January 12, 2024

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, January 18, 2024, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.
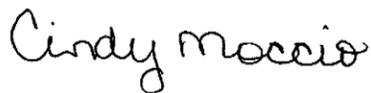
The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:31AM on Thursday, January 18, 2024, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277, pursuant to Health and Safety Code 32155 & 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, January 18, 2024, 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.
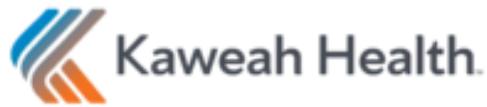
KAWEAH DELTA HEALTH CARE DISTRICT
David Francis, Secretary/Treasurer

Cindy Moccio
Board Clerk, Executive Assistant to CEO

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

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
QUALITY COUNCIL
Thursday, January 18, 2024
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; Tom Gray CMO/CQO; Julianne Randolph, OD, Vice Chief of Staff and Quality Committee Chair; LaMar Mack, 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 Michelle Adams, 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
   o **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Julianne Randolph, OD, Vice Chief of Staff and Quality Committee Chair*

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

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

CLOSED MEETING – 7:31AM

1. **Call to order** – *David Francis, Committee Chair & Board Member*

2. [Quality Assurance](link) pursuant to Health and Safety Code 32155 and 1461 – *Julianne Randolph, OD, Vice Chief of Staff and Quality Committee Chair*

| Mike Olmos – Zone 1 | Lynn Havard Mirviss – Zone 2 | Vacant – Zone 3 | David Francis – Zone 4 | Ambar Rodriguez – Zone 5 |
| President | Vice President | Board Member | Secretary/Treasurer | Board Member |

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

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

OPEN MEETING – 8:00AM

1. **Call to order** – *David Francis, Committee Chair*

2. **Public / Medical Staff participation –** Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves at this time. Members of the public or the medical staff may comment on agenda items after the item has been discussed by the Committee but before a Committee recommendation is decided. In either case, each speaker will be allowed five minutes.

3. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives:
   3.1. Rapid Response Team and Code Blue Committee Report
   3.2. Stroke Program Update
   3.3. Sepsis Quality Focus Team Report

4. **Healthcare Acquired Infection Quality Focus Team Report –** A report of key outcome metrics and action plans to reduce and sustain low infection rates. *Shawn Elkin, MPA, BSN, RN, PHN, CIC, Manager of Infection Prevention and LaMar Mack, MD, MHA, Medical Director of Quality and Patient Safety.*

5. **Annual Review of the Quality and Patient Safety Plans –** A review of the Quality and Patient Safety prioritized initiatives for 2024, and reporting schedule for Quality Council. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*

6. **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.*

7. **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.

| Mike Olmos – Zone 1 | Lynn Havard Mirviss – Zone 2 | Vacant – Zone 3 | David Francis – Zone 4 | Ambar Rodriguez – Zone 5 |
| President | Vice President | Board Member | Secretary/Treasurer | Board Member |

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KAWEAH DELTA HEALTH CARE DISTRICT

QUALITY COUNCIL - CLOSED MEETING

THURSDAY JANUARY 18, 2024

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 4-12

KDHCD - QUALITY COUNCIL - CLOSED MEETING

THURSDAY JANUARY 18, 2024

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KDHCD - QUALITY COUNCIL - CLOSED MEETING

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KDHCD - QUALITY COUNCIL - CLOSED MEETING

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KAWEAH DELTA HEALTH CARE DISTRICT

QUALITY COUNCIL - CLOSED MEETING

THURSDAY JANUARY 18, 2024

CLOSED MEETING SUPPORTING DOCUMENTS

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KDHCD - QUALITY COUNCIL - CLOSED MEETING

THURSDAY JANUARY 18, 2024

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KDHCD - QUALITY COUNCIL - CLOSED MEETING

THURSDAY JANUARY 18, 2024

CLOSED MEETING SUPPORTING DOCUMENTS

PAGES 4-12

RRT/Code Blue Prostaff Report

Q3 2023

Shannon Cauthen MSN, CCRN-K

GTWG Performance

One more quarter of >85% overall compliance qualifies us for the **Gold** Award from the AHA!

Percent of Patients

- n=3
- n=20
- n=28
- n=27

07/01/...

Time Period
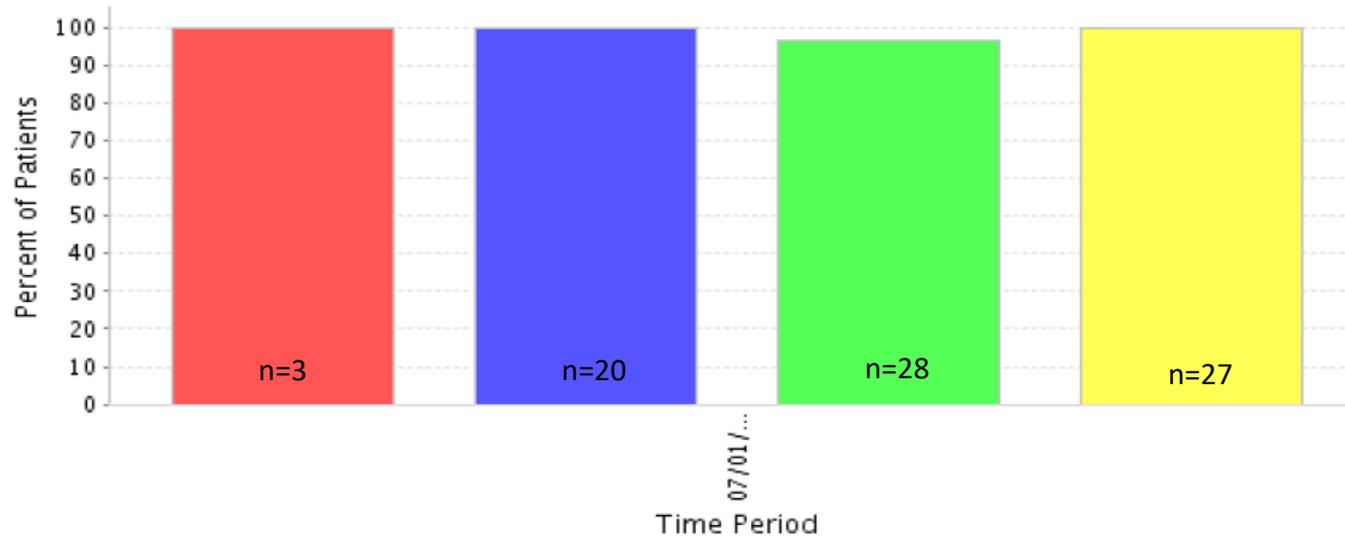
■ CPA: Time to first shock <= 2 min for VF/pulseless VT first documented rhythm: My Hospital
■ CPA: Time to IV/IO epinephrine <= 5 minutes for asystole or Pulseless Electrical Activity (PEA): My Hc
■ CPA: Percent Pulseless Cardiac events monitored or witnessed: My Hospital
□ CPA: Confirmation of airway device placement in trachea: My Hospital

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RRT and Resuscitation Scorecard

RRT Resuscitation Quality Scorecard

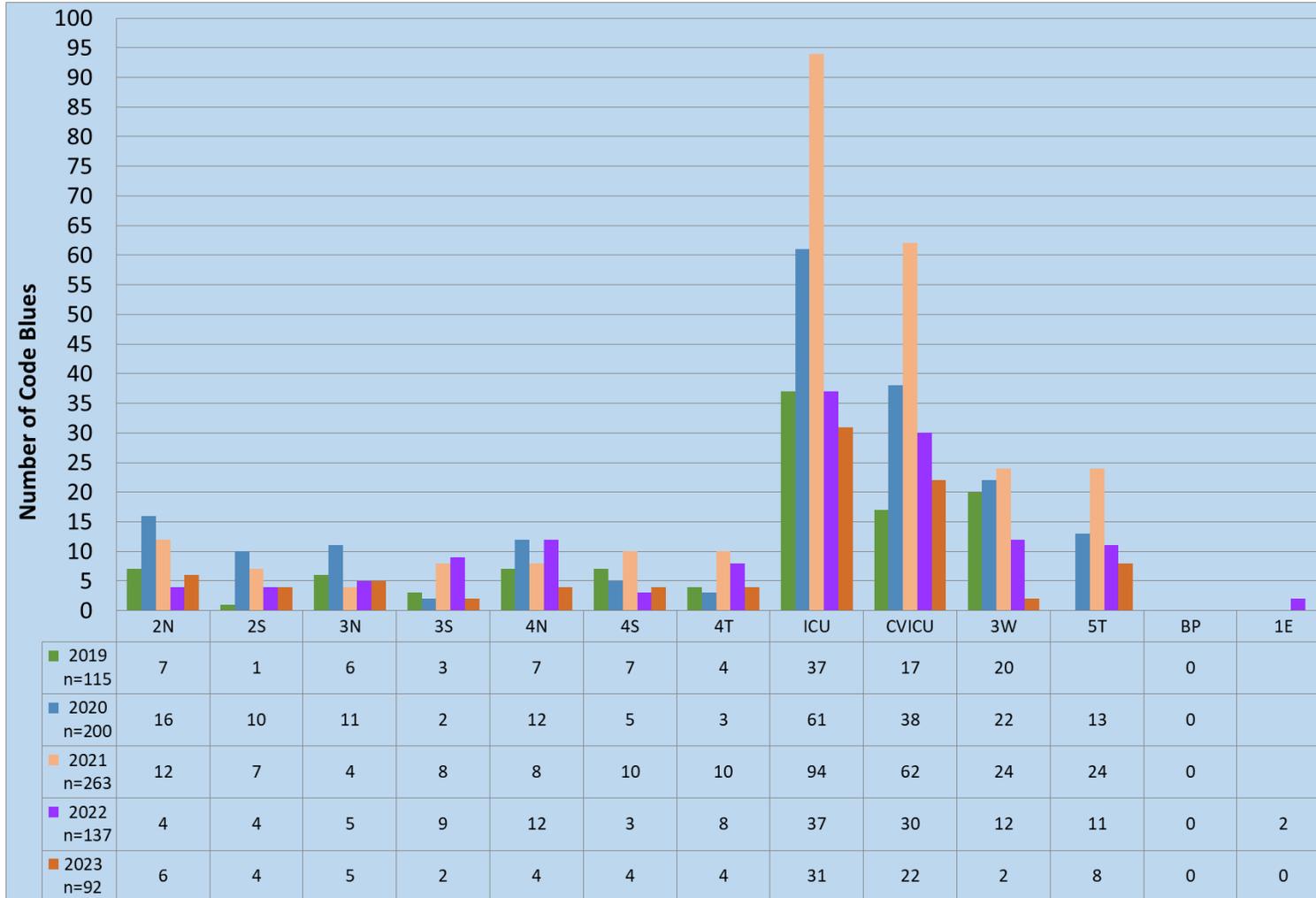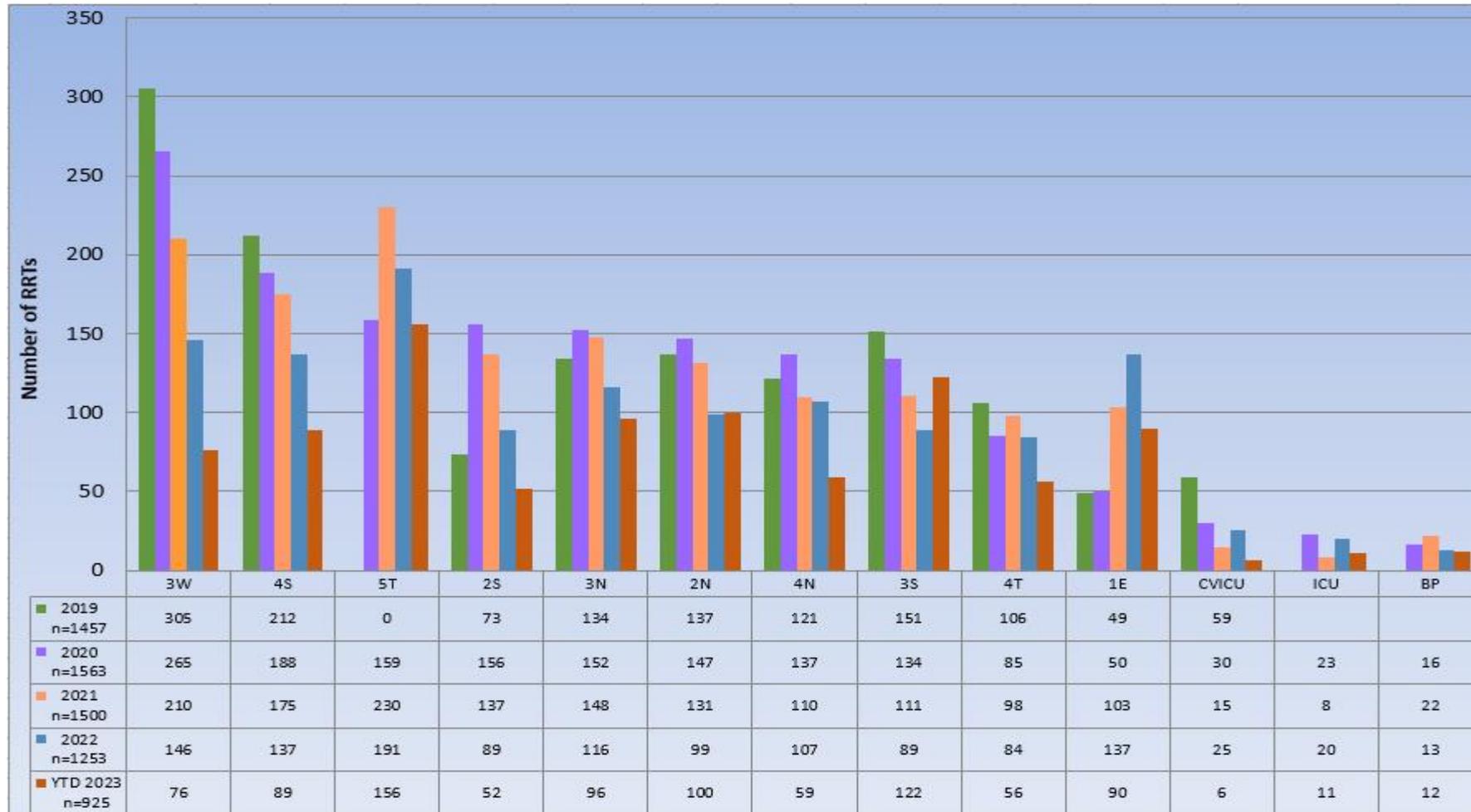### Code Blue Data

	Hospitals (External Benchmark) ALL GWTG	CY 2022 Baseline Mean	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Mean (Rolling 12 months)
Total Code Blues (Med/Surg/ICCU/CC)		12	9	9	17	14	14	13	9	2	14	7	9	9	11
Total COVID-19 Positive Code Blues		2	0	0	2	4	1	0	0	0	0	0	0	0	1
Code Blues per 1000 Discharges Med Surg/ICCU		5	5	6	8	3	4	7	3	0	6	3	2	3	4
Code Blues per 1000 Discharges Critical Care		4	3	2	5	8	9	3	5	2	6	2	5	4	5
Percent of Codes in Critical Care	66% (↑ is better)	49%	44%	22%	38%	71%	71%	29%	67%	100%	50%	43%	67%	56%	55%
Event Survival Rates			56%	67%	47%	57%	71%	43%	33%	100%	79%	71%	44%		61%
Code Blue: Survival to Discharge	20% (↑ is better)	22%	22%	22%	6%	14%	0%	14%	0%	100%	21%	14%	33%	56%	25%
Deaths from Cardiac Arrest (expired during event)		4	4	3	9	8	4	8	6	0	3	2	5	4	5
Overall Hospital Mortality Rate		2.87	2.4	2.15	3.05	3.54	3.2	2.29	2.84	2.47	2.85	1.9	1.79	2.69	2.60

RRT Data

			Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Mean
Total RRTS		108	110	98	125	121	96	133	104	102	90	125	103	88	108
RRTs per 1000 Patient Discharge Days		86	93	83	100	98	87	100	88	81	71	98	79	72	87
RRT Mortality	21% (↓ is better)	19%	17% n=19	21% n=21	18% n=22	22% n=27	17% n=16	17% n=22	16% n=17	15% n=15	24% n=22	13% n=16	17% n=17	13% n=11	18%
RRTs Within 24 hours of Arriving to Inpatient Unit	15% (↓ is better)	21%	23% n=25	22% n=22	23% n=29	26% n=31	24% n=23	26% n=35	24% n=25	28% n=29	36% n=32	26% n=32	30% n=31	25% n=22	26%
RRT- Med-Surg to Intermediate Critical Care Transfers	*9%	17%	23% n=25	15% n=15	16% n=20	14% n=17	24% n=23	23% n=30	27% n=28	18% n=18	22% n=20	22% n=27	22% n=23	20% n=17	21%
RRT- Med-Surg to Critical Care Transfers	*29%	10%	6% n=7	14% n=14	9% n=11	9% n=11	1% n=1	10% n=13	7% n=7	17% n=17	10% n=9	12% n=15	9% n=9	11% n=10	10%
RRT-Intermediate Critical Care Transfers to Critical Care	*32%	7%	8% n=9	4% n=4	9% n=11	10% n=12	8% n=8	9% n=12	5% n=5	10% n=10	6% n=5	6% n=8	8% n=8	14% n=12	8%

Better than Target
Does not meet Target
*Target Goal not Being Established

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Code Blues by Location

	2N	2S	3N	3S	4N	4S	4T	ICU	CVICU	3W	5T	BP	1E
2019 n=115	7	1	6	3	7	7	4	37	17	20		0	
2020 n=200	16	10	11	2	12	5	3	61	38	22	13	0	
2021 n=263	12	7	4	8	8	10	10	94	62	24	24	0	
2022 n=137	4	4	5	9	12	3	8	37	30	12	11	0	2
2023 n=92	6	4	5	2	4	4	4	31	22	2	8	0	0

Goal: To guarantee appropriate placement of patients so that as many code blues as possible occur in Critical Care where advanced monitoring and early intervention are more likely to result in a positive patient outcome. (Note, the AHA does not include the ICCUs in their definition of Critical Care).

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RRTs by Location

	3W	4S	5T	2S	3N	2N	4N	3S	4T	1E	CVICU	ICU	BP
2019 n=1457	305	212	0	73	134	137	121	151	106	49	59		
2020 n=1563	265	188	159	156	152	147	137	134	85	50	30	23	16
2021 n=1500	210	175	230	137	148	131	110	111	98	103	15	8	22
2022 n=1253	146	137	191	89	116	99	107	89	84	137	25	20	13
YTD 2023 n=925	76	89	156	52	96	100	59	122	56	90	6	11	12

Completed Projects

- Mock Code Blue Program
  - All Charge Nurses/NMs/ANMs trained on use of simulation equipment
  - Floors conducting two mock codes per month and submitting roster into Workday

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Next Steps

- Secure Funding to expand Mock Code Blue Program to ancillary departments: lab, dietary, etc.
- ER-STOP: Re-assessment program led by DNP student to < RRTs within 24 hours of admission.
- Sidewalk CPR at Stayin' Alive 5k in February 2024
- Revise ICCU Admission Criteria- ensure patients are appropriately placed in ICCU vs. ICU level of care
- Sound Physician Go-Live March 1st, 2024

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The pursuit of healthiness

Stroke Quality Update January 2024

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Stroke Program Leadership

Dr. Sean Oldroyd
Stroke Program Medical Director

Cheryl Smit, RN-BC
Stroke Program Manager

Emma Camarena, RN
Advanced Practice Nurse

Kelsey Zapata, PharmD, BCPS, BCCCP
Emergency Department Pharmacist

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Abbreviations Used During this Presentation

TJC = The Joint Commission

AHA/ASA = American Heart Association; American Stroke Association

GWTG = Get with the Guidelines

EMS = Emergency Medical Services

ED = Emergency Department

ICU = Intensive Care Unit

TIA = Transient Ischemic Attack

Dc = Discharge

rt-PA or Tenecteplase = thrombolytic therapy "clot busting medication"

CT/CTA = Computed tomography scan/computed tomography angiography

LVO = Large vessel occlusion

CMS = Centers for Medicare and Medicaid Services

VTE = Venous thromboembolism

LDL = low-density lipoproteins

NIHSS = National Institutes of Health Stroke Scale

RRT = Rapid Response Team

STL = Stroke Team Lead

EMR = Electronic Medical Record

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Primary Stroke Certification through The Joint Commission (TJC)

Full Re-Accreditation Status after Primary Stroke Survey on January 2023.

