February 10, 2023

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in a Quality Council Committee meeting at 7:30AM on Thursday, February 16, 2023, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:31AM on Thursday, February 16, 2023, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277, pursuant to Health and Safety Code 32155 & 1461.

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Quality Council Committee meeting at 8:00AM on Thursday, February 16, 2023, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

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

The disclosable public records related to agendas are available for public inspection at Kaweah Health Medical Center – Acequia Wing, Executive Offices (Administration Department) {1st floor}, 400 West Mineral King Avenue, Visalia, CA and on the Kaweah Delta Health Care District web page https://www.kaweahhealth.org.

KAWEAH DELTA HEALTH CARE DISTRICT
Michael Olmos, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
Board Clerk, Executive Assistant to CEO & CNO

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

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
QUALITY COUNCIL

Thursday, February 16, 2023
5105 W. Cypress Avenue
Kaweah Health Lifestyle Fitness Center Conference Room

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

OPEN MEETING – 7:30AM

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

CLOSED MEETING – 7:31AM

1. **Call to order** – *David Francis, Committee Chair & Board Member*
2. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Daniel Hightower, MD, and Professional Staff Quality Committee Chair; James McNulty, Director of Pharmacy Services*
3. **Adjourn Closed Meeting** – *David Francis, Committee Chair*

OPEN MEETING – 8:00AM

1. **Call to order** – *David Francis, Committee Chair*
2. **Public / Medical Staff participation –** Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves at this time. Members of the public or the medical staff may comment on agenda items after the item has been discussed by the Committee but before a Committee recommendation is decided. In either case, each speaker will be allowed five minutes.
3. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives:
   - 3.1. Cardiology Services Quality Report
   - 3.2. Central Line Associated Blood Stream Infection (CLABSI) Quality Focus Team
   - 3.3. Rehabilitation Services Quality Report
4. **Pain Management Committee Report –** A report of key quality metrics and action plans associated with pain management processes and opioid safety. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety and Tom Gray, MD, Medical Director of Quality & Patient Safety*
5. **Clinical Quality Goals Update-** A review of current performance and actions focused on the clinical quality goals for Sepsis, and Healthcare Acquired Infections. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*
6. **Adjourn Open Meeting** – *David Francis, Committee Chair*

In compliance with the Americans with Disabilities Act, if you need special assistance to participate at this meeting, please contact the Board Clerk (559) 624-2330. Notification 48 hours prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to the Kaweah Delta Health Care District Board of Directors committee meeting.

KAWEAH DELTA HEALTH CARE DISTRICT

QUALITY COUNCIL - CLOSED MEETING

THURSDAY FEBRUARY 14, 2023

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 4-14

KDHCD - QUALITY COUNCIL - CLOSED MEETING

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KAWEAH DELTA HEALTH CARE DISTRICT

QUALITY COUNCIL - CLOSED MEETING

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KAWEAH DELTA HEALTH CARE DISTRICT

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THURSDAY FEBRUARY 14, 2023

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PAGES 4-14

PCI Data Quality Analysis

Q4 2021 → Q3 2022

Risk Adjusted Data

Neon Green = In the Top 10% of the Nation

Light Green = Better or Equal to the National Average

Red = Worse than National Average

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

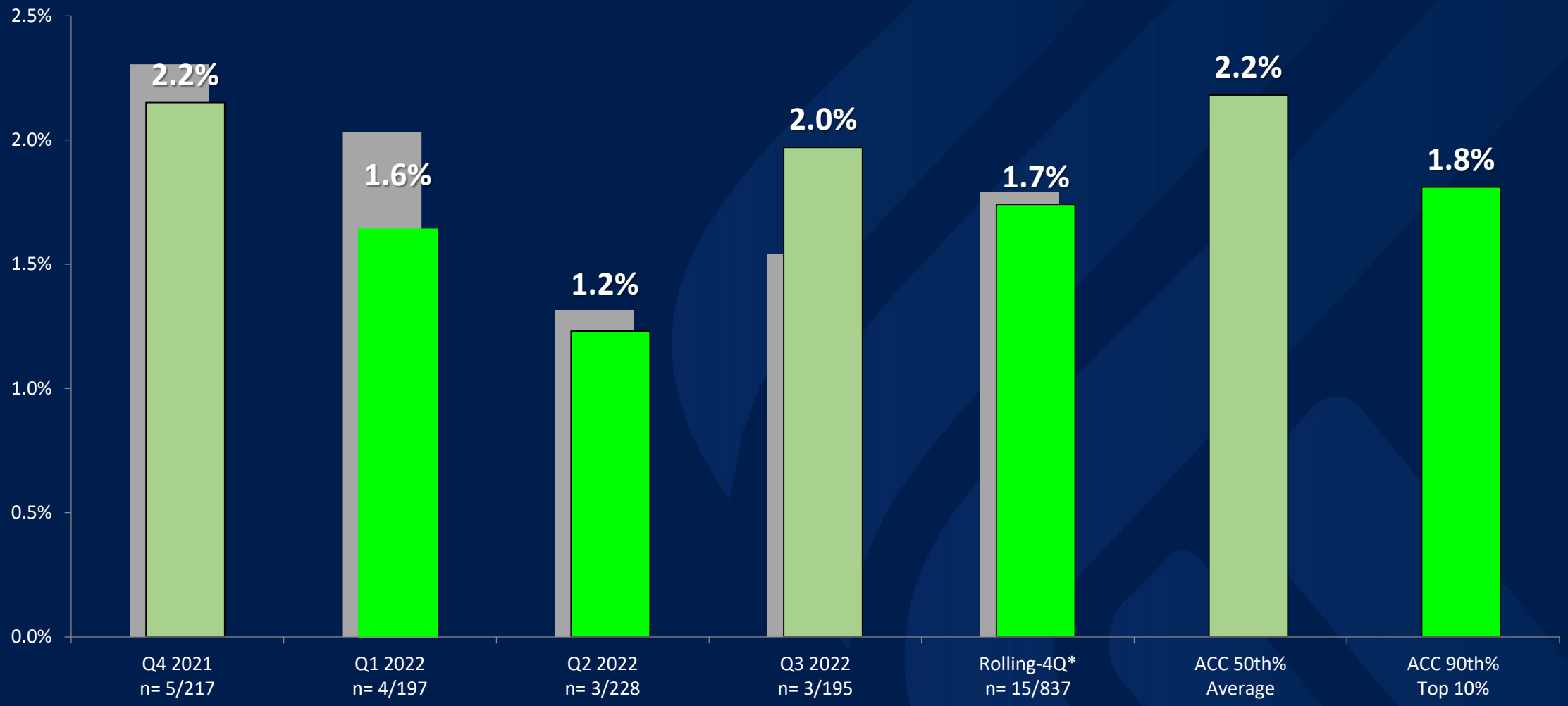
*Comparison Reporting Period Varies per Metric

Quality Improvement for Institutions

American College of Cardiology

Kaweah Health
MORE THAN MEDICINE. LIFE.

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

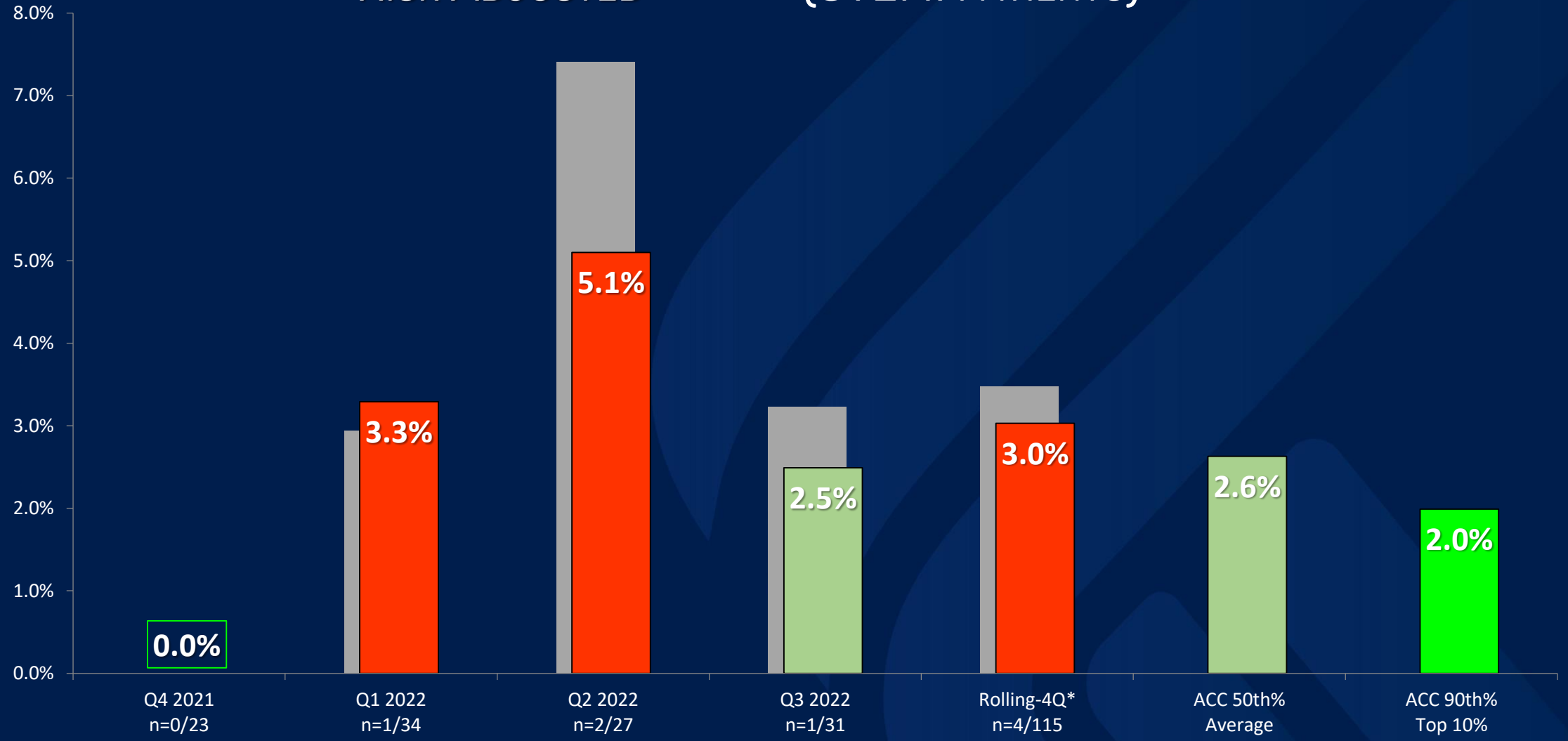


R4Q Risk-Adjusted O/E = 0.79

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

*Comparison reporting period is 10/01/21 through 09/30/22..

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

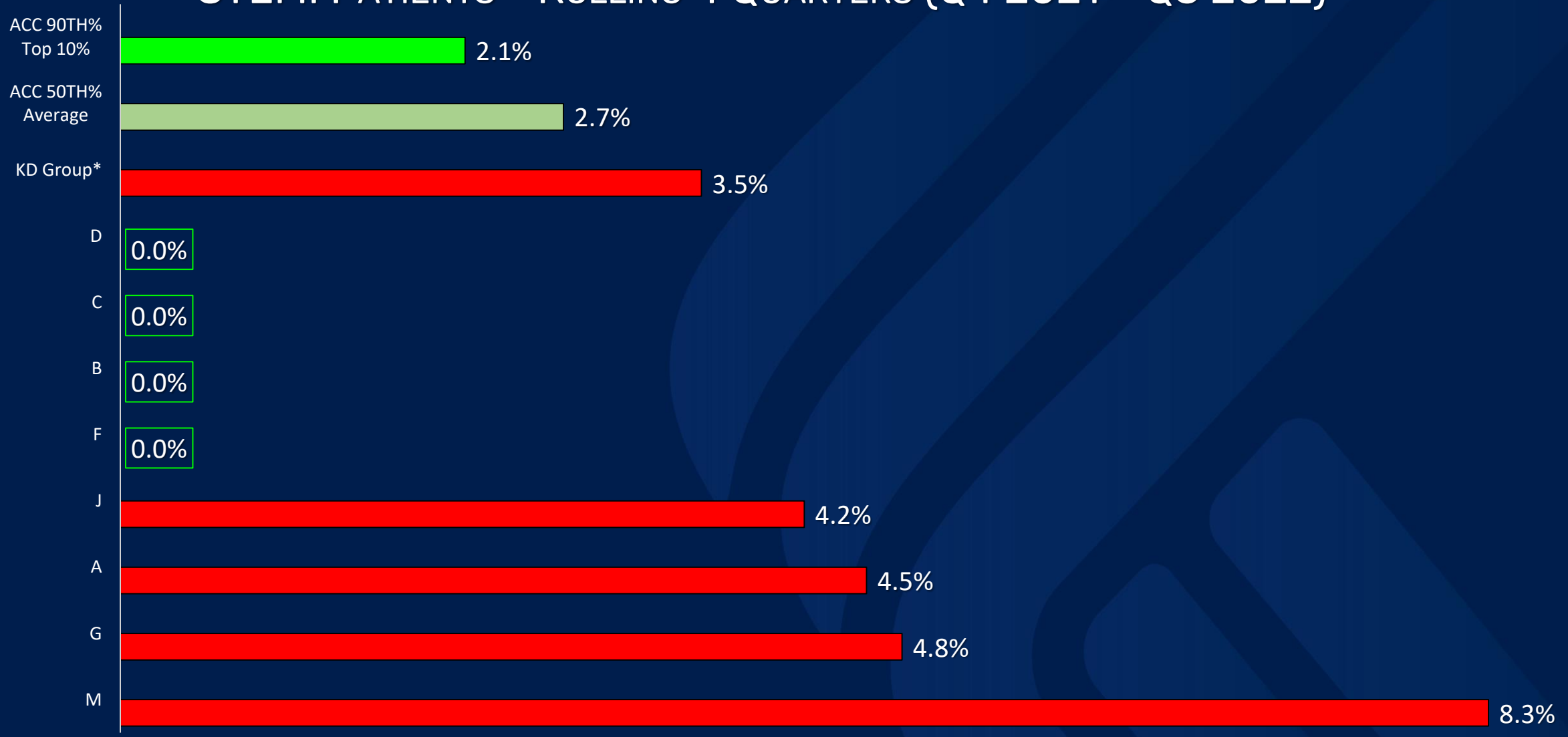


R4Q Risk-Adjusted O/E = 1.14

[1] PCI in-hospital mortality rate for STEMI Pt.'s w/o cardiogenic shock or cardiac arrest. (ref: 13020, 1590, 51)

* Comparison reporting period is 10/01/21 through 09/30/22

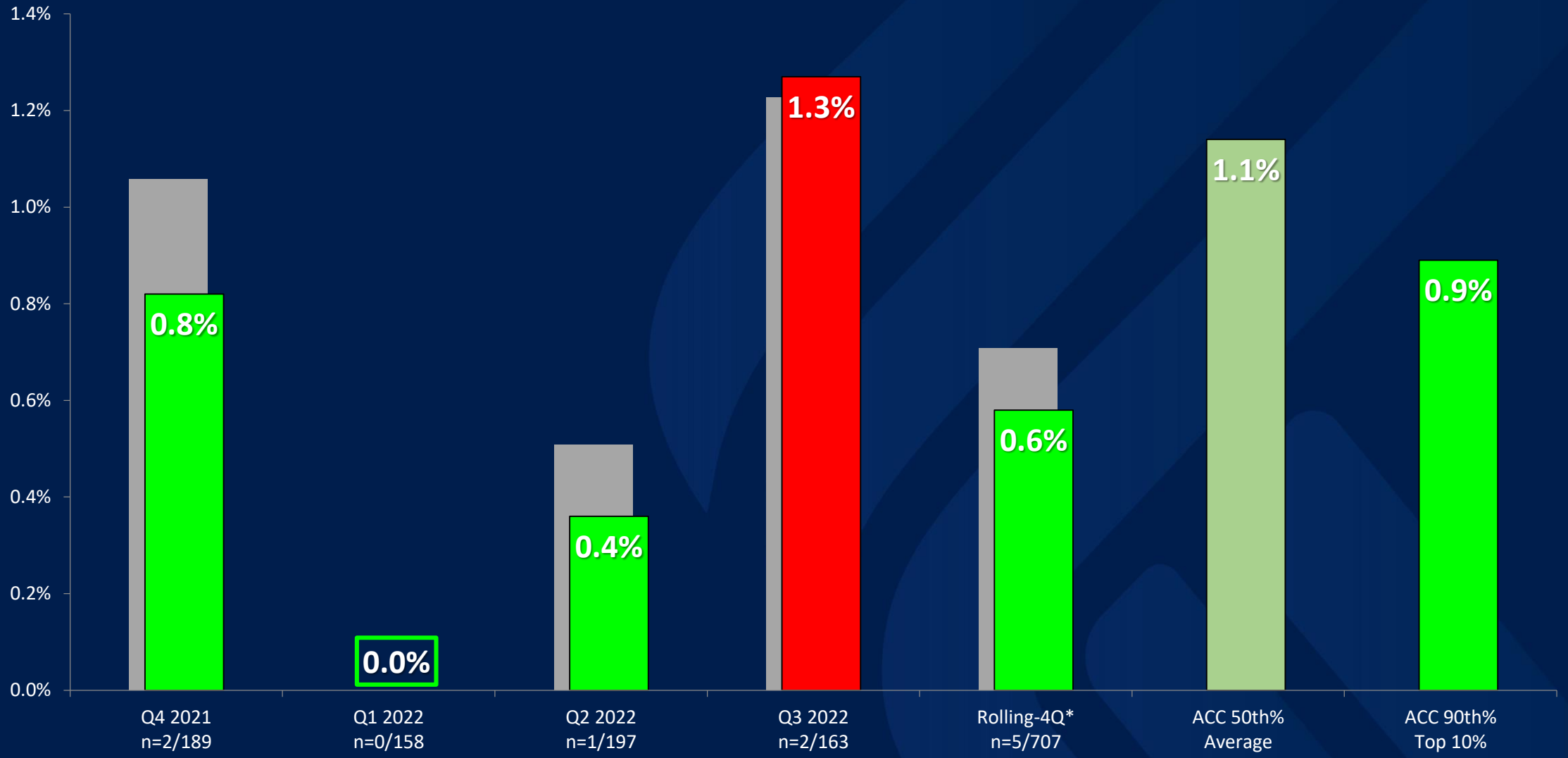
PCI Mortality[1] Rate by Physician
STEMI Patients – Rolling 4 Quarters (Q4 2021 – Q3 2022)



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

* Comparison reporting period is 10/01/21 through 09/30/22– Raw DATA all Quarters – NOT-RISK-ADJUSTED

PCI In-Hospital Mortality Rate[1]
Risk Adjusted[IN-COLOR] (pts w/out STEMI)

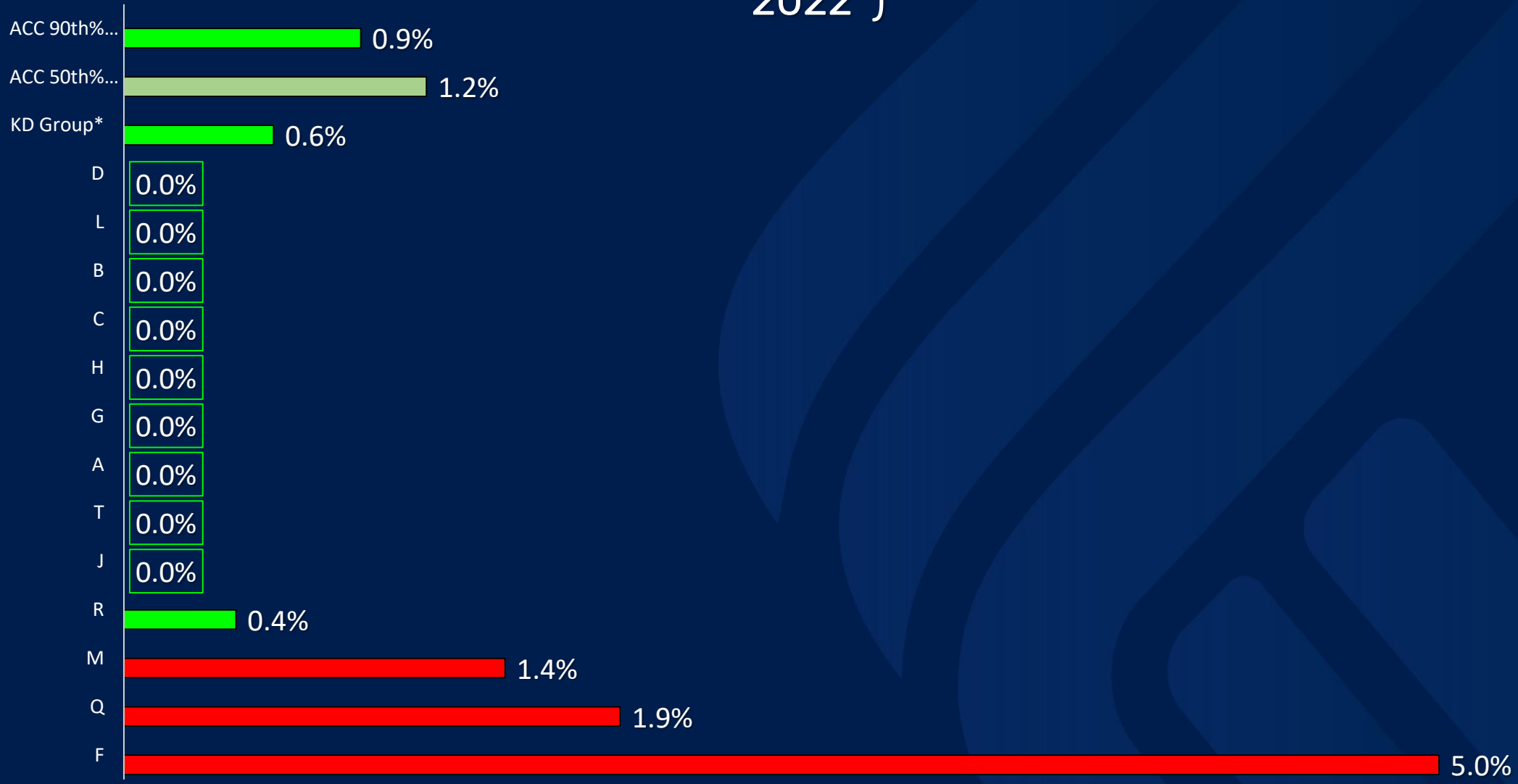


R4Q Risk-Adjusted O/E = 0.5

[1] PCI in-hospital mortality rate for all patients Excluding STEMI. Exclusions include patients with a discharge location of "other acute care hospital." (ref: , 13019)

* Comparison reporting period is 10/01/21 through 09/30/22

PCI Mortality[1] Rate by Physician
N-STEMI, USA, Elective Patients - Rolling 4 Quarters (Q4 2021 – Q3 2022*)



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

* Comparison reporting period is 10/01/21 through 09/30/22– Raw DATA all Quarters – NOT-RISK-ADJUSTED

Kaweah Health

STEMI Triage Guidelines

Thoughtful Pause

➢ Should go to CVICU first, not the Cath Lab

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

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

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

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

Kaweah Health

Quality Initiative

Documentation of Comorbidities

- Plan: Team approach to capturing all patient comorbidities
  - Cardiology NPs round on all STEMI and NSTEMI patients while hospitalized
  - Focus on documentation of comorbidities such as:
    - Age, gender, hx of cerebral vascular disease, peripheral vascular disease, chronic lung disease, diabetes, kidney disease , renal failure, aortic stenosis
    - Previous PCI, In-stent thrombosis within in 30 days of prior PCI, cardiac arrest, STEMI
    - PCI status (i.e. emergent, urgent, or elective; cardiogenic shock, salvage PCI, acute heart failure)
  - Previous risk adjusted data to identify areas of improvement in documentation

