February 9, 2024

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in a Quality Council Committee meeting at 7:30AM on Thursday, February 15, 2024, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:31AM on Thursday, February 15, 2024, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277, pursuant to Health and Safety Code 32155 & 1461.

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, January 18, 2024, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

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 Health Medical Center, Mineral King Wing entry corridor between the Mineral King lobby and the Emergency Department waiting room.

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

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
QUALITY COUNCIL

Thursday, February 15, 2023
5105 W. Cypress Avenue
Kaweah Health Lifestyle Fitness Center Conference Room

ATTENDING: Board Members; Michael Olmos – Committee Chair, Dean Levitan, MD; Gary Herbst, CEO; Keri Noeske, RN, BSW, DNP, Chief Nursing Officer; Tom Gray CMO/CQO; Julianne Randolph, DO, Vice Chief of Staff and Quality Committee Chair; LaMar Mack, MD, Quality and Patient Safety Medical Director; Sandy Volchko DNP, RN CLSSBB, Director of Quality and Patient Safety; Ben Cripps, Chief Compliance and Risk Management Officer; Evelyn McEntire, Director of Risk Management; and Michelle Adams, Recording.

OPEN MEETING – 7:30AM

1. **Call to order** – *Mike Olmos, Committee Chair*
2. **Public / Medical Staff participation –** Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdiction of the Board are requested to identify themselves at this time. For those who are unable to attend the beginning of the Board meeting during the public participation segment but would like to address the Board, please contact the Board Clerk (Cindy Moccio 624-2330) or cmoccio@kaweahhealth.org to make arrangements to address the Board.
3. **Approval of Quality Council Closed Meeting Agenda** – 7:31AM
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Julianne Randolph, DO, Vice Chief of Staff and Quality Committee Chair.*
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management and Ben Cripps, Chief of Compliance and Risk Officer.*
4. **Adjourn Open Meeting** – *Mike Olmos, Committee Chair*

CLOSED MEETING – 7:31AM

1. **Call to order** – *Mike Olmos, Committee Chair & Board Member*
2. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Julianne Randolph, DO, Vice Chief of Staff and Quality Committee Chair*
3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management, and Ben Cripps, Chief Compliance and Risk Officer.*
4. **Adjourn Closed Meeting** – *Mike Olmos, Committee Chair*

OPEN MEETING – 8:00AM

1. **Call to order** – *Mike Olmos, 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. Pain Management Committee Report
    - 3.2. Rehabilitation Services Quality Report
4. **Orthopedic Services Quality Report –** A review of key quality measures and actions focused on the care of the orthopedic patient population. *Kevin Bartel, PT, DPT, MTC, Director of Orthopedics, Neurosciences & Specialty Practice*
5. **Clinical Quality Goals Update-** A review of current performance and actions focused on the clinical quality goals for Sepsis, and Healthcare Acquired Infections. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*
6. **Adjourn Open Meeting** – *Mike Olmos, 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.

Pain Management Committee Quality Report

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

Cindy Vander Schuur RN, BSN
Quality Consultant, Quality & Patient Safety

Thomas Gray, MD
Chief Medical Officer
Chief Quality Officer

February 2024

Pain Management at Kaweah Health

Pain Management Program Mission:

- In 2024 Patient Care Leadership (PCL) will assume responsibility for oversight of pain management and safe opioid prescribing. PCL will continue the program mission of:
  - Develop measures and monitor quality improvement (QI) activities (through pain management dashboard)
  - Ensure our pain management standardized practices meet the highest standards
  - Continually evaluate how pain is managed within our institution to ensure our procedures and protocols address the needs of our patients and empower our staff to provide excellent care.

Patient Care Leadership Committee includes Nursing, Pharmacy, Support Services, Quality & Patient Safety, Outpatient Services, and stakeholders such as organizational Chief's (CNO, COO, CPHO).

Pain Management at Kaweah Health

2023 Pain Committee Goals:

Monitor appropriate and effective pain management; oversee, prioritize and focus QI activities on:

1. Pain assessment – completed accurately (assessment of pain level with appropriate intervention)
2. Types of interventions – pharmacological (opioid vs multimodal) and non-pharmacological. Increase use of multi-modal intervention. Ensure safe prescribing practice.
3. Effectiveness –use of multimodals, right pain medication for right pain level, use of non-pharmacologic pain methods
4. Safety measures – discharge prescribing, adverse drug events related to opioids, and monitor use of naloxone in partnership with the pain service pharmacists and the Medication Safety Committee
5. Increase organizational achievement in best practices utilizing the 2023 Cal Hospital Compare Opioid Honor Roll Program measures to assess performance and progress.

Pain Management at Kaweah Health

Key Activities 2023:

- Ketamine usage: order set development for inpatient pain management
- Opioid prescribing guidelines
- Enhanced patient/family education
- “Stigma training” for targeted providers
- Implementation of stigma reducing interventions
- Involvement of Residents in Pain Management strategies
- Alternatives to Opioids for pain management
- Opioid Use Disorder and Stigma resource materials available for all staff and providers
- Pharmacy review of Narcan use & effectiveness in RRT cases.
- Broadly communicate program goals and progress

KH Pain Management Committee

Pain Management & Opioid Safety Initiatives

Pain Management QI Initiative	Status	Actions Completed Through 2023
1. Ensure opioid safety through monitoring of Adverse Drug Events (ADE) per 1,000 inpatient admission (Medicare FFS Part A claims) Goal: Surpass Bed Size (300+) current rate of 1.66 per 1,000 inpatient admissions (as reported by Health Services Advisory Group HSAG 1/1/22-12/31/22).	• Lower is better. 2019 = 2.29 per 1,000(17/7430); 2020 = 1.15 per 1,000 (7/6074); 2021 = 1.33 per 1,000 (7/5347); 2022 = 1.85 per 1,000 (10/5295) Goal achieved. Jan – Aug 2023 = 2.14 per 1,000 (7/3268) 2023 YTD – too early to determine goal status (metric with very small numerator, only 8 months included YTD which may generate an inflated rate)	• Note - Resident QI project completed May 2022 focused on evaluation of 17 patients with a reported ADE related to opioids from Dec 2020 -Aug 2021 to determine if there was a true ADE. The evaluation utilized the evidenced-based Naranjo Adverse Drug Reaction Probability Scale (a tool that standardized assessment of causality for all adverse drug reactions). Results indicated that only 35% (6/17) were true ADEs. Although the sample was small, it would be reasonable to conclude that the HSAG ADEs related to opioid rate per 1,000 is lower than reported. • eCQM team considering adding Naloxone use as an internal measure to enhance monitoring. • 2023 Goal decreased from 2.46 to 1.66 • Quality RN did a snapshot review of potential fallouts based on patients meeting HSAGs Opioid ADE ICD-10 codes not POA criteria for committee review and action if necessary. The majority of the potential fallouts were identified to be documentation of side effects related to the opioid (e.g. constipation).
2. Ensure opioid safety through monitoring of Adverse Drug Events collected through Pharmacy case review. Number of RRTs where Narcan was effective (Narcan is a reversal agent used to treat opioid overdoses) Goal: Not set as this is an overall monitoring measure. An increase would indicate a potential issue to be evaluated.	• 2021: 54 patients were administered Narcan during an RRT, 27 of them (50%) the RRT RN reported the Narcan was effective (not evaluated by pharmacy). • 2022: 36 patients were administered Narcan during an RRT, 26 of them (72%) the RRT RN reported the Narcan was effective (not evaluated by pharmacy). 2022-The number of patients administered Narcan during an RRT has decreased 33% since 2021. • Jan – Dec 2023: 43 patients were administered Narcan during an RRT, 18 (42%) were determined by pharmacy that Narcan was effective. 2023-The RPh reviews show a 41% decrease in RRT cases improved with Narcan administration since 2022, which may indicate that there are less RRTs related to opioids.	• Committee had identified that often the RRT RNs report of Narcan effectiveness in cases is not consistently accurate (ie. some case review revealed that patients where Narcan was effective during an RRT were not on opioids). Re-education with RRT RNs completed. Plan is to revise process to include a pharmacists case review to identify gaps timely and report actual cases where Narcan was effective (as vetted by pharmacy) as the measure • 2023: Pharmacy began monthly review of Narcan use & effectiveness in RRT cases. Data is reported monthly and included in the Pain Committee dashboard. This results in timely identification of process issues/trends and mitigation/resolution if committee determines necessary.

KH Pain Management Committee

Pain Management & Opioid Safety Initiatives

Pain Management QI Initiative	Status	Actions Completed Through 2023
3. Ensure Opioid safety through discharge prescribing of opioids for < 7 days in duration Goal (internal): 9%	Lower is better % of patients with opioid prescription >7 day: • 2021: 14% • 2022: Decreased to 9.9% Improved from 2021. Within 10% of goal. • 2023: Data Incomplete. The denominator definition of this initiative was revised 7/2023. All patients with a prescription for an opioid at discharge will be included and we will no longer be excluding those patients with an opioid listed as a home medication. The report that pulls this data needed to be revised. Unable to revise. This metric was removed from Pain Management dashboard. Opioid safety will continue to be monitored through the other metrics on the dashboard.	• Committee selected and approved the Opioid Prescribing Engagement Network (OPEN) evidenced based guidelines for acute pain management. There is a link in Cerner and on Compass for easy accessibility. • Data analysis in progress to identify trends (ie. providers, opioid types) • May 2023: Providers receive an alert in Cerner for any inpatient, acute therapy discharge prescription of an opioid >7days. • Letter with multiple links to evidence drafted for approval by MEC to be issued to providers who prescribe opioids for >7 days duration at discharge; Letters were to be issued to providers who exceed recommendations starting Sept 2023 with a cc to Peer Review Coordinators. Due to sudden executive leadership changes this did not move forward; will inform interim CMO/CQO and PCL in handoff.
4. Ensure Opioid safety through discharge prescribing. CMS Measure: Safe Use of Opioids-Concurrent Prescribing (eCQM - Electronic Clinical Quality Measures). CMS Benchmark: 16% State	• Measure description - Inpatient hospitalizations for patients 18 years of age and older prescribed, or continued on, two or more opioids or an opioid and benzodiazepine concurrently at discharge • Denominator exclusions: Inpatient hospitalizations where patients have cancer that overlaps the encounter or are receiving palliative or hospice care (including comfort measures, terminal care, and dying care) during the encounter • 2021 = 18.70% (1053/5642) • This measure will be publically reported in January 2023 on CMS Care Compare. • 2022 = 20.7% (1145/5537) • 2023: 14% (739/5285)Goal achieved.	• Committee selected and approved the Opioid Prescribing Engagement Network (OPEN) evidenced based guidelines for acute pain management. There is a link in Cerner and on Compass for easy accessibility • ISS has completed the eCQM build December 2022. • ISS created a detailed report from Cerner Feb 2023 • Utilizing the ISS report to review and identify trends to act on and data will be shared with the Pain Committee. • ISS has now updated to the 2023 CMS Specifications. • Letter with multiple links to evidence drafted for approval by MEC to be issued to providers who prescribe two or more opioids or an opioid and benzodiazepine concurrently at discharge; Letters to be issued to providers who exceed recommendations starting Sept 2023. Due to sudden executive leadership changes this did not move forward; will inform interim CMO/CQO and PCL in handoff.

KH Pain Management Committee

Type of Pain Management Intervention, Effectiveness, & Assessment Initiatives

Pain Management QI Initiative	Status	Actions Completed Through 2023
2. Increasing Multimodal use when opioids are prescribed in surgical opioid patient populations Goal: 100% ERAS patients with multimodal pain management	Data (higher is better): • 2022: 100% of ERAS elective colorectal patients with multimodal pain management: • Dec 22 to Nov 23 Rolling 12 months: 94% within 10% of goal • CY 2023: Data pending one more month of data.	• Implement opioid prescribing guidelines as described above • Update provider Kaweah Health onboarding materials for pain management Reported through Surgical Quality Committee: • ERAS expanded to Orthopedic populations 1Q 2022 • Plan to expand ERAS to non-elective colorectal and gynecological surgical patients populations late 2023. As of Jan 2024 this has not yet occurred. • 2023: Data abstractor hired. Abstracting elective colorectal cases. • Elective Orthopedic surgery: there are currently discussions occurring regarding the Evidence Based Practice of multimodal usage. • ERAC C-Section data being collected by MCH-currently onboarding new staff member to abstract this data. Data should be available early 2024.
3. Right pain medication administered for level of pain reported. Goal: 95%	Data (higher is better): • 2022: 87% • 2023: 90% within 10% of goal. Increased from 2022.	• Assigned Nursing Director reports this measure and the action plan directly to the Quality Improve Committee (changed to QComm in 2024) • This data is shared with the Pain Pharmacists for them to utilize during Opioid Stewardship Rounds. • This is related to pain management, however is now a Joint Commissions finding, the action plan to address this reported to Accreditation Committee. Fall out reports are sent to managers for follow up monthly by assigned project director

KH Pain Management Committee

Type of Pain Management Intervention & Effectiveness Initiatives		
Pain Management QI Initiative	Status	Actions Completed Through 2023
4. Review and revise patient education materials for pain management Goal: Patient and community awareness to reduce opioid use & achieve XX points on the 2024 Cal Hospital Compare (CHC) Opioid Honor Roll Program. Goal under development pending the release of the 2024 Cal Hospital compare	This is included in the Cal Hospital Compare Opioid Honor Roll program. • In 2021/2022 Kaweah Health achieved 17 points in the program. • *In 2023 Kaweah Health achieved 14 points in the program and received a Participation Certificate. The goal was to achieve ≥26 points. However, the numerical score cannot be compared to 2021/2022 as CHC changed the format of the Honor Roll with different initiatives and a different scoring grid. This was not known to the Committee when setting the 2023 goal. PENDING	• Committee reviewed patient education materials from the CDC on opioid safety. Recommended distributing to patients upon admission/discharge. Materials have been approved by the Patient Education Committee. Discussion Sept 2022 with Patient Care Nursing Managers regarding the addition of the materials to admission/discharge packets. Processes vary by unit. Discussion with ISS to link materials with any acute care, inpatient discharge prescription of an opioid. IN PROGRESS • Education materials are available in Cerner in both English and Spanish. Complete • *The Cal Hospital Compare Opioid Honor Roll scoring system changed in 2023. The 2024 Honor Roll is not available at this time. The Pain Committee will make an appropriate numerical goal when this is available. PENDING • Participation in the 2024 Cal Hospital Compare Opioid Honor Roll will be at the discretion of PCL; to be included in handoff.

