April 11, 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, April 18, 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, April 18, 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, April 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

Kelsie Davis
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, April 18, 2024
5105 W. Cypress Avenue
Kaweah Health Lifestyle Fitness Center Conference Room

ATTENDING: Board Members: Michael Olmos (Chair), Dean Levitan, MD; Gary Herbst, CEO; Keri Noeske, Chief Nursing Officer; Tom Gray CMO/CQO; Julianne Randolph, OD, Vice Chief of Staff and Quality Committee Chair; LaMar Mack, MD, Quality and Patient Safety Medical Director; Sandy Volchko, Director of Quality and Patient Safety; Ben Cripps, Chief Compliance and Risk Management Officer; Evelyn McEntire, Director of Risk Management; and Kyndra Licon, 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 (Kelsie Davis 559-624-2330) or kedavis@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, OD, Vice Chief of Staff and Quality Committee Chair; Mara Miller, PharmD BCPS, Medication Safety Coordinator*
   - **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*
2. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Julianne Randolph, DO, Vice Chief of Staff and Quality Committee Chair; Mara Miller, PharmD BCPS, Medication Safety Coordinator*

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. Diabetes Committee Report
    - 3.2. Rapid Response Team & Code Blue Quality Report
    - 3.3. Home Health Quality Report
    - 3.4. Hospice Quality Report
    - 3.5. Mental Health Quality Report

4. **Health Equity Quality Report –** A review of completed and planned initiatives to identify and address health equity. *Sonia Duran-Aguilar, MSN, MPH, RN, PHN, CNL, CRHCP, Director of Population Health Management; Ryan Gates, PharmD, CRHCP, Chief Population Health Officer.*

5. **Sepsis Quality Focus Team Report -** A review of key quality measures and action plans focused on the care of sepsis patient population. *Erika Pineda, BSN, RN, PHN, CPHQ, Quality Improvement Manager; LaMar Mack, MD, MHA, Medical Director of Quality and Patient Safety.*

6. **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.*

7. **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.

Agenda item intentionally omitted

Unit/Department Specific Data Collection Summarization

ProStaff and Quality Improvement Committee

Unit/Department: Diabetes Management Committee **Report Date:** March 2024

Measure Objective / Goal:

Glucommander™

The key component of the eGlycemic Management System® from Glytec, Glucommander™ (GM) supports intravenous (IV) and subcutaneous (SQ) insulin dosing (and transitions between) for patients with diabetes. GM utilizes evidence-based multivariate algorithms to provide care teams with computer-guided dosing recommendations that continuously recalculate and dynamically adjust to each individual patient's blood glucose trends, insulin sensitivities and response to therapy. Surveillance and summary data are accessed through an online platform.

Society of Hospital Medicine (SHM)

Through an annual subscription, Kaweah Health (KH) participates in the Electronic Quality Improvement Programs (eQUIPS), a web-based online collaborative program that provides bi-annual performance tracking and benchmarking focused on optimizing care of inpatients with hypoglycemia, hyperglycemia and diabetes. *There are currently no regulatory metrics by which to benchmark results*.

Goal 1 Safety: Achieve benchmark performance for hypoglycemia in Critical Care (CC) and Non-Critical Care (NCC) patient population, defined as percent *patient days* with blood glucose (BG) <70
**Excludes Pediatrics, Post-Partum, Mental Health and Skilled Adult Units*

Glycemic Control:

Goal 2 Achieve benchmark performance for hyperglycemia, defined as percent *patient stays* with weighted mean BG >180 for CC and NCC* patients

Goal 3 Achieve benchmark performance [rank] for mean time between first BG <70 and resolution for CC and NCC* patients

Goal 4 Achieve benchmark performance for percent of patients with hypoglycemia with at least one recurrent hypoglycemic day.

Analysis of Measures / Data: (include key findings, improvements, opportunities)

Glytec updated their reporting system, *GlucoMetrics*®. Our previous graphs included hypoglycemia, hyperglycemia and average blood glucoses on the same graph. Hypoglycemia and in-range patient day's data will now be separated into graphs 1a, 1b, 2a and 2b for CC and graphs 3a and 3b for NCC. In this report, in-range data will be shared and displays the percent of patient days KH patients on GM are in range (70-180 mg/dL).

∅ **GOAL 1** Partially Met: Outperformed the available hypoglycemia benchmark statistic for CC units (chart 3) and underperformed the available benchmark statistic for hypoglycemia for NCC units (Chart 4). Although this goal was partially met, hypoglycemia was improved in both CC and NCC.

∅ **GOAL 2** Partially Met: Underperformed the available hyperglycemia benchmark statistic for CC units (Chart 3) and outperformed the available hyperglycemia benchmark statistic for NCC units (Chart 4). CC and NCC improved in this metric with NCC reaching the top decile for hyperglycemia

Although we continue to partially underperform in Goals 1 and 2, our first 6 months/last 6 months SHM 5-year comparison data demonstrates an overall improvement in CC and NCC areas in both hypoglycemia and hyperglycemia (Charts 1 and 2).

Definition of SHM comparison data:

- The first 6 months data is from the first 6 months of the last 5 years of data collection
- The last 6 months data is from the most current data

Chart 1: SHM Report for CC and NCC Units: first 6 months compared to the last 6 months of data. KH CC performance showed an improvement in hypoglycemia (-20%) compared to the last reporting period of spring 2023 (10.7%)na .

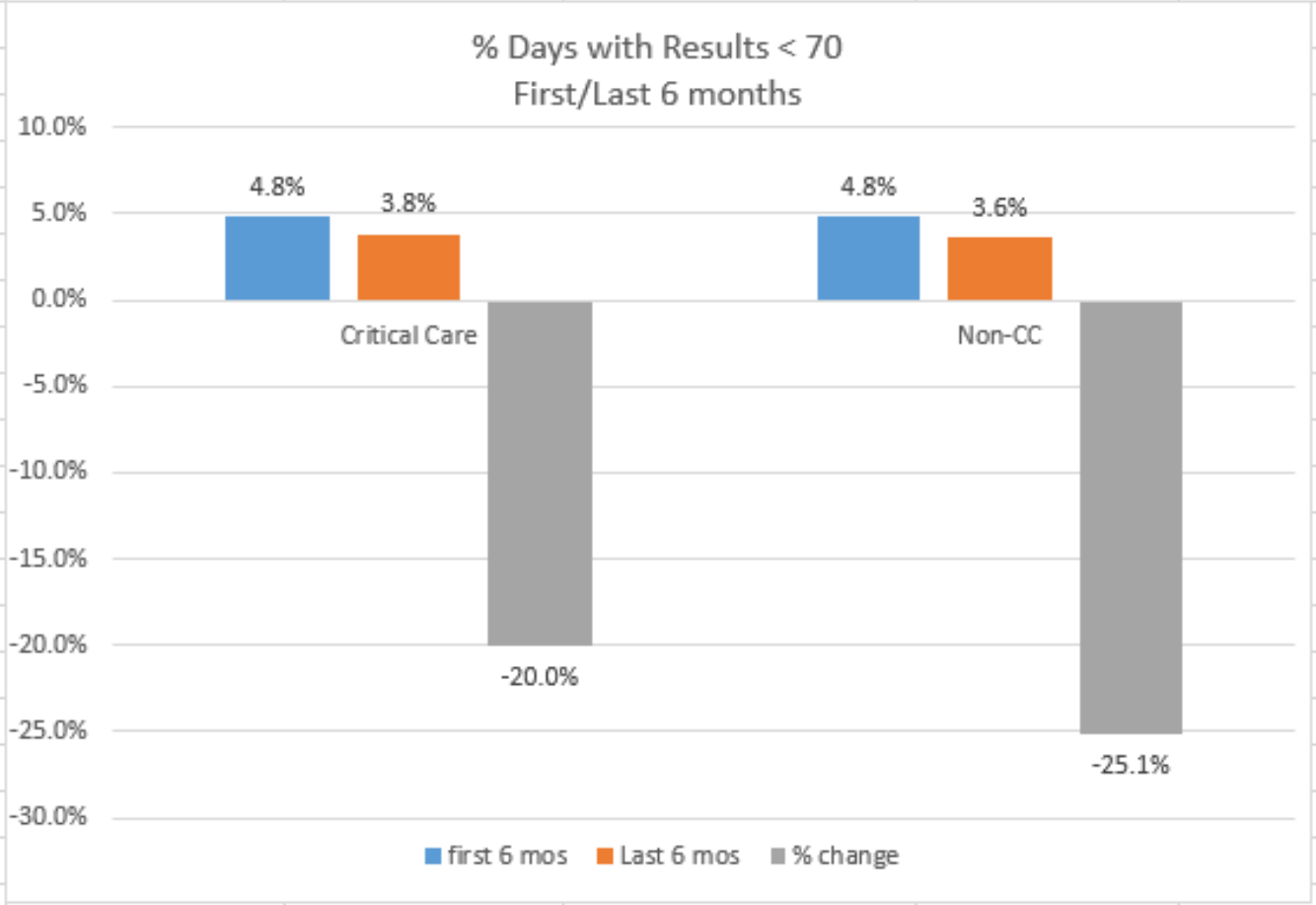


Chart 2: SHM Report for CC and NCC Units: first 6 months compared to the last 6 months of data. KH CC and NCC areas continue to show improvement in hyperglycemia with a % change of -26.3% and -22.6% from five years ago to the most recent report (October 2023).

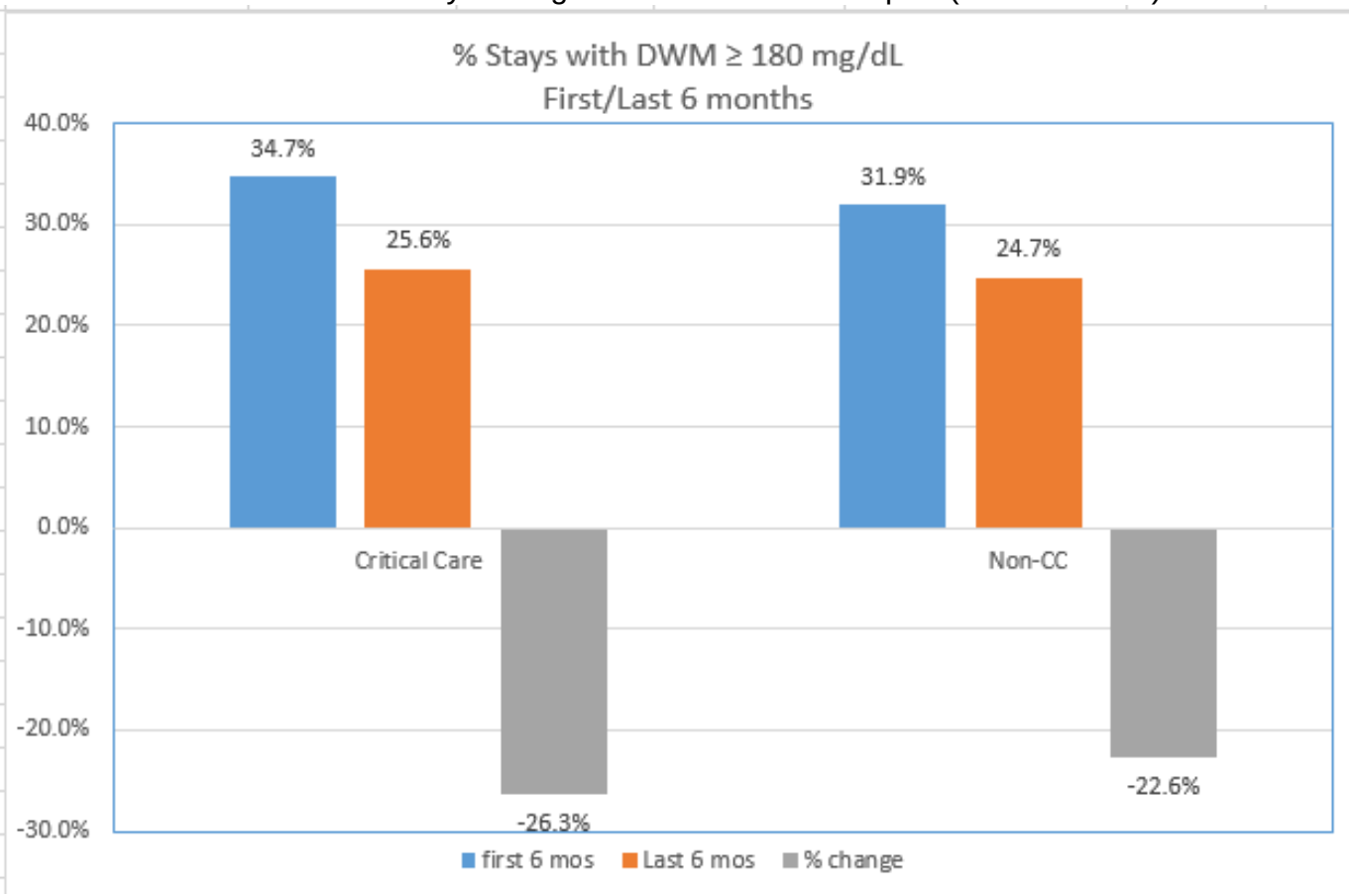
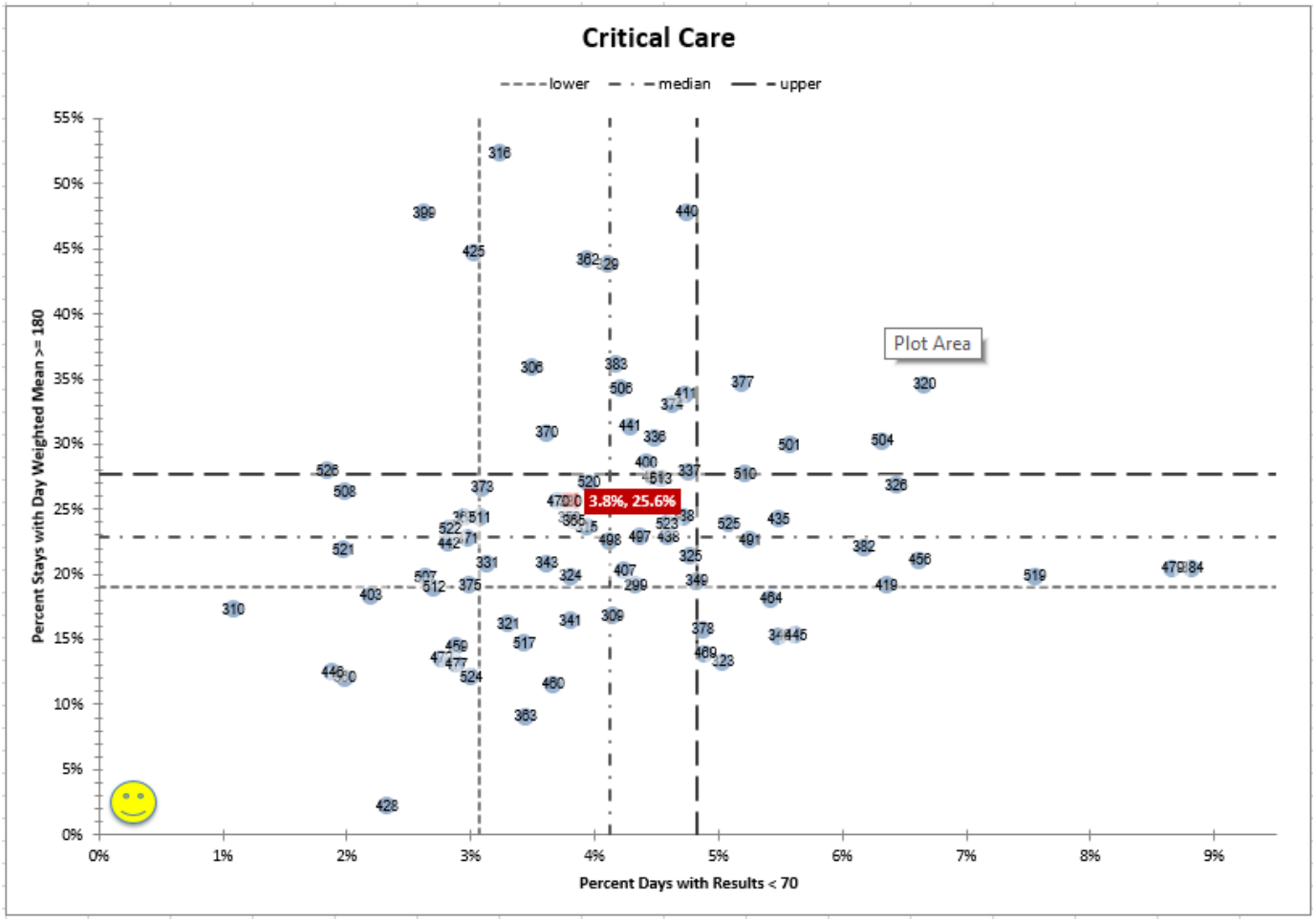


Chart 3– SHM Report for CC Units
(ICU, 3West, CVICU, 1-5Tower)

SHM Scatterplot displays most recent SHM benchmarks for <u>percent of days < 70</u> for hypoglycemia and <u>percent patient stays with DWM BGs ≥ 180</u> among CC units.

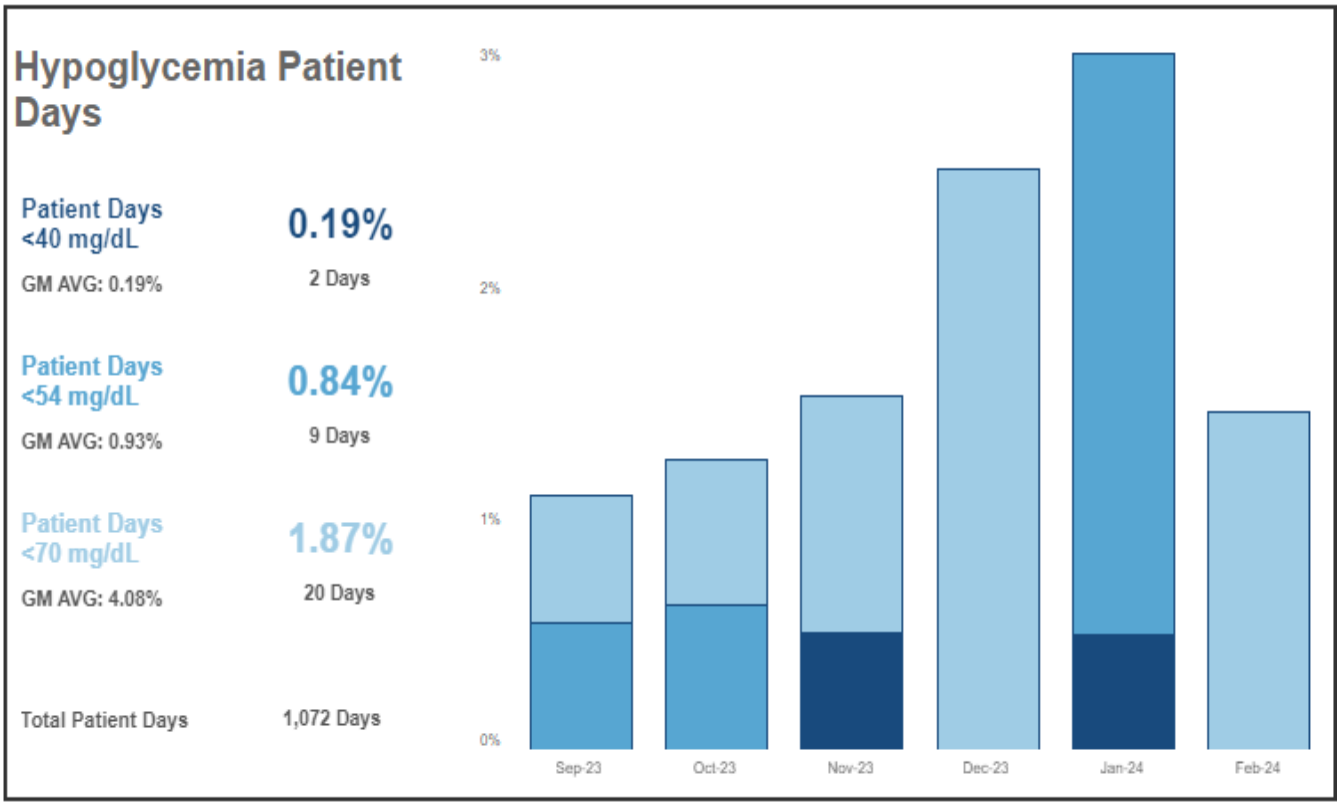
- Hypoglycemia, KHMC CC was at 3.8%, which is a decrease from previous reporting interval 4.5%, outperforming the SHM benchmark of 4.1%
- Hyperglycemia, KH CC was at 25.6% improved from the previous reporting interval, 29.4% which is above the SHM benchmark of 22.9%
- KHMC CC continues to move in the right direction for both HYPO and HYPERglycemia
- We monitor for hypo- and hyperglycemia trends monthly using *GlucoMetrics*® data.



