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SVHCD QUALITY COMMITTEE
AGENDA
WEDNESDAY, September 28, 2016
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	
In compliance with the Americans with Disabilities Act, if you require special accommodations to attend a District meeting, please contact the District Clerk, Gigi Betta at ebetta@svh.com or 707.935.5004 at least 48 hours prior to the meeting.		
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 • QC Minutes, 8.24.16	*Hirsch*	Action
4. SURGERY DEPARTMENT UPDATE	*A. Sendaydiego*	Inform
5. POLICY & PROCEDURES • Infection Prevention Policies • Infection Prevention-Aerosol Disease Control Plan • Communicable Disease Reporting • Multiple Policies August 2016	*Matthews/Kobe/ Lovejoy*	Action
6. QUALITY REPORT SEPTEMBER 2016	*Lovejoy*	Inform/Action
7. CLOSING COMMENTS/ANNOUNCEMENTS The SVH Annual Performance Improvement Fair date has changed to November 17, 2016, 8:00am to 2:30pm in the SVH Administrative Conference Room. The fair is open to the public and Quality Committee members Ingrid Sheets and Carol Snyder will judge entries.	*Hirsch*	
8. ADJOURN	*Hirsch*	
9. UPON ADJOURNMENT OF REGULAR OPEN SESSION	*Hirsch*	
10. CLOSED SESSION: • Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Sebastian*	Action
11. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
12. ADJOURN	*Hirsch*	

3.

CONSENT

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SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
MINUTES
Wednesday, August 24, 2016, 5:00pm
Schantz Conference Room

Members Present	Members Present cont.	Excused	Public/Staff
Jane Hirsch	Brian Sebastian, MD	Kelsey Woodward	Leslie Lovejoy
Michael Mainardi, MD	Howard Eisenstark, MD		Gigi Betta
Susan Idell	Ingrid Sheets		Chris Kutza
Carol Snyder	Joshua Rymer		Fe Sendaydiego
	Cathy Webber		Mark Kobe

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
2. PUBLIC COMMENT	*Hirsch*	
3. CONSENT CALENDAR	*Hirsch*	Action
• QC Minutes, 7.27.16 • Annual Risk Management Report from 7.27.16		**MOTION** by Idell to approve Consent and 2nd by Mainardi. All in favor.
4. MEDICATION SAFETY	*Kutza*	Inform
	Dr. Kutza presented an overview of pharmacy activities related to ensuring medication safety; classification of med errors, how unsafe practices are identified and acted upon, monitoring progress, and the medication reconciliation process.	
5. CYBER SECURITY & RISK MANAGEMENT	*Sendaydiego*	Inform
	Ms. Sendaydiego presented on cyber security and its associated risks, the complexities that are inherent and management strategies to mitigate future malware attacks.	
6. POLICY & PROCEDURES	*Lovejoy*	Action
• Policy IC7471-114 & PC7420-107 Surgical Services • Multiple Policies June 2016	Policy IM8480-07 on Cyber Attack was not approved will be revised by Ms. Sendaydiego and brought back to the next QC meeting in September	**MOTION** by Idell to approve Consent and 2nd by Mainardi. All in favor.

AGENDA ITEM	DISCUSSION	ACTION
	2016.	
7. QUALITY REPORT AUGUST 2016	*Lovejoy*	Inform/Action
	Ms. Lovejoy gave an overview of the PRIME Grant and will include status updates in her regular monthly Quality Reports. Centers for Medicare & Medicaid Services (CMS) published metrics for quality outcomes and SVH was awarded 4 out of 5 stars. SVH has contracted with a web-based credentialing verification organization (CVO) and implementation webinars have begun. CVO credentialing services will virtually eliminate the need for paper processing. The entire process is scheduled to be up and running at the end of October 2016.	**MOTION** by Rymer to approve Report and 2nd by Mainardi. All in favor.
8. CLOSING COMMENTS/ANNOUNCEMENTS	*Lovejoy*	Inform
	The SVH Annual Performance Improvement Fair is on November 17, 2016 from 8:00am to 4:30pm in the Hospital's Administrative Conference Room. The fair is open to the public and Committee members Ingrid Sheets and Carol Snyder will judge the entries.	
9. ADJOURN	*Hirsch*	
10. UPON ADJOURNMENT OF REGULAR SESSION	*Hirsch*	
11. CLOSED SESSION • Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report • Board Quality Dashboard	*Sebastian*	Action
12. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
13. ADJOURNMENT AND ANNOUNCEMENTS	*Hirsch*	
	Meeting adjourned at 6:40pm	

5.