- Survey was successful, the surveyor felt that the team was very engaged in the process and commended KH on our overall stroke program

- Two findings for improvement
  - Timeliness of IV thrombolytic treatment
  - Timeliness of ED provider documentation

- Corrective action plans were submitted to TJC and approved on March 17, 2023

- 2 year certification cycle

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Timeliness of IV thrombolytic treatment

April 4, 2023

- **ED Stroke alert process modified to a two-tier approach, stratified by time since last known well**
  - **Tier 1:** less than 4 hours since last known well. The team will assemble immediately upon the patients return from CT to determine if IV thrombolytics are appropriate
  - **Tier 2:** 4 to 16 hours since last known well. ED stroke care as usual, and if a large vessel occlusion is found, call for possible transfer
- **Transition from alteplase to tenecteplase as the "clot busting" medication for acute ischemic stroke patients**
  - Improved times. Studies have shown improvement in door to needle times with this transition
  - Non-inferior. Multiple trials have shown tenecteplase to be non-inferior to alteplase for ischemic stroke patients
  - Easier/safer administration. Tenecteplase is given as an IV push instead of a bolus and hour long infusion
  - Cost savings. Tenecteplase is approximately $2,000 less per dose than alteplase. KH gives thrombolytics approximately 50 times a year which equates to $100,000 savings
- **KH neurologist to determine appropriateness of thrombolytic administration**
  - Education was sent to ED/RRT nursing staff along with ED providers that our neurologists will make the call regarding thrombolytics and not defer to tertiary care center if the patient has a large vessel occlusion (LVO)

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TJC Corrective Action Plans
2023-2024

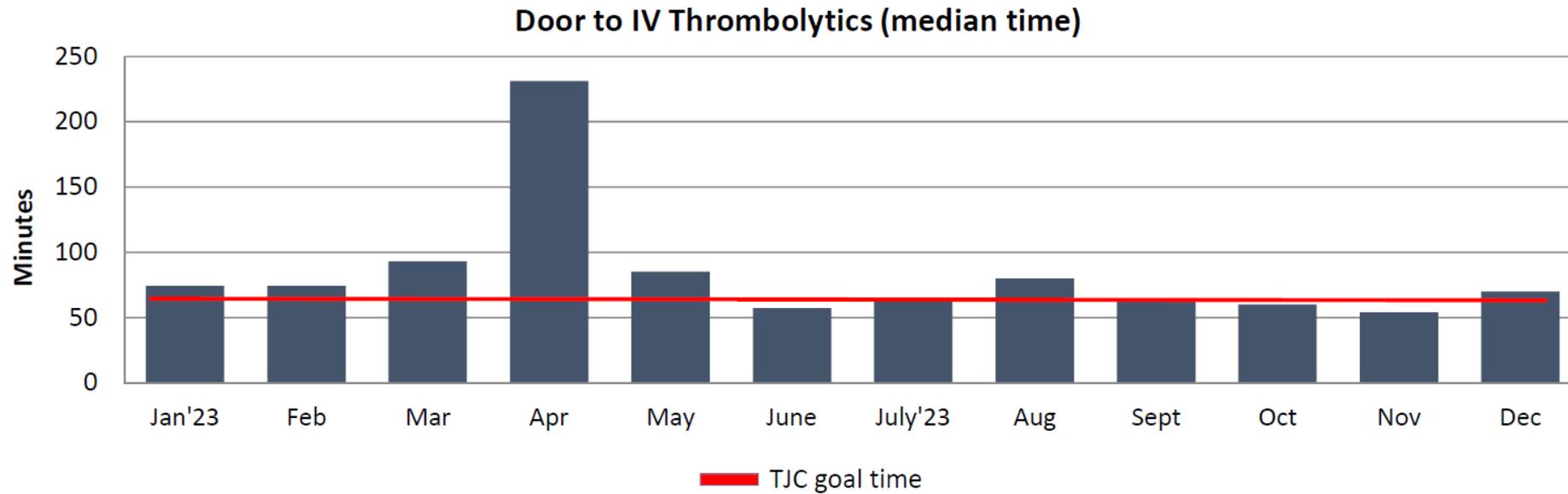## Timeliness of ED provider documentation

- Education with expectations were given to providers on the necessary elements for compliance and the timeliness for completed stroke patient medical records
- This was completed by:
  - E-mail notifications
  - Computer Based Learning (CBL) on the ED Stroke Alert Annual Update
  - Presented at Emergency Medicine resident conference
  - Emergency Medicine partner meeting

- Ongoing compliance monitoring is being conducted and reported to the Stroke Quality Committee meeting

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Stroke Program Initiatives 2023-2024

ED Stroke Alert Process

- RAPID software is available which will enhance imaging to evaluate patients who may be candidates for endovascular treatment. This requires a transfer to a tertiary care center
- Repeated stroke alerts may be called if the patient exhibits worsening stroke symptoms
- PowerPlan developed to address management of symptomatic intracranial bleeding occurring within 24 hours after administration of alteplase for treatment of ischemic strokes
- 2022: Changed stroke screening criteria from FAST to BE FAST
- 2022: Education on Medical ID. This has been shared with EMS, Skylife and ED staff and providers
- **2023 TJC CORRECTIVE ACTION ITEM:** Modification to the ED Stroke Alert Process
- **2023 TJC CORRECTIVE ACTION ITEM:** Transitioned from alteplase to tenecteplase as the "clot busting" medication for acute ischemic stroke patients
- **2023 TJC CORRECTIVE ACTION ITEM**: Education on the various corrective action items shared with ED staff and providers
- **2023 ACTION ITEM:** Modification to CT/CTA orders to prioritize stroke alert patients and expedite CT read times
- **2023 ACTION ITEM**: Planned mock stroke alert training for ED staff and Stroke Team Leads (STLs)

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2023 ED Stroke Alert Dashboard
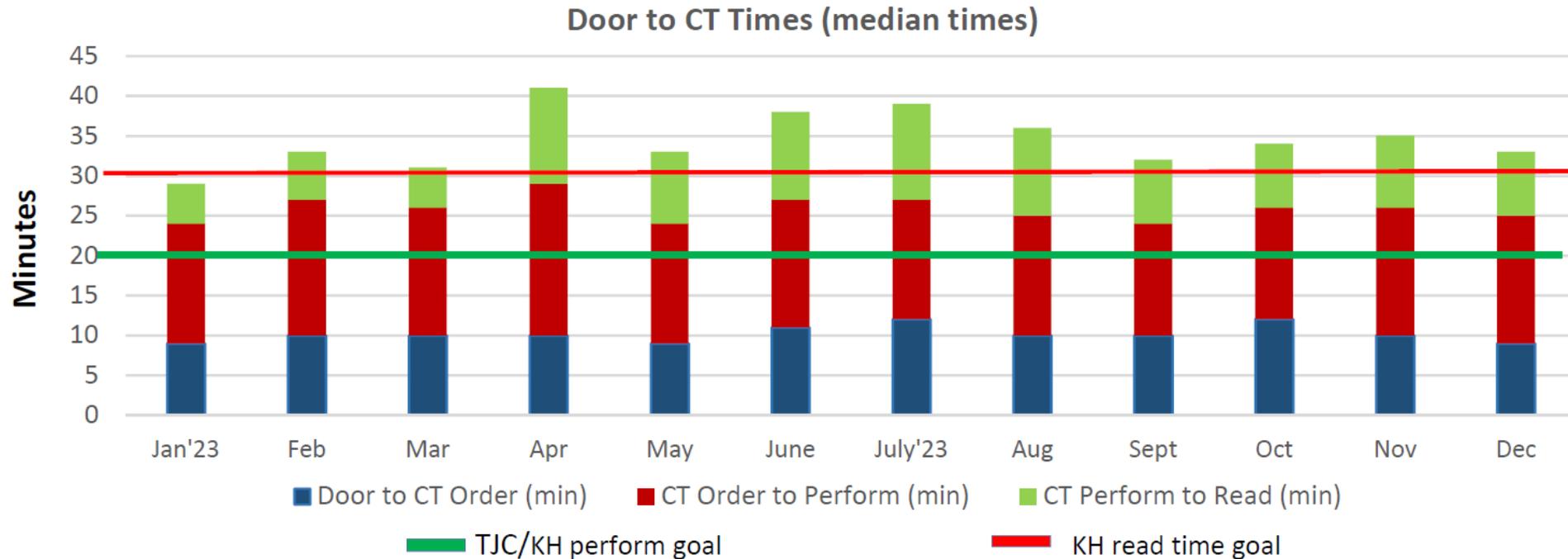
Door to IV Thrombolytics (median time)

The data in this graph includes all thrombolytic patients which differs from the TJC rate because exclusion criteria is not used. TJC expectation is that IV thrombolytics are given within 60 minutes to eligible patients who present for stroke care. AHA/ASA GWTG expectations were update in 2019 with new IV thrombolytic goal time to 45 minutes at least 75% of the time (when applicable). To meet this goal, continued changes to the stroke alert process have been made.

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2023 ED Stroke Alert Dashboard

Door to Stroke Alert (median times)

Per KH ED Stroke Alert process; stroke alerts to be called within 5 min for EMS and 10 min for Triage. Since the opening of the new Triage/zone 5 areas (summer of 2021), significant improvements have been noted in the Triage process.

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2023 ED 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. KH's CT read time goal is 30 minutes

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ED Transfer Process on Ischemic/Hemorrhagic Stroke Patients

TJC Metric: Door to transfer goal <120 minutes.

 Hemorrhage, IV Alteplase and Transfer "drip and ship", Large Vessel Occlusion and Endovascular Eligible

 Large Vessel Occlusion, and Not Endovascular Eligible

 No Large Vessel Occlusion and Not Endovascular Eligible

- Key stakeholders are involved in the transfer process; Skylife, EMS/American ambulance, ED and Case Management
- Ischemic/hemorrhagic stroke transfer guidelines established
- Transfer agreements signed with San Jose RMC and USC/Keck
- Education to physicians and staff regarding transfer goal time of <120 minutes
- RAPID software is available which has enhance imaging to evaluate if patients are candidates for endovascular treatment
- Immediate notification to EMS agencies of possible transfer. This helps to expedite transfer if helicopter transport is not possible. EMS transport the patient to the airport if fixed wing is required or ground transport is needed
- "Ready to Fly" checklist instituted to help improve transfer times
- Collaborative effort between key stakeholders (USC/Keck, Skylife, EMS, KH) to improve processes when a combination of air/ground transport is needed.
- Case Management notifies Skylife dispatch center that this is a "stroke alert" patient requiring expedited transfer
- Follow up communication with key stakeholders after transfer. Cover what went well and what challenges we can improve
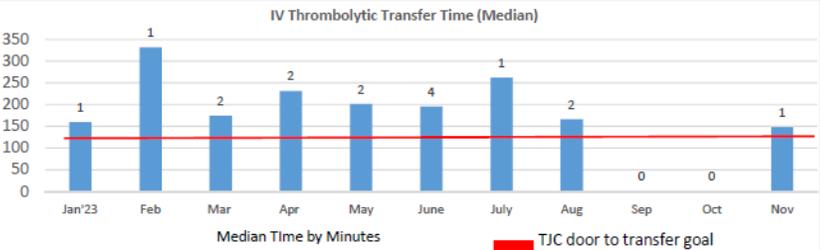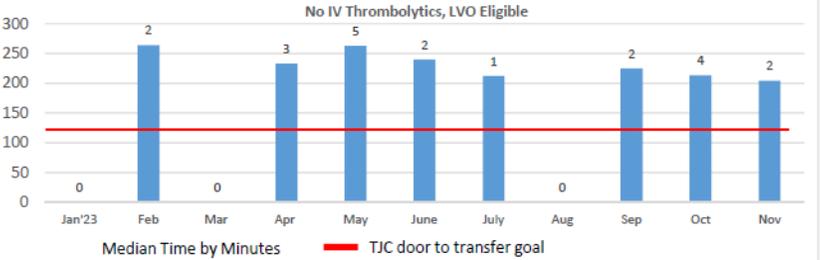
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Stroke Program Initiatives
2023-2024

ED Transfer Process on Ischemic/Hemorrhagic Stroke Patients

2023 TRANSFERS FROM ED TO ANOTHER ACUTE CARE FACILITY
Median Time by Minutes - Goal 120 Minutes

Hemorrhagic Stroke Transfer Time (Median)

Median Time by Minutes — TJC door to transfer goal

Hemorrhagic patients are transferred out for other procedures not done at KH, specifically coiling/clipping of aneurysms or bleeds. The ED Stroke Alert Committee reviews the process on an ongoing basis to help streamline the process, all action items are captured in PDSA document. The Covid 19 pandemic had caused delays in transfer times in 2021 with continued adverse effects due to staffing/resource availability in 2022.

IV Thrombolytic Transfer Time (Median)

Median Time by Minutes — TJC door to transfer goal

Transfers for ischemic strokes occur primarily if a large vessel occlusion is noted and would be eligible for endovascular treatment. As a result of the efforts made by the ED Stroke Alert Committee door to transfer times have improved; however Covid 19 pandemic had caused delays in transfer times in 2021 with continued adverse effects due to staffing/resource availability in 2022.

No IV Thrombolytics, LVO Eligible

Median Time by Minutes — TJC door to transfer goal

This cohort of patients have a large vessel occlusion that would be eligible for endovascular treatment and do not meet criteria for thrombolytic administration. The Covid 19 pandemic had caused delays in transfer times in 2021 with continued adverse effects due to staffing/resource availability in 2022.

READY TO FLY
CHECKLIST FOR ACUTE STROKE TRANSFER

-goal is to reduce time to transfer to less than 120 minutes from 1st arrival-
KEEP THIS FORM WITH PATIENT until transfer

PATIENT NAME_____ DOB_____ FIN_____

RESIDENT PHYSICIAN
- ☐ Receiving Destination (may be preliminary) _____
- ☐ COVID TEST ORDERED
- ☐ 1st Call to ED Case Manager "Heads up" for potential emergent Stroke transfer for transport weather checks.
- ☐ Patient weight and height obtained
  - Wt (kgs) _____
  - Ht (cm) _____
- ☐ Call to ED Pharmacist to notify of potential stroke transfer and tPA status.
- ☐ Non-essential infusions discontinued
- ☐ Essential infusions_____
- ☐ 2nd Call to ED Case Manager to Confirm Transfer Request- Relay remainder of info to AirComm
- ☐ Patient and family informed of need for rapid transfer upon flight crew arrival. Arrange for family visit/updates/well wishes prior to flight crew arrival

Name / Ext:

PATIENT NURSE
- ☐ Team Lead/Charge RN made aware to facilitate 1:1 staffing/expedition of tasks
- ☐ COVID TEST COLLECTED
- ☐ Patient on CPAP/BiPAP or intubated?
  - Yes_ No_
- ☐ Additional med supply for transport obtained from Pharmacy
- ☐ Certified Interpreter notified to be present on flight crew arrival (if applicable) x2501
- ☐ Package patient/belongings
- ☐ IMMEDIATELY "DISCHARGE PATIENT" in Cerner upon leaving unit

ED CASE MANAGER X2411
- ☐ Confirm acceptance of transfer, ETA, and needs to complete process with staff
- ☐ Attending Physician alerted to sign transfer forms

- ☐ TRANSFER FORMS signed and complete
- ☐ Time of transfer _____

*****THIS IS NOT PART OF THE PATIENT'S PERMANENT MEDICAL RECORD*****

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Stroke Program Dashboard
2023

	Bench-marks	2021	2022	Jan'23	Feb	Mar	Apr	May	June	July	Aug	Sep
Grouping of Stroke Patients												
Ischemic		409	383	33	38	34	31	37	36	37	36	34
Hemorrhagic		93	91	7	8	10	4	6	4	5	6	8
TIA (in-patient and observation)		221	211	16	11	12	10	15	13	15	20	11
Transfers to Higher Level of Care (Ischemic)		26	24	0	3	2	5	7	6	6	2	2
Transfers to Higher Level of Care (Hemorrhagic)		14	20	1	2	2	3	3	1	2	2	2
TOTAL NUMBER OF PATIENTS		763	729	57	62	60	53	68	60	65	66	57
Total # of Pts who rec'd thrombolytic (Admitted/Transferred)		40	48	3	2	2	2	3	3	2	2	1
% of thrombolytics - Inpatient & Transfers		9%	11%	9%	5%	6%	6%	7%	7%	5%	5%	3%
% Appropriate vital sign monitoring post thrombolytics	90%	83%	78%	100%	100%	100%	100%	66%	100%	50%	100%	100%
Rate of hemorrhagic complications for thrombolytics pts	0%	7%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Core Measure: OP-23 Head CT/MRI Results	72%	78%	75%	100%	100%	75%	33%	100%	80%	100%	50%	NA
% Appropriate stroke order set used (In-Patient)	90%	92%	95%	96%	92%	88%	95%	97%	97%	89%	98%	100%
% Appropriate stroke order set used (ED)	90%	87%	88%	82%	76%	78%	89%	87%	75%	78%	91%	95%
STK-1 VTE (GWTG, TJC)	85%	88%	89%	90%	79%	73%	73%	73%	76%	79%	80%	79%
STK-2 Discharged on Antithrombotic (GWTG, TJC)	85%	100%	100%	100%	97%	100%	100%	100%	100%	97%	100%	100%
STK-3 Anticoag for afib/aflutter ordered at Dc (GWTG, TJC)	85%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
STK-4 Thrombolytics Given within 60 min (GWTG, TJC)	75%	92%	75%	100%	100%	NA	NA	100%	100%	NA	NA	100%
STK-5 Early Antithrombotics by end of day 2 (GWTG, TJC)	85%	100%	100%	100%	100%	97%	100%	100%	100%	97%	97%	100%
STK-6 Discharged on Intensive Statin (GWTG, TJC)	85%	98%	99%	94%	96%	94%	97%	90%	94%	94%	81%	92%
STK-8 Stroke Education (GWTG, TJC)	75%	99%	100%	91%	94%	91%	100%	100%	100%	100%	100%	100%
STK-10 Assessed for Rehab (GWTG, TJC)	75%	100%	100%	100%	100%	97%	100%	100%	100%	100%	100%	100%
% Dysphagia Screen prior to po intake (GWTG)	75%	86%	81%	80%	71%	71%	87%	83%	69%	81%	85%	71%
% Smoking Cessation (GWTG)	85%	100%	100%	100%	100%	86%	100%	100%	100%	100%	100%	100%
% LDL Documented (GWTG)	75%	99%	99%	97%	100%	97%	93%	97%	95%	94%	92%	97%
% tPA Arrive by 3.5 Hrs; Treat by 4.5 Hrs (GWTG)	75%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%	100%
% NIHSS Reported (GWTG)	75%	97%	97%	90%	100%	97%	100%	100%	95%	97%	100%	97%
Ischemic ALOS/GMLOS excess	<1.0	2.09	3.36	4.45	4.6	1.7	1	3.9	2	2.9	2.4	0.9
Hemorrhagic ALOS/GMLOS excess	<1.0	3.72	9.41	0.9	15.4	-1.25	4.35	20	3.4	9	3.9	5.2
Ischemic Mortality ACA O/E Ratio (Midas)	<1.0	1.18	0.68	1.1	0.6	0	1.4	1.4	2	0.5	0	1.4

