SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE REGULAR MEETING
AGENDA
WEDNESDAY, February 25, 2015
5:00 p.m. Regular Session
(Closed Session will be held upon adjournment of the Regular Session)

Location: Schantz Conference Room
Sonoma Valley Hospital – 347 Andrieux Street, Sonoma CA 95476

AGENDA ITEM	RECOMMENDATION	
MISSION STATEMENT *The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.*		
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
2. PUBLIC COMMENT SECTION *At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less, Under State Law, matters presented under this item cannot be discussed or acted upon by the Committee at this time For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Committee consideration.*	*Hirsch*	
3. CONSENT CALENDAR Quality Committee Minutes, 1.28.15	*Hirsch*	Action
4. SNF ANNUAL REPORT	*Evans*	Inform
5. QUALITY REPORT FOR JANUARY 2015	*Lovejoy*	Inform/Action
6. FINAL 2014 QC DASHBOARD	*Lovejoy*	Inform/Action
7. 2015 QA/QI PRIORITIZATION GRID	*Lovejoy*	Discussion
8. CLOSING COMMENTS/ANNOUNCEMENTS	*Hirsch*	
9. ADJOURN	*Hirsch*	
10. UPON ADJOURNMENT OF THE REGULAR OPEN SESSION	*Hirsch*	
11. CLOSED SESSION: Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Amara*	Action
12. REPORT OF CLOSED SESSION	*Hirsch*	Inform
13. ADJOURN	*Hirsch*	

3.

CONSENT CALENDAR

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING MINUTES
Wednesday, January 28, 2015
Schantz Conference Room

Committee Members Present		Committee Members Excused	Admin Staff /Other
Jane Hirsch Carol Snyder Susan Idell Kelsey Woodward Cathy Webber		Joshua Rymer Ingrid Sheets Paul Amara MD	Leslie Lovejoy Robert Cohen, MD Mark Kobe Gigi Betta

AGENDA ITEM	DISCUSSION	ACTION	FOLLOW-UP
1. CALL TO ORDER	*Hirsch*		
	Meeting called to order at 5:00 pm		
2. PUBLIC COMMENT	*Hirsch*		
	None.		
3. CONSENT CALENDAR	*Hirsch*	Action	
Minutes: A. Quality Committee Minutes, 12.18.14		**MOTION** by Idell to approve Minutes *as amended* and 2nd by Mainardi. All in favor.	Carol Snyder appears twice on 12.18.14 Minutes.
4. QUALITY REPORT DEC. 2014	*Lovejoy*	Inform/Action	
	Ms. Lovejoy shared the Quality Dept. priorities for January 2015 including Regulatory Agency follow-up visits, Population Health, Case Management orientations and redesign, and infrastructure and education.		
5. AHRQ CULTURE OF SAFETY SURVEY REPORT	*Lovejoy*	Inform/Action	
	During the 2014 Wellness Fair at the end of October, the Quality Dept. asked for feedback using the AHRQ (Agency for Healthcare Research and Quality		Email Culture of Safety Report to QC.

AGENDA ITEM	DISCUSSION	ACTION	FOLLOW-UP
	CMS Culture of Safety Survey to measure progress. The next measurement period will be during the Wellness Fair in the fall 2015. In 2015, all Leaders will be trained to use the Midas program to report events. Every year a *fresh* Health Stream module will be assigned to staff.		
6. SVH ANNUAL REPORT	*Hirsch*	Discuss	
			The incorrect Report was included in the QC Agenda Package. Board Clerk to email the correct Annual Report to QC.
7. PROPOSED 2015 QC WORKPLAN	*Hirsch/Lovejoy*	Inform/Discuss/Action	
	Ms. Lovejoy presented the 2015 Work Plan and it was approved by all.	**MOTION** by Mainardi to approve Work Plan and 2nd by Snyder. All in favor.	Board Clerk will add meeting dates to the Work Plan 2015. Bring final plan forward to next meeting.
8. DASHBOARD SUBCOMMITTEE	*Lovejoy, Woodward, Rymer, and Idell*	Discuss	
			Board Clerk to schedule the first Dashboard Subcommittee meeting.
7. CLOSING COMMENTS/ANNOUNCEMNTS	*Hirsch*		
	Ms. Hirsch presents the *BOARD INVOLVEMENT IN QUALITY OVERSIGHT* to the Board of Directors on 2.5.15.		Ms. Hirsh asked the Committee to email any suggestions on the direction and/or level of the Board's involvement.
8. ADJOURN	*Hirsch*		

AGENDA ITEM	DISCUSSION	ACTION	FOLLOW-UP
	Regular session adjourned at 5:42 pm		
9. UPON ADJOURNMENTOF REGULAR OPEN SESSION	*Hirsch*		
10. CLOSED SESSION	*Amara*	Action	
Calif. Health & Safety Code § 32155 • Medical Staff Credentialing & Peer Review Rpt. • Quality Assurance Report			
11. REPORT OF CLOSED SESSION	*Hirsch*		
12. ADJOURN	Closed Session adjourned at 5: 55 pm		

4.

SNF ANNUAL REPORT

2014 Annual Quality Report for Sonoma Valley Hospital's Skilled Nursing Facility

Regulatory Requirements

- Sonoma Valley Hospital's D/P SNF is regulated by the California Department of Public Health Licensing Division, Life Safety Code Division, Office of Statewide Hospital Planning and Development (OSHPD), Cal OSHA, Title 22 California Code of Regulations, and The Department of Health and Human Services Centers for Medicare and Medicaid Services.

Vision, Mission, and Values

- The ***Mission*** of Sonoma Valley Hospital is: "To improve, maintain and restore the health of everyone in our community." Our ***Vision*** is to be the "Lifelong healthcare guide(s) to everyone in our community." The ***Values*** that guide us spell "CREATING"; (Compassion, Respect, Excellence, Accountability, Teamwork, Innovation, Nurturing, and Guidance).

Stakeholders

- Primary Stakeholders of Sonoma Valley Hospital's D/P SNF are; it's patients, our workforce, the physicians, and the community.

Key Performance Measures/SNF

- **Key Performance Measures include:** Patient Satisfaction, Staff Satisfaction, Reducing fall and restraint rates, managing expenses, monitoring Psychotropic drug use, tracking employee turnover, achieving excellent survey outcomes, reducing readmission rates, and administering immunizations against Flu and Pneumonia to all patients.

The 2014 National Quality goals for SNF's are:

- Reduction in Psychotropic Drug use
- Reduction in re-admission rates back to acute care hospitals
- Increase patient satisfaction
- Increase Staff retention

Key Elements of our QAPI Program

- Key elements of our Performance improvement (PI) system include Quality Monitoring for high risk-high volume, high risk- low volume, and problem-prone patients. Our plans are based on industry standards and Best Practices and revised quarterly based on results.