KH Pain Management Committee

Pain Management & Opioid Safety Initiatives

Pain Management QI Initiative	Status	Actions Completed Through 2023
5. Assess and address provider stigma associated with pain management for patients with Opioid Use Disorder (OUD) Goal: Reduce stigma & achieve XX points on the 2024 Cal Hospital Compare (CHC) Opioid Honor Roll Program. See* in above 2 boxes. Goal under development pending the release of the 2024 Cal Hospital Compare	• In 2022-2023 two separate surveys were administered to providers who prescribe opioids. A total of 72 providers responded to these surveys. • Survey results suggest increased stigma in providers that tend to prescribe the most opiates. • Initiative (assessing stigma) included in the Cal Hospital Compare Opioid Honor Roll program. • KH Achieved 17 points in the CHC program in 2021/2022. 2023 goal was ≥26 . 2023 Cal Hospital Compare results = 14 points. Goal unable to meet do to changes in scoring methodology. See* in above 2 boxes.	• Provider education materials addressing stigma with OUD patients available. • Implement stigma reducing strategies • Plan to resurvey to evaluate effectiveness • CME presentation to be planned for 2023/2024 • Implicit Bias education required by CA state law was completed by selected APP's and providers by 12/31/21. • Implicit Bias education for all KH employees began Jan 2023 • Participation in the 2024 Cal Hospital Compare Opioid Honor Roll will be at the discretion of PCL; to be included in handoff. • New OUD and Stigma resource materials targeted for all staff and providers available on Compass

Data Under Development	Status	Actions Completed Through 2023
1. Ketamine usage – reduce opioid use Goal: TBD Metrics: TBD	The current available report is being reviewed to see how data can be pulled electronically	• Dr. M. Tedaldi is leading an initiative to use oral Ketamine in the Med/Surg areas of the hospital. Currently IV Ketamine is only able to be administered in certain specific areas where patients can be closely monitored. Dr. Tedaldi is working on this initiative with pharmacy and the medication safety team and reporting progress to the Pain Management Committee.

Questions?

Live with passion.

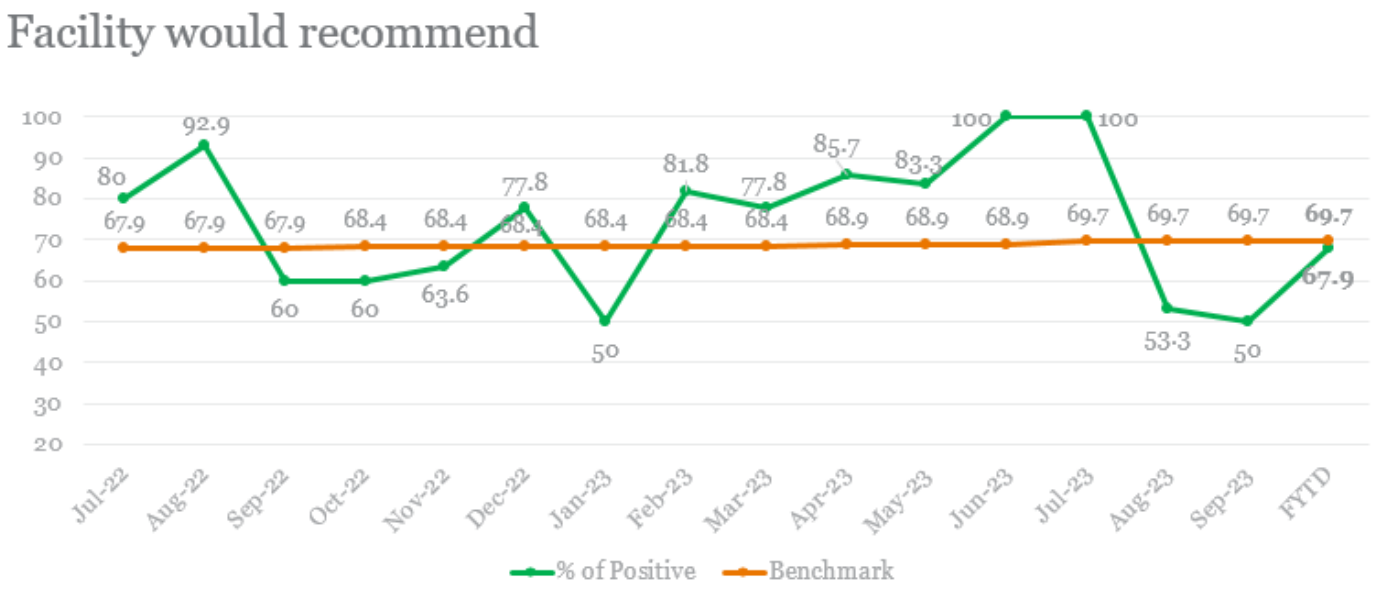
Health is our passion. Excellence is our focus. Compassion is our promise.

Kaweah Health

Unit/Department: Rehabilitation Services **Pro Staff Report Date:** Dec 2023

Measure Objective/Goal:
Acute rehabilitation program evaluation: patient satisfaction and clinical quality including functional outcomes and transfer of care.
Date range of data evaluated: Rehab quarterly report 2Q2023 and 3Q2023

Patient Satisfaction
Analysis of all measures/data: (Include key findings, improvements, opportunities)
In July 2022, the Rehab program transitioned to a new survey platform with NRC however, the surveys are very different. Press Ganey was a mailed survey of 40 questions versus NRC 12 questions via email, text or phone. We have seen a significant improvement in number of surveys collected. Now that we have 5 quarters of NRC survey responses, we have a better understanding and interpretation of the results and have been able to action plan.The key metric we measure is the question “would you recommend this facility” and we action plan utilizing the 4 questions which are correlated to the key metric.



	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	FYTD
N-Size	5	14	10	5	11	9	8	11	9	14	12	9	9	16	4	28

If improvement opportunities identified, provide action plan and expected resolution date:
Our goal for the key metric is currently set as the 50th percentile per NRC. Utilizing the 4 correlated questions we have implemented the following action plans:

- The therapy team will create more patient specific HEP and increase emphasis on HEP on Discharge as well as increase education and communication in accordance with Case Management follow-up therapies including Cardiac Rehab, Out-Patient and Home Health Therapies. – Dec 31, 2023.

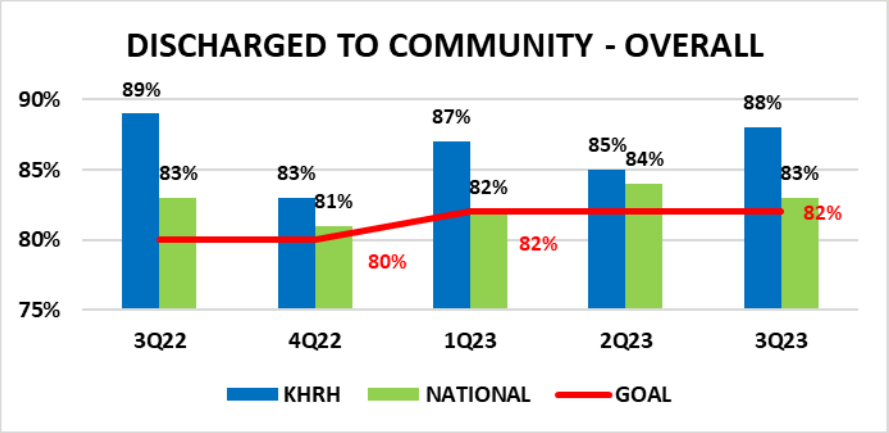
- Re-instating bedside shift report – October 1, 2023
- Up date Mid-stay survey to reflect NRC language – September 1, 2023
- Lunch and Learn topic – reflective listening – September 30, 2023

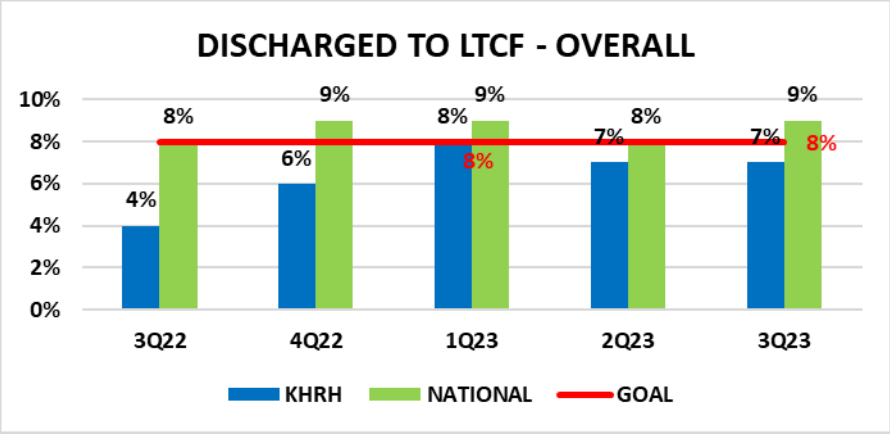
Functional Outcomes

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

Discharged to Community – (higher is better) in 2Q23/3Q23 85%/88% of KH Rehab patients returned to community, exceeding the national average of 84%/85%.

Discharge to LTCH – (lower is better) KH Rehab patients discharging to Skilled Nursing Facility in 2Q23/3Q23 was 7%/7% compared to national average of 8%/9%. The slight increase in patients discharging to SNF instead of home in the last 4 quarters is because, in an effort to grow our program, we are being less restrictive and including more patients that fall outside of the traditional Rehab diagnoses but still qualify for Acute Rehab program. The risk is they may not meet functional level required to return home needing a little more time in SNF.





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

Track the admissions that fall outside of the traditional Rehab diagnoses but still qualify for Acute Rehab program and what their discharge destination is.