Stroke Program
Performance Improvement Initiatives
Fiscal Year 2023-2024

- ➢ ED: Door to IV thrombolytics within 60 minutes
- ➢ ED/ICU: Post IV Thrombolytic monitoring
- ➢ ED: Rapid Identification of hemorrhagic stroke patients
- ➢ ED: ED Provider documentation compliance
- ➢ ED: Stroke alert/tenecteplase process review
- ➢ ED/EMS: EMS patient contact business card
- ➢ ED/RRT: Tenecteplase consent process
- ➢ IN_HOUSE: TIA length of stay
- ➢ STROKE PROGRAM: Follow up calls/patient perception
- ➢ STROKE PROGRAM: VTE prophylaxis compliance

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Stroke Program Initiatives 2023-2024

- Review of possible change as a result of the 2023 AHA/ASA Guidelines for Management of Patients with Aneurysmal Subarachnoid Hemorrhage

- VTE Prophylaxis compliance on the admitted stroke patient population

- Length of Stay (LOS) on our TIA observation patient population

- Nursing dysphagia screening and Speech Therapy process improvement project

- National Institute of Health Stroke Scale (NIHSS) certification process

- Education provided to all District staff, EMS agencies and throughout the community on BE FAST and smartphone Medical ID app information

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Key Initiatives to Improve Stroke Recognition and Treatment

BE FAST

BALANCE Sudden loss of balance

EYES Sudden change in vision

FACE Sudden facial droop

ARM Sudden arm or leg weakness

SPEECH Sudden speech difficulty

TIME to call 911

FAST emergency treatment may reduce disability and save your life
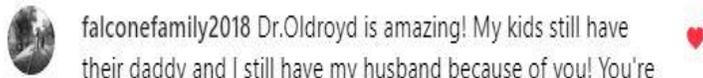
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Action Steps Taken:

- Kaweah Health spearheaded this valley wide initiative to increase awareness and use of the smartphone Medical ID app

- Central valley stroke coordinator group agreed to share this information with their hospital and provider staff, patients and community

- Education provided to all KH staff at the hospital BBQ in May 2022

- Highlighted in Kaweah Compass in May 2022

- Available on Kaweah Health's website: https://www.kaweahhealth.org/our-services/stroke-program/

- Proposal to add Medical ID information in the patient discharge summary/instructions

Key Initiatives to Improve Stroke Awareness: Community Education

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Stroke Program Dashboard 2023-2024

	Bench-marks	2021	2022	Jan'23	Feb	Mar	Apr	May	June	July	Aug	Sep
Grouping of Stroke Patients												
Ischemic		**409**	383	33	38	34	31	37	36	37	36	34
Hemorrhagic		**93**	91	7	8	10	4	6	4	5	6	8
TIA (in-patient and observation)		**221**	211	16	11	12	10	15	13	15	20	11
Transfers to Higher Level of Care (Ischemic)		**26**	24	0	3	2	5	7	6	6	2	2
Transfers to Higher Level of Care (Hemorrhagic)		**14**	20	1	2	2	3	3	1	2	2	2
TOTAL NUMBER OF PATIENTS		763	729	57	62	60	53	68	60	65	66	57
Total # of Pts who rec'd thrombolytic (Admitted/Transferred)		**40**	48	3	2	2	2	3	3	2	2	1
% of thrombolytics - Inpatient & Transfers		**9%**	**11%**	**9%**	**5%**	**6%**	**6%**	**7%**	**7%**	**5%**	**5%**	**3%**
% Appropriate vital sign monitoring post thrombolytics	90%	83%	78%	100%	100%	100%	100%	66%	100%	50%	100%	100%
Rate of hemorrhagic complications for thrombolytics pts	0%	7%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Core Measure: OP-23 Head CT/MRI Results	72%	78%	75%	100%	100%	75%	33%	100%	80%	100%	50%	NA
% Appropriate stroke order set used (In-Patient)	90%	92%	95%	96%	92%	88%	95%	97%	97%	89%	98%	100%
% Appropriate stroke order set used (ED)	90%	87%	88%	82%	76%	78%	89%	87%	75%	78%	91%	95%
STK-1 VTE (GWTG, TJC)	85%	88%	89%	90%	79%	73%	73%	73%	76%	79%	80%	79%
STK-2 Discharged on Antithrombotic (GWTG, TJC)	85%	100%	100%	100%	97%	100%	100%	100%	100%	97%	100%	100%
STK-3 Anticoag for afib/aflutter ordered at Dc (GWTG, TJC)	85%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
STK-4 Thrombolytics Given within 60 min (GWTG, TJC)	75%	92%	75%	100%	100%	NA	NA	100%	100%	NA	NA	100%
STK-5 Early Antithrombotics by end of day 2 (GWTG, TJC)	85%	100%	100%	100%	100%	97%	100%	100%	100%	97%	97%	100%
STK-6 Discharged on Intensive Statin (GWTG, TJC)	85%	98%	99%	94%	96%	94%	97%	90%	94%	94%	81%	92%
STK-8 Stroke Education (GWTG, TJC)	75%	99%	100%	91%	94%	91%	100%	100%	100%	100%	100%	100%
STK-10 Assessed for Rehab (GWTG, TJC)	75%	100%	100%	100%	100%	97%	100%	100%	100%	100%	100%	100%
% Dysphagia Screen prior to po intake (GWTG)	75%	86%	81%	80%	71%	71%	87%	83%	69%	81%	85%	71%
% Smoking Cessation (GWTG)	85%	100%	100%	100%	100%	86%	100%	100%	100%	100%	100%	100%
% LDL Documented (GWTG)	75%	99%	99%	97%	100%	97%	93%	97%	95%	94%	92%	97%
% tPA Arrive by 3.5 Hrs; Treat by 4.5 Hrs (GWTG)	75%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%	100%
% NIHSS Reported (GWTG)	75%	97%	97%	90%	100%	97%	100%	100%	95%	97%	100%	97%
Ischemic ALOS/GMLOS excess	<1.0	2.09	3.36	4.45	4.6	1.7	1	3.9	2	2.9	2.4	0.9
Hemorrhagic ALOS/GMLOS excess	<1.0	3.72	9.41	0.9	15.4	-1.25	4.35	20	3.4	9	3.9	5.2
Ischemic Mortality ACA O/E Ratio (Midas)	<1.0	1.18	0.86	1.1	0.6	0	1.4	1.4	2	0.5	0	1.4

PI Goal: VTE Compliance   2022

Plan – Goals	Solutions (root cause)
AHA Get with the Guidelines Metric: VTE compliance >85% on all ischemic and hemorrhagic stroke patients, when applicable. VTE compliance rate is lower than we would like, fallouts occur with SCDs are ordered and not placed and/or documented in Cerner.	- Patient is low risk, doesn't need SCDs - Admitted patients in 1E - Documentation of SCDs not intuitive for nursing

DO – Implementation (include dates)

- February 2021: Changes made in Cerner i-view allowing nursing the option to choose initiated, continued, discontinued or agitated, unable to apply.
- Requested changes to stroke related PowerPlans: provide a field for providers to choose: pt is low risk, VTE prophylaxis not required. (request was denied October 2021, OSC felt this documentation should be in the provider's notes)
- December 2021: When an order for Sequential Compression Devices (SCDs) is placed, it will generate a task for nursing to "initiate SCDs" along with the continuous order. Education to nursing staff sent out 12/14/21.
- October 2022: PI Project to improve VTE compliance from the provider standpoint. Focus on appropriate screening and treatment.
- December 2022: Collaboration with nursing to improve Core Measure VTE and Stroke VTE prophylaxis compliance.
- March 2023: TY Resident Dr. Jain attempted to incorporate Padua Prediction Score for physicians to use to assist in appropriate VTE prophylaxis. Action not completed due to concern of physician workflow and physicians not utilizing the tool.
- July 2023: ED: Met with ED leadership and agreed to have the equipment band in FirstNet under interventions. This should help in the future when LOS in 1E is longer than anticipated
- July 2023: Nursing: The initiate SCD task was fixed. nursing is now able to see it on their nursing task list; Nursing ensured SCD machines are in each room, sleeves pared to ensure they are readily available; patients coming up from OR/PACU with SCDs on
- August 2023: Physicians: Modifications to all stroke and TIA PowerPlans to offer an option to providers to order "low risk" ambulate patient. This KDHub update went live on 8/8/23 and sent to providers. Dr. Oldroyd will sent a memo to physicians regarding this topic
- August 2023: Nursing: JIRA ticket submitted to clinical education to assist in educating and re-enforcing the importance of why SCDs are needed, placed and documented.
- August 2023: KD Hub update to nursing documentation. Equipment/SCD documentation will also be located in the systems assessment i-view. Kim Roller sent notice out, go live date was 8/17/23
- Sandy Volchko attended Patient Care Management meeting 8/21/23 to reinforce importance of SCDs documentation and referring managers to KD Hub update sent in August
- September 2023 – Evaluate an attestation for end of shift, to include patient refusal (ie. similar to turn workflow), need to evaluate GWTG measure specs to ensure an attestation will meet measure requirements. Consider CNAs do not document in critical care, and minimal in step down (5T & 3W).
- September 2023 Stroke patient report daily – SCDs and dysphagia now on report. Need to verify what elements for SCDs are needed in the report
- September 2023 – Consider adding to CLO report (daily report for nursing units), need to determine which element to include, initiate vs attestation/documentation. Consider adding to HUC duties to verify and follow up with CN if documentation missing.
- December 2023 – Added attestation confirming SCD usage in the Nursing i-view documentation

Ongoing: VTE prophylaxis education with focus on SCD placement is included in nursing competencies, annual stroke education, advanced stroke class and the critical care stroke education.

STUDY – RESULTS (CURRENT AND YTD DATA)

_____

STK 1: VTE Prophylaxis

Data: Sep '22–Aug '23	Goal	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
% VTE Prophylaxis	85%	88%	83%	100%	94%	90%	79%	73%	73%	72%	76%	79%	80%

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| ACT – OUTCOMES & CONCLUSIONS To Date	CONTACT
Outcomes / Conclusions • Ongoing review of process improvement opportunities. • Pending Resident PI project	o Cheryl Smit, RN, Stroke Manager Tel: 624-2133

2021-2022 Stroke Alert Dashboard
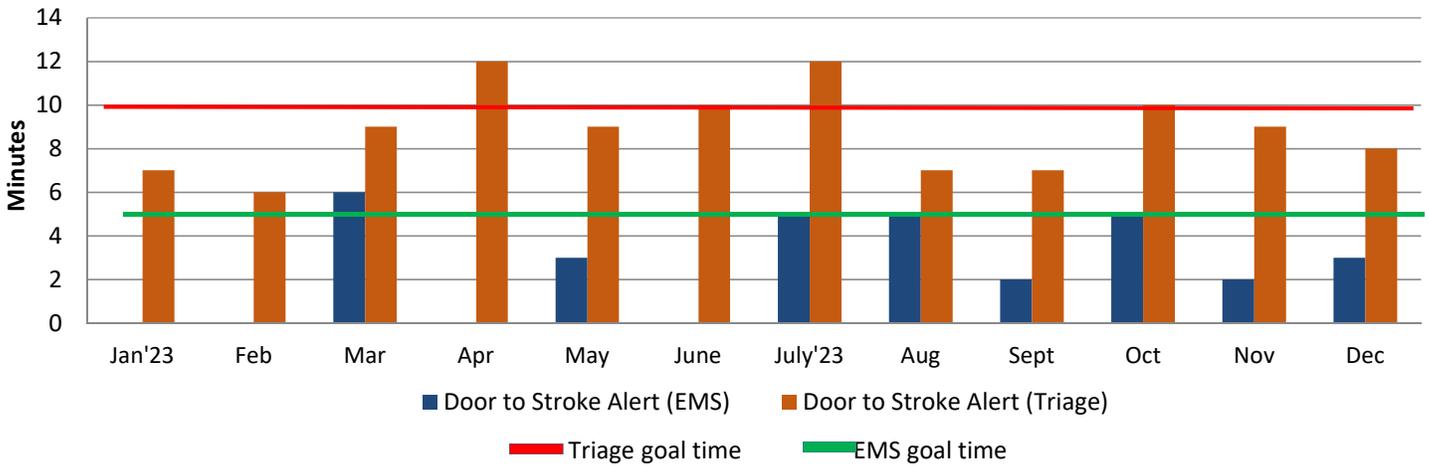
Door to Stroke Alert (median times)

Per KH ED Stroke Alert process; stroke alerts to be called within 5 min for EMS and 10 min for Triage. Since the opening of the new Triage/zone 5 areas (summer of 2021), significant improvements have been noted in the Triage process.

Door to MD Seen (median time)
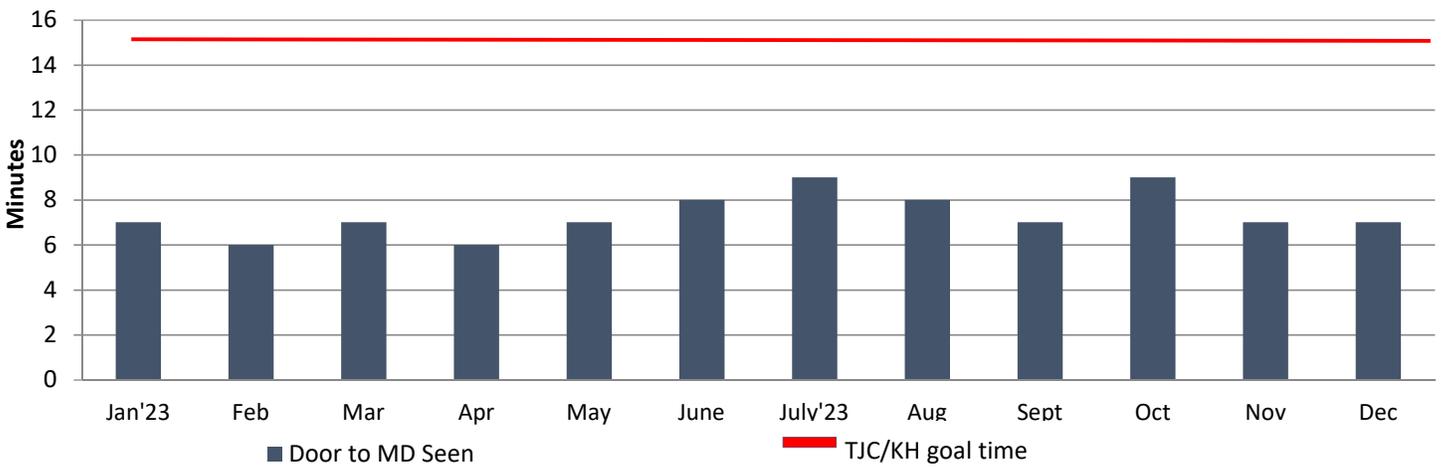
The expectation is that the physician will see the stroke alert patient within 15 minutes of arrival. Improvements made throughout the past year include: early notification from EMS, MD meets the pt at the door upon arrival, scribe documents first seen time in the record.
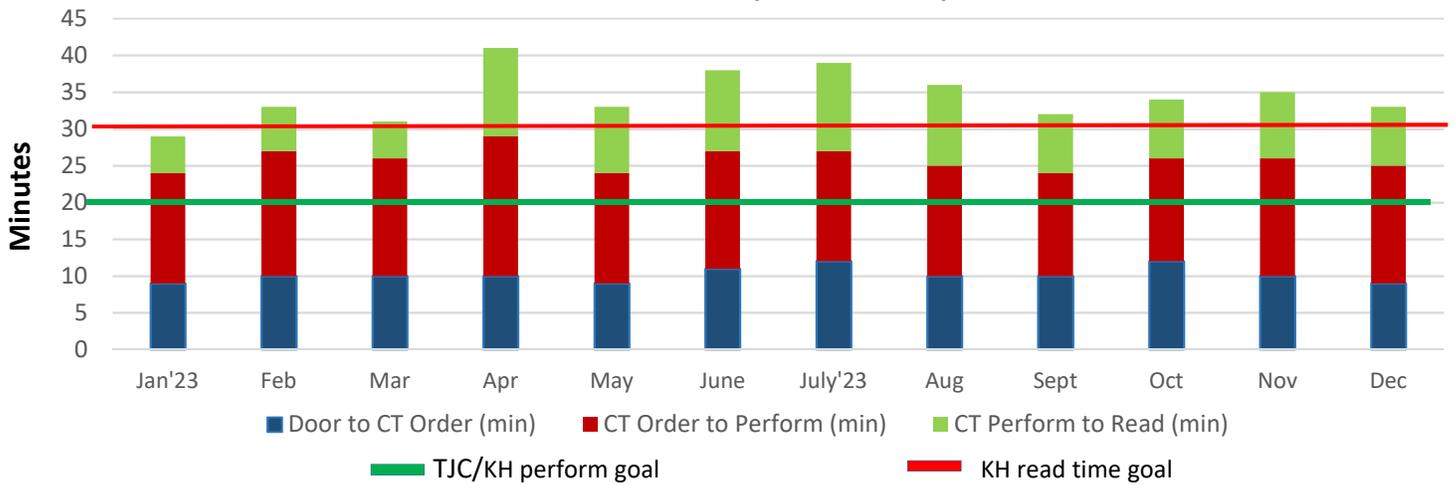
% NIHSS Complete
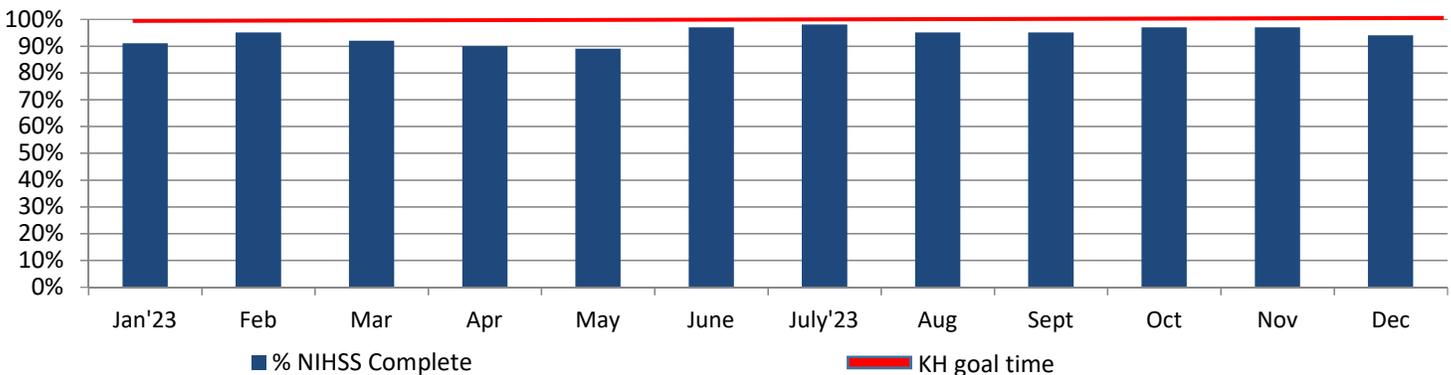
The expectation is that all stroke alert patients will have a NIHSS completed by a certified ED staff member and/or the attending physician; the primary responsible person is the attending/resident physician. This audit ONLY tracks if attending/resident physician have completed a full NIHSS in the ED record.
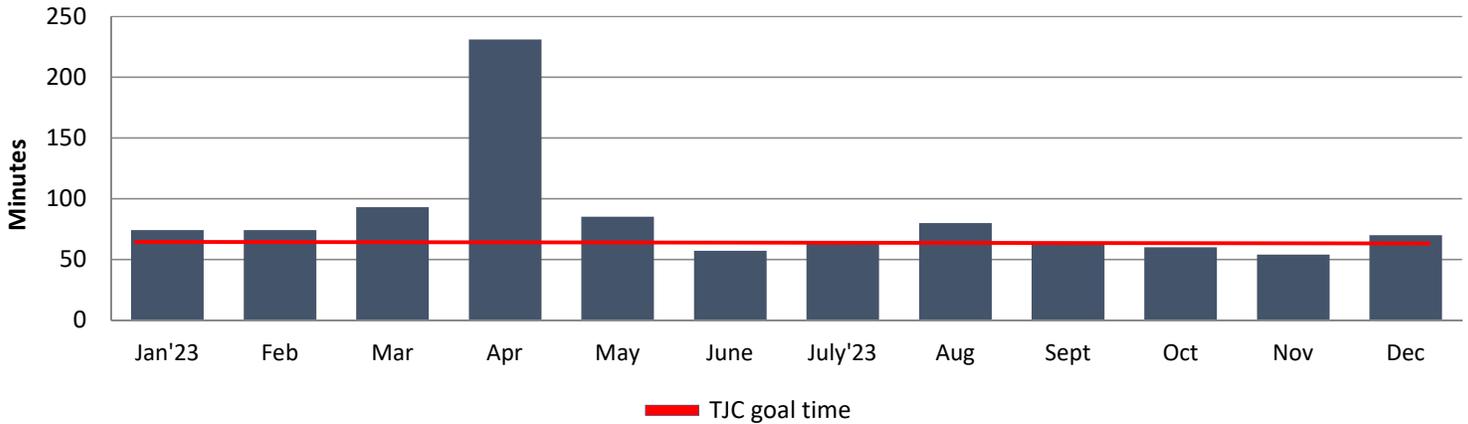
2021-2022 Stroke Alert Dashboard

Door to CT Times (median times)

Legend:
- ■ Door to CT Order (min)
- ■ CT Order to Perform (min)
- ■ CT Perform to Read (min)
- ▬ TJC/KH perform goal
- ▬ KH read time goal

CMS and TJC expectation is that the CT will be performed by 20 minutes and read by 45 minutes of arrival. KH's CT read time goal is 30 minutes

Door to IV Thrombolytics (median time)

Legend:
- ▬ TJC goal time

The data in this graph includes all thrombolytic patients which differs from the TJC rate because exclusion criteria is not used. TJC expectation is that IV thrombolytics are given within 60 minutes to eligible patients who present for stroke care. AHA/ASA GWTG expectations were update in 2019 with new IV thrombolytic goal time to 45 minutes at least 75% of the time (when applicable). To meet this goal, continued changes to the stroke alert process have been made.