POLICY AND PROCEDURE

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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: Infection Prevention Policies August	
APPROVED BY:	DATE: **7-19-16**
Director's/Manager's Signature Kathy Mathews RN	Printed Name **Kathy Mathews RN**

Michael Brown, MD
Chair Surgery Committee — 9-7-16 Date

Douglas S Campbell, MD
Chair Medicine Committee — 9/8/16 Date

Keith J. Chamberlin, MD MBA
President of Medical Staff — 9/15/16 Date

Kelly Mather
Chief Executive Officer — 9/14/16 Date

Jane Hirsch
Chair, Board of Directors — Date

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Policy Submission Summary Sheet

Title of Document: **Infection Prevention Policies**

New Document or Revision written by: **Kathy Mathews RN**

Date of Document: **7-19-16**

Type:	**Regulatory:**
X Revision ❑ New Policy	X CIHQ X CDPH X CMS ❑ Other:
Organizational: X Clinical X Non-Clinical	❑ Departmental ❑ Interdepartmental (list departments effected)

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

IC8610-106 Airborne Infection Isolation Precautions: Revised; N 95 mask is required when caring for a pt with an ATD e.g., varicella, measles, regardless if HCWs are immune. PAPR is required for high hazard procedures. TB signs and symptoms were added. Pts with signs and symptoms consistent with TB are required to be placed in airborne isolation.

IC8610-102 Authority Statement: Clarifies that the PI Committee has the authority to institute appropriate Infection Control actions should there be healthcare associated infection rates beyond the SVH baseline or national benchmarks.

IC8610-124 Ebola Viral Disease Policy & Procedure: Reviewed; no changes

Ebola Virus Disease (EVD) PPE & PAPR Checklist: Reviewed; no changes

Ebola Virus Disease (EVD) PPE & PAPR Competencies: Reviewed; no changes

IC8610-104 Aerosol Transmissible Disease Policy: Revised; a diagnosis of respiratory TB disease should be considered for any patient with symptoms or signs of infection in the lung, pleura, or airways (including larynx), including cough for greater than or equal to 3 weeks, fever, loss of appetite, unexplained weight loss, night sweats, bloody sputum or hemoptysis, hoarseness, fatigue, chest pain or a history of exposure, infection or disease, or travel history to an area where TB is endemic. Fit testing is required annually for healthcare workers with potential exposure to aerosol communicable diseases e.g., TB. PAPRs are required for performance of high hazard procedures on suspected or confirmed ATD patients.

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	7/19/2016 ✓	Yes	
Surgery Committee	9/07/2016 ✓	YES	Kathy to present
Medicine Committee	9/08/2016 ✓	YES	Kathy to present
P.I. or P.T. Committee	n/a	—	
Medical Executive Committee	9/152016 ✓	YES	
Board Quality	9/28/2016		
Board of Directors	10/06/2016		

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Policy and Procedure - Approvals Signature Page

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- 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: Infection Prevention-Aerosol Transmissible Disease Exposure Control Plan	
APPROVED BY:	DATE: **7-19-16**
Director's/Manager's Signature Kathy Mathews RN	Printed Name **Kathy Mathews RN**

Michael Brown, MD
Chair Surgery Committee — Date: 9-7-16

Douglas S Campbell, MD
Chair Medicine Committee — Date: 9-8-16

Keith J. Chamberlin, MD MBA
President of Medical Staff — Date: 9/15/16

Kelly Mather
Chief Executive Officer — Date: 9/14/16

Jane Hirsch
Chair, Board of Directors — Date

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Policy Submission Summary Sheet

Title of Document: **Aerosol Transmissible Disease Exposure Control Plan**

New Document or Revision written by: **Kathy Mathews RN**

Date of Document: **7-19-16**

Type:	**Regulatory:**
X Revision **❑ New Policy**	**X CIHQ** **X CDPH** **X CMS** **❑ Other:**
Organizational: **X Clinical** **X Non-Clinical**	**❑ Departmental** **❑ Interdepartmental** (list departments effected)

