May 8, 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 May 14, 2020, in the Kaweah Delta Support Services Building Emerald Room (1st Floor) 520 West Mineral King Avenue or via GoTo Meeting from your computer, tablet or smartphone. https://global.gotomeeting.com/join/903078061 or call (646) 749-3112 - Access Code: 903-078-061.

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:01AM on Thursday May 14, 2020, in the Kaweah Delta Support Services Building Emerald Room pursuant to Health and Safety Code 32155 & 1461. Board members and Quality Council closed session participants will access closed meeting via Confidential GoTo meeting phone number provided to them.

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Quality Council Committee meeting immediately following the 7:01AM Closed meeting on Thursday May 14, 2020, in the Kaweah Delta Support Services Building Emerald Room or via GoTo Meeting via computer, tablet or smartphone. https://global.gotomeeting.com/join/903078061 or call (646) 749-3112 - Access Code: 903-078-061.

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.

Due to COVID 19 visitor restrictions to the Medical Center - the disclosable public records related to agendas can be obtained by contacting the Board Clerk at Kaweah Delta Medical Center – Acequia Wing, Executive Offices (Administration Department) {1st floor}, 400 West Mineral King Avenue, Visalia, CA via phone 559-624-2330 and on the Kaweah Delta Health Care District web page http://www.kaweahdelta.org.

KAWEAH DELTA HEALTH CARE DISTRICT
David Francis, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
Board Clerk, Executive Assistant to CEO

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

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
QUALITY COUNCIL

Thursday, May 14, 2020

520 Mineral King Ave - Emerald Room, 1st Floor Support Services Building

GoTo Meeting from your computer, tablet or smartphone.
https://global.gotomeeting.com/join/903078061

Call in option: 1-646-749-3112 Access Code: 903-078-061

ATTENDING: Board; Herb Hawkins – Committee Chair, David Francis; 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, DIO & VP of Medical Education; Tom Gray, MD, Quality and Patient Safety Medical Director; Sandy Volchko, Director of Quality and Patient Safety; Ben Cripps, Chief Compliance Officer, and Michelle Adams, Recording.

OPEN MEETING – 7:00AM

1. **Call to order** – *Herb Hawkins, 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. **Approval of Quality Council Closed Meeting Agenda** – 7:01AM
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Monica Manga, MD, and Professional Staff Quality Committee Chair;*
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Anu Banerjee, PhD, VP & Chief Quality Officer*
4. **Adjourn Open Meeting** – *Herb Hawkins, Committee Chair*

CLOSED MEETING – 7:01AM

1. **Call to order** – *Herb Hawkins, Committee Chair & Board Member*
2. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Monica Manga, MD, and Professional Staff Quality Committee Chair*
3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 –– *Anu Banerjee, PhD, VP & Chief Quality Officer*
4. **Adjourn Closed Meeting** – *Herb Hawkins, Committee Chair*

OPEN MEETING – Immediately following the 7:01AM Closed Meeting

1. **Call to order** – *Herb Hawkins, 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. **April Quality Council Report Summary**
   - 3.2. **Stroke Program Quarterly Quality Report**
   - 3.3. **Mental Health Careline Quality Report**
   - 3.4. **Subacute and Transitional Care Quality Report**
   - 3.5. **Sepsis Quality Focus Team Report**
   - 3.6. **Catheter Associated Urinary Tract Infections (CAUTI) Quality Focus Team Report**
   - 3.7. **Resource Effectiveness Committee**
   - 3.8. **Surgical Services**
4. **Leapfrog Hospital Safety Score Dashboard** - A review of measures and improvement actions associated with the components of the Leapfrog Hospital Safety Score. *Sandy Volchko, RN, Director of Quality and Patient Safety*
5. **Central Line Associated Blood Stream Infection (CLABSI) Quality Focus Team Report** – Report on CLABSI rates and quality improvement actions aimed at reducing these healthcare acquired infections. *Amy Baker, RN, Director of Renal Service*
6. **Update: Fiscal Year (FY) 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*
7. **Adjourn Closed Meeting** – *Herb Hawkins, 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.

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KDHCD - BOARD OF DIRECTORS MEETING

THURSDAY, MAY 14, 2020

CLOSED MEETING SUPPORTING DOCUMENTS

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KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

THURSDAY, MAY 14, 2020

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KDHCD - BOARD OF DIRECTORS MEETING

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Quality Council Executive Summary
April 2020

1. **Stroke Program Quality Report –** Joint Commission reaccreditation survey postponed, date tbd. All required stroke measure performing better than benchmark for rolling 12 months. New QI project includes improving processes and time when patient requires transfer to another facilities for care; task force in place.
2. **Mental Health Quality Report –** 17 of the 19 HBIPS (MH core measures) performing well overall; opportunities in admission screening currently being addressed by multidisciplinary team. Assault rates above benchmark, a multidisciplinary team has been working on the development of an Agitation Behavioral Scale and protocol.
3. **SNF, TCS, Short Stay Rehab Quality Report-** Significant and sustained improvement in our overall quality ranking. In the past three years, the program has moved from 3-star quality rating overall to a 5-star overall quality rating. Additionally, with continued strong performance in both staffing and survey results, our quality ratings are now 4 and 5 stars in every category.
4. **Sepsis Quality Focus Team Report Summary -** Sepsis Bundle Compliance Jul 2019-Jan 2020 = 64%; not meeting Org goal of 70%. Actions: comprehensive root cause analysis performed and physician and RN stakeholder meetings in Mar/Apr 2020 resulted in the development of 22 action items that are currently in process.
5. **Catheter Associated Urinary Tract Infections (CAUTI) Quality Focus Team Report Summary -** CAUTI Rate: CAUTIs have decreased, goal has not yet been achieved. We have improved, a 34% decrease this fiscal year (FY). Action: Lean Six Sigma Kaizen event held Jan 2020 resulted in several new improvement strategies, all implemented as of 3/10/20. Committee monitoring for strategy effectiveness to determine if revisions need to be made.
6. **Update: Fiscal Year (FY) 2020 Clinical Quality Goals Summary –** (CAUTI & Sepsis– See above). CLABSI not meeting goal– FYTD SIR 1.34, goal is ≤ .784. Kaizen event (rapid process improvement, six sigma) in February 2020 resulted in several new improvement strategies. Team monitoring progress, some strategies on hold due to COVID-19. MRSA - Biovigil Hand Hygiene Monitoring System Pilot on 4N and ICU a HUGE success. Over 600,000 hand hygiene opportunities with 99.0% compliance. Through 3 months, we have 1 Infection between both units; historically they record 12 infections over 3 months (91% reduction). Capital Committee approved to use throughout medical center 412 beds. Opportunity LOS - Jul-Jan 2020 0.91, goal is <.75

Quality Council Summary
April 2020

Stroke Program Quarterly Quality Report Summary

1. **Reaccreditation Survey** postponed due to COVID-19, date tbd
2. **Get With The Guidelines Measures (Required for Joint Commission Accreditation)**
   - All 15 GWTG measures perform better than benchmark for rolling 12 months; includes measures such as specific medications prescribed in the hospital and at discharge and dysphagia screening (swallow evaluations).
3. **Stroke Alert Measures**

- Performing ≥ 90% or better than benchmark includes: Door to provider time, NIHSS Complete, Door to CT Times, Door to CT Times, Door to EKG Time, and Dysphagia screen completed when ordered.
- Opportunities for improvement include: Door to Stroke Alert, Door to Alteplase, and Door to Lab Time. Current improvement strategies: Revisions to the stroke alert process <4 hours have been made. IV start kits in CT rooms with lab tubes, lab label makers in both CT rooms and specimens taken immediately down to lab.

4. **New Performance Improvement Project:** Focused on the times and process of transferring patients to outside facilities when indicated. This is challenging for us as geography is a significant challenge; a task force has been established to address opportunities.

Mental Health Quality Report Summary

1. **HBIPS (Mental Health Core Measures)**
   90% (17 of 19) of total indicators outperform the target/benchmark statistic majority of the reporting intervals (> 50%).

- We have improved performance since last reporting period in the following measures:
  - SUB-2a (Alcohol/other drug use disorder treatment at discharge)
  - Assaults
  - HBIPS-5a (Patients discharged on multiple antipsychotic medications with appropriate justification)
  - TOB-3 /TOB-3a (Tobacco use treatment provided/offered or offered at discharge
  - CT-3 (Timely transmission of transition record)
- We have a decline in the hours of physical restraint (HBIPS-2a and seclusion use (HBIPS-3a)
- We have a decline in the total fall rate

Opportunities for Improvement:

- HBIPS-1a (Admission Screening): while significantly improved most recent 3 quarters, remains below the benchmark statistic. This indicator requires specific timeframes on violence risk to self/others over the past 6 months and substance use (over the past 12 months). Documentation is improving as the medical director and program director partner with clinical informatics.

2. **Assaults:** while demonstrating positive trend for most 2 recent quarters, overall total assault rates are above benchmark. A multidisciplinary team has been working on the development of an Agitation Behavioral Scale and protocol that will enable the nursing team to offer lower doses of medication earlier in the agitation cycle, rather than waiting until agitation is severe, therefore requiring higher doses of medications and ultimately putting staff and patients at higher risk of assault

Sub Acute, Transitional Care Services, and Short Stay Rehab Quality Report Summary

1. **Falls** - Facility observed percent for falls for long stay patients is 5.9%, remaining well below national average of 45.3%, placing the program in the top 1 percentile nationally.
2. **Hospital Acquired Pressure Injury** - Patients at High risk for Pressure Ulcers (Long Stay residents) showed an increase from prior year 6.3 to 11.8% This puts us at the 79th percentile. Internal Data through 4th in 2019 shows year to date overall SNF rate per 1000/pt. days was 0.71. This is a decrease from 0.89 for 2018. Active participation in the district-wide HAPI prevention plan, maintaining high standards. Managers measure

successes, UBC teams for South Campus nursing continue to monitor progress and Peer review and remediate practice concerns.

3. **Psychoactive Medication Use –** 1/3 measures performs better than benchmark. Includes medications like quetiapine which may be used for depression or for ventilator management cases, as well as lorazepam and diazepam used for seizures and vent management. There are no exclusions for these circumstances which makes this measure challenging. SNF leadership has been working closely with the medical team and our MDS nurses to ensure that appropriate psychiatric diagnoses are captured in the medical record whenever possible. Our LTC pharmacist plays an important role in helping us ensure that we follow all of these medications closely during the transition process. Our primary focus is on unnecessary medications, and monitoring for the potential for dose reductions when possible.

4. It is important to note that we have made significant and sustained improvement in our overall quality ranking. A contribution to this is partly due to the elimination of Self-report of moderate to severe pain measure. In the past three years, the program has moved from 3-star quality rating overall to a 5-star overall quality rating. Additionally, with continued strong performance in both staffing and survey results, our quality ratings are now 4 and 5 stars in every category.

Sepsis Quality Focus Team Report Summary

1. **Sepsis Bundle Compliance** Jul 2019-Jan 2020 = 64%; Not meeting Org goal of 70%
   Current Actions for Improvement:
   - Comprehensive root cause analysis (RCA) conducted on sepsis bundle fall outs March 2020 with Sepsis Team in Quality and Patient Safety, following with 6 hours of meetings with four stakeholder groups (provider and nursing/org) which resulted in 22 improvement strategies in March & April 2020. Strategies in process and monitoring plan in place with Sepsis Committee. The 22 improvement strategies also include 3 strategies already in process before RCA conducted.
   - 2nd Sepsis Coordinator position in process; bundle compliance rates for patients overseen by a coordinator are on average 10% higher than without (Feb 2019-Jan 2020)
2. **Other Sepsis Outcome Measures:**
   - Mortality of patients with any diagnosis of sepsis has decreased by 23% from calendar year (CY) 2018 to CY19.
   - Length of Stay (LOS) for sepsis patients continues to decrease. Since fiscal year (FY) 2017 LOS has progressively decreased from 7.71 to 6.24 in FY20. Estimated cost savings $2,659,230.

Catheter Associated Urinary Tract Infections (CAUTI) Quality Focus Team Report Summary

1. **CAUTI Rate:** CAUTIs have decreased, goal has not yet been achieved. July 2019 to Jan 2020 Standardized Infection Ratio is 1.03. Baseline was 1.557 which equates to a 34% decrease this fiscal year (FY). Goal is a SIR <.828.
2. **Days Between CAUTI:** Mean days between CAUTI baseline (Apr 2018 to Oct 2019) 12.78. Current mean days b/w CAUTI (April 2018 to March 2020) 14.94 (higher is better). Goal is to achieve and sustain >30 days between CAUTI.
3. **Actions for Improvement**

- CAUIT Kaizen (Lean Six Sigma) Event held February 2020; a focused rapid process improvement team met for several days to determine root causes of CAUTIs and developed and executed effective strategies to addressed root causes. Strategies were prioritized based on ability to be effective.

Improvement Strategies (all completed by March 10, 2020)

- Standardize the Unit Shift Safety Huddles to include components of CAUTI prevention bundle
- CAUTI rounds on each unit – Every catheter rounded on daily by Nurse manager, Infection Prevention, Clinical Education, and Advanced Practice Nurse for best practice compliance
- Standard Work developed for handoff on CAUTI prevention components on transfer patients
- Leadership Standard Work developed to standardize Nurse Manager daily, weekly and monthly tasks to address compliance with best practices
- ED Staff education on Catheter alternatives
- Incorporate catheter necessity in critical care provider & nurse rounds
- RN Education: scope of practice with catheter insertion
- CNA Education: peri-care/bath documentation in real time

4. **CAUTI Committee monitoring process** and outcome measures to determine timely if strategies are effective so alternative strategies can be developed

Update: Fiscal Year (FY) 2020 Clinical Quality Goals Summary

1. **CAUTI** – See CAUTI QFT report above
2. **Sepsis** – See Sepsis QFT report above
3. **CLABSI** – FYTD SIR 1.34, goal is ≤ .784. Kaizen event (rapid process improvement, six sigma) in February 2020 resulted in several new improvement strategies. Team monitoring progress, some strategies on hold due to COVID-19.
4. **MRSA** - Biovigil Hand Hygiene Monitoring System Pilot on 4N and ICU a HUGE success. Over 600,000 hand hygiene opportunities with 99.0% compliance. Through 3 months, we have 1 Healthcare Acquired Infection between 4N and ICU - historically they record 12 through 3 months (91% reduction). Capital Committee approved to use through our downtown 412 beds. Under contract review and signing
5. **Opportunity LOS** - Jul-Jan 2020 0.91, goal is <.75

Stroke Program Dashboard 2019/20

	GWTG Bench-marks	2019 Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	2020 Jan	Feb	March
Grouping of Stroke Patients																
Ischemic		30	42	39	43	36	41	31	33	32	50	40	43	39	42	38
Hemorrhagic		4	10	10	9	7	8	2	13	8	10	11	6	8	6	5
TIA (in-patient and observation)		20	28	35	25	24	22	36	36	19	29	42	28	33	44	29
Transfers to Higher Level of Care (Ischemic)		2	2	3	3	2	1	2	4	4	3	0	1	1	2	3
Transfers to Higher Level of Care (Hemorrhagic)		1	1	2	1	1	1	1	2	1	4	1	1	1	1	1
% of Alteplase - Inpatient & Transfers		16%	14%	14%	13%	18%	21%	6%	14%	6%	11%	15%	11%	20%	14%	10%
Total # of Pts who rec'd Alteplase (Admitted Patients)		4	4	4	4	5	8	2	2	1	3	6	4	7	5	3
Total # of Pts who rec'd Alteplase (& Transferred Out)		1	2	2	2	2	1	0	3	1	3	0	1	1	1	1
TOTAL NUMBER OF PATIENTS		57	83	89	81	70	73	72	88	64	96	94	79	82	95	72
Rate of hemorrhagic complications for Alteplase pts	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
% Appropriate vital sign monitoring post Alteplase	90%	50%	50%	57%	66%	71%	67%	75%	100%	50%	80%	83%	67%	75%	75%	100%
Core Measure: OP-23 Head CT/MRI Results	72%	NA	50%	100%	100%	33%	66%	0%	0%	75%	75%	100%	50%	100%	NA	NA
% tPA Arrive by 2 Hrs; Treat by 3 Hrs. (GWTG)	85%	100%	100%	83%	100%	100%	100%	100%	100%	100%	67%	100%	100%	100%	80%	NA
STK-5 Early Antithrombotics by end of day 2 (GWTG, TJC)	85%	100%	100%	100%	100%	100%	100%	100%	100%	97%	100%	100%	96%	92%	93%	97%
STK-1 VTE (GWTG, TJC)	85%	100%	100%	100%	100%	100%	100%	100%	100%	97%	93%	95%	98%	100%	100%	95%
STK-2 Discharged on Antithrombotic (GWTG, TJC)	85%	100%	97%	100%	98%	98%	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%
STK-3 Anticoag for afib/aflutter ordered at Dc (GWTG, TJC)	85%	80%	89%	100%	100%	100%	100%	100%	100%	100%	100%	90%	89%	100%	89%	100%
% Smoking Cessation (GWTG)	85%	100%	100%	100%	100%	100%	100%	100%	100%	88%	100%	100%	100%	100%	100%	100%
STK-6 Discharged on Statin (GWTG, TJC)	85%	100%	100%	100%	100%	98%	96%	92%	94%	94%	98%	100%	100%	100%	98%	100%
% Dysphagia Screen prior to po intake (GWTG)	75%	100%	93%	94%	88%	88%	98%	94%	92%	92%	96%	96%	96%	85%	85%	91%
STK-8 Stroke Education (GWTG, TJC)	75%	88%	91%	84%	89%	93%	92%	100%	92%	96%	100%	100%	100%	93%	97%	94%
STK-10 Assessed for Rehab (GWTG, TJC)	75%	97%	100%	100%	100%	97%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
STK-4 Alteplase Given within 60 min (GWTG, TJC)	75%	100%	25%	25%	100%	100%	100%	NA	50%	100%	100%	100%	NA	100%	100%	100%
% LDL Documented (GWTG)	75%	92%	88%	100%	96%	94%	96%	98%	88%	97%	93%	98%	92%	91%	84%	96%
Intensive Statin Therapy (GWTG)	75%	91%	82%	90%	89%	91%	80%	90%	88%	91%	96%	93%	94%	94%	91%	88%
% tPA Arrive by 3.5 Hrs; Treat by 4.5 Hrs (GWTG)	75%	100%	80%	86%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	86%	100%
% NIHSS Reported (GWTG)	75%	97%	98%	97%	100%	97%	100%	100%	95%	97%	96%	97%	98%	100%	93%	92%
% Appropriate stroke order set used (In-Patient)	90%	90%	97%	97%	94%	93%	90%	95%	96%	99%	95%	87%	84%	95%	97%	99%
% Appropriate stroke order set used (ED)	90%	85%	92%	90%	92%	94%	93%	93%	94%	88%	88%	84%	87%	94%	92%	88%
LOS Hemorrhagic (Mean)		13.5	10.8	6.86	13.88	4	4.38	3	7.5	5	16.5	10.36	5.53	4.8	4	9
LOS Ischemic (Mean)		5.61	6.42	4.94	5.21	6.72	4.95	4.5	5.25	4.32	5.08	4.25	3.14	5	5.08	5.27

PI Goal: Post Alteplase Monitoring & Assessment 2020

Plan – Goals

- Patients who receive Alteplase for acute ischemic stroke are in need of consistent performance and documentation of post-Alteplase monitoring, including blood pressure, pulse, respirations, and NIH Stroke Scale
- KDH Stroke Program monitors compliance of vital sign and neuro checks on all patients that have received Alteplase. Compliance is defined as all checks are completed; if any are missed then we deem the case to be noncompliant.
- November 2017: Goal of 90% compliance of post Alteplase monitoring by March 2018

Solutions (root cause)

- Early 2017: ED Stroke Alert Task Force created and implemented Alteplase flowsheet that is used by both ED and ICU.
- Good compliance since the initiation of the flowsheet; however, a few checks have been missed in recent months.
  - Occurring during change of shift
  - Nursing travelers caring for the post Alteplase patient prior to completion of orientation/education

DO – Implementation (include dates)

March 2017: Developed Alteplase flowsheet, education to ED and ICU post Alteplase monitoring

- June 2017: Included Alteplase flowsheet in stroke alert packets
- August 2017: Modification to Traveler Competency checklist
- November 2017: Re-emphasis on compliance with flowsheet; primarily during change of shift
- January 2018: ED and ICU RNs to perform vital sign/neuro check upon transfer to ensure no lapse in
- Ongoing summaries of Alteplase cases shared with staff and physicians at the ED Stroke Alert Subcommittee monitoring.
- Spring 2019: ICU leadership to focus education on compliance with post alteplase monitoring
- October 2019: Working on converting the paper flowsheet to electronic version in Cerner
- March 2020:
  - The paper post alteplase flowsheet will continue…we will **not** be converting to the electronic version**.**
  - Current annual CBL competencies for ICU, CVICU and ED will be updated to include post alteplase monitoring, flowsheet review and the importance of compliance
  - Provide education to ICU, CVICU and ED staff on face-to-face hand-off and review of the post alteplase form

STUDY – RESULTS (CURRENT AND YTD DATA)

Figure 1. Post-Alteplase Compliance

Data: Apr'19-Mar'20	Goal	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% compliance	90%	66%	71%	67%	75%	100%	50%	80%	83%	67%	89%	75%	100%

ACT – OUTCOMES & CONCLUSIONS To Date

Outcomes / Conclusions

- Close coordination and provision of feedback on a concurrent basis helps departments identify nurses who need reinforcement of their role in post-Alteplase monitoring
- Significant improvements have been made since the implementation of the post Alteplase flowsheet, refining the stroke alert process, and having designated Stroke Team Leads in the ED.
- Continued focus on staff compliance with post alteplase monitoring.

CONTACT

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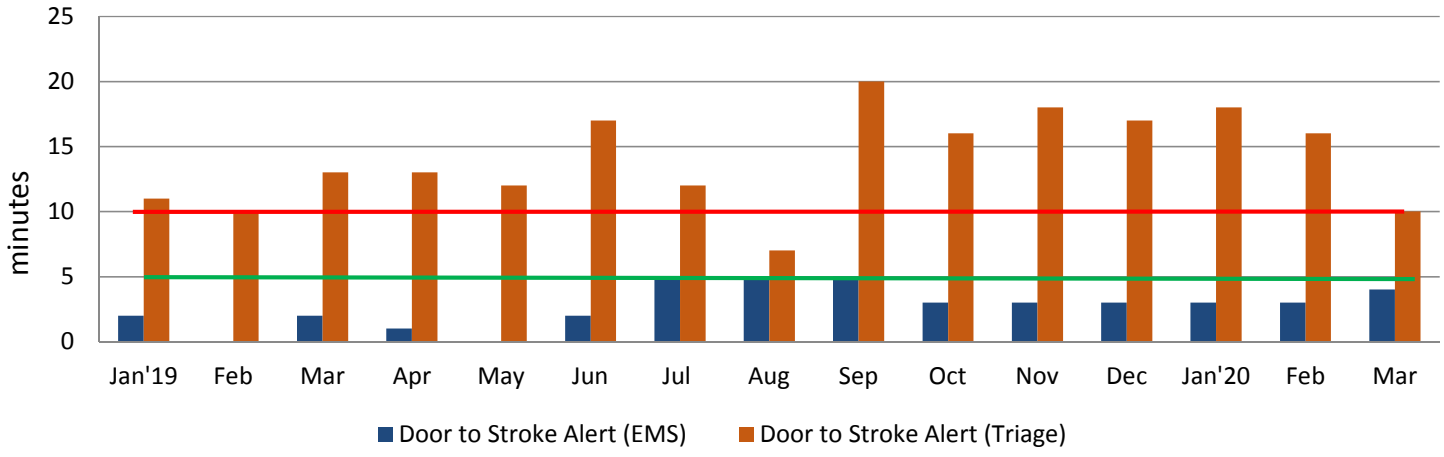
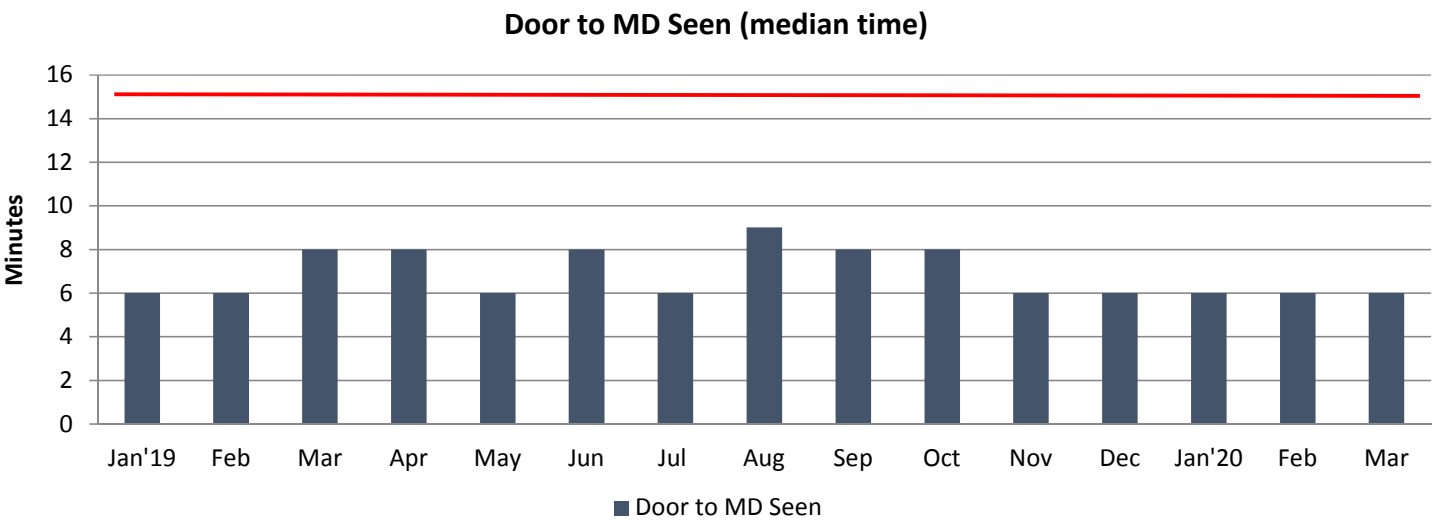
  Tel: 624-2133

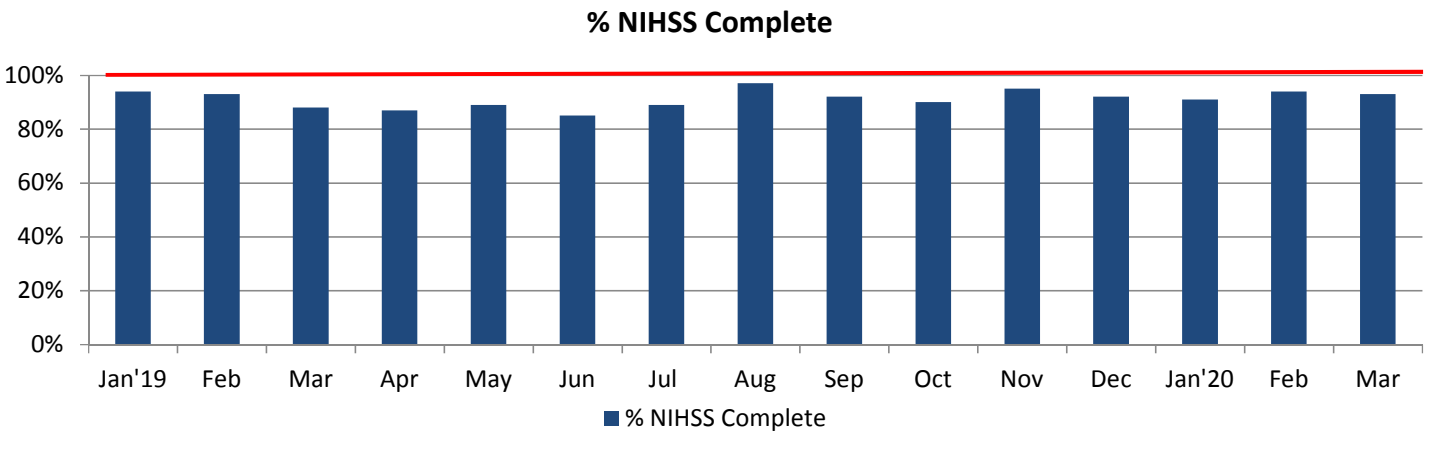
2019-2020 Stroke Alert Dashboard



Per KDH ED Stroke Alert process; stroke alerts to be called within 5 min for EMS and 10 min for Triage. ED Stroke Alert Triage task force convened to look for opportunities for improvement March 2020.



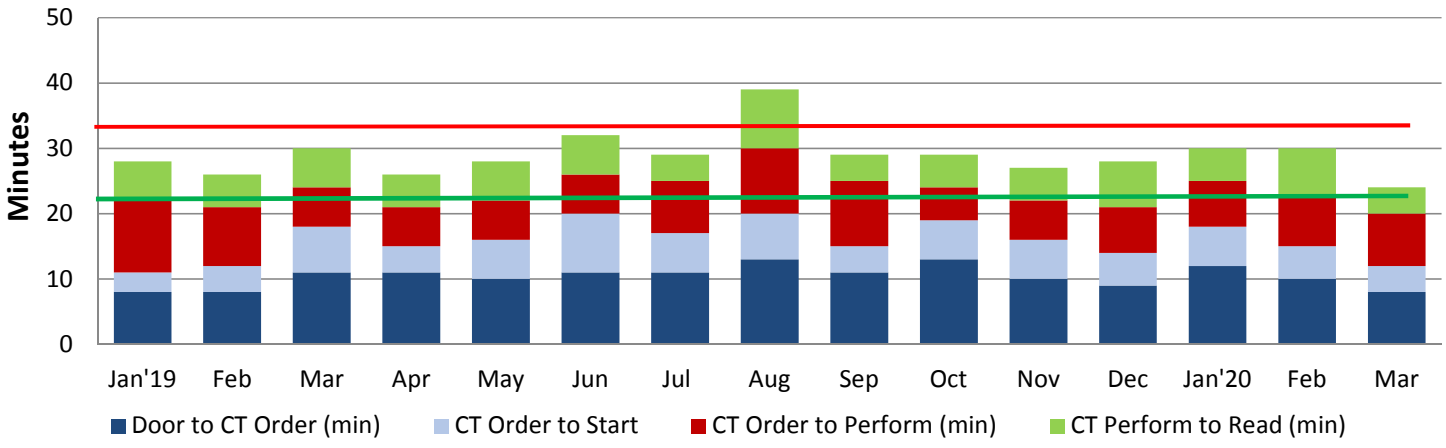
The expectation is that the physician will see the stroke alert patient within 15 minutes of arrival. Improvements made throughout the past year include: early notification from EMS, MD meets the pt at the door upon arrival, scribe documents first seen time in the record.



The expectation is that all stroke alert patients will have a NIHSS completed by a certified ED staff member and/or the attending physician; the primary responsible person is the attending/resident physician.

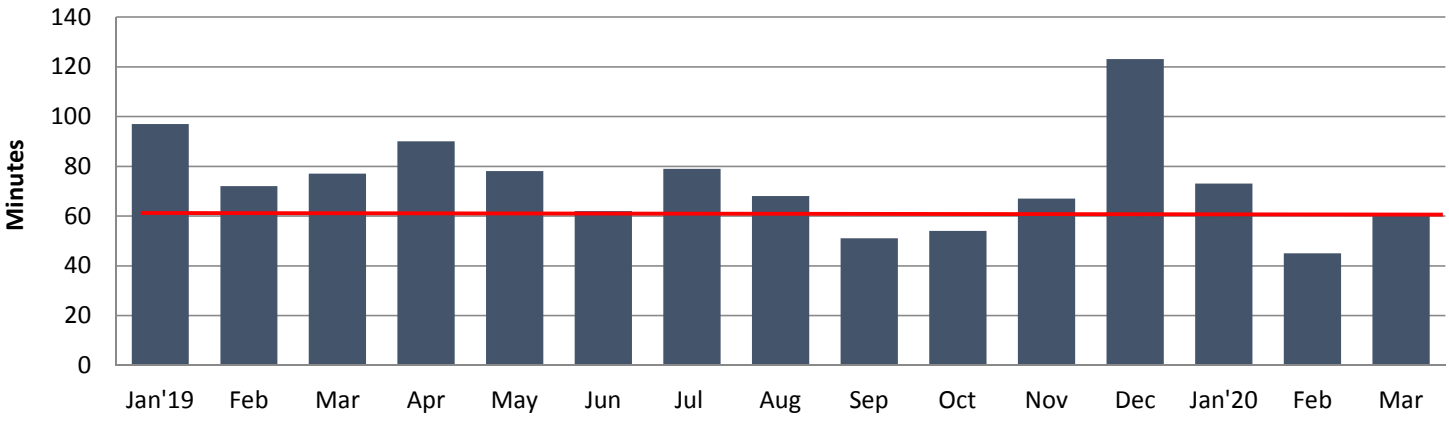
2019-2020 Stroke Alert Dashboard

Door to CT Times (median times)



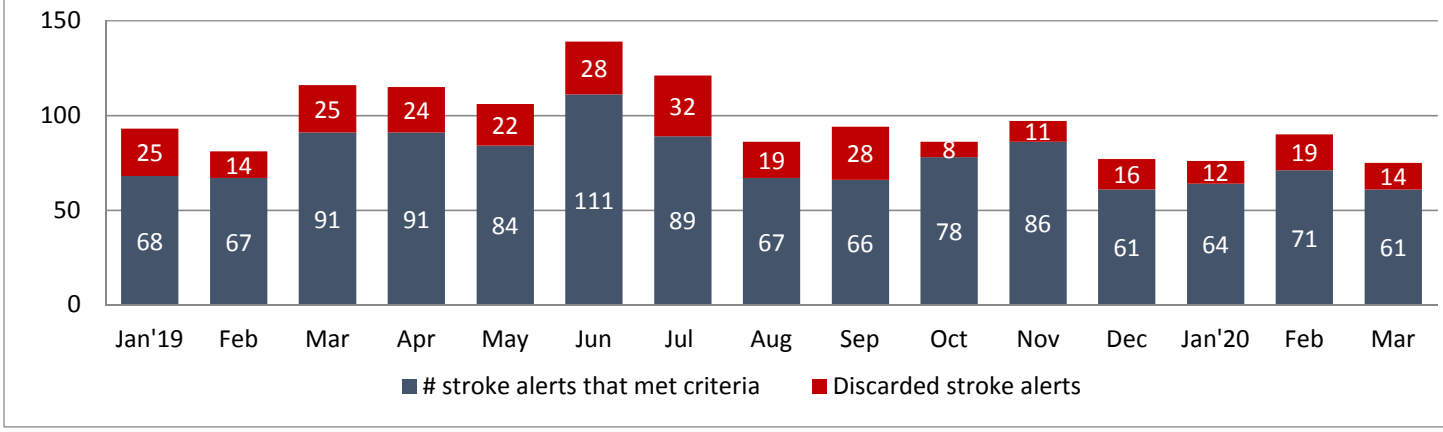
CMS and TJC expectation is that the CT will be performed by 20 minutes and read by 45 minutes of arrival. KDH's CT read time goal is 30 minutes. Starting 2019; tracking of CT start times will be included in this measurement. start time is define by the first CT images in Synapse.