ED Stroke Alert Volume

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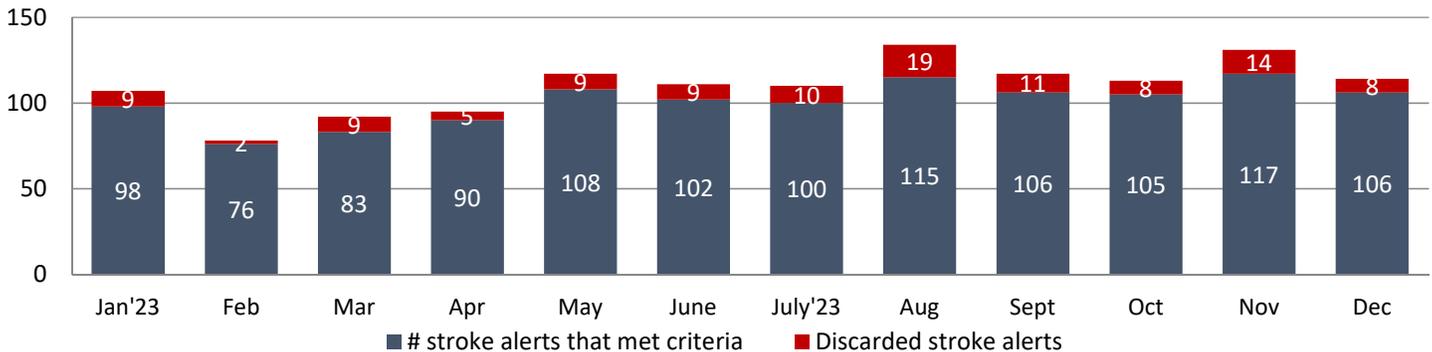
Stroke alert criteria includes: pt presenting with stroke like symptoms +BE FAST screen, stroke alerts called prior to arrival and up to 1 hour after arrival. Excluded cases: >1 after arrival or if stroke alert was cancelled.

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2021-2022 Stroke Alert Dashboard

Door to Lab Time (median times)

Legend: ■ Door to Lab Draw ■ Lab Draw to Verified ▬ TJC/KH goal time
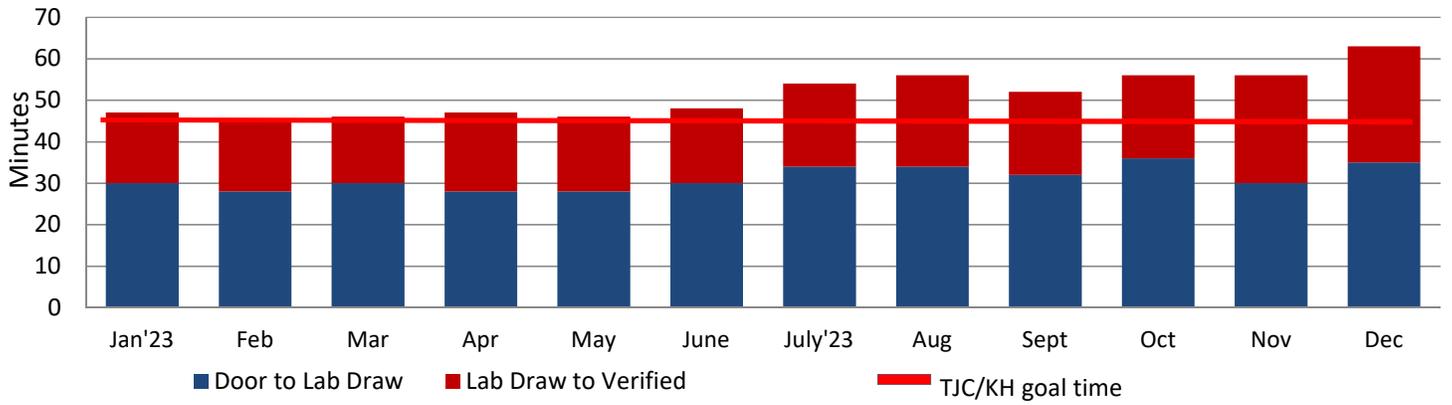
TJC expectation is that laboratory tests are completed within 45 minutes of arrival. Changes in stroke alert process has been made early 2019 to improve lab verified times. Action items taken: IV start kits in CT rooms with lab tubes, lab label makers in both CT rooms and specimens taken immediately down to lab.

Door to EKG Time (median time)

Legend: ▬ TJC/KH goal time
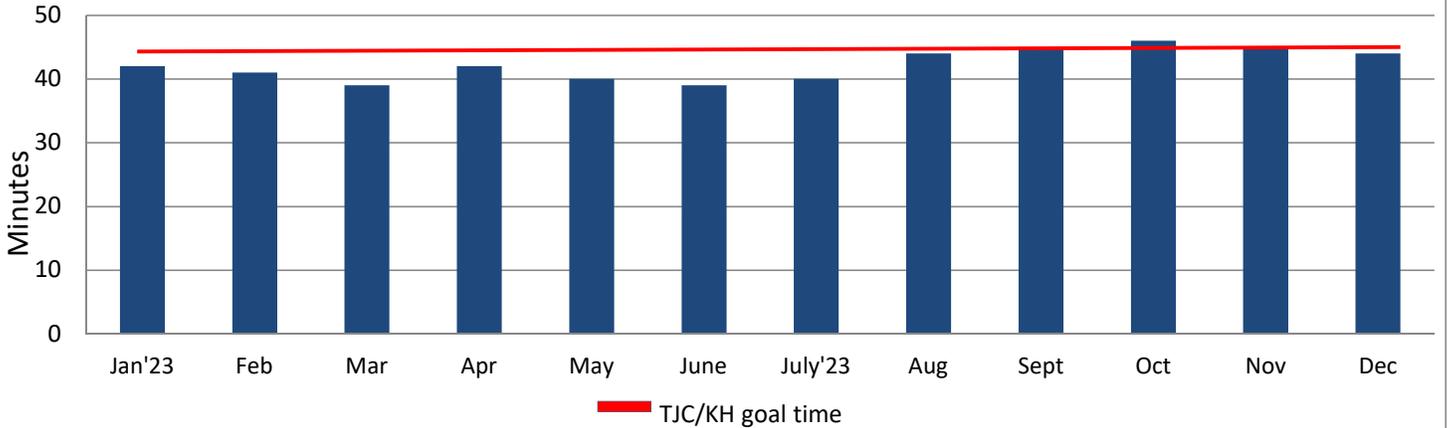
TJC expectation is that EKGs are completed within 45 minutes of arrival.

% Dysphagia screen completed when ordered

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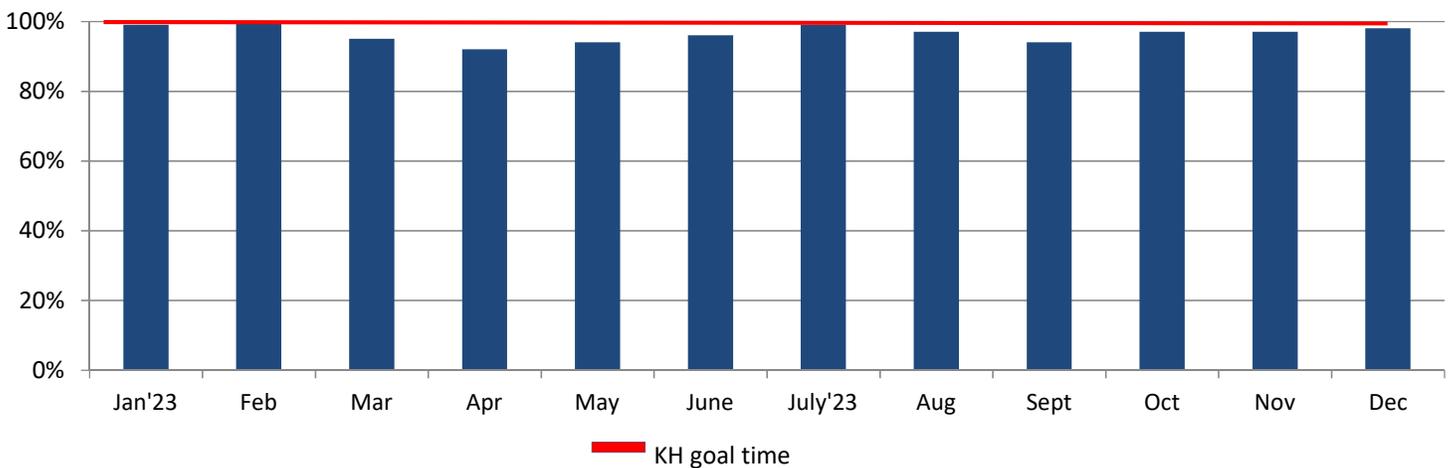
Dysphagia screening should be completed by the RN on all stroke alert patients prior to any po intake, including meds. Dysphagia screening is part of the ED stroke alert order sets. Goal is 100% compliance.

2023-2024
In-House Stroke Alert Dashboard

Stroke Alert Location

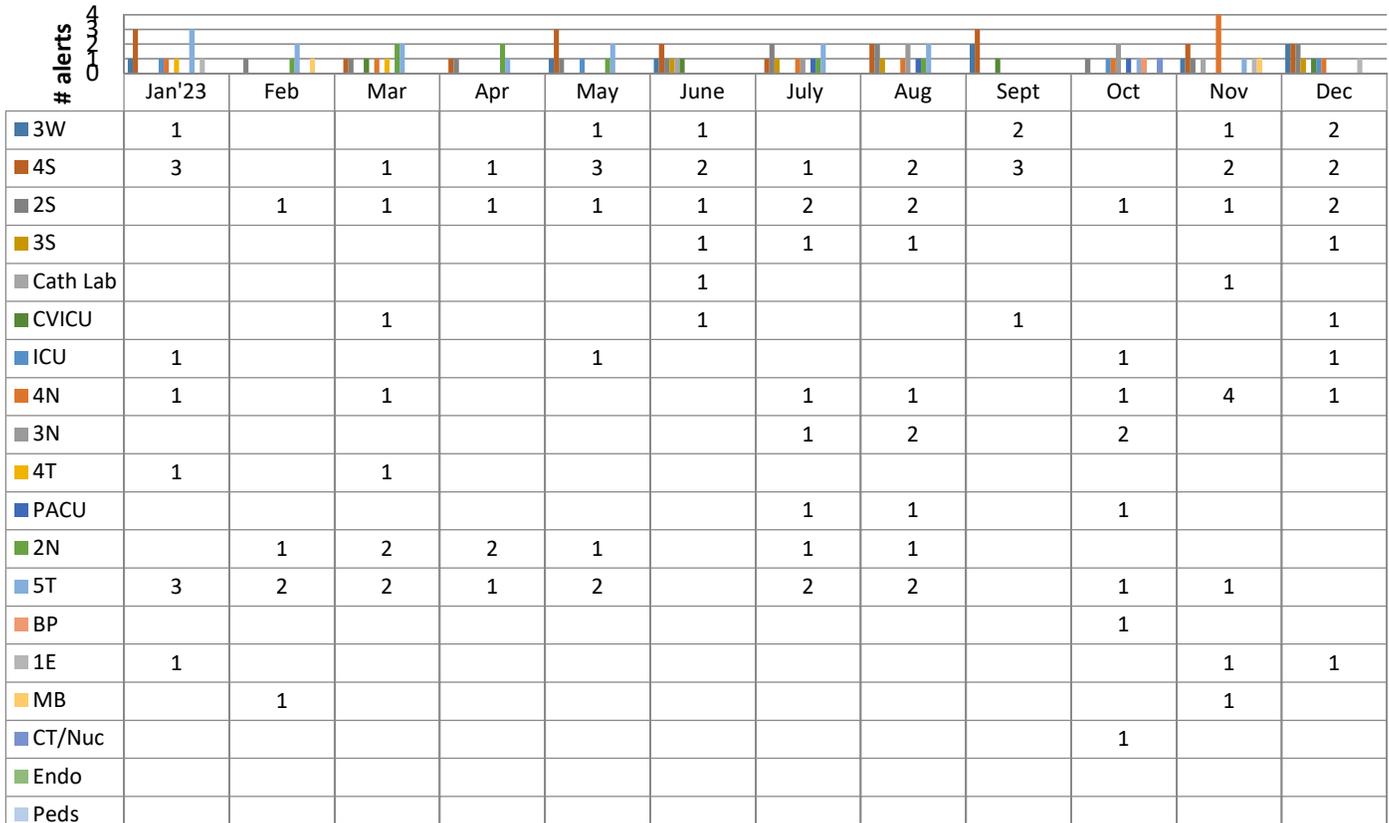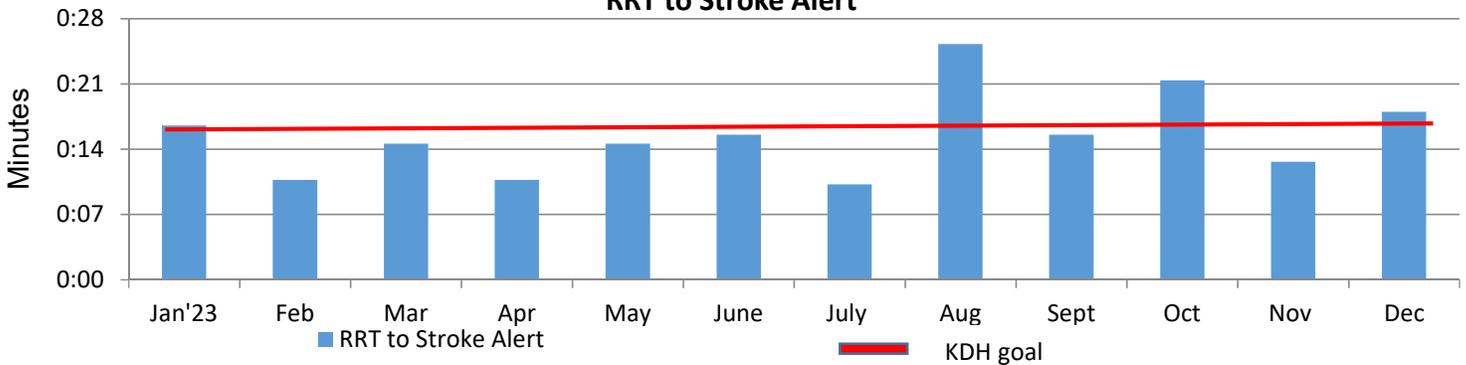|	Jan'23	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
3W	1				1	1			2		1	2
4S	3		1	1	3	2	1	2	3		2	2
2S		1	1	1	1	1	2	2		1	1	2
3S							1	1	1			1
Cath Lab						1					1	
CVICU			1			1			1			1
ICU	1				1					1		1
4N	1		1				1	1		1	4	1
3N							1	2		2		
4T	1		1									
PACU							1	1		1		
2N		1	2	2	1		1	1				
5T	3	2	2	1	2		2	2		1	1	
BP										1		
1E	1										1	1
MB		1									1	
CT/Nuc										1		
Endo												
Peds												

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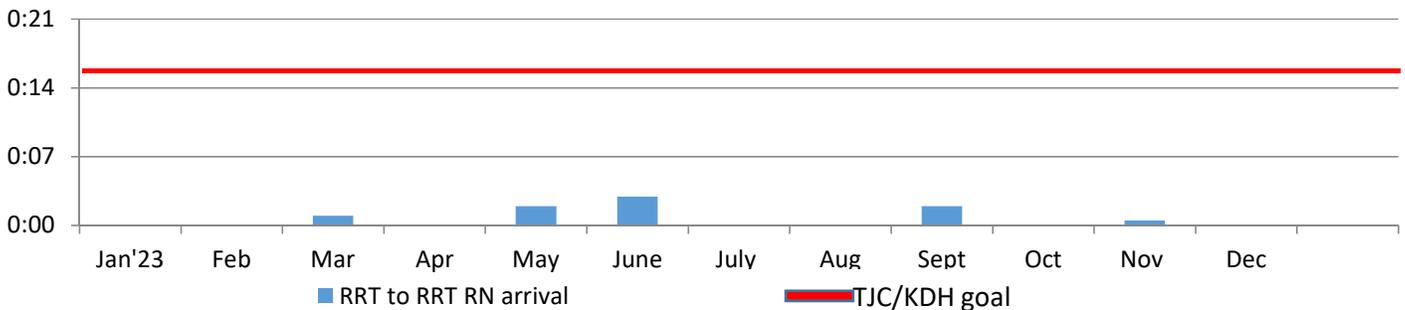
TJC expectation is that a designated provider is at the bedside within 15 minutes of stroke alert. KDH has designated the RRT RN as the provider for in-house stroke alerts.

