August 11, 2022

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, August 18, 2022, 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, August 18, 2022, 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, August 18, 2022, 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
Michael Olmos, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
Board Clerk, Executive Assistant to CEO

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

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
QUALITY COUNCIL

Thursday, August 18, 2022
5105 W. Cypress Avenue
Kaweah Health Lifestyle Fitness Center Conference Room

ATTENDING: Board Members; David Francis – Committee Chair, Michael Olmos; Gary Herbst, CEO; Keri Noeske, RN, BSW, DNP, Chief Nursing Officer; Marc Mertz Acting CEO, Chief Strategy Officer, Monica Manga, MD, Chief of Staff; Daniel Hightower, MD, Professional Staff Quality Committee Chair; Tom Gray, MD, Quality and Patient Safety Medical Director; Sandy Volchko DNP, RN CLSSBB, Director of Quality and Patient Safety; Ben Cripps, Chief Compliance and Risk Management Officer; Evelyn McEntire, Director of Risk Management; and Rita Pena, Recording.

OPEN MEETING – 7:30AM

1. **Call to order** – *David Francis, Committee Chair*
2. **Public / Medical Staff participation –** Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdiction of the Board are requested to identify themselves at this time. For those who are unable to attend the beginning of the Board meeting during the public participation segment but would like to address the Board, please contact the Board Clerk (Cindy Moccio 559-624-2330) or cmoccio@kaweahhealth.org to make arrangements to address the Board.
3. **Approval of Quality Council Closed Meeting Agenda** – 7:31AM
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Daniel Hightower, MD, and Professional Staff Quality Committee Chair; James McNulty, Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*
   - **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** – *David Francis, Committee Chair*

CLOSED MEETING – 7:31AM

1. **Call to order** – *David Francis, Committee Chair & Board Member*
2. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Daniel Hightower, MD, and Professional Staff Quality Committee Chair*

3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management, and Ben Cripps, Chief Compliance and Risk Officer.*

4. **Adjourn Closed Meeting** – *David Francis, Committee Chair*

OPEN MEETING – 8:00AM

1. **Call to order** – *David Francis, 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. Value Based Purchasing Report
   - 3.2. Safety Attitudes Questionnaire, Safety Culture and Action Plan
   - 3.3. Kaweah Health Scope of Service
   - 3.4. Rehabilitation Hospital Quality Report
   - 3.5. Orthopedic Service Line Quality Report

4. **Sepsis Quality Focus Team Report** – A review of the Centers for Medicare and Medicaid Sepsis Core Measure Bundle performance and action plan. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety and Tom Gray, MD, Medical Director of Quality and Patient Safety.*

5. **Update: Clinical Quality Goals** - A review of current performance and actions focused on the fiscal year 2022 clinical quality goals. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety*.

6. **Adjourn Open Meeting** – *David Francis, 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.

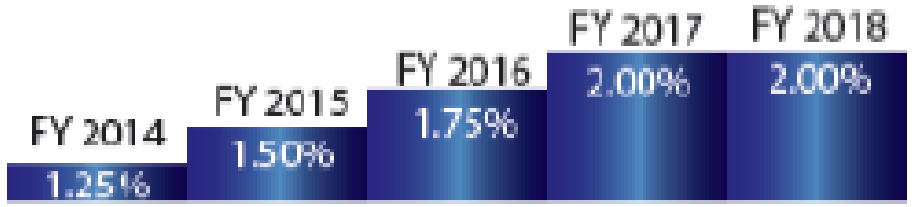
Abbreviations

CMS: Centers for Medicare and Medicaid Services
DRG: Diagnosis Related Groups
ECE: Extraordinary Circumstances Exception
FY: Fiscal Year
CY: Calendar Year
TPS: Total Performance Score
VBP: Value Based Purchasing
CHA: California Hospital Association
CAUTI – Catheter Associated Urinary Tract Infection
SSI – Surgical Site Infection
CLABSI – Central Line Associated Blood Stream Infection
COPD – Chronic Obstructive Pulmonary Disease
PHE – Public Health Emergency
MRSA - Methicillin-resistant Staphylococcus Aureus
VBP – Value Based Purchasing

VBP Payment Method

- “The Hospital VBP Program is funded by a 2% reduction from participating hospitals’ base operating diagnosis-related group (DRG) payments for FY 2018 and beyond.
- Resulting funds are redistributed to hospitals based on their Total Performance Scores (TPS).
- The actual amount earned by each hospital depends on the range and distribution of all eligible/participating hospitals’ TPS scores for a FY.
- It is possible for a hospital to earn back a value-based incentive payment percentage that is less than, equal to, or more than the applicable reduction for that program year.”

CMS Quality Patient Assessment Instruments



VBP CMS Final Rule During Public Health Emergency (PHE) COVID-19 Pandemic

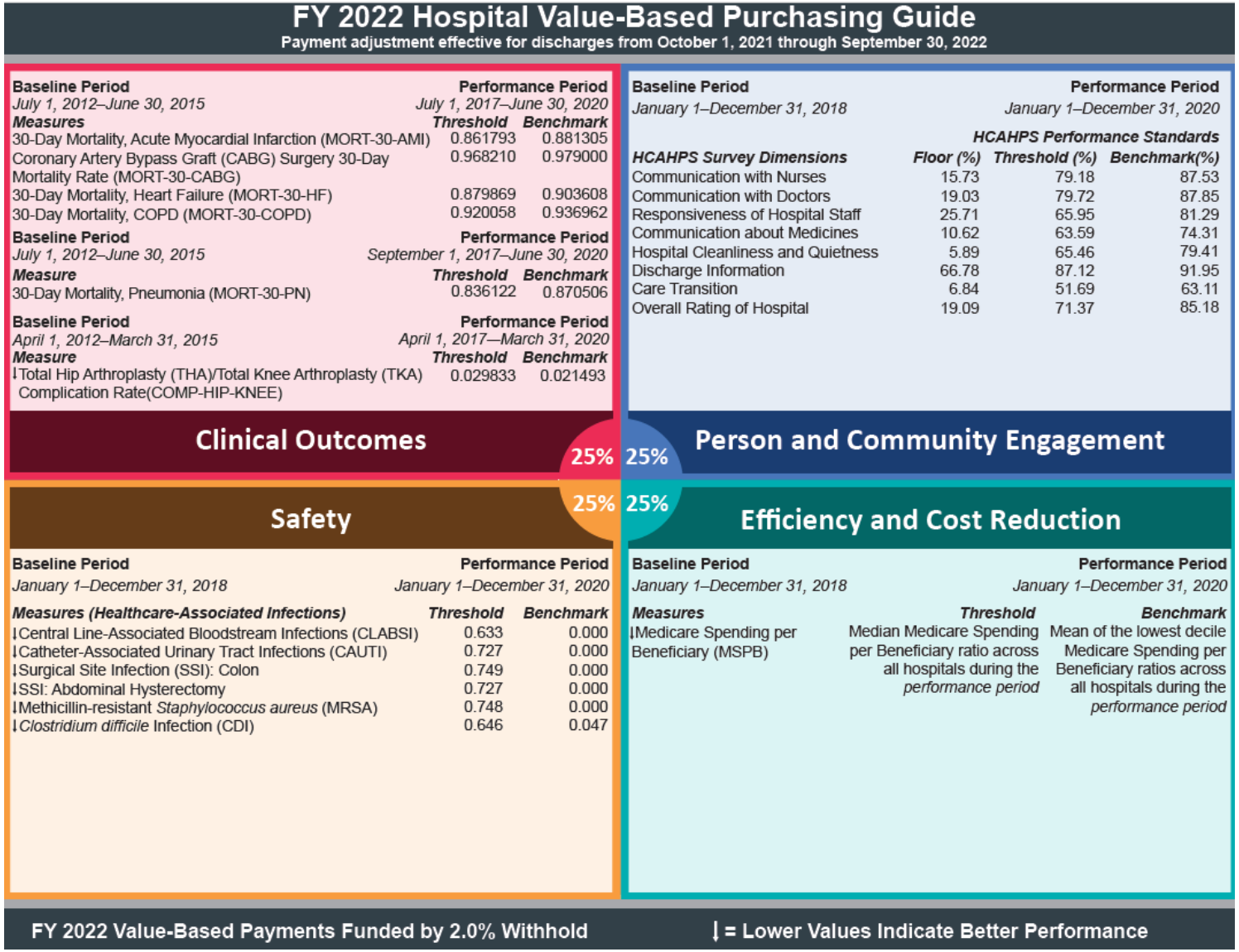
According to the CMS Final Rule Issued in early 2022 the following changes will be made to the VBP 2023 program due to the COVID-19 PHE.

- Establish the measure suppression policy for the duration of the COVID- 19 PHE;
- Suppress the Hospital Consumer Assessment of Healthcare Providers and Systems survey, Medicare Spending Per Beneficiary, and five HAI measures, for the FY 2022 program year;
- Suppress the Pneumonia (PN) 30-Day Mortality Rate measure for the FY 2023 program year; and
- Remove the Patient Safety and Adverse Events Composite (CMS PSI 90) measure beginning with the FY 2023 program year.
- As a result of the above measure suppressions for the FY 2022 program year, CMS believes that calculating a total performance score (TPS) for hospitals using only data from the remaining measures, all of which are in the Clinical Outcomes Domain, would not result in a fair national comparison. Therefore, **CMS will not calculate a TPS for any hospital based on one domain and will instead award to all hospitals a value-based payment amount for each discharge that is equal to the amount withheld**. CMS will also calculate measure rates for all measures and publicly report those rates where feasible and appropriately caveated. The agency will also update the baseline period for certain measures affected by the ECE granted in response

FY2022 VBP

Payment adjustment effective for discharges from Oct 1, 2021 through Sept 30, 2022 for performance achieved during the following performance periods:

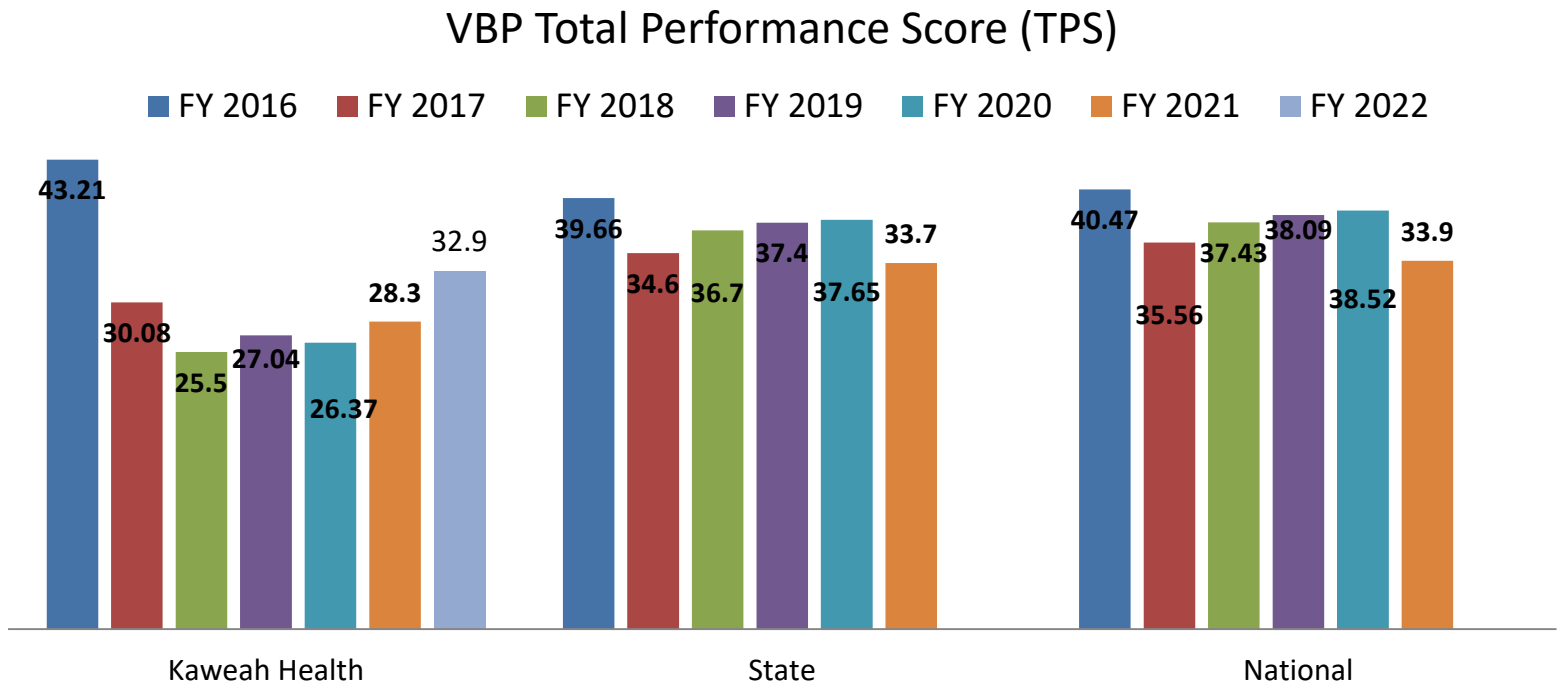
- Safety, Efficiency and Engagement Domains Outcomes = CY 2020
- Clinical Care Domain Outcomes = July 1, 2017 through June 30, 2020



Estimated FY2022 VBP

Kaweah Health's Estimated VBP Total Performance Score (if PHE exemption did not occur)

- Kaweah Health VBP Total Performance Score (TPS) improved over 3 consecutive years. 2019 = 26.37; 2022=32.9 and would have earned VBP funds if the PHE exemption were not in place
- Kaweah Health is exempt from VBP program for FY2022 due to PHE exemption; data represents KH's performance, however the Total Performance Score will not be used in VBP 2022 per CMS Final Rule
- State and National TPS not released by CMS



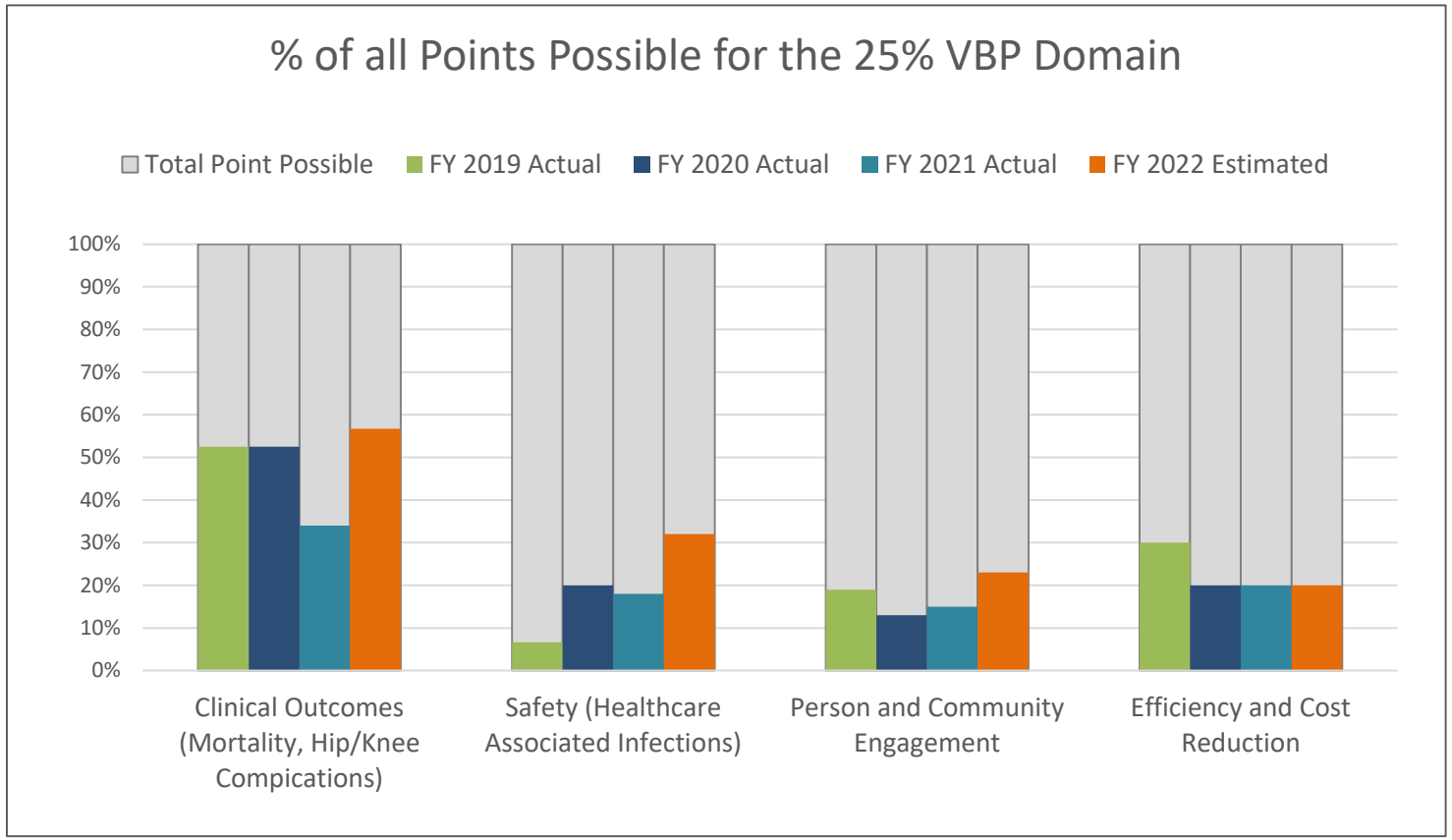
FY 2021 Actual VBP Cost	
Contribution	Payment Received
2% = $1,868,400	1.48% = $1,693,100
($175,300)	

FY 2022 *Estimated* VBP Cost	
Contribution	Payment Received
2% = $1,939,700	(109.8 % of 2% withheld) $2,130,000
$190,300	

Estimated FY2022 VBP

Kaweah Health's Estimated Domain Scores (if PHE exemption did not occur)

- FY2022 estimated VBP points improved from last 3 years in 3 domains: Clinical Outcomes, Safety and Person & Community Engagement; no change in points awarded for Efficiency and Cost Reduction Domain
- The Clinical Outcomes domain measures are the only measures included in the revised VBP 2022 program; Kaweah Health like many hospitals applied and received an exemption due to the PHE.