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

Kaweah Health

Quality Initiative

Treatment Algorithm for Invasive Cardiac Procedures

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

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

Kaweah Health

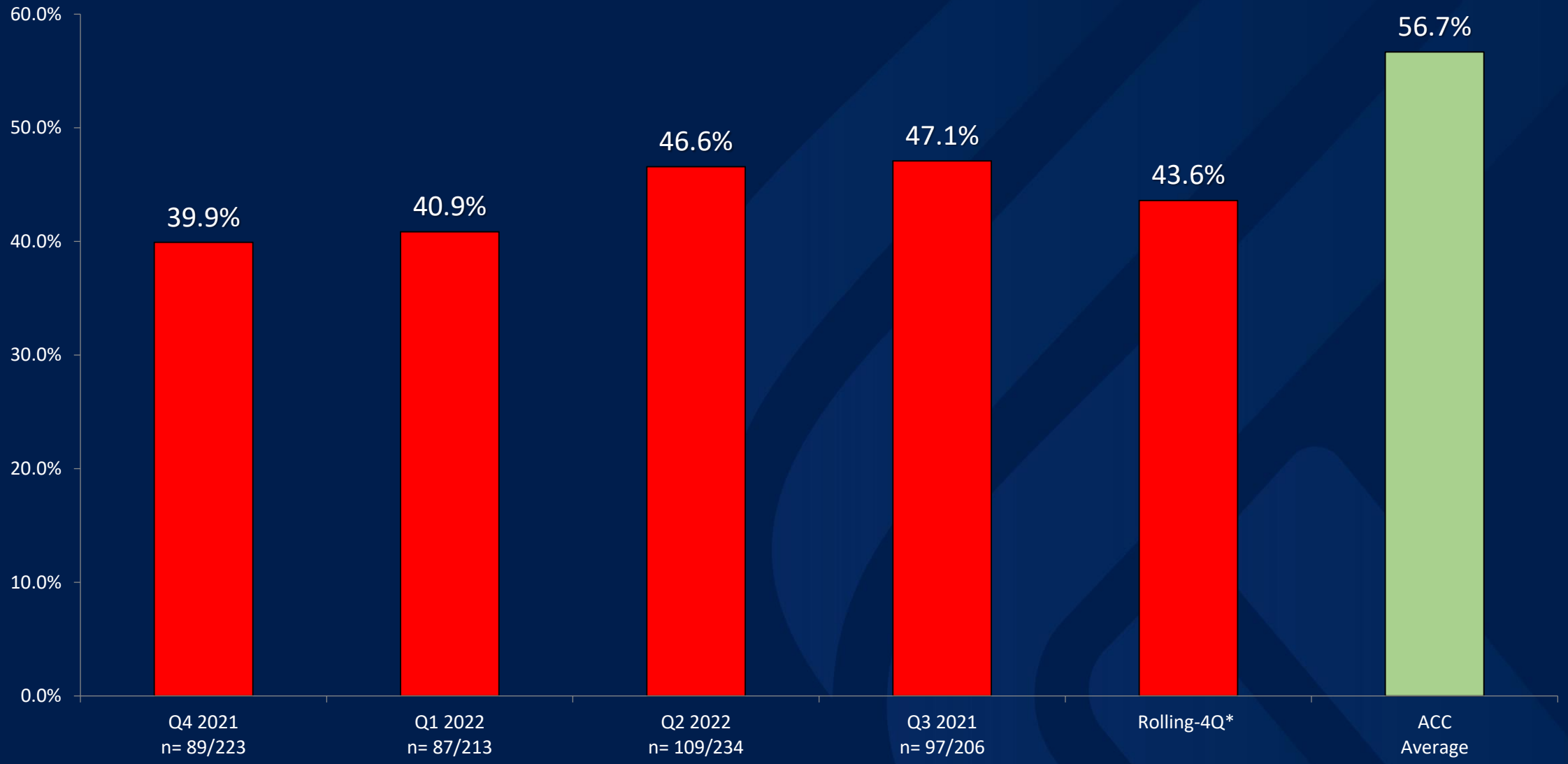
Quality Initiative

Vitally Important Ethical Steps

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

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

PCI Radial Artery Access

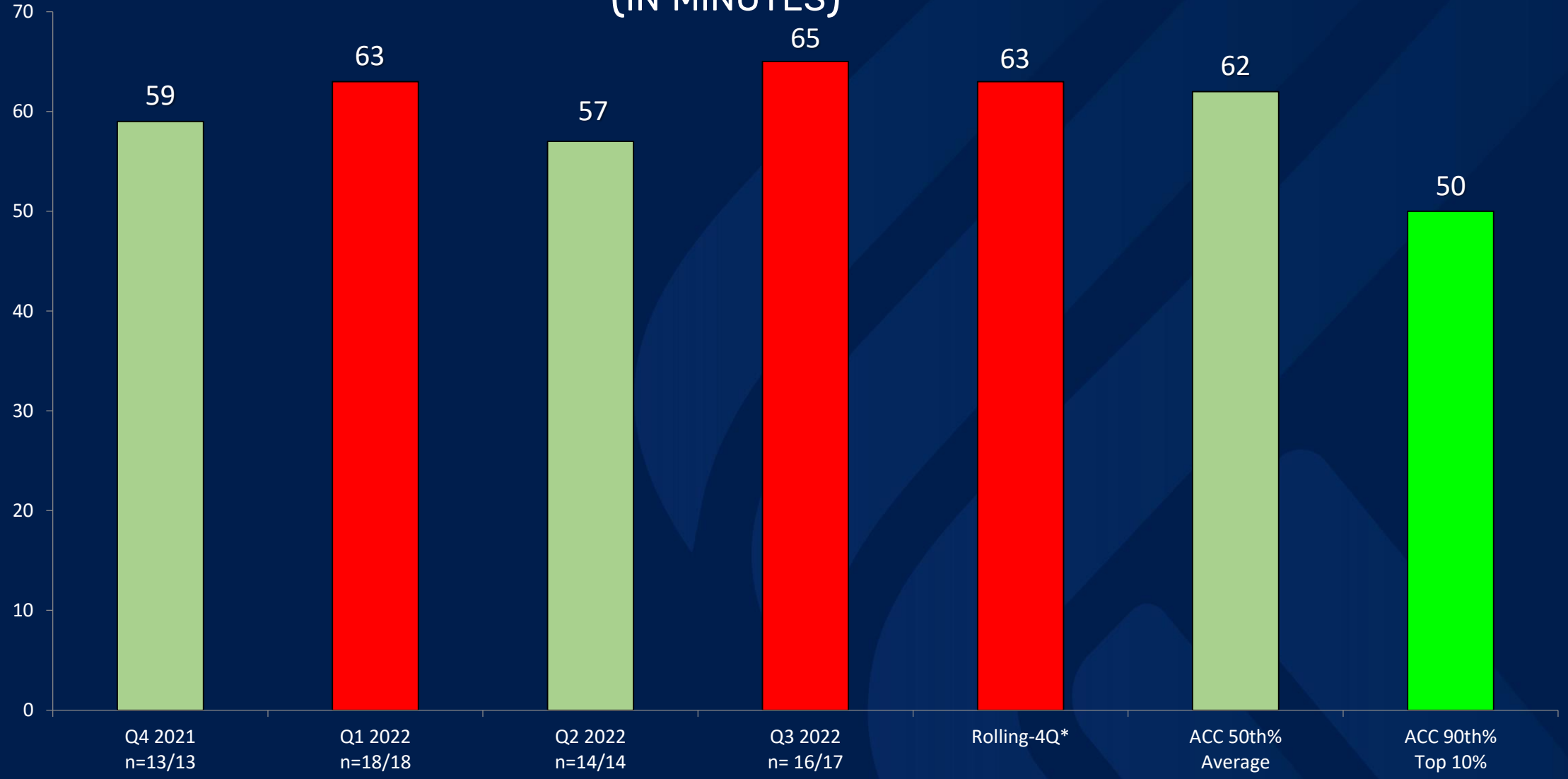


R4Q O/E = 1.1

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

* Comparison reporting period is 10/01/21 through 09/30/22

Door to Balloon Time: Immediate PCI for STEMI (in minutes)[1]

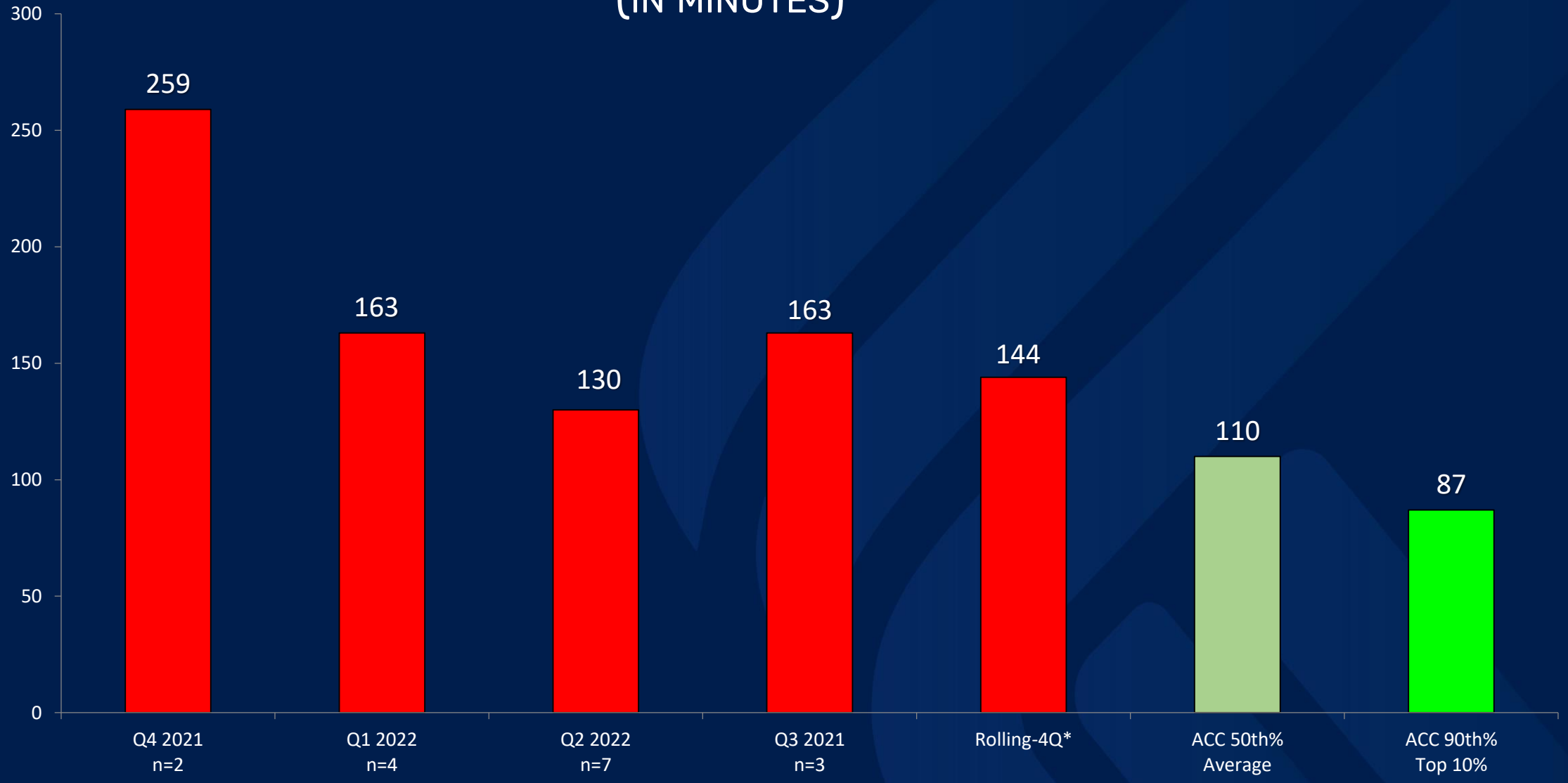


R4Q O/E = 1

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

* Comparison reporting period is 10/01/21 through 09/30/22

Door to Balloon Time: Immediate PCI for STEMI Transfers (in minutes)[1]



R4Q O/E = 1.3

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

* Comparison reporting period is 10/01/21 through 09/30/22

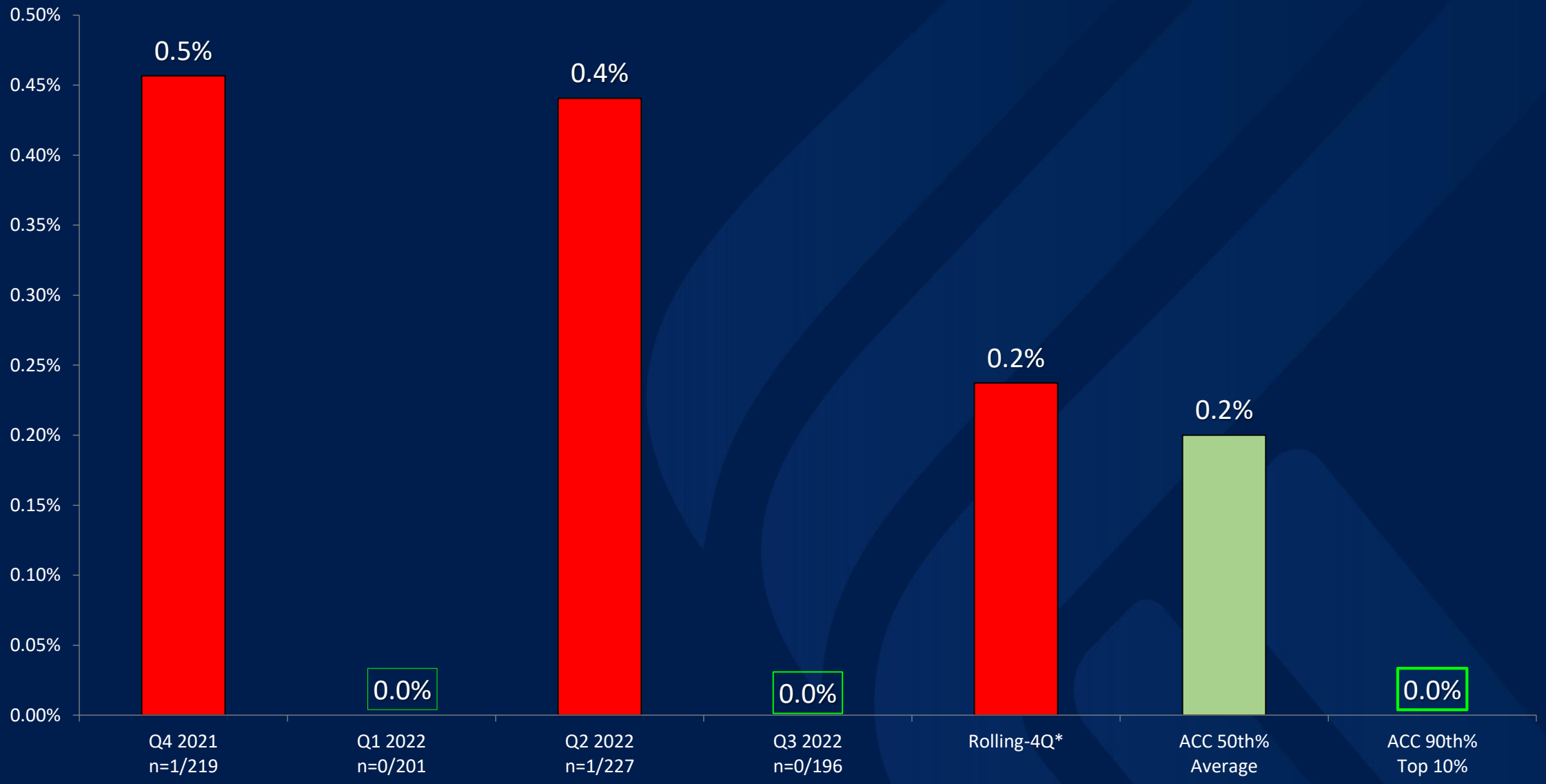
Kaweah Health

Quality Initiative

Best Practice in Door To Balloon

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

Stroke Post PCI[1]



R4Q O/E = 1.2

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

* Comparison reporting period is 10/1/21 through 09/30/22

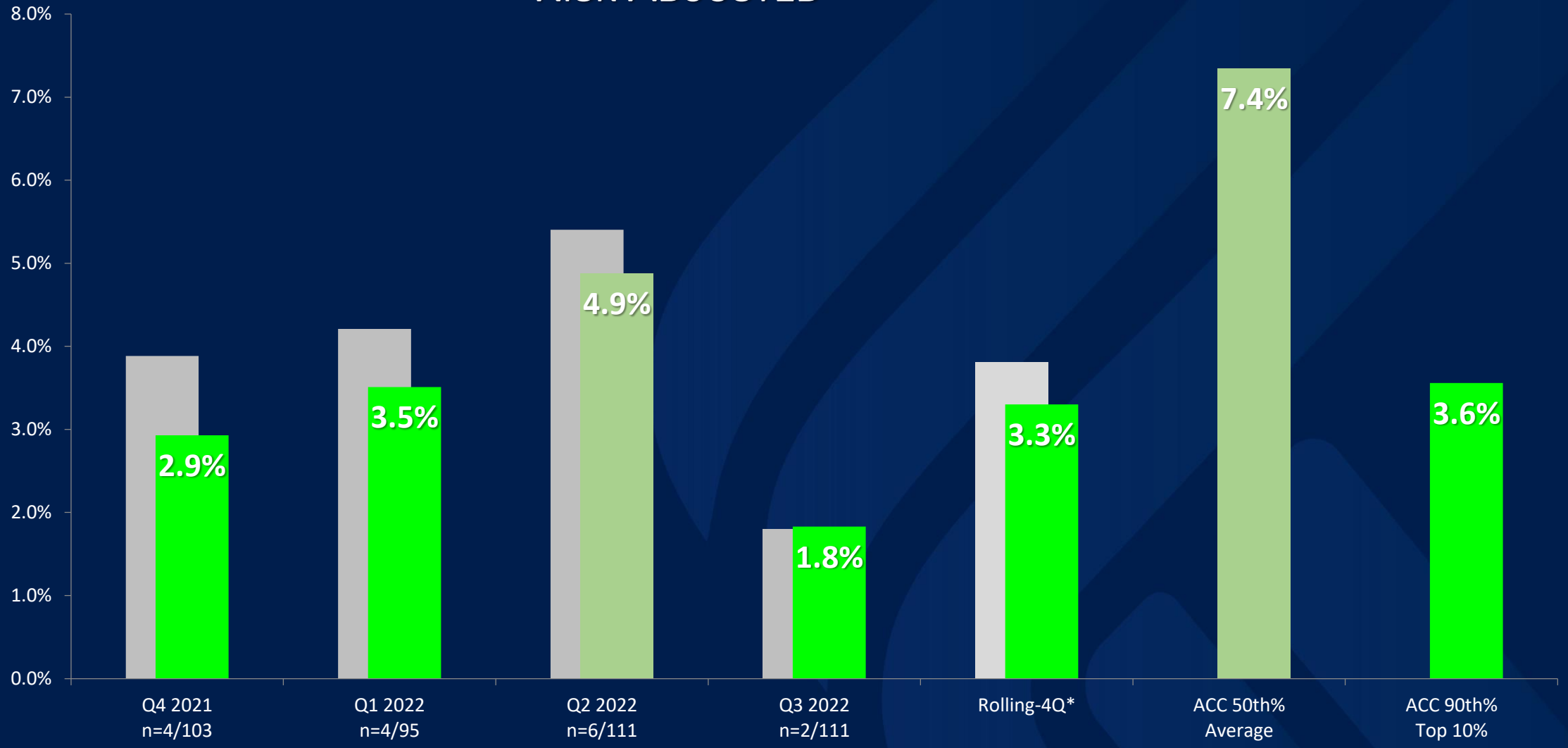
Kaweah Health

Quality Initiative

Stroke Recognition and Treatment

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

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



R4Q Risk-Adjusted O/E = 0.43

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

* Comparison reporting period is 10/01/2021 through 09/30/22

Kaweah Health

Quality Initiative

Acute Kidney Injury

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

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

Transfusion Post-PCI of RBCs[1]

R4Q O/E = 0.9

[1] Proportion of pt.'s who receive a transfusion of whole blood or RBCs during or after, but within 72 hours of PCI procedure.

Exclusions: Patients on dialysis; EP study or CABG or other major surgery during the same admission; Pt.'s with a pre-procedure hemoglobin <8g/dL or no value. (ref: 4288)

* Comparison reporting period is 10/01/21 through 09/30/22

Kaweah Health

Kaweah Health Policy (TR-036)

Guidelines for Usage of Blood Products (Release Criteria)

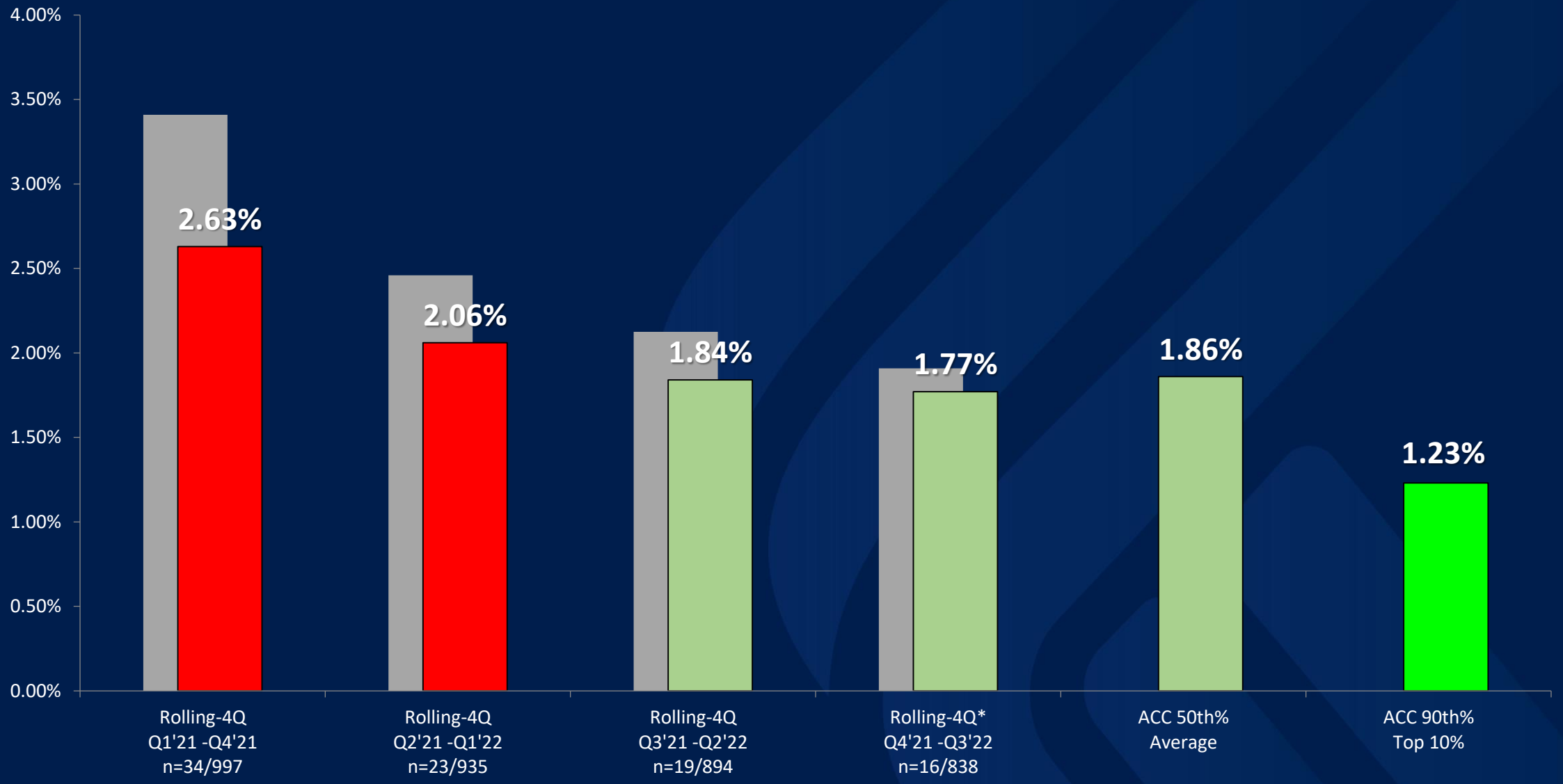
Date Approved: 12/13/2022

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

B. Transfusion may be administered when hemoglobin levels are 8-10 grams/dl in the following circumstances:

1. Acute Blood Loss/Active Bleed
2. Presence of Symptomatic Anemia
3. HGB <9 w/ Chemotherapy
4. HGB <10 w/ Radiation Treatment

Risk Standardized Bleeding Rate[1]



R4Q Risk standardized bleeding ratio = NA / Non-Risk-Adjusted O/E = 1.4 [1] Pt's with a Bleeding event defined as 1) occurring within 72 hours of procedure (Bleeding at access site, hematoma at access site, retroperitoneal bleed, GI, GU or any transfusion) 2) occurring during hospitalization (hemorrhagic stroke, tamponade, Hgb drop ≥4 g/dL requiring transfusion, or a procedural intervention/surgery to reverse/stop or correct the bleeding) Exclusions: subsequent PCI procedures, death w/in 24 hours, CABG this hospitalization, transfusion in presence of mechanical support. (ref: 4934) * Comparison reporting period is 10/01/21 through 09/30/22

Kaweah Health

Quality Initiative

Bleeding Reduction Protocol

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

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

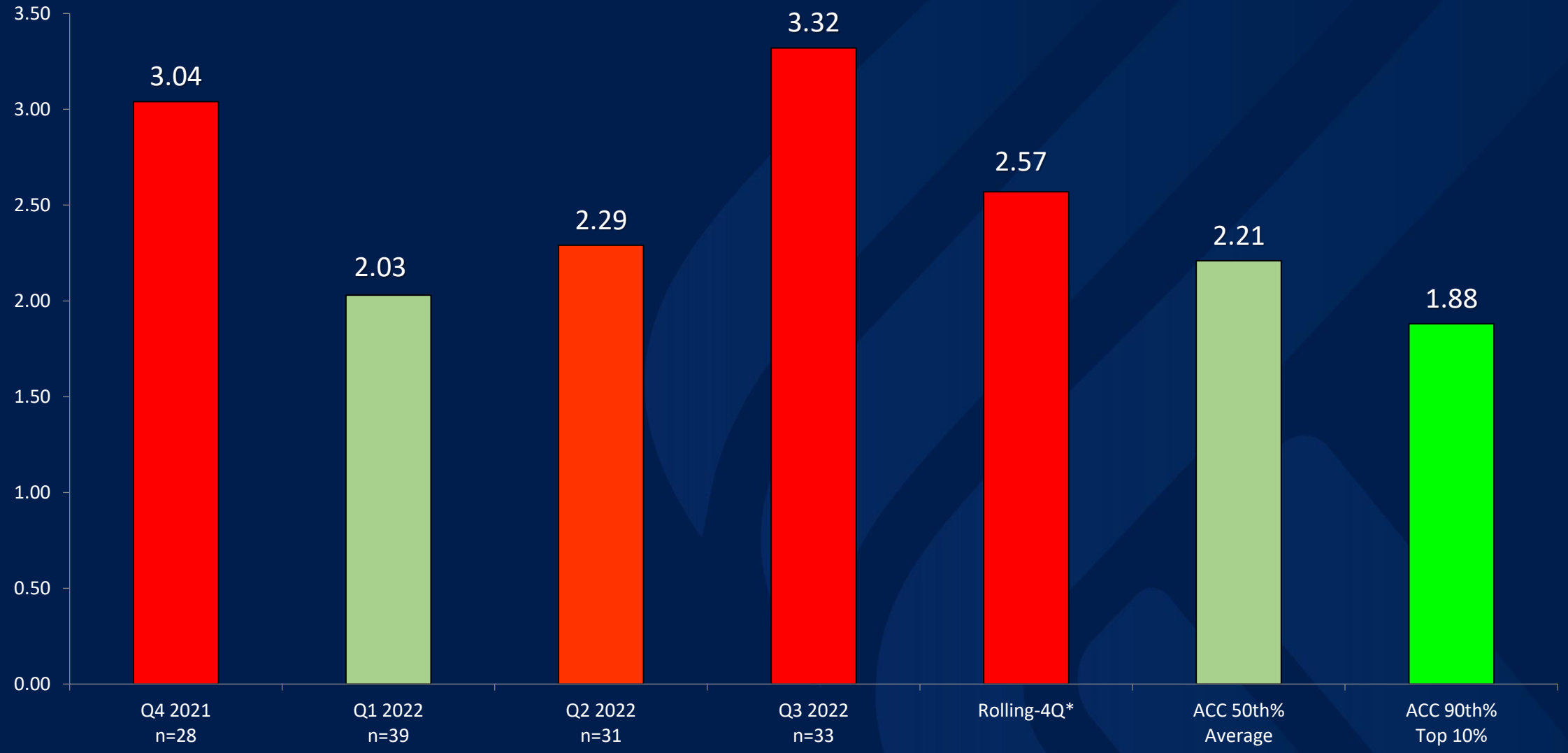
Kaweah Health

Quality Initiative

Bleeding Reduction Protocol (cont.)

