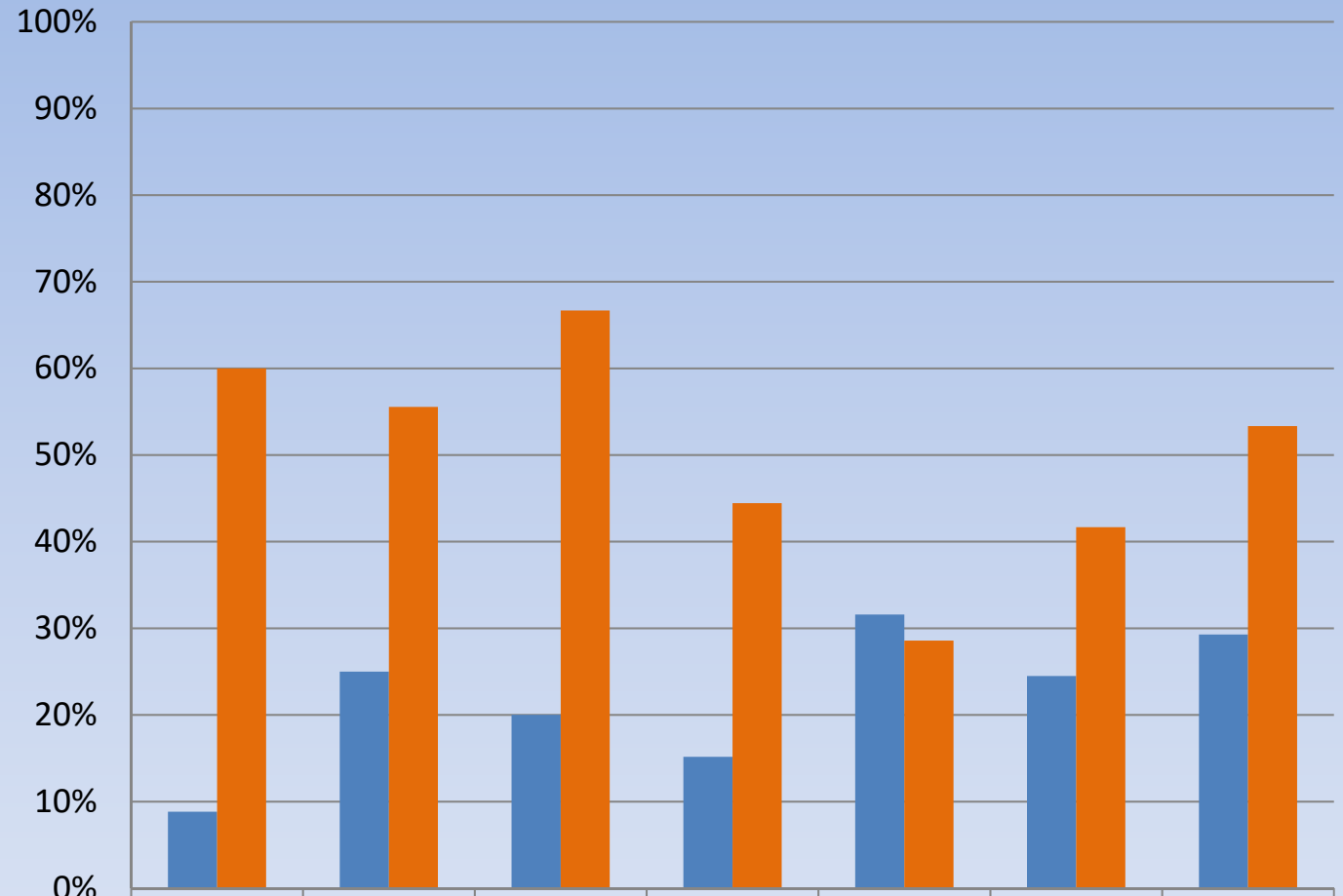
Med Surg- Shockable vs Non Shockable Codes Survival to Hospital Discharge

AHA Survival Outcomes

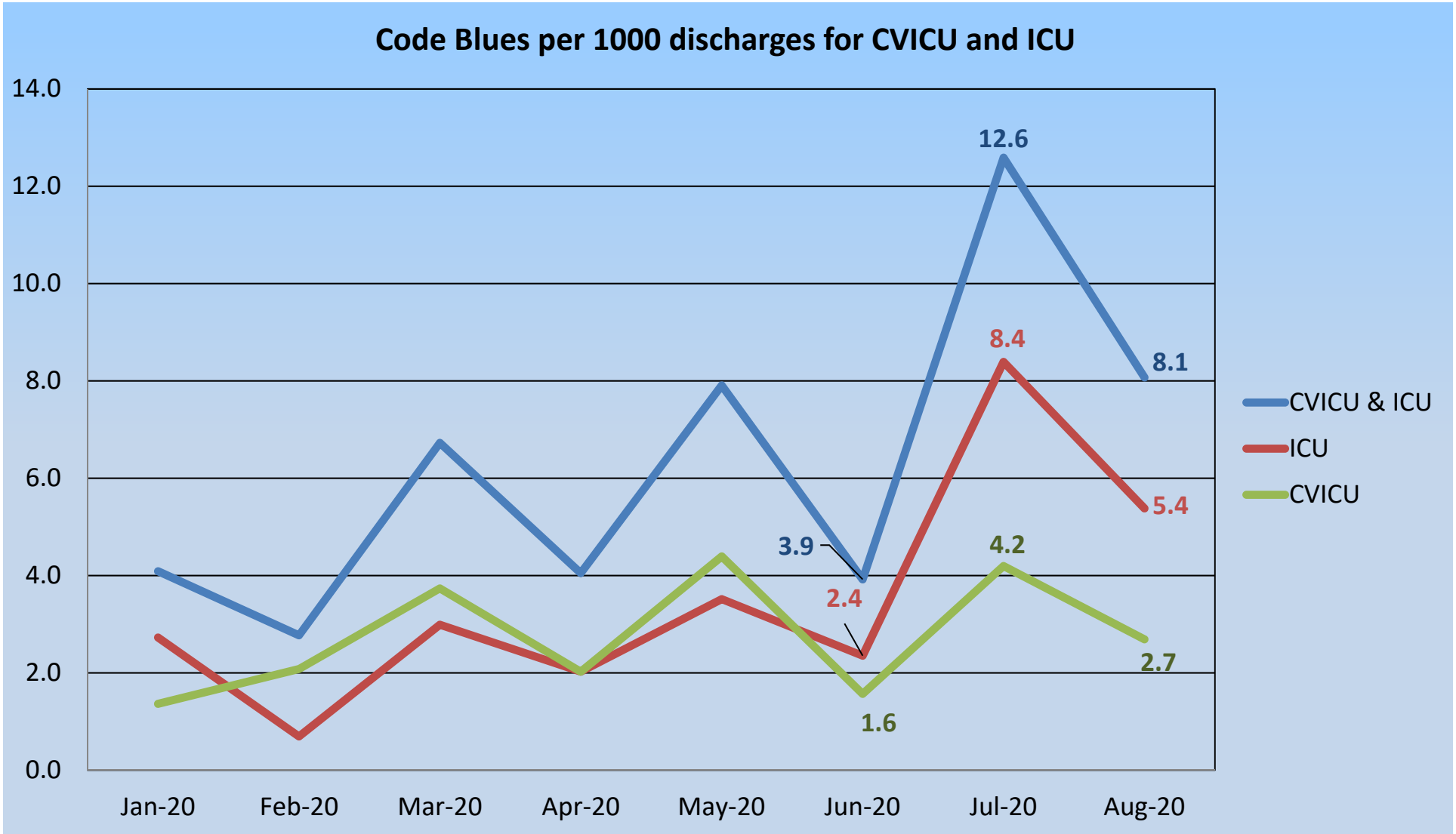
Discharged Alive

PEA/A=11.4%

VF/VT= 36.5%



	2014	2015	2016	2017	2018	2019	2020
Asystole and PEA: Survived to Hospital Discharge	9%	25%	20%	15%	32%	24%	29%
Vfib and Vtac: Survived to Hospital Discharge	60%	56%	67%	44%	29%	42%	53%



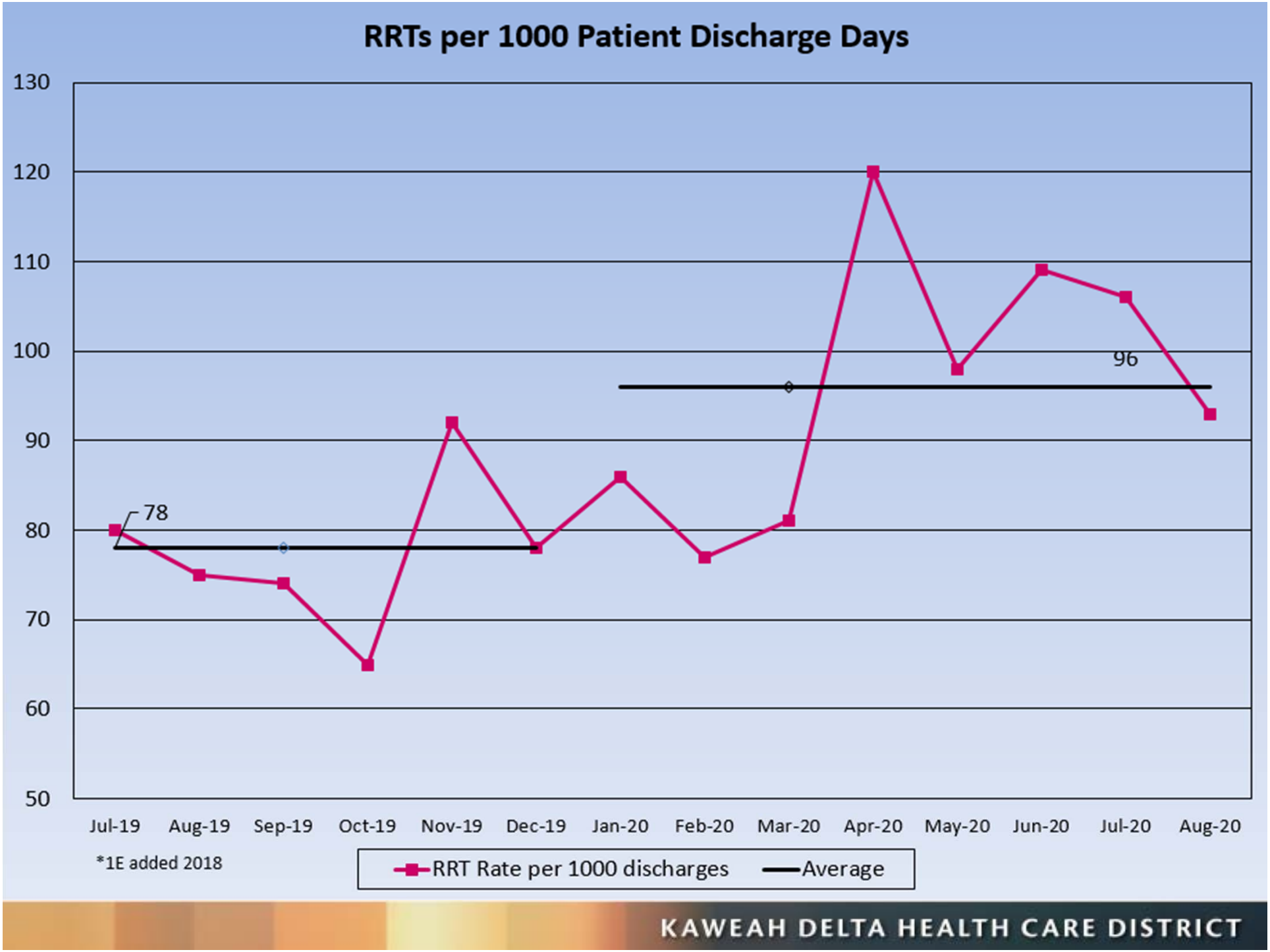
Count of Critical Care Code Blues			
	June 2020	July 2020	August 2020
CVICU and ICU	5	18	12
ICU	3	12	8
CVICU	2	6	4

TeamSTEPPS Data

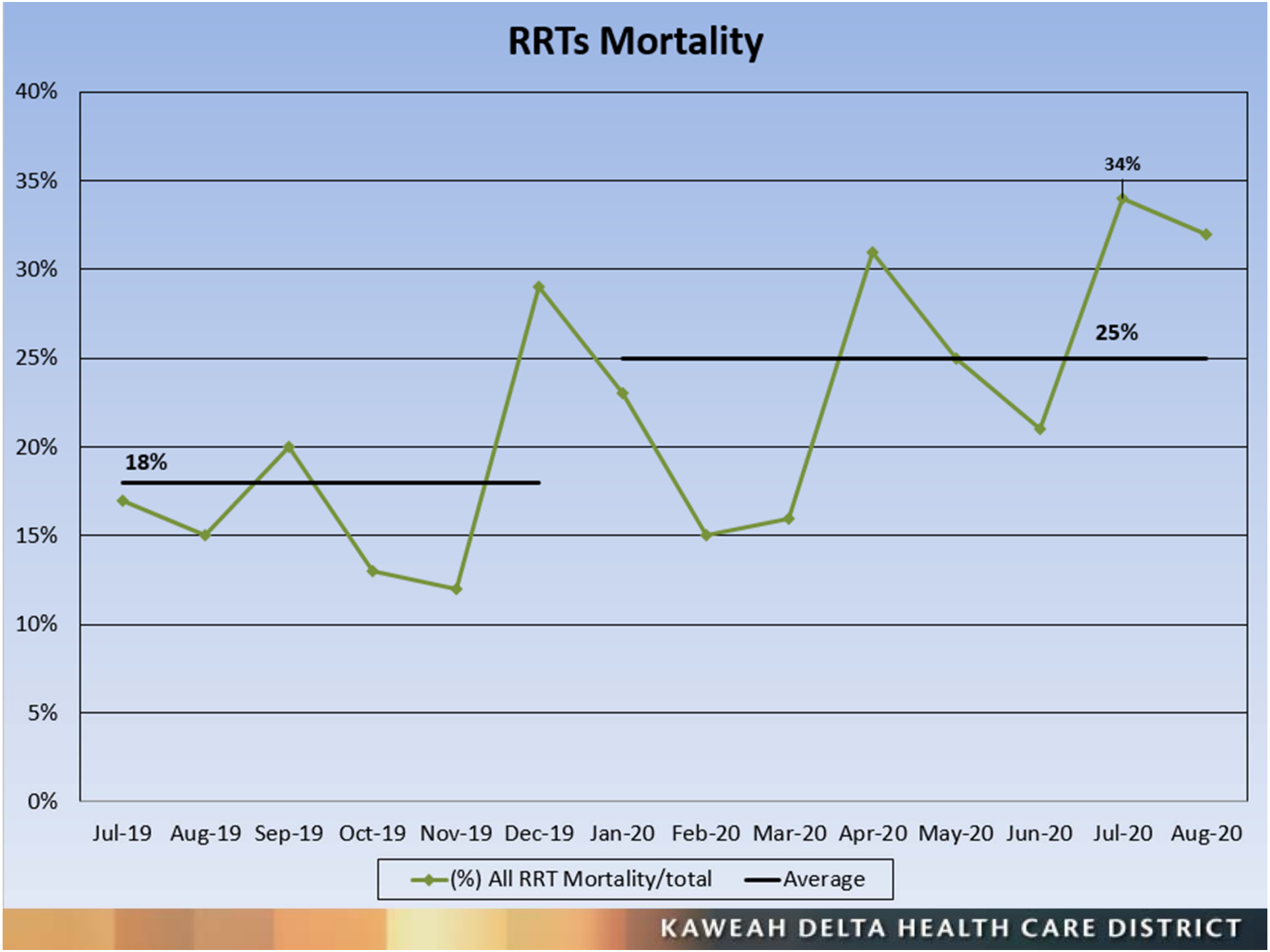
	Q1 2020	Q2 2020	July	August	Total 2020	Total 2019
No. of Cardiac Arrests	41	36	32	23	132	135
Code blues COVID Positive	-	8	14	10	32	0
Deaths from Cardiac Arrests	21	25	13	11	70	46
No. of days in ICU post arrest	304 n=20	85 n=11	101 n=19	31 n= 12	521 n=62	-
No. of days in Hospital post arrest	533 n=20	198 n=11	189 n=19	40 n= 12	960 n=62	657
Overall Hospital Mortality Rate per 1000 patients	2.838	3.165	3.783	3.604	-	2.197

Rapid Response System Data

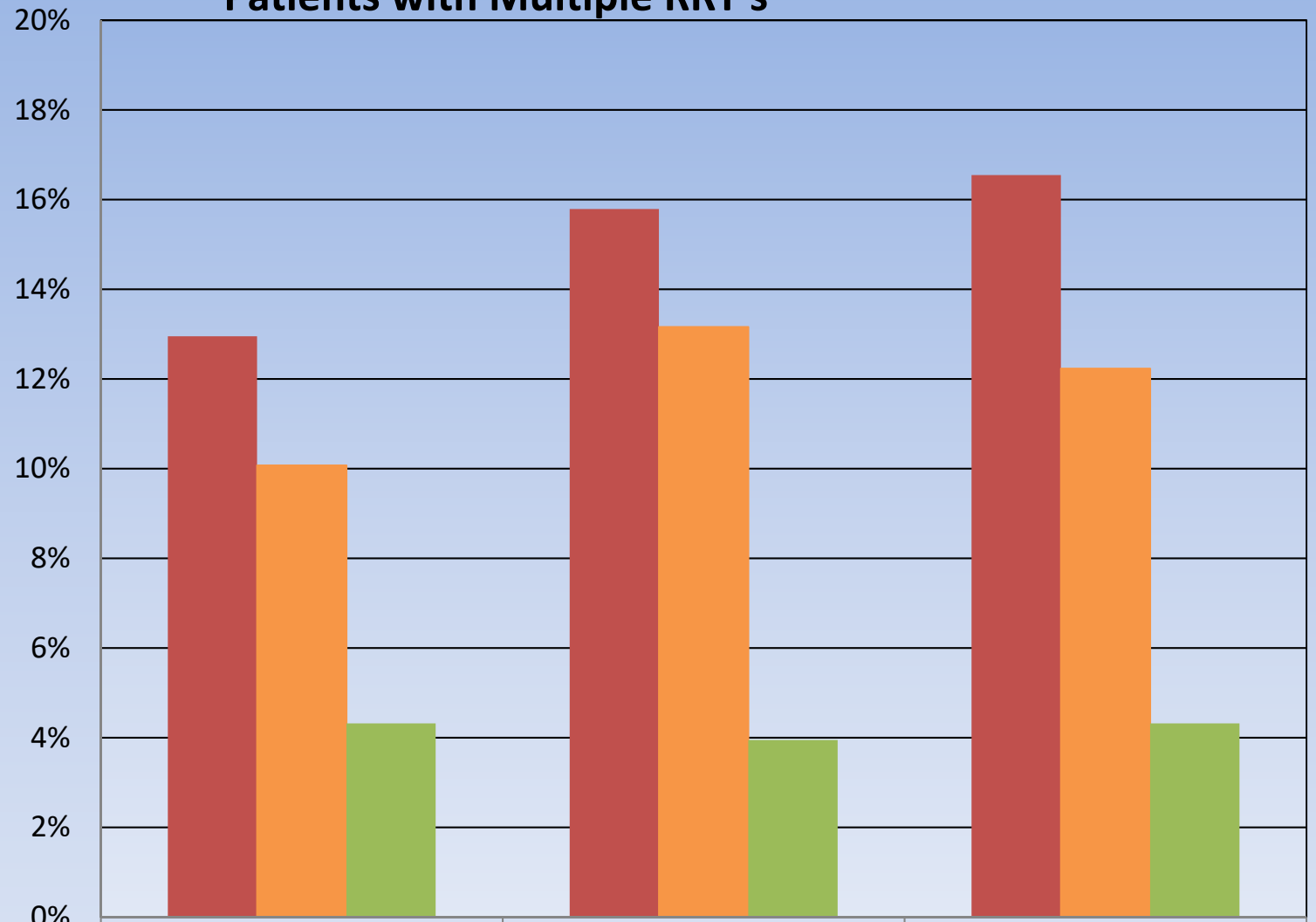
KAWEAH DELTA HEALTH CARE DISTRICT


RRTs per 1000 Patient Discharge Days
130
120
110
100
90
80
70
60
50
78
96
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
*1E added 2018
RRT Rate per 1000 discharges
Average
KAWEAH DELTA HEALTH CARE DISTRICT

Alert Location	Q 1 2020	Q 2 2019	Jul-19	Aug-19	Totals
KDMC 3W	72	60	25	23	**180**
KDMC 4S	46	51	18	11	**126**
KDMC 4N	30	44	17	13	**104**
KDMC 2S	30	41	16	10	**97**
KDMC 3N	34	38	11	13	**96**
KDMC 3S	36	35	13	11	**95**
KDMC 2N	39	28	9	13	**89**
KDMC 5T	-	24	19	25	**68**
KDMC 14	21	18	10	11	**60**
KDMC 1E	16	10	3	5	**34**
KDMC CV	12	6	4	3	**25**
KDMC IC	7	10	2	0	**19**
KDMC BP	2	4	3	1	**10**
KDMC Pediatric Adult	-	-	2	0	**2**
RRT Tracked Total	**273**	**369**	**152**	**139**	**1005**
Labor Triage/ Mother Baby	5	5	0	5	**15**
KDMC CVOR/Cath lab	7	0	0	1	**8**
Surgery (Pre/Post op)	3	4	0	1	**8**
KDMC Pediatric	1	1	2	0	**4**
KDMC 2E	0	0	2	2	**4**
KDMC ED	2	0	0	1	**3**
Endoscopy	0	0	0	0	**0**
KDMC CT/radiology	0	0	0	0	**0**
RRT Not Tracked Total	**18**	**10**	**4**	**10**	**42**


RRTs Mortality
40%
35%
30%
25%
20%
15%
10%
5%
0%
34%
25%
18%
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
(%) All RRT Mortality/total
Average
KAWEAH DELTA HEALTH CARE DISTRICT

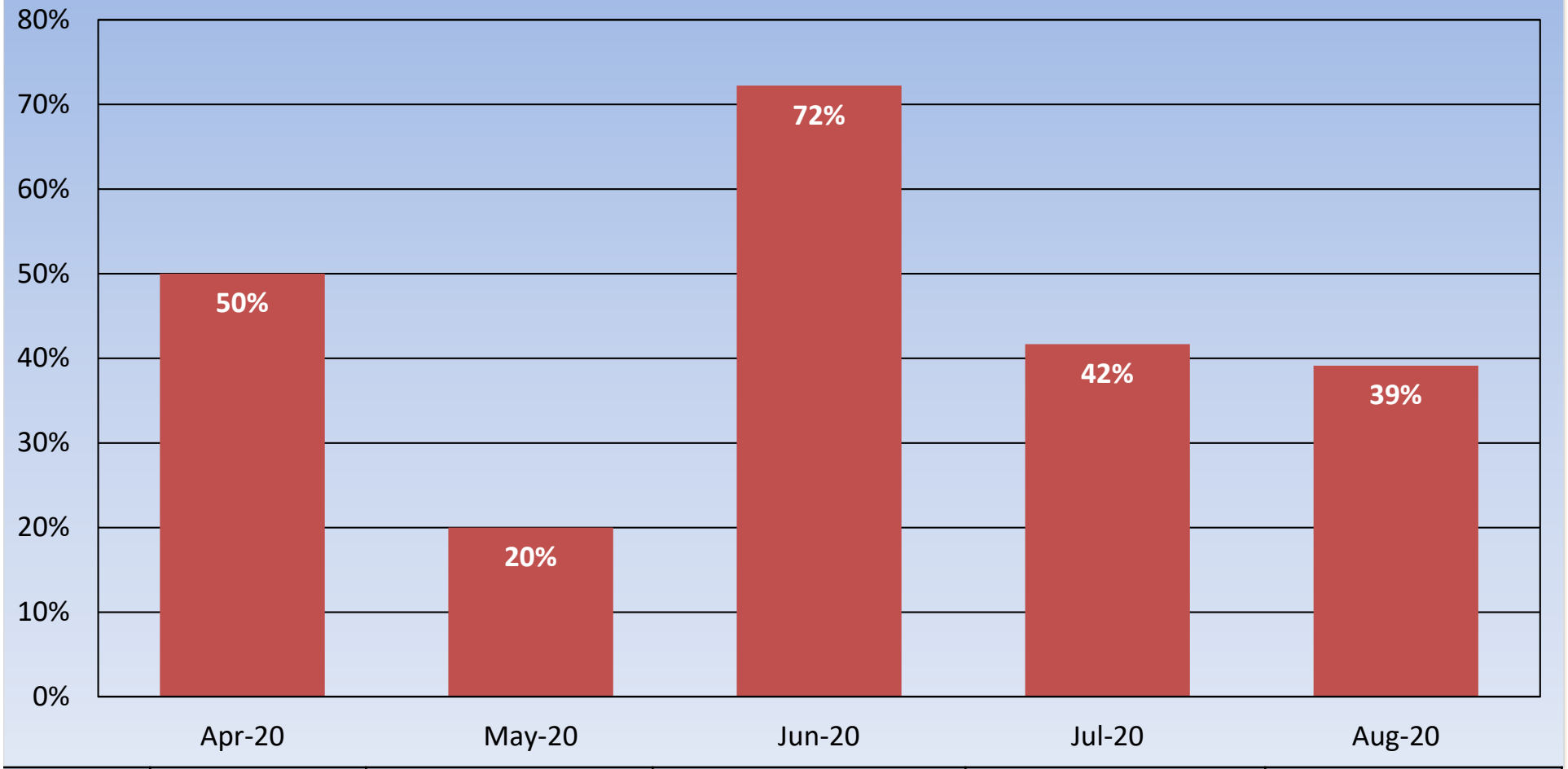
Patients with Multiple RRT's



	Jun-20	Jul-20	Aug-20
Total Number of Multiple RRT's	13%	16%	17%
2 RRT's	10%	13%	12%
3 or more RRT's	4%	4%	4%

