August 8, 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, August 15, 2024, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

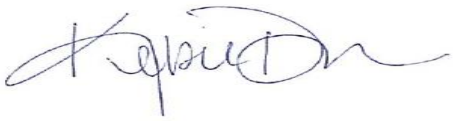
The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:31AM on August 15, 2024, 2024, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277, pursuant to Health and Safety Code 32155 & 1461.

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, August 15, 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



Kelsie Davis
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, August 15, 2024
5105 W. Cypress Avenue
Kaweah Health Lifestyle Fitness Center Conference Room

ATTENDING: Board Members: Michael Olmos (Chair), Dean Levitan, MD; Gary Herbst, CEO; Keri Noeske, 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, Director of Quality and Patient Safety; Ben Cripps, Chief Compliance and Risk Management Officer; Evelyn McEntire, Director of Risk Management; and Kyndra Licon, Recording.

OPEN MEETING – 7:30AM

1. **Call to order** – *Mike Olmos, 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 (Kelsie Davis 559-624-2330) or kedavis@kaweahhealth.org to make arrangements to address the Board.
3. **Approval of Quality Council Closed Meeting Agenda** – 7:31AM
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Julianne Randolph, DO, Vice Chief of Staff and Quality Committee Chair; Keri Noeske and Janice Nini*
   - **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** – *Mike Olmos, Committee Chair*

CLOSED MEETING – 7:31AM

1. **Call to order** – *Mike Olmos, Committee Chair*

2. **Approval of July Quality Council Closed Session Minutes –** Mike Olmos, Committee Chair; Dean Levitan, Board Member
3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Julianne Randolph, DO, Vice Chief of Staff and Quality Committee Chair; Keri Noeske and Janice Nini*
4. **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.*
5. **Adjourn Closed Meeting** – *Mike Olmos, Committee Chair*

OPEN MEETING – 8:00AM

1. **Call to order** – *Mike Olmos, Committee Chair*
2. **Public / Medical Staff participation –** Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves at this time. Members of the public or the medical staff may comment on agenda items after the item has been discussed by the Committee but before a Committee recommendation is decided. In either case, each speaker will be allowed five minutes.
3. **Approval of July Quality Council Open Session Minutes –** Mike Olmos, Committee Chair; Dean Levitan, Board Member
4. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives:

    4.1. **Stroke Committee Quality Report**
    4.2. **Rehabilitation Quality Report**

5. **Emergency Department Quality Report –** A review of key quality performances and action plans related to care process in the Emergency Department. Keri Noeske, Chief Nursing Officer.
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** – *Mike Olmos, 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.

Agenda item intentionally omitted

OPEN Quality Council Committee
Thursday, July 18, 2024
The Lifestyle Center Conference Room

Attending: Board Members: Mike Olmos (Chair) & Dr. Dean Levitan; Gary Herbst, Chief Executive Officer; Dr. Paul Stefanacci, CMO/CQO; Mark Mertz, Chief Strategy Officer; Sandy Volchko, Director of Quality & Patient Safety; Jag Batth, Chief Operating Officer; Ryan Gates, Chief Population Health Officer; Erika Pineda, Quality Improvement Manager; Shawn Elkin, Infection Prevention Manager; Kyndra Licon, Program Coordinator – Recording.

Mike Olmos called to order at 7:30 am.

Approval of Closed Session Agenda: Dean Levitan made a motion to approve the closed agenda, there were no objections.

Mike Olmos adjourned the meeting at 8:30 am.

Mike Olmos called to order at 8:32 am.

3. **Approval of June Quality Council Open Session Minutes –** Mike Olmos, Committee Chair; Dean Levitan, Board Member.
    - Approval of June Quality Council Open Session Minutes by Dean Levitan and Mike Olmos.

4. **Sepsis Quality Focus Team Report -** A review of key quality measures and action plans focused on the care of sepsis patient population. *Erika Pineda, BSN, RN, PHN, CPHQ, Quality Improvement Manager; LaMar Mack, MD, MHA, Medical Director of Quality and Patient Safety.*
    - Discussed current quality priorities to improve quality, why it is important, and why we want to work on this. Sepsis measures and care is based on the time zero. When a physician documents 'sepsis' before a blood culture is taken or received from the lab, it starts the clock of time zero. It has been hard to nail down the time zero and we have not always been inaccurate with that number. We are in the process of standardizing that and a set of protocols for time zero are established to be consistent with the care bundles. In April we had 2 patients documented as having septic shock but they were ruled out. We need to try to find a way to consistently get into the GME Curriculum to help our residents understand the sepsis bundle. We have our new ED director she will be doing one-to-one coaching with the staff when there is a fallout. Gary would like to see a more detailed Sep 1 Early Management Bundle Compliance dashboard (the 1 hour bundle compliance). Opportunities for improvement are differential diagnoses of infection and it is not customary to treat every differential diagnosis. The providers do not order the blood culture timely and or blood is not being drawn timely. The action plan is to continue education to providers during concurrent review of cases, resident project establishing 'time zero' through documentation in Sepsis and lastly, sepsis brief updated to ED chief resident and provider education. Accomplishments are: length of stay, saved 6 sepsis lives for FYTD 2024, completing the implementation of sepsis bundle to all inpatient units, more fluids being ordered/administered, ED physician collaboration with ED pharmacy team. Discussion on the difference between diagnosis and differential diagnosis.

5. **Clinical Quality Goals Update-** A review of current performance and actions focused on the clinical quality goals for Sepsis, and Healthcare Acquired Infections. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*
    - At the time the document was submitted we did not have June numbers. Gary would like to receive the June update for HAI QFT dashboard. We have had too many CLABSIs to achieve the overall goal. When you look at the central line utilization rate year after year it is coming down which is very positive, we see progress. We know where the opportunity to improve is CVICU. The multidisciplinary rounds (MDR) are key and since they were instituted in ICU it has made a difference. Bringing Sound on has also been helpful in many key ways. The MDR plan started in ICU and plan is to move into CV, 5T, etc. which is starting 3rd Qtr. We are seeing a decrease in the process metrics in HAI prevention, expanding the multidisciplinary rounds will continue the downward trend. 5 straight months of zero events in MRSA. We have 7 events overall for FYTD 24. We will have a conversation about skin decolonization with CHG bathing at the next meeting. A lot of progress in the process measures for the HAI QFT meeting. Gary would like a column added to the dashboard reflecting to the committee the percentile of the national goal. Send FY 24 and FY 25 measures to Gary.

6. **Adjourn Open Meeting** – *Mike Olmos, Committee Chair*

Mike Olmos adjourned the meeting at 9:23 am.

Committee minutes were approved for distribution to the Board by the Committee Chair on

Stroke Quality Focus Team Report

Quality Council Report
August 2024

Cheryl Smit, BSN, RN, Stroke Program Manager
Sean Oldroyd, DO Stroke Program Medical Director

2024 Quality Priority: In-House Stroke Alert

Goal/Objective: Structure RRT & In-House Stroke Alert process to ensure optimal outcomes for in-house stroke patients

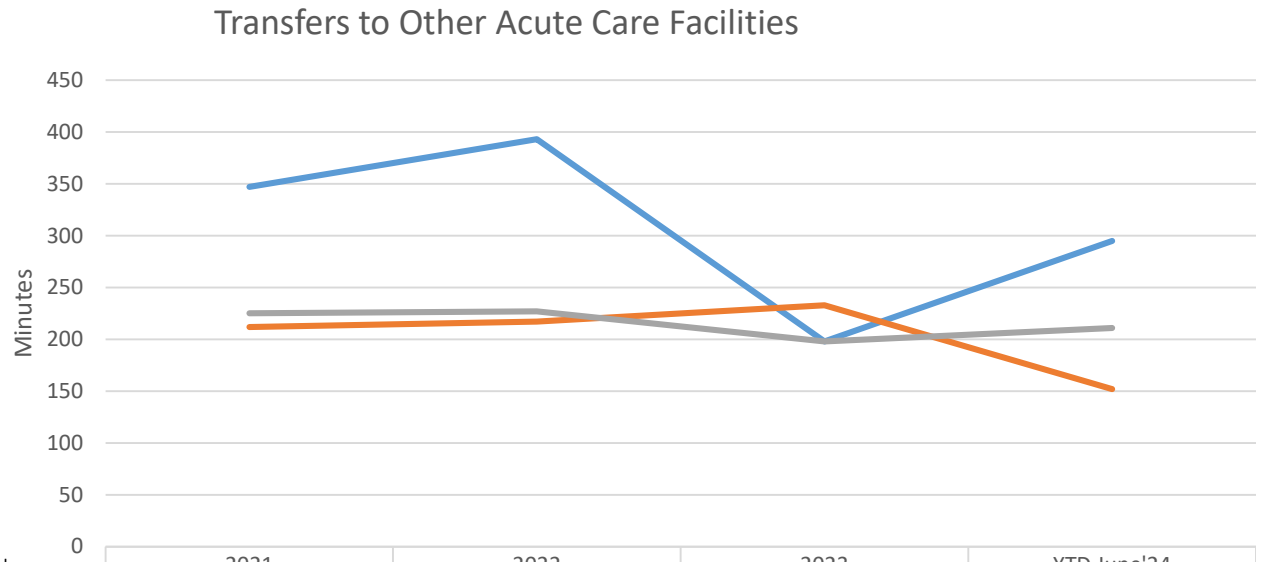
2024 PLAN

- Standardized communication tools that mitigate delays in early recognition and timely management
- Utilize scripting tool for RRT RNs to clearly describe patient status to the neurologist during in-house stroke alerts (August 2024)
- Stroke Committee to review gaps in process/care (September 2024)
- Define roles and expectations of all key stakeholders (November 2024)
- Train acute care RNs and RRT RNs on stroke identification/ assessment, in-house stroke alert process, and chain of command (November 2024)
- Acute care practitioner and neurology education on the in-house stroke alert process, their role in the process and chain of command (November 2024)

Measures of Success:

- Rate of complete and accurate documentation for all in-house stroke alert cases
  - Develop enhanced measures to monitor process (August 2024)
  - Target of 100% compliance (November 2024)

Current Performance: Transfers to Other Acute Care Facilities



Patients who had:	2021	2022	2023	YTD June'24
Hemorrhage	347	393	198	295
IV Thrombolytic	212	217	233	152
Large Vessel Occlusion	225	227	198	211