SHM Benchmark: HYPOglycemia 4.1%, HYPERglycemia 22.9%

Graph 1a and 1b – GlucoMetrics® Report for CC Units
Displays % patient days < 70 for hypoglycemia and Patient Days In-Range (70-180 mg/dL) for the past 6 months among CC units for patients **treated with Glucommander™ IV.**
Graph 1a: CC Hypoglycemia Data

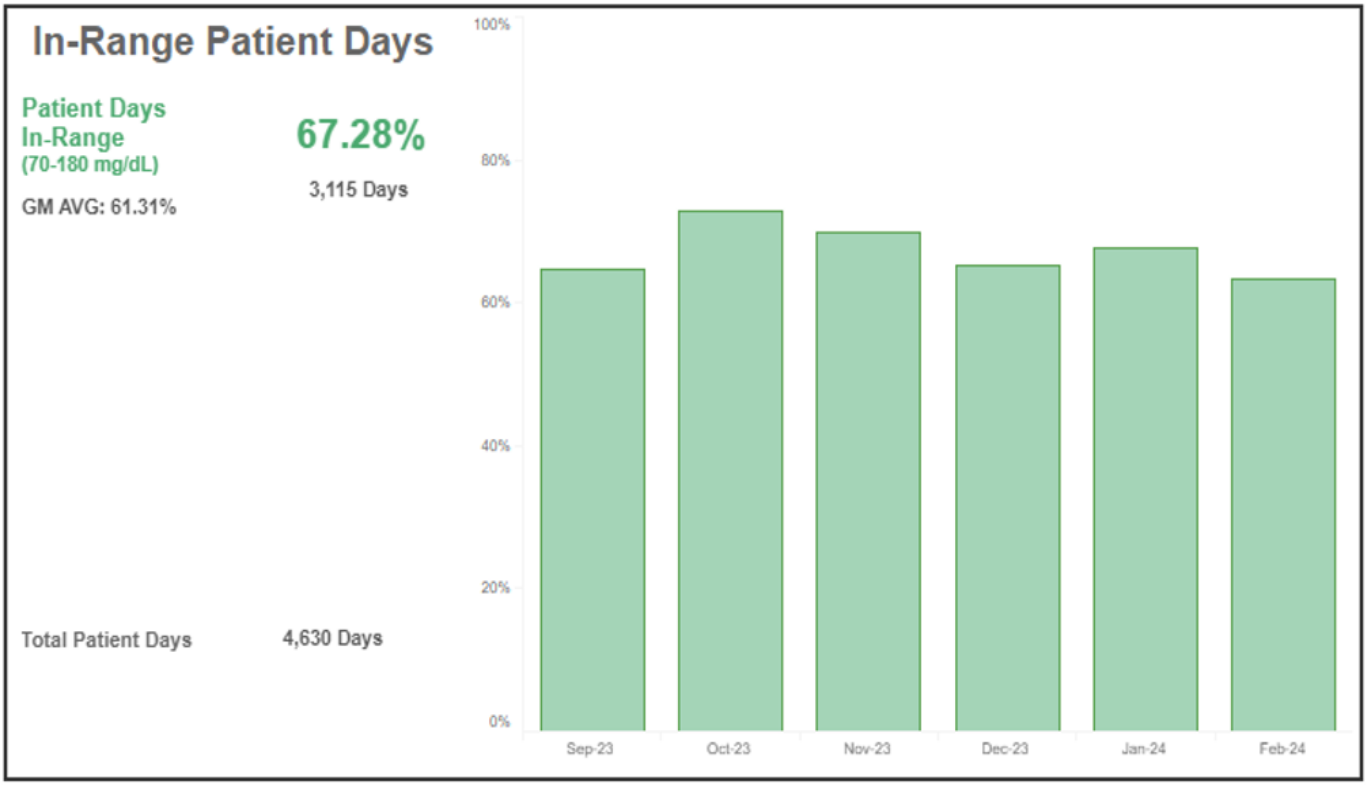
- Glucommander™ IV hypoglycemia patient days color coding indicates categories for patient days < 70 mg/dL, <54 mg/dL and <40 mg/dL.
- Compared to GM average, we continue to outperform other hospitals in patient days less than 70 mg/dL and less than 54 mg/dL. KH is even with other GM hospital for patient days less than 40mg/dL
- The last 6 months average of 1.9% is better than the SHM benchmark of 4.1%



Patient Days with a hypoglycemic event.
SHM Benchmarks: HYPOglycemia=4.1%

Graph 1b. GlucoMetrics® CC In-Range Data

- In-Range Patient Days displays the percent of patient days patients **treated with Glucommander™ IV and SQ** remain in glycemic range (70-180 mg/dL).
- KH is at 67.3% for the last 6 months which is above the GM average of 61.3%.
- For this metric: higher is better.

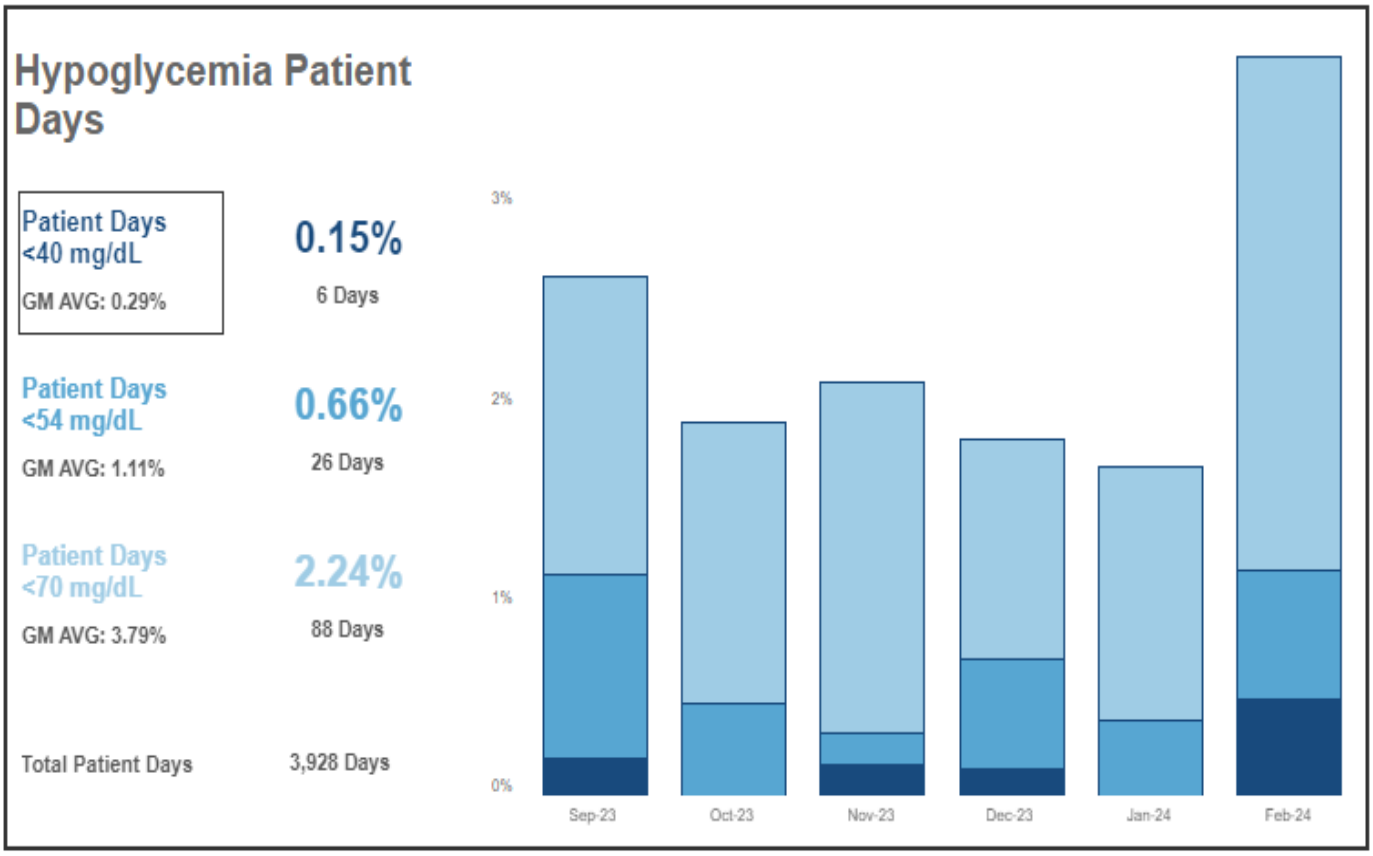


Patient Days with average of blood glucose measurements between 70 and 180 mg/dL.

Graph 2a and 2b – GlucoMetrics® Report for CC Units
Displays % patient days < 70 for hypoglycemia and Patient Days In-Range (70-180 mg/dL) for last 6 months among critical care units for patients **treated with Glucommander™ SQ.**

Graph 2a: CC SQ Data

- In the last 6 months, KH has outperformed other hospitals who also use **Glucommander™ SQ**.
- Last 6 months: average patient days with BG < 70 mg/dL was 2.24%, better than GM average of 3.79% and better than the SHM benchmark of 4.1%. There was an increase in Feb 2024 to 3.7%, but continues to outperform both SHM benchmark and GM average.

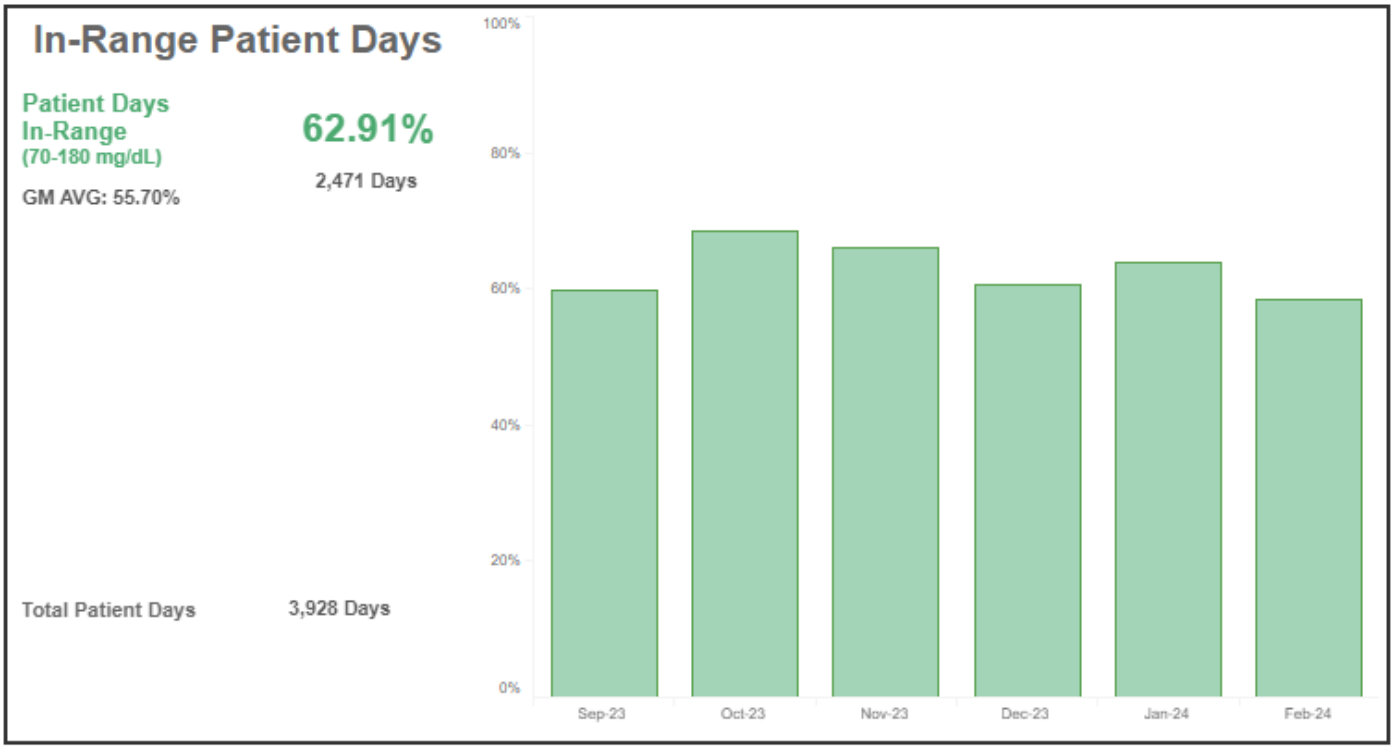


Patient Days with a hypoglycemic event.

SHM Benchmarks: HYPOglycemia=4.1%

Graph 2b – CC SQ In-Range Data

- In-Range Patient Days displays the percent of patient days patients treated with **Glucommander™ SQ** remain in glycemic range (70-180 mg/dL)**.**
- KH is at 62.9% for the last 6 months which is above the GM average of 55.7%.
- For this metric: higher is better.
-

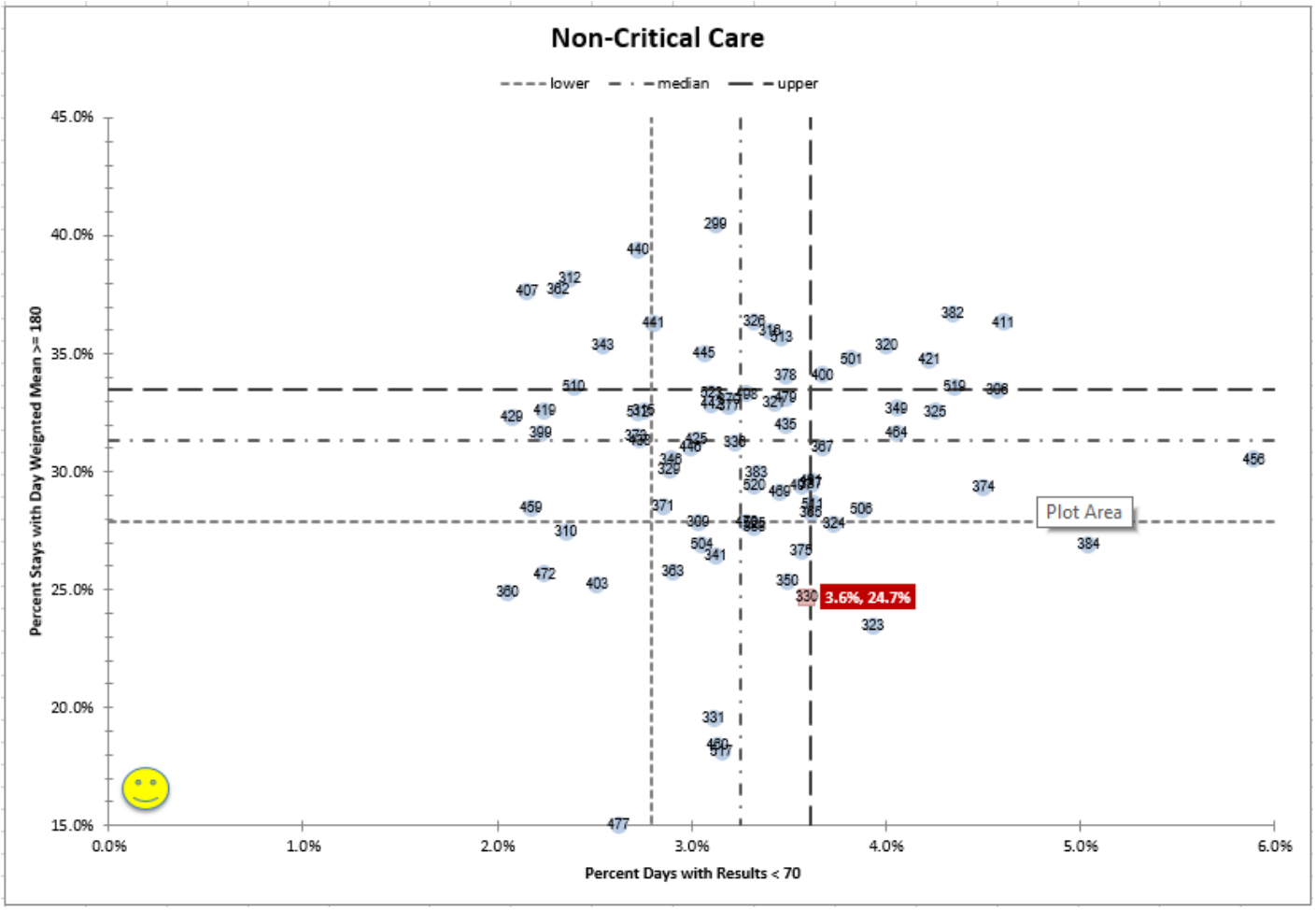


Patient Days with average of blood glucose measurements between 70 and 180 mg/dL.

Chart 4– SHM Report for NCC Units
(1-4Tower, 2North, 2South, 3North, 3South, 4North, 4South, Broderick Pavilion)

SHM Scatterplot displays SHM benchmarks for <u>percent of days < 70</u> for hypoglycemia and <u>percent patient stays with DWM BGs ≥ 180</u> among NCC units.