QAPI –Key Elements

- PDSA (“Plan, Do, Study, Act”)
- RCA (Root Cause Analysis)
- PI (Performance Improvement Committee)
- Safety Committee
- LEM (Leadership Evaluation Manager)
- Monthly Dashboard
- Quality Control Monitoring

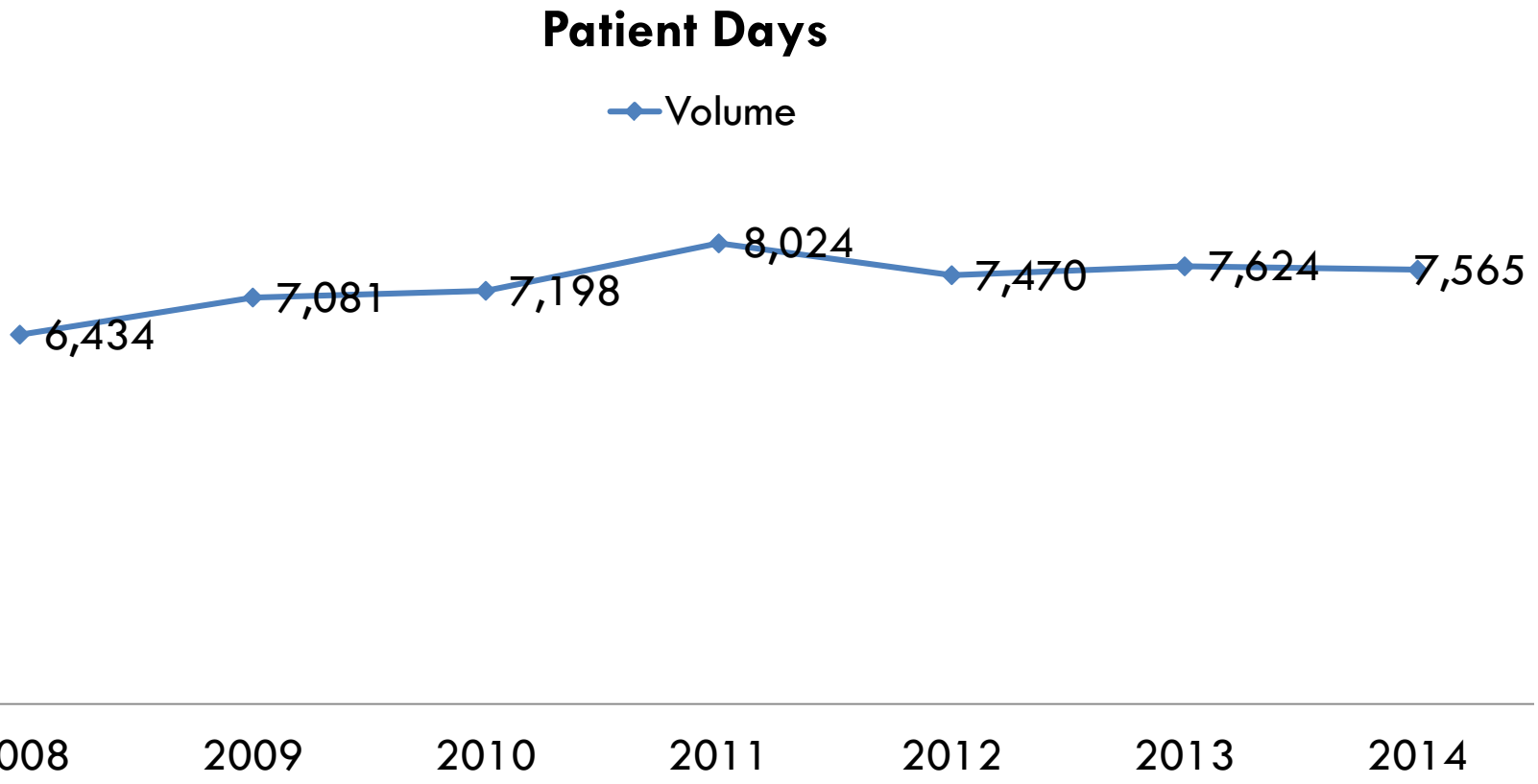
PDSA – Cost Accounting

The SNF's 2014 "Plan, Do, Study, Act" was based on our new cost accounting project which began in March 2014. The project was led by Michelle Donaldson, CRO and Leslie Lovejoy, CNO/CQO.

We started the project with a -10% profit margin. We have implemented changes in resource utilization on the SNF. To date, we have achieved a + 9% profit margin through our cost accounting tactics.

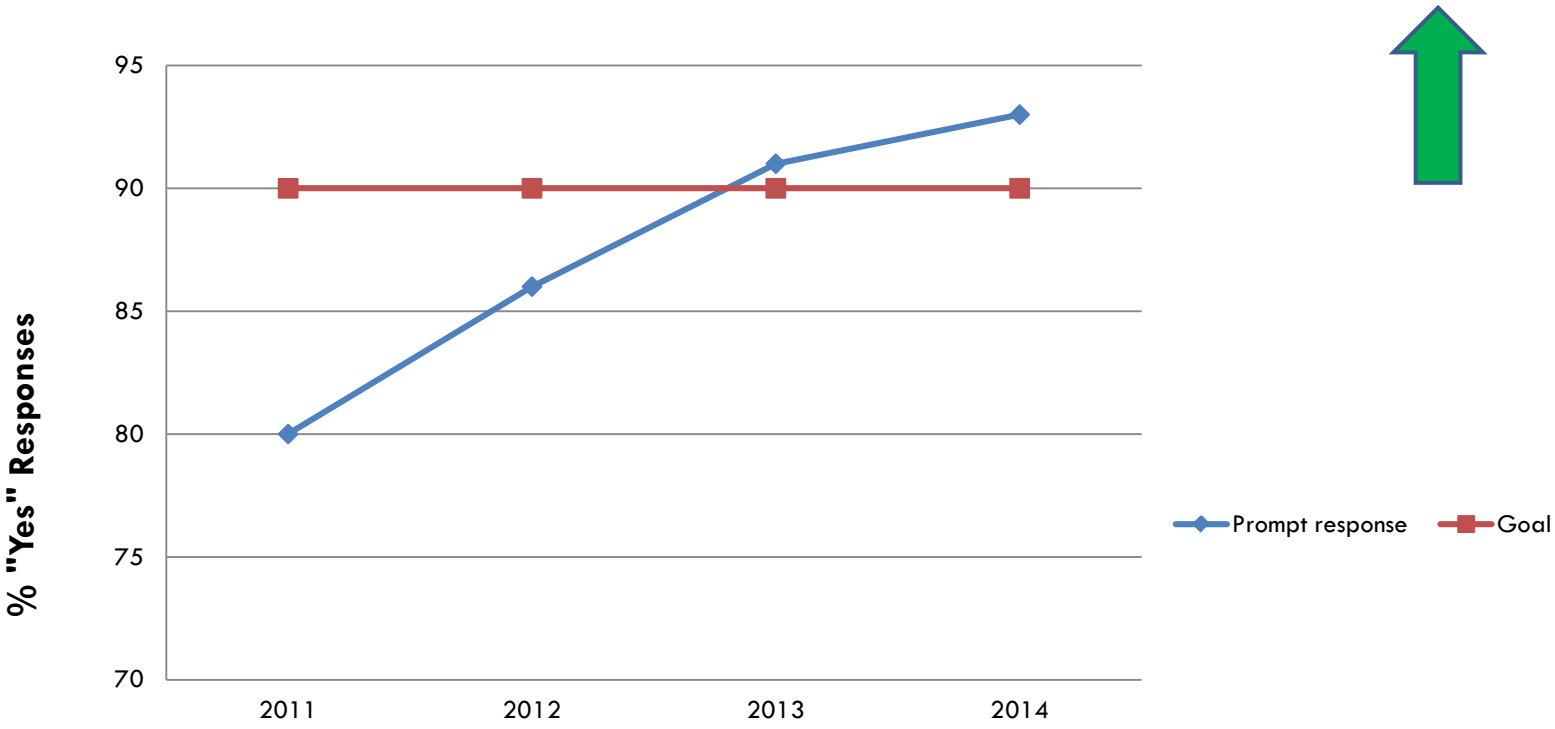
The project has had an impact on almost every department in the hospital. Physician ordering practices have changed as a result of this project.

Trends in Growth



Patient Satisfaction

"Prompt Response to Call Lights" as measured by the Post Discharge questionnaire.

