SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING AGENDA
Wednesday, April 23, 2014
5:00 p.m. Regular Session
(Closed Session will be held upon adjournment of the Open 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	*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: A. Quality Committee Minutes, 03.26.14	*Hirsch*	Action
4. POLICY & PROCEDURE APPROVAL	*Lovejoy*	Action
5. QUALITY REPORT APRIL 2014	*Lovejoy*	Inform
6. ANNUAL PERFORMANCE IMPROVEMENT EVALUATION AND GOALS REPORT	*Lovejoy*	Inform/Action
7. CLOSING COMMENTS/ANNOUNCEMENTS	*Hirsch*	
8. ADJOURN	*Hirsch*	
9. UPON ADJOURNMENT OF THE REGULAR OPEN SESSION	*Hirsch*	
10. CLOSED SESSION: Calif. Health & Safety Code § 32155 – Medical Staff Credentialing & Peer Review Report	*Amara?*	Action
11. REPORT OF CLOSED SESSION	*Hirsch*	Inform

3.

CONSENT CALENDAR

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING MINUTES
Wednesday, March 26, 2014
Schantz Conference Room

Committee Members Present	Committee Members Present	Committee Members Absent/Excused	Admin Staff /Other
Jane Hirsch John Perez Robert Cohen M.D. Susan Idell	Leslie Lovejoy Howard Eisenstark Kevin Carruth	Paul Amara M.D. (vacation) S. Douglas Campbell M.D.	Melissa Evans Gigi Betta Richard Adams Carol Snyder

AGENDA ITEM	DISCUSSION	ACTION	FOLLOW-UP
1. CALL TO ORDER	*Hirsch*		
	Meeting called to order at 5:02pm. Mr. Hirsch introduced Richard Adam and Carol Snyder, both applicants for the Quality Committee open positions and sitting in on tonight's meeting.		
2. PUBLIC COMMENT	*Hirsch*		
	None.		
3. CONSENT CALENDAR	*Hirsch*	Action	
A. QC Meeting Minutes, 2.26.14		**MOTION:** by Idell to approve 2.26.14 Minutes and 2nd by Eisenstark. All in favor.	
4. POLICIES & PROCEDURES	*Lovejoy*	Action	
a) Emergency Department b) Environmental Services c) Information Management d) Organizational Multiple Departments e) Pharmacy f) Record of Care		**MOTION:** by Eisenstark to accept Polices a-f and 2nd by Idell. All in favor.	
5. ANNUAL SKILLED NURSING FACILITY REPORT 2013	*Evans*	Inform	
	Ms. Evans gave a comprehensive and engaging report on the SVH Skilled Nursing Facility for 2013.		
6. QUALITY REPORT FOR MARCH 2014	*Lovejoy*	Inform	

AGENDA ITEM	DISCUSSION	ACTION	FOLLOW-UP
	Ms. Lovejoy gave the Quality Report for the month of March 2014 which covered Survey Preparation, Performance Evaluations, Employee Satisfaction Survey, Improvement Plan for Fiscal Stewardship, the Quality section of the SVH website and Orientation.		Ms. Lovejoy to bring a Press Ganey Employee Satisfaction Survey to next meeting.
7. CLOSING COMMENTS/ANNOUNCEMNTS	*Hirsch*		
8. ADJOURN	*Hirsch*		
	There was a group discussion on the topic of transparency in pricing and Ms. Hirsch distributed handouts on the subject. Public session adjourned at 6:15pm.		
9. UPON ADJOURNMENTOF REGULAR OPEN SESSION	*Hirsch*	Inform	
10. CLOSED SESSION	*Amara*	Action	
11. REPORT OF CLOSED SESSION/ADJOURN	*Hirsch*	Inform	
	Closed session adjourned at 6:30pm.		

4.

POLICY & PROCEDURE APPROVAL

SONOMA VALLEY HOSPITAL
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POLICY AND PROCEDURE
Approvals Signature Page

Review and Approval Requirements

The SVH departmental/organizational policies and/or procedures on the attached list have been reviewed and approved by the following organizational leaders for meeting all of the following criteria. All of these policies and procedures are:

- Consistent with the Mission, Vision and Values of the Sonoma Valley Health Care District
- Consistent with all Board Policy, Hospital Policy and Hospital Procedures
- Meet all applicable law, regulation, and related accreditation standards
- Consistent with prevailing standards of care
- Consistent with evidence-based practice

We recommend their acceptance by the Quality Committee and that the Quality Committee forward them to the Sonoma Valley Health Care District Board with a recommendation to approve.