- Hypoglycemia: KH NCC improved from 4.2% to 3.6%, which is just above the SHM benchmark of 3.3%
- Hyperglycemia: NCC hyperglycemia rates decreased to 24.7% from 27.3%, outperforming the SHM benchmark of 31.3%, placing KH in the top decile (≤ 24.9%)

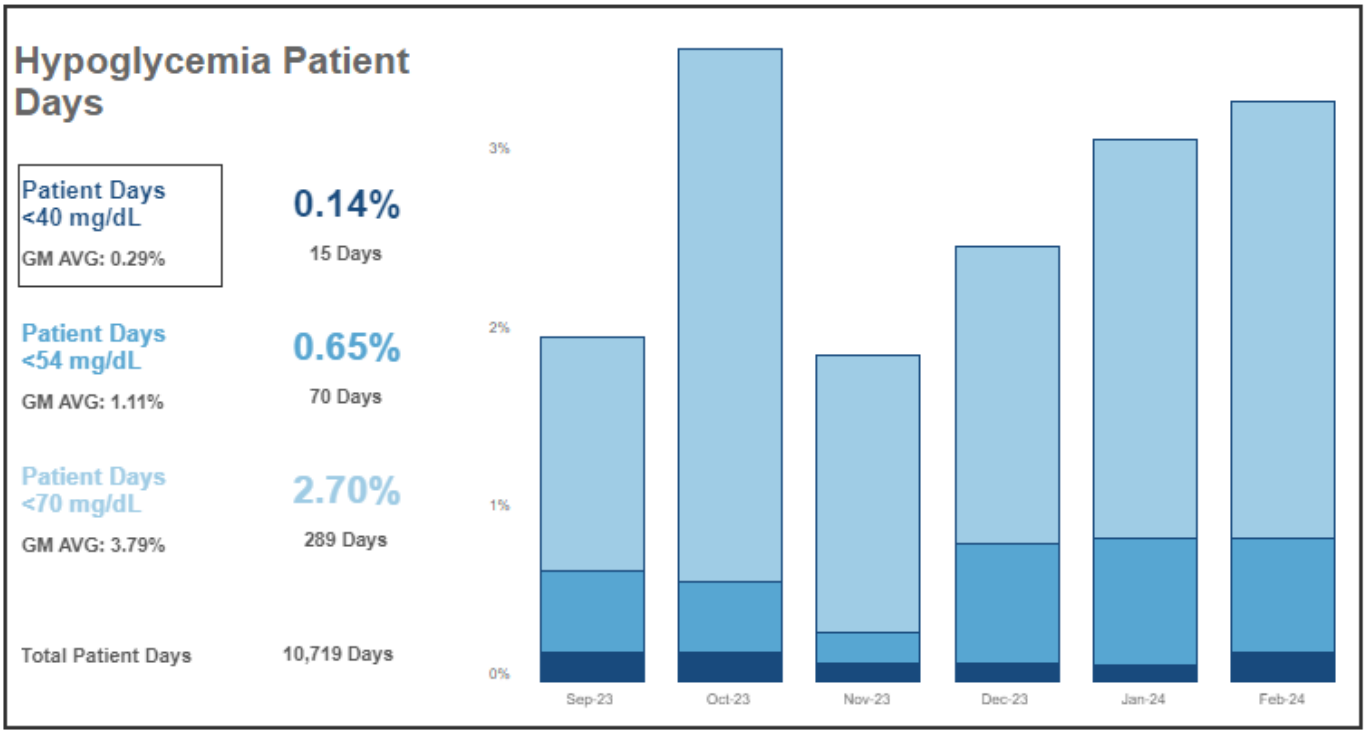


SHM Benchmarks: HYPOglycemia 3.3%, HYPERglycemia 31.3%

Graph 3a and 3b – GlucoMetrics® Report for NCC Units
Displays % patient days < 70 for hypoglycemia and Patient Days In-Range (70-180 mg/dL) for the last 6 months among NCC units for patients **treated with Glucommander™ SQ.**

Graph3a: NCC SQ Hypoglycemia rates

- In the last 6 months, KH has outperformed other hospitals who also use **Glucommander™ SQ**.
- Last 6 months: average patient days with BG < 70 mg/dL was 2.7%, better than GM average of 3.79% and better than the SHM benchmark of 3.3%
- KH also outperformed other hospitals who use Glucommander for both patient days less than 54 mg/dL (0.65%) and less than 40 mg/dL (0.14%).

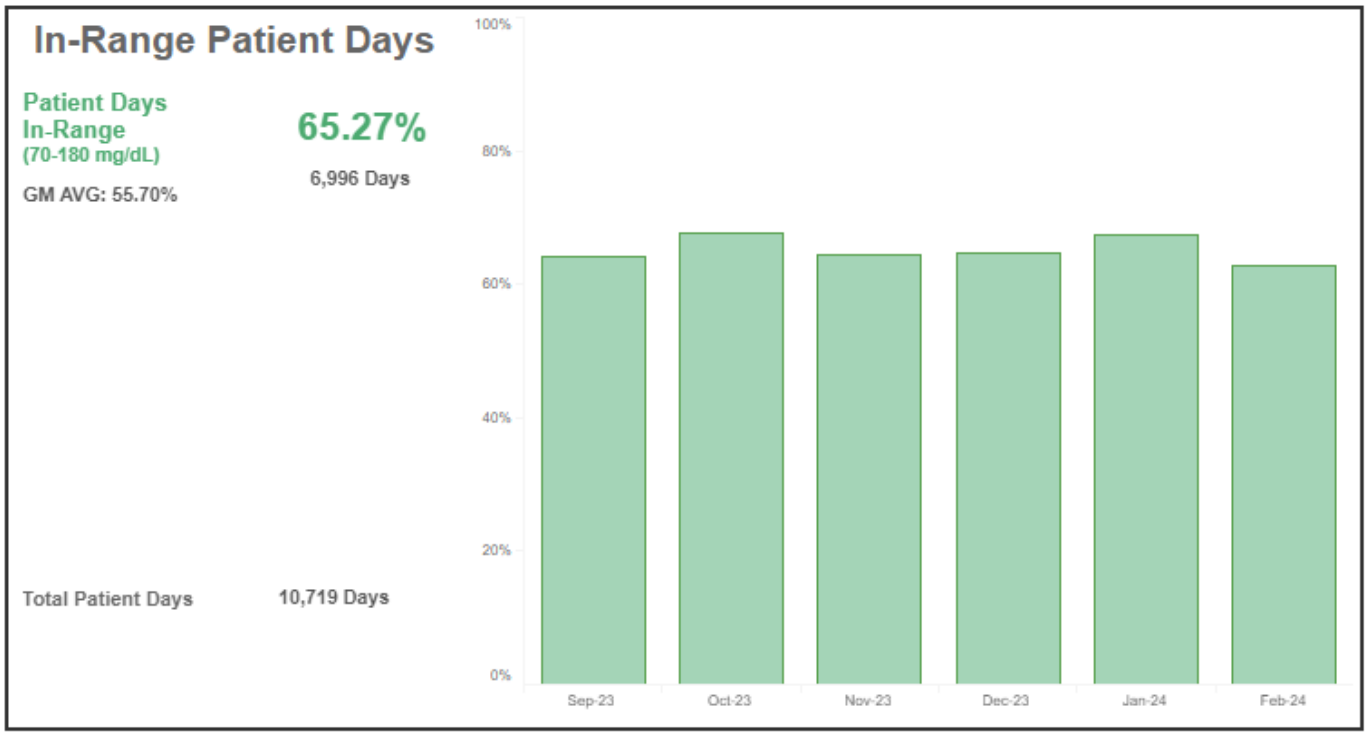


Patient Days with a hypoglycemic event.

SHM Benchmarks: HYPOglycemia=3.3%

Graph 2b – NCC SQ In-Range Data

- Patient days in range (70-18 mg/dL) for patients **treated with Glucommander™ SQ,** outperformed other hospital who also use Glucommander. The Glucommander average was 55.7%
- For this metric: higher is better.
- Last 6 months, KH was at 65.27%



Patient Days with average of blood glucose measurements between 70 and 180 mg/dL.

✓ **GOAL 3** Met: In the last 6 years, KH has met this goal for resolution of hypoglycemia after initial identification of hypoglycemic event for CC units (Chart 5) and NCC units (Chart 6)

Chart 5 – SHM Report (May 2023-October 2023) for Critical Care Units

Kaweah Health time between glucose < 70mg/dL and documented resolution of hypoglycemia for critical care is 48.9 minutes. This time outperforms the top quartile of ≤57.9 minutes.

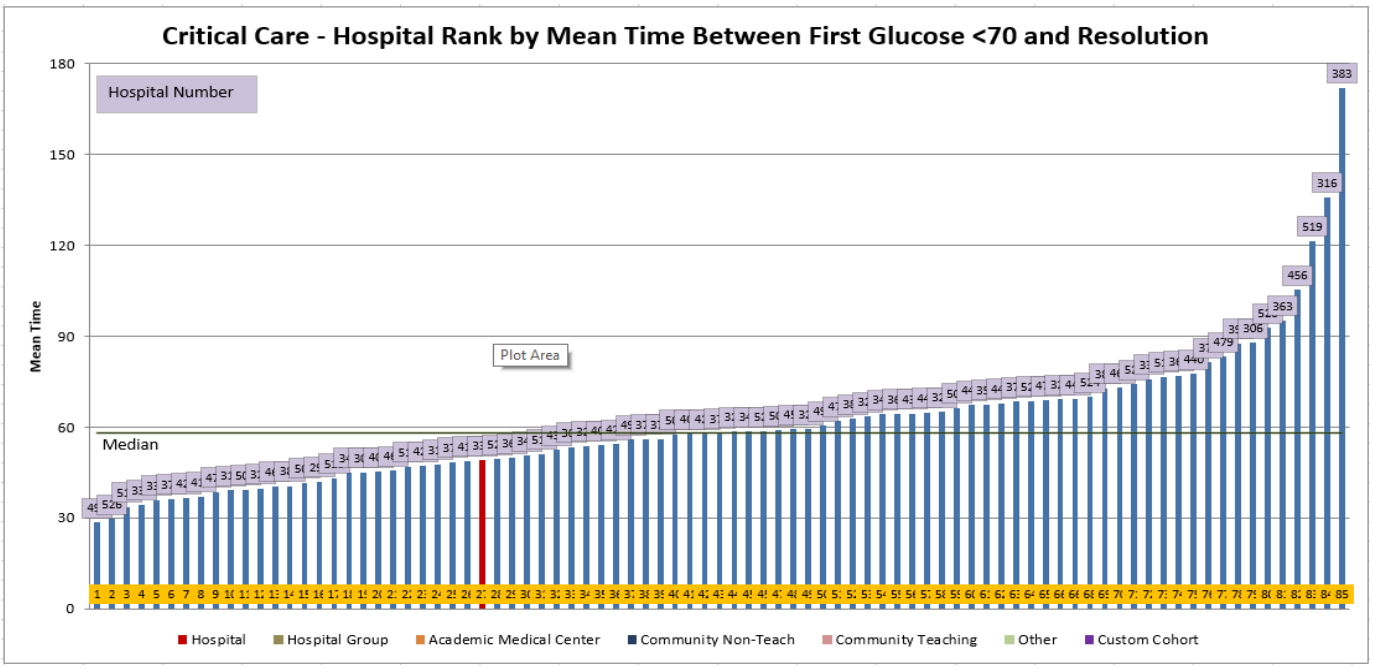
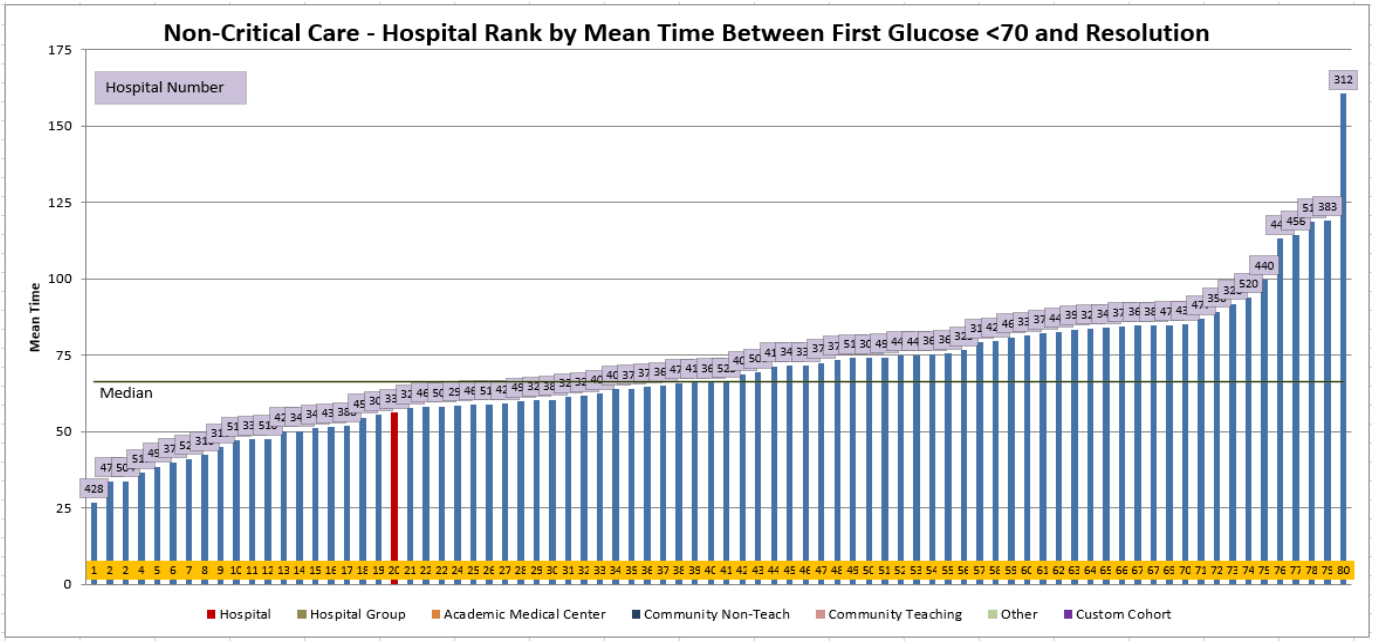


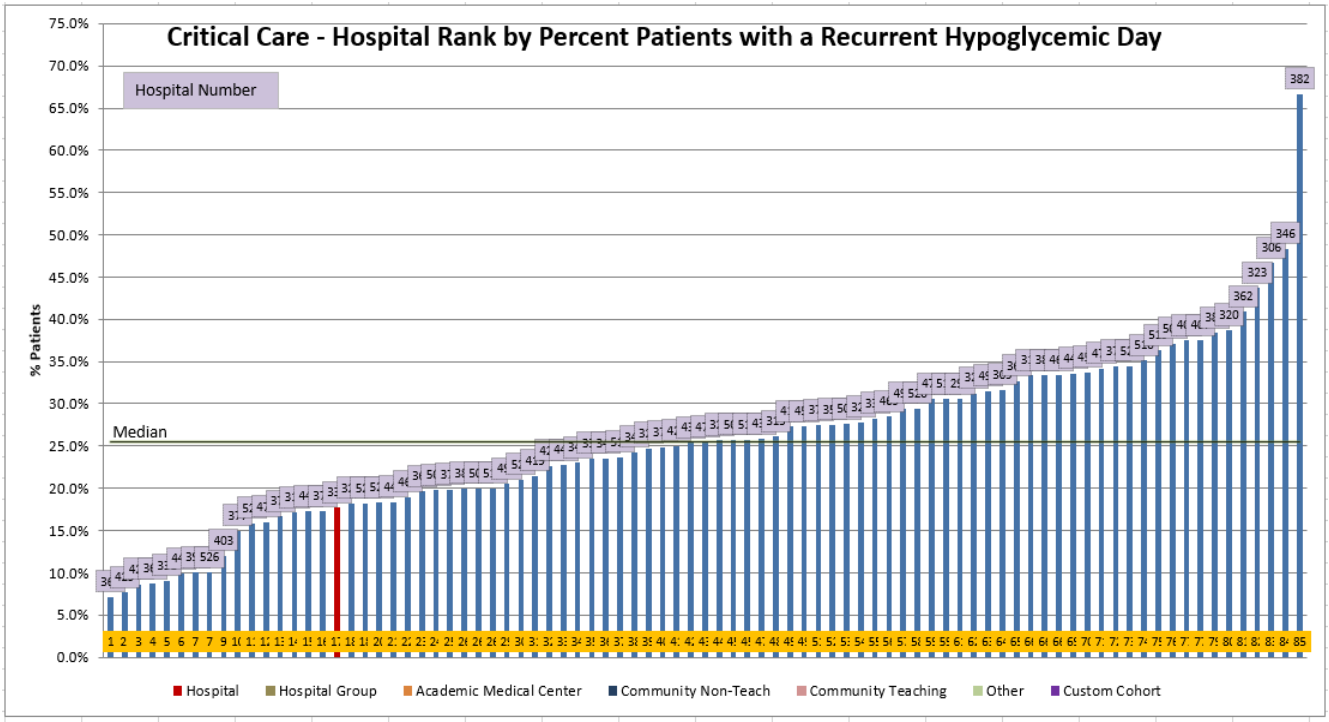
Chart 6 – SHM Report (May 2023-October 2023) for Non-Critical Care Units

Kaweah Health time between glucose < 70mg/dL and documented resolution of hypoglycemia for non-critical care is 56.1 minutes. This time is outperforms the top quartile of ≤66.2 minutes, which places NCC in the top decile

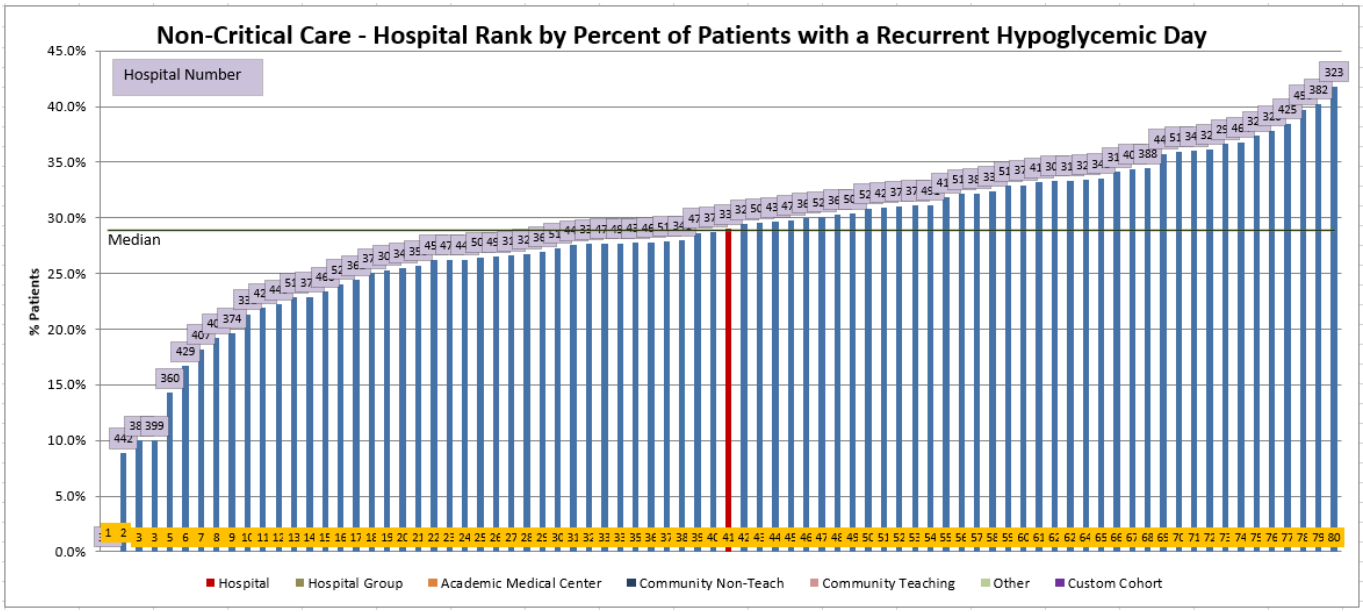


Goal 4: Achieve benchmark performance for percent of patient with hypoglycemia with at least one recurrent hypoglycemic day for CC (chart 7) and NCC patients (chart 8).

✓ Goal Met (chart 7): The percent of CC patients with a recurrent hypoglycemic day is at 17.7%, outperforming the benchmark of 25.5% and placing KH in the top quartile (≤18.9%).