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

Post-PCI Length of Stay[1] – STEMI

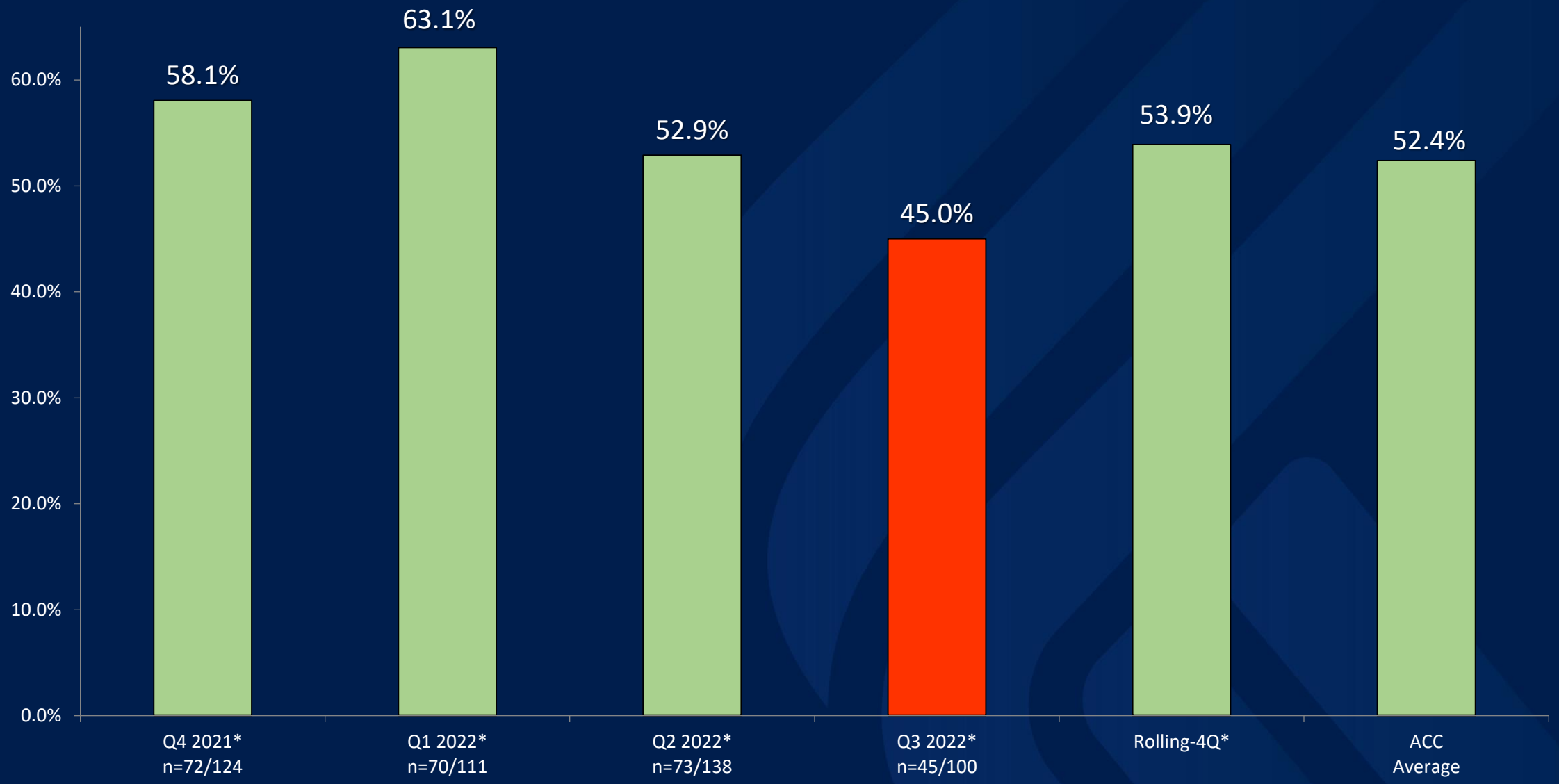


R4Q O/E = 1.2

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

* Comparison reporting period is 10/01/21 through 09/30/22

Post-PCI Same Day Discharge - Electives



R4Q O/E = 0.8

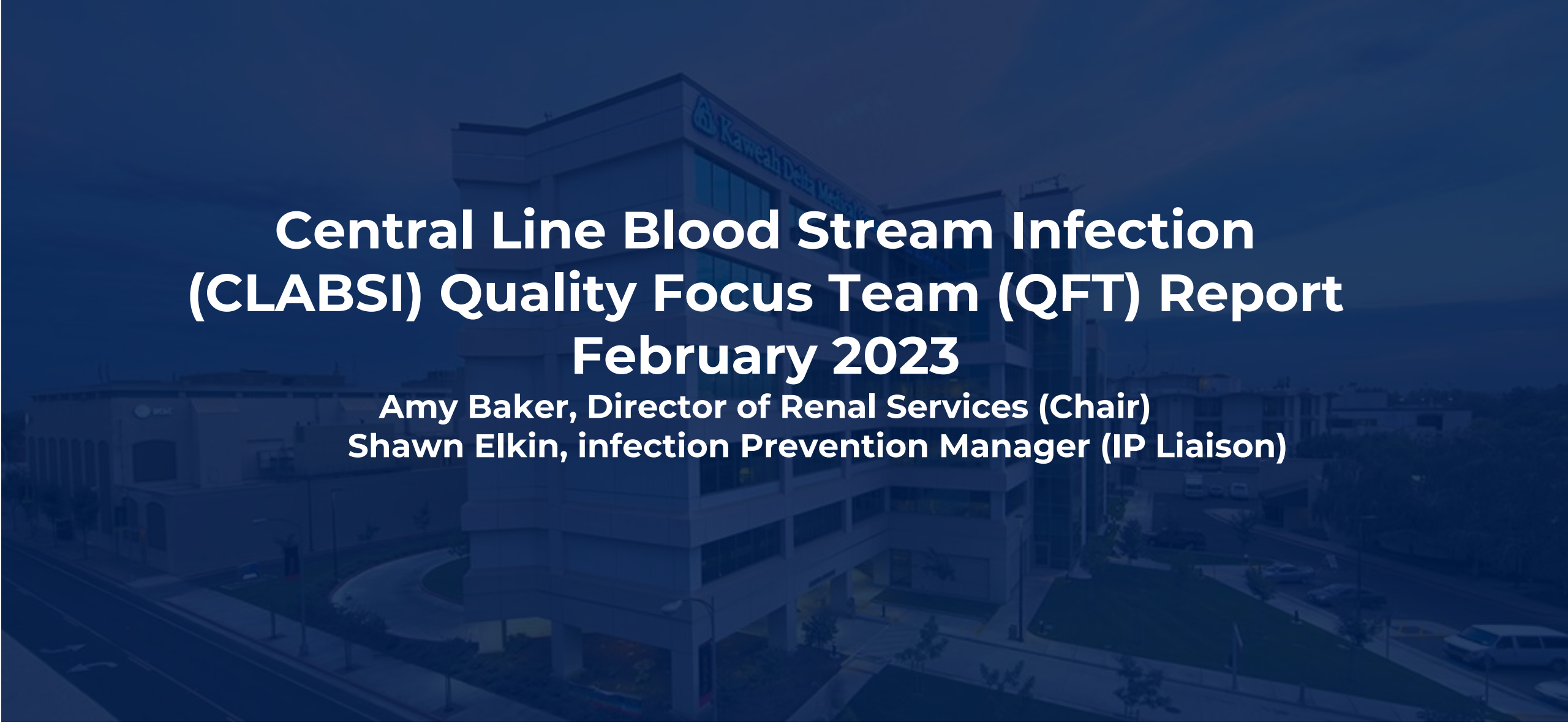
[1] Elective scheduled patients discharged on the same day as procedure. Exclusions: mortalities and pt.'s discharged to Another Acute Care Facility or AMA (ref:4971)
When no Percentile rankings are available, US Like Volume Group R4Q Averages are used for comparison purposes.

* Comparison reporting period is 10/01/21 through 09/30/22

Live with passion.

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

Kaweah Health



Central Line Blood Stream Infection (CLABSI) Quality Focus Team (QFT) Report February 2023

Amy Baker, Director of Renal Services (Chair)
Shawn Elkin, infection Prevention Manager (IP Liaison)

Post Kaizen- Gemba Data

- **Increase in number of CLABSI events for month of December**
- **Decrease in compliance with valid rationale order for month of December**

Measure Description	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
OUTCOME MEASURES												
Number of CLABSI	1	0	2	2	1	2	3	0	0	1	1	3
FYTD SIR	1.18	1.05	1.09	1.12	1.07	1.13	2.26	1.14	0.802	0.792	0.784	1.026
PROCESS MEASURES CL Gemba												
% of pts with bath within 24 hrs	97%	95%	n/a	95%	96%	95%	95%	97%	96%	95%	95%	96%
% of CL with valid rationale order	99%	95%	n/a	98%	97%	96%	96%	96%	93%	99%	96%	94%
% of CL dressings clean, dry and intact	97%	99%	n/a	97%	96%	98%	98%	97%	96%	97%	98%	98%
% of CL that had drsg change no > than 7 days	97%	99%	n/a	97%	97%	92%	94%	96%	98%	98%	98%	98%
% of patients with proper placed gardiva patch	98%	96%	n/a	95%	95%	90%	95%	94%	94%	95%	97%	98%
% of CL pts with app & complete documentation	96%	92%	n/a	92%	93%	91%	91%	95%	96%	94%	94%	95%
# of Pt Central Line days rounded on	990	834		1296	1087	892	910	838	792	787	746	715

CLABSI QFT- Ongoing Meeting Objectives

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

CLABSI QFT- Ongoing Meeting Objectives

- Chlorhexidine Bathing for Med/Surg level Patients
  - Practice change presented at Patient Care Leadership Meeting
  - Subcommittee needed to work out details
    - Details include:
      - Certified Nursing Assistant can perform CHG bathing
      - Does CHG need to scanned in MAR
- Continue to review Central Line Power Plans to optimize

End of Fiscal Year Performance

FY22 Clinical Quality Goals

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

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

Our Mission

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

Our Vision

To be your world-class healthcare choice, for life

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

*based on July-Dec 2021 NHSN predicted

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

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

Current Fiscal Year

FY23 Clinical Quality Goals

	July-Nov 22 Higher is Better	FY23 Goal	FY22	FY22 Goal
SEP-1 (% Bundle Compliance)	79%	≥ 77%	76%	≥ 75%

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

Our Mission

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To be your world-class healthcare choice, for life

Lower is Better	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	June 2023	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual/ number expected)	FY23 Goal (VBP 2024; National Mean 2019)	FY22 FY21 FY20
CAUTI Catheter Associated Urinary Tract Infection Excluding COVID INCLUDING COVID-19 PATIENTS	1 (1)	1 (0)	2 (0)	1 (0)	2 (0)	3 (0)							14 (23 predicted over 12 months)	0.810 (0.900 Including COVID)	≤0.650	1.092 0.54 1.12
CLABSI Central Line Associated Blood Stream Infection Excluding COVID INCLUDING COVID-19 PATIENTS	3 (0)	0 (0)	0 (0)	0 (1)	1 (0)	3 (2)							10 (17 predicted over 12 months)	0.770 (1.026 Including COVID)	≤0.589	1.132 0.75 1.20
MRSA Methicillin-Resistant Staphylococcus Aureus Excluding COVID INCLUDING COVID-19 PATIENTS	2 (0)	0 (0)	0 (0)	0 (0)	0 (0)	2 (0)							5 (8 predicted over 12 months	1.167 (0.873 Including COVID)	≤0.726	1.585 2.78 1.02

*based on July 2021-June 2022 NHSN predicted

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

- Kaweah Health has had 7 CLABSI events this fiscal year.
- FYTD SIR is greater than goal.

Questions?

Live with passion.

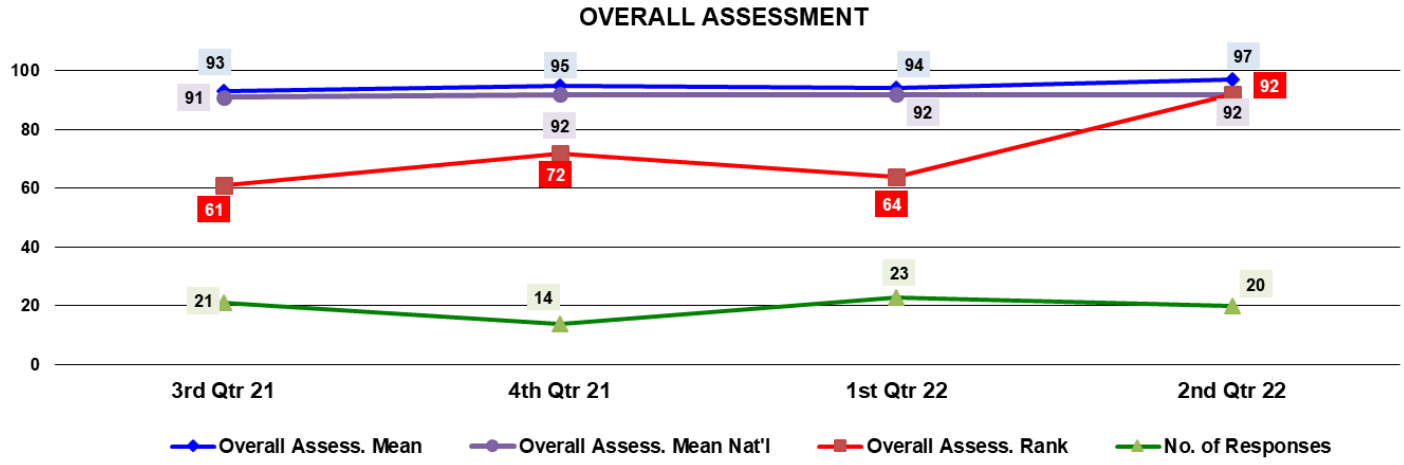
Health is our passion. Excellence is our focus. Compassion is our promise.

Kaweah Health

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

Measure Objective/Goal:
Acute rehabilitation program evaluation: patient satisfaction and clinical quality including functional outcomes and transfer of care.
Date range of data evaluated: Rehab quarterly report, 2nd and 3rd quarter of 2022

Patient Satisfaction
Analysis of all measures/data: (Include key findings, improvements, opportunities)
In the 2nd quarter of 2022, the mean score for the overall assessment of care was 97, placing the program in the 92nd percentile. In July 2022, the Rehab program transitioned to a new survey platform with NRC. We have seen a significant improvement in number of surveys collected, however the surveys are very different. Press Ganey was a mailed survey of 40 questions versus NRC 12 questions via email, text or phone. We will need to have a few quarters of NRC survey responses to set goals and better understand and interpret the results.

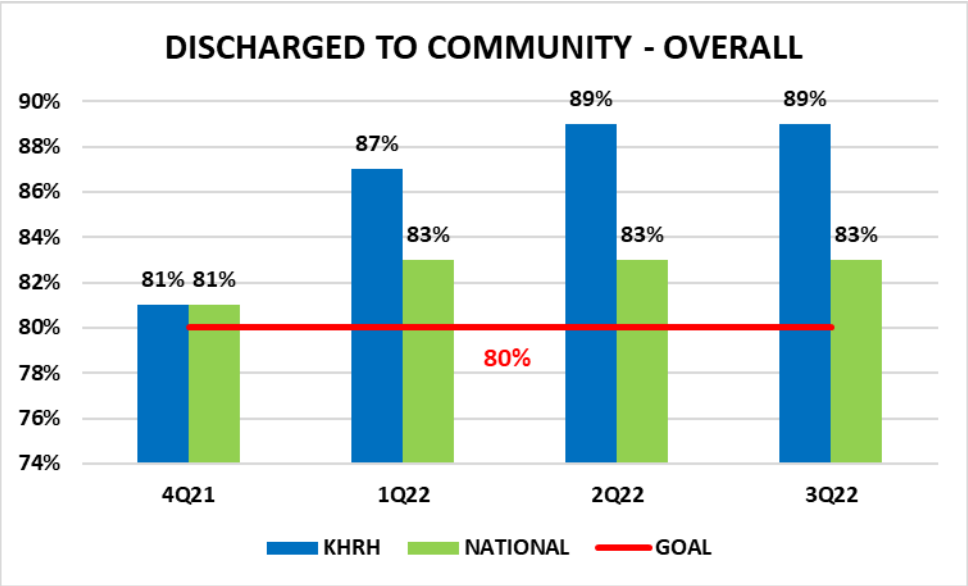


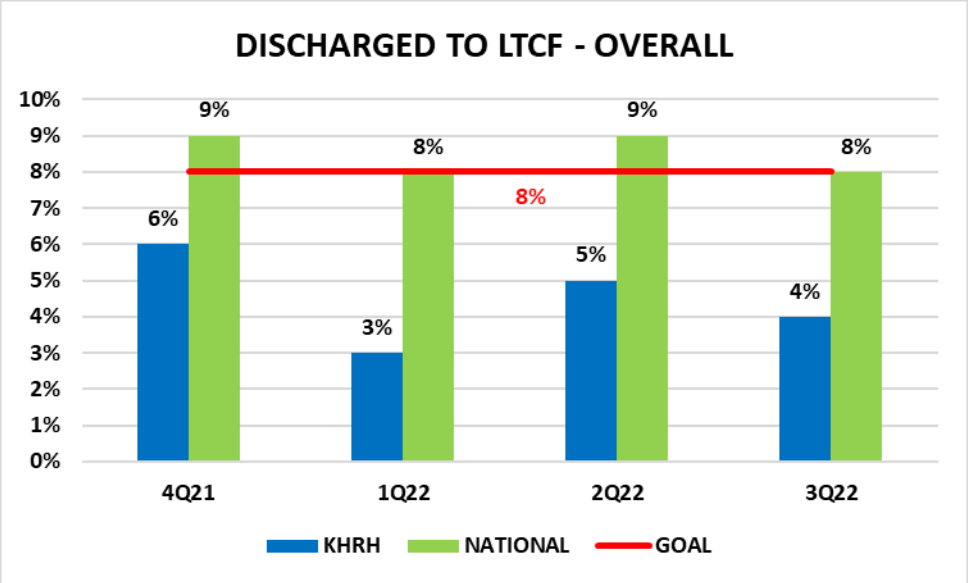
<u>If improvement opportunities identified, provide action plan and expected resolution date:</u>
Patient satisfaction is maintaining above the 90th percentile, so initiatives in place will continue, including:

- leaders responding and rounding to feedback from mid-stay surveys
- use of goal board to assist with patient engagement in setting and reviewing their goals
- patients journaling their Speech Therapy sessions to increase awareness of progress
- Rehab Medical Director following up with physician concerns in mid-stay survey

Functional Outcomes

<u>Analysis of all measures/data: (Include key findings, improvements, opportunities)</u>
Discharged to Community – (higher is better) in both 2nd and 3rd quarter 2022 89% of KH Rehab patients returned to community, exceeding the national average of 83.
Discharge to LTCH – (lower is better) KH Rehab patients discharging to Skilled Nursing Facility in 2Q22 were 5% compared to national average of 9% and 3Q22 4% compared to 8%.



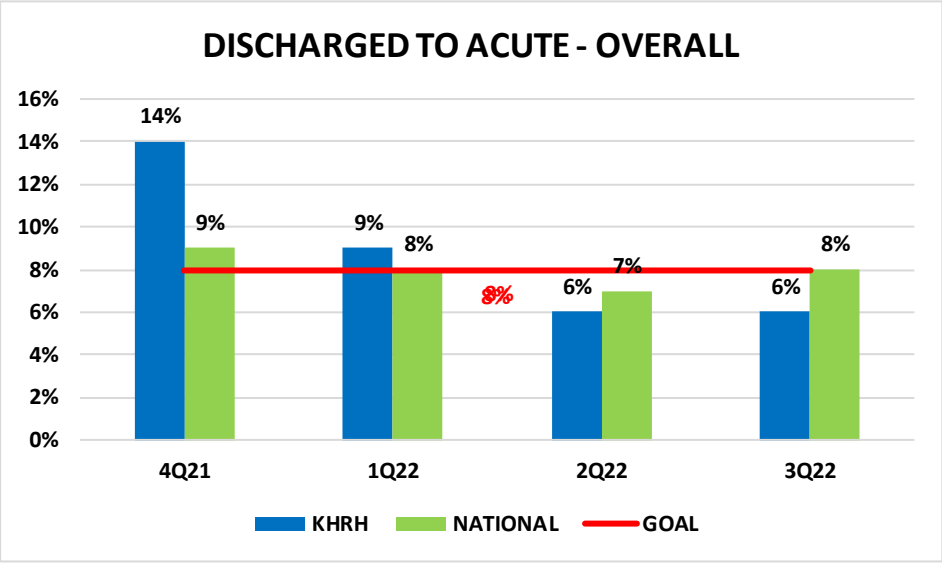


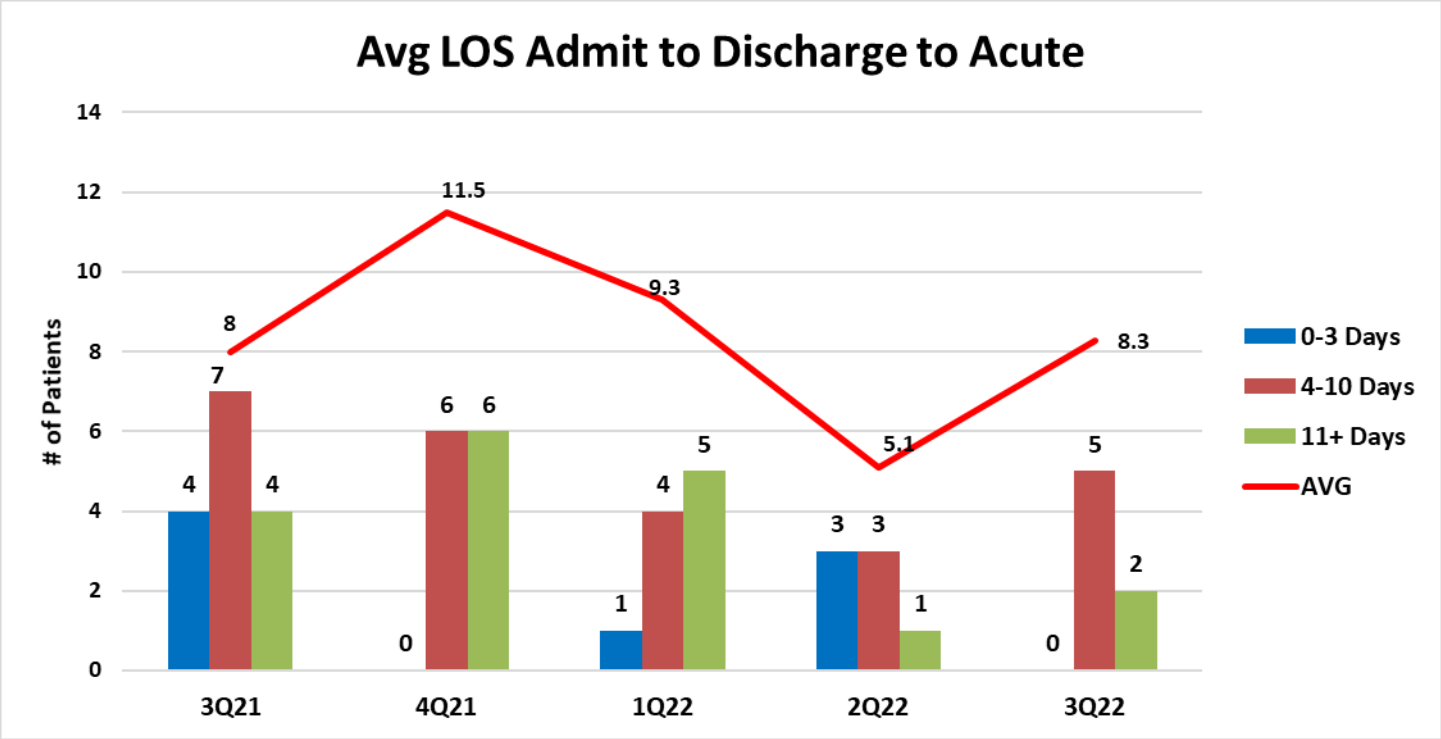
<u>If improvement opportunities identified, provide action plan and expected resolution date:</u>
Clinical outcomes continue to be strong, compared to the nation.

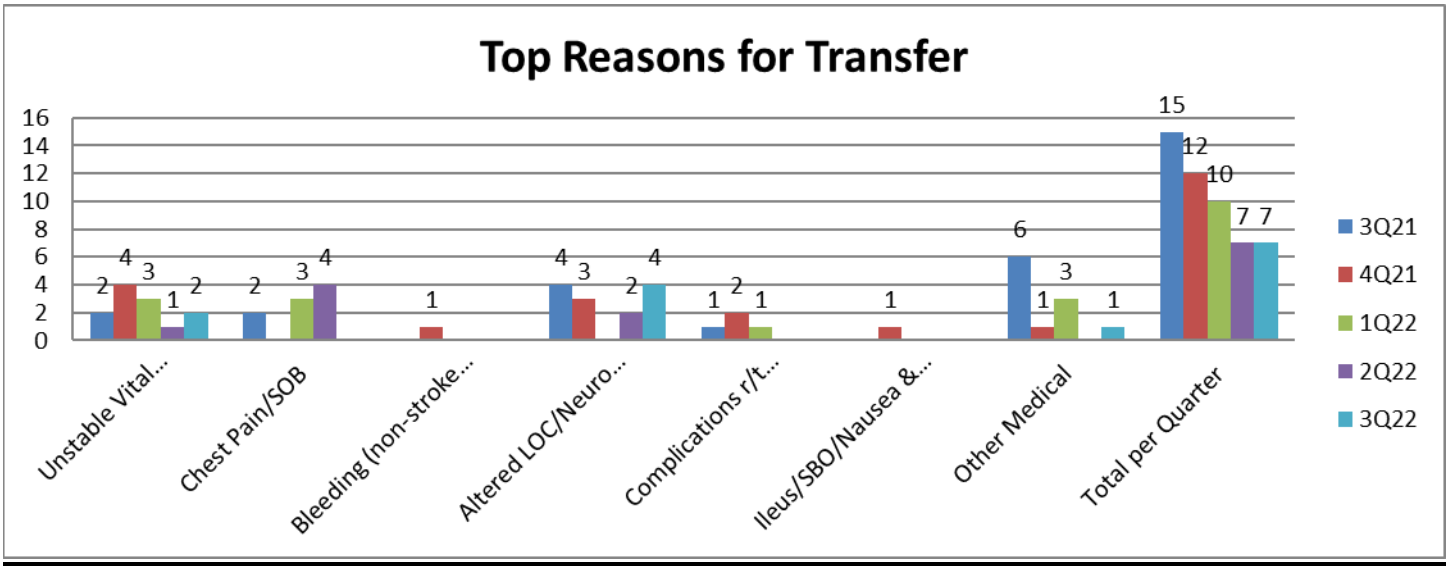
Transfer of Care
<u>Analysis of all measures/data: (Include key findings, improvements, opportunities)</u>
Discharged to Acute – (lower is better) In 2Q22, KH Rehab patients discharging back to the Acute Medical Center was 6%, below the national average of 7% and 3Q22, we continued to be better than the nation at 6% versus the nation at 8%. The decline is associated with having a different complexity of patients. The Case Mix Index for KH closer to nation for improved comparison.