2024 GOAL

Transfer times below TJC goal of 120 minutes or less

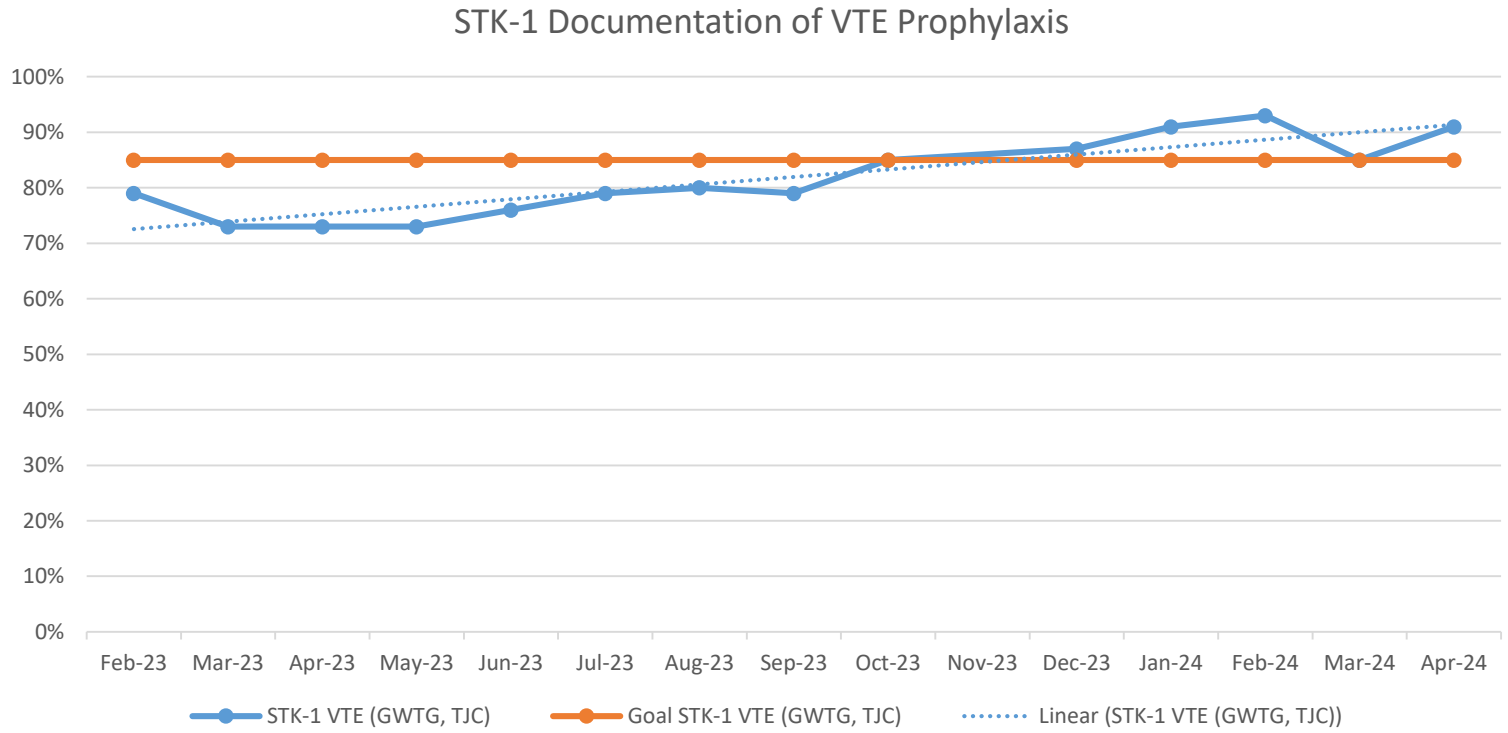
Time is Brain: Expedited transfers improve patient outcomes

2024 PLAN

High Level Action Plan

- ED Stroke Alert Committee reviews each case to identify if below action plans have been effective and determine if further action is needed to address process and care gaps (ongoing)
- Education given to ED providers, ED staff, and transfer center staff (ongoing)
- Re-designed Ischemic/Hemorrhagic Transfer Guide and process (May 2024)
- Transfer partnership with CRMC/Fresno as the first transfer option, followed by USC/Keck (May 2024)
- Ongoing collaboration with CRMC and other receiving facilities, EMS, and Air Methods (Skylife) to expedite transfers
- Evaluating strategies for identification of hemorrhagic stroke patient when a patient is outside the 24 stroke alert window (population that has longest transfer time)

Current Performance: STK 1 VTE Prophylaxis



2024 PLAN

High Level Action Plan

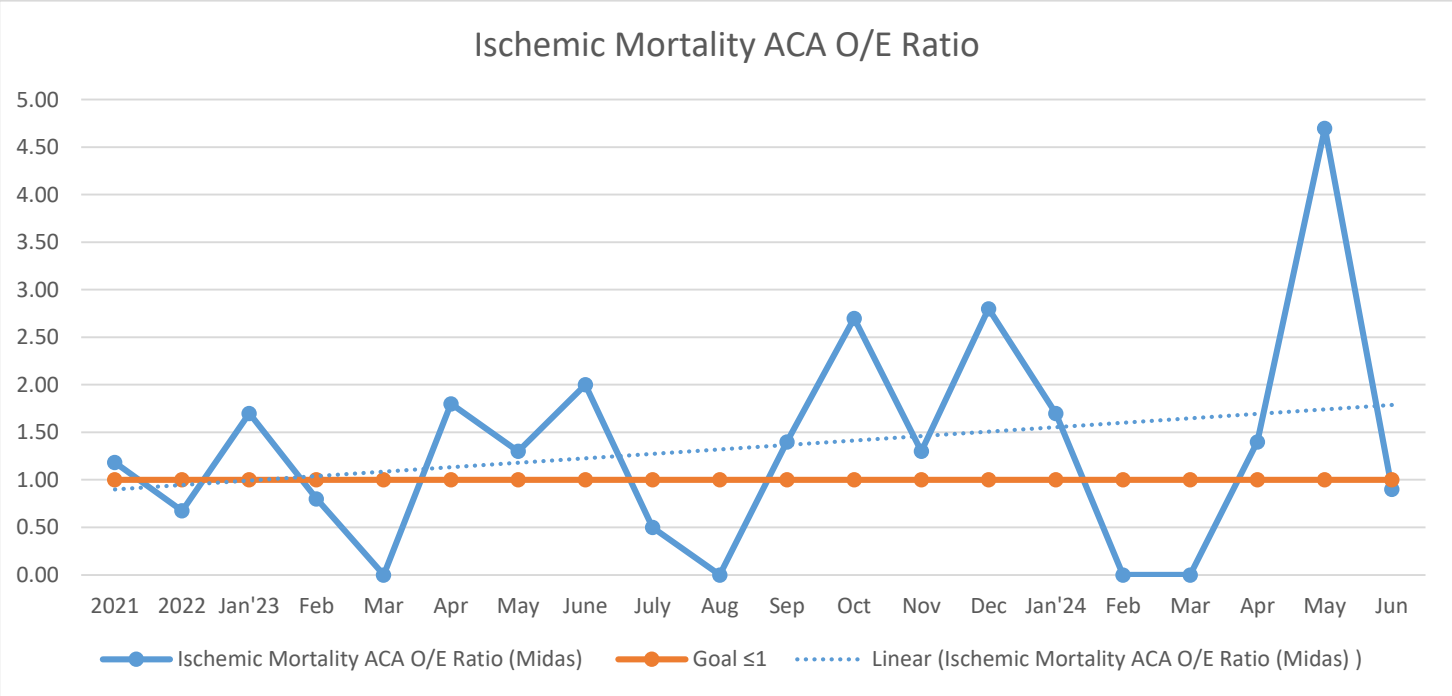
- Medical Surgical Non IV Thrombolytic and TIA admission PowerPlans prompt the provider to select the most appropriate VTE prophylaxis (January 2024)
- Nursing unit verification process established to ensure SCDs are in place (August 2024)
- VTE prophylaxis education with focus on SCD placement is included in nursing competencies/annual stroke education (April-June 2024)

2024 GOAL

VTE Prophylaxis rate exceeds the TJC goal of 85%

Mechanical prophylaxis is an evidenced-based strategy that prevents dangerous blood clots from forming

Current Performance: Ischemic Mortality O:E Ratio



2024 GOAL

Ischemic stroke mortality expected to be below an O:E ratio of 1.0

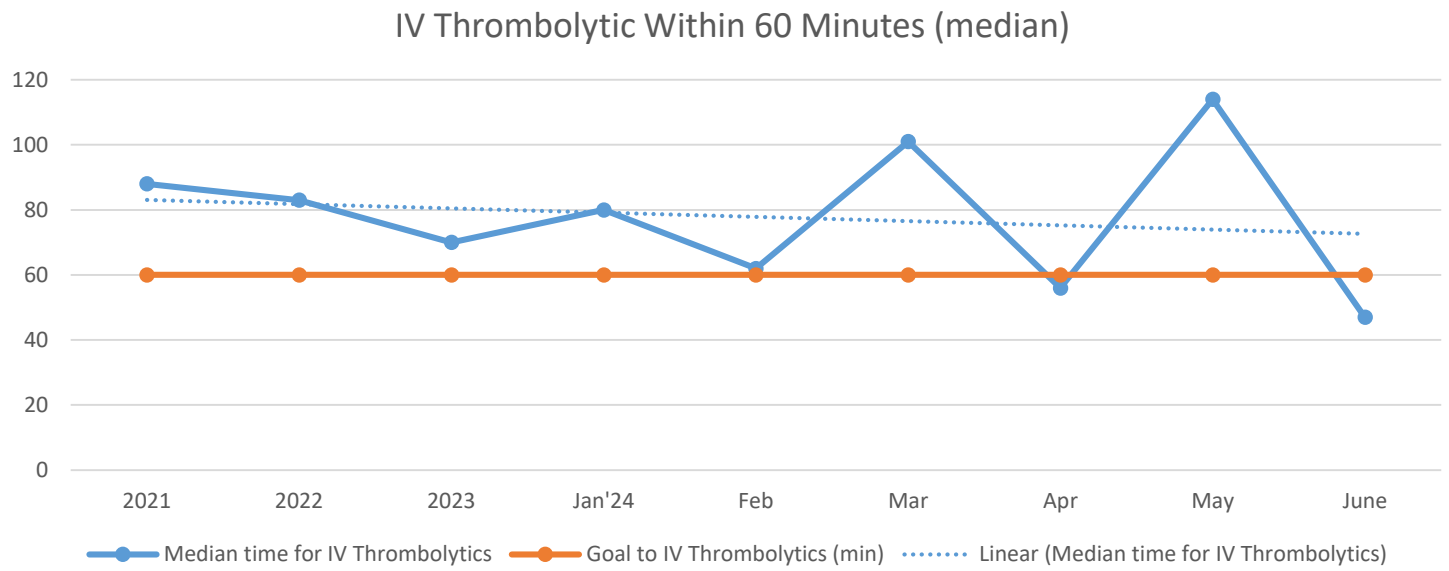
M&M's provide a venue for the Identification of potential ACTIONABLE gaps in care

2024 PLAN

High Level Action Plan

- Plan to develop a format and structure for Stroke/Neurology M&M Conferences (December 2024)
- Stroke Committee review of each case to identify potential actionable gaps in process/care related to mortality and length of stay (September 2024)
- Identification of potential ACTIONABLE gaps in care related to mortality and length of stay (September 2024)

Current Performance: Door to IV thrombolytic



2024 GOAL

The median time for IV thrombolytic administration will be given within 60 minutes on eligible patients with stretch goal of 45 minutes

The decision to administer IV thrombolytics must be made quickly and is based on timely communication with family members

2024 PLAN

High Level Action Plan

- Developed EMS info card for timely family communication when administering IV thrombolytics (September 2024)
- ED Stroke Alert Committee reviews each case to evaluate effectiveness of QI strategies and identify process and care gaps (ongoing)
- Mock stroke alert training for ED staff and Stroke Team Leads (ongoing)

Primary Stroke Re-certification

Goals/Objectives: Successful Primary Stroke Re-Certification survey

Survey window November 30, 2024 – February 28, 2025

Survey Preparation Plan

Education and strong care team partnerships enhance stroke awareness and communication.

Early recognition and timely evidenced based care results in the best outcomes for stroke patients.

- Verification of knowledge and execution of evidenced-based processes for stroke care
- Mandatory RN annual stroke education and competencies for stroke core units (April – June 2024)
- Annual ED provider stroke alert training with >85% compliance (May 2024)
- Staff education and competency files of members are up to date and validated by leaders in key areas, such as physicians, nursing, pharmacists (September 2024)
- ED and stroke core unit tracers (mock surveys) to validate knowledge and competence of all staff in patient care areas (September 2024)
- Develop strategies and timeline to ensure all staff members are familiar with relevant standards and expectations (September 2024)

Measure of Success:

Successful recertification without major deficiencies or recommendations (February 2025)

Staff competency files have all required elements listed by The Joint Commission, with a target of 100% compliance (November 2024)

Stroke Program Accomplishments and Initiatives

Accomplishments:

- Improved door to transfer times for IV thrombolytic patients with large vessel occlusion by 35% from 2023 to 2024
- Improved STK-1 VTE compliance by 15% from 2023 to 2024 YTD (January-April)
- Developed a scripting tool for RRT RNs to clearly describe patient status to the neurologist during in-house stroke alerts
- Successfully collaborate with the GME Program on multiple stroke-related quality improvement projects, including MRI compatibility of implantable devices, VTE prophylaxis, and TIA order set revisions
- Meets or exceeds the benchmarks for Achievement (7/7) and Quality (6/6) Measures in the American Heart Association's Get with the Guidelines registry (January-April 2024)
- Meets or exceeds the benchmark for Overall Diabetes Cardiovascular Initiative Composite Score in the American Heart Association's Get with the Guidelines registry (January-April 2024)
- Meets or exceeds the benchmarks for Primary Stroke Certification (8/8) through The Joint Commission (January-April 2024)

Initiatives:

- Stroke Alert Process Change: Have increased the "last known well time" window from 16 hours to 24 hours. Studies have shown benefits in treating large vessel occlusion patient within a larger window of time
- In-House Stroke Alert Process: Current review of the in-house stroke process by defining roles and expectations of all key stakeholders. Developing enhanced measures to monitor processes.
- Preparation for Primary Stroke Re-Certification: Re-certification survey window: Nov 30, 2024 - Feb 28, 2025. Certification cycle: 2 year

How has this been achieved?