∅ Goal Not Met (chart 8): NCC did not achieve this goal. The percent of patients with a recurrent hypoglycemic day is at 29%, which is just above the benchmark for this SHM measure (28.9%), but NCC improved from the previous reporting interval (30.4%)



Improvement Opportunities Identified:

1. The Advance Nursing Practice Team partners with medical staff to foster collaboration and improvement:
    - Dr. Zhao, as the Diabetes physician champion, continues to make connections with providers both in critical care and med-surg to identify provider needs related to diabetes management.
    - APN invited by individual Hospitalist to provide diabetes and Glucommander™ education every 2-3 weeks.
2. Exploration of structure, function, impact of consult team developed to respond to needs of nursing and medical staff with goals to
    - Improve glycemic management and patient outcomes.
    - Improve knowledge and skillset of nursing, pharmacist and medical staff through education, training, consultative services.
    - Demonstrate return on investment (ROI) through improved throughput, decreased length of stay
        - Inpatient Diabetes Management (IPDM) Nurse Practitioner (NP) continues to devote 3 hours daily to reviewing management of targeted cases, 8-10 new cases daily, maintaining a daily caseload of 25-30 patients.
        - Compiling data for IPDM NP to review potential cost avoidance in the prevention of hypoglycemic events.
        - Continue to meet with Sr. Consultant from Project Management & Consulting and Director of Population Health to develop a strategic business plan for the Inpatient Diabetes Management team
3. The Advance Nursing Practice Team reviews and responds to Adverse Drug Events (ADEs) related to hypoglycemia and Glucommander™ (GM), such as:
    - Transcription errors of GM orders to GM
        - Order integration project is in progress to eliminate need for nursing order re-entry; actively working towards MAR and Order integration with Glytec team; Go-Live anticipated April 2024
    - Recommendation for Inpatient Diabetes Management Team referral for recurrent hypoglycemia or persistent hyperglycemia or previous history.
4. Inpatient Glycemic Management team (APN and Endocrinologist)
    - No inpatient Endocrinologist will be available after March 2024 (Dr. Saif will no longer be at KH)
    - Help to optimize the difficult to manage patients (i.e. Renal, recurrent hypoglycemia, insulin resistant, steroid-induced hyperglycemia) using a non-GM power plan started in February 2024.
    - Reduce rates of inpatient hypoglycemia/hyperglycemia to or below SHM benchmark. Improve efficiency of progression to goal. Goal: change of 10% if not meeting benchmark numbers beginning Spring 2024.
    - Partnered with Glytec, Dr. Zhao and KH team to review transition from IV to SQ insulin to optimize patient glycemic control. Decision made to transition to SQ using the once per day option of day 1 transition.

- Regular meetings with KH ISS, clinical education, Glytec to implement/transition to the GM upgrade scheduled for April 2024 (3.5.3.0)

Submitted by: **Date Submitted:** March 25, 2024

Emma Camarena, DNP, RN, ACCNS-AG, CCRN
Director of Nursing Practice

Cody Ericson MSN, RN, FNP, CCRN
Advanced Practice Nurse-Critical Care Services

Dr. Lu Zhao, DO
Critical Care Pulmonary & Adult Hospital Medicine
Diabetes Physician Champion

RRT/Code Blue QCOMM Report

Q4 2024

Shannon Cauthen

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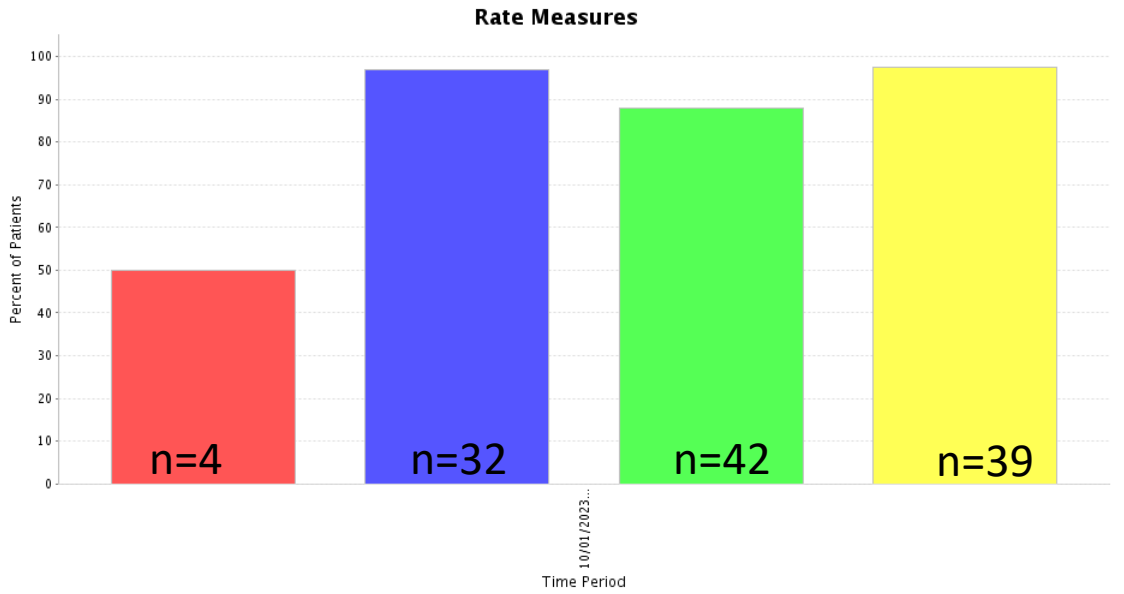
Get With the Guidelines

Q4 2023 (July-September)



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RRT and Resuscitation Scorecard

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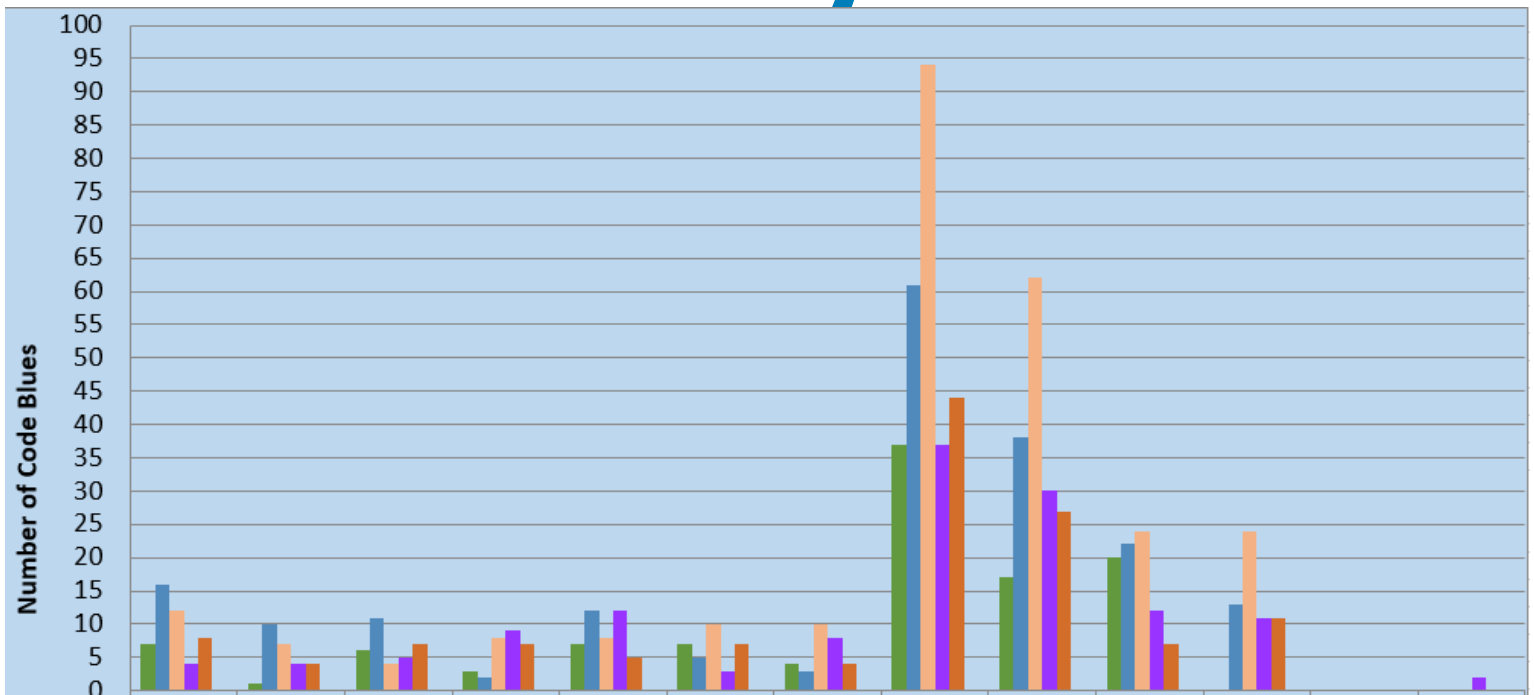
RRT Resuscitation Quality Scorecard

	Hospitals (External Benchmark) ALL GWTG	CY 2022 Baseline Mean	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Mean (Rolling 12 months)
Code Blue Data															
Total Code Blues (Med/Surg/ICCU/CC)		12	14	14	13	9	2	14	7	9	9	7	11	21	11
Total COVID-19 Positive Code Blues		2	4	1	0	0	0	0	0	0	0	0	0	0	0
Code Blues per 1000 Discharges Med Surg/ICCU		5	3	4	7	3	0	6	3	2	3	4	3	9	4
Code Blues per 1000 Discharges Critical Care		4	8	9	3	5	2	6	2	5	4	2	5	7	5
Percent of Codes in Critical Care	66% (↑ is better)	49%	71%	71%	29%	67%	100%	50%	43%	67%	56%	29%	64%	43%	58%
Event Survival Rates			57%	71%	43%	33%	100%	79%	71%	44%	56%	57%	73%	67%	63%
Code Blue: Survival to Discharge	20% (↑ is better)	22%	14%	0%	14%	0%	100%	21%	14%	33%	56%	14%	9%	10%	24%
Deaths from Cardiac Arrest (expired during event)		4	8	4	8	6	0	3	2	5	4	3	3	7	4
Overall Hospital Mortality Rate		2.87	3.54	3.2	2.29	2.84	2.47	2.85	1.9	1.79	2.69	2.45	3.09	3.25	2.70
RRT Data			**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Mean**
Total RRTS		108	121	96	133	104	102	90	125	103	87	115	119	128	110
RRTs per 1000 Patient Discharge Days		86	98	87	100	88	81	71	98	79	71	100	93	99	89
RRT Mortality	21% (↓ is better)	19%	22% n=27	17% n=16	17% n=22	16% n=17	15% n=15	24% n=22	13% n=16	17% n=17	13% n=11	23% n=25	22% n=23	24% n=29	19%
RRTs Within 24 hours of Arriving to Inpatient Unit	15% (↓ is better)	21%	26% n=31	24% n=23	26% n=35	24% n=25	28% n=29	36% n=32	26% n=32	30% n=31	25% n=22	26% n=30	23% n=27	25% n=32	27%
RRT- Med-Surg to Intermediate Critical Care Transfers	*9%	17%	14% n=17	24% n=23	23% n=30	27% n=28	18% n=18	22% n=20	22% n=27	22% n=23	20% n=17	23% n=26	13% n=16	21% n=27	21%
RRT- Med-Surg to Critical Care Transfers	*29%	10%	9% n=11	1% n=1	10% n=13	7% n=7	17% n=17	10% n=9	12% n=15	9% n=9	11% n=10	7% n=8	11% n=13	6% n=8	9%
RRT-Intermediate Critical Care Transfers to Critical Care	*32%	7%	10% n=12	8% n=8	9% n=12	5% n=5	10% n=10	6% n=5	6% n=8	9% n=9	14% n=12	12% n=14	6% n=7	9% n=12	9%

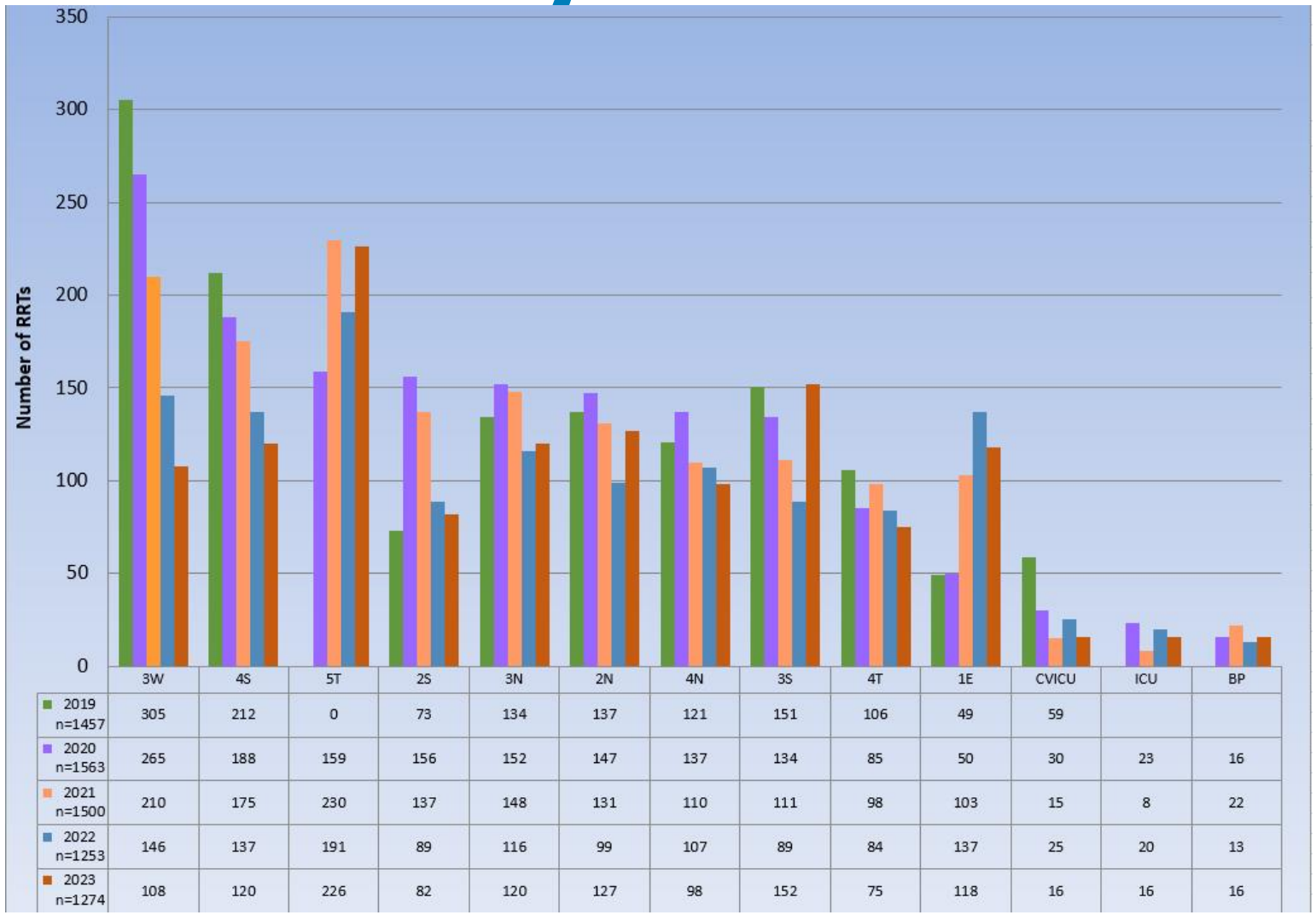
Better than Target
Does not meet Target
*Target Goal not Being Established

Code Blues by Location



	2N	2S	3N	3S	4N	4S	4T	ICU	CVICU	3W	5T	BP	1E
2019 n=115	7	1	6	3	7	7	4	37	17	20	0	0	0
2020 n=200	16	10	11	2	12	5	3	61	38	22	13	0	0
2021 n=263	12	7	4	8	8	10	10	94	62	24	24	0	0
2022 n=137	4	4	5	9	12	3	8	37	30	12	11	0	2
2023 n=131	8	4	7	7	5	7	4	44	27	7	11	0	0
2024 n=0	0	0	0	0	0	0	0	0	0	0	0	0	0

RRTs by Location



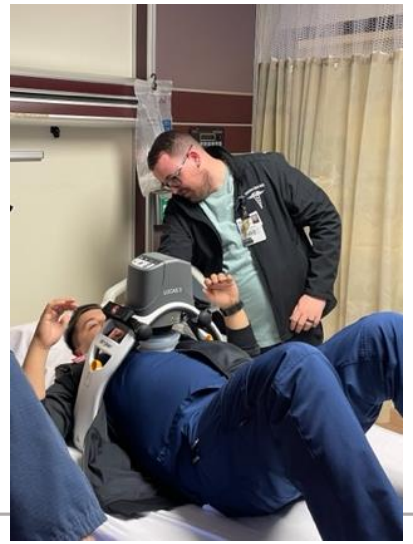
	3W	4S	5T	2S	3N	2N	4N	3S	4T	1E	CVICU	ICU	BP
2019 n=1457	305	212	0	73	134	137	121	151	106	49	59		
2020 n=1563	265	188	159	156	152	147	137	134	85	50	30	23	16
2021 n=1500	210	175	230	137	148	131	110	111	98	103	15	8	22
2022 n=1253	146	137	191	89	116	99	107	89	84	137	25	20	13
2023 n=1274	108	120	226	82	120	127	98	152	75	118	16	16	16

2023 Projects

-Sidewalk CPR (June 2023)
-LUCAS (CPR Device) Implementation (August 2023)
-Mock Code Blue Program (October 2023)

2023 Projects

American Heart Association.
2023
GET WITH THE GUIDELINES.
SILVER
RESUSCITATION



Kaweah Health
MORE THAN MEDICINE. LIFE.

2023 Projects

Kaweah Health
MORE THAN MEDICINE. LIFE.

2024 Next Steps

-Foster relationship building between new RRT nurses and floor staff
-Revise ICCU Admission Criteria- vetting by Medical Staff
-Continue Mock Code Blue program and grow as able ($)
-Continue community engagement
-Await eligibility confirmation for Gold Award from AHA
-Improve patient outcomes

Abby, daughter of ICU BSM, after attending Sidewalk CPR

The pursuit of healthiness

Kaweah Health
MORE THAN MEDICINE. LIFE.

Unit/Department:
Home Health

ProStaff/QIC Report Date:
February 2024

Data for this report was obtained from two sources, the *Star Report* on the *Care Compare* website, the Centers for Medicare & Medicaid Services (CMS) platform for which quality measures are publicly reported for home health agencies. Currently, the January 2024 refresh on *Care Compare* reflects data from April 1, 2022 thru March 31, 2023. Kaweah Health Home Health is at an overall 3-Star rating, out of a 5-Star rating system.

And, in order to review *real time data* for analysis that reflects the outcomes of the current interventions in place, Strategic Healthcare Programs (SHP), a web-based program that analyzes the Outcome and Assessment Information Set (OASIS*) submitted to CMS monthly, was evaluated.