Organizational: Multiple (refer to attached Summary Sheet)	
APPROVED BY	DATE: **2/28/2014**
Director's/Manager's Signature	Printed Name

Leslie Lovejoy
Leslie Lovejoy, RN
Chief Nursing Officer, CQO

3-12-14
Date

Robert Cohen
Robert Cohen, MD
Chief Medical Officer

3/14/14
Date

D. Paul Amara, MD
President of Medical Staff

Date

Kelly Mather
Chief Executive Officer

Date

Sharon Nevins
Chair, Board of Directors

Date

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Policy Submission Summary Sheet

Title of Document: **Pharmacy Department**
New document or revision written by: Chris Kutza, Director of Pharmacy

Type **X Revision X New Policy**	**Regulatory** ❑ **CMS** ❑ **CDPH** (formerly DHS) ❑ **TJC** (formerly JCHAO) ❑ **Other:**
X Organizational: Clinical	**X Departmental** ❑ **Interdepartmental**

Please briefly state changes to existing document/form or overview of new document/form here:
(include reason for change(s) or new document/form)

MM8610-114 Vaccine Screening-Pneumococcal and Influenza—Updated (Replaces MM-120)
MM8610-119 Pharmacist Review of Medication Orders—Updated (Replaces MM-119, 175, 183)
MM8610-120 Access to Patient Information for Medication Management—Updated (Replaces MM-118)
MM8610-121 Floorstock Medications—Updated (Replaces MM-144)
MM8610-122 Formulary Management—Updated (Replaces MM-102)
MM8610-123 Storage of Medications—Updated (Replaces MM-111)
MM8610-124 Inspection of Nursing Units and Medication Storage Areas—Updated (Replaces MM-146)
MM8610-125 Temperature Monitoring of Medication Storage—Updated (Replaces MM-174)

Reviewed By	Date	Approved (Y/N)	Comment
Douglas Campbell, MD - Chairman PMC	3/13/14	yes	
D. Paul Amara, MD - MedStaff President	4/17/14	y.	
Michael Braun, MD - Chairman Surgery	4/2/14	yes.	

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Policy Submission Summary Sheet

Title of Document: Organizational-**Multiple Departments**

Type: **Revision**

Policy	Comments
EC LS8610-103 Material Flammability Standards	reviewed; updated to standard of TB 117-2000
EC SAF8610-117 Cell Phone Usage	retire; not a safety issue
ECEQP8610-On-Call Engineer	reviewed; updated with staff changes
ECLS8610-106 Fire Alarm Testing	reviewed; only minor changes in wording
ECLS8610-111 Fire Drill Procedure	revised to include new wing
ECSAF 8610-116 Smoking Policy	retire; refer to LD8610-133
LD8610-133 Smoking Policy	reviewed; added smoking locations
EM 8610-Chart 17 element of NIMS	delete; in EOP Plan
IM8610-117 Telephone & Verbal Orders	Delete; new policy MS8610-120
IM8610-102 Disclosure of PHI	delete; duplicate to RC8610-116
IM8610-201 IS security agreement & code of ethics	retire; refer to IM8610-183 IM System Security and Password Control
LD8610-128 Meal Reimbursement	Retire; included in Travel Policy HR8610-135
LD8610-104 Mileage Allowance	reviewed; updated milage rate from State of CA to IRS Standard
LD8610-114 Customer Relations	revised with minor changes
LD8610-118 Investment Policy	not Leadership policy; sent to Board
LD8610-142 Complaints and Service of Legal Proceedings	reviewed; updated with minor changes
LD8610-202 Leased Employees & Letter of agreement	retire; not a policy
LD8610-314 Involving Patients & Families in safe Care	retire; no longer in use
LD8610-316 Organ Tissue Donation	reviewed; no changes
LD8610-320 Plan for Patient Family Education	reviewed; minor word changes
MS8610-120 Verbal and Telephone Order Policy	new policy; already through committees
PC8610-111 Routine Care of the Pediatric Patient	Revised; updated assessment regarding less than 5 yrs; use of elimination Flow Chart
PC8610-127 Pediatric assessment	Reviewd; updated reference to current standard
PC8610-151 Autopsy Policy	reviewed; updated to current standard
PC8610-161 Do Not Resucitate	reviewed; no changes
PC8610-163 Hand off Communication SBAR	reviewed; no changes
PC8610-303 Car Seat Safety Program	reviewed; no changes
PCLB8610-205 Nitrazine Testing for Amniotic Fluid	reviewed; updated to Standard
PCLB8610-204 Critical Value Reporting	reviewed; no changes
PCLB8610-Point of Care Testing	reviewed; no changes
PCLB8610-201- AccuChek Inform II Glucose Monitoring	revised to include Standards and procedure of Inform II System
RC8610-114 Retention of Health Information	revised; includes McKesson Patient Folder for records 2012- to current
New Policies	
EC-SAF8610-145 Electrical Safety Testing Policy	new policy
EC-LS8610-102 Hospital Fire Response Plan	new policy
LD8610-303 Vendor PO Assignment	new policy

Reviewed By:	Date	Approved (Y/N)
Policy & Procedure Team	**02/26/2014**	**Yes**
Surgery Committee	**3/5/14**	
Medicine Committee	**3/13/14**	

5.