Average LOS Prior to Discharge to Acute – In 2Q22, the avg. number of days from Rehab admission to transfer to Medical Center was 5.1 days and 3Q22 8.3 days. In 2Q22, 3 patients were transferred back to acute in first 3 days but in 3Q22 there were 0 as patients were appropriate at the time of admission to Acute Rehab (AR).

Top Reasons for Transfer - In both 2Q22 and 3Q22, 7 patients transferred back to the Acute Medical Center, demonstrating a continued positive downtrend in re-admissions. "Altered LOC/Neuro changes" continued to be one of the main reasons for transfers out which will likely continue given NIHSS protocol consistent with NIHSS protocol resulting in early intervention for suspected worsening/new strokes. In addition, “chest pain/SOB” had a slight spike. Will monitor next quarter to see if it was an anomaly. Otherwise, all appropriate transfers due to diagnosis and treatment plans.







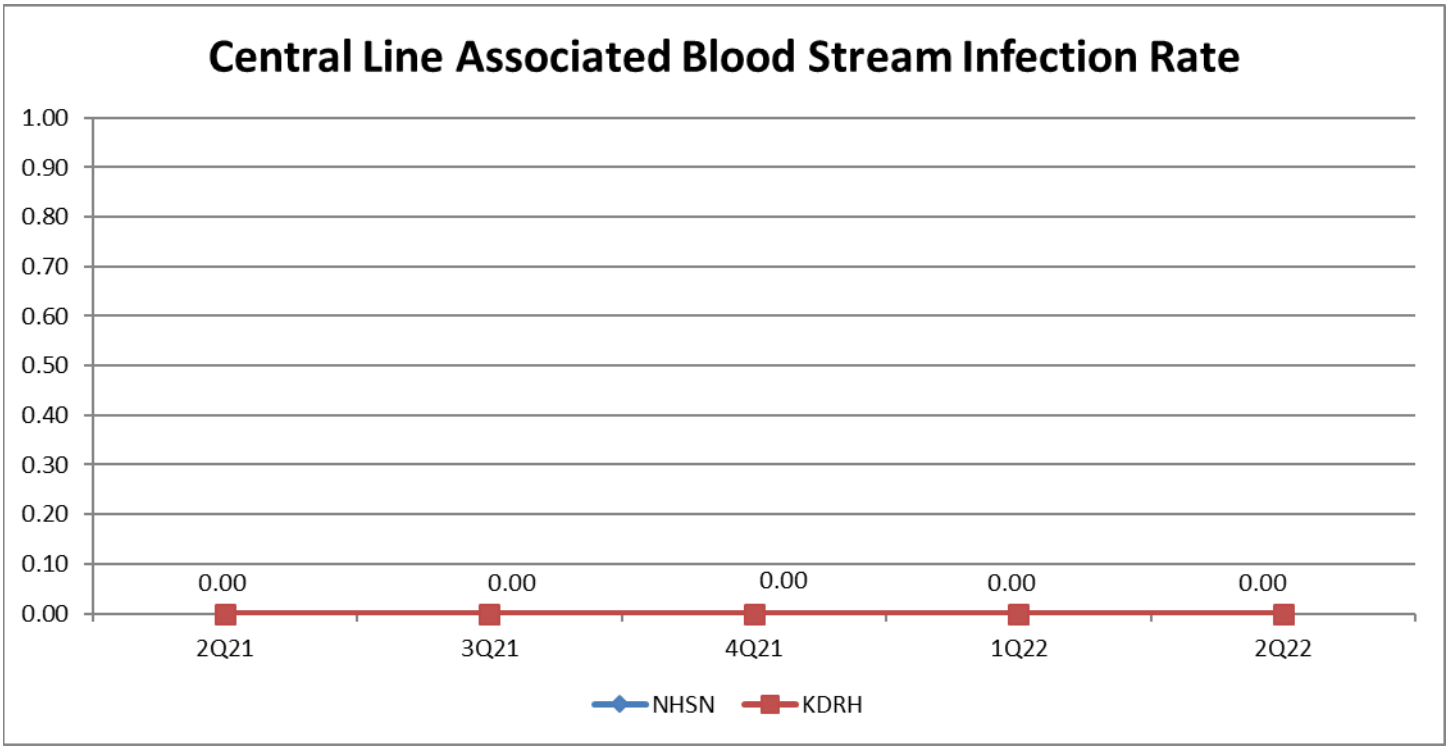
If improvement opportunities identified, provide action plan and expected resolution date:

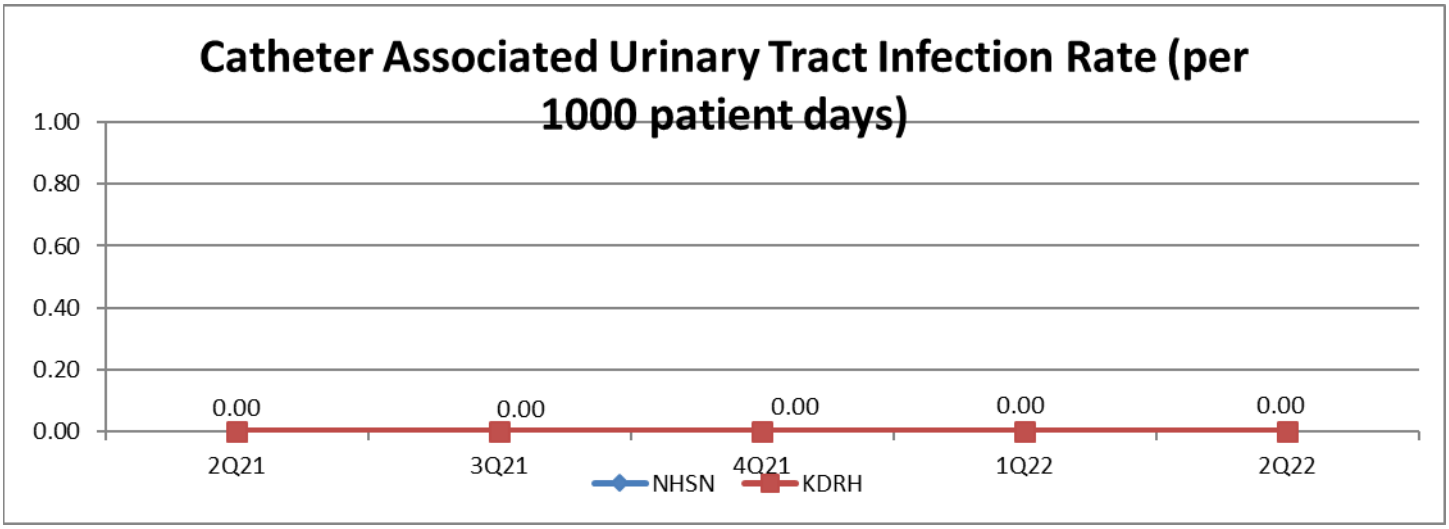
Monitor closely “chest pain/SOB”. Work with Case Management and ED to facilitate possibly return before the 3 day interruption of stay expires including review any changes in condition and determine if the patient is still appropriate for Acute Rehab.

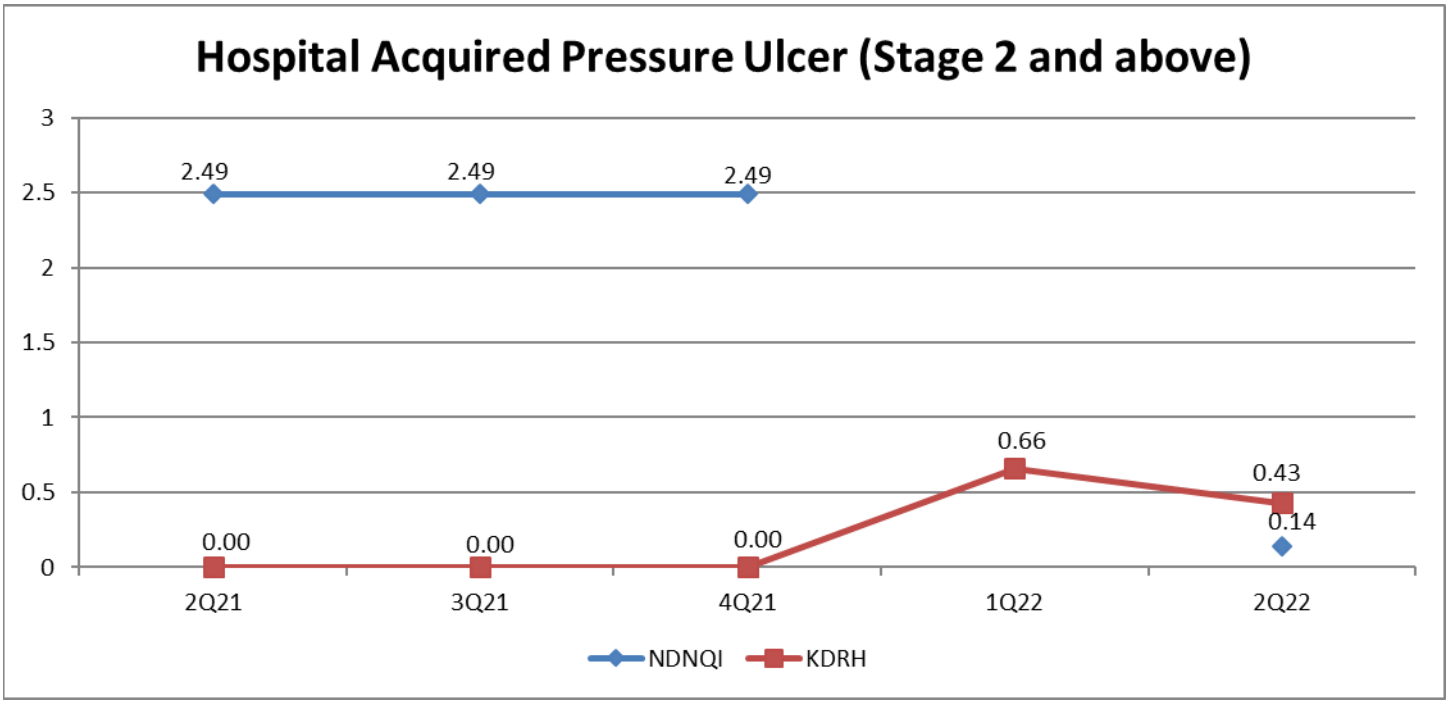
Measure Objective/Goal:
Nursing indicators relative to NDNQI

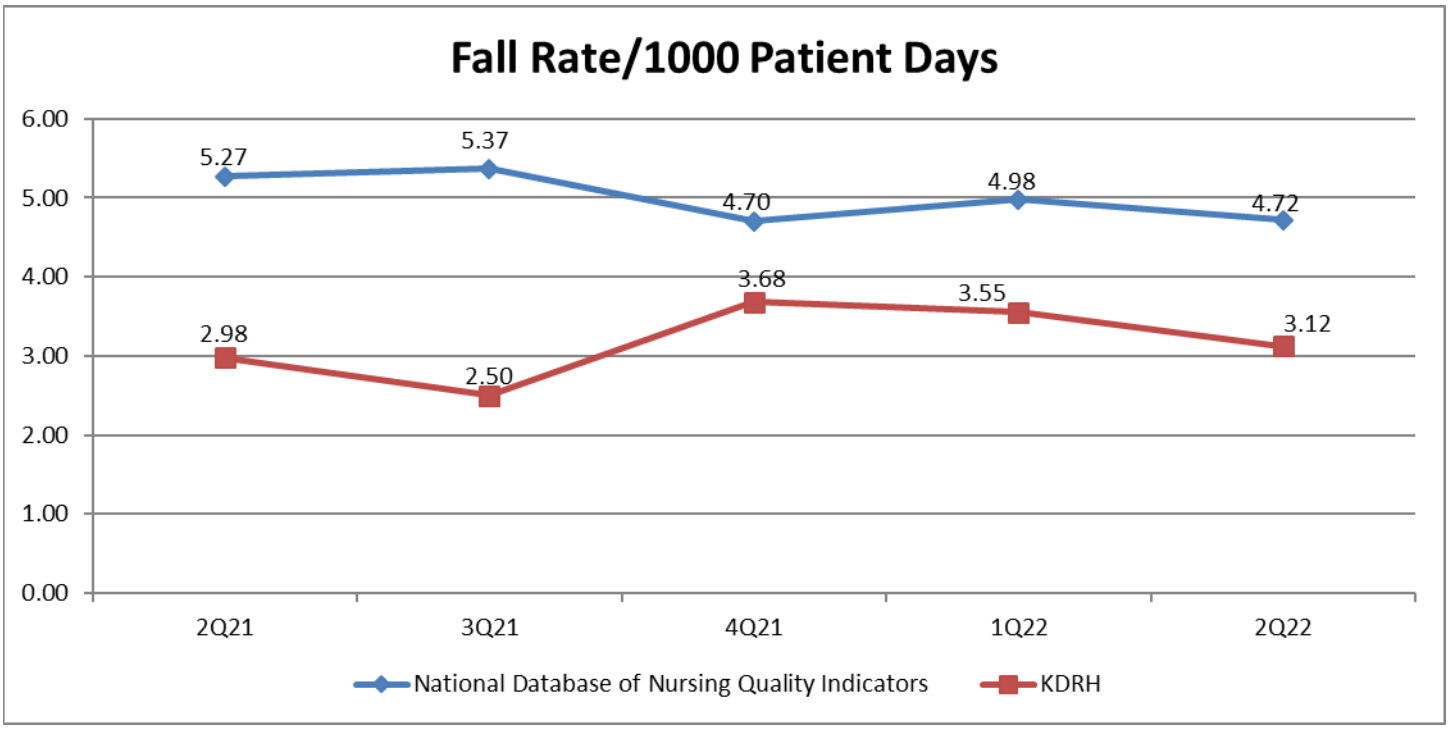
Date range of data evaluated: 1st and 2nd quarter 2022

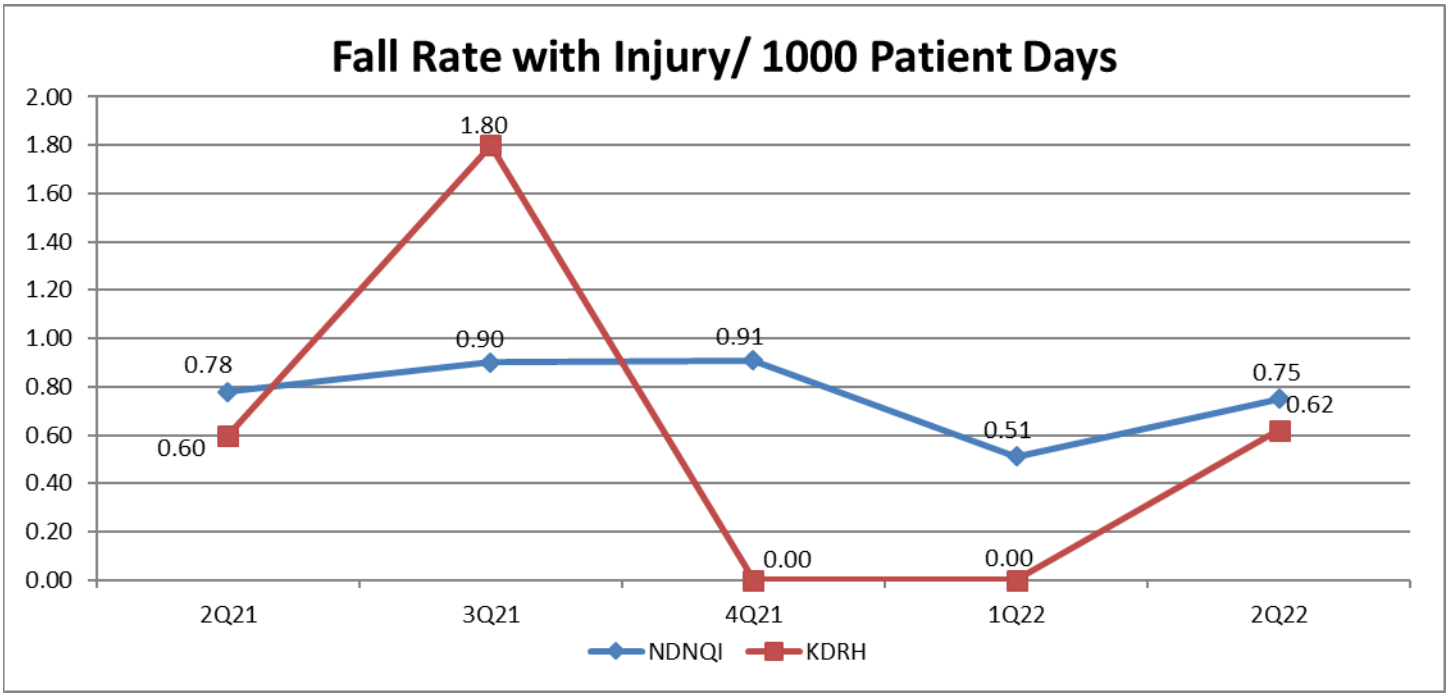
Analysis of all measures/data: (Include key findings, improvements, opportunities)
Kaweah Delta Rehab had zero incidence of central line blood stream infections and CAUTI. Hospital acquired pressure ulcer stage II or above for 1Q22 0.66 and 2Q22 was 0.43. Fall rate per 1000 patient days and fall rate with injury/1000 patient days were below NDNQI benchmarks in 1Q22 and 2Q22.






Hospital Acquired Pressure Ulcer (Stage 2 and above)
3
2.5
2
1.5
1
0.5
0
2.49
2.49
2.49
0.00
0.00
0.00
0.66
0.43
0.14
2Q21
3Q21
4Q21
1Q22
2Q22
NDNQI
KDRH


Fall Rate/1000 Patient Days
6.00
5.00
4.00
3.00
2.00
1.00
0.00
5.27
5.37
4.70
4.98
4.72
2.98
2.50
3.68
3.55
3.12
2Q21
3Q21
4Q21
1Q22
2Q22
National Database of Nursing Quality Indicators
KDRH



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

Measure Objective/Goal: Hand Hygiene compliance

Date range of data evaluated: 1st and 2nd quarter 2022

Analysis of all measures/data: (Include key findings, improvements, opportunities)
1Q22 and 2Q22 hand hygiene in OT, PT, Rehab Nursing and Wound Clinic have all consistently exceeded KH wide goal of 95%.

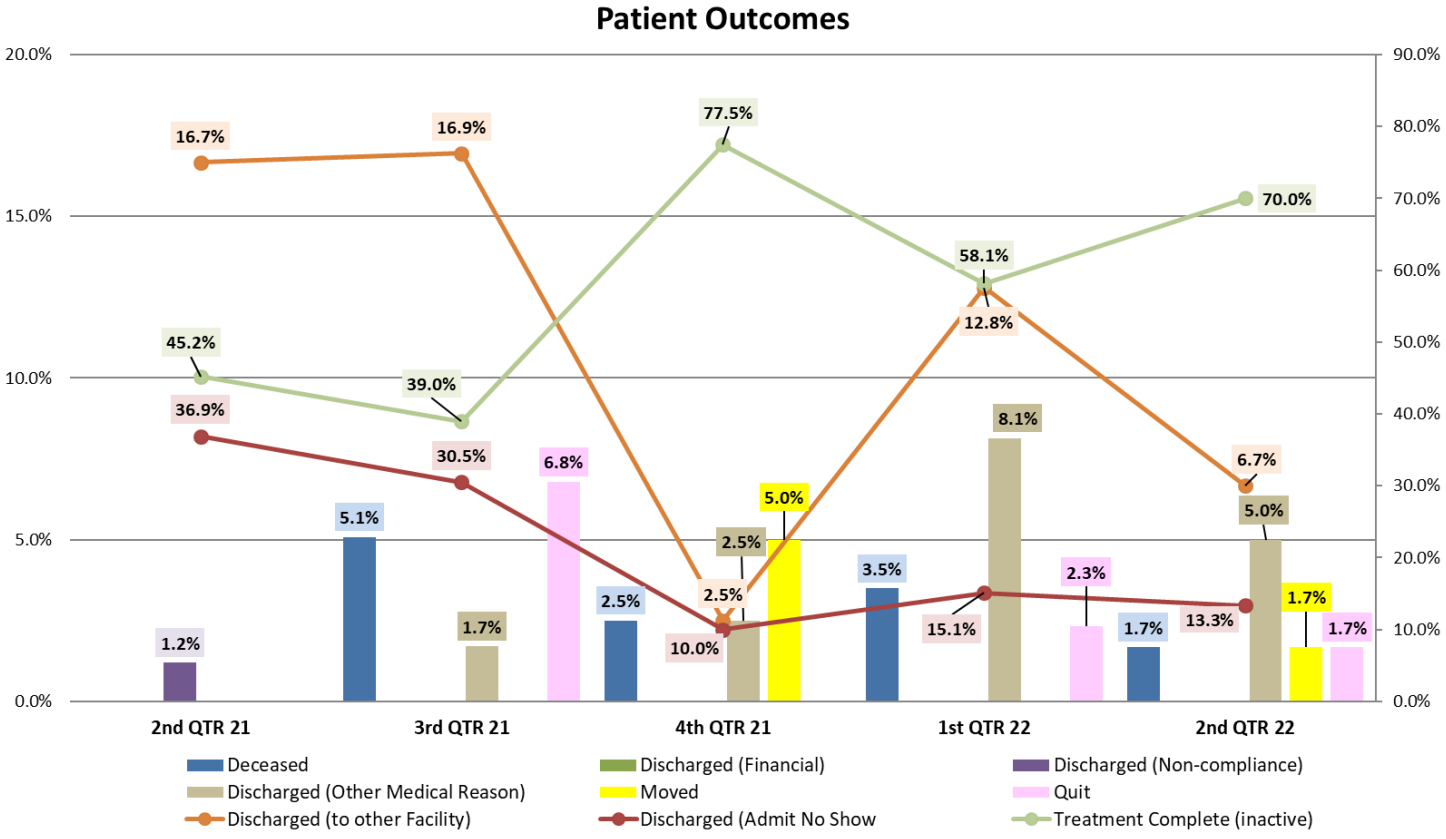
If improvement opportunities identified, provide action plan and expected resolution date:
Improve compliance with utilizing Biovigil on West campus.

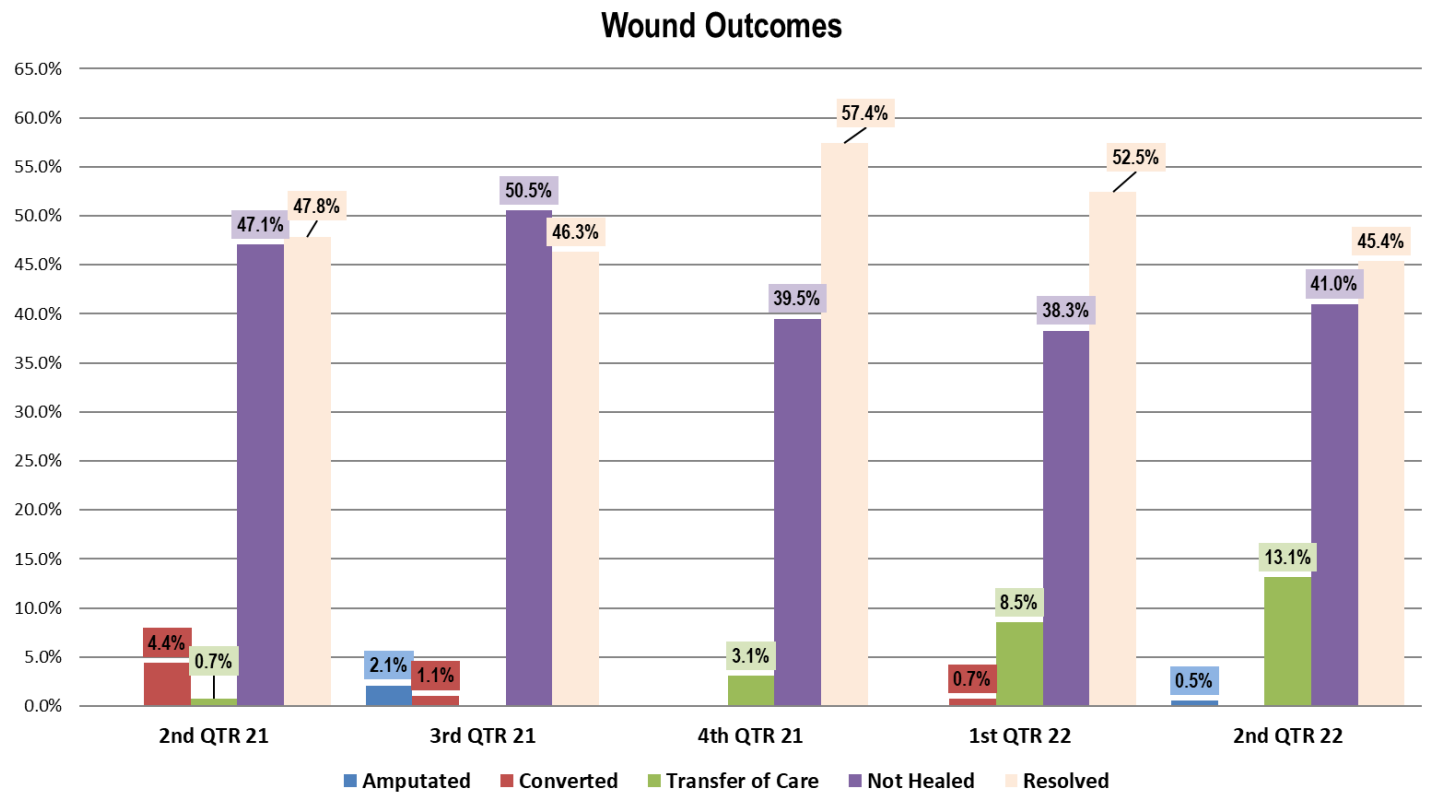
Measure Objective/Goal: Wound Center outcomes

