Kaweah Delta Health Care District
Board Of Directors Committee Meeting

***Health** is our Passion. **Excellence** is our Focus. **Compassion** is our Promise.*

NOTICE

The Quality Council Committee of the Kaweah Delta Health Care District will meet at the Kaweah Health Lifestyle Fitness Center Conference Room {5105 W. Cypress Avenue, Visalia, CA} on Thursday, January 16, 2025:

- 7:30AM Open meeting.

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 meeting.

All Kaweah Delta Health Care District regular board meeting and committee meeting notices and agendas are posted 72 hours prior to meetings (special meetings are posted 24 hours prior to meetings) in the Kaweah Health Medical Center, Mineral King Wing near the Mineral King entrance.

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

KAWEAH DELTA HEALTH CARE DISTRICT

David Francis, Secretary/Treasurer

Kelsie Davis

Board Clerk / Executive Assistant to CEO

DISTRIBUTION:

Kaweah Delta Health Care District
Board Of Directors Committee Meeting

***Health** is our Passion. **Excellence** is our Focus. **Compassion** is our Promise.*

Governing Board, Legal Counsel, Executive Team, Chief of Staff, www.kaweahhealth.org

Kaweah Delta Health Care District
Board Of Directors Committee Meeting

***Health** is our Passion. **Excellence** is our Focus. **Compassion** is our Promise.*

Kaweah Delta Health Care District Board of Directors Quality Council
Meeting held: Thursday, January 16, 2025 • Kaweah Health Lifestyle Fitness Center Conference Room
Attending: Board Members: Michael Olmos (Chair), Dean Levitan, MD; Gary Herbst, CEO; Keri Noeske, Chief Nursing Officer; Paul Stefanacci 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; Cindy Vander Schuur, Patient Safety Manager; and Kyndra Licon, Recording.

OPEN MEETING – 7:30 AM

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 jurisdictions 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 – 7:31 AM**
    - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – Julianne Randolph, DO, Vice Chief of Staff and Quality Committee Chair; Mara Miller, PharmD, BCPA, Medication Safety Coordinator.

    - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – Evelyn McEntire, RN, BSN, Director of Risk Management; Ben Cripps, Chief of Compliance and Risk Officer; Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.

4. **ADJOURN OPEN MEETING –** Mike Olmos, Committee Chair

CLOSED MEETING – 7:31 AM

3. **CALL TO ORDER –** Mike Olmos, Committee Chair

Kaweah Delta Health Care District
Board Of Directors Committee Meeting

***Health** is our Passion. **Excellence** is our Focus. **Compassion** is our Promise.*

4. **Approval of December Quality Council Closed Session Minutes –** Mike Olmos, Committee Chair; Dean Levitan, Board Member
    - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – Julianne Randolph, DO, Vice Chief of Staff and Quality Committee Chair; Mara Miller, PharmD, BCPA, Medication Safety Coordinator.

5. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management; Ben Cripps, Chief Compliance and Risk Officer; Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*

6. **ADJOURN CLOSED MEETING –** Mike Olmos, Committee Chair

OPEN MEETING – 8:00 AM

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 December 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 Annual Review of Quality and Patient Safety Plans
    4.2 Orthopedics Quality Report

5. **Value Based Purchasing –** A review of completed and planned initiatives to identify and address Value Based Purchasing. *Erika Pineda, Quality Improvement Manager*.

Kaweah Delta Health Care District
Board Of Directors Committee Meeting

***Health** is our Passion. **Excellence** is our Focus. **Compassion** is our Promise.*

6. **Rapid Response Team Code Blue Rapid Response Team Code Blue Quality Report–** A review of key process and outcome measures related to rapid response and code blue processes. *Shannon Cauthen, MSN, RN, CCRN-K, NE-BC, Director of Critical Care Services*

7. **Clinical Quality Goals Update –** A review of current performance and actions focused on the clinical quality goals for Sepsis, and Healthcare Acquired Infection. Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.

8. **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 meeting.

Agenda item intentionally omitted

OPEN Quality Council Committee
Thursday, December 12, 2024
The Lifestyle Center Conference Room

Attending: Board Members: Mike Olmos (Chair) & Dean Levitan, Board Member; Gary Herbst, Chief Executive Officer; Marc Mertz, Chief Strategy Officer; Sandy Volchko, Director of Quality and Patient Safety; Dr. Paul Stefanacci, Chief Medical Officer; Dr. Mack, Dr. Randolph, Vice Chief of Staff and Chair; Ben Cripps, Chief Compliance and Risk Management Officer; Evelyn McEntire, Director of Risk Management; Ryan Gates, Chief Population Health Officer; Jag Batth, Chief Operations Officer; Keri Noeske, Chief Nursing Officer; Dr Hightower, Chief of Staff; Erika Pineda, Quality Improvement 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 8:04 am.

Mike Olmos called to order at 8:04 am.

3. **Approval of November Quality Council Open Session Minutes –** Mike Olmos, Committee Chair; Dean Levitan, Board Member.
    - Approval of November Quality Council Open Session Minutes by Dean Levitan and Mike Olmos.
4. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives:

    4.1 Subacute Quality Report – reviewed with no discussion.

5. **Hand Hygiene Quality Update –** a review of current performance and actions focused on the clinical goal for Hand Hygiene. *Shawn Elkin, Infection Prevention Manager.*
    The data indicated we have been below our 95% goal overall for the past 3 quarters. The committee expected a decrease in compliance starting in early 2024 as there was a big push to have more staff participate in the Biovigil system (badge). We anticipated a period for a learning curve but that doesn't apply anymore. There was a significant increase from 31% of staff having the expected pair time to 51%. It's time to have a look at the data to find out what is going on. In the third quarter, we are at 93% compliant. Looking at the data on the following slides there are identified units and in the reference material is the full hand hygiene dashboard. It's clear which units and some units have been under the goal for 2 years and others by quarters. There are trends with CNAs, Techs/LVNs, Aids, and EVS workers who appear to be driving a significant amount of noncompliance. The discussion at the committee was that this was a knowledge deficit and the members felt it was accountability. Mike asked– is it the situation where folks do not remember to wash hands? As far as the use of the system for noncompliance. Shawn - It is very difficult to not perform hand hygiene as the badge will give a verbal and physical notification as you enter a patient's room. It's a matter of accountability. It's not a knowledge deficiency. The badge itself detects and records hand hygiene events by sensing alcohol-based hand sanitizer use for appropriate hand hygiene practice. Now that the staff are using the system there is a downfall for

compliance. Mike - Is the badge itself clean? It can be cleaned with the purple top wipes. At the end of the shift, the staff is to clean the badge and place it on the base station to transfer data. Our KH Badge checks/assigns a badge to you and will download/clear the data from the last user. You can pick up a badge and any station and drop it off at any station. Discussion on the availability of badges and accuracy of data. The committee was informed that a thorough review is underway. The committee action plan is associated with hand hygiene opportunities putting in place processes for leaders to hold staff accountable. Increase leadership awareness of unit/department hand hygiene compliance. Knowledge deficit related to improving ahead hygiene performance. Infection Prevention has an abundance of PowerPoint, and written material, and has a whole library for leaders to share with the staff. Issued last week and will continue each month. Hand hygiene compliance is managed through the quality focus team. Mike - Sandy will we have to tighten up our accountability if we are not receiving improvement? Sandy - Yes, there is no excuse.

6. **Renal Services Quality Report –** A review of key performance indicators and actions associated with care of Dialysis Services. *Amy Baker, MSN, RN, Director of Renal Services.*

   The market continues to grow as this population is dependent on dialysis. This will be the fifth clinic opening. We have sadly increased over the last few years (150 patients). We have the capacity for a full 3rd shift and possible 4th shift. Before COVID, we were running 4 shifts (Monday, Wednesday, and Friday), and then COVID and our other clinics opened. This is an area that can be heavily influenced by marketing. Marketing has coordinated a nice article in Vital Signs magazine, created a flyer for patients to see when they walk into 4 Norths and has been included in handout packets. We recently received our star rating, we have the highest rating between Fresno and Bakersfield (4-star clinic) which made it to our social media pages and marketing created a banner. We had five transplants this year which is a new record. Our social worker contributes tremendously as they are heavily involved to those transplant stories. There was a feature done by the patient's spouse who donated her kidney. Connie – Leadership, we have come a long way in implementing infection prevention measures. They conduct numerous audits each month with a high level of transparency, and many of these audits consistently achieve 100% compliance, reflecting a strong emphasis on accountability within the team. The team is well-informed about the expectations for each element of the model during employee audits. If any aspect of best practice is not met, the charge nurse addresses the issue directly with the employee, reinforcing accountability and implementing progressive discipline as needed. This approach aims to enhance the overall quality of care, which is reflected in the team's performance. Mike - As a KH facility does your facility utilize Biovigil? Connie - There have been growing pains but yes, it's made a big difference. Biovigil is designed from the treatment chair to the next treatment chair, it will give you that reminder to hand hygiene.

7. **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.*

   FYTD25 CLABSI, CAUTI, and MRSA have had 3 events thus far. With all 5 of our metrics only one of the five is meeting our goal. Reminder our goal is set for the top 30%. CLABSI goal: 0.486, currently 0.70. CAUTI goal: 0.342, currently 0.420. MRSA goal: 0.435, currently 1.71. The utilization of the central line is achieving goal: 0.663, currently 0.62. Urinary catheter goal: 0.64, currently 0.94.

MRSA decolonization for patients with lines goal: 100% of at-risk patients nasally decolonized Jul – Oct 2024 100% of screen patients nasally decolonized. 11% of patients admitted from a skilled nursing facility are not screened or decolonized. 23% of patients readmitted from another acute care facility within 30 days were not screened or decolonized. CHG bathing implementation has been delayed from 10/8 to 11/19 due to Cerner upgrade processes. The goal is set for 100% of the line patients to have CHG bathing.
HAI QFT committee increased hand hygiene goal to 60% of staff are active users of Biovigil. Currently, 50% of staff are active users. The hand Hygiene compliance rate overall is 94% (goal 95%) – a decreasing trend noted over 3 quarters.
Improve environmental cleaning effectiveness for high-risk areas >90% of areas in high-risk areas are cleaned effectively the first time. July – Aug 2024 pass cleanliness effectiveness testing 94% of the time in high-risk areas. EVS has a robust plan for testing patient surfaces in rooms and providing follow-up education and staff training. The only failures identified during testing were bed rails, highlighting a specific area to focus on. Discussion points include exploring additional surfaces to target and weighing the risks and benefits of universal versus targeted MRSA decolonization. Universal decolonization is costly ($350,000 per year) and carries a risk of drug resistance, whereas targeted decolonization requires testing positive before treatment.
Admission processes should include key questions to improve strategy implementation, with patient access teams supporting this effort. For Foley catheter usage, data shows that 68% of patients have urinary retention as an indication. This raises concerns about processes and the need for physician engagement to manage these cases effectively. Learning from aggressive approaches in other organizations may help address these issues. In October, the sepsis management goal was met. While 25% of patients received the one-hour bundle, there is an opportunity to refine the process to ensure appropriate populations receive timely intervention. The interim ED director and manager have strong expertise in managing code sepsis, which involves a focused sequence of tasks for patients at risk of sepsis. Notably, one life was saved in October due to these efforts.

Adjourn Open Meeting – *Mike Olmos, Committee Chair*

Mike Olmos adjourned the meeting at 9:33 am.

Annual Review of Quality (AP.41) and Patient Safety Plan (AP.175)
2025 Quality and Patient Safety Initiatives & Quality Focus Team (QFT) Review

Quality Initiative	Type	Priority Category	Key Considerations	Measures of Success	Assigned Leader(s)
Quality Council (QC)	QAPI Oversight Committee - Board of Directors (BOD) Quality & Patient Safety Sub-Committee (per AP.41)	☒ High Risk ☒ Problem Prone ☒ High Volume	• Responsible for success of QAPI and Patient Safety Plans • Oversight committee where governance, medical staff leadership and hospital leadership oversee QAPI • QAPI reporting topics cover scope of services provided	• As determined by each QAPI program topic or service line report	Chaired by BOD Member
Quality Committee ("QComm")	QAPI Oversight Committee (Medical Staff) (per AP.41)	☒ High Risk ☒ Problem Prone ☒ High Volume	• Delegated responsibility for success of QAPI and Patient Safety Plans • Oversight committee where medical staff leadership and hospital leadership oversee QAPI • QAPI reporting topics cover scope of services provided	• As determined by each QAPI program topic or service line report	Chaired by the Vice-Chief of Staff
Patient Safety Committee (PSC)	Org Oversight Committee (per AP.175)	☒ High Risk ☒ Problem Prone ☒ High Volume	• Responsible per AP.175 Patient Safety Plan • Oversees Midas Event Triage and Ranking Committee (METER) and Quality-Risk Committee (QRC) • Oversees all action plans related to Root Cause Analysis and Focus Review teams • Oversees safety culture improvement action plan including Just Culture • Oversees patient safety priority QI work (ie. HAPI, Fall Prevention, National Patient Safety Goals).	• As determined by individual action plans • Reportable never events • Priority measures such as 2 identifier events, critical findings, and topic specific reported by committee listed below	Director of Quality and Patient Safety
Midas Event Triage & Ranking Committee (METER)	Patient Safety Subcommittee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Objective: Rank and Triage Events through a multidisciplinary team daily so that immediate notification of high risk events can be made to Medical Staff Leadership and Hospital Leadership • Events are reviewed daily Monday through Friday (weekend events reviewed Monday	• Volume and severity of events; events escalated	• Director of Risk Management

			with RM notification processes in place on weekends) • Events are triaged using a criticality matrix in which members of the committee would come to consensus on event scoring		
Quality-Risk Committee	Patient Safety Subcommittee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Reviews Midas event reports weekly to identify trends • Reviews product changes for patient safety elements and makes recommendations to Value Analysis Committee	• Volume and significance of events, reports submitted anonymously • Specific event types trended and reported to the committee as identified; Other quality data utilized specific to the topic when available	Director of Risk Management
Just Culture Committee	Patient Safety Subcommittee, Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Key strategy in organization safety culture improvement action plan • National Quality Forum (NQF) safe practice included in Leapfrog Safety Grade	• Just Culture measures included in the Safety Culture Survey	Director of Organizational Development
Medication Safety	Org Oversight Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Oversees the Medication Error Reduction Program (MERP) per CA state requirements • Oversees Patient Care Medication Safety Task Force QI work • Collaborative partnership with Patient Safety Committee on medication elements of high risk processes such as anticoagulation, medication reconciliation and procedural sedation safety which are Joint Commission National Patient Safety Goals. • Utilizes externally reported medication events to evaluate organizational process and procedures to evaluate risk and	• Several measures monitored as determined annually by the committee through the MERP and Adverse Drug Event (ADE) committee work. • Examples of monthly trended data includes utilization reversal medications • Home medication list review for high risk patients within 24 hours of hospital admission metrics include: number of medication histories completed, total admission discrepancies and total	Director of Pharmacy and Medication Safety Coordinator

			recommend improvements to improve medication safety • Oversees Adverse Drug Event Committee review of all reported medication events and reviews high or potential high severity reported events	admission discrepancies per patient	
Adverse Drug Event (ADE) Committee	Org Sub-Committee Medication Safety	☒ High Risk ☒ Problem Prone ☒ High Volume	• Reviews, tracks and trends and resolves (or escalates) adverse drug event Midas reports • Uses the Just Culture Algorithm to identify organizations process and systems that contributed the medication event and make QI recommendations to improve medication safety • Make recommendations for Root Cause Analysis or Focused Review as determined necessary	• ADE volume and tracked trends as reported to Medication Safety Committee	Medication Safety Coordinator
Patient Care Medication Safety Committee	Org Sub-Committee Medication Safety	☒ High Risk ☒ Problem Prone ☒ High Volume	• Multidisciplinary team that develops, plans and implements QI strategies on medication related issues identified by ADE or Medication Safety Committee	• Metrics determined by topics identified, examples include anticoagulation measures, diversion prevention measures.	Director of Nursing Practice, Medication Safety Coordinator, Medication Safety Specialist
Sepsis QFT	OHO Strategic Initiative Quality Focus Team (QFT)	☒ High Risk ☒ Problem Prone ☒ High Volume	• Established QFT since 2016 • High volume diagnosis, high mortality rates nationally (problem prone) • Centers for Medicare and Medicaid Services (CMS) SEP-1 bundle compliance publically reported on CMS care compare website	• SEP-1 Bundle compliance • Mortality	Medical Director of Quality & Patient Safety; Manager of Quality and Patient Safety
Handoff Communication QFT No longer meeting, pending Chartis review	Quality Focus Team (QFT)	☒ High Risk ☒ Problem Prone ☒ High Volume	• QFT established in 2018; QI work recommended by TJC in a Sentinel Event Alert issued in September 2017. • Several sources indicate need for improvement work (ie. trended event reports, sentinel event data, and external literature)	• Midas event "Handoff" category volume & significance • Handoff internal audit results by unit	Director of Trauma Program

			○ Midas Event volume – Handoff category: 2019 = 65, 2020 = 30, 2021 = 27, 2022 = 61, 2023 (Jan-Nov) = 26.		
Hospital Acquired Pressure Injury (HAPI) QFT	Quality Focus Team (QFT); reports to PSC	☒ High Risk ☒ Problem Prone ☐ High Volume	• PSI3 (HAPI) is a component of Leapfrog Safety Score & CMS public report • Mandated reporting to California Department of Public Health (CDPH)	• Percent of patients with stage 2+ • Proportion of HAPIs that are device related • PSI3 (>Stage 2+)	Director of Nursing Practice
Healthcare Associated Infections (HAI) QFT	OHO Strategic Initiative, QFT	☒ High Risk ☒ Problem Prone ☐ High Volume	• CMS Value-Based Purchasing (VBP) and star rating Measure • Leapfrog safety grade metric • TJC National Patient Safety Goal (hand hygiene)	• Standardized Infection Ratio (SIR) for Central Line Associated Blood Stream Infection (CLABSI), Catheter Associated Urinary Tract Infection (CAUTI), and Methicillin-Resistant Staphylococcus Aureus (MRSA) • Standardized Utilization Ratios (SUR) for central lines and urinary catheter • HAI Bundle compliance measures • Hand Hygiene compliance	Medical Director Quality & Patient Safety, Manager of Infection Prevention, Directors of: Quality & Patient Safety, Post Acute Nursing, Renal Services and Environmental Services
Best Practice Team (HF, PN, COPD)	OHO Strategic Initiative, Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• CMS VBP and star rating Measure • High volume medical diagnosis (PN & HF) • CMS Readmission Reduction Program population	• Observed/expected (o/e) mortality and risk adjusted readmission rates • examples of key performance indicators (KPI) include discharge medications, inpatient medication management, order set utilization	Director of Respiratory Services; Medical Director of Best Practice Teams
Fall Prevention Committee	Org Committee, reports to PSC	☒ High Risk ☒ Proble m Prone ☐ High Volume	• Nursing sensitive quality indicator • Case reviews of fall events and collection an dissemination of contribution factors data	• Total falls and injury falls; contributing factors	Director of Nursing Practice