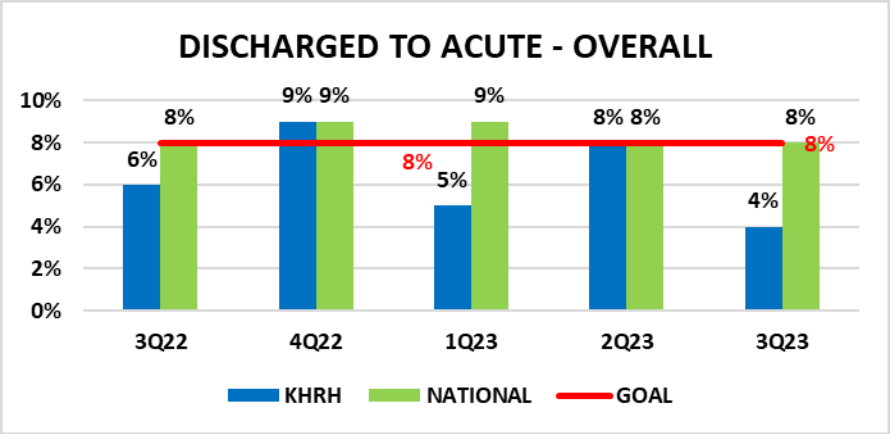
Transfer of Care

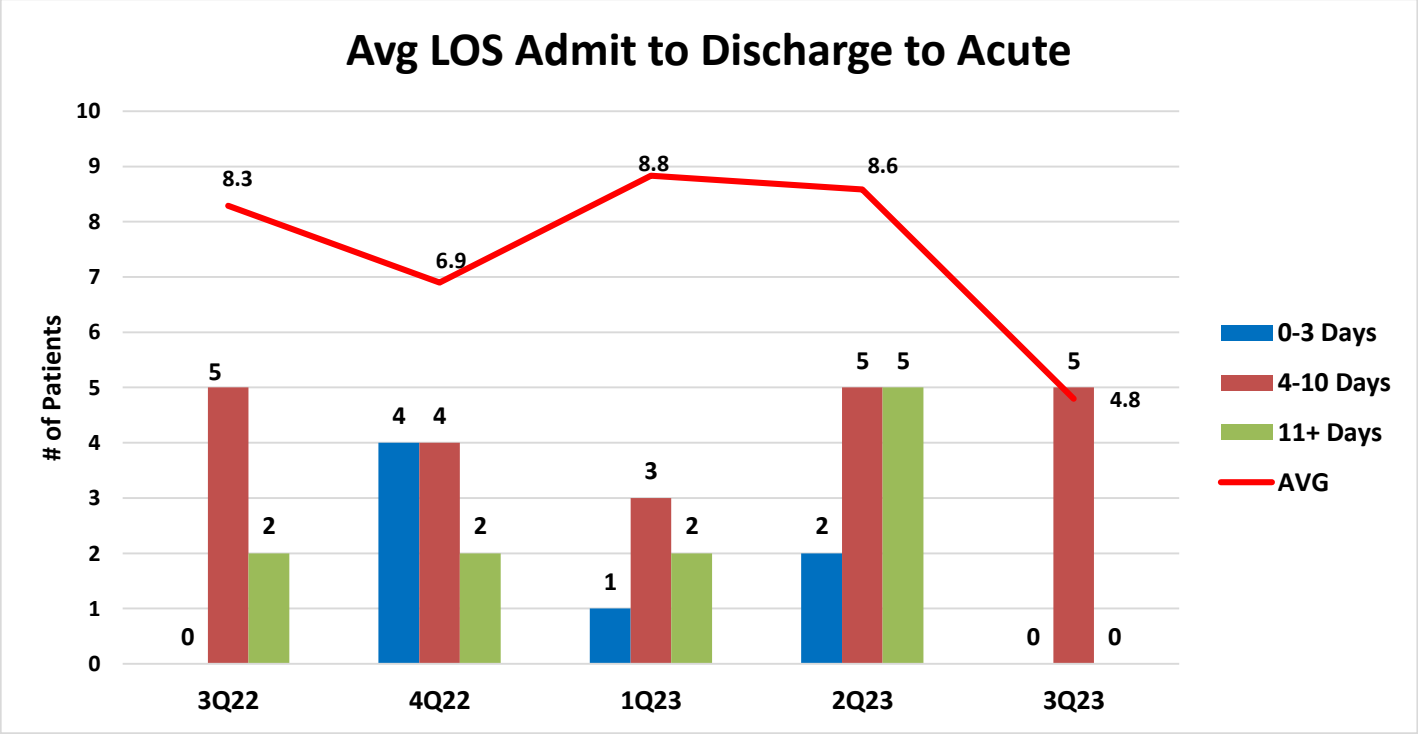
Analysis of all measures/data: (Include key findings, improvements, opportunities)

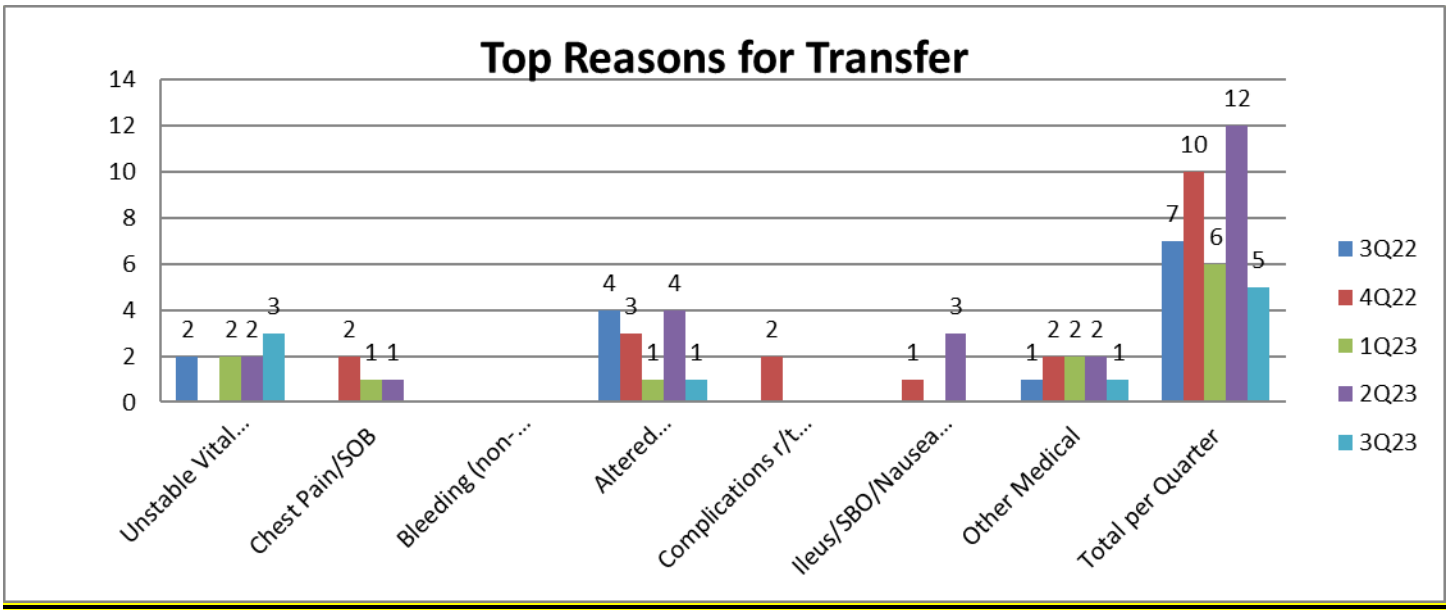
Discharged to Acute – (lower is better) In 2Q23, KH Rehab patients discharging back to the Acute Medical Center was 8%, same as the national average and 3Q23, we improved to 4% versus the nation at 8%. The Case Mix Index for KH 1.38 in 3Q23, closer to nation 1.42, which allows for improved comparison and as the acuity of the patient is increasing, we may end up closer to the nation in regards to transfers back to acute than we have been in the past.

Average LOS Prior to Discharge to Acute – In 2Q23, the avg. number of days from Rehab admission to transfer to Medical Center was 8.6 days and 3Q23 4.8 days. In 2Q23, 2 patients were transferred back to acute in first 3 days but in 3Q23 there were 0. The average LOS being at about 5-8 days from admission over the last year supports that the patients were appropriate at the time of admission to Acute Rehab (AR).

Top Reasons for Transfer - In 2Q23 there were 12 and 3Q23 there were 5 patients transferred back and admitted to the Acute Medical Center. In discussion with Dr Matsuo, all were appropriate transfers due to diagnosis and treatment plans.





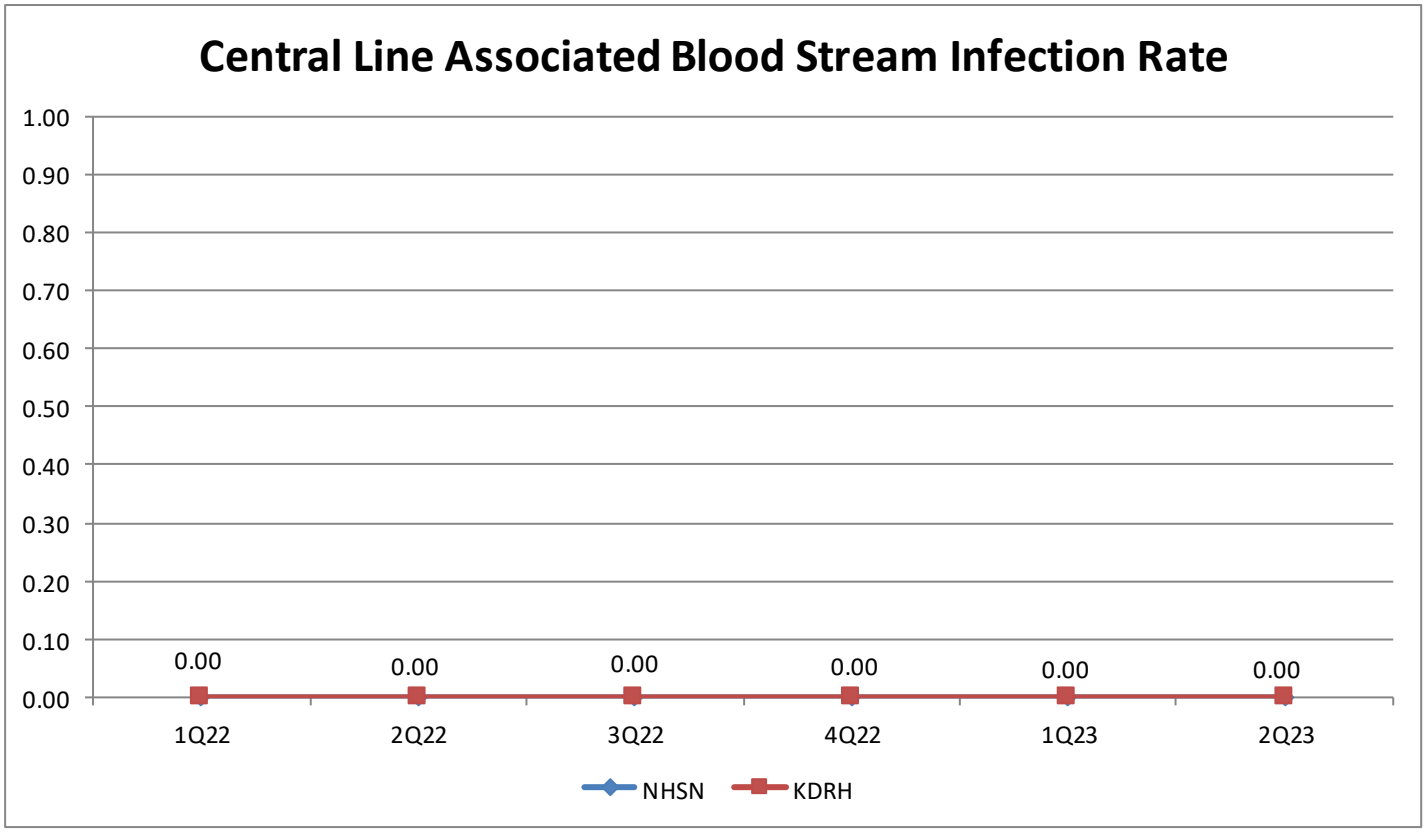


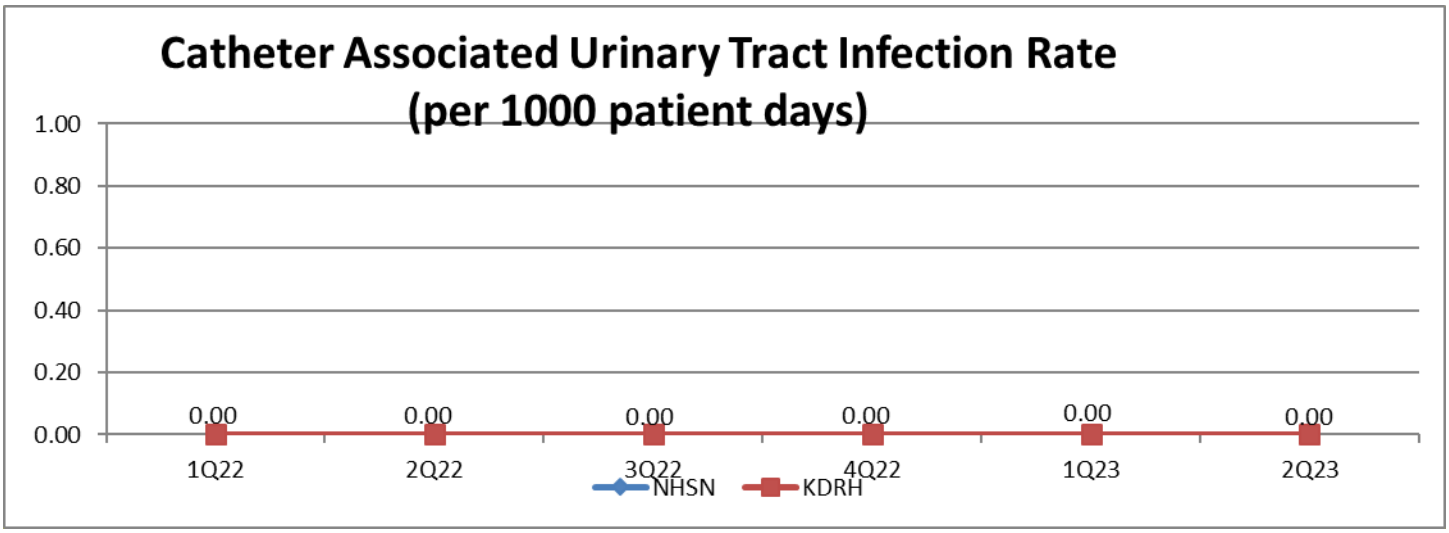
If improvement opportunities identified, provide action plan and expected resolution date:

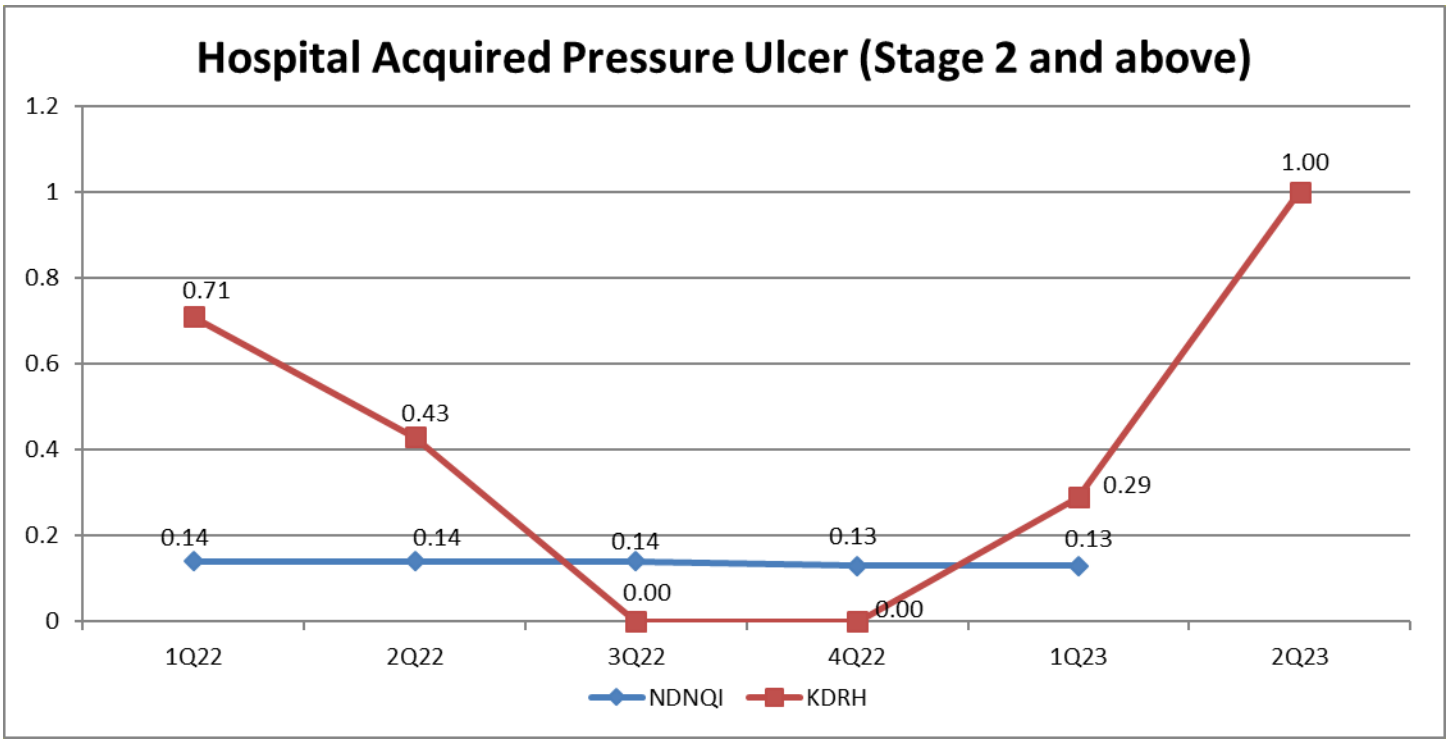
Measure Objective/Goal:
Nursing indicators relative to NDNQI

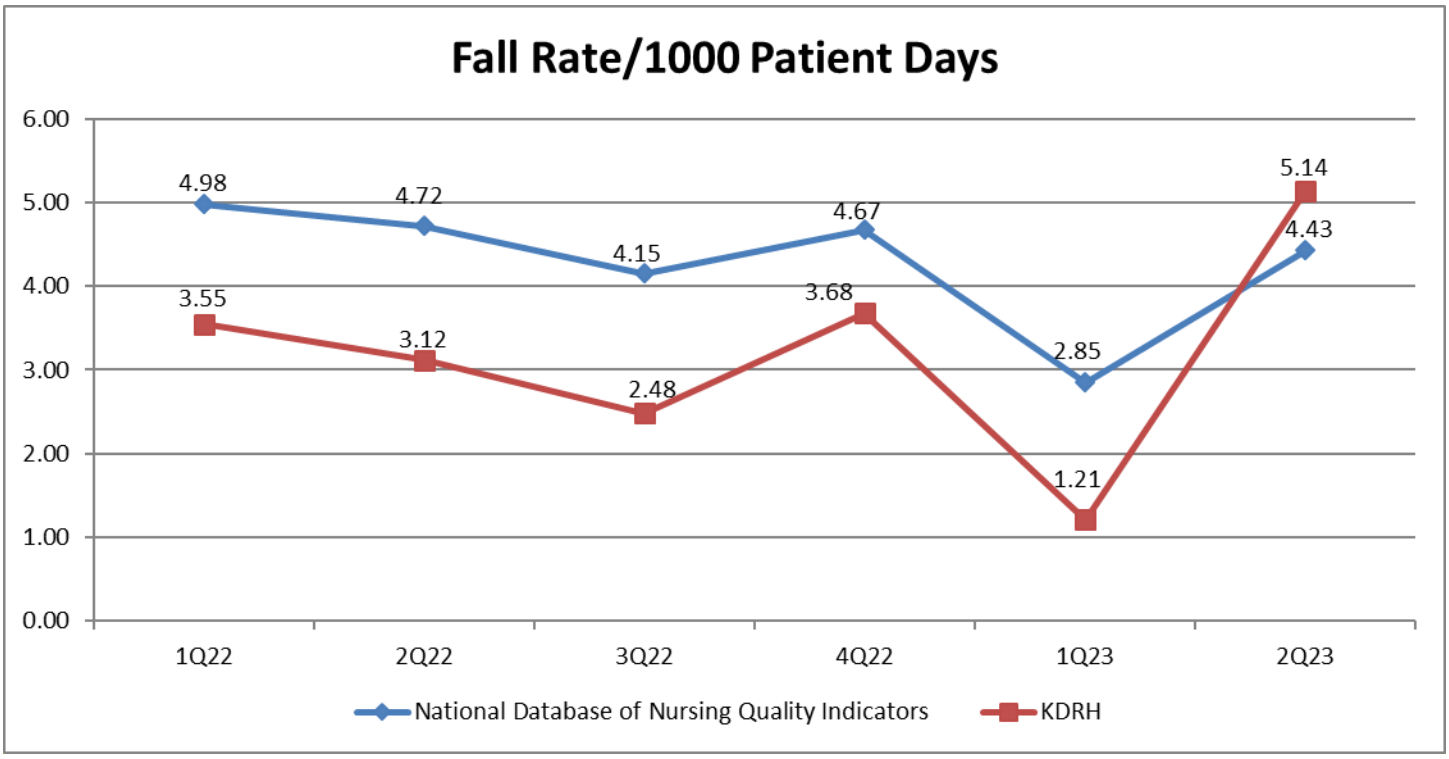
Date range of data evaluated: 1Q23 and 2Q23

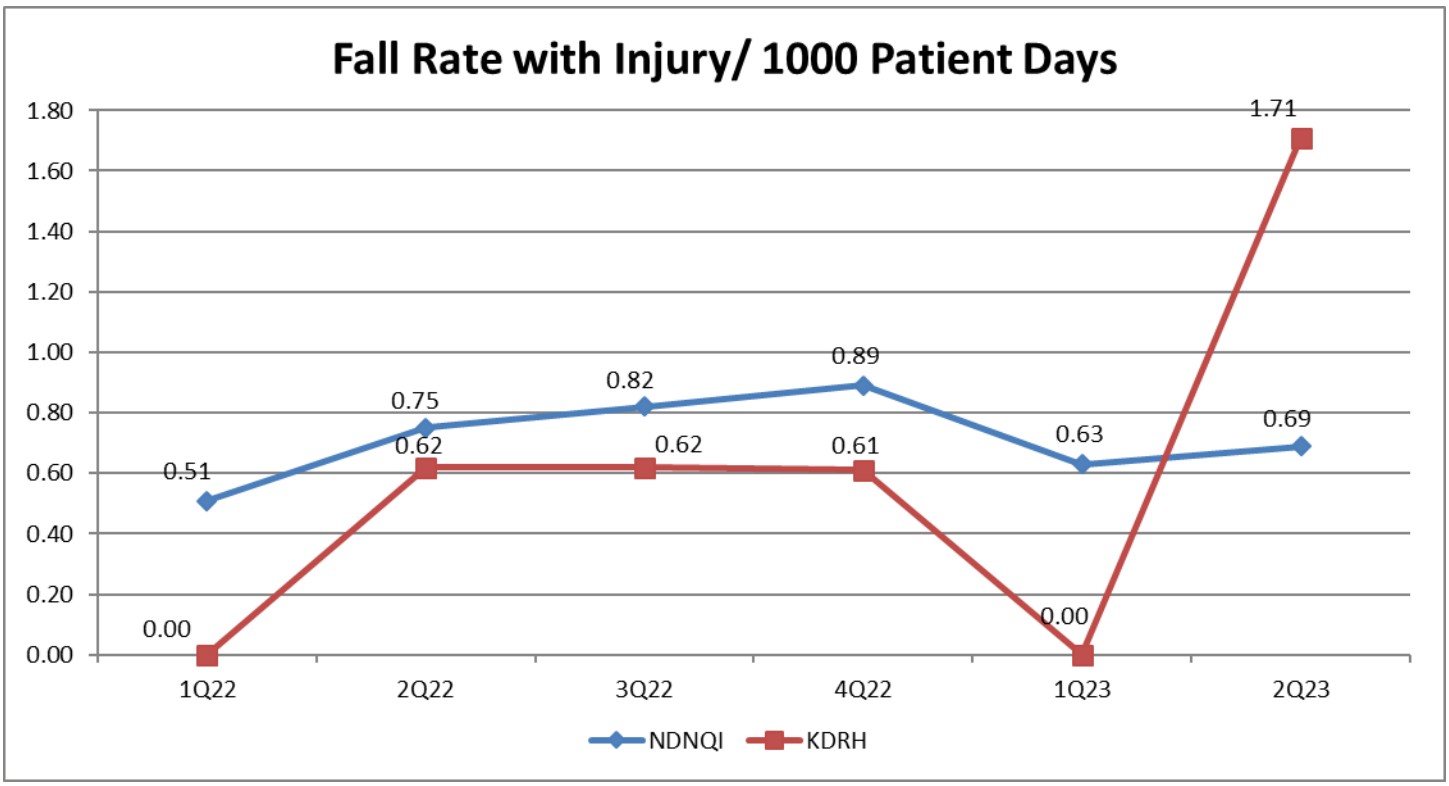
Analysis of all measures/data: (Include key findings, improvements, opportunities)
Kaweah Health Rehab had zero incidence of central line blood stream infections and CAUTI. Hospital acquired pressure ulcer stage II or above for 1Q23 and 2Q23 increased to .29/1.0 associated with a knee immobilizer causing skin breakdown, which was above the NDNQI. Fall rate per 1000 patient days and fall rate with injury/1000 patient days moved above NDNQI benchmarks in 2Q23.




Catheter Associated Urinary Tract Infection Rate
(per 1000 patient days)
1.00
0.80
0.60
0.40
0.20
0.00
0.00
0.00
0.00
0.00
0.00
0.00
1Q22
2Q22
3Q22
4Q22
1Q23
2Q23
NHSN
KDRH


Hospital Acquired Pressure Ulcer (Stage 2 and above)
1.2
1
0.8
0.6
0.4
0.2
0
0.71
0.43
0.00
0.00
1.00
0.29
0.14
0.14
0.14
0.13
0.13
1Q22
2Q22
3Q22
4Q22
1Q23
2Q23
NDNQI
KDRH





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

Continue existing initiatives for CAUTI with renewed focus on GEMBA rounds, peri care and bathing.

