September 08, 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, September 15, 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, September 15, 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, September 15, 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, September 15, 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; 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. Pain Committee Quality Report
    - 3.2. Cardiology Service Line Quality Report
    - 3.3. CLABSI Quality Focus Team Quality Report
    - 3.4. Cardiac Surgery Quality Report
    - 3.5. Maternal Child Health Service Line Quality Report
    - 3.6. Hospital Acquired Pressure Injury (HAPI) Quality Focus Team Report
    - 3.7. Handoff Communication Quality Focus Team Report
    - 3.8. Diversion Prevention Quality Report
    - 3.9. Best Practice Teams Report

4. **Fall Prevention** – A review of measures and current actions for the Fall Prevention Program. *Emma Camarena, DNP, RN, Director of Nursing Practice.*

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.

KAWEAH DELTA HEALTH CARE DISTRICT

QUALITY COUNCIL - CLOSED MEETING

THURSDAY SEPTEMBER 15, 2022

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 4-19

KDHCD - QUALITY COUNCIL - CLOSED MEETING

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Pain Management Committee Quality Report

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

Tom Gray, MD
Medical Director of Quality & Patient Safety

September 2022

Pain Management at Kaweah Health

Committee Mission:

- Responsible for oversight of pain management and safe opioid prescribing
- Develop measures and monitor quality improvement (QI) activities
- Ensure our pain management standardized practices meet the highest standards
- Continually evaluate how pain is managed within our institution to ensure our procedures and protocols address the needs of our patients and empower our staff to provide excellent care.

Pain committee membership includes Nursing, Pharmacy (Pain Service), Quality, Physician stakeholders such as Palliative Care, Anesthesia, Emergency Medicine, GME Residents, Medical Director of Quality & Patient Safety, as well as consultation with Medical Director of Surgical Quality.

Pain Management at Kaweah Health

Committee Goals:

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

1. Pain assessment – completed accurately and at appropriate time intervals (includes reassessment)
2. Types of interventions – pharmacological (opioid vs multimodal) and non-pharmacological. Increase use of multi-modal intervention. Ensure safe prescribing habits.
3. Effectiveness –use of multimodals, right pain medication for right pain level, use of non-pharmacologic pain methods
4. Safety measures – in partnership with Medication Safety Committee, monitor use of naloxone, discharging prescribing, and adverse drug events related to opioids
5. Increase points in Cal Hospital Compare Opioid Honor Roll Program from 17 to ≥ 26 points to reflect “excellent progress” or 22 points to reflect “most improved”

Pain Management at Kaweah Health

Key Activities 2021:

1. Development of pain management measures and dashboard
2. Completion of a gap analysis for all Joint Commission standards related to pain management
   - All standards compliant
   - Opportunities to enhance processes identified and included in 2022 plan
3. Completion of the Cal Hospital Compare (CHC) Opioid Safe Hospital Organizational Assessment (Honor Roll Program)
   - Kaweah Health earned 17/36 points in the self assessment
   - CHC is a non-profit organization that is helping to address California's opioid epidemic and reduce opioid related deaths. CHC uses the Opioid Management Hospital Self-Assessment to assess performance and progress across the following 4 domains of care: 1) Safe & effective opioid use, 2) Identifying and treating patients with Opioid Use Disorder, 3) Overdose prevention, 4) Applying cross-cutting opioid management best practices
   - Hospitals score each element on a 1-4 scale (higher score indicates high degree of progress); items <4 included in 2022 action plan

Key Activities 2022:

1. Completion of the 2023 Cal Hospital Compare (CHC) Opioid Safe Hospital Organizational Assessment (Honor Roll Program)
2. Goal is to achieve ≥26 points on the Organizational assessment through the implementation of several initiatives that also address several key measures, including:
   - Opioid prescribing guidelines
   - Enhanced patient/family education
   - "Stigma training" for targeted providers
   - Broadly communicate program goal s and progress

KH Pain Management Committee

Pain Management & Opioid Safety Initiatives

Pain Management QI Initiative	Status	Action Plan 2022
1. Ensure opioid safety through monitoring of Adverse Drug Events (ADE) per 1,000 Inpatient admission (Medicare FFS Part A claims) Goal: Surpass national benchmark of 2.46 per 1,000 patients (as reported by Health Services Advisory Group HSAG 3/1/21-2/28/22)	• Lower is better. 2019 = 2.29 per 1,000(17/7430); 2020 = 1.15 per 1,000 (7/6074); Mar 2021 -Aug 2022 = 1.52 per 1,000 (8/5349)). Goal achieved.	• Resident QI project completed May 2022 focused on evaluation of 17 patients with a reported ADE related to opioids from Dec 2020 -Aug 2021 to determine if there was a true ADE. The evaluation utilized the evidenced-based Naranjo Adverse Drug Reaction Probability Scale (a tool that standardized assessment of causality for all adverse drug reactions). Results indicated that only 35% (6/17) were true ADEs. Although the sample was small, it would be reasonable to conclude that the HSAG ADEs related to opioid rate per 1,000 is lower than reported.
2. Ensure opioid safety through monitoring of Adverse Drug Events collected through Rapid Response Team (RRT) case review. Number of RRTs where Narcan was effective (Narcan is a reversal agent used to treat overdoses) Goal: Not set as this is a overall monitoring measure, an increase would indicate potential issue to be evaluated since the narcan effectiveness is initial documentation and not vetted by pharmacy (see action plan)	• 2021 – 54 patients were administered Narcan during an RRT, 27 of them (50%) the RRT RN reported the Narcan was effective (not evaluated by pharmacy). In the first 6 months of 2022 19 patients were administered Narcan, annualized estimate 38, less than 2021; however the RRT RN reported the Narcan was effective in more of the cases, 15, annualized estimate of 30.	• Committee identified that often the RRT RNs report of Narcan effectiveness in cases is not consistently accurate (ie. some case review revealed that patients where Narcan was effective during an RRT were not on opioids). Re-education with RRT RNs completed. Plan is to revise data and process to include a pharmacists case review to identify gaps timely and report actual cases where Narcan was effective (as vetted by pharmacy) as the measure.

KH Pain Management Committee

Pain Management & Opioid Safety Initiatives

Pain Management QI Initiative	Status	Action Plan 2022
3. Ensure Opioid safety through discharge prescribing of opioids for < 7 days in duration Goal: Decrease 5% from 2021; reevaluating goa	• (lower is better) % of patients with opioid prescription >7 day 14% in 2021. Decreased to 8.5% Jan-June 2022. GOAL ACHIEVED	• Develop and implement discharge prescribing guidelines. Committee selected the Opioid Prescribing Engagement Network (OPEN) evidenced based guidelines for acute pain management. Plan to provide link in Cerner at the point of order entry for easy accessibility. • Data analysis in process to identify trends (ie. providers, opioid types)
4. Ensure Opioid safety through discharge prescribing. NEW! CMS Measure: Safe Use of Opioids-Concurrent Prescribing (eCQM - Electronic Clinical Quality Measures). Benchmark not yet released	• Measure description - Inpatient hospitalizations for patients 18 years of age and older prescribed, or continued on, two or more opioids or an opioid and benzodiazepine concurrently at discharge • Denominator exclusions: Inpatient hospitalizations where patients have cancer that overlaps the encounter or are receiving palliative or hospice care (including comfort measures, terminal care, and dying care) during the encounter • 2021 = 18.70% (1053/5642) Benchmark not yet released by CMS PENDING • CMS reports this measure will be publically reported in 2022 (date not yet released)	• Develop and implement evidenced based OPEN guidelines as noted above • Work in progress with ISS to build this measure in Cerner so that accurate submission to CMS can be accomplished and data analysis can identify root causes to address.

KH Pain Management Committee

Type of Pain Management Intervention & Effectiveness Initiatives

Pain Management QI Initiative	Status	Action Plan 2022
1. Increasing peripheral nerve blocks (Anesthesia) **Goal:** Increase volume from 2021; reduces need for opioids	• 37 peripheral nerve blocks completed CY 2021, 19 completed Jan-July 2022. PENDING	• Focusing increasing nerve blocks on the amputation surgical population. Baseline data report request pending.
2. Increasing Multimodal use when opioids are prescribed in surgical and chronic opioid patient populations **Goal:** Increase % of patients with opioid and multimodal administered from previous year	Data (higher is better): • % of opioid and multimodal administration surgical patients: 2020 = 57.5%; 2021 = 65.3%, Jan – July 2022= 66.6%. GOAL ACHIEVED • % of opioid and multimodal administration chronic opioid patients: 2020 = 52.9%; 2021 = 50.5%, Jan-July 2022 =55.2%. GOAL ACHIEVED • Power plans evaluated for presence of multimodal order options available to providers. • Enhanced Recovery After Surgery (ERAS) in place for elective colorectal surgical patients and also initiated for C-Section patients in 4Q 2021	• Implement opioid prescribing guidelines as described above • Update provider Kaweah Health onboarding materials for pain management Reported through Surgical Quality Committee: • ERAS expanded to Orthopedic populations 1Q 2022 • Plan to expand ERAS to non-elective colorectal and gynecological surgical patients populations late 2022
Right pain medication administered for level of pain reported. **Goal:** 95%	• Aug 2021-July 2022 = 89%	• Assigned Director reports action plan to Quality Improvement Committee; data analysis in process

KH Pain Management Committee

Type of Pain Management Intervention & Effectiveness Initiatives

Pain Management QI Initiative	Status	Action Plan 2022
3. Review and revise patient education materials for pain management **Goal:** Patient and community awareness to reduce opioid use & achieve **≥26 points** on the Cal Hospital Compare Opioid Honor Roll Program.	• Included in the Cal Hospital Compare Opioid Honor Roll program. • Kaweah Health Achieved 17 points in the program in 2021 (reported early 2022). 2022 evaluation and submission to Cal Hospital Compare is by 3/1/23 PENDING	• Committee reviewed patient education materials from the CDC on opioid safety. Recommend distributing to patients upon admission/discharge. Materials currently being reviewed by the Patient Education Committee. Discussion planned for Sept 2022 with Patient Care Nursing Managers regarding the addition of the materials to admission/discharge packets. Materials available in both English and Spanish.
4. Assess and address stigma associated with provider pain management for patients with Opioid Use Disorder (OUD) **Goal:** Reduce stigma & achieve ≥26 points on the Cal Hospital Compare Opioid Honor Roll Program.	• 44 providers who prescribe opioids responded to survey in early 2022 • Survey results suggest increased stigma in providers that tend to prescribe the most opiates. • Initiative (assessing stigma) included in the Cal Hospital Compare Opioid Honor Roll program. • KH Achieved 17 points in the program in 2021 (reported early 2022). 2022 evaluation and submission to Cal Hospital Compare is by 3/1/23 PENDING	• Provider education under development that addresses stigma with OUD patients • Plan to resurvey in 2023 to evaluate effectiveness

KH Pain Management Committee

Pain Assessment Initiatives

Pain Management QI Initiative	Status 2021	Action Plan 2022
1. RN knowledge of pain score assessment prior to & after pain med admin **Goal:** 95%	• Knowledge of pain score assessment prior. Baseline (June-July 2021) = 88%; Aug-Dec 2021 = 98%; Jan-July 2022 = 96% Goal achieved • Knowledge of pain score assessment post – baseline (June-July 2021) = 79%; Aug-Dec 2021 = 99%; Jan- July 2022 94%. Goal not achieved	At the elbow education planned to start September 2022, "show on the road".
2. RN knowledge of appropriate us of PAIN-AD scale to assess pain for non-verbal pts **Goal:** 95%	• Baseline (June-July 2021) = 88%; Aug-Dec 2021 = 98% ; Jan- July 2022 95%. Goal achieved	Continue to monitor to sustain
3. Reassessing patients pain within 75 min of opioid administration **Goal:** under evaluation due to documentation timing	• Evaluation of nursing processes indicated that the reassessment is occurring within appropriate timeframe, but not documented until later in the shift. Broad Nursing education assigned to RNs in August 2021.	Plan in progress, performance related to timing of documentation under review with nursing leadership; monitor RRT data for outcomes related to reassessment timing

Questions?

Live with passion.

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

Kaweah Health

PCI Data Quality Analysis

Q4 2020 → Q3 2021

Risk Adjusted Data

Neon Green = In the Top 10% of the Nation

Light Green = Better or Equal to the National Average

Red = Worse than National Average

Gray = Non-Risk Adjusted Value (for Reference only)

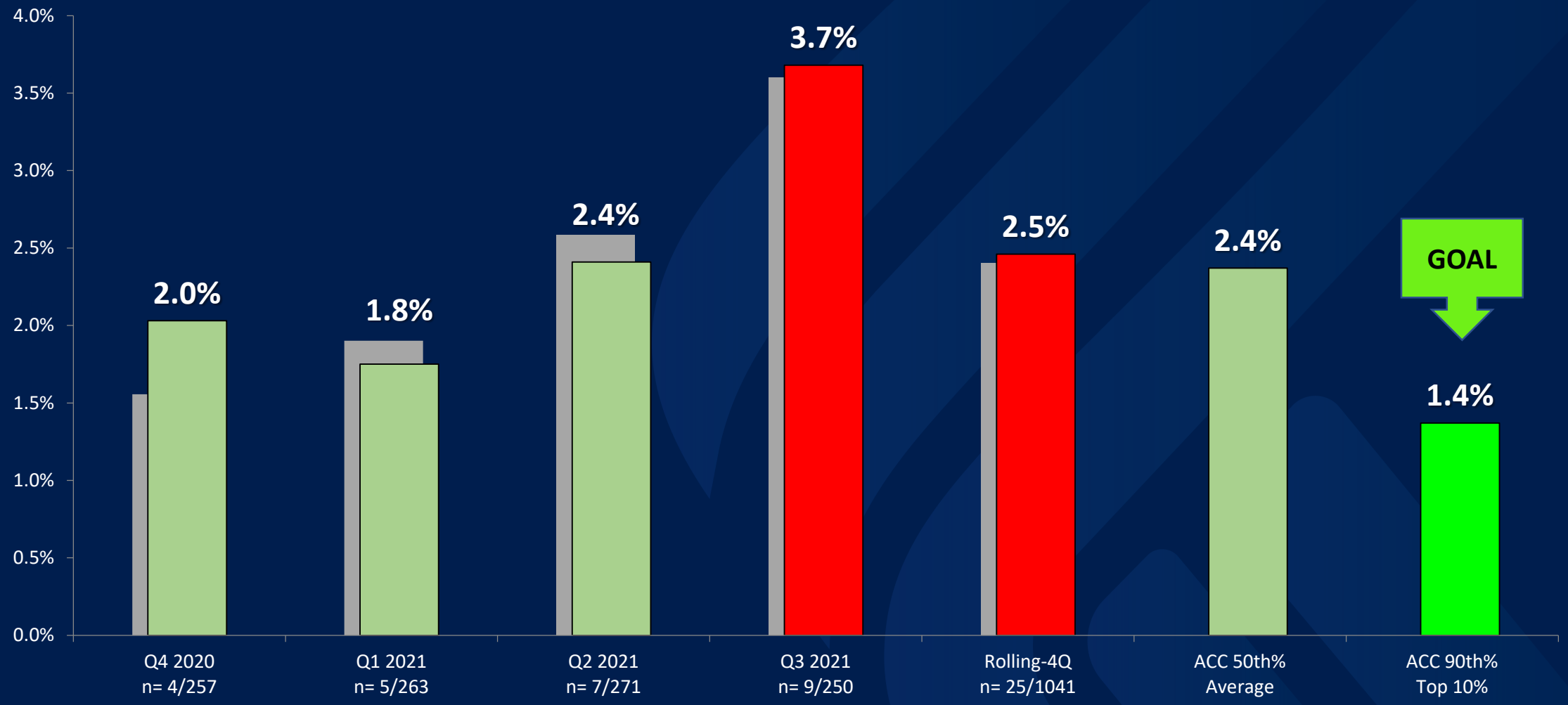
*Comparison Reporting Period Varies per Metric

Quality Improvement for Institutions

American College of Cardiology

Kaweah Health
MORE THAN MEDICINE. LIFE.

PCI In-Hospital Mortality Rate[1]
Risk Adjusted[IN-COLOR] (All Patients)



R4Q Risk-Adjusted O/E = 1.1

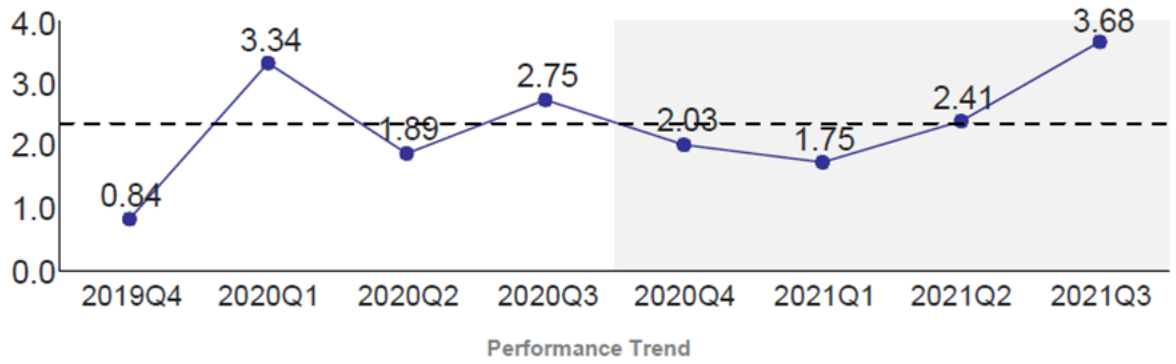
[1] PCI in-hospital mortality rate for all patients, risk adjusted. Exclusions include patients with a discharge location of "other acute care hospital." (ref: 4739, 4736)

*Comparison reporting period is 10/01/20 through 09/30/21

PCI Mortality Rate[1]

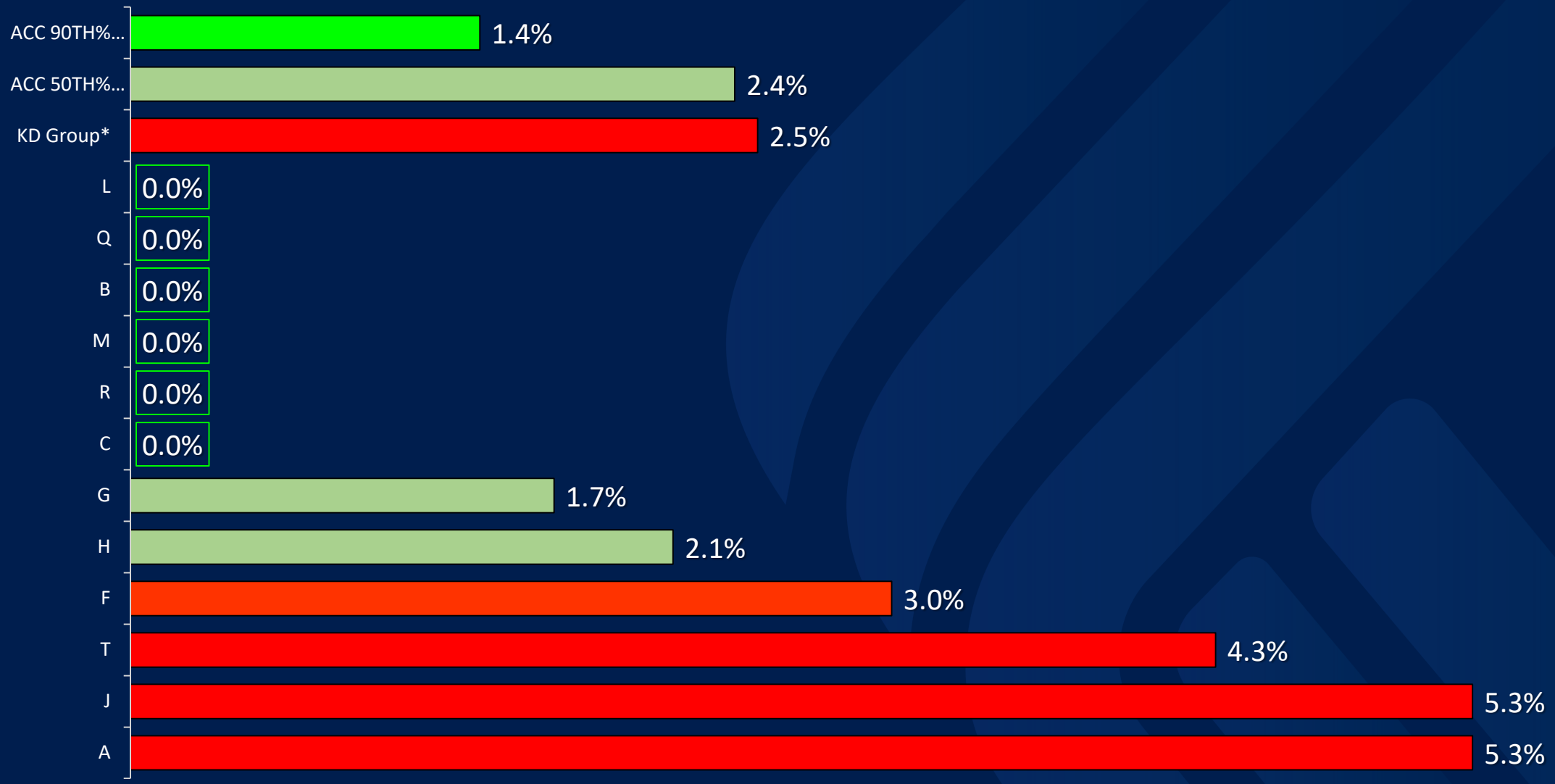
Risk Adjusted two years

(All patients)



[1] PCI in-hospital mortality rate for all patients, risk adjusted. Exclusions include patients with a discharge location of “other acute care hospital.” (ref: 4739, 4736)

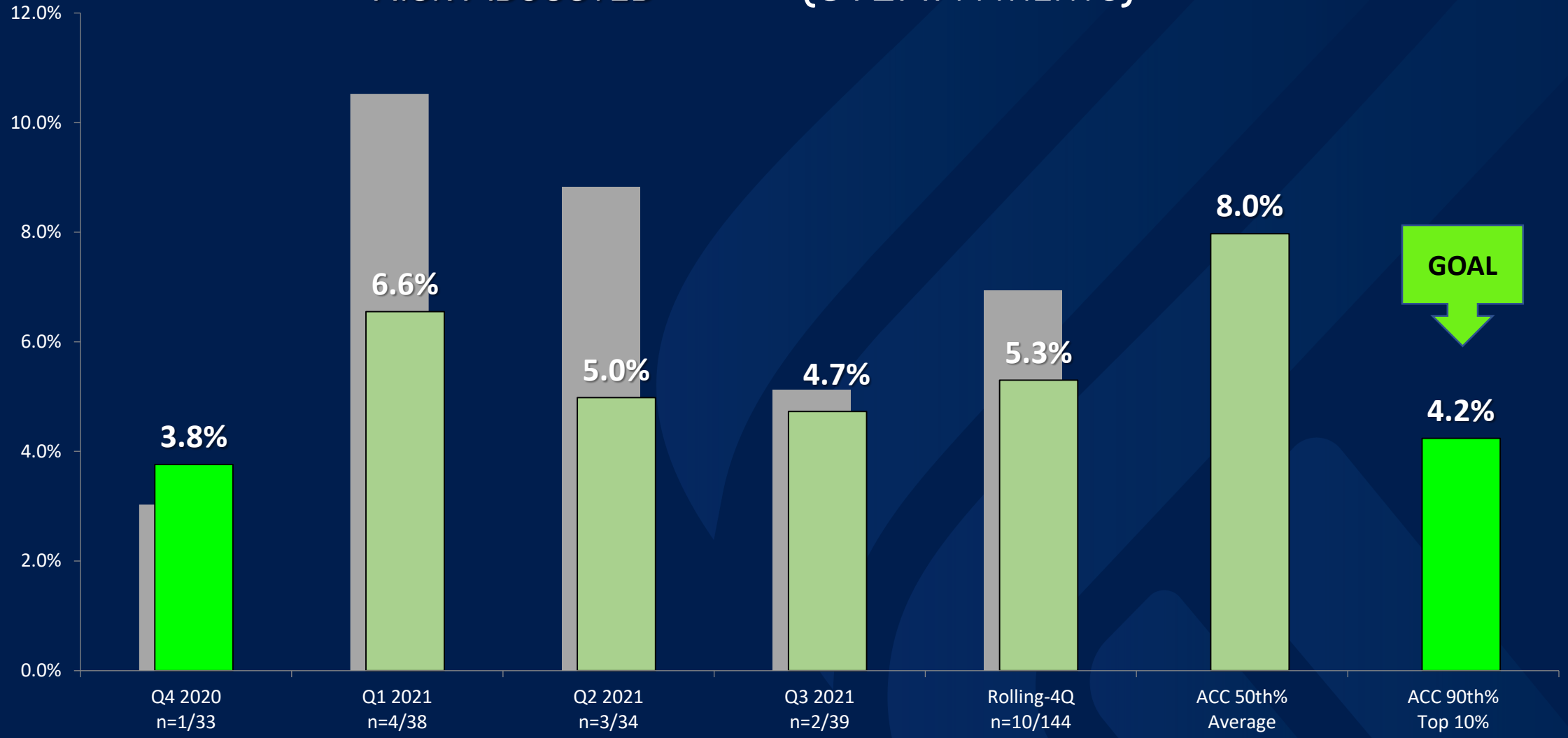
PCI Mortality[1] Rate by Physician
All patients - Rolling 4 Quarters (Q4 2020 – Q3 2021*)



[1] PCI in-hospital mortality rate for all patients for that MD. Exclusions include patients with a discharge location of "other acute care hospital." (ref: NCDR/ACC Physician Dashboard)

* Comparison reporting period is 10/01/20 through 09/30/21– Raw DATA all Quarters – NOT-RISK-ADJUSTED

PCI In-Hospital Mortality Rate[1] Risk Adjusted[IN-COLOR] (STEMI patients)



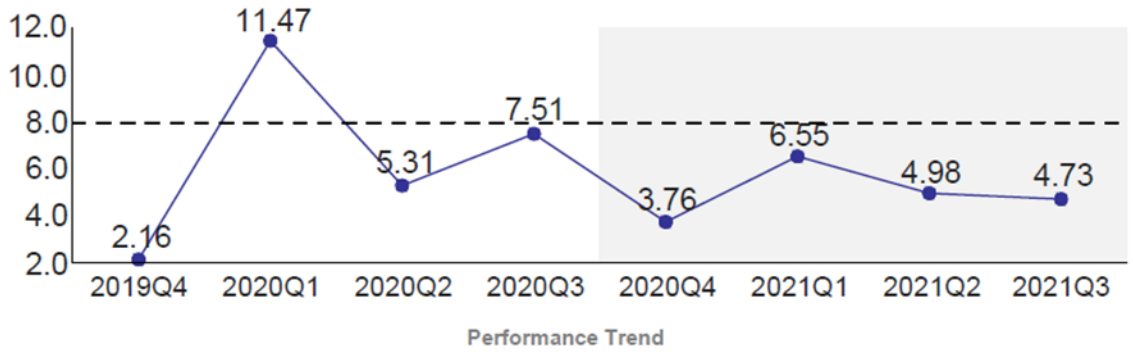
R4Q Risk-Adjusted O/E = 0.7

[1] PCI in-hospital mortality rate for STEMI Pt.'s. (ref: 4740, 4734)

* Comparison reporting period is 10/01/20 through 09/30/21

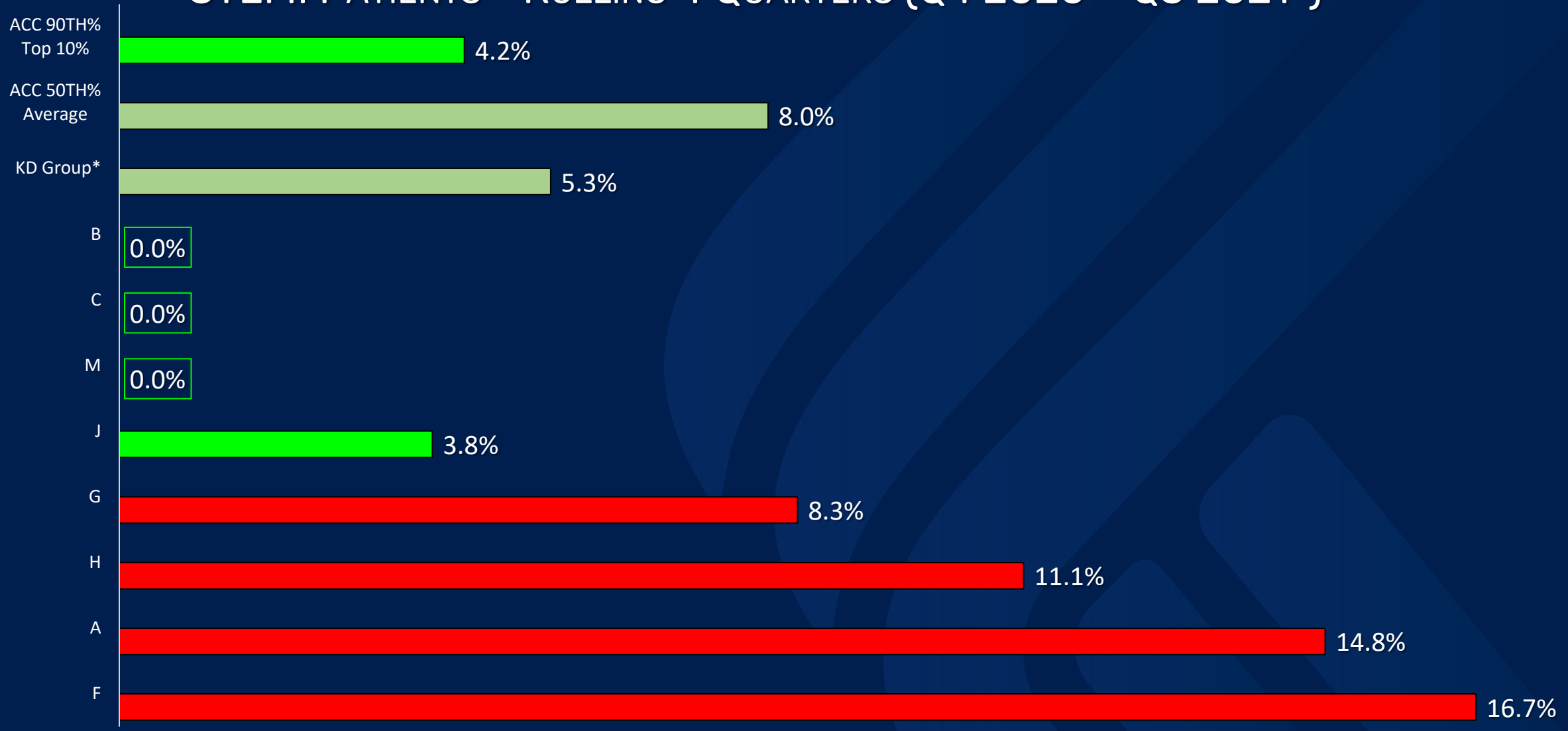
PCI Mortality Rate[1]

Risk Adjusted two years (STEMI patients)



[1] PCI in-hospital mortality rate for STEMI patients, risk adjusted. Exclusions include patients with a discharge location of "other acute care hospital." (ref: 4740, 4734)

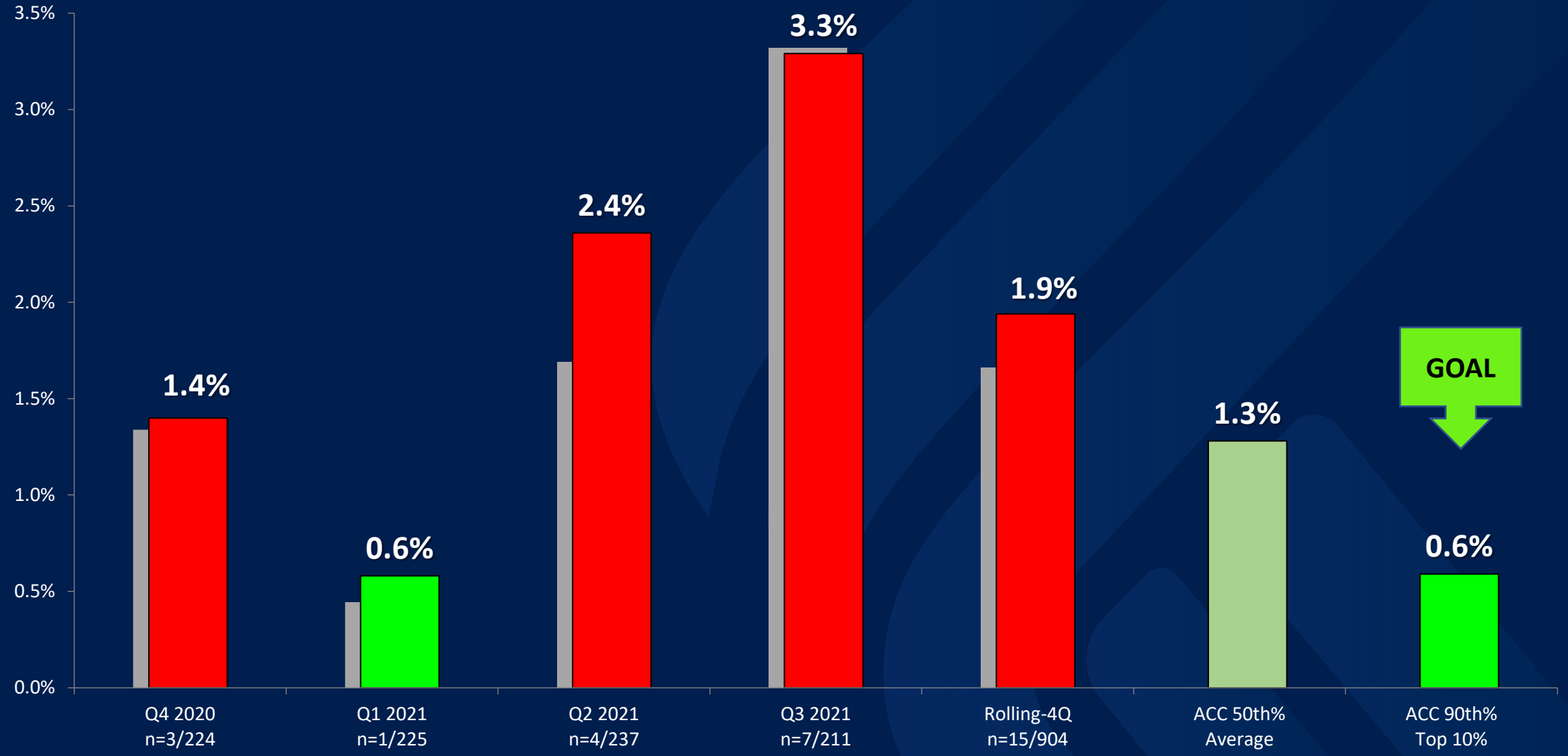
PCI Mortality[1] Rate by Physician
STEMI Patients – Rolling 4 Quarters (Q4 2020 – Q3 2021*)



[1] PCI in-hospital mortality rate for STEMI patients for that MD. Exclusions include patients with a discharge location of "other acute care hospital." (ref: NCDR/ACC Physician Dashboard)

* Comparison reporting period is 10/01/20 through 09/30/21– Raw DATA all Quarters – NOT-RISK-ADJUSTED

PCI In-Hospital Mortality Rate[1]
Risk Adjusted[IN-COLOR] (NSTEMI, unstable angina, electives)



R4Q Risk-Adjusted O/E = 1.7

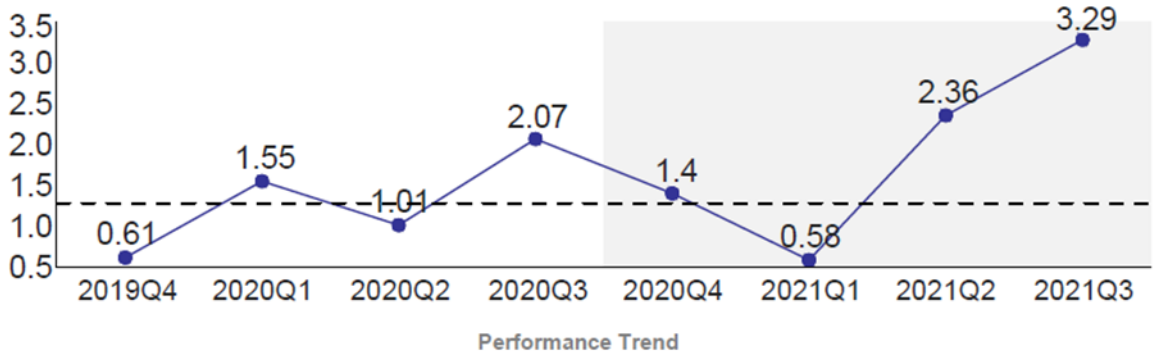
[1] PCI in-hospital mortality rate for all patients Excluding STEMI. Exclusions include patients with a discharge location of "other acute care hospital." (ref: 4741, 4735)

* Comparison reporting period is 10/01/20 through 09/30/21

PCI Mortality Rate[1]

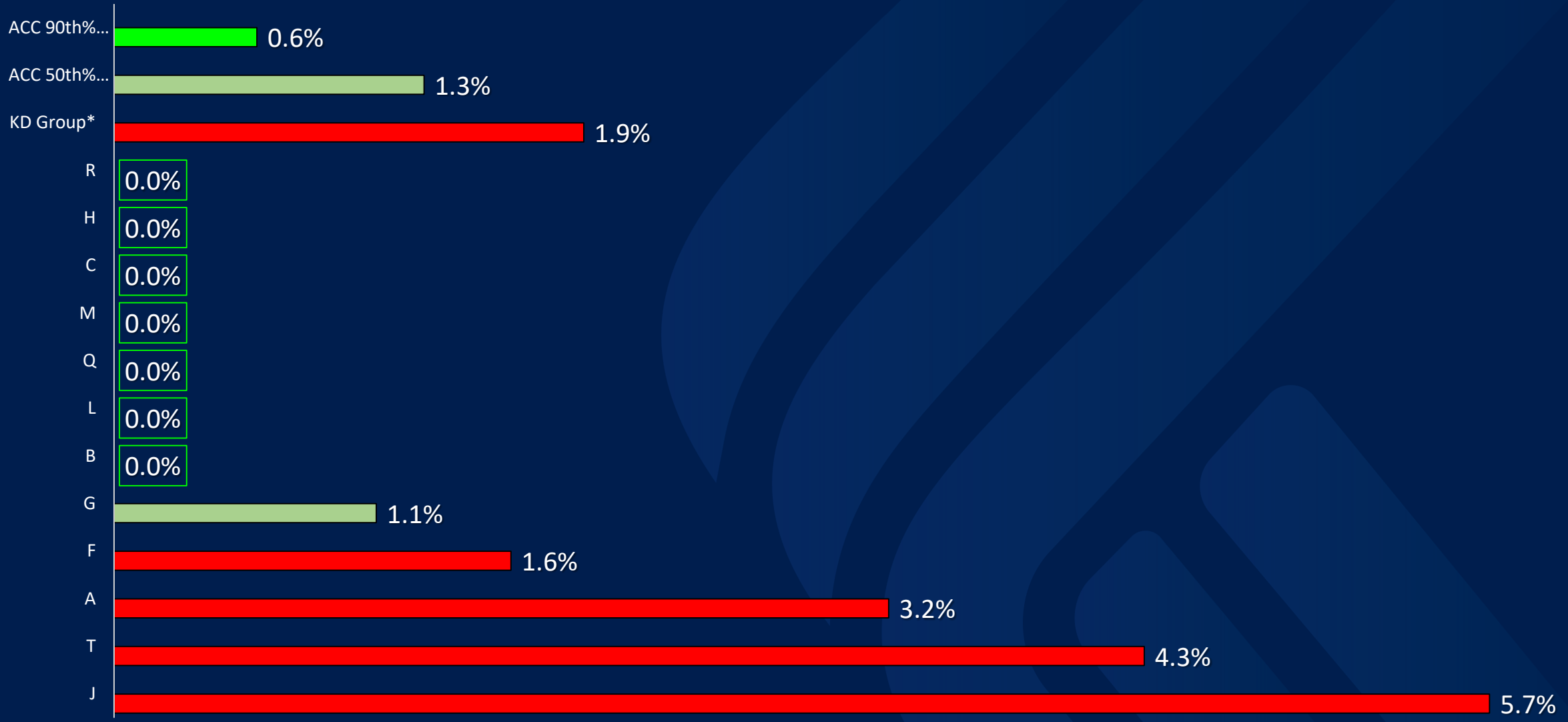
Risk Adjusted two years

(NSTEMI, unstable angina, electives)



[1] PCI in-hospital mortality rate for all patients Excluding STEMI patients, risk adjusted. Exclusions include patients with a discharge location of "other acute care hospital." (ref: 4741, 4735)

PCI Mortality[1] Rate by Physician
N-STEMI, USA, Elective Patients - Rolling 4 Quarters (Q4 2020 – Q3 2021*)



[1] PCI in-hospital mortality rate for N-STEMI, USA, Elective patients for that MD. Exclusions include patients with a discharge location of "other acute care hospital." (ref: NCDR/ACC Physician Dashboard)

* Comparison reporting period is 10/01/20 through 09/30/21– Raw DATA all Quarters – NOT-RISK-ADJUSTED

Kaweah Health

STEMI Triage Guidelines

Thoughtful Pause

➢ Should go to CVICU first, not the Cath Lab

- Cardiac Arrest with CPR ≥ 20 minutes and un/minimally responsive
- Cardiogenic Shock, age ≥ 80
- STEMI ≥ 24 hours without Chest Pain
- Excess risk of bleeding (e.g. active internal bleed, ICH<3 mos, Hct<22, PLT<30K)
- Altered Mental Status
- Apparent sepsis or other conditions (other than pure cardiogenic shock) that would markedly increase the risk of dying within 30 days
- Pre-existing DNR / No Code Status

❖ Consider lytic agents for symptoms < 3 hours, anticipated DTB time > 120 minutes and low risk of bleeding

❖ These are intended as guidelines, not to supersede clinical judgement

*Adopted from the Cleveland Clinic Heart Institute: Triage Guidelines for STEMI patients.

Kaweah Health

Predicted Mortality Model

Elements included in the Mortality Risk Adjustments- v5

- Age, Gender
- Cerebral Vasc. Disease
- Peripheral Vasc. Disease
- Chronic Lung Disease
- Previous PCI
- In-stent Thrombosis w/in 30 days of prior PCI
- Diabetes Mellitus
- CHSA Clinical Frailty Scale
- NYHA Class I/II/III/IV
- Kidney Disease (pre-op creatinine)
- Renal Failure (Dialysis)
- Left Ventricular Ejection Fraction
- Systolic Blood Pressure
- Cardiac Arrest - timing
  - Responsiveness after arrest, prior to PCI
- Surgical Treatment recommendation
- Aortic Stenosis
- STEMI (any timing or stability)
- PCI of Left Main or Proximal LAD
- PCI Status
  - Salvage PCI
  - Refractory Cardiogenic Shock
  - Cardiogenic Shock
  - Acute Heart Failure
  - Emergent, urgent, elective
  - Cardiovascular Instability

*Risk Factors taken from the American College of Cardiology Metrics #48-51: PCI in-hospital Risk Standardized Mortality Risk Model for Predicted Mortality: version 5 (Release date 1/25/2022)

Kaweah Health

Quality Initiative

Treatment Algorithm for Invasive Cardiac Procedures

- Targeted Temperature Management
  - Immediate hypothermia measures to be implemented on cardiac arrest patients
- 12-Lead ECG must be done within 10 minutes of arrival to hospital
- ACT initiated – (Do not delay cooling measures)
  - Assessment for unfavorable resuscitation features
  - Consultation between ED, Critical Care and Cardiology physicians
  - Transport to Cath Lab urgently when consensus reached

*Rab, Tanveer, and Karl B. Kern. "Cardiac Arrest A Treatment Algorithm for Emergent Invasive Cardiac Procedures in the Resuscitated Comatose Patient." Journal of the American College of Cardiology 66.1 (2015): 62-73.