Door to Alteplase (median time)



The data in this graph includes all Alteplase patients, no exclusion criteria. TJC expectation is that IV thrombolytics are given within 60 minutes to eligible patients who present for stroke care at least 50% of the time. 2019 AHA/ASA has set new IV thrombolytic goal time to 45 minutes at least 75% of the time. To meet this goal, changes to the stroke alert process <4 hours have been made.

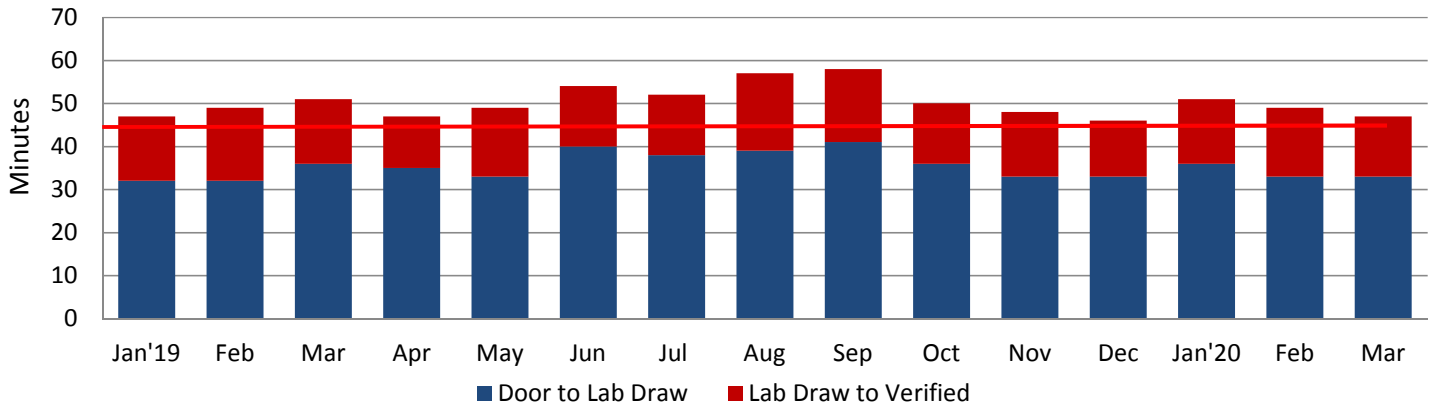
ED Stroke Alert Volume



Stroke alert criteria includes: pt presenting with stroke like symptoms +FAST screen, stroke alerts called prior to arrival and up to 1 hour after arrival. Excluded cases: >1 after arrival or if stroke alert was cancelled.

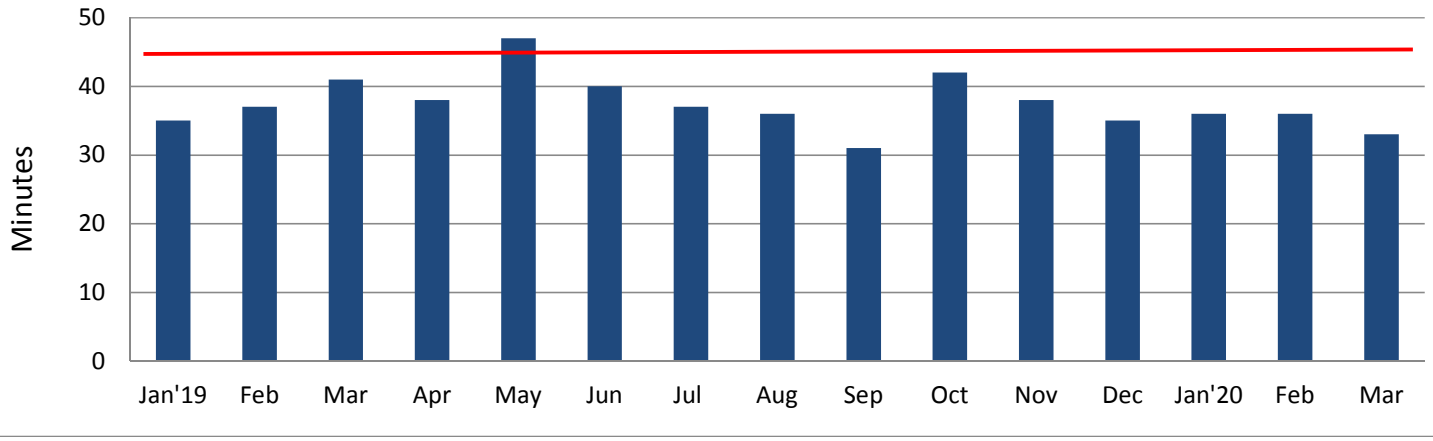
2019-2020 Stroke Alert Dashboard

Door to Lab Time (median times)



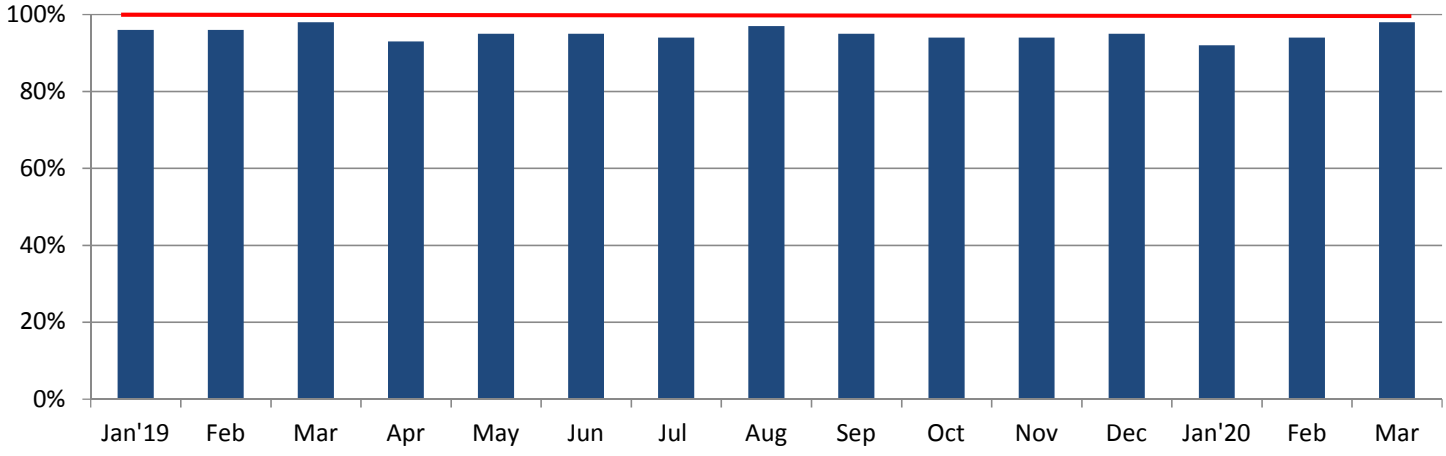
TJC expectation is that laboratory tests are completed within 45 minutes of arrival. Changes in stroke alert process has been made early 2019 to improve lab verified times. Action items taken: IV start kits in CT rooms with lab tubes, lab lable makers in both CT rooms and specimens taken immediately down to lab.

Door to EKG Time (median time)



TJC expectation is that EKGs are completed within 45 minutes of arrival.

% Dysphagia screen completed when ordered

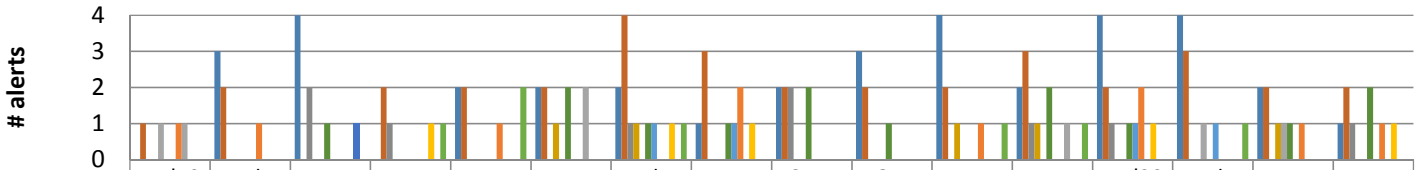


Dysphagia screening should be completed by the RN on all stroke alert patients prior to any po intake, including meds. Dysphagia screening is part of the ED stroke alert order sets. Goal is 100% compliance.

2019-2020

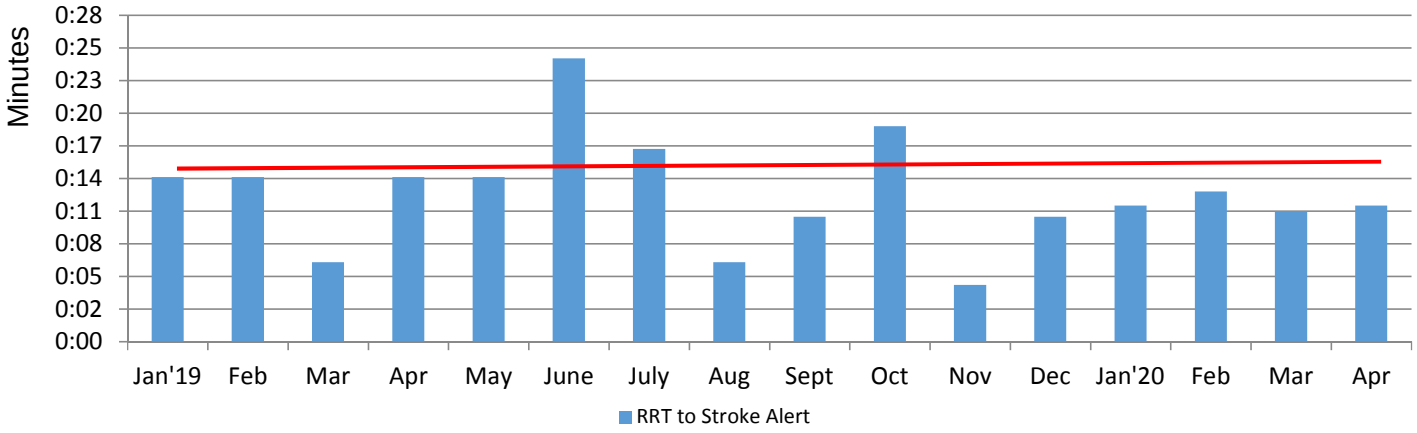
In-House Stroke Alert Dashboard

Stroke Alert Location



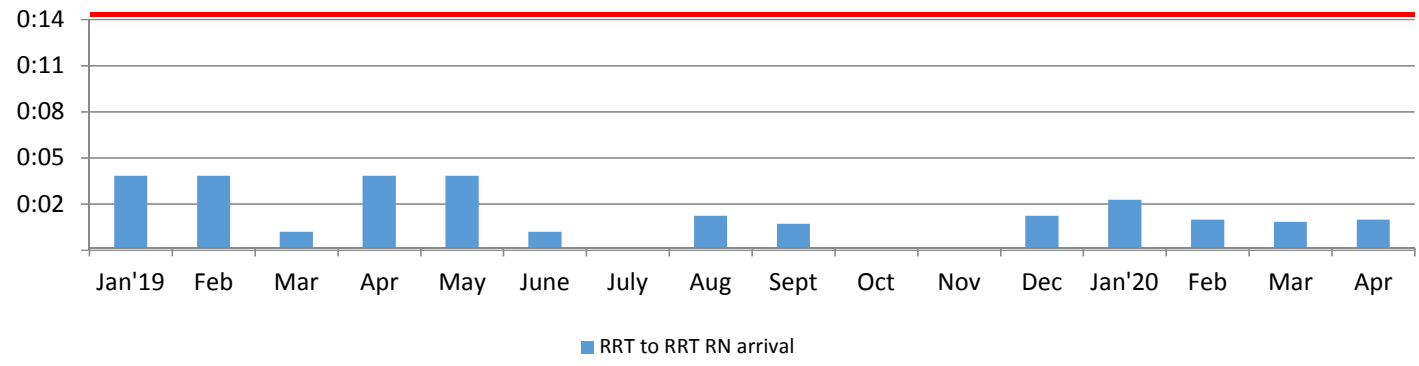
	Jan'19	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan'20	Feb	Mar	Apr
3W		3	4		2	2	2	1	2	3	6	2	4	4	2	1
4S	1	2		2	2	2	4	3	2	2	2	3	2	3	2	2
2S			2	1			1		2			1	1			1
3S						1	1				1	1			1	
Cath Lab	1								0					1	1	
CVICU			1			2	1	1	2	1		2	1		1	2
ICU							1	1	0				1	1		
4N	1	1			1			2			1		2		1	1
3N	1					2			0			1				
4T				1			1	1	0				1			1
PACU			1													
2N				1	2		1				1	1		1		

RRT to Stroke Alert



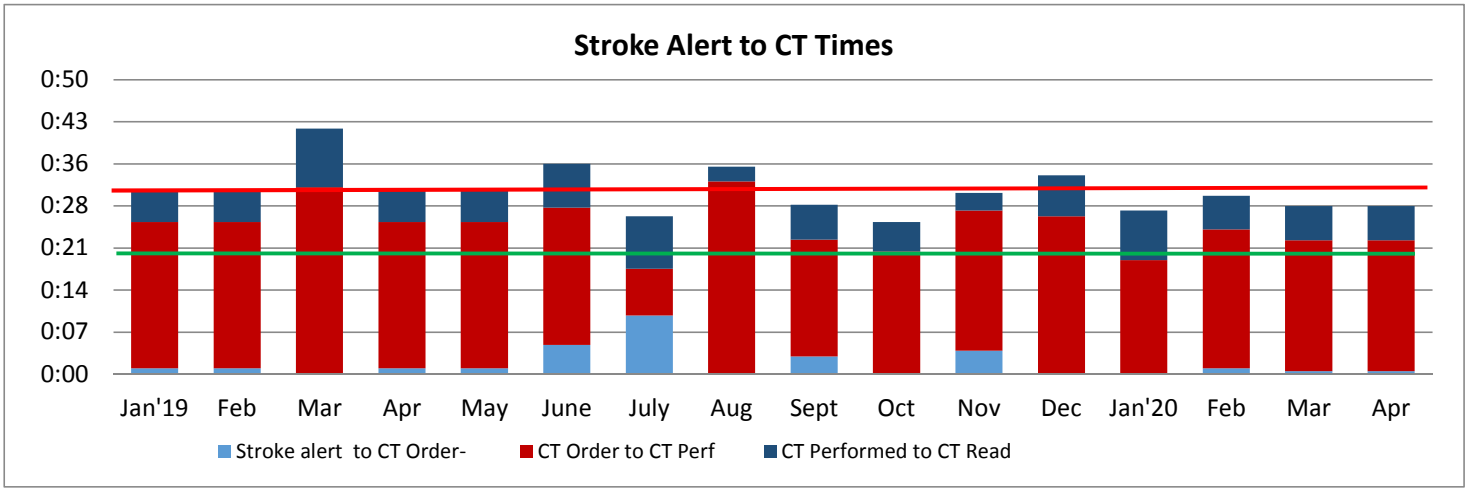
If patients exhibit any new or worsening neuro deficits while in the hospital; RNs are to call an RRT. The RRT RN will evaluate and determine if a stroke alert should be called. The goal from calling RRT to stroke alerts should be <15 minutes.

RRT to RRT RN arrival

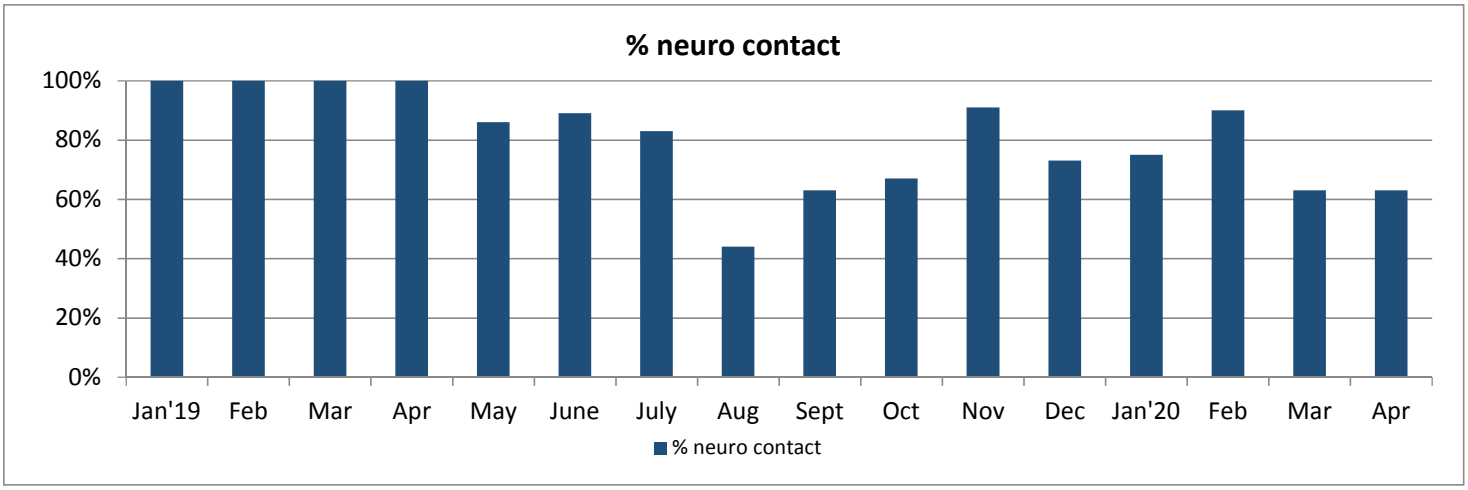


TJC expectation is that a designated provider is at the bedside within 15 minutes of stroke alert. KDH has designated the RRT RN as the provider for in-house stroke alerts.

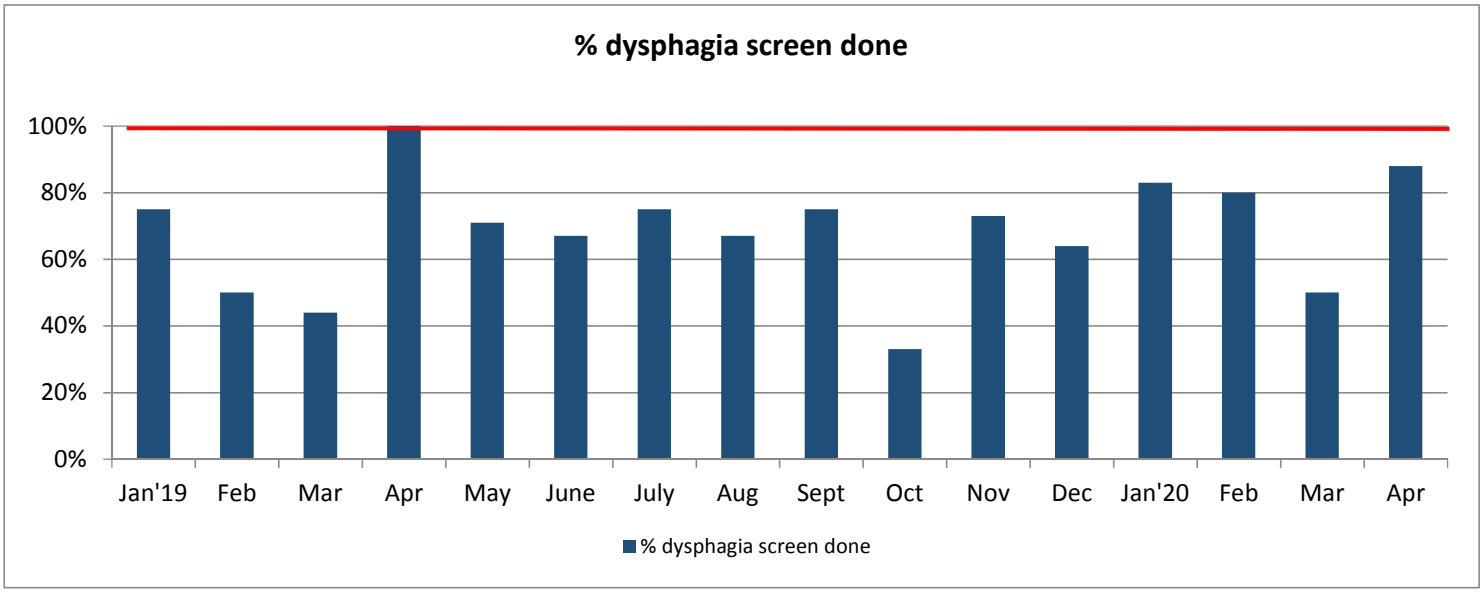
2019-2020
In-House Stroke Alert Dashboard



TJC expectation is that the CT will be read within 45 minutes of arrival. KDH's goal is 30 minutes **(red line).** TJC added a new metric in 2018; the expectation is that the CT will be performed within 20 minutes of alert **(green line).**



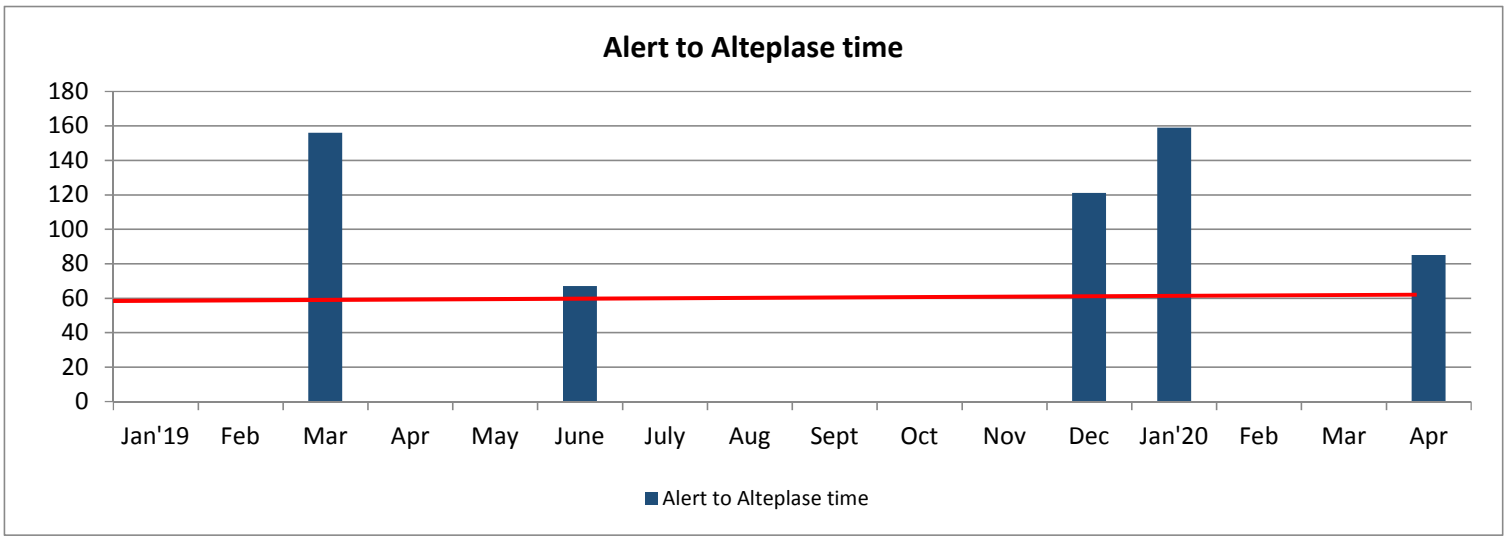
Neurology consultation should occur on all in-house stroke alerts.



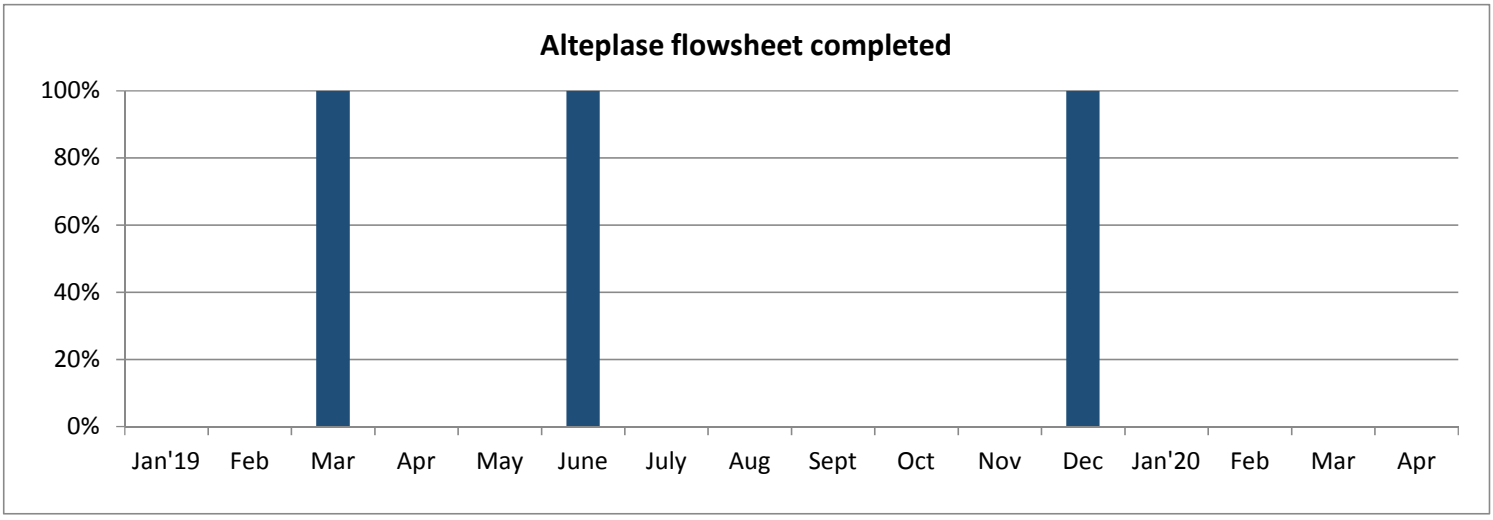
Whenever there are new or worsening neurological deficits ≥3 points, the RN should perform a dysphagia screen to evaluate the patient's ability to swallow.

2019-2020

In-House Stroke Alert Dashboard



ED Patients: TJC expectation is that IV thrombolytics are given within 60 minutes to eligible patients who present for stroke care at least 50% of the time. In-House Stroke alerts: KDH expectation is that IV thrombolytics are given within 60 minutes to eligible patients who have been identified with new or worsening stroke symptoms



PI Goal: ED Door to Transfer Process 2020

Plan – Goals	Solutions (root cause)
• **Door to transfer of the hemorrhagic stroke patient: <120 minutes (STK-OP-1b)** • **Door to transfer: drip 'n ship <120 minutes (STK-OP-1c)** • **Door to transfer: acute ischemic stroke: + large vessel occlusion/+MER eligible: <120 minutes (STK-OP-1d)** • **Door to transfer: acute ischemic stroke: + large vessel occlusion/-MER not eligible: <120 minutes (STK-OP-1e)** • **Door to transfer: ischemic stroke: no alteplase, -+ large vessel occlusion: <120 minutes (STK-OP-1f)**	• Streamline transfer process by working closely with EMS, Skylife and receiving hospitals. •

DO – Implementation (include dates)

November 2018: ED Transfer Process Task Force developed. Interdisciplinary team including our local EMS agencies, Skylife, and ED staff/providers, Nursing, and Case Management.

Spring 2019: Stroke Team Lead (STL) training. ED RNs who are selected as Stroke Team Leads take a computer based learning course, attend STL didactic session and shadow an experienced STL.

Spring 2019: Education to staff and physicians/residents regarding the goal times for transfer.

Summer 2019: Discussions with EMS agencies have taken place to ensure we have a contact name and phone number for decision making.

August 2019: Collaborated with receiving hospitals on improving transfer process and timeliness. Ensure we have established transfer agreements with the receiving hospitals.

September 2019: Fastest transfer time information is posted in staff and physician lounges and in the EMS documentation room.

September 2019. Ischemic/Hemorrhagic transfer guide posted in key areas to reinforce goal of <120 -minute transfer.

October/November 2019: Collaborated with receiving hospitals who have Synapse to utilize PowerShare which allows hospitals to share imaging.

December 2019: Because of the ongoing ED construction, inability to utilize helipad, and/or need for fixed wing air transport; Skylife has secured a car rental to ensure timely transportation of the crew to the hospital.

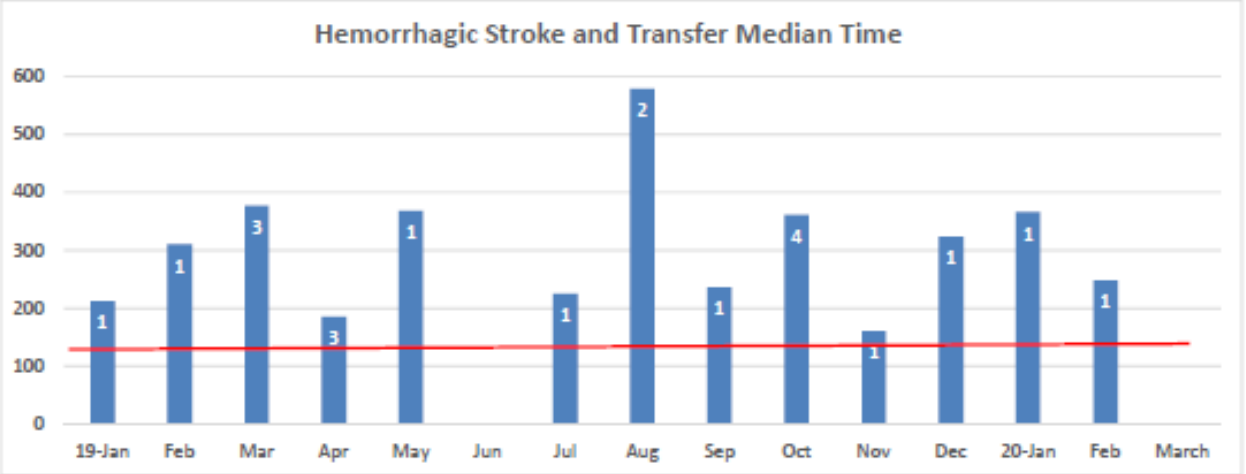
January/February 2020: Skylife to provide Flight Vector app for our ED staff and case managers to help track helicopter arrivals to our facility and receiving facility.

Ongoing 2019: Investigating ways to acquire RAPID software to help identify viable penumbra prior to transfer of patients with last known well >4 hours.

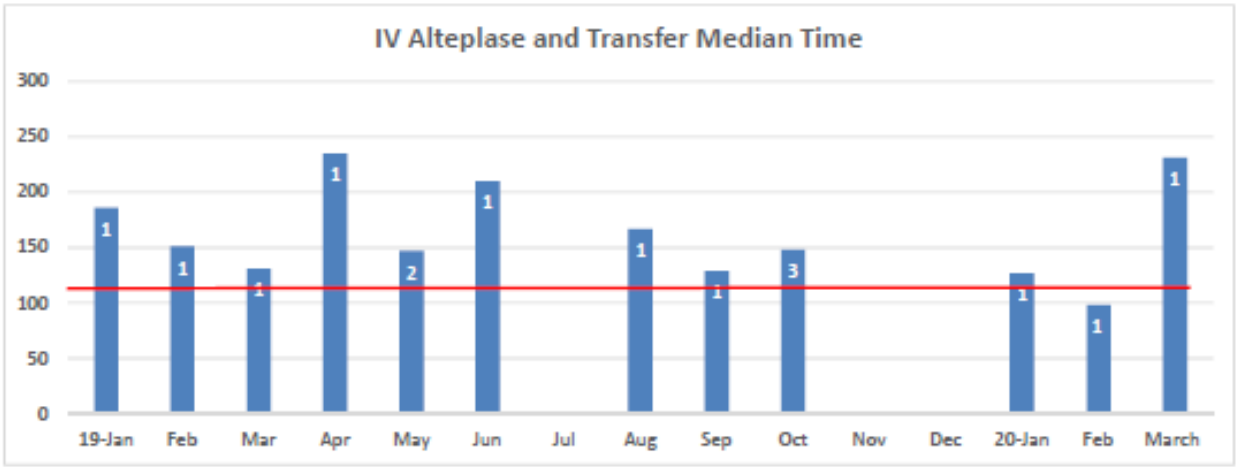
Ongoing: Annual Provider education includes transfer goal of <120 minutes for the ischemic and hemorrhagic stroke patients, and potential patient identification issues.