FY2023 VBP

Payment adjustment effective for discharges from Oct 1, 2022 through Sept 30, 2023 for performance achieved during the following performance periods:

- Safety, Efficiency and Engagement Domains Outcomes = CY21
- Clinical Care Domain Outcomes = July 1, 2018 through June 30, 2021
- PSI90 removed from VBP 2023 as of the Final Rule issued in 2022 (CMS recognized it was a duplicative measure as it is included in the Hospital Acquired Condition Program)
- Hospitals are awarded points for achieving the benchmark and for improving from the hospitals baseline performance for each measure

FY 2023 Hospital Value-Based Purchasing Quick Reference Guide

Payment adjustment effective for discharges from October 1, 2022 to September 30, 2023

Clinical Outcomes — 25%

Mortality Measures

Baseline Period: July 1, 2013–June 30, 2016 | Performance Period: July 1, 2018–June 30, 2021*

Measure ID	Measure Name	Achievement Threshold	Benchmark
MORT-30-AMI	Acute Myocardial Infarction 30-Day Mortality	0.866548	0.885499
MORT-30-CABG	Coronary Artery Bypass Graft Surgery 30-Day Mortality	0.968747	0.979620
MORT-30-COPD	Chronic Obstructive Pulmonary Disease 30-Day Mortality	0.919769	0.936349
MORT-30-HF	Heart Failure 30-Day Mortality	0.881939	0.906798
MORT-30-PN	Pneumonia 30-Day Mortality	0.840138	0.871741

Complication Measure

Baseline Period: April 1, 2013–March 31, 2016 | Performance Period: April 1, 2018–March 31, 2021*

Measure ID	Measure Name	Achievement Threshold	Benchmark
COMP-HIP-KNEE	Total Hip Arthroplasty/Total Knee Arthroplasty Complication	0.027428	0.019779

Person and Community Engagement — 25%

Baseline Period: Jan. 1, 2019–Dec. 31, 2019 | Performance Period: Jan. 1, 2021–Dec. 31, 2021

HCAHPS Survey Dimensions	Floor (%)	Achievement Threshold (%)	Benchmark (%)
Communication with Nurses	53.50	79.42	87.71
Communication with Doctors	62.41	79.83	87.97
Responsiveness of Hospital Staff	40.40	65.52	81.22
Communication about Medicines	39.82	63.11	74.05
Hospital Cleanliness and Quietness	45.94	65.63	79.64
Discharge Information	66.92	87.23	92.21
Care Transition	25.64	51.84	63.57
Overall Rating of Hospital	36.31	71.66	85.39

Safety — 25%

Patient Safety Composite

Baseline Period: Oct. 1, 2015–June 30, 2017 | Performance Period: July 1, 2019–June 30, 2021*

Measure ID	Measure Name	Achievement Threshold	Benchmark
☆⇩ PSI 90	Patient Safety and Adverse Events Composite	0.972658	0.760882

Healthcare-Associated Infections

Baseline Period: Jan. 1, 2019–Dec. 31, 2019 | Performance Period: Jan. 1, 2021–Dec. 31, 2021

Measure ID	Measure Name	Achievement Threshold	Benchmark
⇩ CAUTI	Catheter-Associated Urinary Tract Infection	0.676	0.000
⇩ CDI	Clostridium *difficile* Infection	0.544	0.010
⇩ CLABSI	Central Line-Associated Bloodstream Infection	0.596	0.000
⇩ MRSA	Methicillin-Resistant Staphylococcus *aureus*	0.727	0.000
⇩ SSI	Colon Surgery	0.734	0.000
	Abdominal Hysterectomy	0.732	0.000

Efficiency and Cost Reduction — 25%

Baseline Period: Jan. 1, 2019–Dec. 31, 2019 | Performance Period: Jan. 1, 2021–Dec. 31, 2021

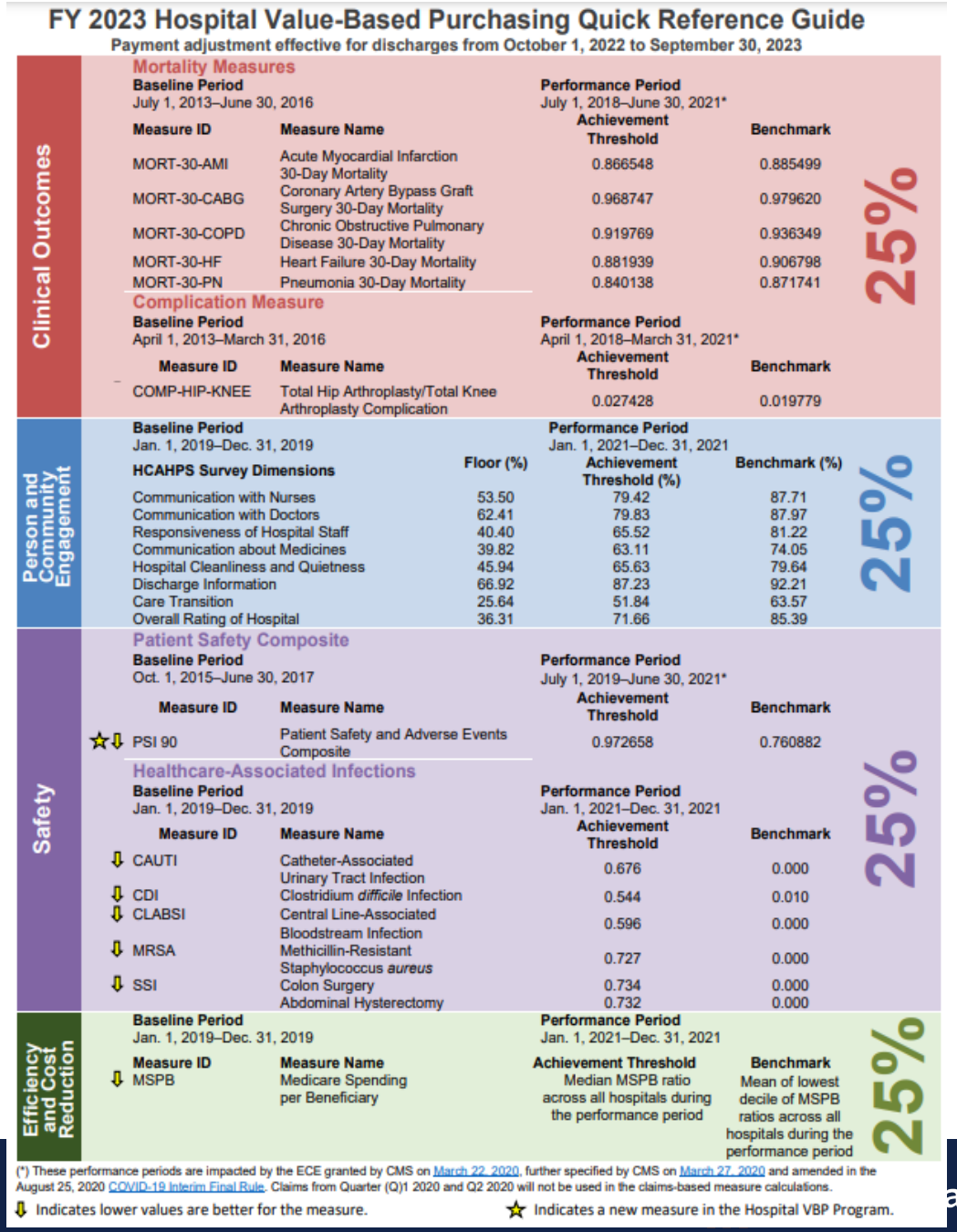
Measure ID	Measure Name	Achievement Threshold	Benchmark
⇩ MSPB	Medicare Spending per Beneficiary	Median MSPB ratio across all hospitals during the performance period	Mean of lowest decile of MSPB ratios across all hospitals during the performance period

(*) These performance periods are impacted by the ECE granted by CMS on March 22, 2020, further specified by CMS on March 27, 2020 and amended in the August 25, 2020 COVID-19 Interim Final Rule. Claims from Quarter (Q)1 2020 and Q2 2020 will not be used in the claims-based measure calculations.

⇩ Indicates lower values are better for the measure. ☆ Indicates a new measure in the Hospital VBP Program.

FY2023 VBP

- CMS has not yet released any performance reports for VBP 2023, the following information presented shows Kaweah Health's performance on the Safety, Engagement and Outcomes domains using internal data sources to gage performance/improvement in the VBP measures
- Summary of 2023 VBP predicted performance direction:
  - Clinical Outcome Measures – 5/7 improved compared to performance from 2022 VBP
  - Safety Measures – 1/6 improved compared to performance from 2022 VBP (several measures impacted by COVID-19 pandemic)
  - Patient Engagement Measures – 6/8 measures improved compared to 2022 VBP



FY 2023 Hospital Value-Based Purchasing Quick Reference Guide

Payment adjustment effective for discharges from October 1, 2022 to September 30, 2023

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HCAHPS Survey Dimensions	Floor (%)	Achievement Threshold (%)	Benchmark (%)
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⇩ SSI	Colon Surgery	0.734	0.000
	Abdominal Hysterectomy	0.732	0.000

Efficiency and Cost Reduction — 25%

Baseline Period: Jan. 1, 2019–Dec. 31, 2019 | Performance Period: Jan. 1, 2021–Dec. 31, 2021

Measure ID	Measure Name	Achievement Threshold	Benchmark
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FY2023 VBP Clinical Outcome (25% of VBP Points)

Mortality monitored through the Midas system which is not a direct comparison to CMS mortality measures but provides a reliable indication of risk adjusted mortality outcomes. Midas is in hospital observed/expected ratio; CMS reports a risk adjusted 30 day mortality percentage.

	VBP FY 2022 Performance	VBP FY2023 Performance
Clinical Outcome Population Measure (Medicare population)	July 1, 2017 through June 30, 2020 (PN Sept 1, 2017 through June 30, 2020) (THA/TKA April 1, 2017--March 31, 2020) VBP 2022 Performance Period	July 1, 2018 through June 30, 2021 VBP 2023 Performance Period
Acute Myocardial Infarction (AMI) Mortality observed/expected	0.88 (28/32)	0.83 (23/28)
Coronary Artery Bypass Graft (CABG) Surgery; Mortality observed/expected	1.27 (5/4)	1.22 (4/3.28)
Heart Failure Mortality observed/expected	1.00 (56/56)	0.96 (46/47.9)
COPD Mortality observed/expected	1.15 (16/14)	1.27 (10/7.89)
Pneumonia –Viral Mortality observed/expected	0.67 (26/38)	0.84 (22/26.3)
Pneumonia –Bacterial Mortality observed/expected	1.00 (14/14)	0.95 (10/10.5)
Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA) complication Rate	1.79 (11/614)	1.39 (5/360)

*Midas initiated June 2015; unable to obtain VBP 2023 baseline since the period for VBP 2023 is July 1, 2013 through June 30, 2016

FY2023 VBP Safety (25% of VBP Points)

	VBP FY 2022 Performance	VBP 2023 Baseline Performance	VBP FY2023 Performance
Safety Measure (Medicare population)	CY2020 VBP 2022 Performance Period	CY 2019 Infections PSI-90 3Q 2015–2Q 2017	CY 2021 (YTD ending July 2021) VBP 2023 Performance Period
CAUTI Standardized Infection Ratio	0.340	1.168	0.908
CLABSI Standardized Infection Ratio	0.598	0.790	0.956
MRSA Standardized Infection Ratio	2.481	1.218	2.020
C Diff Standardized Infection Ratio	0.123	0.226	0.498
SSI – Colon Standardized Infection Ratio	0.154	0.167	0.860
SSI – Hysterectomy Standardized Infection Ratio	0.000	1.145	1.275

*CMS through the VBP program awards achievement points and improvement points based on the organizations baseline performance

FY2023 VBP Patient Engagement (25% of VBP Points)

	VBP FY 2022 Performance	VBP 2023 Baseline Performance	VBP FY2023 Performance
HCAHPS Measure	CY2020 VBP 2022 Performance Period	CY 2019	CY 2021 VBP 2023 Performance Period
Communication with Nurses	76.52%	76.58%	77.48%
Communication with Doctors	76.42%	76.02%	78.20%
Responsiveness of Hospital Staff	65.45%	67.20%	69.82%
Communication about Medicines	64.64%	60.49%	62.77%
Hospital Quietness and Cleanliness	60.09%	58.64%	62.88%
Discharge Information	87.92%	86.56%	87.30%
Care Transition	44.45%	46.60%	49.90%
Overall Rating of Hospital	70.66%	71.64%	73.50%

*CMS through the VBP program awards achievement points and improvement points based on the organizations baseline performance

Kaweah Health Action Strategies for Improvement

Organizational priority is established to address domain measure groups through various priority Quality Focus Teams or program initiatives that each report into the Kaweah Health Quality Improvement Program. Improvement initiatives include:

- **Clinical Outcome Domain** – Best Practice Team initiative lead by Dr. Michael Tedaldi. Goals of reducing mortality, readmissions and length of stay by standardizing care to key populations
- **Safety Domain** – Quality Focus Teams established for CAUTI, CLABSI, MRSA. Surgical Site Infection (SSI) Committee lead by Dr. LaMar Mack (reports to Infection Prevention Committee) oversees SSI trends, case reviews and improvement work.
- **Patient Experience** – Board of Directors subcommittee established to oversee improvement action plans

Questions?

Live with passion.

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

Kaweah Health

Safety Culture Action Plan Update

August 2022

SAFETY ATTITUDES QUESTIONNAIRE (SAQ) TIMELINE

MARCH 2021
Results from 2020/2021 SAQ survey reports disseminated to leadership

JUNE 2021
SAQ Action plans developed and received by 6/18/21

JULY - OCT 2021
SAQ role debriefs completed by 9/20/21, action plan developed QIC by 10/15/21

AUG 2021
Leaders submit worksheets to VP for employees ≤ 2.88 on annual evaluation or believed to be under-performing

2Q 2022
Pulse Survey Administered

Stress Recognition Annual training completed; Safety culture action plan by role completed

1Q 2023
SAQ Administered

APR – MAY 2021
Unit/Department SAQ results debriefed with staff

Leader TeamSTEPPS training

Just culture staff awareness campaign

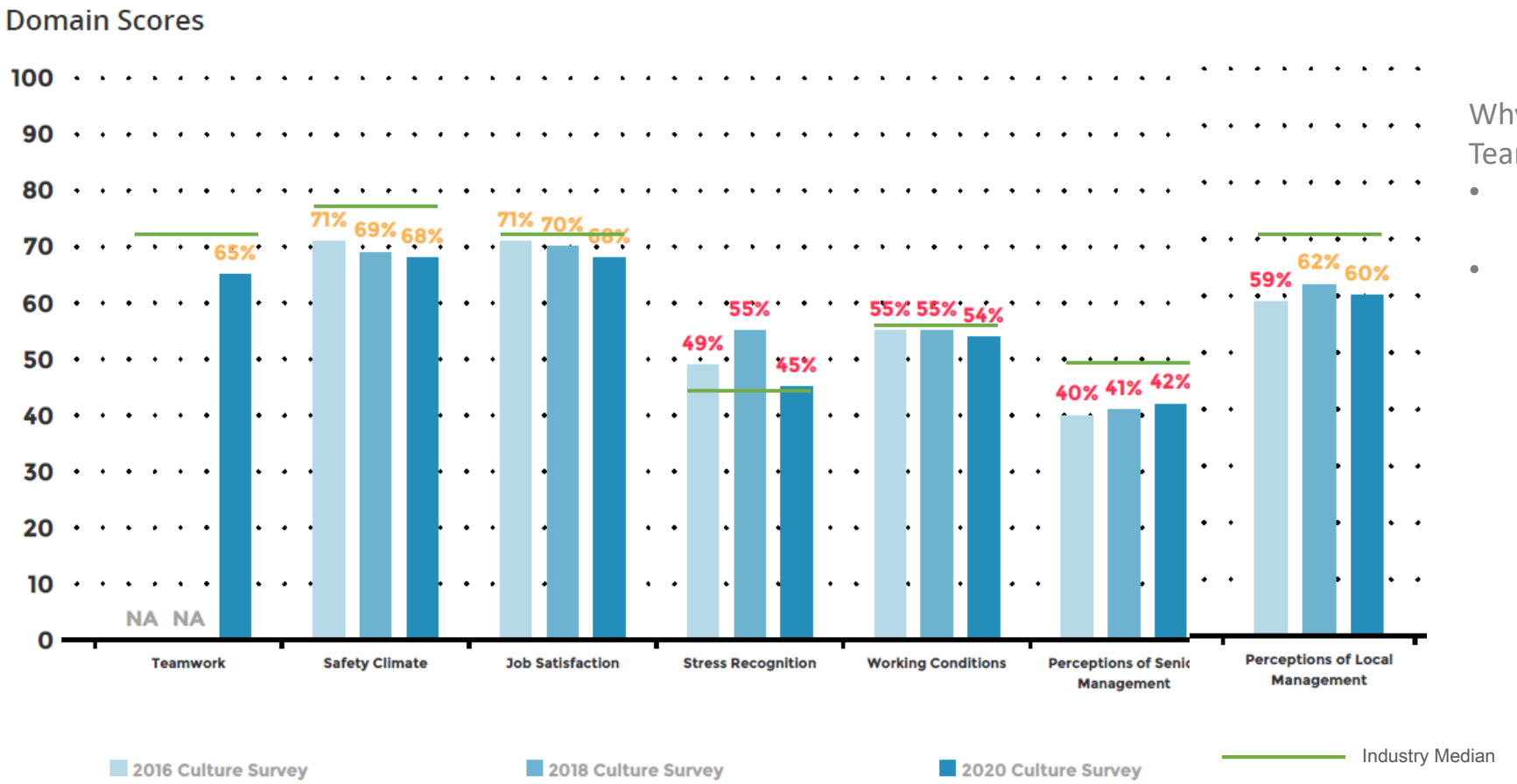
JULY 2021
SAQ Results and action plan reported to Board of Directors

JULY- DEC 2021
Event reporting and just culture education to targeted units/depts. Revisions to select event reporting forms and acknowledgements

4Q 2021
Staff TeamSTEPPS simulation training (medical team training) offered ongoing

3Q 2022
Action plan update and survey results reported to Board of Directors

SAQ Results 2020/2021 - Trending by Domain



Why is there no historical data in Teamwork Category?

- 2 Questions in the Teamwork Climate category changed
- An analysis was conducted by Pascal Metrics and it was determined that you cannot trend at the domain level or those specific questions when changing from one domain to the other. Therefore we cannot compare Teamwork Climate domain scores to our past survey results

What is Working Well
SAQ Results 2020/2021
Questions ≥ 80% Positive Response

Domain	Question
Teamwork Climate	It's easy for personnel here to ask questions when there is something that they do not understand
Safety Climate	I know the proper channels to direct questions regarding patient safety in this work setting
	I am encouraged by others in this work setting to report any patient safety concerns I may have
	Medical errors are handled appropriately in this work setting
Job Satisfaction	I like my job
	I am proud to work in this work setting
Custom - Just Culture	When I see others doing something unsafe for patients, I speak up
	Nurses/staff support a culture of patient safety in this work setting
	When staff make clinical errors, we focus on learning rather than blaming
	The unit manager supports and leads a culture of patient safety in my work setting

Where is the Opportunity for Improvement?
SAQ Results 2020/2021
Questions ≤ 60% Positive Response

Domain	Question
Job Satisfaction	Morale in this work setting is high
Stress Recognition	I am more likely to make errors in tense or hostile situations
	Fatigue impairs my performance during emergency situations (e.g., emergency resuscitation, seizure)
Working Conditions	Problem personnel are dealt with constructively by our senior management
Custom - Just Culture	The event reporting system is easy to use
Perceptions of Senior Management	The staffing levels in this work setting are sufficient to handle the number of patients
Perceptions of Local Management	Problem personnel are dealt with constructively by our local management

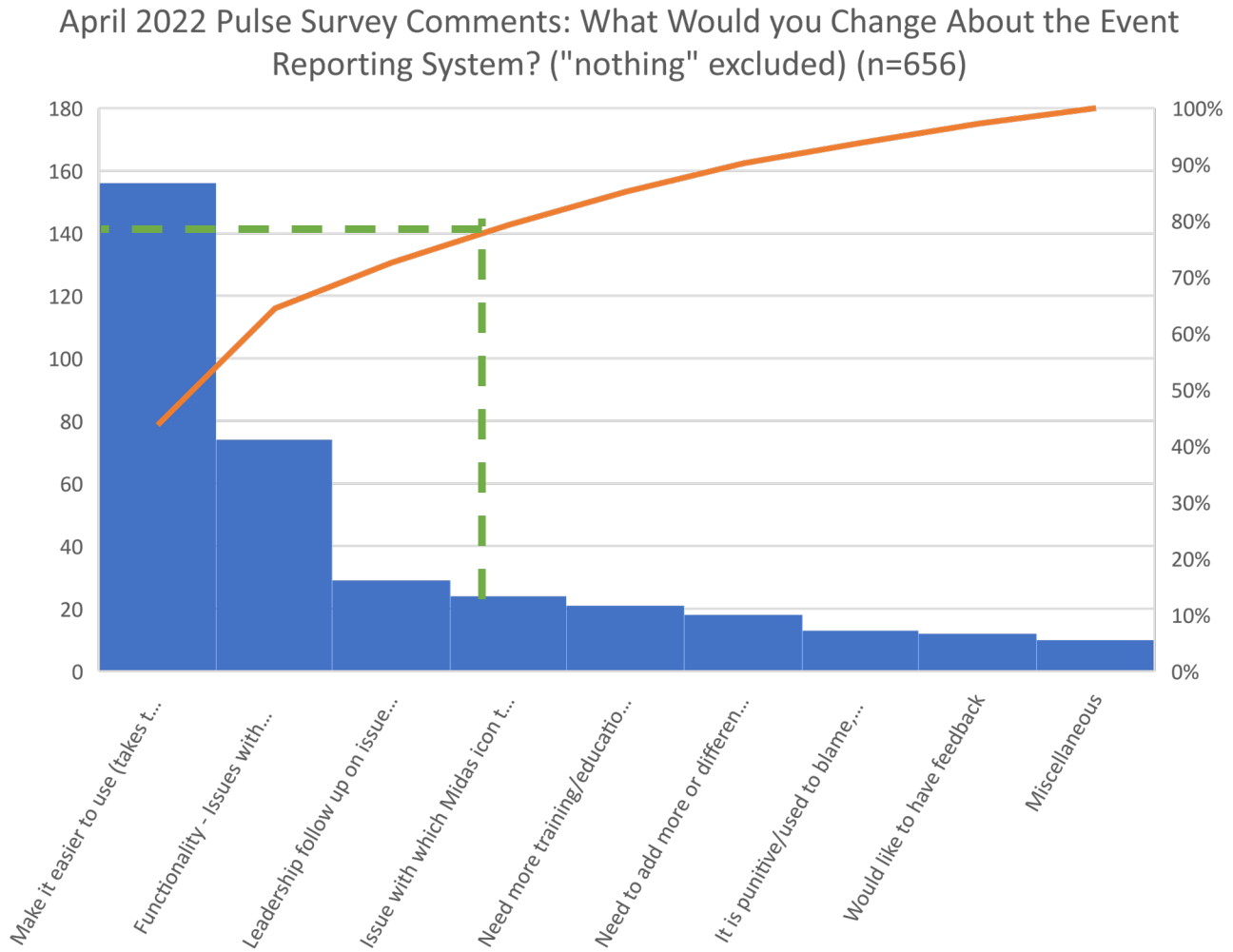
2022 Pulse Survey Positive Response Rate Vs 2020/21 SAQ

Pulse survey administered after improvement strategies implemented to evaluate effectiveness. Questions are answered on a 1-5 Likert scale. A positive response is considered a 4 "agree" or a 5 "strongly agree"

SAQ (Proprietary) Question	2020/21 SAQ	Like Pulse Survey Question	May 2022 Pulse
Fatigue impairs my performance during emergency situations (e.g., emergency resuscitation, seizure)	48%	I recognize that being mentally or physically exhausted impacts my ability to work during critical situations.	87%
I am more likely to make errors in tense or hostile situations	58%	I recognize that during high risk, high stress, complex situations I am more likely to make a mistake.	76%
Morale in this work setting is high	58%	Personnel have a good attitude and positive outlook in my work area.	74%
Problem personnel are dealt with constructively by our local management	51%	My local management (Manager and Director) deals with challenging personnel appropriately and effectively.	66%
Problem personnel are dealt with constructively by our senior management	56%	My Executive Team member deals with challenging personnel appropriately and effectively.	61%
The event reporting system is easy to use.	59%	The event reporting system is easy to use.	53%
The staffing levels in this work setting are sufficient to handle the number of patients	36%	Staffing is satisfactory for the number of patients we care for in my area.	45%

Pulse Survey Comment Analysis - "What would you change about the event reporting system?"

