SVHCD QUALITY COMMITTEE
AGENDA
WEDNESDAY, May 24, 2017
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 Quality Committee meeting, please contact the District Clerk, Stacey Finn, at sfinn@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 • Minutes 04.26.17	*Hirsch*	Action
4. POLICY & PROCEDURES	*Lovejoy*	Action
5. HEALING AT HOME DEPARTMENT ANNUAL REPORT	*Lee*	Inform
6. QUALITY REPORT MAY 2017	*Lovejoy*	Inform/Action
7. ANNUAL PERFORMANCE IMPROVEMENT PROGRAM REVIEW	*Lovejoy*	Inform
8. UPON ADJOURNMENT OF REGULAR OPEN SESSION	*Hirsch*	
9. CLOSED SESSION: Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Lovejoy*	Action
10. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
11. ADJOURN	*Hirsch*	

3.

CONSENT

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SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
April 26, 2017, 5:00 PM
MINUTES
Schantz Conference Room

Members Present	Members Present cont.	Excused	Public/Staff
Jane Hirsch Michael Mainardi, MD Ingrid Sheets Kelsey Woodward Howard Eisenstark, MD Joshua Rymer		Susan Idell Carol Snyder Brian Sebastian MD Cathy Webber(?)	Leslie Lovejoy Mark Kobe Melissa Evans Deborah Bishop Cynthia Lawder, MD James DeMartini, MD

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	Meeting called to order at 4:58 p.m.	
2. PUBLIC COMMENT	*Hirsch*	
	No public comment.	
3. CONSENT CALENDAR	*Hirsch*	Action
• QC Minutes, 03.22.17		**MOTION:** by Mainardi to approve, 2nd by Sheets. All in favor
4. POLICY & PROCEDURES	*Lovejoy*	Action
	Dr. Mainardi questioned the reference of moderate sedation with Propofol when it is deep sedation. Mr. Kobe responded that it is moderate sedation when it is below a certain dosage.	**MOTION:** by Rymer to approve, 2nd by Mainardi. All in favor.
5. QUALITY REPORT APRIL 2017	*Lovejoy*	Inform
	Ms. Lovejoy reviewed the report. She is making an offer to a Director of Quality and Risk next week.	
6. QUALITY IN MEDICAL IMAGING	Dr. DeMartini	
	Dr. DeMartini presented an over view of California Advanced Imaging Medical Associates and the current state of imaging equipment, diagnostics being performed and future needs at SVH.	

AGENDA ITEM	DISCUSSION	ACTION
6. PATIENT CARE SERVICES DASHBAORD Q1 2017	*Kobe*	Inform
	Mr. Kobe reported on the first quarter dashboard metrics. Overall numbers look great with minor lags in only one department. Patient experiences (CAHPS) scores are not out yet. It is hoped that the recent wage increase for nursing will improve nursing turnover rates.	
7. SKILLED NURSING ANNUAL DEPARTMENT REVIEW	*Evans*	Inform
	Ms. Evans reports that the Skilled Nursing department continues to receive excellent survey results and high ratings for post-acute care. The department meets or exceeds most of its quality goals and has excellent staff and patient satisfaction scores. The continued focus will be on the national goals as well as making improvements on reducing psychotropic drug rates and reducing employee turnover. Ms. Evans said they are always working to increase the profit margin. She also reported that they are in the process of trying to retain a fulltime Medical Director to care for unassigned patients.	
ED ANNUAL REPORT	*Bishop/Lawder*	
	The volume in the Emergency Department has continued to rise over the past few years, with an average of 925 patients seen each month. Employee engagement and satisfaction are very high, but the department continues to face challenges with staff retention. Because of this consideration is being given to the implementation of a two year contract with new nursing graduates. Future plans for performance improvement in the Emergency Department are to improve patient flow, implement nursing protocols and single sign on technology, and a new patient satisfaction rating system that will provide almost immediate feedback regarding patient experience, called Rate My Hospital.	

AGENDA ITEM	DISCUSSION	ACTION
9. UPON ADJOURNMENT OF REGULAR SESSION	*Hirsch*	
	Regular session adjourned at 6:48 p.m.	
10. CLOSED SESSION • Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Hirsch*	Action
11. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
	The Medical Staff Credentialing was unanimously approved.	
12. ADJORN	*Hirsch*	
	Meeting adjourned at 6:52 p.m.	

4.

POLICIES & PROCEDURES

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

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.

Kelly Mather
Chief Executive Officer

Date

Jane Hirsch
Chair, Board of Directors

Date

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	5/16/2017	Y	
Quality Committee	5/24/2017		
Board of Directors	6/01/2017		

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

Policy Submission Summary Sheet

Ellen Shannahan, Director of Materials Management		Ken Jensen, Chief Financial Officer	
Signature: Ellen Shannahan	DATE: 5-17-17	Signature:	DATE:

ORGANIZATIONAL

REVISIONS

GL8610-152 Mercury-free Purchasing
Added reference to GL8610-166 Product Evaluation Guidelines

GL8610-166 Product Evaluation Guidelines
Added Environmental Preferred Purchasing Questions

Lynn McKissock, Director of Human Resources	
Signature: Lynn McKissock	DATE: 5/17/17

ORGANIZATIONAL

REVISIONS

HR8610-104 Classification of Employees
Revised to address employment status as it relates to overtime pay and/or benefit eligibility. Removed reference to payment practices, recording time worked and salary adjustments, which are addressed in the Compensation and Time & Attendance policies. Added language in regards to Per Diem requirements in the Nursing departments.

