March 6, 2020

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Quality Council Committee meeting at 7:00AM on Thursday March 12, 2020, in the Kaweah Delta Medical Center – Acequia Wing – Executive Office Conference Room {400 W. Mineral King, Visalia}.

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee meeting immediately following the 7:00AM Open Quality Council Committee meeting on Thursday March 12, 2020, in the Kaweah Delta Medical Center – Acequia Wing – Executive Office Conference Room {400 W. Mineral King, Visalia} pursuant to Health and Safety Code 32155 & 1461.

All Kaweah Delta Health Care District regular board meeting and committee meeting notices and agendas are posted 72 hours prior to meetings in the Kaweah Delta Medical Center, Mineral King Wing entry corridor between the Mineral King lobby and the Emergency Department waiting room.

The disclosable public records related to agendas are available for public inspection at the Kaweah Delta 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 http://www.kaweahdelta.org.

KAWEAH DELTA HEALTH CARE DISTRICT
Nevin House, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
Board Clerk, Executive Assistant to CEO

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KAWEAH DELTA HEALTH CARE DISTRICT
BOARD OF DIRECTORS
QUALITY COUNCIL

Thursday, March 12, 2020

Kaweah Delta Medical Center – Acequia Wing
400 W. Mineral King Avenue, Visalia, CA Executive Conference Room

ATTENDING: Herb Hawkins – Committee Chair, Board Member; David Francis, Board Member; Gary Herbst, CEO; Regina Sawyer, RN, VP & CNO; Anu Banerjee, PhD, VP & Chief Quality Officer, Byron Mendenhall, MD, Chief of Staff; Monica Manga, MD, Professional Staff Quality Committee Chair; Daniel Hightower, MD, Secretary/Treasurer; Harry Lively, MD, Past Chief of Staff; Lori Winston, MD, VP of Medical Education & DIO; Tom Gray, MD, Quality and Patient Safety Medical Director; Sandy Volchko, Director of Quality and Patient Safety; Ben Cripps, Chief Compliance Officer, and Rosie Gonzales, Recording

OPEN MEETING – 7:00AM

Call to order – *Herb Hawkins, Committee Chair & Board Member*

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.

1. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement intiatives:

   1.1. **Patient Experience Quality Report**
   1.2. **Value Based Purchasing Report**
   1.3. **Infection Prevention Quality Report**
   1.4. **Fall Prevention Quality Report**

2. **Emergency Department Quality Update** – A review of key measures and actions for the Emergency Department. *Kona Seng, OD, Medical Director of Emergency Services, and Tom Siminski, RN, Director of Emergency Services.*

3. **Maternal Child Health Quality Report –** A review of performance measures and actions focused on the obstetric and pediatric populations. *Juan Sabogal, MD, Medical Director of OB, Julianne Randolph, DO, Medical Director of Pediatrics, Jose Dosado, MD, NICU Medical Director, and Tracie Plunkett, Director of Maternal Child Health.*

4. **Hospital Acquired Pressure Injury (HAPI) Quality Focus Team Report** – A review of measures and action plans related to the prevention of HAPI. *Mary Laufer, DNP, RN, Director of Nursing Practice.*

5. **Update: Fiscal Year 2020 Clinical Quality Goals** - A review of current performance and actions focused on the FY 2020 clinical quality goals. *Sandy Volchko, RN, Director of Quality and Patient Safety.*
6. **Approval of Quality Council Closed Meeting Agenda** – Kaweah Delta Medical Center Executive Conference Room – immediately following the open Quality Council meeting
    - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of Professional Staff Quality Committee (Pro-Staff) – *Monica Manga, MD, and Professional Staff Quality Committee Chair;*
    - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of Professional Staff Quality Committee (Pro-Staff) – *Anu Banerjee, PhD, VP & Chief Quality Officer*

Adjourn Open Meeting – *Herb Hawkins, Committee Chair & Board Member*

CLOSED MEETING – Immediately following the 7:00AM open meeting

Call to order – *Herb Hawkins, Committee Chair & Board Member*

1. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of Professional Staff Quality Committee (Pro-Staff) – *Monica Manga, MD, and Professional Staff Quality Committee Chair*
2. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of Professional Staff Quality Committee (Pro-Staff) – *Anu Banerjee, PhD, VP & Chief Quality Officer*

Adjourn Open Meeting – *Herb Hawkins, Committee Chair & Board Member*

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.

Patient Experience (HCAHPS) Performance: World-Class Service
April 2020

Time Period	3Q18 -2Q19		July – Dec 2019	
HCAHPS Measure	**Full Adj**	**CMS** 50th percentile	**Mode Adj**	**Comments/Improvement Efforts**
	-	-	-	-
# of surveys 22% response rate	1660	-	921	-
Communication with Nurses	**77%** Below CMS	81%	79%	1) Introductions and closing encounters 2) Share the care 3) Communication white boards
Communication with Doctors	**75%** Below CMS	82%	79%	1) Greet patients/companions with smile 2) Sit at the bedside 3) Conclude with "Is there anything else I can do for you?"
Responsiveness of Staff	**64%** Below CMS	70%	72%	1) Hourly Rounding 2) Proactive toileting
Communication about Meds	**60%** Below CMS	66%	66%	1) Medicine Guide
Cleanliness of Environment	**66%** Below CMS	76%	74%	2) Leader Rounding 3) Increased surveillance
Quietness of Environment	**48%** Below CMS	62%	55%	*No new interventions*
Discharge Information *(Yes)*	**84%** Below CMS	87%	90%	1) Medicine Guide 2) Patient Guide 3) Discharge advocates meet with admits r/t preferences and expectations 4) NRC Discharge Phone Calls 5) Rebuild Discharge Instructions
Care Transition *(Strongly Agree)*	**45%** Below CMS	53%	50%	*Same as above*
Overall Rating of Hospital **(0 = worst; 10 = best)**	**70%** ***(9 or 10)*** Below CMS	73%	75%	**OPERATION ALWAYS** *Purpose: Consistently provide world-class service* **→Increase leader rounding on patients** **→Build consistent Service Standards across units and divisions** → Gold Star Discharge Program (early discharges home) →Pursue Unity & Consistency
Willingness to Recommend ***(Definitely Recommend)***	**69%** Below CMS	72%	73%	*Same as above*

Value Base Purchasing (VBP) Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: Quality & Patient Safety ProStaff/QIC Report Date: January 15, 2020

Measure Objective/Goal:

Goal is to earn at least 2% back of annual contribution with zero balance. This goal was not met.

Date range of data evaluated: CY 2019

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

Value base purchasing total performance estimated score calculated by the California Hospital Association for CY 2019 is 23.3%.

All hospitals contribute 2% per Medicare beneficiary. For FY 2021, it is estimated that Kaweah will contribute 3.47%. This will be an annual loss of $363,500 (less than previous years).

Final annual VBP report from CMS will come out July or August 2020. California Hospital Association provides a highlight report with estimated numbers.

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

Areas that received zero points:

- All patient experience domains (includes 8 measures)
- CLABSI
- MRSA
- CAUTI

Areas awarded points:

- Pneumonia mortality (2 points)
- Total Knee and Hip Post-Operative Complication (7 points)
- AMI mortality (5 points).
- SSI (1 point)
- C-Diff (6 points)
- Heart failure mortality (1)
- Medicare spending per beneficiary (3 points)

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

Next Steps/Recommendations/Outcomes:

- Patient Experience is implementing “Operation Always” with department specific action plans, increased leader patient rounding, and use of new survey vendor in July 2019.
- Infection prevention has teams in each area working on improvements. In 2019, last year Kaweah implemented and IV safety team to round on all lines and monitor expired IVs. Kaizen events are schedule for January and February 2020 to focus the teams efforts on current root causes through rapid process improvement.
- Mortality committee meets every month with the largest improvement opportunity in earlier palliative care and implementing General Inpatient Hospice beds. Disease specific teams are also working on best practices.

Submitted by Name: Sandy Volchko, Director of Quality & Patient Safety; Shaye Garrett, Quality Data Coordinator.

Date Submitted: January, 2020

Kaweah Delta HEALTH CARE DISTRICT

Value Base Purchasing Dashboard

Clinical Outcomes	CMS Excellence	CMS Benchmark	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Total
Mortality Not Risk Adjusted Rate -Medicare															
Acute Myocardio Infarction	6.78%		20	23.77	12.5	14.28	12.5	0	20	0	6.25	14.28	0	0	9.74
Heart Failure	3.23%		3.57	7.895	0	10.7	0	20	13.33	8.33	0	6.67	9.092	4.762	6.464
Pneumonia	3.57%		3.333	2.632	5.26	4.65	16.66	18.18	8	8.33	9.52	13.33	3.704	11.11	8.669
COPD Empysema	1.26%		20	9.09	0	0	7.14	10	0	0	0	0	0	0	14.286
Comp Hip Knee — Complication elective THA/TKA	0.032	2.30	5.88	2.08	1.92	2.17	2.94	4.00	2.00	0.00	0.00	0.00	0.00	0.00	6.25
Safety - Hospital Acquired Infections - Dr. Boken, & Shawn Elkin, Manager of Infection Prevention															
CLABSI - Per 1000 line days	Incident Rate		1.76	1.70	1.69	0.77	0.83	0.86	0.89	0.00	0.00	2.60	3.62	1.77	1.38
Quarterly SIR	0.00	0.784	1.979			0.9			0.315			3.075			1.6
CAUTI - Per 1000 catheter days	Incident Rate		0.77	1.60	4.02	0.00	2.37	0.79	0.83	0.84	3.56	3.00	0.87	0.00	1.55
Quarterly SIR	0.00	0.828	2.1			1			1.83			1.37			1.6
SSI Colon - Rate Per 100 procedures	Incident Rate		0.0	0.0	0.0	4.8	0.0	0.0	5.9	0.0	0.0	0.0	0.0	0.0	0.9
Quarterly SIR	0.00	0.781	0			0.296			0.348			0			0.2
SSI Abdominal Hysterectomy - Rate Per 100 procedures	Incident Rate		0.0	0.0	0.0	0.0	0.0	0.0	0.0	11.8	5.3	5.6	0.0	0.0	1.9
Quarterly SIR	0.00	0.722	0			0			3.89			4.02			2.0
C. difficile - Per 10,000 patient days	Incident Rate		1.2	3.3	1.3	1.2	2.4	0.0	1.1	2.5	2.4	1.3	1.2	2.6	1.7
Quarterly SIR	0.09	0.852	0.315			0.9			0.3			Pending			0.5
MRSA - Per 10,000 patient days	Incident Rate		1.06	2.98	0	0	0	0	0.97	2.18	1.06	1.12	1.11	0	0.9
Quarterly SIR	0.00	0.815	2.49			0			2.31			0.698			1.4

Person and Community Engagement	CMS Excellence	CMS Benchmark	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Total July-Nov. 2019
Patient Experience - Ed Largoza, Director of Patient Experience															
Communication with Nurses	87.12	79.08	82.6%	78.0%	76.8%	78.4%	79.6%	79%	81.9%	74.4%	79.86%	77.34 %	77.63%	83.85%	79.18%
Communication with Doctors	88.44	80.41	78.9%	79.0%	80.6%	80.8%	81.0%	80%	78.9%	78.8%	78.99%	79.81%	75.95%	83.45%	79.47%
Responsiveness of Hospital Staff	80.14	65.07	62.30%	67.4%	70.7%	73.1%	70.3%	68.90%	75.4%	67.0%	70.38%	68.92%	74.35%	75.56%	72.59%
Communication about Medicines	73.86	63.3	66.6%	66.7%	58.3%	63.6%	68.1%	63.30%	74.7%	49.3%	68.89%	70.3%	63.03%	74.93%	66.21%
Cleanliness of Hospital Environment	79.42	65.72	73.2%	72.20%	64.3%	63.3%	67.9%	66.30%	68.5%	66.1%	70.10%	65.57%	76.37%	78.15%	73.01%
Quietness of Hospital Environment	79.42	65.72	60.5 %	58.3%	48.7%	56.4%	57.7%	52.70%	53.6%	52.5%	51.78%	60.4%	50.66%	65.06%	56.36%
Discharge Information	92.11	87.44	84.2%	85.0%	85.7%	86.6%	89.1 %	85.70%	88%	91.6%	90.26%	88.01%	88.97%	91.75%	90.10%
Care Transition	62.5	51.14	48.9 %	48.3%	48.5%	47.4%	51.8%	53.30%	49.5%	44.1%	48.89%	53.74%	49.06%	54.16%	50.55%
Overall Rating of Hospital	85.12	71.59	74.3%	75.7%	73%	76.3%	80.5 %	77%	77.7%	78.7%	74.42%	73.76%	70.09%	80.45%	75.62%

Summary:

VBP CY 2019 or FY 2021- COPD mortaltiy has been added to clinical outcomes. COPD & Pnumonia team have met and implementing best practices in managaging this paitent population and reporting at next pro-staff.