Comment Category	
	656
Make it easier to use (takes too long, too difficult, etc..)	156
Functionality - Issues with entering FIIN, empoloyee and facility (ie. outpatient) look up	74
Leadership follow up on issues/accountability	29
Issue with which Midas icon to use/icon location	24
Need more training/education on it's use/intent	21
Need to add more or different categories/event types, drop down options	18
It is punitive/used to blame, call-out others, or when there is a conflict	13
Would like to have feedback	12
Miscellaneous	10
Events are not taken seriously/pointless/waste of time/nothing ever done about issues	4



Safety Culture Summary

- Quality Improvement efforts addressed the 7 SAQ questions that resulted in less than 60% positive response from the 2020/2021 survey (see reference slides for summary of improvement actions)
- Additional improvement actions such as enhancements to team training and just culture program also in place (see reference slides for summary of improvement actions)
- Pulse survey resulted in improvement in 6/7 “like” SAQ questions indicating that improvement strategies have been effective.
- One 2022 pulse survey question did not improve from the 2020/21 SAQ “The event reporting system is easy to use”.
  - Free text question “What would you change about the Midas system” posed to pulse survey respondents to solicit insight and data to guide improvement. This is a custom question that is not part of the SAQ proprietary measurement tool, but is part of our just culture measurement strategy.
  - Free text responses grouped into categories; Pareto chart developed to guide brainstorming for improvement strategies (see previous slide)
  - **Next Steps** – Refine and develop plan to address root causes

Questions?

Reference Materials
Action Plan Summary for Safety Culture Improvement

SAQ 2020/2021 Questions ≤ 60% Positive Response

Domain	Question	Analysis (solicited during staff debrief sessions)	Action Plan
Job Satisfaction	Morale in this work setting is high	• SAQ administered in Dec 2020 to Feb 2021, **SAQ results could be associated with timing of survey during COVID-19 surge** • SAQ Results compared to like questions in the employee engagement (EE) survey which showed several like EE questions scored higher than the matching SAQ question. Which Indicates timing of SAQ survey was a factor with low scoring results for this SAQ question (SAQ was administered during height of pandemic/staff shortages).	• Include a measure in the May 2022 pulse survey to evaluate results. Question "Personnel have a good attitude and positive outlook in my work area" added to pulse survey questions.
Stress Recognition	I am more likely to make errors in tense or hostile situations	• Significant increase in SAQ Stress Recognition domain score from 2016 to 2018 due to mandatory training for all staff in SAQ departments/units approximately 4 months before 2018 SAQ administered; Training was embedded in new hire orientation only ongoing • Overall 10 point drop in the 2021 Stress Recognition domain score from the 2018 survey, but above the industry median. • Pascal Metrics (industry expert) indicates improvement strategies should be focused on education	• include Stress Recognition in Mandatory Annual Testing (MAT) in 2022; Administered 3/1/22 • Evaluate effectiveness via pulse survey in May 2022 with SAQ like stress recognition questions
Stress Recognition	Fatigue impairs my performance during emergency situations (e.g., emergency resuscitation, seizure)		

SAQ 2020/2021 Questions ≤ 60% Positive Response

Domain	Question	Analysis (solicited during staff debrief sessions)	Action Plan
Working Conditions	Problem personnel are dealt with constructively by our senior management	• Results analyzed from highest to lowest by work setting and disseminated to VP	• Employee Relations class targeted to leaders within chain of command, this class offering is ongoing • METER committee established May 2021 which escalates egregious or trending concerns due to lack of professionalism or personnel issues. From May 2021-July 2022 5,570 events reviewed in total, 150 events escalated to Executive Team (ET). 88/150 were escalated to ET only, 10 escalated to Chief of Staff (COS) only, and 52 went to both ET and COS. • Human Resources tracking employees with an evaluation score of less than 2.5% and working with the Directors and Managers to ensure improvement or appropriate next steps. Occurs each quarter (first of January, April, and July). • Linked In Learning sessions “Monthly Leadership Topics” which included topics on managing difficult situations • Pulse survey question in May 2022 to evaluate effectives

SAQ 2020/2021 Questions ≤ 60% Positive Response

Domain	Question	Analysis (solicited during staff debrief sessions)	Action Plan
Custom - Just Culture	The event reporting system is easy to use	Feedback solicited during SAQ staff debrief sessions which revealed the following insight: • Staff commented on the difficulty of selecting category type and several mandatory fields. The requirement to select a category was removed approximately 1.5 years ago, as well as several categories were removed. Many staff not aware of changes. Staff who were commented on other event forms that continue to be long (ie. falls and adverse drug events). • Staff commented they do not submit events because they don't know if anyone reads them or does anything with them • Some commented that the event reporting process feels punitive and unaware that events can be submitted anonymously	• Targeted education provided to 28 units/depts through staff meetings (lowest score, high risk processes/care) completed 1Q 2022. Education objectives included: Importance of reporting and why, what and how to report, and just culture review • Stakeholder review and revision of falls and adverse drug event reporting forms completion target date • Implemented staff email thank you and acknowledgement of receipt of event report and communication of review by METER Committee (Midas Event Triage & Ranking)(Jan 2022). • Optimization of event reporting system, to include restructure of event categories and type in partnership with Cal Poly Department of Industrial and Manufacturing Engineering (target completion Oct 2022) • Evaluate effectiveness through pulse survey question "The event reporting system is easy to use" and solicit comments to help identify root causes

SAQ 2020/2021 Questions ≤ 60% Positive Response

Domain	Question	Analysis	Action Plan
Perceptions of Senior Management	The staffing levels in this work setting are sufficient to handle the number of patients	• Analyze results with employee engagement survey results (July 2021); SAQ results could be associated with timing of survey during COVID-19 surge. • Results analyzed from highest to lowest by work setting and disseminated to VP	• Budget planning included leader sign off, shift bonus • Recruiting events, hiring in anticipation turnover, shift bonuses • Student RN interns, travelers • Improving efficiency for staff, for example, reducing documentation time • Eliminating work that is not necessary or impactful • Retention committee formed 2Q 2022 • Exit and onboarding and stay pulse surveys starting 1Q 2022 • Kaweah Health School of Nursing under development with Unitek • Employee Huddles have addressed questions about staffing & pay • Evaluate effectiveness through pulse survey in May 2022, considering additional pulse survey to determine who "problem personnel" are
Perceptions of Local Management	Problem personnel are dealt with constructively by our local management	• Analyze results with employee engagement survey results; SAQ results could be associated with timing of survey during COVID-19 surge. • Results analyzed from highest to lowest by work setting and disseminated to VP	• Employee Relations class targeted to leaders within chain of command; class is ongoing • METER committee established May 2021 which escalates egregious or trending concerns due to lack of professionalism or personnel issues. From May 2021-July 2022 5,570 events reviewed in total, 150 events escalated to Executive Team (ET). 88/150 were escalated to ET only, 10 escalated to Chief of Staff (COS) only, and 52 went to both ET and COS. • Human Resources tracking employees with an evaluation score of less than 2.5% and working with the Directors and Managers to ensure improvement or appropriate next steps. Occurs each quarter (first of January, April, and July). • Linked In Learning sessions "Monthly Leadership Topics" which included topics on managing difficult situations • Pulse survey May 2022 to evaluate effectives, considering additional pulse survey to gain insight on the identity of the "problem personnel".

Safety Culture – Organizational Initiatives – 2021/22

Addresses SAQ Domain	Safety Culture QI Strategy
Teamwork Climate	TeamSETPPS Leadership (Medical Team Training) • 38 Kaweah leaders participated in training May & June 2021. Plan to have another cohort before the end of 2022 • Evaluation indicated the training accomplished goals: participants felt it was useful to their role/work, and learning occurred • >60 medical team tools implemented in 38 Kaweah locations/departments TeamSTEPPS Staff • All new hires in patient care roles complete CUS (I am concerned, uncomfortable, this is a safety situation) training; achieved training goals (>90% correct response rate) from 2017-2022 (2020 n=6,726). 99% of staff indicate ability to use CUS during a patient safety situation in 2022 • Broad dissemination of "Say it again, Sam" (aka 2 challenge rule) TeamSTEPPS tool, approved by Patient Safety Committee for 3Q 2021 • 1Q 2022 Staff version of TeamSTEPPs simulation training go live
Perceptions of Local and Senior Management Safety Climate	Just Culture Steering Committee • Plan for Just Culture expanded staff awareness campaign 2021-2022 to include: • GME Just Review lessons learned published • Video rolled out at staff meetings and incorporated into new employee and physician orientations • Leadership refresher training and scenario reviews • Monthly topics (LTM, staff meetings, Communication Board, Compass) • Evaluate training of new medical staff leaders and charge nurses • Incorporating JC into mandatory annual training • Pulse survey for staff to gage effectiveness • Just Culture Champion Certificate Program – Planned for 2023 • Planned action: Charge nurse 2 hour training on Just Culture Sept-Dec 2022
Safety Climate	• 12 Good Catch awards (staff and providers) in 2021 • Hero of the Year awarded in 2022 • Sepsis Heroes awarded monthly (providers and RNs who provide best practice care to septic patients) • Safety Star – awarded monthly for exceptional hand hygiene compliance as noted in the BioVigil system

Safety Culture – Organizational Initiatives – 2021/22

Addresses SAQ Domain	Safety Culture **BY ROLE** QI Strategy
Teamwork Climate	Action Plan: • Local leadership evaluate role & unit/department specific concerns; corrective action plan • Continue to reinforce TeamSTEPPS® tool "CUS" through the organization, and broadly introduce, spread and reinforce the TeamSTEPPS® 2 Challenge Rule (Kaweah Health terms this tool: "Say it again, Sam".). Say is again Sam campaign started Nov 2021. • Developing plan to incorporate job shadowing in RN orientation to gain a better understanding of ancillary roles (ie. telemonitors, lab, and transporters). In progress

Scope of Services

Purpose
Kaweah Health offers its services to patients whose medical needs can be met within the capability of Kaweah Health's employees, medical staff and facilities.

Criteria for Entry/Admission to Service
Kaweah Health's scope of services includes general, psychiatric and rehabilitation inpatient and outpatient diagnosis and treatment as well as home health and hospice care services. All departments collaborate to provide the best care possible for our patients, to improve outcomes, and achieve our mission, vision and goals. Each individual area of Kaweah Health defines the types and ages of patients served, the hours of operation, staffing, the types of services provided, and the goals or plans to improve quality of service.

For each program or service, Kaweah Health defines the appropriate professional staff and facilities needed to provide the services in a manner consistent with Kaweah Health's mission. Additionally, Kaweah Health identifies types of patient conditions and concerns that cannot be appropriately treated at the hospital and arranges for appropriate referral and/or transfer for such patients.

Patients
The population served at Kaweah Health includes all ages regardless of national or ethnic origin, economic status, lifestyle, creed or philosophical beliefs. Patients can expect appropriate procedures, treatments, interventions and care will be provided according to established policies, procedures, protocols and order sets that have been developed to ensure patient safety and positive quality outcomes. Appropriateness of procedures, treatments, interventions, and care will be based upon patient assessments, re-assessments, and desired outcomes. Respect for patient individual needs, rights and confidentiality will be maintained.

Services
Kaweah Health is fully licensed and accredited. The hospital offers primary and specialty services; these professional services are offered in a caring and compassionate manner.

Clinical Diagnostic/Treatment Services
Adult & Pediatric Medical/Surgical services and Subspecialties
Adult Critical Care Services
Operative and Invasive Services
Anesthesia
Emergency Services
Level III Trauma Services
Diagnostic Radiology Services

- General Radiology
- MRI
- CT Scan
- Ultrasound
- Nuclear Medicine
- Mammography

Interventional Radiology
Acute Rehabilitation Services
Rehabilitation Services – Outpatient

- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Hyperbaric and Wound Care

Respiratory Care
Clinical Laboratory and Pathology Services
Sleep Lab
Cardiopulmonary Diagnostics
Case Management/Discharge Planning
Nutritional Services
Pharmaceutical Services
Home Health Services
Home Infusion Pharmacy Services
Hospice
Infusion Therapy Services (outpatient)
Chaplaincy Services
Cardiac Cath Lab
Cardiac Clinic Services
Cardiovascular Surgery
Cardiac Rehabilitation Services
Pulmonary Rehabilitation
Pain Management Services
Urgent Care
Maternal Health Services
Neonatal Intensive Care
Occupational Medicine
Neurological Services
Neurosurgical Services
Dialysis for Inpatients and Outpatient
Oncology Services - Inpatient and Outpatient
Acute Mental Health Services
Rural Health Clinics
Subacute Services
Urology Services

Support Services

Administration
Admissions
Materials Management Services
Employee Assistance Program
Environmental Services
Food Services
Finance
Human Resource Management
Information Technology
Plant, Engineering and Maintenance Services
Employee Health Services
Health Records Information Services
Sterile Processing
Education Services
Volunteer Services

Quality Management Services
Linen Services
Patient Accounting
Physician Recruitment
Medical Staff
Risk Management
Compliance and Internal Audit
Infection Prevention
Patient and Family Services

Community Services
Community Outreach
Community Support Groups
Library Services
Population Health Management Clinic
Marketing/Public Relations
Diabetes Education
Lifestyle Center

Employees
Kaweah Health is committed to excellence in clinical practice. We recognize that people are our major resource, ever capable of growth. Professional competence and quality care are assured through the recruitment, retention and continuing education of a highly skilled employee.

Staffing plans for patient care units are evaluated to determine that the personnel can provide competent services within the scope of professional licensing and training for the appropriate level and scope of care needed. Staffing plans are department specific and available in each nursing unit.

Collaboration
Kaweah Health maintains and promotes positive relationships with the community and provides patient-centered care and services through: A mission, vision, and value statement that serves as a foundation; Strategic planning with Governance, Leadership, and Physicians; establishment of shared values that guide employee behavior; ongoing evaluation of services provided through participation in national performance improvement activities; priority focus on patient relations, their interests, needs and expectations; and establishing and coordinating programs and services with other providers, associations, public and private agencies, physicians, and insurers.

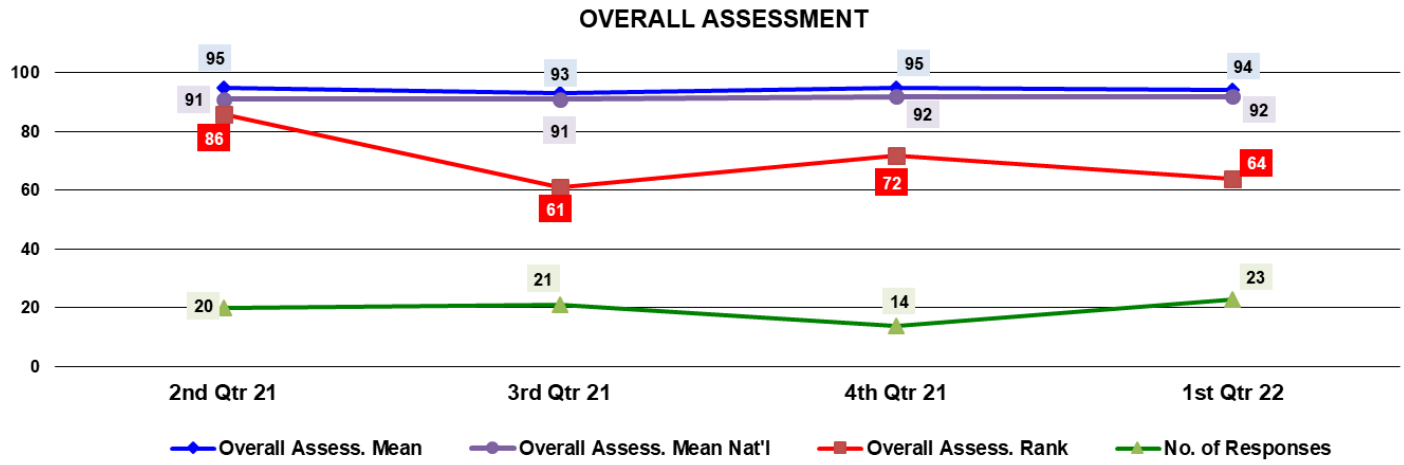
Support Services
Other hospital services will be available to ensure that direct patient care services are maintained in an uninterrupted and continuous manner by coordinated, identified organizational functions such as leadership/management, information systems, environmental services, fiscal/patient financial services, and performance improvement. These services support the comfort and safety of our patients and are fully integrated with the patient service departments of the organization.

References
LD 01.03.01, EP3 and PC 01.01.01, EP7

Unit/Department: Rehabilitation Services **Pro Staff Report Date:** May 2022

Measure Objective/Goal:
Acute rehabilitation program evaluation: patient satisfaction and clinical quality including functional outcomes and referral review
Date range of data evaluated: Rehab quarterly report, 4th quarter 2021 and 1st quarter of 2022

Patient Satisfaction
Analysis of all measures/data: (Include key findings, improvements, opportunities)
In the 4th quarter of 2021, the mean score for the overall assessment of care was 95, placing the program in the 72nd percentile. For 1st quarter 2022, mean was 94 placing also placing in the 64th percentile. Scores continue to show a steady positive trend. Kaweah Health Rehab will be switching vendors from Press Ganey to NRC in July 2022, which will result in new data being collected.



If improvement opportunities identified, provide action plan and expected resolution date:
Patient satisfaction is maintaining above the 90th percentile, so initiatives in place will continue, including:

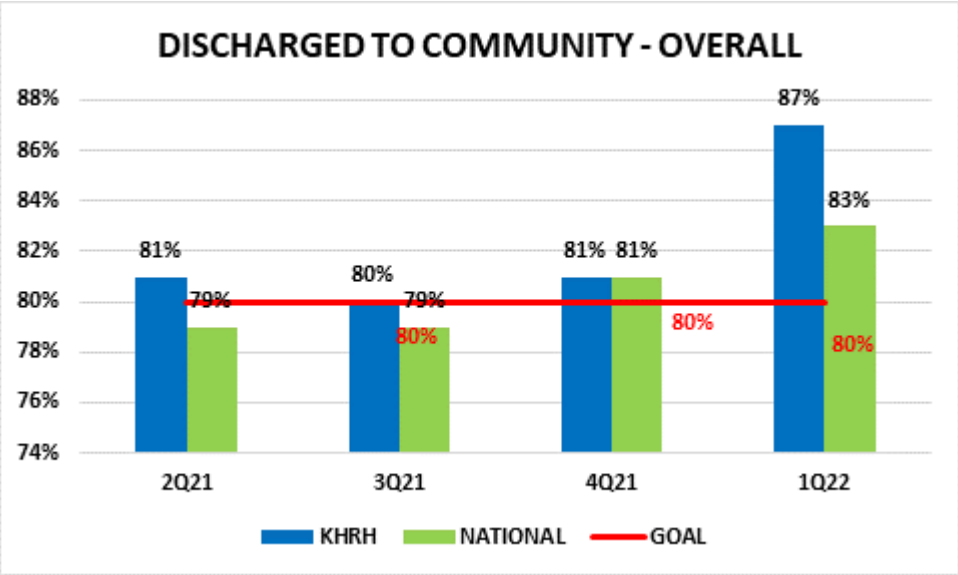
- offering white noise device as part of rounding based on patient's need
- leaders responding and rounding to feedback from mid-stay surveys
- use of goal board to assist with patient engagement in setting and reviewing their goals
- patients journaling their Speech Therapy sessions to increase awareness of progress
- Rehab Medical Director following up with physician concerns in mid-stay survey and the doctors being available to call family if they express questions or concerns with case management.