Kaweah Health

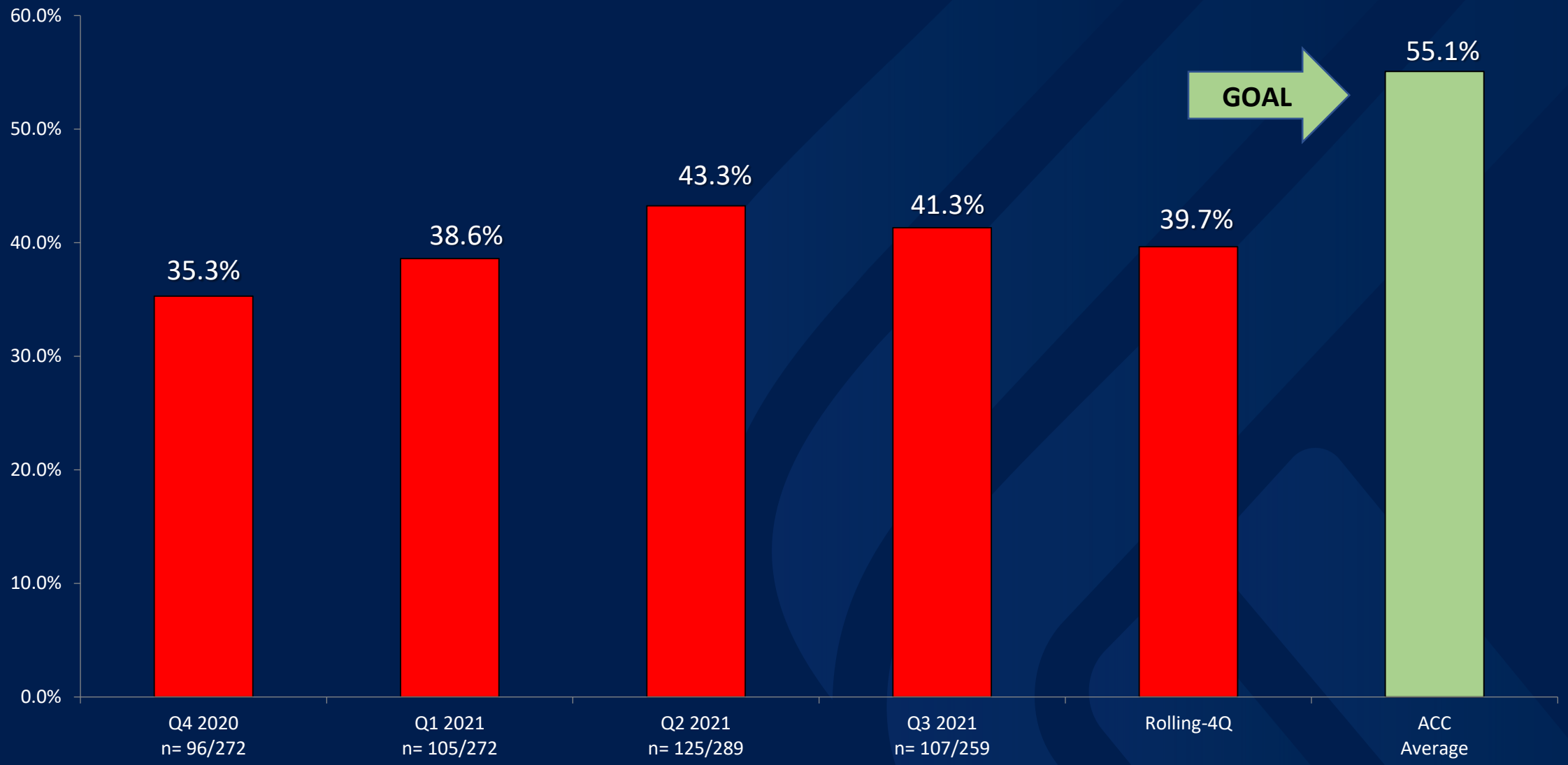
Quality Initiative

Vitally Important Ethical Steps

- Physician collaboration & coordination between departments is required
- Cardiologist must participate in all thoughtful pause discussions
- ED physician and Cardiologist will consult with an Intensivist as needed for difficult cases
- Intensivist will respond to the ED for thoughtful pauses as requested
- Thoughtful pause must be documented in patient's EMR by a Provider
- Honest communication between all parties is required to maintain transparency and trust. Families must be given aggressive treatment options with their corresponding prognosis or futility
- Ethical issues are unavoidable in the care of critically ill patients but we must maximize our ethical decision-making
  - Clinical judgments of the multidisciplinary physicians must be observed whenever possible
  - Diagnostic tools and data must be readily available for discussion in real time so that critical decisions can be made quickly
  - Additional research into emerging data on this topic and diagnostic tools to keep our patients receiving state of the art care
  - Transparent discussions at the practice and policy making levels about what characterizes appropriate or futile care
  - Assessing patient wishes, respecting DNR and advanced directives even in times of family crisis and proxy decision makers
- Lastly and importantly, frank and honest discussions with families as to what is futile care

*Rab, Tanveer, and Karl B. Kern. "Cardiac Arrest A Treatment Algorithm for Emergent Invasive Cardiac Procedures in the Resuscitated Comatose Patient." Journal of the American College of Cardiology 66.1 (2015): 62-73.

PCI Radial Artery Access

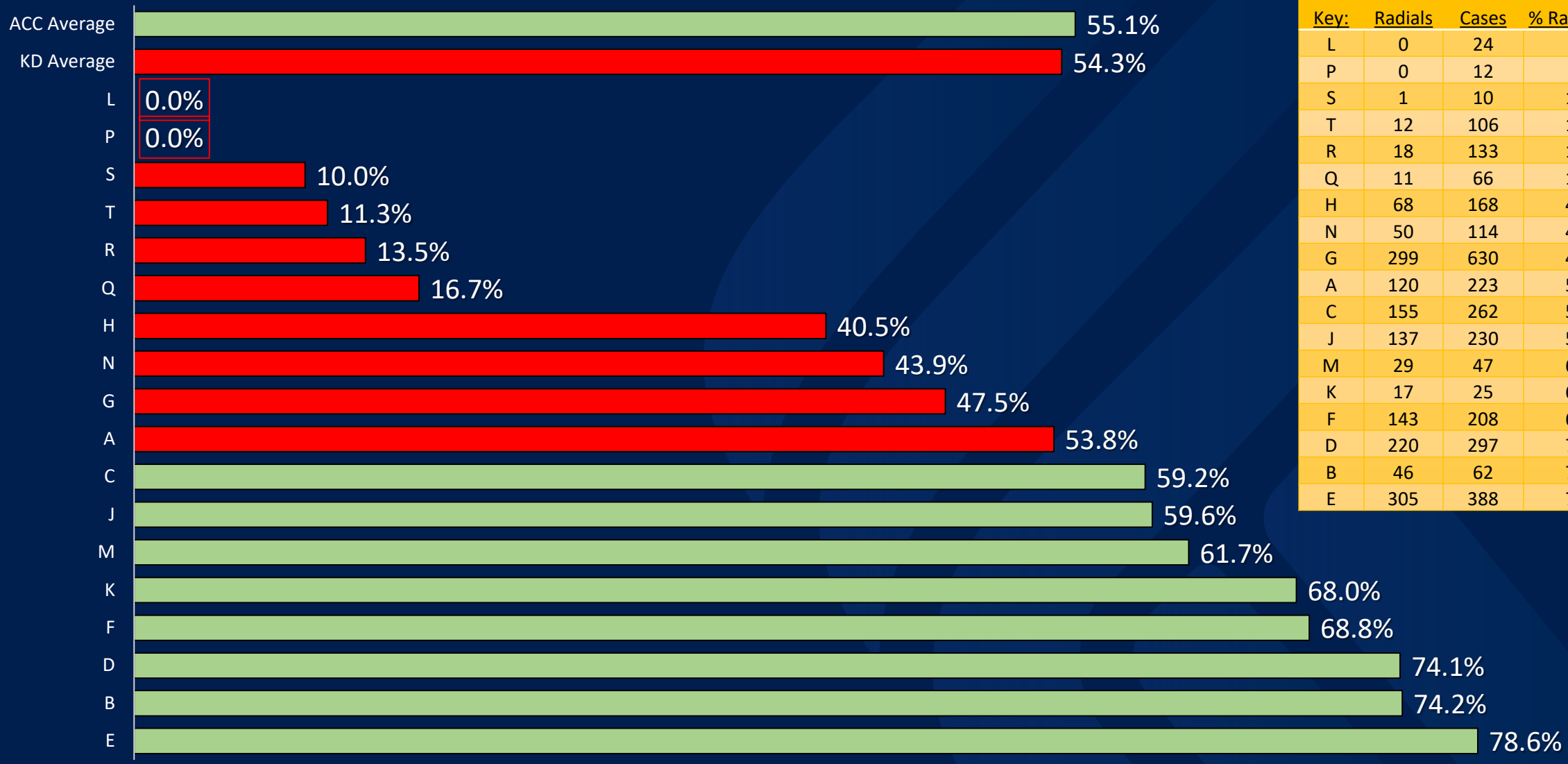


R4Q O/E = 1.1

(ref: NCDR Detail Line 4163) When no Percentile rankings are available, US Like Volume Group R4Q Averages are used for comparison purposes.

* Comparison reporting period is 10/01/20 through 09/30/21

All Cath's Radial Artery Use[1] by Physician
Rolling 4 Quarters (Q4 2020 – Q3 2021*)

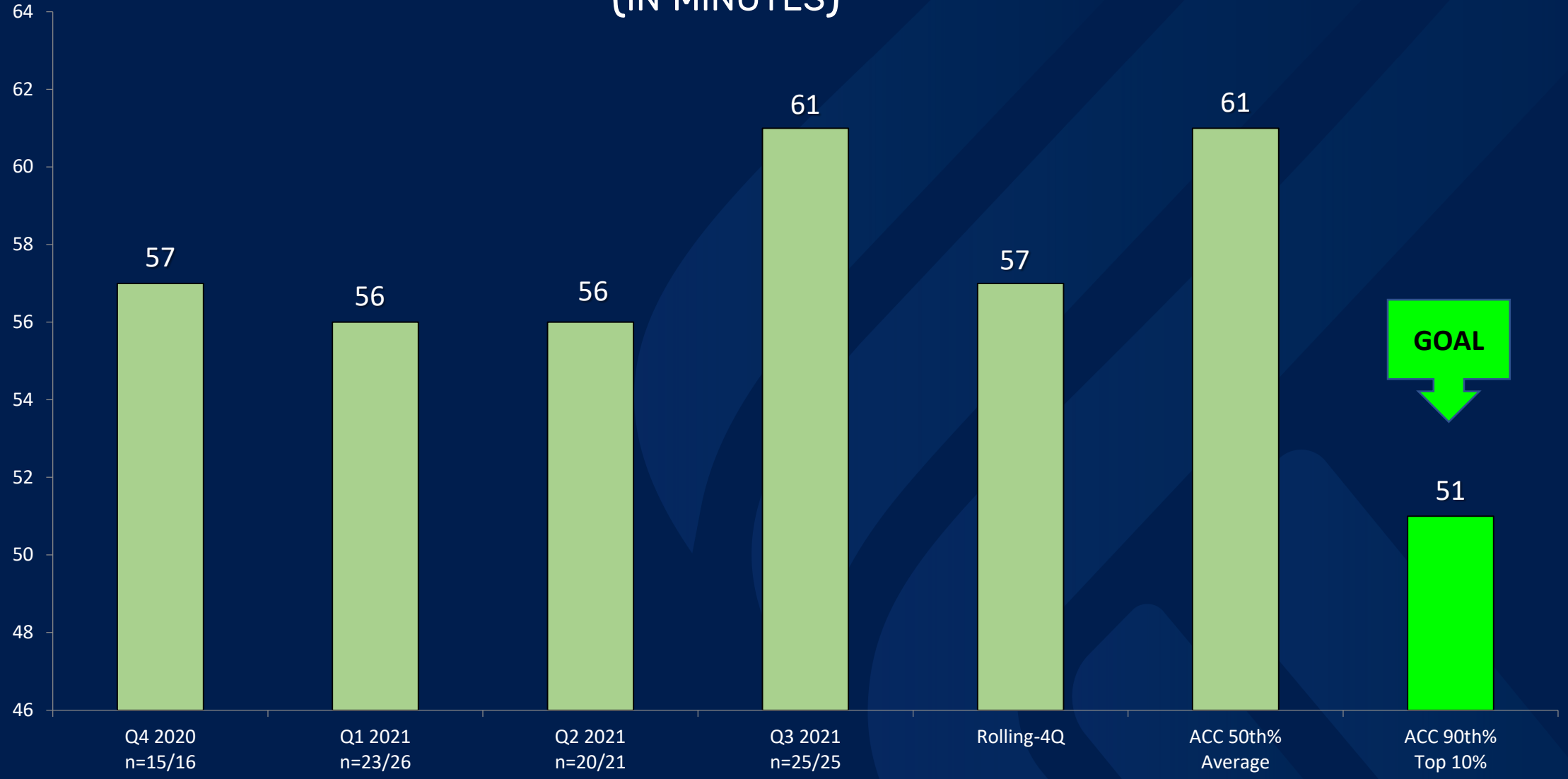


Key:	Radials	Cases	% Radial Usage
L	0	24	0.0%
P	0	12	0.0%
S	1	10	10.0%
T	12	106	11.3%
R	18	133	13.5%
Q	11	66	16.7%
H	68	168	40.5%
N	50	114	43.9%
G	299	630	47.5%
A	120	223	53.8%
C	155	262	59.2%
J	137	230	59.6%
M	29	47	61.7%
K	17	25	68.0%
F	143	208	68.8%
D	220	297	74.1%
B	46	62	74.2%
E	305	388	78.6%

[1] PCI & Diagnostic Cardiac Catheterization Procedures - Arterial Access Site equaling "Radial" for all patients for that MD. No Exclusions; Pt.'s with an aborted Radial attempt included in denominator (ref: SENSIS Statistical Manager) When no Percentile rankings are available, US Like Volume Group R4Q Averages are used for comparison purposes.

* Comparison reporting period is 10/01/20 through 09/30/21– *RAW DATA

Immediate PCI for STEMI (in minutes)[1]

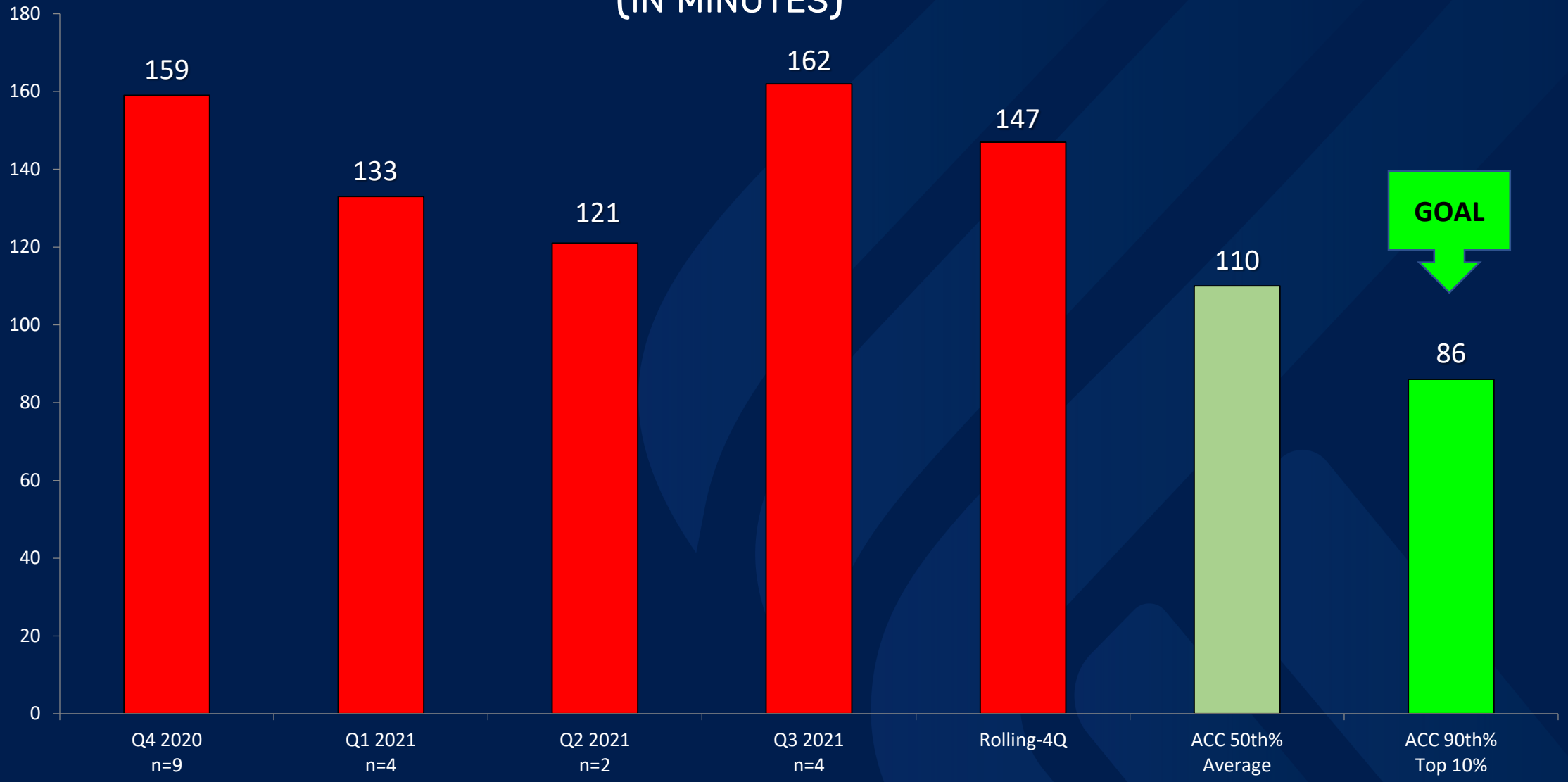


R4Q O/E = 0.9

[1] Median time frame from hospital arrival to immediate PCI for STEMI pts in minutes. Exclusions: Patients transferred in from another acute care facility; Reasons for delay does not equal none. N= pt.'s receiving PCI within 90 minutes. (ref: 4448)

* Comparison reporting period is 10/01/20 through 09/30/21

Immediate PCI for STEMI Transfers (in minutes)[1]



R4Q O/E = 1.3

[1] Median time from ED arrival at STEMI transferring facility to immediate PCI at STEMI receiving facility among transferred patients (excluding reason for delays); Reasons for delay does not equal none. (ref:4452, 10888)

* Comparison reporting period is 10/01/20 through 09/30/21

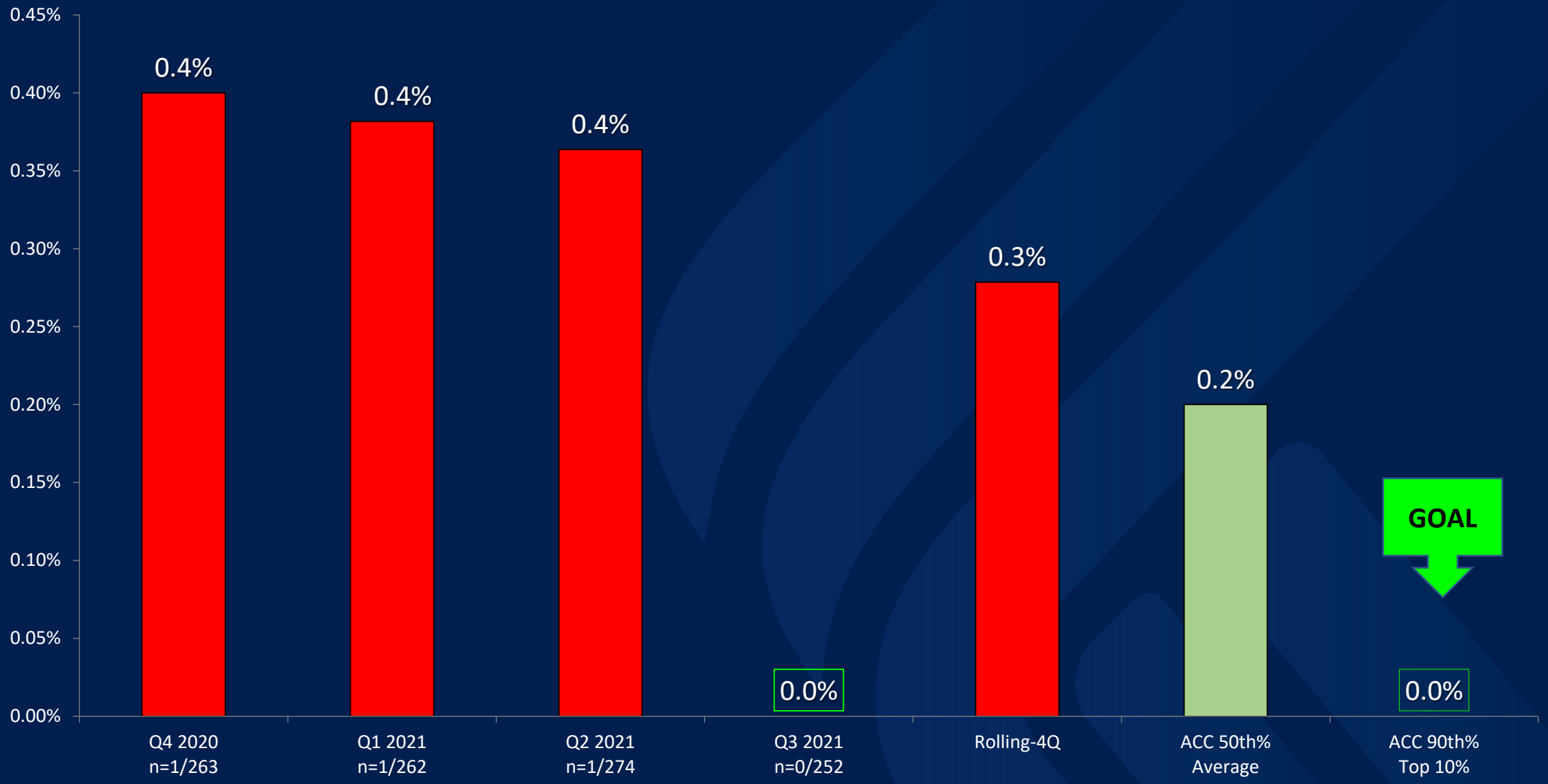
Kaweah Health

Quality Initiative

Best Practice in Door To Balloon

- 4 Staff on call at all times (initiated Fall 2020)
  - Crew response time of 20 minutes
- Recognition of staff: Monthly fastest Door to Balloon award to incentivize staff
- Cardiac Alerts to be called at the time of leaving transferring hospitals
- Initial ED EKG to be placed in EMR or Tracemaster immediately
- STEMI taskforce with ED, Quality and Cath Lab to review ED STEMI hand off practices
  - Including STEMIs called in the field and from other facilities
- Cardiac Alerts called within 10 minutes of ED arrival unless Thoughtful Pause is documented

STROKE POST PCI[1]



R4Q O/E = 1.4

[1] Exclusions: Patients with an Intervention this admission (Surgery, EP, Other); Pt's discharged to *Other Acute Care Facility* (ref: 4235)

* Comparison reporting period is 10/01/20 through 09/30/21

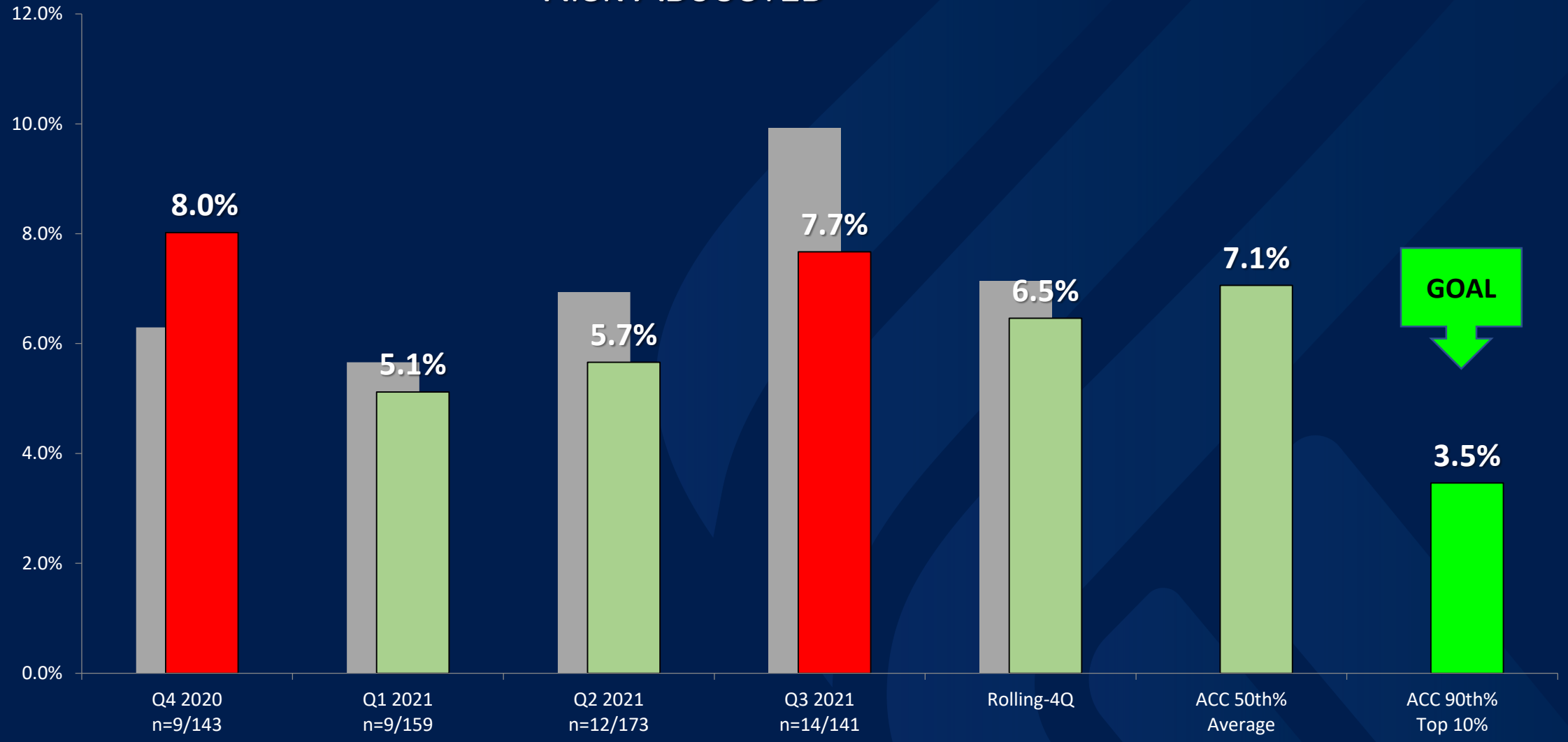
Kaweah Health

Quality Initiative

Stroke Recognition and Treatment

- Assess Stroke Risk factors in PCI for each patient
- Age, gender, history of CVA, End Stage Renal Disease, Diabetes, Hypertension, Peripheral Vascular Disease, Smoking, Congestive Heart Failure, Atrial Fibrillation, CABG surgery or emergent PCI
- Rapid recognition of stroke symptoms in Cath Lab
- Use of the clear protocol for recognition and interventions will facilitate efficient care in the unlikely event of a stroke in Cath Lab

Acute Kidney Injury[1] Post PCI
Risk Adjusted[IN-COLOR]



R4Q Risk-Adjusted O/E = 0.8

[1] Proportion of pt.'s with a rise of serum creatinine of > 50% or ≥0.3 mg/dL over the pre-procedure baseline; all pt.'s w/ New Requirement for Dialysis. Exclusions: pt.'s on dialysis pre-procedure; pt.'s second PCI within this episode of care; same day discharges. (ref: 4882)

* Comparison reporting period is 10/01/20 through 09/30/21

Kaweah Health

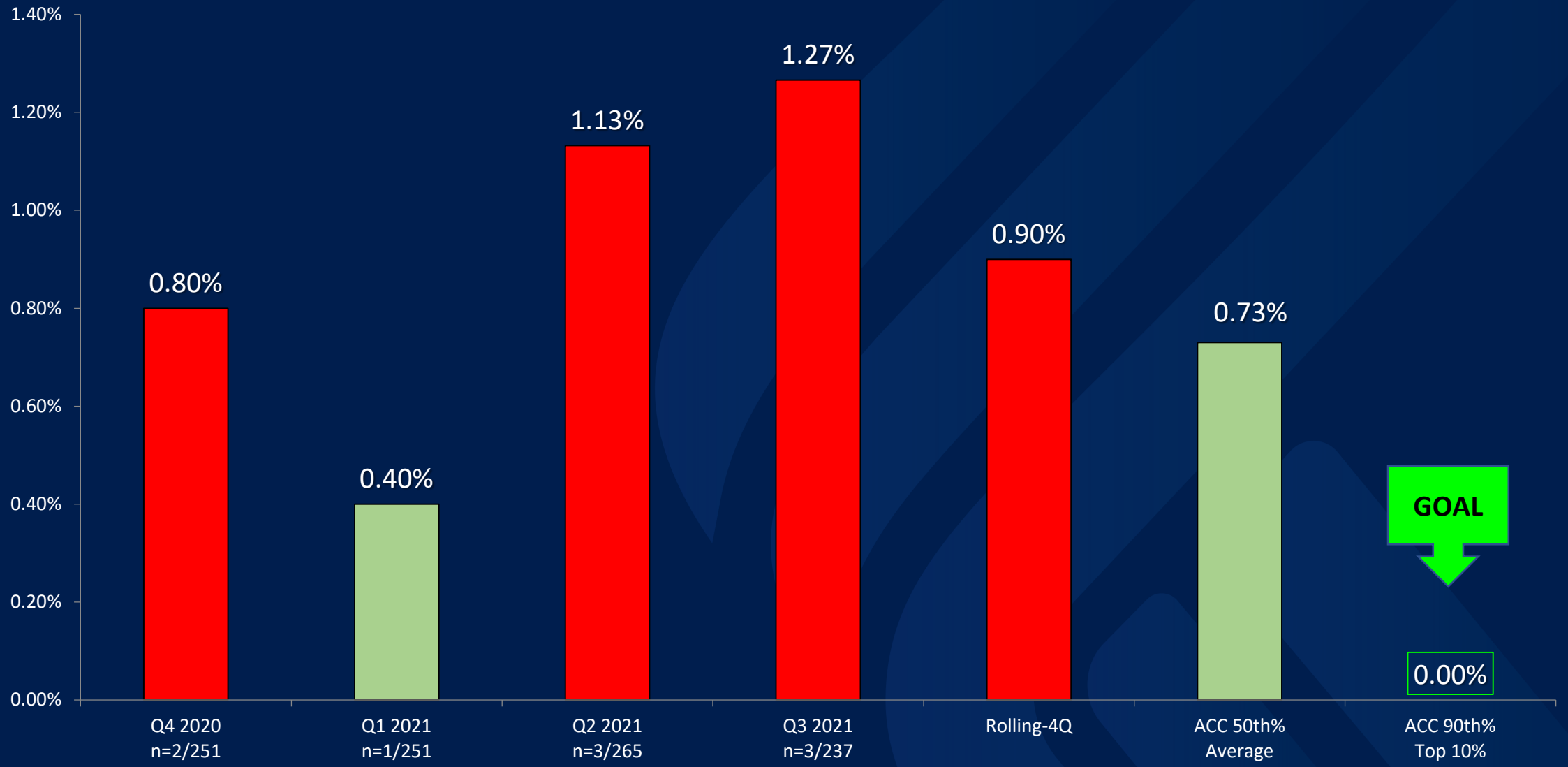
Quality Initiative

Acute Kidney Injury

- Renal impairment = estimated glomerular filtration rate ≤ 60mL/min
- Hydration Needs
  - Pre procedure: Normal Saline at 250 ml/hour to be started upon arrival
  - Intra procedure:
    - LVEDP <18 → NS 500 mL/hr for 4 hours
    - LVEDP >19 → NS 250 mL/hr for 4 hours
  - Post procedure: Normal Saline at 250 ml/hour for 6-24 hours
- Outpatients; increase in oral hydration encouraged the day before arrival. Patients are encouraged to drink clear liquid up to 2 hours prior to procedure
- Post procedure labs must be ordered; Metabolic panel one day post procedure
- Track and Report contrast utilization for Diagnostic and Interventional procedures

*Merschen, Richard. "An Overview of Chronic Kidney Disease and Useful Strategies for Clinical Management." Cath Lab Digest, Mar. 2012. http://www.cathlabdigest.com/articles/Overview-Chronic-Kidney-Disease-Useful-Strategies-Clinical-Management

Transfusion Post-PCI of RBCs[1]



R4Q O/E = 1.2

[1] Proportion of pt.'s who receive a transfusion of whole blood or RBCs during or after, but within 72 hours of PCI procedure.
Exclusions: Patients on dialysis; EP study or CABG or other major surgery during the same admission; Pt.'s with a pre-procedure hemoglobin <8g/dL or no value. (ref: 4288)

* Comparison reporting period is 10/01/20 through 09/30/21

Kaweah Health

KAWEAH HEALTH POLICY (TR-00036)

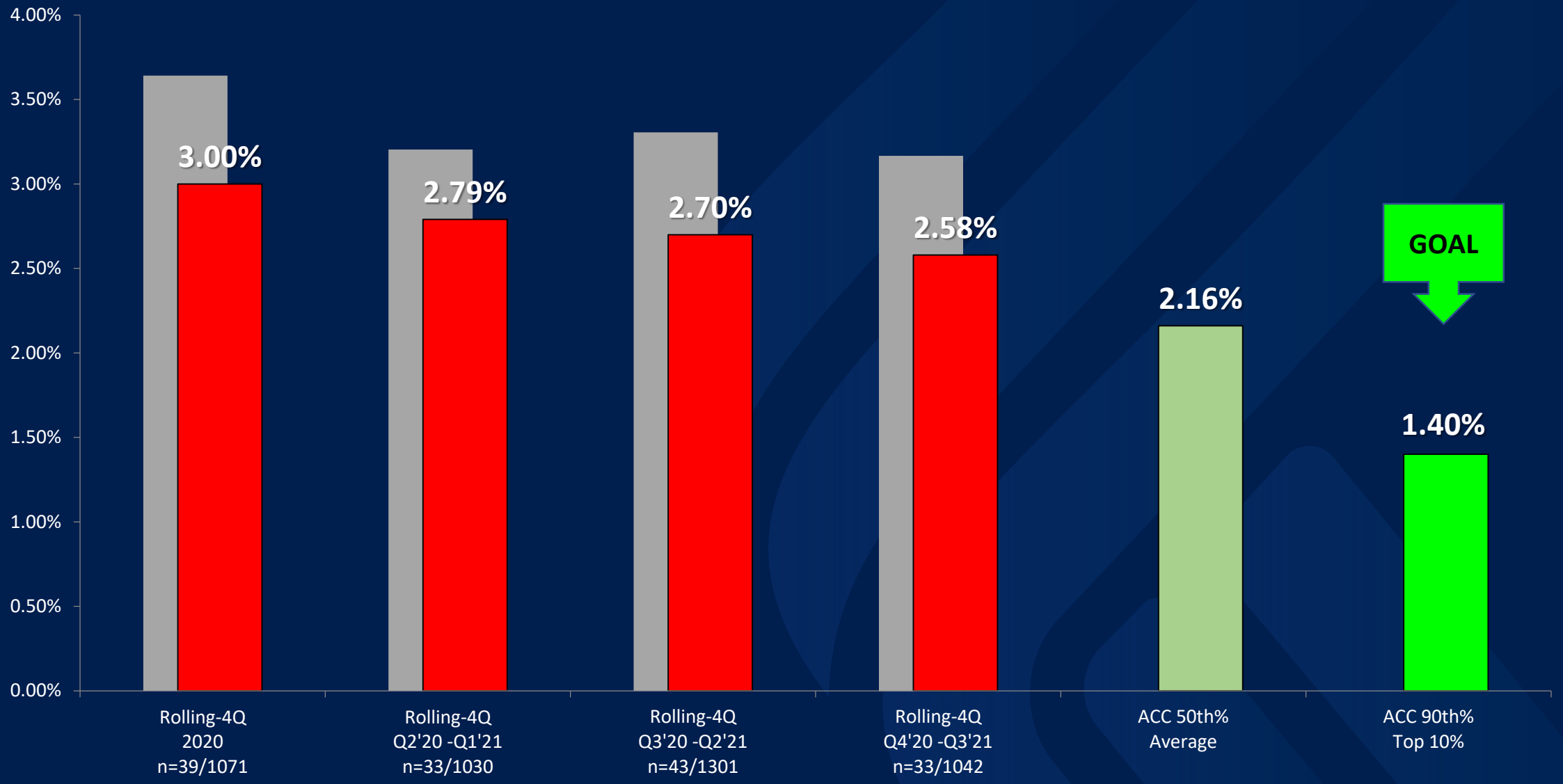
GUIDELINES FOR USAGE OF BLOOD PRODUCTS (RELEASE CRITERIA)

DATE APPROVED: 09/08/2015

A. Pre-transfusion hematocrit of less than 24% or hemoglobin less than 8 grams/dl.

B. Transfusion may be administered when hemoglobin levels are 8-10 grams/dl in the following circumstances:
   1. Acute Blood Loss/Active Bleed
   2. Presence of Symptomatic Anemia
   3. HGB <9 w/ Chemotherapy
   4. HGB <10 w/ Radiation Treatment

Risk Standardized Bleeding Rate[1]



R4Q Risk standardized bleeding ratio = 0.93 / R4Q O/E = 1.5 [1] Pt's with a Bleeding event defined as 1) occurring within 72 hours of procedure (Bleeding at access site, hematoma at access site, retroperitoneal bleed, GI, GU or any transfusion) 2) occurring during hospitalization (hemorrhagic stroke, tamponade, Hgb drop ≥4 g/dL requiring transfusion, or a procedural intervention/surgery to reverse/stop or correct the bleeding) Exclusions: subsequent PCI procedures, death w/in 24 hours, CABG this hospitalization, transfusion in presence of mechanical support. (ref: 4934) * Comparison reporting period is 10/01/20 through 09/30/21

Kaweah Health

Quality Initiative

Bleeding Reduction Protocol

- Establish a vascular site protocol in accordance with SCAI safe femoral access guidelines
  1. Radial as Primary Access Site
  2. Use of Ultrasound Guidance for accessing the artery
  3. Use of Fluoroscopy to mark the Femoral head
  4. Micro puncture needle used as standard device

- Hemostasis Management Best Practices standardized for Post Procedure Bleeding and Sheath Removal
  - Education Program on Hemostasis Management & Early Recognition of Post-op Bleeds
    - Includes recognition of signs and symptoms of bleeding & Standardized Communications between:
      1. The procedure team and physician emphasizing the quality of the groin stick and use of sealant devices
      2. The procedure team and post-op nurse emphasizing the vascular access site assessment

Kaweah Health

Quality Initiative

Bleeding Reduction Protocol (cont.)