Improvement teams continue to meet monthly that include: Mortality -Pneumonia/COPD, Heart Failure, Infection Control -CLABSI, CAUTI, SSI, MDRO-C, Patient Experience, and Cost savings.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2019

		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
I. Overall Surgical Site Infections (SSI)	**IR/SIR**						**SSIs calculated internally though standard incidence rate and externally through Standardized Infection Ratio (SIR) from National Health and Safety Network (NHSN).**
A. #Total Procedure Count		1458	1493	1507			**Annual running total: 4,458**
B. Total Infection Count *[note: SSI events can be identified up to 90 days from the last day of the month in each quarter and only DIP and Organ Spc SSI are reported in NSHN]*		~~5~~ **6**	**5**	**7**			**1st QTR:** ~~5~~ corrected 6 **Predicted:** 17.45 **2nd QTR:** 5 **Predicted:** 17.45 **3rd QTR:** 7 **Predicted:** 16.51
C. Incidence Rate (IR) [# of total SSI infections/# total procedures x 100]	Internal 0.70 Goal	**0.34**	**0.33**	**0.46**			**1st QTR:** Well exceeded the District's goal of 0.70 SSI incidence rate - 36% better. **2nd QTR:** Well exceeded the District's goal of 0.70 SSI incidence rate. **3rd QTR:** Consistently below the 0.70 SSI achieved District's goal for 3 quarters in a row.
D. SIR Confidence Interval (CI-KDHCD predicted range, based on risks)		0.105 - 0.635	0.105 - 0.635	0.185 - 0.839			**1st QTR:** Better than California 2017 SSI Benchmark of 0.89. *[Benchmark provided by CDPH 2017 Annual Report for overall top performance]* **2nd QTR:** Better than California 2017 SSI Benchmark of 0.89. *[Benchmark provided by CDPH 2017 Annual Report for overall top performance* **3rd QTR:** Better than California SSI Benchmark of 0.89. **For 3 quarters our total number of NHSN reportable SSI events places us in the top 8% of hospitals reporting this metric, according to recent NHSN release of 2018 summary data.**
E. Standardized Infection Ratio (SIR)	NHSN	**0.29**	**0.29**	**0.42**			**1st QTR:** SB, FUSN x 2, KPRO, FX, CHOL, PACE, COLO, VHYS, CSEC, CBGB (5 of these events were superficial and are not counted by CMS or by CDPH for public reporting) **2nd QTR:** COLO x 2, HPRO, CHOL, FUSN, HER, BRST, CSEC (3 of these events were superficial and are not counted by CMS or by CDPH for public reporting) **3rd QTR:** HYST x 4, CBGB, CSEC, APPY x 2, LAM (2 of these events were superficial and not counted by CMS or by CDPH for public reporting). A task force was developed to review the high quantity of HYST events.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2019							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
F. Action Plan for Improvement							**1st QTR:** Scripting for 3 different Time-Out sessions almost complete (1st pre-op antibiotic administration check; 2nd universal timeout; 3rd debrief timeout verfiy whether a change in wound status occurred). Pursuuing questions about clean closure for colorectal surgeries - some surgeons have resevations about the process, whether or not it is an effective process for reducing SSI (it is supported by data meta-analysis and described prevention guidelines). **2nd QTR:** Clean closure for gastrointestinal procedures now supported by all surgeons. Timely pre-op antibiotic administration improved slightly. Hematomas were involved in SSI development for 2 events. Anastomosis leaks identified as potential source of 2 SSI events. Endogenous skin flora and care of the incision at home post-operatively is also suspected as source of infections for remaining SSI events. **3rd QTR:** Created a taskforce to determine actions related to reducing HYST events. Review new ACOG literature for reduction of HYST SSI. Deep dive review of all other cases. Identified pre-op antibiotic timing and blood glucose control, poor documentation/ communication, and patient anxiety and compliance as variables contributing to SSI events. Action plans developed to address all these factors.
II. Specific Surgical Review	**SIR**						
A. Colon Surgery (COLO) CMS/VBP							
1. #Total Procedure Count		53	51	35			**Annual running total:** 139
2. Total Infection Count		**0**	**1** **[1]**	**0** **[0]**			**1st QTR:** 0 **Predicted:** NA **2nd QTR:**1 **Predicted:** 3.14 (note: 1 SIP COLO not reported in NHSN) **3rd QTR**:
3. SIR CI (KDHCD predicted range, based on risks)		0 - 0.959	0.016 - 1.571	, 1.475			**1st QTR:** No different than 2019 National Benchmark of 0.781. **2nd QTR:** No different than 2019 National Benchmark of 0.781. **3rd QTR:** No different than 2019 National Benchmark 0.781.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2019							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]		0 [0]	0.32 [0.66]	0 [0]			**1st QTR:** 1 COLO event (superficial SSI - not reported to CMS or CDPH). Intra-operatively there were 7 observers (non-staff) observing this procedure and a lot of activity going in and out of the surgery. **2nd QTR**: 1 COLO event (superficial SSI - not reported to CMS or CDPH). Second COLO event is a DIP in a medicare patient. **3rd QTR:** No COLO events.
B. Cesarean Section (CSEC)							
1. #Total Procedure Count		351	351	394			**Annual running total:** 1,096
2. Total Infection Count		0	1	1			**1st QTR:** 0 **Predicted:** NA **2nd QTR:**1 **Predicted:** 2.99 **3rd QTR:** 1 **Predicted:** 3.31
3. SIR CI (KDHCD predicted range, based on risks)		0 - 0.908	0.017 - 1.652	0.015, 1.493			**1st QTR:** Better than California 2016 CSEC Benchmark of 0.89. **2nd QTR:** Better than California 2016 CSEC Benchmark of 0.89. **3rd QTR**: Better than California 2016 CSEC Bencmark of 0.89.
4. SIR (Standardized Infection Ration) total		0	0.34	0.303			**1st QTR:** 1 CSEC event (deep SSI); this case was likely unpreventable. Patient had a spontaneous appendiceal rupture post-operatively that complicated the post-operative course. **2nd QTR:** First QTR CSEC was identified in NHSN as a SIP. Second QTR CSEC is also a SIP CSEC event that occured 10 days post-op and is attributed to patient's non-compliance with care of the surgical site post discharge. **3rd QTR:** 1 CSEC event likely associated with prolonged premature rupture of membranes. Group A Strep for both patient and infant.
C. Spinal Fusion (FUSN)							
1. #Total Procedure Count		37	58	54			**Annual running total:** 149
2. Total Infection Count		1	1	0			**1st QTR:** 1 **Predicted:** 0.47 **2nd QTR:**1 **Predicted:** 0.73 **3rd QTR:** 0 **Predicted:** 0.63
3. SIR CI (KDHCD predicted range, based on risks)		NA	NA	NA			**1st QTR:** Worse than California 2016 FUSN Benchmark of 0.82. **2nd QTR:** Worse than California 2016 FUSN Benchmark of 0.82. **3rd QTR:** Better than California 2016 FUSN Benchmark of 0.82.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2019							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
4. SIR (Standardized Infection Ration) total		2.12 [2.12]	1.36 [1.36]	0			**1st QTR:** 2 FUSN events (2 deep SSI); A trend was identified with this particular type of SSI event. Spinal Fusion patients are transferred from the acute care setting to the District's long-term rehab facility. Identified a gap in continuity-of-care through communication of discharge orders, specialists do not follow their patients to long-term care rehab and will not be consulted regarding surgical wound healing and evaluation. Long-term care rehab nurses are unfamiliar with some interventions related to the SSI prevention bundle. Neurosurgery and Orthopedic service line representatives will now be attending SSI Prevention Committee. A midlevel practioner from the orthopedic service line will now follow patients to lont-term rehab to assess incision sites and consult. Long-term rehab nurses will be reintroduced to SSI Prevention Bundle interventions as a part of annual compentency training. **2nd QTR:** 1 FUSN event spinal abscess. Escalated this and the other two FUSN cases for physician review. **3rd QTR:** No FUSN events.
D. Hysterectomy (HYST) CMS/VBP							
1. #Total Procedure Count		23	26	54			**Annual running total:** 103
2. Total Infection Count		0	0	4 (4)			**1st QTR:** 0 **Predicted:** NA **2nd QTR:** 0 **Predicted:** 0.49 (note: 2 SIP HYST not reported in NHSN) **3rd QTR:** 4 **Predicted:** 0.872
3. SIR CI (KDHCD predicted range, based on risks)		NA	NA	NA			**1st QTR:** Better than 2018 Benchmark of 0.722. **2nd QTR**: Better than 2018 Benchmark of 0.722. **3rd QTR:** Worse than 2018 Benchmark of 0.722.
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]		0 [0]	0 [0]	4.587 (4.36)			**1st QTR:** No events. **2nd QTR:** No events. **3rd QTR: 4 HYST events. Taskforce identified the following variables: All events occurred less than 10 days post-op; all events were deep; Anxiety disorders were not addressed; poor glucose control; pre-op antibiotic timing too close to cut-time.**
II. Ventilator Associated Events (VAE)	**SIR**						
A. Ventilator Device Use SUR (standardized utilization ratio)		1.23	1.519	1.467			**1st QTR:** 758vd **Predicted:** 615.75vd **2nd QTR:**781vd **Predicted:** 514.09vd **3rd QTR:** 678vd **Predicted:** 462.178vd

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2019							
		Q1	**Q2**	**Q3**	**Q4**	**AVG. or TOTAL YTD**	**SUMMARY / ACTION**
B. Total VAEs ICU (NHSN Reportable)	Includes IVAC Plus	**4**	**5**	**1**			**1st QTR:** 4 **Predicted:** 3.97 **2nd QTR:** 5 **Predicted:** 4.08 **3rd QTR:** 1 **Predicted:** 1.33
1. SIR Total VAE CI (KDHCD predicted range, based on risks)		0.320 - 2.432	0.448- 2.711	0.014 - 1.390			This is an internal quality driven metric. A State or National benchmark has not been made available.
2. Total VAEs SIR		**1.35**	**2.62**	**0.282**			**1st QTR:** ICU had 2 VAC, 1 IVAC, 1 PVAP events. **2nd QTR:** ICU had 3 VAC, 3 IVAC, 1 PVAP events. **3rd QTR:** ICU had 1 PVAP event.
C. Total IVAC Plus -ICU		**2**	**4**	**1**			**1st QTR:** 2 **Predicted:** 1.48 **2nd QTR:** 4 **Predicted:** 2.62 **3rd QTR:** 1 **Predicted:** 1.327
1. Total IVAC Plus CI (KDHCD predicted range, based on risks)		0.226 - 4.455	0.832- 6.314	0.038, 3.718			This is an internal quality driven metric. A State or National benchmark has not been made available.
2. Total IVAC *Plus* ICU SIR		**1.01**	**2.617**	**0.754**			**1st QTR:** 2 PVAP events **2nd QTR:** 1 PVAP event **3rd QTR:** 1 PVAP event
D. CVICU/**KDHCD** Total VAEs (not NHSN/Internal)		**2**	**5**	**0**			**1st QTR:** 1 PVAP event **2nd QTR:** 2 VAC & 1 IVAC event **3rd QTR:** 1 VAC event
E. Total VAEs-Both Units		**6**	**10**	**1**			**1st QTR:** 3 VAC,1 IVAC, 2 PVAP; pursuing implementation of subglottic suctioning, and scheduled oral care. **2nd QTR:** 5 VAC, 4 IVAC, 1 PVAP; pursuing methods to reduce VAC events thereby reducing IVAC plus events. **3rd QTR:** 1 PVAP, 1 VAC; reinforcing new recommendations to start at a PEEP of 6, pushing oral care, sedation vacation and subglottic suctioning.
III. Central Line Associated Blood Stream Infections (CLABSI) CMS/VBP	**NHSN SIR**						
A. Total number of Central Line Days (CLD)		3648	3496	3665			**Annual running total:** 7144
B. Central Line Device Use SUR (standardized utilization ratio)		**0.76**	**0.72**	**0.817**			**1st QTR:** 3648 **Predicted:** 4,787.70 **2nd QTR:** 3496 **Predicted:** 4,814.87 **3rd QTR:** 3665 **Predicted:** 4,486.50
C. Total Infection Count Valule Based Purchasing (VBP) # events = [ ]		**5** **[4]**	**3** **[2]**	**4** **[3]**			**1st QTR:** 5 **Predicted:** 3.17 **2nd QTR:** 3 **Predicted:** 3.21 **3rd QTR:** 4 **Predicted:** 3.162 *(CMS) actual:3 predicted: 2.221*