QUALITY AND RESOURCE MANAGEMENT REPORT APRIL 2014

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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To: Sonoma Valley Healthcare District Board Quality Committee
From: Leslie Lovejoy
Date: 04/24/2014
Subject: Quality and Resource Management Report

March Priorities:

1. Website Privacy Breach Response
2. Credentialing Process
3. Budget Priorities for FY 2015
4. Annual Performance Improvement Fair

1. In 2013, a spreadsheet containing protected healthcare information was inadvertently posted on the website. We were notified and letters were sent to patients and public notice was made as required. The Compliance Committee made sure the issue was rectified and after investigation, actions were taken to ensure it did not happen again. We are currently responding to two parties regarding this breach. A class action lawsuit was filed first against the Hospital Foundation and then finally against the hospital. This case will be heard in court in June and we believe that it will be dismissed as there is precedence in another case just recently closed in favor of the hospital involved. The second effort involves a detailed response to the Federal Office of Civil Rights which is due on April 28th. The district has business insurance that includes cyber breach protection and has hired attorneys to represent us in both arenas. This month has seen a great deal of activity as we move to respond to both issues. Celia Lenson, Director of Medical Records and Privacy Officer and Fe Sendaydiego, Chief Information and Security Officer have done an exceptional job in ensuring that we are meeting deadlines and providing the necessary information to the attorneys.

This has heightened awareness for leadership and employees. We perform annual competencies every year on protecting PHI, and the Compliance Committee monitors any potential or actual violations. We are transparent with CDPH when events occur. We are at risk particularly through our email system as it is not secure at this time.

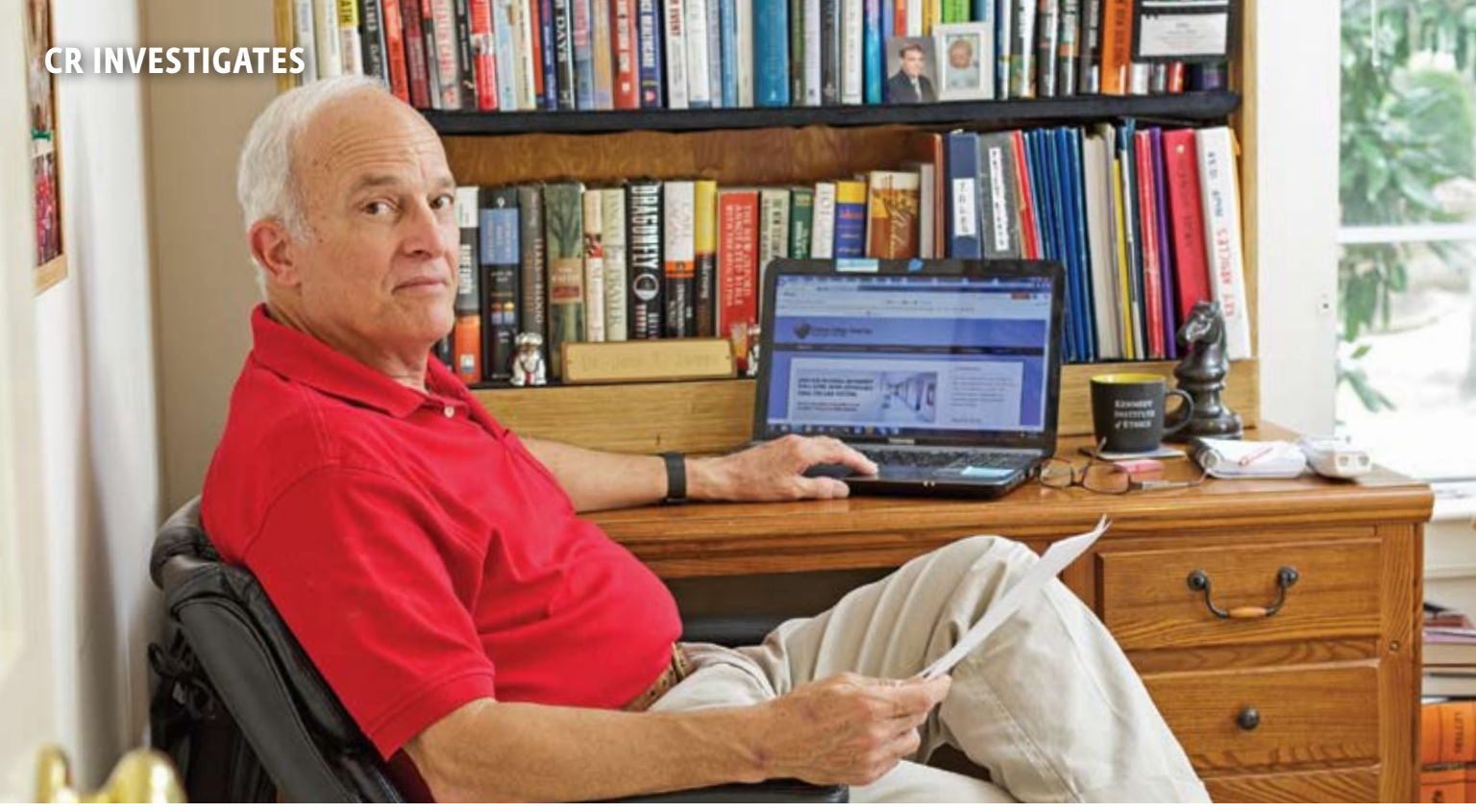
2. Credentialing Process: In order to ensure that credentialing and reappointment occurs smoothly, we are electing to bring the process in-house instead of using the Credentialing Verification Organization. We have had some interruptions in service related to hospital finances and the ability to meet net 30 deadlines. This all came to a head this month and has created some problems with timely reappointments due in May. The Medical Staff Coordinator, Quality Data Analyst and Quality Assistant will support this process beginning July 1st.