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

- Annual fit testing replaced every two years for employees with potential for occupational exposure to TB. Deleted previous exception language which is no longer allowed by CalOSHA regulations.
- PAPR is required for high hazard procedures for suspected or confirmed ATDs e.g, pulmonary Tuberculosis
- Signs and symptoms of a suspected case of TB are defined i.e., fever, cough > or equal to 3 weeks, loss of appetite, unexplained weight loss, night sweats, bloody sputum or hemoptysis, hoarseness, fatigue, chest pain, a history of TB exposure, infection or disease and travel history to an area where TB is endemic.
- Other minor changes

Reviewed by:	Date	Approved (Y/N)	Comment
P & P team	07/19/2016 ✓	Yes	
Safety Committee	07/28/2016 ✓	Yes	Kathy to present
Surgery Committee	9/07/2016 ✓	YES	Kathy to present
Medicine Committee	9/08/2016 ✓	YES	Kathy to present
PI Committee	n/a	/	
MEC	9/15/2016 ✓	YES	
Board Quality Committee	9/28/2016		
Board of Directors	10/06/2016		

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POLICY AND PROCEDURE
Approvals Signature Page

Review and Approval Requirements

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- 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: **IC8610-123 Communicable Disease Reporting to the Public Health Department**	
APPROVED BY:	DATE: **6-21-16**
Director's/Manager's Signature Kathy Mathews RN	Printed Name **Kathy Mathews, RN CIC**

Brian Sebastian, MD
Chair, P.I. & P.T. Committees
9/21/16
Date

Keith J. Chamberlin, MD MBA
President of Medical Staff
9/15/16
Date

Kelly Mather
Chief Executive Officer
9/14/16
Date

Jane Hirsch
Chair, Board of Directors
Date

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Policy Submission Summary Sheet

Title of Document: **Organizational Infection Prevention Policy**

New Document or Revision written by: **Kathy Mathews RN**

Date of Document: **6-21-16**

Type:	**Regulatory:**
X Revision ❑ New Policy	X CIHQ X CDPH X CMS ❑ Other:
Organizational: X Clinical X Non-Clinical	❑ Departmental ❑ Interdepartmental (list departments effected)

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

IC8610-123 Communicable Disease Reporting to the Public Health Department - Revised;
The California Department of Public Health (CDPH), in consultation with the California Conference of Local Health Officers, updated the reportable disease lists in the California Code of Regulations (CCR) Title 17, Division 1, Chapter 4, Subchapter 1, Article 1, Section 2500 (reporting from providers to local health departments [LHDs]) and Section 2505 (reporting from laboratories to LHDs). These changes, effective as of May 24, 2016, are summarized in the revised P&P and can be found at:
http://www.cdph.ca.gov/HealthInfo/Documents/Reportable_Diseases_Conditions.pdf

- The following conditions have been **removed** and are no longer required to be reported to the local health department:
  - Pelvic Inflammatory Disease (PID)
  - Severe Acute Respiratory Syndrome (SARS)
  - *Staphylococcus aureus* infection
  - Toxic Shock Syndrome

- The following conditions have been **added** and are now required to be reported to the local health department:
  - Chikungunya Virus Infection – *report within one working day*
  - Flavivirus infection of undetermined species – *report immediately by telephone*
  - Novel Virus Infection with Pandemic Potential – *report immediately by telephone*
  - Respiratory Syncytial Virus (only report a death in a patient less than five years of age) – *report within seven calendar days*
  - Zika Virus Infection - *report immediately by telephone*

- The following conditions have been **reworded** for clarity:
  - Acquired Immune Deficiency Syndrome (AIDS) is reworded to Human Immunodeficiency Virus (HIV) Infection, stage 3 (AIDS) o Human Immunodeficiency Virus (HIV), Acute Infection now appears as a separate condition in the list.
  - Anaplasmosis/Ehrlichiosis now appear as two separate conditions in the list
  - Chickenpox (Varicella) (only hospitalizations and deaths) is reworded to Chickenpox (Varicella) (outbreaks, hospitalizations and deaths)
  - Dengue is reworded to Dengue Virus Infection
  - *Haemophilus influenzae*, invasive disease is reworded to *Haemophilus influenzae*, invasive disease, all serotypes

- The following conditions have a change in a reporting requirement:
  - *Haemophilus influenzae*, invasive disease, is now required to be reported only in persons less than five years of age (previously was in persons less than 15 years of age).
  - Hantavirus Infection is now required to be reported within one working day of identification (previously was immediately reportable).