STUDY – RESULTS (CURRENT AND YTD DATA)

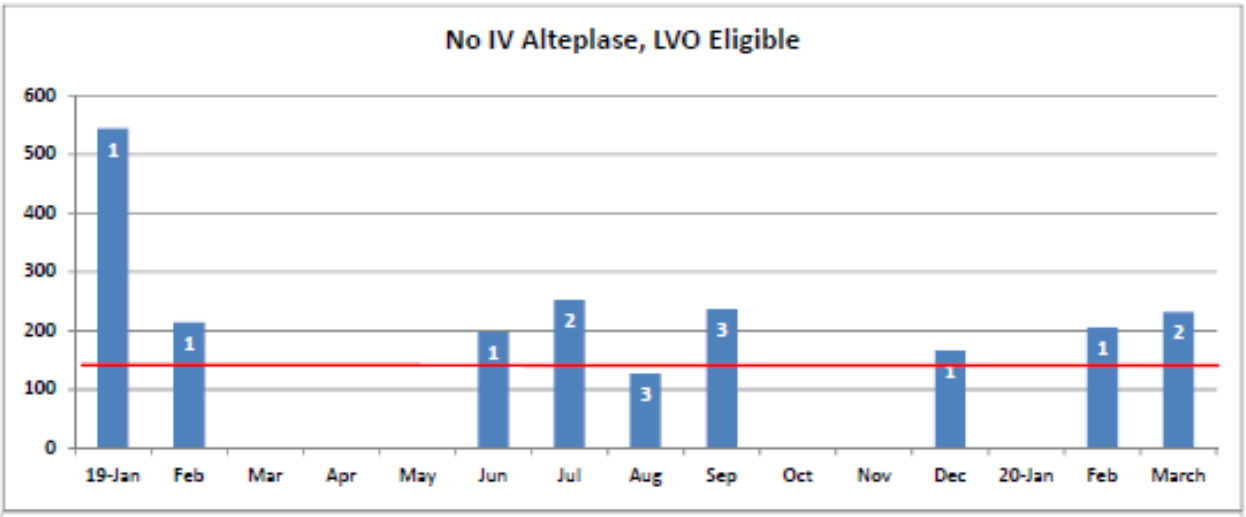
2019/20 TRANSFERS FROM ED TO ANOTHER ACUTE CARE FACILITY
Median Time by Minutes - Goal 120 Minutes



New TJC metric as of January 2019. TJC expectation is that if patients require transfer to a tertiary center that the door to transfer should be <120 minutes. Only a few hemorrhagic patients are transferred out for other procedures not done at KDH, specifically coiling/clipping of aneurysms or bleeds. A Transfer Task Force has been set up to help streamline the process, all action items are captured in PDSA document.



New TJC metric as of January 2019. TJC expectation is that if patients require transfer to a tertiary center that the door to transfer should be <120 minutes. These are considered our "drip and ship" cases. Transfers for ischemic strokes occur primarily if a large vessel occlusion is noted on CTA that would be eligible for endovascular treatment. As a result of the effects made by the ED Stroke Alert Committee and the Transfer Process Task Force door to transfer times have improved over the last several months.



New TJC metric as of January 2019. TJC expectation is that patients requiring transfer to a tertiary care center that the door to transfer should be less than 120 minutes. This cohort of patients have a large vessel occlusion that would be eligible for endovascular treatment and do not meet criteria for Alteplase administration. A Transfer Task Force has been set up to help streamline the process.

ACT – OUTCOMES & CONCLUSIONS To Date	CONTACT
Outcomes / Conclusions • Ongoing review of process improvement opportunities. • We are close to the goal time if the patient is an ischemic stroke with a large vessel occlusion, however, our hemorrhagic stroke patient transfer times are significantly higher. • Need early identification of ischemic/hemorrhagic stroke patients even when the last known well is >16 hours.	o Cheryl Smit, RN, Stroke Manager Tel: 624-2133

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee / Quality Improvement Committee

Unit/Department: Mental Health **ProStaff / QIC Report Date:** 2/18/20

Measure Objective/Goal:

The Joint Commission and the National Association of Psychiatric Health Systems (NAPSH), the National Association of State Mental Health Program Directors (NASMHPD) and the NASMHPD Research Institute, Inc. (NRI) collaborated on the development of a set of core performance measures for Hospital-Based Inpatient Psychiatric Services (HBIPS). Following successful pilot testing, hospital data collection for the HBIPS measures began with October 1, 2008 discharges. HBIPS measures were endorsed by the National Quality Forum (NQF) in May 2010. The measure maintenance process is guided by expertise and advice provided by the Technical Advisory Panel; measures are updated periodically.

The **Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program** was established by the Affordable Care Act with the intent to encourage inpatient psychiatric facilities and clinicians to improve the quality of inpatient care. The program was implemented on October 1, 2012 as a CMS pay-for-reporting program

FY2019 Chart-Abstracted Measures

MEASURE ID	MEASURE NAME	ENDORSED BY	
		CMS (IPFQR)	THE JOINT COMMISSION
HBIPS-1a	Admission Screening		✓
HBIPS-2a	Hours of Physical Restraint Use	✓	✓
HBIPS-3a	Hours of Seclusion Use	✓	✓
HBIPS-5a	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	✓	✓
SMD-1	Screening for Metabolic Disorders	✓	
SUB-2	Alcohol Use Brief Intervention Provided or Offered	✓	✓
SUB-2a	Alcohol Use Brief Intervention	✓	✓
SUB-3	Alcohol/Other Drug Use Treatment Provided or Offered at Discharge	✓	✓
SUB-3a	Alcohol/Other Drug Use Disorder Treatment at Discharge	✓	✓
TOB-2	Tobacco Use Treatment Provided or Offered	✓	✓
TOB-2a	Tobacco Use Treatment	✓	✓
TOB-3	Tobacco Use Treatment Provided or Offered at Discharge	✓	✓
TOB-3a	Tobacco Use Treatment at Discharge	✓	✓
CT-2	Care Transitions with Specified Elements Received by Discharged Patients	✓	
CT-3	Timely Transmission of Transition Record	✓	

We anticipate that CMS will establish performance benchmarks in the future, with financial penalties for underperformance. KD mental health leadership team partners with quality/patient safety department liaisons to establish internal benchmarks aligned with national standards available in the public domain.

Measure Objective/Goal:

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

The **National Database of Nursing Quality Indicators (NDNQI)** was founded by the American Nurses Association (ANA) in 1998. Having been managed by The University of Kansas School of Nursing since 2001, NDNQI was purchased by Press Ganey, a long-standing leader in performance measurement, in 2014. NDNQI promotes nursing excellence through the most robust source of comparative norms in the industry. Nursing sensitive quality measures and indicators reflect the impact of nursing actions on patient outcomes.

NDNQI is the largest provider of unit-level performance data to hospitals and its metrics satisfy Joint Commission and CMS requirements. KD mental health outcomes are compared with other adult inpatient psychiatric units (grouped by hospital size/number of staffed beds and teaching status) for the following indicators:

- Total Falls per 1,000 Patient Days
- Injury Falls per 1,000 Patient Days
- Total Assault Rate per 1,000 Patient Days
- Injury Assault Rate per 1,000 Patient Days

Date Ranges of Data Evaluated:

Oct2018 – Oct2019	: SUB-3, 3a, CT-2	**Q3 2017 – Q2 2019**	: Fall, Assault Indicators
Q1 2017 – Q4 2019	: SMD-1, TOB-2, TOB 2a, TOB 3, TOB 3a, CT-3	**Q4 2016 – Q3 2019**	: Remaining Measures

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

- 90% (17 of 19) of total indicators outperform the target/benchmark statistic majority of the reporting intervals (>50%).

Improvements Since Last Reporting Period

- Improved performance: **SUB-2a and ASSAULTS; HBIPS-5a; TOB-3, 3a; CT-3**
- Decline in hours of physical restraint (**HBIPS-2a**) and seclusion use (**HBIPS-3a**)
- Decline in **Total Fall** rate

Opportunities

- **HBIPS-1a:** *while significantly improved most recent 3 quarters, remains below the median and benchmark statistic*

  This indicator requires specific timeframes on violence risk to self/others (over the past 6 months) and substance use (over the past 12 months). Documentation is improving as the medical director and program director partner with clinical informatics.

- **ASSAULTS:** *while demonstrating positive trend for most 2 recent quarters, overall total assault rates are above benchmark*

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:

HBIPS-1a: Indicator results are available to psychiatry medical staff leaders (medical director and program director) for review prior to monthly HBIPS multidisciplinary team meeting; report detail includes individual attending/resident names for each deficiency. Cerner adjustments made and training facilitated. Q4 2019 shows the trend in a positive direction.

- **ASSAULTS:** Results of multidisciplinary feedback facilitated by risk management and mental health clinical leaders (July 2019):
  - ☑ Include "known history of violence" in nursing handoff, Treatment Team meetings and FLASH meetings
  - ☑ Relocate video surveillance camera from gymnasium to E2 unit
  - ☑ Include security officers in daily FLASH meetings (safety huddles); security officer will incorporate new information in security daily pass-down report.
  - ☑ Implement documentation of known history of violence into the electronic record as an adjunct to the Broset screening tool (defer to organization-wide implementation of work-place violence prevention strategy to "flag" known violence-risk persons in Cerner)
  - ☐ Evaluate the availability of additional crisis prevention training to include techniques to physically contain a physically aggressive person, when verbal de-escalation is no longer effective (currently under review by safety specialist and MH Leadership Team).

Next Steps/Recommendations/Outcomes:

The Need

Address ongoing patient assaults with development of Agitation Scale/Protocol that will enable nursing team to offer lower doses of medication earlier in the agitation cycle, rather than waiting until agitation is severe, therefore requiring higher doses of medications and ultimately putting staff and patients at higher risk of assault.

The Solution

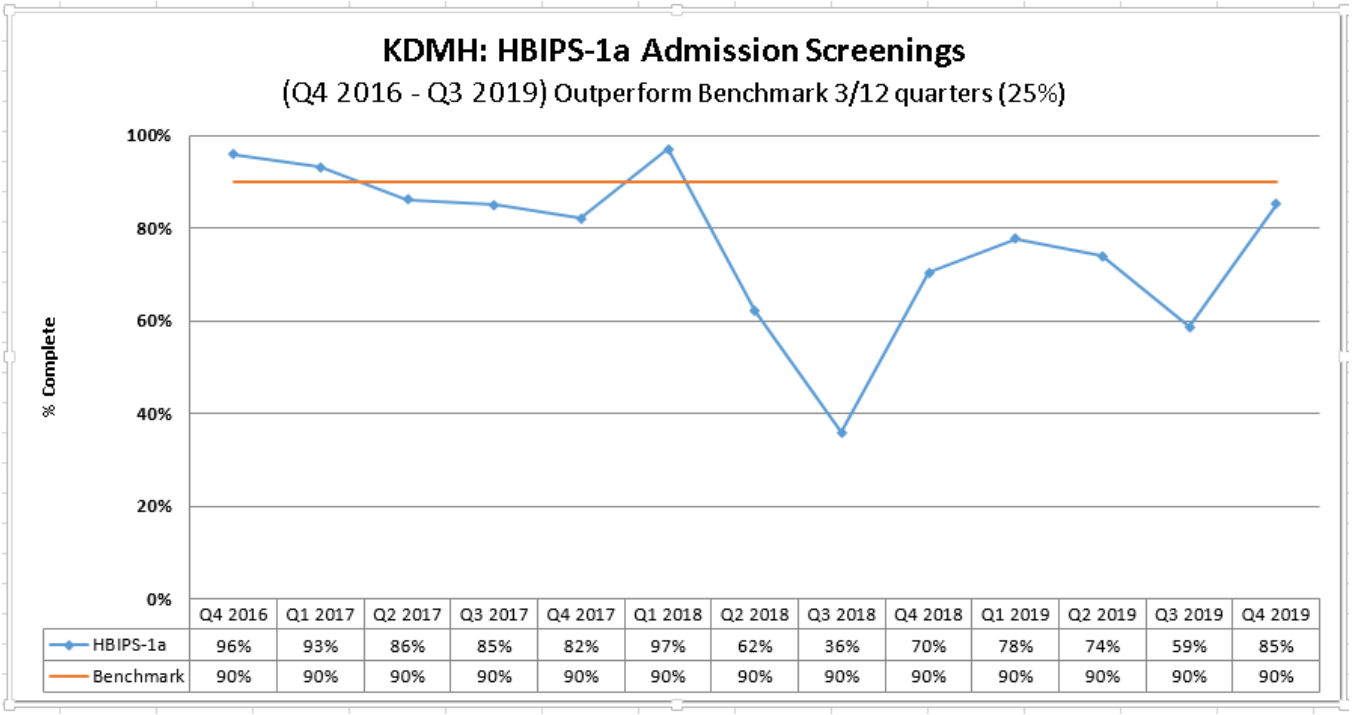
A paradigm shift by approaching agitation in the same mindset we treat pain. It is possible to offer lower doses of medication earlier in the agitation cycle, rather than waiting for when agitation is severe therefore requiring higher medication doses, and higher risk of patient assaultive or self-harm behaviors.

The Tool

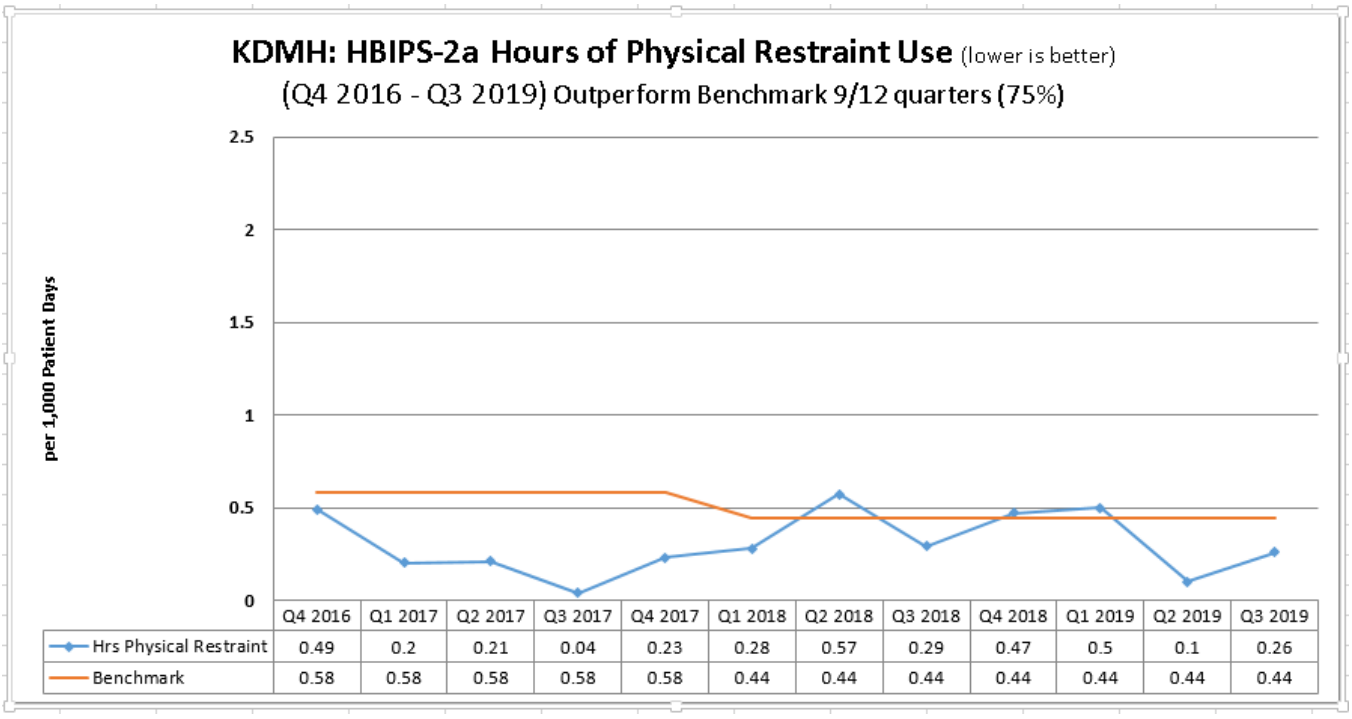
The Agitation Behavioral Scale is an evidenced based tool designed initially for patients with Traumatic Brain Injury. It was found while researching if there was any acute psychiatry specific scale that could be utilized by nursing staff. The scale is based on objective observations of known behaviors indicative of agitation. Along with other de-escalation interventions, the scale provides nursing staff a tool to intervene early in the agitation progression process by providing the ability to offer smaller doses of oral PRN medication with the goal of stopping the progression of the agitation cycle.

Submitted by Name: *Jaime Hinesly, LMFT* **Date Submitted:** 2/18/20

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

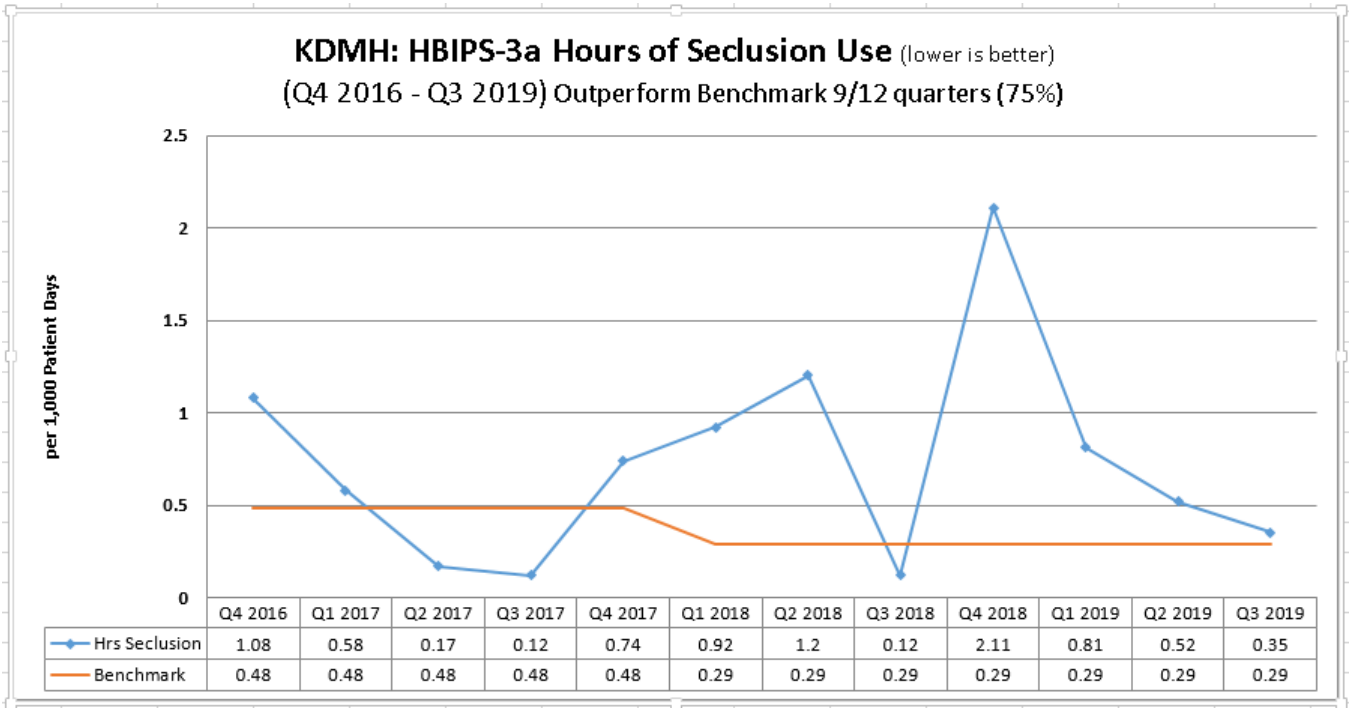


	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019
HBIPS-1a	96%	93%	86%	85%	82%	97%	62%	36%	70%	78%	74%	59%	85%
Benchmark	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

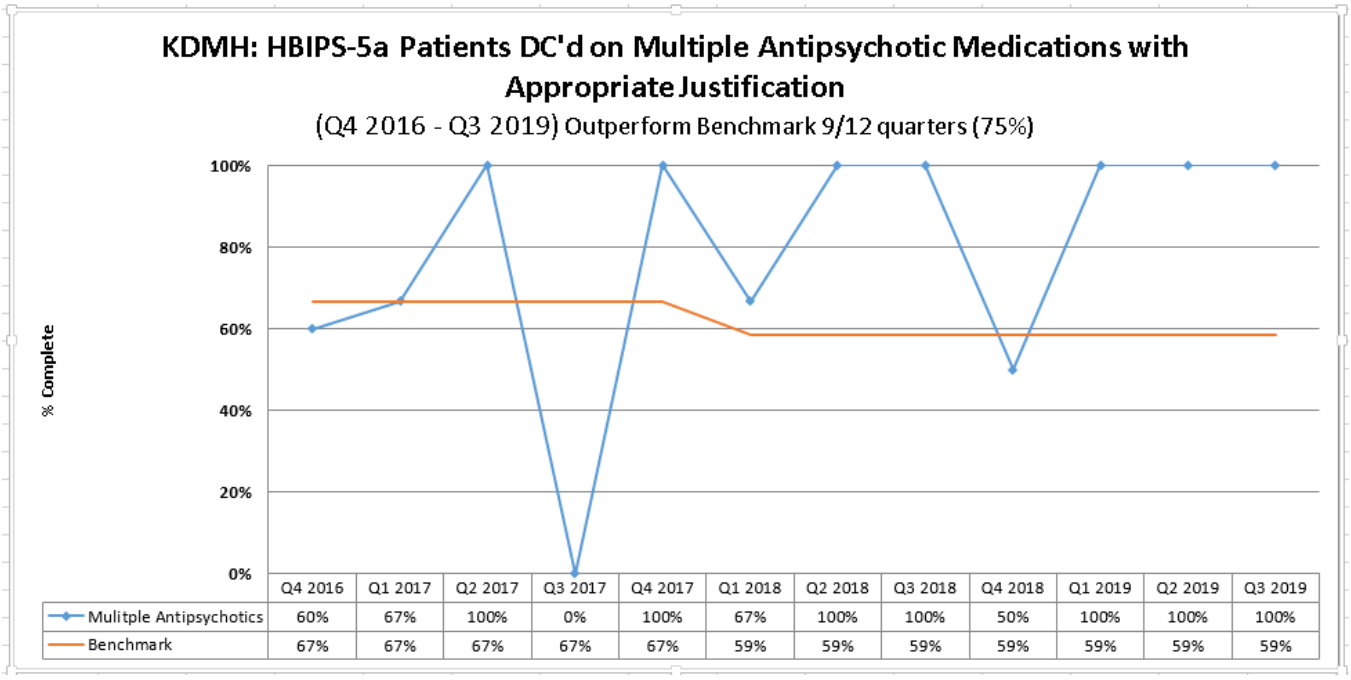


	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019
Hrs Physical Restraint	0.49	0.2	0.21	0.04	0.23	0.28	0.57	0.29	0.47	0.5	0.1	0.26
Benchmark	0.58	0.58	0.58	0.58	0.58	0.44	0.44	0.44	0.44	0.44	0.44	0.44

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



	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019
Hrs Seclusion	1.08	0.58	0.17	0.12	0.74	0.92	1.2	0.12	2.11	0.81	0.52	0.35
Benchmark	0.48	0.48	0.48	0.48	0.48	0.29	0.29	0.29	0.29	0.29	0.29	0.29



	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019
Mulitple Antipsychotics	60%	67%	100%	0%	100%	67%	100%	100%	50%	100%	100%	100%
Benchmark	67%	67%	67%	67%	67%	59%	59%	59%	59%	59%	59%	59%

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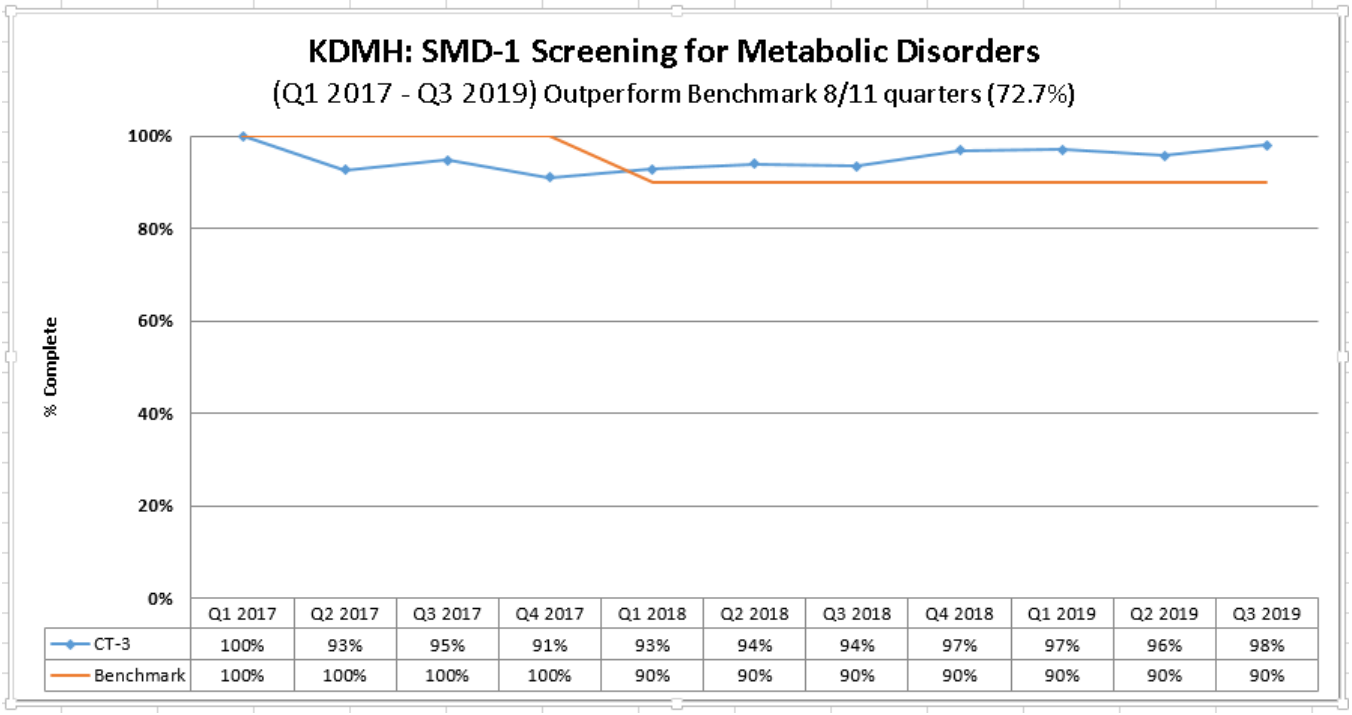
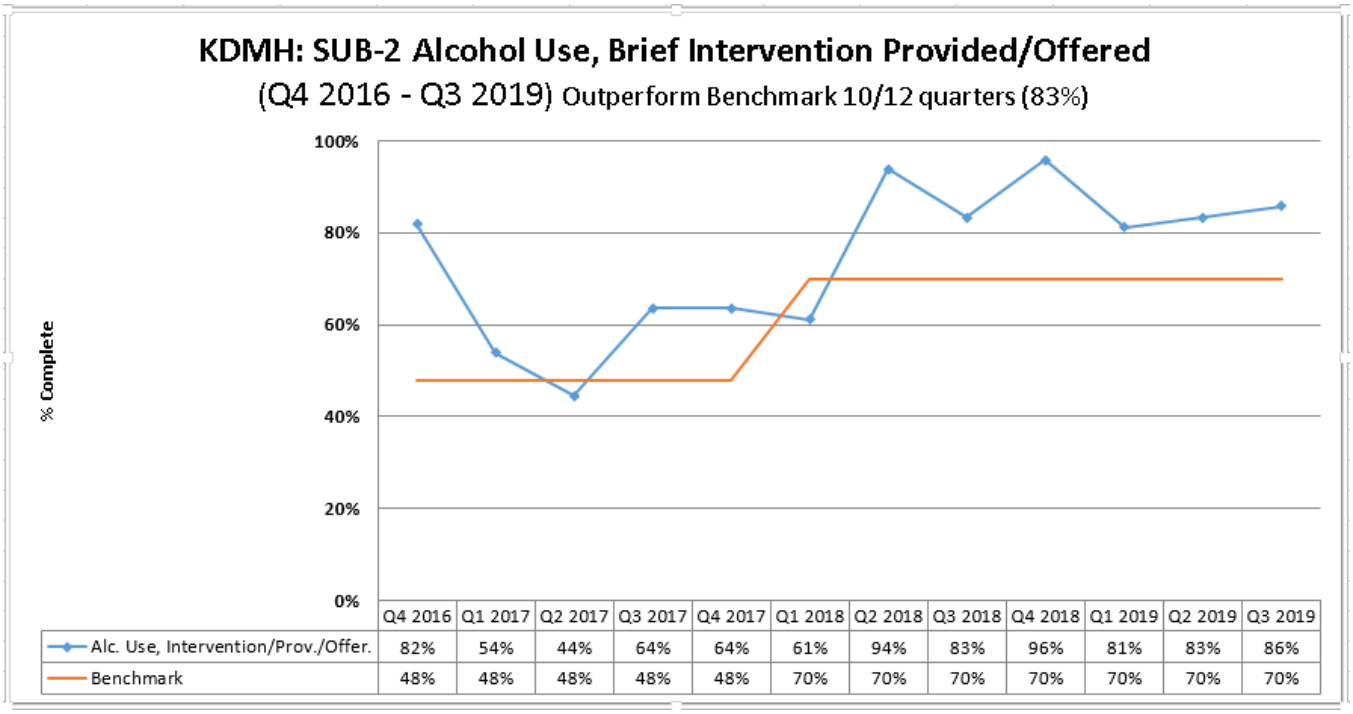


	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019
CT-3	100%	93%	95%	91%	93%	94%	94%	97%	97%	96%	98%
Benchmark	100%	100%	100%	100%	90%	90%	90%	90%	90%	90%	90%

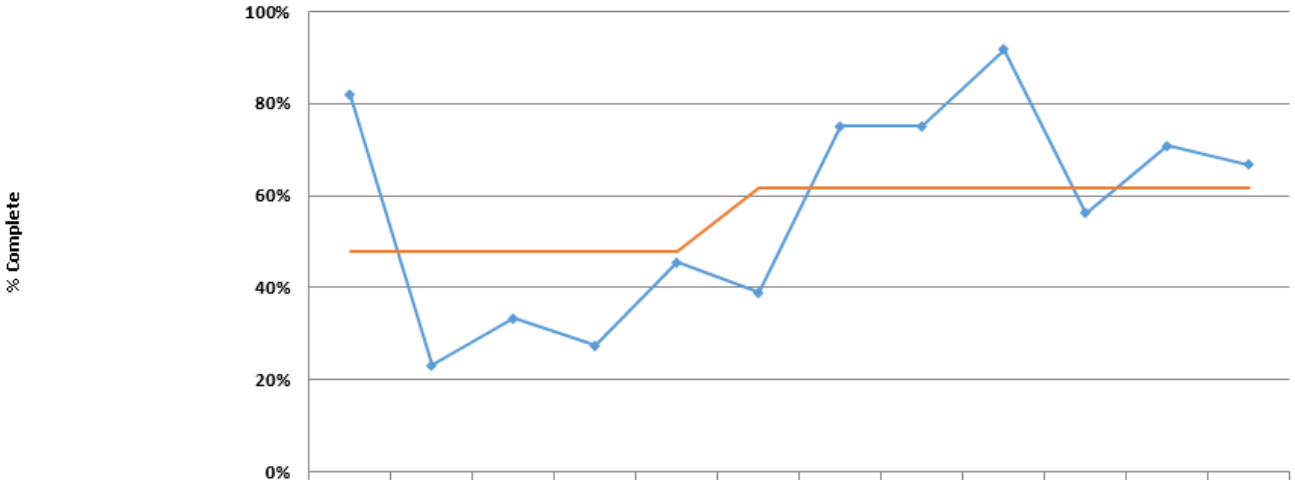


	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019
Alc. Use, Intervention/Prov./Offer.	82%	54%	44%	64%	64%	61%	94%	83%	96%	81%	83%	86%
Benchmark	48%	48%	48%	48%	48%	70%	70%	70%	70%	70%	70%	70%