3. We are now in budget development mode. I do not anticipate any changes in the Quality initiatives. We are on track to integrate hospital data systems into one interactive database. In order to support the move towards continuous financial stability, this department has made the following decisions to date:

- Change the Patient Satisfaction Vendor from Press Ganey to NRC(National Research Corporation AKA Picker)
- Bring credentialing in-house
- Move from The Joint Commission to the Center for Improvement in Healthcare (CIHQ) as our deemed status and accrediting agency.

4. Annual Performance Improvement Fair: SVH will hold its first annual Performance Improvement Fair on Thursday, September 18th from 0730-1530. All Leaders are expected to form a team, complete and present a project. Two categories: Clinical and Nonclinical will be judged by members of this committee and prizes awarded. There are two goals for this fair. One is to encourage leaders to develop their continuous performance improvement skills and the second is to recognize the efforts made by the organization to improve patient care. As we get closer, I will ask for two members of this committee to join the judging team.

Topics for discussion: 2013 Annual Performance Improvement Program Review and Prioritization of 2014 projects.



IN HIS SON'S MEMORY John James, Ph.D., dedicated his life to studying hospital safety after his son died from a medical error in 2002.

Survive your stay at the hospital

Medical errors are linked to 440,000 deaths each year

TWELVE YEARS AGO, John James' 19-year-old son died after cardiologists at two Texas hospitals made a series of mistakes. James says they failed to properly diagnose and treat the cause of an abnormal heartbeat. At the time he was the chief toxicologist for NASA in Houston, responsible for overseeing the air astronauts breathe in space. Now retired, he has responded to the tragedy by dedicating his life—and his son's memory—to improving hospital safety.

He founded Patient Safety America, an organization that educates people about risks they may face in hospitals. He became active in Consumer Reports' own Safe Patient Project, which works with people across the country who have been harmed by medical care. And last year he wrote a comprehensive analysis on the number of people who die at least in part because of medical errors in hospitals.

His conclusion—published in the Journal of Patient Safety, a peer-reviewed medical journal—was sobering. He estimated that 440,000 people each year die after suffering a medical error in the hospital. Some patients, for example, might have gotten the wrong drugs or developed infections because doctors or nurses failed to wash their hands. Others may have failed to get needed tests or treatments.

"Four-hundred-forty-thousand is a frightening figure," James says. It's more than 1,000 deaths per day, for example, or more than half of the deaths that occur in U.S. hospitals each year. "And it makes patient harm in hospitals the nation's third leading cause of death, trailing only heart disease and cancer," James says.

Our Ratings of 2,591 hospitals can help you find a safe one.

Too many deaths

James, like other researchers who have studied hospital safety, is quick to emphasize that his analysis is inexact. Establishing firm numbers is hard, in part because much of what happens in hospitals goes unrecorded, and because untangling how much any hospital death stems from an underlying health problem and how much stems from medical error is messy, complicated, and sometimes controversial.

But his figures are in line with other research. Fifteen years ago the Institute of Medicine stated that up to 98,000 hospital patients per year die from medical errors. Almost four years ago the Department of Health and Human Services estimated that 180,000 people each year die in part because of their hospital care—but that was limited to Medicare patients. James'

PHOTO: JILL HUNTER

analysis—which was based on the results of four key hospital safety studies, all published between 2008 and 2011—pushed further by, for example, estimating the number of deaths caused by errors that go unrecorded or that stem from missed diagnoses.

"The truth is that whether it's 100,000 or 200,000 or 400,000 deaths a year is almost immaterial," says James. "What matters is that too many people are dying in hospitals because of medical mistakes, not enough is being done to stop it, and patients need more information."

Our hospital safety score helps fill that gap. It includes information for a record 2,591 hospitals in all 50 states plus the District of Columbia, combining five measures of patient safety into a 1 to 100 score. (See "Safety Score: Where to Find High- and Low-Scoring Hospitals," on the next page, for more.) And our score includes new information on hospital mortality rates. As in James' analysis, the results are sobering.

What we found

Our analysis uses two measures of hospital mortality, both using information from the Centers for Medicare & Medicaid Services—the most recent, reliable, and comprehensive data publicly available—on patients 65 and older. The first focuses on hospital patients admitted with medical conditions, such as heart problems; the second, on surgery patients.

Medical patients. This is based on the chance that a patient who has had a heart attack or been diagnosed with heart failure or pneumonia will die within 30 days of entering the hospital. Only 35 hospitals nationwide earned a top rating in the measure. By comparison, 66 hospitals got our lowest rating.

"The differences between high-scoring hospitals and low-scoring ones can be a matter of life and death," says John Santa, M.D., medical director of Consumer Reports Health. For example, pneumonia patients at Cedars-Sinai Medical Center in Los Angeles, which earned a top rating in this measure, had a 7 percent chance of dying within 30 days. That compares with a 22 percent chance of death for similar patients at Delano Regional Medical Center, 2 hours north in Delano, Calif. Overall, pneumonia patients in top-scoring hospitals are at least 40 percent less likely to die within 30 days of admission than similar patients in low-scoring hospitals.