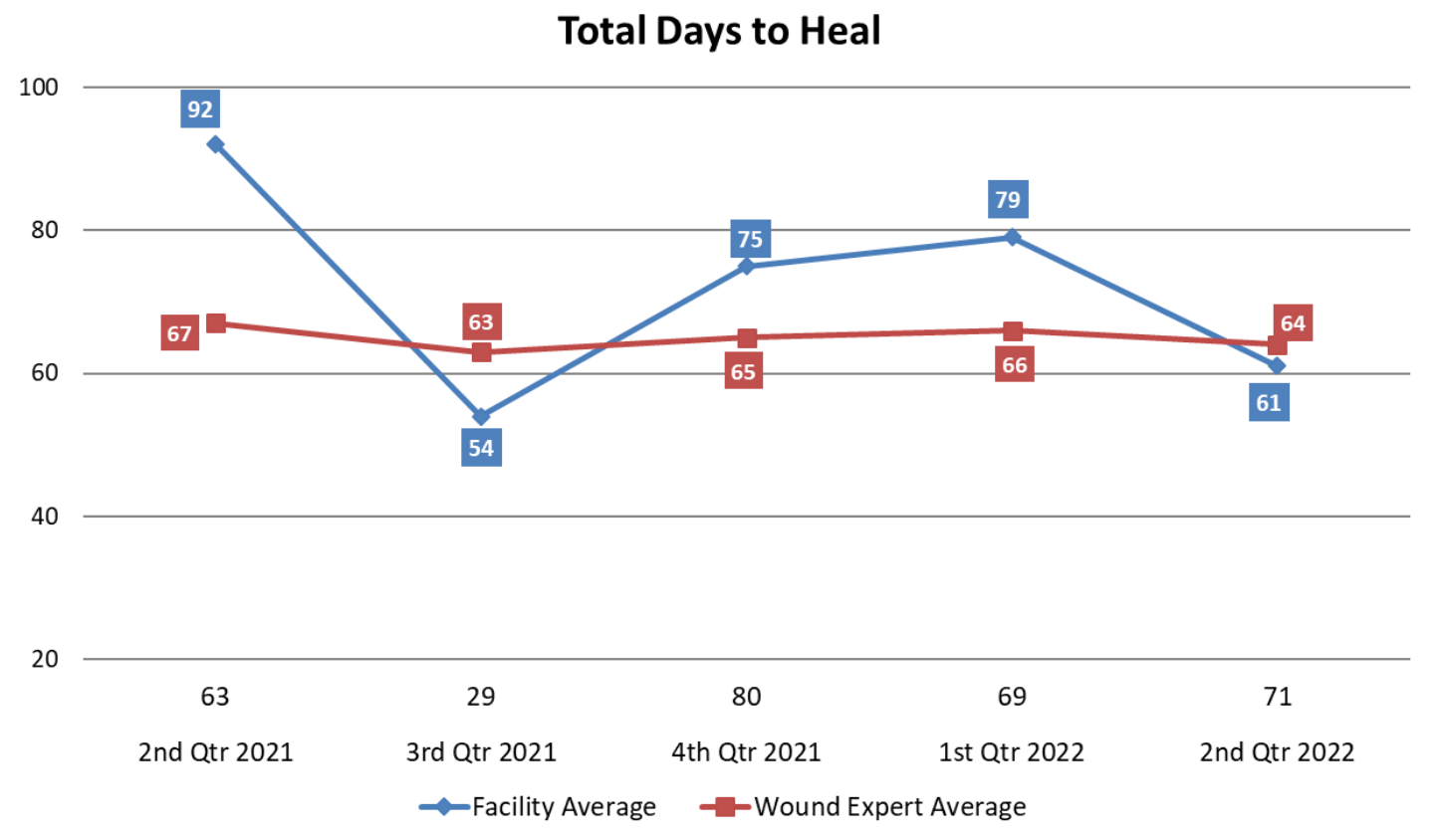
Date range of data evaluated: 1st and 2nd quarter 2022

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

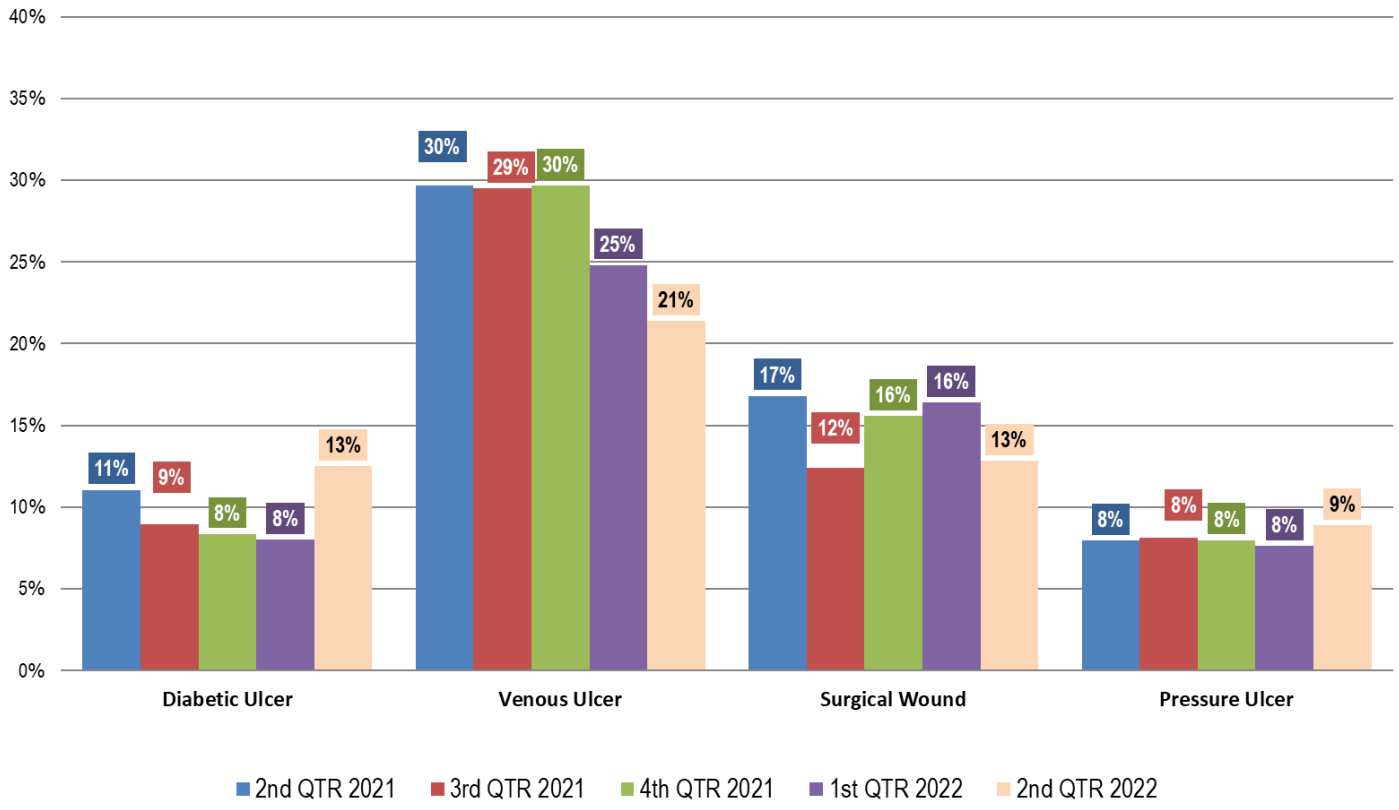
All wound outcomes, 70% of the wound center patient's complete treatment up 12% from 1Q22 to 2Q22. Data for the 2nd quarter of 2022, April through June reveals we are performing 3 days under compared Wound Expert Center's average on "days to heal". We averaged 61 days compared to 64 the wound expert average. We have 72 wounds included comparing to 78998 wounds. Diabetic Ulcers (16 total wound): Kaweah Wound Center Average Days to heal 49 compared to 84 with Wound Expert Facility Average. This is 50% better than last quarter. Pressure Ulcers (4 wounds): Kaweah Wound Center Average Days to heal 102 compared to 64 with Wound Expert Facility Average. Surgical Wounds (17 wounds): Kaweah Wound Center Average Days to heal 64 compared to 7 with Wound Expert Facility Average. Venous Stasis Ulcers (29 Wounds: Kaweah Wound Center Average Days to heal 118 compared to 67 with Wound Expert Facility Average. One patient took over 1,000 days to heal. The number of patients at the wound center continues rise for 1Q22 and 2Q22 thanks to the FNP working 3 days a week. A full time FNP has now been hired. We expect a continued increase in wounds and wound outcomes. HBO was down secondary to not having a certified provider to supervise patients. The new FNP has under gone training and certification.



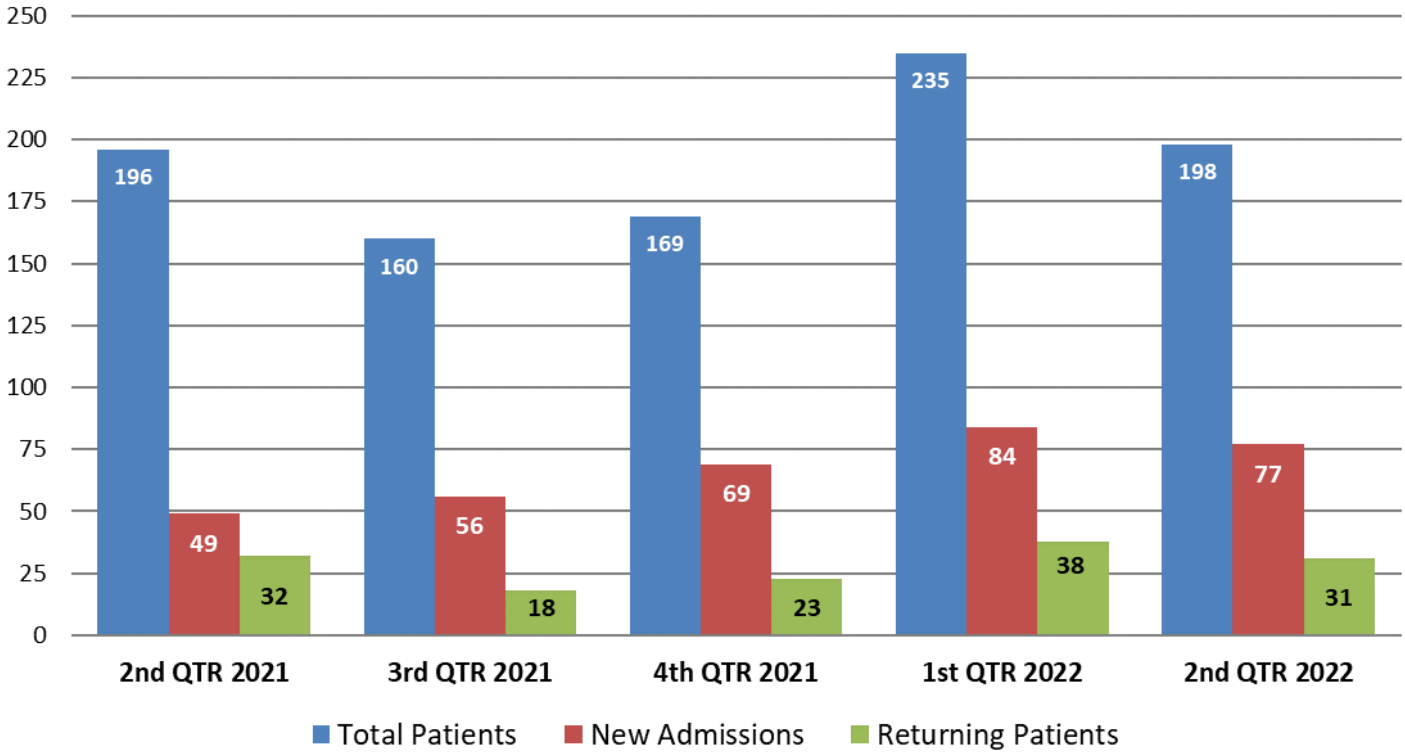

Wound Outcomes
65.0%
60.0%
55.0%
50.0%
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
4.4%
0.7%
47.1%
47.8%
2.1%
1.1%
50.5%
46.3%
3.1%
39.5%
57.4%
0.7%
8.5%
38.3%
52.5%
0.5%
13.1%
41.0%
45.4%
2nd QTR 21
3rd QTR 21
4th QTR 21
1st QTR 22
2nd QTR 22
Amputated
Converted
Transfer of Care
Not Healed
Resolved

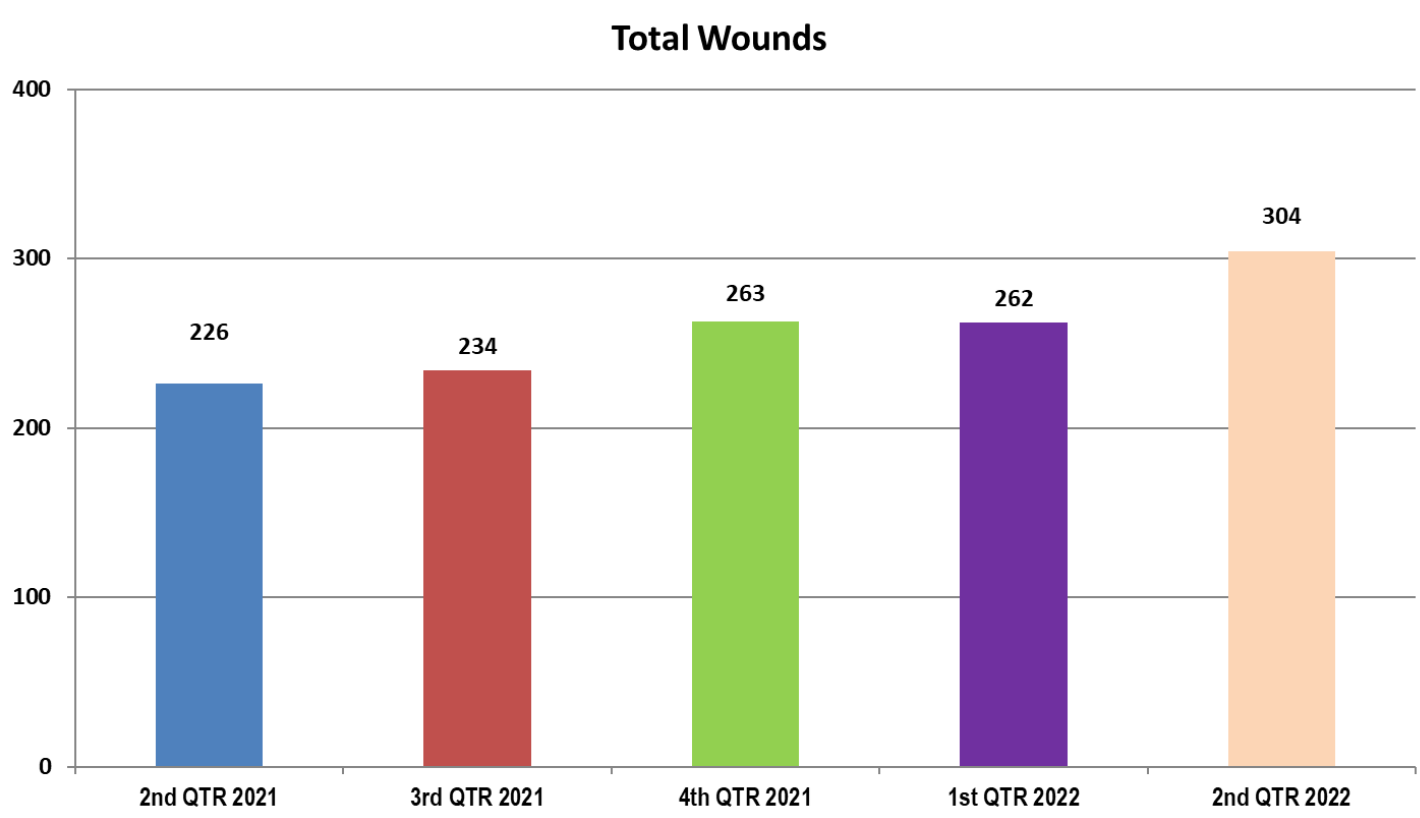

Total Days to Heal
100
80
60
40
20
92
54
75
79
61
67
63
65
66
64
63
29
80
69
71
2nd Qtr 2021
3rd Qtr 2021
4th Qtr 2021
1st Qtr 2022
2nd Qtr 2022
Facility Average
Wound Expert Average

Treated Wounds



Facility Data





If improvement opportunities identified, provide action plan and expected resolution date:
3rd and 4th quarter: Focus on how to heal venous stasis ulcers, identify treatments, which are making improvements. Implement monthly discussion of patient not healing. Focus on Documentation. Wound labeling, and identifying as well as resolving or discharging patients efficiently. Stalled wound meetings with medical director to address wounds that have not healed in 100 days. Implement screenings to identify patients that need additional interventions. Look at education to patient and continue to develop resources for patients.

Submitted by Name: Molly Niederreiter **Date Submitted:** Nov 14 2022

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Outpatient Therapies (7799, 7800, 7803, 7804, 7806, 7807)

ProStaff Report Date: 11/14/22

Measure Objective/Goal: The outpatient therapy departments objectively measure function by using specific functional outcome measures consistently throughout the episode of a patients' care. Measuring outcomes of care, including body functions and activity completion, among patients with similar diagnosis is the foundation for determining which intervention approaches comprise best clinical practice. The goal of this data collection is to look at how each clinic is performing with regards to improving function in patients in each of the outpatient settings. With this data, we are able to identify trends and areas for improvement when providing care to specific body regions. There are 5 different outcome measures utilized pending the body region that is being evaluated. Those measures consist of one for arm impairments, one for leg impairments, one for neck impairments, one for back impairments, and one for neurological impairments (such as after stroke or brain injury).

Functional Outcome Measure Questionnaires, which list a number of daily activities and require patients to scale how easy or difficult it is to complete those activities based on their condition, are completed by patients prior to initiating therapy, at regular intervals during therapy, and upon discharge.

Date range of data evaluated: Quarterly data beginning July 2021 thru Sept 2022

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) Dinuba Therapy Specialists:
   - Is meeting goals for all outcome measures (Upper Extremity, Lower Extremity, Back, and Neck).
   - Steady improvement over last 3 quarters with Upper Extremity Scores.
   - Steady improvement in outcome measures for Back over the past year.

2) Exeter Therapy Specialists:
   - Meeting goals for Lower Extremity, Back, and Neck.
   - Under goals for Upper Extremity
   - Trending downward over the past 3 quarters with outcome measures for the Lower Extremity, but overall improved from same quarter of last year.
   - Much improved outcome measures for Back from previous quarter

3) Loves Lane Therapy Specialists:
   - Is meeting goals for all outcome measures (Upper Extremity, Lower Extremity, Back, and Neck).

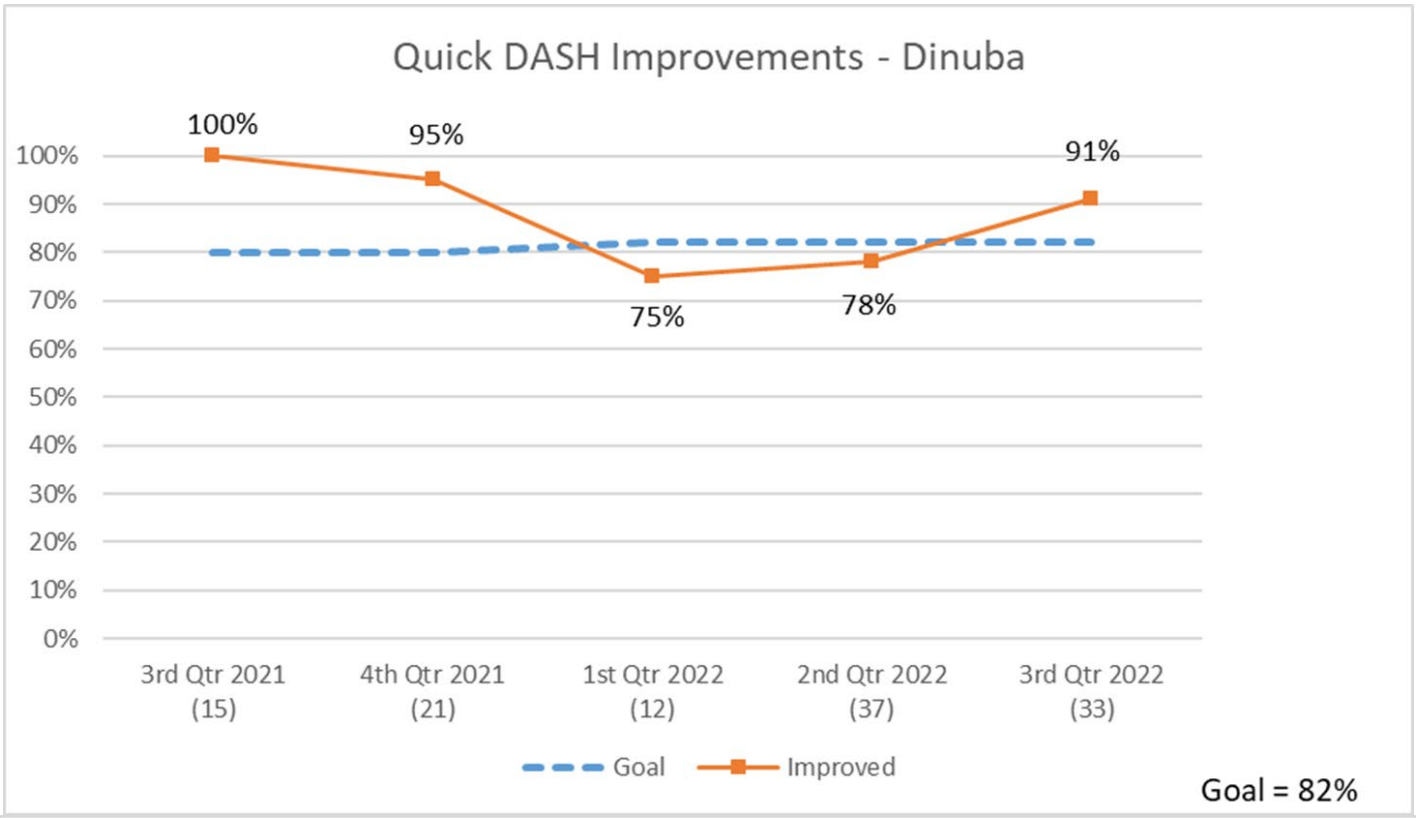
4) Therapy Specialists at Akers:
   - Meeting goals for outcome measures for Back and Lower Extremity.
   - Just under goals for outcome measures for Upper Extremity in both PT and OT
   - Steady downward trend over last 3 quarters for outcome measures involving the Neck.

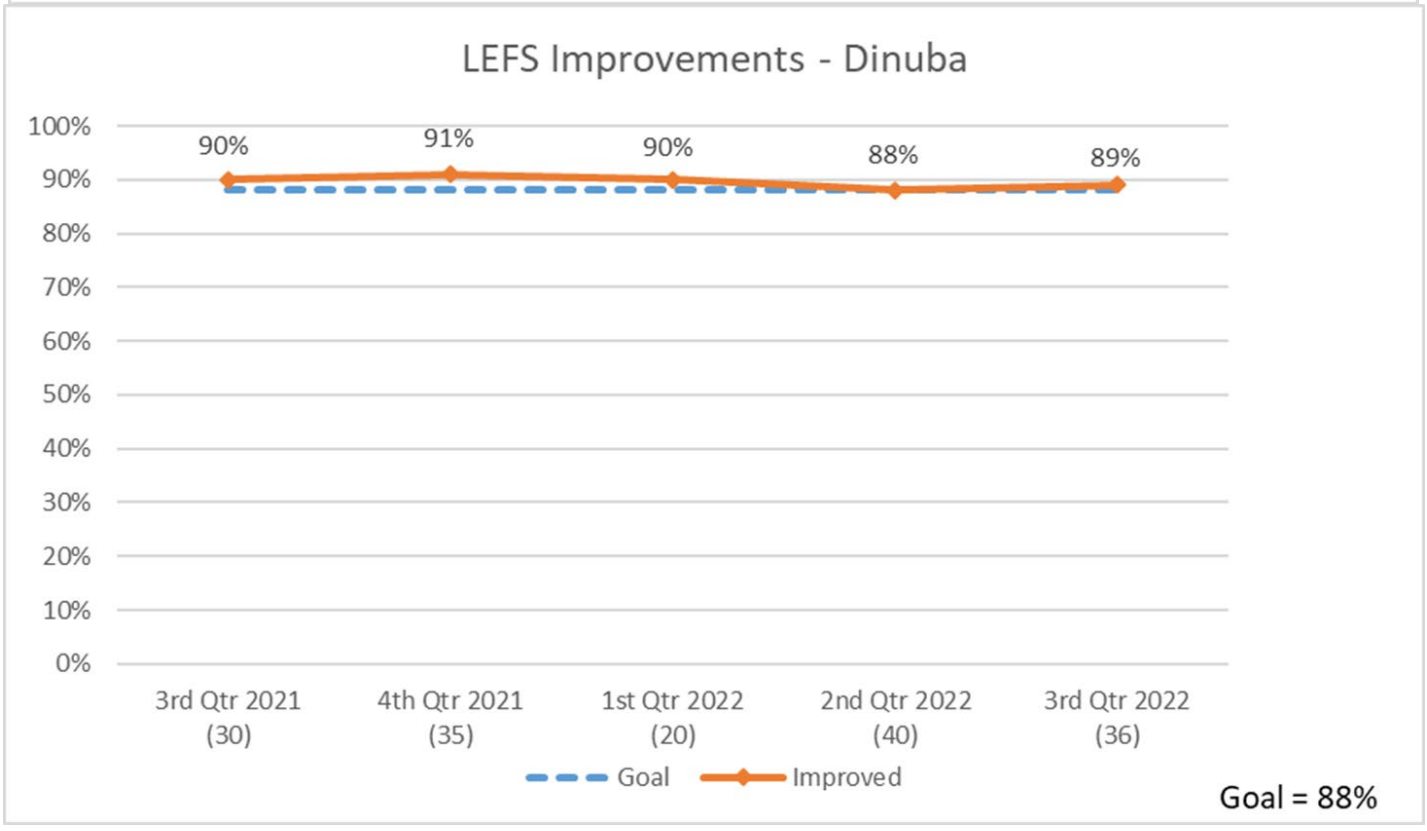
5) Therapy Specialists at Neuro clinic:
   - Is not meeting goal for patient improvements on outcome measure involving neurological disorders
   - Much improved volume of collected outcome measures over the past 2 quarters.