KAWEAH DELTA HEALTH CARE DISTRICT

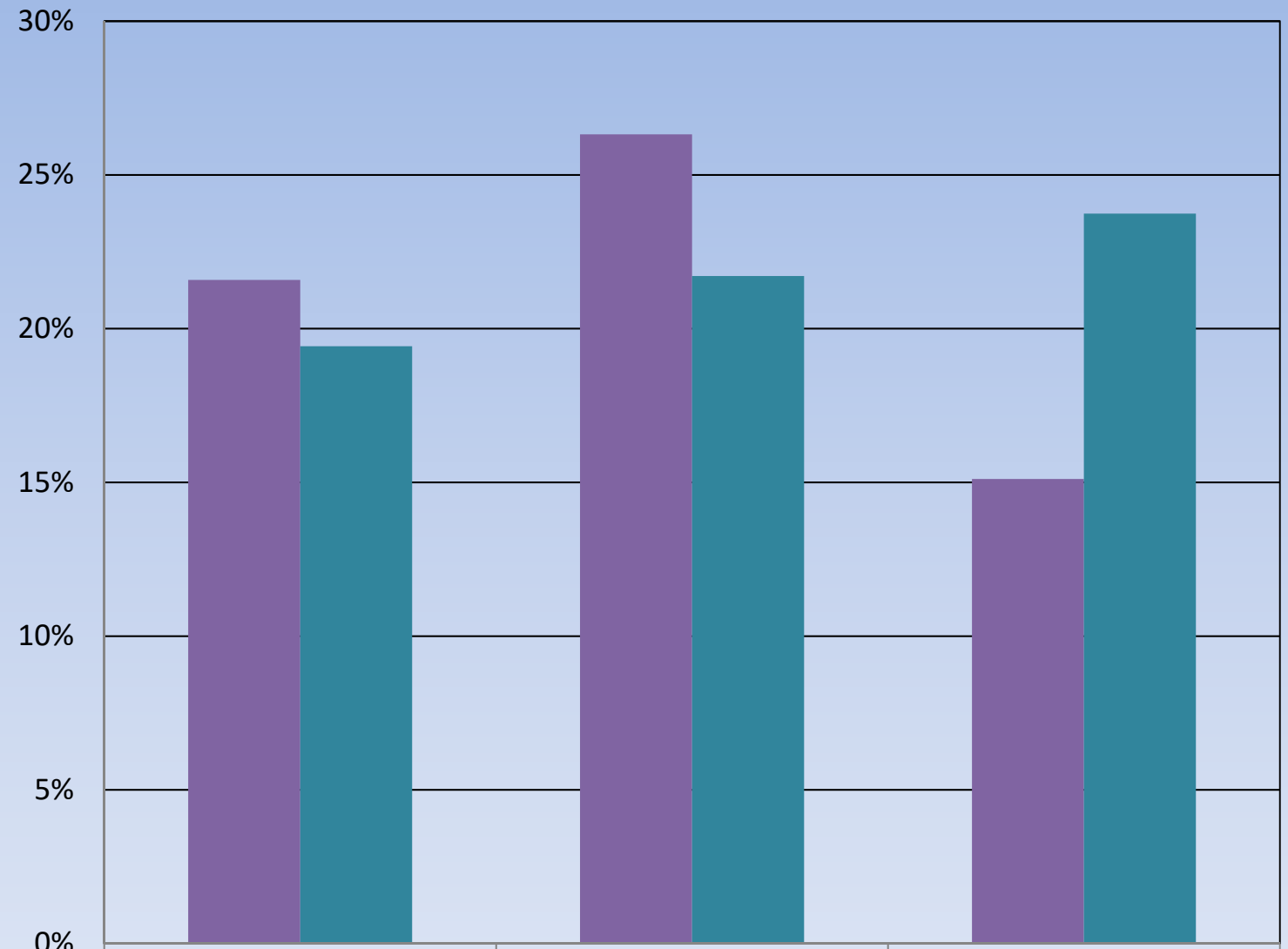
Multiple RRT mortality



Total Number Multiple RRTs	20	15	18	24	23
Multiple RRT Mortality	10	3	13	10	9

KAWEAH DELTA HEALTH CARE DISTRICT

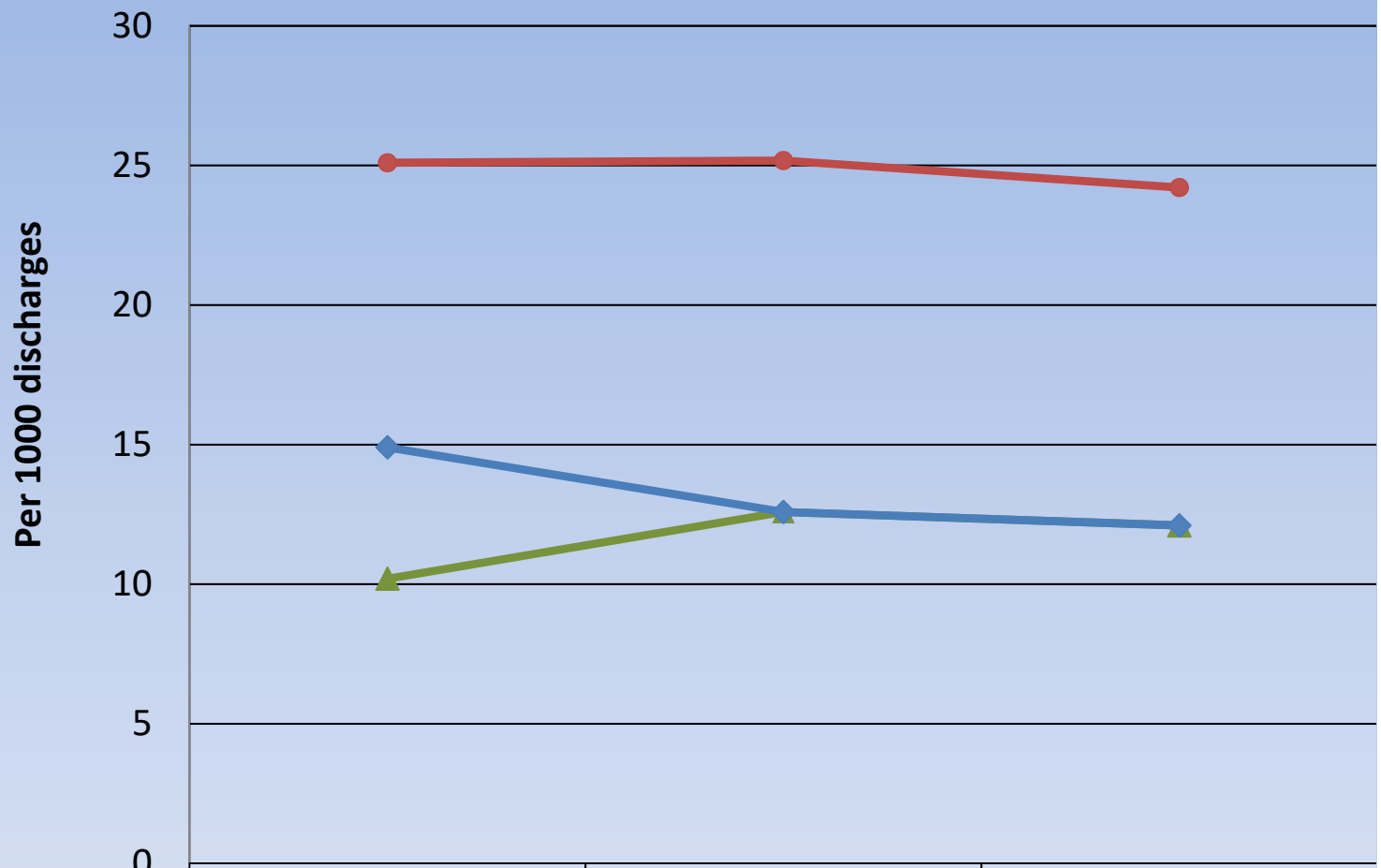
Disposition of RRT



	Jun-20	Jul-20	Aug-20
(%) Transferred to ICU/CVICU	22%	26%	15%
(%) Transferred to ICCU	19%	22%	24%

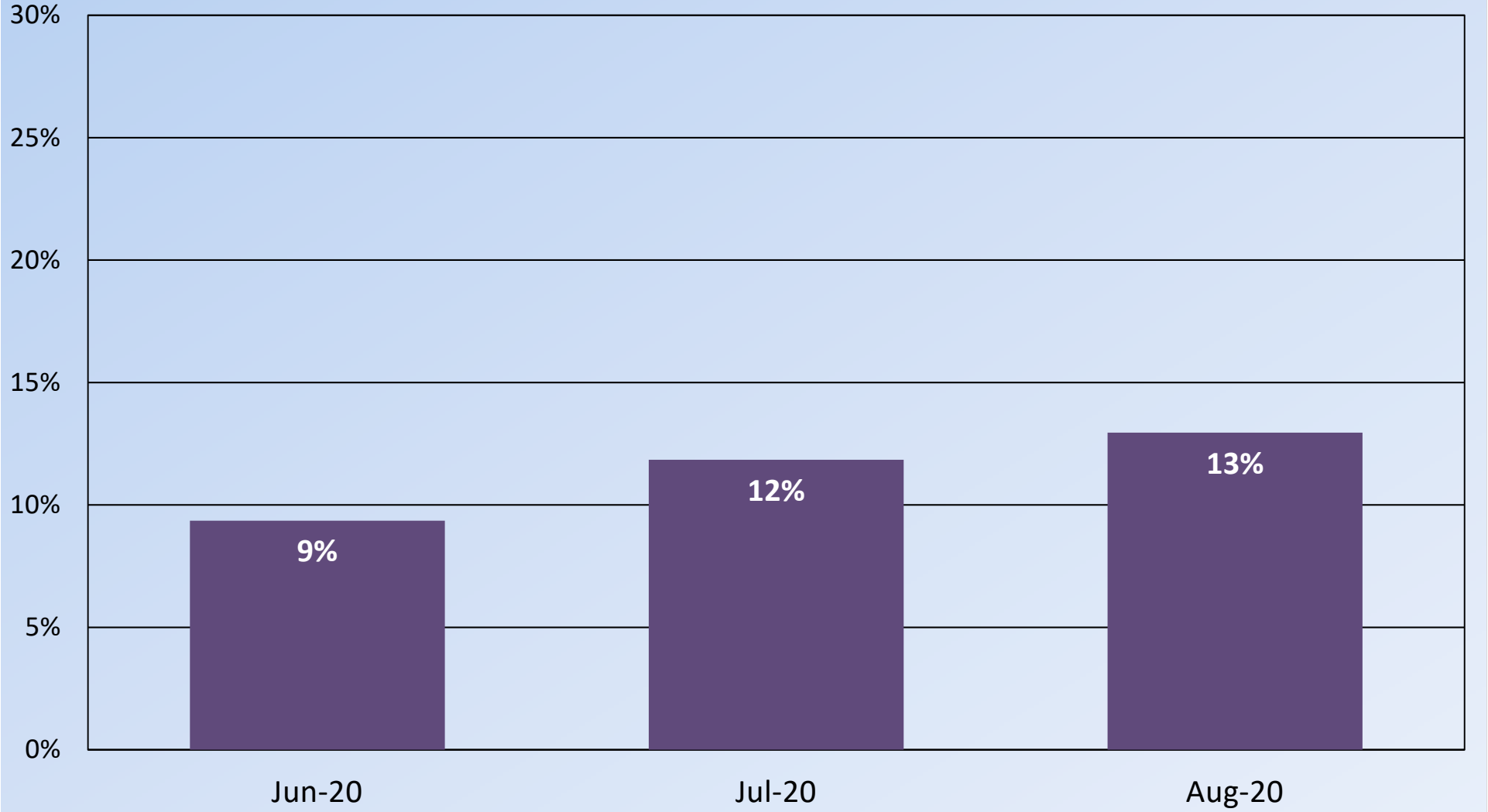
KAWEAH DELTA HEALTH CARE DISTRICT

RRTs Admitted from ED within 24 hours



	Jun-20	Jul-20	Aug-20
RRT within 24 hr admit from ED	25	25	24
RRT within 24 hours of admit transferred to (ICU/ICCU)	10	13	12
RRT within 24 hours of admit from ED: Stayed in Room	15	13	12

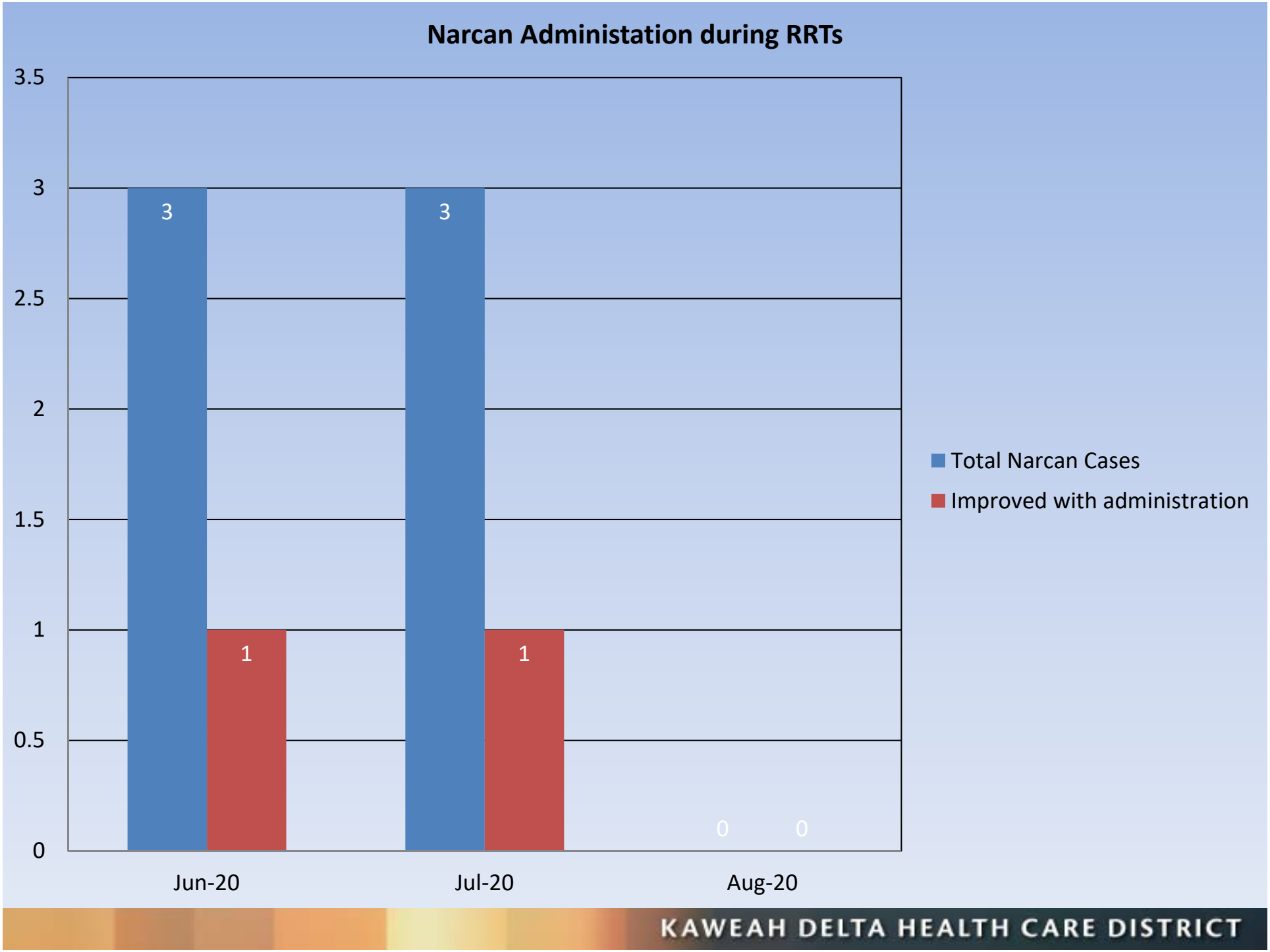
RRTs within 24 hours of Admit from ED



	0-4 hours	4-8 hours	8-12 hours	12-24 hours
July 2020 N= 36	17%	22%	22%	39%
August 2020 N= 36	14%	17%	19%	50%

RRTs on 3w	June	July	August
Total Number of RRTs on 3w	18	25	12
RRTs on 3w transferred to critical care	4	14	3
Multiple RRTs on 3w (last RRT in 3w)	4	6	8
Multiple RRTs Transferred to critical care	2	3	3
Multiple RRTs Stayed in room	2	2	5
Multiple RRTs Change in resuscitation status	1	1	0

RRTs on 3w within 12 hours after admission from ED	June	July	August
RRTs on 3w within 12 hours after admission from ED	2	3	1
Transferred to critical care	0	3	0
Stayed in room	2	0	1


Narcan Administation during RRTs
3.5
3
2.5
2
1.5
1
0.5
0
3
1
3
1
0
0
Jun-20
Jul-20
Aug-20
Total Narcan Cases
Improved with administration

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: Rapid Response **ProStaff/QIC Report Date: August 18, 2020**

Measures Analyzed:

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

Date range of data evaluated:

January 2019 to December 2019

Analysis of all measures/data: (See Attachment)

- Med Surg/ ICCU: 2020 Q 2 code blues have resulted in an increased incidence of 4.7/1000 discharges; this is an increase from Q 1 2020 of 2.6/1000 discharges.
    - 25% of Med Surg/ICCU Code blues had a diagnosis of COVID-19
- Med Surg: There is an equal amount of code blues in Med Surg compared to ICCU for Q 1 and Q2 2020.
- ICU/CVICU: Q 1 2020 code blues are increased at 4.5/1000 discharges. Q2 2020 code blues are increased at 5.3/1000 discharges
- RRTs per 1000 Patient Discharge Days: Total RRT cases for 2020 average 95/1000 discharges. This is an increase in RRT cases from year 2018 with an average of 78/1000 discharges.
- Multiple RRT Mortality: Q 1 2020 mortality for multiple RRTs cases has increased to 33%. Q 2 2020 mortality for multiple RRTs cases has increased to 49%.
- RRTs within 24 hours of Admit from ED: There was a decrease in Q 1 and Q 2 RRTs within 24 hours of Admit from ED.
- The committee was interested in monitoring RRT cases on 3w for 2020.
    - Trends were not identified at this time.
- The committee was interested in monitoring RRT cases with Narcan adminstration for 2020.
    - Trends were not identified at this time.

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

Next Steps/Recommendations/Outcomes:

1. The medical director role has been filled by Dr. Tang in January 2020. Under his leadership the following quality improvement projects have been started.
    a. RRT nurses are attending quality improvement committees to increase RRT presence and participation in quality initiatives.
    b. Formalization of processes and role definition of each member of the RRT team. We are developing checklists to ensure consistency with practice.
    c. Formalization of RRT handoff after a rapid response and utilizing a physician communication handoff tool.
    d. ICU step-down and downgrade rounding protocols. This process includes checking for SIRS criteria, lab work, rounding on previous RRT patients, and following up with the nursing staff caring for the patient to ensure patients are continuing to improve clinically.
    e. Improve early identification. Educational opportunities for our bedside nurses and ensuring the information taught during the orientation process for newly hired nurses and care providers are accurate and that it relays the urgency of our cause.
    f. Formalization of family activated of RRT process.
2. The committee continues to evaluate the cause for an increase in the number of code blues and RRTs for 2020.
3. The committee plans to compare our 2020 data to the following benchmark studies after implementation of our quality improvement projects.
    a. Reduction in number of cardiac arrest (in-hospital)
    b. Reduction in deaths from cardiac arrest
    c. Reduction in number of days in ICU post arrest
    d. Reduction in number of days in hospital after arrest
    e. Inpatient deaths

Submitted by Name:

Dr. Tang
Dr. Gray
Linde Swanson
Jeanette Callison
Jon Knudsen
Eileen Paul

Date Submitted:

8//18/2020

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

Stroke Quality Update July 2020

Stroke Program Leadership

Sean Oldroyd, DO
Stroke Program Medical Director

Cheryl Smit, RN
Stroke Program Manager

Abbreviations Used During this Presentation

TJC = The Joint Commission
AHA/ASA = American Heart Association; American Stroke Association
GWTG = Get with the Guidelines
EMS = Emergency Medical Services
ED = Emergency Department
ICU = Intensive Care Unit
TIA = Transient Ischemic Attack
Dc = Discharge
rt-PA or Alteplase = thrombolytic therapy “clot busting medication”
CT/CTA = Computed tomography scan/computed tomography angiography
LVO = Large vessel occlusion
CMS = Centers for Medicare and Medicaid Services
VTE = Venous thromboembolism
LDL = low-density lipoproteins
NIHSS = National Institutes of Health Stroke Scale

Primary Stroke Certification through The Joint Commission (TJC)

- **TJC Recertification survey has been postponed due to COVID 19**
- 2 year certification cycle
- Initial accreditation March 9, 2018
  100% compliant with all Standards; No plans for improvement requested

Stroke Program Initiatives 2019-2020

ED Stroke Alert Process

- Process changes in 2020 as a result of AHA/ASA new guidelines for ischemic stroke patients (December 2019)
- ED triage stroke alert process modification to improve door to stroke alert timing
- RAPID software now available which will enhance imaging to evaluate patients who may be candidates for endovascular treatment. This requires a transfer to a tertiary care center
- Door to transfer goal is 120 minutes

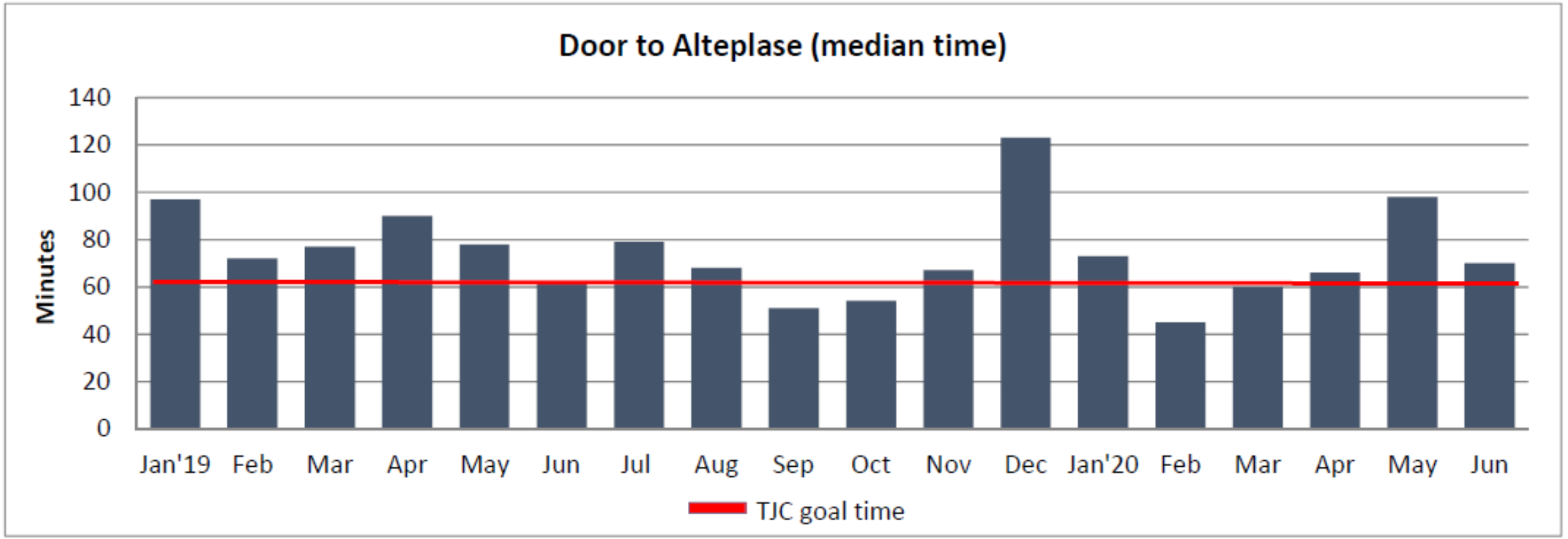
Key Initiatives to Improve Time to Thrombolytic Therapy

TJC and AHA/ASA's expectation is to administer thrombolytics (Alteplase) within 60 minutes 50% of the time for all patients who meet criteria. KDH/ED goal is Door to Alteplase within 45 minutes of arrival.