Surgical patients. This looks at surgery patients who had serious but treatable complications—such as blood clots in the legs or lungs, or cardiac arrest—and died in the hospital. More hospitals did well in this measure, with 173 earning a top rating. By comparison, 228 hospitals got our lowest rating. And again, the differences between high- and low-scoring hospitals are dramatic: For every 1,000 patients who develop serious complications in a top hospital, 87 or fewer die; in a low-rated hospital, more than 132 die. Patients in top-rated hospitals are at least 34 percent less likely to die than similar patients in low-rated hospitals.

Staying alive

Why do some hospitals do a better job than others at keeping patients alive? "Likely because they do a lot of things—some little, some big—well," Santa says. "That includes everything from making sure staff communicates clearly with patients about medications, which can help prevent drug errors, to doing all they can to prevent hospital-acquired infections."

That's what they've done at Sanford Medical Center, at the University of South Dakota in Sioux Falls. It earned the highest safety score of any teaching hospital in the country and also got a top rating in avoiding death in surgical patients. The hospital instituted strict protocols for hand washing, says Mike Wilde, M.D., chief medical officer at Sanford, as well as for inserting and removing urinary catheters and central-line catheters, which provide drugs, fluids, and nutrition to patients. Those are two of the most common and deadly causes of infections in hospitals.

Accountability is also key. "It's easy to blame a provider, but a lot of times it can be the systems in place," Wilde says. So the staff now examines whether errors stem from a poorly functioning device or a failure to follow a safety protocol.

When a patient does die from a preventable error, there should be a thorough examination of why and steps taken to prevent similar errors in the future. "I want to know if someone dies on my watch or after they have left my watch, why they died, and how the death might have been prevented," says Don Goldmann, M.D., chief medical and scientific officer of the nonprofit Institute for Healthcare Improvement.

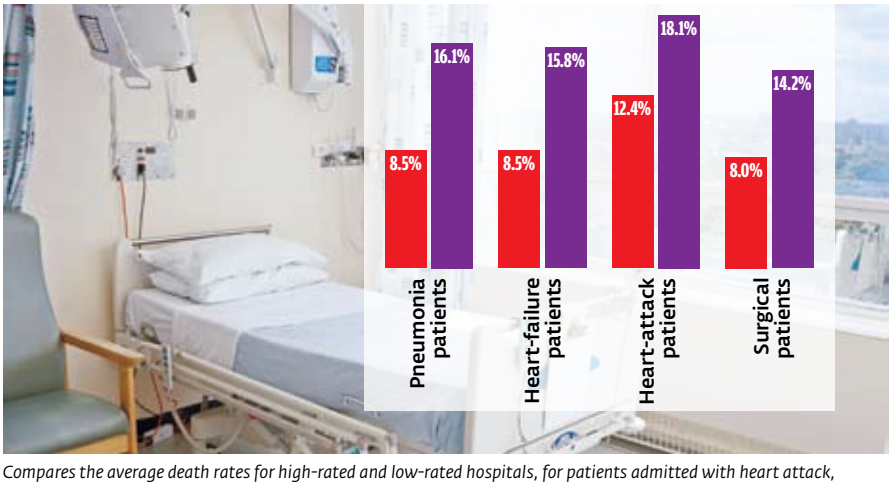
That kind of soul searching can yield better care. In 2006, the University of Pennsylvania Health System established a Mortality Review Committee. One program they came up with focused on detecting sepsis, a bloodstream infection, and starting timely and appropriate antibiotic treatment. Survival rates of hospital patients with severe sepsis rose from 40 percent to 56 percent. And survival rates from septic shock, which occurs when the infection causes blood pressure to plummet, rose from 42 percent to 54 percent.

Continued on next page

BY THE NUMBERS

The hospital you choose really matters

Death rates are much higher in some than in others.



Compares the average death rates for high-rated and low-rated hospitals, for patients admitted with heart attack, heart failure, or pneumonia, and for surgery patients with serious, treatable complications. Data come from the Centers for Medicare & Medicaid Services for patients 65 and older.

PHOTO: GETTY IMAGES

What you can do

"Informed, active patients and family members are the best defense against hospital errors," James says. Lisa McGiffert, head of the Consumer Reports Safe Patient Project, agrees. Here are three of the most important steps she says patients should take to stay safe in the hospital:

- Have a friend or family member with you to be your advocate when you are unable to speak up for yourself.
- Before a planned hospitalization, do your homework. Learn as much as you can about what to expect while at the hospital, and ask about your treatments, especially medications or tests.
- If something goes wrong, keep a journal documenting what is happening.

For more information, go to:

- *SafePatientProject.org* to see what you can do to reduce the risk of patient harm in the U.S. health care system.
- *ConsumerReports.org/shareyourhospitalstory* to tell us about problems you may have experienced in the hospital.
- *ConsumerReports.org/hospitalratings* to see our complete hospital Ratings.