Multidisciplinary team awareness & engagement

Ongoing collegial discussion of fall out events in monthly Stroke and ED Stroke Alert Committees

Questions?

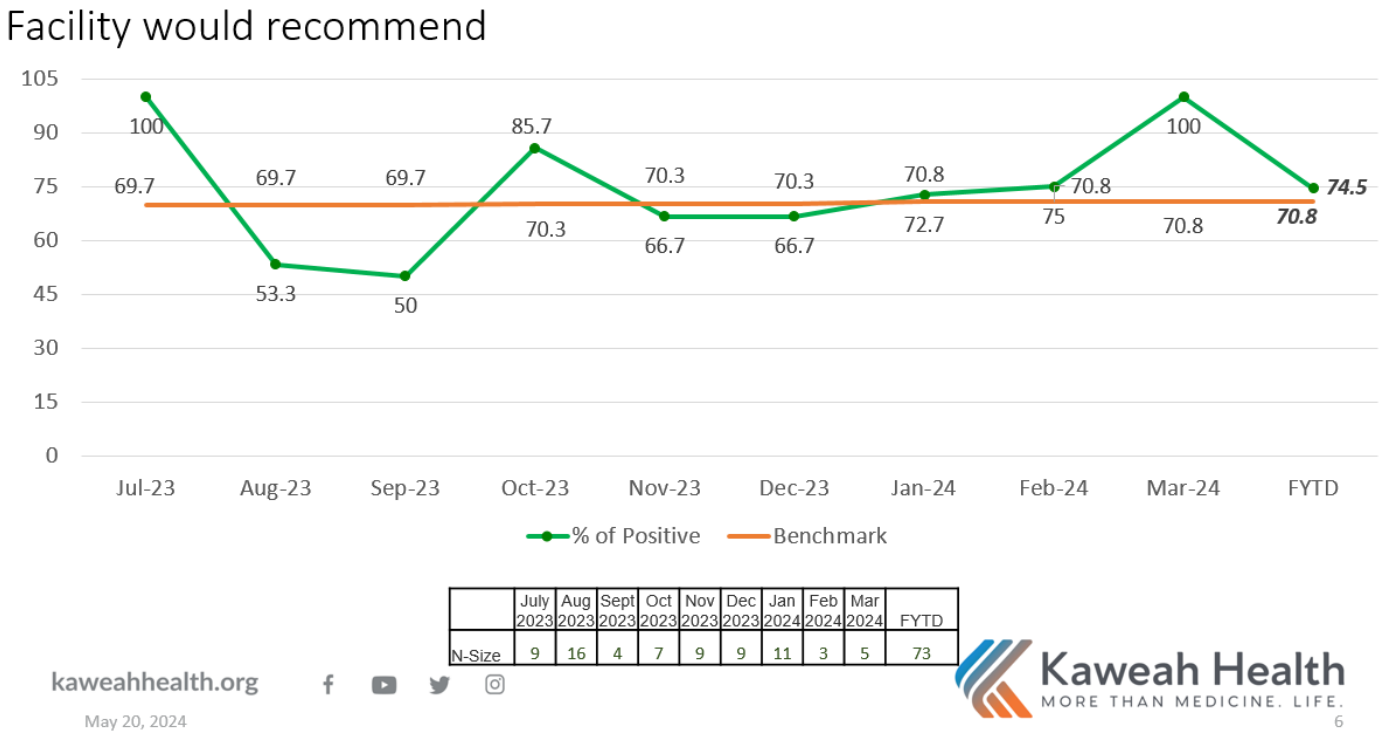
Abbreviations Used During this Presentation

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
NIHSS = National Institutes of Health Stroke Scale
RRT = Rapid Response Team
STL = Stroke Team Lead
SCD=Sequential Compression Devices
EMR = Electronic Medical Record

Unit/Department: Rehabilitation Services **Pro Staff Report Date:** May 2024

Measure Objective/Goal:
Acute rehabilitation program evaluation: patient satisfaction and clinical quality including: functional outcomes and transfer of care.
Date range of data evaluated: Rehab quarterly report 4Q2023 and 1Q2024

Patient Satisfaction
Analysis of all measures/data: (Include key findings, improvements, opportunities)
A patient experience survey is texted to patients after discharge. There are 5 questions in total, 4 of which are correlated to the 1 Net Promotor question of "would you recommend this facility". We utilize the 4 correlated questions to assist in action planning. For 4Q2023, there were 2 months below goal and 1Q2024 all 3 months were above goal of 50th percentile per NRC.



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

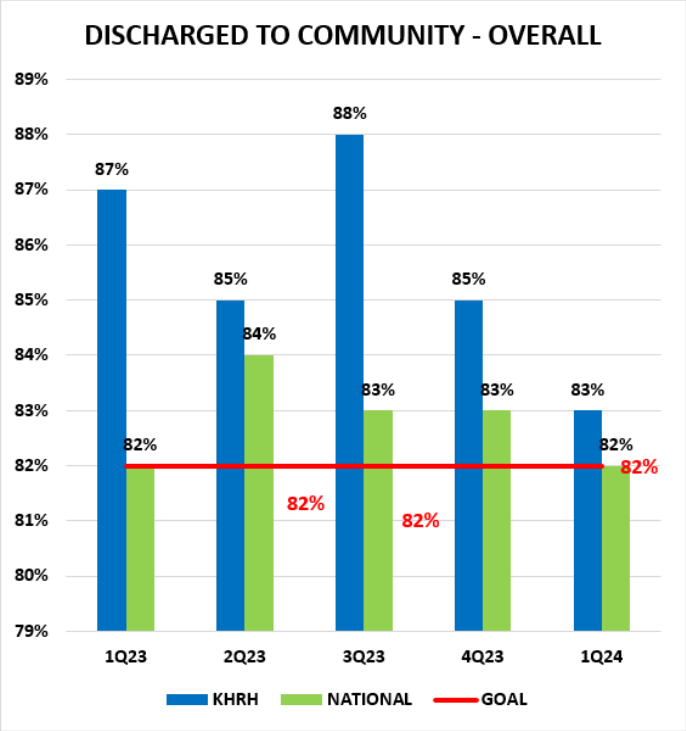
- Increase the 'n' – create educational flyer re: NRC survey to provide patients – July 31 2024
- Check with NRC what contact number is receiving the text for survey – not always going to patient – July 31 2024
- Lunch and Learn Compassionate Listening – May 15 2024

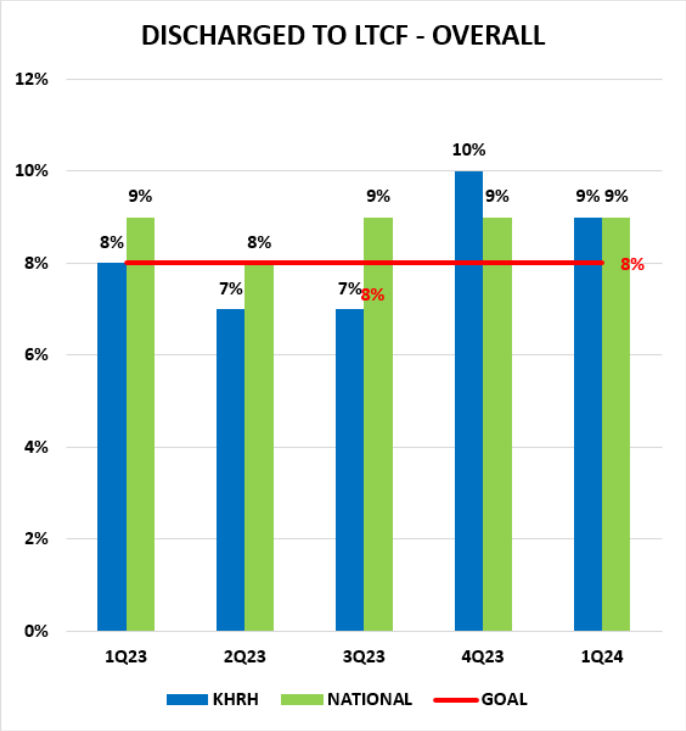
Functional Outcomes

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

Discharged to Community – (higher is better) in 4Q23/1Q24 85%/83% of KH Rehab patients returned to community, exceeding the national average of 83%/82%.

Discharge to LTCH – (lower is better) KH Rehab patients discharging to Skilled Nursing Facility in 4Q23/1Q24 was 10%/9% compared to national average of 9%/9%. The slight increase in patients discharging to SNF instead of home is associated with our effort to grow our program. We are accepting patients with a high case mix index (complexity) who may not reach the functional level to return home in the length of stay established/allowed, resulting in needing a little more time in SNF to return home safely.





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

- Track the case mix index in relation to their discharge destination.