Initiatives:

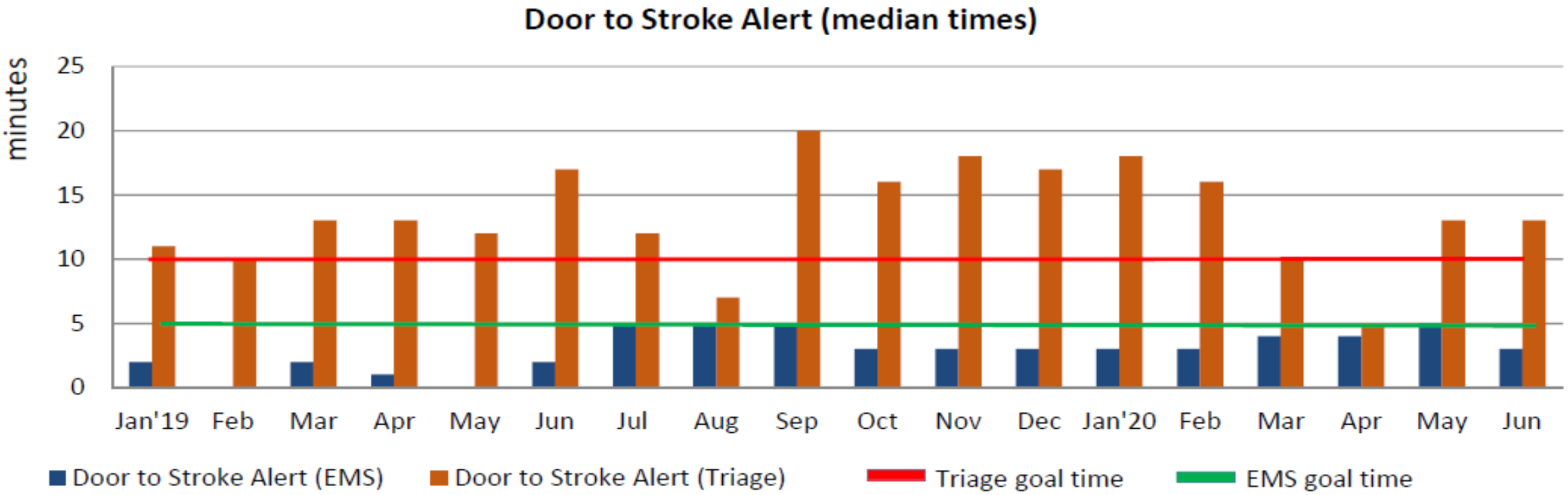
- Designated Stroke Team Lead in the ED
- Stroke Packet with documents needed for timely administration of thrombolytic therapy
- Patients go directly to CT from Triage or EMS after a brief physician evaluation
- Decreased images on CT/CTA scans
- Radiologist calls Stroke Team Lead when CT read and if a large vessel occlusion is found on CTA images
- Patient immediately evaluated by Resident/Physician upon return from CT
- 24/7 interpreter services available in the ED
- Staff, Physician, Resident and EMS education on stroke alert process
- Follow up communication with key stakeholders after thrombolytic therapy
- **RECENT ACTION ITEM**: Dotphrase was developed for the ED physicians with prompts to document reasons for delay in alteplase or why alteplase was not given if last known well (LKW) time was <4.5 hours
- **RECENT ACTION ITEM**: Stroke Team Lead (STL) Orientation packet developed and implemented

2019-2020 ED Stroke Alert Dashboard



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. AHA/ASA GWTG expectations were update in 2019 with new IV thrombolytic goal time to 45 minutes at least 75% of the time (when applicable). To meet this goal, changes to the stroke alert process <4 hours have been made.

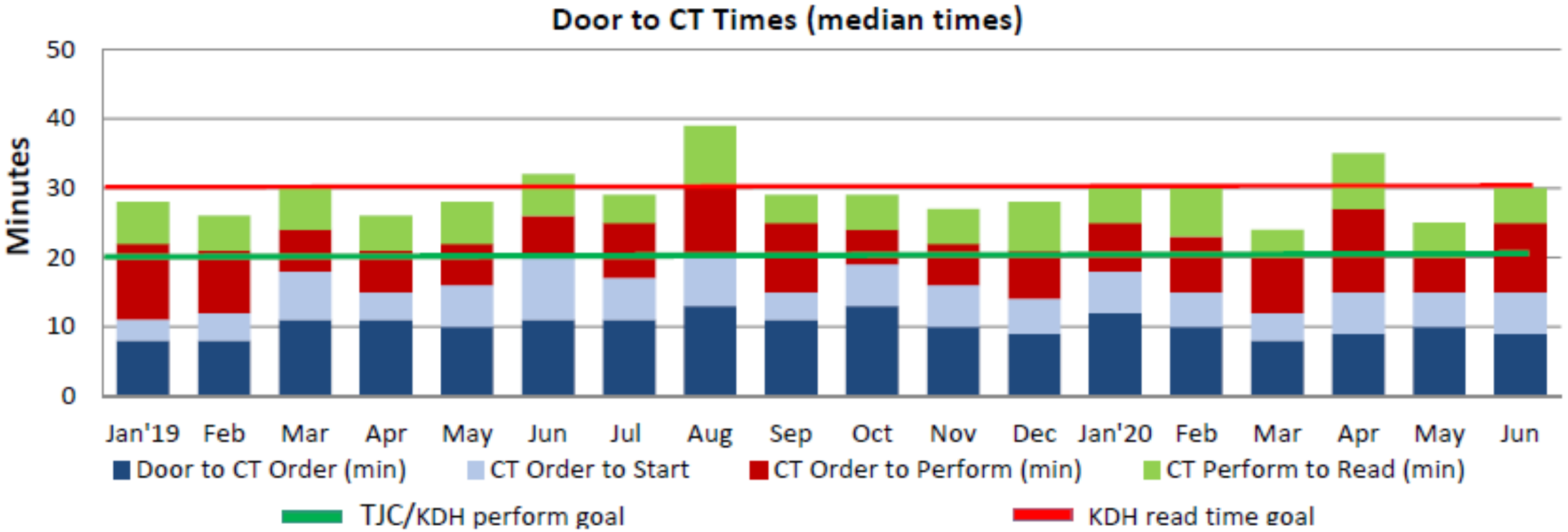
2019-2020 ED Stroke Alert Dashboard



Per ED Stroke Alert process; stroke alerts should be called within 5 minutes of EMS arrival and within 10 minutes if arriving through triage. Door to stroke alert times have improved over the last several months as a result of key initiatives made in the ED:

- Educational sessions with local EMS agencies on stroke assessments and KDH's stroke alert process.
- Collaboration between the ED and EMS personnel on alerts called prior to arrival.
- The majority of stroke alerts brought in through EMS are called "prior to arrival" which explains to 0 minutes from door to alert for EMS

2019-2020 ED Stroke Alert Dashboard



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

Stroke Program Initiatives
2019-2020

ED Transfer Process on Ischemic/Hemorrhagic Stroke Patients

January 2019: TJC added new metrics on door to transfer times. Door to transfer goal <120 minutes.

- Hemorrhage
- IV Alteplase and Transfer “drip and ship”
- Large Vessel Occlusion and Endovascular Eligible
- Large Vessel Occlusion and Not Endovascular Eligible
- No Large Vessel Occlusion and Not Endovascular Eligible

Transfer Task Force has been established and includes all key stakeholders; Skylife, EMS, ED and Case Management

RECENT ACTION ITEM: Ischemic/hemorrhagic stroke transfer guidelines established

RECENT ACTION ITEM: Transfer agreements signed with San Jose RMC and USC/Keck

RECENT ACTION ITEM: Education to physicians and staff regarding transfer goal time of <120 minutes

RECENT ACTION ITEM: RAPID software now available which will enhance imaging to evaluate if patients are candidates for endovascular treatment.

ED Transfer Process on Ischemic/Hemorrhagic Stroke Patients

ISCHEMIC/ HEMORRHAGIC STROKE TRANSFER GUIDE

TRANSFER GOAL TIME
<120 MINUTES

ED Physician: accepting physician established
USC MD line: 323-442-6111

ED Physician: notify ED CM regarding transfer and accepting facility
****CM: Notify Skylife to activate team*
****Skylife: activate team and check weather conditions for USC and San Jose RMC*

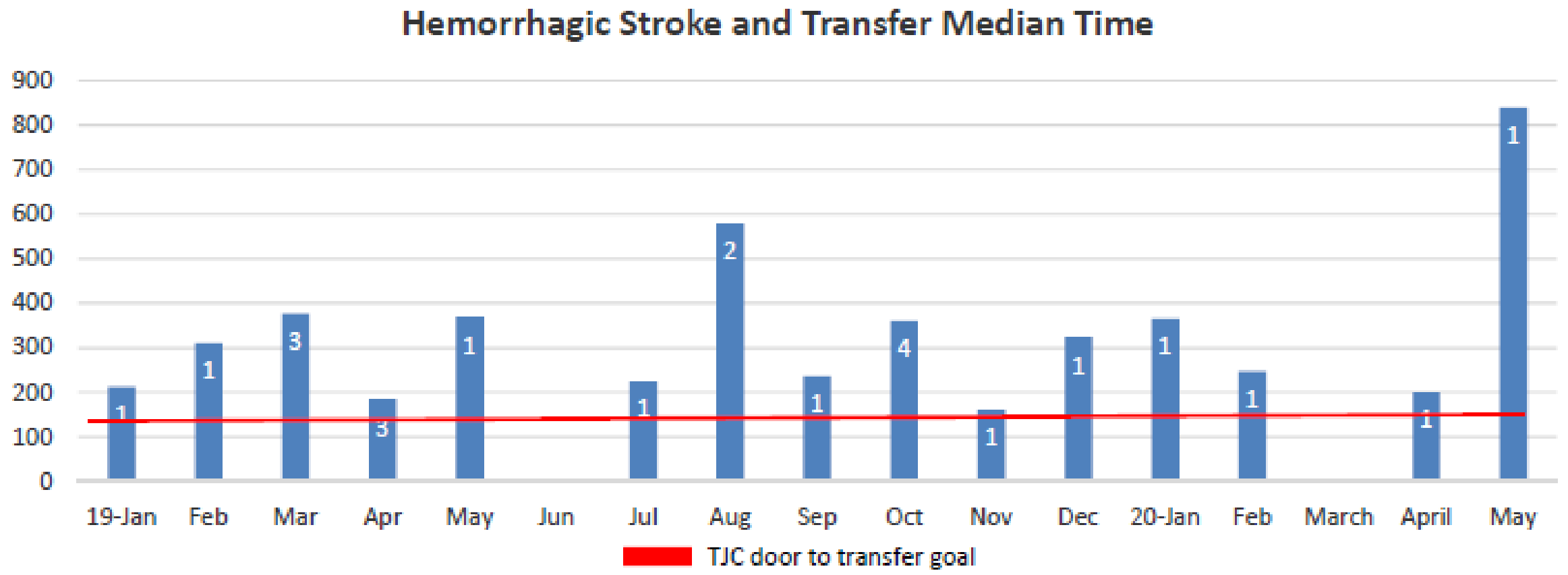
1st CALL
USC KECK ETC TRANSFER CENTER: 323-442-9922
If issues with transfer process, contact Dr. Russin at ***626-616-0269***

IF WEATHER OR OTHER TRANSPORT ISSUES check with ED physician and call San Jose RMC for immediate transfer

2nd CALL CALL SAN JOSE RMC TRANSFER CENTER: ***855-762-6375***

3rd CALL BAKERSFIELD MEMORIAL HOSPITAL TRANSFER CENTER: ***661-869-2337***

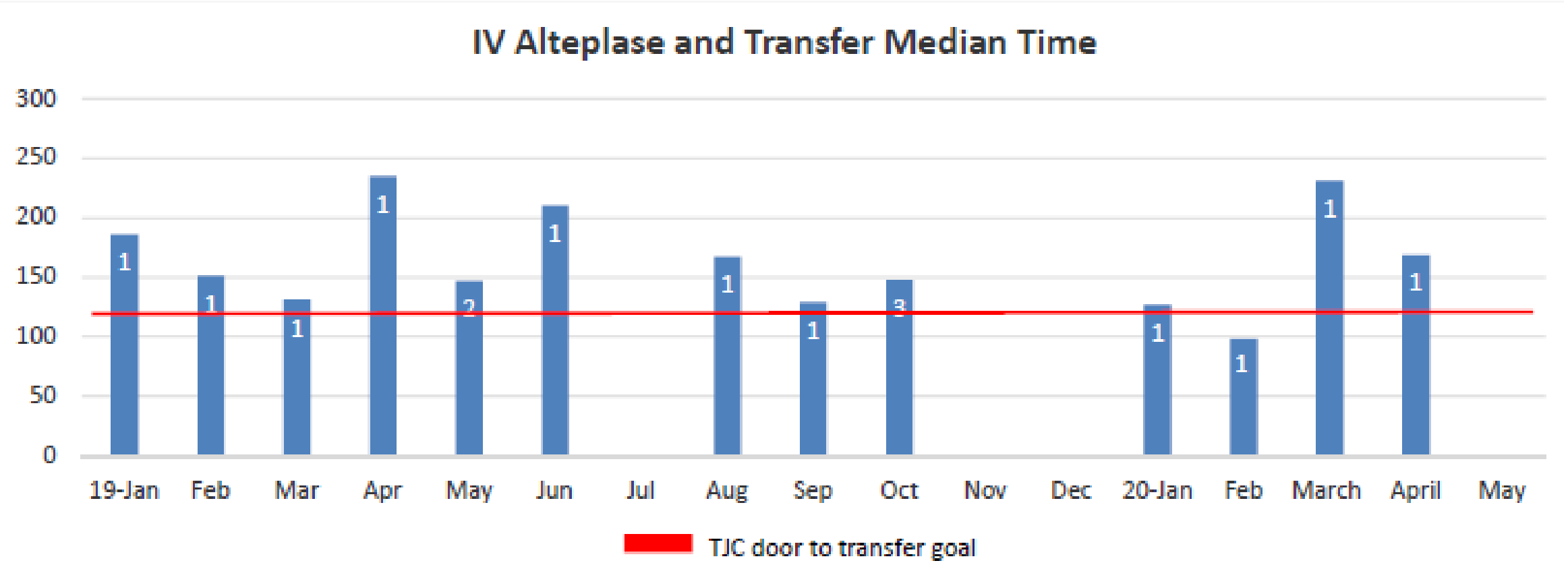
ED Transfer Process on Ischemic/Hemorrhagic Stroke Patients
2019/2020 Transfer from ED to Another Acute Care Facility Dashboard



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, all action items are captured in PDSA document.

ED Transfer Process on Ischemic/Hemorrhagic Stroke Patients

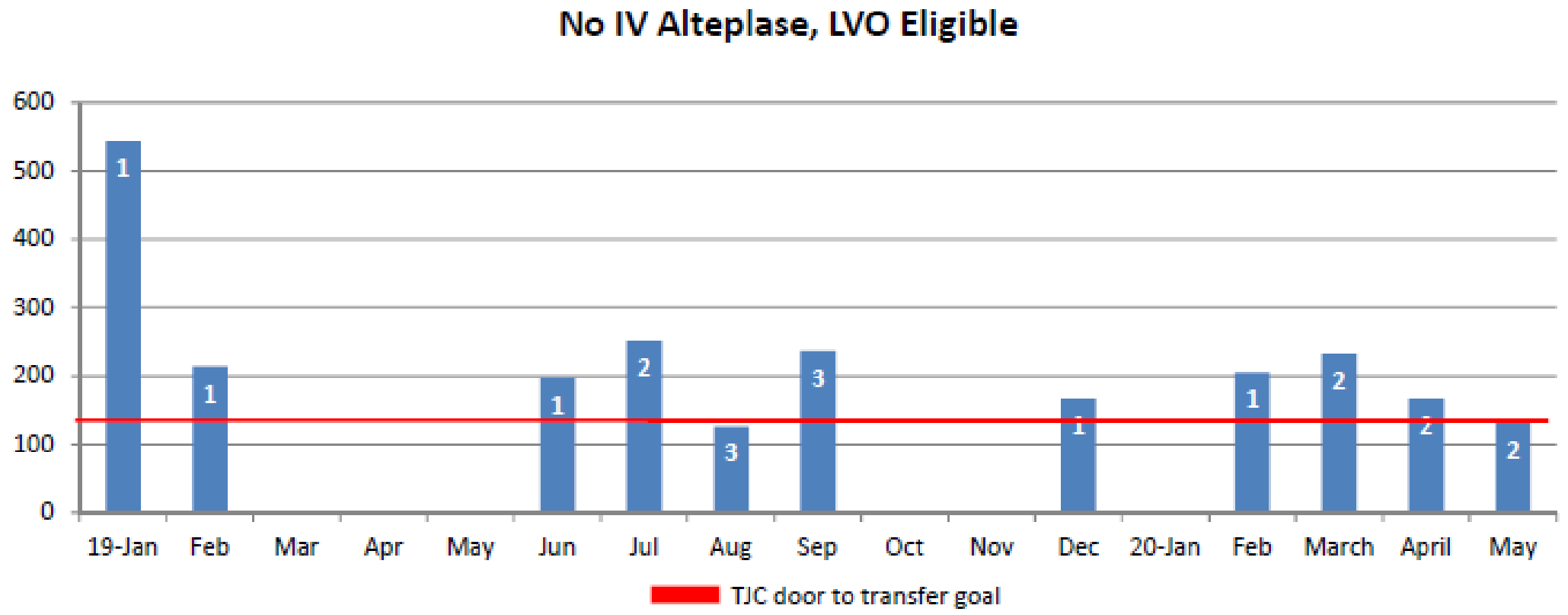
2019/2020 Transfer from ED to Another Acute Care Facility Dashboard



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. As a result of the effects made by the ED Stroke Alert Committee and the Transfer Process Task Force door to transfer times have improved over the last several months.

ED Transfer Process on Ischemic/Hemorrhagic Stroke Patients

2019/2020 Transfer from ED to Another Acute Care Facility Dashboard



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.

2019-2020 Stroke Program Dashboard

	GWTG Bench-marks	2019 Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	2020 Jan	Feb	March	April	May
Grouping of Stroke Patients																		
Ischemic		30	42	39	43	36	41	31	33	32	50	40	43	39	42	38	23	28
Hemorrhagic		4	10	10	9	7	8	2	13	8	10	11	6	8	6	5	7	6
TIA (in-patient and observation)		20	28	35	25	24	22	36	36	19	29	42	28	33	44	29	24	21
Transfers to Higher Level of Care (Ischemic)		2	2	3	3	2	1	2	4	4	3	0	1	1	2	3	3	2
Transfers to Higher Level of Care (Hemorrhagic)		1	1	2	1	1	1	1	2	1	4	1	1	1	1	1	1	1
% of Alteplase - Inpatient & Transfers		16%	14%	14%	13%	18%	21%	6%	14%	6%	11%	15%	11%	20%	14%	10%	8%	7%
Total # of Pts who rec'd Alteplase (Admitted Patients)		4	4	4	4	5	8	2	2	1	3	6	4	7	5	3	1	2
Total # of Pts who rec'd Alteplase (& Transferred Out)		1	2	2	2	2	1	0	3	1	3	0	1	1	1	1	1	0
TOTAL NUMBER OF PATIENTS		57	83	89	81	70	73	72	88	64	96	94	79	82	95	72	58	58
Rate of hemorrhagic complications for Alteplase pts	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
% Appropriate vital sign monitoring post Alteplase	90%	50%	50%	57%	66%	71%	67%	75%	100%	50%	80%	83%	67%	75%	75%	100%	100%	100%
Core Measure: OP-23 Head CT/MRI Results	72%	NA	50%	100%	100%	33%	66%	0%	0%	75%	75%	100%	50%	100%	NA	0%	100%	NA
% tPA Arrive by 2 Hrs; Treat by 3 Hrs. (GWTG)	85%	100%	100%	83%	100%	100%	100%	100%	100%	100%	67%	100%	100%	100%	80%	NA	100%	100%
STK-5 Early Antithrombotics by end of day 2 (GWTG, TJC)	85%	100%	100%	100%	100%	100%	100%	100%	100%	97%	100%	100%	96%	92%	93%	97%	100%	96%
STK-1 VTE (GWTG, TJC)	85%	100%	100%	100%	100%	100%	100%	100%	100%	97%	93%	95%	98%	100%	100%	95%	100%	91%
STK-2 Discharged on Antithrombotic (GWTG, TJC)	85%	100%	97%	100%	98%	98%	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
STK-3 Anticoag for afib/aflutter ordered at Dc (GWTG, TJC)	85%	80%	89%	100%	100%	100%	100%	100%	100%	100%	100%	90%	89%	100%	89%	100%	100%	100%
% Smoking Cessation (GWTG)	85%	100%	100%	100%	100%	100%	100%	100%	100%	88%	100%	100%	100%	100%	100%	100%	100%	100%
STK-6 Discharged on Statin (GWTG, TJC)	85%	100%	100%	100%	100%	98%	96%	92%	94%	94%	98%	100%	100%	100%	98%	100%	100%	97%
% Dysphagia Screen prior to po intake (GWTG)	75%	100%	93%	94%	88%	88%	98%	94%	92%	92%	96%	96%	96%	85%	85%	91%	90%	77%
STK-8 Stroke Education (GWTG, TJC)	75%	88%	91%	84%	89%	93%	92%	100%	92%	96%	100%	100%	100%	93%	97%	94%	100%	96%
STK-10 Assessed for Rehab (GWTG, TJC)	75%	97%	100%	100%	100%	97%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	97%
STK-4 Alteplase Given within 60 min (GWTG, TJC)	75%	100%	25%	25%	100%	100%	100%	NA	50%	100%	100%	100%	NA	100%	100%	100%	NA	NA
% LDL Documented (GWTG)	75%	92%	88%	100%	96%	94%	96%	98%	88%	97%	93%	98%	92%	91%	84%	96%	100%	90%
Intensive Statin Therapy (GWTG)	75%	91%	82%	90%	89%	91%	80%	90%	88%	91%	96%	93%	94%	94%	91%	88%	88%	97%
% tPA Arrive by 3.5 Hrs; Treat by 4.5 Hrs (GWTG)	75%	100%	80%	86%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	86%	100%	100%	100%
% NIHSS Reported (GWTG)	75%	97%	98%	97%	100%	97%	100%	100%	95%	97%	96%	97%	98%	100%	93%	92%	100%	96%
% Appropriate stroke order set used (In-Patient)	90%	90%	97%	97%	94%	93%	90%	95%	96%	99%	95%	87%	84%	95%	97%	99%	97%	96%
% Appropriate stroke order set used (ED)	90%	85%	92%	90%	92%	94%	93%	93%	94%	88%	88%	84%	87%	94%	92%	88%	89%	98%
LOS Hemorrhagic (Mean)		13.5	10.8	6.86	13.88	4	4.38	3	7.5	5	16.5	10.36	5.53	4.8	4	9	5.5	
LOS Ischemic (Mean)		5.61	6.42	4.94	5.21	6.72	4.5	4.5	5.25	4.32	5.08	4.25	3.14	5	5.08	5.27	3.41	

Vital Sign and Neuro check monitoring after Alteplase

		2019												2020				
	GWTG Bench-marks	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May
Grouping of Stroke Patients																		
Ischemic		30	42	39	43	36	41	31	33	32	50	40	43	39	42	38	23	28
Hemorrhagic		4	10	10	9	7	8	2	13	8	10	11	6	8	6	5	7	6
TIA (in-patient and observation)		20	28	35	25	24	22	36	36	19	29	42	28	33	44	29	24	21
Transfers to Higher Level of Care (Ischemic)		2	2	3	3	2	1	2	4	4	3	0	1	1	2	3	3	2
Transfers to Higher Level of Care (Hemorrhagic)		1	1	2	1	1	1	1	2	1	4	1	1	1	1	1	1	1
% of Alteplase - Inpatient & Transfers		16%	14%	14%	13%	18%	21%	6%	14%	6%	11%	15%	11%	20%	14%	10%	8%	7%
Total # of Pts who rec'd Alteplase (Admitted Patients)		4	4	4	4	5	8	2	2	1	3	6	4	7	5	3	1	2
Total # of Pts who rec'd Alteplase (& Transferred Out)		1	2	2	2	2	1	0	3	1	3	0	1	1	1	1	1	0
TOTAL NUMBER OF PATIENTS		57	83	89	81	70	73	72	88	64	96	94	79	82	95	72	58	58
Rate of hemorrhagic complications for Alteplase pts	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
% Appropriate vital sign monitoring post Alteplase	90%	50%	50%	57%	66%	71%	67%	75%	100%	50%	80%	83%	67%	75%	75%	100%	100%	100%

Vital signs and neuro checks are to be completed after the initiation of Alteplase: q 15 minutes x2 hours, q30 minutes x6 hours, then q 1 hour x16 hours. The expectation is that we are 90% compliant with this metric. Working closely with ED and ICU leadership the last several months on various actions needed for improvement in this area. A task force had met in March 2020 to address the issues, as noted in the chart above we have been 100% compliant since the action items were implemented.