Safety score: Where to find high- and low-scoring hospitals

Damariscotta, Maine, population 2,218, and Cleveland, Ohio, may seem like unlikely spots to find two of our top-scoring hospitals. But both are home to hospitals ranking in the top of our updated safety score: Miles Memorial Hospital (now Lincoln Health), with a 78 on our 100-point scale, and Lutheran Hospital, part of the Cleveland Clinic, with a 75.

"We are a very small community, and our patients are our neighbors, friends, and family," says Cindy Coyne, R.N., director of quality and patient safety at Miles. "We work hard to take care of them." Though the setting is very different, the sentiment is similar at Lutheran Hospital. "Patient care is what we think about every day," says Brian Donley, M.D., president of Cleveland Clinic Regional Hospitals. "We empower every person in our system to take the steps necessary to make patient safety a priority." Other top hospitals are spread across the country, in suburbs, rural areas, and big cities. The message: Success can happen anywhere.

The flip side is that low-performing hospitals are also easy to find. The average score for hospitals is just 51, and 43 hospitals got a score below 30. "It is unacceptable that so many hospitals are doing so poorly," says John Santa, M.D., medical director of Consumer Reports Health, "especially since our Ratings show that some hospitals can do a good job at keeping patients safe."

78
SAFETY SCORE
Miles Memorial Hospital, in tiny Damariscotta, Maine, earned a top safety score.

75
SAFETY SCORE
Lutheran Hospital, Cleveland, Ohio, was also a top-performer.

Ratings Hospitals

Top-scoring

Hospital name and location	Safety score
Miles Memorial Hospital Damariscotta, Maine	78
Oaklawn Hospital Marshall, Mich.	77
Aurora Medical Center of Oshkosh Oshkosh, Wis.	75
Lutheran Hospital Cleveland, Ohio	75
Palm Drive Hospital Sebastopol, Calif.	74
Marshalltown Medical & Surgical Center Marshalltown, Iowa	74
Hillside Hospital Pulaski, Tenn.	73
Margaret R. Pardee Memorial Hospital Hendersonville, N.C.	73
Spectrum Health United Hospital Greenville, Mich.	73
St. John Medical Center Westlake, Ohio	73
Sonoma Valley Hospital Sonoma, Calif.	73
UnityPoint Health - Trinity Regional Medical Center Fort Doge, Iowa	73
UnityPoint Health - Finley Hospital Dubuque, Iowa	73
Lovelace Westside Hospital Albuquerque, N.M.	73
Boulder Community Hospital Boulder, Col.	73

Bottom-scoring

Hospital name and location	Safety score
Bolivar Medical Center Cleveland, Miss.	11
Tulane Medical Center New Orleans, La.	19
Harris Hospital Newport, Ark.	20
Lake Cumberland Regional Hospital Somerset, Ky.	20
Delta Regional Medical Center Greenville, Miss.	21
Beckley ARH Hospital Beckley, W.V.	21
Faxton-St. Luke's Healthcare Utica, N.Y.	23
Poplar Bluff Regional Medical Center Poplar, Mo.	24
Kings County Hospital Center Brooklyn, N.Y.	24
Avoyelles Hospital Marksville, La.	25
Nyack Hospital Nyack, N.Y.	25
St. Petersburg General Hospital St. Petersburg, Fla.	25
Methodist Hospitals Gary, Ind.	25

Note: Hospitals are ordered by unrounded safety score. Hospital names are from the most recent American Hospital Association annual survey.

What's behind our hospital Safety Score

We combined five safety categories into a score between 1 and 100. Data are the most recent available from the Centers for Medicare & Medicaid Services. Mortality, readmission, and scanning apply to patients 65 or older; communication, to all adults; and infections, to all patients. **Mortality** represents the chance a patient who has had a heart attack, heart failure, or pneumonia will die within 30 days of admission, or the chance that a surgical patient with serious complications will die in the hospital. **Readmission** represents the chance that a patient is readmitted to a hospital within 30 days of initial discharge. **Scanning** reflects the percentage of chest and/or abdominal CT scans that are ordered twice for the same patient, once with contrast and once without. **Infections** reflects a hospital's success in avoiding infections from central-line and urinary catheters in intensive care units, and infections after certain surgeries. **Communication** indicates how well staff explain medications and discharge planning to patients.

6.

ANNUAL PERFORMANCE IMPROVEMENT EVALUATION AND GOALS REPORT

Performance Improvement Plan/Program
Annual Program Evaluation 2013

Purpose

The Quality Department, in cooperation with the Performance Improvement Committee and the Administrative Leadership, has completed an appraisal of the Performance Improvement Program.

The purpose of this appraisal is to:

- Evaluate the comprehensiveness and scope of the program.
- Assess the effectiveness of the FOCUS / PDSA model.
- Measure the extent of interdisciplinary collaboration.
- Assure that all key functions and dimensions of performance have been addressed.
- Provide the Governance, Administration and Medical Staff leaders with the results of prior year activities to assist in development of priorities for improvement.
- Determine the extent to which the Performance Improvement Program supported the mission and vision.

Scope and Applicability

This is an organization-wide program. It applies to all settings of care and services provided by the Sonoma Valley Hospital.