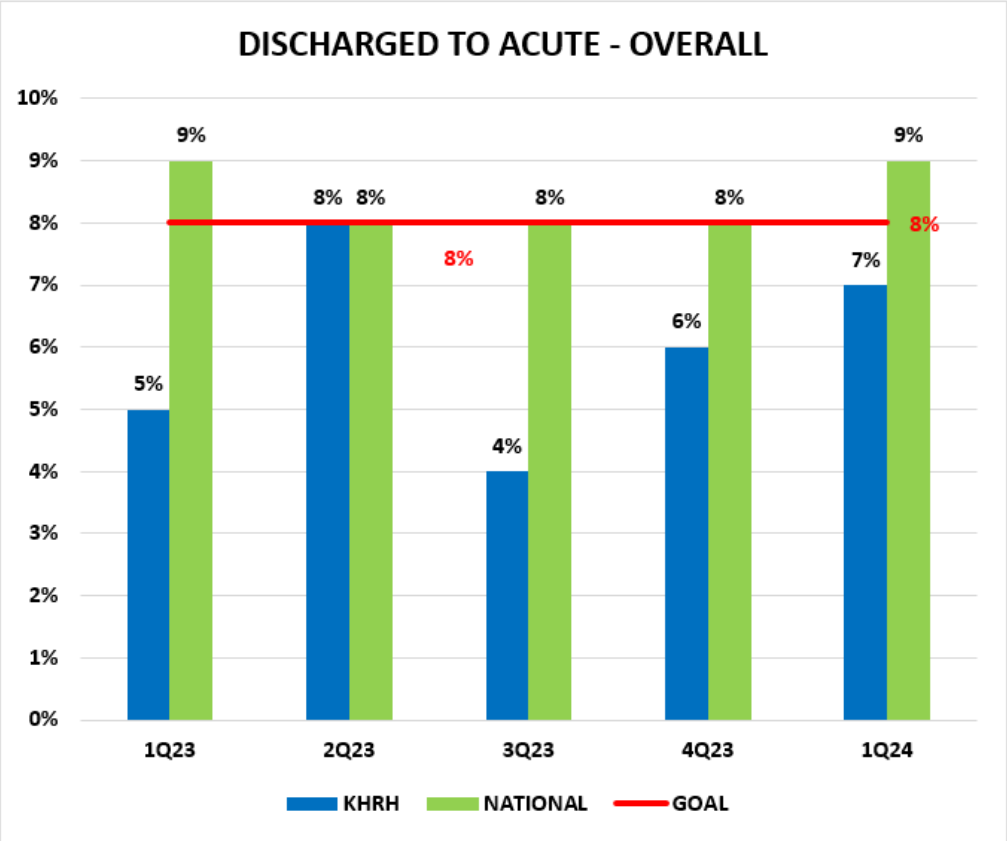
Transfer of Care

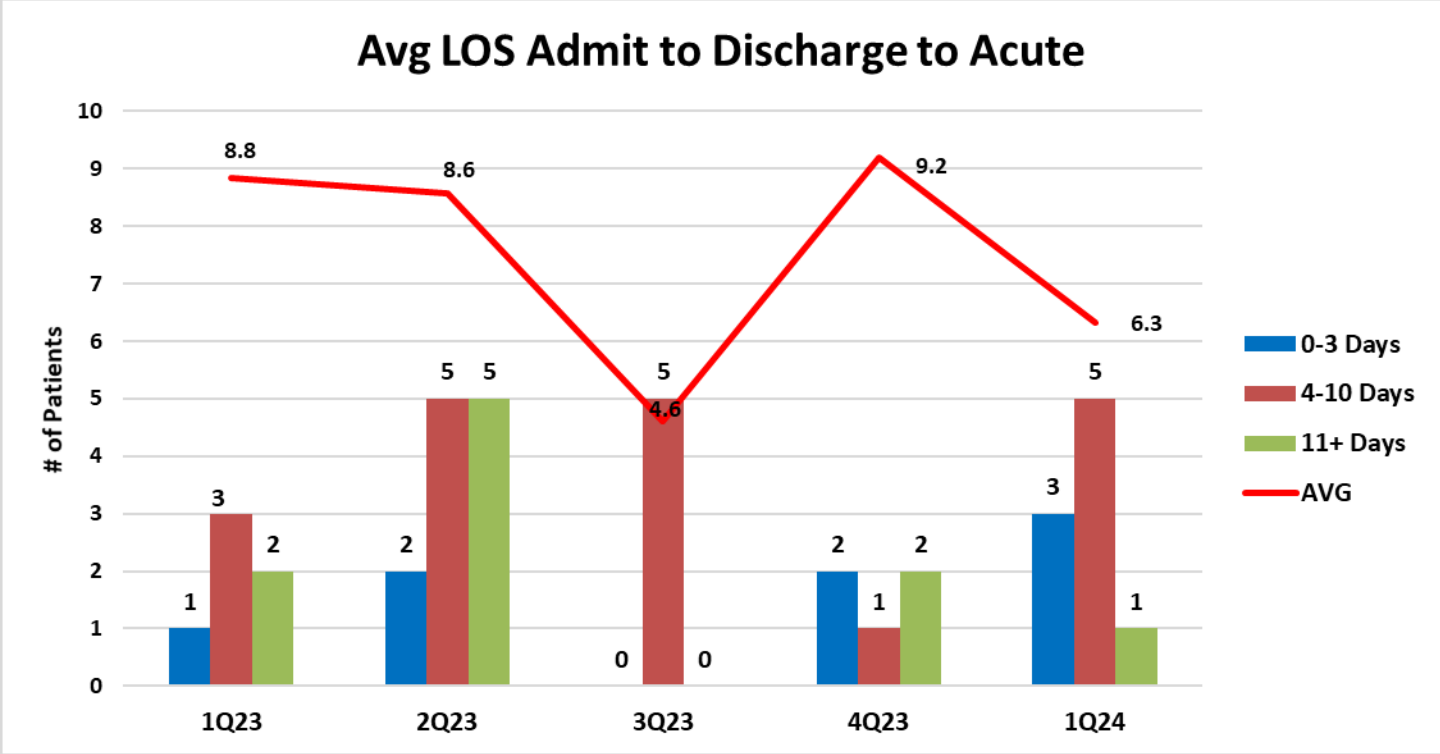
Analysis of all measures/data: (Include key findings, improvements, opportunities)

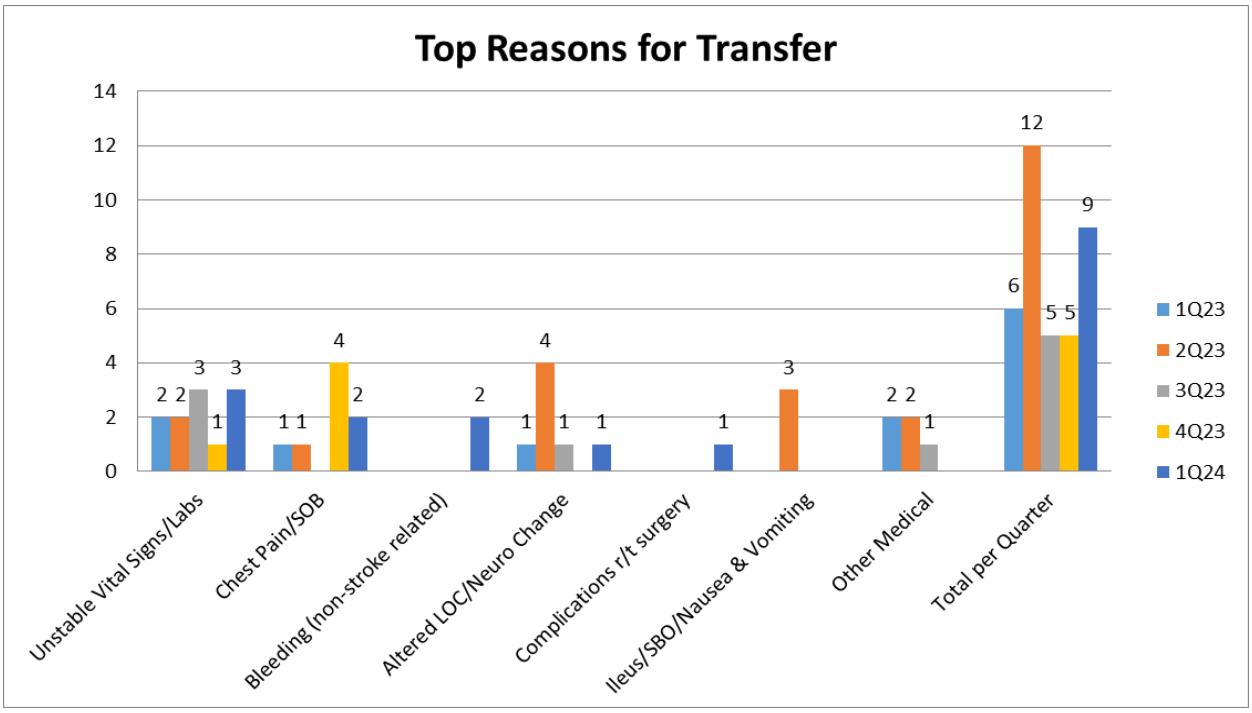
Discharged to Acute – (lower is better) In 4Q23, KH Rehab patients discharging back to the Acute Medical Center was 6%, lower than the national average of 8% and 1Q24, increased to 7% versus the nation at 9%. The Case Mix Index for KH 1.44 in 1Q24, closer to nation 1.43, which allows for improved comparison and as the acuity of the patient is increasing, we may end up closer to the nation in regards to transfers back to acute than we have been in the past.

Average LOS Prior to Discharge to Acute – In 4Q23, the average number of days from Rehab admission to transfer to Medical Center was 9.2 days and 1Q24 6.3 days. The average LOS prior to transfer back to acute ranging from 4.6 to 9.2 over the last year demonstrates that the patients were appropriate at the time of admission to Acute Rehab (AR), no trend identified.

Top Reasons for Transfer - In 4Q23 there were 5 and 4Q24 there were 9 patients transferred back and admitted to the Acute Medical Center. In discussion with Dr Matsuo, all were appropriate and unpreventable transfers due to diagnosis and treatment plans. Majority unstable vitals, ALOC and 2 GI bleeds.







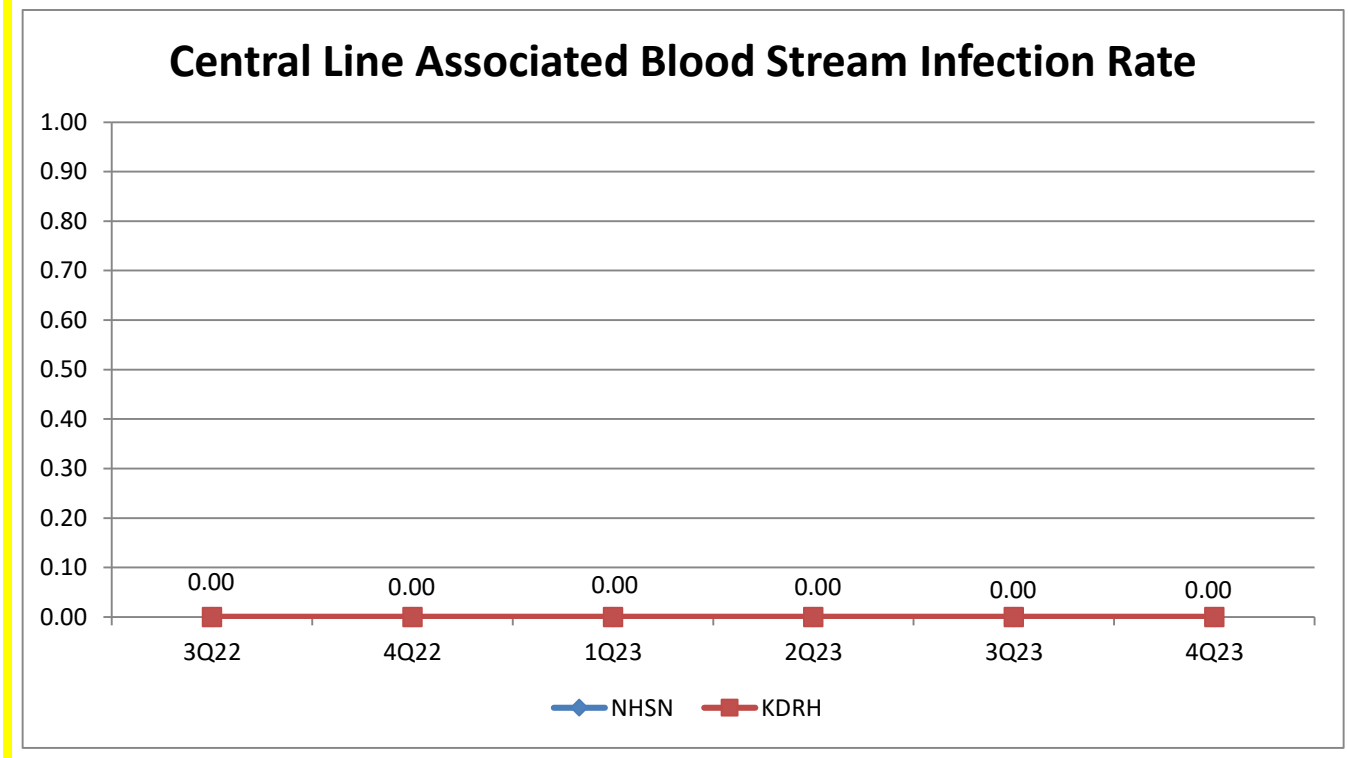
If improvement opportunities identified, provide action plan and expected resolution date:

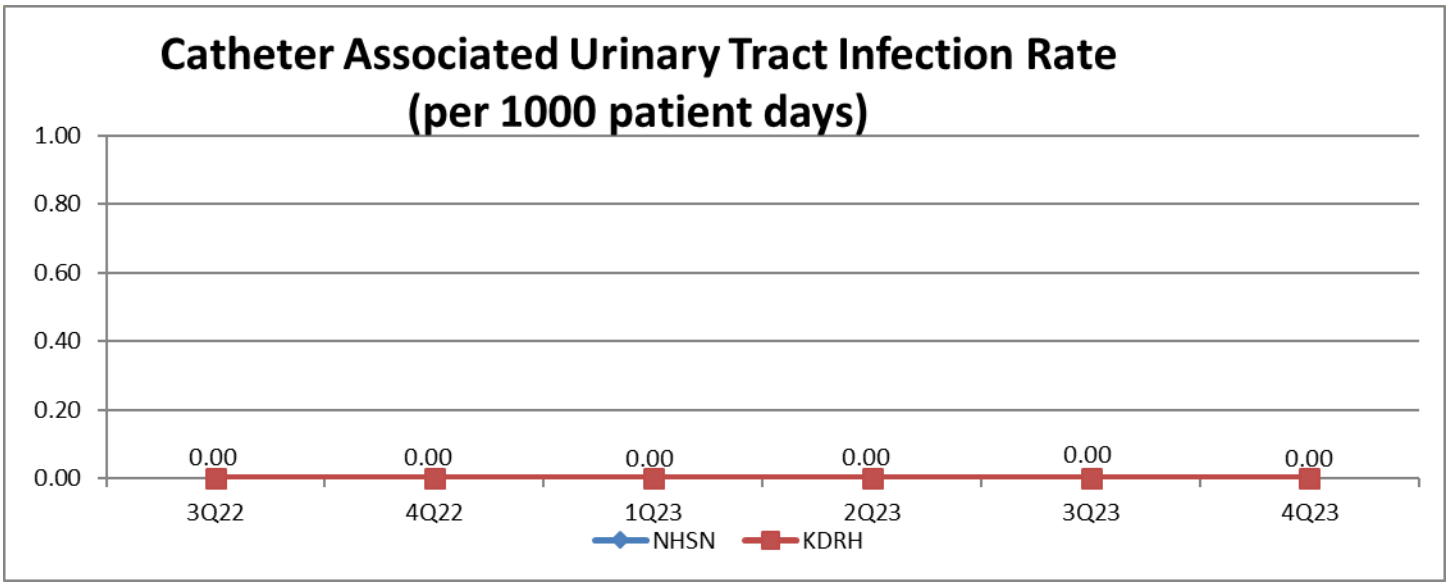
Measure Objective/Goal: Nursing indicators relative to NDNQI

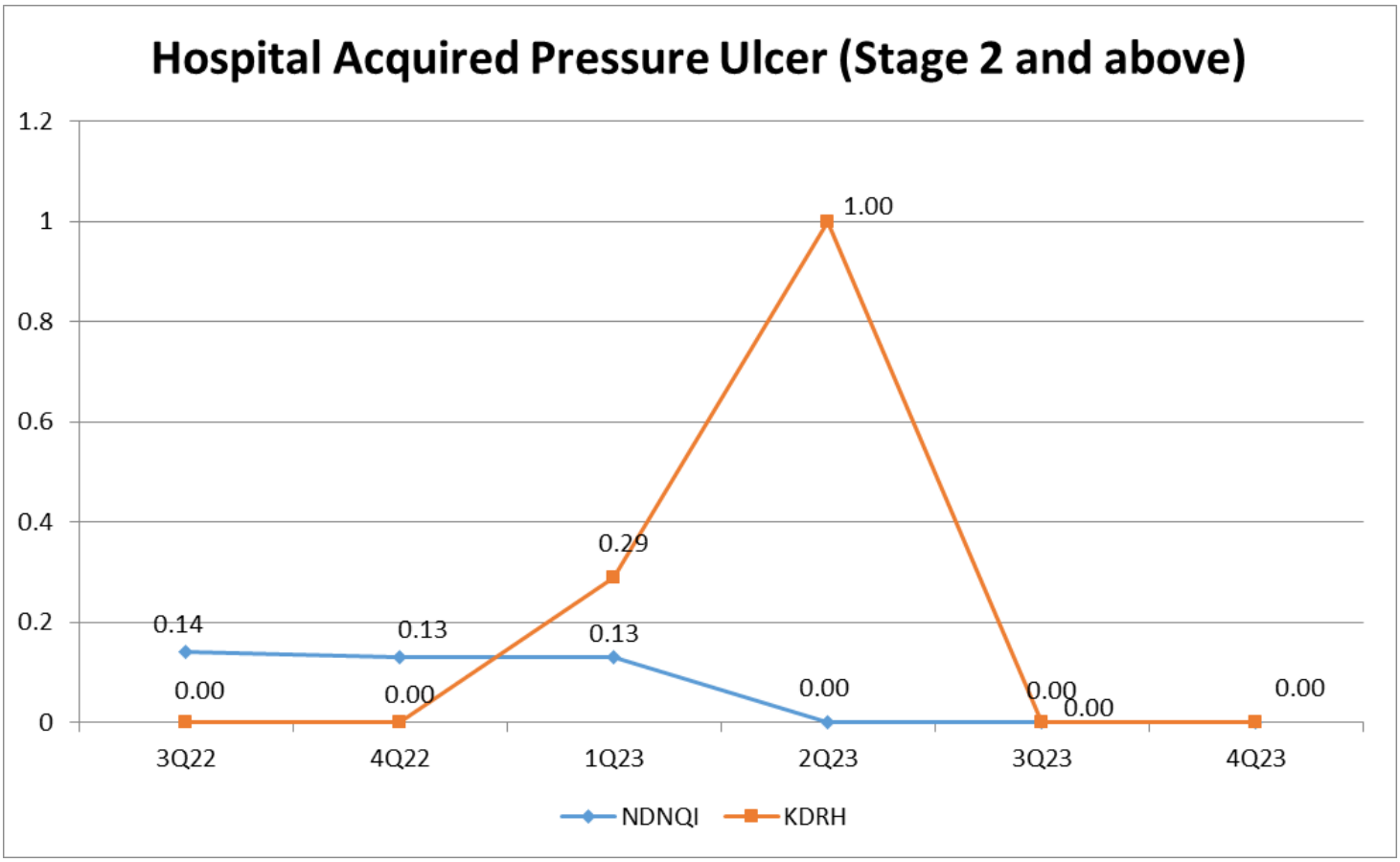
Date range of data evaluated: 3Q23 and 4Q23

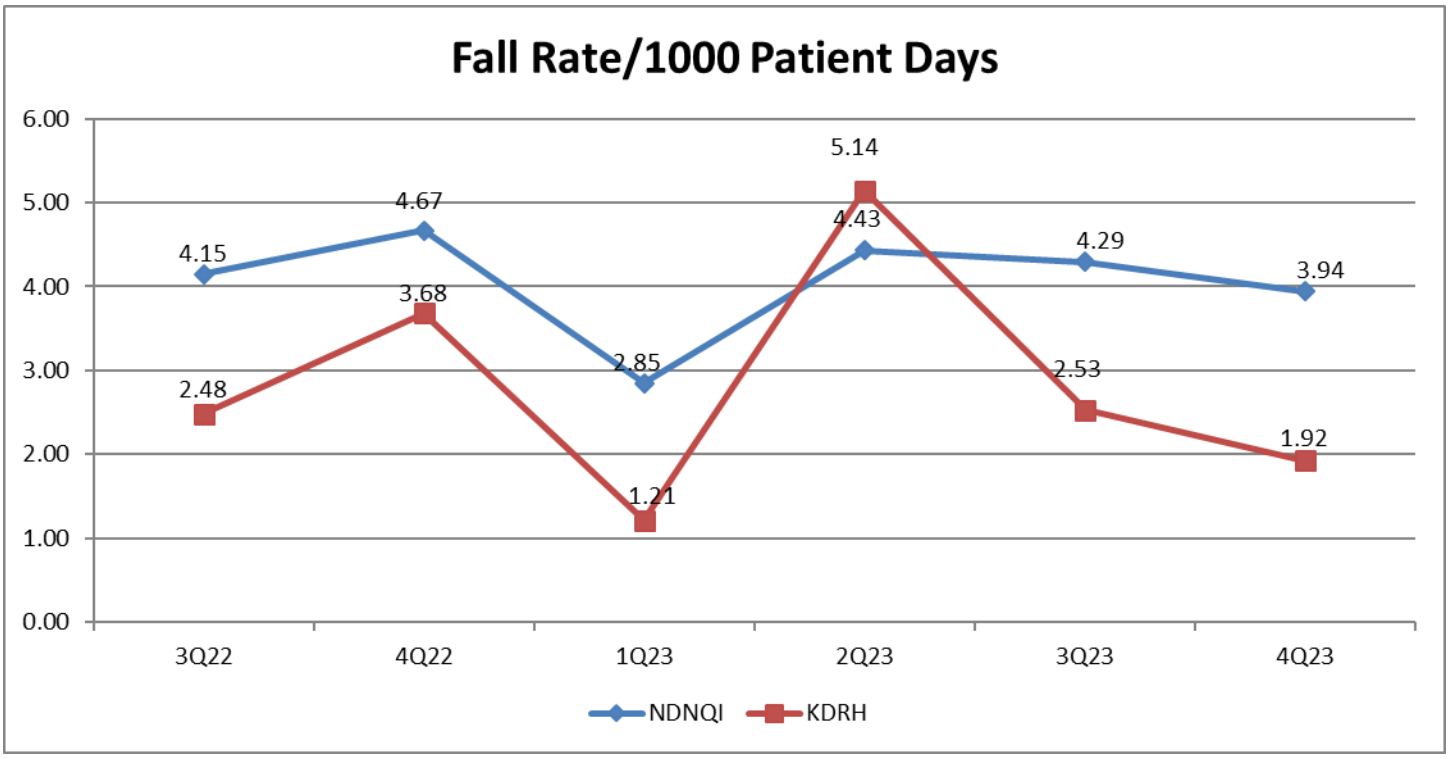
Analysis of all measures/data: (Include key findings, improvements, opportunities)