Action plans:

- Bedside handoff communication between the ED and ICU RN
- Key staff member education with staff member involved in missing elements
- **RECENT ACTION ITEM:** Current annual computer based learning (CBL) competencies for ICU, CVICU and ED will be updated to include post alteplase monitoring, flowsheet review and the importance of compliance
- **RECENT ACTION ITEM:** Provide education to ICU, CVICU and ED staff on face-to-face hand-off and review of the post alteplase form

Stroke Program
Performance Improvement Initiatives
Fiscal Year 2020

Door to Alteplase <60 minutes.

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

Nutritional Support s/p Failed Swallow Evaluation

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

Follow-Up Calls/Perception of Care

Continue TJC requirement that we monitor perception of care.

Dysphagia screening process

Continue to monitor/track.

TIA work-up/admission

New measure. The goal of this project is to reduce TIA length of stay by using a visible LOS time tracker for physicians which may improve the length of stay, this would be similar to how the ED tracks their patients.

Stroke Program
Performance Improvement Initiatives
Fiscal Year 2020

Patient Education

New measure. This project was initiated by our GME TY resident during the previous year and will be continued for the upcoming year. Goal is to improve patient education metric in GWTG and improve 30 day readmission and mortality rates by physician engagement in stroke education, primarily in lifestyle modification.

Transfer Process

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

Admission guideline criteria

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

New guidelines developed and implemented in May 2020.

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

Decreasing Patient Falls in an Inpatient Mental Health Unit

Melissa Quinonez, MSN, RN-BC, PHN, Jaynell Tipton, BSN, RN, Julie Peddicord, RN-BC

Introduction

Falls in hospitals in general are associated with serious injuries and increased length of stay.
There are numerous factors that contribute to falls in the inpatient Mental Health setting including medications, mental status , and co-morbid health conditions.

Purpose

Triggered by an increase in the number of patient falls in this setting beginning in 2016, nursing leaders challenged direct care staff of a 48-bed acute mental health hospital to examine existing practices to determine methods to decrease fall rates.

Outcomes Evaluation

- Patient Falls per 1000 patient days
- Injury Falls per 1000 patient days
- Suspected Intentional Falls vs. Actual Falls

Methods & Approach

Fall Prevention Task Force (nursing, psychiatrist, resident & pharmacist)

- Began data collection in July 2017 to record fall circumstances and identify trends. Reports to CUSP team
- Pharmacist began to review falls to identify medication changes, drug half-life and other considerations when medication was believed to be a possible contributing factor

Falls University

- Re-joined Falls University with the medical center (formally conducted separately at Fall Prevention Task Force)

Monthly Meetings

- Falls reviewed/discussed monthly at staff meetings, Mental Health Minutes, UBC and CUSP meetings

Pilot Outcome-Edmonson Fall Risk Assessment

- Reviewed literature searching for evidence-based risk assessments. We found a few different fall risk assessments geared toward the Mental Health population and selected the Edmonson Fall Risk Assessment. The staff was educated on the use of the tool and it was piloted on the unit for 60 days. Assessment was discontinued due to greater number of false negatives, inability to clarify key aspects with the author and lack of standardized instruction/education for tool.

Consult with John Hopkins

- We learned that there is no Mental Health specific assessment tool, but John Hopkins QI department is researching. Suggestions they provided for reducing fall risk in the setting included reducing clutter in milieu, using observers on high risk patients, completing orthostatic vital signs on patients, beds in low positions and hourly rounding. These are all interventions that are currently in use with the exception of hourly rounding – we round q15 minutes.

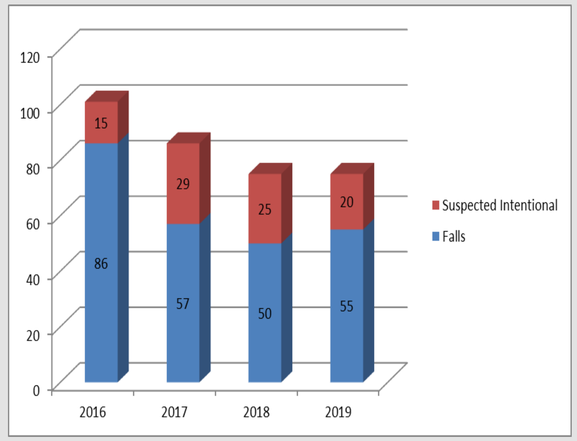
Video Cameras

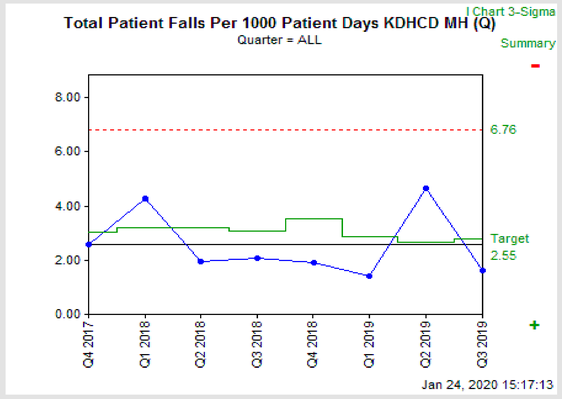
- Starting in late 2017 we began to use our video cameras to review falls that occurred in common areas. This provides us with the ability to identify factors/injuries/hazards that staff may not have been aware of as well as identify suspected intentional falls.

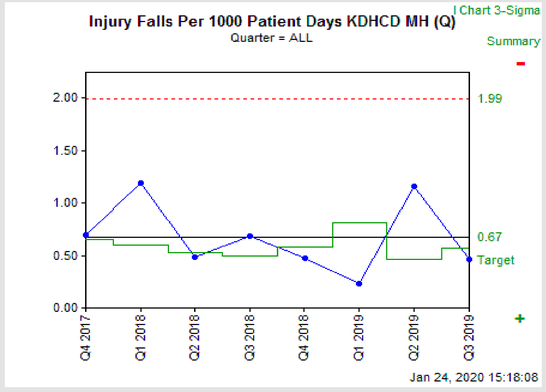
Room Sweeps

- We have revised our room safety checklist and staff are empowered to correct findings such as environmental hazards in the moment and to report findings to the charge nurse.

Results







Conclusion

In total, Mental Health falls have gone down 26% since 2016.

Factoring in the suspected intentional falls, Mental Health falls have gone down 37% since 2016

NDNQI Falls Data for 3Q 2019 is below the benchmark for Total Patient falls per 1000 patient days (Target 2.55/ actual 1.62) and Injury Falls per 1000 patient days (Target 0.67/actual 0.46)

Recommendations

Continue data analysis for 2020 falls. We are looking at each fall for trends in the areas of age/sex/time of day/day of week/activity level/location/environmental factors/injury levels/cognition/medical status/medications/substance abuse and risk factors that were present at the time of the falls.

Clinical Educator will be highlighting falls as one of our monthly education topics for 2020.

Conduct further research regarding intentional falls in the Mental Health Setting.

We have implemented a debrief form for staff to complete post fall which will continue to be utilized.

We are reviewing our process for administering PRN/emergency medications and are working on a scale similar to the pain scale to assist nursing staff in assessing which meds to give to patients for their symptoms/level of agitation.

Literature Cited

Slade, S. C., Carey, D. L., Hill, A. M., & Morris, M. E. (2017). Effects of falls prevention interventions on falls outcomes for hospitalised adults: protocol for a systematic review with meta-analysis. *BMJ open*, *7*(11), e017864. https://doi.org/10.1136/bmjopen-2017-017864
Edmonson D., Robinson S., Hughes L.(2011). Development of the Edmonson Psychiatric Fall Risk Assessment Tool. *J Psychosoc Nurs Ment Health Serv.* 49(2) 29-36. doi: 10.3928/02793695-20101202-03 [link]

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee / Quality Improvement Committee

Unit/Department: Mental Health **ProStaff / QIC Report Date:** 8/17/20

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

FY2020 Chart-Abstracted Measures

MEASURE ID	MEASURE NAME	ENDORSED BY	
		CMS (IPFQR)	THE JOINT COMMISSION
HBIPS-1a	Admission Screening		✓
HBIPS-2a	Hours of Physical Restraint Use	✓	✓
HBIPS-3a	Hours of Seclusion Use	✓	✓
HBIPS-5a	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	✓	✓
SMD-1	Screening for Metabolic Disorders	✓	
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.

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:

Jun 2019 – Jun 2020	: HBIPS-1a	**Q2 2018 – Q1 2020**	: Fall, Assault Indicators
Apr 2019 – Apr 2020	: HBIPS-2a, 3a, 5a; SMD-1; SUB 2, 2a, 3, 3a; TOB-2, 2a, 3, 3a; CT-2; CT-3		

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

- 90% (17 of 19) of total indicators outperform the target/benchmark statistic majority of the reporting intervals (>50%).

Improvements Since Last Reporting Period

- Improved performance: **HBIPS-1a. Improved from 25% with outperformance of benchmark, to currently 42%. If you look at the overall graph, the overall trend is upward to complete outperformance.** Significant improvement is due to:
  - ☑ 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
  - ☑ Cerner adjustments made and training facilitated
- **Continued improved performance: HBIPS-5a, SMD-1, TOB-2, TOB-3**
- Decline in hours of physical restraint (**HBIPS-2a**)
- **Total Fall** rate remains lower than previous reporting periods

Opportunities

- **TOB-2a:** *while KDMHH outperformed this benchmark 8 out of 12 months, this measure remains below the median and benchmark statistic*

- **ASSAULTS:** *Overall, total assault rates remain above benchmark for past 3 quarters. This includes an increase in use of seclusion by 15%.*

- **FALLS:** *Out of total of eight quarters, KDMHH didn't meet benchmark twice. Most recent quarter, KDMHH did outperform benchmark and with changes made, we hope to continue in this direction.*

- ***FALLS WITH INJURY:*** *For last two documented quarters, KDMHH had 1 fall per quarter with injury which puts us .44 above desired benchmark.*

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

TOB-2a: TOB -2A is during the admission process, nursing screens for tobacco use history and should counsel the patient on risks therein, and ask if the patient would like to quit, would like a smoking cessation medication, etc.

The barrier to this measure is patients who are stating they do not want to quit, end up charted as "refused counseling", however it is more likely the patient was unable to participate in the assessment process due to mental illness acuity.

While there is a significant barrier to improvement on this measure, KDMHH team will:

- ☐ Remediate the education for nursing staff to ensure they are clear on what the criteria is for "Practical Counseling".

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
- ☑ Relocate video surveillance camera from gymnasium to E2 unit
- ☑ Include security officers in daily FLASH meetings (safety huddles); security officer will incorporate new information in security daily pass-down report.
- ☑ 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 and MH Leadership Team).
- ☐ Implement new training with AVADE next FY 21/22. This is on hold due to financial struggles from COVID-19 global pandemic. Until we can obtain this training, our Safety Specialist is conducting mental health specific CPI Training at KDMHH.

FALLS INCLUDING WITH INJURY: Falls in hospitals in general are associated with serious injuries and increased length of stay. There are numerous factors that contribute to falls in the inpatient Mental Health setting including medications, mental status , and co-morbid health conditions.

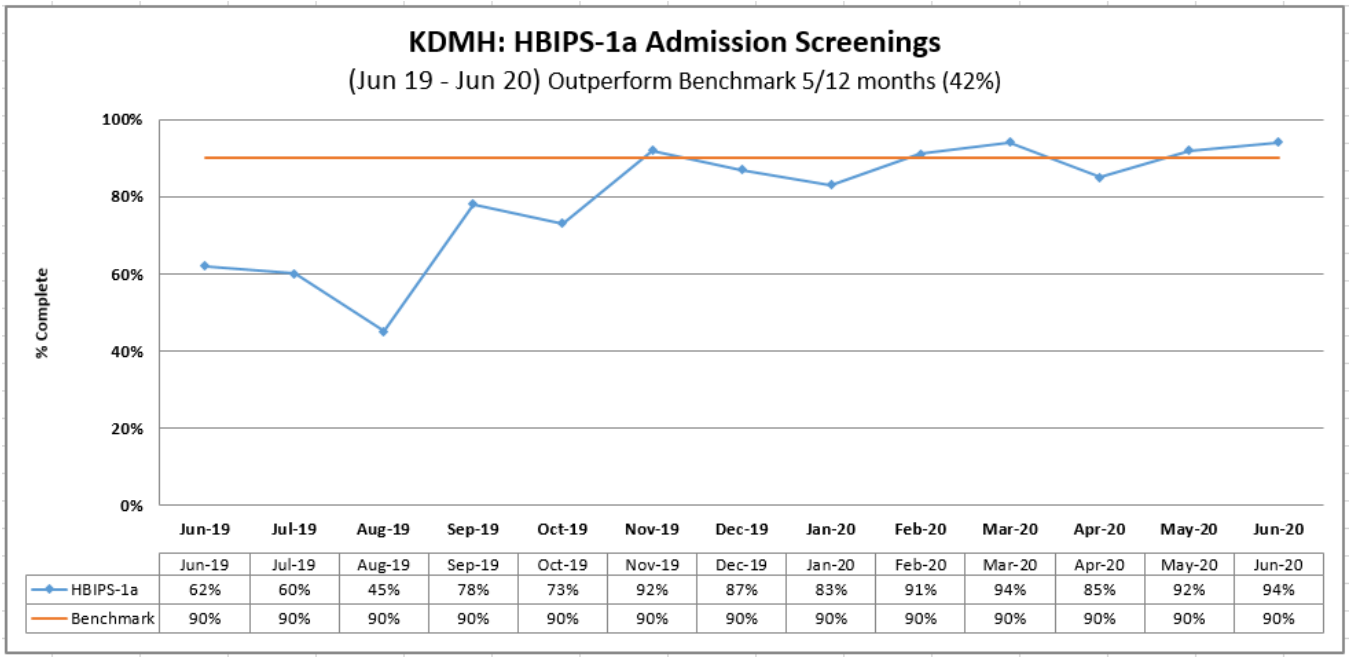
KDMHH team will:

- ☑ Staff will continue their involvement with Falls University
- ☐ Attached Patient Safety Symposium Poster will be presented to staff and used as an educational tool
- ☐ Beginning next month, September, Falls University takeaways will be reviewed during monthly staff meetings
- ☐ UBC will work on the case studies of the falls with injury and present findings at staff meeting

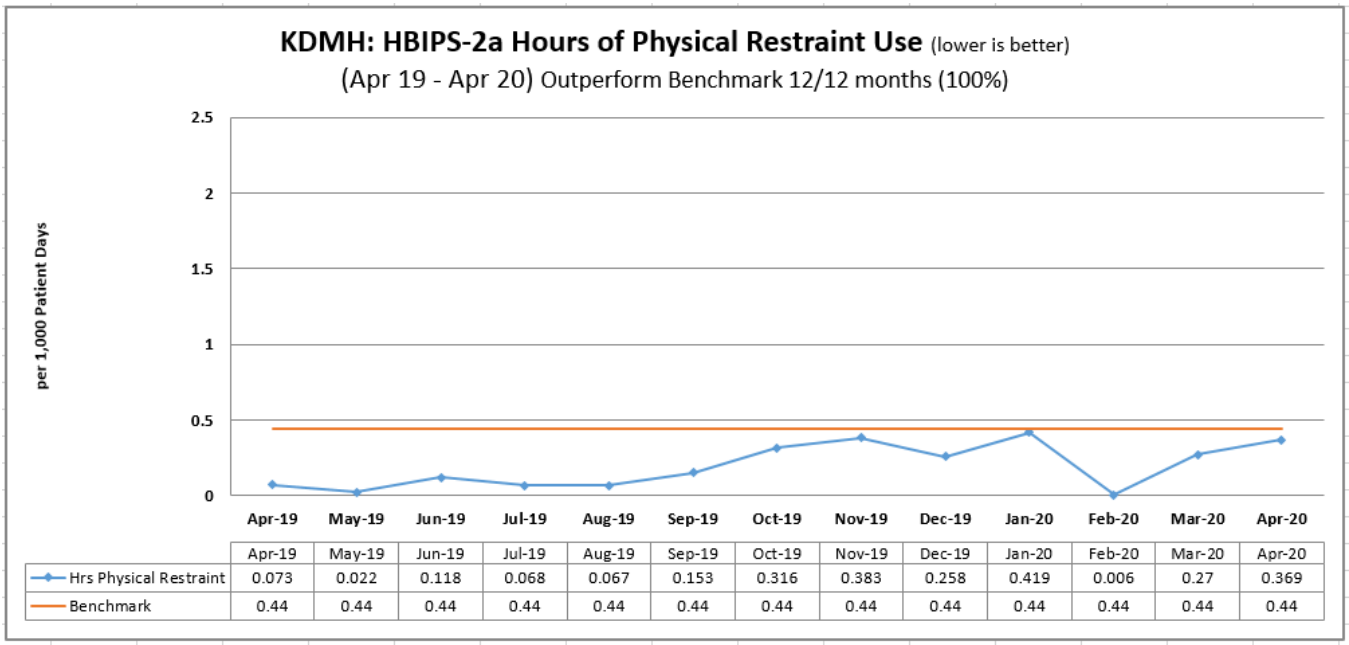
Next Steps/Recommendations/Outcomes:

In addition to plans and outcomes detailed above, clinical education and management will be implementing a series of mock Code Grays. This will assist staff in elevating their level of comfort and expertise when responding to assaultive patients.

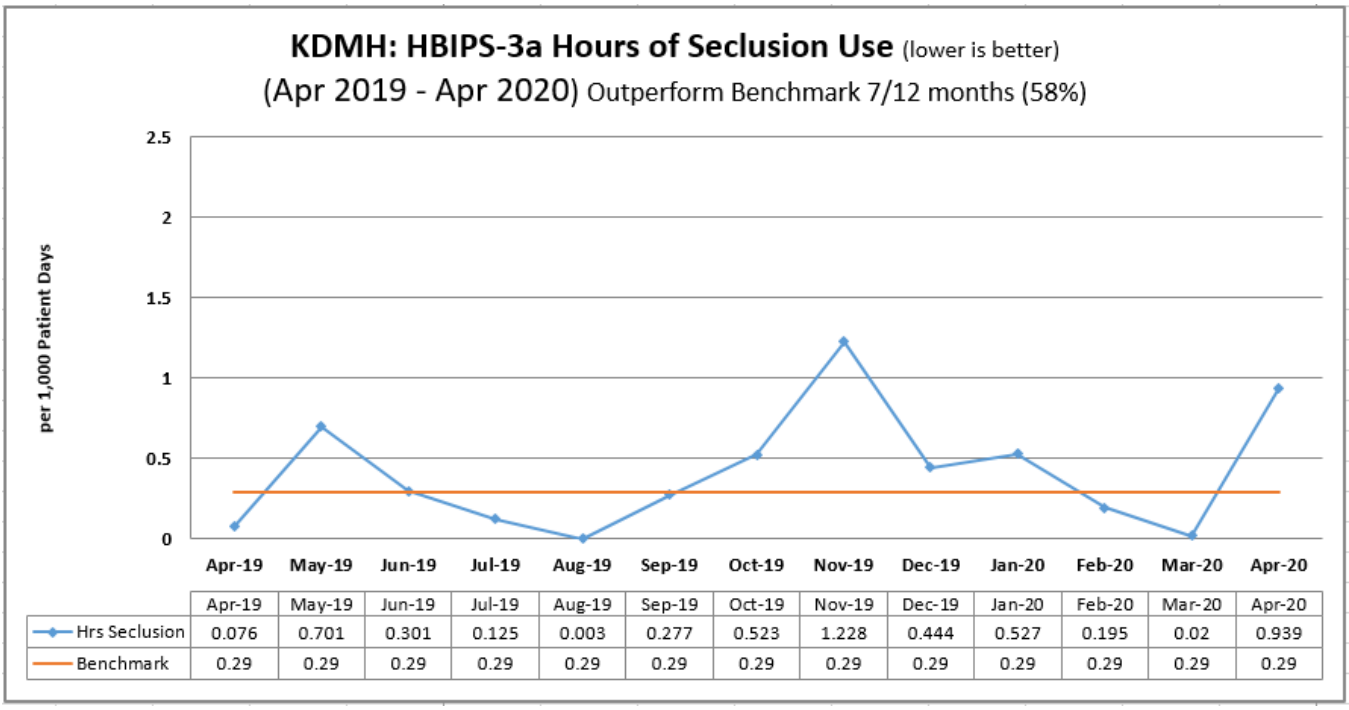
Submitted by Name: *Jaime Hinesly, LMFT* **Date Submitted:** 8/17/20



	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
HBIPS-1a	62%	60%	45%	78%	73%	92%	87%	83%	91%	94%	85%	92%	94%
Benchmark	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Hrs Physical Restraint	0.073	0.022	0.118	0.068	0.067	0.153	0.316	0.383	0.258	0.419	0.006	0.27	0.369
Benchmark	0.44	0.44	0.44	0.44	0.44	0.44	0.44	0.44	0.44	0.44	0.44	0.44	0.44

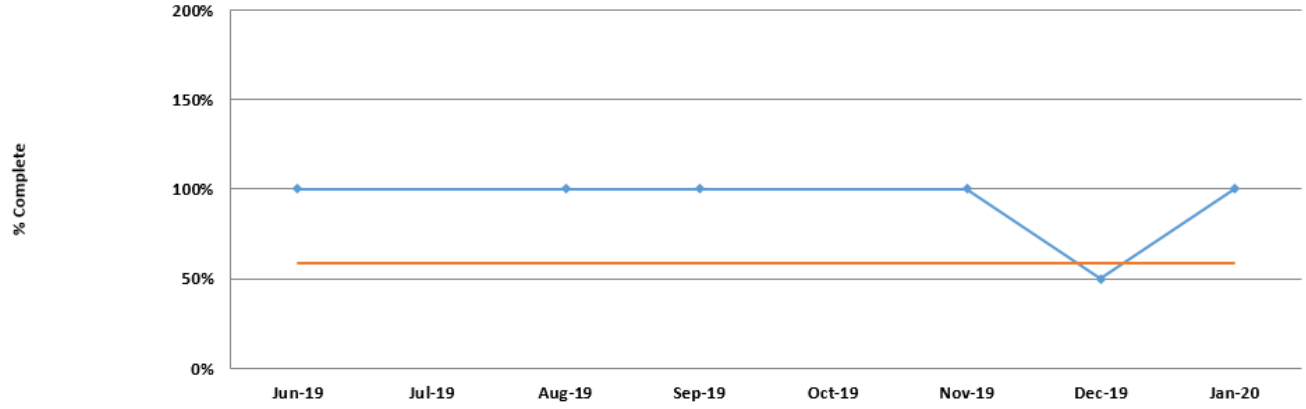


	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Hrs Seclusion	0.076	0.701	0.301	0.125	0.003	0.277	0.523	1.228	0.444	0.527	0.195	0.02	0.939
Benchmark	0.29	0.29	0.29	0.29	0.29	0.29	0.29	0.29	0.29	0.29	0.29	0.29	0.29

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

KDMH: HBIPS-5a Patients DC'd on Multiple Antipsychotic Medications with Appropriate Justification

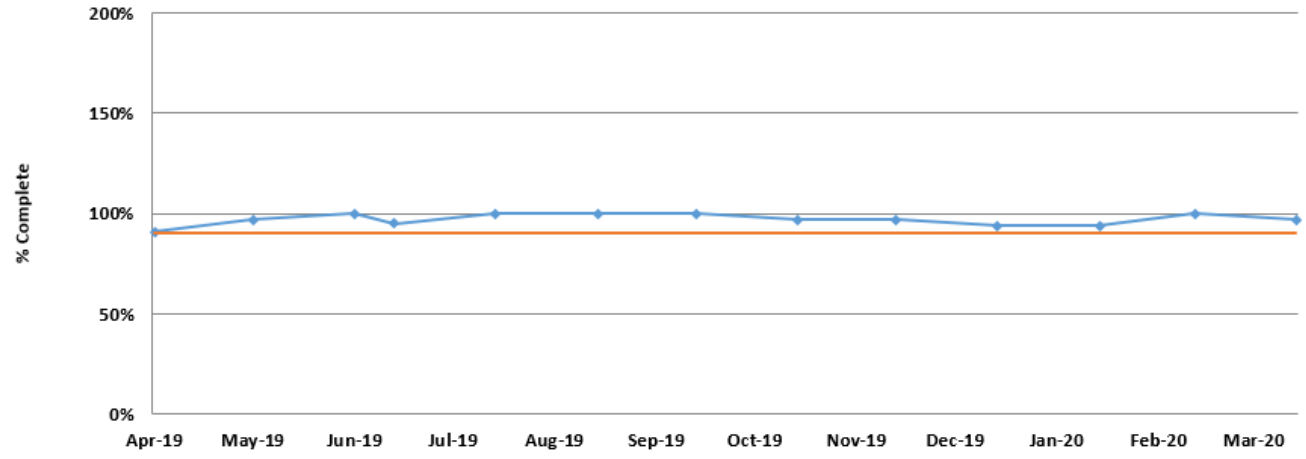
(6 opportunities/12 months) Outperform Benchmark 5/6 opportunities (83%)