- Manual sheath removal
  - Hold manual pressure minimum of 20 minutes
  - Frequent vital signs and distal pulse monitoring
  - Diligent vascular access site assessment
  - Assess Patient for pain
- Vascular sealant device
  - Hold manual pressure minimum of 5 minutes
  - Frequent vital signs and distal pulse monitoring
  - Diligent vascular access site assessment
  - Assess patient for pain
- RN Education: Mandatory self study presentation (Post Study test must be completed)
  - Added to Nursing Unit Annual Competency
  - Added to core curriculum nursing education (Cardiac and CVICU units)
    - 4 Tower, 2 North, 3 West, CVICU, ICU and CVICCU.
- Post-PCI Bleed Mock Simulation performed 2/year. In the skills lab and the nurses home unit

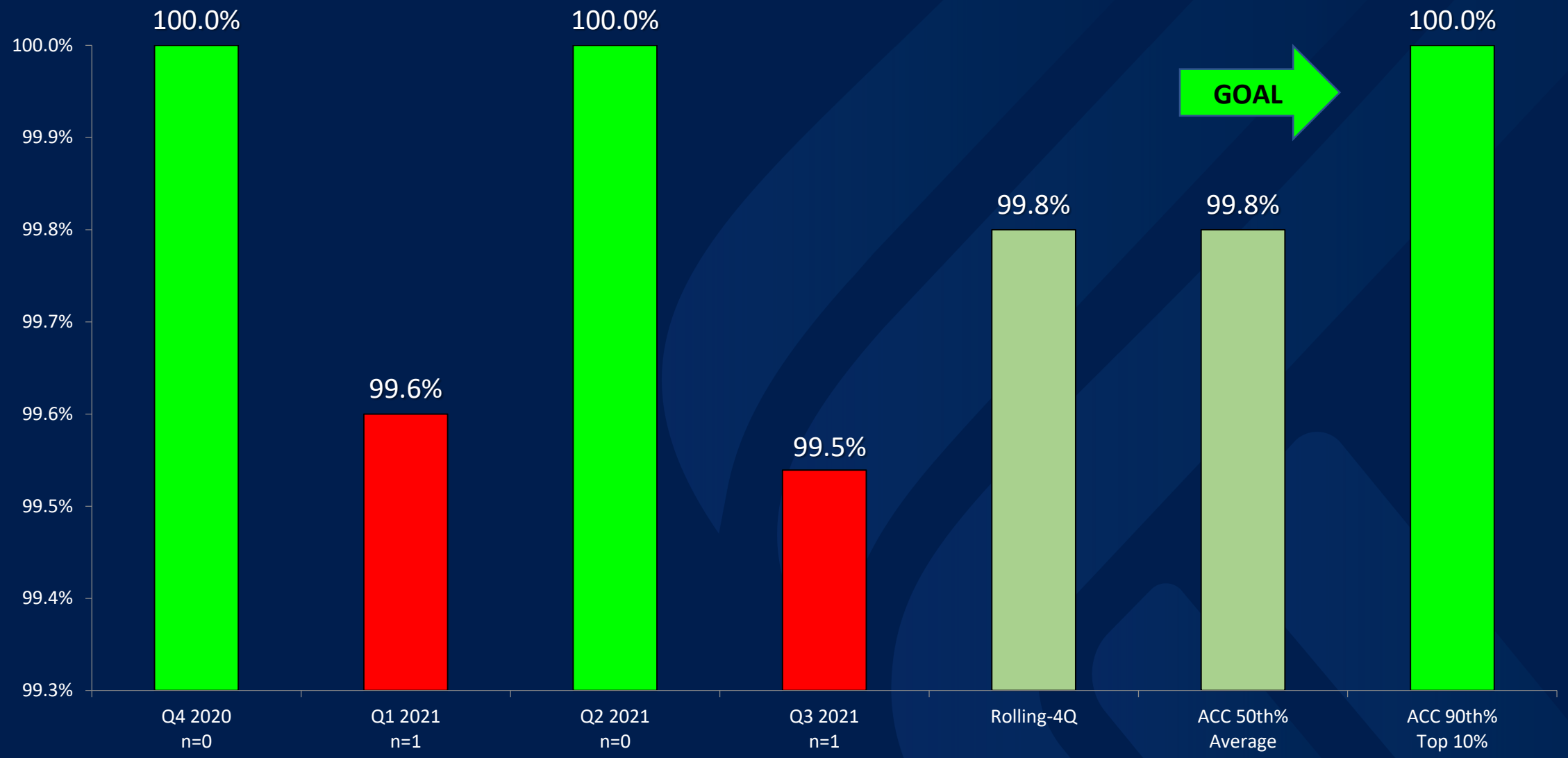
ASA Prescribed at DC[1]

R4Q O/E = 1.0

[1] Proportion of pt.'s (without a documented contraindication) with a PCI attempted or performed that were prescribed aspirin at discharge. Exclusions: pt.'s that were discharged on Comfort Measures only; discharged to "Other acute care hospital", "Hospice", "Left against medical advice (AMA)" or deaths. (ref: 4702)

* Comparison reporting period is 10/01/20 through 09/30/21

P2Y12 Inhibitor Prescribed at DC[1]

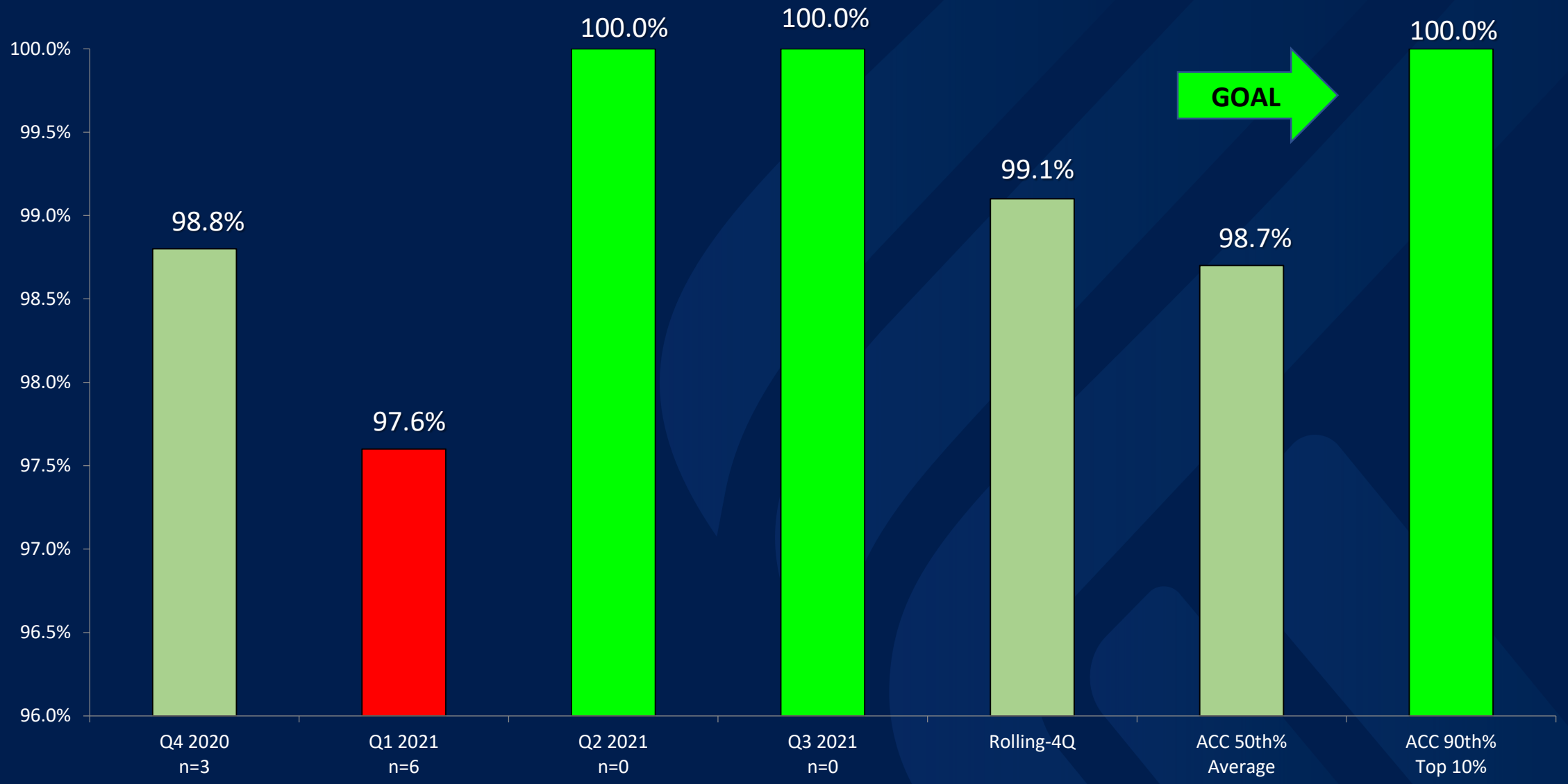


R4Q O/E = 1.0

[1] Proportion of pt.'s (without a documented contraindication) with a cardiac stent placed that were prescribed a thienopyridine/P2Y12 inhibitor at discharge. Exclusions: pt.'s that were discharged on Comfort Measures only; discharged to "Other acute care hospital", "Hospice", "Left against medical advice (AMA)" or deaths (ref: 4711)

* Comparison reporting period is 10/01/20 through 09/30/21

STATINS PRESCRIBED AT DC[1]



R4Q O/E = 1.0

[1] Proportion of pt.'s (without a documented contraindication) with a PCI attempted or performed that were prescribed a statin at discharge. Exclusions: pt.'s that were discharged on Comfort Measures only; discharged to "Other acute care hospital", "Hospice", "Left against medical advice (AMA)" or deaths. (ref: 4707)

* Comparison reporting period is 10/01/20 through 09/30/21

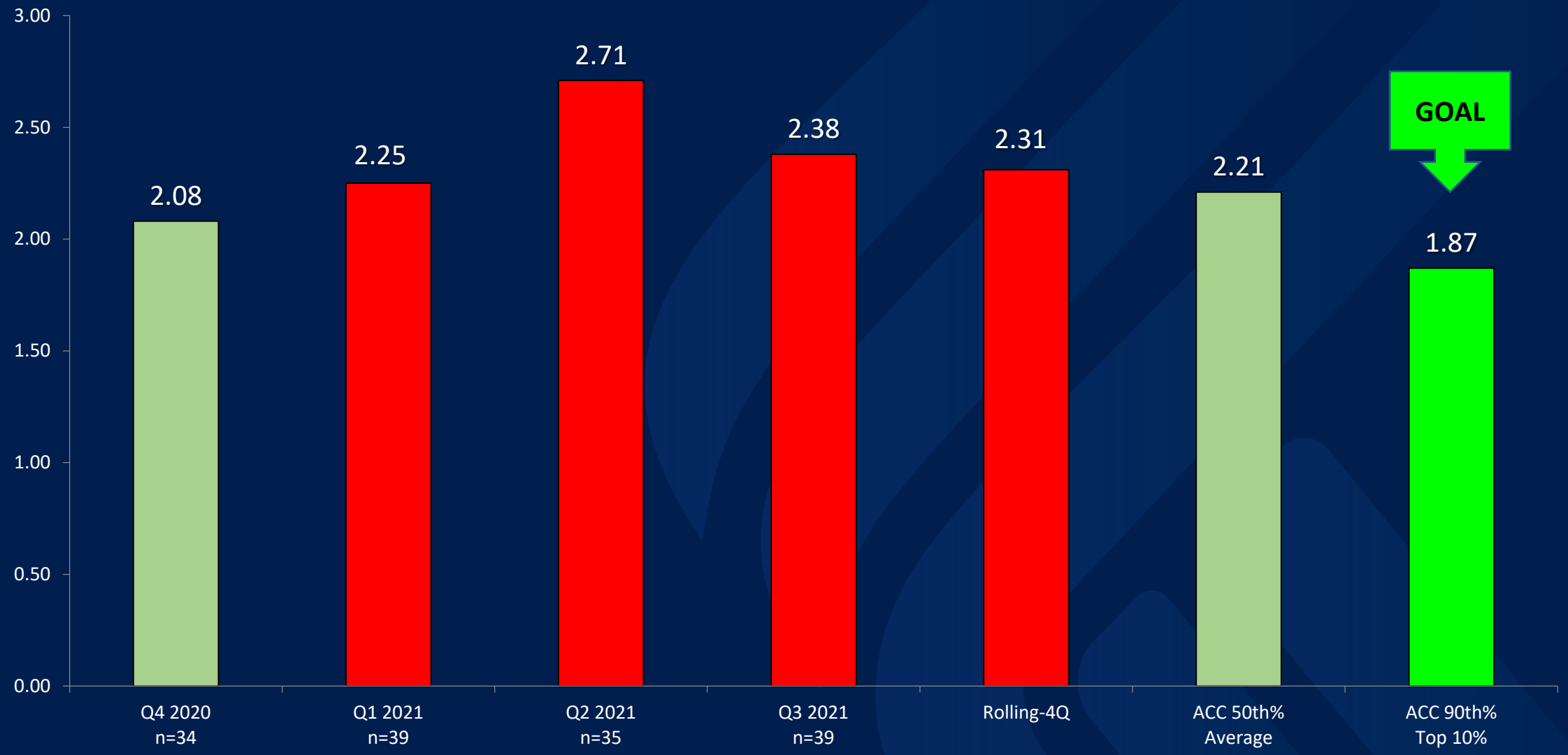
Kaweah Health

Quality Initiative

Discharge Medications

- Implement PCI specific Discharge Order Set
- Educate Hospitalists and Nurse Practitioners on importance of specific discharge medications in this patient population and utilization of new Order Set.
- Track utilization of Order Set & track fallouts
- Continue to contact Lead Hospitalist, Lead Nurse Practitioner with all fallout specifics
- Improve Clinical documentation in the Discharge Summary of any contraindications
- Improve Clinical documentation in the Discharge Summary clarifying any pending diagnosis (i.e. possible NSTEMI, possible MI)

Post-PCI Length of Stay[1] – STEMI

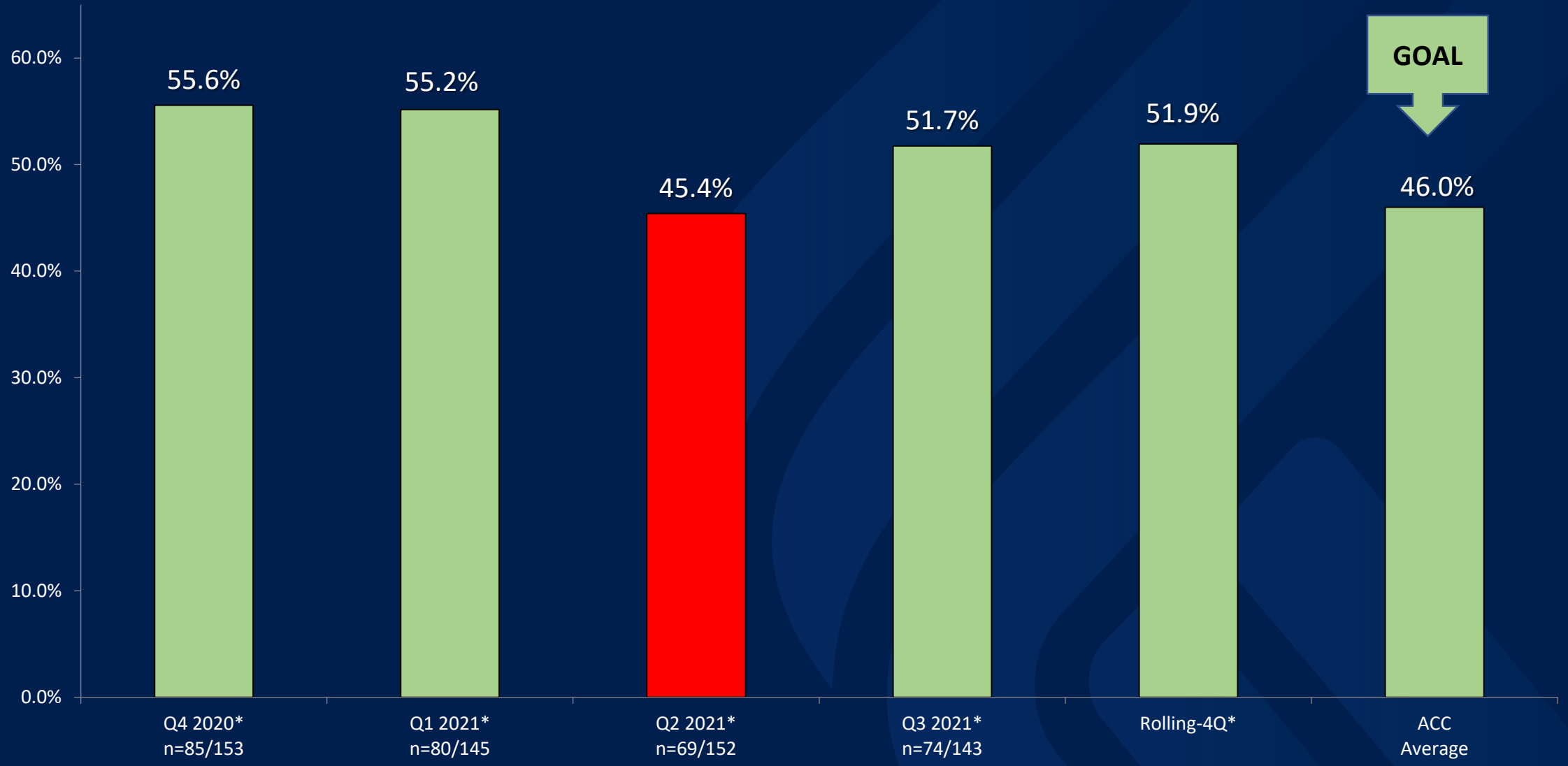


R4Q O/E = 1.0

[1] Median Post-procedure length of stay in STEMI patients. Exclusions: pt.'s discharged to Another Acute Care Facility; death during procedure (ref:4340, 10894)

* Comparison reporting period is 10/01/20 through 09/30/21

Post-PCI Same Day Discharge - Electives



R4Q O/E = 0.9

[1] Elective scheduled patients discharged on the same day as procedure. Exclusions: mortalities and pt.'s discharged to Another Acute Care Facility or AMA (ref:4971)

When no Percentile rankings are available, US Like Volume Group R4Q Averages are used for comparison purposes.

* Comparison reporting period is 10/01/20 through 09/30/21– *RAW DATA ALL QUARTERS

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Kaweah Health

Central Line Blood Stream Infection (CLABSI) Quality Focus Team (QFT) Report August 2022

Amy Baker, Director of Renal Services (Chair)
Emma Camarena, Director of Nursing Practice(Co-Chair)
Shawn Elkin, infection Prevention Manager (IP Liaison)

Post Kaizen- Gemba Data

- **Continue to struggle with process measure of % of CL patient with appropriate and complete documentation and changing dressing every seven days.**

CLABSI Committee Dashboard

Measure Description	Benchmark/ Target	Mar-20	Qtr 2 2020	Qtr 3 2020	Qtr 4* 2020	Qtr 1* 2021	Qtr 2* 2021	Jul-21*	Aug-21*	Sep-21*	Oct-21*	Nov-21*	Dec-21*	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
OUTCOME MEASURES																				
Number of CLABSI	0	0	6	5	3	3	2	0	4	3	3	1	1	1	0	2	2	1	2	3
FYTD SIR	≤0.596	0	1.84	1.28	0.78	0.7	0.38	0.000	1.374	1.57	1.6	1.37	1.26	1.18	1.05	1.09	1.12	1.07	1.13	2.26
PROCESS MEASURES CL Gemba																				
% of pts with bath within 24 hrs	99%	n/a	80%	87%	96%(e)	96%	95%(e)	97%			96%	97%	97%	97%	95%	n/a	95%	96%	95%	95%
% of CL with valid rationale order	100%	n/a	94%	96%	98%(e)	98%	98%(e)	99%			99%	96%	96%	99%	95%	n/a	98%	97%	96%	96%
% of CL dressings clean, dry and intact	100%	n/a	93%	93%	96%(e)	95%	96%(e)	97%			97%	96%	98%	97%	99%	n/a	97%	96%	98%	98%
% of CL that had drsg change no > than 7 days	100%	n/a	92%	94%	98%(e)	99%	96%(e)	98%			99%	99%	99%	97%	99%	n/a	97%	97%	92%	94%
% of patients with proper placed gardiva patch	100%	n/a	86%	90%	94%(e)	94%	94%(e)	96%			97%	88%	97%	98%	96%	n/a	95%	95%	90%	95%
% of CL pts with app & complete documentation	100%	n/a	83%	87%	92%(e)	93%	93%(e)	94%			96%	96%	97%	96%	92%	n/a	92%	93%	91%	91%
# of Pt Central Line days rounded on	n/a	n/a	2791	3653	2278(e)	3256	2166(e)	1092			1240	1265	1047	990	834		1296	1087	892	910

CLABSI QFT- Ongoing Meeting Objectives

- CLABSI Quality Focus Team continues to meet once a month
  - Each CLABSI case is reviewed with unit nurse manager and bedside nurses who provided care to patient
  - CLABSI's are reviewed monthly during Hospital Acquired Infection Case Reviews.
    - Nurse Manager attends to hear case review and see identified fallouts
  - Unit specific action plans are and reviewed based on any deficiencies
  - Unit RN's provide feedback from the bedside
  - Action plan is reviewed with units UBC's
- Additional projects are reviewed and implemented by CLABSI QFT

CLABSI QFT- Plans for Improvement

- **New Peripheral Intravenous Catheter Implemented Called Nexiva**
- Conversion occurred July 18 to 29, 2022
- This new IV product reduces catheter complications by
  - Reducing manipulations
  - Reduces accidental dislodgement
  - Lessens blood exposure
  - Lower chances for mechanical phlebitis
- The Nexiva IV catheter has Vialon biomaterial which softens us to 70% in the vein which makes it more comfortable for the patients and reduces the chance of mechanical phlebitis

End of Fiscal Year Performance

FY22 Clinical Quality Goals

Our Mission

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

Our Vision

To be your world-class healthcare choice, for life

	July 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.

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.

- Kaweah Health has had 20 events in FY22 exceeding the estimated goal
- If excluded COVID-19 patients, we would have 13 CLABSI's
- Excluding Covid patients our SIR is 0.66, slightly above our goal of 0.596

Questions?

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Kaweah Health

Cardiac Surgery Data Quality Analysis

Q4 2020 → Q3 2021

Risk Adjusted Data

Green = Better or Equal to the STS National Average

Red = Worse than the STS National Average

Gray = Non-Risk Adjusted Value (for Reference only)

Data Analysis by the Society of Thoracic Surgeons National Adult Cardiac Surgery Database

STAR RATINGS 2020
ISOLATED CORONARY ARTERY BYPASS GRAFTING

STAR RATINGS ARE ONLY CALCULATED ENDING Q2 & Q4 EACH YEAR

The Society of Thoracic Surgeons

STS CABG Composite Quality Rating
Participant: 30045
STS Period Ending Jun 2021

Domain	Rating	Participant		STS				
		Score	98% CI	Score	Min - Max	10th	50th	90th
Overall	★★	**96.96%**	(96.10-97.70)	**96.79%**	(91.04-98.98)	95.30%	96.95%	98.06%
Absence of Mortality	★★	**97.72%**	(96.61-98.58)	**97.54%**	(92.00-99.32)	96.28%	97.70%	98.60%
Absence of Morbidity	★★	**88.98%**	(86.55-91.20)	**89.42%**	(74.39-96.26)	85.06%	89.83%	93.24%
Use of IMA	★★	**99.00%**	(98.06-99.62)	**99.36%**	(80.47-99.99)	98.63%	99.63%	99.90%
Medications	★★★	**98.44%**	(97.28-99.27)	**94.30%**	(45.31-99.96)	86.59%	96.90%	99.46%

★ Worse than Expected. Participant's performance is significantly worse than expected for their specific case-mix.

★★ As Expected. Participant's performance is not statistically different than expected for their specific case-mix.

★★★ Better than Expected. Participant's performance is significantly better than expected for their specific case-mix.

Kaweah Health

Star Ratings 2020
Aortic Valve Replacement

Star Ratings are only calculated ending Q2 & Q4 each year

The Society of Thoracic Surgeons

STS AVR Composite Quality Rating
Participant: 30045
STS Period Ending Jun 2021

Domain	Rating	Participant		STS				
		Score	95% CI	Score	Min - Max	10th	50th	90th
Overall	★★	**95.45%**	(92.97-97.26)	**95.39%**	(85.27-98.60)	93.11%	95.70%	97.28%
Absence of Mortality	★★	**98.02%**	(96.31-99.09)	**97.80%**	(93.02-99.40)	96.65%	97.96%	98.76%
Absence of Morbidity	★★	**89.26%**	(84.54-92.99)	**89.93%**	(77.51-95.90)	86.34%	90.25%	93.10%

★ Worse than Expected. Participant's performance is significantly worse than expected for their specific case-mix.

★★ As Expected. Participant's performance is not statistically different than expected for their specific case-mix.

★★★ Better than Expected. Participant's performance is significantly better than expected for their specific case-mix.

Kaweah Health

STAR RATINGS 2020
CABG w/ AORTIC VALVE REPLACEMENT

STAR RATINGS ARE ONLY CALCULATED ENDING Q2 & Q4 EACH YEAR

The Society of Thoracic Surgeons

STS AVR + CABG Composite Quality Rating
Participant: 30045
STS Period Ending Jun 2021

Domain	Rating	Participant		STS				
		Score	95% CI	Score	Min - Max	10th	50th	90th
Overall	★★	**92.90%**	(89.64-95.40)	**92.20%**	(79.35-97.47)	88.61%	92.63%	95.23%
Absence of Mortality	★★	**96.29%**	(93.35-98.22)	**96.02%**	(86.94-99.01)	93.79%	96.34%	97.85%
Absence of Morbidity	★★	**84.09%**	(77.53-89.45)	**83.23%**	(65.03-93.39)	77.26%	83.71%	88.60%

★ Worse than Expected. Participant's performance is significantly worse than expected for their specific case-mix.

★★ As Expected. Participant's performance is not statistically different than expected for their specific case-mix.

★★★ Better than Expected. Participant's performance is significantly better than expected for their specific case-mix.

Kaweah Health

Healthgrades

Specialty Clinical Quality Awards & Ratings

Specialty Clinical Quality Awards

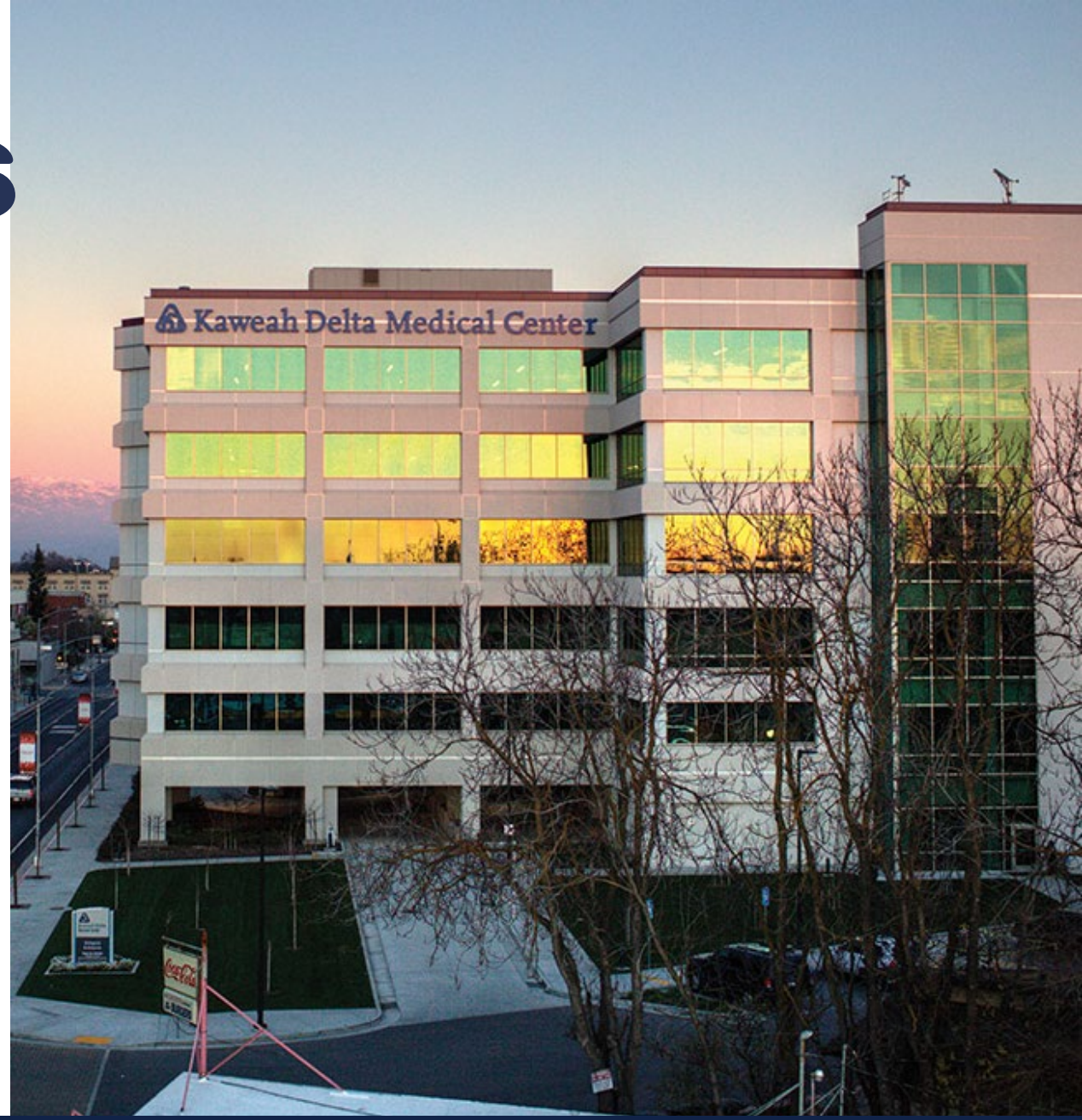
America's 50 Best Hospitals for Cardiac Surgery Award™ (2022, 2021, 2020)
Superior clinical outcomes in heart bypass surgery and heart valve surgery

America's 100 Best Hospitals for Cardiac Care Award™ (2019)
Superior clinical outcomes in heart bypass surgery, coronary interventional procedures, heart attack treatment, heart failure treatment, and heart valve surgery

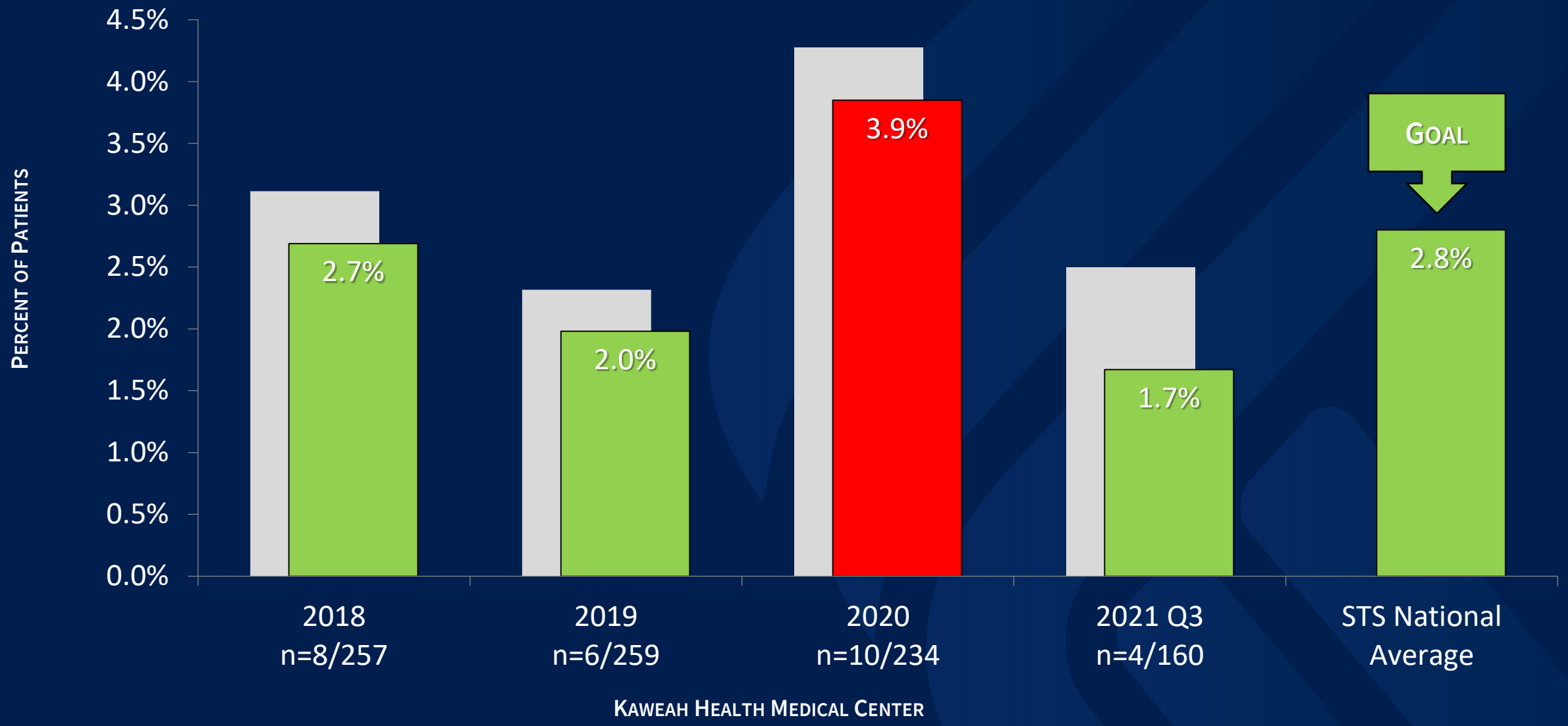
Hospital Quality Awards

America's 250 Best Hospitals Award™ (2021, 2020, 2019)
Top 5% in the nation for consistently delivering clinical quality

Resource 12/10/2021: www.healthgrades.com/hospital-directory/california-ca-southern/kaweah-health



All Operative Mortality[1]
Risk Adjusted in Color



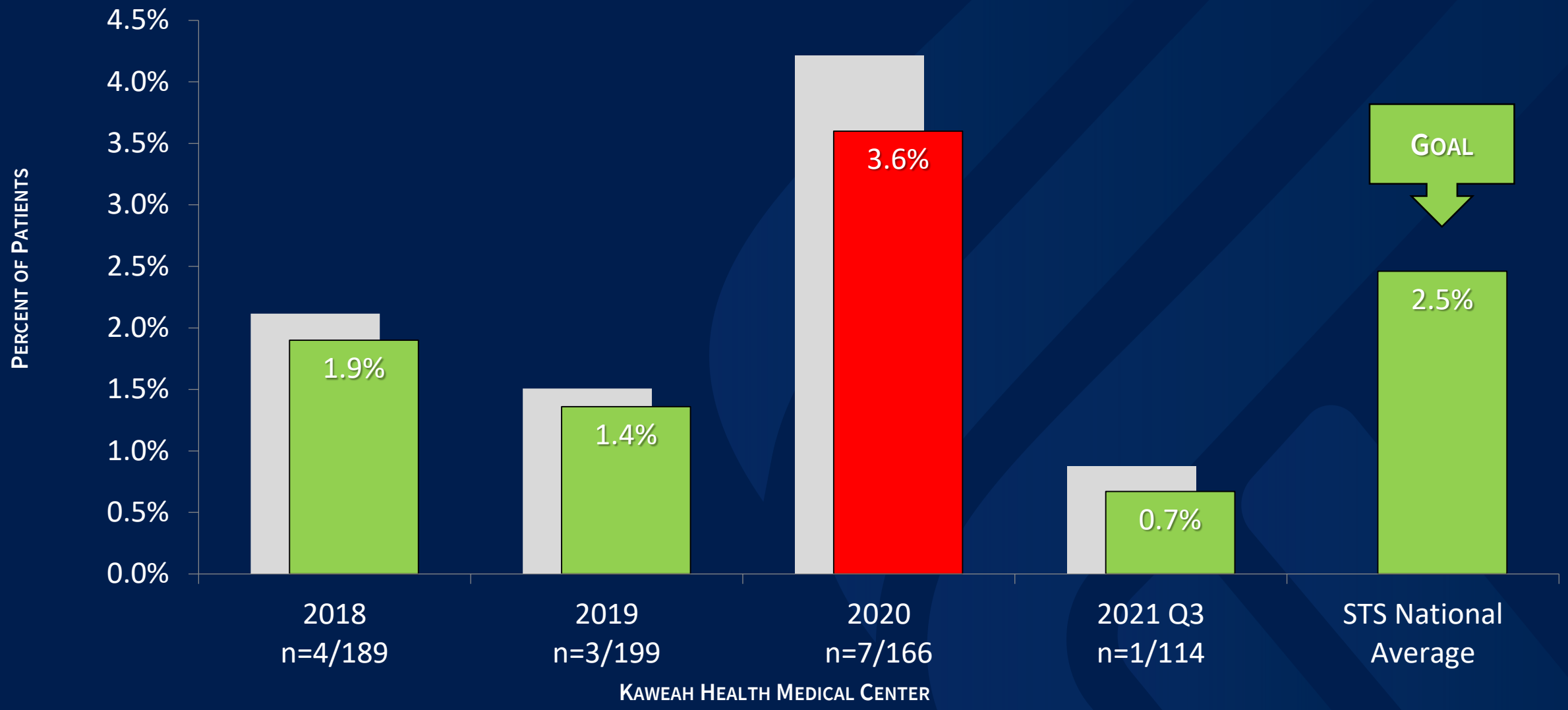
Kaweah Health Medical Center

2021 Risk-adjusted O/E = 0.59

*STS National Average Comparison reporting period 01/01/2021 through 09/30/2021

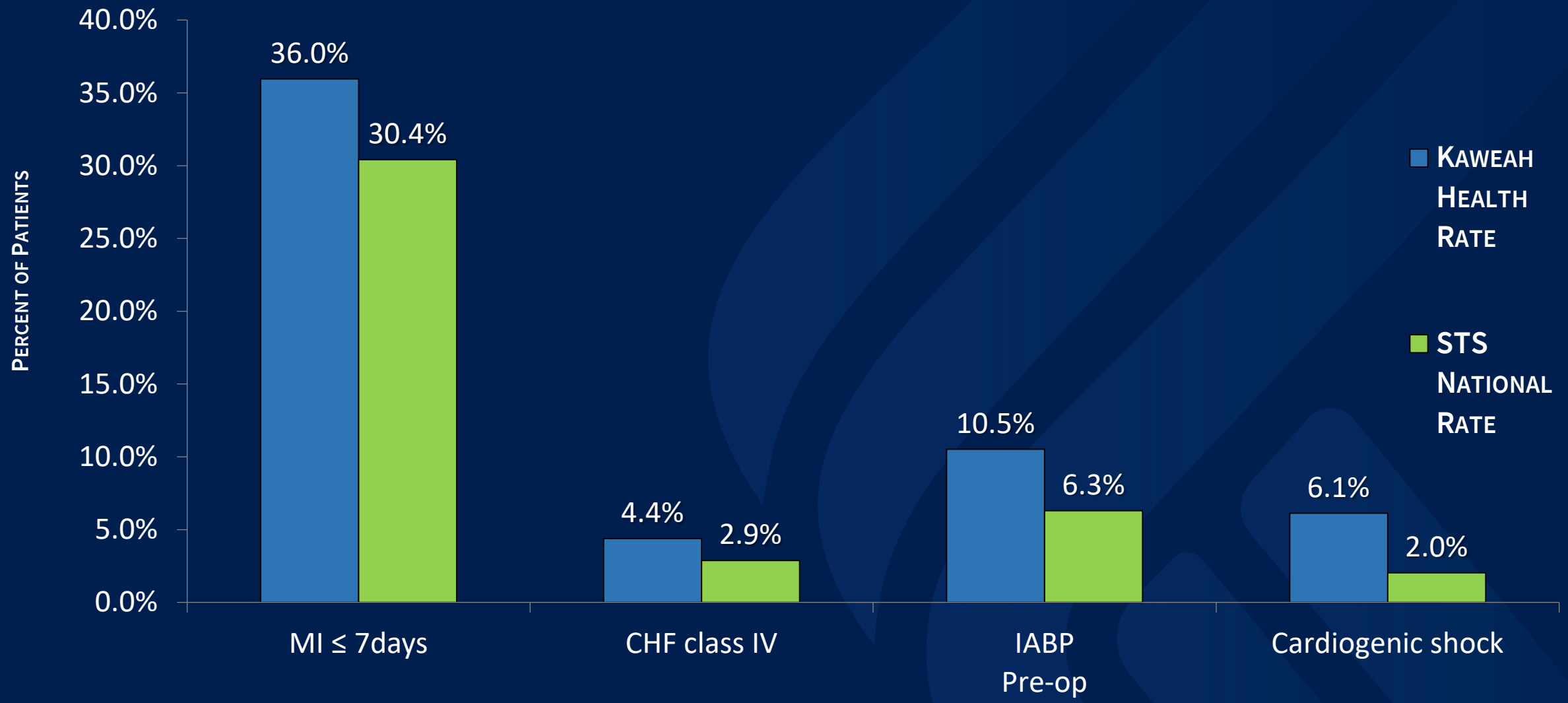
[1] Includes all 7 Major Procedure Categories (CABG, AVR, AVR+CABG, MVR, MVR+CABG, MVP, MVP+CABG)
Excludes Other category procedures, Q3-2020 forward COVID+ pt.'s Excluded.

CABG Operative Mortality
Risk Adjusted in Color



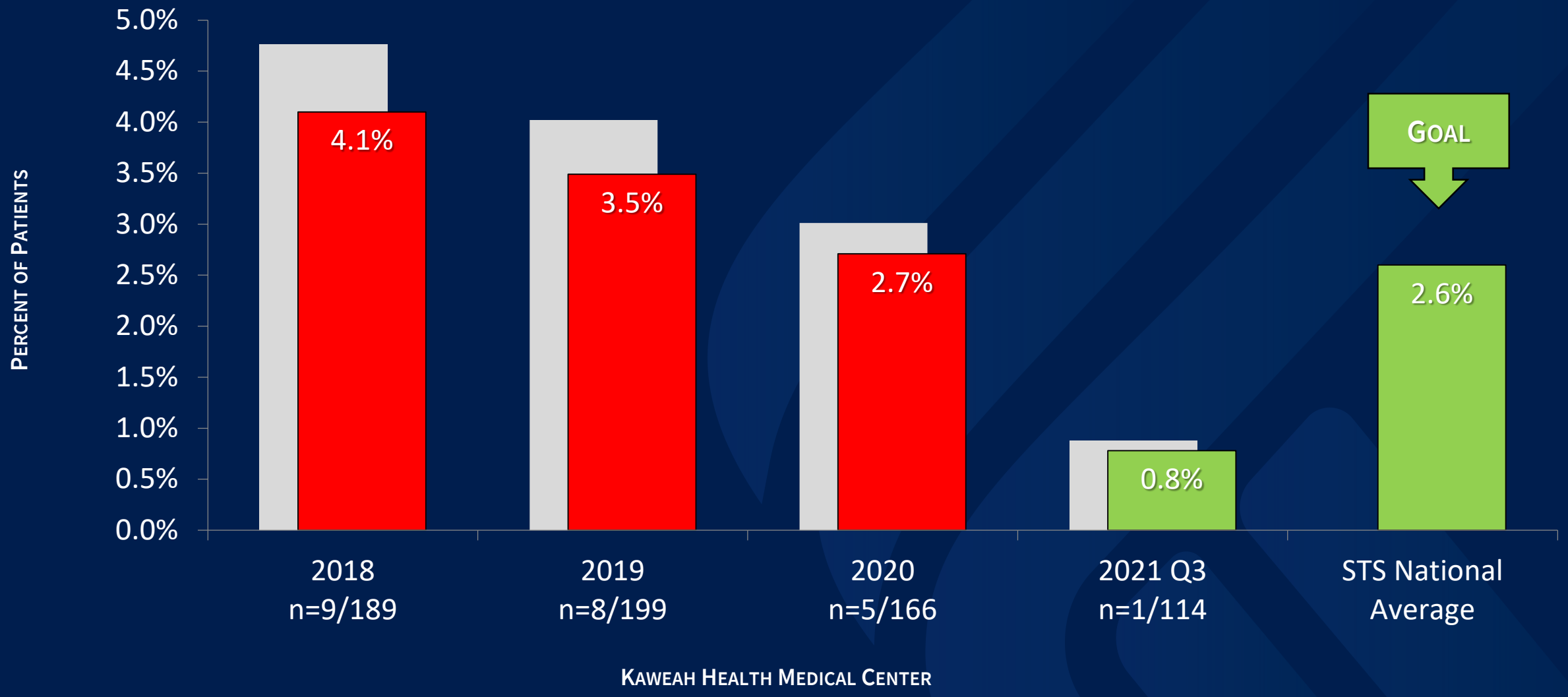
2021 Risk-adjusted O/E = 0.27
*STS National Average Comparison reporting period 01/01/2021 through 09/30/2021
Q3-2020 forward COVID+ pt.'s Excluded.