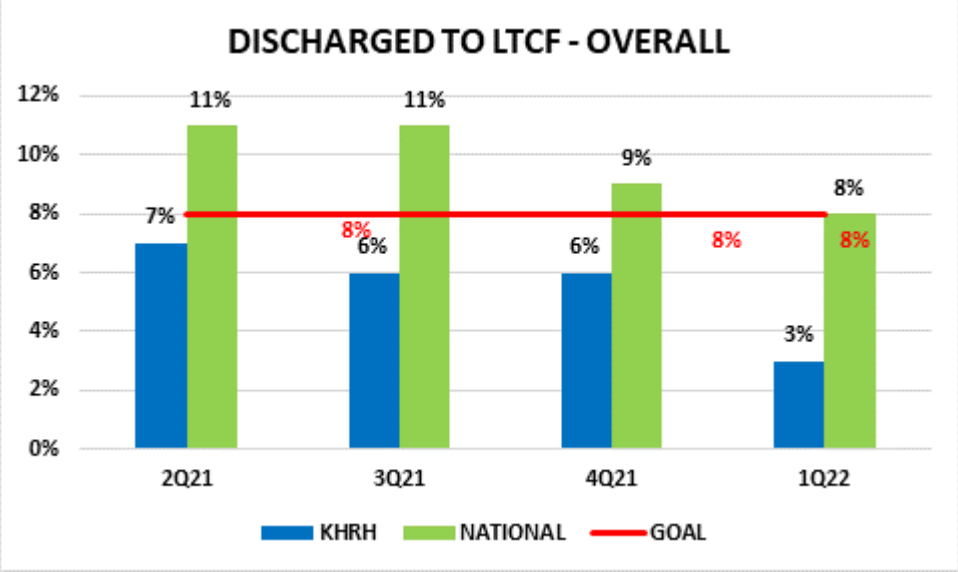
Functional Outcomes

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

Discharged to Community – (higher is better) In 4Q21 81% of KH Rehab patients returned to community, matching the national average of 81%. For 1st quarter 2022, we improved to 87% of KH Rehab patients returned to community, exceeding the national average of 83%.

Discharge to LTCH – (lower is better) KH Rehab patients discharging to Skilled Nursing Facility in 4Q21 were 6% compared to national average of 9% and 1Q22 3% compared to 8%.





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

Clinical outcomes continue to be strong, compared to the nation.

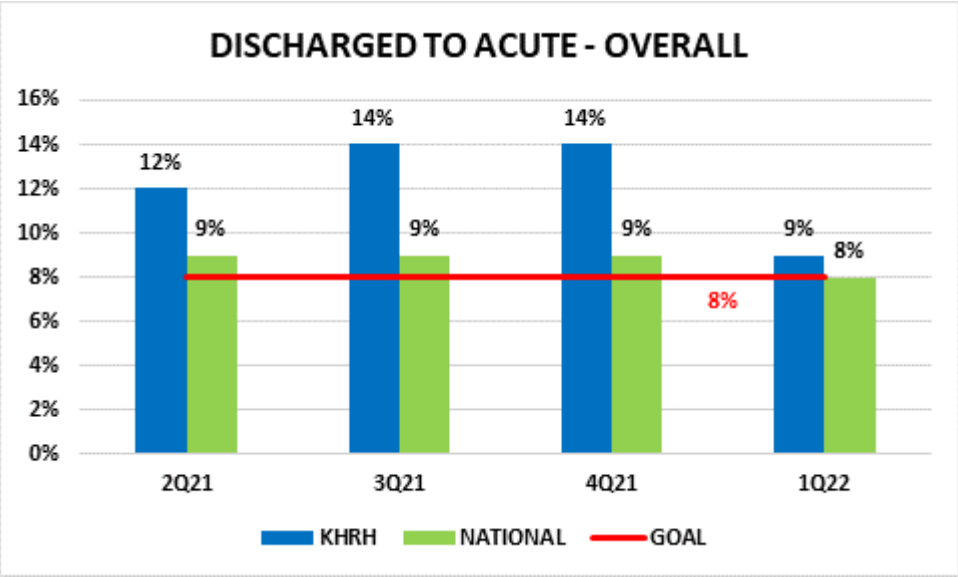
Transfer of Care

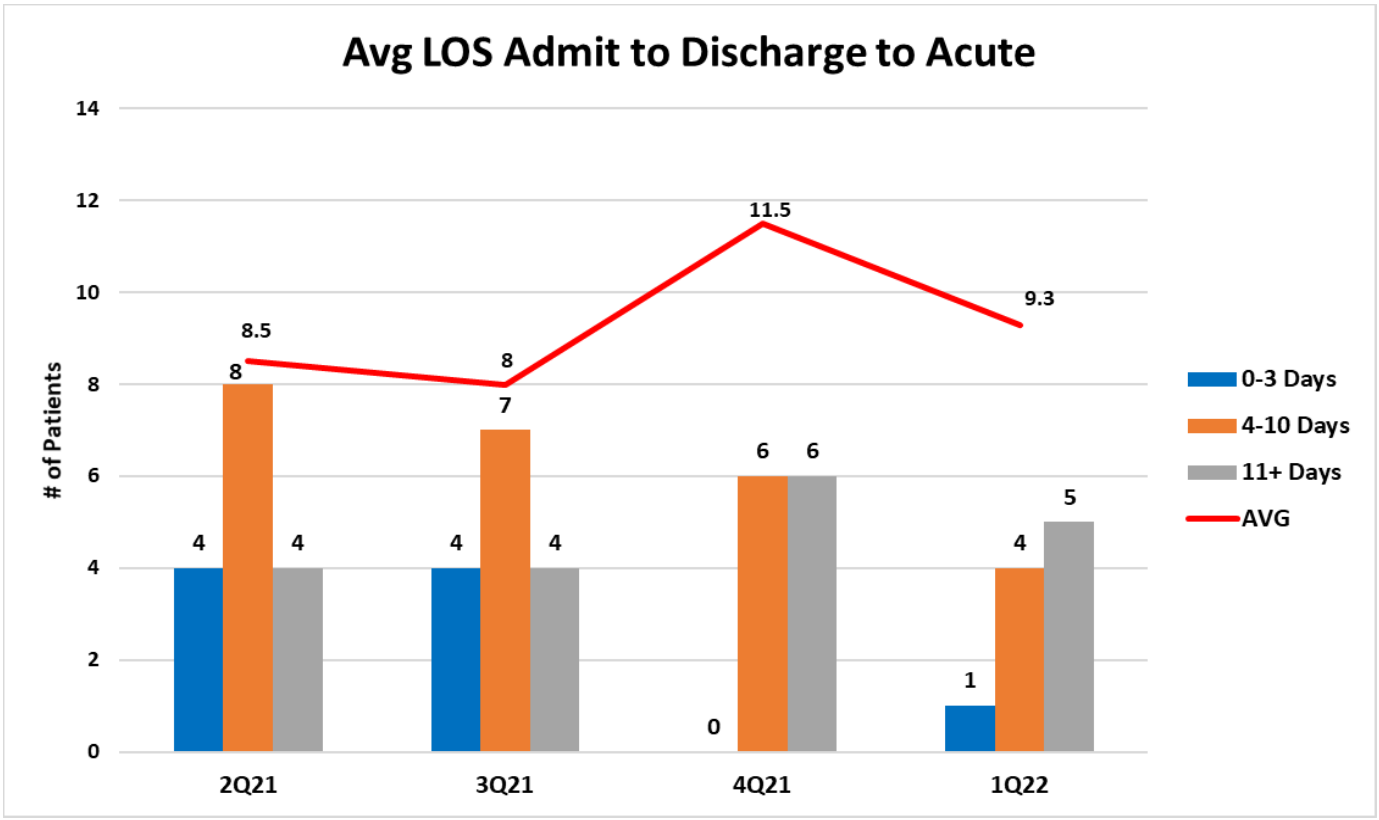
Analysis of all measures/data: (Include key findings, improvements, opportunities)

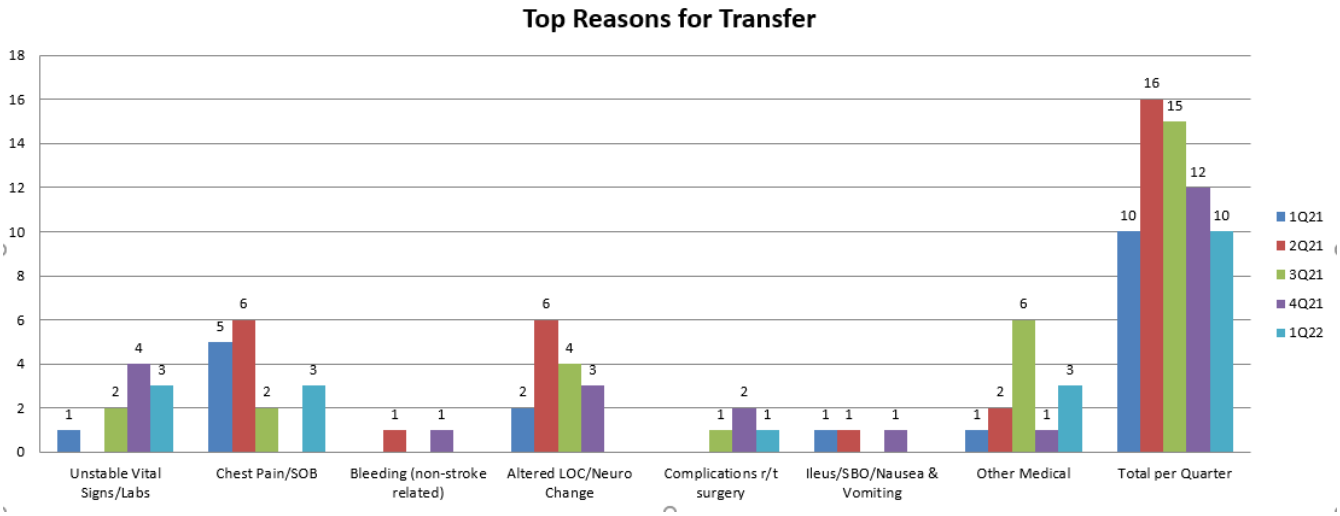
Discharged to Acute – (lower is better) In 4Q21, KH Rehab patients discharging back to the Acute Medical Center was 14%, above the national average of 9%. However, in 1Q22, we had significant improvement dropping to 9% versus the nation at 8%. The decline is associated with having a different complexity of patients. Our stroke population was only 26% of impairments, much lower than previous, compared to nation at 23%. The Case Mix Index for KH was 1.40 versus nation at 1.44. The acute transfers we have were low in CVA, 3% for KH versus 8% for nation.

Average LOS Prior to Discharge to Acute – In 1Q22, the avg. number of days from Rehab admission to transfer to Medical Center was 9.8 days. There was one outlier with a LOS of 24 days, thus we also utilized a distribution chart to better analyze at what point during their Rehab stay they transferred back to Medical Center. There was one patient who was not appropriate for Rehab at the time they were admitted as this patient came to Rehab prior to a needed procedure being completed. She returned to the acute medical center (AMC) the next day for her procedure. All other patients were appropriate at the time of admission to Acute Rehab (AR).

Top Reasons for Transfer - In the 4th quarter of 2021, 12 patients and in the 1st quarter 2022 10 patients transferred back to the Acute Medical Center, demonstrating a continued positive downtrend in re-admissions. One trend identified was the same patient returning to the AMC multiple times. Dr. Matsuo's analysis: Overall, the patients discharging to the AMC is trending down. "Altered LOC/Neuro changes" continued to be one of the main reasons for transfers out which will likely continue given NIHSS protocol consistent with NIHSS protocol resulting in early intervention for suspected worsening/new strokes. There was a slight spike in unstable vitals/labs send out, which I cannot attribute to a particular issue. Will monitor next quarter to see if it was an anomaly. In 1st quarter 2022, the "other medical" represents 2 trauma patients readmitted with unstable fractures requiring surgery. Otherwise, all appropriate transfers due to diagnosis and treatment plans.







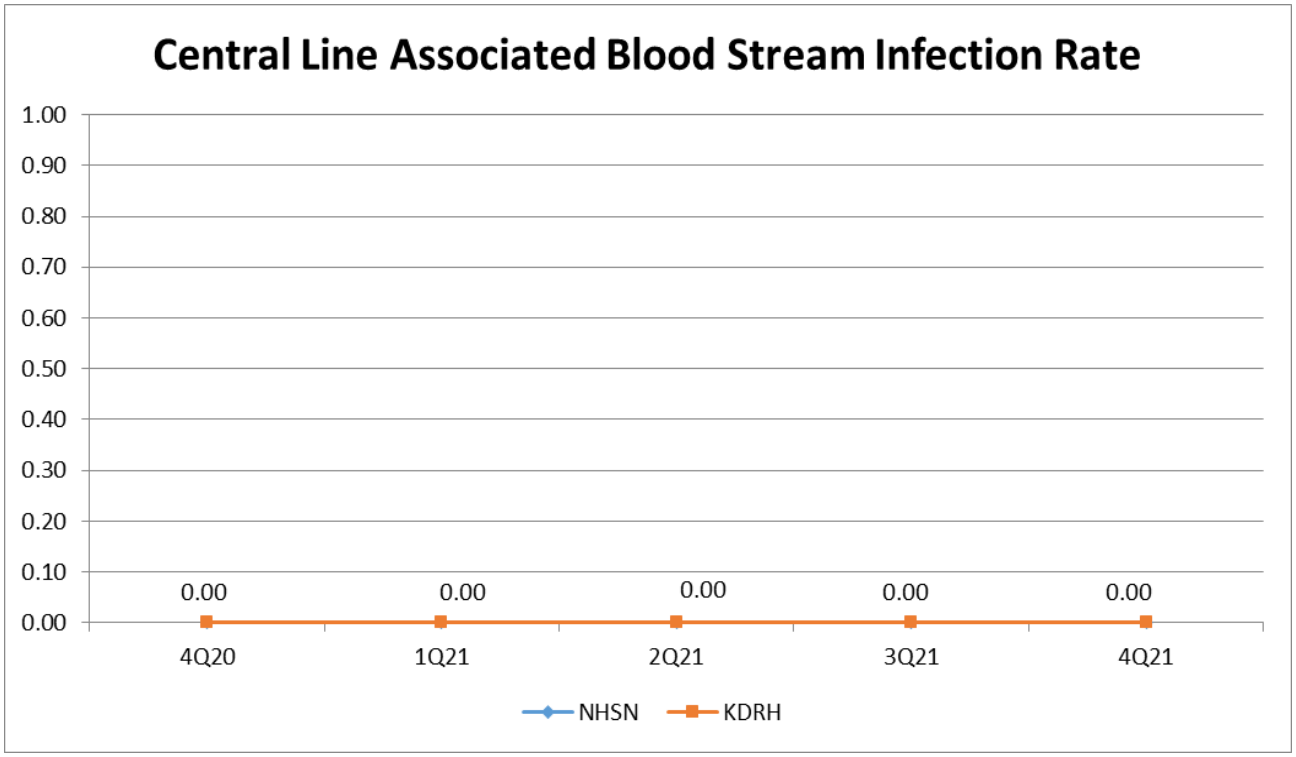
If improvement opportunities identified, provide action plan and expected resolution date:

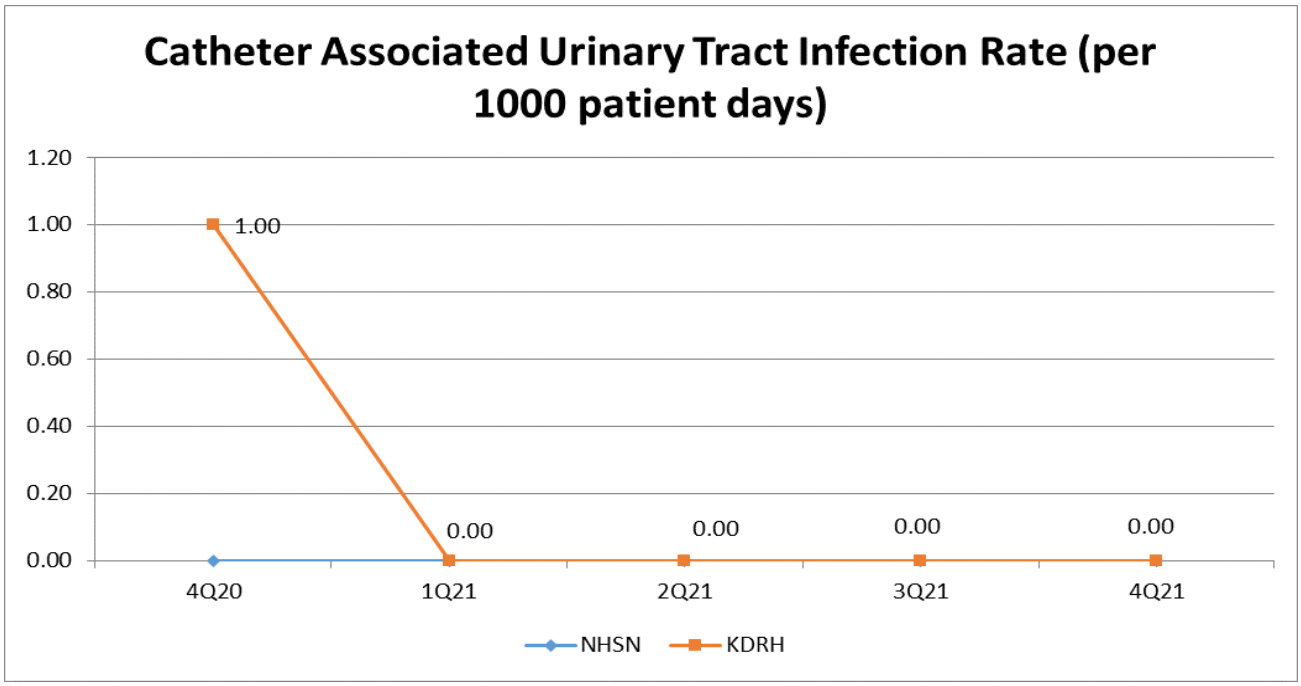
Continue to monitor closely “unstable vitals/labs”. We have met with the ACTS team in an effort to improve communication and collaboration on the increasing number of trauma patients we are accepting, will continue to collaborate with ACTS on trauma patients and develop Trauma Admission Power Plan. Additional action plans currently initiated are Wound Care Power Plan and quarterly Lunch & Learn series presented by Rehab Providers with topics specific to patients who returned to the Medical Center. New action plans: 1 - Determine if goal of 8% for Discharge to Medical Center is appropriate, as it has not been met in 5 quarters. Will utilize information as to the differences in our area compared to the nation i.e. the Tulare County population co-morbidities such as diabetes, chronic kidney disease, amputation, strokes, etc. 2 – Work with Case Management and ED to facilitate possibly return before the 3 day interruption of stay expires including review any changes in condition and determine if the patient is still appropriate for Acute Rehab.