	Jun-19	Aug-19	Sep-19	Nov-19	Dec-19	Jan-20
Mulitple Antipsychotics	100%	100%	100%	100%	50%	100%
Benchmark	59%	59%	59%	59%	59%	59%

KDMH: SMD-1 Screening for Metabolic Disorders

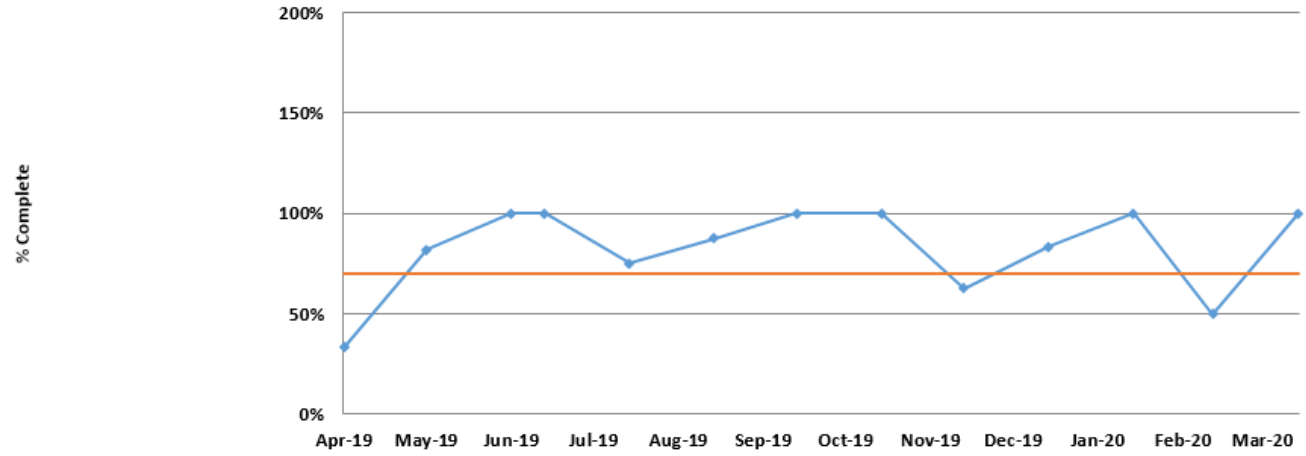
(Apr 2019 - Apr 2020) Outperform Benchmark 12/12 months (100%)



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
CT-3	91%	97%	100%	95%	100%	100%	100%	97%	97%	94%	94%	100%	97%
Benchmark	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

KDMH: SUB-2 Alcohol Use, Brief Intervention Provided/Offered

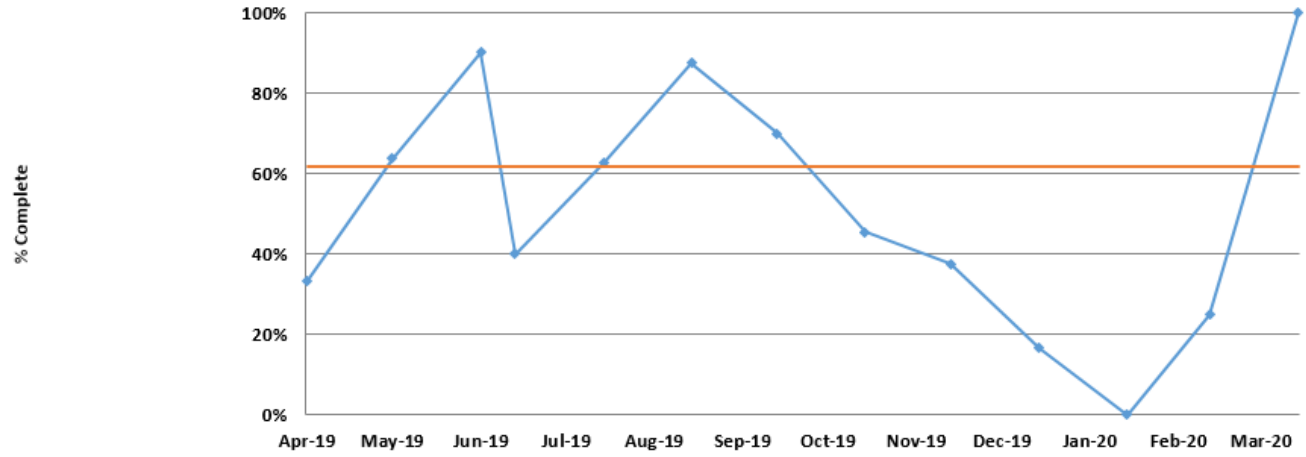
(Apr 2019 - Apr 2020) Outperform Benchmark 10/12 months (83%)



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Alc. Use, Intervention/Prov./Offer.	33%	82%	100%	100%	75%	88%	100%	100%	63%	83%	100%	50%	100%
Benchmark	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%

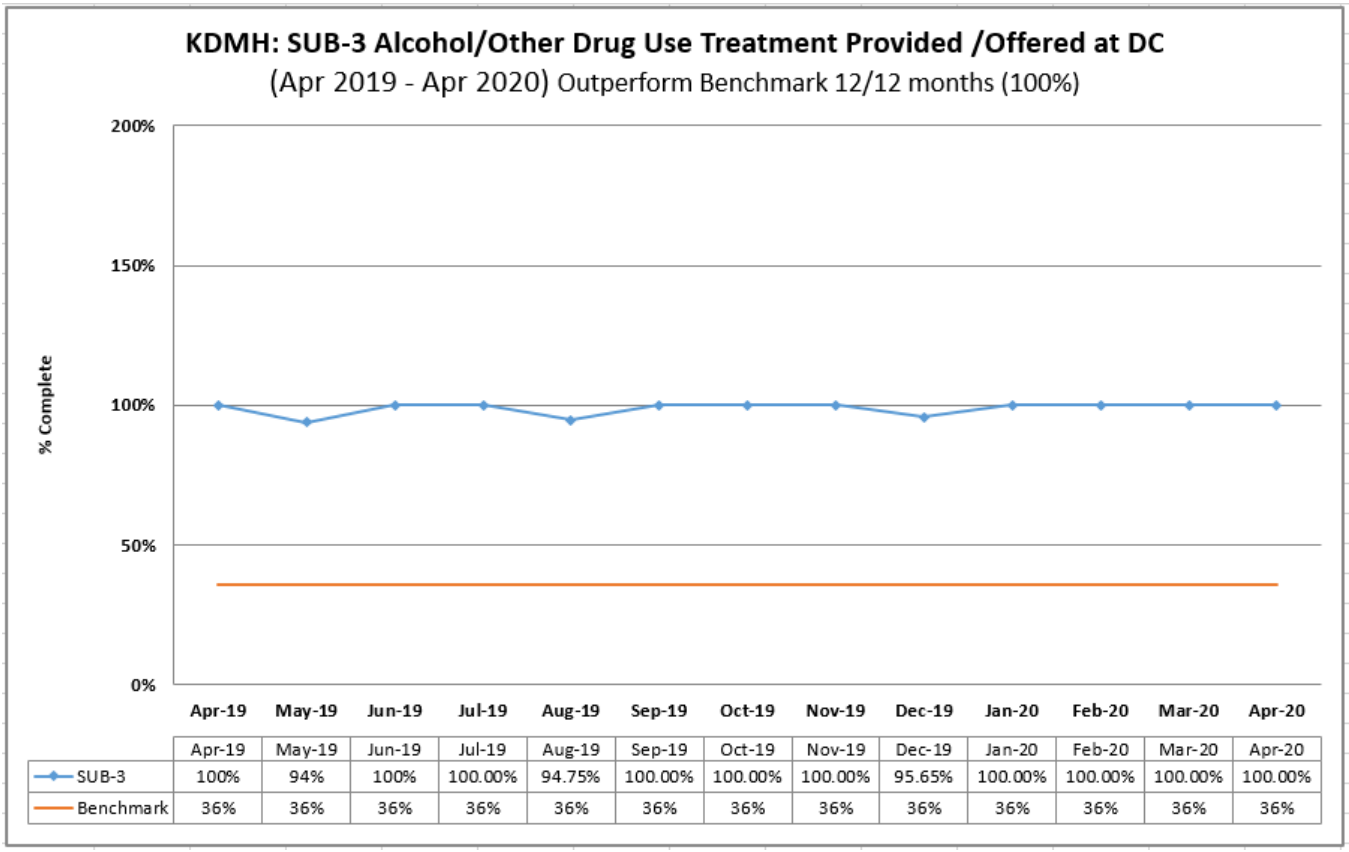
KDMH: SUB-2a Alcohol Use Brief Intervention

(Apr 2019 - Apr 2020) Outperform Benchmark 6/12 months (50%)

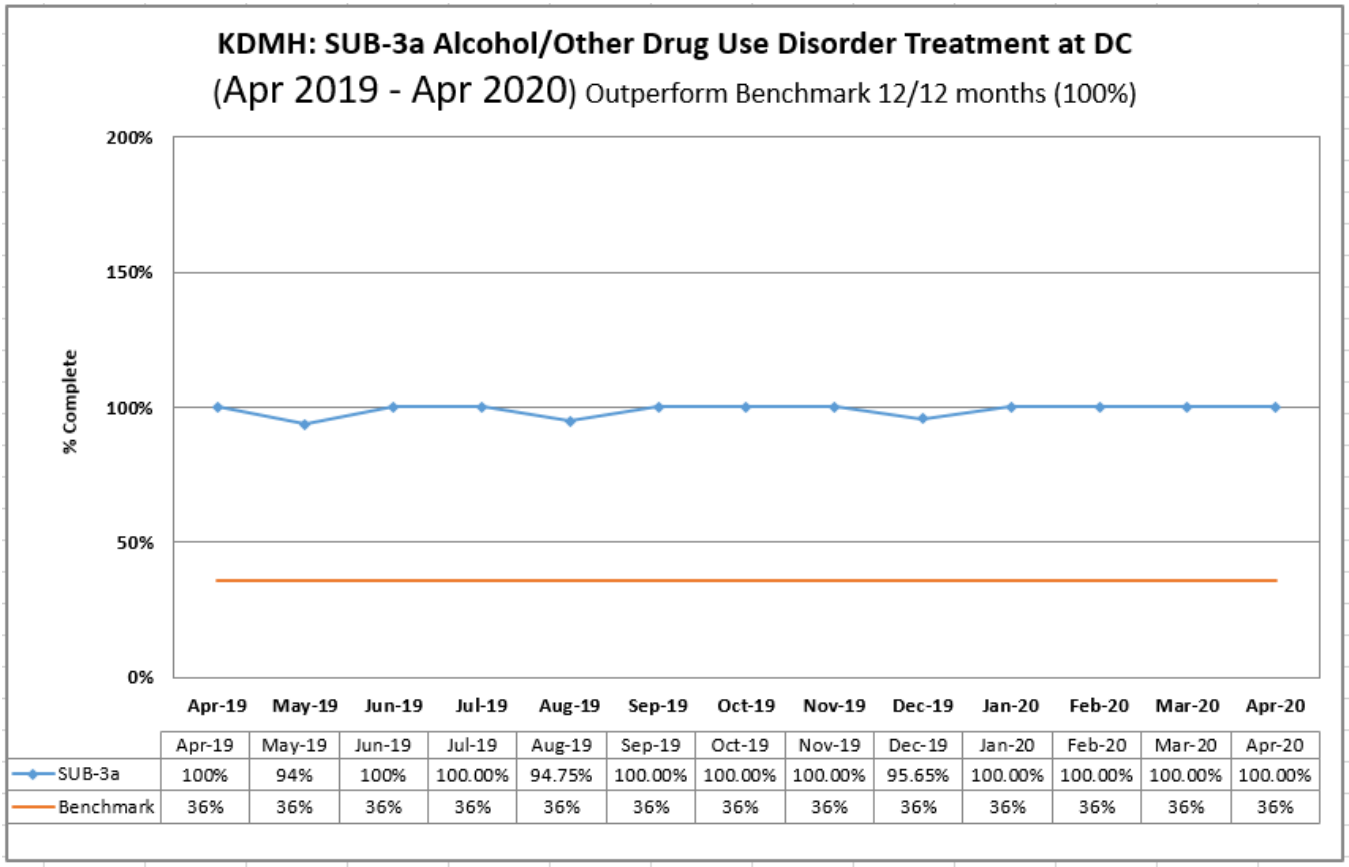


	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Alcohol Use Brief Intervention	33%	64%	90%	40%	63%	88%	70%	45%	38%	17%	0%	25%	100%
Benchmark	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%

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



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
SUB-3	100%	94%	100%	100.00%	94.75%	100.00%	100.00%	100.00%	95.65%	100.00%	100.00%	100.00%	100.00%
Benchmark	36%	36%	36%	36%	36%	36%	36%	36%	36%	36%	36%	36%	36%

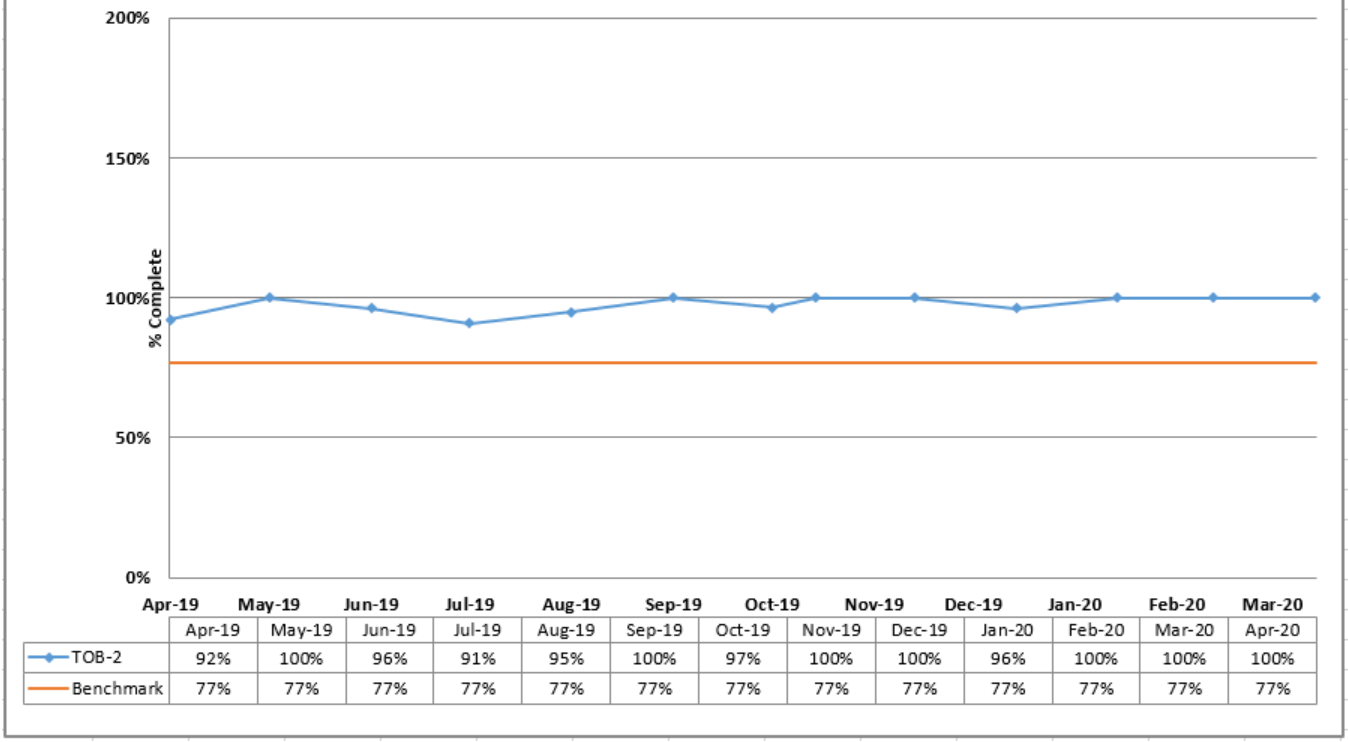


	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
SUB-3a	100%	94%	100%	100.00%	94.75%	100.00%	100.00%	100.00%	95.65%	100.00%	100.00%	100.00%	100.00%
Benchmark	36%	36%	36%	36%	36%	36%	36%	36%	36%	36%	36%	36%	36%

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

KDMH: TOB-2 Tobacco Use Treatment Provided/Offered

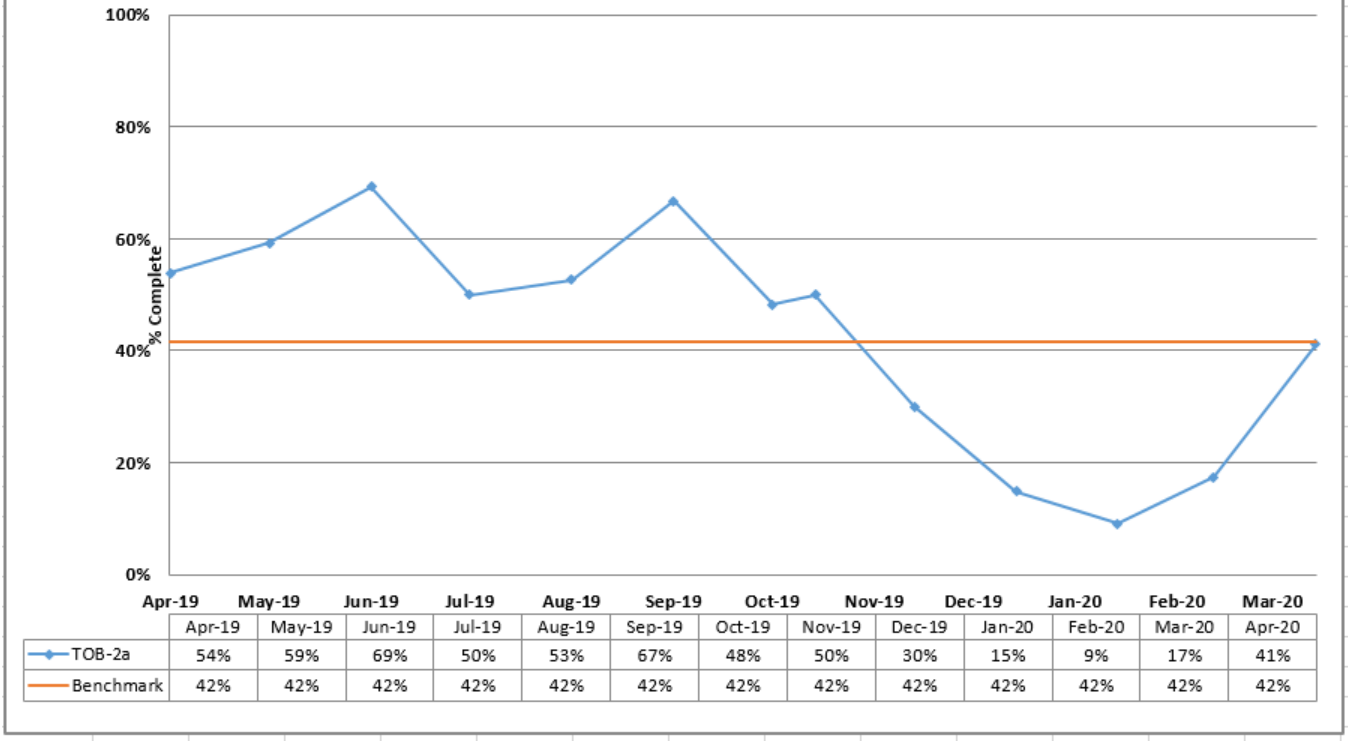
(Apr 2019 - Apr 2020) Outperform Benchmark 12/12 months (100%)



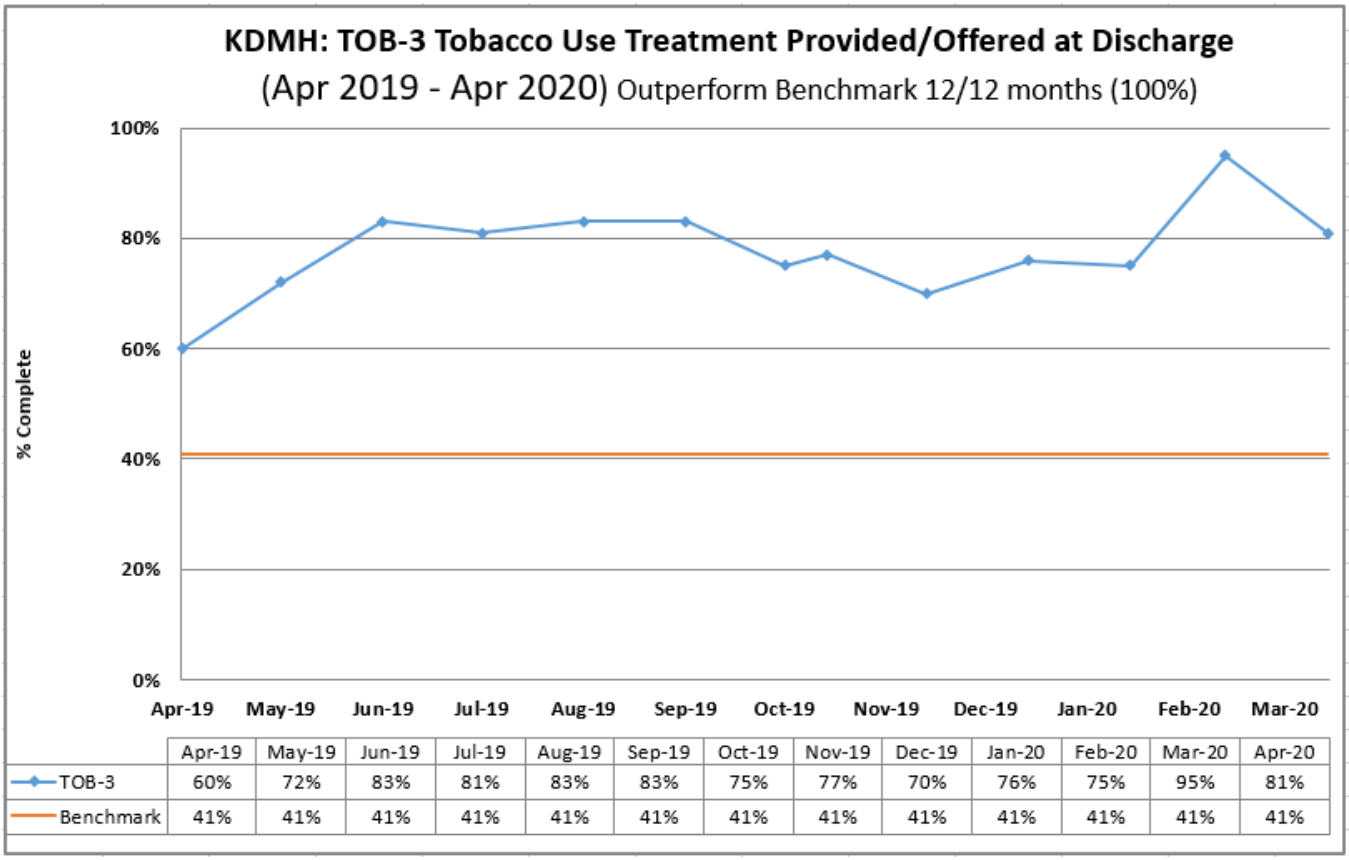
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
TOB-2	92%	100%	96%	91%	95%	100%	97%	100%	100%	96%	100%	100%	100%
Benchmark	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%