Changes to Section 2505

A new subsection requires laboratories to attempt to obtain a bacterial culture isolate in certain cases.

- The following diseases have been **added** to subsection (e)(2); laboratory results suggestive of these diseases must now be reported to the local health department within one working day.
  - Babesiosis
  - Chikungunya Virus Infection
  - Flavivirus infection of undetermined species
  - *Entamoebe histolytica* (not *E. dispar*)
  - Zika Virus Infection

The subsection related to isolate and specimen submission has been re-organized as follows:

- (m)(1) lists the specimens to be submitted as soon as available to the local or state public health laboratory. The following specimen has been **added**:
  - Zika virus immunoglobulin M (IgM)-positive sera
- (m)(2) lists the isolates to be submitted as soon as available to the local or state public health laboratory. The following isolates have been **added**:
  - Drug resistant *Neisseria gonorrhoeae* isolates (cephalosporin or azithromycin only)
  - *Shigella* isolates
- (m)(3) is a **new** subsection. It states that laboratories must attempt to obtain a bacterial culture isolate whenever there is a laboratory test result indicative of infection with any of the pathogens listed in subsection (m)(2). These pathogens are:
  - Drug resistant *Neisseria gonorrhoeae* isolates (cephalosporin or azithromycin only)
  - *Listeria monocytogenes* isolates
  - *Mycobacterium tuberculosis* isolates (see (f) for additional reporting requirements)
  - *Neisseria meningitidis* isolates from sterile sites
  - *Salmonella* isolates (see Section 2612 for additional reporting requirements)
  - Shiga toxin-producing *Escherichia coli* (STEC) isolates, including O157 and non-O157 strains
  - *Shigella* isolates

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	6/21/2016	Yes	
Surgery Committee	7/06/2016	Yes	Kathy to present
Medicine Committee	7/14/2016	Yes	Kathy to present
P.I. or P. T. Committee	7/28/2016	Yes	Kathy to present
Medical Executive Committee	9/15/2016	YES	
Board Quality	8/24/2016		
Board of Directors	9/01/2016		

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SUBJECT: Communicable Disease Reporting to the Public Health Department	POLICY # IC8610-123 PAGE 1 OF 2
DEPARTMENT: Organizational	EFFECTIVE: 7/91
APPROVED BY: CQO	REVIEW/REVISED: 4/92 2/94 3/05 8/07 5/10 11/11 8/13, 6/16

Purpose:

The California Department of Public Health (CDPH), in consultation with the California Conference of Local Health Officers, updated the reportable disease lists in the California Code of Regulations (CCR) Title 17, Division 1, Chapter 4, Subchapter 1, Article 1, Section 2500 (reporting from providers to local health departments [LHDs]) and Section 2505 (reporting from laboratories to LHDs). These changes, effective as of May 24, 2016, are summarized below.

Policy:

Section 2500 specifies that healthcare providers must report all cases of the listed conditions to the local health department within the specified timeframe. The updated Section 2500 condition list is posted on the Division of Communicable Disease Control website and can be found at: http://www.cdph.ca.gov/HealthInfo/Documents/Reportable_Diseases_Conditions.pdf

Section 2505 specifies that laboratories must report all laboratory testing results suggestive of diseases of public health importance to the local health department within the specified timeframe. A subsection of Section 2505 specifies isolates or specimens that must be submitted to the public health laboratory. A new subsection, described below, requires laboratories to attempt to obtain a bacterial culture isolate in certain cases. The updated Section 2505 diseases list is posted on the Division of Communicable Disease Control website and can be found at: http://www.cdph.ca.gov/HealthInfo/Documents/Title17Section2505List.pdf

Outbreaks or an unusual occurrence of any disease (even if it is not included in Section 2500) must be reported to DPH.