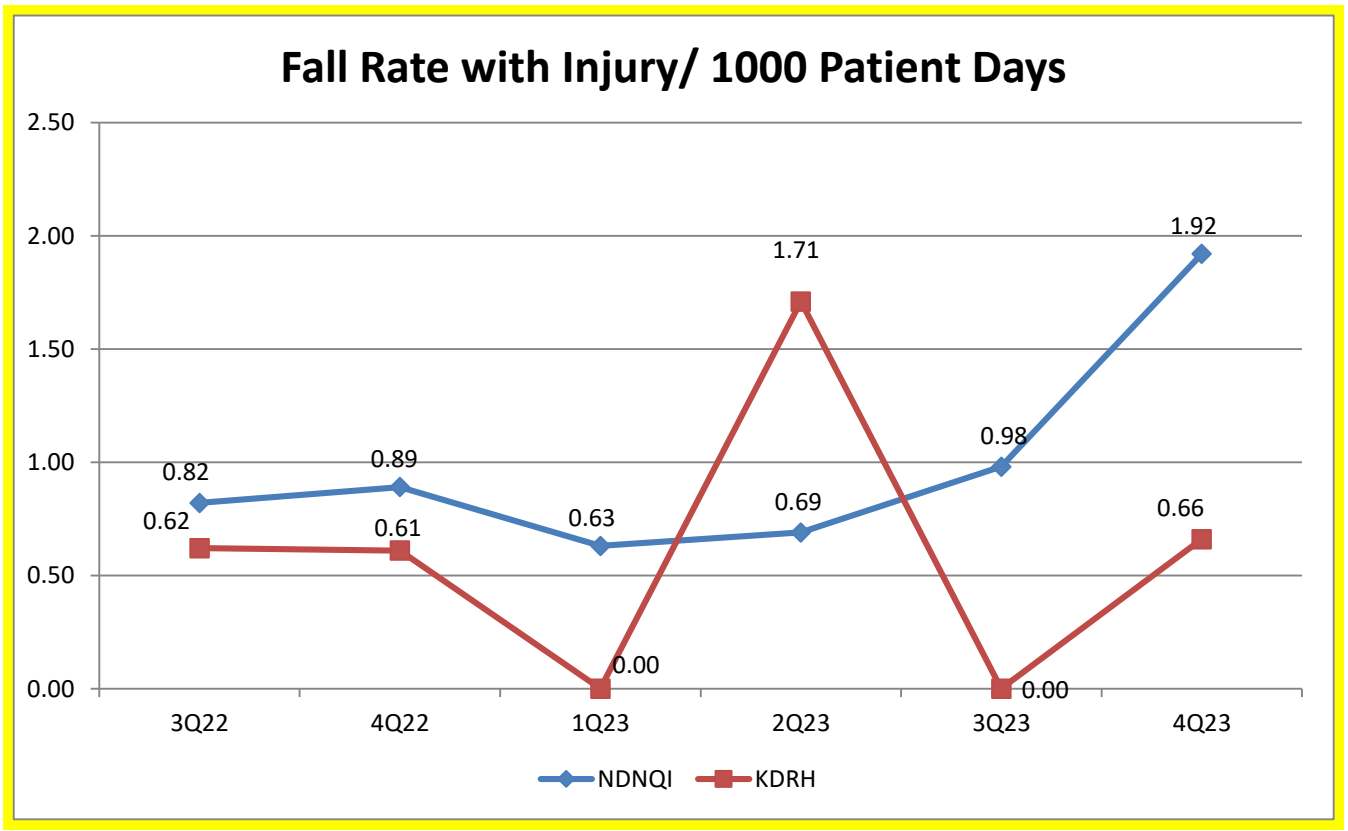
Kaweah Health Rehab had zero incidence of central line blood stream infections CLABSI and catheter associated urinary tract infection CAUTI. Hospital acquired pressure ulcer stage II or above for 3Q23 and 4Q23 decreased to 0 for both quarters. Fall rate per 1000 patient days and fall rate with injury/1000 patient days returned below NDNQI benchmarks in 3Q23 and 4Q23.




Catheter Associated Urinary Tract Infection Rate
(per 1000 patient days)
1.00
0.80
0.60
0.40
0.20
0.00
0.00
0.00
0.00
0.00
0.00
0.00
3Q22
4Q22
1Q23
2Q23
3Q23
4Q23
NHSN
KDRH


Hospital Acquired Pressure Ulcer (Stage 2 and above)
1.2
1
0.8
0.6
0.4
0.2
0
0.14
0.13
0.13
0.00
0.00
0.29
1.00
0.00
0.00
0.00
0.00
3Q22
4Q22
1Q23
2Q23
3Q23
4Q23
NDNQI
KDRH

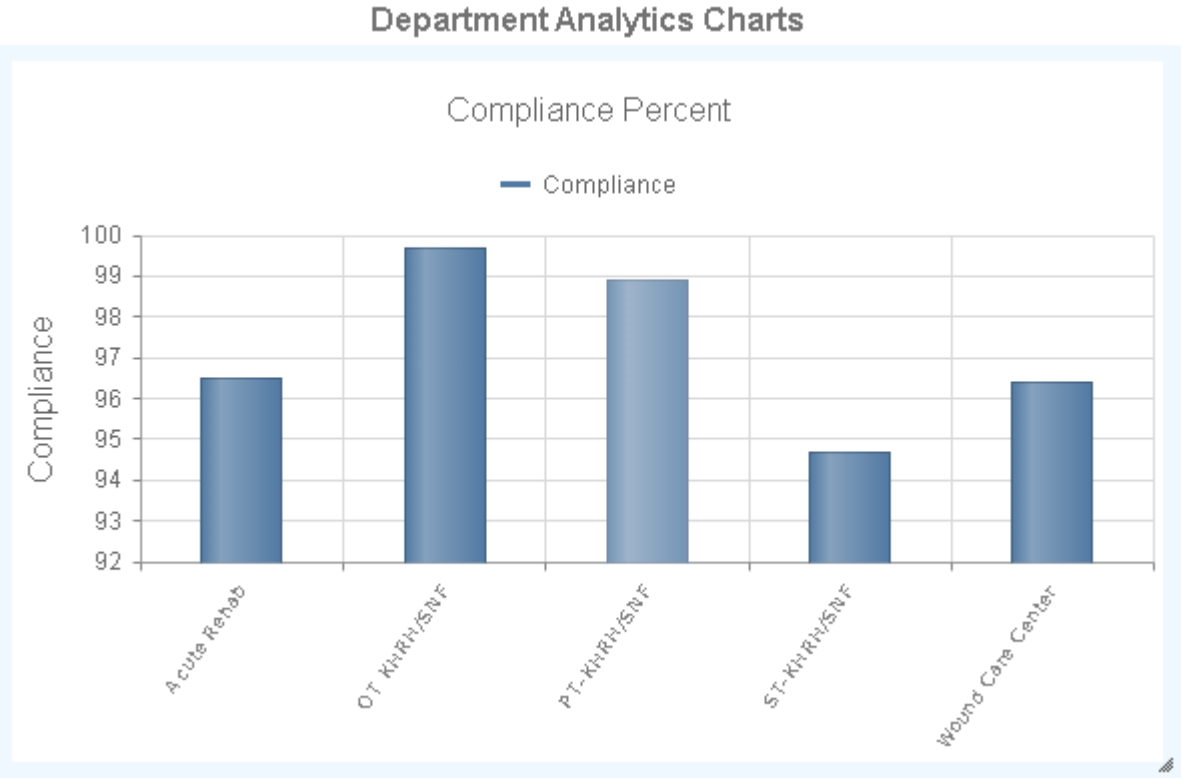




If improvement opportunities identified, provide action plan and expected resolution date:

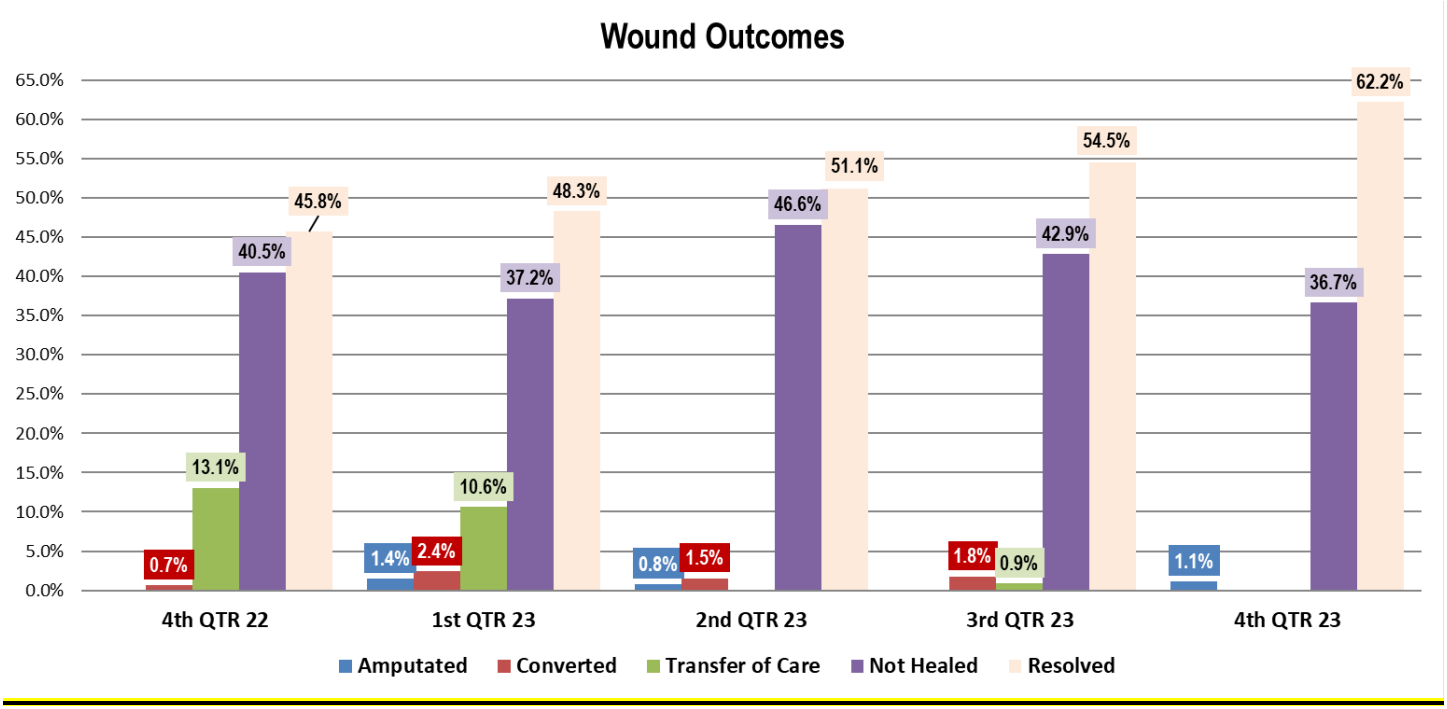
- Auditing completion of bed shift which includes fall risk.

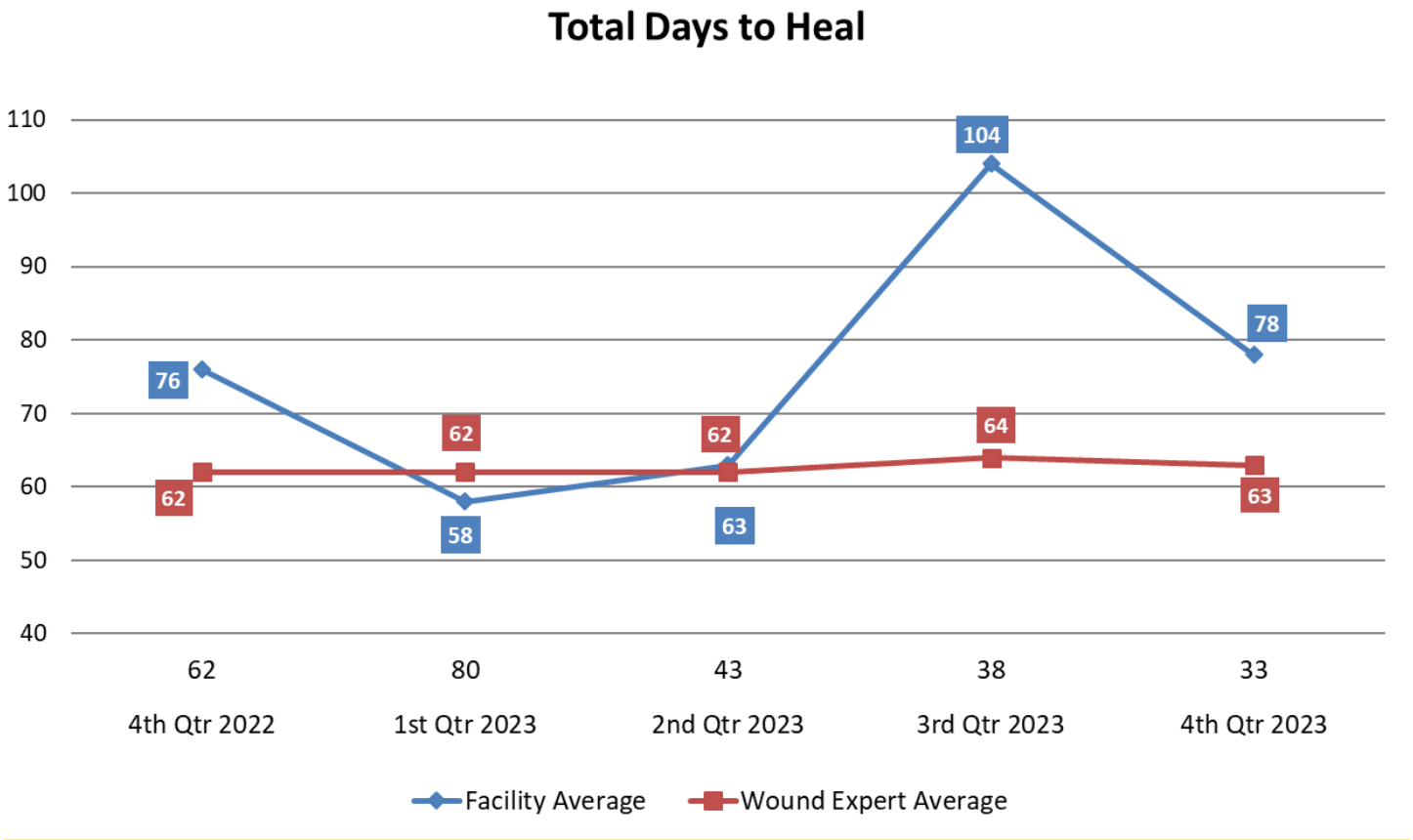
Measure Objective/Goal: Hand Hygiene compliance
Date range of data evaluated: 2Q23 and 3Q23
Analysis of all measures/data: (Include key findings, improvements, opportunities)
4Q23 and 1Q24 hand hygiene in OT and PT were above goals of 97.5%
Acute Rehab Nursing 96.5% and Wound Clinic 96.4% were slightly below goals.