Kaweah Health Pt. Populations



*STS National Average Comparison reporting period 01/01/2021 through 09/30/2021– Isolated CABG cases ONLY

CABG Re-Operation[1]
Risk Adjusted in Color



2021 Risk-adjusted O/E = 0.3

*STS National Average Comparison reporting period 01/01/2021 through 09/30/2021

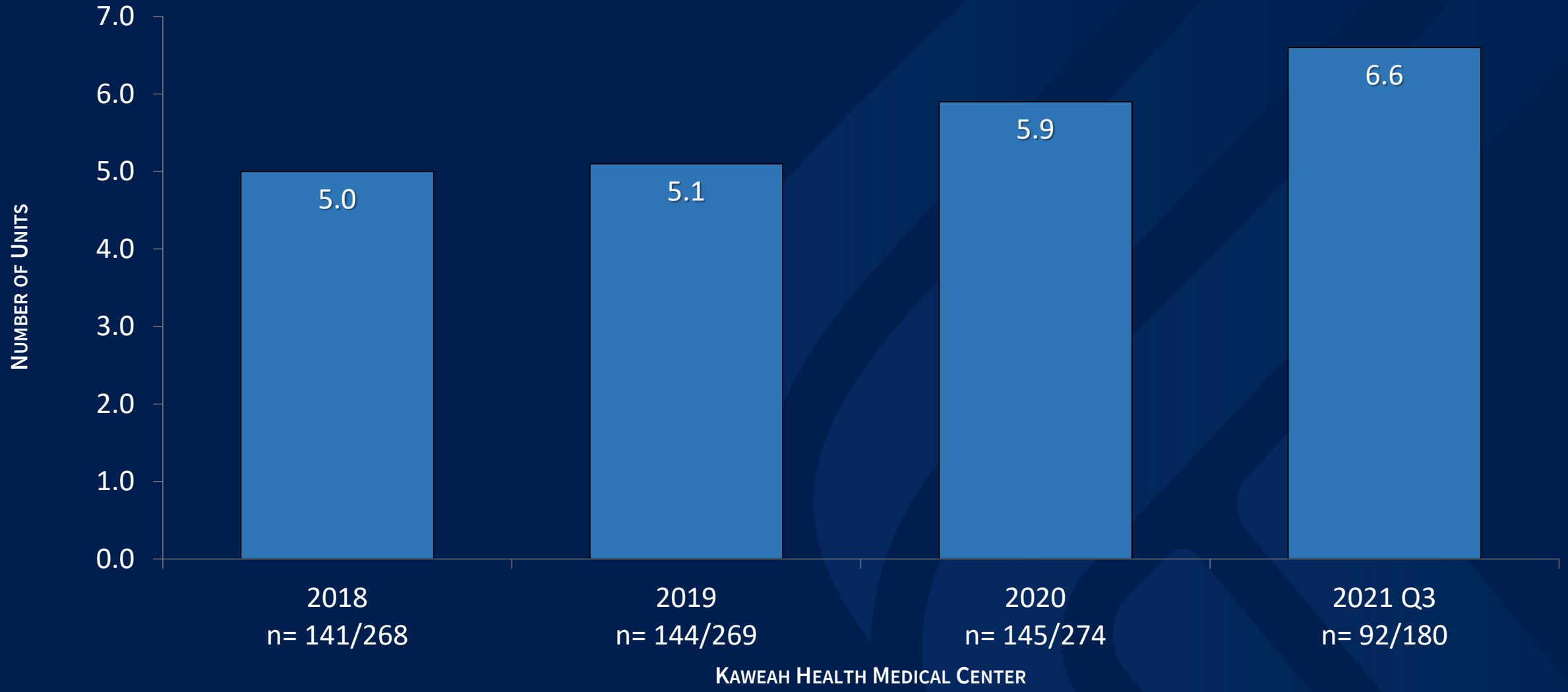
[1]Surgeries include Reoperation for bleeding/tamponade, valvular dysfunction, unplanned coronary artery intervention, aortic reintervention or other cardiac reason, Q3-2020 forward COVID+ pt.'s Excluded.

Quality Initiative:

Intra-operative Patient Safety

- Time out performed with entire surgical team (Surgeon, Anesthesia, RN, Techs and Perfusion)
- Surgeon led briefing on procedure expectations with entire surgical team after each Time out
- Perfusion check list completed prior to each case; line safety time out with anesthesia prior to case start
- Minimize trips to the Sterile Core by Nursing staff
- Minimize OR traffic (i.e.: coordinated switching of staff for breaks)
- Noise reduction implemented during cases:
  - Discussions about current surgical case only
  - Avoid conversations about other issues
  - Music to be calming and at a lower volume
  - All phones & beepers at the Nurses desk

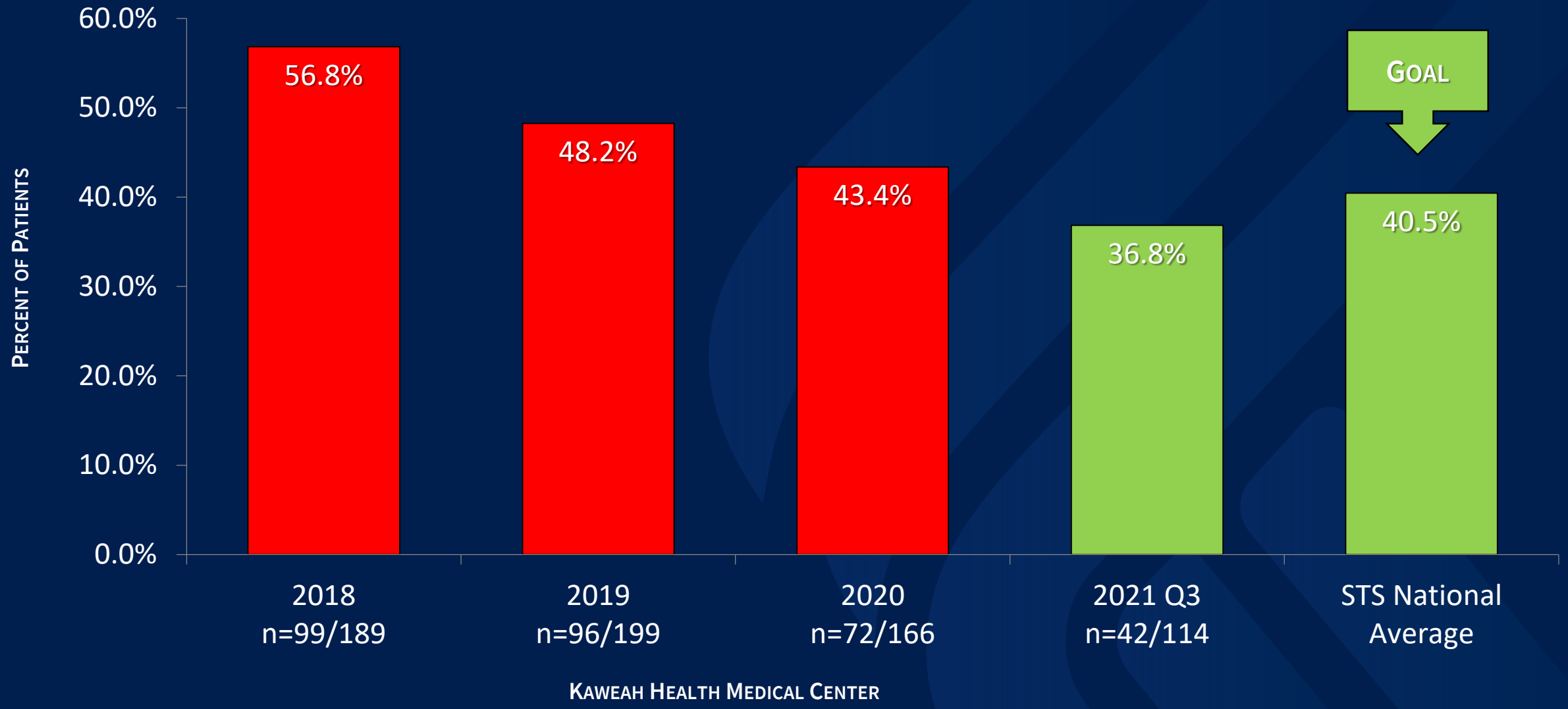
Red Blood Cell Usage – Average Units / Pt. receiving RBC[1] (No National Comparison Data)



[1] All STS surgeries – Includes any blood given Intra-op and Post-op (Excludes patients that did not receive any blood from Average; excludes pre-op Hgb<8, Emergent/Salvage, COVID+ patients)

*Comparison Data is not reported on the STS National Outcomes Report

CABG Intra & Post-Op Blood Product Usage[1]



2021 O/E = 0.9

*STS National Average Comparison reporting period 01/01/2021 through 09/30/2021

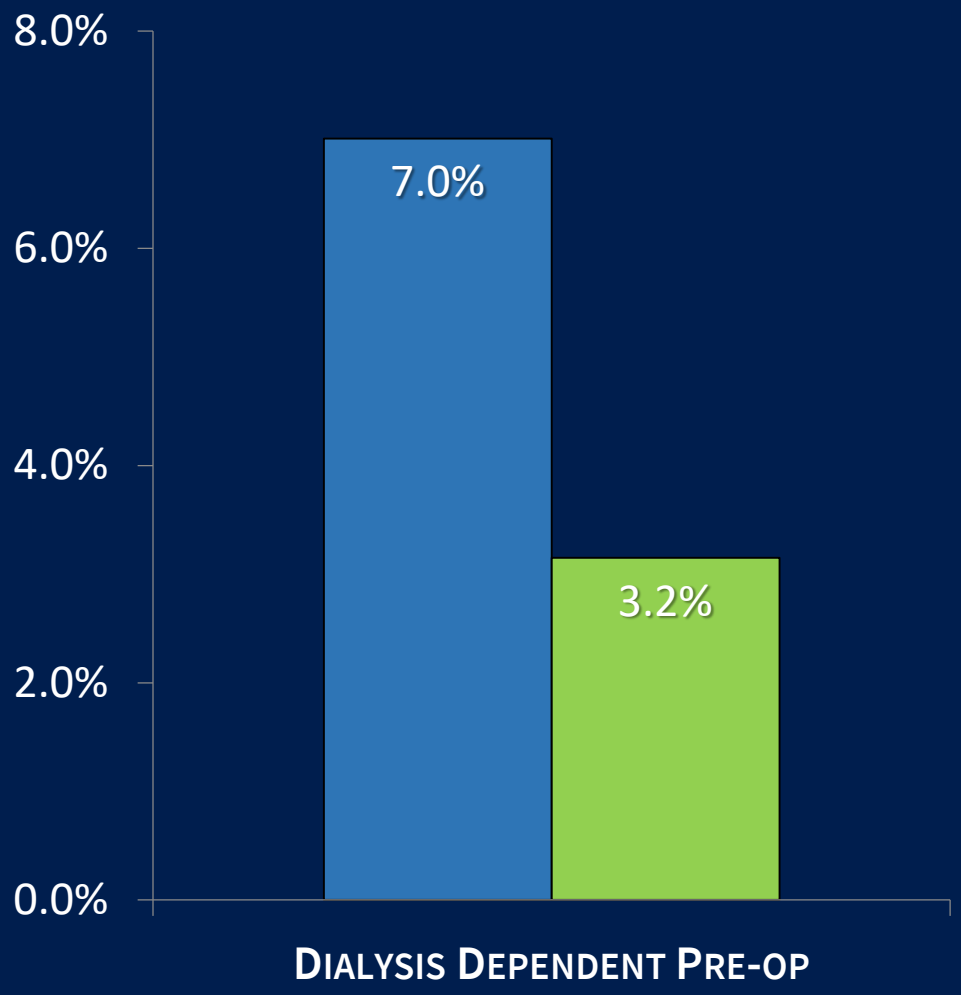
[1]Surgeries where at least one unit of Red Blood Cells, Fresh Frozen Plasma, Platelets or Cryoprecipitate was given Intra-and/or Post-operatively. Q3-2020 forward COVID+ pt.'s Excluded.

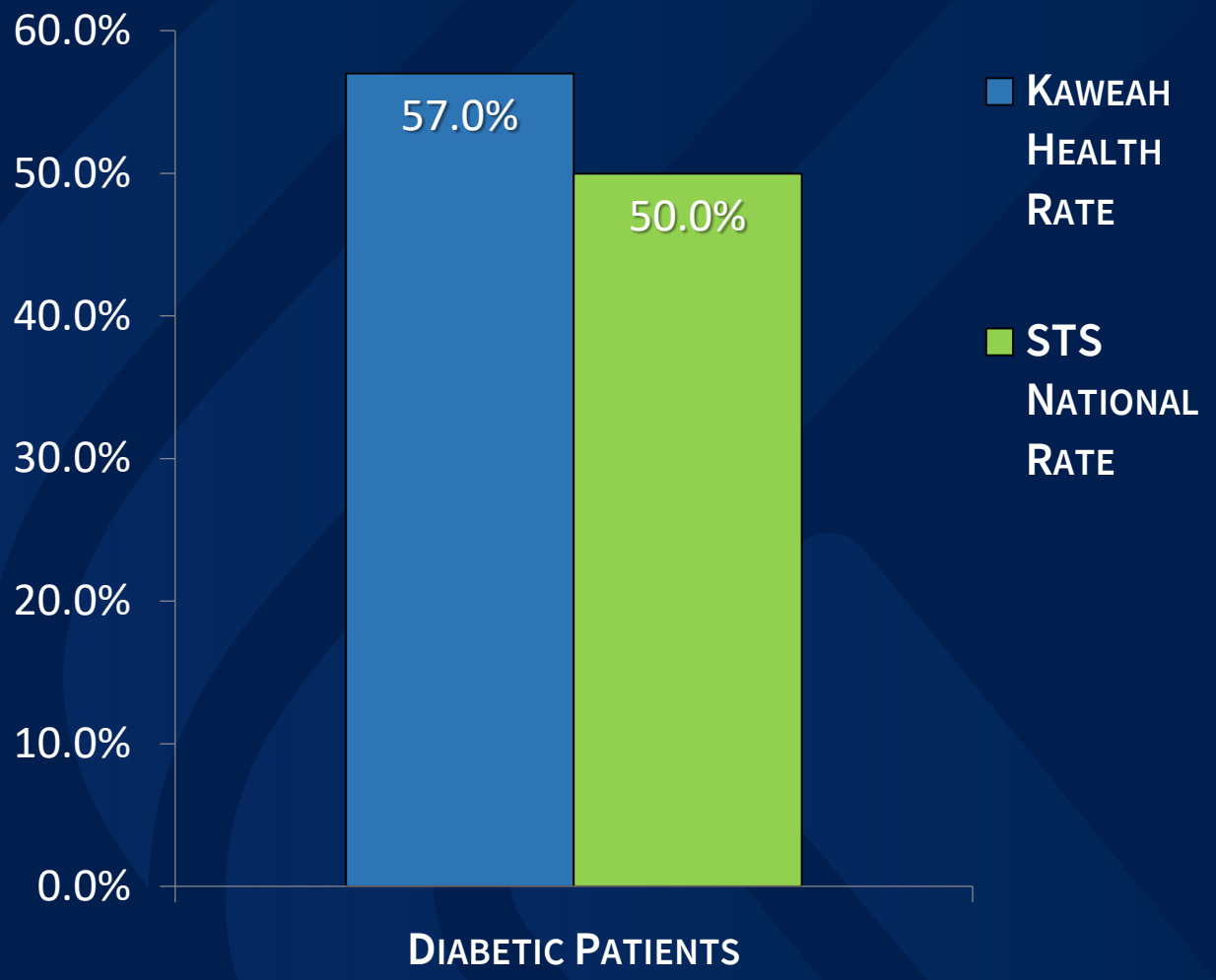
Quality Initiative:

Bleeding Event & Blood Product Usage

- Quarterly review of blood usage throughout Pt. stay
- TEG coagulation monitoring
- Antifibrinolytic agents
- Heparin monitoring
- Heparin coated circuits
- Hemostasis achieved during procedure
- Cell saver utilized during surgery
- Restrictive transfusion criteria
- Surgeon approval of each transfusion
- Treatment of pre-operative anemia or transfusion as needed

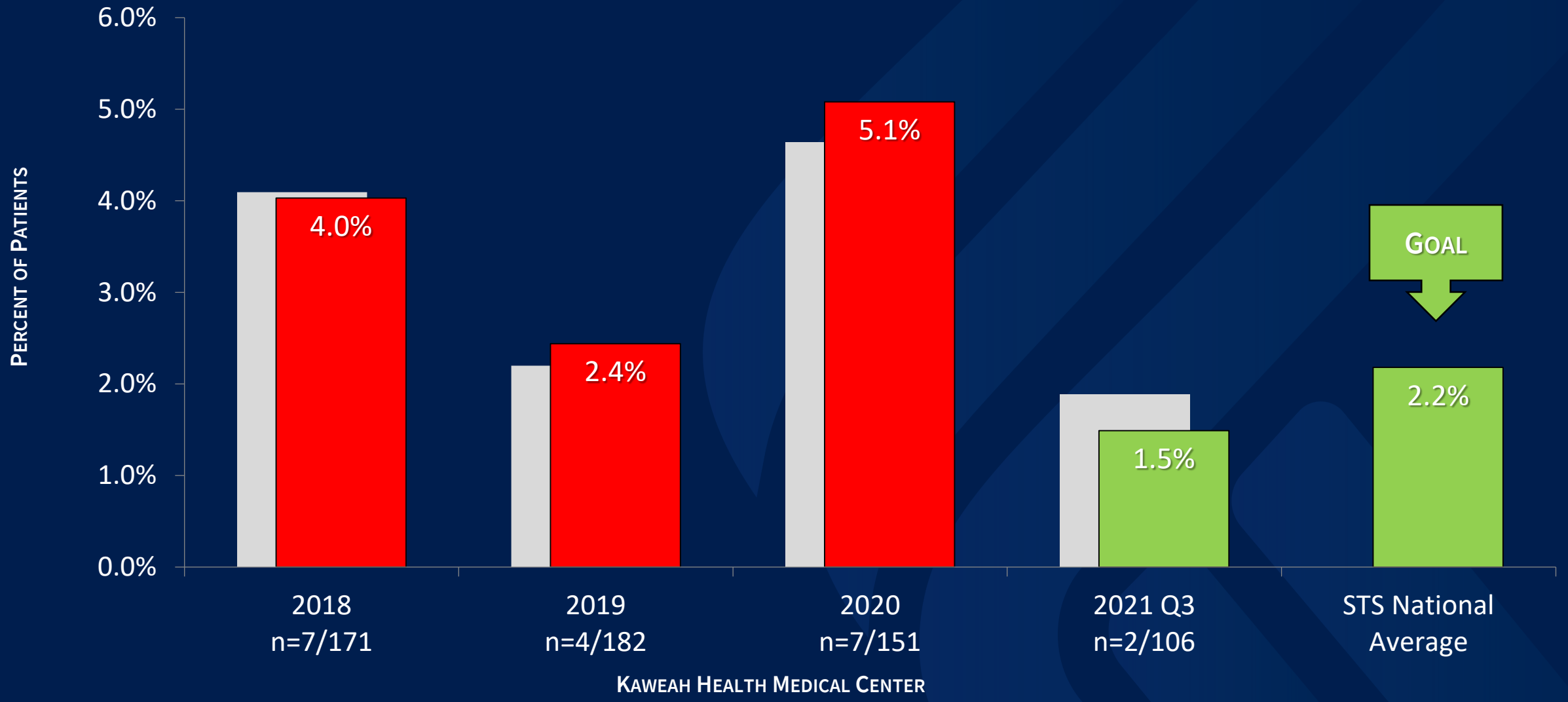
Kaweah Health Pt. Populations





*STS National Average Comparison reporting period 01/01/2021 through 09/30/2021- Isolated CABG cases ONLY

CABG Post-Op Renal Failure[1]
Risk Adjusted in Color



2021 Risk-adjusted O/E = 0.7

*STS National Average Comparison reporting period 01/01/2021 through 09/30/2021

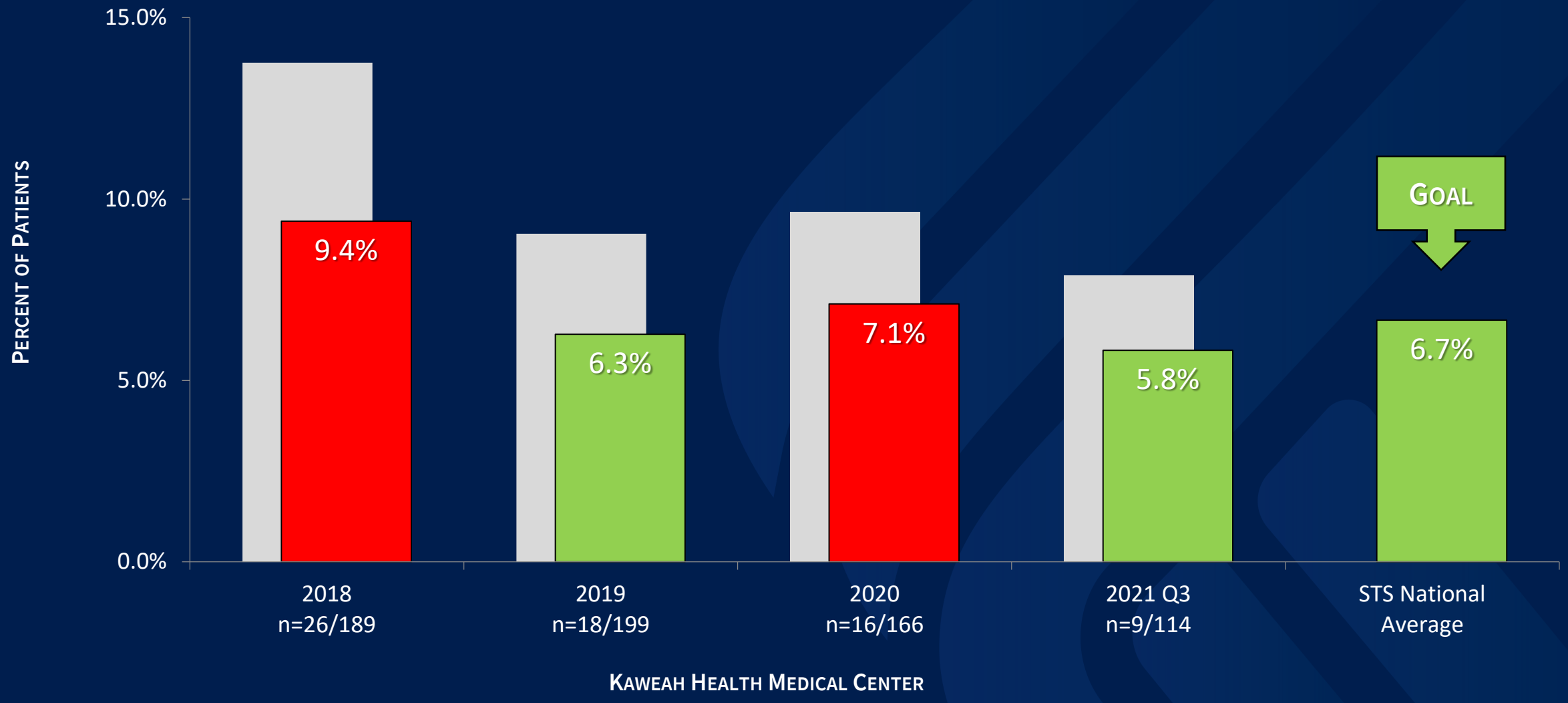
[1] Excludes patients with preoperative dialysis or preoperative Creatinine ≥ 4, Q3-2020 forward COVID+ pt.'s Excluded.

Quality Initiative:

Renal Failure

- Risk factor evaluation pre-operatively
- Timing of surgery considered
- Diabetes control
- Liberal hydration
- Intra-operative blood flow & pressure controlled by perfusion and anesthesia
- Blood pressure management peri-operatively

CABG Prolonged Ventilation
Risk Adjusted in Color



2021 Risk-adjusted O/E = 0.9

*STS National Average Comparison reporting period 01/01/2021 through 09/30/2021

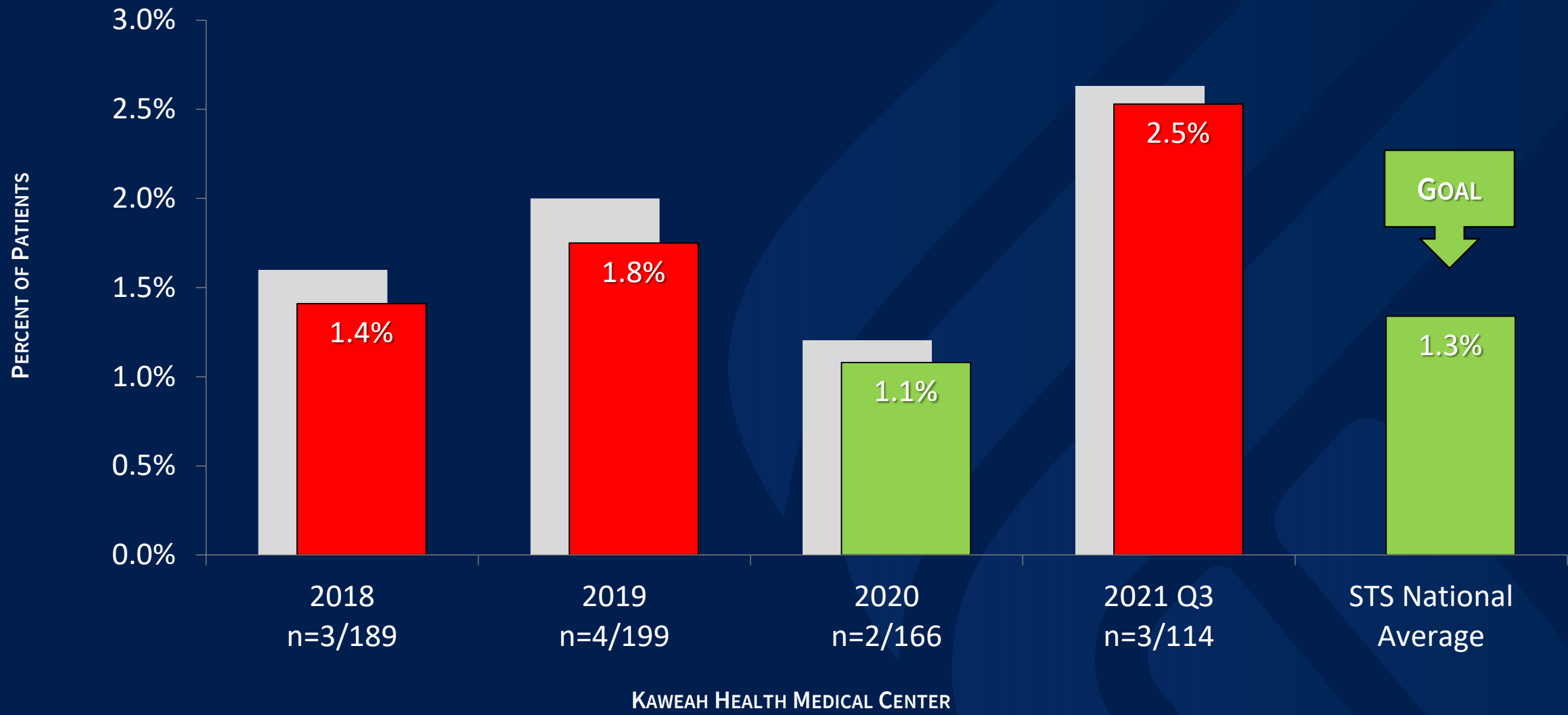
Q3-2020 forward COVID+ pt.'s Excluded.

Quality Initiative:

Prolonged Ventilation

- Monthly audit & analysis of prolonged ventilation times and delayed Extubation due to medical necessity
- Action Plan for 100% completion of Cardiac Extubation Tool ~ monitored by CVICU nurse manager
- Sedation and Analgesia to be used in an appropriate and conservative manner
- Avoid Benzodiazepines and narcotic drips
- To illicit calm awakening utilize Propofol & precedex drips when medically necessary
- Train nursing, medical and ancillary staff on the Fast Track Extubation Protocol available in PolicyTech
- Address ventilation time of each Pt. in rounds and shift reports by RN, RT & MD
- Promote Respiratory Therapy Education Tool for patients
- Review of Anesthesia Protocols
- Positive Base excess or > -2.0 on CVICU arrival
- Core Temperature > 36.0°C on CVICU arrival

CABG Post Op Permanent Stroke
Risk Adjusted in Color



Kaweah Health Medical Center

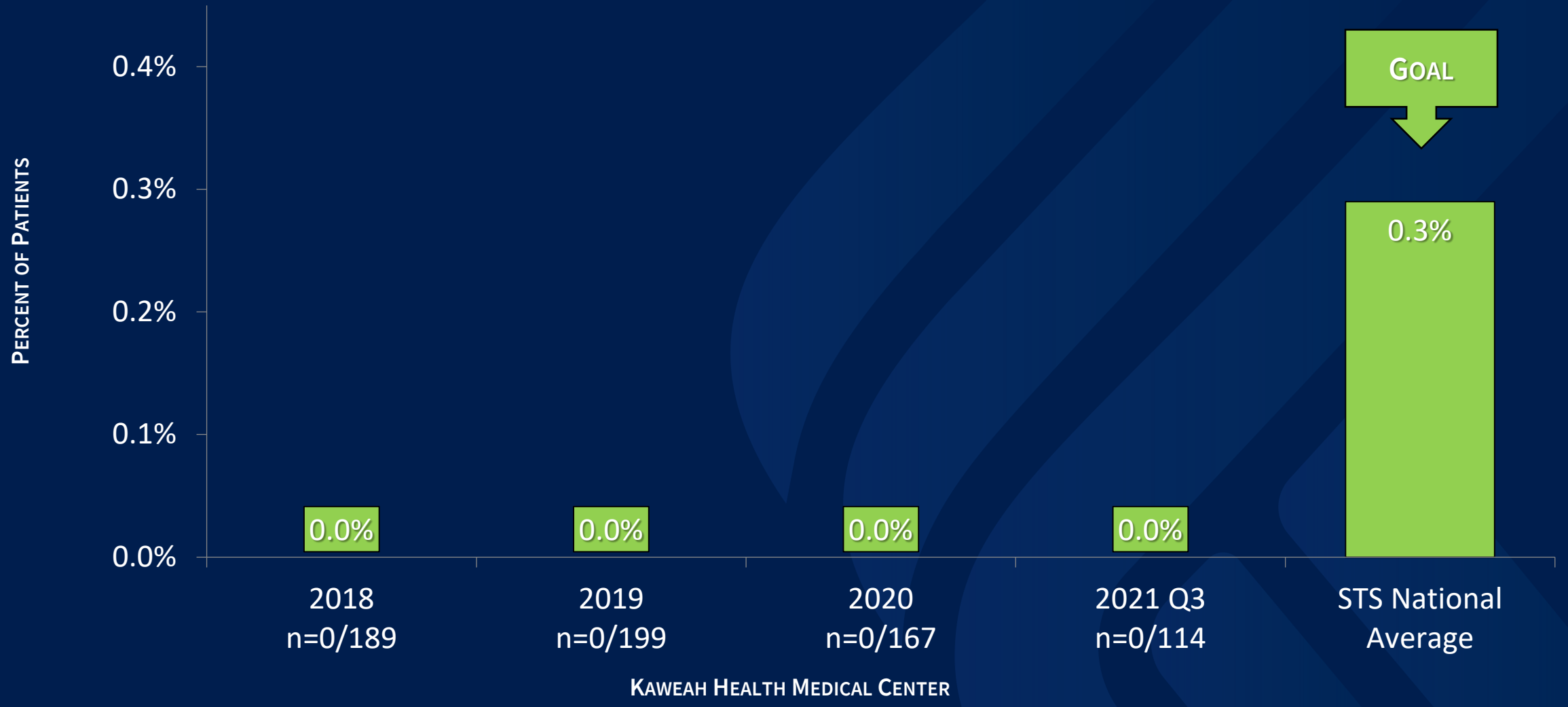
2021 Risk-adjusted O/E = 1.9
*STS National Average Comparison reporting period 01/01/2021 through 09/30/2021
Q3-2020 forward COVID+ pt.'s Excluded.

Quality Initiative:

Stroke Prevention

- Risk factor, neurological evaluation
- TEE, CT of the aorta with evaluation as needed
- Carotid Doppler ~ Ultrasound
- Invox cortical brain monitoring
- Intraoperative blood flow & pressure control by perfusion and anesthesia
- Intraoperative temperature control

CABG Post Op Deep Sternal Wound Infection
Risk Adjusted in Color



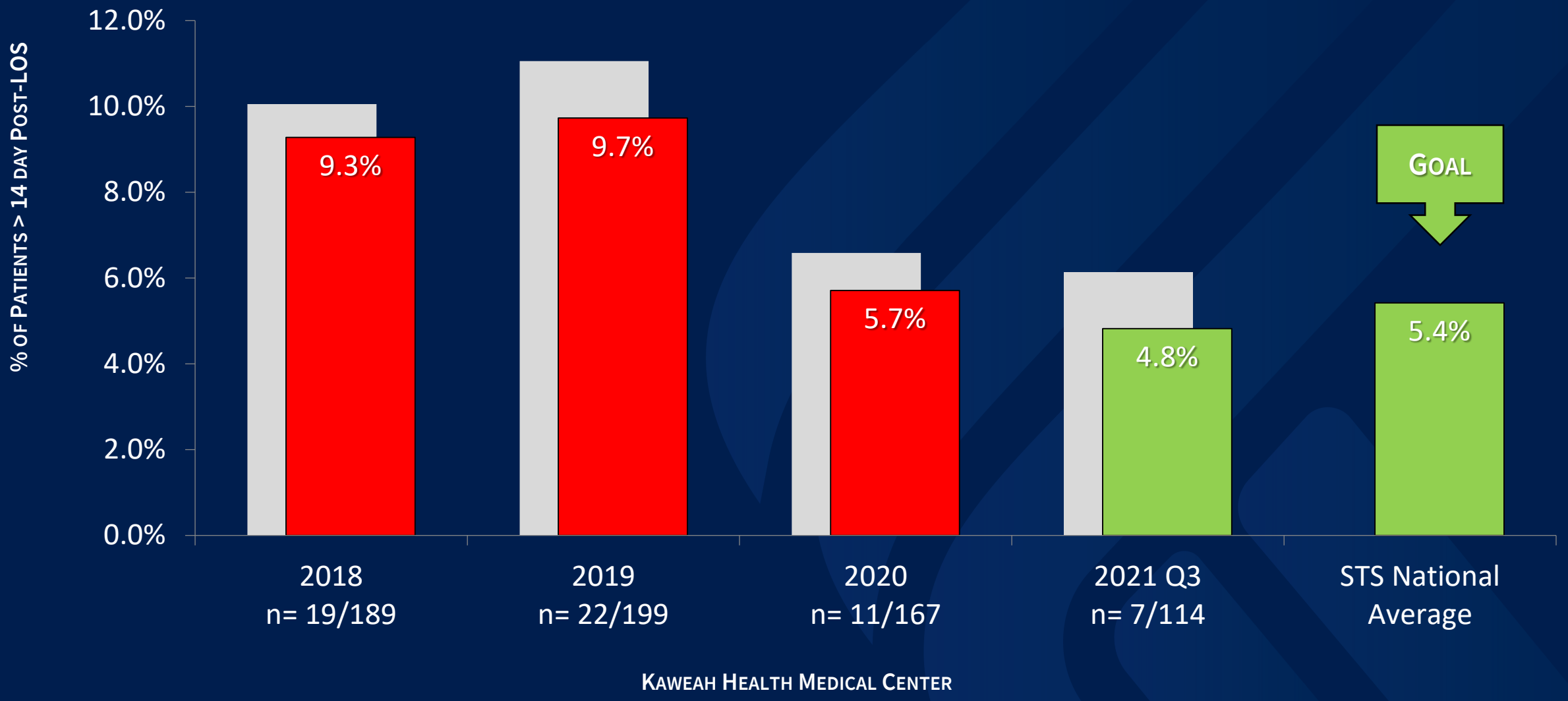
2021 Risk-adjusted O/E = 0
*STS National Average Comparison reporting period 01/01/2021 through 09/30/2021
Q3-2020 forward COVID+ pt.'s Excluded.

Quality Initiative:

Infection Prevention

- Glucose control w/ Glucommander – insulin drip or subcutaneous
- Two Chlorhexidine baths prior to surgery
- Chlorhexidine mouth wash used morning of surgery
- MRSA screening of each patient
- Terminal cleaning of operating rooms monitored daily
- Disposable ECG monitoring cables on each patient
- Use of Early closure technique for vein harvest incisions
- Vancomycin paste for sternal application
- Silver Nitrate or Prevena suction dressing applied to sternum
- Prophylactic antibiotic treatment for 48 hours
- Early removal of central lines and Foley catheter

CABG Post Op Length of Stay >14 Days
Risk Adjusted in Color



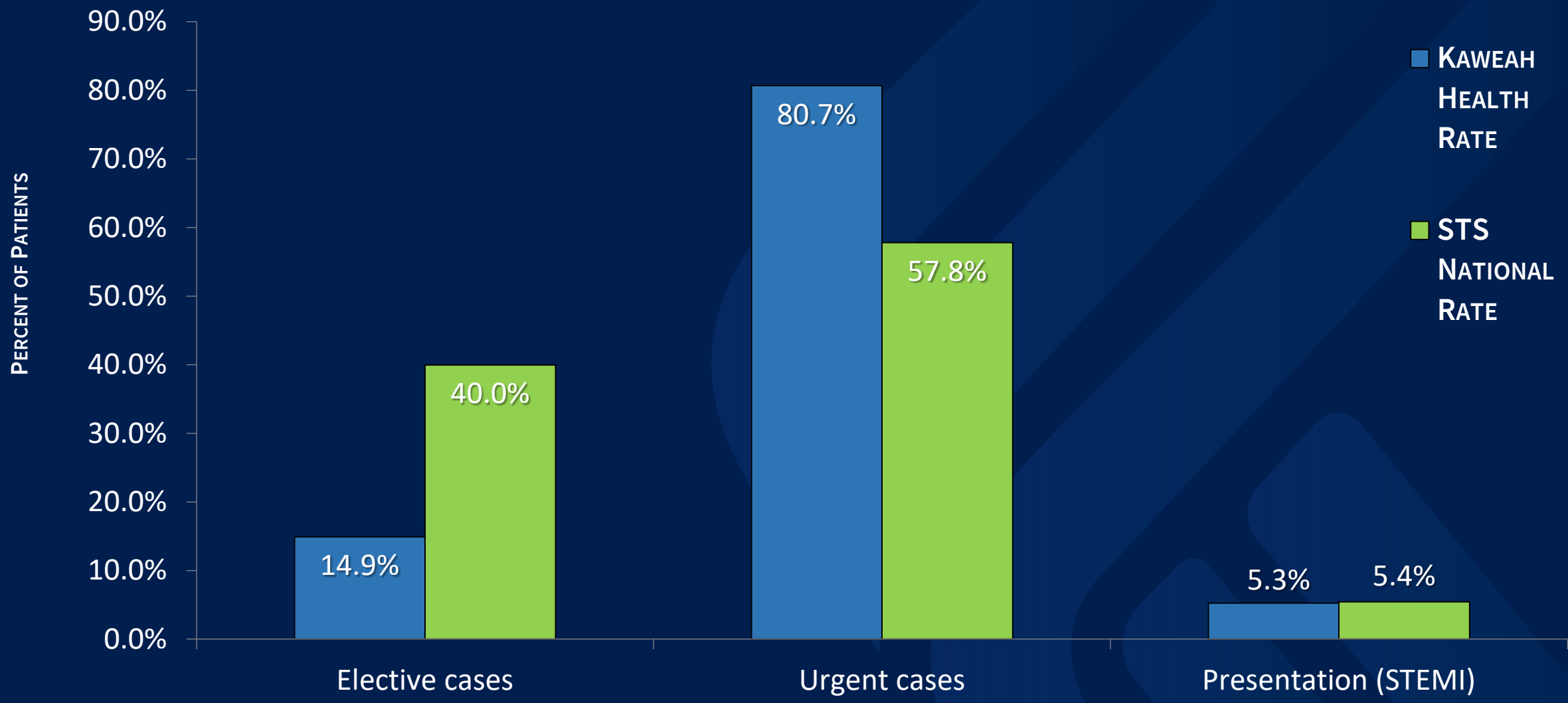
Kaweah Health Medical Center

2021 Risk-adjusted O/E = 0.9

*STS National Average Comparison reporting period 01/01/2021 through 09/30/2021

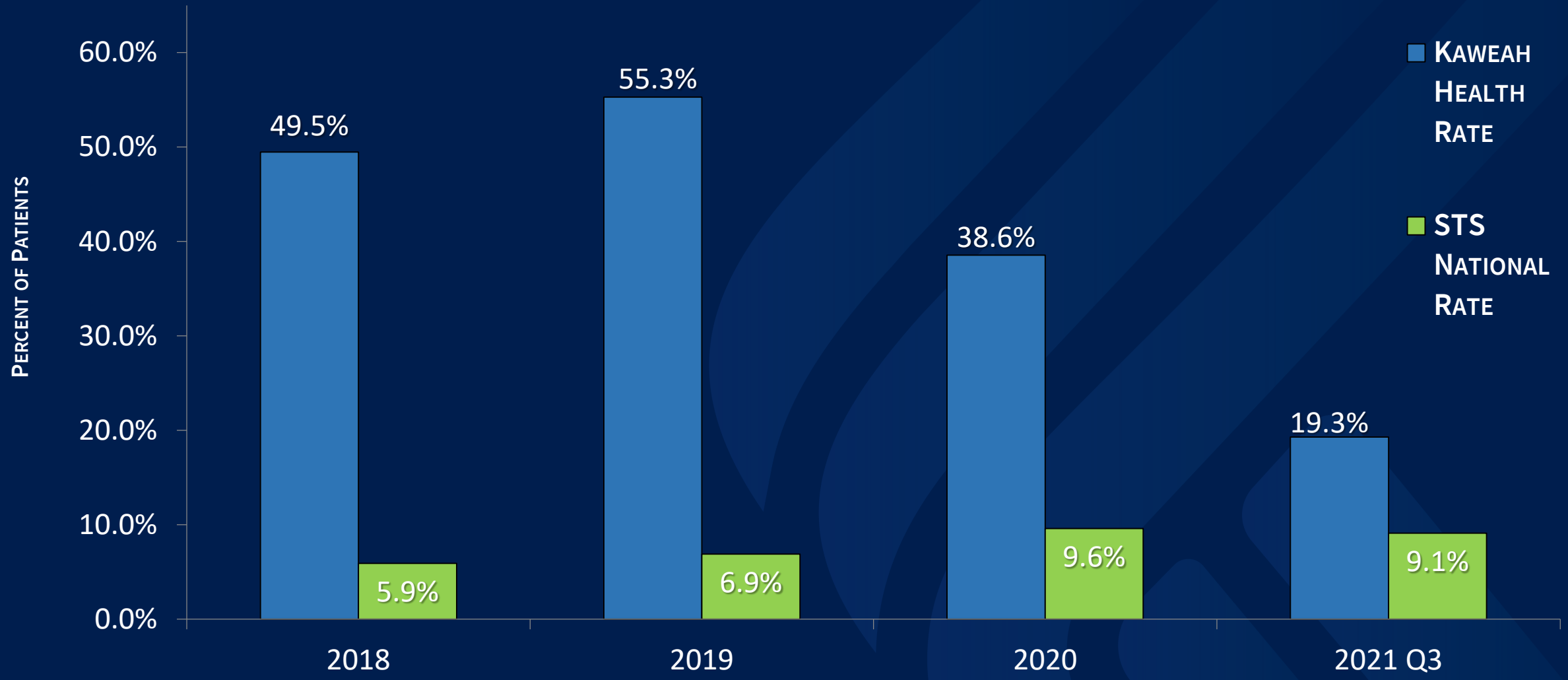
Post-operative Length of Stay: Long Stay is greater than 14 days (PLOS > 14 Days), Q3-2020 forward COVID+ pt.'s Excluded.