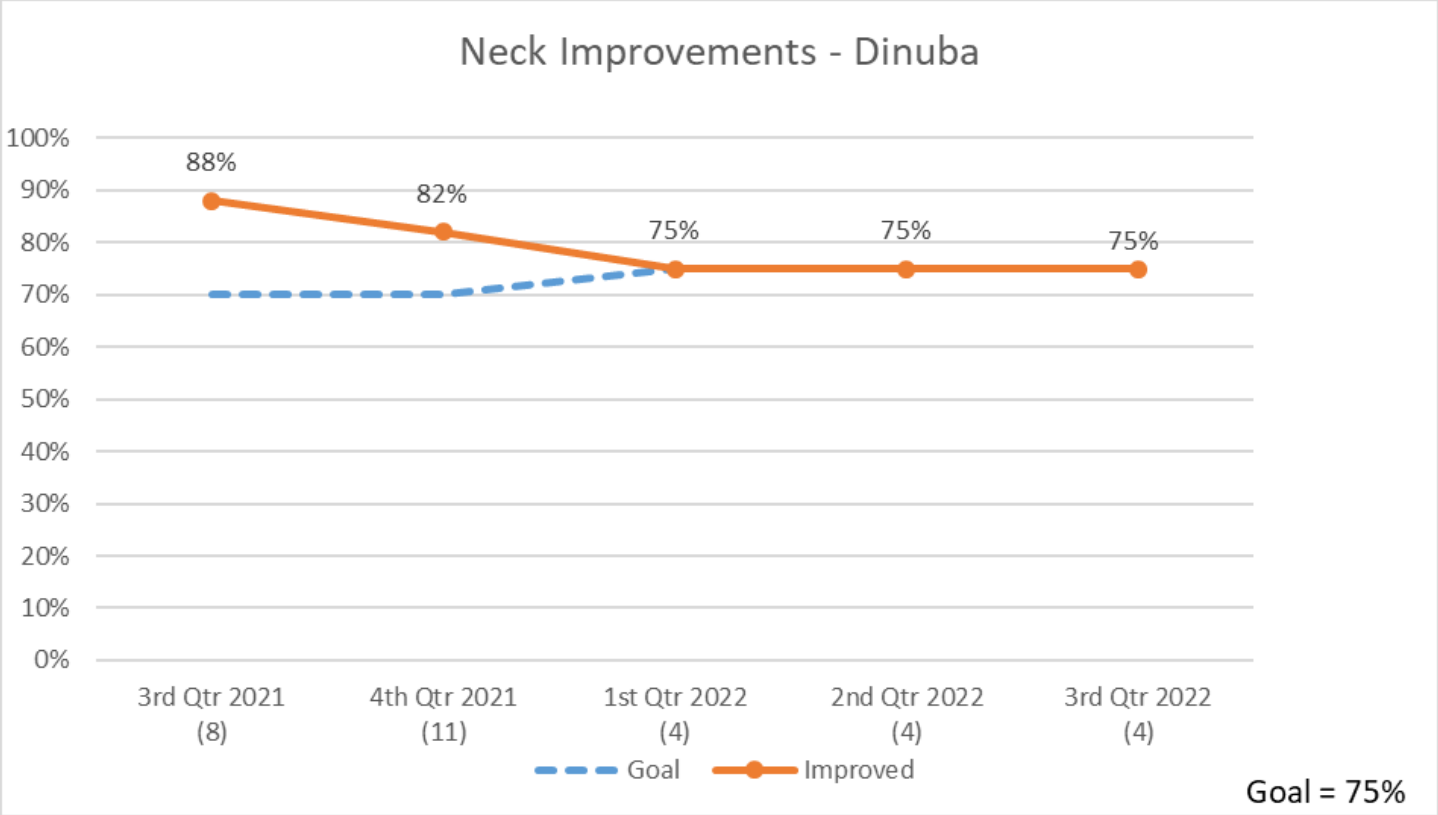
6) Hand Therapy Specialists:
   - Just under meeting outcome measure goals for Upper Extremity

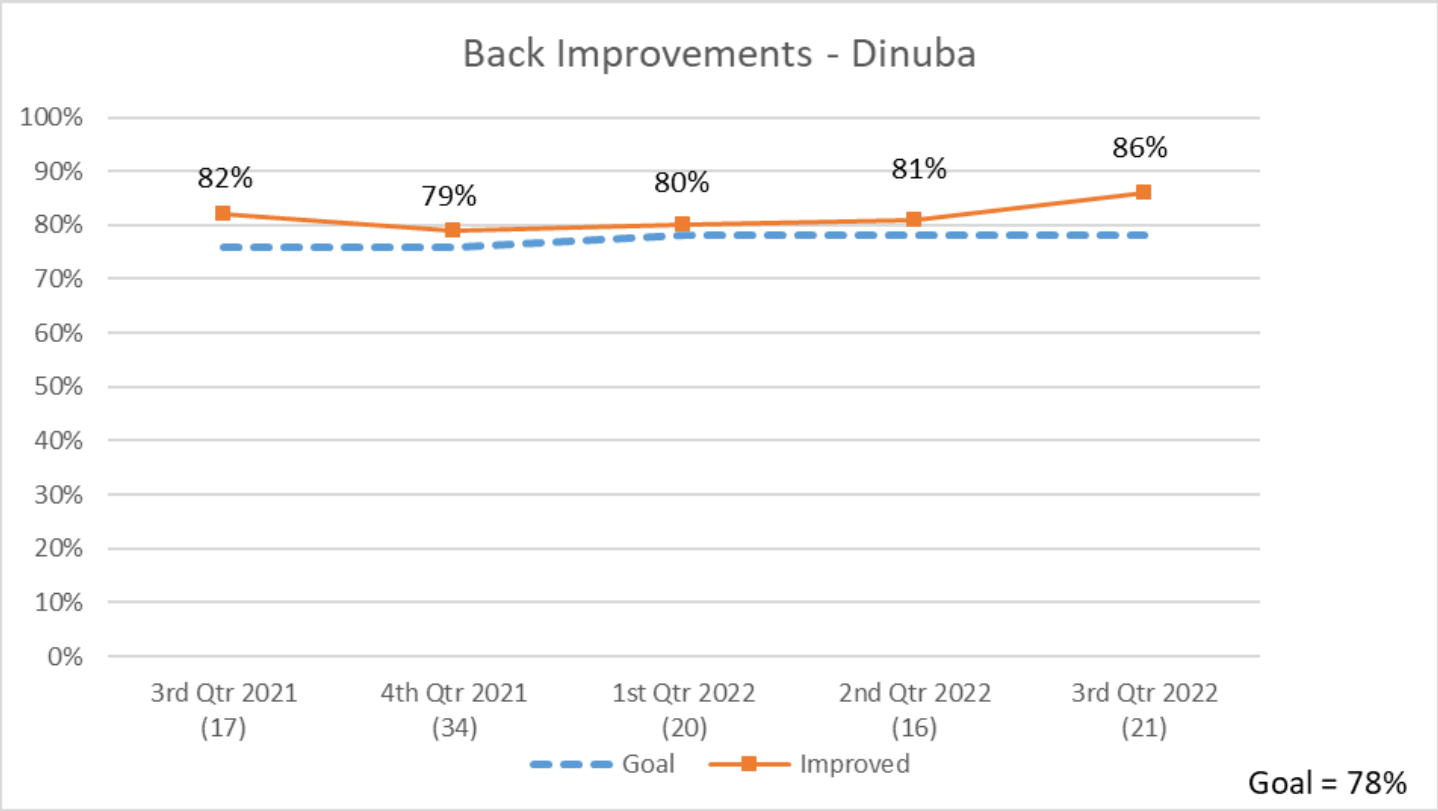
Unit/Department Specific Data Collection Summarization

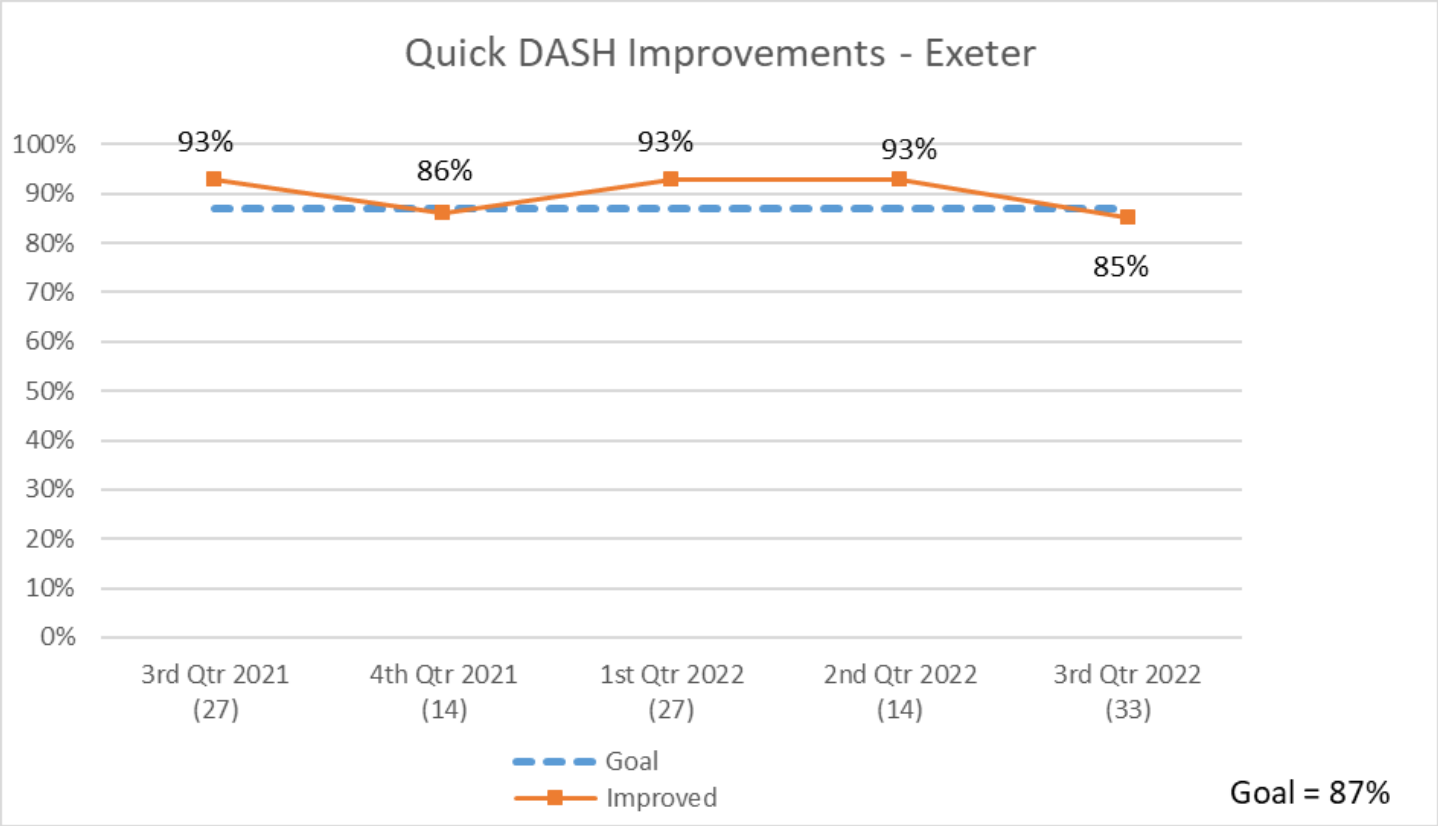
Professional Staff Quality Committee

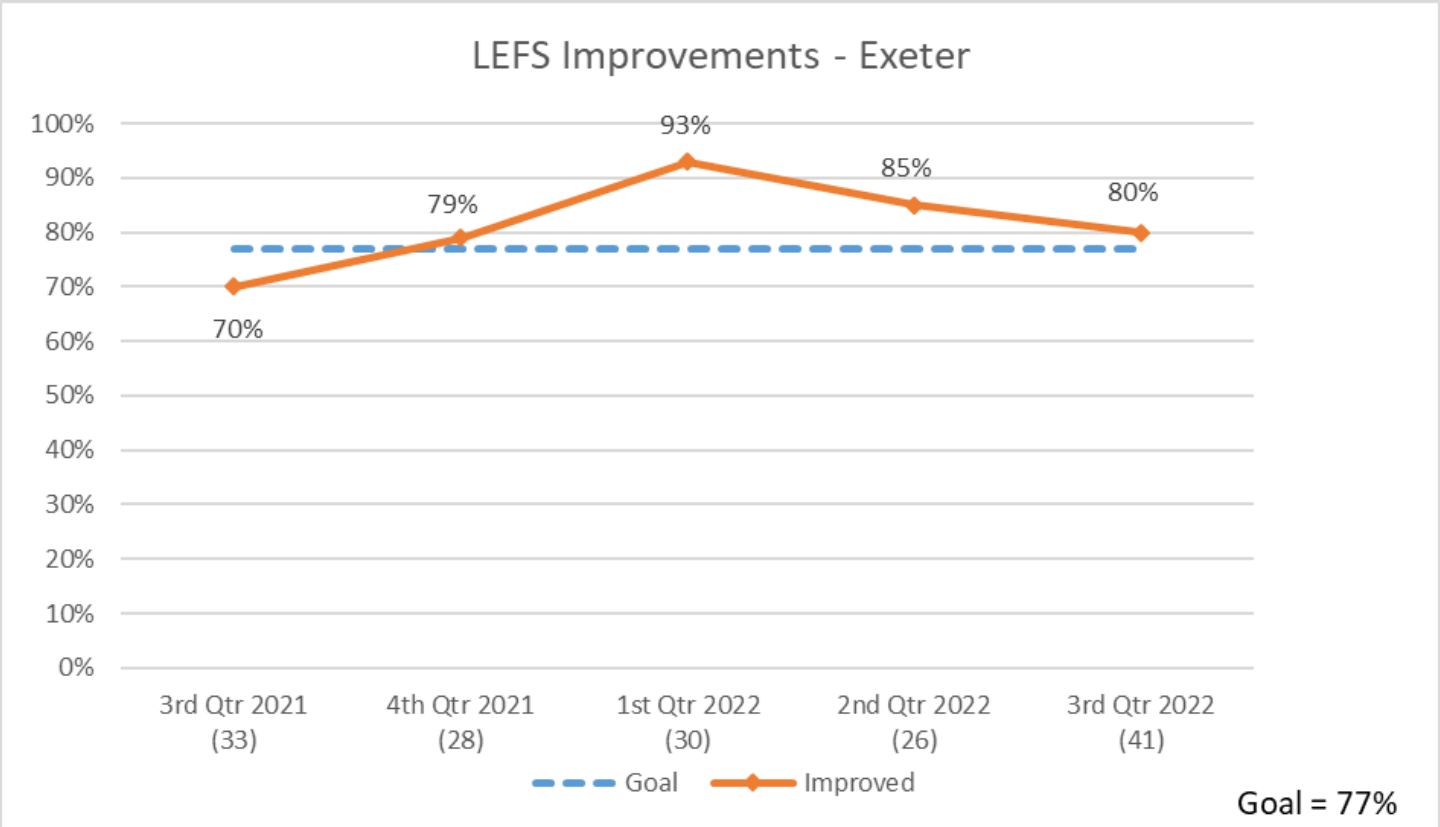


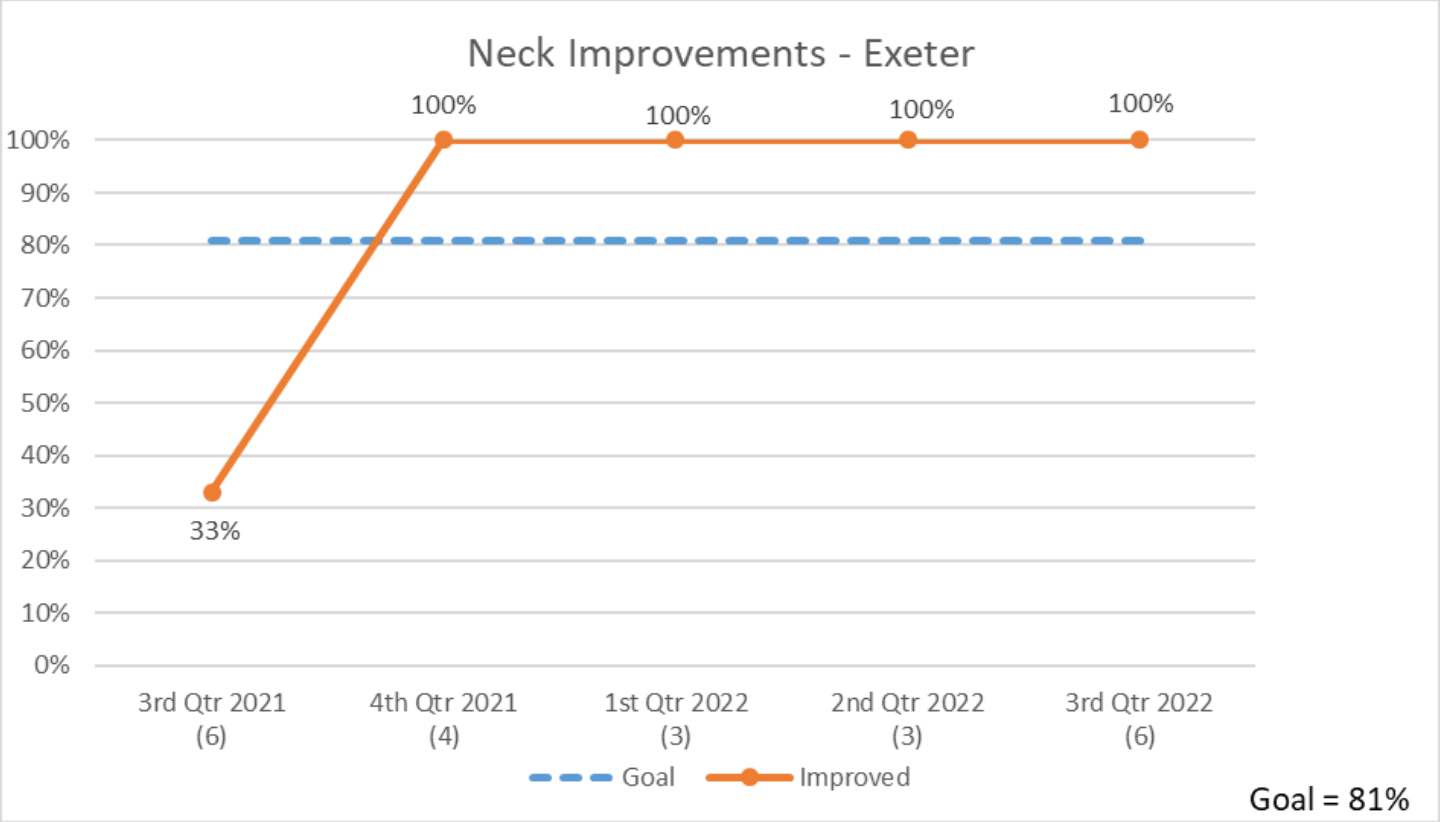


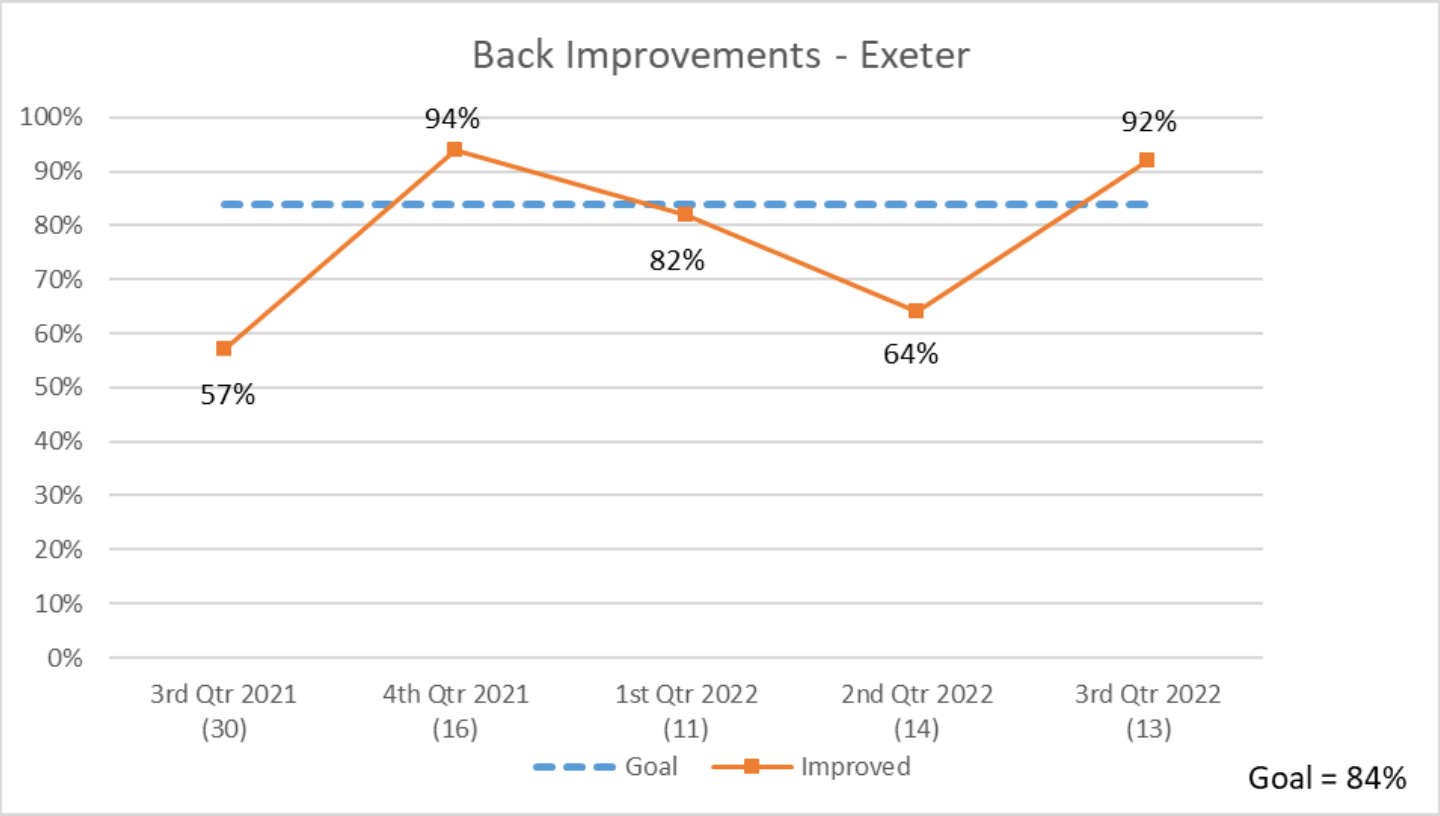

Neck Improvements - Dinuba
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
88%
82%
75%
75%
75%
3rd Qtr 2021 (8)
4th Qtr 2021 (11)
1st Qtr 2022 (4)
2nd Qtr 2022 (4)
3rd Qtr 2022 (4)
Goal
Improved
Goal = 75%

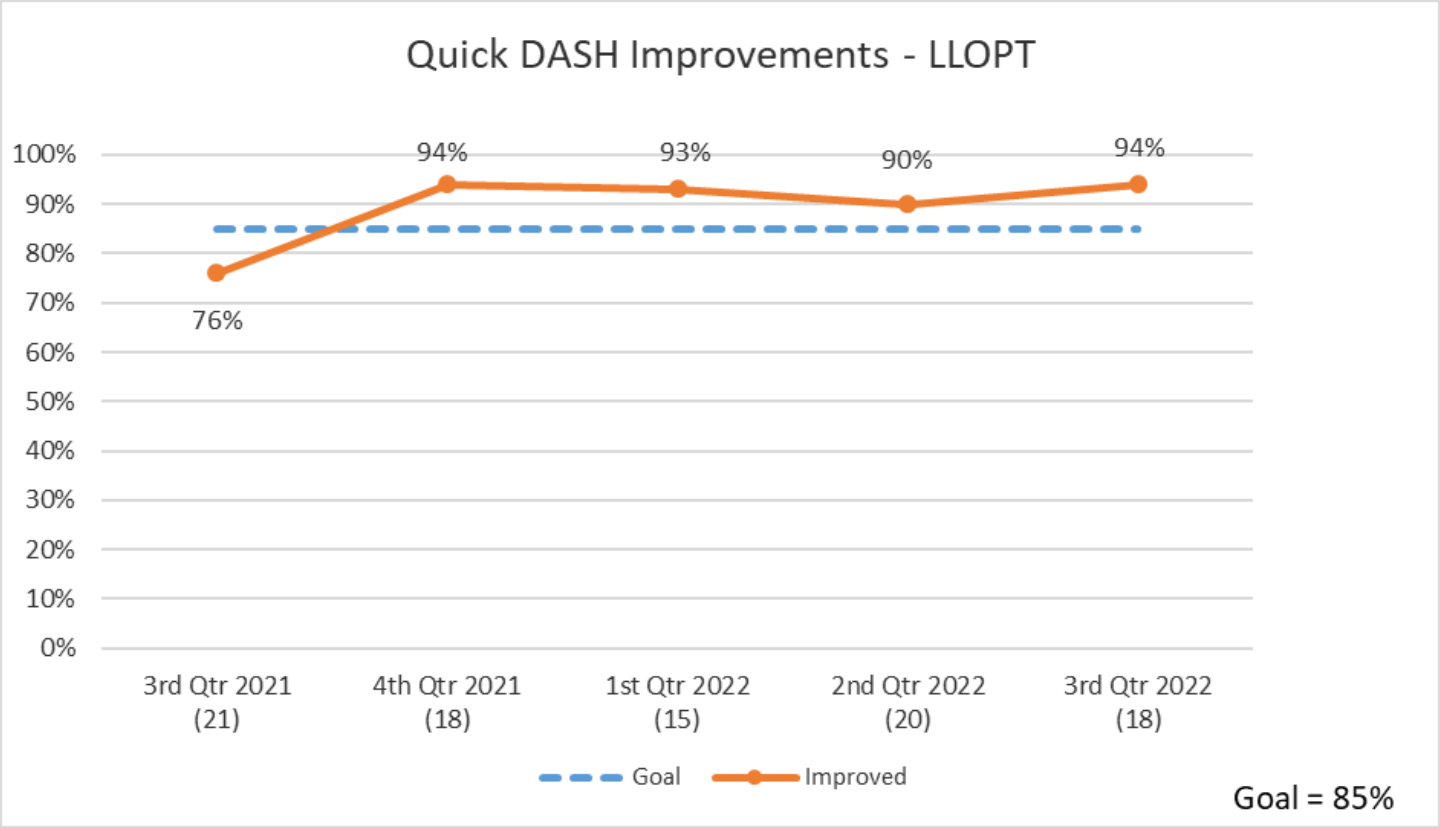

Back Improvements - Dinuba
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
82%
79%
80%
81%
86%
3rd Qtr 2021 (17)
4th Qtr 2021 (34)
1st Qtr 2022 (20)
2nd Qtr 2022 (16)
3rd Qtr 2022 (21)
Goal
Improved
Goal = 78%