Falls University	Sub-Committee of Fall Prevention Committee	☒ High Risk ☒ Problem Prone ☐ High Volume	• Case reviews of fall events and collection and dissemination of contribution factors data • Reports to Fall Prevention Committee	• Contributing factors to falls	Director of Nursing Practice
Diabetes	OHO Strategic Initiative, Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• High volume, high risk volume patient population	• Hypo and Hyperglycemia rates	Director of Nursing Practice, Medical Director of Quality & Patient Safety
Trauma Quality Program	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Trauma program oversight and QI work related to ACS trauma designation	• Various measures through data registry including documentation of assessment findings, airway management, timeliness of diagnostic studies, timeliness of surgical intervention, mortality rates	Director of Trauma Program, Medical Director of Trauma
Stroke Quality Program	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• The Joint Commission (TJC) certified program • High risk population • Oversees work of the ED Stroke Alert sub task force	• Various process measures through American Heart/Stroke Association including medication management, discharge indicators, timeliness of diagnostics studies and assessments	Manager of Stroke Program and Medical Director of Stroke Program
Health Equity	OHO Strategic Initiative, Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• TJC Sentinel Event issued January 2022 • New TJC Leadership standard 2023 • New TJC National Patient Safety Goal for 2024 • National and ACGME initiative	• Measures to identify disparities in care in key population; • 2024 Social Determinates of Health (SDOH). • Measures related to the effectiveness of demographic (REaL) collection (ie. Rate of "unknown" responses in a REaL field in the patients EMR)	Chief Population Health Officer, Director of Population Health
Patient Safety Indicator (PSI) Committee	Org Committee	☒ High Risk ☒ Problem Prone ☐ High Volume	• Review of coded complications of the surgical population • Reported on CMS Care Compare website • Component of CMS star rating, VBP program	• PSI rates	Medical Director of Surgical Quality, Director of Quality and Patient Safety

Annual Review of Quality (AP.41) and Patient Safety Plan (AP.175)
2025 Quality and Patient Safety Initiatives & Quality Focus Team (QFT) Review

Surgical Quality Committee (SQIP)	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Oversees PSI (coded complications of care) • Oversees implementation of Enhanced Recovery After Surgery (ERAS) program (evidenced based care targeted at the surgical population	• ERAS measures • PSI measures • Surgical Site Infection measures	Director of Surgical Services, Medical Director of Surgical Quality
Population Health Steering Committee	Org Oversight Committee; Medication Reconciliation OHO Initiative	☒ High Risk ☒ Problem Prone ☒ High Volume	• Quality Incentives Program (QIP) previously Public Hospital Redesign & Incentives Program (PRIME) • Oversees Population Health Quality Committee work	• Calendar year 2023 reporting 10 measures, tracking over 25. • In Calendar year 2024 likely increasing the number of measures reported to DHCS to be >10	Director of Population Health
Rapid Response/Code Blue	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• TJC data monitoring requirements for accredited hospitals	• Several measures as submitted to American Heart Association registry including volume, location and outcome	Director of Critical Care Services
Mortality	Org Committee	☒ High Risk ☒ Problem Prone ☐ High Volume	• Review of unexpected deaths for follow up with quality of care concerns, coding or documentation	• Rates of cases with quality of care concerns, coding or documentation	Medical Director of Quality and Patient Safety, Manager of Quality Improvement
Infection Prevention Committee	Org Oversight Committee	☒ High Risk ☒ Problem Prone ☐ High Volume	• Oversees the Infection Prevention Plan • Oversees Surgical Site Infection task force • Oversees regulatory compliance with IP standards	• Several measures monitored through quarterly dashboard including surgical site infection rates, ventilator associated events, line infection rates, MRSA.	Manager of Infection Prevention, Medical Director of Infection Prevention
Accreditation Regulatory Committee	Org Oversight Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Oversees compliance with regulatory standards and plans of correction	• Various measures determined by plans of correction • Regular tracer data for compliance with regulatory standards	Director of Accreditation
Environment of Care Committee	Org Oversight Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Oversees the EOC Plan and Workplace Violence Program (CA state mandate) • Oversees compliance with EOC regulatory standards per annual plan	• Various measures determined by annual plan; can include preventive maintenance completion rates, workplace violence, and employee injury rates.	Safety Officer

Emergency Management	Sub Committee of EOC	☒ High Risk ☒ Problem Prone ☐ High Volume	• Oversees the Emergency Operations Plan • Oversees compliance with EOP and Emergency Management regulatory standards.	• Various measured determined by annual plan and district wide exercises.	Safety Officer
Patient Throughput	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Committee that oversees various projects related to throughput including: work of 5 sub-groups: o Patient progression (includes discharge (d/c) management, d/c lounge & RN) o ED to inpatient admission process (includes RN to RN handoff, ED launch point enhancements) o Observation program (includes power plan enhancements, PCP and outpatient appointment processes) o Tests and treatments (ie. turnaround time)	• Various throughput measures including average length of stay (LOS) (obs and admitted patients) • ED throughput measures including ED boarding times, admit hold volume, ED LOS, visit volume. time to provider, time from door to admit, time from admit to arrival on unit.	CNO & COO
Patient Care Leadership	Org Committee	☒ High Risk ☒ Problem Prone ☒ High Volume	• Organization wide oversight committee for patient care related practices and procedures. Facilitate discussion and collaboration of patient care leaders to ensure organization wide awareness, appreciation, consistency, and coordination of patient care activity in all settings. Provides oversight of patient care Quality Improvement initiatives that cross divisions/disciplines. Create and participate in subcommittees and/or workgroups to address performance improvement related to patient care delivery as needed	• Measure related to patient care delivery which includes accrediting/regulatory changes or strategic initiatives such as pain management & opioid safety	CNO & COO

*All committees report to Quality Committee "QComm" per AP.41

Kaweah Delta Health Care District

Administrative Manual

Policy Number: AP41	**Date Created: Not Set**
Document Owner: Cindy Moccio (Board Clerk/Exec Assist-CEO)	**Date Approved: 01/26/2022**
Approvers: Board of Directors (Administration)	
Quality Improvement Plan	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

I. Purpose

The purpose of Kaweah Health's Quality Improvement Plan is to have an effective, data-driven Quality AssessmentPerformance Improvement program that delivers high-quality, excellent clinical services and enhances patient safety.

II. Scope

All Kaweah Health facilities, departments, patient care delivery units and/or serviceareas fall within the scope of the quality improvement plan requirements.

III. Structure and Accountability

Board of Directors

The Board of Directors retain overall responsibility for the quality of patient care. The Board approves the annual Quality Improvement Plan and assures that appropriate allocation of resources is available to carry out that plan.

The Board receives reports from the Medical Staff and Quality Council. The Board shall act as appropriate on the recommendations of these bodies and assure that efforts undertaken are effective and appropriately prioritized.

Quality Council

The Quality Council is responsible for establishing and maintaining the organization's Quality Improvement Plan and is chaired by a Board member. The Quality Council shall consist of the Chief Executive Officer, representatives of the Medical Staff and other key hospital leaders. It shall hold primary responsibility for the functioning of the Quality Assessment and Performance Improvement program. Because District quality improvement activities may involve both the Medical Staff and other representatives of the District, membership is multidisciplinary. The Quality Council requires the Medical Staff and the organization's staff to implement and report on the activities for identifying and evaluating opportunities to improve patient care and services throughout the organization. The effectiveness of the quality

improvement and patient safety activities will be evaluated and reported to the Quality Council.

Quality Committee ("QComm")

In accordance with currently approved medical staff bylaws, shall be accountable for the quality of patient care. The Board delegates' authority and responsibility for the monitoring, evaluation and improvement of medical care to the Quality Committee "QComm", chaired by the Vice Chief of Staff and co-chaired by the CMO/CQO (or designee). The Chief of Staff delegates accountability for monitoring individual performance to the Clinical Department Chiefs. QComm shall receive reports from and assure the appropriate functioning of the Medical Staff committees. QComm providesoversight for medical staff quality functions including peer review.

QComm has responsibility for oversight of organizational performance improvement. Membership includes key medical staff and organizational leaders including the Chief of Staff, Medical Director of Quality and Patient Safety, Secretary-Treasurer, Immediate Past Chief of Staff, Chief Executive Officer, Chief Operating Officer, Chief Nursing Officer, Chief Informatics Officer, Chief Human Resources Officer, Chief Financial Officer, Chief Compliance and Risk Management Officer, Chief Strategy Officer, Directors of Quality and Patient Safety, Nursing Practice, Pharmacy, Accreditation, and Risk Management; Manager of Quality and Patient Safety, Manager of Infection Prevention and Environmental Safety Officer. This committee reports to Medical Executive Committee and the Quality Council.

The QComm shall have primary responsibility for the following functions:

1. **Health Outcomes:** The QComm shall assure that there is measureable improvement in indicators with a demonstrated link to improved healthoutcomes. Such indicators include but are not limited to measures reported to the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC), and other quality indicators, as appropriate.

2. **Quality Indicators:**
   a. The QComm shall oversee measurement, and shall analyze and track quality indicators and other aspects of performance. These indicators shall measure the effectiveness and safety of services and quality of care.
   b. The QComm shall approve the specific indicators used for these purposes along with the frequency and detail of data collection.
   c. The Board shall ratify the indicators and the frequency and detail of data collection used by the program.

3. **Prioritization:** The QComm shall prioritize quality improvement activities toassure that they are focused on high- risk, high-volume, or problem- prone areas. It shall focus on issues of known frequency, prevalence or severity and shall give precedence to issues that affect health

outcomes, quality of care and patient safety. The QComm is responsible toestablish organizational Quality Focus Teams who:

a. Are focused on enterprise-wide high priority, high risk, problem prone QI issues
b. May require elevation, escalation and focus from senior leadership
c. Have an executive team sponsor
d. Are chaired by a Director or Vice President
e. May have higher frequency of meetings as necessary to focus work and create sense of urgency.
f. Report quarterly into the QAPI program

4. **Improvement:** The QComm shall use the analysis of the data to identifyopportunities for improvement and changes that will lead to improvement. The QComm will also oversee implementation of actions aimed at improving performance.

5. **Follow- Up:** The QComm shall assure that steps are taken to improve performance and enhance safety are appropriately implemented, measured and tracked to determine that the steps have achieved and sustained the intended effect.

6. **Performance Improvement Projects:** The QComm shall oversee quality improvement projects, the number and scope of which shall be proportional to the scope and complexity of the hospital's services and operations. The QComm must also ensure there is documentation of what quality improvement projects are being conducted, the reasons for conducting those projects, and the measureable progress achieved onthe projects.

Medical Executive Committee

The Medical Executive Committee (MEC) receives, analyzes and acts on performance improvement and patient safety findings from committees and is accountable to the Board of Directors for the overall quality of care

IV. Graduate Medical Education

Graduate Medical Education (Designated Institutional Official (DIO), faculty and residents, are involved in achieving quality and patient safety goals and improving patient care through several venues including but not limited to:

a) Collaboration between Quality and Patient Safety Department, Risk Management, and GME Quality Subcommittee
b) GME participation in Quality Improvement Committee and Patient Safety Committee
c) GME participation in KDHCD quality committees and root cause analysis (including organizational dissemination of lessons learned)

V. Methodologies:

Quality improvement (QI) models present a systematic, formal framework for

establishing QI processes within an organization. QI models used include the following:

- Model for Improvement (FOCUS Plan-Do-Study-Act [PDSA] cycles)
- Six Sigma: Six Sigma is a method of improvement that strives to decrease variation and defects with the use of the DMAIC roadmap.
- Lean: is an approach that drives out waste and improves efficiency in work processes so that all work adds value with the use of the DMAIC roadmap.

1. The **FOCUS**-**Plan, Do, Check, Act (PDCA)** methodology is utilized to plan, design, measure, assess and improve functions and processes related to patient care and safety throughout the organization.

   - **F**—**Find** a process to improve
   - **O**—**Organize** effort to work on improvement
   - **C**—**Clarify** knowledge of current process
   - **U**---**Understand** process variation
   - **S**—**Select** improvement

   - **Plan:**

     - Objective and statistically valid performance measures are identified for monitoring and assessing processes and outcomes of care including those affecting a large percentage of patients, and/or place patients at serious risk if not performed well, or performed when not indicated, or not performed when indicated; and/or have been or likely to be problem prone.

     - Performance measures are based on current knowledge and clinical experience and are structured to represent cross-departmental, interdisciplinary processes, as appropriate.

   - **Do:**

     - Data is collected to determine:
       - ♦ Whether design specifications for new processes were met
       - ♦ The level of performance and stability of existing processes
       - ♦ Priorities for possible improvement of existing processes

   - **Check:**

     - Assess care when benchmarks or thresholds are reached in order to identify opportunities to improve performance or resolve problem areas

   - **Act:**

- Take actions to correct identified problem areas or improve performance
- Evaluate the effectiveness of the actions taken and document the improvement in care
- Communicate the results of the monitoring, assessment and evaluation process to relevant individuals, departments or services

3. **DMAIC (Lean Six Sigma):** DMAIC is an acronym that stands for Define, Measure, Analyze, Improve, and Control. It represents the five phases that make up the road map for Lean Six Sigma QI initiatives.

- **Define** the problem, improvement activity, opportunity for improvement, the project goals, and customer (internal and external) requirements. QI tools that may be used in this step include:
  - Project charter to define the focus, scope, direction, and motivation for the improvement team
  - Process mapping to provide an overview of an entire process, starting and finishing at the customer, and analyzing what is required to meet customer needs
- **Measure** process performance.
  - Run/trend charts, histograms, control charts
  - Pareto chart to analyze the frequency of problems or causes
- **Analyze** the process to determine root causes of variation and poor performance (defects).
  - Root cause analysis (RCA) to uncover causes
  - Failure mode and effects analysis (FMEA) for identifying possible product, service, and process failures

Improve process performance by addressing and eliminating the root causes.

- Pilot improvements and small tests of change to solve problems from complex processes or systems where there are many factors influencing the outcome
- Kaizen event to introduce rapid change by focusing on a narrow project and using the ideas and motivation of the people who do the work
- **Control** the improved process and future process performance.
  - Quality control plan to document what is needed to keep an improved process at its current level. Statistical process control (SPC) for monitoring process behavior
  - Mistake proofing (poka-yoke) to make errors impossible or immediately detectable

VI. Confidentiality

All quality assurance and performance improvement activities and data are protected under the Health Care Quality Improvement Act of 1986, as stated in the Bylaws, Rules and Regulations of the Medical Staff, and protected from discovery pursuant to California Evidence Code §1157.

VII. Annual Evaluation

Organization and Medical Staff leaders shall review the effectiveness of the Quality Improvement Plan at least annually to insure that the collective effort is comprehensive and improving patient care and patient safety. An annual evaluation is completed to identify components of the plan that require development, revision or deletion. Organization and Medical Staff leaders also evaluate annually their contributions to the Quality Improvement Program and to the efforts in improving patient safety.