2023-2024
In-House Stroke Alert Dashboard

Stroke Alert to CT Times

Legend:
- Stroke alert to CT Order-
- CT Order to CT Perf
- CT Performed to CT Read
- TJC/KDH goal
- KDH goal
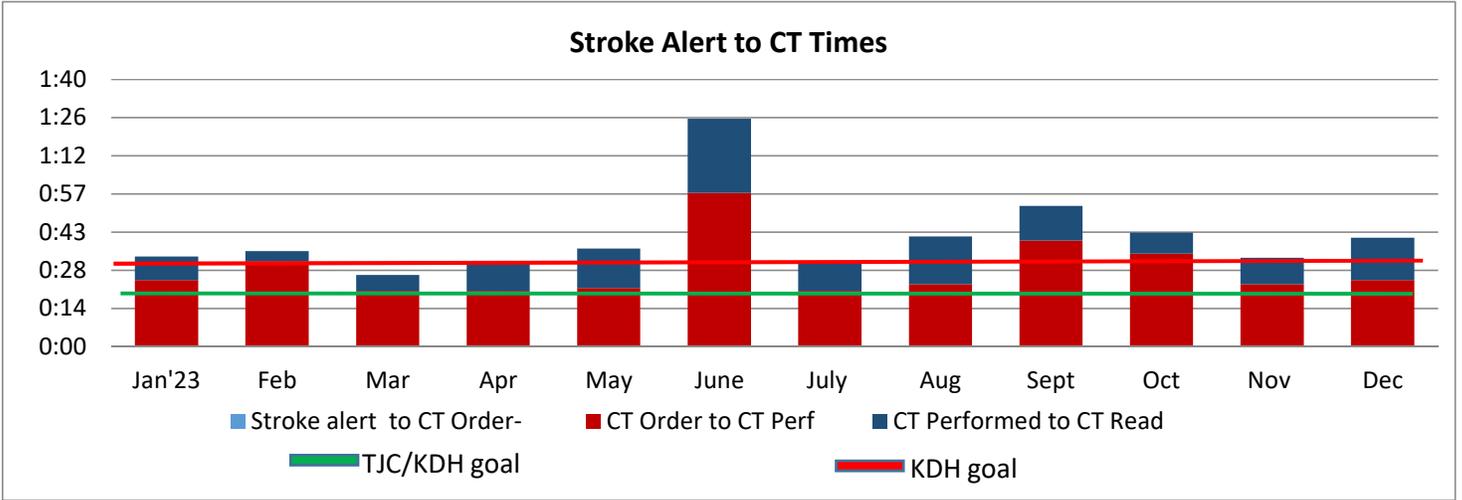
TJC expectation is that the CT will be read within 45 minutes of arrival. KDH's goal is 30 minutes **(red line).** The expectation is that the CT will be performed within 20 minutes of alert **(green line).**

% neuro contact

Legend: % neuro contact
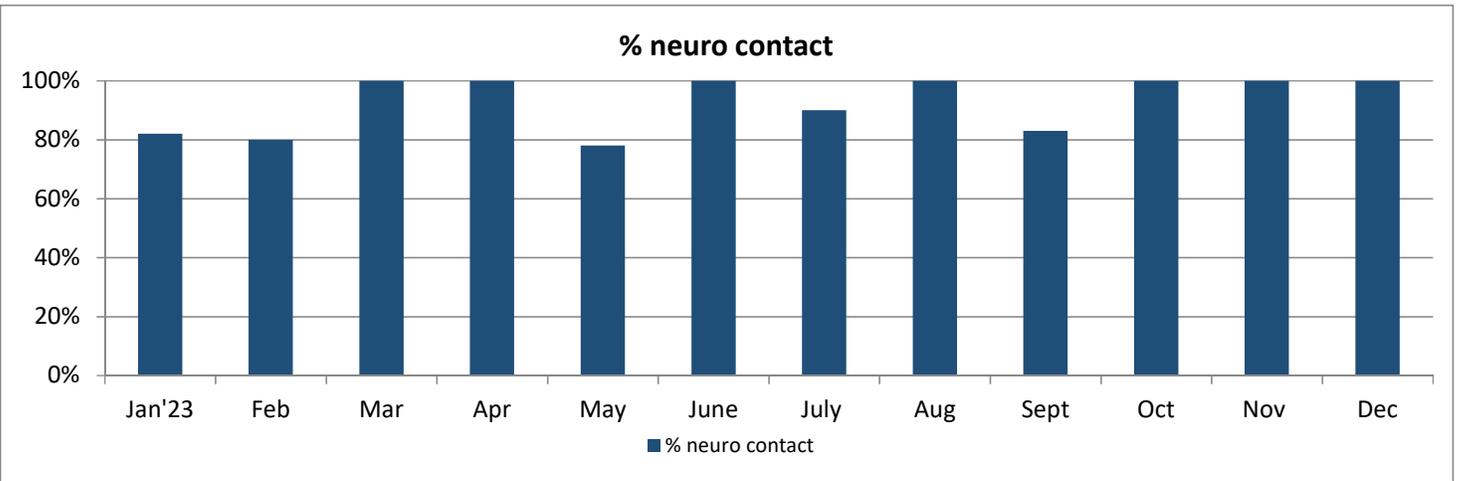
Neurology consultation should occur on all in-house stroke alerts.

% dysphagia screen done

Legend:
- % dysphagia screen done
- KDH goal
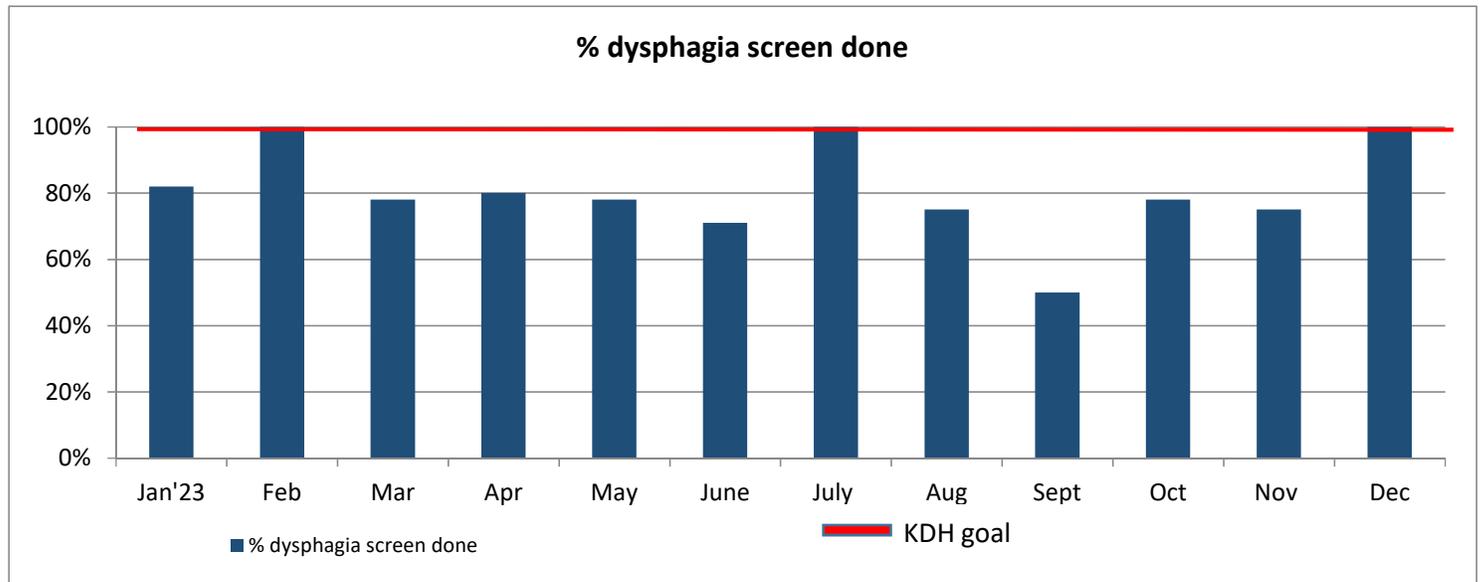
Whenever there are new or worsening neurological deficits ≥3 points, the RN should perform a dysphagia screen to evaluate the patient's ability to swallow.

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Alert to thrombolytic time

■ Alert to thrombolytic time ▬ TJC goal
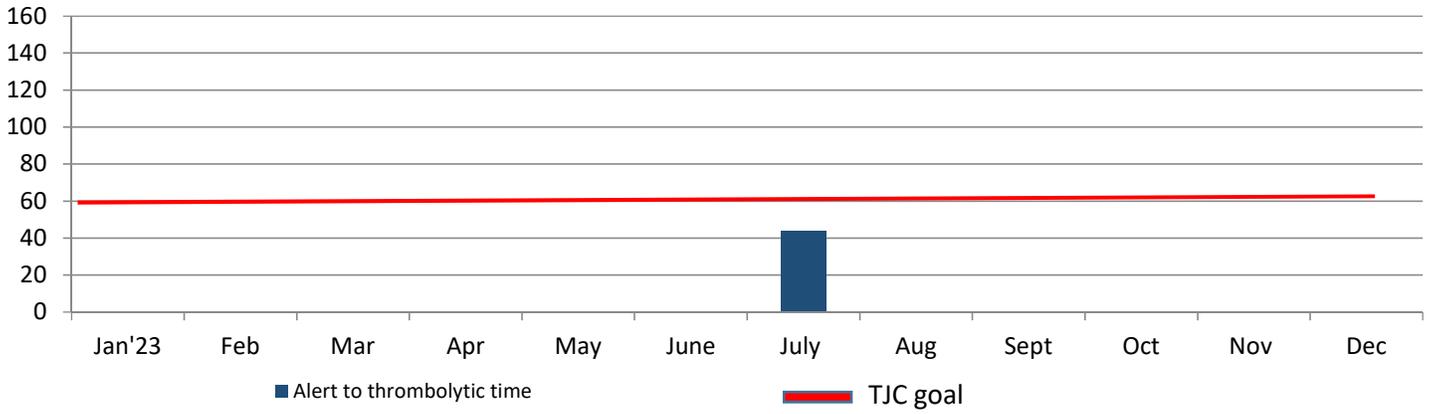
ED Patients: TJC expectation is that IV thrombolytics are given within 60 minutes to eligible patients who present for stroke care at least 50% of the time. In-House Stroke alerts: KDH expectation is that IV thrombolytics are given within 60 minutes to eligible patients who have been identified with new or worsening stroke symptoms. In-house thrombolytic administration rarely occurs; however it is tracked to ensure compliance throughout the continuum of care.

Thrombolytic flowsheet completed
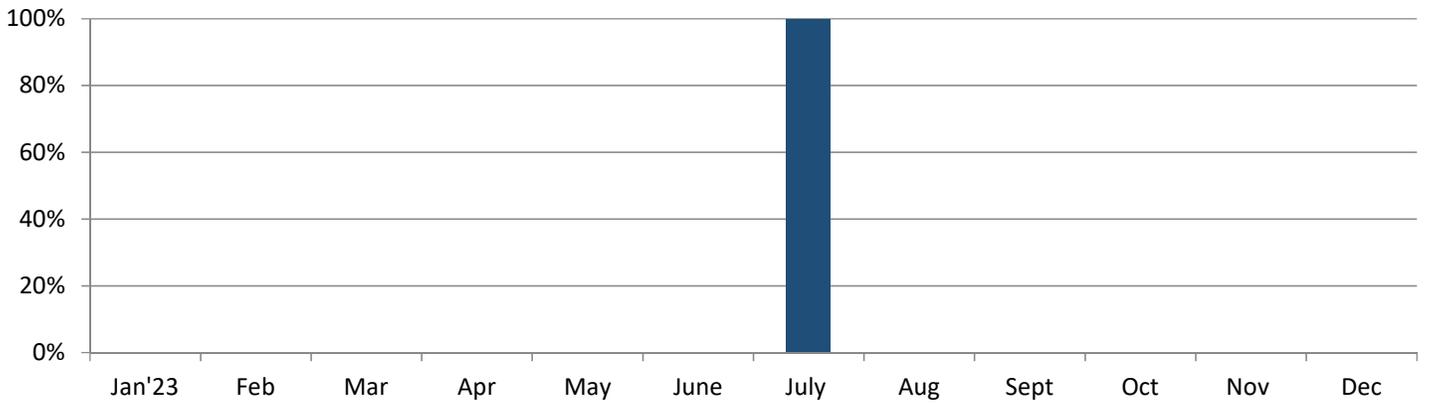
KH expectation is that post thrombolytic monitoring is in compliance with our standardized protocol. All key elements must be completed to be determined as compliant.

2023 TRANSFERS FROM ED TO ANOTHER ACUTE CARE FACILITY
Median Time by Minutes - Goal 120 Minutes

Hemorrhagic Stroke Transfer Time (Median)

Median TIme by Minutes — TJC door to transfer goal

Hemorrhagic patients are transferred out for other procedures not done at KH, specifically coiling/clipping of aneurysms or bleeds. The ED Stroke Alert Committee reviews the process on an ongoing basis to help streamline the process, all action items are captured in PDSA document. The Covid 19 pandemic had caused delays in transfer times in 2021 with continued adverse effects due to staffing/resource availability in 2022.

IV Thrombolytic Transfer Time (Median)

Median TIme by Minutes — TJC door to transfer goal

Transfers for ischemic strokes occur primarily if a large vessel occlusion is noted and would be eligible for endovascular treatment. As a result of the efforts made by the ED Stroke Alert Committee door to transfer times have improved; however Covid 19 pandemic had caused delays in transfer times in 2021 with continued adverse effects due to staffing/resource availability in 2022.

No IV Thrombolytics, LVO Eligible

Median Time by Minutes — TJC door to transfer goal

This cohort of patients have a large vessel occlusion that would be eligible for endovascular treatment and do not meet criteria for thrombolytic administration. The Covid 19 pandemic had caused delays in transfer times in 2021 with continued adverse effects due to staffing/resource availability in 2022.

Sepsis
Quality Focus Team Report

January 2024

Erika Pineda BSN, RN, PHN, CPHQ
Quality Improvement Manager
Dr. Lamar Mack, MD, MHA
Medical Director of Quality & Patient Safety

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Acronyms

- ALOS - Average Length of Stay
- BC – Blood Culture lab test
- Dx - Diagnosis
- ED – Emergency Department
- EM – Emergency Medicine GME Program
- FM – Family Medicine GME Program
- GMLOS – Geometric Length of Stay
- ICD10 – Billing Codes
- LA – Lactic Acid Lab Test
- RRT – Rapid Response Team
- SEP-1 – CMS Sepsis Bundle Measure

- VBG – Venous Blood Gas lab test
- VS – Vital Signs
- HR – Heart Rate
- PPR – Peripheral Pulse Rate
- APR – Apical Pulse Rate
- IBW – Ideal Body Weight
- PNF – Provider Notification Form
- OFI – Opportunity for Improvement

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SEP-1 Early Management Bundle Compliance

CA State Compliance 65% ~ National Compliance 59% ~ Top Performing Hospitals 80%

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

Goal for FY24 =

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Sepsis Quality Focus Team DASHBOARD

CMS SEP-1 Bundle Compliance

	Goal	FY2020	FY2021	FY2022	FY2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	YTD
SEP-1 CMS % bundle compliance	85%	66.9%	74.6%	75.0%	73.0%	68%	77%	76%	76%									75%
Number of CMS compliant cases (n)	n/a	198	206	300	243	13	17	16	22									68
Total number CMS cases abstracted (d)	n/a	296	276	400	333	19	22	21	29									91
% Concurrent bundle compliant cases	75%	78%	77%	79%	86%	88%	86%	100%	88%									90%
Number of concurrent compliant cases (n)	n/a	646	785	656	479	46	51	29	46									172
Number of concurrent cases abstracted (d)	n/a	829	1013	835	560	52	59	29	52									192
Number of Non-Compliant CMS cases *with* coordinator	n/a					1	0	1	0									2
Number of Non-Compliant CMS cases *without* coordinator	n/a					5	7	4	7									23
% of Non-Compliant CMS cases *with* coordinator	n/a					17%	0%	20%	0%									
% of Non-Compliant CMS cases *without* coordinator	n/a					83%	100%	80%	100%									

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

SEP-1 Early Management Bundle Compliance

CA State Compliance 65% ~ National Compliance 59% ~ Top Performing Hospitals 80%

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

Sepsis Quality Focus Team DASHBOARD

SEP-1 Bundle Elements	Goal	FY2020	FY2021	FY2022	FY2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	YTD
3 hr SEP-1 Bundle % Compliance	95%	76.0%	78.6%	88.0%	79.0%	79%	82%	81%	79%									80%
3hr SEP-1 BundleTotal Patients abstracted (d)	n/a	296	276	401	334	19	22	21	29									91
% Antibiotics adminstered	95%	97.3%	95.7%	93.0%	94.0%	95%	95%	100%	86%									94%
% Blood Cultures drawn	95%	93.8%	92.0%	93.0%	94.0%	89%	90%	86%	100%									91%
% Lactic Acid drawn	95%	95.6%	97.9%	98.0%	98.0%	100%	100%	100%	100%									100%
% Fluid Resuscitation completed	95%	88.3%	90.7%	92.0%	84.0%	92%	93%	93%	88%									91%
6 hr bundle % Compliance	95%	85.4%	93.5%	90.0%	91.0%	83%	94%	91%	95%									91%
6hr SEP-1 BundleTotal Patients abstracted (d)	n/a	186	170	250	204	12	17	11	21									61
% Repeat LA drawn	95%	89.6%	94.0%	92.0%	92.0%	92%	100%	91%	95%									95%
% Reassessment completed	95%	92.9%	98.5%	91.0%	99.0%	100%	100%	100%	100%									100%
% Vasopressors initated when indicated	95%	93.30%	100%	100%	100%	89%	91%	100%	100%									95%

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

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

SEPSIS ANY DIAGNOSIS OBSERVED/EXPECTED MORTALITY RATIO
September 2022 – October 2023

- Ratio < 1.0 indicates that at least expected deaths do not exceed actual (Lower ratio is better)

- FY 2023 KH Ratio: 1.12 (140/125)

- KH FY 2024 Goal is ≤0.78 o/e sepsis Mortality

- FY 2024 (July – October) KH Ratio: 0.80 (27/33.59)

- Sepsis 1-Hour Bundle go live date 6/20/23

Midas Risk Adjusted Model v6 comparison analysis (582-624 sites)
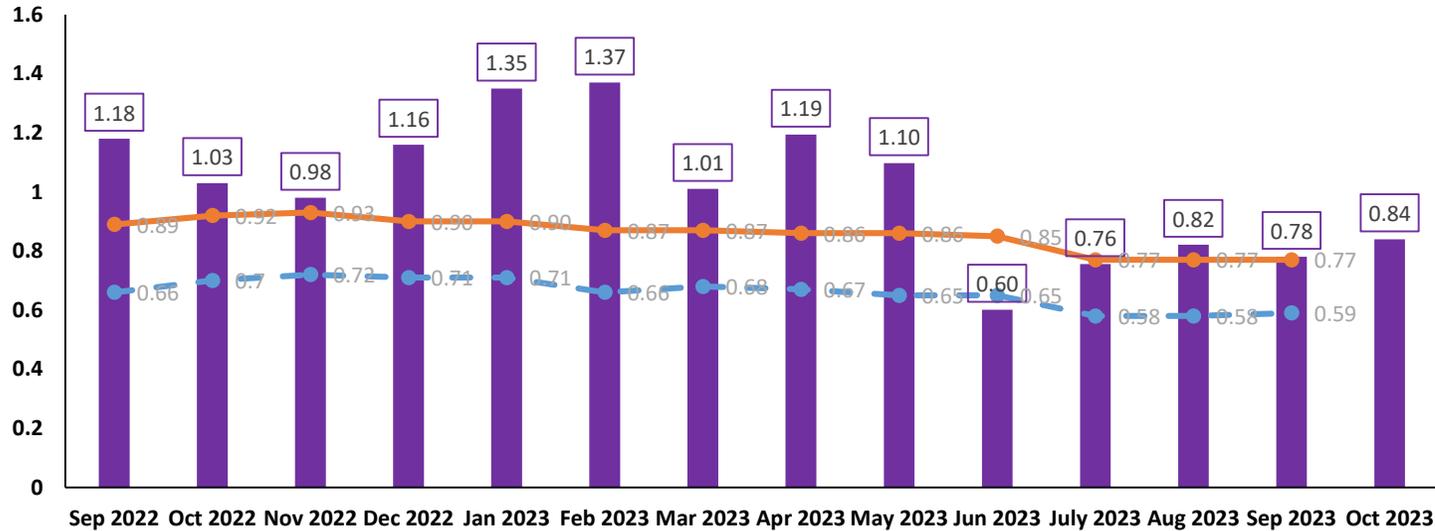
Chart legend:
- ■ Kaweah Health Sepsis Any Dx 0/E Mortality Ratio
- ●--- Midas 25th Percentile_All Midas Participating Facilities (National) Ratio
- ●— Midas 50th Percentile _All Midas Participating Facilities (National) Ratio