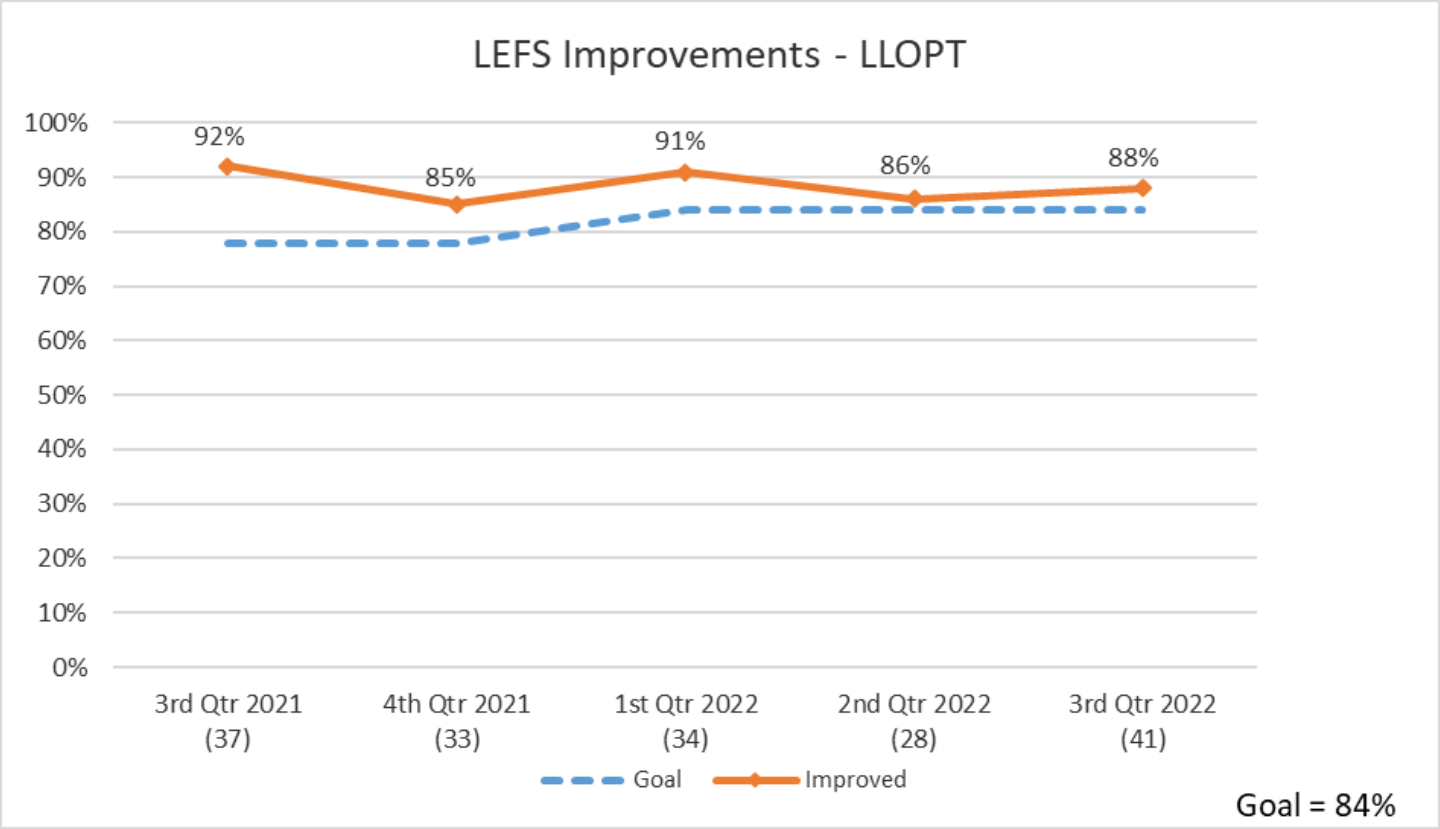

Quick DASH Improvements - Exeter
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
93%
86%
93%
93%
85%
3rd Qtr 2021 (27)
4th Qtr 2021 (14)
1st Qtr 2022 (27)
2nd Qtr 2022 (14)
3rd Qtr 2022 (33)
Goal
Improved
Goal = 87%

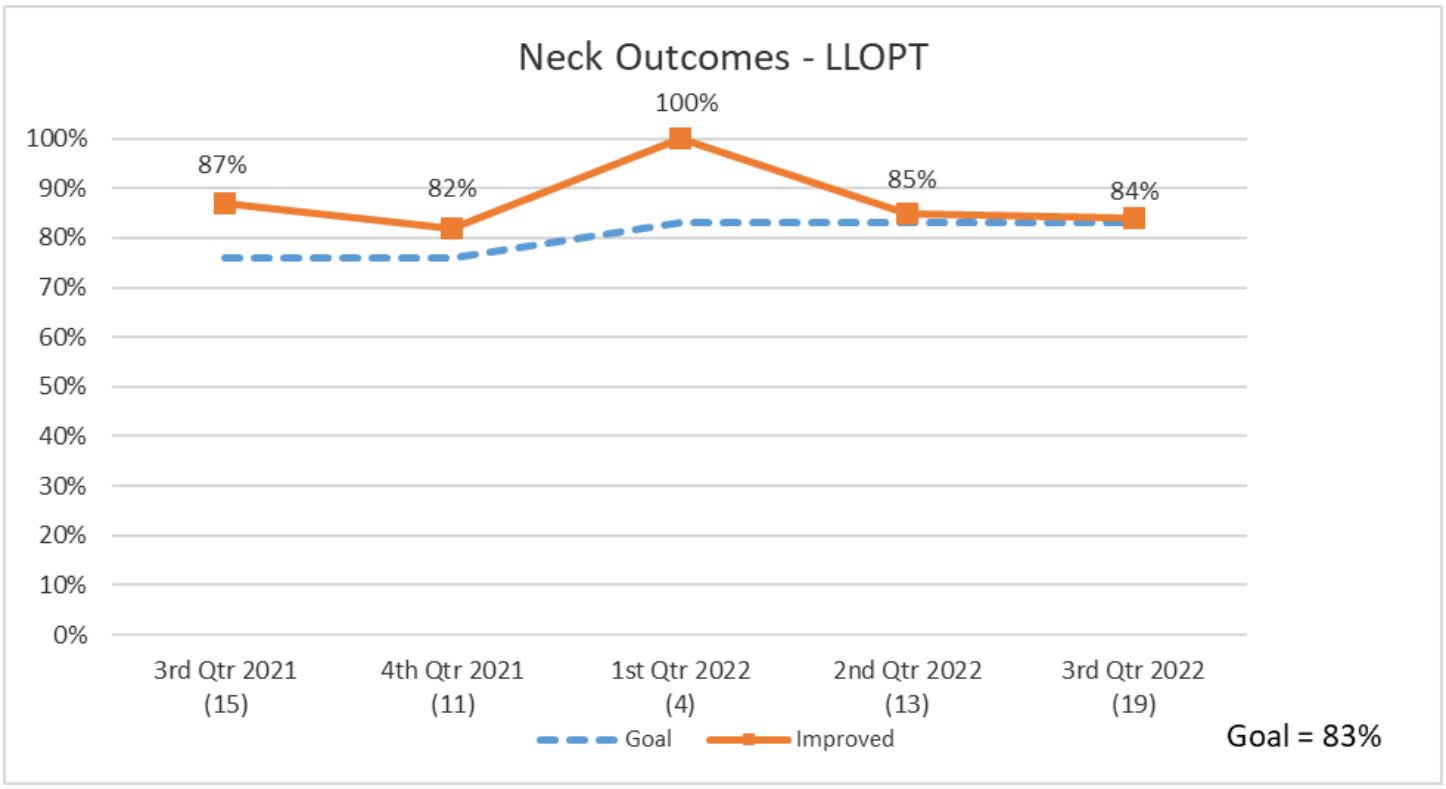

LEFS Improvements - Exeter
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
70%
79%
93%
85%
80%
3rd Qtr 2021 (33)
4th Qtr 2021 (28)
1st Qtr 2022 (30)
2nd Qtr 2022 (26)
3rd Qtr 2022 (41)
Goal
Improved
Goal = 77%

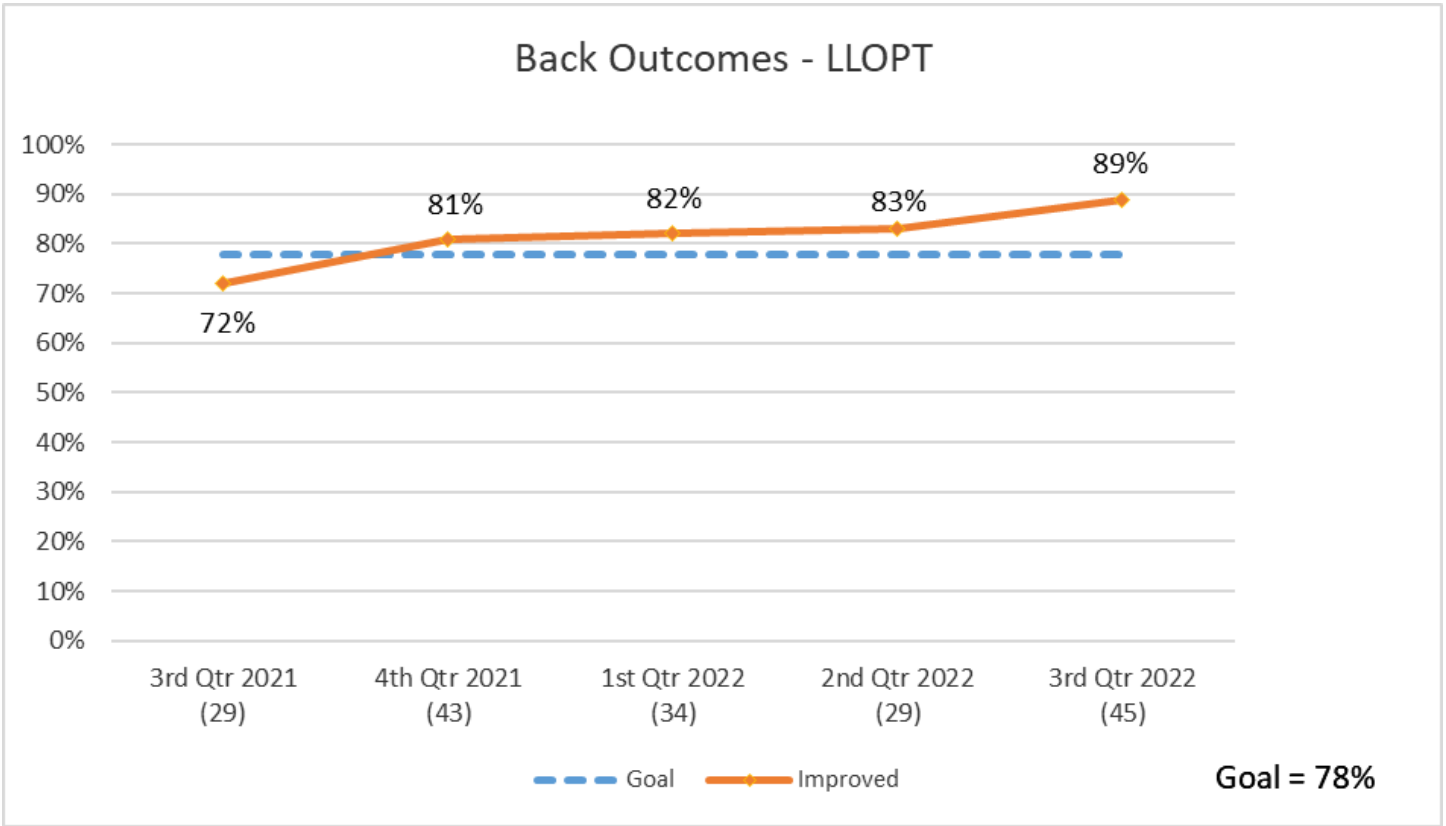

Neck Improvements - Exeter
100%
100%
100%
100%
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
33%
3rd Qtr 2021 (6)
4th Qtr 2021 (4)
1st Qtr 2022 (3)
2nd Qtr 2022 (3)
3rd Qtr 2022 (6)
Goal
Improved
Goal = 81%


Back Improvements - Exeter
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
94%
92%
82%
64%
57%
3rd Qtr 2021 (30)
4th Qtr 2021 (16)
1st Qtr 2022 (11)
2nd Qtr 2022 (14)
3rd Qtr 2022 (13)
Goal
Improved
Goal = 84%


Quick DASH Improvements - LLOPT
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
94%
93%
90%
94%
76%
3rd Qtr 2021 (21)
4th Qtr 2021 (18)
1st Qtr 2022 (15)
2nd Qtr 2022 (20)
3rd Qtr 2022 (18)
Goal
Improved
Goal = 85%

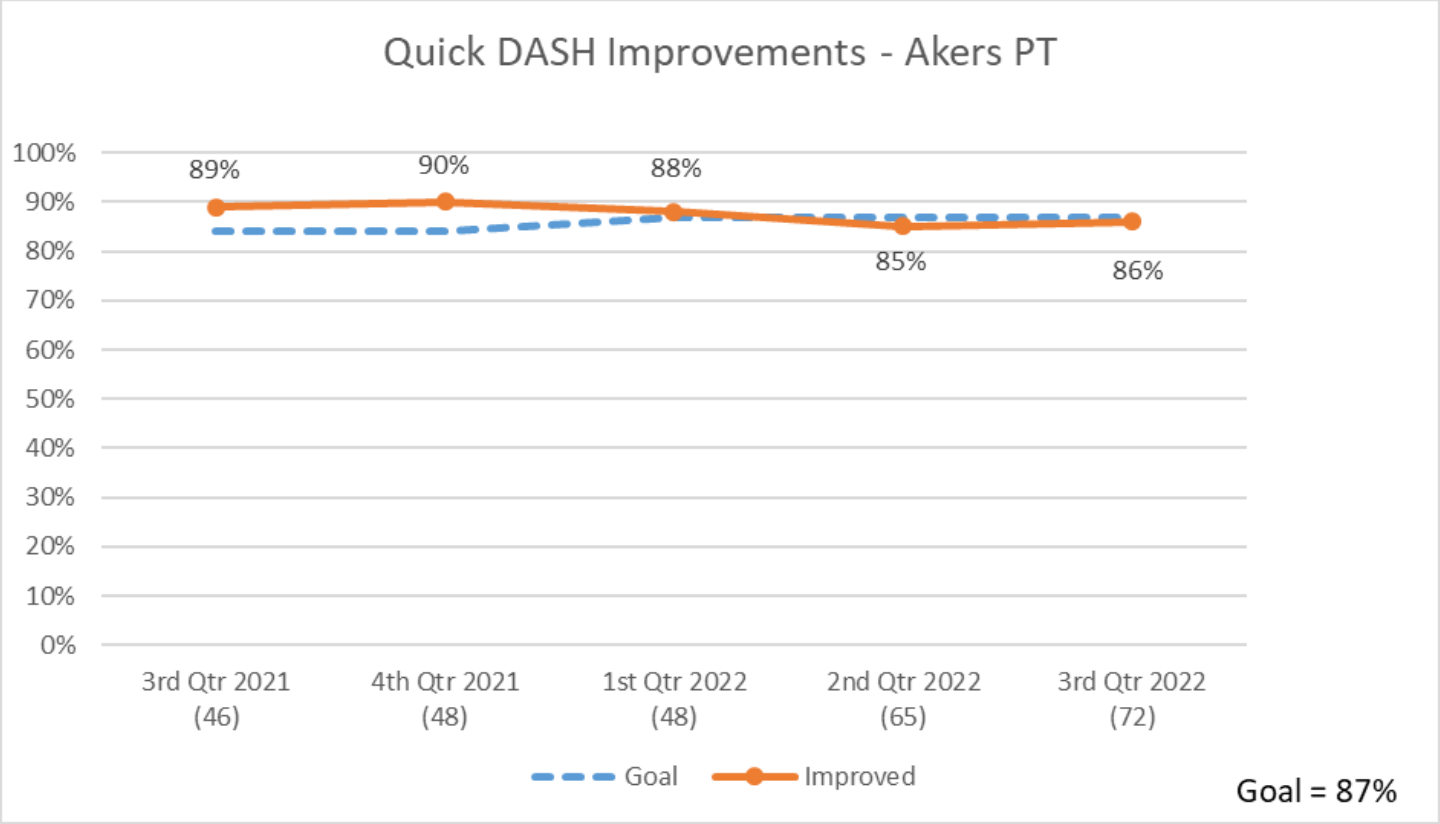

LEFS Improvements - LLOPT
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
92%
85%
91%
86%
88%
3rd Qtr 2021 (37)
4th Qtr 2021 (33)
1st Qtr 2022 (34)
2nd Qtr 2022 (28)
3rd Qtr 2022 (41)
Goal
Improved
Goal = 84%

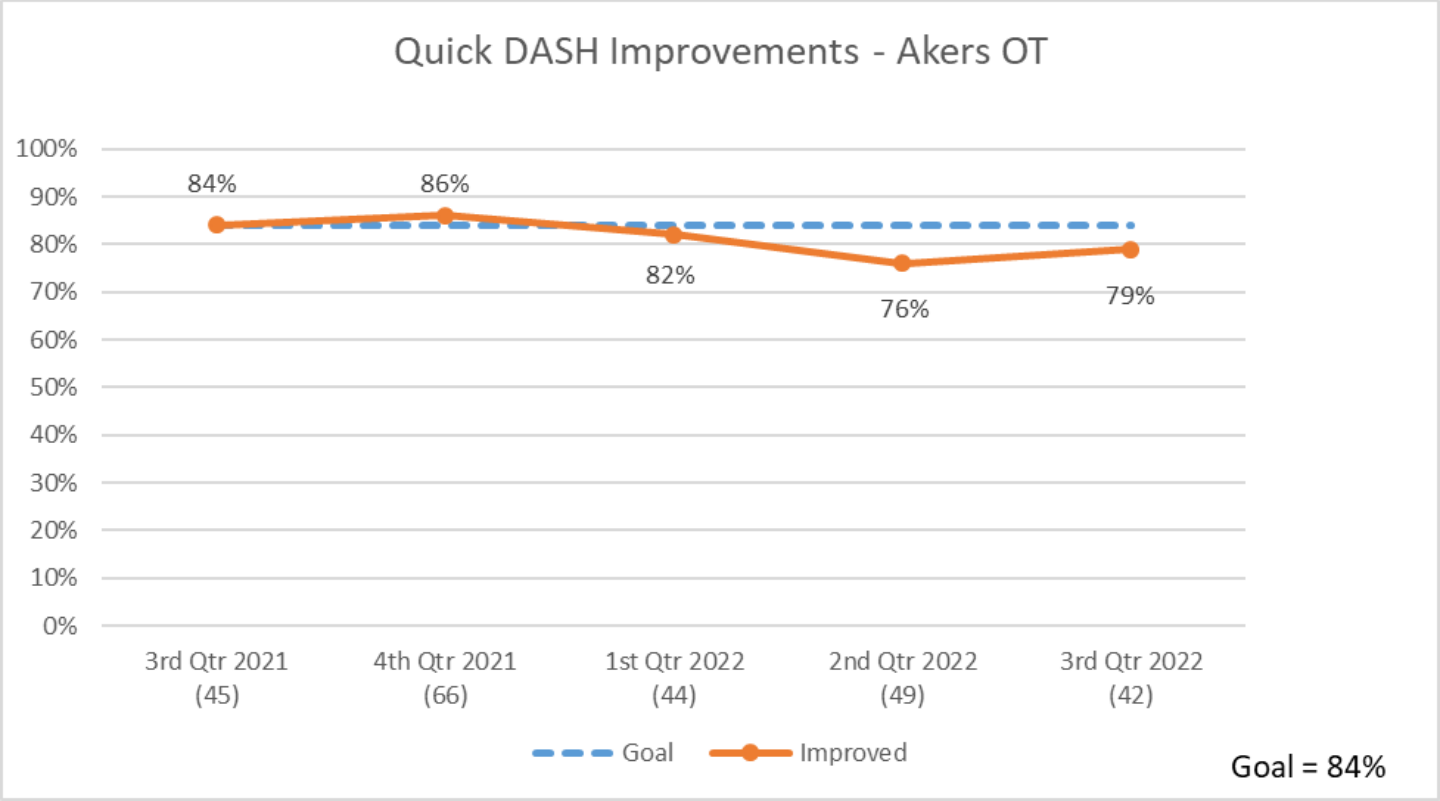

Neck Outcomes - LLOPT
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
87%
82%
100%
85%
84%
3rd Qtr 2021 (15)
4th Qtr 2021 (11)
1st Qtr 2022 (4)
2nd Qtr 2022 (13)
3rd Qtr 2022 (19)
Goal
Improved
Goal = 83%


Back Outcomes - LLOPT
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
72%
81%
82%
83%
89%
3rd Qtr 2021 (29)
4th Qtr 2021 (43)
1st Qtr 2022 (34)
2nd Qtr 2022 (29)
3rd Qtr 2022 (45)
Goal
Improved
Goal = 78%