VIII. Attachments

Components of the Quality Improvement and Patient Safety Plan:

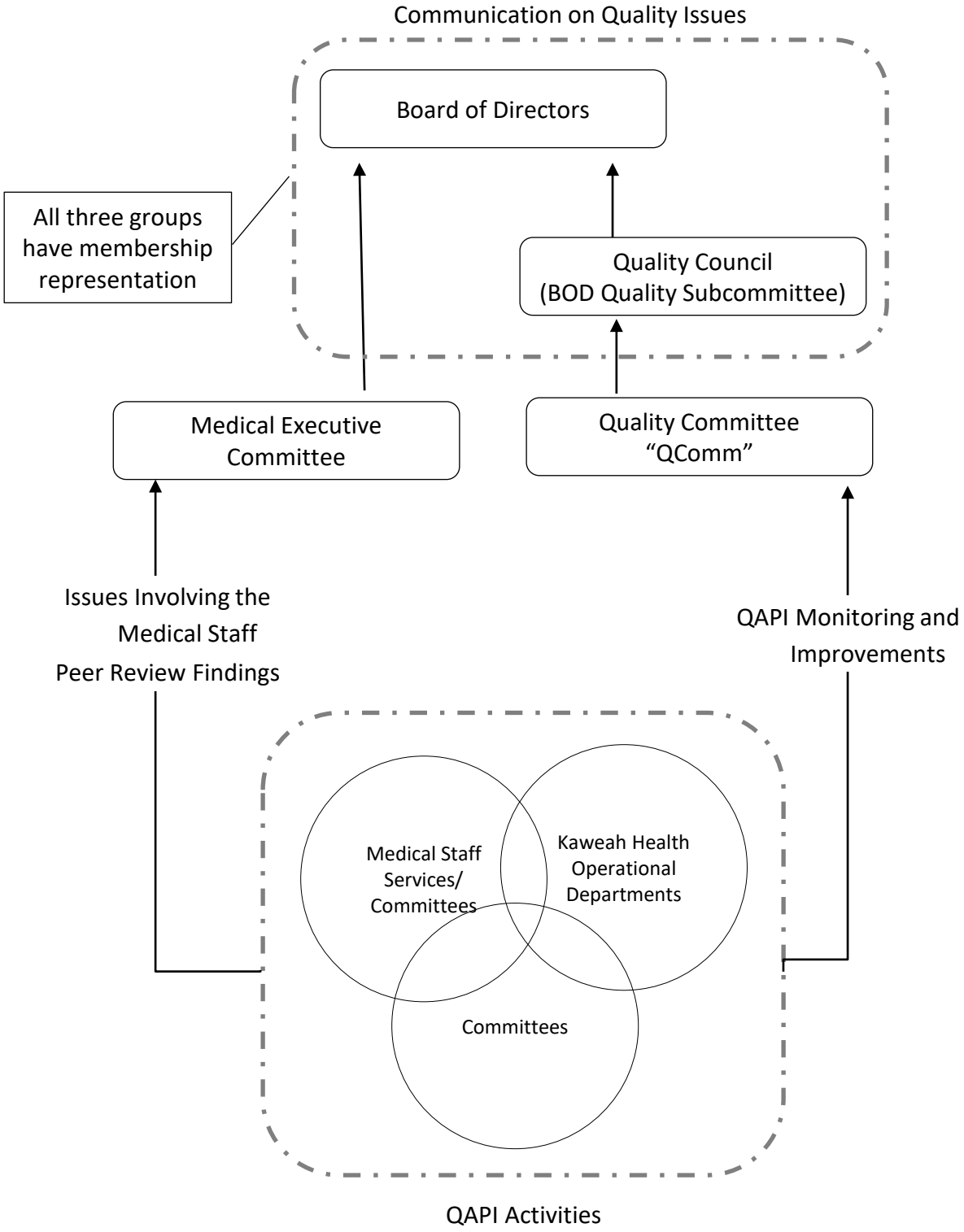
Attachment 1: Quality Improvement Committee Structure
Attachment 2: Kaweah Health Reporting Documents
Attachment 3: Quality and Patient Safety Priorities, Outstanding Health Outcomes Strategic Plan

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

Attachment 1

Kaweah Health

Quality Reporting Structure



Quality Committee "QComm" Participating Depts/Services/Committees

Departments within Kaweah Health participate in the Quality Improvement plan by prioritizing performance improvement activities based on high-risk, high-volume, or problem-prone areas. Department level indicators shall focus on issues of known frequency, prevalence or severity and shall give precedence to issues that affect health outcomes, quality of care and patient safety. Departments and committees include, but are not limited to:

Professional & Patient Care Services
Laboratory
Blood Utilization
Dept of Radiology/imaging Services (including Radiation Safety Report)
Dept of Emergency Medicine
Dept of Pathology
EOC (Security, Facilities, Clinical Engineering, EVS, Employee Health, Workplace Violence)
Peer Review
Patient Access
Population Health
Nutrition Services
Quality Incentives Program (QIP), includes all Rural Health Clinics (Exeter, Lindsay, Woodlake, Dinuba, Tulare)
Pharmacy
Inpatient Pharmacy
Med Safety & ADE (Quarterly)
MERP Annual Review
Chemo Annual Review
Infection Prevention Services
Infection Prevention Committee
Healthcare Acquired Infection Prevention Committee & Hand Hygiene
Risk Management
Risk Management (RCA and Focus Review Summary)
Grievances
Mental Health Services
Dept of Psychiatry, Mental Health Hospital
Maternal Child Health/ Dept of OB/GYN & Peds
Labor & Delivery
Mother Baby
Neonatal Intensive Care Unit
Pediatrics
Respiratory Services
Sleep Lab and EEG
Respiratory Therapy and Pulmonary Function Test
Care Management
Patient & Family Services
Case Management
Interpreter Services
Palliative Care Committee
Episodic Care
Emergency Dept. Quality Report
Trauma Service
Urgent Cares
Cardiovascular Services

Dept of Cardiovascular Services (ACC, STS); Cath lab, IR, CVCU, 4T and Cardiac Surgery
Telemonitoring Report
Non Invasive Inpatient Services
Critical Care Services
Intensive Care Unit, CVICU (non-cardiac), 3W, 5T
Organ Donation
Rehabilitation Services
Rehabilitation
Inpatient Therapies (KDMC, Rehab, South Campus)
Outpatient Therapies: Medical Office Building Akers (MOB), Exeter, Sunnyside, Dinuba, Lovers Lane, Therapy Specialists at Rehab/Neuro
Outpatient Wound Clinic at Rehab (included in Rehab report)
Post Acute Services
KH Home Infusion Pharmacy (KHHIP)
Hospice
Home Care Services (Home Health)
Short-Stay Rehab
Skilled Nursing Services (subacute and short-stay)
Surgical Services
SQIP - Surgical Quality Improvement Committee
Ambulatory Surgery Center/PACU/KATS
Operating Room
Sterile Processing Department
Inpatient units: Broderick Pavilion, 3N, 4S
Anesthesia Services
Orthopedics
Endoscopy
Renal Services/ Dept of Renal Services
4 North
KH Visalia Dialysis
Publically Reported Measures

Value Based Purchasing Report
Healthgrades
Leapfrog Hospital Safety Score
Committees
Health Equity
Falls Committee
RRT/Code Blue
Patient Care Leadership (pain management)
HAPI Committee (includes inpatient wound care)
Sepsis Quality Focus Team
Healthcare Acquired Infection Committee (CAUTI, CLABSI, MRSA, Hand Hygiene)
Stroke Committee Report
Diabetes Committee Report
Accreditation Regulatory Committee Minutes & Audit Summary
Workplace Violence Committee
Bioethics Committee
Throughput Committee
Mortality Committee
Patient Safety Committee
HIM - HIM Committee

Attachment 3

Kaweah Health Outstanding Health Outcomes

FY2025 Strategic Plan Measures & Goals

Measure Name	Goal
Healthcare Acquired Infections	
Central Line Bloodstream Infection (CLABSI)	≤0.486 Standardized Infection Ratio
Central Line Utilization	≤0.6633 Standardized Utilization Ratio
Catheter-Associated Urinary Tract Infection (CAUTI)	≤0.342 Standardized Infection Ratio
Indwelling Urinary Catheter Utilization	≤0.6363 Standardized Utilization Ratio
Methicillin-Resistant Staphylococcus Aureus (MRSA)	≤0.435 Standardized Infection Ratio
Sepsis	
SEP-1 Bundle % Compliance (CMS Core Measure)	≥81%
Sepsis All Diagnosis Mortality Rate	≤0.61 Observed/Expected
Diabetes	
% Hypoglycemia in Critical Care (CC) Patients	< 4.3%
% Hypoglycemia with at least one recurrent hypoglycemic day CC Patients	<26.8%
% Hypoglycemia in Non-Critical Care (NCC) Patients	< 3.4%
% Hypoglycemia with at least one recurrent hypoglycemic day NCC Patients	<29.6%
Health Equity	
Achieved compliance on all Joint Commission HE National Patient Safety Goal Elements of Performance	4/4 elements compliant
Quality Incentive Pool (QIP)	
Number of QIP measures that achieve target	15/15 QIP Measures achieve goal
Mortality & Readmission	
Heart Failure (HF) Mortality	≤0.48 Observed/Expected
Chronic obstructive pulmonary disease (COPD) Mortality	≤0.70 Observed/Expected
Pneumonia (PN) Bacterial Mortality	≤0.57 Observed/Expected
Pneumonia (PN) Viral Mortality	≤0.44 Observed/Expected
HF Readmission	≤12.1%
COPD Readmission	≤9.09%
PN Readmission	≤8.24%
Cardiovascular Services	
PCI In-Hospital Risk-Adjusted Mortality Rate – STEMI	≤1.9%
Risk-Standardized Acute Kidney Injury Post PCI	≤ 5.6%
Risk Standardized Bleeding Rate	≤ 1.24%

Policy Number: AP175	Date Created: Not Set
Document Owner: Kelsie Davis (Board Clerk/Executive Assistant to CEO)	Date Approved: 02/06/2024
Approvers: Board of Directors (Administration), Kelsie Davis (Board Clerk/Executive Assistant to CEO)	

Patient Safety Plan

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

I. Purpose

- Encourage organizational learning about medical/health care risk events and near misses
- Encourage recognition and reporting of medical/health events and risks to patient safety using just culture concepts
- Collect and analyze data, evaluate care processes for opportunities to reduce risk and initiate actions
- Report internally what has been found and the actions taken with a focus on processes and systems to reduce risk
- Support sharing of knowledge to effect behavioral changes in itself and within Kaweah Delta Healthcare District dba Kaweah Health (Kaweah Health)

II. Scope

All Kaweah Health facilities, departments, patient care delivery units and/or service areas fall within the scope of the quality improvement and patient safety plan requirements.

III. Structure and Accountability

A. Board of Directors

The Board of Directors retains overall responsibility for the quality of patient care and patient safety. The Board approves annually the Patient Safety Plan and assures that appropriate allocation of resources is available to carry out that plan.

The Board receives reports from the Patient Safety Committee through the Professional Staff Quality Committee. The Board shall act as appropriate on the recommendations of these bodies and assure that efforts undertaken are effective and appropriately prioritized.

B. Quality Council

The Quality Council is responsible for establishing and maintaining the organization's Patient Safety Plan and is chaired by a Board member. The Quality Council shall consist of the Chief Executive Officer, representatives of the Medical Staff and other key hospital leaders. It shall hold primary responsibility for the functioning of the Quality Assessment and Performance Improvement program. Because District performance improvement activities may involve both the Medical Staff and other representatives of the District, membership is multidisciplinary. The Quality Council requires the Medical Staff and the organization's staff to implement and report on the activities for identifying and evaluating opportunities to improve patient care and services throughout the organization. The effectiveness of the quality improvement and patient safety activities will be evaluated and reported to the Quality Council.

C. Patient Safety Committee

The Patient Safety Team is a standing interdisciplinary group that manages the organization's Patient Safety Program through a systematic, coordinated, continuous approach. The Team will meet monthly to assure the maintenance and improvement of Patient Safety in establishment of plans, processes and mechanisms involved in the provision of the patient care.

The scope of the Patient Safety Team includes medical/healthcare risk events involving the patient population of all ages, visitors, hospital/medical staff, students and volunteers. Aggregate data* from internal (IS data collection, incident reports, questionnaires,) and external resources (Sentinel Event Alerts, evidence based medicine, etc.) will be used for review and analysis in prioritization of improvement efforts, implementation of action steps and follow-up monitoring for effectiveness. The Patient Safety Committee has oversight of Kaweah Health activities related to the National Quality Forum's (NQF) Safe Practices (SP) Medication Safety, Section #4 Maternity Care, #5 ICU physician staffing, #6 A-D Culture of Safety Leadership Structures & System Documentation, Culture Measurement, Feedback & Intervention Documentation, Nursing workforce and Hand Hygiene, #7 Managing Serious Errors, and #8 Bard Code Medication Administration.

1. The Patient Safety Officer is the Chief Quality Officer
2. The Patient Safety Committee is chaired by the Patient Safety Officer or designee.
3. The responsibilities of the Patient Safety Officer include institutional compliance with patient safety standards and initiatives, reinforcement of the expectations of the Patient Safety Plan, and acceptance of accountability for measurably improving safety and reducing errors. These duties may include listening to employee and patient concerns, interviews with staff to determine what is being done to safeguard against occurrences, and immediate response to reports concerning workplace conditions.
4. Team membership includes services involved in providing patient care, such as: Pharmacy, Surgical Services, Risk Management, Infection Prevention, and Nursing. The medical staff representative on the team will be the Medical Director of Quality & Patient Safety.

D. Medication Safety Quality Focus Team

The Medication Safety Quality Focus Team (MSQFT) is an interdisciplinary group that manages the organizations Medication Safety Program including the District Medication Error Reduction Plan (MERP).

The purpose of the MSQFT is to direct system actions regarding reductions in errors attributable to medications promoting effective and safe use of medication throughout the organization. Decisions are made utilizing data review, approval of activities, resource allocation, and monitoring activities. Activities include processes that are high risk, high volume, or problem prone, some of which may be formally approved by the MSQFT as a District MERP goal (see Policy AP154 Medication Error Reduction Plan).

The MSQFT provides a monthly report to the Pharmacy and Therapeutics Committee and quarterly reports to the Professional Staff Quality Committee and directly to Quality Council. The MSQFT Chair is a member of the Patient Safety Committee. A quarterly report is presented at Patient Safety Committee in addition to active participation in patient safety activities related to medication use.

IV. Organization and Function

A. The mechanism to insure all components of the organization are integrated into the program is through a collaborative effort of multiple disciplines. This is accomplished by:

1. Reporting of potential or actual occurrences through the Occurrence Reporting Process Policy (AP10) by any employee or member of the medical staff. Examples of potential or actual occurrences include pressure ulcers, falls, adverse drug events, and misconnecting of: intravenous lines, enteral feeding tubes and epidural lines.
2. Reporting of potential or actual concerns in a daily leadership safety huddle which involves issues which occurred within the last 24 hours, a review the steps taken to resolve those matters when applicable, and anticipate challenges or safety issues in the next 24 hours. The daily safety huddle occurs Monday to Friday with the exception of holidays and includes directors and vice presidents that represent areas throughout the organization. The purpose of the daily safety huddle is immediate organizational awareness and action when warranted. Examples of issues brought forth in the Daily Safety Huddle include, patients at risk for elopement, violence, or suicide, and also can include potential diversion events, patient fall events, and medication related events.

3. Communication between the Patient Safety Officer and the Chief Operating Officer to assure a comprehensive knowledge of not only clinical, but also environmental factors involved in providing an overall safe environment.
4. Reporting of patient safety and operational safety measurements/activity to the performance improvement oversight committee, Quality Committee “Qcomm”. QComm is a multidisciplinary medical staff committee composed of various key organizational leaders including: Medical Staff Officers, Chief Executive Officer, Chief Operating Officer, Chief Medical Officer/Chief Quality Officer, Chief Nursing Officer, and Directors of Nursing, Quality Improvement & Patient Safety, Risk Management, Safety Officer and Pharmacy.
5. Graduate Medical Education
    i. Graduate Medical Education (Designated Institutional Official (DIO), faculty and residents, are involved in achieving quality and patient safety goals and improving patient care through several venues including but not limited to:
        1. Collaboration between Quality and Patient Safety Department, Risk Management, and GME Quality Subcommittee
        2. GME participation in Quality Improvement Committee and Patient Safety Committee
        3. GME participation in Kaweah Health quality committees and root cause analysis (including organizational dissemination of lessons learned)

B. The mechanism for identification and reporting a Sentinel Event/other medical error will be as indicated in Organizational Policies AP87. Any root cause analysis of hospital processes conducted on either Sentinel Events or near misses will be submitted for review/recommendations to the Patient Safety Committee, Quality Committee and Quality Council.

C. As this organization supports the concept that events most often occur due to a breakdown in systems and processes, staff involved in an event with an adverse outcome will be supported by:

1. A non-punitive approach without fear of reprisal (just culture concepts).
2. Voluntary participation into the root cause analysis for educational purposes and prevention of further occurrences.
3. Resources such as Pastoral Care, Social Services, or EAP should the need exist to counsel the staff
4. Safety culture staff survey administered at least every 2 years to targeted staff and providers.

D. As a member of an integrated healthcare system and in cooperation with system initiatives, the focus of Patient Safety activities include processes that are high risk, high volume or problem prone, and may include:

1. Adverse Drug Events
2. Nosocomial Infections
3. Decubitus Ulcers
4. Blood Reactions
5. Slips and Falls
6. Restraint Use
7. Serious Event Reports
8. DVT/PE

E. A proactive component of the program includes the selection at least every 18 months of a high risk or error prone process for proactive risk assessment such as a Failure Modes Effects Analysis (FMEA), ongoing measurement and periodic analysis. The selected process

and approach to be taken will be approved by the Patient Safety Committee, QComm and Quality Council.

The selection may be based on information published by The Joint Commission (TJC) Sentinel Event Alerts, and/or other sources of information including risk management, performance improvement, quality assurance, infection prevention, research, patient/family suggestions/expectations or process outcomes.

F. Methods to assure ongoing inservices, education and training programs for maintenance and improvement of staff competence and support to an interdisciplinary approach to patient care is accomplished by:

1. Providing information and reporting mechanisms to new staff in the orientation training.
2. Providing ongoing education in organizational communications such as newsletters and educational bundles.
3. Obtaining a confidential assessment of staff's willingness to report medical errors at least once every two years.

G. Internal reporting – To provide a comprehensive view of both the clinical and operational safety activity of the organization:

1. The minutes/reports of the Patient Safety Committee, as well as minutes/reports from the Environment of Care Committee will be submitted through the Director of Quality Improvement and Patient Safety to the Quality Committee.
2. These monthly reports will include ongoing activities including data collection, analysis, and actions taken and monitoring for the effectiveness of actions.
3. Following review by Quality Committee, the reports will be forwarded to Quality Council.

H. The Patient Safety Officer or designee will submit an Annual Report to the Kaweah Health Board of Directors and will include:

1. Definition of the scope of occurrences including sentinel events, near misses and serious occurrences
2. Detail of activities that demonstrate the patient safety program has a proactive component by identifying the high-risk process selected
3. Results of the high-risk or error-prone processes selected for proactive risk assessment.
4. The results of the program that assesses and improves staff willingness to report medical/health care risk events
5. A description of the examples of ongoing in-service, and other education and training programs that are maintaining and improving staff competence and supporting an interdisciplinary approach to patient care.

V. Evaluation and Approval

The Patient Safety Plan will be evaluated at least annually or as significant changes occur, and revised as necessary at the direction of the Patient Safety Committee, Quality Committee, and/or Quality Council. Annual evaluation of the plan's effectiveness will be documented in a report to the Quality Council and the Kaweah Health Board of Directors.

VI. Confidentiality

All quality assurance and performance improvement activities and data are protected under the Health Care Quality Improvement Act of 1986, as stated in the Bylaws, Rules and Regulations of the Medical Staff, and protected from discovery pursuant to California Evidence Code §1157.