HR8610-155 Paid Sick Leave
Corrected references to other policies.

HR8610-156 Paid Time Off
Cleaned up general language for clarity, keeping the content focused on PTO only (removing reference to Disability hours and reference to the option of accepting or declining benefits). PTO is accrued for employees that work at a .5 or above. Added language in regards to not using PTO as a bank account. Added language in regards to an emergency PTO withdrawal, upon approval, for financial hardship/catastrophic event.

RETIRED

HR8610-167 Employee Emergency Fund

5.

HEALING AT HOME DEPARTMENT ANNUAL REPORT

Sonoma Valley Hospital
Healing At Home
2017 Annual Quality Review

Introduction and Overview: Healing At Home is a Medicare certified, state licensed Home Health Agency (HHA) which serves the hospital district and extends into the nearby communities of Santa Rosa, Petaluma, and metropolitan Marin County. As a department of the hospital, Healing At Home is governed by the Sonoma Valley Hospital District Board of Directors. Dr Streeter is the current Medical Director for the agency. Healing At Home offers the following services: Skilled Nursing; Physical, Occupational and Speech Therapy; Home Health Aide; and Medical Social Work.

Aspects of care include but are not limited to: Skilled observation and assessment; wound care; Diabetic teaching; IV therapy; ostomy care and education; catheter care; home safety assessment; gait/transfer training; activities of daily living training; counseling for long-range planning and decision making; brief therapy to facilitate coping; treatment of language and swallowing disorders; assistance with personal care; nutritional assessment and education; pain assessment and management; and palliative care.

Mission: It is the mission of Sonoma Valley Hospital Healing At Home to restore, maintain and improve the health of everyone in our community.

Vision:

We envision a Home Health Agency that is:

- Patient centered and focused on each patient's care, well being, and dignity.
- Collaborative, values-based, and multi-disciplinary with each employee held accountable to provision of high quality, evidence-based care.
- Dedicated to promotion of all levels of wellness in staff, patients, families, and caregivers.

Statistical Overview:

Staff Category	Function	Total FTE's
Management	Administers and manages agency operations, policies and procedures, QAPI, staffing, and coordination of care across the continuum.	1.0 Director
Quality Management Coordinator	Oversees department QAPI program, leads PI Projects, prepares and presents quarterly reports, performs chart audits, and educates staff in regulatory and documentation requirements.	1.0 Quality Management Coordinator (QMC)
Intake and Chart Review Nurses Lead RN Lead PT	Takes referrals, coordinates with referring sources when patients are admitted, and assists QMC with chart review. Oversees clinical care, reviews daily notes and triages patient calls.	2.2 FTE (3 RNs and 1 PT-part of her time)
Support Staff	Support staff for reception, medical	4.0 FTE: Medical Records Analyst,

	records, EMR, medical equipment and supplies, patient billing, and staff and patient scheduling.	Scheduling Coordinator, Reimbursement Specialist, and Technology/Equipment Specialist
Nursing	Skilled Nursing assessments and care, patient education, wound care, IV care, disease and medication management. Aide for personal care.	6.4 FTE (7 RN Case Managers) 4 per-diem RNs 1 per-diem Home Health Aide
Rehab	Functional and safety assessments, patient and caregiver training, speech and swallow assessments and teaching, Durable Medical Equipment assessment and recommendations, training in safe management of activities of daily living.	Physical Therapy: 3.9 FTE (5 PTs) 2 per-diem PTs Occupational Therapy: 1.8 FTE (3 OTs) Speech Therapy: 0.5 FTE (1 ST shared with SVH
Medical Social Work	Psychosocial assessments, long-term planning including Advance Directives, short term counseling, community resource assistance	Medical Social Worker: 0.6 FTE One per diem MSW

Volumes and Margins: Annual patient visits over the past 5 years have ranged from 11,046-13,460. The highest volume was in fiscal year 2014-2015 when the agency expanded regionally into Marin County and was attempting to partner with Marin General Hospital. The higher volume came with attendant higher costs due to driving time and mileage. This had an adverse effect on margins. The Home Health Financial Improvement Project recommended discontinuation of the larger geographical service area which in turn lowered volumes to the current average of 11,200.

Home Health margins have dropped from +5% to -5% over the past 2 years. The major causes are decreasing reimbursements from all payers and increased costs (primarily labor with annual salary increases). Analysis has revealed opportunities to improve the margins:

- Renegotiating insurance contract rates
- Robust and on-going utilization review to reduce skilled nursing visits/episode and increase therapy utilization to best practice benchmarks.
- Relocate home health offices to the hospital which will reduce overhead by $100,000/year (thus creating a positive margin) and improve collaboration of care.
- Appeal all insurance denials.

Quality Metrics:

Healing At Home measures the following OASIS Outcome Indicators:

- Improvement in Dyspnea
- Improvement in Transferring
- Improvement in Ambulation
- Improvement in Oral Medication Management

- Improvement in Bathing
- Improvement in Pain
- Improvement in Urinary Incontinence
- Improvement in Surgical Wounds
- Acute Care Hospitalization

Healing At Home measures the following OASIS Process Measures:

- Drug Education Provided to Patients
- Depression Risk Assessment at Admission
- Pressure Ulcer Prevention Intervention

Results/Trends/Use of Data to Improve:

See graphs for trended results from April 2016-March 2017.