KDMH: TOB-2a Tobacco Use Treatment

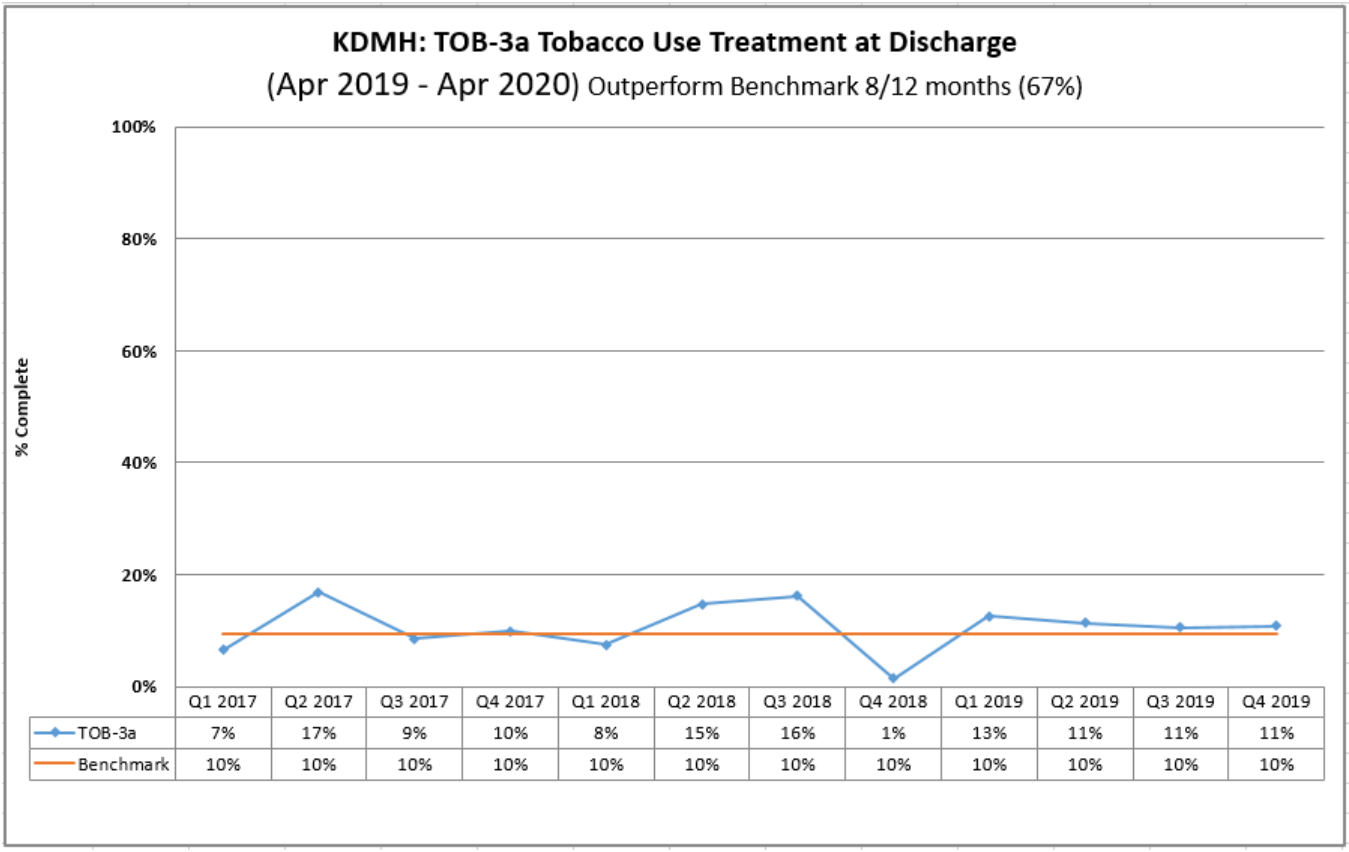
(Apr 2019 - Apr 2020) Outperform Benchmark 8/12 months (67%)



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
TOB-2a	54%	59%	69%	50%	53%	67%	48%	50%	30%	15%	9%	17%	41%
Benchmark	42%	42%	42%	42%	42%	42%	42%	42%	42%	42%	42%	42%	42%

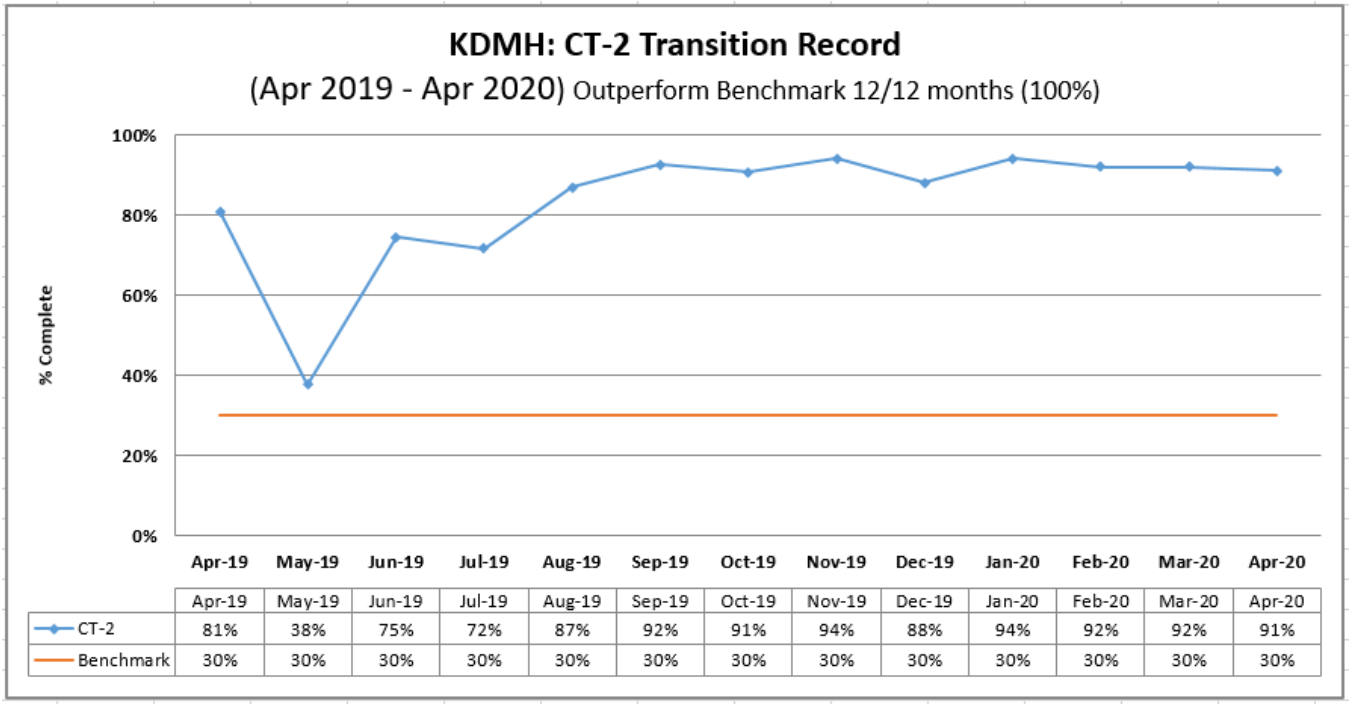


	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
TOB-3	60%	72%	83%	81%	83%	83%	75%	77%	70%	76%	75%	95%	81%
Benchmark	41%	41%	41%	41%	41%	41%	41%	41%	41%	41%	41%	41%	41%

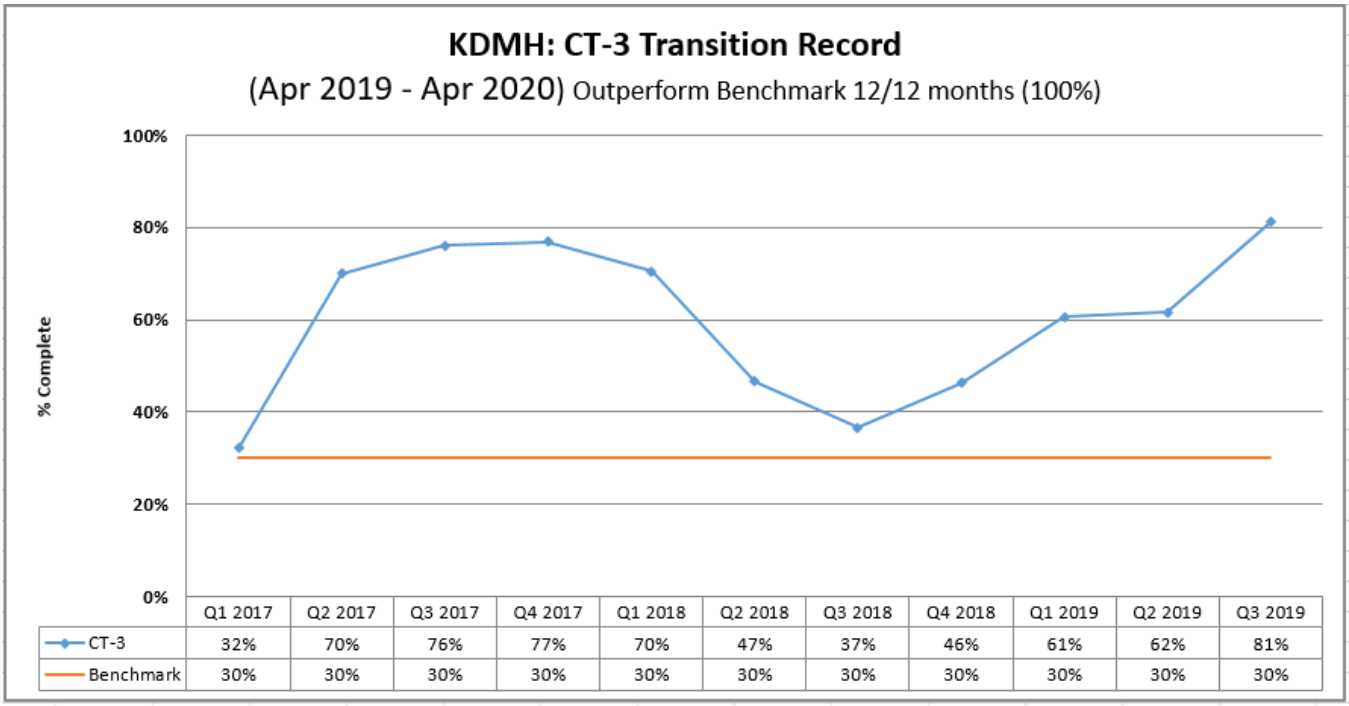


	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019
TOB-3a	7%	17%	9%	10%	8%	15%	16%	1%	13%	11%	11%	11%
Benchmark	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%

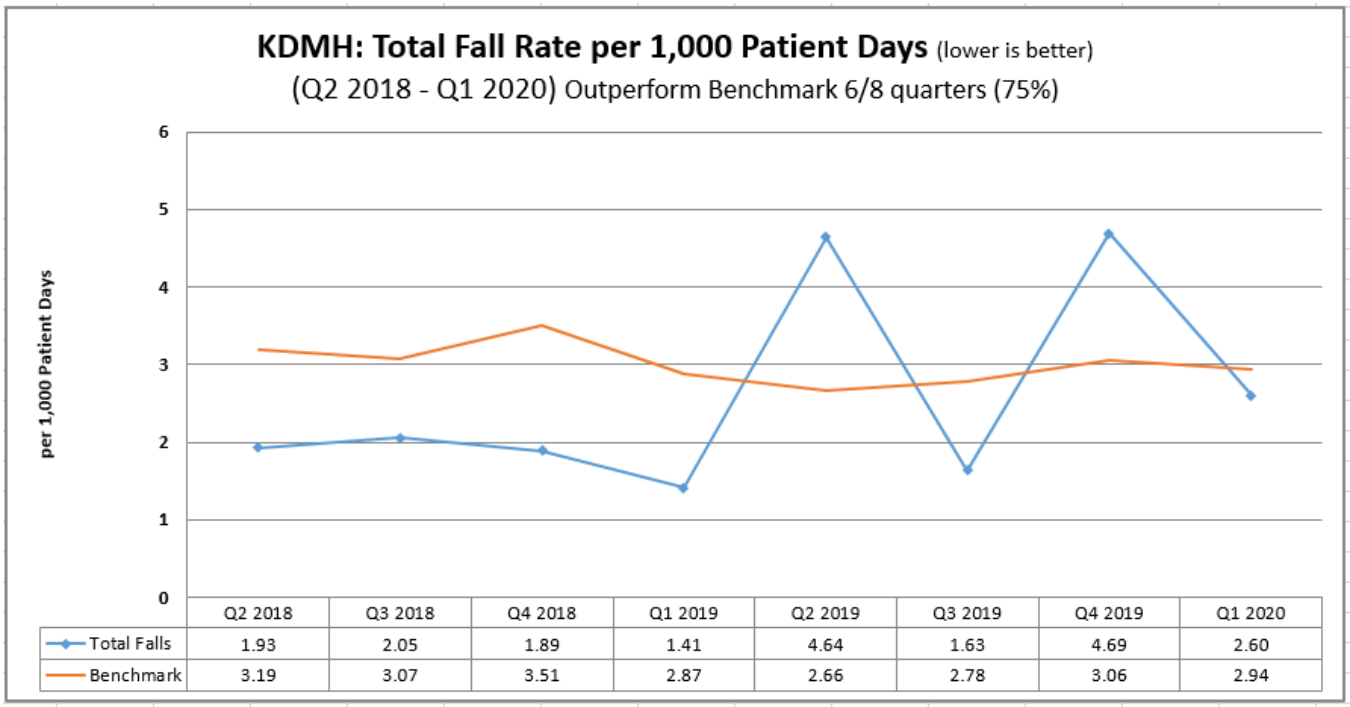
Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.



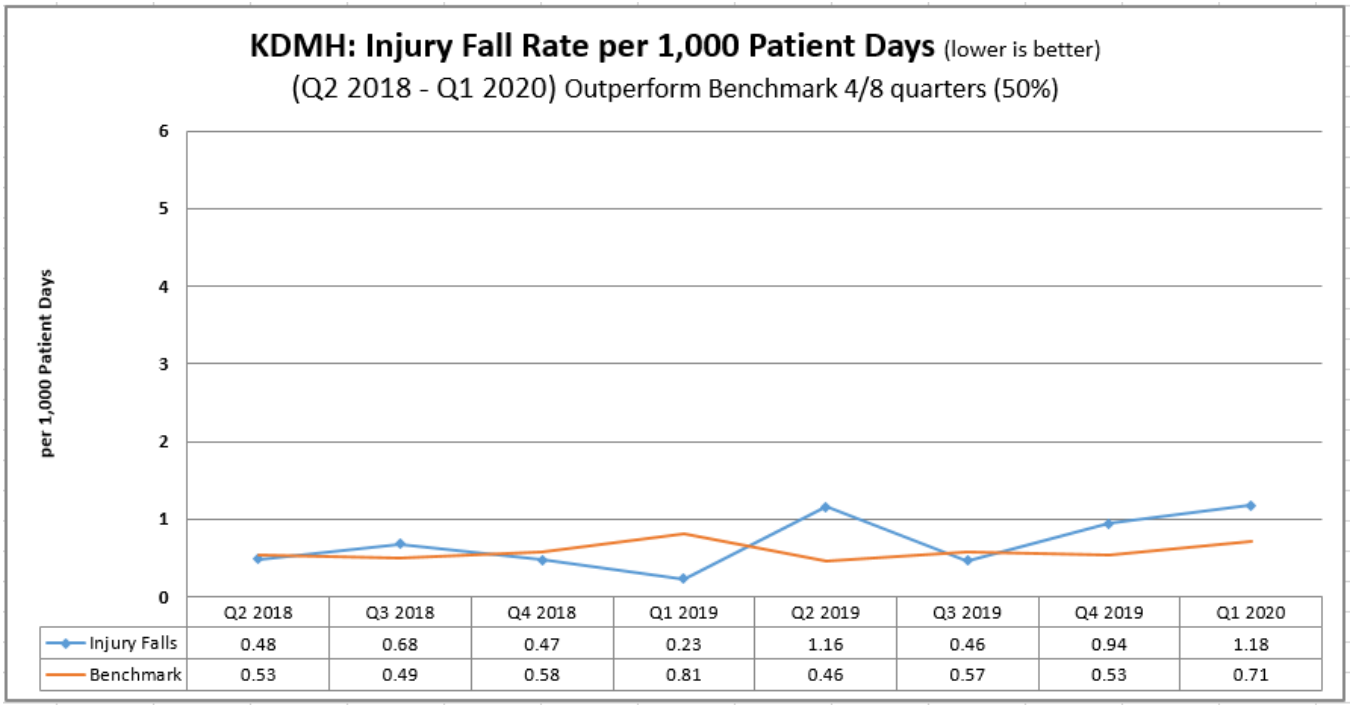
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
CT-2	81%	38%	75%	72%	87%	92%	91%	94%	88%	94%	92%	92%	91%
Benchmark	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%



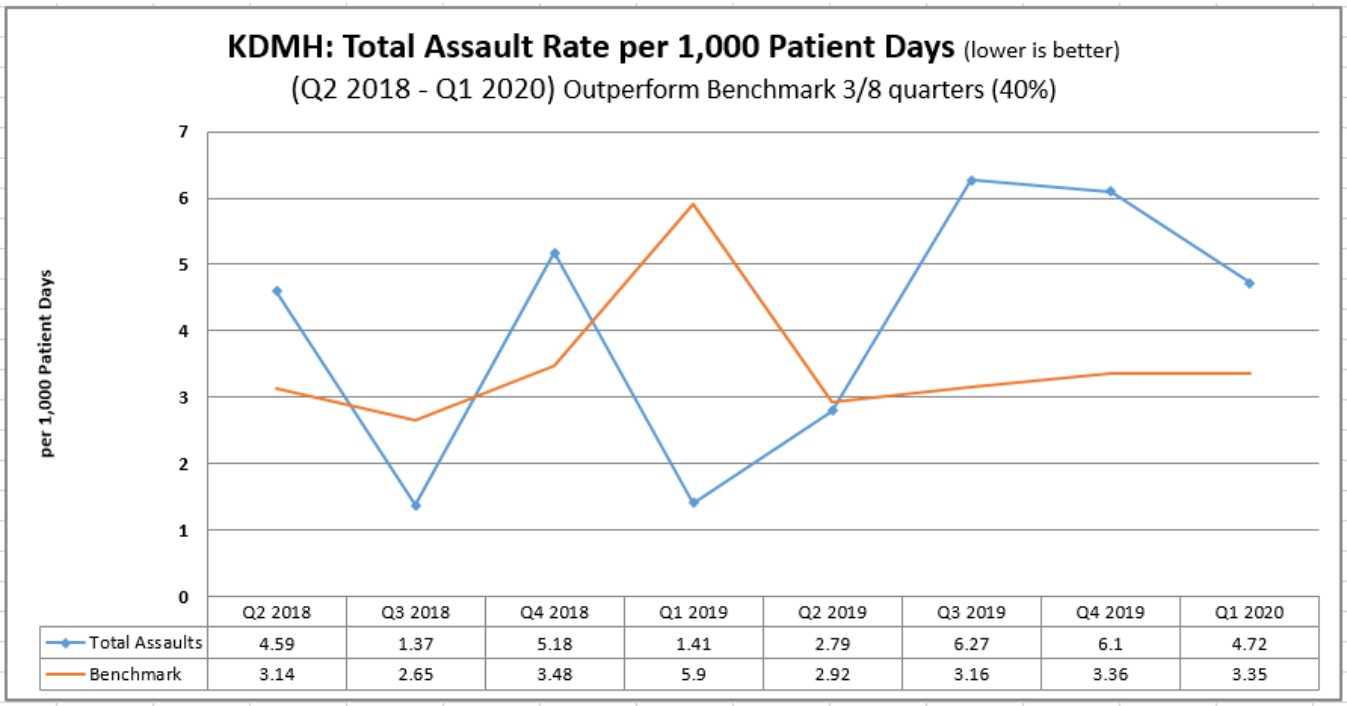
	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019
CT-3	32%	70%	76%	77%	70%	47%	37%	46%	61%	62%	81%
Benchmark	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%



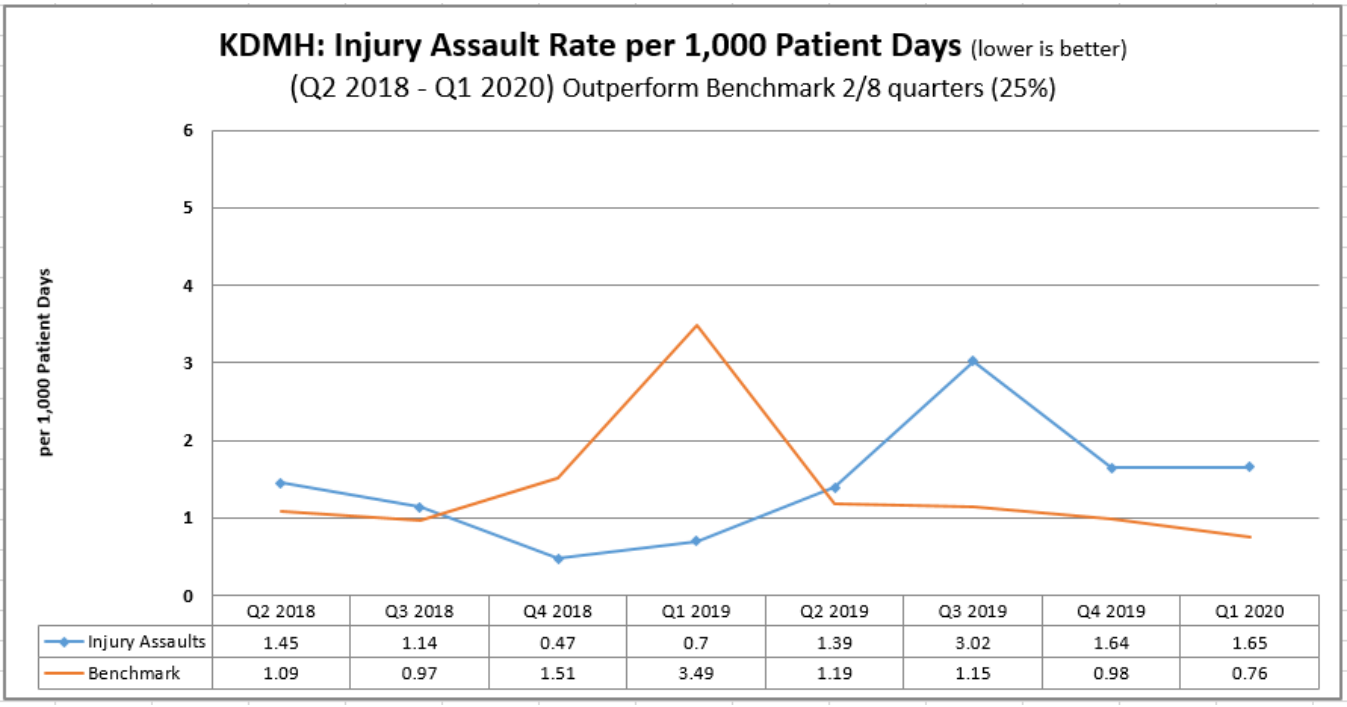
	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020
Total Falls	1.93	2.05	1.89	1.41	4.64	1.63	4.69	2.60
Benchmark	3.19	3.07	3.51	2.87	2.66	2.78	3.06	2.94



	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020
Injury Falls	0.48	0.68	0.47	0.23	1.16	0.46	0.94	1.18
Benchmark	0.53	0.49	0.58	0.81	0.46	0.57	0.53	0.71



	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020
Total Assaults	4.59	1.37	5.18	1.41	2.79	6.27	6.1	4.72
Benchmark	3.14	2.65	3.48	5.9	2.92	3.16	3.36	3.35



	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020
Injury Assaults	1.45	1.14	0.47	0.7	1.39	3.02	1.64	1.65
Benchmark	1.09	0.97	1.51	3.49	1.19	1.15	0.98	0.76

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Hospice **ProStaff Report Date: 07/14/2020**

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 Percy and Company quarterly (Qtr. 1, 2020). Hospice CAHPS survey results for reporting period of 01/01/2020-03/31/2020 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 Percy and Company 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 Percy and Company 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 Percy and Company results and the data posted on Hospice Compare. Hospice has implemented interventions to improve the measure. Most recent quarterly Percy and Company results look to exceed nationals in overall results posted on Hospice Compare.

Table 1.

Source	Current Hospice Compare	Hospice Compare Previewer Report	Percy and Company Quarterly Results
Reporting Period	07/01/2017-06/30/2019	07/01/2017-06/30/2019	01/01/2020-03/31/2020
Top Box Score : Response "always"	77%	77%	88 %
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:

The measure "Getting Timely Help" has improved significantly (see scores Table 1). Hospice Compare has not yet refreshed for the current time frame. The data will continue to lag behind current data found on Percy and Company site. The domain "Getting Timely Help" was originally selected as a 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:

The original goal was 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 (Percy and Company), 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 2 of 2020 Results: 90%: Percy and Company survey results are more current and provide more "real time" measurements of improvement. Qtr. 2 results have not been posted yet. The actions put in place to meet this measure have caused a continual increase in scores. With current measures the trajectory should continue to go up. This measure will be evaluated at the end of quarter 2 to determine if we have achieved stability of the increase so as to be retired.

Plan of action for 2020

- Continue the current staffing model. Evaluate and analyze data.
    - 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 backup 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 quarter to confirm improvement is sustained.

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 92% which exceeds the national average but is 5% lower than the Q3 of 2019.

Date range of data evaluated:

Hospice's most recent Percy and Company quarterly (Qtr. 1, 2020) survey results are reflective of the period from 01/01/20-03/31/20.

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

There has been a decrease in the score for providing emotional and spiritual support. While we continue to exceed the national average we want to ensure sustainability of this metric. Discussions will continue at staff meetings and follow up phone calls to patients by MSW's and chaplain services will be strongly encouraged.