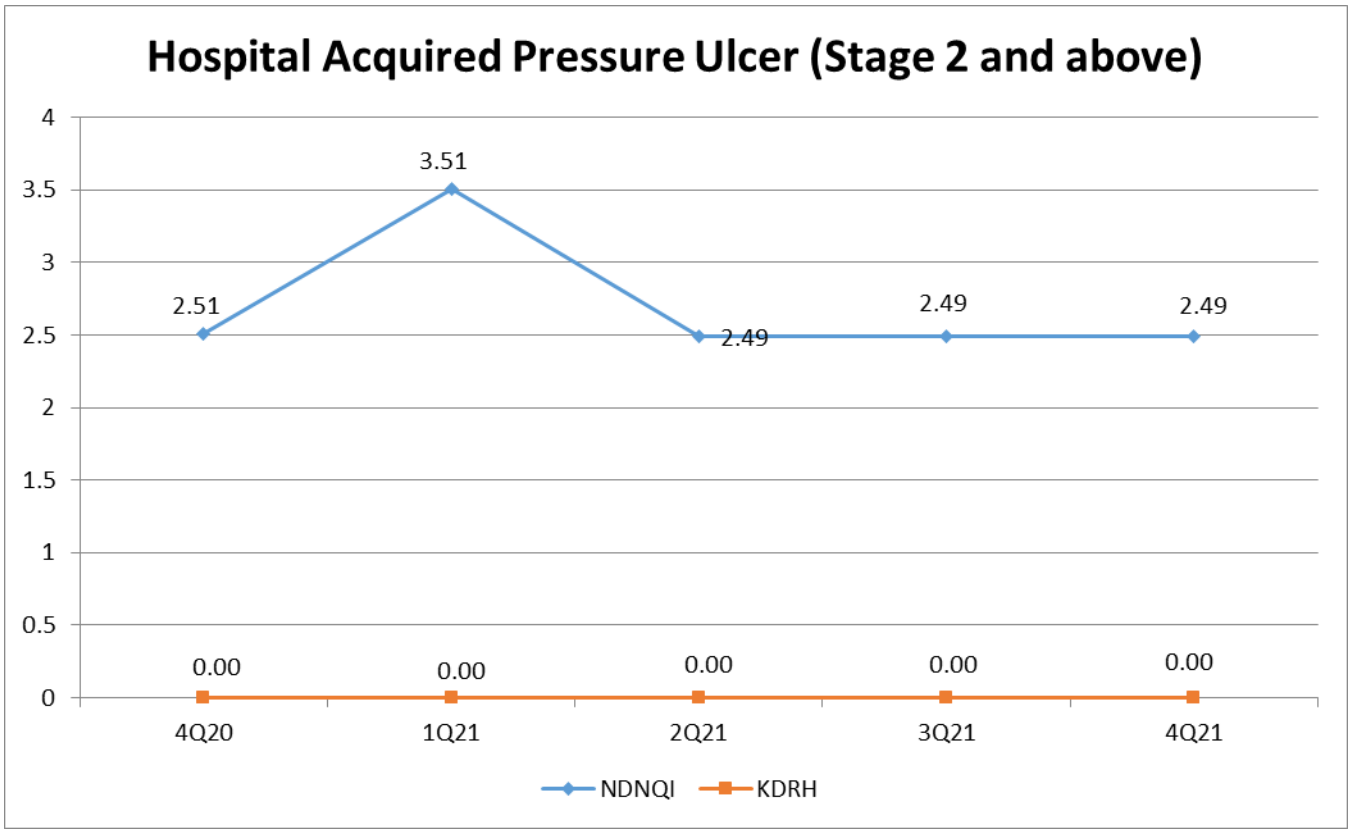
Measure Objective/Goal:
Nursing indicators relative to NDNQI

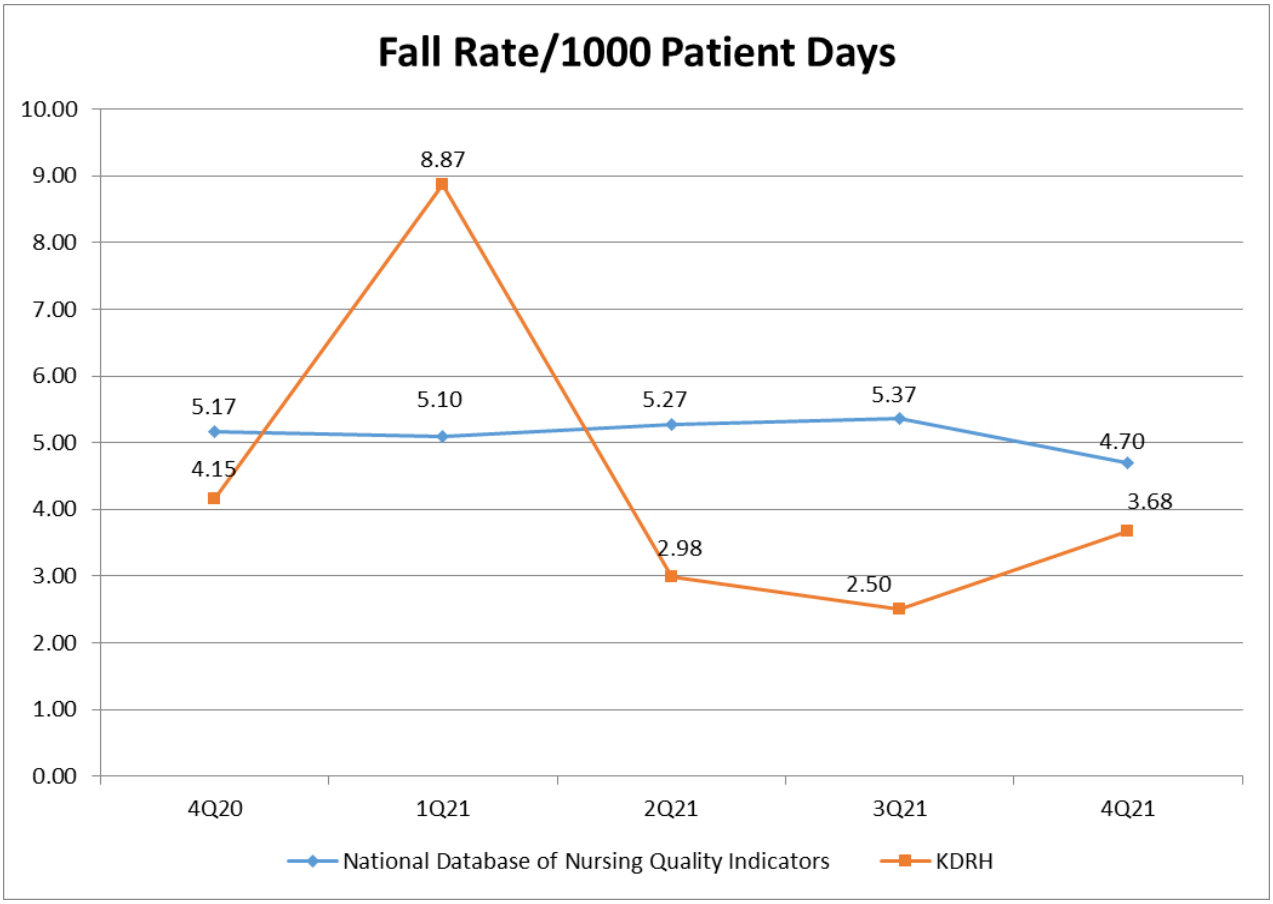
Date range of data evaluated: 3rd and 4th quarter 2021

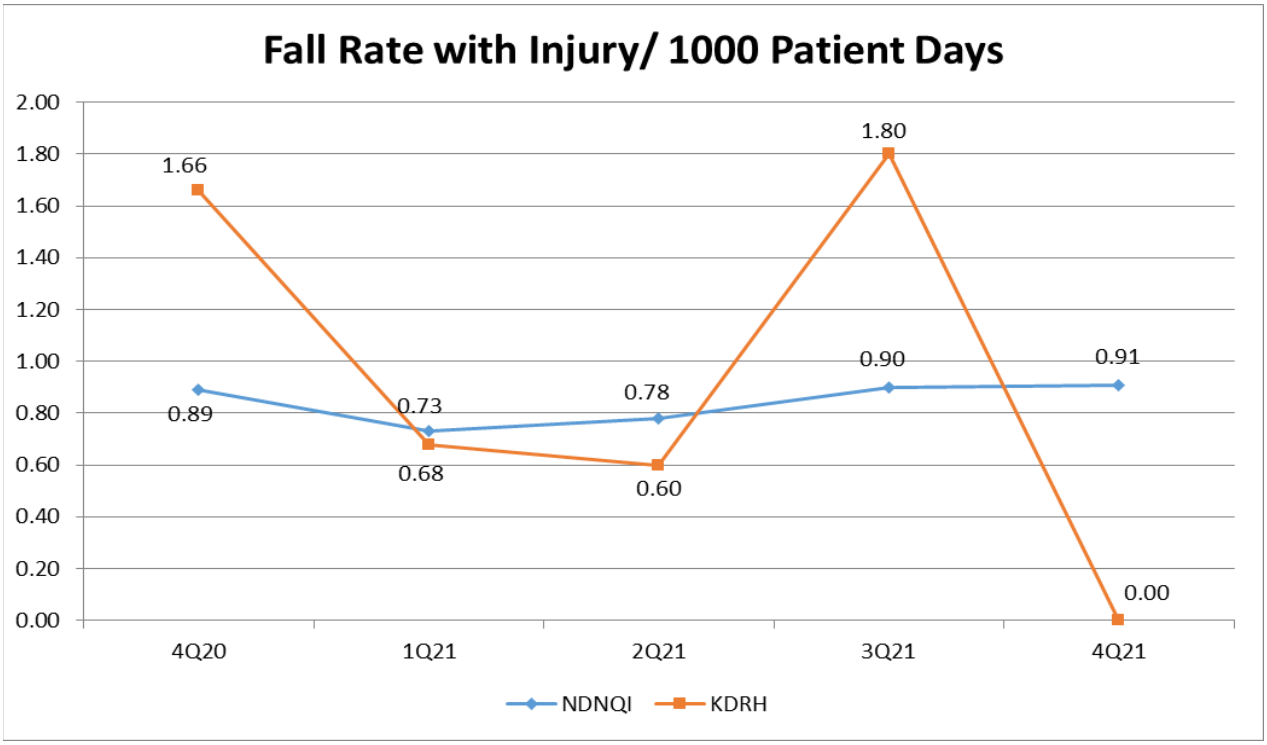
Analysis of all measures/data: (Include key findings, improvements, opportunities)
Kaweah Delta Rehab had zero incidence of central line blood stream infections, hospital acquired pressure ulcer stage II or above and CAUTI. Fall rate per 1000 patient days was below NDNQI benchmarks in 3Q21 and in 3Q21, 5 falls (3 unwitnessed).




Catheter Associated Urinary Tract Infection Rate (per 1000 patient days)
1.20
1.00
0.80
0.60
0.40
0.20
0.00
1.00
0.00
0.00
0.00
0.00
4Q20
1Q21
2Q21
3Q21
4Q21
NHSN
KDRH


Hospital Acquired Pressure Ulcer (Stage 2 and above)
4
3.5
3
2.5
2
1.5
1
0.5
0
3.51
2.51
2.49
2.49
2.49
0.00
0.00
0.00
0.00
0.00
4Q20
1Q21
2Q21
3Q21
4Q21
NDNQI
KDRH





If improvement opportunities identified, provide action plan and expected resolution date:
Continue existing initiatives for CAUTI with renewed focus on GEMBA rounds, peri care and bathing as well as focus on validation of CNA transfer competency has helped reduce avoidable falls. Virtual Falls University restarted. Rehab Nurse Manager attends and invites staff to participate.

Measure Objective/Goal: Hand Hygiene compliance

Date range of data evaluated: 3rd and 4th quarter 2021

Analysis of all measures/data: (Include key findings, improvements, opportunities)
In 3rd quarter 2021, overall compliance rate of 97.4%. For 4th quarter 2021, overall compliance rate of 94%, which is below the target of 95%.

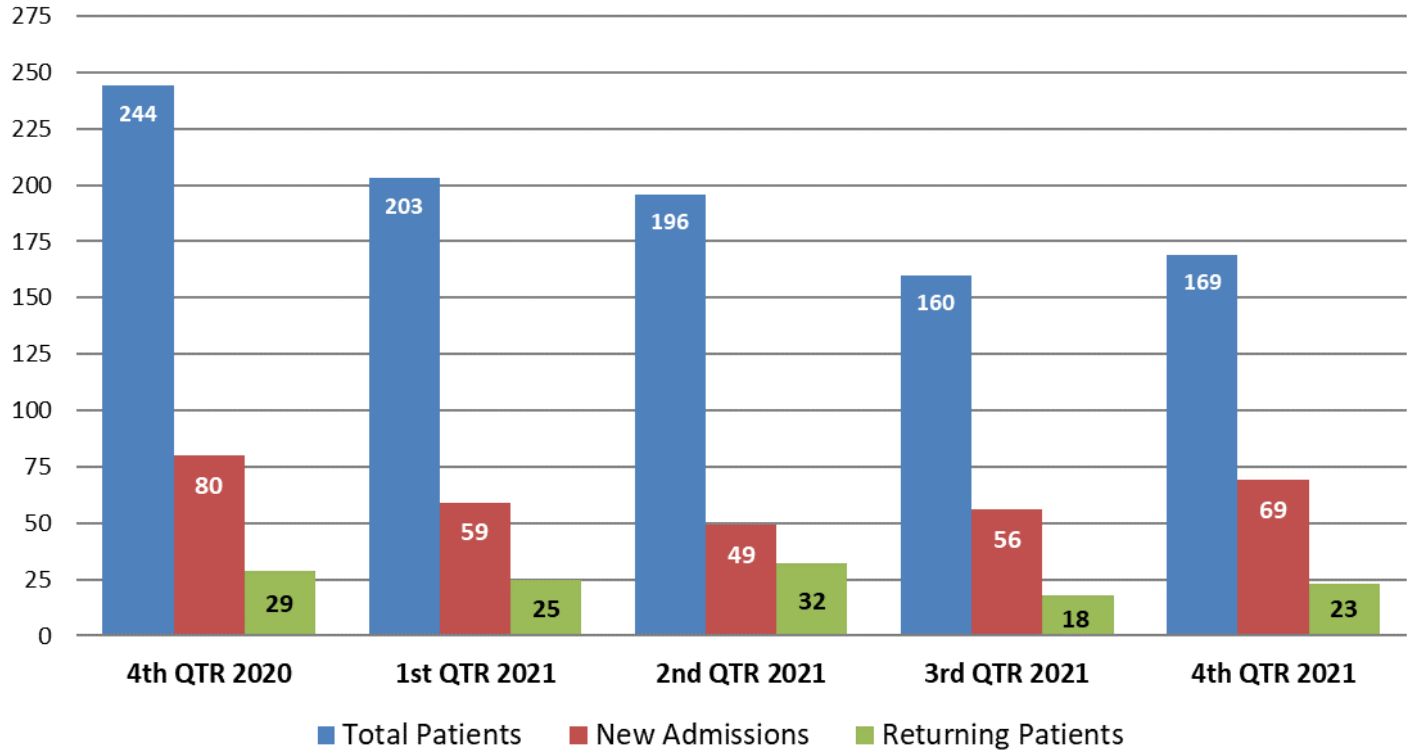
If improvement opportunities identified, provide action plan and expected resolution date:
Initiatives include implementation of Biovigil on West campus in March of 2022.

Measure Objective/Goal: Wound Center outcomes

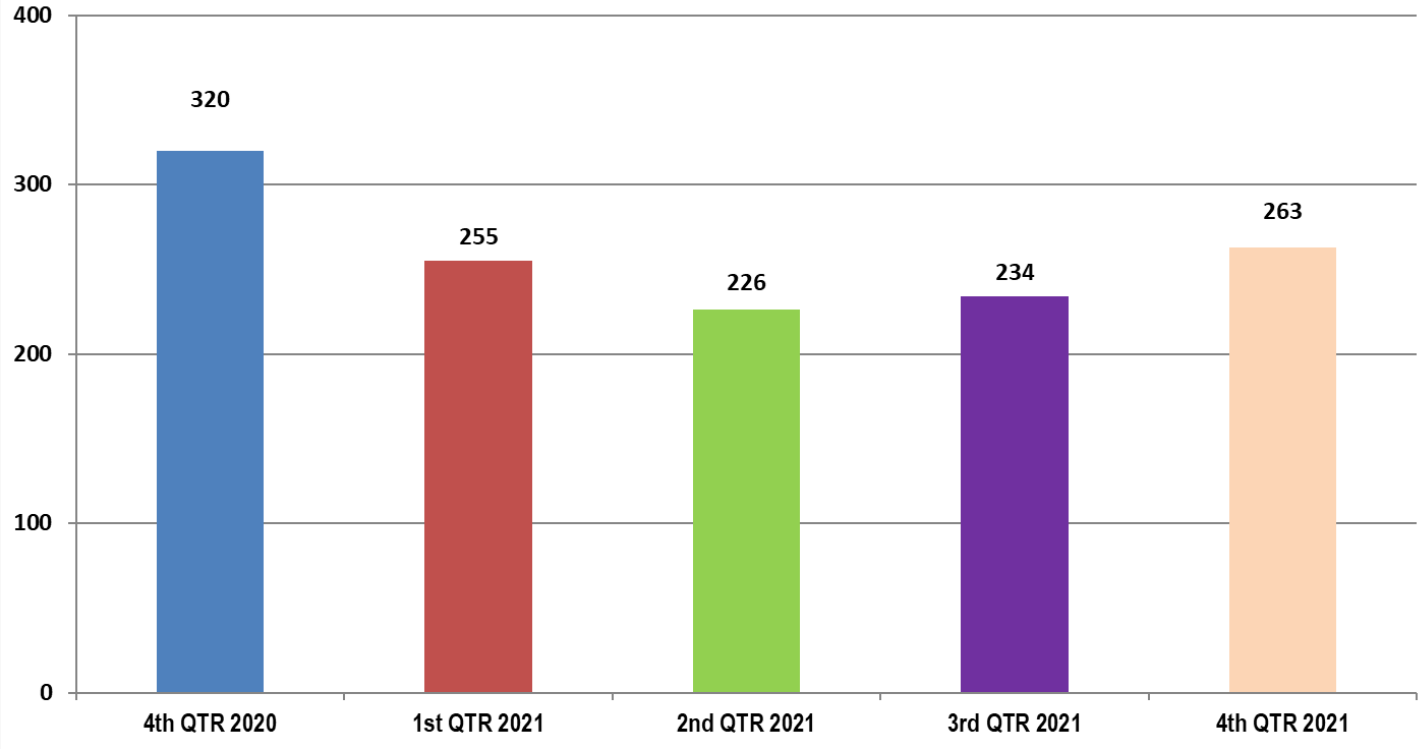
Date range of data evaluated: 3rd and 4th quarter 2021

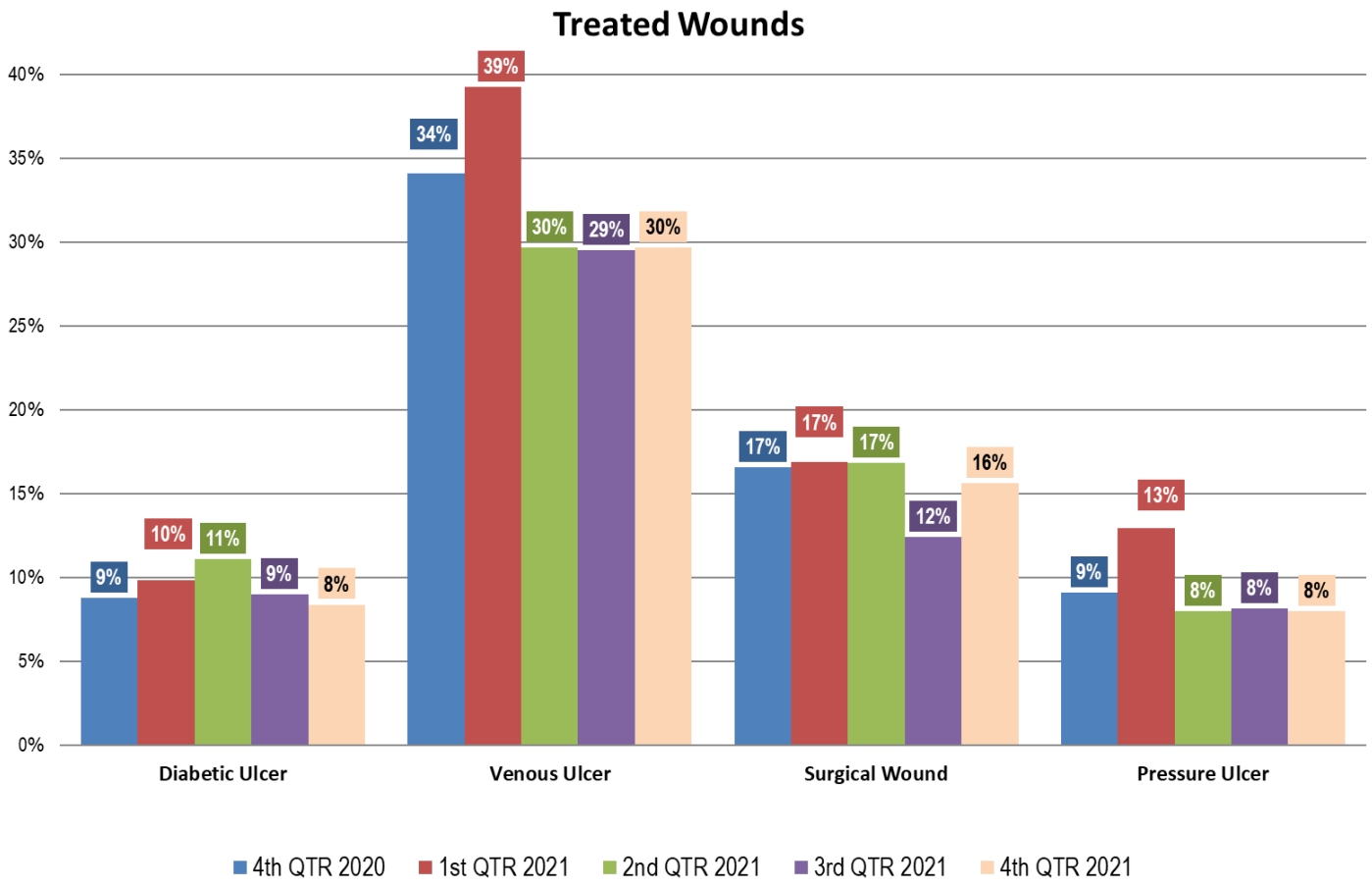
Analysis of all measures/data: (Include key findings, improvements, opportunities)
For total days to heal, in 3rd quarter 2012 KH performed 9 days under (54) compared Wound Expert Center's average of 63. In the 4th quarter 2021, we were 10 days above, KH 75 versus 65 days. 4th quarter data: Diabetic Ulcers (4 total wounds): Kaweah Wound Center Average Days to heal 35 compared to 88 with Wound Expert Facility Average. Pressure Ulcers (3 wounds): KH average days to heal 79 compared to 66. Surgical Wounds (9 wounds): KH average days to heal 63 compared to 73. Venous Stasis Ulcers (32 Wounds): KH average days to heal 104 compared to 68, 1 took over 100 days to heal, 2 took over 200 days and 1 took 443 days to heal. All wound outcomes: in 3rd quarter 2021, 47.8% of the wound center patient's complete treatment, in 4th quarter 77.5% completed treatment, which is a significant improvement from the 2 previous quarters. The number of patients at the wound center continues rise thanks to the FNP working 3 days a week while recruiting for full time, thus here is a significant increase in wounds and wound outcomes. Total wound outcomes was 163 in 4th quarter 2021 with 57% resolved compared to 95 3rd quarter 2021 with 46% resolved. HBO was down running only one round of divers.