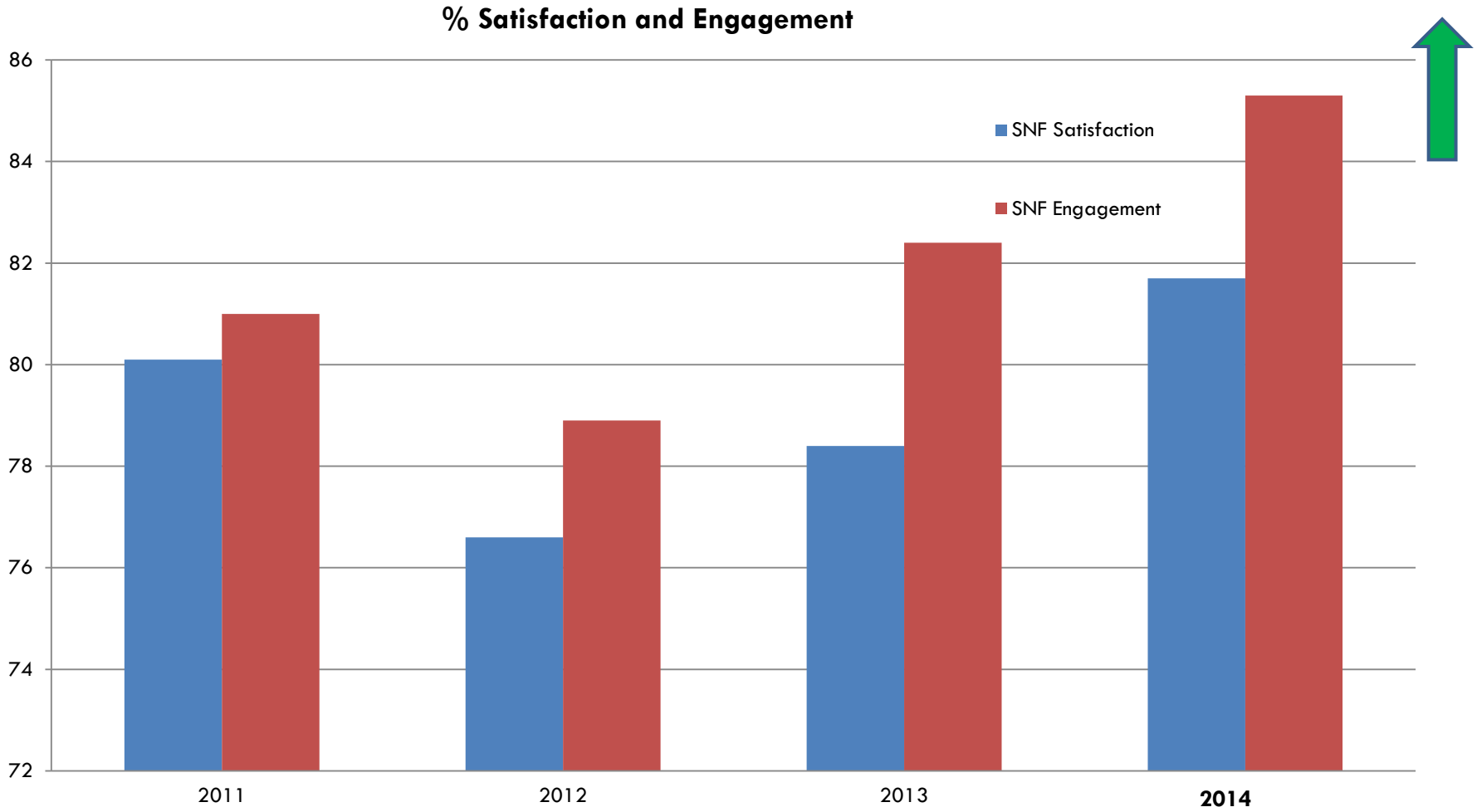


Key Areas of Patient Satisfaction

- SVH 's D/P SNF has focused on several key areas of Patient Satisfaction throughout the organization; *Prompt Response to call lights, a Clean and Quiet environment, and Nurses kept you informed*. The SNF has reached the 90% benchmark in all 3 areas.
- In order to align with the goals of the acute care hospital we focused solely on "prompt response to call lights" in 2014 and achieved a 93% patient satisfaction score.

  (Results derived from the 2014 Post- Discharge Questionnaires).

SNF Staff Satisfaction and Engagement- Press Ganey Results



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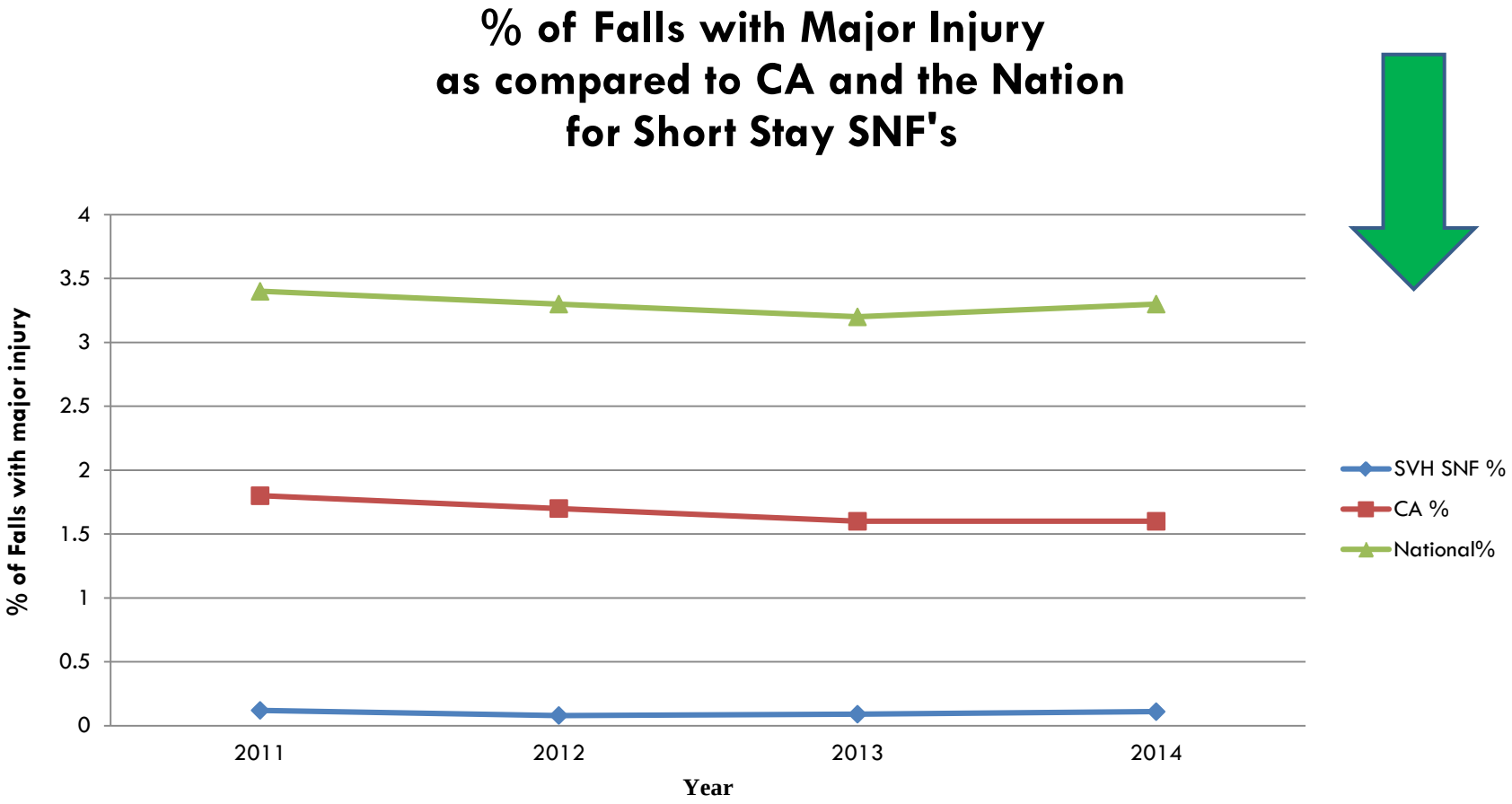
2014 Staff Satisfaction Action Plan

The Skilled Nursing staff voted on the following tactics in 2014 to increase staff satisfaction:

- "SNF Employee of the Month" (Melissa to provide gift basket.)
- New speakers to attend staff meetings.
- More breakfast "pot lucks" to include night shift.