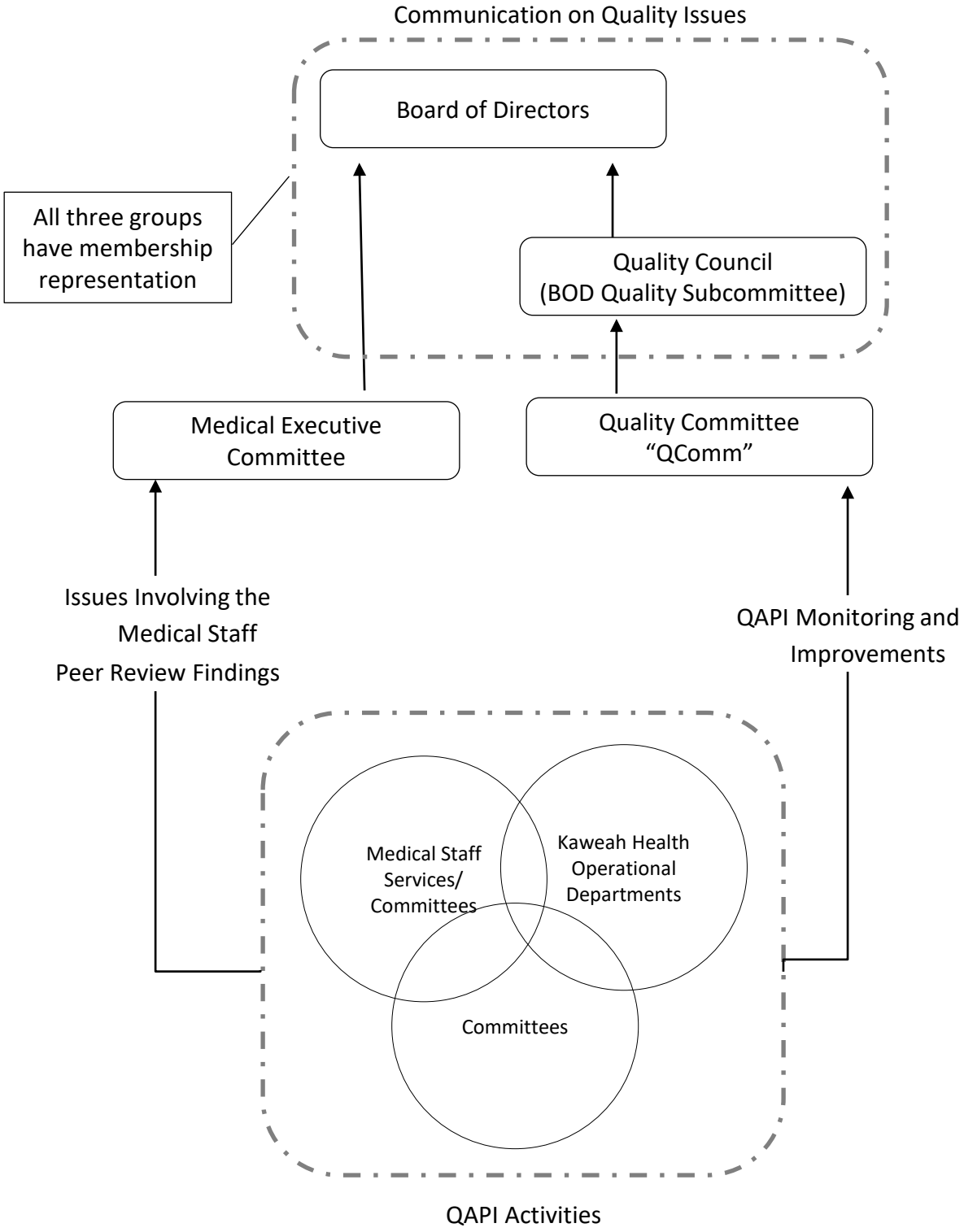
Attachments - Attachment 1: Quality Improvement/Patient Safety Committee Structure

techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

Attachment 1

Kaweah Health

Quality Reporting Structure



Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Orthopedic Service Line
Surgical Site infection

ProStaff Report Date: 12/6/2024

Submitted by: Kevin Bartel, Director of Surgical Service Lines

Measure Objective/Goal: Measuring the standardized infection ratio (SIR) of total arthroplasty, spinal fusion and hip fracture surgical patients who experienced a **surgical site infection** within 90 days after surgery. An incidence rate calculation is determined using the total number of Total Knee (KPRO), Total Hip (HPRO), Spine fusion (FUSN) and hip fracture (FX) surgical procedures (performed during a 12-month period) versus the total number of infections for each respective procedure type using CDC/NHSH criteria. This criteria includes only inpatient surgical cases, and some "day" surgeries that stay overnight in observation status before being discharged. The goal of this data collection is to identify opportunities to prevent infections with orthopedic-related procedures.

Date range of data evaluated: July 1, 2023 – June 30, 2024 (12 months)

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

Type of SSI	Total # of Procedures	Actual # of infections	Predicted # of Infections	Standardized Infection Ratio
KPRO	233	0	1.705	0
HPRO	195	0	2.781	0
FUSN	330	5	5.168	0.968
FX	221	0	2.22	0
Total	979	5	12.774	0.626

Overall, the Orthopedic total joint, spine and hip fracture procedures performed from July 1, 2023, through June 30, 2024 at Kaweah Health resulted in 5 total surgical site infections.

For the current reporting period, the number of infections for all individual surgical types (total hip arthroplasty, total knee arthroplasty, spine fusion and hip fracture procedures) were below the predicted number of infections for each respective procedure type. Total hip arthroplasty, total knee arthroplasty and hip fracture all resulted in zero incidence of surgical site infection. All of these 5 identified surgical site infections during this reporting period were related to spinal fusion surgical procedures.

- Three of these surgical site infections noted dehiscence of the wound
- Four of the infections were identified as superficial incisional primary (SIP) infections
- One of the infections was on a patient with known poorly controlled diabetes who returned to the ED 4 weeks after initial fusion surgery due to wound dehiscence, with infection found to be at the level of the bone.

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

1. The Joint Camp class for THA/TKA patients continues to be the primary source of education on all topics related to a patient's surgery. The pre-surgery education for patients, specifically on the topic of appropriate surgical site incision care, is considered to be a critical element in helping to reduce the number of surgical site infections. Compliance with Joint Camp attendance (30% average) continues to be low, and has not reached pre-pandemic compliance levels (~70%). The joint camp education has moved solely online (versus previously being in-person). The educational video has been refined to last only 12 minutes (previously was 48 minutes), and we are working directly with orthopedic provider offices to propose workflows that allow the patient to view the educational video (and receive a hard-copy joint camp book) on-site during their orthopedic visit as a way of improving compliance.

2. The Enhanced Recovery after Surgery (ERAS) program is led and monitored by the orthopedic program's Nurse Practitioners (NP) and Kaweah Quality department. This program helps to support a standardized approach to pre and post-surgical care protocols in order to enhance recovery after a total joint surgery. Orthopedic service line leadership is now a regular participant in the Surgical Quality Improvement Committee (SQIP), and will continue to monitor compliance with this ERAS program and act on initiatives required to improve compliance.

3. Discussing standard of practice among orthopedic surgeons with variances being presented at the monthly Co-Management meeting as appropriate. This will continue to be done monthly through case reviews, discussion and reviewing data/reports related to SSI data.

Next Steps/Recommendations/Outcomes:

Orthopedic Service Line Director and clinical staff/leadership will be regularly attending the SQIP meeting, and will remain engaged with IP team related to known SSIs within the orthopedic service line, to stay current with SSI topics related to prevention and best practices. Orthopedic SSI cases will be reviewed and discussed with orthopedic surgeons on a regular basis, so that timely discussion and decisions can occur regarding ways to mitigate the incidence of infection. Continue to hardwire ERAS program with nursing staff, therapies, and surgeons in the coming year.

Submitted by Name: Kevin Bartel, DPT **Date Submitted**: 12/6/2024

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: Orthopedic Service Line Complication Rate

ProStaff Report Date: 12/6/2024

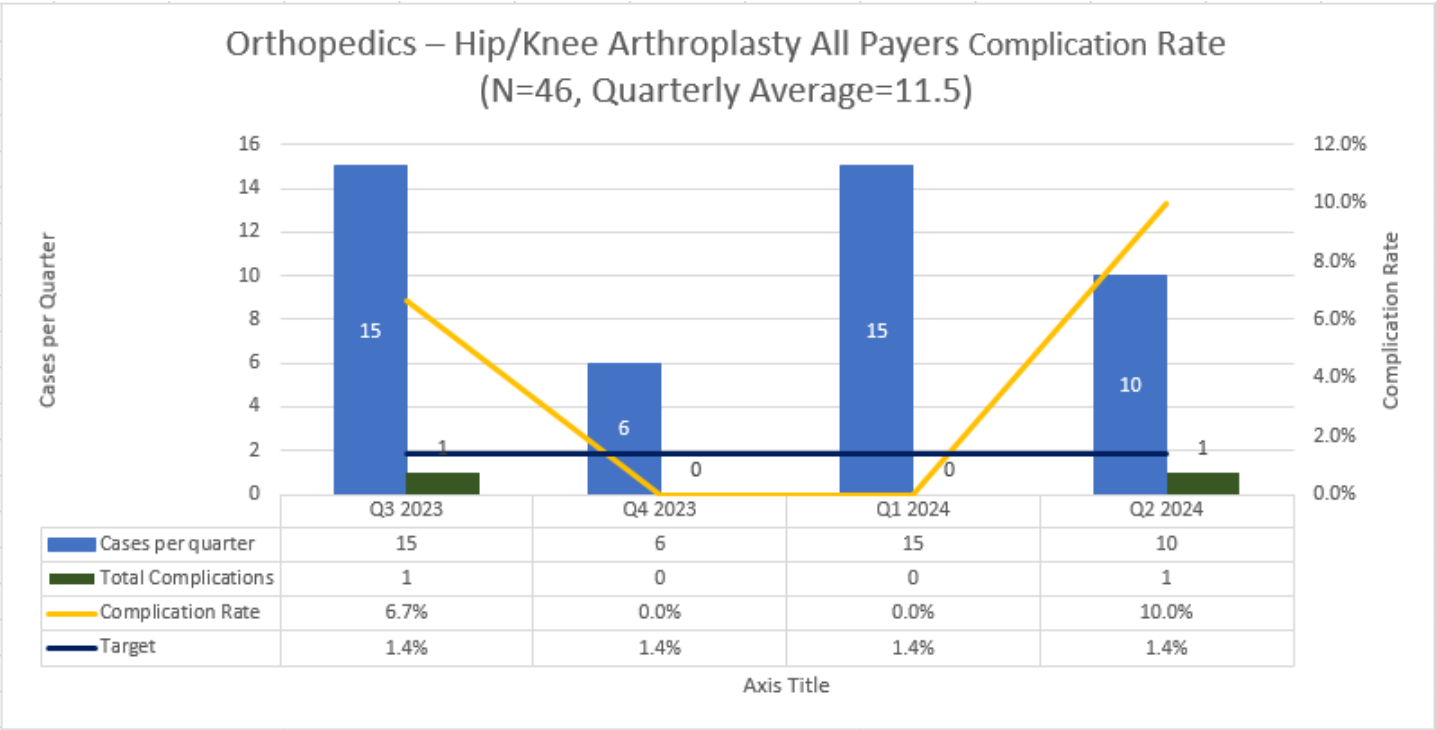
Measure Objective/Goal: Monitor and measure the **complication rate** for total arthroplasty patients who underwent either a total hip or knee joint replacement, on qualified inpatient stays. The benchmark sources are both CMS and hospitals within the STATIT database. The CMS target is **1.4%** for Medicare patients and **2.3%** target for all payers within the Midas database.

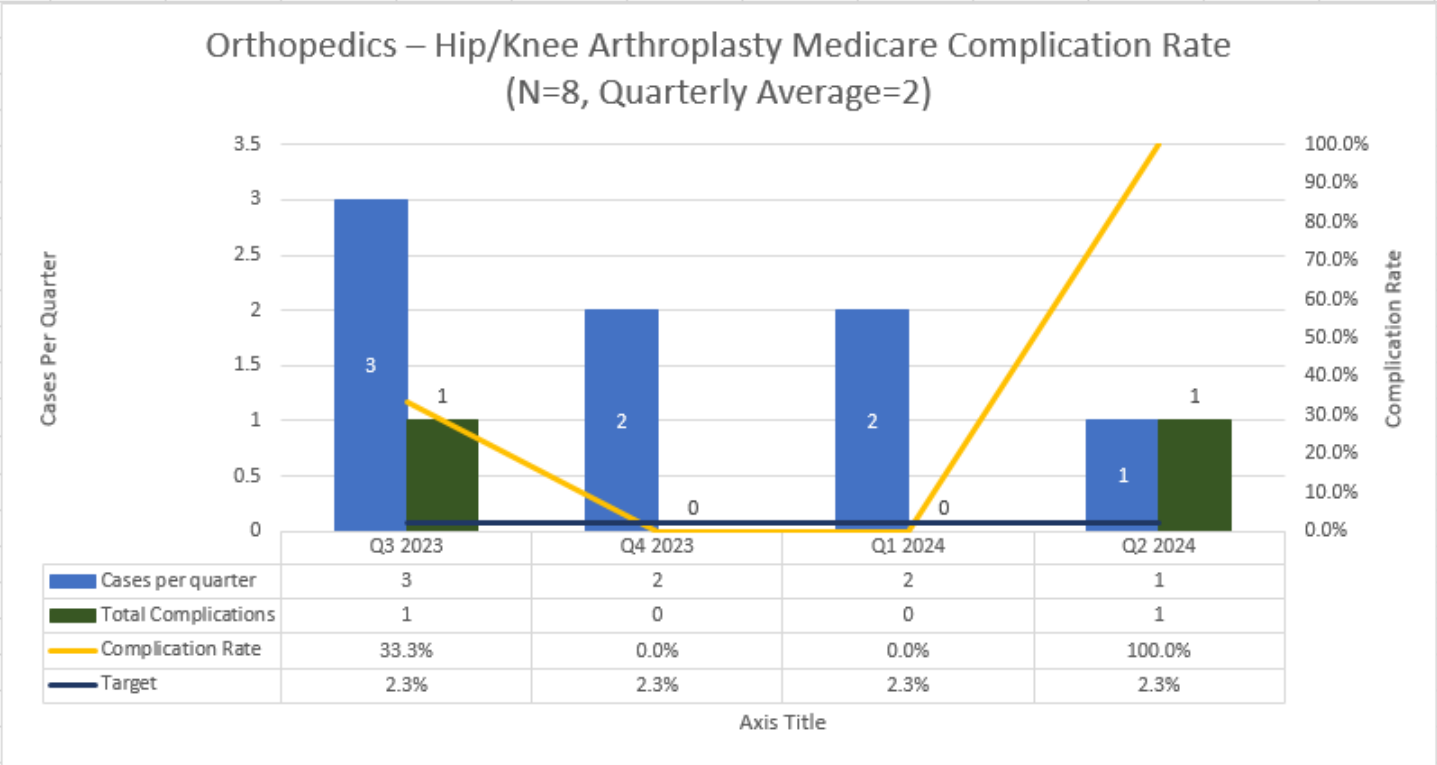
The inclusion criteria for complication include the following:

1. Mechanical complication within 90 days
2. Wound Infection or periprosthetic joint infection within 90 days
3. Surgical site bleeding within 30 days
4. Pulmonary embolism within 30 days
5. Death within 30 days
6. Acute myocardial infarction with 7 days
7. Pneumonia within 7 days
8. Sepsis, septicemia, or shock within 7 days

Date range of data evaluated: July 1, 2023 – June 30, 2024 (12 months)

Analysis of all measures/data: (Include key findings, improvements, and opportunities) (If this is not a new measure, please include data from your previous reports through your current report):





	Q3 2023	Q4 2023	Q1 2024	Q2 2024
Cases per quarter	3	2	2	1
Total Complications	1	0	0	1
Complication Rate	33.3%	0.0%	0.0%	100.0%
Target	2.3%	2.3%	2.3%	2.3%

All Payers

Overall complication rate: 4.3%, which is above the benchmark of 1.4%.

Past reports: 3.4% (Q3 2022-Q2 2023), 3.2% (Q1 2021-Q1 2022)

- The complication in Q3 2023 involved a patient with extensive cardiac history who, during the course of her postoperative recovery at the hospital, was hypotensive and diagnosed with cardiogenic and hypovolemic shock, both not present on admission.
- The complication in Q2 2024 involved a patient undergoing total hip arthroplasty, with a periprosthetic fracture identified intraoperatively by the surgeon, which qualified as a mechanical complication. The patient was discharged home the day following surgery with no further complications.

Medicare

Overall complication rate: 25%, which is well above the target benchmark of 2.3%.

**In Q3 2022, CMS updated exclusion criteria to exclude index encounters with a principal diagnosis code of COVID-19 or with a secondary diagnosis code of COVID-19 coded as present on admission. This change has resulted in substantially reduced total qualifying encounters since then. This lower denominator value reduces the margin for error when trying to achieve targets, especially when the number of qualifying inpatient total joint surgeries is decreasing in general (as the majority of these procedures are now done on an outpatient status)

- Both complications are the same as those described in the above “All Payers” section

Next Steps/Recommendations/Outcomes:

1. Coordinate daily patient rounding involvement from Ortho NPs to facilitate routine patient assessment, patient care management and coordination of care. Identified complication cases are reviewed as needed at the orthopedic co-management meeting to identify any opportunities for improvement in patient care management.

2. Orthopedic NPs have created and optimized a daily communication email with Kaweah case management and post-acute liaisons to spotlight priority orthopedic patients and their status/discharge plan. They will continue to facilitate patient transfer to next level of rehabilitation care (i.e. inpatient rehab, short stay, SNF, home health) in effort to optimize patient access to recovery and education, as appropriate.

3. Recent efforts to refine the Joint Program at Kaweah Health, moving the education and resource materials fully online. The goals of this are to improve pre-surgery patient education compliance, advocate for family/friend support throughout the surgical process for the patient, and identify evidence-based clinical treatment pathways with goals to reduce incidence of SSI, complications and readmissions after total joint surgery. Additionally, workflows have been put in place to understand our patients' pre-operative functional level and identify any social barriers that may impact their ability to be safely discharged home following surgery. Will continue to work with orthopedic provider offices to refine the workflows that will enhance access of this education to our patients prior to surgery.