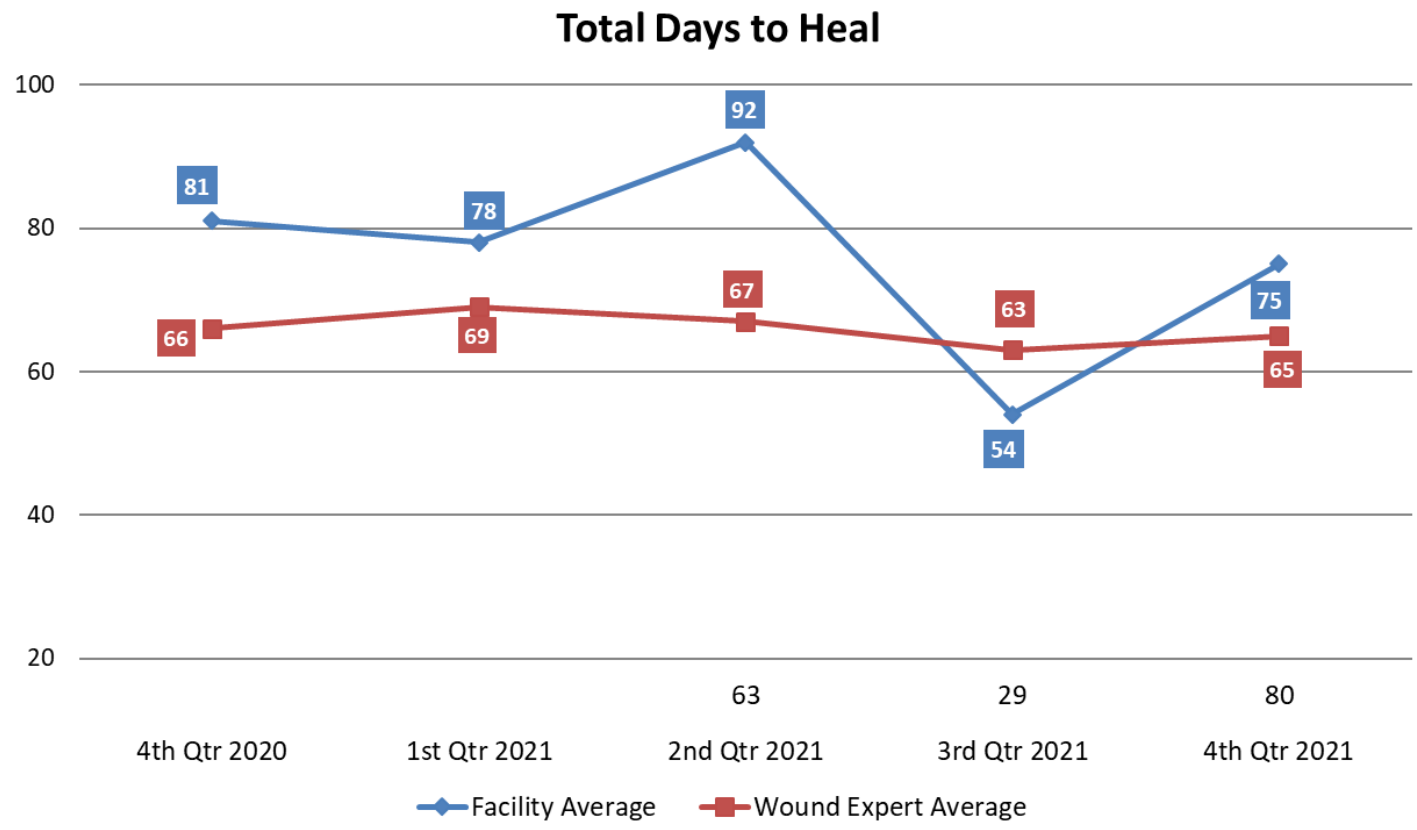
Facility Data

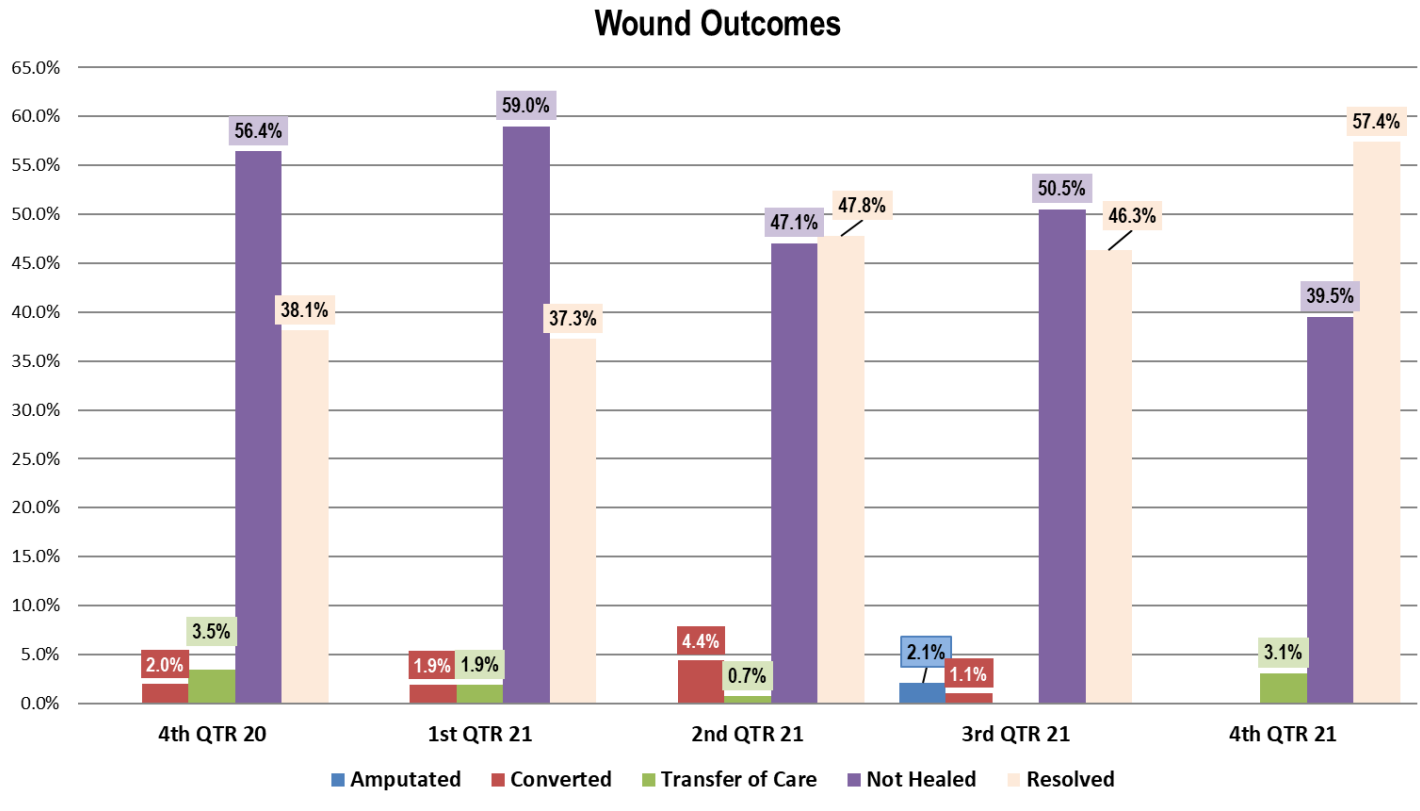


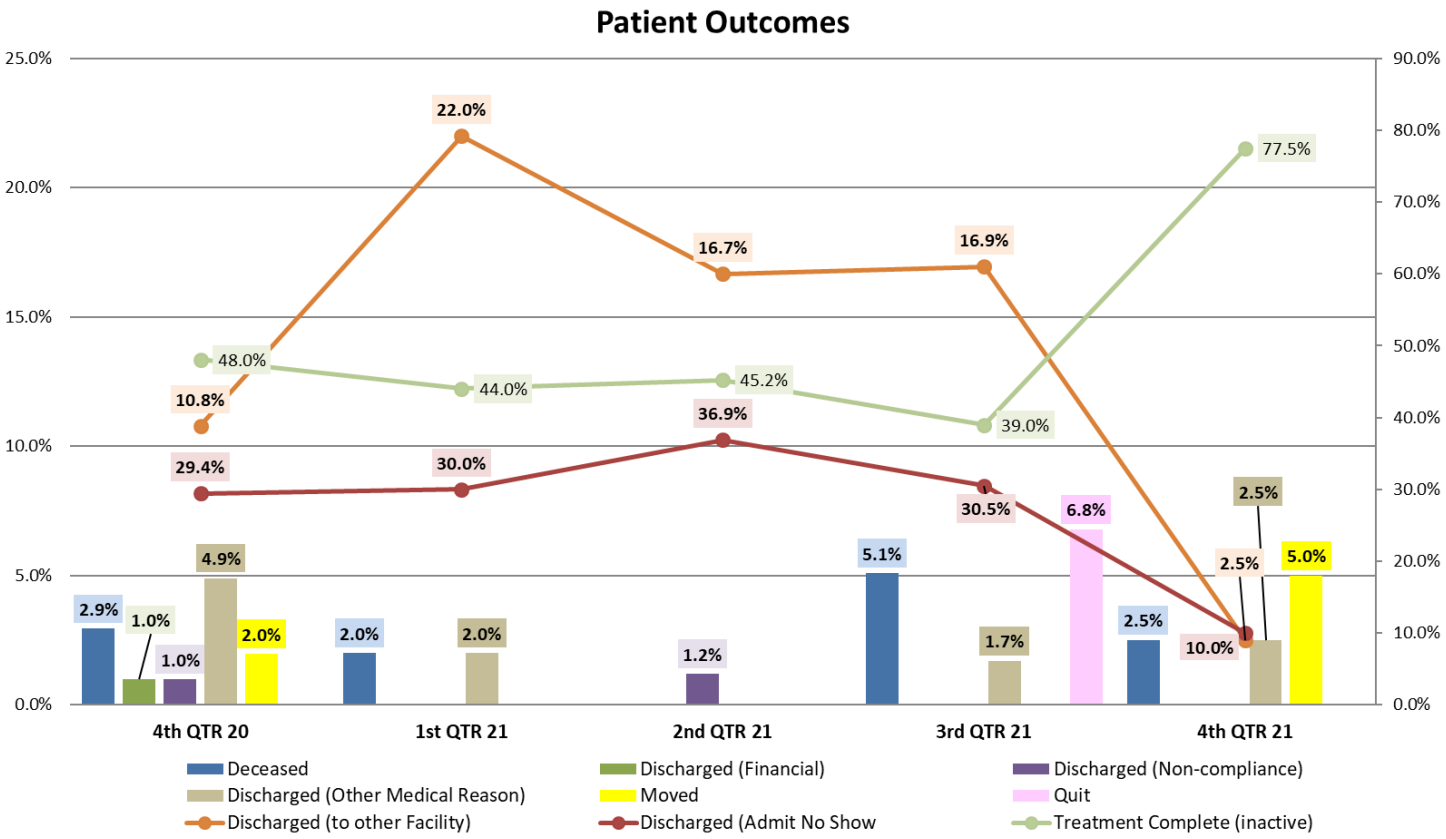
Total Wounds




Treated Wounds
40%
35%
30%
25%
20%
15%
10%
5%
0%
9%
10%
11%
9%
8%
34%
39%
30%
29%
30%
17%
17%
17%
12%
16%
9%
13%
8%
8%
8%
Diabetic Ulcer
Venous Ulcer
Surgical Wound
Pressure Ulcer
4th QTR 2020
1st QTR 2021
2nd QTR 2021
3rd QTR 2021
4th QTR 2021


Total Days to Heal
100
80
60
40
20
81
78
92
54
75
66
69
67
63
65
63
29
80
4th Qtr 2020
1st Qtr 2021
2nd Qtr 2021
3rd Qtr 2021
4th Qtr 2021
Facility Average
Wound Expert Average


Wound Outcomes
65.0%
60.0%
55.0%
50.0%
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
56.4%
38.1%
3.5%
2.0%
59.0%
37.3%
1.9%
1.9%
47.1%
47.8%
4.4%
0.7%
50.5%
46.3%
2.1%
1.1%
39.5%
57.4%
3.1%
4th QTR 20
1st QTR 21
2nd QTR 21
3rd QTR 21
4th QTR 21
Amputated
Converted
Transfer of Care
Not Healed
Resolved



If improvement opportunities identified, provide action plan and expected resolution date:
We will continue to work on increasing volume while we are in transition of hiring a full time provider. We continue to work on increasing the Hyperbaric volume and have provided training to an additional provider.

Submitted by Name: Molly Niederreiter **Date Submitted:** May 16 2022

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: **Orthopedic Service Line Surgical Site infection** **ProStaff Report Date:** **06/17/2022**

Submitted by: Kevin Bartel, Director of Orthopedic Service Line

Measure Objective/Goal: Measuring the percentage of total arthroplasty surgical patients who experienced a **surgical site infection** within 90 days after surgery. An incidence rate calculation is determined using the total number of THR/TKR surgeries (performed during a 12-month period) versus the total number of infections using CDC/NHSH criteria. The goal of this data collection is to identify opportunities to prevent infections with total arthroplasty procedures.

Date range of data evaluated: January 1, 2021 – December 31, 2021 (12 months)

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

Overall, the joint procedures performed on hips and knees from January 1, 2021, through December 31, 2021 at Kaweah Health resulted in just 1 infection and an overall standardized infection ration of .22, or 22% of predicted number of infections based on procedures performed and risk-adjusted elements. This surgical site infection occurred during March 2021 involving knee arthroplasty 13 days post-op. Patient was discharged with Home Health. Unfortunately, the patient did not avail him/her-self to Home Health care. The patient presented in the Emergency Department with an opened surgical incision and infection involving the joint. Year total individual and cumulative standardized infection ratios (SIR) are well below predicted levels indicating a much better than national average comparison of Kaweah Health to other organizations who perform knee and hip arthroplasty.

Type of SSI	Total # of Procedures	Actual # of infections	Predicted # of Infections	Standardized Infection Ratio
KPRO	239	1	1.506	0.664
HPRO	212	0	2.990	0.000
Total	451	1	4.496	0.222

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

1. Identified opportunity to educate providers on the timing of pre-operative MRSA/MSSA screening and nasal decolonization treatment application to optimize the post-operative window for protection (projected implementation by August 2022).
2. The ERAS program is led by the program's Nurse Practitioner. The Joint Camp for THA/TKA patients has returned to an in-person format, offered alongside the existing online educational video as options for patient education. In-person Joint Class will continue as the COVID-19 infection rate allows.
3. Discussing standard of practice among orthopedic surgeons with variances being presented at the monthly Co-Management meeting as appropriate.

Next Steps/Recommendations/Outcomes:

Orthopedic NP continues to attend monthly surgical site infection (SSI) subcommittee meeting to stay current with SSI topics related to prevention and best practices. SSI data and information will be shared with orthopedic surgeons on a regular basis. Continue to hardwire ERAS program with nursing staff, therapies, and surgeons in the coming year.

Submitted by Name: Kevin Bartel, DPT **Date Submitted**: 6/17/22

Orthopedic Service Line
Complication Rate

06/17/2022

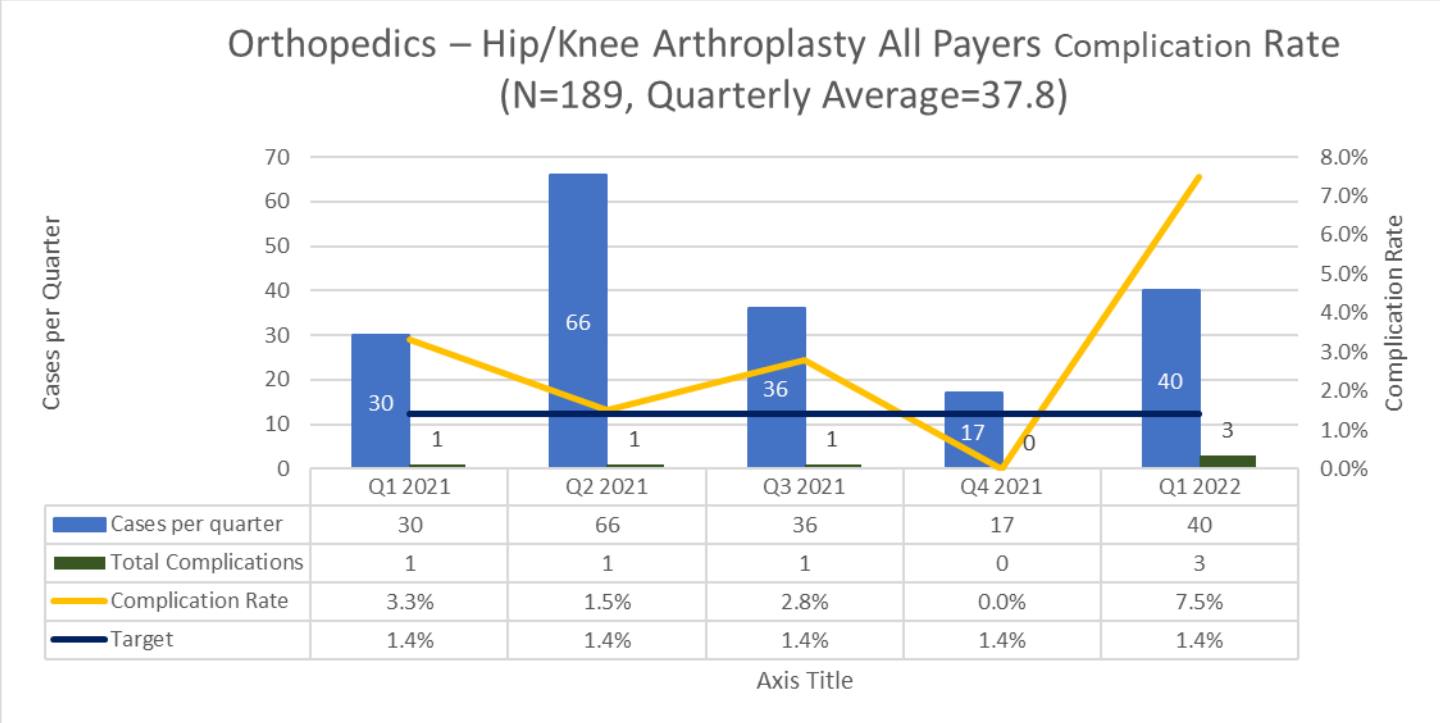
Measure Objective/Goal: Monitor and measure the **complication rate** for total arthroplasty patients who underwent either a total hip or knee joint replacement. The benchmark sources are both CMS and hospitals within the STATIT database. The CMS target is **2.3%** for Medicare patients and **1.4%**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

The inclusion criteria for complication include the following:

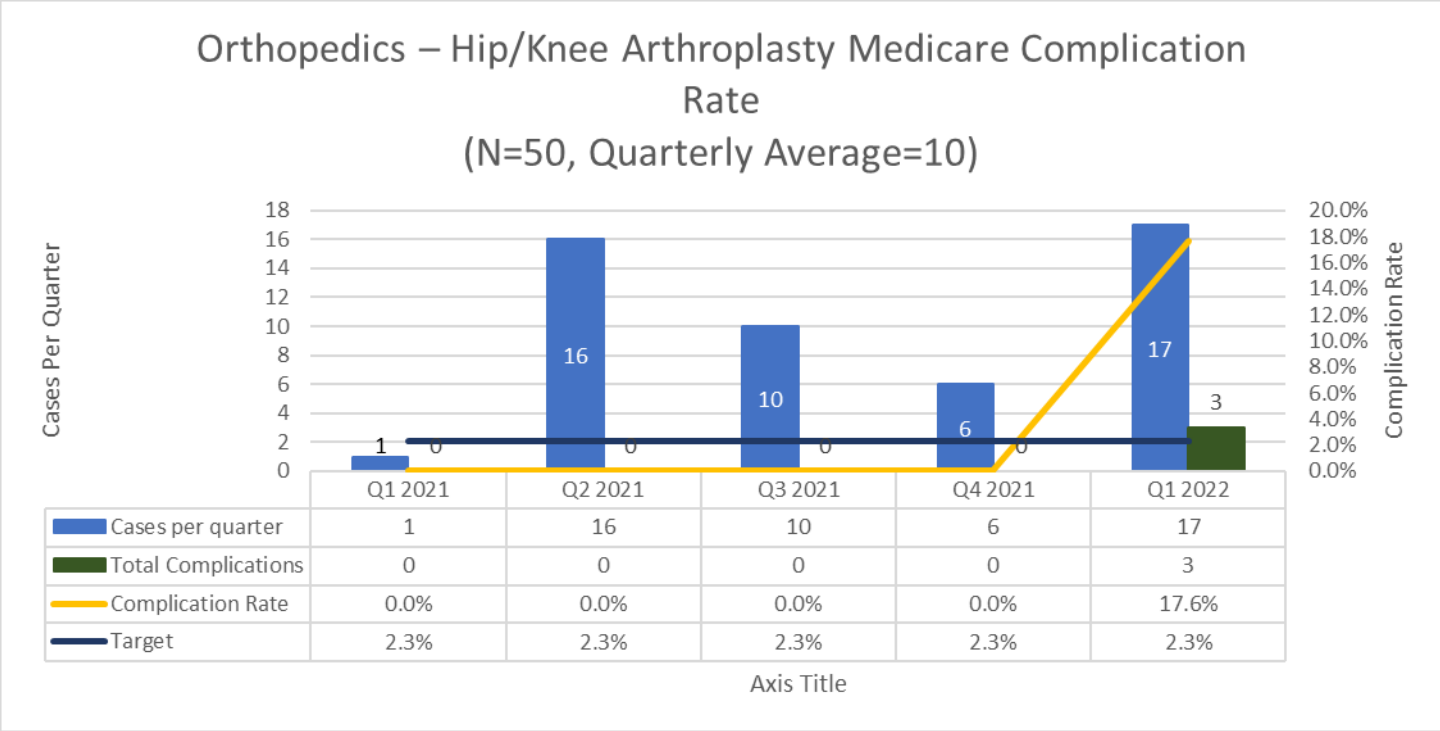
1. Mechanical complication within 90 days
2. Wound Infection or periprosthetic joint infection within 90 days
3. Surgical site bleeding within 30 days
4. Pulmonary embolism within 30 days
5. Death within 30 days
6. Acute myocardial infarction with 7 days
7. Pneumonia within 7 days
8. Sepsis, septicemia, or shock within 7 days
9. Acute respiratory failure and edema at discharge and not present at admit
10. Acute renal failure at discharge and not present at admit

Date range of data evaluated: Quarter 1, 2021 through Quarter 1, 2022 (15 months of data)

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



	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022
Cases per quarter	30	66	36	17	40
Total Complications	1	1	1	0	3
Complication Rate	3.3%	1.5%	2.8%	0.0%	7.5%
Target	1.4%	1.4%	1.4%	1.4%	1.4%



	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022
Cases per quarter	1	16	10	6	17
Total Complications	0	0	0	0	3
Complication Rate	0.0%	0.0%	0.0%	0.0%	17.6%
Target	2.3%	2.3%	2.3%	2.3%	2.3%

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

Across the reported date range, 6 total complications seen in the All Payers group, resulting in a 3.1% complication rate overall, above the benchmark of 1.4%. Within the Medicare Payer group, overall performing well except for Q1 2022, with 3 total complications (2 of which came from the same patient), leading to a 6% complication rate, which is higher than the 2.3% benchmark. All identified complications were either acute respiratory failure or acute renal failure, all of which were identified at inpatient discharge and were not present on admission.