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

KDMH: SUB-2a Alcohol Use Brief Intervention

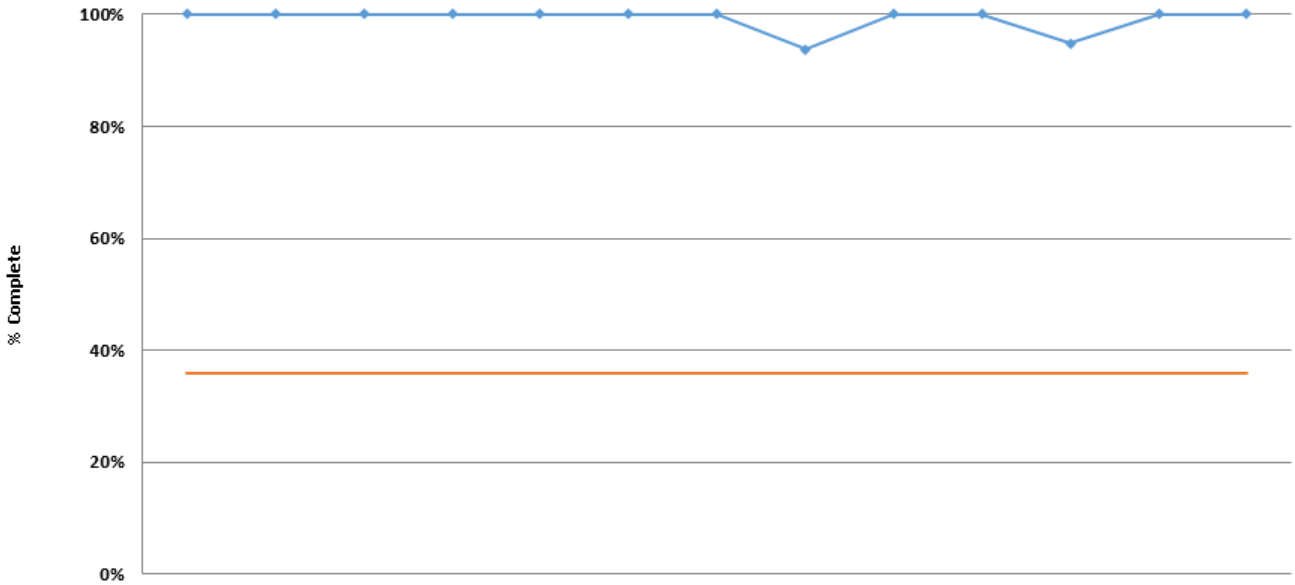
(Q4 2016 - Q3 2019) Outperform Benchmark 6/12 quarters (50%)



	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019
Alcohol Use Brief Intervention	82%	23%	33%	27%	46%	39%	75%	75%	92%	56%	71%	67%
Benchmark	48%	48%	48%	48%	48%	62%	62%	62%	62%	62%	62%	62%

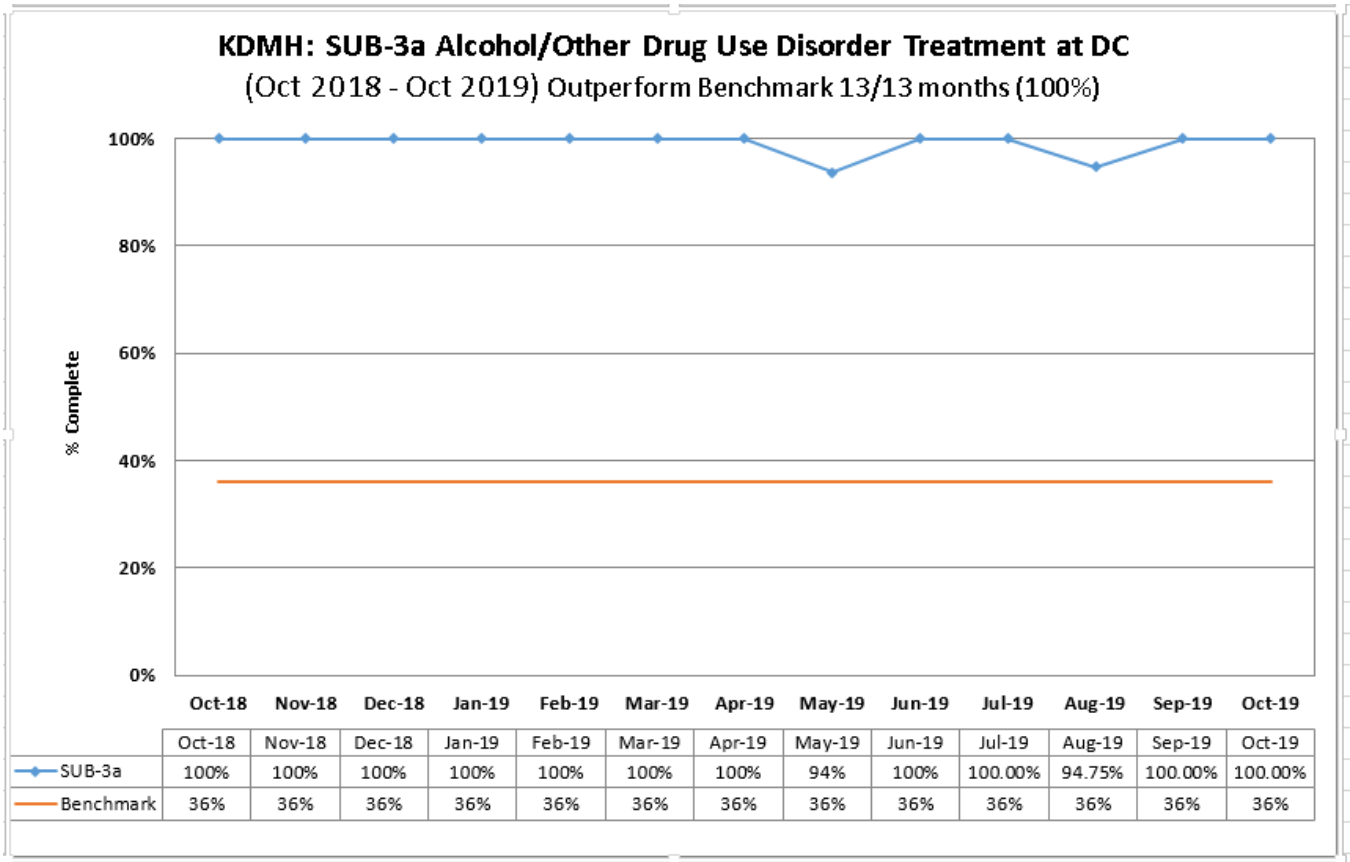
KDMH: SUB-3 Alcohol/Other Drug Use Treatment Provided /Offered at DC

(Oct 2018 - Oct 2019) Outperform Benchmark 13/13 months (100%)

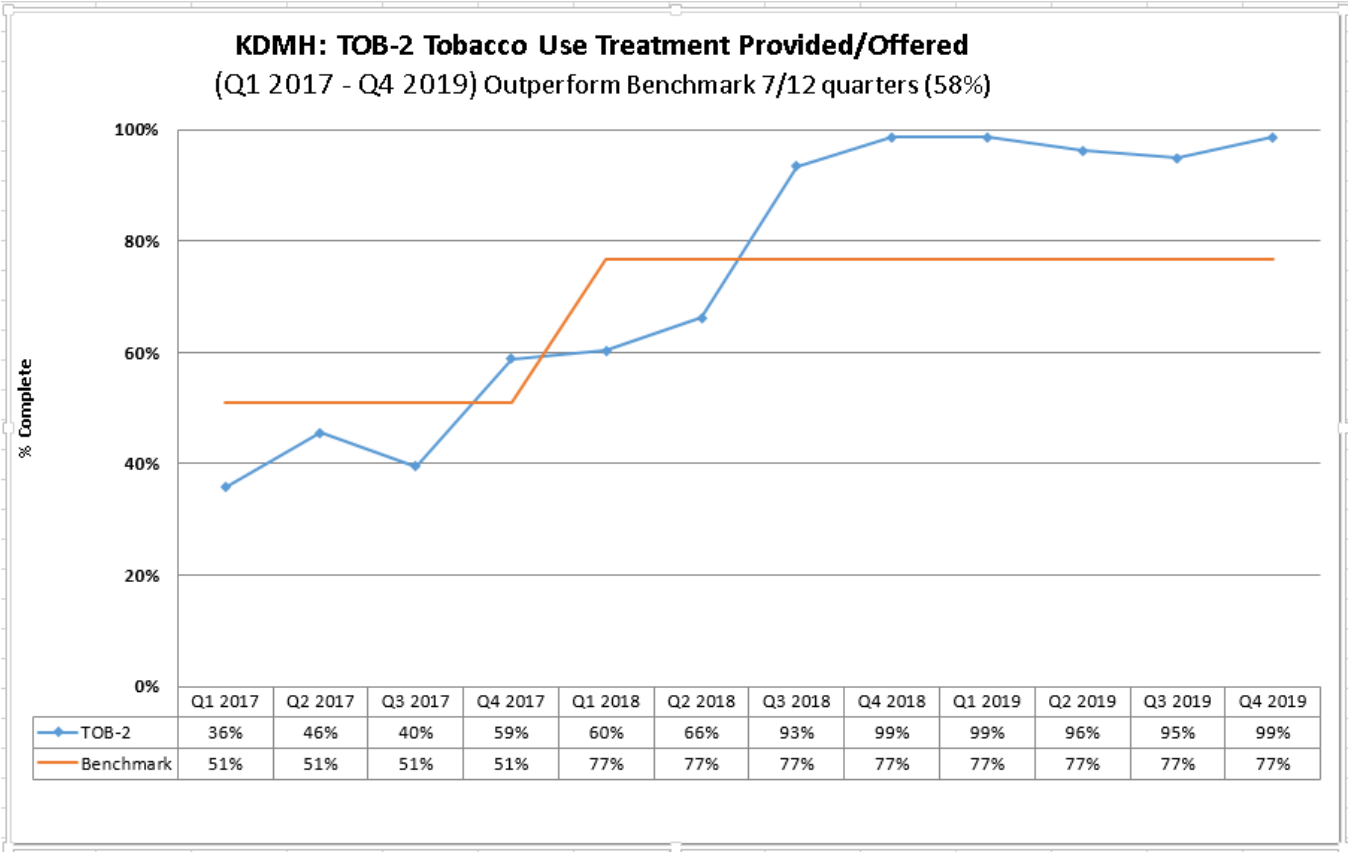


	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
SUB-3	100%	100%	100%	100%	100%	100%	100%	94%	100%	100.00%	94.75%	100.00%	100.00%
Benchmark	36%	36%	36%	36%	36%	36%	36%	36%	36%	36%	36%	36%	36%

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

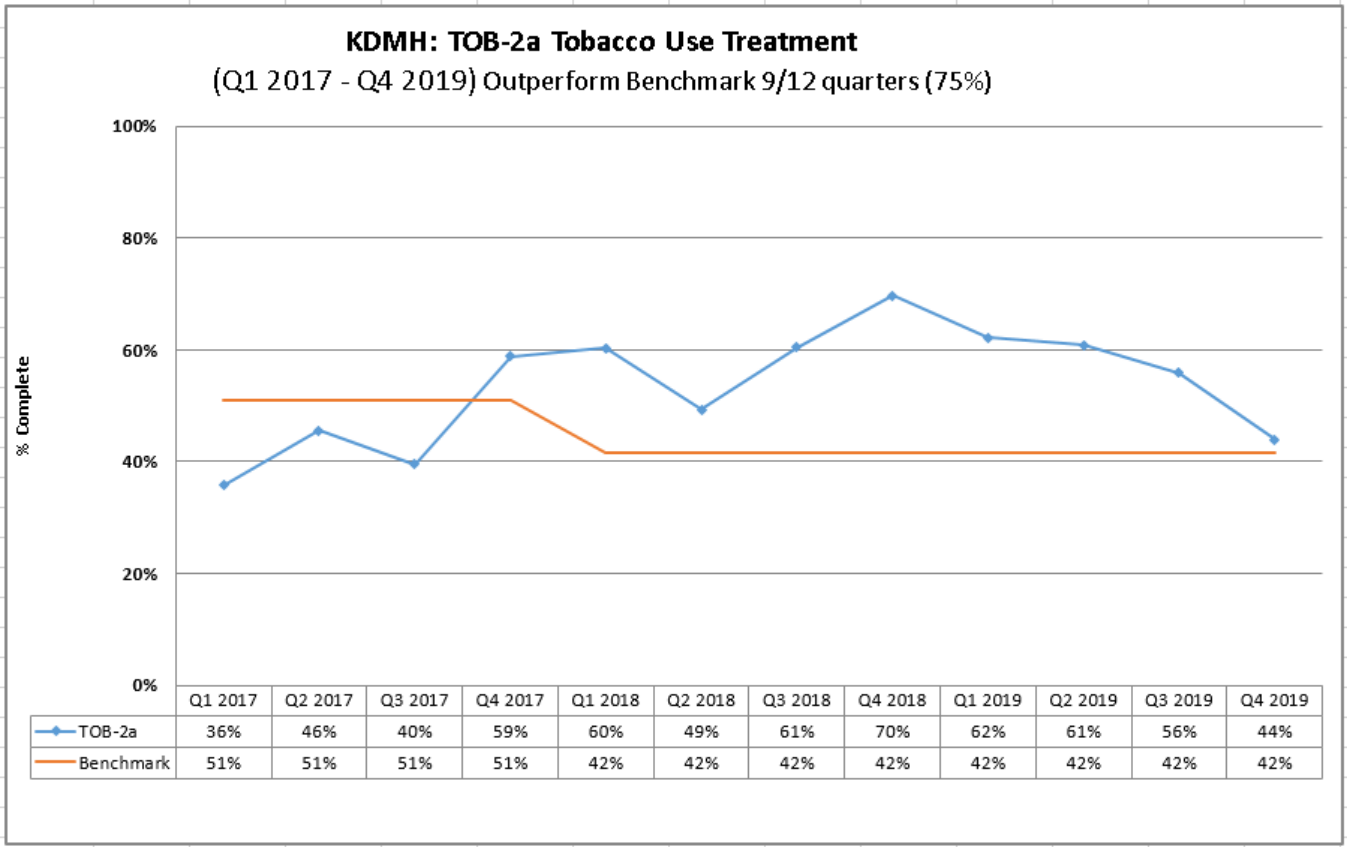


	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
SUB-3a	100%	100%	100%	100%	100%	100%	100%	94%	100%	100.00%	94.75%	100.00%	100.00%
Benchmark	36%	36%	36%	36%	36%	36%	36%	36%	36%	36%	36%	36%	36%

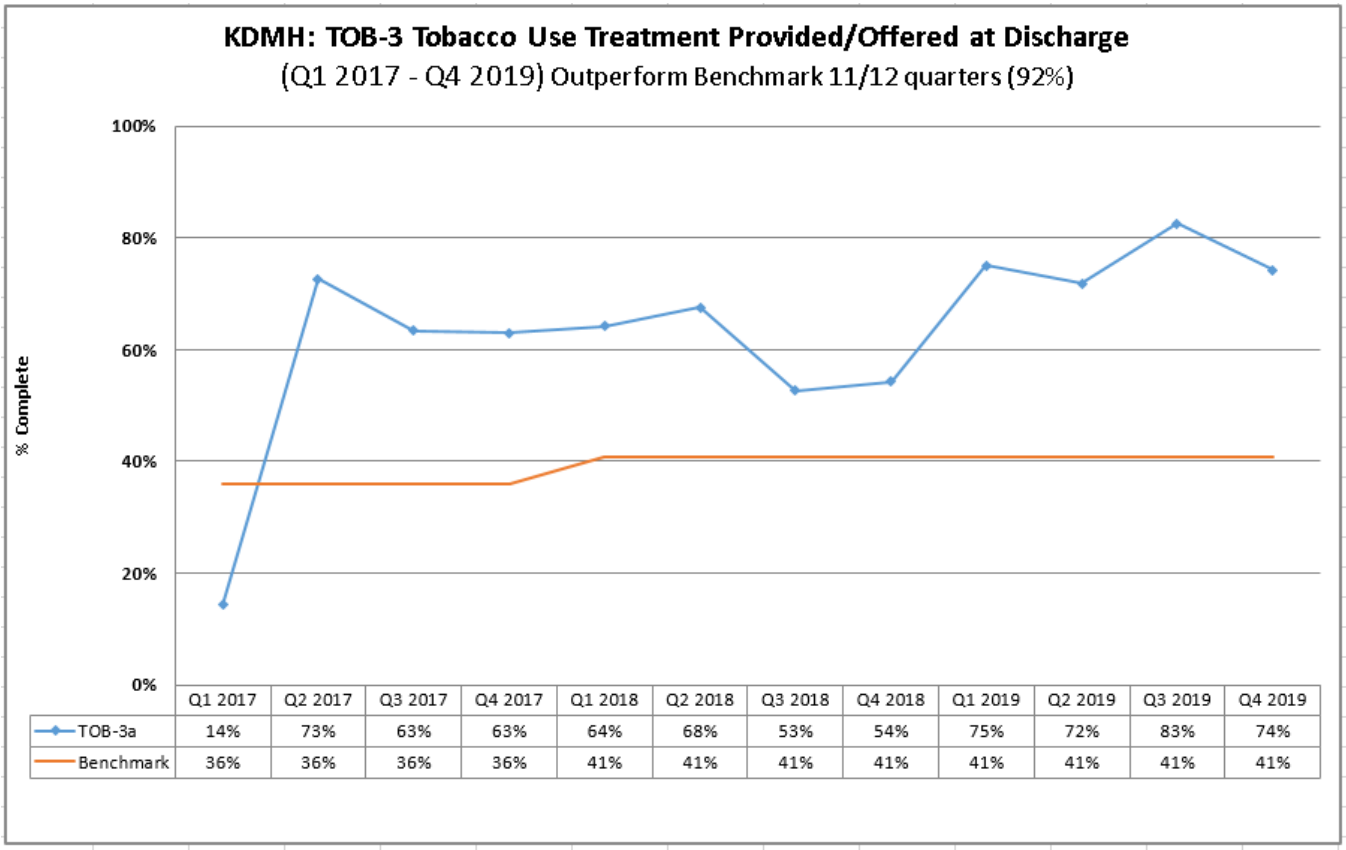


	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019
TOB-2	36%	46%	40%	59%	60%	66%	93%	99%	99%	96%	95%	99%
Benchmark	51%	51%	51%	51%	77%	77%	77%	77%	77%	77%	77%	77%

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



	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019
TOB-2a	36%	46%	40%	59%	60%	49%	61%	70%	62%	61%	56%	44%
Benchmark	51%	51%	51%	51%	42%	42%	42%	42%	42%	42%	42%	42%

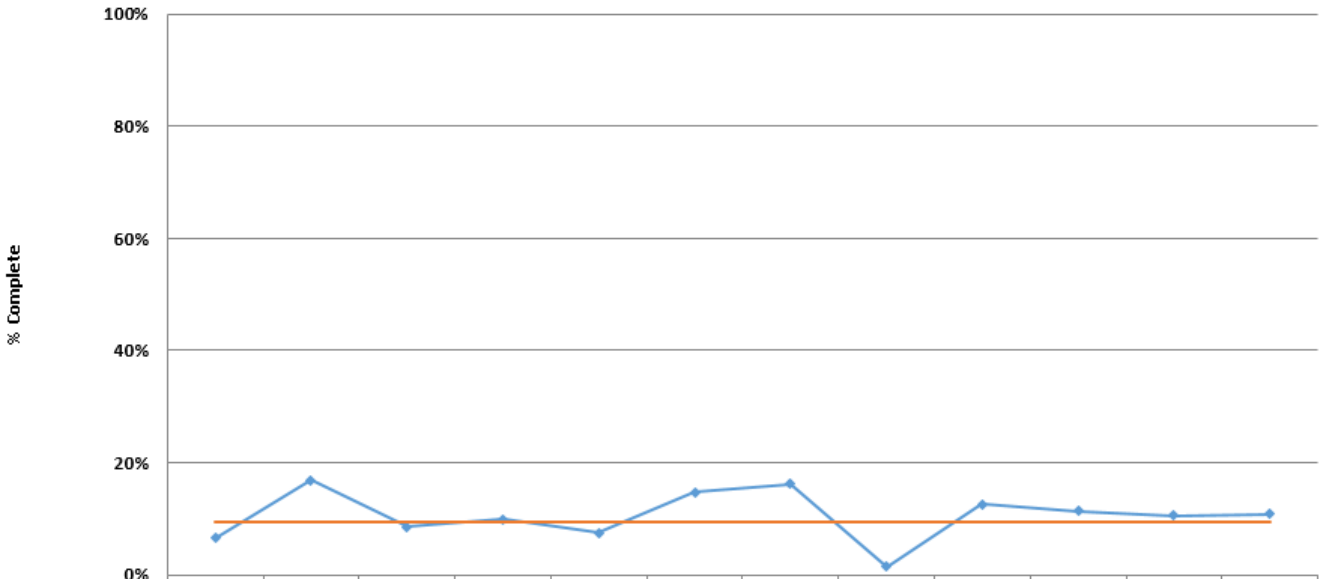


	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019
TOB-3a	14%	73%	63%	63%	64%	68%	53%	54%	75%	72%	83%	74%
Benchmark	36%	36%	36%	36%	41%	41%	41%	41%	41%	41%	41%	41%

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

KDMH: TOB-3a Tobacco Use Treatment at Discharge

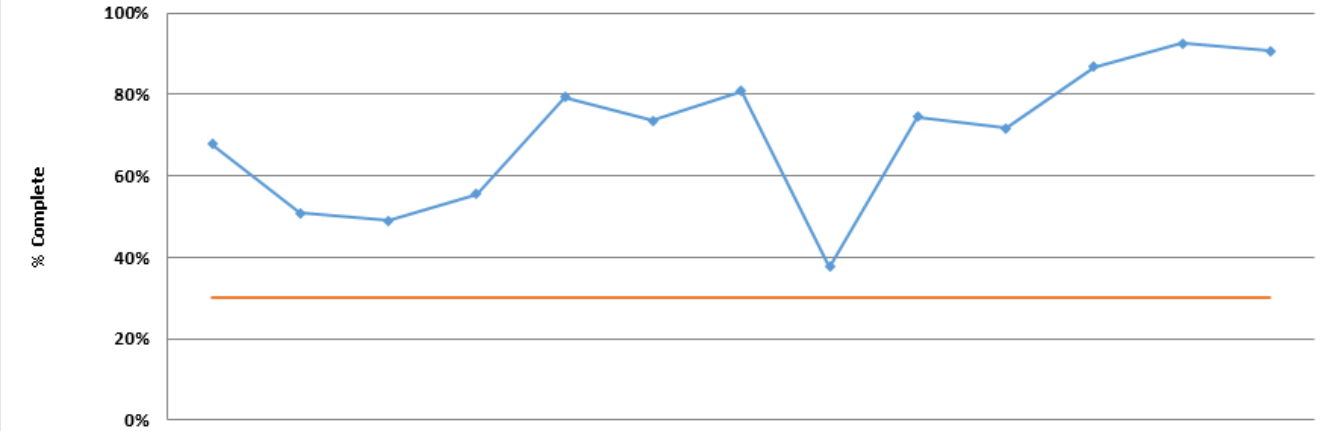
(Q1 2017 - Q4 2019) Outperform Benchmark 8/12 quarters (67%)



	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019
TOB-3a	7%	17%	9%	10%	8%	15%	16%	1%	13%	11%	11%	11%
Benchmark	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%

KDMH: CT-2 Transition Record

(Oct 2018 - Oct 2019) Outperform Benchmark 13/13 months (100%)

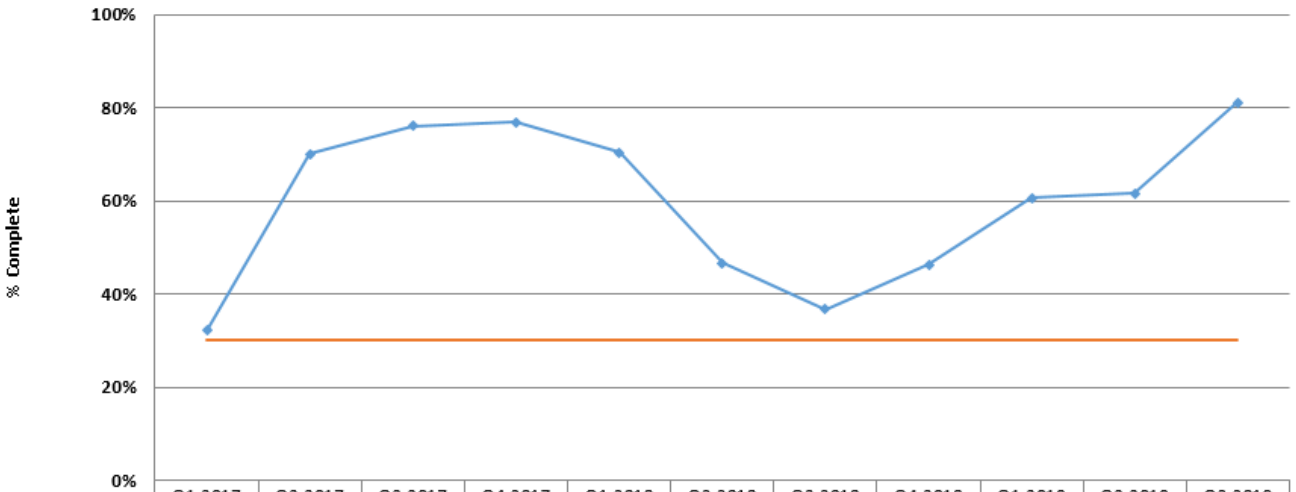


	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
CT-2	68%	51%	49%	56%	79%	74%	81%	38%	75%	72%	87%	92%	91%
Benchmark	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%

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

KDMH: CT-3 Transition Record

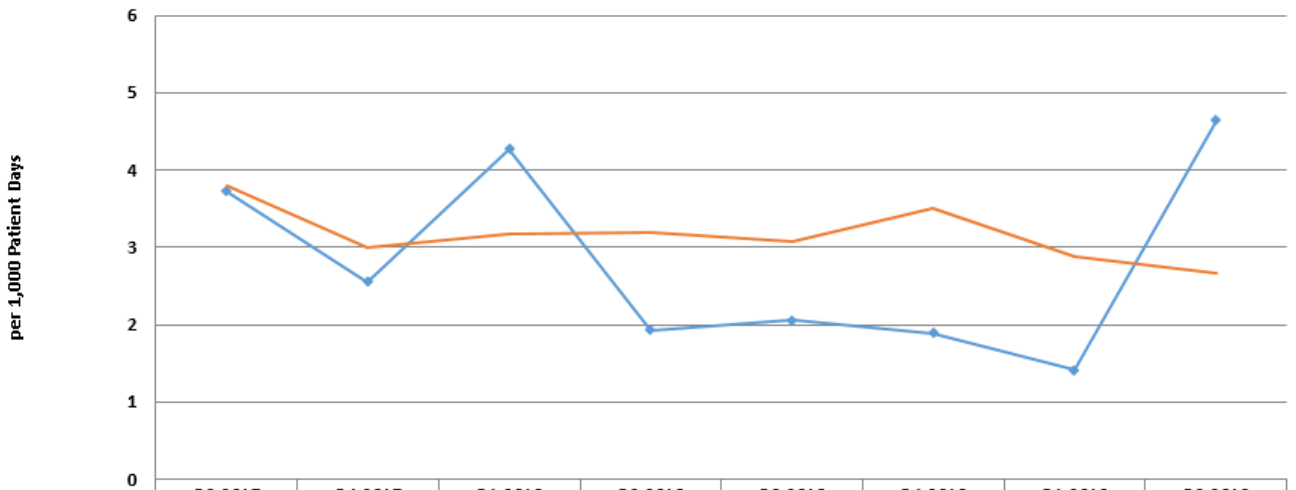
(Q1 2017 - Q3 2019) Outperform Benchmark 11/11 quarters (100%)



	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019
CT-3	32%	70%	76%	77%	70%	47%	37%	46%	61%	62%	81%
Benchmark	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%

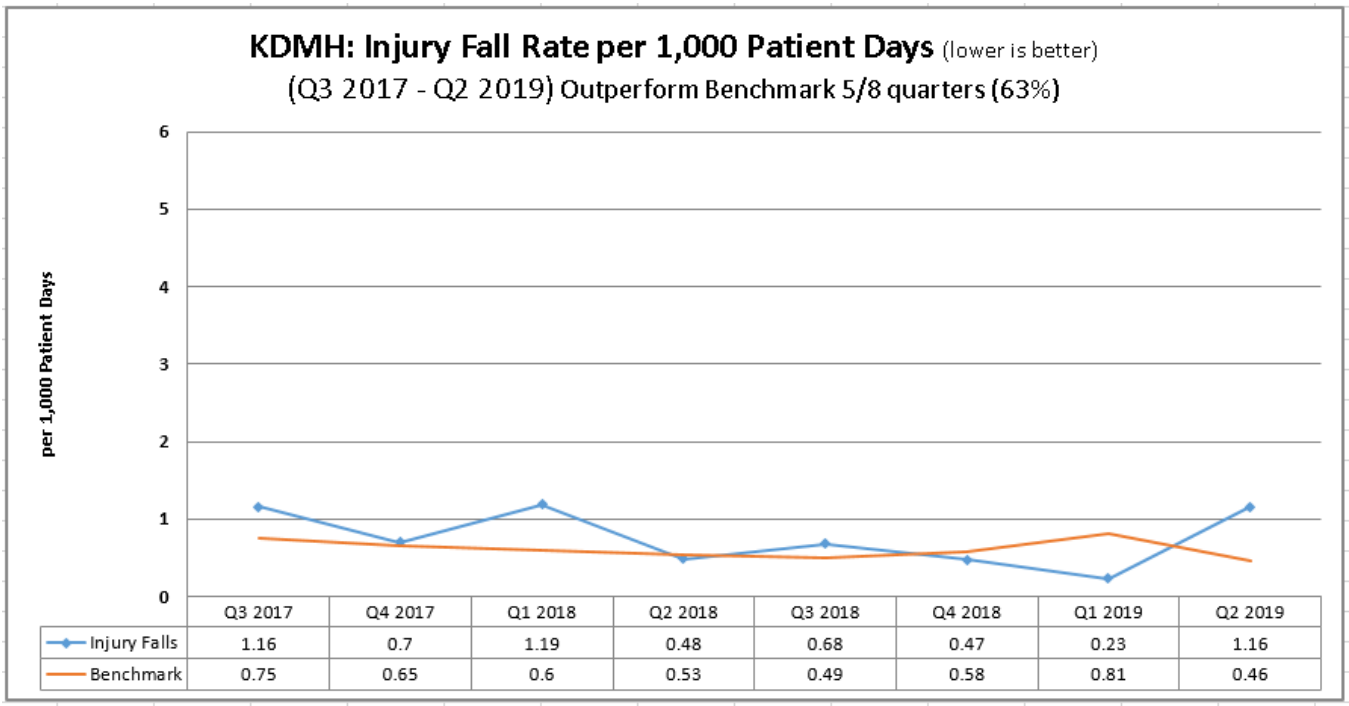
KDMH: Total Fall Rate per 1,000 Patient Days (lower is better)

(Q3 2017 - Q2 2019) Outperform Benchmark 6/8 quarters (75%)

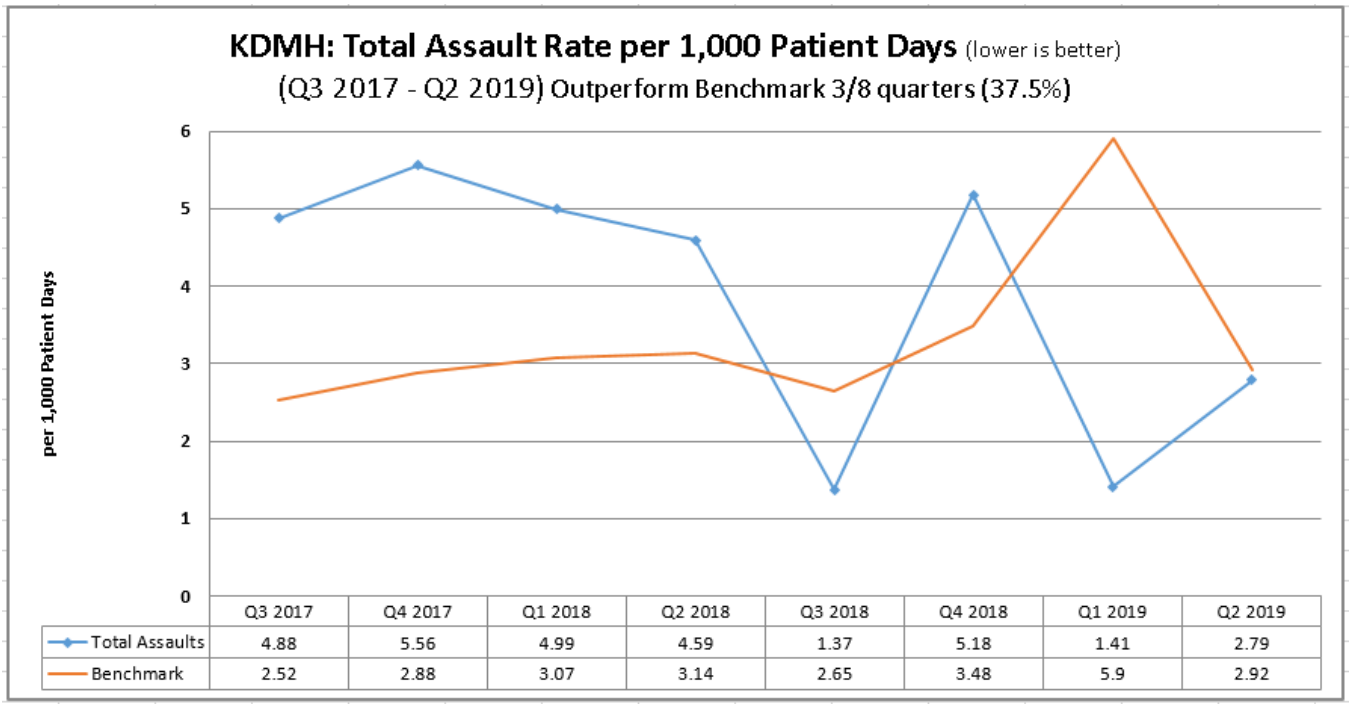


	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019
Total Falls	3.72	2.55	4.27	1.93	2.05	1.89	1.41	4.64
Benchmark	3.8	3	3.17	3.19	3.07	3.51	2.87	2.66