(All of these have been accomplished).

Falls



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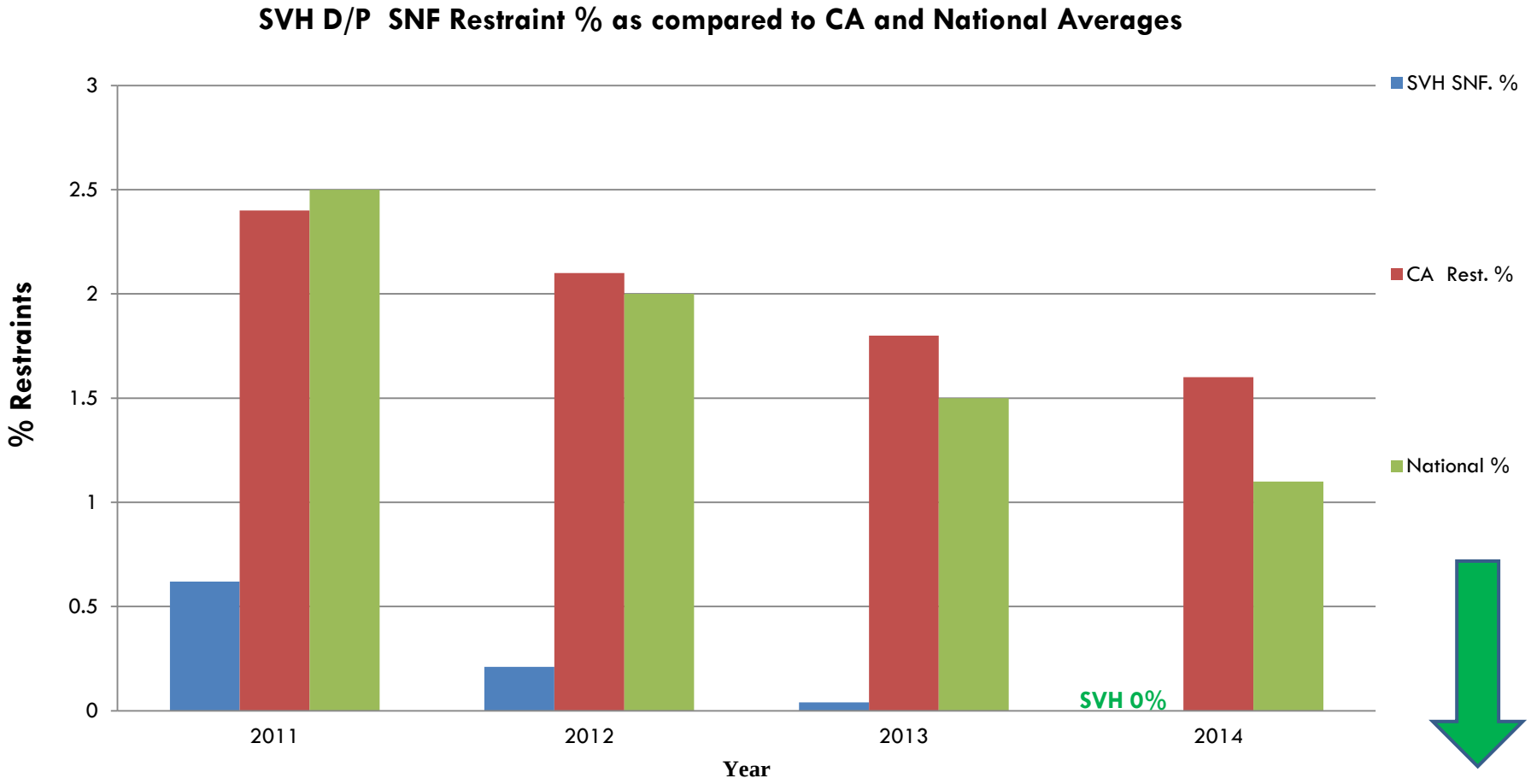
Fall rates

- Fall prevention is a priority on the SNF. We have a PI project dedicated to falls and report results to QAPI and Safety Committee quarterly. Results are compared against CA and National averages over a 4 year period. Our results are considerably lower than CA and National averages (0.09% to 0.12%) but we have not seen a significant reduction in falls despite our increase in technology. We have purchased new personal alarms, use low beds with alarms, and place patients at risk in close proximity to Nursing Station. Staff receives ongoing training in fall prevention. *There is a correlation between low restraint rates and consistent fall rates.* (Data derived from Certification and Survey Provider Enhanced Report (CASPER) reports, and SVH's QAPI program.

SNF Restraint Rates

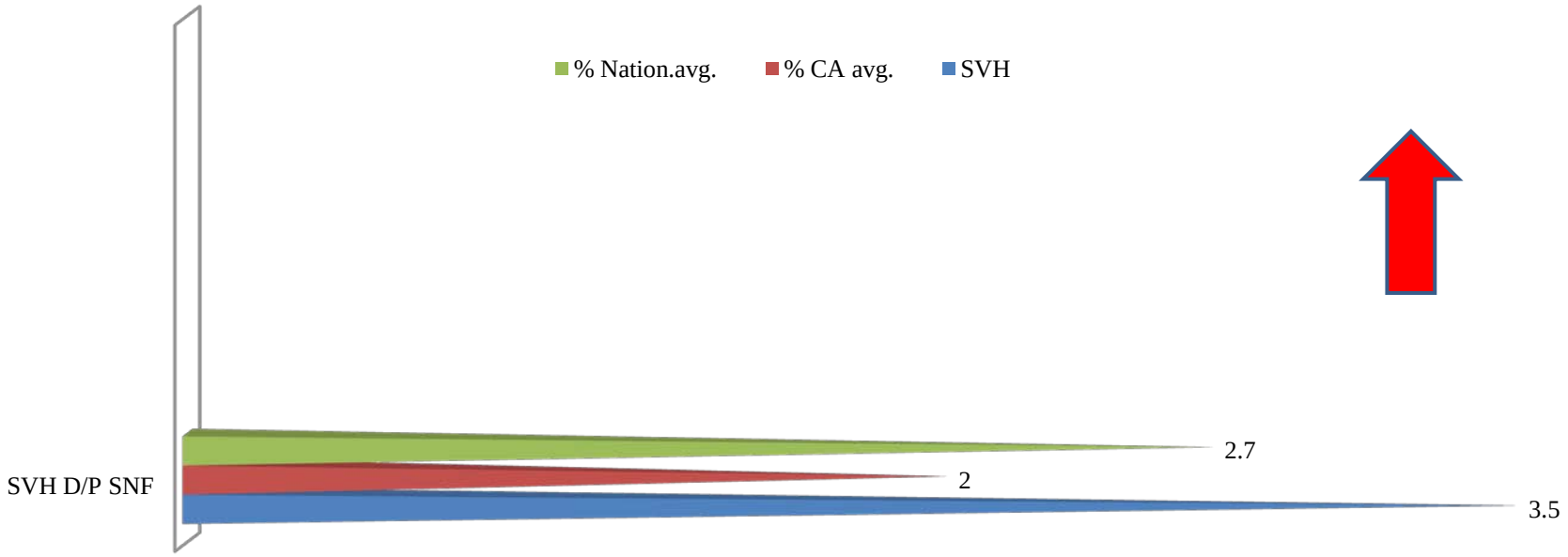


Restraint Rates on the SNF

- The Restraint rate has dramatically decreased over the past 4 years. The staff at SVH's D/P SNF are aware that the only reason to use restraints is if the patient is attempting to discontinue life sustaining treatment. Our Restraint rate for 2014 was 0%. We score well below CA and National benchmarks for the past 4 years. We attribute positive result to extensive training and competency testing on the SNF. (Data obtained from MDS 3.0 reports, CASPER reports, AHCA Quality data and our own QAPI results.)