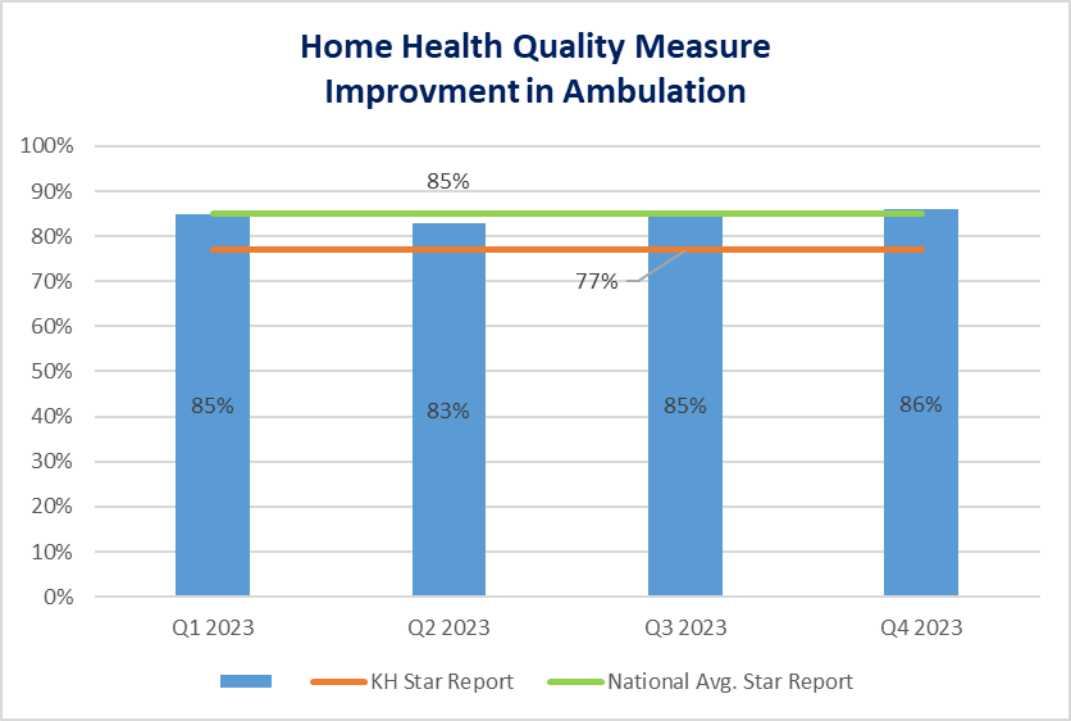
OASIS is a data collection tool that all Medicare-certified home health agencies are required to collect and transmit to CMS for all patients whose care is reimbursed by Medicare and Medicaid.

Measure Description:
"How often patients got better at walking or moving around"

--Home Health Clinicians (registered nurses, physical therapists) complete OASIS data upon a patient's admission to home health. Clinicians must assess the patient's ability to walk SAFELY on a variety of surfaces using a 6-point scale; ranging from 0-independent to 6-bedfast. At discharge, the patient's ability is reassessed. If a patient is assessed to be at the same level, they are considered *stabilized*. "Stabilized" is counted as a negative outcome for this measure. Patients who are assessed to have *less ability* to walk safely at discharge, are considered to have *deteriorated*, also a negative outcome. Patients assessed to be independent upon admission and remain independent upon discharge are not counted as a negative outcome in this measure.

Measure Objective/Goal:
Improvement in Ambulation/Locomotion

- **CMS Star Report January 2024: KH HH 77%, National avg. 85%**



**Higher percentages are better for this measure. Graph depicts the most recent data in individual quarters to accurately assess response to most recent performance improvement interventions and guide upcoming action plans.*

Date range of data evaluated: *(indicated in graph above)*

- **Star Report January 2024: April 1, 2022 to March 31, 2023; avg. KH HH 77%, National Average 85%**
- **SHP data; January 1, 2023 to December 31, 2023; avg. 84%**

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

Opportunity for improvement in this area existed and a multifocal plan was executed that included two additional outcome measures; *Improvement in Bathing* and *Improvement in Oral Medications* to help ensure overall *Outstanding Community Health* consistent with Kaweah Health District Pillar.

--Clinician barriers to completing an accurate assessment vary from home to home; home environment may include clutter, pets, patient may have draining wounds, tubing from oxygen, lack of equipment to help with mobility and function, and clinician understanding of ability vs *safe ability* when performing their activities of daily living.

--Charting fatigue and over estimation of patient ability is reported by clinicians as reason for inconsistencies in scoring OASIS ambulation data accurately.

--SHP, home health OASIS scrubber tool that checks for inconsistencies in the various areas assessed upon admission, is being underutilized by field clinicians prior to submission of OASIS documentation.

<u>If improvement opportunities identified, provide action plan and expected resolution date:</u>
Our interventions are reflecting a positive upward trend towards our goals. However, the National Average also increased during this time period. Opportunity for improvement continues to exist in this area to ensure we reach our goal of meeting, and *exceeding* the National Average. The following plan of action shall be implemented;
--Clinicians will be provided with early feedback on their OASIS scoring of functional assessment to ensure accurate capture of patient's ability and appropriateness for home health services.
--Encourage clinicians to utilize the 5 day rule and reach out to the next clinician who sees patient within the assessment time frame. CMS encourages a collaboration between all clinicians who assessed a patient within 5 days of the first OASIS assessment. This ensures an accurate capture of a patient's need and the opportunity to provide the resources needed to help achieve *Outstanding Community Health* consistent with the Kaweah Health District pillar.
--Educator and Intake Utilization RN will perform daily audits of clinician charting, and identify OASIS inconsistencies and provide immediate feedback to clinician.
--Educator will meet with Intake Utilization RN, to provide feedback on OASIS inconsistencies and identify trends.
--All staff meeting in March 2024, educator will review use of SHP when completing OASIS, to ensure all staff are following best practice to reduce any inconsistencies prior to OASIS submission. Educator will review report of staff who are using SHP and meet one-on-one with staff who need additional education.

<u>Next Steps/Recommendations/Outcomes:</u>
Educator and RN Intake Auditor will perform chart audits to monitor the effectiveness of these interventions. Educator will report current SHP data along with these findings, including any identifiable trends to Home Health Manager at least every 30 days. Educator will analyze OASIS outcome data reports for this measure quarterly and report to Home Health Manager and Director. Educator and Home Health Manager will modify interventions until we meet, or exceed, the national average for three or more quarters.

<u>Submitted by Name:</u>
Shannon Esparza, RN

<u>Date Submitted:</u>
February 29, 2024

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department:
Home Health

ProStaff/QIC Report Date:
February 2024

Data for this report was obtained from two sources, the *Star Report* on the *Care Compare* website, the Centers for Medicare & Medicaid Services (CMS) platform for which quality measures are publicly reported for home health agencies. Currently, the January 2024 refresh on *Care Compare* reflects data from April 1, 2022 thru March 31, 2023. Kaweah Health Home Health is at an overall 3-Star rating, out of a 5-Star rating system.

And, in order to review *real time data* for analysis that reflects the outcomes of the current interventions in place, Strategic Healthcare Programs (SHP), a web-based program that analyzes the Outcome and Assessment Information Set (OASIS*) submitted to CMS monthly, was evaluated.

> ***OASIS is a data collection tool that all Medicare-certified home health agencies are required to collect and transmit to CMS for all patients whose care is reimbursed by Medicare and Medicaid.***

Measure Description:

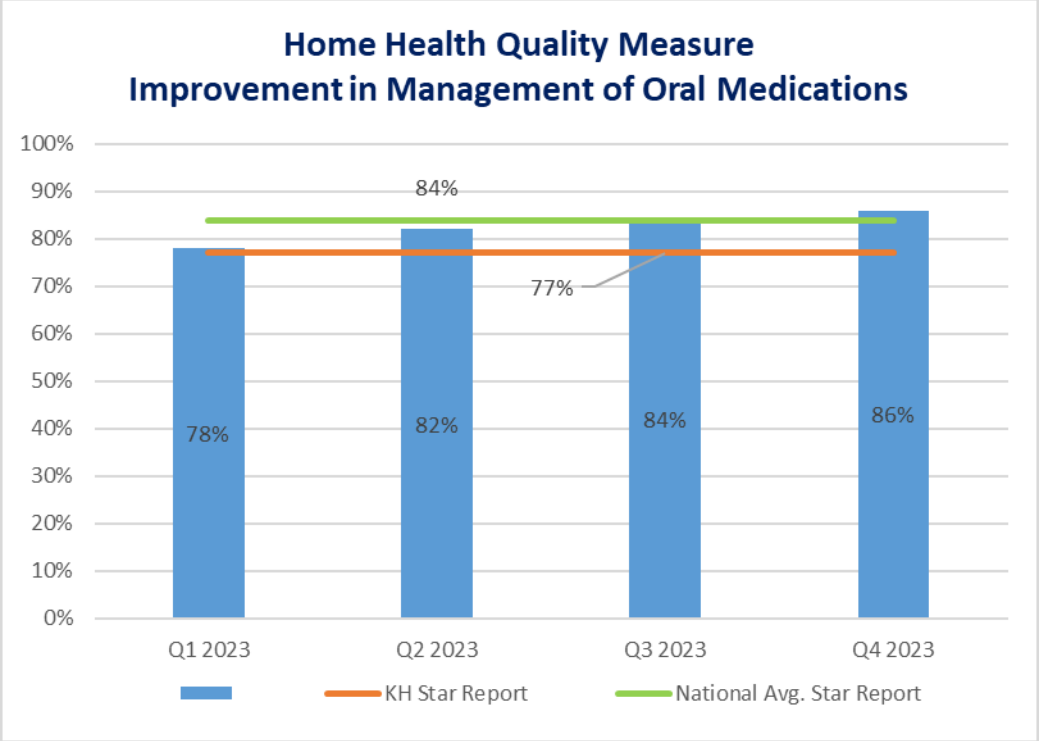
"How often patients got better at taking their drugs correctly by mouth"

--Home Health Clinicians, i.e. registered nurses and physical therapists, assess the patient's ability to take all oral medications *reliably* and *safely* upon admission to home health. At discharge, the same assessment is performed. If a patient is assessed to be at the same level at discharge as they were at admission, they are considered to have *stabilized* in their medication regime. "Stabilized" is counted as a *negative* outcome for this measure. Patients who are assessed to require more assistance at discharge are considered to have *deteriorated* in their ability, also a negative outcome for this measure. Patients assessed to be independent upon admission and remain independent upon discharge, or who do not take any oral medications are not counted in this measure.

Measure Objective/Goal:

Improvement in Management of Oral Medications

- **CMS Star Report January 2024: KH HH 77%, National Average 84%**



**Higher percentages are better for this measure. Graph depicts the most recent data in individual quarters to accurately assess response to most recent performance improvement interventions and guide upcoming action plans.*

Date range of data evaluated: *(indicated in graph above)*

- **Star Report January 2024: April 1, 2022 to March 31, 2023; avg. KH HH 77%, National Average 84%**
- **SHP data; January 1, 2023 to December 31, 2023; avg. 83%**

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

-- Assessment includes the ability to self-administer the correct medication, the correct dosage, at the prescribed frequency via the prescribed route

--Clinicians must differentiate the patient's ability to perform the steps in this measure *independently* versus the *level of family/caregiver assistance* needed with medication regimen.

--Patient's *ability t*o obtain the medication from where it is routinely stored, accurately read the label or identify medication by placing a character on label, open the container and remove the correct dosage at the appropriate time and frequency, is evaluated.
--OASIS guidance requires the clinician consider a patient's ambulatory/functional ability to meet this task.
--Medical record review noted inconsistencies with clinicians scoring the patients' ability to obtain their oral medication higher than they assessed their ability to ambulate. Ambulation is an essential part of this measure due to the need to gather all medications to administer and must be considered per CMS guidance.
--Educator reviewed with clinicians whose assessments displayed inconsistencies in scoring medication regime ability and functional ability to provide immediate feedback.
--Opportunity for directed teaching based on various scenarios clinicians may encounter when observing a patient in their home environment was presented and discussed in a staff meeting in Fall 2023 with all clinicians who complete OASIS assessments.
--Cognitive ability can impact patient's ability to safely manage medications.
--Clinicians report hesitancy to consider a patient to have a higher level of need for assistance with oral medications when there is no caregiver to assist with administration.

<u>If improvement opportunities identified, provide action plan and expected resolution date:</u>
Our interventions are reflecting a positive upward trend towards our goals. However, the National Average also increased during this time period. Opportunity for improvement continues to exist in this area to ensure we reach our goal of meeting, and *exceeding* the National Average. The following plan of action shall be implemented;
--Educator and Intake RN auditor will review data from clinician charting and OASIS for inconsistencies and meet with clinician to provide immediate feedback.
--Encourage collaboration when multiple disciplines/services lines are caring for a patient to ensure clinicians utilize the "5 Day Rule" allowed by CMS. CMS encourages collaboration between all clinicians who assessed a patient, within 5 days of the first OASIS assessment to ensure positive outcomes for all patients.

This will ensure accurate capture of a patient's need and the opportunity to provide the resources needed to help achieve *Outstanding Community Health* consistent with the Kaweah Health District pillar.

Next Steps/Recommendations/Outcomes:

Educator and RN Intake Auditor will monitor the effectiveness of these interventions weekly during chart audits. Educator will report these findings along with trends to Home Health Manager at least every 30 days. Educator will analyze OASIS outcome data reports for this measure quarterly and report to Home Health Manager and Director. Educator and Home Health Manager will modify interventions until we meet, or exceed, the national average for three or more quarters.

Submitted by Name:
Shannon Esparza, RN

Date Submitted:
February 29, 2023

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

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

Home Health **February 2024**

Data for this report is obtained from the *Star Report* on the *Care Compare* website, the Centers for Medicare & Medicaid Services (CMS) platform for which quality measures are publicly reported for home health agencies. Currently, the January 2024 refresh on *Care Compare* reflects data from April 1, 2022 thru March 31, 2023. Kaweah Health Home Health is at an overall 3-Star rating, out of a 5-Star rating system.

In order to show real time data and ensure the most current data for analysis, Strategic Healthcare Programs (SHP), a web-based program that analyzes the Outcome and Assessment Information Set (OASIS) submitted to CMS monthly, was evaluated.

OASIS is a data collection tool that all Medicare-certified home health agencies are required to collect and transmit to CMS for all patients whose care is reimbursed by Medicare and Medicaid.

Measure Description:

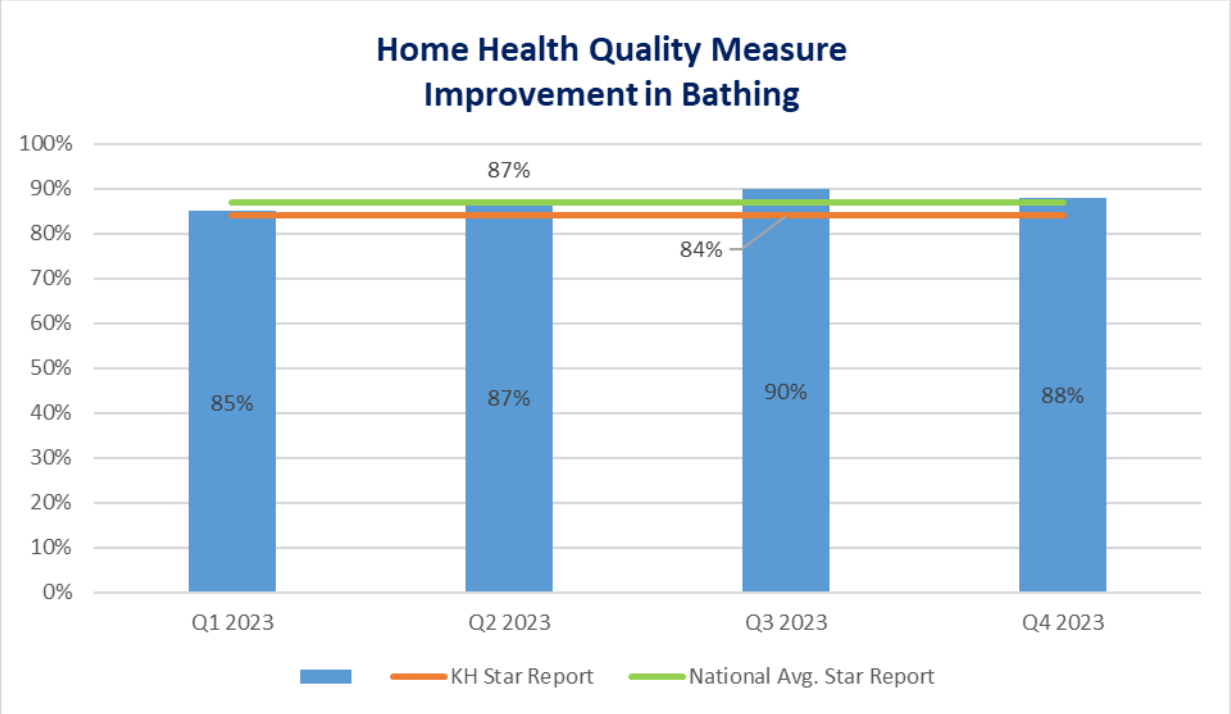
"How often patients got better at bathing"

--Clinicians (registered nurses, physical therapists) complete OASIS data upon a patient's admission to home health. A patient's current ability to bathe entire body and what level of assistance may be required to *safely* bath including *transferring in/out of the tub/shower*, is measured upon admission to home health using a 6-pt-scale. The 6-point bathing scale represents the most independent level first, then proceeds to the most dependent. At discharge, this ability is again measured using the same scale. If a patient is assessed to be at the same level, they are considered *stabilized*. "Stabilized" is counted as a negative outcome for this measure. Patients who are assessed to have *less ability* to bathe their entire body safely at discharge, are considered to have *deteriorated*, also a negative outcome. Patients assessed to be independent in bathing upon admission and again at discharge are not counted in this measure.

Measure Objective/Goal:

Improvement in Bathing

- **CMS Star Report July 2023: KH HH 83%, National Average 86%**



**Higher percentages are better for this measure. Graph depicts the most recent data in individual quarters to accurately assess response to previous interventions and guide upcoming action plan.*

Date range of data evaluated: *(indicated in graph above)*

- **Star Report January 2024: April 1, 2022 to March 31, 2023; avg. KH HH 84%, National Average 87%**
- **SHP data; January 1, 2023 to December 31, 2023; avg. 89%**

Analysis of all measures/data: (Include key findings, improvements, opportunities)
--Clinicians must assess the patient's ability to bathe the entire body and the assistance that may be required to *safely* bathe, including transferring in/out of the tub/shower.
--Adaptive methods, assistive devices, and MD ordered restrictions need to be communicated to the first clinician assessing the patient to ensure an accurate scoring of patient ability.

--Clinicians must utilize their professional, clinical judgement when determining what level the patient can perform the task *safely,* not just simply complete the activity*.*
-- CMS guidance stresses the importance of considering mental/emotional/cognitive status when assessing this measure.
----Opportunity for directed teaching based on various scenarios clinicians may encounter when observing a patient in their home environment was presented and discussed in a staff meeting in Fall 2023 with all clinicians who complete OASIS assessments.

<u>If improvement opportunities identified, provide action plan and expected resolution date:</u>
Our interventions are reflecting a positive upward trend towards our goals. However, the National Average also increased during this time period. Opportunity for improvement continues to exist in this area to ensure we reach our goal of meeting, and *exceeding* the National Average. The following plan of action shall be implemented;
--Educator and Intake RN will review data from clinician charting and OASIS for inconsistencies and meet with clinician to provide immediate feedback.
--Clinicians will utilize the "5 Day Rule" allowed by CMS. CMS encourages a collaboration between all clinicians who assessed a patient within 5 days of the first OASIS assessment. This will ensure accurate capture of a patient's need and the opportunity to provide the resources needed to help achieve *Outstanding Community Health* consistent with the Kaweah Health District pillar.
--Ongoing OASIS education at the individual and group level via staff meetings and email to ensure

<u>Next Steps/Recommendations/Outcomes:</u>
Educator and RN Intake Auditor will monitor the effectiveness of these interventions weekly during chart audits. Educator will report these findings along with trends to Home Health Manager at least every 30 days. Educator will analyze OASIS outcome data reports for this measure quarterly and report to Home Health Manager and Director. Educator and Home Health Manager will modify interventions until we meet, or exceed, the national average for three or more quarters.