Findings

In 2013 the organization resolved most of the issues that arose from a number of accreditation and licensing surveys in 2011 involving opportunities for improvement within the organization's Performance Improvement Program. In addition, the organization made the decision to proceed with changing the focus and agency for CMS deemed status from the Joint Commission to the Center For Improvement of Healthcare Quality(CIHQ). It was decided to streamline the number of surveying agencies and to focus on meeting regulatory standards that stem from either state or federal agencies. Over the past year there was a great deal of improvement in the development of a performance improvement infrastructure and department specific performance improvement such that each department identified the complexity of work flow processes and opportunities to improve based on some form of prioritization process. The senior team performed a formal organization-wide Performance Improvement Project prioritization process that identified four projects: Implementation of a Culture of Safety Program; Electronic Health Record implementation for Home Care; Sevenex Cost Reduction Project; and the development of a Woman's Health Service Line. Three of the four programs were successfully implemented and have moved to continuing performance monitoring and refinement. Each of the prioritized projects aligned with both our strategic plan and with the hospital's overarching mission, vision and values.

This year, there was an increased use of the PDSA as Leaders have become more confident in the process and the expectations have been set that all projects will be reported using this process. Departmental quality monitoring and reporting has become uniform with the exception of those departments seeing changes in leadership this year. The is now an on-boarding process to help new leaders get up to speed and beginning in 2014, an annual Performance Improvement Fair to continue to improve the organization's use of performance improvement tools and to move towards data driven decision making. In addition, the implementation of

powerful and user friendly database tools that interface with Paragon and McKesson have begun to break down silos and improve data sharing. In 2014, additional statistical process control modules, a cost accounting system interface and bringing all leaders on board will further enhance the organization's performance improvement efforts. There continue to be opportunities in the areas of: determining outcome measures, continued monitoring once change has been implemented; and project development.

Interdisciplinary collaboration was demonstrated through the Sorry Works process, Culture of Safety Program Root Cause Analysis process, RAC audit and Denial Process; Meaningful Use 2; Safety Committee Performance Improvement projects and Performance Improvement Committee project reports. Increasing the meetings of the Medical Staff Performance Improvement Committee and the further development of the Board Quality Committee allowed for more consistent and coordinated reporting of projects and mandated activities, including Pharmacy and Therapeutics. Developing and posting of a Quality page which includes the Board Quality Dashboard has increased public awareness of hospital performance.

The Performance Improvement Program does support the hospital's mission and is well on the way to supporting an organizational Culture of Quality and Safety.

Assessment of Performance

The effectiveness of the PI program is measured by its accomplishments. Data was collected and aggregated on performance measures and thoroughly analyzed. Intensive assessments were completed when SVH detected or suspected a significant undesirable performance or variation. Progress was made on the following program goals:

I. Performance Improvement Infrastructure

Performance Goal	Outcome
95% of departments reporting Quality Monitoring on Quarterly basis	Met
100% Leaders have a Quality and Patient Satisfaction Goal as part of the Studor Leadership Evaluation management System	Met
Work with medical staff groups to identify key performance indicators: Dashboard includes all mandated quality monitoring; 100% quarterly monitoring of all indicators	Met for both quality and utilization review. Revised the quality indicators for the reappointment process.
100% of mandated P&T reporting completed	Met. Annual MERP reviewed and approved.
Identify and purchase data analysis tools to support decision making process	Met. Midas Datavision, McKesson Interqual, Risk Management database developed and E-Notification
Provide education to leaders on use of tools and using and interpreting graphs	Not met; installation of final tools slated for summer 2014 with training to follow by end of 2014.

II. Performance Improvement efforts in 2013 focused on:

Performance Initiative	Outcome
Improve Patient Satisfaction: move to 50th percentile rank for Inpatient HCAHPS	Varied between 5 of 8 to 2of 8 at or above 50th %tile rank.
Improve Patient Satisfaction: Emergency Department Ambulatory Surgery Outpatient Services	 7 of 8 over 50th %tile rank 4 of 5 over 50th %tile rank 1 of 6 over 50th %tile rank
Improve the unusual/adverse event reporting	Increased by 10%
Improve Patient Safety: Implement the Good Catch Program & Culture of Safety	93% staff trained; now annual Heath Stream competency; Total Good Catch Awardees in 2013:30
Assessment of Opportunities for Improvement for Surgical Services	Consultant recommendations regarding leadership, patient throughput, pre-admission process, implant costs were identified. Implementation of action plan in 2014.
Improve performance evaluation process	Electronic Tool developed for 2014 evaluations
Improve Key Inventory process	New policy and process established
Improve contract evaluation for clinical contracts to include performance metrics	100% of all clinical contracts have established performance metrics
Development of an Emergency Department Transitional Care Record	Not completed; will pick up in 2014-2015
Improve patient flow process for emergency department to inpatient	Flow process analysis completed for ED
Improve performance for Value Based Performance metrics	100% for 9 of the last 12 months.
Improve organizational & departmental policy and procedure infrastructure and monitor for updating	100% of organizational policies now in infrastructure with process for monitoring upcoming review dates.
Improve Telemetry services and staff competencies	Moved to 24/7 tele techs (100%); providing 20 hours of telemetry education 2013-2014
Improved and standardized Code Blue Crash Carts	100% of all crash carts are standardized

III. Accomplishments/Awards

Project	Outcomes
Board Quality Dashboard	Posted on website
Culture of Safety & Patient Satisfaction	Per Consumer Reports, one of the top 15 safest hospitals in the nation
Skilled Nursing Facility	National Bronze Award for Quality
Healing at Home	Home Care Elite Award for quality outcomes

Assessment of Effectiveness

The Performance Improvement Program is meeting the needs of the Performance Improvement Committee, Medical Executive Committee and Sonoma Valley Hospital.