Psychotropic Drug Use

% Off Label Psychotropic Drugs as compared to CA and the Nation in 2014



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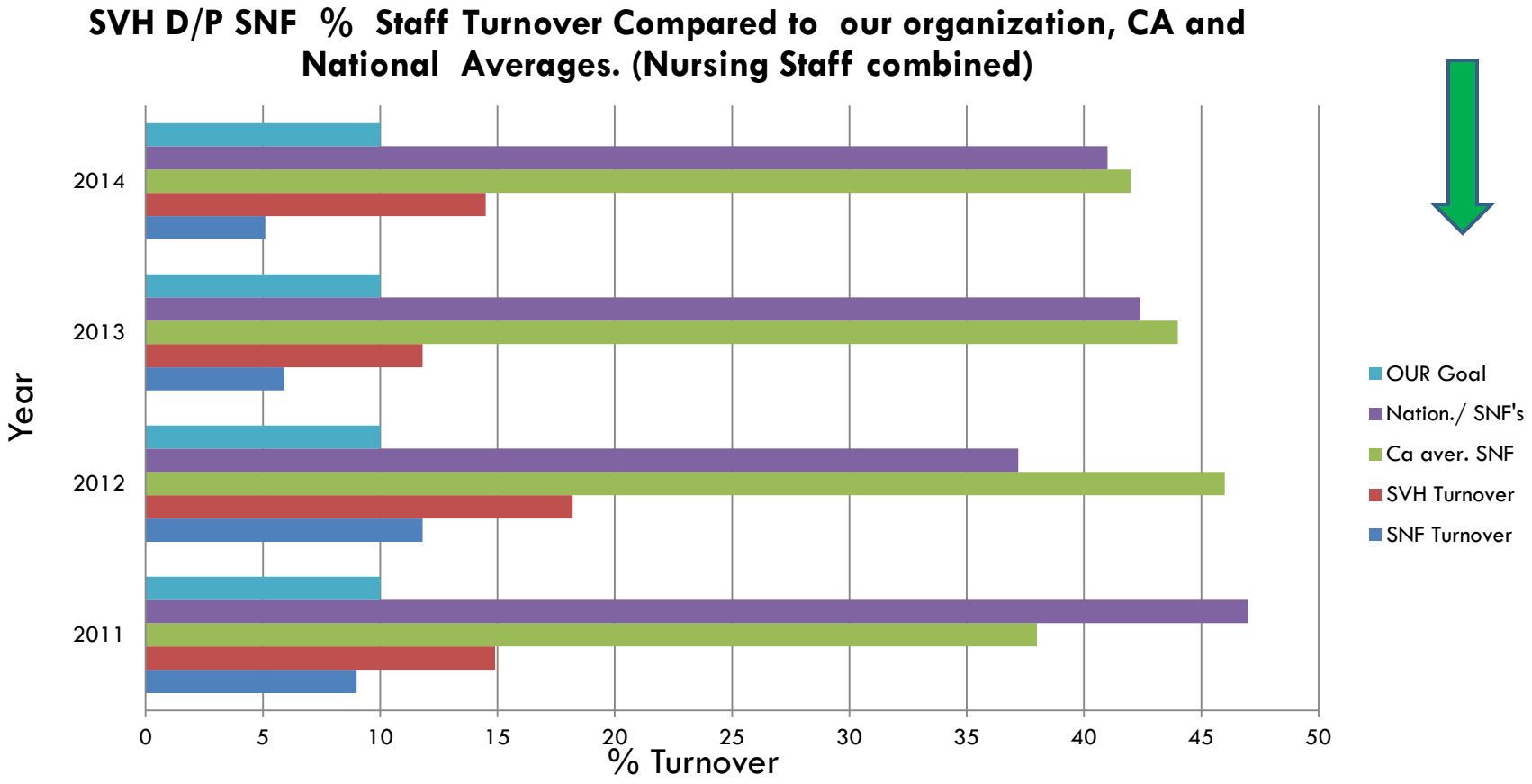
Psychotropic Drug Rates on the SNF

- Psychotropic drug use was 3.5% on our SNF in 2014. This is over the CA and National average of 2.0 – 2.7 %.
- We attribute this to a patient population who is more acutely ill and suffers from acute delirium.

(Results derived from MDS data and CASPER reports).

Employee Turnover



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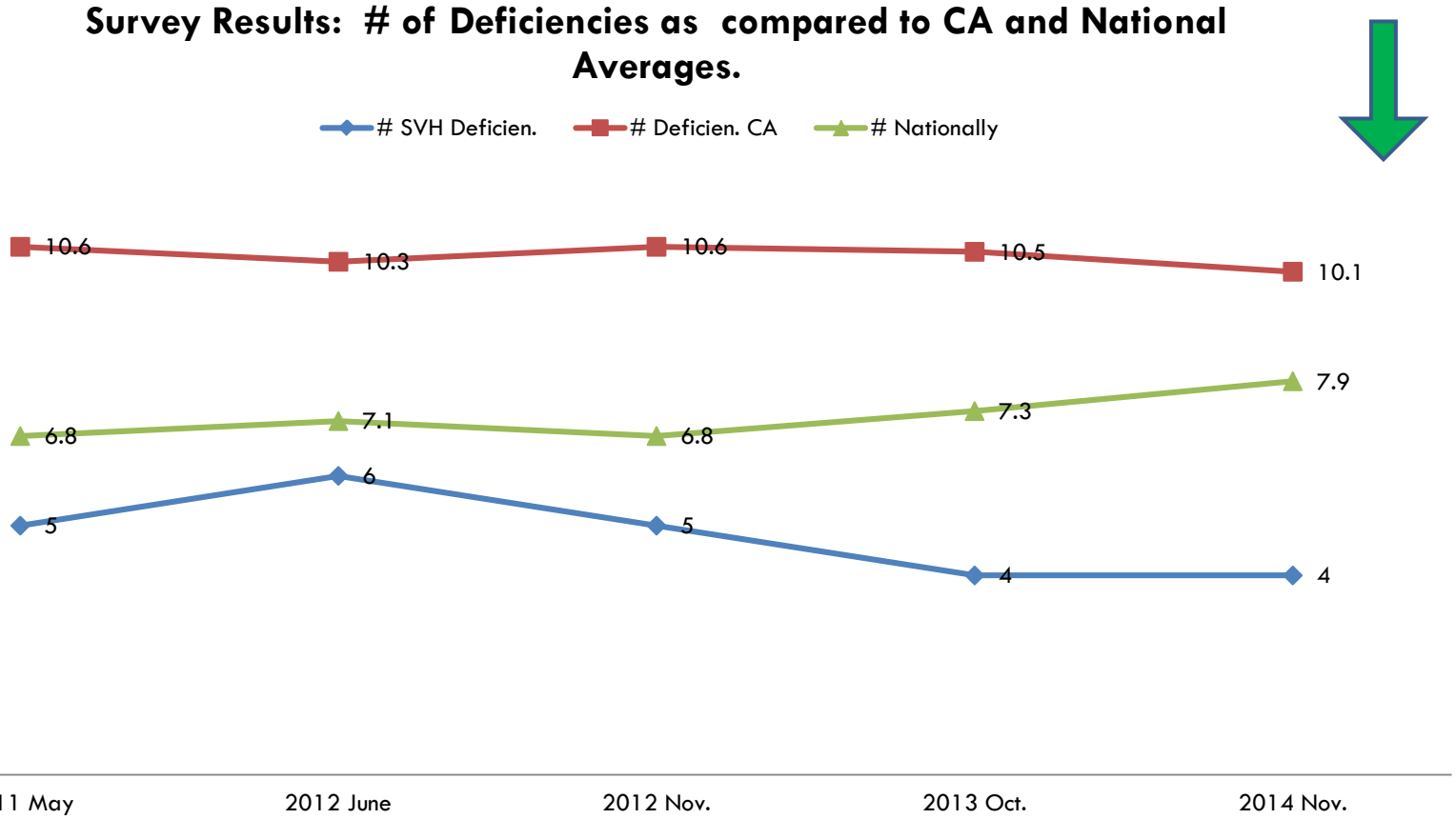
Employee Turnover in the SNF