Procedure:

Section 2500 specifies that healthcare providers must report all cases of the listed conditions to the local health department within the specified timeframe

The Infection Preventionist is informed of a reportable communicable disease and contacts the DPH, sends appropriate documents or completes a Confidential Morbidity Report form and forwards it to Sonoma County PHD in the timeframe specified by law.

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SUBJECT: Communicable Disease Reporting to the Public Health Department	POLICY # IC8610-123 PAGE 2 OF 2
DEPARTMENT: Organizational	EFFECTIVE: 7/91
APPROVED BY: CQO	REVIEW/REVISED: 4/92 2/94 3/05 8/07 5/10 11/11 8/13, 6/16

The Sonoma Valley Hospital Laboratory will fax the test results of patients with reportable diseases to Sonoma County PHD when a communicable disease is identified by the Laboratory. The Laboratory also reports results to the Infection Control Coordinator by telephone for urgent cases, uploads critical lab values to the IP desktop daily, and/or places a copy of test results in the IP mailbox in the Laboratory. (Also refer to SVH Laboratory Communicable Disease Reporting Policy).

Reference:

Title 17, California Code of Regulations (CCR), §2500, §2593, §2641-2643, and §2800-2812: Reportable Diseases and Conditions

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Policy and Procedure - Approvals Signature Page

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- 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 Policies August List	
APPROVED BY:	DATE: **7-19-16**
Director's/Manager's Signature	Printed Name **Mark Kobe, RN MPA**

Michael Brown, MD
Chair Surgery Committee — Date: 9-7-16

Douglas S Campbell, MD
Chair Medicine Committee — Date: 9-8-16

Keith J. Chamberlin, MD MBA
President of Medical Staff — Date: 9/15/16

Kelly Mather
Chief Executive Officer — Date: 9/14/16

Jane Hirsch
Chair, Board of Directors — Date

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Policy Submission Summary Sheet

Title of Document: **Organizational Policies**

New Document or Revision written by: **Multiple Policies-August List**

Date of Document: **7-19-16**

Type:	**Regulatory:**
X Revision ☐ New Policy	X CIHQ X CDPH X CMS X Other: State Law
Organizational:	☐ Departmental ☐ Interdepartmental (list departments effected)
X Clinical ☐ Non-Clinical	

Please briefly state changes to existing document/form or overview of new document/form here:

Policies below reviewed and no changes except for additional CIHQ References:

GL8610-180 Scope and Integration of Services
PR8610-140 Abuse Reporting
PR8610-144 Abuse Prohibition for Patients at SVH
PR8610-150 Abuse Prohibition-Prevention
PR8610-154 Abuse Prohibition-Screening
PR8610-146 Abuse Prohibition-Identification
PR8610-156 Abuse Prohibition-Training
PR8610-152 Abuse Prohibition Protection During Investigation
PR8610-142 Protecting Patients from Abuse and Neglect
PR8610-166 Patient Rights to Visitation
PR8610-162 Patient Rights to Access to Protective Services
PC8610-152 Pediatric Family Issues

PR8610-148 Abuse Prohibition-Investigation Instructions: Revised; changed title from VP Patient Care Services to Chief Nursing Officer and used Administration of Skilled Nursing Unit to include that level of involvement and oversight.

PR8610-160 Patients Rights and Responsibilities: Revised; removed all the TJC related rights, aligned the policy to the posted rights and the CIHQ CMS language. Neither the state nor CMS indicate patient responsibilities but I left the verbiage in because the posted responsibilities are logical in terms of patient centered care.

PC8610-126 Color Coded Wristbands: Revised; remove the portion of policy that states we must have a patient sign a declination form if they chose not wear the bands.

QS8610-120 Pain Management: Revised; Added CPOT to scales; removed CRIES scale which we do not use and added NIPS scale. Removed that we hand out a pamphlet on admission, do education on an annual basis and provided education to students and staff. Added that we evaluate pain with vital signs.

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	7/19/2016 ✓	Yes	
Surgery Committee	9/07/2016 ✓	YES	
Medicine Committee	9/08/2016 ✓	YES	
P.I. or P. T. Committee	n/a		
Medical Executive Committee	9/152016 ✓	YES	
Board Quality	9/28/2016		
Board of Directors	10/06/2016		

6.