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2019							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
D. SIR Confidence Interval		0.577 - 3.492	0.238 - 2.543	0.402 - 0.3051			**1st QTR:** No different than 2019 National Benchmark of 0.784. **2nd QTR:** No different than 2019 National Benchmark of 0.784. **3rd QTR:** No different than 2019 National Benchmark of 0.784.
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]		**1.58 [1.82]**	**0.97 [0.93]**	**1.265 [1.35]**			**1st QTR:** 5 events - must attempt to achieve 1 or less CLABSI events per Quarter. Implementing "Operation Stomp-Out CLABSI" interventions (29 in all). IV Safety Team has been hard at work gathering daily data from observations and intervening in the moment to ensure safe and effective line CVC and PIV line management. Transitioning interventions toward providers and GME residents. Discussing different options such as rotating the line in the IJ position for more effective dressing securement, investigating axillary vein access for subclavian line placement. Contacting hospital affiliate- Cleveland Clinic Infection Prevention to determine CLABSI prevention practices employed by that organization. Developing a CLABSI prevention CBL for residents. Continuing to offer Safety Symposium regarding CLABSI prevention for nurses. **2nd QTR:** 3 events (61% decrease from 1st QTR SIR). To achieve an SIR of 0.784 <1 CLABSI is predicted per quarter. Implemented use of Prevantix CHG swabs for scrub-the-hub activities (5 sec scrub/5 second dry). Moving forward with Operation Stomp-Out CLABSI initiatives. Working on central line documentation in Cerner. IV Safety Team continues to perform interventions such as dressing changes/advocating for line discontinuation. IV Safety Team is undergoing their 6 month evaluation process as this intervention was temporarily piloted this year. **3rd QTR:** 4 events of CLABSI identified within one month (September) . Two of the 4 events involved a

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2019							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
							bloodstream infection caused by yeast. Two of the 4 events were >4 days post insertion, the other two occured closely after insertion. All providers involved in inserting the lines implicated in a bloodstream infection received a CLABSI notification letter. Multiple factors related to each CLABSI event were identified, compared and trended. A deep dive into potential sources of yeast related bloodstream infections performed. Work is underway to develop an action plan related to these findings.
IV. Catheter Associated Urinary Tract Infections (CAUTI) CMS/VBP	**NHSN SIR**						
A. Total number of Catheter Device Days (CDD)		3908	3738	3931			**Annual running total:** 3908
B. Catheter Device Days SUR (Standardized Utilization Ratio)		**0.743**	**0.749**	**0.802**			**1st QTR:** 3908 **Predicted:** 5257.86 **2nd QTR:** 3738 **Predicted:** 4,992.08 **3rd QTR:** 3931 **Predicted:** 4,903.62
C. Total Infection Count Value Based Purchasing (VBP) # of events = [ ]		**7** **[6]**	**5** **[2]**	**10** **[6]**			**1st QTR:** 7 **Predicted:** 3.95 **2nd QTR:** 5 **Predicted:** 3.76 **3rd QTR**:10 **Predicted:** 3.96 *(CMS) actual: 6 predicted: 2.37*
D. SIR Confidence Interval		0.720 - 0.767	0.487- 2.945	1.283, 4.503			**1st QTR:** Worse than 2019 National Benchmark of 0.828 **2nd QTR:** No different than National Benchmark of 0.828. **3rd QTR:** No different than National Benchmark of 0.828.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2019							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]		1.77 [2.89]	1.33 [0.87]	2.526 [2.535]			**1st QTR:** Many of these events are due to keeping the indwelling urinary catheter longer than indicated; collecting urine cultures when not indicated. Approvals are occuring for implementation of a new order set for Urine Cultures (to help ensure when cultures are ordered they are really indicated), also implementation of a CAUTI algorithim will be starting soon. Considering dual nurse insertion of indwelling urinary catheters to reduce risk of contamination during insertion. **2nd QTR:** Urinalysis orderset implemented, however, provider have not used it frequently as it hasn't been added to their favorites in Cerner, ISS is working to address this. CAUTI prevention algorithm has been added to the Nursing Standard of Practice which is still under revision. CAUTI prevention algorithm will be added to physician ordersets so that nursing has greaterly flexibility to inact appropriate measures without waiting for physician approval to do so. **3rd QTR:** To date CAUTI far exceeds predicted values. Infection Prevention and Advance Practice Nurses perform daily rounds for indwelling urinary catheters. Education has been provided to GME residents during their grand rounds. Infection prevention and the hospital Antimicrobial Stewardship Pharmacist intervene daily informing nurses and providerd to avoid running urine cultures in the absence of symptoms for a urinary tract infection. Nurse leaders have been notified of instances in which documentation was not present
							to support actions such as retaining or reinserting indwelling urinary catheters. A strong effort is being made to hold healthcare personnel accountable to their actions and to ensure that alternatives to an indwelling urinary catheter are implemented fully in advance of catheter insertion.
V. Clostridium *difficile* Infection (CDI) CMS/VBP	**SIR**						
A. Total Infection Count	All units	5 [5]	3 [3]	6 [6]			**1st QTR:** 5 **Predicted:** 16.93 **2nd QTR:** 3 **Predicted:** 15.62 **3rd QTR:** 6 **Predicted:** 15.627

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2019

		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
B. SIR CI (KDHCD predicted range, based on risks)		0.108 - 0.655	0.049- 0.523	0.156, 0.799			**1st QTR:** Better than 2019 National Benchmark of 0.852 **2nd QTR:** Better than 2019 National Benchmark of 0.852. **3rd QTR:** Better than 2019 National Benchmark of 0.852.
C. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]		**0.3 [0.30]**	**0.19 [0.19]**	**0.384 [0.384]**			**1st QTR:** Continued implementation of the C. diff. algorithm, interventions provided by Antimicrobial Stewardship Pharmacist and Infection Prevention. **2nd QTR:** Incredible work done to consistently maintain a low C. difficile rate to interventions described during 1st QTR. **3rd QTR:** Joint effort made by Antimicrobial Stewardship Pharmacist and Infection Prevention to ensure providers and nurses follow the C. diff testing algorithm. C. diff. rates remain consistently better than national and State benchmarks.
VI. Hand Hygiene	**95%**						
A. All units Percentage of correct Hand Hygiene observations/opportunities (30 observations/month/unit)		**88%**	**90%**	**90%**			**1st QTR:** 3,397 of 3,877 hand hygiene observations were compliant. **2nd QTR:** 3,547 of 3,938 hand hygiene observations were compliant. **3rd QTR**: 2,930 of 3,273 hand hygiene observations were compliant. Will initiate pilot study using a remote hand hygiene surveillance system for 6 months on 4N and ICU units starting December 2019.
VII. VRE (HAI) Blood-Hospital Onset (HO)	**BM**						
A. Total Infection Count		**0**	**0**	**0**			**1st QTR:** 0 **Predicted:** 0 **2nd QTR:** 0 **Predicted:** 0 **3rd QTR:** 0 **Predicted:** 0
B. Prevalence Rate (x100)		**0**	**0**	**0**			**1st QTR:** 0 **2nd QTR:** 0 **3rd QTR:** 0
C. Number Admissions		7236	7209	7048			21,493
VIII. MRSA (HAI) Blood CMS/VBP	**SIR**						
A. Total Infection Count (IP Facility-wide)		**3 [3]**	**1 [1]**	**4 [4]**			**1st QTR:** 3 **Predicted** 1.41 **2nd QTR:** 1 **Predicted:** 1.43 **3rd QTR:** 4 **Predicted:** 1.963
B. SIR CI (KDHCD predicted range, based on risks)		0.541 - 5.785	0.035- 3.462	0.647, 4.914			**1st QTR:** No better than 2019 National Benchmark of 0.815. **2nd QTR:** No different than National Benchmark of 0.815. **3rd QTR**: No different than National Benchmark of 0.815.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2019

		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
C. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]		2.13 [2.13]	0.70 [0.70]	2.037 [2.037]			**1st QTR:** Many of the identified MRSA BSI are also CLABSI events. Reviewing culture practices with providers through our Operation Stomp-Out CLABSI campaign. Also, working on initiating a "Do U Disinfect Everytime (D.U.D.E.) campaign to highlight the importance of hand hygiene compliance, "scrub-the-hub" and cleaning the patient environment. Trialed and will be universally using Prevantics CHG wipes to perform "scrub-the-hub" a 5 second process. Stakeholders are supporting all these interventions. **2nd QTR:** Interventions described above under 1st QTR continue. There has been evaluation underway regarding nasal decolonization products that may be useful in addressing seasonal spike in MRSA BSI during the Flu Season. **3rd QTR:** Two MRSA BSI events this quarter were due to serial blood cultures to validate effectiveness of treatment. Unfortunately, the serial testing contributed to the two events being reported as healthcare onset events. The remaining two MRSA events involved one case that appears to have been unpreventable, the last case may have been due to a combination of retaining peripheral IV access too long and poor management of the dressing. This last patient also had MRSA in respiratory secretions. In response to these findings, LVNs were added to the pilot process of the IV Safety Team. Their role includes timely removal/replacement of peripheral IV lines.
IX. Influenza Rates (Year 2018-2019)	**NHSN**						
A. All Healthcare Workers 5,384 working/5,279 total vaccination (90 declined)		98.0%					**Season 2018-2019**: **Action:** Once again Kaweah Delta has consistently exceeded the Healthy People 2020 goal of 90% vaccination rate.

Approved IPC: 6/27/2019
Approved IPC: 9/19/2019
Approved IPC: 12/19/2019
Approved IPC:

Prepared by Shawn Elkin, MPA, BSN, RN, PHN, CIC
Infection Prevention Manager

Unit/Department Specific Data Collection Summarization

QIC/Professional Staff Committee Report

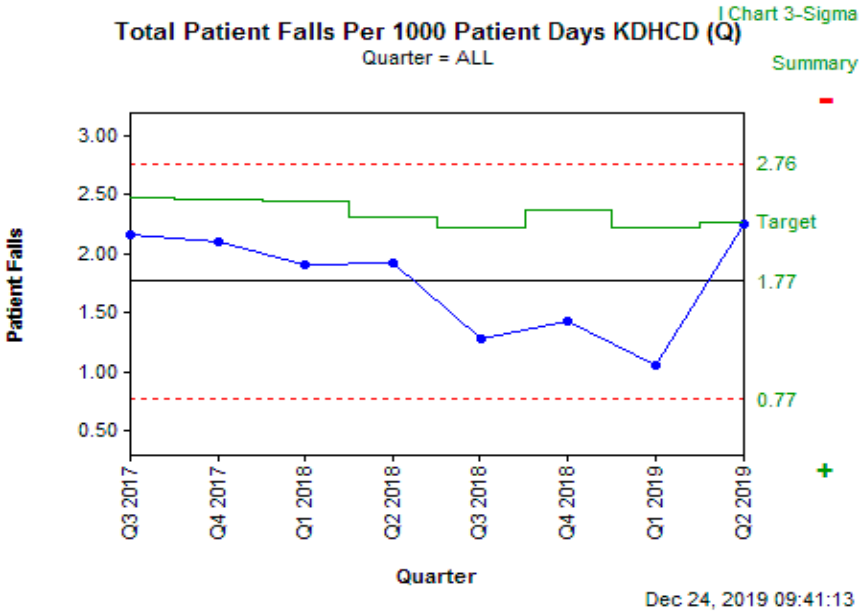
Unit/Department: Falls Committee **QIC/ProStaff Report Date: March 4, 2020**

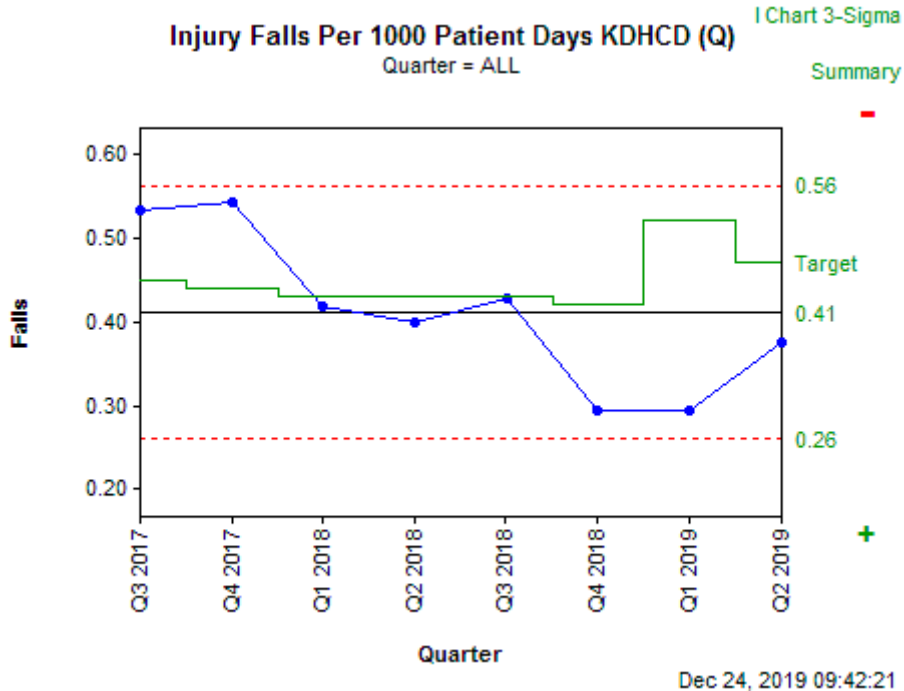
Measure Objective/Goal:

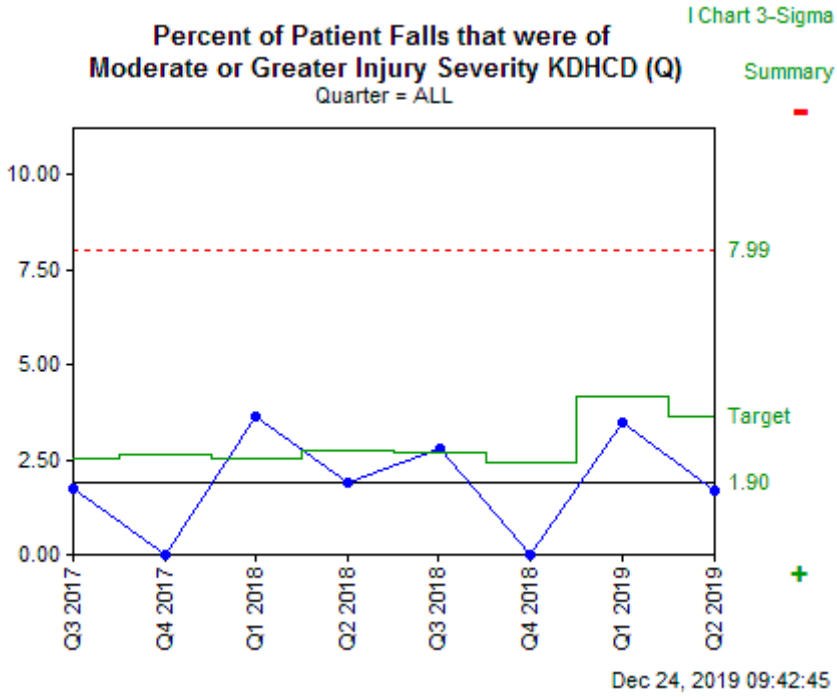
1. KDHCD Nursing Unit Falls Data:
   - Total Falls per 1000 patient days
   - Total Injury Falls per 1000 patient days
   - Percent of Falls with Moderate to Severe Injury
2. Inpatient Unassisted Falls: Spot check January-October 2019
3. Falls U Root Cause Analysis Questions January-December 2019

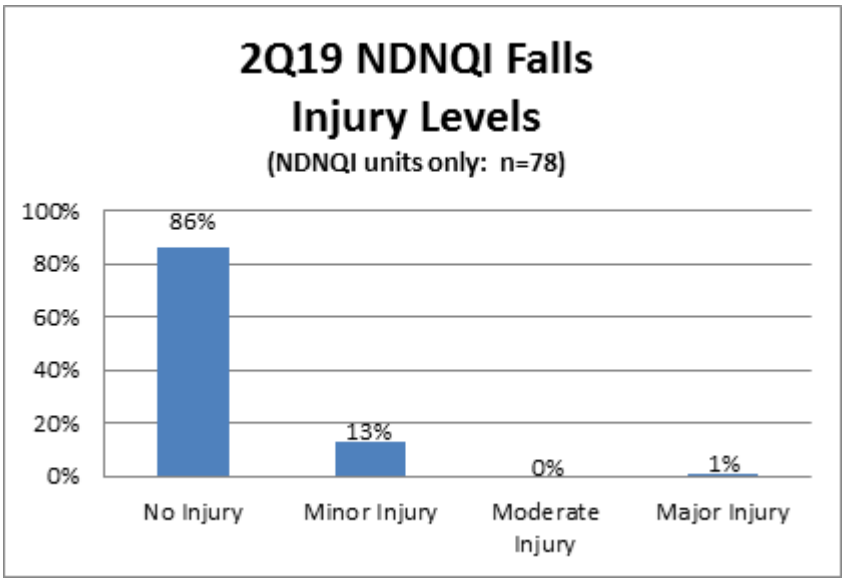
Date range of data evaluated:

1. KDHCD Q 2, 2019

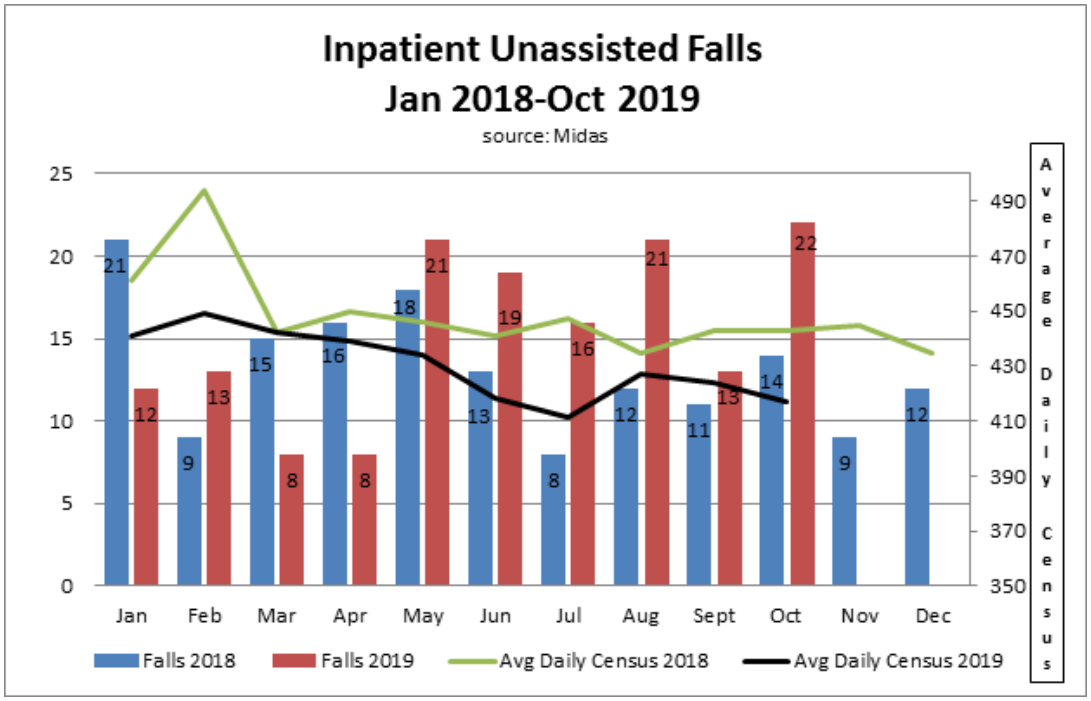




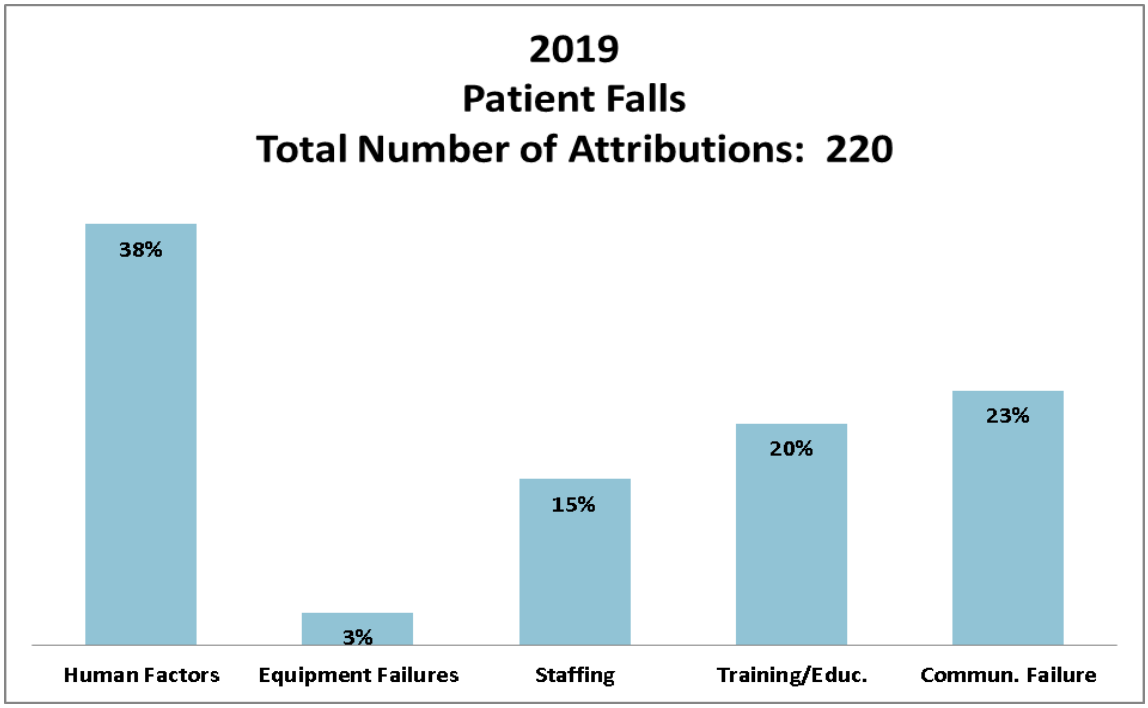

I Chart 3-Sigma
Percent of Patient Falls that were of
Moderate or Greater Injury Severity KDHCD (Q)
Quarter = ALL
Summary
10.00
7.50
5.00
2.50
0.00
7.99
Target
1.90
Q3 2017
Q4 2017
Q1 2018
Q2 2018
Q3 2018
Q4 2018
Q1 2019
Q2 2019
Dec 24, 2019 09:42:45


2Q19 NDNQI Falls
Injury Levels
(NDNQI units only: n=78)
100%
80%
60%
40%
20%
0%
86%
13%
0%
1%
No Injury
Minor Injury
Moderate Injury
Major Injury

2. Inpatient Unassisted Falls, Spot check: January-October, 2019



3. Falls U Root Cause Analysis Questions January-December 2019



Analysis of all measures/data for Q2, 2019: (Include key findings, improvements, opportunities)

1. KDHCD hospital data:
   - Overall, fall metrics remain at or below target for all indicators.
   - Total falls per 1000 patient days 2.26, below target (2.27).
   - Total injury falls per 1000 patient days 0.38, below target (0.47).
   - Percent of falls with moderate or greater injury 1.67, below target (3.65). It is important to note 86% of falls were without injury, 13% were minor and 1% was categorized as major. The major injury fall was a 2nd and 4th metatarsal fracture in a 28 year old.
   - Falls involving psychosocial and behavioral issues continue to be the most challenging falls to manage throughout the District.
   - It was identified through Falls University follow up that staff did not consistently connect bed data cables correctly. As a result of this analysis, education was provided to clinical staff on December18, 2019.
2. Inpatient Unassisted Falls, Spot check:
   - While total falls and total injury falls continue to be below target, it was identified at Falls University that an increase in total falls was noted in Q 2, 3 and through October 2019 which was not related to typical seasonal variations (see Inpatient Unassisted Falls above). An analysis of this trend identified clinical nurse attendance at Falls University was suspended due to Operation Bottom Line in May, 2019. This trend and attribution was discussed at Patient Care Leadership in December 2019 and it was decided clinical nurses will now be, once again, required to attend Falls University effective January 3, 2020.
3. Falls U Root Cause Analysis Questions January-December 2019

   Analysis of the five root cause analysis questions, comparing 2019 data against 2018 data demonstrates the following as possible contributing factors to the fall:
   - Human factors (fatigue, lack of critical thinking, failure to follow policy and procedure, inability to focus on task, rushing to complete the task) increased by 28%.
   - Equipment failures decreased by 25%.
   - Staffing (primary nurse on break, adequate staffing) decreased by 35%.
   - Would training or education (staff competency) have prevented the fall increased by 5%.
   - Communication failures (between staff or between patient and staff) decreased by 11%.

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

- Improve onboarding of clinical staff. Explore creation of an enduring class which educates new staff on the pathophysiology of falls and the KDHCD falls prevention program/policies. This is on the project list for 2020.
- Continue weekly review of falls at Falls University with publication of Falls U Take Aways each week. This continues to be an excellent opportunity to provide real time education and discussion of prevention strategies. Clinical Nurses will once again be required to attend.
- Reinforcement of unit level accountability: 1) Falls University, 2) inclusion of NDNQI Falls metrics in unit-level QIC reports, 3) review of outliers as appropriate at NPIC and Falls Committee.