- Employee turnover on the SNF has been between 5-11% for the past 4 years . In 2014 the turnover rate was 5.7 %. We score below organizational, State and Federal averages. We attribute this low turnover to highly satisfied and engaged staff. (Data derived from CAHF, AHCA and SVH's Human Resources Department.

Survey Results



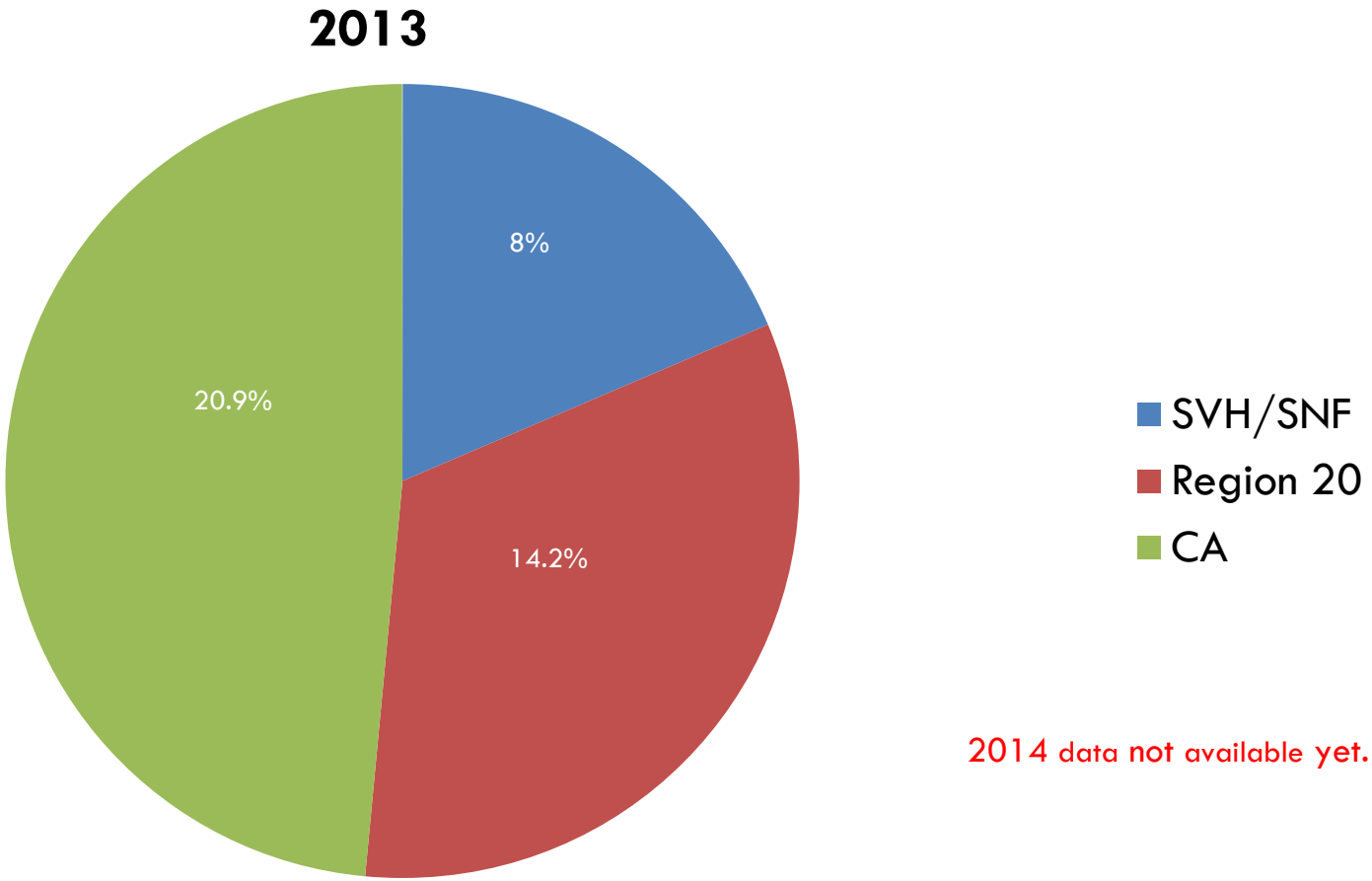
Medicare's 5 – Star Rating System

- Medicare.gov *Nursing Home Compare* website provides a "5 - star rating system for consumers to make informed decisions about Skilled Nursing Facilities.
- Ratings are based on Health Inspections, staffing ratios and quality measures.
- After our most recent survey in November, 2014, Sonoma Valley Hospital's D/P SNF is currently rated as a 5 – Star SNF.

AHCA Quality Awards

- SVH D/P SNF has earned the American Health Care Association, (AHCA), National Quality Award in 2013 and 2014.
- In 2014 we earned the National Silver Quality Award. The award is based on the Malcolm Baldridge criteria for excellence.
- There were only 6 SNF's in CA to earn this award.

30 day Re- admission Rates from SNF to Acute Care Hospitals.



2014 data not available yet.

30 day readmission rate

- The 30 day readmission rate from our SNF back to Acute care hospital(s) was 8.0% in 2013. (Compared to 14.2% for our region and 20.9% for CA.)
- We attribute this low readmission rate to the ability of our SNF to care for patients who are more acutely ill.

Data derived from Health Services Advisory Group, Medicare Fee for Service Hospital Readmissions Report 2013.

Strategic Challenges on the SNF

- Small, 27 bed D/P SNF in an acute care setting.
- Extensive physician training has been required to avoid over utilizing resources that decrease our profitability.
- District owned, we accept patients with no insurance.
- Managed Care increasingly involved in approving SNF days.
- All RN Nursing staff is more expensive than hiring LVN's.
- HPPD's are higher than most SNF's due to acuity, (approx. 6.2 HPPD compared to the 3.2 HPPD State requirement.)

Strategic Advantages of the SNF

- Close proximity to acute hospital and ER.
- All of the acute care services are available to us.
- Electronic Medical Records.
- Frequent MD visits and all RN staff allow for the admission of more acutely ill patients.
- 24 hour physician and pharmacy available.
- History of strong community support.

5.