QUALITY REPORT
SEPTEMBER 2016

To: Sonoma Valley Healthcare District Board Quality Committee
From: Leslie Lovejoy
Date: 09/28/16
Subject: Quality and Resource Management Report

August Priorities:

1. PRIME Grant Activities
2. Laboratory CLIA Survey Action Plan
3. Credentialing Verification Organization Selection
4. Leadership Dashboard
5. New Date for Annual PI Fair

1. *Prime Grant Activities*

Our first report on infrastructure metrics is due by the end of the month. We will meet our goals and be eligible for the next drawn down of grant money in October. The team is working on completing the Medication Reconciliation Discharge Instructions and the Transition Record and expect to have the completed and ready for physician and staff education in October. Policies and procedures have been completed including standardized workflows which include the Sound Hospitalist grant program. I am meeting with SVCHC scheduling to discuss linkages for patients not currently linked with a primary care giver. I will then work on a data sharing MOU with the clinic.

2. *Laboratory CLIA Survey Action Plan*

We had our CMS certification survey for our Clinical Laboratory in July. After many iterations and discussions regarding the cited deficiencies, the following action plan was developed and in process.

Deficiency	Quality Monitoring	Responsible Person
The Proficiency Testing policy did not include review of patient outcomes.	Proficiency Testing is performed on a regular schedule, three times per year, established by API for all analytes which have Proficiency Testing available. 100% of Failures will be reviewed to determine Patient Outcomes. Data will be collected for each Failure by the Technical Supervisor. The Proficiency Testing Exception Summary will be completed by the Technical Supervisor and reviewed by the Laboratory Manager and the Laboratory Director for accuracy and completeness. Proficiency Testing results and Failures are reported in the Quarterly Laboratory	Lois Valenzuela, Lab Manager

	Performance Improvement report. Failures will be reported to the Medical Executive Committee by the Laboratory Director.	
The Validation of Analytical Methods policy/procedure did not include precision testing for all new tests.	Policy and Procedure updated. The data will be reviewed by the Technical Supervisor, Laboratory Manager and Laboratory Director once for each new test and before patient results are reported. Data from reference lab will be reviewed at the same time.	Lois Valenzuela, Lab Manager
The lab did not have a formal Individualized Quality Control Program (IQCP) to demonstrate that the practice of performing Quality Control (QC) for each new lot number or shipment is acceptable QC surveillance for the Alere Determine HIV-1/2 AG/AB Combo test system.	IQCP updated to include all elements. Patient data will be reviewed by the Clinical Lab Scientist daily for the above test for accuracy for manual data entry. Expected compliance with correct data entry is 100%. Manual entry error rates are reported in the Laboratory Performance Improvement data and reviewed by the Laboratory Director. In addition, reference lab data reports will also be reviewed through the department's Performance Improvement monitoring system.	Lois Valenzuela, Lab Manager
No Manual & Auto Differential Correlation policy was signed by the Laboratory Director and Laboratory Manager in place in 2014 or January through July of 2015.	Continue the Manual & Auto Differential Correlation policy that was put into place in July 16, 2015. We are unable to go back to 2014 and remediate this finding.	Lois Valenzuela, Lab Manager
Related to other deficiencies we were cited for individual performance: Medical Director of the Lab. Review the Laboratory Director Responsibilities, as they are described in the Federal Code of Regulations, Title 42, Standard 493.1407, with the Laboratory Director. The Laboratory Director must sign an attestation that he understands the responsibilities and will fulfill all responsibilities.	The Chief Ancillary Officer will review the Laboratory Director Responsibilities, as they are described in the Federal Code of Regulations, Title 42, Standard 493.1407, with the Laboratory Director. The Chief Ancillary Officer will monitor performance regularly by meeting with the Laboratory Director quarterly.	Dawn Kuwahara, CAO
The Chief Ancillary Officer will review the Technical Consultant responsibilities as they are described in the Federal Code of Regulations, Title 42, Standard 493.1413 in its entirety with the	The Chief Ancillary Officer will monitor performance regularly by meeting with the Technical Consultant quarterly. The Technical Consultant job performance is monitored yearly in the Annual Performance Evaluation.	Dawn Kuwahara, CAO

Technical Consultant. The Technical Consultant must sign an attestation that he understands the responsibilities and will fulfill all responsibilities.		