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

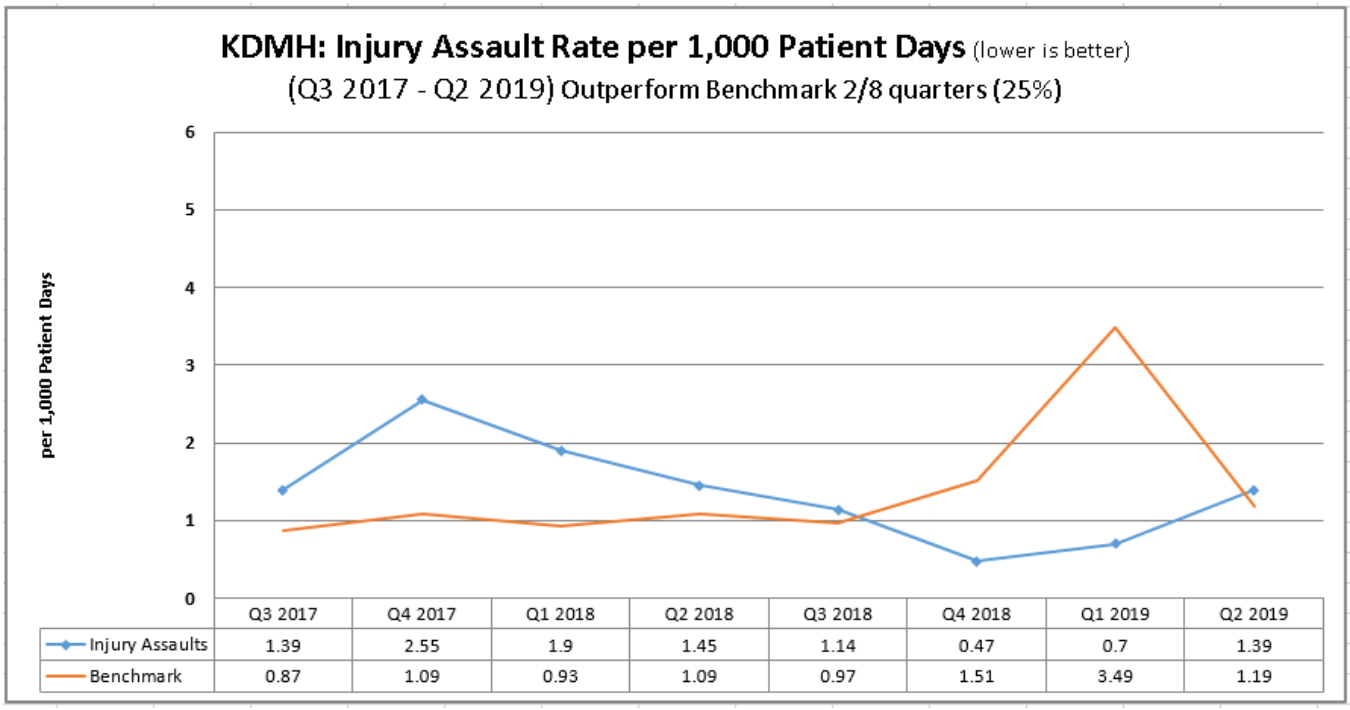


	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019
Injury Falls	1.16	0.7	1.19	0.48	0.68	0.47	0.23	1.16
Benchmark	0.75	0.65	0.6	0.53	0.49	0.58	0.81	0.46



	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019
Total Assaults	4.88	5.56	4.99	4.59	1.37	5.18	1.41	2.79
Benchmark	2.52	2.88	3.07	3.14	2.65	3.48	5.9	2.92

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



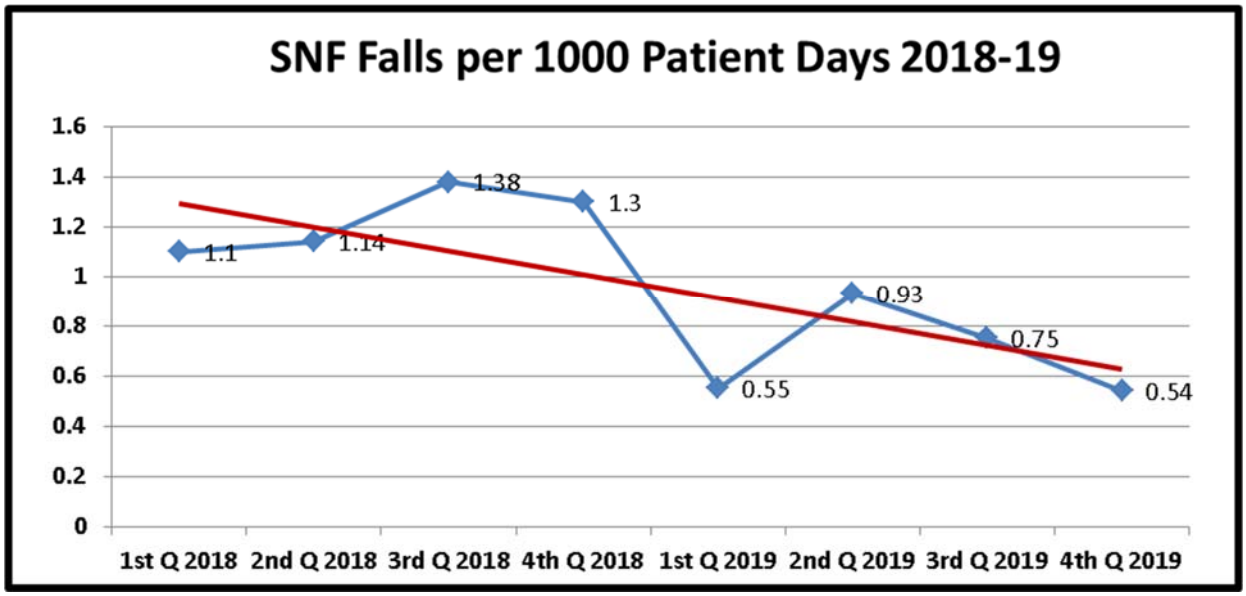
	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019
Injury Assaults	1.39	2.55	1.9	1.45	1.14	0.47	0.7	1.39
Benchmark	0.87	1.09	0.93	1.09	0.97	1.51	3.49	1.19

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

Unit/Department: Sub Acute, TCS, and SS Rehab Report Date: April, 2020

Measure Objective/Goal: FALLS

Facility observed percent for falls for long stay patients is 5.9%, remaining well below national average of 45.3%, placing the program in the top 1 percentile nationally.



- Staff continue to participate in, and has a high rate of compliance with, district-wide initiatives for fall prevention. While falls are infrequent, they do occur most commonly with our short-stay population, all of whom are involved with therapy programs to enhance functional mobility.

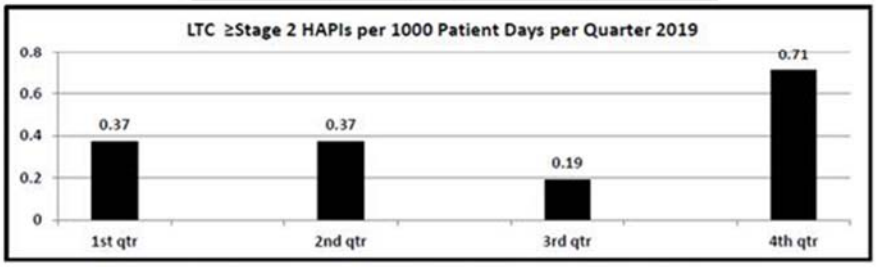
Measure Objective/Goal: Pressure Injuries

A. There were 0 pressure injuries new or worsened (HAPI) reported for the 4th quarter internal data for the two departments typically housing our shorter stay clients (Transitional Care and Short Stay Rehab).
B. Patients at High risk for Pressure Ulcers (Long Stay residents) showed an increase from prior year 6.3 to 11.8% This puts us at the 79th percentile. This quarter the four patients with pressure injuries have a history of documented chronic non-adherence to skin prevention interventions or diagnosis of skin failure.
C. Internal Data through 4th in 2019 shows year to date overall SNF rate per 1000/pt. days was 0.71. This is a decrease from 0.89 for 2018.

Skin Integrity

LTC ≥ Stage 2 HAPIs per 1000 Patient Days per Quarter 2019

1st qtr	2nd qtr	3rd qtr	4th qtr
0.37	0.37	0.19	0.71



Improvement Opportunities:

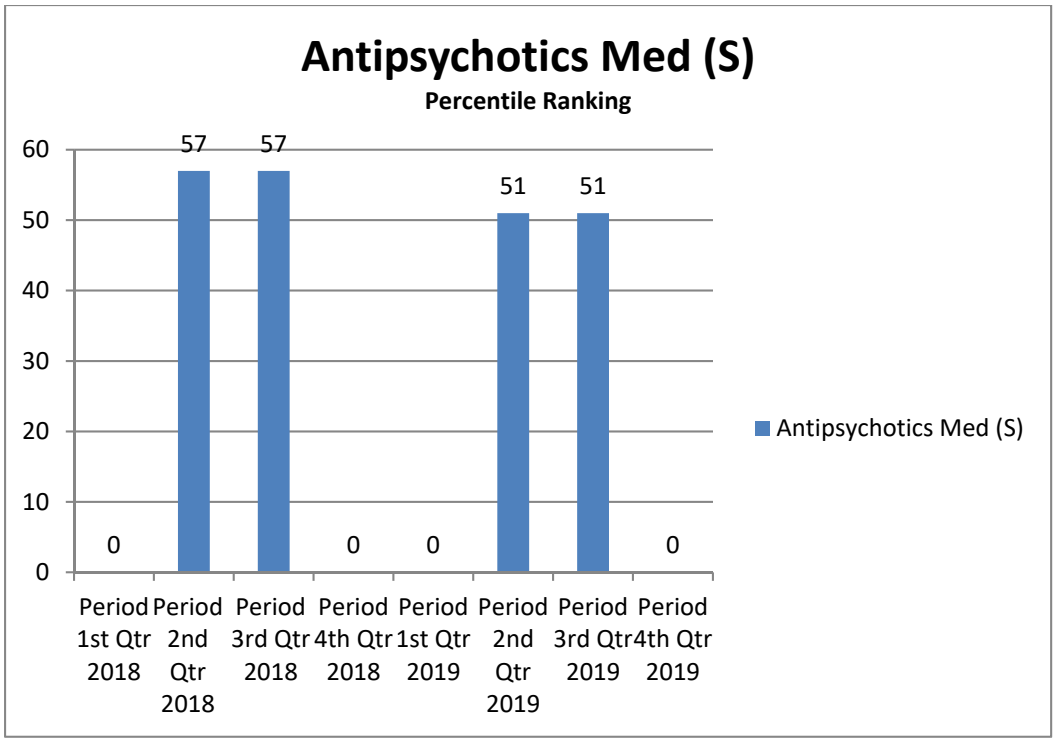
- All three units continue to actively participate in the district-wide HAPI prevention plan.
- Licensed nurses (RN/LVN) use the Districts high standard practices when managing fragile and chronic wound cases. This included working closely with the wound nurses and utilizing standardized treatment sets available to us.
- Managers measure successes and celebrate days with no new pressure injuries.
- UBC teams for South Campus nursing continue to monitor progress and Peer review and remediate practice concerns.

Measure Objective/Goal: Self-Reported Moderate/Severe Pain

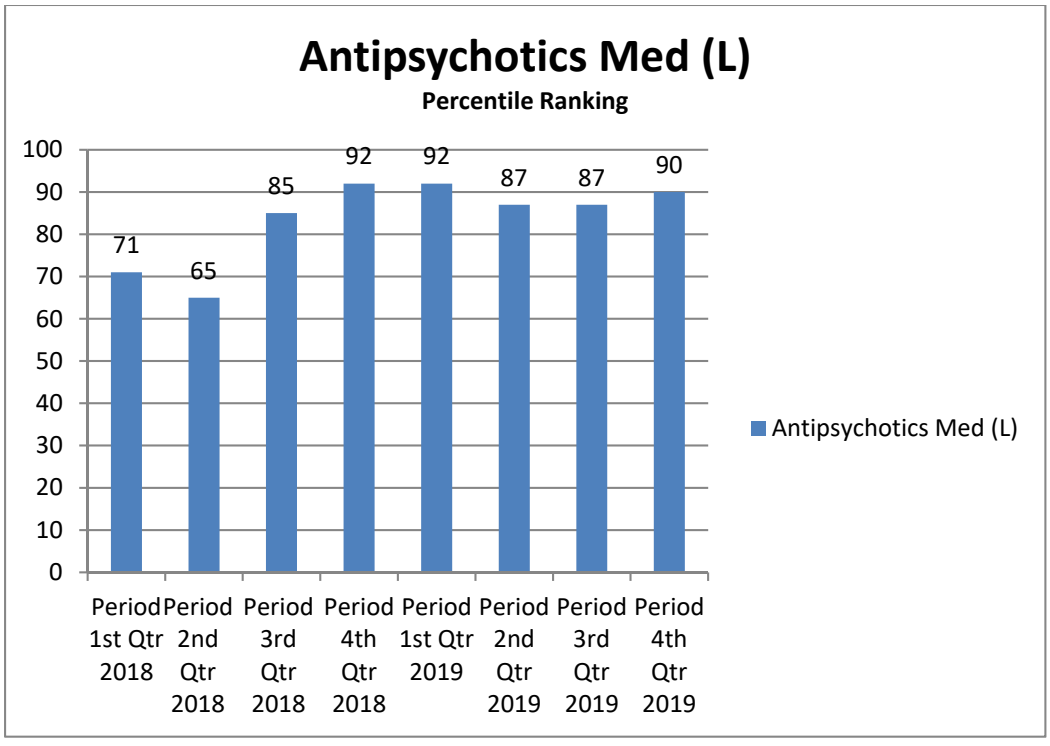
This quality indicator is no longer a measure in the 5 Star rating.

Measure Objective/Goal: Psychoactive Medication Use

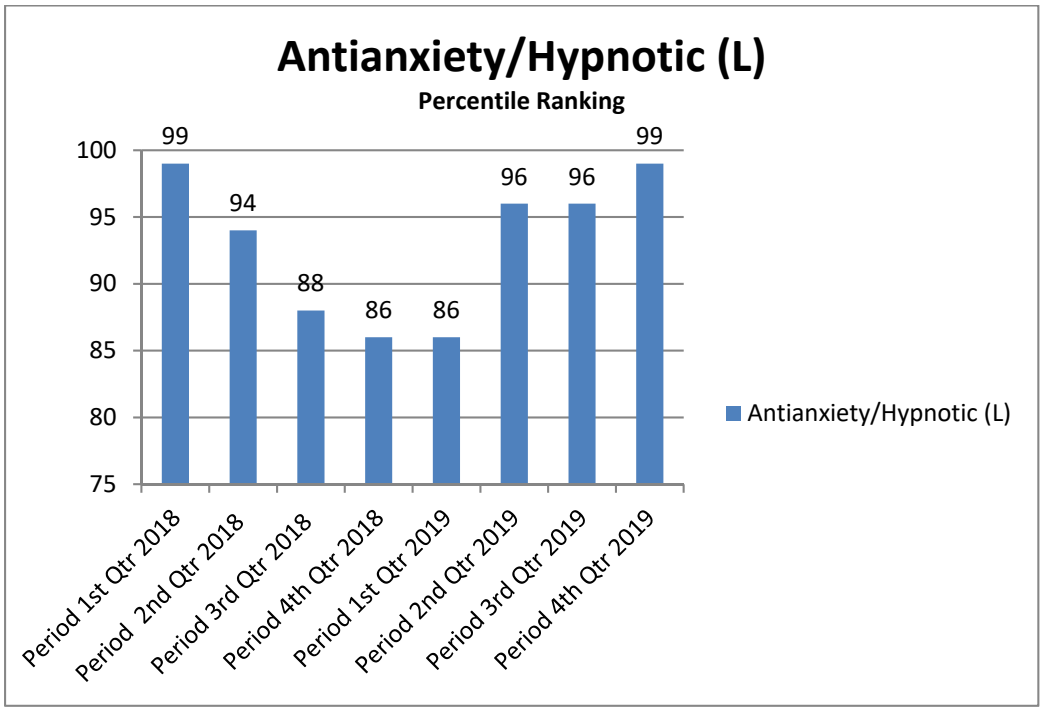
- **Short Stay residents (<100 days):** Antipsychotic medication use for short stay patients is 0%, below national average of 2%. This quality indictor measures only cases with newly prescribed antipsychotics.



- **Long Stay residents:** The facility percent for antipsychotic use in long stay residents is 24.6%, the national average is 14.3%. Included in this measure are medications like quetiapine which may be used for depression or for ventilator management cases.



- **Long Stay residents:** Antianxiety/Hypnotic Medication use for long stay is 50% utilization, compared to 19.6% national average. There are no exclusions for medical diagnosis for this measure. Medications included in this measure are lorazepam and diazepam used for seizures and vent management.



Improvement Opportunities

SNF leadership has been working closely with the medical team and our MDS nurses to ensure that appropriate psychiatric diagnoses are captured in the medical record whenever possible. A small number of these diagnoses are excluded from this quality measure.

Our LTC pharmacist plays an important role in helping us ensure that we follow all of these medications closely during the transition process. Our primary focus is on unnecessary medications, and we also monitor for the potential for dose reductions when possible.

Note:

It is important to note that we have made significant and sustained improvement in our overall quality ranking. A contribution to this is partly due to the elimination of Self-report of moderate to severe pain measure. In the past three years, the program has moved from 3-star quality rating overall to a 5-star overall quality rating. Additionally, with continued strong performance in both staffing and survey results, our quality ratings are now 4 and 5 stars in every category.

Submitted by: Elisa Venegas

Date: April 8, 2020

Sepsis Core Measure
(Sep-1 Early Management Bundle)

KAWEAH DELTA HEALTH CARE DISTRICT

Sep-1 Early Management Bundle

Three Hours

- **Blood Cultures prior to ABX**
- Lactic Acid & **REPEAT in 6 hours if elevated (>2)**
- Broad Spectrum Antibiotics
- 30ml/kg Crystalloid Fluids for Initial Hypotension/Lactic Acidosis (SBP<90 or LA≥4) **(MUST DOCUMENT WEIGHT THAT YOU USED TO CALCULATE FLUIDS – IT CAN BE AN ESTIMATED WEIGHT OR IBW)**

Six Hours Septic Shock

If hypotension persists after fluid administration-

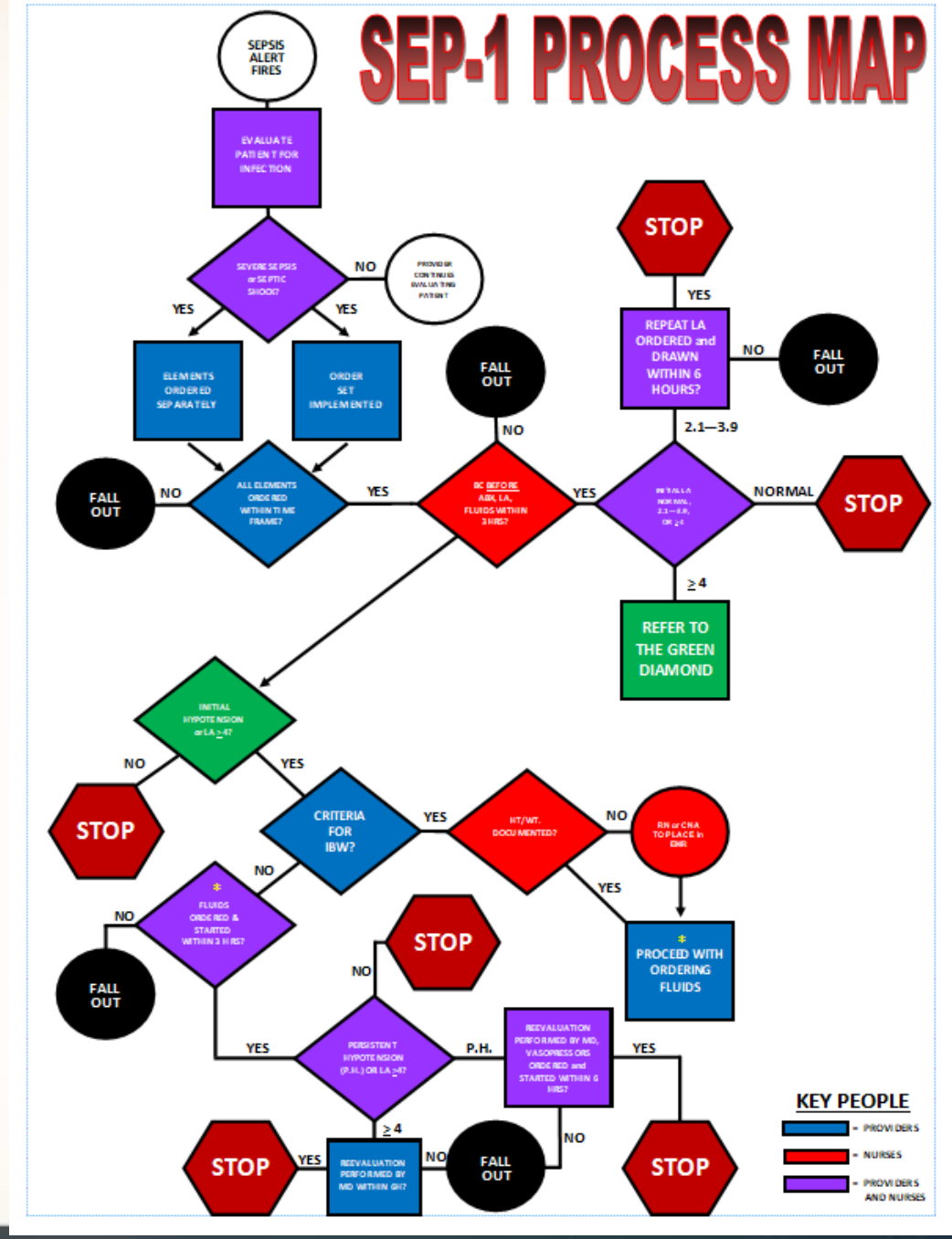
- Vasopressors
- Reassessment (if hypotension persists or initial LA ≥ 4). Any of the following:
  - CVP
  - SvO2
  - Bedside Cardiovascular US
  - Passive Leg Raise

OR

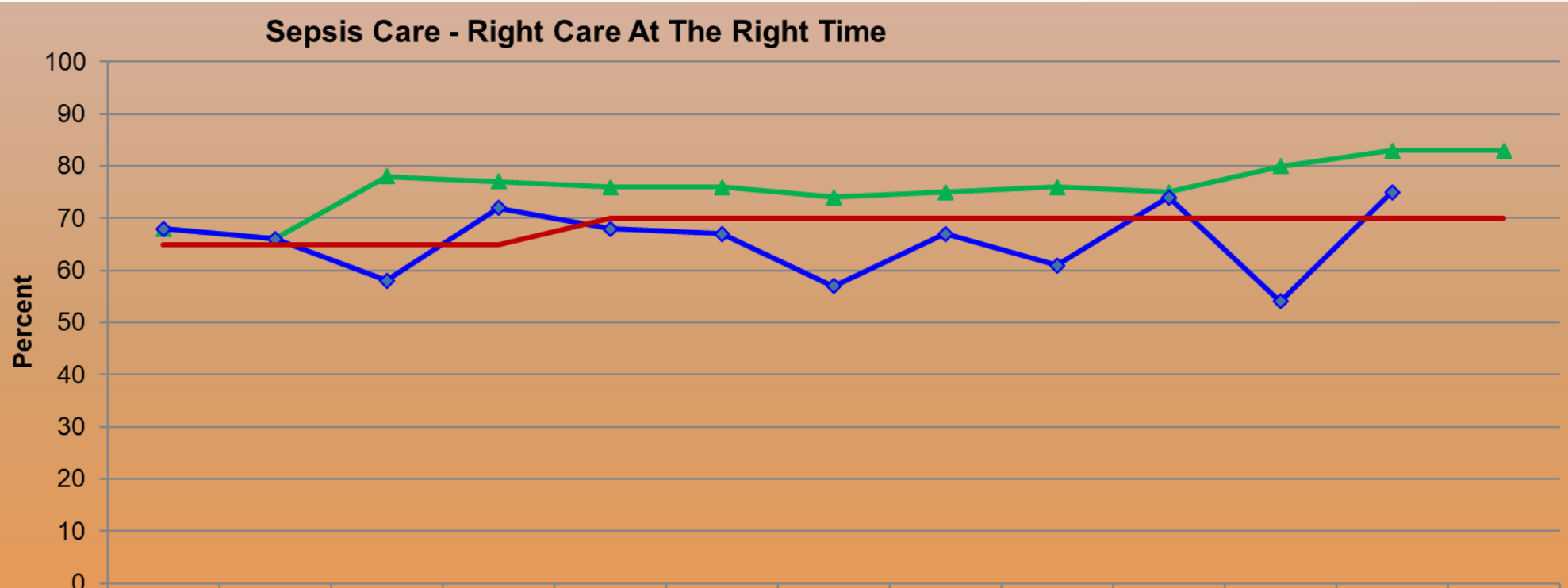
  - Focus Exam – by provider (Five of the following):
    - VS, SpO2, Cardiopulmonary, Cap refill, skin, & peripheral pulses, UO

CMS Sepsis Bundle

- The CMS Sepsis bundle requires a multidisciplinary team approach; the care requirements are timed, with several decision points throughout the process , and the required documentation is precise
- To make it easier, the early management bundle has been put into order sets

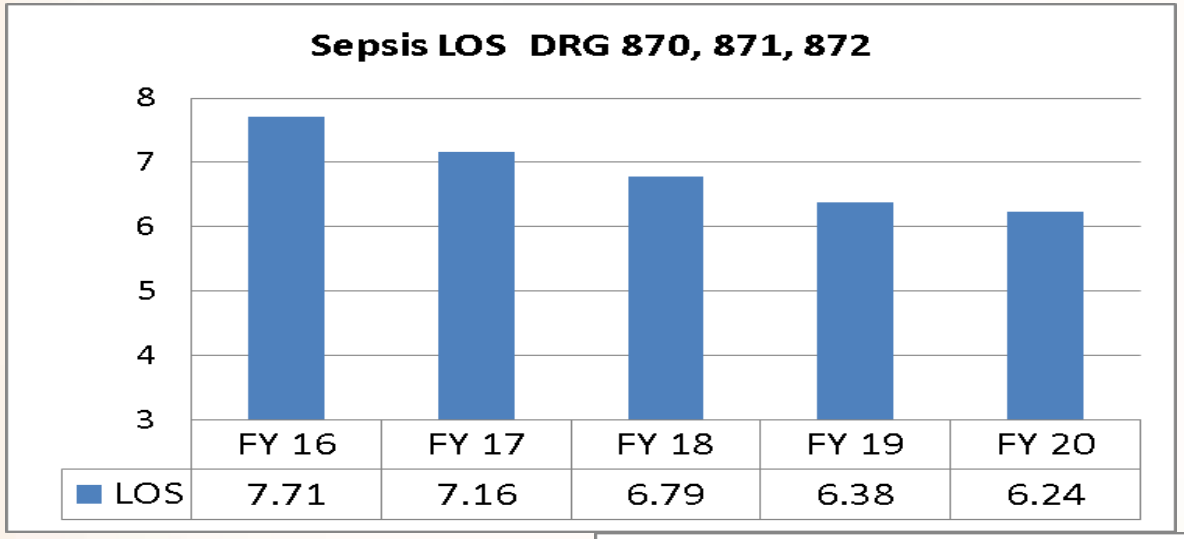


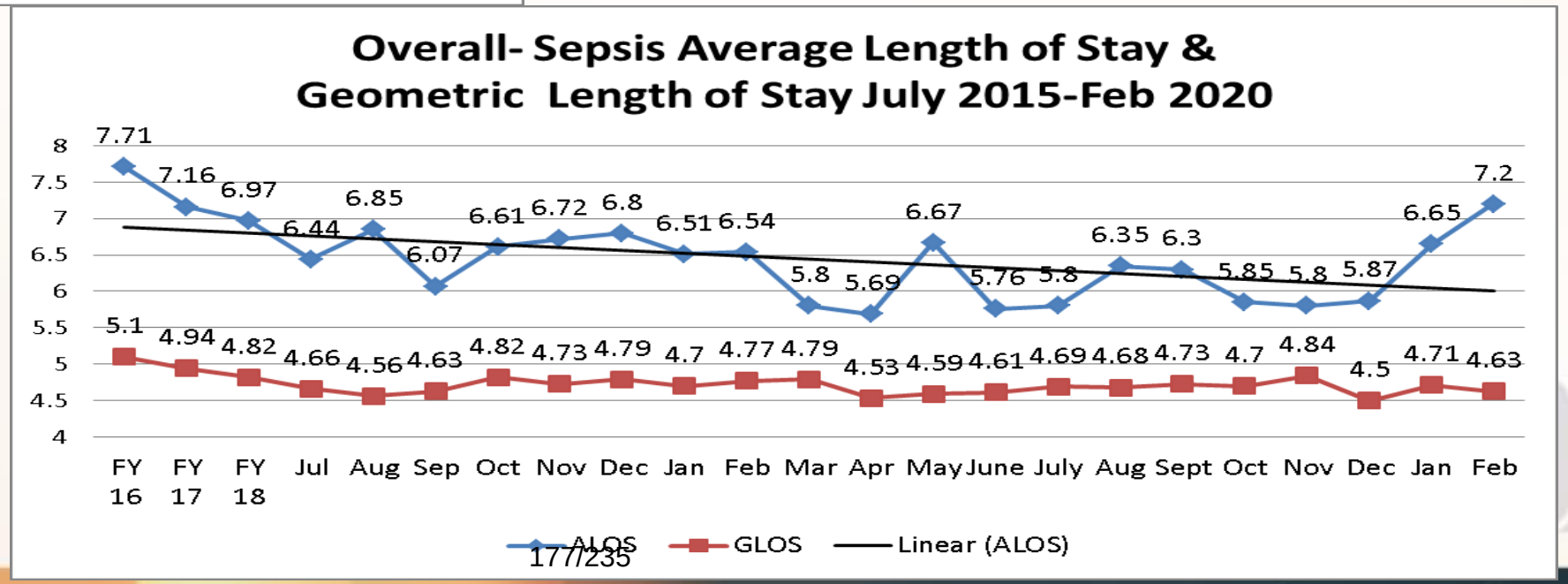
Sep-1 Early Management Bundle Compliance
CA State Compliance 63%
National Compliance 59%



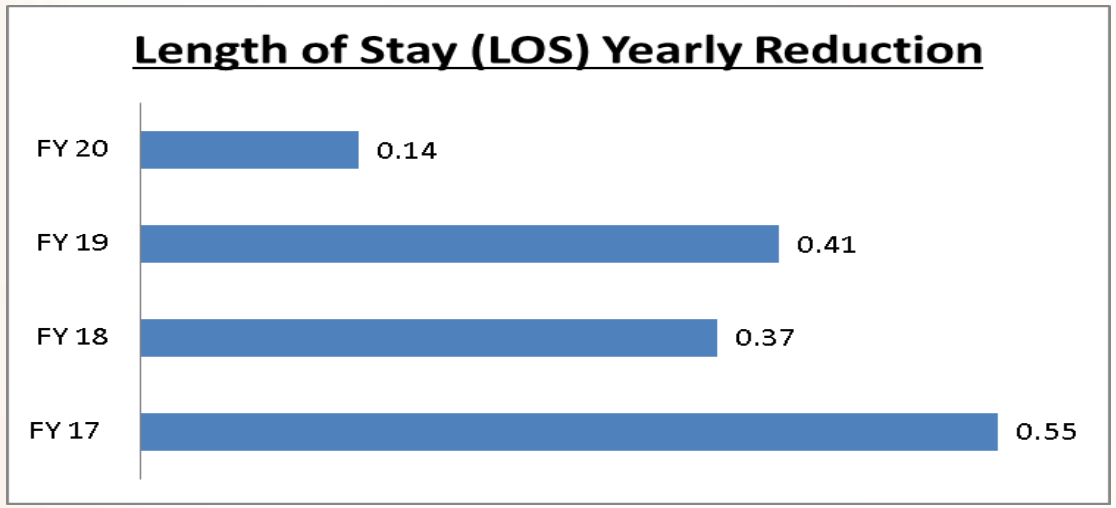
	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Concurrent	68	66	78	77	76	76	74	75	76	75	80	83	83
Sepsis-CMS	68	66	58	72	68	67	57	67	61	74	54	75	
Goal	65	65	65	65	70	70	70	70	70	70	70	70	70