- Presented in staff meeting re: removal of patient care devices for accurate skin assessment q shift in prevention of HAPI. - November 2023
- Unit communication on the assignment board re: who high fall risk patients are – October 2023
- Communicate fall risk at bedside shift report and safety huddle, check for bed alarms – October 2023

Measure Objective/Goal: Hand Hygiene compliance

Date range of data evaluated: 2Q23 and 3Q23

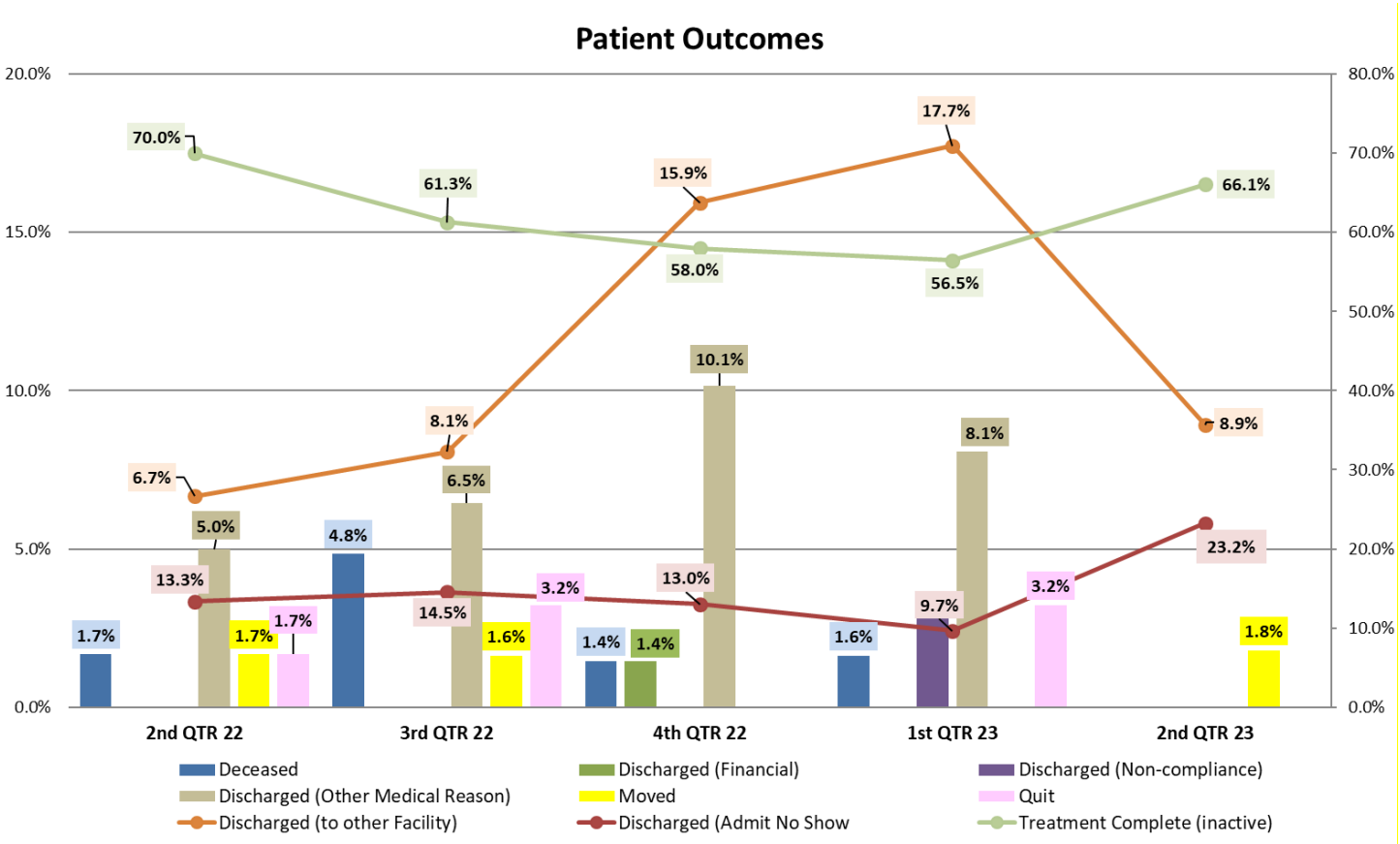
Analysis of all measures/data: (Include key findings, improvements, opportunities)
2Q23 and 3Q23 hand hygiene in OT, PT, ST, SNF Nursing were above goals of 97.5%
In 2Q23 Acute Rehab Nursing 96.2% and Wound Clinic 88.2% were below goals. In 3Q23 Acute Rehab Nursing improved to 96.9% and Wound Clinic improved to 96.1%.

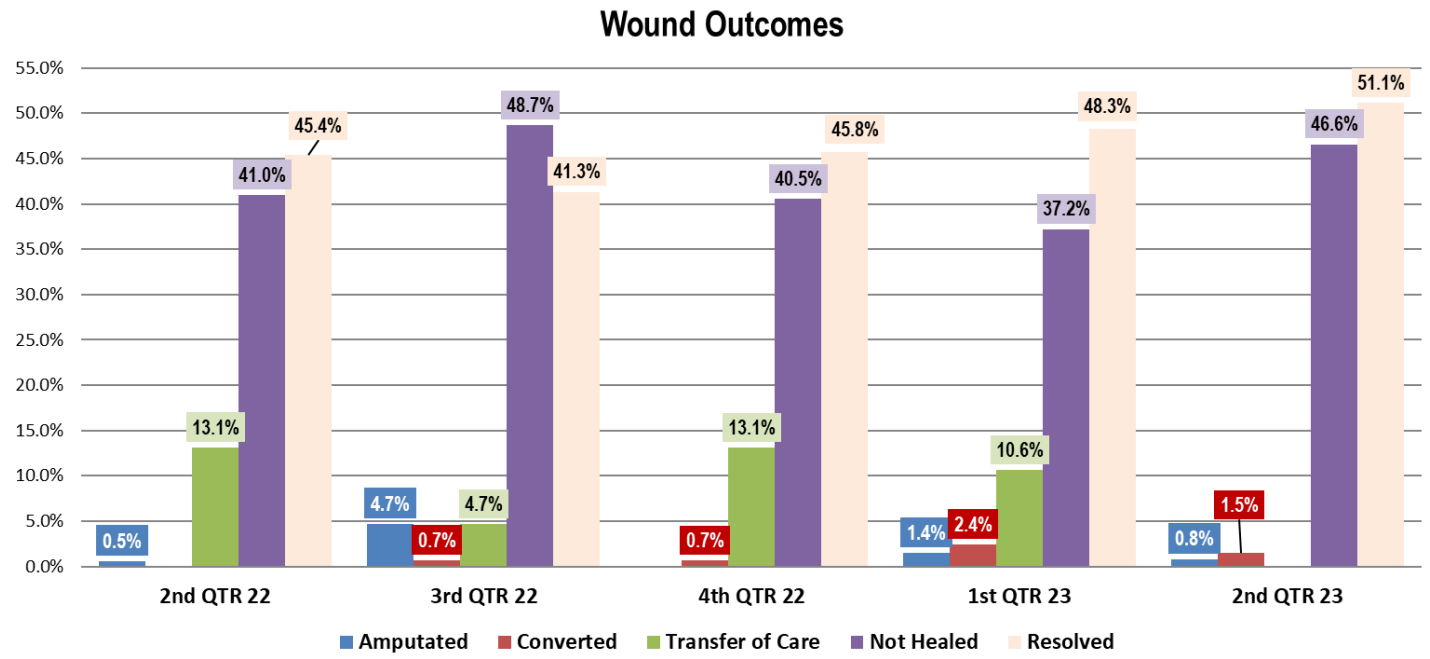
If improvement opportunities identified, provide action plan and expected resolution date:
Focusing on not only compliance but also actual use/donning of badge.

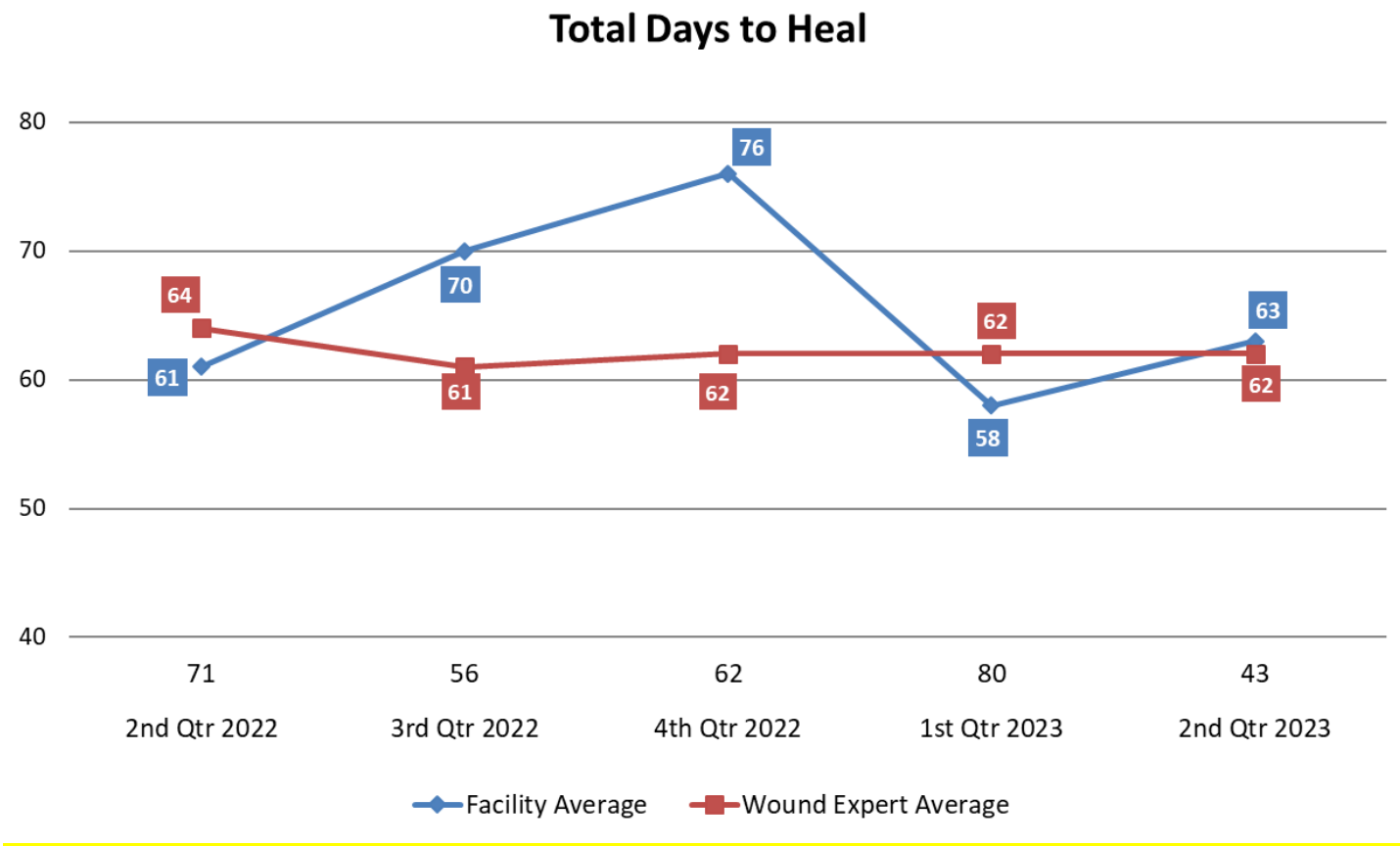
Measure Objective/Goal: Wound Center outcomes

Date range of data evaluated: 1Q23 and 2Q23

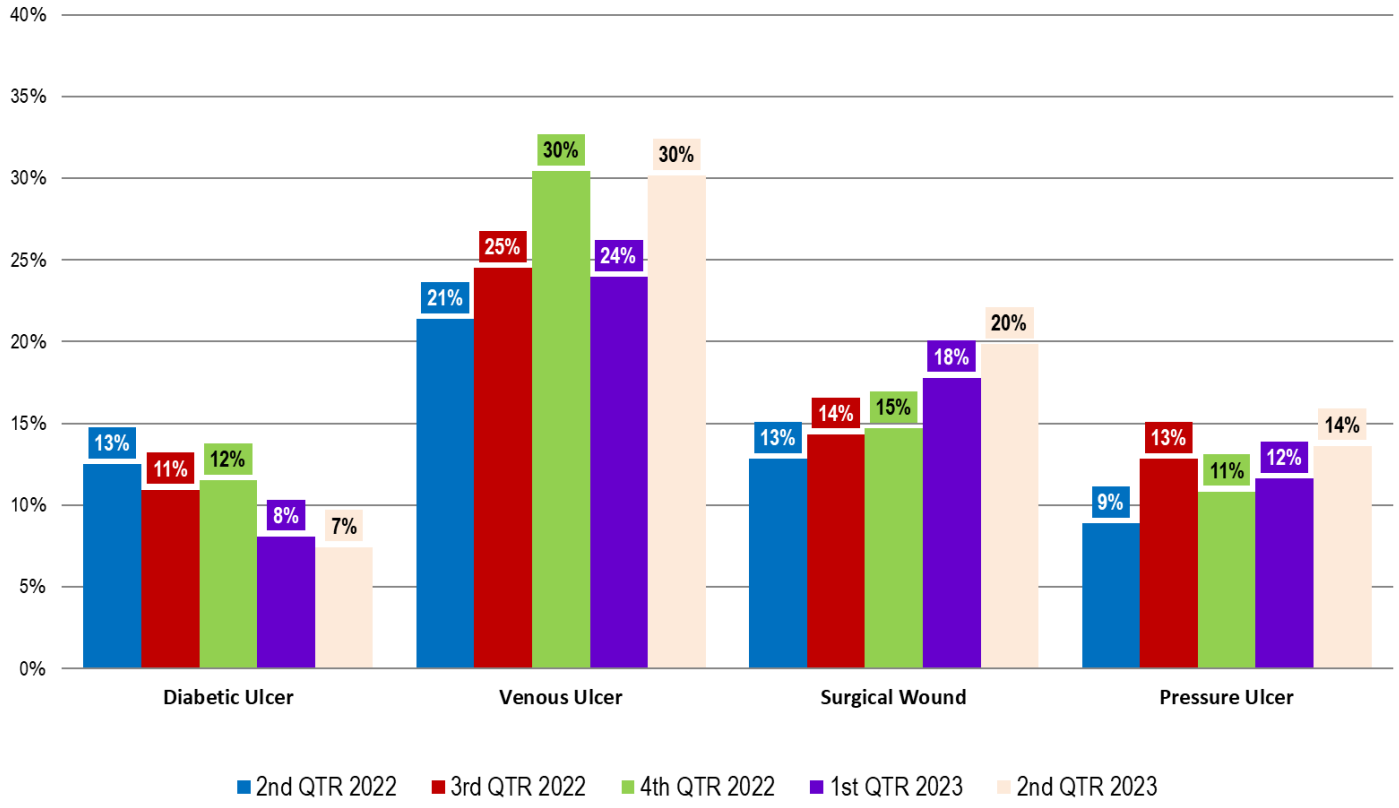
Analysis of all measures/data: (Include key findings, improvements, opportunities)
Percentage of patients completing treatment in 1Q23 was 56.5% improved to 66.1% in 2Q23. Wound outcomes for those that were resolved improved in both 1Q 48.4% and 2Q 51.1%. For "overall days to heal" in 1Q23 KH is performing below Wound Expert Center's average on "days to heal", in 2Q23 KH was 1 day longer. The distribution of types of wounds saw a spike in venous ulcers but otherwise stable. Volume at the Wound Center dropped in 1Q23 and 2Q23, partly associated with loss of the La Salle contract.