Next Steps/Recommendations/Outcomes:

1. Consideration of discharge to short stay skilled nursing when appropriate vs direct discharge to home setting if patient remains at risk for falls
2. Coordinate daily patient rounding involvement from Ortho NP to facilitate routine patient assessment and coordination of care.
3. Working with the surgeons to coordinate home health physical therapy prior to discharge. The focus with HHPT will include home safety assessment, strength/ROM exercises, gait/balance training and nursing care as appropriate.
4. With the move from inpatient qualified stays to outpatients stays and a focus on same day discharge, the orthopedic nurse practitioner is working closely with physical therapy to evaluate for safe discharge home.

Submitted by Name: Kevin Bartel, DPT **Date Submitted**: 6/17/22

Unit/Department Specific Data Collection Summarization

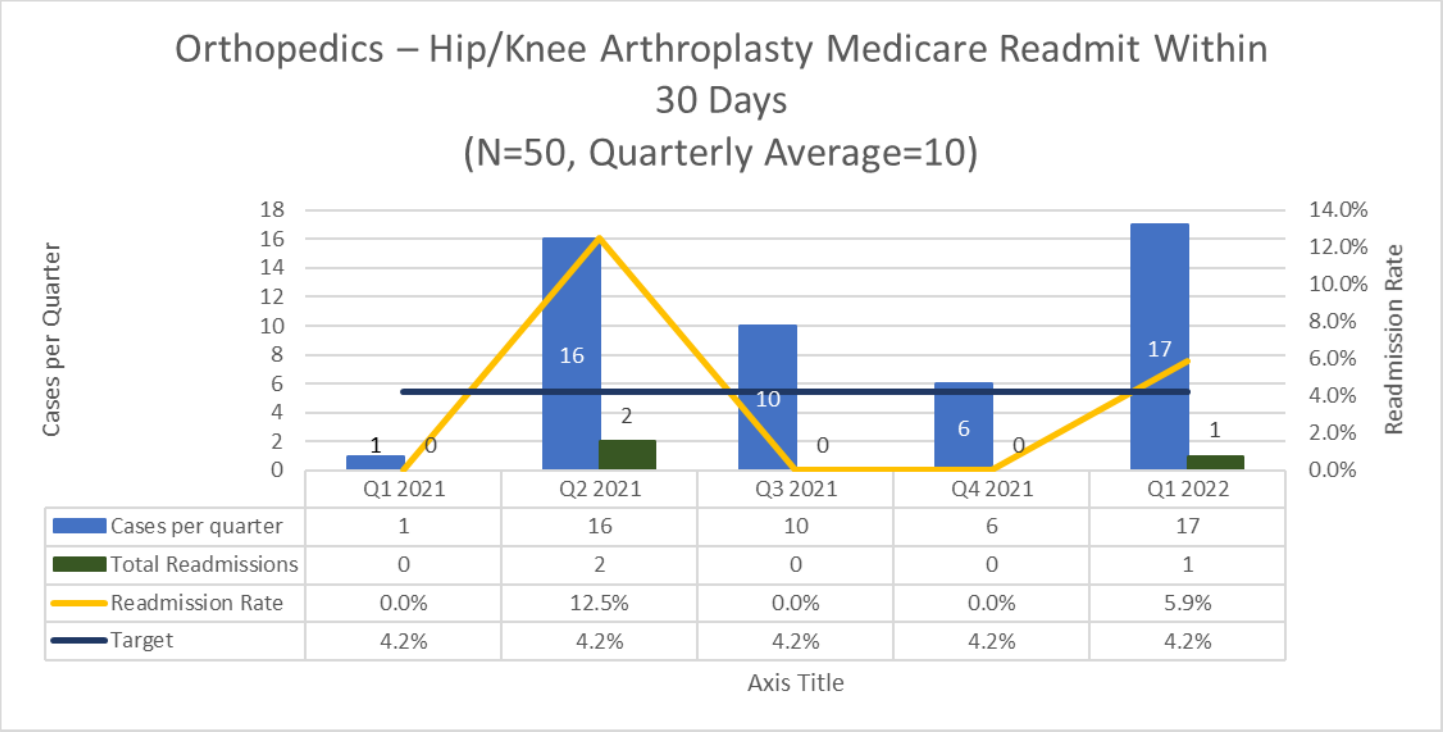
Professional Staff Quality Committee

Unit/Department: **Orthopedic Service Line Readmission Rate** **ProStaff Report Date:** **06/17/2022**

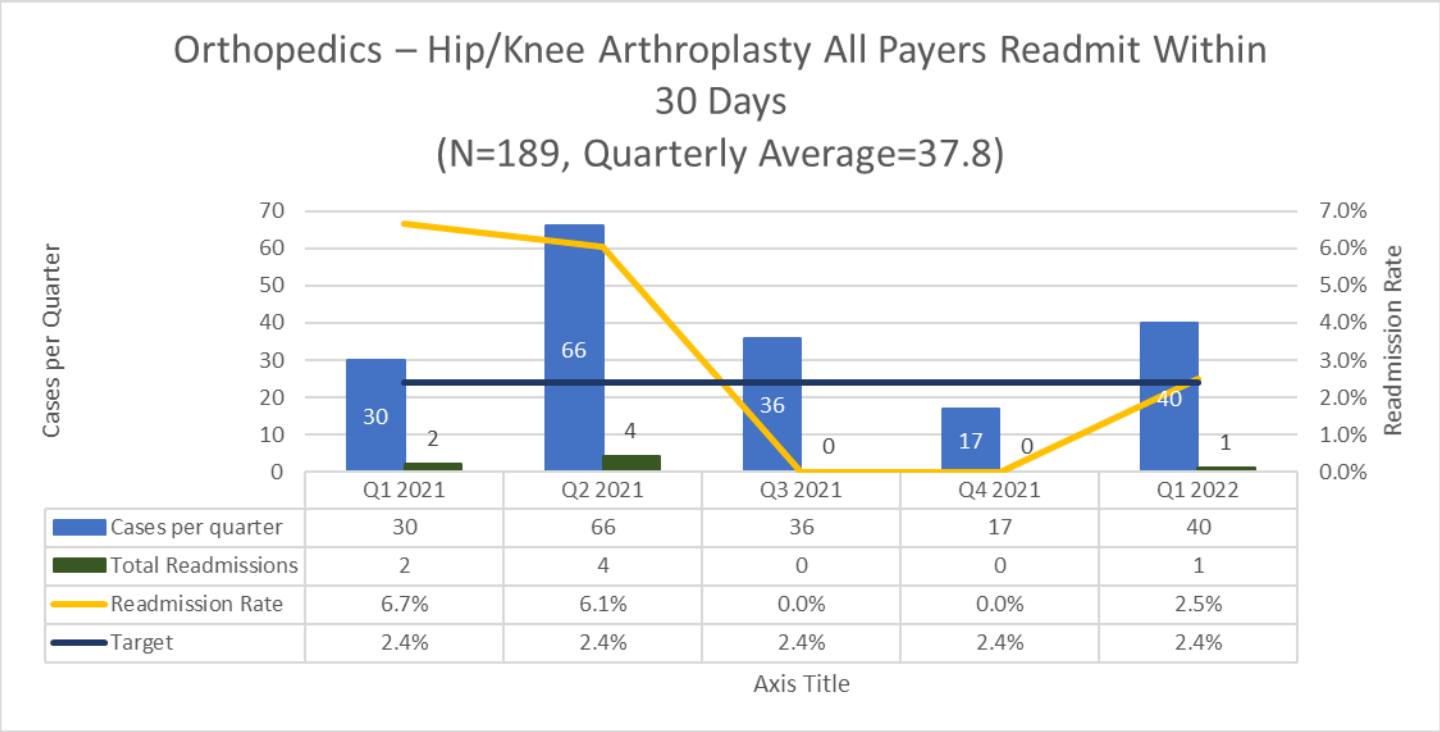
Measure Objective/Goal: Monitor and measure any cause 30-day **readmission rate** for total arthroplasty patients who underwent a joint replacement. The benchmark sources are both CMS and hospitals within the Midas database. The CMS target is **4.2%** for Medicare patients and **2.4%** target for all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

Date range of data evaluated: Quarter 1, 2021 through Quarter 1, 2022 (15 months of data)

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



	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022
Cases per quarter	1	16	10	6	17
Total Readmissions	0	2	0	0	1
Readmission Rate	0.0%	12.5%	0.0%	0.0%	5.9%
Target	4.2%	4.2%	4.2%	4.2%	4.2%



	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022
Cases per quarter	30	66	36	17	40
Total Readmissions	2	4	0	0	1
Readmission Rate	6.7%	6.1%	0.0%	0.0%	2.5%
Target	2.4%	2.4%	2.4%	2.4%	2.4%

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

Overall, performing well with the Medicare patients in regards to re-admissions, with 3 of the 4 quarters in 2021 containing no re-admissions. Total of three re-admissions out of 50 Medicare cases in the last 15 months, resulting in a 6% readmission rate, higher than the 4.2% readmission rate benchmark. Overall seeing an increased percentage of Medicare elective cases in current reporting period (26%) than in last year's reporting timeframe (15%). The all payer readmission rate was higher than the national benchmark at 7 re-admissions out of 189 in the last 15 months, averaging a 3.7% re-admission rate compared to 2.4% target. Improvement seen in the past three quarters reported to reduce overall readmission rate to 1.0% over that timeframe. Three of the 7 readmissions were related to superficial surgical site infections that required a washout procedure with IV antibiotics. One was for wound dehiscence, and another one was for a fall at home after discharge resulting in a femur fracture. The remaining two readmissions were related to non-orthopedic medical causes.

Next Steps/Recommendations/Outcomes:

1. Standardized education and increased emphasis with prevention of surgical site infections during the pre-op Joint Camp education class. Focus on post-operative care of surgical sites and plan of care if signs and symptoms of infection occur with plan to call surgeon and not to report to Emergency room.
2. Identified opportunity to educate providers on the timing of pre-operative MRSA/MSSA screening and nasal decolonization treatment application to optimize the post-operative window for protection (projected implementation by August 2022), as a way of reducing incidence of SSI.
3. Working with surgeons to coordinate home health physical therapy prior to discharge when patient is identified as at risk for falls.

Submitted by Name: Kevin Bartel, DPT **Date Submitted:** 6/17/2022

Sepsis Quality Focus Team Report

August 2022

Kaweah Health
MORE THAN MEDICINE. LIFE.

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 Sespis Bundle Measure
- VBG – Venous Blood Gas lab test
- VS – Vital Signs
- HR – Heart Rate
- PPR – Peripheral Pulse Rate
- APR – Apical Pulse Rate

SEP-1 Early Management Bundle Compliance

CA State Compliance 64% ~ National Compliance 60% ~ Top Performing Hospitals 79%

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

Goal for FY22 = ≥75%

Kaweah Health Sepsis Quality Focus Team DASHBOARD

CMS SEP-1 Bundle Compliance	Goal	FY2019	FY2020	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	YTD
SEP-1 CMS % bundle compliance	75%	66.9%	74.6%	68%	75%	57%	77%	90%	82%	56%	81%	83%	91%	79%	64%	75%
Number of CMS compliant cases (n)	n/a	198	206	21	24	17	30	27	27	18	30	24	31	30	21	300
Total number CMS cases abstracted (d)	n/a	296	276	32	32	30	39	30	33	32	37	29	34	38	33	399
% Concurrent bundle compliant cases	75%	78%	77%	78%	77%	79%	76%	80%	76%	78%	82%	82%	83%	77%	76%	79%
Number of concurrent compliant cases (n)	n/a	646	785	46	58	46	45	64	51	70	32	59	67	51	67	656
Number of concurrent cases abstracted (d)	n/a	829	1013	59	75	58	59	80	67	90	39	72	81	68	87	835
Number of Non-Compliant CMS cases *with*coordinator	n/a			0	1	2	1	1	1	1	0	0	0	1	1	9
Number of Non-Compliant CMS cases *without* coordinator	n/a			10	9	11	7	2	5	13	7	5	3	8	12	92
% of Non-Compliant CMS cases *with* coordinator	n/a			0%	11%	18%	14%	50%	20%	8%	0%	0%	0%	13%	8%	12%
% of Non-Compliant CMS cases *without* coordinator	n/a			100%	89%	82%	86%	50%	80%	92%	100%	100%	100%	77%	92%	87%

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

SEP-1 Early Management Bundle Compliance

CA State Compliance 64% ~ National Compliance 60% ~ Top Performing Hospitals 79%

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

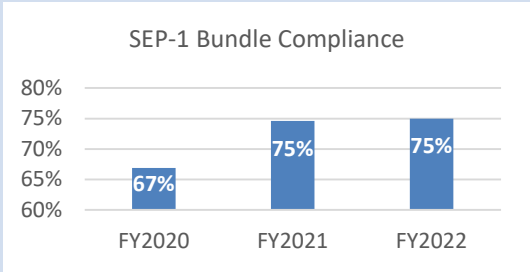
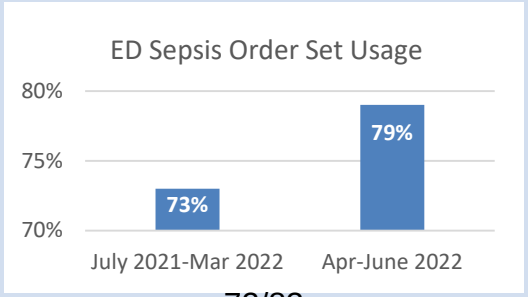
Kaweah Health

Sepsis Quality Focus Team DASHBOARD

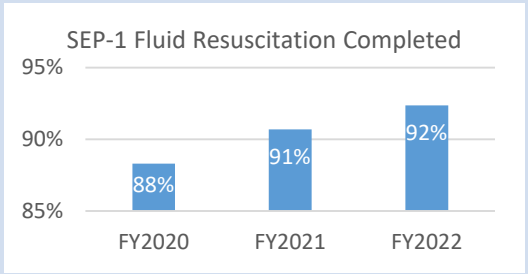
CMS SEP-1 Bundle Element	Goal	FY2019	FY2020	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	YTD
3 hr SEP-1 Bundle % Compliance	95%	76.0%	78.6%	71%	84%	63%	85%	90%	85%	67%	84%	86%	94%	84%	73%	88%
3hr SEP-1 BundleTotal Patients abstracted (d)	n/a	296	276	32	32	30	39	30	33	32	37	29	34	38	33	399
% Antibiotics administered	95%	97.3%	95.7%	87%	94%	80%	92%	100%	94%	84%	92%	96%	97%	97%	97%	93%
% Blood Cultures drawn	95%	93.8%	92.0%	93%	97%	88%	97%	93%	90%	89%	97%	92%	100%	89%	88%	93%
% Lactic Acid drawn	95%	95.6%	97.9%	92%	97%	95%	97%	100%	100%	96%	100%	100%	97%	100%	97%	98%
% Fluid Resuscitation completed	95%	88.3%	90.7%	92%	89%	89%	91%	93%	100%	80%	89%	100%	100%	93%	82%	92%
6 hr bundle % Compliance	95%	85.4%	93.5%	92%	87%	86%	90%	100%	95%	83%	96%	87%	96%	92%	85%	91%
6hr SEP-1 BundleTotal Patients abstracted (d)	n/a	186	170	13	23	14	30	22	22	18	24	15	23	25	20	249
% Repeat LA drawn	95%	89.6%	94.0%	92%	87%	86%	90%	100%	100%	83%	96%	93%	96%	92%	90%	92%
% Reassessment completed	95%	92.9%	98.5%	100%	100%	100%	100%	100%	89%	100%	100%	100%	100%	100%	91%	91%
% Vasopressors initiated when indicated	95%	93.30 %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Sepsis Alert Measures																
Total Number of Coordinator-Involved Alerts				387	584	635	528	589	700	848	458	736	796	615	617	7493
% of alerts that resulted in a time zero				15%	13%	9%	11%	14%	10%	11%	9%	10%	10%	11%	14%	11%

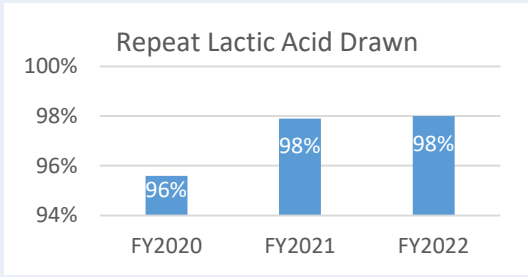
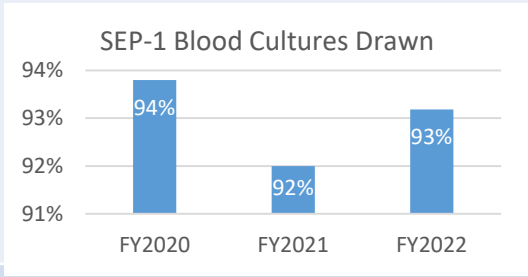
KEY >10% away from goal | Within 10% of goal | Within 5% of goal | Outperforming/meeting goal