The goal for all of the above measures is to be at or above the National and State Benchmarks. When these outcomes trend below the benchmarks, the agency has created PI Projects to improve the results. The most recent projects were Improvement in Dyspnea in 2015 and Improvement in Urinary Incontinence in 2016. Sustained improvement has been maintained from the Dyspnea Project. We are still working to improve Urinary Incontinence with staff education and new tools.

There was a significant downward dip in the key Patient Outcome Measures in Q2 2016 which triggered an on-going rapid cycle project to address all of these outcomes with focused review and targeted education. Our PI Project for 2017 is Improving OASIS Outcomes. It cannot be overstated how important these measures are for quality patient care as they all affect the health and safety of our patients; they are publicly reported on Home Health Compare and affect our Medicare reimbursement. This year, two nurses became certified in OASIS and will lead the staff education initiatives.

Additional Measures:

- Medication Errors: trend is that the most common error is omission
- Potentially Avoidable Events: most common is falls, unsurprising in our patient population. All falls are reported, all reports are analyzed for trends, none discernible.
- HHCAHPS: Patient Satisfaction. Goal is Overall Rating of Care >80%, currently is 87.5%

Future Quality Initiatives:

- 2017 PI Project: Improving Oasis Outcomes
- Six CE Classes annually presented by Home Health clinicians
- On-going OASIS Education by Certified OASIS Specialists, Lisa O'Hara RN QMC and Jenny Shipston RN, Intake and Chart Review Nurse
- Continued monitoring of all QC, Patient Outcome and Process Measures
- Annual review and update of department QAPI Plan

Attachments:

- Quality Assurance and Performance Improvement Plan 2017-2018
- Executive Summary 1/1/17-3/31/17
- Trended Outcomes Analysis 4/2016-3/2017
- Trended Process Measures 4/2016-3/2017

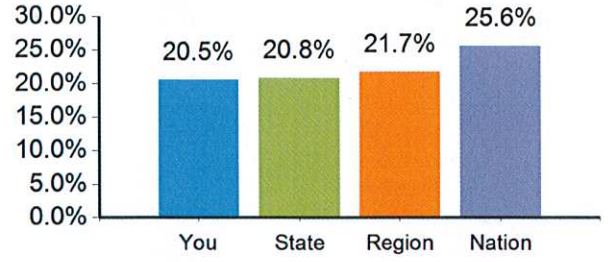
Executive Summary

Prepared for: Healing at Home (557041) **Provider Number:** 557041

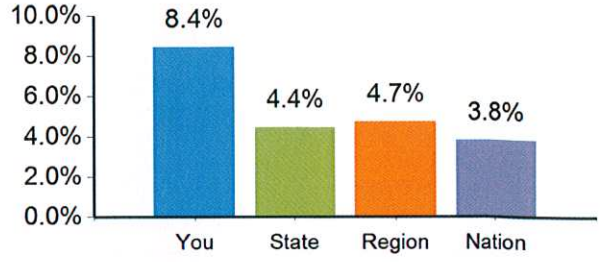
Data Represents: Ends of care between 1/1/2017 through 3/31/2017 **Branch ID:** N

Case Mix Summary	Your Score	State Norm	Regional Norm	National Norm
Average Patient Age	82	77	77	75
Percent Medicare Traditional Patients	53.2%	52.7%	55.9%	66.1%
Average SOC Case Weight	0.960	0.908	0.960	1.104
Surgical Wound at SOC	18.4%	21.1%	20.8%	21.9%
Pressure Ulcer at SOC	7.8%	6.7%	6.4%	5.5%
Stasis Ulcer at SOC	1.4%	1.9%	2.0%	1.6%
Overview of Quality Initiative Measures	**Your Score**	**State Norm**	**Regional Norm**	**National Norm**
Improvement in Pain	91.5%	74.3%	73.4%	80.7%
Improvement in Dyspnea	83.8%	77.0%	75.5%	81.4%
Improvement in Bathing	86.0%	74.6%	73.9%	79.9%
Improvement in Transferring	63.9%	66.3%	66.2%	75.5%
Improvement in Ambulation/Locomotion	78.5%	70.8%	70.3%	78.2%
Improvement in Management of Oral Meds	72.5%	60.2%	61.0%	71.9%
Improvement in Status Surgical Wound	88.9%	93.7%	93.5%	91.5%
Process of Care	**Your Score**	**State Norm**	**Regional Norm**	**National Norm**
Timely Initiation of Care	98.1%	94.9%	95.0%	95.1%
Utilization Data:	**Your Score**	**State Norm**	**Regional Norm**	**National Norm**
Skilled Nursing Visits per Case	10.5	9.6	11.6	11.9
Home Health Aide Visits per Case	0.3	0.9	1.2	1.6
All Therapy Visits per Case	6.3	6.0	8.5	10.8