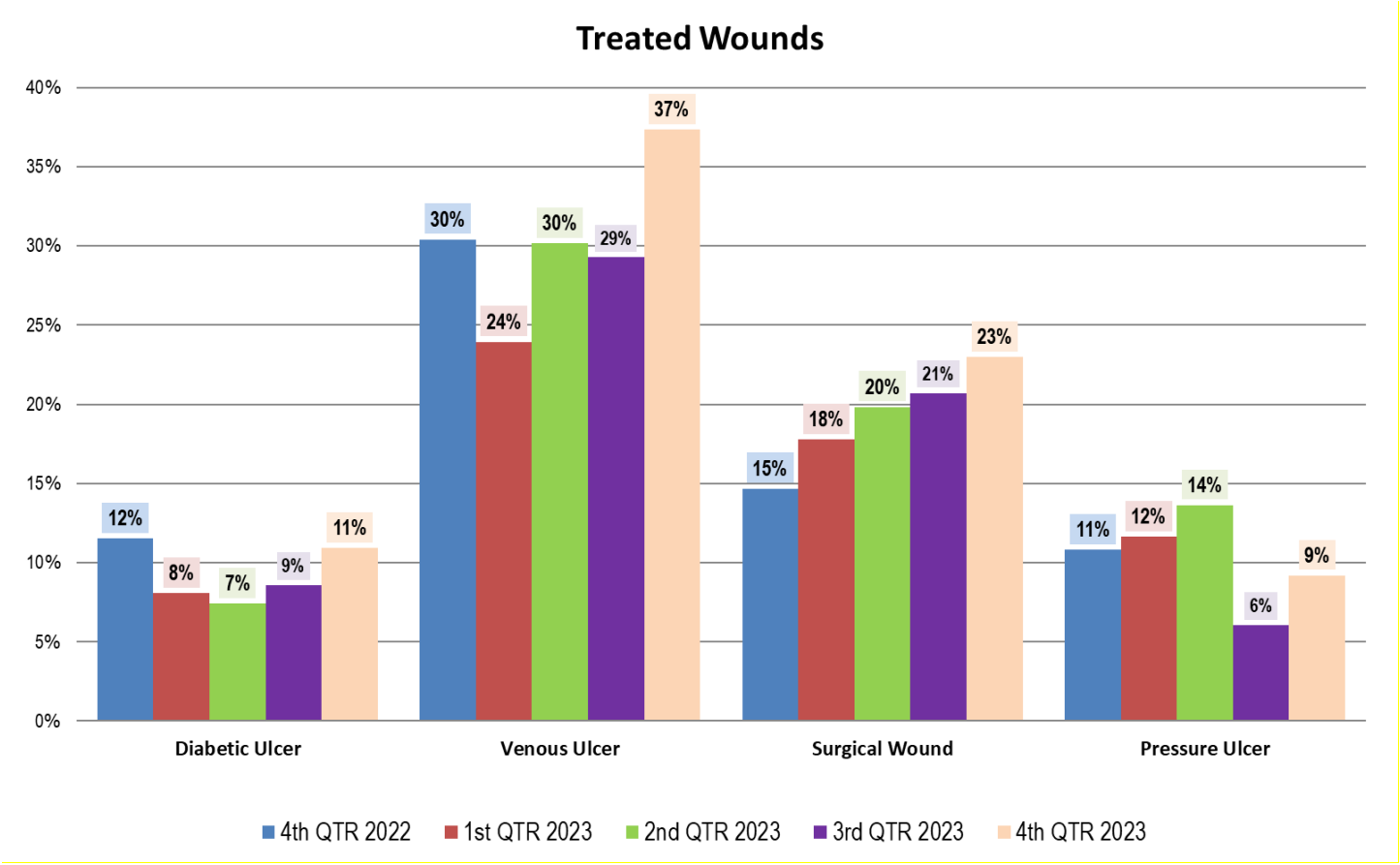


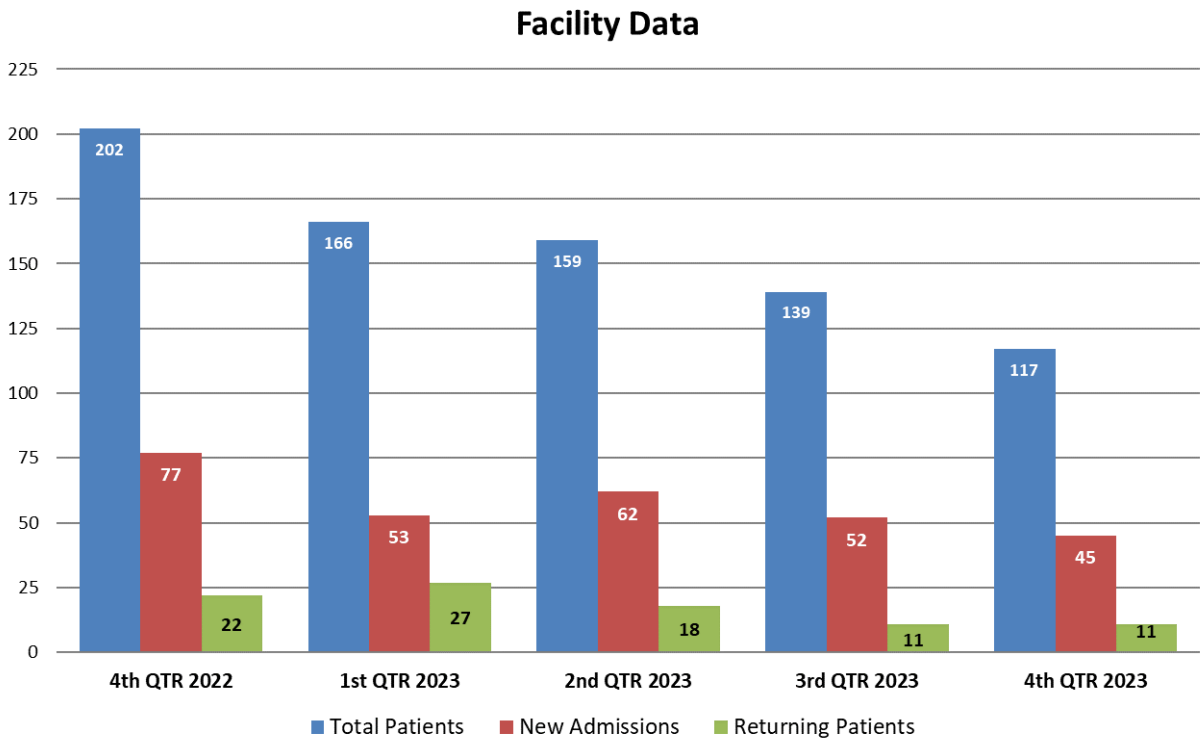
If improvement opportunities identified, provide action plan and expected resolution date:
Focusing on not only compliance but also actual use/donning of badge relative to scheduled hours of work.

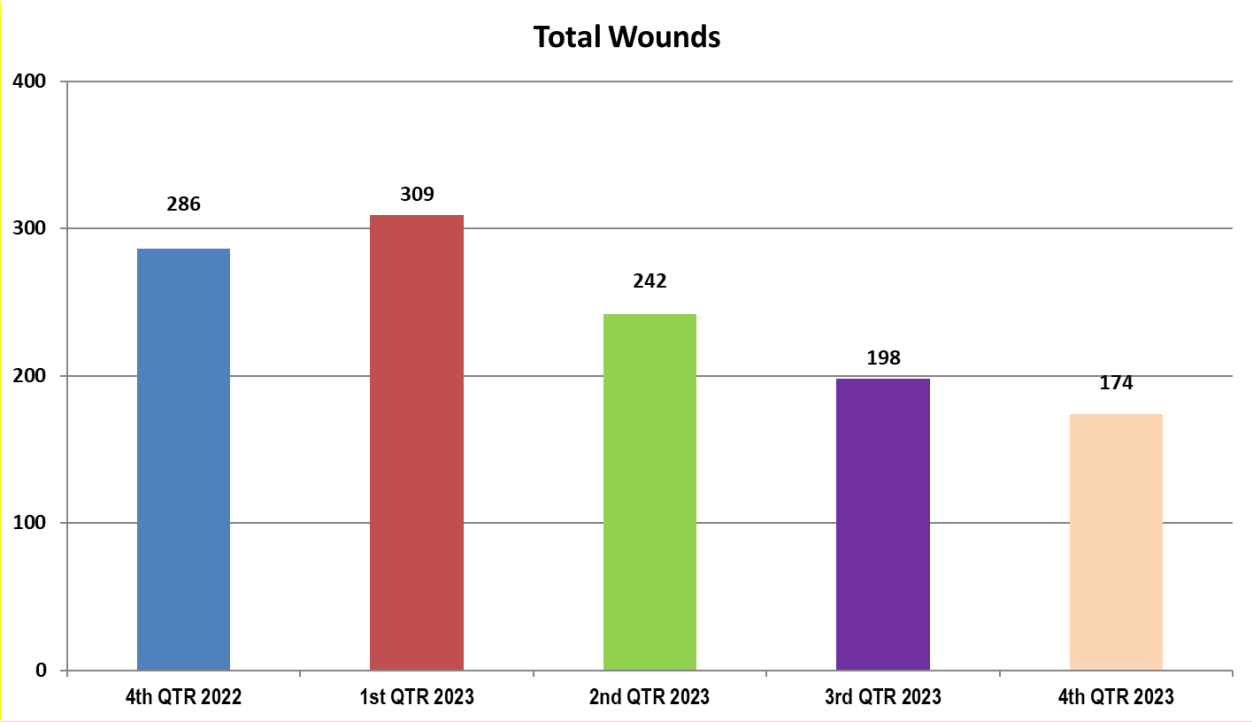
Measure Objective/Goal: Wound Center outcomes
Date range of data evaluated: 3Q23 and 4Q23
Analysis of all measures/data: (Include key findings, improvements, opportunities)
For the 4th quarter of 2023 October through December reveals we are performing 15 days over compared Wound Expert Center's average on "days to heal". We averaged 78 days compared to 63 the wound expert average. We have 33 wounds included comparing to 73117 wounds. All wound outcomes, 58.5% of the wound center patient's complete treatment. Less than 11.3 were referred out which is down over all. Overall outcomes have improved apart from Venous Stasis Ulcers. Staff continue to call patients who have not come in for follow up to increase compliance with attendance.