Root Causes & Improvement Strategies

Root Cause of SEP-1 Bundle Not Fully Implemented	Data	Potential/Actual QI Strategy Action
Do not know patient is septic because the alert did not fire • Alert suppressed for 48 hrs after initial alert • Creatinine >2 not recognized by Cerner/in the alert algorithm • Alert does not fire when a string of VS are documented all at once, it suppresses an abnormal VS(s) that requires patient evaluation • Alert does not fire when multiple VS are entered with one value abnormal and the others are not • Alert does not fire for providers (fires inappropriately such as when ED providers reestablished a relationship with an in-patient to back-document, or fires for triage provider after patient is in "back")	SEPSIS ALERT EVALUATION Inpatient & ED Patients Sensitivity – 0.57; Specificity – 0.95 Inpatient ONLY Sensitivity – 0.59; Specificity – 0.83 	• Improve sensitivity and specificity of alert • Suppress alert in ICU based on ICD10 sepsis dx – IN PROCESS • Alert suppression (for RNs) changed from 48 hrs to 13 hrs (per shift) COMPLETE • Evaluate the ability to color code sepsis alerts for worsening symptoms IN PROCESS
Do not know the patient is septic because the RN did not evaluate the alert and execute provider notification process • Alert fatigue, accountability	• "6 Attributes Test" completed indicating that 4/4 RNs surveyed in different units were able to articulate the who, what, where, when, why and how of the provider notification process • Provider notification data pending	• Root cause analysis indicates that options on the provider notification form need to be expanded. RNs not completing form because options for not notifying the provider do not include all applicable options. FORM REVISIONS COMPLETE, COMMUNICATE CHANGES TO STAFF, COMPLETE
Provider not using order sets for known septic patients where bundle elements are easily accessed • Resident & provider knowledge • Personal preference to go a la cart	Performance improved to 79% order set usage in the ED following EM GME simulation training (April-May 2022) 	• ED simulation training to cover SEP-1 elements for all EM residents; held 3/21/22. COMPLETE • Revising lactic acid only" order in SEP-1 order set to a VBG based on provider feedback as non-use of order set due to workflow to get a full VBG vs only the lactic acid IIN PROCESS • FM simulation training to occur approx. 10/2022 IN PROCESS • Including breakdown of order set usage by inpatient and ED and sharing with provider stakeholders COMPLETE • Survey ED providers on reasons for not using order set to target strategies IN PROCESS, SURVEY COMPLETE 5/2022 PHYSIICAN STAKEHOLDERS REVIEWING RESULTS

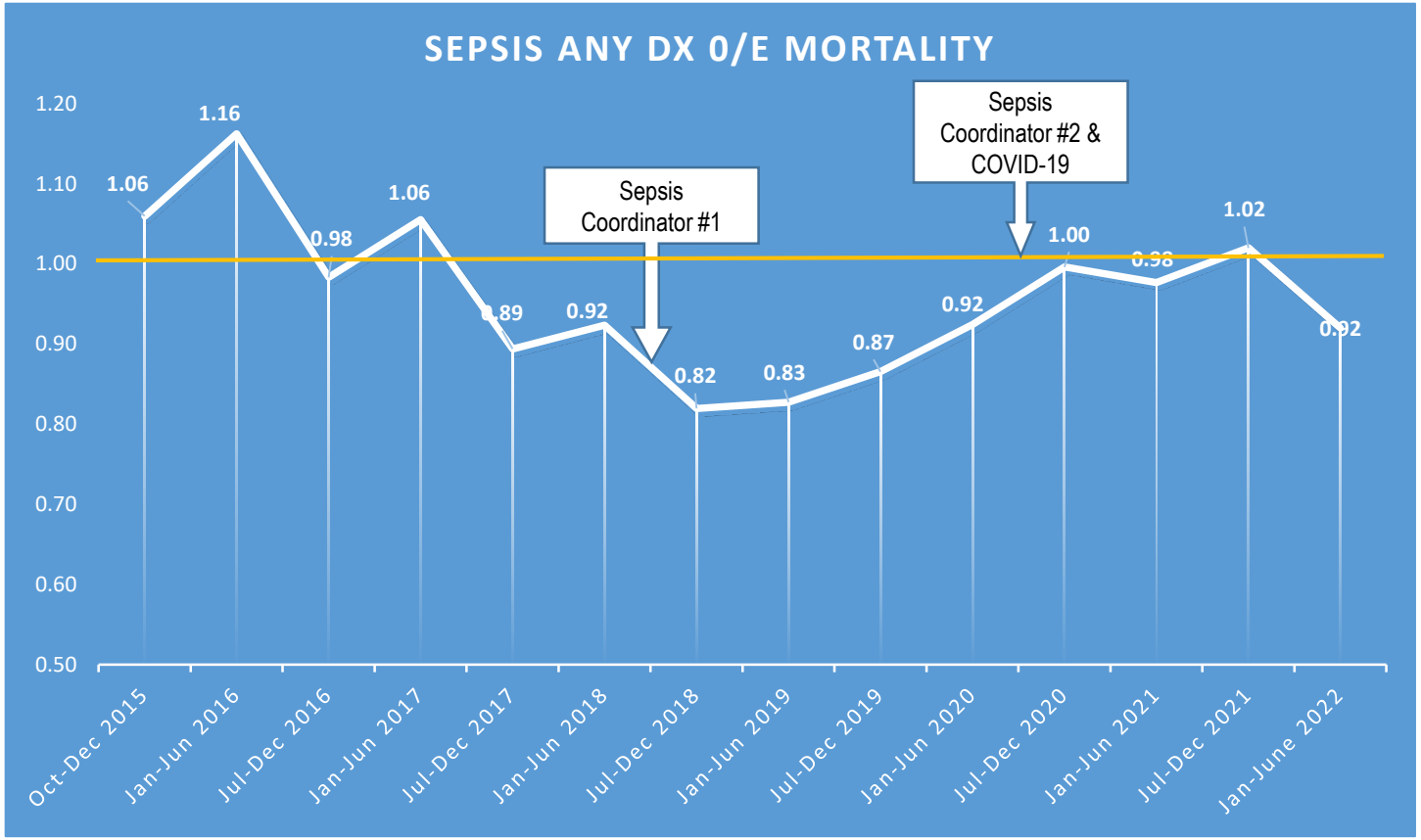
Root Causes & Improvement Strategies

Root Cause of SEP-1 Bundle Not Fully Implemented	Data	Potential QI Strategy
Fluids (none ordered or insufficient volume) • Contraindication to receiving more fluids • BP is normal, LA>2, still needs fluids • Not using order set - Staggering fluid resuscitation, see how pt responds and d/c fluids before needed amount is infused (pt doesn't need more and literature support is low grade)		• Increase use of order sets • Lack of awareness of contraindication exclusions • Survey ED providers on reasons for not using order set to target strategies IN PROCESS, SURVEY COMPLETE 5/2022 PHYSIICAN STAKEHOLDERS REVIEWING RESULTS

Repeat lactic acid (LA) or blood culture (BC) not ordered
• Providers don't order repeat LA because the first result was not that high or elevation expected due to comorbid conditions
• Provider orders "routine" so lab is not completed timely; there is no need to use the SEP-1 power plans since all the elements were completed in ED
• Do not know the patient is septic
  • Patient not presenting in typical fashion, looking for other sources of infection
  • RNs not executing provider notification process consistently
  • RRT not called for abnormal VS/labs (RRT initiates bundle as indicated)
  • No one is closely identifying sepsis (no sepsis coordinator, lack of comprehensive patient oversight)
	
	 
		• Reflex order for any LA
		• Provider orders repeat LA "timed" or "STAT" (provider awareness)
		• Improvements to the workflow of lactic acid collection in ED to ensure timing meets bundle requirements (1E lab vs nurse draw issue)
		• Optimize alert and turn on for providers (see previous section)
		• Improve the RN provider notification process

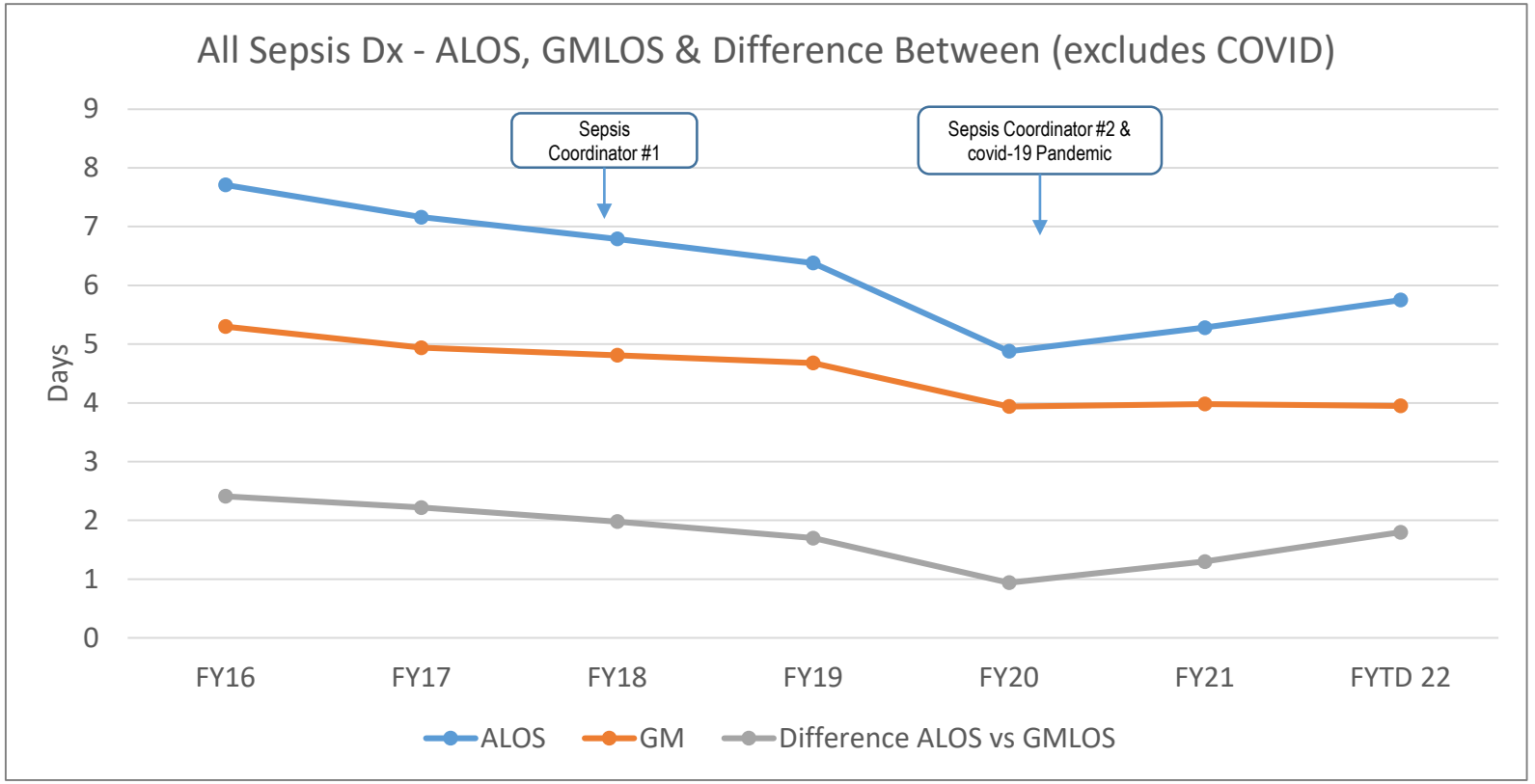
Patients sepsis not recognized because they present in atypical fashion OR SIRS and organ dysfunction not due to sepsis • Order bundle elements a la cart as work up is completed • Sepsis left on the differential (not using dot phrase)	See order set usage data	Education on dot phrase – included in simulation training. EM SIMULATION TRAINING COMPLETE , FM SIMULATION TRAINING SCHEDULED 10/2022

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



- Goal ≤ 1.0 which indicates that at least expected deaths do not exceed actual
- Significant change in how sepsis mortality is measured since o/e mortality includes septic patients with COVID-19 dx starting in 2020, but does risk adjust for COVID
- Sepsis o/e mortality is not a direct comparison pre and post pandemic
- Despite COVID-19 patient inclusion, o/e mortality remains at ≤ 1.0

Sepsis Any Diagnosis – Outcomes Length of Stay



- 25% decrease in ALOS from FY16 (ALOS=7.71) to FY22 (ALOS=5.75)
- 25% (0.6 days) in the difference between ALOS and GMLOS from FY16 (difference 2.41 days) to FYTD22 (difference 1.81 days).
- COVID-19 cases removed in FY20-22. SEP-1 bundle does not apply to COVID-19 patients.

Sepsis QFT Actions & Next Steps

- Key Improvement strategies in process:
    1. Root cause evaluation with ED providers on use of the sepsis order sets
    2. Executing enduring Emergency Medicine and Family Medicine enduring (annual) GME Sepsis simulation training, with goal of multidisciplinary involvement
    3. Optimizing sepsis alert to reduce alert fatigue (ie. suppressing alerts for circumstances where patient is already known to be septic)
    4. Evaluate and improve the RN provider notification process for sepsis alerts

Next Steps:

- Review root causes identified with complete stakeholder group for input and additions
- Review suggested improvement strategies with complete stakeholder group, and solicit input to expand list
- Prioritize and execute improvement strategies

Questions?

Live with passion.

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

Kaweah Health

Clinical Quality Goal Update

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

July 2022

FY22 Clinical Quality Goals

	July 21-June 22 Higher is Better	FY22 Goal	FY21	FY21 Goal
SEP-1 (% Bundle Compliance)	75%	≥ 75%	74%	≥ 70%

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

Our Mission

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

Our Vision

To be your world-class healthcare choice, for life

Lower is Better	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual/ number expected)	FY22 Goal	FY21 FY20
CAUTI Catheter Associated Urinary Tract Infection COVID-19 PATIENTS	1 0	3 1	5 5	2 0	2 1	1 0	3 1	3 2	2 0	1 0	1 0	1 0	16 (12 predicted over 6 months)	1.092 0.66 Excluding COVID (Feb 2022)	≤0.676	0.54 1.12
CLABSI Central Line Associated Blood Stream Infection COVID-19 PATIENTS	0 0	4 3	3 3	3 0	1 1	1 0	1 0	0 0	2 0	2 0	1 0	2 0	11 (9.5 predicted over 6 months)	1.132 0.66 Excluding COVID	≤0.596	0.75 1.20
MRSA Methicillin-Resistant Staphylococcus Aureus COVID-19 PATIENTS	2 0	0 0	1 0	3 1	0 0	2 0	1 1	1 1	0 0	2 0	1 0	0 0	5 (3.6 predicted over 6 months	1.585 1.40 Excluding COVID	≤0.727	2.78 1.02

*based on July-Dec 2021 NHSN predicted

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

Key Strategies

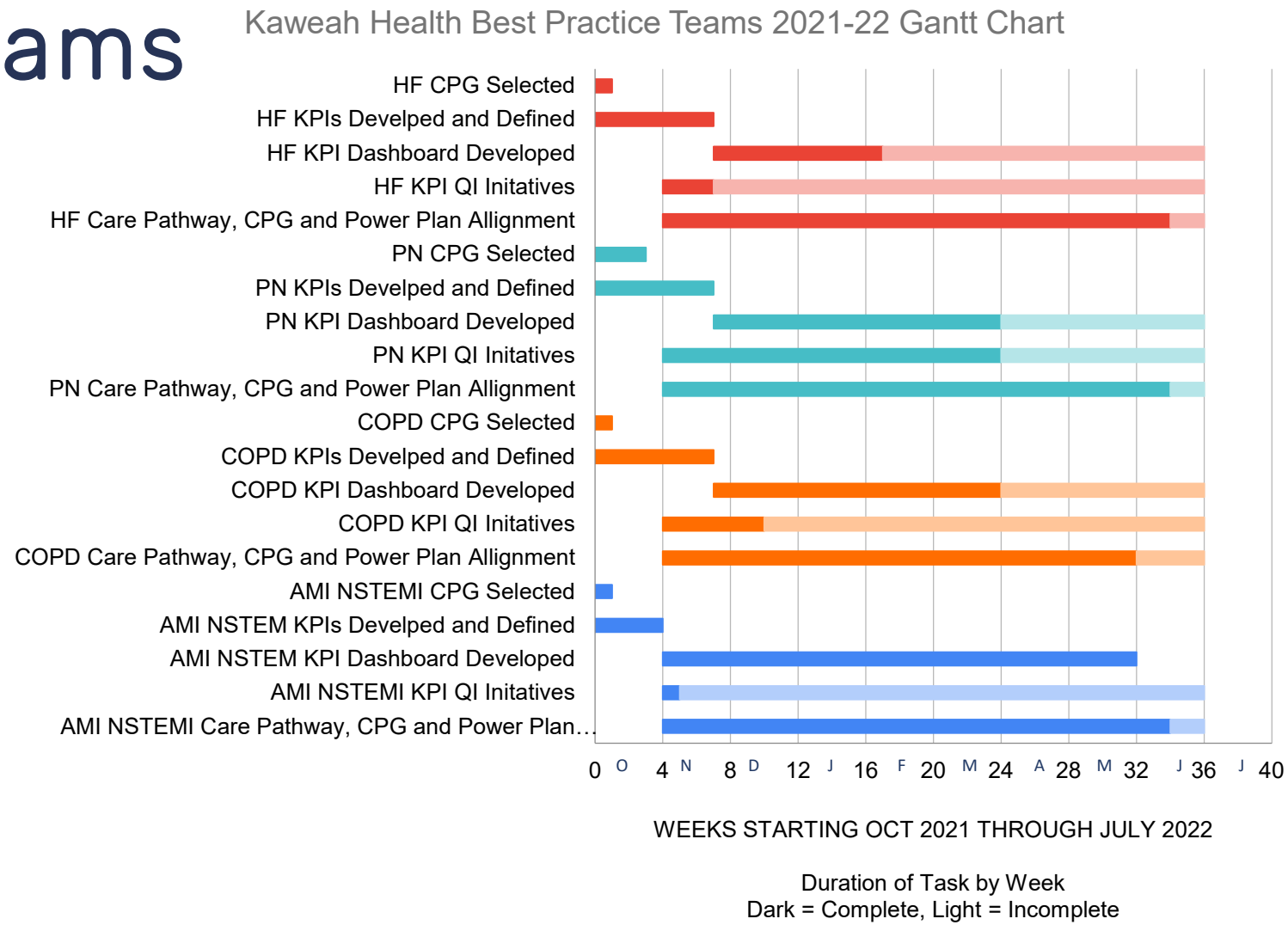
Sepsis, CAUTI, CLABSI & MRSA

1. Refining root cause analysis of Sepsis order set utilization
   - for committee review and QI action planning 3Q2022
2. Provider notification of Sepsis Alert
   - Revised process so it's easier for RNs to document
3. Sepsis Simulation training (GME)
   - Emergency Management GME program sim program in March 2022; Family Medicine sim program simulation scheduled for Oct 2022
3. Culturing Practices
   - Data analysis and follow up with provider groups
   - Alert for repeat cultures in place
4. Root Cause Analysis
   - Process & practice assessment from IV supply vendor
   - Equipment enhancements – conversion to medline products and new bladder scanners for each unit!
   - Review of current data & cases and quantifying contributing factors to target improvement strategies
5. MRSA Decolonization
   - 4N & ICU Pilot – 100% patients decolonized, expanded additional 3 months; evaluation for Aug/Sept 2022.
   - All other units – targeting those who should be decolonized, working on optimizing processes to achieve decolonization. Key element in process is identification of the at risk patient through medical record triggers and workflow

Kaweah Health Best Practice Teams

Goal: Improve patient outcomes by standardizing care on 4 key patient populations (AMI- NSTEMI, COPD, HF & PN)

- Standardized care based on Clinical Practice Guideline (CPGs) and operationalize the standardized care through Care Pathways, provider power plans and new Cerner functionality (Care Pathways)
- 4 “Core Teams” established for each population, includes Medical Director, Quality Facilitator, Operational Director & Advanced Nurse Practitioner (APN)
- Outcomes include: Mortality, Readmission and Length of Stay
- Key Performance Indicators (KPIs) defined, dashboards in development and QI work underway!!



Outcome Data

Kaweah Health Best Practice Teams Outcome Dashboard FY 2021

	Goal	Baseline (FY 2019)	1Q - 2Q 2021*	3Q 2021*	4Q 2021*	1Q 2022*	2Q 2022*	FYTD July 21-June 22*
Readmission Medicare Population	AMI (non-STEMI) – 11.01	12.34	12.5	7.14% (1/14)	12.5% (3/24)	6.67% (1/15)	0% (0/15)	7.35% (5/68)
	COPD – 12.87	16.09	10	27.27% (3/11)	28.57% (2/7)	22.22% (2/9)	14.29 % (1/7)	23.53% (8/34)
	HF – 14.58	18.22	21.28	15.79% (6/38)	12.20% (5/41)	10.17% (6/59)	14.82% (8/54)	13.02% (25/192)
	PN Viral/Bacterial – 11.30	14.13	13.51	15.79% (6/38)	15.39% (6/39)	15.91% (7/44)	20% (8/40)	16.67% (27/162)
O/E Mortality Medicare Population	AMI (non-STEMI) - 0.71	0.75	0.84	0.85 (n=16)	0.96 (n=13)	1.50 (n=9)	1.02	0.99 (n=49)
	COPD – 1.92	2.4	0.93	2.73 (n=13)	0 (n=9)	1.49 (n=13)	0.95	1.41 (n=40)
	HF – 1.42	1.78	0.911	0.38(n=44)	0.62 (n=51)	0.78 (n=65)	0	0.52 (223)
	PN Bacterial – 1.48	1.85	1.04	0 (n=6)	1.15 (n=13)	0 (n=9)	0	0.53 (n=43)
	PN Viral - 1.07	1.34	0.64	1.25 (n=23)	1.65 (n=26)	1.21 (n=37)	0.38	1.09 (n=109)

*Midas updated to version 4.0 with revised risk adjustment algorithm

Questions?

Live with passion.

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

Kaweah Health