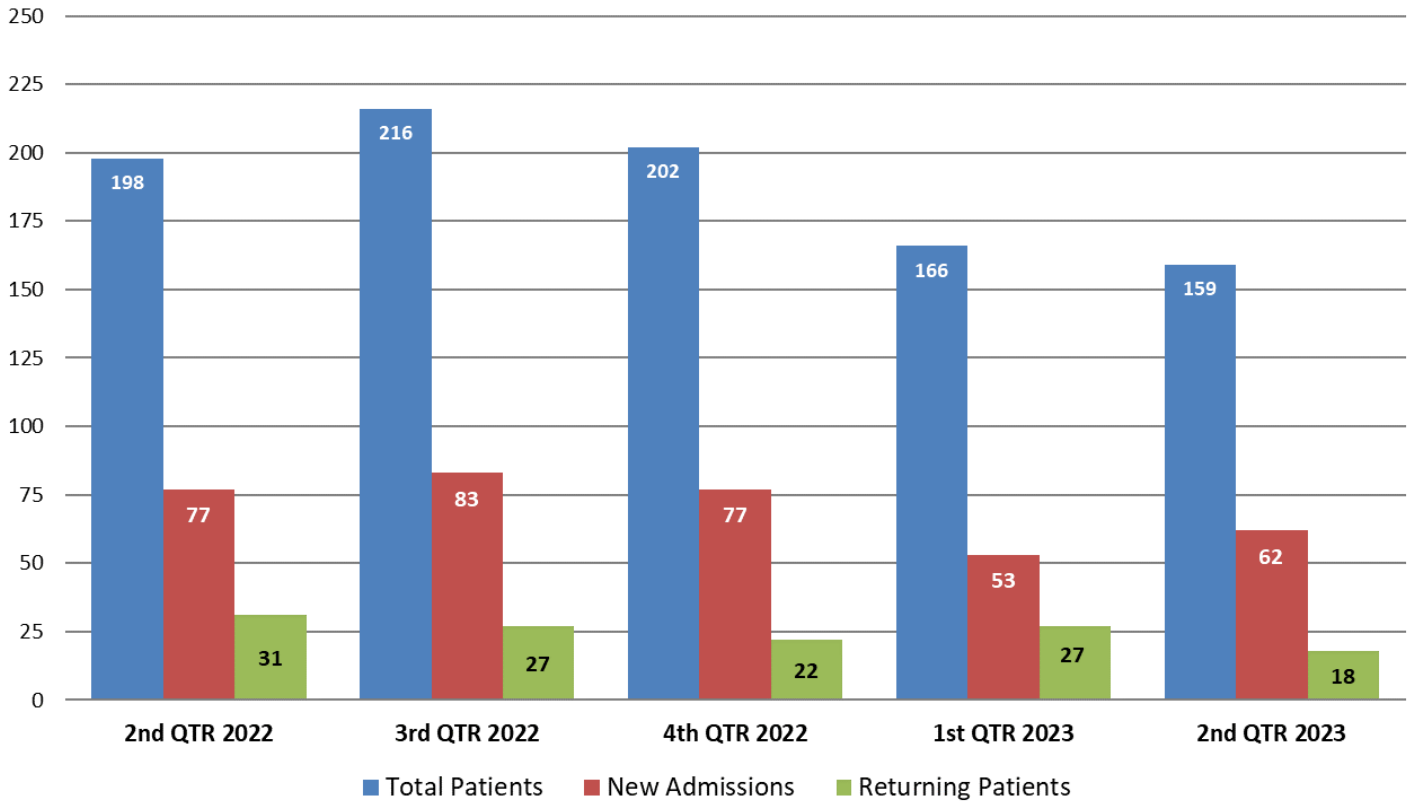

Wound Outcomes
55.0%
50.0%
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
0.5%
13.1%
41.0%
45.4%
4.7%
0.7%
4.7%
48.7%
41.3%
0.7%
13.1%
40.5%
45.8%
1.4%
2.4%
10.6%
37.2%
48.3%
0.8%
1.5%
46.6%
51.1%
2nd QTR 22
3rd QTR 22
4th QTR 22
1st QTR 23
2nd QTR 23
Amputated
Converted
Transfer of Care
Not Healed
Resolved

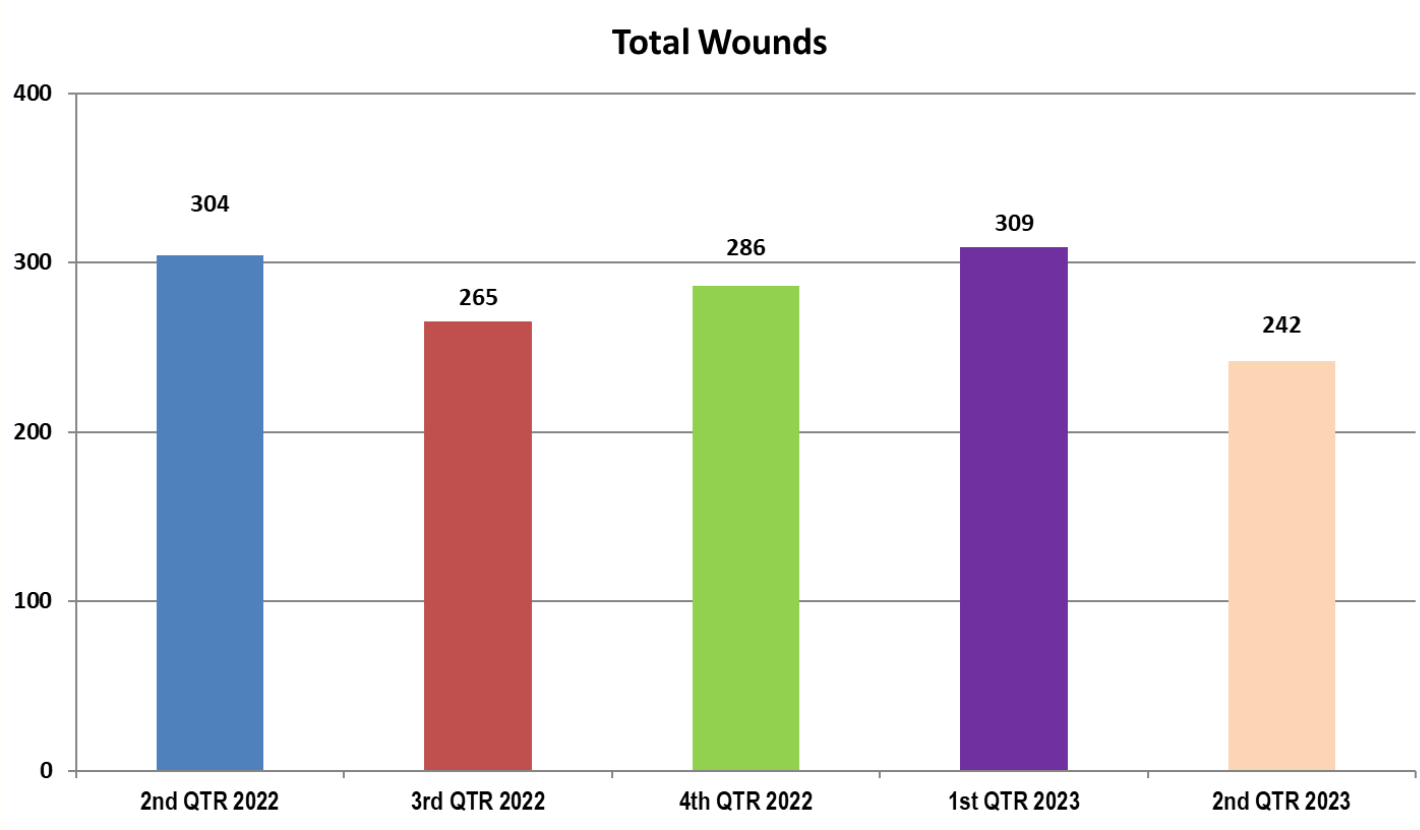

Total Days to Heal
80
70
60
50
40
64
61
70
76
61
62
62
58
63
62
71
56
62
80
43
2nd Qtr 2022
3rd Qtr 2022
4th Qtr 2022
1st Qtr 2023
2nd Qtr 2023
Facility Average
Wound Expert Average

Treated Wounds



Facility Data





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

- Marketing at referrals sources – October 2023
- Attended Wound Nurse meeting – October 2023
- Marketing in KH ED to increase referrals – October 2023

Submitted by Name: Molly Niederreiter **Date Submitted:** Dec 6 2023

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Orthopedic Service Line
Surgical Site infection

ProStaff Report Date: 12/7/2023

Submitted by: Kevin Bartel, Director of Orthopedic Service Line

Measure Objective/Goal: Measuring the standardized infection ratio (SIR) of total arthroplasty, spinal fusion and hip fracture surgical patients who experienced a **surgical site infection** within 90 days after surgery. An incidence rate calculation is determined using the total number of Total Knee (KPRO), Total Hip (HPRO), Spine fusion (FUSN) and hip fracture (FX) surgical procedures (performed during a 12-month period) versus the total number of infections for each respective procedure type using CDC/NHSH criteria. The goal of this data collection is to identify opportunities to prevent infections with orthopedic-related procedures.

Date range of data evaluated: July 1, 2022 – June 30, 2023 (12 months)

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

Type of SSI	Total # of Procedures	Actual # of infections	Predicted # of Infections	Standardized Infection Ratio
KPRO	324	3	2.129	1.409
HPRO	215	0	2.768	0
FUSN	335	3	5.354	0.56
FX	256	2	2.523	0.793
Total	1130	8	12.774	0.626

Overall, the Orthopedic total joint, spine and hip fracture procedures performed from July 1, 2022, through June 30, 2023 at Kaweah Health resulted in 8 total surgical site infections and an overall standardized infection ratio of 0.626, or 62.6% of predicted number of infections based on procedures performed and risk-adjusted elements. This is improved compared with the most recent reporting period (January 1, 2022 – December 31, 2022) which showed an overall SIR of 0.805, 80.5% of predicted number of infections based on procedures performed.

For the current reporting period, the number of infections for total hip arthroplasty, spinal fusion and hip fracture procedures were below the predicted number of infections for each respective procedure type. Compared with the last reporting period, all procedure types showed improvement in their respective SIR.

The number of infections for total knee arthroplasty exceeded the predicted number of infections, with an SIR of 1.409, indicating that there were 140.9% more surgical site infections than the predicted number of infections, based off of the number of total knee procedures performed. This was improved from an SIR of 2.308 in the last reporting period.

2 of the 3 KPRO infection cases involved total knee revision surgeries, with known higher risk for infection in each case given the patient's history and clinical presentation. One of these cases

involved a 2-stage revision surgery, where pre-surgical knee infection was known and managed. However, this patient went to jail shortly after surgery, so post-operative incision care quality is unknown.

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

1. The Joint Camp class for THA/TKA patients continues to be the primary source of education on all topics related to a patient's surgery. The pre-surgery education for patients, specifically on the topic of appropriate surgical site incision care, is considered to be a critical element in helping to reduce the number of surgical site infections. Compliance with Joint Camp attendance (30-40% average) continues to be low, and has not reached pre-pandemic compliance levels (~70%). Internal discussions and planning on going to create a refined and intentional pre-surgical class (mandatory) that would better support efforts to educate our patients and reduce incidence of SSI.
2. The Enhanced Recovery after Surgery (ERAS) program is led and monitored by the orthopedic program's Nurse Practitioners (NP). This program helps to support a standardized approach to pre and post-surgical care protocols in order to enhance recovery after a total joint surgery. Orthopedic service line leadership will continue to monitor compliance with this program.
3. Discussing standard of practice among orthopedic surgeons with variances being presented at the monthly Co-Management meeting as appropriate. This will continue to be done monthly through case reviews, discussion and reviewing data/reports related to SSI data.