<u>Submitted by Name:</u>
Shannon Esparza, RN

<u>Date Submitted:</u>
February 29, 2024

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: **Hospice**

Date submitted: **April 2024**

Measure Objective/Goal:

To ensure that safety and support are paramount for patients discharged live from Hospice and for families of patients who expired while on Kaweah Health Hospice through the Kaweah Health Hospice bereavement program.

Date range of data evaluated:

November 1, 2023 through February 29, 2024

--With regard to bereavement, data is gathered from the Hospice EMR, Crescendo, which was implemented on November 1, 2023. The designated family member of an expired patient is contacted shortly after the death to determine if they are accepting of bereavement services. If they are, they are enrolled in the Bereavement program in Crescendo and periodic phone calls and mailers are provided to the bereaved. In addition, they are made aware of grief support groups and special programs that take place throughout the year to support the loved ones. Reports are available to staff through the Crescendo reporting platform to audit patients in the bereavement program.

Information for contacting the primary caregiver after death is to be collected by the Hospice nurse at the time of admission. This information must be complete and include the name, address and phone number. It was determined that there were issues with this information being collected accurately and completely. This caused delays with being able to reach the caregiver or provide bereavement services.

As for live discharges, a report can be obtained from Crescendo, which outlines all patients that were live discharges from Kaweah Health Hospice. Unless transferred to another hospice or a revocation, the primary care physician of the patient shall be notified of the discharge and transfer to their care and a discharge summary sent upon request. The lack of this being sent was a Joint Commission finding on the most recent survey. This was corrected. It is most recently noted there has been a decline again in this happening. Therefore, ongoing attention is required.

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

--Current data from the date range obtained from audits/reports from Crescendo shows that of 124 discharges from Hospice due to death, 5 refused bereavement services. Of the 119 that accepted services, 20 patients (17%) had incorrect or incomplete primary

caregiver information collected by Hospice staff during admission. The lack of incorrect information can lead to delays in bereavement support at the least or lack of services at the worst. To help prevent this, extra work is required of the bereavement coordinator and office staff to attempt to locate and contact the bereaved.

As for live discharges, it was recently discovered through an audit that upon moving to the new EMR, there was a drastic decrease in documentation of proper discharge procedures, including notifying the new primary care physician of the discharge and a discharge summary available. This had been built into the old Hospice EMR, Suncoast, but not in Crescendo, which was an oversight. The lack of this meant it did not trigger a reminder to staff. There is a very good possibility this was happening, as most of these patients were pediatric patients, and great care is taken in the transfer of care. However, without proper documentation, this cannot be substantiated. In the most recent audit conducted in March 2024, of the 8 live discharges meeting criteria, none had proper and complete documentation. This is not only a regulatory issue, but could be a patient safety issue.

<u>If improvement opportunities identified, provide action plan and expected resolution date:</u>
There is opportunity for improvement in this area and we want to ensure longevity in this success. Therefore, the following plan of action continue to be implemented:

--A "Primary Caregiver" form has been created and shall be completed by the admitting hospice nurse on every admission.
--The Hospice intake RN shall audit all admission paperwork to ensure the Primary Caregiver form is complete with name, address and phone number. This shall then be scanned into the EMR.
--A template will be created in Crescendo for all discharges that prompts the discharge nurse of all requirements for the discharge, including notification of physician assuming care and the availability of a discharge summary upon request.
--Education shall be provided to all nursing staff regarding proper completion of this form as well as proper discharge procedure and documentation for all live discharges, except for revocation or transfer to another hospice.
--Reinforcement of these initiatives will take place at every Hospice skilled nursing meeting.

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

With the interventions implemented as outlined above, we shall continue to monitor and analyze internal Hospice audits and reports from Crescendo. Audits will be done monthly

and targeted education shall be provided to those nurses not in compliance. The goal for both items that contribute to this shall be 100%.

Submitted by Name:
Tiffany Bullock, Director
Kaweah Health Hospice

Date Submitted:
April 2024

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: **Hospice**

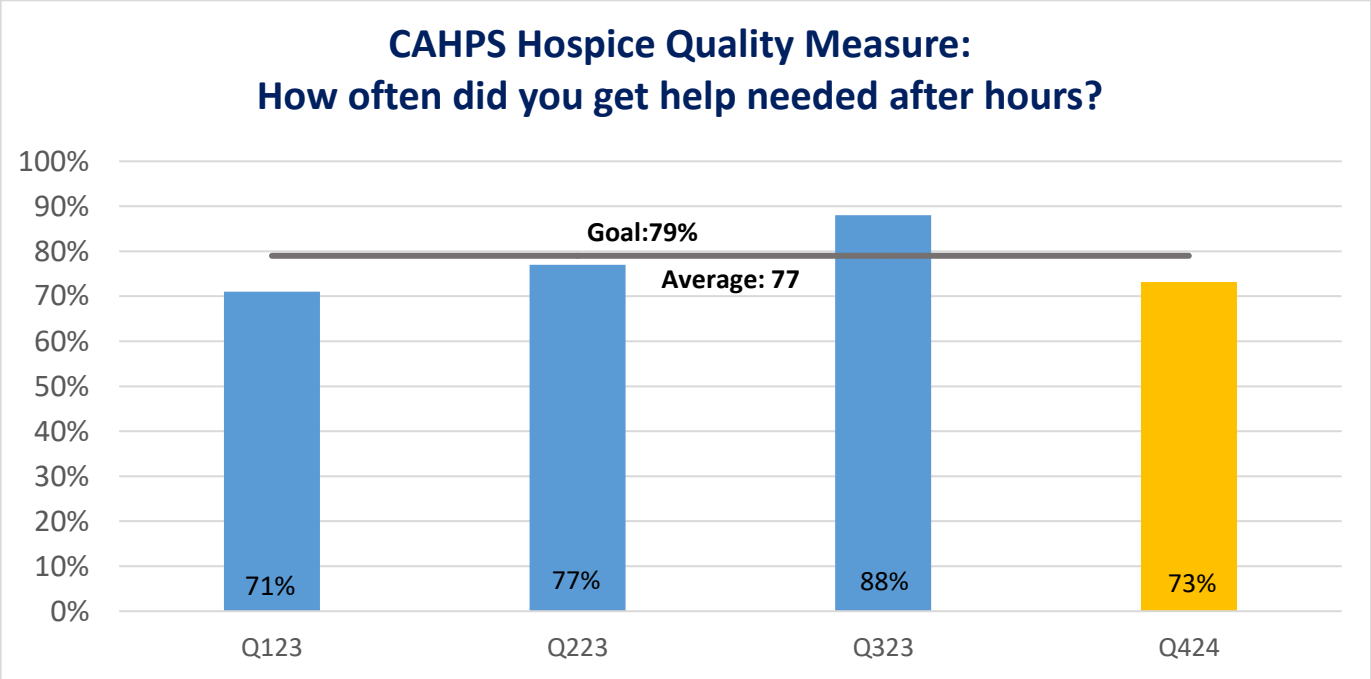
Date Submitted: **April 2024**

Kaweah Health Hospice utilizes NRC, a CMS approved third party vendor for distribution of satisfaction surveys and reporting of results. When calculating, an average of the last 4 quarters was used. By utilizing this data, the results have more current, relevant and detailed data than that reported by CMS on Hospice Compare. This information from NRC will eventually be submitted to CMS and will be publicly reported.

Measure Objective/Goal:

How often did you get help needed after hours?

- **Average of Quarters January 1, 2023-December 31, 2023: 77%**



Date range of data evaluated:

January 1, 2023-December 31, 2023

-- Data is gathered from the surveys administered by a third party vendor, as part of the Hospice CAHPS survey. Hospices are required to participate in these surveys, which measures caregiver satisfaction. Information is then submitted to CMS by the third party vendor.

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

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

-- Current data from the date range shows an average score on this initiative of 77%. While the NRC benchmark is 76% and we exceed this, the decision was made to continue to focus on this initiative due to a slight drop from the last reporting period of 2%. The goal had been 79%. In addition, there was a 15-point drop from Q3 2023 (right after the initiative) to Q4 2023. This means we have not met full sustainability of this initiative. The ability for families/patients in hospice to reach an on call nurse is crucial. We want to ensure sustainability of this and initiate action immediately.

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

There is opportunity for improvement in this area. The following plan of action shall be implemented/continued:

--Reinforce to hospice nurses the importance of timely returning calls. Ensure weekend nurse utilizes back up nurse for triaging calls if nurse is busy and return calls could be delayed.

--The recent hiring of LVNs who aide in taking calls on weekends should assist with success of this initiative. They have already been trained and are taking shifts.

-- Reinforcement of these initiatives will take place at every Hospice skilled nursing meeting.

Next Steps/Recommendations/Outcomes:

Once initiatives are implemented, we shall continue to monitor and analyze vendor data over next 4 quarters. Due to the lag time in these reports (approximately 6 months), it may take at least 4 quarters before results of the above-outlined plan are shown. The goal will be 79%.

Submitted by Name:
Tiffany Bullock, Director
Kaweah Health Hospice

Date Submitted:
April 2024

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

Mental Health Department Specific Data Collection Summarization

Quality Committee

Unit/Department: Department of Psychiatry/Mental Health Hospital Report Date: 2/20/24

Measure Objective/Goal:

HBIPS- Hospital Based Inpatient Psychiatric Services Measures:

Kaweah Health

Quality Dashboard

Hospital-Bases Inpatient Psychiatirc Services Measures: (Care Compare)
M.Quinonez Director of Mental Health Services

Metrics		CMS Benchmark	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23 *	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Total
HBIPS-2a	Physical Restraint-Overall Rate - (hours/days)	0.44 / 0.38*	0.06	0.19	0.42	0.09	1.07	0.55	0.26	0.71	0.30	1.37	0.42	0.86	0.37	0.51
HBIPS-3a	Seclusion-Overall Rate -(hours/days)	0.29 / 0.36*	0.55	0.89	0.59	0.83	1.57	0.52	0.66	2.61	1.07	4.43	10.06	0.89	0.83	1.99
HBIPS-5a	Multiple antipsychotic medications at discharge with appropriate justification - overall rate	65.0% / 62.0%*	75.0% 3/4	100.0% 4/4	100.0% 3/3	100.0% 2/2	100.0% 3/3	100.0% 4/4	100.0% 5/5	100.0% 2/2	100.0% 4/4	83.33% 5/6	100.0% 3/3	100.0% 5/5	85.71% 6/7	94.23% 49/52
SUB-2	Alcohol Use Intervention Provided/Offered	69.92% / 65.00%*	100.0% 10/10	75.0% 6/8	90.0% 9/10	70.0% 7/10	100.0% 8/8	75.0% 6/8	85.71% 6/7	100.0% 9/9	88.89% 8/9	63.64% 7/11	100.0% 10/10	85.71% 6/7	100% 4/4	86.49% 96/111
SUB-2A	Alcohol Use Brief Intervention	61.76% / 76.00%*	60.0% 6/10	57.14% 4/7	50.0% 5/10	40.0% 4/10	50.0% 4/8	50.0% 4/8	57.14% 4/7	88.9% 8/9	55.56% 5/9	36.36% 4/11	70.0% 7/10	57.14% 4/7	100% 4/4	57.27% 63/110
SUB-3	Alcohol/Other Drug Use Tx provided/offerred at D/C	36.00% / 75.00%*	95.46% 21/22	100.0% 21/21	100.0% 24/24	100.0% 26/26	100.0% 23/23	94.12% 16/17	95.83% 23/24	95.65% 22/23	100% 25/25	100% 25/25	96.30% 26/27	100% 25/25	94.44% 17/18	98% 294/300
SUB-3A	Alcohol/Other Drug Use Disorder Tx at D/C	36.00% / 62.00%*	95.46% 21/22	100.0% 21/21	100.0% 24/24	100.0% 26/26	100.0% 23/23	94.12% 16/17	95.83% 23/24	95.65% 22/23	100% 25/25	100% 25/25	96.30% 26/27	100% 25/25	94.44% 17/18	98% 294/300
IMM-2	Influenza Immunization-screening for immunization status	80.89% / 77.00%*	100.0% 51/51	100.0% 53/53	100.0% 53/53	100.0% 53/53	N/C	N/C	N/C	N/C	N/C	N/C	98.11 52/53%	100% 52/52	100% 51/51	99.73% 365/366
TOB-2	Tobacco Cessation FDA Approved Provided during stay	76.62% / 72.00%*	77.27% 17/22	85.00% 17/20	91.30% 21/23	90.91% 20/22	85.71% 24/28	85.71% 18/21	93.75% 15/16	80% 24/30	96.55% 28/29	76.92% 20/26	86.36% 19/22	95% 19/20	96.55% 28/29	87.66% 270/308
TOB-2A	Tobacco Treatment Provided During Stay (Practical Counseling)	41.52% / 42.00%*	22.73% 5/22	35.00% 7/20	17.39% 4/23	27.27% 6/22	21.43% 6/28	33.33% 7/21	37.5% 6/16	36.7% 11/30	62.07% 18/29	34.62% 9/26	27.27% 6/22	15% 3/20	37.93% 11/29	32.14% 99/308
TOB-3	Tobacco Treatment Provided/Offered at Discharge	40.80% / 58.00%*	40.00% 8/20	63.16% 12/19	72.73% 16/22	77.27% 17/22	77.78% 21/27	40.00% 8/20	40.00% 6/15	53.57% 15/28	50% 12/24	45.83% 11/24	65% 13/20	33.33% 6/18	62.96% 17/27	56.64% 162/286
TOB-3A	Tobacco Cessation Medication FDA Approved Provided at Discharge	9.52% / 18.00%*	10.00% 2/20	5.26% 1/19	4.55% 1/22	13.64% 3/22	14.82% 4/27	5.00% 1/20	0% 0/15	0% 0/28	4.17% 1/24	0% 0/24	5% 1/20	0% 0/18	0% 0/27	4.90% 14/286
CT-2	Care Transitions w/specified elements received by discharged patients	30.00% / 67.00%*	79.25% 42/53	83.02% 44/53	75.47% 40/53	92.45% 49/53	92.45% 49/53	92.45% 49/53	81.13% 43/53	84.91% 45/53	75.93 41/54	81.13% 43/53	77.36% 41/53	75.47% 40/53	66.04% 35/53	81.48% 519/637
SMD-1	Screening for Metabolic Disorders	90.00% / 77.00%*	97.44% 38/39	100% 37/37	100% 34/34	100% 39/39	100% 33/33	97.22% 35/36	91.43% 32/35	96.88% 31/32	100% 37/37	97.06% 33/34	94.29% 33/35	92.69% 38/41	97.5% 39/40	97.25% 459/472

Mental Health Department Specific Data Collection Summarization

Quality Committee

Workplace Violence, Seclusion and Restraints:

Kaweah Health
MORE THAN MEDICINE. LIFE.

MENTAL HEALTH QI DASHBOARD: Workplace Violence, Seclusion and Restraints

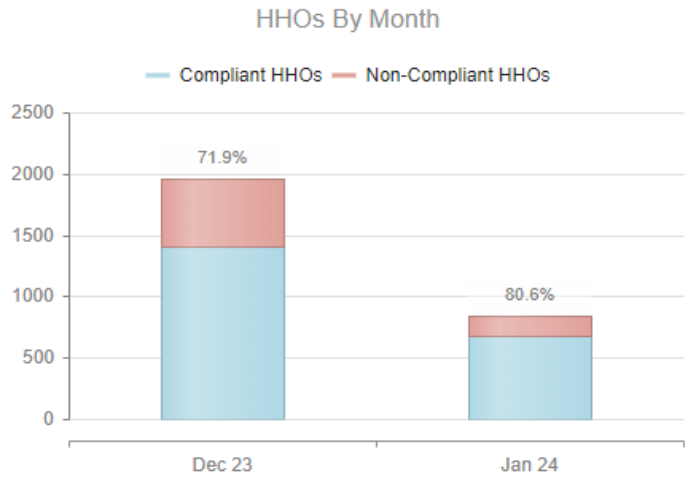
WORKPLACE VIOLENCE FOCUS STUDY August 2023 - July 2024	Target by end of FY24	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Total
VERBAL ABUSE	173	17	31	18	16	12	23							117
NON-VERBAL ABUSE/POSTURING	108	15	28	6	0	0	0							49
ASSAULT: PATIENT-STAFF	94	9	14	11	16	8	22							80
BATTERY: PATIENT-STAFF	32	3	8	1	2	1	2							17
TOTAL NUMBER OF MH WPV EVENTS	207	18	53	27	21	14	25							158
SECLUSION/RESTRAINT FOCUS STUDY	**Target by end of FY24**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Total**
MANUAL HOLD EVENTS	99	8	27	8	5	5	10							63
RESTRAINT EVENTS	68	4	19	7	12	6	12							60
SECLUSION EVENTS	211	16	41	41	16	14	27							155
ASSAULT: PATIENT-PATIENT	28	1	10	2	0	4	2							19
BATTERY: PATIENT-PATIENT	16	0	3	1	1	1	0							6
SELF-ABUSE	40	1	3	2	1	0	3							10

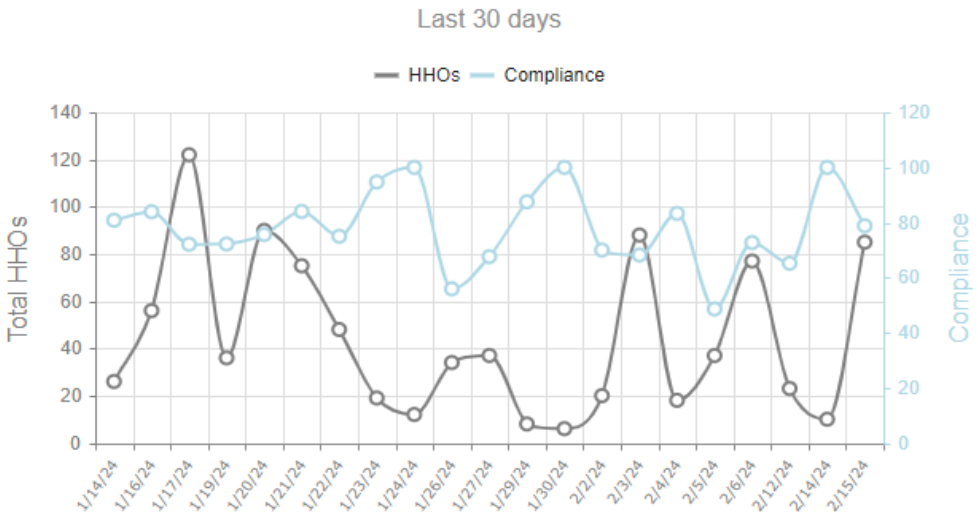
WORKPLACE VIOLENCE FOCUS STUDY August 2022- July 2023	Target	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Total
VERBAL ABUSE	TBD	21	10	10	13	9	11	13	14	37	16	7	32	193
NON-VERBAL ABUSE/POSTURING	TBD	13	8	12	10	8	5	3	5	14	9	4	30	121
ASSAULT: PATIENT-STAFF	TBD	12	7	12	11	1	7	4	5	18	7	7	14	105
BATTERY: PATIENT-STAFF	TBD	6	2	5	2	0	2	3	2	7	6	0	1	36
TOTAL NUMBER OF MH WPV EVENTS	TBD	26	18	16	12	10	12	13	16	41	20	11	35	230
SECLUSION/RESTRAINT FOCUS STUDY	**Target**	**Aug-22**	**Sep-22**	**Oct-22**	**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Total**
MANUAL HOLD EVENTS	TBD	21	9	11	6	2	6	1	4	10	11	6	23	110
RESTRAINT EVENTS	TBD	12	2	4	5	1	4	5	2	17	10	4	10	76
SECLUSION EVENTS	TBD	16	14	23	13	11	21	14	16	36	15	15	41	235
ASSAULT: PATIENT-PATIENT	TBD	5	1	6	2	1	4	0	2	3	1	2	5	32
BATTERY: PATIENT-PATIENT	TBD	2	3	1	1	1	4	0	0	6	0	0	0	18
SELF-ABUSE	TBD	10	3	1	3	1	1	3	1	9	7	3	3	45

Mental Health Department Specific Data Collection Summarization

Quality Committee

Hand Hygiene/Biovigil:





Mental Health Department Specific Data Collection Summarization

Quality Committee

Suicide Risk Rounds:

Suicide Risk Data - Gemba Rounds Results						
*Non-compliance is corrected in the moment during daily rounds, or risk is mitigated by implementing strategies per MH 31.01						
Overall-Acute Psych						
	Question	Qtr 1 2023	Qtr 2 2023	Qtr 3 2023	Qtr 4 2023	Jan-24
1	Columbia Full Assessment done on admission	100% 125/125	100% 778/778	100% 828/828	100% 605/605	100% 243/243
2	C-SSRS shift screen been done every shift (not required at admission)	100% 123/123	99.7% 708/710	100% 718/718	100% 563/563	100% 233/233
3	Room Sweeps completed each shift	100% 125/125	100% 778/778	100% 828/828	100% 605/605	100% 243/243
4	Pt monitored per policy (Q15 minute checks/ 1:1 if applicable)	100% 125/125	100% 778/778	100% 828/828	100% 605/605	100% 243/243
5	Order for No Sharps (no sharps located in patient room)	100% 125/125	100% 778/778	100% 828/828	100% 605/605	100% 243/243
6	Order for Safety Blanket (regular linen/curtains removed from room)	100% 125/125	100% 778/778	100% 828/828	100% 605/605	100% 243/243

Mental Health Department Specific Data Collection Summarization

Quality Committee

Patient Experience:

Kaweah Health
MORE THAN MEDICINE. LIFE.