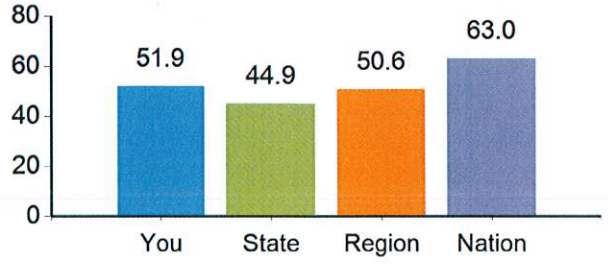
All Acute Care Hospitalization



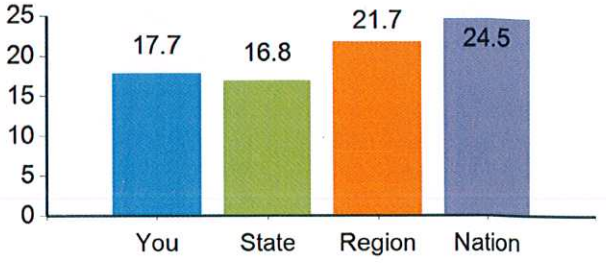
ED Care Without Hospitalization



Average Case LOS



Total Average Visits per Case



Trended Outcomes Analysis

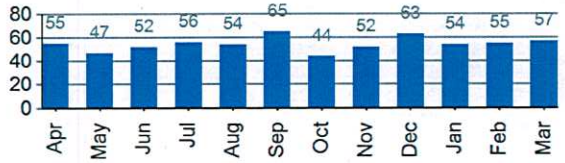
Prepared for: Healing at Home (557041)
Represents: April 2016 - March 2017

Provider Number: 557041
Branch ID: N

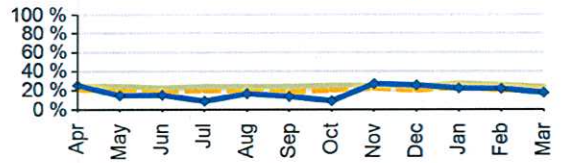
Legend: Your Agency | Your Agency | State | National