Next Steps/Recommendations/Outcomes:

Orthopedic NP and Director will continue to attend quarterly surgical site infection (SSI) subcommittee meeting to stay current with SSI topics related to prevention and best practices. Orthopedic SSI cases will be reviewed and discussed quarterly at this committee meeting, with relevant outcomes shared with orthopedic surgeons on a regular basis, so that timely discussion and decisions can occur regarding ways to mitigate the incidence of infection. Continue to hardwire ERAS program with nursing staff, therapies, and surgeons in the coming year.

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Submitted by Name: Kevin Bartel, DPT **Date Submitted**: 12/7/2023

Unit/Department: Orthopedic Service Line Complication Rate **ProStaff Report Date:** 12/7/2023

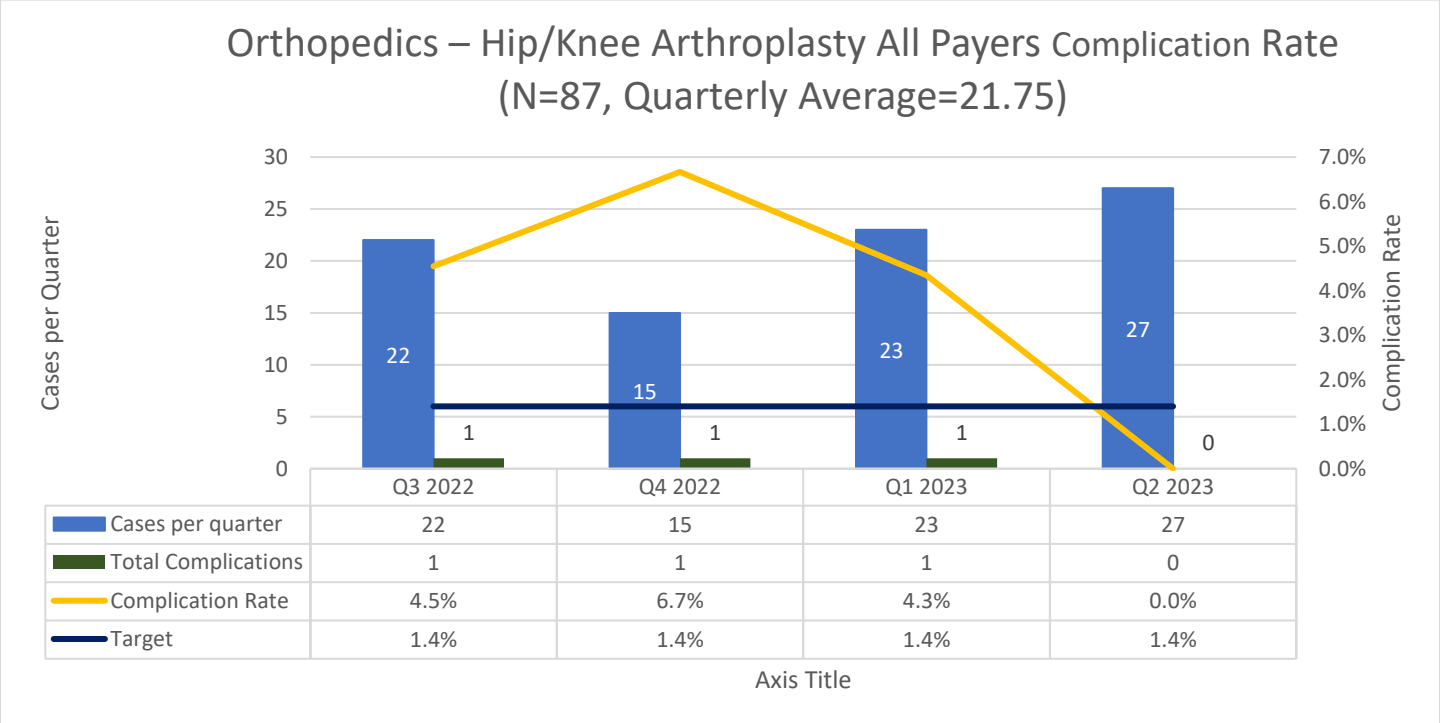
Measure Objective/Goal: Monitor and measure the **complication rate** for total arthroplasty patients who underwent either a total hip or knee joint replacement, on qualified inpatient stays. The benchmark sources are both CMS and hospitals within the STATIT database. The CMS target is **2.3%** for Medicare patients and **1.4%** target for all payers within the Midas database.

The inclusion criteria for complication include the following:

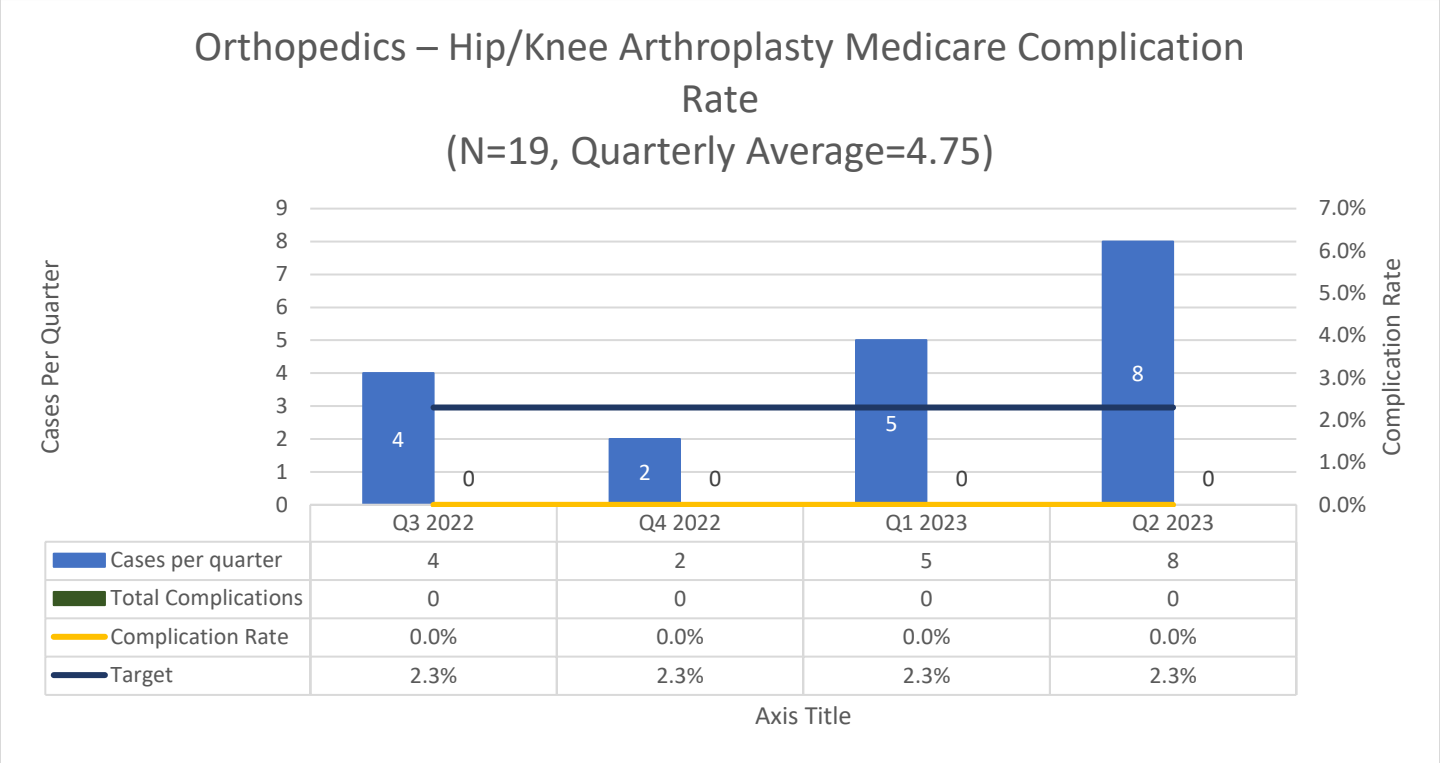
1. Mechanical complication within 90 days
2. Wound Infection or periprosthetic joint infection within 90 days
3. Surgical site bleeding within 30 days
4. Pulmonary embolism within 30 days
5. Death within 30 days
6. Acute myocardial infarction with 7 days
7. Pneumonia within 7 days
8. Sepsis, septicemia, or shock within 7 days

Date range of data evaluated: Quarter 3, 2022 through Quarter 2, 2023 (12 months)

Analysis of all measures/data: (Include key findings, improvements, and opportunities) (If this is not a new measure, please include data from your previous reports through your current report):



	Q3 2022	Q4 2022	Q1 2023	Q2 2023
Cases per quarter	22	15	23	27
Total Complications	1	1	1	0
Complication Rate	4.5%	6.7%	4.3%	0.0%
Target	1.4%	1.4%	1.4%	1.4%



	Q3 2022	Q4 2022	Q1 2023	Q2 2023
Cases per quarter	4	2	5	8
Total Complications	0	0	0	0
Complication Rate	0.0%	0.0%	0.0%	0.0%
Target	2.3%	2.3%	2.3%	2.3%

All Payers

Overall complication rate: 3.4%, which is slightly above the benchmark of 1.4%.

Past reports: 1.5% (Q1-Q4 2022), 3.2% (Q1 2021-Q1 2022)

- The complication in Q3 2022 involved a patient who sustained a patellar tendon rupture 2-3 weeks after their TKA, resulting in a subsequent hospital admission and surgery with eventual transfer to acute rehab.
- The complication in Q4 2022 was due to the presence of a pulmonary embolism 3 weeks after surgery, which was treated at the hospital.
- The complication in Q1 2023 involved a complex TKA on a patient with rheumatoid arthritis, which resulted in periprosthetic joint infection.

Medicare

Overall performing well with no complications reported, against a target benchmark of 2.3%.
**In Q3 2022, CMS updated exclusion criteria to exclude index encounters with a principal diagnosis code of COVID-19 or with a secondary diagnosis code of COVID-19 coded as present on admission. This change has resulted in substantially reduced total qualifying encounters since then. This lower denominator value reduces the margin for error when trying to achieve targets.

Quarterly average encounters: This report: 4.75 Past report: 11 (Q1-Q4 2022)

Next Steps/Recommendations/Outcomes:

1. Coordinate daily patient rounding involvement from Ortho NPs to facilitate routine patient assessment, patient care management and coordination of care. Identified complication cases are reviewed as needed at the orthopedic co-management meeting to identify any opportunities for improvement in patient care management.
2. For total joint surgeries, there continues to be a move from inpatient qualified stays to outpatient stays and a focus on same day discharge. The orthopedic nurse practitioner is working closely with the patient/family, physical therapy and case management to evaluate for safe discharge home.
3. Orthopedic NPs have created and optimized a daily communication email with Kaweah case management and post-acute liaisons to spotlight priority orthopedic patients and their status/discharge plan. They will continue to facilitate patient transfer to next level of rehabilitation care (i.e. inpatient rehab, short stay, SNF, home health) in effort to optimize patient access to recovery and education, as appropriate.
4. Discussions and efforts are currently being made to refine the Joint Program at Kaweah Health, with goals to improve pre-surgery patient education compliance with our Joint Class, advocate for family/friend support throughout the surgical process for the patient, and identify evidence-based clinical treatment pathways with goals to reduce incidence of SSI, complications and readmissions after total joint surgery. Goal is to implement these changes by April 2024.