4. For total joint surgeries, there continues to be a move from inpatient qualified stays to outpatient stays and a focus on same day discharge. This trend has greatly reduced the overall number of qualifying encounters that are tracked for this quality measure. Discussions are occurring with the Quality department to identify and establish appropriate quality measures that can be tracked and reported for the outpatient total joint cases performed at Kaweah, which make up the vast majority of the total joint surgeries completed.

Submitted by Name: Kevin Bartel, DPT **Date Submitted**: 12/6/2024

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

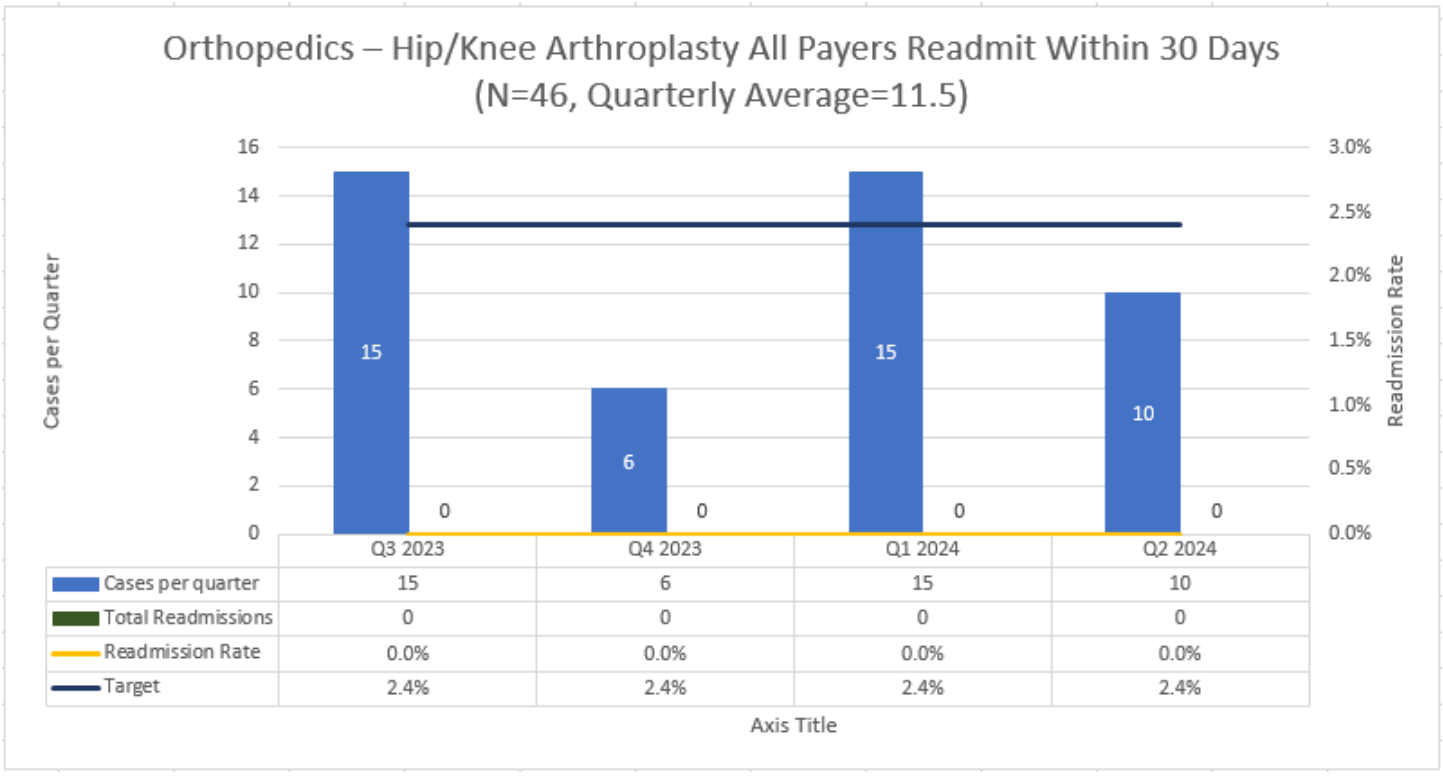
Unit/Department: Orthopedic Service Line Readmission Rate

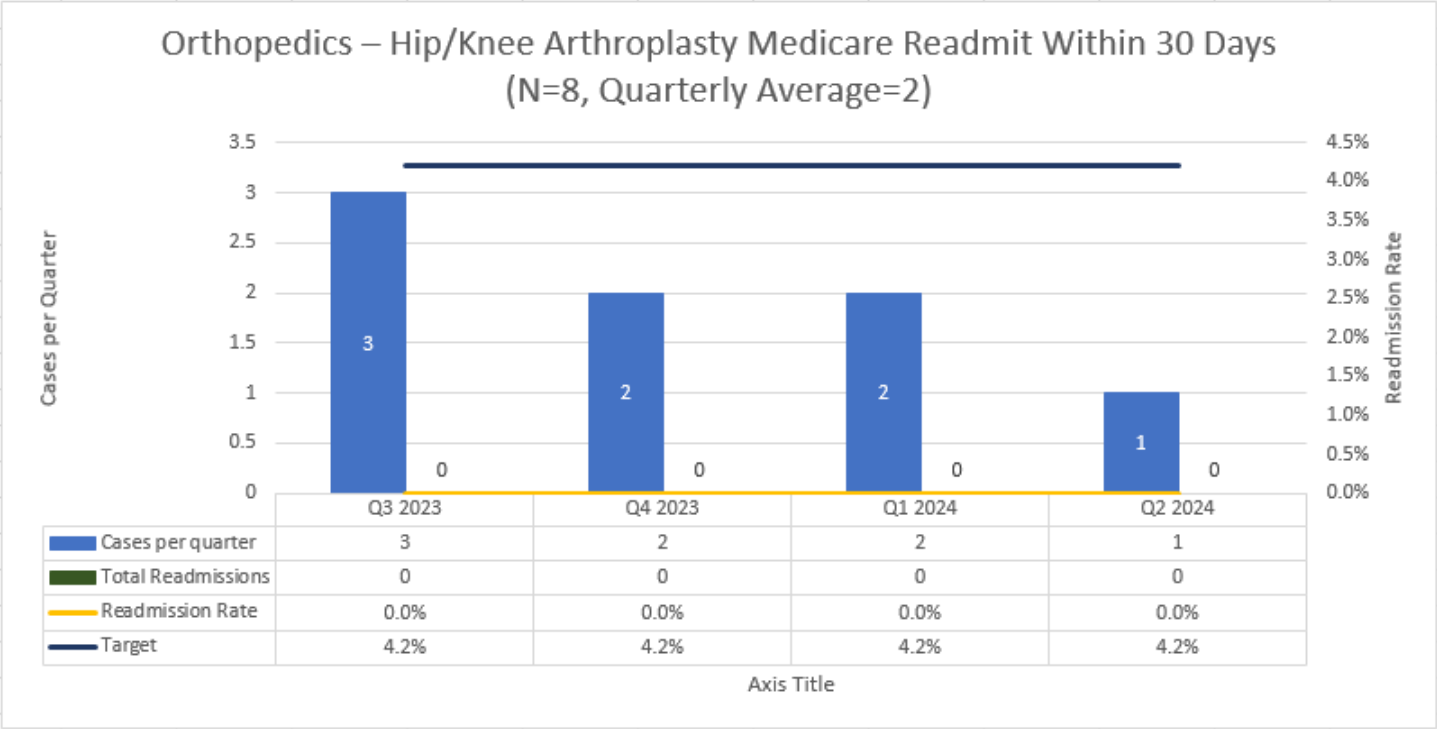
ProStaff Report Date: 12/6/2024

Measure Objective/Goal: Monitor and measure any cause 30-day **readmission rate** for total arthroplasty patients who underwent a joint replacement. The benchmark sources are both CMS and hospitals within the Midas database. The CMS target is **4.2%** for Medicare patients and **2.4%** target for all payers.

Date range of data evaluated: July 1, 2023 – June 30, 2024 (12 months)

Analysis of all measures/data: (Include key findings, improvements, opportunities)
(If this is not a new measure, please include data from your previous reports through your current report):





All Payers

Overall readmission rate: 0%, which is below the benchmark of 2.4%.

Previous report: 5.7% (Q3 2022 – Q2 2023)

- No readmissions noted in this reporting period for qualifying encounters

Medicare

Overall readmission rate of 0%, below the benchmark of 4.2%.

Previous report: 5.2% (Q3 2022 – Q2 2023)

**In Q3 2022, CMS updated exclusion criteria to exclude index encounters with a principal diagnosis code of COVID-19 or with a secondary diagnosis code of COVID-19 coded as present on admission. This change has resulted in substantially reduced total qualifying encounters since then. This lower denominator value reduces the margin for error when trying to achieve targets, especially when the number of qualifying inpatient total joint surgeries is decreasing in general (as the majority of these procedures are now done on an outpatient status)

Next Steps/Recommendations/Outcomes:

1. Standardized education and increased emphasis with prevention of surgical site infections during the pre-op Joint Camp education class. Focus on post-operative care of surgical sites and plan of care if signs and symptoms of infection occur with plan to call surgeon and not to report to Emergency room.

2. Coordinating care alongside our Emergency Department physicians to improve communication with primary surgeon if patient shows to the ED, so that optimal care management and collaboration can occur in efforts to reduce incidence of readmission as appropriate.

3. Orthopedic NPs will continue to facilitate patient transfer to next level of rehabilitation care (i.e. inpatient rehab, short stay, SNF, home health) in effort to optimize patient access to recovery and education, as appropriate.

4. Working more closely with Orthopedic providers and offices to improve processes in proactively identifying and providing resources for surgical patients' needs to optimize their recovery after surgery (i.e appropriate DME, home support, etc).

5. Recent efforts to refine the Joint Program at Kaweah Health, moving the education and resource materials fully online. The goals of this are to improve pre-surgery patient education compliance, advocate for family/friend support throughout the surgical process for the patient, and identify evidence-based clinical treatment pathways with goals to reduce incidence of SSI, complications and readmissions after total joint surgery. Additionally, workflows have been put in place to understand our patients' pre-operative functional level and identify any social barriers that may impact their ability to be safely discharged home following surgery. Will continue to work with orthopedic provider offices to refine the workflows that will enhance access of this education to our patients prior to surgery.

6. For total joint surgeries, there continues to be a move from inpatient qualified stays to outpatient stays and a focus on same day discharge. This trend has greatly reduced the overall number of qualifying encounters that are tracked for this quality measure. Discussions are occurring with the Quality department to identify and establish appropriate quality measures that can be tracked and reported for the outpatient total joint cases performed at Kaweah, which make up the vast majority of the total joint surgeries completed.

Submitted by Name: Kevin Bartel, DPT **Date Submitted:** 12/6/2024

VALUE BASED PURCHASING

Kaweah Health VBP Final FFY 2025 Performance Report CMS Snapshot

CHA FY 2025 VBP **Estimated** Cost	
Contribution	CHA Estimated Payment Receive
2% = $1,820,100	$1,106,700
Estimated Loss: ($-713,500)	

Outperforming (Earned points):

- Elective THA/TKA Complication Rate (Safety Domain-only metric to earn points)
- HAIs: CAUTI, MRSA (Safety Domain)

Opportunities (Did not earn points [Zero]):

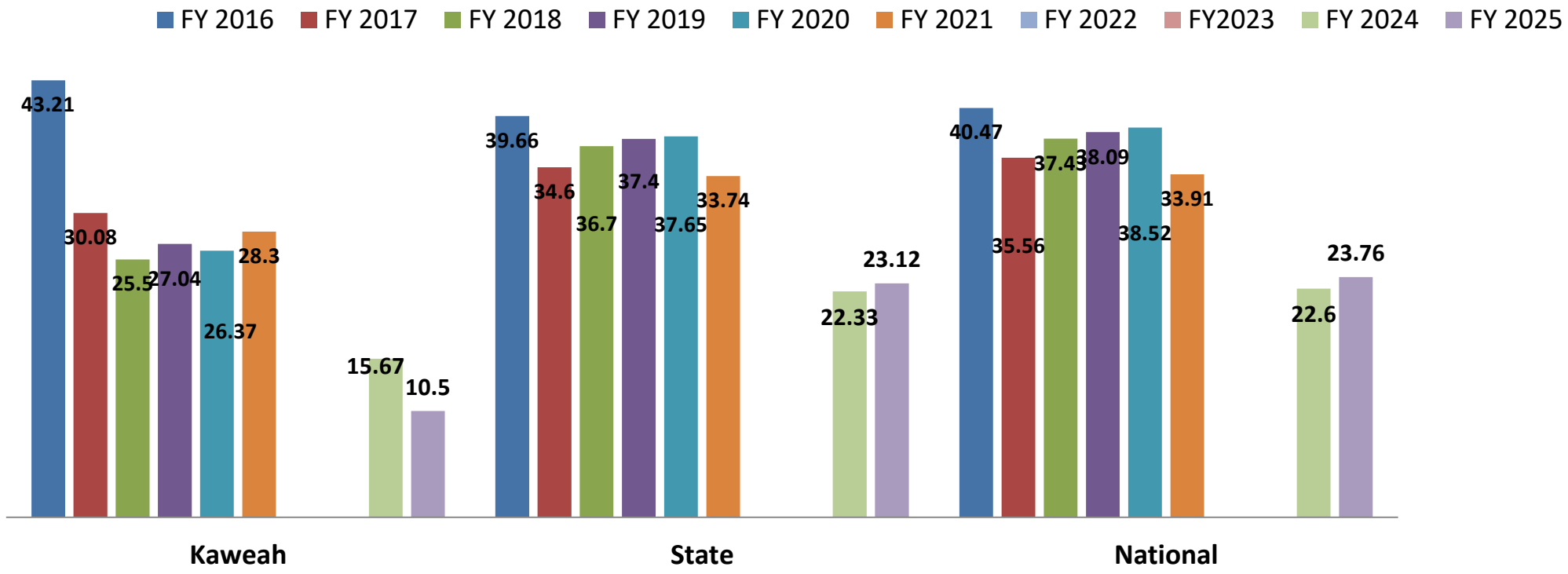
- Mortality: AMI, COPD, CABG, HF, & PN (Clinical Outcomes Domain)
- HAIs: C Diff, CLABSI, SSI (Safety Domain)
- Pt Experience Survey/HCAPHS (we performed lower in all dimensions except **1%** increase for Cleanliness & Quietness of Hospital compared to baseline performance for VBP HCAPHS) [Person & Community Engagement Domain]
- Medicare Spending per Beneficiary (MSPB) [Efficiency & Cost Reduction Domain]

Not enough volume of cases to compare or generate a score (does not negatively impact performance)

- SSI-Abdominal Hysterectomy

Kaweah Health VBP Performance

State and National TPS decreased in FY 2024 after a 2 year hiatus due to the suppression of the VBP program due to Extraordinary Circumstances Exception

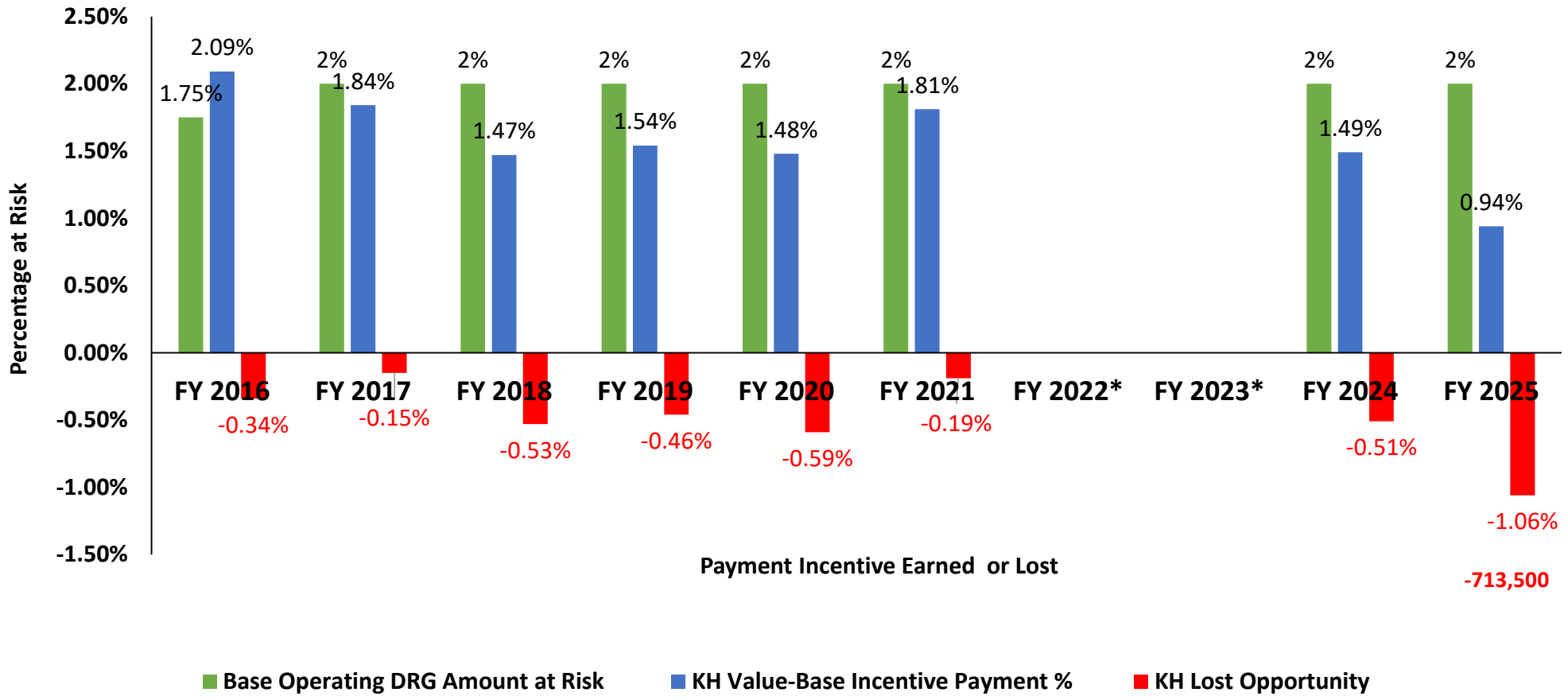


Kaweah Health VBP Performance

CHA FY 2025 VBP **Estimated** Cost	
Contribution	CHA Estimated Payment Receive
2% = $1,820,100	$1,106,700
Estimated Loss: ($-713,500)	