Kaweah Health Pt. Populations



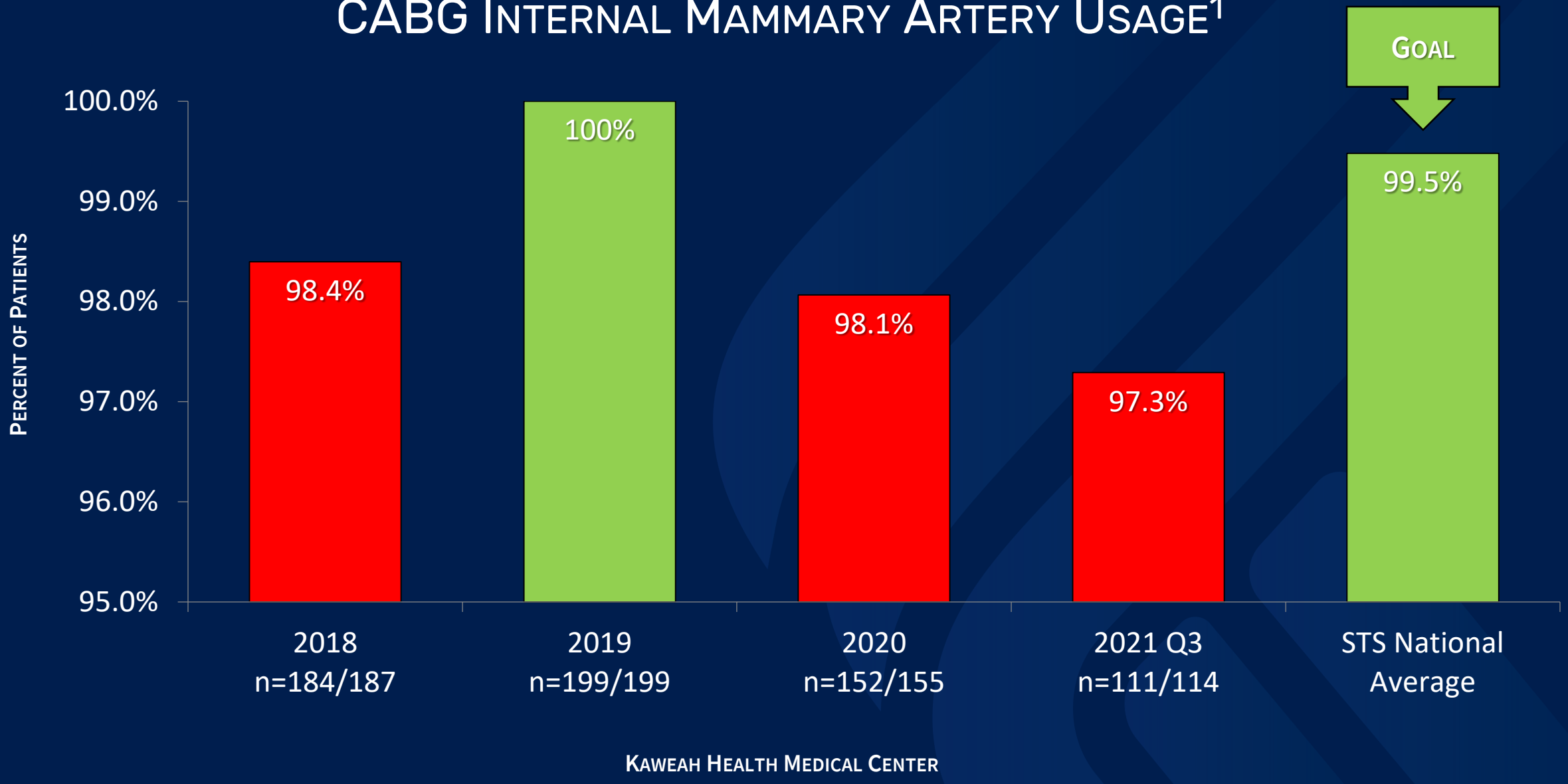
*STS National Average Comparison reporting period 01/01/2021 through 09/30/2021– Isolated CABG cases ONLY

Kaweah Health Radial Artery Usage



*STS National Average Comparison reporting period - 1/1 through 12/31 of each year – Isolated CABG cases ONLY

CABG Internal Mammary Artery Usage[1]

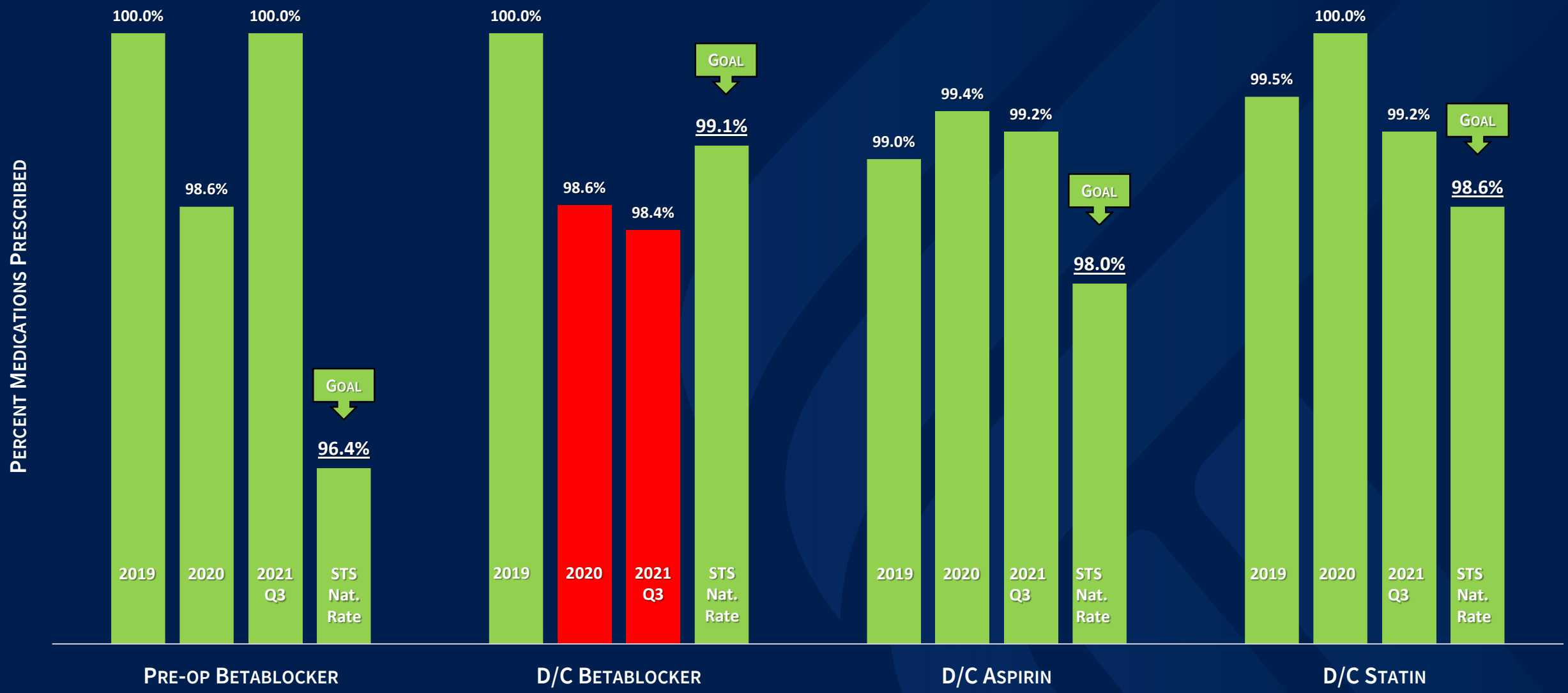


2021 O/E = 1.0

*STS National Average Comparison reporting period 01/01/2021 through 09/30/2021

[1]Surgeries where at least one internal mammary artery, left or right, was used as a bypass graft. Excludes emergent or salvage cases, No LAD disease, previous thoracic or cardiac surgery, subclavian stenosis or Hx of mediastinal radiation. Q3-2020 forward COVID+ pt.'s Excluded.

CABG Prescribed Medications Pre-op & Discharge



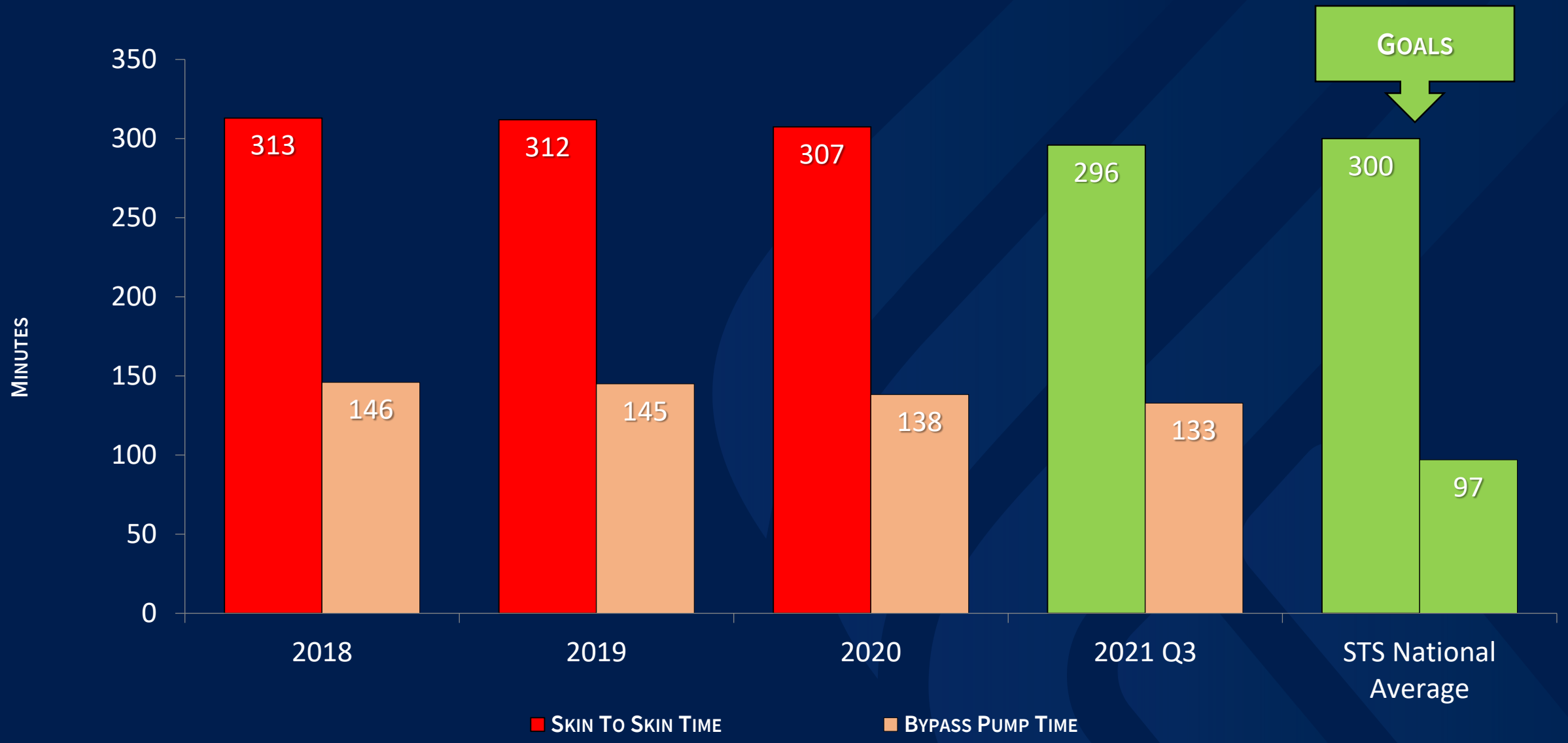
2021 O/E = 1.0

*STS National Average Comparison reporting period 01/01/2021 through 09/30/2021

Performance is measured by the proportion of patients who receive all of the perioperative medications for which the patient is eligible . The required perioperative medications are: 1) preoperative beta blockade therapy; 2) discharge anti-platelet medication; 3) discharge beta blockade therapy; and 4) discharge anti-lipid medication.

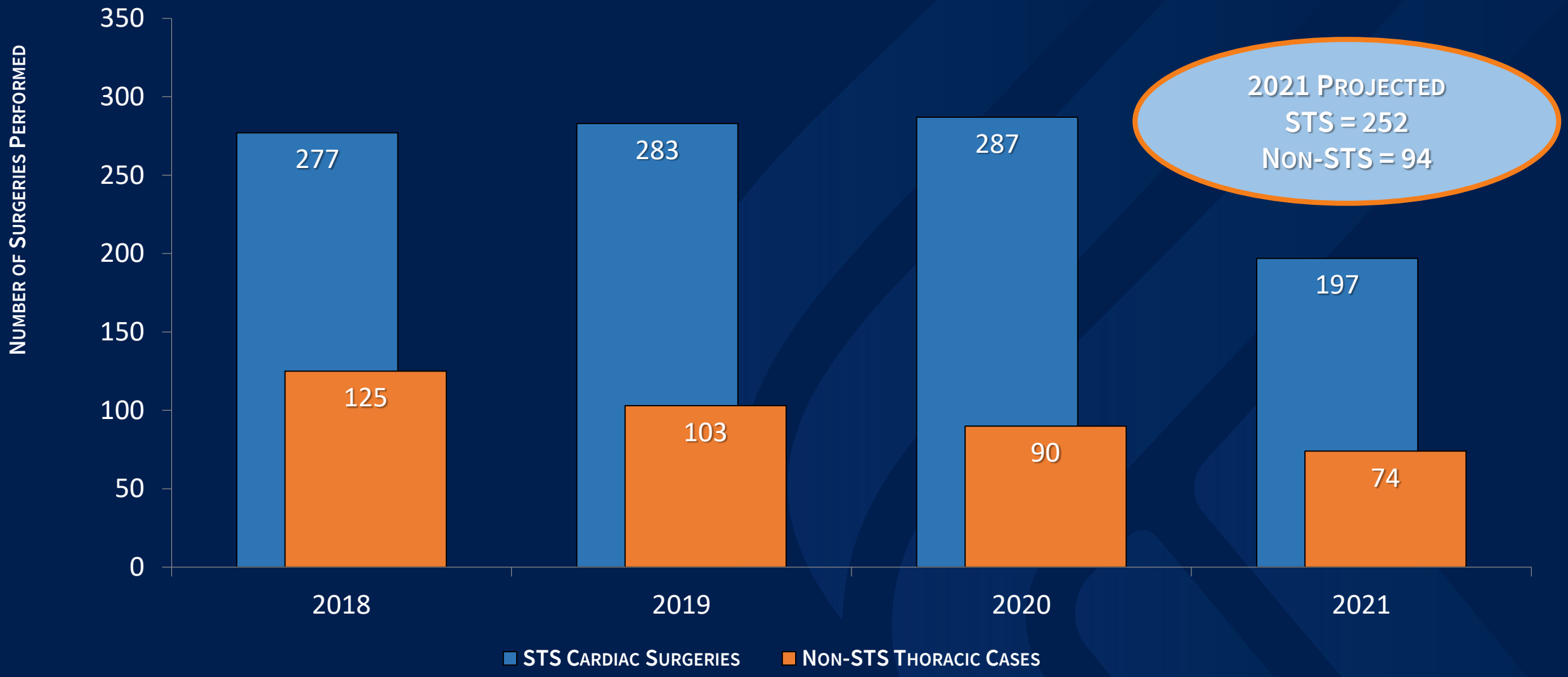
Note: patients who die prior to discharge are not eligible for discharge medications; contraindicated medications are considered non-eligible.

CABG Skin-to-Skin and Bypass Pump Durations



2021 O/E Skin Times = 1.0
2021 O/E Pump Times = 1.4
*STS National Average Comparison reporting period 01/01/2021 through 09/30/2021

Kaweah Health Cardiothoracic Surgery Volumes[1]



[1] Cardiac surgery as defined per STS database. Includes all 7 Major Procedure Categories (CABG, AVR, AVR+CABG, MVR, MVR+CABG, MVP, MVP+CABG) + Other Heart only procedures.

Live with passion.

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

Kaweah Health

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: **2E Labor and Delivery**

ProStaff/QIC Report Date: January – June 2022

Measure Objective/Goal:

1. Early Elective Induction of patient with no medical indication
    a. **Goal is 0%**
2. Decision to ready time for unscheduled Cesareans Sections less than or equal to 30 minutes
    a. **Goal is 90%**
3. Pitocin use for labor induction/augmentation to be started in less than or equal to 1 hour of order received
    a. Goal is 90%
4. Pitocin increased by 2 mu/minor 5mu/min(depending on order) every 30 minutes until regular uterine contractions achieved defined as contractions every 2-3 minutes, lasting 80-90 seconds
    a. Goal is 90%
5. ERAC Data:
    No Data at this time due to staffing issues in Quality Dept. Will resume soon.
6. Bio-vigil Compliance:
    a. Goal is 95%

Date range of data evaluated:

July 2021 to December 2021 (Measure 5 a & b are new measures)

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):

1. Goal met at 0% – Will continue to monitor
2 Goal not met at 81% - Improving from 74% last reporting period
3 Goal met at 95%- Continue to monitor
4 Goal not met at 66% – will continue perform unit rounding each shift to work with staff and monitor
5 No Data for this measure this reporting period.
6 Goal Met at 96% - will continue to monitor

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

If improvement opportunities identified, provide action plan and expected resolution data Next Steps/Recommendations/Outcomes:

1. Goal met no interventions, continue to monitor.

2. Continue to monitor and follow up with staff in the moment to educate and coach. Also in the process of making documentation appear “face up” to make it easier to remember to document this piece.

3. Goal met, continue to monitor

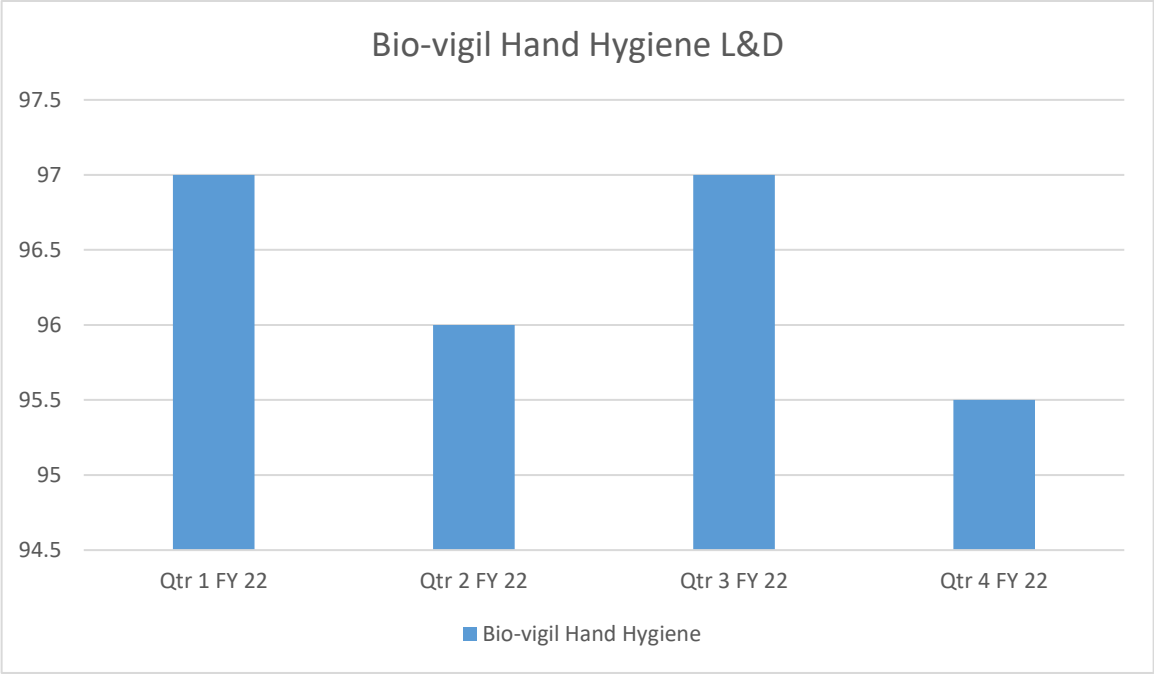
4. Pitocin increased by 2 mu/minor 5mu/min every 30 min until regular contractions: Will continue to monitor and follow up with staff in the moment if possible or after if necessary. Identify barriers to staff starting on time. Report monthly to UBC to get feedback and via prostaff. New Labor Rounds have started. However, due to severe staffing shortages on Labor & Delivery there has been decreased ability to increase Pitocin at the ordered rate and frequency. We continue to work improve staffing.

5. Continue to work on this measure. Look forward to new data coming soon

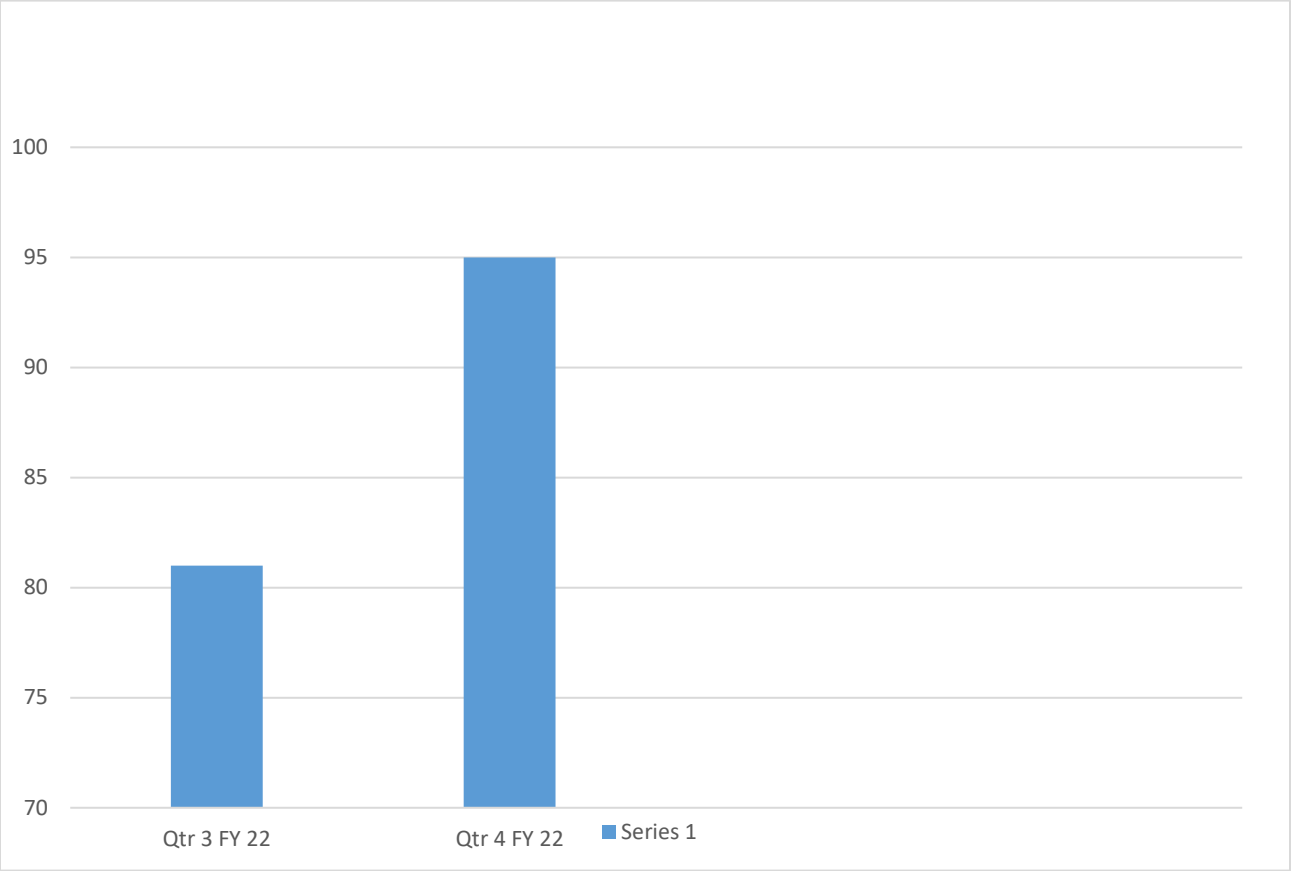
6. Goal met, continue to monitor

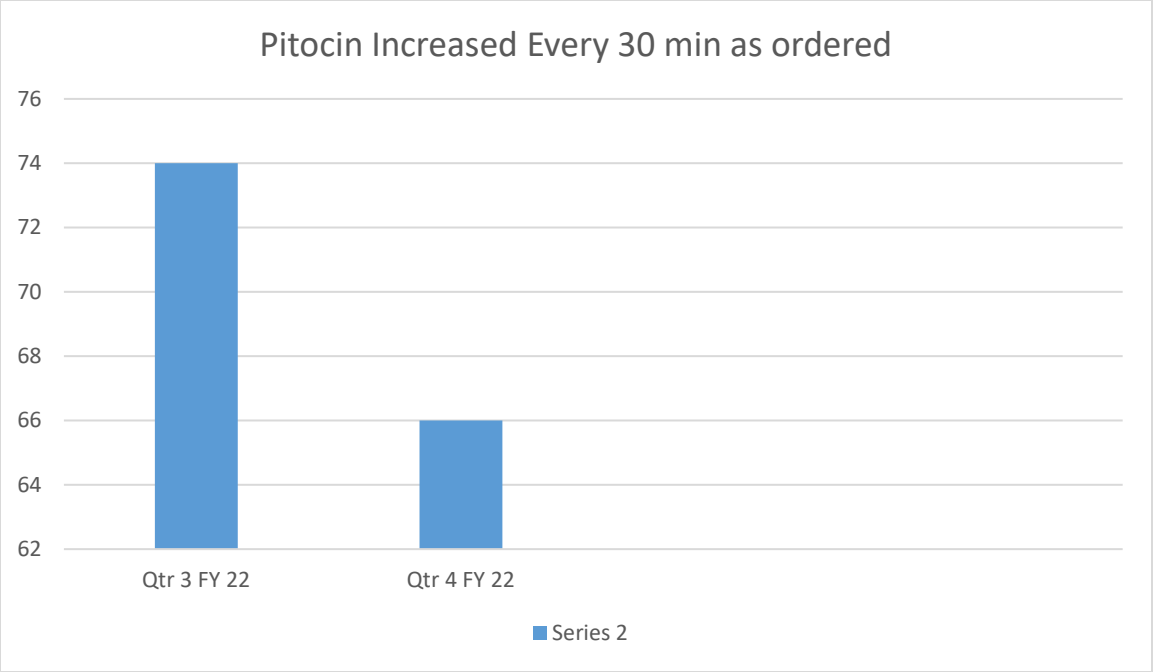
Submitted by Name: **Tracie Sherman** **Date Submitted:** **7/13/22**

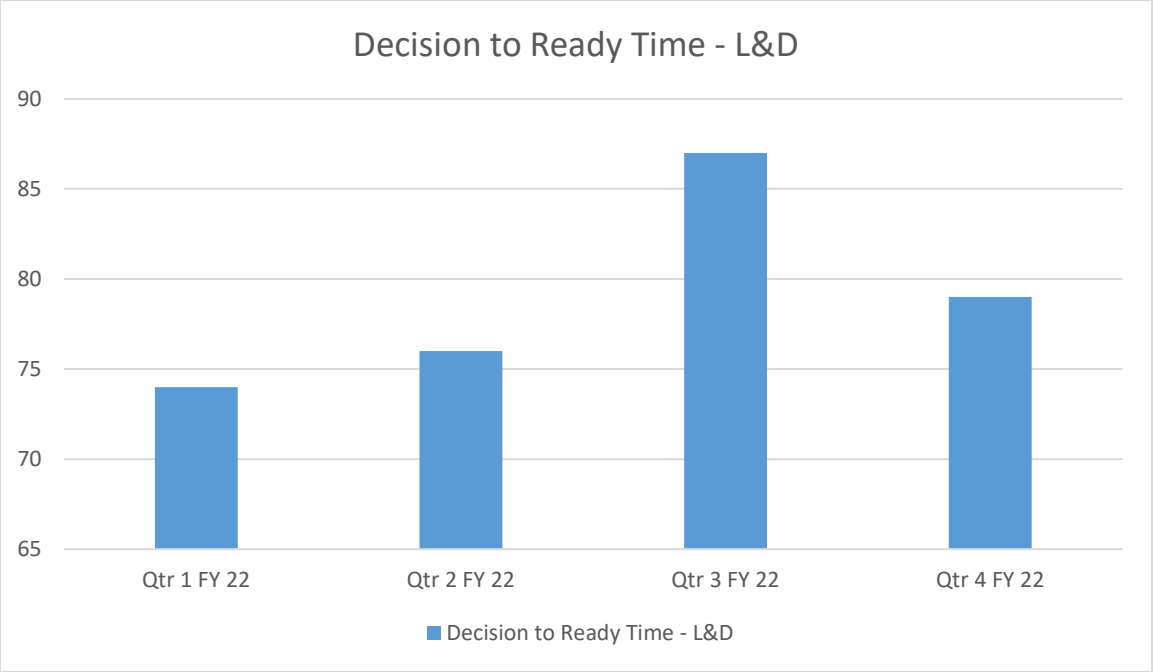
Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.


Bio-vigil Hand Hygiene L&D
97.5
97
96.5
96
95.5
95
94.5
Qtr 1 FY 22
Qtr 2 FY 22
Qtr 3 FY 22
Qtr 4 FY 22
Bio-vigil Hand Hygiene

Pitocin Started ≤ 1 hour



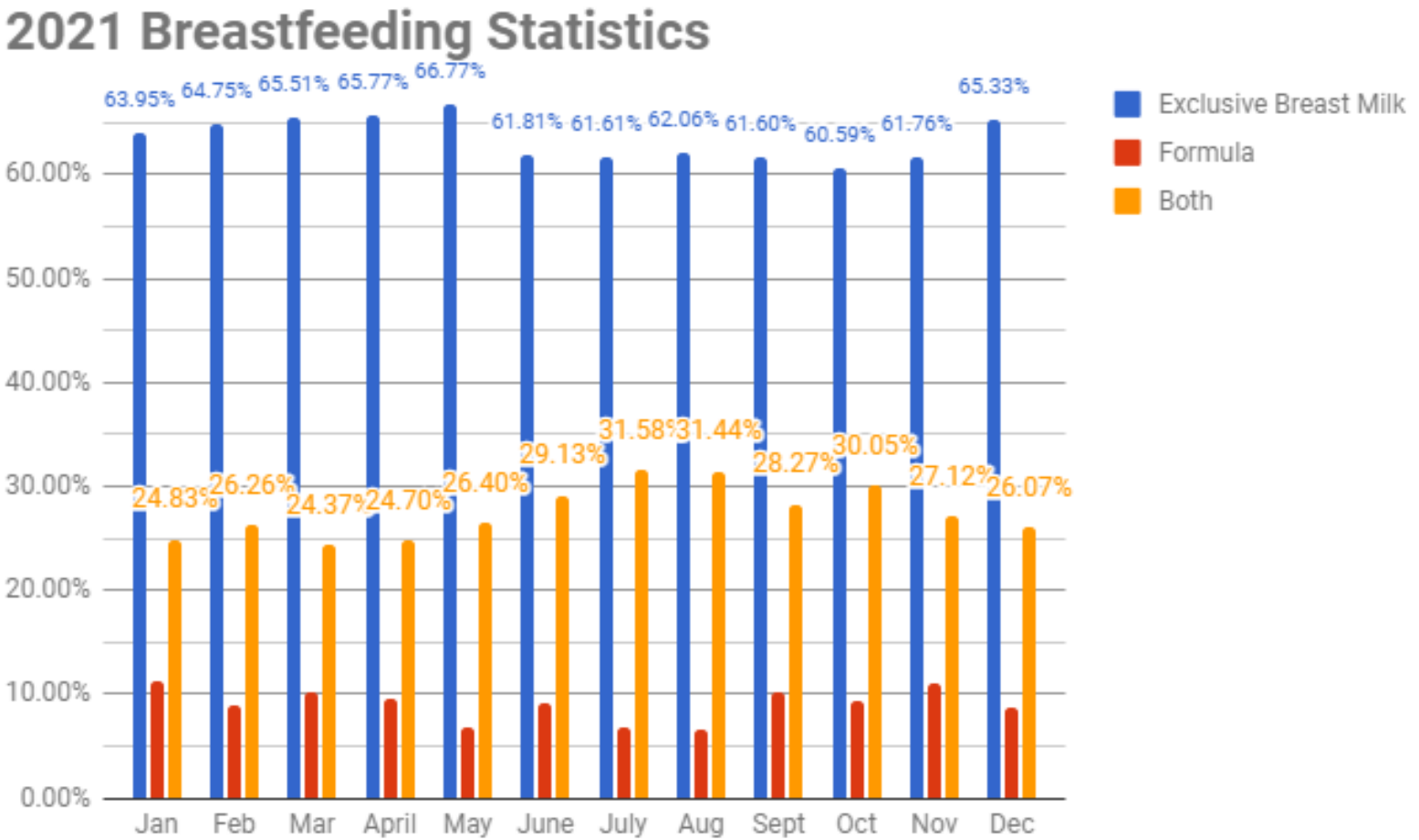

Pitocin Increased Every 30 min as ordered
76
74
72
70
68
66
64
62
Qtr 3 FY 22
Qtr 4 FY 22
Series 2


Decision to Ready Time - L&D
90
85
80
75
70
65
Qtr 1 FY 22
Qtr 2 FY 22
Qtr 3 FY 22
Qtr 4 FY 22
Decision to Ready Time - L&D

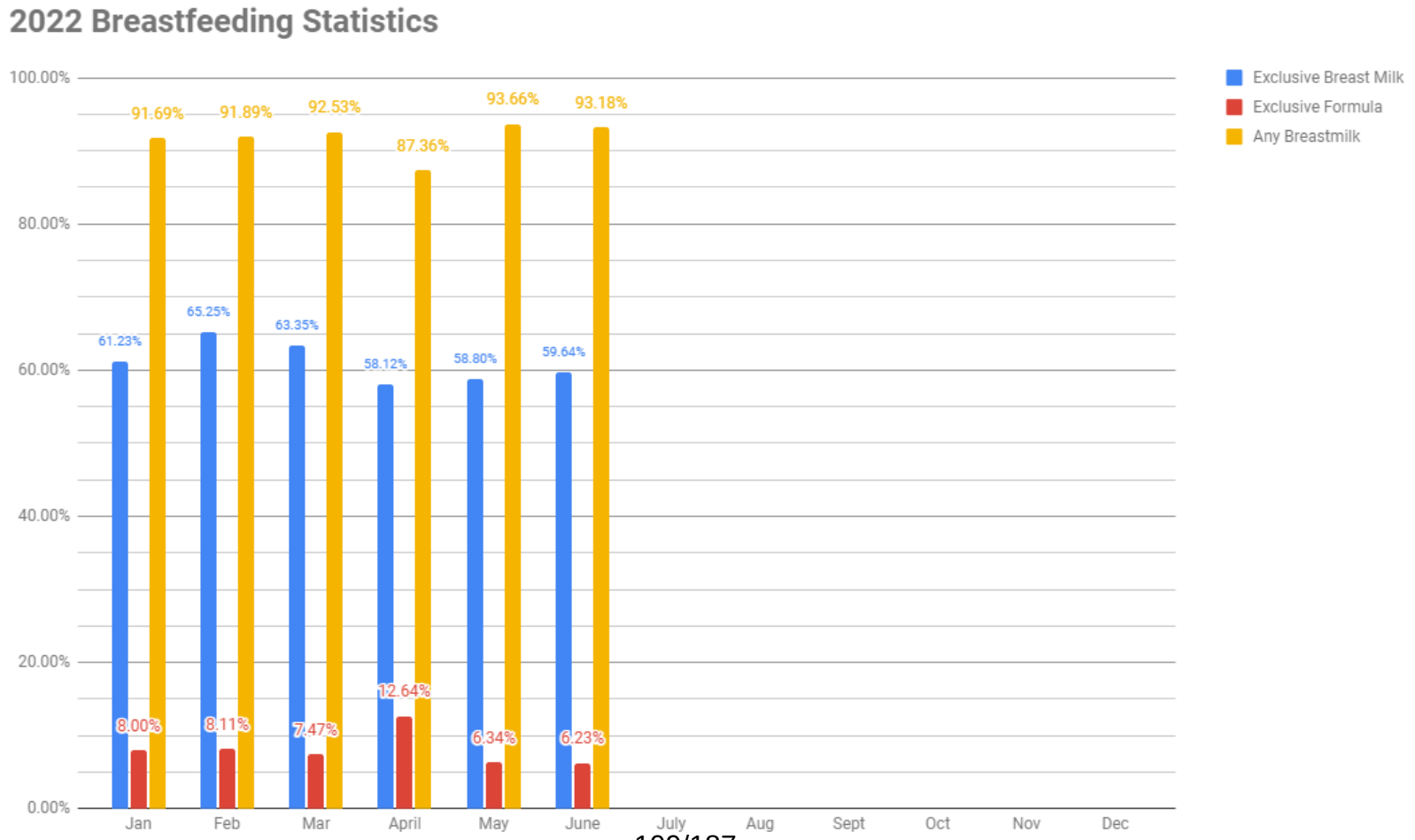
MOTHER/BABY QUALITY DATA

JANUARY – JUNE 2022

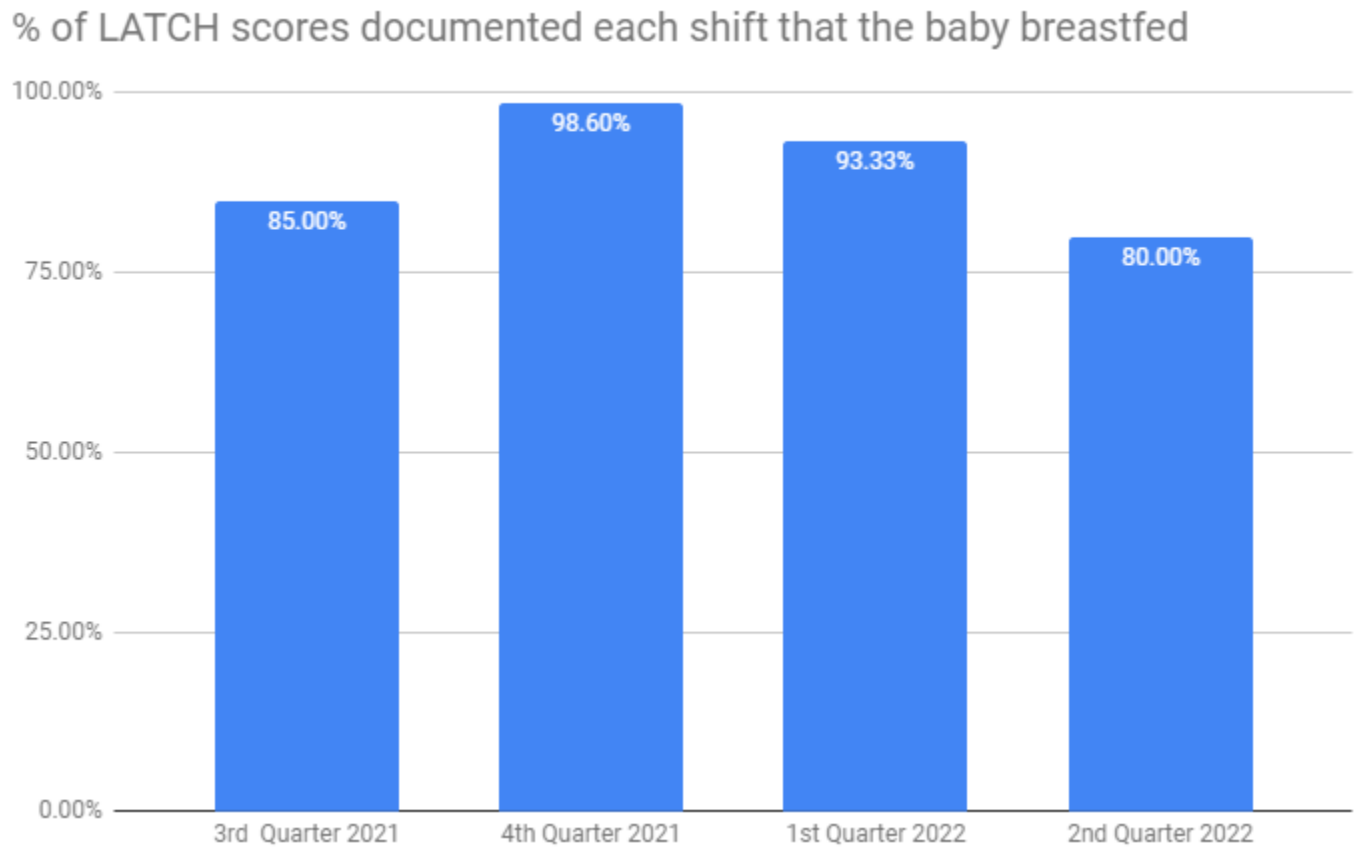
BREASTFEEDING STATS - 2021



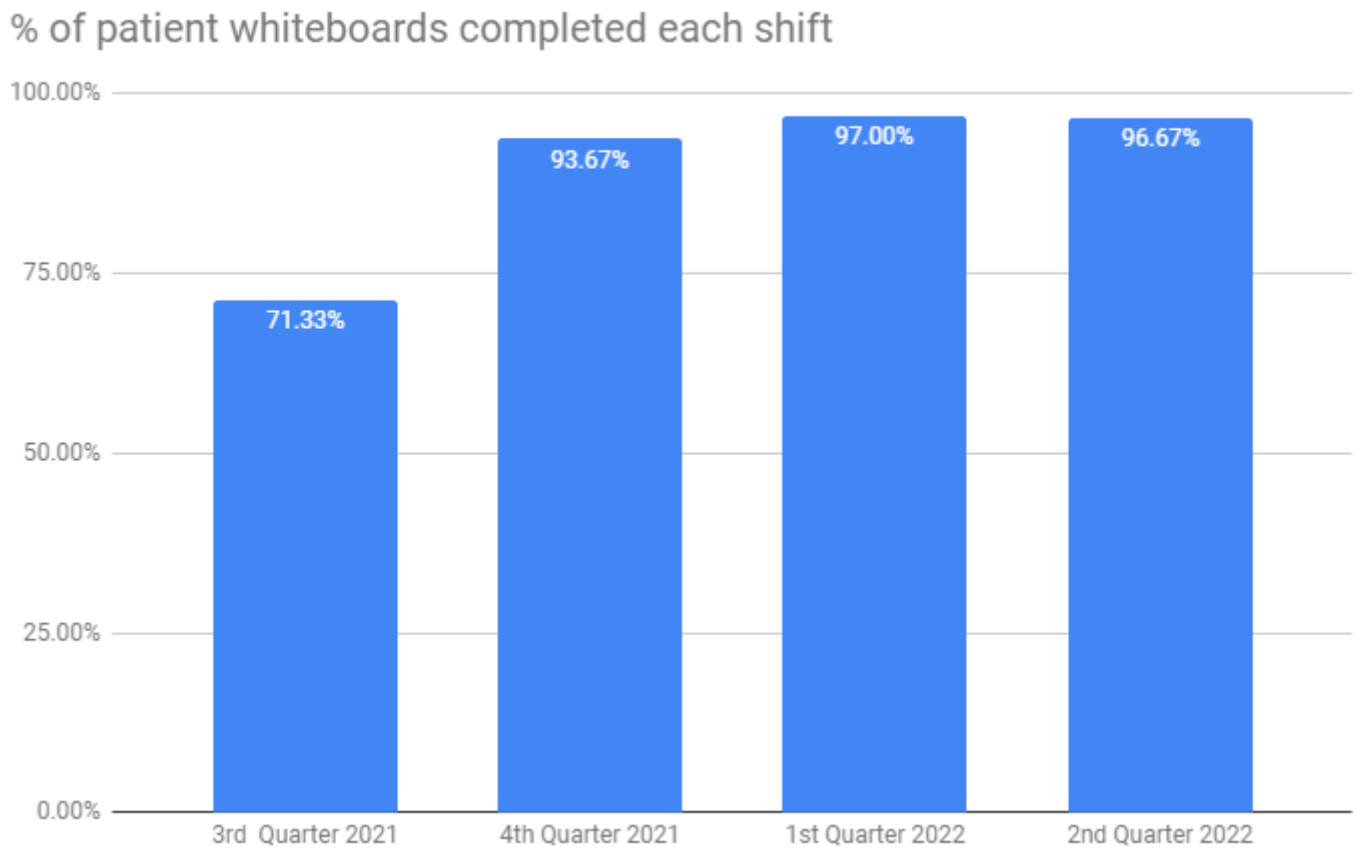
BREASTFEEDING STATS – 2022



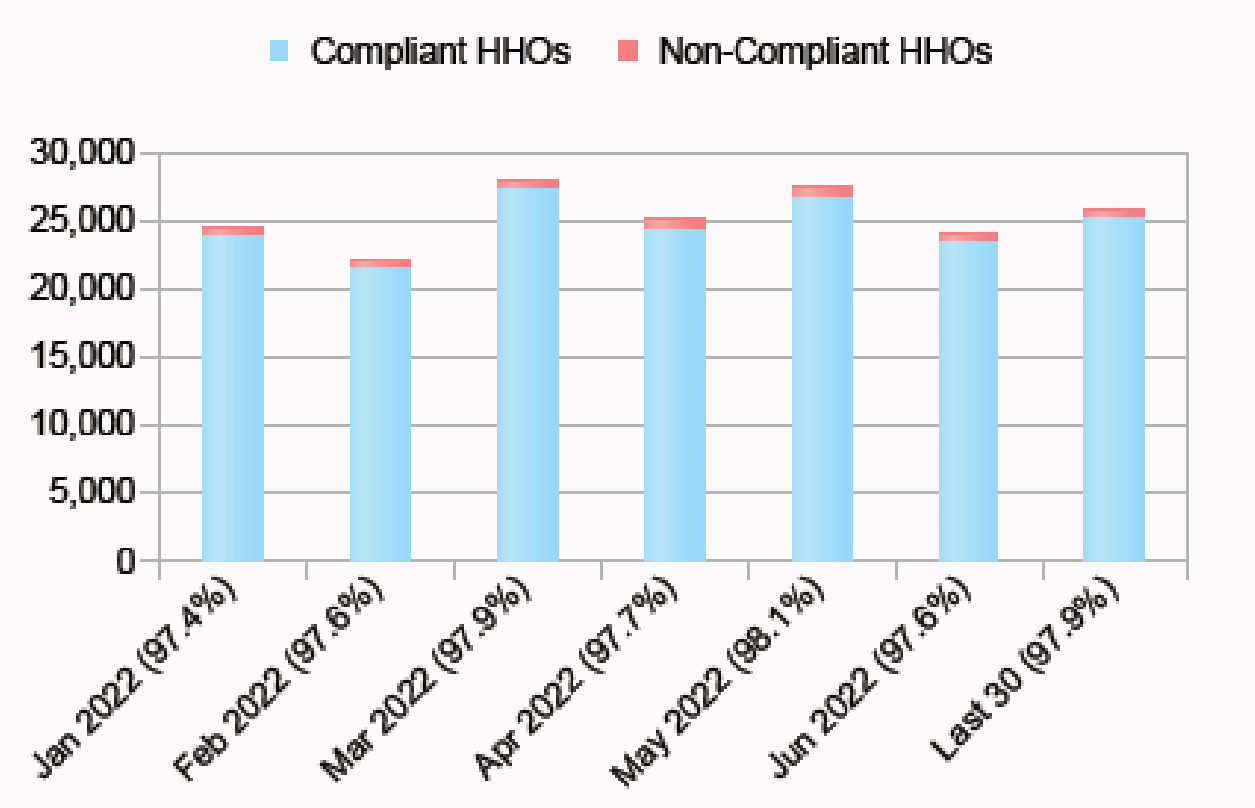
LATCH SCORES (AUDITS STARTED JULY 2021)