Wound Outcomes
65.0%
60.0%
55.0%
50.0%
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
0.7%
13.1%
40.5%
45.8%
1.4%
2.4%
10.6%
37.2%
48.3%
0.8%
1.5%
46.6%
51.1%
1.8%
0.9%
42.9%
54.5%
1.1%
36.7%
62.2%
4th QTR 22
1st QTR 23
2nd QTR 23
3rd QTR 23
4th QTR 23
Amputated
Converted
Transfer of Care
Not Healed
Resolved


Total Days to Heal
110
100
90
80
70
60
50
40
76
62
58
62
62
63
104
64
78
63
62
80
43
38
33
4th Qtr 2022
1st Qtr 2023
2nd Qtr 2023
3rd Qtr 2023
4th Qtr 2023
Facility Average
Wound Expert Average


Treated Wounds
40%
35%
30%
25%
20%
15%
10%
5%
0%
12%
8%
7%
9%
11%
30%
24%
30%
29%
37%
15%
18%
20%
21%
23%
11%
12%
14%
6%
9%
Diabetic Ulcer
Venous Ulcer
Surgical Wound
Pressure Ulcer
4th QTR 2022
1st QTR 2023
2nd QTR 2023
3rd QTR 2023
4th QTR 2023


Facility Data
225
200
175
150
125
100
75
50
25
0
202
77
22
166
53
27
159
62
18
139
52
11
117
45
11
4th QTR 2022
1st QTR 2023
2nd QTR 2023
3rd QTR 2023
4th QTR 2023
Total Patients
New Admissions
Returning Patients



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

- Wound Clinic operations transitioning to Healogics on July 10th 2024.

Submitted by Name: Molly Niederreiter **Date Submitted:** May 22 2024

Emergency Department Quality Report

Dr. Khoa Tu, Medical Director & Keri Noeske, CNO August 2024

ED Length of Stay

Goal/Objective: Improve ED length of stay for discharged patients to 214 minutes or less.

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EMERGENCY DEPARMTENT DASHBAORD

PATIENT EXPERIENCE		CY23Q3			Y23Q4			CY24Q1			CY24Q2		
	Benchmark/ Goal	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024
ED Volume	N/A	7889	8264	7838	7818	7910	8589	8208	7564	8039	7898	8416	8161
Median LOS in Min for discharged Pts	214 (3.6)	270	279	276	265	271	289	298	284	275	288	290	297

Goal was NOT met this fiscal year and will continue as a goal for FY25: Median LOS is over 4 hours

- **High Volume: In FY24, the ED cared for over 85,000 patients in 96,000 visits; record numbers for our facility.**
- **Staffing Challenges: For both providers and clinical staff**

Improvement Opportunities Identified:

1. Improve patient flow to ensure patients are being tracked for treatments by nursing staff.
2. Utilize intake space near triage for low acuity ED patients pending discharge due to nursing treatments. Help improve flow and access for these patients.
3. Continue to decrease turnaround time and validate appropriate use of imaging tests and procedures in the ED setting.
4. Implement a split flow front end model to move low acuity patients to Zone 6/Fast Track. Ensure stable nurse and provider staffing for this area to be used consistently.

ED Left during Treatment

Goal/Objective: Decrease percent of patients who left during treatment to under 3%.

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EMERGENCY DEPARMTENT DASHBAORD

PATIENT EXPERIENCE		CY23Q3			Y23Q4			CY24Q1			CY24Q2		
	Benchmark/ Goal	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024
ED Volume	N/A	7889	8264	7838	7818	7910	8589	8208	7564	8039	7898	8416	8161
% of Pts Left during treament	<3%	4.1%	4.2%	4.4%	3.6%	4.1%	5.7%	5.3%	4.6%	3.4%	5.0%	5.0%	6.2%

Goal was NOT met this fiscal year and will continue as a goal for FY25

- **Higher rates of patient leaving during treatment due to our longer length of stay.**
- **Patients who leave during treatment have been assessed by the provider but have not stayed for the duration of the treatment and to receive the results of their tests and treatments.**
  - **Patients typically leave without informing the clinical team they are leaving**

Improvement Opportunities Identified:

1. Improve patient flow to ensure patients are being tracked for treatments by nursing staff.
2. Utilize intake space near triage for low acuity ED patients pending discharge due to nursing treatments. Help improve flow and access for these patients.
3. Continue to decrease turnaround time and validate appropriate use of imaging tests and procedures in the ED setting.
4. Implement a split flow front end model to move low acuity patients to Zone 6/Fast Track. Ensure stable nurse and provider staffing for this area to be used consistently.
5. Increase communication by the clinical team with the patients on what to expect while they are being treated.
6. Communicate with the patients about progress and updates while waiting for treatments, procedures, or results.

ED Patient Experience

Goal/Objective: Achieve a patient feedback score greater than 4.

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EMERGENCY DEPARMTENT DASHBAORD

PATIENT EXPERIENCE		CY23Q3			Y23Q4			CY24Q1			CY24Q2		
	Benchmark/ Goal	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024
ED Volume	N/A	7889	8264	7838	7818	7910	8589	8208	7564	8039	7898	8416	8161
Press Ganey Survey Tool - Patient Feedback Score	FY23 4.0	3.89	3.86	3.96	4.06	4.1	4.03	4.18	3.94	3.86	3.85	3.94	3.93

The ED achieved the FY25 Goal for an average score of 4 on the Patient Feedback survey.

- **There does not seem to be a correlation between experience scores and ED volumes.**
- **Review of the survey questions led to limited understanding of the primary areas of opportunities in the ED to improve the patient experience.**

Improvement Opportunities Identified:

Based on community feedback, advisory committee insights, and survey responses for patients admitted to the hospital we have identified areas for improvement.

1. Improve the cleanliness of the ED. Increased EVS (Environmental Services) in the department. The ED will always be fully staffed due to high volumes and frequent turnover.
2. Improve the timeliness of disposition discussions with patients by providers.
3. Increase communication frequency with patients waiting on tests and treatments by the nursing staff.
4. Ensure privacy for patient when talking with clinical staff and providers.

ED Blood Culture Contamination
Goal/Objective: Achieve a blood culture contamination rate less than 3%.

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Emergency Department Quality Improvement Dashboard

	Goal	Jan 2023	Q1 Feb 2023	March 2023	April 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	March 2024	April 2024	May 2024	June 2024
Blood CX	3%	3.9%	1.6%	1.6%	1.4%	1.6%	2.2%	2.4%	2.6%	2.9%	1.7%	1.5%	1.3%	2.3%	2.4%	3.7%	3.3%	3.1%	3.8%

This Goal was achieved this fiscal year. The average contamination rate of the blood cultures was 2.6%

- **After March of 2024, we experienced an increase in the contamination rate over 3%, due to a reallocation of the resource designated to perform blood culture draws.**

Improvement Opportunities Identified:

1. The clinical education team is remediating training for the nursing staff to demonstrate the techniques to ensure blood drawn for cultures is not contaminated.
2. If the rate does not return to less than 3% after remedial training, the ED tech resource previously used for all blood culture draws will be reinstated.

ED Sepsis Order Set Compliance
Goal/Objective: Achieve Sepsis Order Set Compliance greater than 80%.

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Emergency Department Quality Improvement Dashboard

	Goal	Q1 Jan 2023	Feb 2023	March 2023	April 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	March 2024	April 2024	May 2024	June 2024
% of ED Sepsis Order Set Compliance	80%	75.0%	70.0%	85.0%	67.0%	72.0%	81.0%	89.0%	86.0%	88.0%	92.0%	100.0%	83.0%	85.0%	85.0%	89.0%	81.0%	84.0%	pending
CMS % Sepsis Bundle Compliance	80%	66.0%	60.0%	100.0%	63.0%	74.0%	64.0%	65.0%	77.0%	76.0%	76.0%	82.0%	67.0%	71.0%	85.0%	71.0%	67.0%	80.0%	pending

This Goal was achieved this fiscal year. The average compliance for Order Set completion was 87.5%

- **The ED team is very attentive to the diagnosis of sepsis and implementation of the best practice order set for the patients to ensure the best outcomes.**

Improvement Opportunities Identified:

1. Review bundle compliance fallouts, focus on ensuring all interventions are implemented for consistent treatment.
2. Continue to educate and monitor success with the order set compliance.

Outstanding Health Outcomes Update

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

August 2024

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Outstanding Health Outcomes (OHO) Dashboard

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	FY24 National Ranking*
SEP-1 CMS % bundle compliance	85%	75%	73%	68%	77%	76%	76%	82%	69%	71%	85%	71%	67%	80%		75%	Not Avail 62% Mean 82% top 10
Sepsis and Related Conditions o/e mortality	≤0.78		1.12	0.75	0.82	0.78	0.84	1.38	1.02	0.92	0.93	0.93	0.82	1.18		0.96	~20

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	0	2	3	1	2	0	0	17	
CLABSI SIR	0.49	1.01 Ex COVID	0.93 Ex COVID	0.83	1.16	2.22	0.00	1.15	0.00	1.29	2.31	0.86	1.50	0.00	0.00	1.06	72
Central Line Utilization Rate	0.663	1.02	0.88	0.749	0.791	0.828	0.774	0.685	0.876	0.822	0.799	0.66	0.79	0.749	0.67	0.76	42

Catheter Associated Urinary Tract 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	1	1	0	0	2	0	1	9	
CAUTI SIR	0.40	1.09 Ex COVID	0.55 Ex COVID	0.00	0.00	1.06	0.00	0.97	0.46	0.46	0.00	0.00	0.07	0.00	0.61	0.40	30
Indwelling Uninary Catheter (IUC) Utilization Rate	0.67	1.18	1.22	0.869	0.925	1.040	1.080	1.10	1.077	1.025	1.07	0.98	1.00	0.82	0.89	0.99	71

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	3	2	0	0	0	0	0	7	
MRSA SIR	0.51	1.11 Ex COVID	0.66 Ex COVID	0.00	0.00	1.47	0.00	**1.32**	3.00	2.26	0.00	0.00	0.00	0.00	0.00	0.73	54

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

*National Percentile Ranking National Healthcare Safety Network (NHSN) FY24 (Jul 2023-Jun 2024)

Action Plan Summary

Our Mission

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

Our Vision

To be your world-class healthcare choice, for life

Sepsis

- Focus on 1 hr bundle and expanding to inpatient areas, new order sets/power plans in process with physician stakeholders
- Exploring potential processes for a "Code Sepsis" with ED Leadership
- Six Sigma improvement work in process to re-identifying root causes of SEP-1 non-compliance to focus improvement work on the highest contributing factors

Healthcare Acquired Infections

- 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 (MDR) started January 2024 in ICU, addresses line necessity (less lines=less infections), monitoring line utilization rates to evaluate effectiveness; ICU central line and ICU utilization rates for last 2 months (March & April 2024) have been lower that FY23 SUR. Plan to spread MDRs to DCVICU and Step Down units following Intensivist-Hospitalist transitions.
        - Reinvigorate the Standardized Procedure – medical staff approved criteria for nurses to remove urinary catheters, procedure approved, pending education
    - Decolonization rates
        - Nasal Decolonization– Significantly improved from 32% (Jan-June 2023) to 84% (July – Jan 2024). 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, and review of workflow of Mupirocin order to administration processes
        - Skin Decolonization – developing process for skin decolonization through CHG bathing
    - Cleaning effectiveness in high risk areas
        - Quantifying the effectiveness of cleaning during EVS onboarding and annual review with ATP testing; continue to measure cleaning effectiveness through ATP testing in high risk areas (ie. OR's, ICUs) – last 2 reported months of cleaning effectiveness (Feb & March 2024) 92% an increase from 66% in FY23.
    - Hand Hygiene (use of BioVigil system for monitoring)
        - Increase use of BioVigil system, improvement from 31% of active users achieving target badge hours in FY 2023, to 56% (July 23' to May 24'). Next steps, additional tools provided to leaders and staff to support increase use, and evaluation of active users with the denominator
        - Started March 2024 – RECOGNITION PROGRAMS for units/departments that have achieve highest % of staff meeting 80hrs active time (paired) per month!

Questions?

The pursuit of healthiness