*VBP Exclusion Reason for FY 2022 & FY 2023:

- Due to a public health emergency, CMS suppressed several measures
- There was not enough data to award a Total Performance Score



FFY 2025 Domains and Measures (CY 2023 Discharges)

- Opportunities driving FY 2025 performance: Mortality, Patient Experience, HAIs: CLABSI, Cdiff, SSI colon, & Medicare Spending Per Beneficiary
- FY25 Lowest result recorded since data collection began in 2016
- **FY22 & FY23 HVBP Exclusion due to COVID 19

Value Base Purchasing KH Dashboard: Historical and FFY 2025 Performance

Indicators	Kaweah Health Historical Performance				National Performance		KH Performance
Clinical Outcomes Domain 25% (Claims Data)	**FFY21** Mortality (AMI, CABG, COPD, CABG 7/16-6/19) PN (9/17-6/19) Hip/Knee (4/16-3/19)	**FFY22**** Mortality (AMI, CABG, COPD, CABG 4/17-6/20) PN (9/17-6/20) Hip/Knee (4/17-3/20)	**FFY23**** Mortality (4/18-3/21) Hip/Knee (4/18-6/21)	**FFY24** Mortality (4/19-3/22) Hip/Knee (4/20-3/23)	**FY25** Benchmark (National Top 10%)	**FY25** 50th Percentile (National Median)	**FFY25** Mortality (7/20-6/23) Hip/Knee (4/20-3/23)
AMI 30-Day Mortality	0.8729	0.8736	0.8577	0.8443	0.8900	0.8726	0.8424
COPD 30-Day Mortality	0.9031	0.9014	0.9125	0.8994	0.9322	0.9151	0.9027
CABG 30 Day Mortality	N/A	0.9806	0.9745	0.9663	0.9798	0.9701	0.9701
CHF 30-Day Mortality	0.8913	0.8904	0.8638	0.8564	0.9103	0.8840	0.8593
Pneumonia 30-Day Mortality	0.8399	0.8386	0.8283	0.8154	0.8744	0.8415	0.7924
Elective Total Hip and Knee Arthroplasty Complication Rate	0.0244	0.0225	0.0234	0.0222	0.0253	0.0179	0.0206
Person and Community Engagement Domain 25% (HCAHPS Data*)**	**FFY21 (CY 1/19-12/19)**	**FFY22** (CY 1/20-12/20)**	**FFY23** (CY 1/21-12/21)**	**FFY24 (CY 1/22-12/22)**	**FY25 Benchmark (Top 10%)**	**FY25 50th Percentile (National Median)**	**FFY25 (CY 1/23-12/23)**
Communication with Nurses	76.58%	76.52%	76.10%	71.97%	87.71%	79.42%	73.50%
Communication with Doctors	76.02%	76.42%	75.07%	71.17%	87.97%	79.83%	74.78%
Responsiveness of Hospital Staff	67.20%	65.45%	65.62%	58.26%	81.22%	81.22%	59.84%
Communication about Medicines	60.49%	64.64%	61.92%	54.92%	74.05%	63.11%	57.86%
Cleanliness and Quietness of Hospital Environment	58.64%	60.10%	60.70%	54.19%	79.64%	65.63%	59.15%
Discharge Information	86.56%	87.93%	85.34%	83.13%	92.21%	87.23%	85.00%
Care Transition	46.60%	44.45%	45.84%	42.49%	63.57%	51.84%	42.27%
Overall Rating of Hospital	71.36%	70.66%	69.38%	61.25%	85.39%	71.66%	68.47%
Safety 25% CDC-NHSN Data	**FFY21 (CY 1/19-12/19)**	**FFY22** (CY 1/20-12/20)**	**FFY23** (CY 1/21-12/21)**	**FFY24 (CY 1/22-12/22)**	**FY25 Benchmark (National Top 10%)**	**FY25 50th Percentile (National Median)**	**FFY25 (CY 1/23-12/23)**
CAUTI - (SIR)	1.893	0.868	0.933	1.153	0.000	0.650	0.423
CLABSI - (SIR)	1.146	1.024	1.253	0.788	0.000	0.589	1.217
C. difficile - (SIR)	0.291	0.188	0.498	0.605	0.014	0.520	0.555
MRSA - (SIR)	1.577	3.306	2.107	0.986	0.000	0.726	1.080
SSI Colon - (SIR)	0.498	0.622	0.703	0.348	0.000	0.717	1.457
SSI Abdominal Hysterectomy - (SIR)	N/A	N/A	N/A	N/A	0.000	0.738	N/A
Efficiency & Cost Reduction 25% (Claims Data)	**FFY21 (CY 1/19-12/19)**	**FFY22** (CY 1/20-12/20)**	**FFY23** (CY 1/21-12/21)**	**FFY24 (CY 1/22-12/22)**	**FY25 Benchmark (National Top 10%)**	**FY25 50th Percentile (National Median)**	**FFY25 (CY 1/23-12/23)**
Medicare Spending/Beneficiary	0.9699	0.9884	0.9689	0.9602	0.8399	0.9869	1.0106

Green: Outperformed-Earned points

Red: Underperformed-Zero Points

N/A: not enough to generate scoring (i.e., SSI hyster) or not yet part of program (i.e CABG mortality)

FFY 2026 Domain Measures, Timelines & Action Plans

Action plans developed & reported into the QAPI program through the following Kaweah Health Workgroups/Committees

- Readmissions & Mortality – Best Practice Teams, Cardiovascular Services (OHO report)
- Elective Total Hip/Knee Complication – Orthopedic Service Line Director & Orthopedic Co-Management Committee
- Patient Experience – New Patient Experience Team & Patient Experience Steering Committee (OHO Report)
- Healthcare Acquired Infection – HAI Quality Focus Team (OHO report)
- Sepsis – Sepsis Quality Focus Team working on improving SEP-1 and Sepsis Mortality (OHO report)

Domain	Measure	Baseline Period	Performance Period
Clinical Outcomes	Mortality Measures (AMI, CABG, COPD, HF)	July 1, 2016–June 30, 2019	July 1, 2021–June 30, 2024
	Complication Measure	April 1, 2016–March 31, 2019	April 1, 2021–March 31, 2024
Person and Community Engagement	HCAHPS Survey	January 1, 2022–December 31, 2022	January 1, 2024–December 31, 2024
Safety	Healthcare-associated infection (HAI) Measures & SEP-1 Measure	January 1, 2022–December 31, 2022	January 1, 2024–December 31, 2024
Efficiency and Cost Reduction	MSPB Hospital	January 1, 2022–December 31, 2022	January 1, 2024–December 31, 2024

Abbreviations

CMS: Centers for Medicare and Medicaid Services
DRG: Diagnosis Related Groups
ECE: Extraordinary Circumstances Exception
FFY: Federal Fiscal Year
CY: Calendar Year
TPS: Total Performance Score
VBP: Value Based Purchasing
CHA: California Hospital Association
HAI: Healthcare-Associated Infection
CAUTI – Catheter Associated Urinary Tract Infection
CLABSI – Central Line Associated Blood Stream Infection
MRSA - Methicillin-resistant Staphylococcus Aureus
CDIFF – Clostridium Difficile Infection
SSI: Surgical Site Infection

MSPB: Medicare Spending per Beneficiary
IQR: Inpatient Quality Reporting
THA/TKA: Total Hip Arthroplasty/or Total Knee Arthroplasty
HCAPHS: Hospital consumer Assessment of Healthcare Providers and Systems
AMI: Acute Myocardial Infarction
COPD: Chronic Obstructive Pulmonary Disease
HF: Heart Failure
PN: Pneumonia
HF: Heart Failure
CABG: Coronary Artery Bypass Grafting

The pursuit of healthiness

More than medicine. Life.

Kaweah Health
MORE THAN MEDICINE. LIFE.

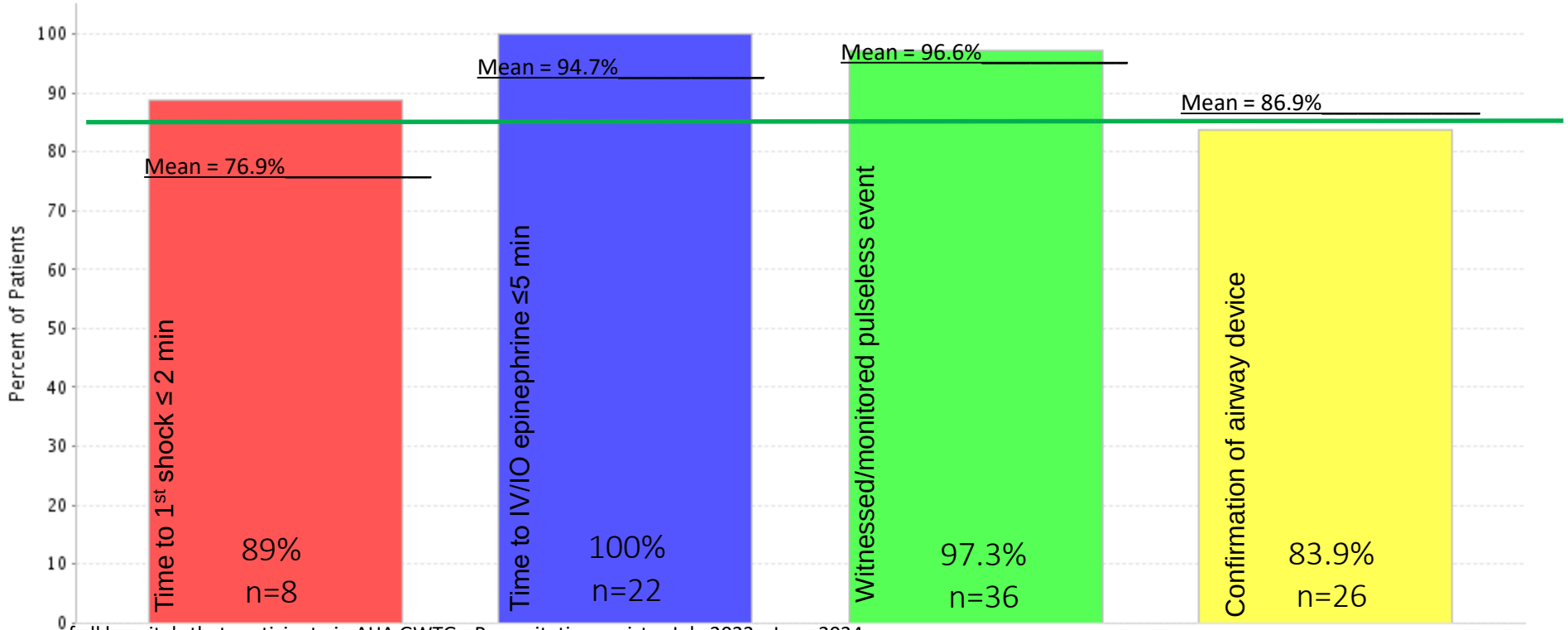
RRT/Code Blue QCOMM Report

Q3 2024

Shannon Cauthen

KH Code Blue Process Measures
Get With the Guidelines

3Q 2024 (July - Sept)



Higher performance in process measures leads to overall improved outcomes for patients who experience a Code Blue.

AHA awards organizations who achieve >85% in all 4 measures in a calendar year

Mean = National mean of all hospitals that participate in AHA GWTG - Resuscitation registry July 2023 - June 2024

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 Hospital
CPA: Percent Pulseless Cardiac events monitored or witnessed: My Hospital
CPA: Confirmation of airway device placement in trachea: My Hospital

Kaweah Health
MORE THAN MEDICINE. LIFE.

RRT and Resuscitation Scorecard

Kaweah Health
MORE THAN MEDICINE. LIFE.

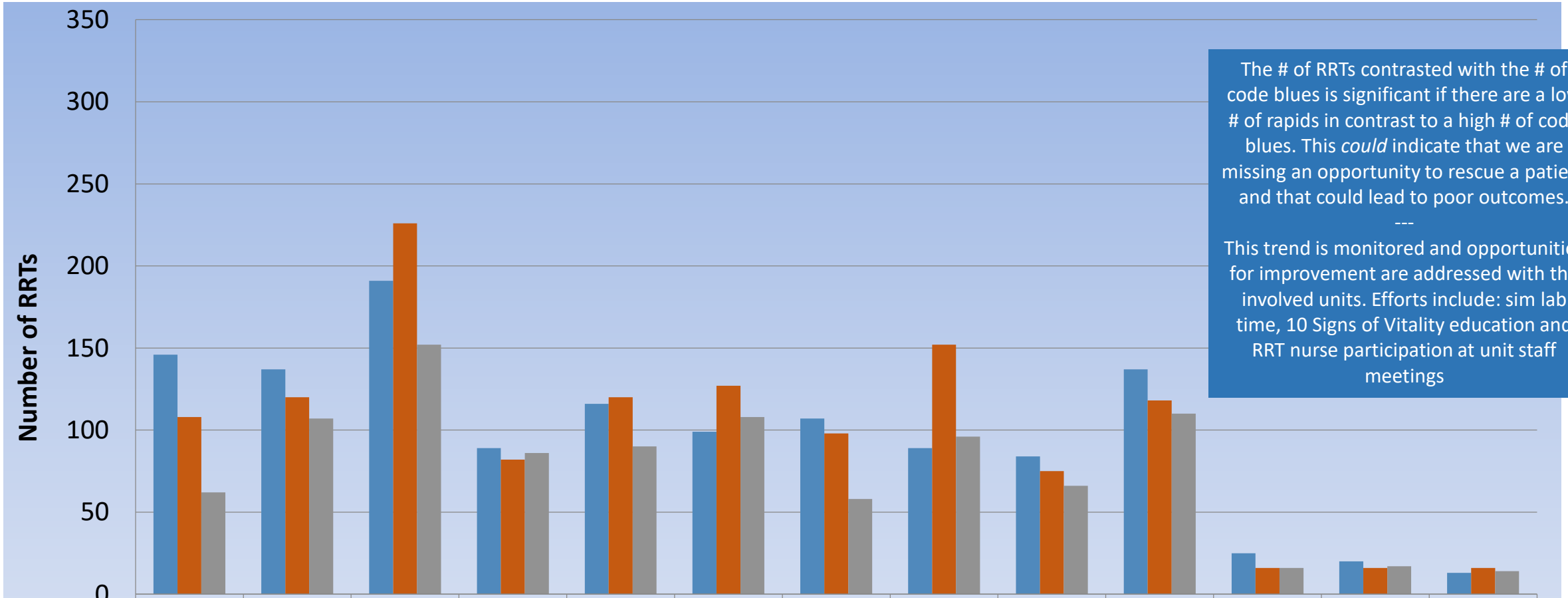
RRT & Code Blue Dashboard

Code Blue Data	All GWTG Hospitals Mean - CY 2023 (updated for 2Q24 data)	CY 2023 Baseline Mean	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Mean (Rolling 12 months)
Total Code Blues (Med/Surg/ICCU/CC)		11	7	11	21	13	8	12	12	9	22	5	16	21	12
Code Blues per 1000 Discharges Med Surg/ICCU		4	4	3	9	4	2	6	3	3	7	1	4	7	4
Code Blues per 1000 Discharges Critical Care		5	2	5	7	6	4	4	6	4	9	2	8	8	5
Percent of Codes in Critical Care	66% (↑ is better)	58%	29%	64%	43%	62%	63%	42%	67%	56%	55%	60%	69%	52%	55%
Event Survival Rates		63%	57%	73%	67%	69%	75%	58%	50%	67%	82%	80%	81%	71%	69%
Code Blue: Survival to Discharge	26% (↑ is better)	24%	14%	9%	10%	15%	13%	25%	8%	22%	18%	20%	6%	38%	15%
Deaths from Cardiac Arrest (expired during event)		4	3	3	7	4	2	5	6	3	4	1	3	6	4
Overall Hospital Mortality Rate		2.70	2.45	3.09	3.25	3.62	2.65	3.27	2.71	2.59	2.63	2.67	2.16		2.83

RRT Data			Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Mean
Total RRTS		110	115	119	128	148	117	119	107	120	90	113	92	125	115
RRTs per 1000 Patient Discharge Days		89	100	93	99	114	93	94	81	88	66	79	66	90	89
RRT Mortality	16% (↓ is better)	19%	23% n=25	22% n=23	24% n=28	20% n=26	12% n=13	28% n=31	20% n=21	17% n=20	17% n=15	19% n=21	16% n=14	19% n=24	20%
RRTs Within 24 hours of Arriving to Inpatient Unit	15% (↓ is better)	27%	26% n=30	23% n=27	25% n=32	20% n=30	23% n=27	13% n=16	19% n=20	23% n=28	32% n=29	24% n=27	20% n=18	27% n=34	23%
RRT- Med-Surg to Intermediate Critical Care Transfers	*9%	21%	23% n=26	13% n=16	21% n=27	18% n=26	22% n=19	19% n=23	21% n=22	20% n=24	10% n=9	15% n=17	12% n=11	27% n=31	18%
RRT- Med-Surg to Critical Care Transfers	*29%	9%	7% n=8	11% n=13	6% n=8	7% n=11	8% n=9	9% n=11	5% n=5	5% n=6	10% n=9	10% n=11	3% n=3	6% n=8	7%
RRT-Intermediate Critical Care to Critical Care Transfers	*33%	9%	12% n=14	6% n=7	9% n=12	10% n=15	3% n=4	13% n=12	5% n=5	7% n=8	6% n=5	5% n=6	8% n=7	4% n=5	8%

Better than Target | Does not meet Target | *Direction of goal is not being established