COMPLETION OF WHITEBOARDS

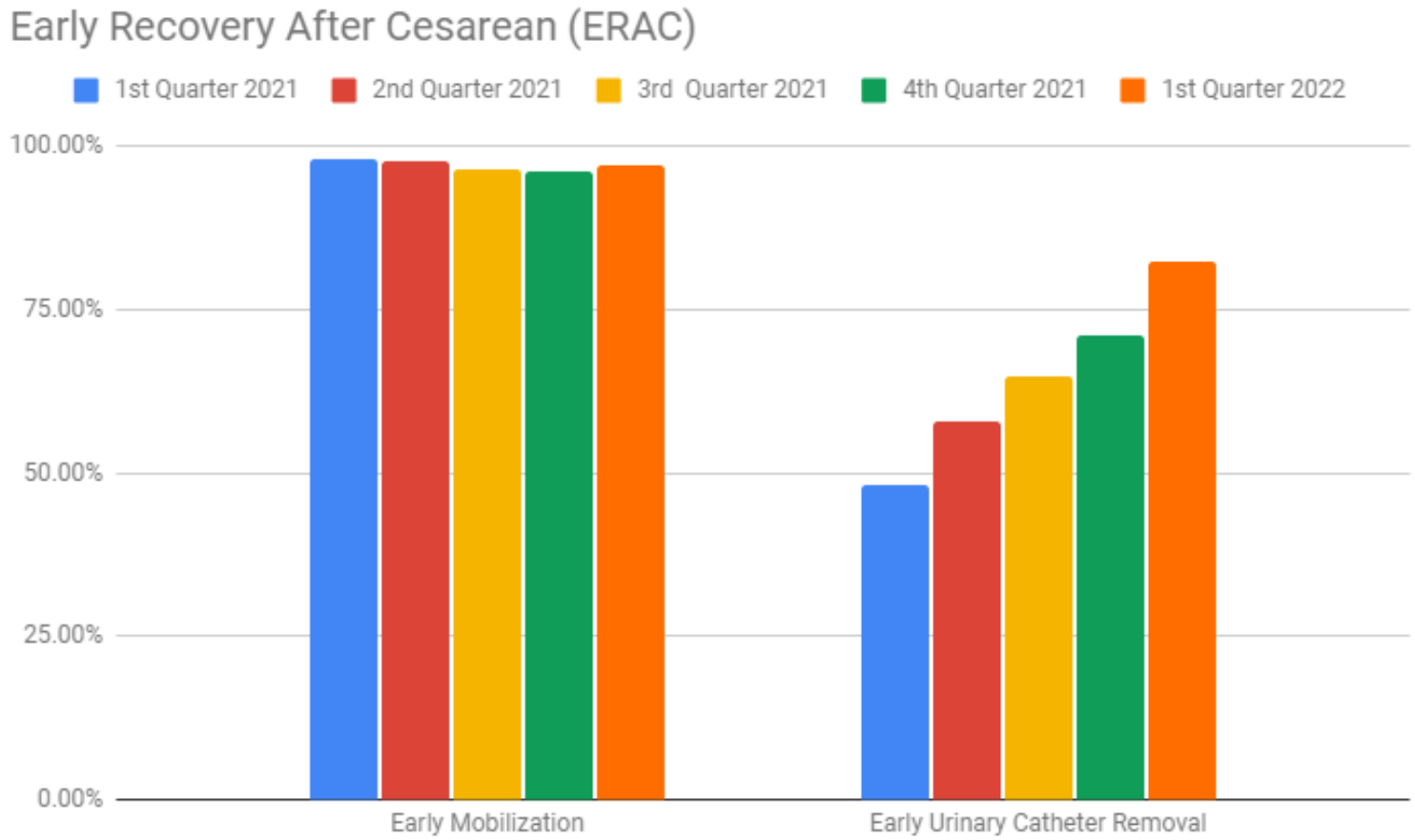


BIOVIGIL HAND HYGIENE



EARLY RECOVERY AFTER C-SECTION (ERAC) BUNDLE

(WE DO NOT HAVE DATA FOR 2ND QUARTER 2022 DUE TO STAFFING IN QUALITY DEPARTMENT)



Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Unit/Department: Mother Baby **QIC Report Date: July 2022**

Measure Objective/Goal:

CDPH Model Hospital policy directs us to assess the infant at the breast for early identification of latch-on difficulties and direct observation of the infant at breast to assure adequate breastfeeding prior to discharge. We utilize the LATCH assessment tool and it is required to be assessed at least one time during the shift while the infant is at the breast. Our internal benchmark is 100%.

Date range of data evaluated:

January 2022 – June 2022

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

We currently are performing below the goal of 100%. Our measure of success was as follows:

- January - March 2022 93.33%
- April - June 2022 80.00%

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

Education has been provided through several avenues including unit huddles, breastfeeding education class and UBC group discussions and minutes. Reminders are occurring shift to shift and peer to peer as well. Individuals who have falllouts are addressed individually and provided with education.

Next Steps/Recommendations/Outcomes:

We will continue to monitor this measure until we achieve and sustain 100% compliance rate.

Submitted by Name: Melissa Filiponi, RNC-MNN, BSN

Date Submitted: 07/11/22

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

Quality Improvement Committee

Unit/Department: Mother Baby **QIC Report Date: July 2022**

Measure Objective/Goal:

Our goal is to increase communication and patient awareness in their plan of care through use of the whiteboards installed in each room. The whiteboards are updated at the beginning of every shift and throughout the shift as the plan of care changes. Our internal benchmark is 100%.

Date range of data evaluated:

January 2022 – June 2022

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

We currently are performing below the benchmark of 100%. Our current measure of success is as follows:

- January - March 2022 97.00%
- April - June 2022 96.67%

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

We participated in the hospital wide initiative and audits occur once per shift every week. Those fallouts are addressed individually with the care team.

Next Steps/Recommendations/Outcomes:

We will continue to monitor this measure until we achieve and sustain 100% compliance rate.

Submitted by Name: Melissa Filiponi, RNC-MNN, BSN

Date Submitted: 07/11/22

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

Quality Improvement Committee

Unit/Department: Mother Baby **QIC Report Date: July 2022**

Measure Objective/Goal:

To ensure that those providing direct patient care are performing hand hygiene in an effort to reduce hospital acquired infections. The internal goal is 95%.

Date range of data evaluated:

January 2022 – June 2022

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

We currently are performing above the benchmark of 95%. Our measure of success is as follows:

- January – March 2022 97.63%
- April – June 2022 97.8%

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

Those who are non-compliant are addressed individually.

Next Steps/Recommendations/Outcomes:

We will continue to monitor this measure until we achieve and sustain 95% compliance rate.

Submitted by Name: Melissa Filiponi, RNC-MNN, BSN

Date Submitted: 07/11/2022

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

Quality Improvement Committee

Unit/Department: Mother Baby **QIC Report Date: July 2022**

Measure Objective/Goal:

Enhanced Recovery After Cesarean is an evidenced-based, multidisciplinary approach to improving surgical care for elective cesarean sections. This pathway minimizes surgical complications and prepares the patient for safe postoperative course and successful discharge. Mother/Baby is responsible for early mobilization and early urinary catheter removal with goals of 90%.

Date range of data evaluated:

- January 2022 – March 2022
- April 2022 – June 2022 No data due to staffing in the Quality Department

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

We currently are performing above the benchmark of 90% in regards to early mobilization. Our measure of success is as follows:

- January – March 2022 was 97.13%

We currently are performing below the benchmark of 90% with an increase in compliance in regards to early catheter removal. Our measure of success is as follows:

- January – March 2022 was 82.20%

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

We will continue to educate staff on the importance of early urinary catheter removal. A small percentage of our fall outs are related to the patient having complications and orders received by the physician to keep the urinary catheter in place. GEMBA's occur every shift to identify those patients who need their foley catheters removed and a plan is created with the primary care nurse and charge nurse.

Next Steps/Recommendations/Outcomes:

We will continue to monitor this measure until we achieve and sustain 90% compliance rate.

Submitted by Name: Melissa Filiponi, RNC-MNN, BSN

Date Submitted: 07/11/22

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

Quality Improvement Committee

Unit/Department: Mother Baby **QIC Report Date: July 2022**

Measure Objective/Goal:

Babies receiving exclusive breast milk while in the hospital (TJC PC-05 Benchmark 52.2%)

Date range of data evaluated:

January 2022 – June 2022

- January – March 2022 63.27%
- April – June 2022 58.85%

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

We currently are performing above the benchmark of 52.2% however we have seen a decline in our exclusive breastfeeding rates and we believe there is a direct correlation with allowing an additional visitor.

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

We are currently fully staffed with 7 days a week coverage spanning an average of 21 hours a day. We implemented coverage on Labor/Delivery to see our new mom's prior to delivery providing them with education so they can make an informed decision on how they want to feed their baby while in the hospital. We have implemented our breastfeeding bundle which included the following: change in lactation scheduling, mandatory breastfeeding education for RN's, breastfeeding education provided to our pediatricians, selection preference form to be collected on admission to Labor and Delivery and an investigative form for nursing to complete when formula is given. In addition to the above bundle, our lactation team has now changed their focus to include assisting with the first feed post-delivery and following the mothers who choose to do both breast and formula encouraging only breastfeeding while in the hospital. We continue to follow-up on those babies who receive formula when mom's choice was exclusive breastfeeding through BIB University (Breast is Best), very similar to Falls U, where staff are invited to share their stories so we can identify gaps in care. We relaunched our FREE breastfeeding classes (virtually) in February 2022 in hopes to provide more education to our community.

Next Steps/Recommendations/Outcomes:

We continue to support our mother's choice of exclusive breastfeeding.

Submitted by Name: Melissa Filiponi, RNC-MNN, BSN

Date Submitted: 07/11/22

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

Unit/Department: Pediatrics **ProStaff Report Date: July 2022**

Measure Objective/Goal:
Total Patient Falls per 1000 patient days
Goal: .90
Goal not met.

Date range of data evaluated:
January-June 2022

Analysis of all measures/data: (Include key findings, improvements, opportunities)
We had 1 Patient fall during this quarter. This is below the benchmark.

If improvement opportunities identified, provide action plan and expected resolution date:
Parents of patients educated on not allowing patient to play on the bed. Playroom is not currently in use, patients must play in their room, with play mats on the floor safely throughout stay. Parent information sheet updated and given to parents regarding safe play in the rooms.

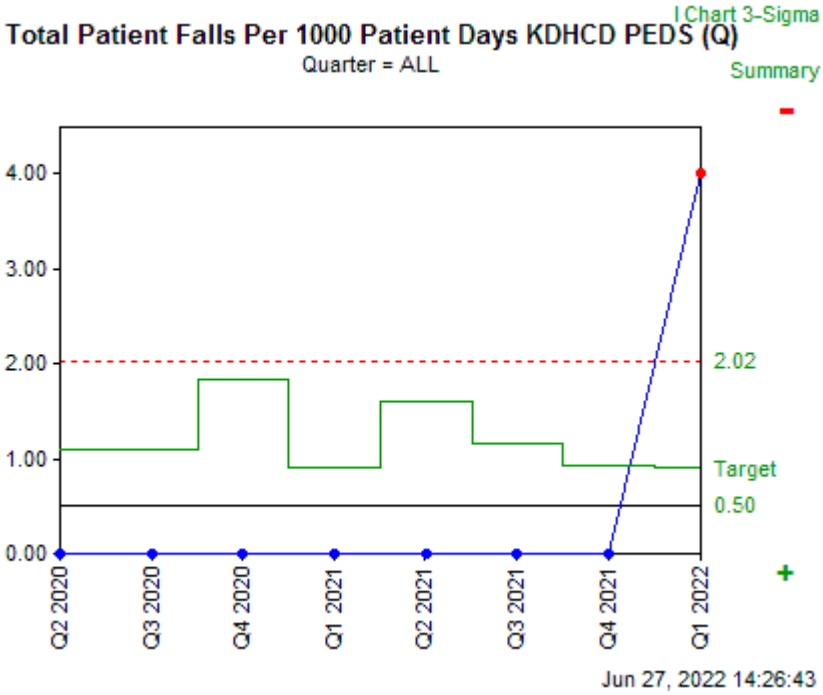
Next Steps/Recommendations/Outcomes:
We will continue to implement fall risk precautions and educate families on safe sleep as well as monitored activities within room by caregiver. We will continue to have parents sign waivers when they decline Safe Sleep.

Submitted by Name:	**Date Submitted**
Danielle Grimaldi, RN, BSN, CPN	06/27/22

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



Date	KDHCD	Target
Q1 2022	4.00	0.90
Q4 2021	0.00	0.93
Q3 2021	0.00	1.15
Q2 2021	0.00	1.60
Q1 2021	0.00	0.90
Q4 2020	0.00	1.84
Q3 2020	0.00	1.10
Q2 2020	0.00	1.09

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

Unit/Department: Pediatrics **ProStaff Report Date: July 2022**

Measure Objective/Goal:

Percent of PEWS fallouts-PEWS score charted every 4 hours on every patient.
Goal: 90% or greater no fallouts.
Goal Met

Date range of data evaluated:

January-June 2022

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

Using data received within the last 180 days, we have had a 98% success rate in PEWS score being charted every 4 hours. Results are better than benchmark for PEWS score.

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

Next Steps/Recommendations/Outcomes:

Continue to maintain PEWS scoring greater than 90% expected with next report date.

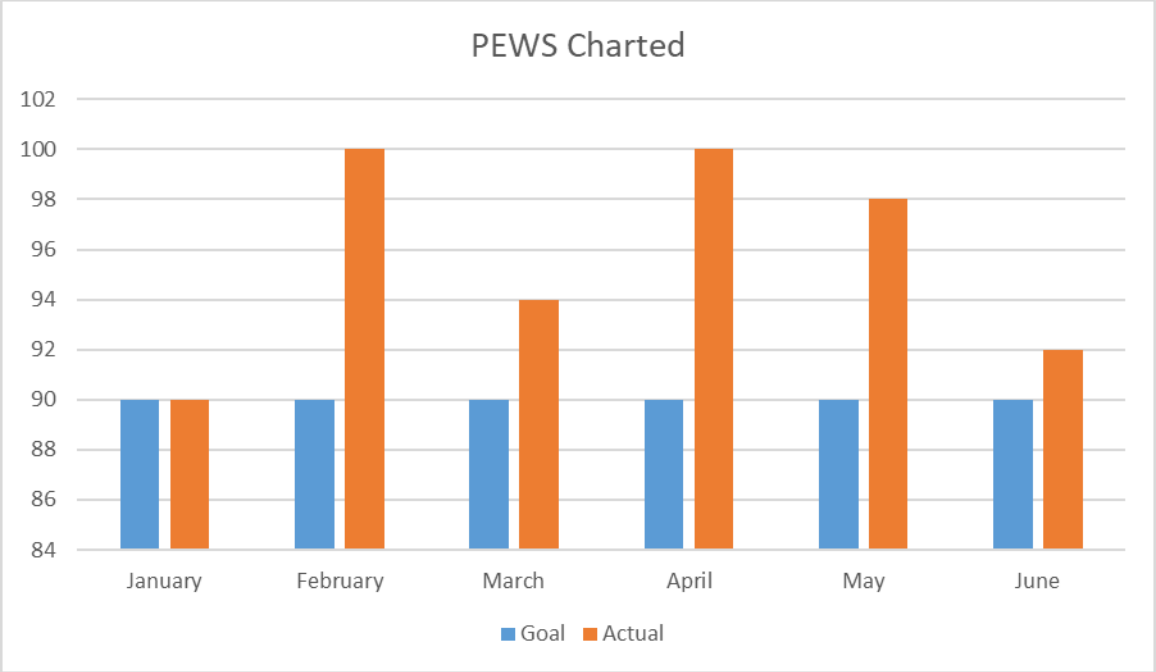
Submitted by Name: Danielle Grimaldi, RN, BSN, CPN

Date Submitted: 06/27/22

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



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

Unit/Department: Pediatrics **ProStaff Report Date: July 2022**

Measure Objective/Goal:

Percent of patients with stage 2 or greater HAPI: 0.00
Goal: N/A
Goal Met

Date range of data evaluated:

January -June 2022

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

We had 0 HAPIs stage 2 or greater for this quarter on Peds. Raw data attached reports 2 HAPI's on Peds in 2021. These 2 events were adult pts that were located on the Pediatrics floor as part of the Peds Pod overflow.

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

Next Steps/Recommendations/Outcomes:

We will continue identifying patients at risk for skin breakdown and implement appropriate preventative measures.

Submitted by Name: Danielle Grimaldi, RN, BSN, CPN

Date Submitted: 06/27/22

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

2022 Stage 2+ HAPI QFT Dashboard

Measure Description Outcome Measures	2022 Benchmark/ Target	2019 Baseline	2020 Baseline	2021 Baseline	Jan-22	Feb-22	Mar-22	Apr-22	May-22
HAPI Stage 2+ per 1,000 pt days (all HAPIs)	1.13 (-10% from 2021)	1.64	1.61	1.26	0.43	0.36	1.16	0.25	1.41
Device Associated HAPI per 1,000 pt days	0.55 (-10% from 2021)	0.74	0.72	0.61	0.11	0.12	0.46	0.12	0.94
PSI 3 - Claims-based HAPI Stage 3, 4, and Unstageable per 1,000 discharges	**0.6** - Hospital Compare (Q3 2017-Q2 2019) **0.35** - Midas 50th Percentile (2019)	0.79	0.95	1.42	0.00	0.00	0.00	1.16	0
Process Measures	(-10% from 2021)	2019	2020	2021	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Respiratory Device associated HAPI per 1,000 pt days	0.36		0.44	0.40	0.11	0.00	0.00	0.00	0.24
% of Respiratory Device associated HAPI's (out of all of the device associated HAPI's)	58%		61%	65%	100%	0%	0%	0%	25%
Unit Level	(-10% from 2021)	2019	2020	2021	Jan-22	Feb-22	Mar-22	Apr-22	May-22

Other Units	2022 Benchmark/ Target	2019	2020	2021	Jan-22	Feb-22	Mar-22	Apr-22	May-22
ED	n/a	4	3	0	0	0	0	0	0
Sub-Acute	n/a	5	6	5	0	0	0	0	0
Surgery	n/a	6	0	0	0	0	0	0	0
Cath Lab	n/a	1	0	0	0	0	0	0	0
Pediatrics	n/a	0	0	2	0	0	0	0	0

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

Unit/Department: Pediatrics **ProStaff Report Date: July 2022**

Measure Objective/Goal:
Central Line Associated Blood Infections
Goal: 0.00
Goal Met.

Date range of data evaluated:
January- June 2022

Analysis of all measures/data: (Include key findings, improvements, opportunities)
We had 0 CLABSIs for this quarter. We are performing equal with the benchmark.

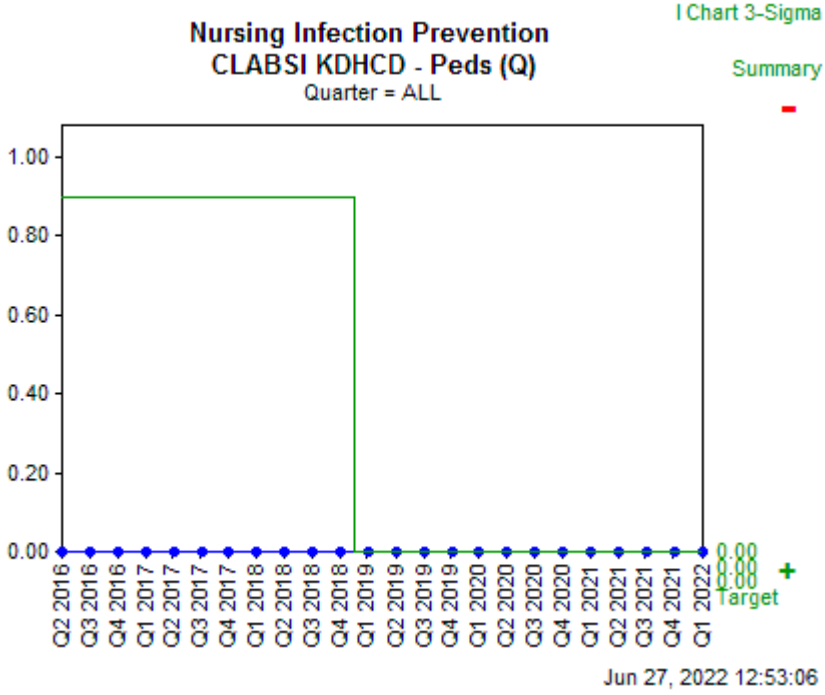
If improvement opportunities identified, provide action plan and expected resolution date:

Next Steps/Recommendations/Outcomes:
We will continue to use aseptic technique to perform scheduled dressing and cap changes. We will also continue to evaluate need for central line on a daily basis.

Submitted by Name:	**Date Submitted:**
Danielle Grimaldi, RN, BSN, CPN	06/27/22

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



Date	KDHCD	Target
Q1 2022	0.00	0.00
Q4 2021	0.00	0.00
Q3 2021	0.00	0.00
Q2 2021	0.00	0.00
Q1 2021	0.00	0.00
Q4 2020	0.00	0.00
Q3 2020	0.00	0.00
Q2 2020	0.00	0.00
Q1 2020	0.00	0.00
Q4 2019	0.00	0.00
Q3 2019	0.00	0.00
Q2 2019	0.00	0.00
Q1 2019	0.00	0.00
Q4 2018	0.00	0.90
Q3 2018	0.00	0.90
Q2 2018	0.00	0.90
Q1 2018	0.00	0.90
Q4 2017	0.00	0.90
Q3 2017	0.00	0.90
Q2 2017	0.00	0.90
Q1 2017	0.00	0.90
Q4 2016	0.00	0.90
Q3 2016	0.00	0.90
Q2 2016	0.00	0.90

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

Unit/Department: Pediatrics **ProStaff Report Date: July 2022**

Measure Objective/Goal:

Catheter Associated Urinary Tract Infection
Goal: 0.00
Goal met.

Date range of data evaluated:

January-June 2022

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

We had 0 CAUTIs for this quarter. We are performing equal to the benchmark.

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

Next Steps/Recommendations/Outcomes:

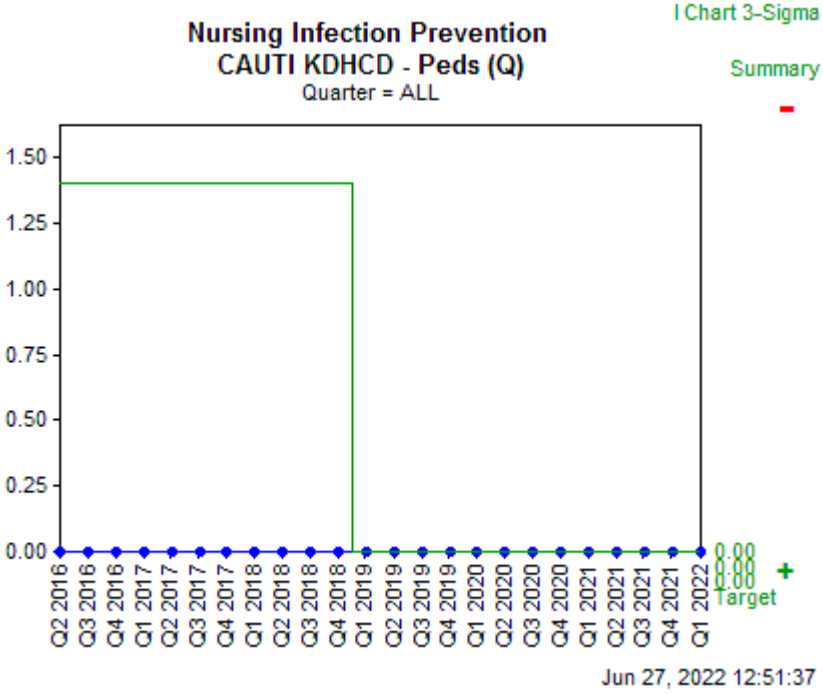
We will continue to use aseptic technique to insert urinary catheters, and we will continue to provide perineal care every shift. We will also continue to evaluate need for urinary catheter on a daily basis.

Submitted by Name: Danielle Grimaldi, RN, BSN, CPN

Date Submitted: 06/27/22

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee



Date	KDHCD	Target
Q1 2022	0.00	0.00
Q4 2021	0.00	0.00
Q3 2021	0.00	0.00
Q2 2021	0.00	0.00
Q1 2021	0.00	0.00
Q4 2020	0.00	0.00
Q3 2020	0.00	0.00
Q2 2020	0.00	0.00
Q1 2020	0.00	0.00
Q4 2019	0.00	0.00
Q3 2019	0.00	0.00
Q2 2019	0.00	0.00
Q1 2019	0.00	0.00
Q4 2018	0.00	1.40
Q3 2018	0.00	1.40
Q2 2018	0.00	1.40
Q1 2018	0.00	1.40
Q4 2017	0.00	1.40
Q3 2017	0.00	1.40
Q2 2017	0.00	1.40
Q1 2017	0.00	1.40
Q4 2016	0.00	1.40
Q3 2016	0.00	1.40
Q2 2016	0.00	1.40

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Pediatrics **ProStaff Report Date: July 2022**

Measure Objective/Goal:
Injury Falls per 1000 patient days
Goal: 0.18
Goal Not Met

Date range of data evaluated:
January-June 2022

Analysis of all measures/data: (Include key findings, improvements, opportunities)
We had 1 injury falls during this quarter. This is below the benchmark for Injury Falls per 1000 patient days during this data range.

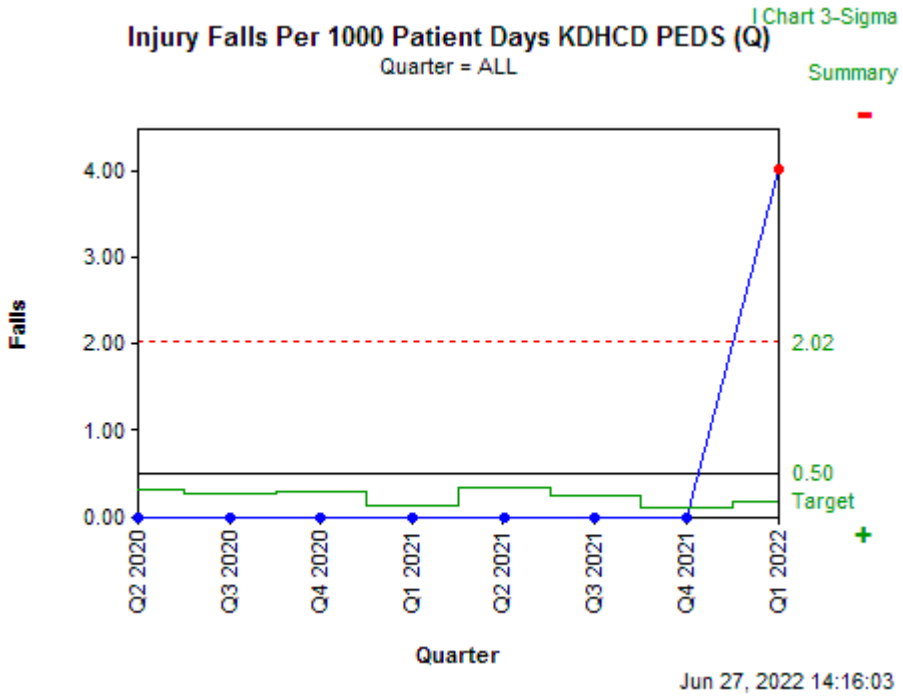
If improvement opportunities identified, provide action plan and expected resolution date:
Parents of patients educated on not allowing patient to play on the bed. Playroom is not currently in use, patients must play in their room, with play mats on the floor safely throughout stay. Parent information sheet updated and given to parents regarding safe play in the rooms.

Next Steps/Recommendations/Outcomes:
We will continue to implement fall risk precautions and educate families on safe sleep as well as monitored activities within room by caregiver. We will continue to have parents sign waivers when they decline Safe Sleep. Actively using soft play mats on the floor next to the bedside of active toddlers.

Submitted by Name: Danielle Grimaldi, RN, BSN, CPN

Date Submitted: 06/27/22

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



Quarter	Falls	Target
Q1 2022	4.00	0.18
Q4 2021	0.00	0.10
Q3 2021	0.00	0.26
Q2 2021	0.00	0.34
Q1 2021	0.00	0.13
Q4 2020	0.00	0.30
Q3 2020	0.00	0.27
Q2 2020	0.00	0.33

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

Unit/Department: Pediatrics **ProStaff Report Date: July 2022**

Measure Objective/Goal:

Hand Hygiene- Compliance KDMC PEDS
Goal: 95%
Goal Met.

Date range of data evaluated:

January- June 2022

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

Using data received within the last 180 days, we have had a 97% success rate in hand hygiene compliance. Results are better than benchmark for hand hygiene compliance goal.

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

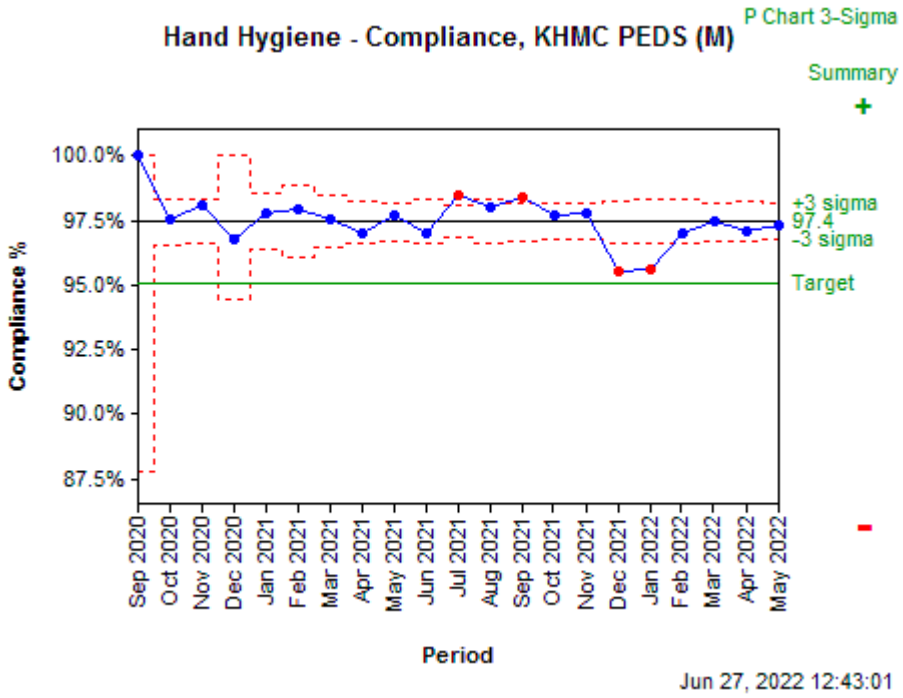
Next Steps/Recommendations/Outcomes:

Continue to maintain hand hygiene compliance scoring greater than 95% expected with next report date.

Submitted by Name: Danielle Grimaldi, RN, BSN, CPN

Date Submitted: 06/27/22

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



Period	# Compliant	# Screens	Compliance %
May 2022	4352	4474	97.3%
Apr 2022	3837	3954	97.0%
Mar 2022	4191	4302	97.4%
Feb 2022	2973	3067	96.9%
Jan 2022	2891	3026	95.5%
Dec 2021	3350	3507	95.5%
Nov 2021	4500	4602	97.8%
Oct 2021	4755	4868	97.7%
Sep 2021	4200	4271	98.3%
Aug 2021	3216	3282	98.0%
Jul 2021	5546	5633	98.5%
Jun 2021	3105	3201	97.0%
May 2021	4026	4122	97.7%
Apr 2021	3414	3521	97.0%
Mar 2021	2177	2232	97.5%
Feb 2021	1171	1196	97.9%
Jan 2021	1797	1838	97.8%
Dec 2020	240	248	96.8%
Nov 2020	2961	3020	98.0%
Oct 2020	2721	2791	97.5%
Sep 2020	24	24	100.0%

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: ***NICU*** **ProStaff/QIC Report Date:** *July, 2022*

Measure Objective/Goal:

1. *CLABSI per 1000 device days: Goal-Meet or exceed benchmark*
2. *VAP per 1000 ventilator device days: Goal-Meet or exceeds benchmark*
3. *Monthly hand hygiene compliance: Goal-Meet or exceeds benchmark*

Date range of data evaluated:

January 2022 through June 2022 (Central line days and vent days for entire year)

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):

1. *KD NICU 0/1000 central line days. No CLABSI in 31 months. 290 Central line days in this reporting timeframe.* ***Goal met.***

CLABSI Rate for KDMC NICU 2022

Month	Indicator Value	Benchmark Value	Central line days in this month	# of CLABSI	Year to date # of Central Line Days
1st quarter					
January	0/1000	1.32/1000	64	0	64
February	0/1000	1.32/1000	37	0	101
March	0/1000	1.32/1000	34	0	135
2nd Quarter					
April	0/1000	1.32/1000	47	0	182
May	0/1000	1.32/1000	35	0	217
June	0/1000	1.32/1000	73	0	290
3rd Quarter					
July	0/1000	1.32/1000		0	
August	0/1000	1.32/1000		0	
September	0/1000	1.32/1000		0	
4th Quarter					
October	0/1000	1.32/1000		0	
November	0/1000	1.32/1000		0	
December	0/1000	1.32/1000		0	

Indicator 1: CLABSI Rate at KDMC NICU

Benchmark Source: NHSN/CDC 2012 NICU Level II/III

Level of benchmark: 1.32/1000 patient days. Pooled mean all weights

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

2. *KD NICU VAP- No VAP in the NICU. 53 vent days in this reporting timeframe.* ***Goal met***

	VAP Rate NICU 2022		
1st Quarter	Indicator Value	Benchmark Value	Vent Days
January	0	1.15/1000	0
February	0	1.15/1000	9
March	0	1.15/1000	5
2nd Quarter			
April	0	1.15/1000	21
May	0	1.15/1000	11
June	0	1.15/1000	7
3rd Quarter			
July	0	1.15/1000	
August	0	1.15/1000	
September		1.15/1000	
4th Quarter			
October	0	1.15/1000	
November	0	1.15/1000	
December	0	1.15/1000	
			Total Vent days for the Year- 53

Indicatory 1: VAP Rate at KDMC NICU

Benchmark Source: NHSN 2012 Pooled mean of all weight groups

Level of Benchmark: 1.15/1000 patient days. NICU Level II/III

3. *Monthly Hand Hygiene Opportunities > 96%- Over all Hand Hygiene date for the given reporting timeframe-97.08%.* ***Goal met***

BIOVIGIL®
Kaweah Health

Compliance by Month
1/1/2022 1:00:00 AM (-07:00) - 6/30/2022 (-07:00)

Month	Total Compliant (HHO)	Total Non Compliant (HHO)	Total (HHO)	Entry Compliance	Exit Compliance	Total Compliance
June 2022	1,123,777	39,800	1,163,577	95.50%	97.58%	96.58%
May 2022	1,169,107	32,952	1,202,059	96.34%	98.10%	97.26%
April 2022	1,295,994	36,144	1,332,138	96.42%	98.09%	97.29%
March 2022	877,566	24,697	902,263	96.33%	98.13%	97.26%
February 2022	664,879	20,409	685,288	95.98%	97.99%	97.02%
January 2022	669,739	20,714	690,453	95.96%	97.97%	97.00%
Total	5,801,062	174,716	5,975,778	96.11%	97.97%	97.08%

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

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

1. *Continue to participate in CLABSI collaborative. Maintain central line bundle. Report findings to CPQCC. Daily GEMBA rounding on all central lines.*
2. *NICU VAP policy and bundle in place.*
3. *Soap and water as well as hand sanitizer available in every patient room. Continue to monitor compliance beyond reporting requirements. Continue to monitor success and opportunities with Biovigil data.*

Next Steps/Recommendations/Outcomes:

1. *Continue with current standardized insertion practice and care of all central lines.*
2. *No VAP. Benchmark met; continue to support current P&P.*
3. *Continue to monitor HH compliance through Biovigil.*

Submitted by Name:
Felicia T. Vaughn

Date Submitted:
July 11th, 2022

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

Quality Improvement Committee

Unit/Department: HAPI QFT & Inpatient Wound Prevention **Report Date:** July 2022

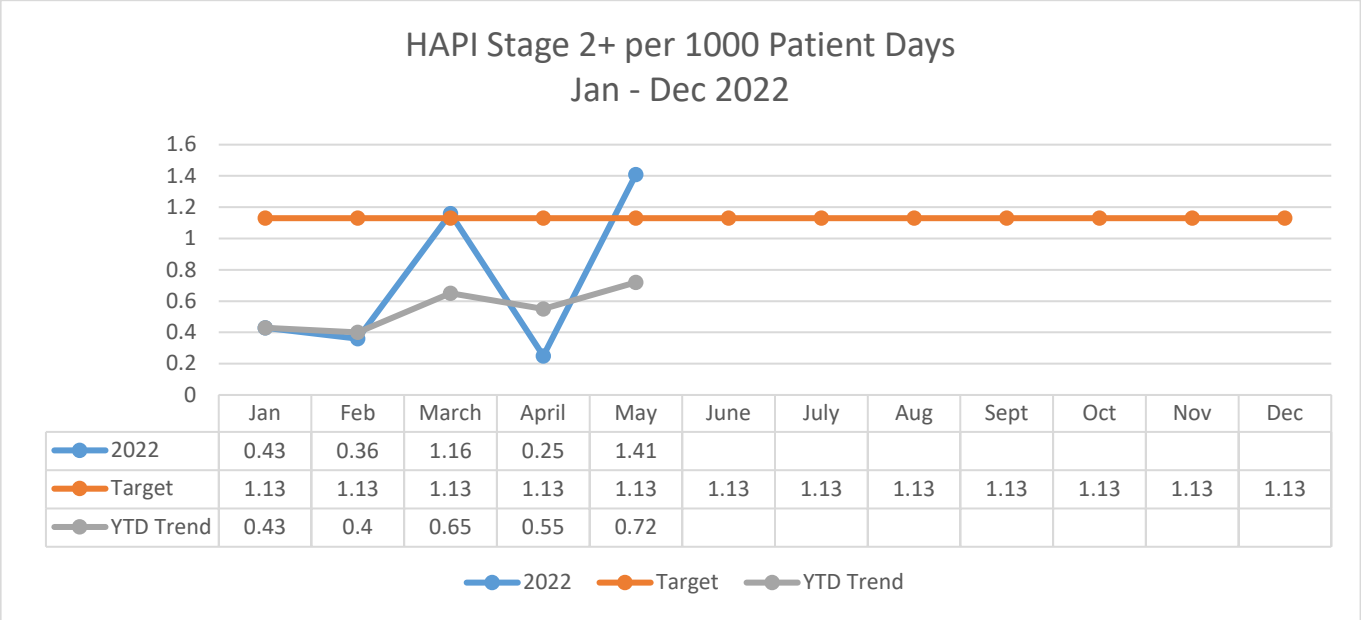
Measure Objective / Goal:

Hospital Acquired Pressure Injuries (HAPI), Total and Device-Related
Incidence data compiled from staff/unit-level self-report, with and without prompting from wound nurse consultant. Includes Stage 1-4, unstageable, suspected deep tissue pressure injury (DTPI).