Key findings:

There has been a 5% decrease in survey scores for "Getting Support Relative/Emotional". This measure includes getting emotional and spiritual support as of Q12020. While 92% 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 95% 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 nursing has instituted a practice of requesting patients allow at least one contact with the social workers and chaplain before declining the service. Currently all staffing positions for clinicians providing visits to patients are filled. This should allow proper time for interaction with family. In addition, Hospice now has a new Medical Director, Dr. Ryan Howard. Dr. Howard initiates contact with patients and families in the acute setting more frequently and it is hopeful this will begin the process of providing that support.

Expected Resolution Date:

Expected resolution is Quarter 3 of 2020. The goal is for improvement each quarter with a 95% or higher.

Plan of action for 2020

- Test new scripting
- The admission nurse will recommend one visit from each team member within the first 5 days or per pt. request.
- 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.

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Measure Objective/Goal:

Results of the Hospice Quality Measure of **"Treating patient with respect"** will meet or exceed the US national percent of 91%. The current score is 88% which is below the national average and is a drop of 6% from previous measurement data.

Date range of data evaluated:

Hospice's most recent Percy and Company quarterly (Qtr. 1, 2020) survey results are reflective of the period from 01/01/20-03/31/20.

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

There has been a decrease in the score for treating patient with respect. There is opportunity for increase in this measure and any decrease should be analyzed as has occurred with this measure.

Opportunities:

There is opportunity to improve this score. The goal is to get to the 95% or greater. Education is taking place with clinicians to ensure they are discussing with families and patients what being treated with respect means.

Expected Resolution Date:

Expected resolution is Quarter 3 of 2020. The goal is for improvement each quarter with a 95% or higher.

Plan of action for 2020

- Admitting clinicians should be discussing with patient/family members what being treated with respect means to them.
- All staff should be mindful to arrive timely and to notify patient/family of any changes in scheduled visits/times.
- A phone call will be made by each team member to chat and to set up the appt.

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:**

Tiffany Bullock, MSN, RN
Director of Hospice Services

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

		Measure Score Cut Points by Initial Decile Rating						
	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 Dyspnea	Measure 7. Acute Care Hospitalization
	0.5	0.0-83.3	0.0-32.9	0.0-38.9	0.0-32.5	0.0-48.6	0.0-45.0	19.5-100.0
	1.0	83.4-90.3	33.0-44.6	39.0-52.5	32.6-48.7	48.8-61.9	45.1-60.8	17.7-19.4
	1.5	90.4-93.6	44.7-54.2	52.6-61.7	48.8-59.7	62.0-69.6	60.9-69.0	16.7-17.6
	2.0	93.7-95.8	54.3-62.0	61.8-69.2	59.8-68.4	69.7-75.0	69.1-75.2	15.8-16.6
	2.5	95.9-97.2	62.1-68.4	69.3-74.9	68.5-75.5	75.1-79.4	75.3-79.5	15.0-15.7
	3.0	97.3-98.1	68.5-73.8	75.0-79.7	75.6-80.9	79.5-83.1	79.6-83.4	14.3-14.9
	3.5	98.2-98.9	73.9-78.9	79.8-83.3	81.0-85.2	83.2-86.2	83.5-86.6	13.4-14.2
	4.0	99.0-99.4	79.0-83.4	83.4-86.9	85.3-88.5	86.3-89.3	86.7-90.1	12.2-13.3
	4.5	99.5-99.9	83.5-88.9	87.0-90.8	88.6-91.9	89.4-92.9	90.2-93.9	10.4-12.1
	5.0	100.0-100.0	89.0-100.0	90.9-100.0	92.0-100.0	93.0-100.0	94.0-100.0	0.0-10.3
	Your HHA Score	98.3	67.4	66.1	69.6	74.0	83.1	12.7
	Your Initial Group Rating	3.5	2.5	2.0	2.5	2.0	3.0	4.0
14	Your Number of Cases (N)	2,363	1,347	1,618	1,433	1,718	805	678
15	National (All HHA) Middle Score	97.2	68.5	75.0	75.5	79.5	79.5	15.0
16	Your Statistical Test Probability Value (p-value)	0.000	0.202	0.000	0.000	0.000	0.006	0.049
17	Your Statistical Test Results (Is the p-value < 0.050?)	Yes	No	Yes	Yes	Yes	Yes	Yes
	Your HHA Adjusted Group Rating	3.5	2.5	2.0[2]	2.5	2.0[2]	3.0	4.0

19	Your Average Adjusted Rating	2.8
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 data from January 1, 2019 to December 31, 2019; claims data from January 1, 2019 to December 31, 2019.*

[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.*

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department:
Home Health

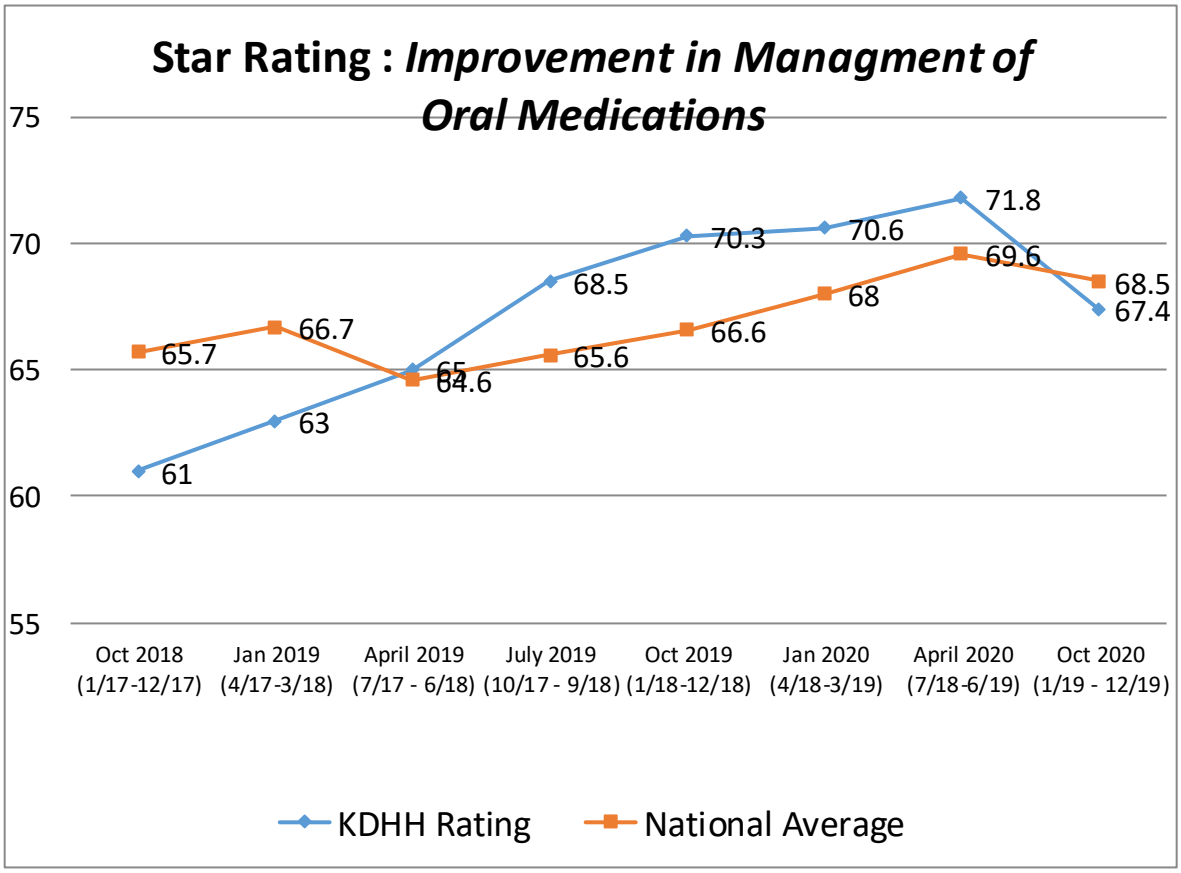
ProStaff/QIC Report Date:
July 2020

Measure Objective/Goal:
Improvement in Management of Oral Medications

- **Latest CMS Star Rating Data Home Health: 67.4%**
- **Latest CMS Star Rating National Average Data: 68.5**

Date range of data evaluated:
CMS 5-Star Report: January 1, 2019 through December 31, 2019

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



--Evaluations of patient ability that are deemed "stabilized" by discharge are still counted as a negative factor. Level of caregiver involvement in assistance with medication regimen must be differentiated between patient's actual ability versus convenience.
--Functional ability as well as cognitive ability may impact patient's ability to safely manage medications.

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

-- If a patient requires supervision to ambulate safely, then they must also be scored as "unable to manage medications independently" with regards to ability to manage medications according to OASIS guidance rules.

<u>If improvement opportunities identified, provide action plan and expected resolution date:</u>
--Intensify chart reviews to determine trends among patient populations that typically do not improve. Check for discrepancies between how OASIS question was answered versus clinician documentation.

--Comparison between documentation and OASIS ADL answers and the specific Oral Medication Management question.

--Auditors to consult with clinician if auditing has identified areas of discrepancy between clinician documentation and OASIS answer. Auditors to directly seek clarification of clinician's understanding of the question and intent of answer, lack of supportive charting. Auditors to ensure interventions regarding medication management issues and safety be added to the MD ordered Plan of Care if relevant.

--Clinicians to promote the use of Home Health issued weekly medication boxes/planners, and ensure education of patient and/or caregiver in proper use.

--Ensuring appropriate referrals have been made to Physical and/or Occupational therapies if safety issue is identified to be related to ambulation/functional ability.

--All Staff OASIS education session planned for August 2020 with emphasis on the Oral Medication Management question.

<u>Next Steps/Recommendations/Outcomes:</u>
Continue to analyze data, monitor and track progress, and provide proactive, in-the-moment teaching opportunities when presented. Identify trends of those populations that typically lack improvement to develop action plan as needed. Our goal is that we will meet or exceed the national average in this measure for 3 or more reporting cycles.

<u>Submitted by Name:</u> **<u>Date Submitted:</u>**
Allison Carey, RN **July, 14, 2020**

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: **ProStaff/QIC Report Date:**
Home Health **July, 2020**

Measure Objective/Goal:
Improvement in Ambulation: How Often Patients Got Better at Walking or Moving Around

- **Latest CMS Star Rating Home Health Score: 66.1 %**
- **Latest CMS Star Rating National Middle Score: 75%**

Date range of data evaluated:
CMS Star Ratings Report: January 1, 2019 to December 30, 2019

Analysis of all measures/data: (Include key findings, improvements, opportunities)
--Data for CMS 5-Star Reports is gathered from both OASIS (Outcome and Assessment Information Set) scores that are documented during clinician assessment as well as Medicare claims data.

--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 more assistance at Start, but hopefully require less assistance as they improve and get stronger through the home health episode.

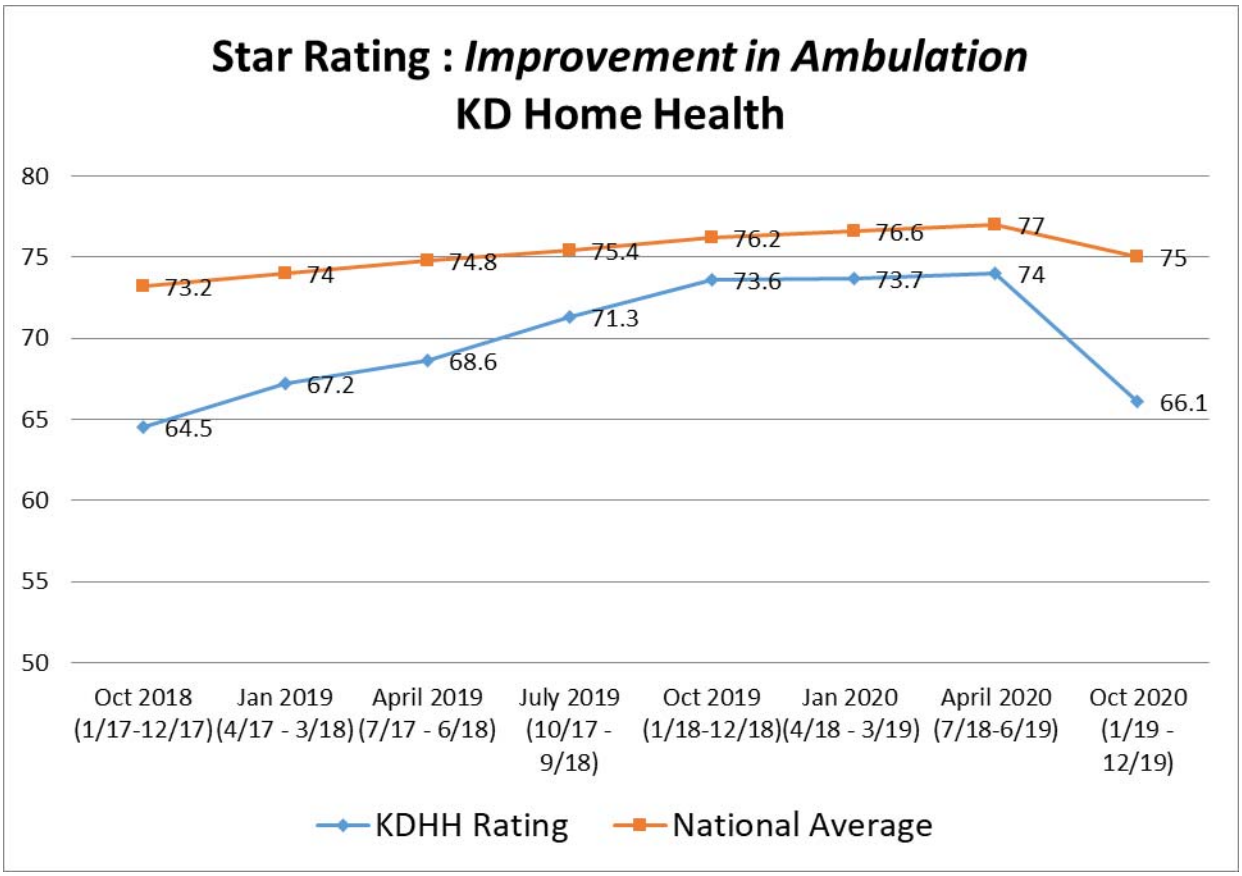
--A common thread among cases that did not show improvement in ambulation safety continues to be that patient ability was not captured correctly during the initial assessment, despite repeated staff education. There has been a notable difference in the way nursing staff perceives a patient's ability versus a therapy assessment.

--The month of December 2019 had the lowest physical therapy visit utilization for the year with 646 PT visits compared to the average of 760.

--OASIS data review shows that 97% of the patient plan of cares did address function.

--Previous action plan included attempting to have layout of charting of functional elements and OASIS scoring documentation be re-organized to allow more consistent follow through with documentation. Our EMR vendor informed us that the current organization of documentation cannot be altered.

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



<u>If improvement opportunities identified, provide action plan and expected resolution date:</u>
--Continue strict auditing of clinician charts. Corrections, if applicable, should be completed prior to OASIS submission. Goal of audit review will be daily.

--Physical therapy staff has now reached projected goal of staffing level. Monitor if there has been an increased therapy visit volume and if this shows reflection of improved outcomes.

--As of June 2020, we have reached out to a consultant for assistance in alternate methods of teaching clinicians how to accurately capture patients' functional status when scoring OASIS.

----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 questions. The goal is that this training will occur in August 2020.

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

Next Steps/Recommendations/Outcomes:

We will continue to monitor, provide direct intervention and proactive, in-the-moment teaching opportunities until we meet, or exceed, the national average for three or more quarters.

Submitted by Name:
Allison Carey, RN

Date Submitted:
July 13, 2020

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department:

Home Health

ProStaff/QIC Report Date:

July, 2020

Measure Objective/Goal:

Improvement in Bathing

- **Latest CMS Star Rating Data Home Health: 74%**
- **Latest CMS Star Rating National Average Data: 79.5%**

Date range of data evaluated:

CMS Star Report: January 1, 2019 through December 30, 2019

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

--Data for CMS 5-Star Reports is gathered from both OASIS (Outcome and Assessment Information Set) scores that are documented during clinician assessment as well as Medicare claims data.

--This measure has historically been one of our stronger measures with star ratings up until the October Star Report preview was release in July 2020. These metrics and pending action plans are still currently under review.

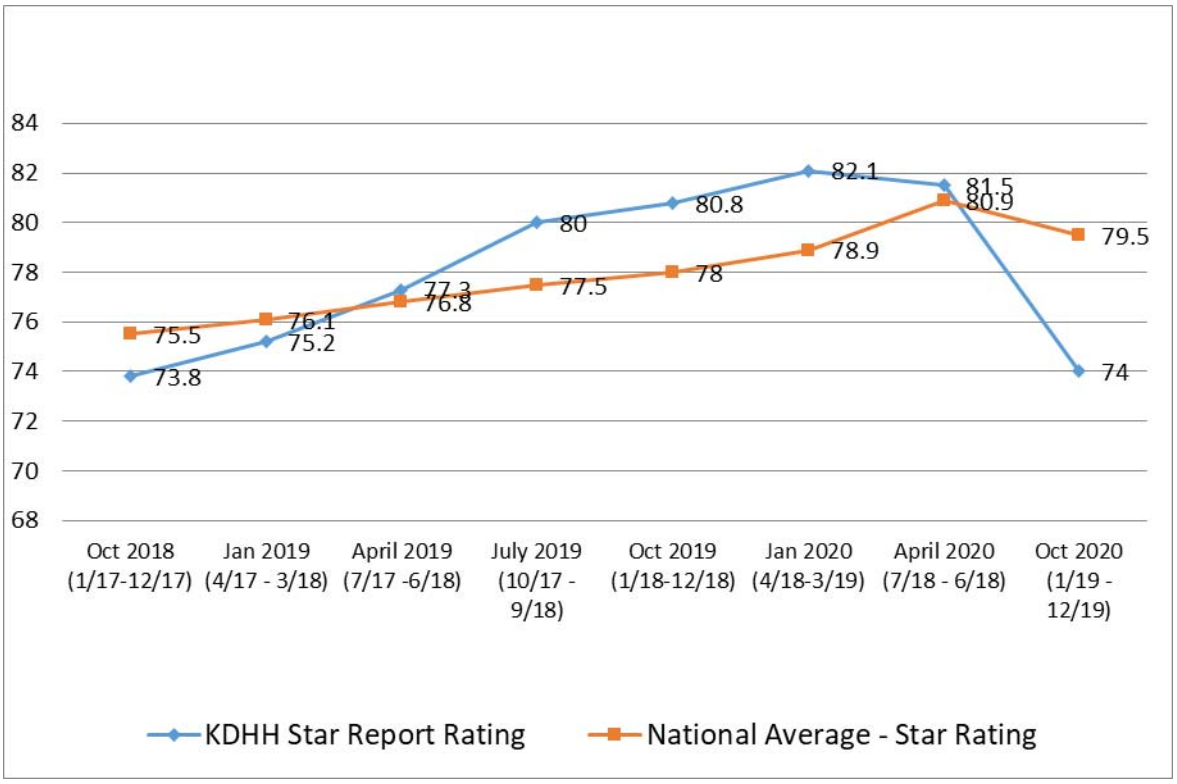
--Evaluation that is deemed "stabilized" still counts as a negative factor

--The month of December 2019 showed decreases in all areas of patient functional improvement on OASIS data. Total number of Occupational Therapy visits for this month was 232. Average monthly visits for OT is 247. This month's visit data also shows lowest amount of Physical Therapy visits compared to previous months as well as highest percentage of hospital readmissions within the first 30 days of care.

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

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee



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

--Goal is to perform strict chart auditing daily to determine if discrepancies are noted between the clinician's documentation and related OASIS scoring. Corrections, if applicable, should be completed prior to OASIS submission.

--Management continues to pursue adequate OT staffing to complete timely assessments and implementation of Plan of Care elements focused on activities of daily living.

--Reached out to private consultant for assistance in alternate methods of teaching clinicians how to accurately capture functional status when scoring OASIS.

--Chart review for tracking of patient hospitalization rates and impact on patients' ability to achieve ADL improvement goals.

<u>Next Steps/Recommendations/Outcomes:</u>

Continue to monitor, provide direct intervention and proactive teaching opportunities until we meet, or exceed, the national average for 3 or more quarters.

<u>Submitted by Name:</u>
Allison Carey, RN

<u>Date Submitted:</u>
July 13, 2020

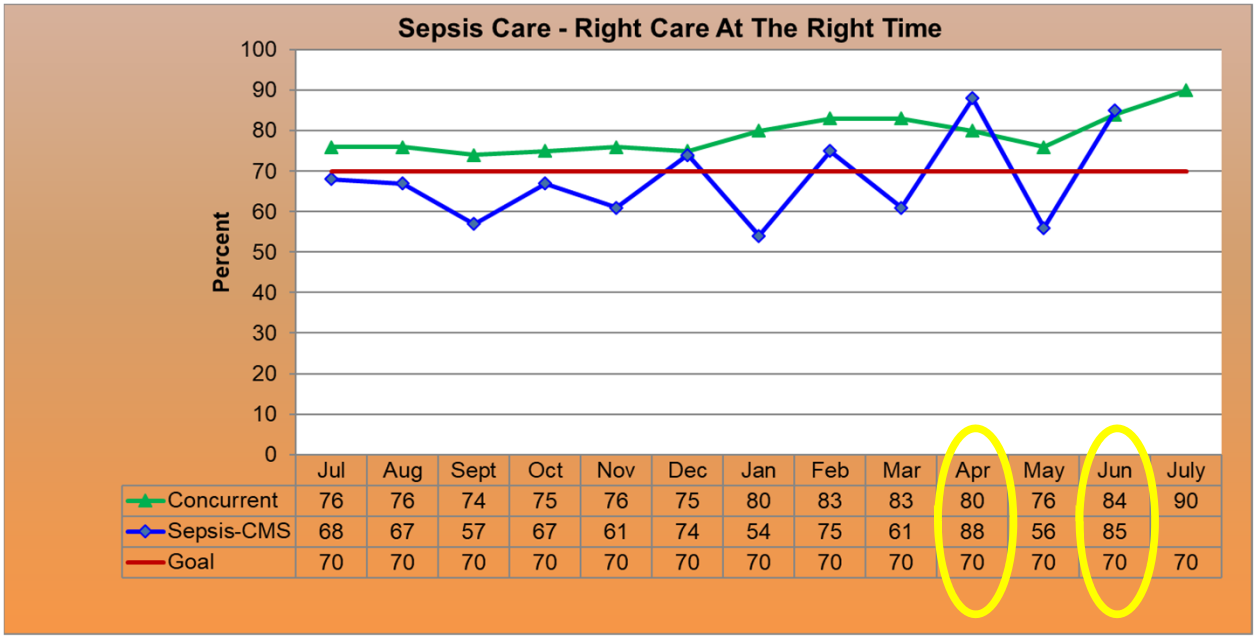
Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Sepsis Quality Focus Team
Quality Council Report – Fall 2020

Dr. Tom Gray, Q&PS Medical Director &
Evelyn McEntire, QI Manager

SEP-1 Early Management Bundle Compliance

CA State Compliance 64%
National Compliance 60%
Top Performing Hospitals 82%
KDHCD NEW FY 2021 GOAL = 70%

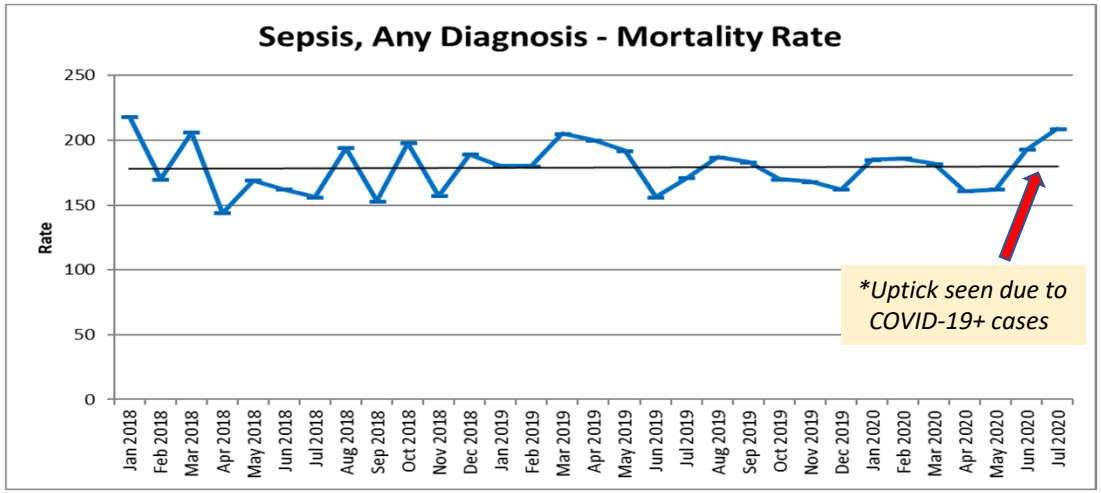


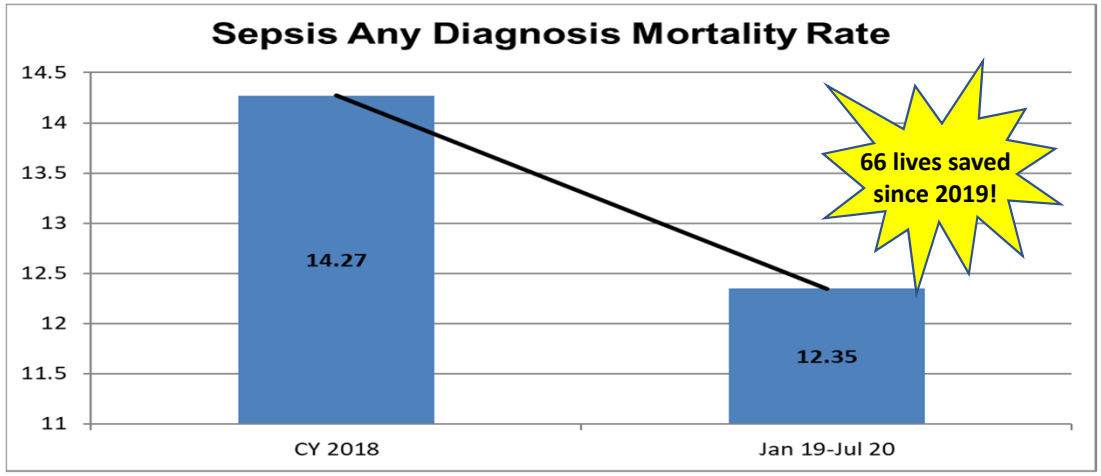
	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July
Concurrent	76	76	74	75	76	75	80	83	83	80	76	84	90
Sepsis-CMS	68	67	57	67	61	74	54	75	61	88	56	85	
Goal	70	70	70	70	70	70	70	70	70	70	70	70	70

KDMC has recently performed in the top decile for sepsis bundle compliance in the nation!