Utilization Outcomes

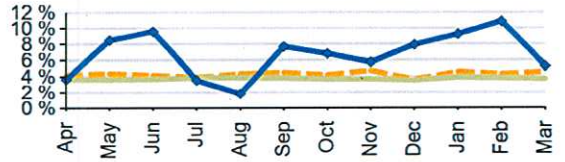
Patient Count



All Acute Care Hospitalization



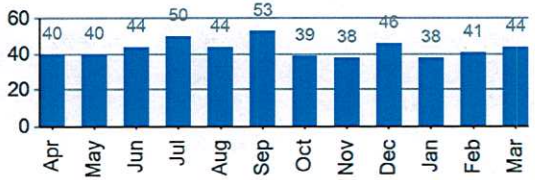
ED Care Without Hospitalization



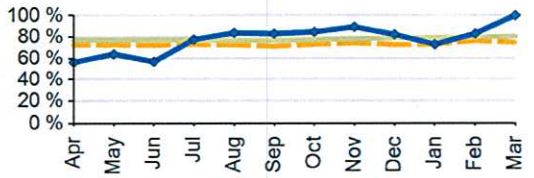
Improvement Outcomes

A missing data marker indicates that data is not available for the month

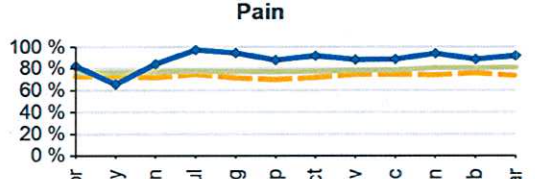
Patient Count



Bathing

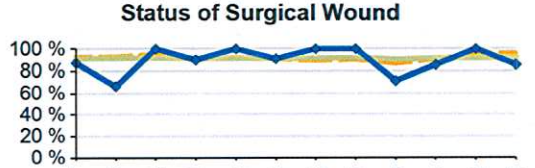


Pain

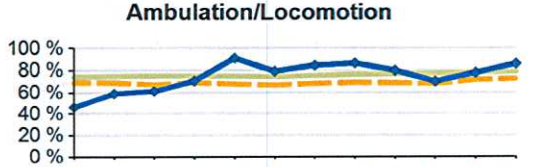


Bed Transferring

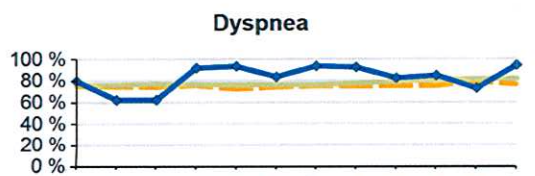
Status of Surgical Wound



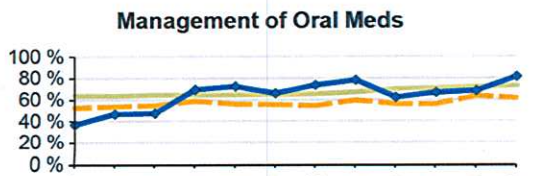
Ambulation/Locomotion



Dyspnea



Management of Oral Meds



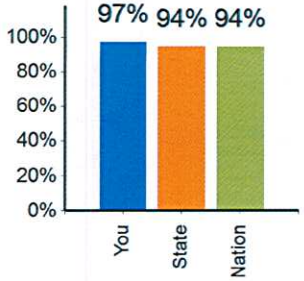
Trended Process Measures

Prepared for: Healing at Home (557041)
Represents: April 2016 - March 2017

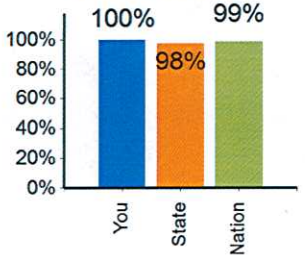
Provider Number: 557041
Branch ID: N

Measures Collected at SOC & ROC - Cumulative

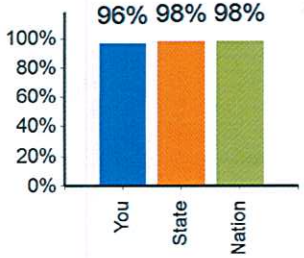
Timely Initiation of Care



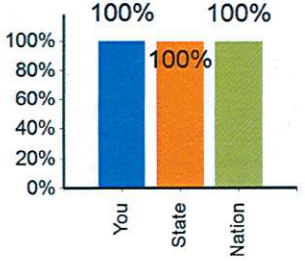
PrUlcer Prevention in Plan of Care



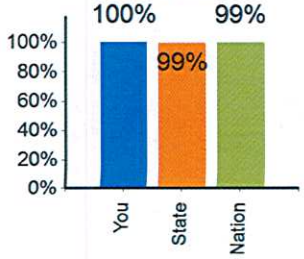
Depression Asmnt Conducted



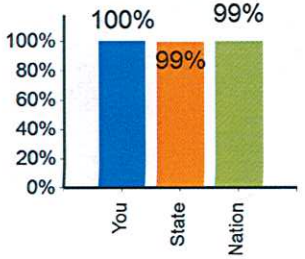
Fall Risk Asmnt Conducted



Pain Assessment Conducted

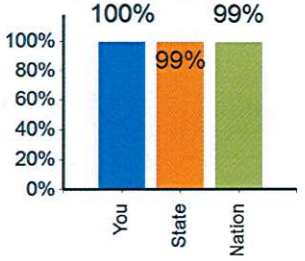


PrUlcer Risk Asmnt Conducted

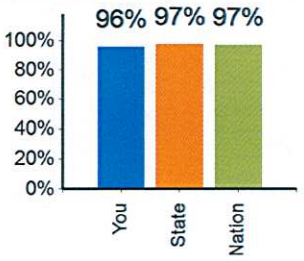


Measures Collected at Transfer & Discharge - Cumulative

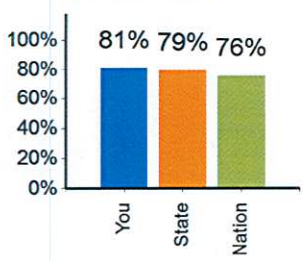
Pain Interventions Implemented



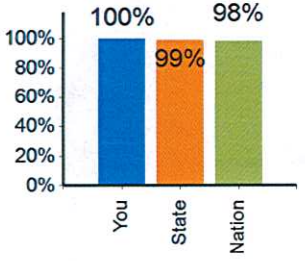
Diabetic Foot Care & Pt/CG Ed. Implemented



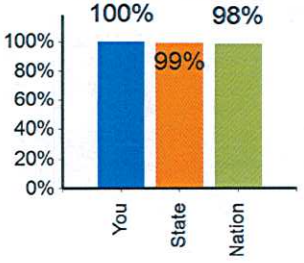
Immunization Received for Current Flu



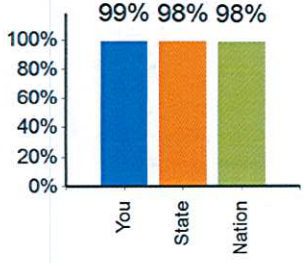
Heart Failure Symptoms Addressed



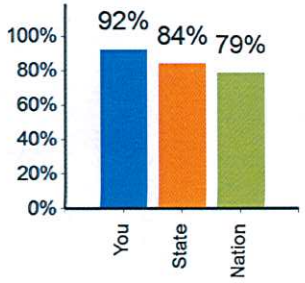
PrUlcer Prevention Implemented



Pt/CG Drug Ed. on All Meds Implemented



PPV Ever Received



Quality Assurance & Performance Improvement Plan
2017-2018

Department: Healing At Home
Customers:

Internal	**External**
Patients and their families	Regulatory Agencies
Caregivers for our patients	CAHSAH
Home Health Multidisciplinary Team	Kaiser Home Health
Physicians	Hospice Agencies
SVH Departments (e.g. Lab, HR, ED)	All Referral Sources
	County/State Agencies
	Insurance Companies

Workflow Processes:

High Risk	**High Volume**	**Low Volume**	**Problem Prone**
IV Cases	Chart review	IV Cases	Intake Process
Medication Management	OASIS Assessments	Flu Shot Process	Orientation Process
Level of Care transitions	Insurance Authorization Process	Pediatric patients	Technical problems with software, training and IT backup
Complex Wounds/High Tech Wound Therapy	Interdisciplinary Referral process	Clinical Competencies (including new equipment)	Insurance Authorization Process
HHA Supervision	Psychosocial Issues/APS Referral Process	Supra-pubic catheters	DNR/POLST process
Waived Testing	INR Monitoring	Tube feeding	OASIS Assessments
Infections (wound, IV, GU, HAIs)	Immunization Monitoring		INR Monitoring
Home Safety	Intake process		
	Patient Satisfaction		

HEALING AT HOME
SKILLED HOME HEALTH CARE
A Service of Sonoma Valley Hospital

Quality Assurance & Performance Improvement Plan
2017-2018

Definitions:

High Risk: Workflow processes that would have the greatest impact on patient safety, quality outcomes, or the ability for the department to function.