Chart data (Kaweah Health bars): Sep 2022: 1.18, Oct 2022: 1.03, Nov 2022: 0.98, Dec 2022: 1.16, Jan 2023: 1.35, Feb 2023: 1.37, Mar 2023: 1.01, Apr 2023: 1.19, May 2023: 1.10, Jun 2023: 0.60, July 2023: 0.76, Aug 2023: 0.82, Sep 2023: 0.78, Oct 2023: 0.84

Midas 50th Percentile: 0.89, 0.92, 0.93, 0.90, 0.90, 0.90, 0.87, 0.87, 0.86, 0.86, 0.85, 0.77, 0.77, 0.77

Midas 25th Percentile: 0.66, 0.7, 0.72, 0.71, 0.71, 0.66, 0.68, 0.67, 0.65, 0.65, 0.58, 0.58, 0.59

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Sepsis Any Diagnosis - Outcomes Length of Stay

All Sepsis Dx - ALOS, GMLOS & Difference Between (excludes COVID)
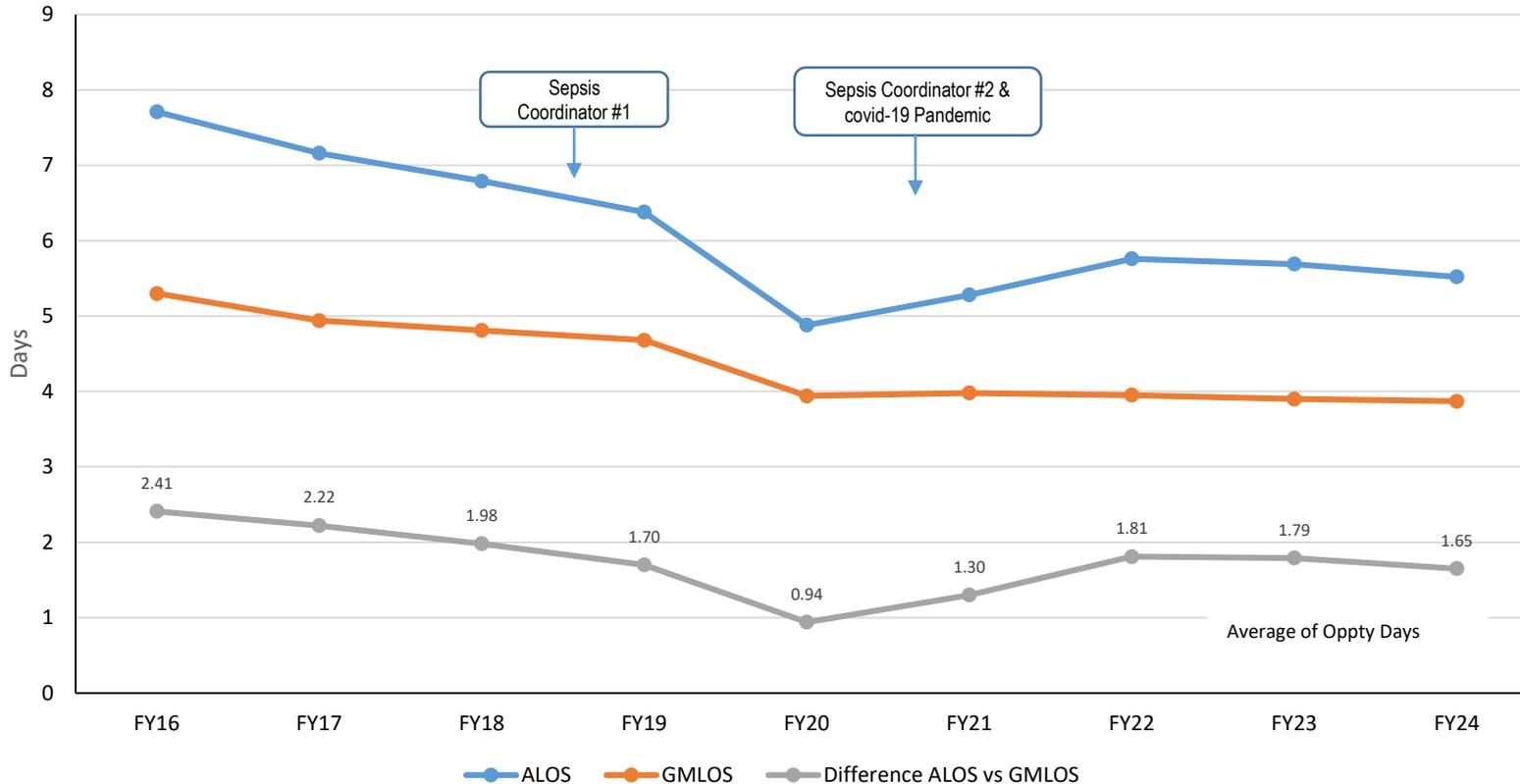
- 8% decrease in ALOS from FY23 (ALOS=5.6) to FY24 (ALOS=5.52)

- Average opportunity days in FY24: 1.65

- FY23 Kaweah Health ALOS 5.69 days vs. CMS GMLOS 3.90 Difference of 1.79 days.

- COVID-19 cases removed in FY20-24. SEP-1 bundle does not apply to COVID-19 patients.

FY 2024 includes July –October only

Sepsis QFT Actions & Next Steps

- Key Improvement strategies in process:
  - Secure GME Resident engagement & Support: Secured one ED Chief Resident (s) to attend monthly Sepsis Committee meeting consistently (In Progress)
  - Resident education event (Orientation) In Progress 6/21/23
  - Standing educational activities for GME residency: Sepsis SIM every 18 months (Ongoing) ED GME SIM 12/21/23
  - ED Provider (s) education ongoing by ED Medical Staff leadership (In progress)
  - HealtheAnalytics Sepsis data retrieval dashboard developed to track 1-hr. bundle compliance (Final Validation in progress)
  - Sepsis Committee meeting on a monthly basis to address concerns timely (In progress)
  - SEP - 1 fall outs deep dive & collegial in Sepsis Committee (In progress)
  - Continue education/follow-up with providers, & caregivers during concurrent review of cases (In progress)
  - Sepsis committee driven SEP-1 fall out educational letters to providers (In progress)
  - Expansion of ED 1-Hour Sepsis order set to inpatient population (In planning phase)
  - Working with ISS Partners to make ED Sepsis one-hour order set a ED provider favorite in EMR (In progress)

Sepsis QFT Actions & Next Steps

- Key Improvement strategies in process:

    - Transitional Year Resident Project – Sepsis Decision Making tool Modification (In progress)

    - Transitional Year Resident Project – 3 hour sepsis re-evaluation pop-up EMR reminder 3.25 hrs. after initial ED Sepsis power plan ordered (In progress)

    - Ongoing partnership with Education Department as needed for refresher on CMS Sepsis requirement (Completed 9/26/23)

    - Improve communication regarding blood culture collection between nurse, phlebotomist & providers (In progress)

    - Ongoing modified Kaizen event to evaluate current barriers to meeting SEP-1 requirements (In process)

    - Advocate for Unit Based Nurse Sepsis Champions hospital wide - presented to Patient Care Leadership 7/19/23. Ongoing discussion in Sepsis committee for best strategy (Not feasible at the moment)

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Sepsis QFT Actions & Next Steps

Next Steps:

- Ongoing evaluation for the "One-Hour" Sepsis bundle to reduce Sepsis mortality

- Strengthen partnership with HIM/Coding related to Sepsis

- Explore standardized procedure for Rapid Response Team initiation of Sepsis bundle

- Ensure to secure the most points for SEP-1 composite measure for the CMS Value Based Purchasing program

- One of our current RN Sepsis coordinators will be transitioning into a position as a Nurse Practitioner at our Exeter clinic. We are actively recruiting for a New RN Sepsis Coordinator to fill this role

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CMS NEWS: Value Based Purchasing Domains & Measurement for Calendar Year 2024 Discharges

Safety
- **CAUTI:** Catheter-associated Urinary Tract Infection
- **CDI:** *Clostridium difficile* Infection
- **CLABSI:** Central Line-associated Bloodstream Infection
- **MRSA:** Methicillin-resistant *Staphylococcus aureus* Bacteremia
- **SSI:** Surgical Site Infection – Colon Surgery and Abdominal Hysterectomy
- *** SEP-1:** Severe Sepsis and Septic Shock Management Bundle (Composite Measure)

Clinical Outcomes
- **MORT-30-AMI:** Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization
- **MORT-30-CABG:** Hospital 30-Day RSMR Following Coronary Artery Bypass Graft (CABG) Surgery
- **MORT-30-COPD:** Hospital 30-Day, All-Cause, RSMR Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization
- **MORT-30-HF:** Hospital 30-Day, All-Cause, RSMR Following Heart Failure (HF) Hospitalization
- **MORT-30-PN:** Hospital 30-Day, All-Cause, RSMR Following Pneumonia (PN) Hospitalization (updated cohort)
- **COMP-HIP-KNEE:** Hospital-Level, Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

Person and Community Engagement
HCAHPS Survey Dimensions
- Communication with Nurses
- Communication with Doctors
- Responsiveness of Hospital Staff
- Communication about Medicines
- Cleanliness and Quietness of Hospital Environment
- Discharge Information
- Care Transition
- Overall Rating of Hospital

Efficiency and Cost Reduction
**MSPB:** Medicare Spending per Beneficiary

CMS has adopted SEP 1: Severe Sepsis and Septic Shock Management Bundle (Composite Measure) to the Safety Domain for Pay for performance Value based Purchasing Program starting Jan 1, 2024

VBP SEP 1 planned Measurement Period:
Baseline Period: January 1–December 31, 2022 (CY 2022)
Kaweah Health Performance Period in CY 2022: 76%

Performance Period: January 1–December 31, 2024 (We h*ave to perform better than our own and/or the National CMS Benchmark*
CMS Benchmark (s): Achievement Threshold 60%   Benchmark/Top Decile: 84%

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SEPSIS: Every Second Counts
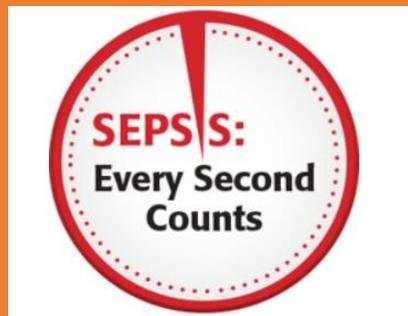
Dr. LaMar Mack, Medical Director, Quality and Patient Safety Ext. 2117
Sandy Volchko, RN-Director, Quality and Patient Safety. Ext. 2169
Erika Pineda, RN-Manager, Quality and Patient Safety. Ext. 2876
Ryan Smith, RN-Sepsis Coordinator. Ext. 5905
Jared Cauthen, RN-Sepsis Coordinator. Ext. 6903

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Quality Council Report
Healthcare Acquired Infection (HAI) Quality Focus Team (QFT) Report
January 2024

Committee Purpose

The multidisciplinary **HAI Quality Focus Team** works collaboratively to reduce healthcare acquired infections through best practices throughout Kaweah Health Medical Center.

Accomplishments

The HAI QFT was first convened Oct 19, 2023 as the result of combining 3 QFTs into this one large "brain trust" for HAI prevention. FYTD Nov 2023 MRSA and CAUTI rates are nearing the top 30% in the country (FY24 goal), due to the efforts from past committee leaders and members, and will be continued through this new QFT, excellent work by all involved in keeping our patients safe.

Top Priority Quality Improvement & Patient Safety Initiatives

The following report summarizes the Quality Improvement work underway by the committee and includes the committee dashboard. There are 6 quality improvement initiatives:

1. Reducing Line Utilization through Multidisciplinary Rounds in ICU
2. Reducing Line Utilization through a Standardized Procedure to remove Indwelling Urinary Catheters
3. Reducing MRSA and HAIs Through CHG Skin Decolonization
4. Reducing MRSA and HAIs Through Nasal Decolonization (Mupirocin treatment)
5. Reducing MRSA and HAIs Through Effective Cleaning Practices
6. Reducing MRSA and HAIS Though Hand Hygiene

Acronyms

ATP - Adenosine Triphosphate
CAUTI - Catheter Associated Urinary Tract Infection
CHG - Chlorhexidine gluconate
CLABSI - Central Line Associated Bloodstream Infection
DMAIC – Define, Measure, Analyze, Improve, Control (6 sigma model for improvement)
ER – Emergency Room
ET – Executive Team
EVS – Environmental Services Department
FDA – Federal Drug Administration
HAI – Healthcare Acquired Infection
HHO – Hand Hygiene Opportunities
IUC – Indwelling Urinary Catheter
IP – Infection Prevention Department
MAK – Medication Administration Check
MRSA - Methicillin-resistant Staphylococcus aureus
SIR – Standardized Infection Ratio
SUR – Standardized Utilization Ratio
SNF – Skilled Nursing Facility

1

Healthcare Acquired Infection (HAI) Quality Focus Team Dashboard

Central Line Associated Blood Stream Infection (CLABSI)

	FY 2024 Target	FY 2022	FY 2023	23-Jul	23-Aug	23-Sep	23-Oct	23-Nov	23-Dec	24-Jan	24-Feb	24-Mar	24-Apr	24-May	24-Jun	FYTD 24
CLABSI Events		20 / 18 Ex COVID	16 / 14 Ex COVID	1	2	3	0	3								9
CLABSI Predicted Events		17.735	15.02	1.21	1.37	1.35	1	1.141								1.2142
CLABSI SIR	0.486	1.01 Ex COVID	0.93 Ex COVID	0.83	1.16	2.22	0	2.629								1.3678

Central Line Standard Utilization Ratio (SUR) in ICU

	FY 2024 Target	FY 2022	FY 2023	23-Jul	23-Aug	23-Sep	23-Oct	23-Nov	23-Dec	24-Jan	24-Feb	24-Mar	24-Apr	24-May	24-Jun	FYTD 24
All Units	0.663	0.758	0.667	0.749	0.791	0.828	0.774	0.685								0.77
ICU		1.017	0.877	0.683	0.921	0.963	0.644	0.783								0.80

Catheter Associated Blood Stream Infection (CAUTI)

	FY 2024 Target	FY 2022	FY 2023	23-Jul	23-Aug	23-Sep	23-Oct	23-Nov	23-Dec	24-Jan	24-Feb	24-Mar	24-Apr	24-May	24-Jun	FYTD 24
CAUTI Events		25 / 23 Ex COVID	13 / 12 Ex COVID	0	0	2	0	2								4
CAUTI Predicted Events		22.9	21.89	1.53	1.75	1.89	2	2.053								9.223
CAUTI SIR	0.401	1.09 Ex COVID	0.55 Ex COVID	0	0	1.06	0	0.974								0.4068

Indwelling Urinary Catheter (IUC) Utilization Ratio (SUR)

	FY 2024 Target	FY 2022	FY 2023	23-Jul	23-Aug	23-Sep	23-Oct	23-Nov	23-Dec	24-Jan	24-Feb	24-Mar	24-Apr	24-May	24-Jun	FYTD 24
All Units	0.672	0.848	0.869	0.869	0.925	1.040	1.080	1.10								1.00
ICU		1.183	1.221	1.148	1.205	1.08	1.287	1.408								1.23

Methicillin-Resistant Staphylococcus Aureus (MRSA)

	FY 2024 Target	FY 2022	FY 2023	23-Jul	23-Aug	23-Sep	23-Oct	23-Nov	23-Dec	24-Jan	24-Feb	24-Mar	24-Apr	24-May	24-Jun	FYTD 24
MRSA Events		12 / 10 Ex COVID	7 / 6 Ex COVID	0	0	1	0	1								2
MRSA Predicted Events		9	9	0.68	0.68	0.68	0.68	0.76								3.48
MRSA SIR	0.51	1.11 Ex COVID	0.66 Ex COVID	0	0	1.47	0	1.32								0.558
% of patients Nasal MRSA+ with Decolonization	100%	26%	36%	73%	84%	87%	86%	100%	81%							85%
% of ACTVE BioVigil Users Achieving target Badge Hours (>80hrs/month)	50% (10% increase annually FY25+)	38%	31%	43%	47%	45%	49%	47%								46%
Volume of Hand Hygiene Opportunities Captured in BioVgil	Increase from FY23	10,744,821	11,524,456	973,203	1,118,593	1,118,422	1,170,286	1,080,382								5,460,886
ATP Tests in High Risk Areas ≤399 RLU	80%	72%	66%	81%	82%	78%	72%									78%
Number of ATP Test	≥1,400 (1/24)	588	1994	275	293	433										1001

KEY

Does not meet goal/benchmark	Within 10% of goal/benchmark	Outperforming/ meeting goal/benchmark

DMAIC Project Summary: ICU Rounds - Line Utilization Reduction

Reports to: Healthcare Acquired Infection (HAI) QFT	Project Leader: Dr. L Mack, Dr. Javed, Shannon Cauthen	Start Date: 10/19/21
Team members/ Subject experts: Dr. T. Gray (ET Sponsor), leaders from involved disciplines including: Dietary, Case Management, Infection Prevention, Therapies		Revision (date): 1/8/24
		Revision #: 4

DEFINE

Background/Problem Statement:

The quantity of device related healthcare acquired infection events such as Central Line (CL) Associated Bloodstream Infection (CLABSI), Catheter Associated Urinary Tract Infection (CAUTI) events at Kaweah Health exceed predicted values assigned to the healthcare organization based on specific risk adjustments given attributes defined by the National Healthcare Safety Network (NHSN) through use of logistical regression analyses. Removing central lines and Indwelling Urinary Catheters (IUC) when they are no longer indicated is an evidenced-based practice recommended by the CDC as a strategy to reduce CAUTI and CLABSI rates.

Current Condition:	Kaweah Health SIR/SUR FY23	KH SUR FYTD 24 July – Nov 2023	FY24 Goal
SUR All Locations – Central Lines	0.667	0.77	≤0.663
SUR All location– IUCs	0.869	1.00	≤0.672
SUR ICU location – Central Lines	0.87	0.80	n/a
SUR ICU location– IUCs	1.22	1.23	n/a
Unit Gemba Rounds – % IUCs with order & indication	94% (CY22)	93%	100%
Unit Gemba Rounds – % of CL with valid rationale order	96% (CY22)	94%	100%

MEASURE

SMART Target / Goal:

SUR Central Line – reduce SUR to ≤0.663 by 6/30/24; SUR IUC – reduce SUR to ≤0.672 by 6/30/24

ANALYZE

Problem Analysis / Root Cause, Gap:

Data analysis of utilization rates by unit indicate critical care and step down units make up 4/5 units with higher utilization rates than expected; 4N (renal unit) is the 5th unit, related to patient population.