Sepsis Length of Stay

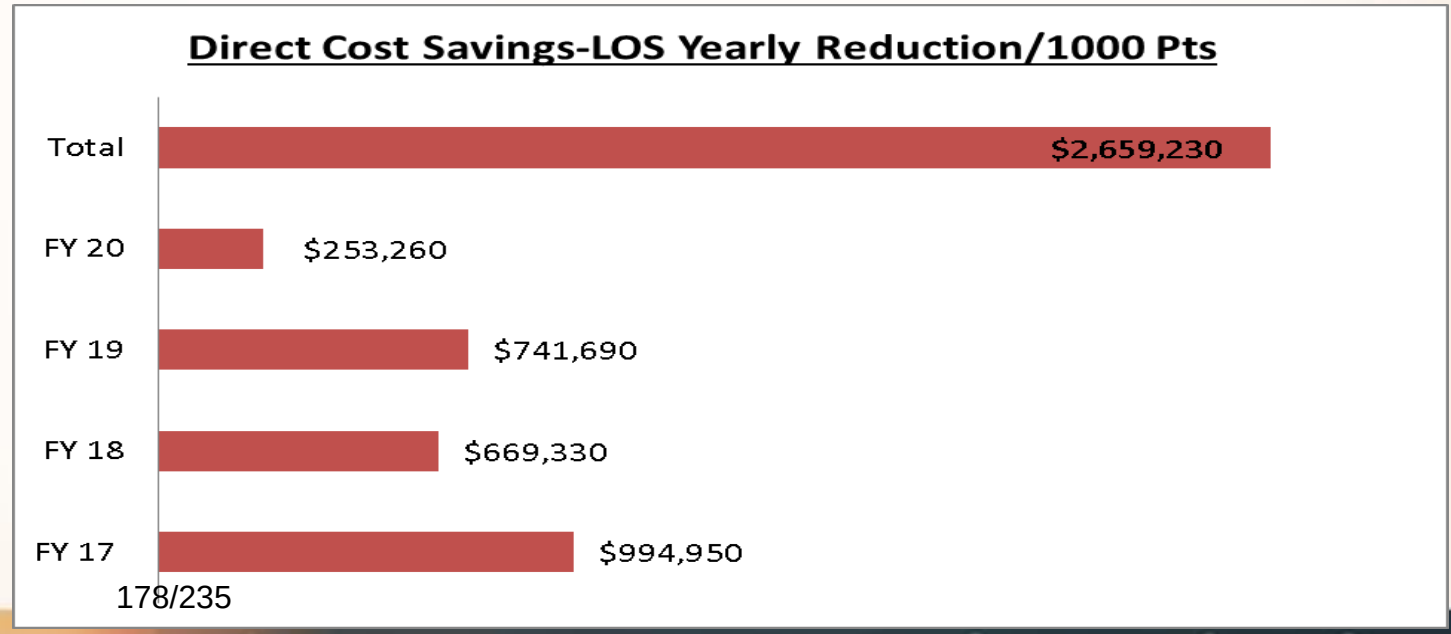




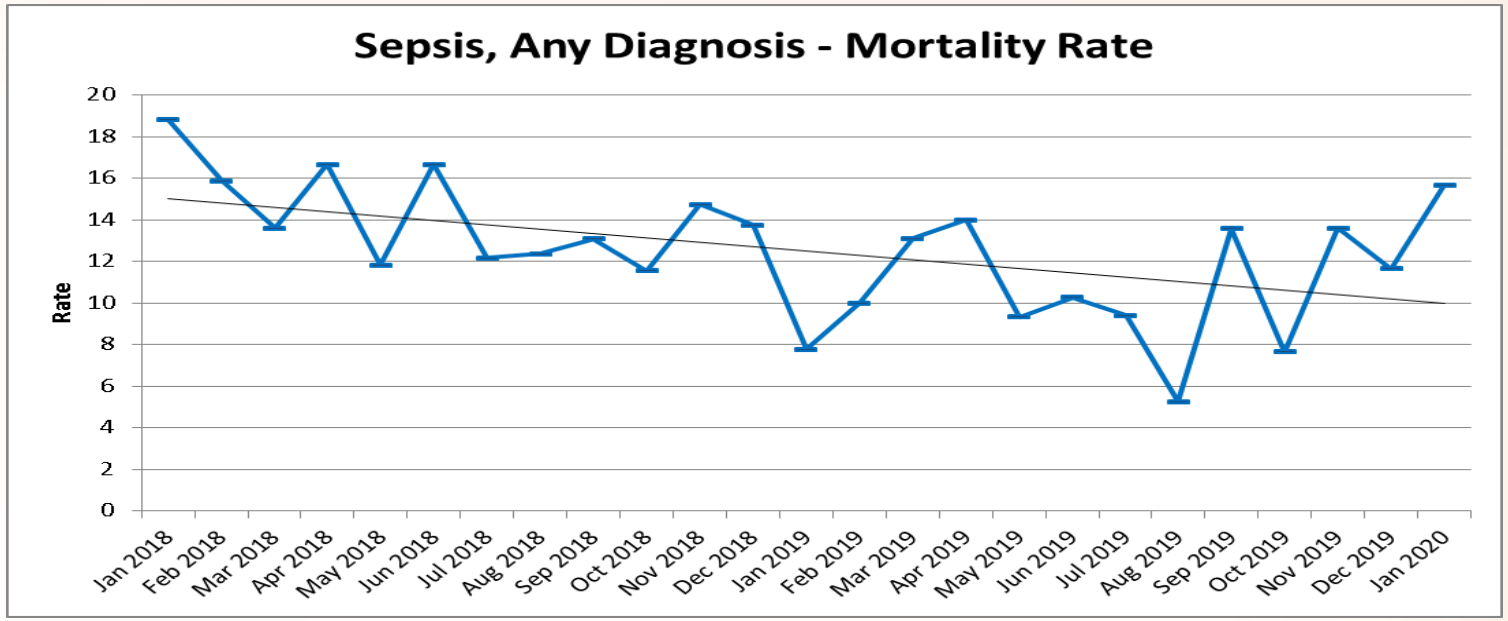
Length of Stay Reduction & Savings

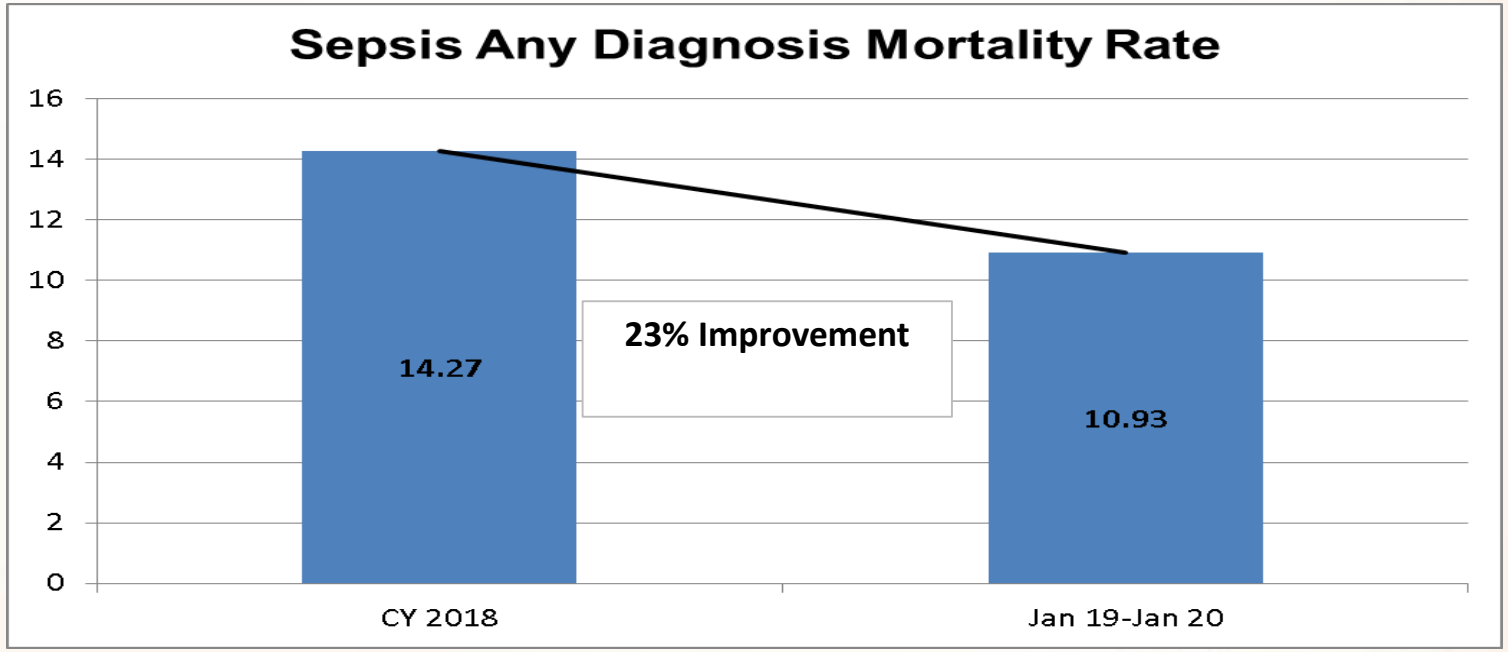


Still Have 1.70 ALOS Excess that Equals to $3.8 Million in Remaining Cost Savings



Reducing Mortality & Saving Lives

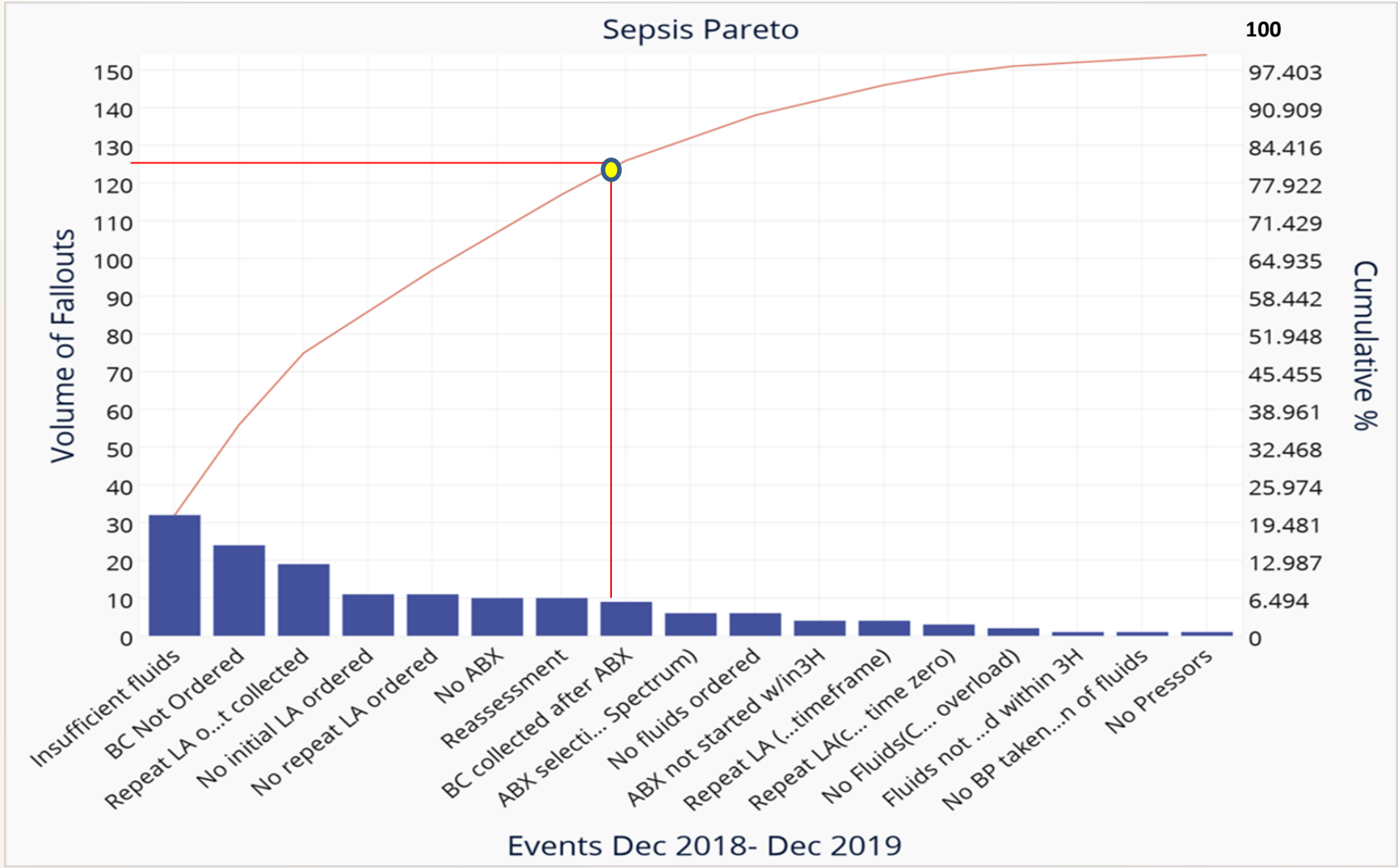




New Initiatives to Increase Sepsis Bundle Compliance

- All CMS Sepsis fallouts from Dec 2018-Dec 2019 were analyzed by the Sepsis Team and root causes were identified
- Pareto chart developed to focus our efforts on the root causes that would yield the biggest outcomes for our patients

80/20 Rule: Sepsis Bundle Fallouts



Fall Out	Total	Cumulative Total	%	Cumulative %
Insufficient Fluids	32	32	20.78	20.78
BC Not Ordered	24	56	15.58	36.36
Repeat LA Not Collected	19	75	12.34	48.70
No Initial LA Ordered	11	86	7.14	55.84
No Repeat LA Ordered	11	97	7.14	62.99
No Abx	10	107	6.49	75.47
Reassessment	10	117	6.49	75.47
BC Collected after Abx	9	126	5.84	81.82

Quality Improvement Strategies

- Lean six sigma event involving resource experts to target the 80% of fallouts
  - Refining order sets
  - Make it easy to document we have done the right thing
- Engagement of a second coordinator
- Increasing awareness
  - GME
  - Nursing
  - Medical Staff

Summary & Actions

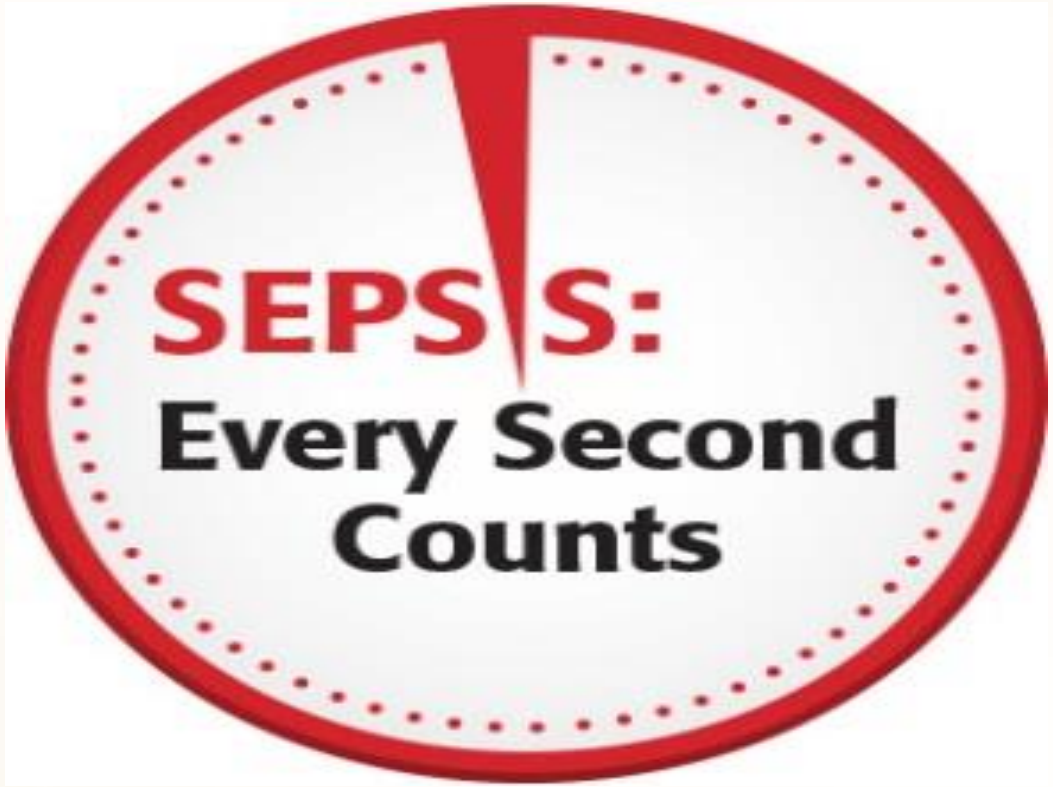
Summary

- Sepsis Bundle Compliance Jul 2019-Jan 2020 = 64%
  - Not meeting org goal of 70%
  - Fluid resuscitation, repeat lactic acids, provider reassessments and obtaining blood cultures continue to be the greatest concern
  - Sepsis Bundle Compliance Jul 2019-Jan 2020 = 76% *for cases followed by Sepsis Coordinator*

Actions

- All identified quality improvement strategies to be implemented promptly. Examples:
  - *Provider-related*: Increase provider notification of newly identified septic patients; Develop a "catch-up" sepsis order set for use for patients with delayed sepsis presentation; Sepsis Coordinator to provide *ongoing* education to providers and GME; Develop dot phrases to simplify provider documentation requirements
  - *Nurse-related*: Enhance sepsis screening PowerForm and make completion mandatory when sepsis alert fires including provider notification in real time; Integrate process to efficiently and consistently document patient height/weight for appropriate fluid administration; Develop process to accurately record lab collection times in the medical record; Develop a Handoff Checklist to ensure all required care is provided timely between shifts and departments
- Quality improvement strategies will be presented to the sepsis committee. Progress and compliance will be continuously monitored and tracked.

Questions?



Catheter Associated Urinary Tract Infection (CAUTI) Quality Focus Team Report

April 9, 2020

Kari Knudsen, Director of Post-Surgical Care (Chair)
Alisha Sandidge, Advanced Practice Nurse (Co-Chair)
Shawn Elkin, Infection Prevention Manager (IP liaison)

KAWEAH DELTA HEALTH CARE DISTRICT

Background - CAUTI

Prevalence of CAUTI at KD Patients are acquiring CAUTIs at rates that exceed national benchmarks

- CAUTI SIR from July 2019 to November 2019 was 1.76. Goal of ≤ 0.828 (CMS 50th percentile)
- Number of CAUTIs observed = 11, expected = 6
- CAUTIs result in poor outcomes for patients, a negative public perception of care through publically reported safety scores and financially impact the organization through Hospital Acquired Condition (HAC), Value Based Purchasing (VBP) programs as well as increased costs in treatments and extended length of stay (LOS)

As a result…

- A Kaizen, meaning 'Change for Good' was held January 20-22, 2020
- The CAUTI subcommittee transitioned to a QFT effective March 10, 2020

KAIZEN Current State Review

- Days between CAUTI from 4/2018 to 11/2019 is 12
- Catheter insertion is not a significant root cause of CAUTIs
- CAUTI have not increased because we have more catheters or insert more under emergent circumstances
- There is no disparity in care by gender; CAUTIs are 50/50
- CAUTI's are not isolated to one unit or unit type
- RN's are not using the standardized procedure frequently
- We do not have consistency with standard work- bundle best practices
- The weekly Hospital Acquired Infection (HAI) audit has not helped consistency in bundle practices or to reduce CAUTI
- The "Vital Few" are:
  - Removal of catheter when not indicated
  - Retention management
  - Bathing/Peri-care
  - Unnecessary culture

KAIZEN Analysis

Analysis:

Identified Root Causes

(in order from most significant to least):

1. **Communication**
2. **Leadership Standard Work**
3. **Peri-care/Bathing**
4. **Prompt Catheter Removal**
5. **Culture Ordering**
6. **Retention Management**
7. **Staff Consistency with prevention bundle**
8. **Alternatives to Catheter Insertion**

Kaizen improvement strategies focused on addressing the top 4 root causes

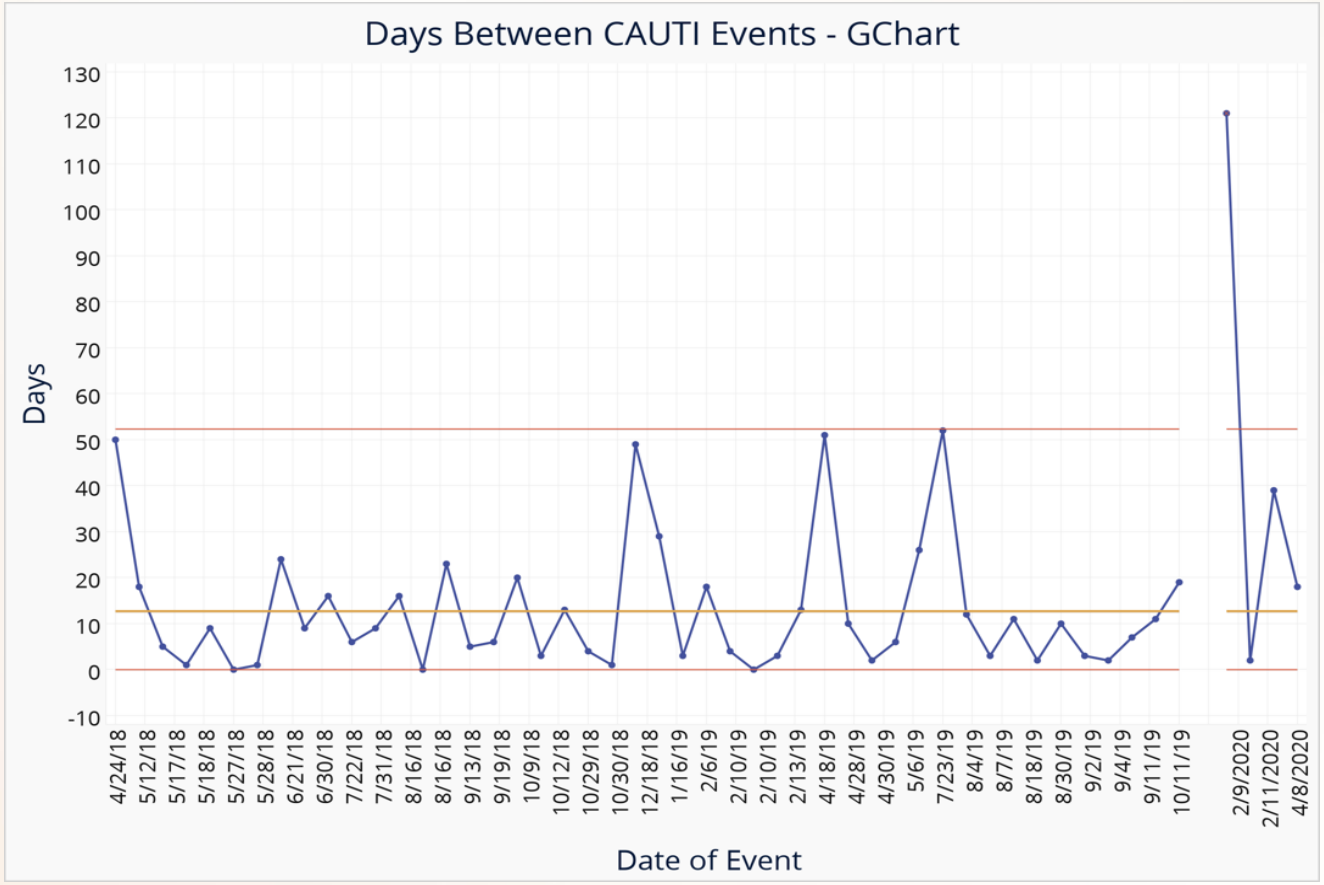
Action Plan

Action Plan:

Improvement Strategy	Who?	When?
Standardize the Unit Shift Safety Huddles to include components of prevention bundle	Maria Trujillo	3/10/20
IUC Gemba (CAUTI rounds) – Every catheter rounded on daily by NM, IP, Clin Ed/APN for best practice compliance	Kari Knudsen	3/10/20
Standard Work developed for handoff on CAUTI prevention components on transfer pts	Kristie Alvarado	3/10/20
Leadership Standard Work developed to standardize NM daily, weekly and monthly tasks to address compliance with best practices	Mary Laufer	3/10/20
ED Staff education on Catheter alternatives	Tom S.	2/14/20
Incorporate catheter necessity in critical care MD/RN rounds	Ryan T., Maria & Shawn	1/31/20
RN Education: scope of practice with IUC insertion	Kaizen	3/10/20
CNA Education: peri-care/bath documentation in real time (During IUC Gemba)	Kaizen	3/10/20

Days Between CAUTI

April 24, 2018 through April 8, 2020



Results Report March 2020

FYTD SIR (7/2019-3/2020) = 1.03 Goal = <0.828

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

Mean days b/w CAUTI 10/2019 to April 2020= 45
***astronomical point noted at 121 days between 10/11/19 and 2/9/20**

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CAUTI QFT – Plans for Improvement

- Retention Management- create standardized retention management orders for post removal of indwelling urinary catheter (IUC) that exist upon discontinuation of the IUC
- IUC insertion order-
  - Add initial straight catheterization option prior to inserting IUC
  - Add change of IUC prior to specimen collect if in greater than 72 hours
- Culture of Culturing- change orders for urine culture to reduce number of cultures collected
  - Auto discontinue urine culture order if specimen not collected within 12 hours
  - Add hard stop criteria to the urinalysis with reflex culture if indicated order. Criteria would represent signs of urinary tract infection
  - Add 'Restricted' to label of culture only order with criteria of when this order should be used

Future State Predictions

Organizational Clinical Quality Goals FY20

Scenario #1															
	Current									Future State Scenario				SIR GOAL	VBP 2021
	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		
CAUTI (SIR)	0.65	2.76	2.34	0.68	0.00	0.00	0.00	1.33	0.67	0.00	0.00	0.00	0.77	<0.828	50 perc
numerator (actual)	1	5	4	1	0	0	0	2	1	0	0	0	14	or	0.774
denominator (predicted)	1.53	1.81	1.71	1.47	1.46	1.03	1.7	1.5	1.5	1.5	1.5	1.5	18.21	14	

QUESTIONS?

Quality Council Update: Resource Effectiveness Committee (REC)

May 2020

KAWEAH DELTA HEALTH CARE DISTRICT

Resource Effectiveness Committee Purpose 2019

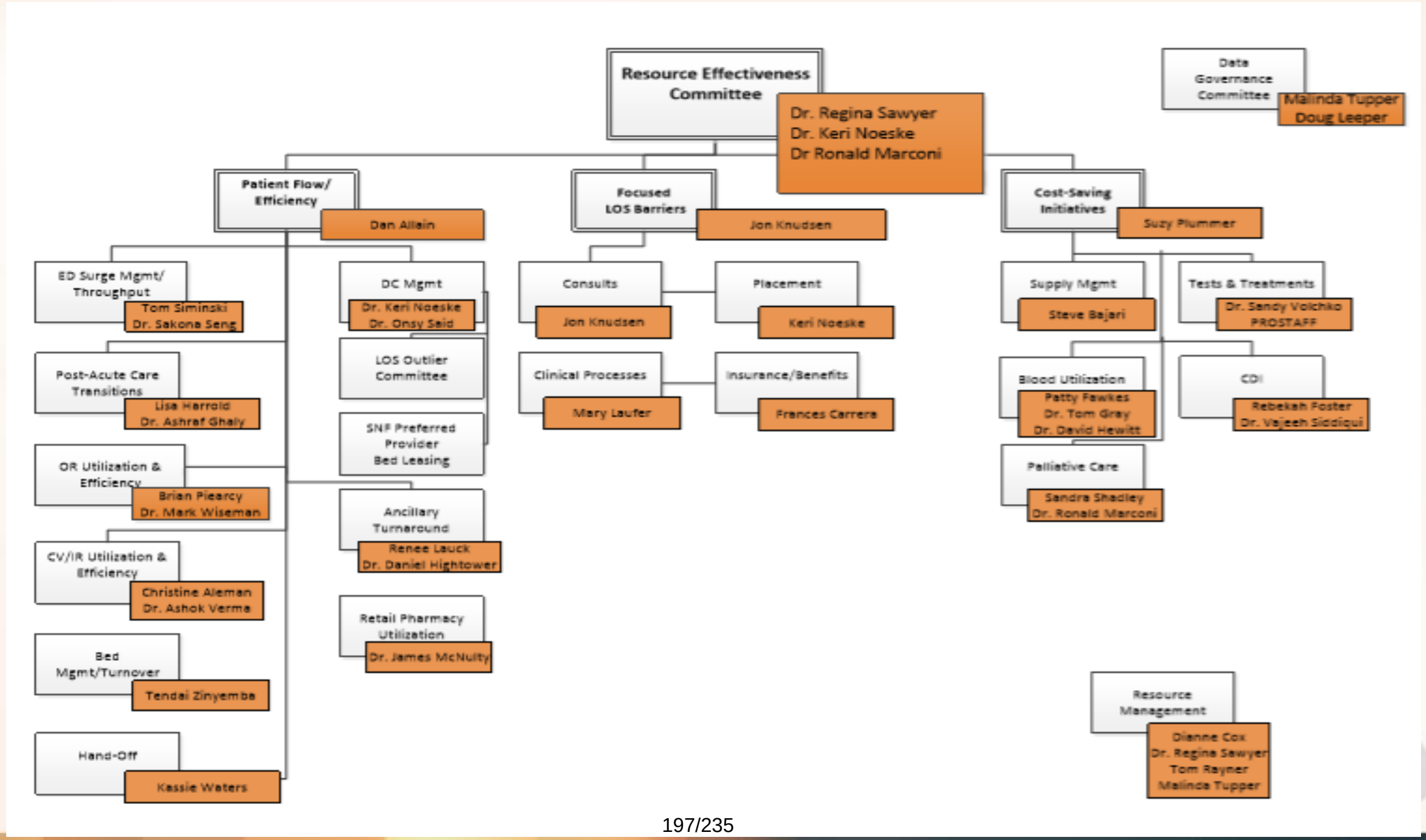
- Ensure implementation and provide oversight and support of performance improvement goals impacting patient flow, population management, and cost savings initiatives throughout the Kaweah Delta continuum.

- Assist in providing necessary resources and removing barriers to REC teams to ensure success of the team's goals.

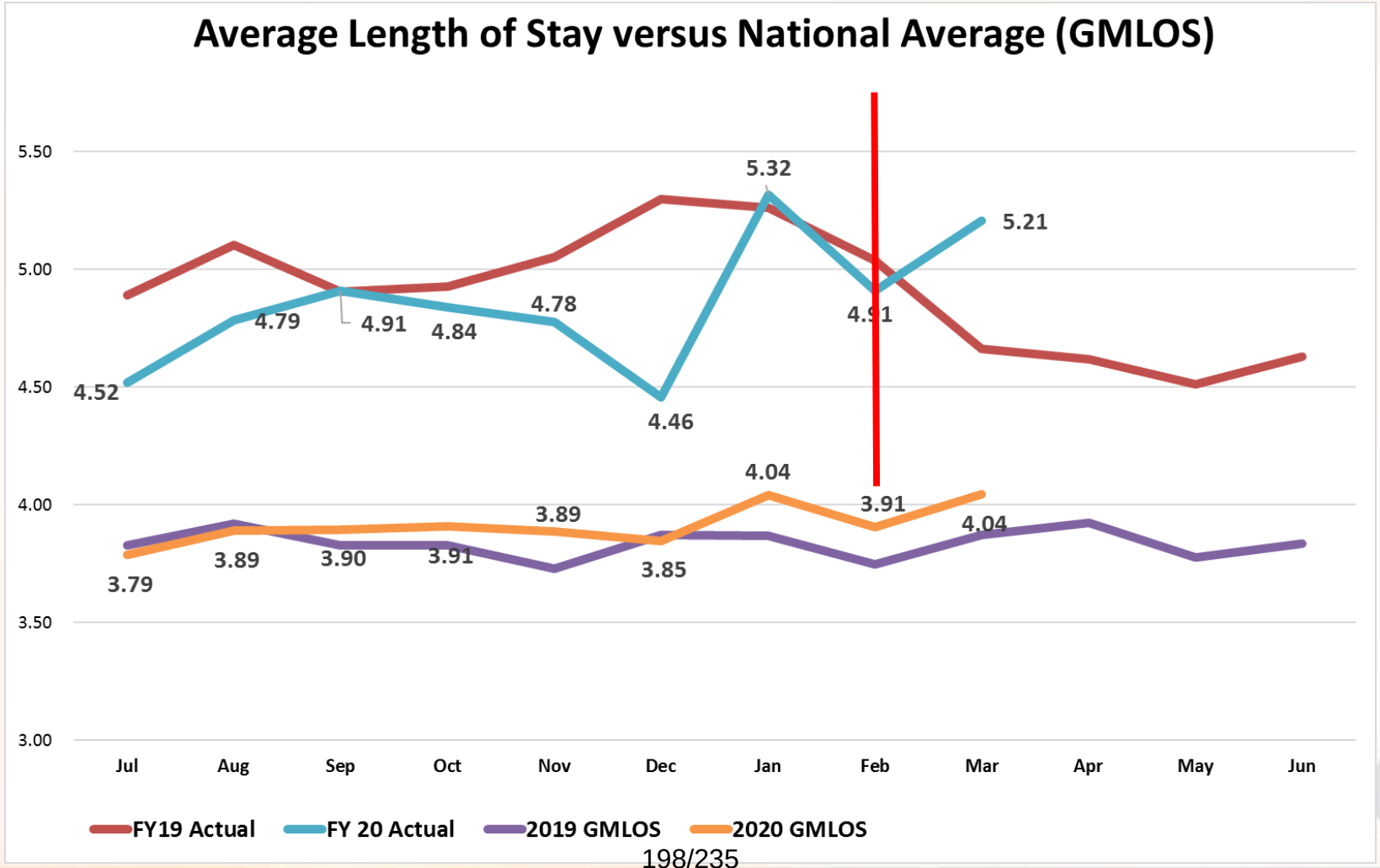
- Ensure REC and subcommittees are aligned with the strategic plan goals of the organization.

Resource Effectiveness Committee Purpose 2020

- Implement performance improvement strategies to impact patient throughput, length of stay, and cost savings initiatives throughout the Kaweah Delta continuum.
- Identify barriers to improvement strategies, implement action plans related to the barriers with engagement from both Kaweah Delta staff and medical staff.
- Provide resources and remove barriers to REC teams to facilitate success of the identified goals and improvement strategies.
- Ensure REC and subcommittees are aligned with the strategic plan goals of the organization.