Submitted by Name:
Rose Newsom, MSN NE-BC
Director of Nursing Practice
Falls Committee Chair

Date Submitted:
December 24, 2019

Kaweah Delta
HEALTH CARE DISTRICT

GENERAL METRICS	DECEMBER 2019		JANUARY 2020		FEBRUARY 2020	
	KDHCD	GOAL	KDHCD	GOAL	KDHCD	GOAL
ED Volume	7419		7705		7446	
Percent of Patients Left Without Being Seen	1.1%	1.5%	1.4%	1.5%	1.8%	1.5%
Percent of Patients Left During Treatment	1.6%	1.5%	1.9%	1.5%	2.3%	1.5%
Percent of Patients Left Against Medical Advice	0.8%	NA	0.6%	NA	1.0%	NA
Percent of Patients Admitted	24%	NA	24%	NA	24%	NA
Percent of Patients Discharged	70%	NA	69%	NA	69%	NA
		CMS State		CMS State		CMS State
ED THROUGHPUT METRICS		Benchmark		Benchmark		Benchmark
Median Length of Stay in Minutes for Admitted Patient (Hours)	445 (7.4)	407 (6.8)	525 (8.8)	407 (6.8)	507 (8.45)	407 (6.8)
Median Length of Stay in Minutes for Discharged Patient (Hours)	206 (3.4)	186 (3.1)	207 (3.5)	186 (3.1)	208 (3.5)	186 (3.1)
Median Length of Stay in Minutes for Admit Decision to ED Depart (Hours)	219 (3.6)	197 (3.3)	302 (5.0)	197 (3.3)	294 (4.9)	197 (3.3)
Average Length of Stay in Minutes for Admitted Mental Health Patients (Hours)	781 (13)		628 (10.4)		792 (13.2)	
CENSUS TOTALS BY DISPOSITION						
Number of Patients Arriving by Ambulance	1973		1985		1992	
Number of Trauma Patients	149		127		136	
Number of Patients Admitted	1774		1841		1821	
Number of Patients Discharged	5190		5350		5048	
Number of Mental Health Patients Admitted	82		91		91	
PATIENT EXPERIENCE		GOAL		GOAL		GOAL
Emergency Room Overall Care Percent 9S-10S	56.52%	62%	*73%	62%		62%
Would Recommend Percent Definitely YES	78.26%	76%	81%	76%		76%
KEY	> 10% Above Benchmark/Goal		Within 10% of Benchmark/Goal		Outperforming or Meeting Benchmark/Goal	

*90TH PERCENTILE

Maternal Child Health Quality Report 2020

Presented by

Juan Sabogal MD, OB/GYN Department

Marius Dosado MD, Medical Director Neonatal Intensive Care Unit

Julianne Randolph DO, Medical Director Pediatric Department

KAWEAH DELTA HEALTH CARE DISTRICT

Labor & Delivery/Mother Baby Quality Report

Quality Data 2019

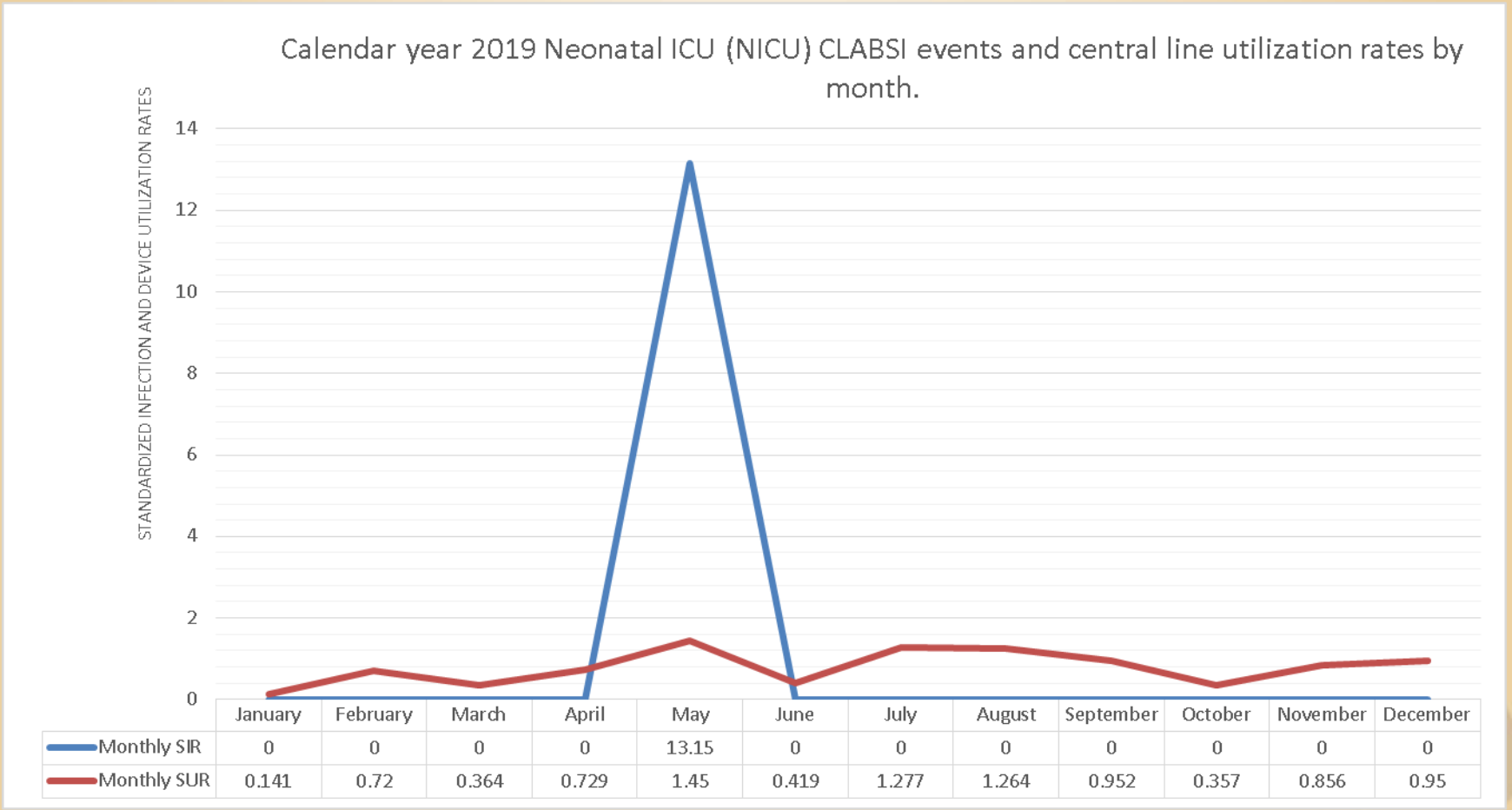
Measure	Rate	Benchmark
Early Elective Deliveries (PC01)	0	0
Primary C-Sections Normal, Term, Singleton, Vertex (NTSV) (PC02)	23.8%	24%
Antenatal Steroids (PC03)	100%	98%
MD notification of new onset Hypertension within 60 min	93.6%	90%

New Quality Initiatives

- Laborist Program: This program started March 16, 2019. This program has been very beneficial in providing for the safety of all of our Obstetrical patients in the hospital.
- Enhanced Recovery After Surgery/C-Section (ERAS): The Department of OB in collaboration with the Anesthesia Dept, is working on development and implementation of ERAS Perioperative Pathways. These pathways have been proven to improve the recovery process and has been implemented in other surgical procedures including the Orthopedics Service Line. We are currently in the process of creating the order sets.
- Nitrous Oxide for Laboring Patients: Labor & Delivery started using Nitrous Oxide in December 2019. This is a new service for pain management for Laboring patients. This option allows our patients another alternative to IV pain medications and epidurals. It is another tool to improve their experience and also allow for a non-opioid choice for pain management.

NICU Quality Report

CLABSI Data



	January	February	March	April	May	June	July	August	September	October	November	December
Monthly SIR	0	0	0	0	13.15	0	0	0	0	0	0	0
Monthly SUR	0.141	0.72	0.364	0.729	1.45	0.419	1.277	1.264	0.952	0.357	0.856	0.95

New Quality Initiatives

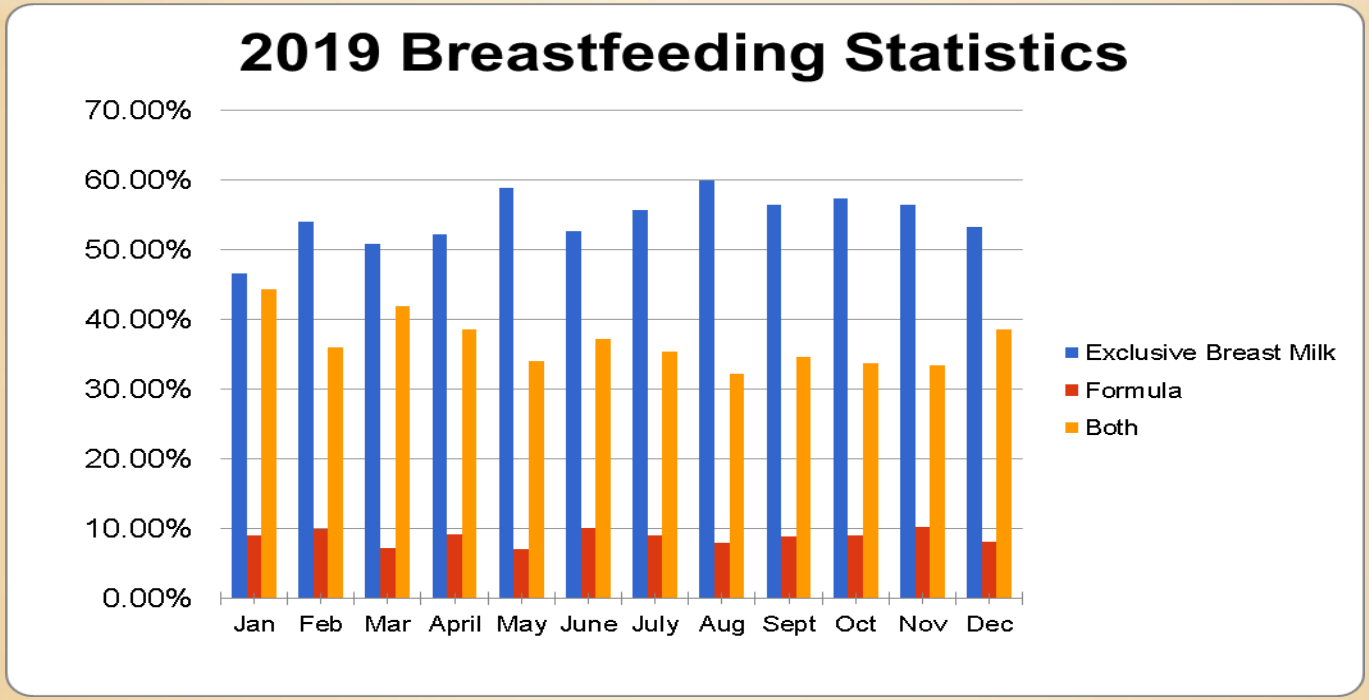
- New Order Set for Oxygen Therapy, Feeding Assessment, Antibiotic Stewardship.
- Milk Technician Certification: Staff will receive training and certification for the Milk Technician role in the NICU. This is a Joint Commission Recommendation for NICU's. This will standardize the process and improve patient safety for our NICU Babies. This program is provided by Columbus State Community College and will start in April, 2020.
- Sleep, Eat, Console: This is a new program that may allow us to keep some of our Drug Effected Infants with their mothers. This may be an alternative to the use of methadone to treat their addiction. After mother is discharged these babies could be admitted to Pediatrics for the remainder of their stay. More to come.
- Moving to the New NICU!!!

Pediatrics Quality Report

Pediatric Quality Dashboard

Measure	Rate	Benchmark
Falls	10.31	1.47/1000 pt days
Peripheral IV infiltrations	0	0

Exclusive Breastfeeding Rates and Initiatives



- In conjunction with feeding orders, Lactation Staff have adjusted their workflows to include spending 8 hours/day on the Labor & Delivery, Labor Triage and Antepartum Testing Units. This is allowing them to see patients prior to delivery to provide education and information regarding breastfeeding as being the best for their babies. This will also allow time to help with first feeds which can be critical to successful breastfeeding.
- We have partnered with our rural health clinics to ensure we are all educating the same way with the same information and resources.