Pareto Chart - IUC Utilization Rates by Adult Unit (July-Nov 2023)

Pareto Chart - CL Utilization Rates by Adult Unit (July-Nov 2023)

IMPROVE

Countermeasure / Action Plan / Solutions:

1. Obtain Sound group HAI standard work, evaluate line liberation rounds in ICU. To discuss with Sound group at weekly meeting, Dr. Mack meeting with Dr. Javed 11/8/23. Dr. Javed planning to move forward with multidisciplinary rounds (includes "highly aggressive line liberation"). Potential barrier is limited PICC team resources (these are heavily utilized by Sound in other organizations)
2. Plan to initiate ICU rounds starting January 2024; multidisciplinary members notified and reviewing round format
3. Multidisciplinary ICU Rounds (MDR) initiated week of 1/1/24

Results / Metrics:

SUR Metrics to be added starting in Feb 2024 following round implementation

CONTROL

Follow-Up / Sustainability:

Rounding template developed to be used during rounds to standardize and sustain practice and improvements

DMAIC Project Summary: Standardized Procedure - Line Utilization Reduction

Reports to: Healthcare Acquired Infection (HAI) QFT	Project Leader: Dr. L Mack	Start Date: 10/19/21
Team members/ Subject experts: Kari Knudsen, Dr. Mack, Dr. T. Gray (ET Sponsor)		Revision (date): 1/4/24
		Revision #: 4

DEFINE

Background/Problem Statement:

The quantity of device related healthcare acquired infection events such as Catheter Associated Urinary Tract Infection (CAUTI) events at Kaweah Health exceed predicted values assigned to the healthcare organization based on specific risk adjustments given attributes defined by the National Healthcare Safety Network (NHSN) through use of logistical regression analyses. Removing Indwelling Urinary Catheters (IUC) when they are no longer indicated is an evidenced-based practice recommended by the CDC as a strategy to reduce CAUTI rates. Nursing standardized procedures to remove IUCs based on physician approved criteria has been a successful strategy in other healthcare organizations

Current Condition:

	Kaweah Health SUR FY23	KH SUR FYTD 24 July – Nov 2023	FY 24 Goal
Add all location SUR	0.869	1.00	≤0.672
SUR ICU location– IUCs	1.22	1.23	n/a

MEASURE

SMART Target / Goal:

SUR – reduce SUR all locations to ≤0.672 by 6/30/24

ANALYZE

Problem Analysis / Root Cause, Gap:

Inappropriate use of IUCs for a variety of reasons:
- Failure of adoption and support of nurse driven IUC removal protocol
  - Resistance to remove IUC
  - Failure to clarify rationale for IUC when patient condition changes
  - High use in critical care

IMPROVE

Countermeasure / Action Plan / Solutions:

1. 11/6/23 Standardized procedure to remove IUCs approved and currently moving through additional committee approval; will need a strong role out and trust that push back will not occur. Standardized procedure allows RN to remove ordered IUC based on criteria (reviewed with Drs Betre, Rosenburg, Mack)
2. Review of SP by QComm on 12/6/23 and plan for MEC approval. Other supportive processes updated (ie. Retention management).
3. Kari Knudsen convening a taskforce to develop roll out plan to include key medical staff leaders

Results / Metrics:

IUC SUR FYTD24 (through Nov) = 1.23

CONTROL

Follow-Up / Sustainability:

Control Plan: 1) Standardized procedure ensures same process is applied for all patients meeting criteria. 2) Sharing data and results with stakeholders

DMAIC Quality Improvement Project Tracker

Kaweah Health

Name of Project & Committee: **Chlorhexidine Gluconate (CHG) Decolonization**	Date Initiated: 11/2/23
Reports to: Healthcare Acquired Infection (HAI) Quality Focus Team	Updated date: 1.8.24
Team Members: Amy Baker, Dr. Mack (MD champion), Dr T. Gray (ET Sponsor)	

DEFINE

The quantity of device and non-device related healthcare acquired infections events at Kaweah Health exceed predicted values assigned to the healthcare organization based on specific risk adjustments given attributes defined by the National Healthcare Safety Network (NHSN) through use of logistical regression analyses. This includes HAIs Central Line Associated Bloodstream Infection (CLABSI), Catheter Associated Urinary Tract Infection (CAUTI), and Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infection (BSI). Chlorhexidine gluconate (CHG) is an antiseptic that is widely used in healthcare due to its excellent safety profile and wide spectrum of activity. Daily bathing with CHG has proven to be effective in the prevention of healthcare-associated infections and multidrug-resistant pathogen decolonization.

MEASURE

Current Condition: Current process at Kaweah is that patients with a central line are (inconsistently) ordered CHG bathing wipes either through the RN contacting the patient's provider, or IP will enter a phone order through Medical Director of Infection Prevention. The CHG bathing wipes are profiled in pharmacy, and RN MACs the CHG bathing wipes and performs the bath.

SMART GOAL

Reduce MRSA SIR to 0.51 by 6/30/24
CHG metric under evaluation

ANALYZE

- Process to MAK and store CHG bathing wipes very complex, creating difficult and time intensive workflow
- Confusion from regulatory bodies on CHG bathing products FDA status
- CHG bathing wipes require knowledge to execute safely/effectively
- No current process to educate/competency Certified Nursing Assistants (CNAs) to provide CHG bathing

Root Causes that Analysis Identified

Issue/Root Cause #1- **FDA Status of CHG Bathing Wipes**
Issue/Root Cause #2- **CNA Knowledge/competency gap on CHG Bathing**
Issue/Root Cause #3- **Unlicensed personnel applying CHG wipe at Kaweah Health**

IMPROVE

Activity	Who is Responsible	Completion Date
Root Cause #1- Confusion with FDA status of CHG bathing wipes Connect with CDPH IP to obtain clarification. Discussed with CDPH HAI Program Personnel and CDPH Antimicrobial Pharmacist the regulations regarding use of CHG bathing wipes. CDPH personnel provided MRSA decolonization policies from different California healthcare facilities with CHG bathing criteria and Certified Nurse Assistant competency checklist of use of CHG wipes. State Pharmacist indicated that she is unaware of any FDA restriction on CHG bathing wipes and verified that it is an intervention recommended by the CDC to reduce MRSA colonization on patients at risk of infection. Reviewed FDA information regarding CHG wipes. Confirmed FDA considers CHG a medication. Verified the FDA did not provide blanket approval for over-the-counter use of CHG wipes. The manufacturers of CHG wipes are required to provide evidence of CHG safety and efficacy for FDA NDA approval. Sage Brand CHG wipes used by Kaweah Health are approved for over-the-counter use by the FDA. Shared findings with hospital Pharmacy and Nursing Director. Pharmacy has some concerns about unlicensed personnel administering CHG to patients as this is out of their scope. However, application of a topical over-the-counter medication that is not absorbed may potentially be interpreted as not being administered. Currently Kaweah Health Certified Nursing Assistants can apply zinc-oxide topically to skin for skin breakdown due to diaper rash. Application of CHG through a premoistened wipe would be a	Shawn Elkin	11/15/23

Name of Project & Committee: **Chlorhexidine Gluconate (CHG) Decolonization**	Date Initiated: 11/2/23
Reports to: Healthcare Acquired Infection (HAI) Quality Focus Team	Updated date: 1.8.24
Team Members: Amy Baker, Dr. Mack (MD champion), Dr T. Gray (ET Sponsor)	

similar action. Nursing Leadership evaluating the process of unlicensed personnel applying CHG via a wipe at Kaweah Health. Unlicensed personnel will be required to demonstrate competency if approval is granted at Kaweah Health for unlicensed personnel to use CHG wipes.		
Root Cause # 1- Confusion with FDA status of CHG bathing wipes Meeting with nursing and pharmacy to discuss CDPH information, establish a task force. To include a person from critical care, med/surg educator, surgical services	Amy Baker	**3/1/24**
Root Cause #3- Unlicensed personnel applying CHG wipe at Kaweah Health Need to address concerns about unlicensed personnel administering medication. Risk Management completed risk assessment but Title 22 denotes unlicensed personnel cannot administer medication. Decision needs to be made- Is this administer medication or is this applying a wipe topically?	Amy Baker	**2/1/24**
RESULTS/METRICS		
See HAI QFT Dashboard; additional metrics under evaluation and will be reported as plan is finalized and executed		
CONTROL		
Control Plan: tbd as plan continues to be developed and implemented		

Kaweah Health   DMAIC Quality Improvement Project Tracker

Name of Project & Committee: **MRSA Mupirocin Nasal Decolonization**	Date Initiated: 11/2/23
Reports to: Healthcare Acquired Infection (HAI) Quality Focus Team	Updated date: 1/4/24
Team Members: Shawn Elkin, Amy Baker, Dr. Mack (MD champion), Dr T. Gray (ET Sponsor)	

DEFINE

The quantity of non-device related healthcare acquired Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infection (BSI) events at Kaweah Health exceed predicted values assigned to the healthcare organization based on specific risk adjustments given attributes defined by the National Healthcare Safety Network (NHSN) through use of logistical regression analyses. The Centers for Disease Control indicate that to reduce MRSA BSI organizations need to focus on 3 areas: Hand Hygiene, environmental cleaning, & targeted decolonization (removal of MRSA for patients who are screened per criteria and test positive for nasal MRSA). Current process at Kaweah is that once screening is completed there is an automated order for Mupirocin (nasal ointment) to decolonize. This automatic process is dependent on the completion of the screening. Auto decolonization tested in 4N and ICU in FY23, went medical center-side in June 2023.

MEASURE

Current/Baseline Condition:

Decolonization rate for *screened* patients: FY23 32%

Nasal Screening Rates for Targeted Populations:

Admitted from SNF – FY23= 8%

Readmitted within 30 days – FY23 = 22%

Chronic Dialysis Patients – FY23 = 33%

Identifying Patients Admitted from SNF

9/25 (36%) admitted from SNF patients identified correctly in EMR upon admission (sample from Jan-Aug 2023)

SMART GOAL

100% of at-risk targeted populations for decolonization nasal screened by 6/30/24

100% of patient screened decolonized by 6/30/24

100% of admitted from SNF, readmitted within 30 days, and chronic dialysis patients (per ICD-10 code) identified & nasal screened (add joint and Cardiovascular (CV) surgery patient populations) by 6/30/24

ANALYZE

- Need to add targeted screening/testing/decolonization rates for joint and CV surgery population

When we screen patients we are 100% at treating with mupirocin for patients that test positive for nasal MRSA, due to the automatic ordering process.

5 Why's - Nasal Screening Rates for Target Populations (what are we not screening who should be screened 100% of time):

- Current process: patient access enters admitting source in EMR, admitting RN needs to verify admission source when completing screening (EMR does not trigger RN that admit from SNF was entered by registrar)

Not populating screening with known admission source:

- RN does not verify admitted source consistently
- Screening is long (all screenings required, not just MRSA)
- Documentation is difficult (can't find admitting source from registrar), or past admissions
- Lack of time
- Patient poor historian
- RN does not understand significance of positive screenings
- There is no electronic trigger for screening patients admitted to the ICU (this is just an expectation).

Documentation of admission source not always accurate

- Need to fact find to further understand processes. Data sources could be from the ED physician or on an EMS run sheet, direct admission with information from the transfer center or bed coordinator, but it isn't getting into the medical record accurately.

Root Causes that Analysis Identified

Issue/Root Cause #1- Admitting RN cannot find admission source easily

Issue/Root Cause #2- Poor accuracy of admission source

Issue/Root Cause #3- Lack of auto-population (ie. 30-day readmission, ICU admission, Dialysis admission)

DMAIC Quality Improvement Project Tracker

![Kaweah Health logo]

Name of Project & Committee: **MRSA Mupirocin Nasal Decolonization**	Date Initiated: 11/2/23
Reports to: Healthcare Acquired Infection (HAI) Quality Focus Team	Updated date: 1/4/24
Team Members: Shawn Elkin, Amy Baker, Dr. Mack (MD champion), Dr T. Gray (ET Sponsor)	

IMPROVE

Activity	Who is Responsible	Completion Date
Evaluate standardizing swabbing for all plan to admit patients from ER; Inquire with lab on cost of swabbing & testing at plan to admit patients in ED. Obtained total lab processing costs for MRSA swabbing and C. auris swabbing, respectively (see Results/Metrics below).	Shawn Elkin	12/31/23
Fall outs may be occurring because the auto order does not profile the medication until the next day. Investigate with pharmacy the workflow of the medication profiling timing.	Shawn Elkin	2/1/24
ICU admission. Shawn to set up task force to look at automating process to screen all ICU patients. Scheduled a taskforce to hardwire auto-order MRSA swab for all ICU inpatient encounters. Taskforce will also work towards a solution for identifying MRSA target patient populations.	Shawn Elkin	4/1/24

RESULTS/METRICS

Fiscal Year to Date July – December 2023 increase in decolonization of screened patients from 32% to 84%
For the month of October 2023: 11 out of 14 (79%) of patients testing positive for nasal MRSA colonization discharged before treatment could start. 1 out of 14 (7%) were delayed getting to inpatient location. 1 out of 14 (7%) were decolonized and uncertain why case hit the report as missing treatment. 1 out of 14 (7%), uncertain why auto-order for Mupirocin treatment didn't fire. Of note, a similar screening/testing process was developed for another multidrug resistant organism (Candida auris), review of the process during the month of October 2023 for this organism resulted in 82 of 104 patients admitted to the ICU were screened/tested for Candida auris. Analysis of the 22 patient admitted to ICU and not screened/tested for Candida auris elucidated the following (1) nursing lack of familiarity that patients admitted to ICU need to be tested for MRSA and Candida auris (2) A secondary process that triggers the nurse to screen/test later in the healthcare continuum and not just at admission (3) Holding nurses accountable to accurately complete admission screening questions (4) Modification of one of the screening questions "readmission/admission to acute care facility with 30 days" as this triggers only MRSA nares swab and not Candida auris testing when both should be performed.
December 2023 Decolonization Rate – patient with Mupirocin Order and Administration = 81% (13/16)
The 3 individuals who did not receive Mupirocin after testing positive for MRSA colonization were discharged within the following time range from positive MRSA test results (31 to 48 hours) (see action plan related to pharmacy workflow)
Mupirocin treatment requires twice a day topical application to the nares over 5 days. These three individuals were discharged in advance of starting administration and would be considered outliers to the established nasal decolonization process.

Kaweah Health

Name of Project & Committee: **MRSA Mupirocin Nasal Decolonization**	Date Initiated: 11/2/23
Reports to: Healthcare Acquired Infection (HAI) Quality Focus Team	Updated date: 1/4/24
Team Members: Shawn Elkin, Amy Baker, Dr. Mack (MD champion), Dr T. Gray (ET Sponsor)	

MRSA Decolonization Dashboard

	Disch Dt Tm 2023						
Kaweah Health MORE THAN MEDICINE. LIFE.	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
DECOLONIZATION PROCESS							
# Admissions	1,531	1,593	1,492	1,548	1,511	1,508	9,183
# Pts with MRSA screening form completed	1,306	1,347	1,259	1,305	1,273	1,264	7,754
% Pts with MRSA screening form completed	85%	85%	84%	84%	84%	84%	84%
# Pts Considered MRSA Risk	288	277	248	249	249	278	1,589
% Pts with MRSA Nasal Screen (lab result) Den # Pts Considered Risk	118%	123%	124%	128%	128%	126%	124%
# Pts with MRSA Nasal Screen (lab result)	340	340	308	319	318	351	1,976
% Pts with Positive MRSA Nasal Screen (lab result)	6%	6%	5%	4%	5%	5%	5%
# Pts with Positive MRSA Nasal Screen (lab result)	22	19	15	14	15	16	101
Decolonization Rate patients with Mupirocin Order and Administration	73%	84%	87%	86%	100%	81%	84%
# Pts with Mupirocin Order and Administration	16	16	13	12	15	13	85
BY ADMIT SOURCE							
% Pts Admitted from SNF who had MRSA nasal screen (lab result)	7%	9%	8%	7%	8%	9%	8%
# Pts Admitted from SNF who had MRSA nasal screen (lab result)	23	32	24	23	24	32	158
% Pts re-admitted (30 d) who had MRSA nasal screen (lab result)	24%	21%	26%	22%	25%	15%	22%
# Pts re-admitted (30 d) who had MRSA nasal screen (lab result)	80	73	81	70	81	53	438
% Pts on chronic dialysis who had MRSA nasal screen (lab result)	34%	36%	35%	35%	34%	29%	34%
# Pts on Chronic dialysis who had MRSA nasal screen (lab result)	117	122	108	113	109	102	671

Decolonization Rate- Number of patients who tested positive for nasal MRSA, received mupirocin within 24 Hrs of Discharge.

_____

Feasibility analysis on automation of MRSA testing for all admitted patients. Below are laboratory costs for swabbing and processing test results for MRSA nares colonization, Candida auris colonization and the total for both tests. Lab costs for processing MRSA nasal swab =$15.00. Lab costs for processing Candida auris swab = $10.77. Note costs do not include nursing time to obtain specimen or any additional laboratory personnel costs.

Month	# of Admissions	MRSA Cost	MRSA Subtotal	C. Auris Cost	C. Auris Subtotal	Monthly Total
Jan-23	2042	$15.00	$30,630.00	$10.77	$21,992.34	$52,622.34
Feb-23	1932	$15.00	$28,980.00	$10.77	$20,807.64	$49,787.64
Mar-23	2100	$15.00	$31,500.00	$10.77	$22,617.00	$54,117.00
Apr-23	1597	$15.00	$23,955.00	$10.77	$17,199.69	$41,154.69
May-23	1726	$15.00	$25,890.00	$10.77	$18,589.02	$44,479.02
Jun-23	2022	$15.00	$30,330.00	$10.77	$21,776.94	$52,106.94
Jul-23	2106	$15.00	$31,590.00	$10.77	$22,681.62	$54,271.62
Aug-23	2289	$15.00	$34,335.00	$10.77	$24,652.53	$58,987.53
Sep-23	2059	$15.00	$30,885.00	$10.77	$22,175.43	$53,060.43
Oct-23	2101	$15.00	$31,515.00	$10.77	$22,627.77	$54,142.77
Nov-23	2154	$15.00	$32,310.00	$10.77	$23,198.58	$55,508.58
Annual Total			**$331,920.00**		**$238,318.56**	**$570,238.56**

CONTROL PLAN
To be determined

Name of Project & Committee: Effective Cleaning Processes (MRSA Reduction)	Date Initiated: 11/16/23
Reports to: Healthcare Acquired Infection (HAI) Quality Focus Team	Updated date: 1/8/24
Team Members: Tendai Zinyemba, Dr T. Gray (ET Sponsor)	

DEFINE
The quantity of non-device related healthcare acquired Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infection (BSI) events at Kaweah Health exceed predicted values assigned to the healthcare organization based on specific risk adjustments given attributes defined by the National Healthcare Safety Network (NHSN) through use of logistical regression analyses. The Centers for Disease Control indicate that to reduce MRSA BSI organizations need to focus on 3 areas which include environmental cleaning. Timely detection of cleaning failure is critical for quality assurance. Adenosine Triphosphate (ATP) testing is a secondary quality assurance process that provides a real time and quantitative indication of cellular contaminants, when used to measure surface cleanliness.

MEASURE
Current Condition: ATP Testing is currently occurring in high-risk locations ICU, CVICU, All ORs (main OR, CVOR, OBOR) Cath Lab and Endo). Real-time re-education and recleaning is completed for the area(s) that do not initially pass ATP Testing.

SMART GOAL
Sustained improvement and reach ATP pass rate of 80% by 6/30/24
Reduce MRSA SIR to 0.51 by 6/30/24

ANALYZE
Based on the monthly Rank reports by site and Rank report by area, ICUs have been failing the most (2W, 5T & 3W). The surfaces that failed the most include: overhead table; call button; & bedrail

Root Causes that Analysis Identified

Issue/Root Cause #1- ATP testing process structure: comprehensive assessment of skill for all staff

Issue/Root Cause #2- ATP testing timing: Ensure that testing occurs real-time to mitigate false negatives from other variables such as room set-ups etc, which could result in added touching of the high touch areas pre-testing.

Issue/Root Cause #3- Continuous education by the Leadership team and EVS Coordinator: More structure around cause and effect of sustained cleaning outcomes.