Indicator #1 HAPI Stage 2+ per 1000 Patient Days

Goal 1.13 (-10% from 2021)

Date Range March 2022 – May 2022



	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
2022	0.43	0.36	1.16	0.25	1.41							
Target	1.13	1.13	1.13	1.13	1.13	1.13	1.13	1.13	1.13	1.13	1.13	1.13
YTD Trend	0.43	0.4	0.65	0.55	0.72							

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

- ✓ **Goal #1** Met: Met for Months of March (1.16), and April (.25), but not for May (1.41)
- ✓ Met: Cumulative YTD below target (.72)

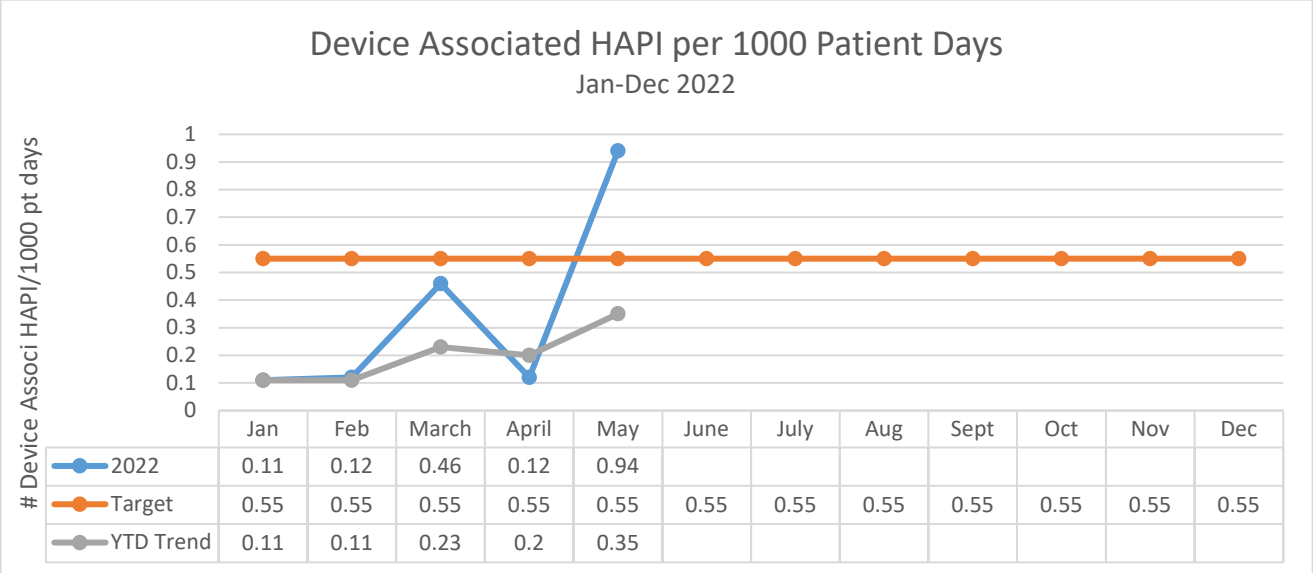
HAPIs have been below or at our targeted benchmark up until May 2022 for 10 months straight. Unfortunately, our YTD trend is trending up instead of down. Wound care are regularly attending PCM and NPC meetings quarterly to share wound care education and latest products and methods with the managers and NPC teams. CSI meetings were restarted in March 2022 and continue to run smoothly. We are now to the point where there are only 1-2 reviews needed every 2 weeks and are able to handle many of those with a quick phone call to the managers to evaluate the reviews. Takeaways are then sent out to the nursing Managers to share with their teams. We have added a wound care test and booth to our competency fair line up. So all bedside care staff will be required to take the wound

care module test this month and will then attend the wound care booth to show competency during the in person fair later this year.

Indicator #2 Device Associated HAPI per 1000 Patient Days

Goal 0.55 (-10% from 2021)

Date Range March 2022 – May 2022



	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
2022	0.11	0.12	0.46	0.12	0.94							
Target	0.55	0.55	0.55	0.55	0.55	0.55	0.55	0.55	0.55	0.55	0.55	0.55
YTD Trend	0.11	0.11	0.23	0.2	0.35							

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

- ✓ **Goal #1** Met: Met for Months of Mar (.46), April (.12) and NOT Met in May (.94)
- ✓ Met: Cumulative YTD below target (0.11)

Device related HAPIs are also trending in the same fashion as HAPIs. This month saw an increase over baseline for the first time in 10 months. See notes above about similar interventions for device related HAPIs. ICU has designed a Skin/Wound resource RN for both AM and PM shifts. GEMBA rounds continue to discuss wound care issues for each patient with lines on all critical care floors.

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

2022 Stage 2+ HAPI QFT Dashboard

Measure Description Outcome Measures	2022 Benchmark/ Target	2019 Baseline	2020 Baseline	2021 Baseline	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD 2022
HAPI Stage 2+ per 1,000 pt days (all HAPIs)	1.13 (-10% from 2021)	1.64	1.61	1.26	0.43	0.36	1.16	0.25	1.41								0.72
Device Associated HAPI per 1,000 pt days	0.55 (-10% from 2021)	0.74	0.72	0.61	0.11	0.12	0.46	0.12	0.94								0.35
PSI 3 - Claims-based HAPI Stage 3, 4, and Unstageable per 1,000 discharges	**0.6** - Hospital Compare (Q3 2017-Q2 2019) **0.35** - Midas 50th Percentile (2019)	0.79	0.95	1.42	0.00	0.00	0.00	1.16	0								0.22
Process Measures	(-10% from 2021)	2019	2020	2021	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD 2022
Respiratory Device associated HAPI per 1,000 pt days	0.36		0.44	0.40	0.11	0.00	0.00	0.00	0.24								0.07
% of Respiratory Device associated HAPI's (out of all of the device associated HAPI's)	58%		61%	65%	100%	0%	0%	0%	25%								20%
Unit Level	(-10% from 2021)	2019	2020	2021	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD 2022
4N - HAPI 2+ per 1,000 pt days	1.09	1.34	2.02	1.22	0.00	1.28	0.00	0.00	0.00								0.24
3W - HAPI 2+ per 1,000 pt days	2.29	2.26	3.2	2.55	0.00	0.00	0.00	0.00	0.00								0.00
ICU - HAPI 2+ per 1,000 pt days	3.72	7.1	7.44	4.14	0.00	0.00	3.98	0.00	0.00								0.83
CVICU - HAPI 2+ per 1,000 pt days	3.87	5.2	6.23	4.31	5.68	0.00	2.78	3.55	0.00								2.49
2N - HAPI 2+ per 1,000 pt days	0.63	0.1	0.22	0.71	0.00	0.00	1.15	0.00	0.00								0.23
2S - HAPI 2+ per 1,000 pt days	0.81	0.7	1.51	0.90	0.00	0.00	0.00	0.00	0.00								0.00
3N - HAPI 2+ per 1,000 pt days	0.99	0.86	0.72	1.11	0.00	0.00	0.00	0.00	6.92								1.41
3S - HAPI 2+ per 1,000 pt days	0.08	0.46	0.5	0.09	0.00	0.00	0.00	0.00	0.00								0.00
4S - HAPI 2+ per 1,000 pt days	1.03	1.37	0.66	1.15	1.96	0.00	2.02	0.00	3.33								1.47
4T - HAPI 2+ per 1,000 pt days	0.25	1.23	0.45	0.28	0.00	1.65	0.00	0.00	3.38								0.98
BP - HAPI 2+ per 1,000 pt days	0	0	0.62	0	0.00	0.00	0.00	0.00	0.00								0.00
Rehab - HAPI 2+ per 1,000 pt days	0.14	0.75	0.00	0.16	0.00	2.38	0.00	2.11	0.00								0.83
5T - HAPI 2+ per 1,000 pt days	1.31		0.4	1.46	0.00	0.00	5.35	0.00	0.00								1.06
Other Units	2022 Benchmark/ Target	2019	2020	2021	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD 2022
ED	n/a	4	3	0	0	0	0	0	0								0
Sub-Acute	n/a	5	6	5	0	0	0	0	0								0
Surgery	n/a	6	0	0	0	0	0	0	0								0
Cath Lab	n/a	1	0	0	0	0	0	0	0								0
Pediatrics	n/a	0	0	2	0	0	0	0	0								0
Mother Baby	n/a	1	0	0	0	0	0	0	0								0
Transitional Care (South Campus)	n/a	1	1	1	0	0	0	0	0								0
Short Stay (Rehab)	n/a	0	0	3	0	0	0	0	0								0

Meeting or Better than Target

Does not meet Target

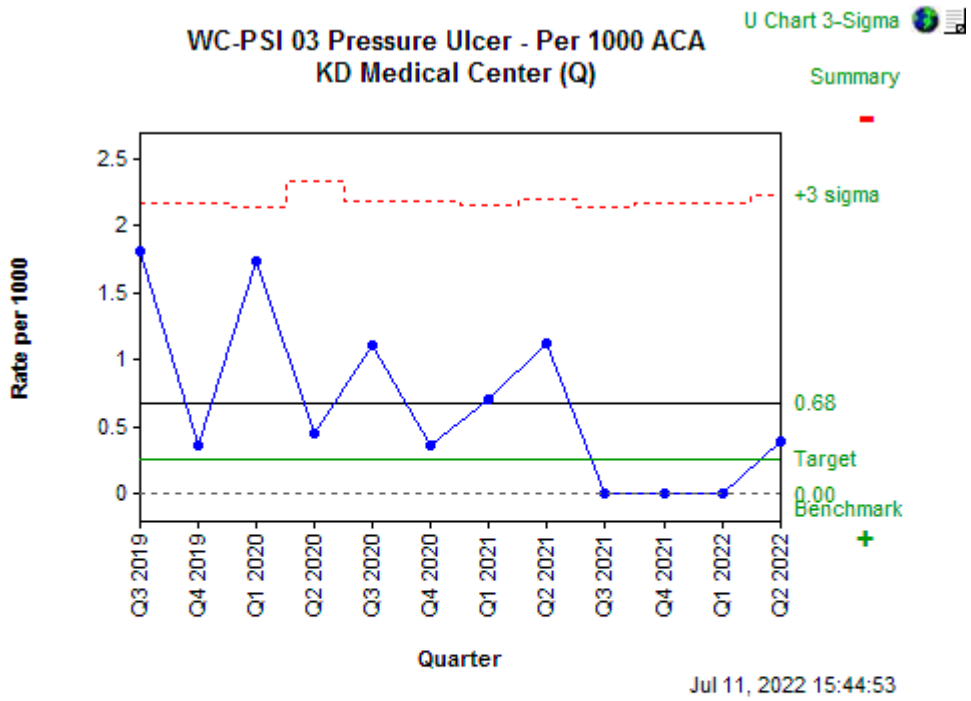
PSI 03: Pressure Ulcer Rate

Pressure ulcers have been associated with an extended length of hospitalization, sepsis, and mortality. The Agency for Healthcare Research an Quality (AHRQ) developed measures that health providers use to identify potential in-hospital patient safety problems for targeted institution-level quality improvement efforts. Patient Safety Indicator (PSI) 03 includes stage 3 or 4 pressure ulcers or unstageable (secondary diagnosis) per 1000 discharges among surgical or medical patients ages 18 years and older. *Exclusions: stays less than 3 days; cases with principal stage 3 or 4 (or unstageable) pressure ulcer diagnosis; cases with a secondary diagnosis of stage 3 or 4 pressure ulcer (or unstageable) that is present on admission; obstetric cases; severe burns; exfoliative skin disorders.*

Indicator #3 PSI-03 Claim-based HAPI Stage 3, 4, Unstageable per 1000 discharges

Goal 0.26 (Hospital Compare)

Date Range Q1 2022 – Q2 2022



Quarter	Numerator	Denominator	Rate per 1000	Benchmark
Q2 2022	1	2525.00	0.40	0
Q1 2022	0	2764.00	0.00	0

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

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

- ✓ **Goal #3 Not** Met for Quarter 2 2022 (1)

We had one PSI 3 this quarter in May 2022. PI reviewed the data and it appears that even though this falls into the criteria for PSI 3, it was due to skin failure which should take it out as a true PSI 3. It was sent back to CMS for a second level review to determine if this truly should count as a PSI. More information to come once we hear back on this review.

Improvement Opportunities Identified, Action Plan and Expected Resolution Date / Next Steps, Recommendations, Outcomes:

Ongoing

- ✓ CSI reconvened in March 2022. Floors have continued to complete Root Cause Analysis audits for each identified wound and encouraged to bring their staff. Managers continue to prioritize these evaluations and participation is good.

- ✓ Continued development Skin/Wound Resource Nurse (SWRN) criteria for the floors. Managers have requested they utilize their charge nurses for this role. Continued work to determine tracking, attendance and ongoing development of this role with the wound care team.

- ✓ Wound care classes changed to quarterly.

- ✓ Mandatory yearly competency added specifically for wound care to both the online learning modules as well as in the fall for the in person competency fair.

Work in Progress

- ☐ It was determined by the HAPI QFT committee that we will hold the 5-day Kaizen until our traveler numbers decrease across the hospital due to rapid turnover of staff.

Submitted By: **Date Submitted:** July 11, 2022

Rebekah Foster, Director of Care Management and Specialty Care

Handoff

Date: 6/13/22

For Presentation To: Quality Improvement Committee (QIC)

Project Leader: Kassie Waters

Facilitator: Cindy Vander Schuur

Situation

During Greeley mock survey (April 4-6, 2022) There were several instances in which staff were asked to discuss handoff communication for unit-to-unit transfers. Currently, there is no standardize SBAR process consistently used.

Background

1. A Sentinel Event Alert (SEA) was issued by The Joint Commission (TJC) September 2017. Following a review of internal event reporting data and a gap analysis was conducted based on the recommendations by TJC in the SEA. The gap analysis indicated that Kaweah Health at the time had several opportunities in adequately addressing TJCs recommendations and improving the handoff process. Gaps included:
    a. No institutional approach to handoff that identifies/defines critical content of the handoff.
    b. Utilize/enhance handoff with EMR capabilities (cerner implementing at the time)
    c. Measure and monitor use of standardized handoff forms and impact of poor handoff
2. As a result a Quality Focus Team (QFT) was established by our Executive Team and Quality Council (QC) in 2018 to address these gaps. Baseline data was collected using TJC survey tool. Measures included the “defective” rate of handoff as reported by the handoff receiver and sender. Kaweah Health “defective” handoff rate was significantly higher (lower is better) than the comparative from TJC (data included in table 1 below)
3. Since 2018 leadership over the project has switch several times, but the goals remained continuous and efforts put forth to continue to standardized handoff to reduce the defective rate and decrease reported events related to. The team continues to report into QC quarterly.
4. In Aug 2018, post Cerner implementation, the QFT completed an RN survey on use of the Cerner handoff tool. Consistent use of the handoff tool was 42% (results are in table 2)

5. In 2019 there were 65 Midas events reports submitted under Handoff event type, 14 of which resulted in some level of harm to patients

Table 1 – Baseline Handoff Data 2018

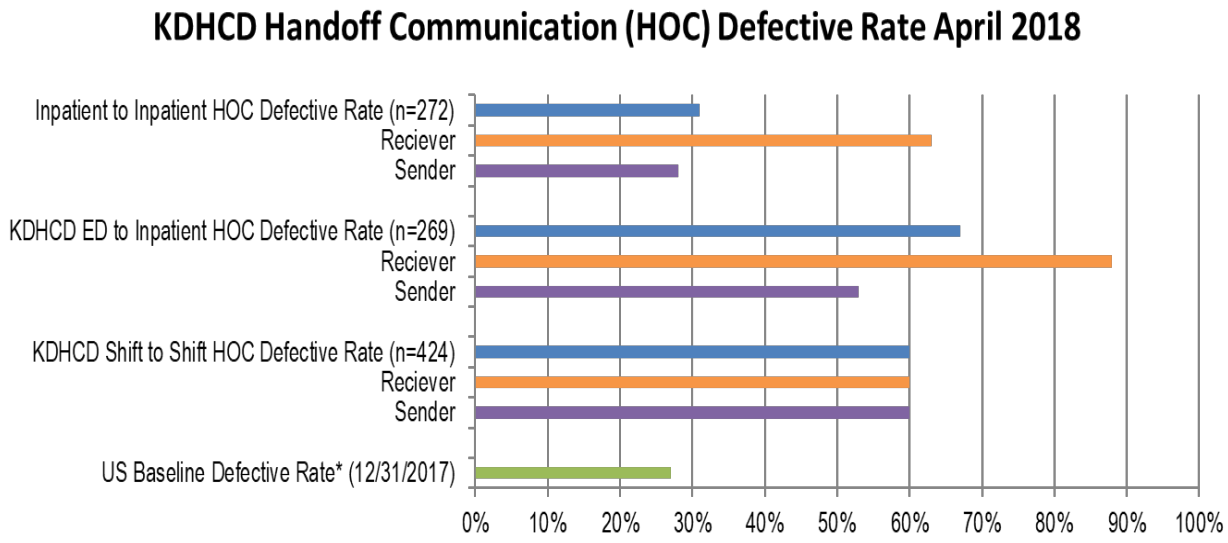


Table 2 – QFT Survey of Use of Cerner Handoff Tool

Handoff Communication Pre QFT – September 2018
Results of Handoff Survey (staff surveyed August 2018)

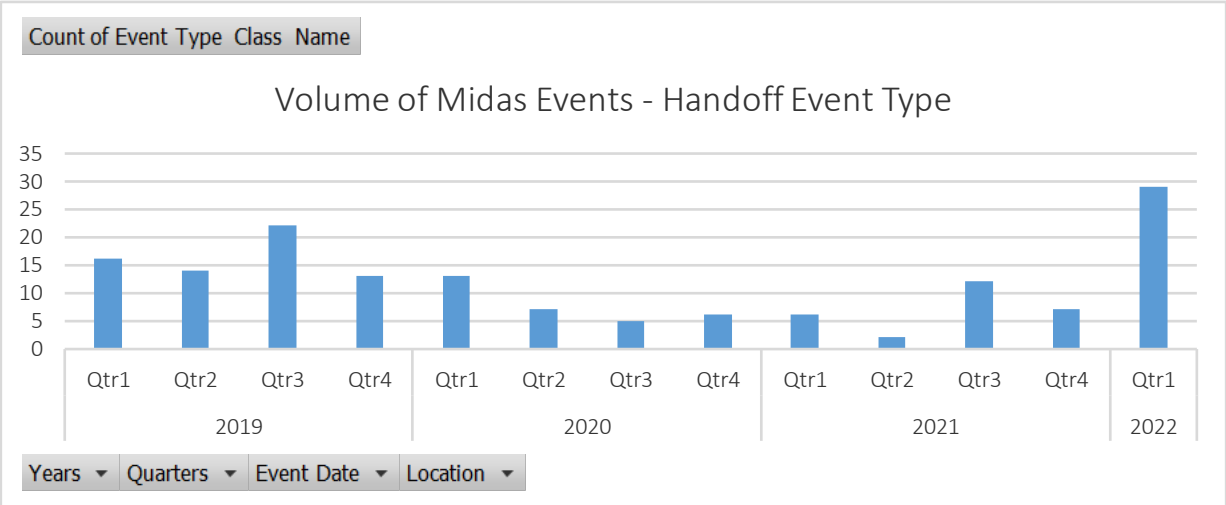
Do you use the Cerner Handoff Communication Tool during shift to shift report and transferring patients in/out of your department?

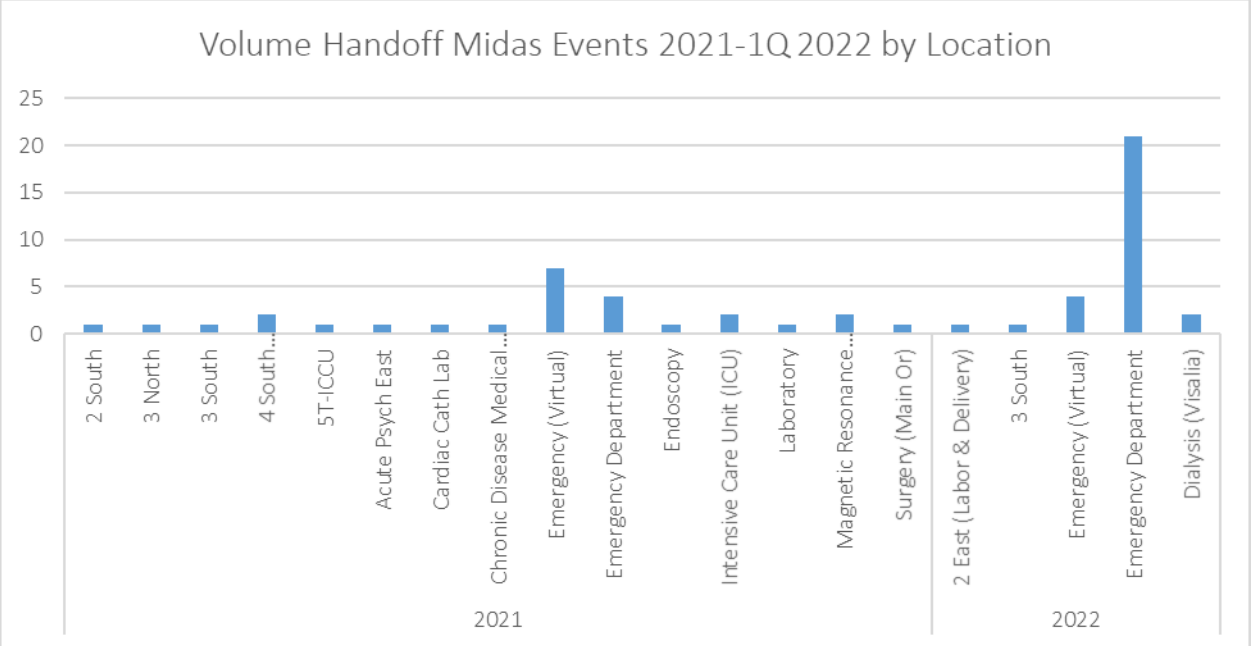
Yes	No	Sometimes	Total
80	74	38	192
42%	39%	20%	100%

Analysis

1. The defective rate or the use of Cerner tools has not been remeasured broadly since 2018.
2. Midas event report data from 2019-1Q 2022 indicates decreasing events submitted in 2020 through 2Q 2021 compared to 2019. However increasing events starting 3Q21 through 1Q22. An overall decrease in event reports was noted overall during 2020 due to decrease volumes at the start of the pandemic. Also, several event reports were submitted for the 1E location in 1Q 22 once new leadership was established for that location as a way to measure/track & trend handoff events for awareness of the issue

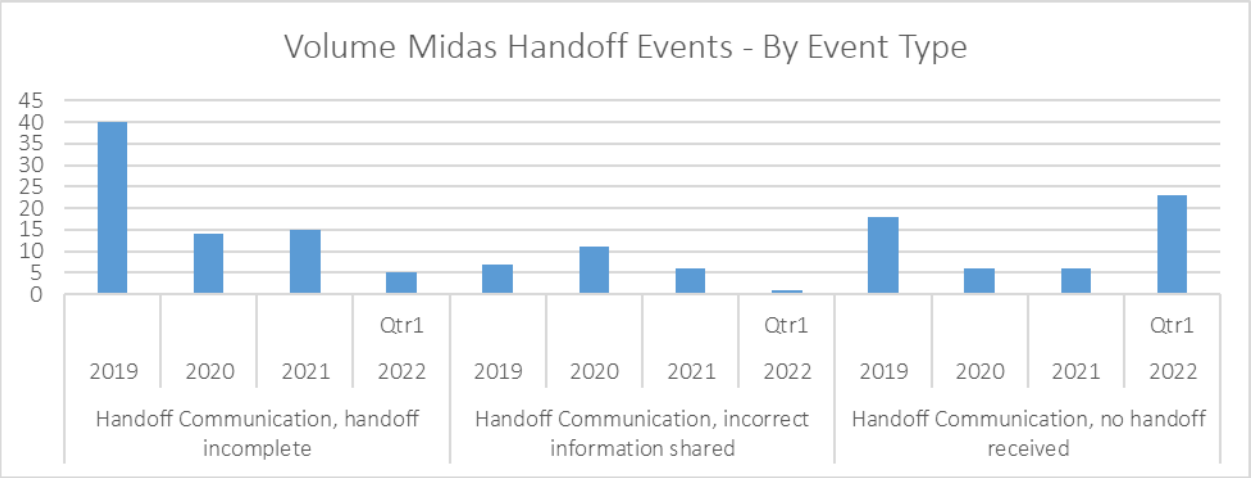
and to help direct future improvement efforts. 23/29 Handoff Midas events in 1Q 2022 were categorized under “no handoff received” event type.





Count of Significance	Column Labels				
Row Labels	2019	2020	2021	1Q 2022	Grand Total
E-Medication Event, Causing Temporary Harm & Intervention	1				1
Near Miss Safety Event, Early Barrier Catch	4	1	1	1	7
Near Miss Safety Event, Last Strong Barrier Catch	1		3	2	6
Near Miss Safety Event, Unplanned Catch	7	1	1		9
Not a Safety Event	2			1	3
Precursor Safety Event, Minimal Temporary Harm	3	2	3	1	9
Precursor Safety Event, No Detectable Harm	24	19	14	11	68

Precursor Safety Event, No Harm	12	5	5	12	34
Serious Safety Event, Moderate Temporary Harm	9	3		1	13
Serious Safety Event, Severe Permanent Harm	1				1
Serious Safety Event, Severe Temporary Harm	1				1
Grand Total	65	31	27	29	152



Recommended Next Steps

Who Is Recommending	What (Action/IOU)	When Due (Status)	Action Responsibility
Interim Process			
Kassie Waters & Michelle Peterson	ED & acute care units will utilize SBAR (Situation, Background, Assessment, and Recommendation) handoff tool until Cerner tool is completed. ED educator will provide education for all staff and include tool on-boarding new employees. • Added risk assessments to tool. • ED also making condense flyers to post in key areas where handoff occurs. House wide SBAR tool was sent out via Essential Information to Know with generic form to use.	ED - July 2022 8/1/22	Kassie Waters & Michelle Peterson Kassie Waters & Lacey Jensen

Who Is Recommending	What (Action/IOU)	When Due (Status)	Action Responsibility
Long Term Process – Cerner Electronic Handoff Tool			
Kassie Waters/ Handoff QFT	• ISS presented New Cerner Handoff best practices. Presented tool to key stakeholders. • Surgery & Cath Lab – will use current tool until OR elements can be added. • ED – Good to go with EMR tool. • Peds – Likes EMR tool but need peds elements to be built in. • Mental Health – pending. • Sub-acute/Rehab – go live in Oct or Nov with ECD build • Mother/Baby – good process just need titles of SBAR placed into it.	Complete 8/8/22 8/11/22 8/8/22 8/16/22 Pending Pending	Kassie Waters & Leah Daugherty
Kassie Waters/ Handoff QFT	• Finalize and build handoff tool	8/22/2022	Leah Daugherty & Kim Roller
Kassie Waters/ Handoff QFT	Go-Live • Rollout and educate staff. Aug-Sept (will review best time for education with Directors) ○ Via mandatory classroom teaching of the EMR. ○ Video showing poor and well done handoff using the EMR tool.	Aug-Sept 2022	Kassie Waters, Lacey Jensen, & Leah Daugherty
Kassie Waters/ Handoff QFT	• Re-evaluate tool	Oct-Nov 2022	Kassie Waters

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: Kaweah Health – Diversion Prevention Committee

ProStaff/QIC Report Date: 8/22/2022

Measure Objective/Goal:

The Diversion Prevention Committee Goals include:

- Develop an organizational program to build awareness of and response to behaviors suspicious for drug diversion.
- Build a culture within the organization of attention to drug diversion prevention.
- Implement education with orientation and annual training related to awareness of and response to drug diversion for all staff and providers.
- Ensure continued awareness and knowledge of diversion prevention strategies at all levels of the healthcare team including non-patient care areas.
- Develop a Leadership training program to provide enhanced skills for detecting and preventing diversion activities.
- Ensure accountability for action items related to routine audits and medication related reports by department leaders.
- Use of technology and automation to ensure audits and reporting are routine and applicable.
- Communicate noted trends identified through Pharmacy audits such as Bluesight, Pyxis overrides, etc. or the occurrence reporting system to department leaders.
- Monitor all active audits outlined in the CMS diversion plan of correction until compliance is met and audits are closed.

The Diversion Prevention Committees Measures of Success include:

- All existing District staff will complete the appropriate MAT training module regarding diversion prevention topics with at least 90% compliance each quarter.
- All new hire District staff will complete orientation education regarding diversion prevention topics with at least 90% compliance each quarter.
- Committee members to verify efficacy of ongoing diversion prevention education by conducting 15 or more interviews each of varied District staff, residents, and medical staff each quarter with at least 90% answering 4/4 questions correctly.
- Provide education to the Leadership group at least once per quarter to provide enhanced knowledge and skills for detecting and preventing diversion activities.
- Monthly review of audit dashboard reveals improvements in audit outcomes.

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

Date range of data evaluated: Mar - Jul 2022

The Diversion Prevention Committee was formed in April 2021 in response to a recognized need for education and monitoring after two unrelated diversion events were identified within the organization. The initial goals are to increase awareness of the risk of diversion in the health care setting and increase knowledge of the signs and symptoms of diversion.

From March - July 2022 the following goals were achieved:

Diversion Prevention Awareness Mandatory Education (Ongoing):

- Diversion Prevention Strategies Education (ongoing) – All Employees:
  - **Goal Met** - April 2022: 99.81% of existing District staff completed the appropriate MAT I training module.
    Goal: At least 90% compliance this quarter.
  - **Goal Met** - April 2022: 99.75 % of new hire District staff completed the appropriate MAT I training module on diversion awareness, prevention, signs and symptoms of abuse and diversion and expectations of all team members diversion prevention topics. *Goal: At least 90% compliance this quarter.*
  - **Goal Met** - April - June 2022: 92% of existing District staff and providers (varied roles of District staff, residents, and medical staff) answered 4/4 questions correctly during 148 interviews conducted by DPC members.
    Goal: At least 90% compliance this quarter.
- Leadership Awareness Education (ongoing):
  - **Goal Met** - July 2022: District Leadership was provided ongoing education of diversion recognition via educational memes.
  - **Goal Met** - Beginning August 2022 - 1:1 education with each KHMC clinical manager and director of Bluesight data and IRIS score analytics provided by Medication Safety Specialist RN and Controlled Medication Coordinator.

Pharmacy-Related Monitoring:

- Pharmacy continues to monitor on a monthly basis the following with reduced sample size and bring to DPC should new trends arise. None noted for this time period.
  - Diversion 6 - Monitoring of Diluted Controlled Substance and Fentanyl Waste
  - Diversion 11 – Short Case Reviews

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

All goals met this quarter. No new Pharmacy-related trends or concerns noted this quarter.

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

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

The purpose of the Diversion Prevention Committee is to identify opportunities and create action items on an ongoing basis.

At this time, the improvement opportunity continues to be to raise awareness and increase knowledge of the identification and risks of diversion for all staff and providers at KDHCD using creative and varied methods in addition to computer-based learning. Interviews of staff and leaders by Committee members will continue on a quarterly basis to monitor learning retention and effectiveness of ongoing education. This will allow the Committee to identify existing gaps and associated actions. Education will be changed or reinforced based on those findings.

Review of Pharmacy-related internal audits such as Bluesight analytics and IRIS score review as well as monitoring of occurrence reports and employee behavior concerns will also steer the Committee's continued efforts to educate, inform and monitor diversion-related activities to prevent the diversion of medications in the health care setting.

Next Steps/Recommendations/Outcomes:

Continue to monitor the effectiveness of the education through staff, provider and leader interviews by Committee members.

Create additional education as needed based on interviews, audits and occurrence reports.

Continue to monitor potential diversion-related events and increase surveillance by organizational staff and providers.

Modify existing goals within the Diversion Prevention Committee to meet the identified needs and opportunities for growth within the organization.

Incorporate Substance Abuse awareness and actions into the scope of the committee to support our teams.

Submitted by:
Shannon Cauthen, Co-Chair – Director of Critical Care Services
Evelyn McEntire, Co-Chair – Director of Risk Management

Date Submitted:
August 22, 2022

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

Best Practice Team Update

Michael Tedaldi, MD - Kaweah Health Medical Director of Best Practice Teams
Sandy Volchko, Director of Quality & Patient Safety
Wendy Jones, Director of Respiratory Services
Molly Niederreiter, Director of Rehabilitation Services
Emma Mozier, Director of Medical-Surgical
Christine Aleman, Director of Cardiovascular Operations

September 2022

Kaweah Health Best Practice Teams Acronyms

Best Practice Teams
evidence based practices
for world-class patient care

- ACE - Angiotensin Converting Enzyme inhibitors(medication to treat heart failure)
- ARBs - Angiotensin-Receptor Blocker (medication to treat heart failure)
- ARNI - Angiotensin Receptor-Neprilysin Inhibitor (medication to treat heart failure)
- AMI NSTEMI – Non-ST Elevation Acute Myocardial Infarction
- BB – Beta Blocker (heart medication)
- CAP – Community Acquired Pneumonia
- CHFrEF (“reduced EF” or “systolic HF”)
- CKD – Chronic Kidney Disease
- CMS - Centers for Medicare & Medicaid Services
- COPD - Chronic Obstructive Pulmonary Disease
- CPG – Clinical Practice Guideline
- CPW – Care Pathway
- D - denominator
- ED – Emergency Department
- EF – Ejection Fraction
- EKG - electrocardiogram
- FYTD – Fiscal Year to Date
- GFR - glomerular filtration rate
- GOLD Standards - Global Initiative for Chronic Obstructive Lung Disease
- HF – Heart Failure
- KPI – Key Performance Indicator
- LOS – Length of stay
- N - Numerator
- O/E – Observed divided by Expected
- PN – Pneumonia
- QI - Quality Improvement
- SARA - Selective Aldosterone Receptor Antagonist

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

Best Practice Teams

AMI (non-STEMI), COPD, Heart Failure & Pneumonia

Initiation

- Prioritized & staggered
- Team identification: Q&P/S Facilitator, MD Champion, RN Director, process stakeholders
- Best Practice Guideline selection

Goal: Identify clinical processes that will yield optimal patient outcomes

Phase I

- Clinical KPIs Selection
- Measures defined
- Dashboard developed
- Initial QI work (ie. power plan optimization/ work flow) to achieve targets

Goal: Identify KPIs that will reduce mortality o/e & complications (2° LOS & Readmission)

Phase II

- Care Pathway developed
- Integrated into Cerner power plans & workflow
- QI Measures added to dashboard
- QI work to achieve targets

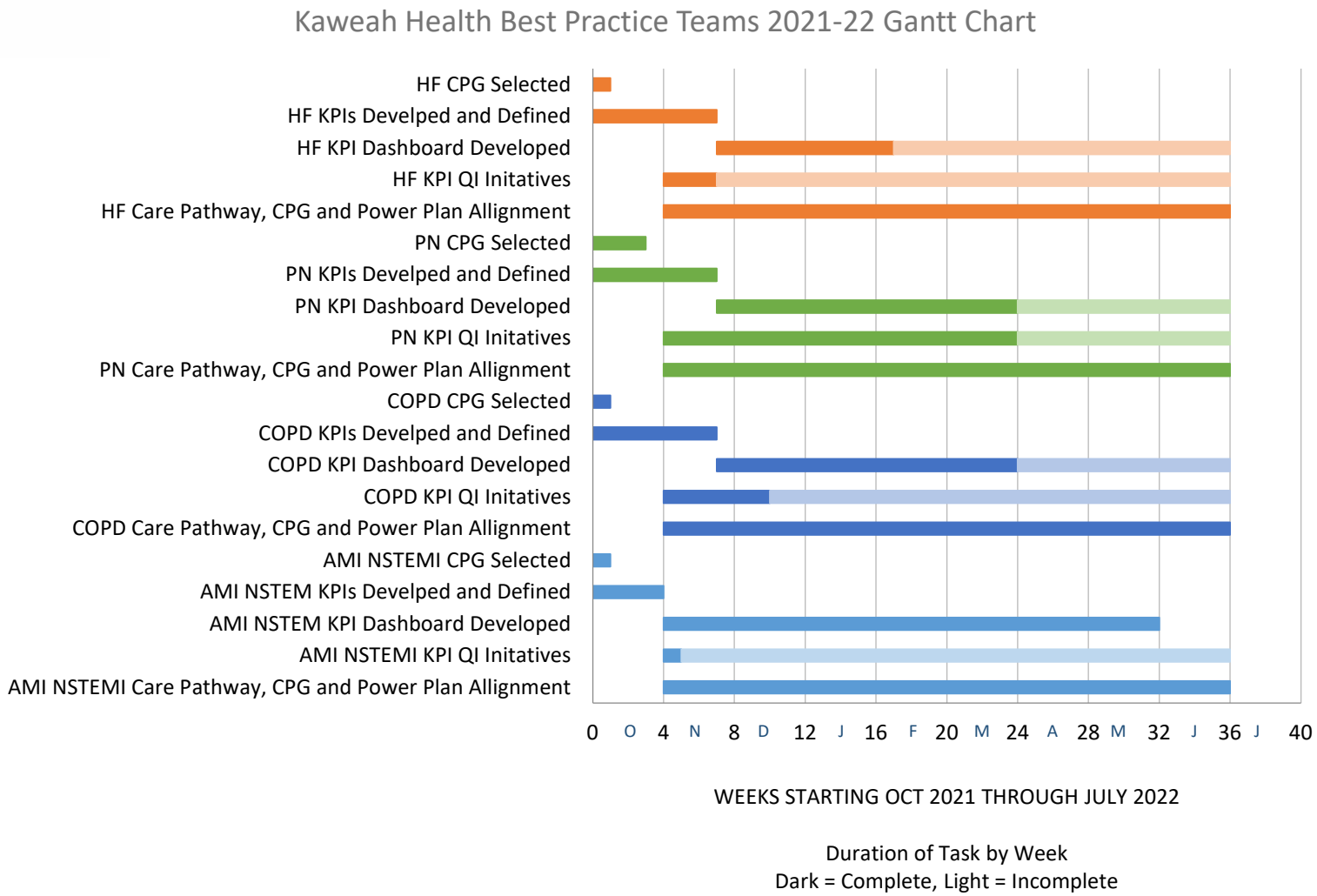
Goal: Improve efficiency and further reductions in LOS, mortality o/e & readmission

Best Practice Teams

evidence based practices for world-class patient care

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), Clinical Educator
- Outcomes include: Mortality, Readmission and Length of Stay
- Key Performance Indicators (KPIs) defined, dashboards in development and QI work underway!!



Outcome Data

Best Practice Teams
evidence based practices
for world-class patient care

Kaweah Health Best Practice Teams Outcome Dashboard FY 2022

	Goal (reduction from 2019 baseline)	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

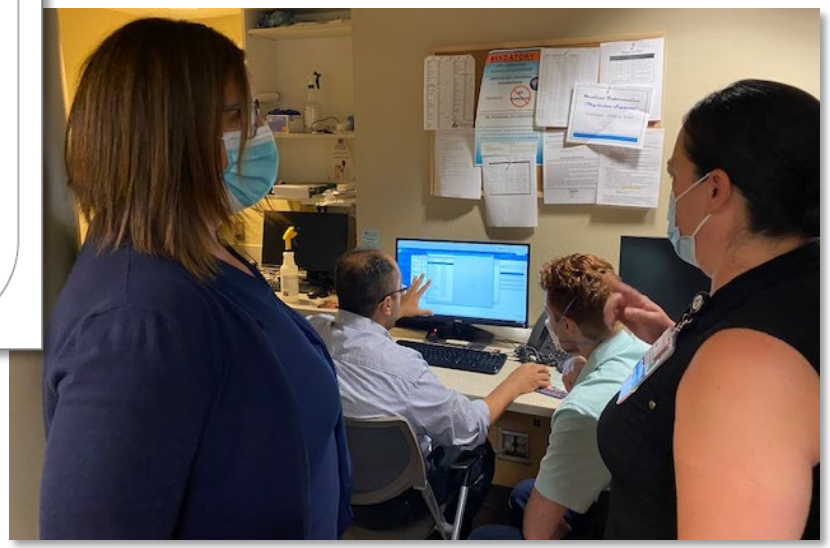
Best Practice Teams

evidence based practices
for world-class patient care

Best Practice Team Hospitalist Event

August 13 & 20

- Strategy to address power plan utilization and improve KPIs - Awareness of new power plans available with evidenced based care options
- All power plan changes on display and for active discussion and feedback from hospitalists
- Encourage and assist in switching favorites to new power plan



Team Charter

Pneumonia (PN)

Key Initiatives August 2022

- Dashboard under development
- CPGs and order set(s) reviewed for alignment
- Optimizing implementation of a Pneumonia Severity Index (PSI) tool
- Order set revisions to operationalize best practices NOW LIVE including: ED Sepsis order set (used for severe PN, Antibiotic selection, inclusion of PSI tool to direct Antibiotic type and level of care) MED Pneumonia Admission order set (for transition of IV to PO (by mouth) Antibiotic.

PROJECT NAME: Pneumonia BPT	CHAMPION: Dr. M. Tedaldi	QI Facilitator: Lorena Domenech
DIRECTOR: Molly Niederreiter	APN: Alisha Sandidge	ET SPONSOR: Keri Noeske

PROBLEM STATEMENT:
Mortality, readmission and LOS data indicates opportunity in standardizing care and reducing variation through clinical practice guideline and care pathway implementation.

SHORT TERM PROJECT GOALS:

1. Select clinical practice guidelines (CPGs) COMPLETE
2. Develop Key Performance Indicators (KPIs) COMPLETE
3. Develop dashboards for outcome and KPIs IN PROCESS
4. improve KPI performance IN PROCESS

LONG TERM PROJECT GOALS:

1. Reduce mortality by 20% from 2019 baseline
2. Reduce readmissions by 20% from 2019 baseline
3. Reduce Length of Stay

SCOPE: (WHAT DOES THIS INCLUDE AND NOT INCLUDE?) Includes CAP patients in Emergency Department and admitted into the Medical Center

FINANCIAL IMPLICATIONS:
Penalties associated with the CMS Value-Based Purchasing Program (mortality), penalties associated with CMS Readmission Reduction Program & reputational costs with CMS star ratings.