New Quality Initiatives

New Pediatric Metrics

1. Emergency Department consults to Pediatrician prior to transfer
2. Pediatric Re-Admissions
3. Admission time to orders placed
4. Length of Stay by Diagnosis

Upcoming/Current Quality Projects

1. Pediatric M&M's

2. Implementing new clinical pathways for Asthma, Bronchiolitis and Soft-tissue/skin infections

3. Pearls & Pitfalls in collaboration with the ED.

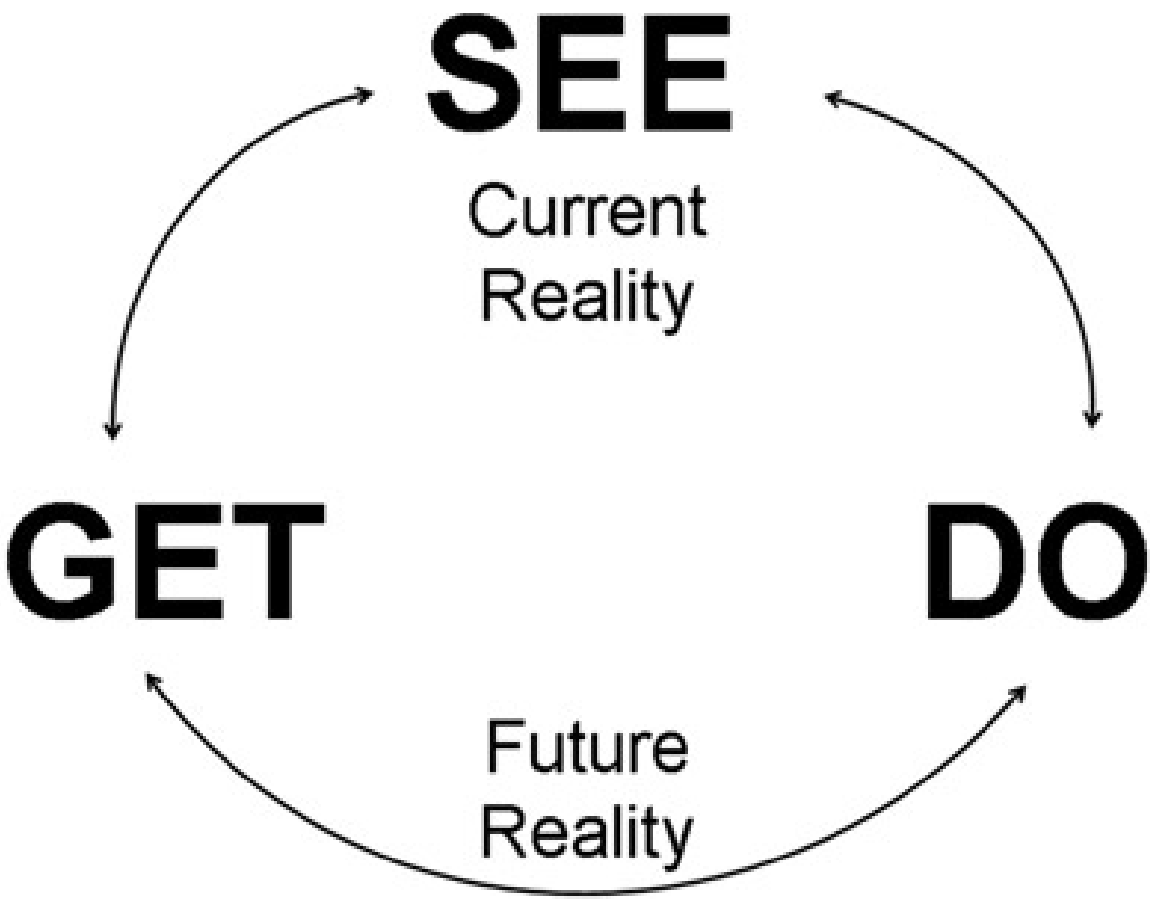
Questions?

Hospital Acquired Pressure Injury (HAPI) Prevention Quality Focus Team Interim Report

Mary Laufer, DNP, RN, NE-BC
Director of Nursing Practice
Quality Council
March 2020

KAWEAH DELTA HEALTH CARE DISTRICT

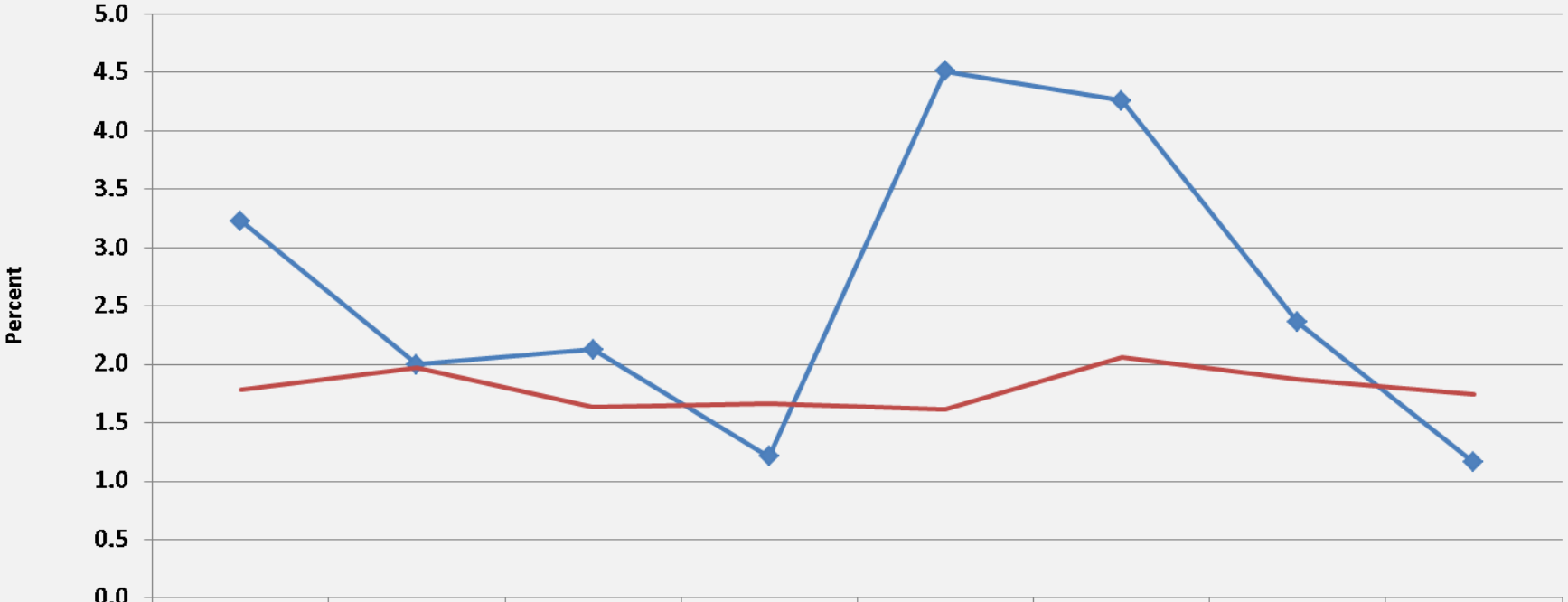
Be Proactive



FranklinCovey, 2005

National Database of Nursing Quality Indicators (NDNQI) One Day Prevalence Study

NDNQI One Day Prevalence - Percentage of Surveyed Patients with Hospital Acquired Pressure Injuries (HAPI) Stage 2+
4Q 2017 - 3Q 2019 (lower is better)

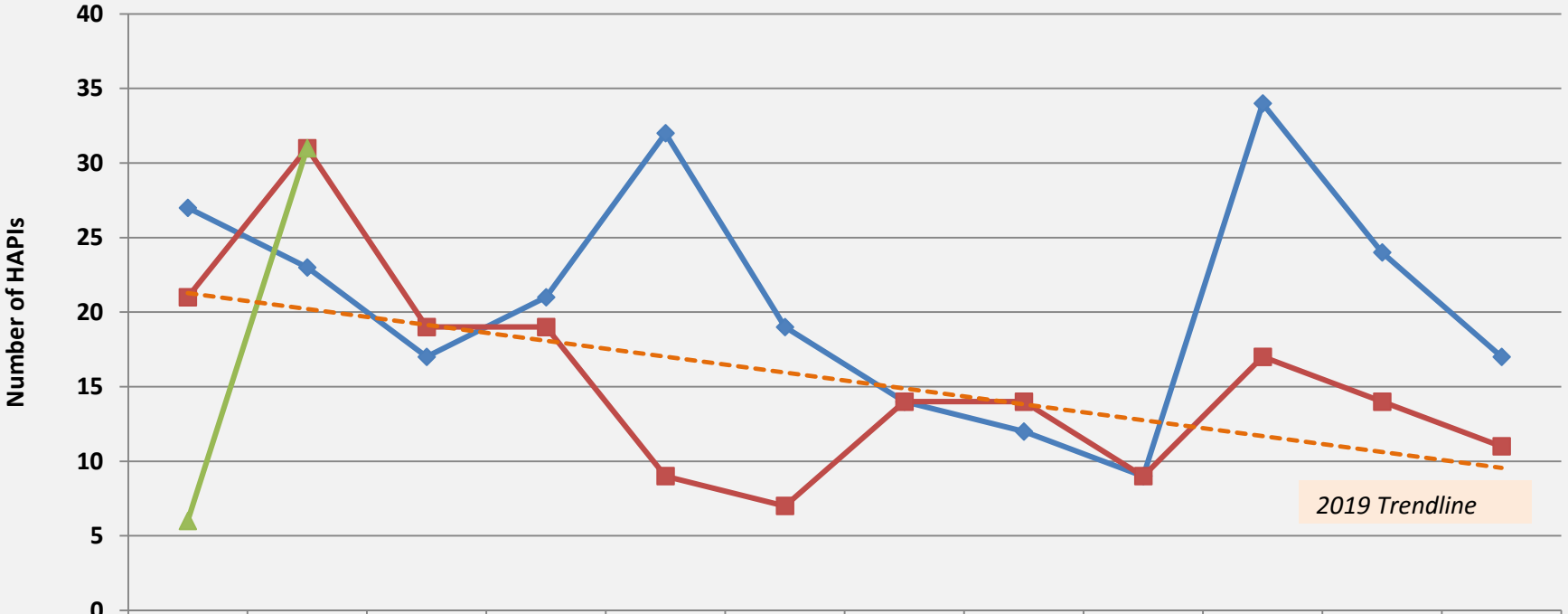


	4Q 2017	1Q 2018	2Q 2018	3Q 2018	4Q 2018	1Q 2019	2Q 2019	3Q 2019
KDHCD	3.23	2.00	2.13	1.21	4.51	4.26	2.36	1.16
Target	1.8	2.0	1.6	1.7	1.6	2.1	1.9	1.7

Hospital Acquired Pressure Injury (HAPI) Incidence

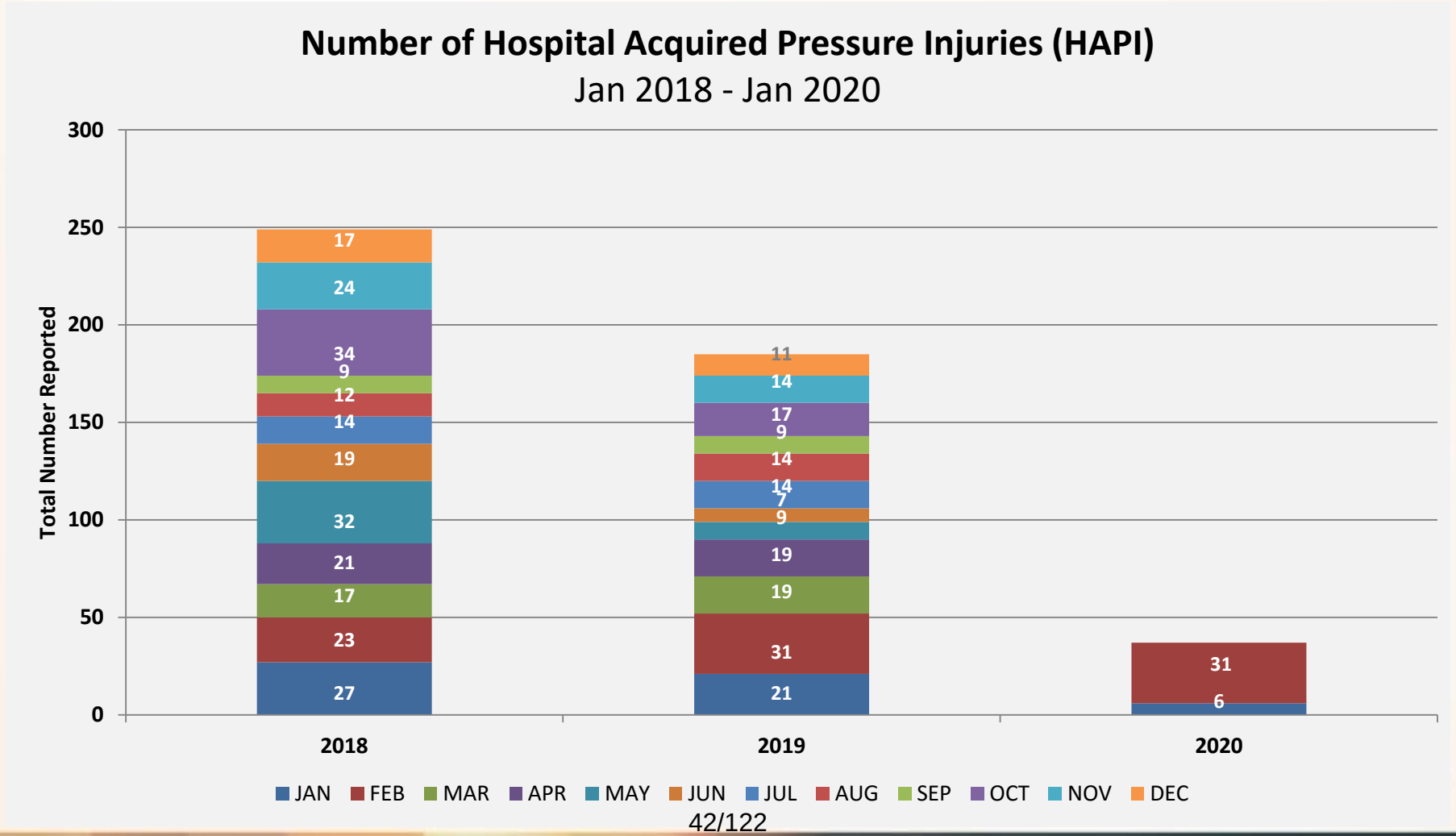
Number of Hospital Acquired Pressure Injuries (HAPI)