QUALITY COMMITTEE REPORT FEBRUARY 2015

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

To: Sonoma Valley Healthcare District Board Quality Committee
From: Leslie Lovejoy
Date: 02/25/15
Subject: Quality and Resource Management Report

February Priorities:

1. Nurse Leaders Retreat
2. Performance Evaluations
3. Leadership education schedule for Quality 2015
4. Roll –out of Surgery Scheduling and Preop process
5. Quality Dashboard Revision meeting

1. Nurse Leaders Retreat

All the nurse leaders meet offsite at least twice per year to identify process ans systems issues, competencies and opportunities to continue to build a highly skilled and professional nursing team. We include the Skilled Nursing Facility and Home Care as well. Last year we addressed telemetry coverage and skills, cross training, skills fair competencies, mock codes drills and bar code scanning for electronic medication administration. This year, we will be working on the development of a big picture nursing scorecard, wound care, effective documentation, implementing a medical screening process for the OB nurses, and standardizing the acuity system. We are also in the process of a transition in the CNO role and have two new managers for OB and Med Surg that will need mentoring over this year.

2. Performance Evaluations

We are in the process of doing annual performance improvement evaluations for the whole organization. The process involves employee self evaluation and goal setting and then a one to one with their leader to review performance and set 2015 goals.

3. Leadership education schedule for Quality 2015

Over the past two years, we have set an infrastructure and electronic process for reporting for leadership in the area of Quality. Based on interactions with leaders and observations from surveys, I have decided that this year will be on in which we revisit the process and begin to refine and hardwire them. I will be looking at department specific QAPI plans and quality monitoring with each leader to ensure that what is being measured is meaningful and their efforts at continuous improvement are effective. I also want to look at the e-notification system now that 90% of leaders have been trained and are using it and standardize how it is being used. I also want to prepare the leaders for the new Midas module that we will be training on in July. I have attached the schedule for your information.

4. New Surgical Services Scheduling and Preop Process

As part of the Surgical Services Transformation Project, a performance improvement project was started to address the surgery scheduling and preoperative process for both outpatient and inpatient surgeries. It was decided to return to a paper chart for outpatient surgeries until a true electronic outpatient record could be built and maintain an electronic record for all inpatient surgeries. In addition, scheduling forms were revised using best practices from other hospitals and the flow of information from the physician's office to the department was improved in order to reduce waste and increase efficiency. Now that we have all the pieces in place and through committees, we will be hosting a physician office luncheon, this month, to roll-out the new process and set expectations beginning March 1st. The team will monitor the effectiveness of the new process going forward to look at any issues that emerge.

Topics for discussion: SNF Annual Report; 2015 QA/PI Project Prioritization; proposed Quality Dashboard for 2015

Quality Assurance & Performance Improvement

Ongoing Leadership Coaching and Learning Opportunities 2015

I. ***Webinar Topic: Dissecting the CMS QAPI Audit Probe***

February 27, 2015 11AM – 12:30 PM Schantz Conference Room

II. ***Need Some Coaching? Drop-in for Consultations during Quality Clinic!***

1st Thursday of every month from 9AM -10:30AM

3rd Wednesday of every month from 1PM – 2:30PM

The focus is on how to write PI plans, plans of correction for surveys,quality indicators; developing performance improvement projects; creating data reports and how to talk about your data; deciding on and writing up your annual PI project for the Fair.

III. ***Get the most out of Microsoft Outlook***. *Cindi Newman will be sending invitations for 2 workshops this year.*

Let's get organized! Learn how to use Outlook to manage all your emails and set priorities.

IV. ***E-Notification Drop In Sessions in the IT Training Room***

Every Thursday from 3PM to 4PM

Keep caught up with your work list and documentation of responses to grievances!

E. ***IHI Open University (self serve)****: Learn at your own pace from national best practices.*

Quality Modules

Patient Safety Modules

Leadership

Population Health

Contact Cindi Newman to get signed up.

F. ***Introduction to Statistical Process Control: What is the data telling me?***

A Basic introduction to variation in data, the use of control charts to look at your data and knowing how and when to respond to changes. A prequel to using STATIT PIMD for the novice.

June 18th from 2PM -4PM

G. ***STATITPIMD Training:***

A new Midas module implementation and training for leaders wishing to apply Statistical Process control to Data management and Decision Makin. ***More to come on this****. Classes will begin in July and be ongoing for the rest of the year.*

Annual PI Fair: Wednesday, September 30, 2015 0730-1530 Basement Conference Room

6.

QUALITY COMMITTEE DASHBOARD 2014

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

BOARD QUALITY COMMITTEE DASHBOARD 2014

The following are quality and patient safety indicators selected by the Board Quality Committee for quarterly reporting as part of the oversight mandate for ensuring the organization has an effective quality assurance and performance improvement program (QAPI).

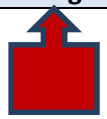
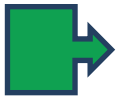
1. Surgical Services Volumes by Service Fiscal Year 2014/2015

	Jul-Sept2014 Q1.FY15		Oct-Dec2013 Q2.FY14		Jan-Mar2014 Q3.FY14		Apr-Jun2014 Q4.FY14		Totals
SERVICE	**IP**	**OP**	**IP**	**OP**	**IP**	**OP**	**IP**	**OP**	
General	29	58	24	33	27	44	27	56	**298**
OBGYN	16	11	17	29	14	26	12	16	**141**
Ophthalmology	0	55	0	37	0	59	0	65	**216**
Orthopedic	46	106	51	101	70	98	52	93	**617**
Pain Management	0	44	0	63	0	35	1	55	**198**
Podiatry	0	4	1	6	0	11	0	7	**29**
Urology	0	12	0	1	3	10	0	9	**35**
Vascular Surgery	0	1	0	2	0	3	0	2	**8**
Endoscopy	8	83	11	91	18	89	17	93	**410**
Totals	**99**	**374**	**104**	**363**	**132**	**375**	**109**	**396**	**1952**

2. Emergency Department Patient Performance

a. **Time from presentation to the ED to time seen by MD based on a sampling of cases.**

Measurement:	Emergency Department Patient Throughput (Lower # is Better)
Category:	Patient Safety
Definition:	Time from arrival in ED to being seen by an MD in minutes (Average)

CALENDAR YEAR 2013	2014 Q1	2014 Q2	2014 Q3	2014 Q4	Q Change	YTY (2013/14) Trend	Benchmark Goal	Benchmark Perform
27.72	20.69	26.64	27.01	30.06			30	

Note: Reliable data collection in EMR is in development >>>GO LIVE with PhysDoc 05/2014<<<<

b. Time from decision to admit to bed on inpatient unit until patient departure from ED based on a sampling of cases.

Measurement:	Time from admit decision to depart to bed (Lower # is Better)
Category:	Patient Safety
Definition:	Time from decision to admit patient to departure to assigned bed in minutes (Average)

CALENDAR YEAR 2013	2014 Q1	2014 Q2	2014 Q3	2014 Q4	Q Change	YTY (2013/14) Trend	Benchmark Goal	Benchmark Perform
60.69	47	103.471	117.127	170.457			96	

Patient Satisfaction: Quality Patient Experience

Patient satisfaction is measured by the Press Ganey Patient Satisfaction Questionnaire that is mailed to the patient's home two weeks post discharge. There are many questions on the survey and the hospital has shown a significant improvement over the past two years. We chose 3 questions upon which to focus our attention.