Resource Effectiveness Committee
Dr. Regina Sawyer
Dr. Keri Noeske
Dr Ronald Marconi
Data Governance Committee
Malinda Tupper
Doug Leeper
Patient Flow/ Efficiency
Dan Allain
Focused LOS Barriers
Jon Knudsen
Cost-Saving Initiatives
Suzy Plummer
ED Surge Mgmt/ Throughput
Tom Siminski
Dr. Sakona Seng
DC Mgmt
Dr. Keri Noeske
Dr. Onsy Said
LOS Outlier Committee
SNF Preferred Provider Bed Leasing
Ancillary Turnaround
Renee Lauck
Dr. Daniel Hightower
Retail Pharmacy Utilization
Dr. James McNulty
Post-Acute Care Transitions
Lisa Harrold
Dr. Ashraf Ghaly
OR Utilization & Efficiency
Brian Piearcy
Dr. Mark Wiseman
CV/IR Utilization & Efficiency
Christine Aleman
Dr. Ashok Verma
Bed Mgmt/Turnover
Tendai Zinyemba
Hand-Off
Kassie Waters
Consults
Jon Knudsen
Placement
Keri Noeske
Clinical Processes
Mary Laufer
Insurance/Benefits
Frances Carrera
Supply Mgmt
Steve Bajari
Tests & Treatments
Dr. Sandy Volchko
PROSTAFF
Blood Utilization
Patty Fawkes
Dr. Tom Gray
Dr. David Hewitt
CDI
Rebekah Foster
Dr. Vajeeh Siddiqui
Palliative Care
Sandra Shadley
Dr. Ronald Marconi
Resource Management
Dianne Cox
Dr. Regina Sawyer
Tom Rayner
Malinda Tupper

Length of Stay



Service Changes Made

- **Interventional Radiology**
  - Available for emergent cases on weekends
  - Non-emergent cases hold until Monday/Tuesday (opportunity)

- **CV/IR**
  - Cath Lab Block Time changes
  - Only in house cases in the evenings (1730-1930)
  - More availability for multiple cases at one time
  - Pulling patients from units using rounding notes real time
  - Same day discharges for PCI patients

- **Discharge Management**
  - Possible discharges identified and communicated at 1600 for earlier preparation
  - Case managers, charge nurses, hospitalists involved in early identification
  - Morning discharges, goal for each hospitalist (VHMG & FHCN) to discharge 1-2 pts by 11am
  - Escalating challenges to leadership for immediate involvement
  - Collecting discharge and barriers data daily
  - Manager presence in daily rounds to facilitate movement of patients

Service Changes Made

- **Post Acute Care**
  - Two intake case management liaisons seeing patients at the hospital (faster screening)
  - Improved intake process, elimination of steps that created more time to decision for liaisons and providers
  - Improving availability of TCS for weekend admissions, intake liaisons working new admissions to TCS

- **Hospice Services – Improving capacity**
  - Opening new cases and seeing patients on weekends.

- **PICC line insertion**
  - PICC nurses now available Saturdays

- **Advanced Wound Care Planning**
  - Wound nurses now available Saturdays

Current Focus

- Throughput Goals
  - Revisit barriers in throughput
  - Simplify goals – easily accessible information
- Address LOS barriers
  - Consults
  - Clinical Practices
  - Placement
  - Financial/Insurance
- Cost Savings – Identify cost savings projects, develop strategies to improve.
  - Supply Chain, Resources, Service Lines

2020 Opportunities

- Evaluate an increase in availability of services (6-7 days/week)
- Remove discharge placement barriers (Committee Focus)
- Engage consultants earlier (Committee Focus)
- Create organizational plan for ED surge response (Underway)
- Train and orient new leaders to the initiative (Complete)
- Provide individual feedback to physicians on discharge times and LOS
- Create physician support for length of stay and medical necessity documentation issues

3.72 REC Committtee Dashboard_2020 (002)

Resource Effectiveness Committee - Patient Flow / Efficiency

Team	Sub-Committee	Metric	Note	Goal	Baseline	Oct-19	Nov-19	Dec-19
Patient Flow / Efficiency Committee	ED Surge Management /Throughput	Median LOS admit	Working with multiple departments to identify barriers to patient admissions. Using real time data to manage for daily improvement	407	514	438	416	445
		Median LOS discharge	Development of Surge Strike Team, protocol/triggers, trials	186	228	212	205	206
		Median LOS admit decision to depart	Using real time data to manage for daily improvement	197	305	215	197	219
	Post-Acute Care Transitions	Acceptance Rate for Referrals West Campus	West campus liaisons began processing referrals for all post acute beds mid December, referral logs combined into one. Comparison of 2019 average results to baseline 3rd quarter 2018, occupancy rate improved 14% for short stay to 87% and 5% for TCS to 78% (excluding months when roof project reduced census). RH dropped from 45% baseline, but has remained stable at 41%, same as fiscal year 2018 and 2019. Short stay occupancy improved 7% from fiscal year 2018. (2019 overall reduced because of roof project)	40%	27%	22%	24%	22% combined South & West Campus
		Acceptance Rate for referrals South Campus (TCS)		40%	17%	22%	32%	N/A
	OR Utilization & Efficiency	Turnover times	Looking at- wheels in to wheels out and wheels in to cut time (current cut times vary by speciality)	National Avg to in/out= 30 min	currently at 32 min	40	34	
	CV/IR Utilization & Efficiency	% of block usage	New block started 9/16. Decrease in call back hours (avg 89 hrs per pay period).	>80%	60%	80%	79%	
		Same day discharge-PC	potential discharges- goal 45%. Continue to address at daily safety huddles & at cardiac co-mgmt.	45%	<10%	10%		
	Bed Management / Turnover	Turnaround time	Department working on recruitment to fill vacant positions. Assessing discharge times and volumes to ensure optimized staffing.	60 min or <		72 min	70 min	68 min
	Hand-Off		Meeting with 2S and ED UBC's complete, ISS meeting complete and iPads with stands in process of being ordered. Plan for both UBC's to meet in Jan to discuss "agreements for process", will start pilot late Feb. Goal: improve HO process from ED to floor and increase use of HO process overall. Re-evaluate the 2 units involved in pilot to see if we can improve the overall score collected by PI in April 2018	50%	63%	pending	pending	
	DC Management	Patient Satisfaction-Discharge Process	Top Box Percentile: Hospital Staff Took Preferences into Account	46.4	36.4	45.48	pending	pending
		All Cause Readmission Rates	FY 2018 as baseline (30 day readmissions-all patients)	9.6	13.4	14	pending	pending
		Prioritization of Discharges-Peak Discharge Time for the Month	This will be evaluated with a shift in discharge times being seen from 1400-1700 to 1100-1400	1200	1500	1400	pending	pending
	LOS Outlier Committee	LOS Acute Adult Inpatier	Baseline FY 18 ALOS	4.69	5.18	4.81	4.38	pending
	SNF Preferred Provider Bed Leasing	Utilization Rate	Utilization Range (3beds/day)	50%	24%	58.10%	71.10%	94.60%
	Ancillary Turnaround	Imaging	**CT** TAT Order to completion Goal 100 Minutes	90%	80%	100%	63%	57%
			CT TAT Completion to Final **READ** Goal 180 Minutes	90%	80%	100%	100%	100%
			MRI TAT Order to completion Goal 150 Minutes	90%	80%	100%	58%	49%
			MRI TAT Completion to Final **READ** Goal Minutes	90%	80%	100%	100%	100%
			US TAT Order to completion Goal 75 Minutes	90%	80%	100%	80%	40%
			US TAT Completion to Final **READ** Goal 200 Minutes	90%	80%	100%	100%	100%
			XR TAT Order to completion Goal 30 Minutes	90%	80%	100%	60%	65%
			XR TAT Completion to Final **READ** Goal 180 Minutes	90%	80%	100%	100%	100%
		Physical Therapy	The goal is for 95% of PT evaluations to be completed within 24 hrs	95%	90.70%	87%	92%	91%
		Speech Therapy	The goal is for 95% of speech evaluations to be completed within 24 hrs.	95%	82.10%	80%	96%	100%
		Non-Invasive Cardiology	Measurement is based on order completion to final read by Cardiologist	>85%	86%	87%	81%	84%
		Lab	Clinical Lab goal is to complete 83% or higher of the "morning run" workload by 0730	>83% by 0730	83%	78%	80%	80%
	Retail Pharmacy	% of Capture Rate	Continued capture rae improvement with delivery tech and increased focus on all med-surg floors	≧80%	68%	74%	77%	79%

3.73 Committtee Dashboard_2020 LOS

Resource Effectiveness Committee - Focused DRG/Population

Team	Sub-Committee	Metric	Note	Goal	ALOS Excess Baseline (FY 2018)	ALOS Excess YTD-Sept 2019	Change
Focused DRG / Population Management	**Sepsis**	ALOS Excess	**Sepsis Coordinator**: making significant impact **Mission Care Group:** Sepsis dc to SNF program started 1/2019 Lab contract with MCG execution Pharmacy collaboration underway Annualized cost savings due to lower acuity is nearing $1 million	0.25 day reduction	1.98	1.70	**-0.28**
	Colon Surgery	ALOS Excess	- ERAS program launched with continued evaluation and optimization - Interdisciplinary team, including participation with NSQUIP, to identify and resolve barriers to timely discharge - Continue to ID patients with LOS > GMLOS for timely intervention	0.25 day reduction	2.50	2.85	**0.35**
	Hip Fracture	ALOS Excess	**Committee Initiative:** Dashboard reviewed and discussed at each meeting **Initiatives**: -Megan (orthopedic NP) developed a spreadsheet with the reason for delay (if longer than the GMLOS) that is reviewed monthly -Working directly with Brian Piearcy regarding OR delays -Working on identifying comfort care hip fractures patients early with case management and discharging to SNF setting/South campus -Work directly with palliative care team for early involvement -Dr. Tang created new pre-op guidelines, following up with hospitalist regarding the new pre-op guidelines -Meeting with Cardiologist regarding delays in reading echocardiograms -Working with the physicians to utilize the hip fracture order set 100% of the time -Educating bedside nursing to initiate orders (missed at times) *Overall hip fracture LOS dropped by .18 compared to last year (from 5.74 last year to 5.56 this year) **Challenges:** - Fluctuating with LOS with DRG 480-hip fractures with major complications (last month-LOS at 11 days, GMLOS 6.4 days) - RN not activating MD orders post-op = delaying care (i.e. PT orders, antibiotics); working with Emma in 4S to resolve - Expedite diagnosis of non-operative hip fracture (i.e. palliative care/hospice); working with Keri Noeske - OR availability delaying surgery; working with Brian	0.25 day reduction	0.86	0.97	**0.11**
	Vascular Surgery	ALOS Excess	Dashboard to be discussed at next meeting	0.25 day reduction	2.41	3.52	**1.11**
	AMI	ALOS Excess	**Committee Initiative:** LOS Dashboard presented and discussed at AMI Workgroup.	0.25 day reduction	1.22	1.18	**-0.04**
	Heart Failure	ALOS Excess	**Committee Initiative:** LOS Dashboard presented at Jan 2019 HF Committee. **Major findings:** - DRG 291 (HF & shock with MCC) accounts for 54% of cases and has the greatest LOS opportunity. Upon drilling down into 291, it becomes clear that while DRG 291 is the primary code, the secondary diagnosis that drive the admission are likely the greatest contributors to LOS. - 58% of cases with comorbid Chronic Kidney Disease - 16 out of top 20 LOS outliers had CKD **Recommendations:** - Involve pulmonology, cardiologists and hospitalists to discuss opportunities to improve LOS	0.25 day reduction	1.25	1.23	**-0.02**
	PNA	ALOS Excess	**Committee Initiative:** LOS dashboard will be integrated as standing agenda item **Potential drivers of increased LOS include:** 1. Time in Emergency department (lack of prompt diagnosis: <2 hours) 2. Delay in receiving first antibiotic dose in ED 3. Lack of Clinical Pathway to promote patient progression/optimal care **Challenges:** 1. Require NP Coordinator to manage optimal collaborative care and through-put In-Patient Initiatives: 2. Severity of illness score (curb65 or Pneumonia Severity Index) 3. Review and update Pneumonia Clinical Pathway (In progress) 4. Review Physician order set by Physician champion (update/edit/validate) 5. Transition from IV to P.O. antibiotics (antibiotic stewardship) 6. Aspiration prevention: Increase in use of post pyloric enteral tube 6. Implementation of Oral Hygiene Care Initiative	0.25 day reduction	1.04	0.94	**-0.10**
	COPD	ALOS Excess	**Committee Initiative:** LOS dashboard will be integrated as standing agenda item **Potential drivers of LOS include:** 1. Patient/Family unfamiliar with disease process and the need for self-management 2. Knowledge deficient related to local resources 3. Failure to seek medical attention in timely manner 4. NP Coordinator for full time management of COPD/Pneumonia **In-Patient Initiatives:** 1. Full time NP Coordinator to track patient progress with self-managing disease process with goal of discharge within 3 days 2. Staffed/provider education 3. Currently working in Collaboration with Pharmacy to provide medication education and optimal self-administration techniques 4. Updating Clinical Pathway 5. Medical Director/physician champion to review/edit or validate current physician order set	0.25 day reduction	0.82	1.14	**0.32**
Focused DRG / Population Management	**Stroke**	ALOS Excess	**Committee Initiative:** LOS dashboard presented at Jan 2019 Stroke Committee. **Main potential drivers of LOS to be explored include:** - Delays in PEG Tube placement (timely decision/order by physician and delay in placement after order due to IR delays) - Committee requested data comparing LOS differences between physicians and groups - Subgroup stroke patients by DC disposition (i.e. SNF, Rehab, Home, Home Health, Other) - TCS admissions on weekends - if not admitted to call Tom Rayner	0.25 day reduction	1.63	2.31	**0.68**
	Diabetes	ALOS Excess	**QFT Initiative:** LOS dashboard integrated as standing agenda item at Diabetes QFT Meeting. **Potential drivers of LOS include:** 1) Hypoglycemia and hyperglycemia rates 2) Continued optimization of Glucomander system & continued training of staff and physicians 3) Poor outpatient care: Patients being admitted severely out of control (i.e. Diabetes education program, diabetes co-management, outpatient perioperative glycemic program in collaboration with surgery dept for elective cases) **Challenges:** ~50% of admitted patients have diabetes. Inpatient Diabetes Coordinator position recruitment/budgeting on hold. **Inpatient Initiatives:** 1) Total re-design of the Glucomander training and onboarding of RNs 2) Revision and redesign of physician Computer Based Learning Module (CBLM) 3)) RN Diabetes Educator dedicated full-time to inpatient starting March to: - provide daily reviewand follow up of hypoglycemic events - staff and provider education - prioritized high risk patient education 4) Diabetes patient education materials revamped to include "survival skills" and committee resources 5) NP dedicated to full-time to inpatient setting 6) Dr. Saif, endocrinologist, taking consults **Outpatient Initiatives:** 1) Initiative launched in March in coordination with PCPs at RHC & FMC with CDMC & DM education programs. Report of patients with diabetes with A1c >8 or w/o A1c on record. Intervention stratified based on geography and A1c status (lab check, DM education, CDMC co-management, PCP management with PharmD consultation in RHCs) ; 369 patients identified (233 with A1c >8, 136 w/o A1c) 2) Diabetes support groups, EBL, Project Dulce, Lindsay Diabetes Collaborative, continue 3) Discussions around pre/post operative diabetes control for elective surgeries	0.25 day reduction	1.49	1.44	**-0.05**
	Humana	ALOS Excess	**Interventions:** - Virtual Care Team rounds Monday - Friday with weekend case management coverage - ED casemanager interventions - CDMC co-management porgrams and transitions of care **Results:** $1,028,506 in annualized cost savings across all focus DRGs	0.25 day reduction	1.14	0.82	**-0.32**
	PRIME	PRIME Metric Performance	Status reviewed monthly at PRIME Steering Committee Operational reports created to support workflows, monitoring and accountability	DY 13YE Budget = Perform on 82% of metrics	DY 13 YE 72% Performance + 10 metrics in High-Performance Pool	DY14 YE Performance 79% + 10 high-performing metrics from DY14 YE = revenue over budget	**$ 4,028,572.00**

Baseline or Below | Improved/Moving Toward Goal | Meeting Goal

3.74 Committtee Dashboard_2020 cost savings

Team	Sub-Committee	Metric	Note	Goal	Baseline	Current Month	Current Barriers
Cost-Saving Initiatives	Supply Management	Reduction in cost related to Cardiac Service Line supplies.	6/2019-All Cath Lab contract are signed and will go live July 1, 2019. We now have a 90% dual vendor relationship with Boston and Abbott for Cardiac Rhythm. We are continuing our Prime Vendor relationship with Boston for Interventional Cardiology supplies.	Reduce spend on supplies in fiscal year 2020 by $1,500,000	Current spend is $7.7 million annually	Note that current annualized estimated savings is $1,233,627.	
		Reprocessing	Decision has been made to proceed with reprocessing of certain items. Measuring savings monthly.	$500,000-FY 2020	None-New Process	$40,487 in November 2019	
	Blood Utilization	Monitor and maintain blood product waste	Working with ISS on an alert/rule that will trigger to show most recent hematocrit and hemoglobin results when blood products are ordered. Education being sent to units with fallouts each month so that staff can be re-educated to expectations regarding blood usage. Additional research and education might be needed regarding how quickly blood reaches a temperature that prevents return to the blood bank.	< or = 3 units/month	2.66 units of blood waste (January-March 2019 average)	0 (December 2019)	None
	Palliative Care	Billing of Inpatient Palliative Care Consults effective 1/1/2020	Expect increase in reimbursement related to NP PC Visits	80% of IP PC consults billed after 1/1/2020	None-not currently billing	Effective 1/1/2020	
		Timeliness of the Inpatient Palliative Care Consult		15% of IP PC consults will occur and be documented within 24 hours	Currently 11%	11%	
	Tests & Treatments	Project 1: Obtaining CT specific data for the ED and establish baseline for current CT usage and future goals.	Project 1: Establishment of CT workgroup to focus on usage in the ED to identify opportunities for improvement and establish work plans. Finance and Cerner data has been obtained related to CT usage in the ED, however information needs to be researched to determine source of variances to establish baseline and opportunity. In addition, a request has been made for ED provider level CT ordering information so that trends in ordering can be reviewed and addressed as needed. 8/19-Source of truth for actual CTs per 1,000 visits has been established. Working with physician leadership in the ED to identify body location of CT for focused study. Also working with ISS to address data challenges that don't identify the supervising physician in cases where residents are ordering CTs. Focused reviews after information is refined will be completed by Dr. Seng to determine if overutilization is an issue. Working to develop an audit of abdominal CTs for Medical Necessity. Pursuing other data sources to determine if supervising physician can be reported.	Provide data and analysis to determine if there is overutilization of CTs in the ED.	Project 1: **TBD**	Project 1: TBD	Change in project leadership-reassessing
		Project 2: Eliminating Unnecessary Urine Analysis & Culture testing. Project 3: Eliminating Unnecessary A1c testing. Project 4: Reduce VBG testing in sepsis patients. Project 5: Reduce duplicate/repetitive orders of basic and comprehensive metabolic panels. (On hold)	Project 2: Urine Culture-CAUTI and Antibiotic Stewardship teams have met and established new order sets and pathways to be implemented in April. Training materials to be standardized with Marketing and then rolled out. Project 3: A1c only needs to be tested every 60 days and does not need to be reordered with every admission. Data obtained of A1cs ordered within 60 days on the same patient and needs to be analyzed to assess issue volume. Project 4: VBG in sepsis patients are ordered twice for the initial and repeat lactic acid. This adds to duplicate testing of chemistries and denials of payments. VBG panel has been removed from the Sepsis bundle as of 6/26/19.	Project 2: Urine Analysis & Cultures-Reduce the number of testing per 1000 patient days by 30%. Project 3: Estimated 2,400 A1C ordered with in 60 days/year at a direct cost of $19,008/year ($7.92/unit). Goal to be determined. Project 4: Decrease use of VBG of sepsis patients by 50%.	Project 2: Urine Culture- FY 2018 volume was 22,7716 with annual total direct cost of $205,818 Project 3: A1c- FY 2018 volume was 29,465 with annual total direct cost of $233,281. Estimated 2,400 A1C ordered with in 60 days/year at a direct cost of $19,008/year ($7.92/unit). Project 4: Need to assess actual usage of VBG in sepsis patients for baseline (just have estimates right now).	Project 2: Medical Informatics Manager is meeting with all the physicians to make sure they have the correct order set in favorites to limit the number of unnecessary urine cultures. Data reports have been written and now performing analysis to find the highest opportunity by performing specific drill downs. Project 3: Meeting with diabetes management team. Project 4: Received VBG data. VBG duplicates testing in July was zero. This exceeds our goal of reducing duplicate lab testing by 50% in sepsis patients.	Change in project leadership-reassessing
	CDI	3M Report for HIM and CDI Mismatches	Implementation of tool in 3M to identify mismatches between CDI and Coding team	To review mismatches to identify charge opportunities	$84,556/month in gross charges identified	$343,290 for December 2020	None

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: Surgery **ProStaff Report:** December 13, 2019

Measure Objective/Goal:

1. Immediate Use Sterilization (IUSS): Goal 2.4%
2. First case delays: Goal decrease first case start delays by 20% in the first 3 months and 30% in 6 months.
3. Block Utilization: Goal increase utilization to 60% in first 3 months and 78% in 6 months.

Date range of data evaluated:

Immediate Use Sterilization (IUSS): January 2019-November 2019

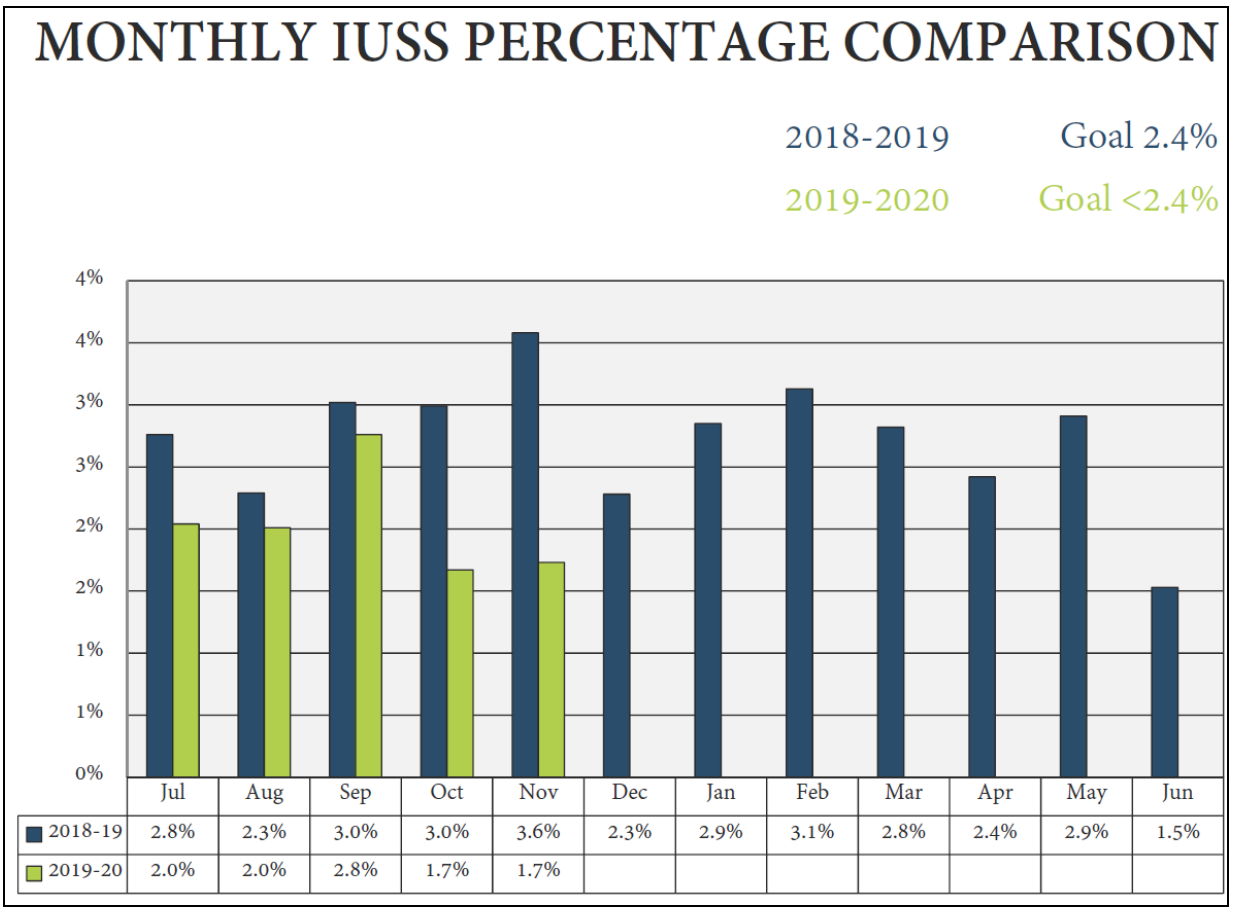
First Case Delays: September, October, November 2019

Block Utilization: September and October 2019. *(November data is still being extracted).*

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):

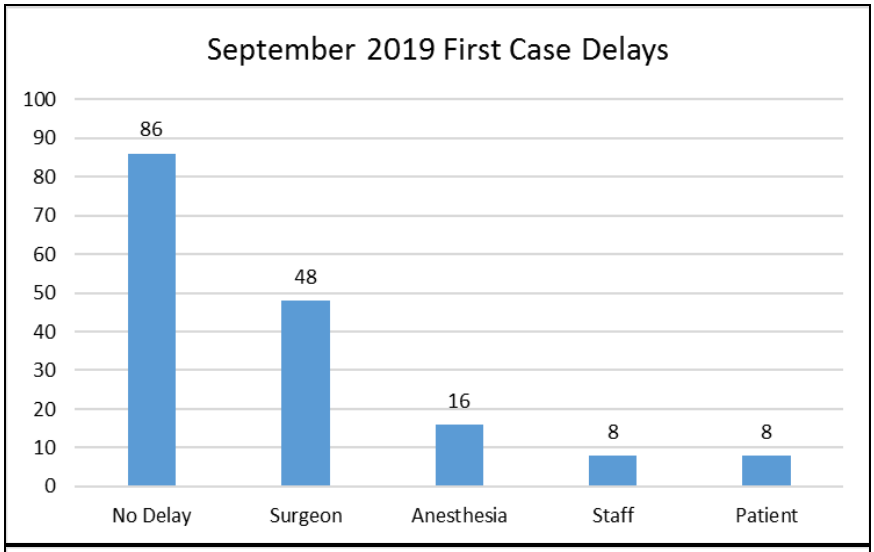
1. **Immediate Use Sterilization (IUSS):** *(IUSS is compared to the total # of cases)*

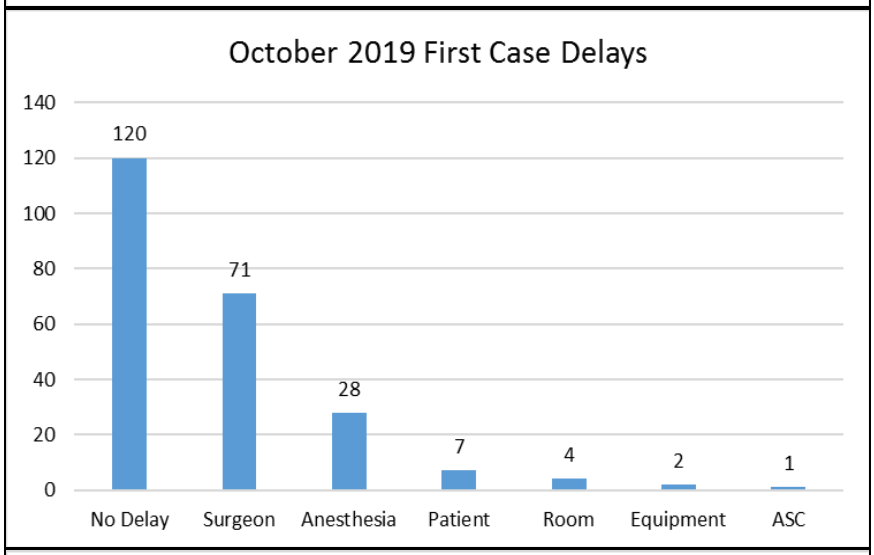


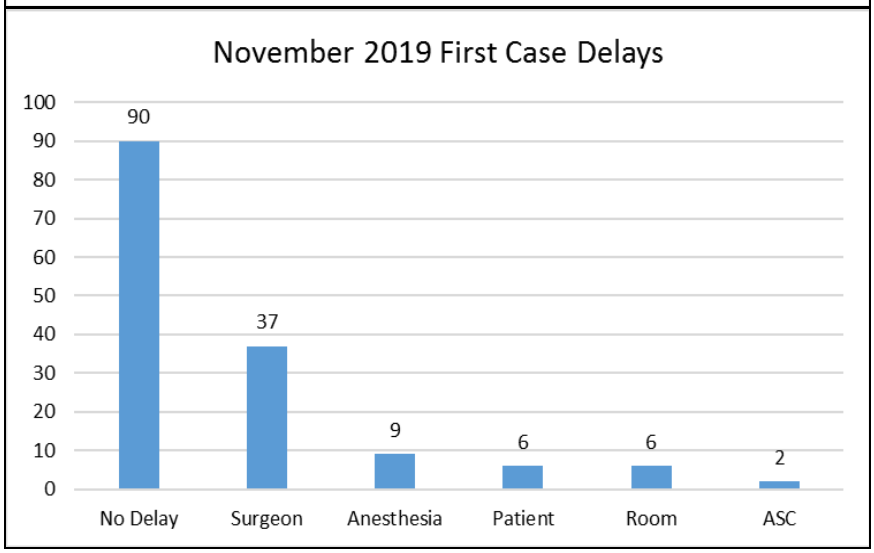
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
2018-19	2.8%	2.3%	3.0%	3.0%	3.6%	2.3%	2.9%	3.1%	2.8%	2.4%	2.9%	1.5%
2019-20	2.0%	2.0%	2.8%	1.7%	1.7%							

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

2. First Case Delays: *Reasons why cases do not start on time.*

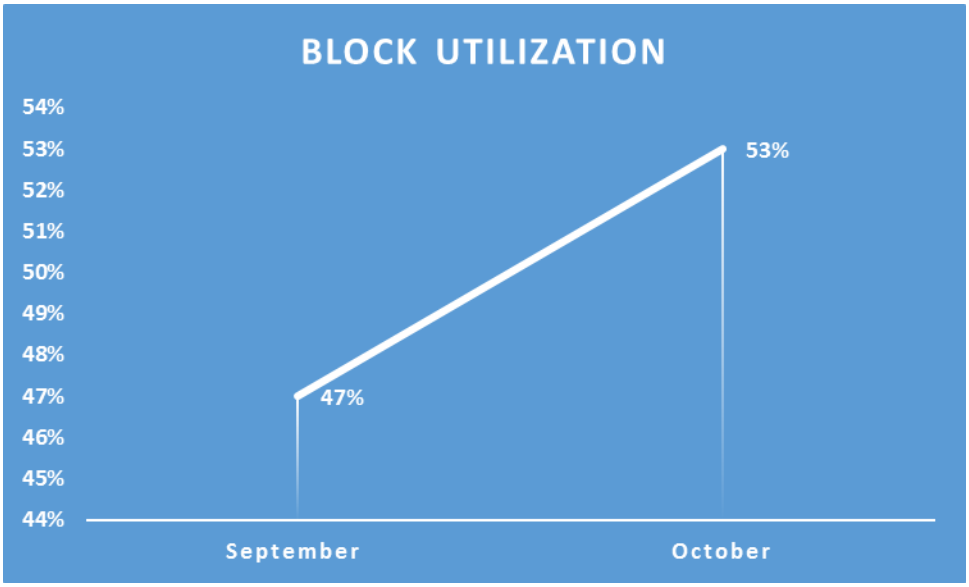






Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

3. Average % Block Utilized:



<u>If improvement opportunities identified, provide action plan and expected resolution date:</u>

1. **Immediate Use Sterilization (IUSS):**
   a. Continue to purchase instrumentation to decrease IUSS.
   b. Increase Vender Trays to decrease IUSS for the following cases.
   c. Decrease scheduling conflicts to allow sterile processing adequate time to turn over trays/instrumentation.
   d. Continue a 1430 huddle. The huddle consists of Surgery Manager, Sterile Processing Manager, Surgery Charge Nurse, Sterile processing a.m. and p.m. Team Leads, Radiology Tech lead, and 2 Surgery Schedulers.
      1. Each person comes to the meeting prepared to discuss the following day's schedule. This has eliminated miscommunication between departments, scheduling conflict, etc…
2. **First Case Delays:**
   a. Educate staff in pre-op and intra-op on proper delay codes.
   b. Delay codes will be reported at the OR Governance Committee and Department of Surgery.
   c. Graphs will be displayed on the electronic communication board in the surgeons lounge for transparency.
   d. Trends of surgeons with first case delays will be included when making decisions regarding block utilization by the O.R. Governance Committee.