MENTAL HEALTH QI DASHBOARD: PATIENT EXPERIENCE

Patient Experience Survey	Target	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Total
Total number of surveys completed	n/a	58	59	67	69	58	70	62	72	49	62	50	50	61	787
Did a doctor explain the reason for your admission?	85%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	98.3%	87.0%	93.3%	91.8%	90.0%	93.1%	92.3%
How satisfied were you with the way nurses treated, respected and listed to you?	85%	91.4%	91.5%	93.9%	95.7%	96.5%	91.4%	90.4%	91.6%	89.8%	96.8%	96.0%	86.0%	93.2%	92.6%
How satisfied were you with the way doctors treated, respected and listened to you?	85%	84.5%	76.3%	80.0%	88.4%	94.7%	88.6%	88.8%	86.2%	77.5%	93.5%	96.0%	82.0%	91.7%	86.8%
How satisfied were you with how the nurses explained things to you?	85%	84.5%	88.1%	92.4%	89.8%	96.6%	92.9%	95.1%	90.2%	91.8%	93.5%	94.0%	87.8%	93.2%	91.5%
How satisfied were you with how the doctors explained things to you?	85%	88.0%	84.7%	81.9%	82.6%	94.8%	85.7%	82.3%	87.5%	83.4%	90.4%	90.0%	83.7%	90.6%	86.6%
How satisfied were you with how clean your room and bathroom were?	85%	82.8%	83.0%	77.6%	79.7%	89.6%	85.7%	87.1%	86.1%	87.7%	88.6%	94.0%	72.0%	86.9%	84.7%
How satisfied were you with how quiet your room was at night?	85%	69.0%	69.5%	75.7%	73.9%	87.9%	85.7%	83.9%	83.4%	67.3%	83.6%	86.0%	72.0%	77.0%	78.1%
How satisfied were you with your involvement in discharge planning?	85%	82.8%	83.0%	83.4%	85.5%	91.4%	92.8%	88.7%	85.9%	87.5%	87.0%	90.0%	82.0%	86.8%	86.7%
Did you receive any education on new medication?	85%	85.0%	81.8%	93.0%	90.5%	92.5%	80.3%	89.5%	85.5%	93.8%	94.9%	87.5%	87.5%	93.0%	88.8%

Mental Health Department Specific Data Collection Summarization

Quality Committee

Barcode Medication Administration Compliance:

Date: Feb 16, 2024 13:40 BCMA Compliance Report 1 / 1

Facility	Nurse Unit	Total Medications Given	Medications Scanned	Medications Scanned %	Wristbands Scanned	Wristbands Scanned %
KH Mental Health		**148036**	**143478**	**96.92%**	**137410**	**92.82%**
	KHMH AP	88587	85813	96.87%	81619	92.13%
	KHMH PW	59449	57665	97.00%	55791	93.85%
Grand Total		**148036**	**143478**	**96.92%**	**137410**	**92.82%**

Date range of data evaluated:

HBIPS: December 2022-December 2023
Workplace Violence, Seclusion and Restraint Focus Study: August 2022-January 2024
Hand Hygiene: December 2023-January 2024
Suicide Prevention (Gemba): March 2023-January 2024
Patient Experience: January 2023-January 2024
BCMA: January 2023-January 2024

Analysis of all measures/data:

Meeting target:

- 8 of the 14 HBIPS Measures
- Suicide Prevention Measures
- 7 of the 9 Patient Experience Measures
- BCMA-Barcode Scanning

Opportunities for improvement in the following areas:

- Physical Restraints (HBIPS 2a)
- Seclusion Rate (HBIPS 3a)

- Alcohol Use Brief Intervention (SUB-2a)
- Tobacco Treatment-practical counseling (TOB-2a)
- Tobacco Treatment-offered at discharge (TOB-3)
- Tobacco Treatment-medication at discharge (TOB-3a)
- Workplace Violence, Seclusion and Restraint events
- Hand Hygiene/Biovigil
- Patient Experience: Cleanliness and Quiet Environment
- BCMA-Wristband Scanning

Action plan and expected resolution date:

HBIPS: Alcohol Use Brief Intervention (SUB-2a), Tobacco Treatment-practical counseling (TOB-2a), Tobacco Treatment-offered at discharge (TOB-3), Tobacco Treatment-medication at discharge (TOB-3a)

Alcohol Use Brief Intervention requires a brief intervention to be provided by the admitting nurse for patients that are screened positive for unhealthy alcohol use. Tobacco measures require the patient to be offered practical counseling, cessation medication and an outpatient referral by discharge. *Please note, if patients refuse, this counts as an outlier.

Action Plan:

- We have requested changes to Cerner to eliminate some of the options such as “referral not offered” and referral information given, appointment not made” as these are not valid reasons. Staff will now only have the option to select “referral made” or “refused referral”. In addition, we are revising the workflow related to smoking cessation counseling at discharge. Our PFS team will include smoking cessation referrals as part of their psychosocial assessment. The assessment and referral link is being added to Cerner. Individual staff follow up is completed for all outliers. We have a very high number of patients that refuse medication, counseling/brief interventions and outpatient referrals. We will continue to work on encouraging patients to participate in cessation activities.

Workplace Violence, Seclusion and Restraints:

We have remained consistently above the CMS Benchmark/Joint Commission National Rate for seclusion and restraints for the past year. Seclusion and Restraints are considered a treatment failure and used as a last resort when patients are in imminent danger of harming themselves and/or others and less restrictive interventions have failed. The increase in seclusion and restraints seems to correlate strongly with the workplace violence events.

Mental Health Department Specific Data Collection Summarization

Quality Committee

When analyzing the focus study data, it was found that the same 11 patients make up 65.9% of the events. These patients are long term patients, 8/11 of them are conserved patients. The remaining 3 patients had a history of assault and were discharged back to law enforcement. 31% of our inpatient beds are being filled with conserved patients. Due to the violent and aggressive behaviors displayed by many of these conserved patients, they are difficult to place and their length of stay is ranging from 3 months to a year awaiting long term placement.

Our goal is to decrease seclusion, restraints and workplace violence events by 10% by the end of FY24 and to meet CMS Benchmark for Seclusion and Restraint rates.

Action Plan:

- Mental Health Leadership team developed a small workgroup to explore opportunities for improvement. The team identified 3 root causes: Managing Aggression, Programming and Attentiveness. Our plan was outlined using a DMAIC template and we have begun work on several activities in each of these areas which are reviewed monthly at the Mental Health Workplace Violence Committee meeting.
    - Managing Aggression:
        - Debrief tool developed and implemented, data shared at the monthly Charge Nurse Meeting
        - Explore training modules that may be assigned throughout the year and develop updated psych program curriculum for new psych staff
        - Develop a workplace violence toolkit specific to the Mental Health setting
        - Recovery Principals/Wellness and Recovery Action Plan training
    - Programming:
        - Managing long term patients: Considering separate wing for conserved/long term patients with specialized group programming
        - Revised group schedules, incorporating outside partners (dietary, chaplain, pharmacy, residents) to add variety
    - Attentiveness:
        - Review nursing documentation/standards of care requirements, simplify to allow more direct patient care time
        - Revise Mental Health Worker duties to focus on anticipating patient needs
- Continue Focus Study data collection and analysis
- Workplace Violence Committee: Mental Health Specific WPV Committee began meeting in May 2022
- Review of Seclusion/Restraint/Workplace Violence daily during treatment team huddle at 0930 to allow for changes in plan of care including medication adjustments
- Advanced CPI Training specific to Mental Health Completed in June 2022, Renewals done annually

- Increased Security: Have been working with Security Leadership to ensure adequate coverage at Mental Health, currently there are several open positions and LOA's. Have developed a plan to collaborate with ED leadership and Security Leadership when acuity is high at the MH hospital to re-distribute available resources based on unit needs.
- Work with Tulare County Public Guardian in regards to placement of conserved patients
- The Agitation Behavioral Scale (ABS) was implemented in FY20 to assess the imminent potential for violence. The scale is conducted each shift and as needed and PRN medications are available to be given based on the score.
- Resident project developed to address Anxiety
- Plans have been drawn up to replace the current Nurses Station for staff safety
- Collaborating with Risk Management and Visalia Police Department for coordination of violent and aggressive patients to determine inpatient MH needs vs. need for jail setting
- Environment has been updated with psych safe furniture, positive/calming murals and use of sensory and activities rooms
- Safety Specialist has committed to being stationed at MH on Mondays to run mock code grays / de-escalation drills with staff and to provide feedback and support during actual events. Video review was conducted with Safety Specialist and opportunities for improvement were identified and will be addressed during mock codes and CPI classes. – Currently the safety specialist position is open, however, the drills are continuing
- Restraint and Seclusion Policy review / Annual Competency Modules completed annually
- Implementation of Individualized Patient Behavioral Plans with input from the Treatment Team (case by case)

<u>Hand Hygiene/Biovigil</u>

The Biovigil sensors were installed at the Mental Health Hospital in December 2023. Training modules have been assigned to all staff with an expectation to fully implement by March 1, 2024. There are several staff that have already begun using the system. We have some barriers related to accessing hand sanitizer dispensers and locations of the sensors due to the environment and safety requirements at Mental Health. We do not have hand sanitizing stations available in each patient room however we have ordered pocket sized hand sanitizers.

Mental Health Department Specific Data Collection Summarization

Quality Committee

Patient Experience: Cleanliness and Quiet Environment

The Mental Health Hospital has not been collecting Patient Experience data since 2018. At that time, we used Health Stream. Patient surveys would be given to the patients at discharge and submitted to Health Stream for analysis. In December 2022, a new Patient Experience Survey was developed and implemented by our Unit Based Council (UBC).

- Surveys are given to patients at discharge and turned in before they leave the hospital
- Data analysis is completed internally
- Data presented monthly during UBC and shared with staff, physicians and Environmental Services (EVS)
- After collecting data for the last 13 months, we have set our goal at 85% (85% of patients select "satisfied" or "very satisfied")

We are currently meeting our target in all areas with the exception of patient room cleanliness and quiet environment at night. We will be presenting our results to our UBC team in March to begin developing an action plan. In the interim, we have added this topic to our weekly huddle to remind staff of the importance of cleanliness and providing a quiet, healing environment at night.

Barcode Medication Administration Scanning:

Wristband scanning is currently below benchmark, however there has been significant improvement since 2022 where our compliance was 81%. Currently we are at 92.8% and our goal is to reach 95% compliance.

Action Plan:

- Intermittently functional bar code scanners have been replaced.
- Education for all licensed staff has been added to the Mental Health Huddle including how-to instructions for printing armbands
- Clinical Educator running report monthly and rounding with staff to provide face to face feedback

Submitted by Name:
Melissa Quinonez
Director of Mental Health Services

Date Submitted:
2/20/24

Health Equity at Kaweah Health

March 27, 2024

kaweahhealth.org

Kaweah Health
MORE THAN MEDICINE. LIFE.

Kaweah's Health Equity Committee

Kaweah Health's - Health Equity Committee

- ✓ Identify an individual to lead activities to improve health care equity
- ✓ Assess the patient's health-related social needs
- ❑ Analyze quality and safety data to identify disparities
- ❑ Develop an action plan to improve health care equity
- ❑ Take action when the organization does not meet the goals in its action plan
- ❑ Inform key stakeholders about progress to improve health care equity

https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_npsg-16.pdf?db=web&hash=F4FA36C38D4D4146D38956F0392272DE

KH Current Health Equity Activities

- Health Equity Committee formed – March 2023
  - Identification of responsible individual and committee membership
- Health Equity Committee Charter approved - August 2023
- Review of regulatory health equity standards
  - Joint Commission, CMS and HCAI
- Review, selection and completion of Health Equity assessment tool
  - HSAG's Health Equity Roadmap
- Review, selection and implementation of Social of Determinants of Health patient screening tool
  - PRAPARE Tool implemented December 2023
  - SDOH HealtheAnalytics Dashboard under construction to monitor implementation and assist with disparities identification

KH Current Health Equity Activities Cont.

- Application and award of HRSA Rural Care Coordination Grant for Maternal Health
  - Goal of the grant is identify disparities in maternal health outcomes and put interventions in place to address disparities with a focus on the farmworker population
- CalAIM Programs impacting health equity
  - Enhanced Care Management – expanding populations of focus
  - Community Supports – emphasis on housing
- Participation in completion of the Community Health Needs Assessment (CHNA)
- Attendance to NCQA's Health Equity Summit by Health Equity Committee leadership
  - Sonia Duran-Aguilar, Dr. Omar Guzman, Ryan Gates
- Presenter and Break-Out Session facilitator at the Annual Women Farmworker Women's Conference Nov. 2023 – Sonia Duran-Aguilar

Sepsis Quality Focus Team Report

April 2024

Dr. Lamar Mack, MD, MHA
Medical Director of Quality & Patient Safety
Erika Pineda BSN, RN, PHN, CPHQ
Quality Improvement Manager

Acronyms

- ALOS - Average Length of Stay
- BC – Blood Culture lab test
- Dx - Diagnosis
- ED – Emergency Department
- EM – Emergency Medicine GME Program
- FM – Family Medicine GME Program
- GMLOS – Geometric Length of Stay
- ICD10 – Billing Codes
- LA – Lactic Acid Lab Test
- RRT – Rapid Response Team
- SEP-1 – CMS Sepsis Bundle Measure
- VBG – Venous Blood Gas lab test
- VS – Vital Signs
- HR – Heart Rate
- PPR – Peripheral Pulse Rate
- APR – Apical Pulse Rate
- IBW – Ideal Body Weight
- PNF – Provider Notification Form
- OFI – Opportunity for Improvement
- VBP – Value Based Purchasing

Patient Safety Awareness Week: Sepsis Booth

- Sepsis education Booth during PSAW celebration 3/14/24
- About 220 attendees were educated on Sepsis
- Sepsis Plinko activity

Patient Safety Awareness Week: Sepsis Recognitions

Attending HERO of Heroes Award

- Dr. Dries Van Dyk, DO one of our Emergency Medicine Attending Physicians was recognized for having the most Sepsis Hero cases by an Attending in 2023 by providing all elements of evidence based Sepsis treatment. The Sepsis HERO of Heroes recognition is presented to providers who have achieved exemplary contributions and outstanding performance in the treatment of Sepsis.

KAWEAH HEALTH
SEPSIS HEROES

Resident HERO of Heroes Award

- Dr. David Castro, DO one of our Emergency Medicine Residents was recognized for having the most Sepsis Hero cases in the entire 2023 year by providing all elements evidence based Sepsis treatment to the most septic patients. The Sepsis HERO of Heroes recognition is presented to providers who have achieved exemplary contributions and outstanding performance in the treatment of Sepsis.

SEP-1 Early Management Bundle Compliance

CA State Compliance 65% ~ National Compliance 59% ~ Top Performing Hospitals 80%

Percent of patients with sepsis that received "perfect care." Perfect care is the right treatment at the right time.

Goal for FY24 =

Kaweah Health

Sepsis Quality Focus Team DASHBOARD

CMS SEP-1 Bundle Compliance

	Goal	FY2020	FY2021	FY2022	FY2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	YTD
SEP-1 CMS % bundle compliance	85%	66.9%	74.6%	75.5%	73.0%	68%	77%	76%	76%	82%	69%	71%						74%
Number of CMS compliant cases (n)	n/a	198	206	300	243	13	17	16	22	23	18	27						136
Total number CMS cases abstracted (d)	n/a	296	276	400	333	19	22	21	29	28	26	38						183
% Concurrent bundle compliant cases	75%	78%	77%	79%	86%	88%	86%	100%	88%	89%	89%	89%						89%
Number of concurrent compliant cases (n)	n/a	646	785	656	479	46	51	29	46	51	48	49						320
Number of concurrent cases abstracted (d)	n/a	829	1013	835	560	52	59	29	52	57	54	55						358
Number of Non-Compliant CMS cases *with*coordinator	n/a					1	0	1	0	1	1	0						4
Number of Non-Compliant CMS cases *without coordinator*	n/a					5	7	4	7	4	7	11						45
% of Non-Compliant CMS cases *with* coordinator	n/a					17%	0%	20%	0%	20%	14%	0%						
% of Non-Compliant CMS cases *without* coordinator	n/a					83%	100%	80%	100%	80%	86%	100%						
KEY	>10% away from goal						Within 10% of goal			Within 5% of goal				Outperforming/meeting goal				

SEP-1 Early Management Bundle Compliance

Percent of patients with sepsis that received "perfect care." Perfect care is the right treatment at the right time.