Measurement:	Noise Level in and around rooms (Higher # is Better)
Category:	Patient Satisfaction
Definition:	% of Patients responding to Patient Satisfaction Survey who gave a score of 5 (Very Good)

**new Survey Vendor*

CALENDAR YEAR 2013	2014 Q1	2014 Q2	2014 Q3	2014 Q4	Q Change	YTY (2013/14) Trend	Benchmark Goal	Benchmark Perform
73%	69.4%	74.7%	42.9%	52.8%			90.00%	

Measurement:	Explanations re: tests and treatments (Higher # is Better)
Category:	Patient Satisfaction
Definition:	% of Patients responding to Patient Satisfaction Survey who gave a score of 5 (Very Good)

**new Survey Vendor*

CALENDAR YEAR 2013	2014 Q1	2014 Q2	2014 Q3	2014 Q4	Q Change	YTY (2013/14) Trend	Benchmark Goal	Benchmark Perform
86.93	86.3%	88.5%	*Not measured w/ new vendor*	*Not measured w/ new vendor*			90.00%	

Measurement:	Likelihood to recommend SVH to others (Higher # is better)
Category:	Patient Satisfaction
Definition:	% of Patients responding to Patient Satisfaction Survey who gave a score of 5 (Very Good)

**new Survey Vendor*

CALENDAR YEAR 2013	2014 Q1	2014 Q2	2014 Q3	2014 Q4	Q Change	YTY (2013/14) Trend	Benchmark Goal	Benchmark Perform
88.95	90.6%	91.3%	71.4%	75.5%			90.00%	

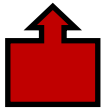
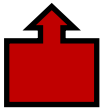
3. Readmissions Rates: Quality Patient Outcomes

Data is captured for patients who return to SVH within 30 days. The hospital focuses on four specific diagnostic groups as they are currently tied to Medicare pay-for-performance.

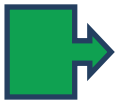
Measurement:	Readmission Rates for Medicare Patients (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	Readmitted to SVH within 30 days - All Diagnosis

CALENDAR YEAR 2013	2014 Q1	2014 Q2	2014 Q3	2014 Q4	Q Change	YTY (2013/14) Trend	Benchmark Goal	Benchmark Perform
5.80%	3.101%	5.385%	4.959%	7.76%			16.0%	

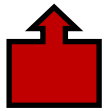
Measurement:	Readmission Rates for Medicare Patients (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	Readmitted to SVH within 30 days with Same Diagnosis (DRG)

CALENDAR YEAR 2013	2014 Q1	2014 Q2	2014 Q3	2014 Q4	Q Change	YTY (2013/14) Trend	Benchmark Goal	Benchmark Perform
2.24%	2.5%	4.6%	2.8%	4.3%			TBD	TBD

Measurement:	Readmission Rates for Medicare Patients (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	Readmitted to SVH within 30 days with AMI (Heart Attack)

CALENDAR YEAR 2013	2014 Q1	2014 Q2	2014 Q3	2014 Q4	Q Change	YTY (2013/14) Trend	Benchmark Goal	Benchmark Perform
0.00%	0.00%	0.00%	0.00%	0.00%			18.0%	

Measurement:	Readmission Rates for Medicare Patients (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	Readmitted to SVH within 30 days with CHF (Congestive Heart Failure)

CALENDAR YEAR 2013	2014 Q1	2014 Q2	2014 Q3	2014 Q4	Q Change	YTY (2013/14) Trend	Benchmark Goal	Benchmark Perform
9.17%	**0.00%**	**0.00%**	**9.09%**	**0.00%**			**23.0%**	
			1 readmission					

Measurement:	Readmission Rates for Medicare Patients (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	Readmitted to SVH within 30 days with PNE (Simple Pneumonia)

CALENDAR YEAR 2013	2014 Q1	2014 Q2	2014 Q3	2014 Q4	Q Change	YTY (2013/14) Trend	Benchmark Goal	Benchmark Perform
2.78%	**0.00%**	**0.00%**	**0.00%**	**0.00%**			**17.6%**	

Measurement:	Readmission Rates for Medicare Patients (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	Readmitted to SVH within 30 days with COPD (Chronic Obstructive Pulmonary Disease)

CALENDAR YEAR 2013	2014 Q1	2014 Q2	2014 Q3	2014 Q4	Q Change	YTY (2013/14) Trend	Benchmark Goal	Benchmark Perform
4.13%	**0.00%**	**0.00%**	**0.00%**	**15.39%**			**TBD**	**TBD**

2 Readmissions

Measurement:	Readmission Rates for Medicare Patients (Lower # is better)
Category:	Quality Patient Outcomes
Definition:	Readmitted to SVH within 30 days Hip/Knee Arthroplasty

CALENDAR YEAR 2013	2014 Q1	2014 Q2	2014 Q3	2014 Q4	Q Change	YTY (2013/14) Trend	Benchmark Goal	Benchmark Perform
2.70%	**0.00%**	**0.00%**	**0.00%**	**0.00%**			**5.4%**	

Chart Definitions:	Calendar Year	Average of all quarters previous year
	Q Change	Change from previous quarter/calendar year
	YTY Trend	Change from previous calendar year s based on an average of the annual values.
	Benchmark goal	External standard or internally set benchmark for quality performance
	Benchmark Perform	Most recent quarter performance against the benchmark goal
		Red means performance declined or does not meet the benchmark goal
		Green means improved performance or meeting the benchmark goal

4. Hospital Acquired Infections: Quality Patient Outcomes and Safety

Infections are tracked for 16 different categories of infections are reported in detail only if quarterly or YTD performance does not meet the benchmark set and therefore potentially merits clinical and management remedial action. The following table summarizes those infection categories being tracked which are within benchmark.

Infection Category	Within Benchmark
Central line associated bloodstream infections	
Hospital acquired Cdiff infections	
Inpatient, MRSA infections	
VRE bloodstream infections	
Hip surgical site infections	
Knee surgical site infections	
Overall surgical site infections	
Class I SSI rate	
Class II SSI rate	
Total Joint SSI rate	
Ventilator Associated Events	
Hospital acquired Pneumonia	
Inpatient Hospital acquired Catheter associated urinary tract infections	
Home Care associated infections	
MRSA Active Surveillance cultures	
Flash sterilization measurements	

7.

PERFORMANCE IMPROVEMENT PRIORITIZATION MATRIX 2015

Sonoma Valley Hospital

Quality Assessment/Performance Improvement Project Prioritization and Approval Grid

2015-2016

Score of 18 or greater chosen as high risk areas for performance improvement activities for this year

Type of Risk	Indicator or Activity	Rationale	Depts	Probability		Human Impact	Environ	Business Impact	Internal Resources	External Resources	Total Score	Outcome
				High Prob 5	Low Prob 1	High Impact 5	↔	Low Impact 1	Weak Resources 1	Strong Resources 5		Approved/tabled/ Not approved
Hi Vol, Med Risk, & PP	**Population Health: CCN and Outpatient Delivery system**	Improve patient care; reduce hospital utilization; improve population health status	Case Mgmt, Nut. Serv., Social Serv, Outpatient depts, Home Care, SNF, & Medical Staff	5		3	0	4	3	5	20	Approved
Leads	**Lovejoy, Cohen, Donaldson**											
Hi vol, Hi Risk, & PP	**Paragon 12.1 & 13 Upgrade**	Improve ease of accuracy of charting for patient care	Informatics, Patient Care Team, Medical Staff,IT	5		5	2	1	1	4	18	Approved
Leads	**Sendaydiego, Cohen**											
Hi Vol, Hi risk, & PP	**Home Care Transforma-tion Project**	Fiscal Stewardship and Process Efficiencies	Home Care Team; IT; Informatics; Business Office	5		3	0	4	3	3	18	Approved
Leads	**Donaldson, Lovejoy, Lee**											

Hi Vol, Hi Risk, & PP	**Email Encryption**	Improve security of PHI	IT; All email Users	5		3	0	3	5	3	19	Approved
Leads	**Sendaydiego, Lovejoy**											
Key												
Risk: hi or low risk to patient/staff safety												
Volume: hi or low volume of patients/staff												
Problem prone: hi or low potential for process or systems issues												
Probability: refers to potential success of team; 1= very low, 5=very high												
Impact: will the initiative have an impact on: Patients/Staff, the envionment, our business												
Resources: do we have the resources to effectively address this initiative.												