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

3. Block Utilization:

a. There is a need for block time in the Operating Room and there are underutilized block minutes surgeons currently have.

b. Utilization is defined as total allotted minutes for a specific surgeon compared to the total minutes used.

c. The idea is to increase OR utilization time and give more block to current surgeons who need more time and give block to new surgeons entering the district.

d. Dr. Wiseman, Dr. Tang and I have been creating a formalized way to track utilization time.

i. Formula: Surgery minutes + Turnover minutes / Block minutes – Released block minutes = Block Utilization.

e. Two Letters have been sent to surgeons regarding their utilization data. If they are below 50% utilization, they will have 3 months starting in October to increase their volume or it will be released back to the department. October, November, and December data will be analyzed and the O.R. Governance will make decisions on where the new time will be utilized.

Next Steps/Recommendations/Outcomes:

1. Immediate Use Sterilization (IUSS):

a. Continue to meet with new surgeons to understand their need vs want. Budget accordingly to their expected volume.

b. Surgery/Sterile Processing Liaison committee makes recommendations for more instrumentation purchases.

c. Surgery and Sterile Processing have a small list in the departments on instrumentation they may need or have replaced. The Sterile Processing manager looks at the lists on a monthly basis.

Outcome: IUS at 2.4%.

2. First Case Delays:

a. Clearly define current delay codes in the EMR.

b. Educate staff on proper coding.

c. Present at the O.R. Governance Committee and Department of Surgery committee for transparency.

d. Display First case start (pt. in the room) percentages within the department.

e. Factor first case delays into decisions when allocating block time to surgeons.

Outcome: Decrease first case delays by 20% in 3 months.

3. Block Utilization:

a. Complete data extraction, present the data to the OR Governance Committee, and have a letter sent to individual surgeons who have underutilization for each month.

b. Give surgeons who have underutilized time 3 months to increase their volume.

c. After the 3 months, remove time currently allotted to surgeons who have not met criteria and give the new time to surgeons who need more block as well as to new surgeons.

Outcome: Increase utilization to 60% in 3 months.

Submitted by Name: Brian Piearcy, Director Surgical Services

Date Submitted: December 13, 2019

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

Leapfrog Hospital Safety Score

May 2020

LEAP FROG SCORECARD May 2020

Outcome Measure (lower is better)	CURRENT Kaweah Apr/May 2020 Results	Apr/May 2020 Results Time Period Covered	Data Source	Worst Performing Hospital	Avg. Performing Hospital Spring 2020	Best Performing Hospital
Letter Grade	C					
Overall Score	2.7773					
Foreign Object Retained	0.135	07/01/2016 - 06/30/2018	CMS	0.36	0.02	0
Air Embolism	0	07/01/2016 - 06/30/2018	CMS	0.799	0.00	0
Falls and Trauma	0.472	07/01/2016 - 06/30/2018	CMS	1.625	0.44	0
CLABSI	1.927	04/1/2018 - 03/31/2019	CMS	2.952	0.70	0
CAUTI	1.756	04/1/2018 - 03/31/2019	CMS	2.849	0.77	0
SSI: Colon	0.982	04/1/2018 - 03/31/2019	CMS	2.922	0.81	0
MRSA	1.744	04/1/2018 - 03/31/2019	CMS	3.265	0.82	0
C. Diff.	0.343	04/1/2018 - 03/31/2019	CMS	1.953	0.63	0
PSI 3: Pressure Ulcer Rate	0.65	07/01/2016 - 06/30/2018	CMS	2.35	0.49	0.03
PSI 4: Death Rate, Surg. Inpatients w/ Serious Treatable Complications	212.08	07/01/2016 - 06/30/2018	CMS	215.45	162.89	91.71
PSI 6: Iatrogenic Pneumothorax Rate	0.26	07/01/2016 - 06/30/2018	CMS	0.47	0.27	0.12
PSI 11: Postoperative Respiratory Failure Rate	6.62	07/01/2016 - 06/30/2018	CMS	16.32	7.67	1.83
PSI 12: Perioperative PE/DVT Rate	3.8	07/01/2016 - 06/30/2018	CMS	7.24	3.83	1.54
PSI 14: Postoperative Wound Dehiscence Rate	0.82	07/01/2016 - 06/30/2018	CMS	1.51	0.95	0.51
PSI 15: Abdominopelvic Accidental Puncture/Laceration Rate	1.31	07/01/2016 - 06/30/2018	CMS	2.4	1.29	0.36

Process Measure (higher is better)	CURRENT Kaweah Apr/May 2020 Results	Apr/May 2020 Results Time Period Covered	Data Source	Worst Performing Hospital	Avg. Performing Hospital Spring 2020	Best Performing Hospital
Computerized Physician Order Entry (CPOE)	100	2019	2019 Leapfrog Hospital Survey	5	79.13	100
Bar Code Medication Administration (BCMA)	100	2019	2019 Leapfrog Hospital Survey	5	82.30	100
ICU Physician Staffing (IPS)	100	2019	2019 Leapfrog Hospital Survey	5	57.47	100
SP 1: Culture of Safety Leadership, Structures & Systems	120	2019	2019 Leapfrog Hospital Survey	0	117.44	120
SP 2: Culture Measurement, Feedback, & Intervention	120	2019	2019 Leapfrog Hospital Survey	0	117.14	120
SP 4: Identification & Mitigation of Risks & Hazards	100	2019	2019 Leapfrog Hospital Survey	0	97.86	100
SP 9: Nursing Workforce	100	2019	2019 Leapfrog Hospital Survey	0	98.21	100
SP 19: Hand Hygiene	60	2019	2019 Leapfrog Hospital Survey	0	57.59	60
H-COMP-1: Nurse Communication	90	04/01/2018-03/31/2019	CMS	76	91.04	97
H-COMP-2: Doctor Communication	88	04/01/2018-03/31/2020	CMS	79	90.93	96
H-COMP-3: Staff Responsiveness	84	04/01/2018-03/31/2021	CMS	64	84.39	95
H-COMP-5: Communication about Medicines	77	04/01/2018-03/31/2022	CMS	61	77.87	90
H-COMP-6: Discharge Information	85	04/01/2018-03/31/2023	CMS	70	86.53	94

Letter Grade Key: A = >3.133 B= >2.964 C= >2.476 D= >2.047

Regional Comparison

Hospitals within 100 Miles	Spring 2020 Grade
Community Regional - Fresno	D
Adventist Medical Center - Hanford	A
Adventist Medical Center - Selma	C
Sierra View Medical Center	C
Saint Agnes Medical Center	C
Kaiser Foundaton Hospital Fresno	A
Madera Community Hospital	C
Bakersfield Heart Hospital	B
Bakersfield Memorial Hospital	A
Adventist Health Bakersfield	A
Mercy Hospital Downtown Bakersfield	C
Kern Medical Center Bakersfield	C
Mercy Hospital Southwest Bakersfield	C
Mercy Medical Center - Merced	C
Twin Cities Community Hospital	B
Other Facilities	
Cleveland Clinic -Euclid Hospital	A
John Hopkins Hospital	A
UCLA - LA	A
Harbor UCLA Medical Center	C
Mayo Clinic	A

Top 5 Action Items

	Improvement Initiative	Committee / Task force	Timeline	Leader Assigned
1	HACs/PSIs - Proactive identification of PSI before final coding by CDI; weekly review by stakeholders and follow up with HIM, peer review or clinical process changes	PSI Cmte and Q&P/S	April 2020	Rebehak Foster, Anu Banerjee, Sandy Volchko & Evelyn McEntire
2	CAUTI - Kaizen Improvement Strategies including enhance shift huddles and daily catheter rounding and monitoring process measures for compliance with best practices	CAUTI Cmte	March 2020	Kari Knudsen
3	CLABSI - Kaizen improvement strategies including daily central line rounding and data collection/analysis of process measures for compliance with best practices	CAUTI & CLABSI Cmte	April 2020	Amy Baker
4	Leapfrog/National Quality Forum Safe Practices - workgroups to ensure implementation of all safe practices including bar code administration, safety & culture, and nurse staffing/adverse events	Quality & Patient Safety	Aug 2020	Sandy Volchko, Lacey Jensen, Mary Laufer, Jon Knudsen
5	Patient Experience - Operation Always with leader rounding and data collection via "MyRounding" app. Follow up with leadership on performance.	Kaweah Care Cmte	March 2020	Ed Largoza

LEAP FROG SCORECARD PREDICTIONS - MAY 2020 SCORING ALGORITHM APPLIED

Outcome Measures Lower is Better	Data Source	Avg. Performing Hospital Spring 2020	ECE Submitted Re: COVID-19		ECE NOT Submitted – Re COVID-19		ECE Submitted – Re COVID-19		ECE NOT Submitted – Re: COVID-19		Regional Facility #1 Score Fall 2019 Results	Regional Facility #2 Score Fall 2019 Results	Worst Performing Hospital	Best Performing Hospital
			Sept/Oct 2020 Results Time Period Covered	Predicted Score Sept/Oct 2020 (using Spring 2020 National Means)	Sept/Oct 2020 Results Time Period Covered	Predicted Score Sept/Oct 2020 using Spring 2020 National Means &NHSN Rights)	Apr/May 2021 Results Time Period Covered	Predicted Score Apr/May 2021 (Using Spring 2020 National Means)	Apr/May 2021 Results Time Period Covered (includes NHSN Rights)	Predicted Score Apr/May 2021 (Using Spring 2020 National Means & NHSN Rights)				
Letter Grade				**C**		**B**		**B**		**A**	A	A		
Overall Score				2.9415		3.06		3.0128		3.1409				
Foreign Object Retained	CMS	0.02	07/01/17-06/30/19	0.079	07/01/17-06/30/19	0.079	07/01/17-06/30/19	0.079	07/01/17-06/30/19	0.079	0	0	0.36	0
Air Embolism	CMS	0.00	07/01/17-06/30/19	0	07/01/17-06/30/19	0	07/01/17-06/30/19	0	07/01/17-06/30/19	0	0	0	0.799	0
Falls and Trauma	CMS	0.44	07/01/17-06/30/19	0.396	07/01/17-06/30/19	0.396	07/01/17-06/30/19	0.396	07/01/17-06/30/19	0.396	0	0.29	1.625	0
CLABSI	CMS	0.70	10/01/2018-09/30/2019	2.651	01/01/2019-12/31/2019	1.23	04/01/2019-9/30/2019	0.8	07/01/2019-6/30/2020	0.94	0.497	0	2.952	0
CAUTI	CMS	0.77	10/01/2018-09/30/2019	0.821	01/01/2019-12/31/2019	1.36	04/01/2019-9/30/2019	1.343	07/01/2019-6/30/2020	0.969	1.073	0.482	2.849	0
SSI: Colon	CMS	0.81	10/01/2018-09/30/2019	0.498	01/01/2019-12/31/2019	0.376	04/01/2019-9/30/2019	0.4118	07/01/2019-6/30/2020	0	0.888	0.736	2.922	0
MRSA	CMS	0.82	10/01/2018-09/30/2019	1.946	01/01/2019-12/31/2019	1.303	04/01/2019-9/30/2019	1.304	07/01/2019-6/30/2020	1.33	0	0	3.265	0
C. Diff.	CMS	0.63	10/01/2018-09/30/2019	0.342	01/01/2019-12/31/2019	0.285	04/01/2019-9/30/2019	0.285	07/01/2019-6/30/2020	0.284	0.685	0.61	1.953	0
PSI 3: Pressure Ulcer Rate	CMS	0.49	07/01/2017-06/30/2019	0.793	07/01/2017-06/30/2019	0.793	07/01/2017-06/30/2019	0.793	07/01/2017-06/30/2019	0.793	0.33	0.28	2.35	0.03
PSI 4: Death Rate, Surg. Inpatients w/ Serious Treatable Complications	CMS	162.89	07/01/2017-06/30/2019	257.813	07/01/2017-06/30/2019	257.813	07/01/2017-06/30/2019	257.813	07/01/2017-06/30/2019	257.813	N/A	176.8	215.45	91.71
PSI 6: Iatrogenic Pneumothorax Rate	CMS	0.27	07/01/2017-06/30/2019	0.35	07/01/2017-06/30/2019	0.35	07/01/2017-06/30/2019	0.35	07/01/2017-06/30/2019	0.35	0.26	0.26	0.47	0.12
PSI 11: Postoperative Respiratory Failure Rate	CMS	7.67	07/01/2017-06/30/2019	2.088	07/01/2017-06/30/2019	2.088	07/01/2017-06/30/2019	2.088	07/01/2017-06/30/2019	2.088	8.83	5.06	16.32	1.83
PSI 12: Perioperative PE/DVT Rate	CMS	3.83	07/01/2017-06/30/2019	2.137	07/01/2017-06/30/2019	2.137	07/01/2017-06/30/2019	2.137	07/01/2017-06/30/2019	2.137	3.57	2.23	7.24	1.54
PSI 14: Postoperative Wound Dehiscence Rate	CMS	0.95	07/01/2017-06/30/2019	0	07/01/2017-06/30/2019	0	07/01/2017-06/30/2019	0	07/01/2017-06/30/2019	0	0.94	1.16	1.51	0.51
PSI 15: Abdominopelvic Accidental Puncture/Laceration Rate	CMS	1.29	07/01/2017-06/30/2019	1.31	07/01/2017-06/30/2019	1.31	07/01/2017-06/30/2019	1.31	07/01/2017-06/30/2019	1.31	1.25	0.94	2.4	0.36

LEAP FROG SCORECARD PREDICTIONS - MAY 2020 SCORING ALGORITHM APPLIED

Process Measures Higher is Better	Data Source	Avg. Performing Hospital Spring 2020	Sept/Oct 2020 Results Time Period Covered	Predicted Score Sept/Oct 2020 (using Spring 2020 National Means)	Sept/Oct 2020 Results Time Period Covered	Predicted Score Sept/Oct 2020 using Spring 2020 National Means &NHSN Rights)	Apr/May 2021 Results Time Period Covered	Predicted Score Apr/May 2021 (Using Spring 2020 National Means)	Apr/May 2021 Results Time Period Covered	Predicted Score Apr/May 2021 (Using Spring 2020 National Means)	First Compared Kaiser Fresno Score Fall 2019 Results	Second Compared Adventist Hanford Score Fall 2019 Results	Worst Performing Hospital	Best Performing Hospital
Computerized Physician Order Entry (CPOE)	2019 Leapfrog Hospital Survey	79.13	2020	100 REMOVED Evaluation section	2020	100 REMOVED Evaluation section	2020 REMOVED Evaluation section	100	2020	100	100	100	5	100
Bar Code Medication Administration (BCMA)	2019 Leapfrog Hospital Survey	82.30	2020	100	2020	100	2020	100	2020	100	100	100	5	100
ICU Physician Staffing (IPS)	2019 Leapfrog Hospital Survey	57.47	2020	100	2020	100	2020	100	2020	100	100	100	5	100
SP 1: Culture of Safety Leadership, Structures & Systems	2019 Leapfrog Hospital Survey	117.44	2020	120	2020	120	2020 Combined SP 1,2 4 & 9	120	2020	120	110.77	120	0	120
SP 2: Culture Measurement, Feedback, & Intervention	2019 Leapfrog Hospital Survey	117.14	2020	120	2020	120	2021 Combined SP 1,2 4 & 9	120	2020	120	120	120	0	120
SP 4: Identification & Mitigation of Risks & Hazards	2019 Leapfrog Hospital Survey	97.86	2020	100	2020	100	2022 Combined SP 1,2 4 & 9	100	2020	100	100	100	0	100
SP 9: Nursing Workforce	2019 Leapfrog Hospital Survey	98.21	2020	100	2020	100	2020 NEW Mat Section	100	2020	100	94.12	100	0	100
SP 19: Hand Hygiene	2019 Leapfrog Hospital Survey	57.59	2020	60	2020	60	2020	60	2020	60	42	60	0	60
H-COMP-1: Nurse Communication	CMS	91.04	10/01/2018-09/30/2019	90	10/01/2018-09/30/2019	90	04/01/2019-03/31/2020	90	04/01/2019-03/31/2020	90	91	90	76	97
H-COMP-2: Doctor Communication	CMS	90.93	10/01/2018-09/30/2019	88	10/01/2018-09/30/2019	88	04/01/2019-03/31/2020	88	04/01/2019-03/31/2020	88	93	89	79	96
H-COMP-3: Staff Responsiveness	CMS	84.39	10/01/2018-09/30/2019	84	10/01/2018-09/30/2019	84	04/01/2019-03/31/2020	84	04/01/2019-03/31/2020	84	83	83	64	95
H-COMP-5: Communication about Medicines	CMS	77.87	10/01/2018-09/30/2019	77	10/01/2018-09/30/2019	77	04/01/2019-03/31/2020	77	04/01/2019-03/31/2020	77	76	79	61	90
H-COMP-6: Discharge Information	CMS	86.53	10/01/2018-09/30/2019	85	10/01/2018-09/30/2019	85	04/01/2019-03/31/2020	85	04/01/2019-03/31/2020	85	86	87	70	94

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

May 6, 2020

Amy Baker, Director of Renal Services (Chair)
Emma Camarena, Advanced Practice Nurse (Co-Chair)
Shawn Elkin, Infection Prevention Manager (IP liaison)

KAWEAH DELTA HEALTH CARE DISTRICT

Background - CLABSI

Prevalence of CLABSI's at KD Patients are acquiring CLABSI's at rates that exceed national benchmarks

•CLABSI SIR from July 2019 to December 2019 was 1.47. Goal of ≤ 0.784 (CMS 50th percentile)

•Number of CLABSI's from January to December 2019 were 17

•Number of CLABSI's from July 2019 to April 2020 observed= 11

•CLABSI's result in poor outcomes for patients, a negative public perception of care through publically reported safety scores and financially impact the organization through Hospital Acquired Condition (HAC), Value Based Purchasing (VBP) programs as well as increased costs in treatments and extended length of stay (LOS)

As a result…

•A Kaizen, meaning 'Change for Good' was held February 3, 4, 6,7, and 11, 2020

•The CLABSI subcommittee transitioned to a QFT effective March 10, 2020

•Biovigil Pilot for 5 months on 4 North and ICU began December 16,2019

•IV Safety Team started in October 2019

KAIZEN Current State Review

- Days between CLABSI's from 4/2018 to 1/2020 is 17
- CLABSIs are associated with both insertion practices and maintenance practices
- CLABSI's have not increased because we have more central lines or insert them under emergent circumstances
- We do not have consistency with best practices in CLABSI prevention
- No standard MD training on CLABSI prevention training
- CLABSI's are not isolated to one unit or unit type
- The weekly Hospital Acquired Infection (HAI) audit has not helped consistency in bundle practices or to reduce CLABSI's
- The "Vital Few" are:
  - Central Line Site (Location: Internal Jugular and Femoral)
  - Bathing not received
  - Line necessity was not addressed
  - Hemodialysis
  - Expired peripheral IV

KAIZEN Analysis

Analysis:

Identified Root Causes (in order from most significant to least):

1. Line Necessity
2. Bundle Practice
3. Education
4. Cultures
5. Central Line Insertion
6. Bathing
7. Leadership Standard Work
8. Documentation
9. Human Factors

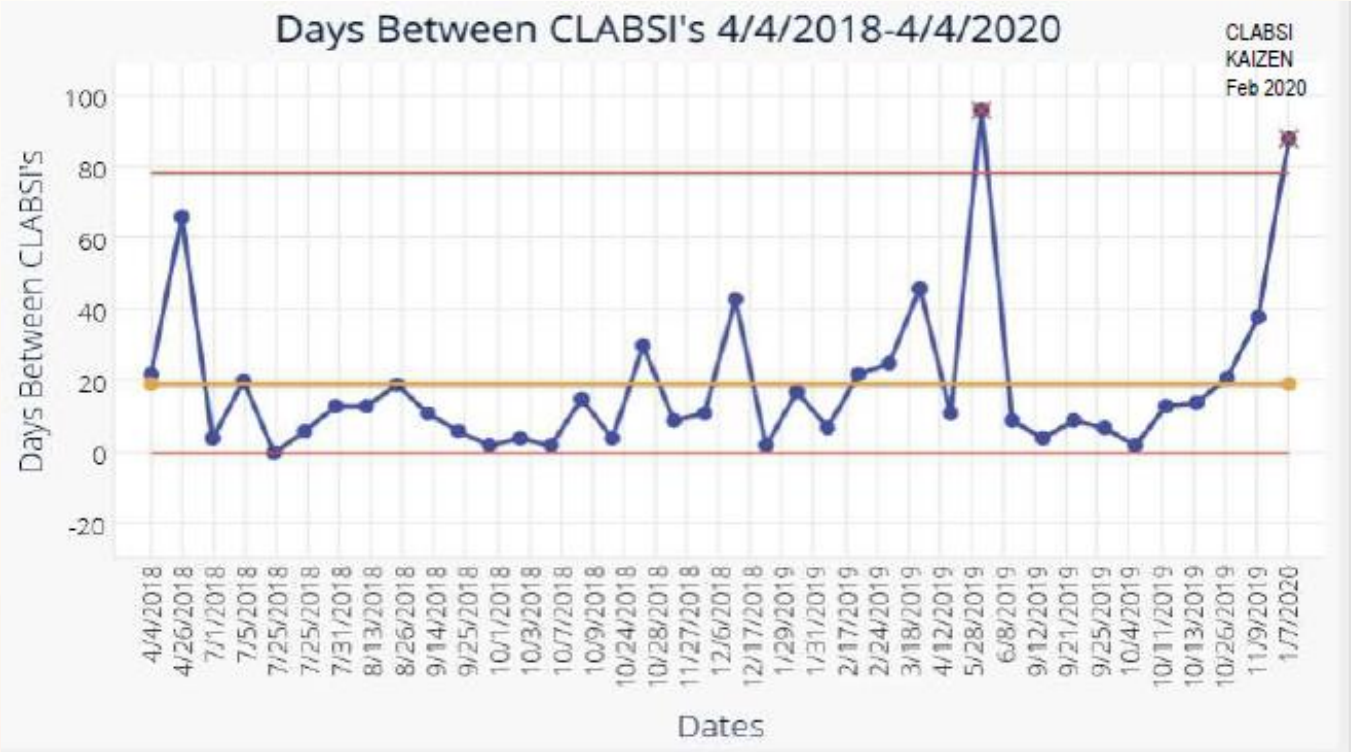
Kaizen improvement strategies focused on addressing the top 4 root causes

Action Plan

Improvement Strategy	Who?	When?
Line Necessity –Implementation of interventions delayed due to COVID-19 pandemic	Emma C. Joetta D.	March 31, 2020 (TPN orders 7/2020)
Bundle Practice-Implementation of interventions delayed due to COVID-19 pandemic	Amy Baker	March 31, 2020
Education-Implementation of interventions delayed due to COVID-19 pandemic priorities	Eileen P. Enri S.	March 31, 2020 (Comp Fair 6/20)
Culture (the culture of culturing)-Implementation of interventions delayed due to COVID-19 pandemic priorities	Dr. Gray & Shawn Elkin	March 6, 2020
Leadership Standard Work-Implementation of interventions delayed due to COVID-19 pandemic	Mary Laufer	March 31, 2020
Improve location and par of central line supplies • Include in manager communication plan; • Include in RN & CNA education that they need to follow up with CN or manager that PAR level needs to be adjusted; also talk to manager & central distribution	Kaizen Team Education Team	
Email Take-Always after CLABSI committee review of events	Amy Baker	
Insertion: New site = New kit to be included with MD/resident education with Dr. LeDonne—Conference cancelled due to COVID-19 pandemic.	Dr. Gray Shawn Elkin	

*COVID-19 Pandemic impacted resources 3 weeks after CLABSI Kaizen

Days Between CLABSI



Results Report

BASELINE DATA
July-Dec 2019
SIR = 1.47
Goal = ≤0.784

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

Update: April 2020
July 2019-April 2020
SIR = 0.89
Mean days between CLABSI 4/2018 to 4/2020 =19.23

Mean days between CLABSI 1/2020 to 4/2020 = 87

*Astronomical point noted at 87 days in April 2020

CLABSI QFT – Plans for Improvement

- Shift culture and attitude about CLABSI's to a never event
- Continue to review Kaizen initiatives and remaining Kaizen improvement strategies
  - Monitor success of Gemba walks to ensure bundle compliance and accurate central line documentation (unit-level dashboards)
  - Finish work postponed by COVID 19
- Focus on accurate Central Line Day Counts to ensure our count is correct
- Collaborate with ISS to make changes to electronic medical record to increase compliance with documentation of central lines
- Send educational take aways after each CLABSI QFT to increase RN awareness of CLABSI problem and solutions
- Bedside RN's will present CLABSI cases to QFT in timely manner to hold bedside staff accountable for infection

Future State Predictions

Organizational Clinical Quality Goals FY20

	Current									Future State Scenario				FYTD	Baseline	SIR GOAL
	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	Total		
CLABSI (SIR)	0.00	0.00	2.70	3.67	1.11	0.00	0.98	0.00	0.00	0.79	0.00	0.00	**0.73**	**0.90**	**1.253 ↓28%**	**<0.784 or 12**
numerator (actual)	0	0	3	4	2	0	1	0	0	1	0	0	11	10		
denominator (predicted)	1.19	1.23	1.11	1.09	1.8	1.13	1.02	1.27	1.22	1.26	1.26	1.26	15.12	11.06		

QUESTIONS?

6.a Clinical Goals APRIL 2020

CLINICAL QUALITY GOALS

SEPSIS

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.

GOAL >70%

FEBRUARY 2020
75%

JULY 2019-FEB 2020
HIGHER IS BETTER

65%

MRSA

Methicillin-resistant Staphylococcus aureus (MRSA). Standardized Infection Ratio (SIR) is the the number of patients who acquired MRSA while in the hospital divided by the number of patients who were expected.

GOAL ≤.815

AS OF JULY 2019
INFECTIONS: 8
PREDICTED: ≤6 EVENTS

MARCH 2020
NUMBER OF PATIENTS WHO ACQUIRED MRSA
1

JULY 2019-MAR 2020
LOWER IS BETTER

1.33

CAUTI

A catheter-associated urinary tract infection (CAUTI) . Standardized Infection Ratio is the number of patients who acquired a CAUTI while in the hospital divided by the number of patients who were expected.

GOAL ≤.828

AS OF JULY 2019
INFECTIONS: 14
PREDICTED: ≤13 EVENTS

MARCH 2020
NUMBER OF PATIENTS WHO ACQUIRED CAUTI
1

JULY 2019-MAR 2020
LOWER IS BETTER

1.03

CLABSI

A central line-associated bloodstream infection (CLABSI). Standardized Infection Ratio (SIR) is the number of patients who acquired a CLABSI while in the hospital divided by the number of patients who were expected.

GOAL ≤.784

AS OF JULY 2019
INFECTIONS: 11
PREDICTED: ≤10 EVENTS

MARCH 2020
NUMBER OF PATIENTS WHO ACQUIRED CLABSI
1

JULY 2019-MAR 2020
LOWER IS BETTER

0.90

OPPORTUNITY LOS

Length of Stay (LOS). The difference between the expected LOS and the actual LOS of acute med/surg inpatients, excluding OB/Delivery, Normal Newborns, Neonatology and Uncoded plus Mental Health, Rehab, and SNF.

GOAL ≤0.75

MARCH 2020: 1.16

JUL 2019-MAR 2020: 0.95

6.b Leadership Clinical Quality Goals April 2020 Leadership Meeting

Kaweah Clinical Quality Goals

April 2020

Sepsis

Kaweah Clinical Quality Goal Calculator - FY20

	Current								Future State Scenario					FYTD	Baseline	Goal
	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	Total		
SEP-1 Early Management Bundle	68%	67%	58%	67%	61%	74%	54%	75%	76%	80%	80%	80%	**70%**	**65%**	**Baseline 67% ↓3%**	**Goal 70%**
numerator	13	16	14	20	17	17	14	18	19	20	20	20	208	129		
denominator	19	24	24	30	28	23	26	24	25	25	25	25	298	198		

Sepsis Six Sigma:

- Root causes identified, 19 QI strategies developed and prioritized
- 2nd Sepsis Coordinator on hold r/t COVID-19, help from light duty and other Q&P/S staff

Sepsis QI Strategies

Project Prioritization Matrix: Sepsis QFT, April 2020

Group Strategy Affects	Improvement Strategy		DIFFICULTY or Cost/ Time to Implement Rate 5 to 1 High = 1 Low = 5		FEASIBILITY (likelihood of Success/ability to achieve the outcome Rate 5 to 1 High = 5 Low = 1		SCOPE Strategy affects multiple or a high volume root cause Rate 5 to 1 High = 5 Low = 1		LEVERAGE (Positive Impact on Other Processes) Rate 5 to 1 High = 5 Low = 1	Total Project Priority
ED Pro	ED - Build and utilize SEP-1A "Catch Up" order set so all bundle components can be ordered (not "grayed out") GO LIVE 4/28	x	4.0	x	5.0	x	5.0	x	5.0	**500.0**
CC/INPT RN	Make form revisions to "provider notification"; provide prompts for critical thinking and order set initiation, and title it differently to eliminate confusion IN PROCESS	x	2.0	x	4.0	x	4.0	x	5.0	**160.0**
ED Pro & CC/HOS	Build dot phrase - If it's not Sepsis, document it IN PROCESS	x	4	x	2	x	4	x	5	**160.0**
ED Pro/ ED GME	Schedule ED and GME regular education/awareness of bundle, and order set usage IN PROCESS	x	2	x	4	x	4	x	4	**128.0**
ED Pro	Improve ED provider notification IN PROCESS	x	4.0	x	2.0	x	4.0	x	3.5	**112.0**
ED/CC RN	Hand off sheet/pathway checklist (concerns about paper lost); can checklist be triggered electronically for RN when order set is used? This way checklist is available electronically, and can be available to print anywhere in patients Sepsis hospitalization course regardless of location. Similar to existing workflow with MRI safety form, belonging forms "ad hoc" forms. Ideally it populate, and reminder to complete. IN PROCESS	x	3	x	2	x	4	x	4	**96.0**

CAUTI, CLABSI & MRSA

Kaweah Clinical Quality Goal Calculator - FY20

	Current									Future State Scenario				FYTD	Baseline	SIR GOAL
	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	Total		
CAUTI (SIR)	0.65	2.76	2.34	0.68	0.00	0.00	0.00	1.24	0.81	0.00	0.00	0.00	**0.78**	**1.03**	**1.557 ↑51%**	**<0.828 or 14**
numerator (actual)	1	5	4	1	0	0	0	2	1	0	0	0	14	14		
denominator (predicted)	1.53	1.81	1.71	1.47	1.46	1.03	1.7	1.61	1.24	1.5	1.5	1.5	18.06	13.56		

	Current									Future State Scenario				FYTD	Baseline	SIR GOAL
	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	Total		
CLABSI (SIR)	0.00	0.00	2.70	3.67	1.11	0.00	0.98	0.00	0.00	0.79	0.00	0.00	**0.73**	**0.90**	**1.253 ↑39%**	**<0.784 or 12**
numerator (actual)	0	0	3	4	2	0	1	0	0	1	0	0	11	10		
denominator (predicted)	1.19	1.23	1.11	1.09	1.8	1.13	1.02	1.27	1.22	1.26	1.26	1.26	15.12	11.06		

	Current									Future State Scenario				FYTD	Baseline	SIR GOAL
	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	Total		
MRSA (SIR)	2.67	1.33	1.33	0.00	0.00	2.78	0.00	1.09	1.09	0.00	0.00	0.00	**0.91**	**1.16**	**1.410 ↑18%**	**<0.815 or 7**
numerator (actual)	2	1	1	0	0	2	0	1	1	0	0	0	8	8		
denominator (predicted)	0.75	0.75	0.75	0.72	0.72	0.72	0.64	0.92	0.92	0.73	0.73	0.73	8.76	6.89		

Kaizen Six Sigma Improvement Strategy Examples:

- Catheter and Central Line Gemba Rounds ongoing daily!
- Enhanced shift huddles, education and awareness of bundles
- Culture of culturing
- Enhance hand hygiene, IP practices

What is a Gemba Walk?

A gemba walk is the term used to describe personal observation of work – where the work is happening. In Japanese Gemba means “real thing.” This concept stresses:

Observation: In-person observation, the core principle of the tool

Value-add location: Observing where the work is being done (as opposed to discussing a warehouse problem in a conference room)

Teaming: Interacting with the people and process in a spirit of Kaizen (“change for the better”)

Date of Gemba: _____ Unit: _____ KDHCD CL and IUC GEMBA QUALITY ROUNDS Clinician Completing Form: _____

Patient		Central Line (CL) GEMBA									BOTH CL & IUC	Indwelling Urinary Catheter (IUC) GEMBA							
Room	FIN #	CL Insertion date (m/d)	Is there an order present &	Type of CL	Is CL dsg clean, dry & intact?	Was last dressing change on > than 7 days? Write date of last dsg change	Is guardiva fully covering site? (n/a if pt	S / Sx of infection	Is document-ation appropr and	Follow Up Required because of Gemba Round	Bath Documented within last 24 hrs?	Pericare documented within last 12	IUC Insertion date	Is there an order present & valid rational	Have we attempted to remove the	Have alternatives been attempted?	Are there S/ Sx of UTI?	Follow Up Required because of Gemba Round	Was the IUC removed as result of
		(m/d):	y n n/a		y n n/a	y n (m/d):	y n n/a	y n	y n		y n	y n	(m/d):	y n	y n	y n n/a	y n		y n
		(m/d):	y n n/a		y n n/a	y n (m/d):	y n n/a	y n	y n		y n	y n	(m/d):	y n	y n	y n n/a	y n		y n
		(m/d):	y n n/a		y n n/a	y n (m/d):	y n n/a	y n	y n		y n	y n	(m/d):	y n	y n	y n n/a	y n		y n
		(m/d):	y n n/a		y n n/a	y n (m/d):	y n n/a	y n	y n	235/235	y n	y n	(m/d):	y n	y n	y n n/a	y n		y n