RRTs by Location

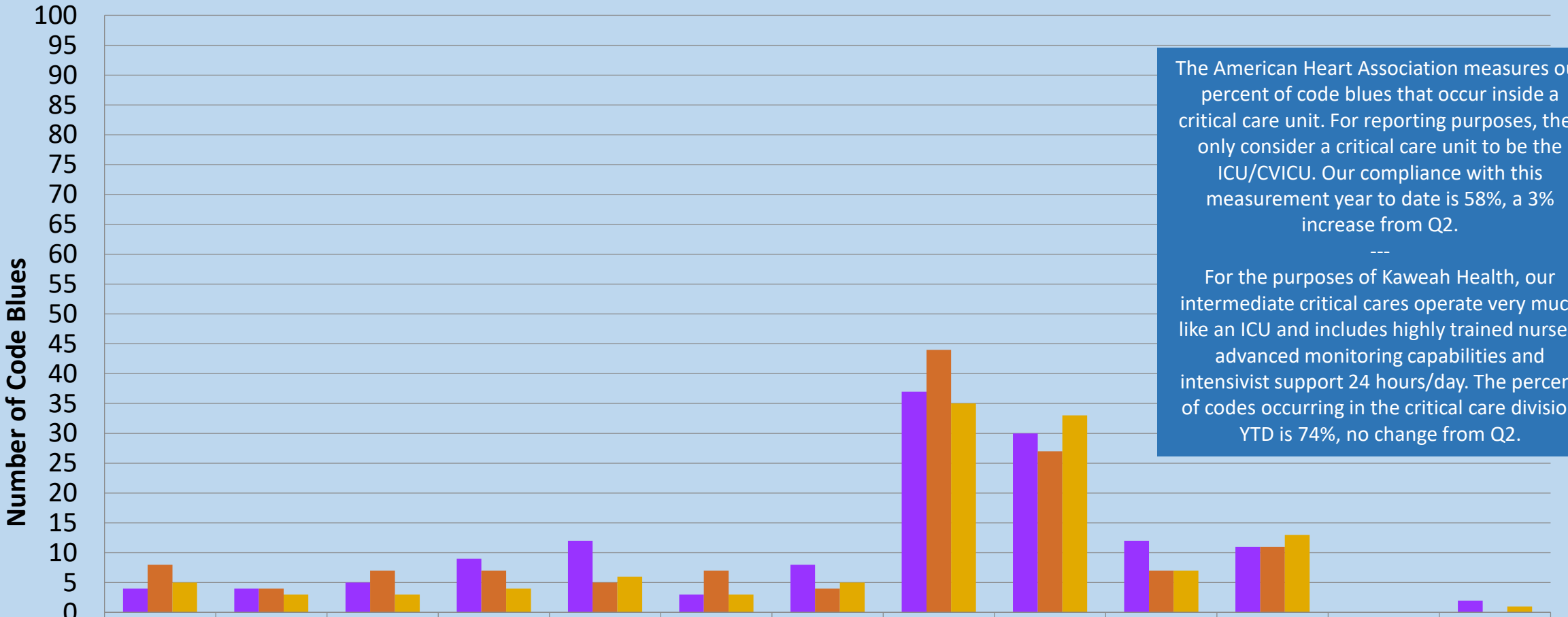


	3W	4S	5T	2S	3N	2N	4N	3S	4 Tower	1E	CVICU	ICU	BP
2022 n=1253	146	137	191	89	116	99	107	89	84	137	25	20	13
2023 n=1274	108	120	226	82	120	127	98	152	75	118	16	16	16
YTD 2024 n=982	62	107	152	86	90	108	58	96	66	110	16	17	14

The # of RRTs contrasted with the # of code blues is significant if there are a low # of rapids in contrast to a high # of code blues. This *could* indicate that we are missing an opportunity to rescue a patient and that could lead to poor outcomes.

This trend is monitored and opportunities for improvement are addressed with the involved units. Efforts include: sim lab time, 10 Signs of Vitality education and RRT nurse participation at unit staff meetings

Code Blues by Location



	2N	2S	3N	3S	4N	4S	4T	ICU	CVICU	3W	5T	BP	1E
2022 n=137	4	4	5	9	12	3	8	37	30	12	11	0	2
2023 n=131	8	4	7	7	5	7	4	44	27	7	11	0	0
2024 n=118	5	3	3	4	6	3	5	35	33	7	13	0	1

The American Heart Association measures our percent of code blues that occur inside a critical care unit. For reporting purposes, they only consider a critical care unit to be the ICU/CVICU. Our compliance with this measurement year to date is 58%, a 3% increase from Q2.

For the purposes of Kaweah Health, our intermediate critical cares operate very much like an ICU and includes highly trained nurses, advanced monitoring capabilities and intensivist support 24 hours/day. The percent of codes occurring in the critical care division YTD is 74%, no change from Q2.

Opportunities for Improvement

Opportunities:

- Increase compliance w/ confirmation of airway device placement

- Decrease the number of RRTs within 24 hours of admission.
  - Potential Root Causes
    - Improper level of care placement upon admission

Action Plan:

- Work w/ Respiratory Therapy Department to educate RTs on confirming airway device placement on a patient who codes that is already intubated or trached (unique to events in the ICUs/ICCUs)

- ER-STOP Trial complete September 30th.
  - Awaiting specific results based on the population the project was trialed on (VHMG Admissions to MS)

Upcoming Projects

- On-going support of 10 SOV Teaching during Hospital Orientation
- RRT nurse attendance and participation at unit staff meetings for education and hands-on training

Gold Award Celebrations!

Kaweah Health
MORE THAN MEDICINE. LIFE.

The pursuit of healthiness

Kaweah Health
MORE THAN MEDICINE. LIFE.

Outstanding Health Outcomes (OHO)
QUALITY & PATIENT SAFETY PRIORITY

Healthcare Acquired Infection (HAI) Reduction

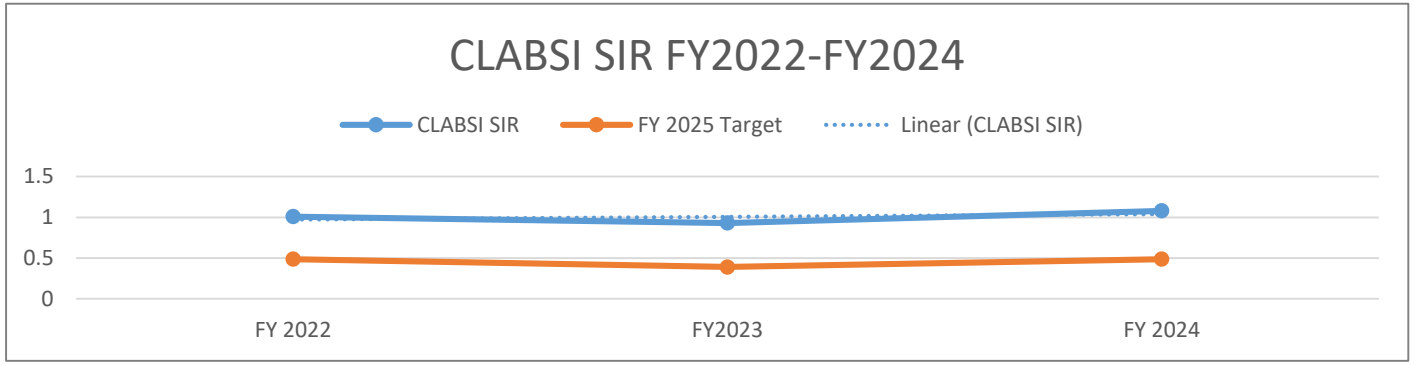
January 2025

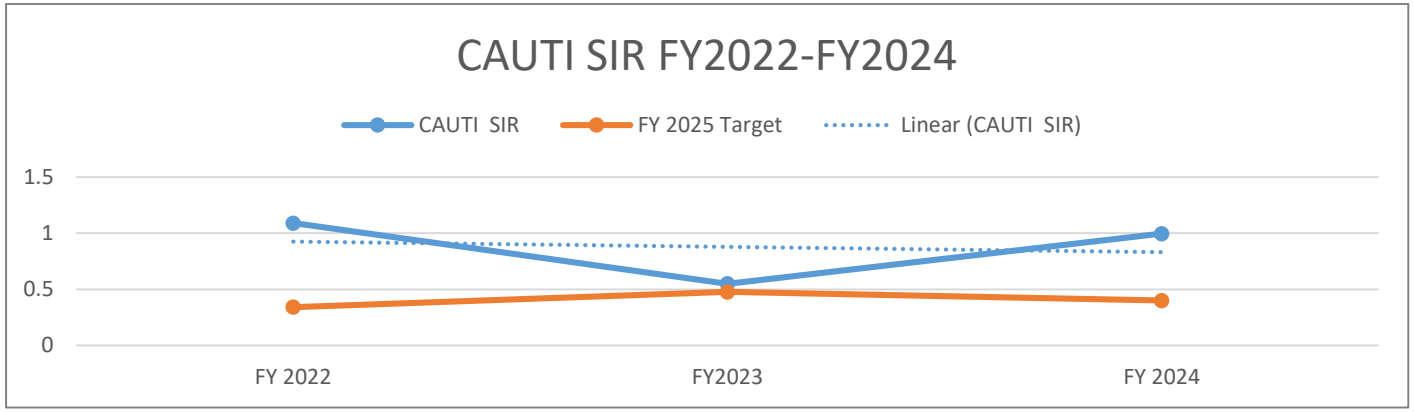
OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

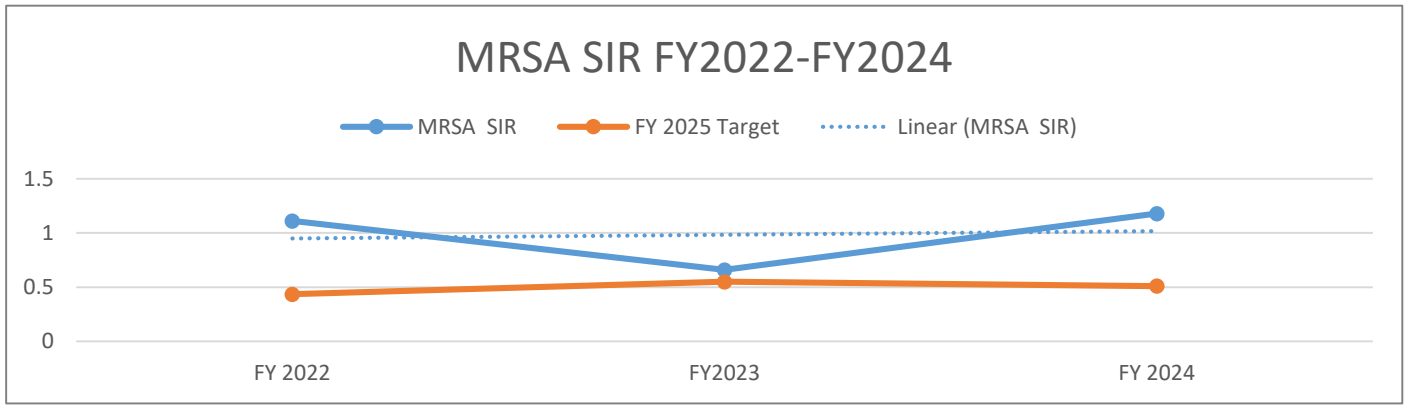
(number of actual infections/number of predicted infections by CMS)

CLABSI - Central Line-Associated Bloodstream Infection; CAUTI - Catheter-Associated Urinary Tract Infection; MRSA - Methicillin-Resistant Staphylococcus Aureus

Historical Baseline







FY25 PLAN – HAI Reduction CLABSI, CAUTI & MRSA SIR

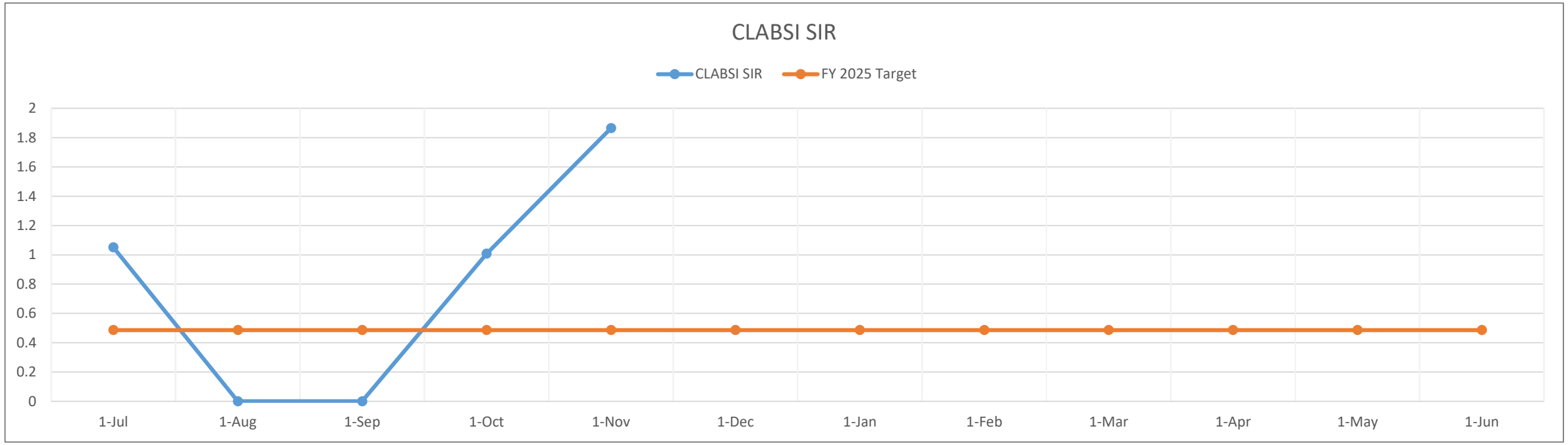
High Level Action Plan

- Reduce line utilization; less lines, less opportunity for infections to occur
  - Goal: reduce central line utilization ratio to <0.66
  - Goal: reduce urinary catheter utilization ratio to <0.64
- MRSA nasal and skin decolonization for patients with lines.
  - Goal: 100% of at risk patients nasally decolonized
  - Goal: 100% of patients with lines have a CHG bath
- Improve hand hygiene (HH) through increased use of BioVigil electronic HH monitoring system
  - Goal: 60% of staff are active users of BioVigil
  - Goal: 95% compliance with hand hygiene
- Improve environmental cleaning effectiveness for high risk areas
  - Goal: 90% of areas in high risk areas are cleaned effectively the first time (all area not passing are re-cleaned immediately)

FY25 GOAL

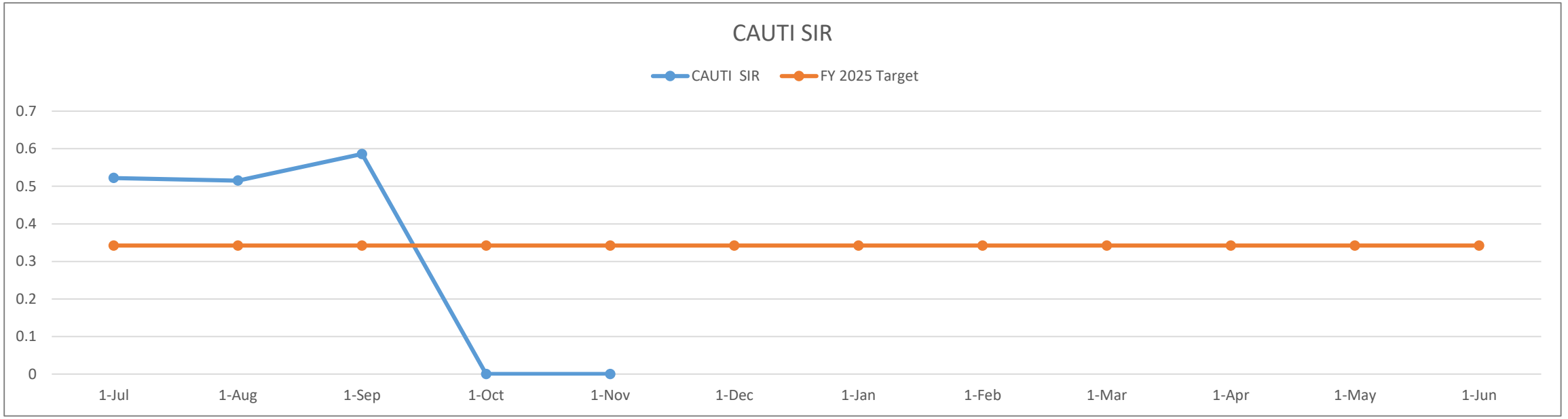
Decrease: CLABSI SIR to <0.486; CAUTI SIR to < 0.342; MRSA <0.435

OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)
(number of actual infections/number of predicted infections by CMS)



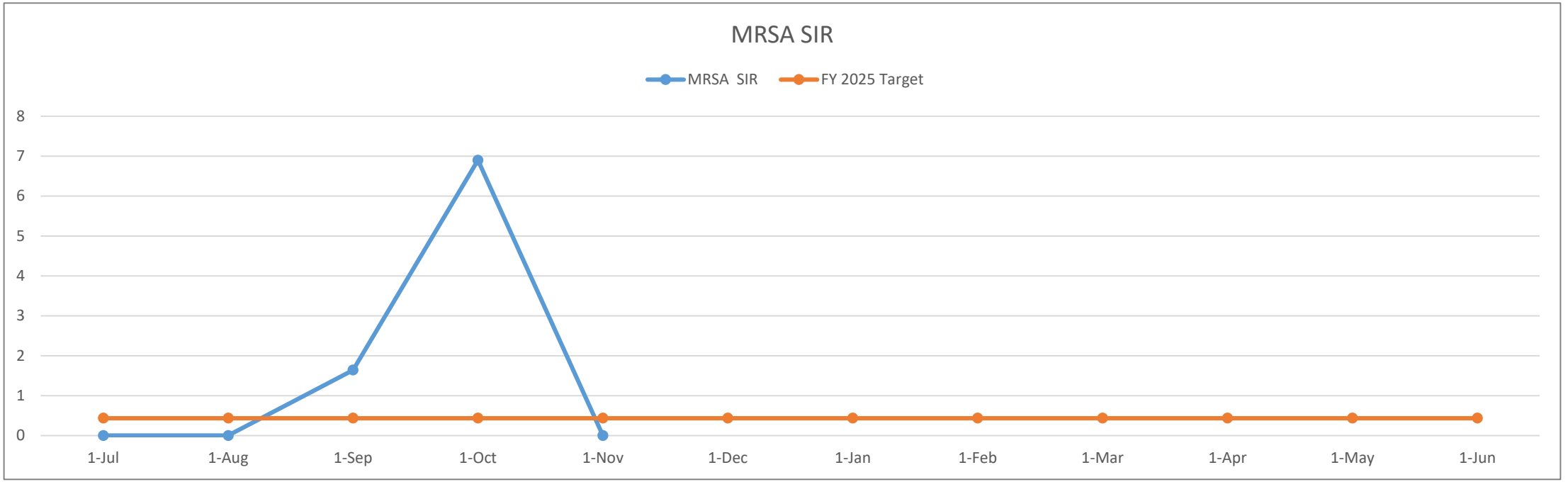
	FY 2025 Target	FY 2024	24-Jul	24-Aug	24-Sep	24-Oct	24-Nov	24-Dec	25-Jan	25-Feb	25-Mar	25-Apr	25-May	25-Jun	FYTD 25
CLABSI Events		17	2	0	0	1	2								5
CLABSI Predicted Events		16.06	1.051	1.117	0.121	1.008	1.072								5.369
CLABSI SIR	<0.486	1.06	1.903	0	0	0.992	1.865								0.93

OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)
(number of actual infections/number of predicted infections by CMS)



	FY 2025 Target	FY 2024	24-Jul	24-Aug	24-Sep	24-Oct	24-Nov	24-Dec	25-Jan	25-Feb	25-Mar	25-Apr	25-May	25-Jun	FYTD 25
CAUTI Events		9	1	1	1	0	0								3
CAUTI Predicted Events		22.58	1.917	1.94	1.707	1.577	1.54								8.861
CAUTI SIR	<0.342	0.4	0.522	0.515	0.586	0.00	0.00								0.420

OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)
(number of actual infections/number of predicted infections by CMS)



	FY 2025 Target	FY 2024	24-Jul	24-Aug	24-Sep	24-Oct	24-Nov	24-Dec	25-Jan	25-Feb	25-Mar	25-Apr	25-May	25-Jun	FYTD 25
MRSA Events		7	0	0	1	2	0								3
MRSA Predicted Events		9.62	0.501	0.482	0.485	0.290	0.51								3.051
MRSA SIR	<0.435	0.73	0	0	1.64	6.9	0								0.98

OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

The last data point did not meet goal because:

- Evidenced-based prevention strategies to reduce HAIs are not occurring

Targeted Opportunities

- Reduce line utilization; less lines, less opportunity for infections to occur
  - Goal: reduce central line utilization ratio to <0.663
  - July-Nov 2024 0.62
  - Goal: reduce urinary catheter ratio to <0.64
  - July-Nov 2024 0.92
- MRSA nasal and skin decolonization for patients with lines.
  - Goal: 100% of at risk patients nasally decolonized
  - Jul-Nov 2024 100% of screen patients nasally decolonized
  - Jul-Nov 2024 12% of patients admitted from a skilled nursing facility (at risk population) not screened or decolonized (if screen has a positive result)
  - Jul-Nov 2024 23% of patients re-admitted from another acute care facility within 30 days not screened or decolonized (if screen has a positive result)
  - Goal: 100% of line patients have CHG bathing
  - Will provide update following process implementation, delayed from 10/8 to 11/19 due to Cerner upgrade processes
- Improve hand hygiene (HH) through increased use of BioVigil electronic HH monitoring system
  - Goal: 60% of staff are active users of BioVigil
  - Jul-Nov 2024 52% of staff are active users
  - July-Nov 2024 HH Compliance rate overall 94% (goal 95%) – decreasing trend noted over 3 quarters
- Improve environmental cleaning effectiveness for high risk areas
  - Goal: >90% of areas in high risk areas are cleaned effectively the first time (all area not passing are re-cleaned immediately)
  - July- Nov 2024 Pass cleanliness effectiveness testing **95%** of the time in high risk areas

OHO FY25 Plan: HAI Reduction of Standardized Infection Ratio (SIR)

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
Expand Multidisciplinary rounds to include other stakeholders to reduce line use	12/2/24	Buy in from physician stakeholders
Skin decolonization for all line patients through CHG bathing training for CNAs and implementation to all units	10/8/24 Delayed until 11/19	Cerner update – ISS instituted a "Freeze" from 10/16-11/4. Went live 11/19, not all CNAs completed checklist as of 12/2/24. This is related to new education processes in workday/Lippincott. Completion reports sent to mangers regularly with options to get CNAs signed off if they work in an area where there are less patients with central lines.
MRSA screening form workflow changes to ensure patients who reside at a SNF and/or have been readmitted in past 30 days are automatically MRSA decolonized for a positive nasal swab result	1/31/25	Time to establish Cerner workflows for patient access to assist nursing in collecting relevant information from patients
Hand Hygiene compliance dashboard disseminated monthly to leadership (increase awareness and accountability). QI resources disseminated to leadership to use for unit/dept level improvement work	12/2/24 and ongoing	Requests for additional badges/docking stations; periodic inaccurate reports due to the workflow behind electronic removal of termed employees (inhibits leaders ability to hold staff accountability)
Effective cleaning – Post staff competency, identify targeted equipment/surfaces for focused QI work	12/1/24	None
Bedrails most often failing testing – focused attention on cleaning through huddles, coaching.	12/31/24	None
Transport staff to help with patient care equipment cleaning	Ongoing	None
Prevention bundles – regular rounding by Advanced Practice RN to identify and correct in the moment; Evaluation of new IV insertion kits with markers to ensure site is date/timed to aid in timely dressing change	12/1/24 & Ongoing TBD	None

Thank you

Live with passion.

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

Kaweah Health

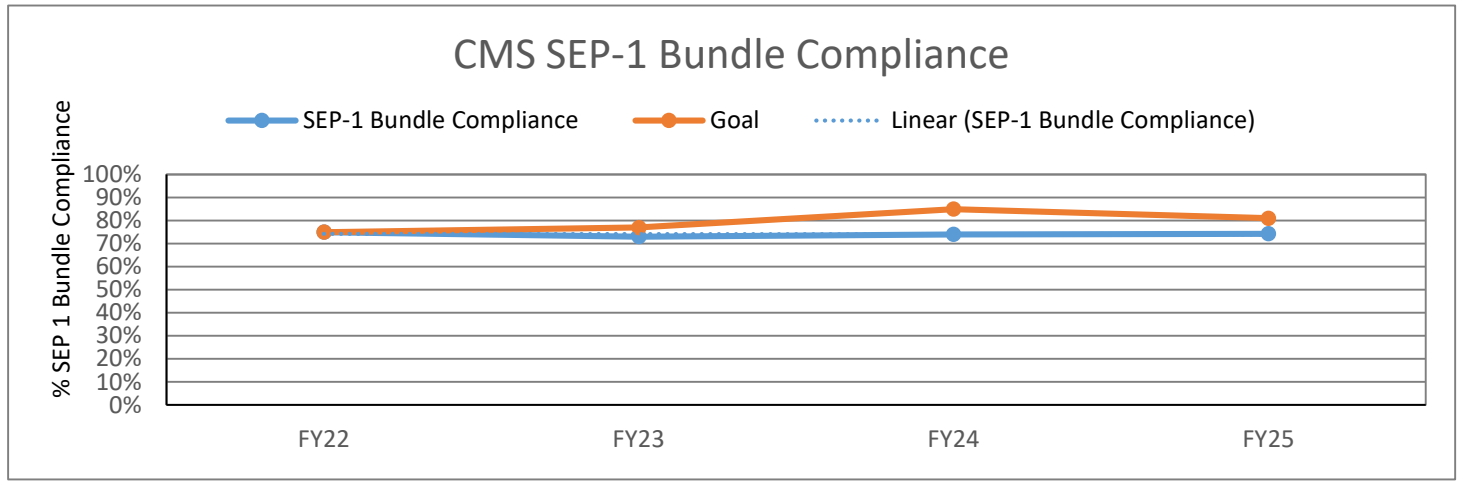
Outstanding Health Outcomes (OHO)
QUALITY & PATIENT SAFETY PRIORITY

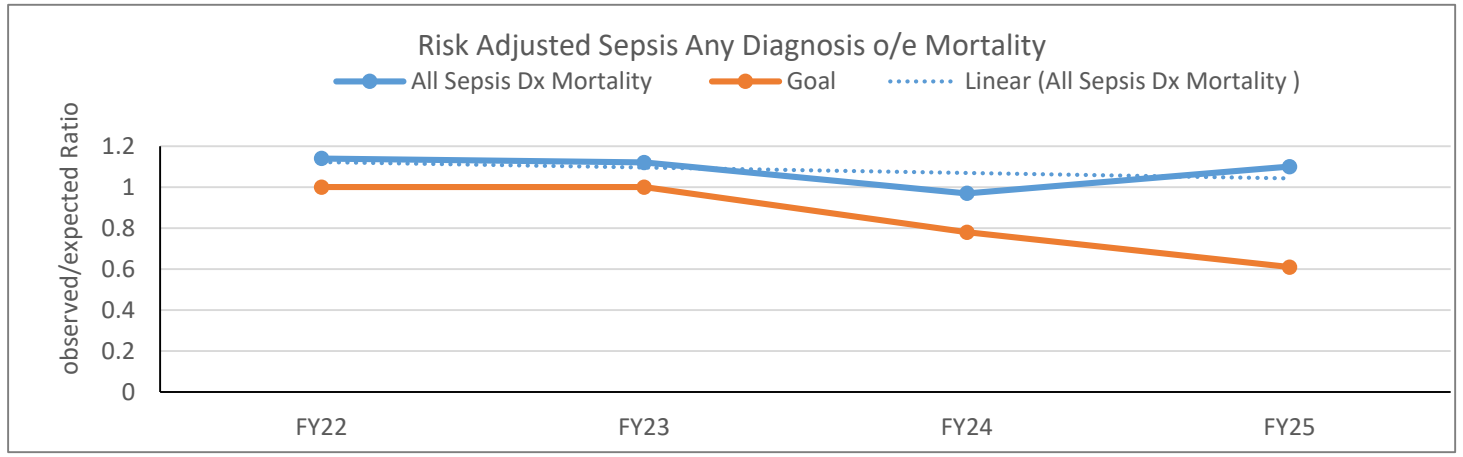
Sepsis CMS SEP-1 & Sepsis Mortality

January 2025

OHO FY25 Plan: CMS SEP 1 and Mortality (observed/expected)

Historical Baseline





FY25 GOAL

Increase SEP-1 Bundle Compliance ≥ 81%

Decrease Sepsis any diagnosis Mortality ≤ 0.61

FY25 PLAN – CMS SEP-1

High Level Action Plan

- Provide Early Goal Directed Therapy (Sepsis work up and Treatment)

  % of Patients provided top 3 most frequently missed Sepsis bundle elements

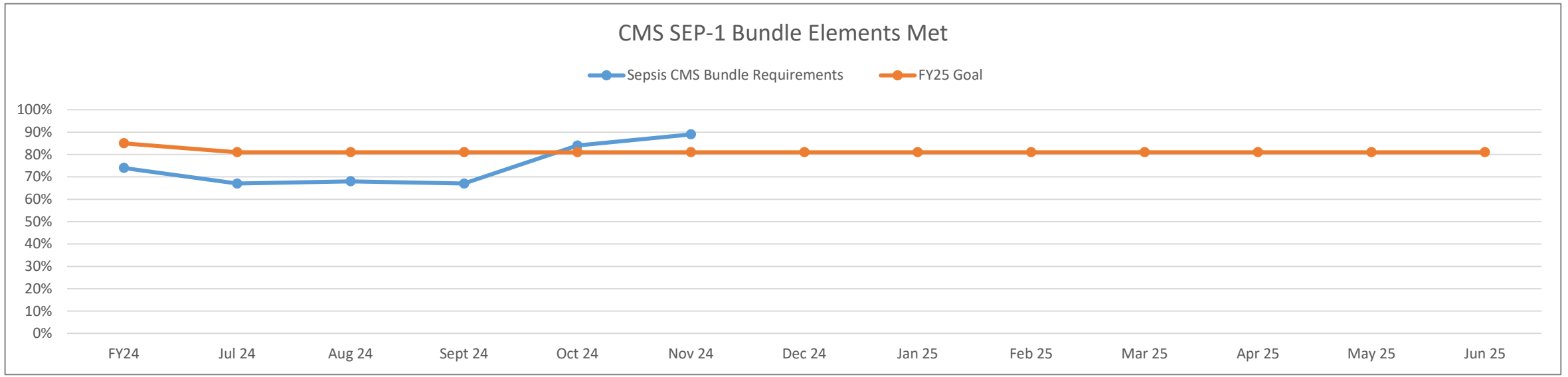
  Goal FY 25 95%

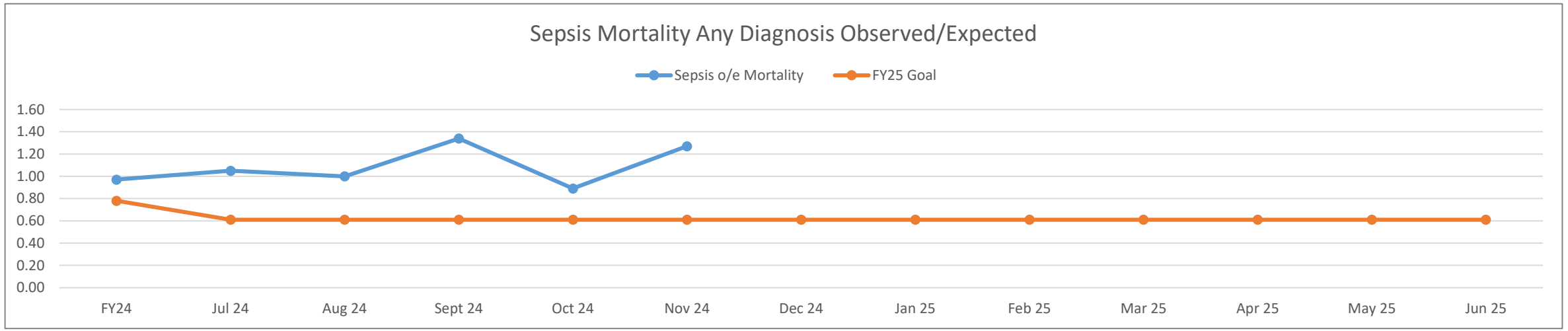
  - IV Fluid Resuscitation
  - Antibiotic Administered
  - Blood Cultures Drawn
- Provide Early Goal Directed Therapy (Sepsis Treatment)

  Goal FY 25 = 30%

  - Pts with Sepsis that Received Abx within 60 Minutes of Pt 1st Seen
  - Pts Met 1- Hr Bundle

OHO FY25 Monthly Update: CMS SEP-1 & Mortality





OHO FY25 Monthly Update: CMS SEP-1 & Mortality

The last data point did not meet goal because:

- Differential diagnosis of infections are not being treated with Sepsis interventions or are not being refuted when Sepsis is no longer entertained
- Providers ordering Sepsis bundle elements outside the Sepsis power plan omitting important information required by CMS (i.e., lesser fluids)
    - Providers prefer to order or not order fluid at their discretion due to concerns for fluid overloading patients (afraid to harm pts)
- 1 (one) case BC & Initial LA not ordered timely by ED provider, & 1 (one) case BC , Repeat LA, & Fluids noted ordered timely by ED provider- Sepsis reassessment not documented by ED provider
- ED Throughput challenges

Targeted Opportunities

- Provide Early Goal Directed Therapy (Sepsis work up and Treatment)

  FY25

  - % of Patients provided top 3 most frequently missed Sepsis bundle elements at KH (Higher performance = Better care)
  - IV Fluid Resuscitation 95%
  - Antibiotic Administered 91%
  - Blood Cultures collection 92%

  Goal = 95%
- Provide Early Goal Directed Therapy (Sepsis Treatment)

  FY25

  - Pts with Sepsis that Received Abx within 60 Minutes of Pt 1st Seen by ED Provider 31.77%
  - Pts Met 1- Hr Bundle 28.16%

  Goal = 30%

OHO FY25 Monthly Update: CMS SEP-1 & Mortality

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
1. GME Resident engagement and ongoing education throughout the year, not just during yearly orientation ○ Ongoing collaboration with Chief ED Residents ✓ Ongoing education during weekly didactic ○ 2 Resident project focus on Sepsis power plan utilization awareness & ED Provider pop-up to declare or refute sepsis prior to inpatient transfer ○ Collaboration with Dr. Stanley for engaging educational material ○ Engage with ACTS team for ongoing Sepsis education to surgical residents	Ongoing	GME program strict curriculum limited time to devote to ongoing Sepsis education throughout the year
2. Code Sepsis in ED (workgroup in progress)	Preliminary Discussion to continue in January 2024	ED Throughput challenges, treatment space limitations & staffing challenges No designated blood culture resource Potential for 13-16 code Sepsis in a 24 hour window ED leadership support onboarding Dec 2024
3. Enhancements to EMR to help care team identify patients that need Sepsis work up and treatment timely ○ Sepsis reference checklist added to Sepsis order set	10/2024	None

OHO FY25 Monthly Update: CMS SEP-1 & Mortality

CURRENT IMPROVEMENT ACTIVITIES	EXPECTED COMPLETION DATE	BARRIERS
4. Sepsis multidisciplinary collaboration with SIM (Simulation in Medical Science) Lab ○ Planned for Spring 2025 (possible in situ SIM)	Spring 2025	Potential Inpatient (hospitalist, intensivist) engagement limitations
5. Mortality summary reviews presented to Sepsis committee workgroup for Sepsis 1-hour bundle success review, analysis & improvement strategies	November 25, 2024	None
6. Improve Severe Sepsis Alert Specificity (EMR optimization) ○ Collaborate with ISS team and Cerner EMR resources to optimize Sepsis alert ○ Decrease lookback window (for labs and vital signs) from Cerner 36 hours to 8 hrs for more meaningful alerts	TBD	Limitations within Cerner cloud Concerns with disrupting existing algorithm

Thank you

Live with passion.

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

Kaweah Health