Unit/Department Specific Data Collection Summarization

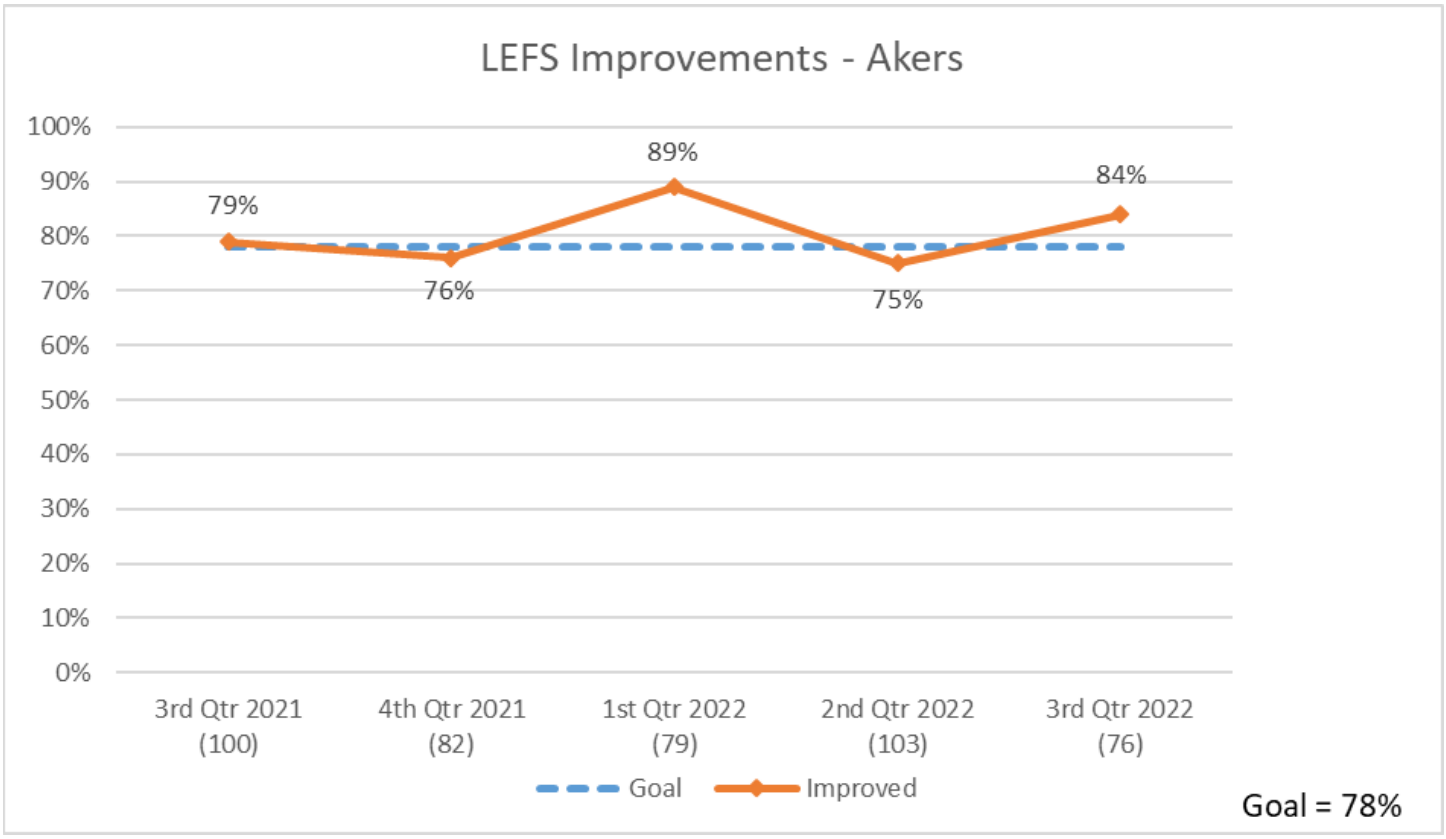
Professional Staff Quality Committee

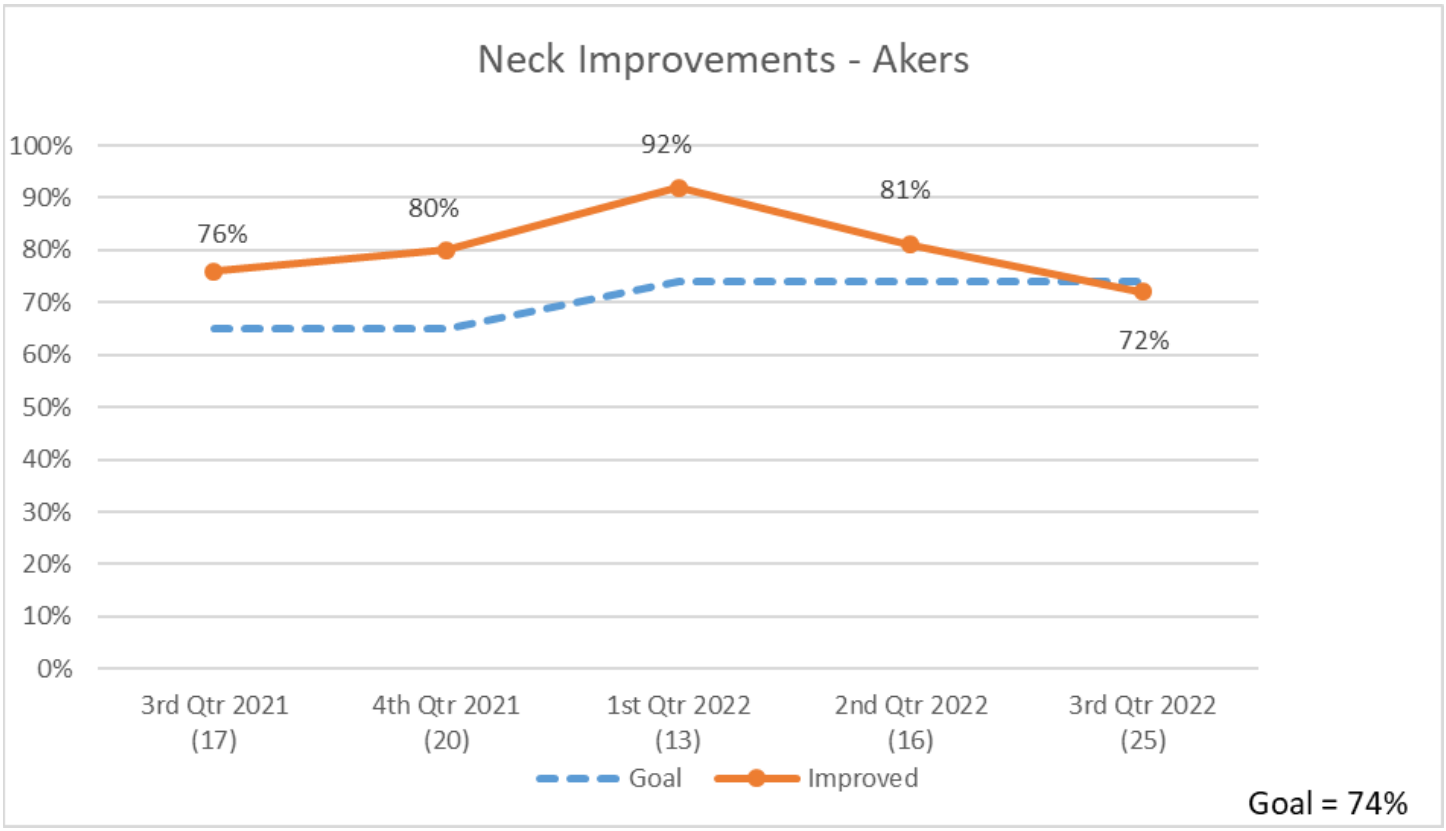


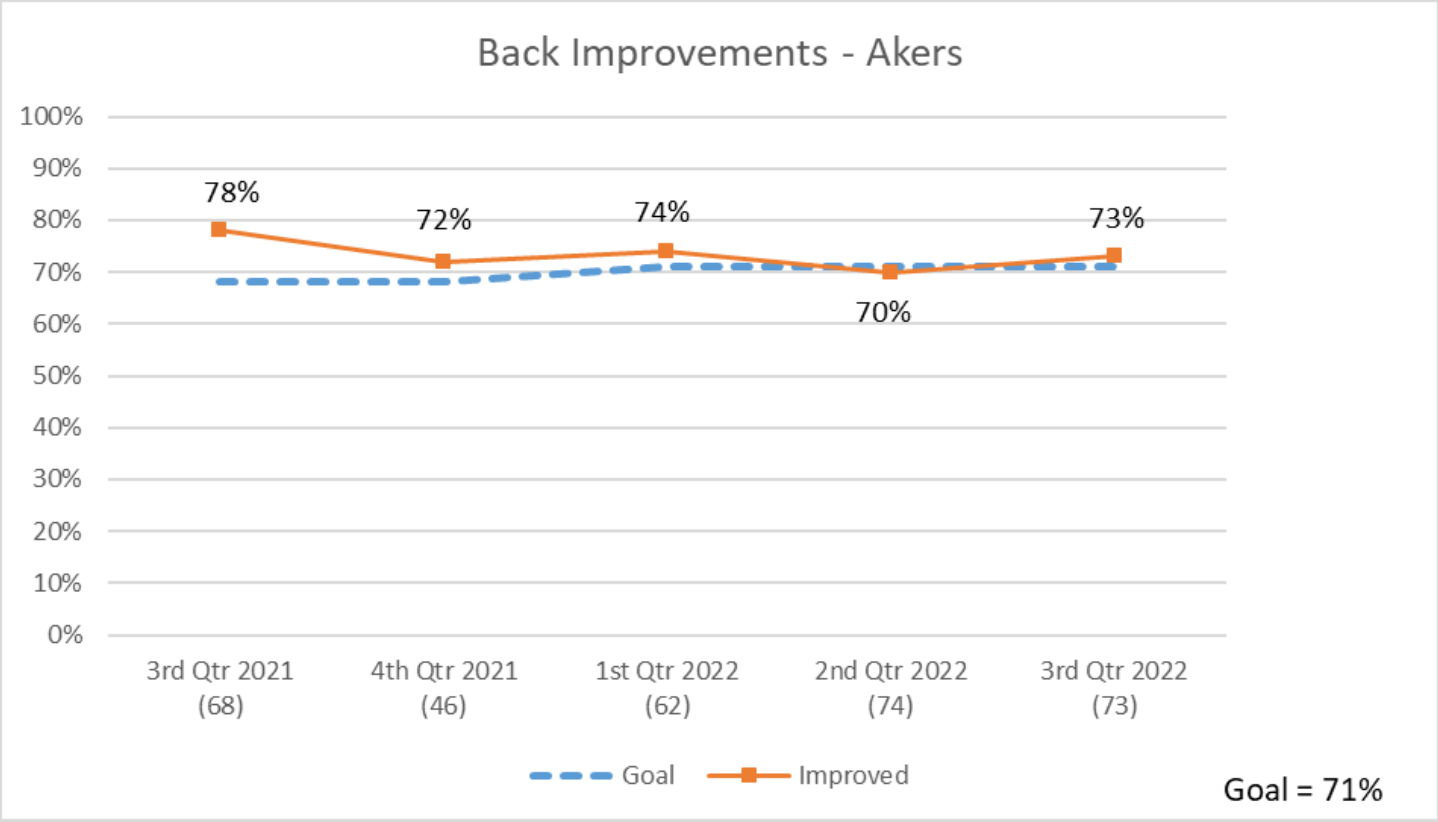


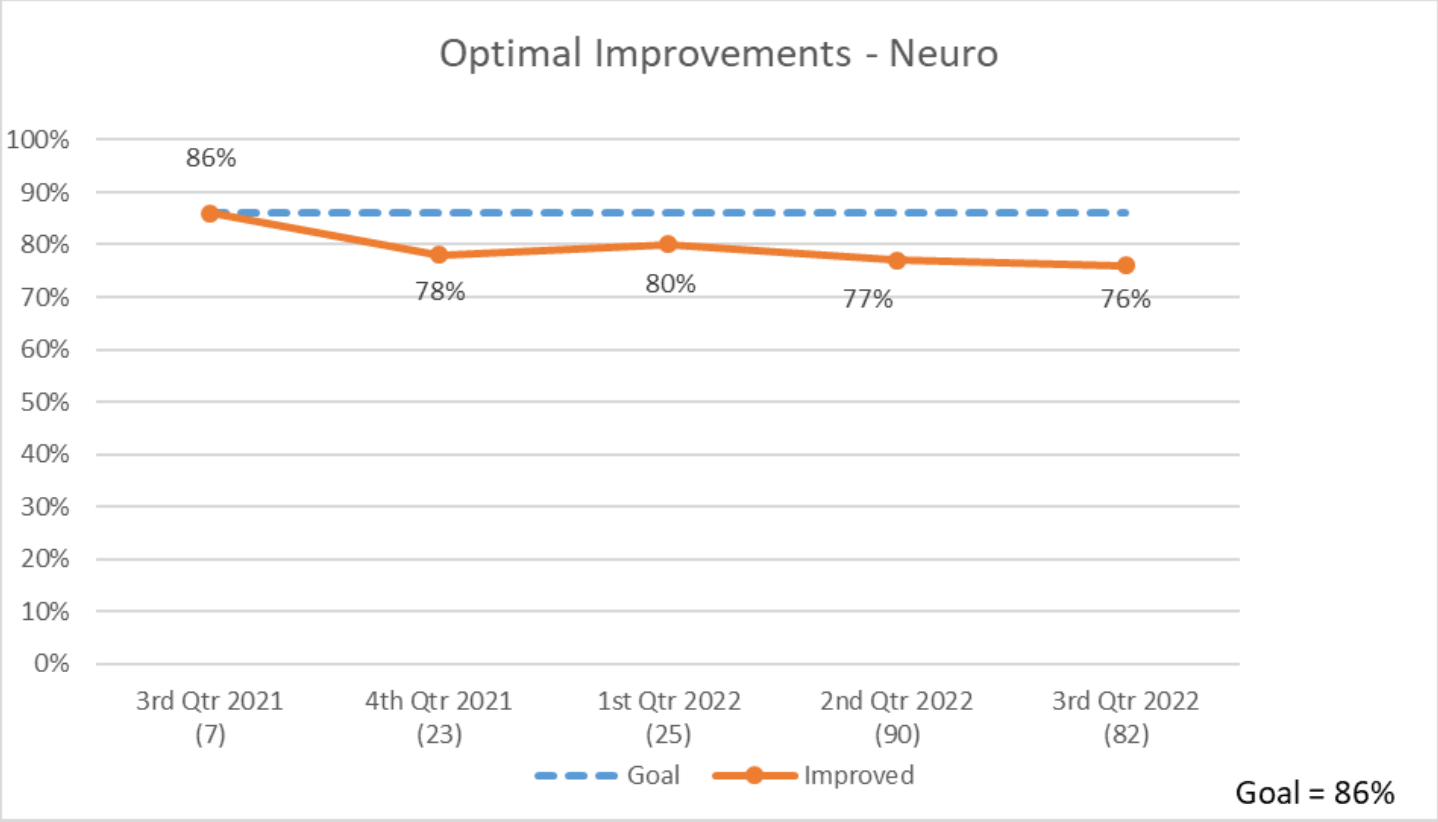
Unit/Department Specific Data Collection Summarization

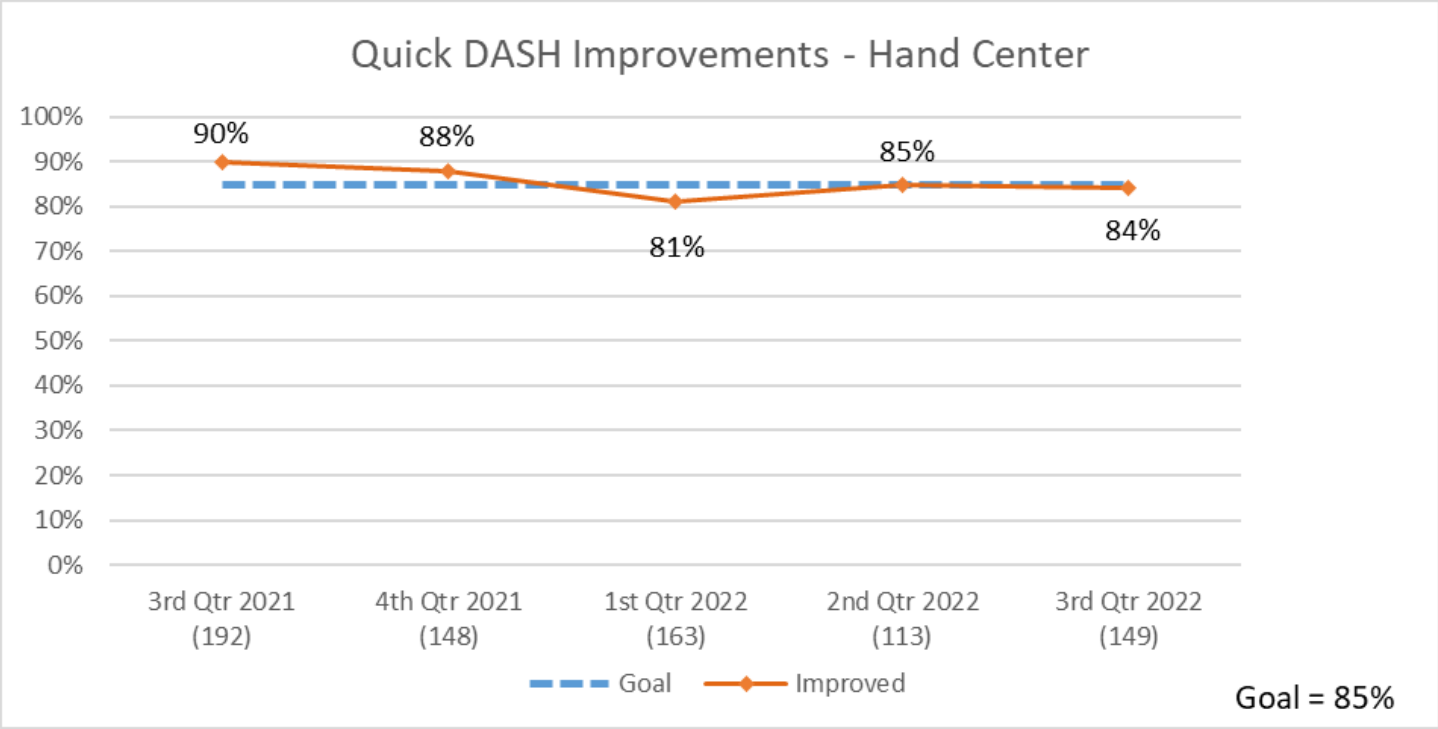
Professional Staff Quality Committee






Back Improvements - Akers
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
78%
72%
74%
70%
73%
3rd Qtr 2021 (68)
4th Qtr 2021 (46)
1st Qtr 2022 (62)
2nd Qtr 2022 (74)
3rd Qtr 2022 (73)
Goal
Improved
Goal = 71%


Optimal Improvements - Neuro
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
86%
78%
80%
77%
76%
3rd Qtr 2021 (7)
4th Qtr 2021 (23)
1st Qtr 2022 (25)
2nd Qtr 2022 (90)
3rd Qtr 2022 (82)
Goal
Improved
Goal = 86%


Quick DASH Improvements - Hand Center
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
90%
88%
81%
85%
84%
3rd Qtr 2021 (192)
4th Qtr 2021 (148)
1st Qtr 2022 (163)
2nd Qtr 2022 (113)
3rd Qtr 2022 (149)
Goal
Improved
Goal = 85%

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

In-Services have been completed and continue to be identified at the outpatient clinics to drive scores in lower scoring areas. Staff training and education provided to improve volume of scores being captured. Each staff members individual scores are now being provided to managers so that they can compare individuals to clinic averages. This has allowed for individual staff awareness and training opportunities for them to build their knowledge base and skills to improve scoring.
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Next Steps/Recommendations/Outcomes:

Managers will continue to be notified of individual staff member scores for outcome measures so that they can be compared to clinic averages. This will enable a more individual analysis of scores to find those that do exceptionally well with their patient outcomes, as well as those that have room for improvement. This will allow for individual attention and training for them to build their knowledge base and skills to improve scoring.

Submitted by Name: Jonah Miller, MPT **Date Submitted:** 11/14/22

Pain Management Committee Quality Report

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

Tom Gray, MD
Medical Director of Quality & Patient Safety

January 2023

Pain Management at Kaweah Health

Committee Mission:

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

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

Pain Management at Kaweah Health

Committee Goals:

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

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

Pain Management at Kaweah Health

Key Activities 2022-2023:

1. Gap analysis review for all Joint Commission standards related to pain management
   - All standards compliant
   - Opportunities to enhance processes identified and included in 2022-23 plan
2. Completion of the 2023 Cal Hospital Compare (CHC*) Opioid Safe Hospital Organizational Assessment (Honor Roll Program)
   - Kaweah Health earned 17/36 points in the self assessment in 2022
   - Goal is to achieve ≥26 points on the Organizational assessment in 2023 through the implementation of several initiatives that also address several key measures, including:
   - Opioid prescribing guidelines
   - Enhanced patient/family education
   - "Stigma training" for targeted providers
   - Broadly communicate program goals and progress

*CHC is a non-profit organization that is helping to address California's opioid epidemic and reduce opioid related deaths. CHC uses the Opioid Management Hospital Self-Assessment to assess performance and progress across the following 4 domains of care: 1) Safe & effective opioid use, 2) Identifying and treating patients with Opioid Use Disorder, 3) Overdose prevention, 4) Applying cross-cutting opioid management best practices Hospitals score each element on a 1-4 scale (higher score indicates high degree of progress); items <4 included in 2022 action plan

KH Pain Management Committee

Pain Management & Opioid Safety Initiatives

Pain Management QI Initiative	Status	Action Plan 2023
1. Ensure opioid safety through monitoring of Adverse Drug Events (ADE) per 1,000 Inpatient admission (Medicare FFS Part A claims) **Goal:** Surpass national benchmark of 2.46 per 1,000 patients (as reported by Health Services Advisory Group HSAG 3/1/21-2/28/22)	• Lower is better. 2019 = 2.29 per 1,000(17/7430); 2020 = 1.15 per 1,000 (7/6074); 2021 = 1.33 per 1,000 (7/5347); Jan 2022 – Aug 2022 = 2.18 per 1,000 (8/3668). Goal achieved.	• Note - Resident QI project completed May 2022 focused on evaluation of 17 patients with a reported ADE related to opioids from Dec 2020 -Aug 2021 to determine if there was a true ADE. The evaluation utilized the evidenced-based Naranjo Adverse Drug Reaction Probability Scale (a tool that standardized assessment of causality for all adverse drug reactions). Results indicated that only 35% (6/17) were true ADEs. Although the sample was small, it would be reasonable to conclude that the HSAG ADEs related to opioid rate per 1,000 is lower than reported. • eCQM team considering adding Naloxone use as an internal measure to enhance monitoring.
2. Ensure opioid safety through monitoring of Adverse Drug Events collected through Rapid Response Team (RRT) case review. Number of RRTs where Narcan was effective (Narcan is a reversal agent used to treat overdoses) **Goal:** Not set as this is a overall monitoring measure, an increase would indicate potential issue to be evaluated since the narcan effectiveness is initial documentation and not vetted by pharmacy (see action plan)	• 2021: 54 patients were administered Narcan during an RRT, 27 of them (50%) the RRT RN reported the Narcan was effective (not evaluated by pharmacy). • Jan – Nov 2022: 35 patients were administered Narcan during an RRT, 25 of them (71%) the RRT RN reported the Narcan was effective (not evaluated by pharmacy). The number of patients requiring Narcan during an RRT has decreased since 2021.	• Committee identified that often the RRT RNs report of Narcan effectiveness in cases is not consistently accurate (ie. some case review revealed that patients where Narcan was effective during an RRT were not on opioids). Re-education with RRT RNs completed. Plan is to revise data and process to include a pharmacists case review to identify gaps timely and report actual cases where Narcan was effective (as vetted by pharmacy) as the measure. • Process to be revised by 2Q2022 for monthly pharmacy review of RRT cases (Narcan use & effectiveness) so that trends can be identified and addressed timely

KH Pain Management Committee

Pain Management & Opioid Safety Initiatives

Pain Management QI Initiative	Status	Action Plan 2023
3. Ensure Opioid safety through discharge prescribing of opioids for < 7 days in duration Goal (internal): 9% (decreased by 5% from 2021 goal)	• (lower is better) % of patients with opioid prescription >7 day: 14% in 2021. • Decreased to 9.3% Jan-Nov 2022. Improved from 2021. Within 1% of goal.	• Committee selected and approved the Opioid Prescribing Engagement Network (OPEN) evidenced based guidelines for acute pain management. There is a link in Cerner and on Compass for easy accessibility. • Data analysis in progress to identify trends (ie. providers, opioid types) • Letter drafted and approved by MEC to issue to providers who prescribe opioids for >7 days duration upon discharge; workflow plan to issue letters in process • Providers will receive an alert in Cerner for any inpatient, acute therapy discharge prescription of an opioid >7days.
4. Ensure Opioid safety through discharge prescribing. NEW! CMS Measure: Safe Use of Opioids-Concurrent Prescribing (eCQM - Electronic Clinical Quality Measures). CMS Benchmark: 16% State	• Measure description - Inpatient hospitalizations for patients 18 years of age and older prescribed, or continued on, two or more opioids or an opioid and benzodiazepine concurrently at discharge • Denominator exclusions: Inpatient hospitalizations where patients have cancer that overlaps the encounter or are receiving palliative or hospice care (including comfort measures, terminal care, and dying care) during the encounter • 2021 = 18.70% (1053/5642) • This measure will be publically reported in January 2023 on CMS Care Compare. • Dec 2021 – Nov 2022 = 20.7% Within 5% of goal.	• Committee selected and approved the Opioid Prescribing Engagement Network (OPEN) evidenced based guidelines for acute pain management. There is a link in Cerner and on Compass for easy accessibility • ISS has completed the eCQM build December 2022. • ISS is creating a detailed report from Cerner, available Feb 2023 • Will utilize the ISS report to review and identify trends to act on and will be shared with the Pain Committee.

KH Pain Management Committee

Type of Pain Management Intervention & Effectiveness Initiatives

Pain Management QI Initiative	Status	Action Plan 2023
1. Increasing peripheral nerve blocks (Anesthesia) **Goal:** Increase volume from 2021; reduces need for opioids	• 37 peripheral nerve blocks completed CY 2021, 23 completed Jan-Nov 2022. PENDING	• Focusing increasing nerve blocks on the amputation surgical population. Baseline data report request pending. • Follow up with Department of Anesthesia
2. Increasing Multimodal use when opioids are prescribed in surgical opioid patient populations **Goal: 100%** ERAS patients with multimodal pain management	Data (higher is better): • Dec 2021 – Nov 2022 = 100% of ERAS elective colorectal patients with multimodal pain management: Goal achieved • Power plans evaluated for presence of multimodal order options available to providers. • Enhanced Recovery After Surgery (ERAS) in place for elective colorectal surgical patients in 4Q 2021	• Implement opioid prescribing guidelines as described above • Update provider Kaweah Health onboarding materials for pain management Reported through Surgical Quality Committee: • ERAS expanded to Orthopedic populations 1Q 2022 • Plan to expand ERAS to non-elective colorectal and gynecological surgical patients populations late 2023 • Data pending
Right pain medication administered for level of pain reported. **Goal:** 95%	• Dec 2021-Nov 2022 = 88% Goal not achieved	• Assigned Nursing Director reports this measure and the action plan directly to the Quality Improvement Committee. • This data was shared with the Pain Pharmacists for them to utilize during Opioid Stewardship Rounds.

KH Pain Management Committee

Type of Pain Management Intervention & Effectiveness Initiatives		
Pain Management QI Initiative	**Status**	**Action Plan 2023**
3. Review and revise patient education materials for pain management **Goal:** Patient and community awareness to reduce opioid use & achieve **≥26 points** on the Cal Hospital Compare Opioid Honor Roll Program.	• Included in the Cal Hospital Compare Opioid Honor Roll program. • Kaweah Health Achieved 17 points in the program in 2021 (reported early 2022). 2022 evaluation and submission to Cal Hospital Compare is by 3/31/23 PENDING	• Committee reviewed patient education materials from the CDC on opioid safety. Recommend distributing to patients upon admission/discharge. Materials have been approved by the Patient Education Committee. Discussion Sept 2022 with Patient Care Nursing Managers regarding the addition of the materials to admission/discharge packets. Processes vary by unit. Discussion with ISS to link materials with any acute care, inpatient discharge prescription of an opioid. Materials available in Cerner in both English and Spanish.
4. Assess and address stigma associated with provider pain management for patients with Opioid Use Disorder (OUD) **Goal:** Reduce stigma & achieve ≥26 points on the Cal Hospital Compare Opioid Honor Roll Program.	• 44 providers who prescribe opioids responded to survey in early 2022 • Survey results suggest increased stigma in providers that tend to prescribe the most opiates. • Initiative (assessing stigma) included in the Cal Hospital Compare Opioid Honor Roll program. • KH Achieved 17 points in the program in 2021 (reported early 2022). 2022 evaluation and submission to Cal Hospital Compare is by 3/31/23 PENDING	• Provider education under development that addresses stigma with OUD patients • Plan to resurvey in 2023 to evaluate effectiveness • CME presentation planned for 2Q2023 • Implicit Bias education required by CA state law was completed by selected APP's and providers by 12/31/21. • Implicit Bias education for KH employees began Jan 2023

KH Pain Management Committee

Pain Assessment Initiatives

Pain Management QI Initiative	Status 2021	Action Plan 2023
1. RN knowledge of pain score assessment prior to & after pain med admin **Goal:** 95%	• Knowledge of pain score assessment prior. Baseline (June-July 2021) = 88%; Aug-Dec 2021 = 98%; Jan-Oct 2022 = 98.5% Goal achieved • Knowledge of pain score assessment post – baseline (June-July 2021) = 79%; Aug-Dec 2021 = 99%; Jan- Oct 2022 = 97.3%. Goal achieved	• Continue to monitor to sustain • Education ongoing ad hoc through unit leaders
2. RN knowledge of appropriate us of PAIN-AD scale to assess pain for non-verbal pts **Goal:** 95%	• Baseline (June-July 2021) = 88%; Aug-Dec 2021 = 98% ; Jan- Oct 2022 = 96%. Goal achieved	• Continue to monitor to sustain • Education ongoing ad hoc through unit leaders
3. Reassessing patients pain within 75 min of opioid administration **Goal:** 95%	• Evaluation of nursing processes indicated that the reassessment is occurring within appropriate timeframe, but not documented until later in the shift. Broad Nursing education assigned to RNs in August 2021. • Dec 2021 – Nov 2022 = 57.7% Goal not achieved	• Plan in progress, performance related to timing of documentation under review with nursing leadership; monitor RRT data for outcomes related to reassessment timing. • Discussion with assigned leader is pending

Questions?

Live with passion.

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

Kaweah Health

Outstanding Health Outcomes Update

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

February 2023

FY23 Clinical Quality Goals

	July-Nov 22 Higher is Better	FY23 Goal	FY22	FY22 Goal
SEP-1 (% Bundle Compliance)	79%	≥ 77%	76%	≥ 75%

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

Our Mission

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

Our Vision

To be your world-class healthcare choice, for life

Lower is Better	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	June 2023	Estimated Annual Number Not to Exceed to Achieve Goal*	FYTD SIR** (number of actual/ number expected)	FY23 Goal (VBP 2024; National Mean 2019)	FY22 FY21 FY20
CAUTI Catheter Associated Urinary Tract Infection Excluding COVID INCLUDING COVID-19 PATIENTS	1 0	1 0	2 0	1 1	2 0	3 0							14 (23 predicted over 12 months)	0.810 0.900 Including COVID	≤0.650	1.092 0.54 1.12
CLABSI Central Line Associated Blood Stream Infection Excluding COVID INCLUDING COVID-19 PATIENTS	3 1	0 0	0 0	0 0	1 0	3 1							10 (17 predicted over 12 months)	0.770 1.026 Including COVID	≤0.589	1.132 0.75 1.20
MRSA Methicillin-Resistant Staphylococcus Aureus Excluding COVID INCLUDING COVID-19 PATIENTS	2 0	0 0	0 0	0 0	0 0	2 0							5 (8 predicted over 12 months	1.167 0.873 Including COVID	≤0.726	1.585 2.78 1.02

*based on July 2021-June 2022 NHSN predicted

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

Questions?