IMPROVE

Activity	Who is Responsible	Completion Date
Root Cause #1- ATP testing process structure: comprehensive assessment of skill for all staff **Improvement strategy** EVS Leadership will commence ATP testing for all new hires during onboarding and also for all EVS staff during annual competency validation, In addition to the 80 ATP tests/month in ORs	EVS Managers & EVS Director	1/29/24
Root Cause #2- ATP testing timing: Ensure that testing occurs real-time to mitigate false negatives from other variables such as room set-ups etc, which could result in added touching of the high touch areas pre-testing. **Improvement strategy** Share plan with Nursing leadership for ICUs, and then implement onboarding training and annual competency assessments.	EVS Managers & EVS Director	Communicate to ICUs Director by 1/19/24 Implement onboarding ATP assessment by 1/29/24
Root Cause #3- Continuous education by the Leadership team and EVS Coordinator: More structure around cause and effect of sustained cleaning outcomes **Improvement strategy**	EVS Managers; EVS Coordinator; & EVS Director	Ongoing

Name of Project & Committee: Effective Cleaning Processes (MRSA Reduction)	Date Initiated: 11/16/23
Reports to: Healthcare Acquired Infection (HAI) Quality Focus Team	Updated date: 1/8/24
Team Members: Tendai Zinyemba, Dr T. Gray (ET Sponsor)	

Share data with staff real-time post testing and also trends bi-monthly in staff meetings, to ensure that staff continue to be aware of their impact on HAIs reduction.		
RESULTS/METRICS		
See HAI QFT Dashboard		
CONTROL		
Departmental procedure will be modified around onboarding and annual training will be modified to ensure it aligns with the new process outlined. Routine follow up with the Leadership team and staff will occur thereafter.		

DMAIC Quality Improvement Project Tracker

Kaweah Health

Name of Project & Committee: **Hand Hygiene (Healthcare Acquired Infection Reduction)**	Date Initiated: 11/2/23
Reports to: Healthcare Acquired Infection (HAI) Quality Focus Team	Updated date: 1/8/24
Team Members: Tendai Zinyemba, Shawn Elkin, Dr. Mack (MD champion), Dr T. Gray (ET Sponsor)	

DEFINE

The quantity of device and non-device related healthcare acquired infections events at Kaweah Health exceed predicted values assigned to the healthcare organization based on specific risk adjustments given attributes defined by the National Healthcare Safety Network (NHSN) through use of logistical regression analyses. This includes HAIs Central Line Associated Bloodstream Infection (CLABSI), Catheter Associated Urinary Tract Infection (CAUTI), and Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infection (BSI) The Centers for Disease Control indicate that one of the most effective ways to reduce HAIs is through Hand Hygiene. Hand hygiene is currently monitored primarily through the electronic surveillance system "BioVigil" and through manual observations or patient reported feedback in KH locations that do not use BioVigil.

MEASURE

Current Condition:

The Biovigil hand hygiene monitoring system is available throughout the Kaweah Healthcare District with the exception of Rural Health, Urgent Cares, and Industrial Health Clinics. The system provides scheduled and custom reports to leaders and individuals using the system. The Biovigil badge prompts the wearer of a hand hygiene opportunity when sensors installed at entries/exits of patient care areas are crossed.

- FY23 Active BioVigil users achieve target badge hours >80hrs/month = 31%
- FY23 volume of hand hygiene opportunities (HHO) captured in BioVigil = 11,524,456

SMART GOAL

Reduce MRSA SIR to ≤ 0.51 by 6/30/24
Increase active users to 50% by 6/30/24 (with 10% increase each FY), which will increase HHOs captured

ANALYZE

- Hand hygiene rates of entry, exit, total compliance exceeds 95% (at/above goal), however, the year-to-year/quarter-to-quarter trend demonstrates a consistent decrease in overall compliance rates.
- Paired Biovigil badge time (the duration in which healthcare personnel wear/use a Biovigil badge), is set at >80 hours per month, yet 52% to 68% of healthcare personnel at Kaweah Health are not pairing to a Biovigil badge for the minimum expected duration.
- The proportion of Biovigil active users to Biovigil registered users is 1,542 to 4,987, respectively (31%). Given the number of healthcare personnel with patient contact approximately (70%) it would be expected that our Biovigil active users would reflect the same percentage.
- Discuss with GME to determine if residents are considered "active users" if they are not they can be removed from the denominator

Root Causes that Analysis Identified

Issue/Root Cause #1- Healthcare personnel are not holding themselves accountable to performing hand hygiene when prompted by the Biovigil hand hygiene monitoring system.

Issue/Root Cause #2- Healthcare personnel at Kaweah Health are not being held accountable to wearing a Biovigil badge for a duration of 80 hours/month, or at all.

Issue/Root Cause #3- Potential inflated denominator of active users (determined not a root cause 12/13/23) residents not included in denominator

IMPROVE

Activity	Who is Responsible	Completion Date
Leaders holding staff accountable - Use of BioVigil added to HR Progressive Discipline policy (HR216)	HR	**June 2023**
Leaders holding staff accountable - Leaders receive scheduled hand hygiene reports from Biovigil for the healthcare personnel they oversee and will reinforce improved usage of the Biovigil hand hygiene monitoring system.	Shawn Elkin	**Ongoing**

1

DMAIC Quality Improvement Project Tracker

Name of Project & Committee: **Hand Hygiene (Healthcare Acquired Infection Reduction)**	Date Initiated: 11/2/23
Reports to: Healthcare Acquired Infection (HAI) Quality Focus Team	Updated date: 1/8/24
Team Members: Tendai Zinyemba, Shawn Elkin, Dr. Mack (MD champion), Dr T. Gray (ET Sponsor)	

Leaders holding staff accountable. IP sending manual observation outcomes/fallouts with leaders	Shawn Elkin	Ongoing – at least once a month
Leaders holding staff accountable – IP to evaluate new report for leadership focused on badge hours so it is easier for them to hold staff accountable and is aligned with goal	Shawn Elkin	2/15/24
Inflated denominator - Will determine if GME Residents, mid-level practitioners, and Providers will use the Biovigil hand hygiene monitoring system. Meeting with Dr. Winston to determine. Meeting determined that residents are not included in denominator because there is no active use. GME Leadership open; challenges include consistency with medical staff. Can we apply logic of medical education from ground up?	Shawn Elkin	12/13/23 Determined to not be a root cause
Execute a recognition campaign for staff/units for achieving high badge hours for 1) direct pt care (Kari) and 2) support services (Tendai). Award for % of users in dept's > 80hrs badge time	Shawn Elkin	3/1/24

RESULTS/METRICS

	FY 2024 Target	FY 2022	FY 2023	23-Jul	23-Aug	23-Sep	23-Oct	23-Nov
% of ACTVE BioVigil Users Achieving target Badge Hours (>80hrs/month)	50% (10% increase annually FY25+)	38%	31%	43%	47%	45%	49%	47%
Volume of Hand Hygiene Opportunities Captured in BioVgil		10,744,821	11,524,456	973,203	1,118,593	1,118,422	1,170,286	1,080,382

CONTROL

Control Plan: In progress, to include standardized reports to ensure leaders have valuable information to assess usage and hold staff accountable

2

Reference Material - HAI Brain Trust Quality Focus Team Dashboard Data Definitions

Central Line Associated Blood Stream Infection (CLABSI)	**DATA DEFINITION**
CLABSI Events	Number of patients with a CLABSI as defined through the National Healthcare Safety Network (NHSN)
CLABSI Predicted Events	Number of predicted CLABSI events as reported by NHSN (includes risk adjustment for teaching facility, bed size...)
CLABSI SIR	Standardized Infection Ratio is the actual number of events divided by the predicted
	Numerator: Number of patients with a CLABSI as defined through the National Healthcare Safety Network (NHSN)
	Denominator: Number of predicted CLABSI events as reported by NHSN (includes risk adjustment for teaching facility, bed size...)
	Target SIR: ≤0.589
Central Line Standard Utilization Ratio (SUR) in ICU	Central Line Standard Utilization Ratio (SUR) is the number of patients with a central line divided by the patient days in the ICU location
	Numerator: Total number of ICU patients with central line
	Denominator: Number of ICU patient central line days as determined by documentation in the EMR
Catheter Associated Blood Stream Infection (CAUTI)	**DATA DEFINITION**
CAUTI Events	Number of patients with a CAUTI as defined through the National Healthcare Safety Network (NHSN)
CAUTI Predicted Events	Number of predicted CAUTI events as reported by NHSN (includes risk adjustment for teaching facility, bed size...)
CAUTI SIR	Standardized Infection Ratio is the actual number of events divided by the predicted
	Numerator: Number of patients with a CAUTI as defined through the National Healthcare Safety Network (NHSN)
	Denominator: Number of predicted CAUTI events as reported by NHSN (includes risk adjustment for teaching facility, bed size...)
	Target SIR: ≤0.650
Indwelling Urinary Catheter (IUC) Utilization Ratio (SUR) in ICU	IUC Standard Utilization Ratio (SUR) is the number of patients with a IUC divided by the patient days in the ICU location
	Numerator: Total number of ICU patients with IUC
	Denominator: Number of ICU patient IUC days as determined by documentation in the EMR
Methicillin-Resistant Staphylococcus Aureus (MRSA)	**DATA DEFINITION**
MRSA Events	Number of patients with a MRSA blood stream infection as defined through the National Healthcare Safety Network (NHSN)
MRSA Predicted Events	Number of predicted MRSA blood stream events as reported by NHSN (includes risk adjustment for teaching facility, bed size...)
MRSA SIR	Standardized Infection Ratio is the actual number of events divided by the predicted
	Numerator: Number of patients with a MRSA Blood Stream Infection as defined through the National Healthcare Safety Network (NHSN)
	Denominator: Number of predicted MRSA Blood Stream Infection events as reported by NHSN (includes risk adjustment for teaching facility, bed size...)
	Target SIR: ≤0.726
% of patients Nasal MRSA+ with Decolonization	Numerator: Number of Patients who screened and tested positive for nasal MRSA upon admission and were ordered & administered Mupurocin for decolonization
	Denominator: Number of Patients who screened and tested positive for nasal MRSA
% of ACTIVE BioVigil Users Achieving target Badge Hours (>80hrs/month)	Target of 80 badge hours (aka. staff are "paired" with a BioVigil badge) per month was derived from using a 50% and 75% usage goal based on most full time staff work approximately 160 hours a month [Nursing staff work 144 hours a month]. An employee would have exceptional use if the badge hours increase to greater than 30 hours/wk. An employee working a 36 hr./wk. could potentially meet target badge hours by pairing with it for 18 hours/wk. He or she would have exceptional use if the badge hours increase to greater than 27 hours/wk.
Volume of Hand Hygiene Opportunities (HHO) Captured in BioVigil	Total number of HHO captured and reported through the BioVigil system through all locaitons at Kaweah Health
	Target volume of HHO is based off of improvement from FY23
% ATP Tests in High Risk Areas ≤399 RLU	ATP testing is a way to measure the cleanliness of a surface. ATP stands for adenosine triphosphate, an energy molecule. The test measures whether or not a surface can support the growth of bacteria and other pathogens. The lower the result, the less likely it is that bacteria and pathogens can survive on the surface. ATP tests ≤399 Relative Light Units (RLU) have an acceptable level of "bioburden" left on the surface after cleaning to verify effective cleaning and reduce healthcare acquired infections (Those ≥399 RLU are recleaned immidately following testing)
Number of ATP Tests Completed in High Risk Areas	Volume of ATP Testing completed in ICU, CVICU, All Ors (main OR, CVOR, OBOR) Cath Lab and Endo

2024 Quality Council/Board Quality Topic Review Schedule

TOPIC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
PUBLICALLY REPORTED/NATIONAL QUALITY PROGRAMS												
Annual Review of Quality and Patient Safety Plans	X B											
Leadership Clinical Quality Goals	X	X	X	X	X	X	X	X	X	X	X	X
Leapfrog Hospital Safety Score					X						X B	
Healthgrades											X B	
Value Based Purchasing					X	B						
Safety Culture – SAQ & Action Plan					X						X	
QUALITY & PATIENT SAFETY COMMITTEES												
Fall Prevention Committee			X B						X			
Hospital Acquired Pressure Injury (HAPI) Committee					X						X	
Diabetes Committee				X						X B		
Pain Management (Patient Care Leadership)		X						X				
Rural Health Clinics (QIP Program)			X					X				
Environment of Care (including annual Work Place Violence report)					X						X	
Nurse Staff and Adverse Events Annual analysis					X							
Infection Prevention Dashboard Hand Hygiene, SSI, C Diff, CAUTI & CLABSI			X			X B			X			X
Hand Hygiene Report						X B						X
Health Equity Committee				X						X B		
CARDIAC SERVICES												
Cardiac Surgery Society of Thoracic Surgery(STS)					X B						X	
Cardiology American College of Cardiology (ACC) Data		X						X	B			
CRITICAL CARE												

Revised: Dec 2023

2024 Quality Council/Board Quality Topic Review Schedule

TOPIC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Emergency Dept Report						X					X	B
Rapid Response Team Code Blue	X	B		X			X			X		
Trauma Committee				X						X		
SURGICAL SERVICES Surgical Quality Improvement Program					X						X	B
ORTHO/NEURO/REHAB												
Stroke	X						X	B				
Rehabilitation		X						x				
Orthopedics		X						x				
MATERNAL CHILD HEALTH												
Perinatal Core Measures, Pediatrics, NICU,			X		B				X			
Labor & Delivery, Obstetrics			x		B				X			
RENAL SERVICES												
Renal Services - Network 18						X					X	B
MENTAL HEALTH												
CMS Core Measures				X						X		
POST ACUTE SERVICES												
Subacute						X					X	
Hospice, Home Health				X						X		
2024 QUALITY FOCUS TEAMS												
SEPSIS Quality Focus Team (QFT)	X	B		X			X			X		
Handoff Communication QFT			X	B			X		X			X
HAI QFT		X			X			X	B		X	
2024 BEST PRACTICE TEAMS												
Heart Failure BPT	X			X			X			X		
Pneumonia (PN) BPT	X			X			X			X		
COPD BPT	X			X			X			X		
AMI (non-STEMI) BPT	X			X			X			X		
CLOSED AGENDA ITEMS												
QComm Report	X	X	X	X	X	X	X	X	X	X	X	X

Revised: Dec 2023

2024 Quality Council/Board Quality Topic Review Schedule

TOPIC	JAN		FEB		MAR		APR		MAY		JUN		JUL		AUG		SEP		OCT		NOV		DEC	
Medication Safety *J McNulty*	X						X						X	B					X					
MERP Annual Review													X	B										
Root Cause Analysis	X		X		X		X		X		X		X		X		X		X		X		X	

Outstanding Health Outcomes Update

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

January 2024

Kaweah Health — MORE THAN MEDICINE. LIFE.

Sepsis (SEP)

	FY 2024 Target	FY 2022	FY 2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	FYTD 24
SEP-1 CMS % bundle compliance	≥85%	75%	73%	68%	77%	76%	76%	76%								75%
Sepsis and Related Conditions o/e mortality	≤0.78		1.12	0.75	0.82	0.78	0.84	1.38								0.92

Central Line Associated Blood Stream Infection (CLABSI)

	FY 2024 Target	FY 2022	FY 2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	FYTD 24
CLABSI Events		18 Ex COVID	14 Ex COVID	1	2	3	0	3								9
CLABSI SIR	≤0.486	1.01 Ex COVID	0.93 Ex COVID	0.83	1.16	2.22	0.00	1.15								1.15
Central Line Utilization Rate (ICU)	≤0.663	1.02	0.88	0.749	0.791	0.828	0.774	0.685								0.77

Catheter Associated Blood Stream Infection (CAUTI)

	FY 2024 Target	FY 2022	FY 2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	FYTD 24
CAUTI Events		23 Ex COVID	12 Ex COVID	0	0	2	0	2								4
CAUTI SIR	≤0.401	1.09 Ex COVID	0.55 Ex COVID	0.00	0.00	1.06	0	0.974								0.41
Indwelling Uninary Catheter (IUC) Utilization Rate (ICU)	≤0.672	1.18	1.22	0.869	0.925	1.040	1.080	1.10								1.00

Methicillin-Resistant Staphylococcus Aureus (MRSA)

	FY 2024 Target	FY 2022	FY 2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	FYTD 24
MRSA Events		10 Ex COVID	6 Ex COVID	0	0	1	0	1								1
MRSA SIR	≤0.51	1.11 Ex COVID	0.66 Ex COVID	0.00	0.00	1.47	0.00	1.32								0.57

KEY

Does not meet goal/benchmark	Outperforming/ meeting goal/benchmark

Action Plan Summary

Sepsis

- Focus on 1 hr bundle, expand to inpatient
- Re-identifying root causes of SEP-1 non-compliance to focus SEP-1 QI on the highest contributing factors

Healthcare Acquired Infections

- New super "HAI Brain Trust" Quality Focus Team established, approved by Quality Improvement Committee
- Combine and focus efforts on process metrics that affect the SIRs for CAUTI, CLABSI & MRSA and includes:
  - Line utilization (both central lines and indwelling urinary catheters
    - Multidisciplinary rounds started January 2024 in high risk areas, addresses line necessity (less lines=less infections)
  - Decolonization rates
    - Nasal - Improved from 32% (Jan-June 2023) to 84% (July – Nov 2023), November 100%. Includes patients who are screened and test positive for MRSA upon admission and not discharged within 24 hours of Mupirocin order (decolonization agent). Next Steps – determining and addressing root causes of patients missed screening
    - Skin – New discussions on process for skin decolonization through CHG bathing
  - Cleaning effectiveness in high risk areas
    - Additional training, including cleaning and testing processes
  - Hand Hygiene (use of BioVigil system for monitoring)
    - Increased use of system, improvement from 31% of active users achieving target badge hours in FY 2023, to 48% FYTD24. Next steps, additional tools provided to leaders and staff to support increase use, and evaluation of active users with the denominator
    - COMING SOON – RECOGNITION PROGRAMS for units/departments that have achieve highest % of staff meeting 80hrs active time (paired) per month!

More than medicine. Life.

Kaweah Health

Questions?

The pursuit of healthiness

Kaweah Health
OUTSTANDING HEALTH OUTCOMES GOALS--Strategic Plan & At-Risk Incentive Compensation Program
For the Fiscal Year Ended June 30, 2024

Outcome Measure Description	Previously-Approved	Proposed		
		Measure	Percentile	
CAUTI SIR	0.478	0.401	70th	National Healthcare Safety Network (NHSN)--2022
Foley Catheter SUR	0.7	0.6718	70th	National Healthcare Safety Network (NHSN)--2022
CLABSI SIR	0.39	0.486	70th	National Healthcare Safety Network (NHSN)--2022
Central Line SUR	0.68	0.6633	70th	National Healthcare Safety Network (NHSN)--2022
MRSI SIR	0.55	0.507	70th	National Healthcare Safety Network (NHSN)--2022
Sepsis Bundle (SEP-1)	85%	85%		Kaweah-defined Target
Sepsis Mortality O/E	0.78	0.78	50th	Midas National Benchmark--Q2 2023
Hospital Readmissions--AMI	6.15%	5.64%	75th	Midas National Benchmark--January--September 2023
Hospital Readmissions--COPD	9.00%	10.53%	75th	Midas National Benchmark--January--September 2023
Hospital Readmissions--HF	11.72%	11.80%	75th	Midas National Benchmark--January--September 2023
Hospital Readmissions--PNEUMONIA	9.00%	9.76%	75th	Midas National Benchmark--January--September 2023
Mortality--AMI	0.70	0.60	75th	Midas National Benchmark--January--September 2023
Mortality--COPD	0.70	0.66	75th	Midas National Benchmark--January--September 2023
Mortality--HF	0.52	0.44	75th	Midas National Benchmark--January--September 2023
Mortality--Bacterial Pneumonia	0.53	0.65	75th	Midas National Benchmark--January--September 2023
Mortality--Viral Pneumonia	0.65	0.44	75th	Midas National Benchmark--January--September 2023

Glossary:
  SIR--Standardized Infection Ratio
  SUR--Standardized Utilization Ratio
  AMI--Acute Mycardial Infarction
  COPD--Chronic Obstructive Pulmonary Disease
  HF--Heart Failure
  O/E--Observes to Expected
  CAUTI--Catheter Associated Urinary Tract Infection
  CLABSI--Central Line Associated Blood Stream Infection
  MRSA--Methicillin-resistant Staphylococcus aureus