Jan 2018 - Feb 2020



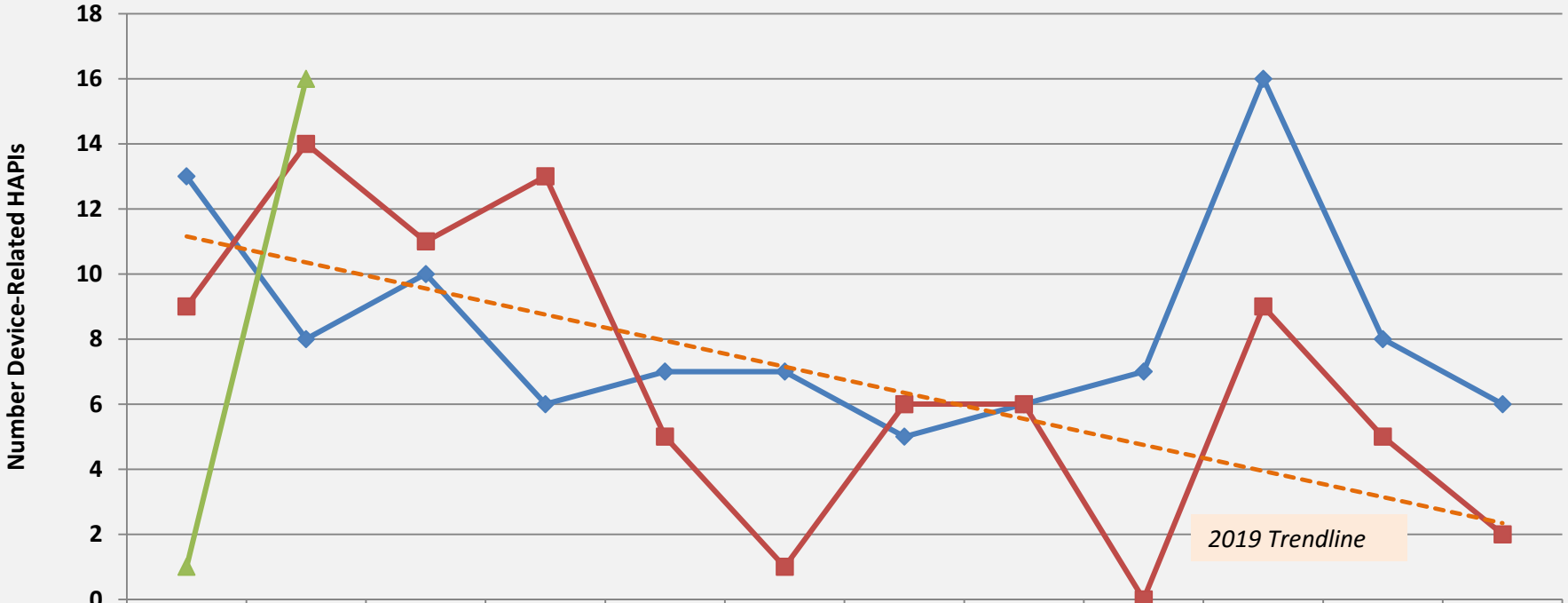
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
2018	27	23	17	21	32	19	14	12	9	34	24	17
2019	21	31	19	19	9	7	14	14	9	17	14	11
2020	6	31										

Hospital Acquired Pressure Injury (HAPI) Incidence



Device-Related Hospital Acquired Pressure Injury (HAPI) Incidence

Number of Device-Related Hospital Acquired Pressure Injuries (HAPI)
Jan 2018 - Jan 2020



	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
2018	13	8	10	6	7	7	5	6	7	16	8	6
2019	9	14	11	13	5	1	6	6	0	9	5	2
2020	1	16										

Addressing Opportunities

- Protective Dressing Power Plan
- Wound Class curriculum
- Pressure injury identification and documentation in Emergency Department
- Prevalence study schedule and follow-up

Knowledge – Skills – Attitude

- Resources available
- Supplies accessible
- Success celebrated
- Event inquiries engaging
- Practice development inclusive

Clinical Quality Goals FY20

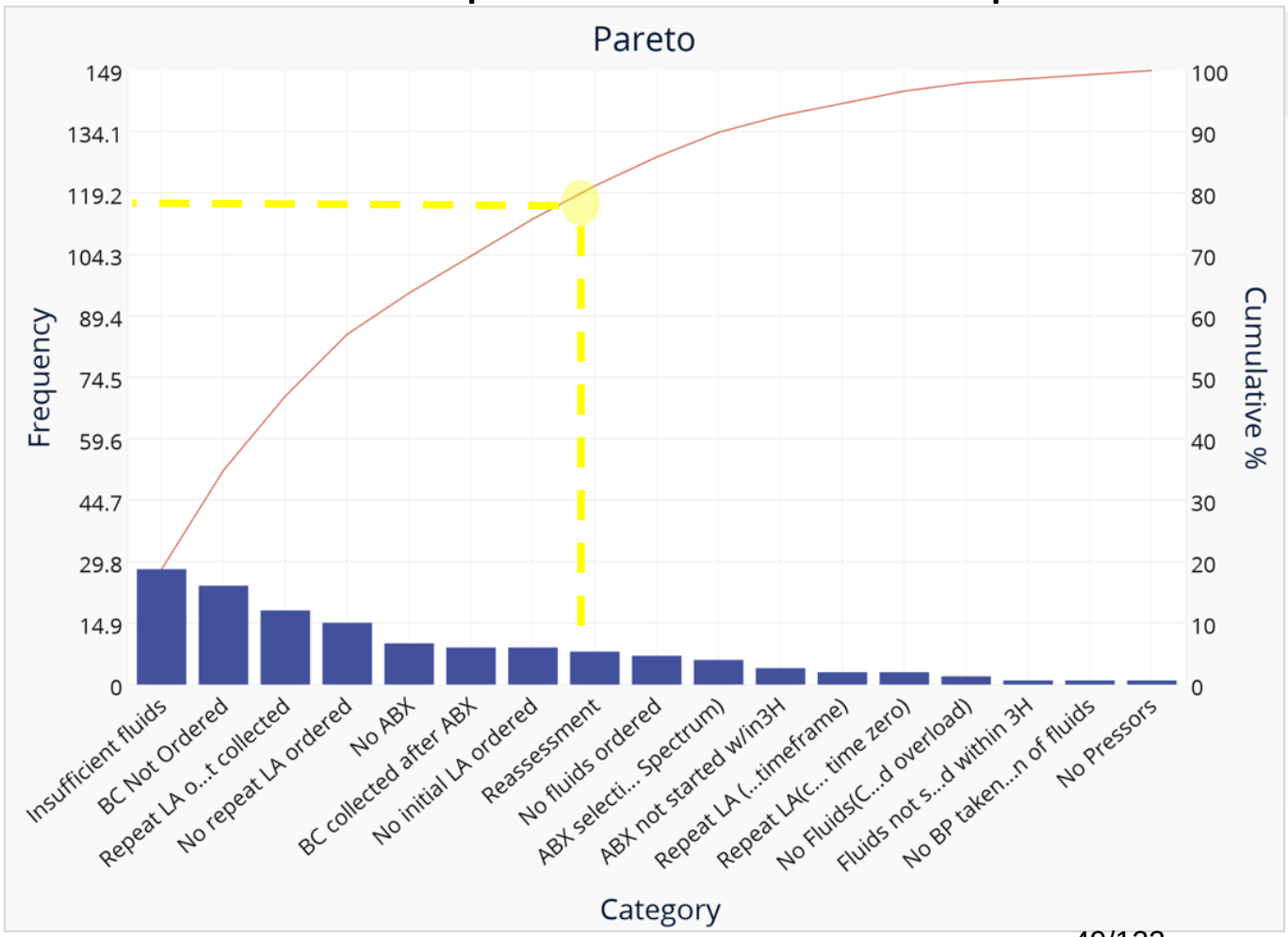
Kaweah Delta Clinical Quality Leadership Goals FY 2020

	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019
SEP-1 Early Management Bundle	68%	67%	58%	67%	61%	74%

- 2nd Sepsis Coordinator Approved!
  - Estimating 6% increase in bundle compliance
- System revisions and RRT support for off coordinator hours
- Sepsis Six Sigma Style, includes all subject matter experts!

Kaweah Delta Clinical Quality Leadership Goals FY 2020

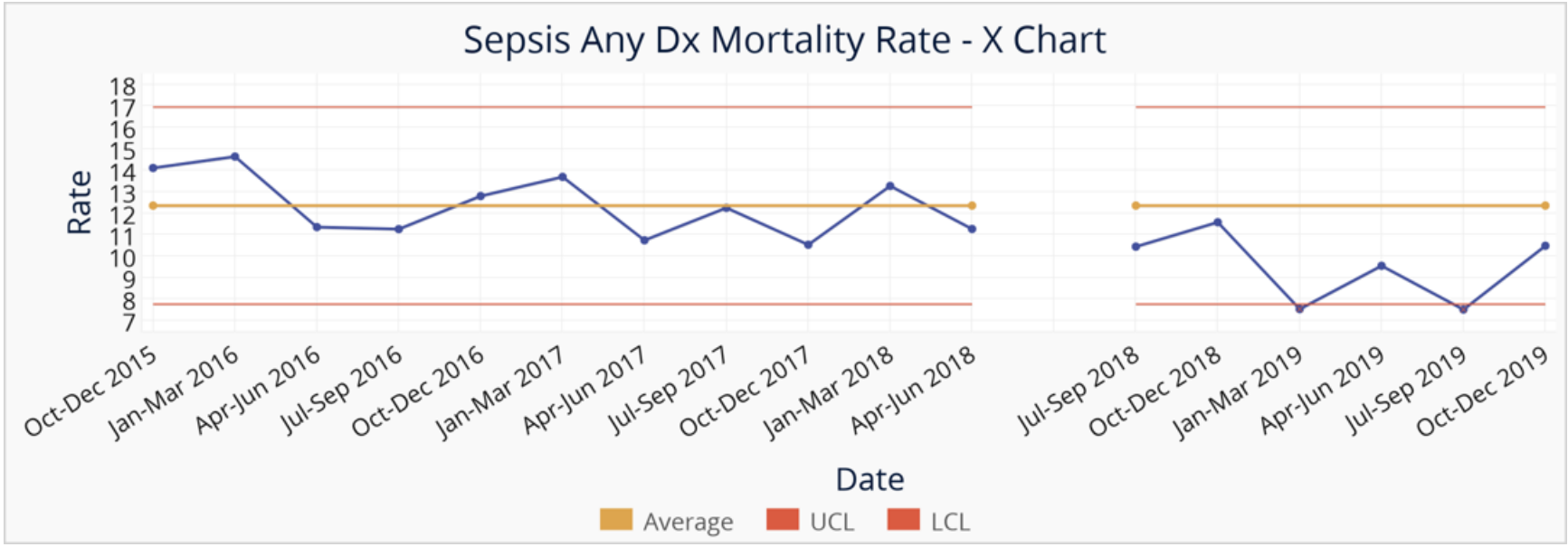
Reasons for Sepsis Bundle Non-Compliance



Results

	Frequency	Cumulative Frequency	Percentage	Cum Percentage
Insufficient fluids	28	28	18.79	18.79
BC Not Ordered	24	52	16.11	34.9
Repeat LA ordered but not collected	18	70	12.08	46.98
No repeat LA ordered	15	85	10.07	57.05
No ABX	10	95	6.71	63.76
BC collected after ABX	9	104	6.04	69.8
No initial LA ordered	9	113	6.04	75.84
Reassessment	8	121	5.37	81.21

Mortality Rate: Sepsis Any Dx



X Chart Statistics

	Stage 1	Stage 2
UCL	16.9434	16.0048
Average	12.3501	9.5107
LCL	7.7567	3.0165

Kaweah Delta Clinical Quality Leadership Goals FY 2020

	Current						Future State Scenario								
	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	April 2020	May 2020	June 2020	**Total**	**SIR GOAL <0.815 or 7**	**VBP 2021 50 perc 0.763**
MRSA (SIR)	2.67	1.33	1.33	0.00	0.00	2.78	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.68**		
numerator (actual)	2	1	1	0	0	2	0	0	0	0	0	0	6		
denominator (predicted)	0.75	0.75	0.75	0.72	0.72	0.72	0.73	0.73	0.73	0.73	0.73	0.73	8.76		