Objectives for Next Evaluation Period

With input from the medical staff and leadership, the Administrative Team performed an assessment of potential organizational performance improvement activities for 2014 that aligns with the strategic plan and core strategic initiatives and reflects the scope and complexity of patient care services. In addition to departmental and interdepartmental continuous performance improvement activities, the organization will focus on the following priorities (see attached matrix for evaluation and outcomes for 2013 and prioritization of 2014 projects).

Policy	Update
Annual PI Program Evaluation	2013
Standards	
CMS - §482.21, §482.22, §482.23, §482.26, §482.30, §482.42	

Performance Improvement Prioritization & Decision Matrix:2013-2014

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	Property Impact	Business Impact	Internal Resources	External Resources	Total Score
				High Prob 5 ◄►	Low Prob 1	High Impact 5 ◄►		Low Impact 1	Weak Resources 1 ◄►	Strong Resources 5	
Hi Vol, Hi Risk, & PP	Culture of Safety	Patient/MD /Employee Satisfaction	All Dept	3		5	2	4	2.5	2.5	19
	Leslie to lead										
Lo vol, Hi Risk, & PP	Women's Health Program	New Service	OB, Surgery, Imaging	4		5	3	5	2	5	24
	Jackie to lead										
Hi Vol, Hi risk, & PP	Sevenex Projects	Fiscal Stewardship and Process Efficiencies	All Depts	3		5	1	4	3	5	21
	Michelle to lead										
Hi Vol, Hi Risk, & PP	Electronic Health Record	New IT System	Home Care	5		5	2	4	3	4	23
	Barbara to lead										

Evaluation and Next Steps											
1	***Culture of Safety Project***										
	Outcomes:	8% increasein E notifications over baseline; 10% of all reports were Good Catches; 93% of all staff									
		trained; met or exceeded national AHRQ benchmarks for survey									
	Next Steps:	Coach leaders to have discussions at staff meeting;									
		All leaders will be on the Midas system by the end of 2014									
		Attach patient safety to leader rounding on staff and in daily huddles									
		Re-do the survey at the Wellness Fair in October to increase participation.									
		Determine a methodology to roll program out to physicians as appropriate.									
2	***Sevenex Project/Medicare Breakeven***										
	Outcomes:	Cost savings $57,000 per year/23% of goal to reduce $250/per Medicare benficiary									
	Next steps:	Staff and Physician education for the project structure and savings for increased buy-in									
		Analyze wins & challenges in the Medicare BE portfolio to drill into quick wins & long term commitments									
		Analyze gaps for reasons projects have stalled									
		Expand needed resources such as clinical support for closure of projects									
		Incorporate program to include front line staff support for projects and recognize them @ leadership mtgs									
		Incorporate more physicians into projects with secure support from executive team									
3	***Electronic Health Record for Home Care***										
	Outcomes:	Met end of August deadline for go live; staff trained and billing cycle completed electronically									
	Next Steps:	The Electronic Health Record will support geographic expansion and volume growth by 25% in 2014									
4	***Womens Health Service Line***	Not completed									

Performance Improvement Prioritization & Decision Matrix:2014-2015

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	Property Impact	Business Impact	Internal Resources	External Resources	Total Score
				High Prob 5 ◄►1	Low Prob	High Impact 5	◄►	Low Impact 1	Weak Resources 1◄►	Strong Resources 5	
Hi Vol, Hi Risk, & PP	Skilled Nursing Facility PI project	Improve efficiency, reduce waste, improve patient care	Skilled Nursing, Pharmacy, Medical Staff, Lab, Business Office	3		4	2	5	5	5	24
	Michelle, Leslie, Melissa & Robbie to lead										
Lo vol, Hi Risk, & PP	Meaningful Use 2 Attestation	Improve Doc & Quality of Care	Nursing, Quality, Medical Staff, IT, Admitting	5		5	2	5	3	5	25
	Fe to lead										
Hi Vol, Hi risk, & PP	Functional Units of Service Development Using Cost Accounting	Fiscal Stewardship and Process Efficiencies	Inpatient Care, Home Care, Emergency Department; Outpt Surgery & OPDxs & Rehab	4		5	2	5	3	3	22
	Michelle to lead; Barbara, Mark, Allan, Dawn & Leslie										

Hi Vol, Hi Risk, & PP	ICD10 Implementation		Medical Records, IT, Admitting, Quality	4		5	2	5	2	2	20
	Med Rec lead; team: Celia L.,Robbie, Fe, Quality rep; Lisa, Judy										
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.											