High Volume: Those activities that are done over and over that through habituation may result in a less than positive outcome or reduce the effectiveness of the workflow process.

Low Volume: Those activities that are not done frequently enough to ensure continued skill levels in performing the activity.

Problem Prone: Those activities that have an inherent risk in breaking down either due to the complexity of the process or to skill demands of the person doing the activity.

Quality Assurance/Quality Control Monitoring:

Indicator Name	**Type of Indicator: Process/Outcome**	**Goal/Threshold**	**Frequency of Monitoring**	**# of Observations**
QC Indicators • Refrigerator Temperature • Patient Supplies Outdates • Ultrasound Machines • Glucometers • Clinician Bag and Supply Check • Pulse Oximeters	**Threshold**	**100%**	3x/week Monthly Bi-Annual Annual Annual Annual	Varies monthly Monthly One/ultra-sound One/monitor One/staff One/monitor
OASIS outcome goals: Improvement in: • Dyspnea • Transferring • Ambulation	Patient Outcomes	Benchmarks: National/State • 78.0%/79.3% • 74.5%/69.1% • 76.4%/73.6%	Monthly	100% of OASIS patients

• Oral Medication • Bathing • Pain • Urinary Incontinence • Surgical Wounds • Acute Care Hospitalization (ACH)		• 67.6%/64.2% • 78.5%/76.9% • 78.2%/74.9% • 53.8%/55.6% • 91.7%/92.9% • 24.8%/20.7% (less is better for ACH)		
OASIS process goals: • Drug Education • Depression Risk Assessment • Pressure Ulcer Prevention Interventions	Process	Benchmarks: National/State • 98.1%/98.2% • 98%/97.2% • 99.2%/98.7%	Monthly	100% of OASIS patients
Medication Errors: Tracking and Reporting	Process	100%	Quarterly	100%
Potentially Avoidable Outcome Reporting	Patient Outcome	Varies by Event	Quarterly	100% OASIS patients
HHCAHPS	Patient Experience	National Benchmark: > 80%	Quarterly	Returned surveys
Home Healthcare Associated Infection	Patient Outcome	Zero	Quarterly	100% of all cultures

Quality Assurance & Performance Improvement Plan
2017-2018

Definitions:

Indicator Name:	What is the name of the process you are monitoring?
Process Indicator:	What is part of the process e.g. thawing of food
Outcome Indicator:	Is it the end product of a process e.g. documentation
Goal or Threshold:	Using a national/state or best practices standards
Frequency of Monitoring:	Daily, weekly, monthly?
# of Observations:	Do you do 100% ; 30 observations per month, what will be your sample size? Rule of thumb is if there are fewer than 30 opportunities,S:\Home Care\PI Plan 2012\Healing At Home PI Plan 2015-2016.doc do 100%, if there are more than 30 do 30 observations.

6.

QUALITY REPORT
MAY 2017

To: Sonoma Valley Healthcare District Board Quality Committee
From: Leslie Lovejoy
Date: 05/24/17
Subject: Quality and Resource Management Report

May Priorities:

1. PRIME Grant Activities
2. New Director of Quality & Risk Management
3. Medical Staff Activities

1. *Prime Grant Activities*

The Community Health Coach team met for the first time on Friday the 12th to do a bit of orientation and to set the training schedule. We are starting with four community volunteers, including Ingrid. Everyone has completed Wellness University and is ready to meet with Jenny individually for some hands on training during the next few months. We will have two more volunteers beginning in the late summer.

I have been rounding on the frontline staff to see how the new transition record process is going and have identified some educational opportunities. Jenny and I will continue to work with the frontline staff to improve the process.

2. Interviews:

I have hired a new Director of Quality and Risk Management. Her name is Danielle Jones and she comes to us from Ukiah Valley Medical Center where she has filled the position of Director of Quality and Education. She has case review for peer review experience, has coordinated accreditation activities and has a strong quality background in Lean and Human Factors Design. She will start on June 19th.

3. Medical Staff Activities:

Most of my time each month has been devoted to keeping the medical staff office activities on schedule. We have an excellent partner in Verge Solutions, the new credentialing verification organization we implemented last September. Most of the entire process is now electronic and we are starting to build the needed reports to keep us in regulatory compliance. The Medical staff chairs are doing file review and quality review on the Verge website and have indicated that they approve. We are going through some process pains as all out data is being uploaded and some physicians need a little more help with the change than others. The whole process is becoming more efficient and there are less manual tasks to be completed.

Topic: Healing at Home Department Annual Report & Annual Performance Improvement Program Review

7.

ANNUAL PERFORMANCE IMPROVEMENT PROGRAM REVIEW

Quality Assurance/Performance Improvement
Program Review 2016

Purpose

The Quality Department, in cooperation with the Medical Staff Performance Improvement Committee and 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 Sonoma Valley Hospital.

Findings

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, including considerations of risk, volume and problem proneness. Leaders have improved in their ability to write plans of corrections for deficiencies including the integration of monitoring activities as part of their departmental plans. It was also identified that we have an opportunity to improve these plans as many lack depth and quality monitoring varies from department to department. The Board Quality Committee identified a structure for annual department reports that will strengthen and deepen the thought processes involved in developing a QAPI plans and the reporting of data. This will be implemented in 2017.