Reducing Mortality & Saving Lives

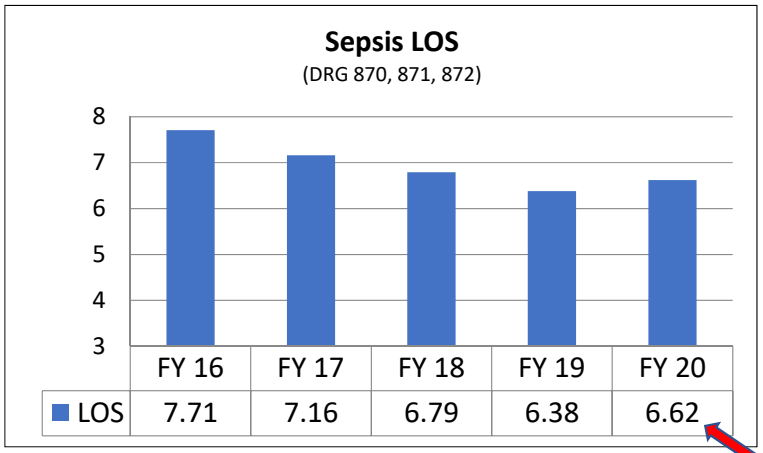
*This data includes COVID-19+ cases; however, CMS data does not.

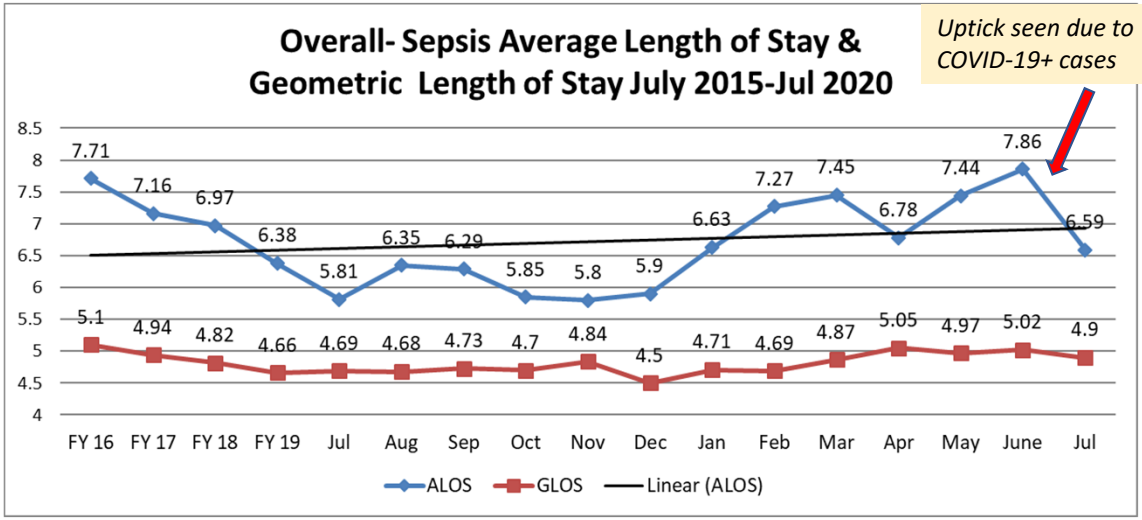




Sepsis Length of Stay (LOS)

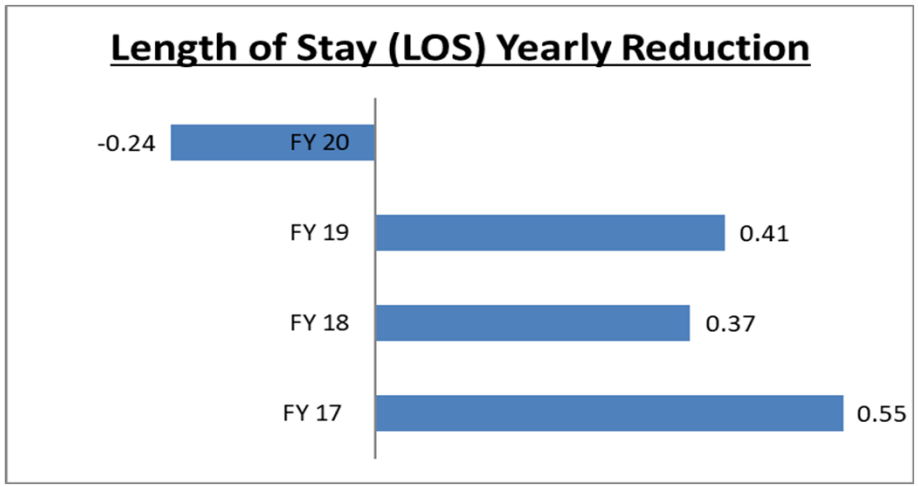
*This data includes COVID-19+ cases; however, CMS data does not.

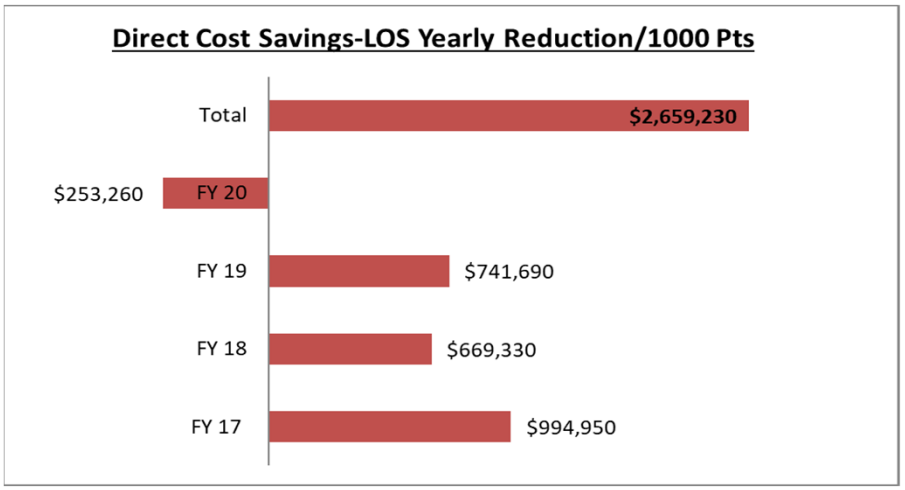




Sepsis LOS Reduction & Savings

*This data includes COVID-19+ cases; however, CMS data does not.





FY20 LOS continued to show a reduction through March; however, we have seen an increase in LOS for septic patients as related to COVID-19 infections from April – July 2020.

Sepsis Kaizen Update

ED Pro	2. ED - Build and utilize SEP-1A "Catch Up" order set so all bundle components can be ordered (not "grayed out")	x	4.0	x	5.0	x	5.0	x	5.0	500.0
CC/INPT RN	6. Make form revisions to "provider notification"; provide prompts for critical thinking and order set initiation, and title it differently to eliminate confusion	x	2.0	x	4.0	x	4.0	x	5.0	160.0
ED Pro & CC/HOS	11. Build dot phrase - If it's not Sepsis, document it	x	4	x	2	x	4	x	5	160.0
ED Pro/ ED GME	9. Schedule ED and GME regular education/awareness of bundle, and order set usage	x	2	x	4	x	4	x	4	128.0
ED Pro	1. Improve ED provider notification by Sepsis Coordinator when attempting to avoid fallouts concurrently	x	4.0	x	2.0	x	4.0	x	3.5	112.0
ED/CC RN	20. Hand off sheet/pathway checklist (concerns about paper lost); can checklist be triggered electronically for RN when order set is used? This way checklist is available electronically, and can be available to print anywhere in patients Sepsis hospitalization course regardless of location. Similar to existing workflow with MRI safety form, belonging forms "ad hoc" forms. Ideally it populate, and reminder to complete.	x	3	x	2	x	4	x	4	96.0
CC/INPT RN	7. Mandatory for RN to fill out "provider notification form" after sepsis alert fires - alerts suppressed for 48hrs, so RNs do not receive multiple alerts. THIS IS DEPENDENT ON #6 Investigate what happens if you bypass the alert one time it appears very difficult to get it back - further education/awareness of where to find alert.	x	4.5	x	3.0	x	2.0	x	3.0	81.0
CC/INPT RN	10. (Q&P/S) obtain safety summit compliance rates to validate if new staff are getting instructions upon hire of requirements	x	4	x	3	x	2	x	3	72.0
ED Pro	16. Reflex alert, when Abx ordered (specific list of Abx) provider gets alert "do you want BC"	x	4	x	4	x	4	x	1	64.0
ED/CC/ HOS pro	15. > 126ml/hr option added to ED AND INPATIENT ADULT SEPSIS order sets	x	4	x	3	x	2	x	2	48.0
ED RN	18. Evaluate BC labeling process; set up meeting with ED and Lab and ISS/Bridge to determine if there is a process where the actual time the labs were drawn (via generic label) can be used when "real" label is printed after provider order is obtained	x	1	x	2	x	5	x	4	40.0
CC/INPT RN	5. Evaluate Workflow in Cerner r/t sepsis alerts & notification (long term) (Sepsis Q&P/S team). Potentially alerts can fire to cell phones.	x	1.0	x	2.0	x	4.0	x	4.0	32.0
ED/CC/ HOS Pro	13. Add to ED AND INPATIENT order set Reflex LA order when previous LA >2	x	2	x	4	x	4	x	1	32.0
CC/HOS Pro	3. Admit to CC/3W Orders: Short list of orders... if this not done... for each piece of bundle, this is like a continuation of initial sepsis orders or "active "hold" orders to keep the ball rolling.	x	1.5	x	4.0	x	1.0	x	3.5	21.0
ED/CC/ HOS Pro	17. Dot phrase for when Abx are urgent and BC cannot be drawn beforehand, so provider documentation is in EMR (...sepsisbc)	x	4	x	3	x	1	x	1	12.0
CC/INPT RN	8. Evaluate what clin Ed provides to new RNs about sepsis alerts and how to respond? Ideally hands on training upon hire, look at alerted patient and walk through documentation.	x	1	x	4	x	2	x	1	8.0
CC/HOS Pro	22. Standardized documentation of attending reassessment (Dr. Malli's phrase)	x	3	x	2	x	1	x	1	6.0
ED RN	13. ED Techs input height and weight in EMR; RN input for BIBA patients HOLD dependent on #14	x	2	x	1	x	1	x	1	2.0
ED RN	14. IBW automated in fluid order when height and weight are documented	x	2	x	1	x	1	x	1	2.0
CC/INPT RN	4. Evaluate criteria of firing an alert (Q&P/S team)	x	1.0	x	1.0	x	1.0	x	1.0	1.0

QI Initiatives

- Kaizen work began March 2020
- Key Stakeholders: Physicians, GME Residents, Nursing, ISS, Clinical Education in ED, ICUs, ICCUs
- Over 20 identified QI strategies identified
- Eight (8) strategies have been completed and implemented
- Ten (10) strategies are in development and nearing completion
- Three (3) strategies in parking lot
- Concurrent and CMS bundle compliance are trending above national average and Org goal in June, pending July results
- Data reveals an increase in compliance of the 3-hour and 6-hour bundles (Former top fallouts: Abx, BC, LA, reassessment, vasopressors)

Kaweah Delta

Sepsis Summary & Actions

Summary

	July 2020	FYTD %	FY21 Goal	FY20	Last 6 Months FY20
SEP-1 (Bundle Compliance)	67%	tbd	≥ 70%	67%	69%
Sepsis Coordinator Coordinator Bundle Compliance	90%	tbd	≥ 70%	78%	81%

Successes as a result of Kaizen work:

- 100% compliance of provider reassessment for nearly 5 consecutive months (formerly the most frequent fallout)
- 100% compliance of 6 out of 9 bundle elements in June 2020
- Improved provider documentation and use of sepsis order sets
- Improved sepsis 3-hour bundle compliance (lactate management, blood culture orders, antibiotic administration)
- Improved sepsis 6-hour bundle compliance (repeat lactic acid lab, fluid resuscitation, and reassessment by provider)

Actions

Continued work by Kaizen group:

- Increased use of sepsis order sets
- Administer IV fluid resuscitation within expected timeframe
- Nursing documentation
- Ongoing sepsis education to nursing, providers, and GME residents

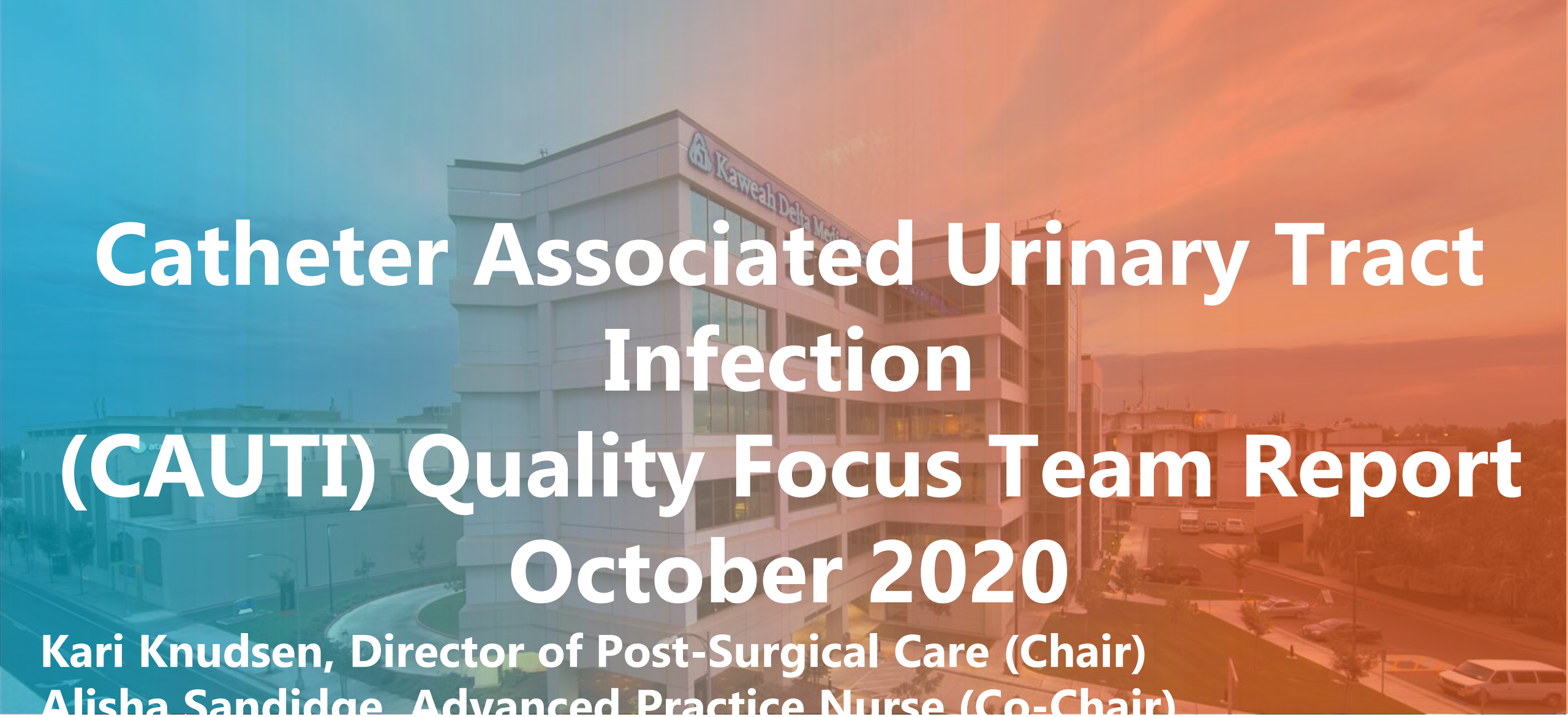
Kaweah Delta

COVID-19
Clinical Quality Review Update
October 2020

COVID-19 Clinical Quality Summary

Data Summary

- Data reviewed from April to August 2020
- Average length of stay >11 days May-June, 8.46 July, and 9.6 days in August
- Diabetes and Hypertension continue to be the most prevalent comorbidities
- Proportion of high severity cases has increased in August since May: proportion of ventilated patients May 14.9%, June 12.1%, July 10.3%, Aug 14.5%
- Mortality rate remains low in August at 18.4%, from a high of 33% in April
- Readmission rates increasing to 10% from 4% in July and August



Catheter Associated Urinary Tract Infection (CAUTI) Quality Focus Team Report October 2020

Kari Knudsen, Director of Post-Surgical Care (Chair)
Alisha Sandidge, Advanced Practice Nurse (Co-Chair)

Kaweah Delta

CAUTI- FY21 Goals

	July 2020	Aug 2020	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual divided by number predicted)	FY21 Goal	FY20	Last 6 Months FY20
CAUTI	3	0	13	tbd	≤0.727	1.12	0.85

Jan –July 20 **SIR=0.85**
Actual= 8; Predicted = 9.4

*based on FY20 NHSN predicted values
**Standardized Infection Ratio – Number of actual infections Kaweah had divided by the number of infections CMS predicts Kaweah should have

KAIZEN Root Cause

Analysis:

Identified Root Causes

(in order from most significant to least):

1. Communication
2. Leadership Standard Work
3. Peri-care/Bathing
4. Prompt Catheter Removal
5. Culture Ordering
6. Retention Management
7. Staff Consistency with prevention bundle
8. Alternatives to Catheter Insertion

Kaizen improvement strategies focused on addressing the top 4 root causes

Initial KAIZEN initiatives focused on the top **4** root causes

Since April 2020 we have incorporated strategies to address **7** of the root causes, including:
Culture ordering
Retention Management
Alternatives to Catheter Insertion

Post KAIZEN-Gemba Data

CAUTI Committee Dashboard						
Measure Description	Benchmark/ Target	Mar-20	Apr-20	May-20	Jun-20	Jul-20
OUTCOME MEASURES						
Number of CAUTI	0	0	1	3	1	3
Quarterly SIR (all payor)	≤ 0.838	0.52			1.02	
FYTD SIR (all payor) BASELINE (FY19) =1.557	≤ 0.838	0.96	0.93	1.09	1.03	
PROCESS MEASURES						
IUC Shift Huddles						
% Huddles Accurately Completed	100%	74%	89%	93%	88%	92%
% insertion missed (removed in July)	0%	19%	40%	46%	50%	
% cleanliness missed	0%	81%	60%	54%	50%	
IUC Gemba Rounds						
% of pts with appropriate cleanliness	100%	98%	99%	98%	95%	97%
% of IUCs with order & valid rationale	100%	90%	93%	92%	93%	92%
% of IUCs where removal was attempted	n/a	8%	5%	6%	7%	0%
% of pts where alternatives have been attempted	n/a	15%	12%	12%	10%	8%
# of Pt Catheter days rounded on	n/a	616	720	948	877	1037
% of IUCs removed because of Gemba Round	n/a	7%	6%	3%	4%	2%
# of IUCs removed because of Gemba Round	n/a	46	42	33	35	22

Total Catheter days rounded on – 4198
97% of patients with daily bath and peri-care each shift
92% have order and valid rationale
178 catheters removed as a result of the Gemba

IUC GEMBA Next Steps

- IUC Gemba form revised to guide intent of intervention versus data review
- Rapid Cycle Post Gemba Rounds with Resident, IP, QI team

CAUTI QFT- Plans for Improvement

- New! CAUTI reduction email group and all near misses go out to this group for awareness/follow patient in Gembas
- CAUTI QFT summary provided monthly with updates, data and next steps
- Changes made to the case review process to reduce CAUTI by ensuring identified opportunities are addressed at the unit level and globally
- Changes to the UA orders are live! the UA and UA with reflex culture have mandatory criteria for testing included in the order, the culture only order has the 'restricted use' language
- The IUC Insert Powerplan is live! plan for this powerplan to be embedded in existing powerplans (coming soon), as well as task to change the IUC at 30 days if chronically retained coming soon
- Adult Urinary Retention Management orders are live! This bundles many orders required to manage acute urinary retention for ease of ordering and implementation
- Urine Culture Only Powerplan coming soon to guide intentional use and create clarity around the use of this limited use case order
- Evaluation of reason provided for insertion of IUC order is underway- neurogenic bladder and acute retention are priorities
- Present on admission catheter care order set coming soon to guide the care of a catheter that is not inserted at KD
- Bathing prioritization reevaluation underway in collaboration with CLABSI QFT to standardize how this work is prioritized
- Safety Summit CAUTI education for newly hired staff relaunch post-COVID is underway

Clinical Quality Goal Update
September 2020

kaweahDelta.org

Kaweah Delta

FY 21 Clinical Quality Goals

	Jul-Sept Higher is Better	FYTD %	FY21	FY20	Last 6 FY20
SEP-1 (% Bundle Compliance)	tbd	tbd	≥ 70%	67%	69%

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

Our Mission

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

Our Vision

To be your world-class healthcare choice, for life

	July 2020 Lower is Better	Aug 2020 Lower is Better	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual divided by number expected)	FY21 Goal	FY20
CAUTI Catheter Associated Urinary Tract Infection	3	0	13	tbd	≤0.727	1.12
CLABSI Central Line Associated Blood Stream Infection	2	1	9	tbd	≤0.633	1.2
MRSA Methicillin-Resistant Staphylococcus Aureus	1	0	5-6	tbd	≤0.748	1.02

*based on FY20 NHSN predicted

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

Sepsis Top Key Improvement Strategies

Top Initiatives (six sigma teamwork):

- Sepsis alert notification of providers, revision of electronic form and mandatory follow up
- Sepsis handoff, electronic version to ensure flow from ED to inpatient
- Re-launching mandatory education for new hires post-COVID
- Resident education (new residents in July 2020)

July Fall Outs:

- 7 Fall outs of 21 cases in sample
- 6 during non-Sepsis Coordinator hours (3/6 were days when sepsis was not covered due to coordinators working back at bedside
- No trends in bundle elements missed, included antibiotics not ordered, repeat lactic acids not complete, sepsis diagnosis descriptions, fluids not done or not completed timely

CAUTI
Top Key Improvement Strategies

- Several cerner workflow/order changes to promote best practices and culture of culturing
  - Order for urinary catheter to include best practice catheter maintainence orders for all power plans
  - Urine culture only order (reduce risky culture ordering)
  - Discontinue UA when specimen not received timely
  - Evaluating option for a “time clock” for lines (how long has X line be in place?)
  - Workflow to accurately count device days
- NEW CAUTI Case Review form and process – lesson learned and identification of systems/process opportunities
- Relaunching mandatory CAUTI/CLABSI education post COVID-19
- Rapid Cycle Post Gemba Rounds – Afternoon follow up rounds to ensure items are completed that were identified in the morning Gemba rounds (ie. line removals)
- Bathing prioritization – in collaboration with CLABSI committee

CLABSI, MRSA
Top Key Improvement Strategies

- NEW CLABSI Case Review form and process – lesson learned and identification of systems/process opportunities
- Relaunching mandatory CAUTI/CLABSI education post COVID-19
- Rapid Cycle Post Gemba Rounds – Afternoon follow up rounds from Q&P/S RN and Resident physician to ensure items are completed that were identified in the morning Gemba rounds (ie. line removals)
- Bathing prioritization – rapid cycle pilot on 4N, patients with lines listed (by room number) on unit white board, crossed off as baths completed. Plan to bring to all managers and standardize process on all units. Will also include central line dressing changes due that day.
- CNA education in the moment through October to ensure proper technique is used when bathing a patient with a central line