Submitted by Name: Kevin Bartel, DPT **Date Submitted**: 12/7/2023

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

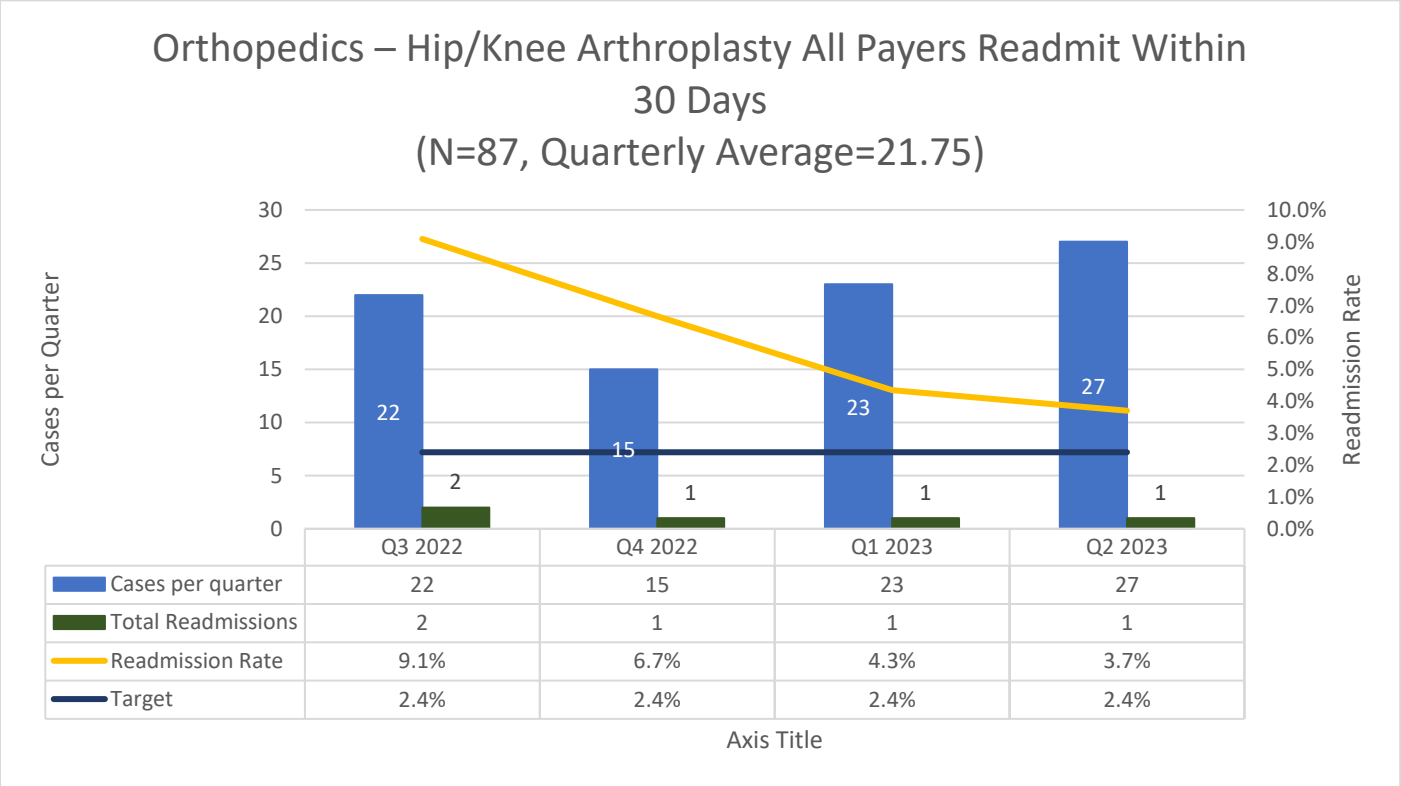
Unit/Department: Orthopedic Service Line Readmission Rate

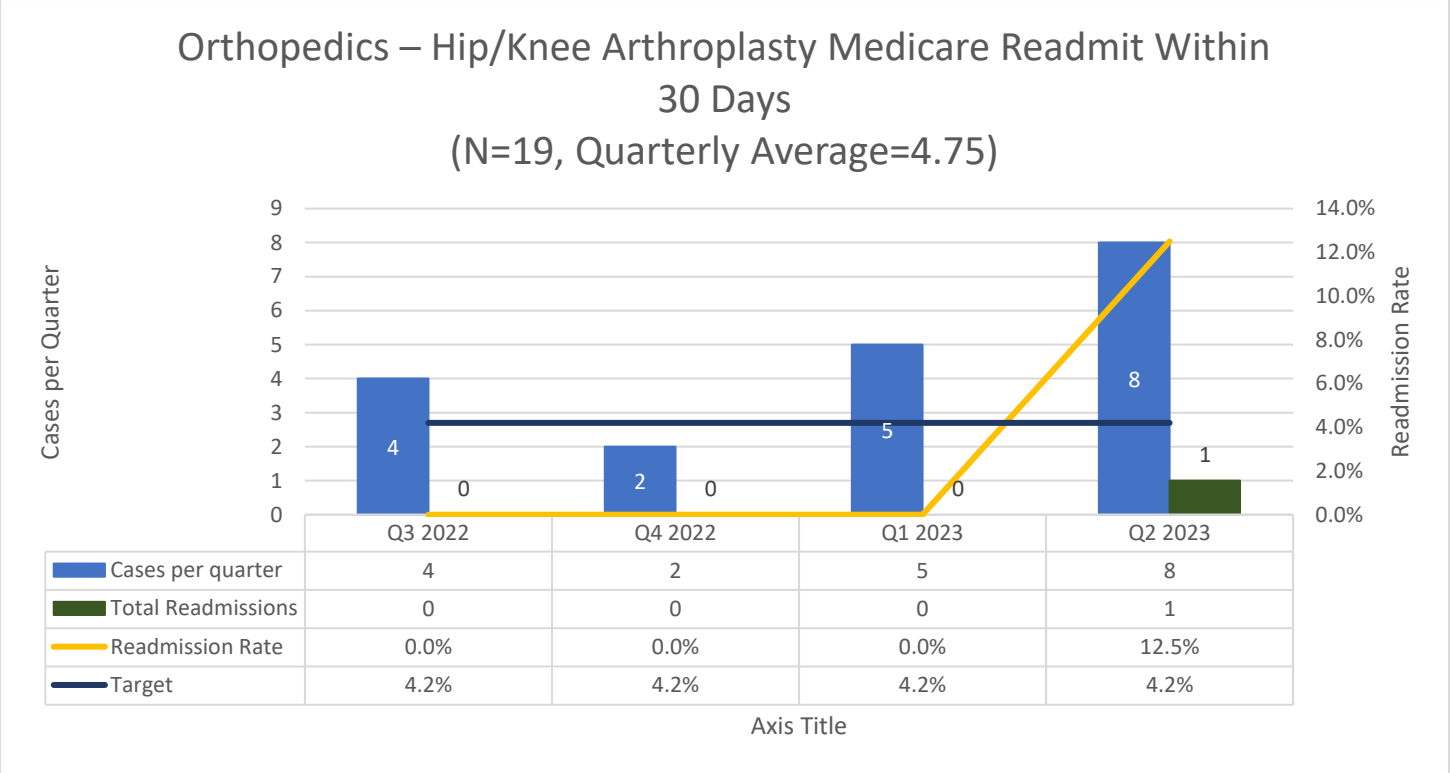
ProStaff Report Date: 12/7/2023

Measure Objective/Goal: Monitor and measure any cause 30-day **readmission rate** for total arthroplasty patients who underwent a joint replacement. The benchmark sources are both CMS and hospitals within the Midas database. The CMS target is **4.2%** for Medicare patients and **2.4%** target for all payers.

Date range of data evaluated: Quarter 3, 2022 through Quarter 2, 2023 (12 months)

Analysis of all measures/data: (Include key findings, improvements, opportunities)
(If this is not a new measure, please include data from your previous reports through your current report):





All Payers

Overall readmission rate: 5.7%, which is above the benchmark of 2.4%.

Past reports: 3.6% (Q1-Q4 2022), 6% (Q1 2021-Q1 2022)

- Q3 2022 had two readmissions; one due to altered mental status related to acude kidney injury and metabolic acidosis, with patient readmitting 1 day after surgery. The other due to patellar tendon rupture secondary to a fall while the patient was transitioning into the car, with patient admitted 8 days after surgery.
- Q4 2022 had one readmission due to the presence of a pulmonary embolism 3 weeks after surgery, which was treated at the hospital.
- Q1 2023 had one readmission for systemic inflammatory response syndrome (SIRS) without infection, with hypotension, admitted 2 days after surgery.
- Q2 2023 had one readmission for acute deep vein thrombosis (DVT), admitted 14 days after surgery.

Medicare

One readmission overall in the reported timeframe, in Q2 2023 as listed above. Overall readmission rate of 5.2%, slightly above the target benchmark of 4.2%.

**In Q3 2022, CMS updated exclusion criteria to exclude index encounters with a principal diagnosis code of COVID-19 or with a secondary diagnosis code of COVID-19 coded as present on admission. This change has resulted in substantially reduced total qualifying encounters since then. This lower denominator value reduces the margin for error when trying to achieve targets.

Quarterly average encounters: This report: 4.75 Past report: 11.25 (Q1-Q4 2022)

Next Steps/Recommendations/Outcomes:

1. Standardized education and increased emphasis with prevention of surgical site infections during the pre-op Joint Camp education class. Focus on post-operative care of surgical sites and plan of care if signs and symptoms of infection occur with plan to call surgeon and not to report to Emergency room.
2. Coordinating care alongside our Emergency Department physicians to improve communication with primary surgeon if patient shows to the ED, so that optimal care management and collaboration can occur in efforts to reduce incidence of readmission as appropriate.
3. Orthopedic NPs will continue to facilitate patient transfer to next level of rehabilitation care (i.e. inpatient rehab, short stay, SNF, home health) in effort to optimize patient access to recovery and education, as appropriate.
4. Working more closely with Orthopedic providers and offices to improve processes in proactively identifying and providing resources for surgical patients' needs to optimize their recovery after surgery (i.e appropriate DME, home support, etc).
5. Discussions and efforts are currently being made to refine the Joint Program at Kaweah Health, with goals to improve pre-surgery patient education compliance with our Joint Class, advocate for family/friend support throughout the surgical process for the patient, and identify evidence-based clinical treatment pathways with goals to reduce incidence of SSI, complications and readmissions after total joint surgery. Goal is to implement these changes by April 2024.

Submitted by Name: Kevin Bartel, DPT **Date Submitted:** 12/7/2023

Outstanding Health Outcomes Update

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

February 2024

Kaweah Health
MORE THAN MEDICINE. LIFE.

Outstanding Health Outcomes (OHO) Dashboard

Sepsis (SEP)	FY 2024 Target	FY 2022	FY 2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	FYTD 24
SEP-1 CMS % bundle compliance	85%	75%	73%	68%	77%	76%	76%	82%								76%
Sepsis and Related Conditions o/e mortality	≤0.78		1.12	0.75	0.82	0.78	0.84	1.38	1.02							0.95

Central Line Associated Blood Stream Infection (CLABSI)	FY 2024 Target	FY 2022	FY 2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	FYTD 24
CLABSI Events		18 Ex COVID	14 Ex COVID	1	2	3	0	3	0							9
CLABSI SIR	0.39	1.01 Ex COVID	0.93 Ex COVID	0.83	1.16	2.22	0.00	1.15	0.00							1.14
Central Line Utilization Rate (ICU)	0.68	1.02	0.88	0.749	0.791	0.828	0.774	0.685	0.876							0.78

Catheter Associated Blood Stream Infection (CAUTI)	FY 2024 Target	FY 2022	FY 2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	FYTD 24
CAUTI Events		23 Ex COVID	12 Ex COVID	0	0	2	0	2	1							5
CAUTI SIR	0.40	1.09 Ex COVID	0.55 Ex COVID	0.00	0.00	1.06	0.00	0.97	0.46							0.41
Indwelling Uninary Catheter (IUC) Utilization Rate (ICU)	0.70	1.18	1.22	0.869	0.925	1.040	1.080	1.10	1.077							1.01

Methicillin-Resistant Staphylococcus Aureus (MRSA)	FY 2024 Target	FY 2022	FY 2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	FYTD 24
MRSA Events		10 Ex COVID	6 Ex COVID	0	0	1	0	1	3							1
MRSA SIR	0.55	1.11 Ex COVID	0.66 Ex COVID	0.00	0.00	1.47	0.00	1.32	3.00							0.96

KEY	Does not meet goal/benchmark	Within 10% of goal/benchmark	Outperforming/ meeting goal/benchmark

Action Plan Summary

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

Sepsis

- Focus on 1 hr bundle and expanding to inpatient areas, new order sets/power plans in process with physician stakeholders
- Six Sigma improvement work in process to re-identifying root causes of SEP-1 non-compliance to focus improvement work on the highest contributing factors

Healthcare Acquired Infections

- New super "HAI Brain Trust" Quality Focus Team established, approved by Quality Improvement Committee
- Combine and focus efforts on process metrics that affect the SIRs for CAUTI, CLABSI & MRSA and includes:
    - Line utilization (both central lines and indwelling urinary catheters
        - Multidisciplinary rounds started January 2024 in high risk areas, addresses line necessity (less lines=less infections), monitoring line utilization rates to evaluate effectiveness
    - Decolonization rates
        - Nasal – Significantly improved from 32% (Jan-June 2023) to 84% (July – Jan 2024). Includes patients who are screened and test positive for MRSA upon admission and not discharged within 24 hours of Mupirocin order (decolonization agent). Next Steps – determining and addressing root causes of patients missed screening, and review of workflow of Mupirocin order to administration processes
        - Skin – New discussions on process for skin decolonization through CHG bathing
    - Cleaning effectiveness in high risk areas
        - Quantifying the effectiveness of cleaning during EVS onboarding and annual review with ATP testing; continue to measure cleaning effectiveness through ATP testing in high risk areas (ie. OR's, ICUs)
    - Hand Hygiene (use of BioVigil system for monitoring)
        - Increased use of system, improvement from 31% of active users achieving target badge hours in FY 2023, to 47% (July 23' to Jan 24'). Next steps, additional tools provided to leaders and staff to support increase use, and evaluation of active users with the denominator
        - Starting February 2024 – RECOGNITION PROGRAMS for units/departments that have achieve highest % of staff meeting 80hrs active time (paired) per month!

Questions?

The pursuit of healthiness