The senior team performed a formal organization-wide Performance Improvement Project prioritization process that identified four projects: CALHEN Projects on Sepsis, Preventing Iatrogenic Delirium, and Reducing C. Difficile Infections; Inpatient Optimization Team, and Paragon 13 Implementation. It was decided to incorporate Paragon 13 with Paragon 14 upgrade and complete both projects in 2017. The CALHEN projects resulted in implementing evidence-based best practices in the management of sepsis, early mobilization protocols for ICU

patients and refinement of our current infection control practices. Additional projects are monitored by the Project Review Team to ensure that they are on-track, completed and retired.

The organization held its Third Annual Performance Improvement Fair to continue to improve the organization's use of performance improvement tools and to move towards data driven decision making.
There was great improvement in the quality of the projects and in the presentations. There were 10 Clinical Projects and 12 Ancillary projects submitted for the fair. The Quality Department rotated projects throughout the hospital over two weeks after the PI Fair to allow staff, physicians and community members to review them. For the first time, we invited the community to the PI Fair.

The Quality Department provided education to leadership on the topics of CIHQ standards interpretation and compliance; use of outlook tools to manage emails; and Program Beta provided a educational session on Human Factors Design. The department held drop-in Quality/ Risk Management Clinics on a monthly basis to provide coaching and provided weekly drop in sessions for leaders to become proficient in e-notification reporting and management. The CQO attended the annual CIHQ and the Hospital Quality Institute conferences and brought back best practices that are in the process of being adopted. The Quality Data Analyst attended the annual Midas conference bringing back refinements to our use of this database that have improved data gathering and reporting. An annual review of the budget for Quality, Risk Management and Patient Safety indicates adequate staffing and resources have been allocated to these functions.

This was also the year of refining and building more effective databases for reporting. With the decision to move to an outside Credentialing Verification Organization in September 2016, the department has been working to fully move all medical staff files into an electronic database. In preparation for the Care Transitions Program, the department has developed and implemented the Midas Community Case Management module. This module will allow us to track not only our health coach interactions but to also build indicators to determine if our program has made an impact. It will also allow for the department to generate focused studies and data gather the need information to meet Prime Grant performance metrics.

Data requirements increased in 2016 with the implementation of the CMS values based performance model being applied to Medi-Cal patients. Partnership Health contracted with the hospital to participate in their QIP project. Performance on key quality metrics will result in earning a certain increase in payment, however, that has not been clearly communicated. The Quality Department also provided Anthem Blue Cross with hospital data this year for their Q-HIP program and the Blue Center for Excellence for Bariatrics. We completed our action plans for Leapfrog and did our final hospital quality survey. Lastly, in a combined effort, Information systems and Quality were able to successfully send Electronic Quality Measures to CMS. This data had to be mapped to portions of the electronic record so that the data could be pulled right from the record rather than manually abstracted. There is an incentive for this coming in 2019.

Interdisciplinary collaboration was demonstrated through the Sorry Works process, Culture of Safety Program; Good Catch Program; Project Review Team, IT Steering Committee, Clinical Informatics Team; Utilization Review Program; Pharmacy and Therapeutics Committee; Grievance Committee; departmental and cross departmental performance improvement projects and organization-wide performance improvement. Increasing the meetings of the Medical Staff Performance Improvement Committee and the further development of the

Board Quality Committee Quality Scorecard allowed for more consistent and coordinated reporting of projects and mandated activities.
The Performance Improvement Program supports 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 Goals*

Performance Goal	Outcome
Provide an organized schedule of education for Leaders, Physicians and Board members to enhance skills in performance improvement with a focus on best practices to improve patient safety.	Dr. Rory Jaffee, Medical Director of CHPSO provided a talk on Patient Safety in October 2016 which was well received.
Increase frontline staff and physician involvement in performance improvement and patient safety activities. Work with physician leadership to engage in projects that make patient care processes better.	Drs Streeter, Hubbell, Sebastian all functioned as Project Champions for the CALHEN projects. Dr Verducci provided direction in the initial Care Transitions PI Grant project.
Improve quality monitoring and case identification for medical staff quality of care reviews.	We began using the Quality management module of our Midas database to track all case review activities. A monthly report of case review efforts is now routinely part of the Quality Report to the Medical Executive Committee.
Work with Information systems to develop ability to meet E Quality Measures reporting	We successfully transmitted one quarter's data to CMS electronically directly from the electronic record.
Develop a process for leadership to share the results of e-notification reporting for their department.	We developed a process that leaders can access to run monthly reports on their department's data so that they can share with their teams. What's missing is verification that it is being done. Will need to round on leaders and attend staff meetings in 2017-2018 to promote hardwiring.
Participate in CALHEN and CHPSO improvement projects and reporting for external benchmarking.	We reported data this year to both. Attached please find both reports for your review.
Develop relationship with National Registries for Orthopedics and Bariatric data sharing.	Dr. Cohen is working on this initiative and Dr. Perryman is working on the Bariatric data.
Implement PRIME Grant to improve the patient experience, reduce readmissions and decrease ED utilization.	Currently completing 2016 baseline data; have built Transition Record process; follow- up phone calls; Midas Care Transitions module developed
Complete Leapfrog Action Plan and Hospital Survey	Completed survey. Score went from D to C. Will

	not be completing the survey going forward. Score will improve organically based on improved performance on CMS indicators.
Complete Q-HIP Blue Cross Annual Quality Survey	Completed
Invite frontline staff to participate in Quality committee and share their perspective.	Did not complete; not sure if this is something the BQC wants to pursue.
Invite Quality Board members to observe in huddles and other committees.	Did not complete; not sure if this is something the BQC wants to pursue.