Kaweah Health

Sepsis Quality Focus Team DASHBOARD

CMS SEP-1 Bundle Compliance

	Goal	FY2020	FY2021	FY2022	FY2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	YTD
3 hr SEP-1 Bundle % Compliance	95%	76.0%	78.6%	88.0%	79.0%	79%	82%	81%	79%	86%	77%	74%						80%
3hr SEP-1 BundleTotal Patients abstracted (d)	n/a	296	276	401	334	19	22	21	29	28	26	38						183
% Antibiotics adminstered	95%	97.3%	95.7%	93.0%	94.0%	95%	95%	100%	86%	100%	92%	89%						94%
% Blood Cultures drawn	95%	93.8%	92.0%	93.0%	94.0%	89%	90%	86%	100%	96%	96%	88%						92%
% Lactic Acid drawn	95%	95.6%	97.9%	98.0%	98.0%	100%	100%	100%	100%	96%	96%	100%						99%
% Fluid Resuscitation completed	95%	88.3%	90.7%	92.0%	84.0%	92%	93%	93%	88%	86%	88%	93%						90%
6 hr bundle % Compliance	95%	85.4%	93.5%	90.0%	91.0%	83%	94%	91%	95%	83%	88%	96%						90%
6hr SEP-1 BundleTotal Patients abstracted (d)	n/a	186	170	250	204	12	17	11	21	12	17	23						113
% Repeat LA drawn	95%	89.6%	94.0%	92.0%	92.0%	92%	100%	91%	95%	92%	94%	100%						95%
% Reassessment completed	95%	92.9%	98.5%	91.0%	99.0%	100%	100%	100%	100%	75%	100%	94%						96%
% Vasopressors initated when indicated	95%	93.30%	100%	100%	100%	89%	91%	100%	100%	100%	90%	100%						96%

KEY	>10% away from goal	Within 10% of goal	Within 5% of goal	Outperforming/meeting goal

Sepsis Any Diagnosis – Outcomes Observed/Expected (o/e) Mortality

KH Goal for FY24 ≤0.78 o/e

Kaweah Health

Sepsis Quality Focus Team DASHBOARD

	FY24 Goal	FY2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	YTD
Sepsis Any Diagnosis - Observed/Expected (o/e) Ratio	≤0.78	1.12	0.76	0.82	0.78	0.84	1.38	1.02	0.92	1.09					0.96
Number of Observed Mortality (N)	n/a	140	5	8	5	9	12	19	19	15					92
Total number Expected Mortality (D)	n/a	125	6.62	9.77	6.42	10.78	8.71	18.71	20.59	13.82					95.41

KEY: >10% away from goal | Within 10% of goal | Within 5% of goal | Outperforming/meeting goal

Ratio < 1.0 indicates that at least expected deaths do not exceed actual (Lower ratio is better)

- FY 2024 (July – February) KH Ratio: 0.96 (92/95.41) 18% away from 0.78 FY 24 goal
- *16% improvement compared to FY 23 ratio of 1.12*
- ED Sepsis 1-Hour Bundle CHANGES go live date 3/5/24
- Inpatient MED Adult Severe Sepsis and Septic Shock power plan go live date 4/2/24
- Best performing facilities have o/e ratios significantly lower than 1.0 (i.e. 0.6)

Midas Risk Adjusted Model v6 comparison analysis All payer (582-624 sites)

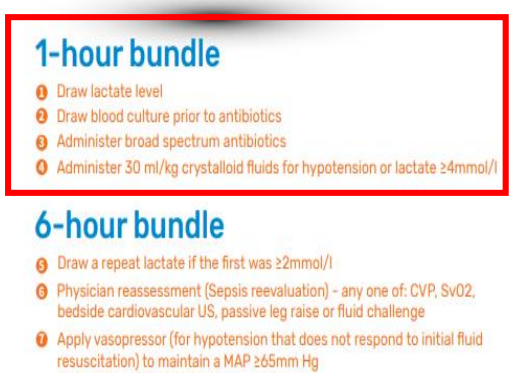
Sepsis Mortality Improvement Initiative One-Hour Bundle Dashboard

Order sets usage (Power Plan) have been shown to reduce hospital length of stay, hospital readmissions, and increase compliance with evidence-based practices

Sepsis One Hour Bundle Dashboard CMS SEP 1 Population

	2023							2024	
	June	July	August	September	October	November	December	January	February
# ED Sepsis 1-Hour Bundle Power Plan Usage (Numerator)	6	29	38	45	56	50	57	62	52
# Sepsis as Prin or Sec Dx (Denominator)	45	45	49	57	68	66	71	78	66
% Pts Had 1-Hour Bundle_Power Plan Usage_Pts w Sepsis Principal or Secondary Diagnosis	**13%**	**64%**	**78%**	**79%**	**82%**	**76%**	**80%**	**79%**	**79%**
# Pts Received Antibiotics (Numerator)	39	43	48	56	67	66	71	77	66
# Sepsis as Prin or Sec Dx (Denominator)	45	45	49	57	68	66	71	78	66
% Pts w Sepsis that Received ABX_Pts w Sepsis Principal or Secondary Diagnosis	**87%**	**96%**	**98%**	**98%**	**99%**	**100%**	**100%**	**99%**	**100%**
# Pts Received ABX w/i 60 Min of Pt 1st Seen by Any ED Provider (Numerator)	14	10	11	10	21	20	15	17	20
# Sepsis as Prin or Sec Dx (Denominator)	45	45	49	57	68	66	71	78	66
% Pts w Sepsis that Received ABX w/i 60 Min Pt 1st Seen by any ED Provider_Pts w Sepsis Principal or Secondary Diagnosis	31%	22%	22%	18%	31%	30%	21%	22%	30%
# Pts Met 1 Hr Bundle (Numerator)	12	9	10	7	18	17	14	13	18
# Sepsis as Prin or Sec Dx (Denominator)	45	45	49	57	68	66	71	78	66
% Pts Met 1- Hr Bundle_Pts w Sepsis Principal or Secondary Diagnosis	27%	20%	20%	12%	26%	26%	20%	17%	27%

*Includes Antibiotic, Blood Culture, & Initial Lactic Acid



Source: Healthe Analytics
Report subject to change depending on cases billed/coded/amended for sepsis every month

Sepsis Mortality Improvement Initiative One-Hour Bundle Dashboard

Order sets usage (Power Plan) have been shown to reduce hospital length of stay, hospital readmissions, and increase compliance with evidence-based practices

Sepsis One Hour Bundle Dashboard CMS SEP 1 & Midas Mortality Population

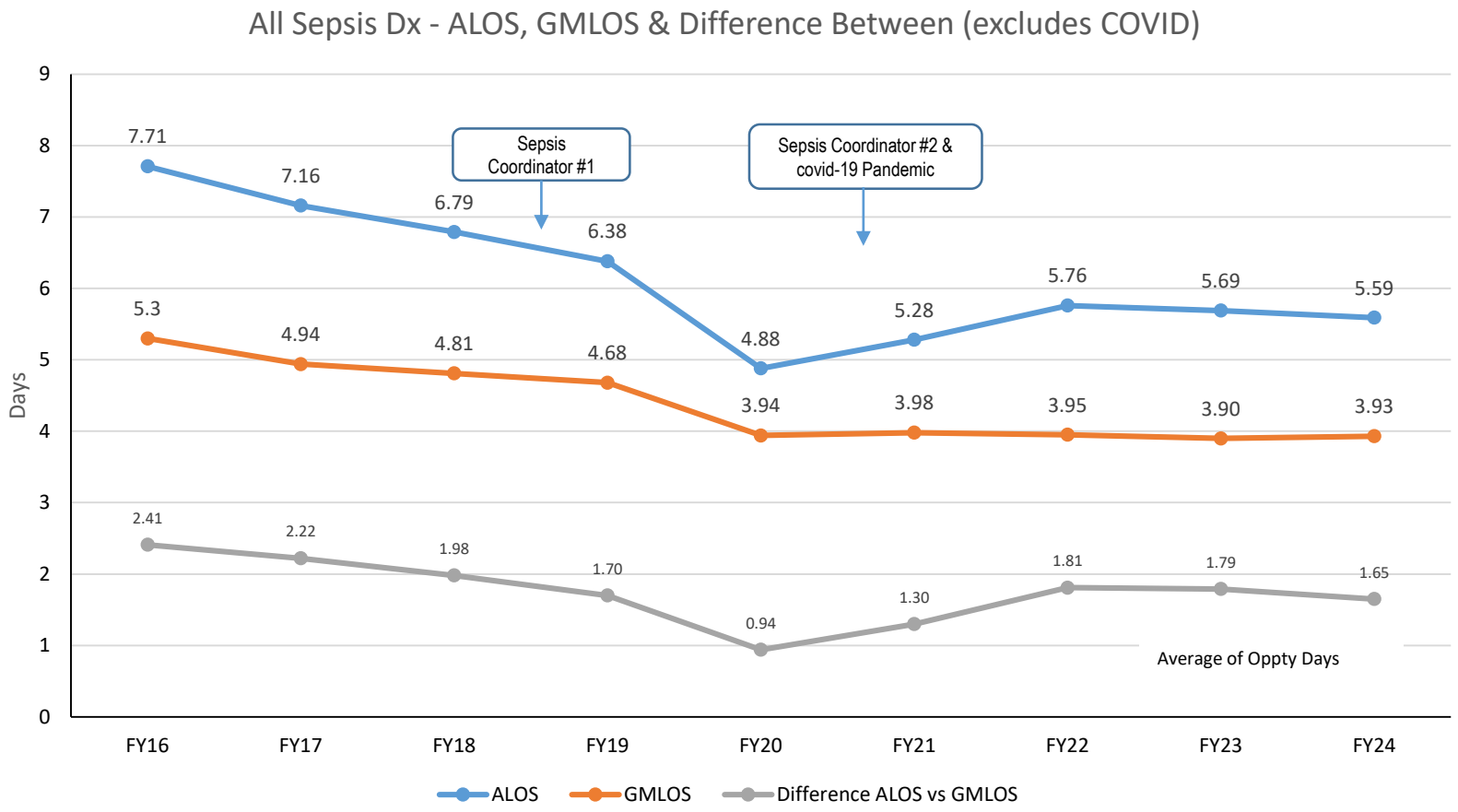
	2023							2024	
	June	July	August	September	October	November	December	January	February
# ED Sepsis 1-Hour Bundle Power Plan Usage (Numerator)	11	58	68	69	84	72	81	105	78
# Sepsis as Principal or Secondary Diagnosis (Denominator)	93	85	92	94	106	96	107	131	98
% Pts Had 1-Hour Bundle_Power Plan Usage_Pts w Sepsis Principal or Secondary Diagnosis	**12%**	**68%**	**74%**	**73%**	**79%**	**75%**	**76%**	**80%**	**80%**
# Pts Received ABX (Numerator)	84	83	91	93	105	95	107	130	98
# Sepsis as Principal or Secondary Diagnosis (Denominator)	93	85	92	94	106	96	107	131	98
% Pts w Sepsis that Received ABX_Pts w Sepsis Principal or Secondary Diagnosis	**90%**	**98%**	**99%**	**99%**	**99%**	**99%**	**100%**	**99%**	**100%**
# Pts Received ABX w/i 60 Min of Pt 1st Seen by Provider (Numerator)	20	16	17	17	23	26	17	21	27
# Sepsis as Principal or Secondary Diagnosis (Denominator)	93	85	92	94	106	96	107	131	98
% Pts w Sepsis that Received ABX w/i 60 Min Pt 1st Seen by Provider_Pts w Sepsis Principal or Secondary Diagnosis	**22%**	**19%**	**18%**	**18%**	**22%**	**27%**	**16%**	**16%**	**28%**
# Pts Met 1-Hour Bundle (Numerator)*	17	15	16	12	20	22	15	17	25
# Sepsis as Principal or Secondary Diagnosis (Denominator)	93	85	92	94	106	96	107	131	98
% Pts Met 1-Hour Bundle_Pts w Sepsis Principal or Secondary Diagnosis	**18%**	**18%**	**17%**	**13%**	**19%**	**23%**	**14%**	**13%**	**26%**

*Includes Antibiotic, Blood Culture, & Initial Lactic Acid

- Noticeable improvement in ED Sepsis 1-Hour power plan usage for January & February 2024

Source: Healthe Analytics
Report subject to change depending on cases billed/coded/amended for sepsis every month

Sepsis Any Diagnosis - Outcomes Length of Stay



- 1.76% decrease in ALOS from FY23 ALOS=5.69) to FY24 (ALOS=5.59) ⬇
- Average opportunity days in FY24: 1.65
  (7.84% decrease in FY24 vs. FY23)
  Lower is better ⬇
- FY24 Kaweah Health ALOS 5.59 days vs. CMS GMLOS 3.93 Difference of 1.65 days.
- COVID-19 cases removed in FY20-24. SEP-1 bundle does not apply to COVID-19 patients.

FY 2024 includes July – January only

Sepsis QFT Actions & Next Steps

- Key Improvement strategies in process:
  - Secure GME Resident engagement & support: Secured one ED Chief Resident (s) to attend monthly Sepsis Committee meeting consistently (In Progress)
  - Chief Resident engagement and ongoing communication regarding SEP 1 compliance & non compliance (In Progress)
  - Standing educational activities for GME residency: Sepsis SIM every 18 months (Ongoing) ED GME SIM 12/21/23
  - ED Provider (s) education ongoing by ED Medical Staff leadership (In progress)
  - HealtheAnalytics Sepsis data retrieval dashboard developed to track 1-hr. bundle compliance (Final Validation Completed)
  - Sepsis Committee meeting on a monthly basis to address concerns timely (In progress)
  - SEP - 1 fall outs deep dive & collegial discussion in Sepsis Committee (In progress)
  - Continue education/follow-up with providers, & caregivers during concurrent review of cases (In progress)
  - Sepsis committee driven SEP-1 fall out educational letters to providers (In progress)

Sepsis Committee Actions & Next Steps

- Ensure to secure the most points for SEP-1 composite measure for the CMS Value Based Purchasing program (Sepsis CMS VBP effectove as of 1/1/2024)
- Modified Kaizen Project to evaluate current barriers to meeting SEP-1 requirements, report will be presented to Sepsis workgroup for Action Planning on April 9, 2024
- Strengthen partnership with HIM/Coding related to Sepsis (In Progress)
- KH is held to Sepsis 3 coding guidelines therefore we piloted HIM/CDI Sepsis working diagnosis list:
  - ✓ Sepsis coordinator trialed reaching out to providers for missed documentation opportunities for February & March Sepsis discharges (Majority of Providers Responded)
- March 14 -Patient Safety Week –Sepsis Booth (Big Success!)
- One of our RN Sepsis coordinators transitioned into a position as a Nurse Practitioner at our Exeter clinic. We are actively recruiting for a New RN Sepsis Coordinator to fill this role (In Progress)

Sepsis QFT Actions & Next Steps

- Key Improvement strategies in process:
  - Working with ISS Partners to make ED Sepsis one-hour order set an ED provider favorite in EMR (Completed)
  - Expansion of ED 1-Hour Sepsis order set to inpatient population (Med Surge went live 4/2/24, ICCU in Progress [discussion with stakeholders ongoing])
  - Transitional Year Resident Project – Sepsis Decision Making tool Modification (Completed 3/12/2024)
  - Ongoing partnership with Education Department as needed for refresher on CMS Sepsis requirement (In progress)
  - Sepsis Heroes list monthly recognition for providers and care team (In progress)

Sepsis Committee Actions & Next Steps

Changes to the ED Sepsis 1-Hr Bundle

Continuous Infusions

Bolus

For patients with a BMI > 30 use IBW to calculate target volume goal.

☑ Sodium Chloride 0.9% - Normal Saline - Bolus
30 mL/kg, IV Bolus, Soln-IV, Once
Comments: Administer within 30 minutes of orderingInfuse IV bolus over 1 hour

☐ Sodium Chloride 0.9% - Normal Saline - Bolus
250 mL, IV Bolus, Soln-IV, Once
Comments: The total volume of crystalloids and/or colloids given will now be 250 ml total in place of 30 mL/kg as there is a concern for fluid volume overload.

☐ Sodium Chloride 0.9% - Normal Saline - Bolus
500 mL, IV Bolus, Soln-IV, Once
Comments: The total volume of crystalloids and/or colloids given will now be 500 ml total in place of 30 mL/kg as there is a concern for fluid volume overload.

☐ Sodium Chloride 0.9% - Normal Saline - Bolus
1,000 mL, IV Bolus, Soln-IV, Once
Comments: The total volume of crystalloids and/or colloids given will now be 1000 ml total in place of 30 mL/kg as there is a concern for fluid volume overload."

☑ VBG (Lactic Acid Only) Gem
T;N+180, Blood, Timed Study
Comments: A sepsis reevaluation was performed 5 minutes after the required fluid volume was administered

Medications

☑ Rocephin
2 g, IV Piggyback, Soln-IV, Once, Indication: Empiric
Comments: Start antibiotic order if unable to get blood culture in 30 minutes

Consider adding vancomycin if MRSA is suspected

☐ vancomycin
20 mg/kg, IV Piggyback, Soln-IV, Once, Indication: Empiric
Comments: Maximum of 2 grams. Pharmacist may adjust dose as necessary. Start antibiotic order if unable to get blood culture in 30 minutes.START ROCEPHIN FIRST IF ORDERED TOGETHER.

Azithromycin (Zithromax) in addition to ceftriaxone (Rocephin) if suspected source of sepsis is pneumonia (DO NOT give as monotherapy.)

☐ Zithromax
500 mg, IV Piggyback, Soln-IV, Once, Indication: Other (Please specify in comments)
Comments: Indication: Empiric Start antibiotic order if unable to get blood culture in 30 minutes.START ROCEPHIN INFUSION FIRST

If Pneumonia is suspected, then please calculate the Pneumonia Severity Index (PSI) Score by selecting the "PSI Score" order below.

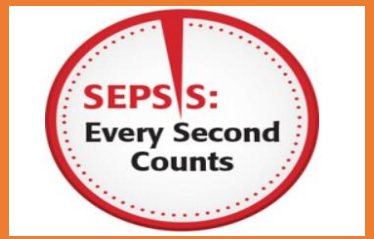
☐ PSI Score

Consider piperacillin/tazobactam (Zosyn) if pseudomonas is suspected (e.g., diabetic foot infection, suspicion of hospital acquired pneumonia)

☐ Zosyn
4.5 g, IV Piggyback, Soln-IV, Once, Indication: Empiric
Comments: Start antibiotic order if unable to get blood culture in 30 minutes

If allergic reaction to penicillin is NOT an IgE-mediated allergy (urticarial rash, angioedema, etc.), cephalosporins have low cross-reactivity and may be safely used. Previous tolerance of penicillins or cephalosporins may also delabel allergies. If concerned for TRUE IgE-mediated B-lactam allergy, please contact pharmacy (ext. 5854) for alternatives or to help with screening previous B-lactam use.

Dr. LaMar Mack, Medical Director, Quality and Patient Safety Ext. 2117
Sandy Volchko, RN-Director, Quality and Patient Safety. Ext. 2169
Erika Pineda, RN-Manager, Quality and Patient Safety. Ext. 2876
Jared Cauthen, RN-Sepsis Coordinator. Ext. 6903



Outstanding Health Outcomes Update

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

April 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%	69%	71%						74%
Sepsis and Related Conditions o/e mortality	≤0.78		1.12	0.75	0.82	0.78	0.84	1.38	1.02	0.92						0.94

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	2	3	1				15
CLABSI SIR	0.39	1.01 Ex COVID	0.93 Ex COVID	0.83	1.16	2.22	0.00	1.15	0.00	1.29	2.31	0.86				1.22
Central Line Utilization Rate	0.68	1.02	0.88	0.749	0.791	0.828	0.774	0.685	0.876	0.822	0.799	0.66				0.77

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	1	0	0				6
CAUTI SIR	0.40	1.09 Ex COVID	0.55 Ex COVID	0.00	0.00	1.06	0.00	0.97	0.46	0.46	0.00	0.00				0.34
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	1.025	1.07	0.98				1.02

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	2	0	0				7
MRSA SIR	0.55	1.11 Ex COVID	0.66 Ex COVID	0.00	0.00	1.47	0.00	1.32	3.00	2.26	0.00	0.00				1.12

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; ICU central line and ICU utilization rates for last 2 months (March & April 2024) have been lower that FY23 SUR
    - Reinvigorate the Standardized Procedure – medical staff approved criteria for nurses to remove urinary catheters
  - Decolonization rates
    - Nasal Decolonization– 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 Decolonization – developing 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 BioVigil 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
    - Started March 2024 – RECOGNITION PROGRAMS for units/departments that have achieve highest % of staff meeting 80hrs active time (paired) per month!

Questions?

The pursuit of healthiness