MEASURES:
KPIs (in order of priority)

1. ED Sepsis power plan Utilization
   N:Patients with dx CAP/suspected Pneumonia & ED Sepsis power plan used
   D: Patients with ED diagnosis of Community Acquired Pneumonia/suspected pneumonia
2. First dose of antibiotic administered within 3 hours of suspected or confirmed diagnosis
   N: Patients who received antibiotic within 3 hours of suspected or confirmed diagnosis
   D: All patients admitted with CAP
3. Pneumonia admission power plan Utilization In patients
   N: Patients with power plan ordered
   D: All patients admitted with CAP
4. Switch from IV to PO antibiotics within 48 hours of first antibiotic treatment
   N: number of patients transitioned from IV to PO within 48 hours
   D: All admitted patients with CAP
5. Rate of documented Pneumonia Severity Index (PSI)
   N: Patients with a documented PSI score in the Emergency Department
   D: Patients with diagnosis of Community Acquired Pneumonia/ suspected pneumonia in ED

Future KPIS

- Documentation of Clinical Stability Tool

N:Number of patients who had a completed Clinical Stability Tool
D: The number of patients on med surge with CAP diagnosis

Initiation	Team identification and guideline selection
Phase I	Key Performance Indicator selection, plan and initiate QI activities to achieve KPI goals
Phase II	Development/revision of care pathway, measure expansion, dashboard development

Team Charter

Heart Failure (HF)

Key Initiatives August 2022

- Dashboard under development
- CPGs and order set(s) reviewed for alignment
- HF Order set revisions now live operationalize best practices including: addition of medication options with specific evidenced-based parameters (ie. Aldactone, Hydralazine, Entresto

Next steps:

- Order set approved, working on increasing use
- Working with Population Health on frequently admitted patients
- Evaluating insurance coverage for key medication treatment (ie. Entresto) and communicating with providers

PROJECT NAME: Heart Failure	CHAMPION: Dr. M. Tedaldi	QI Facilitator: Lorena Domenech
DIRECTOR: Emma Mozier	APN: Craig Dixon	ET SPONSOR: Keri Noeske

PROBLEM STATEMENT:
Mortality, readmission and LOS data indicates opportunity in standardizing care and reducing variation through clinical practice guideline and care pathway implementation.

PROJECT GOAL:

1. Select clinical practice guidelines (CPGs)
COMPLETE
2. Develop Key Performance Indicators (KPIs)
COMPLETE
3. Develop dashboards for outcome and KPIs
IN PROCESS
4. improve KPI performance
IN PROCESS

LONG TERM PROJECT GOALS:

1. Reduce mortality by 20% from 2019 baseline
2. Reduce readmissions by 20% from 2019 baseline
3. Reduce Length of Stay

SCOPE: (WHAT DOES THIS INCLUDE AND NOT INCLUDE?) Medical Center processes

FINANCIAL IMPLICATIONS:
Penalties associated with the CMS Value-Based Purchasing Program (mortality), penalties associated with CMS Readmission Reduction Program & reputational costs with CMS star ratings.

MEASURES:
KPIs (in order of priority)

1. What percentage of patients with Systolic Heart Failure (EF <40%) are discharged on correct BB, ACE/ARB/ARNI/SARA
    1b. contraindications to (goal directed) med therapy documented appropriately? I.E Bradycardia/ hypotension for BB as well as CKD Stage 3b and greater(GFR≤30) and or serum potassium above 5 meq
2. What percentage of our patients with CHFrEF (“reduced EF” or “systolic HF”) that are eligible have been switched over to Entresto (ARNI) in house?
3. Percent of patients who started on ACE and d/c’d on an ARNI (Entresto)

TIMELINE & PLAN:

Initiation	Team identification and guideline selection
Phase I	Key Performance Indicator selection, plan and initiate QI activities to achieve KPI goals
Phase II	Development/revision of care pathway, measure expansion, dashboard development

Team Charter

Chronic Obstructive Pulmonary Disease (COPD)

Key Initiatives August 2022

- Dashboard under development
- CPGs and order set(s) reviewed for alignment
- COPD Order set revisions completed & approved to operationalize best practices including: Antibiotic options, steroid dosing/frequency, defining medication based on GOLD category, delineating medications for acute and maintenance therapy, diagnostic studies
- Establish baseline order set usage and work to increase utilization

PROJECT NAME: COPD BPT	CHAMPION: Dr. M. Tedaldi	QI Facilitator: Stacey Cajimat
DIRECTOR: Wendy Jones	**APN: Emma Camarena**	**SPONSOR: Keri Noeske**
PROBLEM STATEMENT: Mortality, readmission and LOS data indicates opportunity in standardizing care and reducing variation through clinical practice guideline and care pathway implementation.	**SHORT TERM PROJECT GOALS:** 1. Select clinical practice guidelines (CPGs) COMPLETE 2. Develop Key Performance Indicators (KPIs) COMPLETE 3. Develop dashboards for outcome and KPIs IN PROCESS 4. improve KPI performance IN PROCESS	LONG TERM GOALS: 1. Reduce mortality from 2.40 to 1.92, by end of FY 22 (-20% from 2019 baseline)) 2. Reduce readmissions from 16.09 percent to to 12.87%, by end of FY 22. (-20% from 2019 baseline) 3 Reduce Length of Stay
SCOPE: (WHAT DOES THIS INCLUDE AND NOT INCLUDE?) Inpatient admissions and discharges.	**MEASURES:** KPIs (in order of priority) 1. What percentage of patients had Pulmonary Function Test (PFT) performed? 2. What percentage of COPD patients received the Pneumonia immunization on discharge? 3. What percentage of our patients the received Influenza immunization on discharge? 4. What percentage of patients accepted smoking cessation information on discharge? 5. What percentage of patients were referred to pulmonary rehab and attended? 6. What percentage of patients had principal discharge diagnosis of COPD and any diagnosis of CHF, any diagnosis of PN and any diagnosis of both CHF and PN?	
FINANCIAL IMPLICATIONS: Penalties associated with the CMS Value-Based Purchasing Program (mortality), penalties associated with CMS Readmission Reduction Program & reputational costs with CMS star ratings.		

TIMELINE & PLAN:	
Initiation	Team identification and guideline selection
Phase I	Key Performance Indicator selection, plan and initiate QI activities to achieve KPI goals
Phase II	Development of care pathway, measure expansion, dashboard development

Team Charter

Acute Myocardial Infarction – Non ST Elevated Myocardial Infarction (AMI – NSTEMI)

Key Initiatives August 2022

- Dashboard under development
- CPGs and order set(s) reviewed for alignment
- Order set revisions completed and approved for 4 different order sets that intersect with care of NSTEMI population
- Operationalizing best practices through order set utilization: adding and revising medication orders and lab test to align with CPGs and pre-checking options

PROJECT NAME: AMI Non-STEMI BPT	CHAMPION: Dr. Michael Tedaldi	Quality RN Facilitator: Cindy Vander Schuur
DIRECTOR: Christine Aleman	APN: Cody Ericson	ET SPONSOR: Keri Noeske

PROBLEM STATEMENT:

Mortality, readmission, and length of stay (LOS) data indicates opportunity in standardizing care and reducing variation through clinical practice guideline and care pathway implementation.

SHORT TERM PROJECT GOALS:

1. Select clinical practice guidelines (CPGs) COMPLETE
2. Develop Key Performance Indicators (KPIs) COMPLETE
3. Develop dashboards for outcome and KPIs IN PROCESS
4. improve KPI performance IN PROCESS

LONG TERM GOALS

1. Reduce mortality by 5% from 2019 baseline
2. Reduce readmissions by 10% from 2019 baseline
3. Reduce length of stay

SCOPE: (WHAT DOES THIS INCLUDE AND NOT INCLUDE?)

*Inpatient Medical Center processes.

GUIDELINES:

*Denominator: Patients with a diagnosis of NSTEMI who went to the Cath Lab.

NSTEMI Definition:

1. Negative EKG (no ST elevation)
2. Positive Troponin resulted ≥ 0.5

*Baseline Data: Monthly starting July 2021

FINANCIAL IMPLICATIONS:

Penalties associated with the CMS Value-Based Purchasing Program (mortality), penalties associated with CMS Readmission Reduction Program & reputational costs with CMS star ratings.

MEASURES: KPIs (in order of priority)

Process Measures:

1. Percent of NSTEMI patients who have a 12 lead EKG done within 10 minutes of arrival.
2. Percent of NSTEMI patients administered oral beta blockers within 24 hours of positive Troponin.
3. Percent of NSTEMI patients who received IV UFH (unfractionated Heparin) or therapeutic subcutaneous (SQ) Lovenox (1mg/kg) within one hour of positive Troponin result.
4. Diagnostic Consideration/Measure: Percent of NSTEMI patients with a second Troponin done within 4 hours. (for risk stratification and early diagnosis) Using resulted time of initial Troponin.
5. Diagnostic Consideration/Measure: Percent of NSTEMI patients with a second EKG done within 4 hours. (for risk stratification and early diagnosis)
6. For NSTEMI patients who undergo revascularization: Percent of patients discharged on DAPT (dual antiplatelet therapy: Plavix, Effient, or Brilinta with aspirin) that do not have a contraindication such as aspirin sensitivity or history of gastrointestinal bleeding.

TIMELINE & PLAN:

Initiation	Team identification and guideline selection
Phase I	Key Performance Indicator selection, plan and initiate QI activities to achieve KPI goals
Phase II	Development/revision of care pathway, measure expansion, dashboard development. Address order sets including medication orders

Team Charter

Acute Myocardial Infarction – Non ST Elevated Myocardial Infarction (AMI – NSTEMI)

Key Initiatives August 2022

- Dashboard under development
- CPGs and order set(s) reviewed for alignment
- Order set revisions completed and approved for 4 different order sets that intersect with care of NSTEMI population
- Operationalizing best practices through order set utilization: adding and revising medication orders and lab test to align with CPGs and pre-checking options

PROJECT NAME: AMI Non-STEMI BPT	CHAMPION: Dr. Michael Tedaldi	Quality RN Facilitator: Cindy Vander Schuur
DIRECTOR: Christine Aleman	APN: Cody Ericson	ET SPONSOR: Keri Noeske

PROBLEM STATEMENT:

Mortality, readmission, and length of stay (LOS) data indicates opportunity in standardizing care and reducing variation through clinical practice guideline and care pathway implementation.

PROJECT GOAL:

Short Term:

1. Select clinical practice guidelines (CPGs) COMPLETE
2. Develop and improve Key Performance Indicators (KPIs) IN PROGRESS

Long Term:

1. Reduce mortality
2. Reduce readmissions
3. Reduce length of stay

SCOPE: (WHAT DOES THIS INCLUDE AND NOT INCLUDE?)

*Inpatient Medical Center processes.

GUIDELINES:

*Denominator: Patients with a diagnosis of NSTEMI who went to the Cath Lab.

NSTEMI Definition:

1. Negative EKG (no ST elevation)
2. Positive Troponin resulted ≥ 0.5

***Baseline Data:** Monthly starting July 2021

FINANCIAL IMPLICATIONS:

Penalties associated with the CMS Value-Based Purchasing Program (mortality), penalties associated with CMS Readmission Reduction Program & reputational costs with CMS star ratings.

MEASURES: KPIs (in order of priority)

Process Measures:

1. Percent of NSTEMI patients who have a 12 lead EKG done within 10 minutes of arrival.
2. Percent of NSTEMI patients administered oral beta blockers within 24 hours of positive Troponin.
3. Percent of NSTEMI patients who received IV UFH (unfractionated Heparin) or therapeutic subcutaneous (SQ) Lovenox (1mg/kg) within one hour of positive Troponin result.
4. Diagnostic Consideration/Measure: Percent of NSTEMI patients with a second Troponin done within 4 hours. (for risk stratification and early diagnosis) Using resulted time of initial Troponin.
5. Diagnostic Consideration/Measure: Percent of NSTEMI patients with a second EKG done within 4 hours. (for risk stratification and early diagnosis)
6. For NSTEMI patients who undergo revascularization: Percent of patients discharged on DAPT (dual antiplatelet therapy: Plavix, Effient, or Brilinta with aspirin) that do not have a contraindication such as aspirin sensitivity or history of gastrointestinal bleeding.
7. Percent of correct usage of CARD ACS/NSTEMI Admission order set.

TIMELINE & PLAN:

Initiation	Team identification and guideline selection
Phase I	Key Performance Indicator selection, plan and initiate QI activities to achieve KPI goals
Phase II	Development/revision of care pathway, measure expansion, dashboard development. Address order sets including medication orders

Best Practice Teams

evidence based practices
for world-class patient care

Big Picture Next Steps

- Post medical staff event continue connect with hospitalists to ensure smooth transition to new order sets
- Develop and refine dashboards for each team so improvement is targeted
- Improve Key Performance Indicators through addressing identified root causes

Thank you

Live with passion.

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

Kaweah Health

Falls Prevention Committee

Quality Council Report
September 15, 2022
Emma Camarena, Director of Nursing Practice

Facts about Falls

Millions of people, 65 and older fall each year

- **More than 1 out of 4 will fall each year**
- **Less than half tell their doctor**
- **Falling one time doubles the chances of falling again**

Centers for Disease Control and Prevention. https://www.cdc.gov/falls/facts.html

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Facts about Falls

Falls are Serious and Costly

- **One out of 5 falls causes a serious injury**
- **Each year, 3 million older people seek treatment in the ED**
- **Over 800,00 patients are hospitalized each year**
- **Each year, 300,000 older people are hospitalized for hip fractures caused by falls**
- **95% of hip fractures are caused by falling**
- **Falls are the most common cause of traumatic brain injury**
- **In 2015, falls totaled more than $50 billion in medical costs (75% paid by Medicare/Medicaid)**

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Centers for Disease Control and Prevention. https://www.cdc.gov/falls/facts.html

The Problem of Falls

In Hospital

- **Each year, between 700,00 and 1,000,000 patients will fall in the hospital**
- **Falls increase health care utilization due to injuries**
- **2008: CMS does not reimburse hospitals for certain types of traumatic injuries which may occur after a fall**
- **Difficult to manage-competing priorities:**
  - **Treating problem patient was admitted with**
  - **Keeping the patient safe**
  - **Helping the patient maintain or recover physical and mental function**
- **Fall prevention involves managing the patient's underlying fall risk factors**

Agency for Healthcare Research and Quality. https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/overview.html#Problem

Kaweah Health

Kaweah Health Nursing Falls Data, Benchmarked Nationally:

Measure Objective/Goal:

1. Kaweah Health Nursing Falls Data:
   - Total Falls per 1000 patient days
   - Total Injury Falls per 1000 patient days
   - Percent of Falls with Moderate to Severe Injury
2. Total Falls with Injury level (2020-Q1 2022)
3. Falls U Root Cause Analysis Questions CY 2022 Quarter 1-2

** The National Database of Nursing Quality Indicators® (NDNQI®) provides a national database of more than 2,000 U.S. hospitals that features nursing-sensitive outcome measures used to monitor relationships between quality indicators and outcomes.*
Participating Kaweah Health nursing units include: 2North, 2South, 3North, 3South, 3West, 4North, 4South, 4Tower, Broderick Pavilion, ICU, CV-ICU, CV-ICCU (5Tower), Mental Health, Pediatrics, and Acute Rehab.

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Falls Definitions

The NDNQI Definitions for Injury follow:

Definition: unplanned descent to the floor with or without injury to the patient

Injury level:

- None—patient had no injuries (no signs or symptoms) resulting from the fall, if an x-ray, CT scan or other post fall evaluation results in a finding of no injury.
- "Minor—resulted in application of a dressing, ice, cleaning of a wound, limb elevation, topical medication, bruise or abrasion.
- Moderate—resulted in suturing, application of steri-strips/skin glue, splinting or muscle/joint strain.
- Major—resulted in surgery, casting, traction, required consultation for neurological (basilar skull fracture, small subdural hematoma) or internal injury (rib fracture, small liver laceration) or patients with coagulopathy who receive blood products as a result of the fall.
- Death—the patient died as a result of injuries sustained from the fall (not from physiologic events causing the fall).“

AHRQ website. https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/measurefallrates.html

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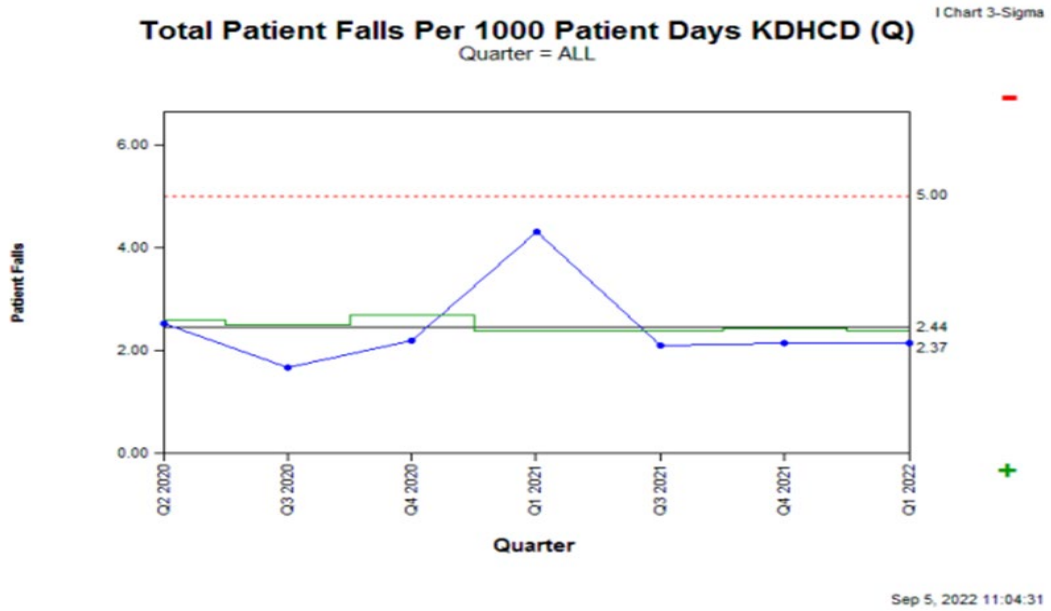
KH Nursing Falls Data

Total Falls per 1000 patient days

Goal met: The total falls per 1000 patient days for Q1-2022 is 2.14, below the target of 2.37, no change from Q4-2021.

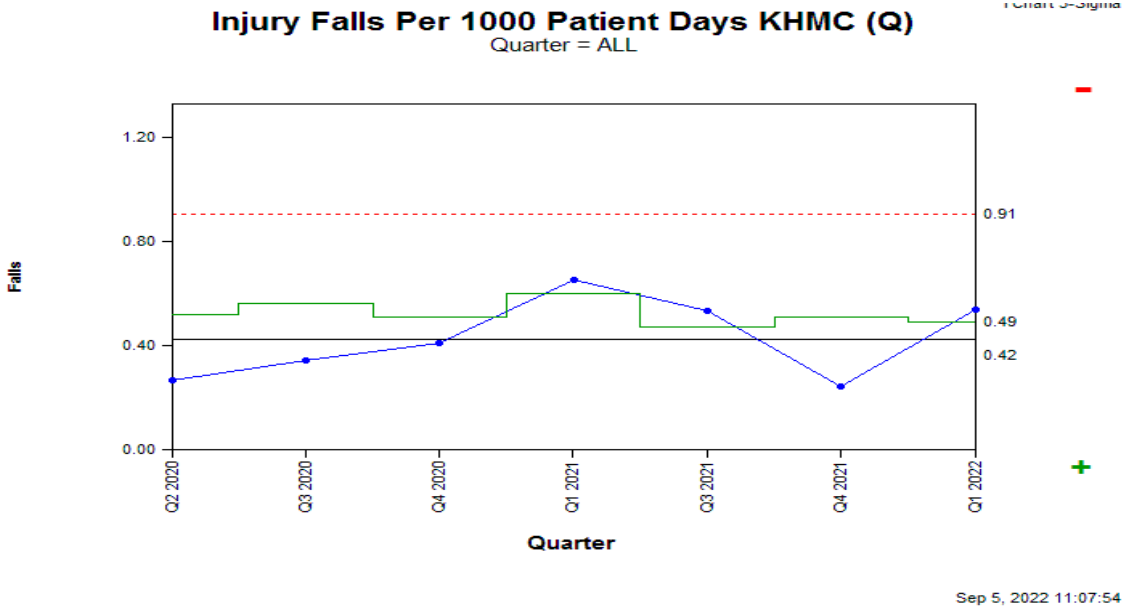


	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q3 2021	Q4 2021	Q1 2022
Patient Falls	2.53	1.66	2.19	4.32	2.09	2.14	2.14
Target	2.60	2.50	2.69	2.37	2.38	2.42	2.37

KH Nursing Falls Data

Injury Falls per 1000 Patient Days

Goal not met: The injury falls per 1000 patient days for Q1-2022 is 0.53, above the target of 0.49, an almost 121% increase from Q4-2021.



	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q3 2021	Q4 2021	Q1 2022
Falls	0.27	0.34	0.41	0.65	0.53	0.24	0.53
Target	0.52	0.56	0.51	0.60	0.47	0.51	0.49

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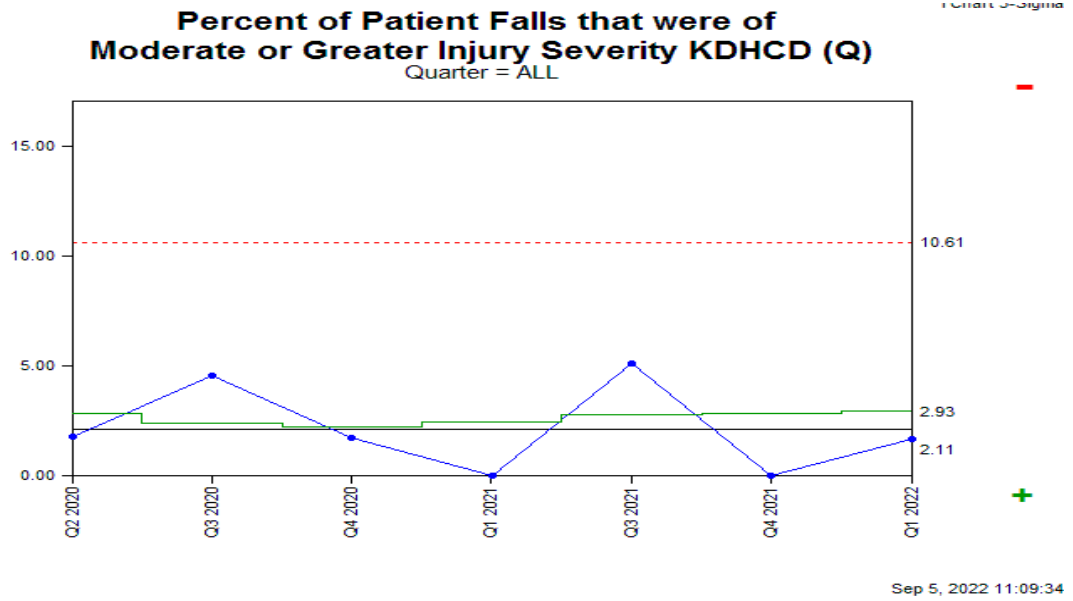
KH Nursing Falls Data

Percent of Patient Falls with Moderate to Severe Injury

Goal met: The percent of falls with moderate or greater injury 1.67 below target of 2.93, maintaining goal from Q4-2021.



	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q3 2021	Q4 2021	Q1 2022
KDHCD	1.75	4.55	1.69	0.00	5.08	0.00	1.67
Target	2.85	2.41	2.23	2.46	2.75	2.80	2.93

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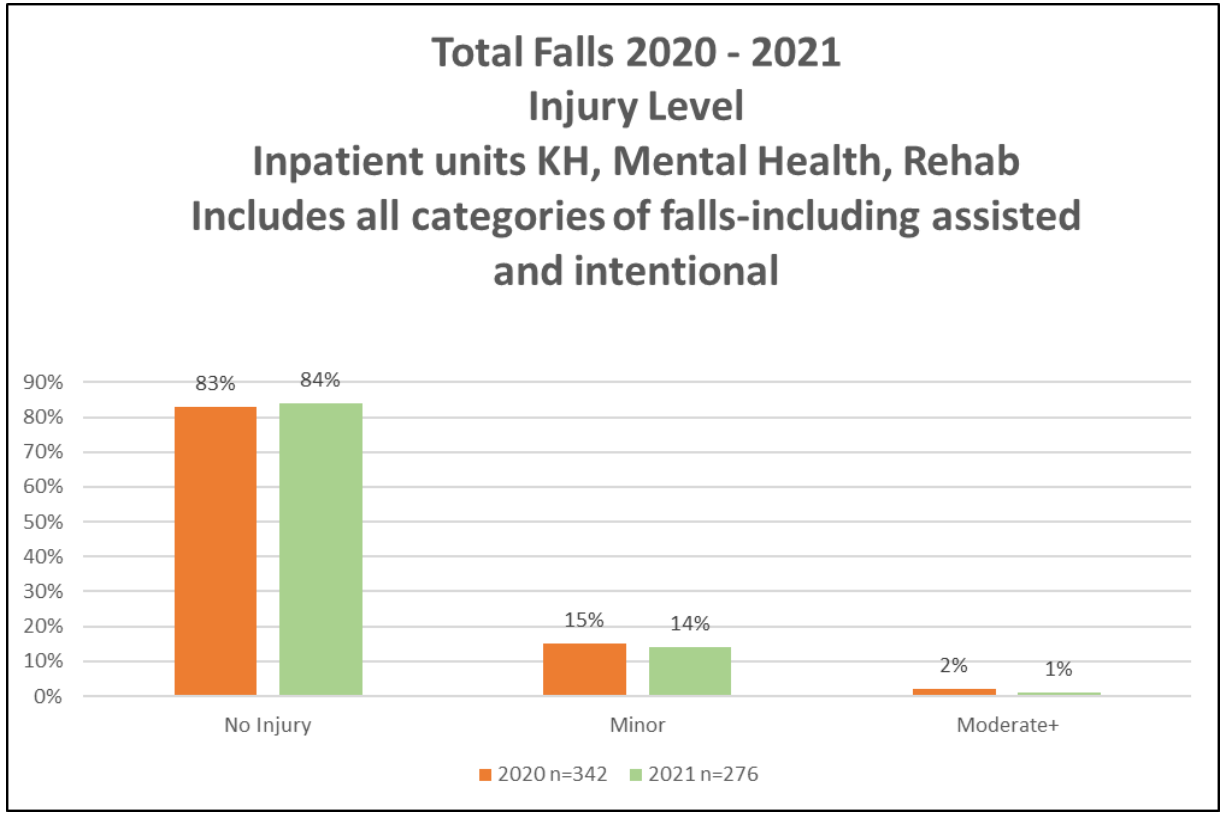
Total Falls with Injury Level CY 2019-2020

Goal met:

- From 2020 to 2021 patient who fell at KH were 1.2% more likely to have no injury.
- Minor injury level falls improved slightly with a 7% decrease from 2020 to 2021 and a 50% decrease in moderate + injury level falls.



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Falls University

Root Cause Analysis Questions

Kaweah Health is committed to eliminating falls with injuries and ensuring zero harm.
The purpose of Falls University is to review unassisted patient falls weekly to learn and improve in a non-punitive environment.
The following questions are asked to assist in analyzing the root cause of each fall.

1. Was the fall related to human factors (i.e. fatigue, lack of critical thinking, failure to follow policy and procedure, inability to focus on task, rushing to complete the task)?
2. Was the related to equipment failures?
3. Was the fall related to staffing (i.e. primary RN on break, adequate staffing)?
4. Would training and/or education have prevented the fall (staff competency)?
5. Was the fall related to failure in communication (i.e. between staff, between patient/family and staff)?

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Root Cause Analysis Questions

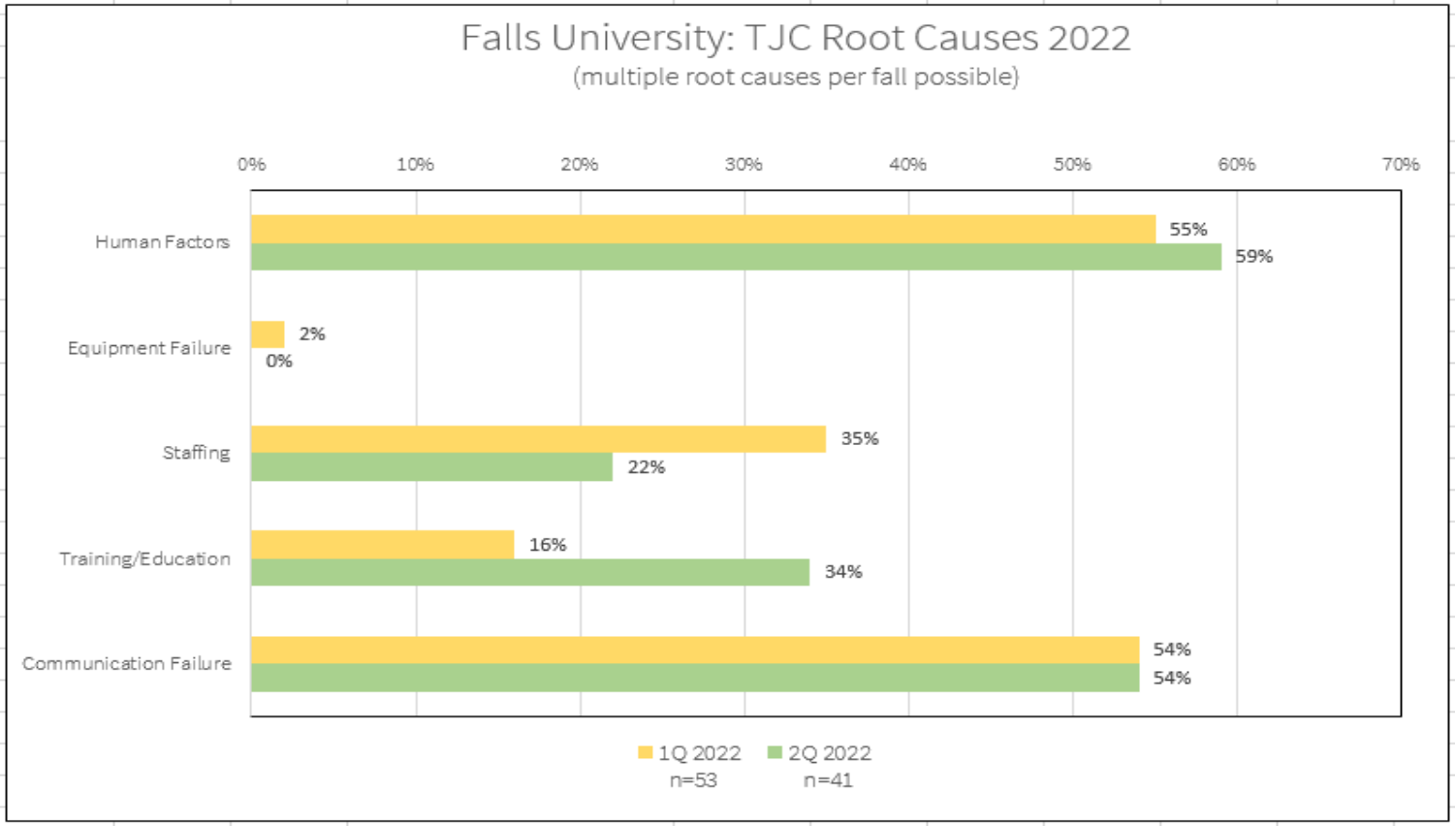
Falls University 2022

In quarter 2, human factors, training, and communication failures were the highest root cause of falls.

- Human factors: 59%, the percent change from Q1 to Q2 was an almost 7% increase
- Training or education: 34%, an increase of almost 53% from Q1
- Communication failure: 54% which was unchanged from Q1

Improvements noted:

- No equipment failure
- Staffing root cause improved to 22% from 35% in Q1



Kaweah Health

Falls University Take-Aways

Follow-Up

Following Falls University an email listing identified “Take-aways” is provided to the Nurse Managers to share with staff.
Example:

Falls University Take-Aways
Aug 30, 2022

Here is the most recent edition of Falls U TakeAways. Please share with your teams at safety huddles, staff meetings and any other venue you think is appropriate. Each of us is responsible for reviewing and then incorporating the TakeAways into our professional practice.

The following TakeAways were identified during Falls University this afternoon:

- As you leave a patient room, double check that the bed alarm is turned on for at-risk patients, and tabs alarms are on patients who are sitting up in a chair.
- Consider rounding more frequently on new patients you are not as familiar with.
- Consider placing a shower mat down in the bathroom, anticipating that they may decide to step out of the shower on their own without notifying staff
- Try to have elderly patients with dementia close to the nursing station and consider using a tele-sitter.
- Be alert and in tune to your patients' requests. Perhaps they are anxious and would feel better sitting up in a chair for a while, even if it is late in the evening.
- Keep your patients medical condition in mind. Are they in the hospital for a problem that may make them more likely to fall? Physiological falls may happen even with all falls precautions in place.

These are challenging times – please know that we appreciate everything you do, every day.
Do not forget to take care of YOU!

Kaweah Health

Improvement Opportunities

Background

- Prior to the pandemic, staff learned about fall prevention strategies through didactic education and yearly follow up competency testing
- Education included use of the Johns Hopkins Falls risk assessment, fall prevention strategies, use of bed alarms and fall prevention devices, and documentation of individualized plans of care (IPOC)
- The pandemic caused a disruption in the normal care of patients and supplies
- With surge charting, staff were only required to chart risk assessments once per shift and with changes and IPOCs were completed if time permitted
- Staff turnover also played a part in the disruption of care with experienced staff leaving, stepping away from patient care and retiring
- Contract staff, unfamiliar with Kaweah Health policies and procedures are now staffing all patient care units

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Improvement Opportunities

Assessment

1. Kaweah Health's total patient falls per 1000 patient days is consistently below the NDNQI benchmark. Falls with injury increased in the first quarter of 2022 but of note, falls with moderate or severe injuries continued to stay below the NDNQI benchmark.

   *The NDNQI benchmark changes quarterly, red areas indicate where KH was above the benchmark for that quarter.

Kaweah Health Overall	Benchmark 1Q2022 only	2Q 2020	3Q 2020	4Q 2020	1Q 2021	2Q 2021	3Q 2021	4Q 2021	1Q 2022
Total Falls	2.37								2.14
Injury Falls	0.49								0.53
Moderate or Greater Injury Falls	2.93								1.67

2. Falls assessment questions are asked during tracer rounds performed on inpatient units. From December 2021 to March 2022, notable improvements include compliance of fall risk assessment, IPOC documentation and patient education.

	Observations	Total Observations March 2022	Yes	No	March 2022 % Compliant	Feb 2022 % Compliant	Jan 2022 % Compliant	Dec % Compliant	Nov % Compliant	Oct % Compliant	Sept. % Compliant	Aug % Compliant	July % Compliant	June % Compliant	May % Compliant
5	Fall Assessments: Is the Johns Hopkins risk score completed each shift?	50	45	5	90.0%	90.0%	100.0%	96.4%	77.1%	80.0%	92.3%	88.6%	88.6%	93.0%	95.8%
6	Fall Assessments: If a patient is identified as a fall risk, is there an individualized IPOC with interventions?	25	25	0	100.0%	87.0%	100.0%	100.0%	66.7%	66.7%	84.6%	85.2%	87.9%	84.8%	85.7%
7	Fall Assessments: If the patient is a fall risk, is there documentatiom that the patient and family have been provided with fall prevention education?	20	19	1	95.0%	100.0%	100.0%	100.0%	80.0%	50.0%	63.6%	81.0%	76.0%	87.5%	61.9%

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Improvement Opportunities

Recommended Next Steps

1. The Falls Committee resumed monthly meetings to :
   - Review current falls data
   - Discuss improvement opportunities
   - Recommend prevention strategies
2. Move to biweekly Falls University meetings:
   - Allow opportunities for staff to review falls and provide input for root causes
3. Revision of policies
4. Standardize Falls prevention equipment
5. Optimize EMR charting
6. Provide staff education re: changes

Who Is Recommending	What (Action/IOU)	When Due (Status)	Action Responsibility
Falls Committee	Review and revise policy PC.88	09-12-2022	Emma Camarena
Falls Committee	Standardize Falls prevention equipment (Tabs alarms, crash mats, fall socks, etc.). Purchase fall alarms/equipment. Trial new fall prevention technology (i.e. Bluetooth alarms).	Currently in progress.	Alisha Sandidge Emma Camarena
Falls Committee	Optimize EMR charting for care planning (IPOCs), pre and post intervention	In progress/TBD	Kim Roller
Falls Committee	Staff education once above are complete to include basic fall prevention, policy updates, falls prevention equipment, IPOCs, etc	TBD	Emma Camarena Alisha Sandidge Gloria Dickerson

Thank you for your time

Kaweah Health

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

September 2022

FY22 Clinical Quality Goals

	July 21-June 22 Higher is Better	FY22 Goal	FY21	FY21 Goal
SEP-1 (% Bundle Compliance)	76%	≥ 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	≤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

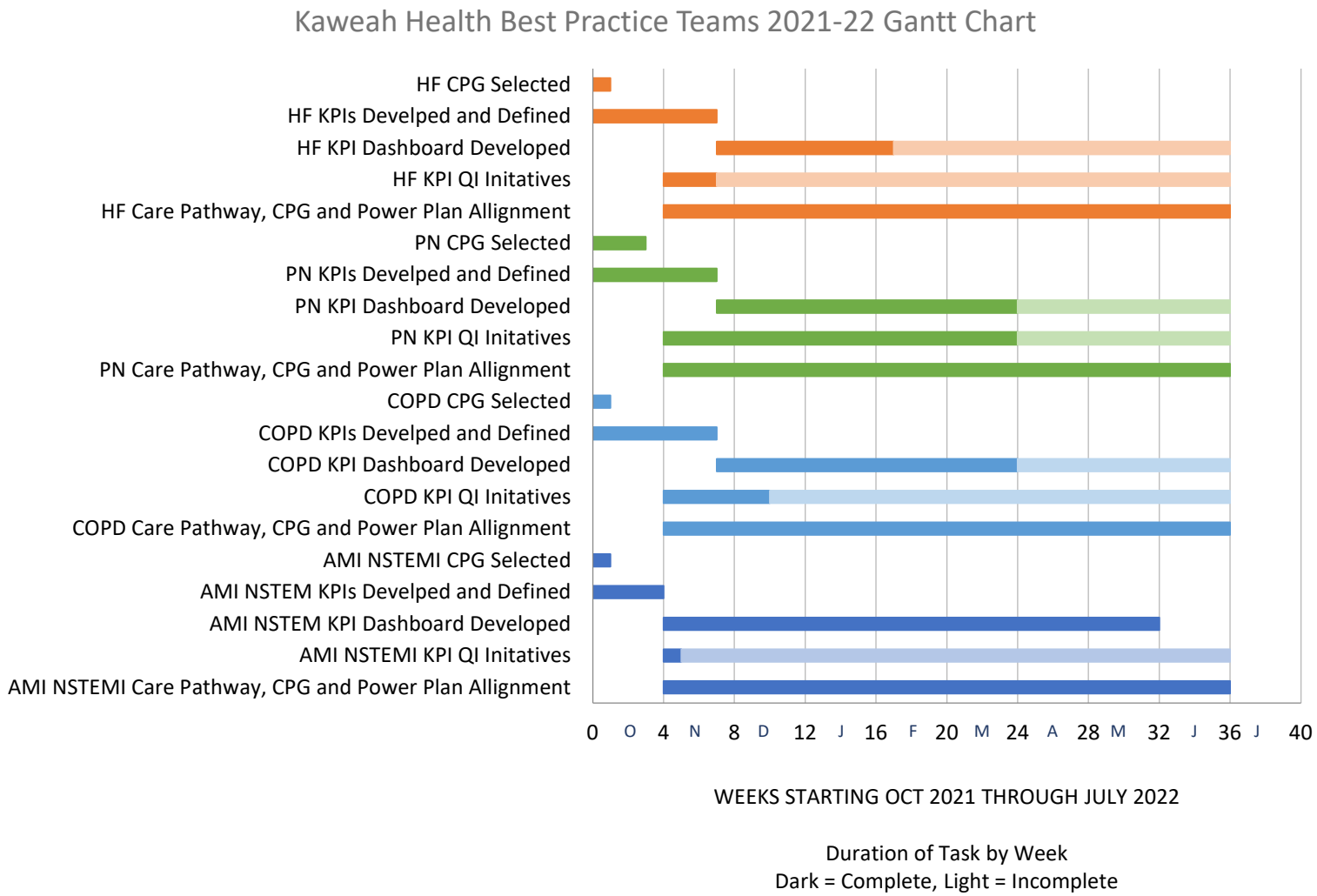
1. Refining root cause analysis of Sepsis order set utilization
    - for committee review and QI action planning 3Q2022
2. Provider notification of Sepsis Alert
    - Revised process so it's easier for RNs to document
3. Sepsis Simulation training (GME)
    - Emergency Management GME program sim program 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
    - 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 and recommendation to spread to other inpatient units sent to Prostaff for voting at September meeting.
    - 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

Best Practice Teams

evidence based practices for world-class patient care

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), Clinical Educator
- Outcomes include: Mortality, Readmission and Length of Stay
- Key Performance Indicators (KPIs) defined, dashboards in development and QI work underway!!



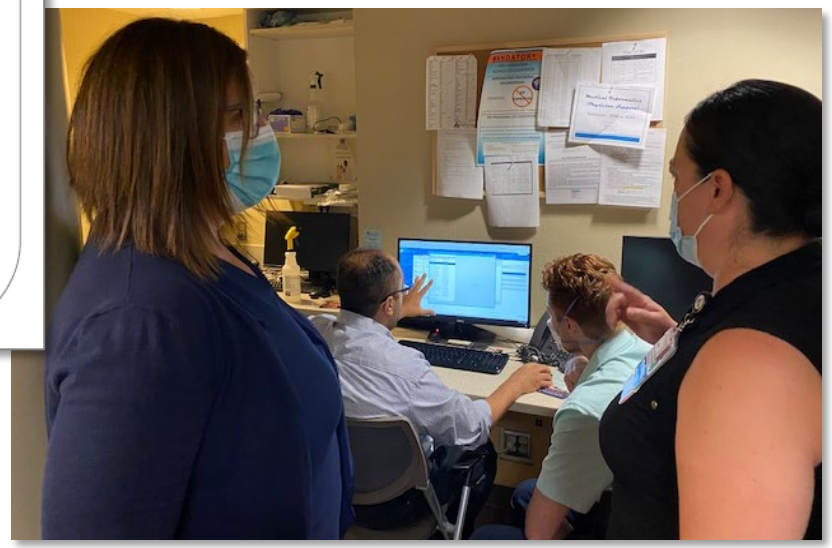
Best Practice Teams

evidence based practices
for world-class patient care

Best Practice Team Hospitalist Event

August 13 & 20

- Awareness of new power plans available
- Solicit feedback
- Switch favorites to new order set



Outcome Data

Best Practice Teams
evidence based practices for world-class patient care

Kaweah Health Best Practice Teams Outcome Dashboard FY 2022

	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