II. *Performance Improvement, Reportable Outcome Measures*

Hospital Compare Quality Performance Report : Overall Star Rating: 4 (22.21% of hospitals receive this rating= better than average)	Data Range:4thQ 2015-3rd Q 2016
Outpatient Measures: • Flu Vaccination of staff & MD's 86% • Median time to transfer to another facility for acute coronary intervention (rate) 166 minutes • Aspirin on arrival (95%) • Median time to ECG (3 minutes) • Median time from ED arrival to departure for ED discharged patients (150 minutes) • Median time from ED arrival to provider contact for ED patients (14 minutes) • Left without being seen (2%) • Median time to pain mgmt for long bone FX (55 minutes) • Received Head CT/MRI scan interpretation w/45 minutes of ED arrival (40%) • Appropriate F/U interval for normal colonoscopy in average risk patient (55%) • Colonoscopy interval for patients with HX of Adenomatous Polyps – avoidance of inappropriate use (91%)	Data Range: 3Q2015-2Q2016 • Needs improvement; more a documentation issue • Needs improvement, up from 56 minutes. State/National rates (70/59) • Needs improvement state/national rates are (95/96%) we are down from 100% • Better than state/national (9/7 minutes) • Needs improvement. Low volume ED sate/national rates (138/112 minutes) • Better than state/national rates of (21/19 minutes) • Same as state/national (2/2%) • Below state average but above national rate (58/52 minutes) Has improved since last report. • Below state/national (71/70 minutes), continues to be a problem. Medical Imaging and ED will take on this year as a PI project. • Below both state/national (76/80%), improved from last report and expect to see more improvement as abstraction criteria have changed. • Above both state/national (80/87%), much improved over last year due to better physician documentation and changes in abstraction.

Inpatient Measures: • Median time from ED arrival to ED departure for admission (300 mins) • Admit decision time to ED departure time (106 mins) • Influenza Immunization of patients (97%) • Elective delivery before 37 weeks (0%)	 • National Benchmark for low volume EDs is 212 minutes/State is 272 minutes. • Improved from last year's report. National benchmark for low volume EDs is 58/State is 91 • Better than State and National benchmark of 94% • Better than State and National benchmark of 2%
Thirty Day Mortality Rates for AMI, Heart Failure, Pneumonia & Stoke	No different than the national rate
Thirty Day All Cause Readmission Rate	SVH 9.4%, State & National Benchmarks 18.5%
Patient Safety Indicators Aggregate (.90)	Same as national benchmark Medicare claims data for 2015 resulted in a HAC penalty of 1% in 2017 for inpatient Medicare patient reimbursement
Values Based Purchasing Score/CMS CMS did not report in October of 2016	This process is under discussion as it may no longer relevant when they move to Electronic Quality Measures.
Leapfrog Hospital Survey and Score (C-D))	Action Plan in place; complete survey by end of June. Score moved to D in spring 2016.
HCAHPS (3 Stars: average performance; 51.58% of hospitals score here)	Rolling average score places us above State and National averages as reported by CNO

Assessment of Effectiveness

The Performance Improvement Program, in 2016, met 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 2017 that align 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.

A. Prioritized Organizational Performance Improvement Projects for 2016 include the following:

- Medication Reconciliation PI Project: this will be a 2-3 year project to improve medication histories and medication reconciliation through the continuum and then through the Care Transition process. Steering Committee: Dr. Streeter, Chris Kutza (Pharmacy), Mark Kobe, Leslie Lovejoy, Lisa Mahaffey (M/S) & Deborah Bishop (ED). Oversight will be in the Medicine Committee.

- Transition Record PI Project: this began in 2016 and will carry through 2017 until hardwired. Physician Champions: Drs Verducci/Streeter. Team: Quality, Case Management, Nurse Leaders. Oversight will be Medicine & Surgery Committees.

- CAUTI Reduction Project: to reduce urinary catheter related infections. Team: Infection Preventionist, Nursing, Medical Staff. Oversight will be the Medical Staff Performance Improvement Committee.

- OP Optimization Project: to look for opportunities to improve utilization and reduce waste on the outpatient services side of patient care delivery. Team: Chief Revenue Officer. Chief Ancillary Officer, and Outpatient Department staff and leaders.

B. Performance Improvement Infrastructure Goals:

- Assist the CEO in creating an organization-wide scorecard for monthly reporting to Medical Staff Committees and the Board.

- Work with department leaders and their staff to revise, refine and improve their department specific QAPI plans including development and reporting of meaningful quality and patient safety indicators.

- Integrate the statistical process control software (STATIT) into data mining and display for at least three Performance Improvement Projects this year.

- Define and develop the tools to build a "High Reliability" Organization.

- Provide education to frontline staff and leaders on continuous quality improvement methods.

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