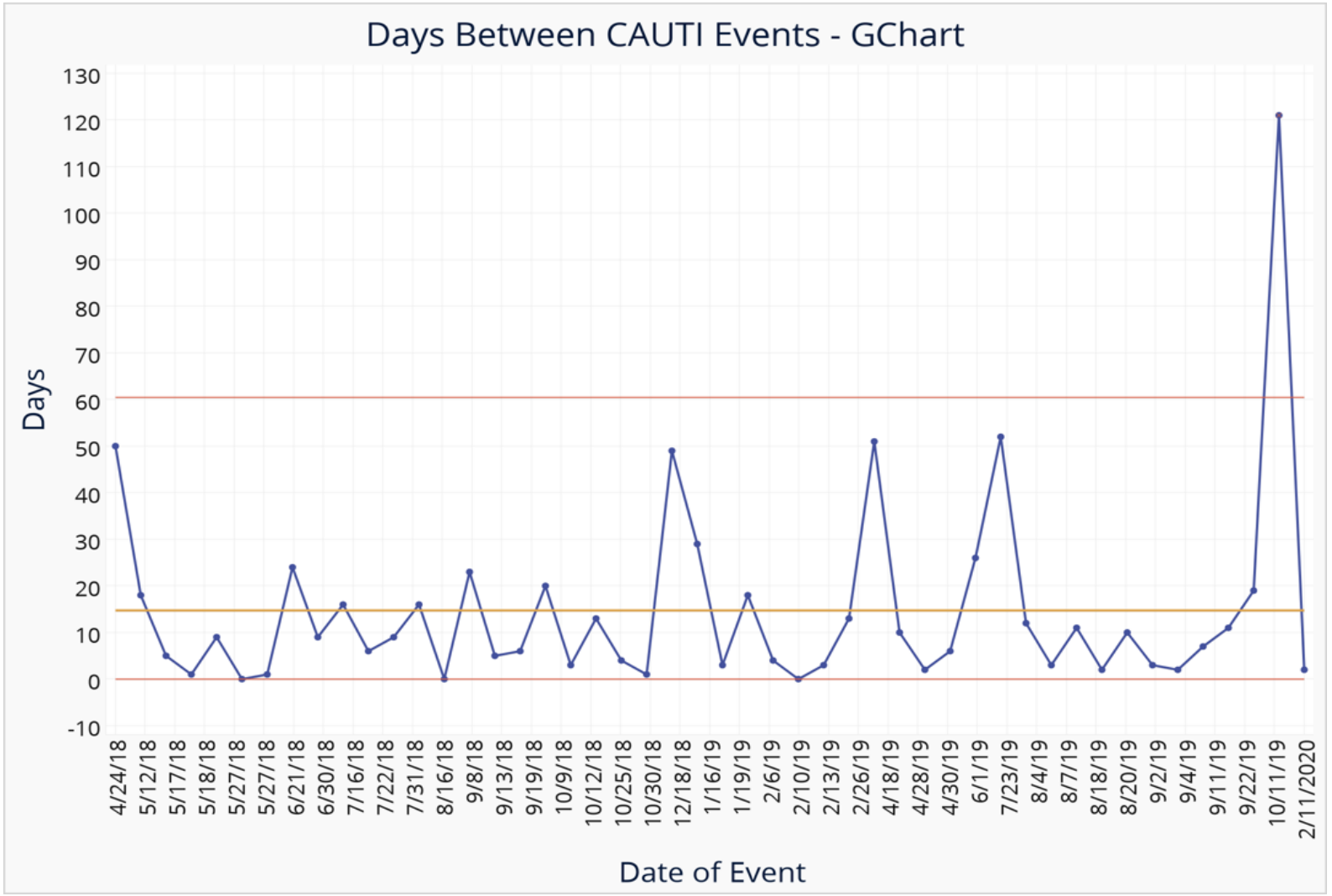
Actual MRSA in FYTD = 6

Number we can have to meet goal = 7

FYTD SIR = 1.18

Baseline = 1.41

Kaweah Delta Clinical Quality Leadership Goals FY 2020



Results Report

FYTD SIR= 1.03
Base = 1.557
Goal = <0.828

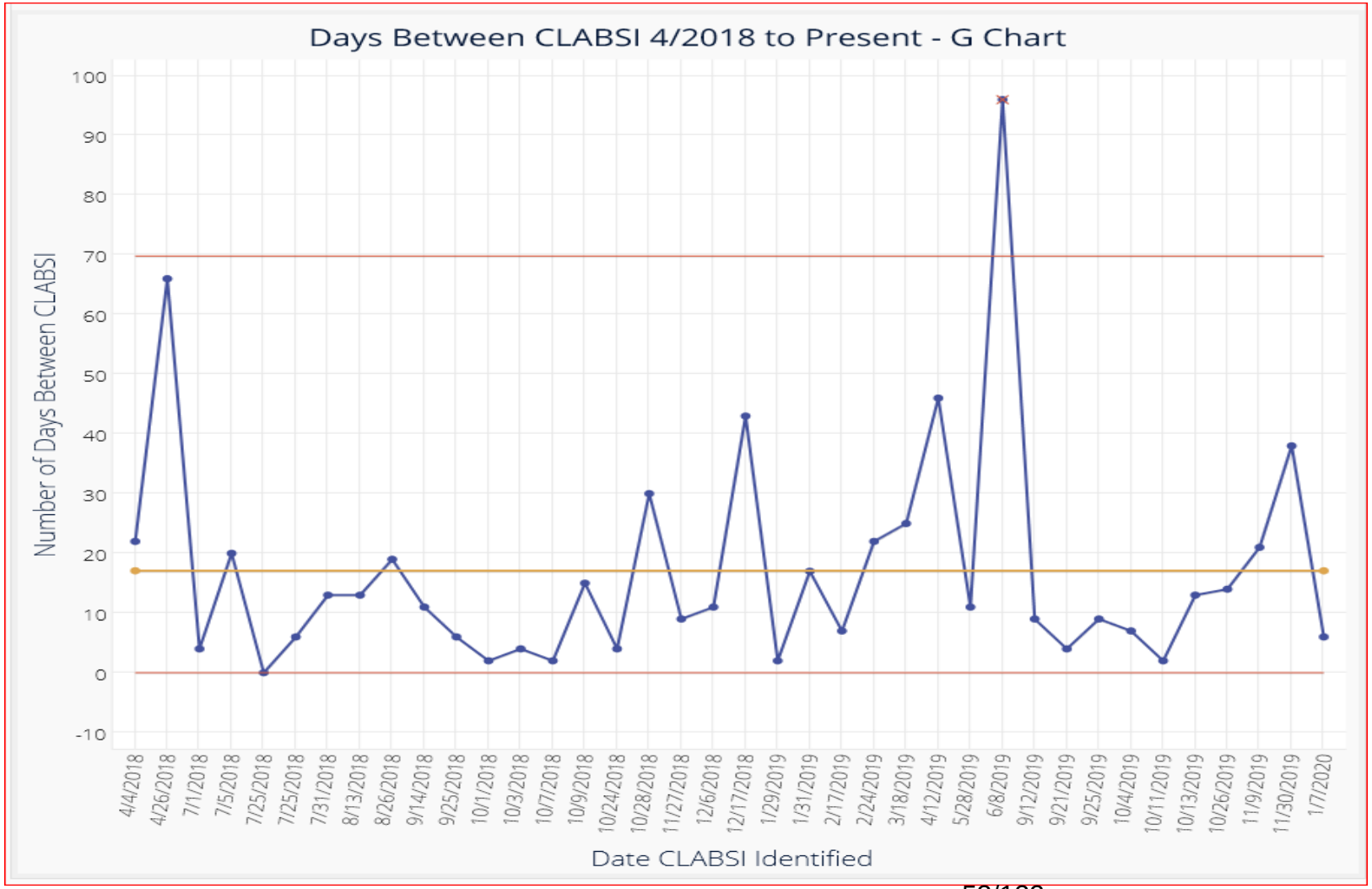
Mean days b/w CAUTI 4/1208 to 10/2019= 12.78
Goal >30

Mean days b/w CAUTI 4/2018 to Feb 2020= 14.75
***astronomical point noted at 121 days between 10/11/19 and 2/9/20**

For FY20 we can have 15 CAUTIs and meet goal of ≤0.828

Since July 2019 we have had 13

Kaweah Delta Clinical Quality Leadership Goals FY 2020



Results Report

FYTD SIR = 1.34
Base = 1.25
Goal = ≤0.784

Mean days between CLABSIs 4/2018 to 1/2020 = 17
Goal > 40.5

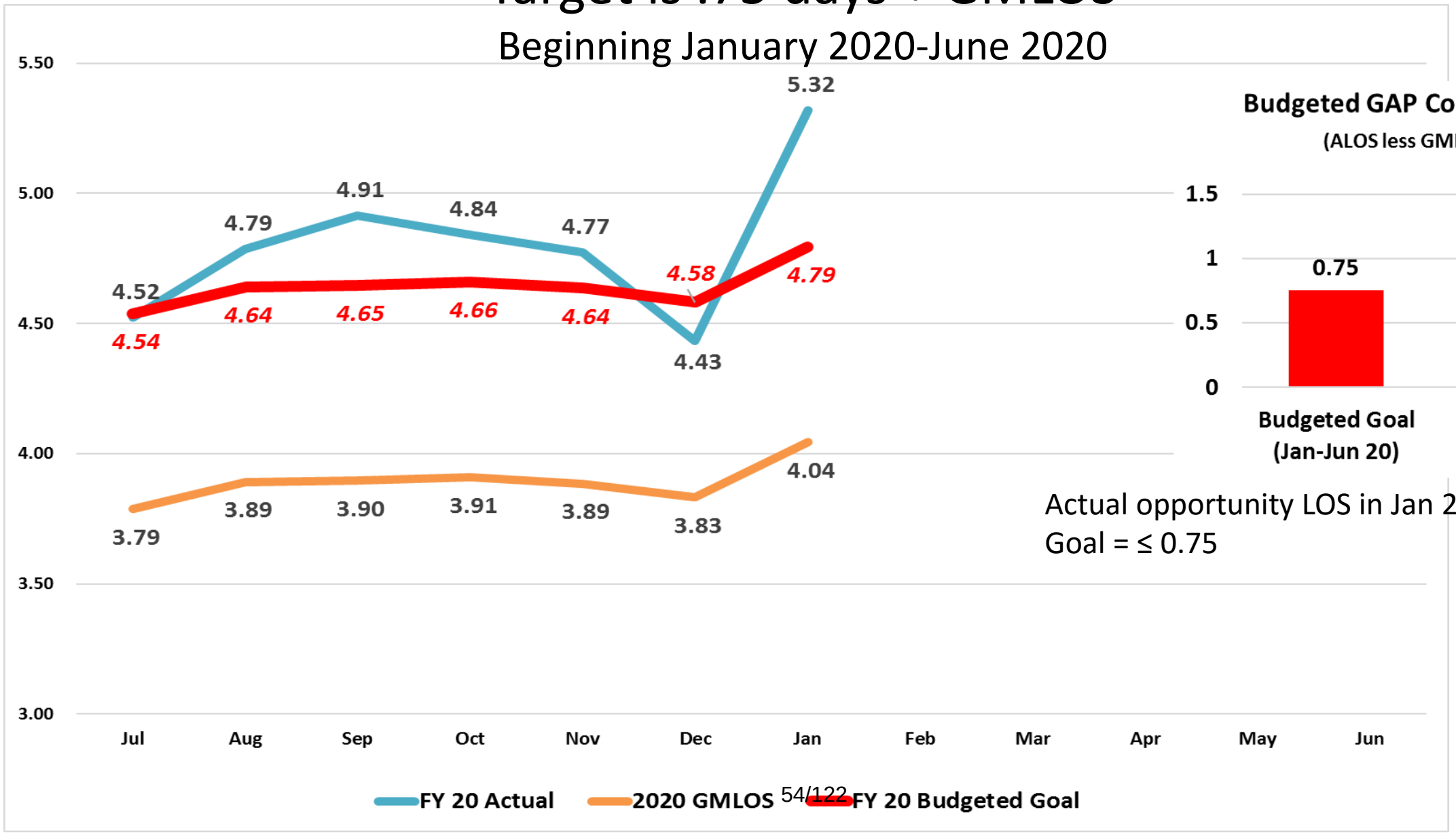
For FY20 we can have 11 CLABSIs and meet goal of ≤0.784

Since July 2019 we have had 11

Average Length of Stay FY 20 Goal

Target is .75 days + GMLOS

Beginning January 2020-June 2020



Actual opportunity LOS in Jan 2020 = 1.27 days

Goal = ≤ 0.75