3. *Medical Staff Priorities*

We are making good progress on the implementation of the new Credentialing Verification Organization and expect that it will be complete by mid October. The Case review process has been improved and is working well. Since January 2016, 87 cases have been reviewed by the medical staff in peer review with outcomes being reported to individual physicians. Track and trending reports are currently being refined and a database has been created which allows for improved reports to the committees.

4. *Leadership Dashboard*

The hospital has been measuring leadership performance on key metrics according to the Studer pillars (Service, Quality, People, Finance, Growth, Innovation and Community) for the past 4-5 years. With the purchase of the STATIT module, we decided to bring it in-house and create our own scorecard process. Currently we have defined the template, see attached, and are in the process of building the indicators for the scorecard. Leaders will enter their data onto an excel spreadsheet which is then pushed into STATIT and generates the scorecard. Not everyone has a goal in each pillar as it may not apply to their department. Performance on these metrics aggregates up to the CEO dashboard and are used annually during performance evaluations and operations reviews.

5. *New PI Fair Date*

Thursday November 17th from 0800-1630.

Leadership Dashboard
September 2016

Pillar	Goal	Required	Scoring Range	weight	July.Outcome	July. Score	Aug.Outcome	Aug. Score	Sept.Outcome	Sept. Score	Oct.Outcome	Oct. Score	Nov.Outcome	Nov. Score
Service	Consistently maintain inpatient satisfaction having at least 6 of the 9 HCAHPS scores at the 70th percentile. (monthly score is the Rolling 12 Month aggregate)	ALL	4 = 7 and above (Exceptional) 3 = 4 to 6 (Fully Successful) 2 = 2 to 3 (Needs Improvement) 1 = 1 and below (Unsatisfactory)	25	2 of 9	2	5 of 9	3	6 of 9	3	6 of 9	3	6 of 9	3
Quality	Rolling 12 month Patient Safety Score is at or above a total score of 67% as measured by the monthly Midas VBP calculator report.	Mark, Leslie, Kelly & Robbie	4= 68% above (Exceptional) 3= 65 to 67% (Fully Successful) 2= 62 to 64% (Needs Improvement) 1= 61% or below (Unsatisfactory)	30	78	4	70	4	66	3				
People	Have at least 75% of staff participation in the annual employee partnership survey	ALL	4 = Greater than 81%(Exceptional) 3 = 75% to 81% (Fully Successful) 2 = 65% -74% (Needs Improvement) 1 = 64% or Below (Unsatisfactory)	15	100	4	100	4	100	4	100	4	100	4
Growth	Increase gross outpatient revenue by at least 3% over the prior year	Dawn, Celia, Michelle & Kelly	4 = Better than 4%; 3 = 3%; 2 = 2%; 1 = 2% or worse	5	3.2%	3	4.8%	4	5%	4	5%	4	5.2%	4
Finance	Manage year to date expenses for all departments which report to the leader at or below the flex budget.	ALL	4 = Better than 2% (Exceptional) 3 = 0% or better (Fully Successful) 2 = 1 to -5 (Needs Improvement) 1 = -6 or worse (Unsatisfactory)	15	0%	3	0%	3	0%	3	0%	3	0%	3
Community	Participate in maintaining and improving the hospital community reputation and improve the health of our community by giving at least 15 hours of service each year.	All	4 = Greater than 20 (Exceptional) 3 = 15 (Fully Successful) 2 = 10 to 14 (Needs Improvement) 1 = 9 and Below (Unsatisfactory)	10	10	2	7	4	0	4	0	4	12	4

Annual Performance Improvement Fair

WHEN: Thursday, November 17, 2016 from 8:00am to 4:30pm

WHERE: Administrative Conference Room

WHAT: Come view the innovative performance improvement projects the organization has focused on in an effort to improve the quality, safety and affordability of patient care. Each Department/Leader will have a story to tell!!

PARTICIPATE: Come and vote for your favorite in the annual People's Choice Award. Judges from the Board Quality Committee, Senior Leadership and Medical Staff will award First Prizes to Clinical and Support Services entries.